NHS
North West
Ambulance Service
NHS Trust

Board of Directors Meeting

Wednesday, 27th September 2023

9.45am – 12.45pm

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

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2324/068	Patient Story	09:45	Information	Deputy Chief Executive & Director of Strategy, Partnerships and Transformation
INTRODUCTION				
BOD/2324/069	Apologies for Absence	10.00	Information	Chair
BOD/2324/070	Declarations of Interest	10.00	Decision	Chair
BOD/2324/071	Minutes of Previous Meeting held on 26th July 2023	10:00	Decision	Chair
BOD/2324/072	Board Action Log	10:05	Assurance	Chair
BOD/2324/073	Committee Attendance	10:10	Information	Chair
BOD/2324/074	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2324/075	Chairman & Non-Executive Directors Update • Lucy Letby: Review of Systems and Processes	10:15	Information Discussion	Chair
BOD/2324/076	Chief Executive's Report	10:30	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2324/077	Temporary Amendment to Board Standing Orders	10:40	Decision	Director of Corporate Affairs
BOD/2324/078	Statement of Responsibilities	10:50	Decision	Director of Corporate Affairs
BOD/2324/079	Updated Fit & Proper Persons Framework	11:00	Assurance	Director of People
QUALITY AND PERFORMANCE				
BOD/2324/080	Integrated Performance Report	11:10	Assurance	Director of Quality, Innovation, and Improvement
BOD/2324/081	IPC Annual Report 2022/23	11:30	Assurance	Director of Quality, Innovation, and Improvement
BOD/2324/082	Emergency Preparedness Resilience and Response (EPRR) Annual Assurance 2023/24	11:40	Assurance	Deputy Chief Executive
BOD/2324/083	EPRR Policy	11:50	Decision	Deputy Chief Executive
BOD/2324/084	NWAS Strategic Winter Plan 2023/24	12:00	Decision	Deputy Chief Executive
BOD/2324/085	Learning from Deaths Report Q1 2023/24	12:10	Assurance	Medical Director

BOD/2324/086	Quality and Performance Committee Chairs Assurance Report, from the meeting held on 24th July 2023	12:20	Assurance	Prof A Esmail, Non-Executive Director
WORKFORCE				
BOD/2324/087	2023/24 Flu Campaign	12:30	Assurance	Director of People
CLOSING				
BOD/2324/088	Any Other Business Notified Prior to the Meeting	12:40	Assurance	Chair
BOD/2324/089	Items for Inclusion on the BAF	12:45	Assurance	Chair
DATE AND TIME OF NEXT MEETING				
9.45am, Wednesday, 29th November 2023 in the Oak Room, Ladybridge Hall, HQ, Bolton				

Exclusion of Press and Public:
In accordance with Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

NHS
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NHS Trust

Minutes
Board of Directors

Details: 9.45am Wednesday, 26th July 2023
Oak Room, Ladybridge Hall, Trust Headquarters

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

In attendance:

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

Minute Ref:

BOD/2324/044 **Staff Story**

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

The film featured Steven Wheeler, a Senior Systems Manager at 111, who in April 2023 helped to introduce Visual Interactive Voice Recognition (IVR) to the NWAS 111 call system. It was noted that the system had saved time for 111 advisors and patients.

The story described how the new development enhanced the existing IVR call menu system, currently in operation in 111. It was noted that NWAS was the first ambulance service to introduce visual IVR into their 111 contact centres

and so far, there had been promising signs of improvements, with call handling times reducing by 60 seconds per call. In terms of utilisation, it was confirmed that 22% of callers were utilising the new development and feedback from staff had been encouraging.

The approach by the staff to embrace the new development was recognised and the 111 team had been supportive of the idea, to benefit patients and staff.

The Director of Operations praised the engagement in 111 and noted that the trust was seeking to utilise the development across the PTS contact centres.

Mr David Whatley queried roll out to other ambulance sectors.

The Director of Operations noted that NWAS were the only trust to date, that had implemented the initiative, however others were showing an interest.

The Chief Executive acknowledged the work undertaken by 111 and praised the Senior Leadership team for their hard work. He added it had been great to see improvement embedded at local team level, which was very positive from a learning perspective.

The Director of Quality, Innovation and Improvement referred to the recently approved Trust's Quality Account and the contribution by 111 in terms of improvement. She added the learning provided continued opportunities.

The Chair thanked the Senior Systems Manager for the staff story and noted the major benefits particularly in terms of call handling in a call centre environment.

The Board:

- Welcomed and acknowledged the content of the staff story.

BOD/2324/045 Apologies for Absence

Apologies for absence were received from Mrs L Ward, Director of People.

BOD/2324/046 Declarations of Interest

There were no declarations of interest to note.

BOD/2324/047 Minutes of the Previous Meeting

The minutes of the previous meeting held on 31st May 2023 were agreed as a true and accurate record.

The Board:

- Agreed the Minutes of the Meeting held on 31st May 2023 were a true and accurate record.

BOD/2324/048 Board Action Log

The Board noted the updates to the Board action log.

The Board:

- Noted the updates to the action log.

BOD/2324/049 Committee Attendance

The Board noted the Committee Attendance.

The Board:

- Noted the Committee Attendance Record.

BOD/2324/050 Register of Interest

The Board:

- Noted the Register of Interest presented for information.

BOD/2324/051 Chair & Non-Executives' Update

The Chair provided a Chair and Non-Executive Update.

He reported that Board member appraisals had been undertaken and the Executive Directors had provided a number of non-executive briefings, including updates on external regulatory reporting requirements.

He noted a one-to-one meeting with the Chair of Cheshire and Mersey ICB, in relation to Emergency, Preparedness, Resilience and Response (EPRR) and UEC Recovery Plan governance.

He advised that the Trust Board had held an excellent Board Development Session in relation to sexual safety and a further meeting with AACE had been scheduled, to allow shared good practice.

In terms of the ICS, he noted the significance of winter planning across the system.

He referred to the Northern Ambulance Alliance (NAA) and recent work to control the number of large projects which involved the trust, from a resource perspective. He noted the NAA was an excellent organisation and provided opportunities for shared learning, which was extremely valuable.

He announced that he had received and accepted an offer of Chair at Lancashire Teaching Hospitals NHS Foundation Trust, and although there had been no objections by the NWAS Trust Board, there were some governance issues to be worked through.

He noted the significance of governance and advised that a six-month review process would be held, to discuss the position. He also noted the challenge of timescales, in relation to the timings of the announcement, and stated he would have preferred to have further and earlier discussions with NWAS board colleagues. He added he was willing to discuss the matter further, with board members, outside of the meeting.

The Chief Executive also noted the governance and monitoring processes required, which would be conducted between the Trust's Deputy Chair, the Chair, and himself, to ensure clear and robust internal processes were established and maintained.

The Chair confirmed that a public dual announcement would be issued on the 27th of July 2023.

The Board:

- Noted the Chair and Non-Executives' Update.

BOD/2324/052 Chief Executive's Report

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

In terms of PES, he noted that progress and improvement, in terms of performance, continued. He thanked the Director of Operations and the teams for their hard work.

In relation to 111, he noted performance remained stable, with innovative practice ongoing and a national interest in the trust's developments.

He advised that the Director of Operations had provided evidence to the Chair of the Manchester Arena Inquiry, in June, and work continued to ensure the Trust achieved the local and national recommendations.

He acknowledged that projects continued across the organisation, in line with strategic priorities.

He noted that June had been a busy month for trust events, and he thanked the networks for their hard work. He congratulated Steve Bell, Clinical Effectiveness Lead, and others, for supporting the EMS Research Forum Annual Conference.

He referred to the work of the digital and risk and safety team and congratulated them on their achievements at the recent HSJ awards. He also thanked teams for their input into the Covid enquiry.

He reported a 999 BT outage issue, on 25th June 2023, which had impacted on the trust and other ambulance trusts. The trust had worked closely with the NHSE and other northwest trusts to work through the action required. He

added the trust were working with AACE, the government and BT to understand the issues to ensure lessons can be learned to avoid a further event in the future.
He referred to National Volunteers Week 1-7 July 2023 and the NHS 75th anniversary. He thanked all staff for their involvement.

He reported that the trust was working with government ministers on NHS recovery work, with a large focus from an ambulance perspective on UEC recovery plans. He emphasised the need to keep focused to deliver on relevant aspects of the plans.

He noted that NWAS continued to work with system partners, in respect of the ongoing doctors' industrial action.

He reported, with great sadness, the death of Kirsty Done, Anne Lister and Terry Whitham and acknowledged that the trust's thoughts were with their families, friends, and colleagues at this time.

He announced that Mr Ged Blezard, Director of Operations, would be retiring from his post and moving onto a different role within the organisation at the end of September. He acknowledged the significant contribution made by Mr Blezard and noted that interim arrangements would be announced at the Board meeting in September.

Mr D Rawsthorn referred to a recent local radio news article related to the police and mental health calls.

The Chief Executive confirmed there were no new developments to report, however the trust was working closely and in partnership with the regions police services to ensure any future decisions did not impact on the emergency care of patients.

Dr A Chambers acknowledged the need to ensure non-executive board members were visible across the areas of the trust and noted the good achievements, and the awards noted in the report.

Deputy CEO referred to the recent inspection findings at North East Ambulance Service and that NWAS had met with ICB Board members and agreed to complete a review and assessment, to understand if any lessons could be learnt for NWAS, principally around practices, processes, and behaviours.

Mrs C Butterworth referred to innovative developments in 111 and queried the evaluation of benefits and their impact on the workforce, as well as the wellbeing and efficiency gains.

The Director of Operations advised that it would be some time before the total performance gains could be understood, but there were signs of a more satisfied workforce.

The Chair thanked the Director of Operations for his hard work and for holding down a difficult job during significant challenging times such as Covid 19 and seasonal pressures.

The Board:

- Noted the content of the Chief Executives Update.

BOD/2324/053 **Trust Strategies – People Strategy, Service Development Strategy, Quality Strategy and Sustainability Strategy**

The Deputy Chief Executive presented the trust's supporting strategies.

He reported the trust's intention to develop supporting strategies and supporting plans to support the overall Trust Strategy.

He referred to the plan on a page, which outlined the basis for the supporting strategies, and described that each strategy was developed by key staff and led by the relevant Exec Lead. He added that the trust aimed to ensure that key priorities were included, and alignment could be evidenced and supported by interdependencies.

In terms of the Quality Strategy, it was noted that clear measures including key priorities, were included, with the importance of safety culture and the need to innovate as an organisation.

Prof A Esmail supported the Quality Strategy, which had been discussed in detail at the Quality and Performance Committee on 24th July 2023.

The Deputy Chief Executive also referred to the People Strategy and confirmed that culture and EDI were a key thread.

Mrs C Butterworth referred to performance management.

The Deputy Director of People recognised that the People Strategy included a process for tracking and achievability through the measures.

Dr D Hanley welcomed the Service Development Strategy, discussed in detail at the Resources Committee meeting on 21st July 2023. He noted the Strategy was very ambitious and welcomed a review in Part 2 Board of Directors meeting, particularly in respect of the capital programme and resources to fulfil the strategy requirements.

The Chair referred to the Sustainability Strategy. He noted the finance element of the strategy and the terms used for finance and where this fit in terms of the Green Plan.

The Director of Finance advised that the issue had been discussed and the interrelation and sustainability embedded with the overall financial impact which impacted on the service delivery model and other elements.

The Chief Executive confirmed the strategies allowed the trust ability to manage and monitor professional accountability, in terms of delivery of the strategies.

Dr A Chambers noted the strategies were live and accessible.

The Deputy Chief Executive noted that the first annual plan assurance report had been presented to the Resources Committee. He noted the correlation between the annual plan and strategy and directorate progress. He added achievability would be monitored via the Planning Board and the trust had followed the screening tool process and conducted a comprehensive equality impact assessment.

Prof A Esmail referred to future monitoring reports and whether current reports to Board would provide assurance in relation to performance against the strategies.

The Deputy Chief Executive noted that discussion had been held with the Director of Quality, Innovation, and Improvement, and linkages would be made in future versions of the Integrated Performance Report (IPR) presented to the Board of Directors.

The Director of Quality, Innovation and Improvement confirmed the need to look at the Single oversight Framework, the trust's IPR and the Board Assurance Framework, with a single oversight report to be presented to Board and Board assurance committees in the future.

The Chair thanked the Executive Directors and their teams for their hard work in producing the supporting strategies.

The Board:

- Noted the assurance provided on the strategy development process followed.
- Approved the supporting strategy content as a set of strategies which collectively delivered the trust's vision.
- Noted the interdependencies between the supporting strategies as outlined in appendix A.

BOD/2324/054 Board Assurance Framework

The Director of Corporate Affairs presented the proposed Q1 2023/24 position of the Board Assurance Framework (BAF).

She presented the proposed changes, recommended by the Executive Leadership Committee (ELC), and advised that the rationale for the proposed risk score changes could be seen in s3 of the report.

She advised that the BAF included a new forecasted position section, which provided key headlines for Q2 2023/24.

The ELC recommended the following changes to strategic risk scores and recommended rewording of SR09–

- A decrease of SR03 from 20 to 15.
- An increase of SR06 from 10 to 15.

Mr D Rawsthorn welcomed the changes to the BAF and supported the inclusion of the forecast for the following quarter.

The Chair queried the rationale for the proposed changes.

The Director of Quality, Innovation and Improvement noted that the increase in risk score for SR06 had been discussed by the ELC and the rationale reflected a moment in time. She referred to the mitigating actions undertaken to reduce the risk, since the risk had been reviewed.

Mr D Rawsthorn referred to the SIRO report and strategic risk SR08, he acknowledged the area was constantly being challenged, in terms of cyber security.

The Chair agreed and stressed the importance to continue to monitor the position for SR08.

The Board:

- Approved the 2023/24 Q1 position of the Board Assurance Framework.
- Agreed the amendment to the wording of SR09.

BOD/2324/055 Patient Safety Incident Response Framework (PSIRF) Local Priorities

The Director of Corporate Affairs presented the PSIRF Local Priorities.

She reported that NHS England issued the final documents relating to the implementation of the Framework in August 2022. She added that the Framework formed part of the NHS Contract and was mandated for all Trusts with a go live date of September 2023.

She advised that the following local priorities had been identified for NWAS and supported by the trust's Quality and Performance Committee:

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

She noted that if at any point the trust wished to review and update the priorities, the Board of Directors would be consulted to agree any change.

Prof A Esmail, noted the priorities had been considered by the Q&P Committee and the priorities linked to key themes from serious incidents received by the trust.

Mrs C Butterworth referred to system priorities and the extent of the trust's ability to influence focus across the ICS.

The Medical Director noted that the trust had the ability to influence some elements of patient safety, however some areas were out with the trust's gift and a balance was necessary.

The Director of Quality, Innovation and Improvement noted that PSIRF was an opportunity to promote the trust's priorities, amidst system pressures, and the partnership and collaborative work was fundamental to deliver the priorities.

The Chair felt the priorities were extremely relevant and fit with past and present board discussions, in terms of themes from serious incidents. He fully supported the priorities.

The Board:

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

BOD/2324/056 **Audit Committee Chairs Assurance Report from the meeting held on 21st July 2023.**

Mr D Rawsthorn, Non-Executive Director presented the Audit Committee Chairs Assurance Report, from the meeting held on 21st July 2023.

He also referred to the short meeting held in June 2023 and an annual private meeting with the trust's external auditors, which had been a positive meeting.

The Board:

- Noted the assurances provided.

BOD/2324/057 **Charitable Funds Committee Chairs Assurance Reports from the meetings held on 21st June 2023 and 19th July 2023**

Mr D Rawsthorn, Non-Executive Director presented the Chairs Assurance Report from the Charitable Funds Committee meeting.

He noted that the level of Charity activity had increased with good recruitment and future forward plans.

The Board acknowledged the good work of the Charity and the Hardship Fund, which had been well received, with a significant number of applications.

The Board:

- Noted the assurances provided.

BOD/2324/058 Integrated Performance Report

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

She reported an error on in the effectiveness section of the report, bullet point 2, which should refer to STEMI rather than stroke performance.

The Director of Corporate Affairs noted that complaints and incidents activity had been discussed by the Q&P Committee, with complaints work ongoing.

Prof A Esmail reported that the Committee had discussed performance and noted the hard work undertaken and continued improvement by the complaints and incidents team.

In terms of patient experience, there was nothing of exception to note.

The Medical Director referred to the effectiveness section of the report and highlighted a key issue for improvement, which involved recording of the second pain score.

He noted that the trust's EPR, phase 3 project would consider a forcing function to remind clinicians to complete the second score and further work was underway, as a sector, to look at the measure in more detail.

The Chair noted the time lag in reporting, and observed the assurance provided, however noted the continuation in deterioration. He asked the Chair of the Quality and Performance Committee to ask the questions and discuss the issue in more detail.

The Director of Operations provided an overview of operational performance he noted that June had been the hottest month and there had been extreme calls to the trust on 24th and 25th June 2023.

He noted that although here had been some improvement in hospital handover times, there was some variation in performance across the trust, which impacted on the trust's overall CAT 2 mean performance.

In terms of 111, he noted a relatively stable performance, with PTS operating under activity, with levels improving.

The Chair noted the reduction in call volume, however acknowledged the peaks and troughs in performance.

Mr D Rawsthorn noted the ARP standards for C1 and C2 performance, however he recognised a poorer performance for C3 and C4 calls.

The Director of Operations advised of a focus on C1 and C2 calls, however C3 and C4 plans for improvement were in place, he noted it was expected that the C2 sub categorisation work, and use of UEC funding would provide improvements.

Dr A Chambers noted discussion had been held at the Quality and Performance Committee meeting, to clarify the position.

Mr C Butterworth acknowledged see and treat performance, and queried if there was room for further improvement.

The Director of Operations advised there was some room for improvement, and project work was being undertaken, to address the complex issue. He confirmed that a deep dive had been presented to the Quality and Performance Committee, which had provided detail and explored the issues and plans in place.

The Director of Finance referred to the financial position provided in the paper and advised of no exceptions to be reported to the Board.

The Deputy Director of People confirmed that the trust's performance against the workforce indicators had been discussed in detail at the Resources Committee meeting and challenges remained in recruitment to 111 and UEC workforce recovery planning. She added that generally, the workforce indicators performance position was improving.

The Chair noted the overall improved position, in terms of performance, and thanked the teams for their input, across the trust.

The Board:

- Noted the content of the report.
- Noted the recommendations in the report.
- Chair of the Quality and Performance Committee to question and discuss the ongoing issue of recording the second pain score.

BOD/2324/059 Infection Prevention and Control Board Assurance Framework

The Director of Quality, Innovation and Improvement presented the Infection Prevention and Control (IPC) Board Assurance Framework (BAF).

She noted the IPC BAF was a generic document, and the domains were set by NHS England.

She noted that the assurance provided in the report, included the trust's transition from an NHSE funded FIT Testing programme to a Trust programme, the recruitment undertaken and NWAS had broadened the number of people across the organisation, able to conduct testing.

The Board:

- Noted and acknowledged the significant steps of improvement, in relation to IPC within the Trust.
- Noted the gaps in control and the measures being taken to improve performance and provide further assurance.

BOD/2324/060 Senior Information Risk Owner (SIRO) Annual Report 2022/23

The Director of Quality, Innovation and Improvement presented the SIRO report for 2022/23.

The Director of Quality, Innovation and Improvement noted the timescales for reporting and the assurance received from the trust's external auditors.

The Trust had met standards in relation to the Data Security and Protection Toolkit (DSPT) with some moderate assurance in relation to mandatory training.

She noted the Information Governance Sub Committee had strengthened assurance and KPIs had shown a sustained high level of delivery and performance and meeting requirements from a regulatory perspective.

In terms of cyber security, she advised that monitoring of measures allowed focus on high level metrics and detail, and work plans were in place with information asset owners.

Mr D Rawsthorn confirmed the reports had been presented to the Audit Committee and the work of the Information Governance Subcommittee noted.

The Chair noted the issue of mandatory training and achievability of the standard. It was noted that turnover of staff provided a challenge for the trust in terms of compliance.

Mrs C Butterworth referred to the challenge of performance against the trust's mandatory training targets, which were impacted by maternity leave and turnover of staff. Mr D Rawsthorn also acknowledged the importance of a like-for-like reporting on the standard.

The Chair thanked the team for their efforts and the assurance provided by the SIRO report.

The Board:

- Noted the content of the report and the progress made.
- Received assurance that the trust had effective systems and processes in place to maintain the security of information.

BOD/2324/061 **Medicines Management Annual Report including Controlled Drugs Annual Report 2022/23**

The Medical Director presented the Medicines Management Annual Report, including Controlled Drugs Annual Report 2022/23.

He advised that the report provided an overview of activity during 2022/23 and outlined the forward plans for 2023/24.

He reported that the trust's Quality and Performance Committee had considered the report and actions related to controlled drugs and the home office license. He noted that a review of management of the challenges and improving compliance had been undertaken, particularly in relation to vehicle audits.

He advised that the Chief Pharmacist contributed at a national level, in terms of medicines management and future working. He updated the Board of Directors in relation to the Home Office license and associated resource constraints, which impacted on timings of approvals and adjustments. He added that NWAS had responded to a recent Home Office Notice of a low-level non-compliance, and actions had been completed and submitted by the trust.

The Chair clarified the assurance process for ensuring that actions had been taken.

Prof A Esmail advised that the Quality and Performance Committee had raised the issue of non-compliance, in relation to the trust's external regulators, and would continue to monitor the position.

Mr D Whatley referred to action being taken to reduce wastage of medicines.

The Medical Director advised that the wastage referred to was not unusual in a healthcare setting, and the type of wastage evidenced good clinical practice.

The Board:

- Noted the achievements and assurance provide in the report.
- Noted the forward plan for 2023/24.

BOD/2324/062 **Learning from Deaths Report Q4 2022/23**

The Medical Director presented the Learning from Deaths Report Q4 2022/23.

He reported that the paper described the opportunities for the trust to learn from deaths. He advised that the main contributory factors to patient deaths were identified in the trust's DatixCloudIQ system and were attributed to challenges in Emergency Operational Centres (EOC), specifically the emergency response where demand outstripped available resource.

Prof A Esmail stated that the Quality and Performance Committee had considered the paper and had discussed the future tracking of learning through the Patient Safety Incident Framework, which would improve the learning process for the trust.

The Medical Director highlighted the issue of poor documentation, referred to in the report, which were not acceptable. He added the issue usually referred to the quality of documentation, and this was being monitored and the trust's patient and public panel were represented on the review panel.

The Chair referred to the trust's internal systems and processes which should ensure that staff to follow the correct procedures.

The Medical Director noted that some human error had to be factored in, however gaps identified were part of work plans, for frontline teams.

The Chair noted the bullet points for improvement and the need to ensure that the list wasn't routinely repeated. He requested further discussion outside of the meeting, on how the reporting can be refreshed and reported in the future.

The Board:

- Supported the quarterly dashboard as the report to be published on the Trust public account.
- Noted the trust is fully compliant with the Learning from Deaths Framework.
- Acknowledged the good practice identified.
- Further discussion to be held with Medical Director, outside of the meeting on the future format of reports, in relation to bullet points describing the areas for improvement.

BOD/2324/063 **Resources Committee Chairs Assurance Report from the meeting held on 21st July 2023**

Dr D Hanley, Non-Executive Director, presented the Resources Committee Chairs Assurance Report from the meeting held on 21st July 2023.

The Committee received a presentation from the NHSE on electric vehicles and NWAS had been commended on their contribution to the work. He provided an overview of the assurances received and the areas of moderate assurance.

The Board:

- Noted the Chairs Assurance Report from the Resources Committee meeting held on 21st July 2023.

BOD/2324/064 WRES, WDES and Gender Pay Gap Reporting

The Deputy Director of People presented the WRES, WDES and Gender Pay Gap Reporting.

She advised that the content had been presented to the Executive Leadership Committee and Resources Committee on 21st July 2023.

In terms of the Workforce Race Equality Standard (WRES) she noted a positive shift, with the number of BME workforce reported at 365 by 31st March 2022, compared to 325 the previous year. She noted a reduction in the numbers of BME staff entering disciplinary processes.

In relation to Workforce Disability Equality Standard (WDES), she reported a mixed position, in terms of improvements and representation. She noted an increased focus on reporting, recruitment progress and improvements in terms of reasonable adjustments and perceptions of career progression. She added there had been a worsening position from the staff survey perspective, with plans in place to improve the position.

She advised that the trust's Gender Pay Gap data evidenced an increase in women entering more of the quartiles, particularly at the start of the bottom of the pay scales, however more male counterparts were in the post at the top of the pay scale. She acknowledged some general improvement in the gender pay gap, with key to focus on career progression and higher education perspective, more students joining are female and good access for females to move through the pay bands.

She noted improvements in the position could be slow, due to the timescales involved in making a difference to the overall data.

Dr D Hanley noted that Resources Committee continued to monitor the trajectory of the gender pay gap.

The Director of Quality, Innovation and Improvement referred to the mean and median figures and stated if more women were entering lower grade posts, she'd expect to see a shift in the mean. She queried if further action could be taken to improve the position.

The Deputy Chief Executive noted that the trust's Diversity and Inclusion (D&I) Sub Committee discussed the data and that further work and monitoring of the metrics would be carried out. He added that structural changes to pay had been implemented under Agenda for Change, which needed to be factored into future reporting. He noted that further work was required, to be monitored by the D&I Sub Committee and overseen by the Resources Committee.

Dr A Chambers referred to opportunities to work in partnership with education providers to impact on graduates and apprenticeships entering the organisation.

The Deputy Director of People noted a difference in the type of targets reported by higher education institutes.

The Chair noted the need to ensure that the trust focused on actions as well as data and the need to ensure the areas of focus, in terms of equal career opportunity and pay improved. He also noted that the work of the disability network required further focus to improve the position.

The Director of Finance noted the challenges in terms of identifying disabled employees and the need to promote openness and transparency in the trust. She added that future work plans focused on improvement for people with non-visible disabilities.

The Chair recognised the various challenges and thanked the Deputy Director of People for a helpful report.

The Board:

- Noted the progress undertaken.
- Noted the planned actions for improvement.
- Recommended approval of the data for onward reporting.

BOD/2324/065 **Communications and Engagement Team Report Q1 2023/24**

The Deputy Chief Executive presented the Communications and Engagement Team Report Q1 2023/24.

He provided an overview of the paper and key activity. He acknowledged that Mr J Loughran was present at the meeting, as an observer, from the Patient and Public Panel. He also highlighted that patient and staff stories were available on the Trust's Green Room for learning across the organisation.

He added that a significant number of staff were accessing the website and the green room and noted the headlines for inclusion in the next quarterly update to the Board of Directors.

The Board:

- Noted the content and impact of the report.

At this point in the meeting, the Deputy Chief Executive read out a question from the Patient and Public Panel (PPP) – What plans do the Board have to promote the development and use of the "Wait Times" app to reduce the number of people calling 999 and going to the ED?

The Director of Operations advised that the app was a new development that was being piloted in a small number of hospital trusts. He added there were opportunities for the northwest hospitals to join the pilot, but this was not a decision which involved NWAS. He noted that the app would not impact on

where NWAS transported patients to and would always base the patient destination upon clinical need.

It was noted that further clarification on the position was required, and the Chair requested a further separate discussion between the Director of Operations and the Mr J Loughran, PPP member, following the meeting.

BOD/2324/066 **Any Other Business Notified prior to the meeting.**

There was no other business notified prior to the meeting.

BOD/2324/067 **Items for inclusion on the BAF**

There were no items identified for inclusion in the BAF.

Date and time of the next meeting –

9.45 am on Wednesday, 27th September 2023 in the Oak Room, Ladybridge Hall, Trust HQ.

Signed _____

Date _____

Status:	
Complete & for removal	
In progress	
Overdue	
Included in meeting agenda	

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
110	26th July 2023	2324/050	Integrated Performance Report (Effectiveness Performance Reporting)	Chair of the Quality and Performance Committee to question and discuss the ongoing issue of recording the second pain score.	Medical Director	27th September 2023		Included on the Q&P Committee action tracker.	
111	26th July 2023	2324/062	Learning from Deaths Q4 2022/23 Report	Chair requested further discussion on the format of future reports, in relation to the bullet points describing the areas identified for improvement.	Medical Director	27th September 2023		Included on the Q&P Committee action tracker.	

NWAS Board and Committee Attendance 2023/24

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

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

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

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

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

Nomination & Remuneration Committee							
	26th April	31st May	26th July	27th September	29th November	31st January	27th March
Catherine Butterworth	✔	✔	✔				
Dr Alison Chambers	✔	x	✔				
Prof Aneez Esmail	x	✔	✔				
Dr David Hanley	✔	✔	✔				
David Rawsthorn	✔	✔	✔				
David Whatley	✔	✔	✔				
Peter White (Chair)	✔	✔	✔				

CONFLICTS OF INTEREST REGISTER
NORTH WEST AMBULANCE SERVICE - BOARD OF DIRECTORS

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision is required within a meeting, in relation to the service line.
Catherine	Butterworth	Non-Executive Director	HR Consultant (no live commissions) for NLaG Acture Trust and Beacon GP Care Group				√	Position of Authority	Apr-22	Present	Agreed with Chairman not to accept or start any NHS HR contracts without his prior approval and support.
			Non Executive Director - 3 x Adult Health and Social Care Companies owned by Oldham Countil				√	Position of Authority	Apr-22	Present	Withdraw from decision making process if the organisations listed within the declaration were involved.
			Director / Shareholder for 4 Seasons Garden Companies: 4 Seasons Garden Maintenance Ltd 4 Seasons Gardens (Norden) Ltd 4 Seasons Design and Build Ltd 4 Seasons lawn treatments Ltd CFR HR Ltd (not currently operating) - removed 25th May 2022				√	Position of Authority	Apr-22	Present	4 Seasons garden maintenance Ltd has secured and operates NHS Contracts for grounds maintenance and improvement works at other NW NHS Acute Trusts but these pre date and are disassociated with my NED appointment at NWAS. To withdraw from the meeting and any decision making process if the organisations listed within the declaration were involved.
Alison	Chambers	Non-Executive Director	Self Employed, A&A Chambers Consulting Ltd	√				Self employment	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Trustee at Pendle Education Trust		√			Position of Authority	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Non Executive Director Pennine Care Foundation Trust				√	Position of Authority	Jul-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
Salman	Desai	Director of Strategy, Partnerships and Transformation	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Board member of Charity Dignity in Dying			√		Board member	May-22	Present	
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			A member of Festival Medical Services, a 'not for profit' registered charity staffed by volunteers, delivering professional medical services at events throughout the country. NWAS does not sub-contract events nor does FMS operate any significant activity in the North West.		√			Non Financial Professional Interest.	Jul-22	Present	If FMS run events in the North West, these would be undertaken via usual NWAS command functions and EPRR planning and I would remove myself from any interactions and engage with the NWAS Deputy Director should involvement be required from the Medical Directorate.
David	Hanley	Non-Executive Director	Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	Present	No conflict.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Member of the JESIP Ministerial Board, HM Government		√			Position of Authority	Jan-22	Present	No conflict.
			Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care)		√			Position of Authority	Apr-19	Present	N/A
			Member of the NW Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Maxine	Power	Director of Quality, Innovation and Improvement	Daughter employed at NWAS as Service Delivery Programme Assurance Manager in PTS.			√		Non financial personal interest.	Sep-23	Present	Declare an interest and withdraw from discussions as and when required.
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	31.3.22	N/A
			Member of Green Party			√		Other Interest	May-19	Present	Will not use NED position in any political way and will avoid any political activity in relation to the NHS.
			Member of Cumbria Wildlife Trust			√		Other Interest	Apr-19	Present	N/A
Lisa	Ward	Director of People	Member of the Labour Party			√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
			Member of Chartered Institute of Personnel and Development		√			Non financil professional interest	Jun-23	Present	Declare an interest and withdraw from discussions as and when required.
			Daughter employed at DHSC as economic analyst			√		Non financial personal interest.	Sep-21	Sep-23	Declare an interest and withdraw from discussions as and when required.
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Whatley	Associate Non Executive Director	Trustee Pendle Education Trust		√				Apr-23		Withdrawal from the decision making process if the organisations listed within the declarations were involved.
			Governor, Nelson and Colne College Group		√				Apr-23		
			Independent Member of Audit Committee, Pendle Borough Council		√				Apr-23		
			Wife is employed at Manchester Teaching Hospitals NHS FT as a Biochemist				√		Apr-23		
Peter	White	Chairman	Chair of Lancashire Teaching Hospitals NHS Foundation Trust	√				Second Trust Chair Position in another NHS organisation	Aug-23	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	No Conflict
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Carolyn	Wood	Director of Finance	Husband was Director of Finance at East Lancashire Hospitals NHS Trust				√	Other Interest	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 September 2023
SUBJECT:	Chief Executive's Report
PRESENTED BY:	Daren Mochrie, Chief Executive

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☒	☒	☒	☒
SR06	**SR07**	**SR08**	**SR09**	**SR10**
☒	☒	☒	☒	☒

PURPOSE OF PAPER:	For Assurance
EXECUTIVE SUMMARY:	The purpose of this report is to provide members with information on a number of areas since the last CEO's report to the Trust Board dated 26 July 2023. The highlights from this report are as follows: PES • Stable performance for July and August and NWAS are one of only a few meeting the interim Cat 2 30 min target. • Continuing to lead the sector on call pick up. • Conveyance to ED comparable with the best performing trusts. 111 • Visual IVR saving 43 seconds per call. • Trial of homeworking health care advisers has experienced some technology issues. • Interim national support continues to add capacity. PTS • Activity in July 23 was 10% below contract baselines.
RECOMMENDATIONS:	The Board is recommended to: • Receive and note the contents of the report
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People

	☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:			
	Outcome:			

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1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional, and national issues of note in relation to the trust since the last report to the Trust Board on 26 July 2023.

2. PERFORMANCE

2.1 Paramedic Emergency Service

July and August operational performance remained stable. There has been some slight deterioration in C2 performance, that said NWAS are one of only a few Ambulance Trusts currently meeting the interim Cat 2 within 30 mins target NWAS met the C1 90th centile target. Call volumes reduced in August however we did see a 3% increase in incidents.

Call pick up improved through July and August, continuing to achieve the mean call answer time in 1 second (10 second target). NWAS continue to lead the sector in this measure.

Hear & Treat is also performing well at just under 14%, whilst See & Treat remains challenged NWAS has the highest conveyance to non-emergency departments of nearly 7% which makes the conveyance to ED comparable with the best performing trusts.

We have deployed approximately 100 staff during August which is part of our UEC recovery plan. Further tranches of staff are planned in November and January/February.

2.2 NHS 111

NWAS 111 continue to improve our delivery of safe and effective service to the Northwest with several internal innovations and workstreams, as well as working alongside external stakeholders and other 111 providers. Interim national support provided by Vocare and IC24 has continued to add capacity into our call handling teams resulting in our calls being answered in a timelier manner.

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

The department has been working closely with the quality team and has taken part in the safety culture survey. We have been commended for our engagement in the survey, achieving over three-hundred responses, allowing us to pick out some amazing trends and themes on how safe our culture is at 111. Whilst the analysis of the results is still in its early phase, the initial signs are extremely positive, and we are looking forward to sharing the results in full with all our key stakeholders.

Whilst we have ambitions to continue our trial of health advisors working from home, due to some technological challenges, we have revised the plan. We are working closely with our internal IT colleagues, whilst they liaise with external tech providers to help establish next steps, aiming to have a working product at some point soon. Whilst it is disappointing that this hasn't progressed at the pace we anticipated, we are committed to delivering this program of work, and will continue to work in unison across NWAS and beyond to enable this work to be delivered safely.

2.3 **Patient Transport Service**

Due to reporting timing issues PTS performance is reported one month in arrears. Trust-wide PTS activity in July 23 was 10% below contract baselines; notably Cumbria and Lancashire were 22% and 24% below baselines respectively. Year to date (July 2022 – July 2023) activity is 10% below the baseline.

3. ISSUES TO NOTE

3.1 **Local Issues**

High Sherriff visit to Parkway

At the beginning of August Area Director, Ian Moses, welcomed to Parkway the High Sheriff of Greater Manchester, Mary Liz Walker.

The office of the High Sheriff is a yearly non-political royal appointment with part of the role dedicated to supporting and encouraging emergency services. As a result, the visit was requested to give her a better understanding of how we operate in the region.

As well as Ian, she met Greater Manchester's Head of Operations, Dan Smith, Service Delivery Manager, Angie Lee, and ROCC Tactical Commander, Phil Howcroft. She also spoke with staff about their roles as she was given a tour of the emergency call handling suite, Clinical Hub, Dispatch and the ROCC and informed how they integrate and function over a GM and North West footprint.

We were able to demonstrate how multiple parts of the organisation come together to give patients the best clinical care possible and introduced her to the Gazetteer Team to answer queries about locating potentially complex patient locations and addresses.

She was very appreciative and impressed by the staff's speed, efficiency, and professionalism.

3.2 **Regional Issues**

Reap Level

During the period covered by this report, the trust both increased and decreased its REAP level. The ability to change REAP level is part of our response to manage

system wide pressures and the move to REAP level 3 allows us to focus our resources on essential services to meet the increased demand

Meeting Corporate Colleagues

I often visit stations and call centres around the region as it is the ideal way to speak to staff directly and understand what they feel the challenges are for our service and what they think we could do better. It is important to recognise that everyone who works for NWAS has a part to play which is why I also undertake visits to corporate teams, and I have spent some time with Finance and Procurement colleagues.

Thanks to them we can purchase the medical equipment used on our ambulances and the drugs we administer to patients, the utility bills in all our properties are paid on time, we have fuel for the vehicles, and we all get our salaries each month. Finance representatives sit on major project groups to make sure we don't go over budget and the correct funds are in place, and they deal with invoices ranging from twenty pounds to thousands of pounds.

I also paid a visit to colleagues in the Communications Team who, amongst other things, were busy organising this year's staff Star Awards; the plans for winter to support the operational winter plan, developing the content for social media over the next few weeks together with public engagement events alongside colleagues in the Patient Engagement Team.

Hidden Disabilities – Sunflower Scheme

Hidden disabilities can be physical, mental, or neurological and there are currently 911 conditions classified as hidden disabilities including autism, ADHD, anxiety, dyslexia, lupus, learning difficulties, dementia, diabetes, chronic pain, endometriosis, coeliac disease, Crohn's disease and long COVID.

The Hidden Disabilities Sunflower Scheme is a simple tool for people with hidden disabilities to voluntarily share they have a disability or condition that may not be immediately apparent and was launched in the UK in 2016. It was originally introduced across major airports and is widely recognised in the travel industry. It has more recently been adopted by supermarkets and in sports arenas and is now being introduced into the NHS. We believe all our staff should be able to recognise staff and patients who may choose to wear the sunflower logo and understand its meaning.

To establish the current level of understanding around hidden disabilities and the sunflower scheme within NWAS, the trust launched a short survey where the responses will help influence our approach to supporting staff and patients.

MDVS Pilot

The Mobile Data and Vehicle Solutions (MDVS) pilot will replace the current Thorcom MDT, Garmin Sat nav and reverse camera screens. The changes that will see us use a smarter, less distracting software, will help keep us compliant with the Road Safety Act and UK law.

We are acutely aware of the dangers of taking our eyes off the road while driving. The new software's features, which include voice confirmation, limited screen information displayed (over 7mph), simplified alerts and safety/critical information, will not only keep us compliant, but most importantly, will help keep our crews and patients safe when responding to incidents.

EPR (Electronic Patient Records) – iPad Go Live

During August EPR was successfully rolled out across the trust.

The project has taken18 months of hard work to get to this point with significant input from many trust departments, including operational teams and corporate services. Due to the diligence shown over the previous few months by the testing and soft launch teams, relatively few problems were reported and those that were were resolved quickly by the support mechanism in place.

The feedback around ease of use is very encouraging although GP Connect, which lets staff share and view GP practice clinical information and data took a little longer to embed. This is a major step towards full system integration, bringing considerable improvements in accessing a patient's medical history.

Estuary Point Emergency Operations Centre Business Continuity Incident

On Friday 8 September the air conditioning units at Estuary Point developed a leak in the call taking and 111 suites, leading to 12 positions being affected. Despite mitigations being put in place the fault continued. Business Continuity Plans (BCP) were invoked and call handling and Clinical hub staff were dispersed to other sites at Parkway, Broughton and Middlebrook, dispatch was unaffected. From a call taking perspective this worked really well, however, this did have an impact on HR/mandatory training as the training suite was utilised the following day to house 16 call taking position. Enacting the BCP provided an opportunity for lessons learnt and these will be considered. Mandatory training will be recovered over winter

Subsequently the system has been checked, filters replaced and is now working correctly

3.3 **National Issues**

Lucy Letby Trial

We were all shocked and saddened by the details which have been revealed at the conclusion of the Lucy Letby trial.

As NHS employees, the entire focus of our career is to bring comfort, relief, and care to our patients and to hear of someone who has betrayed that trust in the course of their work deeply affects us all.

Our thoughts go to the families of the victims and hope they are receiving the care and support they will most definitely need. Statements have been issued by NHSE and other relevant parties which can be found on their website.

We must never be afraid to speak out if we are concerned about the care being given to patients or if we feel the actions of others could put the health and lives of patients, colleagues and our organisation at risk and all concerns raised will be investigated and taken seriously.

Industrial Action

Industrial action has continued for both Junior Doctors and Consultants. Hospital consultants are the NHS's most senior clinicians, who's roles cannot be covered by other staff. Strike action by Hospital consultants will still deliver Christmas Day levels of care, meaning emergency departments will still be open and staffed with consultants, but disruption and longer waits should be expected.

We are now entering the ninth month of industrial action across the NHS and staff continue to work hard to provide patients with the best possible care under the circumstances.

NHS Trusts with participating BMA members are communicating directly with patients whose care will be affected and will ensure that public-facing channels (websites / social media etc) are kept up-to-date with details of local service impact. Where necessary, NHS Trusts will also provide specific updates to local stakeholders and health and care partners as required.

The NHS has tried and tested plans in place to mitigate risks to patient safety and manage the disruption caused by industrial action.

Urgent and emergency care services will continue to be open for those who need them, and the NHS will also continue to deliver planned care wherever possible, especially for patients in greatest clinical need.

Meetings with the Prime Minister & Secretary of State for Health & Social care (SoS)

In my July report I mentioned that in my Association of Ambulance Chief Executives Chairs role, I attended an Urgent and Emergency Care roundtable with the SoS for Health & Social Care and senior leaders from NHSE. This was to discuss progess in a number of areas of the Urgent and Emergency Care recovery plan. Since then, I have also met with the Prime Minister, SoS and senior leaders from the NHS and professional bodies to discuss plans and preparation for winter resilience. It is a credit to the AACE leadership team that the Ambulance Sector continues to be front and centre of these conversations at the highest level within Government.

4. GENERAL

NWAS Chair, appointed Chair at Lancashire Teaching Hospitals

At the end of July, Peter White wrote to the whole NWAS team confirming that he had been appointed as Chair for Lancashire Teaching Hospitals NHS Foundation Trust, a role he is taking on alongside his position as NWAS Chair until his appointment term ends in January 2025.

He has been a non-executive for NWAS since 2014 and has been inspired by the challenging but extremely rewarding work of the NHS. The work he has done in NWAS will be of great benefit in his new role and he wishes to use what he has learnt to continue to improve healthcare and responses to the people of the North West.

Changes to the Executive Leadership Committee

Over the coming months, a number of changes will be made to the composition and roles of the Executive Leadership Committee and specifically overall responsibility for the PES, EOC, Resilience, Patient Transport and NHS 111 services.

After 36 years of dedicated service and unwavering commitment, Director of Operations Ged Blezard will retire at the end of September. However, he is not fully ready to hang up his greens just yet and will return temporarily under the trust's 'retire and return' scheme in an alternative position until the end of March 2024.

From 1 October, Salman Desai, Deputy Chief Executive and Director of Strategy, Partnerships and Transformation will take on an interim role as Chief Operating Officer. Alongside his current portfolio, Salman will lead the strategic direction of the trust's operational services while Ged takes a step back.

These interim changes will remain until a robust recruitment process, overseen by NHS England, takes place to determine the future leadership of these services.

It is the Board's opinion that Salman's appointment as interim Chief Operating Officer will ensure a seamless transition. Working with the operational senior leadership team to provide strong continuity of leadership, will enable us to continue to move forward, at a time of change, especially as we go into the winter period. I am confident Salman will have a very positive impact on our operational services enabling us to continue to provide the highest quality of patient experience to the communities we serve whilst fostering an open, inclusive, and values-based culture.

RAAC (Reinforced Autoclaved Aerated Concrete)

The has been a lot of recent headlines over the use of RAAC in schools, with some having to close due to the risk of collapse.

The concrete was widely used in construction during the period of 1950 to 1990, a time when many of the properties NWAS owns were built. A few weeks ago, NWAS appointed a surveyor to examine some of our oldest and largest buildings and of the 11 looked at, one was identified as potentially containing RAAC. Further tests were

carried out to determine the exact composition of the material and the area closed off and a number of PES and PTS vehicles temporarily relocated. However, the results show no presence of RAAC.

A full survey of all NWAS properties built within this timeframe is being undertaken as quickly as possible and local teams will be kept informed of the results of these.

Safe in the back Campaign

In collaboration with all UK ambulance services, the Association of Ambulance Chief Executives (AACE) launched a new campaign to improve safety inside ambulances.

On average, at least one road traffic collision that happens each day will involve an ambulance, resulting in anything from minor bumps and scrapes to major accidents. Given this statistic, it's hard to believe that a high proportion of ambulance staff do not wear their seatbelt when in an ambulance, but that it what a survey undertaken in 2022 unveiled.

It is hoped that this campaign will raise awareness of the issue and increase compliance with safety belts and appropriate harnesses/securing devices legislation for staff and patients.

PSIRF - The Patient Safety Incident Response Framework (PSIRF)

The PSIRF framework will replace the current Serious Incident Framework (2015).

Go-live is scheduled for October and represents a significant shift in the way the NHS responds to patient safety events and is a major step towards establishing a safety management system across the NHS and will fundamentally change how we react to patient safety events as an organisation. There will no longer be a distinction between serious events and other events. PSIRF will allow us to cover all which have caused harm or had the potential to cause harm and deliver a considered and proportionate response to address these issues effectively. PSIRF fosters real compassionate engagement and active involvement for those affected, which can only be a positive for our patients and colleagues

Network collaboration event – Maternal Health inequalities

To mark Black History Month, the Race Equality Network and Women's Network will be hosting an in-person event on 5 October to raise awareness of maternal health inequalities faced by people from black and ethnic minority backgrounds from a patient safety and staff wellbeing perspective.

This event is a fantastic opportunity to better understand the disparities that exist in the maternity care of black and ethnic minority people. The REN is committed to raising awareness of such disparities and finding practical solutions to help improve them. Clinicians strive to provide the best possible care to our patients, this is best achieved from evidence-based practice and continued clinical insight, clinical information and guidance from experts in this field, to improve the care we provide This session hopes to inform, educate, and offer practical solutions to work towards

rectifying the disparity that shows that black women are four times more likely to die in childbirth

This will be one of the first collaboration events between the NWAS networks and we are really pleased to be doing an event on such an important topic which affects us and our patients.

PRIDE

On Saturday 26 August, some of our colleagues attended the Manchester Pride parade. We were part of the thousands of people who marched, which included firefighters, the police, other NHS workers as well as other organisations

Despite the train strikes more staff than ever joined the parade. It's really moving and humbling every year to see our staff being able to be open and celebrate who they are, as well as hearing the level of support from the crowds thronging the streets. This year it was also great to see so many NWAS allies joining the parade, showing their support for their colleagues, and celebrating the diversity of our teams.

Star Awards

The Star Awards, held at Bolton Whites Hotel was a huge success with lots of positive feedback. A massive 300 nominations were submitted recognising staff in all areas of the service and from across the North West with the shortlisted staff being highlighted on the night in front of hundreds of their colleagues and accompany guests

HSJ Award

The team have been shortlisted for a Health Service Journal (HSJ) Award in the Patient Safety category after working with North West NHS trusts in a series of collaborative events to share ideas and best practice for improving hospital handovers.

The improvement collaborative has helped to reduce the number of over 60-minute handover delays in the North West by 47 per cent, only slightly short of its target of achieving a 50 per cent reduction by 31 March 2023.

The joined-up approach led by NWAS alongside NHS health and care quality improvement organisation Aqua and NHS England North West included representatives from 20 NHS trusts across the region covering 26 emergency departments. The work began in October 2022 and involved getting together to propose innovative ideas and putting them into action. There was then an evaluation process to measure the impact before coming back together to share findings and next steps in May 2023.

This initiative has been selected to make the HSJ Awards shortlist following a thorough judging process which whittled down a record-breaking 1,456 entries to 223 shortlisted projects, making it the biggest awards programme in the award's 43-year history.

The official HSJ Awards ceremony will be held on 16 November 2023 in London.

BBC Ambulance returns

This latest series returned to our TV screens at the end of August and features our colleagues in South Cumbria, Lancashire and Greater Manchester. It's been months in the planning, with eight weeks spent filming earlier this year and has been a huge undertaking from teams in Communications, EOC, PES, Fleet and Regional Planning.

The programme is one of the BBC's most successful prime time shows with approximately four million viewers per episode and it is a great way to showcase the amazing work our staff do both on the frontline and behind the scenes. I want to thank everyone involved in making the series happen and to the many patients who have allowed the cameras into some very private moments.

Annual General Meeting

The trusts Annual General Meeting was held in-person at Ladybridge Hall on 6 September, where the Chair and I were accompanied by Carolyn Wood, Director of Finance to present the 2023/23 Annual Report and Accounts

Staff Survey

This year's staff survey launched on 20 September and is one of the largest workforce surveys in the world and offers a snapshot in time of how people experience their working lives. Staff experiences and insights are valuable in helping us to continue to shape the organisation as a great place to work. The survey is aligned to the NHS People Promise to track progresses against its ambition to make the NHS the workplace we all want it to be by 2024

The staff survey is managed by our independent survey provider, Picker, who at the end of the campaign, analyse all the responses and provide us with the results which are completely anonymised.

In our Thoughts

It is with great sadness that I write to inform you of the death of our colleagues Betty Pennington, Adrienne Newman, and former colleague Ann Rawson.

Betty was a hugely well-respected and much-loved colleague in Lancashire, qualifying as a paramedic in 2008 and becoming the trusts' first-ever Research Fellow.

Adriene passed away after a short illness and was a well loved and respected Paramedic in the Oldham Group and her passing was a huge shock to many and a deep loss to NWAS.

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Ann was a retired 999 call taker based at Parkway. She was a well loved and respected colleague

The trust sends sincere condolences to the family, colleagues and friends of Betty Adrienne and Ann.

We have sadly lost a number of colleagues in the last year and while we remember them in our own way, the national memorial service is an event where ambulance staff can come together to commemorate the lives of those who meant so much to us. This year, it was held on 7 September at the National Memorial Arboretum in Staffordshire.

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

There are no legal implications contained within this report

6 EQUALITY OR SUSTAINABILITY IMPACTS

There are no equality or sustainability implications associated with the contents of this report

7 RECOMMENDATIONS

The Board is recommended to:

- Receive and note the contents of this report

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th September 2023				
SUBJECT:	Temporary Amendment to Board Standing Orders				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The composition of the Board of Directors has been updated in the Standing Orders to reflect the decision of the Nominations & Remuneration Committee on 26th July 2023 to appoint the current Director of Strategy, Partnerships and Integration/Deputy Chief Executive as the Chief Operating Officer for a 12-month period following the retirement of the Director of Operations on 30th September 2023. The Chief Operating Officer post will be a voting member of the Board.				
RECOMMENDATIONS:	The Board of Directors are requested to approve the amended Standing Orders.				
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation				

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Not Applicable			
	Date:	N/A		
	Outcome:	N/A		

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1. PURPOSE

The purpose of the report is to present the amended Standing Orders to reflect a temporary change to the composition of the Board of Directors following the retirement of the Director of Operations on 30th September 2023.

2. COMPOSITION OF THE BOARD OF DIRECTORS

From 1st October 2023, the Deputy Chief Executive/Director of Strategy, Partnerships and Integration will assume the role of Chief Operating Officer/Deputy CEO, providing strategic leadership of the service delivery directorate for a period of 12 months and this post will be a voting member of the Board.

The Standing Orders have therefore been updated to reflect these changes.

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

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to approve the changes to the Standing Orders.

North West Ambulance Service NHS Trust

Standing Orders, Reservation of Powers & Scheme of Delegation

Approved by the Board of Directors: 26th April 2023

Record of amendments

Number	Section	Date
1	Updated document issued for implementation	1 July 2006
2	Updated following Board approval, 27 September 2006	1 October 2006
3	Annual review, July 2007	25 July 2007
4	Annual review, September 2008	1 October 2008
5	Annual review, September 2009	30 September 2009
6	Annual review, November 2010	24 November 2010
7	Annual review, January 2012	25 January 2012
8	Annual review, January 2013	27 February 2013
9	Annual review, September 2014	24 September 2014
10	Annual review, September 2015	30 September 2015
11	Temporary amendment to the Composition of the Trust	24 February 2016
12	Annual Review, September 2016	28 September 2016
13	Change in Voting Rights and Board Membership General Review and Refresh	31 October 2017
14	Temporary Change in Voting Rights during Interim Period	26 September 2018
15	Annual Review, March 2019	24 April 2019
16	Annual Review, March 2020	27 May 2020
17	Annual Review, March 2021	28 April 2021
18	Annual Review, March 2022	27 April 2022
19	Annual Review, March 2023	26 April 2023
20	Temporary Change to Voting Rights and Board Membership	27 September 2023

CONTENTS

STANDING ORDERS

RESERVATION OF POWERS & SCHEME OF DELEGATION

1. Introduction

1.1 Statutory Framework

1.1.1 North West Ambulance Service NHS Trust ('the Trust') is a statutory body which came into existence on 1 July 2006, under (Establishment) Order No 2006/1622.

1.1.2 The principal place of business of the Trust is:

Ladybridge Hall,
Chorley New Road,
Bolton,
BL1 5DD.

1.1.3 NHS Trusts are governed by statute, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999 and the Health and Social Care Act 2012. The statutory functions are conferred by this legislation.

1.1.4 As a statutory body, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

1.1.5 The Membership and Procedure Regulations (1990) as amended requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.6 These Standing Orders apply to the North West Ambulance Service NHS Trust and its statutory elements.

1.2 Interpretations

The Chair of the Trust is the final authority in the interpretation of Standing Orders (on the advice of the Chief Executive and Director of Corporate Affairs).

1.3 Definitions

Terminology	Definition
Accountable Officer	Is the officer responsible and accountable for funds entrusted to the Trust; and is responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive, or their appointed replacement, is the Accountable Officer for this Trust
Board of Directors	The Board of Directors means the Chair; Non-Executive Directors and both voting and non-voting Executive Directors.
Chair of the Board of Directors	Is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall, if the Chair is absent from the meeting or otherwise unavailable, be deemed to include the Vice-Chair of the Trust, or other Non-Executive Director.
Chief Executive	The Accountable Chief Officer of the Trust
Committee	A committee appointed by the Board of Directors

Terminology	Definition
Committee Members	Formally appointed by the Board of Directors to sit on, or to chair specific committees
Directors	Are the Non-Executive Directors and Executive Directors (including non-voting Directors)
Director of Finance	The Chief Financial Officer of the Trust
The Trust	North West Ambulance Service NHS Trust
Funds held on Trust	Are those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
Motion	A formal proposition to be discussed and voted on during the course of a Board of Directors or Committee meeting
Nominated Officer	An Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust
Secretary	A person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the Law, Standing Orders and Department of Health guidance
Vice Chair	The Non-Executive Director appointed by the Trust to take on the chair's duties is the Chair is absent for any reason

All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

1.4 NHS Framework

1.4.1 In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter. The majority of these can be found on the department of health website.

1.4.2 The Code of Accountability for NHS Boards requires that, *inter-alia*, Boards draw up a schedule of decisions reserved to the Board known as the 'Reservation of Powers to the Board' and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives through a Scheme of Delegation. The Code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Code of Conduct for NHS Boards makes various requirements concerning possible conflicts of interest of members of the Board.

1.4.3 The Code of Practice on Openness in the NHS or the Freedom of Information Act 2000 and sets out the requirements for public access to information on the NHS.

1.5 Delegation of Powers

1.5.1 The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions by Delegation (SO5), the Board is given powers to 'make arrangements for the exercise, on behalf of the Trust, of any of their functions by a Committee, Sub Committee or Joint Committee appointed by virtue of SO4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust sees fit or as the Secretary of State may direct'. Delegated powers are included within these Standing Orders and (Reservation of Powers to the Board and Scheme of Delegation). The Standing Financial Instructions is a separate document. These documents have effect as if incorporated into these Standing Orders.

1.6 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will ensure decision-making is informed by intelligent information. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. The Board of Directors: Composition of Membership, Tenure and Role of Members

2.1 Composition of the Board of Directors

2.1.1 In accordance with the Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) the voting membership of the Board of Directors shall comprise the Chair and five Non-Executive Directors, together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent Non-Executive Directors.

In addition to the Chair, the Non-Executive Directors shall normally include:

- one appointee nominated to be the Deputy or Vice-Chair
- one appointee nominated to be the Senior Independent Director
- up to three non-voting Associate Non-Executive Directors

The Voting Executive Directors shall include:

- Chief Executive
- Chief Operating Officer / Deputy Chief Executive
- Executive Director of Quality, Innovation and Improvement
- Executive Director of Finance
- Executive Medical Director
- ~~Executive Director of Operations~~

The Board may appoint additional Directors, to be non-voting members of the Trust Board, these currently include:

- Director of People
- ~~Director of Strategy, Partnerships and Transformation~~
- Director of Corporate Affairs

2.2 Appointment of Chair and Executive Directors/Directors

2.2.1 The Chair and Non-Executive Directors of the Trust are appointed by NHSE~~/I~~, on behalf of the Secretary of State for Health and Social Care.

2.2.2 Associate Non-Executive Directors are appointed by the Trust.

2.2.3 The Chief Executive is appointed by the Chair and the Non-Executive Directors.

2.2.4 Other Executive Directors/Directors shall be appointed by a committee comprising the Chair and the Non-Executive Directors, under recommendation from the Chief Executive

2.2.5 Where more than one person is appointed jointly to an Executive Director post in the Trust, those persons shall become appointed as an Executive Director, jointly. Where the post has voting rights attached, the joint appointees will have the power of one vote; and shall count as one person.

2.3 Terms of Office

2.3.1 The regulations governing the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office of the Chair and Non-Executive Directors are contained in the Membership and Procedure Regulations and as directed by NHSE/I, under its delegated authority from Secretary of State for Health.

2.3.2 In line with NHS England's Code of Governance for NHS Provider Trusts, Chairs and Non-Executive Directors should not remain in post beyond nine years from the date of their first appointment and any decision to extend a term beyond nine years should be subject to rigorous review and consideration of progressive refreshing of the Board should be taken into account. In exceptional circumstances, terms may be extended for a limited time beyond nine years however should be subject to annual re-appointment by NHS England. Serving more than nine years could be relevant to the determination of a non-executive's independence.

2.4 Appointment and Powers of Vice-Chair

2.4.1 To enable the proceedings of the Trust to be conducted in the absence of the Chair, the Board of Directors may elect one of the Non-Executive Directors to be Vice-Chair, for a period that does not exceed the remainder of their appointed term as a Non-Executive Director of the Trust.

2.4.2 Any Non-Executive Director so elected may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The appointment as Vice-Chair will end with the termination for any reason of that Non-Executive Director's period of office as a director. On such resignation or termination the Board of Directors may then appoint another Non-Executive Director as Vice-Chair, in accordance with the provision of this Standing Order.

2.4.3 When the Chair is unable to perform their duties due to illness or absence for any reason, his duties will be undertaken by the Vice-Chair who shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties.

2.4.4 In order to appoint the Vice-Chair, nominations will be invited by the Chair. Where there is more than one nomination, a vote will be conducted and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this being acceptable to the Directors present, the Board will be requested to confirm that person as Vice-Chair at the meeting in which the nomination is made.

2.5 Role of Members

2.5.1 The Board will function as a corporate decision-making body, Officer and Non-Officer members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

Executive Members
Executive Members shall exercise their authority within the terms of these Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Chief Executive
The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

Director of Finance
The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Members
The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair
The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall work closely with the Chief Executive and ensure that key and appropriate issues are discussed by the Board in a timely manner, together with all necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

Senior Independent Director

The Senior Independent Director shall be available to hear any issues or concerns that individuals feel unable to raise with the Chair or any Executive Director.

2.5.2 In line with NHS England's Code of Governance for NHS Provider Trusts, where directors have concerns about the operation of the Board or the management of the trust that cannot be resolved, these should be recorded in board minutes. In the case of the resignation of a Non-Executive Director, any such concerns should be provided in a written statement to the Chair for circulation to the Board.

2.6 Corporate Role of the Board

2.6.1 All business shall be conducted in the name of the Trust.

2.6.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.6.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided in SO3.

2.7 Schedule of Matters reserved to the Board and Scheme of Delegation

2.7.1 The Board has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Reservation of Powers to the Board and are incorporated into the Standing Orders. Those powers which it has delegated to individuals and other bodies are contained in the Scheme of Delegation.

3. Meetings of the Trust

3.1 Ordinary Meetings of the Trust Board

3.1.1 All ordinary meetings of the Board of Directors shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

3.1.2 Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may from time to time determine. A minimum of six meetings shall be held each year.

3.1.3 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

> 'That representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'

as required under s.1(2) of the Public Bodies (Admission to Meetings) Act 1960.

3.1.4 The Chair (or person presiding at the meeting) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

> 'That, in the interests of public order, the meeting adjourn for [the period specified] to enable the Board to complete business without the presence of the public'

as required under s.1(8) of the Public Bodies (Admission to Meetings) Act 1960.

3.1.5 The Board of Directors or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting, shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the Board of Director meetings without express permission of the Board of Directors.

3.1.6 Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 *Regular meeting of the Trust*

Agendas will be sent to members at least five days before the meeting. Supporting papers, whenever possible, shall accompany the agenda and will in any event be despatched no later than three clear days before the meeting, except in an emergency.

3.2.2 *Exceptional meetings of the Trust*

A notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer of the trust authorised by the Chair to sign on their behalf, shall be delivered to every Director, so as to be available to them at least three clear days before the meeting.

3.2.3 *Meetings called by Directors*

In the case of a meeting called by Directors in the event that the Chair has not called the meeting, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.2.4 *Public notice*

Before each meeting of the Board, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting, as required under s.1(4)(a) of the Public Bodies (Admission to Meetings) Act 1960.

3.3 Setting the Agenda

3.3.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

3.3.2 A Director may request that a matter is included on an agenda. This request should be made in writing to the Chair and Director of Corporate Affairs at least seven clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than seven days before a meeting may be included on the agenda at the discretion of the Chair.

3.3.3 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board meeting.

3.4 Annual Public Meeting

The Trust will publicise and hold an annual public meeting in accordance with the NHS Trusts (Public Meetings) Regulations 1991. The meeting shall take place no later than 30 September each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting.

3.5 Chair of the Meeting

3.5.1 The Chair shall preside at any meeting of the Trust Board, if present. In their absence, the Vice Chair shall preside.

3.5.2 If the Chair and Vice-Chair are absent, the directors present, who are eligible to vote shall choose a Non-Executive Director who shall preside. An Executive Director may not take the chair.

3.5.3 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and the Chair's interpretation of the Standing Orders shall be final. In this interpretation the Chair shall be advised by the Director of Corporate Affairs and in the case of Standing Financial Instructions the Chair shall be advised by the Director of Finance.

3.6 Voting

3.6.1 It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

3.6.2 Where it is necessary to take a vote to determine an issue, the decision shall be determined by a majority of the votes of the directors present and eligible to vote. If the result of the vote is equal, the Chair of the meeting shall have a second or casting vote.

3.6.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may be held, if a majority of the directors present and eligible to vote, so request. Unless specifically agreed beforehand, the voting record of each individual director will not be made public, or recorded

3.6.4 The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors present and eligible to vote so request.

3.6.5 If a director so requests, his vote will be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded

3.6.6 Under no circumstances may an absent director vote by proxy.

3.6.7 An officer who has been appointed formally by the Trust to act up for an Executive Director during a period of incapacity, or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of that Executive Director. An officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence, but without formal acting up status, may not exercise the voting rights of that Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.6.8 Where the office of a director who is eligible to vote is shared jointly by more than one person:

- either or both of those persons may attend and take part in the meetings of the Trust Board.
- if both are present at a meeting they will cast one vote if they agree.
- in the case of disagreement no vote will be cast.
- the presence of either or both of those persons will count as the presence of one person for the purpose of establishing a quorum.

3.6.9 Where necessary, a director may be counted as present when available constantly for discussions through an audio or video link and may take part in voting on an open basis.

3.7 Quorum

3.7.1 No business shall be transacted at a meeting of the Board unless at least six of the Directors who are eligible to vote (including at least three Executive and three Non-Executive Directors with voting powers) are present.

3.7.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.7.3 A director will not count towards the quorum on a matter where he is ruled to be ineligible to participate in the discussion, or vote, due to the declaration of a conflict of interest. If a quorum is not available for the passing of a resolution on any matter, that matter may be discussed further at the meeting, but no resolution can be made. That position shall be recorded in the minutes of the meeting.

3.8 Record of Attendance

3.8.1 The names of the directors and others invited by the Chair present at the meeting, shall be recorded in the minutes.

3.8.2 If a director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

3.9 Minutes

3.9.1 The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

3.9.2 There should be no discussion on the minutes, other than as regards their accuracy, unless the Chair considers discussion appropriate.

3.9.3 Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

3.10 Notices of Motion

3.10.1 Subject to the provision of Standing Order 3.11 and 3.13 a director of the Trust desiring to move a motion shall give notice of this in writing, to the Chair, at least seven working days before the meeting. The Chair shall insert all such notices that are properly made in the agenda for the

meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.11 Motions: Procedure at and During a Meeting

3.11.1 When a motion is under debate, no motion may be moved other than:

- an amendment to the motion
- the adjournment of the discussion, or the meeting
- that the meeting proceed to the next business
- that the question should now be put
- the appointment of an ad-hoc Committee to deal with a specific item of business
- that a member/Director be not further heard
- a motion under Section 1(2) or Section 1(8) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public including the press

3.11.2 The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the seconder and the consent of the Trust Board.

3.12 Rights of reply to motions.

3.12.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment to it.

3.13 Motion to Rescind a Decision of the Trust Board

3.13.1 Notice of a motion to rescind any decision of the Board of Directors (or general substance of any decision) which has been passed within the preceding six calendar months, shall bear the signature of the director who gives it and also the signature of four other directors who are eligible to vote.

3.13.2 When the Board of Directors has debated any such motion, it shall not be permissible for any director, other than the Chair to propose a motion to the same effect within a further period of six calendar months.

3.14 Suspension of Standing Orders

3.14.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the directors of the Trust are present and the majority of those present, vote in favour of suspension.

3.14.2 In this instance:

- a decision to suspend Standing Orders shall be recorded in the minutes of the meeting
- a separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors
- no formal business may be transacted while Standing Orders are suspended
- the Audit Committee shall review every decision to suspend Standing Orders

3.15 Variation and Amendment of Standing Orders

3.15.1 These Standing Orders shall be amended only if:

- a notice of motion under SO 3.10 has been given; and

- no fewer than half of the appointed Non-Executive Directors vote in favour of the amendment; and
- at least two-thirds of the Directors who are eligible to vote are present; and
- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State

4. Committees

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Secretary of State for Health, the Board of Directors may appoint committees of the Trust.

4.2 Applicability of Standing Orders to Committees

4.2.1 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees established by the Trust. In which case the term 'Chair' is to be read as a reference to the Chair of other Committees as the context permits and the term 'member' is to be read as a reference to a member of other Committees also as the context permits. There is no requirement to hold meetings of Committees established by the Trust in public.

4.3 Terms of Reference

4.3.1 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.3.2 Approved Terms of Reference for all Board Committees shall be held by the Director of Corporate Affairs.

4.4 Delegation of Powers by Board Committees

4.4.1 The Board of Directors shall authorise any delegation of powers to be exercised by its formally constituted Committees. The Board of Directors shall approve the terms of reference of these committees and any specific powers.

4.5 Approval of Appointments to Committees

4.5.1 The Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Board determines and regulations permit that persons, who are not Directors, shall be appointed to a Committee, the terms of such appointment shall be determined by the Board.

4.6 Appointments for Statutory Functions

4.6.1 Where the Trust is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

4.7 Minutes

4.7.1 Minutes, or a representative summary of the issues considered and decisions taken, of any Committee appointed under this Standing Order are to be formally recorded. The Chair of such Committees and sub-committees are to provide a representative summary of the issues considered and any decisions taken to the next Board of Directors meeting.

4.8 Statutory and Mandatory Committees

The mandated committees to be established by the Board are:

4.8.1 Audit Committee

The Board of Directors shall appoint a committee to undertake the role of an audit committee. This role shall include providing the Board of Directors with an independent and objective review of the financial systems and of general control systems that ensure the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with laws, guidance and regulations and codes of conduct governing the NHS. The Committee will comprise of a minimum of three Non-Executive Directors of which one must have significant, recent and relevant financial experience. This Committee will pay due regard to good practice guidance, including, in particular the NHS Audit Committee Handbook.

The Terms of Reference of the Audit Committee shall be approved by the Board of Directors and will be reviewed on a periodic basis.

4.8.2 Audit Panel

The Board of Directors shall nominate its Audit Committee to act as its Audit Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

The Audit Panel's functions are to advise the Board of Directors on the selection and appointment of the External Auditor. This includes the following:

i. Agree and oversee a robust process for selecting the External Auditors in line with the organisation's normal procurement rules.
ii. Make a recommendation to the Board of Directors as to who should be appointed.
iii. Ensure that any conflicts of interest are dealt with effectively.
iv. Advise the Board of Directors on the maintenance of an independent relationship with the appointed External Auditor.
v. Advise the Board of Directors on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
vi. Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed External Auditor.
vii. Advise the Board of Directors on any decision about the removal or resignation of the External Auditor.

4.8.3 Nominations & Remuneration Committee

In line with the requirements of the 1990 Membership and Procedure Regulations, Regulations 17-18, a Remuneration Committee will be appointed and constituted to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Very Senior Managers including:

- All aspects of salary (including any performance related elements)
- Provisions for other benefits, including pensions and cars
- Arrangements for termination of employment and other contractual terms

4.8.4 Charitable Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

4.8.5 **Non-Mandatory Committees**

The Board of Directors shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

These are subject to change at the discretion of the Board of Directors. All new or amended non-mandatory committees will have the same standing and will be subject to the same standing orders.

5. Arrangements for the Exercise of Functions by Delegation

5.1 Introduction

5.1.1 Subject to Reservation of Powers to the Board, the Scheme of Delegation and such directions as may be given by the Secretary of State, the Board of Directors may delegate any of its functions to a committee or sub-committee appointed by virtue of SO4, or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the Board thinks fit.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair acting jointly and after having consulted with at least two Non-Executive Directors and two Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Board of Directors shall approve the constitution and terms of reference of these committees and their specific powers.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust, which have not been retained as reserved by the Board of Directors or delegated to a committee of the Trust Board, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust Board.

5.5 Schedule of Decisions Reserved for the Board of Directors

5.5.1 The Board of Directors shall adopt a Schedule of Decisions Reserved for the Board of Directors setting out the matters for which approval is required by the Trust Board.

5.5.2 The Board of Directors shall review such Schedule at such times as it considers appropriate; and shall update after each review.

