NHS
North West
Ambulance Service
NHS Trust

Board of Directors Meeting

Wednesday, 27th March 2024

9.45am – 12.35pm

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

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
PATIENT STORY				
BOD/2324/133	Staff Story	09:45	Information	Deputy Chief Executive
INTRODUCTION				
BOD/2324/134	Apologies for Absence	10.00	Information	Chair
BOD/2324/135	Declarations of Interest	10.00	Decision	Chair
BOD/2324/136	Minutes of Previous Meeting held on 31st January 2024	10:00	Decision	Chair
BOD/2324/137	Board Action Log	10:05	Assurance	Chair
BOD/2324/138	Committee Attendance	10:10	Information	Chair
BOD/2324/139	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2324/140	Chairman & Non-Executive Directors Update	10:15	Information	Chair
BOD/2324/141	Chief Executive's Report	10:25	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2324/142	Board Assurance Framework (BAF) Risks 2024/25	10:35	Decision	Director of Corporate Affairs
BOD/2324/143	Trust Risk Appetite Statement 2024/25	10:45	Decision	Director of Corporate Affairs
BOD/2324/144	Patient Safety Incident Response Updated Policy	10:55	Decision	Director of Corporate Affairs
BOD/2324/145	Modern Slavery Act 2015	11:05	Decision	Director of Finance
QUALITY AND PERFORMANCE				
BOD/2324/146	Integrated Performance Report	11:15	Assurance	Director of Quality, Innovation, and Improvement
BOD/2324/147	Learning from Deaths Q3 Report	11:30	Assurance	Medical Director
BOD/2324/148	Learning from Deaths Policy	11:40	Decision	Medical Director
BOD/2324/149	EPRR Annual Assurance Update	11:45	Assurance	Deputy Chief Executive
BOD/2324/150	Quality and Performance Chairs Assurance Report from the meetings held on 29th January 2024 and 26th February 2024	11:55	Assurance	Prof A Esmail, Non-Executive Director
BOD/2324/151	Resources Committee Chairs Assurance Report, from the meeting held on 22nd March 2024	12:05	Assurance	Dr D Hanley, Non-Executive Director

WORKFORCE				
BOD/2324/152	Annual Staff Survey Results and Culture Review Presentation	12:15	Information	Director of People
STRATEGY, PLANNING AND TRANSFORMATION				
BOD/2324/153	Estates & Fleet Strategic Plan	12:25	Decision	Director of Finance
CLOSING				
BOD/2324/154	Any Other Business Notified Prior to the Meeting	12:35	Assurance	Chair
BOD/2324/155	Items for Inclusion on the BAF	12:35	Assurance	Chair
DATE AND TIME OF NEXT MEETING				
9.45am, Wednesday, 29th May 2024 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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Minutes
Board of Directors

Details: 9.45am Wednesday, 31st January 2024
Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chair
Mrs C Butterworth	Non-Executive Director (via MS Teams)
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
Mrs L Ward	Director of People
Mr D Whatley	Associate Non-Executive Director
Mrs C Wood	Director of Finance

In attendance:

Ms D Earnshaw	Corporate Governance and Assurance Manager (Minutes)

Minute Ref:

BOD/2324/112 **Patient Story**

The Deputy Chief Executive presented the patient story, which highlighted the benefits of the EPR onward referral scheme in Cumbria, digitally designed for frontline paramedic and nursing staff to make direct referrals to GP services using the electronic patient record (EPR).

The film detailed the story of a daughter who called the service for her mother, and detailed the action taken by an NWAS paramedic to make a referral, based on his assessment of the patient, and went on to outline the process used to transfer documents to the Cumbria Health on Call (CHoC).

The story noted that the time, from arrival to clearing the scene, took 30 mins and highlighted the number of resource hours saved, since implementation of the scheme in the Cumbria area.

The Chief Executive congratulated the team on a good story and welcomed future upscaling of the referral scheme across other areas of the trust.

Mr D Rawsthorn queried the timing of the incident and whether a similar outcome would have been achieved had the referral been made to CHoC out of hours.

The Board recognised the significance of the role of the GP in determining the success and outcome of the referral and recognised the scheme had a high reputation in the local area.

Dr D Hanley queried if there was an agreement in place for call back time performance.

The Chief Executive noted that the out of hour services had KPIs for call back times, with some variance in performance across the region.

The Director of Quality, Innovation and Improvement highlighted the board's previous decisions to support EPR developments, and the trust's digital infrastructure generally.

She noted the hard work undertaken by the teams behind the scenes, instrumental to solving front line problems, and the overall goal to return resources to the community. She praised Jay Bullock, who had worked hard to contribute to the success of the systems and confirmed the plan to roll out the scheme across the areas.

The Deputy Chief Executive also noted the work undertaken with CHoC and Fylde Coast Medical Services, based on good working relationships, and he referred to other contributory factors which required consideration, to ensure a measured approach to the roll out across the trust.

The Chair noted an excellent patient story, which highlighted the digital journey undertaken by the trust. He referred to previous conversations by the board and the challenges felt by ambulance services and welcomed the good outcomes for the patient and the service.

He referred to Mr Rawsthorn's support for the digital work of the trust and praised the hard work of all the staff involved.

The Board:

- Welcomed and acknowledged the content of the staff story.

BOD/2324/113 Apologies for Absence

There were no apologies for absence.

BOD/2324/114 Declarations of Interest

There were no declarations of interest to note.

BOD/2324/115 Minutes of the Previous Meeting

The minutes of the previous meeting, held on 29th November 2023 were accepted as true record.

The Board:

- Approved the minutes of the meeting held on 29th November 2023.

BOD/2324/116 Board Action Log

In relation to Action 114 - Freedom to Speak Up, the Director of Quality, Innovation, and Improvement referred to recent AACE slides, for presentation and discussion at the next meeting of the Q&P Committee.

The Chair asked the Medical Director and Director of Quality, Innovation, and Improvement to consider the actions logged, complete timescales and ensure a planned approach for assurance to the board.

Regarding the EPPR Annual Assurance Report, the Deputy Chief Executive noted work on the core standards involved further discussions with the ICB and a paper. He confirmed the paper would be presented to the March meeting of the Quality and Performance Committee, and the next meeting of the Board of Directors

The Board:

- Noted the updates to the action log.

BOD/2324/117 Committee Attendance

The Board noted the Committee Attendance.

BOD/2324/118 Register of Interest

The Board noted the Register of Interest presented for information.

BOD/2324/119 Chair & Non-Executives' Update

The Chair noted his attendance at a recent Racial Equity Conference, and discussions on the North West BAME Assembly Anti Racist Framework.

He reported the trust's Board Development Session on 24th January 2024 included two very good sessions on the Anti Racist Framework and working with primary care, attended by Dr Paula Gowan, Regional Medical Director. He noted discussions had been effective and welcomed more consistent meetings with primary care colleagues in the wider system.

In terms of recent ICS meetings, he referred to the considerable financial pressures on acute partners within the system and the impact of their requirement to balance the books on the trust, and the further impact on the trust's performance.

For clarity, the Chair summarised the trust's position on anti-racism, and that the recent board development session facilitated discussion amongst board members on the North West BAME assembly and NHS England North West antiracist framework. He confirmed the board discussions provided a good level of debate, highlighting the importance of the issue and the trust's commitment to improve representation and inclusion as part of its core business.

He advised that the trust's commitment would be supported by the BAME assembly framework and a road map, to enable the board to progress, review, and update in line with required milestones.

The Chief Executive highlighted the role of the Board to lead the organisation and promote a holistic approach, with more work to be completed by the board, management, SPTLs and team leaders to support an anti-racist organisation.

On a separate issue, the Chair reported that all board members had recently received individual emails from a group of Senior Paramedic Team Leaders outlining their concerns regarding the proposed changes to their roles, as part of the leadership review. He reported the action taken by the board, assurance provided and acknowledged that the review process, ongoing within the trust, had taken longer than originally expected.

He noted the non-executives were committed and extremely interested in how policy and processes had been followed. He added non-executives challenged and sought assurance, to ensure that the proposed changes will create capacity and deliver a leadership model that is fit for purpose and achieve the intended objectives.

The Board:

- Noted the Chair and Non-Executives' Update.

BOD/2324/120 Chief Executive's Report

The Chief Executive presented the Chief Executive's report and updated the board members on activity since the last meeting.

In terms of 999 he reported some reduction in performance and noted the effectiveness of the trust's winter plans to manage the winter challenges. He

noted some significant periods of increased calls in the stack which triggered patient safety measures, as well as the ongoing challenge of hospital handover times.

He noted 999 calls were being picked up within 2 seconds and praised the staff for an excellent achievement. He referred to a relatively stable 111 and PTS performance, with recruitment plans and initiatives in place.

He advised of recent annual commander training and the presence of the executive team members across sites of the trust during the festive period. He noted REAP Level 4 had been invoked over the reporting period and collaborative work taken with system partners.

He provided an update on paramedic student activity, mobile data in ambulances and confirmed an advert had been published for a new Director of Operations.

In his AACE role, he noted his recent speaker engagements across the country, including an invitation to a labour party event with Prof A Esmail, Non-Executive Director.

He reported that work progressed to provide reasonable adjustments for staff, well supported by the Director of Finance, and of work to address unacceptable behaviour in relation to sexual safety and misogyny.

He referred to recent improvements and developments related to body worn cameras with some recent convictions reported, with more detail to be presented to the board in due course.

He confirmed a significantly improved position in the uptake of the staff survey and noted a forthcoming piece of work to evaluate the results and identify required improvements.

He sadly reported the death of Mr Stephen Fry, an NWAS EMT1 and expressed the condolences of the Board, to Stephen's family at this time.

Mr D Rawsthorn referred to the issue of hospital handovers and the uncomfortable and challenging situations caused to staff and patients waiting outside A&E departments in ambulances.

The Chief Executive expressed his concern at the impact on staff, dealing with the position on a daily basis. He noted that although the trust was one of the better performing trusts, the position was of significant concern for NWAS, and work continued at the most senior level, to identify collaborative actions.

Dr D Hanley referred to the challenge of personal care for patients waiting on ambulances. The Chief Executive agreed these were significant challenges and outlined the roles and responsibilities of the ambulance crews and emergency departments.

Mrs C Butterworth praised the work of the trust call takers and the executives in their hard work to improve performance.

Finally, the Chair referred to the use of body worn cameras, and the recent media issues highlighted in the police force, which could have an onward impact on compliance by ambulance staff. He emphasised the significant benefits, from a safety factor, for staff.

The Board:

- Noted the content of the Chief Executive's Update.

BOD/2324/121 Board Assurance Framework Q3 2023/24

The Director of Corporate Affairs presented the proposed 2023/24 Q3 position of the Board Assurance Framework.

She presented the changes to the Board Assurance Framework (BAF), recommended by the Executive Leadership Committee as follows –

- Decrease of SR04 from 16 to 12.

She confirmed that the BAF had been submitted to the Board Assurance Committees in January and discussions held on the outstanding actions for completion by the end of 2023/24.

The Board:

- Approved the Q3 position of the Board Assurance Framework.

BOD/2324/122 Board Corporate Calendar 2024/25

The Director of Corporate Affairs presented the Board Corporate Calendar 2024/25.

The Board:

- Approved the Board Corporate Calendar for 2024/25.

BOD/2324/123 Charitable Funds Committee Chairs Assurance Report

Mr D Rawsthorn presented the Charitable Funds Chairs Assurance Report from the meeting held on 17th January 2024.

He confirmed the Charity was doing well and his assurance in relation to the progress made. The board noted Mr D Whatley, non-executive director, would take over as Chair in 2024/25.

The Chair thanked Mr D Rawsthorn for his excellent leadership as Chair of the Charitable Funds Committee.
The Board:

- Noted the assurances provided.

BOD/2324/124 **Audit Committee Chairs Assurance Report**

Mr D Rawsthorn presented the Audit Committee Chairs Assurance Report from the meeting held on 19th January 2024.

The Chair referred to the amber assurances and queried the rationale.

Mr D Rawsthorn referred to the Clinical Audit paper and the need for Q&P Committee to also review the paper, to provide the Committee with assurance.

In terms of waivers, he noted the good position of the waiver position, which provided a good example of corporate health. He noted a higher number of waivers had been presented at the previous meeting, with one waiver identified where the complete process had not been followed. He noted that since the meeting, procurement had reviewed the position.

The Chair thanked Mr D Rawsthorn for his hard work as Chair of the Audit Committee, who played a vital role in providing assurance to the Board.

The Board:

- Noted the assurances provided.

BOD/2324/125 **Integrated Performance Report**

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

She confirmed the shorter timeline to produce the January report and highlighted two minor points of correction in the report, to be highlighted by the executive directors during the discussion.

The Director of Corporate Affairs reported the number of complaints remained largely stable, however reported a reduced position in closure rate. She noted the challenges associated with timely closure of the more complex cases and advised that work continued with service lines, to close complaint cases.

She noted the changes in reporting incidents, following the introduction of PSIRF and NHSE guidance and explained a caveat in data reporting, related to the patient safety data.

The Chief Executive referred to the term used for safety incidents, previously known as SIs, which are now referred to as Patient Safety Incidents PSIs.

The Medical Director referred to the need to ensure that the board monitored the impact and effectiveness for patients, in response to the new PSIRF arrangements, in terms of interpreting the numeric and descriptors for incidents.

The Director of Corporate Affairs confirmed effectiveness would be reviewed as part of learning and advised that as the trust entered further into the reporting cycle there would be an opportunity to understand the data further.

Prof A Esmail supported future evaluation of the effectiveness of the PSIRF data reporting process, and confirmed he had bi monthly meetings with the Patient Safety Lead, to understand and monitor patient safety learning, for discussion at the Quality and Performance Committee, who will interrogate the data.

The Chair highlighted the risk to the Board when changes in reporting occur, particularly in relation to regulatory requirements and patient safety, he emphasised the need for all board members to have a clear understanding of PSIRF reporting.

He requested a future report to review the effectiveness and learning identified from the PSIRF reporting process.

The Director of Corporate Affairs confirmed a paper would be presented to Board in October 2024.

The Deputy Chief Executive provided an overview of patient satisfaction feedback received in the period, and noted significantly lower returns, which were being explored by the team.

The Medical Director highlighted the stroke care bundle, which had been maintained at a very good level, due to the high standards of the clinical team. The Board recognised the hard work of the staff and noted the AQI data had been reviewed by the Quality and Performance Committee on 29th January 2024.

Mr D Whatley referred to the cardiac submission data, impacting on the trust's ability to provide reporting to the NHS England and requested assurance on the significance of the issue.

The Medical Director highlighted some of the ongoing challenges, however confirmed recent confidence that issues could be resolved. He advised the issues related to a recording issue rather than a care issue and were related to obtaining the data from the system and extracting reports for external partners. He emphasised that there is no reduction in the quality of care which can be demonstrated to NHS England.

The Chair praised the performance of the stroke care bundle and the excellent work of the team.

The Deputy Chief Executive provided an overview of the trust's service line performance, which remained stable. He referred to non-conveyance rates and the work undertaken by the trust to improve the position, with some particular good performance across the region.

In terms of call pick up, he confirmed good performance, with emergency calls being answered within 2 secs, due to a stable workforce position, supported by the Director of People and the team. He added that duplicate calls had reduced, with good work undertaken to make improvements.

The Medical Director highlighted the work undertaken within the clinical infrastructure to make improvements, which required constant attention and noted their role as extremely important, and a good return on investment, which made a huge difference to patients.

The Deputy Chief Executive referred to Category 1 and 2 (C1 and C2) performance, during the trust's busiest period, and noted the need to ensure a continued focus on the Category 3 – 5 calls. He highlighted the issue of handover delays, which impaired the trust's ability to deploy resources to C2 calls and the ability to meet longer-term handover targets.

The Chief Executive referred to the national work being undertaken with regional leaders, for a greater focus on the handover targets and to impact the performance targets in 2024/25.

In terms of hospital handover, he noted the significant variance across the areas, and acknowledged the ongoing work required with the ICBs and NHSE.

He referred to 111 and the work ongoing and planned for 2024/25 across the integrated call centres, to improve recruitment and attrition.

He reported some under activity in PTS performance, mainly attributed to aborted journeys, with improvement plans to be actioned with providers and ICS partners.

Mr D Rawsthorn referred to C3 and C4 performance and queried the type of patients included in these categories and the average waiting times.

The Deputy Chief Executive explained the trust's process, to categorise patients, and the type of calls falling within category 3 and 4.

Mr D Rawsthorn referred to the narrative in the report which stated an improved position in performance, however noted this should highlight improvement in C1 and C2 calls not the other call categories.

The Director of Finance presented an overview of the trust's financial position, presented to the Resources Committee on 26th January 2024.

The Director of People reported workforce indicators were stable, sickness absence more stable than previous winters, some recurring themes in service lines with pressures, impacting on turnover and appraisal compliance.

She outlined the work of the Attendance Improvement Teams which continued to provide support to operational teams, with a deep dive presented to the Resources Committee on 26th January 2024. She also referred to the turnover position and the areas of risk in the contact centres.

The Chair queried the nature of the ongoing issues related to turnover in the contact centre, and mainly EOC.

The Director of People referred to high turnover, particularly amongst new call handlers, with a range of factors requiring more focus, such as preceptorship and mentorship. She referred to learning, identified to improve the position.

The Chair further queried the type of support that was required for new call handling staff.

The Director of People referred to the pressures of volume and numbers of new staff, which impacted on the quality of initial support delivered to new staff.

The Chair emphasised the need for lessons to be learnt, to improve the experience for new starters, and improve the overall future position.

The Chief Executive and Director of People noted the challenges across the sector.

The Director of People provided an overview of the vacancy position across the service lines.

The Deputy Chief Executive referred to the earlier query raised by Mrs C Butterworth, in relation to body worn cameras. He confirmed the number of Camera allocations was 5,308 for operational staff, and 5,723 for all users, including commanders. The operational staff allocations in the six months before the reallocation and re-launch varied between 790 and 1100.

Dr D Hanley queried the impact of the increase in uptake on the number of incidents reported.

The trust's Corporate Programme Board and Health, Safety, Security and Fire Sub Committee held responsibility for reporting assurances on the subject and Mr D Rawsthorn confirmed he met with the trust Health and Safety lead on a frequent basis, and discussion included the issue of body worn cameras.

The Director of Quality, Innovation and Improvement supported a future focus on reporting of violence and aggression as a section in the report, across all service lines and directorates.

The Board:

- Noted the content of the Integrated Performance Report and the recommendations provided.
- Requested a review of the PSIRF Reporting process at a future board meeting.

BOD/2324/126 Learning from Deaths Q2 Report

The Medical Adviser presented the Learning from Deaths Q2 Report.

He provided an overview of the learning identified from the quarterly data and the actions taken to disseminate the lessons learnt within the organisation.

He noted the key areas of improvement, which included making clear management plans for patients with more detail in patient assessment, referrals and ensuring calls were triaged correctly using NHS Pathways.

He referred to a shift in focus in terms of medication given to patients at end of life with work across the wider system to standardise practice and allow the service to adjust to the patient's needs.

The Chair welcomed sight of the learning and examples included in the report.

Dr D Hanley, referred to the infographic and statistics relating to the most deprived areas in the region.

The Medical Director noted the graph had been included for the first time in the report and that reporting, and development of data would be seen in more detail in the Q3 and Q4 reports, with work to be identified with the trust's public health registrars to obtain a more holistic view on the position to inform required improvements.

The Board:

- Noted the areas identified for improvement and the areas of good practice.
- Approved publication of the report on the Trust public account.

BOD/2324/127 Complaint Investigation Policy

The Director of Corporate Affairs presented the Complaints Investigation Policy.

See highlighted developments made, since 2021, incorporated into the Policy, and detailed at s2 of the report. She noted the Equality Impact Assessment required further work, following submission to the Executive Leadership Committee, and would be circulated to board members following the meeting.

The Board:

- Approved the Complaint Investigation Policy.
- Noted the Equality Impact Assessment would be circulated to Board members following the meeting.

BOD/2324/128 Quality and Performance Committee Chairs Assurance Report

Prof A Esmail presented the Quality and Performance Committee Chairs Assurance Report from the meeting held on 27th November 2023.

He outlined the rationale to support the areas of moderate assurance.

The Board:

- Noted the assurances provided.

BOD/2324/129 Resources Committee Chairs Assurance Report

Dr D Hanley presented to the Resources Committee Chairs Assurance Report from the meeting held on 26th January 2024.

He referred to the challenges in relation to the financial position and achieving required efficiencies.

The Director of Finance clarified the trust's efficiency position and associated timescales.

The Board:

- Noted the assurances provided.

BOD/2324/130 Communications and Engagement Dashboard

The Deputy Chief Executive presented the Communications and Engagement Dashboard for Q3 2023/24.

He referred to the activity during the quarter and the priorities of the team, which included EDI initiatives, body worn cameras, and successful winter campaign communications.

He reported a reduced level of Freedom of Information requests, however noted the trust remained compliant with requirements. He went on to summarise activity in relation to social media and the trust's green room.

Mr D Rawsthorn referred to the Hearts and Minds Campaign and the link to body worn cameras, and the importance of internal communications.

The Deputy Chief Executive noted the work required by the team to communicate the rationale for encouraging uptake.

The Director of Quality, Innovation and Improvement referred to the increase in number of MP letters into the service.

The Deputy Chief Executive noted the numbers varied from month to month, and data included only small numbers, with significant monthly variation.

The Chair referred to the information and intelligence obtained from the patient and public through the various channels and emphasised the value in collating the information to inform the trust's future priorities and strategies.

The Deputy Chief Executive confirmed the work of the Diversity and Inclusion Sub Committee and its role to ensure information was being used to inform developments and ensure lessons learnt improved EDI experiences.

The Board:

- Noted the assurances provided.

BOD/2324/131 Any Other Business Notified Prior to the meeting

There were no other items of business notified prior to the meeting.

BOD/2324/132 Items for inclusion on the BAF

There were no items identified for inclusion in the BAF.

Closing Remarks

At this point the Chair summarised the key points of the meeting, which included an excellent patient story; discussions on body worn cameras and the continued pressures on hospital handover delays, and the impact on operational staff and patients.

He thanked the Committee chairs for the assurances provided and noted the good work related to stroke care bundle.

He referred to the pressures of contact centre recruitment and the great work undertaken to manage and achieve the call performance during the challenging period.

He welcomed a further understanding of the targets to be achieved for hospital handover times and the importance of the future tenders for the PTS and 111 services.

He emphasised the need to continue to measure learning from the new PSIRF reporting process, and for the robust understanding of the data by non-executive colleagues.

He welcomed good discussion and internal communication initiatives to manage the issue of body worn cameras.

The Chair acknowledged the departure of Mr David Rawsthorn as a Non-Executive Director and praised his valuable input into the role over the years, he thanked him for his hard work as Chair of the Audit Committee and the safe pair of hands he provided.

He noted Mr Rawsthorn had also championed sustainability and the North Cumbria area, to ensure all regions of the trust were considered in the wider picture. He added he was extremely grateful for his support, tenacity, and leadership and that he would be missed by the board.

Mr D Rawsthorn thanked the Chair for his words and referred to the significant changes across the health care system, over the past 5 years. He praised the trust's efficient handling of the Covid pandemic and the calm approach of the Director of Operations and Executives in their handling of the challenges.

Date and time of the next meeting –

9.45 am on Wednesday, 27th March 2024 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
114	29.11.23	101	Freedom to Speak Up Bi annual report	Requested Quality and Performance Committee receive the outcome of the deep dive into the concerns raised including the effectiveness of the processes to manage FTSU concerns related to cultural experiences Prof A Esmail, the Director of Quality, Innovation and Improvement and Medical Director to hold further discussions on the issues raised, post Lucy Letby case.	FTSU Lead / L Ward Prof A Esmail / M Power / C Grant	31st January 2024	27th March 2024	Added to the Quality and Performance Committee action log. **31.1.24 -** AACE slides on the Lucy Letby Case to be tabled and discussed at Q&P Committee meeting on 26.2.24. Medical Director and Director of QII to consider the actions and ensure a planned approach for assurance to the Board.	
115	29.11.23	106	EPRR Annual Assurance Report	Board to receive a further EPRR core standards assurance report to include the impact of the recent changes and an action plan.	S Desai / D Mochrie	31st January 2024	27th March 2024	**31.1.24 -** work in progress. Report to be presented to the Quality and Performance Committee and to the Board of Directors on 27th March 2024.	
116	31.01.24	125	Complaints Investigation Policy	To circulate the Complaints Investigation Policy Equality Impact Assessment to Board members.	Director of Corporate Affairs				

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	✔	✔	✔	✔	x			
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	✔	✔	✔	✔	x	✔	✔	
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		✔		✔	✔	x	x	✔	✔	
Salman Desai					✔	✔	✔	✔	✔	
Prof Aneez Esmail (Chair)		✔		✔	✔	✔	✔	✔	✔	
Dr Chris Grant		✔		✔	✔	x	✔	✔	✔	
Dr David Hanley		✔		✔	✔	✔	✔	✔	✔	
Dr Maxine Power		✔		✔	✔	✔	✔	✔	✔	
Angela Wetton		✔		✔	✔	✔	✔	✔	✔	

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

Nomination & Remuneration Committee						
	26th April	31st May	26th July	27th September	29th November	31st January
Catherine Butterworth	✔	✔	✔	x	✔	✔
Dr Alison Chambers	✔	x	✔	✔	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	Sep-23	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	Deputy Chief Executive/Chief Operating Officer	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 PES.			√		Non financial personal interest.	Sep-23	Present	Declare an interest and withdraw from discussions as and when required.
			Advisor (Associate Specialist) to The Value Circle - a specialist agency providing advice to NHS organisations		√			Advisory role	Dec-23	Present	All advice provided out of working hours and not linked to my role at NWAS. Benefits to be declared if applicable.
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	30.9.23	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 March 2024				
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 24 January 2024. The highlights from this report are as follows: PES • All response standards improved since January • Patient handover improved compared to previous two months • 90,422 incidents in February, a similar amount to January • Currently on track to deliver the 30 min C2 mean UEC response standard 111 • KPIs have improved compared to last year • 10% national call handling support to continue for Q1 and Q2 • Continued focus on workforce and vacancies PTS • Contract award under extended standstill period • Proposed changes to the leadership structure is being considered • Activity is 10% below contracted baseline				
RECOMMENDATIONS:	The Board is recommended to: • Receive and note the contents of the report				
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:				

	☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

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

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1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 24 January 2024

2. PERFORMANCE

2.1 Paramedic Emergency Service

Operational Ambulance Response Programme (ARP) performance has improved when compared to previous months. All response standards have also improved compared to January 2024. These improvements are due to the increase in operational resources both within PES and EOC. In addition, patient handover has improved when compared to the previous two months (although handover remains on average 7 minutes longer than February 2023). This improvement places the Trust in a very strong position to deliver the 30 min C2 mean UEC response standard. Currently C2 mean YTD stands at around 29 minutes. Given an improving trend in response standards it is highly likely the Trust will meet the target.

NWAS for February managed 90,442 incidents which represents a similar volume to January 2024 (when adjusted for the number of days within the month). Incident volume is significantly higher than the previous year, although the impact of industrial action heavily influenced the 2023. The increase in incidents further supports the conclusion that NWAS is delivering increases in response capacity. Critically for patient safety, long waits within C1 and C2 have further reduced. Compared to January 2024, the month of February saw a reduction of around 4k long waits within C2 and a reduction of 100 long waits within C1.

999 call pick-up continues to perform well and remains consistent. This is despite increases in call volume compared to previous years. February 2023, 999 call volume was 97,181 vs 116,879 for February 2024 (note industrial action impacted 999 demand). Call volume is also higher than 2022 and 2021. Currently NWAS are on target to deliver the UEC 10 second mean call pick up target for 2023/2024, the YTD position stands at 2 second mean. NWAS continue to maintain the call workforce position and has the requisite capacity to meet current demands. The Clinical HUB (CHUB) team continue to increase the clinical workforce focusing on secondary triage (Hear & Treat) and patient safety. H&T has increased in February compared to previous months. This is due to increased clinical capacity with the CHUB alongside the increased external CAS capacity funded via National UEC funds. It should be noted that whilst H&T has increased this is not due to extended responses to patients. Overall conveyance remains stable with sustained improvements within conveyance to non-A&E, which is primarily being driven through Lancashire via enhancements to alternative referral pathways.

2.2 NHS 111

111 KPIs have improved for February 2024 vs February 2023. Overall, the call answer KPIs remain stable with a marginal decline in Q4 due to increased call demand. 111 continue to focus on workforce and the vacancy position. A robust plan is in place to deliver a fully established workforce by end of Q2. In addition, 111 are supported by the national call handling arrangements. Currently NWAS receive 10% national support which will continue at a similar rate for Q1 and Q2 next year. The combination of internal recruitment and maintained national support is projected to deliver improvements in KPIs but will not deliver the contracted performance levels, due to funding deficiencies within the existing contract.

2.3 Patient Transport Service

The PTS Contract award for 2025-2030 is under an extended standstill. We do not yet know when the standstill period will close.

In year, as at Month 7, cumulative PTS activity is -10% (-89,460) journeys below contracted baselines with an associated financial variance of -£1,035k at marginal rates. Planned arrivals varied by area with the best performance in Cumbria where we achieved 84% against the arrival KPI target of 90%. The most challenged area is Greater Manchester where we only achieved 69% against the arrival KPI target of 90%. Enhanced Priority Service (EPS) achieved between 64%-86% against the arrival KPI target of 90%. To achieve contract targets, those arriving early and up to 30 minutes late would need to be within the KPI window. We achieved all targets in planned, unplanned and EPS in relation to passenger travel time on vehicle. Hospital abort activity remains high and, in January ranged from 3.5% (Cumbria) to 10.9% (Greater Manchester).

There is an ambitious improvement plan to bring the PTS contract back into a surplus of £1.9m by the end of June 2024. There is good progress on this to date and the service has achieved a reduction in spend on the third-party budget (covering all non-NWAS resources, i.e., taxis, private ambulance and volunteer car service) The total third-party expenditure in 2022/23 was £26.897m, with £24.543m incurred to month 11. The expenditure to month 11 in this financial year is £20.550m.

3. ISSUES TO NOTE

3.1 Local Issues

Station Visits

I recently spent some time working from Blackpool Ambulance Hub and heard about some of the positive work underway in the sector and was able to take away some feedback for us to consider as an Executive Leadership Team, about issues and areas where they feel there is room for improvement.

While I was there, I was able to talk to a PES crew, Jess and Emma, who have recently received a letter of thanks from a patient's family. There were plans for Jess and Emma to meet with the patient's relatives for an in-person 'thank you' but this was cancelled due to the inclement weather. However, I was grateful to get the opportunity to commend them both for their excellent work.

I've also recently visited Blackburn station and spent time with the team discussing a range of topics including the leadership review. It was nice to be able to meet a number of PTS staff, the logistics team, and chat to some PES staff and student paramedics about a range of subjects including the vehicle logistics pilot which is ongoing in the sector.

A Long Service celebration took place in Greater Manchester. This was a small event to follow on from the main long service awards in September and was an opportunity to present medals to some colleagues who didn't receive them first time around. Following the coronation of His Majesty King Charles III, the design of the long service medal changed, and these weren't ready in time for the September event.
As always, it was a pleasure to celebrate those staff who have dedicated many years of their career to the ambulance service and the NHS; its our people who make NWAS so special

3.2 Regional Issues

Increased demand

It continues to be a very busy and challenging time for all our services we recently reached the point where demand and delays caused us to declare a 'critical incident'.

This was due to the risk of harm to patients waiting in the community. The declaration triggered several internal processes, including the authorised withdrawal of ambulance crews from relevant hospitals so they could respond to patients. Thankfully, we did see a slight ease in the situation, which allowed us to stand down from the critical incident level.

In order to try to ease pressures the trust continues to:

- Implement sign-posting scripts in the 999 contact centres to advise any patients with lower acuity needs to access NHS 111 online or direct them towards primary care services, in addition to advising patients to use their own transport if possible.
- Focus on maximising 'hear and treat' capacity within the Clinical Hub, to support as many patients as possible without sending an ambulance resource
- Make sure we only allocate multiple resources to incidents when absolutely necessary
- Continue to have direct conversations with department leads in hospitals where our crews are waiting

We also continue to make use of our public communications channels, including social media sites and the local and regional press, to share public health messaging and advice, and remind people they can help us to help them by using our services appropriately and seeking support elsewhere for anything other than a life-threatening emergency.

Unsurprisingly, the situation in hospitals and the subsequent ambulance delays is making headlines. There was widespread news coverage recently about a Cheshire GP practice taking a patient to hospital themselves due to a delayed ambulance response.

It's not easy to see negative media coverage of this nature when the trust is trying hard to provide the best possible service to patients. Together with our Communications Team, we are responding to these press reports to be open about the challenges we face but also to highlight that, despite the current pressures, all of our staff are working incredibly hard across 999, 111, patient transport and support services to be there for those who need us.

Dr Chris Grant, Medical Director, was interviewed by BBC North West Tonight and BBC Radio Merseyside to reinforce that the pressure on ambulance services, and the wider NHS system, is affecting both patients and staff.

We have secured significant investment and will continue to recruit, train and deploy more staff than ever. Despite the pressures the past few weeks have been less pressured from a UEC perspective and we remain on track to be one of the only ambulance trusts to achieve the interim UEC Cat 2 30 min standard year to date.

Making crews feel safer

In October last year, we extended the body worn video camera (BWVC) pilot to cover the entire NWAS footprint to ensure all operational staff had the option to use a camera for their own safety and security, should they wish to.

Senior Paramedic Team Leader (SPTL) Debs Foster has been on the road for a decade, and unfortunately, during that time, has experienced violence and aggression from those she was only trying to help. Now she has the option to use a camera, she has noticed a difference and always wears a camera whilst on duty and encourages others to do the same.

The BWVCs are a protective tool and while they do not offer any instant protection from situations, they do act as a deterrent to diffuse the situation in the first instance and could be used as evidence and lead to successful prosecutions

3.3 National Issues

Sky News report on 'toxic culture of harassment' in ambulance service

A recent Sky News report included deeply concerning accounts from current and former paramedics, including students, about widespread sexual harassment and a toxic culture of misogyny in the ambulance service.

The interviews were anonymised so while there's nothing to suggest the interviews were about experiences at NWAS, they paint a worrying picture of an issue that does exist within our own organisation and across ambulance trusts, and indeed other NHS trusts, nationwide.

It is a minority of people who think this type of behaviour is acceptable but the trust, and the wider ambulance sector, is very clear that any kind of inappropriate, unwanted sexual behaviour is completely unacceptable and will not be tolerated. We have committed to take action against employees who are found to be acting in this manner.

Any issues raised will be dealt with seriously, and with compassion and empathy. A toolkit will be available on the trusts intranet site to offer extra guidance to managers who are supporting anyone who has experienced any form of unwanted sexual behaviour in the work place. There are also several health and wellbeing resources already available for anyone affected by these issues and need to seek support.

With the launch of our Sexual Safety Statement, we have committed to creating a safe working environment for everyone, free from sexual harm, and we all have a role to play in achieving this.

A vision for the NHS ambulance sector

The Association of Ambulance Chief Executives (AACE) has recently published its vision for the UK NHS ambulance sector in co-designing urgent and emergency care provision.

Recognising that all areas of the NHS system are facing increased demand, leading to poor patient and staff experience, the aim of the vision is to prompt conversations at a national, regional and system level about the potential of what could be achieved with redesign of the current urgent and emergency care model.

The vision calls for a stronger focus on prevention and more investment in out-of-hospital services and the ambulance workforce, infrastructure, and digital innovations, to tackle some of the NHS-wide issues.

This fits with NWAS' strategy to provide the right care, in the right time, in the right place, every time, and our commitment to work closely with partner organisations to improve the overall health of the public.

NHS England culture review of ambulance trusts

NHS England published an independent report into the culture of ambulance trusts.

The report acknowledges the commitment, passion and pride of ambulance service staff, and the complexities and pressures faced daily. It also highlights deep-rooted cultural issues and some negative behaviours that can have a significant impact on others.

The review was commissioned in May 2023 by NHS England following the publication of Listening to Workers - a Speak Up Review of NHS ambulance trusts in England that was published in February 2023 by the National Guardian's Office. It was chaired by Siobhan Melia, the chief executive officer of Sussex Community NHS Foundation Trust who spent time as interim chief executive at South East Coast Ambulance Service NHS Foundation Trust.

Anna Parry, Managing Director of AACE said: "This timely review focuses on many areas that are already a priority for the sector. We know that there is much still to be done to ensure that NHS ambulance services offer a safe, inclusive, well-led working environment for all their people where inappropriate behaviour will not be tolerated, and concerns will be responded to appropriately and compassionately.

The report focuses on solutions and identifies a set of recommendations to improve the experience of the people working in ambulance trusts. In summary, these recommendations are:

- Balance operational performance with people performance at all levels
- Focus on leadership and management culture and develop the ambulance workforce
- Improve the operational environment, line management and undergraduate training
- Translate the NHS Equality, Diversity and Inclusion (EDI) Improvement Plan into a bespoke plan for the sector
- Target bullying and harassment, including sexual harassment and enable freedom to speak up
- Prioritise, support and develop human resources (HR) and organisational development (OD) functions.

It is encouraging that in most areas identified such as leadership and management, workforce pressures and wellbeing, equality, diversity and inclusion, bullying and harassment (including sexual harassment), extensive programmes of work are already well advanced within NWAS and across the ambulance sector.

We all want to create a work environment where everyone can feel safe, included and valued; being a brilliant place to work for all is a core aim of our trust strategy. To achieve this, it's important that senior leaders continue to listen and learn from the experiences of our staff.

The report has been overseen by the Minister for Health who has written to me to ask that I share her letter with the sector. In addition to this, the recommendations will be taken forward by each individual ambulance trust and overseen by a national implementation board. In my AACE Chair's role, I will be a member of the implementation Board with the first meeting due to take place in April.

Speaking up about violence against ambulance colleagues

I recently attended a Women and Equalities Committee evidence session at the House of Commons. It was part of the committee's inquiry into the rise of violence against women and girls.

I joined a panel with representatives from NHS England and the fire service. The committee asked us questions about violence and aggression against women in the emergency services, and wanted to know how we are tackling these behaviours and supporting victims.

Just one case of violence and aggression is too many. That applies to the behaviour in any form, whether it is directed from one colleague to another, from a patient towards staff, or from staff towards a patient.

I described to the committee the work ongoing through AACE and the challenges that face the ambulance sector. I was able to draw on my 33 years in the ambulance sector to explain some of the cultural challenges as well as the ongoing work that has led to an action to address violence, aggression, sexual safety, and misogyny in the ambulance sector. I shared real experiences, including examples of call handlers being sexually abused on the phone. I discussed how we need to ensure we take action when things like this happen.

Some of the key points I made through my evidence included:

- AACE produced guidance and best practice documents. These are to help ambulance services act against inappropriate behaviour. Work continues to support trusts across the UK to adopt these practices.
- We continue to work with various organisations to address workplace challenges. These include the National Police Chiefs' Council, National Fire Chiefs Council, and NHS England.
- We continuously review data from sources like freedom to speak up, the NHS staff survey and quarterly pulse surveys. This allows us to identify areas for improvement.
- Improved safeguarding training has helped more ambulance staff to recognise and report issues like domestic abuse.
- A zero-tolerance approach to unacceptable behaviour, including violence and aggression, is emphasised across the ambulance sector, although there are still challenges in ensuring this is followed through every time, in every service.
- We have made significant progress towards addressing cultural challenges and unacceptable behaviours, but we know there is more work to do.

I assured the committee that we will keep investing in this issue, to make the service a better place for staff and patients.

David Fuller Case

On 13 February, on behalf of AACE, I was invited to attend an Independent Inquiry at the Imperial War Museum in London, into the issues raised by the David Fuller case.

The Inquiry was established to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuary of the Maidstone & Tunbridge Wells NHS Trust, how he was able to offend in the hospitals undetected for so long and what might have stopped him. The Inquiry also considered procedures and

practices in other hospital and non-hospital settings, where bodies of the deceased were kept, or transported, safeguarding their security and dignity. The Inquiry looked at hospital settings, including in the private sector, and non-hospital settings including local authority mortuaries, funeral directors, the ambulance service, medical schools, temporary mortuaries, direct funeral companies and hospices.

Prior to attendance, the trust was asked to submit our response to a number of questions about the management of the deceased and whether we have ever had any reported concerns or incidents relating to deceased patients at a private address or a public location

4. GENERAL

Celebrating the women of NWAS

In honour of International Women's Day on Friday 8 March, the Women's Network held a celebratory event that brought together male and female colleagues from all areas of the trust.

The event, that was partly funded by the NWAS Charity, was opened by CEO of College of Paramedics, Tracy Nicholls, who openly spoke about her difficult upbringing and her career journey. She told us about the different roles she has held in her 29-year career and how the first time she ever experienced bullying was when she was appointed into an executive director role. She also went on to say that she has faced more misogyny in her current role than any other role.

In the Q&A session, she used her experiences to advise colleagues, thank male allies and encourage our female colleagues to take any development opportunity they can.

The rest of the day was made up of panel sessions facilitated by colleagues from across our service lines who used their lived experiences to provide insight into topics such as flexible working, reasonable adjustments, career development and driving change.

College of Paramedics granted Royal Charter

Congratulations to the College of Paramedics, which was last week granted the Charter of Incorporation by His Majesty King Charles III.

The issue of the Royal Charter represents an important milestone and is something members can be very proud of. It provides recognition for the profession and gives strength to the professional voice of the college.

The college, which has more than 20,000 members, is the professional body for paramedics and has been instrumental in developing the paramedic profession.

The recognition is well-deserved. Well-done to all involved, including our colleague and NWAS Clinical Effectiveness Lead Jon Price, who is the President of the College of Paramedics.

Right Care Right Person

I have written to the north west's police chiefs about the evidence I submitted, in my ACCE chair’s role, to the Health Select Committee in relation to the rollout out of Right Care Right Person (RCRP).

RCRP is a partnership approach which aims to ensure that individuals in mental health crisis are seen by the right professional. The evidence was originally submitted to Steve Brine MP, Chair of the Health Select Committee, which was reported in the Health Service Journal.

The Health Select Committee asked me to write to them in my capacity as the chair of the Association of Ambulance Chief Executives and the team gathered the views and feedback of RCRP from ambulance chiefs and their respective services across the country.

In my letter, I highlighted the concerns I and my colleagues feel around the implementation of RCRP and the demands being placed on ambulance and policing. I recognise other organisations must be part of the solution and it can not just be left to the ambulance service or police services.

I assured them that AACE will continue to work closely with the National Police Chiefs' Council (NPCC) to do all we can to help address any local concerns and ensure we are acting in the best interests of patients and our staff. I also offered to meet with them to discuss this matter further and before I attend future cross ministerial meetings.

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 March 2024				
SUBJECT:	Board Assurance Framework (BAF) Risks 2024/25				
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:	Engagement has been undertaken with both Executive and Non-Executive Directors and the proposed BAF Risks for 2024/25 can be viewed in **Appendix 1**.				
RECOMMENDATIONS:	The Board of Directors is asked to: • Approve the proposed 2024/25 BAF Risks.				
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ 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

This report provides the Board of Directors with the proposed Board Assurance Framework (BAF) Strategic Risks for 2024/25.

2. BACKGROUND

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

Engagement has been undertaken with both Executive and Non-Executive Directors and the proposed BAF Risks for 2024/25 can be viewed in **Appendix 1**.

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

The purpose of the Board Assurance Framework (BAF) is to bring together in one place all of the relevant information on the risks to delivery of the Trust's strategic objectives. It forms part of the overall approach to risk management in the Trust.

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors is asked to:

- Approve the proposed 2024/25 BAF Risks.

Appendix 1 – Proposed BAF Risks 2024/25

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

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REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 27 March 2024				
SUBJECT:	Risk Appetite Statement 2024/25				
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 Trust's Risk Appetite Statement underwent a full revision by the Board of Directors during the Board Development Session held in Q4 2023/24. The proposed 2024/25 Risk Appetite Statement has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.				
RECOMMENDATIONS:	The Board of Directors are asked to approve the Risk Appetite Statement for 2024/25.				
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:	Not applicable		
	Outcome:	Not applicable		

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1. PURPOSE

This report provides the Board of Directors with an opportunity to consider the Risk Appetite Statement for 2024/25.

2. BACKGROUND

The Trust's Risk Appetite Statement underwent a full revision by the Board of Directors in Q4 2023/24 during a developmental session with the Board.

The proposed Risk Appetite Statement for 2024/25 has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.

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

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors are asked to approve the Risk Appetite Statement for 2024/25.

RISK APPETITE STATEMENT (RAS) 2024/25

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

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

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

As such:

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

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

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

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

PETER WHITE
Chairman

DAREN MOCHRIE
Chief Executive

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

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REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 27 March 2024				
SUBJECT:	Patient Safety Incident Response Policy				
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:	Executive accountability for PSIRF will move from the Director of Corporate Affairs to the Director of Quality Innovation & Improvement from 1 April 2024 and the NWAS Patient Safety Incident Response Policy has been amended to reflect these changes (Appendix 1). No other amendments have been made.				
RECOMMENDATIONS:	The Board of Directors are requested to: • Approve the amended NWAS Patient Safety Incident Response Policy.				
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:	Not applicable		
	Outcome:	Not applicable		

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1. PURPOSE

This paper provides the Board of Directors with the opportunity to review and approve the revised Patient Safety Incident Response Policy for NWAS under the Patient Safety Incident Response Framework (PSIRF)

2. BACKGROUND

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

3. PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)

The Patient Safety Incident Response Policy sets out how NWAS will responds to patient safety incidents reported by our people, patients, their families, and carers as part of work to continually improve Patient Safety Incident Investigations (PSIIs).

Executive accountability for PSIRF will move from the Director of Corporate Affairs to the Director of Quality Innovation & Improvement from 1 April 2024 and the NWAS Patient Safety Incident Response Policy has been amended to reflect these changes (Appendix 1). No other amendments have been made.

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

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

The decision-making process to agree the PSIRP and Patient Safety Incident Response Policy are within the Trust's risk tolerance parameters as outlined in the Risk Appetite Statement.

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

Innovation (High)	No implication on digital innovation due to the Datix Cloud IQ (DCIQ) system already in place

5. EQUALITY OR SUSTAINABILITY IMPACTS

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

6. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the amended NWAS Patient Safety Incident Response Policy.

North West Ambulance Service NHS Trust

Patient Safety Incident Response Policy

Recommended by	NHS England	
Approved by	Board of Directors	Lancashire & South Cumbria ICB Quality Committee
Approval date		20 September 2023
Version number	1.2	
Review date	March 2025	
Responsible Director	Director of Quality, Innovation & Improvement	
Responsible Manager (Sponsor)	Head of PSIRF	
For use by	All our people	

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
1.0	July 2023		D. Redfern	New Policy
1.1	September 2023	October 2023	J. Taylor	Approval by NWAS BoD & L&SC ICB Quality Cttee
1.2	March 2024	April 2024	J. Taylor	Executive Director Portfolio Changes

Patient Safety Incident Response Policy

1. INTRODUCTION

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety events, for the purpose of learning and improvement.

Patient safety events are unintended or unexpected events (including omissions) in healthcare that could have, or did, harm one or more patients.

The PSIRF replaces the Serious Incident Framework (SIF), (2015) and makes no distinction between "patient safety events" and "serious incidents". It removes the "serious incidents" classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The new framework is not a different way of describing what came before; it fundamentally changes how the NHS responds to patient safety events for learning and improvement.

The PSIRF advocates a co-ordinated and data-driven approach to patient safety responses that prioritises compassionate engagement with those affected, including staff. It embeds a wider system of improvement and prompts significant cultural shift towards patient safety management.

2. PURPOSE

This policy supports the requirements of the PSIRF and sets out North West Ambulance Service NHS Trust's (NWAS) approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purpose of learning and improving patient safety.

This policy supports the four key aims of the framework:

- Compassionate engagement and involvement of those affected by patient safety events.
- Application of a range of system-based approaches to learning from patient safety events.
- Considered and proportionate responses to patient safety events and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with our current Patient Safety Incident Response Plan (PSIRP), which is a separate document setting out how this policy will be implemented.

3. SCOPE

This policy is specific to patient safety event responses conducted solely for the purpose of learning and improvement across NWAS.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a "person focused" approach where the actions or inactions of people, or "human error", are stated as the cause of an event.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes exist for that purpose, and therefore outside of the scope of this policy, such as:

- Claim handling
- Coronial inquests
- Criminal investigations
- Human resources/ employee relations investigations into employment concerns
- Professional standards investigations
- Safeguarding concerns
- Complaints (except where a significant patient safety concern is highlighted)

For clarity, the principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy. Information can be shared with those leading other responses, but these processes should not influence the remit of a patient safety learning response.

4. OUR PATIENT SAFETY CULTURE

NWAS is committed to work towards the move from a retribution approach to types of incidents, such as patient safety, to establishing a just culture within the organisation.

Leaders across NWAS are required to proactively embrace this approach and support from staff side colleagues will be instrumental in supporting the organisation transition to a just culture.

The goals of just culture include:

- Moral engagement,
- Fairness
- Reintegration of the practitioner, and
- Organisational learning

PSIRF will enhance these by creating stronger links between patient safety events and learning for improvement. NWAS anticipates fostering the approach and work collaboratively with those affected including patients and their families, and our people. This will continue to increase transparency and openness amongst our people to report events and allow for wider engagement.

We are clear that patient safety event responses are conducted for the sole purpose of learning and identifying system wide improvements; they are not to apportion blame, liability or define preventability or cause of death.

Our safety culture within NWAS continues to make progress and is a key organisation priority. We have programmes of work in place to improve this including:

- Introduction of new Datix Cloud IQ (DCIQ) system
- Establishment of programme of safety culture surveys across the organisation, with the development of local improvement programmes
- Development of safety data/safety dashboards
- Safety Training programme
- Focused improvement work on duty of candour

- Focused work on speaking up.

5. PATIENT SAFETY PARTNERS

The Patient Safety Partner (PSP) role is a new and evolving role developed by NHS England to help improve patient safety across the NHS.

At NWAS, we're excited to welcome PSPs who will offer support alongside our people, patients, families, and carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and offers great opportunities to share experiences and skills and provide a level of scrutiny. This exciting new role will evolve over time with the main purpose of the role is to be the voice for our patients and community who utilise our services, ensuring patient safety is at the forefront of all that we do.

PSPs will provide objective feedback focusing on maintaining safety and improvement. This may include attendance at our patient safety and quality governance meetings and involvement with the production and review of relatable policies and procedures. The information may be complex, and partners will provide feedback to ensure patient safety is our priority.

PSPs will be supported in their honorary role by the Safety Learning Team and Patient Experience Team who will provide expectations and guidance for the role. They will have regular reviews and training needs will be agreed together, based on the experience and knowledge of each partner.

The PSP role will be reviewed annually to ensure the role is aligned to the patient safety agenda as it continues to develop, and expanded to ensure we are represented by the diverse communities we serve, including population groups who may sometimes experience challenges in accessing our services.

6. ADDRESSING HEALTH INEQUALITIES

The NHS has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way.

The Trust is committed to delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess any disproportionate patient safety risk to patients from across the range of protected characteristics. This data can be captured via our Electronic Patient Records (EPR) and DCIQ system.

In our response toolkit, we will directly address any features of an event which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to any population group, including all protected characteristics. When constructing safety improvement actions in our patient safety learning responses we will consider inequalities.

We will look to address health inequalities as part of our safety improvement work, understanding our services provide care to a proportion of the Core20PLUS5 population cohort identified by NHS England (2021). In establishing our future policy and plan we will work to identify variations of inequality by using our population and patient safety data to ensure it is considered as part of the development process for the future.

Engagement of those involved (patients, families/carers, and our people) following a patient safety event is crucial to our patient safety learning responses. We will ensure that we use available tools to include easy read, translation, and interpretation services alongside any other method appropriate to meet their needs and maximise the potential of being involved.

Information resources produced by NWAS can be made available in alternative formats, such as easy read or large print and may be available in alternatives languages upon request. These requests can be made to our internal communications team.

NWAS endorses a zero tolerance of racism, discrimination, and unacceptable behaviours from and towards our people, our patients, carers, and families.

7. ENGAGING AND INVOLVING PATIENTS, FAMILIES AND OUR PEOPLE FOLLOWING A PATIENT SAFETY EVENT

PSIRF recognises that learning and improvement following a patient safety event can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety response system that prioritises compassionate engagement and involvement of those affected. This involves working with those affected to understand and answer any questions in relation to the event and signpost to relevant support as required.

We are committed to continuous improvement throughout the services we provide. We want to learn from any event where care does not go as planned or expected by our people, patients, their families, carers, and other organisations. Getting involvement right with patients and families in our response is crucial, particularly to support the improvement of the services we provide. This involves being open and honest whenever there is a concern about care/ treatment provided, or when a mistake has been made.

Alongside professional and statutory requirements for Duty of Candour, NWAS commits to being open and transparent because it's the right thing to do; this is regardless of the level of harm caused by an event. In-line with the PSIRF we will support those involved via a network of Engagement Leads who will guide our people, patients, and their families through our patient safety learning responses to conclusion.

In addition, we have a Patient Advice and Liaison Service (PALS) for those with a concern or are unhappy about their experience with NWAS. This allows the organisation to review the concern and make improvements where necessary and feasible.

NWAS loves to hear great things about our people and the services we provide and NWAS welcomes compliments from our patients and their families which are used to assist with learning from excellence.

Our teams at NWAS can support with the following:

- Raising a concern, or a complaint.
- Sending a thank you.
- Healthcare Professional (HCP) and social care concerns/ enquiries.

All relevant contact details and associated forms can be found here.

For our people, NWAS recognises it can be beneficial to seek support because of a patient safety event they have been involved in and NWAS advocates the equal importance of both mental and physical health. Our people are encouraged to access the dedicated 'Invest in Yourself' webpage where there are a range of guides and supportive resources.

