NWAS Annual Report & Accounts 2022/23

Contents

Annual Report 2022/23 CEO & Chair Foreword

We're delighted to present our 22/23 Annual Report which documents our achievements, the challenges and the focus of what has been a headline grabbing year.

Ambulance services and the NHS system has been a huge focus of the media for these 12 months, as we continued to face huge demand on our services and a scale of industrial action not seen by the service in over three decades.

Despite this we have continued to move forward with improvements, and we have led regional and national efforts to improve urgent and emergency care.

We spent a great deal of time preparing our new strategy which we launched in May 2022. This was prompted following the changing landscape within the healthcare sector following the pandemic and various changes within its structure. We have seen how in recent times, our healthcare needs have changed and, as both an emergency service and an NHS trust, North West Ambulance Service (NWAS) must look to how we can adapt and improve in this new world.

Known simply as 'North West Ambulance Service Our Strategy 2022-2025' our organisational strategy provides a picture of where we are now and where we want to be in the future and sets our aims, objectives and how we will achieve them. Our strategy also defines our core purpose, shared by each of us, as well as outlining our values and behaviours that underpin everything that we do.

In this document, you will read much more about how every directorate within NWAS is working towards these new goals and how, in such a short time, so much has been achieved.

As ever, we continue to be extremely proud of the work and commitment of our staff and volunteers in striving to serve and respond to our patients to the best of their ability. We once again have welcomed BBC's 'Ambulance' to film with us towards the end of the year and so, if you have been fortunate not to need our services, you can see for yourself in 23/24 the care and compassion shown by our colleagues. We do hope you will enjoy the series.

As well as the outstanding patient care, the programme also shows the pressure our staff are under and they really are to be applauded for the way in which they manage these challenges. The workforce is the beating heart of any organisation which is why we have had a particular focus on their wellbeing in the last year, and will continue to do so moving forward.

One of the aims of our strategy is to be a ‘great place to work’ through looking after our people, investing in our people and leading our people compassionately.

Our People Plan has been updated to include new goals and ways of improving the physical and mental health of our colleagues, with a focus on recruitment and retention, developing potential so staff can enhance their learning and career opportunities, wellbeing, inclusion, leadership, innovation and improvement.

Much has been done this year make sure our service treats each person fairly based on their individual needs, as well as taking action to proactively address inequalities whether at work or in the services we offer to the public and this will continue to be a priority for us in 23/24.

One of our most significant successes this year has been the large-scale rollout, of a new triage system which brings together our 111 and 999 services into a single system. This was a complex project involving our operational and information technology teams and brings significant benefits, including consistent patient outcomes, regardless of which number they use to call us and increases opportunities for our services to work more closely together. Already used by our 111 teams, NHS Pathways is a clinical tool to assess, triage and direct patients and the public to urgent and emergency care services. This was a huge change to working practice in our emergency operations centres which required significant planning and has been warmly welcomed by our staff.

We are pleased to say that once, again, we were able to add to our ‘trophy cabinet’ with a number of awards. We firmly believe that this shows just how much our trust is a service leader in terms of evolving and setting patient care standards for others to follow.

Our Research and Development Team were recognised at the Greater Manchester Health and Care Research Awards for their collaborative work with the International Observatory on end of life care. The team worked together with Lancaster University, East Lancashire Hospitals NHS Trust and partners across the North West to adapt and evaluate a free, online training programme on advance care planning for use by healthcare providers. They took home the 'collaborative working accomplishment' award alongside being shortlisted for 'primary care or community research contribution'.

The team behind our crisis triage car was also recognised nationally by scooping an NHS Parliamentary Award for Excellence in Urgent and Emergency Care. The collaboration between Mersey Care NHS Foundation Trust, Merseyside Police, British Transport Police and ourselves is a reactive, proactive and preventative resource which provides assessment, treatment, and pathway support at the initial point of crisis.

Our commitment to become an employer of choice and to support our diverse communities was also recognised with the Employers Network for Equality & Inclusion's Gold Award for Talent, Inclusion and Diversity Evaluation in recognition of our steps and actions to

support an inclusive culture. The judges recognised us out of 155 global entries and just 13 gold award winners for our efforts.

No organisation can move forward and improve without learning and this was very much on our minds when our role in the Manchester Arena Inquiry concluded with the publication of the emergency service report in November.

Our actions on that night, alongside our emergency service colleagues, were meticulously analysed and appraised and, at a joint press conference, we fully accepted the findings made by the Inquiry Chair, Sir John Saunders.

There is more detail on this within this report, but we would like to acknowledge our gratitude for all colleagues who took the stand and gave honest and difficult accounts of the events of that tragic night in 2017. This was an incident that NWAS will never forget, it is, and always will be part of our history and the 22 victims who sadly died, will always be remembered.

As an NHS trust, we are measured against national targets – not only for our response times but also for the quality of care that we provide.

It is disappointing that we have not achieved all of these targets, mainly due to unprecedented demand in quarter three, compared to previous years, resulting from a peak in respiratory illness associated with influenza. This was further complicated by periods of industrial action in NWAS and other NHS partners.

To meet the increasing challenges we face with demand, we have expanded our workforce and looked at new ways of introducing clinicians to our frontline.

After two years of study and on-the-job learning, this year, the first 58 apprentice paramedics hit the road after graduating from their course. The apprenticeship degree began in February 2021 in partnership with Cumbria University allows our existing emergency medical technicians to build on the skills they already have and become paramedics without requiring a three-year university degree.

We've recruited 221 paramedics, including a cohort of 15 Australian newly qualified paramedics who commenced in July 2022 and have also recruited 114 emergency medical technicians.

Emergency maternity care in the North West has improved thanks to our partnership with the region's maternity and obstetric teams. Due to a dedicated emergency phone line installed in each obstetric unit across the North West, our 999 emergency call handlers can now connect directly with the midwife or doctor on duty to inform them that a critically ill patient is on the way.

We have also taken steps to play our part in preventative care. We are the first ambulance trust in the country to host public health registrars who joined us on placement from Health Education England. Two registrars have been placed with us alongside a newly recruited public health manager so that we can work together to focus on our role in tackling health inequalities and look at initiatives to reduce demand for our services. This year, they have continued to develop our social prescribing referral pathways, exploring how we can promote public health messages through our Patient Transport Service and developed several projects with our system partners focusing on ill health prevention.

All of the work we do within our communities is ably supported by an extensive network of volunteers who work with us not only on the frontline, but also behind the scenes to help shape new initiatives.

Our Public Patient Panel has proved to be invaluable and gone from strength to strength since its introduction four years ago.

Made up of representatives from local communities, interest groups, the voluntary sector and partner organisations, and offers meaningful opportunities for members to influence decisions and identify improvements in our urgent and emergency care, patient transport, NHS 111 and back office services, including hospital handover improvement collaborative events, cardiac arrest project research, palliative care research, PTS Public Health awareness project along with providing comments and feedback on the introduction of NHS Pathways into Emergency Operational Centres.

Our frontline services are also supported by volunteer car drivers who take patient transport service patients to and from hospital appointments and of course, our long-established community first responders who respond to medical emergencies in their areas.

All of these people assist us in their free time, and we are eternally grateful for all that they do for us and our patients.

We do hope you enjoy the contents of the report and reading about the many projects we have been involved and our priorities for 23/24. There is little doubt that the challenges we face will still be present, but we hope that some of the work we and our healthcare partners have done this year will reduce those and we will start seeing tangible results across the system as a whole.

All of us join the NHS because we want to help people and make a difference to their lives. We want to be a service that not only saves lives and is there for people in urgent need, but to play a part in improving the health of the region, preventing health inequalities and ensuring we represent the communities we serve so they can be assured that we have their needs at the forefront of everything we do.

Peter White
Chairman

Daren Mochrie QAM, MBA, Hon DHC, Dip IMC RCSEd, MCPara
Chief Executive

Performance Report

The trust's Performance Report has been prepared under direction issued by the Department of Health and Social Care Group Accounting Manual 2022/23 in accordance with Chapter 4A of Part 15 of the Companies Act 2006, as amended by SI 2013 No 1970. *The Companies Act 2006 (Strategic Report and Directors' Report) Regulations 2013.*

The Accountable Officer is responsible for preparing the Annual Report and Accounts and considers taken as a whole they are fair, balanced and understandable.

Daren Mochrie QAM, MBA, Hon DHC, Dip IMC RCSEd, MCPara
Chief Executive

Date: 21 June 2023

PERFORMANCE OVERVIEW

The purpose of the overview section is to provide:

- A statement from the Chief Executive Officer providing an overview of the performance of the trust during 22/23.
- A statement of the purpose and activities of the trust, including a brief description of the business model and environment, organisational structure, objectives and strategies.
- A synopsis of the performance analysis and assessment of the trust's progress towards delivering its objectives
- Details of the key issues and risks that could affect the trust in delivering its objectives and affect the trust in delivering its objectives.
- An explanation of the adoption of the going concern basis where this might be called into doubt.

Chief Executive Statement

We had to rise to so many challenges that have been thrown at us over the past year, huge service demands, significant handover delays and industrial action but throughout, I have been consistently impressed and humbled at the commitment and passion shown by all our colleagues for going above and beyond for our patients and our communities.

There was much to do to make our service sustainable over the past year, as we faced demand for ambulances and handover to hospital challenges across the region and by developing strong networks and partnerships with the new Integrated Care Boards (ICBs), we made some important steps forward.

We have also been working with colleagues in NHS England (NHSE) and the Care Quality Commission (CQC) to build strong relationships with the local regulators. We have also built on the inspection of our 111 and 999 services as part of the urgent and emergency system inspections in South Cumbria and Lancashire and Mersey North which reported out in this financial year and resulted in us retaining our overall rating of GOOD.

As demand for our services grows, so too does our need to increase frontline staffing and this has been an ongoing process throughout the year.

The 111 recruitment programme over 22/23 resulted in 240 new frontline staff being recruited and trained between April 2022 and March 2023. This was a real priority for the service as it dealt with the impact of external factors such as Covid-19 and Strep A. The high-level publicity of the outbreak of Strep A, meant a significant unplanned increase in call volume in quarter three and four with a rise in volume of over almost 36,000 more calls compared to the previous year.

Despite this, it was pleasing to see an increase against standards for 95 per cent of calls to be answered within 60 seconds, which increased from 21/22 from an average 18.75 per cent to 36.85 per cent in 22/23. Calls abandoned averaged at 23.1% in 21/22 and this year we saw this decrease to 17.5%.

The integration of both our 111 and Emergency Operational Centres (EOC) has been on our agenda for some time and great progress was made on this in 22/23.

During the unprecedented demand in quarter three, we saw delays in 999 calls being answered and subsequently delays in responses to high acuity patients and so a pilot of dual call handling was implemented. This resulted in 111 health advisors moving across to the EOC environment to answer 999 calls and mitigate the risks associated with delayed call answering.

EOC was further expanded with an additional 366 permanent staff joining the team within 22/23, with a significant reduction in the use of bank staff.

Our call centres are the gateway to our services and both the 111 and 999 numbers are often used as patients simply do not know where else to go for help. This is why the triage of calls is important so we can ensure the right response for our patient and effectively manage the resources we have.

The steps taken during 22/23 to integrate our 999 and NHS 111 call triage systems, using NHS Pathways has exceeded our year one expectations for the clinically safe signposting of patients at the time of their first call or following clinical reassessment call backs. The proportion of our 999 calls now closed with telephone advice – known as ‘Hear and Treat’ has been exceeding 15% during quarter four. This vital change in systems has very clear benefits for patients ensuring they get the right care sooner, or by freeing up ambulances which can then attend those who do need a face-to-face response.

Much of the work undertaken by our Patient Transport Service (PTS) has been in moving back to a pre-pandemic ‘business as usual’ basis. Although activity volumes were slow to recover in the early part of the year, they quickly increased from quarter three when we were at approximately 85% of pre-covid activity.

It is particularly pleasing to see how PTS has evolved in recent years. PTS changed the way in which we accept booking requests and provide transport for patients with dementia, providing safer transport in a PTS ambulance and not a taxi and we increased the number of front-line team leaders providing staff supervision.

During the challenging winter period, our PTS team provided a faster more responsive discharge service to support patient flow with, on average, 85% of discharges between December 2022 and February 2023 collected within 60 minutes.

In November last year, Volume 2, Emergency Response – an in-depth analysis into the emergency response to the Manchester Arena attach was published with 149 recommendations, with 14 of them defined as monitored recommendations for the NWAS. The trust invested in significant resources to ensure all recommendations were reviewed and action taken. This work continues through 23/24 and we remain committed to providing updates to the Inquiry panel as requested.

We have learned much during the year, and we are committed to making positive changes and continuing to improve the care we deliver. I have only briefly mentioned some of this years' developments within our operations and these, and more, are expanded upon within this document. I do hope you find it informative.

History of the Trust

North West Ambulance Service (NWAS) was established on 1 July 2006 following the merger of the Cumbria, Greater Manchester, Lancashire and Mersey Regional ambulance trusts. One of the largest ambulance trusts in England, NWAS provides services to a population of more than seven million people across approximately 5,400 square miles in the communities of Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire, and Glossop in Derbyshire.

The trust employs 7,079 staff who operate from over 100 sites across the region and provide services for patients in a combination of rural and urban communities, in coastal resorts, affluent areas and in some of the most deprived inner-city areas in the country. We also provide services to a significant transient population of tourists, students and commuters.

The North West region is one of the most culturally diverse areas in England, with over 50 different languages spoken by members of the community. Consequently, the trust places considerable emphasis on equality and diversity and public engagement activities to ensure that our services are accessible to all members of the community.

Trust Vision and Aims

At NWAS, we are connected by a shared purpose; *to help people when they need us most*. We aim to achieve the best possible physical and mental health outcomes for each person who needs us. We will provide high-quality emergency care to save lives and make a difference to people with life-threatening illnesses or injuries. For those with less serious conditions, we will tailor our response to each person's needs. This may include urgent clinical assessment, advice over the phone, referring them elsewhere or alternative transport for scheduled appointments.

Our vision, is to deliver the right care, at the right time, in the right place; every time. Each element of our vision has a clear definition;

- Right care means that we will provide outstanding care that is safe, effective and focused on the needs of the patient;
- Right time means that we will achieve all operational performance standards for our paramedic emergency service, NHS 111 and patient transport service;
- Right place means that we will provide care in the most appropriate setting for each patient's needs, taking fewer people to emergency departments by providing safe care closer to home or referring people to other health and care pathways;
- Every time means that we will provide services which are consistent, reliable and sustainable.

To deliver our vision, everyone at NWAS is expected to embody our values: “working together”, “being at our best” and “making a difference”. Our values guide the behaviours that underpin all that we do; putting our values into practice supports us to provide compassionate care and improve outcomes and experiences for our people, patients and communities.

Our 2022-2025 Trust Strategy

During 2021/22; we began an ambitious programme of work to review and rewrite the Trust Strategy and the organisation’s supporting and enabling strategies, as well as reviewing and refreshing our organisational planning processes to ensure alignment to the new strategies.

As part of the development of the Trust Strategy, extensive work was completed to understand what staff, volunteers, patients and service users felt was important for us to focus on over the next three years. This, coupled with extensive analysis of performance data from each of our service lines, informed our new trust strategy aims and objectives which were finalised and approved in May 2022.

There is still more work to do to develop supporting strategies in the areas of Quality, People, Service Development and Sustainability, which will specify our three-year measures of success. We are aiming to have a full complement of supporting strategies finalised and approved by the end of Quarter 1 of the financial year 23/24.

Aims

Our three, organisational, aims provide a framework of what we will focus on between 2022-2025, to achieve our vision:

Aim 1: Provide high quality, inclusive care
We recognise there are health differences between groups in the communities we serve. We will listen to understand and make sure our services are accessible to everyone. We will work to prevent harm while using learning and research to continuously improve patient care and experience. To achieve this aim, we must create the conditions to provide care which is:

- Safe
- Effective
- Person-centred

Aim 2: Be a brilliant place to work
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. We will be a brilliant place to work by:

- Looking after our people
- Investing in our people
- Leading our people compassionately

Aim 3: 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 find solutions which improve access, outcomes and experience for everyone. We will work together to become more sustainable and have a positive effect on our communities and environment. To deliver this aim, we will work together, internally, with partners across the North West, and with communities to work towards:

- One NWAS
- One North West
- One future

Our commitment to equality, diversity and inclusion extends beyond the lifespan of the Trust Strategy, but between 2022-2025, through delivery of our aims, we will focus on the following priorities:

- Making sure everyone who works for NWAS has fair job and career progression opportunities which will improve diversity and representation at all levels of the organisation;

- 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 people and patients;

- Using patient data and experience to drive improvements in access and health inequalities, for people from diverse communities.

Our Services:

Our core services are delivered through the following key services:

- **NHS 111** – deliver 111 services for the North West region and are major contributors to the delivery of integrated urgent care.
- **Emergency Operation Centre (EOC)** – receive and triage 999 calls from members of the public as well as other emergency services, trusts and agencies. EOC staff provide advice and dispatch an ambulance to the scene as appropriate. The clinical hub (CHUB) is based within the EOC and assesses patients via telephone and provides the most appropriate care based on that assessment, known as Hear and Treat (H&T). This may be an ambulance (either emergency or urgent care), GP referral, referral to other services or self-care.
- **Paramedic Emergency Service (PES)** – through solo responders, double crewed ambulances and volunteer community responders who provide emergency care to 999 and urgent calls for the population of the North West. Our PES service delivery is organised around three geographical areas - Cheshire and Merseyside, Cumbria and Lancashire and Greater Manchester (including Glossop in Derbyshire), thus ensuring that our services reflect local community needs.
- **Resilience** – Our Hazardous Area Response Team (HART) and resilience teams respond to major incidents to deliver the trust's statutory responsibilities as a Category 1 responder under the Civil Contingencies Act 2004.
- **Patient Transport Service (PTS)** – provides essential transport to non-emergency patients in Cumbria, Lancashire, Merseyside, and Greater Manchester, who are unable to make their own way to or from hospitals, outpatient clinics or other treatment centres.
- **Corporate Services:** As well as providing clinical services to patients, we also provide a wide array of specialist, non-clinical corporate services. These wider teams offer a unique variety of services for example; estates and facilities, communications, risk management, digital, vehicle maintenance, finance, human resources. Our corporate services support staff to deliver the highest possible quality care, be innovative, effective and responsive to each patient`s individual and specific needs.

Core service delivery is supported by a number of support service functions:

Ambulance Response Programme

The Ambulance Response Programme (ARP) is a framework for ambulance trusts to deliver its service meeting the needs of its patients. The fundamental underpinning principle of ARP is to use the right resource at the right time in the right place, all in line with our strategic aim. The delivery of ARP standards throughout 22/23 continued to be challenging, particularly during Q3 22/23, with recovery of performance during Q4 22/23.

Statutory & Regulatory Financial Duties

We are required to achieve a number of statutory and regulatory financial duties. These are:

- Statutory duty to break even year on year and a regulatory duty to break even each and every year.
- Regulatory duty not to exceed the External Financing Limit set by the Department of Health.
- Regulatory duty to contain capital expenditure, on an accruals basis, within approved Capital Resource Limits.
- Regulatory requirement to achieve the Capital Cost Absorption Duty.
- Regulatory duty to apply the Better Payment Practice Code.

In 22/23, we achieved all of these duties.

In 22/23 our income was £479.483 million and was generated from the following activities:

Income from Activities	**2022/23**
	£000
PES Income	361.446
PTS Income	45.823
111	32.521
Other Income	39.693
Total Income	**479.483**

Key Risks to Delivering Objectives

22/23 Strategic Risks

The key risks for the trust as we moved into 22/23 focused on patient safety, financial effectiveness and value for money, operational performance and workforce recruitment and retention.

The following list identifies the risks for 22/23:

1. There is a risk that we may not deliver safe, effective, and patient centred care leading to avoidable harm, poorer outcomes, and reduction in patient satisfaction.
2. There is a risk that we cannot achieve financial sustainability impacting on our ability to deliver safe and effective services.
3. There is a risk that we do not deliver improved national and local operational performance standards resulting in delayed care.
4. There is a risk that we will be unable to attract or retain sufficient suitably qualified staff and maintain low abstraction levels, which may impact on our ability to

maintain safe staffing levels.
5. There is a risk that sufficient progress is not made in developing a compassionate, inclusive, and supportive culture, impacting adversely on staff wellbeing and engagement, resulting in poor quality services, staff harm and reduced productivity.
6. There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action.
7. There is a risk that the proposed changes to legislation reduces our ability to engage effectively and influence across all the ICS within its regional footprint.
8. There is a risk that enactment of the proposed legislative changes in 2022 could impact on our current regional footprint.
9. There is a risk that due to persistent attempts and/or human error, we may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm.
10. There is a risk that we continue to attract negative media attention arising from long delays and harm, combined with potential criticism from the Manchester Arena Inquiry report, which may lead to significant loss of public confidence.
11. There is a risk of the loss of one or more of the PTS contracts due to the current contract ceasing in March 2023 and the service being put out to competitive tender, which may lead to significant loss of income and achievements of our strategic objectives.

During the second quarter of 22/23, a further strategic risk was identified:

12. There is a risk that the current contract for the 111 service ceases in September 2023 and us being unaware of the Commissioners' intentions may impact on the achievement of our strategic objectives.

Future 23/24 Strategic Risks

Our key risks as we move into the new financial year remain focused surrounding quality and patient safety, financial sustainability, operational performance, workforce, and cyber security.

The following list denotes the risks identified for 23/24:

1. There is a risk that we do not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction.
2. There is a risk that we cannot achieve financial sustainability impacting on our ability to deliver high quality (safe and effective) services.
3. There is a risk that we do not deliver improved national and local operational performance standards resulting in delayed care.
4. There is a risk that we will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualifies staff

impacting adversely on delivery of performance standards and patient outcomes.
5. There is a risk that we do not deliver our People Strategy to improve culture and staff engagement, this may impact on us being a brilliant place to work.
6. There is a risk that non-compliance with legislative and regulator standards could result in harm and/or regulatory enforcement action.
7. There is a risk that we do 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.
8. There is a risk that we suffer 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.
9. There is a risk that we continue to attract negative media attention arising from long delays and harm leading to significant loss of public confidence.
10. There is a risk that the level of uncertainty and unpredictability both nationally and regionally impacts on, or results in, delayed achievement of our strategic priorities and objectives.

Going Concern

After making enquiries, the Board of Directors have a reasonable expectation that the services provided by North West Ambulance Service NHS Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual. Detailed guidance in respect of going concern is set out in International Accounting Standard (IAS1) and the interpretation for the Public Sector context is set out in the Financial Reporting Manual (FREM) and the Department of Health and Social Care Group Accounting Manual (GAM) 22/23. The trust's Letter of Representation for 22/23 to Mazars LLP as external auditors refers to NWAS preparing its accounts on a going concern basis.

Working with ICSs and Partners

This year a strategic focus for us has been the opportunity to work in partnership with the Integrated Care Systems (ICS) and newly formed Integrated Care Boards (ICB) to support the delivery of urgent and emergency care pathways and public/population health agendas. From 1 July 2022, Integrated Care Boards became statutory bodies under the Health and Care Act 2022. ICSs have brought together commissioners of NHS services with health and care providers and other partners who work together to deliver services which meet the needs of specific populations.

ICSs share four goals: working together and supporting integration, reducing bureaucracy, improving public confidence and accountability, and supporting public health, social care,

quality and safety. We are the only regional NHS organisation in the North West that operates across five ICSs:

- Lancashire & South Cumbria Health & Care Partnership
- Cheshire & Merseyside Health & Care Partnership
- Greater Manchester Health & Social Care Partnership
- North East & North Cumbria ICS
- Joined Up Care Derbyshire (which includes Glossop)

While there are challenges with working across many ICS areas, we have gained experience as a key partner within the Urgent and Emergency Care (UEC) system. We deliver UEC services across a large area and have valuable data and insight which helps to identify opportunities for improvement, share learning and best practice. The future of integration needs health and care providers to work together and with patients to design services around people's needs, with a focus on preventing serious health problems and reducing health inequalities. We have an opportunity to work together within our ICSs to support this work and help people when they need us most.

In order to fully participate and be engaged with stakeholders, we have continued to progress system collaboration in achieving shared goals, enhancing NWAS' role as a proactive, trusted partner. We have further developed arrangements with partners that will support system working going forward and enable us to engage effectively and efficiently with partners to ensure a common working together approach.

The capital resource of the trust is managed as part of the overall capital envelope of the Lancashire and South Cumbria ICB. We have managed agreed capital resource of £26,472k with spend for the year within this capital limit.

Our Partnerships and Integration Team works across the ICSs that are taking shape across the region, building effective and efficient stakeholder relationships, ensuring a working together approach between ourselves and all external stakeholders and partners, across traditional and new objectives. The team works with internal directorates and external partners, supporting the stronger emphasis on integrated care which is focused on local places, populations and systems. A lead Partnerships and Integration Manager (PIM) is in place for each ICS area, alongside NWAS' cross directorate senior leadership teams and executive lead.

PERFORMANCE ANALYSIS

Paramedic Emergency Service (PES)

For the financial year 22/23 our Paramedic Emergency Service (PES) has experienced variance in terms of demand and operational challenges throughout the year. Within the Q1 period abstractions remained high due to the ongoing challenge of the COVID-19 pandemic. Q2 and Q3 saw a reduction in abstractions set against an increase in demand into the 999 service. Q4 presented a differing challenge due to industrial action, with acute workforce pressures observed on the days of action. This pressure was however offset by a stepped reduction in demand into the service, which commenced mid-January 2023 and remained in place until early March.

The secondary factor that influenced demand and the proportions of response standards (C1 to C5) was the introduction of NHS Pathways (NHSP) triage system. The NHSP programme will be described in greater detail within the contact centre element of the annual report but understanding the timeline of roll out is an essential factor when appraising ARP outputs such as percentage of incidents within a category of response of non-conveyance measures such as Hear and Treat (H&T). NHSP went live in March 2022 for the Cumbria and Lancashire area of NWAS, with Greater Manchester and Cheshire and Mersey live late July 2023, early August 2023.

Demand is best appraised by the volume of calls received via the 999 service as opposed to incident count. Incident count is influenced by the capacity of the organisation to respond, alongside demand mitigation such as estimated time of arrival scripts and signposting of patients post primary triage. Call volume for the year was broadly equitable to the previous financial year however was influenced by a stepped decrease in call volume for Q4. Daily call volumes for Q2 and Q3 were above the previous financial year and this created significant challenges for the organisation and sector overall.

As already referenced NHSP has positively influenced the proportion of high acuity ARP responses by reducing the proportion of C1 and to a lesser extent C2. This was an anticipated benefit but the effect can only truly be observed post full implementation (end of Q2) and contextualised against the seasonal trend of higher acuity need in the winter periods of Q3/4. The overall annual position for proportion of C1 responses declined significantly compared to 21/22. This is due to the effect of NHSP and the benefit is more evident when appraised against the Q4 position in isolation. The proportion of C2 remained equivalent to 21/22 with the decrease in C1 offset by increased C3 for 22/23.

Non conveyance outputs, specifically H&T again have been influenced by the introduction of NHSP. Post full roll out of NHSP (Q3 and Q4) H&T has maintained a position of over 15%, with the rates of H&T improving by quarter throughout the year. This will be covered in greater detail within the contact centre section but the primary influencing factor is the

introduction of H&T streaming occurring via the call handling workforce within the Emergency Operations Centre (EOC).

In order to appraise the ARP response it is essential to review the impact of extended job cycle times experienced throughout the year, most acutely within Q3. The most significant influencing factor being hospital turnaround time. Turnaround has followed a similar trend to call volume. Q1 did see increases to turnaround times vs 21/22 but Q2/3 saw significant increases to average turnaround. This peaked in December 2022 where average turnaround almost reached an hour (set against the 30-minute standard). This increase had a significant effect on operational capacity and our ability to respond within standard. During Q4 there was a stepped improvement to turnaround however remained above the 30 minute standard.

The table below reflects the Trusts response standards for the year broken down by quarter. ARP standards have been in place since 2017 and are designed to reflect the urgency and acuity of a patient. Category 1 are calls from patients with life threatening illness or injuries. Category 2 are emergency calls, Category 3 are urgent calls and Category 4 are none urgent calls.

	Standard	**7 mins**	**15 mins**	**18mins**	**40 mins**	**120 mins**	**180 mins**
2022/23	Fiscal Quarter of Year	C1 mean	C1 90th	C2 mean	C2 90th	C3 90th	C4 90th
2022/23	Q1	00:08:14	00:14:01	00:40:09	01:29:18	07:15:31	11:46:07
2022/23	Q2	00:08:27	00:14:28	00:41:41	01:33:38	08:03:43	09:57:53
2022/23	Q3	00:09:25	00:16:03	00:58:12	02:09:09	10:36:47	12:40:03
2022/23	Q4	00:08:17	00:14:06	00:27:50	00:58:18	04:33:48	06:29:01

We have achieved one of the ARP standards for the year C1 90th response. The ARP performance outputs by quarter reflect the variation in demand and response capacity. Q2 and Q3 were especially challenging due to increased call volume and job cycle (hospital turnaround).

The sustained pressure through the year (Q1-3) was reflected by our Resource Escalation Plan (REAP). REAP provides a framework to maintain an effective and safe operational and clinical response to patients. REAP has four levels, level one and two being 'normal state' rising to level four which indicates significant risk to service delivery. As we escalate REAP levels, additional actions will be put in place. These vary but are often designed to maximise operational resources. Through the first three quarters of the year NWAS has operated primarily at the highest level at REAP 4. REAP has only consistently deescalated in the later part of Q4. REAP ensures actions are taken across the trust to increase operational resources to support the extreme pressures. This response has been balanced against the need to deliver regulatory compliance and workforce indicators

(mandatory training and appraisals). It is unusual to operate at REAP 4 for such sustained periods and the balance of response to compliance has been complex.

We aspire to meet all operational standards but will retain the greatest focus on the highest acuity patient needs. The achievement of C1 90th is a reflection of this response and approach. The variation by quarter of response times within the C2 category is the most significant concern and area of focus. As more than 60% of all face to face responses sit within C2, the extended responses times within this category have a direct impact on our response times to C3 (urgent) and C4 (non urgent).

At times of extreme pressure, we mitigate delayed response by increasing clinical oversight within the EOC environment. A range of teams and systems are in place. The Clinical Coordination desk (CCD), Complex Incident HUB (CIH) and our Clinical HUB (CHUB) are key to this clinical oversight. The CCD is resourced by senior clinicians who maintain oversight of waiting patients, providing a range of interventions such as clinical call backs, clinical review and immediate allocation of operational resources. The improved position throughout the year in respect to H&T, also supports response standards by appropriately reducing the volume of patients who require an ambulatory response.

The outputs from Q4 provide strong evidence that as demand (call volume) reduces, operational resources improve. The reduced abstractions and hospital pressures significantly improve the organisations response standards. With NHSP being fully embedded, it is anticipated that C1/2 responses will maintain the Q4 position, supported by clinically safe high rates of H&T and we will then be in a better position to deliver on a greater number of standards. Focus under the UEC recovery plan for 23/24 will be on C2 mean response, increasing H&T further and increasing operational resource.

North West 111 Service

NHS 111 call demand continued to be consistent over the year however, there have been periods of volatility based on external factors. (eg. COVID /Strep A).

The high-level publicity of the outbreak of Strep A, meant a significant unplanned increase in call volume in Q3/Q4, seeing a rise in volume of over almost 36,000 more calls in Q3/Q4 than the previous year. The recruitment programme during 22/23 continued to be extensive, with 240 new frontline staff recruited and trained between April 2022 and March 2023.

The NHS 111 service is performance managed against a range of KPIs, the five KPIs below are accepted as common ‘currency’ and are reported by each NHS 111 provider service across England.

Overall 2022/23 Performance

The Key Performance Indicator (KPI) for calls answered is 95% within 60 seconds, this increased from the average 18.75% in 2021/22 to 36.85% during 2022/23.

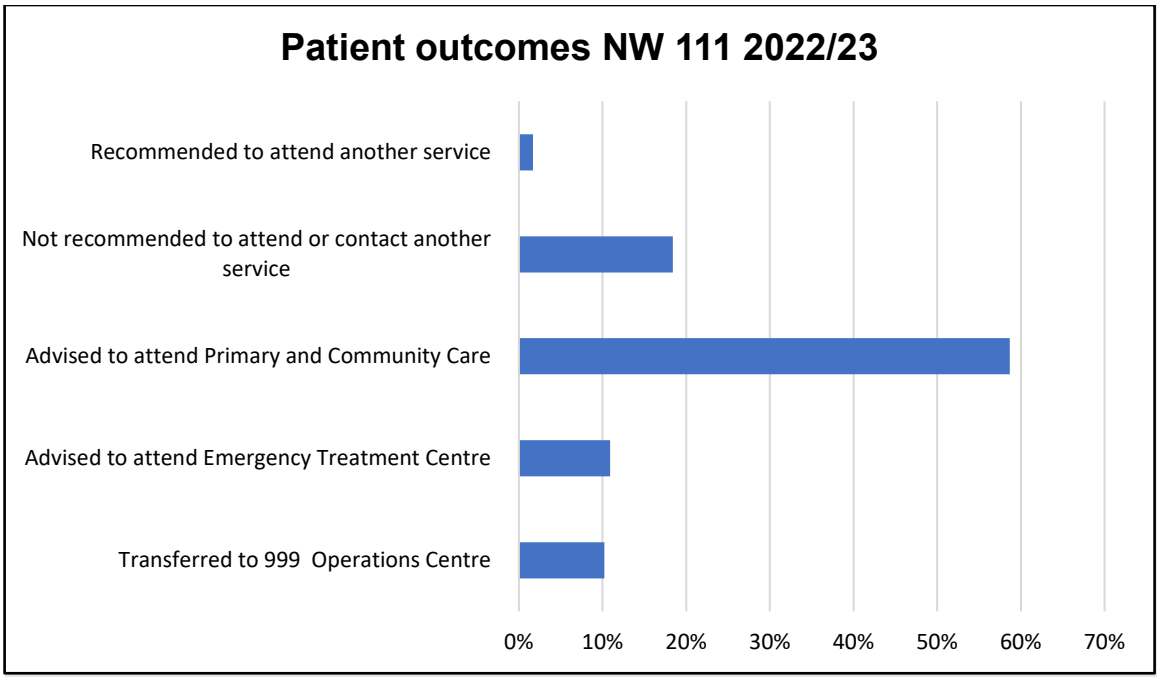
The KPI for calls abandoned is <5% which averaged at 23.1% during 2021/2022 however 2022/23 saw this decrease to 17.5%.