5.5.3 The Schedule of Decisions Reserved for the Board of Directors shall take precedence over any terms of reference or description of functions of any committee established by the Trust Board. The powers and functions of any committee shall be subject to and qualified by the reserved matters contained in that Schedule.

5.6 Scheme of Delegated Authorities

5.6.1 The Board of Directors shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them.

5.6.2 The direct accountability, to the Board of Directors, of the Director of Finance and other Executive Directors to provide information and advise the Board of Directors in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities

5.7 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance, shall be reported to the next formal meeting of the Board for action or ratification by the Director of Corporate Affairs. All members of the Board and all staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. Declarations of Interest and Register of Interests

6.1 Declaration of Interests

6.1.1 In addition to the statutory requirements relating to pecuniary interests, the Trust's Standards of Business Conduct Policy requires Board members to declare interests annually, or as and when they arise, which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as relevant and material are:

- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
- Shareholdings and ownership interests in any publicly listed, private or not might reasonably be expected to do business with the organisation
- A position of authority in another NHS organisation, commercial, charity, voluntary, professional, statutory or other body which could be seen to influence your role within the organisation
- A position on an advisory group or other paid or unpaid decision making forum that could influence how the organisation spends taxpayers money
- Are or could be involved in the recruitment or management of close family members and relatives, close friends and associates and business partners
- Any connection with a private, public, voluntary or other organisation contracting for NHS services
- Any other commercial interest relating to any relevant decision to be taken by the organisation
- Research funding/grants that may be received by an individual or their department.

6.1.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Director of Corporate Affairs.

6.1.4 At the time that Directors' interests are declared they should be recorded in the Board minutes and the Register of Interests. Any changes in interests should be declared at the next Board meeting following the change occurring and will be recorded in the minutes of that meeting.

6.1.5 During the course of a Board meeting, if a conflict of interest is established, the Director(s) concerned should declare such likely conflict of interest and withdraw from the meeting unless requested to remain by the Board members present. The Director should play no part in the relevant discussion or decision.

6.2 Register of Interests

6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally, declarations of interest of the Board. In particular the register will include details of all Directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in SO 6.1.2.

6.2.2 The Register of Interests shall be published on the website and shall be reviewed at least on an annual basis.

6.3 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

6.3.1 Subject to the following provisions of this Standing Order, which is taken from the Membership Procedure Regulations 1990 (as amended), if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or any other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement, disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.3.2 The Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which that person has a pecuniary interest is under consideration.

6.3.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the NHS (Consolidation) Act 2006 Schedule 3 Part 1 Paragraph 10, NHS Act 1997 Schedule 5A Paragraph 11(4) or the 1999 Act Schedule 1 (pay and allowances) shall not be treated as pecuniary interest for the purpose of this regulation.

6.3.4 Subject to SO 6.3.3 and any conditions imposed by the Secretary of State, the Chair or a Director shall be treated for the purpose of this regulation as having indirectly a pecuniary interest in a contract, proposed contract or other matter if:

- The Director, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, which has a direct pecuniary interest in the other matter under consideration; or
- The Director is a partner of, or is in the employment of, a person with whom the contract was made, or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.
- In the case of married persons or persons living together as partners, the interest of one spouse/cohabitee shall, if known to the other, be deemed to be also the interest of that spouse/cohabitee.

6.3.5 For the purpose of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- *'Spouse'* shall include any person who lives with another person in the same household. (Any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse).
- *'Contract'* shall include any proposed contract or other course of dealing.

6.3.6 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- Of their (or a person connected to them) membership of a company or other body if they have no beneficial interest in any securities of that company or other body.
- Of an interest in any company, body or person with which they are connected, as detailed in SO 6.3.2, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of, or in voting on, any question with respect to that contract or other matter.
- The total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the lower, provided however, that the person shall nevertheless be obliged to disclose/declare their interest in accordance with SO 6.1.2.

6.4 Powers of the Secretary of State

The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability shall be removed.

6.5 Committee Responsibilities

This regulation applies to a Committee of the Trust as it applies to the Board and applies to any member of any such Committee (whether or not they are also a Director of the Trust) as it applies to a Director of the Trust.

7. Standards of Business Conduct

7.1 Policy

7.1.1 All staff must comply with the national guidance contained in HSG(93)5 'Standards of Business Conduct for NHS Staff'. The following provisions should be read in conjunction with that guidance and staff should also refer to the Trust's Standards of Business Conduct; Policy on Managing Conflicts of Interest, Gifts & Hospitality and Sponsorship.

7.1.2 It is the responsibility of all Trust staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their official duties.

7.1.3 It is an offence under the Bribery Act 2010 for an employee of the Trust to accept corruptly any inducement or reward for doing, or refraining from doing, anything in their official capacity, or corruptly showing favour or disfavour in the handling of contracts.

7.1.4 It is the responsibility of the Trust to ensure that its Officers are aware that breach of the provision of the Act renders them liable to prosecution and may also lead to the termination of their contracts of employment and superannuation rights within the NHS.

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of a Director or an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or Director of Corporate Affairs of the fact that he is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer must also declare to the Chief Executive any other employment or business or other relationship of their partner, or of a co-habiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.2.3 The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.3 Canvassing of and Recommendations by Directors in Relation to Appointments

7.3.1 Canvassing of Directors of the Trust or members of any Committee of the Trust directly or indirectly, for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Orders shall be included in application forms or otherwise brought to the attention of candidates.

7.3.2 A Director of the Trust shall not solicit for any person, any appointment under the Trust or recommend any person for such an appointment. But this paragraph of Standing Orders shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.3.3 Unsolicited informal discussions outside appointment panels or Committees should be declared to the panel or Committee.

7.4 Relatives of Directors or Officers

7.4.1 Candidates for any staff appointment shall when making an application, disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to dismissal.

7.4.2 The Chair and every Director or Officer of the Trust shall disclose to the Board any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

7.4.4 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, the Standing Order headed 'Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest ' (SO 6.3) shall apply.

8. Custody of Seal and Sealing of Documents

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Director of Corporate Affairs in a secure place.

8.2 Sealing of Documents

8.2.1 The Seal of the Trust shall only be attached to documents where the sealing has first been approved by the Trust Board, or the Chief Executive and the Director of Finance, or their designated acting replacement in accordance with the Scheme of Delegated Authorities

8.2.2 The seal shall be affixed in the presence of the signatories.

8.4 Register of Sealings

The Director of Corporate Affairs shall keep a register of sealings. An entry of every sealing shall be made and a report of all sealings shall be made to the Board at least bi-annually.

9. Partnership Arrangements – Memorandum of Understanding (MoUs)

9.1 The Trust will from time to time, establish partnership arrangements (MoUs) with external organisations or groups (NHS or non NHS) with the aim of achieving identified benefits for the parties involved in the partnership.

9.2 For governance purposes, it is imperative that such partnership arrangements are subject to formal approval by the Executive Leadership Committee prior to any commitment to join the partnership.

9.3 The anticipated outcomes and duration of partnership arrangements will be measured and monitored by the relevant lead Officer. The Director of Corporate Affairs will maintain a register of partnership arrangements which will be presented to the Board for scrutiny on a 6 monthly basis.

9.4 For the avoidance of doubt, the definition of a Partnership is as follows:

'A relationship established between the Trust and an external organisation for the furtherance or development of the Trust's activities, which aim to deliver identified benefits to the satisfaction of all Partners in the relationship. Such relationships would be in addition to the purchaser/provider or client/customer relationships which arise through the Trust's normal business activities.'

Reservation of Powers to the Board

1. Introduction

1.1 Standing Order 1.6 requires that the Trust must adopt a Reservation of Powers and Scheme of Delegation which define the powers retained by the Board. Those powers so determined are detailed below.

2. General enabling provision

2.1 The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

3. Powers reserved to the Board

3.1 Regulations and control

3.1.1 Approval of Standing Orders, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

3.1.2 Suspension of Standing Orders.

3.1.3 Approve variations or amendments to the Standing Orders, schedule of matters reserved to the Board and Standing Financial Instructions.

3.1.4 Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO5.2.

3.1.5 Approval of a scheme of delegation of powers from the Board to committees and officers.

3.1.6 Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.

3.1.7 Require and receive the declaration of officers' interests that may conflict with those of the Trust.

3.1.8 Approve arrangements for dealing and responding to complaints.

3.1.9 Receive reports from committees, including those that the Trust is required by the Secretary of State or other regulation to establish, and take appropriate action.

3.1.10 Confirm the recommendations of the Trust's committees where the committees do not have executive powers.

3.1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

3.1.12 Establish terms of reference and reporting arrangements for all committees and sub-committees that are established by the Board.

3.1.13 Receive reports on instances of use of the seal.

3.1.14 Ratify, or otherwise, instances of failure to comply with Standing Orders or Standing Financial Instructions brought to the Chief Executive's attention in accordance with SO5.7.

3.2 Appointments and dismissals

3.2.1 Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

- Appoint the Chief Executive
- Appoint the Executive Directors

Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests

3.2.2 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements of the Trust's Standing Orders.

3.2.3 Approve the disciplinary procedure for officers of the Trust.

3.3 Strategy, plans and budgets

3.3.1 Define the strategic aims and objectives of the Trust.

3.3.2 Approve all Trust strategies

3.3.3 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.

3.3.4 Approve the Trust's policies and procedures for the management of risk.

3.3.5 Approve Final Business Cases for Capital Investment schemes where the value exceeds £1,000,000.

3.3.6 Approve the Trust's annual revenue and capital budgets.

3.3.7 Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

3.3.8 Approve PFI proposals.

3.3.9 Approve the opening of bank accounts.

3.3.10 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 during the duration of the contract.

3.3.11 Approve proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

3.4 Policy determination

3.4.1 Approve the process for approval, dissemination and implementation of policies.

3.4.2 Approval of policies is delegated to the Executive Leadership Committee however the Board shall maintain responsibility for approving the following policies:

- Health, Safety and Security Policy
- Risk Management Policy
- Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak Up Policy
- Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts, Hospitality & Sponsorship
- Complaints, Incidents and Investigations Policy
- Performance Management and Assurance Framework
- Learning from Deaths Policy
- Disciplinary Policy
- Policy on Prevention and Reduction of Violence

3.5 Audit Arrangements

3.5.1 Approve the appointment (and where necessary dismissal of External Auditors recommended by the Audit Panel).

3.5.2 Approve external auditors' arrangements for the separate audit of funds held on Trust, and submission of reports to the Audit Committee meetings which will take appropriate action.

3.5.3 Receive the Auditors Annual Report from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

3.6 Annual report and accounts

3.6.1 Receive and approve the Trust's Annual Report and Annual Accounts

3.6.2 Receive and approve the Annual Report and Accounts for funds held on trust

3.6.3 Receive and approve the Trust's Quality Account.

3.7 Monitoring

3.7.1 Receive Assurance Reports from Chairs of Committees in respect of their exercise of delegated powers. The remit of each Committee is specified within the relevant Committee Terms of Reference available via the Trust's intranet.

3.7.2 Continuous appraisal of the affairs of the Trust by means of the provision to the Board of reports from directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.

3.7.3 Receive reports from the Director of Finance on financial performance against budget.

4. Review

4.1 This Reservation of Powers to the Board document will be reviewed on an annual basis in conjunction with the annual review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th September 2023				
SUBJECT:	Division of Responsibilities between Chair, Chief Executive, Senior Independent Director and Board Committees				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	One of the provisions of The Code of Governance for NHS Provider Trusts 2023 (NHS Code) requires the division of responsibilities for the Chair, Chief Executive, Senior Independent Director, the Board and its committees to be clear and set out in writing, agreed by the Board of Directors and made publicly available. The attached statement seeks to provide clarity regarding the roles and thereby adheres to the provision within the NHS Code.				
RECOMMENDATIONS:	The Board of Directors are recommended to approve the Statement of Responsibilities for publication on the Trust's website.				
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation				

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:	N/A		
	Outcome:	N/A		

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NHS
North West
Ambulance Service
NHS Trust

STATEMENT OF RESONSIBILITIES

The Code of Governance for NHS Provider Trusts 2023 (NHS Code) requires the division of responsibilities for the Chair, Chief Executive, Senior Independent Director, the Board and its committees to be set out in writing, agreed by the Board of Directors and made publicly available.

The NHS Code also states that 'responsibilities should be clearly divided between the leadership of the board', in addition to 'no individual should have unfettered powers of decision'. As the Trust seeks to adhere to the NHS Code, these responsibilities have been set out in this statement.

Responsibilities of the Board of Directors and its Committees

The Board of Directors are responsible for setting the overall strategic direction of the trust. The business of the trust is managed by the Board of Directors and all the powers are exercised by the Board of Directors on its behalf. The matters reserved for the Board of Directors and those which have been delegated to individual directors or committees are clearly documented within the Scheme of Delegation. The Board operates in accordance with the Standing Orders and Reservations of Power and the organisation operates in accordance with the financial rules set out in the Standing Financial Instructions, agreed by the Board.

The Board has established a number of committees to have oversight and seek assurance in specified areas. Each of these committees has a clear terms of reference that set out the scope of the committee's responsibilities and any delegated powers given to it by the Board. These committees report back to the Board after each meeting, providing assurance or escalating risks as appropriate.

Role of the Chair of the Trust

The Chair is responsible for:

Board of Directors

- Chairing meetings of the Board of Directors and the Nominations & Remuneration Committee.
- Managing the Board and ensuring its effectiveness in all aspects of its role, including regularity and frequency of meetings and that it functions as a unitary Board.
- Setting the Board agenda, taking into account the issues and concerns of all directors. The agenda should be forward-looking, concentrating on strategic matters and taking into account the important issues facing the Trust.
- Ensuring there is appropriate delegation of authority from the Board to the Executive Team.
- Ensuring the effective implementation of Board decisions.
- Ensuring that directors receive accurate, timely and clear information, including that on the Trust's current performance, to enable the Board to take sound decisions, monitor and scrutinise effectively and provide advice to promote the success and sustainability of the Trust.

- Managing the Board to allow enough time for discussion of complex or contentious issues. The Chair should ensure that directors (particularly non-executive directors) have sufficient time to consider critical issues and obtain answers to any questions or concerns they may have and are not faced with unrealistic deadlines for decision making.
- Ensuring that the Board plays a full part in the development and determination of the Trust's strategy and overall objectives.
- Building an effective, complementary, and unitary Board.

Directors

- Facilitating the effective contribution of directors and encouraging active engagement from all members of the Board.
- Promoting effective relationships and open communication between executive and non-executive directors, both inside and outside the boardroom, ensuring an appropriate balance of skills and experience.
- Holding meetings with non-executive directors without the executive directors being present.
- Establishing a close relationship of trust with the Chief Executive providing support and advice whilst respecting executive responsibility.
- Overseeing the application of the Board of Directors' Code of Conduct and if in the Chair's opinion an individual director has failed to observe any part of the code take such action as may be deemed immediately necessary until the matter is investigated or resolved.
- Accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of the organisation is maintained to support an effective FPPT regime.

Induction, development and performance evaluation

- Ensuring that all new non-executive directors participate in a full, formal and tailored induction programme.
- Ensuring that the development needs of directors (in particular non-executive directors) are identified and met. (Members of the Board should be able to continually update their skills and their knowledge and familiarity with the Trust to fulfil their role on the Board and its committees).
- Regularly evaluating the performance of the Chief Executive.
- Identifying the development needs of the Board as a whole to enhance its overall effectiveness.
- Ensuring the performance of the Board, its committees and individual directors (in particular the Chief Executive and the non-executive directors) are evaluated at least once a year; acting on the result of such evaluation by recognising the strengths and addressing the weaknesses of the Board.
- Where appropriate through the Nominations & Remuneration Committee, proposing that new members of the Board are appointed to the Board or overseeing the resignation of others.
- Reporting on the outcome of the appraisal of the non-executive directors to NHSE.

Governance

- Upholding the highest standards of integrity and probity
- Setting the agenda style and tone of the Board of Directors to promote effective decision making and constructive debate.
- Ensuring a clear structure for, and the effective running of, Board and its committees.
- With the assistance of the Company Secretary, promote the highest standards of corporate governance, seeking full compliance with the Code of Governance.
- Ensuring compliance with the Board of Directors corporate governance framework.
- The Chair's direct reports are the Chief Executive, the non-executive directors and the Company Secretary. Other than the Chief Executive no executive director will report directly to the Chair. The Chair reports to the Board of Directors and the Secretary of State via NHSE.

Role of the Chief Executive

Within the authority limits delegated by the Board, and not to the exclusion of any duty detailed in the Accounting Officer Memorandum, the Chief Executive is responsible for:

Business Strategy and Management

- Developing the Trust's objectives and strategy having regard to its responsibilities to service users, carers, staff, partners and other stakeholders.
- The successful achievement of organizational objectives and execution of strategy following presentation to and approval by the Board of Directors.
- Recommending to the Board an annual budget and forward plan and ensuring their achievement following Board approval.
- Optimising as far as is reasonably possible the use of the Trust's resources.

Investment and Financing

- Examining all major capital expenditure proposed and the recommendation to the Board of Directors of those which are material either by nature or cost.
- Identifying and executing acquisitions and disposals, ensuring all major proposals or bids receive appropriate approval in line with the Standing Financial Instructions.
- Identifying and executing new business opportunities.

Risk Management and Controls

- Managing the Trust's risk profile in line with the Board approved Risk Appetite Statement.
- Ensuring appropriate internal controls are in place.

Board Sub-committees

- Making recommendations to the Nominations & Remuneration Committee on remuneration policy, executive remuneration and terms of employment of the executive directors.
- Making recommendations to the Nominations & Remuneration Committee on the role and capabilities required in respect of the appointment of executive directors.

Communication

- Providing a means for timely and accurate disclosure of information, including an escalation route

Human Resources

- Setting Trust HR policies, including management development and succession planning for the Executive Team and approving the appointment and termination of employment of members of that team in conjunction with the Nominations & Remuneration Committee. The duties which derive from these responsibilities include:
    - Leading the executive directors in the day-to-day running of the Trust's business, including chairing the Executive Team meetings and communicating decisions / recommendations to the Board.
    - Ensuring effective implementation of Board decisions.
    - Regularly reviewing operational performance and the strategic direction of the Trust's business.
    - Regularly reviewing the Trust's organisational structure and recommending changes as appropriate.
    - Formalising the roles and responsibilities of the Executive Team, including clear delegation of authority.
    - Ensuring that all policies and procedures are followed and conform to the highest standards.
    - Together with the Chair of the Trust, providing coherent leadership of the Trust, including representing the Trust and ensuring there is effective communication in place with service users, carers, staff, regulators, partners, stakeholders, commissioners, community and the public.
    - Keeping the Chair of the Trust informed on all important, complex, contentious or sensitive matters.
    - Ensuring that the Executive Team provides accurate, timely and clear information to the Board of Directors.
    - Ensuring the development needs of the executive directors are identified and met, including a properly constructed induction programme and appraisal process.
    - Promoting and conducting the affairs of the Trust with the highest standards of integrity, probity and corporate governance.
    - The Chief Executive's direct reports are the executive directors and the Company Secretary.
    - The Chief Executive reports to the Chair of the Trust and the Board of Directors directly

Responsibilities of the Senior Independent Director

The Board of Directors appoint one of the independent Non-Executive Directors to be the Senior Independent Director. The role of the Senior Independent Director is to:

- Act as a sounding board for the Chair and serve as an intermediary for other directors as necessary.
- Undertake the performance evaluation of the Chair, within the chairs appraisal framework guidance provided by NHSE.
- Lead meetings of the non-executive directors without the Chair present at least annually to appraise the Chair's performance or as deemed appropriate.
- Be available to discuss any concerns that contact through the normal channels of Chair, Chief Executive, or Company Secretary has failed to resolve or where such contact is inappropriate.

This statement was approved by the Board of Directors at its meeting on 27th September 2023.

PETER WHITE

Chair

For and on behalf of the Board of Directors

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 September 2023				
SUBJECT:	Fit and Proper Persons Test Framework				
PRESENTED BY:	Lisa Ward, Director of People				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☐	☐	☐	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				

EXECUTIVE SUMMARY:

The purpose of this paper is to inform the Board of the changes to the Fit and Proper Person Test (FPPT) as recommended by the Kark Review 2019.

The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation, and purpose of the existing FPPT as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inception of the FPPT Regulation 5 the Trust has been assessing board members to ensure that they are fit and proper at the recruitment stage and through the annual self-attestation. This has been assured through regular audit.

RECOMMENDATIONS FROM THE KARK REVIEW (2019)

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. The key changes to the FPPT is set out in the published framework. It should be noted that the framework includes the existing FPPT activities which have been embedded within the Trust since the inception of the regulations in 2014.

The framework sets out in detail the full requirements of the FPPT including both the existing and new requirements. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

APPLICATION AND ACCOUTABILITY

The framework has been determined to apply to all our current board members (irrespective of voting rights). The scope of the framework is not extended to Deputy Directors or Assistant Directors. The Area Directors do not hold formal Board positions but the position in relation to these posts will be reviewed prior to presentation of the revised FPPT procedure to determine whether their inclusion may be appropriate and proportionate.

The ultimate accountability for adhering to this framework will reside with the Trust Chair, who will also be subject to the Framework. The accountability for ensuring that Chairs in NHS Trusts, meet the FPPT assessment criteria will reside with NHS England Regional Director. Annually, the Senior Independent Director (SID) or deputy chair will review and ensure that the Chair is meeting the requirements of the FPPT.

CHANGES TO THE FPPT

The main additions to our current approach to meeting the regulations broadly covers the following:

- **Recording of personal data to support the FPPT requirements -** Personal data relating to the FPPT assessment will be retained in local record systems as well as being used to populate specific data fields in the NHS Electronic Staff Record (ESR). The list of information required and the regularity of checking is outlined in Appendix A.

- **Standard Board reference -** A standardised board member reference template is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. Board member references will apply as part of the FPPT assessment when there are new board member appointments and at the point where the board member departs, irrespective of whether there has been a request from another NHS employer.

- **NHS Leadership Competency Framework –** The new competency framework is expected to be introduced over the next six months and references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives and be embedded in recruitment processes.

- **A revised self attestation** -The revised template is detailed in Appendix B and will be completed by new starters and annually by existing Board members.

	Appendix C outlines the self-attestation process and confirms who holds responsibility for reviewing the information, updating ESR and the submission of the annual process. - **Cyclical Disclosure and Barring Service (DBS) Checks –** there is a requirement to undertake three yearly DBS checks for all Board members. - **Social media checks -** there is a requirement for annual social media checks for all Board members. Further guidance how to undertake these checks is expected from NHSE. **NEXT STEPS** Ahead of the implementation of the framework on 30th September 2023, actions are already underway to support this. Along with the communication to Board members in relation to the recording of personal data, the framework has been reviewed and an action plan has been developed to identify keys areas of work required. The People Directorate are working closely with the Corporate Governance team to outline actions required to adhere to the annual self attestation. To support the implementation of the framework, the existing FPPT Procedure will be reviewed to provide clear detail and processes around both the recruitment of Board members and the annual self-attestation requirements. The revised procedure with be presented at the November Board for review and approval.
RECOMMENDATIONS:	The Board are asked to: • Receive assurance from the contents of the report regarding the Trust recommendations for implementation of the new requirements • Note the impact of the framework to their ongoing assessment of fitness as a Board member
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:				
	Date:			
	Outcome:			

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1. PURPOSE

1.1 The purpose of this paper is to inform the Board of the changes to the Fit and Proper Person Test (FPPT) as recommended by the Kark Review 2019 and provide assurance of readiness to implement.

2. BACKGROUND

2.1 Following Parliamentary approval on 24 November 2014 a requirement was placed on NHS provider organisations to meet the terms of the Fit and Proper Person Test (FPPT) as set out under Regulation 5. The requirements set out in the regulations have now been integrated into the CQC's regularity and inspection approach and are reviewed under the 'well-led' domain.

2.2 Since the regulations were brought in, the Trust has reported on its compliance in the form of an annual assurance report provided by the Chair. In addition, compliance to the regulations has been managed through the Trusts FPPT procedure outlining the requirements. The effectiveness of our application of the FPPT has also been externally audited to check compliance. The most recent audit was undertaken by MIAA in in June 2023 and the Trust receive a rating of 'high assurance', with no remedial areas of action required. This provides a strong foundation onto which the new requirements can be built and the discipline of compliance with the core requirements is well-embedded.

2.3 The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation, and purpose of the existing FPPT as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The review included looking at how effective the FPPT is in terms of preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors. The review identified areas that required improvement to strengthen the existing arrangements.

3. EXISTING FIT AND PROPER PERSON CHECKS

3.1 Since the inception of the FPPTCQC Regulation 5 the Trust has been assessing board members to ensure that they are fit and proper both at the recruitment stage through the following assessments:

- Employment history
- Request and review of references
- DBS Test
- Medical clearance
- Professional registration check where applicable
- Check whether the person is Insolvent Check whether the person is a disqualified director Check whether the person is a disqualified charity trustee

- Check any issues relating to FPPT on the person's social media/internet
- Board member completion of FPPT self-attestation at recruitment and annually

3.2 All existing Board members have had these checks during the recruitment pre-employment checks, with appropriate documentation and evidence stored on local paper files held at Headquarters.

3.3 In additional all Board members are required to complete a FPPT self-attestation each year to confirm that they meet the requirements of the regulations. This confirmation is collated in March of each year, with the Chair providing an assurance report to the March Board meeting.

4. RECOMMENDATIONS FROM THE KARK REVIEW (2019)

4.1 The revised Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. The key changes to the FPPT is set out in the published framework. It should be noted that the framework includes the existing FPPT activities which have been embedded within the Trust since the inception of the regulations in 2014.

4.2 The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

4.3 The framework supports transparency and is positioned as the start of an ongoing dialogue between board members about probity and values. NHSE suggest that it should be should considered as a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments which are seen as part of the good practice required to build a 'healthy' board.

4.4 The framework sets out in details the full requirements of the FPPT assessment and this includes:

- When the full FPPT assessment is needed, which includes self-attestations
- New appointment considerations
- Additional considerations in specific situations such as joint appointments, shared roles and temporary absences
- The role of the chair in overseeing the FPPT
- The FPPT core elements to be considered in evaluating board members
- The circumstances in which there will be breaches to the core elements of the FPPT
- The requirements for a board member reference check
- The requirements for accurately maintaining FPPT information on each board member in the ESR record
- The record retention requirements
- Dispute resolution
- Quality assurance over the Framework

4.5 NHS organisations are not expected to collect historic information but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

5. APPLICATION AND ACCOUTABILITY

5.1 The framework applies to:

- Both executive directors and non-executive directors (NEDs), irrespective of voting rights
- Interim (all contractual forms) as well as permanent appointments
- Those individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.((a) Director of the service provider, or (b)performing the functions of, or functions equivalent or similar to the functions of, such a director)

5.2 As such this framework has been determined to apply to all our current board members. The scope of the framework is not extended to Deputy Directors or Assistant Directors. The Area Directors do not hold formal Board positions but the position in relation to these posts will be reviewed prior to presentation of the revised FPPT procedure to determine whether their inclusion may be appropriate and proportionate.

5.3 NHSE have stated that this is the first iteration of the framework and it will be reviewed after 18 months to assess how effectively it has been embedded and its impact within NHS organisations. As part of the future review, 'significant roles' may also be included within the scope of the framework and consideration will be given to implementing a public facing register of board members who have been assessed and approved as being fit and proper.

5.4 The ultimate accountability for adhering to this framework will reside with the Trust Chair, who will also be subject to the framework. The accountability for ensuring that Chairs in NHS Trusts, meet the FPPT assessment criteria will reside with NHS England Regional Director. Annually, the Senior Independent Director (SID) or deputy chair will review and ensure that the Chair is meeting the requirements of the FPPT. An independent internal audit is required every 3 years, which is in line with our current audit cycle.

6. CHANGES TO THE FPPT

6.1 The main additions to our current approach to meeting the regulations broadly covers the following areas:

- Recording of personal data to support the FPPT requirements
- Standard Board reference
- NHS Leadership Competency Framework
- A revised self attestation to be completed by new starters and annual by existing Board members
- Cyclical Disclosure and Barring Service (DBS) Checks
- Social media checks

6.2 **Recording of personal data**

6.2.1 Personal data relating to the FPPT assessment will be retained in local record systems as well as being used to populate specific data fields in the NHS Electronic Staff Record (ESR). The list of information required and the regularity of checking is outlined in Appendix A. The framework notes that the information contained in these records will not routinely be accessible beyond an individual's own organisation.

6.2.2 The use of ESR will be to record the information as set out an Appendix A. It should be noted that much of this information is already collected and processed for the main recruitment pre-employment checks as well as for the FPPT and there will be no substantive change to the data controller arrangements from those already in place for ESR.

6.2.3 The aim of maintaining a record of FPPT outcomes in ESR is to significantly improve the management of the NHS, and ultimately the experience and outcomes for patients, and is therefore in the public interest and done as part of the exercise of the functions of the organisation concerned. Along with the recruitment check information, the annual self attestation information signed off by the Chair will also be recorded on ESR.

6.2.4 It is recognised that existing Board members may have some concerns around the sharing of this data on ESR. In anticipation of this, each Board member has been written to by the Chair to explain the rationale for this along with a privacy notice details the type of information that will be collected and retained within ESR.

6.2.5 A process to identify the appropriate roles to input and report on the FPPT information within ESR will be developed and built into the FPPT Procedure.

6.3 Standard Board reference

6.3.1 A standardised board member reference template is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS. The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS.

6.3.2 Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks.

6.3.3 In addition, NHS organisations are asked to maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Arrangements will be made to store board member

references locally with the appropriate processes to confirm who will be responsible for responding to reference requests for previous Board members.

6.4 NHS Leadership Competency Framework

6.4.1 The Leadership Competency Framework will help inform the 'fitness' assessment in FPPT. This is in line with the Kark Review's (2019) recommendations on professional standards. The Leadership Competency Framework references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives. The new competency framework is expected to be introduced over the next six months.

6.5 Revised self attestation

6.5.1 For existing Board members, the Chair will need to confirm annually on ESR that the individual Board members meets the annual self attestation on their fitness to meet the regulations. The template in Appendix B will be used for both new Board members during the recruitment check process as well as for existing Board members as part of the annual self-attestation process. Appendix C outlines the self-attestation process and confirms who holds responsibility for reviewing the information, updating ESR and the submission of the annual process.

6.5.2 The self attestation will need to be completed by March each year and will be used to information the Chair's annual FPPT declaration to the Board.

6.6 Cyclical Disclosure and Barring checks

6.6.1 The framework sets out an expectation that, whilst not requiring annual validation, DBS checks will be done on a three-year cycle. All Board members have undertaken DBS checks as part of the recruitment process, but currently there are no further checks, unless a Board member changes their role. As such, the Trust will need to introduce three yearly DBS checks for all Board members, unless an individual has already or chooses in the future to sign up to the annual DBS update service.

6.6.2 Those Board members who have not had a check for over the last three years, will be contacted to complete a check, with an aim to have a position by March 2024 where all Board members have had a DBS check in the last three years.

6.7 Social media checks

6.7.1 As part of the recruitment process and annual checks, there is a requirement for the Trust to undertake social media checks. Whilst the Trust has an established Social Media Policy, it does not currently undertake any social media checks. Further guidance is expected from NHSE on how to conduct these checks. In the meantime, the Trust is also seeking legal advice on how to appropriately set out the

expected boundaries around determining the appropriateness of content and historical timeline of the social media checks.

7. NEXT STEPS

6.1 Ahead of the implementation of the framework on 30th September 2023, actions are already underway to support this. Along with the communication to Boad members in relation to the recording of personal data, the framework has been reviewed and an action plan has been developed to identify keys areas of work required. The People Directorate are working closely with the Corporate Governance team to outline actions required to adhere to the annual self-attestation.

7.2 To support the implementation of the framework, the existing FPPT Procedure will be reviewed to provide clear detail and processes around both the recruitment of Board members and the annual self-attestation requirements. The revised procedure with be presented at the November Board for review and approval.

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

8.1 The Trust has a legal responsibility of adhere to Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This would be tested through by the CQC through it's well led inspections. There will also be oversight of compliance with process through Regional NHSE teams.

9. EQUALITY OR SUSTAINABILITY IMPACTS

9.1 There are no equality or sustainability impacts identified with the contents of this paper.

10. RECOMMENDATIONS

10.1 The Board are asked to:

- Receive assurance from the contents of the report regarding the Trust recommendations for implementation of the new requirements
- Note the impact of the framework to their ongoing assessment of fitness as a Board member

APPENDIX A

FPPT CHECKLIST

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Date DBS received	✓	✓	✓	✓	✓	✓	ESR	
Date of medical clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (eg membership of professional bodies)	✓	x	✓	✓	✓	x	Eg NMC, GMC, accountancy bodies.	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other templates to be completed								

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Appendix B

New starter/annual NHS FPPT self-attestation

Fit and Proper Person Test annual/new starter self-attestation

North West Ambulance Service NHS Trust

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

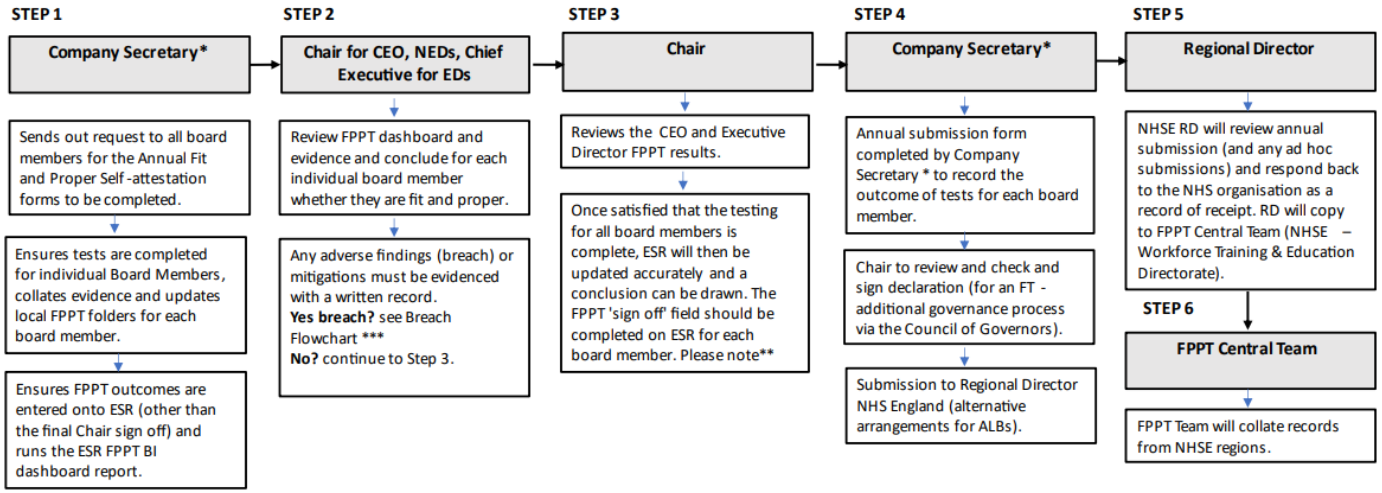
Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	

Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix C

Annual self attestation flow chart



*Or senior member of staff nominated by and behalf of, the Chair, e.g., HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
*** Please refer to the Chairs Guidance for the Breach Flowchart
SID = Senior Independent Director
ESR= Electronic Staff Record

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th September 2023
SUBJECT:	Integrated Performance Report
PRESENTED BY:	Director of Quality, Innovation and Improvement

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04	SR05
☒	☒	☒	☒	☒
SR06	**SR07**	**SR08**	**SR09**	**SR10**
☒	☒	☒	☒	☒

PURPOSE OF PAPER: For Assurance

EXECUTIVE SUMMARY:

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

Quality

Complaints: Serious complaints scoring 4-5 have reduced significantly (**n=2**).

Incidents: Incidents scoring 1-3 (**n=855**) increased for a third consecutive month, whereas level 4-5 incidents (**n=27**) continued a positive downward trend. Lower-level incidents (1-3) were prioritised for closure in this period as finalising more complex incidents (4-5) presented challenges due to annual leave of key clinical staff.

Serious Incidents: there were 3 serious incidents reported to the regulators via the STEIS database.

Safety Alerts: Four new safety alerts have been received; three are closed and one related to safety checks on medical beds, bedrails. grab handles, entrapment and falls. This alert remains open and is scheduled to be closed within the requested time frame.

Effectiveness

Patient Experience: Patient satisfaction scores remain high at 86%, 90% and 94% for PES, 111 and PTS respectively. Negative themes arising in the commentary relate to vulnerable patient needs not being met, whereas positive themes relate to professional and attentive staff.

Ambulance clinical quality indicators: The STEMI care bundle displays marked improvement, from 61% to 76%, approaching the upper control limit.

Activity and Outcomes: Incident volume (**n=92,315**) remains stable, GM Central, Mersey North and GM South are the busiest sectors.

Hear and Treat (H&T) and See and Treat (S&T): H&T rate was 13.6% and S&T rate was 28.4%. Total non-conveyance was 42%. Nationally, the trust ranked 3rd for H&T, 8th for S&C and 10th for S&T.

Operational Performance

Calls: Call volume remains stable.

Call Pick Up: Call pick up within 5 seconds remains consistently high and was 98% in August 2023.

Average hospital turnaround time: Average turnaround time was 36 min, an increase from the previous month. Greater Manchester (GM) has performed under 30 mins for 3 consecutive months. In contrast, Cheshire and Mersey (CM) are experiencing increased delays and have four of the top 5 Trusts with the highest number of lost unit hours for handover delays over 30m. In total, there were 2,623 lost unit hours over 30 minutes.

Ambulance Response Programme (ARP):

Measure	Standard (hh:mm:ss)	Aug 23 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:08:04	4th
C1 90th	00:15:00	00:13:50	3rd
C2 mean	00:18:00	00:27:19	5th
C2 90th	00:40:00	00:57:46	5th
C3 mean	01:00:00	02:14:13	10th
C3 90th	02:00:00	05:28:08	11th
C4 90th	03:00:00	05:33:26	9th

ARP standards were met for C1 90th. The Trust is achieving the UEC recovery standard of 30 minutes for C2 mean and has delivered a stable performance across all ARP standards. Improvement in the performance of other ambulance Trusts have impacted the NWAS national rankings for H&T, S&T and ARP standards.

C1 and C2 Long Waits: Compared with the same month last year there has been a marked reduction in C2 long waits. This is likely to be attributable to the reduction in hospital handover delays.

111: n=173,768 calls were received by 111**.** Average daily calls offered was **n=5,605**. For callback within 20 minutes performance, special cause variation above the upper control limit can be observed in four consecutive data points signalling suggestive of improvement.

Measure	Standard	Aug 23	National ranking
Answered within 60s	95%	53.3%	28th
Average time to answer	--	3m 38s	--
Abandoned calls	<5%	10.1%	24th
Call-back within 20 min	90%	21.1%	--
Average call back	--	41m 45s	--
Warm transfer to nurse	75%	15.5%	--

PTS: Two contracts (Cumbria and Lancashire) are below the baseline activity for both planned and unplanned activity. There are significantly high numbers of aborted journeys in GM associated with unplanned activity (29%) compared with the other contracts in Cumbria, Lancashire, and Merseyside where the aborted journeys are at 8, 17 and 19% respectively.

Finance

The year-to-date expenditure on agency is £0.883m which is under the year-to-date ceiling of £1.753.

As at month 05 (August) the trust is on plan for the efficiency and productivity target.

Organisational Health

Sickness: The overall sickness absence rate for the latest reporting month (July 2023) was 8.33%. This upturn has been seen across Ambulance Services and reflects normal seasonal trends. Whilst sickness remains high, it has been at or below the lower control limit for 6 months, signalling change.

	Turnover: Trust-wide, turnover has decreased to 11.35%. All service lines, with the exception of EOC have observed a decrease, with PES and PTS approaching, or on, the lower control limit. **Temporary Staffing:** The position for August 2023 shows continuing agency usage at a similar rate to previous months at a level equivalent to 0.5% pay bill. This is £152k below cap. **Vacancy Gap:** Overall the vacancy gap has narrowed with the PES and EOC position being particularly strong. It should be noted that the PES growth has not yet been built into establishment and will be introduced in line with the recruitment plan. The challenges remain with PTS and 111 recruitment. PTS plans have been reviewed to improve opportunities to close the gap and recent campaigns have been successful in improving attraction. **Appraisal:** The overall appraisal completion increased to 85% in line with targets. Only 111 are currently behind trajectory with recovery plans in place. **Mandatory Training:** Overall compliance is ahead of the trajectory at 83%. All service lines are on track against trajectory. **HR casework:** The trust is seeing an increase in employee relations casework, mainly linked with disciplinary and grievance matters. There are no obvious hotspots but trends in case types are monitored and inform preventative work such as sexual safety. Overall timescales remain on average below 12 weeks.
RECOMMENDATIONS:	The Board of Directors are requested to note: • The reduction in serious complaints and the impact of small numbers on percentage closure. • Safety alerts have been received and are being managed appropriately. • Improvements in the STEMI care bundle. • Turnover in 111 is stable, however relatively high at 33%. • Turnover in EOC has continued a negative trend over 12 months, now at 18%. • The stable position of H&T, S&T and S&C over time but the variation in performance between sectors on these indicators. • Improvement in the performance of other ambulance Trusts impacting the NWAS national rankings for H&T, S&T and ARP standards. • Reductions in C2 long waits compared with last year. • The stable position of 111 with respect of call volume and improvement in clinical call back. • The activity over plan in PTS contracts in Cumbria and Lancashire. • The high percentage of aborted journeys in Greater Manchester.

CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	25th August 2023		
	Outcome:	Not known at time of submission		

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1. PURPOSE

The purpose of this report is to provide the Quality and Performance committee with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of **August 2023**. The report shows the historical and current performance on Quality, Effectiveness and Operational performance. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

- How are we performing over time? (As a continuously improving organisation)
- How are we performing with respect to strategic goals?
- How are we performing compared to our peers and the national comparators?

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

2 SUMMARY

Complaints: The number of complaints scoring 1-3 has risen slightly in August (**n=192**). Serious complaints scoring 4-5 have reduced significantly (**n=2**). No serious complaints were closed in August due to vacancies in the team and absence over the summer period.

Incidents: Incidents scoring 1-3 (**n=855**) increased for a third consecutive month, whereas level 4-5 incidents (**n=27**) continued a positive downward trend. · This is in line with expectations owing to engagement with service lines to proactively support incident reporting and awareness raising that incidents can be submitted on the DCIQ system via trust mobile devices. ·

The 5 most common themes for incidents reported in August 23 were:

- Care and treatment (n=177).
- Call Handling (n=117).
- Delays (n=87).
- Violence and Aggression (n=72).
- Communication (n=72).

No new themes were noted and all themes are being reviewed as part of the ongoing work of the Patient Safety Incident Response Framework.

Incident Closure: Lower-level incidents (1-3) were prioritised for closure in this period as finalising more complex incidents (4-5) presented challenges due to annual leave of key clinical staff.

Serious Incidents: there were 3 serious incidents reported to the regulators via the STEIS database. The Incident Management Team are collaborating with service lines to improve the duty of candour process and compliance.

Safety Alerts: Four new safety alerts have been received; three are closed and one related to safety checks on medical beds, bedrails. grab handles, entrapment and falls. This alert remains open and is scheduled to be closed within the requested time frame.

Patient experience

- PES responses for August 23 (**n=328**) were 9% lower compared to July 23 of (**n=362**). Whilst the number of returns for August is the lowest for the last 9 months, this is due to a smaller number of see and treat incidents available in the monthly extraction dataset, therefore a smaller number of surveys were sent out. However, at 23%, the return rate is second highest in the same period. In terms of satisfaction, 86% of respondents identified "very good/good" as the outcome, 1% lower than 87% reported in July. Supporting comments were 8% lower from July 23 (**n=268**) to August 23 (**n=246**).
- PTS responses in August 23 (**n=1,228**) were 10% higher than July 23 (**n=1,115**), with supporting comments 8% higher (**n=961** and **n=887** respectively). The overall experience score for August 23 was 94%, 1% higher than 93% reported in July.
- As of 12 September 23, the NHS 111 service returns for August 23 total 95, 48% lower than the 184 returns reported for July 23 at this point. Total returns for August are expected to increase as they are still arriving with the trust. Initial results show a 90% likelihood of the 111 service being recommended, the same as reported for July.
- The former NHS 111 first survey is being replaced with a localised, simpler version of the national 111 survey which is being designed in conjunction with the trust's 111 service. The intention is to increase the number of returns over that of the nationally mandated and very lengthy existing 111 survey. Once the survey is approved it will be included in the report.

Ambulance Clinical Quality Indicators (ACQI's)

- During March 2023 Return of spontaneous circulation (ROSC) achieved for the Utstein group was 36.1% (national mean 49.0%). For the overall group the rate was 29.4% (national mean 27.8%).
- Survival to Discharge rates in March 2023 improved to 8.8% (national mean 8.3%).
- In March 26.7% of patients in the Utstein group survived to hospital discharge. The national mean at 26.5%.
- Mean call to PPCI time in March for patients suffering a myocardial infarction was above the same as the national mean of 2h 33mins.
- Mean call to hospital time in March for patients suffering a hyper acute stroke was below the national mean of 1h 39mins. The trusts performance was 1h 28mins.
- The Stroke Care Bundle performance has not been reported since February which is in line with NHS England reporting schedules.
- The Stemi Care Bundle performance for April shows 76.2% for stroke against a national average of 75.1%.

Data Submission: Due to the introduction of the Electronic Patient Record there has been a significant change in the way that the clinical audit team are abstracting data. The transition has delayed the submission of the April 2023 data which will be submitted late in agreement with NHSE. This may interrupt reporting of this measure in future IPR reports.

Hear & Treat, See & Treat, See & Convey

- For August the trust achieved 13.6% Hear & Treat and ranked 3rd nationally.
- In See & Treat the trust achieved 28.4% are ranked 10th nationally.
- In total there was an aggregate non-conveyance of 42%.
- If NWAS had a similar conveyance avoidance rate to first place SWAST (top performer) we would avoid a further 181 conveyances per day, equating to 5,631 per month.

Hear and Treat is anticipated to rise throughout the remainder of the year. This will be driven by UEC funding and the recruitment of an additional 70 senior clinicians. These clinicians are planned to deploy throughout the winter and into Q4. This will increase triage capacity and as a result increase Hear and Treat. The relatively stable Hear and Treat performance is also influenced by ARP response times. If response increase through winter, it is likely Hear and Treat will increase.

Additional plans are being made to increase triage capacity alongside digital innovation to drive efficiency. NWAS are now live with C2 segmentation at small scale at this point. The volume of C2 triage will increase in line with workforce plans.

See and Treat has improved, and early appraisals indicates this may be related to the wider roll out of iPads and enhanced assessment support and referral. Notwithstanding the improvement, the trust has worsened its national position to 10th (of 11) related to a broader trend of national ranking slippage. This is a trust-wide issue as the best performing NWAS sector would be in the bottom quarter of the national S&T table.

Sectors that perform below average with respect to these metrics are hampered by available referral options. Morecambe Bay has the lowest rate of conveyance to non-AE and the highest overall rate of conveyance, yet they cover a large, rural geography with relatively low access to urgent care facilities, and in some cases the patient can only be referred to UTC once admitted to ED.

PES Emergency (999) Activity

Of the emergency calls received by the trust (**n=118,713**) in August 2023, 77% (**n=92,315**) became incidents. Compared with August 2022, the trust observed a 7% decrease in calls and a 3% increase in incidents. Overall, weekly incident totals in August 23 remained around the mean.

August 23 duplicate calls (**n=24,207**) increased slightly compared to July 23 (**n=22,528**). No outcome incidents for August (**n=15,962**), including those cancelled or closed through signposting, also observed an increase compared to July 23 (**n=14,208**).

Call volume, duplicates, no outcome calls remained relatively stable through the summer period with a limited number of extreme days of pressure. The previous summer saw a more variable response and increased the number of duplicate / follow up calls (a reduction of circa 300 duplicate calls per day). It should be noted that this isn't reflected across the entire sector and NWAS stable long waits are likely to be positively influencing call volume overall.

Incidents increased marginally, likely due to response standards. Incidents are equally a measure of operational capacity as it is demand. As response standards have been stable

and operational resources have improved, the Trusts capacity to respond increases and as a result incidents increase.

The incident ratio for the trust in August 23 was 40% GM ICB, 31% CM ICB, 24% LSC ICB, and 5% NE & NC ICB.

Call Pick-up

Call pick-up has continued to post strong results throughout August 2023, the overall mean answer improving slightly to 1 second (compared to 2 seconds in July and 3 seconds in June) with pick up in 5 seconds at 98% (compared to 97% in July).

NWAS continue to lead the sector in call pick up. As evidence NWAS in August contributed 6 two-minute delays against a national figure of 17.5k. NWAS continue to perform well against the UEC/winter standard of 10 seconds mean call pick up, with August mean at one second. Looking forward, NWAS continue to invest in EMAs to maintain high call pick performance, this investment is supported by UEC recovery funds. Recruitment continues to ensure call pick is maintained through winter and delivers against UEC trajectories.

Hospital Handover

- Average turnaround time has worsened slightly to a 5-month high of 36 min, albeit relatively stable and closer to the 30 min target compared to pandemic related performance.
- GM recorded a third month under the 30 min target, whilst high turnaround time continues to be driven by CM with a 44 min average turnaround for August 23.
- Lost Unit Hours (Turnaround 30m+) displayed a worsening trend over summer, with the final week of August 23 (**n=2,623**) approaching control limits.
- During August 23, 5% of attendances (**n=2,207**) had a handover exceeding 1 hour, with **n=851** of those exceeding 2 hours. Delayed admissions in August 23 (**n=544**) were a 50% improvement compared to August 22 (**n=1,099**).
- The Regional Handover Board will meet on 4 September to discuss the plans for ICB level winter collaboratives. ICB leads are focused on submitting their winter plans to NHS England by early September.
- In September Northern Care Alliance (NCA) plan to commence a handover collaborative with NWAS, focussing on wider primary and community care.

Ambulance Response (ARP) Performance

Measure	Standard (hh:mm:ss)	Aug 23 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:08:04	4th
C1 90th	00:15:00	00:13:50	3rd
C2 mean	00:18:00	00:27:19	5th
C2 90th	00:40:00	00:57:46	5th
C3 mean	01:00:00	02:14:13	10th
C3 90th	02:00:00	05:28:08	11th
C4 90th	03:00:00	05:33:26	9th

For August 23 response time targets were only achieved for C1 90th. C1 and C2 performance has been close to the mean in August, with week commencing 7th August showing least favourable performance. Both C3 mean and 90th encountered a slight decrease in performance at the beginning of August, then settled towards the mean throughout the remaining weeks.

All data points across C1 and C2 performance display common cause, stable around the mean. This is reflected across the majority of IPR indicators in respect to PES. It should be noted that there is increasing variation in response by ICB and sector. As an example, the variance in response by sector for C2 mean is now double the length when comparing best and worst performing sectors. This is primarily being driven by handover delays.

Whilst the Trust is not meeting the 18-minute mean response standard for C2 response, the trust is achieving the UEC recovery standard of 30 minutes. Data points infer a stable period for C2 performance, however it is important to note the national context in which the trust have slipped from second to fifth in mean and 90th.

Additionally for Category 3 mean and 90th response time, although relatively stable from an internal perspective, have slipped in national rankings to 10th and 11th (of 11) respectively. The performance is driven by 3 sectors in particular: M North, M East and G West.

Further plans are in place to ensure NWAS improves response standards and sustains performance over winter. These plans include:

- Increasing clinicians within EOC – this work has now commenced with two cohorts of clinicians now deployed. Additional clinicians will deploy every month through the remainder of the year.
- Commencement of C2 segmentation.
- Increase in operational resources – both paramedic / EMT and vehicles.
- Enhance health and wellbeing and reduce sickness.

A review of UCS resource and deployment is also taking place. The review will appraise the current approach and resources levels. The aim of the review is to ascertain optimal UCS levels alongside review of the scope of practice/deployment.

C1 & C2 long Waits

C1 long waits in August 23 (**n=643**) decreased compared to July 23 (**n=706**). Throughout 2023 C1 long waits have retained at approximately 7% of C1s.

C2 long waits in August 23 (**n=4,614**) increased compared to July 23 (**n=3,294**). Over the previous 5 months C2 long waits have stabilised at an average of 6% of C2s.

Both C1 and C2 metrics have improved when compared to August 22. C2 long waits have reduced by circa 43%. Maintaining no extreme long waits is critical throughout winter.

Operational Performance - NHS 111

Measure	Standard	Aug 23	National ranking
Answered within 60s	95%	53.3%	28th
Average time to answer	--	3m 38s	--
Abandoned calls	<5%	10.1%	24th
Call-back within 20 min	90%	21.1%	--
Average call back	--	41m 45s	--
Warm transfer to nurse	75%	15.5%	--

August 23 has seen a decrease in demand for 111 compared to previous months. Calls offered in August 23 (**n=173,768**) were lower than compared with July 23 (**n=182,664**). Of those calls offered 74% were answered, 10.1% abandoned and additional calls redirected via IVR signposting. In addition, 111 continue to receive national call support with 5% of calls being managed via national channels.

August 23 has seen improvements in most clinical performance metrics. Calls answered in 60 seconds increased to 53% from 52% the previous month; close to the upper control limit. Call abandoned decreased from 11% to 10% over the same period. Average time to answer saw an improvement to 3m 38s, placing the metric just below the mean. For call back in 20 minutes, performance is stable at 21%. This is the fourth consecutive month that the data points are in special cause, above the upper control limit strongly signalling a change, however remaining significantly short of the 90% standard. Warm transfer continues to position just below the mean at 15.5%, increasing from 12.9% in July 23.

PTS

Owing to a lag in PTS reporting, performance is reported one month in arrears. Trust-wide PTS activity in July 23 was 10% below contract baselines; notably Cumbria and Lancashire were 22% and 24% below baselines respectively. Year to date (July 2022 – July 2023) activity is 10% below the baseline.

3 Finance

- The year-to-date expenditure on agency is £0.883m which is under the year to date ceiling of £1.753.
- As at month 05 (August) the trust is on plan for the efficiency and productivity target.

4 Organisational Health

Sickness

The overall sickness absence rate for the latest reporting month (July 2023) was 8.33%. This upturn has been seen across Ambulance Services and reflects normal seasonal trends. Whilst sickness remains high, it has been at or below the lower control limit for 6 months and will be entering a new phase.

The UEC recovery funding will enable further investment in attendance coaching support, wellbeing coordination to improve access and navigation of the available support and specialist MSK and Violence and Aggression support. Recruitment into additional posts in ongoing.

Absence levels remain higher in the contact centre environments, although EOC sickness is signalling a change with 5 points below the lower limit, however 111 remains high (July 13%)

Turnover

Turnover has decreased to 11.35% and remains within the lower limit overall. All service lines with the exception of EOC, have seen a slight decrease in turnover over a number of months with PTS approaching the lower control limit and PES showing special cause.

EOC turnover has increased, continuing a 12-month trend, and with 6 points above the mean, strongly signalling for change. Robust plans are in place to deliver additional staffing in all areas and integrated contact centres are focused on a range of wellbeing interventions to support improved staff experience and retention.

Temporary Staffing

The position for August 2023 shows continuing agency usage at a similar rate to previous months at a level equivalent to 0.5% pay bill. This is £152k below cap.

Vacancy

Chart OH5.1 shows the vacancy gap at -5.7% for August 23. Overall, the vacancy gap has narrowed with the PES and EOC position being particularly strong. It should be noted that the PES growth has not yet been built into establishment and will be introduced in line with the recruitment plan. The challenges remain with PTS and 111 recruitment.

The 111 vacancy position is -17.5% (OH5.5) with vacancies being focused on the Health Advisor and Clinical Advisor roles. Whilst turnover is improving, the recruitment market is proving challenging for call handler positions. Recent changes to support improved attraction and course fill are showing early positive signs.

The PTS vacancy position at –11.0% (OH5.2) and this reflects the increase turnover in staff moving from PTS to PES. Robust plans are in place to reduce the gap over the coming months, but PTS also have bank arrangements in place to help bridge the vacancy position. There are challenges in responding to additional PTS recruitment needs whilst delivering the ambitious requirements of the UEC Recovery delivery plan.

Appraisals

The overall appraisal completion increased to 85% in line with targets. Only 111 are currently behind trajectory with recovery plans in place. The agreed targets for 2023/24 are:

- Service Lines - 85%
- Corporate Directorates - 95%

- Leadership Roles Band 8a and above - 95%

PES and EOC are above target at 87%. PTS slipped to slightly below target at 84%. 111 continue a slight downward trend below target to 77%.

Revised fuller appraisal paperwork has now been rolled out and consideration is being given to how the embedding of this is reviewed through quality audits.

Mandatory Training

Overall compliance is ahead of the trajectory at 83%. All service lines are on track against trajectory.

A new programme for 2023/24 mandatory training has been approved, with PES classroom delivery returning to two days. Additional on-line learning modules have also been included in the overall programmes. The approval of the 2023/24 programme includes the approval of an additional four hours to be allocated to all PES staff to support on-line learning completions and giving eight hours in total. This was in response to feedback from staff, managers and staff side colleagues.

The compliance targets for 2023/24 are to remain the same as those for 2022/23. The targets represent a percentage of all staff and therefore need to take account of longer-term absences from the workplace such as long-term absence and maternity i.e. 100% is not going to be achievable in any one year. In addition, the programme for PES for 2023/24 is increasing in size with a return to a two-day programme and additional committed online hours. This means that whilst it is recommended to maintain the 85% target it goes represent a stretch target in comparison with the 22/23 position.

- 85% PES and PTS classroom overall
- 85% EOC, 111 and PTS online
- 95% for Corporate Teams

Case Management

The trust is seeing an increase in employee relations casework, mainly linked with disciplinary and grievance matters. There are no obvious hotspots but trends in case types are monitored and inform preventative work such as sexual safety. Overall timescales remain on average below 12 weeks.

Overall numbers of live cases currently stands at 121. All case types have seen increase in volume, particularly staff grievances. PES continues to show the highest levels of live open cases and cases closed within the last 12 months. EOC is showing the highest levels of fact finding and disciplinary cases across all service lines.

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

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

6 EQUALITY OR SUSTAINABILITY IMPACTS

A review of data against protected characteristics is being undertaken by the Diversity and Inclusion sub-committee to understand and improve patient experience. Formerly, patient experience data was presented demographically, however challenges in reporting ethnicity preclude our ability to draw conclusions from the data. An initiative to address this is ongoing and reports to the Diversity and Inclusion sub-committee.

A focus on increasing Hear & Treat and See & Treat outcomes supports the trust's sustainability goals.

7 RECOMMENDATIONS

The Board of Directors are requested to note:

- The reduction in serious complaints and the impact of small numbers on percentage closure.
- Safety alerts have been received and are being managed appropriately.
- Improvements in the STEMI care bundle.
- Turnover in 111 is stable, however relatively very high at 33%.
- Turnover in EOC has continued a negative trend over 12 months, now at 18%.
- The stable position of H&T, S&T and S&C over time but the variation in performance between sectors on these indicators.
- Improvement in the performance of other ambulance Trusts impacting the NWAS national rankings for H&T, S&T and ARP standards.
- Reductions in C2 long waits compared with last year.
- The stable position of 111 with respect of call volume and improvement in clinical call back.
- The activity over plan in PTS contracts in Cumbria and Lancashire.
- The high percentage of aborted journeys in Greater Manchester.

North West Ambulance Service NHS Trust

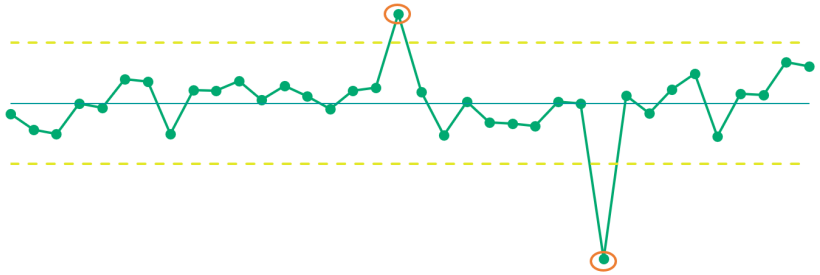
Integrated Performance Report

Board - September 2023

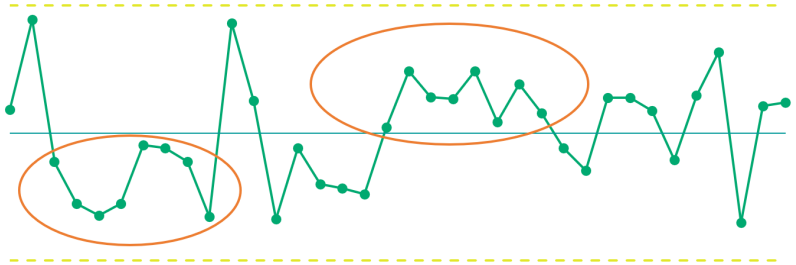
Rules for interpreting SPC Charts

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

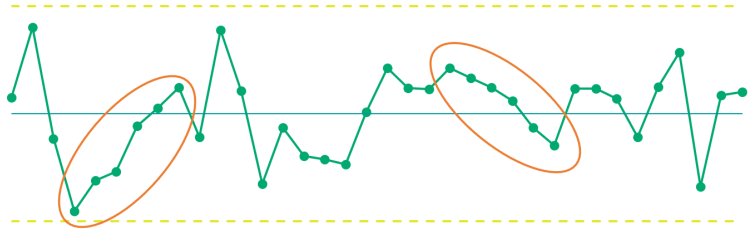
Rule 1: Single data point outside the control limits



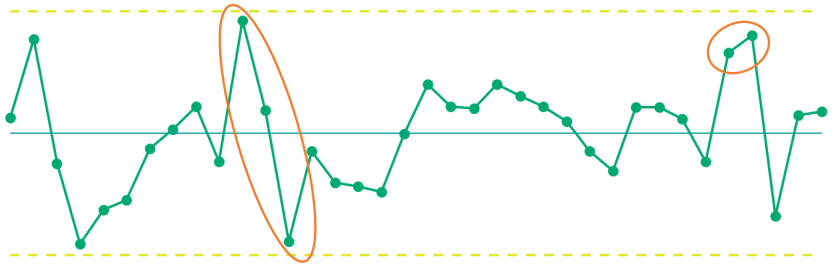
Rule 2: 8 or more consecutive data points above or below the centre line



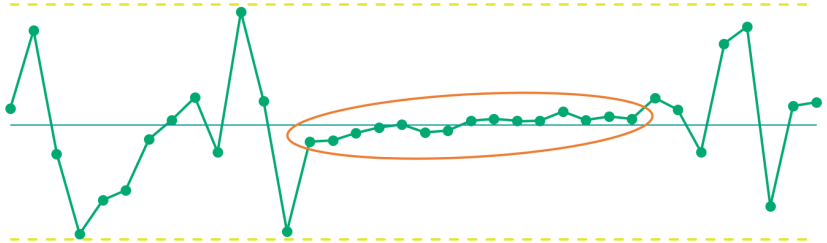
Rule 3: A trend of at least six consecutive points (up or down)



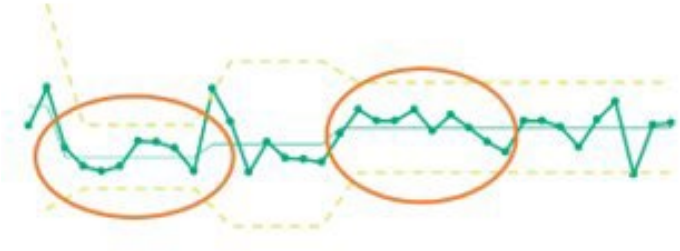
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



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



Example of Limits reset following special cause



Quality & Effectiveness

Q1 COMPLAINTS

Figure Q1.1

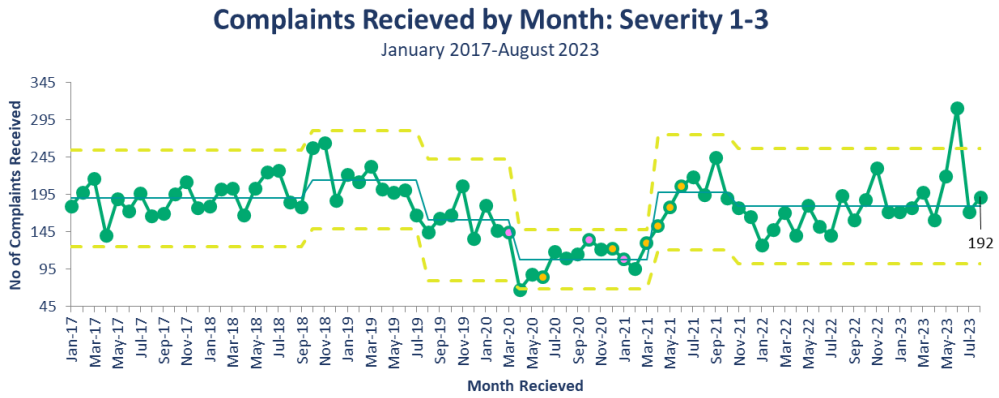


Figure Q1.2

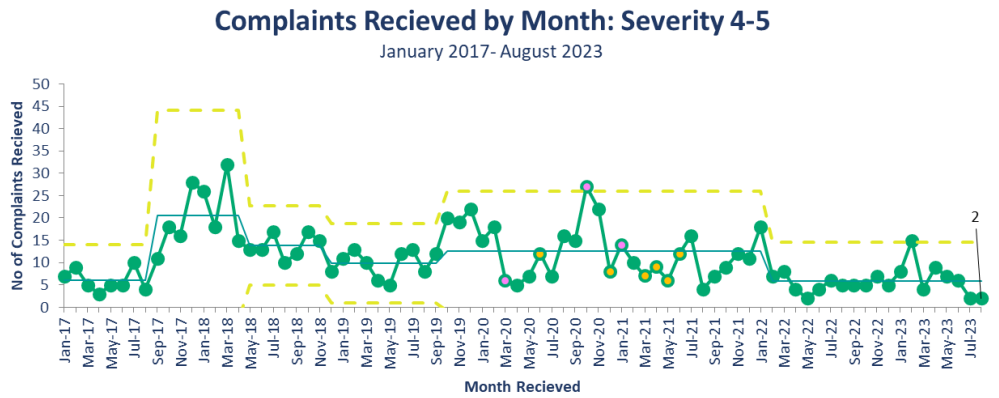


Figure Q1.3

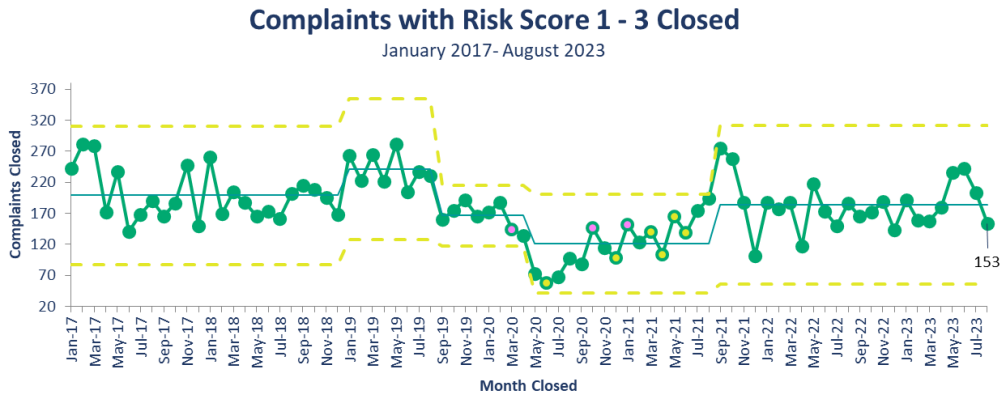


Figure Q1.4

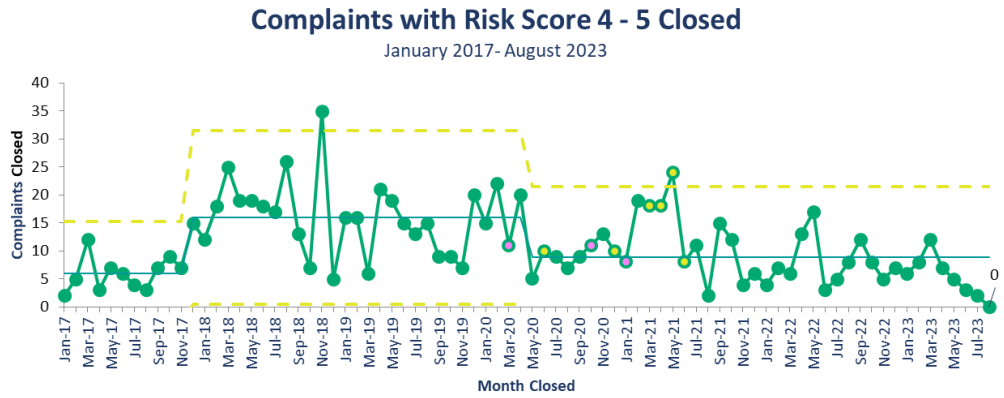


Figure Q1.5

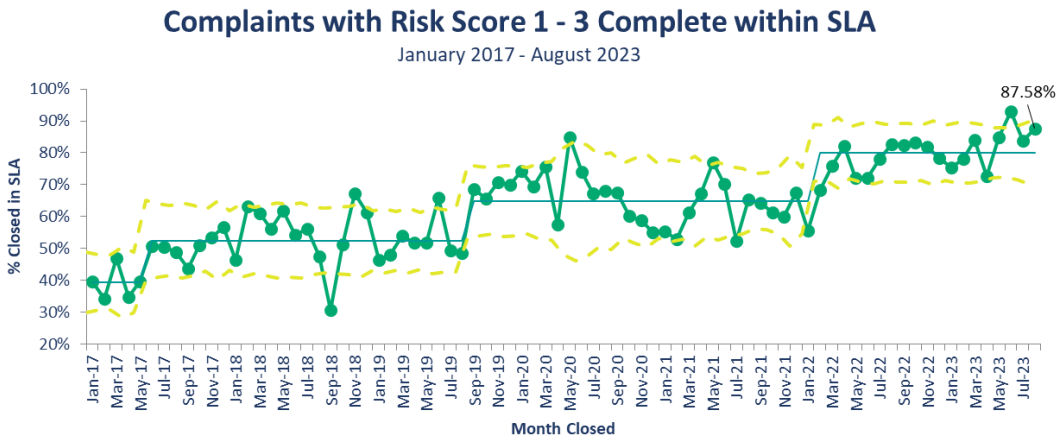
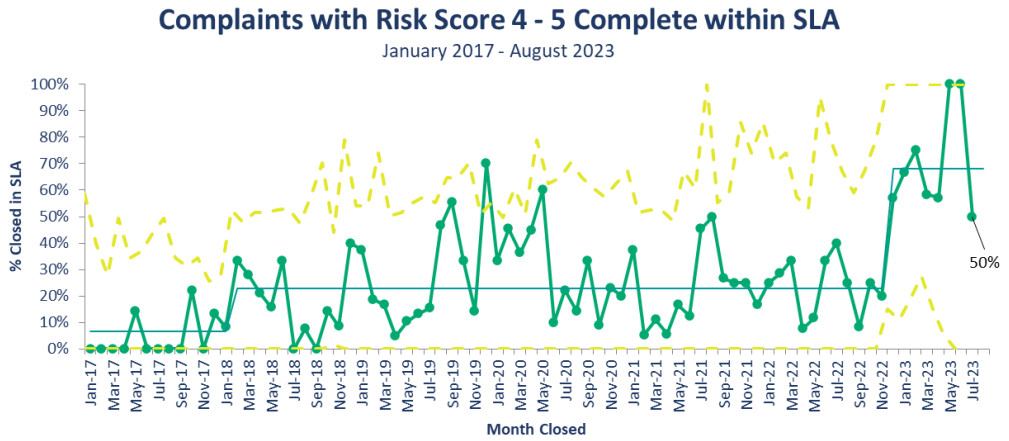