Patients/ families and carers may find support from one of the following sources: (please note this is not an exhaustive list).

- **Learning from Deaths:** *Provides an explanation of what happens following a bereavement (including those referred to a coroner) and how families and carers can comment on care received.* *https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/*

  Help is at hand – Bereavement following suicide: *Specifically, for those bereaved by suicide; practical support and guidance for those who have suffered loss.* *https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf*

- **Mental Health Homicide Support:** *For staff and families; this information has been developed by London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.*

- **Child Death Support:** *Child Bereavement UK and lullaby trust both provide support and practical guidance for those who have lost a child at any age.*

- **Complaints Advocacy:** *The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings, and review information given during the complaints.*

- **Healthwatch:** *Healthwatch are an independent statutory body who provide information to help make a complaint, you can find a list of your local Healthwatch on their website.*

- **Parliamentary and Health Service Ombudsman (PHSO):** *Make final decisions on complaints for patients, families and or carers when deemed not to have been resolved fairly by the NHS in England.*

- **Citizens Advice Bureau:** *Provides UK citizens with information about healthcare rights, including how to make a complaint about care received.*

8. PATIENT SAFETY RESPONSE PLANNING

PSIRF supports organisations to respond to patient safety events and issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, we can explore patient safety events relevant to their context and the populations we serve rather than only those meeting a defined threshold.

NWAS will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement. To fulfil this, we will proactively undertake planning of our current resources for patient safety learning response and our existing safety improvement workstreams.

Our Patient Safety Incident Response Plan (PSIRP) will detail how this will be achieved alongside how we intend to meet both National requirements and our NWAS Local Priorities for patient safety incident responses.

9. RESOURCES AND TRAINING TO SUPPORT PATIENT SAFETY RESPONSES

NWAS has committed to ensuring that we fully embed PSIRF and meet the national training requirements. We have utilised NHS England Patient Safety Response Standards, (2022) to provide resources and the training required for this to happen.

We will have governance arrangements in place to ensure patient safety learning responses are not led by NWAS staff who were involved in the patient safety event itself. Responsibility for patient safety learning responses from our locally agreed NWAS priorities sits with the Patient Safety Incident Response Team.

Patient Safety Learning Responses (PSLRs) sitting outside of our priorities will be led by a suitable senior leader within the relevant service line. Patient Safety Incident Learning Response Leads will have an appropriate level of seniority to influence within the trust, this may depend on the nature and complexity of the patient safety event and the learning response required.

The governance arrangements will ensure patient safety learning responses are not undertaken by staff working in isolation. Patient Safety Incident Response Team will support patient safety learning responses wherever possible and can provide advice on cross-system and cross-area working where this is required.

Our people affected by patient safety events will be afforded the necessary support and given time to participate in patient safety learning responses. All NWAS leaders will work within our just culture principles and utilise other teams to ensure our people are supported. NWAS service lines will ensure processes are adopted so leaders work within this framework to ensure psychological safety.

We will utilise both internal and (where necessary) external subject matter experts with relevant experience, knowledge, and skills.

10. TRAINING

NWAS has invested in one of the nationally mandated training providers from NHS England to ensure those with responsibility for responding and supporting patient safety events had adequate skills and knowledge to support those involved.

A training needs analysis has been developed and will be monitored on an ongoing basis, to ensure those with responsibility for, responding to and supporting patient safety events remains up-to date. This training will be delivered alongside an ambitious programme of safety skills training, including the Patient Safety Syllabus.

11. OUR PATIENT SAFETY INCIDENT RESPONSE PLAN (PSIRP)

Our PSIRP sets out NWAS intends to respond to patient safety events over a period of 12-to-18-month period. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety event occurred, and the needs of those affected as well as the plan.

A copy of our PSIRP can be located on both our internal platform, the Greenroom, and our website.

12. REVIEWING OUR PATIENT SAFETY RESPONSE INCIDENT POLICY AND PLAN

Our PSIRP is a "live document" that will be appropriately amended and updated as we use it to respond to patient safety events. We will review the plan regularly, and at least annually to ensure our focus remains up to date, with ongoing improvement work, our patient safety profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 24 months.

Updated PSIRP and policy will be published on our website, replacing the previous versions.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our lead Integrated Care Board) to ensure efforts continue to be balanced between learning and improvement.

This more in-depth review will include our response capacity, mapping services, a wide review of organisational data (patient safety incident reports, improvement plans, complaints, claims, staff survey results, inequalities data and any other relevant reporting data) and wider stakeholder engagement.

13. RESPONDING TO PATIENT SAFETY EVENTS

Patient Safety Event Reporting Arrangements

All our people (staff and volunteers) are responsible for recording and reporting potential or actual patient safety events on the trusts DCIQ system. The reporter will record the level of harm they believe to have been experienced by those affected. Each patient safety record will be reviewed and triaged by a corporate team and allocated to the relevant service line(s) for review, response, feedback to the reporter and closure.

The organisation has corporate oversight of all patient safety events and service lines have their own mechanisms in place to ensure patient safety events are responded to proportionately and in a timely manner. This will include consideration of Duty of Candour (Duty of Candour Procedure, found on the Green Room here). Most events will require a local review and learning response (if necessary), undertaken by individual service lines. Those events where the opportunity to learning and improvement would be of greatest value, will be led by the trust Patient Safety Incident Learning Response Team.

Events and/or incidents highlighted that appear to meet requirements for reporting externally will be handled by the Patient Safety Incident Learning Response Team. There will be occasions where events require the efforts of cross-system working with relevant partners, the Integrated Care Board (ICB) will support a collaborative approach with these arrangements if required.

Patient Safety Incident Response Decision-Making

NWAS will have arrangements in place to meet the requirement to review patient safety events under PSIRF. Some of these will require a mandatory response, others will require review or referral to another body and/or team; these are set out in the PSIRF plan.

PSIRF itself sets no further national thresholds to determine what method of response should be utilised for learning and improvement. NWAS has developed a range of response mechanisms to balance the efforts between learning and exploring emerging issues alongside ongoing improvement work. During the work to create our plan, we considered our event insight and engagement with key stakeholders to identify our patient safety profile. We have used and will build on this intelligence for our local priorities and our toolkit for responding to patient safety events.

We have established a process for our response to events, that allows for a clear set of mechanisms allowing for oversight of our learning responses.

We will hold a weekly decision-making governance meeting to review events from escalation within service lines, and a decision is made on an appropriate level of response, this is to identify those events that appear to meet the need for further exploration due to the possibility of meeting the criteria for a full review. This group will have delegated responsibility for the consideration of events for PSII (Patient Safety Incident Investigation) or a patient safety learning response for oversight of outcomes. All recommendations made will focus on system-based approaches utilising the SEIPS (systems engineering initiative for patient safety) model, ensuring recommendations are valid and contribute to existing safety improvement plans or establishment of such, if they are required.

The Quality and Performance Committee will hold overall oversight of such processes, allowing for challenge where required, to ensure the Board of Directors can be assured the true intent of PSIRF is being implemented across our organisation to ensure we are meeting to the national response standards.

14. RESPONDING TO CROSS-SYSTEM EVENTS/ISSUES

The Patient Safety Incident Response Team will assist in the coordination of these events identified to other providers directly, via each organisations reporting processes. Where required summary reporting can be utilised to share insights with other providers about their patient safety profile.

We will work with partner providers and relevant ICBs to establish and maintain robust procedures to facilitate flow of information and minimise delays to joint working on cross-system events. The patient safety team will act as a single access point for such working arrangements and hold supportive procedures to ensure this is effectively managed.

NWAS will refer to ICBs to assist with the co-ordination where a cross-system event is felt to be complex to be managed by a single provider, we anticipate the ICB will provide support and advice with identifying a suitable reviewer, should this circumstance arise.

15. TIMEFRAMES FOR LEARNING RESPONSES

Timescales for Patient Safety Incident Investigations (PSIIs)
Where a full PSII is indicated, this will be started as soon as practically possible following the identification and completed within three months. Locally- led PSIIs should not exceed six months.

Timeframe for completion will be agreed with those affected, as part of setting the terms of reference; this remains subject to them willing and able to be involved in that decision. A balance will be drawn between conducting a thorough review, the impact extended timescales can have on those involved and the risk of delaying findings may adversely affect safety.

In exceptional circumstances (i.e., when a partner organisation requests a pause, or processes of external bodies delay access to information) NWAS can consider whether to progress and determine whether new information would indicate the need for further review once this is received. The decision for this would be made by the Patient Safety Event Cases (PSEC) group.

There may be occasions where a longer timeframe is required for completion, in this case, all extended timeframes will be agreed between NWAS and those affected.

Timescales for Patient Safety Learning Responses (PSLRs)
A Patient Safety Learning Response must be started as soon as practically possible following a patient safety event is identified. These learning responses should not exceed six months in duration.

16. SAFETY ACTION DEVELOPMENT AND MONITORING IMPROVEMENT

NWAS acknowledges any form of patient safety learning response will allow the circumstances of an event or set of events to be understood, but this may only be the beginning. To reliably reduce risk, better safety actions are required.

We will have systems and processes in place to design, implement and monitor safety actions using an integrated approach of reducing risk and limit the potential for future harm. This process follows from any initial findings of any form of learning response which could result in aspects of trust's working systems where change could reduce risk and harm. NWAS will generate safety actions in relation to each of these defined areas for improvement. Following this, we will have measures to monitor safety actions and set milestones for review.

Patient Safety Learning Responses should not describe recommendations, as this can lad to premature attempts to devise a solution. To achieve successful improvement, safety action development will be completed in collaborative way with a flexible approach and support from the Quality, Improvement, and Innovation Directorate.

Development of Safety Actions
NWAS will utilise processes for development of safety actions as outlined by NHS England; Safety Action Development Guide, (2022):

- Agree areas for improvement: specify where improvement is needed, without defining solutions.
- Define context: this will allow agreement on the approach taken to safety action development.
- Define safety actions to address areas of improvement focuses on systems in collaboration with those teams involved.

- Prioritise safety actions to decide on testing for implementation.
- Define safety measures to demonstrate if actions are influencing what is intended.
- Safety actions will follow SMART principles and have designated owners.

Safety action monitoring

Safety actions must continue to be monitored within service lines governance arrangements to ensure any actions put in place remain impactful and sustainable.

17. SAFETY IMPROVEMENT PLANS (LOCAL PRIORITIES)

Safety improvement plans bring together findings from various responses to patient safety events and issues. NWAS will have several safety improvement plans in place which are adapted to respond to outcomes of improvement efforts and other influences as national safety improvement programmes.

The NWAS PSIRP has outlined local priorities for focus or response under the PSIRF. These were developed due to the opportunity they offer for learning an improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in risk or harm.

The trust will use the outcomes from existing patient safety reviews and any relevant learning response conducted under PSIRF to create related improvement plans to assist focus on our improvement work. NWAS service lines will work collaboratively with NWAS Corporate Teams and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by patient safety learning responses outside of trust priorities, a safety improvement plan will be developed. These will be identified through the PSIRF governance processes.

Monitoring of progress for safety improvement plans, will be overseen by Regional Improvement and Learning Forum on a scheduled basis.

18. OVERSIGHT ROLES AND RESPONSIBILITIES

Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

NWAS follows the “mindset” principles to underpin the processes we have in place to allow us to implement PSIRF as set out in the framework and supporting guidance.

Responsibilities

Alongside the Trust’s responsibilities, our lead ICBs, and our regulator the Care Quality Commission (CQC), will have specific responsibilities under PSIRF.

Trust Board

The Trust Board is responsible and accountable for effective patient safety incident management across NWAS. This includes supporting and participating in cross-system/ multi-agency responses, and/or independent patient safety incident investigations (PSIIs) where required.

Executive Leads

To meet these requirements, NWAS has designated the Director of Quality, Innovation & Improvement as the executive lead to support PSIRF. This enables us to:

- Ensure NWAS meets the national patient safety standards.
- Ensure that PSIRF is central to overarching safety governance arrangements.
- Quality assuring learning response outputs.

The Director of Quality, Innovation & Improvement will provide direct leadership, advice, support in complex/ high profile cases, and liaise with external bodies, as required, in collaboration with the Medical Director.

The Director of Quality, Innovation & Improvement has the overarching responsibility for the quality of patient safety learning responses, PSIIs, safety learning, and improvement. The Medical Director is overall accountable for patient safety for the Trust.

Both Executive Directors are equipped with the training and professional development as described in the national patient safety incident response standards.

19. COMPLAINTS AND APPEALS PROCESS

NWAS recognises that there will be occasions when patients, services users and carers are dissatisfied with the aspects of care and services provided by the trust.

It is important to understand that there is a distinction between complaints and concerns as the use of the word complaint should not automatically mean that someone expressing a concern enters the complaints process.

The first point of contact with the trust, to raise a concern is via the PALS team.

Complaints are defined as expressions of dissatisfaction from a patient, their family or carer, a person acting as their representative or any person who is affected or likely to be affected by the action, omission or decision of the trust and requires a formal review.

NWAS is committed to dealing with any complaints that may arise quickly and as effectively as possible as set out in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints and concerns can be valuable aids in developing and maintaining standards of care and that lessons learnt from complaints can be used positively to improve services.

Outcomes and recommendations from a complaint will be shared with service lines to ensure any necessary changes can be considered and implemented where appropriate.

If patients, relatives and or carers have a concern or complaint in relation to how a patient safety learning response has or is being handled, they should contact their nominated Patient Safety Incident Learning Response Lead or Engagement Lead in the first instance. Every effort will be made to address specific concerns.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 March 2024				
SUBJECT:	Modern Slavery Act 2015				
PRESENTED BY:	Executive Director of Finance				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☐	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The Board of Directors are requested to approve the following statutory statement relating to the Modern Slavery Act 2015 for publication on the Trust website and inclusion within the Annual Report for 2023/24. This statement meets the current requirements.				
RECOMMENDATIONS:	The Board of Directors is asked to: • Note the content of the report; and • Approve the recommendation of the drafted statutory statement for the year ending March 2024.				
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:			

1. PURPOSE

1.1 The Board of Directors are requested to approve the following statutory statement relating to the Modern Slavery Act 2015 for publication on the Trust website and inclusion within the Annual Report for 2023/24.

2. BACKGROUND

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

2.2 A person commits an offence if:

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

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

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

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

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

- The training about slavery and human trafficking available to its staff.

OR

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

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

3. CURRENT POSITION

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

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

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

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

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

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

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

3.7 The Trust is fully aware of the responsibilities toward patients, employees and the local community and we have a strict set of values that we use as guidance regarding our commercial activities. We therefore expect that all the Trust's suppliers and sub-contractors adhere to the same ethical principles.

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

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

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

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

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

5. EQUALITY OR SUSTAINABILITY IMPACTS

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

6. RECOMMENDATIONS

6.1 The Board of Directors are asked to:

- Note the content of the report; and
- Approve the recommendation of the drafted statutory statement for the year ending March 2024

Appendix 1.

NWAS MODERN SLAVERY ACT 2015
Statutory Statement for the Year Ending March 2024

Background

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

A person commits an offence if:

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

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

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

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

Organisational Structure

North West Ambulance Service NHS Trust serves an approximate population of 7 million covering an area of 5,500 square miles and employs over 7,100 staff. The Trust receives 1.7 million emergency calls per year, which is 16% of the national (999) activity. To meet this demand the Trust has 3 emergency control centres and approximately 720 emergency vehicles.

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

The Trust has an overall annual budget of around £470 million.

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

The Trust has a non-pay budget of £114m per annum which is spent on goods and services. Over 80% of the £114m is spent with the Trusts top 100 suppliers.

Our Supply Chain

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

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

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

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

Safeguarding

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

Recruitment

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

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2024.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th March 2024				
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 Quality and Performance Committee (Q&P) have reviewed in full the trust's quality, effectiveness, and operational data for **February 2024** (unless otherwise stated). Finance and organisational health data has been reviewed by the Resources Committee. Key findings from both have been replicated in this board IPR pending comments. Future board IPR's will be subject to review and refinement based on the comments received.

Changes/revisions to note:

- **Executive Summary:** The format of this report now includes key points from the data slides in the recommendations section and does not include a detailed executive summary (as per previous reports) to avoid duplication with the narrative content of the report.
- **Incident Data:** The implementation of Patient Safety Incident Response Framework (PSIRF) in October 2023 has changed the way we record and present patient safety incidents. Patient data is now presented separately from other incident data, alongside the severity and the themes of the most prevalent incidents. The presentation of patient safety data is under review and will mature.
- **Ambulance Clinical Quality Indicators (ACQI):** the charts for cardiac outcomes include the most recent data, however, there is a gap in the time series whilst we work on the transition from paper records to electronic records. Retrospective data for the gap in submission has been provided to NHSE and will appear in the next report.
- **Operational Performance (999):** We have included (where possible) the data by Integrated Care Board (ICB) and operational sector (as usual). This reflects a request from Q&P to better understand the variation between areas and sectors and gain a more granular insight into operational performance.

RECOMMENDATIONS:	**The Board of Directors are requested to note:** • Updated reporting for safety incidents shows: – Violence and aggression towards staff is the most frequently reported incident. – Call handling is the most frequently reported patient safety related incident. • Cardiac ACQI metrics show improvement, and performance above the national average. • Trust plans aligning with the UEC recovery plan, are indicating success through: – Attaining UEC recovery target 30-minute mean for C2 (monthly and year to date) – Attaining UEC recovery target 10 second mean for call pick up (monthly and year to date). • The trust is in a strong national standing for C1 and C2 performance, placing 3rd for mean and 90th percentile. • Hospital turnaround has improved, although remains persistently above the 30-minute target with significant delays across NWAS. • 111 performance is stable but remains challenged in delivering the national standards even with additional national resource. • PTS activity is stable. • Financial controls are in place and on plan. • Variation can be seen in workforce metrics, notably: – 111 turnover is improving, however remains challenging at 26.9% – EOC turnover worsening to 21.8% – PTS metrics remain challenging including recruitment, absence, and appraisals. – Vacancy gap reflects establishment changes but is starting to reduce with delivery against recruitment plans.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ 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 March 2024
	Outcome:	Not known at time of submission

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1. PURPOSE

The purpose of this report is to provide the Board with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of **February 2024.** The report shows the historical and current performance on Quality, Effectiveness, Operational performance, Finance and Organisational Health. 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?

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

QUALITY

Complaints: The number of complaints received and the number closed are stable. Closure within SLA (complaints scoring 1-3) has improved.

Incidents: Changes in safety incidents reporting are reflected in this report. Non-patient (classified as 'Trust' or 'Staff (including volunteers)') related incidents retain the legacy scoring system (Q2.1 and Q2.2), whereas patient incidents are recorded separately, and are not subject to closure within SLA, although level of harm is assessed. In February 2024, 16 patient incidents were classified as 'serious harm' and 10 classified as 'fatal'.

The segregation of patient incidents occurred in Oct 2023 therefore Q2.3 shows weekly data-points from that date.

Violence and aggression is the most common theme for non-patient incidents and combined medicine related incidents the second most common. The most common theme for patient incidents is care and treatment; delay-based incidents have reduced since the previous report.

Most frequent safety incidents:	**Most frequent patient safety incidents:**
Violence & Aggression (124)	Care and Treatment (105)
Medicines – all (91)	Delays (86)
Communication (68)	Call Handling (74)
Call Handling (56)	Communication (43)
Road Traffic Collision with Vehicle (51)	Call Management (28)

Incidents referred to NHSE: Under the new Patient Safety Incident Response Framework (PSIRF), there were 4 Patient Safety Incident Investigations (PSII); one was referred externally (under national priorities) and three reviewed internally by the Patient Safety Event Case Group (PSEC).

Safety Alerts: One new applicable alert has been received (NatPSA/2024/003/DHSC_MVA) detailing a shortage in Salbutamol Nebuliser Solution. The trust issued a communication (CI1023) concerning the safety alert giving guidance to clinicians in managing the risk.

EFFECTIVENESS

Patient experience

PES responses (n=313) are 5.7% lower compared to last reporting period (n=332), with comments showing a similar decrease of 5.3%. The overall experience score (87.2%) is 1.7 percentage points higher than December (85.5%).

PTS responses (n=1,108) are 7.8% higher than the last reporting period (n=1,028), with supporting comments also higher by 9.5%. The overall experience score (91.2%) is 0.2 percentage points higher than December (91.1%).

In 111, there were 97 responses for February, a decrease of 38.6% compared to December, attributable to lag time between when surveys are sent out and the IPR reporting window. Overall, 86.6% of responses recommended the service, an increase of 3.7 percentage points compared to the previous report (82.9%).

Plans to increase returns across all service lines include increasing the number of patients who receive a survey, offering more ways to provide feedback, continuing to raise awareness with staff about the importance of feedback, and responding to patients about the difference sharing their experience has made.

Ambulance Clinical Quality Indicators (ACQI's)

Trust level cardiac ACQI submission has now been re-established, following a gap in submissions due to data quality concerns. Retrospective data for the gap in submission has been provided and will appear in the next report. Of note:

- **Return of Spontaneous Circulation (ROSC) overall performance.** Last reported in October 23, displaying common cause at 35.6%. Trust performance is above the national average (29.6%).
- **ROSC Utstein performance**. Last reported in October 23, approaching the upper control limit at 59.3%. Trust performance is above the national average (52.4%).
- **Survival to discharge overall performance**. Last reported in October 23, indicating improvement (special cause) at 11.9%. This is above the national average of 10.0%.
- **Survival to discharge Utstein performance**. Last reported in October 23, indicating improvement (special cause) at 35.7%. Trust performance is above the national average of 30.7%.
- **Stroke care bundle.** Last reported in August 23, indicating improvement (special cause) at 99.1%. This is above the national average of 97.7%.
- **STEMI care bundle.** Last reported in October 23, indicating improvement at the upper control limit at 79.3%. Trust performance is above the national average of 78.9%.

Hear & Treat (H&T), See & Treat (S&T), See & Convey (S&C)

The H&T rate for February 23 was 15.3%, whilst the S&T rate was 27.2%, equating to a total non-conveyance rate of 42.5%. Nationally, the trust ranked 4th for H&T, 8th for S&C and 10th for S&T.

H&T capacity is likely to increase into Q1 2024/2025. Recruitment into the Clinical Hub (CHUB) continues with a further 20 clinicians planned to deploy in the next two months. This will bring the CHUB up to full UEC funded establishment. Additional external CAS capacity is also likely to continue through Q1. The increase in capacity equates to a further 200 secondary triages per day.

The impact and potential benefits of C2 segmentation are now identified. Work with the national team has enabled a shift in approach which is anticipated to increase H&T within C2. H&T is unlikely to reach the peak levels experienced in 22/23 due to improvements in response standards and reduction in long waits, which reduces the opportunities to H&T.

S&T has decreased with one weekly data points outside the lower control limits; this is likely a reflection of the increase in H&T.

Overall conveyance rates are stable with 8 percentage point variation across sectors. There has been improvement in S&C to non-AE for 8 consecutive weeks, leading to a new phase, with East Lancashire sector a primary causal factor, delivering the highest rate of non-AE conveyance in the trust (13.06%) due to work to improve pathways and access into Same Day Emergency Care (SDEC).

PES Emergency (999) Activity

Of the n=116,879 emergency calls received by the trust in February, 77% (n=90,442) became incidents. Call volume has increased 20% from the previous year due to the impact of industrial action in 2023, which reduced call volume into the service in the same month in 2023. Compared to 2022, calls have increased 5%. Incidents have also increased.

Calls resulting in no outcome (n=14,176) have decreased compared to the previous reporting periods e.g. December 23 (n=19,579). This is due to improvements in response standards, which reduce both duplicate calls (less patients calling to request updates) and no outcome calls (such as closure due to self-conveyance).

999 Call Pick Up

We have continued to perform well on Call Pick Up (CPU); mean CPU (n=1) and 90th CPU (n=0) have remained stable. This is due to the maintained levels of 999 call handlers funded via UEC investment. The reduction of follow up calls and similar enquiries is also supporting CPU. From April 2024 two new AQI targets will be implemented (CPU is currently reportable under ARP but from April 24 this will adjust to a target-based metric). The targets are a mean of 10 seconds and a 90th percentile of 20 seconds; the trust is expected to comfortably achieve the standards.

999 Ambulance Response (ARP) Performance

Measure	Standard (hh:mm:ss)	Feb 24 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:08:03	3rd
C1 90th	00:15:00	00:13:40	3rd
C2 mean	00:18:00	00:28:59	3rd
C2 90th	00:40:00	01:00:36	3rd
C3 mean	01:00:00	02:17:22	8th
C3 90th	02:00:00	05:13:57	8th
C4 90th	03:00:00	06:08:31	7th

The trust performed well responding to higher acuity patients compared to the sector. C2 performance was below the 30-minute UEC recovery standard at 28:59, meaning the trust is likely to achieve the annualised standard based on our year-to-date position of 28:08 minutes. Improvements have been delivered primarily through the utilisation of UEC funding and the delivery of increased double crewed ambulance (DCA) hours. DCA hours have increased by 2,000 hours per week when compared to February 23.

Lower acuity (C3 and C4) response times were stable. Ongoing review of the response model is anticipated to support further improvements. A review of inter-facility transfers and healthcare professional related calls (IFT/HCP) has commenced alongside a review of Urgent Care response.

Notable is the variation in response across operational sectors. This is highlighted by a difference of over 20 minutes for C2 mean in operational sector North Cumbria (19:36) compared to Mersey North (42:00) and Mersey East (42:15).

999 C1 & C2 long Waits

C1 long waits (n=641) decreased 18% compared to the previous report (n=785). The year-to-date percentage of C1 long waits of all C1s is 7.35%.

C2 long waits (n=4,975) decreased 53% compared to the previous report (n=10,636). The year-to-date percentage of C2 long waits of all C2s is 10.5%.

C1 long waits are stable. C2 long waits have improved following winter pressures, as expected. Extreme long waits are reduced for both categories; only 5 extreme waits were recorded for C2 in 49,000 incidents.

Hospital Handover

Average turnaround time has improved to 45m:10s compared to the previous IPR period (December 2023) of 47m:03s, however, performance is still considerably above the national standard of 30 minutes and is 7 minutes higher than the February 2023 position (38:34). The following actions are ongoing to support handover improvement:

- Strategic withdrawal from sites is still being tested and enacted in a dynamic way as part of the patient safety plan.
- Correspondence has been sent to all partners from the medical director clarifying the NWAS position on handover and patient safety.
- There is ongoing dialogue with the ICB and provider collaborative senior leadership across all areas. Sites with long delays are all subject to focussed improvement work which NWAS is actively participating in.
- CAM is engaged in ICB-wide improvement work to increase the number of patients appropriately sent to non-ED alternatives.

NHS 111

111 Measure	Standard	Feb 24	National ranking
Answered within 60s	95%	46.5%	30th /37
Average time to answer	--	06m 55s	--
Abandoned calls	<5%	16.1%	29th /37
Call-back within 20 min	90%	29.9%	--
Average call back	--	49m 39s	--
Warm transfer to nurse	75%	19.72%	--

February observed an expected decrease in demand for 111 following winter pressures. Calls offered (n=191,548) were 12.2% lower than December 23 (n=218,135).

February has continued a stable performance period for 111. Calls answered in 60 seconds were stable at 46.5% but significantly below the 95% target. Abandoned calls (16.1%) and average time to answer (03:46) were stable. For call back in 20 minutes (29.0%), performance has displayed special cause for consecutive months, however it remains significantly short of the 90% standard. Warm transfer to nurse has improved to 19.7%, slightly above the mean, but short of the 75%.

The national support currently in place will continue into 2024/2025 financial year; this may vary week on week but is targeted between 10%-15% of offered activity. Projections indicate, despite a fully established workforce being in place in Q2 2024/2025, national support will still be required to the current funding gap in the 111 contract.

PTS

Owing to a lag in PTS reporting, performance is reported one month in arrears. PTS activity for January 2024 was stable. Greater Manchester (GM) is the busiest area, but incurs a high rate of aborted unplanned activity (37%) compared with the trust average (28%).

PTS is progressing an improvement plan with an update due at the end of March 2024. Outstanding QAVs have been scheduled to be completed by the end of the financial year. A 10-day standstill period before concluding the award of contracts for the PTS bid has been extended by commissioners for an undetermined period.

3 FINANCE

- The year-to-date expenditure on agency is £1.73m which is under the year-to-date ceiling of £3.70m.
- The trust has underspent against budget due to interest received being greater than planned.
- The trust has delivered the year to date efficiency & productivity target and is forecasting to remain on plan by the end of the year.

4 ORGANISATIONAL HEALTH

Sickness

Trust absence levels recovered in January following a peak in December, however the peak was less pronounced than the previous 3 years. Overall trends for the last 12 months indicate a stable position although with a higher mean than pre-pandemic levels.

Whilst PES, 111, and EOC sickness remain stable, levels are higher in the contact centre environments. In contrast, PTS displayed consecutive special cause above the upper control limit at 11.1%. In mitigation, PTS are enacting a compliance plan to improve sickness absence management.

The overall position is consistent with trends across the ambulance sector, although we remain at the higher end of the sector average, highlighting the need for continued focus on sickness management fundamentals. The primary reasons for absence continue to be mental health, injury, musculoskeletal (MSK)/back problems and gastro-intestinal problems. The Attendance Improvement Team (AIT) continues to support management of attendance.

The UEC recovery funding has enabled 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 these additional posts is complete.

Turnover

Turnover for January (10.6%) continued a downward (improving) trend, approaching the lower limit. This is driven by improvement in 111 and PES.

PTS turnover is stable at 10.2% with recruitment plans to deliver additional staffing over the remainder of the year. Causes of turnover are primarily retirement and ill health.

EOC turnover is worsening at 21.8%, approaching the upper control limit. This is the only service line showing a consistently increasing (worsening) trend. There is a focus in contact centres to support retention, and analysis is underway to understand emergency medical dispatcher (EMD) turnover. Initial indications show that internal movement (e.g. career change to start EMT course) and available external opportunities are causal factors.

Turnover in 111 has displayed a downward (improving) trend since March 2023 to 26.9%, approaching the lower control limit, however it remains the service line with the highest turnover rate by 5 percentage points.

PES turnover has gradually improved since April 2023, now at 6.4% and the best performing service line.

Temporary Staffing

The position temporary staffing shows continuing agency usage at a similar rate to previous months at a level equivalent to 0.4% pay bill, £176k below cap.

Vacancy

The trust vacancy position is –6.3% for February, reflecting establishment changes from the UEC recovery funding. The challenges remain in PTS and 111 recruitment.

The PTS vacancy position is –11.96%, reflecting an increase in turnover, including PTS staff moving to PES. Recruitment plans have been revised to enable increased new starters for the remainder of the year. PTS have robust bank arrangements in place to bridge their vacancy position.

The EOC position has worsened to –6.7%, driven by the dispatch workforce. Recruitment plans are in place to seek to maintain a stable position for the rest of the year.

PES show a slight under-establishment of –1.38%, primarily owing to an under-establishment within the EMT1 workforce. Recruitment plans are being delivered, with interventions to ensure that the Q4 EMT1 courses are fully populated.

The current 111 vacancy position is –13.29% with vacancies in the Health Advisor and Clinical Advisor roles. Whilst turnover is improving, the recruitment market is proving challenging for call handler positions. Shortfalls on courses are being supplemented through agency recruitment. The trust is also engaging in an international recruitment pilot for Clinical Advisors.

Plans for recruitment to an integrated call handler role (under the Integrated Contact Centre programme of work) have commenced with large scale advertising underway. Improvements are expected into Q4 but projections indicate the gap will not be fully closed.

Appraisals

Overall appraisal completion has improved to 83.1%. Whilst the trust-wide position is stable, variation exists between service lines, driven by special cause in PTS for five consecutive data points, now at 76%, indicates a deteriorating position. The 111 service line is 83.2% showing special cause and indicating improvement. PES are close to the target at 84.5% and EOC have fallen slightly behind target at 83%.

The targets for 2023/24 are:

- Service Lines - 85%
- Corporate Directorates - 90%
- Leadership Roles Band 8a and above - 90%

Mandatory Training

Overall compliance is ahead of the trajectory at 89% and all service lines are ahead of target. An additional 5 online modules were added to the programme, initially impacting compliance, however this is now recovered.

Case Management

Employee relations casework have decreased from n=126 to n=103 between the reporting periods, primarily owing to a reduction in fact finding cases and grievances. The highest rate of live cases per staff (prevalence) occurs in PTS (1.7%). Average case length has extended to 13.6 weeks due to high volume and increased complexity of cases.

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

The Diversity and Inclusion sub-committee are reviewing the trust's protected characteristics data to understand and improve patient experience. Formerly, patient experience data was presented demographically, however challenges in reporting ethnicity preclude our ability to draw conclusions. With a much higher proportion of ethnicity data completion in 111, a development to enable data sharing across NWAS systems is in progress. Ethnicity data is now flowing from 111 Cleric into the PTS system and development work to extend this into C3 (999) is now completed and in testing phase, with a working group set up to support it into 'go-live'. Updates on this development are reported into the Diversity and Inclusion sub-committee.

7 RECOMMENDATIONS

The Board of Directors are requested to note:

- Updated reporting for safety incidents shows:
  - Violence and aggression towards staff is the most frequently reported incident.
  - Call handling is the most frequently reported patient safety related incident.
- Cardiac ACQI metrics show improvement, and performance above the national average.
- Trust plans aligning with the UEC recovery plan, are indicating success through:
  - Attaining UEC recovery target 30-minute mean for C2 (monthly and year to date)
  - Attaining UEC recovery target 10 second mean for call pick up (monthly and year to date).

- The trust is in a strong national standing for C1 and C2 performance, placing 3rd for mean and 90th percentile.
- Hospital turnaround has improved, although remains persistently above the 30-minute target with significant delays across NWAS.
- 111 performance is stable but remains challenged in delivering the national standards even with additional national resource.
- PTS activity is stable.
- Financial controls are in place and on plan.
- Variation can be seen in workforce metrics, notably:
  - 111 turnover is improving, however remains challenging at 26.9%
  - EOC turnover worsening to 21.8%
  - PTS metrics remain challenging including recruitment, absence, and appraisals.
- Vacancy gap reflects establishment changes but is starting to reduce with delivery against recruitment plans.

North West Ambulance Service NHS Trust

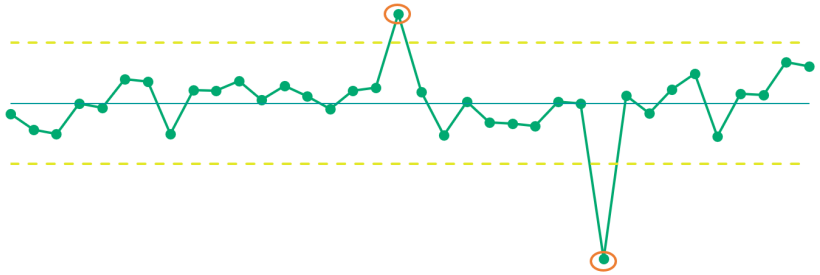
Integrated Performance Report

Board - March 2024

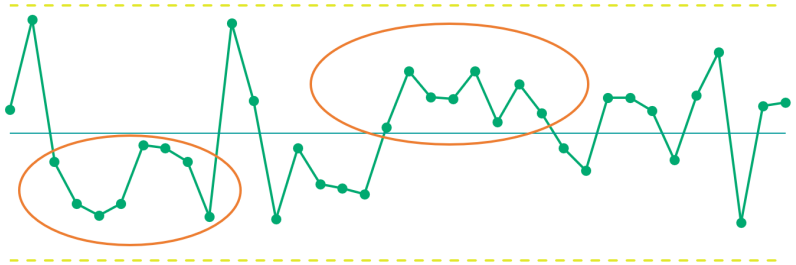
Rules for interpreting SPC Charts

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

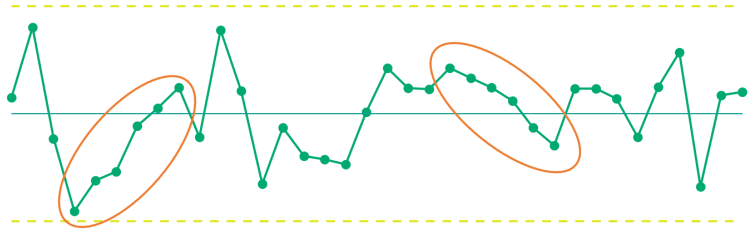
Rule 1: Single data point outside the control limits



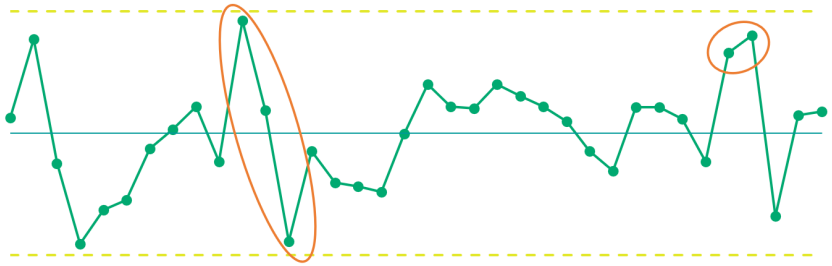
Rule 2: 8 or more consecutive data points above or below the centre line



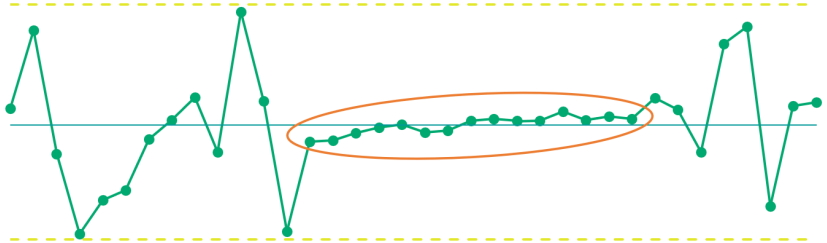
Rule 3: A trend of at least six consecutive points (up or down)



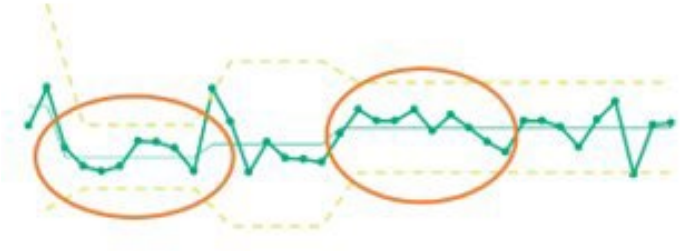
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



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

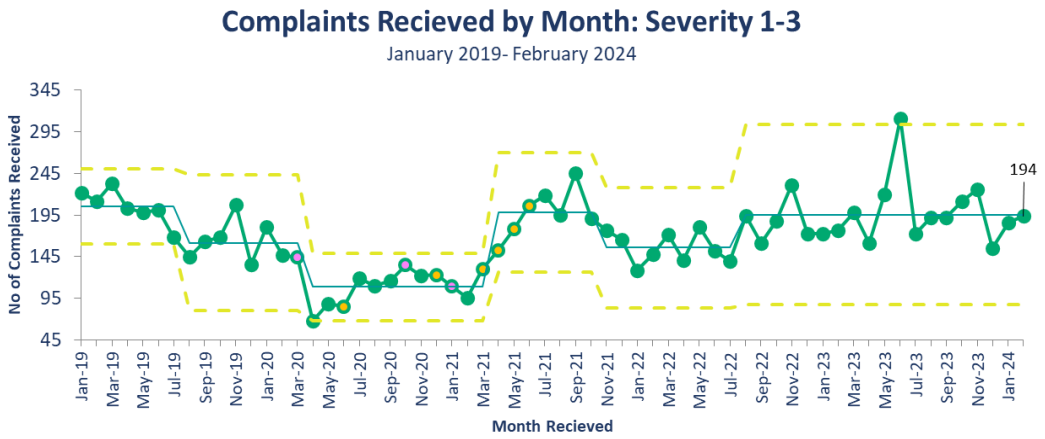


Figure Q1.2

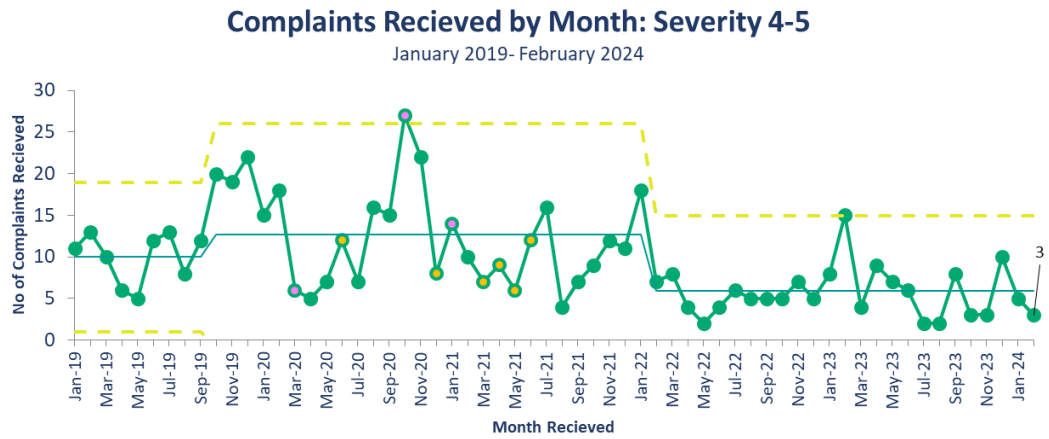


Figure Q1.3

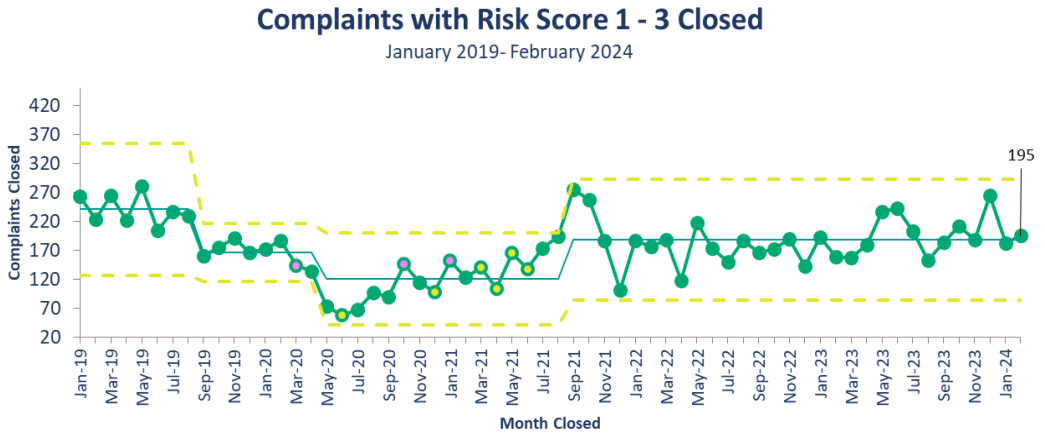


Figure Q1.4

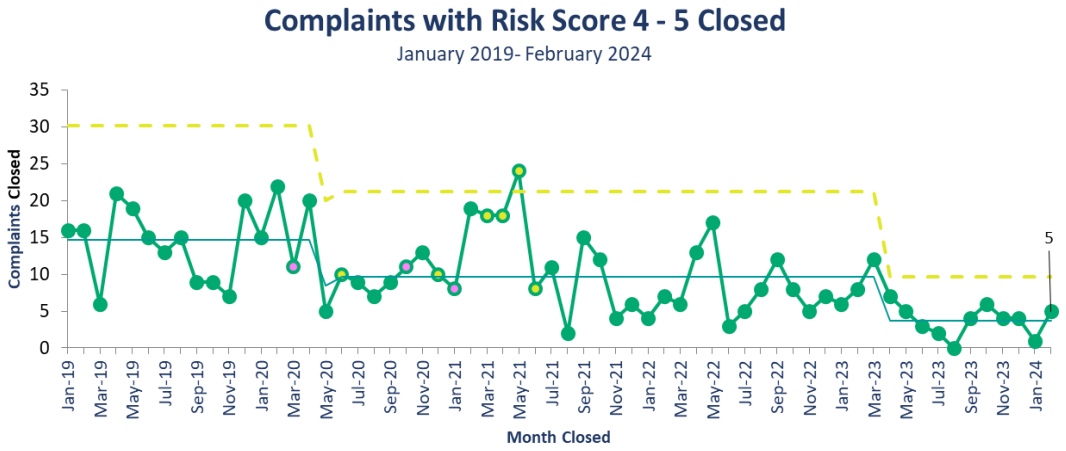


Figure Q1.5

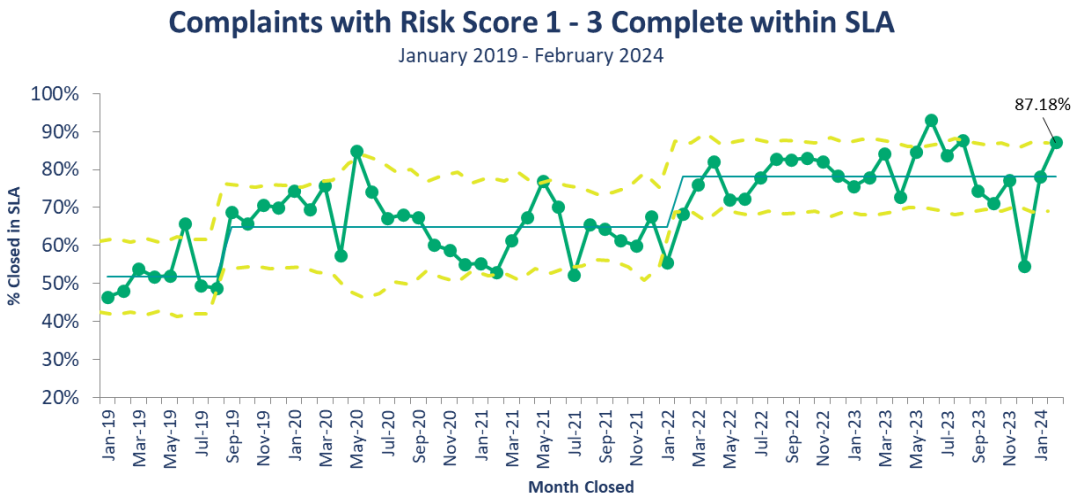
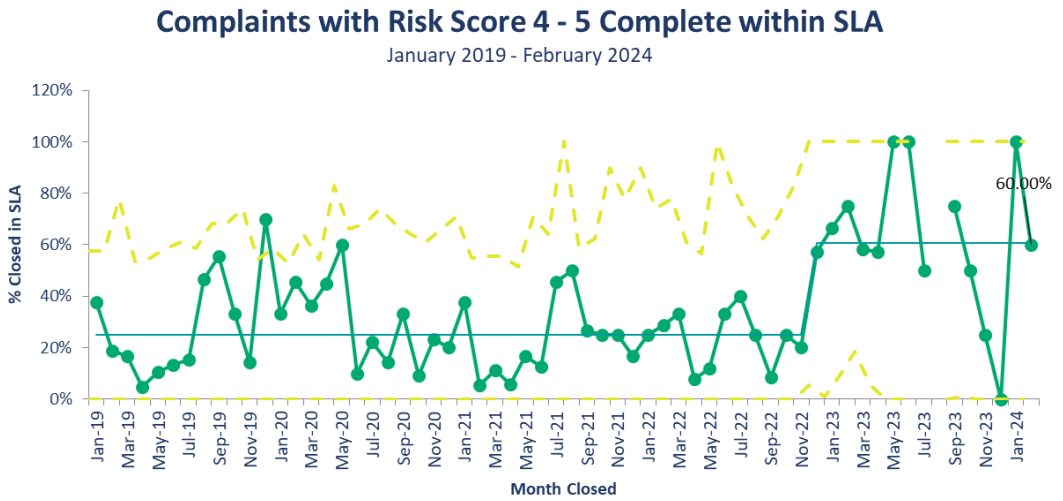


Figure Q1.6



Q2 Incidents

Figure Q2.1

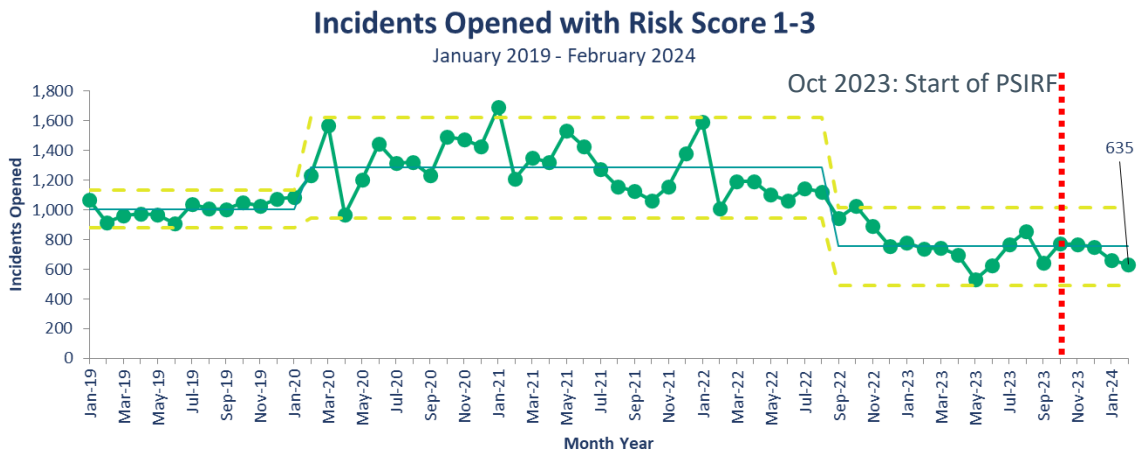


Figure Q2.2

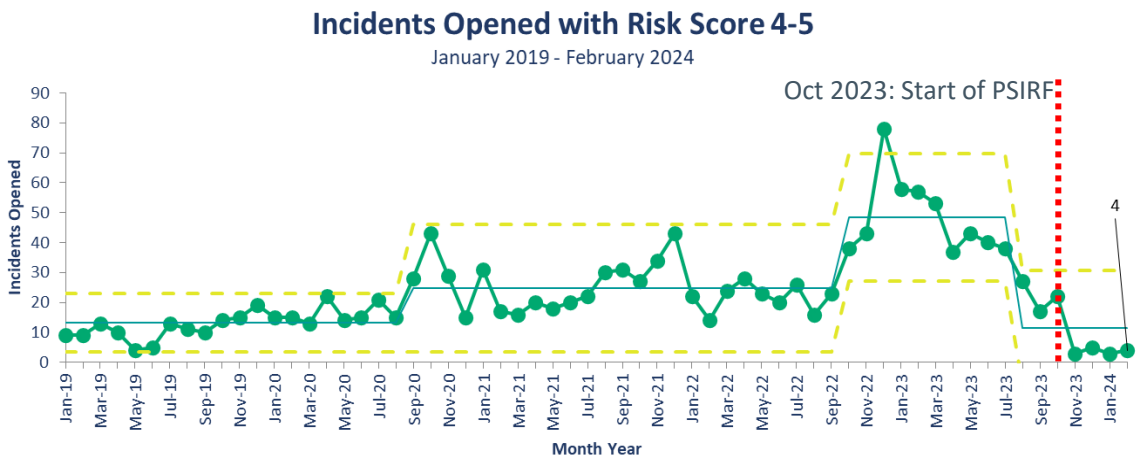
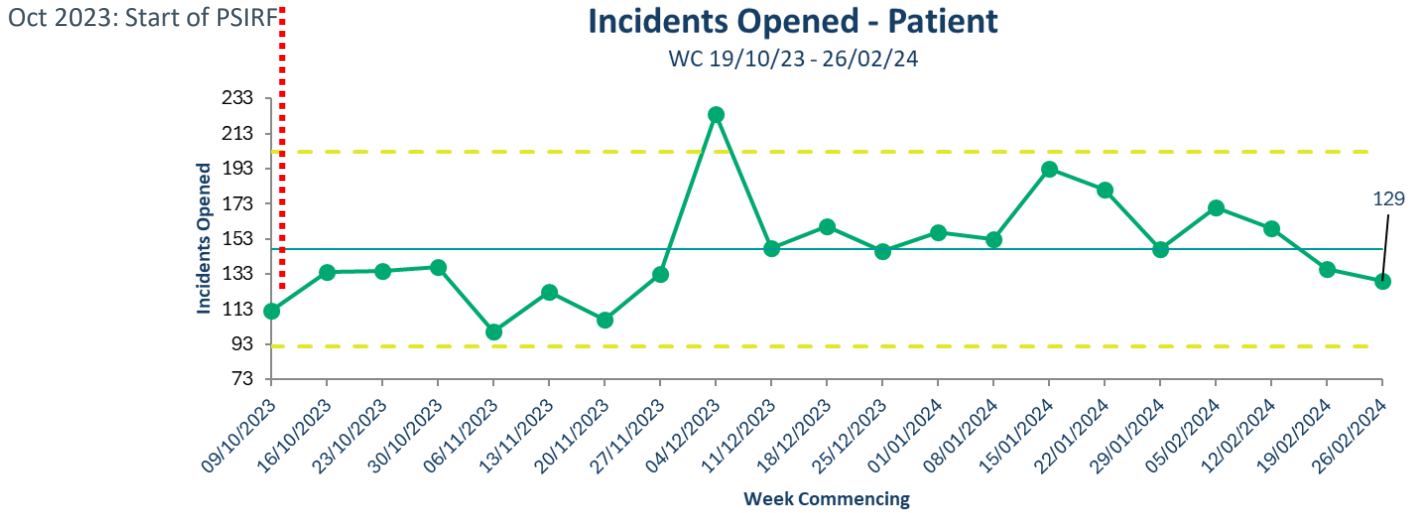


Figure Q2.3



PSIRF level of harm (Feb 24):

None (n=405)
Low (n=114)
Moderate (n=58)
Severe (n=16)
Fatal (n=10)

*Data will be displayed monthly by SPC when datapoints are sufficient.

