North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 27 January 2021
9.45 am - 12:45 pm
via Microsoft Teams

AGENDA

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INTRODUCTION					
BOD/2021/114	Apologies for Absence	09:45	Information	Chairman	
BOD/2021/115	Declarations of Interest	09:45	Decision	Chairman	
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BOD/2021/117	Board Action Log	09:50	Assurance	Chairman	29 - 30
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BOD/2021/119	Register of Interest	10:00	Assurance	Chairman	33 - 34
STRATEGY					
BOD/2021/120	Chairman & Non-Executive Directors Update	10:00	Information	Chairman	
BOD/2021/121	Chief Executive's Report	10:05	Assurance	Chief Executive Officer	35 - 46
BOD/2021/122	Northern Ambulance Alliance Progress Report	10:15	For Discussion	Chief Executive Officer	47 - 52
GOVERNANCE AND RISK MANAGEMENT					
BOD/2021/123	Board Assurance Framework & Corporate Risk Register Q3 2020/21	10:20	Decision	Director of Corporate Affairs	53 - 100
BOD/2021/124	Corporate Calendar 2021/22	10:30	Decision	Director of Corporate Affairs	101 - 104
BOD/2021/125	Risk Management Policy 2021/22	10:40	Decision	Director of Corporate Affairs	105 - 138
BOD/2021/126	Anti-Fraud, Bribery and Corruption Policy	10:50	Decision	Director of Finance	139 - 164
BOD/2021/127	Audit Committee Chairs Assurance Report - from the meeting held on 15th January 2021	11:00	Assurance	Mr D Rawsthorn, Non-Executive Director	165 - 168
QUALITY AND PERFORMANCE					
BOD/2021/128	Integrated Performance Report	11:10	Assurance	Director of Quality, Innovation and Improvement	169 - 224
BOD/2021/129	IPC BAF Refresh	11:30	Assurance	Director of Quality, Innovation and Improvement	225 - 236
BOD/2021/130	Complaints, Incidents and Investigations Policy	11:40	Decision	Director of Quality, Innovation and Improvement	237 - 260
BOD/2021/131	Quality and Performance Committee Chairs Assurance Report - from the meeting held on 18th January 2021	11:50	Assurance	Prof A Chambers, Non-Executive Director	261 - 266

BOD/2021/132	Resources Committee Chairs Assurance Report - from the meeting held on 22nd January 2021	12:00	Assurance	Mr M O'Connor, Non-Executive Director	267 - 272
WORKFORCE					
BOD/2021/133	Workforce Governance Structure	12:10	Decision	Director of People	273 - 290
BOD/2021/134	Equality, Diversity and Inclusion Report	12:20	For Discussion	Director of People	291 - 304
BOD/2021/135	Organisational Values: Implementation Plan	12:30	Assurance	Director of People	305 - 316
CLOSING					
BOD/2021/136	Any Other Business Notified Prior to the Meeting	12:40	Decision	Chairman	
BOD/2021/137	Items for Inclusion on the BAF	12:45	Decision	Chairman	

Date and Time of Next Meeting: 9.45 am Wednesday, 31 March 2021 via Microsoft Teams

NHS North West Ambulance Service NHS Trust

Minutes
Board of Directors

Details: Wednesday 25th November 2020, 9.45am
Microsoft Teams

Present:

Mr P White	Chairman
Prof A Chambers	Non-Executive Director
Mr S Desai	Director of Strategy & Planning
Mr M Forrest	Deputy Chief Executive
Mr G Blezard	Director of Operations
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director
Mr D Mochrie	Chief Executive
Mr M O'Connor	Non-Executive Director
Prof M Power	Director of Quality, Innovation and Improvement
Mr D Rawsthorn	Non-Executive Director
Prof R Thomson	Associate Non-Executive Director (Clinical)
Ms L Ward	Director of People
Ms A Wetton	Director of Corporate Affairs
Mc C Wade	Associate Non-Executive Director (Digital)
Ms C Wood	Director of Finance

In attendance:

Ms R Foot	Freedom to Speak Up (FTSU) Guardian
Mrs P Harder	Head of Corporate Affairs
Ms D Earnshaw	Corporate Governance & Assurance Manager (Minutes)

Minute Ref:

BOD/2021/73 Patient Story

The Director of Strategy and Planning presented the patient story to the Board of Directors and advised the story focused on a laryngectomy patient, their experience of the emergency service and the lessons learnt by the Trust following the 999 response. He presented a short film that included narrative spoken on behalf of the patient and described the incident and the response by the service. The patient acknowledged that if her husband had not have been present to explain her condition, it could have been a completely different outcome.

The film went on to outline the lessons learnt and improvements made by the Trust, which included the use of medical ID bracelets and car stickers to identify neck-breathing patients. The service placed a marker against the patient's address on the NWAS call system to ensure the crew had the relevant equipment and encouraged patient use of the emergency SMS service.

The Director of Strategy and Planning stated that the Trust had improved their learning of patients with a laryngectomy through patient engagement with laryngectomy groups and had produced an e-learning module for staff.

The Medical Director confirmed the Trust had added algorithms and protocols on the held devices to ensure that staff could deliver the relevant 24/7 care.

Prof R Thompson queried how monitoring of quality information from vulnerable and minority groups was taken by call takers during calls. The Medical Director confirmed the service operated across a wide range of diverse communities and explained protocols were in place that would be triggered if the call taker could not understand the caller at the first stage of triage. He added that in these cases the patient would receive a high category of response.

The Director of Operations advised the default position would involve a clinician providing an oversight of the call and where possible, make an assessment. If this was not possible, the patient received the high response of Category 1 or 2. He added the call system recorded calls to replay and decipher information when necessary.

Prof A Chambers queried how NWAS reached other support and educational forums. The Director of Strategic Planning advised that the Patient and Public Panel were involved in identifying external groups. He said the Panel acted as a critical friend to the Trust and worked to establish communications with outside groups and the service. He confirmed that following the case of the patient story there was a commitment to continue work with wider groups in the future.

The Board:

- Welcomed the Patient Story and thanked all involved.
- Commended the contribution of PPP member's involvement with the Trust.