Figure Q1.6



Q2 Incidents

Figure Q2.1

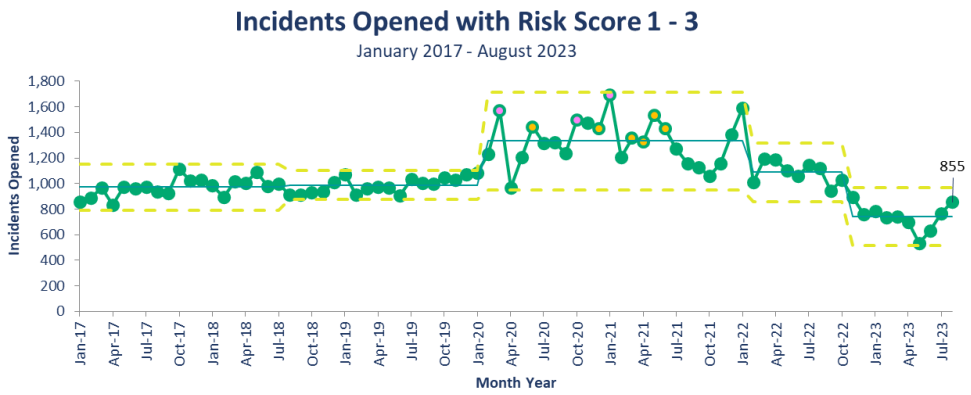


Figure Q2.2

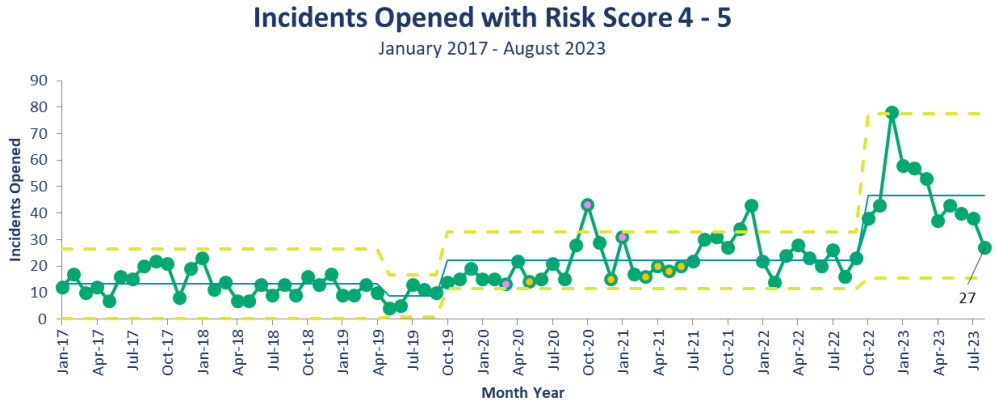


Figure Q2.3

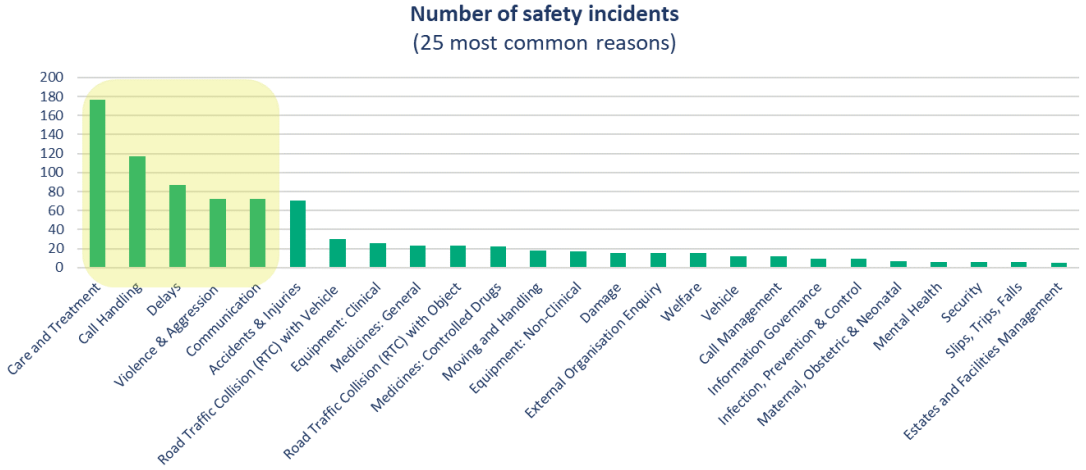


Figure Q2.4

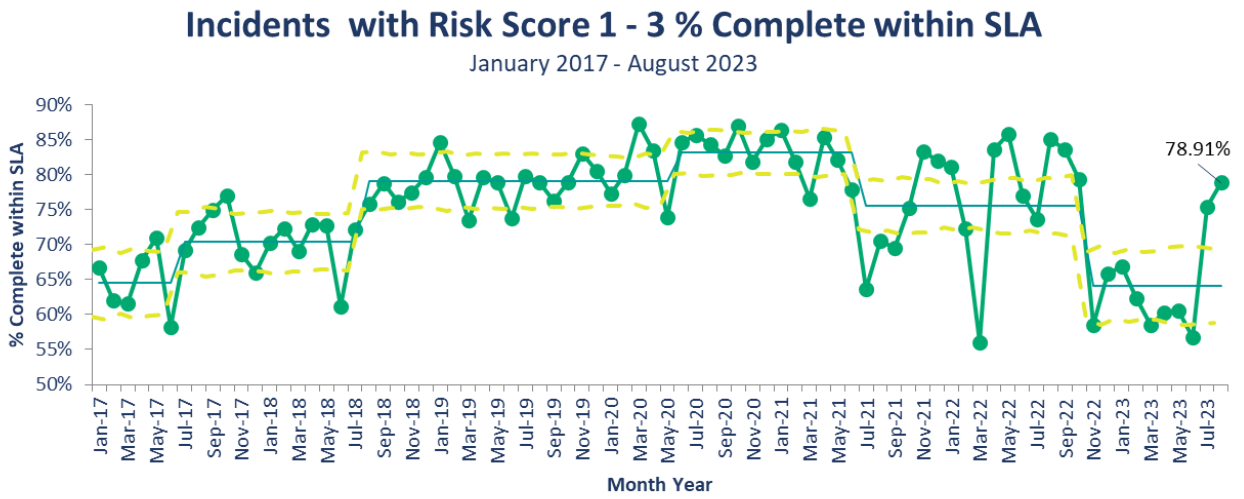
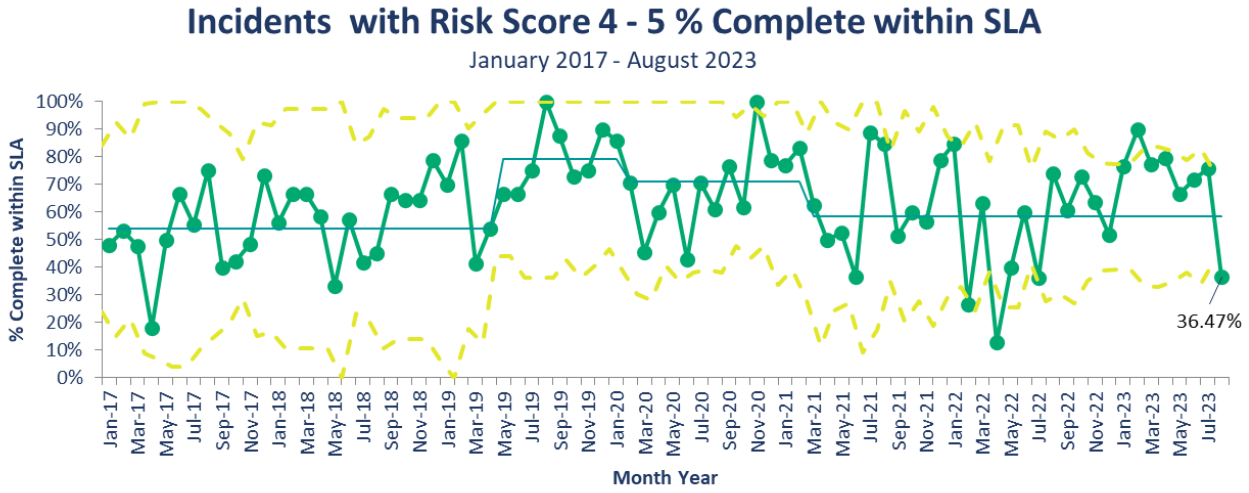


Figure Q2.5



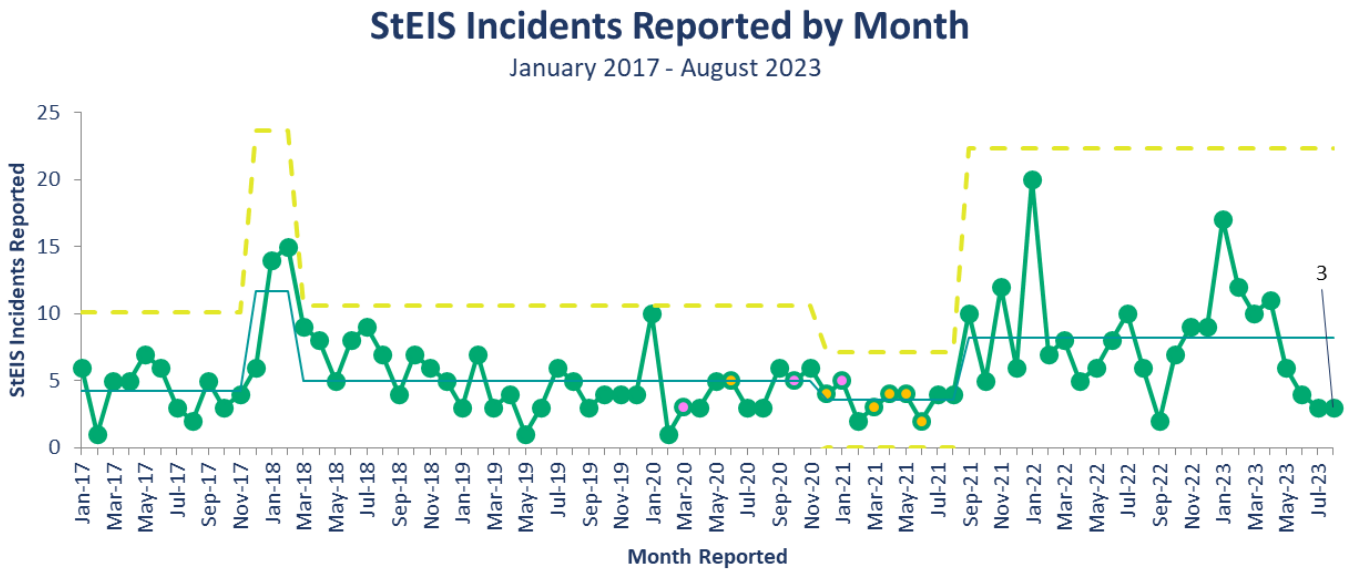
SLAs are calculated using the following measures/targets.

No exceptions are taken into account:

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

Q3 SERIOUS INCIDENTS

Figure Q3.1



Q5 SAFETY ALERTS

Table Q5.1

Safety Alerts	Number of Alerts Received (Sep 22 – Aug 23)	Number of Alerts Applicable (Sep 22 – Aug 23)	Number of Open Alerts	Notes
CAS Helpdesk Team	2	1	0	Management of national patient safety alerts. NWAS have updated health notifications procedure
National Patient Safety Alert – NHS England	1	1	0	Use of Oxygen cylinders where patients do not have access to medical gas line supplies. Owner: Medical Directorate through Medicines Optimisation Group, governance to CESC. Clinical Bulletin issued CI976 17/01/2023. Action complete.
National Patient Safety Alert - DHSC	3	0	0	
National Patient Safety Alert - OHID	1	0	0	
CMO Messaging	5	0	0	
MHRA – National Patient Safety Alerts	7	1	1	Medical beds. trolleys, bed rails, grab handles: risk of death from entrapment or falls. Patient Safety Specialist Team and MDLO assessing relevance, deadline 01/03/24
MHRA - Medicine Alerts	53	1	0	Class 2 recall of Amiodarone PFS. All batches NWAS procured were checked and none of the affected batch had been bought by NWAS so no further action.
IPC	0	0	0	

E1 PATIENT EXPERIENCE

Figure E1.1

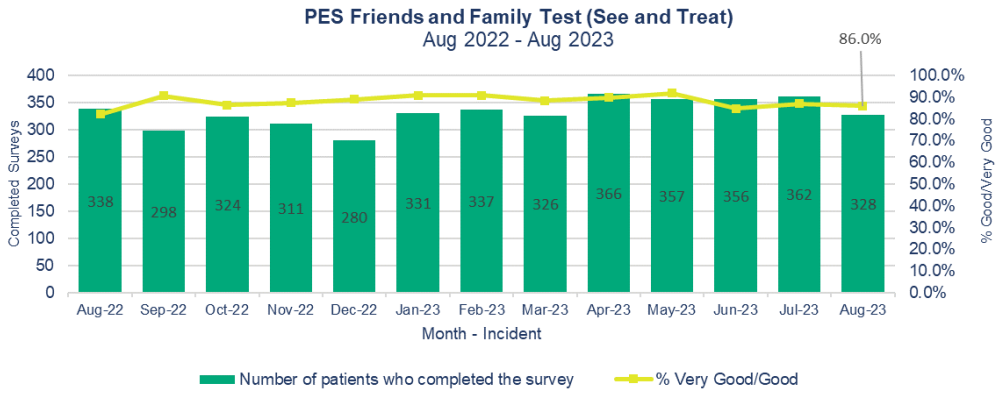
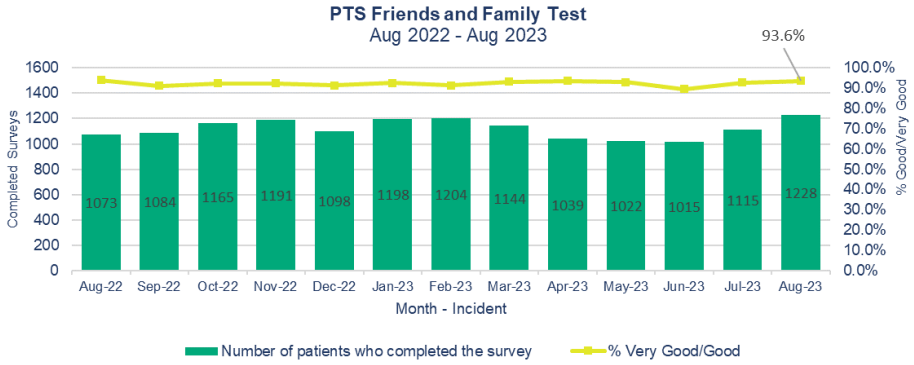


Figure E1.2



PES Positive

- *"I can't praise the two paramedics who attended highly enough. The call was for a patient receiving palliative care at home. They did everything to make sure she was as comfortable as possible at the time and also got the occupational therapist involved for me who was able to get a care package put in place from there".*
- *"Staff kept us informed of delays yet arrived far earlier than expected. Staff were professional, compassionate and courteous! Excellent."*
- *"Very professional, having a very caring approach, as well as positive advice to help them make it easier for me and them lifting me up from the floor."*

PES Negative

- *"I called in regard to a vulnerable individual with a history of suicide attempts and self-harm. The issue was reported to the police, who said it was passed on to the ambulance. When I called three hours later for an update, the police had not attended and when I spoke to the ambulance service, they had not had anything reported to them by the police. They then sent an ambulance out, but this was 3 hours after I had initially called."*

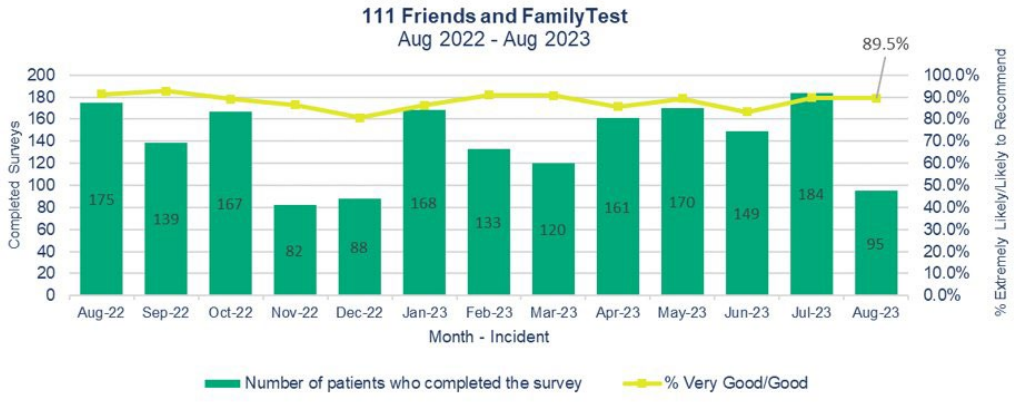
PTS Positive

- *"I have a lot of health issues as well as mental health issues and every single guy /gal who have come to take me and drop me off have been absolutely lovely. I can't stress that enough. The level of care is exceptional. They know exactly how to act when you're scared and absolutely brilliant when taking your mind off whatever you're about to face. They took their time with me, helped me up into the ambulance so I didn't fall and they even help you get buckled in. I've had various appointments in different places but every single one of them have been beyond and more. I'm so very grateful for this service and those who attend."*
- *"I live on the first floor so the men had to take me down on a chair which is not easy and they did a first-class job thank you very much."*

PTS Negative

- *"Because, despite stressing my brother is immobile and needs a capable crew and a scoop chair, you keep sending an unsuitable ambulance/crew. This has happened several times now. It's all in his notes which you have but seem to ignore?"*
- *"Got me to the hospital late. Hospital refused to see me. Have had to attend another appointment."*
- *"The transport didn't come and I missed my appointment. I now have to wait until 14 August for my next appointment."*

Figure E1.3



NHS 111 Positive

- *"A very good service to call on when worried it might be more serious than waiting for a GP appointment, but not enough to justify a 999 call."*
- *"111 service gave me confidence that I was not alone. I felt ill and a Dr came to see me, examined me and looked at my medication. He then told me to go to my GP the following day."*

- **NHS 111 Negative**
- *"I originally rang at approx 10:30am and was told that a Dr would call within the hour or maybe slightly longer, I did not receive a call until 7pm. I then had to go for an appointment at 9.15pm and was seen at 10pm. Nearly 12 hours after the original phone call.."*
- *"An utter waste of time. I called on a Saturday and was told to see my GP - on Monday... which I would have done anyway. So NHS 111 telling me to go see them and not directing me to any other service out there. Care was useless."*

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

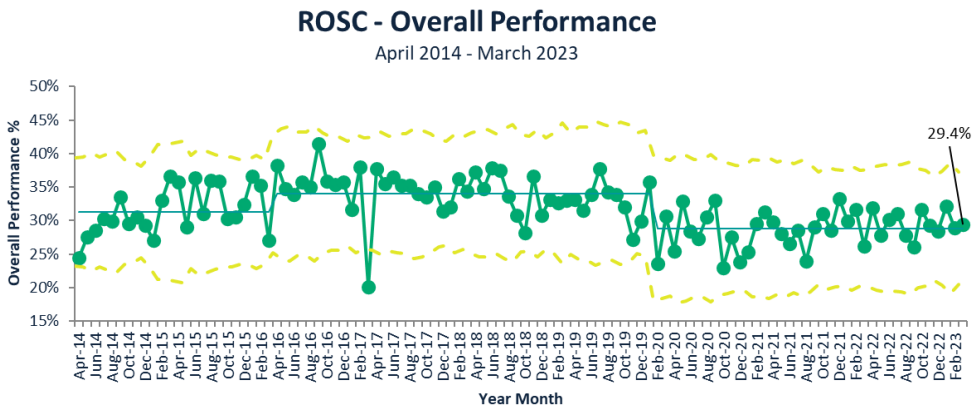


Figure E2.2

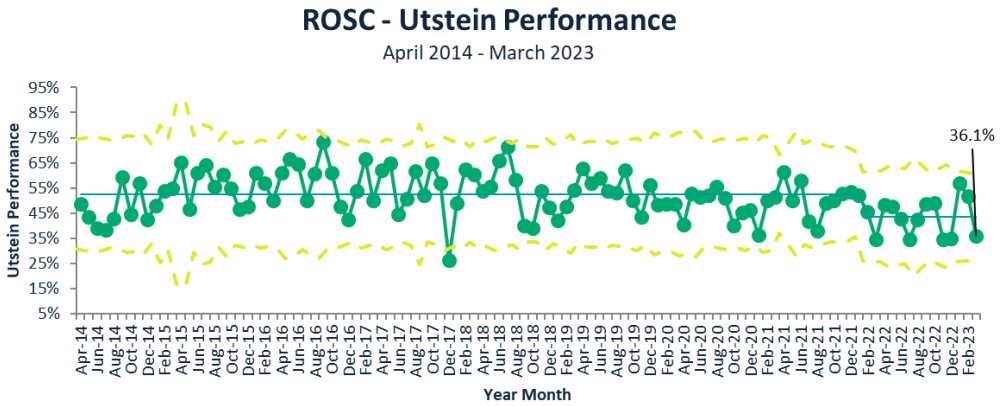


Figure E2.3

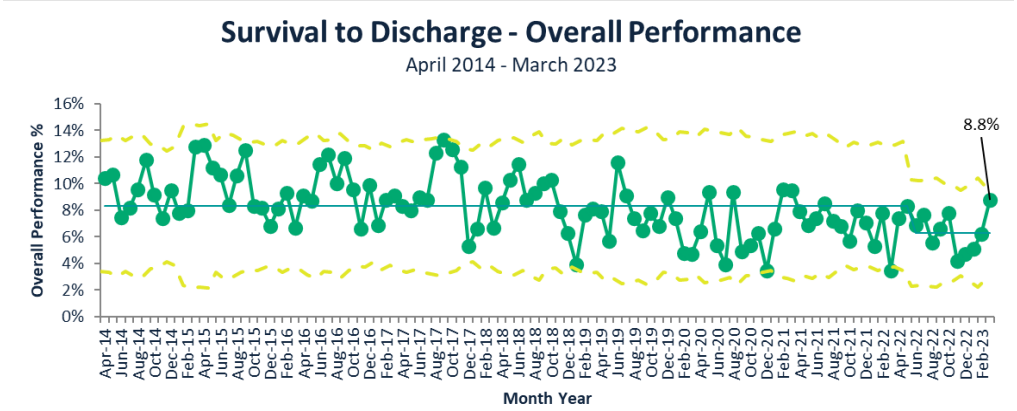


Figure E2.4

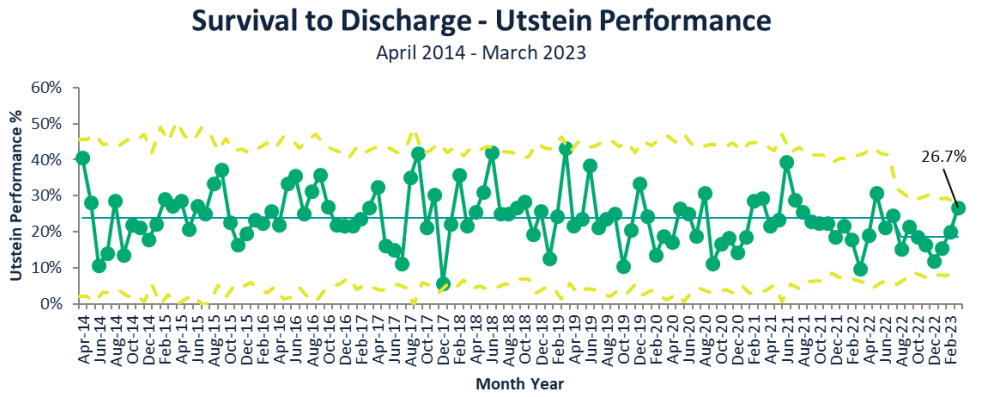


Figure E2.5

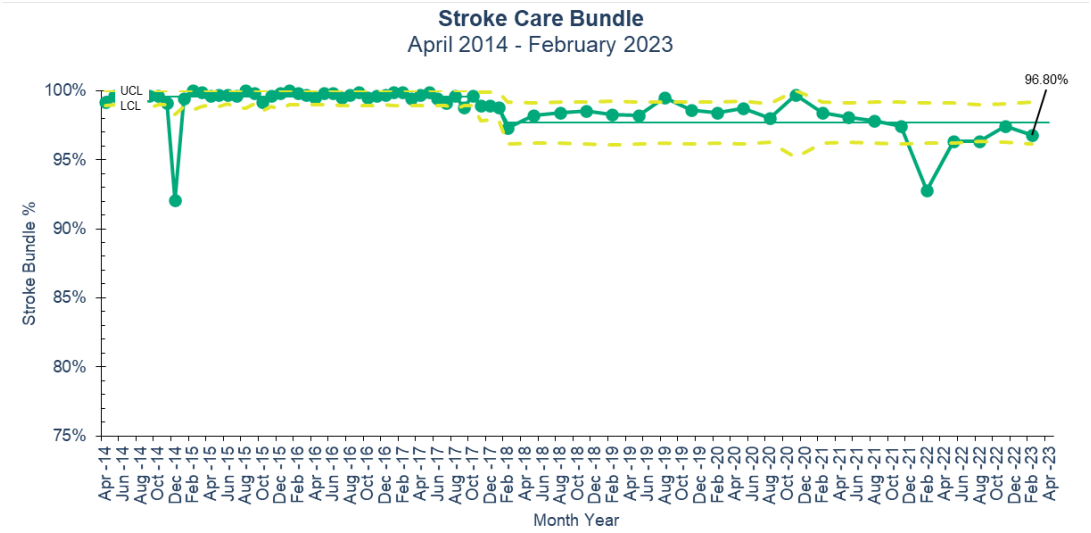


Figure E2.6

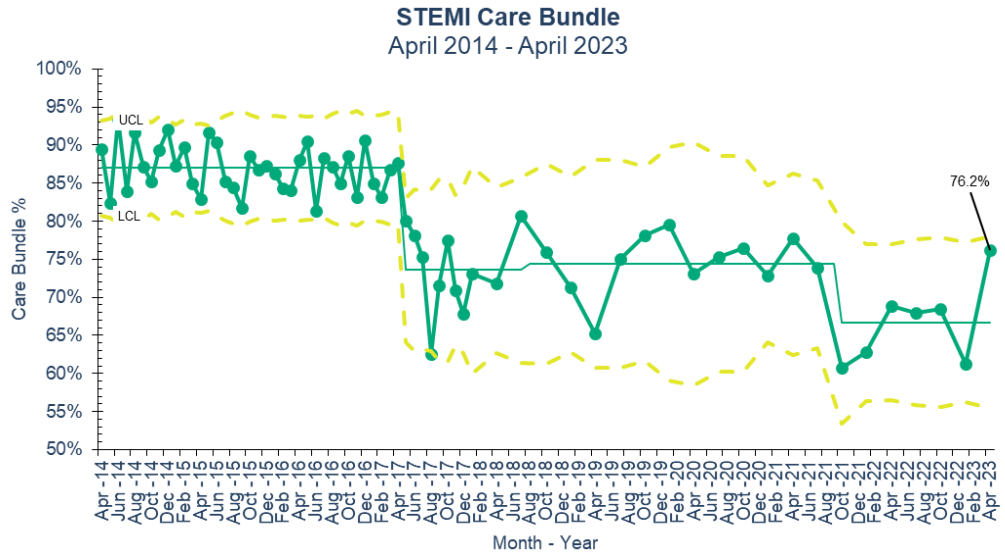


Table E2.1

Month Year	Stroke Care Bundle Performance
Feb-18	97.3%
May-18	98.2%
Aug-18	98.4%
Nov-18	98.5%
Feb-19	98.3%
May-19	98.2%
Aug-19	99.5%
Nov-19	98.6%
Feb-20	98.4%
May-20	98.7%
Aug-20	98.0%
Nov-20	99.7%
Feb-21	98.4%
May-21	98.1%
Aug-21	97.8%
Nov-21	97.4%
Feb-22	92.8%
May-22	96.3%
Aug-22	96.3%
Nov-22	97.4%
Feb-23	96.8%

Table E2.2

Month Year	STEMI Care Bundle Performance
Jan-18	73.1%
Apr-18	71.8%
Jul-18	80.7%
Oct-18	76.0%
Jan-19	71.3%
Apr-19	65.2%
Jul-19	75.0%
Oct-19	78.1%
Jan-20	79.5%
Apr-20	73.1%
Jul-20	75.3%
Oct-20	76.5%
Jan-21	72.8%
Apr-21	77.7%
Jul-21	73.9%
Oct-21	60.7%
Jan-22	62.8%
Apr-22	68.9%
Jul-22	67.9%
Oct-22	68.5%
Jan-23	61.3%
Apr-23	76.2%

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

E3 ACTIVITY & OUTCOMES

Figure E3.1

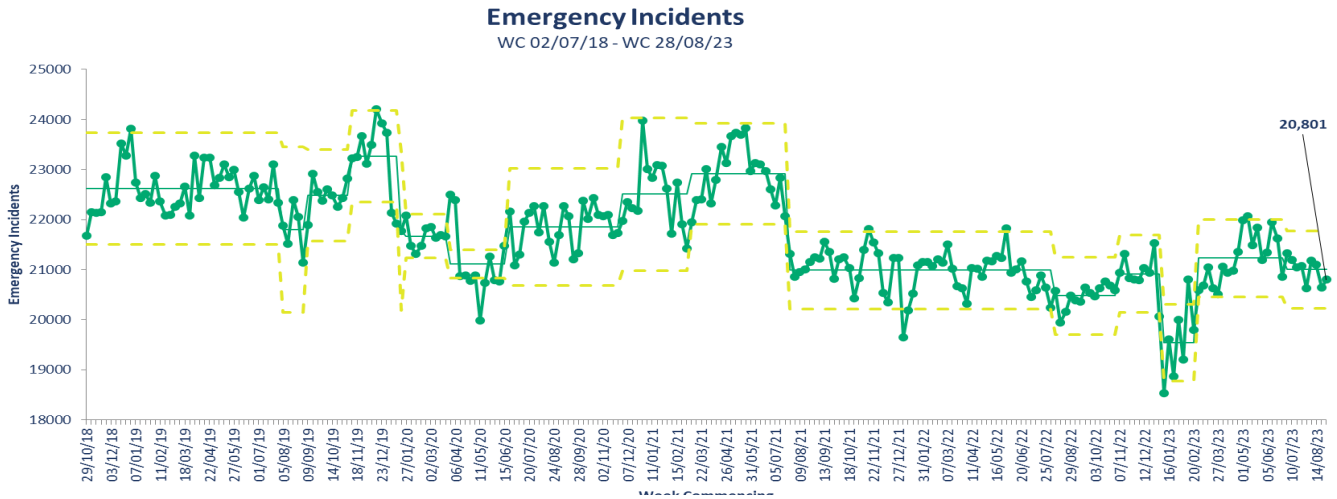


Figure E3.2

Figure E3.3

Sector	No. of Emergency Incidents
G Central	9,648
M North	9,578
G South	9,564
G West	8,806
G East	8,639
M East	7,655
CL East Lancashire	7,007
M West	6,160
CL South Lancashire	5,979
M South	5,281
CL Fylde	5,122
CL North Cumbria	4,765
CL Morecambe Bay	4,021

Figure E3.4

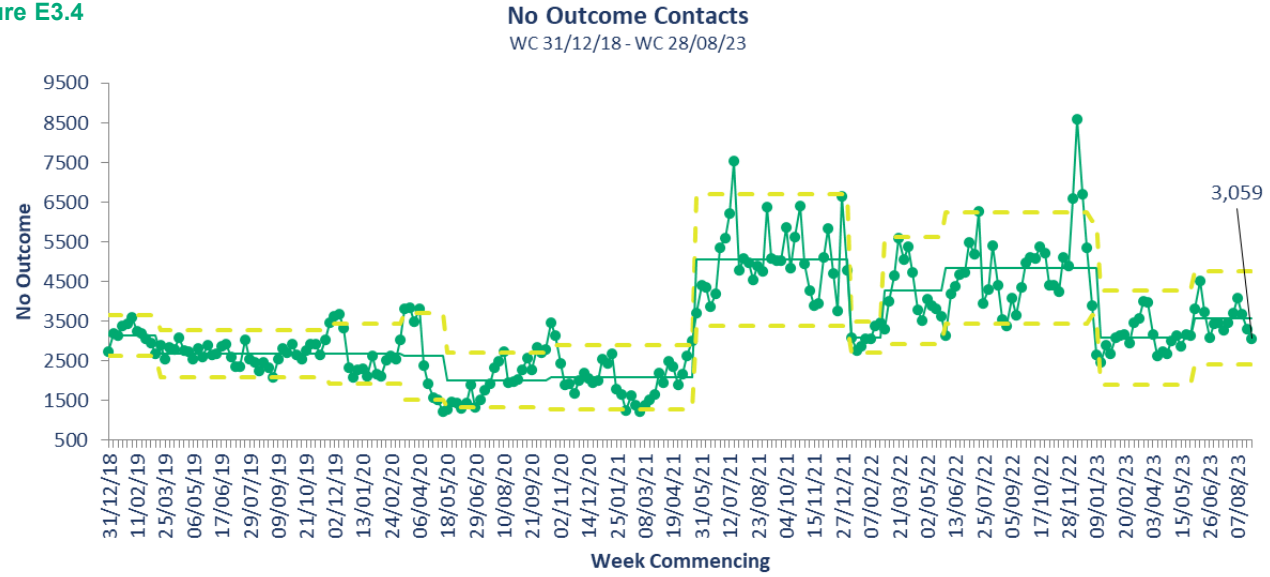


Figure E3.5

Aug	Calls	% Change from previous year	Incidents	% Change from previous year
2020	116,022		96,134	
2021	141,603	22%	93,369	-3%
2022	127,821	-10%	89,655	-4%
2023	118,713	-7%	92,315	3%

Figure E3.6

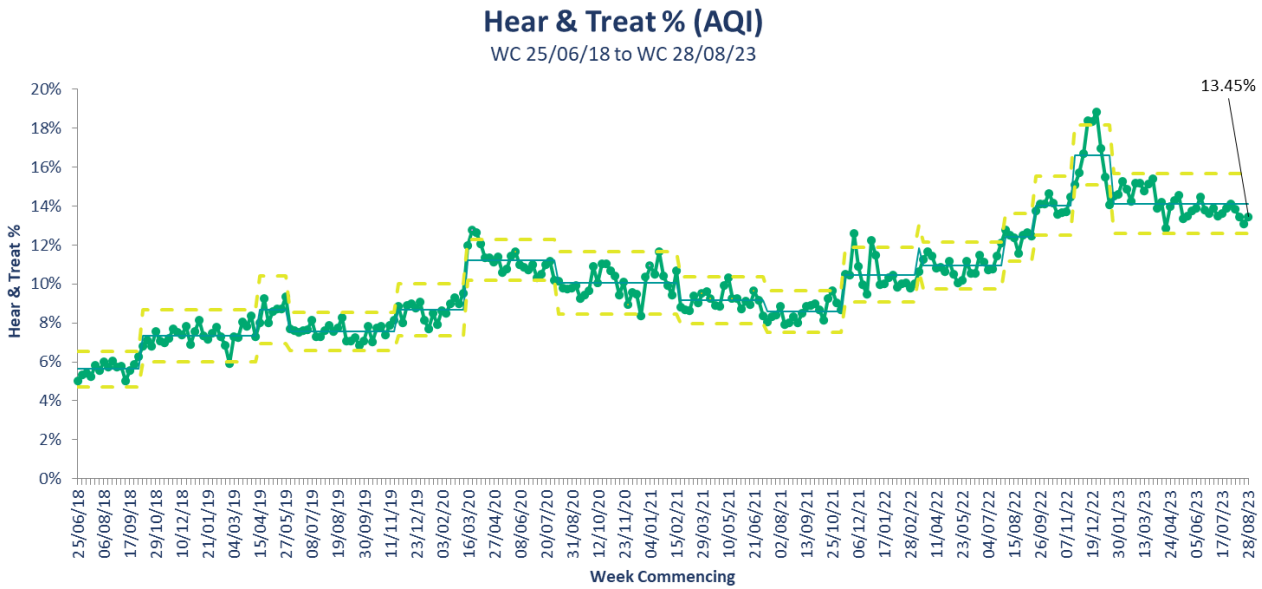


Figure E3.7

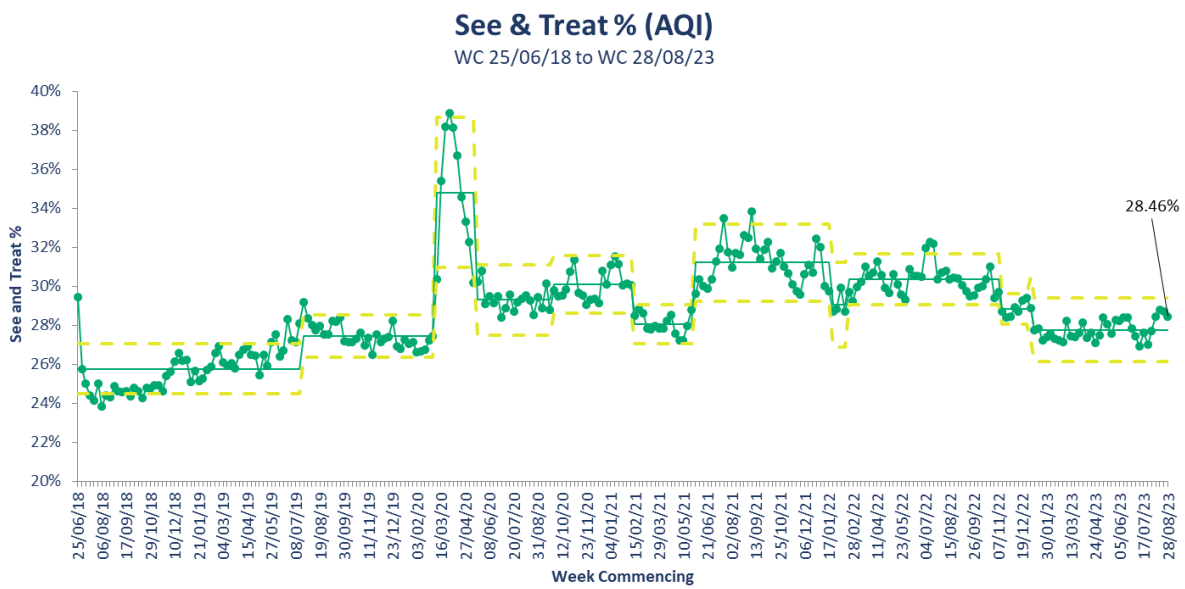


Figure E3.8

Sector	Monthly Hear & Treat %
CL Fylde	17.01%
G Central	14.81%
CL South Lancashire	14.35%
G West	14.03%
G East	13.96%
M East	13.81%
CL East Lancashire	13.29%
M North	13.17%
M West	13.17%
G South	12.96%
M South	12.67%
CL Morecambe Bay	10.97%
CL North Cumbria	10.64%

Figure E3.9

Sector	Monthly See & Treat %
G West	29.88%
M South	29.58%
CL Fylde	29.50%
G Central	29.38%
CL East Lancashire	29.27%
CL North Cumbria	29.08%
CL South Lancashire	28.34%
G East	28.30%
G South	27.75%
M West	27.58%
CL Morecambe Bay	27.48%
M North	27.46%
M East	25.98%

Figure E3.10

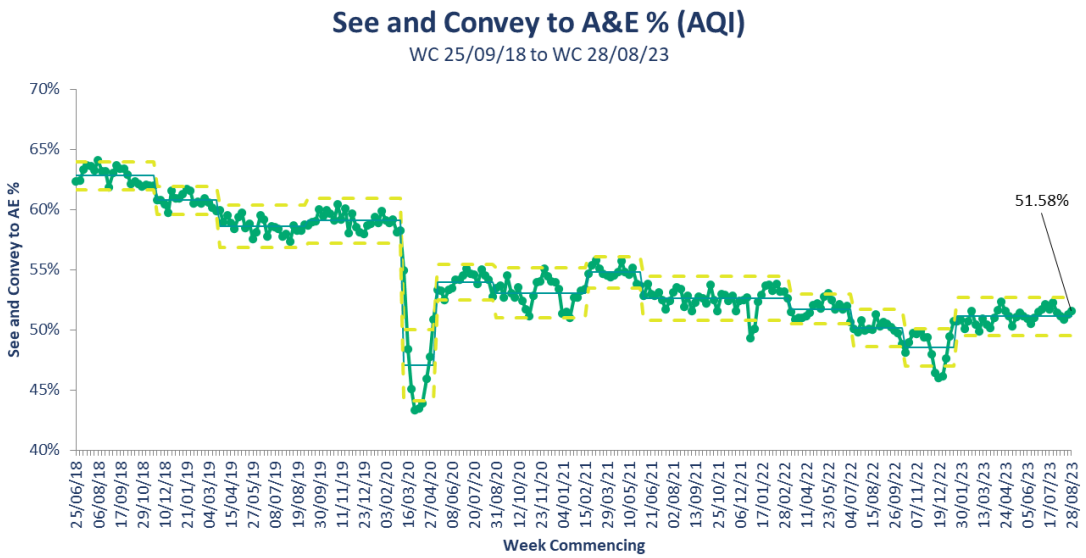


Figure E3.11

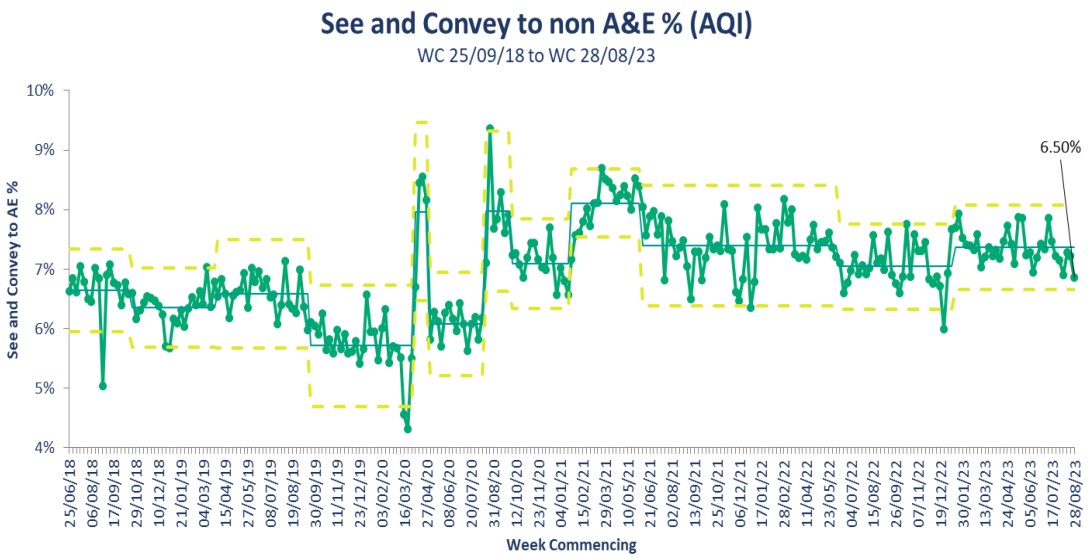


Figure E3.12

Sector	Monthly See & Convey	%
CL Fylde		53.49%
G Central		55.81%
G West		56.09%
CL South Lancashire		57.31%
CL East Lancashire		57.44%
G East		57.75%
M South		57.75%
M West		59.25%
G South		59.29%
M North		59.37%
M East		60.21%
CL North Cumbria		60.28%
CL Morecambe Bay		61.55%

Figure E3.13

Sector	Monthly See & Convey to AE	%
CL South Lancashire		47.97%
CL Fylde		47.97%
CL East Lancashire		48.81%
M West		49.32%
G Central		49.59%
G West		50.49%
M South		51.15%
G East		51.93%
M North		52.23%
CL North Cumbria		53.17%
M East		53.22%
G South		53.98%
CL Morecambe Bay		57.60%

Figure E3.14

Sector	Monthly See & Convey to Non AE	%
CL Morecambe Bay		3.95%
G South		5.31%
CL Fylde		5.53%
G West		5.60%
G East		5.82%
G Central		6.22%
M South		6.61%
M East		6.99%
CL North Cumbria		7.11%
M North		7.14%
CL East Lancashire		8.63%
CL South Lancashire		9.35%
M West		9.94%

Figure E3.15

Rank	Trust	Hear & Treat	%
1	West Midlands		16.8%
2	London		14.4%
3	North West		13.6%
4	South East Coast		12.2%
5	East Midlands		11.8%
6	South Western		10.5%
7	East of England		8.7%
8	South Central		8.4%
9	Yorkshire		8.1%
10	Isle of Wight		7.7%
11	North East		7.3%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		37.6%
2	South Central		34.8%
3	East of England		33.8%
4	Isle of Wight		33.1%
5	East Midlands		33.0%
6	South East Coast		30.6%
7	London		29.9%
8	North East		29.9%
9	West Midlands		29.1%
10	North West		28.4%
11	Yorkshire		27.7%

Figure E3.17

Rank	Trust	See & Convey	%
1	South Western		51.9%
2	West Midlands		54.2%
3	East Midlands		55.2%
4	London		55.7%
5	South Central		56.8%
6	South East Coast		57.3%
7	East of England		57.5%
8	North West		58.0%
9	Isle of Wight		59.2%
10	North East		62.9%
11	Yorkshire		64.2%

Operational

O1 CALL PICK UP

Figure O1.1

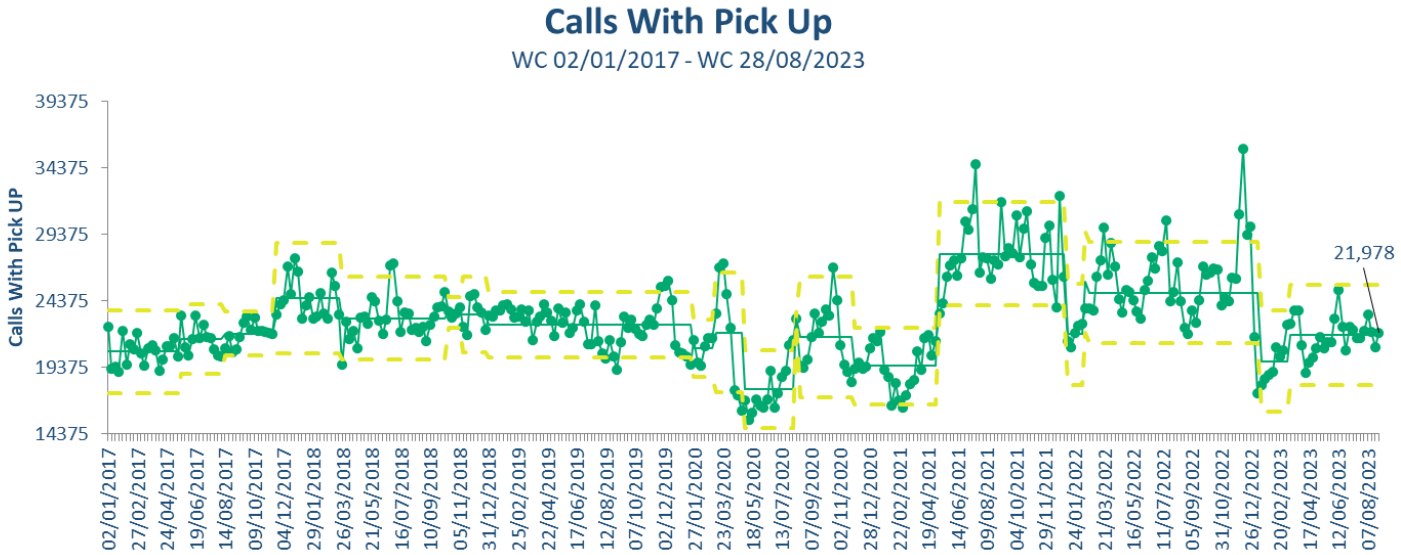
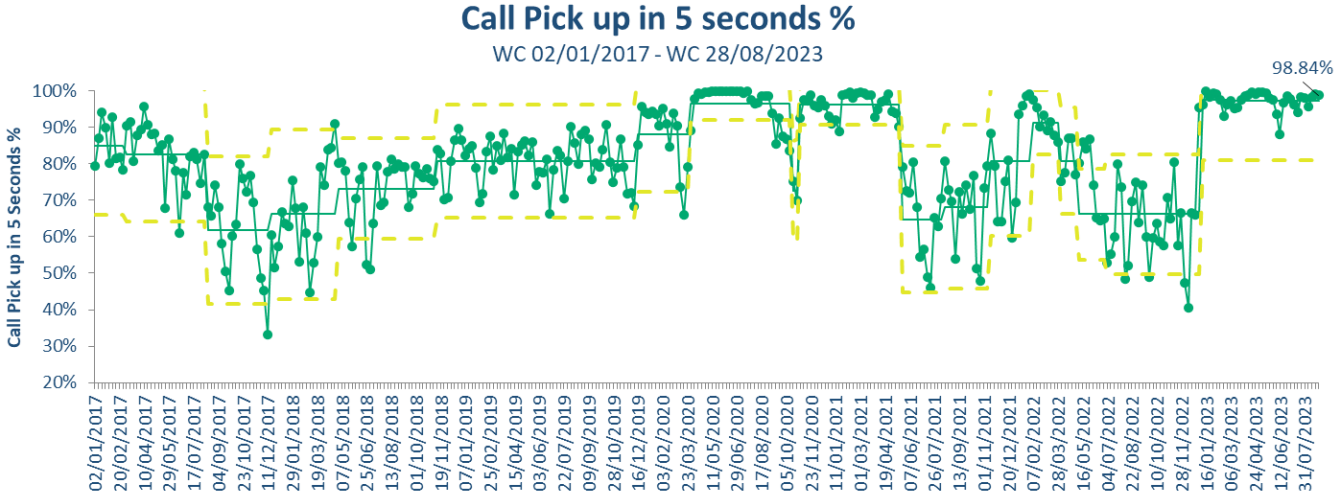


Figure O1.2



O2 A&E TURNAROUND

Figure O2.1

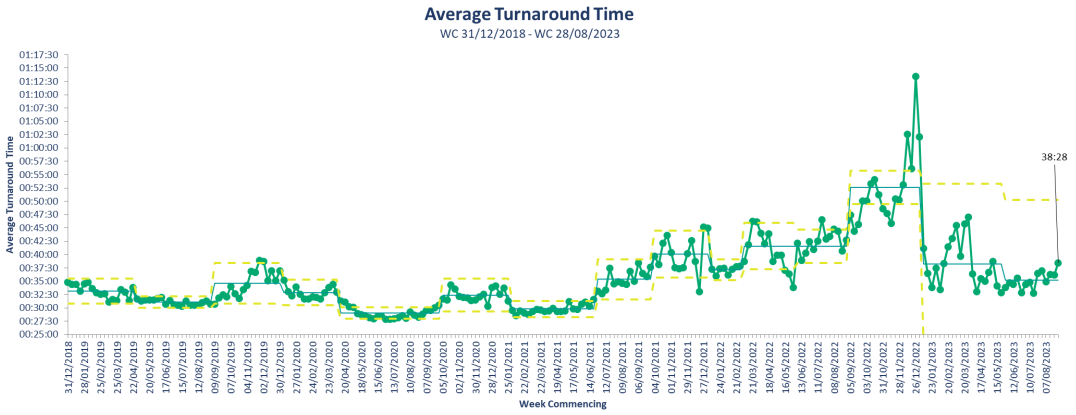


Figure O2.2

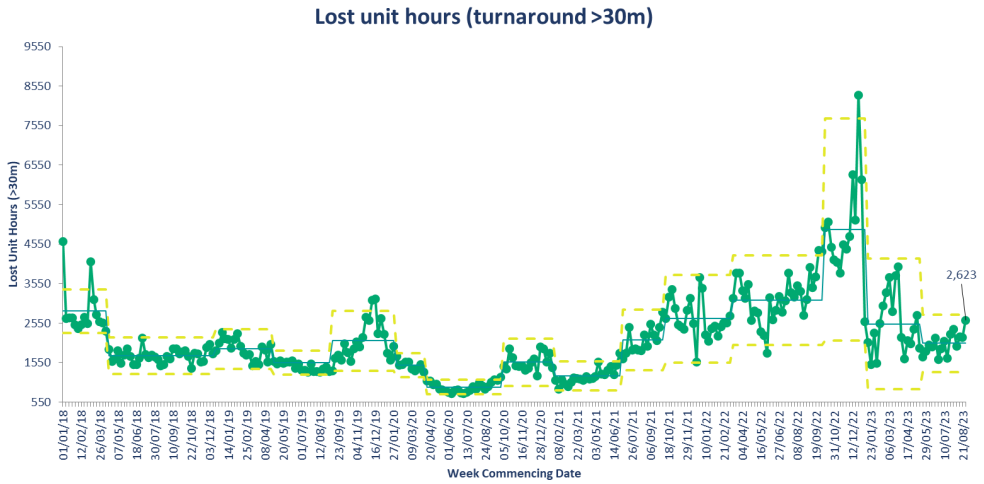


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Aug-22	45,186	0:43:33	0:31:50	11:22
Sep-22	44,198	0:46:00	0:34:15	11:32
Oct-22	44,715	0:52:16	0:40:13	11:25
Nov-22	44,310	0:48:32	0:37:10	11:57
Dec-22	43,703	0:58:51	0:48:18	11:40
Jan-23	42,663	0:44:05	0:32:25	12:03
Feb-23	40,467	0:38:35	0:25:35	11:37
Mar-23	46,166	0:43:52	0:31:25	11:41
Apr-23	46,435	0:35:20	0:22:55	11:28
May-23	49,233	0:35:33	0:23:17	11:35
Jun-23	46,866	0:34:17	0:22:25	11:29
Jul-23	48,412	0:34:46	0:22:55	11:28
Aug-23	47,374	0:36:21	0:24:43	11:23

Table O2.2

Top 5 Trusts with most lost unit hours	
Trust	**Lost Unit Hours**
Blackpool Victoria Hospital	1,541
Arrowe Park Hospital	1,013
Whiston Hospital	990
Countess of Chester Hospital	744
Aintree University Hospital	531

Table O2.3

Month	No. of patients waiting outside A&E for handover
Aug-20*	38
Sep-20	46
Oct-20	355
Nov-20	347
Dec-20	406
Jan-21	528
Feb-21	129
Mar-21	182
Apr-21	196
May-21	282
Jun-21	491
Jul-21	585
Aug-21	674
Sep-21	902
Oct-21	1156
Nov-21	739
Dec-21	824
Jan-22	708
Feb-22	590
Mar-22	936
Apr-22	1057
May-22	891
Jun-22	926
Jul-22	975
Aug-22	1099
Sep-22	1490
Oct-22	2319
Nov-22	1283
Dec-22	1775
Jan-23	862
Feb-23	514
Mar-23	1113
Apr-23	538
May-23	898
Jun-23	545
Jul-23	577
Aug-23	544

O3 ARP RESPONSE TIMES

August 2023

Figure O3.1

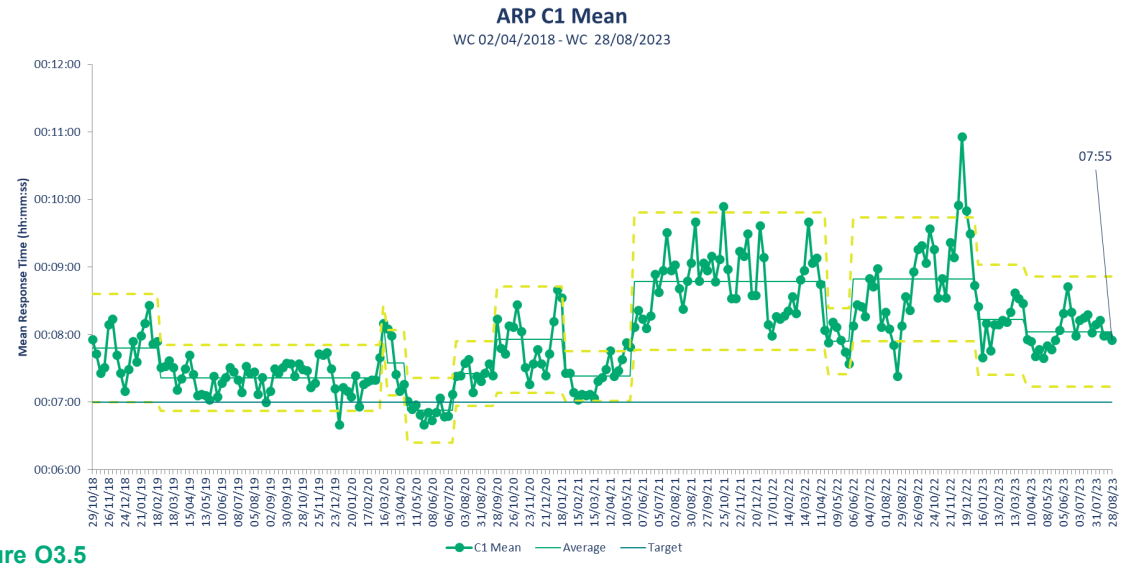


Figure O3.2

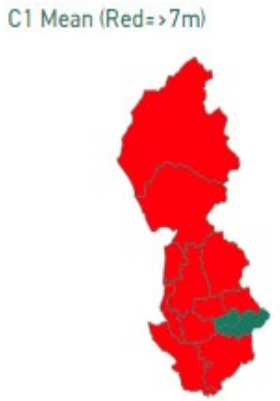


Figure O3.3

Sector	C1 Mean	Time
G South		00:06:41
G Central		00:06:58
G West		00:07:19
M North		00:07:20
G East		00:07:30
CL Fylde		00:08:08
M East		00:08:24
CL East Lancashire		00:08:46
M West		00:08:50
CL South Lancashire		00:09:07
CL Morecambe Bay		00:09:33
CL North Cumbria		00:10:07
M South		00:10:15

Figure O3.4

C1 Mean	
Target	7:00
Aug 2023	8:04
YTD	8:07
Ranking	4th

Figure O3.5

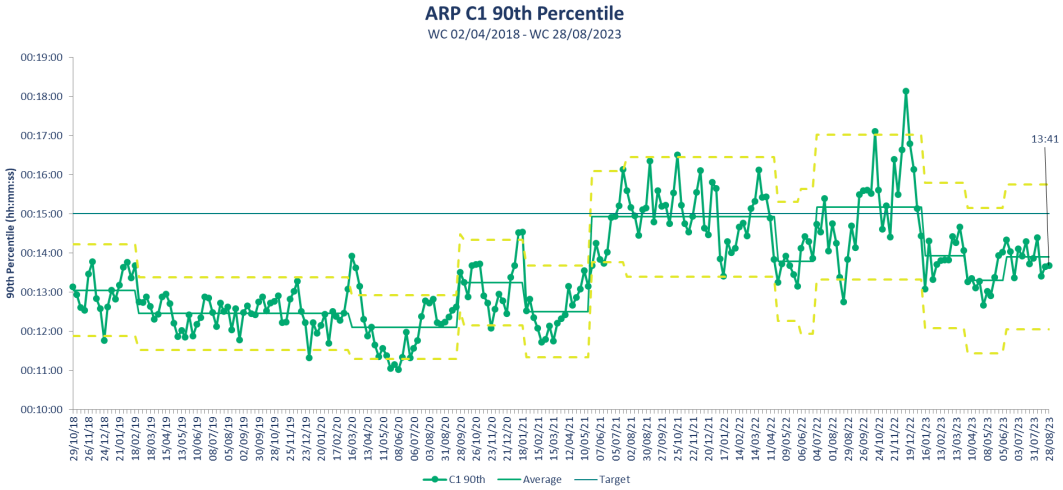


Figure O3.6

Figure O3.7

Sector	C1 90th	Time
G South		00:11:02
G Central		00:11:20
G West		00:11:57
G East		00:12:09
M North		00:12:30
M East		00:13:37
CL East Lancashire		00:14:31
CL Fylde		00:14:35
M West		00:15:23
CL South Lancashire		00:15:28
CL Morecambe Bay		00:17:37
CL North Cumbria		00:18:27
M South		00:18:36

Figure O3.8

C1 90th	
Target	15:00
Aug 2023	13:50
YTD	13:46
Ranking	3rd

August 2023

Figure O3.9

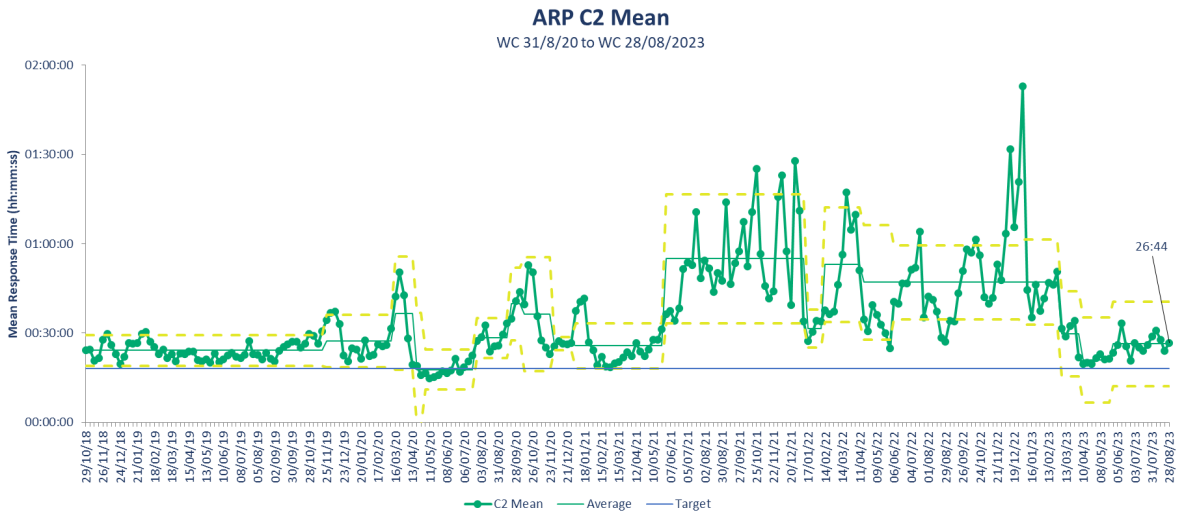


Figure O3.10

Figure O3.11

Sector	C2 Mean	Time
G South		00:18:08
G Central		00:19:39
CL North Cumbria		00:20:16
G East		00:21:41
CL East Lancashire		00:23:43
CL Morecambe Bay		00:25:48
G West		00:25:56
M South		00:29:15
CL South Lancashire		00:30:42
M North		00:35:18
M West		00:36:04
CL Fylde		00:36:26
M East		00:38:25

Figure O3.12

C2 Mean	
Target	18:00
Aug 2023	27:19
YTD	25:29
Ranking	5th

Figure O3.13

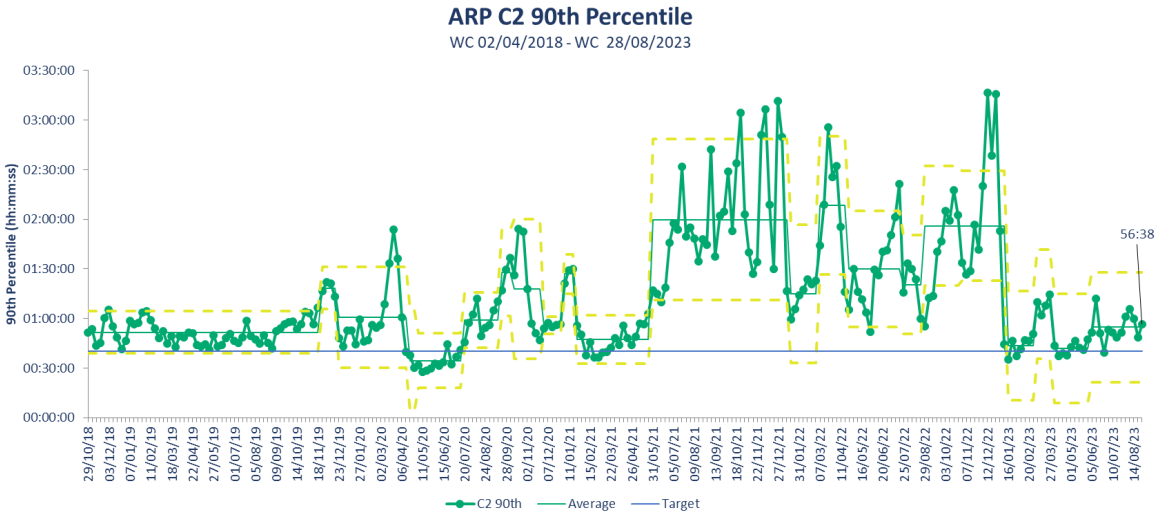


Figure O3.14

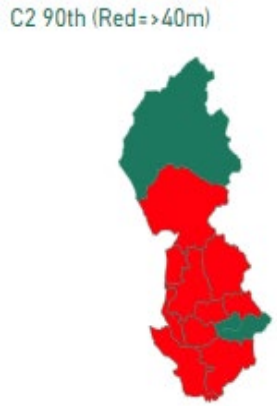


Figure O3.15

Sector	C2 90th	Time
G South		00:34:49
G Central		00:36:15
CL North Cumbria		00:39:37
G East		00:41:26
CL East Lancashire		00:47:16
G West		00:50:54
CL Morecambe Bay		00:56:28
M South		00:59:04
CL South Lancashire		01:02:50
M North		01:16:06
M West		01:20:01
M East		01:20:42
CL Fylde		01:22:01

Figure O3.16

C2 90th	
Target	40:00
Aug 2023	57:46
YTD	52:10
Ranking	5th

August 2023

Figure O3.17

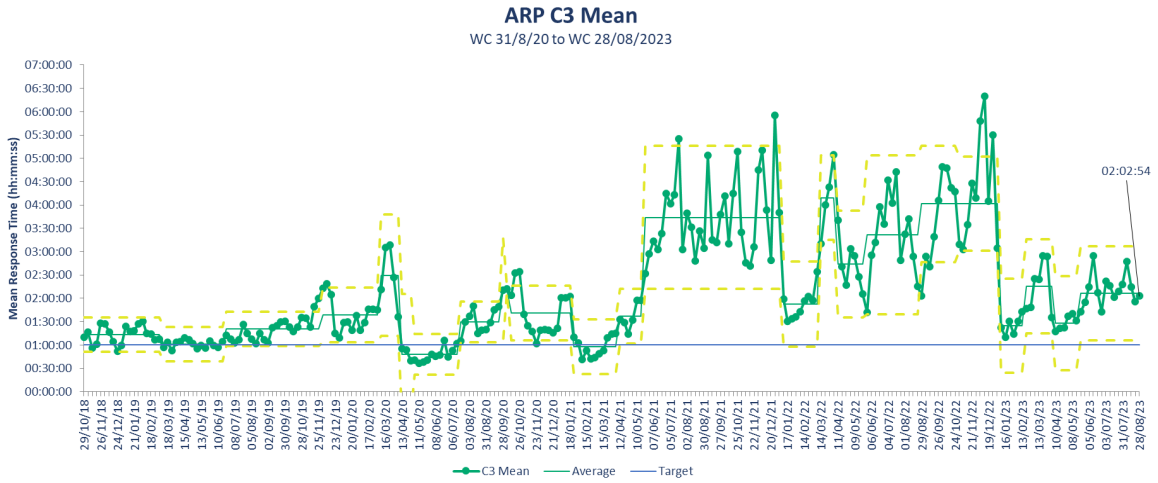


Figure O3.18

Figure O3.19

Sector	C3 Mean	Time
CL North Cumbria		01:02:50
CL Morecambe Bay		01:26:49
CL East Lancashire		01:40:59
G South		01:54:55
CL South Lancashire		01:57:03
M South		02:02:22
CL Fylde		02:12:58
G East		02:23:44
M West		02:26:26
G Central		02:30:42
M North		02:34:54
G West		02:50:23
M East		02:54:07

Figure O3.20

C3 Mean	
Target	1:00:00
Aug 2023	2:14:13
YTD	2:01:41
Ranking	10th

Figure O3.21

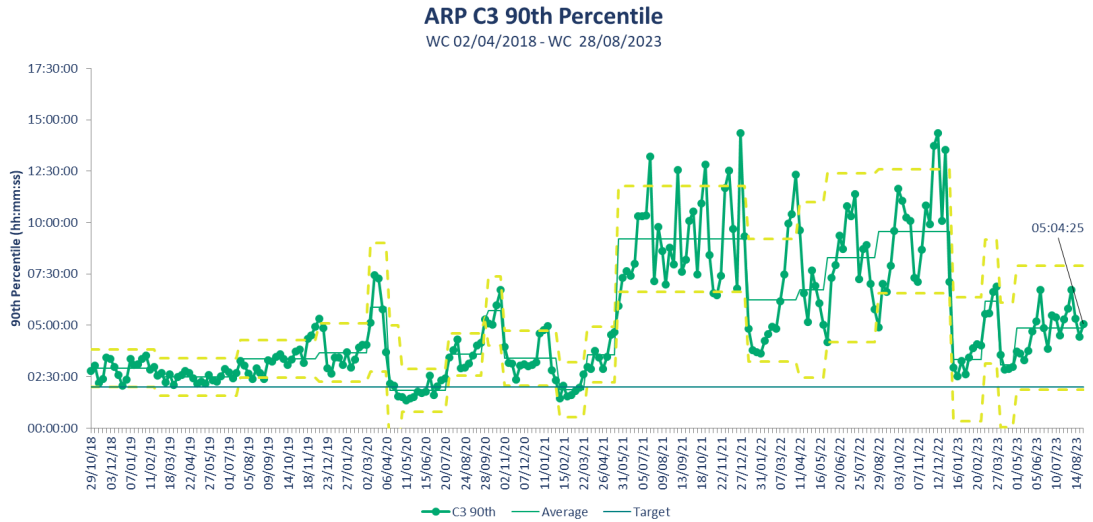


Figure O3.22

Figure O3.23

Sector	C3 90th	Time
CL North Cumbria		02:26:19
CL Morecambe Bay		03:38:08
CL East Lancashire		04:03:17
G South		04:32:08
CL South Lancashire		04:42:03
M South		04:51:47
CL Fylde		05:25:20
G East		05:29:56
G Central		05:48:44
M West		06:04:38
M North		06:33:18
G West		06:36:14
M East		07:21:23