Figure Q2.4

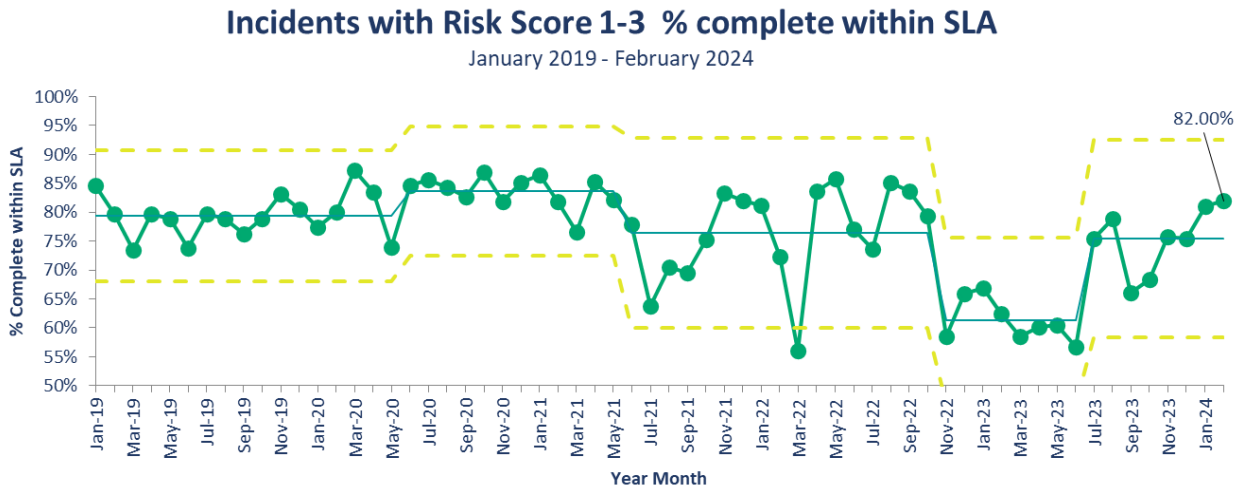


Figure Q2.5

Figure Q2.5

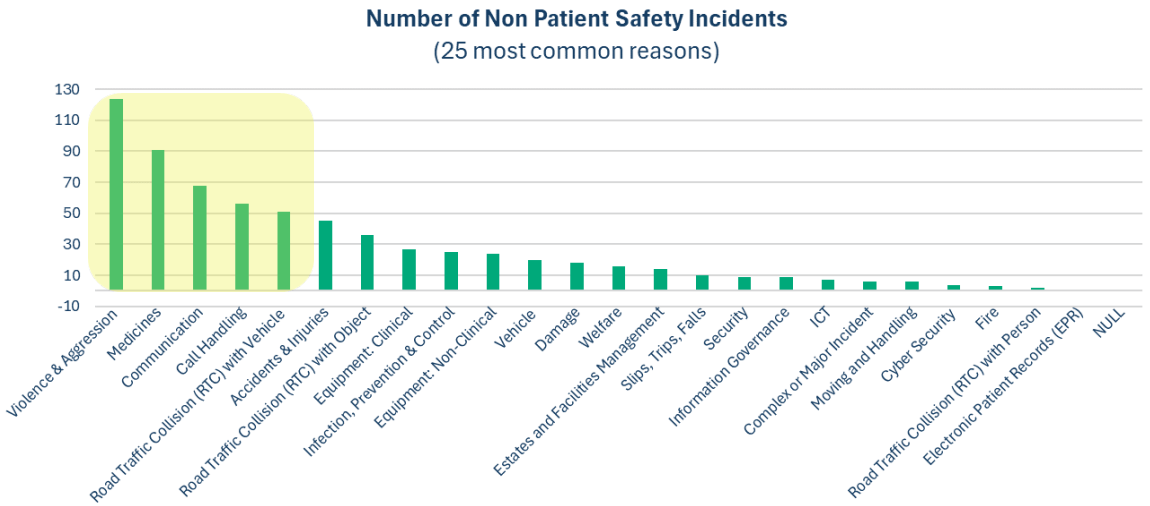
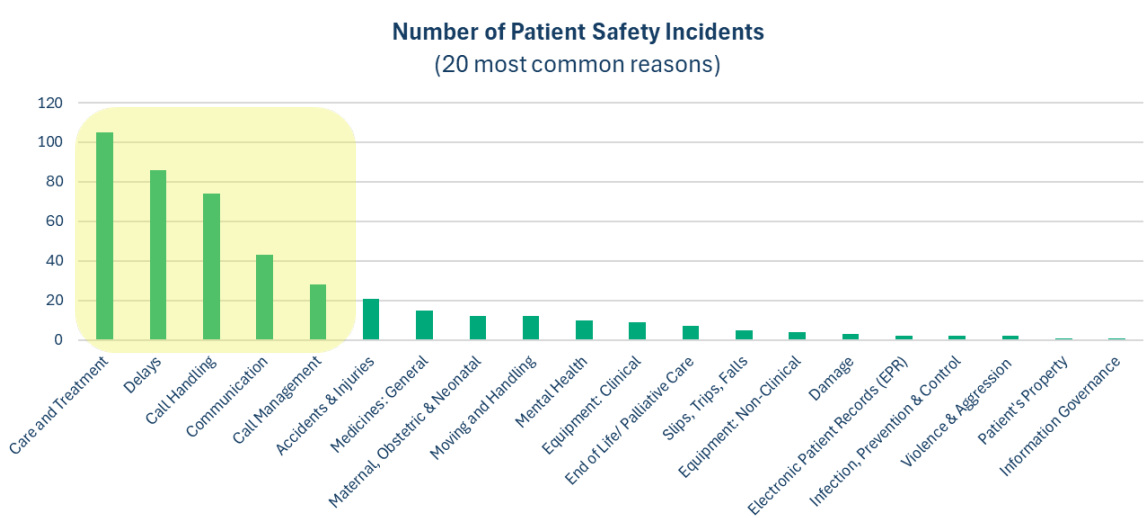


Figure Q2.6

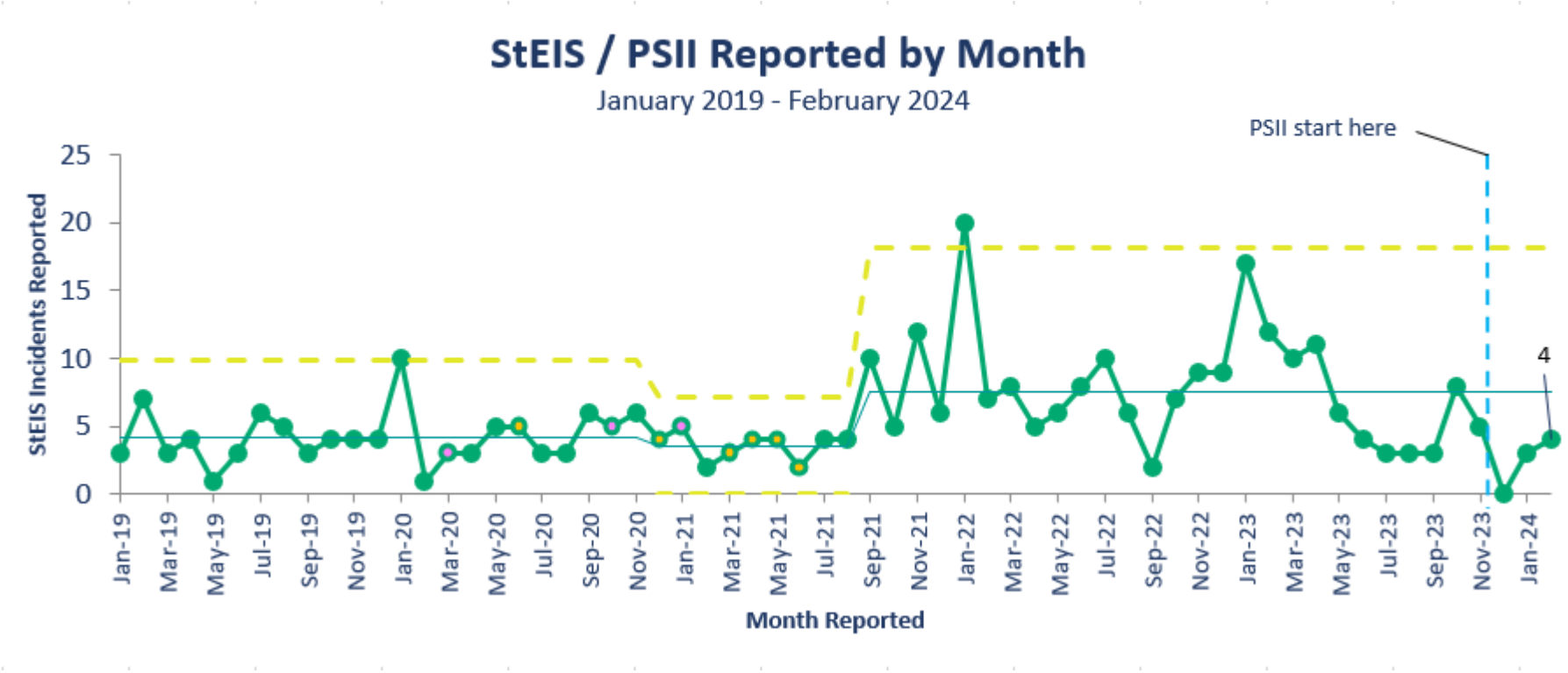


Incident SLA (no exceptions are taken into account):

Risk Score	Target to close from date received (days)
1-2	20
3-4	40
5	60

Q3 Patient Safety Incident Investigations (PSII)

Figure Q3.1



Q5 SAFETY ALERTS

Table Q5.1

Safety Alerts	Alerts Received (Mar 23 – Feb 24)	Alerts Applicable (Mar 23 - Feb 24)	Alerts Open	Notes
CAS Helpdesk Team	1	1	0	CHT/2023/002. Management of national patient safety alerts. Issued 22/3/23. Deadline 11/4/23. NWAS have updated health notifications procedure. **Action Complete.**
Patient Safety Alert: UKHSA	1	0	0	
National Patient Safety Alert: NHS England	1	1	1	NatPSA/2023/014/NHSPS. Identified safety risks with the Euroking maternity information system. Issued 07/12/23 Deadline 07/06/24. Acknowledged and with maternity lead for review.
National Patient Safety Alert: DHSC	7	1	1	NatPSA/2024/003/DHSC_MVA. Shortage in Salbutamol Nebuliser Solution. Bulletin CI1023 gives guidance to clinicians in managing the risk.. Issued 26/2/24. Deadline 8/3/24
National Patient Safety Alert: OHID	1	1	0	NatPSA/2023/003/OHID. Patient synthetic opioids implicated in heroin overdose/deaths. Issued 26/7/23. Deadline 04/08/23. Bulletins issued by Medical Director. **Action Complete**
CMO Messaging	2	0	0	
National Patient Safety Alert: MHRA	5	1	1	NATPSA/2023/010 MHRA. Medical Beds etc, risk of death from entrapment. Issued 31/8/23. Deadline 31/3/24. Reviewed at MDOG, action due to be complete by deadline.
Medicine Alerts: MHRA	50	0	0	The 50 MHRA alerts have been checked to ensure they are not applicable to the trust.
IPC	0	0	0	
National Patient Safety Alert: NHS England Patient Safety	1	0	0	

E1 PATIENT EXPERIENCE

Figure E1.1

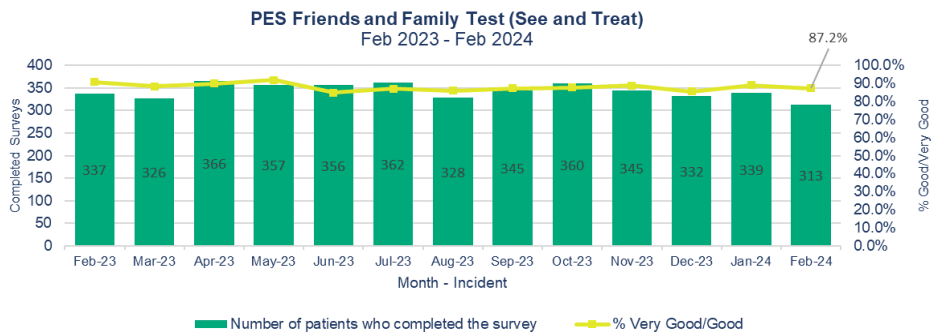
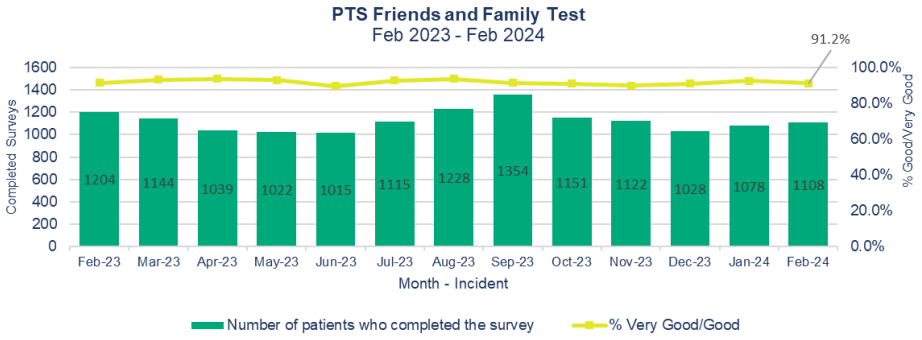


Figure E1.2



PES Positive

- *"I talked, unloaded - they listened. They advised - I learned. I followed their advice in relevant areas and was told to 'never mind them'. They seem to care - made me feel valued. They appeared to believe me - 'some' usually don't. They tested my machines which enabled me to test my other machine etc. Very positive experience."*
- *"The call handler was reassuring and helpful. We received a phone call from a duty doctor to assess the emergency. The paramedic crew were outstanding."*

PES Negative

- *"The old gentleman I had to ring for had fallen over and had a head injury, I was told the ambulance wasn't coming and if it was possible for him to make his own way! He was 94 yrs old with a head injury! After 1.30 an ambulance did turn up even though I was told they were not coming, thankfully he was ok but I do think old people should be at least checked over by a professional at some point."*
- *"My 13yr old daughter took a suspected overdose and wasn't seen by anybody."*

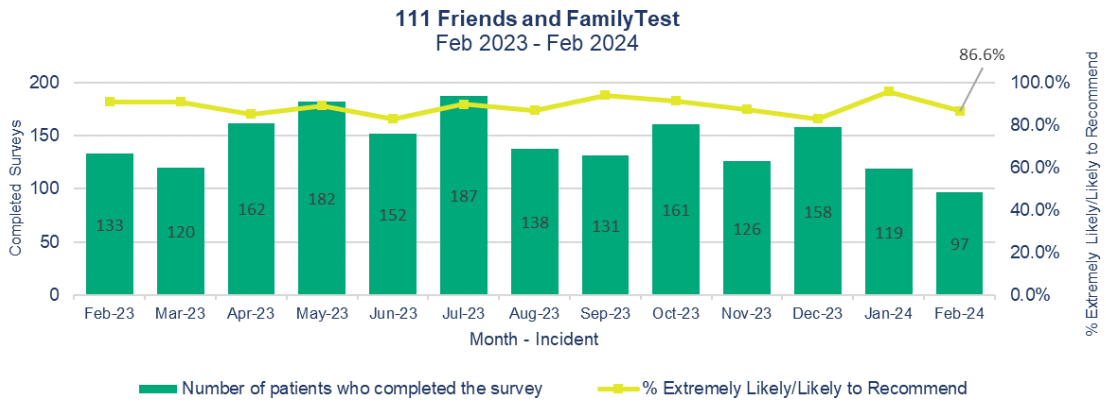
PTS Positive

- *"The crew were cheerful, very caring and helpful and chatted to me on the journey. Arrived in good time for my appointment and didn't wait long for return journey. Useful getting texts that they were en-route both ways. Excellent service."*
- *"Fantastic service. The staff and volunteers are excellent from booking transport to being dropped off at home. My driver, was courteous, and very helpful. Was on time and the car was clean."*
- *Very friendly will do anything to help you nothing is no trouble they make sure you are ok."*

•PTS Negative

- *"I went through a rigorous telephone questioning where I told the gentleman that I needed a wheelchair transport, he asked me if I had my own wheelchair and I told him I did not. 45 minutes before my appt time, a standard saloon taxi arrived which I had to turn away. I then had to spend ages trying to reach my consultant to advise that I couldn't get there. I have been waiting for that appt in order to complete my treatment and get me walking again after not being able to since July. As such I was devastated and am still lacking faith that should I rely on this service in the future that it won't let me down again. It was a careless error to your organisation but has had a very negative impact on me."*

Figure E1.3



NHS 111 Positive

- *"He was very clear, calm and informative. Thank you. He even spoke to my 8-year-old to check she was okay (she was the patient), again - thank you. Rang 111, only waited 15 minutes to get through. After the call, only waited 20 minutes for a Doctor at Wigan Hospital. Attended - seen early - 5 minutes early!"*
- *"The lady realised I was having breathing problems and was instantly alert; told me to go slowly, allowed recovery time after coughing session. She explained everything carefully and checked that I understood. I was advised to use the service and go to out-of-hours clinic which had no appointments for several hours. Cannot praise the service enough. Thank you."*
- *"The person I talked to was calm, asked constructive questions and arranged for an ambulance. We were at the stroke centre in 15 minutes. I can't thank the service enough."*

NHS 111 Negative

- *"It took 13 hours for someone to ring me back, I had a chest infection and then didn't get an appointment until 11am the next day. I rang at 5pm and didn't get a call back till 6:45am."*
- *"Made initial call approx 10:30pm. I was told a doctor would ring in 1-2 hours. 5am called 111 again, told I was top of list and would be called soon. 9am made my own way to urgent care, received a call during journey."*
- *"We were advised to go to a pharmacy the next day (baby had croup). I didn't think they would be able to give us what was needed as I am a health professional myself. Pharmacy called us the next day and confirmed this and booked us an out of hours GP appointment. Also on phone asked about possibility of inhaling a foreign body. When I said 'I don't think so' both times I called, both call handlers marked down as 'no'."*

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

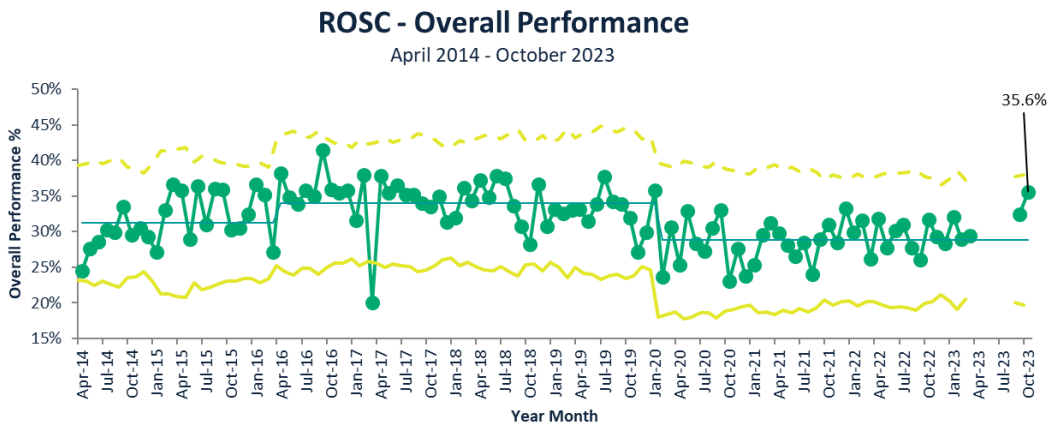


Figure E2.2

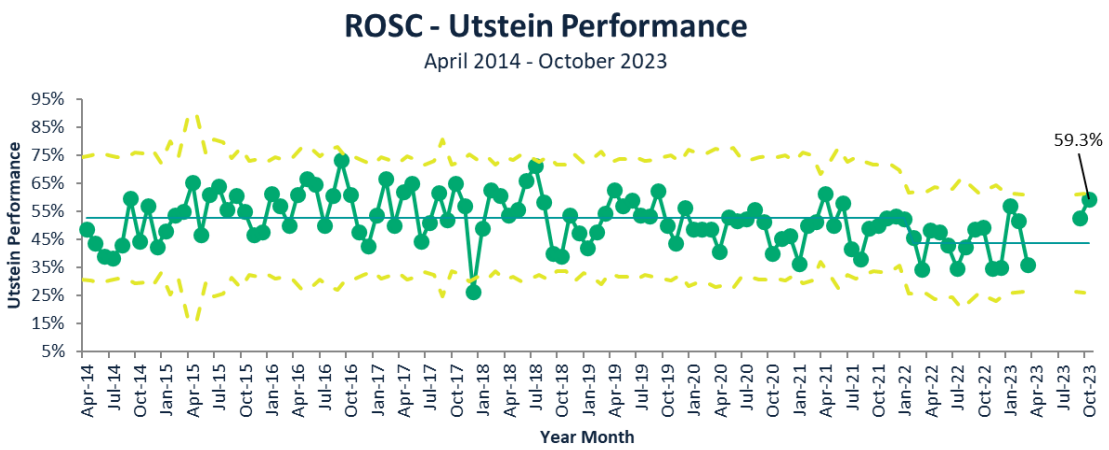


Table E2.3

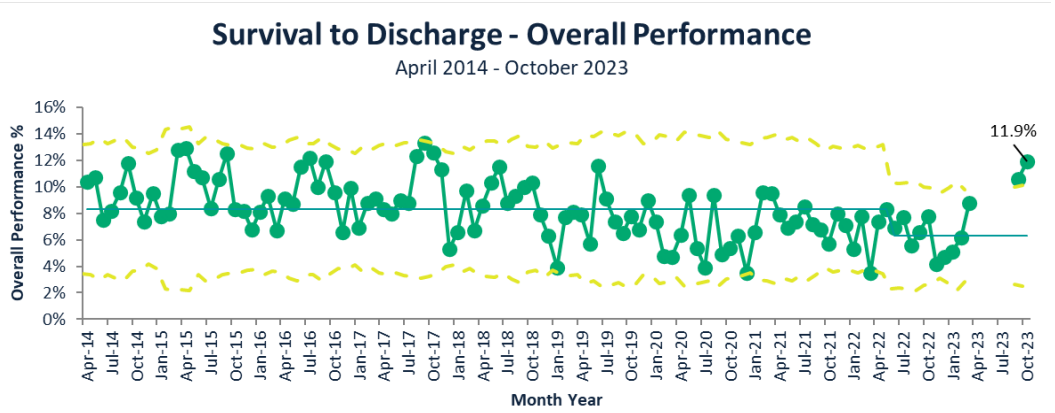


Figure E2.4

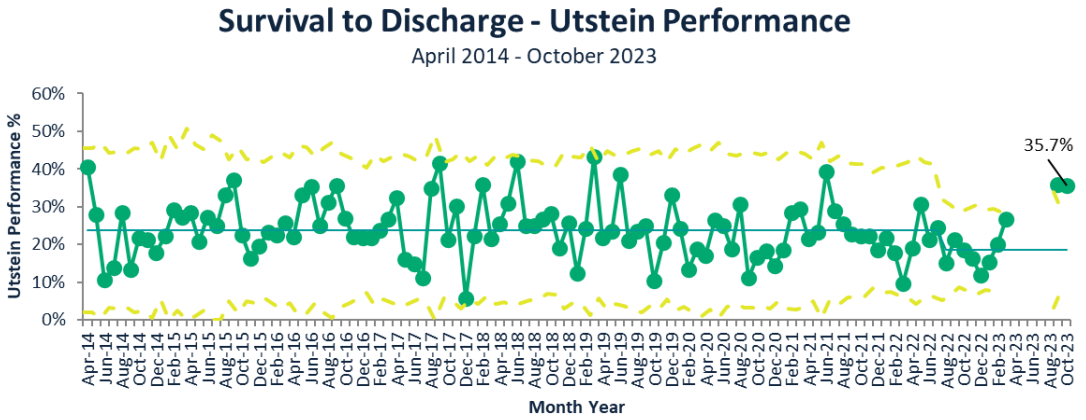


Figure E2.5

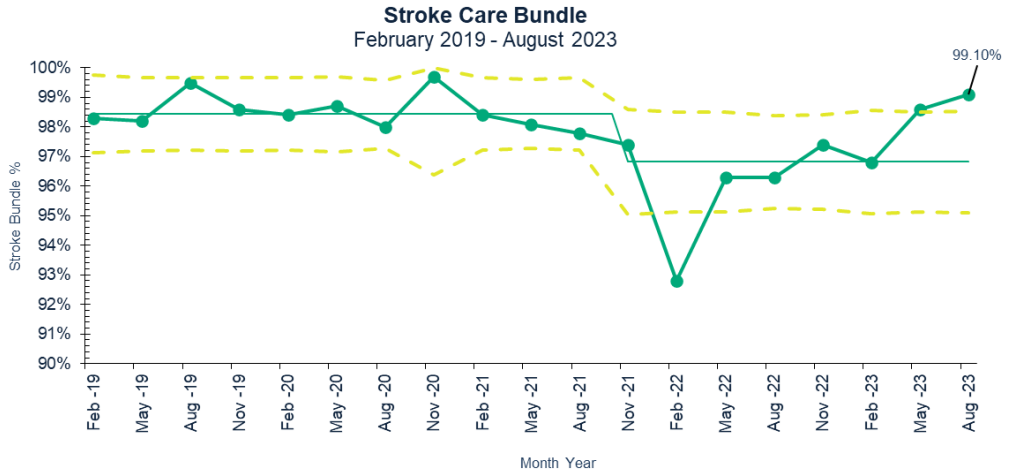


Figure E2.6

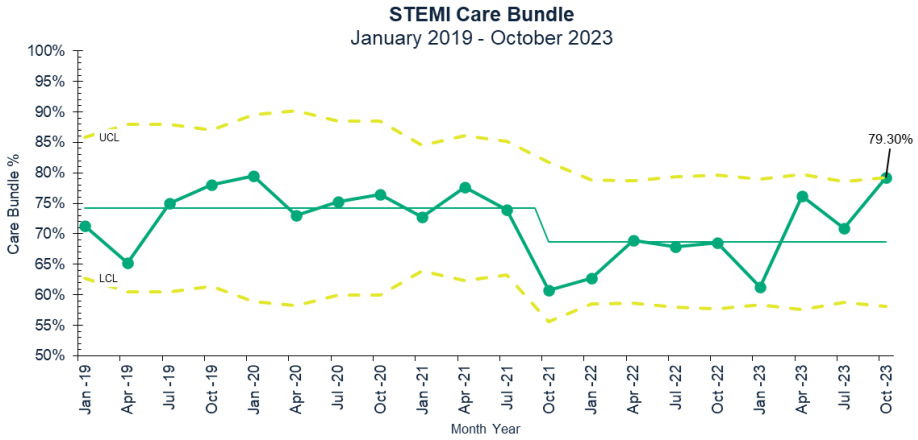


Figure E2.7

Month Year	Stroke Care Bundle Performance
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%
May-23	98.6%
Aug-23	99.1%

Figure E2.8

Month Year	STEMI Care Bundle Performance
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%
Jul-23	70.9%
Oct-23	79.3%

The axis for the Stroke Care Bundle starts at 90%, the axis for STEMI Care Bundle starts at 50%.

E3 ACTIVITY & OUTCOMES

Figure E3.1

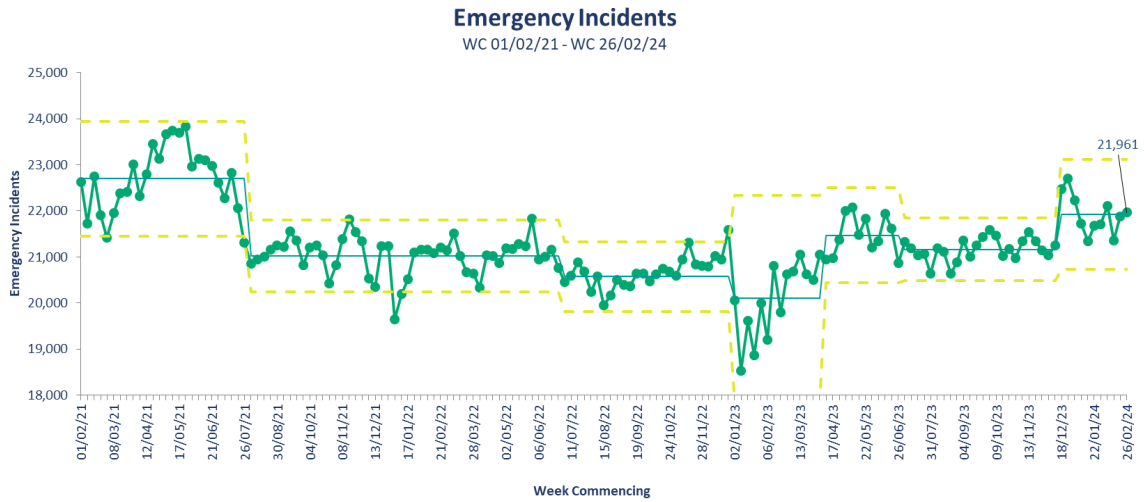


Figure E3.2

Figure E3.3

Sector	No. of Emergency Incidents
M North	9,609
G South	9,462
G Central	9,451
G West	8,650
G East	8,509
M East	7,421
CL East Lancashire	6,991
M West	6,087
CL South Lancashire	5,766
M South	5,393
CL Fylde	4,834
CL North Cumbria	4,288
CL Morecambe Bay	3,891

ICB	No. of Emergency Incidents
Greater Manchester	35,678
Cheshire & Merseyside	28,521
Lancashire & South Cumbria	21,492
North East & North Cumbria	4,291

Figure E3.4

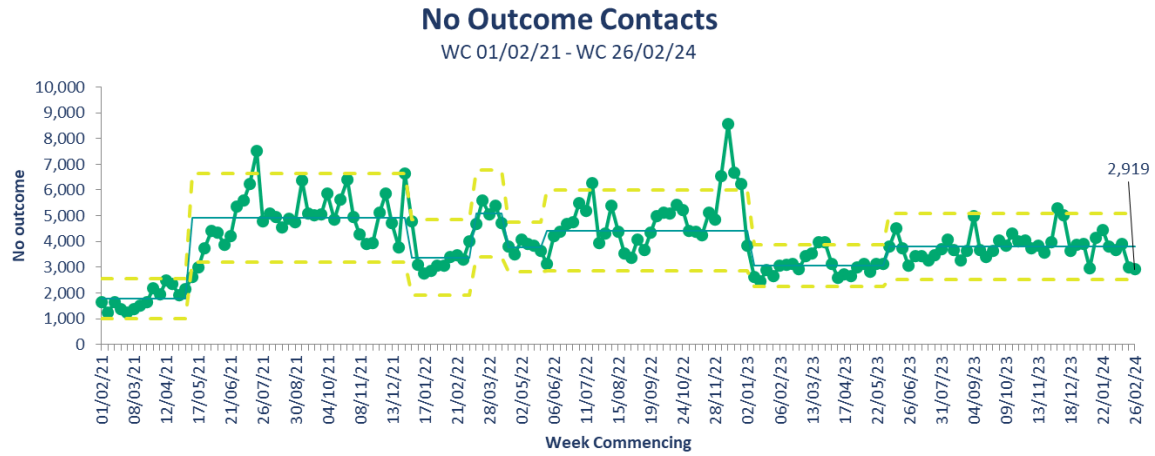


Figure E3.5

Feb	Calls	% Change from previous year	Incidents	% Change from previous year
2021	90,436		88,997	
2022	110,736	22%	84,651	-5%
2023	97,181	-12%	79,935	-6%
2024	116,879	20%	90,442	13%

Figure E3.6

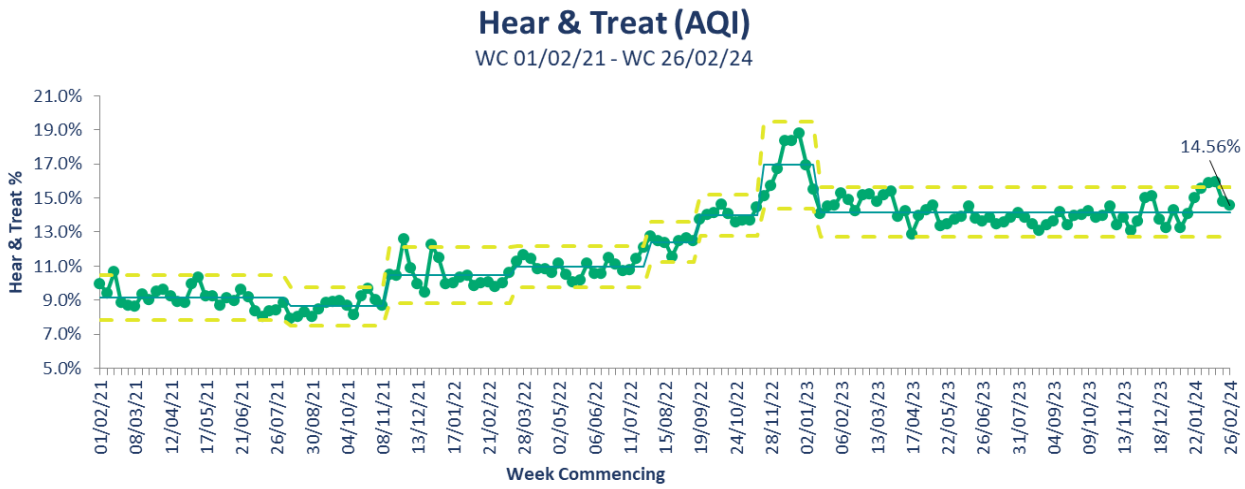


Figure E3.7

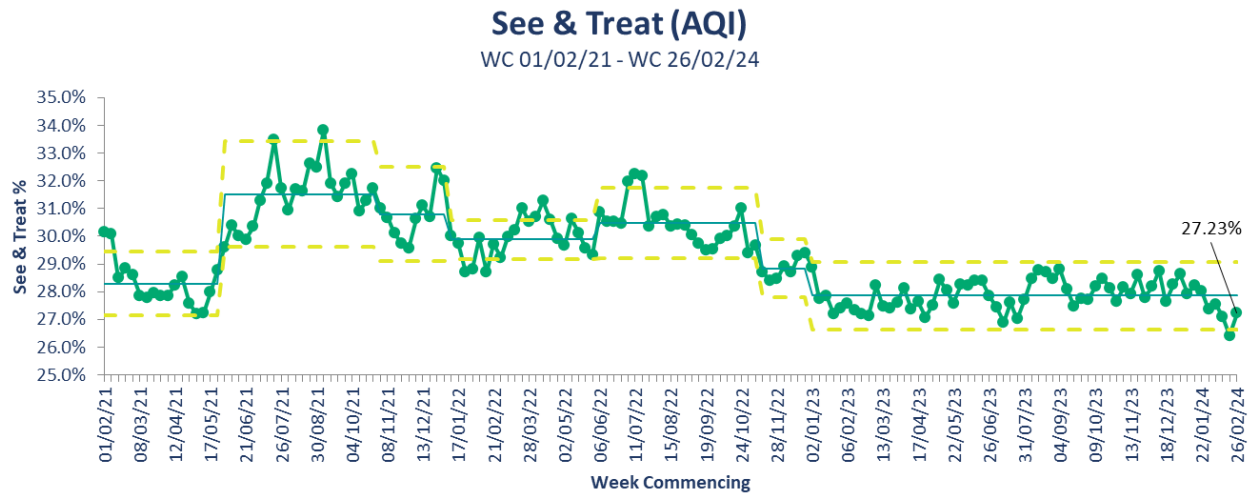


Figure E3.8

Sector	Monthly Hear & Treat	%
G East		17.04%
G Central		16.97%
CL Fylde		16.49%
M East		16.16%
M North		15.90%
M South		15.61%
G West		15.38%
CL South Lancashire		15.12%
M West		14.90%
CL East Lancashire		14.56%
G South		14.00%
CL Morecambe Bay		12.10%
CL North Cumbria		11.40%

ICB	Monthly Hear & Treat	%
Greater Manchester		15.89%
Cheshire & Merseyside		15.69%
Lancashire & South Cumbria		14.70%
North East & North Cumbria		11.40%

Figure E3.9

Sector	Monthly See & Treat	%
M South		30.67%
CL North Cumbria		30.01%
CL Morecambe Bay		29.48%
CL Fylde		29.23%
CL East Lancashire		28.54%
G West		28.12%
CL South Lancashire		27.77%
G Central		27.16%
G East		26.51%
G South		26.44%
M West		26.12%
M North		25.59%
M East		22.26%

ICB	Monthly See & Treat	%
North East & North Cumbria		30.02%
Lancashire & South Cumbria		28.65%
Greater Manchester		27.07%
Cheshire & Merseyside		25.80%

Figure E3.10

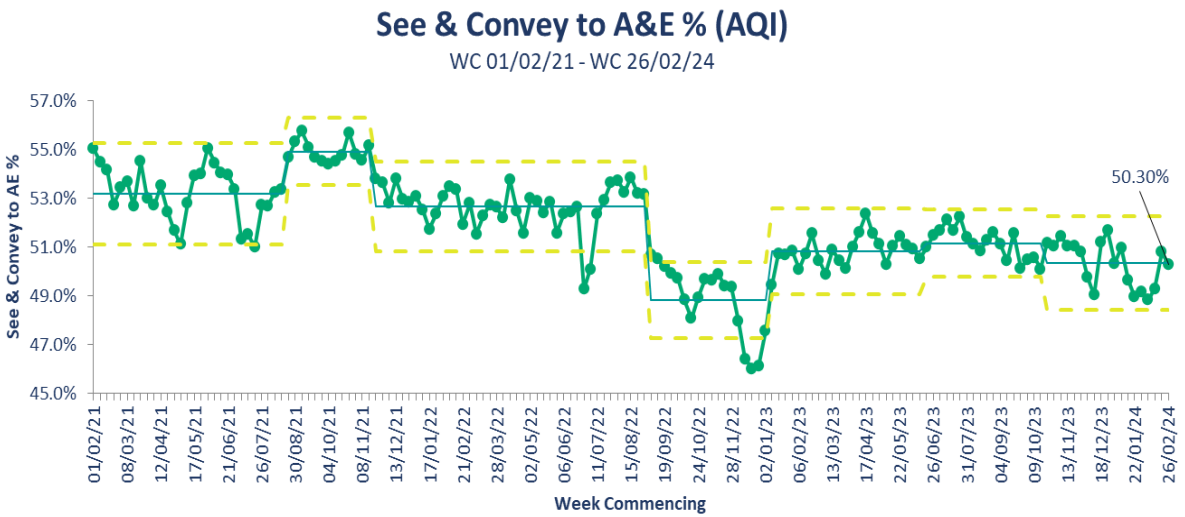


Figure E3.11

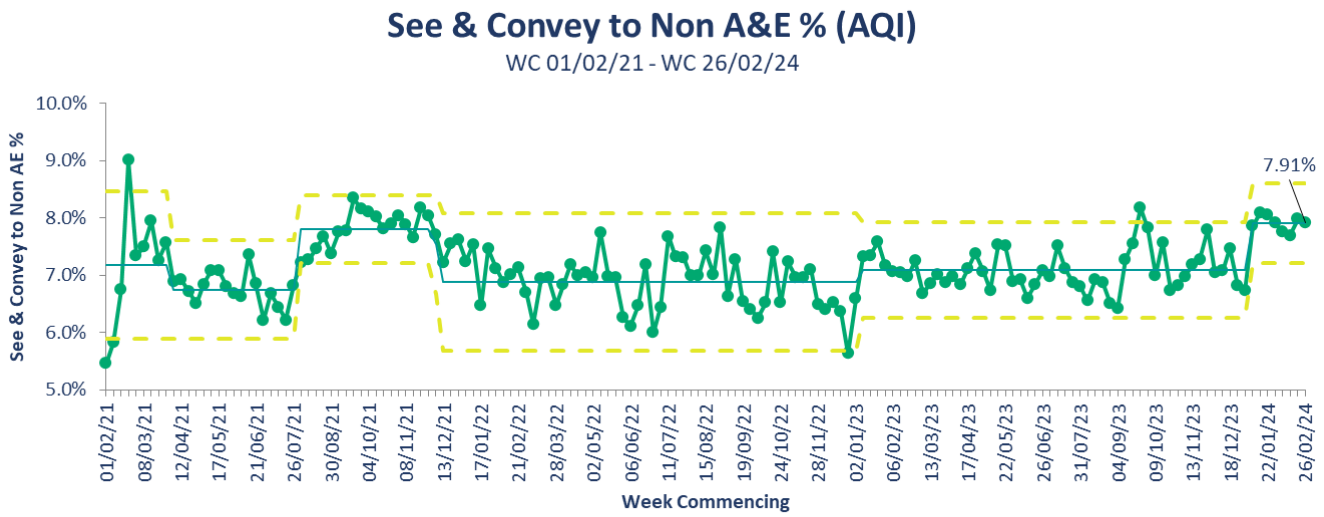


Figure E3.12

Sector	Monthly See & Convey	%
M South		53.72%
CL Fylde		54.28%
G Central		55.87%
G East		56.45%
G West		56.51%
CL East Lancashire		56.90%
CL South Lancashire		57.11%
CL Morecambe Bay		58.42%
M North		58.51%
CL North Cumbria		58.58%
M West		58.98%
G South		59.55%
M East		61.58%

ICB	Monthly See & Convey	%
Lancashire & South Cumbria		56.65%
Greater Manchester		57.05%
Cheshire & Merseyside		58.50%
North East & North Cumbria		58.59%

Figure E3.13

Sector	Monthly See & Convey to AE	%
CL East Lancashire		43.84%
M South		46.50%
CL South Lancashire		47.28%
CL Fylde		47.46%
G West		48.21%
CL North Cumbria		49.02%
G East		49.25%
G Central		49.49%
M West		49.70%
M North		50.75%
M East		53.74%
CL Morecambe Bay		53.92%
G South		54.38%

ICB	Monthly See & Convey to AE	%
Lancashire & South Cumbria		47.41%
North East & North Cumbria		48.96%
Greater Manchester		50.30%
Cheshire & Merseyside		50.50%

Figure E3.14

Sector	Monthly See & Convey to Non AE	%
CL Morecambe Bay		4.50%
G South		5.18%
G Central		6.38%
CL Fylde		6.83%
G East		7.19%
M South		7.21%
M North		7.75%
M East		7.84%
G West		8.30%
M West		9.28%
CL North Cumbria		9.56%
CL South Lancashire		9.83%
CL East Lancashire		13.06%

ICB	Monthly See & Convey to Non AE	%
Greater Manchester		6.74%
Cheshire & Merseyside		8.00%
Lancashire & South Cumbria		9.24%
North East & North Cumbria		9.62%

Figure E3.15

Rank	Trust	Hear & Treat	%
1	London		16.4%
2	East Midlands		16.0%
3	West Midlands		15.7%
4	North West		15.3%
5	South Western		15.3%
6	Yorkshire		14.1%
7	South East Coast		13.6%
8	South Central		12.0%
9	East of England		10.4%
10	North East		8.0%
11	Isle of Wight		7.2%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		36.4%
2	East of England		33.8%
3	South Central		33.8%
4	Isle of Wight		33.2%
5	South East Coast		30.9%
6	East Midlands		30.8%
7	North East		29.9%
8	West Midlands		29.4%
9	London		28.5%
10	North West		27.2%
11	Yorkshire		25.7%

Figure E3.17

Rank	Trust	See & Convey	%
1	South Western		48.3%
2	East Midlands		53.2%
3	South Central		54.1%
4	West Midlands		54.9%
5	London		55.1%
6	South East Coast		55.5%
7	East of England		55.8%
8	North West		57.5%
9	Isle of Wight		59.6%
10	Yorkshire		60.1%
11	North East		62.0%

Operational

O1 CALL PICK UP

Figure O1.1

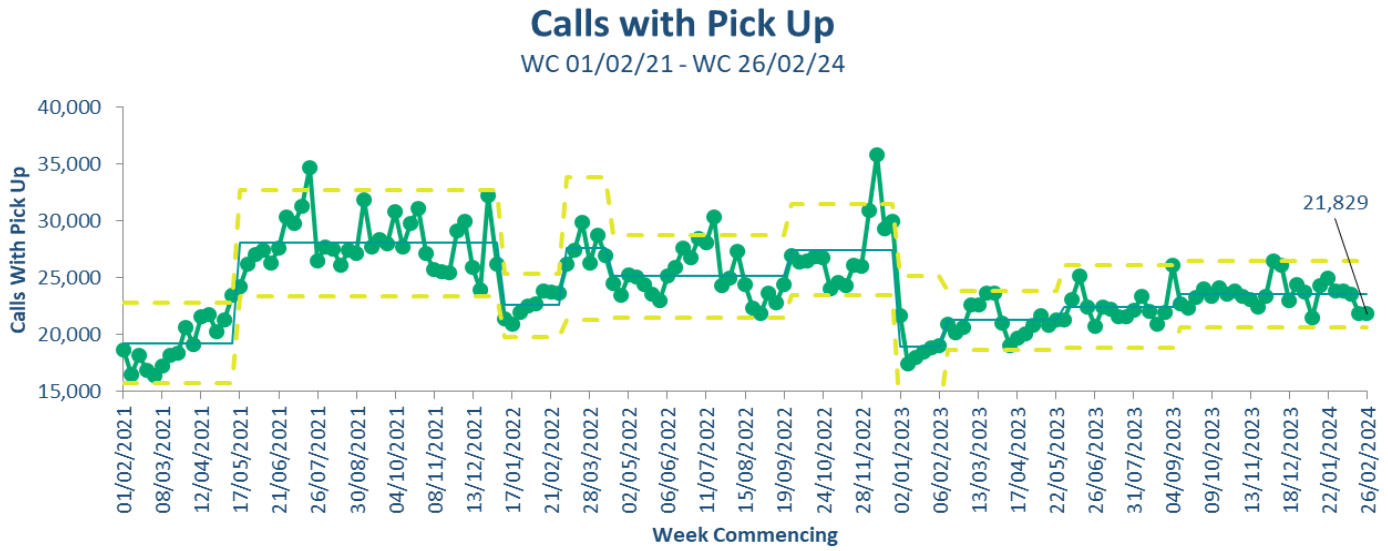
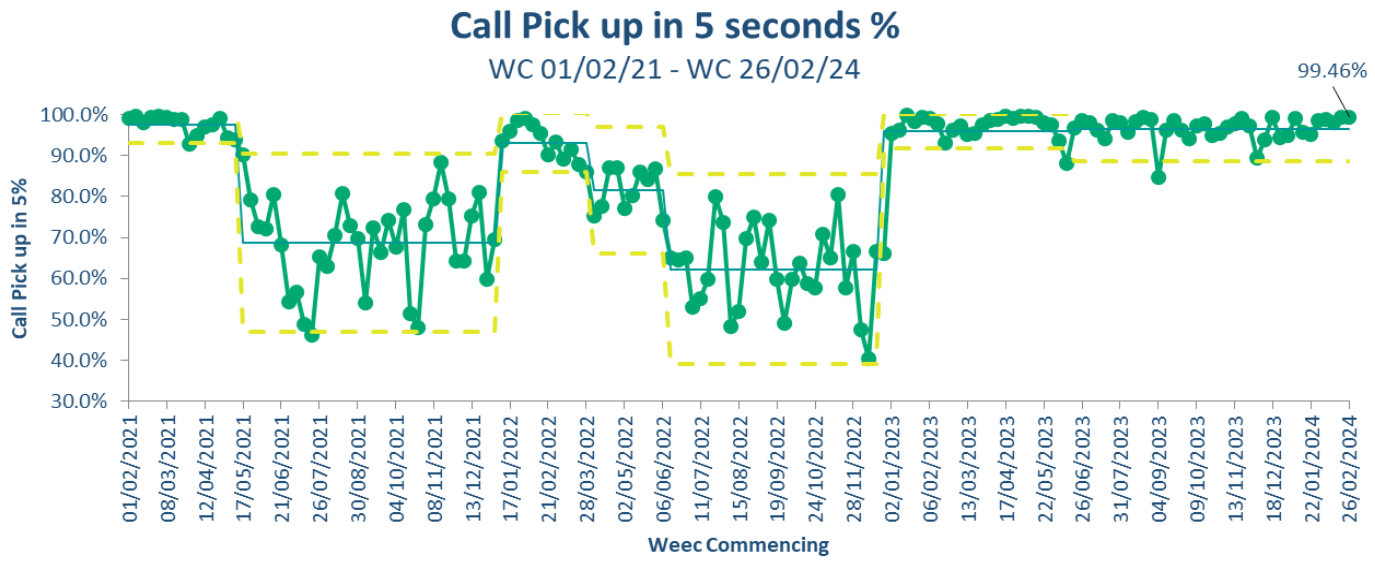


Figure O1.2



O2 A&E TURNAROUND

Figure O2.1

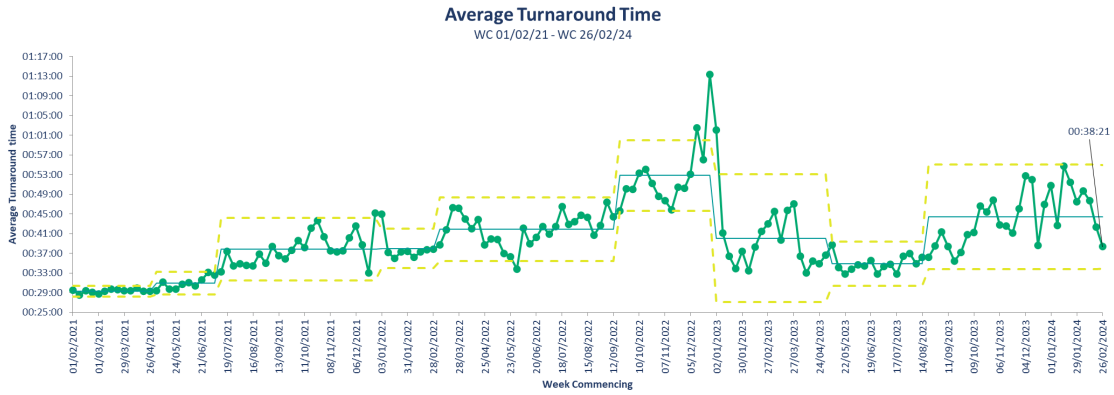


Figure O2.2

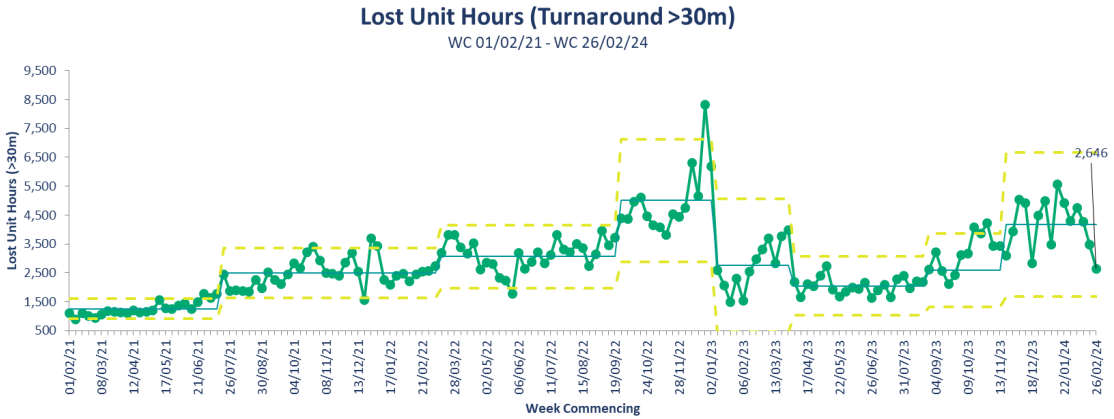


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
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
Sep-23	46,282	0:37:56	0:26:05	11:24
Oct-23	47,585	0:43:51	0:32:40	11:28
Nov-23	46,594	0:43:32	0:31:28	11:03
Dec-23	48,733	0:47:03	0:35:21	11:06
Jan-24	47,951	0:50:04	0:38:36	11:14
Feb-24	44,937	0:45:10	0:34:40	10:31

Table O2.2

Top 5 Trusts with most lost unit hours		
Trust	**Area**	**Lost Unit Hours**
Whiston Hospital	Cheshire & Merseyside	1,564
Aintree University Hospital	Cheshire & Merseyside	1,352
Arrowe Park Hospital	Cheshire & Merseyside	1,243
Royal Liverpool University Hospital	Cheshire & Merseyside	1,077
Blackpool Victoria Hospital	Cumbria & Lancashire	1,039

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	943
Sep-23	1004
Oct-23	1746
Nov-23	1414
Dec-23	2121
Jan-24	2397
Feb-24	1946

O3 ARP RESPONSE TIMES

February 2024

Figure O3.1

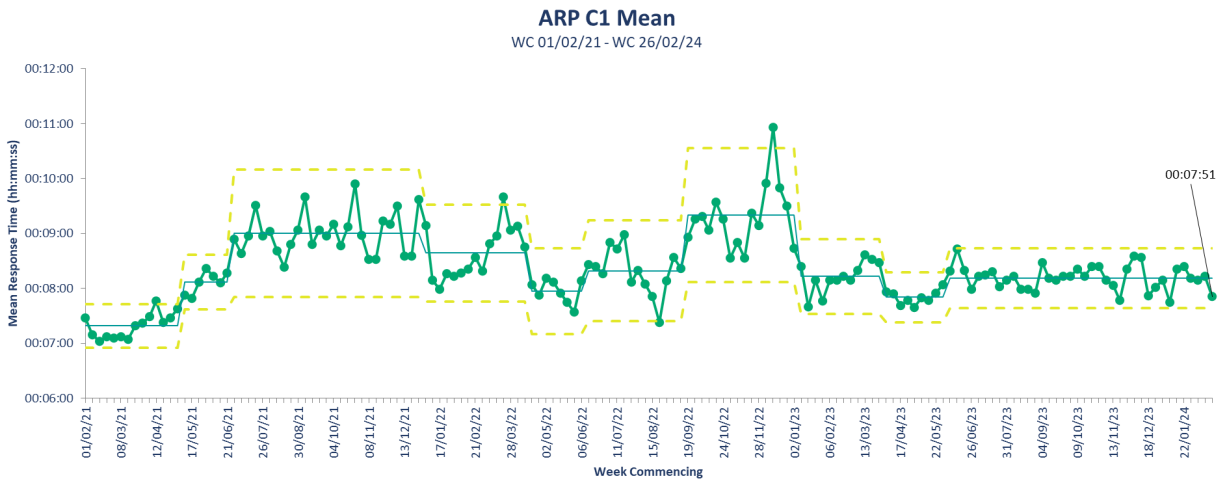


Figure O3.2

Figure O3.3

Sector	C1 Mean	Time
G Central		00:07:05
G South		00:07:11
M North		00:07:17
G West		00:07:27
G East		00:07:41
CL Fylde		00:07:42
M East		00:08:34
CL East Lancashire		00:08:43
CL Morecambe Bay		00:08:43
CL South Lancashire		00:08:58
M West		00:09:01
CL North Cumbria		00:09:16
M South		00:09:52