Description	Target	Year	Q1	Q2	Q3	Q4
Calls abandoned	<5%	2021/22	14.21%	27.61%	28.07%	22.54%
		2022/23	18.84%	10.53%	28.38%	17.25%
Calls answered in 60 seconds	95%	2021/22	47.52%	28.45%	29.32%	33.84%
		2022/23	34.90%	51.40%	32.20%	28.90%
Calls warm transferred	75%	2021/22	19.23%	15.08%	12.54%	12.16%
		2022/23	15.80%	17.20%	10.60%	22.00%
Call backs within 10 minutes	75%	2021/22	5.49%	4.87%	4.71%	6.49%
		2022/23	7.40%	9.70%	7.60%	8.80%
Calls Offered		2021/22	710638	703167	719285	583475
		2022/23	612253	545863	727214	611481
Calls Answered		2021/22	558347	459831	458890	395970
		2022/23	454842	441242	453204	396096

Triage outcomes

Patient outcomes during 22/23 for NHS 111 are detailed within the graph below. 111 continues to support the wider NHS system by ensuring only clinically appropriate patients access Emergency Treatment Centres (ETC) and ambulatory response.

For ETC attendance, 11% of patients will receive a triage outcome due to attendance to an Emergency Department (ED). Due to existence of Clinical Assessment Service (CAS) schemes only half of the 11% of patients are signposted to ED. When 999 referrals are included, only around 16% of all patients triaged are advised to attend ETC or referred to the 999 service. The vast majority of patients are referred to primary care (59%) or another service (2%), with the remaining 18% advised not to attend another NHS service and receive self-care/home management advice.


Patient outcomes NW 111 2022/23
Recommended to attend another service
Not recommended to attend or contact another service
Advised to attend Primary and Community Care
Advised to attend Emergency Treatment Centre
Transferred to 999 Operations Centre
0%
10%
20%
30%
40%
50%
60%
70%

PARAMEDIC EMERGENCY SERVICE (999)

Since the summer of 2022, work has been underway to progress the PES frontline leadership review. This involved a number of listening events, engaging with current frontline leaders, to understand what currently works, what needs improving in any future leadership model, and how the roles come together to achieve the aims of the organisation. This has allowed the development of a draft new structure which, after further refinement, will be implemented in 2023. It is hoped that the new frontline leadership model will help improve staff engagement, will provide an enhanced response to complex and significant incidents, and will bring more focus on quality and clinical aspects of performance.

The Fylde sector moved a step closer to the hub and spoke model with the opening of Blackpool Hub. The staff from Blackpool station moved into the hub in February 2023 and the crews from the surrounding stations joined them throughout March 2023. Spoke locations are being brought online as standby points for crews, allowing them to start and finish their shift at the hub station, but head out to locations across the Fylde to standby and wait for emergency calls. The new model means that all the PES staff in the sector are under one roof along with the operational and clinical leadership teams. The hub also has a training room to allow local update training to be undertaken, and a welfare room with gym equipment to help staff stay fit.

There has been significant focus from the PES team in maintaining resourcing over the winter and during the periods of industrial action. The leadership team worked to make sure that during periods of peak demand, or reduced staffing, resources were available to respond to the sickest patients in a timely manner. This included profiling additional resources for key times, working closely with the acute hospitals to reduce handover delays, and increasing our PES workforce headcount across the region.

The development of alternatives to ED attendance has seen us refer more patients into pathways than ever before, reducing the number of patients being conveyed to emergency departments. The use of Same Day Emergency Care (SDEC) units, Urgent Community Response (UCR) pathways, and Urgent Treatment Centres (UTCs) mean more patients receive the care they need in homely settings, or closer to home, and avoid having to wait to be seen in an emergency department.

Community First Responders (CFRs)

Community First Responders are volunteers who are trained and activated by the trust to attend a range of emergency calls, where a time critical response can make a difference to patient care and outcome.

The responder provides care and support to the patient until the arrival of an emergency ambulance. Quite often, the role of a responder is one of reassurance and, in some instances, for example when a patient has chest pains, simply giving oxygen can make a big difference. However, in extreme cases, the CFR can perform cardio-pulmonary resuscitation (CPR) or use a defibrillator to restart the heart. Chances of survival decrease by 10% with each minute that a person's heart has stopped beating, and CFR availability in the local area can result in a quick response to ensure that treatment is started as early as possible, we currently have a bystander CPR rate of 83% and this treatment helps support the patient in the first minutes of an out of hospital cardiac arrest (OHCA) occurring.

We have continued to support, and proactively engage with communities, organisations, and individuals with the placement of automated external defibrillators (AEDs). These life saving devices are a vital part in increasing the chances of survival from a person suffering an OHCA. Within NWAS, we have over 6,880 community public access defibrillators, which are devices that are available 24 hours a day, seven days a week. These are placed in locked, heated, and coded boxes and members of the public can be directed to them in an emergency and instructed how to use them via the emergency call taker. In addition to these devices, there are a further 6,809 defibrillators registered with NWAS that are in numerous buildings and are accessible if required. These buildings range from leisure centres, shopping centres, supermarkets, healthcare setting, schools etc.

We continue to work with the British Heart Foundation to embed the National Defibrillator Network known as ‘The Circuit’. This is a publicly accessible web-based system that allows direct registration of any accessible AED, and then it is directed to the appropriate ambulance trust and allows for the emergency call takers to direct callers to them.

As we have emerged from the pandemic, our CFRs have provided an estimated 13,296 hours of support both to NWAS and the communities of the North West. We have continued to provide support to them post incident to ensure their wellbeing, and to ensure their education is kept in line with the requirement of the NHS. All our volunteers are enrolled in statutory learning to ensure the care we deliver is of the highest standard.

In addition to this vital support many other tasks were supported by our volunteers, below outlines a snapshot of these:

Crewed welfare vehicles – located at the numerous emergency department’s to allow crews access to refreshments. This provision meant operational staff where able to take much needed welfare breaks during the unprecedented winter period faced by the NHS. This was a new volunteer role within the trust and brought about a new way to allow volunteering for members of the public who did not want the traditional CFR elements. Since the vehicles were introduced, volunteers have given over 6,485 hours of time to

this role on 917 different duties. The feedback from both crews and volunteers has shown how the interaction benefitted all parties.

Enhanced level of knowledge to responders – to allow them to attend lower acuity emergencies and have clinical support available to see if an emergency ambulance was required for the patient. This has ensured we are able to prevent patients who may not of suffered an injury waiting a prolonged period.

As we move forward, we are introducing a new digital way to mobilise CFRs across the region, bringing in new technology based on a smart phone application. This will enhance our communication capabilities between our responders and emergency operations centre, and benefit both patients and responder welfare.

Membership of a Community First Responder scheme is incredibly rewarding, and volunteers could be involved in saving someone's life. Anyone who lives or works in the North West can get involved with their local CFR scheme, by either becoming a First Responder or helping with other vital tasks such as fund-raising, support or administration. Volunteers do not need previous first aid experience to join their local group, as full training will be provided. Further details on Community First Responder schemes are available at https://www.nwascfr.com

CONTACT CENTRES

During 22/23 the EOC/CHUB and 111 services began to integrate, with the long-term goal being full integration of the respective services line into our Integrated Contact Centres. The primary focus for this year has been to integrate governance and senior leadership reporting under the integrated contact centre director.

The primary enabler to integration has been the introduction of NHSP within the EOC environment. The programme to move from MPDS triage tool to NHSP has been our long-standing strategic ambition, which was fully realised during 22/23. With both service lines operating on the same primary triage tool, there is greater scope to integrate front line and management roles and this will be the strategic focus for 23/24. The move to NHSP provides a number of key benefits for contact centres and for ARP performance. In terms of contact centres these benefits include;

- Patients now receive the outcome, treatment or referral appropriate to their clinical need irrespective of the number dialled (ie., 111 or 999).
- Enhanced and closer working of the respective service lines.
- Integration of clinical and leadership governance and structures.
- Ability to flex workforce across the respective service lines to meet peaks in demand and operational pressures.

The contact centres have commenced this journey and already utilise these benefits. As an example, during Q3, the demand faced by the 999 element of the service continued to increase, creating delays in calls being answered and our response to high acuity patients. We implemented a pilot of dual call handling which resulted in 111 health advisors moving across to the EOC environment to answer 999 calls and mitigate the risks associated with delayed call answering.

In terms of the benefits of NHSP in respect to ARP response, the programme has delivered on these from the outset of go live.

These benefits include:

Reduction in proportion of C1 and C2 incidents – Q4 data 22/23 reflects a C1 percentage of incidents at 9.43% against a 21/22 annual position of 13.71% (a reduction of 31%). This is due to the triage mechanism and application of NHSP.

Increase to Hear and Treat – NHSP provides a level of H&T via the call handlers within the EOC (EMAs). The previous triage tool MPDS did not provide this. Around 5% of all call triaged via NHSP result in a call handler H&T where the patient is referred via the Directory of Service to the appropriate care setting (often primary care, UTC or ED).

Overall the programme outlined 25 strategic benefits (five of which are long term benefits relating to integration of the service lines). Of the 20 benefits directly resulting from the programme, 19 have been realised and evidenced.

In addition to this programme and performance outputs previously described, both service lines have continued to innovate to enhance patient care and safety, staff experience and via system development.

111 Highlights include;

- Provision of care advice via SMS text messaging. This innovation was first of type for any 111 service. The system provides patients with clinical advice via text and reduces average handling time (AHT) by around 29% (compared to calls with no SMS). This improves patient experience and increases call handling capacity.
- Visual IVR. This technical innovation enables patients to provide their demographic details whilst waiting to be answered. The system automatically populates this information and is available at the point of the call being answered. This reduces triage times and reduces duplication of questioning.
- Improvements to patient location services via utilisation of address systems such as 'What Three Words'.
- Health Advisor Hybrid working – this pilot provides health advisors with the opportunity to work from home. It is believed long term this innovation will be an enabler to recruitment and retention.
- Booking and Referral Standards (BaRS). NWAS for both 111 and 999 have delivered the first of type for BaRS. BaRS enables two way system messaging, reducing duplication and improving patient safety and experience.

Alongside system improvements a significant focus for 111 has been on staff welfare and wellbeing. These include;

- 111 SharePoint site – now OneSpace: The SharePoint site was recently rebranded as "OneSpace". This rebranding has given the site a clear identity and separates it from the multiple other SharePoint sites now being used across 111 and NWAS. The site is extremely well used, with consistent hits in excess of 20,000 a month from over 700 individual users.
- 111 Champions have continued to support the health and wellbeing of the call centre staff, being recognised by being awarded the making a difference award in our staff awards. They continue to organise health and wellbeing events to encourage good health and support to each other and are a positive influence within the contact centres.
- Employee of the month has been introduced to help recognise excellence within the call centre.
- Introduction of TRIM assessors
- Welfare aux code introduced for support following traumatic or upsetting calls.

- Rota review

EOC/CHUB Highlights

In response to the challenges associated with response and long waits, we have continued to invest within EOC and CHUB. The investment has been across the service line and was supported via COVID and winter funding.

From a call handling perspective, focus post NHSP go live has been on increasing the call handling establishment to ensure high levels of call answering performance / patient access. This is evidenced through Q4 call handling performance.

NWAS also continued to enhance patient safety and clinical leadership across our contact centres. The CHUB has increased their workforce position delivering increased H&T and greater capacity to support the CCD in long wait review of patients.

Other summary highlights EOC/CHUB include;

- Integration of the Regional Trauma Cell, into the Complex Incident Hub, giving a better process of managing and deploying our specialist resources, and having an increased situational awareness of developing incidents across the whole NWAS footprint.
- The CCD has seen an increase and development in its function and ability to manage the developing risks of the long waits and crew support.
- Introduction of the direct to dispatch recruitment, the benefit of this is we are not pulling from our emergency medical advisor (EMA) cohort, ensuring we maintain experience and do not dilute this within the EMA suite, this also means we are bringing in a whole new cross section of knowledge and experience into dispatch.
- Auditing of dispatch has been ongoing for a number of months now; these are reported to the Quality Business Group (QBG) and Regional Clinical Quality Assurance Committee (RCQAC) and has shown 95% compliance in Category 1 and March was the first month we have undertaken the Category 2 dispatch auditing.
- Our Service Centre has seen the move to Cleric for safeguarding and falls referrals, we have seen the training for our team in Carlisle to operate Cleric, leading to a more robust system of escalating high-risk patients within those categories to the relevant service.
- Within the Clinical Hub, the team are continuing to develop ITKs for the EMAs in terms of falls referrals, we are in the final stages of implanting BarS within the GM Area. The team has also trained 18 ‘train the trainers’ drawn from our operational colleagues, who will now cascade this knowledge to colleagues, giving more flexibility for the sectors to manage their own waiting stacks. The PaCCS training is also continuing to roll out within the clinical hub, with a number of clinicians trained and we are looking to increase this throughout the Q1/2 period.

PATIENT TRANSPORT SERVICE (PTS)

Much of 22/23 was influenced by the latter part of the COVID-19 pandemic, with the service gradually transitioning into a recovery phase. Although activity volumes were slow to recover in the early part of the year, they quickly picked up pace as the year progressed. Overall activity during the month of March 2023 was 8% below contract baseline whilst the cumulative 12-month position is 17% below baseline, as shown in the table below.

For the full 22/23 financial year, Cumbria is 30% below baseline, Greater Manchester is 5% below baseline, Lancashire is 29% below baseline and Merseyside is 7% below baseline.

As the PTS contract(s) commenced in July 2016, the 'contract year' runs from July to June the following year. As we are required to report against the contract year, the chart below shows the position for the financial year as well as the PTS contract year to date.

PTS Activity for financial year April 2022 – March 23 and contract year-to-date July 2022 – March 2023

NORTH WEST AMBULANCE PTS ACTIVITY SUMMARY									
Contract	Annual Baseline	Financial Year 01/04/2022 - 31/03/2023				Contract Year 01/07/2022 - 31/03/2023			
		Baseline	Activity	Activity Variance	Activity Variance (%)	Baseline	Activity	Activity Variance	Activity Variance (%)
Cumbria	168,290	168,290	117,480	(50,810)	(30%)	126,218	87,843	(38,375)	(30%)
Greater Manchester	526,588	526,588	498,341	(28,247)	(5%)	394,941	375,290	(19,651)	(5%)
Lancashire	589,181	589,181	416,646	(172,535)	(29%)	441,886	311,209	(130,676)	(30%)
Merseyside	300,123	300,123	278,643	(21,480)	(7%)	225,092	209,951	(15,141)	(7%)
Grand Total	1,584,182	1,584,182	1,311,110	(273,072)	(17%)	1,188,137	984,293	(203,843)	(17%)

National guidance regarding multi-occupancy of PTS vehicles changed in April 2022, meaning that patient transport providers could return to transporting more than one patient on a vehicle, including taxis and volunteers. However, we decided to delay the implementation of this guidance until June 2022 to maintain patient and staff safety; particularly for our most vulnerable patients who are often immunosuppressed.

During 2022, PTS continued to provide support to our Paramedic Emergency Service (PES) via the supply of staff and vehicles. This started to reduce significantly and by quarter three it was minimal, with many of the remaining 44 staff returning to PTS duties. We continued to support those staff seeking to move into PES and enjoyed some success with staff progressing into Emergency Medical Technician 1, urgent care and apprenticeship roles.

These individual successes are cause for celebration, although this did put some resultant pressure on us, given the time taken to recruit to the vacated roles and our continued reliance on private ambulance resources to back fill vacancies.

During Winter 22/23, PTS again provided a more responsive discharge service to support the improvement of flow in our busier hospitals by discharging patients more quickly. The key performance indicator target for discharges is usually 80% in 60 minutes and 90% within 90 minutes. From 12 December 2022 to 05 February 2023, Monday to Friday, on average, 85% of discharges were collected within 60 minutes.

During the year, PTS undertook recruitment of team leaders to achieve the objective of increasing frontline supervision. Working with Learning & Development colleagues, an induction programme was developed to give this group of staff the best possible start in their roles as first line managers. This initiative has been very well received by staff. Although the recruitment is ongoing, PTS is in a much healthier position in terms of team leader numbers. Frontline supervision has increased from 24 in 21/22 to 28 in April 2023 with a further six vacancies still to recruit to. These vacant team leader posts are currently covered in the short-term by existing staff seeking developing opportunities. It is anticipated that the substantive team leader group will be fully established by September 2023.

In the latter part of 22/23, the PTS Bureau, which forms the contact centre and control elements of PTS, successfully trained a small number of their staff in 999 call handling and despatch. Although this was primarily a response to the industrial action (IA), it demonstrates that staff in PTS are enthusiastic and pro-active in providing support and resilience to the wider service delivery. This intervention also allowed us to pilot alternative, more integrated models of delivery.

Whilst activity volumes remained below baseline levels in some areas, PTS was able to utilise any spare operational capacity by taking an increased volume of low acuity activity that originated through the emergency operations centre, again demonstrating collaborative and partnership working on a small scale.

During 22/23, private ambulance providers have continued to support the core PTS operation during its recovery from the seating capacity restrictions introduced because of COVID-19. The support shown by our private ambulance provider partners has been key in our ability to safely deliver services throughout the year. Further work has been ongoing in respect of providing assurance around external providers. This has taken the form of a contract specification review followed by inspections, to ensure the private ambulance providers meet our specified contractual requirements.

Volunteer car drivers are an integral part of providing a safe and effective patient transport operation and during 2022, recruitment recommenced and over 30 new volunteers joined

the service. The “Star in a Car” campaign was relaunched to coincide with the recommencement of recruitment.

New child seats were purchased during 22/23. External training from an industry lead in the field of child seat safety was provided to all volunteers on how to safely secure a child in the seat.

During 22/23 the following service improvements were undertaken:

System developments – a new version of the Cleric Patient Management System was introduced, and we continue to contribute to the development of this product with the supplier**.**

Text service – in March 2023 a new text service was introduced to improve our service to patients. Those patients who opt in are notified via text to confirm their transport booking. Patients can confirm or cancel transport by answering the text message with ‘yes’ or ‘no’ – freeing up valuable capacity. Patients are also notified by text when their transport is mobile and on the way to them. Analysis of the impact of this new initiative will be undertaken during 23/24 to assess the benefits realisation for both NWAS and our service users.

Transporting Patients with Dementia – as a result of learning from incidents, PTS changed the way in which we accept booking requests and provide transport for patients with dementia, providing safer transport in a PTS ambulance and not a taxi.

Team Leader Recruitment and Induction – as noted above, to improve visibility and engagement with staff, we increased the number of frontline team leaders providing staff supervision.

Rapid Discharge Hub Winter – We provided a faster more responsive discharge service to support flow with, on average, 85% of discharges between December 22 and February 23 collected within 60 minutes.

Forward look

Going into 23/24, the focus for PTS will be to return to pre-covid utilisation of 1.8 patients transported per hour in an average eight hour shift. During Covid, this utilisation dropped to 1.2 due to single occupancy of our vehicles. There will also be an increased focus on the better utilisation of taxis and volunteer car drivers.

The level of private ambulance usage has been reviewed and there is a plan to reduce this over the course of the next twelve months. This reduction will gather momentum as the year progresses, subject to activity remaining stable and the PTS recruitment plan being achieved. The detailed trajectory for this improvement is still in the planning stages and should be complete by the end of April 2024. The aim will be to reduce spend on third party resources and to balance any reduced spend with an acceptable level of performance that maintains a safe service.

PTS Quality Standards

The service line continues to make good progress in terms of its priorities and maintaining a high quality of service to our patients. The quality performance standards are set out overleaf.

As we transition from Covid recovery into the new ‘business as usual’, it will be necessary maintain an efficient and effective balance, that ensures PTS continues to meet the demands of the regional and local integrated care systems, delivering the best possible service for our patients.

PTS Quality Standards

				Cumbria					Greater Manchester					Lancashire					Merseyside				
	Area	Metric	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
General	Booking Systems	Online booking system availability	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Telephone booking system availability	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Call Answering	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Call Answering	75%	27%	26%	9%	34%	27%	34%	35%	19%	40%	32%	31%	32%	16%	39%	31%	28%	25%	11%	36%	26%
		Call Handling - Average Waiting	1 minute	276 seconds	433 seconds	713 seconds	274 seconds	323 seconds	235 seconds	351 seconds	595 seconds	226 seconds	293 seconds	246 seconds	380 seconds	632 seconds	239 seconds	294 seconds	258 seconds	431 seconds	683 seconds	260 seconds	323 seconds
	Planned	Missed Collection	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Planned	Misidentification of Patients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Unplanned	Confirmation of Booking	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Eligibility	Application of eligibility criteria	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Planned	Travel time	Travel time	80%	93%	92%	94%	93%	93%	94%	95%	95%	95%	95%	96%	95%	95%	95%	95%	96%	96%	96%	96%	96%
	Arrival at treatment centre	On time arrival	90%	86%	82%	84%	85%	85%	73%	75%	72%	74%	75%	83%	82%	83%	83%	82%	83%	79%	82%	81%	81%
	Collection from Treatment Centre	Timeliness of departure	80%	83%	80%	82%	84%	85%	53%	64%	55%	54%	55%	68%	67%	66%	64%	65%	75%	72%	75%	74%	72%
			90%	93%	93%	93%	95%	95%	77%	84%	77%	74%	76%	86%	84%	84%	83%	83%	90%	89%	91%	90%	88%
Unplanned	Travel time	Travel Time	80%	90%	89%	88%	92%	90%	93%	94%	93%	95%	93%	93%	93%	91%	92%	92%	96%	96%	96%	95%	95%
	Collection from Discharge Centre	Less than 60 minute wait	80%	74%	82%	77%	82%	83%	75%	79%	73%	71%	62%	72%	73%	73%	73%	67%	74%	81%	73%	68%	62%
		On the day pick up within 90 minutes	90%	86%	91%	86%	91%	91%	85%	88%	83%	82%	73%	85%	85%	84%	83%	79%	86%	90%	85%	81%	74%
EPS	Travel Time	Travel Time	85%	97%	97%	97%	95%	96%	96%	96%	97%	97%	96%	96%	96%	96%	96%	95%	96%	96%	97%	97%	97%
	Arrival at treatment centre	On time arrival	90%	88%	85%	84%	84%	83%	71%	71%	70%	71%	72%	82%	79%	80%	82%	79%	77%	77%	79%	81%	81%
	Collection from treatment centre	Timeliness of departure	85%	90%	92%	93%	94%	94%	77%	83%	80%	80%	78%	82%	83%	87%	83%	83%	85%	88%	91%	91%	90%
			90%	98%	98%	98%	99%	98%	90%	94%	91%	91%	90%	93%	93%	95%	94%	93%	95%	97%	98%	98%	97%

RESILIENCE/EPRR

Over the past 12 months there has been a significant shift in the investment and establishment of a dedicated service line designed to provide strategic leadership across Emergency Preparedness Resilience and Response (EPRR) including special operations. This has supported us in being able to develop our resilience service line, led by the assistant director of resilience, by identifying key priorities within its strategy.

Emergency Preparedness Resilience and Response (EPRR).

- **Contingency Planning**

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

  The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect patient care or public health. The manifestations of this could be precipitated by a wide range of triggers from infectious disease as with the COVID-19 pandemic, transport emergencies, industrial incidents/action, infrastructures failures or terrorist attacks. The CCA 2004 requires all NHS organisations and providers of NHS funded care to demonstrate that they can effectively respond to such incidents whilst maintaining core services.

  During 22/23, the Resilience team prepared and responded well with many challenges over the past 12 months, and significant work being brought forward relating to the Manchester Arena Inquiry and Industrial Action. In November 2022, Volume 2: Emergency Response was published with 149 recommendations, 14 of them defined as monitored recommendations for NWAS. We invested in resource to ensure all recommendations were reviewed and action taken, this work continues through 23/24. Industrial action, following a national dispute, commenced late 2022 and continues through 2023. The resilience team has worked across the system to ensure we were able to mitigate any action take and to maintain our ability to respond to patients in a timely manner.

  Other notable work within the EPRR team were included:

  - The state funeral of Her Majesty the Queen – planning and responded regionally, including our staff supporting events in London.
  - Establishment of a defined Resilience service line in the Service Delivery Directorate.
  - Appointment of an assistant director of resilience to provide strategic leadership across EPRR.
  - Women's recruitment taster day for women interested in progressing to HART.

- Introduction of ACT eLearning for all staff through the PROTECT UK app counter terrorism guidance.
- Updated Incident Response Plan (IRP) including vehicle IRP booklets in line with Manchester Arena Inquiry recommendations.
- Over 290 staff trained in skills required to be part of our specialist operations response teams (SORT), including enhanced driving skills for 7.5t vehicles.
- Additional training delivered for all HART operatives: high risk confined space, new PPE (NxGen), high consequence infectious disease (HCID) including Epishuttle
- Digital development for a National Occupational Standards platform.
- Executive & Strategic Commander training delivered by National Ambulance Resilience Unit (NARU).
- Multi-agency training and live exercises with police, fire & rescue services and other agencies.
- Development of strategic partnership working with MANX Care and the Isle of Man Ambulance Service
- Business case approved to develop an estate specific for HART
- Preparatory work for the forthcoming COVID-19 Public Inquiry
- EPRR Annual Assurance self-assessment to determine compliance of resilience arrangements measured against the NHS England & Improvement core standards.

EPRR Annual Assurance

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

NHS England requires this assurance exercise to identify any areas of limited or no compliance (as well as highlighting areas of complete compliance) of resilience arrangements against the EPRR core standards, with any deficiencies in particular areas forming an individual action plan. This plan demonstrates the intention of each trust to address any outstanding issues and give an indication of priority and timescale for resolution.

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

As part of the 2022/23 NHS Core Standards, on 24 October 2022 a submission on the EPRR Annual Assurance self-assessment provided the following:

- **Rating Definition**

  The EPRR assurance rating of **"Substantially Compliant"** represents 89-99% compliance, **"Partially Compliant"** represents 77-88% compliance.

- **Core Standards**

  Out of 50 applicable standards, we have self-assessed full compliance with 45 and partial compliance with five. This represents a compliance figure of 90% and therefore an overall rating of **"Substantially Compliant"**

- **NHS 111 Standards**

  Out of 43 applicable standards, NHS111 has self-assessed full compliance with 36 and partial compliance with seven. This represents a compliance figure of 84% and therefore an overall rating of **"Partially Compliant".**

- **Patient Transport Standards**

  Out of 42 applicable standards, PTS have self-assessed full compliance with 35 and partial compliance with seven. This represents a compliance figure of 83% and therefore an overall rating of **"Partially Compliant".**

- **Interoperable Standards**

  Out of 163 applicable standards, NWAS have self-assessed full compliance with 137 and partial compliance (including two non-compliant) with 24. This represents a compliance figure of 84% and therefore an overall rating of **'Partially Compliant'**.

Special Operations

The special operations discipline within Resilience, manages the following interoperable capabilities work streams.

- Hazardous Area Response Teams (HART)
- Special Operations Response Team (SORT)
- Chemical Biological Radiological and Nuclear (CBRNe) response
- Marauding Terrorist Attack (MTA) response
- Medical Emergency Response Incident Teams (MERIT)
- Command Training & Education
- Major Incident Fleet
- National Inter Agency Liaison Officers (NILOs) and Tactical Advisors

During 22/23 the department was involved in various and wide-ranging projects. Specifically related to HART, with the completion in training 290 staff as Special Operations Response Team operatives (SORT). This project commenced in 2021 led by one of the special operations senior leaders, planning and delivering five days' training in the subject matter of CBRN and MTA. In addition, SORT operatives were also trained in driving 7.5 tonne vehicles and in on scene logging. This training, and resource enhances the current capabilities of HART and all our operational resources in responding to incidents, including those declared as a major incident.

Training and education is a core function with HART and in addition to supporting the SORT training, the HART team delivered a number of other specialist training:

- High Risk Confined Space Rescue
- HART trained in High Risk Confined Space
- HART trained in the new PPE (NxGen)
- High Consequence Infectious Disease (HCID) including Epishuttle

Special operations senior leadership team continue to work with stakeholders in the development of a new HART site based in the Liverpool area, with a site identified and by the end of the financial year reached the planning stage.

The state funeral of Her Majesty the Queen brought national and global attention, however we were extremely proud to support this memorable occasion through special operations.

From a clinical perspective, our HART clinical lead was heavily involved in the standardisation of HART skills nationally as well as agreeing a programme of training for HART specialist paramedics in the administration of Ketamine and front of neck airway access. The clinical leadership continues to strengthen its position working with senior clinicians across the medical directorate, and nationally.

MERIT continues to go from strength to strength with an establishment of 40 doctors who have all attended their annual training programme, with many attending monthly evening CPD sessions held to fit around their busy professional commitments. The Strategic Medical Advisor Cadre has also undertaken their annual training programme in support of the capabilities. MERIT played a key role through a number of incidents we responded to, provided key resource during periods of high demand and through periods of industrial action. MERIT is a key resource providing senior medical response and support for our emergency workface at the scene.

Annual Commander training continued throughout the year with the subject matter specific to CBRN. The annual commander training is mandatory for all strategic, tactical, operational commanders as well as National Interagency Liaison Officers (NILOs), EOC on call and duty control managers from the Emergency Operations Centre. Annual commander training will continue through 23/24 however, significant work has been undertaken to establish a cadre of subject matter experts in the discipline of resilience. This cadre will be established during the year 23/24. The theme for annual commander training in 23/24 will focus once again on recommendations from the Manchester Arena Inquiry, Airwave, National Occupational Standards (NOS), Minimal Occupational Standards (MOS) and Joint Organisation Learning (JOL).

Special operations continue to coordinate with national colleagues from the National Ambulance Resilience Unit (NARU) courses for new commanders, and those undertaking refresher training.

Investing in the future of major incident response, the department has been integral in the successful submission of a business case for 16 new major incident vehicles to replace the current fleet. It had also been involved in the national procurement of two new mass casualty vehicles as well as receiving two new Polaris ATV along with purpose-built Polaris Carriers. Finally, work has been undertaken with national partners to develop the third iteration of the HART fleet.

Other notable areas of work during the year included the ongoing support for the call for evidence for the Manchester Arena Inquiry. In partnership with the resilience department special operations continues to support the trust following the publication of Volume Two: Emergency Response, with 149 recommendations and 14 specific to NWAS known as monitored recommendations. As we move forward to 23/24 and in preparation for the COVID-19 Public Inquiry preparatory work has also commenced to support our input.

The Regional Operations Co-ordination Centre (ROCC)

The ROCC has been an integral part of the trust since its merger in 2006 and operates 24/7 365 days a year and provides an oversight across all its service lines in the North West. It also works closely with key stakeholders locally, regionally and nationally across the NHS, ambulance sector and other key partners such as police and the fire and rescue services.

The ROCC team incorporates oversight of demand and hospitals across the North West. This is done by the Regional Health Control Desk and the Greater Manchester Urgent and Emergency Care (UEC) Hub. This allows us to respond and invoke plans, and enables us to flex our resources to respond to patients in a timely manner.

Following on from the appointment of ROCC tactical commanders in 2019, their role goes from strength to strength working with their team engaging with the system minute by minute. The ROCC provides an integral overview of the systems across the North West and is considered the heartbeat of our organisation. Evidence of this through its inception, and more so during the past 12 months, the ROCC has played an integral function working with the system across the North West through periods of high demands, major incidents, and challenges brought about through the periods of industrial action. Their main area of focus has been aligned to patients and staff safety.

Throughout the industrial action across the NHS, the ROCC led Operation Constant Care and were the first touch point for our senior leaders. The ROCC were also a key stakeholder in joining many North West and national system calls, proving live situational briefs on ambulance performance, demand, hospital status and much more relevant to the system, and in particular patient flow.

The ROCC tactical commanders have demonstrated the asset they are at tactical level and have commenced training courses to fulfil roles such as a National Interagency Liaison Officer (NILO).

The ROCC provides an opportunity for many stakeholders to visit the centre and receive an overview on its function. This offer is taken up by many NHS partners, however more recently and through our JESIP partners, the ROCC hosted a visit from senior officials from the Indonesian National Counter Terrorism Agency. This was a successful visit providing the international visitors an insight into its role, with specific insight into its function in major incident and MTA incidents.

QUALITY WITHIN SERVICE DELIVERY

We value patient care at the heart of everything that we do. How we measure how well we do this goes further than Ambulance Quality Indicators alone. Knowing how well we are doing is harder to measure than how quickly we do it. Indeed, it is this qualitative experience that is important to our clinicians and to our patients alike, where the speed of our response is a natural consequence of how well we are doing it, rather than vice-versa. Further, the quality of our approach makes our response more reliable and consistent.

NWAS covers a diverse demographic and physical geography. Our delivery of care is replicable across our area, with local flexible approaches. Our clinical teams work to standard, evidence-based guidelines, reinforced through classroom based and self-directed mandatory training, supported by side-by-side mentoring and annual appraisals.

We have invested significantly this year in new station premises, giving staff a great working environment, but we recognise that there is still much to do in the maintenance and renewal of some of our ambulance stations. We know that providing good working conditions is critical to attracting and retaining good staff, who then go on to deliver the care to our patients.

Learning lessons when things go wrong is a critical part of continuous improvement. All serious incidents are reviewed by senior managers in the service delivery team, with lessons learned reviewed through our area-based Quality Business Groups. This ensures that our senior clinicians in every area are able to pass on learning to their operational teams. We are well connected with our local networks for trauma, stroke and cardiac care, sharing our data on the effectiveness of the care we provide to the most acutely ill patients.

In 23/24 we will be developing a balanced scorecard of clinical and response time performance measures so that we are able to share a more rounded view of the quality of our response to patients, again showing the output of our work clinically as well as in pure response time performance standards.

FINANCIAL REVIEW 2022/23

This section of the Annual Report outlines the financial performance of the trust for the financial year ended 31 March 2023 and the results outlined in this section relate to the full 12 month period of 1 April 2022 to 31 March 2023. A copy of the full statutory audited accounts is included in this Annual Report together with a glossary of terms to assist the reader in interpreting the accounts.

Financial Duties Review

NHS trusts have a number of financial duties.

Break Even – taking one financial year with another

NHS trusts have a statutory duty to break even taking one financial year with another and we have continued to meet this duty in 22/23. NHS trusts that merge part way through a financial year, are not measured against year on year break even duty as the performance summary relates to the financial performance of predecessor bodies. For North West Ambulance Service NHS Trust, measurement against the break-even duty commenced from 1 April 2007. The cumulative performance against this target for 22/23 is a surplus of £40.769m.

It should be noted that included within operating expenses in 22/23 and 21/22 are fixed asset impairments of £8.856m and £0.323m respectively. These impairments have mainly arisen as a result of a downturn in land and building asset values and have been confirmed by an independent valuation. The Department of Health and Social Care considers financial performance against the break-even duty to be assessed net of impairments.

Break Even – each and every year

NHS trusts have a regulatory duty to break even in each and every financial year. In 22/23 we returned a surplus of £4.866m and therefore achieved this regulatory duty.

External Financing Limit

NHS trusts have a regulatory duty not to exceed the External Financing Limit (EFL) set by the Department of Health and Social Care. The EFL is the method by which the Treasury, through the NHS Executive, controls public expenditure in NHS trusts. The majority of the cash spent by the trust is generated through its service level agreements for NHS patient care. The EFL determines how much more (or less) cash that it generates through income agreements can be spent in a single financial year.

Each year NHS trusts are allocated EFLs as part of NHS financial planning processes. Our EFL for 22/23 was £3.070m. It should be noted that trusts are allowed to undershoot the EFL but not exceed it. We achieved this duty as our EFL balance is in line with target at £3.070m in 22/23.