Figure O3.24

C3 90th	
Target	2:00:00
Aug 2023	5:28:08
YTD	4:42:00
Ranking	11th

August 2023

Figure O3.25

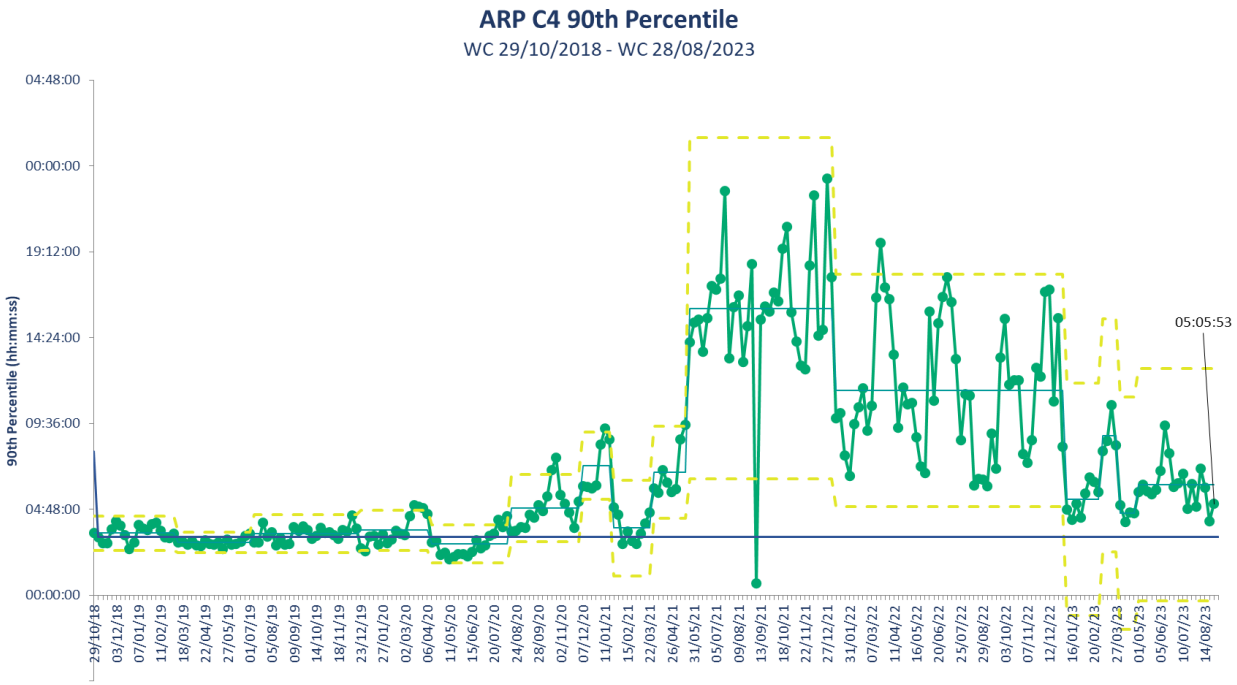


Figure O3.26

Figure O3.27

Sector	C4 90th	Time
CL North Cumbria		03:09:29
M West		03:16:15
CL East Lancashire		03:20:09
M North		04:05:48
CL Morecambe Bay		04:07:27
M South		04:39:56
CL South Lancashire		05:41:27
CL Fylde		06:19:46
G West		06:58:38
G East		06:58:53
G South		07:51:08
M East		09:31:49
G Central		11:02:16

Figure O3.28

C4 90th	
Target	3:00:00
Aug 2023	5:33:26
YTD	6:12:55
Ranking	9th

O3 ARP Provider Comparison

Figure O3.25

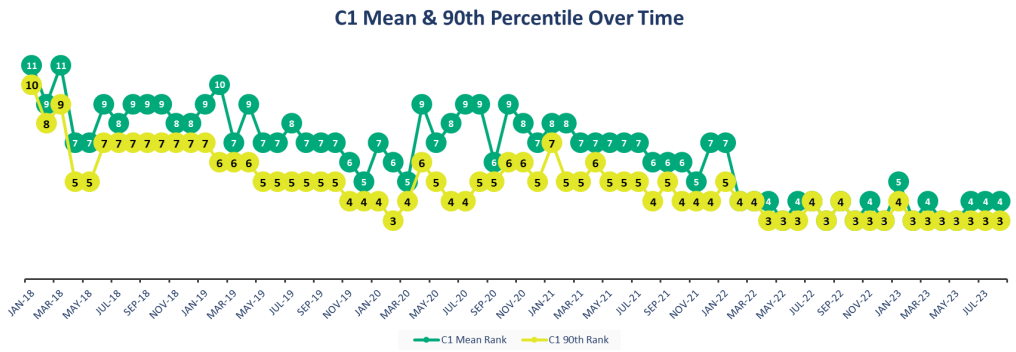


Figure O3.26

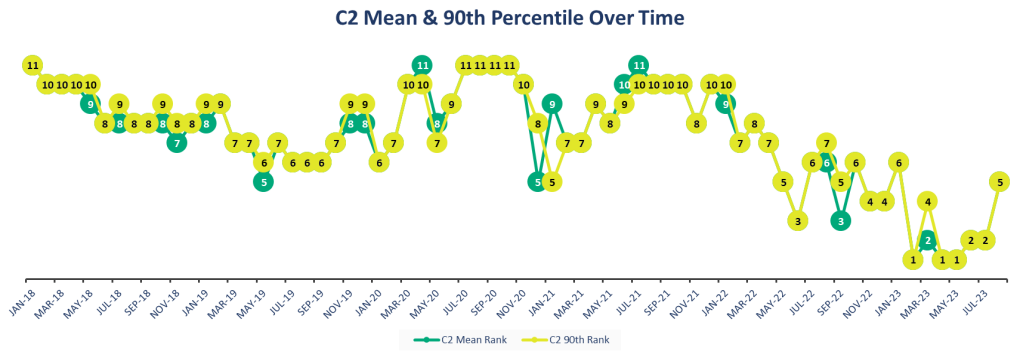


Figure O3.27

Figure O3.28

Rank	Trust	C1 Mean	Time
1	North East		07:14
2	London		07:23
3	West Midlands		08:03
4	North West		08:04
5	Yorkshire		08:25
6	East Midlands		08:28
7	South Central		08:30
8	South East Coast		08:34
9	East of England		08:59
10	South Western		09:01
11	Isle of Wight		10:38

Rank	Trust	C1 90th	Time
1	London		12:15
2	North East		12:29
3	North West		13:50
4	West Midlands		14:13
5	Yorkshire		14:36
6	South Central		15:27
7	East Midlands		15:34
8	South East Coast		15:43
9	South Western		16:56
10	East of England		16:59
11	Isle of Wight		19:13

Rank	Trust	C2 Mean	Time
1	Isle of Wight		0:23:30
2	West Midlands		0:25:44
3	South East Coast		0:26:43
4	Yorkshire		0:26:49
5	North West		0:27:19
6	South Central		0:27:33
7	South Western		0:33:18
8	London		0:34:11
9	North East		0:35:35
10	East Midlands		0:36:49
11	East of England		0:41:36

Rank	Trust	C2 90th	Time
1	Isle of Wight		0:48:06
2	South East Coast		0:54:14
3	South Central		0:55:01
4	West Midlands		0:55:42
5	North West		0:57:46
6	Yorkshire		0:59:23
7	South Western		1:08:56
8	North East		1:13:00
9	London		1:16:28
10	East Midlands		1:19:06
11	East of England		1:31:02

Rank	Trust	C3 Mean	Time
1	Isle of Wight		01:04:11
2	London		01:14:43
3	Yorkshire		01:20:02
4	South Western		01:22:18
5	South Central		01:36:55
6	North East		01:36:58
7	West Midlands		01:37:03
8	East of England		02:04:28
9	South East Coast		02:09:33
10	North West		02:14:13
11	East Midlands		02:19:58

Rank	Trust	C3 90th	Time
1	Isle of Wight		02:29:05
2	London		03:01:49
3	Yorkshire		03:03:55
4	South Western		03:17:17
5	South Central		03:37:14
6	West Midlands		03:57:18
7	North East		03:59:24
8	South East Coast		04:46:58
9	East of England		05:03:23
10	East Midlands		05:20:24
11	North West		05:28:08

Rank	Trust	C4 90th	Time
1	South Western		03:20:53
2	North East		03:42:43
3	Isle of Wight		03:46:31
4	London		04:16:39
5	Yorkshire		04:18:53
6	East Midlands		04:19:42
7	South Central		04:45:38
8	West Midlands		04:58:37
9	North West		05:33:26
10	South East Coast		06:54:11
11	East of England		08:03:34

O3 LONG WAITS

Table O3.29

Year Month	Total No. of C1 long waits
Jun-19	436
Jul-19	523
Aug-19	471
Sep-19	482
Oct-19	582
Nov-19	542
Dec-19	575
Jan-20	425
Feb-20	385
Mar-20	594
Apr-20	329
May-20	186
Jun-20	196
Jul-20	274
Aug-20	437
Sep-20	394
Oct-20	586
Nov-20	447
Dec-20	455
Jan-21	663
Feb-21	340
Mar-21	358
Apr-21	489
May-21	734
Jun-21	971
Jul-21	1,534
Aug-21	1,226
Sep-21	1,501
Oct-21	1,650
Nov-21	1,329
Dec-21	1,590
Jan-22	1,109
Feb-22	985
Mar-22	1,609
Apr-22	1,145
May-22	869
Jun-22	940
Jul-22	1,207
Aug-22	653
Sep-22	804
Oct-22	1,186
Nov-22	959
Dec-22	1,619
Jan-23	694
Feb-23	543
Mar-23	708
Apr-23	509
May-23	505
Jun-23	693
Jul-23	706
Aug-23	643

Figure O3.29

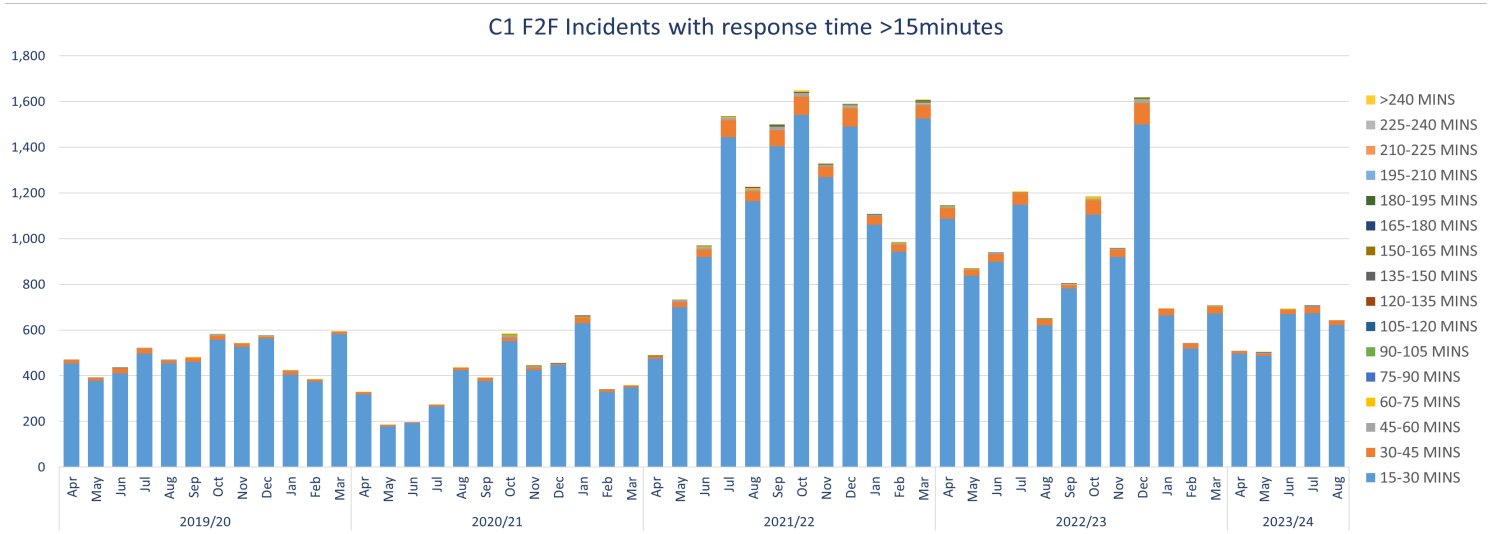


Figure O3.30

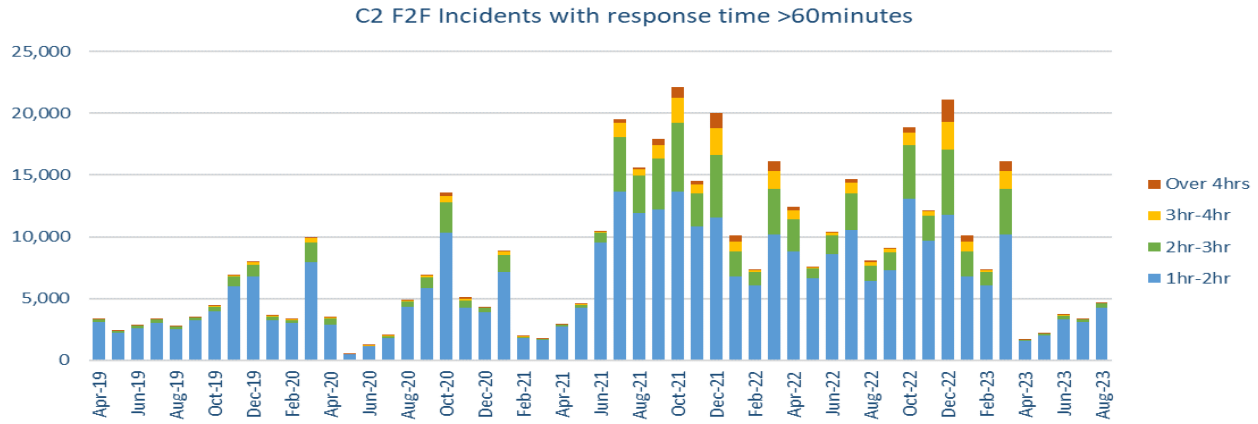
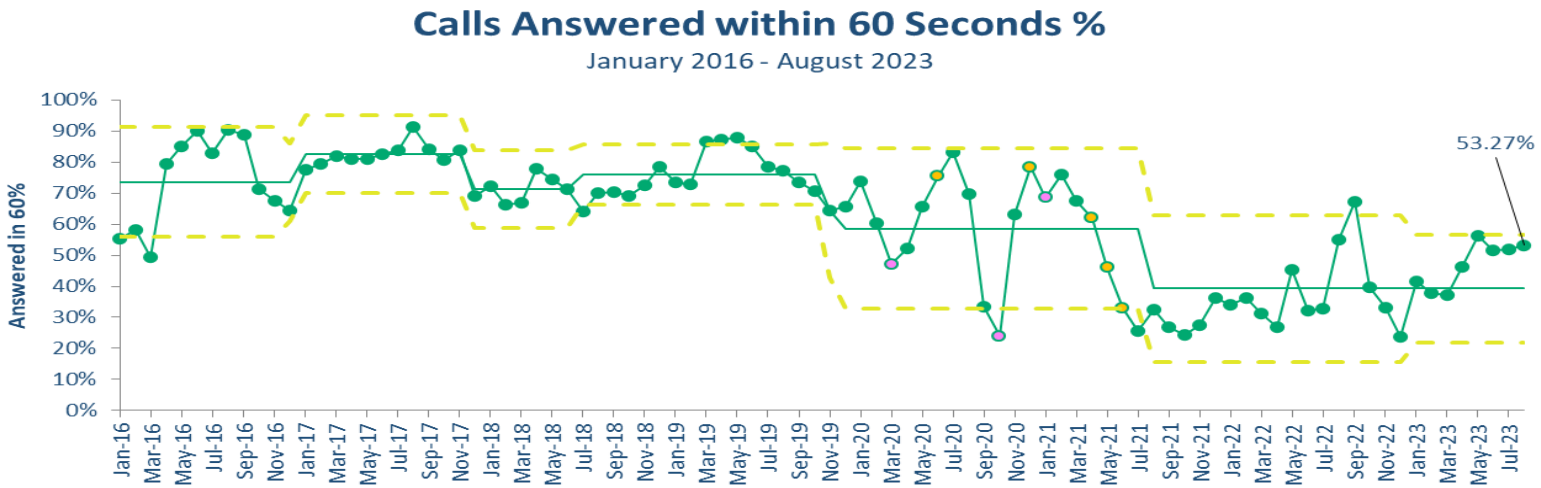


Table O3.30

Year Month	Total No. of C2 long waits
Jun-19	2,817
Jul-19	3,332
Aug-19	2,765
Sep-19	3,479
Oct-19	4,412
Nov-19	6,888
Dec-19	7,998
Jan-20	3,604
Feb-20	3,303
Mar-20	10,001
Apr-20	3,458
May-20	483
Jun-20	1,193
Jul-20	2,003
Aug-20	4,860
Sep-20	6,874
Oct-20	13,563
Nov-20	5,090
Dec-20	4,290
Jan-21	8,889
Feb-21	1,908
Mar-21	1,739
Apr-21	2,918
May-21	4,523
Jun-21	10,503
Jul-21	19,540
Aug-21	15,612
Sep-21	17,922
Oct-21	22,113
Nov-21	14,517
Dec-21	20,037
Jan-22	10,127
Feb-22	7,349
Mar-22	16,135
Apr-22	12,400
May-22	7,564
Jun-22	10,374
Jul-22	14,649
Aug-22	8,051
Sep-22	9,057
Oct-22	18,870
Nov-22	12,153
Dec-22	21,089
Jan-23	4,631
Feb-23	2,048
Mar-23	6,132
Apr-23	1,650
May-23	2142
Jun-23	3670
Jul-23	3294
Aug-23	4614

O4 111 PERFORMANCE

Figure O4.1



Calls Answered within 60 Seconds %	
Target	95%
Aug 2023	53.27%
YTD	52.27%
National	67.6%
Ranking	28th

Figure O4.2

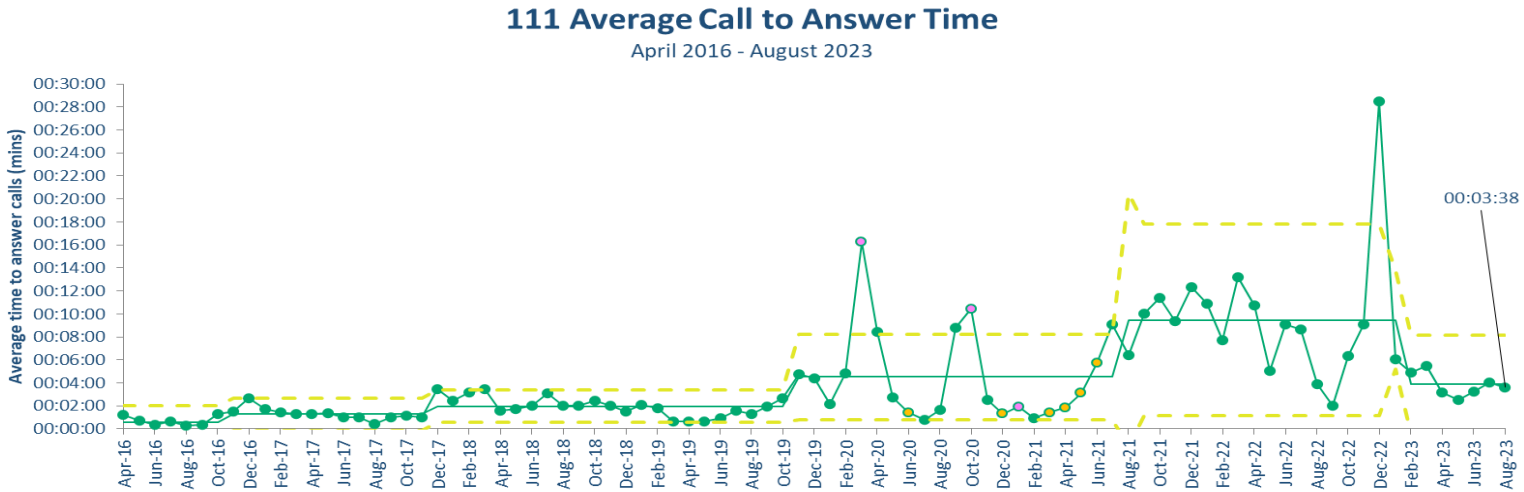
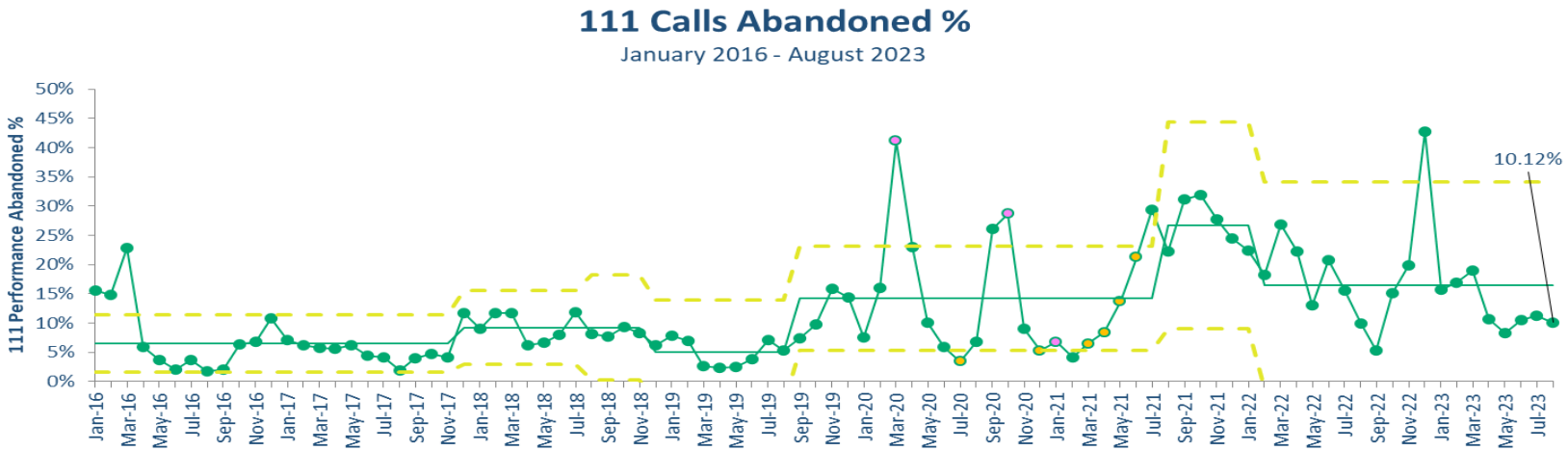
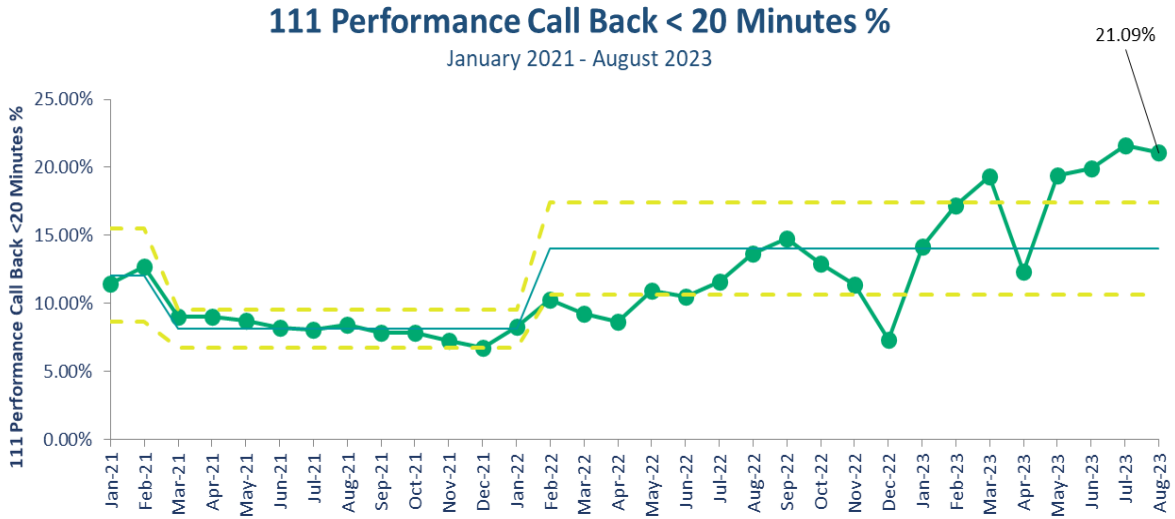


Figure O4.3



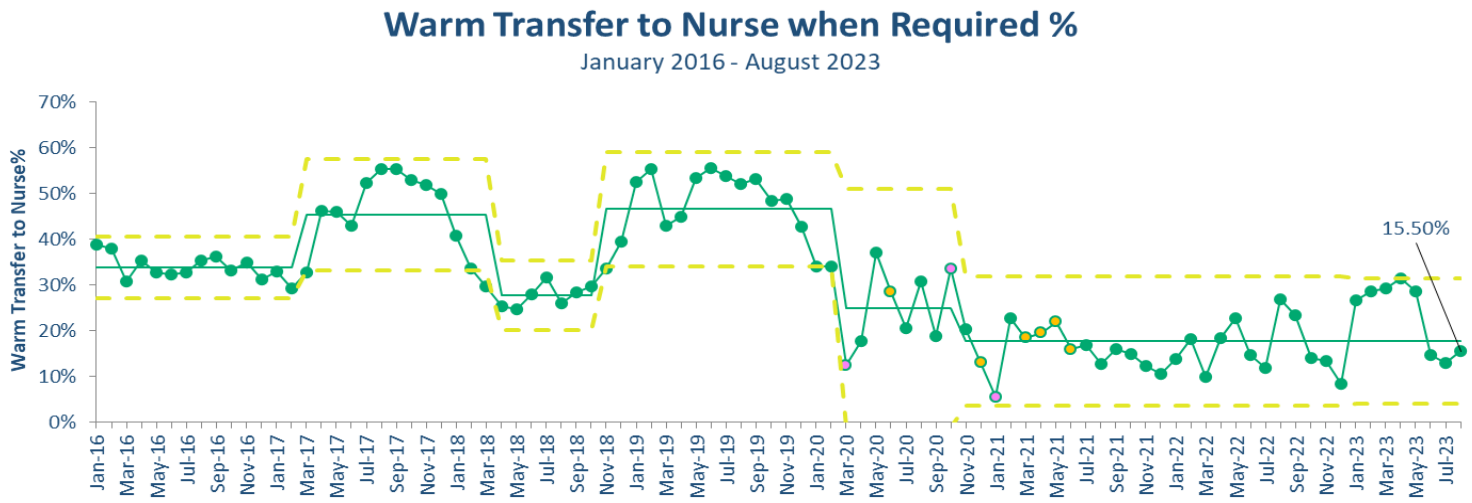
Calls Abandoned %	
Target	<5%
Aug 2023	10.12%
YTD	10.18%
National	8.1%
Ranking	24th

Figure O4.4



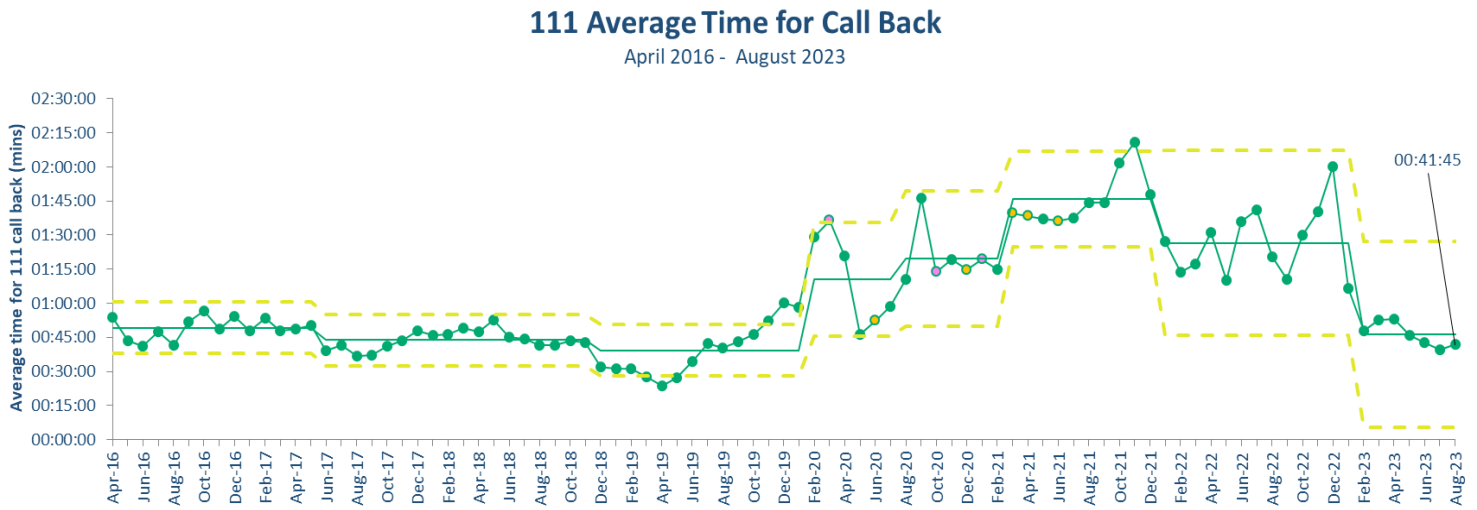
Calls Back <20 Mins	
Target	90%
Aug 2023	21.09%
YTD	21.35%

Figure O4.5



Warm Transfer %	
Target	75%
Aug 2023	15.5%
YTD	20.61%

Figure O4.6



O5 PTS ACTIVITY & TARIFF

Table O5.1

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: July 2023					Year to Date: July 2023 - July 2023			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	10,875	(3,149)	(22%)	14,024	10,875	(3,149)	(22%)
Greater Manchester	526,588	43,882	44,814	932	2%	43,882	44,814	932	2%
Lancashire	589,181	49,098	37,183	(11,915)	(24%)	49,098	37,183	(11,915)	(24%)
Merseyside	300,123	25,010	25,296	286	1%	25,010	25,296	286	1%
NWAS	1,584,182	132,015	118,168	(13,847)	(10%)	132,015	118,168	(13,847)	(10%)

UNPLANNED ACTIVITY									
	Current Month: July 2023					Year to Date: July 2023 - July 2023			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	479	(768)	(62%)	1,247	479	(768)	(62%)
Greater Manchester	49,133	4,094	4,180	86	2%	4,094	4,180	86	2%
Lancashire	58,829	4,902	2,977	(1,925)	(39%)	4,902	2,977	(1,925)	(39%)
Merseyside	22,351	1,863	1,872	9	1%	1,863	1,872	9	1%
NWAS	145,282	12,107	9,508	(2,599)	(21%)	12,107	9,508	(2,599)	(21%)

ABORTED ACTIVITY									
	July 2023								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	240	7,235	3%	37	485	8%	79	3,645	2%
Greater Manchester	2,154	21,729	10%	1,205	4,111	29%	1,053	20,405	5%
Lancashire	1,173	21,555	5%	496	2,990	17%	458	13,024	4%
Merseyside	715	12,185	6%	352	1,807	19%	640	12,157	5%
NWAS	4,282	62,704	7%	2,090	9,393	22%	2,230	49,231	5%

Finance

F1 – FINANCIAL SCORE

Figure F1.1

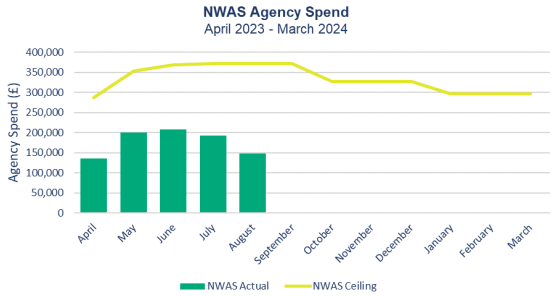


Figure F1.2

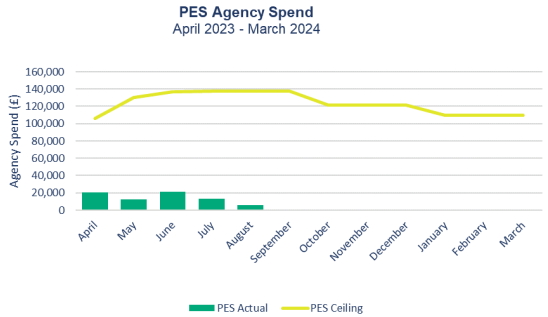


Figure F1.3

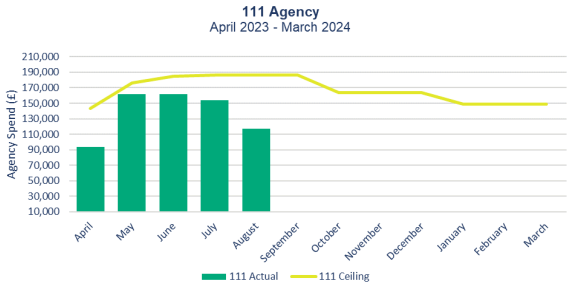


Figure F1.4

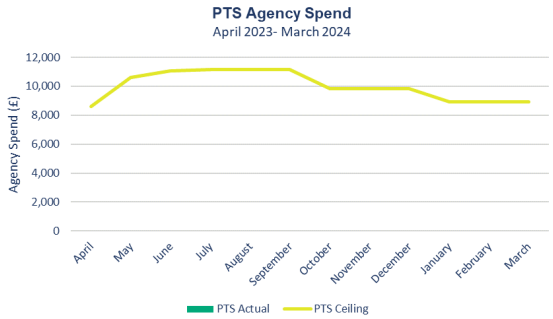


Figure F1.5

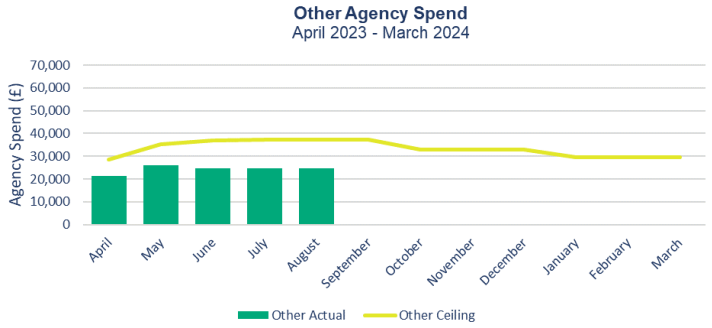
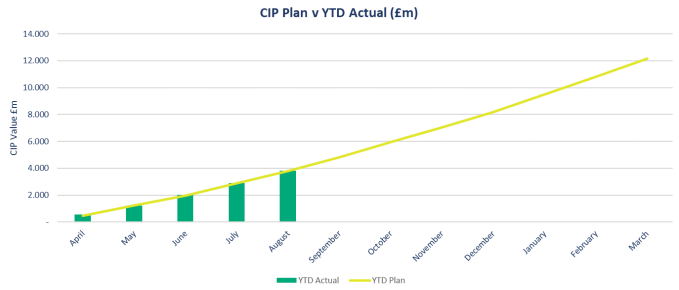


Figure F1.6



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

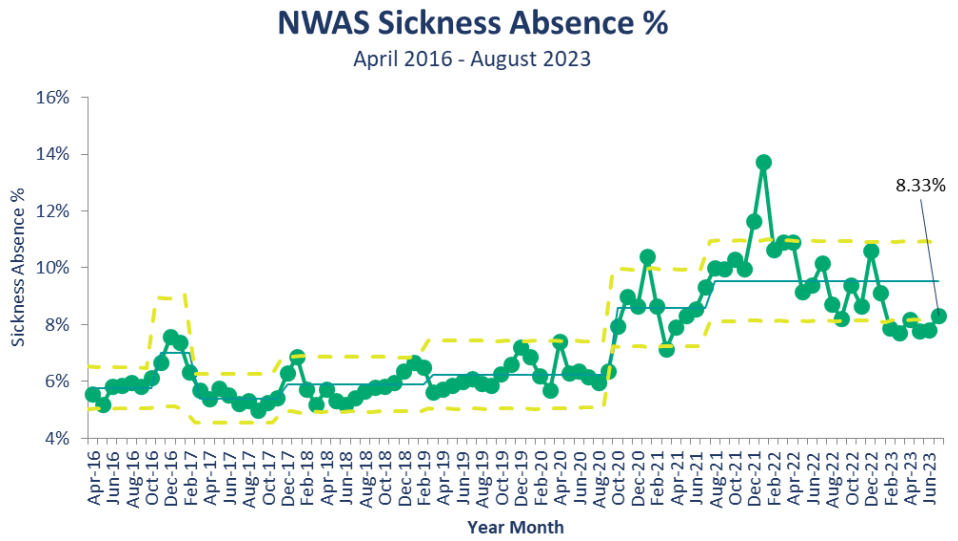


Table OH1.1

Sickness Absence	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Ju-23
NWAS	8.73%	8.21%	9.38%	8.64%	10.60%	9.11%	7.88%	7.71%	8.18%	7.77%	7.82%	8.33%
Amb. National Average	7.45%	7.56%	7.99%	7.66%	9.15%	7.71%	7.06%	6.82%	6.62%			

Figure OH1.2

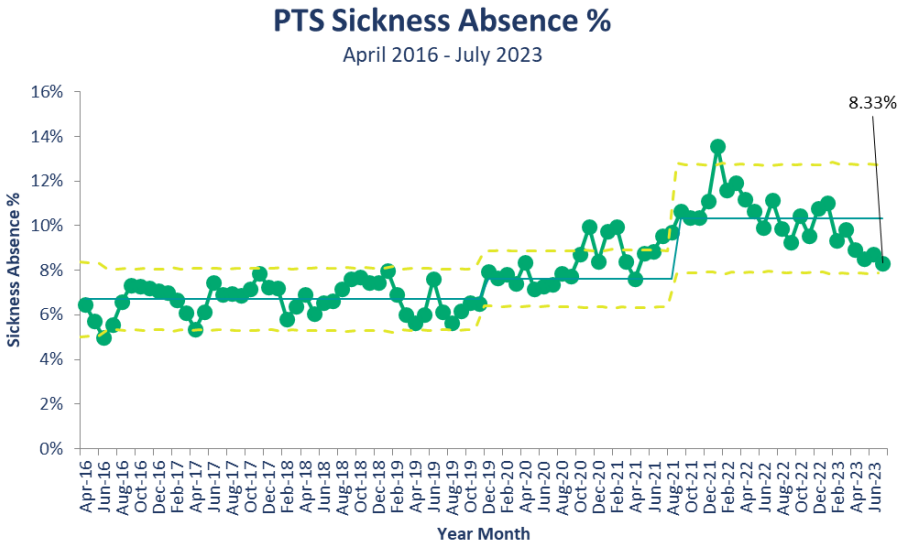


Figure OH1.3

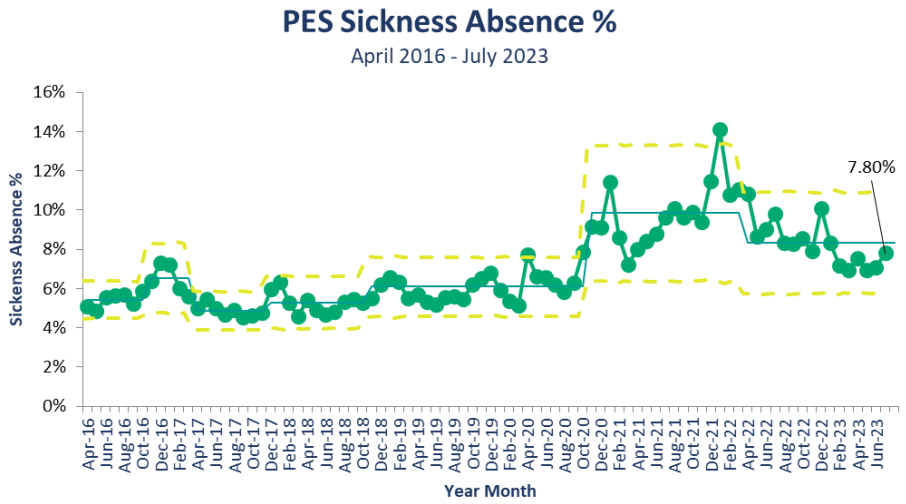


Figure OH1.4

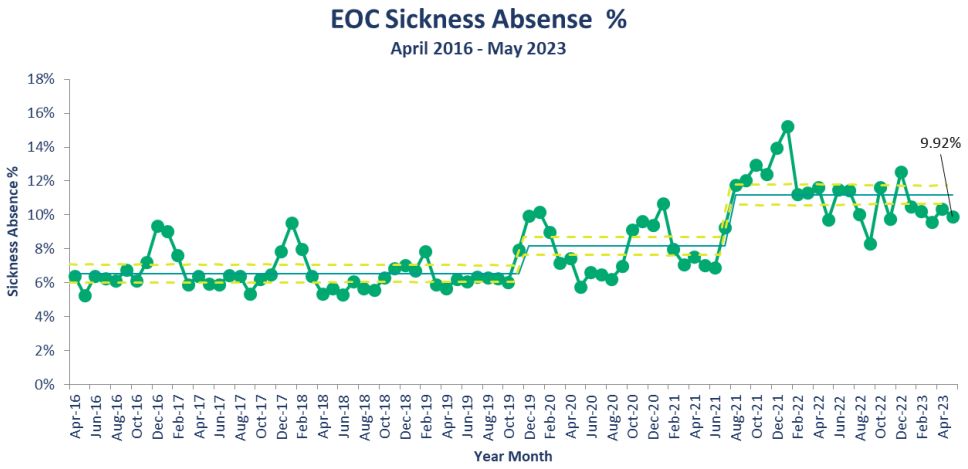
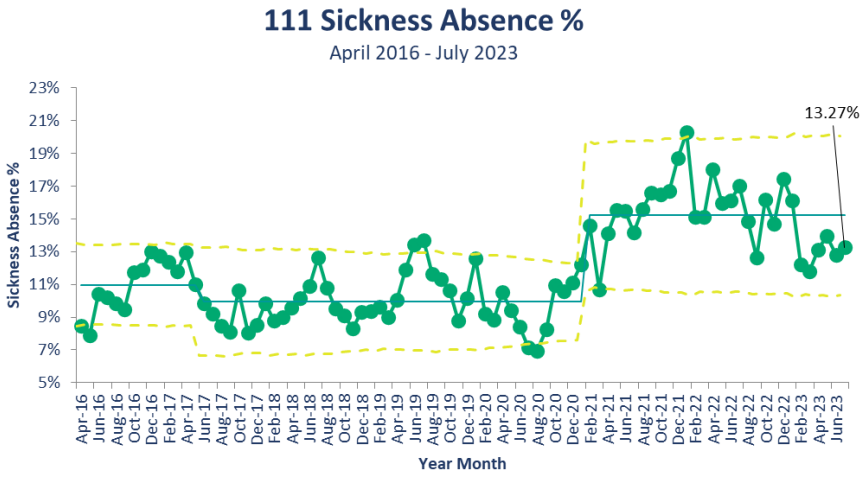


Figure OH1.5



OH2 STAFF TURNOVER

Figure OH2.1

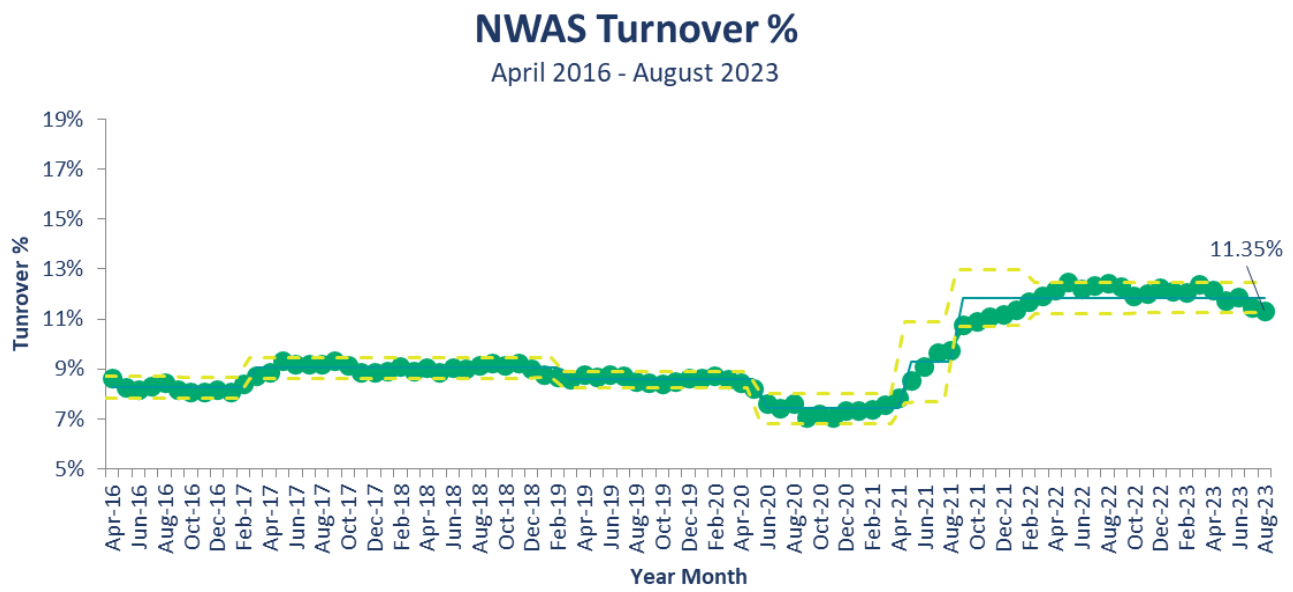


Table OH2.1

Turnover	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
NWAS	12.28%	11.94%	12.01%	12.28%	12.11%	12.09%	12.38%	12.15%	11.73%	11.87%	11.46%	11.35%
Amb. National Average	12.25%	12.19%	12.15%	12.16%	12.19%	12.21%	12.60%	12.17%	11.81%			

Figure OH2.2

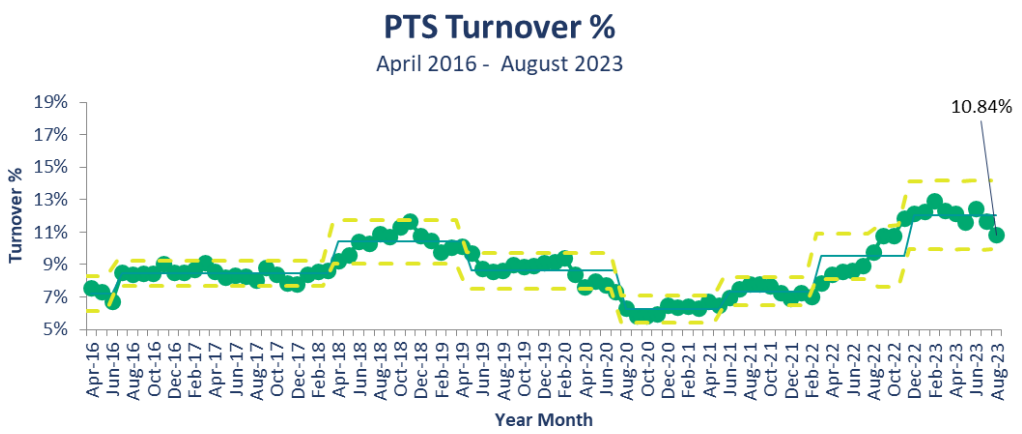


Figure OH2.3

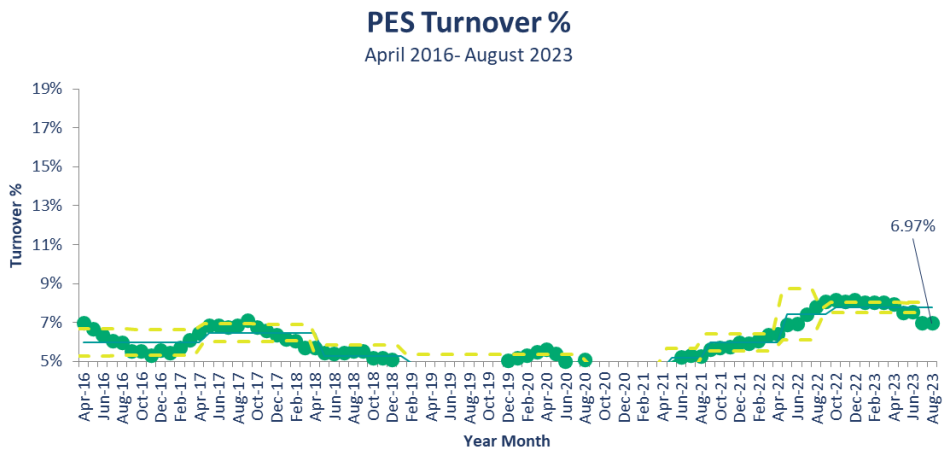


Figure OH2.4

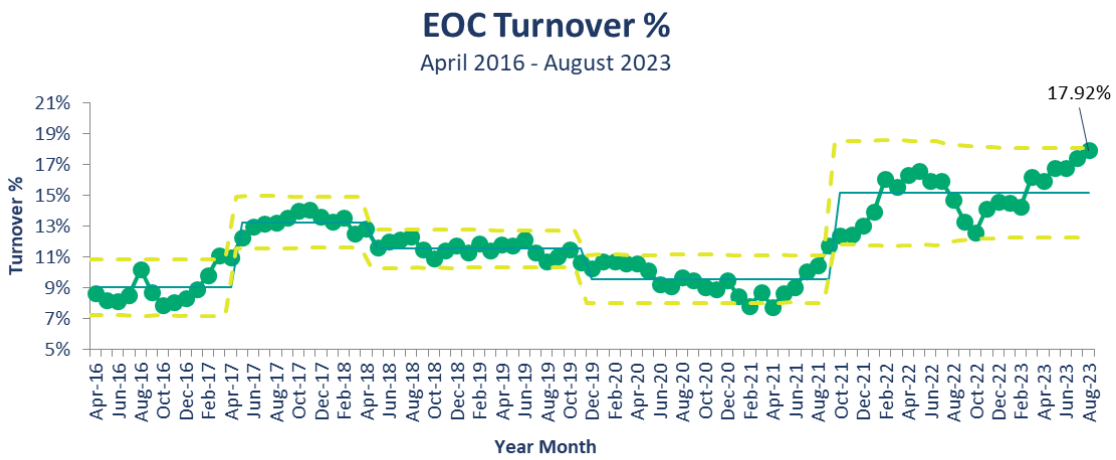
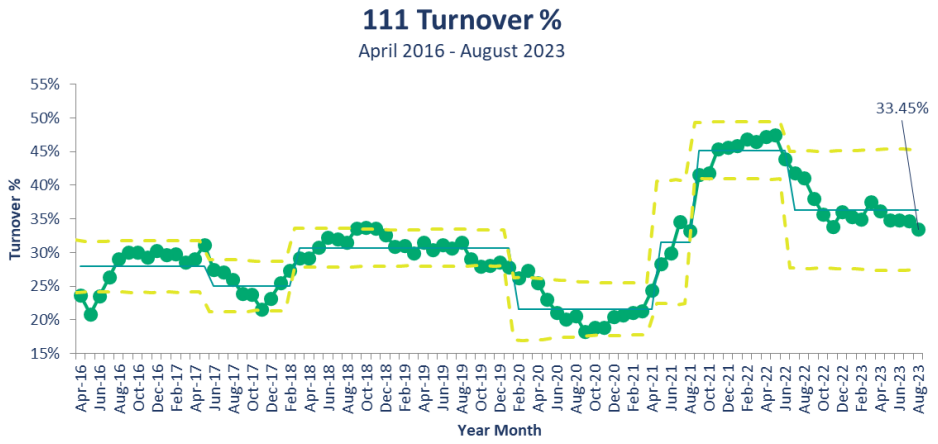


Figure OH2.5



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

OH4 TEMPORARY STAFFING

Figure OH4.1

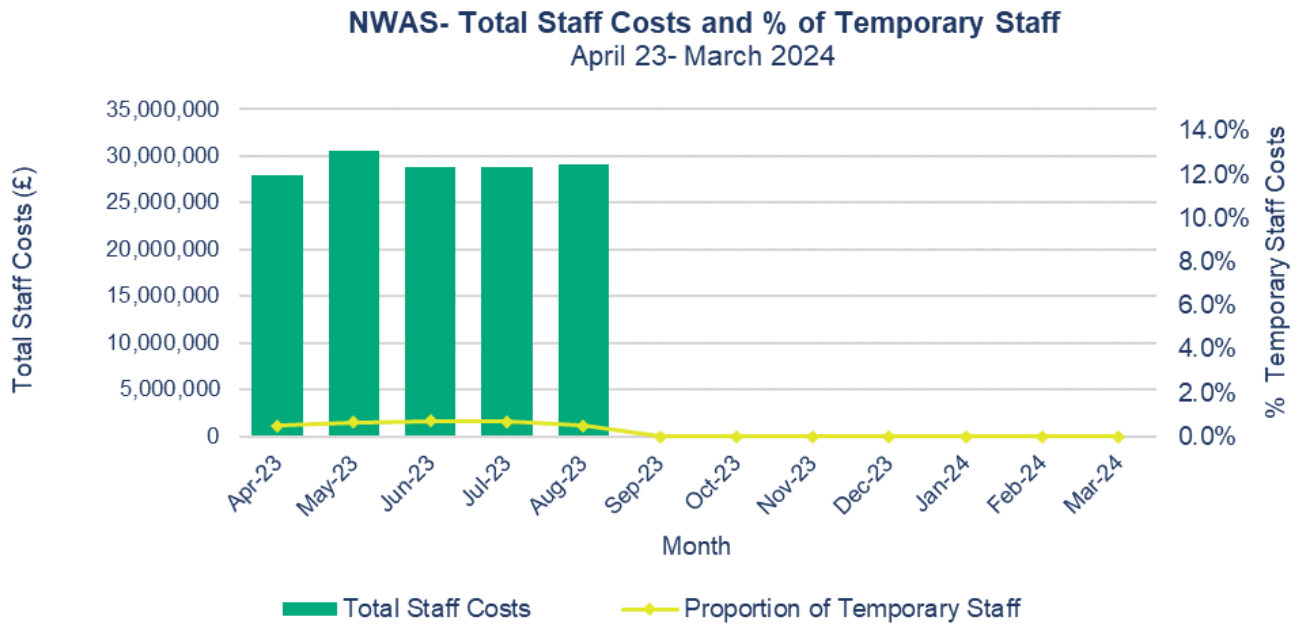


Table OH4.1

NWAS	Sep-22	Oct-22	Nov- 22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug -23
Agency Staff Costs (£)	279,546	176,850	159,947	157,417	140,004	107,701	191,258	135,492	200,114	207,520	192,594	147,684
Total Staff Costs (£)	29,946,339	27,740,005	27,494,954	27,204,469	27,041,860	26,856,025	56,312,765	27,882,122	30,582,073	28,815,903	28,871,609	29,127,865
Proportion of Temporary Staff %	0.9%	0.6%	0.6%	0.6%	0.5%	0.4%	0.3%	0.5%	0.7%	0.7%	0.7%	0.5%

Figure OH4.3

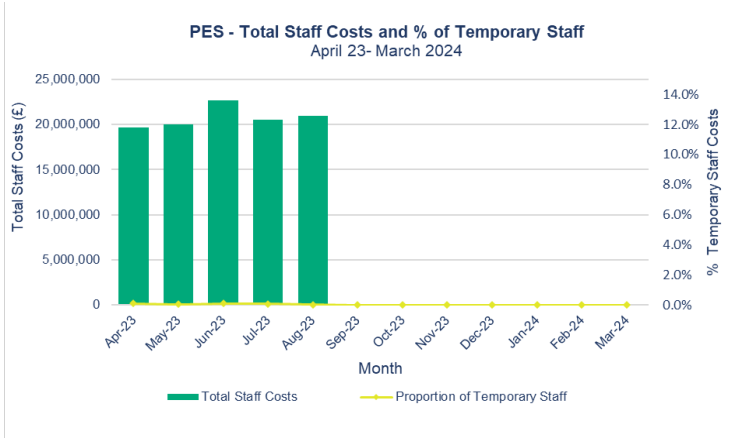


Figure OH4.4

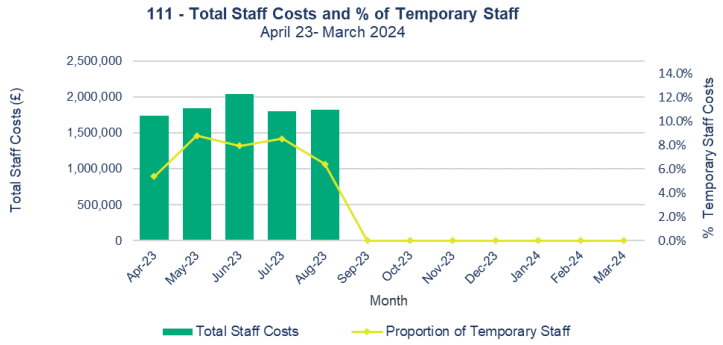


Figure OH4.5

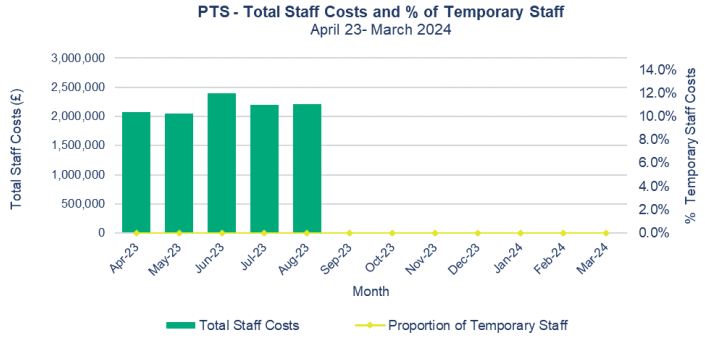
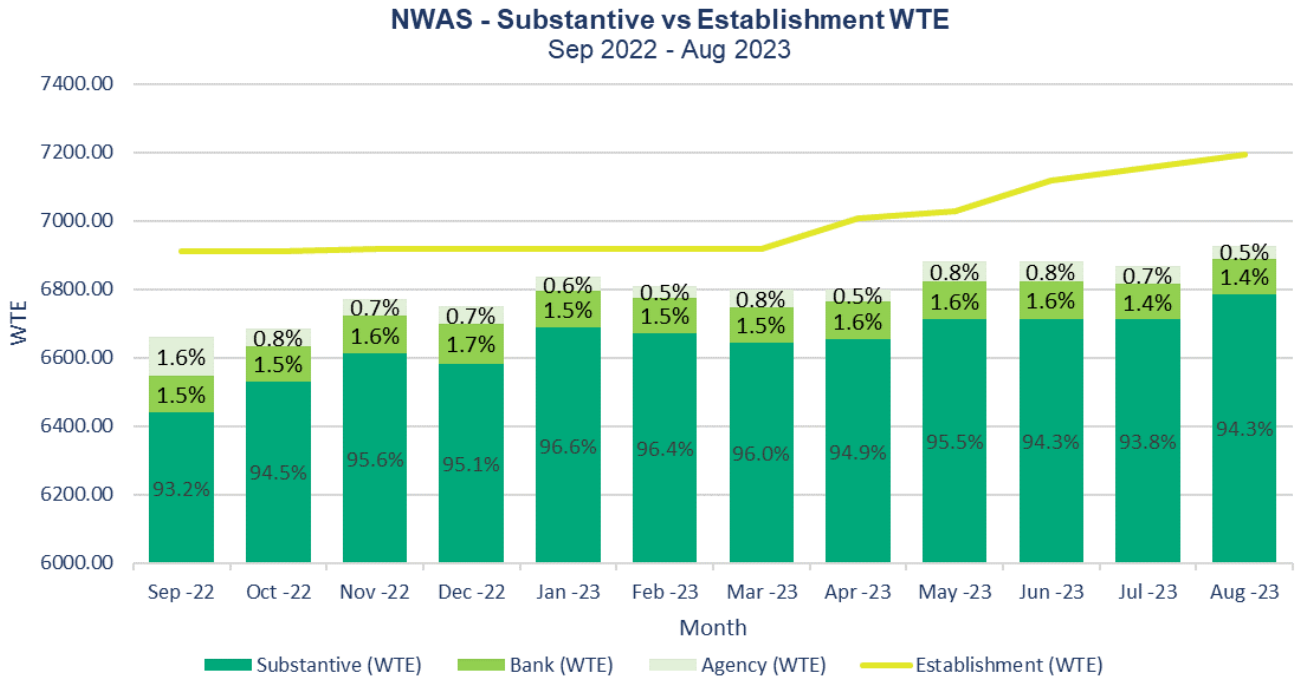


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

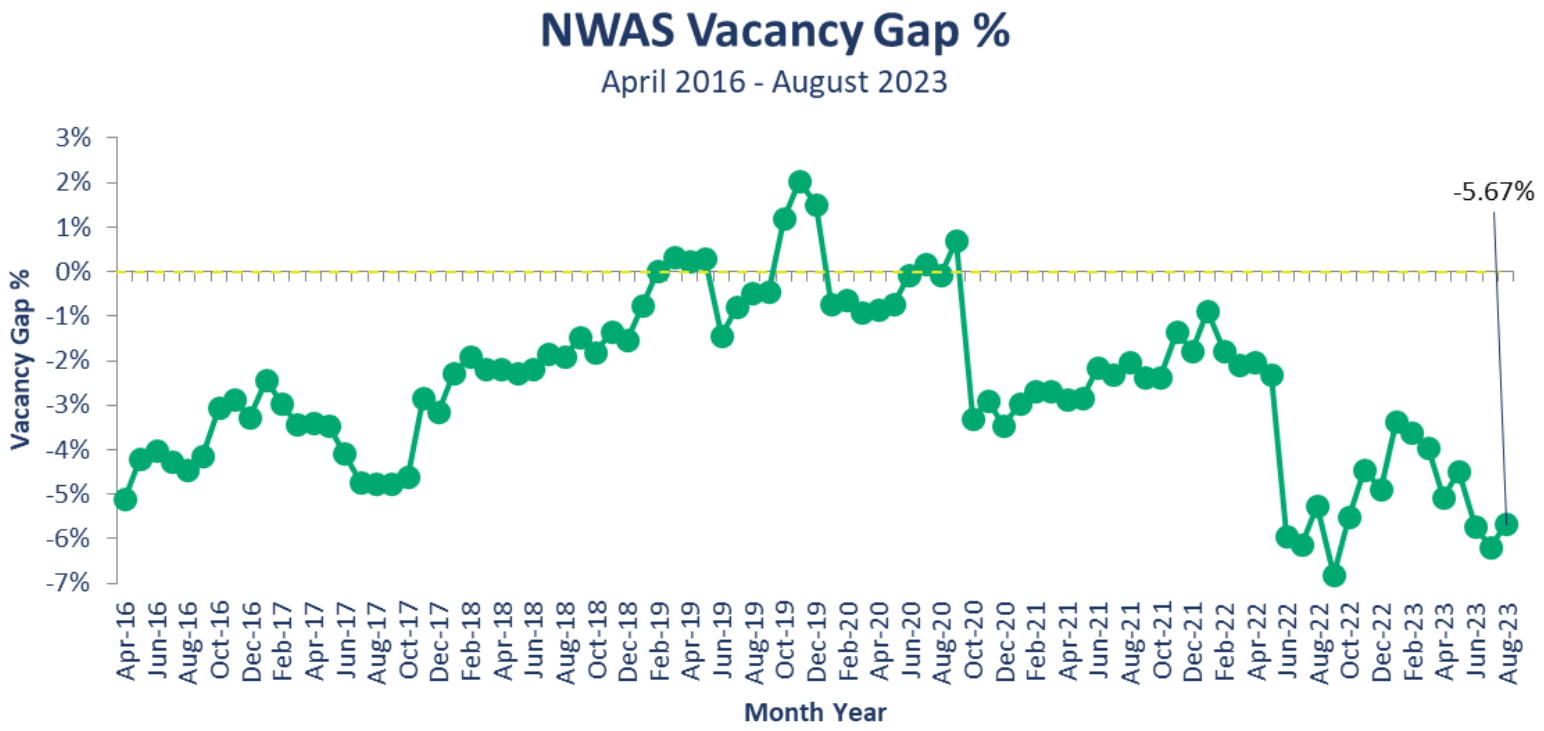


Table OH5.1

Vacancy Gap	Sep-22	Oct-22	N0v-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
NWAS	-6.81%	-5.51%	-4.44%	-4.88%	-3.35%	-3.61%	-3.96%	-5.08%	-4.49%	-5.72%	-6.18%	-5.67%

Figure OH5.2

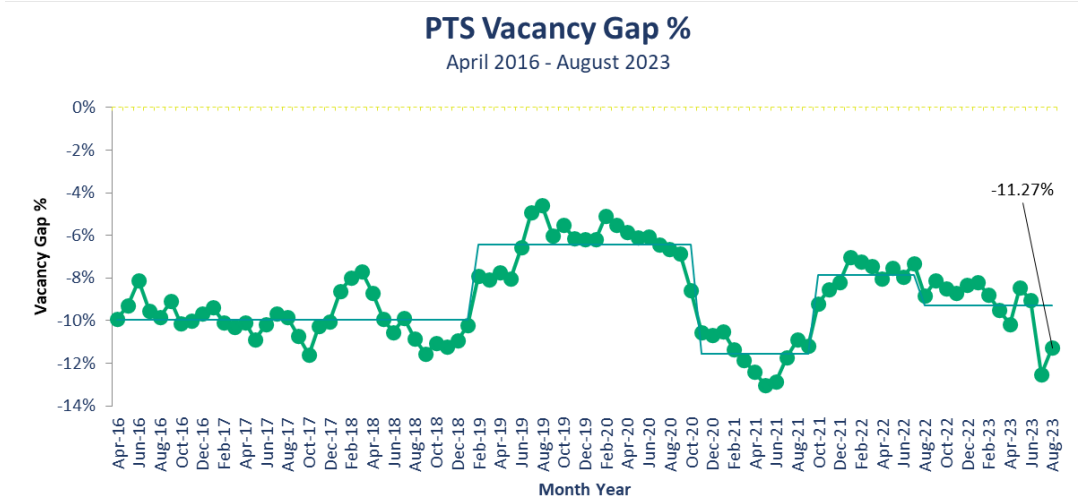


Figure OH5.3

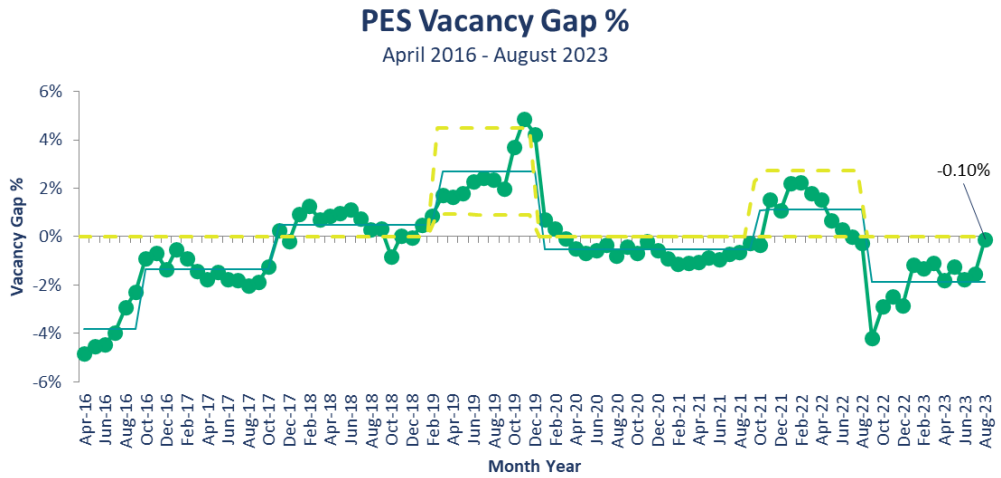


Figure OH5.4

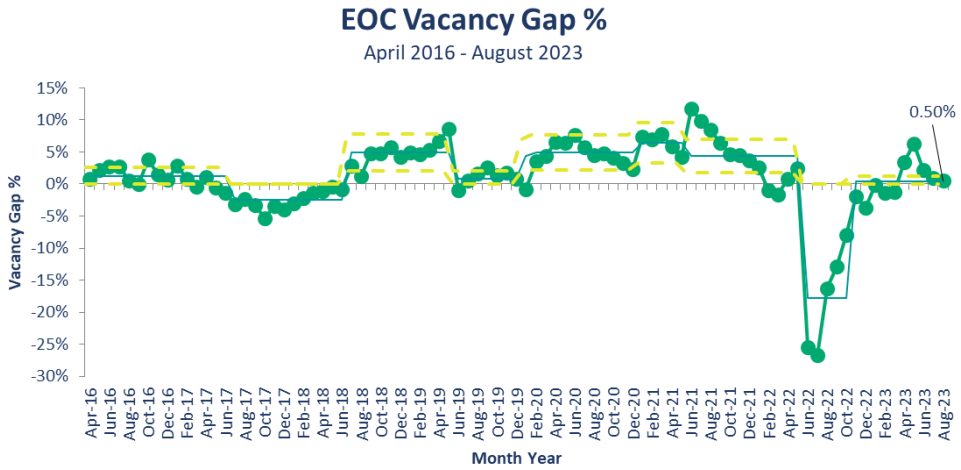
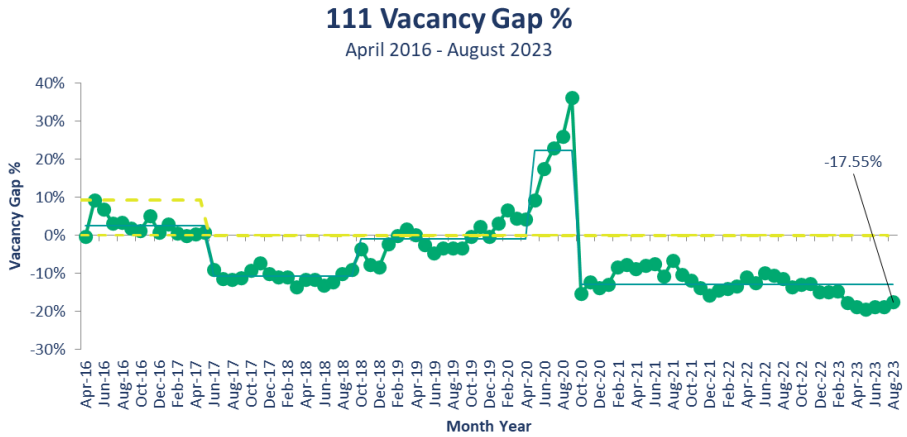


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

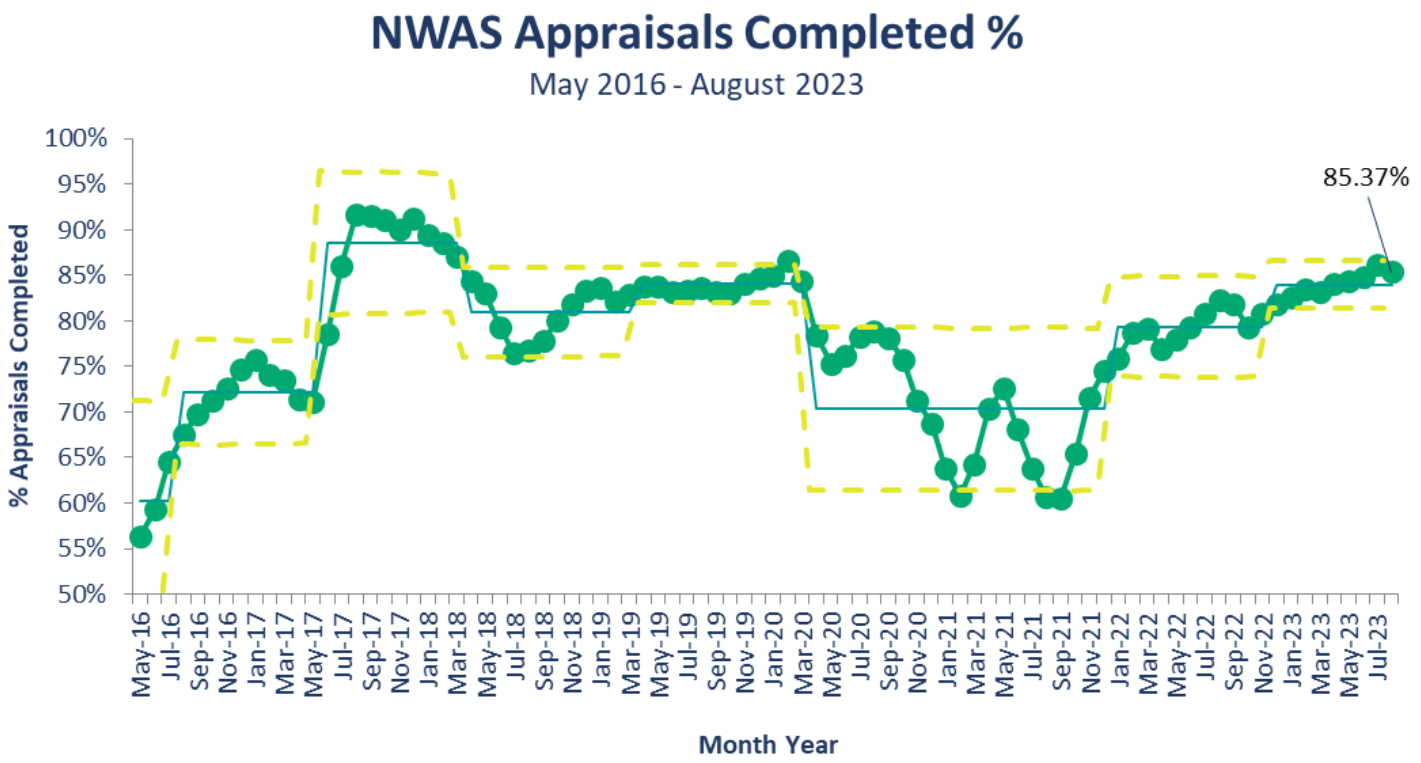


Table OH6.1

Appraisals	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22	Apr-22	May-23	Jun-23	Jul-23	Aug-23
NWAS	82%	79%	81%	82%	82%	83%	83%	84%	84%	85%	86%	85%