ICB	C1 Mean	Time
Greater Manchester		00:07:17
Cheshire & Merseyside		00:08:24
Lancashire & South Cumbria		00:08:34
North East & North Cumbria		00:09:16

Figure O3.4

C1 Mean	
Target	7:00
Feb 2024	8:03
YTD	8:08
Ranking	3rd

Figure O3.5

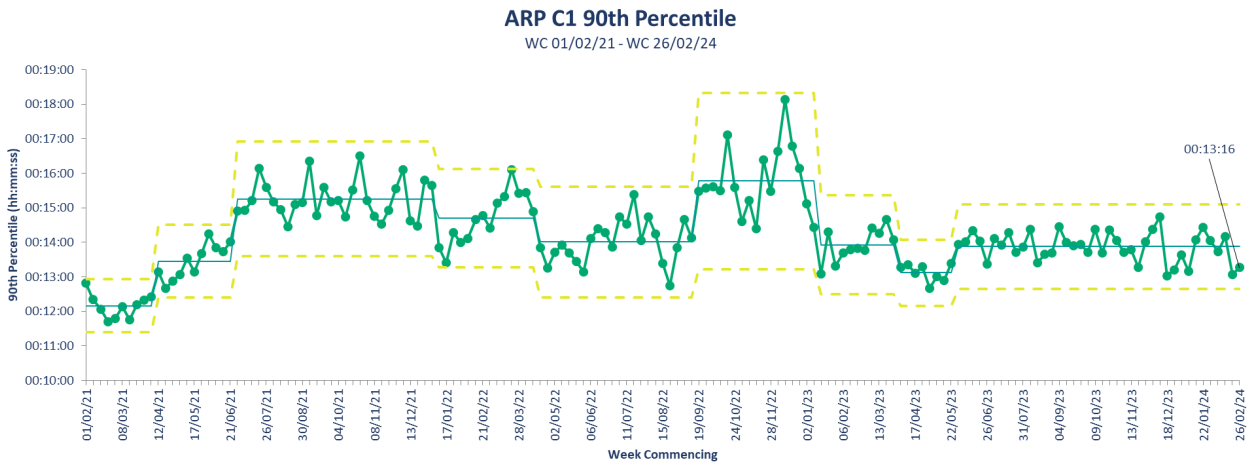


Figure O3.6

Figure O3.7

Sector	C1 90th	Time
G West		00:11:40
M North		00:12:00
G South		00:12:00
G Central		00:12:11
G East		00:12:23
CL Fylde		00:14:15
M East		00:14:33
CL South Lancashire		00:14:43
CL East Lancashire		00:15:01
M West		00:15:39
CL Morecambe Bay		00:15:53
CL North Cumbria		00:16:27
M South		00:17:09

ICB	C1 90th	Time
Greater Manchester		00:12:00
Cheshire & Merseyside		00:14:24
Lancashire & South Cumbria		00:14:58
North East & North Cumbria		00:16:27

Figure O3.8

C1 90th	
Target	15:00
Feb 2024	13:40
YTD	13:47
Ranking	3rd

February 2024

Figure O3.9

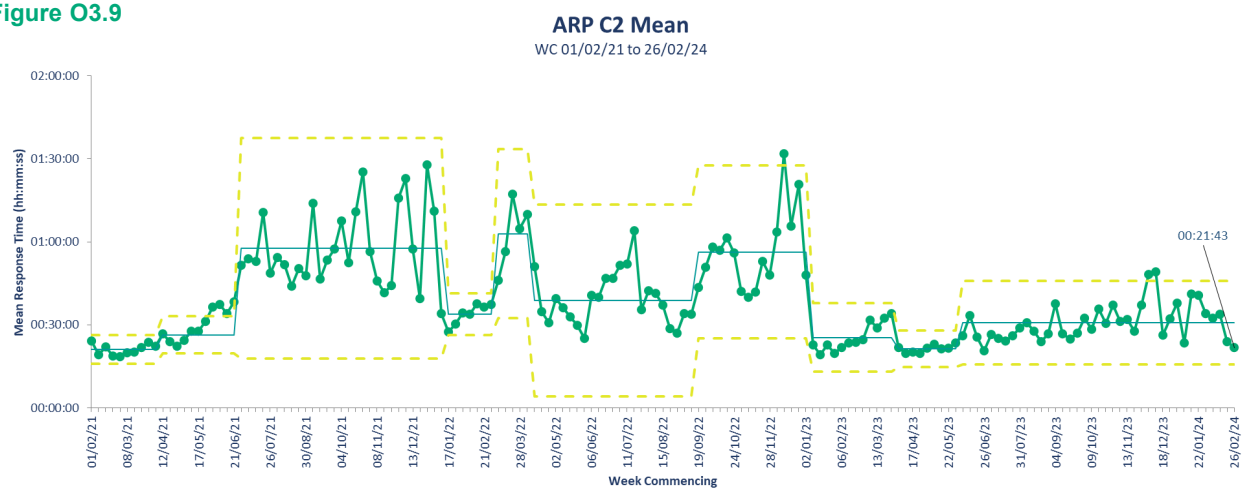


Figure O3.10

Figure O3.11

Sector	C2 Mean	Time
CL North Cumbria		00:19:36
G South		00:21:07
G Central		00:22:41
CL Morecambe Bay		00:23:36
G East		00:24:04
CL East Lancashire		00:24:23
CL Fylde		00:25:16
G West		00:27:54
M South		00:30:03
CL South Lancashire		00:30:36
M West		00:40:18
M North		00:42:00
M East		00:42:15

ICB	C2 Mean	Time
North East & North Cumbria		00:19:35
Greater Manchester		00:23:49
Lancashire & South Cumbria		00:26:04
Cheshire & Merseyside		00:39:29

Figure O3.12

C2 Mean	
Target	18:00
Feb 2024	28:59
YTD	28:08
Ranking	3rd

Figure O3.13

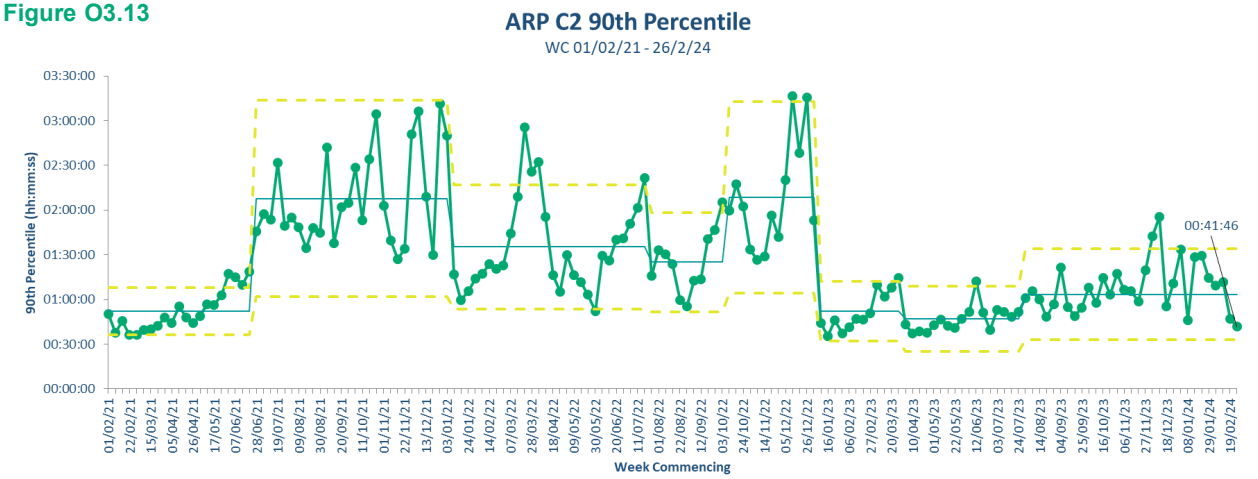


Figure O3.14

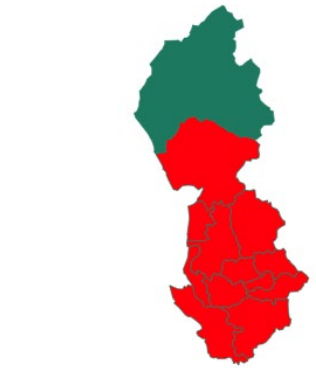


Figure O3.15

Sector	C2 90th	Time
CL North Cumbria		00:37:40
G South		00:41:16
G Central		00:44:24
G East		00:47:09
CL East Lancashire		00:48:02
CL Morecambe Bay		00:48:04
CL Fylde		00:53:52
G West		00:54:34
CL South Lancashire		01:00:32
M South		01:01:52
M West		01:27:12
M North		01:29:50
M East		01:30:27

ICB	C2 90th	Time
North East & North Cumbria		00:37:38
Greater Manchester		00:47:09
Lancashire & South Cumbria		00:52:51
Cheshire & Merseyside		01:24:57

Figure O3.16

C2 90th	
Target	40:00
Feb 2024	01:00:36
YTD	01:01:44
Ranking	3rd

February 2024

Figure O3.17

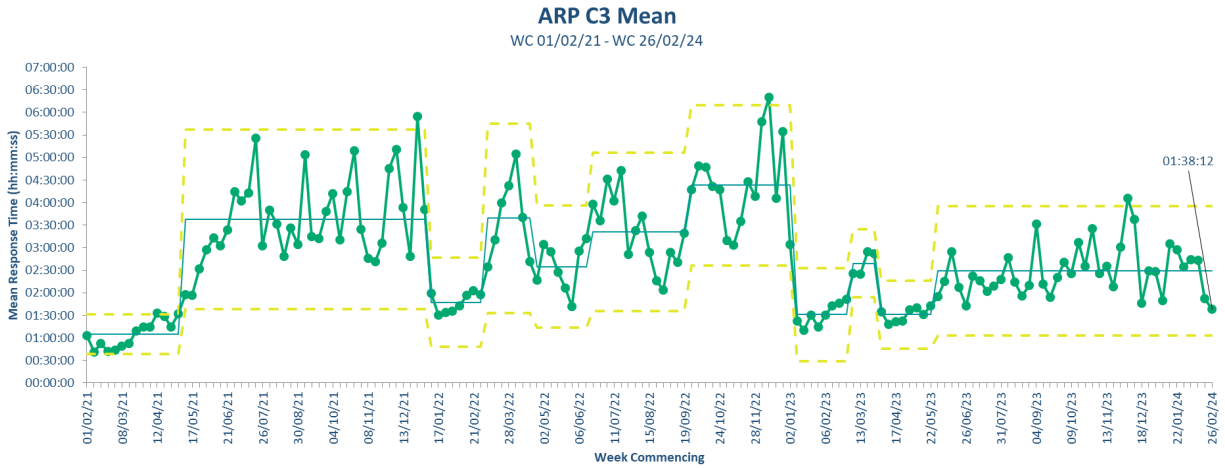


Figure O3.18

Figure O3.19

Sector	C3 Mean	Time
CL North Cumbria		01:05:36
CL Morecambe Bay		01:17:16
M South		01:47:19
CL Fylde		01:48:21
CL East Lancashire		01:57:33
CL South Lancashire		02:04:56
G South		02:06:23
G East		02:28:12
M West		02:32:31
G Central		02:34:48
M East		02:48:52
G West		02:50:08
M North		02:53:04

ICB	C3 Mean	Time
North East & North Cumbria		01:05:33
Lancashire & South Cumbria		01:49:39
Greater Manchester		02:29:57
Cheshire & Merseyside		02:34:02

Figure O3.20

C3 Mean	
Target	1:00:00
Feb 2024	2:17:22
YTD	2:16:43
Ranking	8th

Figure O3.21

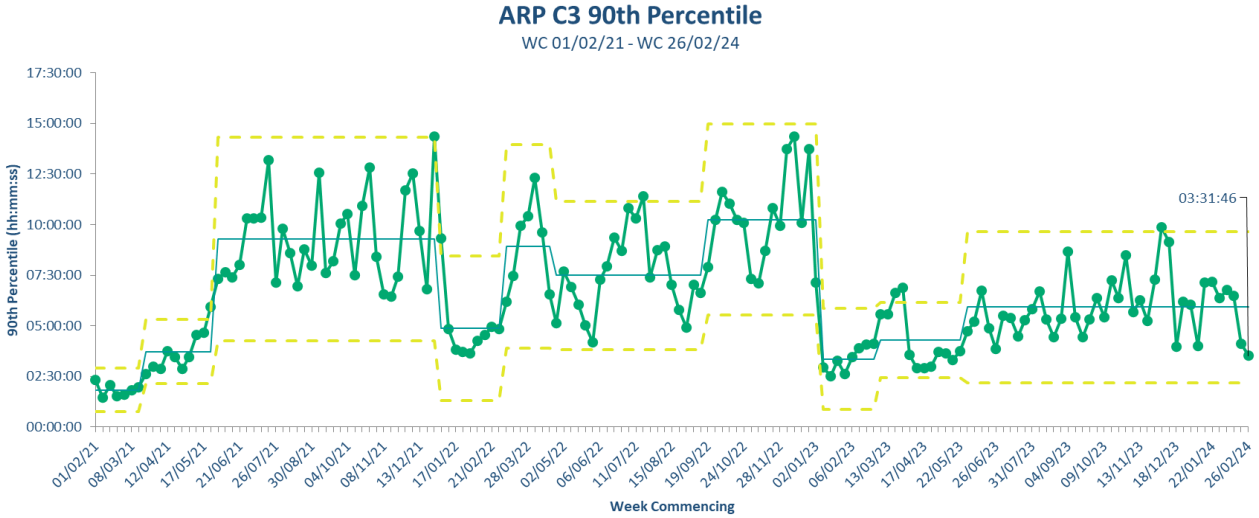


Figure O3.22

Figure O3.23

Sector	C3 90th	Time
CL North Cumbria		02:19:59
CL Morecambe Bay		02:46:34
M South		03:45:01
CL Fylde		03:59:27
CL East Lancashire		04:27:52
CL South Lancashire		04:33:32
G South		04:40:20
G East		05:25:04
G Central		05:40:32
M West		06:10:20
G West		06:25:58
M East		07:04:28
M North		07:18:23

ICB	C3 90th	Time
North East & North Cumbria		02:20:02
Lancashire & South Cumbria		04:03:38
Greater Manchester		05:39:12
Cheshire & Merseyside		06:12:39

Figure O3.24

C3 90th	
Target	2:00:00
Feb 2024	5:13:57
YTD	5:24:13
Ranking	8th

February 2024

Figure O3.25

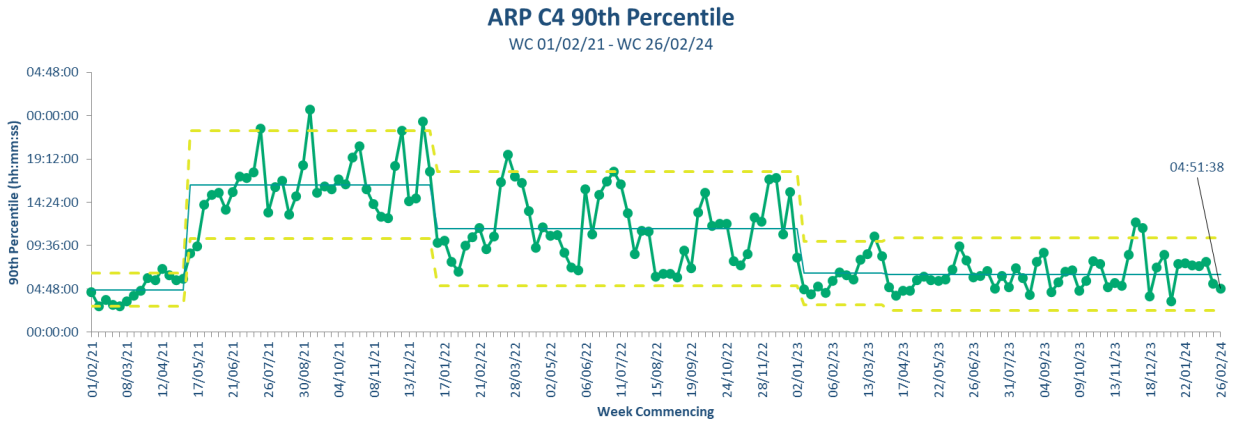


Figure O3.26

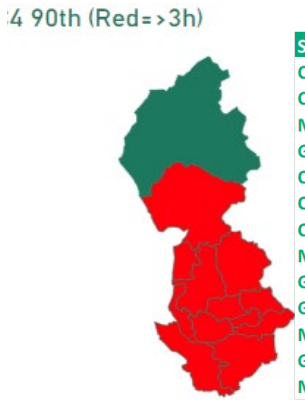


Figure O3.27

Sector	C4 90th	Time
CL North Cumbria		02:40:41
CL Morecambe Bay		04:13:10
M South		04:29:40
G Central		04:56:43
CL East Lancashire		05:06:48
CL South Lancashire		05:11:52
CL Fylde		05:35:26
M West		06:44:09
G South		08:00:29
G East		08:05:25
M North		09:00:19
G West		09:22:53
M East		12:20:38

ICB	C4 90th	Time
North East & North Cumbria		02:40:41
Lancashire & South Cumbria		05:06:25
Greater Manchester		07:29:40
Cheshire & Merseyside		07:35:17

Figure O3.28

C4 90th	
Target	3:00:00
Feb 2024	6:08:31
YTD	6:04:30
Ranking	7th

O3 ARP Provider Comparison

Figure O3.25

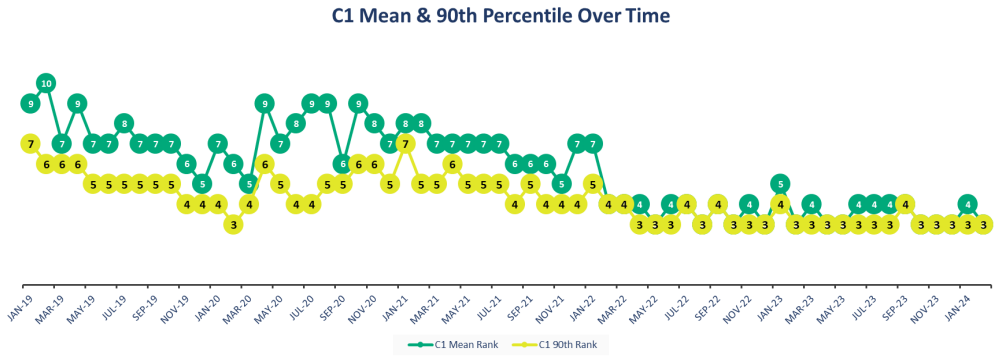


Figure O3.26

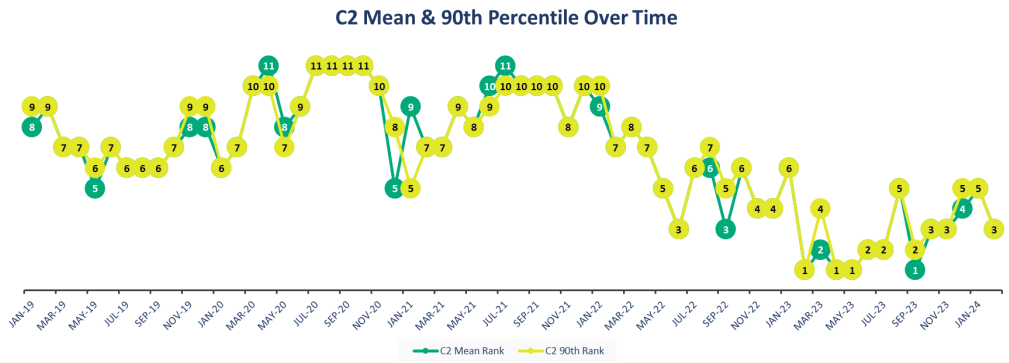


Figure O3.27

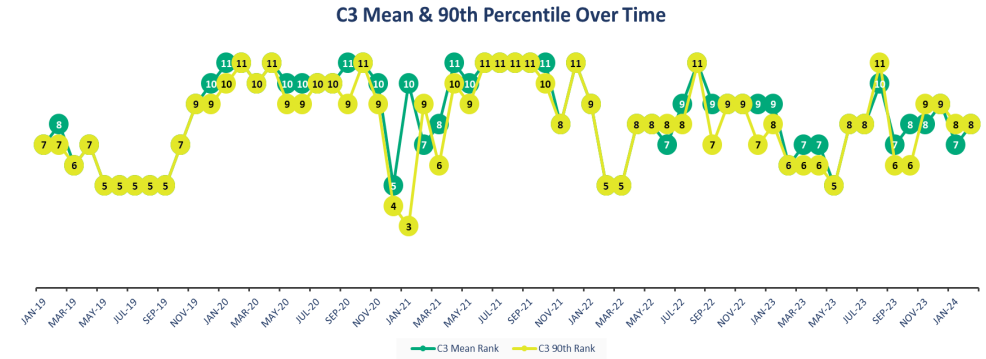
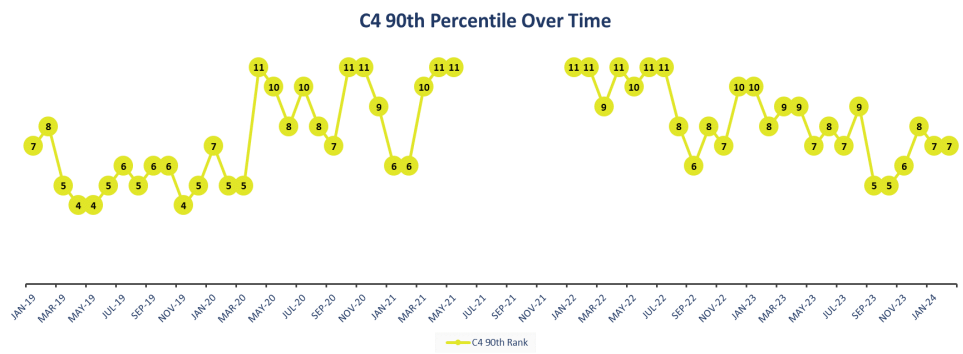


Figure O3.28



Rank	Trust	C1 Mean	Time
1	North East		06:59
2	London		07:21
3	North West		08:04
4	Yorkshire		08:06
5	West Midlands		08:14
6	South East Coast		08:19
7	South Central		08:41
8	East Midlands		09:13
9	East of England		09:23
10	South Western		09:46
11	Isle of Wight		10:02

Rank	Trust	C1 90th	Time
1	North East		12:04
2	London		12:25
3	North West		13:40
4	Yorkshire		14:00
5	West Midlands		14:41
6	South East Coast		15:01
7	South Central		15:37
8	East Midlands		16:20
9	East of England		17:38
10	Isle of Wight		18:03
11	South Western		18:13

Rank	Trust	C2 Mean	Time
1	Isle of Wight		0:25:16
2	South East Coast		0:25:49
3	North West		0:29:00
4	Yorkshire		0:30:20
5	South Central		0:31:48
6	North East		0:33:31
7	West Midlands		0:36:07
8	London		0:37:01
9	South Western		0:43:04
10	East of England		0:45:03
11	East Midlands		0:49:36

Rank	Trust	C2 90th	Time
1	South East Coast		0:51:38
2	Isle of Wight		0:52:21
3	North West		1:00:36
4	South Central		1:01:43
5	North East		1:07:43
6	Yorkshire		1:08:00
7	West Midlands		1:20:10
8	London		1:22:25
9	South Western		1:30:34
10	East of England		1:38:19
11	East Midlands		1:45:38

Rank	Trust	C3 Mean	Time
1	London		01:11:37
2	Isle of Wight		01:15:51
3	North East		01:26:25
4	Yorkshire		01:38:49
5	South Western		01:47:46
6	South East Coast		01:50:54
7	East of England		02:15:09
8	North West		02:17:22
9	South Central		02:30:06
10	West Midlands		02:47:47
11	East Midlands		03:04:34

Rank	Trust	C3 90th	Time
1	London		02:54:14
2	Isle of Wight		02:59:34
3	North East		03:16:11
4	Yorkshire		03:41:22
5	South East Coast		03:58:45
6	South Western		04:30:57
7	East of England		05:09:33
8	North West		05:13:57
9	South Central		05:49:27
10	West Midlands		07:03:44
11	East Midlands		07:14:36

Rank	Trust	C4 90th	Time
1	North East		03:46:39
2	London		03:57:05
3	South East Coast		04:27:52
4	Yorkshire		04:28:17
5	Isle of Wight		04:56:58
6	South Western		05:04:37
7	North West		06:05:17
8	East Midlands		06:45:36
9	West Midlands		07:30:28
10	South Central		07:45:46
11	East of England		09:52:04

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
Sep-23	713
Oct-23	761
Nov-23	665
Dec-23	785
Jan-24	748
Feb-24	641

Figure O3.29

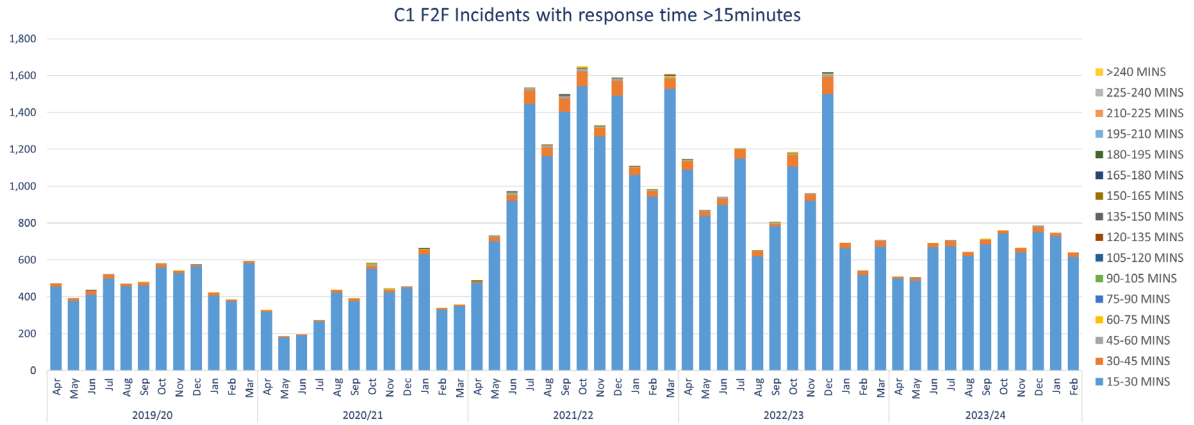


Figure O3.30

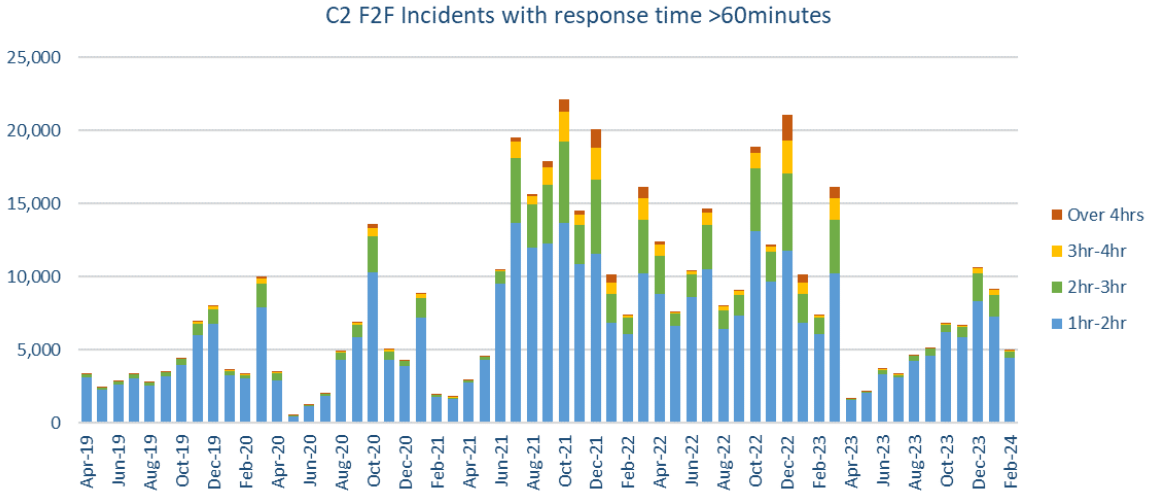
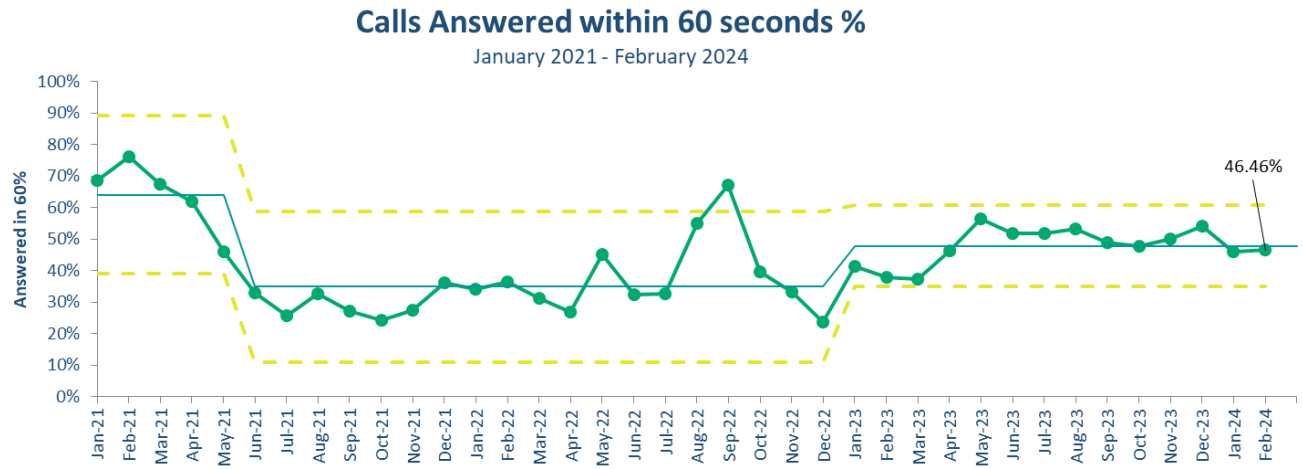


Table O3.30

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	10,127
Feb-23	7,349
Mar-23	16,135
Apr-23	1,650
May-23	2,142
Jun-23	3,670
Jul-23	3,294
Aug-23	4,614
Sep-23	5,089
Oct-23	6,758
Nov-23	6,611
Dec-23	10,636
Jan-24	9,113
Feb-24	4,975

O4 111 PERFORMANCE

Figure O4.1



Calls Answered within 60 Seconds %	
Target	95%
Feb 2024	46.46%
YTD	50.24%
National	58.6%
Ranking	30th / 37

Figure O4.2

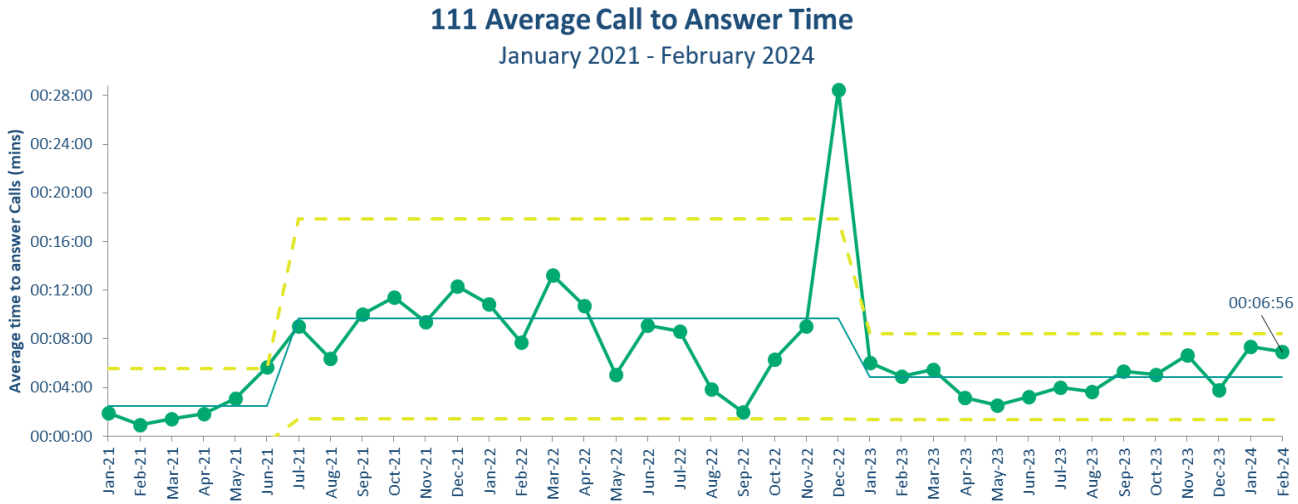
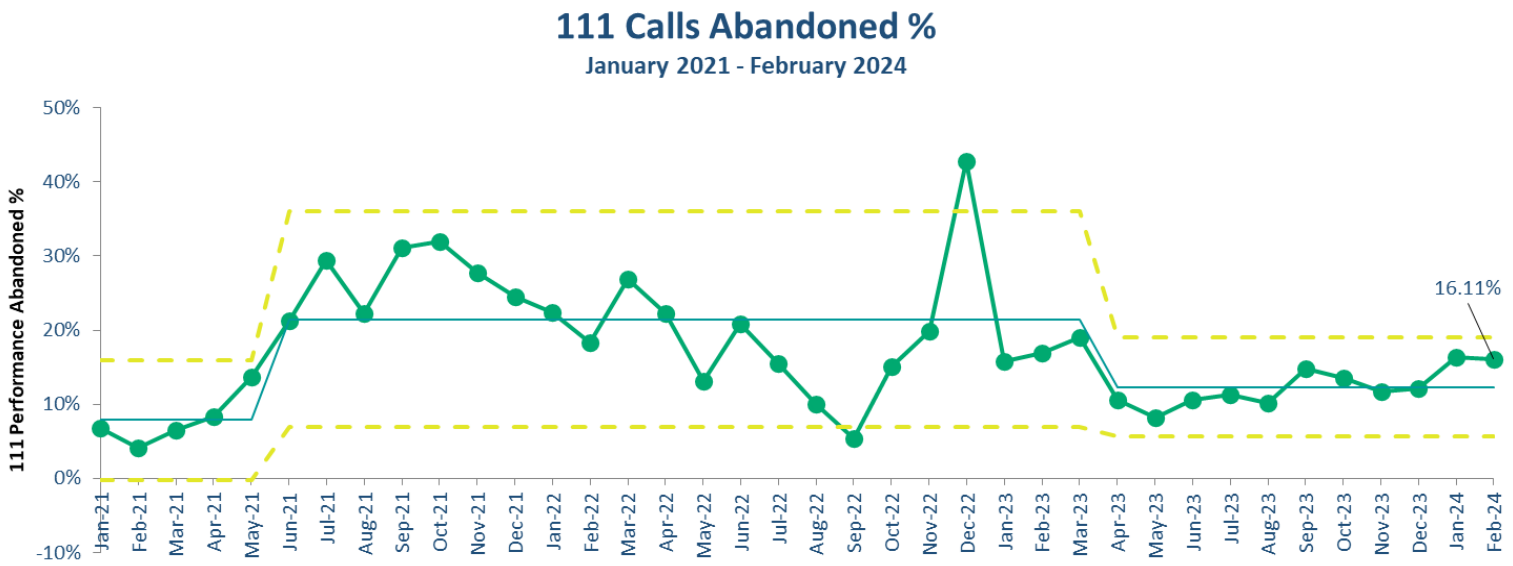
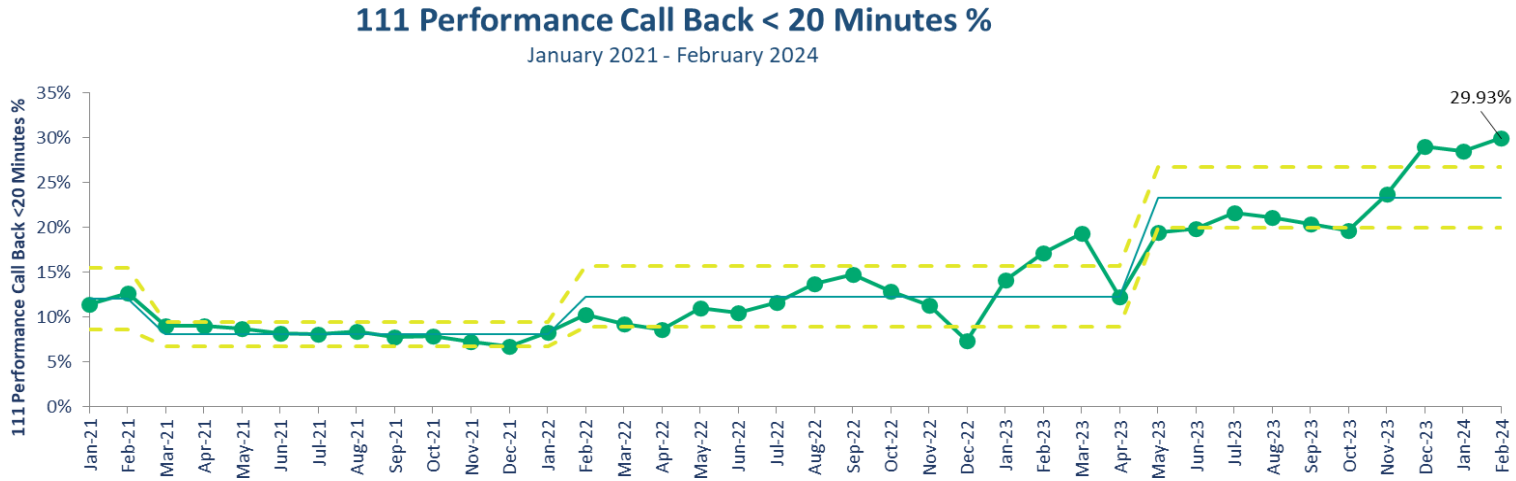


Figure O4.3



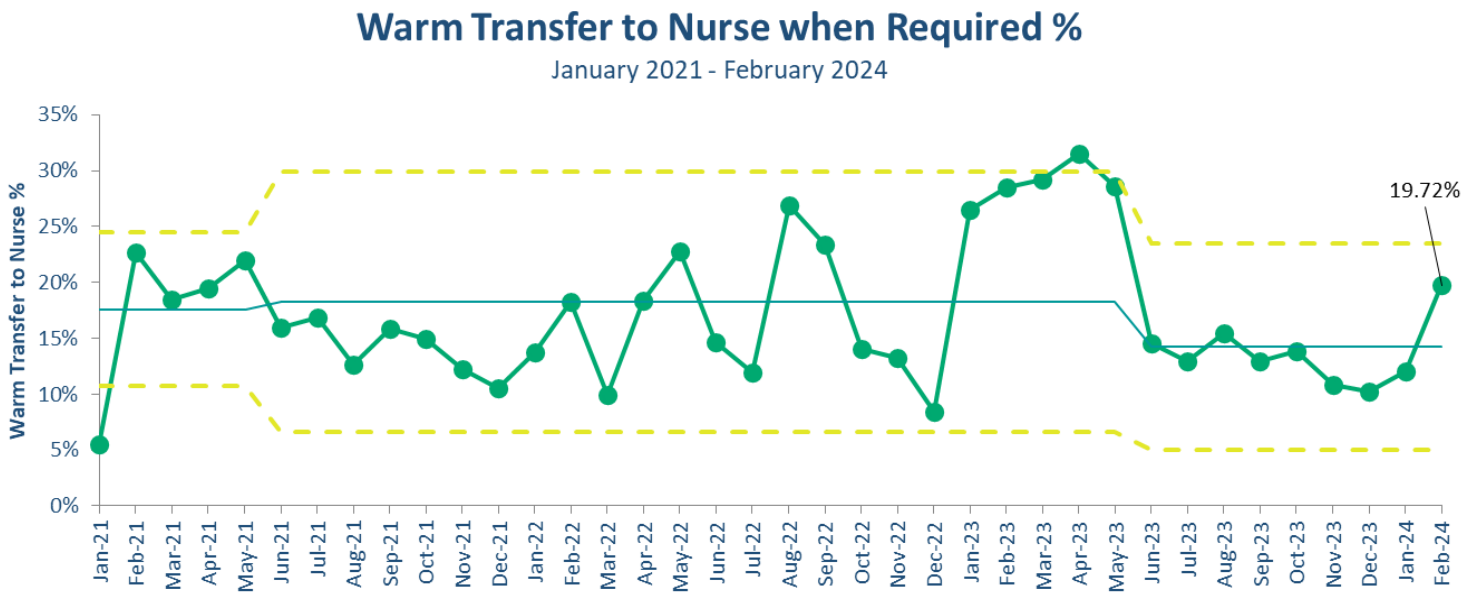
Calls Abandoned %	
Target	<5%
Feb 2024	16.11%
YTD	12.41%
National	11.0%
Ranking	29th / 37

Figure O4.4



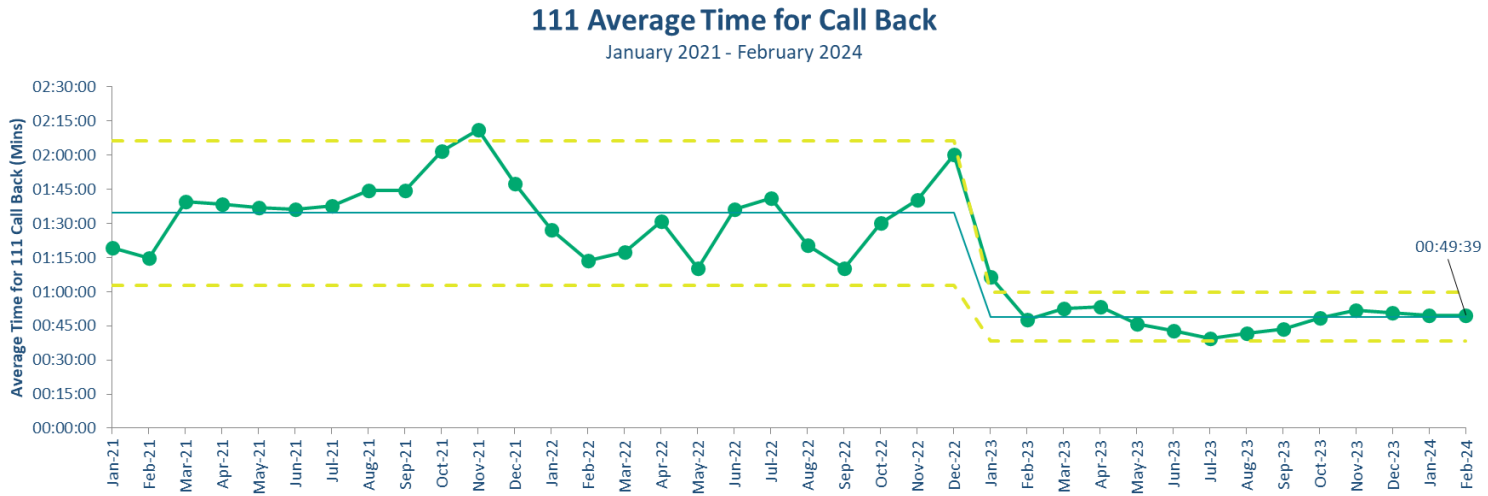
Calls Back <20 Mins	
Target	90%
Feb 2024	29.93%
YTD	22.33%

Figure O4.5



Warm Transfer %	
Target	75%
Feb 2024	19.72%
YTD	16.60%

Figure O4.6



O5 PTS ACTIVITY & TARIFF

Figure O5.1

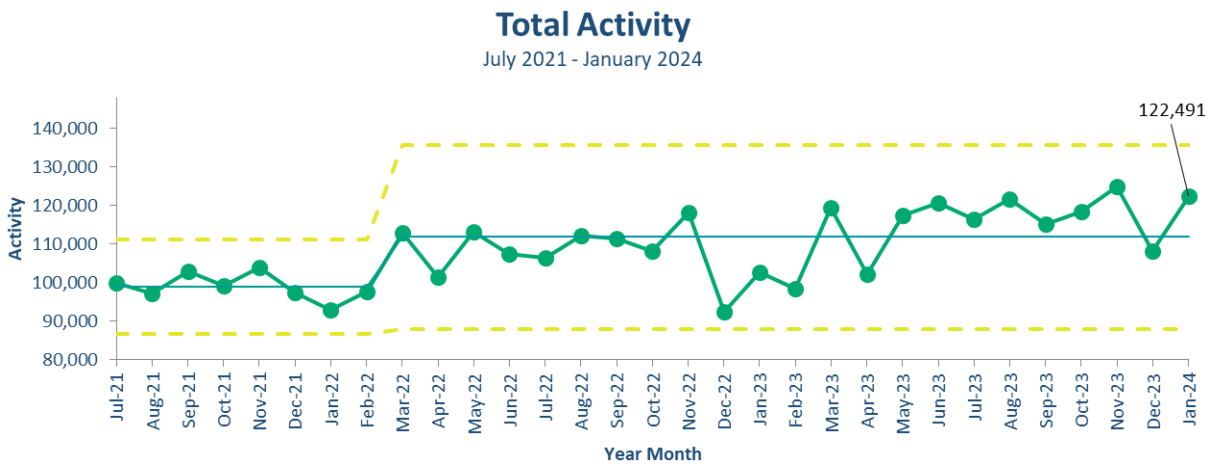


Figure O5.2

Contract	Total Activity
Greater Manchester	48,165
Lancashire	37,102
Merseyside	25,946
Cumbria	11,278

Total Activity	
Plan	132,015
Actual	122,491
YTD Plan	924,106
YTD Activity	834,646

Figure O5.3

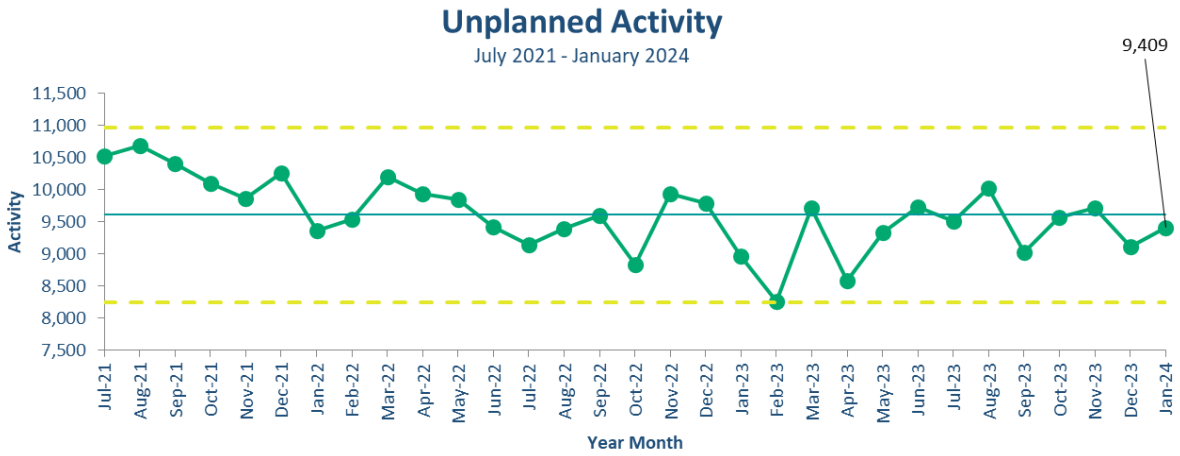


Figure O5.4

Contract	Unplanned Activity
Greater Manchester	4,094
Lancashire	2,996
Merseyside	1,842
Cumbria	477

Unplanned Activity	
Plan	12,107
Actual	9,409
YTD Plan	84,748
YTD Activity	66,336

Figure O5.5

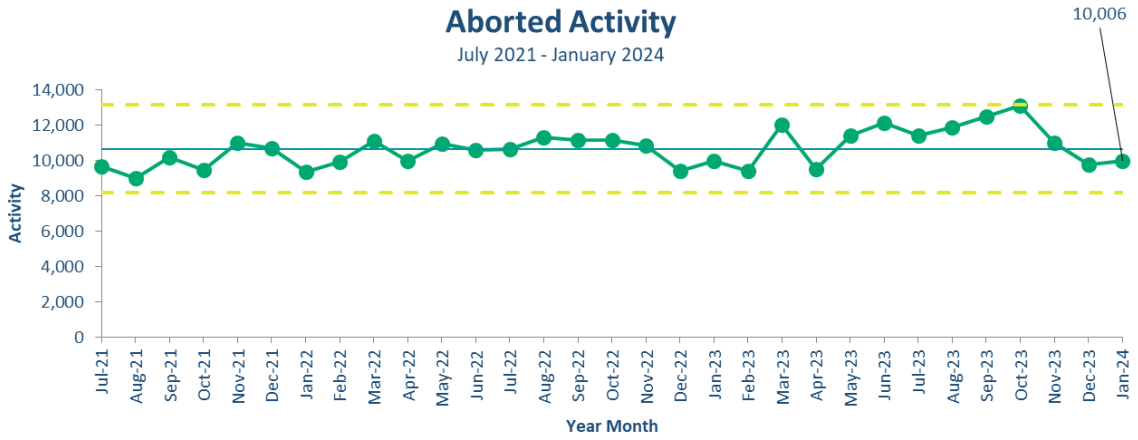


Figure O5.6

Contract	Aborted Activity
Greater Manchester	5,421
Lancashire	2,468
Merseyside	1,759
Cumbria	358

