NHS
North West
Ambulance Service
NHS Trust

Quality Account 2023/24

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Contents

Chief executive statement

I am very happy to introduce this, our 23/24 Quality Accounts, which sets out the work we have done over the past year to maintain and improve the quality of care we provide to our patients and provides information on our priorities for 24/25.

Patient care is at the heart of what we do at North West Ambulance Service NHS Trust (NWAS). We provide help and support in the most difficult and challenging situations, most people who call us do so when scared, worried about a loved one and feeling vulnerable, and for us to be the first they turn to is a humbling and privileged position. For this reason, we are committed to delivering safe, high-quality care for all who need our services.

The past year has been challenging for NWAS and ambulance services across England, with changing patterns of demand and handover delays at hospitals. Despite this, we have seen improvements in our performance compared to last year and this account demonstrates that the improvements we have put in place are starting to have a positive effect.

Our response to Category 1 and 2 calls has improved significantly and shows continued improvement over time. Because these are the most serious and life-threatening calls we receive, we must prioritise our response to these patients, which sometimes results in longer waits for other patients. We know that, unfortunately, this may result in a poor experience for them and their families, something no ambulance service wants, and this remains one of our priorities for the coming year.

We work closely with health and social care partners across the region to establish clinical care pathways for patients that meet their needs, without the need for hospital admission or conveyance. This ensures that patients can receive treatment or services within their own homes and ambulances can be available to other patients more quickly.

During 23/24 we were able to resolve more than 40% of incidents through telephone consultation or referral to alternative services closer to the patient's home. Like other NHS ambulance services, we have received government investment to improve our response to Category 2 patients, who make up more than half of all 999 calls. We are committed to supporting the priorities set out in the Urgent and Emergency Care recovery plan and working with system partners to reduce unwarranted variations in the use of emergency departments.

With the help of the investment we have received, we can recruit and deploy new first responders and expand our ambulance fleet. At peak, we now have 32 extra ambulances and have recruited almost 200 new paramedics and frontline staff. Emergency ambulance service hours have increased by more than 2,500 hours per week compared to March 2023.

A key determinant of ambulance availability and responsiveness is the time it takes for an ambulance patient to be transferred to hospital care and for the ambulance to return to service – known as hospital handovers. We continue to work closely with colleagues in

Integrated Care Boards (ICBs) and acute care settings to reduce these. The success of this effort has been mixed, with some areas of the ICBs making significant progress and others deteriorating. Long handover times reduce the positive benefits of the additional resources gained, as many of our crews must wait to hand over patients which takes them out of the system and unavailable to respond. This is an issue that is recognised across the country and is by no means unique to NWAS, and we will continue to prioritise this issue in our region.

As well as the financial investment to increase our frontline resources, we have also invested in our most important asset – our staff. Details of our work on culture, workforce, staff side partnerships and sustainability are included in the Trust Annual Report and supporting annual reports on equality, diversity and inclusion and wellbeing, which are helpful companion documents to this Quality Account. Without a happy, healthy, and committed workforce, we could not do what we do and each time I meet with colleagues, I am in awe of their enthusiasm and dedication to our patients. As always, it would be remiss of me to not mention the outstanding contribution of all our volunteers. We are very fortunate to have the assistance of members of the community who support us and give up their free time to do so.

This Quality Account provides numerous examples of staff going the extra mile to improve the services we offer every day and of the investment we have made to improve the quality of our services. I do hope what you read in this Quality Account inspires you; whether you are considering joining NWAS as an employee, a volunteer, supporting our charity, working in partnership with us or simply wanting to know more about what we do, we are always keen to hear your views and feedback. We are more than blue lights, we are more than a voice who answers your call; we are an organisation that strives to put you and the health of the North West region at the forefront of all we do, and I hope we make you proud.

Daren Mochrie, QAM, MBA, Hon.DHC, Dip IMC RCSEd, MCPara

Chief Executive Officer

Statement of directors' responsibilities in respect of the Quality Account

Under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011, the directors must prepare quality accounts for each financial year. The Department of Health has issued guidance on the form and content of annual quality accounts (which incorporate the above legal requirements). In preparing the Quality Account, directors must take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of our performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

About us

North West Ambulance Service (NWAS) is one of the largest ambulance trusts in England. We provide services to over seven million people across a geographical area of approximately 5,400 square miles. We employ 7,415 staff from over 100 sites and provide services to patients in rural and urban communities, coastal resorts, affluent areas and in some of the most deprived inner-city areas in the country. We also provide services to a significant transient population of tourists, students and commuters.

The North West region is one of England's most culturally diverse areas, with over 50 languages spoken by community members. Consequently, we place considerable emphasis on equality and diversity and public engagement activities to ensure that our services are accessible to all members of the community. There are more people living with long-term conditions and, as people get older, we can expect there will be more people in our communities living with illnesses. We know from our data that the overall health of our region's population has an impact on demand for our services.

A strategic focus is to collaborate with our integrated care systems (ICS) and integrated care boards (ICB) to support the delivery of public and population health agendas and urgent and emergency care services. We are the only regional NHS organisation in the North West that operates across five ICSs:

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

Our shared purpose, vision and values

At NWAS, everyone is connected by a shared purpose;

'To help people when they need us most.'

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

Our vision is:

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

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

To deliver our vision, everyone at NWAS is expected to embody our values:

'Working together'

'Being at our best'

'Making a difference'

These values guide the behaviours that underpin all that we do; putting our values into practice supports us to provide compassionate care and improve outcomes and experiences for our people, patients and communities.

Our strategy

We have three strategic ambitions:

- Provide high-quality, inclusive care.
- Be a brilliant place to work.
- Work together to shape a better future.

This Quality Account (financial year 23/24) details deliverables for the first aim, 'to provide high quality inclusive care that is safe, effective and person centred'.

Details and specifics related to aims two and three are included within complementary board documents including our Annual Report 23/24 and our Equality, Diversity and Inclusion Annual Report 23/24.

Our services

	NHS 111 deliver services for the North West region and are major contributors to the delivery of integrated urgent care. We signpost patients to the most appropriate care highlighted to them following triage and informed by the Directory of Services.
	Emergency Operation Centres (EOC) receive and triage 999 calls from members of the public as well as other emergency services. EOC staff provide advice and dispatch an ambulance to the scene as appropriate. The Clinical Hub (CHUB) is based within the EOC, assesses patients via telephone and provides the most appropriate care based on that assessment. This may be an ambulance (either emergency or urgent care), GP referral, referral to other services or self-care.
	Paramedic Emergency Service (PES) services are delivered by solo responders, double crewed ambulances and approved private providers who together deliver 999 emergency care for the population of the North West.
	Resilience: Our hazardous area response team (HART) and resilience teams are specially trained and equipped paramedics to provide ambulance response to high-risk and complex emergency situations, including major incidents. They respond to major incidents to deliver our statutory responsibilities as a Category 1 responder under the Civil Contingencies Act 2004.
	Patient Transport Services (PTS) provide essential transport to non-emergency patients in Cumbria, Lancashire, Merseyside and Greater Manchester, who are unable to make their own way to or from hospitals, outpatient clinics or other treatment centres.
	Volunteering: we have one of the largest and longest-established community first responder (CFR) schemes in England, with CFRs operating across all areas of the North West, providing an effective, complementary service in their local communities.

As well as providing clinical services to patients, we provide a wide array of specialist, non-clinical corporate services. These wider teams offer a unique variety of services, for example, estates and facilities, communications, risk management, digital, vehicle maintenance, finance and human resources.

Our Quality Strategy

In 2023 we published our second Quality Strategy. The Quality Strategy (22/25) is one of four supporting strategies which outlines what we will prioritise over the next three years to achieve our aims and ultimately, our vision.

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

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

Over the last five years of our first quality strategy, covering the period of 2018 to 2023, we have taken significant steps to learn. Primarily we are curious about how the care we provide is experienced by patients. We have listened to our staff when they speak up about patient safety, scrutinised learning from incident reports, listened to staff at staff forums and learnt much about how safe, reliable and sustainable our systems are from clinical audits.

Our second quality strategy is better because of this focus on learning and extends our commitment to continue improving safety, effectiveness and patient experience. It sets the scene for the next three years and will consider how we can go even further. There is clear alignment to the overarching Trust Strategy and interdependency with the family of supporting strategies and plans.

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

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

Our quality strategy signals our intention to challenge ourselves and to continue to learn and improve together every day. The opportunity for partnership working to improve quality has never been greater. We have had changes to the way healthcare services are organised with

the establishment of primary care networks (PCN), provider collaboratives (PC) and integrated care boards (ICB). This strategy also signals our intention to double down on our work with providers of primary care, community services, mental health, emergency and urgent care to work towards even more integrated care.

We are proud to serve the people of the North West. This Quality Strategy demonstrates our unwavering commitment to delivering continuous quality improvement for our patients and communities and a significant achievement for 23/24.

Figure 1: The Quality Strategy - Plan on a page.

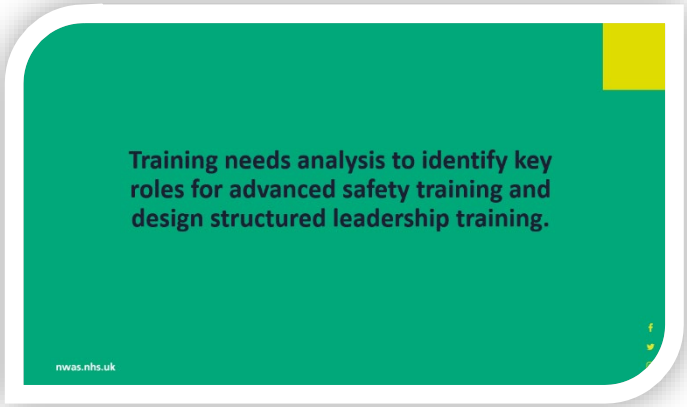
Our strategy is ambitious, and we must balance getting the basics right with striving for excellence. The priorities outlined in this strategy have elements of both "basics" and "excellence" which will be further detailed as we turn our strategy in to action.

Our aims and achievements in 23/24

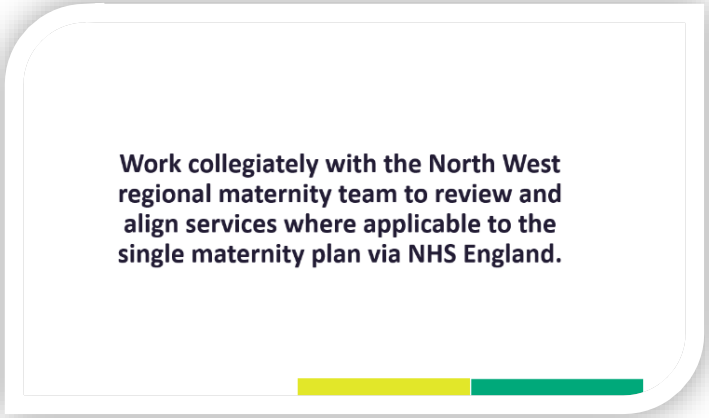
Safe care is about reducing risk and protecting our patients and staff from avoidable harm. Emphasis is placed on the system of care delivery that prevents errors; learning from errors that do occur, understanding the complexities of the systems our people work within and building on a culture of safety that involves our people, partners and patients.

We successfully implemented PSIRF in Q3 23/24. This approach sets out how we are maintaining effective systems for responding to patient safety incidents to aid learning. We engaged with stakeholders and early adopter PSIRF organisations. We also developed our incident reporting, delivered PSIRF training to leaders of PSIRF processes, agreed a cross-system response to patient safety investigations and published our PSIRF Response Plan and Policy.

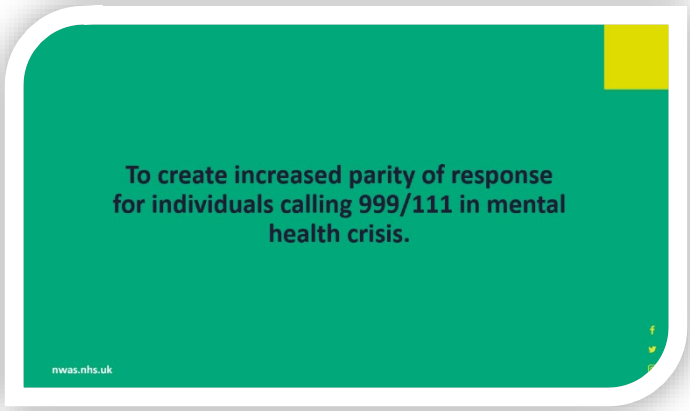
To align with PSIRF we have reviewed our learning mechanisms to share learning from safety insights from a range of data across the organisation. The Patient Safety Learning team and Quality Improvement team led the review via focus groups with stakeholders, establishing a new Regional Clinical Learning and Improvement Group.



We completed our training needs analysis and began training staff using the NHS Patient Safety Syllabus (levels 1-5). In 23/24 level 1 featured on mandatory training for all frontline staff. This training builds a safer system and culture which we will measure via the staff and safety culture survey, incident data and learning from complaints. Staff in management roles have also undertaken duty of candour training.

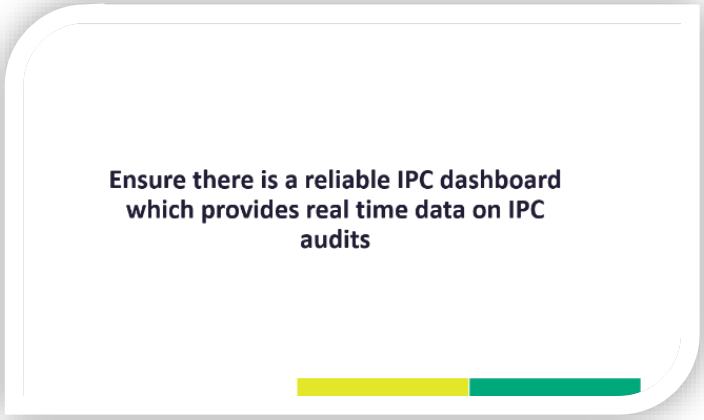


Our consultant midwife has ongoing membership with the NHS England regional perinatal board, aligning services and supporting the development of regional policies and pathways into services. In 23/24 we have launched the North West regional operational pressures escalation level (OPEL) maternal escalation policy to manage system pressures, developed the community transfer guideline and supported timely transfer into maternity units.

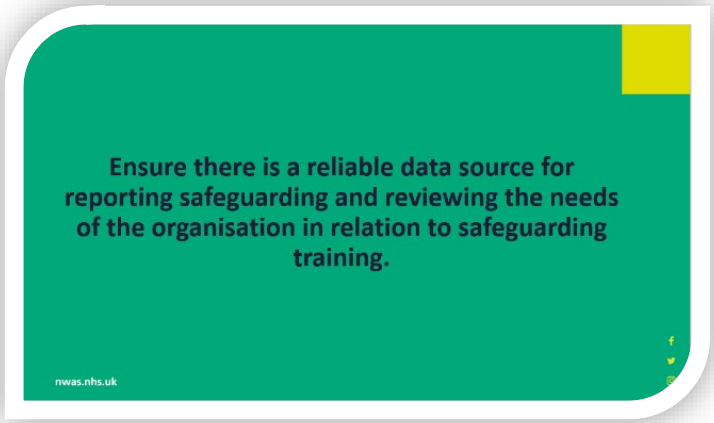


We have worked with partners to implement the 111 press 2 option for patients in mental health crisis. We have worked closely with external partners to implement a robust model of practitioners in our call centres across Greater Manchester (GM) and Lancashire and South Cumbria (L&SC). We have shared themes from serious incidents with ICS partners. NHS England plan to evaluate this national change to services.

The board monitors IPC systems and processes biannually through the IPC board assurance framework, in line with the requirements of the provider licence. New IPC Standards of Cleanliness have not yet been implemented by UK ambulance trusts, however cleanliness on vehicles in contact centres and stations is monitored by facilities management and the IPC team.



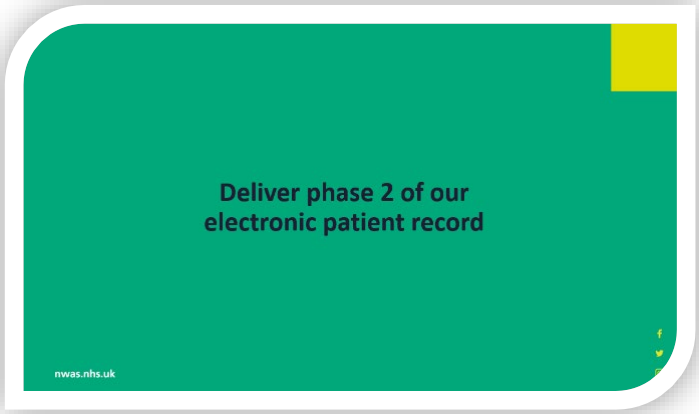
Our automated Power BI dashboard was developed and tested in quarter one. The pilot identified some modifications which were completed. We now have reliable real time data for IPC providing us with assurance that audits are being completed. This enables us to act in a timely way which reduces the risk of infection.



There is regular data available from the safeguarding database which provides a breakdown of safeguarding referrals by type and area. More work is required to develop a fully comprehensive suite of measures and will be carried forward into 24/25. Training compliance is monitored by the learning and development team via the national system (ESR).

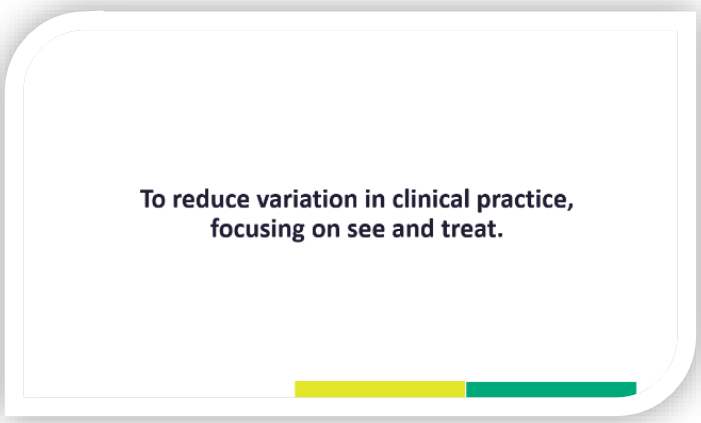
Highly Effective care means we will support people to achieve good outcomes and have the best quality of life possible. Put simply we are committed to, 'no unwarranted waiting' and 'no waste'. Our ambition is that all care is delivered using the most up to date evidence-based practice, ensuring our staff are capable and confident, and that seamless care is delivered having sought people's consent.

Our key measure of effectiveness is the monthly National Ambulance Clinical Quality Indicators (ACQI) which is included in full in this account. Data collection occurs three months in arrears. The sepsis ACQI has been retired and a falls ACQI has been introduced as a pilot for 23/24. NWAS have been at the forefront of the development of the national ACQIs.



We are concluding the EPR development, which has enabled:

- The use of the EPR on iPads.
- New tiles for maternity and mental health.
- 'GP Connect' access for staff to view information directly from GP records.
- Capturing of key information for the Ambulance Data Set (ADS) national reporting.
- Coroners to access all Diagnosis of Death (DoD) records in real time.
- The ability to complete electronic referrals to Clinical Assessment Services (CAS).



We conducted a comprehensive review of see and treat (S&T) variation across our footprint, which included paramedic interviews and responses to an e-survey. This allowed us to establish the eight fundamental causes of variation. These causes now form the S&T and wider ED Conveyance improvement objectives within our 24/25 annual plan.

Our improvement work has continued to focus on increasing access to alternative pathways from the control room via the directory of services, reducing conveyance to ED through better access to alternative pathways from on scene and reducing hospital handover delays. Examples of innovations can be found throughout this quality account.

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

GP Connect now enables clinicians to access patient records at the point of care. Paramedics and technicians have access to vital information such as allergies and medicines. This helps them make an informed assessment and enables safer decision making. It also reduces the need for patients and families to share information on multiple occasions.

The learning disability and autism (LD&A) strategic plan was approved at board and a full implementation plan commenced with the appointment of a substantive LD&A lead. Our consultant midwife has secured funding for a research study: Disparities in access to the North West Ambulance Service during pregnancy, birth and postpartum period and its association with neonatal and maternal outcomes [DIAAS].

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

Listening to patients when things go right and wrong.

Friends and family test (FFT): Each month over 1200 patients complete feedback on our services via the Friends and family test (FFT) and significantly more are contacted for feedback by our corporate patient experience team.

We meet and listen to the experience of patient and community groups both face to face and virtually at listening events, high footfall community events and in local communities across the North West.

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

Patient stories: Over the last year we have delivered our commitment to use patient stories to ensure that our board, assurance committees, learning forums and frontline teams are informed. We have a comprehensive library of stories available.

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

The information gleaned from FFT, complaints, compliments, social medial and patient stories is used in our Integrated Performance Report and Annual Patient Experience Report to provide assurance to the Board. It is also reported on a quarterly basis to Board as an integral part of our corporate communications and engagement team dashboard report. Whilst this information is vital to our corporate strategy and decision making, our ability to obtain, collate and use local survey data, has remained more limited. We are now starting to

provide senior management teams with combined communications and engagement reports highlighting levels of patient satisfaction, themed issues and opportunities for improvement.

Figure 2: Patient and Public Panel members talking at an event.

Our operational performance

Activity and demand: NHS 111

In 23/24, NHS 111 call demand has fallen by 6.8% overall compared with 22/23. However, there have been periods of variation based on external factors, for example winter pressures, industrial action and an unexplained spike at the end of March 2024.

Fiscal year	111 call demand offered	% difference to previous year
20/21	2,387,619	-
21/22	2,716,565	13.8%
22/23	2,496,811	-8.1%
23/24	2,326,127	-6.8%

Table 1: Total number of calls to 111 (23/24) with the percentage change from baseline (22/23) showing an absolute reduction in call demand of 6.8%.

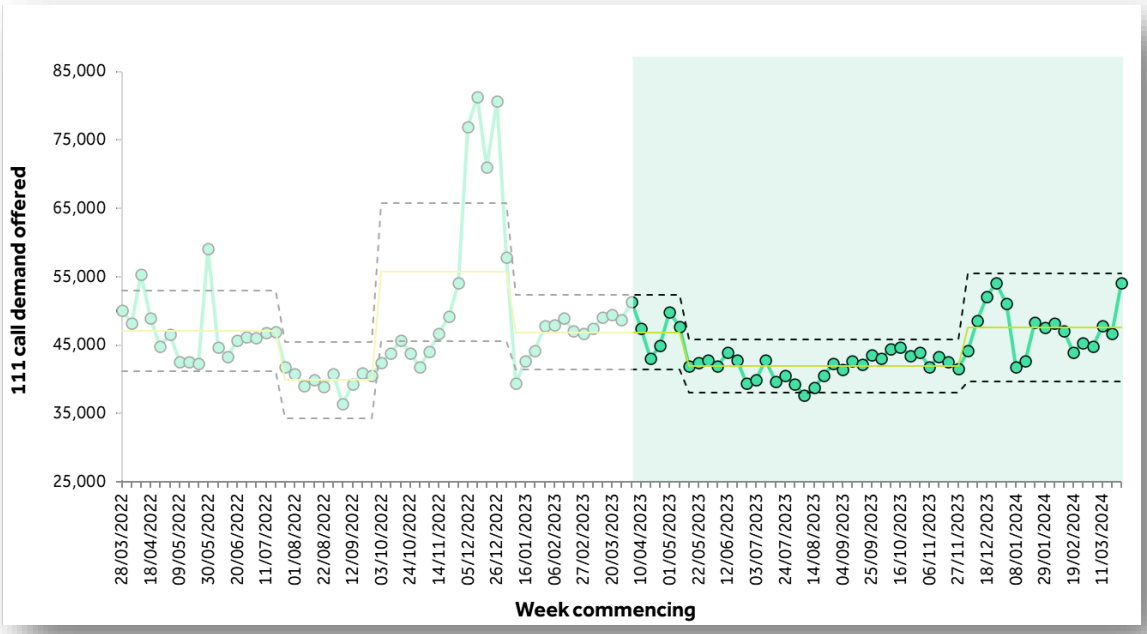


Figure 3: The average number of calls is 44,416 per week or 6,345 per day (23/24) with the reporting year highlighted in green.

The statistical process control chart shows a sharp rise in demand in the baseline year (November 2022) where excess demand from Strep A, NHS industrial action and seasonal flu increased demand across the whole NHS. The demand reduced in January 2023 in line with the expected demand, stabilised and dropped slightly in May 2023, rising again in November. Overall call demand has been more stable in 23/24 than the previous year.