Capital Resourcing Limit

NHS trusts have a regulatory duty to contain capital expenditure on an accruals basis, within an approved Capital Resource Limit (CRL). The CRL is part of the resource accounting and budgeting arrangements in the NHS and its purpose is to ensure that the resources allocated by the Government for capital spending are used for capital rather than to support revenue budgets. The CRL is accruals based in contrast to the EFL which is cash based. The CRL controls the amount of capital expenditure that an NHS body may incur in the financial year.

We had a CRL of £26.472m for 22/23 and had a charge against the CRL of £26.472m - spend in line with the resource and therefore achievement of the duty. Trusts are allowed to underspend against CRL but not overspend.

Capital Cost Absorption (CCA) Duty

NHS trusts have a duty to absorb the cost of capital at a rate of 3.5%. The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. The trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. This was achieved for 22/23 and is the dividend paid on public dividend capital.

Apply the Better Payment Practice Code

This regulatory duty requires NHS trusts to pay all supplier invoices within 30 days. We achieved this duty in all categories in 22/23 and performance is summarised below:

1 April 2022 – 31 March 2023	**Performance**
Non-NHS Creditors % paid within target – Numbers	95.7%
Non-NHS Creditors % paid within target – Value	97.6%
NHS Creditors % paid within target – Numbers	97.9%
NHS Creditors % paid within target – Value	98.9%

Overall performance by the trust against the Better Payment Practice Code has been consistently met since we were established.

In summary, for the 22/23 financial year, we achieved all of the statutory and regulatory financial duties.

In 22/23, our income was £479.483m and was generated from the following activities:

Income from Activities	2022/23
	£000
PES Income	361.446
PTS Income	45.823
111	32.521
Other Income	39.693
Total Income	**479.483**

Late Payment of commercial Debts (Interest) Act 1998

Under this legislation, we can claim interest on the late payment of debts by contracting partners and are required to disclose amounts of interest and compensation paid during the year. During the year, we did not receive any such payments.

Financial Environment - ICS

Throughout 22/23 the NHS was operating under the transitional financial regime, returning from the emergency financial regime that it was operating under for 2 years, during COVID-19. In the transitional period, trusts have continued to be paid monthly block payments including additional payments relating to the costs of responding to the pandemic, including personal protective equipment.

Our achievement of the financial duties continues our track record of strong financial performance and demonstrates sound financial management. Achieving the duties has been challenging, particularly in the context of the current financial regime environment and operational pressure due to Covid, whilst maintaining service quality.

Our cash balance remains strong and was £63.755m as at 31 March 2023. The trust holds its cash within the Government Banking Service (GBS).

Our financial focus continues to be about resilience and sustainability, and as such, we continue to operate under the emergency block arrangements.

The 22/23 capital programme for NWAS continued to invest significant capital resources to procure ambulance vehicles and equipment; enhance our digital infrastructure; investment in digital developments and to maintain and improve the quality of our estate.

The impact of the COVID-19 pandemic was felt throughout 22/23 and additional costs were incurred in responding to COVID-19. In relation to the 22/23 accounts this equated to £31.714m of additional expenditure.

Anti-Corruption and Anti-Bribery Matters

One of the basic principles of public sector organisations is the proper use of public funds. The majority of people who work in and use the NHS, conduct themselves in an honest and professional manner and they believe that fraud, bribery and corruption, committed by a minority, is wholly unacceptable as it ultimately leads to a reduction in the resources available for patient care.

We are committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. We do not tolerate fraud, bribery or corruption and aim to eliminate all such activity as far as possible.

At our most senior level we encourage anyone having a reasonable suspicion of fraud, bribery or corruption to report them and no employee will suffer in any way as a result of reporting these suspicions.

We will take all necessary steps to counter fraud, bribery and corruption in accordance with the NHS Counter Fraud standards, as well as in accordance with relevant UK Legislation.

We have our own dedicated Anti-Fraud Specialist (AFS), who is accredited by the NHSCFA and accountable to them professionally for the completion of a range of preventative anti-fraud, bribery and corruption work, as well as for undertaking any necessary investigations. Locally, the AFS is accountable on a day-to-day basis to the trust's director of finance and also reports, periodically to our Audit Committee.

WORKFORCE

Delivering our overarching aim of delivering the right care, in the right place, at the right time, every time, requires us to have sufficient, highly motivated, trained staff working in safe, supportive environments where they can fulfil their potential. Creating a brilliant place to work, through looking after our people, investing in our people and leading our people compassionately is a core aim of our strategy.

As a trust we are focused on developing roles, careers and supporting education and development to support the transformation set out in the strategy. We also recognise the importance of creating an inclusive environment, where managers lead with compassion and where the safety and wellbeing of our staff is at the heart of what we do.

People Plan

Our People Plan was developed to enable the delivery of the overall trust aims. It was first approved in 2018 and is reviewed annually to ensure that it remains focused on supporting us in delivering our people priorities.

The strategy reflects three main themes: develop, engage and empower, and six overall key priorities:

- Recruitment and retention
- Developing potential
- Wellbeing
- Inclusion
- Leadership
- Innovation and improvement

During 22/23, the People Plan has remained current following a refresh in May 2021. Regular reports on delivery of key priorities are provided to the Strategic Workforce Sub Committee, Resources Committee and the Equality, Diversity and Inclusion Sub Committee.

Improvement goals have been added and reviewed to reflect the emerging priorities from the national People Plan and NHS People Promise, as well as continuing to develop our work to support improving culture. In particular, these included the agreed priorities around equality, diversity and inclusion and the development of just culture principles and approach.

The key priorities are supported by a range of measures and key improvement goals, reflected in more detail in an annual implementation plan. Regular updates on progress are provided to committee and good progress on all key improvement goals was demonstrated during 22/23 despite the impact of industrial action.

Following the launch of the strategy, during 22/23 the People Directorate has been developing the framework ready for a new and revised People Strategy for 2023 and the next three years. A number of priority areas have been agreed building on the existing People Plan and following consultation with stakeholders during 22/23.

Leadership Development

Our leadership development offer continues to build on our 'Be Think Do' leadership model, aimed at ensuring our leaders feel empowered to lead authentically, with compassion, doing the right thing for patients and staff.

Delivery of our 'Making a Difference' leadership development programme continued with the two modules 'Leadership of Self' and 'Leadership of Others' being launched at the start of 22/23. The third module in this suite of programmes 'Beyond Bias' commenced delivery in October 2022, with 121 leaders having attended this module over the first six months of delivery. All of these modules form the basis of a core leadership induction for new leaders but are being extended to existing leaders in order to embed a strong foundation of compassionate leadership.

As an accredited centre for Chartered Management Institute (CMI) programmes, we continued to support new and developing leaders through level 3 and level 5 leadership and management qualifications. In June 2022, we re-commenced delivery of the Level 5 Award in Management Coaching and Mentoring.

In addition, to the core programmes above, we offer a range of masterclasses, essential learning and personal development including the introduction of Civility Saves Lives training.

We have continued to support NWAS leaders and managers to access external development, CPD, qualifications, and system wide leadership development and coaching opportunities, including those provided by partnering organisations such as the North West Leadership Academy and NHSE.

Health and Wellbeing

The past year continued to be challenging for our staff with recovery from the pandemic, operational pressures and industrial action. Supporting our staff with their health and wellbeing has therefore been a key priority, as we continue to enhance the support services available as well as access to information and resources. Our commitment remains to improve the working lives of our people and strive to keep our staff happy, healthy and fit.

Some of key health and wellbeing highlights from the past year include:

- **Health and Wellbeing Leads:** a new Health & Wellbeing Leads Group was established in the summer of 2022 with representation from all operational areas. The membership was widened in early 2023 to include representatives from corporate teams. The purpose of the group is to align with the trust's strategic objectives around workforce wellbeing with the leads taking ownership to develop and manage local People Plans, aimed at enhancing culture, health and wellbeing. The group has been meeting bi-monthly and has been an effective forum for sharing ideas and best practice across different parts of the organisation.

- **Consultant Psychologist:** Through national post pandemic monies, we recruited a consultant psychologist on a one year contract in May 2022 with a remit to review the our health and wellbeing approach and offer. This has led to a number of engagement activities with staff and teams across the organisation to explore what matters to them and consider what actions we could take to improve the employee experience. The findings of the review are being considered in Spring 2023.

- **Work and Wellbeing Passport:** initially launched in 2021, a review of the Work and Wellbeing Passport commenced in the last year with the aim of making it more effective and accessible. The Passport can be used for any member of staff who feels that they may need some additional support at work. The current format of the document combines a traditional Carers' Passport and Wellbeing Passport into one document. The form is easily accessed via the Green Room intranet site and is complimented by a guidance document which details how the form should be used by managers and staff alike. The review has also been looking how best to align the Passport to wider NHS organisational best practice – learning from other organisations, while also considering a new communications campaign to raise awareness of the resource.

- **Mental Health Continuum Delivery Group:** recognising the range of national initiatives that we are committed to, relating to workforce health and wellbeing, in the last year we established a new trust-wide group to coordinate and monitor progress of our activities. The Mental Health Continuum Delivery Group, chaired by an operational leader, brings together our work on the Mental Health at Work Commitment, NHS Health and Wellbeing Framework and the Association of Ambulance Chief Executives (AACE) Employee Wellbeing initiatives.

- **Pro-active, confidential and emotional wellbeing support telephone calls:** 'Just B' trauma and counselling helpline delivered by Hospice UK and funded by the Royal Foundation has been engaging with staff across the region. The service aims to support colleagues who may benefit from emotional and mental health support, but who may not readily seek out that support. It is recognised that some colleagues still feel there are negative connotations and a stigma associated with seeking out emotional wellbeing and mental health support, which may prevent them from seeking help when they need it. Therefore, this approach pro-actively reaches out to staff through a telephone discussion to ascertain if there is a need for any support that they are not currently aware of or receiving.

  The initial rollout of the calls started with staff in our Emergency Operations Centres (EOC), followed by 111 contact centres. Having received positive feedback, we then engaged with staff in the Patient Transport Service most recently and in 23/24, the programme will move on to paramedic and EMT colleagues.

We have also continued to work closely with sector colleagues and with The Ambulance Service Charity (TASC) on wellbeing initiatives, including supporting the national launch of the TASC Mental Health crisis line in November 2022.

Vaccination Campaigns

We managed our annual flu vaccination programme for 22/23 with a similar model as previous years. A number of clinics were set up across the region to encourage all staff to have the vaccine. In addition, flu vaccinators were deployed to offer vaccines via a roving model.

We officially concluded our campaign at the end of February 2022 and the final uptake of the flu vaccine was 49% of staff. Whilst this was lower than previous years, this reflected a similar trend across the NHS.

WORKFORCE ENGAGEMENT

Providing staff opportunities to share their experiences, insights and views is an integral part of a positive employee experience. Staff forums across the trust as well as our annual and quarterly staff surveys continue to be important avenues for seeking staff feedback and understanding their sentiments.

National Staff Survey Result 2022

The NHS Staff Survey (NSS) provides an annual opportunity for staff to share how they feel about their experiences in their NHS trust. The fieldwork for the 2022 NSS was undertaken from 3 October – 25 November. Over 2,200 members of staff participated, equating to 33% of the workforce. While slightly lower than the previous year, this remains a sizeable number of staff who have shared their experience and insights.

The survey has continued to be aligned to the NHS People Promise themes which means that most of the results from 2022 can be compared to the previous year. Based on the themes in the Survey (People Promise + Staff Engagement and Morale), the scores for NWAS remained largely static and in line with the sector average. This is positive in light of the challenging operational context and pressures that staff have continued to work within over the last year.

Key findings

Nationally, while there are some positives emerging from the survey, overall this year's results illustrate a decline in certain key markers of staff experience including staff discontent around pay, lower staff confidence in the quality of care they feel able to deliver, compared with last year and a decrease in staff morale.

Much like the national results, our own results also present a mixed picture showing some good progress in a number of key areas which we can be proud of. While at the same time however, the results identify the need to make greater progress and improvements in other areas. For example, the results show an increase in the percentage of staff overall who have not endured negative experiences such as bullying, harassment, abuse or physical violence from patients, colleagues, and managers (85% 2022, 83% 2021). For the second consecutive year, our results on these questions have been better than the ambulance sector average.

Also for the second year in a row, the results for all the questions relating to relationship with immediate managers have either positively increased or remained static. In all these questions, our responses have again shown a more positive experience compared to the ambulance sector average. The largest increase in this section was on the question relating to the immediate manager taking a positive interest in staff health and wellbeing (65% 2022, 60% 2021).

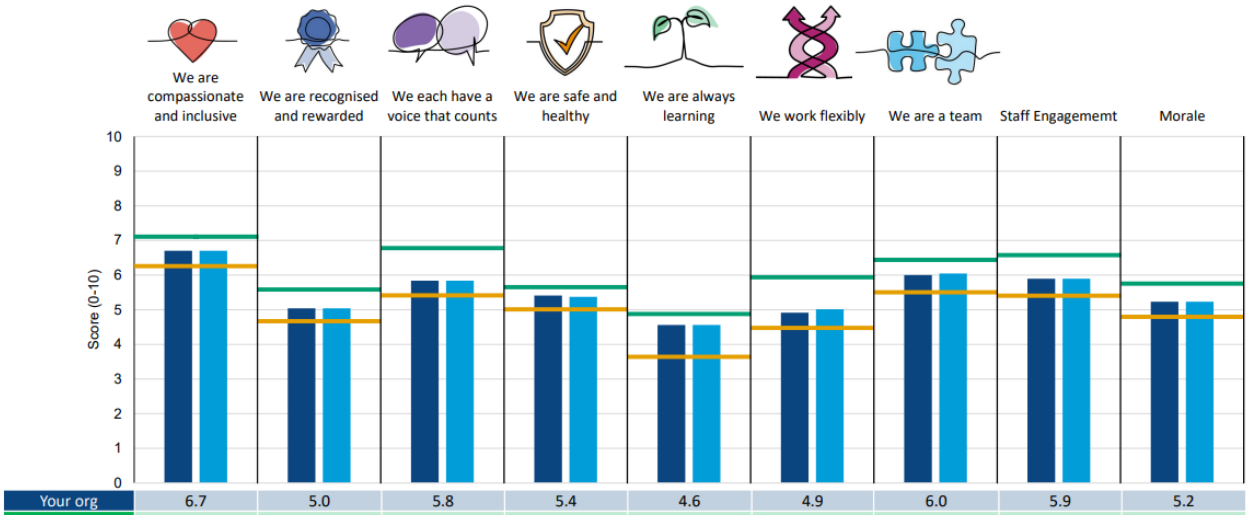
On health and wellbeing, 42% of respondents overall believe the organisation takes positive action, which has improved. However, a quarter of respondents said they 'never or rarely feel burnt out because of work' and less than one in five said they never find work emotionally exhausting.

Less than half of respondents believe that we act fairly with regards to career progression. A decline of around 4% was seen on this question from 2020 to 2021, but there has been an improvement in 2022. Similarly, only around half of respondents said that there were opportunities to develop their career within NWAS.

With regards to raising concerns, two-thirds of respondents overall said they would feel secure in doing so about unsafe clinical practice – but this was less than 2021. Additionally, only 43% of respondents said that feedback was given on changes made following errors / near misses / incident which is below the sector average.

Also, some of the questions from the NSS are used to inform the Workforce Race Equality and Disability Equality Standards (WRES and WDES). Across all the metrics, while there were some positive improvements, there still remains a gap between experiences of staff from ethnic minority backgrounds and those with disabilities, compared to the rest of the organisation.

Performance against each of the key themes is shown in the graph below:



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	6.7	5.0	5.8	5.4	4.6	4.9	6.0	5.9	5.2
Best	7.1	5.6	6.8	5.7	4.9	5.9	6.4	6.6	5.8
Average	6.7	5.0	5.8	5.4	4.6	5.0	6.0	5.9	5.2
Worst	6.3	4.7	5.4	5.0	3.6	4.5	5.5	5.4	4.8
Responses	2214	2213	2207	2210	2118	2210	2214	2216	2215

Next steps

A key recurring theme throughout the NSS responses is the variation in staff experience based on different part of the organisation which staff work in. To explore this further, we are working with local teams to analyse their data and develop local plans responsive to the experiences of staff within those teams. We are also working on developing an organisational action plan, with the support and input of teams and colleagues from across the trust to set out how, as an organisation we will respond to the range of areas for improvement emerging from the results. The action plan will be aligned to the People Promise, and managed by a new Staff Survey Action Group.

National Quarterly Pulse Surveys (NQPS)

The National Quarterly Pulse Survey (NQPS) provides a consistent and standardised approach, nationally and locally, to listening to staff at more regular intervals with a robust data set. NQPS focuses on the core set of nine questions which make up the engagement theme from the NHS Staff Survey which provide insight into motivation, involvement and advocacy.

Scores from Quarters 1, 2 and 4 in 2022/23 are shared in the table below. The National Staff Survey is undertaken in Q3 and therefore the scores for this quarter are contained within the NSS results.

Theme	NWAS Q1	Q1 sector average	NWAS Q2	Q2 sector average	Q3	NWAS Q4	Q4 sector average
Staff Engagement	6.22	5.35	6.18	5.32	National Staff Survey	5.99	5.25
Advocacy	6.49	5.40	6.45	5.45		6.15	5.32
Involvement	5.71	4.89	5.70	4.86		5.64	4.80
Motivation	6.45	5.75	6.39	5.65		6.20	5.64

The scores show that over the last year, our average in each quarter has consistently been greater than the sector average, indicating a comparably more positive employee experience in NWAS.

Findings from the NQPS are considered along with the results from the NSS to better understand staff experiences, and to plan for future improvements.

Partnership Working

We continue to work in partnership with four recognised trade unions - GMB, Unison, Unite and RCN. Meetings are held every month with staff side representatives through the Trust Policy Group to discuss the development and revision of workforce policies and procedures. Trade unions also attend health and wellbeing meetings and are also heavily involved in health and safety groups. Each service line has its consultative mechanism which focuses on staff and patient experience and the management of change.

Whilst we have experienced industrial action during 22/23, as a result of the national dispute over pay, we have worked closely with trade union partners to ensure that the right to strike was balanced effectively against the need to maintain patients' safety.

A review of Partnership Working with ACAS has been delayed as a result of the industrial action however, this review forms part of the People Directorate objectives in 23/24 with work commencing in Q1 of 2023.

EQUALITY, DIVERSITY AND INCLUSION (ED&I)

Embedding equality, diversity and inclusion into the fabric of NWAS continues to be a key organisational priority. The refreshed Trust Strategy published in the summer of 2022 sets out our clear commitment for ED&I to be part of everything we do, and for it to be seen as a responsibility shared by everyone at NWAS.

The Strategy highlights our ambitions to provide accessible care which treats each person fairly based on their individual needs, as well as taking action to proactively address inequalities whether at work or in the services we offer to the public. It also outlines our commitment to inclusive leadership, understanding what it means to be anti-racist, considering the impact of decisions on diverse groups, adopting a zero-tolerance approach to discrimination and developing a workforce representative of the communities we serve.

ED&I Objectives

The trust has due regard to the aims of the Public Sector Equality Duty in the way we manage our workforce and the way in which we provide services to our communities. We publish an annual report detailing our equality and diversity activities with particular focus on work towards both the general and specific duties.

Over the last year, we have continued to deliver on the three ED&I objectives agreed by the Board in 2021. Progress on each of the objectives is monitored through the Diversity and Inclusion Sub-Committee chaired by the deputy chief executive.

The priorities are set out in the table along with significant activities which have been taken in 22/23 relating to these areas:

Priority	Significant activities
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.	• Established ED&I Recruitment Management Group to oversee delivery of this Priority • Took innovative approaches to attraction and tracking of applicants from ethnic minority backgrounds • Commissioned an external end-to-end audit of NWAS recruitment processes to identify barriers to engagement faced by underrepresented groups. • Invested in additional resource in the our Positive Action function to broaden outreach into communities across the North West • Reviewed processes for appointment into leadership positions to ensure fairness of approach, diversity of panels and embedding of inclusion into assessment processes
2. We will educate and develop our leaders and staff to improve understanding of racism,	• Continued to weave ED&I into every mandatary training session delivered by the Learning & Development Team

discrimination and cultural competence, to deliver a step change in the experience of our staff and patient.	• Commissioned the delivery of 'Beyond Bias' – a training module to help leaders understand how bias, prejudice, and discrimination affect the workplace, as well as how diversity may improve patient care and employee experience. • Developed a framework for a Reverse Mentoring programme with an external provider to help senior leaders understand and learn from the experiences of staff from ethnic minority backgrounds. This launches in 23/24.
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.	• Launched a Mental Health dashboard which has significantly increased our insight into the disparity in response time for Mental Health patients compared to physical health patients. • Developed a Learning Disability and Autism plan through co-production with patients and experts. • Implemented a report to track ethnicity data within the Electronic Patient Records system

ED&I achievements and progress

Over the last year, we have secured a number of achievements relating to ED&I and through the new ICB structures, we have been working more collaboratively with partners across systems. A summary of some the key activities and achievement is shared below:

- Achieved Gold in the Employers Network for Equality & Inclusion TIDE kitemark for the first time – demonstrating the robustness of our ED&I processes
- Awarded the highest Disability Confident status - Level 3 Disability Confident Leader – by the Department for Work and Pensions.
- Continued commitment to the Armed Forces Covenant and achieved Gold Member status for the Employer Recognition Scheme for the second time, introducing the Guaranteed Interview Scheme to veterans and currently serving reservists and cadet force adult volunteers.
- Re-accredited for Veteran Aware Status by the Veterans Healthcare Covenant Alliance (VCHA)
- Published Workforce Disability Equality Standard and Workforce Race Equality Standard data with accompanying action plans during October 2022
- Published the Gender Pay Gap Report metrics and accompanying action plan during December 2022
- Produced a refreshed NWAS Community Calendar 2023 showcasing the diversity of the organisation
- Religion, Belief & Culture Forum has been established to explore a range of topics and themes to support staff competency/learning
- Collaborative working with Integrated Care Boards on ED&I agendas
- We have developed a number of policies supporting this work, with Equality Impact Assessments (EIAs) completed for each:
    - New Parent Support Procedure

- Induction Procedure
- Procedure for Managing Disability in Employment
- Shared Parental Leave Procedure
- Breastfeeding Guidance
- Management of HIV and BBV Infected Healthcare Workers Policy

Staff Networks

Diversity is something to be celebrated, and we are proud that our networks continue to provide safe environments where people are encouraged to be themselves, challenge the way things are done and work together with leaders to improve NWAS for everyone.

The following are the five staff networks currently operating in the trust:

- Armed Forces
- LGBT+
- Disability
- Race Equality
- Women's

The ED&I Staff Networks Council provides a regular forum for the networks and other relevant stakeholders to come together on an intersectional basis and work in partnership. An example of this in the last year has been the engagement of the staff networks collaboratively within the Trust Strategy development work, where they contributed ideas and insight into production phases.

Individually, the networks have also continued to make positive progress in their own development and to raise awareness of their respective profiles within our organisation. The Race Equality Network held an event as part of Race Equality Week to provide an opportunity for members share experiences directly with the Board and senior leaders, and share ideas around how we can make improvements in the areas relating to recruitment, staff retention and career progression.

We launched our Women's Network in October 2022. Amongst the activities organised by the Women's Network in the last year was a taster day in the HART team for female paramedics – providing them an opportunity to experience what it is like to be a HART operative. This is a team which currently has relatively lower levels of female staff representation.

The Armed Forces Network organised a conference for their members, and the Disability and LGBT+ Networks have coordinated activities related to Pride, LGBT and Disability History Months.

All staff networks respectively continue to receive the support of an executive sponsor and are provided with a budget to fund their activities.

ED&I Board Development

The Board continued to show commitment to ED&I agendas through participation in development sessions and engagement with Staff Networks. At the most recent ED&I development session in Autumn 2022, the Board explored inclusive behaviours, traits of inclusive leadership, 'bystander' effect and micro-inequities. The session saw the Board engaging with senior operational leaders to consider how we can continue to make positive progress on the ground in relation to developing a more culturally competent and inclusive organisation. In addition, executive directors have engaged in developed to support their roles as visible champions of staff networks.

Despite considerable operational pressures, we hope to continue to develop as a more resilient, more compassionate and considerate organisation for all our staff and patients, and continue to keep equality, diversity and inclusion as vital aspects of each step going forward.

RESOURCING

The 2022/23 year was the first year following the pandemic where the Trust had to develop and submit formal operational plans and experienced investment in sustainable workforce growth to frontline roles.

At an operational and tactical level, agreed workforce plans are actively monitored with service lines and finance monthly, to identify and address any developing trends. The planning process is dynamic with plans being reviewed monthly to allow the opportunity to discuss emerging issues that may impact on the plans and allow flexibility to accommodate changes. The anticipated turnover rate is mapped throughout these plans to allow a forward view over the next twelve months allowing service lines to visualise the anticipated workforce position. These detailed annual plans sit within the context of a five year plan focused on ensuring appropriate Paramedic supply and has informed regular engagement with Health Education England (HEE) and Higher Education Institute (HEI) partners.

Workforce planning

The delivery of the workforce plan is based upon maximising our recruitment and training capacity to support growth in frontline resources. There has also been a focus on ensuring that there is ongoing triangulation of the workforce position against the financial operating plan. Monthly workforce plans are produced for frontline PES, PTS and contact centres.

Throughout the year, the EMT 1 workforce plan has sought to maximise training capacity and there has been a growth of 42 whole time equivalents (WTE) to the baseline. Vacancy gaps narrowed across the year following a challenging recruitment plan and there is a robust recruitment plan in place for 23/24.

The paramedic workforce plan for this year included a growth in establishment of 83 WTE for 22/23. During the year, we have had successful recruitment campaigns recruiting a range of

applicants from International NQPs, graduate paramedics from the North West universities along with applicants from Non-North West universities and qualified paramedics from other UK ambulance services. In addition, we are proud to have had our first cohort of internal paramedic apprentices completing their studies and moving into paramedic posts.

The PTS workforce plan has been focussed on recruiting to the baseline position. To improve the diversity of the PTS workforce, we have engaged several pre-employment courses and these have been supported by the Widening Access Team. The course aims to prepare candidates for applying to PTS care assistant posts. Plans are in place to continue with further pre-employment courses in 23/24.

During the pandemic, we engaged a number of agency staff within our contact centres and 22/23 has seen a return to a normal recruitment approach. Recruitment plans have focussed on ensuring appropriate resource levels during the winter pressure period. During the past year both EOC and 111 call taking recruitment has been challenged by a competitive recruitment market with a reduction in the expected number of applications for roles.

The 111 call taking workforce has been impacted by both by reduced recruitment levels and a high level of turnover of health advisors, particularly during their first two years in post. As a result, the combination of difficulties in filling courses and high attribution rates has led to a continuing vacancy gap. There has been ongoing work to focus on both the attraction and retention of call taking staff. Key activities to support retention have included development of team leader skills; creation of team rotas; supporting preceptorship of new call handlers; stay interviews; improvements to annual leave planning and a short-term recruitment and retention payment. Whilst these have led to improvements in retention, challenges remain and plans continue into 2023.

In addition to engaging in an International Recruitment Programme for paramedics, we were successful in a bid for funding to support a cohort of international nurses. The recruitment to this cohort is ongoing and it is intended that applicants will be placed in clinical advisor roles within 111. Further international nurse recruitment is planned during 23/24.

During this year there has been a significant reduction in agency usage within call taking roles in both 111 and EOC. Bank usage has remained stable and in line with the predicted position outlined on the 22/23 operating plan.

The HR and training teams meet on a bi-weekly basis to review the current recruitment and training plan and ensure that all training places are being maximised. Alongside this, there are regular meetings with service line leads and HR to review the current plans against workforce levels and identify any areas for concern and focus.

The following table summarises the numbers of front-line staff recruited during 22/23:

Staff Group	Permanent	Fixed term	Bank	Internal movements*	Total
UCS/EMT1/Apprentice EMT1	105	24	5	55	189
Paramedic - Band 5 & 6	169	1	64	72	306
PTS	89	2	21		112
EOC	366	59	25		450
111	195	0	5		200
Total	**924**	**86**	**120**	**127**	**1257**

*this includes staff who have moved from different service lines or from Bank posts

Leadership recruitment

The appointment of new leaders continues through values based recruitment in line with our 'Be, Think, Do' leadership framework. Leadership assessment centres have become a critical feature of our approach to fair, equitable and ethical recruitment practice. As part of our plans to review career development, a number of changes have been made to the leadership assessment centre which aim to provide a more streamlined process whilst we await the full response from the ENEI Recruitment Review.

WORKFORCE DEVELOPMENT

We continue to deliver comprehensive induction programmes for all staff new to patient contact roles. In 22/23 a review of programmes and resources resulted in investment in additional educators directly supporting new staff. Two internally delivered qualifications within trust induction programmes went through re-design in year to meet revised qualification specifications and considering learner feedback; these were Level 4 Diploma in Associate Ambulance Practice and the Level 3 Certificate in Emergency Response Ambulance Driving.

Apprenticeships

We also continue to deliver and grow our apprenticeships across our workforce. The Department for Education continues to report apprenticeship date for public sector organisations. For 22/23:

Percentage of apprenticeship starts (both new hires and existing employees who started an apprenticeship) as a proportion of employment starts between 1 April 2022 to 31 March 2023	21.34%
Percentage of total headcount that were apprentices on 31 March 2023	7.46%
Percentage of apprenticeship starts (both new hires and existing employees who started an apprenticeship) between 1 April 2022 to 31 March 2023 as a proportion of total headcount on last day of previous period	3.47%

New emergency medical technicians (EMT) are recruited as apprentices and undertake a Level 4 Diploma in Associate Ambulance Practice delivered in-house, with NWAS as a registered employer-provider.

Our investment in the development of its workforce continues and we have developed a progression pathway through which EMTs are able to join a paramedic apprenticeship programme, remaining in employment, and completing a level 6 degree apprenticeship. With 291 staff recruited to the paramedic apprenticeship, in March 2023 we saw our first cohort complete, with 58 of our EMT colleagues now qualified as paramedics.

We continue to commission external apprenticeships supporting staff development and recruitment across corporate and support roles, including finance, fleet and communications. This year also saw the recruitment of a sustainability apprentice.

Widening Participation

Our widening participation work continues to support events and activities which promote recruitment opportunities and inspire the future workforce, which supports our approach to widening participation in employment and training. The team have redesigned and adopted a blended delivery model of both face to face and virtual delivery of pre-employment programmes.

These include cadet and pre-employment programmes, school and careers fairs, armed forces engagement and bespoke support for internal staff. In year we have delivered 11 pre-employment programmes supporting unemployed staff build confidence, competence and experience within our contact centres and patient transport service, leading to employment opportunities.

Supporting Staff Development

We support access to higher education modules of study as part of the continuing professional development (CPD) offer for paramedics (non-mandatory) with 495 modules supported. We are also working with a local university provider to develop a suite of on-line learning modules which will support staff development.

In addition, we continue to support access to the ParaPass app for all our paramedics. The ParaPass app is a CPD platform which supports paramedics' learning and development and includes case scenarios, quizzes, self-assessments, etc. 3,053 staff currently have access to the app.

The EMT1 bridging programme, which supports staff to gain the Associate Ambulance Practitioner qualification, has continued to be a successful route whereby staff gain the qualification which will support their aspirations to develop and become paramedics. 363 EMT1s have now achieved the qualification with an additional 19 currently on the programme.

The trust has also supported the continued professional development of staff across a spectrum of disciplines, responsive to learning needs identified through the appraisal process and personal development plans. 119 external courses at level 5 and above were supported ranging from attendance at single day workshops to supporting Masters degrees.

Appraisals

We transitioned back to full appraisal conversations during 22/23, with the appraisal process redesigned as a conversation tool.

Our appraisal compliance target set for the year considered the recovery position required. With a target of 80%, 83% of staff had an appraisal meeting with their manager.

Mandatory Training

For 22/23 mandatory training focus was maintained on statutory/high risk content, with the primary impact that the PES classroom training was reduced to one day instead of two days, to manage the statutory/risk minimum and reduce risk of cancellation of whole programme should system pressure necessitate the reset of staff abstractions. On-line learning modules remained the same. Mandatory training was impacted by NHS industrial action and subsequent military aid during the Winter months which necessitated further pauses but remained on track and over plan at that time. All areas met or exceeded their compliance targets with the overall year-end position of 88% compliance against a target of 85%.

COMMUNICATIONS AND ENGAGEMENT

Our Communications and Engagement Strategy 2021-2024 is supported by annual action plans which are delivered by the Communications and Patient Engagement Team. The team is split into two dedicated sub teams providing the full mix of communications and patient engagement services.

The Communications Team provides staff and stakeholder engagement, media handling, film making; website, campaigns, event and crisis management, using the full range of digital and traditional media.

The Patient Engagement Team manage our Patient and Public Panel, its programme of community engagement and proactive patient experience in order to realise service improvements and enhance patient experience.

Together they place patients at the heart of our organisation and support the delivery of excellent care for our communities, ensuring the accurate and timely flow of information to the region's diverse communities, as well as engaging with stakeholders, partner organisations and our own staff.

Communications

The Communications Team has a wealth of experience in dealing with complex engagement activities and this has been utilised to the full with some major challenges in 22/23.

Three key events in the year required the team's expertise in both external and internal communications, balancing ensuring transparency and subject detail, with timeliness of the communication, adapting to the appropriate audience, empathy and personalisation and identifying what the audience wanted and needed to know.

Death of Her Majesty the Queen

For some time, the Communications Team had a plan in place in readiness for the death of notable British figures and were able to respond quickly when the sad announcement came regarding the death of Her Majesty Queen Elizabeth II in September 2022.

Our staff proudly wear a royal crest on their uniform and it was felt that, although colleagues were likely to discover the news via national channels, it was important that a formal message was issued by the chief executive internally and externally, and that official protocol was followed in regards to flags at sites and in all our messaging. Our social media sites were paused to reflect the mood of the nation and apportion the appropriate respect and reverence the sad occasion merited.

The team worked alongside resilience colleagues to ensure actions approved nationally were carried out with a series of bulletins and external media statements during the period between the announcement and then the subsequent Proclamation Day, the period of mourning and the funeral itself.

We were extremely proud and honoured to be represented at the funeral by our Chief Executive, Daren Mochrie.

Manchester Arena Inquiry

In 2019, the Home Secretary announced an independent public inquiry into the Manchester Arena attack on 22 May 2017. The inquiry's objective was to investigate the tragic deaths of the 22 victims and had the same scope as inquests.

The Inquiry commenced in 2020 but various delays meant that Volume 2: Emergency Response, which examined the emergency service response was not reached until 2022 and the final report was published in November.

We fully co-operated with the Inquiry process and it was vital that the communication of the process and findings were timely and most importantly, put the victims and their families at the forefront. We also recognised the strong strength of feeling internally – approximately 300 NWAS staff responded both on the frontline and behind the scenes that night and we were acutely aware that this was an incident that affected many of them emotionally.