BOD/2021/74 Apologies for Absence

Apologies from Mr M O Connor, Non-Executive Director who would be joining the meeting later.

B0D/2021/75 Declarations of Interest

There were no declarations of interest to note.

BOD/2021/76 Minutes of Previous Meeting held on 30th September 2020

The minutes of the previous meeting held on 30th September 2020 were agreed as a true and accurate record.

BOD/2021/77 Action Log

The Board of Directors noted the action and update.

BOD/2021/78 Committee Attendance

Mr D Rawsthorn noted his attendance at the last Board of Directors meeting and confirmed his attendance for the meeting. It was noted Mr R Groome had given apologies for the meeting.

The Chief Executive commended the Non-Executive and Executive members for their attendance at committee meetings and maintaining quoracy to allow decision making throughout the Covid-19 period.

The Board –

- Noted the amendment to the Board and Committee Attendance Record.

BOD/2021/79 Register of Interest

The Board noted the 2020/21 register of interest presented for information and agreed it was a true and accurate record.

BOD/2021/80 Chairman and Non-Executive Directors Update

The Chairman acknowledged that regional and national meetings with Chairs and CEOs across the ambulance services had continued. He reported recent communications with NHSE/I had involved a great deal of discussion on the preparation and administration of the Covid-19 vaccination. He noted that the forthcoming removal of lock down restrictions would have an impact on infection rates across the North West over the Christmas period and add to winter pressures.

He noted that the key focus for the Board is to deliver the best service possible despite the command and control situation to ensure patients were safe and received quality services.

The Board:

- Noted the update from the Chairman.

BOD/2021/81 Chief Executive's Report

The Chief Executive presented a report that provided information on a number of areas since the last report to the Trust Board on 30th September 2020. The report covered (i) Performance, (ii) issues to note, and (iii) general updates. He reported on the key highlights in the report.

In terms of performance, he advised the current operational environment was exceptionally challenging and thanked the Executive Team and Senior Leadership team for their continued hard work.

He stated that following the achievements in 999 response time standards during the summer months, the Covid-19 Wave 2 demands had been exceptionally challenging for 999 and NHS 111 across the North. In response to recent pressure, the Trust had implemented a number of key plans to ensure the service was fully prepared to respond to current demand and into the winter months and s2 of the report provided detail of the actions taken by the Trust.

He stated that the impact of the plans and additional resources had been realised with the Trust aiming to deploy 400 plus ambulances leading into the festive period, which had been approximately 100 more than planned.

The Chief Executive highlighted that Patient Transport Services (PTS) had changed in profile in response to Covid-19 demand and had contributed significantly in supporting 999. In addition, he advised that third party providers had been deployed in line with the Trust's governance arrangements.

He reported that the Trust had seen a number of outbreaks across the organisation with more staff testing positive and the requirement for staff to self-isolate. However, since the approval of the trust's IPC Board Assurance Framework in September there had been significant work on the infrastructure for staff testing for Covid-19, to

provide a timely test, track and trace service for staff, which complimented the national test, track and trace process.

He referred to the Integrated Performance Report that provided detail of Covid-19 rates and added that infection rates continued to be monitored. He advised that the Director of Infection Prevention and Control had been working closely with regulators who, at the Trust's request, provided additional scrutiny via a number of onsite visits. Assurance would be provided to Quality and Performance Committee in January 2021, together with the updated IPC BAF action plan.

The Chief Executive referred to NHS 111 First and explained that the service had not just focused on the initial telephone triage but about other parts of the system to enable alternative pathways such as their own GP, pharmacy or a walk-in centre

He commented that the trust had played a lead role across the North and all areas across the country would be live by 1 December 2020. The trust's first mover sites were Blackpool and Warrington, followed by part of East Lancashire, Bolton and Salford. He added that feedback from Blackpool and Warrington patients had so far been positive and advised as winter gets closer and the effects of the virus continue to be felt, it is important NWAS monitor demand on a regular basis and increase staffing levels at pace. He thanked Jackie Bell, Head of Service for 111 and her team for the excellent progress made, including a Facebook Live session regarding 111 First to raise awareness across the Trust and to answer any questions.

The Chief Executive advised the trust had declared a major incident on the 2nd November 2020 due to the significant high demand, patients waiting and system pressures across the region. He added that within an 8-hour period the trust received 2,266 emergency calls, an increase of 36% on the same time the week previous and had been necessary in order to prevent harm to patients.

In addition to the increase in calls, the Trust saw a significant increase in delays at hospital handover, particularly within Greater Manchester, which affected the trust's ability to respond to patients waiting in the community. By declaring a major incident, the service were able to put in place additional measures and were able to stand down the major incident within 3 hours. He reported a full review would be undertaken to look at the root cause and lessons learned as expected following a Major Incident. He thanked everyone who helped to manage the incident, on behalf of the Board of Directors.

He stated that the Trust continued to participate in the MEN Arena Inquiry and prepare the organisation for giving evidence in the New Year.

He advised the Trust had held their first virtual AGM event, which had been a success and included 70 members of the public and a number of members of the Patient and Public Panel (PPP). He added he was pleased to observe the PPP represented at the Board meeting and recognised the first anniversary of the panel and the encouraging level of current members.

He confirmed that the Trust continued to offer flu vaccinations and that Covid-19 lateral flow testing had been implemented for patient facing staff. He advised he was sad to report a number of assaults on the trust's staff and that work was ongoing with staff and police. He also reported that NWAS had been the first ambulance trust to receive Veteran Aware accreditation in the UK.

Dr D Hanley referred to the Major incident and queried whether the lessons learnt would come back to a future Board meeting. The Chief Executive confirmed a lesson learnt paper was being prepared and presented to an extra-ordinary meeting of the board on 16th December 2020.

The Chief Executive added that it had been admirable that the NWAS team had carried on with business as usual, in addition to responding to Covid-19 pressure to keep track on a number of key strategies and strategic priorities.

At this point in the meeting, the Director of Strategy and Planning referred to questions raised by the Public and Patient Panel as follows:

I understand that NWAS is currently trying to recruit up to 350 new staff, and to acquire additional vehicles, to meet the increased demands of Covid-19 and the Winter. Will planned Finances be able to support and sustain the higher staffing and fleet levels, when we finally return to a state of more routine operations?