Figure OH6.2

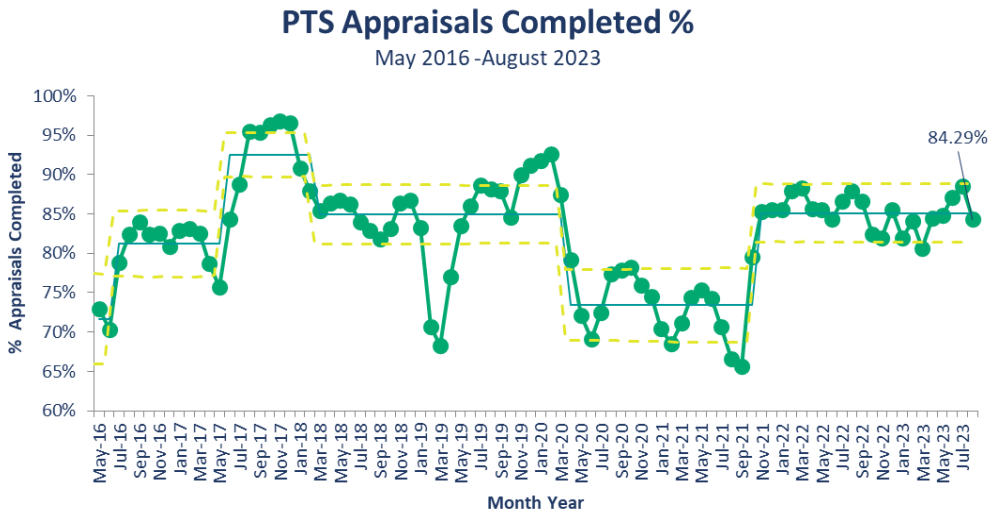


Figure OH6.3

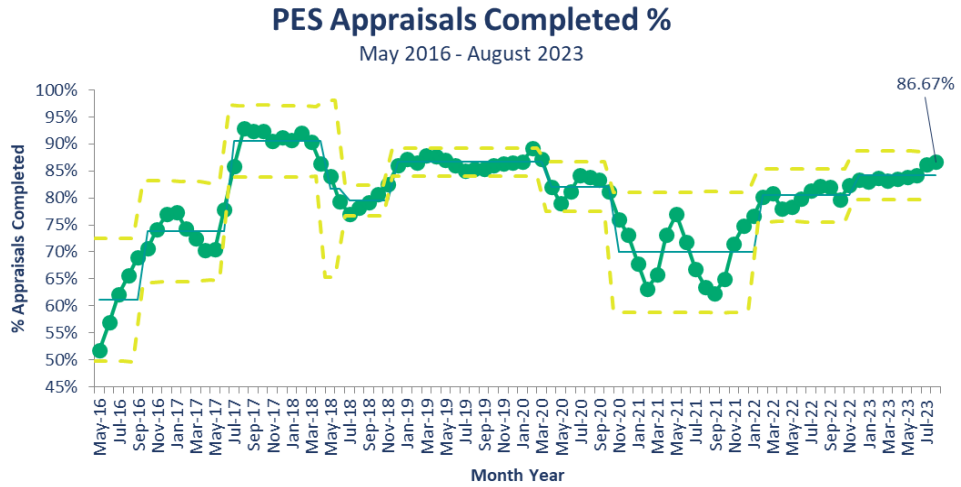


Figure OH6.4

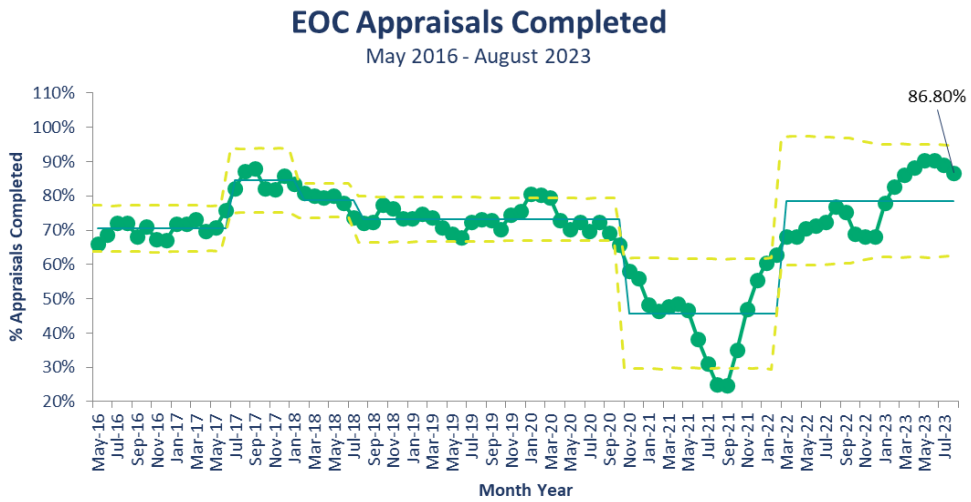
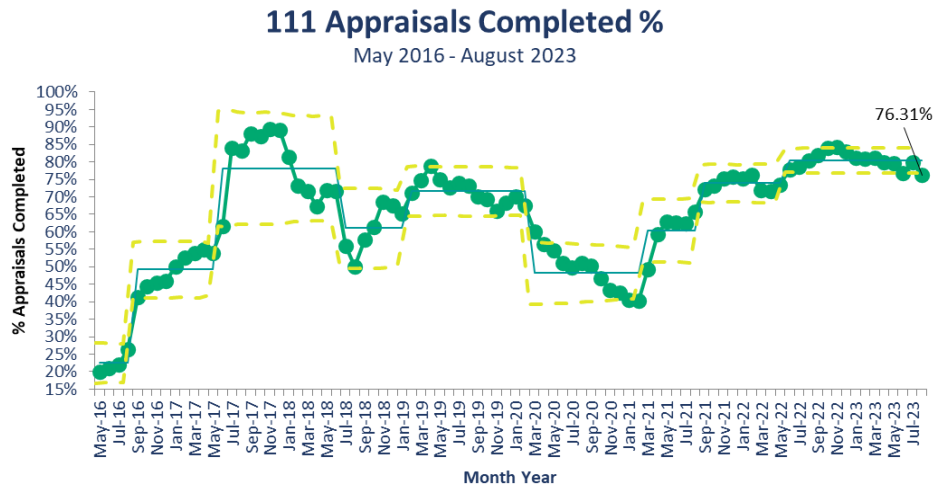


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

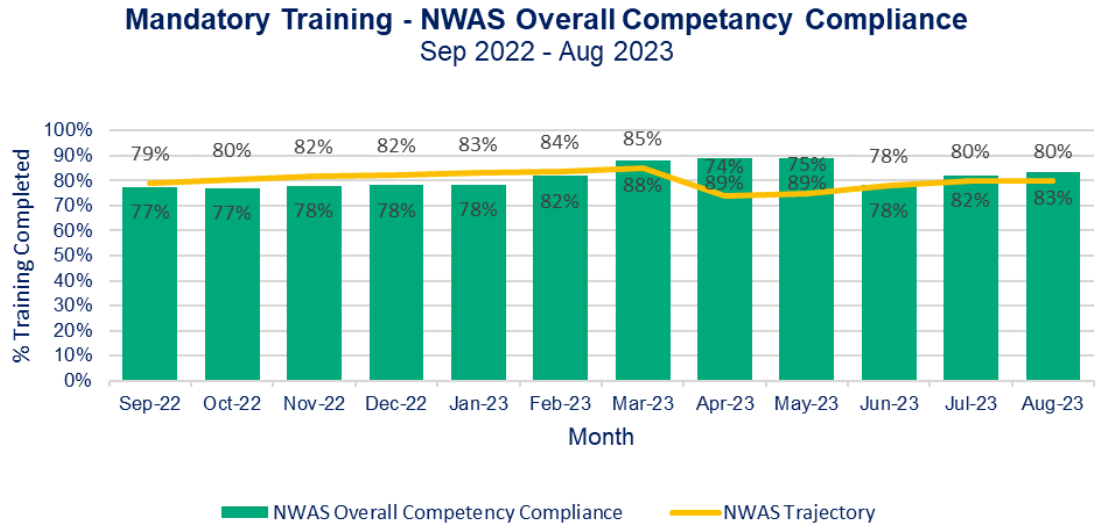


Figure OH7.2

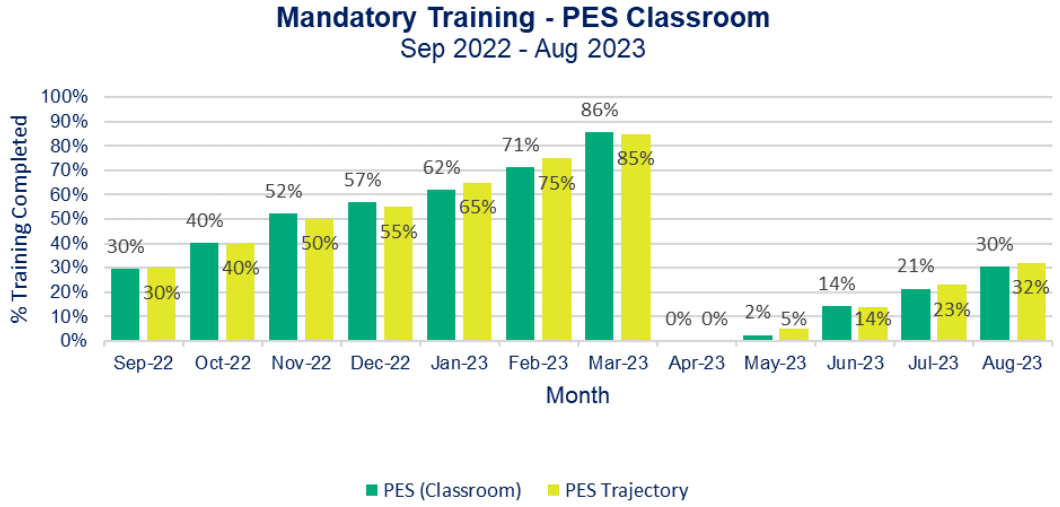


Figure OH7.3

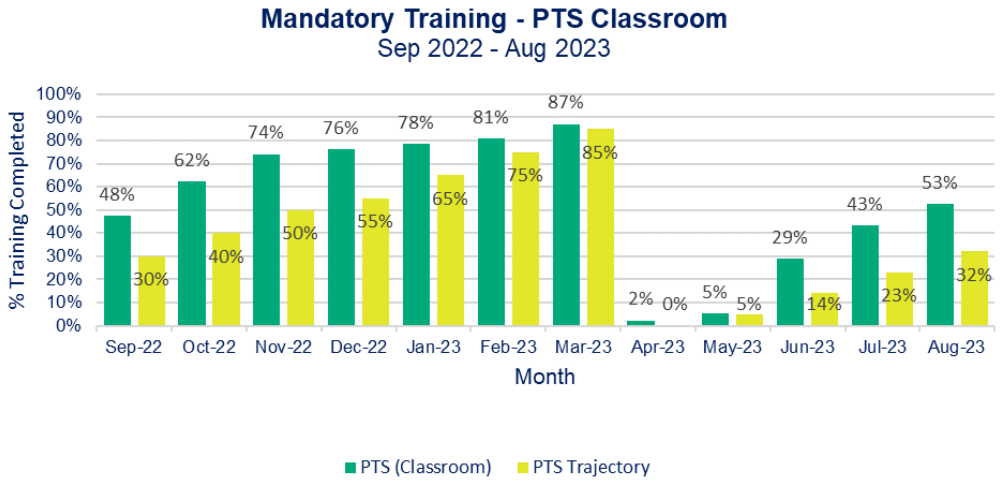


Figure OH7.4

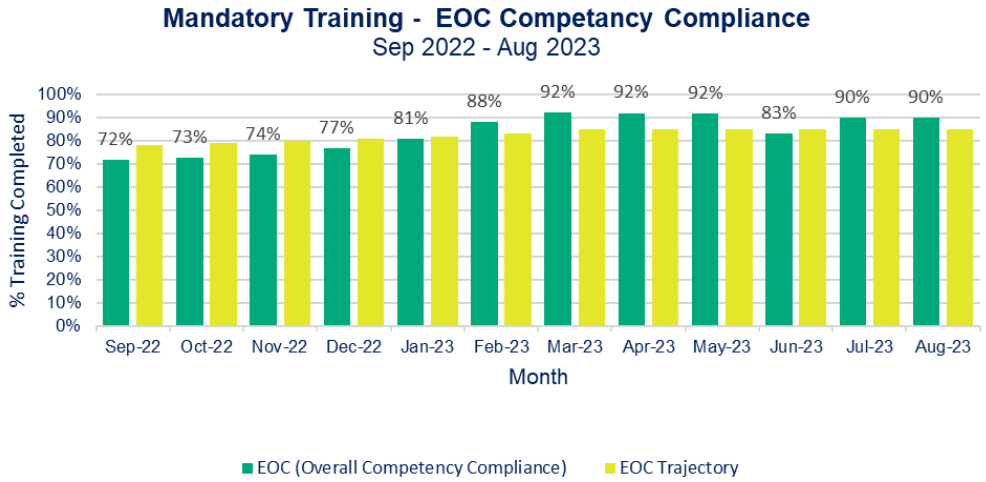


Figure OH7.5

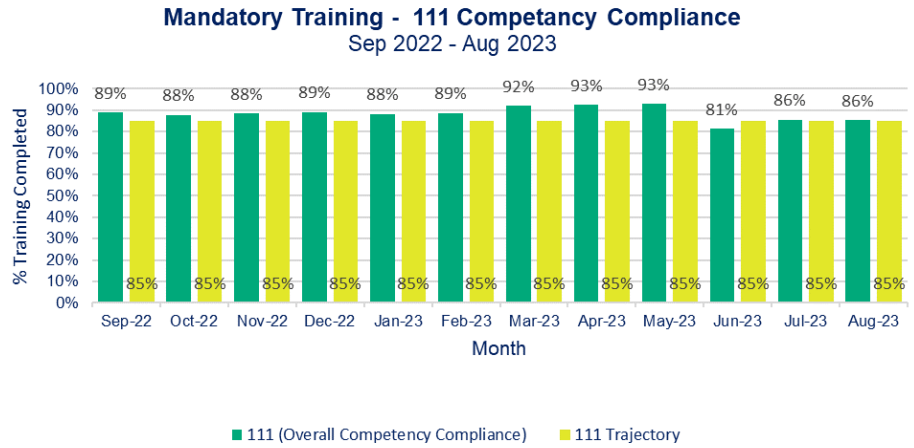
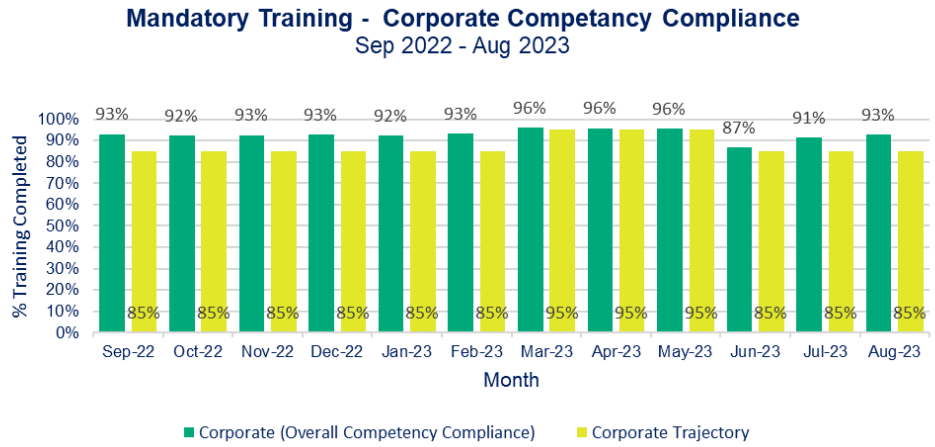


Figure OH7.6



OH8 CASE MANAGEMENT

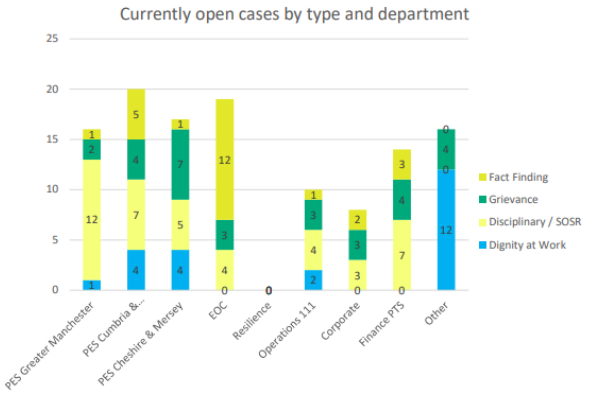
Figure OH8.1

Employee Relation Dashboard @ 05 September 2023. All information related to Dignity at work, Disciplinary, Fact Finding and Grievance cases only

NWAS Summary split by service line and sector

Service Line	Number of Live cases	Prevalence Live cases (numbers per hundred staff)	Number of cases closed in last 12 months	Prevalence closed cases in last 12 months (numbers per hundred staff)	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	53.00	1.3	195.00	4.8	13.96
CAM PES	17.00	1.3	59.00	4.6	18.90
CAL PES	20.00	1.5	53.00	4.0	12.29
GM PES	16.00	1.1	83.00	5.8	11.51
Operations ~ EOC	19.00	1.6	57.00	4.9	7.44
Operations ~ 111	10.00	1.6	58.00	9.4	5.89
Operations ~ PTS	15.00	1.5	63.00	6.1	8.48
Operations ~ Resilience	0.00	0.0	2.00	1.2	8.43
Corporate	8.00	1.5	21.00	3.8	10.01
Other	16.00		33.00		17.27
NWAS Summary	**121.00**	**1.6**	**429.00**	**5.6**	**11.23**

Other * - This included a number of incidents with several staff members involved, making it impossible to attribute them to a certain sector.



Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	23	47	22.45
Disciplinary	42	91	18.57
Fact Finding	25	177	5.21
Grievance	31	114	10.10
Case Summary	**121**	**429**	**11.23**

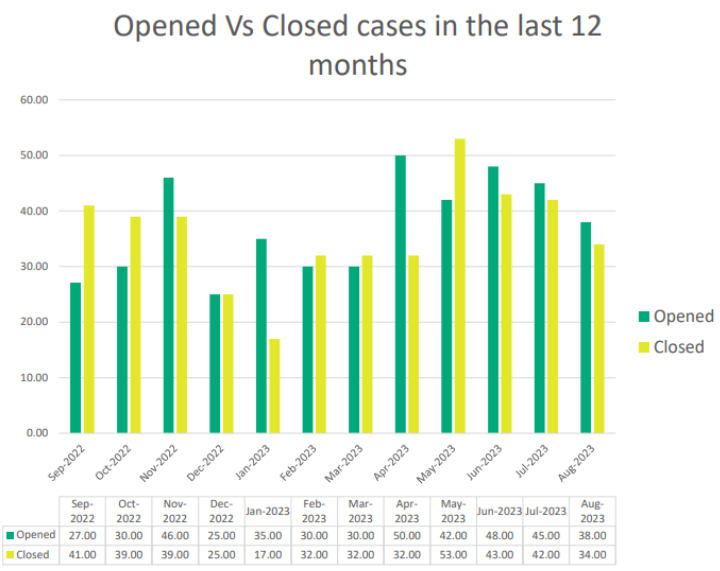
Length of current live cases by case type

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	12	9	2	0
Grievance	24	5	2	0
Fact Finding	22	2	1	0
Disciplinary / SOSR	20	11	8	3
Case Total	**78**	**27**	**13**	**3**

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

Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	14
SOSR	7
Police Investigation	6
Breach of social media policy	6
Poor patient care	6
NWAS Summary	**39**

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



	Sep-2022	Oct-2022	Nov-2022	Dec-2022	Jan-2023	Feb-2023	Mar-2023	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023
Opened	27.00	30.00	46.00	25.00	35.00	30.00	30.00	50.00	42.00	48.00	45.00	38.00
Closed	41.00	39.00	39.00	25.00	17.00	32.00	32.00	32.00	53.00	43.00	42.00	34.00

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 27th September 2023				
SUBJECT:	Infection Prevention and Control (IPC) Annual Report FY 2022/23				
PRESENTED BY:	Emma Orton – Assistant Director of Quality and Nursing and Director of Infection Prevention and Control (DIPC)				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☐	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The purpose of this paper is to introduce the Infection Prevention and Control Annual Report for 2022/2023. This report is a summary of the efforts and challenges the Trust has faced and overcome moving from the global pandemic and transitioning into 'business as usual' whilst acknowledging lessons learned. The Trust has adopted new national guidance to ensure there remains a significant focus on Infection Prevention and Control (IPC) to maintain both staff and patient safety and have considerable preparedness for any emerging infectious diseases. Assurance on delivery of IPC within the trust is monitored through the updated IPC Board Assurance Framework, which is presented to Quality and Performance Committee, as well as Board of Directors. The annual report aligns assurance and provides an understanding of the risks to the organisation during the reporting period. Risks: There are currently three risks aligned to IPC and two from the previous year have been closed. The current risks are; •There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods not suitable for all scenarios, staff are unable to respond safely to Aerosol Generating Procedures (AGPs) leading to risk to personal safety of staff. Score - 12 •There is a risk that due to lack of awareness or capacity 20% of sharps boxes found in sharps bins aren't correctly labelled and / or with temporary safety lock correctly activated resulting in no auditable trail and discarded sharps				

	bins leading to harm or injury to both NWAS staff and external clinical waste collection staff. Score - 8 •There is a risk due to the inaccuracies within the SafeCheck Audit tool that the Infection Prevention & Control Team are unable to gain adequate assurance on compliance with Infection Prevention & Control policies and procedures, leading to an unsafe environment for patients and staff. Score – 8 The report also outlines all other activities that the IPC team lead on, collaborative working with other Trust services and provides a summary of any mandatory reporting.
RECOMMENDATIONS:	The Board of Directors are asked to. • Note the content of the Report. • Note the assurances it provides. • Note the arrangements for ongoing monitoring via the IPC board assurance framework. • Note the key risks and mitigations. • Support the report for publication on the Trust website.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐

PREVIOUSLY CONSIDERED BY:	Infection Prevention and Control Sub Committee	
	Date:	Tuesday 12th September 2023
	Outcome:	Approved for onward submission to the Quality and Performance Committee
	Quality and Performance Committee	
	Date:	Monday 25th September
	Outcome:	Recommendation have not been confirmed as this paper was submitted prior to the Quality and Performance Committee outcome.

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1.	**STATEMENT BY THE DIRECTOR OF INFECTION, PREVENTION & CONTROL**
1.1	This report demonstrates that the Trust has continued to make substantial progress towards achieving the Trust's key priorities for Infection, Prevention and Control (IPC). We continue to be committed to promoting best practice in IPC and to maintain our clinical standards. During this period, we have collaboratively worked across our healthcare services to deliver our organisational work plan. Our IPC Practitioners work together to provide leadership, advice, and support to ensure compliance with the Health and Social Care Act (2008). The team facilitates learning across the Trust through training, education and from learning lessons from incident reports. National guidance and initiatives have been key drivers for elements of our annual work programme, and this evolving work stream will continue into 2023/24. IPC is the responsibility of everyone, and success is achieved when everyone works together. This annual report shows how we are performing, where we do well and where we plan to innovate and continuously improve our services.
2.	**PURPOSE**
	The purpose of this report is to provide the Quality and Performance Committee with an overview of Infection Prevention and Control activity for the Northwest Ambulance service (NWAS). The reporting period is 1 April 2022 until the 31 March 2023.This report will include all aspects of IPC activity and the ongoing response to the coronavirus pandemic and other emerging infectious diseases.
3.	**BACKGROUND**
	Effective systems for the management of Infection prevention and control (IPC) are essential for all NHS providers. NWAS has a legal duty to comply with the Health and Social Care Act 2008, specifically the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. Our approach to IPC is taken from the guidance published by United Kingdom Health and Security Agency (UKHSA) who remain the trusted NHS authority on the implementation of research evidence into NHS practice. The IPC policy is located on the NWAS Green Room and supplemented with several procedural documents for key areas of IPC practice. These policies have been reviewed this year in line with national guidance and have been approved at the IPC Sub Committee. The IPC team monitor compliance to IPC policies, procedures, and training via a series of audits which are carried out locally, by IPC specialist practitioners and by external assessors (such as UKHSA, environmental health and NHSE). During the year we have continued to work with digital teams to update systems to improve the IPC Audit dashboard which allows all service lines to input audit data and review their progress in real time. The dashboard

	also forms assurance reports which are presented to the IPC sub-committee. The team identify IPC practices from when things go wrong by reviewing IPC incidents through the Trust's incident management system, Datix Cloud IQ (DCIQ). Themes from incidents occurring in each area are used alongside audit data to inform our intelligence about which systems need to be improved, where additional training is required, or where risk management systems need to be put in place.
4.	**COMPLIANCE WITH REGULATORY CQC**
4.1	**CQC Assurance** In 2022/2023 the CQC continued to regulate providers using a risk-based model whilst moving towards their new regulatory model, which commenced in April 2023. Their approach during 2022/23 included several non-rated inspections in Urgent and Emergency Care services and 111 and ongoing routine engagement meetings and enquiries. On an annual basis, NWAS undertake Quality Assurance Visits (QAV) across all service lines. The purpose of QAVs is to provide assurance to the trust about the quality and safety of our 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. The IPCT are involved in the QAVs outlined above to provide a specialist oversight on the visit. Non-adherence to IPC policies and procedures are identified and inputted onto the Trust Integrated Action Tracker (IAT) for services to rectify – with the support of the team if required. Any non-compliance is monitored by a follow up IPC audit to ensure all actions have been addressed. The CQC's regulatory mode has recently changed, and as such the QAV is in process of being redesigned – the IPC Specialist Lead has worked with the Accreditation and Assurance Manager to ensure that the internal assurance systems related to IPC are aligned to CQC's new Quality Statements which have replaced the key lines of enquiry and prompts.
4.2	**Regulatory Compliance** The Health & Safety Executive (HSE) requires any deaths and injuries to be reported when a work-related accident has caused the injury. The HSE have national guidance on Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents. National RIDDOR reporting requires the activity to be reported using the methodology of number of incidents per 1,000 staff. The IPCT have worked closely with the Health and Safety Department in relation to staff reporting Covid because of occupational exposure. Staff cases have been reviewed on an individual basis

	in conjunction with the national and local guidance at the point of acquisition of covid. Other factors taken into consideration when assessing cases include community prevalence, exposure outside of the workplace and if the staff member is part of an outbreak reported in the workplace.
4.3	**Estates and Facilities Management** The Estates and Facilities team carry out compliance audits on all NWAS owned properties to ensure the sites remain safe, clean, well maintained and all associated equipment are in a safe operational condition. The team ensures that appropriate maintenance and inspection records are held centrally and comply with statutory legislation. The Head of Facilities Management has attended the IPCSC to provide assurance in relation to HSE legislation to include, but not limited to, the management of; asbestos, water safety, gas & electrical safety, portable appliance testing, air conditioning and air monitoring safety with planned preventative maintenance in addition to reactive maintenance undertaken in line within current contract specifications. The IPC Specialist Lead is a member of the Water Safety Group that commenced this year in line with the requirement in the Health and Social Care Act. A Trust Water Safety plan has been developed and approved by the group. Results of regular monitoring of water samples are reported to the group and any anomalies are recorded on a central database which is monitored by the estates and facilities department and action taken accordingly to address any issues identified which are out of normal parameters. The IPCT are involved at the planning stage of refurbishment and new builds across the organization. The team ensure that these plans include facilities so that the organization are compliant with national guidance on safe disposal of waste, safe disposal of sharps, to store clean linen, have adequate storage for sterile, single use items and that all areas are fitted with surfaces that are able to be cleaned easily with the required cleaning materials.
5.	**IPC GOVERNANCE ARRANGEMENTS**
5.1	In NWAS the corporate responsibility for Infection Prevention & Control sits with the Assistant Director of Nursing and Quality, who is also the Director of Infection Prevention and Control (DIPC). The DIPC provides assurance to the Board and the wider Executive Team through assurance reports, the annual plan, and the IPC Board Assurance Framework. The DIPC is responsible for the Infection Prevention and Control Team. The team is now fully staffed and consists of 1 x Infection Prevention and Control Specialist Lead, 1 x IPC Manager, 4 x IPC Practitioner (1 x on secondment), 1 x IPC Administrator (secondment). The team sits within the Quality, Improvement and Innovation directorate and are overseen by the Assistant Director of Quality, Chief Nurse, Director of Infection, Prevention & Control (DIPC).
5.2	

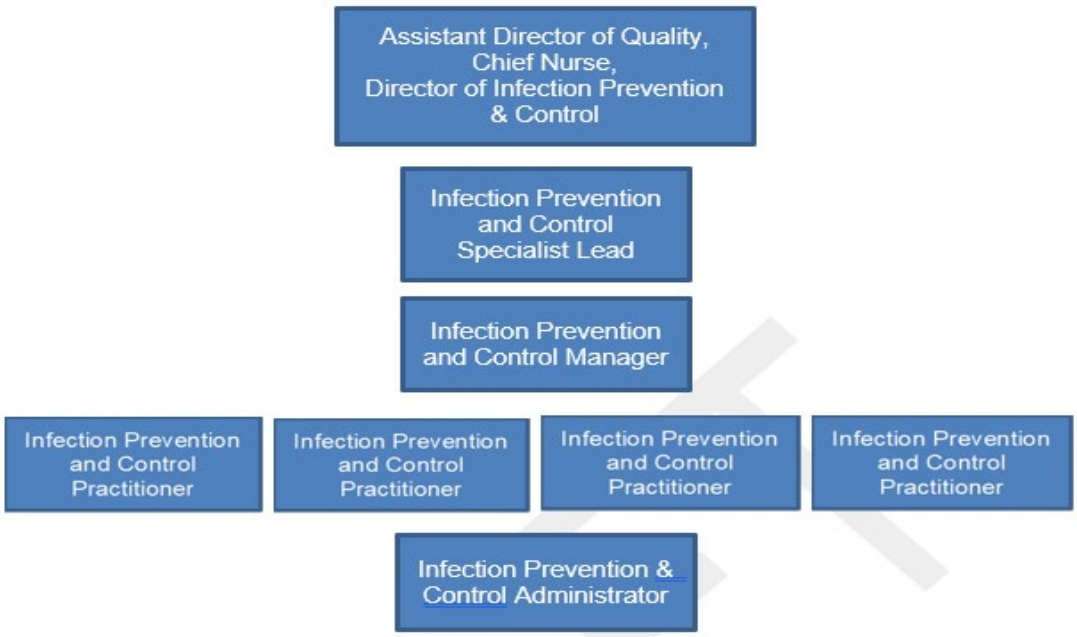


Chart 1 demonstrates the structure of the Infection Prevention and Control Team.

5.3 Progress Against BAF Key Lines of Enquiry

The IPC Board Assurance Framework has been revised in line with the code of practice (the code) on the prevention and control of infections under the Health and Social Care Act 2008 (H&SCA 2008). This act sets out the overall framework for the regulation of health and adult social care activities by the Care Quality Commission (CQC). The Code was reviewed and published in December 2022 to reflect changes brought about by the pandemic and the requirement to move away from the IPC 'Covid' BAF's that were published during the pandemic. The revised BAF is also a reflection of the updated national guidance in terms of the National IPC Manual and the requirement to return to 'business as usual'.

Part 2 of the code sets out the 10 criteria against which the CQC will judge a registered provider on how it complies with the IPC (including cleanliness) requirements, which are set out in the BAF. To ensure that consistently high levels of IPC (including cleanliness) are developed and maintained, it is essential that all providers consider the whole document and its application in the appropriate sector and not just selective parts. A number of sections have been highlighted as 'Not Applicable' for ambulance services as they relate to Antimicrobial Stewardship, Inpatient isolation facilities and access to pathology services. Assurance is provided by providing evidence against each criteria and mitigating actions where the criteria are not fully met.

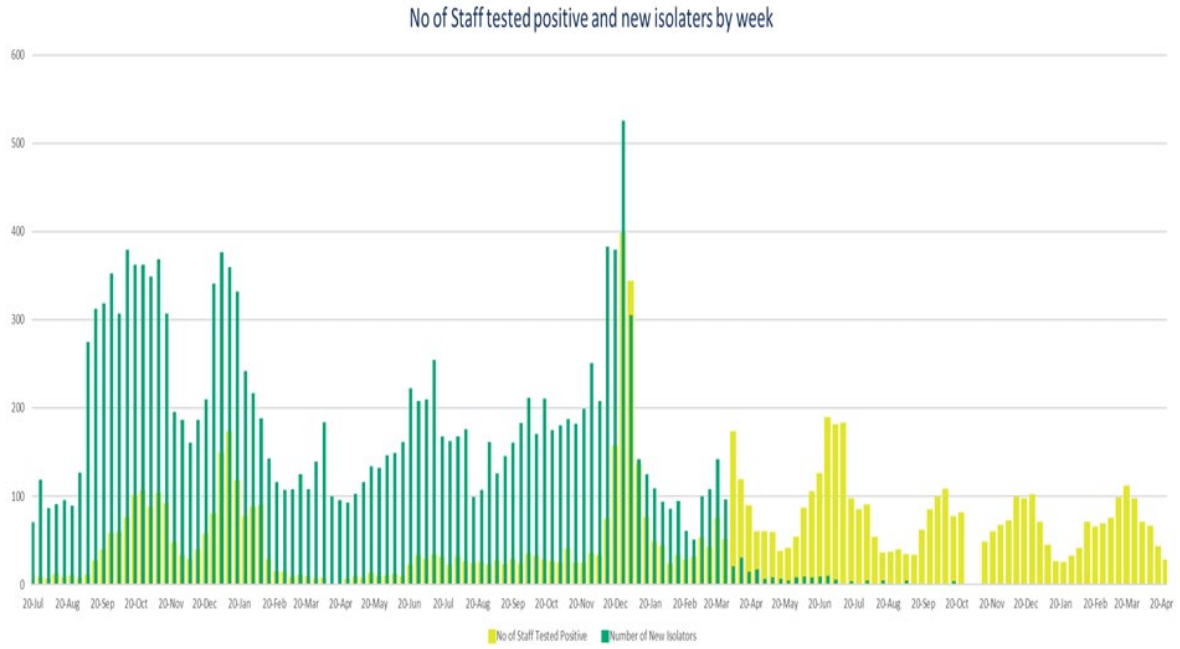
Important to note is the significant improvements made within NWAS relating to IPC – there are no longer any red rated criteria. NWAS is rated green for all criteria (where is it applicable)

	bar 8 amber rated key lines of enquiry. Mitigating actions for these amber rated criteria are included in the document – which include fit testing and standards of cleanliness (which we are awaiting a national document for cleanliness specifications particular to the ambulance service to benchmark). The IPC risks are reviewed monthly, and the IPC BAF will be reviewed 6 monthly at IPC SC – or sooner as required in lien with national guidance. The most up to date version was approved by the Quality and Performance Committee in July.
5.4	**Provide and Maintain a Clean Environment** During the year 2022-2023 environmental cleaning reverted to pre-pandemic levels for non-clinical areas in line with national cleanliness standards. Escalation measures were re-instated in line with national guidance. Vehicles continued to be cleaned daily and in between patients. Enhanced cleaning continued to be undertaken for suspected or confirmed infection cases and where Aerosol Generating Procedures (AGP's) had been undertaken within the vehicle. All Trust vehicles undergo a 6 weekly deep clean carried out – deep clean audit data is presented at the IPCSC for assurance. The IPCT also carry out unannounced audit on vehicles after a deep clean prior to the vehicle going back out on the road. Any issues identified are then escalated to the Fleet Logistics Manager who is responsible for monitoring the contract.
5.5	**Provide Suitable Information on Infections for Staff and Patients** National guidance and local operating processes were disseminated regularly to staff via bulletins, social media, internal intranet, and the IPC Sub-committee. All training materials for staff and volunteers were reviewed throughout the reporting period. Local risk assessments, guidance and procedures remain in place to ensure that patients are appropriately triaged and assessed for level of risk prior to transportation where possible. Liaison with other health care providers in relation to patients with transmissible infections ensures the risk of onward transmission is minimised.
6	**ASSURANCE**
6.1	The NWAS Board Assurance Framework includes a strategic risk related to the safe delivery of high-quality care which is articulated as follows: 'If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety'.

6.2	**IPC Risk Management** During 2022/23 risks in relation to COVID-19 and Infection Prevention and Control (IPC) have been aligned, managed, and monitored as part of the COVID-19 Board Assurance Framework (BAF), in addition to the organisational Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). This Board Assurance Framework was developed to monitor NWAS standards against key healthcare criteria and provided evidence and assurance surrounding the management of any risks identified. Risks are continually reviewed, re-assessed, and added to the organisational risk register. The BAF continues to be reviewed on a quarterly basis. BAF updates are presented to the Quality and Performance Committee and the Audit Committee for assurance, prior to the Board of Directors. The Executive Leadership Committee monitors the organisational management of the BAF. The system for reporting risks has changed over the last 12 months from Datix to DCIQ. There are currently three risks that are aligned to IPC: • There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods not suitable for all scenarios, staff are unable to respond safely to Aerosol Generating Procedures (AGPs) leading to risk to personal safety of staff. • There is a risk that due to lack of awareness or capacity 20% of sharps boxes found in sharps bins aren't correctly labelled and / or with temporary safety lock correctly activated resulting in no auditable trail and discarded sharps bins leading to harm or injury to both NWAS staff and external clinical waste collection staff. • There is a risk due to the inaccuracies within the SafeCheck Audit tool that the Infection Prevention & Control Team are unable to gain adequate assurance on compliance with Infection Prevention & Control policies and procedures, leading to an unsafe environment for patients and staff. These 3 risks have been reviewed monthly and updated as further actions and mitigations have been put in place, this is reported via the IPC Sub Committee for assurance. Of these three risks, only one risk has a risk rating of 12 by the end of March 2023 – this risk has been carried over from the previous financial year. The other 2 risks have been added this year. All risks identified are in relation to areas highlighted in the report, including areas of improvement and additional assurances.
6.3	**Risks Scoring >12**

	Risk ID 236 (12) There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods not suitable for all scenarios, staff are unable to respond safely to Aerosol Generating Procedures (AGPs) leading to risk to personal safety of staff. During 2022/23 this risk has increased from an 8 to a 12- this was due to the withdrawal of the national funding for the support of a third-party provider to provide fit testing for NHS providers. Although some fit testing is being completed within NWAS it is not in sufficient numbers to ensure staff are all compliant with the health and safety national requirements. To mitigate the risk an options appraisal has been developed and is due to be presented at ELC. **New Risks Identified During 2022/23** In May 2022 a new risk (ID 255) was identified with a score of 8 - There is a risk that due to lack of awareness or capacity 20% of sharps boxes found in sharps bins aren't correctly labelled and / or with temporary safety lock correctly activated resulting in no auditable trail and discarded sharps bins leading to harm or injury to both NWAS staff and external clinical waste collection staff. Due to ongoing issues with the audit data collection tool in July 2022 a new risk (ID 322) was placed on the risk register with a score of 8. There is a risk due to the inaccuracies within the SafeCheck Audit tool that the Infection Prevention & Control Team are unable to gain adequate assurance on compliance with Infection Prevention & Control policies and procedures, leading to an unsafe environment for patients and staff.
6.4	**Mitigated Risks (Closed) During 2022/23** Risk ID 3517 was closed in May 2022 - There is a risk that due to the non-compliance of level 2 PPE and in particular mask wearing in ambulance cabs and in ambulance stations, the risk of transmission of COVID 19 has increased between staff members. This risk was impacted by a change to national guidance, that no longer mandated the use of mask wearing in cabs – although masks were available for crews if they wanted to wear them.
7.	**POLICES AND PROCEDURES**
7.1	The Infection Prevention and Control Specialist Lead attended the weekly National Ambulance Service Infection Prevention and Control Group (NASIPCG) and contributes to AACE guidance prior to approval. Once the AACE guidance is approved the IPCT work closely with Communications in NWAS to ensure an update bulletin is distributed to inform staff of any changes and the IPCT also support the Heads of Service in implementing the necessary changes. The trust IPC Policies and Procedures are regularly reviewed and updated to ensure they are aligned to national best practice guidance. Going forward into next year we have a

	requirement to review and update our IPC policies and procedures to ensure we are incorporating a national standard of good practice from the National Infection, Prevention & Control Manual (NIPCM). Work has begun in earnest. NWAS also has responsibility to keep its internal policy and procedures in place in line with the Health and Social Care Act – the current policies that are in place include: • Infection Prevention and Control Policy • Health, Safety and Security Policy • Wound Care Policy • Peripheral Intravenous Cannulation Policy • Linen Policy • Aseptic Non-Touch Technique Policy • Respiratory Protective Equipment Fit Testing Policy The IPC Team monitor compliance to our policies, procedures, and training via a series of audits which are carried out locally, by IPC specialist practitioners and also by external assessors (such as the United Kingdom Health & Security Agency (UKHSA), Environmental Health, NHSI and NHSE). We have continued to develop our IPC Audit Dashboard which allows all service lines to digitally input audit data and review progress in real time. We also learn about IPC practices from when things go wrong by reviewing IPC incidents through our incident management system, Datix IQ. The themes from incidents occurring in each area are used alongside audit data to inform our intelligence about which systems need to be improved, where additional training is required or where risk management systems need to be put in place.
8.	**GOVERNANCE**
8.1	The Trust's Infection Prevention and Control (IPC) Sub Committee continues to meet bi-monthly to ensure ongoing adherence to regulatory compliance. The IPC Sub Committee's terms of reference were formalised, encompassing monitoring of Respiratory Protective Equipment (RPE) usage, and conducting audits of RPE. Even though government guidelines have since been revised, the inclusion of the IPC Sub Committee as a crucial element of IPC governance has become a permanent fixture of NWAS's operational structure. Areas and service lines provide and present an assurance report to the sub-committee. All staff members are mandated to report sickness and COVID-19-related absences to Carlisle Support Centre initially and follow the usual departmental sickness absence

	reporting procedures. This reporting process allows NWAS to generate various reports using the acquired data. The IPCT monitored sickness information provided daily by the Business Intelligence team to evaluate the need to declare an outbreak at specific locations in liaison with service managers. The first chart in this report (Chart 1) illustrates the total count of COVID-19 positive tests per month reported to the Support Centre throughout 2022/23 
8.2	**Test Track and Trace Service (TTT)** The TTT service was crucial during the pandemic, however following the change in national guidance which removed the requirement for individuals to isolate after close contact with a positive covid patient, the service was no longer considered necessary. In July 2022 the TTT team disbanded, and the staff resumed their previous positions. The IPCT absorbed the outbreak management function of the TTT service.
8.3	**Outbreak Management** During the 2022-23 period, the Northwest Ambulance Service (NWAS) continued to report occurrences of COVID-19 outbreaks as per the epidemiological definitions outlined in the United Kingdom Health and Security Agency (UKHSA) document titled "COVID-19: Epidemiological definitions of outbreaks." These outbreaks are declared by an Infection Prevention and Control practitioner and are defined as instances where two or more cases of COVID-19 are linked in either time or place. Within the ambulance service, this could entail

	cases linked to specific stations, call centres, or between crew members that have emerged within 14 days of the first identified case, also known as the index case. The IPC team took the responsibility to monitor the outbreak to ensure an efficient and coordinated response to COVID-19 outbreaks within NWAS, from the initial detection phase to the formal closure and review of lessons learned. It encourages a uniform approach across all levels of NWAS and includes a set of response standards for a declared outbreak.
8.4	**Outbreak Reporting** NWAS has been reporting any Covid outbreaks via the national portal as part of its regulatory compliance obligations. Specifically, a standardised IIMARCH notification form was meticulously completed for every newly identified outbreak and promptly submitted to NHSE/I. These notifications were critical in ensuring that appropriate measures were in place to mitigate the spread of the outbreak and that any potential risks were swiftly identified and addressed. The IIMARCH form contains a concise summary of the facts surrounding the outbreak, the actions taken thus far, and any additional measures deemed necessary to manage the situation effectively.
8.5	**Outbreak Data** During the period spanning from April 1st, 2022, to March 31st, 2023, a cumulative total of 22 outbreaks of Covid were recorded across the complete geographical coverage of NWAS. These outbreaks were spread across the entirety of NWAS's operational footprint.
8.6	**Lateral Flow Testing** All NWAS staff were strongly advised to undergo asymptomatic lateral flow testing twice weekly as per national guidance. This ongoing practice serves to minimise the transmission of the COVID-19 virus within the healthcare setting, thereby safeguarding both staff and patients. NWAS relied on lateral flow testing as the first line of defence in its regular testing regimen for all personnel. The primary objective of asymptomatic lateral flow testing is to proactively minimise the spread of COVID-19 among staff and between staff and patients, thus reducing the incidence of nosocomial infections. As part of NWAS's comprehensive COVID-19 infection prevention and control strategy, the consistent utilisation of asymptomatic lateral flow testing has been instrumental in preventing the emergence of large COVID-19 outbreaks at our sites. Furthermore, the uptake of LFD

	testing among NWAS staff remained consistently high, with clinical staff encouraged to conduct testing before reporting for duty to ensure the safety of their colleagues and, most importantly, their patients. National guidance on twice weekly asymptomatic testing changed and staff were advised that testing was only necessary when they had symptoms of Covid – testing kits were made available on a government portal. NWAS still had some supplies of testing kits, and these were distributed to our larger sites for use by staff when there was an outbreak. Staff members who test positive on a lateral flow test must report their results to Carlisle Support Centre.
9.	**COVID-19**
9.1	There has been a decline in the number of Covid cases nationally throughout the year and fewer staff have tested positive. We have continued with established recording processes for all positive cases in NWAS and staff are followed up using the sickness reporting and management procedure to check on the welfare of staff as well as identifying any contacts of the Covid positive case in the workplace. Where it evidenced that workplace transmission has occurred Covid outbreaks have been declared at those sites and enhanced IPC measures were put in place. Advice was given to both staff and local managers by the IPC Team in line with national guidance.
9.2	**PPE Stock Ordering and Distribution** As national PPE stock availability increased, NWAS procurement team take full responsibility for the ordering and supply of PPE in NWAS. There was a requirement for the Trust to procure PPE for stock distribution from NHSE/I who continued to adopt a 'push stock' system. NWAS' stock was replenished regularly. Stocks continue to be held regionally at central stations across each geographical region. As demand for PPE stock reduced due to changes in National Guidance, NWAS has continued to maintain a healthy level PPE stocks.
9.3	**PPE Recalls and Safety Alerts** NWAS received no PPE recalls in 2022/23. The MHRA issues notice of safety alerts from the Central Alerting System (CAS). The NWAS Board of Directors are notified via the Integrated Performance Report of safety alerts received. During 2022/23 NWAS has received 19 safety alerts through CAS and MHRA, 3 of which were applicable to NWAS. A breakdown of these can be found on the Health & Safety annual report.
9.4	**Respiratory Protective Equipment**

	The filtering face piece (FFP3) respirator mask covers the mouth and nose to protect against particulate hazards, such as airborne infectious viruses and is an essential part of personal protective equipment (PPE) for clinical staff who carry out aerosol generating procedures (AGP's). An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route. The only AGP likely to be completed by NWAS staff is the suctioning of a tracheostomy on a patient with a suspected or confirmed respiratory condition. There are also other infectious diseases where the requirement for respiratory protection is essential. These include Middle Eastern Respiratory Virus (MERS), Avian flu, Monkey Pox (MPox) and other high consequence infectious diseases. Respiratory protective equipment must also be worn if there is a risk of exposure to asbestos. During 2022/23 FFP3 masks were available free of charge to all NHS trusts via the Central Governments push stock. NWAS were able to choose from a list of approved FFP3 masks of which the supply was guaranteed. A selection of 5 masks are available that staff can be fit tested on which provide an option for various face shapes and sizes. Anyone who failed on all 5 of these masks had the powered respiratory hoods (Sundstrom) that are supplied as personal issue to every patient facing member of staff. During the first half of 2022, the operational teams were responsible for fit testing of staff, and they encountered significant challenges during the fit testing process. These challenges were primarily: • The small number of competent fit testers available within the Trust • Low pass rates due to inexperienced fit testers • The lack of staff availability due to operational pressures • Confusing data due to no agreed data collection method and each area capturing the data in different ways. • No way to differentiate between fit test failures and those who could not be tested. In order to overcome these challenges, the IPC team took over the responsibility for fit testing and engaged with Ashfield Healthcare, a nationally funded fit testing provider. This free service was set up by NHSEI to assist NHS organisations to increase fit testing capacity during the pandemic. Plans for fit testing of staff were put in place and two Ashfield fit testers commenced fit testing in the Greater Manchester area early in September 2022. These fit testers spent one day per week testing new staff/apprentices and then one day per week in each of the area sectors. Each area designated a fit test lead which the IPC team liaised with, and they were tasked

with arranging staff availability for fit testing. Despite operational challenges, using this approach resulted in a steady stream of staff being available for fit testing.

The same approach was rolled out across Cumbria and Lancashire early in November 2022 and then Cheshire and Mersey at the end of November 2022. In total, six Ashfield fit testers were deployed across the trust from Monday to Friday.

Due to the geographical size of the Trust, some areas proved difficult to arrange fit testing. Ashfield did not have employed fit testers in North Cumbria and this was overcome by using fit testers from the Northeast who would travel over the day before fit testing and stay in local hotels. This cost was met by NHSEI.

In order to centralise our fit test records, a new process was developed with the support of the OLM team and all staff that were fit tested had a form completed by the tester on Microsoft teams which was then inputted onto ESR. This information captured all staff and whether they passed or failed a fit test or if they did not have a fit test due to facial hair and unwilling to be clean shaven.

By using Ashfield for our fit testing, it provided:

- Access to competent fit testers across the trust.
- Consistent fit testing procedures.
- Higher pass rates due to use of experienced fit testers.
- Ensured logistical challenges were met regarding availability of fit testers in each area, availability of PortaCount machines and consumable items.
- A central store of all fit test information due to the use of an online form which was completed for every fit test or any staff member who could not be fit tested.

At the end of March 2023, the compliance across the organisation for fit testing can be seen in the table below;

	Offered	Not Tested	Total Staff Required	Compliance %
CAL	578	622	1200	48%
CAM	593	526	1119	53%
GM	959	391	1350	71%

A risk is on the risk register to reflect the compliance rates;

- There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods

	not suitable for all scenarios, staff are unable to respond safely to Aerosol Generating Procedures (AGPs) leading to risk to personal safety of staff. Score - 12 Mitigations are in place against the risk to ensure staff are able to practice safely – all staff who maybe required to perform AGP's are provided with an individual issue powered respiratory hood. By the end of quarter 2 in the next financial year a fit testing team will have been recruited and we anticipate that compliance figures will start to increase significantly. Members of the training department have also been trained to fit test and all new starters are fit tested as part of their induction.
9.5	**Respiratory Hoods** NWAS continue to issue powered respiratory hoods as Respiratory Protective Equipment (RPE) as personal issue to all emergency service patient facing staff. The powered respiratory hood which the Trust uses is the Sundstrom SR 520 Hood with the SR700 Fan unit.  This RPE solution comprises of a small motor unit that sits on an IPC compliant belt, in the small of the back. A corrugated hose runs up the wearers back to a hood. The motor unit sucks air in, via two filters, filter it, blows it up the hose and into the hood creating positive pressure. This enables staff with beards, stubble, spectacles, and facial disfigurement to wear the equipment. There is no need for fit testing, however, the user does need to be trained in how to test and wear the equipment. There is a requirement for the Sundstrom hood filtering units to be serviced on an annual basis, to ensure the equipment continues to meet the requirements of the warranty and assurance can be given in relation to the safety compliance for staff. The filter units are serviced in line with the Trust servicing of oxygen regulators and is completed by trained Oxylitre staff. **Compliance Auditing of RPE Preparedness**

	The IPC Team has developed audit systems for monitoring operational compliance of our staff regarding preparedness to attend an incident requiring RPE. This audit is carried out by SPTLs during their clinical contact shifts with front line operational staff. This should happen on three occasions a year. This audit measures whether the staff member is in date for their FFP3 fit test and if not if they have their Sundstrom hood with them.
10.	**VACCINATION**
10.1	**Flu Vaccination Programme.** The Trust managed its annual Flu Vaccination programme for 2022/23 with a similar model as with previous years. The IPC Specialist Lead for the Trust was responsible for coordinating the vaccination of corporate staff within NWAS. Several of the IPC team completed the necessary training to administer the flu vaccine - they then organised and conducted vaccination clinics around the trust liaising with operations managers, emailing corporate staff and booking appointments. The IPC vaccinators vaccinated a number of PTS staff as they had no vaccinators and also attended numerous educational settings vaccinating new starters to the trust. The IPC team managed to vaccinate over 400 staff members. The team had numerous discussions with staff members to support and reassure them of the vaccination process and alleviate any reluctancy. The Trust officially concluded its campaign at the end of February 2023 and the final uptake of the flu vaccine was 3178 or 48.46% of staff. Whilst this was lower than previous years, it should be noted that there was a delay in vaccinations coming into the trust and 435 members of staff received the flu vaccination elsewhere. The IPC team will be fully supporting the flu vaccination program for 2023/2024 with mobile flu clinics around the trust footprint.
10.2	**Staff Welfare - Supporting staff and families.** NWAS employs over 8,000 staff and volunteers. The trust conducted one-to-one risk assessments with staff throughout the pandemic which have been fundamental to understanding individual difficulties, risks and identifying appropriate support measures to minimise those risks. These personal risk assessments are dynamic and constantly updated to reflect any changes in personal circumstances or changes in national guidance. Guidance was provided to the assessor about how to manage the risk conversation to enable an individual to feel comfortable to raise any concerns they were experiencing and highlighting possible support mechanisms available. These support mechanisms included: • Regular welfare checks.

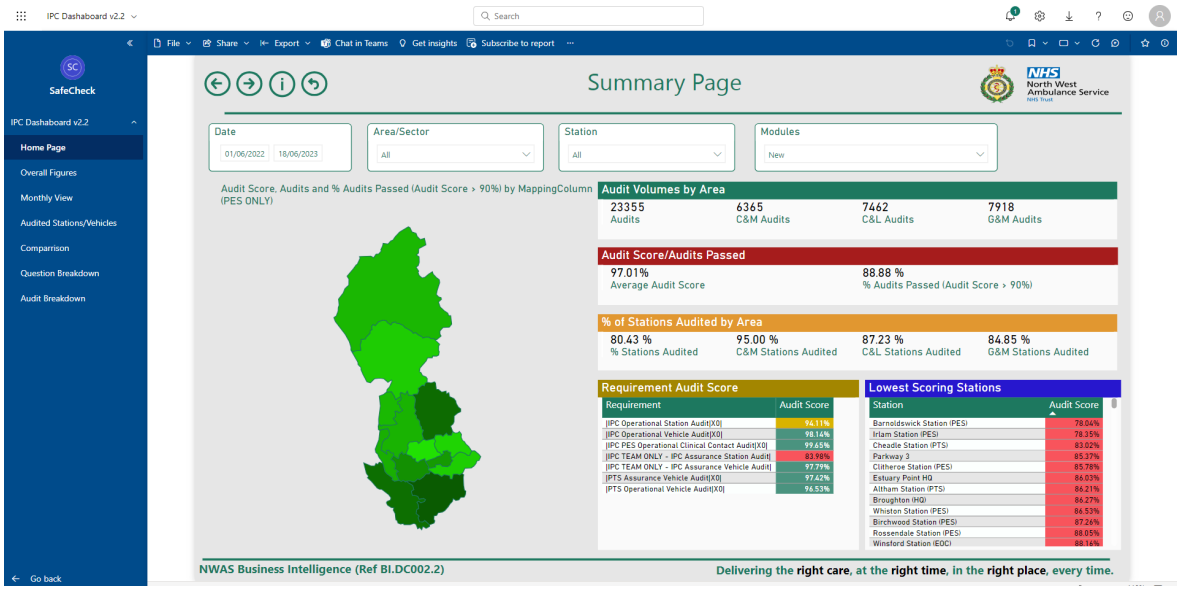
	• Stress risk assessment. • Sign-posting an individual to appropriate therapy or agencies. • Highlighting the wellbeing resources available on the intranet. • identifying a work buddy. • Modifying duties or work arrangements. Regular welfare contact has been carried out with staff during periods of COVID-19 related absence, such as during medical stand down/ shielding, isolation periods and COVID-19 sickness. This enabled staff to maintain contact and inclusion with NWAS and ensure any support required is identified and accessible. In cases where staff have become seriously unwell and hospitalised, regular contact has been maintained with the staff member's family and help and assistance provided wherever possible. Counselling services continue to be provided through the Occupational Health provider and is available to all staff. NWAS have also funded other additional specialist therapeutic support during the pandemic to ensure staff are supported as much as possible.
11.	**FACILITIES MANAGEMENT**
11.1	**Review of Cleaning Regimes Across All Sites** The NHS published the National Standards of Healthcare Cleanliness in April 2021 mandatory for all healthcare settings except for ambulance services trusts. NHSE/I formed a national working group to develop the standard specific for the ambulance sector and the head of facilities management (FM) is a member of this group. Considering these impending changes to cleaning regimes, the FM planned review of the cleaning provision at all sites was temporarily paused. Through 2021 and the continuing pandemic, progress from NHSE/I on the standard was slow. After the pandemic, in late 2022, NHSE/I re-established the working group meetings. In March 2023 the group was provided with a new brief on the national requirements for ambulance Trusts and NWAS are at the forefront of this piece work developing the specification supported by the IPC lead, however no publication date has been set. FM have continued to follow the operating procedures from NHSE/I regarding the safe cleaning of patient and non-patient facing environments through the contractor, JPR Solutions, using the Bacticlean product. This product was originally used for the ambulance deep cleaning and approved by IPC team in the early stages of the pandemic for premises cleaning use.

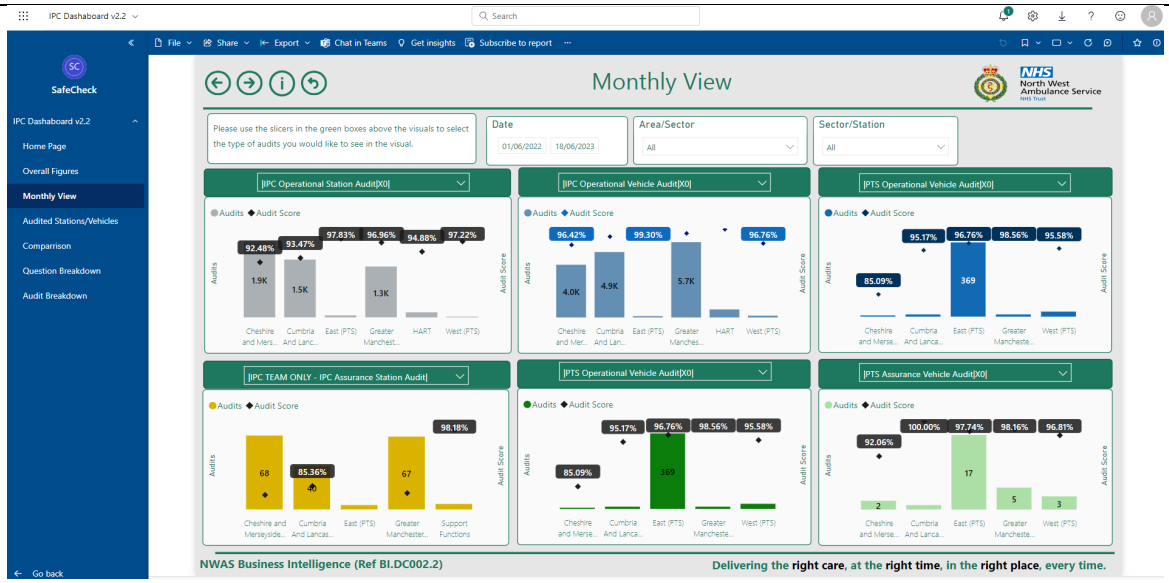
11.2	**Decontamination** With the end of the pandemic and removal of social distancing measures, there has been a noticeable reduction in the need for decontamination. However, the decontamination service for workstations and premises remains available to call on as and when necessary for the Trust through the contractor. This response was demonstrated through several outbreaks in recent months.
11.3	**Premises Cleaning and Increase to Cleaning Provision** The enhanced cleaning provided to the contact centres and large stations during the pandemic, once stabilised was found to be warranted and proved beneficial to the sites in scope, the arrangements remained in place unchanged through 2022. With the premises cleaning contract due for re-tender in September 2022 and no confirmed release for the new standards, the Board approved a one-year extension to the contract. In preparation for this contract renewal, the cleaning provision was reviewed, and the enhanced cleaning was recommended and approved by ELC on a permanent basis to enable a consistent high standard of cleaning at these heavily populated sites
11.4	**Clinical Waste** The clinical waste stream within the Trust is managed and monitored by the Fleet Logistic Team and the contract at present sits with Stericycle. The Trust has robust systems in place for disposing safely and effectively of clinical waste. Due to the increased usage of PPE during the pandemic, it was necessary to increase the amount of clinical waste collections. This was achieved across the Trust geographical footprint to try and prevent the overflowing of clinical waste at sites. The IPC team worked closely with sectors across the Trust and liaised with the Fleet Logistic Team in trying to prevent overflowing receptacles. The IPC team undertook assurance audits and had discussions with operational staff to further improve waste segregation (the IPC team attend the new starter inductions and try and educate staff early on the correct disposal of waste). The Trust has commenced a pilot at one of the Hubs and the ambulances that are based there to improve on waste segregation. This will be achieved by introducing an offensive waste stream which will allow operational staff to dispose of non-clinical waste that's non-infectious. Clinical waste streams are reviewed on a monthly basis during contract management meetings, there is flexibility within the contract for collections to be amended based on fluctuating demand. This is managed by the Fleet team in partnership with Stericycle.

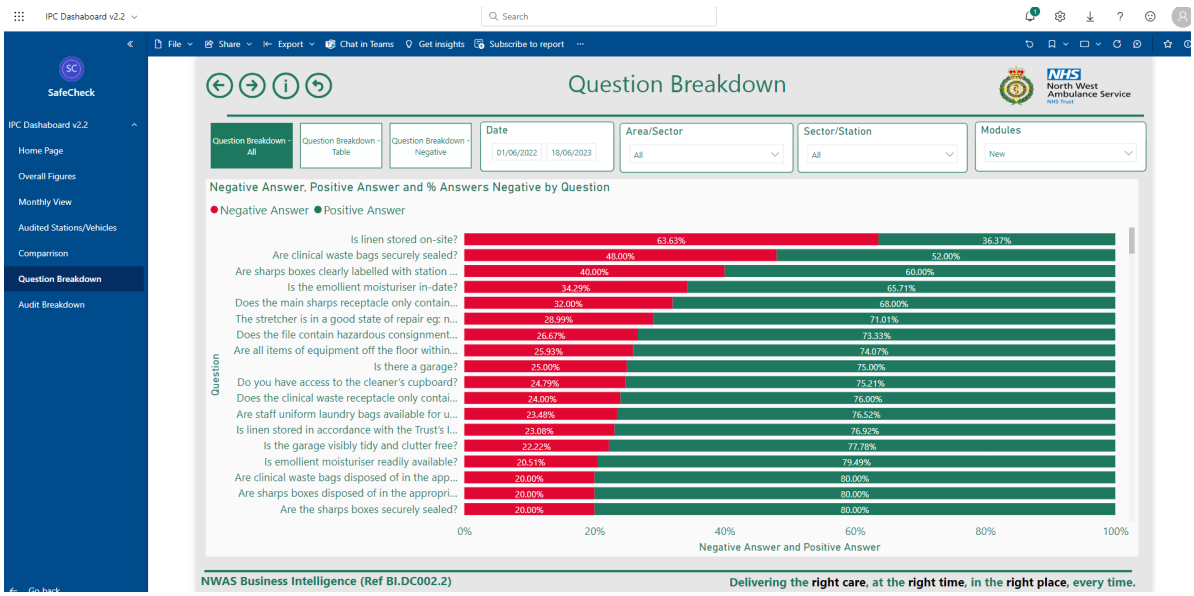
11.5	**Vehicle Cleaning** All ambulances interiors and equipment are cleaned and disinfected after every patient contact with clear guidance provided within the Infection Prevention and Control Procedures which is in line with national guidance. Ambulance vehicle exteriors are cleaned regularly and when as required. An additional Deep Clean service across the entire fleet (PES / PTS / RRV), is in place and provided by an external contractor. Every vehicle (emergency, patient transport, urgent care, and all solo response vehicles) receives a `Deep Clean' every six weeks, delivered through a combination of fixed and mobile sites across the Trust footprint. This service continues to enhance operational availability, patient safety, and staff welfare in the improved cleanliness of each vehicle. To maintain service delivery against performance, an assurance regime monitors all Deep Cleans conducted against a randomised 10% audit program, this is further underpinned by additional unannounced audits carried out by the IPC Team. Deep clean audit results are presented at the IPC Sub Committee for assurance.
12.	**TRAINING**
12.1	As stipulated in our mandatory training program, Infection Prevention and Control (IPC) is a crucial element that all staff members must undertake. It requires the completion of two modules at the time of recruitment, followed by an annual update. To ensure that this critical topic is effectively conveyed, a new presentation has been developed that outlines the IPC guidelines for new starters. Its goal is to ensure that all staff members have a comprehensive understanding of IPC practices and protocols. The presentation encompasses the following. • systems and procedures relating to IPC. • legislation and policies relating to IPC. • definitions of a Healthcare Associated Infection and how to reduce them. • the importance of good personal hygiene in IPC in line with PHE guidance. • roles and responsibilities in Infection, Prevention & Control (IPC) • how to clean and decontaminate vehicles and equipment. • the management of Sharps and linen. • handwashing techniques in IPC. • the importance of risk assessment in relation to IPC The IPC team works closely with the mandatory training team to ensure that all clinical staff completes the mandatory IPC training and are also dedicated to improving local training based on audit findings, which entails ongoing assessments of current practices and protocols to identify areas that require improvement.
13.	**COMMUNICATION AND ENGAGEMENT**

13.1	**IPC Team** The IPC team continue to work hard to maintain their visibility across the Trust. Attendance at locality meetings and forums to share information on IPC is a regular occurrence and the IPC team act as integral support to the QAV processes across the Trust. In addition to the internal engagement, the IPC team have formed strong infrastructures with IPC leads at other health care providers, the United Kingdom Security and Health Agency (UKSHA) IPC leads and NHS England (NHSE) IPC Leads. Work will continue during 2023/24 to gain points of contact within the Integrated Care Systems
13.2	**IPC Communications** The IPC team have reviewed their Trust internet pages and now have a platform for communicating with staff and the wider public. The IPC Team regularly publishes Staff Bulletins through the Trust Communications Team, and these are disseminated via email and displayed at station sites. In addition, information is communicated through operational team managers who disseminate directly to frontline staff through meetings. The IPC Team also utilise social media platforms such as Facebook and Twitter through the Trust Communications Team, this helps the team to communicate with as many staff as we can reach.
13.3	**Unplanned Activity** **MPox** In May 2022 UKHSA confirmed an individual had been diagnosed with monkeypox – this person had travelled to Nigeria where they had picked up the virus prior to arriving in England. Over the next few weeks, it became apparent that there was a significant outbreak, centred in the main around London and the Southeast. Initially the infectious disease was called Monkey Pox – this was changed by UKHSA to MPox. When the outbreak was first reported MPox was classified as a High Consequence Infectious Disease (HCID), however, following review in July UKHSA declared that the outbreak clade was no longer identified as a HCID. By the end of March 2023 there had been 3732 confirmed or highly probable cases of MPox across the UK. National guidance for health care staff was published by UKHSA – this was adopted by NWAS, and communication was sent out to staff to ensure they were aware of signs and symptoms, appropriate PPE to wear and decontamination requirements. Extraordinary meetings, chaired by the DIPC were set up to ensure clear engagement with Operational leaders in the organization and staff side were also involved. **Group A Streptococcus**

	In the past six months, there has been a notable rise in the number of patients in the care/nursing home environment within the Northwest area, this is reflective of the national increase in Group A Streptococcus cases (GAS) in the community that has been reported. The IPCT have been informed of a number of outbreaks in these care settings, specifically in Oldham, where residents have tested positive for IGAS (invasive group A streptococcus) and our crews have had contact with these patients. This situation has posed challenges as there is often a delay in being informed about these cases, resulting in the need to trace staff members, check the amount of contact they had with the patient, schedule appointments with occupational health for risk assessment and potentially offer prophylactic treatment. The IPCT we have collaborated closely with the UK Health Security Agency (UKSHA), hospital departments, and occupational health to implement measures aimed at preventing the further spread of IGAS. Clinical bulletins from UKHSA and advice on preventing the transmission of GAS have been cascaded to staff via communications bulletins and operations managers. **Avian Flu** The national prevalence of Avian flu in 2022-23 increased significantly with outbreaks across the country being identified. The IPCT at NWAS were made aware of an Avian Flu outbreak in and around Salford Quays - impacting on events with no one currently allowed in or on the water. This issue appeared to be specifically at Salford where there was a buildup of bird excrement on the pontoon and jetty leading down to the water. A specialist contractor was commissioned to remove the waste. been contacted to clean this up. A potential risk to NWAS staff was raised if such staff were called to a patient in the water (potentially HART staff) causing them to come into close contact with the excrement. The IPCT worked with UKHSA as the lead for this incident, liaising with the HART team to provide advice to staff on how to minimize the risk of transmission. Such advice was to wash any area of contact to the body thoroughly, and to complete a risk assessment with UKHSA to decide on further actions. This information was provided in the form of a bulletin to all staff. **MRSA Bacteraemia Cases** The IPCT has attended Post Infection Review (PIR) panels for 6 MRSA Bacteraemia cases in Cumbria and Lancashire. These patients who were identified on admission to hospital with a bacteraemia due to MRSA, had a review completed, and had contact with a NWAS crew prior to admission. A thorough analysis of the patient's notes did not identify any lapses of care from NWAS – all procedures were followed correctly, and the bacteraemia cases were not attributed to NWAS. One learning point to come from the PIR was around the lack of documentation of ambulance cleaning after the patient has left the vehicle. This has been

	discussed at the IPC Cell meetings to find an effective solution. The team are exploring digital options to see if this information can be captured on one of the current IT systems.
14.	**INNOVATION**
14.1	All IPC audit data is now captured on Safecheck. The move to SafeCheck meant that all the Trust audits are housed on one system, the system is designed to encourage staff to complete audits in a format which is familiar to them and is easy to pull reports from. The improvement project has developed an advanced information system which will ensure the Trust can improve its analysis of IPC data and compliance and provide broader comparative data from all audits. This data is then presented at the IPCSC in the form of a Dashboard which allows the user to see an overarching view of the Trusts compliance with IPC policies and procedures and also the ability to identify a number of parameters including each stations compliance and overarching compliance to each question in the audit. The data can be formatted to be displayed in a number of ways. See below some screenshots as an example of how the dashboard functions; 





14.2 IPC COMMITMENTS 2023/24

NWAS will continue to maintain its regulatory compliance for infection prevention and control in line with the Health & Social Care Act, in addition to this the IPC team will align closely to the IPC annual workplan which includes the following ambitions:

- Recruitment and induction of IPC Guardians across the Trust, implement training and ongoing support. The IPC guardians will be a very useful resource in supporting the IPCT cascading messages out to all staff in light of updated guidance and any local outbreak notifications.
- Develop in-house NWAS Fit Testing processes and the recruitment of a NWAS Fit Testing Team to work in conjunction with the IPC Practitioners to ensure the ongoing safety of frontline NWAS staff. All guidance will be reviewed in line with the Health and Safety Executive.