The Communications Team worked alongside colleagues in operations and legal as well Greater Manchester Police and Greater Manchester Fire & Rescue to ensure an honest and accountable response.

It was agreed that all three emergency services, plus British Transport Police would take part in a press conference, following the publication of the report, and this took place in Manchester city centre a few hours after it was published.

The team ensured messages to our staff and stakeholders were published to coincide with the press conference so all interested parties were able to hear or read our response at the same time.

While the majority of the resulting media was not complimentary, this was to be expected due to the failings highlighted in the report. What was important to us, was to ensure the victims and their families knew that we acknowledged the mistakes made and that work had been undertaken to reduce the risk of them ever happening again. The objective was to be open, answer questions put to us by the media and to give assurance that we had acted to improve and learn from the incident.

Likewise, we wanted to assure staff that no-one doubted that due to their actions, lives were saved that terrible night. Messages issued internally talked of the bravery and commitment they showed

when dealing with such a devastating scene and signposted them to extra help and support should they need it.

As always, our thoughts remain with the victims of the Manchester Arena Attack.

Industrial Action

December 2022 saw the start of the largest periods of industrial action by ambulance service workers since 1989.

The role of the Communications Team was vital to both staff and the public to ensure staff knew their rights and what agreements had been reached with the unions, and to the public to ensure their safety during the periods of action.

The Communications Team worked closely with the director of operations, medical director and external NHS colleagues to produce accurate and safe advice, manage public expectations and signpost patients to alternative pathways of care.

This was undertaken using a variety of mediums including social media, press statements and interviews with media channels to ensure our messaging reached as many people as possible. Industrial action took place on five occasions, and the team facilitated 36 television and radio interviews with senior managers, issued nine press releases and statements, 46 staff bulletins, 18 stakeholder communications and 249 social media posts.

Campaigns

In September, we launched our Ambulance Academy, a free, educational online resource to help guide children and young people on how to use our services. The Ambulance Academy is for children, young people, teachers and adults and provides useful information about jobs in the ambulance service, first aid, how to give CPR to save a life, and what happens when you call 999. Visitors can also test their skills in our quizzes and download activities to enjoy on a rainy day at home.

Our free resources for teachers are designed to support pre-schoolers to find out about people who help us, whilst our first aid tips and lesson plans for primary and secondary school pupils support learning in health education.

Since its launch, the Academy webpage has had 23,061 visits.

November saw the launch of our winter plan, including our Every Second Counts campaign which helped educate the public on when to call 999. We did this by showing how the rising number of non-urgent calls can block the line for serious emergencies. Working closely with NHSE, ICBs and NWAS service leads, the campaign was launched on social media, radio and our website.

To increase our reach, the team produced two winter guidance leaflets - 'Winter Wise' a guide to self-care at home, wellness and primary care services, and 'We're Here for You This Winter', outlining appropriate use of 999, 111 and Patient Transport Service (PTS). Working with our PTS colleagues, these were distributed on vehicles to patients and their carers and were also distributed to Healthwatch groups, through the patient and public panel and community organisations.

The 'Every Second Counts' video was our highest performing yet with more than 69.7k plays on social media.

To support our colleagues in PTS, the Communications Team re-launched its Star In A Car Campaign which asked the public to volunteer as car drivers, giving up their time to transport patients to and from much-needed hospital appointments. Implementing a new strategy which used volunteer personal accounts on why they decide to give back to NWAS, we promoted the message through new promotional videos and graphics via social media, website, media release and leaflets out to GPs. Interest in the role saw its first spike in years and applications increased.

The Communications Team worked with colleagues in 111 and operations to produce a social media and radio advertising campaign to increase applicants for emergency medical advisor and health advisor roles.

In late spring 2022, EOC recruitment tasked Communications with attracting applicants to the job page and EMA career page to fill 170 call handler posts across Estuary Point, Broughton and Parkway. This was the largest recruitment drive for this role since before the pandemic. Using first-hand accounts of staff already in the role, we used the faces and voices of our EMAs to encourage people to apply for the role.

The campaign's radio station adverts reached more than 800,000 people resulting in 2,294 views on the launch page peaking at 477 views in just one day on the 18th July. The series of posts across all social platforms over six weeks, combined created 196,000 impressions and saw 9,580 engagements

Most importantly, the stream of work we put out, alongside the updates and leadership from service side, helped to fill all 170 job posts in just three months.

Social and Digital Media

NWAS' presence on social media platforms has gone from strength to strength and is by far, the most utilised form of communication for the trust. From our Twitter, Facebook, Instagram and LinkedIn sites, we can quickly get information and news out to over 165,000 followers and it also serves as a news source for the media. In addition to this, we can gauge the opinions of the public and staff through their comments and see how many people have seen the information we publish.

In each quarter, we consistently see social media impressions (the number of times the article has been visible to an individual) of approximately 5m.

Due to social media algorithms, we suffered a reduction in engagement following the pause on posting following the death of Her Majesty and when we restricted posts during the periods of industrial action but despite this, our followers have continued to increase.

Up until November 2022, NWAS' main social media channels were Facebook, Twitter and Instagram. Due to the changing nature of social media and the unpredictability of Twitter, we started to explore more social channels to get our messaging across. In November 2022, we started to make more use of NWAS' LinkedIn profile page and sharing a mixture of job adverts, NWAS updates and staff stories. In the last 12 months, we have increased our LinkedIn followers by 5.3% taking the total number to 7,022.

Site	Followers 2021/22	Followers 2022/23	% Increase
Facebook	72,655	75,505	3.9%
Twitter	62,532	66,181	5.8%
Instagram	15,665	17,004	8.5%
LinkedIn	-	7,036	-

Media

Our press office handled more than 1,200 enquiries during 22/23 ranging from simple incident enquiries – where a journalist wants confirmation of ambulance attendance at public incidents such as road traffic collisions, to more complex enquiries on both a local and national level.

The NHS and ambulance performance has featured heavily in the media in 22/23 as the challenges of hospital handovers and delays became apparent.

In the Summer, following a request from NHSE, we joined with Warrington Hospital to take part in an ITV Tonight special '999: A National Emergency'. We facilitated access to our emergency call centres and an ambulance crew during a shift so the documentary crew could see first-hand how hospital capacity issues were impacting on our performance. The result was a hard-hitting, real-time view of our operations and praise was received from many of our frontline colleagues for highlighting the challenges they face on a daily basis.

We issue media statements at the request of the media and in the main, these are related to negative or neutral articles on topics such as performance, delays, resources and staff welfare. In all our responses, we ensure the journalist has all the facts and strive to be as open and transparent as possible in our 'right to reply'. When a patient has complained to the media, it is important to acknowledge that this is an occasion when someone is disappointed or upset at the service received and so responding with empathy is something the team takes extremely seriously.

The press office aims to proactively issue four stories per month as press releases and post 20-25 new stories onto the website, which the trust uses to highlight the successes and positives providing the much-needed balance in the public eye.

By the end of 22/23, the team had published 162 articles either as press releases or on the website, promoting some fantastic stories such as improving maternity care, day in the life of an emergency call handler, award wins for various teams, the new Trust Strategy, raising awareness of our networks through personal staff journeys and mental health vehicles.

We are delighted to once again be working with Dragonfly Productions on series 12 of the popular BBC documentary ‘Ambulance’.

The series, due for broadcast in Summer/Autumn of 2023 is the highest rated factual programme on BBC1 with episode figures of more than 4m, even higher than Love Island! This series will focus on the work of ambulance crews in Lancashire, Cumbria and Greater Manchester, giving an unprecedented insight into how an ambulance service operates, providing a snapshot of the volume of calls, scale and range of patients, pressures and health issues we deal with and, most of all, the care and commitment shown by our staff in ever challenging and changing circumstances. It does this sensitively by focusing on the stories of patients, ambulance crews and control staff throughout a shift.

Stakeholder Engagement

Stakeholder engagement activities with our stakeholders are extensive, including, but not limited to, ICS, commissioners, NHS trust providers, regulators, A&E Delivery Boards, local MPs, Councils and patient and public groups.

The team handles all of our non-incident related MP enquiries, responding to approximately 50 letters each year. They are also the main point of contact for parliamentary questions, which come in via the Department of Health and NHS England and we have responded to 11 of these in 22/23.

In addition, 461 Freedom of Information and environmental information requests were handled by the Communications team in 22/23. This is a statutory duty as defined by the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 and one which requires 90% of requests to receive a response within 20 working days (subject to any relevant exemptions). In 22/23 the team achieved a compliance rate of 96%. Two of the requests this year were subject to an Information Commissioner’s Office (ICO) investigation following complaints from requestors about information we exempted. We co-operated fully with the ICO in providing evidence and data to explain our position and in both cases, the requestors’ complaints were not upheld.

All stakeholders receive a quarterly newsletter and ad hoc briefings are issued on topics that need swift communication such as the our response to the Manchester Arena Inquiry and industrial action.

In 22/23 four newsletters and briefings were produced together with two editions of 'Your Call', our award-winning publication for staff, patients and public.

The team regularly facilitates representation at Health Overview and Scrutiny Committee (OSC) meetings, VIP visits to our sites and meetings with MPs, liaising with the administrators and managers to ensure attendance and the timely submission of reports and presentations. This year, this has included visits by Mayor of Greater Manchester, Andy Burnham, Liverpool Metro Mayor, Steve Rotheram and Damien Moore MP to their local emergency call centres.

Staff Engagement

Engaging with a predominantly mobile workforce is a challenge year on year but it is vital that staff are kept abreast of developments and have the chance to feedback their views, ideas and suggestions.

After a break due to the pandemic, the internal communications highlight of the year was our staff awards ceremony which in 22/23 was the largest event the team had ever staged.

The Star Awards event took place at Bolton Whites Hotel with entertainment including comedian Dave Spikey and former Britain's Got Talent star Steve Royle and, thanks to the funding from our sponsors, we were able to treat more than 400 staff to night of dancing and music to celebrate their hard work during the challenging pandemic period. A record-breaking 400 nominations were submitted recognising staff in all areas of our service and from across the North West, with the shortlisted staff being highlighted on the night in front of hundreds of colleagues and accompanying guests.

Ever conscious that we need to find new ways of engaging with staff, the Communications Team joined forces with two inspiring colleagues to produce a series of podcasts, with mindfulness and wellbeing as the main focus of discussion. Sector Manager Craig Davis and Performance Manager Martin Thomas host the 'Turn Off the Blues' podcast which features colleagues who are happy to share their experiences and thoughts on topics such as mental health, post-natal depression, the menopause, being a student paramedic and LGBTQ themes. These can be downloaded to listen to at any time via Spotify and Amazon podcasts and while aimed at our staff, it has attracted listeners as far away as America and India.

We continue with the traditional issuing of bulletins which staff can access via email, the intranet, staff app and through our closed staff Facebook group.

In 22/23, this included:

- 39 CEO messages
- 52 weekly bulletins
- 65 clinical bulletins.

- 117 operational bulletins
- 5 health and wellbeing bulletins.
- 4 podcasts
- 9 HR bulletins
- 36 In Our Thoughts bulletins

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

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

The team continues to provide support to all of our staff networks and during 22/23, assisted with the development of the new Women's Network. Having produced a communications toolkit for the network to use, Communications also produced a plan to support the launch event. The network has been warmly received and hosted two well-attended events in 22/23.

With a dedicated member of the team acting as a film maker, we have been able to utilise videos as an alternative to written bulletins as experience has shown these have significantly more reach. This year, the team produced 68 videos inhouse on a wide range of subjects including clinical research, our new strategy, body-worn cameras, Freedom to Speak Up and flu jabs. The use of video has also boosted our reach on social media and are a vital tool for external promotional campaigns.

Our use of film has also enabled us to host a regular Team Talk session which takes place after every Board meeting. Staff can either watch live and post questions to the Board members featured or can watch it at a later date via the intranet. In 22/23, questions from staff have been on topics such as violence and body worn cameras, performance and demand, industrial action, NHS pay and much more.

Other internal communications highlights for the year include the flu campaign, promoting the annual NHS staff survey, the roll out of iPads to frontline staff and the promotional events and hardship fund established by the NWAS charity.

As we move into 23/24, the team is looking forward to continuing to support staff wellbeing as well as enabling staff to celebrate King Charles III's coronation and the NHS' 75th birthday. There are also plans to review all our communications to ensure accessibility is being maintained and ensuring that the way we communicate works for everyone, including users with impairments.

Patient Public and Community Experience and Engagement

Each year, our Patient Engagement Team deliver an extensive patient engagement programme in line with our Patient Public and Community Engagement Framework and Implementation Plan. The plan sets out the ways we propose to engage with and obtain feedback from our patients across all service areas, including our Paramedic Emergency Service (PES), Patient Transport Service (PTS), the NHS 111 Service and our Urgent Care Desk.

Two key components for 22/23 included a review of all our patient experience feedback and reporting channels to ensure best practice as well as best value together with continued willingness to support the preference of diverse groups for virtual engagement. In 22/23 in addition to a small amount of face-to-face work, we continued to use predominantly virtual channels to gather real insights into the care and treatment that patients receive specialist patient and community groups.

A minimum 1% of PTS, PES See and Treat and 1,200 NHS 111 patients receive the opportunity to provide Friends and Family Test (FFT) feedback monthly. In addition, to our NHS 111 postal survey offer and FFT comment/postcards on vehicles, we continued to develop our digital offer by inviting patient feedback via an SMS text weblink and online via our website. Also, instead of the pre pandemic face to face engagement that would normally take place with patient, health practitioner networks, forums and community groups, in 22/23 we attended these virtually via MS Teams and Zoom.

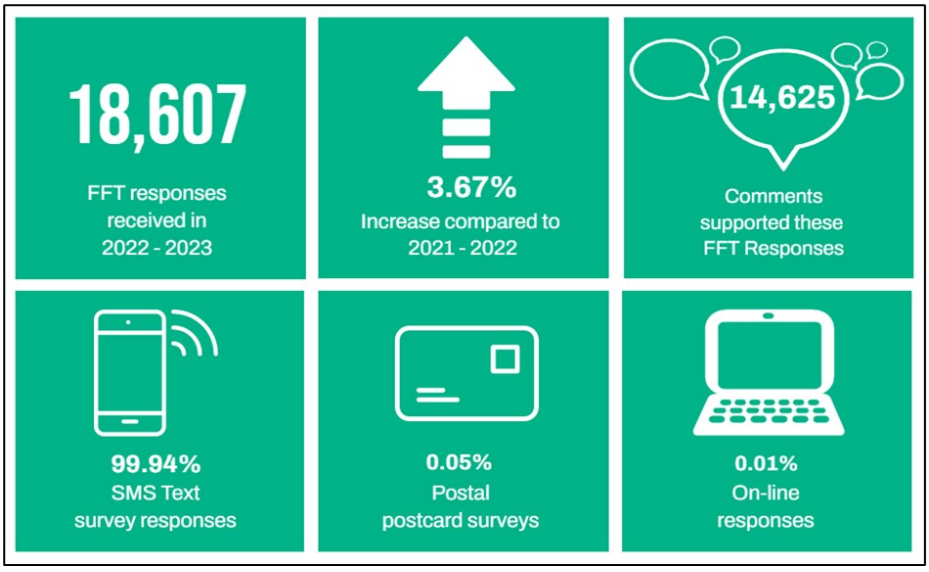
Positively we have continued to grow and develop our Patient and Public Panel (PPP) and to use their feedback and lived experience to better understand patient experience, produce stories, analysis and themed findings which will inform service development.

Patient feedback including Friends and Family Test 2022/23

A summary of patient experience (PE) survey data including FFT by quarter is shown below.

Patient Engagement Surveys (01 April 2022 - 31 Mar 2023)		Patient Transport Service	Paramedic Emergency Service	Urgent Care Service	NHS 111 Service	NHS 111 First Service
Completed PE Surveys	Q1	296	172	37	418	126
	Q2	628	494	139	455	423
	Q3	338	276	187	450	239
	Q4	368	294	149	417	619
	YTD	1,630	1,236	512	1,740	1,407
Cared for appropriately with Dignity, Compassion and Respect (Strongly Agree/Agree)	Q1	97.2%	92.6%	73.8%	n/a	n/a
	Q2	92.7%	94.7%	78.4%	n/a	n/a
	Q3	94.1%	92.6%	89.5%	n/a	n/a
	Q4	95.5%	97.2%	84.5%	n/a	n/a
	YTD	94.9%	94.3%	83.8%	n/a	n/a
Overall Satisfaction Received (Very Satisfied/Fairly Satisfied - Yes)	Q1	n/a	n/a	n/a	89.5%	91.9%
	Q2	n/a	n/a	n/a	90.5%	88.7%
	Q3	n/a	n/a	n/a	89.2%	92.0%
	Q4	n/a	n/a	n/a	86.6%	93.1%
	YTD	n/a	n/a	n/a	88.8%	91.7%
Overall Experience of Service / Recommend Ambulance Service to Friends andFamily (Very Good/Good - Extremely likely/Likely)	Q1	94.1%	88.8%	52.4%	90.9%	85.2%
	Q2	91.1%	89.5%	53.0%	90.5%	84.4%
	Q3	92.7%	85.8%	63.0%	90.3%	87.2%
	Q4	93.7%	96.1%	71.6%	87.0%	91.7%
	YTD	92.8%	90.1%	62.1%	89.6%	87.9%

22/23 Patient Experience Survey Data including FFT by Quarter:



Summary of FFT response feedback data

In relation to what the data tells us we continue to see high levels of satisfaction in relation to the care, compassion and respect our crews provide to patients. Service improvement ambassadors have been established with PTS, NHS 111 and PES colleagues. During 23/24 members of the Patient Engagement Team will attend meetings with them to discuss identified themes from patient feedback and potential areas of improvement.

Board Stories

Patient and staff stories continue to be a powerful tool to describe patients' experiences and any learning outcomes that have been achieved. These are presented bi-monthly to the Board of Directors, Quality and Performance Committee, to staff as part of their mandatory training and are part of education and awareness campaigns. In 22/23, six patient stories were produced highlighting issues of ethnic minority language translation support at patient side, impact of high demand, frequent caller due to a medical condition, learning disability access, use of defibrillation, and a patient with breathing difficulties waiting for an emergency ambulance.

Patient Public and Community Engagement

Whilst patient surveys provide us with a real insight into the care and treatment that patients have received, another method we use to gain qualitative feedback is by engagement with community and patient groups within our region – as mentioned above this has continued to take place virtually during most of the last year. Our focus has been to reassure communities that they are safe using ambulance services as we moved out of the COVID-19 years and reaffirm the basics of what we offer across each of our three main service lines.

We attended in excess of 43 virtual engagement events as either principal speakers, advisory or facilitators. Some examples include: Lancashire Learning Disability Partnership Board, CLP Patients, Public and Carers Voice Forum Meeting, Cumbria Deaf Association, Healthwatch Wirral, Healthwatch Sefton, NCompass, Insight Healthcare, Caribbean and African Health Network.

Feedback themes

Feedback has fluctuated over the year but has consistently demonstrated a general high regard for the ambulance service and in particular the high percentages of patients feeling they were treated with dignity compassion and respect.

Themes during this period have included:

- Constraints and pressures that we have continued to work under as we moved out of lockdown – both as an ambulance service and part of the wider healthcare sector. The public recognise that it is not always the ambulance service's fault when we are delayed getting to patients.

- The impact of the cost-of-living and energy costs with mental health related calls, and secondly whether that will impact on us being able to run ambulances.
- Job roles within the ambulance service
- Ambulance service understanding of young onset dementia.
- PTS criteria including use of escorts and whether PTS staff/volunteers are still required to wear PPE
- Accessing services for both ethnic minority and deaf communities
- Lack of awareness of NHS 111 online, mental health support provision, safeguarding and referral processes.
- Reassurance that we can still provide cover on industrial action days

Positively we are now also seeing the return of large-scale face to face community events and have been able to attend 12 in 22/23. Face to face engagement with students and others at Freshers Fayres has particularly helped with the recruitment of more young people to our Patient and Public Panel as well as help inform the development of the newly introduced online resource: Ambulance Academy.

We will continue to build on our face to face attendance during 23/24 as Health Melas, PRIDE and other high footfall events are back on the events calendar.

During 22/23, we have also delivered five county-based face to face NWAS Community Conversation events of our own. These were successfully first introduced in 2019 but were then paused during the pandemic. Events have been well attended with attendees from a range of public, patients and communities. A key focus for this type of engagement was to listen to, elicit feedback, reassure and answer questions or concerns raised by our North West communities on our Paramedic Emergency Services (PES), Patient Transport Services (PTS) and NHS 111 services. Attendees hear from service themed ‘lightning speakers’ before taking part in short interactive table exercises that helps us identify what we are doing well as well as what needs to be improved. A summary of feedback and what is to be changed as a result is produced and shared with attendees as well as community and specialist patient groups across our North West footprint.

Patient and Public Panel

Our volunteer Patient and Public Panel (PPP), established in 2019, is made up of representatives from local communities, interest groups, the voluntary sector and partner organisations, and offers meaningful opportunities for members to influence decisions and identify improvements in our urgent and emergency care, patient transport, NHS 111 and back office services in a way that suits their lifestyle and the time and commitment they are able to give. Panel members bring expert lived experience and knowledge of our services and offer valuable insights into numerous projects, initiatives, policies, systems and campaigns. During 22/23 almost all involvement was undertaken virtually but this is expected to change in 23/24.

The PPP has a flexible infrastructure to enable patients/the public to become involved at one or more levels that best suit them. All levels are equally important and consist of:

- 'Consult' is virtual, making the most of digital channels to interact with members who can get involved whenever or wherever they choose
- 'Co-produce' panel members work together on short-term projects using co-production techniques
- 'Influence' members take an ongoing, active role in high-level meetings to enhance decision making and discussions.

Our PPP has continued to grow, and we have actively engaged the membership via virtual platforms throughout the past 12 months. We now have 268 PPP members fully inducted, with most already involved in the work of the trust. We hit our 22/23 youth target of 25%, with 68 youth members signed up to our PPP membership and ethnic minority representation from the end of March 2022 at 16% out of our target of 30%. However, we recognise more work needs to be done to continue to engage with young people across the North West and to increase diversity with this cohort of volunteers.

From April 2022 to March 2023, PPP members have been invited to get involved in 85 opportunities with 33 requests for panel involvement from staff across the trust.

Areas the PPP have been involved in include regular attendance at high-level meetings such as area learning forums, attendance at Board and learning from deaths. PPP members have been involved in various projects, including hospital handover improvement collaborative events, taxi in 5 project, cardiac arrest project research, palliative care research, PTS Public Health awareness project along with providing comments and feedback on the introduction of NHS Pathways into Emergency Operational Centres.

The panel membership receives regular information via a weekly roundup newsletter and quarterly bulletin, opportunities to engage with each other on a dedicated NWAS PPP members area including the NWAS Ambulance Academy for young persons and virtual development sessions (CPR, mental health and safeguarding). They have also had the opportunity to provide feedback on key documents and publications at the trust such as the trust's strategy and our winter demand and public health campaign.

We are very proud of our volunteers and their achievements and in 22/23, a PPP achievements summary book was produced in recognition of the Panel's third year anniversary. We are currently in the early planning stages of planning a face-to-face PPP celebration event in the early summer of 23/24 to thank our PPP members for their continuous support and celebrate their achievements, something which has not been possible during the pandemic period.

Recommendations for improvements

Engagement activities with our patient, public, panel and communities allow us to gather considerable feedback across all our service lines and identify specific themes. These are analysed in detail and articulated as recommendations for improvements. Some of these include:

- Feedback from our deaf community has highlighted the increased barriers to accessing 999 services. As a result, we launched the 999 BSL Video Relay service in June 2022. We also piloted an 'Insight' language communication App for operational staff to download on their trust ipads.
- We provided reassurance to our patient, public and community groups post pandemic regarding resources, safety of our services, availability and our overall response via regular stakeholder updates, patient engagement events and information bursts. We also kept them informed on an area based perspective of the availability of local services to support their self-care, with mental health as well as physical health and well-being respectively.
- Feedback from learning dashboards shared with PTS services lent support to purchasing bariatric wheelchairs for our PTS ambulances as well as a review of hospital site maps for patients and third parties to navigate and access hospitals easier.
- Further to feedback at the Lancashire community conversation event, we developed posters PPP information specific for use at mosques and translated our winter watch leaflets into different languages.
- Following PPP review of our 'Faith and Culture Card' a 'new' version will be made available electronically as part of the Directory of Services information available to operational crews. This will support the needs of differing communities at the time of a death.
- We are co-producing a new digital version pictorial communication handbook for staff to upload on to iPads with our PPP. Consideration will also be given to developing a digital version of our multi-lingual phrasebook to further enhance communication with ethnic minority 'new' communities in the region.
- FFT data and thematic dashboards have been co-designed improvements with PTS, PES NHS 111 ambassadors to support regular discussion of service improvement based on patient feedback.
- Following feedback that we need to make our PPP sessions more accessible to younger people we now host them virtually at different times of the day and evening. This supports our younger panel members that may have enrolled classes at colleges and universities during the day and for those panel members that work at different times.
- A recite me function on our website ensures publications such as the Ramadan Guide 23 is more accessible for disability and language needs.
- The PPP weekly round-up and monthly info burst newsletters are now provided in an accessible format for our visually impaired members and those who require their information in high contrast.
- We also have also invested in a photo symbols subscription so we will be able to produce more easy read information in the future.

- Our recent review of the patient engagement reporting platform we use to store and analyse patient feedback supports understanding with patients' survey feedback and well as by demographics so we can identify gaps and issues and look for ways to improve.

Complaints 22/23

We welcome all feedback from patients, including those whose experiences have not met their expectation and so have raised this with us through the complaints process. The complaints we receive offer a unique opportunity to investigate what has happened and where necessary, identify and implement lessons learnt. This can be at an individual and/or a system wide level. Providing a timely compassionate resolution and response to our complainants is one of our core priorities.

There is robust assurance around the monitoring and management of complaints. The Board of Directors receive information on complaints through a monthly integrated performance report. This is supported by assurance reports submitted to the Quality and Performance Committee quarterly. Area Learning Forums monitor actions arising from complaints via associated action plans and the NHS 111 service complaints are reported through the NHS 111 governance reporting procedures.

In 22/23, NWAS received 2,028 complaints in total. In DatixWeb, 994 complaints were reported (1 April 2022 till 3 October 2022) this is broken down by risk score:

- Risk Score 1: 326
- Risk Score 2: 515
- Risk Score 3: 127
- Risk score 4: 17
- Risk Score 5: 9

Of the 944 complaints, the complaints summary below identifies the categorisation and total number.

Complaints by Type	Number of Complaints
Staff Conduct	214
PTS Journey Times	208
Emergency Response Delays	205
Care & Treatment	193
Communication & Information	109
Driving Standards	39
Damage or loss to property	16
End of Life care	1
Safeguarding	1
Not categorised	8
Total	**994**

(Datix Web)

In DCIQ, 1,034 complaints were reported (3 October 2022 - 31 March 2023). This is broken down by risk:

- Low Risk (formerly Risk Score 1 & 2): **902**
- Medium Risk (formerly Risk Score 3): **104**
- High Risk (formerly Risk Score 4 & 5): **28**

Of these 1,034 complaints, the table below identifies the categorisation of complaints and total number.

Complaints Summary 22/23 DCIQ:

Complaint Category	Number of Complaints
Accidents & Injuries	5
Call Handling	152
Care & Treatment	390
Communication	76
Damage	22
Delays	393
End of Life/ Palliative Care	1
Equipment Non-Clinical	1
Infection Prevention & Control (IPC)	1
Information Governance	2
Medicines Controlled Drugs	1
Moving and Handling	18
Road Traffic Incident	6
Security	1
Slips, Trips & Falls	2
Vehicle	4
Violence & Aggression	5
Welfare	9
Total	**1089***

**Number is higher as some complaints had more than one complaint category associated with it.*

DCIQ allows us to scrutinise this data more closely, and for the top three types, we can explore the sub-categories of each where this has been populated.

Top Three Complaints Summary (DCIQ):

Complaints by Type	Sub-Type	Number of Complaints
Delays	Response Times: Resourcing	182
	Access to Emergency Department	10
	NWAS Call Pick up	5
	Response Times: Navigation Systems	2
	Access to PPCI	1
	Safe Discharge	1
	Access/Egress	1
	Waiting for Police Attendance	1
Care & Treatment	Professional Standards (Originally Conduct in Datix Web)	249
	Advice given by NWAS	58
	Treatment provided by NWAS	28
	Referral from NWAS	22
	Equality: Language	2
	Safeguarding	1
	Clinical Records	1
	Arrangements after Patient's death	1
	Confidentiality	1
Call Handling	Professional Standards	43
	Advice given by NWAS	30
	Call Handling timeframes	28
	Call Referral	28
	Eligibility Criteria	6
	Audit	3
	Information Gathering	2
	Escalation	2
	Call Termination	2
	Patient Demographics	2
Total		**712**

The breakdown of complaints by geographical area.

Geographical Area	Number of Complaints
Cumbria & Lancashire	272
Cheshire & Merseyside	318
Greater Manchester	498
No Value	1
Total	**1089***

**Number is higher as some complaints had more than one complaint area associated with it.*

The breakdown of complaints by service line.

NWAS Service Line	Number of Complaints
PES	297
PTS Bureau	237
Emergency Operations Centres (EOC)	203
NHS 111	184
PTS Operations	158
Clinical Hub	3
PTS CRU	2
NWAS	1
North West Air Ambulance (NWAA)	1
PTS Assurance	1
No value	2
Total	**1089***

**Number is higher as some complaints had more than one complaint service line & category associated with it.*

Complaint Outcomes

We have an agreed Redress Procedure to provide guidance on questions of remedy in line with the guidance provided by the Parliamentary and Health Service Ombudsman (PHSO) for reasonable, fair and proportionate remedies during its complaints handling processes. For 22/23 the outcomes of complaints investigated by the Patient Safety team were as shown below with the percentage of the total complaints received shown below:

Upheld	Partly Upheld	Not Upheld	Ongoing
378	515	980	112
19%	26%	49%	6%

Quality Innovation and Improvement

Ambulance Clinical Quality Indicators (ACQIs)

Our key measure of the effectiveness of our services is the National ACQI submission to NHS England. This is produced each month by the clinical audit team and used by clinical leadership to inform their local improvement and feedback to staff.

There are clinical leads for each of the indicators who lead working groups across the trust and work with system partners to learn and share outcomes. Local reporting on the National ACQIs is received quarterly at the trusts Quality and Performance committee and the Clinical Effectiveness sub-committee. Further localised reporting is provided to the clinical leads within the trust for Cardiac Arrest, STEMI, Stroke and Sepsis to contribute to learning and improvement in the quality of healthcare provided. We submit our ACQI outcomes and performance monthly as part of our National NHS England return.

Data collection for these indicators occurs three months in arrears, so the performance data displayed in the below tables are for Quarter 1 - Quarter 3 22/23. To note the Sepsis ACQI has been retired and an Older Adult Falls ACQI will be piloted using March 2023 data.

National Ambulance Clinical Quality Indicator	November Performance 2021/2022	November Performance 2022/23	November National Average 2022/23
Cardiac Arrest (All – ROSC at Hospital)	28.5% (92/323)	29.3% (105/358)	27.8% (827/2978)
Cardiac Arrest (Utstein – ROSC at Hospital)	52.8% (28/53)	34.7% (17/49)	48.2% (214/444)
Cardiac Arrest (All – Survival to 30 days)	8.0% (25/314)	4.2% (15/356)	7.8% (229/2935)
Cardiac Arrest (Utstein – Survival to 30 days)	22.4% (11/49)	16.3% (8/49)	25.1% (106/423)
STEMI PPCI Patients (Call to Angiography)	03:00:00 (109)	02:41:00 (131)	02:30:00 (899)
Confirmed Stroke Patients (Call to Door)	01:51:00 (522)	01:41:00 (516)	01:47:00 (4334)
Diagnostic Stroke Care Bundle	97.4% (856/879)	97.4% (1048/1076)	97.2% (8765/9022)

ACQI Outcomes (Q3 2021/22 - Q3 2022/23
Data Source: NHS England. 2022. Ambulance Quality Indicators 2022/23. [ONLINE] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2022-23/ [Accessed 13 April 2023].

Stroke Care Bundle

Reporting Period: April 2022 – November 2022		
AQI Care Bundle Performance	**NWAS: Outcomes from Stroke Care Bundle**	**National Average & Range**
April 2022	*No National Data Published*	
May 2022	**97.1%**	**96.4%**
June 2022	*No National Data Published*	
July 2022	*No National Data Published*	
August 2022	**96.3%**	**95.9%**
September 2022	*No National Data Published*	
October 2022	*No National Data Published*	
November 2022	**97.4%**	**97.2%**
December 2022	*National data not published at the time of writing*	
January 2023		
February 2023		
March 2023		

ACQI Stroke diagnostic care bundle data
ACQI Stroke Diagnostic Bundle data. Data Source: NHS England. 2022. Ambulance Quality Indicators 2022/23. [ONLINE] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2022-23/ [Accessed 13 April 2023].

Acute ST-elevation Myocardial Infarction Care (STEMI) Bundle

Reporting Period: April 2022 – November 2022		
AQI Care Bundle Performance	**NWAS: Outcomes from STEMI Care Bundle**	**National Average & Range**
April 2022	**64.2%**	**72.0%**
May 2022	*No National Data Published*	
June 2022	*No National Data Published*	
July 2022	**67.9%**	**73.6%**
August 2022	*No National Data Published*	
September 2022	*No National Data Published*	
October 2022	**68.5%**	**72.7%**
November 2022	*No National Data Published*	
December 2022	*No National Data Published*	
January 2023	National data not published at the time of writing	

Table 8: ACQI ST elevation myocardial infarction care bundle data
Data Source: NHS England. 2022. Ambulance Quality Indicators 2022/23. [ONLINE] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2022-23/ [Accessed 13 April 2023].

Post ROSC Care Bundle

Reporting Period: April 2022 – November 2022		
AQI Care Bundle Performance	**NWAS: Outcomes from Cardiac Care Bundle**	**National Average & Range**
April 2022	**76.5%**	**78.6%**
May 2022	*No National Data Published*	
June 2022	*No National Data Published*	
July 2022	**70.2%**	**77.0%**
August 2022	*No National Data Published*	
September 2022	*No National Data Published*	
October 2022	**73.8%**	**76.5%**
November 2022	*No National Data Published*	
December 2022	*No National Data Published*	
January 2023	National data not published at the time of writing	

ACQI post ROSC care bundle data
Data Source: NHS England. 2022. Ambulance Quality Indicators 2022/23. [ONLINE] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2022-23/ [Accessed 13 April 2023].

Sepsis Care Bundle

Reporting Period: April 2022 – June 2022		
AQI Care Bundle Performance	**NWAS: Outcomes from Stroke Care Bundle**	**National Average & Range**
April 2022	*No National Data Published*	
May 2022	*No National Data Published*	
June 2022	**67.3%**	**83.9%**
July 2022	*No National Data Published*	
August 2022	*No National Data Published*	
September 2022	*ACQI retired and will be replaced with Older Adult Falls – March 2023 data*	
October 2022		
November 2022		
December 2022		
January 2023		
February 2023		
March 2023		

ACQI Sepsis care bundle data
Data Source: NHS England. 2022. Ambulance Quality Indicators 2022/23. [ONLINE] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2022-23/ [Accessed 13 April 2023].