Performance standards: NHS 111

There are four primary key performance indicators for the NHS 111 service:

- Calls abandoned – less than 5% of all calls to be abandoned by the caller.
- Calls answered – 95% of all calls to be answered within 10 minutes.
- Calls warm transferred – 75% of clinical calls to be warm transferred.
- Call backs – 75% of call backs to be made within 10 minutes.

Description	Target	Year	QI	Q2	Q3	Q4	Overall
Calls abandoned	<5%	22/23	18.84%	10.53%	28.38%	17.25%	19.38%
		23/24	9.80%	12.10%	12.46%	15.98%	12.71%
Calls answered in 60s	95%	22/23	34.86%	51.41%	32.15%	38.90%	39.26%
		23/24	51.46%	51.36%	50.79%	46.03%	49.82%
Calls warm transferred	75%	22/23	15.80%	17.19%	10.59%	22.02%	16.34%
		23/24	20.28%	12.21%	10.43%	14.71%	14.54%
Callbacks in 10 mins	75%	22/23	7.42%	9.74%	7.63%	12.41%	9.14%
		23/24	15.18%	16.00%	14.30%	14.10%	14.87%

Table 2: 111 Performance Standards 23/24.

Description	Year	% of calls	% point difference to previous year
Calls abandoned	20/21	13.86%	-
	21/22	23.25%	-9.39%
	22/23	19.38%	3.87%
	23/24	12.71%	6.67%
Calls answered in 60s	20/21	64.02%	-
	21/22	35.49%	-28.53%
	22/23	39.26%	3.77%
	23/24	49.82%	10.56%
Calls warm transferred	20/21	18.74%	-
	21/22	14.76%	-3.98%
	22/23	16.34%	1.58%
	23/24	14.54%	-1.80%
Callbacks in 10 mins	20/21	13.17%	-
	21/22	5.38%	-7.79%
	22/23	9.14%	3.76%
	23/24	14.87%	5.73%

Table 3: Shows the percentage change year on year in key performance indicators for 111 services.

There is a reduction in calls abandoned, increase in calls answered in 60s, slight decrease in calls warm transferred to a clinician and an increase in call backs within 10 minutes. The reported performance falls short of the NHS England targets and reflects challenges with demand and capacity gaps which have been mitigated with support from NHS England since April 2023. For context, between 10% and 15% of 111 calls in the North West are delivered to Vocare. This agreement is currently in place until September 2024.

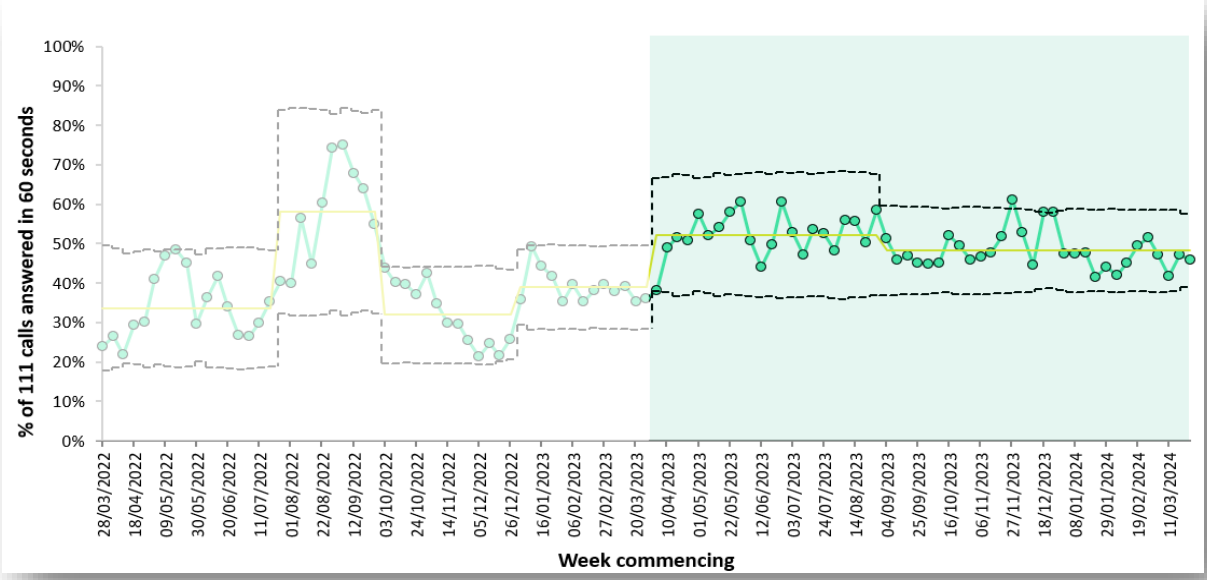


Figure 4: Overall, the percentage of calls answered within 60 seconds was 49.82% in 23/24. The statistical process control chart shows a stable position throughout the reporting year (highlighted in green). There are some notable improvements in November and December, coinciding with the national support received from NHS England and with the implementation of the winter plan, but a return to baseline in quarter four. Overall call demand has been more stable in 23/24 than the previous year.

Integrated Contact Centres (ICC)

During 23/24, the integration of 999 and 111 contact centre service progressed. The long-term goal is full integration of the services into an integrated contact centre (ICC). The primary focus for this year has been to integrate governance and senior leadership, under the ICC director. As of the end of 23/24 phase one is complete, with the senior leadership team now in place. Phase two will complete in June 2024. This will integrate the second tier of leadership from Patient Transport Services (PTS), Emergency Operations Centre (EOC), Clinical Hub (CHUB) and our support centre. The 111 control room improvements are documented in the improvement section of this report and have resulted in significant improvements in staff survey results, reductions in sickness and turnover.

Activity and demand: Paramedic Emergency Services (PES)

999 call demand

In 23/24, 999 call demand has fallen by 5.6% overall compared with 22/23. However, there have been periods of variation based on external factors, for example winter pressures and periods of industrial action by NHS staff throughout the year. This is shown in Figure 5.

Fiscal year	999 call demand	% difference to previous year
20/21	1,288,736	-
21/22	1,632,595	26.7%
22/23	1,531,958	-6.2%
23/24	1,446,701	-5.6%

Table 4: Total number of 999 calls (23/24) with percentage change from the baseline.

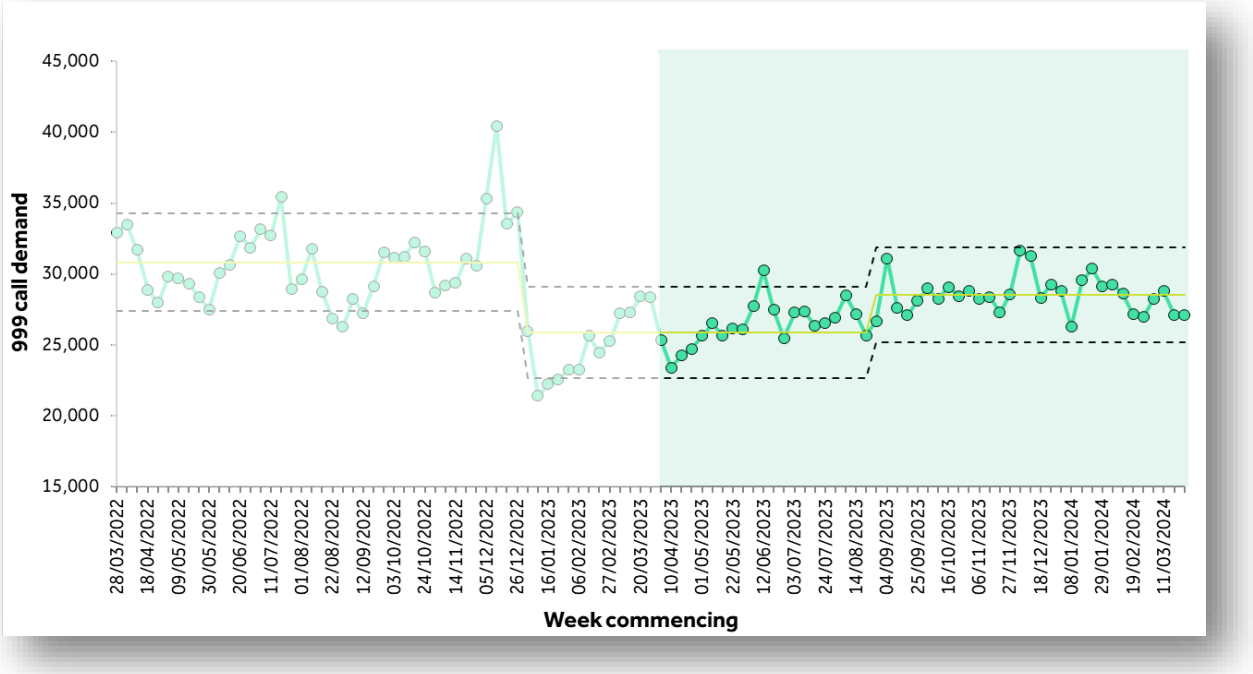


Figure 5: Average number of calls is 27,675 per week or 3,953 per day (23/24) with the reporting year highlighted in green.

The statistical process control chart shows a sharp rise in demand in the baseline year (November 2022) where excess demand from Strep A and seasonal flu increased demand across the whole NHS. The demand reduced in January 2023 (coincident with industrial action by NHS staff), stabilised, then increased in June 2023, rising again in September and December. Overall call demand has been more stable in 23/24 than the previous year.

Incidents requiring a response

In 23/24, 999 emergency incidents requiring a response has increased by 4.3% overall compared with 22/23. The number of incidents responded to is less than the number of 999 calls received for several reasons. These include multiple telephone calls being received for the same incident, estimate time of arrival enquiries and solving the patients' needs through telephone triage and signposting to more appropriate services.

Fiscal year	Emergency incidents	% difference to previous year
20/21	1,141,443	-
21/22	1,129,193	-1.1%
22/23	1,074,933	-4.8%
23/24	1,121,403	4.3%

Table 5: Total number of 999 calls requiring a response (23/24) with percentage change from the baseline.

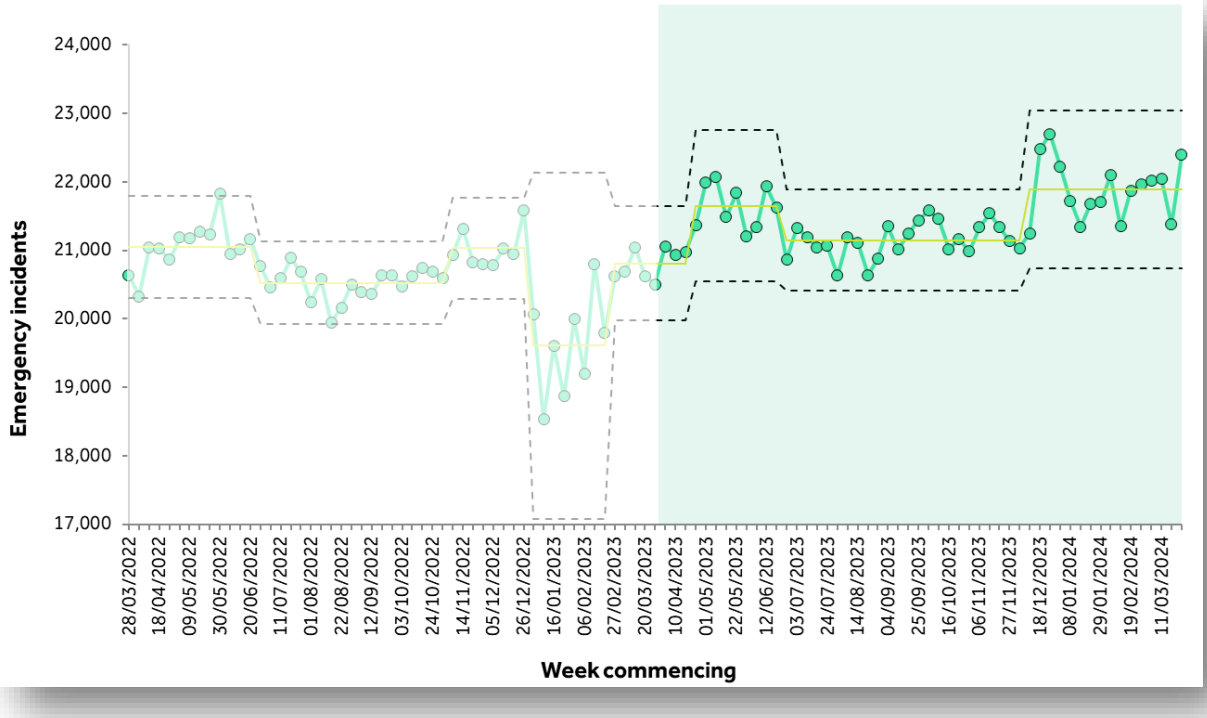


Figure 6: Average number of responses is 21,455 per week, or 3,065 per day (23/24) with the reporting year highlighted in green. There have been peaks in incident demand in April and December 2023. The rise in demand seen in December 2023 has not returned to baseline in 2024 and we see a rise in incident numbers sustained to the end of the reporting period.

Performance standards: Paramedic Emergency Services (PES)

999 call pick up

In 23/24, 999 call pick up within 5 seconds improved by 24 percentage points with performance consistently at 96.8%, comparable with the best ambulance services in the country. Call pick up is a vital safety metric for patients with the most life-threatening conditions (Category 1) as cardiopulmonary resuscitation advice over the telephone is a critical success factor in survival.

Fiscal year	% of 999 calls answered in 5 seconds	% point difference to previous year
20/21	95.0%	-
21/22	75.9%	-19.1%
22/23	72.8%	-3.1%
23/24	96.8%	24.0%

Table 6: Total number of 999 calls answered in 5 seconds (23/24) with the percentage point change from the baseline.

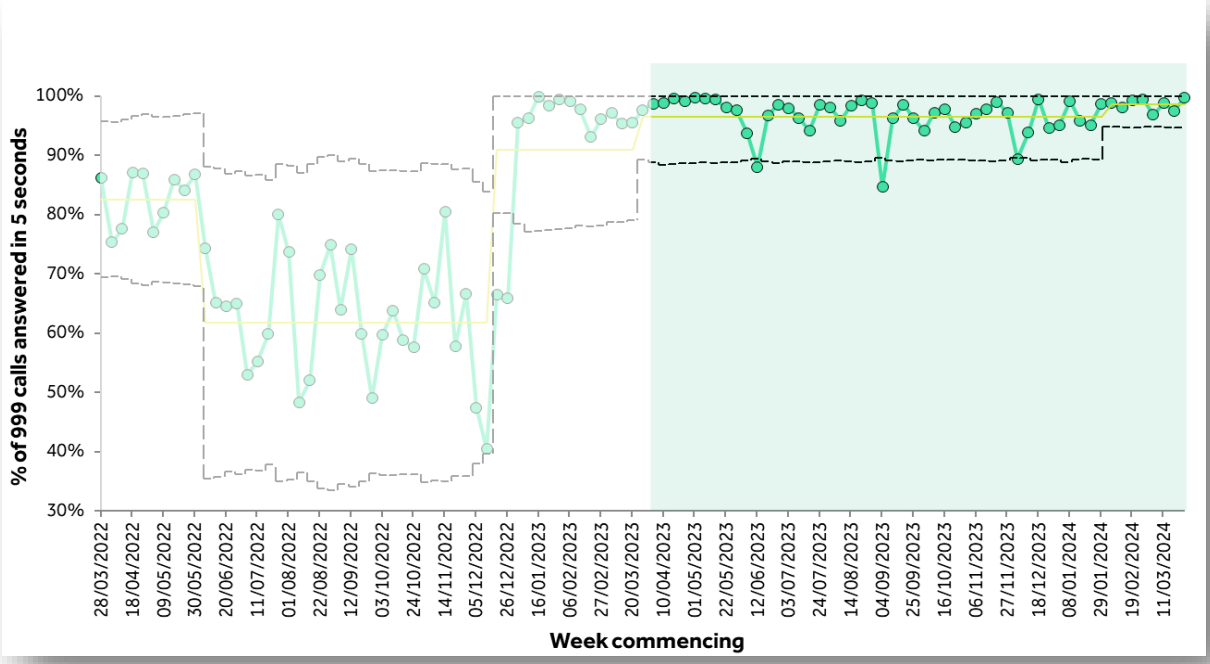


Figure 7: The percentage of 999 calls answered shown weekly demonstrates increased consistency at 96.8% in 23/24. There is some special cause variation through the year where call pick up has dropped below the lower control limit in mid-June, late September, and early December. However, the system has become tightly controlled (evidenced by narrowing of the control limits) suggestive of increased reliability from January 2024. This is associated with call handler availability and demand which both impact this indicator.

Ambulance Response Programme

Our emergency performance is measured through the Ambulance Response Programme (ARP), which aims to make sure we are reaching patients as quickly as we possibly can. Under ARP there are four categories, with Category 1 being the most serious incidents. All categories have a performance standard based on the time it takes to respond to the incident. These performance standards can be seen below:

- Category 1 is for calls about people with life-threatening injuries and illnesses. We aim to respond to these in an average time of 7 minutes and at least nine out of ten times within 15 minutes.
- Category 2 is for emergency calls. We aim to respond to these in an average time of 18 minutes and at least nine out of ten times within 40 minutes.
- Category 3 is for urgent calls. In some instances, you may be treated by ambulance staff in your own home. We aim to respond to these within 120 minutes at least nine out of ten times.
- Category 4 is for less urgent calls. In some instances, you may be given advice over the telephone or referred to another service such as a GP or pharmacist. We aim to respond to these at least nine out of ten times within 180 minutes.
- Category 5 is for signposting advice only; no response times apply.

Standard	7 mins (C1)	15 mins (C1 90th)	18 mins (C2)	40 mins (C2 90th)	120 mins (C3 90th)	180 mins (C4 90th)
Q1	00:08:00	00:13:27	00:23:03	00:46:01	04:01:05	05:58:46
Q2	00:08:09	00:13:57	00:27:15	00:56:22	05:27:37	05:53:04
Q3	00:08:13	00:13:54	00:34:20	01:13:48	06:39:56	06:17:46
Q4	00:08:04	00:13:37	00:29:53	01:03:24	05:11:25	06:00:32
23/24	00:08:07	00:13:45	00:28:44	01:00:33	05:17:59	06:00:46
22/23	00:08:35	00:14:41	00:42:19	01:36:03	07:40:13	10:00:19

Table 7: Ambulance Response Standards 23/24.

Table 7 shows that during 23/24 we have delivered improvements across all standards compared with 22/23. However, in common with all other ambulance trusts we are still working towards achieving the ARP performance standards.

Our performance against the ambulance response programme is monitored by the quality and performance committee and Board of Directors via our Integrated Performance Report. This report highlights our performance against the ARP standards and shows variation between ambulance trusts and Integrated Care systems within our footprint.

In Autumn 2023, NHS England published the Urgent and Emergency Care Recovery plan with a requirement for all systems to bring the Category 2 response time mean under 30 minutes. By 31 March 2024, our C2 mean in 23/24 is 28 minutes 44 seconds.

Category 2 long waits have been a contributing factor for a significant number of adverse incidents. There has been a reduction in the number of Category 2 long waits (over four hours), which has helped to improve clinical outcomes and increase the safety of the service.

Measure	Year	Response time	% difference to previous year
C1 Mean	20/21	0:07:28	-
	21/22	0:08:42	16.50%
	22/23	0:08:35	-1.30%
	23/24	0:08:07	-5.40%
C1 90th	20/21	0:12:31	-
	21/22	0:14:48	18.20%
	22/23	0:14:41	-0.80%
	23/24	0:13:45	-6.40%
C2 Mean	20/21	0:26:54	-
	21/22	0:47:39	77.10%
	22/23	0:42:19	-11.20%
	23/24	0:28:44	-32.10%
C2 90th	20/21	0:58:05	-
	21/22	1:47:54	85.80%
	22/23	1:36:03	-11.00%
	23/24	1:00:33	-37.00%
C3 Mean	20/21	1:16:26	-
	21/22	2:54:38	128.48%
	22/23	3:08:10	7.75%
	23/24	2:14:53	-28.32%
C3 90th	20/21	3:02:19	-
	21/22	7:09:53	135.80%
	22/23	7:40:13	7.10%
	23/24	5:17:59	-30.90%
C4 90th	20/21	4:06:49	-
	21/22	14:07:29	243.40%
	22/23	10:00:19	-29.20%
	23/24	6:00:46	-39.90%

Table 8: Percentage change year on year.

During 23/24, we received investment from the NHS England to improve our response to patients needing a Category 2 response. We now have 32 additional ambulances at peak times and have recruited almost 200 new front-line paramedics and emergency medical technicians. There are now over 2,500 more emergency ambulance hours available every week compared with March 2023.

Variation in weekly response times 23/24

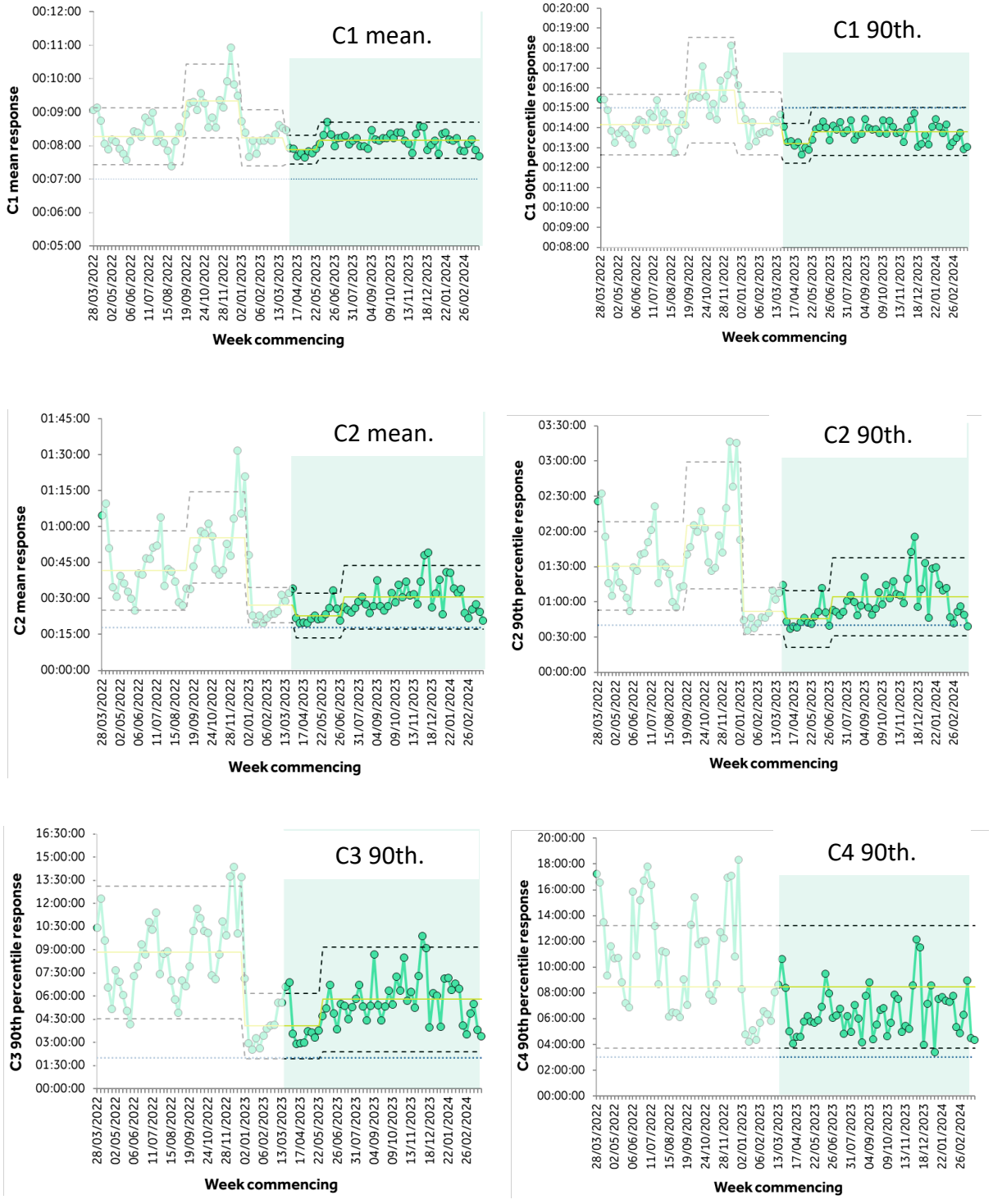


Figure 8: ARP response times 23/24.