The Director of Operations advised that the Trust had an independent review of its demand and capacity. The review has indicated that an uplift in resources is required in order to meet performance standards. Normally the trust would enter into discussions with the lead commissioning team to identify funding to support the increase. This is different due to the pressures of COVID 19. The funding process going forward is unclear at this time but the Trust are looking at ways it can increase its resources through various work streams.

The Chairman congratulated the teams for all their hard work. He particularly noted the achievement of the NHS 111 First project, for implementation during the pandemic, which had been an extra challenge. He added that the Trust continued to adopt a zero tolerance approach to assaults on staff and it was important to ensure support for staff throughout the process.

The Board:

- Received and noted the contents of the Chief Executive's report.

BOD/2021/82 Northern Ambulance Alliance Update

The Chief Executive provided an overview of progress against the key work streams being progressed by the Northern Ambulance Alliance (NAA) and highlighted the key achievements and progress against work streams.

He acknowledged that Covid-19 had slowed down some of the work streams due to key staff abstractions however there had been significant progress made in other areas and referred to Appendix 1 of the report, which detailed progress against plan. He reported that the four Chief Executives of the Alliance had met to reset the work plan as they entered the winter period.

The Chairman added that he had attended calls with the NAA and acknowledged the need to balance Covid-19 pressures with support for work locally. He referred to the recommendations in the Chief Executive's report, which outlined the need to recognise the risks identified by the NAA and support appropriate mitigations. He queried whether this had been an action for the NAA rather than the NWAS Board. The Chief Executive clarified that the action related to the NAA and was for information to the NWAS Board.

The Board:

- Noted the content of the report, the current position and plans for the NAA work streams.

BOD/2021/83 Estates Strategy 2018-2023 Review

The Director of Finance presented a report that detailed recommended changes following a review of the Trust's 5 year Estate Strategy (2018-2023). She referred to the recommendations of the review, to assess the impact and lessons learnt from experiences of operating an estate in a Covid-19 environment and had been supported by the Executive Leadership Committee and Resources Committee, prior to the Board meeting. She advised the review had not been a scheduled review of the strategy but a reaction to Covid-19 and new NHS plans the People Plan and Net Zero NHS.

She advised the recommendations had not affected the overall strategic aims of the 5-year strategy and clear deliverables including the green agenda would be included in the formal review of the Strategy in 2021/22.

Mr R Groome suggested green agenda deliverables be included in the strategy review next year. The Director of Finance confirmed there would be a complete review of the Strategy in line with other strategic plans next year.

The Chief Executive referred to the backlog maintenance and noted the recognition for the NHS and Trust to work within the capital resource limit and that the team would have to prioritise against health and safety requirements which were the must do actions. From an assurance perspective, the Director of Finance added the Board now had visibility of the high and moderate risks and confirmed the backlog maintenance plan were risk based in order to focus the limited financial resource.

Prof A Chambers suggested partnership working with education providers, with regard to location and training and education facilities to consider reducing the risk and enhance estate facilities through partnerships.

Dr D Hanley referred to the hub, spoke model for future estate planning, and suggested that work should involve assessing methods for staff engagement and channels for peer support as part of the process.

The Chairman noted that reports reflected a moment in time and that the level of funding was a challenge. He acknowledged the review had not been a re-write of the Strategy and was pleased to see consideration to the green agenda when the full review was undertaken next year.

The Board of Directors:

- Approved the changes to the Estates Strategy 2018-2023.

BOD/2021/84 Procurement Strategy 2020/21-2024/25

The Director of Finance presented the Trust's Procurement Strategy for 2020/21 to 2024/25. She reported the Strategy identified some of the key achievements from the previous three strategies and included details for frequent reporting to Trust committees, procurement staff development and Trust Cost Improvement Plan (CIP) support.

She advised that the procurement strategy would provide the framework to ensure that procurement supported the delivery of the Trust objectives, during the five-year period and the strategy would evolve as the national procurement landscape develops.

She added that the scope of expenditure covered by the strategy incorporated all non-pay revenue and capital expenditure areas and the non-pay expenditure in the Trust is circa £96m (revenue and capital). She noted the procurement strategy would support the Trust's key strategies and values.

Mr D Rawsthorn referred to the Brexit outcome and confirmed that following discussion at Resources Committee it had been confirmed that whatever the outcome of Brexit the contracting regulations for NHS Trusts were expected to remain the same. He said the Committee had welcomed the Strategy following a comprehensive review of the procurement function by the procurement team.

The Chairman noted his thanks to the procurement team and added that the current climate of the pandemic had highlighted more than ever the need for due diligence and maintaining governance through decision-making processes.

The Board:

- Approved the Procurement Strategy for 2020/21-2024/25.

BOD/2021/85 Board Assurance Framework and Corporate Risk Register Q2 2020/21

The Director of Corporate Affairs presented the Q2 review of the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR). She advised the report was a retrospective view and confirmed the BAF risks are reviewed at Board Committee meetings, which provides the opportunity to identify where assurances support potential mitigation of risks. In support of this process, the Head of Risk and Assurance had collated assurance information throughout the quarter onto the Assurance Map.

She reported that a review of the CRR takes place monthly at the Executive Leadership Committee (ELC) to ensure risks were actively managed. The CRR was included in Appendix 1 of the report and the proposed Q2 position of the BAF with the associated CRR risks scored ≥15 were detailed in Appendix 2. The BAF Heat Maps for 2020/21, year to date, were included in the report at Appendix 3.

She reported that as part of the Q2 review, the proposed changes were as follows:

- SR02: reduction of risk score from 25 to a 20
- SR03: reduction of risk score from 25 to a 20
- SR06: increase of risk score from 8 to a 12
- SR10: re-instigation of the Brexit strategic risk from the 2019/20 BAF.

The Director of Corporate Affairs confirmed the report was based on end of Q2 data and performance reported at 30th September 2020 and acknowledged that assurance against the BAF had progressed which would be incorporated into the Q3 review.