Falls Care Bundle

During 2022 the national teams agreed to stand down the sepsis care bundle and replace the audit bundle with a new audit for falls. This was agreed to be developed and piloted during 22/23 with a view to full submissions commencing from March 2023. Initial returns were required from December 2022. This was deferred across the ambulance sector to allow sufficient time for development. The new bundle will support us in understanding the quality of care delivered to patients who have fallen outside of hospital but whom have not been conveyed to hospital to assure the safety of this care and to develop improvements in care provision for falls patients.

Clinical Audit

We have successfully transitioned from a paper-based paramedic emergency service patient record to an electronic patient record (EPR). The electronic record supports clinicians in offering condition specific sections with pre-determined data entry (where appropriate) in addition to 'free type space' for more detailed data entry.

The move to an EPR has required the development of an in-house clinical audit tool - Apex. The development group (multi-disciplinary team who include digital developers and specialists in the use of Power Business Intelligence (BI) systems working closely with the clinical audit team) have successfully completed three of the five required modules for national mandatory clinical audit. It has been possible to realise some of the anticipated benefits in terms of reducing the number of systems the auditors have historically had to access to complete the audit. Apex remains in phase 1 development – and the scope is to deliver an audit mechanism for each of the AQIs, with an output suitable for several audiences including the national submission requirements, and to frontline staff members as a personal clinical development indicator. At the time of writing phase 1 is close to completion with Apex modules for stroke, Sepsis and STEMI AQIs available for audit use.

Quality Assurance Visits (QAVs)

We have conducted annual Quality Assurance Visits (QAV) across PES, PTS, HART and contact centres since 2012. The purpose of QAVs is to provide assurance about the quality and safety of operational premises, vehicles and services at sector level and provide internal second line assurance and information in relation to key lines of enquiry from the Care Quality Commission.

QAVs include several health and safety focused assessments in parallel to other audits such as the Health and Safety Workplace Inspection (WI), Fire Risk Assessment (FRA), Infection, Prevention and Control Audits (IPC).

After the QAV takes place, the nominated QAV lead produces a report comprising a summary of the key findings and an action log, which is then submitted to the head of operations for sign off. This includes an internal rating system that scores each area assessed as Outstanding, Good or Requires Support.

A central repository of all QAV reports and actions is held on our knowledge management system, SharePoint. The overall position for QAV compliance across the trust (as at 27/03/2023) is strong with 94% of all operational sites having received a QAV in the last 12 months.

Each sector has their own integrated action tracker which is stored on an Excel spreadsheet, which is centrally located in our knowledge management system, SharePoint. The integrated action trackers are managed locally by area administrators and contain actions from various audits. As of 27 March 2023, the current action completion position was challenging with each area averaging at over 70% compliance for closure of actions.

Following imminent changes to the CQC's regulatory model (single assessment framework), we have commenced the journey to redesign our internal QAV assessment framework. This will ensure our internal assurance systems are aligned to CQC's new Quality Statements which have replaced the key lines of enquiry and prompts. This is also an opportunity for us to redesign our internal assurance processes to further improve oversight of safety.

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Care Quality Commission (CQC)

As of 31 March 2023, our overall CQC ratings remain the same as the 20/21 Quality Account:

Ratings	
NWAS overall rating	**Good**
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Our overall CQC Inspection ratings matrix is as follows:

	Safe	Effective	Caring	Responsive	Well-led	Overall
U&EC	Good	Good	Good	Outstanding	Good	**Good**
PTS	Good	Good	Good	Good	Requires Improvement	**Good**
EOC	Good	Good	Good	Good	Good	**Good**
Resilience	Good	Good	Not rated	Good	Good	**Good**
NHS 111	Good	Good	Good	Good	Good	**Good**
Overall	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

In 22/23 the CQC continued to regulate providers using a risk-based model whilst moving towards their new regulatory model, which commences in April 2023. Their approach during 22/23 included a number of non-rated inspections in Urgent and Emergency Care services and 111 and ongoing routine engagement meetings and enquiries.

In February 2022 the CQC announced a system level focussed inspection of Urgent and Emergency care within the Lancashire and South Cumbria Integrated Care System (ICS) and each of the partner agencies within the ICS, and a similar a similar inspection in North Mersey. The CQC also inspected the NWAS 111 service.

Inspection reports were received for paramedic emergency services (PES) within the geographical footprints, the emergency operational control (EOC) service and 111, with system summary reports for the two ICBs also being received for review. We provided feedback and comments on the system summary reports in line with CQC required timescales. The inspections were not rated and thus the overall ratings for NWAS remained the same, with 'Good' overall.

Overall, the inspections provided strong recognition of the safety and quality of our services and no enforcement action was required. Furthermore, no follow up inspection for the organisation was tabled. Several best practices were noted in within the 'innovation station' at Kendal, that there was a strong focus on continuous improvement throughout and that we controlled infection well.

Six 'should do' actions were suggested for PES and EOC. These were:

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

Digital Statement

During 22/23, the digital strategy continued to progress at pace. The Digital Design Forum has continued to offer the opportunity for any staff member to discuss ideas and problems with the digital team and developments, such as digital timesheets being developed as a result. The Digital Champions network was established and brings together those staff who support their colleagues locally and driving digital change. Our digital trainers for the first time are supporting frontline staff with a particular focus on the iPads and EPR.

EPR phase 2 has been developed to include access to the patient's GP record and many clinical advancements which have been requested by staff which will be launched early 23/24. We have led the way nationally in the development of our Directory of Services and now have the pathways system in both 999 and 111 which means patients can be referred to the right place if required.

We have continued to progress our cyber security and the resilience of our infrastructure including significant undertakings in collaboration with operational colleagues such as switch replacements with progress reported through our Information Management Sub Committee, Audit Committee and Resources Committee. We have developed our architecture to support remote working for clinical staff and moving forward to support the new hybrid clinical models with our work on interoperability supporting our integrated models. We are leading innovation in the ambulance sector with new developments being tested including virtual reality, Artificial Intelligence, real time

tracking and our SMART sites and interactive wallboards which has begun roll out across the whole NWAS estate. We have increased access to data to inform strategic planning and decision making with 12,000 unique views of our power BI dashboard every quarter.

Medical Directorate

Freedom to Speak Up

We are committed to an open and honest culture, maintaining high standards of patient care, continuously striving to act honesty and with integrity in its approach to management systems, processes, responsibility as an employer, protecting the people who work within the organisation and communities that it serves from harm.

FTSU (Freedom to Speak Up) Activity 22/23

During 22/23 the Freedom to Speak Up Guardians saw a 3% increase in cases on the previous reporting period with 100 concerns being raised. Common themes mirrored the previous reporting period with concerns revolving around human resource matters, an increase in the number of patient safety concerns and significant increase in concerns connected to racism and sexist behaviours which reflects the picture nationally.

The freedom to speak up guardians continue to be supported by the executive medical director and non-executive directors as well as regular meetings with the CEO and director of people. Work is now ongoing to implement further improvements to Freedom to Speak Up in line with best practice which has been issued this year.

Medicines

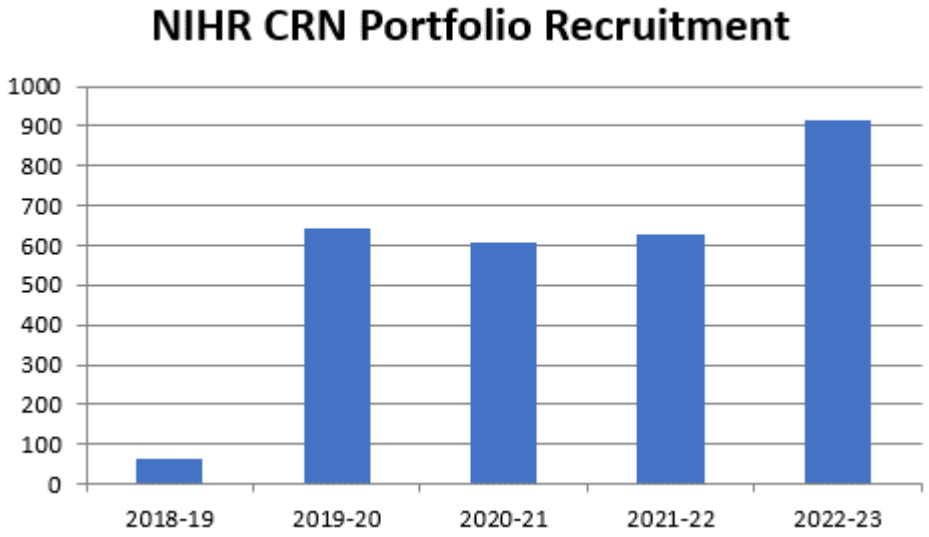
Our Medicines Team consists of pharmacists, pharmacy technicians and medicines assistants, and provides the operational function of procurement, assembly and distribution of all medicines including vaccines, as well as driving the medicines governance and optimisation strategy. Key achievements during 22/23 include:

- Implementation of changes to our medicines formulary, including widening access to naloxone administration to treat opiate overdoses and introducing an antibiotic to minimise infection in patients with an open fracture.
- Securing funding to expand the footprint of the Medicines Supply Hub.
- Reengineering of processes for nerve agent countermeasure medicines.
- Medicines safety campaign tied in with World Patient Safety Day.
- Strengthening controlled drug handling arrangements with a focused group to oversee all aspects of governance and a new dashboard to monitor usage.

Research and Development

Trusts that are research active have been shown to provide a better health care experience and deliver improved outcomes for patients and this is recognised by the Care Quality Commission (CQC). Health and social care providers are subject to inspection under the CQC's 'well-led framework' and are assessed on how well clinical research is embedded into their organisation as a core activity. We strive to enhance the health and wellbeing of our communities by translating high quality research into exceptional service provision and outstanding clinical practice.

Over the last five financial years (FY), we have increased the number of National Institute for Health and Care Research Clinical Research Network (NIHR CRN) Portfolio research studies that our patients, staff and the public can take part in. In FY 18/19, 65 participants took part in NIHR CRN Portfolio research studies with NWAS. By FY 22/23, we increased our research activity substantially so that 913 participants were involved in high quality, national research.



By offering more opportunities to take part in research, participation has increased by 173% which demonstrates our ongoing commitment to fulfil the priorities outlined in our Research Strategy:

1. Ensure that research is visible and supported throughout the whole organisation.
2. Expand our research networks and facilitate research collaborations.
3. Increase our research capacity and capability.

This enhanced performance has attracted additional funding from the NIHR which supports the continued growth of research activity at our organisation. We act flexibly and strategically to maintain research capacity and capability to ensure that we continue to strengthen the culture of evidence-based practice and can continue to deliver safe, effective, and patient-centred care.

Annual Sustainability Report

Introduction

Following the 'Delivering a Net Zero NHS' report, all trusts were asked to produce a strategy in the form of a Green Plan by January 2022 to outline how they plan to work towards Net Zero. As our Green Plan was published in 2019, we were not required to produce a new green plan. However, the guidance for producing a green plan included core chapters which are: workforce and system leadership, sustainable models of care, digital transformation, travel and transport, estates and facilities, medicines, supply chain and procurement, food and nutrition, and adaptation. We have mapped actions across to these areas with a view to include them formally in the 2025 updated version of the plan.

22/23 has seen continued momentum for delivery of the Green Plan actions across NWAS, despite the ongoing pressures an ambulance trust faces. The Green Plan provides us with a framework to deliver sustainable emergency care and has complemented some of the innovations seen this year. Continued roll-out of initiatives such as electric vehicle charging infrastructure for workshop and rapid response vehicles and the degasification of the Estuary Point Control Centre illustrates seized opportunities to scale-up decarbonisation initiatives as well as build on those accelerated during the pandemic, such as remote working.

The following sections outline the progress we have already made in improving our carbon footprint and reducing the environmental impact of our services. It provides an overview of the NHS' modelling and analytics underpinning the carbon footprint, progress to net zero and the interventions made to achieve that ambition.

Energy & Water

There has been a lot of financial pressure on us in relation to energy over the last 12 months. As we recovered from the pandemic, demand for energy started to increase again and could not be met due to a shortage in supply, causing prices to increase. The problem was made worse by cold weather during the winter months and renewable sources like wind and solar producing less power.

Gas costs increased by 49%, taking spending from £320,502 in 21/22 to £477,950 for 22/23. Similarly, electricity rose by 45%, taking spending from £1,083,614 last year to £1,580,925 for 22/23.

Aim

Reduce carbon emissions from energy use, in line with data informed budgets to be on track for net zero by 2040:

- Use less energy
- Replace fossil fuels with low and zero carbon energy sources
- Investigate options to offset, or inset our residual carbon emissions

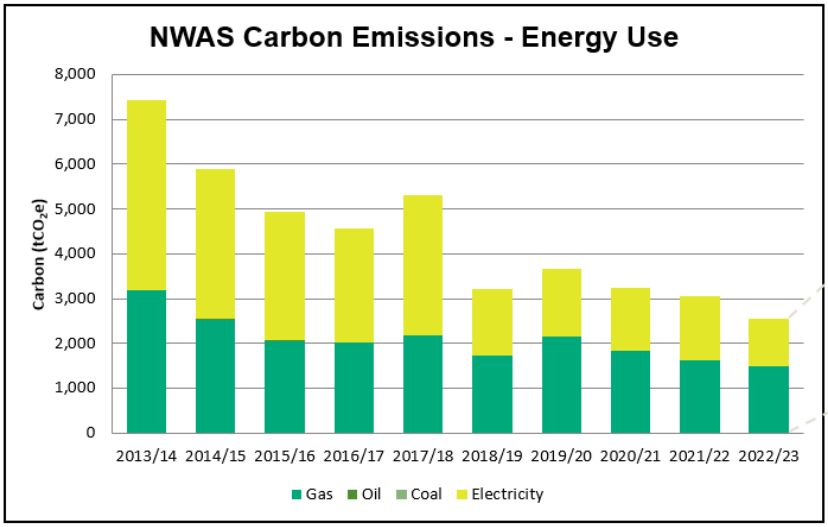
Minimise water use in our buildings:

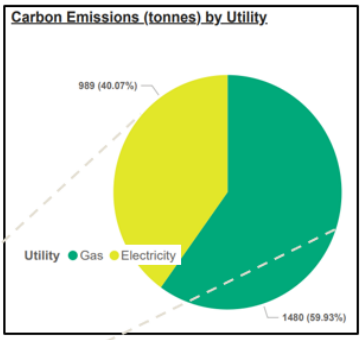
- Eliminate wasted water
- Increase water efficiency

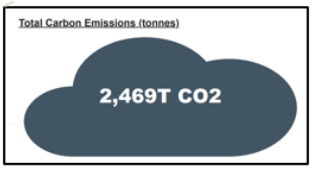
Performance

- Carbon emissions from building energy use decreased by 489 tonnes in 22/23, which is 4872 tCO_2e below the baseline year of 2013.
- This 65% decrease is due to a reduction of fossil fuels, both directly (scope 1) and indirectly (scope 2 – decarbonisation of the grid).
- Overall gas use for space heating decreased due to milder outside air temperatures and improved use of building management systems.
- Overall electricity demand decreased by 24%, due to staff homeworking and the continued roll-out of LED lighting across the estate.
- However, demand for electricity is likely to increase at most of our sites in the coming years, mostly attributable to further use of heat pump technology to degasify the estate.

Utility	Carbon Emissions (tonnes)	Consumption (kWh)	Gross Cost (£)
Gas	1,479.50	8117458	477,950.00
Electricity	989.09	5138972	1,580,925.75
Total	**2,468.59**	**13256430**	**2,058,875.75**

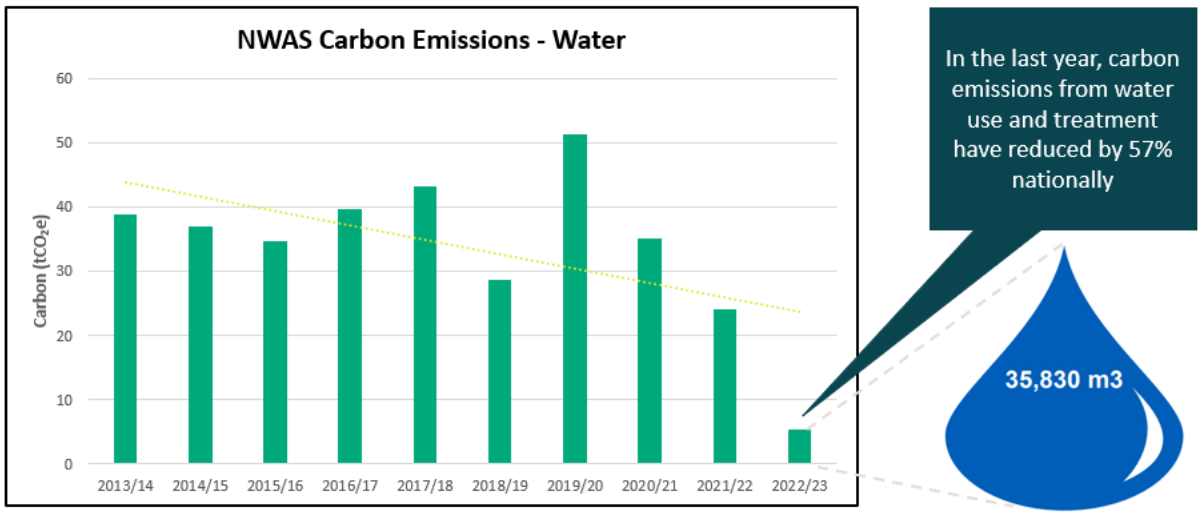






We continue to move in the right direction in line with the annual reduction pathway towards net zero by 2040.

Utility	Consumption (m3)	Gross Cost (£)
Water	35830	294,500.95



- Carbon emissions from water use and treatment have reduced by 57% in 22/23 compared to the previous year. This reduction is entirely due to revised carbon conversion factors that are published nationally and applied to actual consumption data for our sites.
- Although mains water consumption can vary year-on-year, the general trend is heading in the right direction. In 2013, we consumed 42,677m^3 of water, whereas for 22/23 total consumption was 35,830m^3.

We are going into 23/24 more informed than ever before, following a number of completed feasibility studies and on-going works. These include:

- In-depth energy surveying by TEAM Energy at ten of our sites, identifying projects which could bring about carbon savings of over 400 tonnes per annum
- Feasibility studies around fuel cell CHP and its wider use
- Building fabric assessments using our in-house developed heat loss calculator
- Desktop feasibility assessment of several sites to identify a suitable site to become the first net-zero ambulance station
- Development of a net-zero new build and retrofit guide for our ambulance stations (available by end of 2023)

Work with other blue light services, city and regional partners has increased, particularly around progressing a feasibility study for a heat network at co-located sites in Greater Manchester (this work also extends to EV charging mentioned in later sections). This has culminated in a more

strategic estates decarbonisation group which will play a key role in steering the transformational change required to deliver these ambitious carbon reduction objectives.

Given the energy market, we are in a reasonable position with prices protected for the forthcoming financial year to remain on a 100% renewable energy tariff. This was only achieved through a combination of reducing payment terms, further digitising billing, and eliminating unnecessary standing charges.

Plans for Next Year

- Prioritise decarbonisation projects based on the learning from the feasibility studies outlined above
- Agree an LED rollout programme which builds on existing works to achieve 95% or more coverage by end of 2026
- Improve energy optimisation through Building Management System (BMS) projects and management practices
- Prepare and submit for Public Sector Decarbonisation Scheme (PSDS) grant scheme
- Develop and feed in decarbonisation investment opportunities for the estates' capital programme
- Further infrastructure and decarbonisation feasibility studies including PV feasibility assessments for example
- Investigate the potential for innovative zero-carbon procurement options such as power purchase agreements (PPAs)
- Improve engagement on decarbonising the estate both within the estates directorate and trust-wide.

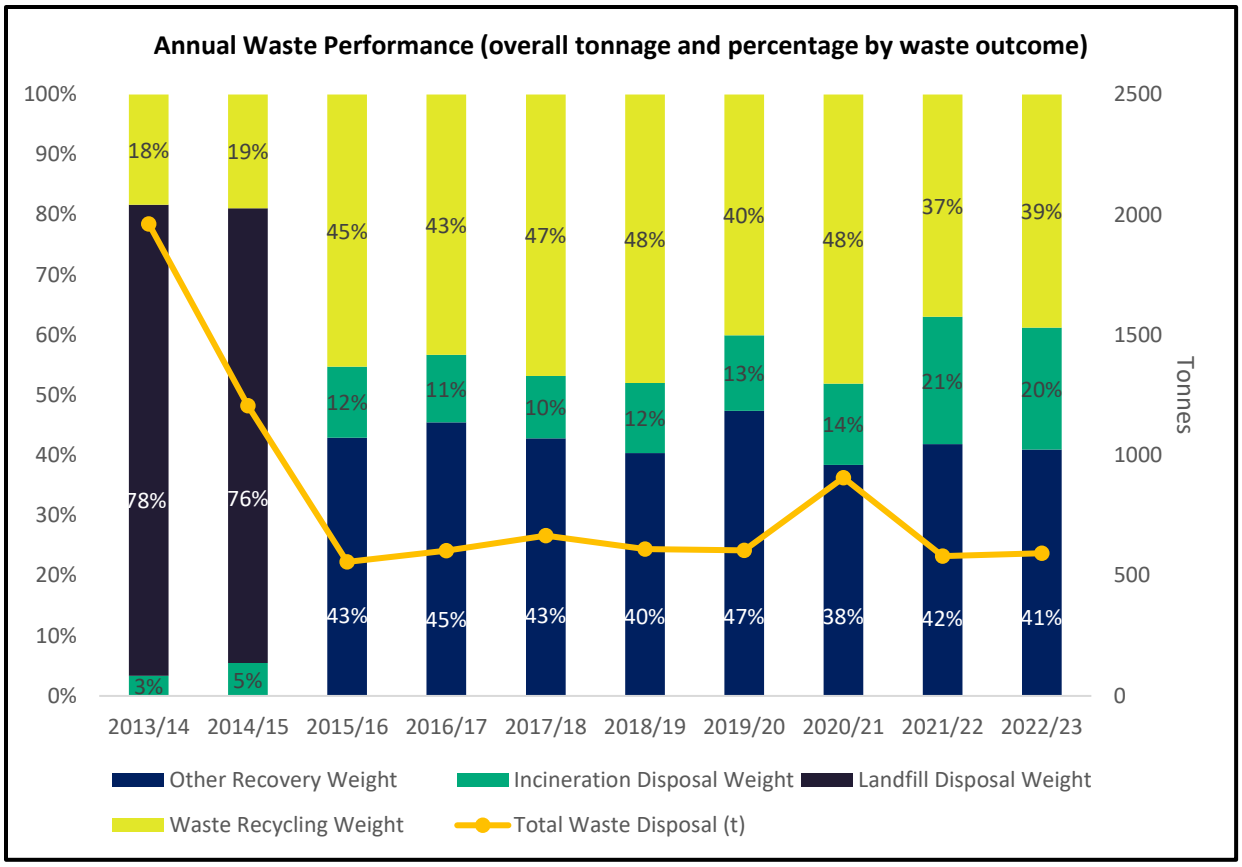
Despite the demands from our buildings and estate, the plan for the forthcoming year is to drive energy reductions and use resources as efficiently as possible.

Waste

Aim

Generate less waste; reuse and recycle more, and ensure unavoidable waste is disposed of in the most sustainable way:

- Reduce the amount of waste we create by working and purchasing in more resource-efficient ways
- Increase the number of items we reuse with a focus on reducing single-use plastics
- Repair or reuse more items that can be repaired or reused
- Increase the amount of waste that we reuse or recycle to 50% of consignment waste by volume, which NWAS were on the way to achieving pre-pandemic
- Maintain zero waste to landfill



Performance

Clinical Waste:

As we continued to respond to the pandemic, clinical waste volumes increased in line with the demands involved with higher patient activity. Since then, we have actively been winding-back additional collections and actively reclassifying clinical wastes to reduce tonnages to pre-covid levels. Further work is planned for 23/24 which will see large portions of waste destined for high temperature incineration, disposed of through alternative treatment, meaning the carbon footprint (and associated costs) will be reduced as we strive towards NHS England's 20:20:60 split for clinical waste target. NHS England encourages a split of 60% offensive waste, 20% waste sent for high temperature incineration (HTI), and 20% of waste sent for alternative treatment (AT), which if successful would reduce NWAS high temperature incinerated waste to <10% of current tonnage.

General and Workshop Waste:

General waste volumes have remained consistent for the last few years (except for 20/21) and as a result there have been no significant changes in waste composition or total waste volumes. NWAS continues to ensure that all recyclable material, such as paper, cardboard, plastics, metals and glass are segregated at the point of generation, and that all provisions are in place for hazardous wastes such as used engine oils, other engine fluids and batteries for safe disposal.

Plans for the Next Year

- Examine the disposal routes for all materials across the trust and look to move waste up the waste hierarchy
- Work with colleagues in Procurement and NHS Supply Chain for a deeper investigation into data related to key product categories of single use plastic – aimed at reducing consumption
- Collaborating with ICB to look at waste management and proposals for a regional approach to reuse and recycling
- Staff training and understanding will be improved by embedding the healthcare waste management guide into local inductions and developing additional waste training (such as toolbox talks, IPC linked-training and guidance documents)
- To develop a metric for measuring and reporting in reuse

Fleet, Travel & Logistics

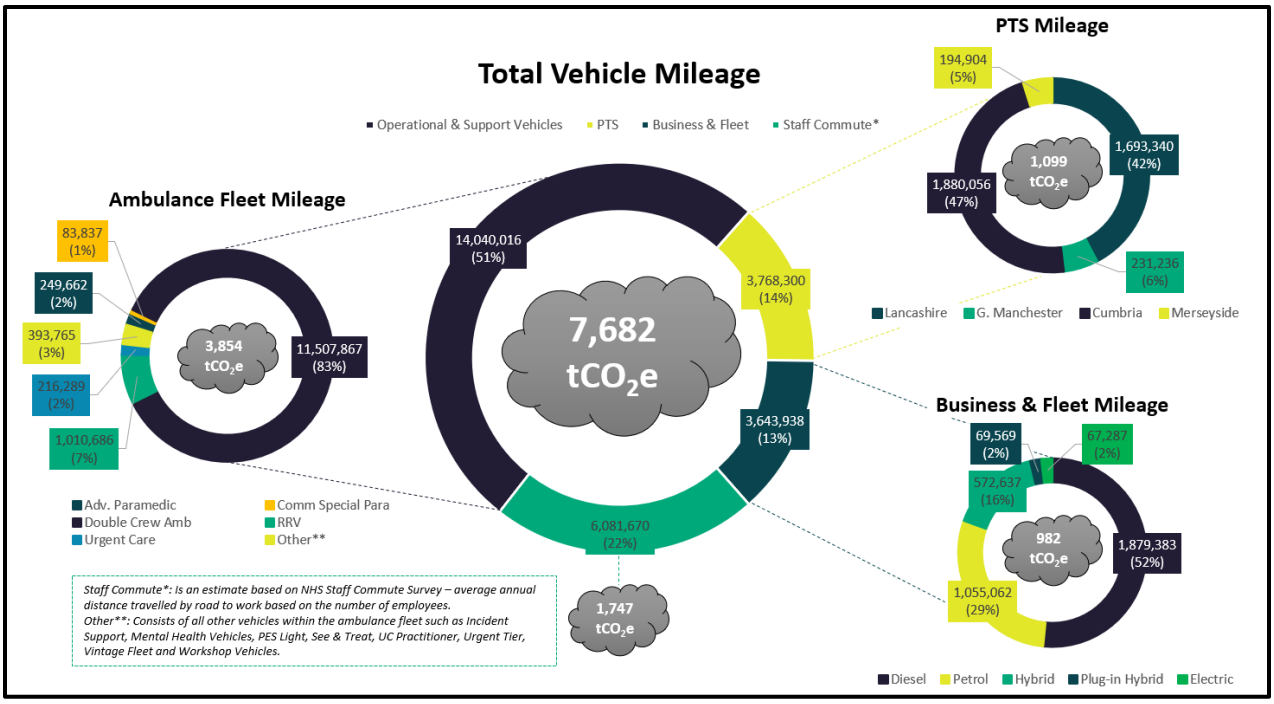
We produce significant carbon emissions from fleet, staff travel, and the logistics associated with our activities and service provision. To deliver high quality care, we make use of a large and varied fleet of vehicles and the analysis accounts for all vehicles used for NHS duties that are directly owned and leased by the trust with emissions totalling approximately 7,682 tCO_2e for 22/23.

We aim to ensure all vehicles purchased or leased are low and ultra-low emission (ULEV), in line with existing NHS operating planning and contracting guidance and meet the NHS Long Term Plan commitment for 90% of the NHS fleet to use low, ultra-low and zero-emission vehicles by 2028. However, the automotive industry has been severely hampered by a shortage of semiconductor chips in recent years, with impacts further exacerbated since the pandemic relating to demand. Ambulances pose a specific challenge and require targeted interventions but for the rest of the fleet, we continue to explore options for a complete transition to zero-emission vehicles by 2032.

Aim

To embed active, clean and low carbon travel to improve air quality and reduce carbon emissions from journeys:

- Reduce air pollution and carbon emissions from our owned and commissioned transport operations
- Use our influence to help fast-track the decarbonisation of transport in our supply chain
- Increase the proportion of people commuting to our sites using active and sustainable travel methods

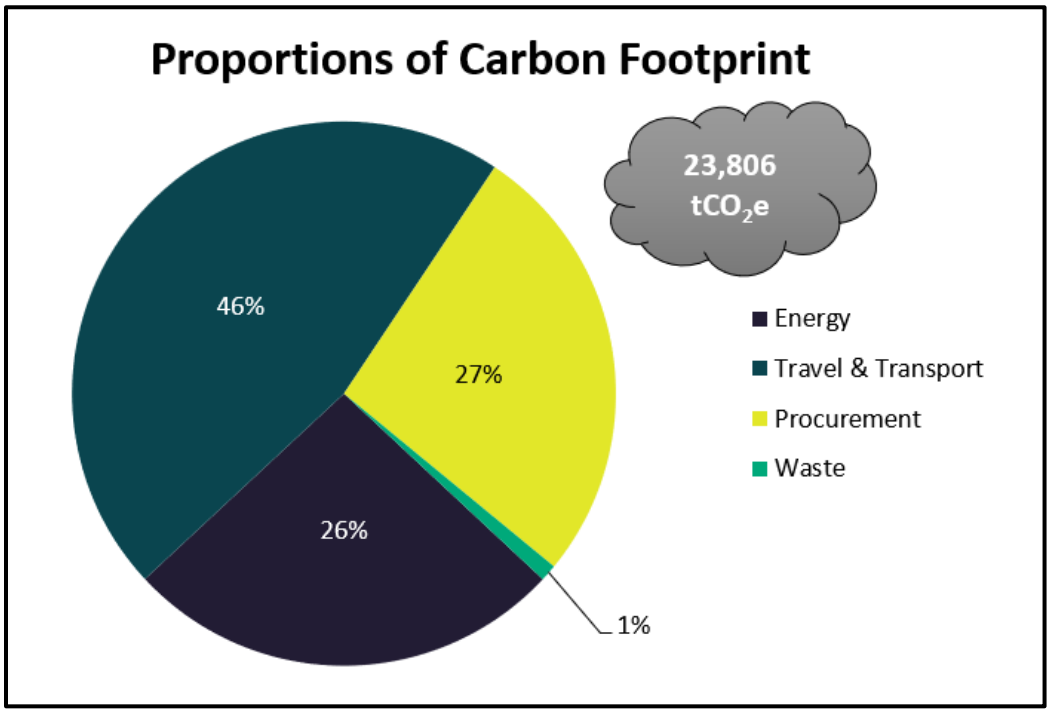


Performance

- This year we have seen a 5.1% increase in vehicle miles, but a decrease in emssions of 82 tonnes largely due to continued rollout of electric RRVs and workshop vehicles
- Overall, there has been a 62% reduction in emissions compared to the baseline year of 2013. A significant proprotion of this decrease is linked to a reduction in business travel since the pandemic, efficiency improvements in diesel vehicles and the aforementioned roll out of electic service vehicles
- There has also been a small but significant increase in the number of staff using electric vehicles and hybrids
- There has been active links with transport authorities to enable more incentivised travel for staff in more urbanised areas. This also links to the planned review of all trust sites to ensure they are accessible by public transport and that active travel facilities are provided on all our sites, such as secure cycle parking, showers and lockers
- Our Car Lease Policy has also undergone review to promote the use of low carbon and zero emission vehicles to essential users

Carbon Footprint

The information provided in the previous versions of this annual report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information estimates the impact of our supply chain from our spend.



Resulting in an estimated total carbon footprint of 23,806 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 93 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO2e/£).

The Accountability Report

Our Accountability Report has been prepared to meet key accountability requirements to parliament and is based on matters required to be dealt with in a Directors' Report, as set out in Chapter 5 of Part 15 of the Companies Act 2006 and Schedule 7 of SI 2008 No 410, The Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008, and in a Remuneration Report, as set out in Chapter 6 of the Companies Act 2006 and Schedule 8 of SI 2013 No 1981, The Large and Medium-sized Companies and Groups (Accounts and Reports) (Amendment) Regulations 2013.