Hospital handover

A key contributor to ambulance availability and response capability is the time that is taken at hospital for ambulance patients to be handed over into hospital care and for the ambulance to become available to respond again. We have continued to work closely with our colleagues in Integrated Care Boards (ICB) and acute trusts to improve hospital handover times. Success in this work has been mixed, with some ICB areas making significant improvements, while others deteriorated.

Month	Hospital attendances	Average turnaround time (hh:mm:ss)	Average arrival to handover time (hh:mm:ss)	Average handover to clear time (hh:mm:ss)
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
Mar 24	49,091	0:42:52	0:32:27	10:25

Table 9: Hospital handover times during fiscal year 23/24.

Hospital handover by ICS

During 23/24 we began publishing hospital handover data by ICS footprint and hospital to support the local improvement teams. As of 31 March 2024, the position is:

ICS	Hospital attendances to ED	Mean at hospital to clear time (hh:mm:ss)	Mean at hospital to handover time (hh:mm:ss)	Mean handover to clear time (hh:mm:ss)
Cheshire and Merseyside	179,463	0:49:53	0:37:58	0:13:25
Lancashire and South Cumbria	133,153	0:39:18	0:30:12	0:10:11
North East and North Cumbria	27,679	0:34:31	0:26:51	0:08:44
Greater Manchester	225,936	0:34:07	0:23:38	0:10:36
Derby and Derbyshire	2,431	0:35:32	0:22:57	0:11:45

Table 10. Hospital handover data by ICS.

Outcomes

Patients we help on the telephone (hear and treat).

We have worked closely with our health and social care partners across the region, to establish clinical care pathways for patients that meet their needs without a journey to hospital. This maintains patient independence in their own homes and reduces the demand on higher acuity services. Feedback from our colleagues across the region is that patients are presenting with more complex needs. However, we have been able to close more than 40% of incidents with either advice on the telephone or a referral to an alternative service, closer to home for the patient. We have a team dedicated to 'hear and treat', which involves getting back in touch with people who have called 999 and are not in a serious or life-threatening situation but could benefit from the right care at home without an emergency ambulance or journey to hospital. Some patients will be referred to our clinical hub and speak with a clinician who will assess over the telephone to determine the most appropriate care. The proportion of patients we can help on the phone has increased to 14.1%.

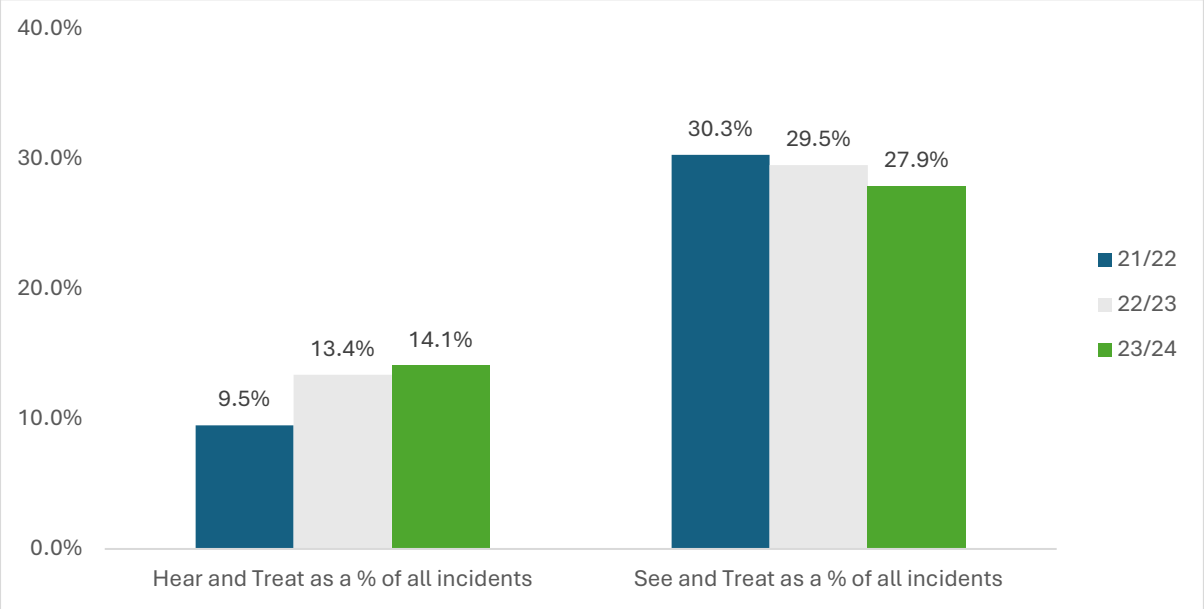


Figure 9: Percentage of hear and treat and see and treat incidents.

Patients not conveyed to hospital (see and treat).

As our hear and treat rates increase, we are only sending ambulances to the patients we cannot help on the phone, who are sometimes sicker or more complex. There will be times where we send a clinician in an ambulance who conducts a face-to-face assessment to establish the best way to treat the patient. Following an assessment, referrals may be made to primary care or urgent care services rather than conveying to an emergency department. This is referred to as ‘see and treat’. In 23/24, see and treat rates were 27.9% and while some of the reduction is explained by increase in hear and treat, increasing our see and treat rates is a focus for our improvement work during 24/25.

Activity: Patient Transport Services (PTS)

PTS activity is reported on a contractual year which runs from 1 July to 30 June. The nine-month position is showing a reduction in patient journeys resulting in a cumulative 10% below baseline, as shown in the table below.

Contract	YTD baseline	YTD activity	YTD activity variance	YTD activity variance %
Cumbria	126,218	97,195	-29,023	-23%
Greater Manchester	394,941	417,519	22,578	6%
Lancashire	441,886	328,788	-113,097	-26%
Merseyside	225,092	226,478	1,386	1%
NWAS	1,188,137	1,069,980	-118,156	-10%

Table 11: PTS activity - contract year to date: July 2023 - March 2024.

Utilisation.

As planned in the previous year the focus for PTS in 23/24 was to return to pre-covid utilisation of 1.8 patients transported per hour in an average eight-hour shift. During Covid, this utilisation dropped to 1.2 due to single occupancy of our vehicles. Covid positive patients could travel together resulting in utilisation occasionally being above 1.0.

Although the objective was to return to pre-covid utilisation rates of 1.8, analysis has shown that since 18/19 the healthcare system has changed in relation to outpatient services. Patients are now travelling to more locations further afield, meaning that the dynamic use of resource can be challenging. Throughout 23/24 utilisation has improved and there has been an upward trend for all counties with Merseyside showing the greatest improvement at 1.51 at the end of March 2024.

Efficiency.

Much of 23/24 has been spent developing and implementing an improvement plan to improve operational and financial efficiency. The main objective of the plan was to reduce reliance on third party resource, specifically private ambulances and to reduce allocations to taxis.

Many of the actions in the plan were to take things back to basics and ensure that all functions were aligned to the same simple objectives, namely, to improve our patients' experience and to deliver a sustainable, competitive service.

During 23/24 the control and contact centre element of PTS moved over to Integrated Contact Centres (ICC) as the establishment of ICC progressed. This was a positive move, delivering part of our strategic UEC direction to integrate services. However, in the operational environment the changes have affected managerial leadership capacity and resilience, which will need further attention during 24/25.

Implementation of the plan commenced in July 2023 with expenditure reductions seen from August 2023. There is still some work to do to standardise allocations to third party resources specifically taxis and this work is continuing.

Quality standards.

As activity increases and work continues to improve utilisation, against a backdrop of reducing reliance on third party provision, it will be necessary to maintain an efficient and effective balance. This will ensure that PTS continues to meet the demands of the regional and local integrated care systems, delivering a safe service and the best possible service for our patients in line with the contract income.

Patient safety.

Maintaining the safety of our vulnerable patients remained a priority throughout 23/24. The eligibility and call taking script was adapted to acknowledge the end of the Covid 19 pandemic but still allowed us to continue to identify our most clinically vulnerable patients, e.g. immunosuppressed patients and those with chronic respiratory illness. This allowed us to continue to make decisions about the most appropriate means to safely transport them to their appointments.

Performance: Patient Transport Services (PTS)

There are four areas of performance targets within the patient transport service (PTS) – call answering, travel time on a vehicle, on time arrival and collection after treatment. These performance areas are measured based on whether or not the journey was planned or unplanned, or if the journey was for someone receiving enhanced priority service (EPS, renal dialysis or cancer treatment). These performance indicators are known as our quality standards.

Contact Centre performance.

- Call answering – 75% of calls answered within 20 seconds.
- Call handling – average length of time taken to answer inbound calls is 60s.

Enhanced priority service (renal dialysis and cancer patients).

- Travel time on vehicle – 85% of patients to travel for no longer than 60 minutes on the vehicle.
- On time arrival – 90% of patients arriving within 45 minutes before the scheduled appointment time.
- Collection after treatment – 85% of patients collected within 60 minutes and 90% of patients collected within 90 minutes of scheduled collection time or patient readiness notification.

Planned journey.

- Travel time on vehicle – 80% of patients to travel for no longer than 60 minutes on the vehicle.
- On time arrival – 90% of patients arriving within 60 minutes before the scheduled appointment time.
- Collection after treatment – 80% of patients collected within 60 minutes and 90% of patients collected within 90 minutes of scheduled collection time or patient readiness notification.

Unplanned journeys.

- Travel time on vehicle – 80% of patients to travel for no longer than 60 minutes.
- On time arrival – No arrival standard.
- Collection after treatment – 80% of patients collected in 60 minutes of booked collection time. 90% of patients collected in 90 minutes of the booking.

Patient Transport Service: 23/24

Service Activity

1,069,980
Total PTS activity year to date

26.5
% of calls answered within 20 seconds

-10%
Variance from baseline* for year to date activity

369 seconds
Average length of time taken to answer inbound calls

*The annual baseline is the expected activity as per the PTS contract. The variance shown is how much we are under or over the expected journeys

Planned Care

	Target	23/24
Passenger time on vehicle is less than 60 minutes	80%	93.7%
% of patients arriving within 60 minutes of scheduled appointment time	90%	78.3%
% of patients collected within 60 minutes of scheduled collection time or patient readiness notification	80%	59.9%
% of patients collected within 90 minutes of scheduled collection time or patient readiness notification	90%	79.6%

Unplanned Care

	Target	23/24
Passenger time on vehicle is less than 60 minutes	80%	92.1%
% of journeys where the patient is picked up no later than 60 minutes after booked collection time	80%	57.4%
% of journeys where the patient is picked up no later than 90 minutes after booked collection time	90%	70.4%

Enhanced Priority Service

	Target	23/24
Passenger time on vehicle is less than 60 minutes	85%	95%
% of patients arriving 45 minutes prior to scheduled appointment time	90%	75.3%
% of patients collected within 60 minutes of scheduled collection time or patient readiness notification	85%	80.6%
% of patients collected within 90 minutes of scheduled collection time or patient readiness notification	90%	92.8%

KPI Data is only published in the contract year so this data from July 2023 - 31 March 2024. All contract years run from 1 July to 31 June

Our quality assurance

Ambulance Quality Indicators (AQIs)

Our key measure of the effectiveness of our services is the monthly National AQI submission to NHS England, produced by the Clinical Audit team. Clinical leadership then use this to inform their local improvement and feed back to staff.

Clinical leads for each of the indicators manage working groups across our footprint and work with system partners to learn and share outcomes. We provide quarterly AQI reports to the Quality and Performance committee and Clinical Effectiveness sub-committee. We provide further localised reporting for STEMI and older adult falls to our clinical leads, to contribute to learning and improvement.

National Ambulance Quality Indicators	April-December performance 22/23	April-December performance 23/24	April-December national average 23/24
Cardiac arrest (all-ROSC at hospital)	29.4% (883/3,004)	31.7% (916/2,892)	28.6% (6,443/22,548)
Cardiac arrest (Utstein-ROSC at hospital)	41.8% (182/435)	51.1% (243/476)	51.8% (1,725/3,330)
Post ROSC care bundle	74.2% (276/372)	73.8% (285/386)	76.6% (2,077/2,710)
Cardiac arrest (all-survival to 30 days)	7.4% (220/2,971)	10.8% (305/2,829)	9.4% (2,087/22,193)
Cardiac arrest (Utstein-survival to 30 days)	22.2% (96/432)	28.9% (134/464)	29.9% (968/3,242)
STEMI care bundle	66.7% (347/520)	75.3% (436/579)	77.6% (3,601/4,640)
STEMI PPCI patients (call to angiography)	02:42:00 (1,048)	02:29:00 (591)	02:28:00 (9,118)
Confirmed stroke patients (call to door)	01:42:00 (4,729)	01:24:00 (4,983)	01:36:00 (40,248)
Diagnostic stroke care bundle	96.9% (3,232/3,334)	98.6% (2,997/3,040)	97.6% (26,507/27,152)

Table 12: AQI submissions Apr-Dec 2023. [1]

[1] AQI Outcomes Data Source: NHS England. 2024. Ambulance Quality Indicators 23/24. [ONLINE] Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2023-24/ [Accessed 14 May 2024].

Data collection for these indicators occurs three months in arrears. The sepsis AQI has been retired and an older adult falls AQI has been introduced as a pilot for 23/24. The data for older adult falls will be published following completion of the pilot cycles and approval by NHS England.

We have submitted 100% eligible cases for the national ambulance quality indicators and two eligible national clinical audit projects: myocardial ischaemia national audit project (MINAP) and sentinel stroke national audit project (SSNAP) during April-December 2023. We have improved across all AQIs.

Local Clinical Audit.

Local audits completed	Number of cases reviewed	Summary and actions to improve practice
Fever in children (under five years of age)	291	Compliance was high - 7 out of 8 care bundle measures achieved over 95% Improvement in documentation of capillary refill times is required
Hypoglycaemia management	390	Compliance was high - all metrics above 95%
Asthma management	219	Compliance needs focus, especially around pre and post treatment peak flows. Clinical Bulletin issued.

Table 13: Local clinical audits between Apr-Dec 2023.

The fever in children (under five years of age) and hypoglycaemia audits have demonstrated excellent care compliance, with metrics being above 95%. The asthma management audit requires a re-audit within 12 months to see if compliance has improved. The clinical audit plan for 24/25 will include a wider portfolio of local projects, including a national clinical audit on patient recontacts occurring within 24 hours of original discharge.

Learning from deaths

Our approach to learning from deaths goes far beyond a process of simply counting, classifying and reporting deaths. This process aids in protecting future patients from avoidable harm, reduce unwarranted variation and provide truly patient-centred care.

In the past year we have once again met all reporting requirements. We produce quarterly learning from deaths reports, reviewed by quality and performance committee and board.

The table below details the number of deaths reviewed and the number of deaths where problems in care have contributed.

23/24 Learning from deaths	Total number of deaths in scope	Total number of deaths reviewed	% deaths reviewed	Total number of deaths where problems in care have contributed
Q1	62	37	59.7%	9
Q2	59	34	57.6%	9
Q3	77	36	46.8%	5
Q4	Not available at the time of publication			
Year-to-date	198	107	54.0%	23

Table 14: Learning from deaths, cases reviewed 23/24.

Cases reviewed through our structured judgement review (SJR) process revealed that contributing factors to patient deaths were multifactorial however, we were able to identify some emergent themes. An emergent theme from incident reporting and learning from deaths suggests there are contributory factors associated with errors in our Integrated Contact Centre (ICC) procedures or an inability to adhere to standards. Specifically, this included incorrect call categorisation and lack of available resources for incident allocation. These included incorrect call triage, incomplete documentation of clinical assessments and investigations, triage tools used inappropriately, failure to refer patients when needed and poor quality of clinical documentation.

The process has highlighted exemplary practices such as:

- Thorough patient assessments.
- Informed decisions on resuscitation.
- Recognition of end-of-life care.
- Challenging healthcare professionals' plans in the absence of an end-of-life care plan.
- Making patient-centred decisions.
- Co-ordinated care with GPs and families.

During 23/24 we have improved and delivered our learning from deaths programme by:

- Meeting all national reporting requirements.
- Patient Public and Panel (PPP) representation at moderation panels.

- Integrating ICC specialists in structured judgment reviews (SJR), ensuring 'end-to-end' and holistic case assessment.
- The consultant paramedic (medical) has pledged to spread and promote best. practices via regional and area learning forum and to individual frontline staff.

Prevention of future deaths

We aim to receive a very low number of Regulation 28 Prevention of Future Death reports as we proactively and continuously seek opportunities for improvement and to ensure that any/all learning actions which may arise from a coroner's investigation are completed in a timely manner.

During 23/24, we received two Regulation 28 Prevention of Future Death reports from HM Coroner. The report and our responses are published on the Chief Coroner's Website.

- Blackpool and Fylde Assistant Coroner issued on 11 June 2023 in relation to inconsistent availability to electronical patient records across service providers and difficulties in information sharing between providers on account of different electronic record providers.
- South Manchester Assistant Coroner issued on 11 December 2023 in relation to the stalled implementation of Joint Operating Protocol between NWAS and the five regional police Forces designed to provide clarity on the lead agency during overdose and mental health incidents and the method by which police officers can escalate concerns prior to the ambulance arrival.

We have responded to both of the Regulation 28 Prevention of Future Death reports. Our responses are published on the Courts and Tribunals Judiciary website.

Compliments

We strive to provide high standard of care for our patients and service users. Compliments are a source of pride that are very important to our staff. Compliments provide us with an opportunity to feedback to staff with the recognition they deserve for truly making a difference to patients' lives. A total of 1,493 compliments were received during the last financial year.

Service line [2]	Cheshire and Mersey	Cumbria and Lancashire	Greater Manchester	Total
Community first responders/ ECFR	1	6	1	8
Emergency Operations Centres (EOC)	26	22	20	68
NHS 111	0	0	73	73
Paramedic Emergency Service (PES)	422	534	548	1,504
Patient Transport Services (PTS) operations	2	26	7	35

Table 15: Feedback by location, area and service.

Themes	Cheshire and Mersey	Greater Manchester	Cumbria and Lancashire	Total
Attitude and behaviour	2	52	0	54
Clinical treatment	417	450	525	1,392
Clinical advice via telephone	19	22	14	55
Patient communication	4	4	3	11
Telephone skills	7	11	8	26
Delivery of care	2	2	0	4
Resource management	0	2	1	3
Speed of response	0	96	12	108
PTS journey	1	7	24	32
Other	0	4	1	5
Total	452	650	588	1,690

Table 16: Feedback by subject and location.

[2] Some compliments received are attributed to multiple service lines, hence the variation in numbers.

What our patient's tell us.

"First time I'd rang 111 and it was a Sunday. I was extremely happy with the time scale and impressed with video call."

"The female paramedic was excellent with my resident who had a learning disability and health anxiety. She knew how to communicate with her and keep her calm."

"I had a volunteer driver today who brought me home from hospital and he was fantastic."

"I would like to thank the paramedics who came to check my elderly mum on Tuesday evening. They were so kind to her and she was much more comfortable when they left."

"We would like to thank the call handler who talked me through how to perform CPR and the ambulance staff who did not give up on my dad and saved his life. Thanks to all these people my dad is still with us and we are eternally grateful."

"Exceptional response time. Saved my father's life during a serious heart attack. The paramedics were thorough and quick. They made a quick decision to take him to hospital where he was operated on, a stent was applied. We are all grateful for the support of your team."

Patient engagement and experience

Patient and Public Panel (PPP): From April 2023 to March 2024, PPP members have been invited to get involved in 88 opportunities, with 27 requests for panel involvement. The PPP regularly attend high-level meetings such as Area Learning Forums, attendance at our board meetings and Learning from Deaths panels. PPP members have been involved in various projects, including the blood pressure data sharing project, end of life care research study, EPR referrals, trust privacy notice, the winter demand management campaign and review of the friends and family test survey cards.

The panel members receive a weekly roundup newsletter and have opportunities to engage with each other on a dedicated PPP members area of our website. We are very proud of our volunteers and their achievements. For the first time, in June 2023, we held a joint volunteers celebration and recognition event in collaboration with our volunteer car drivers (VCDs), community first responders (CFRs) and welfare van volunteers. Feedback from this event will be used to inform how we recognise our volunteers in 2024/25. We will produce a PPP achievements summary book in recognition of the panel's achievements during the last year and their 5th year anniversary in September 2024.

Patient experience surveys and the Friends and Family Test 23/24: Service-based patient experience surveys and the Friends and Family Test (FFT) are important feedback tools. They support the basic principle that people who use NHS services should have the chance to give feedback on their experience. Listening to the views of patients and staff helps to identify what is working well, what we can improve and how.

We have dedicated surveys for our 999, urgent care, PTS and NHS 111 services inviting patients (or those who care for them) to provide feedback on their experience with us. Each year these are reviewed by service teams and our PPP for suitability.

The FFT asks if patients would recommend their friends and family to use our services and gives an option to add comments. We receive a lot of detailed feedback via the FFT which is vital in transforming our services and improving patient experience. The table below provides a summary of survey and FFT feedback data including number of returns and key satisfaction levels by quarter.

Patient experience surveys	Patient Transport Service	Paramedic Emergency Service	Urgent Care Service	NHS 111 Service
Completed PE surveys	1,268	1,158	479	1,844
Cared for appropriately with dignity, compassion and respect. (strongly agree/ agree)	94.7%	93.3%	87.9%	n/a
Overall satisfaction (very satisfied, fairly satisfied- yes)	n/a			87.7%
Overall experience of service/ recommend ambulance service to friends and family (very good/ good- extremely likely/likely)	91.6%	91.2%	71.6%	88.5%

Table 17: 23/24 patient experience survey feedback data including FFT by quarter. NB: fields above showing 'not applicable' indicate that the question was not included in that survey.

Patient public and community engagement: We attended more than 14 virtual engagement events and 19 face to face engagement sessions were attended as either principal speakers, advisors or facilitators. Some examples include Lancashire Teaching Hospitals (LTHTR) Carers Group Forum, Healthwatch Wirral BRIDGE Forum, Salford Deaf Community Group, and the African Caribbean Care Group. We have also been able to attend 28 high-footfall, face to face events in 23/24 and delivered five county-based face to face community listening events of our own.

Feedback themes: Feedback over the year has consistently demonstrated a general high regard for the ambulance service and in particular the high percentage of patients feeling they were treated with dignity compassion and respect (94.7% of survey respondents). Some of the themes and feedback highlighted during the year have included:

- The impact that mental health related calls have on the service and how we deal with these calls and patients.
- Sharing job roles and volunteering within the ambulance service at our community events.
- Lack of awareness of the NHS 111 online service across the board, but especially within ethnic minority groups
- Uncertainty about the criteria to access the patient transport service.
- Accessing services for both ethnic minority and deaf communities.
- Concerns and the need for reassurance that the service is still able to provide care on industrial action days by other parts of the NHS.
- PPP members hearing about the impact of their involvement and having the opportunity to ask further questions of the teams they have worked with.

- Extra support that crews can offer for those with a learning disability, with a focus on autism.
- The usefulness of knowing the estimated time of arrival for an emergency ambulance when calling 999.
- The importance of reaching out to engage with different communities and increasing awareness of cultural differences and specialist health conditions.
- Negative PTS patient feedback in relation to the service provided by some of our third-party taxi companies.

Some of our 23/24 improvements include:

- Sharing more information on how we manage mental health calls via our community 'info-burst' newsletters.
- Involvement of our PPP in the development of our mental health plan and creation of a series of short filmed lived experiences from patients with mental health conditions. The films were shared on our social media channels and used by NHS England as part of national mental health support month (January 2024).
- Feedback from our deaf communities have highlighted barriers to accessing our services are still evident even after the rollout of the BSL 999 services in June 2022. As a result, we have piloted an 'Insight' language communication application for operational staff to download on their iPad's which has been approved by our board and rolled out in October 2023. This has been communicated to all stakeholders and our deaf communities.
- We provided reassurance to our patient, public and community groups during industrial actions days regarding resources, safety of our services, availability and our overall response via regular stakeholder updates, patient engagement events and information bursts. We also kept them informed on an area-based perspective of the availability of local services to support their self-care, with mental health as well as physical health and well-being respectively.
- To improve accessibility to services we have improved our internal processes to support the production of alternative formats and language requests. An accessibility guide and flow chart has been produced to help the team better support requests for alternative formats. This is regularly communicated to our communities on our publications and monthly info-bursts.
- The PPP weekly round-up and monthly 'info-burst' newsletters continue to provide topical health and service information and are provided in an accessible format.
- PPP members are provided with feedback on their involvement via the weekly newsletter. Involvement sessions are recorded and shared on the PPP website area for other members to watch and comment on. In addition, a new feedback/question session is now organised with service teams after the involvement has taken place.
- Our updated digital version pictorial communication handbook to aid communication between staff and patients has been designed and shared with the PPP for feedback.