Finance

F1 – FINANCIAL SCORE

Figure F1.1

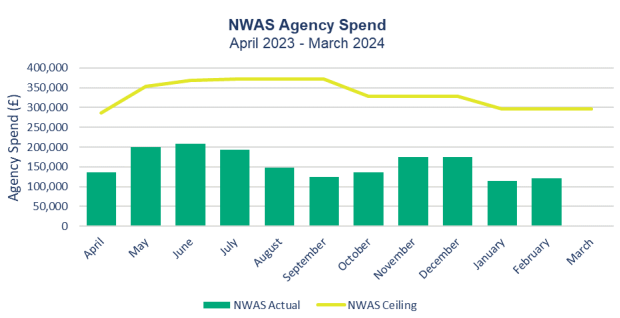


Figure F1.2

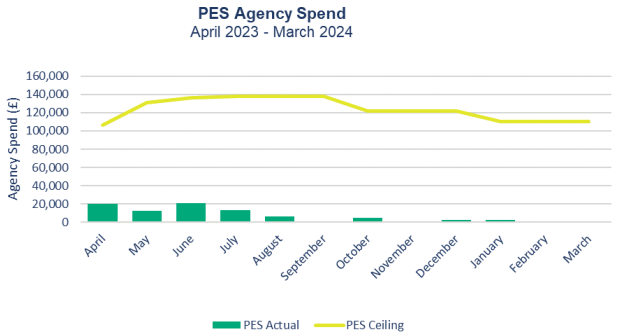


Figure F1.3

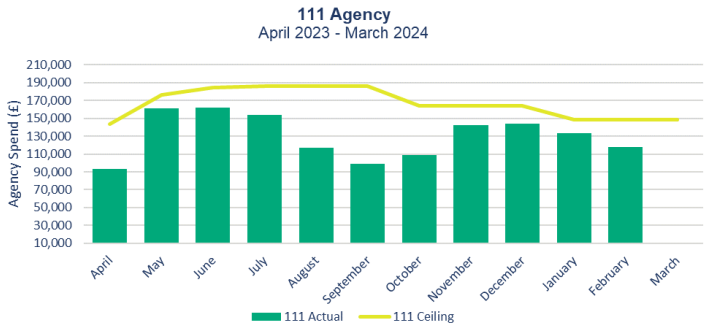


Figure F1.4

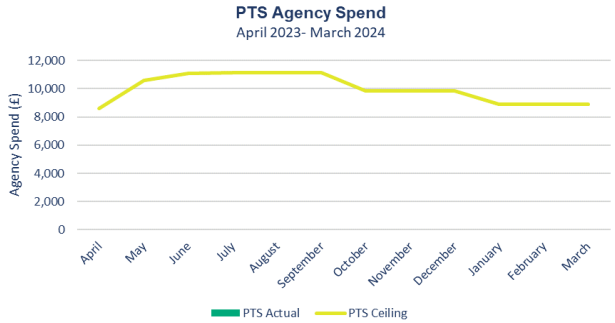


Figure F1.5

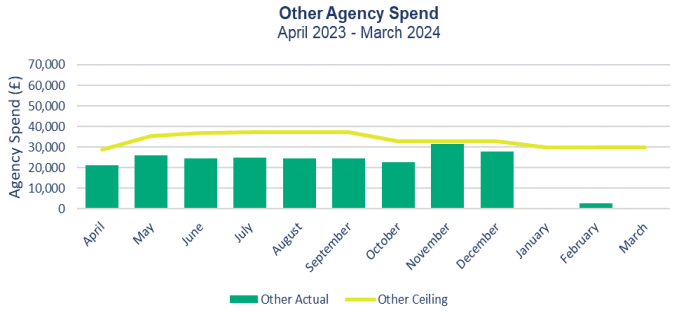


Figure F1.6

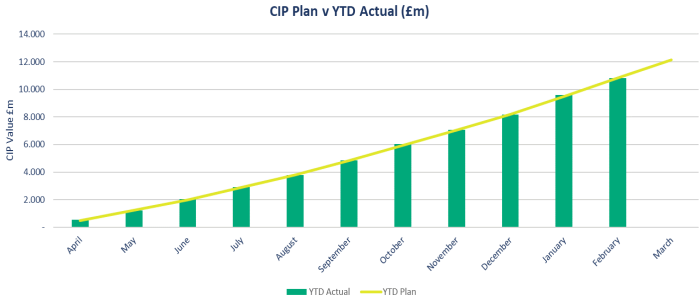


Figure F1.7

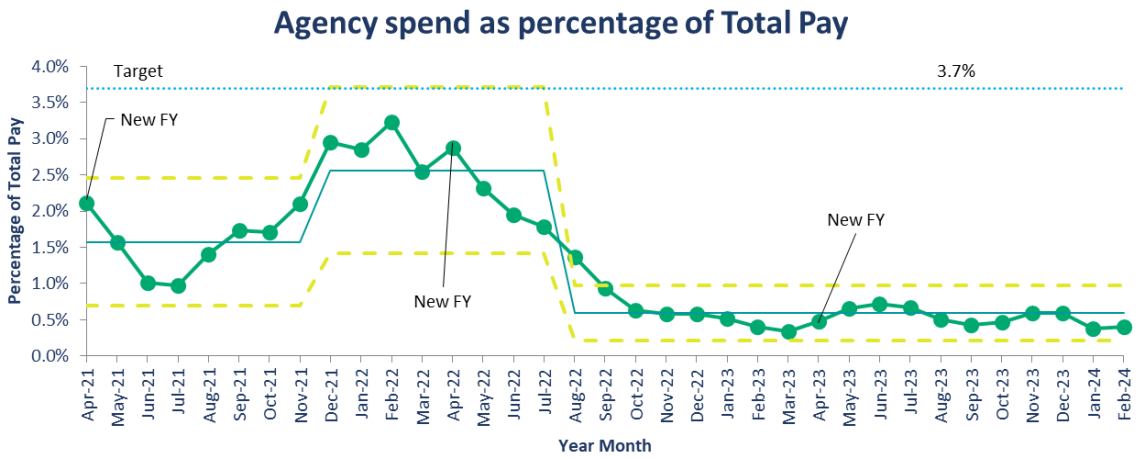


Figure F1.8

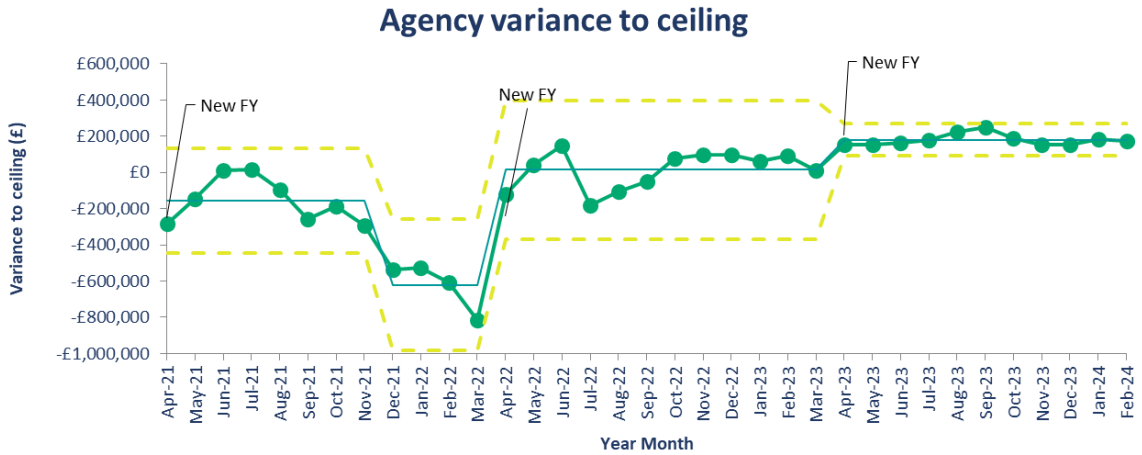
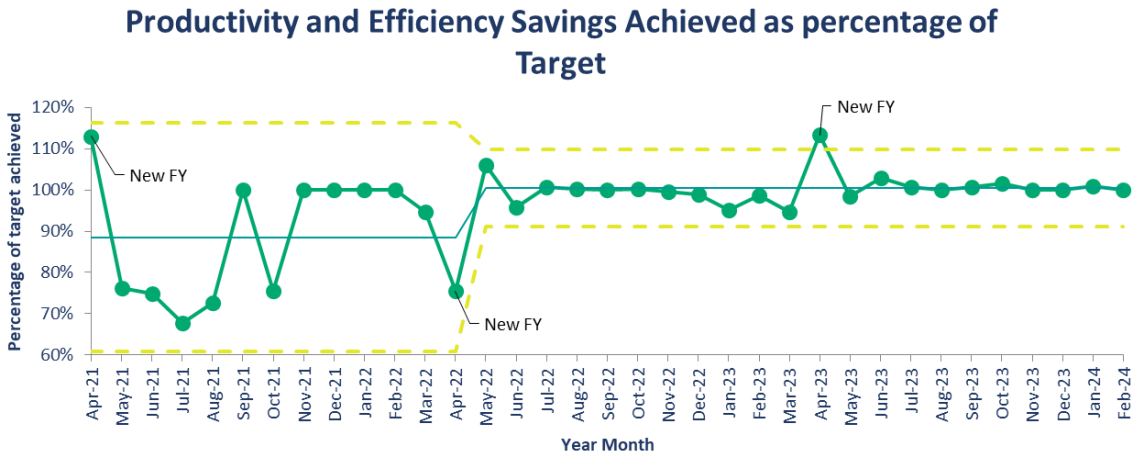


Figure F1.9



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

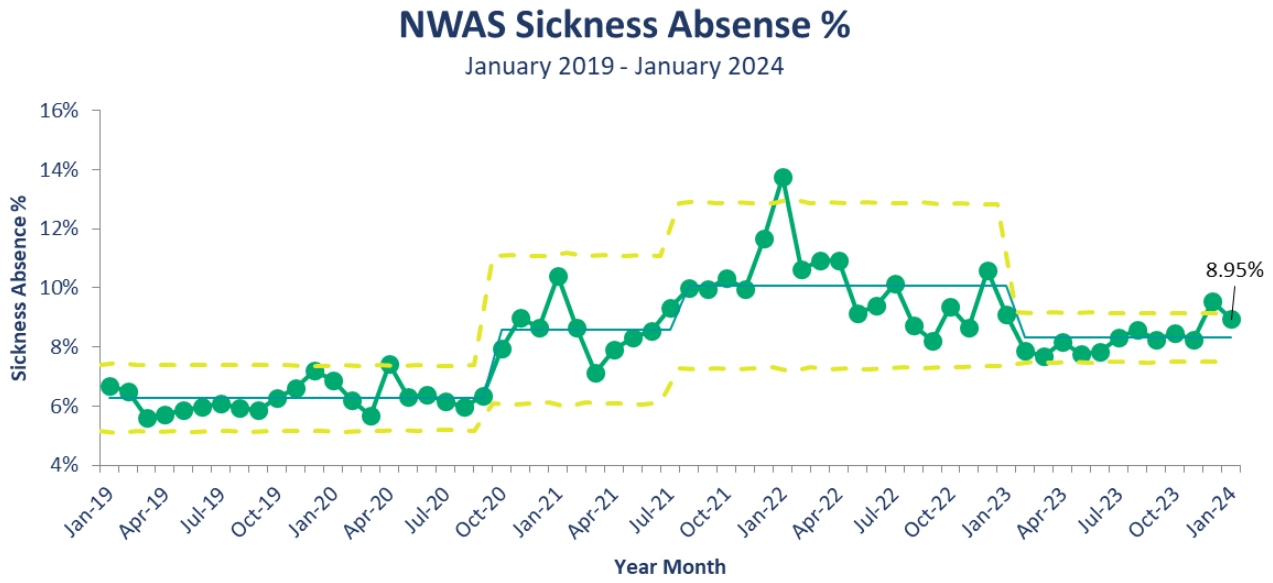


Table OH1.1

Sickness Absence	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Ju-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
NWAS	7.88%	7.71%	8.18%	7.77%	7.82%	8.33%	8.58%	8.26%	8.46%	8.24%	9.55%	8.95%
Amb. National Average	7.06%	6.82%	6.7%	6.3%	6.6%	6.8%	6.9%	6.6%	6.8%	6.8%	7.9%	

Figure OH1.2

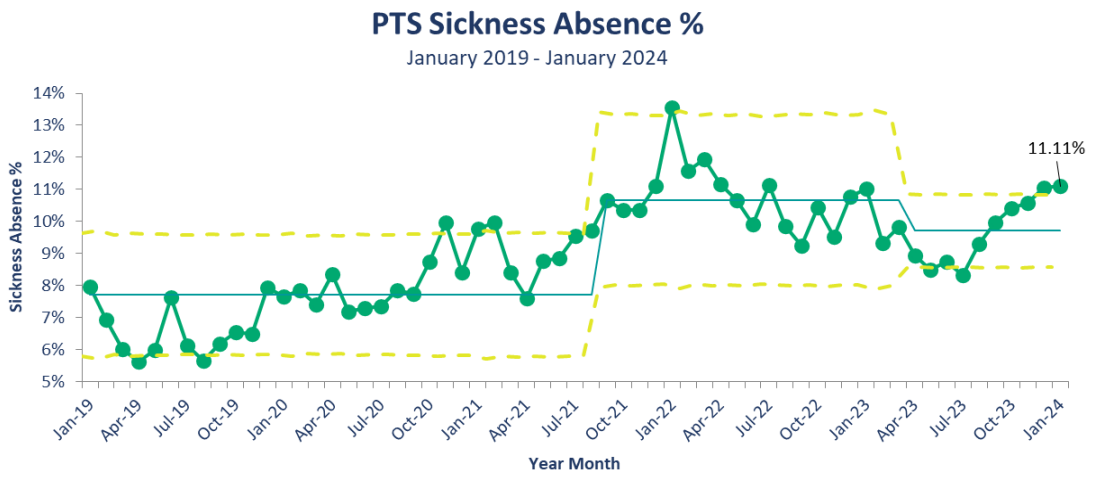


Figure OH1.3

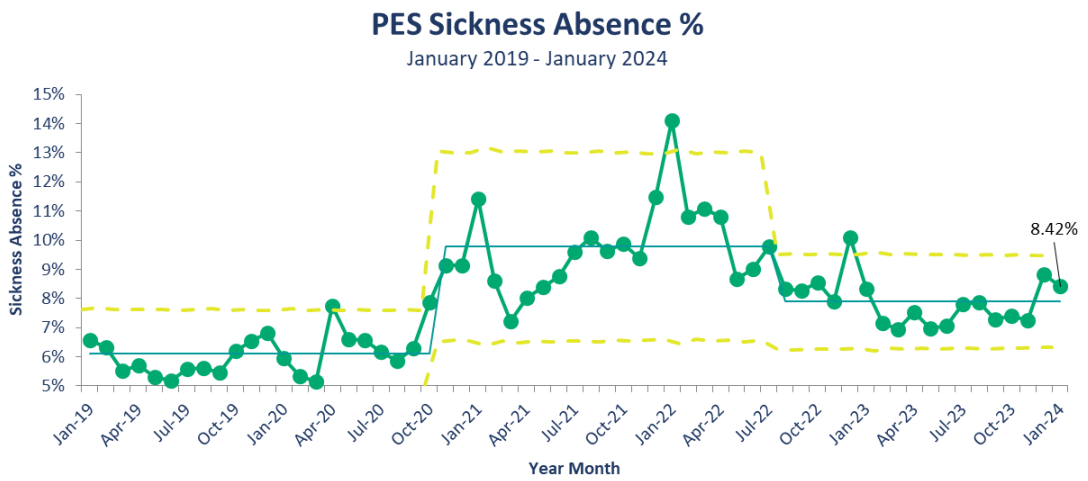


Figure OH1.4

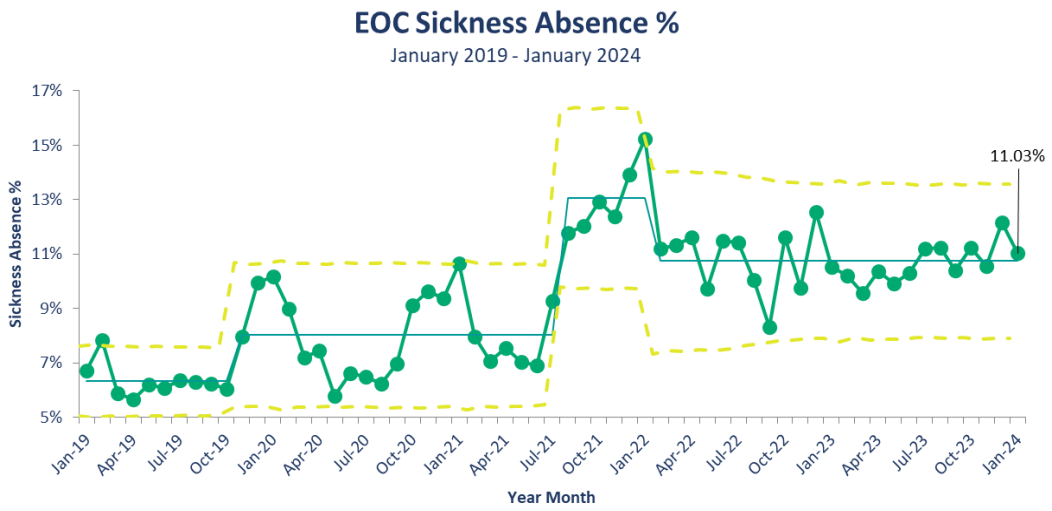
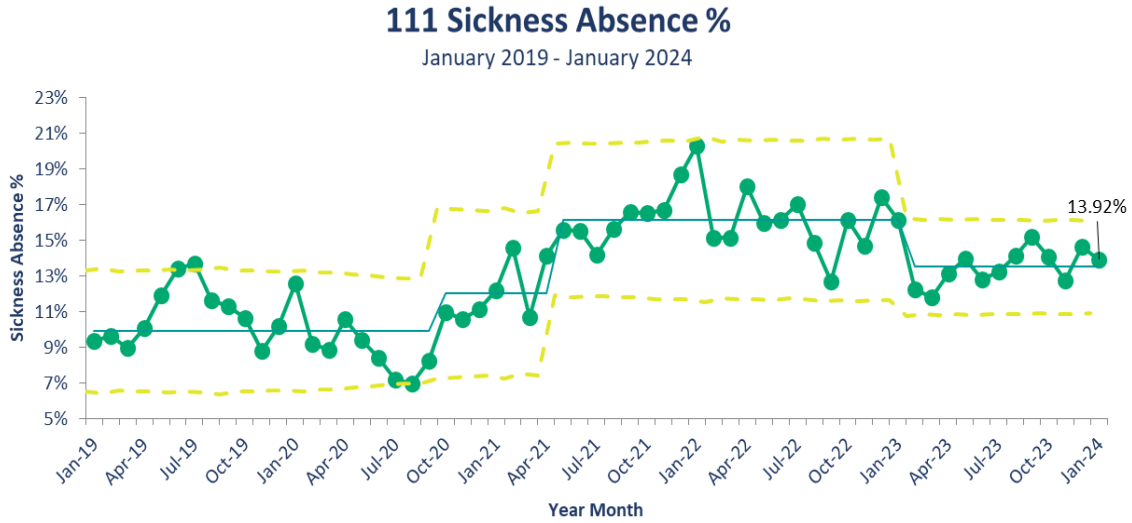


Figure OH1.5



OH2 STAFF TURNOVER

Figure OH2.1

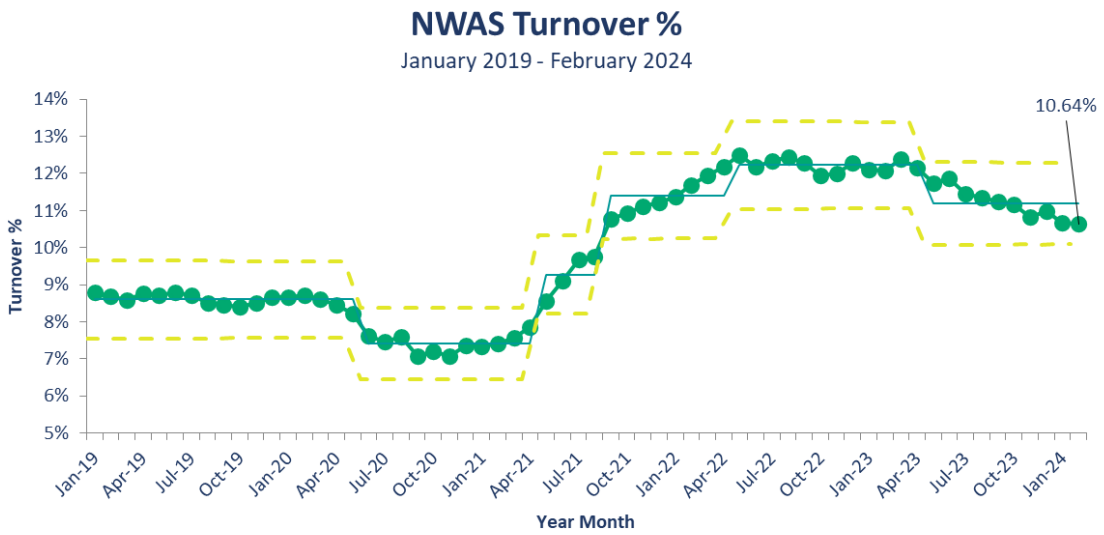


Table OH2.1

Turnover	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
NWAS	12.38%	12.15%	11.73%	11.87%	11.46%	11.35%	11.23%	11.16%	10.83%	10.98%	10.68%	10.64%
Amb. National Average	12.60%	12.17%	11.81%	11.71%	11.49%	11.20%	10.99%	10.96%	10.87%			

Figure OH2.2

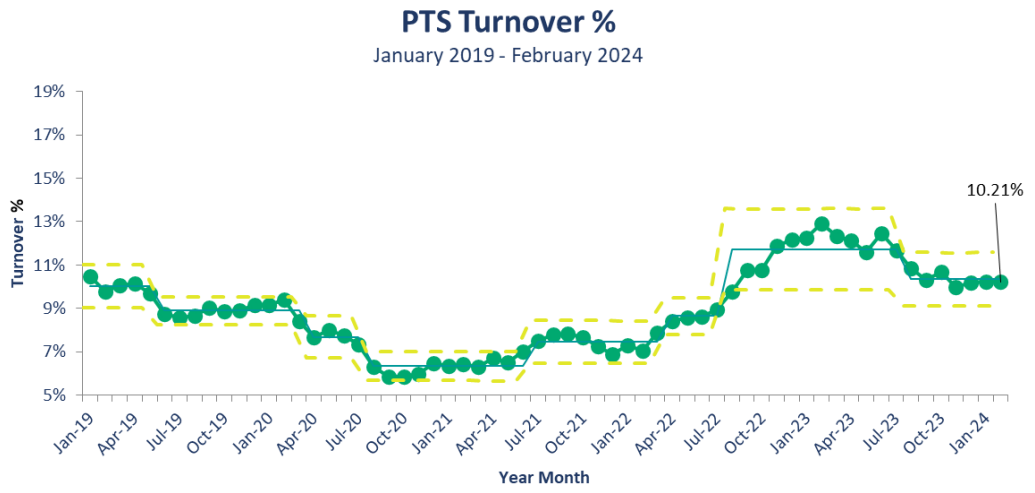


Figure OH2.3

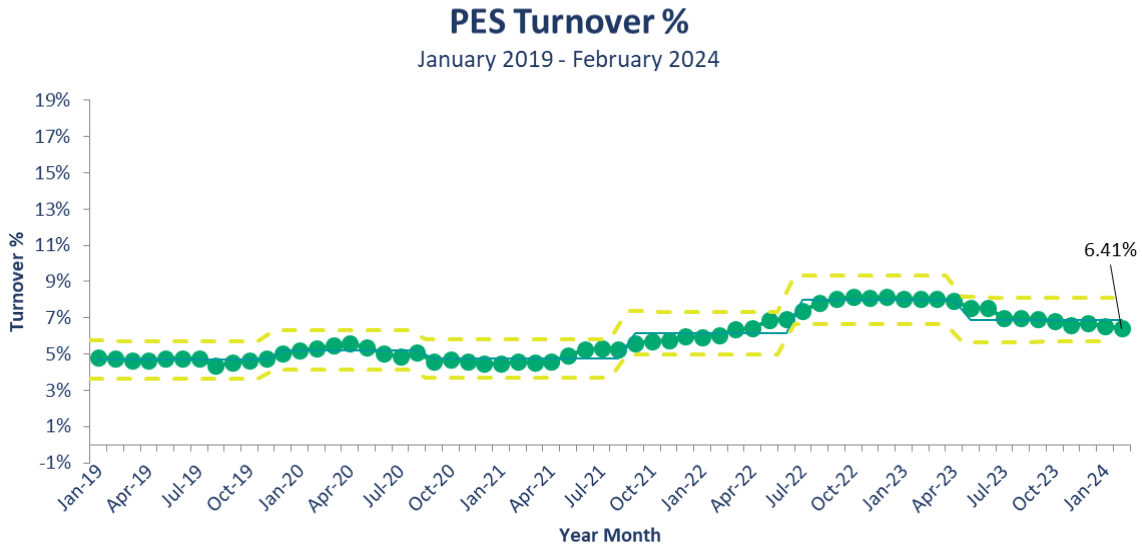


Figure OH2.4

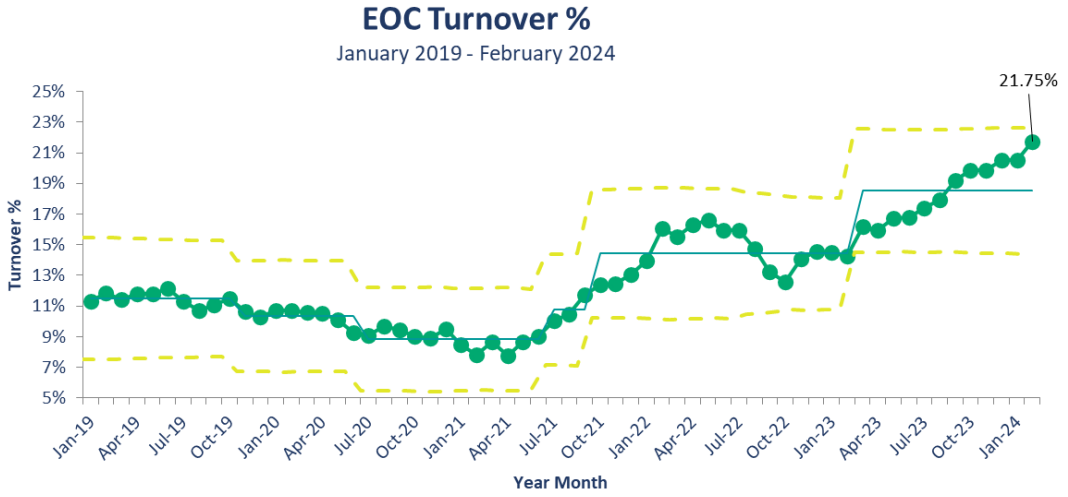
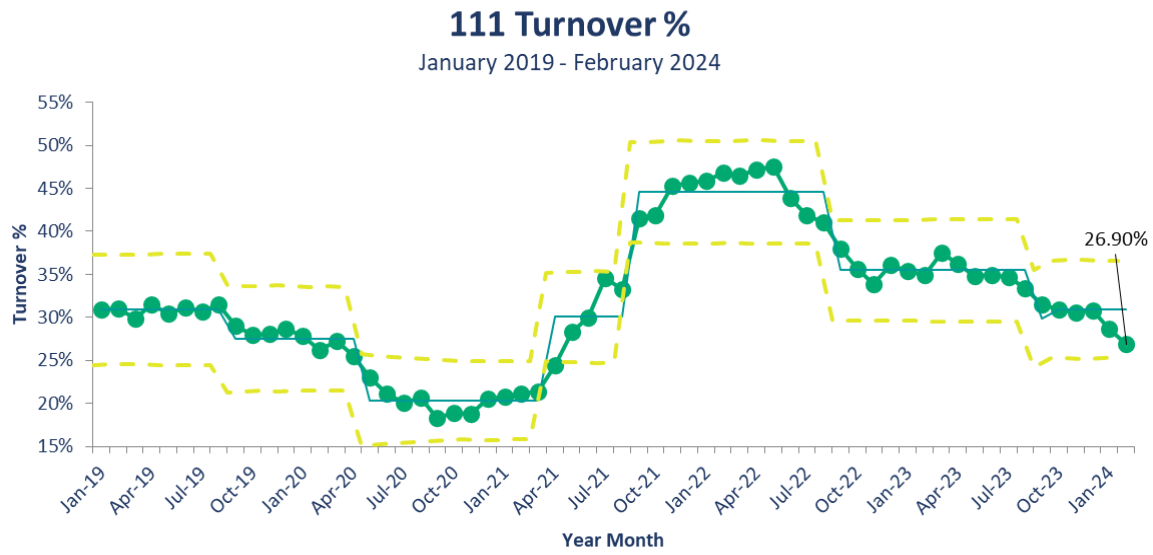


Figure OH2.5



The scale on the 111 and EOC Turnover % is different to the others. 15%-55% for 111 , 5% to 25% for EOC and 5% to 19% for the others.

OH4 TEMPORARY STAFFING

Figure OH4.1

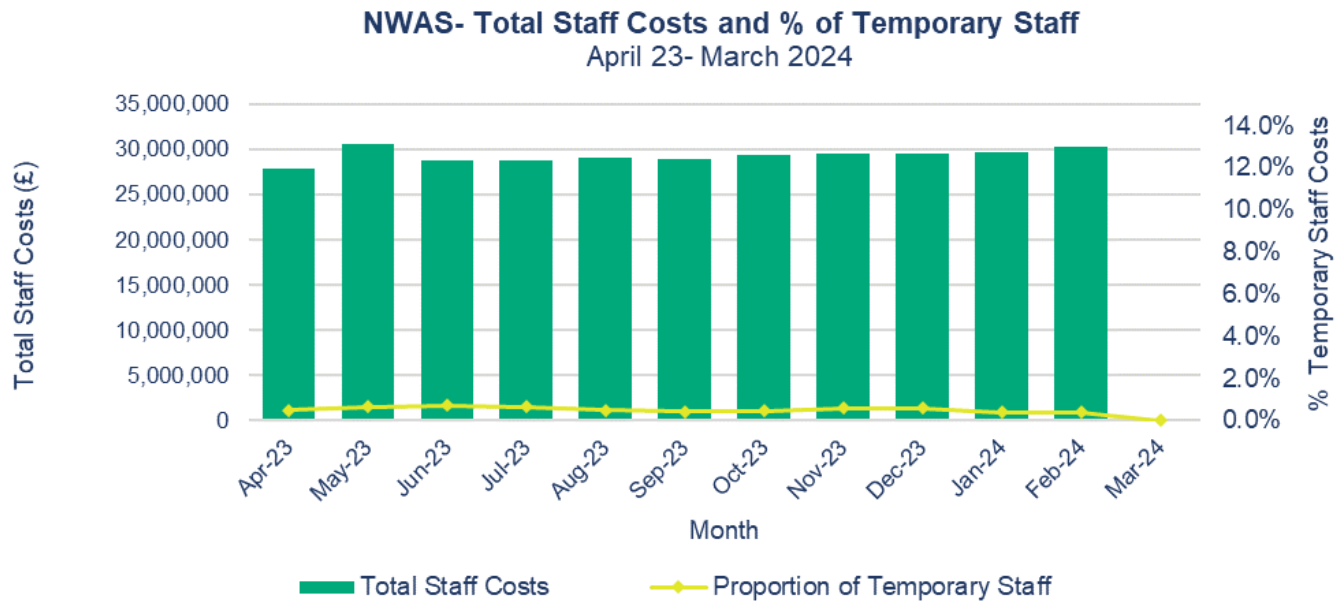


Table OH4.1

NWAS	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug -23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Agency Staff Costs (£)	191,258	135,492	200,114	207,520	192,594	147,684	124,670	136,633	174,789	174,325	114,353	121,308
Total Staff Costs (£)	56,312,765	27,882,122	30,582,073	28,815,903	28,871,609	29,127,865	29,022,514	29,479,928	29,620,537	29,568,340	29,779,636	30,352,345
Proportion of Temporary Staff %	0.3%	0.5%	0.7%	0.7%	0.7%	0.5%	0.4%	0.5%	0.6%	0.6%	0.4%	0.4%

Figure OH4.3

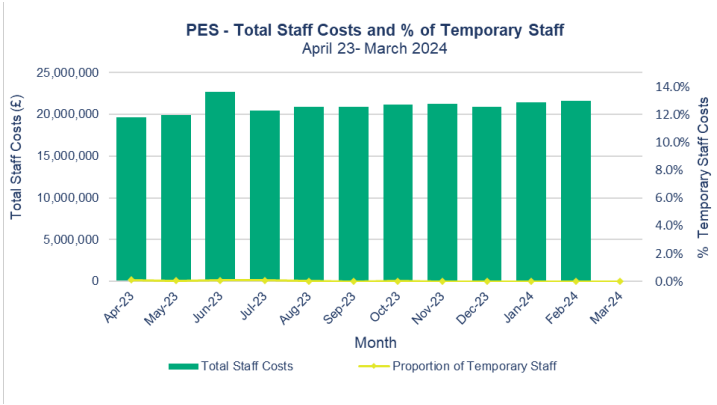


Figure OH4.4

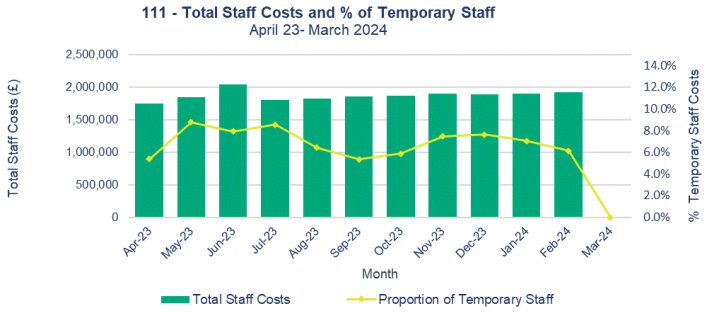


Figure OH4.5

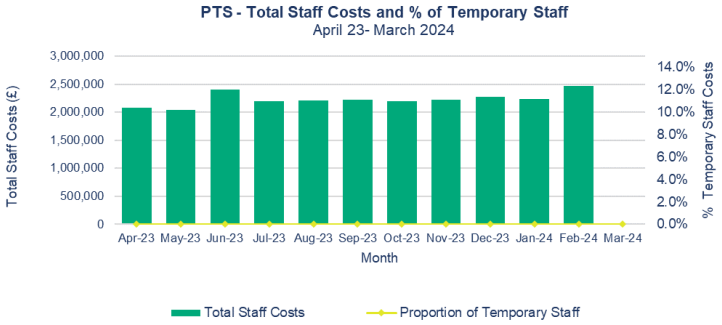
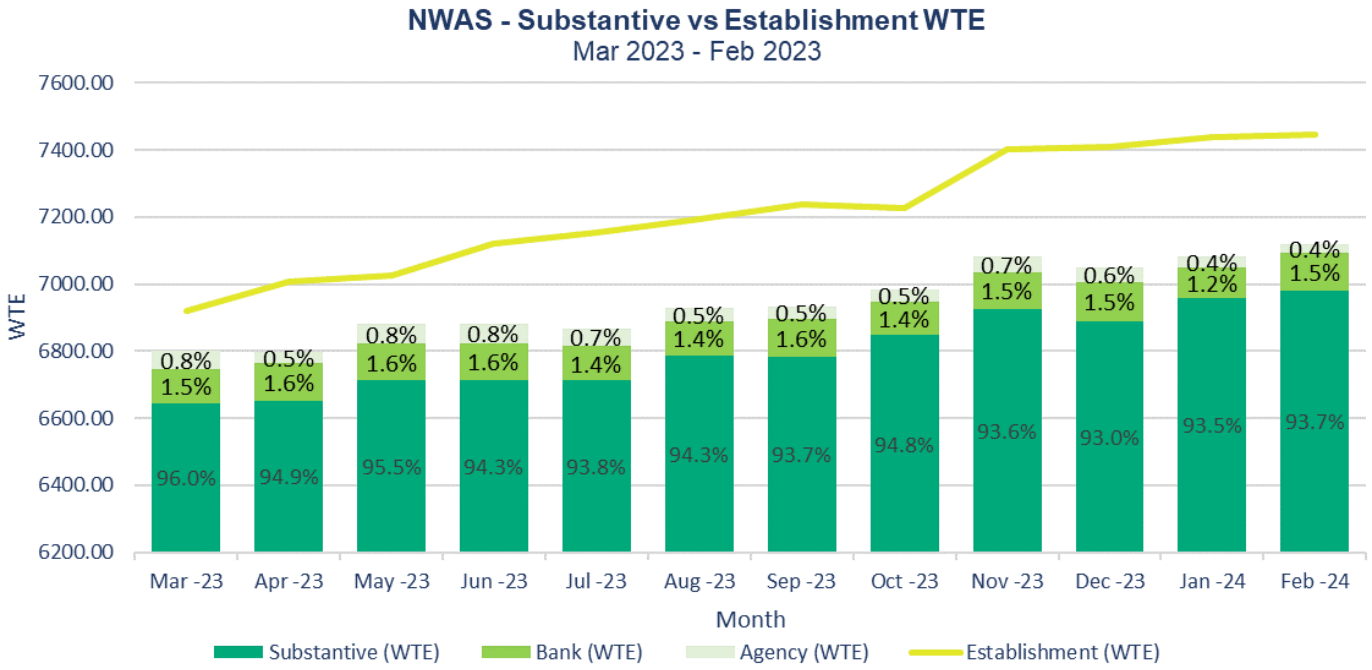


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

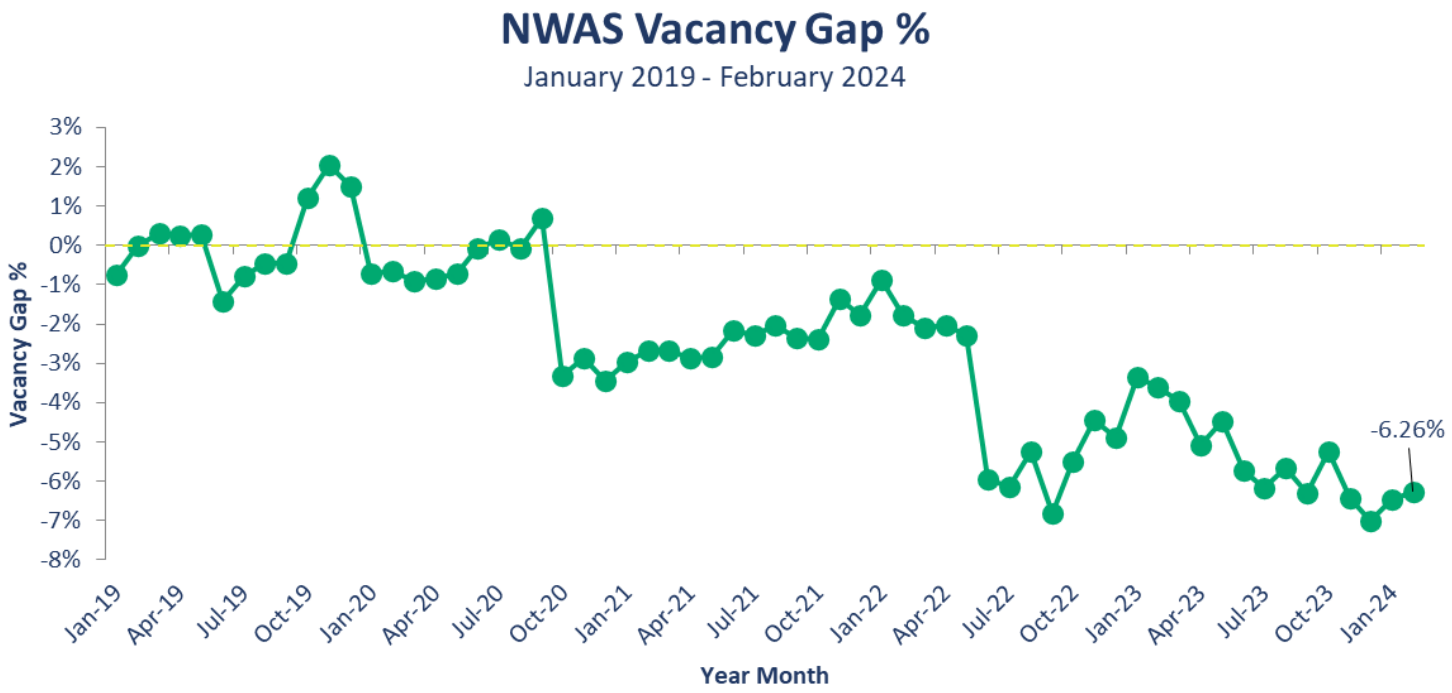


Table OH5.1

Vacancy Gap	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
NWAS	-3.96%	-5.08%	-4.49%	-5.72%	-6.18%	-5.67%	-6.30%	-5.23%	-6.44%	-7.00%	-6.47%	-6.26%

Figure OH5.2

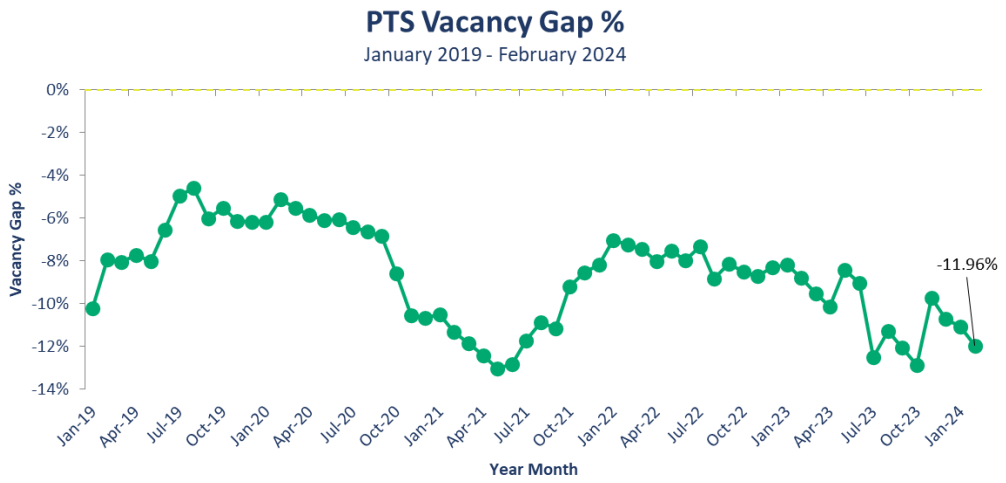


Figure OH5.3

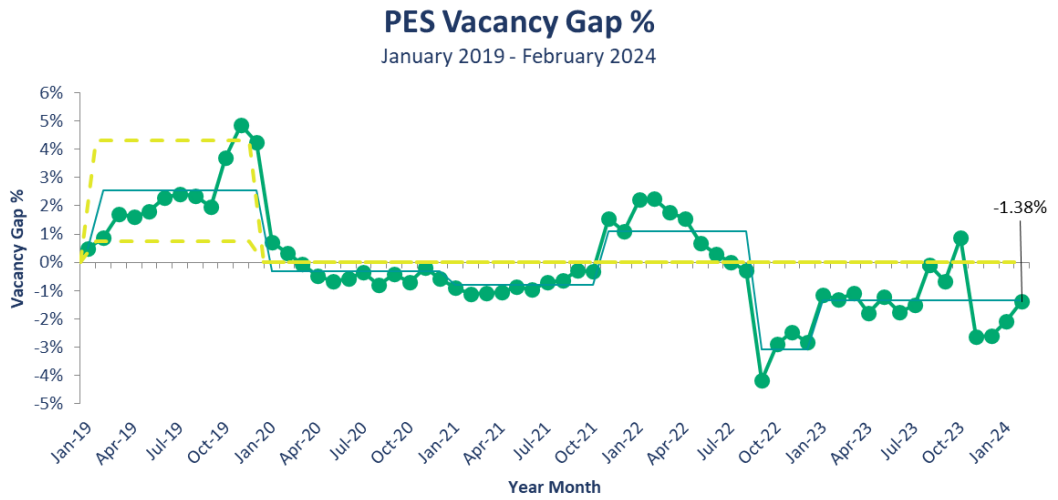


Figure OH5.4

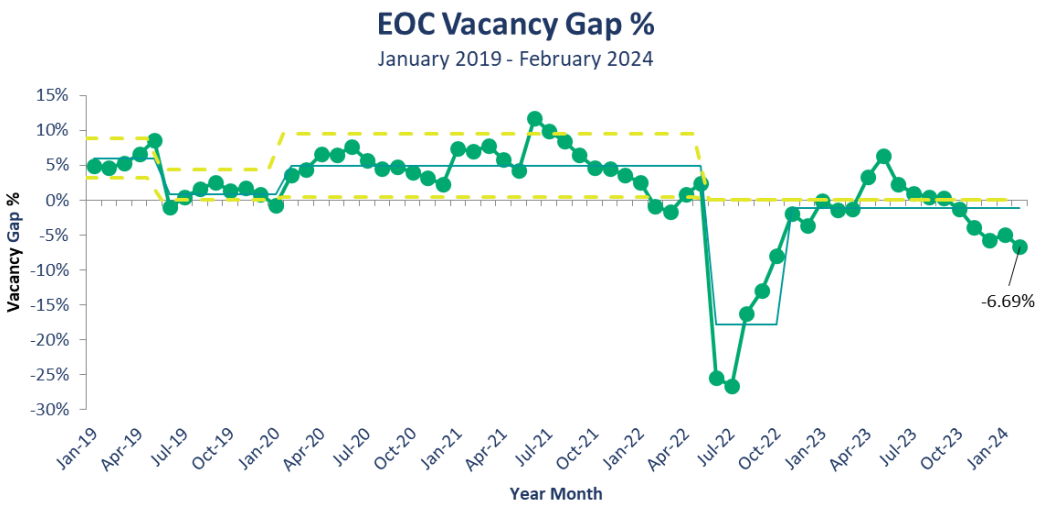
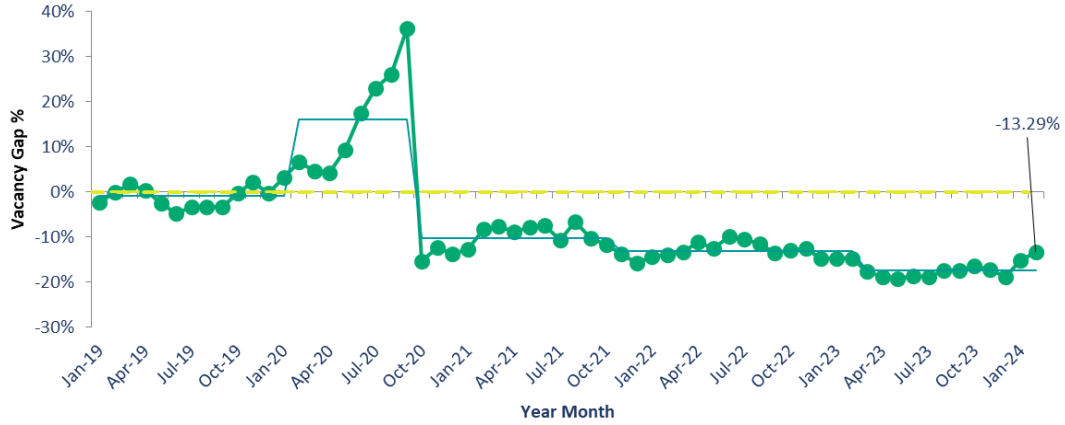


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

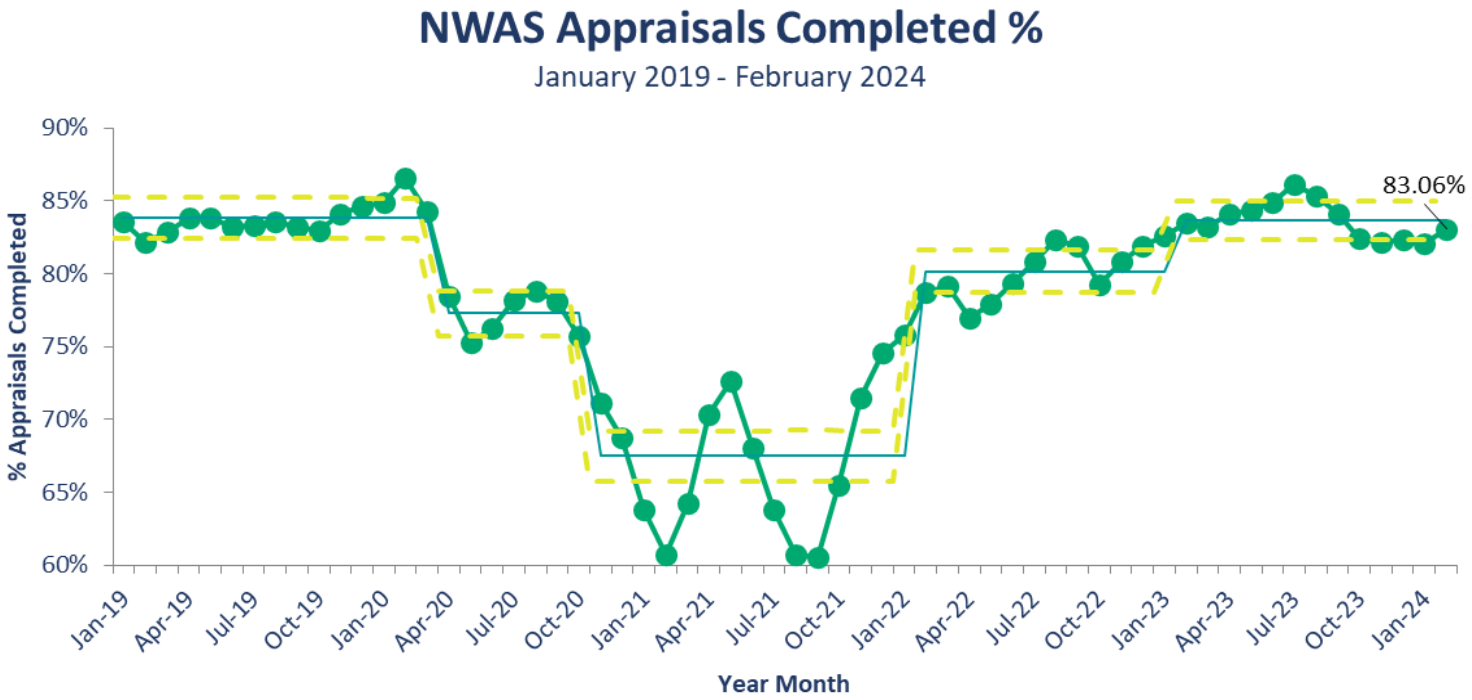


Table OH6.1

Appraisals	Mar-22	Apr-22	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
NWAS	83%	84%	84%	85%	86%	85%	84%	82%	82%	82%	82%	83%

Figure OH6.2

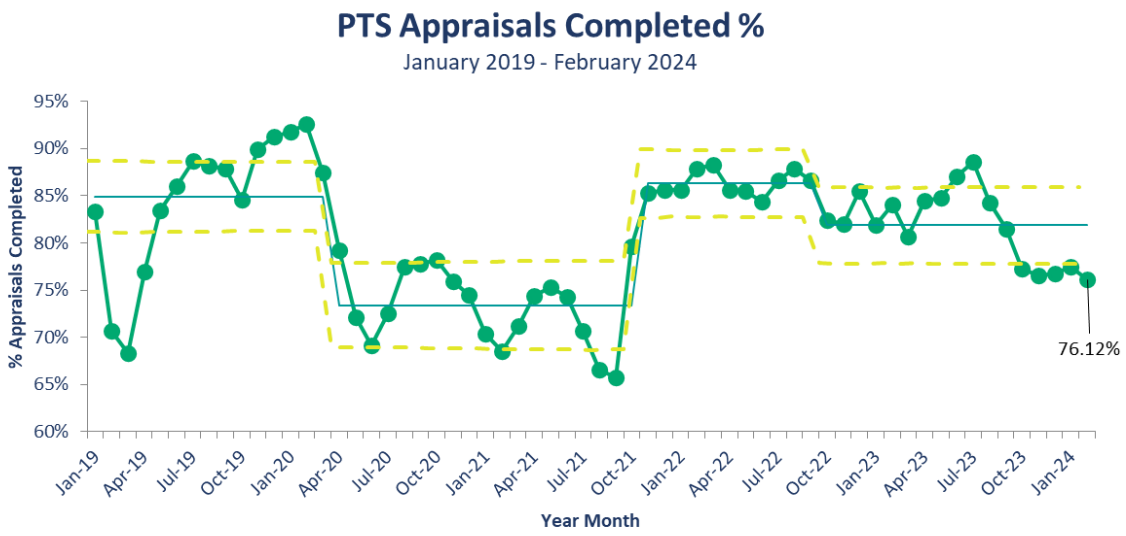


Figure OH6.3

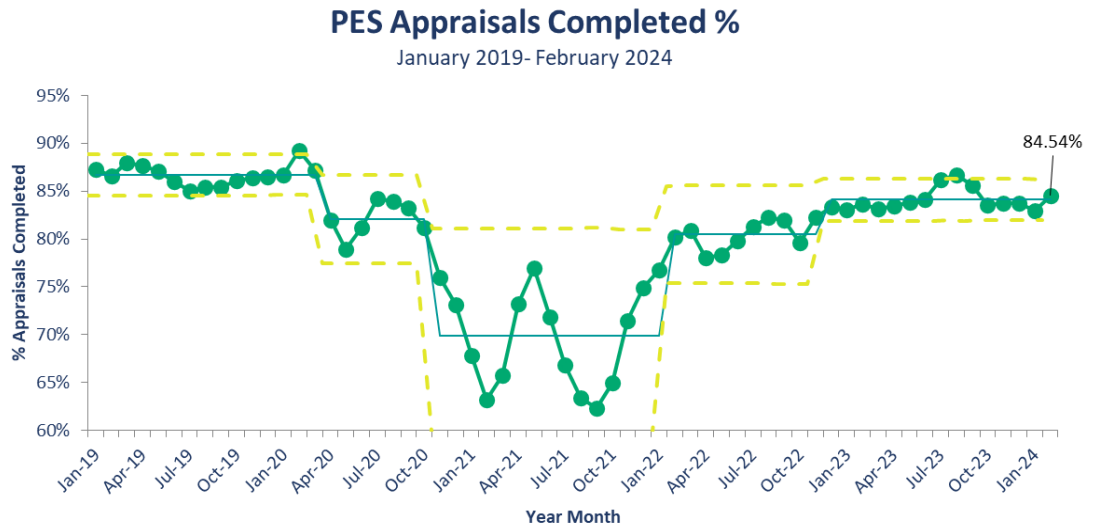


Figure OH6.4

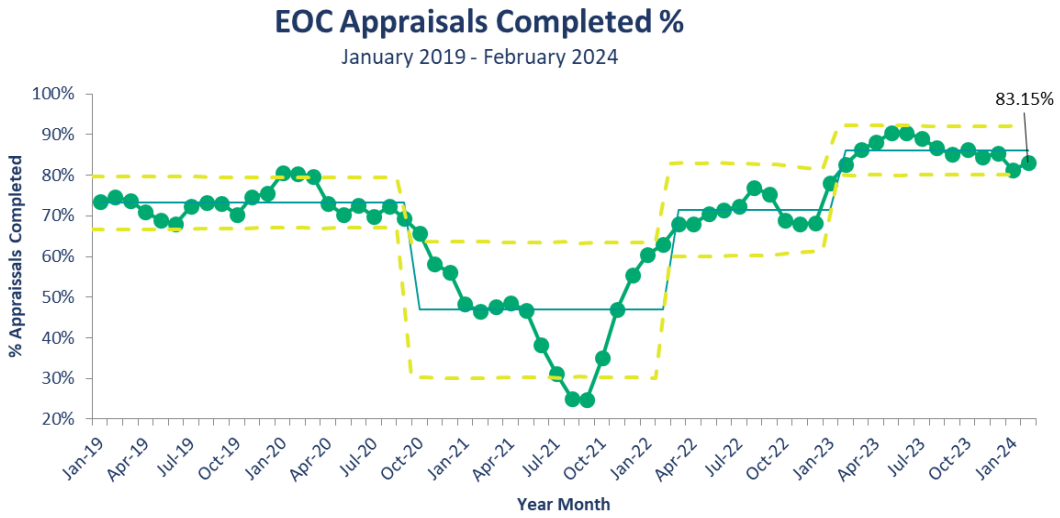
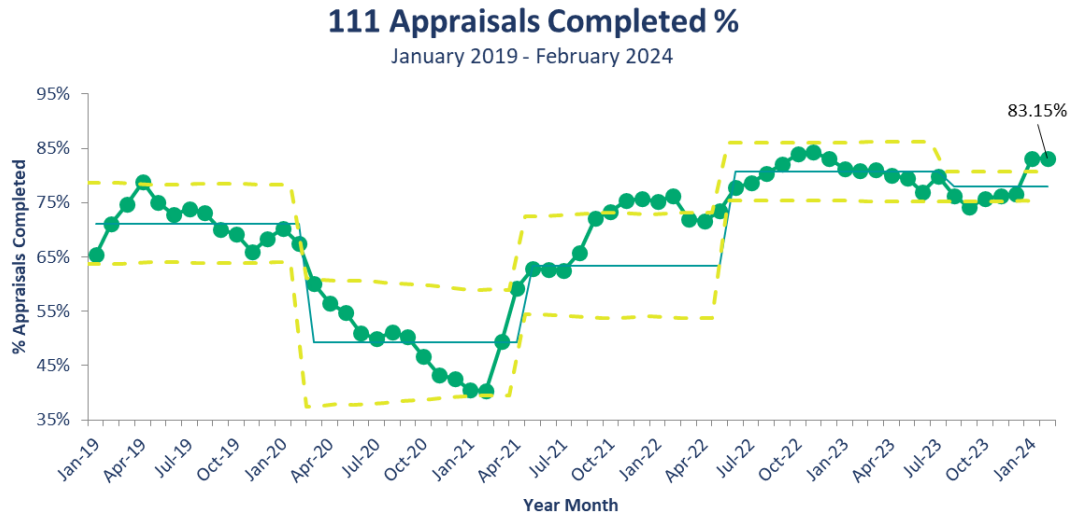