Daren Mochrie QAM, MBA, Hon DHC, Dip IMC RCSEd, MCPara **Date: 21 June 2023**
Chief Executive

Corporate Governance Report

Directors' Report

Membership of the Board of Directors for the 2022/23 reporting period:

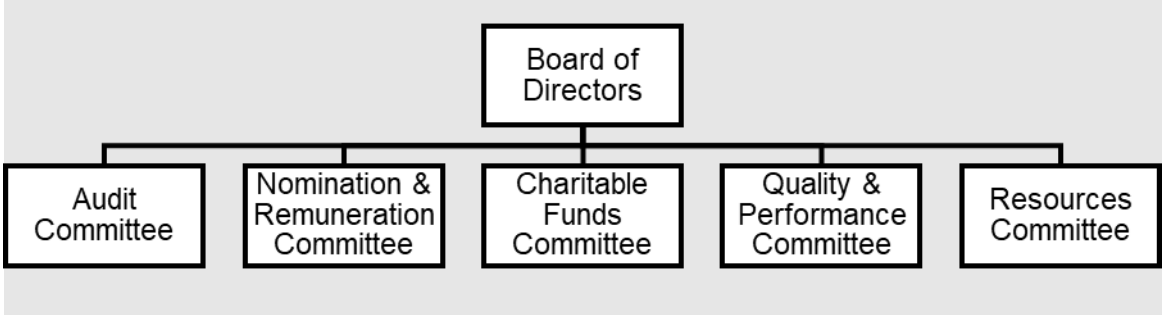
Peter White Chairman	Daren Mochrie Chief Executive
David Rawsthorn Non-Executive Director	Carolyn Wood Director of Finance
David Hanley Non-Executive Director	Ged Blezard Director of Operations
Alison Chambers Non-Executive Director	Dr Chris Grant Medical Director
Aneez Esmail Non-Executive Director	Maxine Power Director of Quality, Innovation and Improvement
Catherine Butterworth Non-Executive Director (From 1st April 2022)	Salman Desai Director of Strategy, Partnerships and Integration
	Angela Wetton Director of Corporate Affairs
	Lisa Ward Director of People

Attendance of Board of Directors Meetings and Committees during 2022/23:

Board Member	Term of Appointment	Board of Directors	Audit Committee	Nominations & Remuneration Committee	Charitable Funds Committee	Quality & Performance Committee	Resources Committee
		Attendance (actual/max)					
		Non-Executive Directors					
Peter White (Chairman)	1/2/19 – 1/2/23 1/2/23 – 31/1/25	7/8		4/4			
David Rawsthorn	25/3/19 – 24/03/21 25/3/21 – 24/03/23 25/3/23 – 24/3/24	8/8	6/6	4/4	3/3		6/6
David Hanley	28/5/19 – 27/5/21 28/5/21 – 27/5/23	8/8	1/1	4/4	2/3	9/9	6/6
Alison Chambers	1/8/19 – 31/7/21 1/8/21 – 31/7/23	8/8	5/6	4/4		8/9	
Aneez Esmail	1/4/2021 – 31/3/23 1/4/23 – 31/3/26	6/8	5/6	3/4		7/9	
Catherine Butterworth	1/4/22 – 31/3/24	8/8	4/6	4/4	2/3		5/6
		Executive Directors					
Daren Mochrie		7/8					
Ged Blezard		7/8			2/3	8/9	6/6
Chris Grant		8/8				9/9	
Salman Desai		8/8			3/3		6/6
Angela Wetton		7/8			3/3	9/9	
Maxine Power		7/8				7/9	1/6
Lisa Ward		8/8			3/3		6/6
Carolyn Wood		7/8			3/3		6/6

Committees

A number of assurance committees reported to the Board of Directors during 1 April 2022 and 31 March 2023, these committees were as follows:



The Terms of Reference for the Audit Committee are based on the model terms of reference incorporated in the HFMA Audit Committee Handbook. In relation to the Committee self-assessment, the HFMA Audit Committee Handbook provides two checklists to aid facilitation of the Committee self-assessment in relation to 1) to test the committee processes; and 2) to test its effectiveness. During Q2 2022/23, MIAA undertook an assessment of the committee processes, the outcome of the assessment was positive however highlighted the requirement to assess the performance of external audit. The Audit Committee received the review of the work of the external auditors at its January 2023 meeting and will be undertaken every three years.

Members of the Audit Committee during 2022/23 were David Rawsthorn (Chair), Alison Chambers, Aneez Esmail and Catherine Butterworth. The Chair of the Committee has the relevant financial experience. The Chair of the Audit Committee presented the Annual Report of the Audit Committee to the Board of Directors on 26 April 2023 to provide a summary of the activities undertaken by the Committee and how the Terms of Reference and key priorities were met during 2022/23. The Audit Committee Terms of Reference for 2023/24 were also approved. The trust's External Audit service is provided by Mazars LLP and the cost for audit of the 2022/23 financial statements was £72,750. Mazars have not provided the trust with any non-audit services during the reporting period.

In April 2023, the Audit Committee received an update relating to the trust's compliance with the FT Code during 2022/23. The FT Code is based on the UK Code of Governance to reflect latest and best practice application of good corporate governance and provides a tried and tested framework for the leadership and direction of board led organisations in the UK. Whilst the trust is not a foundation trust, it takes full account of the NHS Foundation Trust Code of Governance published by Monitor (now NHS Improvement) for trust boards. A summary of the trust's corporate governance arrangements against the FT Code was provided to the committee for assurance and the trust was able to declare compliance with all relevant clauses.

Each committee has formal terms of reference which are approved by the Board of Directors and sets out the powers and functions of the committees. These terms of reference are subject to annual review by the relevant committee with outcomes subsequently reported to the board of directors for approval. This annual review process incorporates a review of committee effectiveness against five themes and identifies areas of development to further strengthen their remit. The five themes Committees are assessed against are:

- Committee focus
- Committee engagement
- Teamworking
- Effectiveness
- Leadership

Register of Interests

The trust maintains a Register of Interest for the Board of Directors and is subject to bi-monthly review by the board. Where details of company directorships have been declared and where those companies are likely to do business or are possibly seeking to do business with the NHS, Board members declare their interest and withdraw from any decision-making process. During 2022/23, there were no identified breaches in respect of any declarations made by the Board of Directors.

As far as the executive directors are aware, there is no information relevant to the auditors for the purposes of their audit report. The executive directors have taken all of the steps they ought to have taken to ensure they are aware of any relevant audit information and to establish that the auditors are aware of that information.

The board considers that its non-executive directors are independent in character and judgement insofar as:

- No non-executive director has a third party business relationship with the trust
- No non-executive director has an income from the trust other than remuneration for their non-executive position
- No non-executive director financially relies on the income earned in their role or is either a supplier or customer of the trust
- No non-executive director has a personal connection to any senior trust managers, and,
- No non-executive director has been on the board for more than nine years.

The Board of Directors Register of Interest is available to view here.

Fit and Proper Persons Requirements: Directors and Non-Executive Directors

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

In March 2023, the Board of Directors received the Chairman's Annual Declaration confirming that all existing executive and non-executive directors met the requirements of Fit and Proper Persons Test which was informed by the application of the Board approved Procedure on Fit and Proper Persons Requirements including:

- Pre-employment checks for all new appointments undertaken in line with the NHS Employment Standards and including the following:
    - Proof of identity
    - Disclosure and Barring Service check undertaken at a level relevant for the post
    - Occupational Health clearance
    - Evidence of the right to work in the UK
    - Proof of qualifications, where appropriate
    - Checks with relevant regulators, where appropriate
    - Appropriate references, covering at least the last three years of employment, including details of gaps in service.
- Additional checks for all directors on the following appropriate registers:
    - Disqualified directors
    - Bankruptcy and insolvency
- Confirmation from the Chair of appointment panels of compliance with the checks process
- All new appointments for non-executive director positions are undertaken in conjunction with NHSE. The pre-employment checks undertaken by NHSE checks are shared with the trust so there is a retained record in the trust of the individual's fitness to undertake their role as non-executive director.
- A review of checks by NHSE in circumstances of the reappointment of non-executive directors to ensure that they remain 'fit and proper'
- Assessment of the Ongoing Independence of non-executive directors carried out by the Director of Corporate Affairs
- Annual and on-going declarations of interest for all Board members
- Annual Fit & Proper Persons Test self-declarations completed by all executive and non-executive directors.
- Annual audit of the personal files has been undertaken to ensure that the files remain up to date and in line with the regulations.
- The Trust completed the MIAA Fit and Proper Persons considerations checklist in January 2023 to provide an additional layer of assurance of our processes. The

checklist measures against a best practice approach and no areas of risk were identified. This was reported to Audit Committee.
- If there have been any individual concerns raised regarding Directors during the previous year, the outcome of any investigations is reviewed to provide continuing assurance that Directors remain 'Fit and Proper'.
- The retention of checks data on personal files.

Information Governance

We have a Senior Information Risk Officer (SIRO) who is accountable for Information Governance (IG) within the organisation and chairs the Information Governance Sub Committee (IGSC). Resilience is provided by the CIO who is also deputy SIRO.

The IGSC reports to the Audit Committee bimonthly through the chair's assurance report, with risks reported via the Audit Committee's chairs report to the executive board. IGSC effectiveness is monitored via the annual governance process review.

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 clinical records management including the registration authority, records management, cyber security and data quality.

We have a well-established team with the trusts Data Protection Officer (DPO) provided by a 3rd party, and the trust cyber security lead well integrated with the team. The IG team now reports into the new Chief Clinical Information Officer (CCIO) who in turn reports into the Chief Information Officer (CIO)

Key areas of delivery and assurance are outlined as follows:

- **Board Assurance:** 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. Actions were completed throughout the year with assurance provided to audit committee. A Digital Maturity self-assessment conducted across all Ambulance Services via AACE demonstrated that we have strong processes in place for Information Governance.
- **Policies and Procedures:** Policies and Procedures are managed through the Information Governance Sub Committee and signed off with Executive Leadership Committee as required. This year new the Records Management policy has been reviewed and a new Records Retention Guidance has been created.
- **DSPT:** The final submission deadline for the Data Security Protection Toolkit (DSPT) for 2022/23 is 30th June 2023. The Trust submitted the baseline at the end of February 2023, the status of the submission is 104 of 113 mandatory evidence items provided. There are two detailed action plans in place for the Information

Governance (IG) and Information Communications Technology (ICT) teams to ensure the evidence is provided for the final submission at the end of June 2023. Mersey Internal Audit Agency (MIAA) have commenced the first phase of the mandatory audit in January 2023, with phase two of the audit commencing in May 2023.

- **Data Breaches:** The Trust effectively uses the RLDatix System to capture data breaches by all levels of staff via the incidents module. During 2022/23 financial year (April 22 to March 23), 141 breaches relating to information governance were reported. Six incidents where externally reported, after meeting the criteria for notification to the Information Commissioners Office (ICO), with no action taken against the Trust.
- **DPO complaints:** The Data Protection Officer (DPO) received a total of seven complaints. All complaints have been escalated and the majority have been closed.
- **DPIAs:** Strong processes are in place to enable delivery of Data Protection Impact Assessments (DPIAs). 25 screening questionnaires have been completed with full DPIAs completed for seven new assets.
- **Data Sharing:** Five information sharing agreements have been completed:
  - NWAS/EMAS-MPDS audit support
  - NWAS/Bolton at Home Services (Careline – NWAS/Medequip)
  - NWAS/GMFRS/fire risk assessment
  - LRF information sharing protocol (Lancashire Resilience Forum)
  - Vocare/NWAS DSA
- **Subject Access Requests:** 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
- **Key Performance Indicators:** All key performance indictors (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%

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

Background

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

A person commits an offence if:

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

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

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

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

Organisational Structure

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

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

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

The Trust is fully aware of the responsibilities it bears towards patients, employees and the local community and as such, has a strict set of ethical values that we use as guidance

with regard to our commercial activities. We therefore expect that all suppliers to the Trust adhere to the same ethical principles.

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

Our Supply Chain

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

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

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

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

Safeguarding

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

Recruitment

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

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

External Compliance

The trust's functions are organised to ensure effective compliance with the external requirements placed upon it by bodies such as the Department of Health and Social Care, the Care Quality Commission, NHS England and NHS Resolution. The trust aims to comply with, and meet, all statutory, legislative and regulatory requirements placed upon it as an employer, an ambulance service and an NHS trust. These include:

- National targets for ambulance response times
- Statutory and regulatory financial duties
- Care Quality Commission registration requirements
- NHS Model Employer standards
- Civil Contingencies Act 2004
- NHS Constitution

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Daren Mochrie QAM, MBA, Hon DHC, Dip IMC RCSEd, MCPara
Chief Executive Officer Date: 21 June 2023

STATEMENT OF DIRECTORS' RESPONSIBLITIES IN RESPECT OF THE ACCOUNTS

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Date…21 June 2023… 05 Morline …… Chief Executive:

Date:…21 June 2023…… ……. Director of Finance: …

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of North West Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in North West Ambulance Service NHS Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership

The Board of Directors has overall responsibility for providing strategic leadership of risk management throughout the organisation, which includes maintaining oversight of strategic risks to achieving Trust objectives via the Board Assurance Framework (BAF) and leading by example in creating a culture of risk awareness. The Director of Corporate Affairs is accountable to the Board of Directors and the Chief Executive for North West Ambulance Service NHS Trust's governance and risk management. The Director of Corporate Affairs, with support from the Head of Risk and Assurance, provides clear focus for the management of organisational risks and for coordinating and integrating all of the Trust's risk management arrangements.

The Board of Directors is presented with a quarterly risk management assurance report, containing the BAF and the Corporate Risk Register (CRR), both of which are subject to scrutiny at the Executive Leadership Committee (ELC) meetings.

Executive Directors of the Trust are responsible for the consistent application of the Risk Management Policy within their areas of accountability, which includes maintaining an awareness of the overall level of risk within the organisation, the management of specific risks that have been identified and promoting a risk aware culture within their Directorates. Senior Management Teams scrutinise Directorate, Departmental/Team

risk registers at their meetings.

Managers within the Trust are responsible for making active use of risk registers to support the management of their service, the management of specific risks that have been identified, promoting a risk awareness culture and ensuring that risk assessments are carried out within the service.

Risk Management Training

Risk management training is incorporated in the Trust's induction programme and annual statutory and mandatory training programme.

Each year Board Development Sessions on risk management, risk appetite, and the BAF are held with the Board of Directors including during the reporting period of 2022/23. These focused sessions provide the Board of Directors with an additional opportunity to discuss and debate the strategic risks and Risk Appetite Statement (RAS) prior to formal approval and the understand and define the risk tolerance levels for the organisation.

The risk and control framework

Risk Management Strategy

The Risk Management Strategy defines the broad aims and principles of risk management activities across the Trust and sets out key targets and milestones until 2024 at which point, it will be refreshed. The primary aim of the strategy is to provide a supportive framework that ensures integration of risk management into policy making, planning and decision making processes and specifically:

- To protect patients, carers, staff and others who come into contact with the Trust;
- To create awareness trough the Trust of the importance of recognising and managing risk and providing our people with appropriate knowledge, skills and support;
- To promote positive risk taking in the context of clinical care and in controlled circumstances;
- To provide a robust basis for strategic and operational planning through structured consideration of key risk elements;
- To enhance partnership working with stakeholders in the delivery of services;
- To improve compliance with relevant legislation and national best practice standards; and
- To enhance openness and transparency in decision making and management.

The Risk Management Strategy underpins other Trust strategies, enabling improved and integrated clinical and corporate risk management systems and risk assurance reporting, thereby enhancing organisational risk maturity. The objectives for the second year of the strategy have been delayed in completion, however, this has not materially impacted on the Trust's risk management arrangements. The areas that have not been achieved as forecasted include the Risk Culture Improvement Plan and the Risk Maturity

Improvement Plan, however, the areas delivered include embedding the use of risk appetite as part of decision making processes, using data for triangulation and informing risk management processes, review of the Trust's systems of assurance, and increasing risk management knowledge across the organisation.

Risk Management Policy

The Risk Management Policy was reviewed during 2022/23 and defines the approach taken by North West Ambulance Service NHS Trust in applying risk management awareness to its decision-making processes at all levels. The main objective of this policy is to establish the foundations for a culture of effective risk management throughout the organisation by setting out clear definitions, responsibilities, and processes to enable the principles and practices of risk management to be applied consistently throughout the organisation.

The Trust risk scoring matrix has been refreshed to ensure standardisation of risk assessments across the Trust. All risks are recorded and managed via the risk management system that is used across the Trust.

Risk management is everybody's responsibility, and the principles of effective risk management should form an integral component of decision-making at all levels.

Where a risk is identified but cannot be managed without some significant change to the way the organisation operates, it is escalated through the relevant line management structure. The policy also requires risk mitigating action plans to be determined and implemented for those risks that are inadequately controlled.

Board Assurance Framework (BAF)

The BAF is an effective method for the management of the organisation's strategic risks i.e., those which could prevent the Trust from achieving its corporate objectives, and links with the Trust's strategic aims, objectives, and vision. It provides structures for evidence to support the Annual Governance Statement and as a result, streamlines reporting to the Board of Directors. The BAF has continued to mature into a comprehensive system and is embedded within the organisation's Integrated Governance Structure.

The BAF includes the following key elements:

- Strategic risks of the Trust, aligned to the Executive Director Lead and mapped to a Board Assurance Committee for monitoring;
- A description of the strategic risk, including opening, quarterly, in-year and final target scores;
- The corporate risks which link to the strategic risk, including risk scoring;
- Alignment of the strategic risks to the organisation's strategic priorities;
- Risk appetite category and risk tolerance score;
- Key controls in place to mitigate the risks;

- Assurance from the key controls;
- Evidence of the controls and assurances identified;
- Any gaps in controls and assurances;
- Action plans to address gaps in controls and assurances.

The Board Assurance Framework is approved by the Board of Directors at the commencement of the financial year and is managed through delegation by its Board Assurance Committees. The Executive Leadership Committee continues to promote effective risk management and leadership whilst overseeing and monitoring the management of the Board Assurance Framework.

The Board of Directors reviews the Board Assurance Framework on a quarterly basis and approves the quarterly position. The final version of the 2022/23 Board Assurance Framework was approved at the end of April 2023, by the Board of Directors.

Risk Management
All departments within Directorates maintain a live, dynamic and well populated risk register via the Trust system. Risk is a key agenda item on all meeting agendas across the Trust. The Trust supports staff throughout the organisation to manage risk at the most appropriate level, ensuring there is a clear process for risk escalation. Risks are escalated via Departmental and Directorate risk registers to the Corporate Risk Register in accordance with the Risk Management Policy.

All business cases must include a full risk assessment and Equality Impact Assessment (EIA) prior to formal approval. All efficiency schemes have processes in place to identify and mitigate risks to quality.

Risk Appetite
As part of the cyclical Board Development Programme, the Board of Directors received a focused session pertaining to risk appetite. Collectively, the Board of Directors has assessed its risk appetite, and this is reviewed and approved annually. It is also taken into account when making decisions.

Quality Governance
Quality Governance is overseen via the Trust's Quality and Performance Committee which monitors the delivery of the Trust's Quality (Right Care) Strategy and compliance with the Care Quality Commission (CQC) and other regulatory requirements, The work of the Quality and Performance Committee is supported by the Executive-led Clinical Effectiveness Sub Committee, Health, Safety and Security Sub Committee, Patient Safety Sub Committee, Infection, Prevention and Control Sub Committee, Emergency Preparedness Resilience & Response Sub Committee, Diversity and Inclusion Sub Committee and the Review of Serious Events meeting.

There are clear Terms of Reference (ToR) for each Board Assurance Committee and

reporting Sub Committee with the committee's effectiveness being reviewed on an annual basis. At the end of 2022/23 the effectiveness reviews concluded that whilst they were fulfilling their duties, there were areas of development to further strengthen their remit which will be implemented during 2023/24. Associated improvements have been themed into five key areas:

- Committee focus;
- Committee engagement;
- Teamworking;
- Effectiveness;
- Leadership.

The developments to strengthen the Committees will facilitate succinct and clear questioning, further refined assurance papers to allow greater clarity on key areas of assurances, provide deeper scrutiny of the Board Assurance Framework, holding Executive Directors to account for their areas of work, simplifying complex topics to ensure understanding by the Committee membership and the effectiveness of Committee meetings.

In addition, the Board Assurance Committees will continue to undertake frequent 'thematic analysis' into key areas of risk during the year, driven by gaps in assurances highlighted on the Board Assurance Framework in a continued drive for improved quality of assurance reports.

During 2022/23, the Board Assurance Committee effectiveness review recommendations from 2021/22 were implemented resulting in the establishment of the following Sub Committees; Clinical Effectiveness Sub Committee, Health, Safety and Security Sub Committee, Patient Safety Sub Committee, Infection, Prevention and Control Sub Committee, Emergency Preparedness Resilience & Response Sub Committee and Diversity and Inclusion Sub Committee. Each of the Sub Committee submits a Chair's Assurance Report after each meeting to the Quality and Performance Committee. In addition, the Quality and Performance Committee has the opportunity to escalate items from its agenda to the Audit Committee. Collectively, continual improvements have been seen in the quality and content of both assurance reports and Chair's Assurance Reports from Sub Committees. These changes allow effective triangulation and consideration of information and increase scrutiny.

There were three Board Assurance Committees, chaired by a Non-Executive Director that oversaw risk management; both clinical and non-clinical and these were:

- Audit Committee; which sought assurance over the risk management processes and controls in place rather than the content and management of individual risks themselves
- Quality and Performance Committee
- Resources Committee.

Clinical risk is monitored via the Trust's Clinical Effectiveness Sub Committee and Quality and Performance Committee.

Whilst clinical risk management is everyone's responsibility, it is managed on a day-to-day basis by operational staff and is collaboratively monitored by the Corporate Affairs Directorate, Quality, Innovation and Improvement Directorate and the Medical Directorate. Clinical risk is reported through the integrated governance, risk, and compliance system, which allows themes and trends to be identified to inform wider organisational learning. All clinical practices are carried out using the best available clinical evidence base; this includes advice that is given to patients via telephone as well as advice and clinical procedures performed when our clinicians are in a face-to-face situation. In the former, the evidence base is largely taken from the papers published in the UK and for the latter, the evidence base is the Joint Royal Colleges Ambulance Liaison Committee's (JRCALC) latest Clinical Guidelines.

The Audit Committee reviews the establishment and maintenance of an effective system of governance, risk management and internal control, across the entire organisation's activities. This includes activities that were both clinical and non-clinical.

2022/23 Strategic Risks

The key risks for the Trust as it moved into 2022/23 focused on patient safety, financial effectiveness and value for money, operational performance and workforce recruitment and retention.

The following list identifies the risks for 2022/23:

1. There is a risk that the Trust may not deliver safe, effective, and patient centred care leading to avoidable harm, poorer outcomes, and reduction in patient satisfaction.
2. There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver safe and effective services.
3. There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care.
4. There is a risk that the Trust will be unable to attract or retain sufficient suitably qualified staff and maintain low abstraction levels, which may impact on our ability to maintain safe staffing levels.
5. There is a risk that sufficient progress is not made in developing a compassionate, inclusive, and supportive culture, impacting adversely on staff wellbeing and engagement, resulting in poor quality services, staff harm and reduced productivity.
6. There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action.
7. There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint.
8. There is a risk that enactment of the proposed legislative changes in 2022 could

impact on the current regional footprint of the Trust.

9. There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm.
10. There is a risk that the Trust continues to attract negative media attention arising from long delays and harm, combined with potential criticism from the Manchester Arena Inquiry report, this may lead to significant loss of public confidence.
11. There is a risk of the loss of one or more of the PTS contracts due to the current contract ceasing in March 2023 and the service being put out to competitive tender which may lead to significant loss of income and achievements of our strategic objectives.

During the second quarter of 2022/23, a further strategic risk was identified:

12. There is a risk that the current contract for the 111 service ceases in September 2023 and the Trust being unaware of the Commissioners' intentions may impact on the achievement of our strategic objectives.

Future 2023/24 Strategic Risks

The key risks for the Trust as it moves into the new financial year remain focused surrounding quality and patient safety, financial sustainability, operational performance, workforce, and cyber security.

The following list denotes the risks identified for 2023/24:

1. 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.
2. There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver high quality (safe and effective) services.
3. There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care.
4. There is a risk that the Trust will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualifies staff impacting adversely on delivery of performance standards and patient outcomes.
5. There is a risk that the Trust does not deliver its People Strategy to improve its culture and staff engagement, this may impact on NWAS being a brilliant place to work.
6. There is a risk that non-compliance with legislative and regulator standards could result in harm and/or regulatory enforcement action.
7. 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.
8. There is a risk that 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.

9. 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.
10. There is a risk that the level of uncertainty and unpredictability both nationally and regionally impacts on, or results in, delayed achievement of our strategic priorities and objectives.

The Governance Framework of the organisation

Whilst the Trust is not obliged to comply with the FT Code of Governance, the Board of Directors constantly reviews its governance arrangements to ensure alignment where applicable. The Board of Directors recognises its accountabilities and provides leadership within a framework of prudent and effective controls which enables risks to be assessed and managed throughout the organisation.

The Board of Directors sets the strategic aims for the organisation and ensures that resources are in place to meet its objectives. It received reports at each meeting held in public on the principal strategic risks through a combination of risk management assurance reports and/or Chair's Assurance Reports from the Board Assurance Committees.

The Board of Directors currently meets at least six times per annum and during the reporting period consisted of:

- The Chair plus 5 other Non-Executive Directors, including a Senior Independent Director (SID)
- The Chief Executive Officer and 5 other voting Executive Directors
- 3 non-voting Executive Directors.

During 2022/23, the following changes to the composition of the Board of Directors:

- One new Non-Executive Director was appointed
- One new Associate Non-Executive Director was appointed.

The Board of Directors has three key roles:

- Formulating strategy for the organisation;
- Ensuring accountability by; holding the organisation to account for the delivery of the strategy; by being accountable for ensuring the organisation operates effectively and with openness, transparency and candour and by seeking assurances that systems of control are robust and reliable;
- Shaping a healthy culture for the Board of Directors and the organisation.

Quality is a central element of all Board of Director meetings. The Integrated Performance Report, which continues to be developed and enhanced, is aligned to the Single Oversight Framework with focus on key quality indicators.

A staff or a patient story opens each meeting of the Board, to ensure that the focus is on quality of patient care remains at the heart of all Board of Directors activity and

decision-making.

At each Board of Directors meeting, the Board reviews reportable events which includes near-misses, serious incidents, serious case reviews, claims and coroner's inquests. The Quality and Performance Committee also reviews these matters in greater detail on a monthly basis, along with complaints and concerns, and learning is disseminated via the Trust Learning Forums which are held locally within geographical areas for both clinical and non-clinical matters. During the year, there have been no nationally defined 'Never Events' as a result of the care and services provided by the Trust.

The Executive Management Team via the Executive Leadership Committee meets weekly and is accountable for the operational management of the Trust. The primary focus of the Executive Management Team includes management of organisational risk and governance; investment and disinvestment; performance delivery; horizon scanning; strategy and policy development, interpretation and implementation, and stakeholder and partner engagement.

Arrangements are in place through the Board of Directors and Board Assurance Committee meetings throughout 2022/23 are detailed on page 101 of the Annual Report.

Whilst NHS Trusts are exempt from the requirement to apply for and hold the licence, direction from the Secretary of State require NHS England (NHSE) to ensure that NHS Trusts comply with the conditions equivalent to the license as it deems appropriate. This includes giving directions to an NHS Trust where necessary to ensure compliance. In accordance with this, the Trust is required to submit to NHSE a Corporate Governance Statement by and on behalf of the Board of Directors confirming compliance with FT4 (8) Condition of the Provider Licence as the date of statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposed to take to manage such risks. The Statement was drafted and approved by the Board of Directors on 31st May 2023 and published on the Trust's website within the prescribed timescales. The Statement from the Board of Directors evidenced the current arrangements in place to mitigate risks to compliance and concluded that there were no material risks. As mentioned elsewhere in this Annual Governance Statement the effectiveness of the Board Assurance Committees is reviewed at least annually and the Trust's performance is considered at each Board of Directors meeting with presentation of the Integrated Performance Report based upon the Single Oversight Framework.

Workforce

The Trust has an approved People Plan in place with a supporting implementation plan enforced by a set of clear measures.

In line with the NHS People Plan, the Trust has moved to a People Plan to enable greater alignment with the NHS Plan and the People Promise. The NWAS People Plan remains

strategic and looks forward on a rolling three-year period, with a supporting set of objectives focussed on the recovery items that were rolled over from 2021/22. Progress against implementation of the strategy is monitored on behalf of the Board of Directors through the Resources Committee and the associated workforce governance structures, with key projects also overseen by the Corporate Programme Board.

The residual impact of the pandemic has caused some of the strategic developments set out in the strategy for 2022/23 to have been paused or delayed. Industrial Action has had an impact on the delivery of objectives for 2022/23. This delay has enabled a focus on meeting the immediate workforce requirements, such as training the Military Resources deployed during periods of Industrial Action and the recovery actions in relation to Mandatory Training and Appraisal Compliance.

Following the launch of the Trust Strategy, the People Directorate has been reviewing its strategic priorities over the next 3 years. The aim is to have a revised People Strategy in place by July 2023.

The Trust's approach to workforce planning and development fully considers the best practice set out in Developing Workforce Safeguards, providing appropriate governance, and monitoring at the strategic, tactical and operational levels. The Trust takes a robust approach to the development, management, and oversight of its workforce plans. Whilst in previous years the workforce element of the operational plan is submitted and approved at the Board of Directors. These plans are reviewed regularly by the Board of Directors, Resources Committee, and the Executive Leadership Committee (ELC). During the pandemic the annual operating plan and associate monitoring was paused and 2022/23 was the first year following the pandemic where the operating plan and its framework were re-introduced. The operating plan for 2022/23 sought to understand staffing levels against planned recruitment along with the potential impact of external influencers such as the impact of the General Practitioner (GP) contract reform on our Paramedic workforce. These plans have been approved at the Executive Leadership Committee and assurance against these plans are reported regularly to the Resources Committee and the Board of Directors.

The Trust produces workforce information in the form of workforce dashboards and workforce plans for the frontline workforce, including our NHS 111 and Emergency Operations Centre (EOC) call centres. The Board of Directors and Senior Management Teams receive monthly reports on workforce data via the Integrated Performance Report (IPR) and supporting workforce dashboards, which demonstrates the position against planned establishment. The People Directorate work closely with service lines to support workforce requirements and individual service line meetings monthly to discuss the current workforce position against the planned position in accordance with the operating plan. These workforce plans are also triangulated with Finance plans. Discussions include the emerging recruitment requirements and the position of fill rates for planned courses. In addition, agency staffing is also discussed to ensure that this is managed within the

agency ceiling. Whilst 2022/23 has been generally stable in comparison to the position during the pandemic, the Industrial Action has led to the need to train and deploy military support at periods of peak demand.

Throughout 2022/23, assurance has been provided against the workforce and recruitment plan. Ad hoc reports have also been provided on specific risks associated with the workforce plan to the Executive Leadership Committee (ELC) and Board Assurance Committees. These reports have included assurance surrounding the management of agency staffing and retention, particularly within NHS 111. The Resources Committee also received an in-depth analysis of workforce issues at least annually, which includes integrated analysis of resource usage and deployment in the context of performance and quality.

At a tactical level, agreed plans are actively monitored with service lines and Finance monthly, to identify and address any developing trends. The planning process is dynamic, and plans were reviewed monthly to allow the opportunity to discuss emerging issues that may impact on the plans and allow flexibility to accommodate changes. The anticipated turnover rate is mapped throughout these plans to allow a forward view over the next twelve months allowing service lines to visualise the anticipated workforce position. These detailed annual plans sit within the context of a five-year plan focused on ensuring appropriate Paramedic supply and which has informed regular engagement with Health Education England (HEE) and Higher Education Institute (HEI) partners.

Operationally, levels of deployment against the plan are monitored on an hour-by-hour basis with reporting to the Executive Leadership Committee (ELC) and Board Assurance Committees. Managers work within the context of the financial boundaries and governance processes, especially regarding the appropriate use of agency within the delegated ceiling and agency framework.

The Trust utilises the Model Ambulance dashboard metric to gain an overview of clinical and non-clinical workforce composition including staff numbers, pay costs, skill mix ratios and productivity in terms of clinical outputs. This in turn supports the Trust to identify potential opportunities to improve efficiencies and productivity.

The Risk Management Framework is used effectively at strategic, tactical, and operational levels to identify and manage workforce related risks. Strategic level risks during 2022/23 have reflected the increased operational demand and call volumes on our workforce, compliance with mandatory training requirements and the significant vacancy gap and rise in staff turnover. These risks have been mitigated and monitored closely at the Executive Leadership Committee, Board Assurance Committees and by the Board of Directors.

Prior to the pandemic, the Trust successfully reduced agency usage through improved workforce planning with a focus on prioritising alternative options above using agency staff. The impact of the pandemic has resulted in significantly increased use in agency

staff in our Emergency Operations Centres (EOC), Clinical Hub and NHS 111. However, during 2022/23, agency usage has been reduced to pre-pandemic levels. The majority of agency has been used in NHS 111 to support filling Health Advisor vacancies. Due to a generally healthy employment market, the Trust has struggled to attract a sufficient volume of applications for Health Advisor roles. In addition, there have also been a high level of turnover within this staff group. There has been a strategic response to this issue, with internal measures taken to support improved retention within the NHS 111 Health Advisor Workforce and approaches to support filling courses. Options to support this have included further development of the advertising strategy along with filling a small proportion of gaps on courses with agency staff. Any recruitment of agency staff is managed on the basis that these staff move onto a Trust contract at the end of 12 weeks.

A particular focus for 2022/23 has been to ensure that Paramedic workforce levels remains at establishment levels in response to the intricated increase in turnover as a result of the GP reform. Approaches taken during the year having included a robust training and recruitment plan for Graduate Paramedics, regular Qualified Paramedic recruitment and an International Paramedic recruitment campaign. The international Paramedic recruitment was undertaken as part of a HEE pilot, and this led to the successful recruitment of 15 international Newly Qualified Paramedics (NQP's) who started in July 2022. Following this, the Trust has been successful in applying for a further International Paramedic recruitment programme with NHSE and recruitment is currently underway with the first cohort of Paramedics commencing in Q1 of 2023/24.

The Trust's Paramedic workforce supply continues to be strengthened through longer term strategic plans to develop and support internal development routes to Paramedic through degree apprenticeships, to increase external supply, to develop partnerships and to actively recruit. This includes the first deployment of Paramedic degree apprenticeships for internal staff and in late 2022/23 this first cohort have started to graduate and become HCPC registered. Associated risks and plans have been closely monitored through the Resources Committee and the Quality and Performance Committee.

The trust is fully compliant with the registration requirements of the Care Quality Commission.

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in

accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency, and effectiveness of the use of resources

The Trust secures the economic, efficient, and effective use of resources through a variety of methods, including:

- A well-established policy framework including Standing Orders, Standing Financial Instructions and Scheme of Delegation
- An organisational structure which ensures accountability and challenge through the Integrated Governance Structure
- Effective Corporate Directorates responsible for revenue and capital planning and the control and management of resources
- A clear planning process, resulting in the approval of an annual financial plan by the Board of Directors
- Budgets delegated across the Trust, with budget holders receiving detailed monthly financial reports
- Budget holders and service lines continue to play an active part in ongoing review of financial performance
- Detailed financial reporting to the Executive Leadership Committee (ELC) and the Resources Committee including income and expenditure; statement of financial position; progress on the achievement of efficiency and productivity programmes; capital expenditure programmes; and key financial risks
- The ELC takes a lead in financial planning, delivery and taking actions for recovery to bring variances back to plan when required
- The ELC throughout the year regularly reviews performance against clinical, performance, workforce and financial indicators
- The Trust receives significant time in improving systems and controls to deliver a more embedded range of monitoring and control processes
- Continued group and control activities for both requisitions and filing of vacancies by the Vacancy Control Panel (VCP), by ensuring established vacancy prior to recruitment and review of budgets before approval to recruit.

The in-year use of resources is closely monitored by the Board of Directors and the following Board Assurance Committees:

- Audit Committee
- Resources Committee
- Quality and Performance Committee

The Audit Committee scrutinises and challenges the effectiveness of the Trust's financial and governance arrangements to manage finance and secure value for money (VFM). The Trust employs a number of approaches to ensure the best value for money in delivering its services. Benchmarking is used to provide assurance and to inform and guide service redesign. This leads to improvements in the quality of services and patient experience as well as financial performance.