	• Enhance our assurance in relation to improving auditing and compliance with FFP3 Masks and Respiratory Protective Equipment. The team will work closely with Operation Leads and the Training Department to improve compliance across the organization. Assurance will be given to the Quality and Performance Committee via the IPC Sub- Committee • Further development of compliance processes with the NWAS Aseptic Non-Touch Technique (ANTT). The team will work with the Trust's Chief Pharmacist to ensure any resources available to staff are in line with aseptic technique. • The IPC Specialist Lead will oversee the Staff Flu Vaccination Campaign for 2023/24 for the Trust. Close working relationships will be developed with key stakeholders including Medicines Management, HR, Communications and Operations staff to plan and deliver an effective campaign to maintain staff safety. • Attend regional IPC collaboratives to facilitate close working relationships with other IPC teams and to ensure our practice is in line with other organisations. • Participate in the national peer review programme for other IPC services in the ambulance sector, as set out by the Association of Ambulance Chief Executives national IPC group. • Collaborative working with the Contracts Manager, Facilities Management, and cleaning contractors to ensure robust processes are in place to maintain high standards of cleanliness. • Continue to strengthen relationships with partners outside of NWAS – this year a representative from United Kingdom Health and Security Agency (UKHSA) and Occupational Health for NWAS will be invited to attend and provide assurance reports for the IPC Sub Committee • Develop further our digital solutions to support IPC Audits and analysis. • Support the reduction of HealthCare associated Gram Negative Bloodstream Infections (GNBSI) by linking in with each local ICS in supporting this ongoing agenda and also by collaborative working and input into NHS England regional action plans. Continue to move towards the goals set within the Right Care strategy and the pillars of quality goals.
15.	The Board of Directors are asked to: • Note the content of the Report. • Note the assurances it provides. • Note the arrangements for ongoing monitoring via the IPC board assurance framework.

	• Note the key risks and mitigations. • Support the report for publication on the Trust website.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th September 2023				
SUBJECT:	Emergency Preparedness Resilience and Response (EPRR) Annual Assurance 2023/2024				
PRESENTED BY:	Deputy Chief Executive				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☐	☐	☒	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☐	☒	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR Annual Assurance process. The NHS Core Standards for EPRR are the basis for the assurance process and are the minimum requirements commissioners and providers of NHS-funded services must meet. The NHS core standards for EPRR cover 10 core domains, with NHS Ambulance Trusts having an additional domain, 'interoperability capabilities'. In addition to the self-assessment across the core domains a 'deep dive' is conducted to gain additional assurance into a specific area. In 2023/2024 the topic is EPRR training. This report provides the findings of the self-assessment in line with the EPRR Annual Assurance process for 2023/2024. The EPRR Statement of Compliance as of 15 September 2023 is as follows: • EPRR Core Standards: **Substantial**				

	• NHS 111 EPRR Core Standards: **Substantial** • PTS EPRR Core Standards: **Substantial** • Interoperability Capabilities: **Substantial** The deep dive is assessed as a scoping exercise and not included in compliance figures. The Trust are fully compliant in 8 of the 10 standards, partially compliant in 2. Further work is ongoing prior to submission to the Lancashire and South Cumbria Integrated Care Board no later than the 30 September 2023. Appendices attached: 1. NHS England letter of intention (May 2023) 2. Action plan (including deep dive) – PES / 111/ PTS 3. Action plan – Interoperable capabilities
RECOMMENDATIONS:	The Board is recommended to: • Receive assurance the EPRR Annual Assurance process 2023/2024 has been completed. • Note the compliance status against each of the 4 core areas and the additional area 'interoperable capabilities' following the self-assessment. • Note the Deep Dive on EPRR Training has been completed. • Note all action plans against the domains are in place to ensure all elements move to compliant. • This report will be presented to Quality & Performance Committee (25/09/23) and Trust Board (27/09/23) prior to submission to the Lancashire and South Cumbria ICB on the 30 September 2023.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☒ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	ELC			
	Date:	20th September 2023		
	Outcome:	Noted.		

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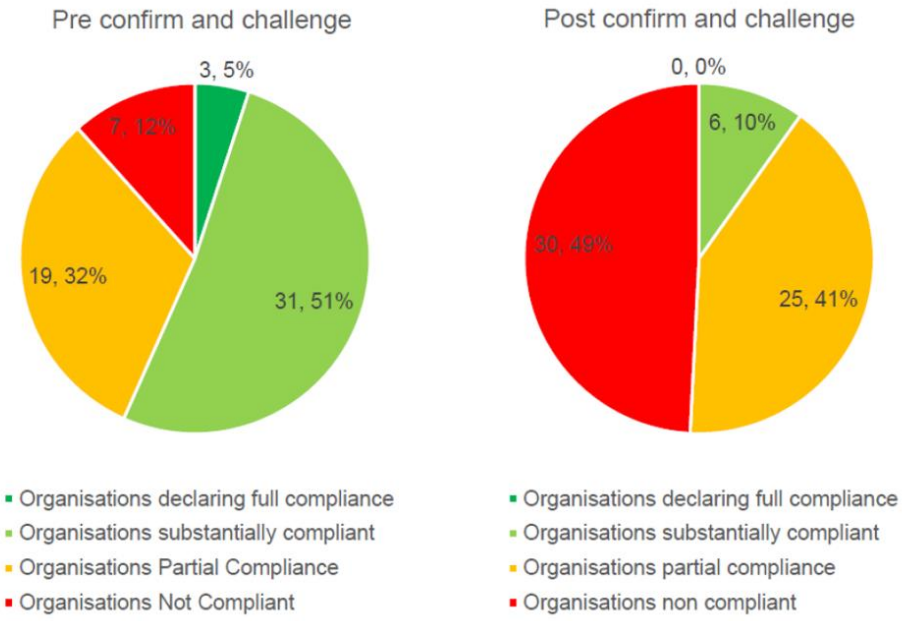
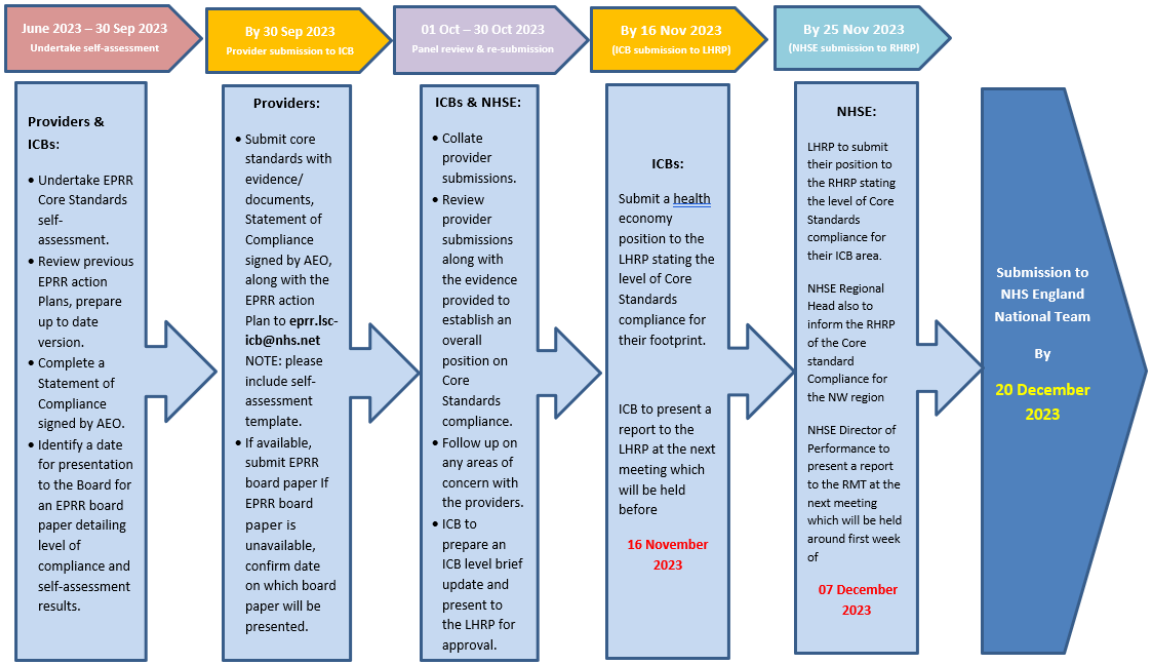
1.	**PURPOSE**
1.1	This report provides the Board the findings from a self-assessment as required and described by the NHS England 2023/2024 Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance process, including the Deep Dive on EPRR Training. The report also includes the current NWAS positions of compliance. The statements, as signed by the AEO, will be included in the final report when the governance process has been completed.
2.	**BACKGROUND**
2.1	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022.
2.1.1	NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR Annual Assurance process.
2.1.2	NHS England requires this assurance process (Letter, 23rd May 2023, **Appendix 1**) identifies any areas of limited or non-compliance (as well as highlighting areas of full compliance) of arrangements against the EPRR core standards and that any deficiencies in particular areas inform an individual Action Plan **(Appendix 2 and 3)**. This plan will demonstrate the intention of each Trust to address any outstanding issues and give an indication of priority and timescale for resolution.
2.1.3	The NHS Core Standards for EPRR (the 'Core Standards') are the basis for the assurance process and are the minimum requirements commissioners and providers of NHS-funded services must meet. They are based on robust delivery of duties under the Civil Contingencies Act (2004).
2.2	The Core Standards cover 10 core domains applicable to all NHS services, the standards within the domains are filtered to ensure they are applicable to the Trust completing the review. In 2022/2023 PTS and NHS 111 was introduced as a core standard for EPRR Annual Assurance, and this continues as part of the process for 2023/2024. It has been requested that the data for Ambulance, PTS and 111 are submitted individually as they are considered to be different services. As there is significant overlap in actions, the tracker will cover all 3 areas.
2.2.1	An additional domain for Ambulance is Interoperable Capabilities. This is assessed and scored but is not included in the overall score for the Service. Therefore the 4 areas for self-assessment as part of the EPRR Annual Assurance for the trust is as follows: • EPRR Core Standard • PTS • NHS 111

	• Interoperability Capabilities
2.2.3	The NHS core standards for EPRR cover 10 core domains: 1. Governance 2. Duty to risk assess 3. Duty to maintain plans 4. Command and control 5. Training and exercising 6. Response 7. Warning and informing 8. Cooperation 9. Business continuity 10. Hazmat and Chemical Biological Radiological Nuclear (CBRN)
2.2.4	Domain 10 is a new standard for the Ambulance Service in 2023. Some elements were listed in 2022 but not applicable, new elements have been added which are. This domain is not applicable to PTS or 111.
2.3	The Interoperable Capabilities section contains: • hazardous area response teams (HART) • special operations response teams (SORT) • mass casualty vehicles (MCV) • command and control (C2) • implementation of the joint emergency services interoperability principles (JESIP)
2.4	Each year a deep dive review is conducted to gain additional assurance into a specific area. Previous years have covered the following topics: • 2015/16 pandemic influenza • 2016/17 business continuity • 2017/18 governance • 2018/19 command and control • 2019/20 severe weather and climate adaptation • 2020/21 n/a • 2021/22 oxygen supply • 2022/23 evacuation and shelter
2.4.1	Following key themes and common health risks raised as part of last year's annual assurance process, the 2023/24 EPRR annual deep dive focuses on EPRR responder training. Training is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning. The deep dive questions are applicable to those organisations indicated in the NHS core standards for EPRR self assessment tool. The outcome of the deep dive will be used to identify areas of good practice and further development whilst seeking additional assurance in this area of the core standards and guide organisations in the development of local arrangements. They are often incorporated into future assurance programmes.

2.5	**Change in assessment method**
2.5.1	As per previous years, NHS organisations undertake the self-assessment against the 2023 Core Standards, the outcome of which is published in the Trust's annual report through the Board. In a change to previous assessment processes, the Trust will then work with the commissioning ICB, providing extensive evidence to support the statements allotted to each standard. The ICB may challenge the declaration or evidence and will decide on the final compliance level once the confirm and challenge process is complete. The results will be presented to the LHRPs and then to the NHS England Regional Head of EPRR who, in turn, report their areas findings to the national team.
2.5.2	Lancashire and South Cumbria ICB require the evidence as shown in the section 'supporting information – including examples of evidence' on the spreadsheet as a minimum. Documents that are in draft, or the supply of insufficient evidence, will rate that standard as partial at best. This change in process is due to a review of the content of standards in a particular area during the 2022 assurance process where several Trusts had their compliance reduced once the evidence had been checked.
	
2.5.3	7% dropped 3 compliance levels (full to non compliance), 39% dropped 2 levels (full to partial, or substantial to non compliant), and 54% dropped 1 compliance level (full to substantial, substantial to partial, or partial to non compliant). The maximum number of challenges accepted was 30.
2.5.4	Having raised a question of standardisation with national EPRR Group (ambulance services), it is apparent that ICBs are offering different levels of challenge in different areas. Lancashire are being stringent in requesting the list of evidence provided on the spreadsheet, other areas are happy for the Trusts to decide themselves what is needed.
2.5.5	NWAS also asked the ICB who would be auditing and what qualifications they had to perform the role. As there is no agreed evidence list and the provision is very subjective,

	this could lead to a lack of parity. It appears the staff doing the audits may not be trained to do so. The Head of EPRR for the ICB will raise this with NHS England.
2.5.6	The Trust have reviewed the standards carefully and critically, interpreting what could be meant by the wording and what evidence could be provided to support the statements. The timeline for submission to the various panels is as follows: 
2.6	**EPRR Annual Assurance and Statement of Compliance**
2.6.1	The spreadsheet provided by the ICB provides the detailed self-assessment across all the core standards and domains, a separate submission is made for each part of the service (wider 'Ambulance', PTS and 111). The Ambulance spreadsheet contains the Interoperability tab, all sheets have a duplicate of the deep dive.
2.6.2	Detailed action plans have been developed, one covering 'Ambulance', PTS and 111 as there is significant overlap in requirements, and one for Interoperable Capabilities. Each action has a clear owner and timeframe, and the RAG rating for the standard as submission. Some actions are applied to Standards where the Trust are considered fully compliant in order to continue improvement. Regular updates take place direct to the Director of Operations. Appendix 2 and 3 provides a copy of the current action plans in place.
2.6.3	Once the internal governance process is completed to ensure the Board are confident in the content of the submission, statements of compliance will be completed by the Director of Operations to be included by 30th September.
2.6.4	Compliance is calculated by using the total number of applicable standards and showing the percentage that are fully compliant (compliance description below).

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Assurance rating thresholds
Fully Compliant – 100%
Substantially Compliant – 89-99%
Partially Compliant – 77-88%
Non-Compliant – 76% or less

2.6.5 The EPRR Annual Assurance Statement of Compliance as of 15 September 2023 is as follows:

- EPRR Core Standards: **Substantial (93%)**
- NHS 111 EPRR Core Standards: **Substantial (91%)**
- PTS EPRR Core Standards: **Substantial (90%)**
- Interoperability Capabilities: **Substantial (90%)**

Work is ongoing between Resilience and other departments to establish if any work on the action trackers can be completed prior to final submission.

2.7 **Organisational Assurance Rating**

2.7.1 The number of core standards applicable differs between organisations. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Core Standard	Non-Compliant	Partially Compliant	Fully Compliant	Overall Compliance
EPRR Core Standard (58)	0	4	54	**Substantially Compliant**
PTS Core Standards ()	0	4	38	**Substantially Compliant**
NHS 111 Core Standards (43)	0	4	39	**Substantially Compliant**
Interoperability Capabilities (136)	0	13	123	**Substantially Compliant**

2.7.2	The dashboard on each spreadsheet shows the breakdowns per domain.

Ambulance

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	1	1	0	0
Duty to maintain plans	11	11	0	0	0
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0
Response	5	4	1	0	2
Warning and informing	4	4	0	0	0
Cooperation	5	5	0	0	2
Business continuity	11	10	1	0	0
Hazmat/CBRN	8	8	0	0	11
Total	**58**	**54**	**4**	**0**	**15**

PTS

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	1	1	0	0
Duty to maintain plans	8	8	0	0	3
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0
Response	5	4	1	0	2
Warning and informing	4	4	0	0	0
Cooperation	1	1	0	0	6
Business continuity	10	9	1	0	1
Hazmat/CBRN	0	0	0	0	19
Total	**42**	**38**	**4**	**0**	**31**

111

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	1	1	0	0
Duty to maintain plans	8	8	0	0	3
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0
Response	5	4	1	0	2
Warning and informing	4	4	0	0	0
Cooperation	2	2	0	0	5
Business continuity	10	9	1	0	1
Hazmat/CBRN	0	0	0	0	19
Total	**43**	**39**	**4**	**0**	**30**

Interoperability

Interoperable Capabilities for NHS Ambulance Service Providers only				
Interoperable Capabilities	**Total Applicable Standards**	**Fully Compliant**	**Partially Compliant**	**Non Compliant**
HART Capability	3	3	0	0
HART Human Resources	8	7	1	0
HART Administration	10	9	1	0
HART Response time standards	4	4	0	0
HART Logisitics	7	6	1	0
SORT Capability	4	4	0	0
SORT Human Resources	10	10	0	0
SORT Administration	13	11	2	0
SORT Response Times	14	10	4	0
MassCas Capability	7	6	1	0
MassCas Equipment	7	7	0	0
Gen C2	4	4	0	0
Resource C2	6	5	1	0
Decision Making C2	3	3	0	0
Recording Keeping C2	3	3	0	0
C2 Learning Lessons	1	1	0	0
Competence C2	19	14	5	0
JESIP	13	11	2	0
Total	**136**	**118**	**18**	**0**

2.7.3 The deep dive is not included in the figures for compliance but is an indication of the preparedness of the organisation in the area of EPRR training. As of 15th September 2023, the trust has 2 partially compliant and 8 fully compliant. The partial compliance covers:

- the lack of availability of national courses for commanders, command support, and Resilience Team staff, and the location which can be prejudicial against staff who do not have the means to stay away over night.
- the need for standardisation of training records, both across the department and across the Trust.

The action plan anticipates this will be fully compliant by the end of March 2024.

2.7.4 The ‘Ambulance’/PTS/111 partially compliant standards are:

- 5 – EPRR Resources
- 8 – Risk Management
- 26 – Incident Coordination Centre Arrangements
- 51 – BC audit

2.7.5 The work required to move these standards to full compliance will be led by the Resilience Team but will require collaboration with other departments. Several departments have already been very engaged in the process, including leads from EOC, PTS, 111, Communications, Training, and Information Governance.

	Funding for resources has been requested from the Commissioners in relation to HART and Manchester Arena Recommendation MR20, the Trust have yet to receive a response beyond acknowledgement of receipt. The Resilience Team have spoken to the Risk Team about running a workshop to improve understanding of risk and mitigation, in addition to reviewing some of the risks on the National Risk Register to explore how the effects on the Trust can be recorded and mitigated. Incident Coordination Centre arrangements will be clarified with the Head of Operations and others in the Integrated Contact Centres in line with NHS England guidance. The standards require the Trust to participate in an external audit for business continuity to provide assurance to both the organisation itself and to NHS England that the quality of the BC management system is sufficient.
2.7.6	Actions to be applied against fully compliant standards include • the addition of the term Accountable Emergency Officer (AEO) into the job description of the role holder, • the creation of exercise and testing documentation and associated assurance processes, • formalising of the assessment and assurance of plans, including multiagency collaboration.
2.8	The Interoperable Capabilities review shows 13 partially compliant standards (1 HART, 3 SORT; 6 Command; 1 Mass Casualty Vehicle; 2 JESIP).
2.8.1	H16 covers the requirement to provide evidence of HART response times and was initially self-assessed as non-compliant. This was non-compliant in the assurance process the previous year. HART response times are currently inputted manually, work has been ongoing with the Trust informatics team to move away from manual input. Due to the demands on the Trust ICT team, this was taken to ELC and other projects were considered to have a higher priority. A programme requires developing that can generate an accurate report of the response time standards and compliance for HART calls including the time of call, the number of staff allocated and when. However, following further discussion at ELC (20/09/23) and assurance provided by the ELC H16 has been changed to **partially-compliant.**
2.8.2	Other requirements to meet full compliance in the next 12 months include: • provision of estates in accordance with guidance (Ashburton update and Croxeth Project) • assurance regarding allocation of the prescribed number of SORT staff in the allotted time, and activation of specific vehicles • procurement of additional PPE (currently unavailable due to design changes by the supplier) • recruitment, selection, training and exercising of commanders • review of the type of evidence provided in command CPD
2.8.3	Key elements which require collaboration are C25-27 which detail the frequency with which commanders should train and exercise, the need for reflection within CPD, and the

	necessity to remove a commander from the rota immediately should the fall out of compliance. This will require a review of training record processes, updating the Workforce Management Plan (due for review 2022), and clear collaboration with the Leadership Review programme to ensure command is included in the job descriptions and assessment centres. Recruitment and selection was listed as standard C7 last year, removal of staff out of compliance was C26, and the Trust were classed as non-compliant for both.
2.9	**NEXT STEPS** The next steps for the Trust are: • To continue through the internal governance process, challenging the process or data provided where necessary to ensure it is confident with the information submitted to the ICB and NHS England at the end of September, • To recognise the collaborative work completed so far and to support the requirements of the action plans (appendices 2 and 3) to bring the standards that are partially compliant to full compliance, and to continue improvement on those already at full compliance, • To be prepared for any challenges presented back to the Trust from the ICB or NHS England, • To engage at a regional and national level with other ambulance service colleagues to discuss the experiences during the process this year and make representation and recommendation to NHS England regarding equitable working going forward.
3.	**LEGAL, RISK and/or GOVERNANCE IMPLICATIONS** ***(including consideration of the Trust's Risk Appetite Statement)*** The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR Annual Assurance process.
4.	**EQUALITY OR SUSTAINABILITY IMPACTS** N/A.
5.	**RECOMMENDATIONS** The Board is recommended to: • Receive assurance the EPRR Annual Assurance process 2023/2024 has been completed.

	• Note the compliance status against each of the 4 core areas and the additional area 'interoperable capabilities' following the self-assessment. • Note the Deep Dive on EPRR Training has been completed. • Note all action plans against the domains are in place to ensure all elements move to compliant. • This report is presented to Trust Board (27/09/23) prior to submission to the Lancashire and South Cumbria ICB on the 30 September 2023.

Classification: Official

Publication reference: PRN0235

To:
- NHS Accountable Emergency Officers
- ICB Accountable Emergency Officers
- NHS England:
  - Regional Directors
  - Regional Directors of Performance and Improvement
  - Regional Directors of Performance
  - Regional Heads of EPRR
- LHRP co-chairs

cc.
- Mike Prentice, National Director for Emergency Planning and Incident Response
- NHS England Business Continuity Team
- CSU managing directors
- Clara Swinson, Director General for Global and Public Health, Department of Health and Social Care
- Emma Reed, Director of Emergency Preparedness and Health Protection Policy Global and Public Health Group, DHSC

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 May 2023

Dear colleagues,

Emergency preparedness, resilience and response (EPRR) annual assurance process for 2023/24

Many thanks to you and your teams for your continued leadership and focus on the delivery of patient care during what has been another challenging year. Amongst the backdrop of a number of concurrent issues, not least the ongoing industrial action, whilst delivering a major recovery plan for urgent and emergency care service, the ability of the NHS to remain resilient and responsive over a sustained period is due to our collective commitment to emergency preparedness, resilience and response (EPRR).

NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR annual assurance process.

The process last year returned us to many of the previous mechanisms following a reduced process in the previous years, due to demands on the NHS. It was also the first time since the introduction of the Health and Care Act 2022 which established Integrated Care Boards as Category 1 responder organisations in the CCA (2004) and as local health system leaders. It is hoped that this year's process will build on these experiences by developing robust local processes for undertaking organisational self-assessments against the core standards and agree the processes to gain confidence with organisational ratings.

This letter notifies you of the start of the 2023/24 EPRR assurance process and the initial actions for organisations to take.

Core standards

The NHS core standards for EPRR are the basis of the assurance process. This year Domain 10 (CBRN) of the core standards have been reviewed and will also incorporate updated interoperable capabilities standards. The refreshed core standards can be found in the NHS core standards for EPRR self-assessment tool.

You are asked to undertake a self-assessment against the individual core standards relevant to your organisation type and rate your compliance for each.

The compliance level for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Deep dive

Following key themes and common health risks raised as part of last year's annual assurance process, the 2023/24 EPRR annual deep dive will focus on EPRR responder

training. Training is a fundamental element of embedding resilience within organisations as part of the cycle of emergency planning.

The deep dive questions are applicable to those organisations indicated in the NHS core standards for EPRR self assessment tool.

The outcome of the deep dive will be used to identify areas of good practice and further development whilst seeking additional assurance in this area of the core standards and guide organisations in the development of local arrangements.

Organisational assurance rating

The number of core standards applicable to each organisation type is different. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with. This is explained in more detail below:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

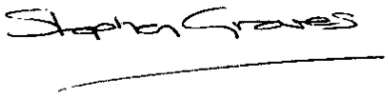
Action to take/next steps:

- All NHS organisations should undertake a self-assessment against the 2023 updated core standards (attached) relevant to their organisation. The outcome from this should then be taken and discussed at a public board or, for organisations that do not hold public boards, be published in their annual report.
- ICBs are required to work with their commissioned organisations and LHRP partners to agree a process to gain confidence with organisational ratings and provide an environment that promotes the sharing of learning and good practice. This process should be agreed with the NHS England regional head of EPRR.
- NHS England regional heads of EPRR and their teams are to work with ICBs to agree a process to obtain organisation-level assurance ratings and provide an environment that promotes the sharing of learning and good practice across their region.

- NHS England regional heads of EPRR are to submit the assurance ratings for each of their organisations and a description of their regional process to myself before Friday 29 December 2023.

If you have any queries, please contact your ICB EPRR Lead or regional head of EPRR in the first instance.

Yours sincerely,



Stephen Groves
Director of NHS Resilience (National)
NHS England

EPRR Core Standards – Ambulance, PTS, 111 2023

Action Tracker

Key	
	Non-Compliant
	Partial Compliance
	Fully Compliant

Standards that have been rated as **fully compliant** have been included on this tracker as there have been points for improvement noted. This recognises that the Trust are not satisfied with compliance but wish to excel. The action trackers on the spreadsheets provided to the ICB and NHS England only hold the actions of the standards where the Trust are **partially compliant**.

Action Plan				Overall Assessment	Substantially Compliant				
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	which has been agreed through the governance structure. It makes reference to roles and responsibilities of staff in different parts of the Trust and the need to align with the Minimum Occupational Standards. This includes EPRR staff, commanders, all those responding in an emergency, and the AEO. The internal governance has been included in the Policy. An assessment is currently underway to establish what tasks are undertaken by the Contingency Planning staff, and the time these take. It is anticipated there will be a business case to look for more staff. A national case has been put forward to increase the size of HART teams from a min of 42 to a min of 50. This has been approved nationally however awaiting uplift through local ICB. A letter was sent to the Commissioners by the CEO on 26th May 2023 from the CEO regarding MR20 (Arena Inquiry) requesting funds. A follow up email was sent on behalf of teh CEO on 25th August 2023 with a reply	Partially Compliant	CEO to follow up response from commissioners CEO and Dir of Finance have followed up on the HART uplift, no response to date.	CEO / Steve Hynes Director of Finance	End October 2023 End October 2023

8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	<u>Evidence</u> • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Risks are reported as a standing agenda item in the quarterly EPRR SC including updates, closers etc in the EPRR field. There is mention of risks highlighted via BC in the Risk Management Policy but it does not extend beyond this. EPRR is not mentioned. Having discussed with the Risk Team, the rationale is that risks have to be identified as directly impacting NWAS. RT and Risk have agreed to a workshop to, in part, train the RT staff in better risk assessment and management, and to go through some of the key NSRA risks and assess them from an NWAS perspective. The organisation would benefit from a more robust process in identification and sharing of risks from NRR and identified through other sources eg LRF **Evidence provided:** Risk Management Policy EPRR SC BAF report July 2023	Partially Compliant	Review of risk management process from lessons, NRR and CRR into and through the Trust	Head of Contingency Planning / Head of Risk and Assurance	End of Jan 2024
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	ICCs are covered in the IRP in terms of Major Incident Suites which are located next to each EOC and will be activated by a Duty EOC Manager. If the Strategic Commander isn't going to the SCG they will attend the Suite. The IRP also covers who else should attend the suite, but does not stipulate what should be in it. The ROCC can also act as a coordination room in the event of a major incident. Both the ROCC and EOCs run from building with UPS and generators so should not be affected by loss of power. This was recently discussed on a benchmarking meeting with other ambulance services. **Evidence provided:** IRP (submitted in standard 10)	Partially Compliant	Review the current rooms and roles and design a function that is fit for purpose	Head of Contingency Planning / Head of Operations (ICC)	End of June 2024

51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Updates are provided to EPRR Sub Committee who question the data and delve deeper with requests amended for future updates. BC status is included in the annaul assurance section in the Board reports but not as standalone comments. BC is audited as part of the EPRR SC Workplan, progress is measured against this and reported into EPRR SC, Q&P and annually to the Board. The BC process is not aligned to a Trust audit programme, there are no available audit reports and it has not been reviewed internally or externally. **Evidence provided**: BC Dashboard July 2023 (submitted in standard 50) EPRR SC report Board report (submitted in standard 3) SFI	Partially Compliant	Internal audit and peer review on the system to be establish on a cyclical basis. NWAS to consider funds for external audit from MIAA in Q12024 as per email from Mary Peters.	Head of Contingency Planning / Audit Team	Jun-24
DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Some staff within the Contingency Planning team are waiting for a place on the Dip HEPRR, there are limited numbers of places on Emergo courses which are mainly in the south. Courses on line are available including STAC and AQC. Some of the national, commander courses have limited availability which could impact recruitment and addition to the rota. They are also in the south of England which means overnight stays which could negatively impact staff who are limited with their options.	Partially Compliant	TNAs are being compiled for commanders, Contingency Planning staff, and all who may respond to an incident. This will be done in phases starting with PES Representation through national groups to ensure sufficient places are available on courses in accessible locations	Head of Contingency Planning / Head of EPRR Training	end March 2024
DD6	EPRR Training	Training Data	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	Commander training attendance is recorded on a spreadsheet, they also complete their own CPD records, and attendance at other courses and exercises is held on ESR This does not include other non-specialist responders, ICC, 111 or PTS staff. The data, where collected is held in different places and formats which make provision for assurance challenging.	Partially Compliant	Standardise the recording of training attendance for all responders	Head of Contingency Planning / Head of EPRR Training	end March 2024

EPRR Core Standards – Interoperable Capabilities
Action Tracker

Key	
	Non-Compliant – unlikely to be completed within 12 months
	Partial Compliance – will be completed within 12 months
	Fully Compliant

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	Y	PROCLUS updated at the start of each shift, as part of NACC national monitoring. Weekly updates of compliance provided. All efforts are made to provide six staff on duty by targeting nights and weekends. All vacancies are offered on overtime. Report partially compliant until national funding supports increased team staffing (7/8). Recruitment of HART personnel commenced in July 2023 to bring team back in line with establisment numbers (currently 4 vacancies). If national funding is agreed the intention is to utilise some of the staff from this recruitment as part of the increase in team numbers, this will be dependent on access to National course availability. **Evidence:** **Overtime Availbility Spreadsheets** **Staffing % Apr-March 23** **IC Shortfall Report** **Overtime Availability emails**	Partially Compliant	To maintain a minimum of 6 on duty at all times requires increased investment into the baseline funding so as to increase establishment. A national reference cost has been supplied by NARU for a HART Unit. Finance Dept are in negotatitaions with local commissioners to increase the baseline funding to the level of the reference cost.	Michelle Brooks	Mar-24	
H16	**HART**	**Record of compliance with response time standards**	Organisations must monitor and maintain accurate local records of their level of compliance with all HART core standards defined in this document. That must include accurate records of compliance with staffing levels and responses time standards for every HART deployment. Organisations must comply and fully engage with any audits or inspections of the HART capabilities that are commissioned by NHS England. Compliance records must be made available for annual audits or inspections conducted by NHS England or NARU and must be made available to NHS commissioners or regulators on their request.	Y	HART response time standards will be captured in the SOE / CAD. HART deployments are internally captured and manually inputted into PROCLUS and a seperate deployment form and spreadsheet documenting time of allocation and number of staff deployed. Work has been ongoing with the Trust informatics team to move away fro manual input, however due to the demands on the Trust ICT team, this was taken to ELC and other projects were considered to have a higher priority. There is no current understanding of expected timescales for completing. **Evidence:** **MS Forms example** **Deployment Responses (fed by the MS Forms)**	Partially Compliant	A programe requires developing that can generate an accurate report of the response time standards and compliance for HART calls including the time of call, the number of staff allocated and when.	Andrew Moody, Data Quality and Innovation Manager	Mar-24	Changed to partially complaint following discussion at ELC 20/09/23.

H32	**HART**	**Capital estate provision**	Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.	Y	Ashburton Point partially compliant as it only has 3 showers instead of the 4 outlined in the service specification. Croxteth however is non compliant although we have a derogation in place supplied by NARU until a new HART site is established at Liverpool. Meetings ongoing to review draft plans for building work at Ashburton. Estates and architects have been exploring options for Ashburton Point for additional showers and storage to meet the compliance standards in the national specification. A new Liverpool HART base is in the planning stages at the old Elm House site. Pre-planning application has been submitted and construction main contractors agreed. Public consultation has been completed and met with positive response. **Evidence:** **Croxteth Derogation Letter** **New Liverpool Plans** **Ashburton Development plans** **HART Estate Spec**	Partially Compliant	Ashburton - Requires building work to take place to increase the numbers of shower cubicles from 3 to 4 to meet the national HART estate contract standards. Work is scheduled to be undertaken and completed by end of March 24. Croxteth - HART Liverpool are moving to a new estate at the Elm House site which requires a provision of a new build. Plans have been drawn and planning permissions applied for.	Ashburton - Deborah Watters. Croxteth - Joe Barrett	Ashburton - March 24. Croxteth - March 25
S21	**SORT**	**Local risk assessments**	NHS Ambulance Trusts must maintain a set of local specific SORT risk assessments which supplement the national SORT risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation may determine what locations are considered high-risk (often in conjunction with the LRF), but the assessment must be for/or include MTA and CBRN specific risks. The organisation must also ensure there is a local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y	The National Ambulance Resilience Unit (NARU) have produced national risk assessments for the Standard Operating procedures for SORT. NWAS has completed a local risk assessment to compliment these national risk assessments.	Partially Compliant	Review of risk management process from lessons, NRR and CRR into and through the Trust	Head of Contingency Planning / Head of Risk and Assurance	End of Jan 2024

S29	**SORT**	**SORT response time**	Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. Any SORT staff available to respond in less than 60 minutes, must be responded as quicky as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders must be assigned to the incident. The NHS Ambulance Trust can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident must be approved by a Tactical or Strategic Commander and must be clearly documented. The decision will be subject to external review post incident.	Y	The Trust has identification, mobilisation and deployment procedures in place for the use of SORT. This is evidenced in EOC-MI-02D procedure and SORT EOC Action cards. These procedures are aligned to the SORT Core standards and Contractual standards. SORT depolyment tests are carried out throughout the year, two examples of these are in the evidence folder. Of note, national EPRRDG has recently identified some concern with the mobilisation of SORT staff and a suggestion has been made for NARU to facilitate a national exercise specifically looking at SORT release since this new standard came into force,	Partially Compliant	Conduct a test in each of the 3 areas in the next 2 weeks to check this can be achieved. Regularly maintain this testing process quarterly. Link this to S40 and test them regularly together.	Head of Special Operations	End of Sept 2023 Q4 2023
S35	**SORT**	**PRPS - minimum number of suits**	NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. Trusts must also ensure they have a financial / revenue replacement plan in place to ensure the minimum number of suits is maintained and replaced as required by the national Equipment Data Sheets.	Y	The Trust has an asset register for Powered Respirator Protective Suits (PRPS). A copy of this asset register is in the evidence folder. Monies for Servicing and replacement of PRPS will come out of the national funding workstream for SORT. Some suits have reached their maximum lifetime and have been decommisioned. Replacement suits cannot currently be purchased from Respirex as they are changing the design of the suit and therefore the numbers of PRPS held by the Trust is currently below the minimum numbers of 260, but once Respirex start supplying the new version of the PRPS suits we will then be able purchase 14 new PRPS suits to bring the numbers up to the required level of 260. The current overall in date PRPS suit numbers held by NWAS are 246	Partially Compliant	As soon as Respirex release the new design of PRPS suit then the Trust will purchase 14 new PRPS suits to increase our stock held up to the minimum required 260 PRPS suits.	CBRNe Manager	Expected release date of new design suit by Respirex is later this year 2023-24. As soon as the new PRPS is released the Trust will purchase 14 PRPS suits from SORT monies.

M4	**MassCas**	**Casualty management arrangements**	NHS Ambulance Trusts must have a Casualty Management Plan (CMP) (including patient distribution model) which has been produced in conjunction with Regional Trauma Networks and / or individual receiving facilities. These plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise.	Y	The Regional Mass Cas Distribution Plan was created in conjunction with wider health stakeholders. Although we have done a few exercises which have involved large numbers of casualties, the plan itself has not been tested recently. NHS England are updating the planning arrangements, NWAS will be part of the exercises associated with this. NWAS are also creating an exercising schedule, the Mass Cas Plans will be included. **NWAS Regional Mass Casualty Distribution Plan version 1.4** **NARU Casualty Management Plan is available to Commanders in electronic battle box for Operational and Tactical Commanders**	Partially Compliant	In conjunction with NHS England, test the new Mass Cas arrangements prior to sign off. Include Mass Cas Plan testing in the exercise schedule	Head of Contingency Planning	End of Q4 2023
C7	C2	**Recruitment and selection criteria**	NHS Ambulance Trusts must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions. Those skills and the mandatory levels of competence are defined within the National Training Information Sheets for Command and the National Occupational Standards for Command. This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y	A leadership review is currently underway within the trust which incorporates what staff will be required to fulfil within each role including command. An assessment is being designed to ensure any staff recruited into a role will be capable of fulfilling their command obligations. This will be complemented by an on-going training and exercise programme. Evidence provided: Leadership review bulletins showing timescales, new roles including commander roles at Op and Tactical. plus future standards for how new roles will meet these standards	Partially Compliant	Completion of strategic leadership review and draft assessments to be signed off	Leadership Review = Matt Cooper Resilience assessments = Andy Wood4	Q2 2024

C25	C2	**Commanders - exercise attendance**	All strategic, tactical and operational commanders must refresh their skills and competence by discharging their command role as a 'player' at a training **exercise every 18 months**. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented **reflective practice** for each exercise. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger multiagency exercises, including table top exercises. The requirement to attend an exercise in any 18 month period can be negated by discharging the individuals specific command role at a **relevant live incident** providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties in their command role as part of the incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. Failure to demonstrate and document these command functions at an exercise or live incident within an 18 month period must **result in the individual being immediately suspended from their command duties** until such time as they are able to fulfil this mandatory competency requirement.	Y	Commanders were provided with a brief that detailed the requirement to provide reflective practices in line with the National Occupational Standards laid out in Schedule 3 of the Standards for NHS Ambulance Service Command & Control. 2. The Trust does retain details but there is no documented process for maintaining the information for attendance on exercises, details exist in a number of spreadsheets including NOS file and Resilience spreadsheet. A further update on the NOS powerpoint presentation will have to include the requirement to produce a mandated reflective practice for an exercise or live inciudent in lieu, every 18 months. 3. The Trust has a Workforce Performance Management Policy, that lays out the process to be adhered to should an individual not meet the functions required for their command role. This includes details on how to rectify the failures. **Evidence** **Evidence NHS Standards for Ambulance Service Command & Control.** **NOS Presentation 2023.** **Worforce Performance Management Plan** **Exercise spreadsheets held by resilience team** **Reflective logs for Operational, Tactical and Strategic**	Partially Compliant	1. Workforce Management Plan needs to be updated, still showing as review 2022. - 2. Written process for how NOS is audited by ADs and how to remove a Commander in the C2 Framework 3. A central repository preferably aligned on Teams to NOS which is maintained within Resilience showing attendance by Commanders on Exercises - maintained by RaCET once recruited.	Vicky Camfield HR HR and Dir Resilience RaCET - once recruited in Q3 2023	1. Q3 2023 2. Q3 2023 3. Q3 2023
C26	C2	**Training and CPD - suspension of non-compliant commanders**	Any ambulance service strategic, tactical or operational commander that has not maintained the competency requirements specified in the National Training Information Sheet applicable to their role, or that has not maintained the relevant continued professional development (CPD) obligations, must be immediately suspended from their command duties. They must be **removed from any active command rota** and must not discharge their command functions at an incident until such time as the minimum level of mandated competence can be fully demonstrated.	Y	1. NOS can be accessed by Area Directors to conduct sampling. Currently no written process exists that clarifies this process apart from the details provided in a powerpoint presentation that was given to commanders between March & May 2023. 2. The Workforce Performance Management Plan lays out the formal process for removal of staff and how to implement training requirements to enable staff to resubmitted onto the Command Rota. TIS only introduced recently, still only details for Tactical and Operational, Strategic is under review. **Evidence** **1. NOS presentation 2023** **2. Workforce Performance Management Plan**	Partially Compliant	1. Workforce Management Plan needs to be updated, still showing as review 2022. 2. Written process for how NOS is audited by ADs and how to remove a Commander in the C2 Framework	Vicky Camfield HR HR and Dir Resilience	1. Q3 2023 2. Q3 2023

C27	C2	**Assessment of commander competence and CPD evidence**	Each NHS Ambulance Trust must have a process in place to check and verify that strategic, tactical and operational commanders are maintaining appropriate levels of CPD evidence and that they are **maintaining the minimum levels of competence** defined within the National Training Information Sheets. As a minimum, this must include obtaining an **annual signed declaration from all active commanders** that they understand the obligations defined within these core standards and that they have maintained the minimum levels of competence and CPD defined within the relevant National Training Information Sheet. Further to these annual declarations, each Ambulance Trust must undertake **'dip sampling'** of multiple CPD portfolios from the strategic, tactical and operational command levels to verify the declarations being made. This assessment of randomly selected CPD portfolios should be undertaken by a suitably competent person, such as an Emergency Preparedness professional. The Accountable Emergency Officer in each Ambulance Trust is responsible for ensuring that any commander at any level who has not been able to maintain the minimum competency requirements is **immediately suspended from discharging command functions** at an incident.	Y	1. Currently the Trust does not have a written process, only that provided through a powerpoint presentation that was delivered to all commanders between March & May 2023. 2. The Trust does not obtain a signed declaration from staff although Section 1 of the Appraisal process discusses mandatory training compliance, this could be extended and include minimum NOS standards. 3. Responsibility for sampling has been given to ADs and Head of Contingency for NILOs, overseen by Director of Resilience, but this was part of the NOS presentation rather than being defined in a written process 4. Currently there is no formal process that details how the AEO is to be included in this process. **Evidence** **1. NOS presentation 2023**	Partially Compliant	1. Written process for how NOS is audited. 2. Produce annual declaration or incorporate NOS into Appraisal form along with mandated training or as an annex to written process. 3. Include NOS compliance in EPRR SC work programme. 4. Need to ensure AEO is involved when a commander is not maintaining competency include in C2 Framework and EPRR policy	1. Dir Resilience & HR 2. Dir Resilience & Head of Contingency. 3. HR and Dir Resilience 4. Head of Contingency Planning	1. Q3 2023 2. Q3 2023 3. Q3 2023 4. Q3 2023	This needs to be reported into EPRR SC
J10	JESIP	**Commanders - interoperability command course**	All active commanders (strategic, tactical and operational) are required to ensure that JESIP forms part of their ongoing continued professional development portfolios and evidence. This must include reflective practice that includes specific JESIP principles from an exercise or live incident every 18 months.	Y	Commanders maintain a CPD over a rolling 18 month period. Although it does not specifically contain JESIP details, the ESR awareness is included, and the exercises are designed to embed JESIP working. Reflective practice is encouraged but may not spell out JESIP application in all circumstances. **Evidence** **CPD portfolio** and templates	Partially Compliant	Review the templates for reflection, consider including specific subjects to think about which can be included in audit e.g. JESIP, the use of plans	AW4, Joe B and ADs (templates and audit) / N Bell (C2 Framework)	End of March 2024	Suggest adding some specifics to reflection templates to ensure focus on certain topics
J13	JESIP	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a M/ETHANE message.	Y	All frontline and EOC staff must complete the JESIP module on ESR - as of 10th September we are at **84%** Mandatory training compliance is shown on the ESR dashboard and should be monitored by Line Managers. Mandatory training is also discussed on PES Level 3 (senior manager) meetings. **Evidence** **email trail**	Partially Compliant	Area Directors, who are responsible for Commander Compliance, should confirm with line managers that JESIP training is being completed and provide the data quarterly to the Head of Contingency Planning for inclusion in the EPRR Sub Committee reports	Area Directors	Report due Oct 2023, Jan 2024, April 2024, July 2024	Evidence needed: have requested records from Rebecca classed as non-compliant at the moment as don't know how near 90% we are

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th September 2023				
SUBJECT:	EPRR Policy				
PRESENTED BY:	Deputy Chief Executive				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☒	☒	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☐	☒	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. This paper presents the final version of the EPRR Policy, based on the Policy Statement taken to EPRR Sub Committee in January but with additions to aid compliance with the EPRR Core Standards Assurance. It has been seen by ELC and will be presented to Quality and Performance Committee (25/09/23) with the amendments made as requested by ELC.				
RECOMMENDATIONS:	The Board is requested to: • Approve the NWAS EPRR Policy and subsequent publication and dissemination via the Green Room.				
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☒ Quality Outcomes ☐ People ☐ Financial / Value for Money ☒ Reputation ☐ Innovation				

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	EPRR Sub Committee as 'EPRR Policy Statement' and ELC.			
	Date:	16th January 23 (EPRR SC) 6th September 23 (ELC)		
	Outcome:	Initial draft agreed at EPRR SC, ELC requested the removal of appendices containing EPRR SC TOR and the sample Work Plan.		

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1. PURPOSE

The purpose of this report is to inform the Board of the content of the NWAS EPRR Policy (Appendix 1), the rationale for the content, and to request approval for publication and dissemination.

2. BACKGROUND

2.1 Expectations from NHS England

2.1.1 The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022.

2.1.2 The Civil Contingencies Act (2004) sets out duties for Category 1 responders, such as NWAS, to:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity management arrangements,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance coordination,
- Co-operate with other local responders to enhance coordination and efficiency.

2.1.3 Various items of documentation are available to support organisations in understanding how to deliver these duties. This includes the Emergency Response and Recovery Guidance (2013), JESIP Doctrine (2021), and the Business Continuity Good Practice Guidelines (2018). NHS England undertake an annual national audit to establish if organisations are compliant with the published Core Standards, which aims to test how NHS funded organisations meet their duties. Content of the required EPRR Policy or Policy Statement are covered in the following standards:

Ref	Domain	Standard
1	Governance	Senior leadership
2	Governance	EPRR Policy statement
3	Governance	EPRR board reports
4	Governance	EPRR work programme
5	Governance	EPRR resource
6	Governance	Continuous improvement
7	Duty to risk assess	Risk assessment
8	Duty to risk assess	Risk management
20	Command and control	On call mechanism

21	Command and control	Trained on call staff
22	EPRR Training	EPRR training
27	Response	Access to planning arrangements
29	Response	Decision logging
56	CBRN	Hazmat governance

2.2 Previous version of the EPRR Policy Statement

2.2.1 In January 2023, a draft EPRR Policy Statement was created and taken to the EPRR Sub Committee for comment. Until this point, NWAS did not have a policy, and the only statements of preparedness were references in the Major Incident Plan.

2.2.2 The Policy was accepted in principle but was not taken to ELC as it was assumed to be EPRR specific. Having discussed it with NWAS Governance staff, it was agreed that the policy affects all the organisation in terms of preparedness, rather than a focus on command and control, and therefore would require presentation at ELC.

2.2.3 This is an opportunity for a final review, prior to publication, to ensure detailed compliance with the NHS England Core standards. The principal content approved by EPRR Sub Committee remains, but more detail has been added to some sections as highlighted below.

2.3 'The NWAS EPRR Policy' content (see Appendix 1)

2.3.1 The key objectives of the document, as detailed in the NHS EPRR Framework 2022, are to ensure the Trust:

- prepare for the common consequences of incidents and emergencies rather than for every individual emergency scenario,
- have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios,
- supplement this with specific planning and capability building for the most concerning risks as identified in the Community and National Risk Registers,
- ensure that plans are in place to recover and learn from incidents and emergencies and to provide appropriate support to affected communities,
- ensure an annual work programme is in place based on risks, statutory responsibilities, and good practice guidance, and it is reviewed and updated in line with national policies including the Terms of Reference.

2.3.2 The **aim and objective** section has been expanded to illustrate the Board's commitment to providing sufficient funding and resources to support alignment with the legislation, working through risk assessments and collaborative planning to maintain normal business and respond to incidents. It also explains the resources which sit under EPRR, namely specialist assets, contingency planning, command and command support, and training. (CS1, CS2, CS5)

2.3.3 **Organisational duties** section is broadly the same, explaining the underpinning principles of good practice for EPRR, taken from NHS England EPRR Framework. (CS7, CS8)

2.3.4 The **roles and responsibilities** section has been expanded to clarify the expectations put upon the Chief Executive, Accountable Emergency Officer, Specialist Assets, commanders, and On Call staff. The detail regarding responsibilities of commanders has been removed and replaced with signposting to NARU Command and Control Guidance for continuity. (CS1, CS2, CS3, CS20, CS56)

2.3.5 The **Governance** around EPRR required further detail in terms of the groups, reporting processes, and report content. It covers the EPRR Sub Committee, Quality and Performance Committee, and Board report content. The Terms of Reference for the EPRR Sub Committee are still held in an appendix to the document, as is a sample Work Programme. (CS1, CS3, CS4, CS5, CS6, CS7, CS8)

2.3.6 Training and exercising have been brought into a section entitled '**Emergency Planning Cycle**' which now starts with Risk Assessment and Mitigation. It references the Trust Risk Management Policy and risk escalation. This is an area where the Trust would benefit from the Resilience (Contingency Planning) and Risk teams working collaboratively to create a more robust risk assessment and monitoring procedure, starting from the National Risk Register and leading to the BAF where needed. Training and exercising previously focused on command and command support roles, it now also covers non-specialist staff, EOC, PTS, 111 and Contingency Planning staff. (CS4, CS6, CS7, CS8, CS20, CS21, CS22, CS27, CS29)

2.3.7 Lessons identified has be renamed **Continuous Improvement** in line with the Core Standard. It covers the debrief processes, references the Debrief Policy, and covers sharing of lessons both internally and externally. (CS4, CS6, CS7, CS8)

2.3.8 **Record keeping and logging** includes logging, loggists, electronic recording, document storage, retention periods, and use in identification of lessons. (CS29)

2.3.9 **Supporting documentation**
The following documents underpin the present Policy:

- Civil Contingencies Act (2004).
- Health and Care Act (2022).
- NHS England Emergency Preparedness, Resilience and Response Framework (2022).
- Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (2022).
- NHS England Core Standards for Emergency Preparedness, Resilience and Response.
- NHS England Business Continuity Management Toolkit (2016).
- NHS Act (2006).

- National Risk Register
- Emergency Response and Recovery Guidance, Cabinet Office (2013)
- NARU Command and Control Guidance (2021)
- JESIP Doctrine (2021)

2.3.10 The Policy is to be read in conjunction with the following documents:

- Trust Incident Response Plan.
- Business Continuity Policy and departmental plans
- CBRN Plan
- Risk Management Policy
- Debriefing Policy

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

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

3.2 The NHS Core Standards (2023) require the Trust to have an EPRR policy in place to

- determine the accountability of senior leadership (CEO and Accountable Emergency Officer),
- provide a statement of commitment from the Board in terms of resources, risk assessments, access to funds, and supporting of the emergency planning cycle,
- ensure a system of governance including publicly accessible Board reports,
- a monitored work programme,
- roles and responsibilities of those covered by EPRR including on call, specialist response, command, command support, trainers, and planners,
- outlining of a continuous improvement process
- risk management

3.3 Establishment of The Policy supports compliance with these requirements. The arrangements contained within The Policy will be reviewed on an on-going basis in light of changes in guidance from NHS England, NARU, National Risk Register, or due to internal changes within NWAS. This Policy will retain compatibility with those contingencies of all Local, Regional and National NHS Agencies and with partner agencies within the Local Resilience Networks of Cheshire, Cumbria, Greater Manchester, Lancashire, and Merseyside.

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified at the time of writing this report.

5. RECOMMENDATIONS

The Board is recommended to:

- Approve the NWAS EPRR Policy and subsequent publication and dissemination via the Green Room.

Emergency Preparedness, Resilience and Response (EPRR) Policy

Recommended by	NWAS Resilience Team
Approved by	G Blezard, Executive Director of Operations
Approval date	TBC
Version number	0.6
Review date	January 2024
Responsible Director	G Blezard, Executive Director of Operations
Responsible Manager (Sponsor)	J Hodson, Head of Contingency Planning
Author	J Hodson, Head of Contingency Planning Andrew Wood
For use by	All Trust Employees

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	16 Dec 2022		A Wood	Implemented in line with NHS England EPRR core standards 2022
0.2	01 Feb 2023		A Wood	Updated following feedback from EPRR SC members
0.3	23 Aug 2023		J Hodson	Aligned with NHS England Core Standards 2023 and additional evidence
0.4	29 Aug 2023		J Hodson	Amendments after feedback
0.5	31 Aug 2023		J Hodson	Amendments following discussion with Governance
0.6	12 Sept 2023		J Hodson	Removal of appendices (TOR and work plan) on request of ELC

EPRR Policy

Contents

1. Introduction

1.1 This Emergency Preparedness, Resilience and Response (EPRR) policy document has been produced to ensure that North West Ambulance Service (NWAS) has the correct structures in place to be properly prepared for dealing with emergencies. It is in place to ensure that it meets the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act (2006), the NHS EPRR Framework (2022), the Health & Care Act (2022), and is in line with NHS Core Standards (NHS England, 2023).

2. Aims & Objectives

2.1 NWAS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. Risks could range from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act (as shown in the National Risk Register, 2023). This is underpinned by legislation contained in the CCA 2004, the NHS Act 2006 and the Health and Care Act 2022.

2.2 The Trust Board is committed to providing sufficient funding and resource to support alignment with the legislation, working through risk assessments and collaborative planning to maintain normal business and respond to incidents. This will be completed by ensuring processes are in place to identify and embed lessons, training staff to a high standard in their roles, and exercising to test plans and assure training. The Board is also committed to having a robust Business Continuity Management System in place to mitigate risk and issues including staff loss, estates or utility disruption, or problems within the supply chain.

2.3 Resources include:

- **Trained specialist assets** (e.g. Hazardous Area Response Team, National Interagency Liaison Officers) in sufficient quantity and based in locations to adequately meet legislative requirements, national standards, inquiry recommendations, and noted good practice.
- **Contingency Planning staff** trained to work with partner agencies to risk assess, create plans, train, design and deliver exercises, plan events, perform debriefs to identify and share lessons, and represent the Trust at multiagency meetings to complete the aforementioned duties.
- **Command cadre** who are suitably qualified, experienced, empowered and practiced in fulfilling their roles to the required standards, and sufficient staff in place to provide the training, assessment, and exercising.
- Persons undertaking these roles should meet the requirements of the National and Minimum Occupational Standards (MOS) as provided by NARU and NHS England

2.4 The aim of the policy is to ensure that NWAS has effective arrangements in place to deliver appropriate care to patients affected by an emergency or incident, and to continue to provide a service to the wider community in such circumstances.

2.5 The key objectives of the document, as detailed in the NHS EPRR Framework 2022, are to ensure the Trust:

- prepare for the common consequences of incidents and emergencies rather than for every individual emergency scenario,
- have flexible arrangements for responding to incidents and emergencies, which can be scalable and adapted to work in a wide range of specific scenarios,
- supplement this with specific planning and capability building for the most concerning risks as identified in the Community and National Risk Registers,
- ensure that plans are in place to recover and learn from incidents and emergencies and to provide appropriate support to affected communities,

- ensure an annual work programme is in place based on risks, statutory responsibilities, and good practice guidance, and it is reviewed and updated in line with national policies including the Terms of Reference.

3. Organisational Duties

3.1 As detailed in the CCA (2004) and the NHS EPRR Framework (2022), the Trust as a Category 1 responder is legally required to comply with the full set of civil protection duties as follows:

- Assess the risk of emergencies occurring and use this to inform contingency planning,
- Put in place emergency plans,
- Put in place business continuity management arrangements,
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency,
- Share information with other local responders to enhance coordination,
- Co-operate with other local responders to enhance coordination and efficiency.

3.2 In addition to the duties outlined, the Trust is required to align with the requirements listed within the NHS England Core Standards for EPRR and the NHS Standards Contract, which are in accordance with the CCA (2004) and the NHS Act 2006 (as amended). These are minimum standards, and the Trust commits to continuous improvement beyond compliance.

3.3 The Trust will also act in accordance with the underpinning principles of good practice for EPRR, as set out in the NHS England EPRR Framework and outlined below:

Preparedness and Anticipation	Anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible. All individuals that may have to respond to incidents should be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and rehearsing arrangements periodically, as appropriate.
Continuity	Set incident response plans and procedures grounded within its existing functions and its familiar ways of working, as much as practically possible.
Subsidiarity	Decisions should be taken at the lowest appropriate level, with coordination at the highest level necessary.
Communication	Set incident response plans and procedures to include effective communication channels in case of incident response. This will also consider communication with the public, when appropriate.

Cooperation and Integration	Effective coordination should be exercised within the organisation and other organisations via local, regional, and national tiers of a response. Mutual aid can be activated across the organisation, UK, and international boundaries, as appropriate.
Direction	Clarity of purpose should be delivered through an awareness of the strategic aim and supporting objectives for the response. These should be agreed and understood by all involved in managing the response to an incident to effectively prioritise and focus the response.

3.4 As a member of AACE, the Trust are part of the national Mutual Aid agreement between NWAS, other Ambulance Trusts and, where applicable, other NHS funded organisations. It has been demonstrated that joint working can resolve difficult issues and problems across organisational boundaries. These mutual aid arrangements should be regularly reviewed and updated.

4. Roles & Responsibilities

4.1 The EPRR Framework (NHS England, 2022), and Minimum Occupational standards (MOS) for EPRR in the NHS (2023) specifies roles and responsibilities within EPRR. All staff in a planning or response role should have specific training to fulfil their responsibilities. All other staff involve in ad hoc response roles, such as functional roles or first on scene, should have enough training and opportunity to exercise to support delivering of their function. This is inclusive of EOC, PTS, and 111.

4.2 A director with delegated authority to allocate resources should always be available to make strategic decisions for the organisation; other staff should also be on-call to provide support. The NWAS on call structure is available 24/7 through a cascade system and incorporates the Integrated Contact Centres, and Command and Support functions. The rotas are centrally managed and staff on the rotas are subject to a clear initial training and Continuous Professional Development process. A supporting document detailing the operational processes to be followed by on call staff will be treated as an annex to this policy.

4.3 The NHS Act 2006 places a duty on relevant service providers to appoint an individual to be responsible for discharging the duties under section 252A(9). This individual is known as the Accountable Emergency Officer (AEO). NHS England expect all NHS-funded organisations to have an AEO regarding EPRR.

4.4 Chief executives may designate the responsibility for EPRR as a core part of their organisation's governance and its operational delivery programmes and will be able to delegate this responsibility to a named director. The independence that Non-executive Directors (NEDs) bring is essential to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.

4.5 The AEO will be a board-level director responsible for EPRR. They will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the board that strategies, systems, training, policies and procedures are in place to ensure their organisation responds appropriately in the event of an incident. AEOs will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response, and the duties recorded in their job description.

Accountable Emergency Officer

- Executive Director, normally of Operations (the title may change but the responsibilities remain)
- Responsible for ensuring that the Trust:
  - and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and the Core Standards.
  - is properly prepared and resourced to deal with an incident, including those requiring specialist response e.g. hazardous materials, terrorist attack, difficult access, cyber.
  - itself and any sub-contractors it commissions have robust business continuity planning arrangements in place that align to ISO 22301 (the national standard around business continuity management systems which the Trust complies with), or subsequent guidance that may supersede this.
  - has a robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served.
  - complies with any requirements of NHS England, in respect of monitoring compliance.
  - provides NHS England with such information as it may require for the purpose of discharging its EPRR functions.
  - is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the Local Health Resilience Partnership (LHRP) and/or Local Resilience For a (LRF), as appropriate.

4.6 Commander roles and responsibilities are listed in the NARU Command and Control Guidance, from Operational, Tactical, and through to Strategic. The document also details the responsibilities of various functional and command support roles. This is reflected in the Trusts Incident Response Plan.

4.7 Other roles noted in the NHS EPRR MOS have a national occupational standard over a number of skills for justice settings, which are both mandatory and optional. The Trust commit to provision of training and experience to support alignment with these standards. The roles are:

- Business Continuity Lead
- Comms Officer
- Command Support Roles
- On Call Staff

5. Governance

5.1 The Board of Directors will receive an annual report which will be included in the publicly available Board papers and minutes, and will contain an overview on:

- Training and exercises undertaken,
- Summary of incidents, including BC, experienced by the organisation,
- Lessons identified and learning undertaken,
- Compliance position relating to the latest NHS England EPRR assurance process.

5.2 Assurance is provided to the Board by the Quality and Performance Committee. The Quality and Performance Committee will receive a Chair's Assurance Report from the Chair of the EPRR Sub Committee containing a summary of the business that has been transacted and basis of any recommendation made. This will:

- Provide assurance in relation to compliance with the CCA (2004) and EPRR Core Standards
- Identify and escalate any EPRR risks.

5.3 The EPRR Sub Committee, chaired by the Trust Accountable Emergency Officer (AEO), has been established to obtain assurance in relation to preparations for major incidents and emergencies, in accordance with the duties under the CCA (2004) and compliance with NHS England Core Standards. The EPRR Sub Committee will meet quarterly and attendance, including the minimum quorum requirements, are laid out in the Terms of Reference (Appendix A). The Chair (AEO) can also request a meeting at any time based around a National or Regional EPRR incident, including a Major Incident, or Business Continuity concern.

5.4 The chair of the EPRR Sub Committee is responsible for the organisation of the EPRR Sub Committee meetings, approval of minutes, actions tracking and any subsequent changes. The Sub Committee has no executive powers other than those specifically delegated within the terms of reference.

5.5 The EPRR Sub Committee work programme is circulated at each bimonthly meeting and reviewed on an annual basis (appendix B). It contains specific roles and responsibilities relating to the production of plans and reports for assurance and is based on the NHS England Core Standards requirements.

5.6 Papers may be presented to the Executive Leadership Committee (ELC) prior to the EPRR Sub Committee as the ELC can provide multidepartment feedback and challenge to ensure robust planning.

5.7 Other forms of external assurance the Trust participates in include annual NHS Core Standards Assurance, JESIP review, Joint Organisational Learning (JOL) action note responses, and National Interagency Liaison Officer (NILO) assessments.

6. Emergency Planning Cycle

Risk management

6.1 As one of the duties under the CCA (2004), the Trust will participate in Local Resilience Forum Risk Groups and bring them into the Trust for centralised discussion. It is the first step in the emergency planning and business continuity process. It will take into consideration the National Risk Register and National Security Risk Assessment. Some of the risks are noted in the NHS England Core Standards with a requirement to hold risk-specific plans. These risks will be managed in line with the Trust's Risk Management Policy and raised within the EPRR Sub Committee if necessary.

Planning

6.2 The Trust will produce a generic Incident Response Plan to act as a framework for response to any type of incident. It will include a command-and-control framework and enough information for staff to make decisions. Risk, event, and site-specific risk plans will form a suite of documents to further inform and support educated decision making. They will be shared digitally internally and externally, and briefings will be undertaken to increase awareness of the plans.

6.3 During planning, discussions with stakeholders will take place to ensure joint risk assessment, shared situational awareness, and the use of common terminology.

Training

6.4 The Resilience team consists of Contingency Planning, Special Operations (incorporating HART), and an EPRR Command and Resilience Training Team. All staff across the team will be required to complete training and exercises relevant to their role to enable them to perform effectively. NARU set

the training requirements for HART and SORT, the Contingency Planning staff will be working towards alignment with the EPRR Specialist Advisor MOS at a level appropriate to their role in the Trust.

6.5 The Trust will maintain a robust training regime to ensure all of those with a response role as either a commander or command support function are given the opportunity to maintain the skills needed to conduct their specific roles. This includes operating with multiagency partners to fully understand the use of JESIP when deployed during an incident. They will be required to adhere to the appropriate powers, policies and procedures during their decision-making process, including the use of the Incident Response Plan and role action cards.

6.6 The Area Directors are accountable for the compliance of the Commanders under their portfolio. The Trust maintains a record of the training conducted by the command and command support cohort, with any concerns or risks raised to the EPRR subcommittee, to ensure mitigation is put in place.

6.7 Those personnel with an on-call function are responsible for ensuring they attend and complete the mandatory and where necessary optional training, to maintain their compliance as laid out in the NHS England EPRR (MOS) which acts as a training needs analysis (TNA). This is to be reflected in their personal Continuous Professional Development folders and in their annual appraisal.

6.8 Any staff with a role in response, whether that is through PES, EOC, PTS or 111, will require up to date training regarding their role, and the opportunity to practice. Training resources include eLearning, face to face formal training sessions, one to one or small group discussion.

6.9 Training provided will be amended if there are any changes in local or national directives, or if lessons have been identified locally or nationally.

Exercising

6.10 The Trust is mandated to exercise its Incident Response Plan in line with national minimum requirements as laid out in the EPRR Framework 2022 and the NWAS Incident Response plan. The minimum requirements are as follows:

Live Exercise & Command Post Exercise	Every 3 years
Tabletop Exercise	Annually
Communications Exercise	6 monthly

6.11 The Trust will comply with this as a minimum. Every opportunity will be used to ensure all those in Command and command support roles maximise the opportunities that are available across the region as the NARU Command and Control Guidance mandates they participate in an exercise every 18 months, in alignment with the rolling Continuous Professional Development (CPD) portfolio. Details of upcoming exercises and training with multi agency partners are available from the Resilience team.

6.12 Non-specialist staff will be offered places on exercises to embed actions and behaviours, attendance will be recorded on ESR for audit purposes.

6.13 A testing cycle will be put in place and provided to the EPRR Sub Group for assurance that plans beyond the IRP are being completed, staff trained, and the plans tested. The tests will be internal to

ensure NWAS processes and action cards dovetail, and completed with multiagency partners to raise awareness and ensure expectations are managed.

7. Continuous Improvement

7.1 Emergency Response and Recovery Guidance (Cabinet Office, 2013) asserts Chief Executives will want to ensure there is appropriate follow-up to lessons identified. This could be revision of plans, procedures, training, strengthening of relationships with stakeholders, and developing targeted exercises to test alternative approaches.

7.2 Following a Business Continuity, Critical or Major Incident activation, the Resilience Team will facilitate a structured debrief to ensure lessons identified and notable practice are recorded. Debriefing should be honest and open, and results disseminated. The Trust Debrief Policy lays out the process and theme headings to be used to capture lessons and ensure that training and Trust processes are amended and reviewed for learning to be correctly embedded.

7.3 As a result of the debrief, a structured debrief report will be produced, which will include an action plan with assigned owners and timescales. It is the responsibility of the Resilience Manager for Quality & Improvement to monitor the owners of actions, ensure they are completed and closed to an acceptable standard. This will also be shared with internal stakeholders through Contingency Briefings, Area Learning Fora, and other internal organisational learning structures.

7.4 All key learning will be presented to the EPRR sub committee in a quarterly report for assurance. This will be included in summary in the annual report to the Board which will be hosted on the Trust internet site for the purposes of public assurance.

7.5 Where lessons would be beneficial for partners to be aware of they will be shared through relevant local groups, on the JOL platform, in in some cases through national meetings.

8. Record Keeping and Logging

8.1 The day-to-day management of people and patients in the NHS is subject to legal obligations such as duties of care, candour and confidentiality as well as professional obligations. This does not change when responding to an incident. However, these events can lead to greater public and legal scrutiny. his may include coroners' inquests, public inquiries, criminal investigations and civil action. When planning for and responding to an incident, all decisions made or actions taken must be recorded and stored in a way that can be retrieved later to provide evidence (NHS England, 2022).

8.2 The Trust has a legal requirement to provide all documents relevant to an incident including the logs used for decision making, debriefs, and amendments to documents and policies brought by lessons learnt. The NHS EPRR Framework 2022 should be referred to for the minimum retention period of EPRR related documents including incidents, exercises, Incident Response Plans, Standing Operating Procedures, Risk Registers and minutes from sub-group meetings.

8.3 The Trust is to ensure it has the appropriate storage across its sites to allow the documentation to be stored correctly. Electronic storage should also be made available and used in accordance with Trust Information Governance procedures.

8.4 The Trust must have appropriately trained loggists to support the management of an incident. It is essential that all those tasked with logging do so, following best practice and understand the importance of logs in the decision-making process, in evaluation and identifying lessons and as evidence for any

subsequent inquiries. All commanders must ensure they are able to complete a log using best practice and submit it in line with the policy laid out in the Trust Incident Response Plan.

8.5 Electronic means including Dictaphones and Body Worn Video Cameras should be utilised to record information regarding decision making but also provide the context in which those decisions were made. This should be completed in line with the Trust Information Governance processes.