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

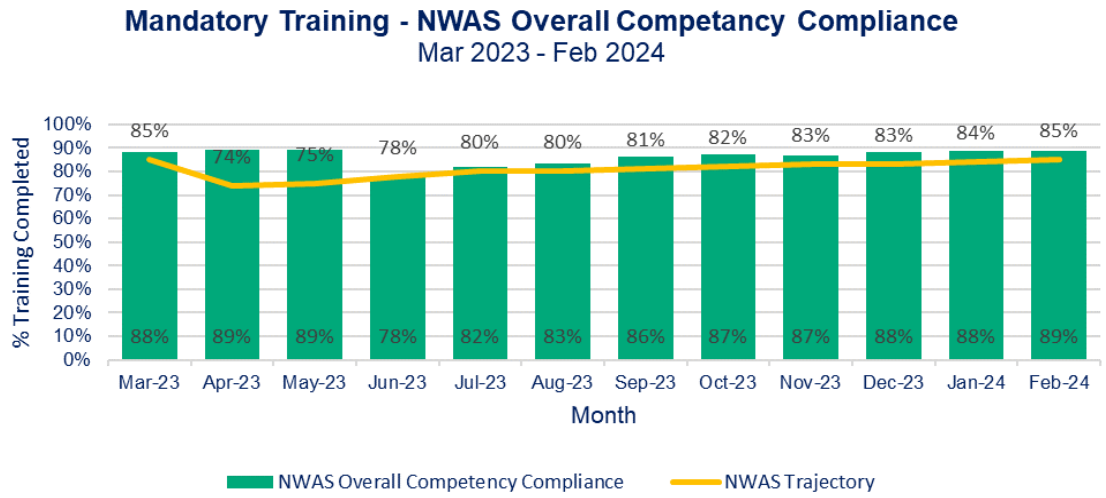


Figure OH7.2

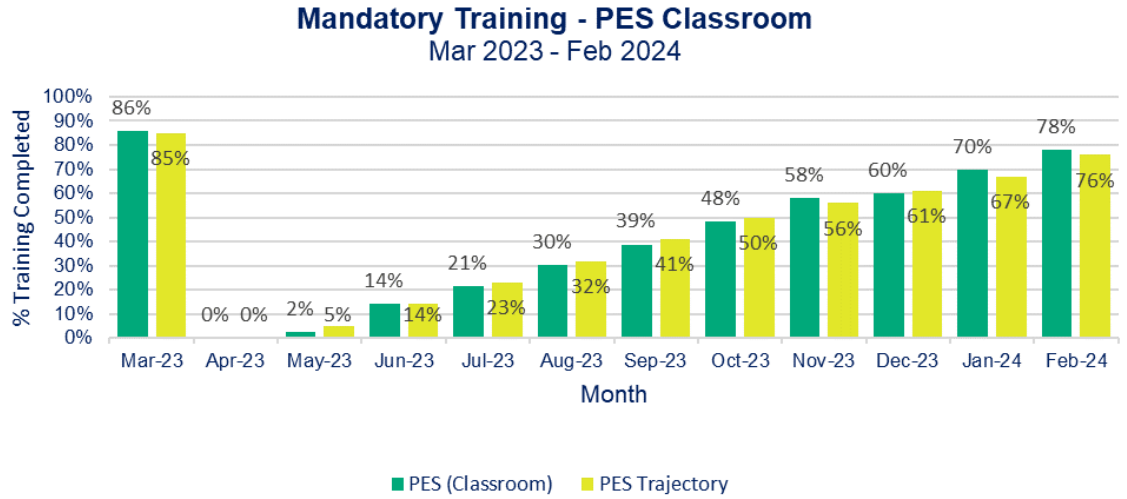


Figure OH7.3

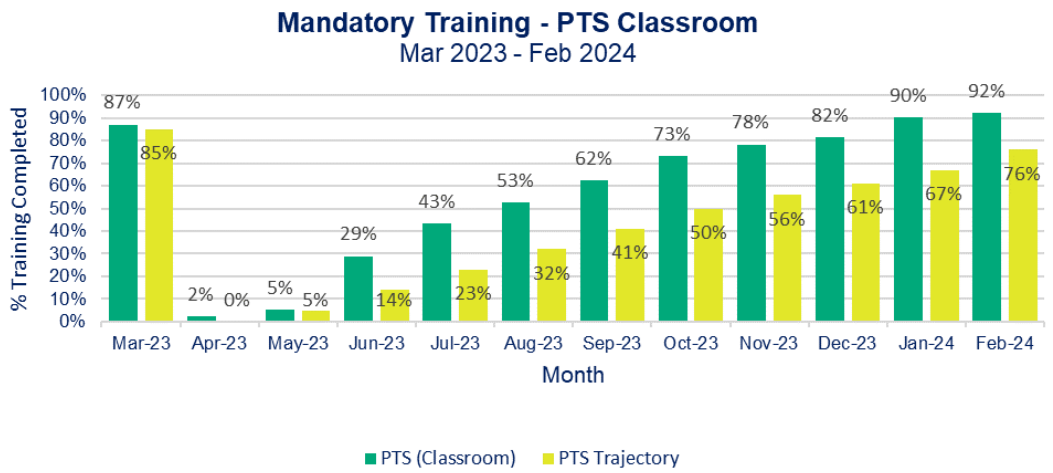


Figure OH7.4

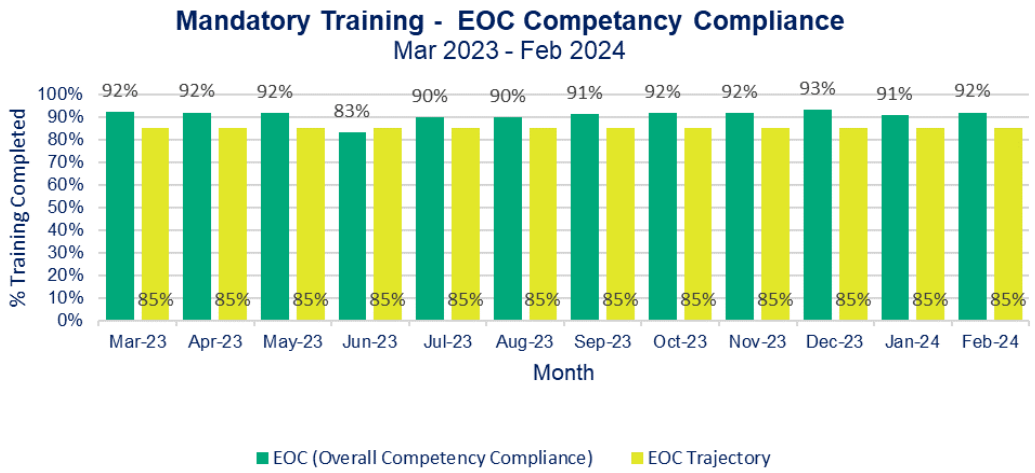


Figure OH7.5

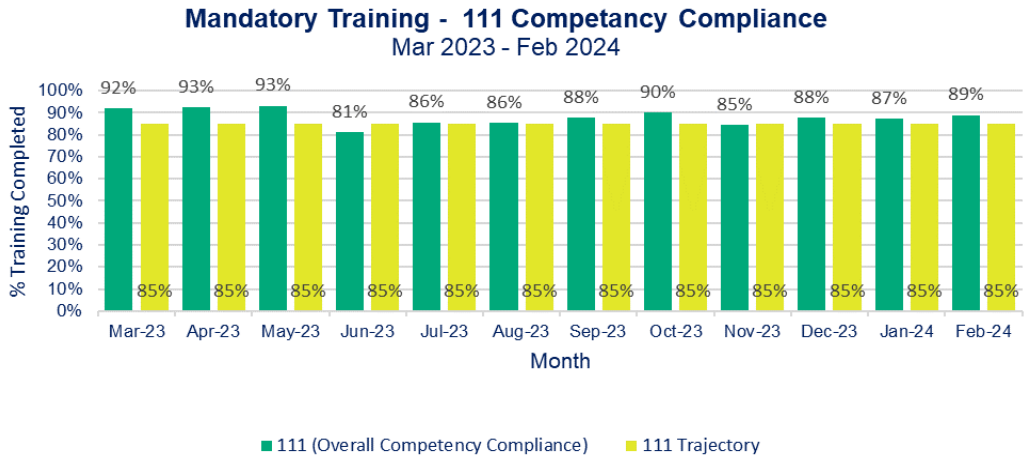
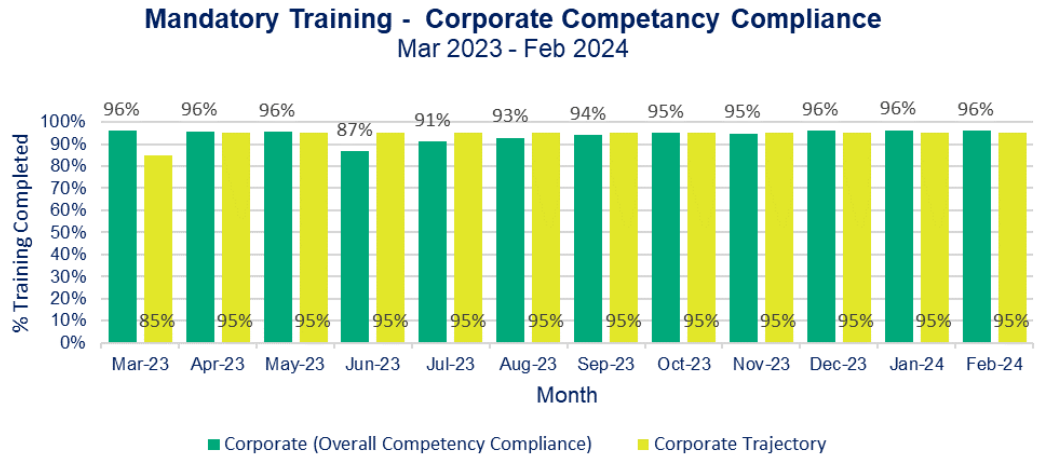


Figure OH7.6



OH8 CASE MANAGEMENT

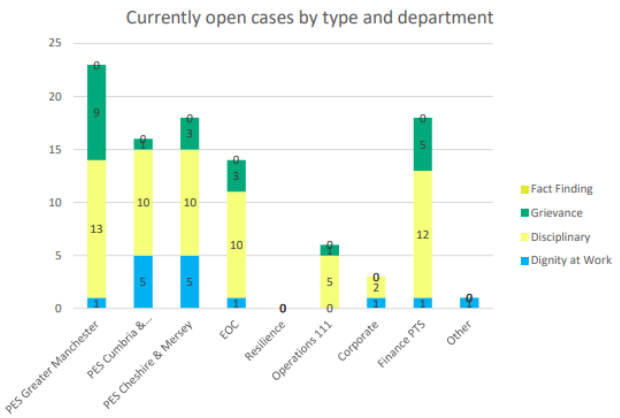
Figure OH8.1

Employee Relation Dashboard @5th March 2024. 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	60.00	1.4	198.00	4.7	16.20
CAM PES	18.00	1.4	79.00	6.0	18.04
CAL PES	16.00	1.2	62.00	4.7	14.25
GM PES	23.00	1.6	56.00	3.9	15.95
Operations ~ EOC	14.00	1.2	61.00	5.2	9.54
Operations ~ 111	6.00	1.0	58.00	9.5	10.01
Operations ~ PTS	18.00	1.7	90.00	8.6	11.37
Operations ~ Resilience	0.00	0.0	1.00	0.7	4.00
Corporate	4.00	0.9	36.00	5.8	17.68
Other	1.00		0.00		
NWAS Summary	**103.00**	**1.4**	**444.00**	**5.7**	**13.59**

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

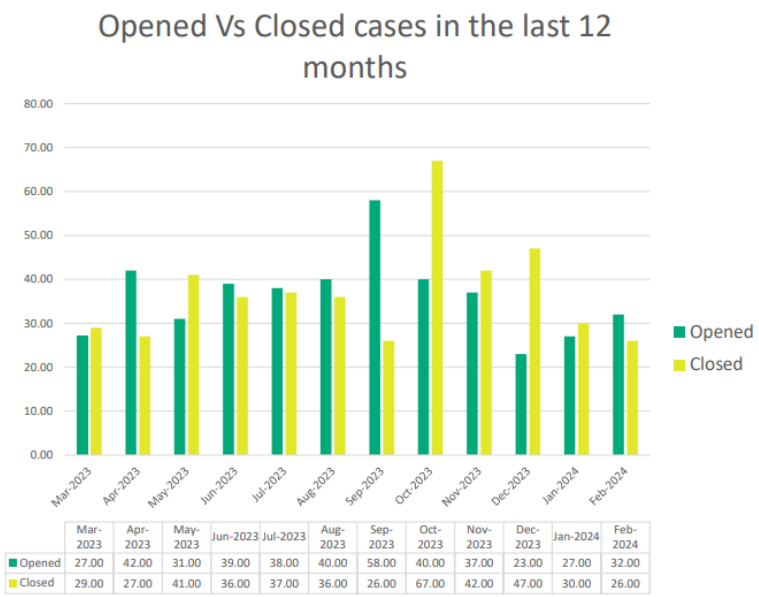


Case Type Summary

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	17	74	17.93
Disciplinary	63	243	14.49
Fact Finding	0	0	0.00
Grievance	23	127	9.33
Case Summary	**103**	**444**	**13.59**

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	9	4	3	1
Disciplinary	27	17	15	4
Fact Finding	0	0	0	0
Grievance	14	8	1	0
Case Total	**50**	**29**	**19**	**5**



	Mar-2023	Apr-2023	May-2023	Jun-2023	Jul-2023	Aug-2023	Sep-2023	Oct-2023	Nov-2023	Dec-2023	Jan-2024	Feb-2024
Opened	27.00	42.00	31.00	39.00	38.00	40.00	58.00	40.00	37.00	23.00	27.00	32.00
Closed	29.00	27.00	41.00	36.00	37.00	36.00	26.00	67.00	42.00	47.00	30.00	26.00

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 March 2024				
SUBJECT:	Learning from Deaths - Summary report and Dashboard Q3 2023/24				
PRESENTED BY:	Dr Chris Grant, 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 Q3 dashboard (Appendix A) describes the opportunities to learn from deaths. The main concerns raised identified in DatixCloudIQ (DCIQ), were attributed issues in Integrated Contact Centres and Paramedic Emergency Services, specifically around the emergency response and treatment/management plan. Of the concerns closed, no causal factors were identified by the investigator. The peer review process ensures the Trust is now compliant with the national framework. The key areas for improvement reflect similar themes from the previous quarter. This includes making a clear management plan for the patient (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 NHS Pathways. The quality of patient records has continued to improve this quarter, with 89% of EPR receiving an adequate or good rating. The peer review also identified areas of good practice. This includes patient centred decisions around frailty. In addition, holistic decision were noted with excellent recognition of the dying patient and clear involvement of those important to the patient. There were six patient records that received a “good” rating for quality, compared with two in the previous quarter. The panel continues to welcome observers from across the organisation to help raise awareness and embed learning from the peer reviews.				

RECOMMENDATIONS:	The Trust Board is recommended to:
	
	• Agree the quarterly dashboard (Appendix A) as the report to be published on the Trust public account.
	• Acknowledge the impact of the SJR process in identifying opportunities for improving care.
	• Acknowledge the good practice identified including:
	  ○ Patient centred decisions around frailty.
	  ○ Clear involvement of those important to the patient when making treatment and management decisions.
	  ○ Holistic decision making.

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:	1. Clinical Effectiveness Sub Committee 2. Quality and Performance Committee			
	Date:	5 March 2024 25 March 2024		
	Outcome:	Accepted		

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1. PURPOSE

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

Appendix A is a summary dashboard of the Q3 2023/24 Learning from Deaths review, and it is proposed this document is published on the Trust's public accounts by 31st March 2024 in accordance with the national framework and trust policy. The Q3 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q3. Learning from the panels is discussed later in this paper.

1.2 This paper was received positively for assurance at the Clinical Effectiveness Sub-committee held on 5 March 2024.

2. BACKGROUND

2.1 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 COHORT SUMMARY

3.1 The number of patients whose deaths were identified as in scope for review was 77 (50 concerns raised in Datix and 27 sampled for SJR).

3.2 Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 04/01/2024. Please note 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).
- 19 external concerns were raised through the Patient Experience module (Feedback).
- No concerns were raised both internally and externally.

3.2.1 Internal Concerns

Of the 31 internal concerns, 11 were reviewed and closed. There were no cases in which the investigation concluded the Trust had contributed in some way to that patient death.

3.2.2 External Concerns

Of the 19 external concerns that have been reported, 15 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. Four concerns have been closed with no causal factors identified.

3.2.4 Outcomes from concerns raised

The outcomes and actions from outstanding concerns will be reported by the patient safety team once the investigations are complete. The themes identified from the closed concerns can be found in section 3.3.2 below.

3.3 SJR Stage 1 Outcomes

21 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the dashboard (Appendix A). 16 patients received appropriate 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'*.

3.3.1 SJR Stage 2 Outcomes

Five cases were identified as needing second stage review following Stage 1. The second stage review concluded that one death was not avoidable, 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.

3.3.2 SJR & Concerns - Learning Themes

Detailed learning themes for concerns and SJRs can be found in the dashboard (Appendix A) and the Infographic (Appendix B). A summary of the themes includes:

EOC:

- Demand outstripped resources.
- Poor communication.
- Missed opportunity to upgrade.

PES:

- Limited information regarding clinical assessment/examination.
- MTS not used or not applied correctly.
- No referral to AVS/GP when appropriate to do so.
- No senior clinical advice sought.
- Quality of EPR.

4. OUTCOME OF LEARNING THEMES

4.1 A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums (ALFs) and individual frontline staff. The Q3 Learning from Deaths infographic (Appendix B) will be shared with the clinical leadership team.

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

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

5.1 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.

6. EQUALITY OR SUSTAINABILITY IMPACTS

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

7. RECOMMENDATIONS

7.1 The Trust Board is recommended to:

- Accept the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care.
- Acknowledge the good practice identified including:
    - Patient centred decisions around frailty.
    - Clear involvement of those important to the patient when making treatment and management decisions.
    - Holistic decision making.
    - Support the dissemination process as described in Section 4

NWAS Learning From Deaths Dashboard - Q3 of 2023 - 2024 (October - December)

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

Total Number of Deaths in Scope (Sample Cohort and Datix Incidents)*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
Oct-23	17	10	58.8%	2
Nov-23	26	11	42.3%	1
Dec-23	34	15	44.1%	2
This Quarter	**77**	**36**	**46.8%**	**5**
This Financial Year	198	107	54.0%	23

** 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.

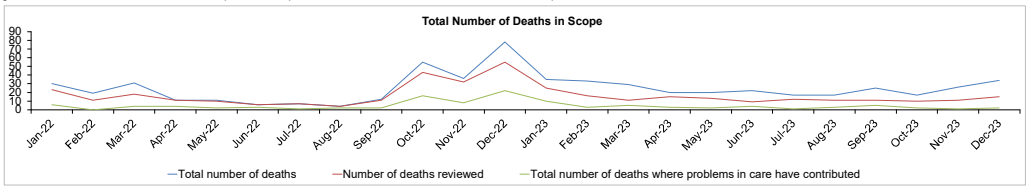


Figure 1

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)

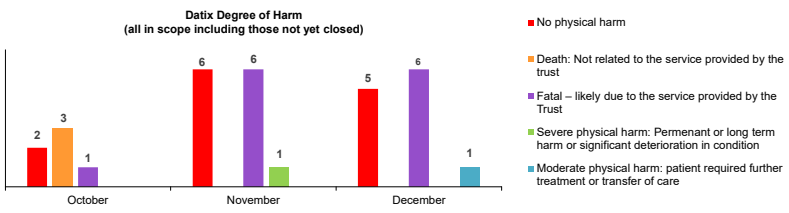


Figure 2

Total Datix Death Incidents in Scope		Number of Deaths Closed on Datix	Of those closed, Number of Deaths likely due to the service provided by the Trust	Lessons Learned complete for those closed and Deaths likely due to the service provided by the Trust
October	**6**	2	0	0
November	**13**	6	0	0
December	**12**	3	0	0
Total	**31**	**11**	**0**	**0**

Table 2

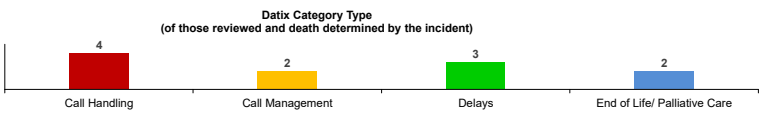


Figure 3

External Concerns

Number of Complaints		Incidents Closed on Pat. Exp.	Number closed and Deaths likely due to the service provided by the Trust
October	5	2	0
November	6	1	0
December	8	1	0
Total	**19**	**4**	**0**

Table 3

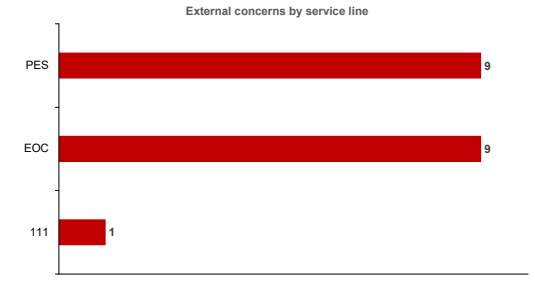


Figure 4

Department	Concern Raised	Cause and Actions	Total
111	Problem with patient disposition	Correct pathway not followed; Staff feedback and/or reflection	1
EOC	Problem with call taking and/or response allocation	Missed opportunity to divert ambulance; Still under review	2
		Still under review; Still under review	1
		Call categorised incorrectly; Missed opportunity to upgrade low acuity incident; Staff feedback and/or reflection	1
		Poor communication; Staff feedback and/or reflection	1
		Call categorised incorrectly; Missed opportunity to upgrade low acuity incident; Not upheld; No actions	1
		Demand outstripped resources; Hospital handover delays; No Action	1
	Problem with call taking and/or response allocation (DIB)	Demand outstripped resources; Staff feedback and/or reflection	1
	Problem with transporting EOLC patient back home/hospice	Demand outstripped resources; Not upheld; No actions	1
PES	Problem of any other type	Still under review; Still under review	1
	Problem related to treatment and management plan	Failure to recognise potential seriousness and complexity of condition; Still under review	1
		No causal factors; Not upheld; No actions	1
		Failure to recognise potential seriousness and complexity of condition; Staff feedback and/or reflection	1
		Failure to recognise potential seriousness and complexity of condition; Not upheld; No actions	1
	Problem with communication	Poor communication; Not upheld; No actions	1
		Crew did not act appropriately; Still under review	1
	Problem with patient disposition	Still under review; Still under review	2

Table 4

Structured Judgement Review Sample (SJR) Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.
This includes deaths classified as requiring a Category 1 or Category 2 response, Category 3 and Category 4 incidents that resulted in deaths and deaths of patients that were not initially conveyed and the ambulance service was re-contacted within 24 hours.

Structured Judgement Review

Incidents used for the Sample Criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
October	6	6	2
November	7	4	1
December	14	11	2
Total	**27**	**21**	**5**

Table 5

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

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‡	0	21	0	**21/21 patients**	**100%**
Right Care	Patient Assessment Rating	3	16	2	**18/21 patients**	**86%**
	Management Plan/Procedure Rating	4	15	2	**17/21 patients**	**81%**
Right Place	Patient Disposition Rating	3	16	2	**18/21 patients**	**86%**

Table 6

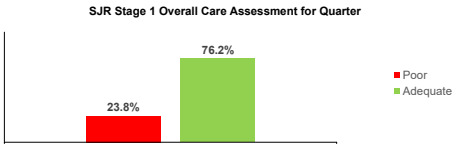


Figure 5

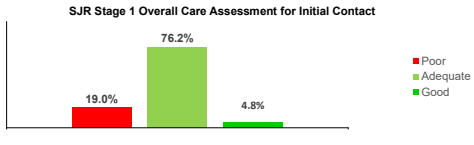


Figure 6

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‡	1	12	0	**12/13 patients**	**92%**
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 7

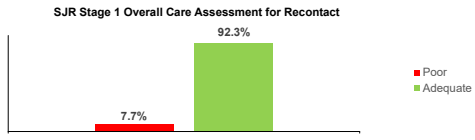


Figure 7

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 21 patients)

Evidence of Poor/Very Poor Practice

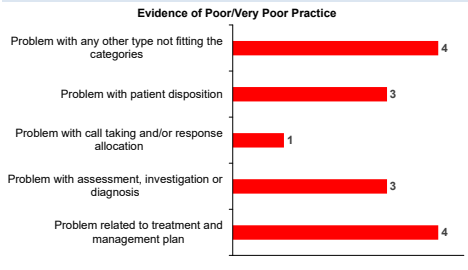


Figure 8

Department	Learning Theme	Learning Detail	Total
PES	Problem with assessment, investigation or diagnosis	Limited information recorded regarding clinical assessment, examination and outcome	3
		No observations recorded	1
	Problem related to treatment and management plan	Crew documented patient refusal but don't stay why - always good to document the wishes or reasons of the patient as gives / builds a picture as to why	1
		MTS not applied correctly	1
		MTS not used	1
		No senior clinical advice sought	1
		Lack of clear impression, working diagnosis and differentials	1
		No specific worsening advice	2
	Problem with patient disposition	No referral to AVS/GP/alternative providers when appropriate to do so	3
	Problem with any other type not fitting the categories	Quality of EPR	4
EOC	Problem with call taking and/or response allocation	Call not triaged correctly (safe with learning)	1

Table 8

Evidence of Good/Very Good Practice

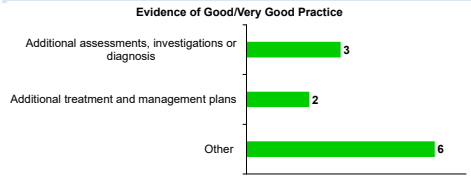


Figure 9

Department	Learning Theme	Learning Detail	Total
PES	Additional assessments, investigations or diagnosis	Documentation states involvement of those important to the patient, with holistic conversation noted	2
		Patient centred decisions around frailty, comorbidities and history	1
		Extensive patient assessment	1
	Additional treatment and management plans	Holistic decision making reported	1
		Multiple sets of observations and discussed patient's condition with GP and family	1
		Excellent recognition of patient dying	2
	Other	Quality of EPR	6

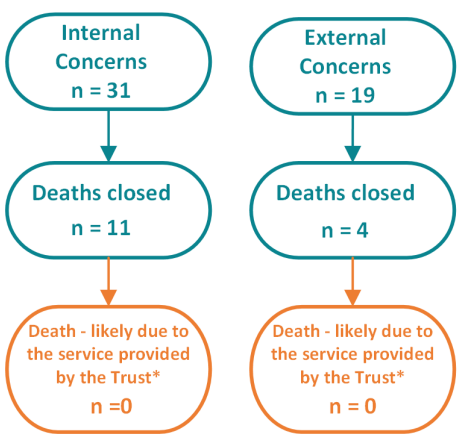
Table 9

Data last accessed 20/02/2024

NWAS LEARNING FROM DEATHS (LFD)

Q3 2023/24 Report

DEATHS WITH CONCERNS RAISED IN DATIX



*as classified by the Datix investigator

100%

had no causal factors identified

KEY LEARNING THEMES FROM CONCERNS

Emergency Operations Centre (EOC)

- Problem with call taking and/or response allocation - demand outstripped resources
- Problem with call taking and/or response allocation - poor communication
- Problem with call taking and/or response allocation - missed opportunity to upgrade

Paramedic Emergency Service (PES)

- Problem related to treatment and management plan - Failure to recognise potential seriousness and complexity of condition

111

- Problem with patient disposition - correct pathway not followed

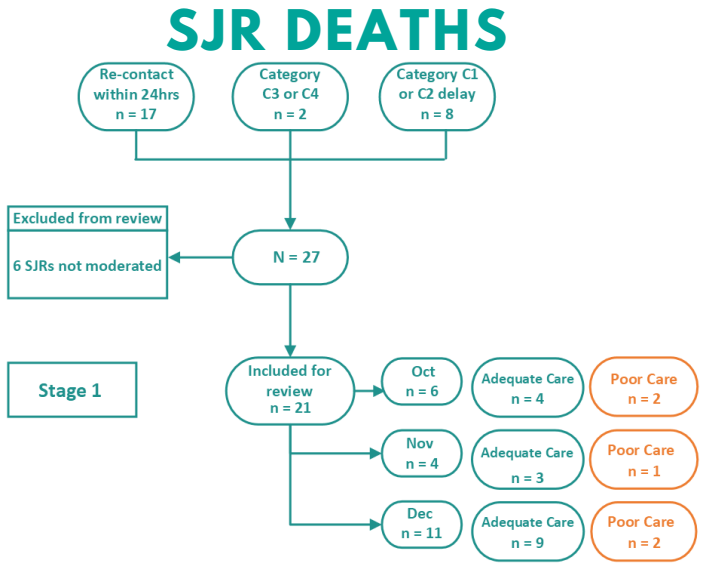
for more information on themes, full dashboard available on request

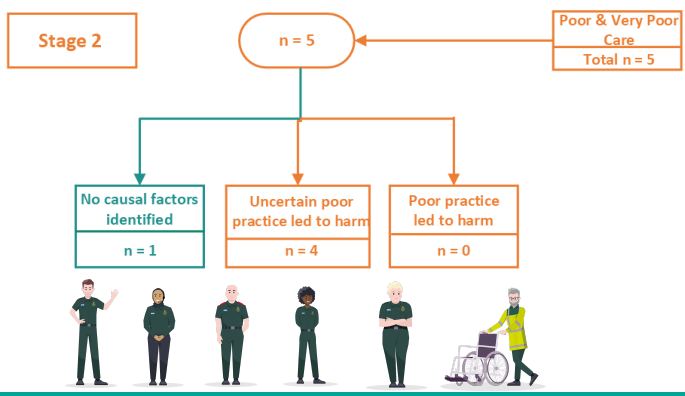
STRUCTURED JUDGEMENT REVIEW PHASES & OUTCOMES

- Call Handling/ Categorisation/ Resource Allocation
- Patient Assessment
- Management Plan/Procedure
- Patient Disposition

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

SJR DEATHS





STAGE 1 - SJR OUTCOMES

76.2% of patients received appropriate care

SJR STAGE 2 THEMES

Problem in call taking and/or response allocation?

- Call not triaged correctly (safe with learning)

Problem in assessment, investigation or diagnosis

- Limited information recorded regarding clinical assessment, examination and outcome
- No clinical observations recorded

Problem relating to treatment and management plan

- MTS not used or not applied correctly
- Crew document patient refusal but don't state reasons why
- No specific worsening advice
- No senior clinical advice sought

Problem with patient disposition

- No referral to AVS/GP when appropriate to do so (x3)

Problem of any other type

- Poor clinical documentation (x4)

EVIDENCE OF GOOD PRACTICE

Additional assessments, investigations or diagnosis

- Patient centred decisions around frailty, comorbidities and history
- Involvement of those important to the patient
- Extensive patient assessment

Additional treatment and management plans

- Multiple sets of observations and discussed condition with GP and family
- Holistic decision making recorded
- Excellent recognition of patient dying

Other

- Quality of EPR (x6)

well done!

Acknowledging good care and practice - **7 letters sent out**

SJR PATIENT DEMOGRAPHICS

29% Female

71% Male

76%

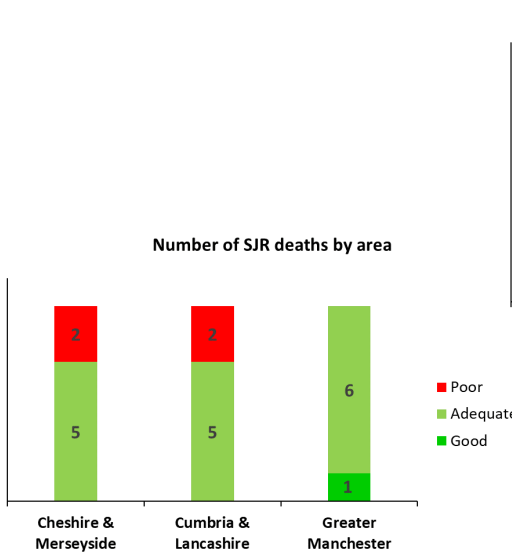
More than 3/4 of patients ethnicity recorded as White (British)

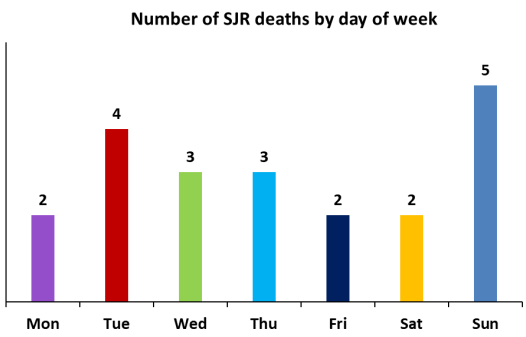
86% of the sample were over 65 years old

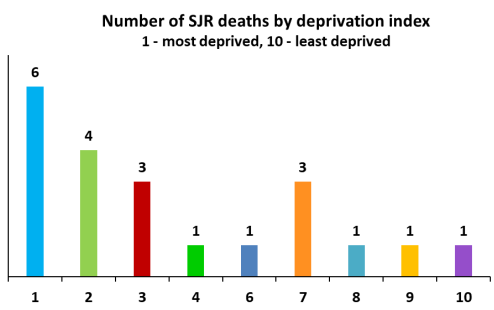
NWAS LEARNING FROM DEATHS (LFD)

Q3 2023/24 Report

SJR PATIENT DEMOGRAPHICS







SJR GENERAL LEARNING THEMES

PES LEARNING

- Crews should continue to utilise Clinical Hub/Critical Incident Hub for escalation regarding resuscitation
- GP not notified when patient passes away at scene
- Asystole ECG strip not uploaded to media for DOA/TOR
- Crews using 'Unwell Adult' MTS card when more appropriate cards are available
- More detailed assessment needed to support decision to leave patient at home
- Crews advocating for patients best interest with other HCPs
- Crews using holistic decision making with palliative/EOL patients
- Good use of CIH for joint decision making
- Quick referral to GP services for assistance with very unwell patients
- Clear and detailed worsening advice documented

EOC LEARNING

- Learning required for EMAs regarding presence of DNAR and how to triage down pathways
- Vehicles not always diverted away when calls are downgraded
- EMAs not recognising when patients are clearly deceased
- Good use of the Non-Clinical Advice Hunt by EMAs for complex calls

SJR ACTIONS

- CP to consider if Duty of Candour is required
- CP to explore timescales within call to provide further information
- AP to provide feedback to crew on poor elements of EPR
- CP/EOL Lead to feedback to local services regarding difficulties arranging EOL care
- EMA to receive audit and feedback around call handling (x2)

IMPROVEMENTS

- To continue to improve the quality of EPRs
- To improve the DCIQ learning from deaths module ready for 2024/2025
- To continue to widely distribute the learning themes to our staff network
- To refine reporting and perform a thematic analysis of the LfD dataset within DCIQ
- To explore how we can link our processes smoothly with PSIRF

PANEL DATES 2023/24

Open for all staff to attend

Period	Date
January 2024 February 2024 March 2024	12th March 2024 16th April 2024 TBC
Further information regarding future panel dates will be distributed in the coming weeks	

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

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th March 2024				
SUBJECT:	Policy on Learning from Deaths – Scheduled Review				
PRESENTED BY:	Dr C Grant, Executive Medical Director				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☐	☐	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	Under the National Framework, the Board of Directors has the accountability for the ownership of Learning from Deaths via the approval of this policy and the commitment to ensuring sufficient resource is available to facilitate review and learning across the organisation. A scheduled review has been undertaken by the Trust's Consultant Paramedic (Medical Directorate) with minor amends and updates identified, to reflect - • the introduction of the Patient Safety Incident Response Framework (PSIRF) and • changes to the Trust's Corporate Governance Structure and process from 1st April 2024/25. The amended Policy (**attached**) has been approved by the Executive Lead and reviewed by the Quality and Performance Committee on 25th March 2024.				
RECOMMENDATIONS:	The Board of Directors are requested to – • Note the minor updates to the Trust's Policy on Learning from Deaths. • Approve the updated Trust Policy on Learning from Deaths.				
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:	Medical Director, Executive Lead			
	Date:			
	Outcome:			

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1. PURPOSE

Under the National Framework, the Board of Directors has the accountability for the ownership of Learning from Deaths via the approval of this policy and the commitment to ensuring sufficient resource is available to facilitate learning across the organisation.

2. BACKGROUND

The North West Ambulance Service (NWAS) has a clear ambition and direction to be the best ambulance service in the UK and is committed to the delivery of safe, effective, and patient centred care for every patient. These commitments are underpinned by a promise to become a sector leading learning organisation whereby the care we deliver is informed by a constant process of scrutiny.

This Policy on Learning from Deaths sets out the practices that will be used within NWAS to review and learn from the deaths of patients who had been under our care. This learning will ensure we are able to protect future patients from avoidable harm, reduce unwarranted variation and provide truly patient-centred care. This Policy is consistent with the national guidance for ambulance trusts on learning from deaths and formally establishes the implementation of a standardised and transparent approach to learning.

3. REVIEW OF POLICY

A scheduled review was undertaken by the Trust's Consultant Paramedic (Medical Directorate) with minor amends and updates identified, to reflect changes to Corporate Governance Structure and process.

The amended Policy (**attached**) has been approved by the Executive Medical Director (Learning from DeathsExecutive Lead), and the Trust's Quality and Performance Committee at the meeting on 25th March 2024.

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

In line with the 2017 National Quality Board's (NQB) Learning from Deaths Framework applicable to all NHS acute, mental health and community Trusts.

5. EQUALITY OR SUSTAINABILITY IMPACTS

No equality or sustainability implications have been identified.

6. RECOMMENDATIONS

- Note the minor updates to the Trust's Policy on Learning from Deaths.
- Approve the updated Policy on Learning from Deaths..

NHS
North West
Ambulance Service
NHS Trust

Policy on

Learning from Deaths

Safe, Effective and Patient Centred Care, Every Time

Recommended by	Quality & Performance Committee
Approved by	Board of Directors
Approval date	27th March 2024
Version number	1.3
Review date	March 2027
Responsible Director	Executive Medical Director
Responsible Manager (Sponsor)	Consultant Paramedic (Medical Directorate)
For use by	All Trust employees and volunteers

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	September 2019	November 2019	Consultant Paramedic (Medical Directorate)	Document creation
0.2	November 2019	November 2019	Consultant Paramedic (Medical Directorate)	Amends following review by Clinical Effectiveness Management Group (CEMG); Sections 8, 9 & 10.
0.3	November 2019	November 2019	Consultant Paramedic (Medical Directorate)	Addition of Section 11 following Head of Legal Services review
1.0	November 2019	December 2019	Consultant Paramedic (Medical Directorate)	Policy finalisation following Committee review. No significant change
1.1	December 2021	January 2022	Consultant Paramedic (Medical Directorate)	Scheduled review. Minor amends and updates reflecting changes to Corporate Governance Structure and process
1.2	December 2023	February 2024	Consultant Paramedic (Medical Directorate)	Scheduled review. Changes to align to PSIRF introduction. Minor changes to reflect Trust strategies update.

Policy on Learning from Deaths

Contents

1. Introduction

In 2016 the Care Quality Commission (CQC) published their report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'. It found that learning from deaths was not being given sufficient priority in many NHS organisations and consequently valuable opportunities for improvement were being missed. The report highlighted NHS organisations could do more to engage families and carers with recognition that their insights are a vital learning source. In 2017, the National Quality Board's (NQB) 'Learning from Deaths framework' applicable to all NHS acute, mental health and community trusts was published.

In 2018, the Department of Health and Social Care announced its intent to extend the principles of the learning from death process to ambulances trusts. Under the auspices of the Association of Ambulance Chief Executives (AACE), the National Ambulance Service Medical Directors (NASMeD) committed to a formal process with the NQB to produce a national framework for the sector.

The NQB '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' was published in 2019. It sets the national standards and requirements for ambulance trusts to undertake a process of learning from deaths and makes a requirement that all ambulance trusts formally develop and publish a Policy on Learning from Deaths. The North West Ambulance Service Policy on Learning from Deaths commits the organisation to a process of learning in order to improve the care delivered to our patients and reducing avoidable harm and deaths.

2. Executive Summary

The North West Ambulance Service (NWAS) has a vision to deliver the right care, at the right time, in the right place. These commitments are underpinned by a promise to provide high-quality, inclusive care and to use learning to continuously improve the safety of our systems, processes, and practices whereby the care we deliver is informed by a constant process of review.

This Policy on Learning from Deaths sets out the practices that will be used within NWAS to review and learn from the deaths of patients who had been under our care. This learning will ensure we are able to protect future patients from avoidable harm, reduce unwarranted variation and provide truly patient-centred care. This Policy is consistent with the national guidance for ambulance trusts on learning from deaths and formally establishes the implementation of a standardised and transparent approach to learning.

This policy goes far beyond a process of simply counting, classifying, and reporting deaths; it is a commitment to supporting our journey towards providing an outstanding service to patients, their families and carers.

3. Scope

This policy applies to all Trust staff, including volunteers.

4. Duties and Responsibilities

Board of Directors

The Board of Directors has the accountability for the ownership of Learning from Deaths via the approval of this policy and the commitment to ensuring sufficient resource is available to facilitate learning across the organisation.

Chief Executive

The Chief Executive has overall responsibility for ensuring a Learning from Deaths process in place within the trust and for meeting all internal and external reporting requirements. The Chief Executive will delegate this responsibility to the Executive Medical Director.

Executive Medical Director

The Executive Medical Director has ownership of the policy on behalf of the Chief Executive. They will ensure that any changes in legislation or national guidance relating to Learning from Deaths are made known to the Executive Leadership Committee and the Board of Directors via the Quality & Performance Committee.

Executive Directors

It is the responsibility of Executive Directors to ensure compliance with this policy within their area of control, to monitor all relevant learning resulting from the learning from deaths process and ensuring that any recommendations regarding actions are implemented.

Consultant Paramedic (Medical Directorate)

It is the responsibility of the Consultant Paramedic (Medical Directorate) to provide professional clinical advice and guidance with regard to the learning from deaths process and ensure reports are completed in order that learning is disseminated and actioned within the organisation.

All Senior Clinicians and Managers

It is the responsibility of senior clinicians and managers to ensure this policy and associated procedures are implemented within their areas of responsibility and to participate fully with the review process in a timely manner. All senior clinicians and manages will commit to providing feedback to their staff on the review process and subsequent learning. Senior clinicians and managers have the responsibility to provide assurance to their management team on the progression and quality of case reviews.

All Employees

It is the responsibility of all employees, and volunteers where necessary, to participate in the learning from deaths process promptly, openly and honestly.

5. Our Approach to Learning From Deaths

Our Policy on Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. In establishing a robust methodology to learn from deaths, and in particular to determine whether harm has occurred during the final episodes of life, we have enabled the opportunity to evolve our systems of care to deliver against our core purpose to save lives and reduce harm. This policy challenges the organisation to scrutinise the care we deliver to patients who die within our care. NWAS must identify suboptimal care which reaches the patient because of something we should have done but didn't, or something we did do but shouldn't have; it challenges us to get better and supports the identification of areas for improvement.

We have adopted a process of structured judgement review in order to systematically and consistently scrutinise the care provided to patients and therefore use the opportunity to increase safety and reliability as well as promote the adoption of improvement methodology to make real changes to practice.

This policy contributes to the systems and processes already established within the Trust and whilst it formally commits the organisation to a process of learning from deaths which occur whilst patients are within our care, it serves to augment organisational learning and compliments the established clinical governance, patient safety and quality improvement procedures including those around the Patient Safety Incident Response Framework (PSIRF) and clinical audit.

This policy seeks to strengthen and develop our partnership approach to information sharing and joint learning. We recognise that opportunities for system-based learning should be actively sought and that working in isolation is detrimental to patients. We will work with our partners across the healthcare system in the North West to proactively share information and collaborate with the aim of supporting system level and cross-agency learning and improvement in accordance with the PSIRF principles. This is not a new commitment, but through the implementation of this policy we will seek to formalise the arrangements we currently have with

our partners and commit to a central role within the health system of the North West in learning from the deaths of patients in our care.

In the emotive period following bereavement, this Policy makes a commitment to family members, carers and loved ones that we will apply a genuinely empathetic approach to listening to concerns and communicating openly with them throughout.

6. Determining Deaths in Scope for Review

This Policy on Learning from Deaths aligns with the definitions and recommendations within the National Framework for NHS ambulance trusts in describing the scope for patients considered as appropriate for case record review. However, it is clear that this does not mean that all deaths in scope must be reviewed. Section 7 articulates how we will determine of those cases that are eligible for consideration, which ones will be subject to a review. Hence, the deaths that are initially in scope are as follows:

- Any patient who dies while under the care of NWAS. These are patients who die from the point of a 999 call being made and their care being transferred to another part of the system, or to the point they are discharged from NWAS after a decision is made not to convey them to hospital. This category includes patients who are transported using subcontracted alternative patient transport. This definition includes the periods of time where the 999 call is being handled, in the time between the 999 call being handled and a resource arriving at the scene, whilst at the scene, during transport or before the handover concludes.

- Any patient who dies after handover. As it is acknowledged that patient identification may be an issue; NWAS is only to consider these deaths in scope when they are notified of them by a partner agency.

- Any patient who dies within 24 hours of contact with NWAS where a decision was taken not to convey them to hospital. This includes ‘hear and treat’ as well as a visit by ambulance clinicians but excludes patients at the end of life and where a specific care plan or advanced directive is in existence.

7. Determining Which Deaths Should be Reviewed

In accordance with the national framework, not all deaths in scope must be or will be reviewed. A two-tier process of selection to determine which cases are selected for case record review will be utilised which is both recommended within the framework and appropriate to ensure maximum benefit for organisational learning within NWAS.

The national guidance stipulates that the Trust must review **all** deaths where ambulance service personnel, other health and care staff, and / or families or carers have raised a concern about the care provided, including concerns about end-of-life care. This includes any concern raised that cannot be answered fully at the time or anything not answered to the satisfaction of the person raising the concern. These notifications, and the subsequent review, investigation, and management fall under the Trust's Patient Safety Incident Response (PSIRF) Policy as detailed in Section 10.

In addition, the Trust will review a sample of each of the four categories listed below.

- Deaths of patients assessed as requiring category 1 and category 2 responses where there has been a delayed ambulance response.

- Deaths of patients assessed as requiring category 3 and category 4 responses.

- Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider, when this information is known by way of notification to NWAS.

- Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with NWAS within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

The Trust will determine a number across the four identified categories listed above which would equate to 40 to 50 case reviews per quarter; this sample size produces a rich source of information on care quality and on problems in care (Royal College of Physicians, 2016).

It is these reviews that this policy pertains to, with the Learning from Deaths methodology providing a bespoke and comprehensive review of the sample incidents.

Additional Reporting Requirements:

- **Deaths of Patients with Learning Disabilities**

The Trust must report all deaths of those aged over four with a known learning disability to the Learning Disabilities Mortality Review (LeDeR) Programme. The Trust will contribute to their review processes when approached and share its review findings with LeDeR when relevant. The Learning Disabilities Mortality Review programme is aimed at reviewing all cases of death of an adult or child with learning disabilities, to identify any factors associated with that death that may have been preventable, and to learn from them. Where it is known or suspected that that an adult or child has a learning disability and has undergone a diagnosis of death, or termination of resuscitation, then details of the learning disability must be recorded on the Diagnosis of Death form and reported to the Support Centre for formal reporting. The Trust commits to participating fully in LeDeR programme reviews when approached to do so.

- **Maternal and Neonatal Deaths**

Maternal deaths will be reported to the Healthcare Safety Investigations Branch (HSIB) and the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). The Trust's Resuscitation (Diagnosis of Death) Policy should be followed for all maternal deaths.

Neonatal deaths are managed in line with the guidance and processes detailed within the Trust's Sudden Unexpected Death in Infancy, Children and Adolescents (SUDICA) procedures which includes formal notification to partner agencies.

The Trust will contribute to HSIB, MBRRACE and SUDICA review processes through this information sharing process and will, when approached, contribute to reviews and investigations and share its review findings when relevant.

- **Paediatric Deaths**

The Child Death Review Statutory and Operational Guidance outlines the Trust's statutory duties with regards to notification and information gathering. The Trust will participate in child

death review meetings, including Child Death Overview Panel (CDOP) meetings, whenever notified. In the event of a sudden unexpected death in a patient under 18 years, the Trust's Sudden Unexpected Death in Infants, Childhood or Adolescents (SUDICA) procedures for the management of these incidents including the involvement of the police and partner agencies will be followed. Attendance at Child Death panels may be required, and this governance resides under the Trust's Safeguarding Team.

- **Safeguarding Concerns**

Any deaths where there are safeguarding concerns (either adult or child) should be referred to the Trust's Safeguarding Team or Head of Safeguarding (Head of Clinical Safety) in line with our statutory duties. The Safeguarding Team has the responsibility for the liaison with partner agencies and for facilitating Trust involvement in any subsequent review processes.

- **Deaths in Custody**

These deaths fall under the relevant police forces' remit; the Trust will participate and contribute to any formal reviews arising from deaths in custody whenever approached.

There may be cases, in addition to reporting provisions listed above, when the Trust will make the decision to conduct our own review of the death in addition to the formal, national process. This is likely only to be applicable if we identify at early stage that there are potential learning improvement actions which need to be taken in advance of the national review process to prevent reoccurrence or further harm. However, this is discretionary and will always be in addition to the Trust's requirements to notify and contribute to the national review programmes of the death.

The Trust will consider each case individually in order to determine whether it should also undertake a review in each circumstance and will consider its decision to undertake an independent review of these deaths in discussion with the relevant review programme, to minimise duplication.

8. Case Record Reviews

NWAS utilises a structured method of case review for those deaths identified for inclusion utilising a standard methodology based upon an adaptation of the Royal College of Physicians' Structured Judgement Review process. The objective of the structured judgement review methodology is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the systems and processes in use where care goes well and to identify points where there may be gaps, problems or difficulty in the care process. In order to identify the strengths and weaknesses of individual patient contact episodes there is a need to look at the full range of care provided to an individual; adopting this holistic care approach allows for the nuances of individual cases and the outcomes of interventions to be considered.

An important feature of this method is that the quality and safety of care is judged and recorded whatever the overall judgement of the case and good care is judged and recorded in the same detail as care that has been judged to be problematic; we commit to doing this. Evidence shows that most of the care provided within the NHS is of good or excellent quality; there is much to be learned from the consideration of high-quality care and these opportunities should not be overlooked. By supporting the implementation of this methodology, the knowledge and expertise gained will be transferable to other areas of reflection and review within the organisation. The methodology could, for example, be used to rigorously assess the care provided for people who have had a cardiac arrest and therefore enhance the organisational learning we can derived from such cases in addition to those identified by the learning from deaths process.

The structured judgement reviews for Learning from Deaths are undertaken by senior clinicians within our organisation and the appropriate subject matter experts depending on each individual case. We will commit to the necessary training for these individuals to provide a consistent and standardised approach across the organisation. Following implementation of the structured judgement reviews methodology and training there is the opportunity to use this acquired expertise in other areas of the Trust's investigation and learning processes; any decision for further adoption of the methodology lies with the responsible managers and directors for those processes.

9. Learning from Reviews

NWAS has a commitment to develop and work on our culture to become a learning organisation; this policy supports the aim of achieving this and contributes to our development as a learning organisation through the processes highlighted.

In accordance with the NQB Framework requirements we publish quarterly Learning from Deaths reports. These reports will draw upon learning from deaths data acquired in the previous quarter and will be submitted to the Clinical and Quality Group, Quality and Performance Committee and ultimately the Trust Board. Following approval Trust wide dissemination of the reports will take place together with associate briefing documents to ensure learning is accessible to all clinicians and staff. The Area Learning Forums will be utilised as key vehicles to present and share reports and key learning ensuring the dissemination is embedded within the formal sharing arrangements within the Trust.

The Trust will commit to share learning from reviews and investigations through the National Ambulance Risk and Safety Forum who will highlight trends to the National Ambulance Quality, Governance and Risk Directors Group (QGARD).

10. Patient Safety Incident Response Framework (PSIRF)

This Learning from Deaths Policy enhances and compliments the NWAS Patient Safety Incident Response Plan and Policy.

PSIRF supports organisations to use their incident response resources to maximise improvement, rather than repeatedly responding to patient safety incidents based on subjective thresholds and definitions of harm, from which new learning will be limited.

Some patient safety incidents, such as deaths though more likely than not due to problems in care (that is, those meeting the Learning from Deaths criteria for investigation) all require a Patient Safety Incident Investigation (PSII) to learn and improve.

Patient safety concerns identified at any stage of the Learning from Deaths process should be escalated by the Consultant Paramedic (Medical Directorate) to the PSIRF Team. The concern should be reported within the Events Module in the Datix Cloud IQ (DCIQ) system. All patient

safety concerns must be reported via the DCIQ system, this also allows the notification to the NHS England, Learning from Patient Safety Events (LFPSE) system.