The governance arrangements are supported and strengthened by an effective internal audit plan. The external auditors provide a key independent source of information for the Audit Committee membership, and the public, in determining and reporting on the financial statements and value for money arrangements across the Trust. Through this process, the Trust has gained independent and objective assurance to the Audit Committee and the Board of Directors that the Trust's risk management, governance and internal control processes are operating effectively.

The Trust has a dedicated, qualified Local Counter Fraud Specialist (LCFS) supported as required by other LCFSs. Any concerns can be directed to the team and, any information is treated in the strictest confidence.

External Auditors, Internal Auditors, and Counter Fraud report to each meeting of the Audit Committee and meet the membership of the Audit Committee without any management present.

Information governance

The programme of work associated with Information Governance throughout 2022/23 has been reported to the Information Governance Sub Committee, chaired by the Senior Information Risk Officer (SIRO) and reporting to the Audit Committee bi-monthly. The work programme aligns to the assertions set out in the Data Security and Protection Toolkit (DSPT). A focus on the work programme in year has been clinical records management including the registration authority, records management, cyber security, and data quality.

The Board Assurance Framework (BAF) included a strategic risk pertaining to cyber security, which provided the opportunity for escalation of risk and assurances to the Board of Directors on a quarterly basis.

We have a well-established team which has recently been expanded with an additional 'Information Governance Officer' role, the trusts Data Protection Officer (DPO) is provided by a third party, and the trust cyber security lead is well integrated with the team. The IG

team now reports into the new Chief Clinical Information Officer (CCIO) who in turn reports into the Chief Information Officer (CIO).

The submission of the Data Security Protection Toolkit (DSPT) for 2021/22 was on 29 June 2022. The Trust submitted a score of 109 of 110 mandatory evidence, the only assertion which the Trust did not have evidence to meet was 3.2.1, '95% of staff have completed annual Data Security Awareness training'. An improvement plan was submitted for this assertion. This gave the status of the final submission 'Standards not Met'. 'Approaching Standards'. Mersey Internal Audit Agency (MIAA) internal auditors gave NWAS substantial assurance rating for 8 of the 10 domains in scope of the audit and 2 were rated as moderate.

The final submission deadline for the Data Security Protection Toolkit (DSPT) for 2022/23 is 30 June 2023. The Trust submitted the baseline at the end of February 2023, the status of the submission is 104 of 113 mandatory evidence items provided. There are two detailed action plans in place for the Information Governance (IG) and Information Communications Technology (ICT) teams to ensure the evidence is provided for the final submission at the end of June 2023.

The Trust effectively uses the RLDatix System (DCIQ) to capture data breaches via the incidents module. During 2022/23 financial year (April 2022 to March 2023), 159 breaches relating to information governance were reported. Each information breach is risk scored against the Trust's risk matrix and investigated thoroughly. Level 4-5 breaches (most serious) are reviewed by the Information Governance team to determine whether they meet the criteria for referral to the Information Commissioners office. Six incidents were reported, after meeting the criteria for notification to the Information Commissioners Office (ICO), with no action taken against the Trust on any of the six reported breaches. Learning from information incidents and breeches is discussed at the Information Governance Sub-Committee and action plans developed accordingly for management of local issues and sharing of learning.

Data quality and governance

The Trust has clear procedures and processes for data quality monitoring and assurance, which provide the basis for planned manual data quality checks which are carried out by the Business Intelligence Team and Internal Audit. In addition, this year we have approved the Data Quality Policy (DQP) which clarifies responsibilities for information asset owners (IAO), with regards to data quality standards. The role of the IAO is to understand what information is held, what is added and what is removed, how information is moved, and who has access and why. As a result, they are able to understand and address risks to the information and ensure that information is fully used within the law for the public good, the policy reinforces the importance of accurate collection, storage and analysis of data, the DQP outlines how to identify common faults and errors and forms the basis of internal data quality audits.

We have also started to build continuous data quality monitoring reports. This initially focused on EPR. This data monitoring has identified where data entry and validation has failed and extreme values have been entered in error, such as pain scores. This progression to 'real time' monitoring of data quality empowers the information asset owners to put the required changes in place to meet the standards outlined in the DQP. We have also secured investment in two additional data quality roles within the business intelligence function to implement our quality audit plans, enact improvements, and enhance our data quality reporting.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality and Performance Committee and the Resources Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is informed in a number of ways:

- The Head of Internal Audit provides me with an independent opinion of the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the internal audit work;
- Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance;
- The Board Assurance Framework itself provides me with evidence on the effectiveness of controls that manage the key risks to the organisation achieving its strategic aims and objectives have been reviewed;
- The overall rating of "Good" and "Outstanding" for the Trust's urgent and emergency care Responsiveness domain, by the Care Quality Commission (CQC) during the last Trust inspection.

My review is also informed by:

- The NHS Data Security and Protection Toolkit;
- Assessment against the NHS Counter Fraud Authority Standards for Providers;
- Peer reviews within the ambulance service sector;
- Internal Audit reports;
- Clinical Audit findings;
- External Audit reports;
- External consultancy reports on key aspects of Trust governance.

The Board of Directors seeks assurance that risk management systems and processes are identifying and managing risks to the organisation appropriately through the following:

- At least annual; a review of the effectiveness of the Trust's system of internal control;
- The Board of Directors ensure that the review covers all material controls, including financial, clinical, operational, and compliance controls, and risk management systems;
- An annual review of the Risk Management Policy;
- A quarterly presentation of the Board Assurance Framework at Board of Directors meetings;
- Monthly integrated performance reporting at Board of Directors meetings, outlining achievements against key performance, safety and quality, and finance indicators;
- Assurance reports at each meeting, providing information on progress against compliance with national standards;
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented.

The follow-up of internal audit recommendations are regularly monitored by the Executive Leadership Committee, Internal Audit, and the Audit Committee. The Trust has a comprehensive risk-based internal audit plan in place and this programme was delivered during 2022/23. The outcome of the 2022/23 internal audit programme, reported via the Head of Internal Audit Opinion, which overall gave the Trust 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. During the year, the following audit assurance outcomes were reported:

- 1 audit was assessed as High Assurance
- 5 audits were assessed as Substantial Assurance
- 3 audits were assessed as Moderate Assurance
- 1 audit was assessed as Limited Assurance, and;
- 0 audits were assessed as No Assurance.

The Trust's internal auditors have also supported the organisation in strengthening arrangements in respect of risk management and internal control. The 2022/23 Internal Audit Programme, audit work has provided assurance across the Trust's critical business systems, namely, financial systems, information and technology, performance, quality and safety, workforce, governance and risk, and legality. Recommendations made have resulted in actions taken to further strengthen systems and controls in year.

During 2022/23, the Trust's Clinical Audit department participated as provider of information to the national clinical audits, and these are as follows:

- National Ambulance Clinical Quality Indicators, a national audit of the care of the patient who were assessed by ambulance clinicians are:
    - Suffering a pre-hospital cardiac arrest;
    - Suffering a pre-hospital heart attack;
    - Suffering a stroke;
    - Suffering from sepsis (until September 2022).

Conclusion

Following my review and taking into account the contents of this report and the evidenced based assurance seen at the Board Assurance Committees, I can confirm that no significant internal control issues have been identified.

Signed…… ……..

Chief Executive Date: 21 June 2023

Remuneration Report

The North West Ambulance Service NHS Trust has established a Nominations and Remuneration Committee that advises the Board of Directors with regard to the appropriate remuneration and terms of service of the Chief Executive and other executive directors including:

- All aspects of salary
- Provision of other benefits
- Arrangements for termination of employment and other contractual terms.

The members of the committee are the Chairman and non-executive directors. The Chief Executive, other directors and any other officers in attendance are not present for discussions about their own remuneration and terms of service.

Policy on Remuneration

The determination of salaries for senior managers for 2022/23 onwards is informed by national guidelines regarding Very Senior Managers' (VSM) pay which cover the Chief Executive, Executive Director and the majority of director posts and where appropriate are approved by NHS England/Improvement.

Contracts of Employment

The Executive Leadership Team are employed on full time contracts. The period of notice required for these posts is six months.

Termination payments are governed by guidelines set by HM Treasury that allow for compensation to be paid in relation to the notice period given, together with any statutory redundancy settlement, if applicable. Any exceptions to this require the prior approval of NHS Improvement and the Treasury.

Performance Related Pay

The broad arrangements for annual salary uplifts and the performance bonus scheme are specified in The Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts (June 2013) and in the subsequent Guidance on pay for Very Senior Managers in NHS Trusts and Foundation Trusts (February 2017).

For 2022/23 VSM salaries have been recommended within the remit of the Senior Salaries Review Body (SSRB) rather than being determined separately for the NHS. The government agreed to accept the recommendation of the SSRB and these recommendations were:

- An across-the-board increase of 3.0% for all VSMs (and ESMs) to be applied and backdated to 1 April 2022.
- A further 0.5% at the discretion of the Remuneration Committee to be applied to VSMs on salaries close to the AfC band 9 upper spine point to ameliorate the erosion of differentials (between current Agenda for Change (AfC) and VSM/ESM pay frameworks). This is aimed at facilitating the introduction of the new VSM pay framework over the course of the coming year.

The Nominations and Remuneration Committee agreed with the recommendations and details of senior managers' remuneration and pensions are shown in the following tables.

Salaries and Allowances 2022/2023 (subject to audit)

Table 1: Single Total Figure Table

Name	Title	FROM 1ST APRIL 2022 TO 31ST MARCH 2023						FROM 1ST APRIL 2021 TO 31ST MARCH 2022					
		Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000	£	£	£000	£000	£000	£000
Peter White	Chair	50 - 55	0				50 - 55	45 - 50	0				45 - 50
Executive Directors													
Daren Mochrie	Chief Executive	190 - 195	0			47.5 - 50	240 - 245	195 - 200	0			30 - 32.5	225 - 230
Gerard Blezard	Director of Operations	120 - 125	2,500			37.5 - 40	160 - 165	120 - 125	4,300			45 - 47.5	170 - 175
Maxine Power	Director of Quality, Improvement and Innovation	115 - 120	8,400			22.5 - 25	145 - 150	115 - 120	8,400			25 - 27.5	150 - 155
Angela Wetton	Director of Corporate Affairs	100 - 105	3,800			10 - 12.5	115 - 120	95 - 100	4,300				100 - 105
Salman Desai	Director Strategy and Planning	125 - 130	11,900			72.5 - 75	210 - 215	115 - 120	10,300			57.5 - 60	185 - 190
Lisa Ward	Director of Organisational Development	110 - 115	5,500			30 - 32.5	145 - 150	110 - 115	5,500			35 - 37.5	150 - 155
Chris Grant	Medical Director	135 - 140	7,100			35 - 37.5	180 - 185	135 - 140	7,000			20 - 22.5	160 - 165
Carolyn Wood	Director of Finance	125 - 130	2,800			20 - 22.5	150 - 155	125 - 130	2,800			35 - 37.5	165 - 170
Non-Executive Directors													
Dr David Hanley	Non-Executive Director	10 - 15	0				10 - 15	10 - 15	0				10 - 15
Catherine Butterworth	Non-Executive Director (started 01/04/2022)	10 - 15	0				10 - 15	0	0				0
David Rawsthorn	Non-Executive Director	15 - 20	0				15 - 20	15 - 20	0				15 - 20
Prof Alison Chambers	Non-Executive Director	15 - 20	0				15 - 20	15 - 20	0				15 - 20
Prof Aneez Esmail	Non-Executive Director	10 - 15	0				10 - 15	10 - 15	0				10 - 15

Table 2: Pension Benefits (subject to audit)

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Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2023	Lump sum at pension age related to accrued pension at 31 March 2023	Cash Equivalent Transfer Value at 1 April 2023	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employers Contribution to Stakeholder Pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Daren Mochrie	Chief Executive	2.5 - 5	0	90 - 95	190 - 195	1,659	56	1,529	28
Gerard Blezard	Director of Operations	2.5 - 5	0 - 2.5	60 - 65	125 - 130	1,263	51	1,158	18
Maxine Power	Director of Quality, Improvement and I	0 - 2.5	0	40 - 45	70 - 75	828	30	759	16
Salman Desai	Director Strategy and Planning	2.5 - 5	5 - 7.5	40 - 45	80 - 85	730	63	631	17
Lisa Ward	Director of Organisational Developme	0 - 2.5	0 - 2.5	35 - 40	60 - 65	648	30	585	16
Chris Grant	Medical Director	2.5 - 5	0	60 - 65	65 - 70	860	33	783	20
Carolyn Wood	Director of Finance	0 - 2.5	0	45 - 50	90 - 95	859	22	794	18

Note: CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023-24 CETV figures.

Notes to accompany remuneration tables:

Auditable Content
Salaries and Allowances 2022/23
Pension Benefits
Staff Numbers and Costs
Exit Packages
Pay Multiples

Pay Multiples (subject to audit)

Entities are required to disclose pay ratio information and detail concerning percentage change in remuneration concerning the highest paid director. The banded remuneration of the highest paid director in North West Ambulance Service NHS Trust in the financial year 2022-23 was £190,000-195,000k (2021-22, £195,000-200,000k).

The range of staff remuneration during 2022/23 was £20,000 - £25,000 to £190,000 - £195,000 (2021/22 £15,000 - £20,000 to £195,000- £200,000). The table below shows percentage changes in remuneration within 2022-23:

Average	Staff costs Average	Highest Paid Director
2022/23	38,092	192,500
2021/22	38,020	197,500
	0.2%	**-2.5%**

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the 25th percentile, median and 75th percentile of remuneration in organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th Percentile Pay Ratio	Median Pay Ratio	75th Percentile Pay Ratio
2022-23	7.3:1	5.8:1	4.1:1
2021-22	7.5:1	5.8:1	4.2:1

There are no significant differences between ratios in the last 2 years.

Table below shows the difference between salary and full remuneration and the relation to the highest paid director.

2022/23	25th Percentile	Median	75th Percentile
Total Remuneration (£,)	26,896	34,270	48,072
Salary component of pay (£,)	26,771	34,127	47,988
Pay and benefits excluding pension: pay ratio for highest paid director	7.2:1	5.6:1	4.0:1

Cash Equivalent Transfer Values – A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation for Early Retirement or Loss of Office

There were no such payments made during 2022/23.

Payments to Past Directors

There were no such payments made during 2022/23.

Staff Report

Executive Directors

During the year, the trust had eight director positions for which VSM salaries are payable.

In addition, the Trust appointed to four further VSM positions as part of the senior operational restructure. These posts operate at a sub-Board level.

For further details please see the Remuneration Report table.

Non-Executive Directors

During the year the trust had the following non-executive directors in place:

- Five non-executive directors on non-executive pay bands
- Chair of the Trust Board on Chair pay band

Whilst non-executive directors and the Trust Board Chair are senior managers of the organisation, they are not trust staff and their terms and conditions are determined by NHSE.

For further details please see the Remuneration Report table.

Senior Manager by Band

The trust's definition of a senior manager is the chief executive and director posts. For a breakdown of salary bands, please refer to the Salaries and Allowances detailed within the Remuneration Report.

Staff Numbers and costs (subject to audit)

The breakdown of staff at 31 March 2023 is as follows:

	Permanent Number	Other Number	Total Number
Medical and dental	4	-	4
Ambulance staff	5,734	-	5,734
Administration and estates	613	7	620
Healthcare assistants and other support staff	97	86	183
Nursing, midwifery and health visiting staff	102	18	120
Scientific, therapeutic and technical staff	1	-	1
Total average numbers	**6,551**	**111**	**6,662**

Staff Composition and Staff Policies

NWAS continues aiming towards having a workforce which is representative of the communities we serve across the North West and being an employer of choice for all.

As required within the NHS contract, the trust published the Workforce Race Equality Standard (WRES) data during the summer of 2022. In the main it showed a worsening with regards the experiences of colleagues from black and minority ethnic backgrounds (BAME) in comparison with the previous year. While some of the metrics are positive, the data indicates that further work is required. The headcount of BAME staff saw a slight decrease over the last year, falling from 342 in 2021 to 325 at the end March 2022, equating to a reduction of 0.2% from 5% to 4.8% of the overall workforce. This was the first time that BAME numbers had been reduced since 2019. The Trust is committed to developing a representative workforce of the communities we serve, thereby improving the overall BAME representation within our employee numbers. An action plan is in place and with assurance provided on a regular basis to the Diversity and Inclusion Sub Committee.

Gender Pay Gap reporting up to end March 2022 (which is the data published during 2022) shows that the gap in the hourly rate of pay between male and female staff reduced from 10.89% March 2021 to 9.8% in March 2022 (using the average calculation) and from 9.2% to 8.6% using the median calculation. The average hourly rate for male and for female staff increased during the same period. Progression into the highest paid roles is also dependent on vacancies created through the year which require recruitment and this impacts on the ability to close the gender pay gap.

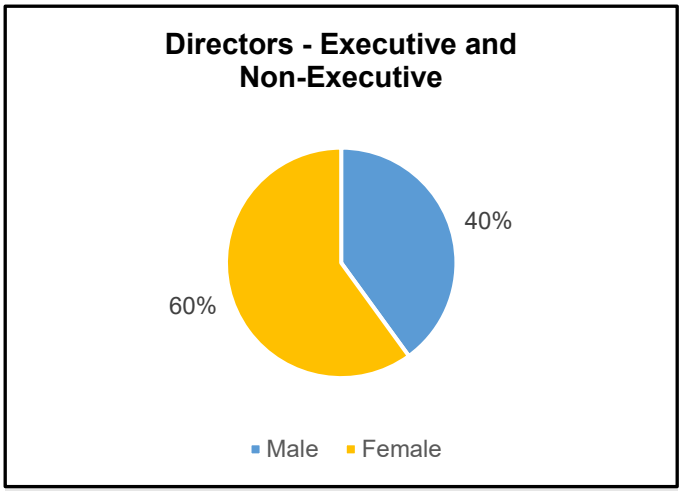
This is the fourth year of reporting Workforce Disability Equality Standard (WDES) data. The data published in 2022 showed an overall increase in the representation in most levels of the organisation. The increase in the percentages reported can be explained in part due to an internal communications campaign aimed at encouraging staff to record and update their disability status on My ESR. This work was driven by the Disability Network and aims to ensure that the Trust has an accurate record of staff representation. Overall, the results indicate a mixed picture in relation to the comparative experience of disabled staff, with good improvements in the experience of disabled staff in relation to harassment and bullying from the public and managers but a worsening of experience in other areas such as career progression. Work to support the experience of disabled staff has continued focus to understand how the Trusts can support and engage with our disabled staff.

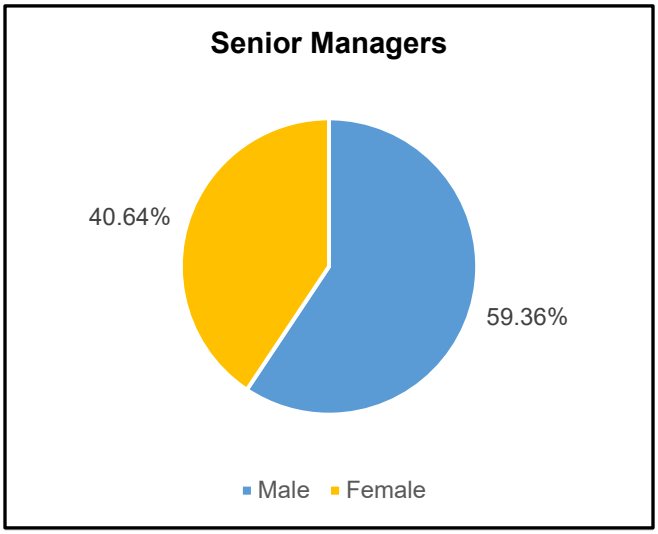
The actions under the ED&I priorities seek to ensure improvement for all diverse groups and there will be continued work with the Staff Networks to ensure that specific actions for our disabled, BAME and female staff are identified and addressed.

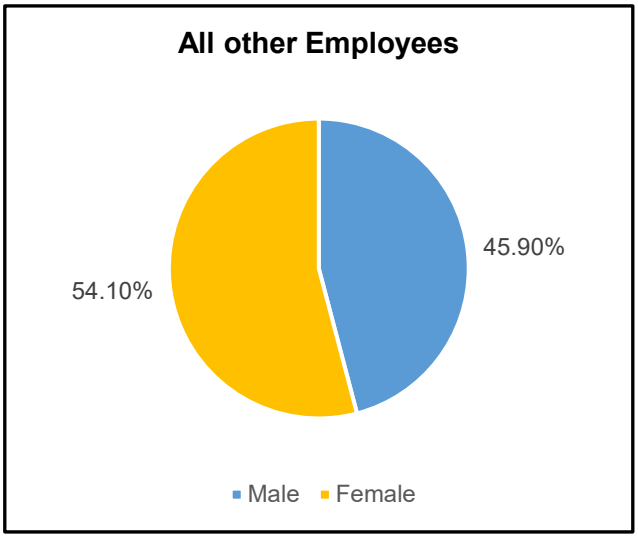
The WRES, WDES and gender pay gap data reflect the ongoing work to support minority groups and address inequalities in the workplace. Whilst there has been some worsening

of the position with some of the data, the continued focus on the data will help to develop actions to support improvement.

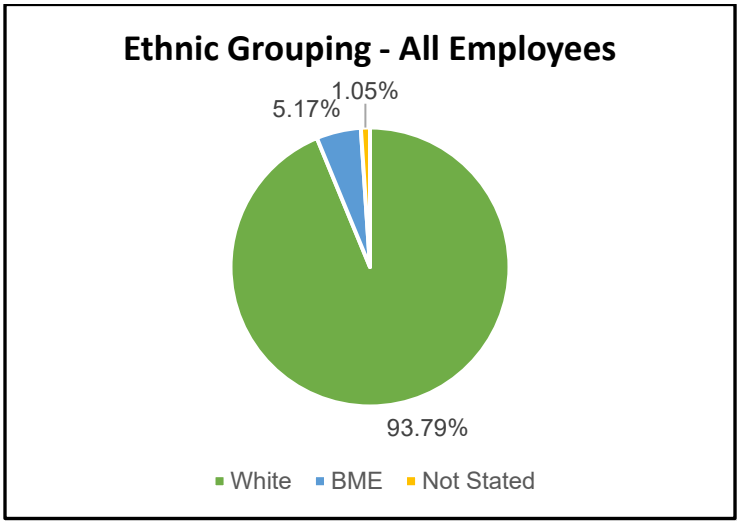
Gender Percentage of Staff as at 31st March 2023







BME Percentage of Staff as of 31st March 2023



Sickness Absence Data

Total days lost in 2022/23 due to sickness is 145,795 averaging 22.6 days per 1 full time equivalent.

Staff Turnover Percentage

The turnover percentage for permanent and fixed term employees up to 31 March 2023 was 12.38%.

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. The regulations require public sector employers to publish information on how much time is spent by their union officials on paid 'trade union facility time' and is detailed for 2022/23 in the tables below:

Number of employees who were relevant union officials during the relevant period
122

Full time Equivalent employee number
115.99

Percentage of Time Spent on Facility Time	
Percentage of time	No of employees
0%	22
1-50%	90
51%-99%	3
100%	7

Percentage of Pay Bill Spent on Facility Time	
First Column	Figures
Provide the total cost of facility time	£586,195
Provide the total pay bill	£338,642,000
Provide the % of the total pay bill spent on facility time, calculated as: (total cost of facility time/ total pay bill x 100)	0.2%

Paid Trade Union Activities
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period/ total paid facility time hours x 100)
0.0%

Expenditure on Consultancy

The expenditure on consultancy costs during 2022/23 was £30k in year.

Ill Health Retirements

During 2022/23 there were 10 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £435k (£417k in 2022/23).

Off-Payroll Engagements

There are no off-payroll engagements to disclose during 2022/23.

Exit Packages (Subject to Audit)

There was one exit packages during 2022/23. Payment was a contractual payment in lieu of notice.

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
£10,000 - £25,000	-	1	**1**
Total number of exit packages by type	**-**	**1**	**1**
Total cost (£)	£0	£20,000	**£20,000**

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF NORTH WEST AMBULANCE SERVICE NHS TRUST

Independent auditor's report to the Directors of North West Ambulance Service NHS Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of North West Ambulance Service NHS Trust ('the Trust') for the year ended 31 March 2023, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2022/23 as contained in the Department of Health and Social Care Group Accounting Manual 2022/23, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements
As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2022/23 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in April 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception
We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer
As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required under section 21 of the Local Audit and Accountability Act 2014 (as amended) to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in January 2023.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice
We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Board of Directors of North West Ambulance Service NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of North West Ambulance Service NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Daniel Watson

Daniel Watson, Key Audit Partner
For and on behalf of Mazars LLP

One St Peter's Square
Manchester
M2 3DE

22 June 2023

Annual Accounts 2022/23

North West Ambulance Service NHS Trust

Annual accounts for the year ended 31 March 2023

Statement of Comprehensive Income

	Note	2022/23 £000	2021/22 £000
Operating income from patient care activities	3	479,483	457,608
Other operating income	4	13,211	12,001
Operating expenses	6, 8	(497,760)	(468,687)
Operating surplus/(deficit) from continuing operations		**(5,066)**	**922**
Finance income	10	1,512	34
Finance expenses	11	49	155
PDC dividends payable		(827)	(1,114)
Net finance costs		**734**	**(925)**
Other gains / (losses)	12	37	70
Surplus / (deficit) for the year from continuing operations		**(4,295)**	**67**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(32)	878
Revaluations	15	645	1,144
Total comprehensive income / (expense) for the period		**(3,682)**	**2,089**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(4,295)	67
Remove net impairments not scoring to the Departmental expenditure limit		8,856	323
Remove I&E impact of capital grants and donations		181	(757)
Remove net impact of inventories received from DHSC group bodies for COVID response		124	449
Adjusted financial performance surplus / (deficit)		**4,866**	**82**

Statement of Financial Position

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	14	2,218	1,040
Property, plant and equipment	14	104,379	105,653
Right of use assets	16	21,693	-
Investment property	17	160	160
Receivables	19	1,052	1,187
Total non-current assets		**129,502**	**108,040**
Current assets			
Inventories	18	1,096	1,294
Receivables	19	19,975	6,911
Cash and cash equivalents	20	63,755	67,354
Total current assets		**84,826**	**75,559**
Current liabilities			
Trade and other payables	21	(66,772)	(50,132)
Borrowings	23	(3,149)	-
Provisions	24	(7,430)	(7,059)
Other liabilities	22	(2,873)	(3,989)
Total current liabilities		**(80,224)**	**(61,180)**
Total assets less current liabilities		**134,104**	**122,418**
Non-current liabilities			
Borrowings	23	(16,838)	(77)
Provisions	24	(14,662)	(19,355)
Total non-current liabilities		**(31,500)**	**(19,432)**
Total assets employed		**102,604**	**102,987**
Financed by			
Public dividend capital		111,571	109,165
Revaluation reserve		4,210	4,215
Income and expenditure reserve		(13,177)	(10,393)
Total taxpayers' equity		**102,604**	**102,987**

The notes on pages 6 to 34 form part of these accounts.

Name	Daren Mochrie
Position	Chief Executive
Date	21-Jun-23

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**109,165**	**4,215**	**(10,393)**	**102,987**
Implementation of IFRS 16 on 1 April 2022	**-**	**-**	**893**	**893**
Surplus/(deficit) for the year	-	-	(4,295)	**(4,295)**
Other transfers between reserves	-	(618)	618	**-**
Impairments	-	(32)	-	**(32)**
Revaluations	-	645	-	**645**
Public dividend capital received	2,406	-	-	**2,406**
Taxpayers' and others' equity at 31 March 2023	**111,571**	**4,210**	**(13,177)**	**102,604**

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**107,009**	**2,614**	**(10,881)**	**98,742**
Surplus/(deficit) for the year	-	-	67	**67**
Other transfers between reserves	-	(385)	385	**-**
Impairments	-	878	-	**878**
Revaluations	-	1,144	-	**1,144**
Transfer to retained earnings on disposal of assets	-	(36)	36	**-**
Public dividend capital received	2,156	-	-	**2,156**
Taxpayers' and others' equity at 31 March 2022	**109,165**	**4,215**	**(10,393)**	**102,987**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Statement of Cash Flows

	Note	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(5,066)	922
Non-cash income and expense:			
Depreciation and amortisation	6.1	20,303	13,900
Net impairments	7	8,856	323
Income recognised in respect of capital donations	4	-	(817)
(Increase) / decrease in receivables and other assets		(13,630)	7,199
(Increase) / decrease in inventories		198	441
Increase / (decrease) in payables and other liabilities		11,755	1,761
Increase / (decrease) in provisions		(4,073)	2,139
Net cash flows from / (used in) operating activities		**18,343**	**25,868**
Cash flows from investing activities			
Interest received		1,512	34
Purchase of intangible assets		(173)	(46)
Purchase of PPE and investment property		(21,483)	(21,304)
Sales of PPE and investment property		137	410
Initial direct costs or up front payments in respect of new right of use assets		(3)	-
Receipt of cash lease incentives (lessee)		1	-
Net cash flows from / (used in) investing activities		**(20,009)**	**(20,906)**
Cash flows from financing activities			
Public dividend capital received		2,406	2,156
Capital element of finance lease rental payments		(2,935)	(1)
Interest paid on finance lease liabilities		(200)	(12)
PDC dividend (paid) / refunded		(1,204)	(379)
Net cash flows from / (used in) financing activities		**(1,933)**	**1,764**
Increase / (decrease) in cash and cash equivalents		**(3,599)**	**6,726**
Cash and cash equivalents at 1 April - brought forward		**67,354**	**60,628**
Cash and cash equivalents at 31 March	20.1	**63,755**	**67,354**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Revenue from contracts with customers

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) scheme. Delivery under this scheme is part of how care is provided to patients. As such CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2022/23 payment under the scheme is included in fixed payments from commissioners based on assumed achievement of criteria.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Note 1.4 Continued

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with Inernational Accounting Standard (IAS) 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Note 1.8 continued

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Note 1.8 continued

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	3	69
Plant & machinery	5	25
Transport equipment	5	14
Information technology	1	15
Furniture & fittings	2	20

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	1	8

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by Office for National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

Note 1.13 continued

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

Note 1.14 Continued

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year; a nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, International Reporting Interpretations Committee (IFRIC) 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
Very long-term	Exceeding 40 years	3.00%	0.66%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2023:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as PDC. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

Note 1.17 Continued

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

There are no other standards, amendments and interpretations in issue but not yet effective or adopted.

Note 1.23 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Operating Lease Commitments

The Trust leases a number of its vehicles. As management has determined that the Trust has not obtained substantially all the risks and rewards of ownership the leases have been classified as operating leases and accounted for accordingly.

Segmental Reporting

Management has determined that it operates only in one segment, that of healthcare.

Note 1.24 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Revaluation of Property, Plant and Equipment

The valuation exercise was carried out in March 2023 with a valuation date of 31 March 2023. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2022 ('Red Book').

Carrying value of Trust's land and buildings at 31st March 2023 is £42m. If the valuation of land and building would have increased by 10% then the value would have been £4m higher.

Provisions

The Trust has taken a prudent view on estimating potential risk associated with various staff related costs i.e. tribunals, Permanent Injury Benefits (PIB) and others. These are based upon most current information available from various bodies such as NHS Resolution, national census information, legal professionals etc. Carrying value of provisions is £22.1m.

Note 2 Operating Segments

The Trust has judged that it only operates as one business segment, that of healthcare.

98.11% (£483m) of the Trust's income in 2022/23 (2021/22 £462m, 98%) is received from NHS organisations such as Commissioners for NHS patient care services.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.1

Note 3.1 Income from patient care activities (by nature)	**2022/23**	**2021/22**
	£000	**£000**
A & E income	361,445	353,132
Patient transport services income	45,823	43,870
Other income	43,525	47,218
Agenda for change pay offer central funding**	14,600	-
Additional pension contribution central funding*	14,090	13,388
Total income from activities	**479,483**	**457,608**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

**'In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023..

Note 3.2 Income from patient care activities (by source)

	2022/23	**2021/22**
Income from patient care activities received from:	**£000**	**£000**
NHS England	29,985	13,696
Clinical commissioning groups	111,921	442,799
Integrated care boards	336,282	
Department of Health and Social Care	125	116
Other NHS providers	157	177
Injury cost recovery scheme	622	621
Non NHS: other	391	199
Total income from activities	**479,483**	**457,608**
Of which:		
Related to continuing operations	479,483	457,608

Note 4 Other operating income

	2022/23			**2021/22**		
	Contract income	**Non-contract income**	**Total**	**Contract income**	**Non-contract income**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Education and training	5,803	-	**5,803**	5,433	-	**5,433**
Non-patient care services to other bodies	2,321		**2,321**	1,119		**1,119**
Reimbursement and top up funding	-		**-**	26		**26**
Receipt of capital grants and donations and peppercorn leases*		-	**-**		817	**817**
Charitable and other contributions to expenditure**		2,470	**2,470**		2,489	**2,489**
Other income	2,617	-	**2,617**	2,117	-	**2,117**
Total other operating income	**10,741**	**2,470**	**13,211**	**8,695**	**3,306**	**12,001**
Of which:						
Related to continuing operations			13,211			12,001

* in 2021/22 Notional income from the DHCS relating to donated assets to NWAS - 75 ventilators were donated to NWAS at the value of £817k.

** Charitable and other contribution contains donated inventories from DHSC below capitalisation threshold for COVID response of £603k (2021/22, £985k), there is an associated expenditure in the note 6.1

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2022/23	**2021/22**
	£000	**£000**
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	3,989	1,964

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2023 £000	31 March 2022 £000
within one year	2,873	3,989
Total revenue allocated to remaining performance obligations	**2,873**	**3,989**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6.1 Operating expenses

	2022/23 £000	2021/22 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	3,480	3,227
Staff and executive directors costs	352,732	327,733
Remuneration of non-executive directors	130	149
Supplies and services - clinical (excluding drugs costs)	5,499	5,707
Supplies and services - general	3,005	2,639
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,715	1,478
Consultancy costs	30	88
Establishment	10,467	11,214
Premises	19,903	21,944
Transport (including patient travel)	61,299	62,582
Depreciation on property, plant and equipment	19,891	13,496
Amortisation on intangible assets	412	404
Net impairments	8,856	323
Movement in credit loss allowance: contract receivables / contract assets	64	54
Change in provisions discount rate(s)	(3,654)	765
Fees payable to the external auditor		
audit services- statutory audit*	87	78
Internal audit costs	92	99
Clinical negligence	3,525	3,562
Legal fees	551	1,453
Insurance	4	11
Education and training	8,631	7,655
Expenditure on short term leases (current year only)	401	-
Operating lease expenditure (comparative only)	-	3,144
Hospitality	11	14
Losses, ex gratia & special payments	492	746
Other	137	122
Total	**497,760**	**468,687**
Of which:		
Related to continuing operations	497,760	468,687
Related to discontinued operations	-	-

*Statutory Audit fees include 20% of non-recoverable VAT. Net audit fees are £73k.