9. Supporting Documents

9.1 The following documents underpin the present policy:

a. Civil Contingencies Act (2004).
b. Health and Care Act (2022).
c. NHS England Emergency Preparedness, Resilience and Response Framework (2022).
d. Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (2022).
e. NHS England Core Standards for Emergency Preparedness, Resilience and Response.
f. NHS England Business Continuity Management Toolkit (2016).
g. NHS Act (2006).
h. National Risk Register
i. Emergency Response and Recovery Guidance, Cabinet Office (2013)
j. NARU Command and Control Guidance (2021)
k. JESIP Doctrine (2021)

9.2 This policy is to be read in conjunction with the following documents:

a. Trust Incident Response Plan.
b. Business Continuity Policy and departmental plans
c. CBRN/Hazmat Plan
d. Risk Management Policy
e. Debriefing Policy

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th September 2023				
SUBJECT:	NWAS Strategic Winter Plan 2023-2024				
PRESENTED BY:	Deputy Chief Executive				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☒	☒	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☐	☐	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. The intention of this paper is to introduce the Board to the NWAS Winter Strategic Plan 2023-2024 following the annual review and revision. The document describes the establishment of winter planning arrangements across the Service Delivery directorate including mitigations to meet predicted demand. Included within the Plan are detailed forecast summaries which utilise several years historical data combined with current influencing factors to provide forecasting data to support operational planning. The Strategic Winter Plan also places into context the challenges NWAS and the whole health system faces during this winter period creating potential disruptive impacts such as activity increase through winter demand, adverse weather conditions, new variants of COVID-19, and the seasonal influenza season.				
RECOMMENDATIONS:	The Board are recommended to approve the content of this plan, providing assurance of the required levels of preparedness for the anticipated winter pressures.				

CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee			
	Date:	20th September 2023 (ELC)		
	Outcome:	Approved.		

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1. PURPOSE

The purpose of this paper is to present the Board with the NWAS Winter Strategic Plan for 2023-2024.

2. BACKGROUND

2.1 This winter will see NWAS and the whole health system under considerable pressure due to the predicted increase in activity, unknown impacts of new variants of COVID-19, continued uncertainty around the UK economic position which may potentially lead to vulnerable members of our community, particularly around energy costs, in what is predicted to be a cold winter.

2.2 The annual 'Winter Letter' from the NHS has been issued on the 27 July 2023, setting out NHS England's expectations for planning and managing the winter period. This communication has been pivotal in ensuring the whole system is focused and working together. It also provides key messages and areas of focus to assist with whole system integration and risk mitigation.

NHS England (2023) have set out four key areas for systems to focus on in preparation for winter:

- Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place.
- Completing operational and surge planning to prepare for different winter scenarios.
- ICBs should ensure effective system working across all parts of the system.
- Supporting our workforce to deliver over winter.

Within the UEC Recovery Plan, NWAS are focused on fulfilling NWAS responsibilities as detailed with the NHS England publication- Working together to deliver a resilient winter: System roles and responsibilities (2023):

- Ensure a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans.

- Increase the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls.

- Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Note the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services.

- Establish sufficient call handling capacity and finalise arrangements for the use of the 'Intelligent Routing Platform' in times of surge.

- Ensure mental health professionals are embedded in all emergency operation centres ahead of winter.

- Use the ambulance auxiliary service when needed.

2.3 A priority whilst developing NWAS' winter planning arrangements is the finalisation of the Winter Strategic Plan providing internal and external assurance and for the development of area and service level specific winter plans. These area based plans contain detailed and focussed information with a more introspective direction to support operational arrangements in each service line; PES areas (GM, C&M and L&SC) and Integrated Contact Centres (EOC, 111 and PTS) and PTS Operations.

2.4 As part of the NHS Winter Assurance/Preparedness process, Trusts are normally required to complete and submit an assurance template. This NWAS document has not been received at this stage, however, the NWAS Winter Strategic Plan will provide assurance of the planning undertaken and the mitigations in place to prepare for this year's winter period and support compliance of the assurance process.

3. LEGAL, RISK and/or GOVERNANCE IMPLICATIONS

3.1 The Trust's contingency planning arrangements, capabilities, and training and education resources assist in providing evidence of compliance with our duties under the CCA (2004), the Health and Care Act 2022 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.

Integral to being properly prepared is the required provision of timely support and tactical advice from subject matter experts to NHS Ambulance Commanders and staff. This requirement is set out in current versions of the:

- EPRR Core Standards (standard C28 and C29 – interoperable capabilities)
- NHS EPRR Framework (section 9.2.1)
- Minimum Occupational Standards (section 4.1 and 4.2)
- National Ambulance Resilience Unit (NARU) Command and Control Guidance (section 3.45 and 3.47).

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

4.1 None identified at the time of writing this report.

5. RECOMMENDATIONS

5.1 The Board are recommended to approve the content of this plan, providing assurance of the required levels of preparedness for the anticipated winter pressures.

NHS North West Ambulance Service NHS Trust

NWAS

Winter Strategic Plan 2023-2024

Recommended by	NWAS Resilience Team
Approved by	S Hynes, Assistant Director Resilience
Approval date	
Version number	0.6
Review date	March 2024
Responsible Director	G Blezard, Director of Operations S Desai Chief Operating Officer/Deputy CEO (1 Oct 2023)
Responsible Manager (Sponsor)	J Hodson, Head of Contingency Planning
Author	A Jackson, Business Continuity Manager
For use by	All Trust employees

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change Record Form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	06/08/2023		A Jackson	Document creation
0.2	05/09/2023		A Jackson	Update following receipt of winter letters from NHS England.
0.3	06/09/2023		A Jackson	Update with service line returns
0.4	08/09/2023		A Jackson	Update following review with SH & JH
0.5	13/09/2023		A Jackson	Update following review and comments by SH
0.6	15/09/2023		A Jackson	Approved draft by SH and JH. Ready submit to ELC for approval.

NWAS Winter Strategic Plan

Contents

1.0 INTRODUCTION

1.1 The North West Ambulance NHS Trust (NWAS) has developed this strategy document to ensure that the high quality of service delivery expected by our patients and stakeholders is maintained throughout the winter period.

The winter period creates particular challenges for the entire health economy regardless of the additional pressures of seasonal illness or severe weather. Last year saw an incredibly challenging winter, with infectious disease rates remaining high, industrial action across public service organisations, constraints in terms of overall capacity impacted by challenges in discharging patients, particularly across community and social care (NHS England, 2023).

1.2 This document is intended to draw on the experiences of past winters and the unprecedented experience of responding during a global pandemic. Paramount is the blending of actions for winter 2023-2024 with current procedures and processes within NWAS. Such actions cannot themselves be considered in isolation, only through the collective preparations of the whole system can the potential impacts of winter pressures and any emerging threats and risks be appropriately mitigated.

NHS England (2023) have set out four key areas for systems to focus on in preparation for winter:

- Continue to deliver on the UEC Recovery Plan by ensuring high-impact interventions are in place.
- Completing operational and surge planning to prepare for different winter scenarios.
- ICBs should ensure effective system working across all parts of the system.
- Supporting our workforce to deliver over winter.

1.3 This document concentrates on a small number of year-round processes and key, seasonal initiatives that will deliver real resilience during the winter period and ensure engagement with local health systems. It is designed to offer assurance at a strategic level that the levels of preparedness for winter in NWAS are high and that this will contribute to the resilience of the whole system. It also serves as an overarching plan to bring together the tactical and operational arrangements in each of the three NWAS Areas (Cheshire & Mersey, Cumbria & Lancashire and Greater Manchester), and NWAS Integrated Contact Centres (EOCs (Emergency Operations Centres), NW 111 and PTS (Patient Transport Services)) in associated documents.

1.4 Within the UEC Recovery Plan, NWAS are focused on fulfilling NWAS responsibilities as detailed within the NHS England publication- Working together to deliver a resilient winter: System roles and responsibilities (2023):

- Ensure a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans.

- Increase the number of deployed resources including any required changes to the skill mix, targeted recruitment plans for clinical and non-clinical crews, review and adapt the response model, in particular through a different use of RRVs

- Increase the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls.
  - Category 2 segmentation will be delivered by NWAS through increasing our clinical capacity to perform remote triage and expanding the clinical workforce within NWAS's Clinical HUB (CHUB). Category 2 segmentation will be delivered by enhancing two existing models: clinical assessment and onward case management within the CHUB, and Hybrid working.

- Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Note the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services.
  - Provision is in place for utilisation of the Directory of Services (DOS) for both primary and secondary 999 triage. A review of access to SDEC and UTC via DOS will provide assurance that all appropriate pathways of care are available to NWAS. Enhancing on scene referral for falls service and other alternative services will also support the reduction in A&E attends via ambulatory care.

- Establish sufficient call handling capacity and finalise arrangements for the use of the 'Intelligent Routing Platform' in times of surge.
  - Plans to improve call answer times to a maximum 10 second mean
  - The Intelligent Routing Platform is in place across the ambulance sector. IRP distributes calls away from the 'home' Trust in the event of a patient calling 999 waiting 4 minutes

- Ensure mental health professionals are embedded in all emergency operation centres ahead of winter.

  Improving the provision of a timely response to people ringing 999 with a mental health need / in mental health crisis. The key to improvement is being able to implement two key aspirations of the Long-Term Plan regarding the ambulance response to mental health, these being provision of Mental Health Practitioners in EOC and Mental Health Response Vehicles.
  - Mental Health Practitioners in EOC
    - Mental health practitioners in EOC from MH trusts 24/7 triaging cat 3-5 MH calls for each geographical area (GM, C&M, C&L, NC). Using mental health practitioners from local mental health trusts, means that they can ascertain if the patient is known to mental health services, access mental health

records, contact care coordinators, make onward appointments and referrals, and refer directly into secondary services if required. It is envisaged that is implemented 24/7 with correct number of practitioners this model could increase hear and treat, reduce unnecessary ambulance dispatch and provide crew call back advice. Having a 24/7 model with appropriate numbers of practitioners would facilitate a timely and responsive telephone triage.

- Mental Health Response Vehicles (MHRV)
  - MHRVs are to provide a joint health response to people in mental health crisis/ with a mental health need who are ringing 999. The key aims are to improve the timeliness, quality, and experience of the response to these individuals by enabling a mental health assessment at scene for those who require it, reduce S136 demand on Police and reduce avoidable conveyance to A&E. Five MHRV are expected end of quarter 3 and two end of quarter 4. Location of MHRV is 2 x GM, 3 X C&M (plus review of existing vehicle), 1 C&L (plus a review of existing vehicle) and 1 NC. These vehicles are to provide a joint health response so will be staffed by a mental health practitioner and EMT.

The challenges to the implementation of both models is revenue and staffing. The revenue for the models is from the Mental Health Investment Standard which sits with ICB MH commissioners and is allocated to a number of objectives the ambulance response being just one. Both models rely on joint working with MH trusts and currently there is a national shortage of mental health practitioners resulting in challenges for staffing both models.

- Use the ambulance auxiliary service when needed.

  - NWAS utilise the ambulance auxiliary service, which is managed via a national contract. NWAS have recently introduced monthly monitoring to ensure that this additional capacity is being optimised to complement core resources and provide much needed additional resilience. Oversight of any issues associated with the national contract will be provided by the Association of Ambulance Chief Executives via their National Directors of Operations Group (NDOG)

1.5 Staff and patient welfare remain the primary focus for NWAS, actions and initiatives within this document set out the commitment to plan for and mitigate where possible challenges predicted to develop during what is anticipated to be a demanding winter period.

2.0 PLANNING FRAMEWORK

2.1 Overview

The winter planning framework supports the continued commitment of NWAS to deliver high quality levels of the right care, at the right time and in the right place; every time.

The majority of the actions undertaken in preparation for and response to winter challenges are underpinned by normal NWAS plans and procedures which are designed to be sufficiently flexible and scalable to ensure an appropriate response but also to integrate with the wider health system.

2.2 This plan functions in conjunction with a number of other key plans and documents, specifically:

- NWAS Incident Response Plan
- NWAS Pandemic Influenza Plan
- NWAS COVID-19 Response & Recovery Plan
- NWAS Resource Escalation Action Plan
- NWAS Business Continuity Policy
- NWAS Departmental Business Continuity Plans
- North West Divert & Deflection Policy
- NHS Operational Pressures Escalation Levels (OPEL) Framework
- NWAS Patient Safety Plan
- NARU National Command and Control Guidance
- NWAS Winter Communications Framework and Plan
- NWAS Area specific, Winter Tactical and Operational arrangements including Festive Arrangements

2.3 Some of these documents also have their own links to or associations with multi-agency plans published under the auspices of the five Local Resilience Fora in the North West.

It also serves to:

- Ensure the wider health community and partners are aware of the NWAS strategy, capacity and potential challenges for this period.
- Ensure that resilience is maintained, and the Trust is able to respond to changes in core business activity, up to and including declaration of a major incident.

- Provide a 'signpost' to other NWAS, core-planning documents including the Trusts Business Continuity arrangements.

2.4 Audit and Review

The plan will be subject to periodic audit and review to identify areas of improvement and good practice following the winter period.

In response to any new COVID-19 variants, the NWAS COVID-19 Response & Recovery Plan will provide continual review of dynamic changes to government or Trust guidelines which require implementation and communicated effectively to those staff and stakeholders affected.

This will be achieved through the scheduled senior management teams governance meeting structure and through the communication methods utilised through the Communication Team.

2.5 Assurance

This plan relates to ambulance specific issues that have been communicated, with NHS England winter planning leads and the lead commissioning ICB (NHS Lancashire & South Cumbria) as part of the NHS England - North Region Winter Assurance process, to ensure a whole systems approach.

The Trust received the NHS winter letter – Delivering operational resilience across the NHS this Winter (PRN00645) which highlights the requirements

2.6 Delivery

2.6.1 The delivery of this document within NWAS will be achieved through comprehensive operational and organisational arrangements, which are designed to provide a quality service to meet the needs of our local communities. The overall strategy will be delivered through the local NWAS plans; three PES Area's, EOC, PTS and NW111 Plans. Ensuring arrangements remain sufficiently flexible to match local demand.

2.6.2 The operational arrangements include the identification of key dates of anticipated high demand, which are derived from analysis of historical data. Such predictions will be subject to adjustment based on shorter-term impacts such as forecasts of severe weather, high seasonal flu levels, fuel shortages or other Business Continuity disruptions including industrial action within or outside of the NHS.

2.6.3 The outcomes of such data analysis will be considered in context with the need for NWAS Operational arrangements to create surge capacity to manage increases in demand of up to 15% for a sustained period of 4-6 weeks. The NWAS Resource Escalation Action Plan (REAP) will be a key driver in the facilitation of such provision alongside partnership working and constant engagement with partners in the wider NHS under the provisions of OPEL.

2.7 Area Distinctions

Due to the size, topography, demography and differential demand and capacity patterns of the NWAS footprint, it is necessary to view the requirements of each distinct geographical area

individually. To this end, this document serves to underpin the arrangements in each of the NWAS functional areas, in terms of the demands on healthcare resilience.

Operational arrangements dealing with the NWAS response in each of the functional areas (Cheshire & Mersey, Cumbria & Lancashire and Greater Manchester) will provide the local, operational detail required to underpin this strategic plan, North West NHSE Winter Plan and local winter planning groups.

2.8 Flexibility

Given the potential for significant changes to the predicted demands, influenza season and those that may be presented with new variants of COVID-19 which may unfold over the winter period, this document will be subject to regular review. It is likely that further resource escalation and changes to the NWAS response will be required to be developed in a dynamic fashion as circumstances evolve. Any such changes will be conducted as part of a partnership approach with other organisations in the wider health economy and in line with existing partnership agreements and policies but may also need to be measured in relation to emerging national ambulance service strategies or threats. NWAS REAP arrangements can also be invoked to mitigate the effects of prolonged or acute periods of pressure or periods of Industrial Action.

2.9 Lessons Identified

2.9.1 In the development stages of this document, lessons identified from the Winter Period of 2022-2023 have been considered and changes have been made to ensure that active learning has taken place to enhance the organisations and the wider NHS resilience capabilities.

2.9.2 Incorporated as part of this learning are lessons identified relating to the response and management of the COVID-19 pandemic. Including the NWAS COVID-19 Response & Recovery Plan which details a methodological approach to a return to a new normal. NWAS undertook a number of interim debriefs during the first and second waves of the pandemic involving staff from across the Trust.

2.9.3 An internal debrief will be arranged in quarter four of 2024 so that lessons from the winter can be captured formally and integrated into planning for winter 2024-2025.

3.0 OPERATIONAL IMPLICATIONS

3.1 Mutual Aid

NWAS has in place cross border arrangements with neighbouring Ambulance Services including the devolved administrations of Wales and Scotland, under a national Ambulance Mutual Aid Memorandum of Understanding (MOU). These arrangements have been vigorously tested during past incidences of acute pressure through public gatherings, industrial action, flooding and snow, in neighbouring services. It should be noted however that should system pressures be widespread or national, then such mutual aid may be limited in extent or difficult to negotiate when neighbouring Trusts are under similar pressures.

3.2 Demand Management

Within NWAS, resources between areas will be managed through the planning process and the evaluation of activity on a daily basis. This function will be conducted through the appropriate NWAS Strategic Commander who may during periods of pressure, be required to operate from the Regional Operational Coordination Centre (ROCC) based at Parkway, Manchester, but is also available for each NWAS Area as an on-call resource.

The ROCC will ensure that resource allocation is managed in a way that addresses regional demand through monitoring of activity patterns.

NWAS operates a robust on-call system which enables the activation of Strategic, Tactical and Operational Commanders together with support from National Interagency Liaison Officers (NILO) and Loggists, at any time, to incidents (including hospital turnaround issues) in any part of the Trust footprint.

Each NWAS geographical areas (Greater Manchester, Cheshire & Merseyside and Cumbria & Lancashire) Area has its own Strategic Commander on call who has the latitude to maintain overall command of each area and the ability to commit funds without recourse to higher authority.

The three delivery areas within NWAS will assess their respective activity demands and resource availability on a daily basis and where possible will allocate resources to the areas of greater demand.

During periods of increased demand, where See & Treat (S&T) options become challenged, the Trust has in place specific arrangements through the Clinical Hub to increase Hear & Treat (H&T) levels to support patient care in line with our Clinical Safety Plan. More details can be found in sections 5.5 and 5.6.2.

Staffing levels are managed and monitored via the Trusts rostering system, so it is possible to actively manage abstractions and ensure that maximum cover is available for the vehicle fleet. There is also the ability to manage the provision of additional vehicles at agreed times given appropriate commissioning arrangements. Emergency Operations Centre (EOC) and NW111 staffing levels may also be adjusted to meet predicted or short-term demand in such a way.

Specific actions and options available to the NW111 service line are detailed within section 5.4.2 of this document.

Patient Transport Service (PTS) priorities and options during periods of high demand are detailed within section 5.9 of this document.

Mutual aid support for the Trust will also be requested when appropriate from the nearest Ambulance Services of West Midlands, Yorkshire, East Midlands and North East as well as Wales and Scotland. This request will be made under existing national ambulance mutual aid arrangements but can also include the deployment of air assets.

NWAS is also obligated to provide mutual aid to other Ambulance Services, on request in response to major incident or to assist if an Ambulance Trust declares a very high REAP level. Such negotiations will take place at Strategic level and release of resources will be highly dependant on available capacity. NARU maintain the national Mutual Aid Plan for Ambulance Services (including the Devolved Administrations).

3.3 Plan Scope

- These arrangements cover the period 02 October 2023 until 01 April 2024 unless otherwise stated.
- The plan covers the identified winter pressure reporting period (to be advised by the NHS) and details the Trust's intentions for delivering its core business.
- Analysis of historical data for this period over previous years has been utilised to identify the anticipated periods of increased demand.
- This document has relationships with other plans and documents as detailed within section 2.0 of this plan.

3.4 Festive Period

NWAS Tactical and Operational arrangements will give due consideration to the Christmas and New Year period, which is traditionally a time of extremely high demand.

Each NWAS area will produce its own area specific Winter Plan, encompassing:

- The analysis of historical data has provided the key dates where activity is expected to rise considerably.
- During this period there are likely to be extremely high levels of activity and demand with peaks expected around the Christmas and New Year periods. It is recognised that individual service lines will have different busiest days depending on the nature of their work - specific details and analysis can be found in the Appendices of this document.
- It is recognised that other factors may change the dynamics of activity levels such as severe weather, seasonal influenza challenges, industrial action or infrastructure disruption.

- The Area Tactical Winter Plans detail the Trusts intentions and methodologies for dealing with the increase of activity and maintaining an appropriate safe delivery of service.
- Appropriate additional operational/staff resources from the Paramedic Emergency Service (PES), EOC, Clinical Hub, NW111 and the Patient Transport Service (PTS) will be identified and profiled for the key dates where possible.
- The related cost pressures will be identified and calculated for all additional resources required.

3.5 Demand Analysis

The capacity levels for NWAS are designed to address the forecasted demand for the winter period. The plans consider previous and current demands.

Planned levels of activity have been based on historical data, tempered with any seasonal Influenza related demands which may have caused unusual spikes in the anticipated activity levels.

All available emergency resources (PES and EOC) will be utilised on key dates and assistance will be sought from the Voluntary Aid Societies (VAS e.g. British Red Cross, St John Ambulance and Mountain Rescue Teams), Private Ambulance Services (PAS- contracted in via an intermediary) as required, as circumstances dictate and as financial constraints allow. Other NWAS resources may also be deployed in support of PES to respond alongside frontline PES colleagues.

In identifying the key dates through historical demand analysis, we are able to forecast busiest days by regional footprint and at NWAS operational area level (Appendix 2). This allows for resource planning depending on anticipated activity levels but will be reviewed against any changes in anticipated or unscheduled activity. NWAS REAP arrangements are also available to support mitigation of a surge in demand or adverse pressure on the Trust.

Information regarding those dates of predicted NWAS high demand will be shared with Commissioners and NHS England North, enabling appropriate measures to be taken to reduce the impacts on the whole system.

Analysis of attendances at each Acute Trust has been developed and will be detailed within the Area Tactical Winter Plans as they are developed.

4.0 NWAS STRATEGY

4.1 NWAS planning will be continuous up to and through winter with regular meetings scheduled to ensure that focus is not lost. This will include dedicated agenda items on a range of existing and regular meeting schedules. Periodic performance teleconferences will also continue with the option to revert to a daily occurrence should pressures dictate.

NWAS Operate a 24/7 Command and Control structure, based upon national standards and in-line with JESIP response principles.

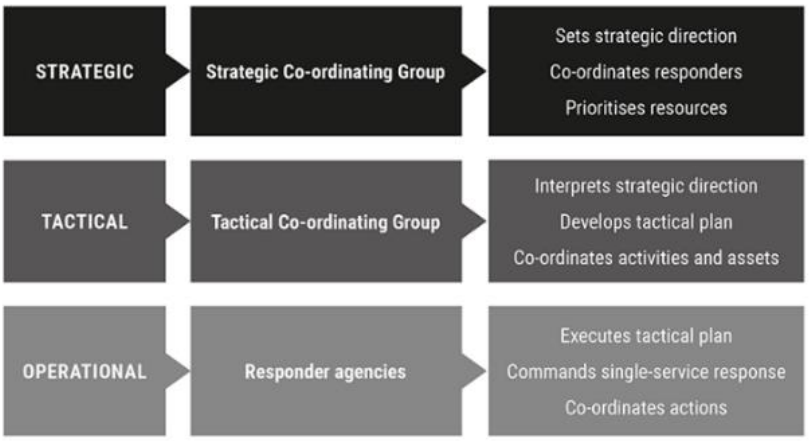


Figure 1 – JESIP Response Principles

The NWAS Strategic Commander will ensure a set of Strategic Intentions are developed and reviewed to ensure consistency should these be required during any period covered by this plan.

In terms of decision-making, the Trust command team utilise the JESIP Joint Decision Making (JDM) Process:

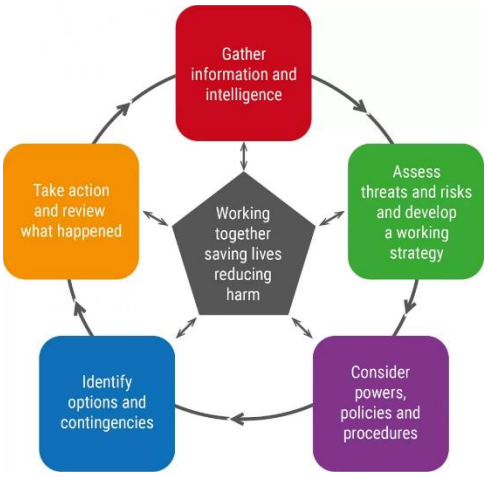


Figure 2 – JESIP JDM

4.2 Within the Emergency Operations Centres (EOC) environment, NWAS has in place long-standing processes, which work to achieve rapid call pick-up and allocation times. Should a disruptive event occur which impacts the effectiveness of EOCs, well established and tested mutual aid processes are in place with other UK ambulance service – through what is commonly known as the 'buddy' system – where neighbouring ambulance service share the affected services activity. Resource profiling is completed in a way which best matches demand to maximise effectiveness and meet the national response measures in place across service lines.

The NWAS Regional Planning Team will ensure that demand and resource profiles are matched through analysis of staff abstraction rates (training, leave and sickness) and monitoring of unit hour utilisation for the Paramedic Emergency Service. The following sections outline key factors, which underpin the NWAS response during the winter period.

4.3 PES Core Response Measures

In July 2017, the Department of Health and NHS England announced new ambulance service standards as part of the Ambulance Response Programme (ARP). The aim of the ARP programme is to improve patient care and survival. ARP is the result of the largest study of an ambulance system ever completed, anywhere in the world. More than 14 million ambulance calls were monitored as part of a trial, with no patient safety concerns.

The system enables ambulance services to be much more stable and able to deal with unexpected events and peaks in demand. ARP will make sure the best, most appropriate response is provided to patients, first time.

Currently, there are four measured categories of call, although other categories of calls exist, the ones shown below are the current measures:

Category	Mean	90th Percentile
Life threatening Category 1	7 minutes	15 minutes
Emergency Category 2	18 minutes	40 minutes
Urgent Category 3	60 minutes	120 minutes
Less Urgent Category 4	-	180 minutes

Figure 3 - Response Categories

Call pick-up times are constantly monitored against nationally agreed standards in all EOC's. This information is displayed in real time on the Trusts performance management dashboard, which is accessible to all appropriate managers.

This information is also monitored within the Regional Operational Coordinating Centre (ROCC) and in each Major Incident Suite when activated.

Activation times are monitored and reviewed daily by Sector and Operational Managers. Improvements aimed at reducing activation times include the utilisation of strategically placed deployment points as part of a Clinical Safety Plan (CSP).

The North West Divert and Deflection Policy provides an agreed process for Senior Trust Commanders to follow to ensure safe treatment and movement of patients across the region and to address any short-term blockages through agreed deflections.

The NWAS Clinical Hub and Directory of Services (DoS) are designed to augment the management of 999 calls.

Analysis of historical data ensures that NWAS are able to place resources appropriately and use relief staff in an effective manner.

The Patient Transport Service (PTS) is also integral to NWAS strategic planning for winter in consideration of the overall provision of contracted, non-emergency transport services. It should be noted that NWAS is the contract holder for PTS in Cumbria, Lancashire, Greater Manchester and Merseyside while the West Midlands Ambulance Service provides the same function in Cheshire, Warrington and the Wirral.

NWAS will be required to provide event cover (i.e. sporting events and mass gatherings) during the winter period. The resourcing of these events is over and above that which is required to deliver the operational delivery plan. These events may coincide with dates of anticipated high activity, as identified in the key date information. Such events are managed through partnership between the Trust Resilience and Operations Teams together with the event organisers, Police and Local Authorities.

The 'Make the Right Call' (https://www.nwas.nhs.uk/get-involved/campaigns/make-the-right-call/) campaign is aimed at advising the public on the appropriate use of the of the Ambulance Service and signposting suitable alternatives for minor ailments. The Trust Communications Team will provide public information through broadcast and social media outlets utilising national templates for any publicity.

4.4 Demand Surge Mitigation

NWAS can meet a sustained increase in activity and cope with significant activity increases over short peak periods but acknowledges the challenges that may face the region and the wider NHS, particularly in respect of any widespread event such as, seasonal influenza or adverse weather. It is recognised (and a lesson identified by all health partners in previous winters) that the Ambulance Service reaches its capacity limits very quickly during severe challenges, and this capacity to cope is heavily influenced by NHS Providers releasing resources in a timely manner.

A dynamic but constant evaluation and review of the pressures on the Trust is made weekly at the Executive Leadership Committee (ELC) and daily within the ROCC.

The NARU REAP arrangements can be used at short notice to mitigate demand and generate additional capacity short of declaring a major incident. This is coordinated through the National

Ambulance Coordination Centre (NACC). Shorter-term effects can be realised through application of the Clinical Safety Plan (CSP) levels to deflect demand in a measured and safe manner.

4.5 Staff Health and Wellbeing

4.5.1 Vaccination Offer

In mid-September 2023 the Trust will launch its annual Flu campaign. In line with national requirements the ambition is to offer 100% of the workforce the flu vaccine and to vaccinate over 75% of staff. A project team has started the preparatory work in summer and has a robust project plan in place which seeks to aim to vaccinate staff. As with previous years, the focus is aimed to try and vaccinate as many staff as possible prior to winter pressures commencing.

COVID booster –NWAS is seeking to understand the offers that might be in place for staff to access the booster and whether if the regional teams can support any onsite pop up clinics to help staff access the booster. There are no plans for the Trusts to stand up an internal vaccination hub for the COVID booster.

4.5.2 Wellbeing Offer to Staff

Push for all areas to progress their local People Plans based on the 2022 Staff Surveys results and recent Q2 Quartey Pulse Survey Results.

Current offer includes:

- Employee Assistance programme
- Treat me right campaign and toolkit – aimed at tackling bullying and harassment
- Mental Health awareness toolkit for managers and staff
- Focus on manager having wellbeing conversations
- Trust champions on: Wellbeing - Further develop and strengthen the network of HWB Leads and Champions
- F2SU Champions
- Staff networks – LGBTQ+, Disability, Race, Womens and the armed forces
- Gambling support guidance
- Peer Supporter / MHFA's / Blue Light Champions
- TRiM – Trauma Risk Management
- Burn out programmes for staff and managers
- Suicide Prevention, Postvention and Awareness Toolkit

4.5.3 Further Work

Continue to develop the Invest in Yourself Support Hub on the Green Room to support staff understanding the wellbeing offer.

The mental health Continuum Group to look at several pieces of national work:

Roll out of the mental health continuum – it is used to show that an individual can move between the different states of wellbeing; thriving, surviving, struggling and crisis

Mental health at Work Commitment - NWAS has signed up to this Commitment, endorsed by The Royal Foundation, which is made up of six standards, based on the Thriving at Work standards and developed with the knowledge and expertise of mental health charities, leading employers and trade organisations

Employee wellbeing and suicide prevention self-assessment matrix - This self-assessment tool has been developed by the Association of Ambulance Chief Executives and comprises of 10 implementation areas relating to staff wellbeing and suicide prevention

External support:

Just B - to undertake proactive wellbeing conversations through externally provided mental health checks

The Ambulance Service Charity – staff can access support through their online wellbeing hub

Trust champions - Wellbeing - Further develop and strengthen the network of HWB Leads and Champions

Financial Wellbeing – further develop the offer for staff with resources and tools to help with management of finances, i.e. the UK Government Child Care Voucher Scheme.

Introduction of local Wellbeing Officers – x4 recruited throughout the NWAS footprint (GM, C&M, Cumbria and Lancashire. The role will work with local areas to promote the wellbeing offer and identify areas of additional support. Roles to commence September / October 2023.

5.0 MITIGATION INITIATIVES

5.1 NWAS employs the following initiatives to enhance service delivery:

- The NWAS Resource Escalation Action Plan identifies rising trends in operational and organisational demands and facilitates escalation/de-escalation through the nationally set REAP levels.
- Trigger mechanisms have been established through REAP arrangements that allow NWAS to respond promptly to substantial increases in demand, in either specific areas or Trust wide.
- NWAS REAP arrangements remain active at all times. The Winter Strategy should be viewed as an adjunct to this and not as a replacement.
- The Trust is engaged with national partners to ensure the REAP elements are reflective of current and future challenges including the NHS OPEL (Operational Pressures Escalation Level) Framework, which standardised local, regional and national escalation levels to respond to severe pressures on the NHS.

5.2 By adopting a consistent NWAS approach, the overall ethos of OPEL can still be reflected in NWAS actions. Indeed, the NHS England OPEL Framework document underscores that system wide pressures can be resolved through close partnership working to manage surges in demand or capacity challenges. It also recognises that local A&E Delivery Boards have the latitude to align existing systems to the standard OPEL triggers and terminology as well as identifying that a rigid, sequential escalation is not always necessary or appropriate. Importantly, the Framework continues to emphasise:

"Not all parts of the system need to meet all triggers in order to escalate – escalation can be service specific if agreed locally."

5.3 In order to communicate the NWAS stance to any given request for the Trust to escalate in parity with an Acute Trust (excepting regional challenges beyond normal surges i.e. significant or major incident) a standard approach will be adopted to ensure consistency of message and action. Each request for escalation or notification that a particular Acute Trust is escalating to a higher OPEL Level will be responded to with a statement which echoes the following declarations:

- All necessary actions for NWAS under REAP have been considered and already implemented or held in reserve should the situation become more challenging.
- NWAS is committed to support both whole system resilience and the management of local surge pressures against the background of patient care and protection of NWAS critical activities.

- NWAS will support any local measure to relieve pressures as far as practicable and within the overall confines of our prevailing REAP level which reflects the overall pressures experienced by NWAS and cannot be flexed locally.

- Engagement with local NWAS managers on duty or on-call is essential so that appropriate supportive measures can be discussed.

- NWAS will work in partnership with the Ambulance Sector across the UK ensuring any pre-planned or live escalation as required. Pre-planning will take place for specific key dates over the winter period e.g. New Year's Eve through to New Year's Day. For live escalation procedures are clearly defined which incorporate the National Ambulance Co-ordination Centre (NACC).

5.4 North West 111

5.4.1 Forecasting and Planning

NW 111 now possess several years of historical data. This assists with accurate demand forecasts that will deliver aide improved roster efficiency and accuracy. As with previous years demand into the service will increase throughout December & January, activity is anticipated to increase significantly from WC 18 December through to WC 01 January. To ensure the best roster cover NW111 will reduce levels of managed shrinkage, such as annual leave and non-essential planned offline activities, for these key weeks.

The improved accuracy of forecasts allow for more accurate recruitment planning. NW 111 have commenced winter recruitment for Service Advisors, Health Advisors and Clinicians.

5.4.2 NW111 Service Delivery

NW 111 operates a diverse approach to delivery, with the aim of improving the patient experience. NW 111 will utilise the delivery methods of the previous winter. Patients are presented with a range of options as well as assessment, dependant on the needs of the patient.

Homeworking for clinical staff – The number of Clinicians with the ability to work from home increased significantly during the COVID pandemic meaning a larger number of the NW 111 Clinical workforce are now able to work remotely. This gives this cohort of staff more flexibility in the hours that they are available to work and makes it easier for them to book additional hours at short notice that meet the demands of the service during peak periods.

This year NWAS will continue to promote the use of NW 111 online and CPCS Pharmacy Services especially during busy periods. These services offer support to patients to self-assess their health needs, whilst ensuring access to all the services open to NW 111 callers are aligned to the clinical need. The NW 111 service provides approximate waiting times and options to receive further guidance via SMS. NW 111 service users now also have the ability to input their demographics via an online form whilst waiting to be answered to help speed up the call taking process.

To ensure the optimisation of the workforce over the peak days and winter overall, NW 111 will utilise non-front-line staff, such as;

- Audit and Governance Team deployed into front line support roles.
- Front line managers supporting front line and operational roles.
- Increased senior management support.
- Clinical Managers able to work additional hours from home.

5.5 Clinical Safety Plan

The NWAS Clinical Safety Plan (CSP) is designed to be both simple and dynamic and is to be utilised in situations of excessive call volume or reduction in staff numbers. This will enable NWAS to respond in a timely and appropriate manner to increased service pressure, enabling an NWAS wide response as soon as identified triggers are met. The plan provides a risk based framework to enable flexible resourcing decisions to be made in the Emergency Operations Centres (EOC). The overriding function of this plan is to ensure that NWAS maintains the highest achievable level of clinical care in the face of demand levels that greatly exceed capacity.

This plan:

- Is applicable to the entirety of NWAS service delivery, it includes actions for all arms of NWAS operations.
- Is considered in conjunction with the National REAP levels and will be employed in conjunction with this plan where appropriate and necessary but is routinely used as a standalone plan.
- Provides an escalating set of flexible, tactical options which may allow the trust to mitigate and manage the risks presented by a significant surge in activity and/or delayed responses to patients. Patients are always informed of the appropriate disposition of their call.

5.6 Emergency Operations Centres and Clinical Hub

5.6.1 Emergency Operations Centres

Across the North West footprint there are three Emergency Operation Centres (EOC); one in each of the operational areas – namely, Cumbria & Lancashire, Greater Manchester and Cheshire & Merseyside.

The EOC's are responsible for managing the emergency 999 call activity through their dedicated call handling suites and once calls are received an ambulance dispatch team are focused on communicating with operational resources to ensure a timely and appropriate response is deployed.

The primary method of managing this process is through a Computer Aided Dispatch (CAD) system, which allows for the inputting of call data, and the rapid electronic communication with resources. To compliment this function within the EOC, a clinical leadership model has been

established to ensure appropriate decision-making support is available to both operational and EOC colleagues - enhancing patient safety.

5.6.2 Clinical Hub

The NWAS Clinical Hub operates as a virtual 'hub' with bases in Merseyside, Lancashire and Greater Manchester, providing a number of functions.

Primarily the desks utilise a robust telephone triage tool to support patients through a Hear & Treat model, answering low acuity calls. Where appropriate, resource requirements will be reviewed and alternate pathways, such as Clinical Assessment Services (CAS) will be utilised.

The virtual hub also provides clinical advice and support to NWAS operational staff and a process for clinical leadership and support for all staff and managers has to facilitate access to Paramedic, Nurse, Senior Paramedics, Advanced Paramedics, Mental Health Practitioners, Clinical Pharmacist, Consultant Paramedics and occasionally, Doctors.

Police/Fire & Rescue Command colleagues can also access this clinical advice through a SPOC (Single Point of Contact) telephone number; this will support on scene decision making and reduce on scene time.

The CHUB functions:

- Clinical advice
- Support for all responders to enable them to leave scene whilst awaiting transport; including booking taxis where appropriate
- Access to senior clinical support for the Advanced Paramedics
- Direct telephone consultations with patients after initial categorisation
- Clinical validation of low acuity incidents, that being Category 3 or below, by a senior clinician. This allows for the trust to focus operational resources on incidents which are more likely to require attendance and subsequent transfer by an ambulance.
- Clinical Validation of Category 2 incidents, in-line with nationally agreed specifications. This allows a more patient focussed ambulance response, for those who are acutely unwell.
- Complex Incident Hub – a function to promote shared decision making to support patient response.

5.7 Regional Operational Coordination Centre (ROCC)

5.7.1 ROCC operates across a 24 hour period and staffed by a ROCC Duty Manager 24 hours and ROCC Tactical Commanders provide cover 7 days a week between the hours of 0600 and 0300.

The ROCC is managed by a Duty Manager and supported by the ROCC Tactical Commander whose role is to monitor and review operational pressures across the NWAS footprint and provide direct management to the Regional Health Control Desk (RHCD) and Greater Manchester System Control Centre (GMSCC) Coordinators. Liaise with EOC's, NWAS Managers, other UK Ambulance Services and Wider NHS Management regarding Provider Organisation pressures and provide reports to NWAS and the wider NHS on system pressures.

5.7.2 The primary role of the ROCC based at Parkway is to be responsible for:

- Resource oversight/monitoring – Emergency Operations Centre (EOC)/Operations/Clinical Hub
- Activity/demand monitoring – Clinical Safety Plan (PSP)
- Coordination – Business as Usual and Major/Large scale Incidents
- Single point of contact for UK Ambulances services and wider health economy partners
- Regional overview - for UK Ambulances services and wider health

5.7.3 ROCC Tactical Commander

Responsible for the regional overview of NWAS Service Delivery, focusing on challenges to patient care, monitoring in real-time performance inhibitors; devise and implement tactical decision making, in response to constantly changing demand to develop long term plans in order to achieve Trust/Directorate objectives.

Assume the role of senior point of contact on behalf of NWAS during the hours of operation, in relation to operational performance and hospital turnaround pressures, after this time it devolves to the on call structure

5.7.4 Regional Health Control Desk

The RHCD provides real-time monitoring of health economy pressures, through daily contact with Acute Provider organisations, gathering soft intelligence relating to capacity and demands within these organisations, reviewing against activity and working to mitigate where possible any impact of increases in demand. The RHCD team consistently monitor and scrutinise delays in handover and any delays noted in clearing by ambulance crews are pro-actively managed.

The RHCD is covered 24/7 and works alongside the GM SCC Hub Coordinators, both of whom are managed by the ROCC Duty Manager as well as being supported by the ROCC Tactical Commander. This dovetailing of local and regional perspectives provides rich intelligence and a pragmatic approach to problem solving. Ensuring pre-emptive and timely escalation occurs to Acute Provider on-call/management teams to request mitigation occurs at the earliest opportunity to support the risk of patients waiting in the community due to delays occurring within Acute Providers.

RHCD Coordinators continue to escalate delays over 60 minutes to Executives at Provider Organisations and continue to proactively monitor delays over the 15 minute threshold for clinical handover. The ethos of early escalation continues to be relevant and practiced by all ROCC functions.

5.7.5 Greater Manchester System Control Centre (GMSCC) Hub

All GM health care providers are signed up to the hub and it is seen as neutral and an 'honest broker' between health and social care systems and now has live data feeds from each acute trust and NWAS; GMHSCP is looking to gain direct input from primary care and community to give a whole system overview. This live data is used to identify pressured systems and provide support / intervention where necessary.

The hub is has become a single point of contact for GM Systems and is accepted as the conduit between GM Heath and social care systems and National / Regional Colleagues, by having a real time understanding of activity and pressures the Hub managers are able to respond to National enquiries on the previous day where trusts have hit performance triggers.

The hub is also seen as a mediator/facilitator between systems which has enabled the team to resolve issues with transfers and repatriations when capacity is challenged across GM, an SOP for this process is in place. The GM SCC Hub holds central records of transfer and repatriation requests with delay and escalation triggers with associated actions. The hub also acts as a mediator between acute trusts and NWAS where there is the potential for, or are actual turnaround delays enabling a working plan to avoid unintentional batching of activity to individual ED sites and ensure ambulances are released in a safe manner. Acute trust senior management teams accept feedback from data analysis on trends and repeated issues and associated suggestions to smooth the flow, the SCC Hub team is seen to provide this feedback in a non-judgemental and supportive way.

The Hub also provides a watching brief on large scale incidents and issues which do or have the potential to affect the GM healthcare economy, this has assisted systems to prepare for predicted issues e.g. outbreaks, extreme weather events.

Across the winter period the GM SCC Hub will operate as the GM Winter Room and coordinate the GM oversight and reporting to regional / national level as appropriate.

The GM SCC Hub Operational Manager is on duty between 0800-2000hrs 7 days a week to support the SCC coordinators and will liaise and escalate any Acute issues.

5.8 Urgent and Emergency Care (UEC) Directory of Service (DoS)

5.8.1 The UEC DoS is an essential resource to safely and appropriately onward refer patients, therefore contributing to reducing avoidable conveyance and delivering the right care, at the right time in the right place for every patient, every time.

5.8.2 The UEC DoS is a central directory that is integrated with NHS Pathways and is automatically accessed if the patient does not require an ambulance or by any attending clinician in the Urgent and Emergency Care services. NWAS migrated all three of the 999 Emergency Operations Centres (EOCs) from MPDS triage tool over to NHS Pathways to have a Single Primary Triage (SPT) tool across NW111 and 999. This enables 999 EOCs to onward refer patients appropriately at the time of the NHS Pathways assessment, during the initial call via the DoS (similar to NW111). Work has continued through 2023, and NWAS are focused on their commitment in striving for equity and

parity in the service referral opportunities available to a patient, irrespective of contact being made via either NW111 or 999.

5.8.3 The North West has also had a focus on maximising service referral opportunities into services such as Same Day Emergency Care (SDEC) and Urgent Community Response (UCR) along with virtual wards to further enhance Emergency Department (ED) avoidance. The expansion of service referral opportunities and agreed referral criteria across the North West will further improve the patient experience and reduce admissions through this winter period.

5.8.4 All front line, patient facing clinicians have the ability to access NHS Service Finder as they cannot currently access DoS when considering onward patient referrals following a face-to-face assessment. The North West of England continues to be the largest user group of NHS Service Finder in the country. NHS Service Finder is fed by real time information from the DoS but does not cater for digital onward referrals. All face-to-face assessment referrals are made via telephone. NWAS have developed an interim solution for digital onward referral, which will be a rapid test of change utilising existing technology within the ePR (Electronic Patient Report) system, ahead of this winter period. Concurrently, NHSE will continue their work on a long-term solution for digital onward referrals from scene. Any of these solutions bring system wide benefits to patients, NWAS and NHS Providers.

5.8.5 The introduction of GP Connect in ePR (Electronic Patient Report) enables greater decision-making support for clinicians to facilitate the reduction in conveyance.

5.9 Patient Transport Services (PTS)

NWAS is able to provide patient transfers at short notice, based on system priorities e.g. clinical priority or response to hospital pressures to moving patients between hospitals, or to discharge patients. With mature escalation and engagement links across the healthcare system, PTS will work with commissioners and hospitals to monitor system activity, adapting to changing circumstances and surge and is able to mobilise an enhanced approach to support system priorities in line with relevant national guidance e.g. HM Govt/NHS' Hospital Discharge Service Requirements in the event of an escalation event is felt be by the system e.g. impact of Flu or Covid-19. Any decisions to respond to any surge in demand will be based on resource capacity at the time and without compromising the PTS Planned and Unplanned specifications.

Through effective engagement and escalation with partner colleagues, NWAS PTS leads will establish the needs of individual Trusts e.g. requests for additional PTS non–emergency vehicle requirements in addition to current contractual arrangements for out of hours in those areas where NWAS holds the contract subject to agreement of funding.

NWAS-operated PTS services will be staffed throughout the identified critical periods and support the demand placed upon the Service where appropriate arrangements exist. Where possible and subject to resource capacity arrangements with approved Private Providers will provide support over the winter period in support of the whole system challenges including supporting the Paramedic Emergency Service (PES) through effective demand surge management.

5.10 Additional Measures

The NWAS approach to winter will be 'business as usual' as far as practically possible but a range of additional measures will be employed to mitigate the effects of increased demand or loss of capacity. These include:

- Executive focus – individual members of the NWAS Executive Leadership Committee have been allocated geographical areas of responsibility and this level of engagement supports wider ELC scrutiny of winter plans and performance.
- PTS staff and vehicles can be utilised to assist PES in reducing admission, discharge and transfer pressures as and when required under the Trusts REAP arrangements and, in such times as a major incident. This will require engagement with and agreements from the Commissioner(s).
- Increase in PES resource hours including Private Ambulance Service
- Annual leave and other staff abstractions for all Service Delivery staff will be monitored and strictly controlled for the period encompassing the Christmas and New Year Public Holidays and beyond (specifically 21 Dec to 3 Jan). For identified weeks during this time, an adjusted limit on leave allowed has been agreed. Staff sickness absence will be subject to the same level of scrutiny and management.
- The NWAS Fleet care department is available to meet operational requirements throughout the critical period. They will also provide a 24/7 on call facility as dictated by demand and capacity.
- A Memorandum of Understanding (MOU) exists between NWAS and St John Ambulance in the event of a Major Incident.
- A national MOU for mutual aid from other NHS Ambulance Trusts exists. This is predominantly for Major Incident support but in the case of a Business Continuity disruption - including widespread severe weather, national high activity, and when informal support from adjacent Ambulance Trusts cannot be guaranteed.
- At times of excessive demand, the triggers within the NWAS REAP may require redeployment of seconded clinical staff fulfilling a non-clinical role. This decision will be taken in line with the processes detailed in the Plan.
- The standing NWAS 'On-call' arrangements (Commanders and support staff) continue as usual but may be enhanced/augmented for times of experienced or predicted pressure. These arrangements include senior clinicians on call.
- NWAS Commanders have been provided with a North West Divert and Deflection Policy which summarises the actions to be taken in the event of pressures at individual hospitals or across entire Acute Trusts.

- Hospital Arrival Screens are well established in EDs and other locations to assist with patient flow through the departments.
- Sector and Operational Managers (PES, EOC and PTS) mointor staffing levels, which are communicated at the weekly service delivery meetings. Additional hours are profiled to meet demand on key dates and these will be subject to scrutiny at the appropriate meetings. Staff Abstraction rates are monitored closely.
- Vigorous management of absenteeism though NWAS Sickness Absence Procedure.
- The NWAS Pandemic Influenza Plan and NWAS COVID-19 Response Plan contains contingencies for support staff redeployment during the risk period.
- The Trust's BCM arrangements include departmental and staff mapping analysis to enable support to be re-directed to critical functions if required, at times of severe pressure. Dedicated arrangements to deal with periods of Industrial Action are also in place.
- Additional front-line staff, together with operational management support, will be deployed on the key dates identified in the area level plans.
- Staffing levels are profiled according to demand patterns. Integrated Contact Centres (EOC, NW111 and PTS) will be profiled aligned to key dates throughout the winter plan.
- Planning with voluntary agencies (SJA, BRC, and Mountain Rescue) is regular and ongoing.

6.0 NWAS CONTINUOUS IMPROVEMENT INITIATIVES

6.1 Fleet Configuration

The core fleet now totals 521 DCA. A replacement program will commence October 2023 and conclude in February 2024 to receive 46 DCA. The Trust will retain the oldest 32 DCA increasing numbers by 4 per week in line with the replacement program. The core fleet will increase to 553 DCA by February 2024 & continue post winter pressures.

6.2 Emergency Control Centres (EOC) Efficiencies

- EOC changes are critical to the maintenance of patient safety and delivery against performance standards and to these ends the following areas are subject to tight focus.
- Monitor and manage mean and 90 percentile call-pickup by matching call-taker availability to demand, managing staffing levels, average handling time (AHT) and call-taker "not ready" time.
- Earlier identification of category 1 calls through the pre-triage sieve, key words and nature of call processes and improvements in call flow.
- Increases in EOC staffing and profiling of recruitment, training and induction in advance of winter period.
- Clinical Coordination Desk. This role is provided by an AP and reviews patients who we anticipate will wait longer than the ARP centile performance. The AP can chose based on clinical need to dispatch a resource, they may review the notes and conclude the patient is safe to wait or pass to a clinician to ring back as potential for H&T.
- Clinical validation of low acuity incidents, that being category 3 or below, by a senior clinician. This allows for the trust to focus operational resources on incidents which are more likely to require attendance and subsequent transfer by an ambulance.
- Clinical Validation of Category 2 incidents, in-line with nationally agreed specifications. This allows a more patient focussed ambulance response, for those who are acutely unwell.
- Introduction of Advanced Practitioners in Urgent and Emergency Care, who operate a hybrid model of response and assist with the navigation of the waiting incident stack.
- Implementation of NHS Pathways as the primary triage tool, this change should allow for a reduction in C1 incidents and an increase in incidents closed at the call-handler level, the system interrogates the DOS allowing the trust to interact with the wider healthcare system in a safe and effective manner.
- Introduction of the Complex Incident Hub, which offers NWAS wide co-ordination of complimentary resource and enhanced care assets. This allows us to use the our specialist resources most appropriately and support critically unwell patients rapidly and effectively.

6.3 Workforce

Regular recruitment and training plans in place across all service lines.

PES - Winter planning has focussed on trying to maximise training capacity

Paramedic Recruitment

- 73 Paramedics have started and been deployed between June and August 2023
- 219 due to start between October 2023 and March 2024
    - 75 due to be deployed before Christmas
    - remaining 144 will deploy between January 2024 and March 2024

EMT Recruitment

- 55 EMT1 have started between June 2023 and August 2023
- 198 EMT are due to start on courses between September 2023 and March 2024
    - 32 are due to be deployed pre Christmas
    - remaining 166 will deploy between February 2024 and June 2024

PTS - workforce plan aims to maximise training capacity to close current vacancy gaps

- 72 places on courses between October 2023 and March 2024

NW111 - ongoing actions to support closing the current vacancy gap and improving turnover for Health Advisors. Actions include:

- Refresh of recruitment and advertising materials and methods
- 154 places on courses between end of September 2023 and March 2024

EOC – ongoing recruitment to support workforce plans. Current vacancy position is health.

Training plan has 128 places on courses between September 2023 and January 2024. The plan is under review to determine is all course places are required. Position requires sufficient flex should there be a need to increase resources.

6.4 Hospital Handover

6.4.1 Overview

NWAS has been leading a quality improvement (QI) programme to support the challenges across the North West and beyond with hospital handover for a number of years. Resources have been developed to support NWAS and hospital teams. These include:

Every Minute Matters: 15 steps to ambulance handover improvement Resource details (learninghub.nhs.uk) which contains training material, case studies and videos.

- Handover safety checklist, Fit2Sit, action and escalation cards Delayed ambulance handover escalation – NWAS Green Room.
- Site coaching and building QI capability training.
- FutureNHS site to support peer learning, networking and share resources from the 2022/23 hospital handover collaborative.
- Monthly data packs have been created and shared with commissioners, ICB leads, CQC, NWAS sector and hospital teams to show NWAS, ICB and local level performance.
- Hospital handover PowerBI dashboards have been designed and improved during 2023/34
- The set up of a Regional Handover Board to lead and co-ordinate the hospital handover collaborative. The Board has representation from NWAS, ICB's, NHS England, hospital Chief Executives.

6.4.2 Initiatives 2023/24

The Northern Care Alliance (NCA) group of hospitals – Salford Royal, Oldham, Fairfield General and Rochdale urgent treatment centre are running a handover collaborative involving NWAS with a wider primary and community care focus. The work starts in September and runs throughout Q3 and Q4 23/24.

Cheshire and Mersey and Greater Manchester ICS's are part of the national UEC Tier 1 support. Cheshire and Mersey have identified Warrington hospital and Liverpool University hospitals as requiring more intensive support from the national teams. Greater Manchester have identified Manchester University hospitals and Wrightington, Wigan and Leigh hospital as requiring more intensive support. A local programme of work has been established with Warrington and Wrightington, Wigan and Leigh hospitals with the NWAS sector teams and QI support.

Local level work is continuing to improve access to SDEC. Sites include Preston, Warrington and Furness.

The Regional Handover Board met on the 4th September to discuss the plans for ICB level winter collaboratives. ICB leads are focused on submitting their winter plans to NHS England by early September.

There is an ambition to set up local handover teams to design and deliver local improvement plans as part of system improvement. Short term funding for some additional QI posts has been agreed to test a new way of working with service delivery in Q3 and Q4 2023/24.

7.0 COMMUNICATIONS

7.1 Overview

NWAS has in place robust Winter Communications Plans which supports the NWAS Strategic Winter Plan, seasonal Influenza vaccination programme, NWAS Pandemic Influenza Plan and NWAS COVID-19 Response Plan as well as contributing to trust compliance with the Civil Contingencies Act (2004) in terms of 'warning and informing'.

7.1.2 The NWAS Communications Team is well linked across the NW system through regular attendance and participation in the regional ICS and NHS England communications leads 111/UEC and winter planning meetings. These meetings also include system based and locality partner trusts and facilitate co-ordinated approaches to demand management and winter planning across the wider healthcare system. Where possible we maximise our collective reach across the NW by working together, sharing our individual communication plans and associated assets, and not duplicating content or putting out competing messages.

7.1.3 Messaging to the public is considered on a local, regional and national footprint using insights from demand data and patient experience. For example, this year we have identified falls, mental health and repeat prescriptions as common conditions for focussed work in Greater Manchester, Cumbria and Lancashire, Cheshire and Merseyside respectively. Our Every Second Count campaign and refreshed suite of demand related messages for social media channels will also support winter demand by educating the public on how to choose services wisely and to signpost them to the most appropriate route to care. All our assets are suitable for use across the local system. Learning from what has worked well in previous campaigns, we will use trusted voices from the organisation, such as staff and managers, to give a 'behind the scenes' look at how the trust manages winter demand and the plans in place to ensure we are always here for people when they need us most.

7.1.4 A further key 111 message to service users is that they can access the same assessment and help from 111 online as the phone service, to encourage as many people as possible to use this route. Promoting NHS 111 online has previously been shown to have a positive impact on appropriate use of services – for example, during winter 2022-23, use of 111 online as a proportion of all service contacts increased to more than 50% (from 25%) while adverts were running. We will also promote the text service offer to users.

7.1.5 Communication toolkits and winter plans are discussed and shared together with regular updates on local system hotspots and identified themes in order to signpost patients to the most appropriate/alternative service. National and regional funding to support communication and engagement campaigns is expected to be allocated and held on a local system basis. Whilst NWAS does not directly receive this funding, allocation to support our work will be made from the existing trust/communications budget.

7.2 Communications Activity

7.2.1 The trust's Winter Communications Plan covers six broad areas of activity:

- General Winter and Flu communication – The trust will support national campaigns around flu and the well-established national campaign; 'help us help you', supplemented with dedicated ambulance service campaigns and messaging.
- Communications specifically relating to the coronavirus.
- Pressure related communication – in reaction to increases in operational and demand pressures relating to use of 999 and NHS 111.
- Business Continuity Management – staff communications during periods of pressure to ensure continuity of core services.
- Public safety messages around key dates (e.g. 5th November, New Year's Eve).
- Communications specific to the post winter recovery period.

7.2.2 Messages will be disseminated through a mix of online and offline tactics including local and community radio, social media and publication advertising along with tapping into face-to-face community events and engagement sessions held by the trust. These will also include harder to reach communities, particularly older adults, and people from ethnic minorities.

During the winter months, new campaigns will be implemented to support the objectives below.

7.3 Specific Objectives

Communication activity will assist in mitigating some of the demand pressures that NWAS will face during the winter period. Specific actions will include:

- Providing our staff, our volunteers and the public with health and wellbeing advice including why they should have the flu vaccination
- Informing the public about making the right choices to access care if they are unwell, especially when to call 999 and when to use other services such as NHS 111 and NHS 111 online
- Raising awareness of the ambulance services role in tackling winter pressures amongst NHS organisations and key stakeholders
- Engaging with staff about our efforts so they feel informed, listened to and able to act as a trusted source of information to patients on winter health matters

7.4 UK Health Security Agency – Adverse Weather and Health Plan (2023)

7.4.1 The Adverse Weather and Health Plan (2023) combines pervious plans such as, Heatwave Plan for England and the Cold Weather Plan for England. Amalgamation of previous arrangements allows for the focus on the health impact of adverse weather year round with a view to supporting government initiatives to build community resilience.

The Plan identifies four key areas or goals it aims to support:

- G1. Prevent the increase in years of life lost due to adverse weather events
- G2. Prevent mortality due to adverse weather events
- G3. Prevent morbidity due to adverse weather events
- G4. Reduce the use of healthcare services due to adverse weather events

7.4.2 The heat-health alert system operates from 1 June to 30 September and the cold health alert system operates from 1 November to 30 March. An out of season alert may still be issued if impacts from adverse weather on health (heat and cold) are expected.

Both systems are based on the Met Office forecasts and data. Depending on the level of alert, a response will be triggered to communicate the risk to the NHS England, government, and public health system. Advice and information will be sent to the public and health and social care professionals, particularly those working with at-risk groups, after an alert is issued or updated.

This includes both general preparation for hot weather and more specific advice when a severe heatwave has been forecast. Delivery groups should implement year-round planning and use the guidance in advance of the summer and winter.

The platform aims to cover the spectrum of action from different groups. In general terms:

• Green (preparedness): No alert will be issued as the conditions are likely to have minimal impact and health; business as usual and summer/winter planning and preparedness activities.

• Yellow (response): These alerts cover a range of situations. Yellow alerts may be issued during periods of heat/cold which would be unlikely to impact most people, but could impact those who are particularly vulnerable.

• Amber (enhanced response): An amber alert indicates that weather impacts are likely to be felt across the whole health service, with potential for the whole population to be at risk. Non-health sectors may also start to observe impacts and a more significant coordinated response may be required.

• Red (emergency response): A red alert indicates significant risk to life for even the healthy population.

These alerts and forecasts are received by the NWAS Resilience Team, Emergency Operations Centres, the ROCC and Communications Team.

7.4.3 The current version of the UK Health Security Agency Adverse Weather and Health Plan can be found here:

Adverse Weather Health Plan (publishing.service.gov.uk)

Local Resilience Fora all have multi-agency severe weather arrangements and NWAS remains an active partner in the planning and response to such incidents to support patient care, wider public safety and staff support.

8.0 REPORTING MECHANISMS

8.1 Although no direct arrangements have been confirmed formally by NHS England, it is likely their response and overview will be in line with previous years, involving the establishment of their North West Winter Room. Anticipated to be stood up during the beginning of the winter period and maintain through to potentially April 2024. The function is anticipated to operate 0800-1700hrs each day (excluding 25 & 26 December). Outside of these times, winter escalation will transfer through to established on-call arrangements for each of the North West Localities (C&M/LSC/GM).

8.2 In terms of specific routine reporting through to the NW Winter Room, this is likely to be achieved, as in previous years, through existing systems which NHSE has been granted access – namely NWAS Hospital Arrival Screen (HAS) and the NACC Dashboard (ProClus). This will provide real-time and live access to NWAS capacity and capabilities.

As in previous years, it is anticipated that the NW Winter Room will chair twice weekly calls with NW Ambulance Services (NWAS, NEAS and YAS). This call will provide ambulance trusts the opportunity to raise any ongoing concerns over internal or external threats and pressures to service delivery. The NW Winter Room lead is then able to escalate and intervene with health systems should be the issue be protracted or sustained.

8.3 NWAS managers will continue to represent local sectors through ICBs/ICSs and provide detailed, local assurances or data as requested.

Where System Control Centres (SCCs) (NHS England, 2022) have been established, NWAS will collaborate and share information and intelligence to support system wide management of pressures. An SCC will generally operate at an Integrated Care Board (ICB) level to lead and facilitate collaboration through senior system-level operational leadership. SCCs will deliver:

- Visibility of operational pressures and risks across providers and system partners.
- Concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges.
- Dynamic responses to emerging challenges and mutual aid.
- Efficient flows of information.

9.0 SPECIFIC CONTINGENCY & BUSINESS CONTINUITY PLANNING

9.1 Seasonal Influenza

In mid-September the Trust will launch its annual Flu campaign. In line with national requirements the ambition is to offer 100% of the workforce the flu vaccine and to vaccinate over 75% of staff. A project team has started the preparatory work in summer and has a robust project plan in place which seeks to aim to vaccinate staff. As with previous years, the focus is aimed to try and vaccinate as many staff as possible prior to winter pressures commencing.

9.2 COVID-19 Response & Recovery Plan

9.2.1 COVID- Response

The NWAS COVID-19 Response Plan was activated during March 2020 in response to the emerging virus and remains in place to manage any response to new variants.

9.2.2 COVID-19 Recovery

The COVID-19 pandemic presented unprecedented challenges across the whole of NWAS, diverting resources and operational delivery away from business as usual and Departmental planning to provide an immediate, coordinated response to COVID-19.

It is good practice in emergency response and business continuity planning, to consider recovery as soon as possible during the response phase. This is because the actions taken in the response phase will affect recovery, sometimes detrimentally so consequences of decisions need to be examined throughout the response phase.

NWAS COVID-19 Recovery identifies those areas within NWAS where change has taken place and the process by which a return to a "new normality" will be facilitated. The arrangements contained within the plan will be reviewed on an on-going basis in light of changes in guidance from the Department of Health & Social Care, UKHSA and the World Health Organisation.

9.3 Severe Weather

9.3.1 Severe winter weather provides one of the greatest challenges to NWAS with snow, ice and flooding all affecting the road infrastructure. The NWAS response is detailed in the Area level plans but essentially relies on the augmentation of the usual fleet with the following:

- NWAS PES vehicles have been fitted with cross climate tyres (four seasons)
- NWAS 4x4 RRVs already in service including HART fleet
- Consideration of short-term hire of additional 4x4 vehicles
- St John Ambulance and British Red Cross 4x4 vehicles
- Those managers with 4x4 lease vehicles

- Civilian Mountain Rescue Teams and other Search and Rescue charities
- Partner agencies e.g. Police, Fire & Rescue Service, RNLI, MCA, Local Authority
- Maritime and Coastguard Agency Search and Rescue helicopters (immediate lifesaving interventions)
- Military Aid to the Civil Community in extreme situations upon exhaustion of NWAS contingencies

9.3.2 Additionally, ambulance stations will receive supplies of grit/salt and, as in previous years, maintain contract arrangements with hospital estates departments or commercial companies to provide a snow moving and gritting service. HART bases have their own snowplough capabilities to maintain access and egress.

Vehicle recovery arrangements are in place either through NWAS Fleet Support or externally contracted sources.

9.3.3 Existing departmental Business Continuity Plans and staff mapping information will be activated in the event of a disruption affecting staff availability with particular emphasis on EOC operations and other core functions. Staff welfare is paramount, but individuals are encouraged to attempt to access normal work locations where safe or nearest NWAS site/alternative site as designated in local Business Continuity Plans.

9.3.4 NWAS Strategic Commanders have Government Purchasing Scheme (GPC) Credit Cards to support the out of hours provision of financial support for emergency accommodation or catering supplies in the event of staff being stranded or required to be billeted near a place of work.

9.4 Industrial Action

9.4.1 Existing departmental Business Continuity and staff mapping arrangements underpin the NWAS response to any threatened periods of industrial action which result in a loss of staff disruption.

9.4.2 Experience gained from previous industrial action, has led to a specific NWAS plan – Operation Constant Care - being developed to deal with the impacts of disruption through strikes and action short of strike. This plan is sufficiently flexible to be tailored to the specific type or period of potential disruption. Knowledge of potential areas of disruption or challenge has been acquired from mitigation of Ambulance Staff, Fire and Rescue Service and Junior Doctors disputes/actions over recent years and this has been factored into a range of contingency plans to ensure enhanced resilience.

9.4.3 The NWAS Operation Constant Care Plan can be initiated in the face of planned or spontaneous action and provides a flexible and scalable response to maintain the Business Continuity of NWAS and protect core response in the face of any degradation of capability. This plan has been updated and reconfigured for each specific sector, which may be affected by industrial action e.g. Fire and Rescue Service, fuel transport or parts of the health sector. The threat of more widespread and

coordinated industrial action during the winter period has been recognised and considered in terms of NWAS and multi-agency planning.

9.4.4 The country, over the last year, has already seen both actual and threats of industrial action occur in both public and private sector organisations; health – including ambulance staff, nurses, doctors and physiotherapists - teachers, rail workers to name but a few.

Although agreements have been made with many cohorts, Trade Union officials have indicated their willingness to re-instate the option of strike action should those agreements not be met.

10.0 DOCUMENT REVIEW

10.1 This document remains in a constant state of review and will be updated and amended as situations develop or change but will be formally reviewed and revised following the standing down of this document.

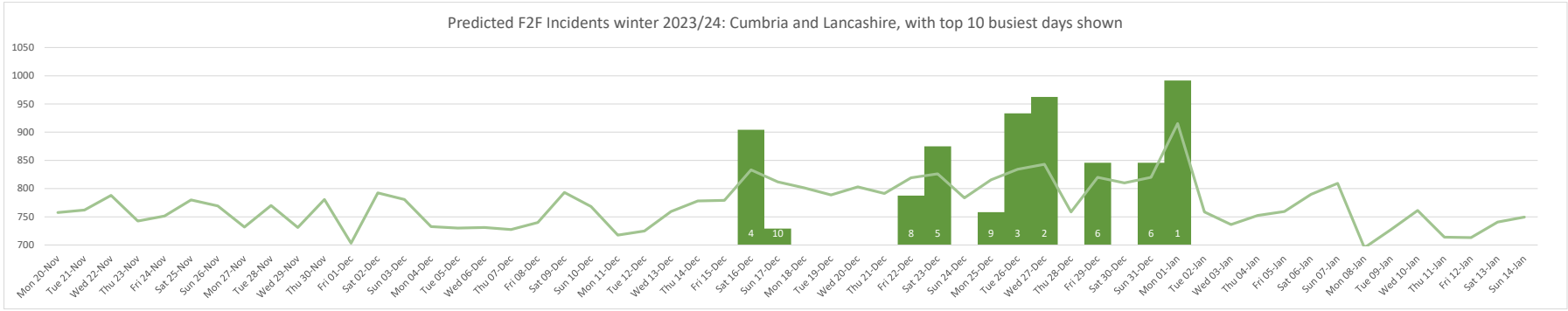
11.0 APPENDICES

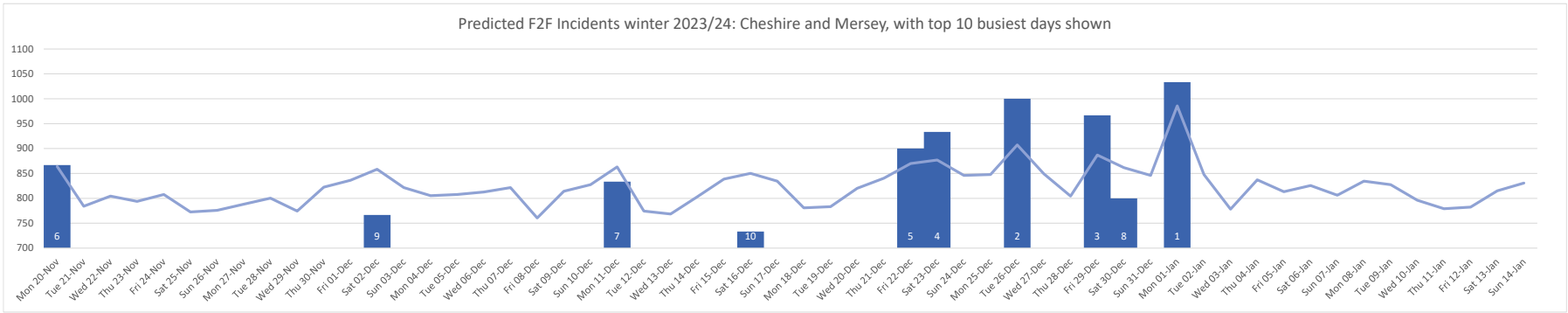
Appendix 1 - 999 Activity Forecast - Including 'Top 10' Busiest Days

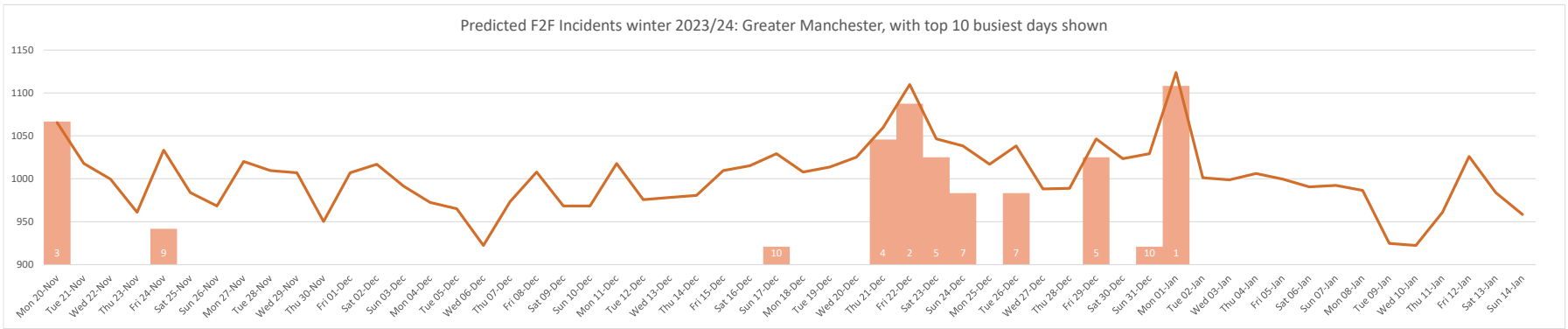
Appendix 2 - 111 Activity Forecast

NHS North West Ambulance Service NHS Trust

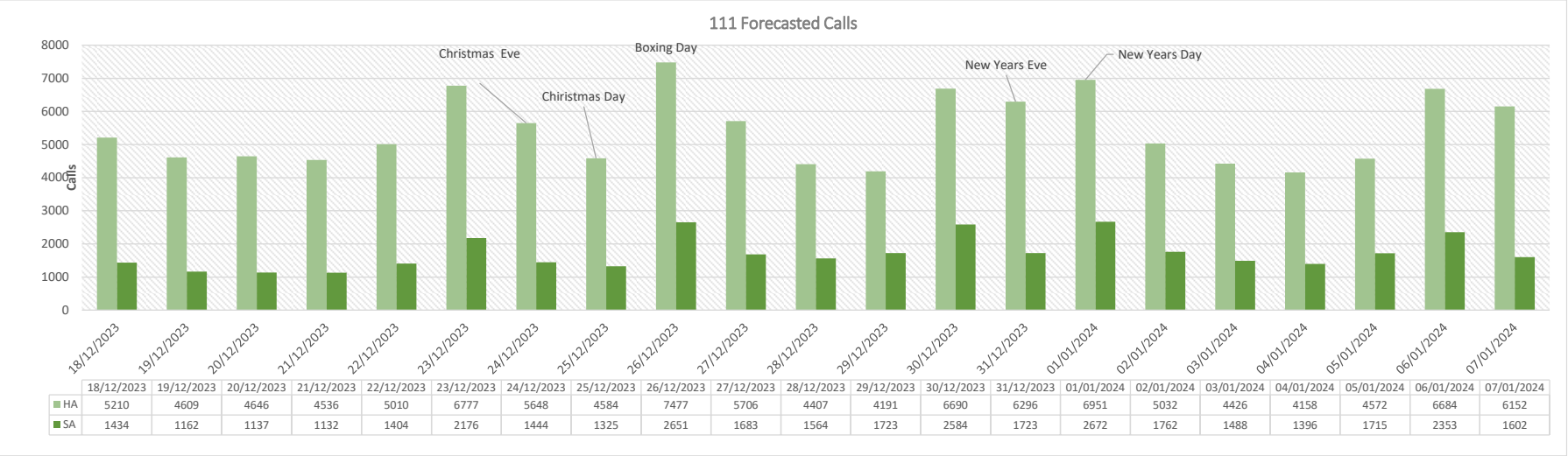
Appendix 1 – 999 Activity Forecast - Including 'Top 10' Busiest Days







Appendix 2 - 111 Activity Forecast



	18/12/2023	19/12/2023	20/12/2023	21/12/2023	22/12/2023	23/12/2023	24/12/2023	25/12/2023	26/12/2023	27/12/2023	28/12/2023	29/12/2023	30/12/2023	31/12/2023	01/01/2024	02/01/2024	03/01/2024	04/01/2024	05/01/2024	06/01/2024	07/01/2024
HA	5210	4609	4646	4536	5010	6777	5648	4584	7477	5706	4407	4191	6690	6296	6951	5032	4426	4158	4572	6684	6152
SA	1434	1162	1137	1132	1404	2176	1444	1325	2651	1683	1564	1723	2584	1723	2672	1762	1488	1396	1715	2353	1602

North West Ambulance NHS Trust
Equality Impact Assessment Form (EIA) - Policies & Procedures

Name of policy or procedure being reviewed: NWAS Winter Strategic Plan 2023-2024

Equality Impact Assessment completed by: Andrew Jackson

Initial date of completion: 14/09/2023

It is anticipated that this EIA will be reviewed throughout the lifecycle of the policy or guidance. Relevant documentation should be maintained relating to the review. Please also record any stakeholders who input into this now or in the future. There is a longer version of this form for assessing the impact of strategy and major plans.