All reported patient safety concerns will be triaged and reviewed against the NWAS Patient Safety Incident Response Plan and Policy to determine the level of learning response. Patient safety incidents that meet a National Requirement or a NWAS Local Priority will require the completion of a pro-forma and will be presented to the Patient Safety Event Cases (PSEC) Group. The PSEC group will determine if the incident meets a National Requirement or a NWAS Local Priority and if a Patient Safety Incident Investigation (PSII) is required.

NWAS will ensure that our people who are affected by the patient safety incident will be afforded the necessary support and given time to participate in a patient safety learning response, under PSIRF. All NWAS leaders will work within our just culture principles and utilise other teams to ensure our people are supported. NWAS service lines will ensure processes are adopted so leaders work within the PSIRF principles to ensure psychological safety.

11. Coronial Engagement

In addition to the statutory and legal requirements place upon us to contribute to and participate in coronial processes, through the implementation of this policy we commit to strengthening the relationships we have with Coroners across the north west region and proactively engage with Coroner's Offices in order to both share learning and enhance the opportunity for learning for us as an organisation.

Through this policy we will commit to embedding the learning and lessons learnt from Coroner's Hearings and conclusions and will implement a process of dissemination across the organisation utilising the Area Learning Forums as a key vehicle to share learning with clinicians and staff. Learning from Deaths reports will, where appropriate, contain significant learning from coronial processes as an included section and key messages will be disseminated within the associated briefing documents.

We recognise that proactive engagement with Coroners will strengthen professional relationships; selected and appropriate learning that the Trust derives because of the implementation of this policy will be shared with Coroner's Offices where the learning will be of interest from those incidents occurring within individual Coroner's jurisdictions.

12. Bereaved Families and Carers

A culture of openness, transparency and candour is essential to improving patient safety. The Trust's established Duty of Candour Procedure will be used to guide the processes for the interaction with bereaved families and carers during reviews of cases identified. NWAS is committed to engaging in a meaningful and compassionate way with bereaved families and carers. They will be provided with a primary point of contact and consulted on how they wish to receive feedback following the process. This will include cases where a joint review is being undertaken and where a death has been referred to the coroner and will be the subject of an inquest.

The Trust also has a statutory and contractual duty to meet the NHS standards of the Duty of Candour wherever there has been a notifiable patient safety incident. Where a case review identified through the Learning from Deaths process identifies concerns, the initiation of the Duty of Candour process will be rigorously applied.

A greater voice to the bereaved families and carers will be established through engagement with the Trust's Patient & Public Panel (PPP). The PPP have provided scrutiny of our learning from death processes and provided assurance that we are meeting the needs of the population we serve. Invited members of the PPP will contribute to the moderation of individual case reviews providing the vital family, carer and public perspective.

13. Supporting Our Staff

NWAS is committed in supporting our staff in the event of a death of family member, friend, colleague or patient. Occupational health provide staff with access to independent and confidential counselling and support to help them deal with work related and personal issues. Contact details can be found on the *Invest in Yourself* pages on the intranet.

The Trust also provides a safe and robust Trauma Risk Management (TRIM) assessment service for any member of staff to access. The TRIM system is a post traumatic peer led risk assessment tool which aims to keep staff functioning after a traumatic event, such as a death of a patient, and provides information about personal resilience to staff and managers as well as identifying staff that may need specialised help. The Trust also has an extensive network of peer support / Blue Light Champions who are also available to provide a listening ear and signpost to further services where necessary.

Our commitment to staff is to have a just culture. The basis for this is a shared set of values in which our staff trust that all case reviews, and where applicable investigations, will result in a timely, fair and comprehensive process. Staff are assured that any actions, omissions or decisions that reflect the conduct of a reasonable person under the same circumstances will not be subject to inappropriate or punitive sanctions.

14. Reporting and Monitoring Arrangements

The Trust will present quarterly reports on the outcomes of the Learning from Death reviews to the Clinical and Quality Group, the Quality and Performance Committee and ultimately to the Board of Directors. Scrutiny will be provided via this established governance process and serve to ensure that this Policy and the associated processes are fit for purpose and delivering upon their intended aims.

The Trust will produce an annual summary of learning from deaths within its Quality Account. This will provide a consolidation of the quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these.

References

CQC (2016) ‘Learning, Candour and Accountability: A Review of the Way NHS Trusts Review and Investigate the Deaths of Patients in England’. London: CQC

NHS England (2022) Patient Safety Incident Response Framework (V1). London: NHS England

NHS Improvement (2018) ‘Just Culture Guide’. London: NHS Improvement

National Quality Board (2018) ‘Learning from Deaths: Guidance for NHS Trusts on Working with Bereaved Families and Carers’. London: National Quality Board

National Quality Board (2019) ‘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’. London: National Quality Board

Royal College of Physicians (2016) ‘Using the Structured Judgement Review Method: A Guide for Reviewers (England)’. London: Royal College of Physicians

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27 March 2024				
SUBJECT:	EPRR Annual Assurance Update				
PRESENTED BY:	Salman Desai, Deputy Chief Executive/COO				
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. The process for assessment in 2023 was different to previous years as NHS England and the ICBs wanted to more scrutiny to ensure the statements from providers could be ratified through uploaded evidence. NWAS was assessed directly by NHS England North rather than L&SC ICB. NHSE North also assessed NEAS and YAS. 2 rounds of check and challenge took place, the final submission and				

	statements of compliance from NWAS was given on 5th December 2023. Some Trusts took the view that it was a self-assessment and remained with their submission position. NWAS took the view that it was an opportunity to understand how NHS England interpreted the standards they presented and to work towards those newly expressed goals. This report provides and overview of the action trackers and updates for the self-assessment in line with the EPRR Annual Assurance process for 2023/2024. The EPRR Statement of Compliance as of December 2023 is as follows: • EPRR Core Standards: non-compliant • NHS 111 EPRR Core Standards: non-compliant • PTS EPRR Core Standards: non-compliant • Interoperability Capabilities: non-compliant As a 'non-compliant' service, NWAS will provide monthly updates to the ICB regarding progress on actions. Core Standards for 2024 will also be discussed in the national EPRRG meetings in January, April and July to improve parity of approach between ambulance services. This has not previously taken place. The Trust has been delivering most of the content of the standards, but the level of governance and assurance requires review. Area for actions are: • Board assurance reporting • Finance and resourcing • Risk • Plan review • Training and exercising • Comms planning • Estates (evacuation and lockdown) • Business continuity • ICC (including CAD testing) • CBRN audit and training • Interoperability Appendices attached: 1..Action plan (including deep dive) – PES / 111/ PTS (focus on standards) 2.Action plan – Interoperable capabilities (focus on standards) 3.Action plan summary (focus on actions)
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 core areas and the additional area 'interoperable capabilities' following the self-assessment. • Note and support all action plans against the domains to ensure all elements move to compliant prior to the next assessment.
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 Subcommittee			
	Date:	11th March 2024		
	Outcome:	Noted		

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1. PURPOSE

1.1 This report provides the Board with an update of the findings from the 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 compliance following the check and challenge delivered by NHS England North.

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.

2.2 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.

2.3 NHS England requires this assurance process 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 1 and 2). This plan will demonstrate the intention of each Trust to address any outstanding issues and give an indication of priority and timescale for resolution. L&SC ICB have requested regular updates for inclusion in their reports to the LHRP.

2.4 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. They are based on robust delivery of duties under the Civil Contingencies Act (2004).

2.5 The core standards cover 10 main 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.

2.6 An additional domain for ambulance services is interoperable capabilities. This is assessed and scored but is not included in the overall score for the Service, nor is it covered in the check and challenge. Therefore the 2 areas for self-assessment as part of the EPRR annual assurance for the trust is as follows:

- EPRR Core Standards (inc PTS and 111)
- Interoperability Capabilities

2.7 The NHS core standards for EPRR cover 10 core domains:

- Governance
- Duty to risk assess
- Duty to maintain plans
- Command and control
- Training and exercising
- Response
- Warning and informing
- Cooperation
- Business continuity
- Hazmat and Chemical Biological Radiological Nuclear (CBRN)

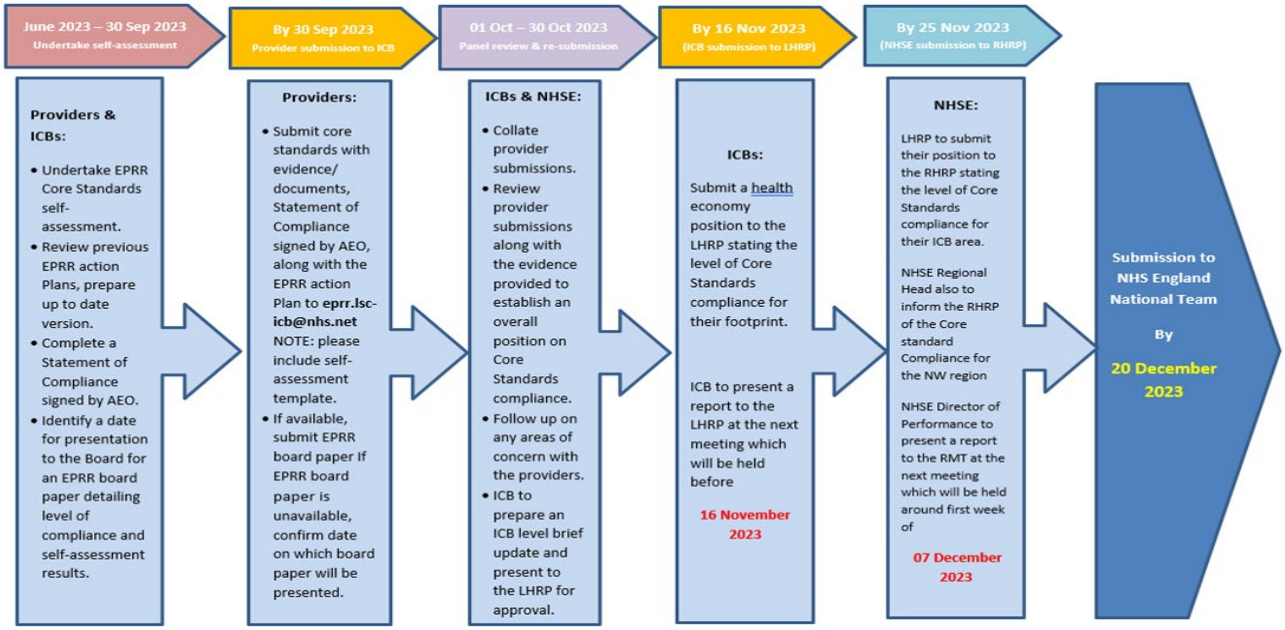
2.8 The Interoperable Capabilities section contains:

- 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)

2.9 The 2023/24 EPRR annual deep dive focuses on EPRR responder training.

2.10 Changes to the assessment methodology

2.10.1 As per previous years, NHS organisations have undertaken a self-assessment against the 2023 core standards, the outcome of which will be published in the trust's annual report. In a change to previous assessment processes, the providers were expected to work with the commissioning ICB, providing extensive evidence to support the statements allotted to each standard. The ICBs are empowered by NHS England to challenge the declaration or evidence and decide on the final compliance level once the confirm and challenge process is complete. The results are 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.



2.10.2 Lancashire and South Cumbria ICB required the evidence to be as shown in the section 'supporting information – including examples of evidence' on the spreadsheet as a minimum. 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.

2.10.3 Having raised a question of standardisation with national EPRR Group (ambulance services), it became apparent that ICBs are offering different levels of challenge in different areas. NWAS raised concerns with commissioners that there was a lack of parity. NHS England North have assessed NWAS, NEAS and YAS instead of the ICBs processing the evidence. The check and challenge process with additional submission took place in October and then again in November, NWAS provided their final submission on the 5 December 2023.

2.10.4 Some providers took the approach that it was a self-assessment and therefore could not be challenged by others. NWAS took the view that it was an opportunity to understand how NHS England interpreted the standards they presented, and to work towards those newly expressed goals to achieve compliance prior to the next submission in Q2 2024.

2.11 EPRR Annual Assurance and Statement of Compliance

2.11.1 NWAS provided the documentation for processing, and statements of compliance signed by the Accountable Emergency Officer. The ICBs included this in a report to NHS England and the Local Health Resilience Partnership.

2.11.2 Initial submission was on 27 September 2023 , final submission was 5 December 2023.

2.11.3 Detailed action plans have been developed, one covering 'NHS Ambulance Service Providers' 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 to continue improvement. A progress summary is also provided as some of the actions cover multiple standards and it is clearer for the updates to be provided in this way.

2.12 Organisational Assurance Rating

2.12.1 The number of core standards applicable differs between organisation types. The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with.

2.12.2 **Prior to check and challenge** and the explanation of expectations provided by NHS England, the NWAS submission was **91% (substantially compliant).**

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**

2.12.3 After the check and challenge and subsequent discussions, the NHS Ambulance Service assessment for NWAS is **41% (non-compliant)**. As PTS and 111 are a subset, they have fewer standards to meet (e.g. they don't have to show representation at LRFs) but the ones they have are the same as those for the wider service. NHS England are happy for them to be included in one piece of work but to have individual statements of compliance.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	3	3	0	0
Duty to risk assess	2	0	2	0	0
Duty to maintain plans	11	5	6	0	0
Command and control	2	1	1	0	0
Training and exercising	4	1	3	0	0
Response	5	3	2	0	2
Warning and informing	4	0	4	0	0
Cooperation	5	4	1	0	2
Business continuity	11	6	5	0	0
Hazmat/CBRN	8	1	7	0	11
Total	**58**	**24**	**34**	**0**	**15**

2.12.4 The **interoperability standards** are shown below at **90% (substantially compliant)** and were not subject to check and challenge therefore have not altered.

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	12	1	0
SORT Response Times	14	12	2	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	16	3	0
JESIP	13	11	2	0
Total	**136**	**123**	**13**	**0**

2.12.5 The action plan anticipates the trust will be fully compliant by the end of June 2024. The actions have been grouped in the summary to allow co-production across departments. This will mean that, although one area (e.g. PTS) may have completed an action, other areas (e.g. Ops) may not which will keep the action open. This will be reported in the progress.

2.12.6 38 actions will bring all 34 partially compliant standards to fully compliant.

2.12.7 Action groups and a summary of content are shown here:

- Board assurance
  - The content of the public Board reports should contain the detail listed in the core standards.
- Finance and resourcing
  - Request for funding from commissions and for HART uplift.
- Risk
  - Review of the process to establish risks to the Trust from risks identified in the National Risk Register, and to reflect this in the Risk Management Policy. This should be included in the annual workplan.
- Plan review
  - Review the Communicable disease, Pandemic and Incident Response plans
- Training and exercises
  - Create a testing programme for plans, and a training/exercising programme, for inclusion in the workplan. Exercises and plans should be matched to risks and logged on DCIQ as mitigation.

    - Formalise plan sharing and recording of feedback.
    - Creation of a Training Needs Analysis for all staff with a role in incident response. This will be updated from debriefs and national directives and should be reflected in Trust mandatory and induction training.
    - Standardisation of recording of training and exercise attendance.
- Comms planning
    - Update the comms incident response plans to include business continuity, critical and Major Incident processes and run an exercise to test it.
    - Establish a sign off process for situation reports and data sharing (links with Information Governance).
- Estates
    - Identify sites at risk from causes listed in the NHSE Evacuation and Shelter Guidance and ensure shelter, evacuation, and lockdown plans are in place and tested.
    - Ensure that PEEPs are in place for those who need them, and that the PEEPs are tested.
- Business Continuity
    - Include a thematic analysis of lessons in the EPRR Group report and to the Board
    - Complete an internal audit/peer review on a cyclical basis, and a periodic external audit (required by Q2 2024).
- ICC
    - Review major incident room processes/requirement and ensure they meet the principles shown in the NHSE EPRR Framework.
    - Develop exercise documentation for downtime and disruptions and an exercise schedule for CAD failure.
- CBRN
    - Roll out the new programme for CBRN training and audit at the Acutes, recorded through an MOU including frequency, show training is aligned with national guidance, and provide a report to the Acutes and NHSE showing the outcomes.
- Interoperability
    - Continue local negotiations with commissioners to increase HART baseline funding (Finance dept).
    - Development of response time reporting application (Digital).
    - Ongoing estates projects.
    - Ensure sufficient specialist assets can be deployed in the mandated timeframe.
    - Ensure the recruitment processes for those with command in their JD include a command assessment, and that ongoing compliance with NOS is monitored with non-compliant staff removed from the rota. To be included in the EPRR Group reports.
    - Recruit additional MERIT doctors to the rota, aligning their training and NOS compliance processes with the commanders and other command support staff.
    - Ensure >90% of staff have completed the JESIP awareness package (Area Directors).

2.12.8 In the interoperability standards, H16 refers to recording HART response times. This was initially rated as red as it hadn't been completed. It was amended to amber as assurances were received that progress was being made and it would be resolved before the next core standards assessment (July 2024).

2.12.9 The work required to move these standards to full compliance will be led by the resilience team but will require collaboration with other departments.

2.12.10 Progress to date in terms of completion:

- Pandemic plan has been reviewed and EPRR Group made aware of the additional information.
- Information sharing – requirement under the CCA, discussion with partners agreed a data sharing agreement is not required.

2.12.11 Progress for standards near completion:

- A template for the public Board report (July) has been developed to give high level assurance regarding training, exercises, lessons, and incidents. This will complete or add to several standards. Reports will go to Board July and January with governance aligned to EPRR Group and Quality and Performance Committee.
- EPRR workplan is under annual review through the EPRR Group.
- Risk and Resilience have nearly completed an assessment of the NRR and reflected it as risks to the Trust. The finished drafts will be shared with risk holders for agreement and mitigation. Risk management policy is receiving peer feedback and now includes a statement regarding NRR and liaison with partner agencies.
- Infectious disease policy review has received feedback, IPC are updating.
- Evacuation, Shelter and Lockdown plan in draft, will be checked through an exercise at Leighton Hospital in May 2024.
- Training needs analysis for all areas due for completion by June, the part for commanders is almost completed and the ICC one started. This will make several standards fully compliant when one for responders is finished in addition to the other 2 parts. Progress is hampered but understood by changes in structures through the Trust, and lack of national guidance outside specific roles.
- CBRN capability and training support for acutes – standardisation of paperwork including agreements, lesson plans, and reports are almost finished, training delivery is underway (7 standards = 12%)

2.12.12 Projected compliance is shown below:

Targets (month end)						
Final submission (Dec 2024) 41%	Current 45%	March 54%	April 88%	May 91%	June 98%	January action outstanding – Board report. Anticipate some slippage in April to May due to new staff taking up roles and needing to complete tasks.

2.13 NEXT STEPS

2.13.1 The next steps for the Trust are:

- To continue through the internal governance process, providing regular updates.
- To identify workstreams or forums that are in place which would be appropriate for action completion.

- To support new workstreams to support action completion.
- 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)

3.1 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.

3.2 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

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

5. RECOMMENDATIONS

5.1 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 core areas and the additional area 'interoperable capabilities' following the self-assessment.
- Note and support all action plans against the domains to ensure all elements move to compliant prior to the next assessment.

EPRR Core Standards – NWAS wide

Action Tracker

Key (core standard compliance)	
	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**.

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
1		**Senior leadership** The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	The Director of Operations, a Board level director, is the AEO for the Trust. Their roles and responsibilities are shown in the job description although we note that the title AEO is not used here, the term 'Accountable Officer' is used. He is referred to as the Trust AEO is other documentation.	Execs to include detail of AEO in JD during the next review	Steve Hynes	01/02/2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
3		**EPRR Board reports** The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements. **Links to 25, 35, 50, 51, 52**	An annual report is taken to the Board with input from the governance structure (ELC, EPRR Sub Committee, Quality and Performance Committee). The Board meeting is held on the Trust internet site and is publicly available, as are the minutes and the paperwork which includes the report. The report includes compliance with Core Standards and highlights action plans. The Core Standards stipulate certain items that should be included, this will be standardised going forward.	Amend the content of the public reports for Board to give high level detail in addition to assurance coming through EPRRSC and Q&P (to include training and exercises undertaken, summary of incidents inc BC, lessons identified and learning undertaken, assurance compliance position, BC position and outcomes)	Joanne Hodson	End Jan 2024		
4a		**EPRR Work programme** The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks	The work programme has been created based on the Core Standards and is monitored through the EPRR Sub Committee and into the Q&P Committee. It includes action plans which are produced from the Core Standards assurance, training updates, debriefs, BC compliance.	Update the annual workplan to reflect risks from DCIQ and NRR to be reported through EPRRSC	Joanne Hodson	End March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		• outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.						
4b		**EPRR Workplan** Links to 23a	See above	Create a training and exercise schedule against workplan to be reported through EPRRSC	Joanne Hodson	End March 2024		
5a		**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.	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 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 the CEO on 25th August 2023 with a reply on the same date to expect a response within the next week or so. None was received so another email was sent on behalf of CEO on 4th September 2023. Financial resources approved to establish an EPRR Training and Education Team, timescale for completion end March 2024.	CEO to follow up response to funding request from commissioners	CEO / Steve Hynes	End Jan 2024		
5b		**EPRR Resource** The Board / Governing Body is	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	CEO and Dir of Finance have followed up on the HART uplift, no response to date.	Director of Finance	End Jan 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	nationally however awaiting uplift through local ICB.					
7		**Risk assessment** The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers. This will also support standards: 10 Incident Response, 11 Adverse Weather, 12 Infectious disease, 13 New and emerging pandemics, 14 Countermeasures, 15 Mass Casualty, 16 Evacuation and shelter, 17 lockdown	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	Review of risk management process from lessons, NRR and CRR into and through the Trust and upload detail to DCIQ	Joanne Hodson Jonathon Taylor	End of Jan 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
8		**Risk management** The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally This will also support standards: 10 Incident Response, 11 Adverse Weather, 12 Infectious disease, 13 New and emerging pandemics, 14 Countermeasures, 15 Mass Casualty, 16 Evacuation and shelter, 17 lockdown	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally once they are noted for EPRR SC. The Trust could have a stronger process to assess EPRR-related risks from all sources including projects, and ensuring that all departments are connected. For example the Green Plan contains associated risks, as does moving the fleet to fully electric.	Review of risk management process from lessons, NRR and CRR into and through the Trust and included in the Risk management policy	Joanne Hodson Jonathon Taylor	End of April 2024		
9		**Collaborative planning** Plans and arrangements have been developed in collaboration with relevant stakeholders including	The organisation works with partner agencies through LRF groups, SAGs, Blue Light Working Groups, and discussion regarding individual plans. NHSE are currently working on the updated Mass Casualty Distribution Plan, NWAS will have a part in this as previously with the current v1.4.	Formalise a robust process for sharing plans, recording feedback and actions taken in plan review	Joanne Hodson	End March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Documents such as the Complex Sites Guidance, and Event Management Guidance influence how the Trust assess risks and plan with partners. There is on going national collaboration with the recommendations from the MAI. An example of collaborative event working is the Eurovision Song Contest which included NWAS, other blue light partners, ICB, private medical provider. BAF Risk SR07 recognises the risks of not working with partner agencies, scored as 8 and can be found in the July 2023 Board papers available publicly.					
12		**Infectious disease** In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	The Resilience Managers attend LRF Risk meetings where NRR and NSRA are discussed. The Trust has taken this information and developed a generic response plan applicable to all incidents that may affect the Trust and the community. It can be bolstered by the use of more specific plans. The Trust has in place IPC and Communicable Disease Plans based on previous planning that has shown to be effective, and is demonstrated through use. The Trust has developed a Pandemic Plan which is cause agnostic and built on learning from COVID plus national guidance. It has gone through the governance structure as shown in the EPRR Policy. Training is mentioned as part	Review the Communicable Disease plan to ensure it contains the latest list of, and information about, HCIDs	Head of IPC	End of March 2024	11/01/24 Updated policy going to ICP SC 29th Jan (update from Julie Dzioban)	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			of normal working practices e.g. the use of PPE. These plans have not been tested, an exercise process will be put in place by the Trust as part of an action plan to look at how we train, test and publish plans.					
13		**New and emerging pandemics** In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic			End of March 2024	11/01/24 to be reviewed by Resilience Team working with IPC. Reviewed plan with go to EPRR and IPC SCs for noting	
15		**Mass casualty** In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties. Links to M4 – casualty management arrangements	The Resilience Managers attend LRF Risk meetings where NRR and NSRA are discussed. The Trust has taken this information and developed a generic response plan applicable to all incidents that may affect the Trust and the community. It can be bolstered by the use of more specific plans. The Incident Response Plan is a generic plan designed to facilitate effective response up to and including Mass Casualty. This will be used in conjunction with the Dispersal Plan 1.4 until the NHSE plan is published which will supersede v1.4. The plans are held on the intranet.	During the IRP review, include the relevant information about MTC and TU from the Burns Annex	Joanne Hodson	End of March 2024	11/01/24 Resilience Team testing action cards in Ex Metis on 26th Jan, IRP expected at Board in March	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			The plans are in line with current guidance and risk assessments and signed off through the governance process shown in EPRR Policy. The IRP outlines training and equipment. NWAS are currently working on the roll out of the new triage process which includes procurement and distribution of triage bands. This will be included in the review of the IRP due in Q4. Training is already underway through mandatory training, and awareness sessions for commanders. The plan was used in Exercise Remija where the scope included from hospital allocation from the loading point through use of the plan (objective 4, cas management).					
16a		**Evacuation and Shelter** In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors. (links with 17)	Departments have their own plans, including Personal Emergency Evacuation Plans (PEEPs) for their staff. Fallback plans for sites are covered in their BC planning, these are applicable to staff and visitors and action cards are available in EOCs. Staff new to a site should receive an induction covering fire exits and muster points. The Health and Safety Tool kit covers topics such as bomb threats, suspicious packages, fire evacuation. The BC plans and PEEPs are signed off within the department structure, unaware if these plans are tested or if staff are trained.	Ensure risk sites are identified and evacuation or shelter and lockdown plans are in place for the causes as listed in NHSE Evac and Shelter Guidance (p.3) which includes structural, power or other utility failure, explosion or suspect package, adverse weather, e.g. flooding, fire, release of irritant fumes or hazardous materials, or a terrorist event	Joanne Hodson Head of Estates / Security	End of March 2024	11/01/24 Email sent to Andrea to inform about the action and suggest discussion	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			One of the sites experienced a need for a full evacuation. The BC plans were followed, debrief date TBC. As few of the NWAS sites have patients in them, the NHSE Guidance is largely not applicable although NWAS will respond to requests for mutual aid using normal procedures and the IRP. Estuary Point has been evacuated previously due to issues in the server room and a leak. The BC plans were followed. **C&C Update** This would be normal MI procedures including attendance at TCG. We are listed in the local area evac plans as an organisation that should be involved. The IRP refers to evac of the vulnerable, LRF plans are also referenced. Section 9.4, page 73 IRP section 9.7 talks about provision of tents to use as temporary shelters. PEEPS and EOC Lockdown where provided in initial submission					
16b		**Evacuation and Shelter** Action 2	As above	Ensure all required PEEPs are in place and tested at the appropriate intervals.	Head of Estates / Security	End of April 2024	11/01/24 Email sent to Andrea to inform about the action and suggest discussion	
16c		**Evacuation and Shelter** Action 3	As above	Seek clarification (via ICBs) as to the expectations placed on NWAS by Acutes and Mental Health	Joanne Hodson	End of March 2024	11/01/24 Email sent 01/01/2024 by JH to ICB asking if this is	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
				providers in the event of an incident at their sites			discussed anywhere or a piece of work required	
17		**Lockdown** In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident. (links with 16a)	The key NWAS sites (EOC and 111) have lockdown procedures in place. The BC plans are signed off within the department structure, unaware if these plans are tested or if staff are trained.	See 16a			11/01/24 Email sent to Andrea to inform about the action and suggest discussion	
21		**Trained on-call staff** Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	**Initial response** The EPRR Policy states the commanders etc should be trained appropriately as per MOS and NOS and NARU Guidelines. The commanders attend NARU courses plus supplementary NWAS updates. The NILOs attend the national NILO course. They all are required to attend the JESIP training and specific plan updates e.g. MTA JOPs 3. EPC Events course. The importance of logging and documentation is covered in the EPRR Policy, IRP, Commander and JESIP courses. The JDM and JESIP principles are referenced in the training and in plans.	Complete TNA for all staff with a role in incident response, including on call staff TNA to be complied for: Phase 1: Commanders and EPRR Staff Phase 2: ICC staff Phase 3: responders (will also address 22)	Joanne Hodson Andrew Wood4	Phase 1: End of March 20204 Phase 2: April 2024 Phase 3: June 2024	Arena Inquiry MAI 20 (training the non-specialist responders) links to this. There is no clear guidance on what to train the responders in and how this is funded. Mandatory training is capped at 3 hours currently. This should involve the training team to ensure processes are in line with NWAS wide processes, and to update any induction or mandatory training as required.	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			Training is provided in line with NARU stipulation but more explicit TNAs are being compiled for commanders, Contingency Planning staff, and all who may respond to an incident. Commanders and command support staff are expected to maintain a NOS CPD spreadsheet with evidence. This is monitored by the Special Operations team and fed to the Area Directors who have responsibility, plus teh EPRR Sub Committee for assurance. **C&C update** As part of a system review, we are completing TNAs for all staff involved in an incident response. Commander portfolio uploaded to illustrate how our commanders work towards 100% completion of NOS as provided by NARU. Email to AW4 from J Butler 15th June 2023 advised this was correct. National Training CX spreadsheet shows that all Strategic commanders have done the basic training required, the same for Tactical and Operational. EPRR (Contingency Planning Team) have recently conducted a TNA sourcing from EPRR Advisor MOS, NARU Commander NOS and existing JDs. This will be used to				The TNA will have to include minimum levels that must be maintained and sustained for all levels of command. The current rota plus an agreed number of trained individuals who can step in if the rota is not maintained. This will allow succession planning which is timely and negate gaps. Minimum standards should also be considered for NILOs and CTAs Phase 2 will require confirmation of what mandated courses and NOS is required from the ICC personnel with an on call function. AW4	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			identify and prioritise courses for staff.					
22		**EPRR Training** The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	The EPRR Policy states the commanders etc should be trained appropriately as per MOS and NOS and NARU Guidelines. The commanders attend NARU courses plus supplementary NWAS updates. The NILOs attend the national NILO course. They all are required to attend the JESIP training and specific plan updates e.g. MTA JOPs 3. The importance of logging and documentation is covered in the EPRR Policy, IRP, Commander and JESIP courses. The JDM and JESIP principles are referenced in the training and in plans. Training is provided in line with NARU stipulation but more explicit TNAs are being compiled for commanders, Contingency Planning staff, and all who may respond to an incident. Incident response has been included in 2023-2024 mandatory training as an interim measure. Commanders and command support staff are expected to maintain a NOS CPD spreadsheet with evidence. This is monitored by the Special Operations team and fed to the Area Directors who have responsibility, plus the EPRR Sub Committee for assurance.	See 21				

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
23a		**EPRR exercising and testing programme** In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care) **Links to 4b** This will also support standards: 10 Incident Response, 11 Adverse Weather, 12 Infectious disease, 13 New and emerging pandemics, 14 Countermeasures, 15 Mass Casualty, 16 Evacuation and shelter, 17 lockdown	Although the Trust doesn't have an exercising and testing programme, the Trust frequently tests departmental BC plans and participates in exercises that test aspects of the IRP, many of which are live. For example, 5 live exercises were run in GM in July and August looking at MTA response. Comms tests are run daily for the Airwave ESICTRL channel. The Trust are planning to form an exercise schedule for plans in addition to the IRP, and creating a robust way of confirming what was tested, how, the outcome, and actions. This is done in part currently through the debrief process but needs to be more robust and include more plans. The debrief updated is provided to the EPRR Sub Committee. Currently have a vacancy in the RM QI post which will cover the more robust planning ahead of exercises.	Create a testing programme for plans, including prioritisation and risk assessment	Joanne Hodson	End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
23b		**EPRR exercising and testing programme** Action 2	See above	Resilience Team to create a document stipulating how to design an exercise and key objectives to be included (e.g. use of JDM and JESIP principles)	Joanne Hodson	End of March 2024		
25		**Staff awareness and training** There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	For 2023 there is a resilience session in the mandatory training plus eLearning covering IOR and JESIP. All responding staff are encouraged to attend exercises, those who do have it recorded on their ESR and reports can be provided. The Resilience Team provide Contingency Briefings on Teams, they are saved and hosted on RD and a shared drive for review. Plans etc are held on the Green Room (intranet) Bulletins are also provided on the intranet of updates to plans, and training/exercise opportunities. Training and exercise attendance is reported to the EPRR SC and is now covered in the EPRR Policy as points to report to the Board. Numbers reported to the EPRR Subcommittee and into the Quality and Performance Committee but that level of detail doesn't currently go to the Board.	See 3 (board report)				
26		**Incident Coordination Centre**	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	Review the current position for ICC / major incident rooms, and roles who may work there, and design a function that is fit for	Head of Operations (ICC)	End of April 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		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.	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.	purpose for NWAS (NHSE EPRR Framework, p.44). This should be resilient to loss of utilities, may include virtual arrangements, and must have a training and testing schedule. Amend the content of the public reports for Board to give high level detail in addition to assurance coming through EPRRSC and Q&P (to include training and exercises undertaken, summary of incidents inc BC, lessons identified and learning undertaken, assurance compliance position, BC position and outcomes) **(see 3)**	Joanne Hodson			

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		Arrangements should be supported with access to documentation for its activation and operation.						
30		**Situation reports** The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	There are stickers in the cab of each frontline vehicle to prompt the delivery of a M/ETHANE prior to exiting the vehicle. This is covered in mandatory training and in the IRP. These are not QA'd or signed off but details might be checked. The requirement is in section 4.6.1 of the IRP. Daily NHS reporting is completed by the ROCC on Proclus. This was also completed during Industrial Action. Clinicians will often use ATMIST or SBAR to pass clinical details. CRIP and COPs are utilised to give updates on RD. Sitreps are used on exercises to embed behaviour. C&C update Using the IA as an example, NHSE provided a template to be filled in, this was done by the AEO/Strategic Commander who had the authority to sign them off. IIMARCH is in section 7.5 of the IRP. This is completed by the commander and shared with the command structure.	Ensure a signoff process is in place for any sitreps to go to NHSE or for LRF incident updates which includes naming conventions and version control (see NHSE EPRR Framework, p.37)	Joanne Hodson	End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			A handover document is in the action cards (4a, 13a, 22a) for operational, tactical and strategic commanders to have a clear record of what has happened and the transfer of responsibility					
33a		**Warning and informing** The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	The Communications Team hold a Major Incident Protocol and team members take part in internal, external, and comms only exercises. It covers what they do should a major incident be declared (terminology aligns) and have holding and update statements. They have an on call structure for leaders to access comms support. The process for logging requests takes place on blank sheets of ruled paper, this will change shortly.	Comms to update their incident response plan including updating terminology, sign off process, and contact details	Julie Treharne	End of April 2024	11/01/24 Comms have a departmental action plan that includes updating their response plan after discussions with the resilience team.	
33b		**Warning and informing**	As above	Comms to create a TNA for their staff in terms of incident response and on call See 21	Julie Treharne	End of April 2024	11/01/24 A list of training for the team has been identified including logging, JESIP, Resilience Direct. This forms the basis of a TNA.	
34		**Incident Communication Plan** The organisation has a plan in place for communicating during an incident which can be enacted.	The MI Comms Protocol is available to on call comms staff and managed by them. It contains action cards for comms roles. Approval by the Strategic Commander is covered in section 7 but not NHSE. The plan contains contact details including various NHS England staff but doesn't clarify if or when they should be contacted.	Comms to run an exercise to test the plan in and out of hours See also 33a and 33b	Julie Treharne	End of June 2024	11/01/24 This is planned in as part of the Comms dept action plan	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			Ex Hancock allowed participation and practice in delivery of comms roles. No exercise taken place out of hours.					
35		**Communication with partners and stakeholders** The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	The Trust can use Cascade to communicate with staff at short notice and for the duration of an incident. They can also utilise the Green Room (intranet), social media, or pass messages on the MDT. The Comms MI Protocol contains contact details for partner agencies and will form part of a media cell as guided by the SCG The Trust are part of an LRF structure where communication comes from the Police or RD alerts. The Trust also have a 'calling tree' process to share information with wider health via ROCC in the event of an incident. The organisation produces an annual report via the Board which is available publicly in the Intranet.	See 33a, 3	Julie Treharne	End of April 2024		
36		**Media strategy** The organisation has arrangements in place to enable rapid and structured communication via the media and social media	The Comms MI Protocol includes holding and update messages. In addition, Comms Staff regularly monitor and respond to social media as part of their day jobs in addition to on call incident role, therefore monitoring and responding is also part of their BAU roles. Training on the use of social media is available on ESR as per news	See 33a	Julie Treharne	End of April 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			article https://greenroom.nwas.nhs.uk/news/social-media-usage-training-available/ and supports the Social Media Policy. and NWAS provides ad hoc media training, records of which are enclosed. Tactical and Strategic Commanders will also receive generic media training as part of NARU Tactical and MAGIC Strategic Commander courses. records of attendance on these courses are attached.					
37		**LHRP Engagement** The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	The AEO delegates responsibility for attendance at Strategic/Executive level multiagency meetings to Area Directors with a deputy of the Head of Operations from that area. This is covered in the EPRR Policy, they are authorised to act in accordance with NWAS governance and to make decisions/approve plans. If no one of this level is available to attend, NWAS will endeavour to send someone who has been briefed but will only be there to report back. They are sometimes supported by a Resilience Manager in an advisory capacity. The Head of Contingency Planning with be attending in an advisory capacity in the future, with Resilience Managers as deputy, to ensure there is a common EPRR thread throughout the area the Trust covers. In the last 12 months: Lancs and SC - Multiple meetings tabled but not held	all areas to ensure 75% attendance at LHRPs with at least 50% Area Director presence, and establish a feedback process to the AEO	Salman Desai	End of April 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			NE and N Cumbria - 4 held, 3 attended by Head of Operations or Area Director) CAM - 1 cancelled, other 4 attended by Hed of Operations or Acting HoO) GM - from 7th June 2022 5 held, attendance at 4 by Head of Operations or Area Director, 1 by Resilience Manager as listening brief					
43		**Information sharing** The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	The Trust has a Data Protection Policy which meets its legal obligations and NHS requirements concerning confidentiality and information security standards under the UK Data Protection Act (DPA 2018), the UK General Data Protection Regulation (UK GDPR). It makes reference to the Caldicott Principles and Guardian, Duty of Candour. The Trust regularly manages data in terms of staff, patients, and the polices dictate how and when to share appropriately. This is applicable in an incident or on a day to day basis. As part of mandatory training, staff must complete an eLearning package on Information Governance. Commanders and command support staff are SC clear to allow the sharing of sensitive information between partner agencies.	Establish what data sharing agreements should be in place and ensure this is facilitated appropriately	Joanne Hodson	End of April 2024	JH emailed ICBs on 01/01/2024 to establish what is required and if this needs to be addressed through LRF or LHRP 11/01/24 JH contacted IG specialists internally for advice	
48		**BC Testing and exercising**	This forms part of the approval process in BCMS C2. Each department undertakes exercises each year. Most are TTX and	BC lessons identified (thematic analysis and action plan) to be included in reports to EPRR SC and subsequently the Board	Joanne Hodson	End of March 2024	11/01/24 NHSE would like to see more types of exercise, and a thematic analysis	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	discussion with debriefs and actions to be completed. 111 and PTS will conduct their exercise regime in line with this process	See 3, 4b, 23			across the depts. RM BC will work with RM QAI to establish a process for this going forward	
50		**BCMS monitoring and evaluation** The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board	KPIs are not explicitly used although, during BIA, the departmental leads are aware of what they are required to deliver. The BC Policy is in place, the BCMS Continuity 2 system supports the policy and alignment with ISO 22301. Performance reporting is done through EPRR SC and Q&P. An annual position statement will be included in the next Board reports, the have previously been covered as part of the EPRR Core Standards assurance feedback. Exercise Clockwork gave lessons identified, this was included in the EPRR SC report.	Amend the content of the public reports for Board to give high level detail in addition to assurance coming through EPRRSC and Q&P (to include training and exercises undertaken, summary of incidents inc BC, lessons identified and learning undertaken, assurance compliance position, BC position and outcomes) **See 3, 51 and 52**	Joanne Hodson	End of March 2024		
51		**BC Audit** The organisation has a process for BC internal audit, and outcomes are	BC is audited as part of the EPRR SC Workplan in terms of the completion of BIAs, BCPs, and exercises, progress is measured against this and reported into EPRR SC, Q&P and annually to the Board.	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 Q1 2024	Joanne Hodson Audit Team	End of June 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		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. Evidence to include an independent business continuity management audit report.	The auditing the quality of 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.	Amend the content of the public reports for Board to give high level detail in addition to assurance coming through EPRRSC and Q&P (to include training and exercises undertaken, summary of incidents inc BC, lessons identified and learning undertaken, assurance compliance position, BC position and outcomes) **(See 3, 50 and 52)**				
52		**BCMS continuous improvement process** There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	All BC exercises include action plans from lessons identified. The BC report to EPRR SC does not cover this much detail and they are not included in the lesson identified tracker. Any risks that need to be highlighted can be done through the department risk register and raised at EPRR SC if required. Examples of improvement include the creation of the BC Policy, provision of a dashboard for the status of the plans and exercises, and provision of reports to EPRR SC for wider awareness. An BC Working Group is planned to share concerns, good practice, lessons, and provide a network to the departmental BC Leads.	**See 50, 51 and 3**	Joanne Hodson Audit Team	End of June 2024		
54a		**CAD**	EOC have several disruptions to the CAD system enabling the use of	Development of an exercise document and outcome report to	ICC Head of Operations	End of April 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	paper-based systems. This is determined by the CAD providers working with NWAS SMT from IMT/EOC. Disruptions such as updates to the CAD and core switch replace are planned to details allowing for minimum disruption to the call taking and testing paper-based systems. EOC have a robust BC plan in place for disruption to the CAD with recent activity September 23. A debrief date is TCB will identify any lessons and update of plans consideration as per debrief policy. EOC do not have a testing schedule for either confirming the plan are appropriate, or that the staff are able to follow the process effectively	show planned down time and any disruptions				
54b		**CAD**	As above	Exercise schedule to be developed to assure system performance and staff knowledge re CAD failure Links to 4 and 23	ICC Head of Operations	End of April 2024		
54c		**CAD**	As above	Process put in place for outcomes of CAD failure exercises to be included in lessons tracker	Joanne Hodson	End of April 2024		
67		**CBRN Capability** (with reference to supporting Acutes) NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the	In 2019 NHS England NW EPRR Leads requested the annual hospital Train the Trainer course would be in the form of delivering Powered Respirator Protective Suit (PRPS) instructor courses. This was negotiated with the NARU and a programme of PRPS instructor courses was delivered for all hospital trainers in the North West.	Rollout new programme of audit together with continuing train the trainer programme *Evidence provided must give assurance that the reviews are done at least biannually*	Head of Special Operations	End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		following CBRN / Hazardous Materials (HazMat) tactical capabilities The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.	Training the hospitals in CBRN and Hazmat in 2020 was limited due to COVID. Prior to this the Trust provided train the trainer session, PRPS instructor courses, and guidance on the initial management of self presenters from incidents. The Hospital Decontamination Train the trainer programme resumed in 2022. NWAS has not inspected hospitals for decon capability since 2016 in person. An interim took place in 2021 during COVID. A new programme is in progress but not currently set up. C&C Update Lesson plan fro Train the Trainer from 2022 attached showing delivery of PRPS training, IOR, waste management, Ram Gene use. Lesson plan designed against national guidance					
68		**Capability review** Links to 67 NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region.	To streamline the hospital Decontamination response capability audit process, it was agreed with NHS England NW EPRR Leads that this process would be carried out virtually by self-assessment questionnaires. Questionnaires were sent to all North West Acute Hospital Trusts and those that returned them were sent a RAG report that was also shared with NHS England NW EPRR leads. The last audits took place virtually in 2021 and NWAS has not inspected hospitals for decon capability since 2016 in	See 67	Head of Special Operations	End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.	person. . There are the early stages of a plan to continue the audits 2023-2024.					
69		**Capability review frequency** NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).	The last audits took place virtually in 2021 and NWAS has not inspected hospitals for decon capability since 2016 in person. There are the early stages of a plan to continue the audits 2023-2024.	See 67	Head of Special Operations	End of March 2024		
70		**Capability review report** Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be	Available reports are from 2013, 2016 and 2021. Other years the reviews did not take place.	See 67	Head of Special Operations	End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.						
71		**CBRN train the trainer (with reference to supporting Acutes)** NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer'	NHS England NW EPRR Leads requested that this year (2019) the annual hospital Train the Trainer course would be in the form of delivering Powered Respirator Protective Suit (PRPS) instructor courses. This was negotiated with NARU and a programme of PRPS instructor courses was delivered for all hospital trainers in the North West. During the Covid19 Pandemic period there was no hospital Train the Trainer courses profile.	NWAS to formalise the process of training including schedule of delivery, governance, and record of attendance.	Head of Special Operations	End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
		sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.						
72		**Aligned training** Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.	All hospital decontamination train the trainer courses are aligned to national procedures and guidance. This includes IOR (JESIP 2023) & PRPS (NARU)	Include references in lesson plans etc as to where the content comes from to provide assurance it is in line with national guidance	Head of Special Operations	End of March 2024		
73		**Training sessions** Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.	The annual hospital train the trainer programme for 2022 involved liaising with hospital EPRR managers to agree and arrange regional / area course venues at hospitals, where courses were delivered so that staff from that area could attend. Emails are available to show how arrangements were made with different hospitals. Lesson plans are standardised and provided. The Trust recognises its responsibility to provide training and will seek to produce appropriate documentation (MOU) with the ICB / NHSE in their role as representation	Production of an MOU with the ICBs / NHSE in terms of commitment to delivery of training and audit processes, including frequency and report provision	Head of Special Operations	End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current standard status
			of the Acutes. A training plan will also be produced for clarity on how the courses will be delivered.					
DD 05		Deep dive - Access to training materials	The Trust send staff on command courses provided by NARU, NILO courses at the Fire Service College, and Emergo Courses provided by UKHSA. These courses are held in Salisbury (NARU), Moreton in Marsh (FSC), and various locations with the further north being Leicester (UKHSA). The numbers of courses and spaces can limit the training of our staff, and the locations mean overnight stays between 1 and 8 nights which could prevent some staff being able to attend.	Representation through national groups to ensure sufficient places are available on courses (inc NILO and HART) in accessible locations	Steve Hynes	End of April 2024	Numbers have been collated, the national request that went to NARU was 60 for 35 places. The respondents did not give time frames or priorities, just that the numbers would be needed in the next 12 months.	
DD 06		Deep dive - 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.	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.	Standardise the recording of EPRR training attendance for all responders in any given role (including command) against the minimum number required as defined in the TNA.	Andrew Wood4 Joanne Hodson Head of L&D	end April 2024		

EPRR Core Standards – Interoperable Capabilities

Action Tracker

Key (core standards compliance)	
	Non-Compliant – unlikely to be completed within 12 months
	Partial Compliance – will be completed within 12 months
	Fully Compliant

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
H8		Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	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 establishment 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.	Finance Dept to continue in negotiations with local commissioners to increase the baseline funding to the level of the reference cost. A national reference cost has been supplied by NARU for a HART Unit	Michelle Brooks	01/03/2024		
H16		Organisations must monitor and maintain accurate local records of their	HART response time standards will be captured in the SOE / CAD. HART deployments are internally captured and manually inputted into	A programme requires developing that can generate an accurate report of the response time standards and compliance for	Andrew Moody, Data Quality and Innovation Manager	01/03/2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		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.	PROCLUS and a separate 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 from 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. This standard has been rated as non-compliant as it has been in place since the previous assessment therefore there is limited assurance of it being completed in the next 12 months.	HART calls including the time of call, the number of staff allocated and when.				
H32		Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.	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	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	Ashburton – Andrea Long. Croxteth - Joe Barrett	Ashburton - March 24. Croxteth - March 25		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
			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.	House site which requires a provision of a new build. Plans have been drawn and planning permissions applied for.				
S21		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	The National Ambulance Resilience Unit (NARU) have produced national risk assessments for the Standard Operating procedures for SORT. Specialist response staff are informed of the hazards and risks in the environment where they may work, and the safe working strategies to employ. NWAS has completed a local risk assessment to compliment these national risk assessments. NWAS are reviewing how the identify and record risks, with and without multiagency partners. Specialist response necessity and capability will be included in the process.	Working with the Resilience Managers and ICC, Special Operations to identify risk sites in terms of MTA and CBRN specific risks and include HART/SORT considerations in the SSPs and ICC SOPs Review how SORT staff are trained to dynamically assess, mitigate and record risks in line with JESIP	Joanne Hodson Joe Barrett Joe Barrett	End of May 2024 End of March 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		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.						
S29		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.	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 deployment 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,	Conduct a test in each of the 3 areas to confirm 30 SORT staff can be activated within 60 minutes Regularly maintain the SORT allocation testing process quarterly. Link this to S40 and test them regularly together.	Joe Barrett Joe Barrett	End March 2024 End March 2024		
S35		NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU (260). These suits	The Trust has an asset register for Powered Respirator Protective Suits (PRPS). Monies for Servicing and replacement of PRPS will come out of the national funding workstream for SORT.	When 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	March 2024	Expected release date of new design suit by Respirex is early 2024.	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		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.	Some suits have reached their maximum lifetime and have been decommissioned. 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.					
S40		In conjunction with standards S29 and S30, MTA pooled equipment vehicles must be maintained at a high state of readiness to deploy. At least one asset must be mobilised within 15 minutes of a SORT response being confirmed as being required for an incident.	The Trust 4 Public Support Units at key locations around the Trust area which carry the MTA kit. An exercise is required to test the EOC deployment plans and ensure the vehicles can be mobilised in the given time frame. This can be done at the same time as S29	Conduct a test in each of the 3 areas to confirm this can be achieved. Regularly maintain this testing process quarterly. Link this to S29 and test them regularly together.	Head of Special Operations	End Sept 2023	Note: Evidence required to show this happens on a regular basis to accommodate changes in the Trust resource position and confirm plans are appropriate	
M4		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	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.	In conjunction with NHS England, test the new Mass Cas arrangements prior to sign off.	J Hodson	End of April 2024		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise	NWAS are also creating an exercising schedule, the Mass Cas Plans will be included.					
C7		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	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.	Completion of strategic leadership review to include Command in the JD and recruitment process with agreed assessment in line with the appropriate NOS	Leadership Review = Matt Cooper Resilience assessments = Andy Wood4	Q2 2024	11 Jan 2024 – Task given to Command & Resilience Trainers to produce a one day package as part of an induction process for potential operational and Tactical commanders, to be completed by mid February depending on recruitment details for posts. AW4	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		the National Occupational Standards for Command. This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.						
C25		All strategic, tactical and operational commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger	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 incident 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.	1. Workforce Management Plan needs to be updated, still showing as review 2022. - 2. Create a written and agreed process for how NOS is audited by ADs and how to remove a Commander in the C2 Framework if they are not compliant with exercise or incident attendance (evidence through submitted reflection) every 18 months 3. Creation of a central repository for NOS which is maintained within Resilience showing attendance by Commanders on Exercises - maintained by CARE team	Vicky Camfield HR Vicki Camfield Andy Wood4 Andy Wood4	1. end of Feb 2024 2. end of Feb 2024 3. end of Feb 2024	08 Jan 2024 - NOS Framework document drafted Dec 2023, this has gone to Senior Directors for feedback by 27th Dec, none received. NOS framework is a bespoke presentation that is being delivered to all commanders between Jan & March 2024, to allow feedback to be received from the cohort. The document will then be updated and released as a final version in April 2024, following agreement at ELC. (AW4) 11 Jan 2024 – reviewed current Exercise spreadsheet and will amend to meet CARE and EPRR core standard requirements, complete by End of Feb 2024	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		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						

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		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						
C26		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	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.	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. end of Jan 2024 2. end of Jan 2024	08 Jan 2024 See response in C25, the NOS framework document includes processes for auditing of individual commanders and who is responsible for conducting audits as well as the process for addressing commanders who fail to maintain the compliance standards that are laid out in the Framework document. This includes the use of the Command & Resilience Training Team being utilised to assist the line managers and individual commanders in meeting the standards through the use of peer support and mentoring. (AW4)	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		minimum level of mandated competence can be fully demonstrated.						
C27		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	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.	1. Create a written process for how NOS is audited, to what standard, and by whom 2. Paragraph to include that by being on the command rota they understand and accept the obligations for a commander including compliance with NOS. 3. Include NOS compliance in EPRR SC work programme and reports, ensuring the AEO is appraised.	1. Andy Wood4 2. Andy Wood4 3. Andy Wood4	1. end of Feb 2024 2. end of April 2024 (post command training) 3. end of April 2024	This is included in the NOS framework and can be closed (03/01/24) This will be included in the framework, it is covered in the Commander training to ensure commanders are aware Next meeting in April	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		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						

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		discharging command functions at an incident.						
C32		The medical director of each NHS ambulance service is responsible for ensuring that the strategic medical advisor, medical advisor and forward doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the National Ambulance Service Command and Control Guidance published by NARU).	1. Procedures in place that includes a rota for Strategic Medical Advisor as well as Medical Advisors and Forward Doctors. 2. Strategic Medical Advisors and Tactical Medical Advisors are available 100% of the time, however there are times when there is not a Forward Doctor available. We are commissioned for 40 doctors but average around 30. 3. MERIT Annual Training Programme details how compliance is conducted against National Standards. Trust has a Training Regime ran by MERIT Team Manager that provides the details.	1. MERIT recruitment to increase numbers to have 3 available at all times to cover the advisory/command support roles	Dr Craig Hooper	March 2024	This was shown as green on the submission but had an action with it	
C33		Personnel that discharge the medical advisor or forward doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise involving ambulance service interoperable capabilities every 18 months. Attendance at these exercises	1. Spreadsheet maintained by MERIT Manager which details who has attended Exercises and who has written a reflective practice. A number still have until the end of the year to complete these, currently 4 of the MERIT cohort are not yet booked on exercises. 2. MERIT Annual Training Programme details the requirement to have a reflective practice, which is one of the requirements to remain on the live rota. 3. Currently struggling to provide live exercises for SMAs due to the fewer	1. All reflective practices for MERIT doctors to be completed and submitted by end of Jan 2024 2. 2024 iteration of MERIT Training Programme to be more detailed on why a MERIT Doctor is removed from the live rota and the process to get them reintroduced once the training package has been completed. 3 Look at opportunities for SMAs to attend Strategic Exercises	Dr Craig Hooper for all and for 3 supported by Head of Contingency to inform on availability of exercises	End of March 2024	This was shown as green on the submission but had an action with it	

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		will form part of mandatory continued professional development and evidence must be included in the form of documented reflective practice for each exercise	numbers of exercises at Strategic level.	4 Align practices and processes with the Command assurance and governance structure				
J10		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.	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.	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	Andy Wood4	End of March 2024	08 Jan 2024 - Command & Resilience Team to review Reflective practice templates and include how the JESIP principles and JDM can be included and update whilst the current command training is being conducted. (AW4)	
J13		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	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.	Area Directors, who are responsible for Commander Compliance, should confirm with line managers that JESIP training is being completed with the aim of at least 90% operational and EOC staff compliance. The data should be submitted 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		

REF	RAG Status	Descriptor	Organisational Evidence	Action Required	Owner	Target date	Progress	Current status
		communications with crews) are familiar with the JESIP principles and can construct a M/ETHANE message.						