In terms of the Corporate Risk Register, she highlighted there were 19 risks, which were detailed within Appendix 1 and were reviewed on a monthly basis by the Executive Leadership Committee.

The Chairman acknowledged that assurance is continuous within the Trust and the quarterly reporting periods allowed for presentation of the risk position to the trust's assurance committees. He thanked the Director of Corporate Affairs and the Head of Risk Assurance for their hard work and added he had received excellent feedback on the NWAS Board Assurance Framework from external partners.

The Board -

- Agreed the decrease in risk score for SR02 from 25 to 20
- Agreed the decrease in risk score for SR03 from 25 to 20
- Agreed the increase in risk score for SR06 from 8 to12
- Agreed the re-instigation of the Brexit strategic risk (SR10) from the 2019/20 BAF
- Agreed the Q2 position of the Board Assurance Framework.

BOD/2021/86 Risk Management Strategy 2020-23

The Director of Corporate Affairs presented the Trust's Risk Management Strategy and advised the Strategy enabled the achievement of good risk management and risk assurance reporting and considered other relevant organisational supporting strategies. She referred to the purpose and aims of the strategy outlined within s3 and the five objectives of the strategy detailed in s4 of the report.

The Director of Corporate Affairs advised a new risk management policy would be presented to the Board of Directors in January 2021 and would support the strategy. She advised that through increasing the use of risk data via the safety management system DATIX, enhancing knowledge of staff and using the triangulation of the data would strengthen the process of operational risk assurance through to Board level.

Mr D Rawsthorn, supported the Strategy and added it had been a clear, simple and solid approach to risk management. The Chairman confirmed the strategy provided a process for capturing frontline operational risks and a process for reporting these to the Board.

The Medical Director referred to objective 4 and noted this was relevant for the frontline operational teams and ensured clinical governance was a routine part of practice with the link back to the Board.

The Chief Executive added the Executive Leadership Committee was committed to embedding the management of risk from operations to Board level.

The Board:

- Approved the Trust's Risk Management Strategy.

BOD/2021/87 Audit Committee Chair's Assurance Report from meeting held on 23rd October 2020

Mr D Rawsthorn presented the Chairs Assurance Report from the Audit Committee meeting held on 23rd October 2020. He reported there had been clinical governance assurance from the trust's Medical Director who had attended Audit Committee.

The Chairman welcomed the good progress of the Audit Committee.

The Board:

- Noted the content of the Audit Committee Chair's Assurance Report from 23rd October 2020.

BOD/2021/88 Common Seal Bi-annual report 2020/21

The Director of Corporate Affairs presented the Common Seal report to the Board of Directors and reported the

use of the Common Seal is determined by Section 8 of the Trust's Standing Orders, where Clause 8.4 of Section 8 requires the occasions of use to be reported to the Board on a bi-annual basis, with the previous report received by the Board on 27 May 2020.

She advised that during the period 1 April 2020 – 30 September 2020, the Trust's Common Seal had been applied on 5 occasions for leases or property transactions and these were detailed in s2 of the report.

The Board:

- Noted the occasions of use of the Common Seal as detailed in s2 of the report.
- Noted compliance with s8 of the Standing Orders.

BOD/2021/89 Charitable Funds Committee Chairs Assurance Report from the meeting held on 28th October 2020

Mr D Rawsthorn presented the Chairs Assurance Report to the Board and advised that a revised Charitable Funds Strategy for 2020/22 would be presented at the next Trust Board meeting.

He added that the Strategy was a holding strategy and highlighted the requirement for the Board to decide on the future of the Charity. The Chairman supported the development of the strategy to define the vision for clear direction in the future.

- Noted the assurance provided in the Charitable Funds Committee Assurance report.

BOD/20201/90 Freedom to Speak Up Guardian Assurance Report Q2 2020-21

The Director of Corporate Affairs introduced the Freedom to Speak Up (FTSU) Guardian to present the Q2 update to the Board of Directors. She added that the role of the Trust Board in relation to FTSU is key and it is the expectation of the National Guardian's Office (NGO), CQC and NHS Improvement that senior leaders are knowledgeable on FTSU matters and work in partnership with the Freedom to Speak Up Guardian (FTSUG) to shape the speaking up culture.

The FTSU Guardian reported 51 concerns during the reporting period with attitudes and behaviours being the most common cause of concern. She advised that during October, 18 FTSU champions were recruited across the service lines with virtual training delivered, despite challenges with Covid-19 restrictions.

She confirmed that all concerns had been fully engaged and there had 41 cases closed with learning and outcomes identified.

The Director of People noted the report was a positive indication of improvement around the management of processes and learning. She noted the ability to reflect on the triangulation had been helpful process to share with senior leaders. She added the Just Culture principles previously reported to Board had involved a fundamental review, which identified the experiences of staff. As a result of the Just Culture audit, work had been undertaken around leadership and culture with a set of actions arising, for inclusion in the organisation's values refresh work, which would be presented for discussion to the Board of Directors meeting in December for formal sign off in January 2021. The Director of People also confirmed that the Treat Me Right campaign launch in Q4 aimed to reset expectations around behaviour in the work place, in response to issues identified through FTSU.

The Director of People reported there had been a delay in the review of the trust's disciplinary policy due to current pressures; however, staff welfare was embedded in the revision of the policy.

The Chief Executive thanked the Freedom to Speak Up Guardian and the team of guardians in their work to raise the profile of FTSU. He added the avenues for staff to raise issues should be clear with a requirement for strong leadership and listening across the trust.

Mr R Groome referred to Appendix 1 of the report and cases closed during Q2 and the level of "no" responses to the question of would you speak up again. The Freedom to Speak Up Guardian advised this mainly related to the FTSU process due to responses being untimely or not receiving the expected outcome. Dr D Hanley added the need for transparency and an assessment of manager's perceptions of the Freedom to Speak up processes. He stated these would determine the necessary triangulations of learning through the outcomes identified. The Director of Corporate Affairs confirmed that FTSU was an ongoing education process to build with Managers and agreed it would be key to promote Freedom to Speak Up as a learning tool rather than seen as an investigation process. She added there was work ongoing with Managers in supporting their own development and learning with staff.