Note 6.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2022/23 or 2021/22.

Note 7 Impairment of assets

	2022/23 £000
Net impairments charged to operating surplus / deficit resulting from:	
Unforeseen obsolescence	151
Changes in market price	8,705
Total net impairments charged to operating surplus / deficit	**8,856**
Impairments charged to the revaluation reserve	32
Total net impairments	**8,888**

The Standard's requirement to take impairments in all cases to reserves in the first instance does not app
Where impairments are posted to the revenue account and a revaluation reserve balance does exist, a tra
made from Revaluation Reserve to the General Fund/I&E Reserve. That transfer will be the lower of the to
or the balance available on the Revaluation Reserve. In 2022/23 three types of assets that suffered an im
estates, IT equipment and vehicles. The 2022/23 impairment on estates is attributable to the revaluation
revaluation impairment is due to the price variation and not consumption of economic value.

In order to establish the correct estates value the Trust had its assets revalued as at 31 March 2023. Lan
were revalued at £41,992k which is £7,711k lower than the carrying value on the Statement of Financial P
(SOFP). This created an increase in revaluation reserve of £613k and a charge to operating expenses of

A number of vehicles were impaired due to changes in their Market Value, the total value of these impairn
£301k. In addition medical equipment was impaired due to unforeseen obsolescence of £147k and IT equ

Note 8 Employee benefits

	2022/23 Total £000
Salaries and wages	277,514
Social security costs	27,930
Apprenticeship levy	1,312
Employer's contributions to NHS pensions	46,249
Temporary staff (including agency)	3,994
Total gross staff costs	**356,999**
Recoveries in respect of seconded staff	-
Total staff costs	**356,999**

Note 8.1 Retirements due to ill-health

During 2022/23 there were 10 early retirements from the trust agreed on the grounds of ill-health (6 in the
March 2022). The estimated additional pension liabilities of these ill-health retirements is £435k (£417k ir

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme

2021/22 £000
335
(12)
323
(878)
(555)

ıly.
ansfer is to be
otal impairment
ıpairment are
of estates. The

d and buildings
osition
£8,324k.

nents was
ıipment of £4k.

2021/22 Total £000
253,236
26,117
1,283
43,980
6,878
331,494
-
331,494

year ended 31
ı 2021/22).

e.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 9.1 National Employment Savings Pension Scheme (NEST)

Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1st July 2013 when the scheme came into operation in the Trust (its staging date), staff who are not eligible to join the NHS Pension Scheme are automatically enrolled into NEST. The scheme is a defined contribution pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

Contributions payable to a defined contribution plan are recognised as an expense as the employee provides services in exchange for the contribution. The Trust contributes 1% of their pensionable pay. The total contribution by the Trust for 2022/23 has been fully charged to expenses in the period. Details of the scheme can be found on the NEST Pensions website at: http://www.nestpensions.org.uk

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2022/23	2021/22
	£000	£000
Interest on bank accounts	1,512	34
Total finance income	**1,512**	**34**

Note 11 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2022/23	2021/22
	£000	£000
Interest expense:		
Interest on lease obligations	200	12
Unwinding of discount on provisions	(249)	(167)
Total finance costs	**(49)**	**(155)**

Note 12 Other gains / (losses)

	2022/23	2021/22
	£000	£000
Gains on disposal of assets	37	70
Total other gains / (losses)	**37**	**70**

Note 13 Intangible assets - 2022/23

	Software licences	Intangible assets under construction	Total		Software licences	Intangible assets under construction	Total
	£000	£000	£000		£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**5,359**	**13**	**5,372**	**Valuation / gross cost at 1 April 2021 - as previously stated**	**5,128**	**208**	**5,336**
Additions	1,590	-	**1,590**	Additions	17	19	**36**
Reclassifications	13	(13)	**-**	Reclassifications	214	(214)	**-**
Valuation / gross cost at 31 March 2023	**6,962**	**-**	**6,962**	**Valuation / gross cost at 31 March 2022**	**5,359**	**13**	**5,372**
Amortisation at 1 April 2022 - brought forward	**4,332**	**-**	**4,332**	**Amortisation at 1 April 2021 - as previously stated**	**3,928**	**-**	**3,928**
Provided during the year	412	-	**412**	Provided during the year	404	-	**404**
Amortisation at 31 March 2023	**4,744**	**-**	**4,744**	**Amortisation at 31 March 2022**	**4,332**	**-**	**4,332**
Net book value at 31 March 2023	**2,218**	**-**	**2,218**	**Net book value at 31 March 2022**	**1,027**	**13**	**1,040**
Net book value at 1 April 2022	**1,027**	**13**	**1,040**	**Net book value at 1 April 2021**	**1,200**	**208**	**1,408**

Note 14.1 Property, plant and equipment - 2022/23

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2022 - brought forward	**14,931**	**27,254**	**6,775**	**22,032**	**67,624**	**27,447**	**5,065**	**171,128**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	(118)	-	-	-	-	-	-	**(118)**
Additions	-	2,331	20,078	154	19	1,067	186	**23,835**
Impairments	-	(304)	-	-	-	-	-	**(304)**
Reversals of impairments	-	272	-	-	-	-	-	**272**
Revaluations	(1,400)	(2,612)	(5,995)	-	-	-	-	**(10,007)**
Reclassifications	-	1,948	(12,177)	596	5,732	3,791	110	**-**
Transfers to / from assets held for sale	-	-	-	-	(5,976)	-	-	**(5,976)**
Disposals / derecognition	-	(420)	-	(3,065)	(289)	-	(254)	**(4,028)**
Valuation/gross cost at 31 March 2023	**13,413**	**28,469**	**8,681**	**19,717**	**67,110**	**32,305**	**5,107**	**174,802**
Accumulated depreciation at 1 April 2022 - brought forward	**-**	**57**	**-**	**13,532**	**35,284**	**13,759**	**2,844**	**65,476**
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	-	-	-	**-**
Provided during the year	-	2,742	-	1,535	7,996	3,995	380	**16,648**
Impairments	1,400	2,096	5,995	146	382	4	-	**10,023**
Reversals of impairments	-	(1,167)	-	-	-	-	-	**(1,167)**
Revaluations	(1,400)	(3,257)	(5,995)	-	-	-	-	**(10,652)**
Transfers to / from assets held for sale	-	-	-	-	(5,976)	-	-	**(5,976)**
Disposals / derecognition	-	(420)	-	(3,065)	(189)	-	(254)	**(3,928)**
Accumulated depreciation at 31 March 2023	**-**	**50**	**-**	**12,148**	**37,497**	**17,758**	**2,970**	**70,423**
Net book value at 31 March 2023	**13,413**	**28,419**	**8,681**	**7,569**	**29,613**	**14,547**	**2,137**	**104,379**
Net book value at 1 April 2022	**14,931**	**27,198**	**6,775**	**8,500**	**32,340**	**13,688**	**2,221**	**105,653**

Note 14.2 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - as previously stated	**11,569**	**24,621**	**15,219**	**20,361**	**65,777**	**18,600**	**4,862**	**161,009**
Additions	3,000	2,519	11,188	1,086	516	-	189	**18,498**
Impairments	-	(89)	-	-	-	-	-	**(89)**
Reversals of impairments	-	967	-	-	-	-	-	**967**
Revaluations	489	(644)	-	-	-	-	-	**(155)**
Reclassifications	-	421	(19,632)	1,225	9,104	8,847	35	**-**
Transfers to / from assets held for sale	(82)	(118)	-	(60)	(7,571)	-	-	**(7,831)**
Disposals / derecognition	(45)	(423)	-	(580)	(202)	-	(21)	**(1,271)**
Valuation/gross cost at 31 March 2022	**14,931**	**27,254**	**6,775**	**22,032**	**67,624**	**27,447**	**5,065**	**171,128**
Accumulated depreciation at 1 April 2021 - as previously stated	**2**	**2**	**-**	**12,748**	**34,900**	**11,599**	**2,467**	**61,718**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2021 - restated	**2**	**2**	**-**	**12,748**	**34,900**	**11,599**	**2,467**	**61,718**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	2,066	-	1,424	7,467	2,160	379	**13,496**
Impairments	1,000	1,996	-	-	690	-	19	**3,705**
Reversals of impairments	(1,109)	(2,273)	-	-	-	-	-	**(3,382)**
Revaluations	107	(1,406)	-	-	-	-	-	**(1,299)**
Transfers to / from assets held for sale	-	-	-	(60)	(7,571)	-	-	**(7,631)**
Disposals / derecognition	-	(328)	-	(580)	(202)	-	(21)	**(1,131)**
Accumulated depreciation at 31 March 2022	**-**	**57**	**-**	**13,532**	**35,284**	**13,759**	**2,844**	**65,476**
Net book value at 31 March 2022	**14,931**	**27,198**	**6,775**	**8,500**	**32,340**	**13,688**	**2,221**	**105,653**
Net book value at 1 April 2021	**11,567**	**24,620**	**15,219**	**7,613**	**30,877**	**7,001**	**2,395**	**99,292**

Note 14.3 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	13,413	28,419	8,681	6,923	29,613	14,547	2,137	**103,733**
Owned - donated/granted	-	-	-	646	-	-	-	**646**
Total net book value at 31 March 2023	**13,413**	**28,419**	**8,681**	**7,569**	**29,613**	**14,547**	**2,137**	**104,379**

Note 14.4 Property, plant and equipment financing - 31 March 2022

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	14,813	27,198	6,775	7,736	32,340	13,688	2,221	**104,771**
Finance leased	118	-	-	-	-	-	-	**118**
Owned - donated/granted	-	-	-	764	-	-	-	**764**
Total net book value at 31 March 2022	**14,931**	**27,198**	**6,775**	**8,500**	**32,340**	**13,688**	**2,221**	**105,653**

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	-	-	-	-	-	-	**-**
Not subject to an operating lease	13,413	28,419	8,681	7,569	29,613	14,547	2,137	**104,379**
Total net book value at 31 March 2023	**13,413**	**28,419**	**8,681**	**7,569**	**29,613**	**14,547**	**2,137**	**104,379**

Note 15 Revaluations of property, plant and equipment

Historically the Trust has used the Capital Charges Estimates indices published by the Department of Health to revalue its assets. In 2008/09 these indices were discontinued and the Trust applied the % movement detailed in the updated forecast indices for assets issued by HM Treasury (ref: PES (2009) 02) which reflected the economic climate and negative pressure on prices. This was in line with guidance issued by the Department of Health.

Due to the fact that the last national revaluation exercise had an effective date of 1 April 2005 (so requiring that values at the preceding balance sheet date of 31 March 2005 reflected the new values), it meant that all NHS bodies must have completed a full property revaluation every 5 years by 31 March, and that the most recent full valuation must be, for specialised property, on a MEA basis.

This year the Trust's land and building assets were revalued by desktop exercise as at the 31st March 2023, using an independent external valuer Deloitte LLP. A full revaluation exercise was undertaken in 2019/20 as part of the 5 year full revaluation cycle. The revaluation exercise was undertaken by the valuers who visited each of Trust's properties in order to establish the fair value of the Trust's estates as at the 31st March 2020. This year 6 sites were inspected where the largest capital investment was undertaken in year. The basis of valuation for all assets under IFRS is Fair Value. Assets that are classified as (Property, Plant and Equipment) PPE and have been valued to Fair Value assuming a continuation of their existing use. This is synonymous with Existing Use Value in the Red Book. The valuation is fully compliant with the requirements of the RICS Valuation Standards - Global Standard 2022 including UK national supplement ("The Red Book"). The signatory to the valuation is Philip Parnel MRICS Partner at Deloitte LLP.

All properties categorised as PPE have been split into land and buildings, and a remaining economic life provided. The componentisation elements of each building have been
- Structure;
- Windows and Doors;
- External Works;
- Roof; and
- Services, fixtures and fittings.

Where provided, the valuers have relied on the site areas from North West Ambulance Service NHS Trust (NWAS).

Where no site area has been provided, valuers sought to ascertain Land Registry plans of the site from NWAS and then measured the site using Ordnance Survey plans in accordance with observed boundaries.
The properties were inspected internally and where access was not possible, properties were inspected externally.

The estimated useful lives of the Trust's property, plant and equipment are as follows:

	Min Life (Years)	Max Life (Years)
Buildings	3	69
Plant & Machinery	5	25
Transport Equipment	5	14
Information Technology	1	15
Furniture and Fittings	2	20

Note 16 Leases - North West Ambulance Service NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee. The Trust is a lessee for a number of leases for vehicles and estates.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Note 16.1 Right of use assets - 2022/23

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	118	-	**118**	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	19,057	4,614	**23,671**	3,359
Additions	214	832	**1,046**	-
Remeasurements of the lease liability	356	(250)	**106**	4
Disposals / derecognition	(8)	(7)	**(15)**	-
Valuation/gross cost at 31 March 2023	**19,737**	**5,189**	**24,926**	**3,363**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	**-**	-
Provided during the year	1,705	1,538	**3,243**	373
Disposals / derecognition	(8)	(2)	**(10)**	-
Accumulated depreciation at 31 March 2023	**1,697**	**1,536**	**3,233**	**373**
Net book value at 31 March 2023	**18,040**	**3,653**	**21,693**	**2,990**
Net book value of right of use assets leased from other NHS providers				655
Net book value of right of use assets leased from other DHSC group bodies				2,335

Note 16.2 Revaluations of right of use assets (ROU)

ROU assets are held at the cost model as it is an appropriate proxy to the current value in use due to the fact that most estates leases arrangements contain rental reviewes to reflect market conditions.

Note 16.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 24.

	2022/23
	£000
Carrying value at 31 March 2022	**77**
IFRS 16 implementation - adjustments for existing operating leases	21,700
Lease additions	1,044
Lease liability remeasurements	106
Interest charge arising in year	200
Early terminations	(5)
Lease payments (cash outflows)	(3,135)
Carrying value at 31 March 2023	**19,987**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.4 Maturity analysis of future lease payments at 31 March 2023

	Total	Of which leased from DHSC group bodies:
	31 March 2023	31 March 2023
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	3,587	367
- later than one year and not later than five years;	6,069	879
- later than five years.	11,945	1,657
Total gross future lease payments	**21,601**	**2,903**
Finance charges allocated to future periods	(1,614)	(219)
Net lease liabilities at 31 March 2023	**19,987**	**2,684**
Of which:		
Leased from other NHS providers	3,149	491
Leased from other DHSC group bodies	16,838	2,193

Note 16.5 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	31 March 2022
	£000
Undiscounted future lease payments payable in:	
- not later than one year;	8
- later than one year and not later than five years;	33
- later than five years.	429
Total gross future lease payments	**470**
Finance charges allocated to future periods	(393)
Net finance lease liabilities at 31 March 2022	**77**
of which payable:	
- later than one year and not later than five years;	2
- later than five years.	75

Note 16.6 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	2021/22
	£000
Operating lease expense	
Minimum lease payments	3,144
Total	**3,144**

	31 March 2022
Future minimum lease payments due:	**£000**
- not later than one year;	2,985
- later than one year and not later than five years;	8,748
- later than five years.	12,792
Total	**24,524**

Note 16.7 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.14.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	**24,524**
Impact of discounting at the incremental borrowing rate	(2,204)
IAS 17 operating lease commitment discounted at incremental borrowing rate	**22,320**
Less:	
Commitments for short term leases	(43)
Irrecoverable VAT previously included in IAS 17 commitment	(577)
Finance lease liabilities under IAS 17 as at 31 March 2022	77
Total lease liabilities under IFRS 16 as at 1 April 2022	**21,777**

Note 17 Investment Property

	2022/23	2021/22
	£000	£000
Carrying value at 1 April - brought forward	**160**	**160**

Note 17.1 Investment property income and expenses

	2022/23	2021/22
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(2)	(14)
Total investment property expenses	**(2)**	**(14)**
Investment property income	90	74

Note 18 Inventories

	31 March 2023	31 March 2022
	£000	£000
Drugs	112	43
Consumables	537	898
Energy	447	353
Total inventories	**1,096**	**1,294**

Inventories recognised in expenses for the year were £1,897k (2021/22: £2,507k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2022/23 the Trust received £603k of items purchased by DHSC (2021/22: £985k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 19 Receivables

	31 March 2023	31 March 2022
	£000	£000
Current		
Contract receivables	16,869	4,258
Allowance for impaired contract receivables / assets	(765)	(732)
Prepayments (non-PFI)	2,813	2,602
PDC dividend receivable	411	34
VAT receivable	407	559
Other receivables	240	190
Total current receivables	**19,975**	**6,911**
Non-current		
Contract receivables	1,052	1,110
Other receivables	-	77
Total non-current receivables	**1,052**	**1,187**
Of which receivable from NHS and DHSC group bodies:		
Current	875	2,796
Non-current	-	77

Note 19.1 Allowances for credit losses

	2022/23 Contract receivables and contract assets	2021/22 Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**732**	**719**
New allowances arising	796	773
Reversals of allowances	(732)	(719)
Utilisation of allowances (write offs)	(31)	(41)
Allowances as at 31 Mar 2023	**765**	**732**

Note 19.2 Exposure to credit risk

As the majority of the Trusts income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2022/23	2021/22
	£000	£000
Cash at 1 April	**67,354**	**60,628**
Net change in year	(3,599)	6,726
At 31 March	**63,755**	**67,354**
Broken down into:		
Cash at commercial banks and in hand	2	2
Cash with the Government Banking Service	63,753	67,352
Total cash and cash equivalents as in SoFP	**63,755**	**67,354**

Note 20.2 Third party assets held by the trust

There are no third party assets held by the trust.

Note 21 Trade and other payables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade payables	918	694
Capital payables	6,927	3,158
Accruals	54,331	34,881
Social security costs	-	3,950
Other taxes payable	-	2,964
Pension contributions payable	4,444	4,329
Other payables	152	156
Total current trade and other payables	**66,772**	**50,132**
Of which payables to NHS and DHSC group bodies:		
Current	4,053	861

Note 22 Other liabilities

	31 March 2023 £000	31 March 2022 £000
Current		
Deferred income: contract liabilities	2,873	3,989
Total other current liabilities	**2,873**	**3,989**

Note 23 Borrowings

	2023 £000	2022 £000
Current		
Lease liabilities*	3,149	-
Total current borrowings	**3,149**	**-**
Non-current		
Lease liabilities*	16,838	77
Total non-current borrowings	**16,838**	**77**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 16.

Note 24 Provisions for liabilities and charges analysis

	Pensions: injury benefits	Legal claims	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2022	**18,886**	**1,738**	**755**	**426**	**4,609**	**26,414**
Change in the discount rate	(3,464)	(190)	-	-	-	**(3,654)**
Arising during the year	241	421	1,783	9	546	**3,000**
Utilised during the year	(732)	(283)	(415)	-	(269)	**(1,699)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	**-**
Reversed unused	-	(257)	(7)	(237)	(1,219)	**(1,720)**
Unwinding of discount	(236)	(13)	-	-	-	**(249)**
At 31 March 2023	**14,695**	**1,416**	**2,116**	**198**	**3,667**	**22,092**
Expected timing of cash flows:						
- not later than one year;	948	501	2,116	198	3,667	**7,430**
- later than one year and not later than five years;	4,502	592	-	-	-	**5,094**
- later than five years.	9,245	323	-	-	-	**9,568**
Total	**14,695**	**1,416**	**2,116**	**198**	**3,667**	**22,092**

The provision relating to other staff pensions consists of £14,695k (2021/22 £18,886k) relating to claims for Personal Injury Benefits recharged by the NHS Pensions Agency. The amounts detailed are amounts that are paid annually to the individuals. The amounts are calculated by the pensions agency following assessment of the individuals claims. The provision includes a prudent assessment of known claims that may result in future liability.

Within legal claims £1,160k (2021/22 £1,368k) represents an amount payable quarterly to an individual. The remaining £256k (2021/22 £370k) relates to Employers Liability Claims recharged monthly by NHS Resolution as and when cases are successful for which the Trust pays up to the first £10k. In addition there is £90k (2021/22 £207k) included in contingent liabilities.

Equal Pay (Agenda for Change) provision relates to expected back-pay liability for Agenda for Change £2.115k (2021/22 £754k),which is based upon expected assimilation using national profiles for staff and the associated payscales published within the Agenda for Change Terms and Conditions. Once these staff have assimilated to Agenda for Change contracts the Trust is obliged to pay outstanding arrears (based on national profiles) and have been included within provisions. All outstanding cases are proceeding using the agreed Agenda for Change procedures.

Note 25 Clinical negligence liabilities

At 31 March 2023, £37,129k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of North West Ambulance Service NHS Trust (31 March 2022: £28,960k).

Note 26 Contingent assets and liabilities

	2023	2022
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	90	207
Gross value of contingent liabilities	**90**	**207**

Note 27 Contractual capital commitments

	2023	2022
	£000	£000
Property, plant and equipment	9,312	13,975
Total	**9,312**	**13,975**

The main capital commitment items relate to procurment of base vehicles and their conversions.

Note 28 Financial instruments

Note 28.1 Financial risk management

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust can borrow from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS England. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2023 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with CCGs till 31st June 2022 and with Integrated Care Boards (ICB) from 1st July 2022, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from available cash funds . The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2023	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	17,396	**17,396**
Cash and cash equivalents	63,755	**63,755**
Total at 31 March 2023	**81,151**	**81,151**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost £000	Total book value £000
Trade and other receivables excluding non financial assets	4,903	**4,903**
Cash and cash equivalents	67,354	**67,354**
Total at 31 March 2022	**72,257**	**72,257**

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost £000	Total book value £000
Obligations under leases	19,987	**19,987**
Trade and other payables excluding non financial liabilities	66,772	**66,772**
Total at 31 March 2023	**86,759**	**86,759**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost £000	Total book value £000
Obligations under leases	77	**77**
Trade and other payables excluding non financial liabilities	43,218	**43,218**
Total at 31 March 2022	**43,295**	**43,295**

Note 29 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2023	31 March 2022
	£000	£000
In one year or less	70,359	43,226
In more than one year but not more than five years	6,069	33
In more than five years	11,945	429
Total	**88,373**	**43,688**

Note 30 Losses and special payments

	2022/23		2021/22	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	21	5	53	30
Stores losses and damage to property	322	221	308	118
Total losses	**343**	**226**	**361**	**148**
Special payments				
Compensation under court order or legally binding arbitration award	30	162	22	141
Ex-gratia payments	80	752	79	719
Total special payments	**110**	**914**	**101**	**860**
Total losses and special payments	**453**	**1,140**	**462**	**1,008**

Note 31 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust Board of Directors or members of the key management staff, or parties related to any of them, has undertaken any material transactions with North West Ambulance Service NHS Trust.

The Department of Health and Social Care is regarded as a related party. During the year 2022/23 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

	Expenditure with Related Party	Income from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
CCGs, ICBs & NHS England	48	465,021	3,400	14,802
NHS Foundation Trusts	2,452	781	589	162
NHS Trusts	257	143	42	-
NHS Resolution	3,525	-	22	-
Care Quality Commission	312	-	-	-
NHS Property Services	685	-	-	-
Department of Health and Social Care	-	125	-	-
Health Education England	-	3,202	-	98

Note 32 Better Payment Practice code

Non-NHS Payables	2022/23 Number	2022/23 £000	2021/22 Number	2021/22 £000
Total non-NHS trade invoices paid in the year	49,608	232,941	46,474	230,637
Total non-NHS trade invoices paid within target	47,467	227,434	44,561	223,189
Percentage of non-NHS trade invoices paid within target	95.7%	97.6%	95.9%	96.8%
NHS Payables				
Total NHS trade invoices paid in the year	483	3,520	352	2,569
Total NHS trade invoices paid within target	473	3,482	343	2,550
Percentage of NHS trade invoices paid within target	97.9%	98.9%	97.4%	99.3%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 33 External financing limit

The trust is given an external financing limit against which it is permitted to underspend

	2022/23 £000	2021/22 £000
Cash flow financing	3,070	(2,156)
External financing requirement	**3,070**	**(2,156)**
External financing limit (EFL)	3,070	4,571
Under / (over) spend against EFL	**0**	**6,727**

Note 34 Capital Resource Limit

	2022/23 £000	2021/22 £000
Gross capital expenditure	26,577	18,534
Less: Disposals	(105)	(340)
Less: Donated and granted capital additions	-	(817)
Charge against Capital Resource Limit	**26,472**	**17,377**
Capital Resource Limit	26,472	17,434
Under / (over) spend against CRL	**-**	**57**

Note 35 Breakeven duty financial performance

	2022/23 £000
Adjusted financial performance surplus (control total basis)	4,866
Breakeven duty financial performance surplus	**4,866**

Note 36 Events after the reporting date

The payward relating to 2022/23 was agreed nationally in May '23 after the end of reporting period, following the negotiations with trade unions and was accepted by the NHS staff council om 2 May 2023.

The amount of pay award was known in March '23 and the accruals were made for the cost of the award and for the income relating to this.

Note 37 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		1,041	2,065	1,558	2,707	2,786	513	135
Breakeven duty cumulative position	3,678	4,719	6,784	8,342	11,049	13,835	14,348	14,483
Operating income		242,220	252,840	259,176	261,312	261,944	266,952	282,429
Cumulative breakeven position as a percentage of operating income		1.9%	2.7%	3.2%	4.2%	5.3%	5.4%	5.1%

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	6,965	6,031	5,319	2,982	41	82	4,866
Breakeven duty cumulative position	21,448	27,479	32,798	35,780	35,821	35,903	40,769
Operating income	316,422	327,731	341,787	370,582	440,004	469,609	492,694
Cumulative breakeven position as a percentage of operating income	6.8%	8.4%	9.6%	9.7%	8.1%	7.6%	8.3%

The breakeven duty is stated in the National Health Service Act 2006 and it states that: each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account.

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

Appendix – Glossary of Terms

(This glossary does not form a part of the statutory accounts)

STATEMENT OF COMPREHENSIVE INCOME

- **Income and Expenditure**
  Often called a Profit and Loss account or an Income and Expenditure account. Public Sector accounts tend to use the term Income and Expenditure to indicate that they are non-profit making organisations.

- **Income from activities**
  Income from patient care activities of the Trust, usually from Clinical Commissioning Groups as the principle commissioner of services.

- **Other operating income**
  Income from non-patient care services such as commercial training, research funding etc.

- **Operating surplus**
  The surplus generated by the normal operations of the Trust before taking into account interest, depreciation and amortisation

- **Depreciation**
  When a fixed asset is purchased, the cost of that asset needs to be charged to the income and expenditure account over the life of the asset to recognise the contribution of that asset to the work of the Trust in each year of ownership. On purchase of a fixed asset, the expected life is assessed and the cost is spread over that life. The value of the asset therefore diminishes, or depreciates, over time.

- **Amortisation**
  Where depreciation applies to tangible fixed assets, amortisation is the same process for non-tangible fixed assets, such as loans to the Trust.

- **Profit / (loss) on disposal of fixed assets**
  The difference between the value of an asset in the balance sheet and the actual sale price of the item. This could be equipment or buildings.

- **Public Dividend Capital (PDC)**
  PDC originated in NHS Trusts as the difference between the valuation of its assets and liabilities on establishment as an NHS Trust. This originating debt is deemed an asset of the Secretary of State, and equates to taxpayers equity in the organisation. The Trust has to make a return on this capital equivalent to 3.5% per annum, and this amount has to be paid over to the Treasury. The original debt can

increase over time due to the allocation of additional capital funds, and is repayable over time.

STATEMENT OF FINANCIAL POSITION

- **Fixed Asset / Non-Current Assets**
  An asset that has a life that extends beyond the current financial year and that will generate economic benefits in future accounting periods – as opposed to current assets, which are realisable immediately or in the next accounting period. Fixed assets are typically equipment or buildings.

- **Current Assets**
  These are assets that are held on the balance sheet of the organisation that have an immediate cash value. These include stocks, that could be sold and realise cash quickly, debtors that can be collected quickly to realise cash or cash held in a bank account.

- **Stock / Inventories**
  Material held as stock which could be sold to realise cash quickly. Can either be valued at **cost** where stock is valued in the books at the purchase price or, **net realisable value** where stock is valued in the books at a value that it could reasonably be expected to fetch if it was sold on the open market today.

- **Debtors / Receivables**
  Money owed to the Trust for services provided.

- **Creditors / Payables**
  Money owed by the Trust for goods and services received.

- **Total Taxpayers' Equity**
  See Public Dividend Capital

NOTES TO THE ACCOUNTS

- **Historical Cost Convention**
  The value of an asset carried in the balance sheet is the amount paid for it on the purchase date.

- **Accruals Convention**
  The accounts are prepared taking account of all income received and receivable, and all expenditure paid and payable for the goods and services delivered and received in the period, and are not based on cash receipts and payments in the period.

- **Off Balance Sheet**
  Refers to fixed assets that are in use by the trust but which are not technically 'owned' by the organisation, and therefore do not appear in the balance sheet. An example of this would be operating leases, where equipment, such as vehicles, is leased by the organisation but never comes into our ownership.

- **Liquid Resources**
  Resources that can be released quickly to enable the organisation to settle debts. Typically, cash in hand or in the bank in short term accounts.

- **Prepayment**
  Where the Trust has paid in advance for goods or services – for example, quarterly payment in advance for telephone rentals.

- **Deferred Income**
  Income received in the financial year but deferred to a subsequent accounting period because the relevant services will be provided in that future accounting period.

- **Reserves**
  Funds set aside in recognition of a future event, project or change, where the need has been recognised but the event has not happened.

TERMINOLOGY

- **Going Concern Basis**
  The accounts are prepared on the basis that the Trust will still be in existence in the next financial year, and that it will therefore be in a position to recover any debtors due to it, and that it will be around to cover its long term liabilities. If it is likely that an organisation will not be in existence beyond this set of accounts, then long term liabilities would become immediately due, and the position of long term debtors would be called into question, resulting in the need to recognise that in the results presented in this set of accounts.

- **Capital Expenditure**
  The amount expended by the Trust that enhances the value of fixed assets whose useful life extends beyond the current accounting period.

- **Revenue Expenditure**
  Expenditure on the day to day operations of the Trust, pay and rations as opposed to capital expenditure.

- **Consumables**

Non pay expenditure on items that have a life of less than one year and are therefore not fixed assets. The term relates to everything from drugs, uniform, stationery through to pieces of disposable equipment.

- **Integrated Care Systems (ICS)**
  ICSs have brought together commissioners of NHS services with health and care providers and other partners who work together to deliver services which meet the needs of specific populations. From 1 July 2022, Integrated Care Boards (ICB) became statutory bodies under the Health and Care Act 2022. ICBs have taken on the commissioning functions of CCGs as well as some of NHS England's commissioning functions.

- **Liability**
  A situation where an organisation has an obligation to pay for something that has already occurred, and around which there is certainty, but is not yet physically paid for.

- **Provisions**
  An allowance in the accounts for a known item, but where the value or timing of the event giving rise to it is uncertain. An example may be where a pay award from 1 January in a given year has not yet been agreed, and the settlement date is uncertain. The organisation would typically provide an estimate for inclusion in the accounts to ensure that the relevant charge to Income and Expenditure is made in the correct year.

- **Contingent Liability**
  A situation where a financial obligation to pay for something that has already happened may arise, but where there is uncertainty or where the final value is difficult to quantify due to dependencies on other things. For example, an outstanding legal claim against the organisation, where if the verdict goes against the organisation, there will be an obligation to pay for an unquantifiable amount. Amounts carried in the accounts under this heading will inevitably be estimates based on the best information available at the time.

- **Value Added Tax (VAT)**
  May be in the form of **output tax** – VAT charged on sales, or **input tax** – VAT paid on purchases. In the NHS, normal NHS healthcare activity does not attract VAT.

- **Post Balance Sheet Event**
  Something that is recognised after the accounts have been finalised, but before publication, which impacts on the results as they are presented, and has a significant impact on how the results should be interpreted.

- **Risk Pooling Scheme**
  This is essentially the NHS insurance scheme, where we pay an annual premium to cover any insurance claims that may arise during the year. The scheme covers all the usual insurance risks around buildings, equipment, fire etc, as well as clinical negligence issues.

- **NHS Resolution**
  NHS Resolution (NHS R) is the body responsible for handling negligence claims against NHS organisations. NHS R also advises NHS organisations on risk management.

- **Losses and Special Payments**
  Any payments made in respect of bad debts, stock write offs, insurance excesses or compensation payments that are not considered a part of the normal business of the Trust.

Things to consider when reading a set of accounts

- **True and Fair View**
  A set of annual accounts is a snapshot at a point in time of how the business is performing. Is it profitable? Is it viable? Is it fit for purpose? It is not and probably never will be 100% accurate. What is important is that the accounts present a fair reflection of performance and viability, and that the items presented in there have been treated according valid and accepted accounting principles, and can be explained and justified in that context.

- **No Surprises**
  The annual accounts should only ever confirm what the Board have been expecting in light of the monitoring reports that have been presented by Director of Finance during the year, and should bear a close resemblance to figures reported at Month 12. If there are significant differences between what the Board was expecting, or from the Month 12 report, then the Director of Finance should include explanations for this in a commentary that accompanies the accounts, and the auditors should be asked to comment on any items of significance.

- **Previous Year**
  It can be useful to compare this year's figures with those of the previous year. Again, the Board should already be aware of any significant movements, and the reasons for them, so any changes should be expected. If there are any changes that have not been explained, then these should be queried and satisfactory explanations obtained to approval.

- **Fixed Assets / Non-Current Assets**
  The Board should be assured that the changes in the fixed asset figures from one year to another reflect the decisions made by the Board on capital investment and disposals during the year. If a revaluation has taken place during the year, this should be explained in the notes, and the Board should ensure that they are fully aware of the impact that this has had on both the Income and Expenditure account and Balance Sheet.

- **Current Assets**
  Again, differences between years should be looked at. Particular things to look for include:

    - Stock – large swings in stock levels year on year can indicate that stock management is inefficient. As a general rule, the Trust should look to carry out as little stock as possible commensurate with ensuring that the right supplies are available at the right time. A very large reduction in stocks in any given year, combined with a reduction in cash balances, may be an indication that the trust is experiencing cash flow problems.
    - Debtors – high levels of debtors may be a result of inefficient debt collection in the Trust and this may be impacting on the cash flow performance.
    - Cash at bank and in hand – this is an indication of the liquidity of the Trust. We should make sure that we have sufficient readily accessible cash available to meet our immediate needs. Significant swings from year to year may indicate that cash management is not as efficient as it should be.

Further Information

Contact the Director of Corporate Affairs at the address, e-mail or telephone number below for information about the Board of Directors or if you would like:

- To view the register of Board of Directors' interests
- To contact the Chair or any member of the Board of Directors
- Information about Board of Directors meetings which are open to the public. Details of meetings are also available on the Trust's website.
- To contact the Chief Executive's office for more information or if you have any comments

Write to: **Director of Corporate Affairs**
North West Ambulance Service NHS Trust
Ambulance Headquarters
Ladybridge Hall
Chorley New Road
Bolton
BL1 5DD

Telephone: 01204 498400

E-mail: angela.wetton@nwas.nhs.uk

Website: www.nwas.nhs.uk