It is now in the final stages of development before being made available for staff to upload on to new iPads.

- From our five events, it is clear there is a lack of awareness of the NHS 111 service overall and the eligibility for use of the patient transport service. This will be a focus for engagement events in 24/25 and information will be included in monthly info-bursts sent to our North West communities.
- Career information and opportunities to volunteer are included as part of our community events. A recruitment campaign launched in early 2024, which will extend to our volunteers later in the year. In addition, we regularly feature the work of our volunteers and how others can get involved. Volunteering options are now included on all our patient surveys.
- Patients have highlighted a lack of knowledge regarding the criteria to access the patient transport service. This is a regular feature in our community events and other engagement sessions. The service has also been heavily promoted as part of our winter demand management campaign.
- Easy read formats of our service information are provided to community event attendees with learning difficulties and additional facilitators are on hand to assist.
- Our stakeholder publication, 'Your Call' features many different health conditions as well as staff and volunteers from different cultures to increase awareness and understanding. A regular programme of filmed staff and patient stories is produced and shared with the board and used for learning.
- We have started to inform patients of the estimated time of arrival for an emergency ambulance.
- Negative taxi feedback was investigated further and issues raised with individual taxi firms.

Complaints

We are committed to providing high standards of care which is centred around our patients and service users. As part of this, we welcome all insights and feedback, including complaints, from our patients, patients' families and from service users. Complaints provide us with a valuable opportunity to review and reflect on our practices and, where necessary, identify and implement learning to continuously improve delivery of care and the experience which our patients and their families receive. Such learning can be at an individual and/or system-wide level.

We are committed to ensuring that those who raise a complaint with us feel that they have been listened to, that we have responded to their concerns and shown empathy and compassion with our response. Doing this remains one of our core priorities.

Complaints are dealt with by the newly named Patient Advice and Liaison Service (PALS) and Resolution team in a way which aims to fairly and compassionately investigate complaints to achieve a fair resolution in line with relevant legislation and in conjunction with the Model Complaint Handling Procedure, as outlined by the Parliamentary and Health Service Ombudsman (PHSO).

The board of directors receive information on complaints through a monthly integrated performance report. This is supported by quarterly assurance reports submitted to the Quality and Performance Committee, as well as the reportable events paper. Area Learning Forums monitor actions arising from complaints via associated action plans. The NHS 111 service complaints are reported through the NHS 111 governance reporting procedure.

Data from previous years has shown that approximately 80% of the complaints we received were suitable for management as low complexity complaints. This is consistent with other NHS trusts across the UK. Training and support have been provided by the PHSO on managing these complaints effectively and efficiently whilst ensuring the focus is on establishing trust and being empathic with patients and families.

Introduction and recruitment of the PALS function in August 2023 has allowed for effective management of these low complexity complaints, with an emphasis on having everyday conversations with complainants.

Medium and high complexity complaints are managed by the Resolution team by way of a full and comprehensive review of the episode of patient care involved and a review of PSIRF priorities (Patient Safety Incident Response Framework). Management of these complaints involves a collaborative approach with teams throughout the organisation, to ensure the matter is addressed as fully as possible and with the Duty of Candour being enacted where appropriate.

Complaint figures.

In 23/24, we received 2,250 complaints. 90% (2,033) of these complaints were managed as low complexity complaints and were able to incorporate the PHSO's guidance on early resolution and everyday conversations. This has enabled efficient management of cases and currently, 82% of low-level complaints are managed within 20 working days.

The three most common themes of complaints received, across the range of low, medium and high levels of complaints, related to:

- Care and treatment.
- Delays.
- Call-handling.

Care and treatment.

We received 930 complaints within this category in 23/24. 29 were managed as high-level, 97 were managed as medium-level and 804 were managed as low-level complaints.

Sub-type	Number
Professional standards	648
Clinical disposition: advice given by NWAS	135
Clinical treatment	62
Clinical disposition: referral	20
Other	65

Table 18: Care and treatment complaint categories, data accessed 12 April 2024.

The complaints regarding care and treatment by service line and area, may vary from total number provided above, as a singular complaint, may involve multiple service lines.

Service line	Number of complaints
Integrated Contact Centres (ICC)	276
Paramedic Emergency Services (PES) Greater Manchester	192
Paramedic Emergency Services (PES) Cumbria and Lancashire	151
Paramedic Emergency Services (PES) Cheshire and Mersey	145
Patient Transport Services (PTS)	284

Table 19: Care and treatment complaints by service line, data accessed 12 April 2024.

Delays.

We received 824 complaints within this category in 23/24. Complaints regarding delay in care or service largely relate to the PES and the PTS services, or on some occasions, both. 19 of these complaints were managed as high-level, 52 were managed as medium-level and 753 were managed as low-level complaints.

Service line	Number of complaints
Paramedic Emergency Service (PES)	198
Patient Transport Services (PTS)	630

Table 20: Service line of delay complaints, data accessed 12 April 2024.

Call-handling.

We received 380 complaints within this category in 23/24. Six of these complaints were managed as high-level, 18 were managed as medium-level and 356 were managed as low-level complaints.

Sub-type	Number
Professional standards	141
Process compliance: advice given by NWAS	81
Process compliance: call referral	51
Call-handling timeframes	30
Eligibility criteria	28
Information gathering (caller)	19
Other	30

Table 21: Call-handling complaint sub-types, data accessed 12 April 2024.

The complaints regarding call-handling, can be broken down by contact centre as follows:

Service line	Number of complaints
NHS 111 service	191
Emergency Operations Centre	120
Patient Transport Services (PTS)	69

Table 22: Call-handling complaint service lines, data accessed 12 April 2024.

Complaint outcomes.

We ensure that complaints are closed on our systems as ‘upheld, ‘not upheld’ or ‘partly upheld’. We work in partnership with service lines to guide and assist with decisions on complaint outcomes and appropriate actions and learning. Regardless of the outcome of the complaint, we continuously strive to learn from all complaints we receive.

In 23/24, we closed 2,323 complaints.

Outcome	High level	Medium level	Low level	Total
Upheld	20	30	491	541 (23%)
Not upheld	12	100	1,105	1,217 (52%)
Partly upheld	9	37	519	565 (25%)

Table 23: Complaint levels and outcomes, data accessed 9 May 2024.

Parliamentary and Health Service Ombudsman (PHSO).

In 23/24, we received 12 notifications of NWAS complaint reviews being conducted by PHSO. Six of these reviews progressed to a 'detailed investigation', of which four remain 'open'. Of the cases that PHSO concluded during 23/24, one was 'partly upheld' and one was 'not upheld'. The remaining six reviews were closed with no further action.

Incidents

Our incidents are now referred to as events. This is to allow for learning from excellence, as well as when things don't go to plan. The way in which event records have a risk score attributed to them changed during this financial year. Our events are split into three 'types': trust events, staff events and patient events.

During the last financial year 13,746 events were reported of which there were 1,818 events without a risk score.

Risk score	Value
1	3,841
2	6,469
3	1,471
4	98
5	49
No risk score	1,818
Total	13,746

Table 24: Risks logged and their scores during 23/24.

The most common event categories were call-handling (1,460), care and treatment (1,226), communication (1,204), delays (1,032), external organisation enquiry (993) and violence and aggression (1,426). These six categories accounted for 53% of events reported in 23/24.

During 23/24, we received 2,485 external incidents from other NHS providers.

Year	Q1	Q2	Q3	Q4	Total
23/24	545	650	653	637	2,485

Table 25: External events received per quarter 23/24.

In addition to the external incidents coming into the trust, we raise events to external agencies and health and social care organisations. During 23/24, we sent 840 externals out to other organisations requesting a response to patient safety incidents.

Year	Q1	Q2	Q3	Q4	Total
23/24	96	99	209	436	840

Table 26: External incidents sent out to other organisations per quarter 23/24.

Serious incidents

When we transitioned to the Patient Safety Incident Response Framework (PSIRF) in October 2023, it was a fundamental change to the way we manage and respond to patient safety incidents for the purpose of learning and improving patient safety. Please note the additional row that shows figures for Patient Safety Incident Investigations (PSII).

Year	Q1	Q2	Q3	Q4	Total
21/22	10	18	23	35	86
22/23	19	17	25	40	101
23/24	21	9	3	0	33
23/24 (PSII)	0	0	8	8	16

Table 27: Serious incidents reported from 21/22-23/24.

Clinical Safety Plan (CSP)

Our CSP was introduced in May 2023. The aim is for this to be both simple and dynamic and to be utilised in situations of excessive call volume or reduction in available staff members. The CSP supports the Resource Escalation Action plan (REAP), which outlines the roles and responsibilities of operational staff in escalation. It details the aim, scheme of delegation, communication of the CSP level, 999 call answer, assessment of risk and assurance of the plan.

The ICC supported implementing CSP to ensure that mitigation is robustly in place, aligning to the rising tide of activity outstripping demand. This supports our Quality Strategy of safety first, highly effective care and person-centred partnerships.

Whilst the conduit for managing the CSP is with the ROCC (Regional Operational Coordination Centre), the actions align to both operational and ICC. We ensure shared ownership to have oversight of the increase in patients waiting for a response. The plan outlines the roles and responsibilities of operational staff and includes a scheme of delegation. The CSP outlines potential actions to take based on risk assessment.

The CSP uses many metrics such as demand, resource availability and waiting incidents, to ensure we identify the correct CSP. The review by Mersey Internal Audit found that the CSP provides moderate assurance. The process has also been reviewed to include patients waiting for a clinical consultation over the telephone. The mitigating actions to support the CSP are logged, along with rationale for decision making and implementation and withdrawal times.

Winter Harm Review

In 23/24 we conducted a review of events that resulted in harm following a winter of extreme pressure across the NHS. We identified and reviewed 118 risk score 4 or 5 events in December 2022 and January 2023 with the following themes:

- Category 2 calls made up the highest proportion of risk score 4 or 5 related incidents.
- 74% of these incidents related to a delay where there was no ambulance resource available to dispatch.
- 9% of these incidents related to a safety issue as a result of a handover delay at an emergency department.
- The remaining 17% of incidents related to call handling or clinical care.
- A theme was identified relating to patients who were receiving palliative or end of life care, for whom no formal end of life care plans were in place.
- Other areas were identified where we could make improvements to accessing our services when needed, for example patients with a learning disability or a language barrier.
- Staff told us of the impact they experienced when patients had come to harm as a result of these intense pressures in the system.
- Since then, we have shared this information both internally and externally with system partners to inform and drive improvement. Work has continued to ensure we reduce ambulance response times and improve systems and processes within our Integrated Contact Centres to ensure patient safety. Furthermore, we continue to undertake work to address inequalities such as the work undertaken to improve outcomes for patients with a learning disability. We have committed to reviewing this each year to generate learning and identify where we have made sustained improvements.

Patient Safety Incident Response Framework (PSIRF)

NHS England nationally mandated implementation of the new Patient Safety Incident Response Framework (PSIRF) from September 2022, with the expectation that NHS provider organisations were live with the new framework by autumn 2023.

PSIRF sets out the NHS' approach to developing and maintaining effective systems and processes for responding to patient safety incidents to learn and improve patient safety. PSIRF replaces the Serious Incident Framework (SIF) and make no distinction between 'patient safety incidents' and 'serious incidents'. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvements.

Unlike the SIF, the PSIRF is not an investigation framework that prescribes what to investigate. Instead, it:

- Advocates a co-ordinated and data-driven approach to patient safety incident responses, that prioritise compassionate engagement with those affected by patient safety incidents.
- Embeds patient safety incident response within a wider system of improvement and prompts significant cultural shifts towards systematic patient safety management.

We successfully implemented PSIRF within the timescales mandated by NHS England, transitioning to PSIRF on 1 October 2023.

Local priorities identified for a Patient Safety Incident Investigation.

NWAS Executive Leadership Committee, Quality and Performance Committee, and the Board of Directors identified local priority areas for PSII for the next 12 to 18 months. These are:

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

During the implementation of PSIRF, we achieved:

Meaningful and compassionate engagement with staff, patients and families under PSIRF.

Under the PSIRF framework, there is a key focus on meaningful and compassionate engagement with our staff, patients and families when involved in a patient safety event. In 23/24, we have committed to strengthening our engagement with those involved to ensure that as part of our duty, we meet their needs to prevent exacerbating any harm that has occurred. Additionally, through meaningful engagement we can learn from patient safety events and potentially prevent similar events occurring in the future. We have continued to develop our engagement in several ways:

- Recruitment of dedicated engagement leads to support all involved through the patient safety incident investigation. This ensures participation throughout the process, with focus on learning for improvement.
- Development of patient safety partner role, who are lay people with unique experiences of using our services, partnering with us to improve patient safety. The role has been invaluable during the implementation of PSIRF to seek the views of the people who may use our service. Our patient safety partners are key members of patient safety governance meetings to keep our patients at the heart of all our conversations. The Patient Safety team and our patient safety partners hosted a PSIRF launch event, which was well attended by members of the Patient and Public Panel (PPP).
- Continuing to develop and strengthen duty of candour through providing support and advice, improved oversight of cases allowing us to engage in a timely way and training staff in specific roles to ensure they can provide compassionate support.
- Continued involvement of patient and staff stories in patient safety events. We share patient stories both internally and externally that speak to the impact on all involved. Through engaging with staff, patients and families sharing how these events have affected them, we have driven conversations to identify learning and improvements to prevent future occurrence.

Safety learning.

To align with PSIRF we have reviewed our learning mechanisms within the organisation to ensure we share learning from safety insights across the organisation. The Patient Safety Learning team and Quality Improvement team led the review, holding a series of focus groups with stakeholders.

We have also launched our Regional Clinical Learning and Improvement Group (RCLIG) which is chaired by our chief consultant paramedic and has representation from across our trust. The RCLIG brings together themes from integrated patient safety learning and any learning which may be of a safety-critical nature needing a timely focus. The group allows a risk-based approach to learning and focuses our resources for improvement where it will have the most impact for the safety of our patients and staff.

Safety skills.

The NHS Patient Safety Syllabus is a training programme for the whole of the NHS, designed to ensure we take all the necessary steps to ensure patients are safe in our care. The Patient Safety Syllabus has five levels and in 23/24 we have commenced roll out of this training across the organisation, with all frontline staff undertaking level one. Our Patient Safety Learning team have also undertaken level two and our patient safety specialist has commenced levels three and four. In addition, many of our staff have also undertaken training on the PSIRF and duty of candour.

Learning from Claire

Claire's family would like to highlight the importance of mental health and would implore everyone to not just to see the fine and bubbly persona that some people may display.

Claire's family have kindly given permission to share her story.

During 23/24 our patients helped us to learn. This was never truer than with the generosity of Claire's family. They shared their story with us following their tragic loss of Claire who they described as 'being someone who people naturally seemed to gravitate to, Claire was "the go to" person. She lit up every room she entered and always tried to make people happy.'

The story of Claire arose following the very tragic circumstances where Claire sent her family a picture of medications that she intended to take. A 999 call was made by a family member who was on their way to Claire as she had taken an overdose. The call was coded as Category 3 (a response within two hours by ambulance services). Over two hours, 13 calls were made from police and family members about Claire's condition and the significant overdose she had taken. Very sadly, on our crew's arrival, Claire went into cardiac arrest and died.

Members of our Mental Health (MH) team and ICC Integrated Contact Centre's (ICC) colleagues worked together to review and identify measures that would mitigate risks associated with overdose. These included the development of 'Advanced Questionnaire Module for High-risk Overdose', allowing EMAs (emergency medical advisors) to rapidly identify patients who have taken a high-risk overdose, empowering them to upgrade to a Category 2 and an immediate clinical call back. The details of the improvements we have made to implement local measures to escalate care and mitigate harm are documented later in this report.

Following discussion with our engagement lead and senior clinical leads, Claire's family agreed for a patient story to be developed and shared within our trust and with external stakeholders to highlight learning that would facilitate developments to help prevent a reoccurrence of the circumstances resulting in Claire's death. To date, her story has been shared both regionally and nationally.

Freedom to Speak Up

In addition to speaking up through management teams and normal workforce processes, we have established well embedded additional speaking up processes to create a culture of safety. We must foster a culture where our people feel safe to speak up and raise concerns. This in turn allows us to provide highly effective care where we learn when things might not go well. Our team of Freedom to Speak Up (FTSU) guardians have this year seen an increase of 54% in the number of concerns raised.

Ambulance services have come under increased scrutiny from both NHS England and national media. Moreover, the case of the Thirlwall Inquiry has prompted a comprehensive review of all NHS speaking up arrangements.

We provide a number of ways to encourage speaking up processes, such as the DCIQ (Datix cloud IQ) platform, staff forums, Freedom to Speak Up guardians, staff Facebook pages and appraisals. These channels enable our staff to voice concerns about their wellbeing, the care they provide or cultural issues.

This year has seen 154 concerns raised with the FTSU guardians, categorised into themes according to the National Guardian's Office (NGO) returns.

Themes	Percentage	Number
Inappropriate attitude and behaviours	50%	77
Patient safety	20%	31
Bullying and harassment	18%	28
Worker safety	10%	15
Fraud	2%	3

Table 28: Concerns by NGO themes.

Positively, the proportion of patient safety concerns has increased. This could be due to the national focus and the fact that we have made it easier for staff to speak up by utilising technology.

We have instigated several new processes to ensure we deal with concerns in a consistent way, ensuring an impartial view which supports both staff and managers to resolve concerns using learning. This reflects in the feedback we have received from staff and managers who have been involved with FTSU guardians.

What our staff tell us.

"There is nothing really to improve on- the guardian has gone above and beyond. He has put my hope back in the process."
Staff member.

"I was happy with the service I received. I wouldn't change anything that immediately comes to mind."
Staff member.

"The freedom to speak up team were keen to support local managers to find a timely, measured collaborative approach that was reasonable to all involved."
Sector manager.

"The team at freedom to speak up see both individual issues, as well as having that broad view of the region to identify themes. I really benefit from the perspective they provide me, highlighting and identifying issues through their unique lens. They've become a trusted team within NWAS, where staff feel able to raise concerns and receive guidance, support and feedback with impartiality."
Consultant paramedic.

These processes were tested by Mersey Internal Audit Agency, who offered substantial assurances following a review. In February 2023, the National Guardian's Office report 'Listening to Workers' made two recommendations to ambulance trusts. We have reviewed these recommendations and allowed our own processes to bed in. We aim to implement the final recommendation in quarter one and two of 24/25. Our policy continues to reflect the NHS policy on 'speaking up' and is compliant with current requirements. We have seen an increase in the number of concerns. This could be viewed as a negative, however it is important to recognise that we have implemented a new way of reporting via an online form. There is a correlation between the number of FTSU concerns raised and the introduction of this tool.

Support and guidance from the non-executive lead for FTSU has again this year been invaluable to ensure we address the small number of concerns by external providers.

Staff safety

We have committed to a comprehensive programme of culture change which is described in detail in our People Plan. Progress against the objectives are set out in our Annual Report 23/24. Keeping our patients and staff safe is our number one priority. This is a focus for the whole organisation.

Health, safety and security

We are committed to ensuring a safe system of work approach to health, safety, security and fire (HSSF) and organisational arrangements have been put in place to fulfil our statutory and mandatory obligations. All staff are responsible for ensuring they follow policies and procedures to keep themselves, their colleagues and patients safe in the workplace. Our partnership with trade unions remains strong and they are full members of the sub-committee and work with service lines on local HSSF management.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

National RIDDOR reporting requires the activity to be reported as incidents per 1000 staff members. The number of employed staff excluding bank workers as of 31 March 2024 is 7,415. The number of staff injury RIDDOR reported in the 12 months to 31 March 2024 is 133. The rate of incident per 1000 staff is 17.9.

Face fit testing for non-clinical staff.

We have carried out a regular cycle of face fit testing for non-clinical staff who require respiratory protective equipment for their role. There are 60 eligible staff, including six new starters who are currently awaiting testing. The overall compliance on 31 March 2024 is 88%. This will be 100% within quarter one of 24/25.

Health Safety Security and Fire incident activity.

The number of patient and staff non-clinical incidents reported in the 12 months to 31 March 2024 is 3,119. Table 29 summarises the health safety security and fire events reported by month, category and service line.

Service Line	Category	Total
Finance	Accidents and injuries	3
	Fire	1
	Welfare	1
	Total	5
Medical	Accidents and injuries	1
	Equipment: non-clinical	1
	Security	1
	Slips, trips, falls	1
	Total	4

People	Accidents and injuries	2
	Slips, trips, falls	1
	Welfare	1
	Total	4
Quality, Innovation & Improvement	Accidents and injuries	1
	Equipment: non-clinical	1
	Violence and aggression	1
	Total	3
Service Delivery	Accidents and injuries	825
	Equipment: non-clinical	158
	Fire	7
	Moving and handling	212
	Security	82
	Slips, trips, falls	193
	Violence and aggression	1,419
	Welfare	207
	Total	3,103
Overall total		3,119

Table 29: HSSF incidents by directorate. Data source: DCIQ last accessed 04/04/2024.

Each directorate holds the responsibility to undertake an incident review with the appropriate level of scrutiny, with learning themes included in a directorate chair report to the Health, Safety, Security and Fire sub-committee.

Violence and aggression.

Deliberate violence and aggression towards our staff or the people who use our services is unacceptable. Violent or aggressive behaviour because of clinical and or medical factors require primary and preventative measures to reduce the prevalence and risk of harm.

Sexual Safety Campaign.

We have committed to signing the NHS England Sexual Safety Charter and the AACE Consensus Statement on reducing misogyny and improving sexual safety. Early results from the 2023 Staff Survey shows around 8% (9% nationally) of respondents have experienced unwanted behaviour of a sexual nature from colleagues, and we have seen an increase in staff speaking up about this. To tackle this problem, we have established a dedicated sexual safety steering group to drive the agenda and identify ways we can make a positive change. To improve sexual safety in the workplace, we launched the 'Stop, Speak, Support' campaign along with a clear statement setting out the expectations around sexual safety and sexual harm.

Stop: Stop and think, is your behaviour appropriate? Is the behaviour of others appropriate?

Speak: Have you spoken up to protect yourself and to protect others?

Support: Do you need help and support?

Over the next year, the steering group will continue to identify ways to improve and change the culture at NWAS. We aim to share real-life experiences with our staff to illustrate the consequences unwanted sexual behaviour can have on our colleagues.

Health and safety executive (HSE).

In March 2023 the HSE issued a series of recommendations to improve safety for preventing muscular skeletal injury and violence and aggression in the workplace. The recommendations arose from the findings from workplace inspections undertaken by the HSE between 2018 and 2022. In August 2023, we were notified the HSE would be visiting us to understand our response to the recommendations. The HSE review took place in two stages. Stage one was in October 2023 where they met with the full Executive Leadership Committee (ELC) to discuss our understanding and approach by the ELC to keeping staff safe. Stage two took place during March 2024, where the HSE inspectors met with multi-disciplinary operational teams at Blackpool and Bolton South. It is anticipated the outcome from the inspection will be shared with us shortly.

MIAA health, safety, security and fire review.

As part of our annual independent audit schedule, an independent review of our governance practices was conducted by Merseyside Internal Audit Agency (MIAA). The overall objective was to provide assurance that we are complying with our Health, Safety and Security Policy (including H&S checks) and it is being operated consistently across our trust. The MIAA report found substantial assurance and summarised there is a good system of internal control designed to meet the system objectives and that controls are generally being applied consistently.

Safeguarding vulnerable children and adults

The Safeguarding team has a statutory function and liaises with both internal and external multi-agency partners in respect of Child Death, Statutory Safeguarding Reviews (Domestic Homicide Reviews, Safeguarding Adult Reviews and Child Safeguarding Practice Reviews) and Local Authority Designated Officer (LADO) referrals in cases where a staff member may be considered a risk to children. It is also the responsibility of the head of safeguarding to report Prevent counter terrorism data to NHS England.