She advised that a recent introduction of triangulation into the leadership and culture dashboard would provide a quarterly view of different areas across the Trust to share at future ELC in Q4 and assurance committees in Q1/Q2 2021/22.

Prof A Chambers noted ongoing support for staff and managing their expectations following closure of a FTSU case was important. The Director of People advised there was ongoing action to support managers through the triangulation period, including mediation.

The Chief Executive stated that learning had been challenging for the trust during the pressures of the last 12 months and added that the positive contributions through the ongoing scrutiny from Non-Executive Directors, Quality Assurance processes, FTSU champions and the Director of Corporate Affairs on National groups evidenced that the trust was making good progress.

The Chairman reminded the Board of the original principles of the strategy in relation to patient safety and incidents and asked if FTSU was the correct process for this.

The Freedom to Speak Up Guardian confirmed that there had been one patient safety concern through the FTSU process and this had been indirect. She added that FTSU feedback indicated that staff would speak up regarding a patient safety concern. She added she was confident that staff were accessing the correct operational processes to raise patient safety concerns and as such, FTSU would be the last resort.

The Chairman noted an incident relating to sexual assault in the FTSU data and requested a further briefing from the Director of People. He thanked the FTSU Guardian for her hard work and integration with other work streams to ensure a joined up approach by the Director of People and FTSU Guardian, which was critical to the process.

The Board:

- Noted the work of the Guardian.
- Noted the themes, trends, issues and learning identified in this report including a further briefing from the Director of People.
- Received assurance from the report.

BOD/2021/91 Freedom to Speak Up Strategy 2020-22

The Director of Corporate Affairs and Freedom to Speak Up Guardian presented the Trust's Freedom to Speak Up Strategy for 2020-2022 following full review and refresh.

She advised that the Strategy had a clearly defined vision, and included four objectives, (i) Staff feel confident in raising a concern and know how to raise it, who to raise it with, and what to expect after they have raised it. (ii) Staff feel safe to speak up and raise concerns, ensuring the organisation is open to receiving concerns raised by our staff. (iii) Staff have confidence in the Trust's processes and feel value in speaking up. (iv) Support the positive development of our organisational culture and ensure that we develop a healthy speaking up culture, which aligns supports and reinforces our wider work on organisational development and cultural change.

Dr D Hanley supported the strategy however felt robust processes and procedures were required to support staff raising the the concern. He added it was important to acknowledge fair treatment and support for them through the process. The Chairman supported Dr Hanley's comments and questioned whether suitable wording could be included in the FTSU procedure for consideration.

The Director of Corporate Affairs agreed to explore the options for wording to include in the Strategy and present suggestions for consideration at a future Trust Board meeting.

The Board:

- Approved the Freedom to Speak up Strategy 2020/22 in principle, pending the inclusion of further wording to be presented to a future Board of Directors meeting.

BOD/2021/92 Covid- 19 Wave 2 Command Structure

The Deputy Chief Executive presented a paper which detailed the NWAS command cell structure implemented to facilitate executive decision making in relation to Covid-19 pressures within the trust and wider health and care system. He advised that the command cell structure focused on learning from phase 1 of the virus and the original command cell created at the start of the pandemic. He added the original cell which met 5 days per week had been strengthened by the addition of an executive cell for 12 hours per day 3 days per week.

He reported that following consultation with Executive Directors and reflections from a Board survey, the proposal for wave 2 of the pandemic included a 7 cell structure with 5 of the cells reporting on a daily basis into the Covid-19 Executive Co-ordinating Group at 8.30am Monday to Friday.

The Deputy Chief Executive referred to the terms of reference whichillustrated the strategic and external structure for a collaborative approach. He added the structure allowed the Board's Assurance Committees to continue and provided a good and strong position.

Mr D Rawsthorn referred to the various governance checklists provided by the Internal Auditors which had been an assurance tool for the Audit Committee that governance had been maintained during Wave 1 of the pandemic.

The Chief Executive also advised that the Trust were part of external structures during Wave 1 with weekly meetings with NW NHSE/I and as a member of the NHSE/I Regional Leadership Group.He added that attendance at resilience meetings, detailed in the paper, ensured significant infrastructure and engagement across a variety of national and regional structures.

The Chairman confirmed the importance of the command cell structure and thanked the Executives for managing the demands of the pandemic whilst continuing to deliver key strategic projects, ensuring governance internally and with stakeholders.

The Board:

- Supported the Wave 2 Covid-19 Command Structure.

BOD/2021/93 Integrated Performance Report October 2020

The Director of Quality, Innovation and Improvement introduced the Integrated Performance Report, which included performance against Quality, Effectiveness, Finance, and organisational health during November 2020 and operational performance in October. She added three additional measures had been included to reflect the trusts strategic aims, (i) hospital handover delays (ii) the number of staff who contracted Covid-19 (iii) the locations including outbreaks.

The Director of Operations provided an update on operational performance in October. He advised that recent months had been extremely challenging for 999 and 111. He stated that call pick up performance for Patient Emergency Services was 80.1%, with average hospital turnaround of 32 minutes 32 seconds across the North West. Mean call answering had increased to 13 seconds and the reasons for this were likely to be multifactorial and include increase in call volume and increase in staff abstractions. He advised that the trust had also offered support to YAS due to a Covid-19 outbreak.

He added that the strategy to increase operational resources had commenced and involved an increased number of resources including private provider use and expanding the scope of practice to a full range of clinical scope.

The Director of Operations advised that a new patient safety plan had been implemented to manage the C2 long waits. He explained the plan involved detailed risk assessments and signposting to the appropriate services where possible.

The Chairman advised that the performance of 999 and 111 was an area of high focus for the Non-Executive Directors and they had received twice-weekly calls and attended a bi-weekly meeting.

Dr D Hanley referred to the Level 4 and 5 incidents and queried whether these were linked to the delayed performance standards.

The Medical Director advised the ROSE reviewed level 4 and 5 incidents on a weekly basis however had not translated into serious incidents. He added that when the call system surges, classically on Mondays across peak pressures, the risk to patient harm increases and triggers a regular review. He advised that the mitigations to address the risk relating to waiting calls are implemented by the critical incident desk and actively monitored by a clinical workforce that is able to support dispatches or a primary health care clinician.