EPRR Core Standards – NWAS wide (inc Interoperability)

Action Summary

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**.

Group	Total actions			
Board assurance	4		4	
Finance and resourcing	2		2	
Risk	3		3	
Plan review	4		4	
Training and exercising	9		9	
Comms planning	4		4	
Estates (evacuation and lockdown)	2		2	
Business continuity	2		2	
ICC (including CAD testing)	4		4	
CBRN audit and training	4		4	
Interoperability	23		22	1

Key (action status)	
	Target date breached
	In progress
	Complete

	Action	Applicable standards	Owner	Target date	Progress update	Current action status
Board assurance						
BA1	**TO IMPROVE -** Execs to include detail of AEO in JD during the next review	1	Steve Hynes	01/02/2024		
BA2	Amend the content of the public reports for Board to give high level detail in addition to assurance coming through EPRRSC and Q&P (to include training and exercises undertaken, summary of incidents inc BC, lessons identified and learning undertaken, assurance compliance position, BC position and outcomes)	3, 6, 25, 35, 50, 51, 52	Joanne Hodson	End Jan 2024	11/01/24 To be submitted to January Board. To ensure continuity, suggest provision to the June Board to give an updated statement of assessment prior to the next submission opening.	
BA3	**TO IMPROVE** – all areas to ensure 75% attendance at LHRPs with at least 50% Area Director presence, and establish a feedback process to the AEO	37	Salman Desai	End of April 2024		
BA4	Update the EPRR Work programme to ensure it is informed by current guidance, good practice, lessons identified, risks, assurance and audit outcomes	4, 23 (action R3, TE1)	Salman Desai	End of March 2024		
Finance and resourcing						
FR1	CEO to follow up response to funding request from commissioners	5a	CEO / Steve Hynes	End Jan 2024		
FR2	CEO and Dir of Finance have followed up on the HART uplift, no response to date.	5b	Director of Finance	End Jan 2024		
Risk						

R1	Review of risk management process from lessons, NRR and CRR into and through the Trust and upload detail to DCIQ	7, 10, 11, 12, 13, 14, 15, 16, 17, 44	Joanne Hodson Jonathan Taylor	End of Jan 2024	11/01/24 Resilience have been working with Risk to reflect Nation Risk Register in the NWAS risks on DCIQ. These will be brought to the next EPRRSC for discussion.	
R2	Review of risk management process from lessons, NRR and CRR into and through the Trust and included in the Risk management policy	8, 10, 11, 12, 13, 14, 15, 16, 17	Joanne Hodson Jonathan Taylor	End of April 2024		
R3	Update the annual workplan to reflect risks from DCIQ and NRR to be reported through EPRRSC	4a	Joanne Hodson	End March 2024		
Plan review						
PR1	Review the Communicable Disease plan to ensure it contains the latest list of, and information about, HCIDs	12	Julie Dziobon	End of March 2024	11/01/24 Updated policy going to ICP SC 29th Jan (update from Julie Dziobon)	
PR2	Resilience team and IPC to review the plan to ensure it uses recognised frameworks and terminology i.e. DATER	13	Joanne Hodson Julie Dziobon	End of March 2024	11/01/24 to be reviewed by Resilience Team working with IPC. Reviewed plan with go to next EPRR and IPC SCs for noting	
PR3	During the IRP review, include the relevant information about MTC and TU from the Burns Annex	15	Joanne Hodson	End of March 2024	11/01/24 Resilience Team testing action cards in Ex Metis on 26th Jan, IRP expected at Board in March	
PR4	Seek clarification (via ICBs) as to the expectations placed on NWAS by Acutes and Mental Health providers in the event of an incident at their sites	16	Joanne Hodson	End of March 2024	11/01/24 JH contacted the ICBs to explain our concerns in terms of provider expectations, NWAS are being	

					invited to Evac and Shelter meetings. NWAS are also drafting a plan to cover this and E1/E2 at a high level	
Training and exercising (testing)						
TE1	Create a training and exercise schedule against workplan to be reported through EPRRSC	4b	Joanne Hodson	End March 2024		
TE2	Create a testing programme for plans, including prioritisation and risk assessment	10, 11, 12, 13, 14, 15, 16, 17, 23	Joanne Hodson	End of March 2024		
TE3	Resilience Team to create a document stipulating how to design an exercise and key objectives to be included (e.g. use of JDM and JESIP principles)	10, 11, 12, 13, 14, 15, 16, 17, 23	Joanne Hodson	End of March 2024		
TE4	Formalise a robust process for sharing plans, recording feedback and actions taken in plan review	9	Joanne Hodson	End March 2024		
TE5	Complete TNA for all staff with a role in incident response, including on call staff. TNA to be complied for: Phase 1: Commanders and EPRR Staff Phase 2: ICC staff Phase 3: responders	21, 22	Joanne Hodson Andrew Wood4	Phase 1: End of March 20204 Phase 2: April 2024 Phase 3: June 2024	Arena Inquiry MAI 20 (training the non-specialist responders) links to this. There is no clear guidance on what to train the responders in and how this is funded. Mandatory training is capped at 3 hours currently. This should involve the training team to ensure processes are in line with NWAS wide processes, and to update any induction or mandatory training as required	

TE6	Comms to create a TNA for their staff in terms of incident response and on call	33, 34, 36	Julie Treharne	End of April 2024	11/01/24 A list of training for the team has been identified including logging, JESIP, Resilience Direct. This forms the basis of a TNA.	
TE7	Standardise the recording of EPRR training attendance for all responders in any given role (including command) against the minimum number required as defined in the TNA. (see TE5, TE8, I12, I22, I23)	DD6, 24	Andy Wood4 Joanne Hodson Paula Davies	End of April 2024		
TE8	**TO IMPROVE -** The Trust to adopt an up to date process of information recording to support the staff accessing their own records, accountable managers accessing for audit and PADR purposes, and reporting through the governance structures	24	Andrew Wood4 Joanne Hodson	End of March 2024		
TE9	Representation through national groups to ensure sufficient places are available on courses (inc NILO and HART) in accessible locations	DD5	Steve Hynes	End of April 20204		
Comms planning						
CP1	Comms to update their incident response plan including updating terminology, sign off process, and contact details	33, 34, 35, 36	Julie Treharne	End of April 2024	11/01/24 Comms have a departmental action plan that includes updating their response plan after discussions with the resilience team.	

CP2	Comms to run an exercise to test the plan in and out of hours	34	Julie Treharne	End of June 2024	11/01/24 This is planned in as part of the Comms dept action plan	
CP3	Ensure a signoff process is in place for any sitreps to go to NHSE or for LRF incident updates which includes naming conventions and version control (see NHSE EPRR Framework, p.37)	30	Joanne Hodson Julie Treharne Pete Ballan	End of March 2024	This needs to be in place wider than acute emergencies, as standard needs to be set across the Trust to include any daily sitreps e.g. ROCC updates	
CP4	Establish what data sharing agreements should be in place and ensure this is facilitated appropriately	43	Joanne Hodson IG	End of April 2024	11/01/24 JH contacted IG specialists internally for advice. JH emailed ICBs on 01/01/2024 to establish what is required and if this needs to be addressed through LRF or LHRP. No response	
Estates						
E1	Ensure risk sites are identified and evacuation or shelter and lockdown plans are in place for the causes as listed in NHSE Evac and Shelter Guidance (p.3) which includes structural, power or other utility failure, explosion or suspect package, adverse weather, e.g. flooding, fire, release of irritant fumes or hazardous materials, or a terrorist event	16, 17	J Hodson Andrea Long	End of March 2024	11/01/24 Email sent to Andrea to inform about the action and suggest discussion	
E2	Ensure all required PEEPs are in place and tested.	16	Andrea Long	End of April 2024	11/01/24 Email sent to Andrea to inform about the action and suggest discussion	

BC						
BC1	BC lessons identified (thematic analysis and action plan) to be included in reports to EPRR SC and subsequently the Board	48	Joanne Hodson	End of March 2024	11/01/24 NHSE would like to see more types of exercise, and a thematic analysis across the depts. RM BC will work with RM QAI to establish a process for this going forward	
BC2	Internal audit and peer review on the BCMS system to be establish on a cyclical basis. NWAS to consider funds for external audit from MIAA in Q1 2024 as per email from Mary Peters.	51, 52	Joanne Hodson Audit team	End of May 2024		
Integrated Contact Centres						
ICC1	Review the current position for ICC / major incident rooms, and roles who may work there, and design a function that is fit for purpose for NWAS (NHSE EPRR Framework, p.44). This should be resilient to loss of utilities, may include virtual arrangements, and must have a training and testing schedule.	26	Pete Ballan Joanne Hodson	End of April 2024		
ICC2	Development of an exercise document and outcome report for down time and any disruptions	54	Pete Ballan	End of April 2024		
ICC3	Exercise schedule to be developed to assure system performance and staff knowledge re CAD failure	54	Pete Ballan	End of April 2024		
ICC4	Process put in place for outcomes of CAD failure exercises to be included in lessons tracker	54	Joanne Hodson	End of April 2024		
CBRN audit and training support to Acutes						
CBRN1	Rollout new programme of CBRN audit for Acutes	67, 68, 69, 70	Joe Barrett	End of April 2024		

CBRN2	NWAS to formalise the process of training including schedule of delivery, governance, and record of attendance.	71	Joe Barrett	End of April 2024		
CBRN3	Include references in CBRN lesson plans etc for Acutes as to where the content comes from to provide assurance it is in line with national guidance	72	Joe Barrett	End of April 2024		
CBRN4	Production of an MOU with the ICBs / NHSE in terms of commitment to delivery of training and audit processes, including frequency and report provision	73	Joe Barrett	End of April 2024		
Interoperability						
I1	Finance Dept to continue in negotiations with local commissioners to increase the baseline funding to the level of the reference cost. A national reference cost has been supplied by NARU for a HART Unit	H8	Michelle Brooks	01/03/2024		
I2	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.	H16	Andrew Moody,	01/03/2024		
I3	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.	H32	Ashburton – Andrea Long. Croxteth - Joe Barrett	Ashburton - March 24. Croxteth - March 25		

I4	Working with the Resilience Managers and ICC, Special Operations to identify risk sites in terms of MTA and CBRN specific risks and include HART/SORT considerations in the SSPs and ICC SOPs	S21	Joanne Hodson Joe Barrett	End of May 2024		
I5	Review how SORT staff are trained to dynamically assess, mitigate and record risks in line with JESIP	S21	Joe Barrett	End of March 2024		
I6	Conduct a quarterly test in each of the 3 areas to confirm 30 SORT staff can be activated within 60 minutes, and at least 1 MTA asset in 15 minutes	S29, S40	Joe Barrett	End of March 2024		
I7	When 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.	S35	Tony Shryane	End of March 2024		
I8	In conjunction with NHS England, test the new Mass Cas arrangements prior to sign off.	M4	Joanne Hodson	End of April 2024		
I9	Completion of strategic leadership review to include Command in the JD and recruitment process with agreed assessment in line with the appropriate NOS	C7	Matt Cooper Andy Wood4	End of June 20204	11/01/24 – Task given to Command & Resilience Trainers to produce a one day package as part of an induction process for potential operational and Tactical commanders, to be completed by mid February depending on recruitment details for posts. AW4	
I10	Workforce management plan to be reviewed and updated (reflects management of commanders non-compliant with the standards set in the NOS)	C25, C26	Vicki Camfield	End of Feb 2024	08 Jan 2024 - NOS Framework document drafted Dec 2023, this has gone to Senior Directors for feedback by 27th Dec, none received.	

I11	Create a written and agreed process for how NOS is audited by ADs and how to remove a Commander in the C2 Framework if they are not compliant with exercise or incident attendance (evidence through submitted reflection) every 18 months, or other CPD requirements (see I10). The AEO should be notified of this.	C25, C26	Vicki Camfield Andy Wood4	End of Feb 2024	11/01/24 NOS framework is a bespoke presentation that is being delivered to all commanders between Jan & March 2024, to allow feedback to be received from the cohort. The document will then be updated and released as a final version in April 2024, following agreement at ELC.	
I12	Creation of a central repository for NOS which is maintained within Resilience showing attendance by Commanders on Exercises - maintained by CARE team	C25, C33	Andy Wood4	End of Feb 2024	11/01/24 reviewed current Exercise spreadsheet and will amend to meet CARE and EPRR core standard requirements, complete by End of Feb 2024	
I13	Create a written process for how NOS is audited (e.g. dip sample), against what standard, and by whom	C27	Andy Wood4	End of Feb 2024	11/01/24 the NOS framework document includes processes for auditing of individual commanders and who is responsible for conducting audits as well as the process for addressing commanders who fail to maintain the compliance standards that are laid out in the Framework document. This includes the use of the Command & Resilience Training Team being utilised to assist the line managers and individual commanders in meeting the	

					standards through the use of peer support and mentoring. (AW4)	
I14	Produce annual declaration for commanders to show they understand their obligations. This could be incorporated into an Appraisal form along with mandated training or as an annex to written process.	C27	Andy Wood4	End of April 2024	This will be included in the framework, it is covered in the Commander training to ensure commanders are aware	
I15	Include NOS compliance in EPRR SC work programme and reports	C27	Andy Wood4	End of April 2024	11/01/24 will be presented at next EPRR SC	
I16	Ensure the AEO is appraised when a commander is not maintaining competency (to be included in C2 Framework and EPRR policy)	C27	Andy Wood4	End of April 2024	11/01/24 will be presented at next EPRR SC	
I17	MERIT recruitment to increase numbers to have 3 available at all times to cover the advisory/command support roles	C32	Craig Hooper	End of March 2024		
I18	All reflective practices for MERIT doctors to be completed and submitted by end of Jan 2024	C33	Craig Hooper	End of March 2024		
I19	2024 iteration of MERIT Training Programme to be more detailed on why a MERIT Doctor is removed from the live rota and the process to get them reintroduced once the training package has been completed.	C33	Craig Hooper	End of March 2024		
I20	Look at opportunities for SMAs to attend Strategic Exercises	C33	Craig Hooper	End of March 2024		
I21	Align practices and processes with the Command assurance and governance structure (I12, I13, I14, I15, I16)	C33	Craig Hooper	End of March 2024		

I22	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	J10	Andy Wood4	End of March 2024	08/01/24 - Command & Resilience Team to review Reflective practice templates and include how the JESIP principles and JDM can be included and update whilst the current command training is being conducted.	
I23	Area Directors, who are responsible for Commander Compliance, should confirm with line managers that JESIP training is being completed with the aim of at least 90% operational and EOC staff compliance. The data should be submitted quarterly to the Head of Contingency Planning for inclusion in the EPRR Sub Committee reports	J13	Area Directors	Report due Oct 2023, Jan 2024, April 2024, July 2024		

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	29th January 2024	**Chair:**	Prof A Esmail, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	C Grant, Medical Director M Power, Director of Quality, Innovation, and Improvement
Members Present:	Prof A Esmail Dr D Hanley Mr S Desai Mrs A Wetton Dr C Grant Dr M Power Dr A Chambers	**Key Members Not Present:**	None

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
Board Assurance Framework (BAF)	• Discussed BAF risks SR01, SR03 and SR06 and the outstanding mitigating actions.	• Gained assurance that BAF risks were being managed effectively and discussed the outstanding mitigating actions for 2023/24.	

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	• Received and noted the integrated performance activity, for onward submission to the Board of Directors on 31 January 2024. • Highlighted the ongoing challenge of hospital handover times, particularly in the Cheshire and Mersey area and the impact on the trust's overall performance position. • Overall ARP performance improved, with improvements required in Category 3 and 4 call compliance.	• Noted the Integrated Performance Report for onward submission to the Board of Directors. • Recognised the improvements made, however noted the ongoing challenge of hospital handover times and service delivery resource challenges.	
Complaints Assurance Report	• Noted complaints activity during Quarter 3. • Noted the good work undertaken by the team. • Future reports to include health inequalities demographics and specific examples of where learning identified has had an impact on practice.	• Received and noted the assurance provided.	
Legal Services Assurance Report	• Received Quarter 3 update, which included the number of inquests received by the trust and contributory factors.	• Received and noted the assurance provided.	
PSIRF Assurance Report Q3 Report 2023/24	• Received serious incident activity during Q3, and acknowledged serious incidents now reported through the Patient Safety Incident Response Framework (PSIRF).	• Received and 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
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	• Discussed triangulation of data and the change in reporting format, which will further develop during 2024/25.		
Medicines Management Report Q3 2023/24	• Progress made by the medicines management team during quarter 3 noted. • Included audits undertaken, and initiatives taken to improve levels of compliance, particularly related to vehicle audits.	• Received and noted the assurance provided.	
Q2 Learning from Deaths Report	• Q3 learning from deaths activity reported. • Noted the key themes and areas of focus. • Acknowledged the actions identified to improvement the quality of record keeping and the collaborative directorate working undertaken. • Supported onward submission to the Board of Directors.	• Received and noted the assurance provided, for onward submission to the Board of Directors.	
Mental Health Thematic Review	• Received a comprehensive update on the steps taken since the thematic review report, presented to the Committee in November 2023. • Noted the system wide work completed and co-ordinated by the trust. • Acknowledged the current risk position and noted that mental health risks to	• Noted the content of the thematic update. • Executive Leadership Committee to review the risk, and the corporate risk register, including narrative, and risk score in February. Further discussion paper to be presented to the Board of Directors on 27th March 2024.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
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	be considered by the executive team in February, as part of the corporate risk register review. • Noted the monitoring and oversight of the trust's Strategic Partnership Transformation Board and a further discussion paper to be presented to the Board of Directors in March 2024.		
Learning Disability and Autism Plan Annual Report	• Received an overview of the trust's Learning Disability and Autism Plan and work undertaken during 2023/24. • Welcomed a comprehensive update and noted the hard work of the team.	• Received and noted the assurance provided.	
Private Ambulance Providers Assurance Report	• Received an annual assurance report, commissioned by the Audit Committee.	• Received and 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

CHAIRS ASSURANCE REPORT

Quality & Performance Committee

Date of Meeting:	26th February 2024	**Chair:**	Prof A Esmail, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	C Grant, Medical Director M Power, Director of Quality, Innovation, and Improvement
Members Present:	Prof A Esmail Dr D Hanley Mr S Desai Mrs A Wetton Dr C Grant Dr M Power Dr A Chambers	**Key Members Not Present:**	None

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
Board Assurance Framework (BAF)	• Discussed at length the outstanding actions related to SR03 and SR01. • Noted the ongoing challenges and clarified risk scores.	• Gained assurance that BAF risks were being managed effectively.	
Quality and Performance Dashboard	• Received performance data which outlined activity since the integrated	• Noted some stability in performance data.	

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

	performance report, presented to the January meeting. • Noted some stability in performance data, however acknowledged ongoing challenges associated with hospital waiting times and the issue of variation of performance in the Cheshire and Mersey area. • Acknowledged the improvements required nationally, to provide more effective local Category 1 and 2 call performance data. • Discussed the ongoing challenges related to DCIQ and inputting of learning from incidents.	• Noted the trust's ongoing performance challenges.	
Improving Patient Safety – Learning from the Letby Case	• Received the early headlines from the Association of Ambulance Chief Executives (AACE) following the Lucy Letby Case. • Discussed the issues of culture, the significance of the role of the Board of Directors. • Recognised the specific challenges related to the size, scale, and structure of the ambulance service. • Discussed the current assurance processes in place. • Noted further discussions to be held by the Committee and the Board of	• Noted and discussed the initial findings from the Association of Ambulance Chief Executives (AACE). • Discussed the factors associated to the structure and scale of the ambulance service. • Acknowledged further discussions to be held by the Committee and the Board of Directors as learning from the case progressed.	

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

	Directors as the learning from the case progressed.		
Mental Health Strategic Plan	• Received a comprehensive mental health strategic plan. • Noted the volume of work required and the disparity between work to be undertaken and resource and funding available. • Recognised the need to prioritise plans in line with available resources. • Further discussion on the plans to be held by executives. • The trust's Mental Health Strategy to be presented to the Committee in Q1 2024/25, along with an Equality Impact Assessment.	• Noted the work undertaken by the team. However, recognised the challenge of managing resources to support the work identified and a need to prioritise plans against available resource. • Noted forthcoming discussions to be held by executives.	
Infection, Prevention and Control (IPC) Assurance Report	• Noted the assurances provided and the actions identified to address gaps in control.	• Received assurance from the report.	
Public Health Plan Assurance Report	• Noted the scale of work and developments planned to address health inequalities. • Recognised the need to dovetail the trust's work with that of the wider health care system. • Discussed the need to ensure that the data analysed by the trust can be effectively utilised by the organisation.	• Acknowledged the work undertaken by the team. • Acknowledged the challenge of the scale of plans and trust's limited resource.	

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

	• Acknowledged the challenge of the scale of plans and trust's limited resource.		
Clinical Audit Q3 Assurance Report	• Discussed the audit activity during Q3. • Discussed the ongoing work to rectify the extraction of data using the apex tool and to meet the NHS England mandated audit data submission requirements.	• Noted the audit activity undertaken. • Noted the work ongoing to meet NHSE mandated audit data submission requirements.	
Emergency, Preparedness, Resilience and Response (EPRR) Annual Assurance Report	• Discussed the EPRR annual assurance report and the NHS England self-assessment process. • Noted the standards that met partial compliance and the actions identified. • Report to be submitted to the public meeting of the Board of Directors in March 2024.	• Noted the updates and content of the EPRR Annual Assurance Report.	
Sub Committee Chairs Assurance Reports	• Received assurances from the sub committees aligned to the Quality and Performance Committee.	• Noted the assurances provided.	

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

CHAIRS ASSURANCE REPORT

North West Ambulance Service NHS Trust

Resources Committee			
Date of Meeting:	22nd March 2024	**Chair:**	Dr D Hanley, Non-Executive Director
Quorate:	Yes	**Executive Lead:**	Ms C Wood, Director of Finance
Members Present:	Dr D Hanley Mr D Rawsthorn Mrs C Butterworth Mr D Whatley Ms L Ward Mr S Desai Mrs C Wood	**Key Members Not Present:**	-

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
Annual Committee Effectiveness Review	• Discussed responses from Members on the effectiveness of the Committee during 2023/24.	• Discussed the outcome of the annual effectiveness review and the draft Terms of Reference for 2024/25.	

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

	• Noted minor amendments to the draft Terms of Reference for 2024/25, for approval by the Board of Directors in April.	• Minor amendments requested, prior to presentation to the Board of Directors in April 2024.	
Board Assurance Framework	• Discussed the strategic risks aligned to the Committee and the achievability of target risk scores.	• Gained assurance that BAF risks were being managed effectively.	
Finance Report	• Received a comprehensive update and discussed the trust's financial position for month 11 2023/24.	• Received and discussed the month 11 2023/24 finance report.	
2024/25 financial planning and opening budgets	• Received a comprehensive update of the financial planning position and the opening budgets. • Acknowledged the challenges related to achieving efficiency targets and further assurance required.	• Noted the financial planning position, including opening budgets. • Further assurance required on the delivery against efficiency targets.	
Provision of bulk fuel and ancillary products Contract Award	• Supported the proposal for onward approval by the Board of Directors.	• Recommended the proposal for approval by the Board of Directors.	
Measured Terms Services Contract Award	• Discussed the specifics of the procurement process in detail. • Supported the proposal for onward approval by the Board of Directors.	• Recommended the proposal for approval by the Board of Directors.	
RRV Replacement Programme 2024/25	• Supported the proposal for onward approval by the Board of Directors.	• Recommended the proposal for approval by the Board of Directors.	

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

Procurement Assurance Report	• Received the assurances provided and noted future format of reports would align to the trust's revised governance reporting arrangements from 1st April 2024.	• Noted the assurances provided.	
Estates, Fleet and Facilities Management Assurance Report	• Noted the assurances provided and that future format of reports would align to the trust's revised governance reporting arrangements, from 1st April 2024.	• Noted the assurances provided.	
Reinforced Aerated Autoclaved Concrete (RAAC) Update	• Received a comprehensive update on the RAAC position, including asbestos assurances.	• Noted the update provided.	
Workforce Indicators Report	• Discussed the workforce indicator performance. • Noted ongoing concerns related to sickness absence and the challenges within the contact centres and PTS. • Staff turnover challenges discussed and noted the pressures in the EOC and retention of call handlers and care assistants. • Noted the initiatives ongoing to improve the overall position. • Mandatory training and appraisal progress discussed and end of year target rates.	• Noted the assurances provided. • Noted the ongoing challenges of staff turnover and retention of contact centre staff, particularly for call handler and care assistant roles.	

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

	• Appraisal completion rates 83%, slightly below target and mandatory training 88% ahead of target. • Received an update on HR case workload.		
Sub Committee Assurance Reports	• Noted the assurances received by the Strategic Workforce Sub Committee. • Noted the assurances received by the Diversity and Inclusion Sub Committee.	• Noted the assurances provided in the Sub Committee assurance reports.	
2024/25 Draft Annual Plan	• Received the draft annual plan and discussed the strategic factors considered. • Recognised the trust awaited planning guidance, which could impact on the content of draft plan. • Noted the ambitious deliverables and the need for ongoing monitoring of the trusts ability to achieve the actions identified. • Supported the plan for further discussion by the Board of Directors.	• Received the Trust's draft annual plan 2024/25. • Noted the ambitious deliverables and the need for ongoing monitoring of the trusts ability to achieve the actions identified.	
Estates and Fleet Strategic Plan	• Received the Estates and Fleet Strategic Plan. • Noted the recent feedback from the trust's Executive Leadership Committee, received following circulation of the plan.	• Supported the Estates and Fleet Strategic Plan for approval by the Board of Directors.	

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

	• Comments to be incorporated into the final version to be presented to the Board of Directors.		
Digital Update	• Noted the digital update and the activity since the last report presented to the Committee. • Requested further clarity in relation to cyber security considerations and recent risks identified.	• Noted the content of the digital update.	

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

North West Ambulance Service NHS Trust

REPORT

REPORT TO BOARD OF DIRECTORS

DATE:	27 March 2024				
SUBJECT:	Estates and Fleet Strategic Plan				
PRESENTED BY:	Executive Director of Finance				
PURPOSE OF PAPER:	For Decision				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
EXECUTIVE SUMMARY:	The purpose of this paper is to present the draft Estates and Fleet Strategic Plan 2024-2030 for approval by the Board of Directors. Strategic plans form part of the trust's strategy and outline how supporting functions would deliver the objectives of the trust strategies. The Estates and Fleet Strategic Plan group began development of the strategic plan in September 2023. The strategic plan is in three parts: • principles which will guide decisions around estates and fleet, and which align with our trust strategies. • the approach to key strategic decisions in estates and fleet. • the development of detailed strategic roadmaps to outline what the estates and fleet portfolios will deliver over the next 6 years. The principles and approach to key strategic decisions were developed with engagement from Service Delivery. The development of the detailed roadmaps will take place in 2024/25. Equality and sustainability impacts should be considered in detail when any project or activity is begun to implement the strategic plan. The strategic plan aims to have a positive impact on equality and sustainability.				

RECOMMENDATIONS:	Trust Board of Directors are recommended to: • Review and approve the contents of the strategic plan; and • Support the completion of strategic roadmaps in financial year 2024/25.
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:	20 March 2024 / 22 March 2024		
	OUTCOME:	Supported with some minor wording amendments		

1. PURPOSE

1.1. The purpose of this paper is to present the draft Estates and Fleet Strategic Plan 2024-2030 to trust Board of Directors for approval.

1.2. This paper will also outline the next steps for the development of strategic roadmaps to implement the principles and approach outlined in the strategic plan.

2. BACKGROUND

2.1. In June 2022, trust Board of Directors approved Our Strategy 2022-2025. In August 2022 Resources Committee agreed to begin production of four supporting strategies, which were approved in July 2023, and which would then be followed by strategic plans which would outline how supporting functions would deliver the objectives of the trust strategy and supporting strategies.

2.2. The development of the Estates and Fleet Strategic Plan began in September 2023. Senior managers from Estates, Fleet and Facilities Management worked with the Strategy, Planning and Transformation team to form the strategic plan group. The group outlined the scope of the strategic plan and agreed the approach to the development of the strategic plan.

2.3. The director of finance was the executive sponsor for the development of the strategic plan.

2.4. ELC have reviewed the strategic plan in March 2024 and recommended some changes to the content which have been incorporated into the final version of the strategic plan.

3. APPROACH

3.1. The scope of the strategic plan is our estates, our fleet, including vehicle workshops, and our facilities management. The project group discussed the length of the strategic plan and agreed that 3 years, to fit in with our trust strategies, was too short a period to realise significant change in many estates projects. It was agreed that a 6-year strategic plan would give enough time for the strategic plan to realise its impact.

3.2. The Estates and Fleet Strategic Plan has been developed in three parts.

- The first part is the principles which will guide decisions around estates and fleet, and which align with our trust strategies.
- The second part outlines the approach to key strategic decisions in estates and fleet.
- The final part of the strategic plan is the development of detailed strategic roadmaps to outline what the estates and fleet portfolios will deliver over the next 6 years.

3.3. The strategic plan group identified the internal and external drivers which impact our approach to estates and fleet and looked at how our estates and fleet should align with our trust strategies.

3.4. The next step was stakeholder mapping to identify where key stakeholders should be engaged to inform our principles and our approach to strategic decisions.

3.5. The key stakeholders identified were in Service Delivery and trade union representatives.

3.6. The principles and key strategic decisions were developed through the engagement with Service Delivery to ensure that the strategic plan reflects the needs of our services.

3.7. The principles, key strategic decisions and the alignment to our strategies are outlined in the strategic plan document. The document has been produced with input from the Communications team to ensure that the design and layout is in keeping with the supporting strategy documents.

4. ENGAGEMENT

4.1. Workshops with Service Delivery colleagues took place in October 2023 and in February 2024. These workshops identified what the priorities for Service Delivery are and what factors we consider when undertaking strategic estates and fleet decisions.

4.2. Draft principles and an outline of our approach to strategic estates decisions were presented to trade union representatives in January and February 2024.

5. NEXT STEPS

5.1. A plan for further engagement and communication with staff and trade unions will be developed to raise awareness of the principles and our approach to delivering the trust strategies.

5.2. The strategic plan group will begin work in 2024/25 on producing estates and fleet strategic roadmaps which implement the principles and strategic decisions.

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

6.1. The Estates and Fleet Strategic Plan outlines our principles and approach to estates and fleet decisions which, when implemented will reduce risks.

Risk appetite category	**Implications**
Compliance / regulatory	3 facet surveys will identify any clear contraventions of fire and health & safety regulation and enable us to address those risks.
Quality outcomes	The strategic plan outlines principles which will support the delivery of high-quality patient care, and which positively impact patient experience.
People	The principles outline our commitment to being an excellent place to work. The approach in the plan also ensures that we consider wellbeing, accessibility and other people factors such as car parking and security in our decision making.
Financial / value for money	Financial value for money is a key component of the assessment process for estates and fleet decisions. The strategic plan commits to using the Green Book principles to inform decisions.
Reputation	The strategic plan aims to engender an overall improvement to the quality of our estate to ensure that we have modern working environments which people can be proud of, which will enhance our reputation as an employer and healthcare provider.

Innovation	Innovation is not the focus of this strategic plan however, to achieve the impacts of our principles, we will need to employ innovative solutions to making our buildings and vehicles environmentally sustainable and making the most efficient use of our resources.

7. EQUALITY OR SUSTAINABILITY IMPACTS

7.1. The strategic plan outlines how our estates and fleet can have a positive impact on equality and environmental sustainability. An Equality Impact Assessment (EIA) screening tool has been completed and shared with the Equality, Diversity and Inclusion team for review. The screening tool identified no negative impacts of the strategic plan. As the strategic plan is intended to implement the trust strategy, the impacts are expected to be the same as those identified in the trust strategy EIA.

7.2. Pending agreement from the EDI team, although the EIA screening tool indicates that a full EIA be completed, it may not be necessary for the strategic plan because, upon initiation of any project or activity linked to this strategic plan, a full EIA and sustainability impact assessment should be completed which relates to that project or activity directly.

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

8. RECOMMENDATIONS

8.1. Trust Board of Directors are recommended to;

- Review and approve the contents of the strategic plan; and
- Support the completion of strategic roadmaps in financial year 2024/25.

Appendix A – Stage 1 EIA Screening Tool

EQUALITY IMPACT & RISK ASSESSMENT SCREENING TOOL - STAGE 1

Directorate:	**Team:**
Strategy, Partnerships and Transformation	Strategy, Planning and Transformation
Name of programme/project/policy:	**EIA lead/author:**
Estates and Fleet Strategic Plan 2024-30	Samuel Eaton
Date of completion:	**Date of review:**
21/03/2024	

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

The Estates and Fleet Strategic Plan outlines the principles which will guide decisions around estates and fleet and which align with our trust strategies and outlines the strategic decisions to which we can apply the principles and which will inform our approach to addressing important decisions in estates and fleet.

GENERAL GUIDANCE

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

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *if you have indicated 'yes' for any questions, please briefly explain*
1	**Do the proposals plan to withdraw a service, activity or presence?**	N	
2	**Do the proposals plan to reduce a service, activity or presence?**	Y	Whilst the strategic plan does not plan to reduce services or presence, it outlines the considerations which might lead to a change in the location of estates.
3	**Are the proposals primarily about improving access to, or delivery of a service?**	N	
4	**Do the proposals plan to change to a commissioned service?**	N	
5	**Do the proposals plan to introduce, review or change a policy, strategy or procedure?**	Y	This strategic plan will inform the decisions taken around estates and fleet for the next 6 years.
6	**Do the proposals plan to introduce a new service or activity?**	N	
7	**Do the proposals impact the ways of working of the current or future workforce?**	Y	The strategic plan aims to inform decisions which will impact how estates, fleet and facilities management teams will work and which will impact the working environment of other staff across the trust.
8	**Do the proposals affect staff, or levels of training for those who will be delivering the service?**	N	*Detail which staff groups are affected*
9	**Do the proposals affect service users?**	Y	The strategic plan aims to ensure that performance and quality are considered as part of estates and fleet decisions which will lead to positive impacts on service users.
10	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab*
	EQUALITY RISK	**Enter Y or N**	**Rationale**
11	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	N	
12	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	N	
13	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	N	The strategic plan aims to embed consideration of accessibility and equality within estates and fleet decisions to ensure that those decisions are compliant with the Public Sector Equality Duty.
14	**Do you plan to publish your information?** Include any "Decision Reports"	N	
15	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	N	
16	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	
17	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	Y	Staff groups have been engaged wih during the development of the strategic plan.
IMPACT	●	**There will be some impact. You should undertake a Stage 2 assessment**	
RISK	●	**There is a high risk**	

	HUMAN RIGHTS IMPACT	Rationale
18	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**	No

Human Rights:

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

Are you intending on proceeding to complete a Stage 2 EIA? ***If no, please provide a rationale***	No. As a strategic plan which is derived from the trust strategy, the likely impacts on equality have been captured within the EIA for the trust strategy. The impacts of the strategic plan itself are positive as the strategic plan has been developed to improve the organisation's services for staff and service users. As and when activities result from the strategic plan, there will be specific EIAs for those individual projects which will outline equality impacts.

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

Comments from the ED&I Team			
Reviewed by:		**Date**	

North West Ambulance Service NHS Trust

Estates and Fleet Strategic Plan 2024-2030

Contents

Introduction

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

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

To achieve this vision, we have three aims; provide high-quality, inclusive care, be a brilliant place to work for all, and work together to shape a better future. Our supporting strategies outline what we will prioritise over the next three years to achieve our aims and ultimately, our vision.

The Estates and Fleet Strategic Plan supports the delivery of our strategy and supporting strategies.

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

This strategic plan replaces the Estates Strategy 2018-2023 and the Fleet Strategy 2019-2024 which have now expired.

The Estates and Fleet Strategic Plan will do 3 things:

1. Set the principles which will guide decisions around estates and fleet, and which align with our trust strategies;
2. Outline the strategic decisions to which we can apply the principles, and which will set out what our approach to addressing important decisions in estates and fleet will be; and
3. Produce a detailed roadmap which will demonstrate what the estates and fleet portfolios will deliver over the next 6 years to implement our strategies.

Our vision is ambitious. To achieve it we need to balance getting the basics right while continuously striving for excellence.

GET THE BASICS RIGHT

When we talk about the basics, we mean the foundations on which high-quality services are built and maintained.

We must consistently get these right to make sure our people have everything they need, every day, to help patients when they need us most.

STRIVE FOR EXCELLENCE

Striving for excellence means we must look for opportunities to continuously learn and improve what we do and how we do it.

We must take opportunities to change areas of our service to respond to the needs of our people, patients and partner organisations to improve health outcomes in our communities.

Estates and Fleet Principles

Our estates and fleet support the delivery of high-quality patient care and a positive patient experience.

These estates and fleet principles are statements of intent which will guide decisions to achieve rational outcomes and provide ensuring parameters to ensure that future decisions are aligned to the trust's vision. Our Strategy 2022-2025 says that we will provide high-quality, inclusive care and that we will focus on reducing harm caused by delays in assessment, response and handover. Our approach to estates and fleet will ensure that we do this by considering the needs of our service model to ensure that our services are situated where they are needed and that our vehicles are available when they are needed.

We recognise that the location of our operational estates which are bases for paramedic emergency services (PES) and non-emergency patient transport services (PTS) can impact on the performance of those services. Although most PES attendances are not dispatched from base, meal breaks and shift change requires crews to travel to their base of operations. When returning to base incurs significant travel time, there is a negative impact on the availability of resources.

Our service delivery model for our integrated contact centres is changing to allow staff to work more flexibly between our 111 and 999 services. For this to work, we need our contact centre estates to be fit for purpose to support an integrated contact centre workforce by being large enough to support co-located 111 and 999 services.

- The approach to designing and maintaining estates and fleet will make sure the service can meet the demands of the public now, and in the future.
- Location of Operational PES and PTS estates will be informed by analysis of performance and demand; this will include consideration of return to base time and cost.
- Operational PES and PTS estates will allow for vehicle readiness, cleanliness and maintenance to be managed efficiently.
- Contact centre estates will enable integration.
- Management and maintenance of vehicles off the road will be proactively managed to improve availability of vehicles.

Our Strategy 2022-2025 aims to be a brilliant place to work for all where we will create an environment where our people feel happy and safe, have access to equal opportunities and are supported to be at their best. Wellbeing will be our priority and we will solve everyday problems by providing the right tools, skills and environment needed to provide the best possible care.

Our approach to estates and fleet will ensure that we provide facilities which promote wellbeing, safety, enhanced learning and reflect the diverse needs of our staff. We will also strive to provide facilities which our staff can be proud of, and which enhances our reputation.

We strive to be a learning organisation where all staff can reach their potential. The provision of spaces which support collaboration and continuing professional development, alongside fit for purpose training facilities in both fleet and estate will enhance retention, quality of learning and care.

Clean, well maintained, and modern estates will give staff a sense of pride in NWAS and improve staff satisfaction. By providing wellbeing facilities such as quiet spaces, gyms, kitchens, and rest facilities we will ensure that staff have everything they need to provide high-quality care, promote staff satisfaction and ensure that we promote mental and physical good health.

We must provide a safe and secure workplace for staff to reduce the risk of stress, enhance staff wellbeing and reduce the risk of illness and injury in our workforce. We recognise that our services operate around the clock, and we understand the impact that this can have on staff feeling safe and secure in their work environment.

We are an inclusive organisation with a diverse workforce. We recognise that people have differing needs, and we will consider accessibility in our approach to estates and fleet.

Our estates and fleet will offer modern work environments that everyone can be proud of.

- Our estates and fleet will provide access to fit for purpose learning and development environments which support core training and continuing professional development.
- Our estates will offer facilities to support NWAS' agile working needs and collaborative spaces will be available for everyone to use.
- Our estates and facilities will be digitally enabled.
- All workspaces will reflect the corporate branding, promote professional standards and be safe and secure.
- NWAS estates will be configured to provide wellbeing facilities which are accessible by all.
- Our facilities will support a range of diverse needs.

A significant limitation of what we can achieve in estates and fleet is the growing pressure on NHS finances. We have a responsibility to ensure that we provide our services in a cost-effective way and which provides value for money to our population. To work within our means requires us to be as efficient as possible, considering the long-term implications of investment decisions.

We also have a responsibility to ensure that we consider social value alongside affordability when determining value for money so that we can maximise the positive impact we have on our communities. The HM Treasury Green Book principles advise us on how to develop proposals in a holistic way that optimises social value from the use of public resources.

A proactive approach to estates and fleet will help us to minimise our spend on maintenance wherever possible. It will also enable us to make the most of the facilities we have by optimising the use of space and vehicles so that we have the most cost-effective facilities.

Climate change is already affecting the UK and as greenhouse gas emissions continue to rise, climate models project that we will continue to see changes to the UK's weather. Limiting this continued impact on our climate requires reduced global carbon dioxide emissions. We must make significant improvements to our estates and change the composition of our fleet so that we can play our part in reducing emissions.

Our estates and fleet will be economically efficient and have a positive impact on the environment and our local communities.

- We will reduce our fleet emissions by increasing our electric vehicles fleet. Our estates and facilities will be designed and managed to support a growing electric vehicle fleet.
- We will reduce business mileage by making sure a variety of commute methods are accessible at current and future estates.
- New estates will be designed to preserve energy, existing estates will be upgraded where appropriate to improve efficiency.
- Facilities will be managed in a way which improves the utilisation of space and reduce energy usage.
- Competitively tendered estates, fleet and facilities management business will include evaluation criterion for social value.
- Our estates and fleet investments and contracts will demonstrate best value for money determined thorough evaluation of net present social value and affordability in line with HM Treasury Green Book principles.
- We will explore commercial opportunities as we continue to review our estates assets.

How are our principles aligned to our supporting strategies?

The principles in this strategic plan are aligned to our supporting strategies which outline what we will prioritise to achieve our aims and our vision. By making sure that we follow these principles, we can be reassured that our decisions are consistent with achieving our vision.

Supporting Strategy	Draft Estates and Fleet Strategic Principles
Service Delivery	• The approach to designing and maintaining estates and fleet will make sure the service can meet the demands of the public now, and in the future. • Location of operational PES and PTS estates will be informed by analysis of performance and demand; this will include consideration of return to base tine and cost. • Operational PES and PTS estates will allow for vehicle readiness, cleanliness and maintenance to be managed efficiently. • Contact centre estates will enable integration. • Management and maintenance of vehicles off the road will be proactively managed to improve availability of vehicles.
Quality	• Our estates and facilities will be digitally enabled. • New estates will be designed to preserve energy, existing estates will be upgraded where appropriate to improve efficiency. • Competitively tendered estates, fleet and facilities management business will include evaluation criterion for social value. • We will explore commercial opportunities as we continue to review our estates assets.

Supporting Strategy	Draft Estates and Fleet Strategic Principles
Sustainability	• We will reduce our fleet emissions by increasing our electric vehicles fleet. Our estates and facilities will be designed and managed to support a growing electric vehicle fleet. • We will reduce business milage by making sure a variety of commute methods are accessible at the current and future estates. • New estates will be designed to preserve energy, existing estates will be upgraded where appropriate to improve efficiency. • Facilities will be managed in a way which improves the utilisation of space and reduces energy usage. • Our estates and fleet investments and contracts will demonstrate best value for money determined through evaluation of net present social value and affordability in line with HM Treasury Green Book principles.
People	• Our estates will offer facilities to support NWAS' agile working needs and collaborative spaces will be available for everyone to use. • Our estates and fleet will provide access to fit for purpose learning and development environments which support core training and continuing professional development. • Our facilities will support a range of diverse needs. • NWAS estates will be configured to provide wellbeing facilities which are accessible by all.

What is our approach to strategic estates prioritisation?

How do we decide which estates need investment and how much investment (New site Vs maintain)?

We are constrained by the availability of capital to fund investment in our estates. We must therefore set out how we will prioritise investments to best meet the needs of our services, support our staff, and deliver our strategy.

Our focus will be on getting the basics right. Facet surveys covering all of our owned estates will provide comprehensive, clear and independent assessment of the current condition of the estate.

Our portfolio is currently a balance between owned, long-term and short-term leases. The overall security and value for money elements should feature in our considerations.

We will consider our operational performance and other quality indicators to identify areas where our estates do not meet the needs of our services and our people. This will include consideration of the location of our workshop estates.

We will be open to emerging opportunities for land/property in key locations and we will consider our lease arrangements and estates shared with our partners.

Our priorities for investment will be those estates with significant risks identified through facet surveys and those which are impacting on operational performance, the quality of our services, regulatory compliance and the quality of our learning environment.

How do we decide the configuration of the estate?

When we have identified the estates which are our priorities for investment, we will perform assessments to determine the most appropriate configuration for those estates.

Our estates will be configured to meet the needs of our service. This means that we will operate from a range of different estates depending on the best model for the location. We will be guided by the Ambulance Service Accommodation Requirements for Ambulance Stations developed by the Association of Ambulance Chief Executives (AACE) National Heads of Estates Group which defines the model for hubs, large ambulance stations, and ambulance stations. We will also consider other regulatory and statutory requirements such as high-speed driving regulations, apprenticeship and OFSTED standards.

The configuration of our estates will be driven by analysis of cost and benefits, where benefit is considered from several perspectives.

- Factors which impact staff such as good transport links, access to parking and our ability to recruit from local populations.
- Financial costs and benefits associated with changing the estates model.
- Demography/geography; consideration of population features such as size, density, dispersion as well as levels of deprivation.
- What opportunities are presented by other estate in the area to rationalise estates or provide additional benefits.

For operational estates, we will consider additional factors.

- The pattern of operational demand; where is the demand, how big is the demand and what do we need to be able to respond to this?
- Relationships with local features; services should be close to major acute hospitals and major roads to reduce journey times.
- Relationships to other related services such as make ready facilities, stores and vehicle workshops.

How do we manage policies/procedures/people to enable efficient utilisation of space within our estates?

Decisions will be appraised and evaluated using tools to objectively analyse the cost and benefits of each option. We will ensure that we are getting the basics right and taking opportunity to strive for excellence.

For us to make the most of our estates, we need to ensure that we are making efficient use of the spaces we have available, such as training facilities, office space and meeting rooms.

We also have a responsibility to ensure that estates are well cared for by the people using them so that they can continue to provide a high-quality workplace for as long as possible.

We will review our policies and procedures around the use of our facilities, considering the processes we use for allocating office space and booking training and meeting rooms. These reviews will be undertaken with consultation from staff and trade union representatives, and with consideration for the principles outlined in this strategic plan.

Fleet

Decisions we make around our fleet are heavily influenced by external drivers. This leaves less scope for strategic decision making. As an ambulance trust the fleet of vehicles is perhaps the most important of the organisation's physical assets. The vehicles within the fleet are the workplace and learning environment for staff, they house sophisticated pieces of medical equipment and provide a caring clinical environment for patients. The vehicles are a vital part of resources and the future fleet requirements need to be considered in the trust's planning of future resources.

We will maintain the current age profiling of the fleet which is:

- 7 years for PES ambulances
- 7 years for PTS ambulances
- 5 years rapid response vehicles
- 7 -10 years all other support vehicles

Our approach to estates decisions will ensure that we have the correct infrastructure to support our fleet by considering the placement of workshops to increase the availability of vehicles. We will undertake a workshop review to understand the workshop infrastructure and how it meets the needs of our services.

The fleet replacement programme will be aligned to the NHS Net Zero Travel and Transport Strategy which includes a roadmap for the phased introduction of zero emission vehicles and sustainable travel modes to meet the NHS Carbon Footprint targets. We will ensure that all of our vehicles procured conform to the European vehicle emissions regulations current at the time of procurement.

The NHS net zero travel and transport roadmap

The NHS will have fully decarbonised its fleet by 2035, with its ambulances following in 2040. Several key steps will mark the transition of NHS travel and transportation:

- By 2026, sustainable travel strategies will be developed and incorporated into trust and integrated care board (ICB) Green Plans.
- From 2027, all new vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances).
- From 2030, all new ambulances will be zero emission vehicles.
- By 2033, staff travel emissions will be reduced by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles.
- By 2035, all vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances) and all non-emergency patient transport services (PTS) will be undertaken in zero emission vehicles.
- In 2040, the full fleet will be decarbonised. All owned, leased, and commissioned vehicles will be zero emission.

The NHS Net Zero Travel and Transport Strategy outlines the economic, health and societal benefits of decarbonising NHS travel and transport which includes the NHS fleet, such as PES and PTS vehicles, business travel and staff commuting.

The NHS fleet and business travel emissions are part of the NHS Carbon Footprint which are those emissions under the direct control of the NHS. The NHS has committed to reducing these emissions by 80% by 2028-2032 and to net zero by 2040. Staff commuting emissions are part of the NHS Carbon Footprint Plus, those emissions are indirectly caused by NHS activity. We have less control staff commuting but we can influence it. The NHS has committed to reducing these emissions by 80% by 2036-2039 and to net zero by 2045.

Our vehicles are a workplace for our staff and we will make the same considerations of wellbeing, accessibility and safety for the people who work in them. We will also ensure that our fleet is able to provide a high-quality environment for patients and service users.

Estates and Fleet Roadmap Development

Starting in 2024-25, we will develop and maintain delivery roadmaps for our estates and fleet which will implement the principles and strategic decisions outlined in this strategic plan.

The roadmaps will be developed using available data with consideration for capital allocation, resources and the wider changes within the trust. They will be developed by the head of estates, the head of facilities management, and the head of fleet and logistics, supported by their teams and by the Strategy, Planning and Transformation Team. The director of finance will be responsible for overseeing the roadmaps.

Glossary

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

Term	Definition
AACE – Association of Ambulance Chief Executives	An association to provide the UK's statutory ambulance services with an organisation that can support them in the implementation of nationally agreed policy.
Facet Survey	Facet surveys are undertaken to assess the condition of our estate. The surveys cover three facets. • **Physical Condition** - the overall physical condition of the Estate assessed on three elements: buildings, mechanical systems, and electrical systems. • **Environmental Management** – a "broad brush" assessment of how the building is affecting the environment in terms of energy performance, efficiency of construction, water consumption and waste and transport management. • **Fire and Health and Safety Requirements** – this facet was not fully assessed, but any clear contraventions were identified and included within the backlog maintenance assessment.
His Majesty's Treasury (HMT) Green Book	The HMT Green Book is a widely recognized guide for best practices in public sector decision-making and policy development in the UK. The HMT Green Book provides instructions on evaluating policies, programs, and projects.
Hub and Spoke	An estates model in which larger central hubs are surrounded by smaller spokes within their locality. **Hubs** act as a reporting point for staff and vehicles. They include management, welfare, training and make ready facilities. They are located close to major acute hospitals or on major routes with most of the ambulance flow. **Spokes** are strategically located unmanned response points which provide crews with rest and welfare facilities.

Low, ultra-low and zero-emission vehicles	Ultra-low emission vehicles are currently defined as having less than 75 grams of CO2 per kilometre (g/km) from the tail pipe. Zero emission vehicles are defined as having 0 tail pipe emissions
PTS - Non-emergency Patient Transport Services	Non-emergency transport
Net Zero	Net zero refers to a government commitment to ensure the UK reduces its greenhouse gas emissions by 100% from 1990 levels by 2050 (2040 for the NHS).
PES - Paramedic Emergency Services	This is sometimes referred to as the 999 service or urgent and emergency care (UEC) service.
Tender, tendering	The procurement process of inviting and evaluating bids from suppliers to provide goods, works or services

The Ambulance Service Accommodation Requirements for Ambulance Stations developed by the AACE National Heads of Estates Group outlines the definitions for different sized stations.

Hub	Fully functioning station that's located in a way that best serves a geographic area, and includes support services, training facilities, as well as areas for training, studying, and cleaning/stocking.
Large Ambulance Station	Fully functioning station that's located in a way that best serves a geographic area, and includes support services, training facilities, as well as areas for training, studying, and cleaning/stocking
Ambulance Station	Traditional stand-alone ambulance facility that can be located anywhere drive time has been considered. The facility will house several vehicles but is not large enough to contain the full facilities of a large ambulance station.
Spoke	An Area located that meets the operational modelling specification that will be directly linked to a hub station and will contain the minimum requirements for vehicle changing and staff amenities.

References

AACE - The Ambulance Service Accommodation Requirements for Ambulance Stations

His Majesty's Treasury (HMT) Green Book

NHS Net Zero Travel and Transport Strategy

OFSTED Education Inspection Framework

Our Strategy 2022-2025

Road Traffic (Exemptions from Speed Limits) Regulations 2023

Road Traffic (Training Courses for Driving Vehicles at High Speeds) Regulations 2023