Statutory reviews 23/24	Safeguarding adult reviews	Domestic homicide reviews	Local safeguarding child practice reviews
Total	96	33	40

Table 30: Safeguarding statutory reviews.

The Safeguarding team works across the footprint and with partner agencies, including commissioners, social care, police and health partners, to review and improve the quality of the safeguarding service provided by our staff, ensuring that all our employees and volunteers have the appropriate knowledge and skills to discharge their safeguarding function in relation to children, young people and adults. Through the head of safeguarding, we provide assurance to the Lancashire and South Cumbria ICB via the Designated Professionals for Safeguarding, that the service is well led and managed and discharges its statutory responsibility in line with legal obligations.

Safeguarding processes are continually reviewed, and the Safeguarding team liaises both locally and nationally, using statutory reviews, audit, legislative updates and general information sharing to highlight updates, hot topics and emerging issues. These inform training and service development within the organisation. The Safeguarding team regularly shares key information with staff, both internally and across social media platforms.

Safeguarding referrals.

We have 27 local safeguarding authorities within our geographical footprint. Referrals are made electronically via our Support Centre in Carlisle to the appropriate local authority. During 23/24, we made 33,298 safeguarding and early help referrals, as illustrated in table 31. The number of referrals rejected by local authorities is less than 2%, indicating that the safeguarding information we share is of a high quality.

	Adults		Children's		
Themes	Safeguarding	Early help	Safeguarding	Early help	Total referrals
Apr 23	463	1,689	480	138	2,770
May 23	472	1,652	491	145	2,760
Jun 23	415	1,618	467	126	2,626
Jul 23	478	1,568	509	121	2,676
Aug 23	500	1,714	448	114	2,776
Sep 23	448	1,720	465	106	2,739
Oct 23	443	1,698	468	95	2,704
Nov 23	434	1,697	442	109	2,682
Dec 23	400	1,963	368	110	2,841
Jan 24	473	1,973	432	99	2,977
Feb 24	495	1,618	444	113	2,670
Mar 24	593	1,835	557	92	3,077
Themes total	5,614	20,745	5,571	1,368	33,298

Table 31: Children and adult safeguarding and early help referrals made during fiscal year 23/24.

Safeguarding training.

The Intercollegiate Documents for Adults (August 2018) and Children (January 2019), published by the Royal College of Nursing, set out minimum safeguarding training requirements for health staff. The most recent versions recommended the inclusion of ambulance staff in level 3 training. We are committed to ensuring that high quality safeguarding practices exist across all business areas of the organisation, with training essential to achieve this. During 23/24, the Safeguarding team have worked with the Occupational Learning team to review the training needs analysis for all areas of our trust, resulting in an increased number of staff now aligned to level 3 safeguarding training. This will strengthen the knowledge base across the organisation and provide a wider platform for advice and guidance for level 1 and 2 trained staff.

Competency	Compliance
Safeguarding adults (version 2) - level 1	95.29%
Safeguarding children (version 2) - level 1	95.22%
Safeguarding adults (version 2) - level 2	92.94%
Safeguarding children (version 2) - level 2	91.67%
Safeguarding adults (version 2) - level 3	94.18%
Safeguarding children (version 2) - level 3	95.32%
Preventing Radicalisation - Basic Prevent Awareness	92.28%

Table 32: Overall compliance for permanent and fixed term employees on 31 March 2024.

Improvement highlights in safeguarding in the last 12 months:

- A new head of safeguarding commenced in post in July 2023.
- We have enhanced quality assurance oversight of referral rejections by our Support Centre to identify themes whereby specific safeguarding support may be required.
- We are continuing to work with our private providers to gain assurance in relation to safeguarding activity, training compliance, policies, procedures and governance.
- Safeguarding eLearning packages have been reviewed and updated to reflect current legislation and guidance.
- We have reviewed the training needs analysis for our integrated contact centre staff. Increased numbers of staff are now aligned to level 3 safeguarding training, in line with the intercollegiate documents: competencies for healthcare staff, for safeguarding adults and children. Our focus moving forward is on developing bespoke, participative safeguarding training to support staff who have contact with patients primarily over the telephone.
- We have reviewed and strengthened our policy and process to manage allegations against professionals in collaboration with our human resources colleagues and operational leads. This enables us to provide the required assurance to our safeguarding boards and to the board as well as ensuring that staff subject to an allegation are supported appropriately.
- We have developed a “one-stop” safeguarding resource on our intranet to support staff in accessing up to date information, advice and guidance. Our next focus will be making this information easily accessible to clinicians via their electronic devices.

Mental capacity

We adhere to the mandatory legal framework of the Mental Capacity Act 2005 as outlined in our policy. During 23/24, staff undertook:

- Mental Capacity Act learning resources on the continued professional development and learning hub.
- Ambulance Mental Health Induction’ module available on electronic staff record (ESR).
- Mental Capacity induction training for emergency medical technician’s working on mental health response vehicles.
- Mental Capacity refresher training as part of face-to-face mandatory training.

In terms of monitoring the use and consideration of the Mental Capacity Act, our electronic patient record (EPR) platform incorporates mandatory fields that our clinical staff will complete. EPR data is available for our audit teams.

Infection prevention and control

Infection, prevention, and control (IPC) measures are vital in protecting the health, safety and welfare of patients and staff. The IPC Board Assurance Framework (BAF) is a framework that sets out the 10 criteria from the Health and Social Care Act (2008).

Systems to manage and monitor infection and risks of infection.

- Chairs assurance report from the IPC subcommittee.
- IPC BAF and IPC Annual Report presented to Board and Quality and Performance committee.
- IPC guidance updated to reflect national guidance.
- Management of outbreaks reported, as required, to NHS England.
- All training packages have been updated in line with the national IPC manual.
- IPC public-facing webpage has been developed where information can be accessed about the IPC service.

Provide and maintain a clean environment in managed premises that facilitates the prevention and control of infections.

- Cleanliness is monitored by audits carried out by Facilities and IPC team.
- Six-weekly deep clean of all vehicles.
- Policies and procedures in place to inform staff of responsibilities in relation to cleaning and decontamination.
- Water Safety Group meets every six months.
- Ventilation testing is carried out in line with national guidance.
- IPC team involved in the planning of new builds and the refurbishment of existing premises to ensure that they meet IPC requirements.

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

- Within our trust, antibiotics are not prescribed – the two antibiotics that are used are administered under patient group directions (PGD) and in line with JRCALC guidance (Joint Royal Colleges Ambulance Liaison Committee). These antibiotics are for emergency use and are a one-off dose.

Provide suitable information on infections for staff and patients.

- Resources available for staff disseminated regularly to staff via bulletins, social media, internal intranet, infographic posters and the IPC cell.
- Risk assessments are carried out when booking patients onto the Patient Transport Service (PTS).

People at risk of developing an infection and onward transmission.

- Safety stations in place at the entrance to all trust sites with access to alcohol gel, cleaning wipes and face masks.
- Desks within each call centre has protective screens in place for vulnerable staff/ staff who wish to use these.

Systems to ensure staff discharge their responsibilities for IPC.

- Regular bulletins and guidance have been published on the intranet, including updated guidance on mpox, measles and other infections.
- Fit testers recruited in each ICB area to improve compliance with fit testing. This is recorded on ESR. Compliance has improved significantly.
- All staff are issued with a Sundstrom hood (respiratory powered piece of equipment) for use if they fail their face fit test.

Cheshire and Merseyside	58.8%	Cumbria and Lancashire	74.1%	Greater Manchester	84.7%
North	45.4%	East Lancashire	80.0%	East	91.3%
East	70.9%	Fylde	78.5%	Central	86.6%
South	63.0%	Morecambe Bay	82.5%	South	76.3%
West	55.8%	North Cumbria	53.6%	West	84.6%
		South Lancashire	75.9%		

Table 33: Staff compliance with face fit testing.

Provide or secure adequate isolation facilities.

- We do not have any isolation facilities; however, staff understand precautions to take and understand the importance of informing the receiving unit to secure suitable facilities to minimise the risk of onward transmission of infection.

Secure adequate access to laboratory support as appropriate.

- We do not have direct access to a laboratory; however, specimens can be obtained from staff via occupational health if needed. Contact tracing has taken place staff who have been in contact with Invasive Group A streptococcus, whooping cough and measles.

Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

- The national IPC manual has been implemented with links to local policies and procedures. Other key policies have been updated in line with national guidance.

Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

- Staff are referred to Occupational Health and risk assessed by their line manager.
- Risk assessments are in place for staff who are pregnant/susceptible to infection and IPC are often consulted to contribute to these.

Medicines management

We are committed to high quality medicines optimisation within the service through having the right medicines available, having the right governance to support medicines use, ensuring medicines are available for use, ensuring medicines are of a suitable quality and supporting medicines to be used safely; this supports the Quality strategy. The following areas provide the workplan undertaken by the Medicines team during 23/24:

Clinical effectiveness of medicines.

- Two new medicines were launched: morphine orodispersible tablets, which offer an additional pain relief option, and sodium chloride 0.9% pre-filled syringes.
- Patient Group Directions have been updated to incorporate new national guidance.

Robust governance for medicines.

- Six new eLearning modules were launched.
- Excellent compliance with completion of all our medicines eLearning modules. A poster was presented to the National Association of Pharmacy Technicians UK conference on this topic.

Digital innovation and integration.

- A new medicines dashboard has been created with our Digital team that allows enhanced oversight on medicines administered to our patients.
- A project deploying paramedic-issue digital-controlled drug keys has been launched and will enhance governance and improve access for controlled drugs.

Safe and secure handling of medicines.

- Ensuring continuity of supply of medicines has been challenging but the close working with our partners has maintained supply for our patients.

Medicines safety.

- Medicines safety week focused on supporting staff to follow the 'six rights' of medicines administration. Our 'six rights' poster was adopted nationally and endorsed by a number of partners.
- Labelling of medicines syringes that are used by our North West Air Ambulance when managing our most critically ill patients has been improved to minimise product selection errors.

Mandatory training

For 23/24 the approach to statutory and mandatory training returned to normal delivery levels, with two days face-to-face training for our paramedic emergency services (PES) staff. The overall year-end position is 89.4% compliance against a target of 85% and with all operational service lines exceeding the 85% target.

The core of our annual delivery is the NHS Core Skills Training Framework (CSTF) which sets out the approach to statutory and mandatory topics for NHS trusts in England. We are fully aligned to the CSTF and subjects are delivered across a mix of face-to-face classroom days and eLearning modules depending upon the staff group.

In addition to the CSTF requirements we prioritised the following additional subjects in the 23/24 statutory and mandatory programme:

- Learning disability and autism eLearning (Oliver McGowan). Although the full national programme had been delayed, we delivered the national eLearning programme and handbook to all staff.
- Mental Health Act and Mental Capacity Act. A face-to-face session was included for paramedic emergency services (PES) and patient transport service (PTS) staff groups.
- Resilience / incident management face to face training for PES and PTS staff groups.
- Additional focus on sharps, infection, prevention and control, aseptic non-touch technique and transmission-based precautions, was built into practical scenarios for PES staff groups.
- Patient safety syllabus eLearning level one national module was mandated for all patient contact staff.
- An annual medicines management update was delivered to all relevant clinical staff in line with updates to patient group directive.
- The ambulance specific dementia tier one eLearning module was mandated for PTS staff groups.

Our improvements

Improvements to working practices

Integrated Contact Centres (ICC's)

Collaboration in governance and audit

Regular collaborative meetings between the 999 and the 111 audit teams throughout the year have fostered a culture of continuous improvement and integration. Together, they reviewed calls triaged using NHS Pathways, aiming to enhance quality and refine the process. Through side-by-side audits, not only are metrics bolstered, but also there are coaching opportunities and real-time feedback. This not only elevates the quality of audits but also enhances the proficiency and performance of staff members, leading to better ICC service.

Clinical hours

Clinical hours have been introduced, giving ICC clinicians 23 hours per year for personal clinical development. They can use this time for face-to-face practice in a setting of their choice. This initiative has been implemented for all clinicians across all contact centres within the service.

Pathways advanced clinical consultation software (PACCS)

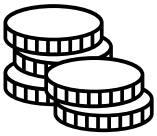
The ICCs are introducing new remote consultation software to allow for increased clinical autonomy in decision making. PACCs integrates with NHS Pathways and the Directory of Services (DoS), allowing for greater flexibility in outcomes and consistent integration with the wider health economy.

Staff welfare

We have been working closely with the Manchester Stress Institute to support all staff across the ICC. Providing training to all front-line managers to support the mental health of their teams. Introducing massage chairs into contact centre locations. Introducing mental health first aiders. Setting up chaplain drop-in clinics. Scheduling drop-in sessions with a councillor across the contact centre sites

Communication

SharePoint has been continuously enhanced to provide comprehensive updates to all divisions within ICC, offering the latest procedures, policies and pertinent information. This platform has played a pivotal role in efficiently and securely giving information to our teams replacing paper-based documents. The emergency medical advisor team now uses SharePoint for accessing and reviewing the latest end-of-call scripts and signposting information. This transition has bolstered patient safety by ensuring the consistent use of the most current procedures.



Investment for improvement

Integrated Contact Centres (ICC's)

Advanced practitioners in urgent and emergency care

We've recruited 80 advanced practitioners and team leaders. They split their time between assessing Category 2 patients over the phone and conducting face-to-face assessments. Their crucial work contributes to maintaining the safety of the Category 2 patient queue and ensures the well-being of all patients.

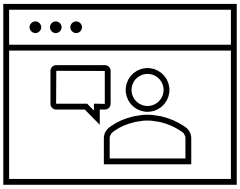
Implementation of new radio system

The ICC has successfully implemented the ambulance radio programme, Life X system. We are among the first English NHS trusts to adopt this. Given its pivotal role as a primary communication platform for all operational resources we deploy, such transitions carry substantial operational risks. However, the rollout of the Life X system occurred without issue, earning commendation as an exemplary model for implementing high-risk system changes. The new system is state of the art technology which provides many benefits for us including major improvements around system architecture and resilience.

Complex Incident Hub (CIH)

The scope of responsibilities within the CIH has been significantly expanded. Initially established to optimise the deployment of our specialist resources by quickly identifying and deploying those resources to incidents where they could add value, the CIH has evolved to offer enhanced support, including senior clinical advice for front line staff. Notably the CIH has taken responsibility for giving maternity-related pre-alerts. This was done at the request of our consultant midwife, as it became apparent that our previous method of sending these pre-alerts via the non-clinical emergency ambulance dispatch team, led to considerable variation in the quality of information given. By introducing a standardised format given by experienced clinicians, there has been a marked improvement in the quality of pre-alerts. This initiative has also led to more front-line ambulance crews accessing senior clinical advice from the CIH desk. This has resulted in better patient experience, strengthened collaboration with maternity services and increased support for ambulance crews.

Improvement case reports (ICC's)

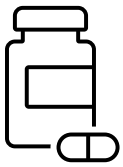


Improving whole-system productivity by offering video consultations across NHS 111 services

In early 2020, we worked closely with NHS Digital on a small-scale trial which looked to offer video consultations to patients contacting our NHS 111 service. Following the success of the trial, we decided to continue and extend the offer across the clinical workforce and factored them into the initial training of clinicians across the service. Implementing and embedding new working practices can often be quite challenging, particularly around new technology. To assist with the roll-out of the programme and kickstart the cultural change to embed the technology into typical working practices, we appointed a number of clinical champions and trainers. The champions have acted as strong advocates of video consultations and the benefits they bring to patients and helped to promote the adoption of the technology.

Feedback from patients has been overwhelmingly positive, with patients reporting they felt better taken care of and received an additional level of reassurance that a clinician had 'seen' and heard their concerns. The evaluation to evidence the impact of the programme highlights that patients who have been triaged using video consultations tend to receive the right level of care sooner. Video consultations give clinicians the ability to recognise when escalation of care is required, enabling them to identify and manage patient risk more effectively.

The evaluation work shows the impact of video consultation triage on whole-system productivity. For example, using the example of paediatric rash outcomes, patients who have been triaged via video consultations are less likely to be diverted to urgent and emergency care pathways. Patients who were triaged using video consultation were 14% more likely to continue their treatment at home than patients who were triaged without video consultations. The productivity benefit of this initiative is quite clear. From a clinical perspective, patients get to the right level of care sooner than they would have done without video consultations, taking pressure off the wider health system through reduced hospital admissions, inefficient referral pathways and timelier diagnosis of conditions.



Implementing local measures to escalate care and mitigate harm

Over the course of 2022 and 2023, our trust saw 16 serious mental-health related incidents where patients had taken an intentional overdose, and several incidents where unfortunately patients had died or come to significant harm. Where a patient or member of the public would contact 999 or 111 in the event of an overdose, they would go through the NHS Pathways triage system which would typically elicit a Category 3 response – which would be responded to 90% of the time within two hours. In a typical triage process, the call handler would request information regarding what medication had been taken, how much was taken and when was this taken. In order to mitigate the harm and risk to patients, we recognised they needed to implement a local measure in order to ensure that patients who had potentially overdosed on high-risk medications could access care much faster.

Working with our internal pharmacy team and using evidence from recent coronial inquests, the team pulled together a list of 20 high-risk drugs that were commonly seen in overdose incidents. We then implemented an advanced questionnaire module into their triage process which would prompt the call handler to ask if the patient had taken any drugs on the high-risk drugs list. If the patient had identified any of the drugs or medication on the list, the incident would be upgraded to elicit a Category 2 response – which would be responded to in an average time of 18 minutes. Additionally, patients who've identified as having taken a high-risk drug would receive a clinical review to determine the level of risk to the patient.

Since implementing the initiative in November 2023, the advanced questionnaire has been used over 4,400 times and over 1,700 calls were upgraded from a Category 3 to a Category 2 response. Patients are being seen quicker and clinicians now spend less time on scene and conveying patients to hospitals faster. The initiative has had a transformative effect on reducing risk to patients in the area with there being a significant reduction in serious incidents relating to overdoses and an improvement in patient safety for vulnerable patients across the region. In terms of the impact on productivity, this has provided significant benefits to the wider system, with reduced hospital admissions in overdose-related incidents, improved health outcomes for patients and patients being treated upstream and directed to appropriate support from system partners.

Improvements to working practices

Paramedic Emergency Services (PES)

Patients not conveyed to hospital

We have worked closely with our health and social care partners across the region to establish clinical care pathways for patients that meet their needs without a journey to hospital. This maintains patient independence in their own homes and reduces the demand on higher acuity services.

Hospital handover

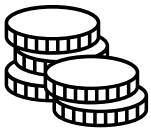
We have continued with the development of a Futures NHS platform to support the delivery of the hospital handover improvements as a national resource. We share Integrated Care Board monthly data packs with all North West hospitals and commissioning leads to identify areas for handover improvement or to identify areas where improvements have occurred. We provide on-site quality improvement coaching at hospitals with local teams to support the implementation of the ambulance handover safety checklist and escalation cards. We are working with the Northern Care Alliance, wider health and social care partners, Greater Manchester Integrated Care Board and Aqua on a programme of work to reduce avoidable patient conveyance to hospital. We have implemented the HALO module on the hospital arrival screen and design of staff training to support this. We are regularly asked to present our improvement at local, regional and national forums sharing the work undertaken by us to improve handover. This work was a Health Service Journal 2023 finalist in the patient safety category. We also won the Health Service Journal Patient Safety Congress 2023 quality improvement poster category and won the overall conference poster category.

Improvement Delivery Group

We have established the Improvement Delivery Group to discuss and oversee change programmes of work and share synergies between work programmes. In 24/25 we aim to establish an organisational-wide Improvement Board to be test ahead of integration into our governance by April 2025.

Quality Assurance Visits (QAVs)

We continue to focus on the design and testing of a standardised process for internal quality assurance. Importantly the quality visits reward those teams who perform well with an acknowledged performance status and identify those areas requiring further support and more frequent review. To keep up with regulatory requirements and improve our internal assurance, we have redesigned our QAV framework according to CQC's single assessment framework. We examined each quality statement and created questions to provide assurance against each evidence category that the CQC will look for. Implementing this visit system is crucial to ensure efficient management oversight and corporate assurance of key standards.



Investment for improvement

Paramedic Emergency Services (PES)

Operational resources

Using the investment received from the UEC recovery fund we have recruited and deployed new operational staff and to increase our operational ambulance fleet, we now have 32 additional ambulances at peak times and have recruited almost 200 new front-line paramedics and emergency medical technicians. There are now over 2,500 more emergency ambulance hours available every week compared with March 2023.

Aspirer digital timesheets

We have replaced our paper system with a bespoke digital solution 'Aspirer' and have evaluated the use. Our evaluation showed that Aspirer was well received by staff, created efficiencies and effectively replaced the old solution, however it also revealed scope for improvement and issues in the scale up and implementation

Command and Resilience Education Training team

In early 2024 we introduced the command and resilience education training team. This was done in response to internal lessons identified from incidents and exercises and findings from the Manchester Arena Inquiry. The aim is to provide a bespoke training team of experienced managers and commanders from diverse backgrounds, to deliver training and peer support to the command cohort. This allows training in realistic exercises, training events and continuous professional development opportunities.

Special Operations: Hazardous Area Response team (HART)

In 23/24, HART recruited a further 16 staff taking the staffing numbers to 94. This increase demonstrates our commitment to maintain the highest safety standards for staff and members of the public in hazardous environments. There are further plans to increase this by an additional 10 staff. Other recruitment included a training manager, a specialist manager and a secondment to assist in training acute hospitals in decontamination. Another success is the development of plans for a brand-new state of the art facility for the Liverpool HART team at Elm House. This is due to be completed by June 2025. The development will see improved facilities including a gym and specialised training and education facilities. It will be the base for the Merseyside major incident fleet.

Improvement case reports (999)

Improving clinical outcomes following heart attack (STEMI)

STEMI Improvement

Background

The ST-segment elevation myocardial infarction (STEMI) Quality Improvement project has been established to raise awareness of the benefits of facilitating early reperfusion for our patients. We aim to collectively improve our call-to-PPCI-centre time in the North West by achieving a 10% reduction in ambulance on-scene time across 12 months.

Key areas for Improvement

The key areas highlighted for improvement are:

1. Time to reperfusion (time on-scene)
2. ECG interpretation
3. Addressing of gender differences

What are we doing?

- April dedicated as STEMI month with multiple targeted communication pieces
- Face to face mandatory training
- A video from an interventional cardiologist
- Multiple patient stories, including a visit to NWAS and a video
- Resource for staff including a 'rapid recap' and 'minutes matters'
- Adaptation of the STEMI ECG criteria to introduce gender specifics

What is next?

- Review the data, to understand the impact of April's STEMI month camp as well as subsequent ongoing work.
- Following data review and feedback, we may identify further areas for testing and improvement.
- Share the work at a future NWAS Quality Improvement Network, to help towards sharing the process followed, hopefully inspiring future projects.

Learning through deep dives – reducing conveyance to Emergency Department

In the last nine months, we have conducted an evidence-based review of Emergency Department (ED) conveyance to: identify causes for variation in see and treat (S&T) levels, develop new initiatives (and support existing ones) to decrease variation in conveyance to EDs, and to make recommendations based on our findings. We conducted a literature review, thematic analysis, semi-structured interviews and anonymised electronic questionnaires. We found seven dominant themes impacting on S&T:

- Perception of a lack of organisational support and risk averse culture.
- Variation in utilisation of clinical guidelines and decision support systems.
- Increased expectations of the paramedic profession and changing scope of practice.
- Conflicting patient and family expectations.
- Pressurised operational environment.
- Inconsistency of care pathway availability and access.
- Need for enhanced clinical supervision, training and education.

Other considerations.

- The percentage of patients conveyed to an ED has reduced to 42.5%, although regional and place variation still exists.
- When accounting for demographics, service reconfiguration and the provision of services (inc. alternatives to ED), the variation in ED conveyance (11%) becomes less significant.
- There is a correlation between hear and treat and see and treat, even though reducing variation could improve S&T levels.
- Hear and treat maximizes vehicular capacity as deployment of resources is not required.
- See and convey of 57.5% includes over 7% of patients conveyed to non-ED.
- Hospital handover delays increase S&T, non-conveyance and use of alternative pathways.
- The potential for non-conveyance to ED appears to be around 55%, however the risk implications require further explorations.