He confirmed that the serious incidents figure at s3.1 in the report challenged a previous spike in calls in 2017 and this historical data enabled the team to keep a close eye on the level of serious incidents.

The Director of Quality, Innovation and Improvement reported a new metric to monitor hospital handover waits which had identified that over two months there had been an increase in the number and length of time patients were waiting outside hospital in A&E departments. She advised that this had been reported to the Quality and Performance Committee and would continue be monitored and reported to the Committee.

Prof A Chambers confirmed that the Quality and Performance Committee had held a robust discussion around patient safety and was being challenged.

Mr D Rawsthorn referred to page 292 of the report and the pilot process for managing C2 long waits in the Emergency Operating Centres (EOCs) and queried whether performance had improved. The Chief Executive reported that this and the significant additional resources to mitigate the risks related to the high level of staff abstractions supported performance, however acknowledged that the service and the region would continue to be under pressure through the winter period.

The Director of Operations reported that the 111 service had been challenged with staff abstractions due to Covid-19 and the introduction of the new Cleric system. He confirmed resources were aligned to meet demand and had involved contingency planning with service providers. He reported that the NHS 111 First service had recently recruited an additional 200 extra staff across the North West with the aim of delivering a safe service and meeting call pick up response time standards.

The Chairman stated that the Non-Executive Directors were briefed regularly on the impact of the pandemic on the 111 and emergency service and had the assurance of the trust's outbreak robust action plan. He added that the trust had worked with NHSE/I and environmental health regulators including Public Health England.

He thanked the teams for their hard work and stated it was good to see the unity between the Executive Directors in assisting the Director of Operations and keeping patient safety at the heart of what NWAS do.

He also thanked volunteers and the PTS staff for all their efforts and support.

The Board:

- Noted the content of the report.
- Supported a further scrutiny paper on the evaluation of serious incidents to Q&P Committee.

BOD/2021/94 Quality and Performance Committee Chairs Assurance Report – from the meetings held on 19th October 2020 and 16th November 2020

Prof A Chambers presented the Chairs Assurance Reports from the Quality and Performance Committee meetings held on 19th October 2020 and 16th November 2020. She highlighted that some assurance items were held at amber due to delays in data collection, including AQI Q1 data, which would be reported in Q3/Q4. She advised that this had been a timing rather than a performance issue and the outstanding reports were expected at Committee in January/February.

The Chairman expressed his thanks for the work of the Quality and Performance Committee during the current climate and stated this was an important piece of assurance work.

The Board:

- Received and noted the contents of the Chairs Assurance reports.

BOD/2021/95 Resources Committee Chairs Assurance Report – from the meeting held on 20th November 2020

Mr R Groome presented the Chairs Assurance Report from the Resources Committee meeting held on 20th November 2020. He reported that there had been a review of the Health and Safety risks to the trust's estate and the moderate and high risks were identified in the form of a 5-year plan. He advised that following discussion, the Committee recognised the need to consider managing the identified risks over a shorter term.

In response to the timescale, the Chief Executive stated that the strategic requirements relating to the capital programme had yet to be refined and future proposals would be presented to the Board.

The Chairman confirmed that the trust had future decisions to make at Board level and accepted that the welfare of staff and their working environments would form part of the discussions.

The Director of People reported an amendment to the Chair's Assurance Report.

She confirmed that the report to the Resources Committee advised that the trust had vaccinated 57% of frontline staff, which is well ahead of the same time in 2019 – by about 10%. The refusal rate is lower than last year but higher than comparators in the sector and that the combined picture at the time of the report was that we had been able to offer the vaccine to 73% of staff. She added the revised national target is 90%, which was a challenge but we are ahead of last's position.

At this point in the meeting, the Director of Strategy and Planning referred to questions raised by the Public and Patient Panel as follows:

Given Government has pledged to meet all Covid-19 related additional expenses until end-March, has NWAS considered how access to these funds for short-term Covid-19 needs, might be used at the same time to invest in systems and/or infrastructure development for the longer-term development of NWAS services?

In response, the Director of People advised the impact of Covid-19 has led to the Trust needing to respond quickly to merging needs and this has led us to consider new ways of working. The funding provided by the government has not necessarily enabled longer-term investment but it has enabled us to think differently about our approach, which should deliver longer-term benefits. For example, our use of PTS staff to support the emergency service has led to the development of an internal pre-apprenticeship programme for these staff, which will continue beyond the current crisis; technological developments have been fast tracked; additional staffing is enabling us to consider moving more quickly with organisational changes.

The Board:

- Noted the Resources Committee Chair's Assurance Report and the amendment to the Flu commentary.
- Supported continued monitoring of the Estates 5 year plan to manage the trust's maintenance backlog.

BOD/2021/96 WRES Briefing Paper and Covid19 EPRR Membership in NWAS

The Director of Operations presented a paper to brief the board on the current position of emergency preparedness, resilience and response (EPRR) and ensuring diversity in decision making for Black, Asian and Minority Ethnic (BAME) communities through the trust's command and control structures.

He added a national Workforce Race Equality Standards (WRES) briefing paper to Board on 19th June 2020 outlined the importance of ensuring diversity in decision making during responses to Covid-19. The paper described the rapid requirement to review EPRR structures for Covid-19 with a view to ensuring they have consideration for BAME staff in decision-making processes.

The paper outlined the steps taken to review the current groups and networks to ensure the EPRR composition reflected the diversity of the organisation. The paper recommended the trust aligning the current work of the Race Equality Network and establishing a BAME Advisory Group with implementation of an NCA decision-making tool.

The Chairman asked if the recommendations provided a robust approach to the inclusion of the BAME community in the decision-making processes.

The Director of Operations confirmed the recommendations supported an interim position with a continued approach to ensuring representation on the Command team and that the Quality and Performance Committee had supported the recommendations.

The Director of People advised that the Director of Strategic Planning and Director of Operations were the nominated Executive Leads and the RACE Equality Network is well established. She added the network was making a demonstrable impact.

The Board:

- Approved the establishment of a BAME advisory group to support COVID-19 decision making as a sub group of the NWAS Race equality Network

- Approved adopting the NCA decision – making flowchart on demonstrating due regards for equality (Appendix 1).