Section 1 – Overview

What kind of policy/procedure is this – eg clinical, workforce?

The purpose of this document is to ensure that the North West Ambulance Service (NWAS), have in place mitigation and sufficient planning to satisfy the requirements of the NHSE Winter Planning process and meet the needs of our community when activity and demand increases due to adverse weather, new variants of COVID-19, or any other factor. The overarching principle is the safety and dignity of our patients in every case.

Who does it affect? (Staff, patients or both)?

Both

How do you intend to implement it? (Trustwide communications plan or training for all staff)?

The NWAS Winter Strategic Plan is marked as 'Official – Sensitive' within the governments marking scheme, which means its distribution has some restrictions placed upon it, such as recipients not sharing more broadly without express permissions. The document is used predominantly by the NWAS Command structure, NWAS ROCC (Regional Operational and Coordination Centre) and NHS England Senior Management and Executive staff. Updates and reviews of this document will be shared with the on-call cadre of staff, and service line leads, but it will not be placed on the Greenroom due its classification.

Section 2 – Data and consultation

In order to complete the EIA it may be useful to consider the following:-

- What data have you gathered about the impact of policy or guidance on different groups?
- What does it show?
- Would it be helpful to have feedback from different staff or patient groups about it?

Please document activity below:

Equality Group	Evidence of Impact
Age	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.

Disability – considering visible and invisible disabilities	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Gender	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Marital Status	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Pregnancy or maternity	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Race including ethnicity and nationality	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Religion or belief	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Sexual Orientation	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Trans	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	Any decision taken which refer to this document as part of the decision-making process, does so understanding that no discriminators are used. The rationale for any decision will be assessed in the interest of patient safety and based upon clinical needs.

Section 3: Impact Grid

Having considered the data and feedback through consultation, please detail below the impact on different groups (Age, Disability – considering visible and invisible disabilities, Gender, Marital Status, Pregnancy or maternity, Race including ethnicity and nationality, Religion or belief, Sexual Orientation, Trans, Any other characteristics for patient or staff e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee):

Equality Group	Evidence of Impact	Is the impact positive or negative?
Age Disability – considering visible and invisible disabilities Gender Marital Status Pregnancy or maternity Race including ethnicity and nationality Religion or belief Sexual Orientation Trans Any other characteristics e.g., member of Armed Forces family, carer, homeless, asylum seeker or refugee	This procedure covers all areas of equality groups	Positive

Advice has also been sought from the HR Advisor for Equality and Diversity with regards to this EIA.

Section 4 – Action plan

At this point, you should prepare an action plan which details the group affected, what the required action is with timescales, and expected progress. You may still be seeking further information as part of your plan. You can use the table 3 above to detail any further action.

Continual review to ensure all patient groups are considered and clinical need and priority is the only discriminator.

Section 5 – Monitoring and Review

You should document any review which takes place to monitor progress on the action plan or add any information through further data gathering or consultation about the project. It is sensible for the review of this to be built into any plans. More information about resources can be found on the greenroom.

Further information about groups this policy may affect can be found here pages 10-11.
https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 September 2023				
SUBJECT:	Learning from Deaths – Q1 Summary Report 23/24 and Annual Dashboard 2022/23				
PRESENTED BY:	Dr Chris Grant – Executive Medical Director				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning. The Q1 dashboard (Appendix A) describes the opportunities to learn from deaths. The main contributory factors to patient deaths, where identified in DatixCloudIQ (DCIQ), were attributed to challenges in Emergency Operational Centres (EOC), specifically around the emergency response where demand outstripped available resources. The peer review process now encompasses EOC and as a result the Trust is fully compliant with the national framework. The key areas for improvement include using a medical model when documenting a patient's assessment, including more detail in a patient assessment, making a referral to GP services when appropriate to do so and ensuring calls are triaged correctly using Pathways. The quality of patient records completion also requires improvement. The peer review also identified areas of good practice. This includes; extensive patient assessment; excellent recognition of a dying patient; holistic decision making; and staff empowered to safely administer subcutaneous morphine. There were two patient records that received a "good" rating for quality. The panel continues to welcome observers to help raise awareness of the LFDs process and embed learning from the peer reviews.				

RECOMMENDATIONS:	The Board is recommended to:
	
	• Support the quarterly dashboard (Appendix A) as the report published on the Trust public account.
	• Support the Annual Dashboard (Appendix B) as the report published on the Trust public account.
	• Acknowledge the good practice identified including:
	  ○ Excellent recognition of patient dying.
	  ○ Staff empowered to safely administer subcutaneous morphine.
	  ○ Holistic decision making recorded.
	• Note the planned review of this Policy and subsequent reports commences Q3.

CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Clinical Effectiveness Sub Committee Quality and Performance Committee			
	Date:	5 September 23 25 September 23		
	Outcome:	Supported		

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1. PURPOSE

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

Appendix A is a summary dashboard of the Q1 2023/24 Learning from Deaths review, and it is proposed this document is published on the Trust's public accounts by 6th October 2023 in accordance with the national framework and trust policy. The Q1 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q1. Learning from the panels is discussed later in this paper.

2. BACKGROUND

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

3. LEARNING FROM DEATHS DASHBOARD Q1 2023/24: APPENDIX A

The number of patients whose deaths were identified as in scope for review was 97 (63 concerns raised in Datix and 34 sampled for SJR)

Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 16/06/2023 and the high-level figures for the previous quarters has also been refreshed (number of concerns, number of deaths reviewed and the number of deaths where problems in care have contributed). It should be noted that due to the complexity, the granular updates for the previous quarters will be received within other patient safety reports and the thematic analysis will be captured within the annual Learning from Deaths Report.

The breakdown of concerns raised:

- 31 internal concerns were raised through the Incidents Module (Events)
- 13 external concerns were raised through the Patient Experience Module (Feedback)
- No concerns were raised both internally and externally.

Internal Concerns:

Of the 31 internal concerns, 16 were reviewed and closed. In 0 cases, the investigation concluded the Trust had contributed in some way to that patient death.

External Concerns:

Of the 13 external concerns that have been reported, eight are still in the preliminary stages of review and so it is unknown at the time of writing if the care given was in line with best practice. Five concerns have been closed and 0 patient deaths had causal factors identified. The content of the reviews so far suggests the learning themes and therefore opportunities for improvement are:

- EOC
    - Call categorised incorrectly.
    - Missed opportunity to upgrade low acuity incident.
    - Problem with call taking and/or response allocation for chest pain.
- PES
    - Problem related to treatment and management plan.

Concerns raised internally and externally:

No concerns were raised internally and externally – note these are different concerns from those referenced above.

Outcomes from concerns raised:

There are 13 internal concerns that are still being investigated. The patient safety team will report the outcomes and actions once the investigations are complete.

Structured Judgement Review (SJR): Cohort Discussion:

Of the 18 patient deaths:

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

Structured judgement review (SJR) methodology

The process requires frontline staff to review and make explicit statements on the practice under review using the 'Sequence of Events' (SoE) and Electronic Patient Record (EPR) as the data source.

The explicit statements of care can be one of five categories ranging from very good to very poor and it is possible to use each of the statement's multiple times in a single review.

The review comprises of Stage 1: review of clinical practice and call handling/ resource allocation. Where less than adequate overall care is identified, a Stage 2 review of the patient death to identify if any causal factors (systemic) problems in care have led to harm.

SJR Stage 1 Outcomes:

16 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the table below. 7 patients received appropriate (adequate) care. The mid-range statement of 'adequate' practice is defined as the expected practices and procedures in compliance with guidance. Any practice identified as beyond expected practice is defined as 'good'. Any practice identified as not reaching expected practice is defined as 'poor.'

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

SJR Stage 2 Outcomes:

Nine cases were identified as needing second stage review following Stage 1. The second stage review concluded that three deaths were not avoidable, two had casual factors and four cases were uncertain whether poor practice had led to harm. The care experienced by these patients in terms of call, handing, categorisation, resource allocation, patient assessment and management plan were below expected levels.

Duty of candour considerations are now taken place formally to conclude the Stage 2 outcomes and actions. Local operational teams will be contacted to consider enacting duty of candour.

SJR Learning Outcomes:

Poor Practice:

The panel identified areas for improvement to:

- Triage calls appropriately
- Re-triage calls appropriately
- Record a full examination, assessment and outcome.
- Use a medical model when documenting on examination findings.
- Record observations when appropriate.
- Assess and document capacity appropriately.
- Perform ECGs when appropriate/
- Apply MTS when appropriate.
- Record a clear management plan.
- Make a referral to AVS/GP services when appropriate.
- Detail specific worsening advice/risk factors
- Take a full patient history including medical, social, and family history.

Good Practice:

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

- Extensive patient assessment Excellent recognition of a patient dying.
- Holistic decision making.
- Staff empowered to administer subcutaneous morphine to patient to alleviate discomfort/distress.
- Quality of EPR.

Actions taken:

- AP feedback on poor documentation.
- Query around EOLC planning.
- Scope out Duty of Candour.
- Potential for SI to be raised.
- EMA to receive audit and feedback around call handling.
- Good practice staff story to be circulated.
- Possible new topic for ‘Rapid Recap’ around alternatives to anxiety presentations.
- Clinical Safety Team to raise a retrospective Learning Disabilities Mortality Review (LeDeR).

Dissemination Process

Disseminating of learning and promoting good practice is undertaken by the Consultant Paramedic (Medical) through the area learning forums (ALFs) and individual frontline staff.

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

Good practice letters have been circulated to commend 6 clinicians, who through their care and professionalism, have supported families and patients to experience a good death during Q1.

Observers were welcomed at the Q1 panels, and the process is supporting colleagues with their own practice.

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

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

5. EQUALITY OR SUSTAINABILITY IMPACTS

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

6. RECOMMENDATIONS

The Board is recommended to:

- Support the quarterly dashboard (Appendix A) as the report published on the Trust public account.
- Support the Annual Dashboard (Appendix B) as the report published on the Trust public account.
- Acknowledge the good practice identified including:
    - Excellent recognition of patient dying.
    - Staff empowered to safely administer subcutaneous morphine.
    - Holistic decision making recorded.
- Note the planned review of this Policy and subsequent reports commences Q3.

NWAS Learning From Deaths Dashboard - Q1 of 2023 - 2024 (April - June)

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

Total Number of Deaths in Scope (Sample Cohort and Datix Incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Apr-23	20	15	75.0%	3
May-23	20	13	65.0%	2
Jun-23	22	9	40.9%	4
This Quarter	**62**	**37**	**59.7%**	**9**
This Financial Year	62	37	59.7%	9

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the patient*

Table 1

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

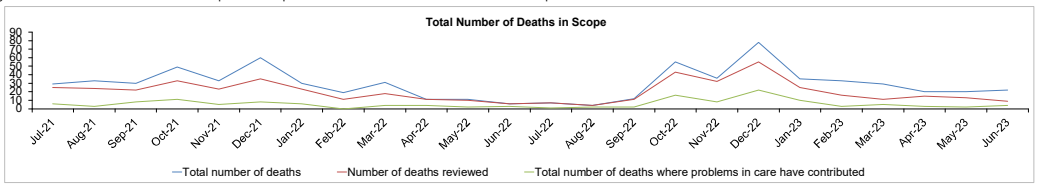


Figure 1

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

Concerns raised in Datix Breakdown

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

Internal Concerns - Incidents (including SIs)

Total Datix Death Incidents in Scope		Risk grading		
		1 or 2	3	4 or 5
April	10	4	0	6
May	12	6	1	5
June	9	2	0	7
Total	**31**	**12**	**1**	**18**

Table 2

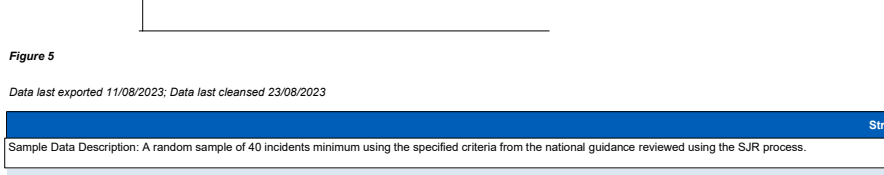


Figure 2

Number of Deaths Closed on Datix		Of those closed, Number of Deaths likely due to the service provided by the Trust	Lessons Learned complete for those closed and Deaths likely due to the service provided by the Trust
April	6	0	0
May	7	0	0
June	3	0	0
Total	**16**	**0**	**0**

Table 3

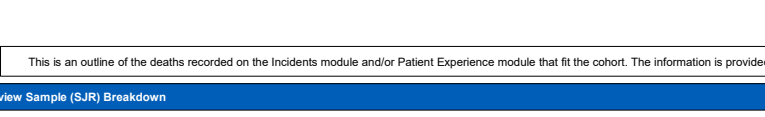


Figure 3

External Concerns

Number of Complaints		Incidents Closed on Pat. Exp.	Number closed and Deaths likely due to the service provided by the Trust
April	3	3	0
May	1	0	0
June	9	2	0
Total	**13**	**5**	**0**

Table 4

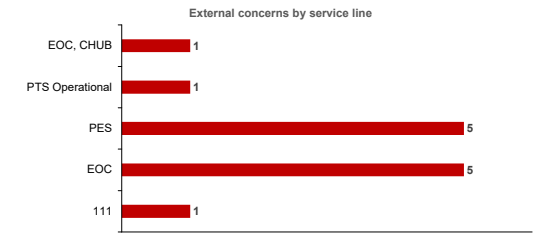


Figure 4

Department	Concern Raised	Cause and Actions	Total
111	Problem with call taking and/or response allocation	Call categorised incorrectly; Missed opportunity to upgrade low acuity incident; Refresher training to be undertaken	1
		Still under review	2
EOC	Problem with call taking and/or response allocation (stroke)	Call categorised incorrectly; Missed opportunity to upgrade low acuity incident, Demand outstripped resources; Partly upheld; No actions	1
	Problem with call taking and/or response allocation (chest pain)	Demand outstripped resources; Still under review	1
	Problem with call taking and/or response allocation (IFT)	Still under review	1
PES	Problem related to treatment and management plan	Still under review	2
	Problem with communication	No causal factors; Not upheld; No actions	2
	Problem with assessment, investigation or diagnosis	No causal factors; Not upheld; No actions	1
PTS Operational	Problem with transporting EOLC patient back home/hospice	Still under review	1
EOC, CHUB	Problem with patient disposition	Still under review	1

Table 5

Internal and External Concerns - Incidents and Complaints

Number of concerns that have been raised internally and externally		Incidents Closed on both modules	Number closed and Deaths likely due to the service provided by the Trust
April	0	0	0
May	0	0	0
June	0	0	0
Total	**0**	**0**	**0**

Table 6

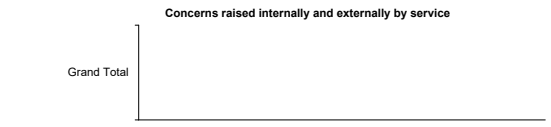


Figure 5

Department	Concern Raised	Cause and Actions	Total

Table 7

Data last exported 11/08/2023; Data last cleansed 23/08/2023

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

Structured Judgement Review Sample (SJR) Breakdown

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

Structured Judgement Review

Incidents used for the Sample Criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April	7	6	3
May	7	6	2
June	4	4	4
Total	**18**	**16**	**9**

Table 8

SJR Category Type			
Month	**C1 and C2 Long waits**	**C3 and C4 Deaths**	**24 hr Re-contact Deaths**
April	0	0	7
May	1	3	3
June	0	0	4
Total	**1**	**3**	**14**

Table 9

SJR Scoring Key:

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

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

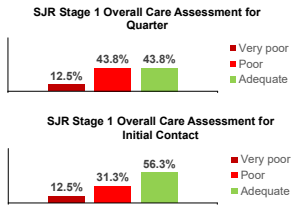


Figure 6

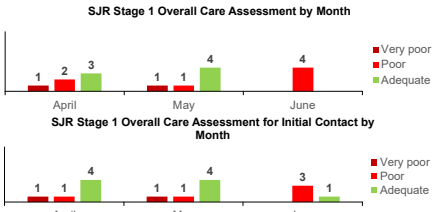


Figure 7

Initial Contact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	3	14	0	**14/17 patients**	**82%**
Right Care	Patient Assessment Rating	4	10	2	**12/16 patients**	**75%**
	Management Plan/Procedure Rating	4	12	1	**13/17 patients**	**76%**
Right Place	Patient Disposition Rating	5	11	1	**12/17 patients**	**71%**

Table 10

Figure 8

Figure 9

Recontact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	3	11	0	**11/14 patients**	**79%**
Right Care	Patient Assessment Rating	0	13	0	**13/13 patients**	**100%**
	Management Plan/Procedure Rating	0	13	0	**13/13 patients**	**100%**
Right Place	Patient Disposition Rating	0	13	0	**13/13 patients**	**100%**

Table 11

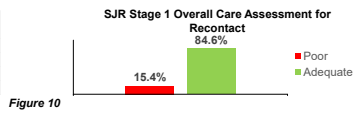


Figure 10

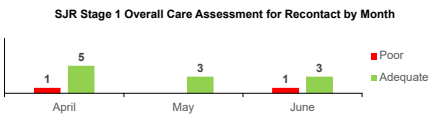


Figure 11

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 16 patients)

Evidence of Poor/Very Poor Practice

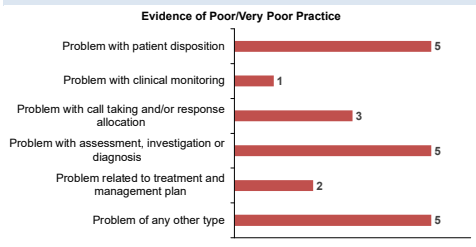


Figure 12

Department	Learning Theme	Learning Detail	Total
PES	Problem with assessment, investigation or diagnosis	Limited information recorded regarding clinical assessment, examination and outcome	1
		No medical model used (including those that lack detail)	2
		12 lead ECG not performed when appropriate to do so	1
		Very brief assessment of patient which lacks detail	2
		No patient history taken, including medical and social history	1
	Problem related to treatment and management plan	MTS not used	1
		Lack of clear management plan	1
	Problem of any other type	Quality of EPR	5
	Problem with clinical monitoring	No observations recorded	1
	Problem with patient disposition	Capacity to consent not assessed correctly	1
		No referral to AVS/GP/alternative providers when appropriate to do so	2
		No specific worsening advice/red flags/risk factors	1
		No specific worsening advice and MTS not applied correctly	1
EOC	Problem with call taking and/or response allocation	Call not re-triaged	1
		Call not triaged correctly	2

Table 12

Evidence of Good/Very Good Practice

Figure 13

Department	Learning Theme	Learning Detail	Total
PES	Additional assessments, investigations or diagnosis	Excellent recognition of patient dying	1
		Extensive patient assessment	1
	Additional treatment and management plans	Holistic decision making reported	1
		Crew empowered to administer subcuatneous morphine to EOL patient to make them comfortable	1
	Other	Quality of EPR	2

Table 13

Data last accessed 23/08/2023

NWAS Learning From Deaths Demographics Dashboard for Q1 2023 - 2024 (April - June)

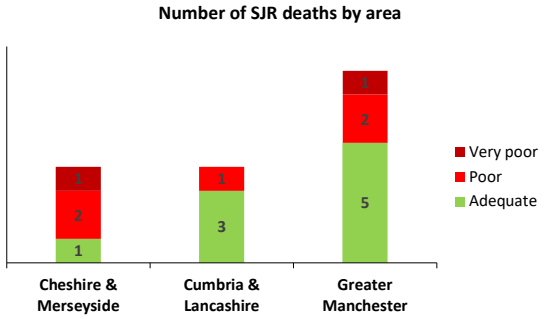


Figure 1

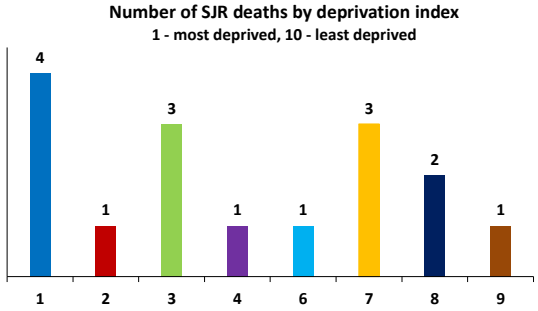


Figure 2

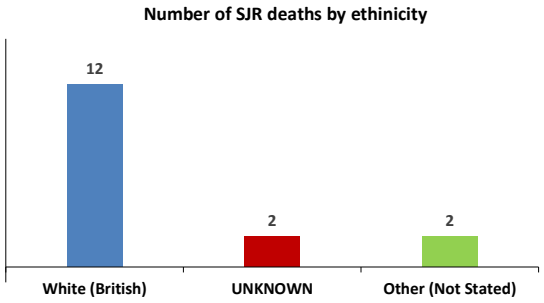


Figure 3

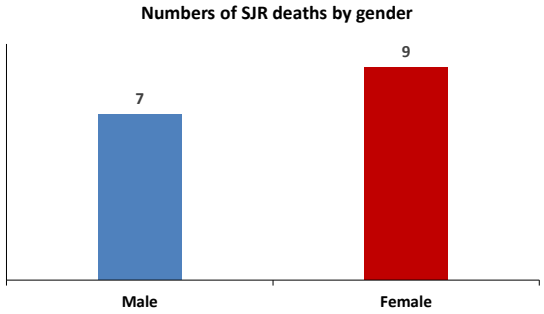
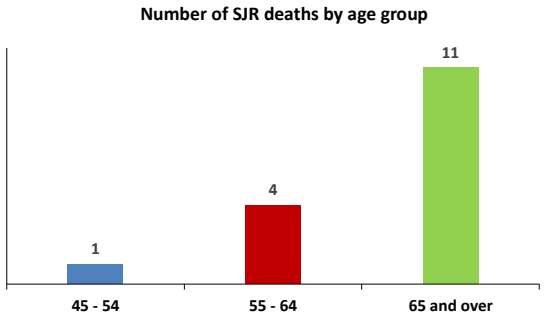


Figure 4



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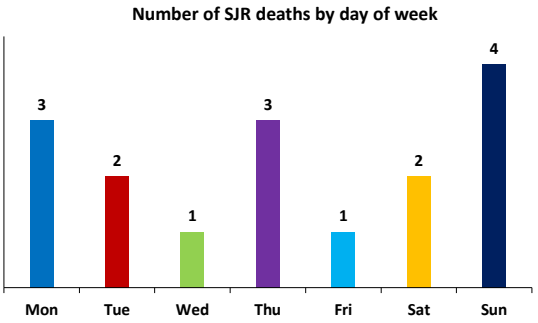


Figure 6

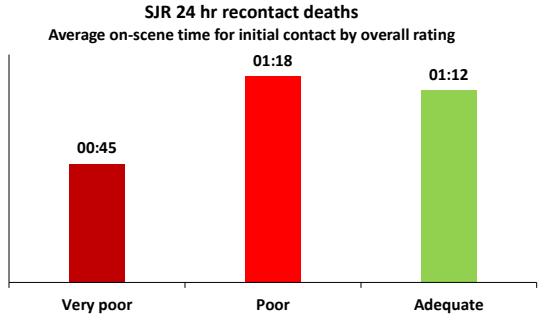


Figure 7

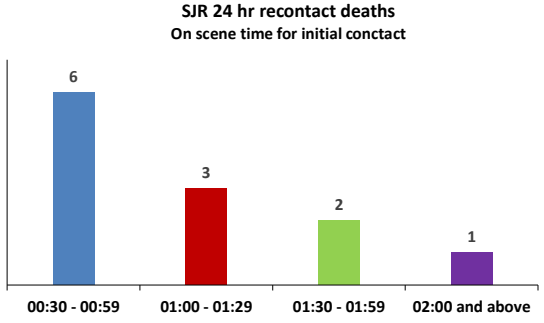


Figure 8

Data last accessed 18/08/2023

NWAS Learning From Deaths Dashboard Annual 2022 - 2023 (April - March)

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

Total number of deaths in scope (Sample cohort and Datix incidents)*		Total number of deaths reviewed	% Deaths reviewed	Total number of deaths where problems in care have contributed
Q1	128	115	89.8%	19
Q2	174	158	90.8%	11
Q3	182	136	74.7%	38
Q4	95	50	**52.6%**	18
This Financial Year	579	459	79.3%	86

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the patient*

Table 1

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

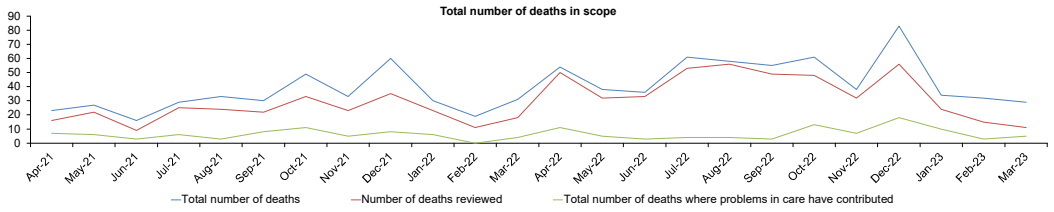


Figure 1

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

Concerns raised in Datix Breakdown

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

External Concerns

Number of external concerns		Number of concerns closed	Number closed and deaths likely due to the service provided by the Trust
Q1	33	31	2
Q2	49	47	1
Q3	33	24	0
Q4	14	5	1
Total	**129**	**107**	**4**

Table 2

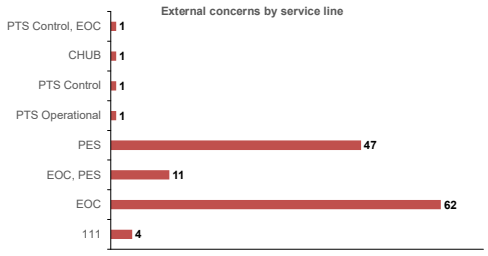


Figure 2

Department	Concern Raised	Cause and Actions	Total
111	Problem with patient disposition	No causal factors; Not upheld; No actions	1
	Problem with call taking and/or response allocation	Incorrect reason of call logged in system; Staff feedback and/or reflection	1
		Still under review	1
	Problem with medication	No causal factors; Not upheld; No actions	1
CHUB	Problem with capacity to consent	Lack of safety netting; Staff feedback and/or reflection, Refresher training to be undertaken	1
EOC	Problem related to treatment and management plan	No causal factors; Incident shared with review panel/internal meeting/committee	1
	Problem with communication	Poor communication; Staff feedback and/or reflection	1
	Problem with transporting EOLC patient back home	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Staff feedback and/or reflection	1
		Demand outstripped resources; Staff feedback and/or reflection	1
		Demand outstripped resources; Refresher training/re-reading procedures; conduct an incident learning review	1
	Problem with call taking and/or response allocation	Incorrect coding of call; Staff feedback and/or reflection	1
		Demand outstripped resources; Staff feedback and/or reflection	1
		Call categorised incorrectly; Missed opportunity to upgrade low acuity incident; Staff feedback and/or reflection	1
		Still under review	4
		Demand outstripped resources; Hospital handover delays, Failure to recognise potential seriousness and complexity of condition; Staff feedback and/or reflection, System/procedure review/update requested	1
		No causal factors; Not upheld; No actions	3
		Demand outstripped resources; Not upheld; No actions	1
		Demand outstripped resources; Incorrect coding of call; Staff feedback and/or reflection, To be discussed at Area Learning Forum	1
		Demand outstripped resources; Partly upheld; No actions	2
		Demand outstripped resources; Hospital handover delays, Failure to recognise potential seriousness and complexity of condition; Staff feedback and/or reflection	1
		Demand outstripped resources; Hospital handover delays; Not upheld; No actions	3
		Demand outstripped resources; Hospital handover delays; Incident shared with review panel/internal meeting/committee, Staff feedback and/or reflection	1
		Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; System/procedure review/update requested	1
	Problem with call taking and/or response allocation (DIB)	No causal factors; Not upheld; No actions	2
		Demand outstripped resources; Not upheld; No actions	1
		Demand outstripped resources; Hospital handover delays; Partly upheld; No actions	1
		Demand outstripped resources; Hospital handover delays, Missed opportunity to divert ambulance, Missed opportunity to upgrade low acuity incident; Staff feedback and/or reflection	1
		Demand outstripped resources; Hospital handover delays; Not upheld; No actions	1
		Incorrect MPDS application; Staff feedback and/or reflection, To be discussed at Area Learning Forum	1
		Demand outstripped resources; Incorrect coding of call; Not upheld; No actions	1
		Demand outstripped resources; Hospital handover delays, Correct pathway not followed; Staff feedback and/or reflection, Incident shared with review panel/internal meeting/committee, To be discussed at Area Learning Forum	1
		Demand outstripped resources; Hospital handover delays, Correct pathway not followed; Staff feedback and/or reflection, Incident shared with review panel/internal meeting/committee, Review of "Trust Meal & Rest Break" policy	1
	Problem with call taking and/or response allocation (stroke)	Demand outstripped resources; Incident shared with review panel/internal meeting/committee	1
		Demand outstripped resources; Hospital handover delays; Not upheld; No actions	2
	Problem with call taking and/or response allocation (patient in labour)	Demand outstripped resources; External Out Complaint, Staff feedback and/or reflection, Incident shared with review panel/internal meeting/committee	1
	Problem with call taking and/or response allocation (chest pain)	Incorrect coding of call, Demand outstripped resources; Hospital handover delays; Staff feedback and/or reflection	1
		Demand outstripped resources; Not upheld; No actions	1
		Demand outstripped resources; Missed opportunity to divert ambulance from lower acuity incident; Staff feedback and/or reflection	1
		Demand outstripped resources; Staff feedback and/or reflection, Incident shared with review panel/internal meeting/committee	1
		Demand outstripped resources; Hospital handover delays; Not upheld; No actions	1
	Problem with call taking and/or response allocation (fall)	Demand outstripped resources; Staff feedback and/or reflection	1
		Demand outstripped resources; Not upheld; No actions	1
		Call categorised incorrectly; Missed opportunity to upgrade low acuity incident; Still under review	1
		Demand outstripped resources; Partly upheld; No actions	1
		Demand outstripped resources; Hospital handover delays; Not upheld; No actions	2
		Demand outstripped resources; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1
		Failure to recognise potential seriousness and complexity of condition; System/procedure review/update requested	1
		Unknown; not investigated; Not upheld; No actions	1
	Problem with call taking and/or response allocation (IFT)	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1
	Problem with call taking and/or response allocation (baby with DIB)	No causal factors; Not upheld; No actions	1
		Demand outstripped resources; Hospital handover delays; Not upheld; No actions	1
	Problem with call taking and/or response allocation, Problem with communication	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1
	Problem with call taking and/or response allocation (paediatric)	Demand outstripped resources; Not upheld; No actions	1
	Problem with call taking and/or response allocation (sepsis)	Demand outstripped resources; Not upheld; No actions	1
		Demand outstripped resources; Partly upheld; No actions	1
	Problem with call taking and/or response allocation (DIB), Problem with communication	Correct pathway not followed, Poor communication; Staff feedback and/or reflection	1
	Problem with call taking and/or response allocation, Problem with mobilisation	No causal factors; Not upheld; No actions	1
EOC, PES	Problem with call taking and/or response allocation	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Partly upheld; No actions	1
	Problem with call taking and/or response allocation (fall)	Demand outstripped resources; Hospital handover delays; Partly upheld; No actions	1
	Problem with call taking and/or response allocation (fall), Problem related to treatment and management plan	Still under review	1
	Problem with call taking and/or response allocation (fall), Problem with mobilisation	Still under review	1
	Problem with call taking and/or response allocation (fall), Problem with communication	Demand outstripped resources; Not upheld; No actions	2
	Problem with call taking and/or response allocation, Problem with communication	Demand outstripped resources; Hospital handover delays; Not upheld; No actions	1
		Demand outstripped resources; Hospital handover delays, Poor communication; Staff feedback and/or reflection	1
	Problem with call taking and/or response allocation, Problem related to treatment and management plan	Demand outstripped resources; Partly upheld; No actions	1
	Problem with call taking and/or response allocation (chest pain), Problem with mobilisation	Poor communication, Crew did not act appropriately; Staff feedback and/or reflection	1
	Problem with call taking and/or response allocation, Problem with patient disposition, Problem with communication	Correct pathway not followed, Poor communication; Incident shared with review panel/internal meeting/committee	1
PES	Problem related to treatment and management plan	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Staff feedback and/or reflection	1
		Still under review	1
		No causal factors; Not upheld; No actions	7
		Failure to recognise potential seriousness and complexity of condition; Staff feedback and/or reflection	1
		Failure to recognise potential seriousness and complexity of condition, Lack of safety netting; Staff feedback and/or reflection, Refresher training to be undertaken	1
	Problem related to treatment and management plan (private ambulance)	Failure to recognise potential seriousness and complexity of condition; Review processes/guidance on requesting assistance from other emergency services	1
	Problem related to treatment and management plan, Problem with communication	No causal factors; Not upheld; No actions	2
		Poor communication; Staff feedback and/or reflection	1
	Problem with capacity to consent	No causal factors; External Out Complaint	1
		Crew did not act appropriately; Staff feedback and/or reflection	1
	Problem with communication	No causal factors; Not upheld; No actions	2
		Poor communication; Staff feedback and/or reflection	3
		Crew did not act appropriately; Not upheld; No actions	1
	Problem with communication of handover	Poor communication; Staff feedback and/or reflection	1
	Problem with patient disposition	Call categorised incorrectly; Missed opportunity to upgrade low acuity incident; Staff feedback and/or reflection	1
		Still under review	2
		No causal factors; Not upheld; No actions	7
		Failure to recognise potential seriousness and complexity of condition; Staff feedback and/or reflection	2
		Correct pathway not followed; Refresher training/re-reading procedures; conduct an incident learning review	1
		Correct pathway not followed; Not upheld; No actions	1
	Problem with patient disposition, Problem with communication	Poor communication; Staff feedback and/or reflection	1
		No causal factors; Staff feedback and/or reflection	1
	Problem with assessment, investigation or diagnosis	No causal factors; Not upheld; No actions	2
		Poor communication; Not upheld; No actions	1
	Problem with assessment, investigation or diagnosis, Problem with communication	Poor communication; Staff feedback and/or reflection	1
	Problem related to treatment and management plan, Problem with patient disposition	No causal factors; Not upheld; No actions	1
	Problem with assessment, investigation or diagnosis, Problem with patient disposition	No causal factors; Not upheld; No actions	1
		Quality of PRF; Staff feedback and/or reflection	1
PTS Control	Problem with transporting EOLC patient back home	No causal factors; Not upheld; No actions	1
PTS Control, EOC		No causal factors; Not upheld; No actions	1
PTS Operational	Problem with mobilisation	Poor communication; Not upheld; No actions	1

Table 3

Internal and External Concerns - Incidents and Complaints

Number of Concerns Raised iInternally and Externally		Number of Concerns Closed	Number Closed and Deaths likely due to the Service provided by the Trust
Q1	3	3	1
Q2	8	5	0
Q3	2	1	0
Q4	0	0	0
Total	13	9	1

Table 4

Department	Concern Raised	Cause and Actions	Total
EOC	Problem with communication	Poor communication; Not upheld; No actions	1
	Problem with communication of handover	Insufficient information conveyed to ED; System/procedure review/update requested	1
	Problem with call taking and/or response allocation	Demand outstripped resources; Staff feedback and/or reflection	1
		Incorrect MPDS application, Demand outstripped resources, Poor communication; Staff feedback and/or reflection, System/procedure review/update requested	1
		Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; External Out Complaint, System/procedure review/update requested	1
	Problem with call taking and/or response allocation (DIB)	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Staff feedback and/or reflection, Incident shared with review panel/internal meeting/committee, External Out Complaint	1
		Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1
	Problem with call taking and/or response allocation (chest pain)	Demand outstripped resources; Inappropriate resource levels across Trust at time of incident; Hospital handover delays; Incident shared with review panel/internal meeting/committee	1
		No causal factors; Not upheld; No actions	1

Table 5

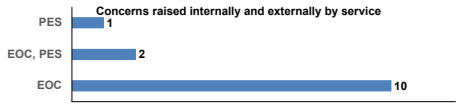


Figure 3

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

Internal Concerns - Incidents (including SIs)

Total Datix death incidents in scope		Risk grading		
		1 or 2	3	4 or 5
Q1	62	17	9	36
Q2	96	21	43	32
Q3	108	8	21	79
Q4	47	7	10	30
Total	266	46	73	147

Table 6

Number of deaths closed on Datix	Of those closed, number of deaths likely due to the service provided by the Trust	Lessons learned for those closed and deaths likely due to service
Q1	54	7	7
Q2	85	5	5
Q3	77	30	23
Q4	18	8	5
Total	216	42	35

Table 7

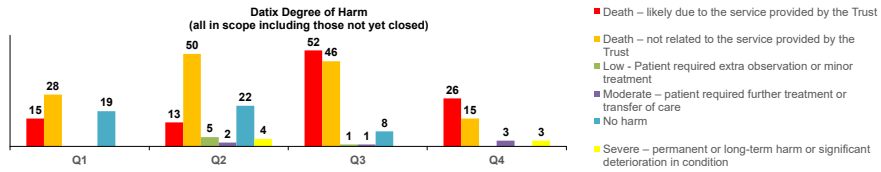


Figure 4

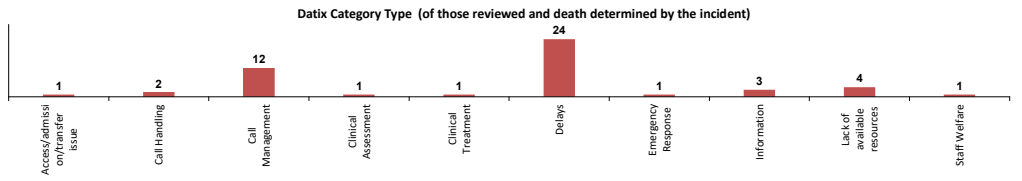


Figure 5

Data last exported 20/04/2023; Data last cleansed 21/07/2023

Structured Judgement Review Sample (SJR) Breakdown

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

Structured Judgement Review

Incidents used for the sample criteria		Number of deaths reviewed	Number of deaths where problems in care have contributed
Q1	30	27	9
Q2	21	21	5
Q3	39	34	7
Q4	34	27	9
Total	124	109	30

Table 8

† SJR Scoring Key:

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

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

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

SJR Category Type			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
Q1	1	2	27
Q2	3	4	14
Q3	10	3	26
Q4	3	4	27
Total	17	13	94

Table 9

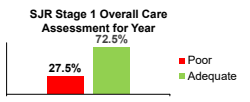
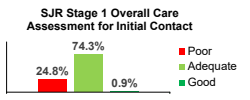


Figure 6

Initial Contact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation	2	107	0	107/109 patients	98%
Right Care	Patient Assessment Rating	20	84	5	89/109 patients	82%
	Management Plan/Procedure Rating	18	84	7	91/109 patients	83%
Right Place	Patient Disposition Rating	11	95	3	98/109 patients	90%

Table 10



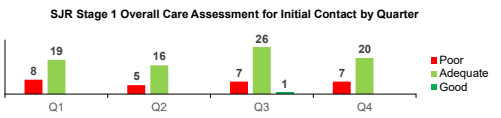
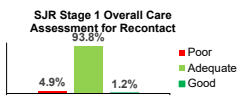


Figure 8

Recontact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation	2	79	0	79/81 patients	98%
Right Care	Patient Assessment Rating	0	78	3	81/81 patients	100%
	Management Plan/Procedure Rating	2	77	2	79/81 patients	98%
Right Place	Patient Disposition Rating	0	80	1	81/81 patients	100%

Table 11



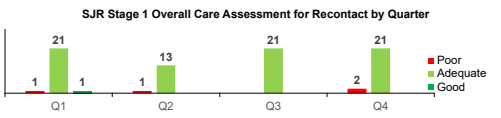


Figure 10

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 109 patients)

Evidence of Poor/Very Poor Practice

Department	Learning Theme	Learning Detail	Total
PES	Problem with resuscitation	Poor senior clinical advice given around the continuation of ALS for 20 mins despite airway being comprised, asystole and ineffective bystander CPR	1
	Problem with medication	IV paracetamol administered to a ?sepsis patient when no reason was clearly indicated	1
	Problem with clinical monitoring	No observations recorded	1
	Problem with assessment, investigation or diagnosis	Breathing assessment lacks details	1
		Capacity to consent not assessed correctly	9
		Limited information recorded regarding clinical assessment, examination and outcome	1
		No assessment of confusion (delirium, 4ATs, fluids and urine)	1
		No chest examination recorded	2
		No ECG performed when appropriate to do so	3
		No indication of the status of the disease or the prognosis, no indication of current treatments, or plan	2
		No medical model used (including those that lack detail)	5
		No pertinent negatives recorded	1
		No physical examination documented	2
		No repeated observations recorded	10
		No systematic examination of respiratory, abdominal, urinary or MSK	2
		Normal oxygen saturations not recorded	1
		Medical model and cardiac assessment not documented	1
		No medication recorded	1
		Clinical examination poorly documented	6
		Lack of clear impression, working diagnosis and differentials	1
		Capacity to consent assessed but no details provided	1
		12 lead ECG not performed when appropriate to do so	1
	Problem related to treatment and management plan	Crew documented patient refusal but don't stay why - always good to document the wishes or reasons of the patient as gives / builds a picture as to why	1
		Details of the GP discussions not recorded	3
		Differential diagnosis and border line infection not considered	1
		MTS not applied correctly	5
		MTS not used	4
		MTS/Pathfinder not applied correctly	2
		No discussion with family members regarding patient's condition/DNACPR/EoLC	1
		No documentation of patient/family wishes for a joint decision	2
		No documented attempt to contact the GP to discuss the patient or the presence of a statement of intent given the nature of the history.	2
		No evidence of sepsis being considered	3
		No referral to AVS/GP/alternative providers when appropriate to do so	7
		No Safeguarding referral made when appropriate to do so	1
		No specific worsening advice/red flags/risk factors	4
		No senior advice being sought	2
		No senior clinical advice sought	1
		Differential diagnosis and safety netting	2
		EOLC planning and safety netting	1
		No specific worsening advice and MTS not applied correctly	1
		Unclear if safeguarding required for NOK	1
		Safety netting not documented	1
		Specific worsening advice not documented	1
		Lack of clear management plan	1
		Failed to recognise EOL care patient	1
		No specific worsening advice	1
		Risks associated with not attending ED not described	1
	Problem of any other type	No documentation of plan, worsening advice or SOS advice	1
		No documented use of the COVID assessment tool for conveyance decision support	1
		Quality of EPR	28
		Possible sepsis 'red flag' missed	2
EOC	Problem with call taking and/or response allocation	Call not re-triaged	2
		Call not triaged correctly (safe with learning)	1
		Call not triaged correctly	1

Table 12

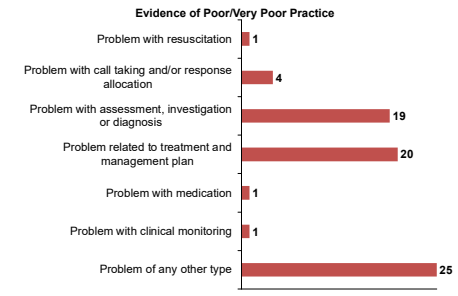


Figure 12

Evidence of Good/Very Good Practice

Department	Learning Theme	Learning Detail	Total
PES	Additional assessments, investigations or diagnosis	Holistic decision not to resuscitate	2
		Full capacity assessment	2
		Multiple sets of observations and discussed patient's condition with GP and family	1
		Extensive patient assessment	1
		Patient aware of risks of not going to ED	1
	Additional treatment and management plans	Handover to OOHGP noted with reference to organising package of care for end of life	1
		Crew waited for GP to arrive and discussed patient's condition with GP and family. Clear documentation of GP discussion with family and actions.	1
		Holistic decision making reported	2
		Recognition of EOLC, challenge to HCP plan, and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists	1
		Patient centred decisions around frailty, co-morbities and history	1
		Excellent recognition of patient dying	1
		Recognition of EOLC and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions when no EOLC plan exists	1
	Other	Documentation states involvement of those important to the patient, with holistic conversation noted	1
		Quality of EPR	16

Table 13

Figure 13

Data last accessed 16/06/2023

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	24th July 2023	**Chair:**	Prof A Esmail, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	C Grant, Medical Director A Wetton, Director of Corporate Affairs M Power, Director of Quality, Innovation, and Improvement G Blezard, Director of Operations
Members Present:	Prof A Esmail Dr A Chambers Dr D Hanley Mrs A Wetton Dr C Grant Dr M Power Mr G Blezard	**Key Members Not Present:**	E Orton, Assistant Director of Quality/DIPC

Link to Board Assurance Framework (Strategic Risks):

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

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

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

Board Assurance Framework (BAF)	• Considered the Q1 position of the Board Assurance Framework. • Discussed the increase in risk score of strategic risk SR06. • Acknowledged the mitigating actions in place and the forecasted reduction in the score by the close of Q2.	• Gained assurance that BAF risks were being managed effectively.	
Deep Dive – Hear and Treat, See and Treat – Job Cycle Time	• Received a deep dive presentation from the Associate Director of Transformation, Integration. • Noted the work undertaken to understand specific challenges and to reduce conveyance rates. • Acknowledged that good progress in hear and treat rates and that work continued to understand and compare qualitative data, conduct research and identify actions from gap analysis. • Recognised that clinical decisions were a complex multi factorial issue which relied on subject matter expertise by clinicians. • Discussed the link with hospital handover improvement work. • Noted the variation in conveyance rates across NWAS and the focus required to address deprivation levels.	• Noted the assurance provided.	
	• Received the Integrated Performance Report for the period June 2023.	• Noted signs of improvement in performance.	

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

Integrated Performance Report – June 2023	• Noted that good work continued to respond to complaints, 93% closed within the required timeframe. • In terms of SI's, care and treatment remained a top theme. • In terms of Effectiveness, noted a typo in the executive summary, which read Stroke bundle rather than stemi-bundle. • Noted the key areas being addressed to improve effectiveness performance. • In terms of call pick up, noted that incident volume had decreased, and a call pick up time in June of 5 seconds, 94%. • The trust met one ARP standard, C1 90th and achieved the UEC recovery standard of 30 minutes for C2 mean. • 111 showed a downturn in demand with some improvements in clinical performance metrics. • PTS activity showed some stability with a continued focus on increasing multi occupancy levels.	• Noted the trust met one ARP standard in the period June 2023.	
Annual Review of the Heat Wave Plan	• Approved the annual review of the heat wave plan.	• Noted the assurance provided. • Approved the Annual Review of the Heat Wave Plan.	
Business Continuity Management Policy	• Approved the Business Continuity Management Policy, produced in line	• Noted the assurance provided. • Approved the Business Continuity Management Policy.	

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

	with the NHE EPRR mandated core standards.		
Trust Service Development Strategy	• Discussed the Trust Service Development Strategy. • Acknowledged the focus on integration of service lines into the wider NHS and the need for the trust to be flexible to adverse and major incidents, through managing the change in delivery model. • Noted the need for shared relationships with partners to achieve the work required at ICS level and the need to work robustly with third party providers. • The Committee referred to the need for a more explicit reference in the Policy to the need to achieve productivity and efficiency and queried if the trust had sufficient resource to achieve the required objectives.	• Noted the content of the Trust Service Development Strategy. • Acknowledged the need for further discussion by the Board of Directors, in terms of assurance that the trust had adequate resource to deliver the objectives required. • Supported the Policy for onward approval by the Board of Directors.	
Incidents and Serious Incidents Q1 2023/24 Assurance Report	• Received Q1 activity and noted 21 serious incidents had been declared during the quarter, related to call management, call handling, delays, treatment and care and mental health. • Noted the learning identified in the report and further work being undertaken on SI reporting in the trust's Datix IQ system.	• Noted the assurance provided.	

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

Patient Safety Incident Response Framework (PSIRF) - Local Priorities	• Received the proposed PSIRF priorities, for approval. • The priorities had been established following collaborative work with internal and external stakeholders. • Approved the three priorities. • Noted these could be reviewed by the Board of Directors as part of the PSIRF review process. • Acknowledged the trust's priorities fit with the national priorities, to be circulated to the Committee for information.	Approved the Trust's PSIRF Priorities as follows – 1. Prevention of deterioration to critically unwell patients. 2. Errors in 999 and 111 call handling which led to a delay with contributing harm. 3. Face to face or telephone assessment, which is managed down an incorrect pathway, contributing to harm.	
Complaints Assurance Report Q1 2023/24	• Noted complaints activity during the period. • Confirmed the process for dealing with complaints related to staff conduct. • Noted the breakdown in subcategories of care and treatment, requested by the Chair on behalf of the Trust's Board of Directors.	• Noted the assurance provided. • Received a breakdown of the subcategories related to Care and Treatment, requested by the Chair on behalf of the Board of Directors.	
Legal Services Assurance Report Q1 2023/24	• Received overview of Legal Services activity during the quarter. • Noted the focus on mental health related calls and work being undertaken with EOCs and the use of NHS Pathways.	• Noted the assurance provided.	
Trust Quality Strategy	• Discussed the Trust Quality Strategy which focused on inclusion of NHSE	• Noted the content of the Trust Quality Strategy.	

Key		
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	priorities and requirements, as well as priority issues for NWAS and front-line staff, which included shared decision making and partnership working. • The Committee acknowledged the priority areas felt appropriate and patient focused. • Noted research had strengthened within the organisation over recent years.	• Supported the Strategy for onward approval by the Board of Directors.	
IPB Biannual Board Assurance Framework	• Noted the assurance provided in the biannual IPC Board Assurance Framework.	• Noted the assurance provided.	
Medicines Management Report Q1 2023/24	• Noted the assurance provided.	• Noted the assurance provided.	
Learning from Deaths Report Q4 2022/23	• Noted the learning provided from the learning from deaths process. • Supported the report, for onward consideration by the Board of Directors.	• Noted the assurance provided. • Supported consideration of the report by the Board of Directors.	
Sub Committee Chairs Assurance Reports	• Noted the assurances provided to the Sub Committees aligned to the Quality and Performance Committee. • Requested future EPRR Sub Committee Chairs Assurance reports, include detail of debriefs and evidence of working collaboratively with partners.	• Noted the assurances provided. • **Action –** requested future EPRR Reports included evidence of debriefs and working collaboratively with partners.	

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

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 September 2023				
SUBJECT:	2023/24 Flu Campaign				
PRESENTED BY:	Lisa Ward, Director of People				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☐	☐	☐	☒	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The purpose of the paper is to update the Board of Directors on the learning and outcomes from the Flu Campaign 2022/23 and to provide assurance the Flu Campaign 2023/24. The frontline vaccinated figure for NWAS at the end of the 2022/23 campaign reported was 49%. Whilst this was lower then some previous years, the Trust sat well within the average rate of vaccinations when compared to other trusts of a similar size across the region. We ranked 13th out of 33 Trusts. This reflects an overall reduction in vaccination rates across the NHS workforce. The 23/24 Flu Vaccination programme letter issued by NHS England outlines the expectation for providers to deliver a 100% offer to eligible staff. With healthcare workers, one of the CQUIN quality indicators is a goal of vaccinating over 75% of staff with maximum payments accruing at 80%. This income has been baselined and will not be adjusted based on flu performance. **OVERVIEW OF LAST YEAR'S CAMPAIGN** The 22/23 campaign was overseen by the People Directorate who also take responsibility for the inward and outward reporting requirements but it was also strengthened through clinical leadership and support from the Medical Directorate. This proved an important step in driving the campaign and supporting clinical delivery and this clinical oversight is being embedded moving forward. A full learning review was undertaken for last years campaign and a range of learning was identified including review of PGDs, numbers and targeting of vaccinators, training and follow up of deferrals. The learning has been built into the 23/24 campaign planning.				

2023/24 Flu Campaign
The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model. This involves the area flu leads identifying a group of vaccinators who then travel to offer and administer the vaccine to all staff in scope within their area.

The Trusts has procured 4000 vaccines and these vaccines are egg free and should therefore meet a number of equality and lifestyle considerations. This year's campaign launched the week commencing 18th September 2023 to enable the campaign to start earlier than the formal national start date of 1 October 2023.

As in previous years the Corporate HR Team will support the overall project and will ensure that all designated vaccinators have access to vaccination recording systems and have the appropriate training on the use of the system. The Corporate HR team also take a lead on fulfilment of national reporting requirements.

This year the Quality Directorate have offered to take a lead clinical role in the campaign and this will be led by the Infection, Prevention and Control Specialist lead who will work closely with the Medical Management Team, along with the Chief Pharmacist support the overall leadership and governance of the project.

Previously the Trust has always used a PGD as part of the clinical governance for the annual flu campaign. However, for this year the Trust is using a Written Instruction (WI) rather than a PGD.

As with last year, there is a national directive to ensure that all vaccinations were also recorded in the National Immunisation and Vaccination System (NIVS). As with last year, vaccinators will input onto both Flumis and NIVS at the point of care (POC).

Training and access to both Flumis and NIVS has been provided to designated vaccinators ahead of the start of the campaign.

INCENTIVES
It has been decided that the campaign will run this year without a financial incentive for having the vaccine. The offering of incentives was discussed as part of the debrief meeting following the last campaign and it was determined that there is little correlation to suggests that incentives significantly impact upon take up. This position has been discussed and approved by the Executive Leadership Committee.

THE HCW FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST
The HCW Flu Vaccination Best Practice Management Checklist has previously been produced by NHSE to help provide internal assurance around the development of the flu

	programme. This year the checklist has not been issued nationally as yet, but it was felt appropriate to use last year's template by means of providing some internal assurance around our approach to this year's campaign. A copy is included at appendix 1 and demonstrates that the Trust's programme has these core components in place for the 2023/24 programme. The only variation is the decision not to include incentives in the campaign. **COVID 19** The 2023/24 COVID booster vaccination programme has launched with an aim to maximise and extend protection during the winter and through the period of greatest risk in December 2023 and early January 2024. Frontline health and social care workers are eligible for a booster and from 18 September the National Booking Service will allow those eligible to book a vaccination. Whilst hospital hubs have confirmed they will not be extending their offering of the vaccination to our staff, this year there is an extensive offering via pharmacies. Staff may also be able to access the booster via their GP. Regular communications will go out to staff over the coming weeks to encourage them to take up the offer of the COVID-19 booster. It should be noted however, that the Trust does not have detailed oversight of uptake until regional statistics are published and then we are only provided with an overall uptake figure without any geographic or service line breakdown. This makes direct management of uptake very difficult. **COMMUNICATION AND ENGAGEMENT** The communications plan has been developed. The plan will include social media and visual messages, as well as normal communication routes. It is proposed that as with previous years, the Trust Board are able to show visible support of the campaign in the form of social media and bulletin features. Vaccination will be available at the Board meeting on 27th September. However, the key message of learning from those Trusts achieving higher vaccination rates is the importance of the engagement of local management teams in effective and positive messaging.
RECOMMENDATIONS:	The Board of Directors are asked to: • Note the approach to the Flu campaign for 2023/24 • Provide senior commitment to offer all frontline staff a flu vaccination • Note the provision of assurance via the Board checklist.

CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee & Resources Committee			
	Date:	19th July 2023		
	Outcome:	Approved		

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1. PURPOSE

1.1 The purpose of the paper is to update the Board of Directors on the learning and outcomes from the Flu Campaign 2022/23 and to provide assurance for delivery of the Flu Campaign 2022/23.

2. BACKGROUND

2.1 Influenza (flu) vaccines are offered free to all NWAS staff as part of the national flu vaccination programme. NWAS has historically participated in the national vaccination programme which is led by the People directorate. The flu vaccination campaign for 2022/23 officially commenced in October 2022 and ended in February 2023.

2.2 The 22/23 flu programme was aligned with one of the quality indicators in the 2022 to 2023 Commissioning for Quality and Innovation (CQUIN) with a goal of vaccinating between 70% to 90% of frontline staff. This funding was provided at the start of the campaign and was not linked to any financial penalty in the event the targeted vaccination rate was not met. The frontline vaccinated figure for NWAS at the end of the campaign reported was 49% and the Trust sat well within the average rate of vaccinations when compared to other trusts of a similar size across the region (13th out of 33). A reduced uptake of the flu vaccine was reported across the wider NHS with the main reason being vaccine fatigue cited for this year's decline in uptake.

2.3 The 23/24 Flu Vaccination programme letter issued by NHS England outlines the expectation for providers to deliver a 100% offer to eligible healthcare workers. For healthcare workers, one of the quality indicators in the 2023 to 2024 Commissioning for Quality and Innovation (CQUIN) is a goal of vaccinating over 75% of staff, reflecting the importance of vaccinating staff both for their own protection and to reduce transmission to vulnerable patients. The maximum payment accrues at 80% compliance. NWAS has negotiated with Commissioners that the full 100% of CQUIN funding has been included in the 2023/24 block contract payment, and no financial penalties will be applied should NWAS, despite best endeavours, fail to national targets.

3. OVERVIEW OF LAST YEAR'S CAMPAIGN

3.1 Last year's campaign was based upon learning from previous Flu campaigns. The campaign is overseen by the People Directorate who also take responsibility for the inward and outward reporting requirement. However, in 22/23, the campaign has clinical support and management from the Medical Directorate.

3.2 A Flu Project Team was established in August 2022 with representatives from HR, PES Area Leads, PTS, Communications, Medicines, IPC and 111. The Flu Lead chaired the group and discussions included designation of area leads, processes for cold chain management of vaccines, training for vaccinators and any key messages to capture for communication releases.

3.3 Area based flu leads were asked to identify small cohorts of vaccinators by early September 2022. This year it was focused on light duties members of staff with the aim of delivering a focused vaccination programme early in the campaign.

3.4 A total of 151 staff were put forward to undertake vaccinator training by the area leads. There were 106 fully trained vaccinators compared to 95 the previous year. Flu leads were asked to seek out primarily light duties staff members to lead on vaccinating in each area to keep vaccinator numbers at a low number of staff who could be dedicated to the task. A total of 89 of the 106 trained went on to administer vaccines with a training to vaccinator rate of 83% compared to last year's rate of 93%. 28 (31%) of these vaccinators were on light duties and they performed 42% of the total vaccinations.

3.5 As with previous campaigns, the Trust used the external Flumis software to record vaccinations against our central staff list.

4. 2022/23 FLU CAMPAIGN DATA

4.1 A total of 3659 staff were vaccinated either within or external to NWAS. The total overall figure available to vaccinate was 7497 which included volunteers and students eligible under the inclusion criteria of the PGD.

4.2

	Received at NWAS	Received elsewhere	Declined	Referred	Deferred	Not Received
No. of staff	3200	459	3289	104	171	274
% of staff	43%	6%	44%	1%	2%	4%

Table 1

4.3 A new inputting option was introduced to Flumis during the last campaign; deferred. This was for people to indicate that they did not want the vaccination at the time of the ask but may wish to take up the offer later in the flu campaign. The aim of this option was to avoid the unnecessarily repeat communication to staff. There was an understanding that all those that deferred their vaccination should be contacted again at the end of the season and either vaccinated or marked as a decline however 171 staff members were left as deferred. Methods to address this will be picked up in the 23/24 campaign.

4.4 Table 2 shows a breakdown of vaccination areas across NWAS. The Trust receives national Foundry reports which take into account vaccinations recorded elsewhere. Our internal Flumis data is only as accurate as the information received and some staff members are reluctant to share information. Foundry reported NWAS as having an uptake of 53%. Foundry also reports other trusts vaccination positions and NWAS sits at 13th out of 33 trusts across the North West with percentage uptake ranging from 72.4% (the Christie Hospital at which vaccinations are mandatory) to 41.7%. This is particularly pleasing given the geographical challenges that our Trust has when

compared with acute trusts which have a static workforce on a much smaller number of sites.

5. 2023/24 FLU CAMPAIGN

5.1 The approach for this year's campaign is based on the learning outlined from last year's campaign along with noting the contents of the national letter issued in April 2023. To commence this year's campaign, the Trust has procured 4000 Seqirus vaccines. This is a single vaccine and is suitable for all ages and is egg free and therefore addresses a range of equality and lifestyle considerations. The vaccines were delivered on 11 September and the Trust's campaign commenced week commencing 18th September 2023. This enables a 3 week head start on the campaign ahead of the formal 1 October 2023 start.

5.2 The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model. This involved the area flu leads identifying a group of vaccinators who then travel to offer and administer the vaccine to all staff in scope within their area. The flu leads take responsibility for reviewing the data around uptake and identifying key sites or staff groups where further targeting of the vaccination is required. The model is best described as a 'roaming model' and relies on vaccinators travelling to deliver vaccinations to staff.

5.3 For staff who are in site-based roles such as in our contact centres, corporate sites, the existing approach of advertising flu clinics will remain in place. In the past we have also put specific clinics into place for PTS staff and in particular those in GM who are not necessarily on the same sites as PES staff. It is proposed that a similar approach for PTS is taken for this year's campaign.

5.4 As in previous years the Corporate HR Team will support the overall project and will ensure that all designated vaccinators have access to vaccination recording systems and have the appropriate training on the use of the system. The Corporate HR team also take a lead on fulfilment of national reporting requirements.

5.5 This year the Quality Directorate have offered to take a lead role in the campaign and this will be led by the Infection, Prevention and Control Specialist lead who will work closely with the Medical Management Team, along with the Chief Pharmacist support the overall leadership and governance of the project.

5.6 Support will also be provided by the Communication Team to ensure that staff are fully aware of the campaign and the benefits of the vaccine.

6. GOVERNANCE AND RECORDING OF VACCINATIONS

6.1 Previously the Trust has always used a PGD as part of the clinical governance for the annual flu campaign. However, for this year the Trust is using a Written Instruction (WI) rather than a PG. A WI is different to a PGD and is not subject to the same legislated framework of a PGD. As there is a national WI, the assumption has been made that the Trust should use the WI as opposed to a PGD.

6.2 As with last year, there is a national directive to ensure that all vaccinations were also recorded in the National Immunisation and Vaccination System (NIVS). As with last year, it is proposed that the vaccinators will input onto both Flumis and NIVS at the point of care (POC). There is a requirement to ensure that all information is inputted onto NIVS within 7 days. As such it is prudent to ensure that the accuracy and timeliness of input is maintained by training vaccinators to input onto both systems.

6.3 As frontline staff all have access to iPads this will support this approach. In case of a loss of IT access, paper forms will be available for use, but will require vaccinators to input onto both Flumis and NIVS at the earliest opportunity.

6.4 Training and access to both Flumis and NIVS has been provided to designated vaccinators ahead of the start of the campaign.

7. INCENTIVES

7.1 Last year the campaign was run without any incentives to encourage staff to have the vaccine. Instead, there were clear messages on the health benefits of having the vaccine.

7.2 The offering of incentives was discussed as post of the debrief meeting following the last campaign and it was determined that there is little correlation to suggest that incentives significantly impact upon take up. Following discussion at ELC it has been determined that there will not be any incentives offered during this year's campaign. Instead, the focus will be on clear communications and a robust plan to ensure all staff have been given the opportunity to receive the vaccine.

8. THE HCW FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST

8.1 The HCW Flu Vaccination Best Practice Management Checklist has previously been produced by NHSE to help provide internal assurance around the development of the flu programme. This year the checklist has not been issued nationally as yet, but it was felt appropriate to use last year's template by means of providing some internal assurance around our approach to this year's campaign. A copy is included at appendix 1 and demonstrates that the Trust's programme has these core components in place for the 2023/24 programme. The only variation is the decision not to offer incentives.

8.2 The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. This is supported by a comprehensive communications plan. Whilst like all ambulance services, the vaccination delivery model for our dispersed workforce presents challenges in how the offer is presented and delivered, the flu team have worked hard to ensure appropriate flexibilities and options are in place to maximise vaccination rates.

9. COVID 19

9.1 The 2023/24 COVID booster vaccination has launched with an aim to maximise and extend protection during the winter and through the period of greatest risk in December 2023 and early January 2024.

9.2 Frontline health and social care workers are eligible for a booster and from 18 September the National Booking Service will allow those eligible to book a vaccination. Whilst hospital hubs have confirmed they will not be extending their offering of the vaccination to our staff, this year there is an extensive offering via pharmacies. Staff may also be able to access the booster via their GP.

9.3 Regular communications will go out to staff over the coming weeks to encourage them to take up the offer of the COVID-19 booster.

9.4 It should be noted that the Trust will not have access to real time information on Covid vaccine uptake as it is not a vaccination provider. As a result, data only becomes available when regional statistics are published and then only at a Trust wide level making targeted communications and management of uptake extremely difficult to achieve.

10. COMMUNICATION AND ENGAGEMENT

10.1 The communications plan has been developed in line with previous years with frequent social media and visual messages. It is proposed that as with previous years, the Trust Board are able to show visible support of the campaign in the form of social media and bulletin features.

10.2 Based on learning from previous years and from other Trusts, the best approach to engage staff to have a vaccination comes from their management teams. It is therefore proposed that there is clear engagement from management teams to support the flu leads and directly encourage staff to have the flu vaccine.

11. EQUALITY AND SUSTAINABILITY IMPLICATIONS

11.1 The vaccine procured by the Trust is egg free and should therefore address potential concerns arising from religious, ethical or life style choices. The campaign will consider any specific advice and guidance linked with pregnancy, age or underlying health conditions.

12. LEGAL and/or GOVERNANCE IMPLICATIONS

12.1 There are no legal implications from this report. The delivery of the flu campaign meets the requirements of national regulatory frameworks.

13. RECOMMENDATIONS

13.1 The Board of Directors are asked to:

- Note the approach to the Flu campaign for 2023/24
- Provide senior commitment to offer all frontline staff a flu vaccination

- Note the provision of assurance via the Board checklist.

Appendix A

HCW Flu Vaccination Best Practice Management Checklist 2023/24

A	**Committed leadership**	**Trust self- assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Commitment recorded through September public board meeting
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	The Trust has ordered 4000 vaccines which can be delivered to the majority of our staff taking into account age and religious belief.
A3	Board receive an evaluation of the flu programme 2022 to 2023, including data, successes, challenges and lessons learnt	Both Resources Committee and the Board of Directors have received an evaluation of learning from the 2022/23 flu programme and how changes have been built into the 2023/24 programme. Presented to September meetings.
A4	Agree on a board champion for flu campaign	The Director of People will be the champion for the Flu campaign. The Medical Director will support with key clinical messaging.
A5	All board members receive flu vaccination and publicise this	Plans are in place for delivery of the Flu Vaccination to Board in September. This forms a clear part of the communications campaign
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Cross functional flu team has been established. Strengthened this year by a clinical lead and oversight from IPC team. Trade Unions briefed at JPC September and involved in campaign.
A7	Flu team to meet regularly from September 2023	Regular meetings already commenced.
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Communications campaign will include clinical and evidence-based messaging with direct support from Medical Director, Chief Pharmacist, Chief Consultant Paramedic and Assistant Director of Nursing.
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Individuals will be invited to drop-in clinics prior advertised in the weekly bulletin. Mobile vaccination will be led by local Flu Coordinators with both regional and local communications.
B3	Board and senior managers having their vaccinations to be publicised	Board and senior manager commitment to uptake and subsequent publicity.

B4	Flu vaccination programme and access to vaccination on induction programmes	Vaccination will be offered at induction.
B5	Programme to be publicised on screensavers, posters and social media	Range of communications methods included in the plan
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Flu leads will have access to daily reporting through the FLUMIS system to enable them to target uptake but weekly reports will also be circulated to senior leaders and will be shared with the Executive Leadership Committee.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	The Trust approach is to identify a small cohort of dedicated vaccinators who will work at either the static sites or on a roaming model. The number of vaccinators has been built based on previous experience.
C2	Schedule for easy access drop-in clinics agreed	Appointments in drop-in clinics will be made available in advance of the campaign
C3	Schedule for 24-hour mobile vaccinations to be agreed	Schedule for roaming vaccination will be agreed but flexed based on data as the campaign progresses
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Incentives are not being offered this year.
D2	Success to be celebrated weekly	This forms part of the flu communications plan.