Ongoing proposals/objectives.

Following an evidence-based review, the recommended targets include reducing variation in S&T and increasing non-conveyance rates. The objectives within the annual plan for improving non-conveyance in 24/25 are:

- Reduce variation in S&T.
- Increase the number of patients managed by see and convey to ED.

Additionally, collaborations are ongoing at various sites across the North West to:

- Test alterative care pathways (same day emergency care and/or specialist units).
- Implement a consultant-led ‘Single Point of Access’ before conveyance.
- Develop EPR direct referral capability (Fylde Coast Medical Services (FCMS) and Cumbria Health on Call (CHoC).

Improving referrals to primary care from on scene

In the Integrated Contact Centres (ICCs), it is standard practice to digitally refer patients into services following an NHS Pathways assessment, without the requirement of a verbal handover or negotiation. Front-line clinicians however have historically telephoned services to "negotiate" a referral into the service. At times of high demand, this can result in prolonged "at scene" times when trying to safely refer patients into services, awaiting clinician call backs. It is accepted that on-scene clinicians can gather a more comprehensive clinical picture as they are able to record baseline observations, accurate frailty scores, NEWS2 scores, ECG, assess patient mobility etc.), yet the route of referral is not streamlined. It was hypothesised that EPR Onward Referrals would prove to deliver efficiencies in terms of job cycle times as well as providing an improved patient experience.

In December 2023, a pilot commenced to evaluate the benefits of introducing EPR Onward Referrals. We undertook a multiple directorate approach, working closely with two of the Acute Visiting Scheme (AVS) providers in the Cumbria and Lancashire areas. The pilot utilised existing technology in the form of the Electronic Patient Report (EPR). When a clinician at scene deems a patient to be clinically appropriate to refer into an AVS provider, they can select the AVS provider (specifically Cumbria Health on Call – CHoC or Fylde Coast Medical Services – FCMS) as the receiving location. The patient record then becomes visible to the receiving location within the One Response EPR weblink. Clinicians are asked to call the receiving location to confirm they have visibility of the patient on the system and then request that the doctor calls the patient directly. Clinicians can then clear the scene to be available for other 999 calls.

To date, over 1000 patients have been referred in this new way, with no adverse outcomes. Testimonials from patients, staff and the AVS providers demonstrate that this is a safe and effective process. Senior clinical reviews of cases referred did not raise any concerns. Early indications demonstrate that the process does reduce job cycle times, therefore bringing efficiencies.

The annual plan sets out an aspiration to upscale this new process across the wider North West footprint. Other providers from other ICBs are already keen to work with us to achieve this.

In the longer term, NHS England digital technology will enable further integration work for referrals from scene utilising the Booking and Referral Standards (BaRS) technology. As there is no clear timeline on the rollout of BaRS across the Urgent and Emergency Care (UEC) footprint, this work could realise efficiencies and patient experience improvements in the interim, whilst not requiring any investment in software development.

Improving maternity services

Following the publication of the three-year delivery plan for maternity and neonatal services, we have worked with the NHS England regional maternity and obstetric team on the perinatal board and the regional perinatal safety team. The formalised reporting mechanisms and collaborations help to strengthen working relationships with maternity and neonatal care partners to provide the right care and the right time for perinatal and neonatal patients across the North West. Our consultant midwife role is a professional liaison for the regional maternity services. She is responsible for escalating risk and governance to respective trusts and addressing concerns with the pre-hospital care we delivered. Establishing these key relationships ensures that we have midwifery representation and allows for shared learning. In 23/24 we have:

- Developed and implemented a policy to standardise community transfers to an obstetric unit across all 23 maternity units in the North West.
- Launched our first Maternity and Neonatal Care policy in January 2024, to support standardisation across the service.
- Focused workstreams to address care provision gaps across incidents. This included the procurement of transwarmers to support pre-hospital thermoregulation of newborns and neonatal mask sizes 00 to ensure staff have the correct equipment to effectively ventilate babies born at extremes of gestation.
- Created a dedicated maternity EPR record tile to support clinicians in ensuring contemporaneous and complete records during maternity and newborn incidents, addressing identified documentation gaps. This also supports quality improvement initiatives, such as the impact of transwarmers and data capture.
- Supported the delivery of pre-hospital PROMPT for over 100 senior clinicians and collaborated with local maternity units to deliver focused training days. This has strengthened joint working practices and supports increased awareness of our role in providing maternity and newborn care.
- Become the first pre-hospital assessor to support multi-disciplinary confidential enquires of maternal deaths undertaken by MBRRACE-UK. The role involves assessing the quality-of-care case-by-case to inform future practice and improvements in care, potentially impacting future outcomes.
- Supported thematic analysis for a national report exploring learning from maternal death investigation in which ambulance services attended. This is ongoing and will be published in 2024.
- Recently joined the Royal College of Midwives research prioritisation steering group via our consultant midwife, one of only 17 members across the UK. This ensures that the group acknowledges urgent and emergency care when exploring research focus and allows the national project team access to our existing networks.

Several staff members have driven forward maternity focused projects, including a quality improvement project in Cumbria to address human factors associated with the allocation of maternity equipment in vehicles as 'high acuity low occurrence' (HALO) incidents. This is recognised as an example of excellence, with an internal Star Award nomination for the leading paramedic. Following on from work in Lancashire, there is a proposed project to introduce a maternity 'grab bag' to streamline identifying the required maternity and neonatal equipment when attending incidents.

The consultant midwife is a member of the AACE maternity and neonatal leads group. In 23/24 the group reviewed and updated the following JRCALC clinical practice guidelines to best reflect learning from incidents and recognise the difficulties faced pre-hospital:

- Breech birth.
- Bleeding in pregnancy over > 20 weeks.
- Hypertension in pregnancy, including eclampsia (currently under review, our consultant midwife is the lead for this guideline).
- Birth imminent (currently under review, our maternity quality and governance practitioner part of the author group).

Our service is uniquely placed to tackle health inequality and improve patient outcomes across the North West. We aim to align our research to the needs of our population and target areas that would benefit health improvement. Our research strategy supports the development of research that enhances the urgent and emergency care we deliver and building our research capacity and capability is a strategic priority.

The consultant midwife has received a prestigious National Institute for Health and Care Research: Research for Patient Benefit grant. This will fund a study into access to our services during pregnancy, birth and the early postpartum phase, exploring maternal and infant outcomes for families who seek our services. We will explore influencing factors, with a focus on intersectionality, ethnicity and deprivation to investigate opportunities and develop recommendations.

Improving services for people with learning disability

Following our successful NHS England bid in 2022 to develop a new Learning Disability and Autism plan (LD&A), we created a dedicated LD&A specialist role to lead on the work in the mental health team. The NHS Long Term Plan listed learning disability as one of its healthcare improvement priorities, recommending a system-wide collaborative approach. Our plan reflects compliance with this, as well the national Learning Disability Improvement Standards, National Mortality review learning, NICE guidelines and current Care Quality Commission (CQC) regulation of mandatory training and awareness to all healthcare sectors. This work also supports Association of Ambulance Chief Executive's current agenda to reduce health inequalities following a national consensus with major healthcare organisations. In 23/24 we have:

- Worked with our partners to produce a thematic analysis of focus groups with subject matter experts, patients and others with lived experience.
- Provided high level clinical oversight and recommendations for psychiatric consultants and learning disability (LD) nursing teams on an external engagement programme with an 'expert panel'.
- Supported complaint, serious incident, Datix reporting and mortality reviews to inform thematic analysis and further learning. This supports patient safety projects on the back of Patient Safety Incident Response Framework (PSIRF) investigations.
- Collected direct feedback from our neurodiverse staff to gauge their opinions on our practice, providing rich insight.
- Near 90% compliance with the first element of the respective mandatory training across service lines, meeting the regulatory requirement from the CQC.
- Collaborated with UCLAN and JMU to co-deliver LD&A learning material and modules to paramedic students.
- Included hidden disability awareness in staff inductions, highlighting the positives of us joining the Sunflower Scheme.
- Introduced enhanced sensory provision as standard in new ambulance vehicles in the fleet. This supports the quality of assessment for patients with sensory needs. Further collaboration between the Mental Health and Digital Innovation teams will support the SMART vehicle project.
- Increasing representation at LD&A community and partner engagement events in collaboration with the Widening Access team. There is ongoing engagement with our Patient Public Panel, regional LD Partnership Boards, the North West LD Operational Delivery Network and our Disability Network; this ensures we continue to hear the voice of our patients and partners.

The NHS Benchmarking Network contacted requested our participation in the NHS England commissioned audit for December 2023; the first occasion they have circulated the questions across the ambulance sector. Our response to the 79 questions provided

assurance to external partners and regulatory bodies of our ongoing quality improvement work outlined in our first LD&A plan.

We are increasing engagement with hospital and community LD teams, supporting pro-active organisation of enhanced pathways/flags and personalised care for complexed patients. Patient markers and hospital passports are now the Cleric platform allowing access by our clinicians.

Closer feedback relationships with ICB LeDeR Mortality Review teams (NHS programme: Learning from lives and deaths – People with a learning disability and autistic people) has improved consistency and accuracy of reporting. There is ongoing closer engagement with ICBs to share learning and identify patient safety themes.

Improving services for people in mental health crisis

Our Mental Health team, work at strategic level with system partners to deliver on the aspirations of the NHS Long term Plan (2019) and to improve the safety, effectiveness, experience, and outcomes for patients contacting us with a mental health need. An overview of the progress and achievements from 23/24 is summarised below.

Mental health practitioners (MHP) in Emergency Operations Centres (EOC).

The model for MHP working in our EOC varies across our footprint. In Greater Manchester (GM), MHP's employed by the mental health trust have been providing support for 12 hours a day, seven days a week. Confirmation and commitment for funding has been secured and the MH Team are now working with GM ICB (Integrated Care Board) and trust partners to develop the long term 24/7 model which will go live in October 2024.

In Lancashire and South Cumbria, MHP continue to triage MH calls 24/7 in our Preston EOC. On-going engagement continues with the ICB to secure commitment for the continuation of this model. We are also working with ICB and acute trusts to agree a model for the management of Category 3-5 MH calls moving forward.

Mental health response vehicles (MHRV).

Throughout 23/24, the MH team have worked with ICB's, NHS England and MH trusts to agree a model of MHRV. We have now taken stock of these vehicles and a plan is in place in conjunction with the MH trusts, to deploy these vehicles in Q1 2024. An evaluation of the MHRV will be undertaken throughout 2024 to identify the outcomes and learning and to inform the long-term model.

Integrated Care Board	Number of vehicles	Base location
Cheshire and Merseyside	4	Warrington, Bebington, Northwich and Toxteth
Greater Manchester	2	Salford and Oldham
Lancashire and South Cumbria	1	Broughton
North Cumbria	1	Carlisle

Table 34: Mental health vehicles and their operational bases.

111 option 2.

NHS 111 option 2 went live on the 30 April 2024 following engagement with MH trusts and ICBs throughout 23/24. This service provides a single point of access for patients who present with a MH crisis. Work will continue with system partners, NHS England and the

ICB's to evaluate this workstream across 2024 to ensure the service remains timely and patient focused.

Mental Health training and education.

The provision of a MH development practitioner role has enabled additional resilience within the team to support with the development of a suite of training, including supporting mandatory training, the MHRV induction and training around capacity and mental state examination.

Patient safety.

A thematic review of MH serious incidents has enabled several quality improvements to be made including the development of the advanced Questionnaire module for high-risk overdoses, the establishment of a non-fatal opiate overdose practitioner role funding by local authorities and the sharing of self-harm and suicide data across the North West. Monthly meetings with our legal team continue to highlight new or emerging risks and themes/early learning.

Right care, right person engagement.

The Home Office Right Care Right Person (RCRP) is an approach designed to ensure that people of all ages, who have health and/or social care needs, are responded to by the right person, with the right skills, training and experience to best meet their needs. This is currently being introduced by police forces within our footprint and has brought to the forefront the need for a formal joint position on concern for welfare calls and other patient groups who present to our services. The mental health and ICC team, in collaboration with colleagues from the quality directorate, have developed numerous partnership agreements, memorandums of understanding and procedures to mitigate any potential adverse impacts of this approach.

Developing our approach to population and public health

Building on the continuing, valuable work from the public health registrars, this year we made a significant investment to recruit our first substantive, full-time public health manager. This makes us the second ambulance trust in England to do so, placing us in a strong position to develop its longer-term strategic goals to support population health improvement and reduction of health inequalities.

The public health workplan aligns with the Quality strategy objectives to develop effective collaborations with our system partners (GPs, voluntary sectors, prevention groups, etc.) and to reduce variation in patient outcomes and experience. Our focus is on identifying opportunities for our staff and volunteers to improve health and wellbeing in the population by preventing illness and its reoccurrence and in doing so, supporting the longer-term sustainability of the NHS.

Working closely with our teams and the partnership integration managers, we have continued to develop relationships with regional and national public health networks. This year, following national guidance from the Association of Ambulance Chief Executives, we conducted a baseline assessment of our public health maturity. Our assessment indicated we are developing and building up good practice, which demonstrates our commitment to work as an effective partner to support the reduction of health inequalities. To improve our maturity, we are working on a three-year plan to develop the enablers across three areas:

- Improving staff capability and capacity.
- Improving the input, analysis and utilisation of our data.
- Developing and embedding prevention interventions into our operational delivery model to provide holistic care.

Examples of our achievements this year and how these will help us achieve our medium-term aims, include:

Improving staff capability and capacity.

Our aim is to increase awareness and understanding of public health, prevention and health inequalities across teams. As part of this work, we have conducted a survey for all our staff and volunteers to explore their current perceptions of what makes us healthy and whether they engage in conversations with patients to provide advice or signpost them to services available. Results will help us identify which training resources we need to develop in the next two years, as well as the best way to make these accessible to our staff and volunteers.

Improving the input, analysis and utilisation of data.

To identify where we can make the most impact, we need to understand where we see variation in access, experience and outcomes for our population. This year, we started looking at the way patient transport services are accessed; we are interested to learn who

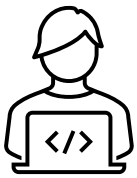
access them across the region and any differences in access depending on patient characteristics such as age, gender, ethnicity and deprivation. We will share results with our NHS partners to identify patient groups who are not accessing the service and hence being at a disadvantage of accessing the care they need.

We are exploring innovative ways to use the patient data we collect to support identification of undiagnosed hypertension, which is a main risk factor for heart attacks and strokes. In previous years we carried two small pilots with two groups of GPs, where we shared blood pressure readings from patients not conveyed to hospital. Results were encouraging and showed potential of using our data in this way. This year we engaged with new partners to explore whether we can spread this work across wider areas, in a way that is manageable for GPs and for ourselves.

Ensuring our operational delivery model enables staff to provide holistic care.

This year we launched a pilot in Wigan, Greater Manchester, to test a new single pathway for social prescribing referrals. Clinicians can now contact the Carlisle support centre 24/7, who submit a standardised Cleric referral form to the relevant social prescribing provider. This bypasses the need for crews to contact the social prescriber directly; a common barrier to out-of-hours referrals. In November-December 2023, 38 referrals have been made in the Wigan area. Since then, the roll-out has continued across Bolton, Central/North Manchester, Rochdale, Salford and Oldham. We also introduced social prescribing referrals to Patient Transport Services and we developed two training videos to help develop awareness on services available to support patients' health and wellbeing.

In addition to this work, we are also collaborating with external and internal partners, to identify ways to improve our capacity to act on the values of 'anchor' organisations. We already do significant work in relation to environmental sustainability, widening access and partnership working, but where possible, we are exploring new ways to do more. As part of our work with Cheshire and Mersey Prevention Pledge, we worked with our Health and Wellbeing team and Liverpool Heart and Chest Hospital to provide on-site health checks to our staff as part of our Wellbeing Festival in November at Estuary Point. The health checks were well received and we will work with the Health and Wellbeing team to explore opportunities to offer these in future events.



Improving services through delivery of our digital plan

Our digital work programme in 23/24 has enabled us to move forward in delivering against our Digital Strategy. Key achievements for 23/24 include:

- We have continued to invest in making sure that teams have the right digital tools to work effectively and efficiently. We upgraded mobile phones to the O2 network and implemented of a solution to support the global management of mobile data. All vehicle phones were replaced for the patient transport service (PTS) and paramedic emergency service (PES).
- We have worked with the 111 service to develop the Azure Virtual Desktop, so that 111 colleagues can answer calls from anywhere in the UK. This will provide a different form of resilience for the service.
- We complete 90% of digital support issues within the service level agreement.
- We have progressed with the development of our electronic patient record (EPR), Directory of Services (DoS), interoperability and digital infrastructure and developed the EPR Management Application and rolled out to over 35 receiving North West locations, including coroners. The work by the EPR team is being shortlisted for a Health Service Journal (HSJ) award in the 'improving out of hospital care through digital' category.
- We have continued to develop DoS functionality, increasing the number of services available and implementing the Pharmacy First programme. The DoS team have worked with the EPR team to develop and pilot with two providers for EPR onward referrals. This enables clinicians to reduce their time on scene by completing an electronical referral. The pilot is being evaluated to look at expanding this across the North West.
- We transitioned our telephone lines from Integrated Services Digital Network (ISDN) over to Session Initiated Protocol (SIP). This has improved our resilience, future-proofed the service and improved the quality of service.
- We have implemented the Booking and Referrals Standard (BaRS), enabling electronic referrals between our 999 Computer Aided Dispatch (CAD) system and the Clinical Assessment Service (CAS). The technology is now being developed to support the CAD-to-CAD process, to reduce manually sharing data.
- We continue to maintain our cyber resilience and protect our data. Compliance with all relevant cyber certifications has been achieved. We have maintained a strong rate of patching servers (97.7% of servers patched at the end of the year). There were 18 cyber breaches, which equates to just 1.5 per month.
- Work has commenced on the Wide Area Network (WAN) programme, which will enable us to utilise our network traffic between that which is routed to our data centres and that which is direct to the internet.
- Investment into our business intelligence function has enabled the team to grow, supporting our data and reporting needs. Along with the growth of the team, new

ways of working have been implemented to be more agile in delivering the reporting products. This is by educating our users through the methods and increasing their knowledge of data and how to analyse it.

- We have developed direct data feeds with our Integrated Care Boards (ICBs) through their System Control Centres (SCC), which enables the ICB teams to access the data on an almost real time basis.
- With support from NHS England, we have developed the data feeds for the Ambulance Data Set (ADS) using the 999 CAD system. As part of phase 2 of the ADS programme, we are working with the EPR team in extracting the clinical data from EPR so it can be combined with other clinical data that NHS England hold. This will be a future development in 24/25, which will give the opportunity to understand the clinical outcomes of our patients and where we can improve these.
- Patient ethnicity data has been historically difficult to obtain from external national systems. The innovation team have developed a solution which is due to be implemented in April 2024. This will enable the sharing of ethnicity data from the 111 system into the 999 CAD. The availability of this data will help us better understand the outcomes across the diverse population we serve.
- We have continued our innovative approach to creating digital solutions for problems. This year we have developed our Aspirer solution, providing our paramedic emergency service (PES) teams with a solution that enables them to digitally record their shifts, enabling them to be paid accurately each month. The Aspirer development is continuing, with the move into trust-wide appraisals and potentially being used for contact shifts.
- We have built a new relationship with Lister Alliance, which will enable us to pilot the smart ambulance concept. We continue our partnerships with the University of Manchester, Lancaster University, the Northern Ambulance Alliance and AACE digital transformation group. We have been selected to be part of the Clinical Entrepreneurship Programme. This will provide funding to develop our innovations and the opportunity to learn from other NHS organisations.

Improvement case report Patient Transport Services (PTS)

Reducing cancelled journeys in patient transport services

PTS increased access to the online booking system in 2023 and now we have more than 8,500 users across the North West. This allows staff across the healthcare system to book transport online without the need to call into the contact centre and be held in a call queue.

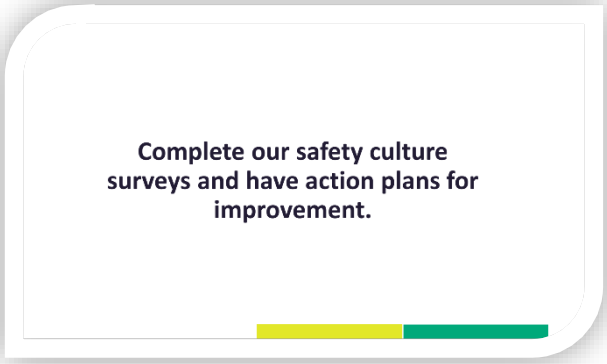
During 2023, an assessment of resource capacity identified it is not utilised as well as it was before the pandemic. We continuously monitor this and aim to return to using multi-occupancy vehicles. This work is still ongoing but is progressing well. The “Text NO” service was introduced to help increase resource capacity and make access to the service easier for patients. This enables patients using the text reminder service to respond "NO" to a reminder to cancel their transport and free up valuable capacity.

In 23/24 there were more digital developments with starting the planning phases of Passenger Zone, which we will aim to implement in 24/25. Passenger Zone will allow patients and their representatives to use the PTS online portal through secure access and book their own transport subject to their eligibility. In turn improving the patient experience and reducing the time spent in a call queue. This will also have a positive impact on staff and achievement of the quality standard which is currently 75% of calls to be answered in 20 seconds.

Maintaining the safety of our vulnerable patients remained a priority throughout 23/24. We adapted the eligibility and call-taking script to acknowledge the end of the pandemic, but still allow us to identify our most clinically vulnerable patients. This allows us to present the most appropriate and safe transport for their appointments.


Quality Aims 24/25
nwas.nhs.uk

Safer care



What success looks like?

Our four service lines (111, 999, PTS and Resilience) and our Integrated Contact Centres (ICC) will all understand the safety culture in their teams and have engaged staff in conversations about speaking up, the barriers to speaking up and the improvements which can be made locally. They will each have an action plan to improve safety culture.

What success looks like?

Information will be collated from different sources by operational and clinical leads to look for learning themes across multiple sources of information. This learning will be presented and discussed at the learning forums and improvement plans shaped around integrated learning from data, staff report, listening to patients and observations of care.

What success looks like?

All teams will be clear about the local quality improvement priorities and will also be focused on PSIRF priorities as a fundamental component of their learning and improvement planning. They will articulate locally defined priorities:

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

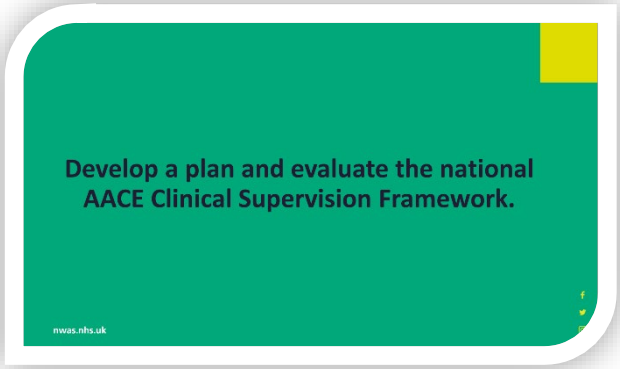
What success looks like?

The newly established regional clinical learning and improvement group will have active engagement from across our trust and will be an exemplar for local learning forums to emulate.

What success looks like?

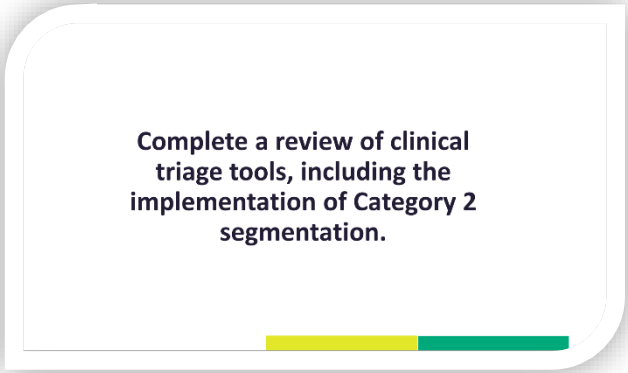
We will continue to prioritise the most vulnerable patients and ensure staff are confident in risk assessment, referral and management via the appropriate training. We will expand the use of digital referral beyond the control room to test direct referrals to local authority via the IPAD technology.

Highly effective care



What success looks like?