BOD/2021/97 Strategic Winter Plan 2020-21

The Director of Operations presented the Strategic Winter Plan for 2020/21. He reported that the Plan had undergone annual review and described the establishment of the Winter Planning Oversight Group, the group's outputs and the intended recipients of the plan.

He reported that the plan placed into context the challenges for NWAS and the health system across the country and the unprecedented potential of the forthcoming winter period, the impact of COVID-19, EU Exit and the seasonal influenza. He added that the Quality and Performance Committee approved the Plan in October and had received a further update on progress in November.

The Director of Operations added that at the end of each winter, the trust held a debriefing meeting and the Covid-19 pandemic had been the focus for the review. He stated the review included consideration for the latest national guidance and advice with an assessment of the impacts and pressures on each service line with operational plans in place.

The Chief Executive added the Trust had taken a holistic approach in producing the Winter Plan and considered a number of other strategic plans to ensure winter pressures were not dealt with in isolation.

The Director of Quality, Innovation and Improvement and the Director of People added that programmes to roll out Covid-19 lateral flow testing for staff and initial preparation for the forthcoming Covid-19 vaccination programme were underway.

The Chairman reported that he was involved in regional discussions regarding the Covid-19 vaccination and that the delivery of the programme would likely prove a logistical challenge but it was important that staff are able to take the vaccination with confidence, which in turn would provide a positive message to the wider community.

At this point in the meeting, the Director of Strategy and Planning referred to questions raised by the Public and Patient Panel as follows:

When NHS 111 First is fully rolled out and operational across NWAS regions, what proportion of 999 calls do you expect to be handled completely by 111 First? Do you have a target figure for this?

In response, the Director of Operations advised that NHS 111 First will not be taking any work away for the 999 system. It is designed to reduce A&E attendance by the general public.

The Board:

- Noted the contents of the Strategic Winter Plan 2020/21.

BOD/2021/98 Final Quality Accounts 2019-20

The Director of Quality, Innovation and Improvement presented the Trust's regulatory Draft Quality Accounts (QA) for 2019/20. She explained that the NHSE/I had issued guidance that confirmed a revised recommended deadline to publish and post Quality Accounts by 15th December 2020.

She reported that any formal submission from internal and external stakeholders was included in the drat QA and once all stakeholder information has been received, a final approved version of the 2019/20 QA would be posted on the public facing NHS Choices website and NWAS Internet/Intranet sites.

She advised the board to note the feedback received from external stakeholders at s11, page 30 of the Accounts and that should there be a requirement to make revisions to the draft, the accounts would be re-circulated prior to the next Board meeting.

Mr R Thomson congratulated the staff and the team for their hard work and efforts on the Quality Accounts.

The Board:

- Noted the feedback from external stakeholders.
- Approved the Quality Accounts for 2019/20.
- Noted that the final Accounts would be published on public facing NHS Choices Website and the NWAS Internet and Intranet sites.

BOD/2021/99 **Charitable Funds Annual Reports and Accounts 2019-20**

The Director of Finance presented the audited Charitable Funds Annual Report and Accounts for 2019/20 for approval and adoption.

She reported that the income for the year amounted to £472k and total expenditure during 2019/20 was £154k, where main element was the planned purchase of medical equipment. She added that overall funds increased by £318k.

The report included a suite of documents including the Audit Report, Charitable Fund Accounts and letters of representation and independence.

The Board:

- Approved and adopted the Charitable Funds Annual Report and Accounts for 2019/20.

BOD/2021/100 **Communications and Engagement Dashboard Report - Q2 2020-21**

The Director of Strategy and Planning presented the Communications and Engagement Dashboard Report for Quarter 2, which included the key outputs and highlights.

He reported the Communications and Engagement Team had continued to respond to the Covid-19 pandemic during Q2, from an internal and external communications perspective, as well as patient and public engagement. He added that the highlights in Q2 included sharing key messages from ministerial briefings, continued use of new staff channels such as the Facebook group, the Covid-19 daily bulletin and dedicated page on the Green Room to share the latest information. He added that the team had worked with partner organisations ahead of hospitality reopening after the lock down period, to share important public messages. He stated that the team had focused on virtual patient and public engagement, with more than 40 opportunities to engage.

In terms of Freedom of Information (FOI) requests, the Director of Strategy and Planning reported a significant increase in requests of 122% on Q1, however despite the increase; the team had exceeded performance against the national target of 90% completion within 20 days and achieved 96%. He thanked the team for their focused effort and for the collaboration from other trust departments.

Mr D Rawsthorn thanked the Director of Strategy and Planning for the excellent paper and particular the FOI performance.

The Chairman stated it was critically important that staff and patient engagement had continued through the Covid-19 pandemic and with excellent results in the current climate.

The Board:

- Noted the Communications and Engagement Dashboard Report for Q2 2020-21.

BOD/2021/101 **Recovery Planning & Q3/Q4 Objectives 2020/21**

The Director of Strategy and Planning presented an update on the trust's strategic plans and annual planning process. He reported that the trust's strategic plans incorporated an annual planning process that involved Directorate objectives and

plans, 5 year Integrated Business Plan milestones and their contribution to Integrated Care System (ICS) plans

He advised that this year, due to the impact of Covid-19, the directorate objectives were replaced by the recovery planning process and each service area had identified the objectives required to migrate from the full Covid-19 response to new business as usual including essential objectives for the remainder of the year.

He added that 80% of the recovery objectives were completed and stated that objectives for Quarter 3 and 4 focused on essential objectives. These included the four 'super projects' (i) Electronic Patient Record (ii) Unified Communications Programme (iii) 111 First and (iv) Single Patient Management System (SPMS).

The Director of Strategy and Planning confirmed s6 included details of the planning process and the lessons learnt with next steps. He advised that further objective planning would be held at a future Strategic Development day in February 2021 and essential objectives for Quarter 3 would be reported in January 2021.

At this point the Director of Strategy and Planning referred to questions raised by the Public and Patient Panel as follows:

Given the current pressures of unemployment rising amongst the younger generation, and as Government is currently keen to support and fund increased employment, could NWAS now consider providing more Apprenticeships for younger people?