We will enhance our clinical supervision processes, using the AACE Clinical Supervision Framework foundation and principles. Encouraging professional relationships which feel psychological safe for reflection and learning. Environments where all staff members with direct contact with patients feel able to support one another, using formal and informal approaches to explore personal and emotional responses to their work.



What success looks like?

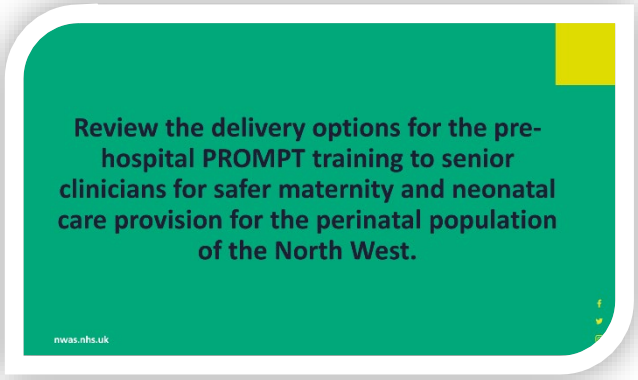
We will review the appropriate tools utilised for remote clinical consultation and develop an evidence based and clinically effective recommendation as to the optimal approach. The ICCs will ensure the appropriate validation of incidents in-line with national specification. Including the revalidation of Category 2 incidents.

What success looks like?

We would expect to achieve see and treat rates at a level which, in combination with patients managed by telephone advice, reduces the number of people conveyed to ED to 45% over a two-year period. We expect to see improvement in the use of alternative pathways, as well as those treated at scene.

What success looks like?

Continual engagement with service users, staff and external stakeholders to improve access to the right care by the right professional promptly. Success will include meeting the key deliverables of our strategic plans and the ambitions set by the NHS Long Term Plan (2019) whilst reducing patient harm and improving patient experience.



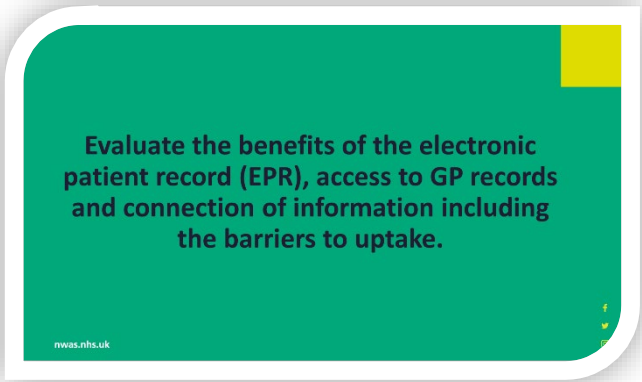
What success looks like?

Implementation aimed at enhancing confidence of staff and their skills in managing complex neonatal and obstetric emergencies. Evaluation to demonstrate impact on protocol adherence, standards of practice and reducing risk of harm.

Patient centred care

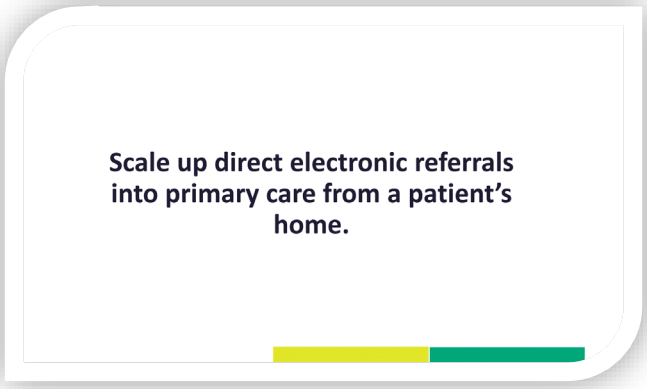
What success looks like?

We will have a Patient Safety Partner Policy which aligns with the NHS England Framework for Involving Patients in Patient Safety ensuring our patient safety partners are orientated to our organisation and receive appropriate training and support. They will be integrated into our patient safety work through membership on safety governance meetings, involvement in improvement projects, staff training and safety events.



What success looks like?

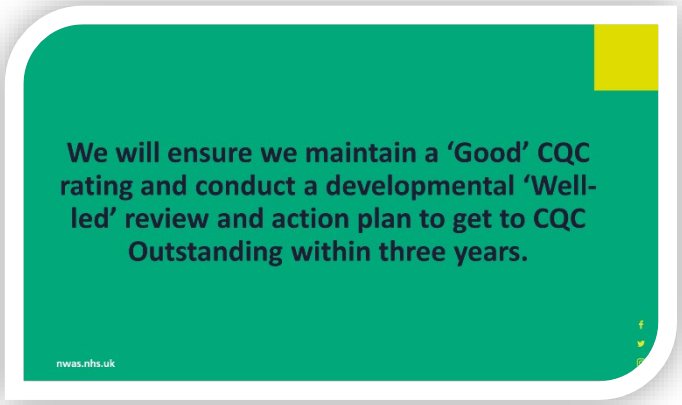
A clear understanding of how the use of data within a clinical setting is providing benefits to delivery of patient care. A completed evaluation of the utilisation of shared care records within appropriate use case settings.



What success looks like?

Following the pilot in Lancashire and South Cumbria, we plan to upscale EPR Onward Referrals in line with high quality inclusive care focussed on person centred partnerships. The intention is to work provider by provider to realise the time efficiencies and improved patient journey across the North West footprint. The plan is to work with the Mersey provider next**.**

Quality standards and compliance



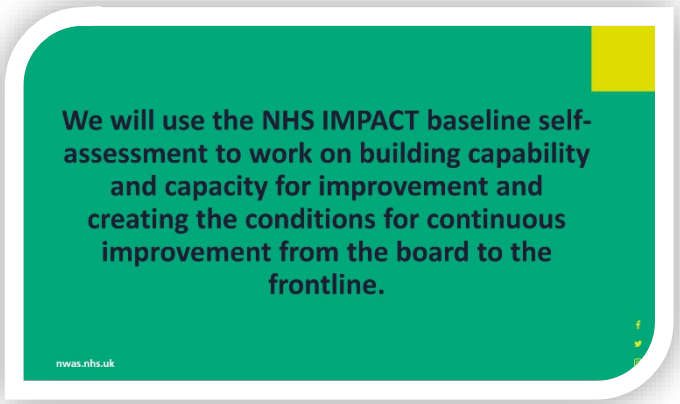
What success looks like?

We will maintain our 'Good' CQC rating with the ambition to become outstanding in line CQC's new single assessment framework.

What success looks like?

We will form a new team focused on violence prevention and reduction aligned to the NHS England National Security Standard. This role will focus on a key aspect of staff safety - that of reducing violence and aggression incidents and severity for staff and develop robust systems and processes of support for staff following such incidents.

Continuous improvement

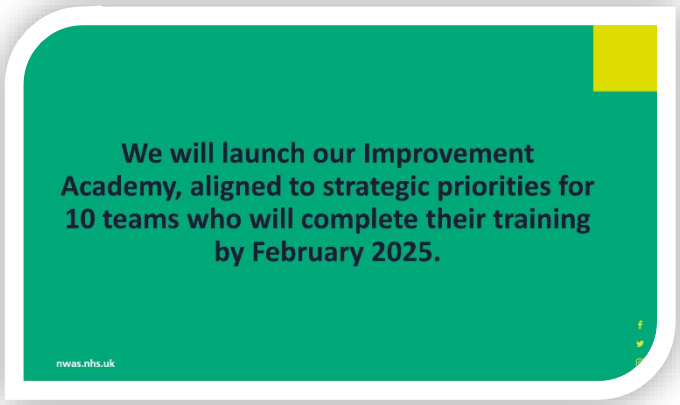


What success looks like?

Take the North West Ambulance Service findings of the NHS Impact Self-Assessment and develop a measurable action plan to move the organisation from the baseline position of progressing to improving and sustaining providing an action plan by September 2024.

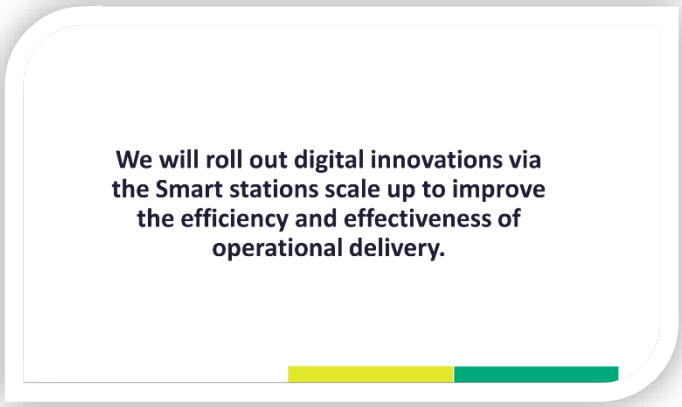
What success looks like?

All departments in partnership with the Quality, Innovation and Improvement directorate will produce and implement departmental improvement plans which will be presented to our corporate programme board and quality and performance committee.



What success looks like?

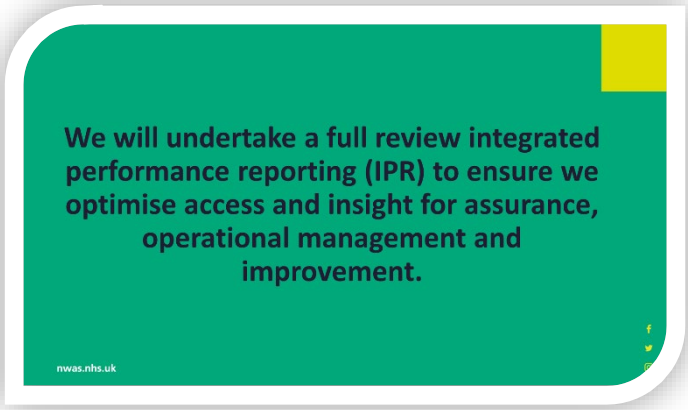
The Improvement Academy will continuously upskill our workforce with improvement methodology, equipping 60-80 individuals per cohort with the tools and knowledge required to deliver long-term change and improvement within their areas. There will also be immediate benefits following each cohort, as each of the 10 attending teams will have a focussed project aim intended to improve an area within the trust strategy.



What success looks like?

Completing the roll out of three systems:

- Install digital key cabinets.
- Strengthen controlled drugs (CD) access to CD safes.
- Displaying consistent, relevant, and up-to-date information on the digital wallboards.



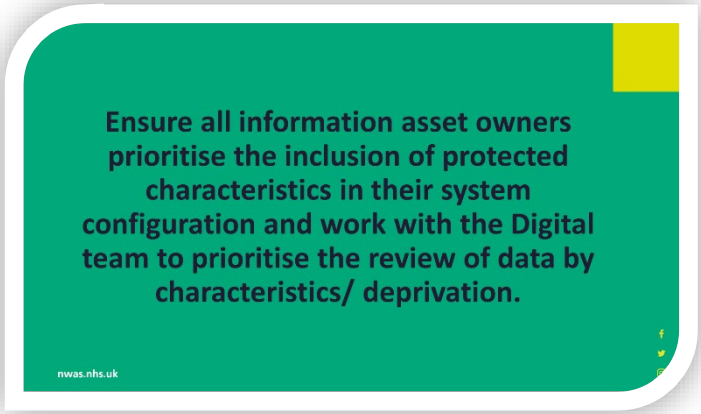
What success looks like?

The integrated performance report (IPR) will be accessible to decision makers to monitor key metrics on quality, effectiveness, operational performance, finance and organisational health. The IPR will be used to monitor the progress of elements of the Annual Plan, Board Assurance Framework (BAF), and the Trust Strategy.

Equality, diversity, and inclusion

What success looks like?

We will directly address if there are factors of an individual incident or theme identified which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular group of our population which will include protected groups. Furthermore, we will ensure that when constructing safety improvement plans, we will consider inequalities.



What success looks like?

Information asset owners will understand the importance of protected characteristics for inclusion within their assets. A plan will have been created to either ensure the inclusion within the asset or a link for those protected characteristics is able to be achieved within the data warehouse.

What success looks like?

We will engage with research that contributes to the local and national effort to tackle health inequalities. By increasing the number of opportunities for patients, the public and our staff to participate in public health research, we will grow the number of National Institute for Health and Care Research Clinical Research Network Portfolio studies we support.

Formal statements on quality

Review of services

During 23/24 we have provided and/or sub-contracted NHS urgent and emergency care services across the North West. The income generated by the NHS services reviewed represents 100% of the total income generated from the provision of relevant health services by our trust for this period. We have reviewed all the data available on the quality of care in the NHS services provided.

Participation in clinical audits

NHS England Ambulance Clinical Outcome Indicators

English ambulance services are required to undertake specific ambulance clinical audit and submit the data on prescribed dates throughout the year, directly to NHS England. In addition, the ambulance service clinical audit data informs the out-of-hospital cardiac arrest registry, Sentinel Stroke National Audit Programme (SSNAP) and the Myocardial Infarction National Audit Project (MINAP).

The mandated clinical audits are:

Outcome from cardiac arrest – return of spontaneous circulation (ROSC):

- Overall
- Utstein comparator group

Outcome from cardiac arrest – survival to discharge

- Overall
- Utstein comparator group

Post ROSC care bundle:

- The number of patients who received the appropriate care bundle after sustaining ROSC for 10 minutes or longer after an out-of-hospital cardiac arrest where resuscitation (advanced or basic life-support) was commenced/continued by the ambulance service.

Outcome from acute ST-elevation myocardial infarction (STEMI):

- Time from call to angiography
- The number of patients with a pre-hospital diagnosis of suspected STEMI confirmed on the electrocardiogram, who received the appropriate care bundle.

Outcome from stroke:

- Time from call to hospital arrival.
- The number of face, arm, speech test (FAST) positive or suspected stroke patients assessed face to face who received the stroke diagnostic bundle of care.

This data is published nationally on the NHS England website

NHS England are seeking to formally include the current pilot measure reviewing care received by older adults who have fallen and are discharged on scene in the 24/25 ambulance clinical audit schedule by the end of Q1. The proposed audit will review the care where the patient receives a face to face or phone call assessment and the patient is discharged at scene but recontacts the ambulance service within 24 hours of the original call. For the purposes of this audit, ambulance services will agree a specific span of dates through which data will be collected and analysed, with a single report produced in the year. It is anticipated the stroke diagnostic bundle will be removed from the quarterly cycle to an annual audit of care received due to consistent and sustained levels of compliance.

Participation in clinical research

We are dedicated to providing high quality care to our patients by meeting not only their immediate healthcare needs, but also having a positive impact on their future health and wellbeing. As an NHS organisation, we have a responsibility to provide our patients, staff and the public with the opportunity to participate in health care research.

Our research strategy expresses our commitment to host and develop research that will not only enhance the quality of the urgent and emergency care we deliver, but will ensure that the communities we serve have equitable access to our high quality, clinical services to continue improving the health outcomes for all our patients.

Our mission is to embed a culture of research excellence and to be at the vanguard of generating new evidence that supports the delivery of first-rate, urgent and emergency care. Our vision is to enhance the health and wellbeing of the communities we serve by translating high quality research into exceptional service provision and outstanding clinical practice.

The Research and Development (R&D) team has continued to make strides in embedding research across the organisation. Income was secured from the National Institute for Health and Care Research (NIHR) for a research fellow and two research paramedics who promote and deliver across the organisation, ensuring that patients, staff and the public can take part in research.

For the fourth consecutive year, we successfully triggered NIHR Research Capability Funding (RCF) by successfully recruiting participants to NIHR Clinical Research Network (CRN) Portfolio research studies. The purpose of NIHR RCF is to help research-active NHS organisations to act flexibly and strategically to maintain research capacity and capability.

Our staff were principal investigators and local collaborators for NIHR CRN Portfolio studies and we continued to offer researcher development opportunities. Our consultant midwife became an NIHR Senior Research Leader: Nursing and Midwifery Programme. Three staff members participated in one-year, research internships with NIHR Applied Research Collaborations North West Coast (ARC NWC) and ARC Greater Manchester (GM). One colleague completed the NHS R&D North West and NIHR North West Research Workforce Learning and Development North West Early Career Researcher Development Pathway programme.

We hosted the 999 EMS Research Forum Annual Conference for the first time. The conference theme was "Working with our communities to deliver pre-hospital and emergency care research" and the event was opened by our CEO. Our R&D team attended an NIHR CRN GM Research Festival to help engage with local communities and raise awareness of opportunities for the public to get involved in NIHR research.

We actively maintained partnerships with our local NIHR applied research collaborations and NIHR Clinical Research Networks CRNs, health and care providers, higher education institutions and other external stakeholders to cultivate research collaborations. We remained an active member of the National Ambulance Research Steering Group (NARSG), a collaboration between all UK ambulance services that provides a forum to foster research partnerships, be involved in developing research grants and identify new research opportunities.

The R&D team won the 'special award for exceptional experience' at the NIHR Greater Manchester Health and Care Research Awards 2023 and was also recognised at the Lancaster University Staff Awards for its collaboration with academic and NHS partners across the region to develop and evaluate ACP Support, an online training resource supports health care providers in having advance care planning (ACP) discussions with people approaching end of life.

Performance in clinical research.

In 23/24, we opened seven new research studies that were approved by the NHS Health Research Authority (HRA). Five of the newly approved research studies were NIHR CRN Portfolio studies.

We had eight NIHR CRN Portfolio studies open to recruitment in 23/24 to which we successfully recruited 906 research participants including staff, patients and the public.

Financial year	20/21	21/22	22/23	23/24
Number of studies open to recruitment	5	9	10	8
Number of participants	604	630	923	906

Table 35: National Institute for Health Research Clinical Research Network portfolio performance at NWAS.

The five new NIHR CRN portfolio research studies we confirmed our capacity and capability to deliver in 23/24 included:

- Exploring the use of pre-hospital pre-alerts and their impact on patients, ambulance service and emergency department staff (pre-alert study).
- A multi-centre randomised controlled trial of the clinical and cost effectiveness of pre-hospital whole blood administration versus standard care for traumatic haemorrhage (SWiFT).
- Specialist pre-hospital redirection for ischaemic stroke thrombectomy: a cluster randomised controlled trial with included health economic and process evaluations (SPEEDY).
- What are the barriers to health promotion advice delivered by staff working in urgent care and emergency departments? (promoted study).
- Paramedic delivery of end-of-life care (ParAid study): a mixed methods evaluation of service provision and professional practice.

In 23/24, confirmation of capacity and capability was issued for two non-portfolio studies:

- Knowledge exchange workshops with paramedics to support RADOSS project.
- Occupational stress risk assessment: Association of Ambulance Chief Executives (AACE) ambulance trust control rooms.

Research grants.

We were a co-applicant for three successful NIHR bids:

- Research for patient benefit (RfPB) under-represented disciplines and specialisms highlight notice: nurses and midwives: disparities in access to North West Ambulance Service during pregnancy, birth and postpartum period and its association with neonatal and maternal outcomes [DIAAS].
- Health and Social Care Delivery Research (HSDR) programme: what works to reduce harms related to patient safety, experience, flow, outcomes and costs of ambulances queuing with delayed handovers at emergency departments (STALLED).
- INSIGHT inspiring students into research programme.

Publications.

The research publications that were either authored or co-authored by our staff in the financial year 23/24 are listed in the Appendix.

Use of the CQUIN payment framework

This year the flu programme was aligned with one of the quality indicators in the 23/24 Commissioning for Quality and Innovation (CQUIN) with a goal of vaccinating over 75% of frontline staff. This funding was provided at the start of the campaign and was not linked to any financial penalty in the event the targeted vaccination rate was not met. We reported at the end of the campaign that 48.63% of frontline staff were vaccinated and we sat well within the average rate of vaccinations when compared to other trusts of a similar size across the region. A reduced uptake of the flu vaccine was reported across the wider NHS with the main reason being vaccine fatigue cited for this year's decline in uptake.

NHS number and general medical practice code validity.

- We did not submit records during 23/24 to the secondary uses service for inclusion in the hospital episode statistics which are included in the latest published data. The requirement did not apply to ambulance trusts during 23/24.

Clinical coding error rate.

- We were not subject to the payment by results clinical coding audit during 23/24 by the audit commission.

Data security protection toolkit.

- In February 2024, we completed the Data Security Protection Toolkit (DSPT) interim submission which provided an overall score for 23/24 of 92% (99 of the 108 compliance evidence standards were met). Mersey internal audit agency (MIAA) have undertaken a review of a selection of these assertions, within the 10 standards and reported NWAS assurance level in respect of the veracity of the self-assessment is substantial.

We are progressing with the actions and will submit all relevant evidence against the 34 assertions (108 compliance evidence standards) by the end of June 2024.

CQC rating

We welcomed the CQC whilst they carried out a focussed inspection of Lancashire and South Cumbria Integrated Care System (ICS) and Cheshire and Merseyside ICS in 2022. The service lines included: emergency and urgent care, emergency operations centre and NHS 111. Whilst this was not a 'ratings' inspection, we have maintained our 'Good' rating.

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Provider Wide	Good	Good	Good	Good	Good	Good
Emergency and Urgent Care	Good June 2020	Good June 2020	Good June 2020	Outstanding June 2020	Good June 2020	Good June 2020
Emergency Operations Centre	Good June 2020	Good June 2020	Good June 2020	Good June 2020	Good June 2020	Good June 2020
Patient Transport Service	Good Jan 2017	Good Jan 2017	N/A	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017
Resilience	Good Nov 2018	Good Nov 2018	Good	Good Nov 2018	Good Nov 2018	Good Nov 2018
111	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017	Good Jan 2017

Table 36: Our CQC ratings.

In 23/24 the CQC continued to regulate providers using a risk-based model whilst redeveloping their new regulatory model, with staggered rollouts nationwide of the new Single Assessment Framework (SAF). In Q4 23/24, the SAF went live in North West. Their approach during 23/24 included ongoing routine engagement meetings and enquiries.

We actively review any feedback and concerns raised through active engagement meetings with the CQC. Any recommended changes to our policies or procedures are fully considered and implemented when appropriate. This interactive and close collaboration with the CQC is showing a reduction in the amount of formal CQC enquiries.

Financial year	20/21	21/22	22/23
Number of CQC enquiries	91	65	57

Table 37: Breakdown of CQC enquiries received each year which required a written response.

System Oversight Framework (SOF)

NHS England's System Oversight Framework provides the framework for overseeing systems and providers and identifies potential support needs. The framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan, NHS People Plan and the shared local ambitions and priorities of individual ICSs:

- Quality of care, access and outcomes.
- Preventing ill health and reducing inequalities.
- Finance and use of resources.
- People.
- Leadership and capability.

As part of the NHS England's oversight, performance is monitored across each of these themes whereby providers are allocated to 1 of 4 segments that identify the nature of support needs. Segment 1 reflects no specific needs and segment 4 reflects providers that require mandated intensive support.

NHS England has assessed that we are segment 2, which by default, all ICSs and trusts are allocated unless the criteria for moving into another segment are met.

Further information in relation to the Oversight Framework is on the NHS website.

Stakeholder feedback

We work in collaboration with all partners and the Quality Account has been shared with over 105 external partners including Commissioners, Providers, Councils and Healthwatch groups.

We have shared our Quality Account with 340 members of our Patient and Public Panel.

Statement from the Lancashire and South Cumbria Integrated Care Board.

Lancashire and South Cumbria Integrated Care Board (ICB) undertakes the role of host Commissioner for the North West Regional Ambulance and NHS 111 Commissioning team who support ambulance and 111 Services on behalf of ICBs that make up the North West region. In doing this it ensures that robust Commissioning, Quality, Contract and Performance Management is in place to enable and support North West Ambulance Service (NWAS) to provide effective services to the residents of the North West.

These services comprise:

- Paramedic Emergency Service (PES): the 999 ambulance service.
- NHS 111 services.
- Patient Transport Services (PTS): enabling eligible patients to access outpatient, discharge and other hospital appointments for Greater Manchester, Merseyside, Lancashire and Cumbria. Services for Cheshire are not provided by NWAS.

In its role as host Commissioner, Lancashire and South Cumbria welcomes the opportunity to review and support the 23/24 NWAS Quality Account.

Ambulance and NHS 111 Services Governance.

NWAS provides services across five “county” areas; Cumbria, Lancashire, Cheshire, Merseyside and Greater Manchester. This is a complex geography where the “county” footprints now form three full ICB footprints of Lancashire and South Cumbria, Greater Manchester and Cheshire and Mersey, and North Cumbria as part of North East and North Cumbria, supporting a diverse population of circa 7.5 million with many rural and inner city areas.

The Strategic Partnership Transformation Board (SPTB) operates on behalf of the 4 ICBs and is attended by a designated ICB lead at executive level as well as by Senior Clinical Leads from each area. The primary function of the SPTB is to assure commissioners that NWAS are meeting all required national targets, KPIs and deliver safe and effective services.

2023/24 Quality Account Overview.

It has been another challenging year not only for NWAS but the whole of the NHS in 23/24 with winter pressures across the NHS system, industrial action continuing, Strep A and seasonal flu. Despite this NWAS has managed to improve the majority of its national targets

on previous years, improved staff sickness levels and continues to 'Put Care at the heart of all they do.' This has taken a lot of hard work not only from NWAS and all of their 7,415 staff and volunteers but also with the collaborative work undertaken with the North West ICBs and external stakeholders to reduce hospital handover times where possible and safely find the most appropriate care for their patients calling 999 or 111. This all evidences that NWAS is fulfilling its main purposes 'to help people when they need us the most, work together and being at or best.'

999 - Paramedic Emergency Services (PES).

In recognition of the challenges felt across the Urgent and Emergency Care (UEC) system 22/23 and most English ambulance services NHS England in January 2023 introduced the UEC Recovery plan.

One specific workstream covers increasing ambulance capacity, as it recognises the increased complexity of ambulance call-outs and amount of care provided at scene. The national plan sets a goal to reduce the Category 2 mean performance to 30 minutes for 23/24, itself recognising that resolving the response time issue needs longer-term changes, including additional vehicles and workforce.

It is pleasing for Commissioners to see within the Quality Account how NWAS have responded to this by investing in an extra 32 ambulances at peak times and recruiting 200 new paramedics and emergency medical technicians, which has resulted in not only improvements in all national Ambulance Response Program (ARP) target times but achieving the UEC recovery category 2 mean (the response allocated to those requiring an emergency response for patient presenting with potential heart attacks, strokes and difficulty in breathing) of 30 minutes with a response time for year end of 28 minutes and 44 seconds, when many other English ambulance services struggled to achieve this target. This is also despite an increase in 999 incidents received of 4.3% on 22/23.

It is noted that again NWAS has increased its 'Hear and Treat'. This is when a 999 call is categorised as none life threatening at point of call and either the call handler can refer the patient to a local service or for more complex cases a clinician calls the patient back to triage them further and establish if a service closer to home may be able to appropriately support their needs rather than dispatching an emergency ambulance. Of all its 999 incidents 14.1% were closed with Hear and Treat, increasing emergency ambulance availability to respond to the more life threatening 999 calls. Not surprisingly this has the resulted in a slight drop in 'See and Treat', when ambulance clinicians assess a patient on scene and either onward refer to a local service or give self-care advice, on 22/23. NWAS achieved 27.9% See and Treat in 23/24, with a further 7.22% being transported to alternatives to A&E resulting in only 50.9% of NWAS patients calling 999 being transported to A&E and aligning to the UEC recovery plan to reduce conveyance. The Quality Account outlines the comprehensive review undertaken to understand See and Treat across the North West using qualitative and

quantitative data which will be crucial to ensure reduction in variation across the North West for this Ambulance Quality Indicator (AQI) and will inform improvement in objectives within the 24/25 annual plan.

The NWAS Quality Account also outlines how they have significantly improved the time a 999 call is received into the NWAS system and is answered by a call handler, this is reported as call pickup up time. In 22/23 NWAS were challenged at times answering 72.8% under 5 seconds, but in 23/24 NWAS achieved 96.8%. This has taken a great deal of work and is crucial in maintaining patient safety by allowing the identification quickly of those who need an ambulance immediately with presentations like cardiac arrest, and also giving the caller appropriate advice to support the patient to aid better outcomes, until an NWAS clinician arrives on scene.

Although performance has improved, and NWAS should be congratulated on their continued drive for improvement, it is noted that there is still a way to go to achieve the NHS England National ARP standards for all categories of 999 calls. Commissioners via SPTB will continue to support NWAS achieving this along with their main priorities to increase the number of patient supported safely and appropriately closer to home rather than being transported to hospital, developing a single point of access to not only support NWAS but other healthcare professionals in the North West in identifying the most appropriate service to support patients needs, reducing variation in hospital handover times in the north west, achieving the national hospital handover standard and eliminating patients waiting in ambulances to access A&E.

NHS 111.

Again it was very pleasing to see within the Quality Account despite periods of variation within the year for the number of 111 calls received an improvement in many of their national Key Point Indicators (KPIs) standards. It was also encouraging to see that given the significant increase in 111 demands during COVID, 23/24 saw a decrease in 111 demand by 14.5% on 2022/23 with calls averaging 44,416 a week and reported as being more stable than in the previous year.

Call abandonment, when a caller waiting for their 111 call to be answered hangs up and a good indicator of long waits and pressure on the service, reduced to 12.71% in 23/24 from 19.38% in 22/23. This is against a target of under 5%. There has also been an increase in calls answered within 60 seconds, NWAS achieving 49.82% and an improvement on the previous year by 10.56%. Work has also been ongoing to expand and embed the utilisation of video consultations, which outputs have seen an increase of 14% in 23/24 for patients receiving home treatment in comparison to engagement purely on the telephone. Patient feedback has also been positive with patients reporting they feel taken better care of and reassured by their assessment having included a visual aspect.

Although there have been significant improvements it still at times has been a challenging 12 months, with extra support being given nationally with certain cohorts of patients, and much work being undertaken to support the introduction in April 2024 of mental health patients calling 111 and then pressing 2 to access local mental health crisis lines.

Significant work has been undertaken within 111 to support and develop their staff and work undertaken to integrate with the wider NWAS contact centres for patients calling 999. It has been rewarding to see with the new leadership team in place and further work underway to further develop the NWAS Integrated Contact Centres (ICC) with 111, 999, PTS and the Clinical Hub (CHUB) the improvements in staff turnover, sickness and staff surveys. This should not only give NWAS staff greater development opportunities but better job satisfaction whilst also developing a more robust, flexible and efficient workforce which the commissioners fully support, and supported via SPTB.

Patient Transport Services (PTS).

Patient Transport Services (PTS) were significantly impacted by the COVID pandemic with initially many transportation requirements cancelled as hospital appointments were cancelled. With a reduction in activity PTS released its staff to support PES operations as their performance became more challenging. This did however enable PTS staff further career development with many staying within the PES service when COVID restrictions started to ease.

The Quality Account outlines the aim for PTS to return to pre COVID levels initially however, there has been a realisation that COVID has changed ways of working and there has been an increased need to transport patients further, which has been challenging.

There has been acknowledgement of a reliance of utilisation of third-party providers and plans to reduce this which does align with NHS England's 2024/25 Planning Guidance to reduce utilisation of 'bank staff' and increase the NHS providers own staff base whilst reducing attrition.

As outlined in the Quality Account some of the PTS KPIs are still challenged, but some like time on vehicle less than 60 minutes have improved. PTS will also support the North West NHS system in 24/25 with a focus on discharge to aid patient flow throughout the hospitals, which in turn should reduce pressures within A&E.

With the current changes in leadership structure and further integration with the ICCs it is hoped there will be improvements seen in the coming months and encouraging that there is a focus on achieving this whilst maintaining a safe service for their cohort of patients, which is generally the most vulnerable and frail within our communities

Quality.

The Quality account highlights the introduction of NWAS' new Quality Strategy, which supports the overall Trust strategies, and commissioners are grateful that this was designed to reflect the wishes of the North West population with engagement of over 200 staff and a diverse range of stakeholders, with a focus on learning to provide a high level of quality inclusive care. The NWAS aim of 'Safety First' also aligns to the NHS Patient Safety Strategy as does the 300 members of the Patient and Public Panel, involving patients, families and stakeholders, and is welcomed by commissioners along with the work this group have already undertaken within the Account.

Patient Safety.

In 22/23, as with all English Ambulance services, NWAS saw a large amount of serious incidents raised and investigation under the national framework, with delayed responses linked to a large proportion. As 999 Category 2 response times have improved in 23/24 for NWAS it is positive to see that the number of serious incidents raised has decreased. NWAS have also worked incredibly hard during 23/24 to introduce the Patient Safety Incident Reporting Framework (PSIRF) with commissioners and external stakeholders on 1 October 2023, and were one of the first English ambulance services to go live.

PSIRF, part of the NHS Patient Safety Strategy NHS England » Patient Safety Incident Response Framework, has replaced older systems of working and is a new approach to responding to patient safety incidents, or as many are now called events. It has been pleasing that ICB representatives have been included in the NWAS membership of their internal meetings to review Patient Safety Events, and the increase in inclusion of patients' families within these investigations.

Summary.

It has been another extremely challenging 12 months for the NHS as a system, the North West and for NWAS. However, there are now more definite signs of improvements for NWAS with improved national standards, and for the NHS systems with reduced hospital handover times. It has been pleasing to see the innovative way NWAS has responded to many of the challenges faced that will continue during the coming years.

As with the whole of the NHS there are still improvements to be strived for and an improvement in patient outcomes and safety. With the North West ICBs more mature than 12 months ago this will enable more collaborative and ambitious programmes of work to better support the population of the North West, reduce variation of patient outcomes and develop a more collaborative and patient centred NHS system.

The SPTB and North West ICBs will continue to support NWAS with this by driving forward NWAS' 4 Improvement Priorities of:

- Reducing Conveyance to Hospital.

- Improving Hospital turnaround for ambulances waiting to handover their patient.
- Managing Demand.
- Developing a Single Point of Access for NWAS clinicians to access to support their patient's need.

Commissioners would like to thank NWAS and all their staff for the hard work undertaken during this extremely challenging period and the support they have given to the population of the North West, outlined well in this Quality Account.

Statement from the Lancashire County Council Health Scrutiny Committee.

The Lancashire County Council Health Scrutiny function welcomed the detail included in the Quality Accounts report on the examples of the challenges faced in 23/24 and how improvements had been made.

The range of information that the trust is required to reference in this report in line with NHS England guidance was acknowledged, and members noted the challenges in producing a report accessible to both professionals and the public. The Quality Account is well presented and reflects the requirements to benchmark against peers.

In relation to the detail contained in the report, the Committee expressed a view that consideration could be given to producing a separate summary document of the report, or precises included within the body of the report, with a particular focus on those sections providing a wide-ranging level of information.

However, overall members felt that the report was well set out with a good balance of information. The trust should be commended in providing a very comprehensive report which was felt to be an honest reflection of the challenges faced.

The Lancashire Health Scrutiny function welcomed the opportunity to comment on the North West Ambulance Service NHS Trust Quality Accounts for 23/24 and would welcome early involvement with the planning process to produce the Trust's 24/25 Quality Account.

Statement from a North West Ambulance Service Patient, Public Panel member.

It is a very thorough and detailed overview of the extent and complexity of the work undertaken by NWAS. I think that the community commitment and engagement in patient experience, safety and clinical effectiveness comes across strongly throughout the various sections of the account. Other priority areas I wished to see are already in the account including evaluation, training and research. Quality improvement is clearly demonstrated in the vision and work by NWAS. Excellent overall account reflecting the highly professional and caring work by NWAS which I enjoyed reading immensely thank you for sharing.

Appendices

Glossary of terms

AACE. The Association of Ambulance Chief Executives provides ambulance services with a central organisation that supports, coordinates and implements nationally agreed policy.

Advanced Paramedics (APs). Advanced paramedics offer a high level of clinical skills and leadership. They co-ordinate and provide clinical advice for some of the more complex incidents we attend, whilst also being responsible for a team of senior paramedics.

ARP. Ambulance Response Programme: In 2017, following the largest clinical ambulance trials in the world, NHS England implemented new ambulance standards across the country. This was to ensure the sickest patients get the fastest response and that all patients get the right response first time.

BAF. Board assurance framework is used to record and report an organisational key strategic objectives, risks, controls and assurances to the board.

C1. Category 1: An immediate response to a life-threatening condition, such as cardiac or respiratory arrest. Response time to 90% of all incidents is 15 minutes.

C2. Category 2: A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport. Response time to 90% of all incidents is 40 minutes.

C3. Category 3: An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting. Response time to 90% of all incidents is two hours.

C4. Category 4: A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic. Response time to 90% of all incidents is three hours.

Cardiac arrest. A medical condition wherein the heart stops beating effectively, requiring CPR and sometimes requiring defibrillation.

CEO. Chief executive officer.

CHUB. The clinical hub is a department within our emergency operations centres that is a multidisciplinary team including clinicians, dispatchers, navigators and managers.

Cleric. Ambulance software solution.

Community first responder (CFR). A member of the public who volunteers to provide an immediate response and first aid to patients requesting ambulance assistance.

CCA. Civil Contingencies Act, 2004 requires NHS organisations and providers of NHS-funded care, to show that they can deal with a wide range of incidents and emergencies that could affect health or patient care while maintaining services.

CIH. Complex Incident Hub.

CPR. Cardiopulmonary resuscitation.

CQC. Care Quality Commission is the independent regulator of all health and social care services in England.

CQUIN. The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.

CSTF. NHS core skills training framework which sets out NHS England training approach to statutory and mandatory educational topics.

Datix Cloud IQ (DCIQ). Datix Cloud IQ is a profound shift in focus for a healthcare risk management application, moving beyond the simple capture and review of data on adverse outcomes towards a managed process of exposing and resolving the issues that lead to those outcomes.

Defibrillator (also AED). Medical equipment to provide an electric shock to a patient's heart which is not functioning properly.

Directory of Services (DoS). A central directory that is integrated with NHS Pathways and is automatically accessed if the patient does not require an ambulance or by any attending clinician in the urgent and emergency care services.

DSPT. The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

Duty of Candour. Every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

ECG. Electrocardiogram (ECG) is a simple test used to check a heart's rhythm and electrical activity.

ED. The Emergency Department is for serious injuries and life-threatening emergencies.

EMT. The purpose of the emergency medical technician role is to assist in the delivery of high-quality and effective pre-hospital clinical care, responding to 999 emergencies, inter-hospital transfers and urgent hospital admissions.

EOC. Emergency Operational Control receives and responds to 999 calls and other calls for ambulance service assistance.

EPR. Electronic patient record is a periodic health care record of a single individual, provided mainly by one healthcare organisation.

EPS. Enhanced priority service is a service for PTS patients receiving renal dialysis or cancer treatment.

ESR. Electronic Staff Record is a payroll database system commissioned by the Department of Health and Social Care that NHS organisations are entitled to use.

FAST. A simple test for the presence of a stroke – face, arms, speech, time.

FFT. The NHS Friends and Family Test is to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give your views after receiving NHS care or treatment.

Fit testing. Face fit testing is required for employees wearing tight-fighting respirators to ensure individual fit and good seal between face and respirator.

FTSU. Freedom to Speak Up (FTSU) is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon. Speaking up is about anything that gets in the way of providing good care.

HALO module. Hospital Arrival Screens (HAS) are used to show what time an ambulance arrives at hospital, what time a patient handover occurs and what time a vehicle is cleared to attend another job. Since October 2022, Hospital Arrival Screens have a new capability to capture when patient delays occur via the HALO module.

Hear and treat. An incident when a person does not require an ambulance, but a clinician is able to provide treatment and advice over the phone.

HSE. Health and Safety Executive is a regulatory body to ensure safe working practices are adhered to.

HSJ. Health Service Journal is a news service that covers policy and management in the National Health Service in England.

ICB. Each Integrated Care System (ICS) will have an Integrated Care Board (ICB), a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS.

ICC. Integrated Contact Centres. Our 111, 999, Patient Transport Service (PTS) and Clinical Hub call-handling services have been brought together as one integrated contact centre.

ICS. Integrated care systems are partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

IPC. Infection prevention and control.

JRCALC. Joint Royal Colleges Ambulance Liaison Committees role is to provide robust clinical speciality advice to ambulance services within the UK and it publishes regularly updated clinical guidelines.

LD&A. Learning Disability & Autism.

LfD. Learning from deaths process sets out the practices used within our service to review and learn from the deaths of patients who had been under our care. The Clinical Audit team and senior clinicians lead the process. This learning ensures we can protect future patients from avoidable harm, reduce unwarranted variation and provide truly patient-centred care.

MBRRACE-UK. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries collaboration. MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP) which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths.

MHRV. Mental Health Response Vehicles are a new, first-line response service to attend patients presenting via 999 or 111 using a new national specification of Mental Health Vehicle, to patients who are requiring an ambulance response, where the primary complaint is a mental health concern.

NACQI/ACQI/AQI. National Ambulance Clinical Quality Indicator.

NEWS. National Early Warning Score is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

NHS England. NHS England leads the National Health Service (NHS) in England.

NHS Pathways. NHS Pathways is a clinical tool used for assessing, triaging and directing the public to urgent and emergency care services.

NIHR Applied Research Collaborations. The National Institute for Health Research (NIHR) is the nation's largest funder of health and care research and provides the people, facilities and technology that enables research to thrive. NIHR Applied Research Collaborations (ARCs) support applied health and care research that responds to and meets, the needs of local populations and local health and care systems.

NIHR CRN. National Institute for Health Research Clinical Research Network (CRN) supports patients, the public and health and care organisations across England to participate in high-quality research, thereby advancing knowledge and improving care. The CRN is comprised of 15 local clinical research networks and 30 specialties who coordinate and support the delivery of high-quality research both by geography and therapy area. National leadership and coordination are provided through the CRN Coordinating Centre.

NWAS. North West Ambulance Service NHS Trust.

PACCS. Pathways advanced clinical consultation software.

PSIRF. The Patient Safety Incident Response Framework outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted.

Paramedic. A state registered ambulance healthcare professional.

PCN. Primary care networks are groups of practices working together to focus local patient care.

PDSA cycles. The Plan-Do-Study-Act cycle is shorthand for testing a change i.e., by planning it, trying it, observing the results and acting on what is learned. This is the scientific method, used for action-oriented learning.

PGD. Patient Group Directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber.

PES. Paramedic Emergency Service responds to 999 emergency ambulance calls.

Power BI. Power BI is a collection of software services, apps and connectors that work together to turn your unrelated sources of data into coherent, visually immersive and interactive insights.

PPP. Our Patient and Public Panel consists of volunteers who live in the north west of England and are involved in public and patient engagement activities e.g. responding to

surveys, giving feedback on publications, focus groups activities, attending committees or formal meetings.

PTS. Patient Transport Service is a non-emergency transport service that provides for hospital transfers, discharges and outpatients appointments for those patients unable to make their own travel arrangements.

QAV. Quality assurance visits. The purpose of QAVs is to provide our assurance about the quality and safety of operational premises, vehicles and services and provide internal second line assurance and information in relation to key lines of enquiry from the Care Quality Commission.

QI. The term 'quality improvement' refers to the systematic use of methods and tools to try to continuously improve quality of care and outcomes for patients. There are a range of different methods and tools, such as Lean, Six Sigma and the Institute for Healthcare Improvement's Model for Improvement.

RCF. Research capability funding.

RIDDOR. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

ROSC. Return of Spontaneous Circulation.

SafeCheck. SafeCheck is an electronic database which was originally designed to replace paper process checks e.g., vehicle, equipment and medicine check book. SafeCheck is now used to capture routine audit work e.g., infection prevention and control.

See and convey ED. Any patient conveyed to a consultant-led Emergency Department (or if department is not specified) including stroke/PPCI units.

See and convey non-ED. Any incident with any patient conveyed to any facility other than an ED, including urgent treatment centres, minor injuries units, walk in centres, emergency, medical, or surgical assessment units, same day emergency care, hospital to hospice.

See and treat. An incident with face-to-face response, but no patient conveyed including patient refusal, deceased, or not found, ambulance staff arranged an alternative appointment or follow up visit, or ambulance staff attended and gave clinical advice.

SharePoint. SharePoint is a digital platform that enables document sharing and news updates.

Single Assessment Framework. The Care Quality Commission (CQC) has introduced a new way of assessing health and social care services in England, known as the Single Assessment Framework (SAF).

SJR. Structured judgement reviews are a methodology used for investigations.

SMART programme. Our internal digital and quality improvement programme.

SPTLs. Senior paramedic team leader working as part of a crew or as a solo responder to attend urgent and critical emergency situations in a variety of environments. They use advanced clinical skills and manage a clinical team.

Statistical process control. An analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

StEIS. Strategic Executive Information System.

STEMI. ST elevation myocardial infarction is a life-threatening heart attack.

Stroke. Blockage or bleeding of the blood vessels in the brain that can lead to death or disability.

UEC. Urgent and Emergency Care (UEC) services perform a critical role in keeping the population healthy.

Urgent Care Service. Part of the paramedic emergency service which provides responses to lower acuity calls.

Utstein. Cardiac arrest and CPR outcome reporting process.

Research publications 23/24

The following research publications were either authored or co-authored by our staff (in bold) during the financial year 23/24:

1. Aldhamy, H., Maniatopoulos, G., McCune, V. L., **Mansi, I.,** Althaqafy, M., & Pearce, M. S. (2023). Knowledge, attitude and practice of infection prevention and control precautions among laboratory staff: a mixed-methods systematic review. Antimicrobial resistance and infection control. *Journal of Paramedic Practice* [online], 12(1), p.57. Available at: https://doi.org/https://dx.doi.org/10.1186/s13756-023-01257-5

2. Aldhamy, H., Maniatopoulos, G., McCune, V. L., **Mansi, I**., Althaqafy, M., & Pearce, M. S. (2023). Knowledge, attitude and practice of infection prevention and control precautions among laboratory staff: a mixed-methods systematic review. Antimicrobial resistance and infection control. *Journal of epidemiology and community health*, 77(Supplement 1), A106 [online]. Available at: https://dx.doi.org/10.1136/jech-2023-SSMabstracts.220

3. Alghamdi, A., Hann, M., Carlton, E., Cooper, J. G., Cook, E., Foulkes, A., Siriwardena, A. N., Phillips, J., Thompson, A., **Bell, S**., Kirby, K., Rosser, A., & Body, R. (2023). Diagnostic accuracy of clinical pathways for suspected acute myocardial infarction in the out-of-hospital environment. *Annals of emergency medicine* [online], 82(4), pp.439-448. Available at: https://dx.doi.org/10.1016/j.annemergmed.2023.04.010

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5. Alotaibi, A., Alghamdi, A., Martin, G. P., Carlton, E., Cooper, J. G., Cook, E., Siriwardena, A. N., Phillips, J., Thompson, A., **Bell, S.**, Kirby, K. L., Rosser, A., **Pennington, E**., & Body, R. (2023). External validation of the Manchester acute coronary syndromes ECG risk model within a pre-hospital setting. *Emergency medicine journal: EMJ* [online], 40(6), pp.431-436. Available at: https://doi.org/10.1136/emermed-2022-212872

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7. Alqurashi, N., **Bell, S.**, Wibberley, C., Lecky, F., & Body, R. (2023). A qualitative study to explore current challenges and future opportunities relating to the prehospital triage of patients with traumatic brain injury. *Emergency Medicine Journal* [online], 40 (Supplement 1), A8. Available at: https://dx.doi.org/10.1136/emermed-2023-999.18

8. Ashton, C., **Mayoh, D**., & Jones, A. (2023). Does the patient's presenting condition influence the timeliness of stroke care in the pre-hospital setting. *International Journal of Stroke* [online], 18(1 Supplement), p.43. https://dx.doi.org/10.1177/17474930221142512

9. Barrett, J.W., Eastley, K.B., Herbland, A., Owen, P., 4 ; Naeem, S., Mortimer, C., King, J., Foster, T., Rees, N., Rosser, A., Black, S., Bell, F., Fothergill, R., Mellett-Smith, A., Jackson, M. ; McClelland, G., Gowens, P., Spaight, R., **Igbodo, S.,** Brown, M., Williams, J.(2024). British Paramedic Journal [online], 8(4), pp.10-20. Available at: https://doi.org/10.29045/14784726.2024.3.8.4.10

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11. **Bell, S., Pennington, E.,** & Hill, J. E. (2023). Video vs direct laryngoscopy for adults undergoing endotracheal intubation. *Journal of Paramedic Practice* [online], 15(6), pp.255-259. Available at: https://dx.doi.org/10.12968/jpar.2023.15.6.255

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Contact details

If you have any questions or concerns after reading this report, please contact us via e-mail: nwasquality.accountfeedback@nwas.nhs.uk

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