In response, the Director of People advised that apprenticeships are a core part of the trust's recruitment, education and development strategy and we are proud to be an apprenticeship provider rated Good by Ofsted. Apprenticeships offer the main recruitment route into the emergency service and we are piloting apprenticeships as the main recruitment route into our 999 call centres. We also review entry-level positions within our corporate teams and have successfully used apprenticeships in Finance, HR, IT and Fleet to develop our future workforce. Although apprenticeships are open to young people, we see them as a way to attract a range of diverse candidates, enabling us to offer good quality work based learning, which delivers recognised qualifications but more importantly well supported and developed staff who can deliver high quality services.

The Board:

- Noted the Strategic Update for 2020/21.

BOD/2021/102 Any Other Business Notified Prior to the Meeting

BOD/2021/94 - The Medical Director confirmed that Q1 AQI data would be reported to the CEMG and Quality & Performance Committee in Q4.

BOD/2021/103 Items for Inclusion on the BAF

No items for escalation to the BAF.

BOD/2021/104 Questions from the Public

The Chairman invited questions from the Patient and Public Panel.

The panel members referred to the Charitable Funds Committee and asked if it was the intention to involve the Public Panel in the distribution or activities. The Director of Corporate Affairs confirmed that community involvement from a Patient and Public Panel perspective would be sought for the next iteration of the Charitable Funds Strategy.

The Chairman closed the meeting at 1.30pm and thanked the members of the public for their attendance.

Date and Time of Next Meeting:

The next meeting of the Board of Directors will be held on Wednesday 16th December 2020 via Microsoft Teams.

Signed: _____

Date: _____

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Minutes
Extra-ordinary meeting of the Board of Directors

Details: Wednesday 16th December 2020, 10.00am
Microsoft Teams

Present:

Mr P White	Chairman
Prof A Chambers	Non-Executive Director
Mr S Desai	Director of Strategy & Planning
Mr M Forrest	Deputy Chief Executive
Mr G Blezard	Director of Operations
Dr C Grant	Medical Director
Mr R Groome	Non-Executive Director
Dr D Hanley	Non-Executive Director
Mr D Mochrie	Chief Executive
Mr M O'Connor	Non-Executive Director
Prof M Power	Director of Quality, Innovation and Improvement
Mr D Rawsthorn	Non-Executive Director
Ms A Wetton	Director of Corporate Affairs
Ms C Wood	Director of Finance

In attendance:

Ms D Earnshaw	Corporate Governance & Assurance Manager (Minutes)

Minute Ref:

BOD/2021/105 APOLOGIES FOR ABSENCE

Apologies for absence were received from Prof R Thomson, Associate Non-Executive Director (Clinical) and Ms L Ward, Director of People.

B0D/2021/106 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

BOD/2021/107 WELL LED DEVELOPMENTAL REVIEW – ACTION PLAN UPDATE

The Director of Corporate Affairs presented a developmental review and an updated action plan following the Well-Led Developmental External Review carried out during Quarter 4 of 2019/20.

She advised that following acceptance of 19 recommendations an action plan was developed and included in appendix 1 of the report.

She reported that out of the 23 separate actions, 11 had been fully completed and closed with 12 partially completed and part of preparations for 2021/22.

Mr D Rawsthorn referred to the action plan and the issue of Board visibility. He highlighted that Non-Executive Director members had been visible in a number of ways to staff and were not always captured but do take place. The Chairman added that visibility under the current circumstances was difficult due to virtual meetings and discussions and agreed it was difficult to capture this activity. He advised that not being able to spend time together face-to-face had its disadvantages; however, he encouraged the continued input from his Non-Executive Director colleagues despite current restrictions.

The Deputy Chief Executive confirmed he had written to the Non-Executive Directors regarding development reviews, opportunities, and encouraged their responses, virtually or social distanced meetings if necessary.

The Chairman referred to action 7 on the Well Led Action Plan and queried whether the Culture and Leadership dashboard work was on track for January 2021. The Director of Corporate Affairs confirmed that work was in progress and the action plan reflected the very latest position.

The Board:

- Noted assurance Well Led Developmental Review Report and updated Action Plan.

BOD/2021/108 CHARITABLE FUNDS STRATEGY 2020-2022

The Director of Corporate Affairs presented an updated Charitable Funds Strategy for 2021-2022 and advised that the Charitable Funds Committee (CFC) supported the strategy.

She reported that the revised strategy was a 2-year strategy, at the request of the CFC and reflected a reactive approach. She added that the strategy aspired to support cultural change across the trust to enable staff to support the Charity 'as their own' through fundraising; mobilise the sizeable and active volunteer community, and where possible limit 'restricted' fund allocation.

She advised that the three clear objectives included (i) to provide equipment, uniform and training for volunteer Community First Responders (ii) to build awareness of life-saving skills and defibrillators in our communities and (iii) to support NWAS staff with additional new equipment and better working environments (above the provision from the exchequer).

The Director of Corporate Affairs advised that the strategy refresh would involve planning a workshop in 2021/22 with the Community Resuscitation Team and the Patient and Public Panel to co-produce an options appraisal for consideration by the Board of Directors to enable decisions on proposals for the future purpose of the charity.

Mr D Rawsthorn advised this was a holding strategy, which reflected and aligned to current activity and gave the flexibility to make a difference.

The Board:

- Approved the Charitable Funds Strategy 2020-2022.

BOD/2021/109 CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

The Director of Corporate Affairs presented the revised Terms of Reference (TOR) for the Charitable Funds Committee, which reflected the revised Charitable Funds Strategy 2020-22.

She advised that the revised TOR were included in the report and the fundraising responsibilities removed, in line with the Strategy. Mr D Rawsthorn confirmed that the Charitable Funds Committee supported the TOR.

The Board:

- Approved the revised Terms of Reference for the Charitable Funds Committee.

BOD/2021/110 CQC ACTIVITIES UPDATE

The Director of Quality, Innovation and Improvement presented the CQC Activities Update. She reported that the Trust had an outstanding action from its 2018/19 CQC Inspection action plan, which was to review the PES hard copy vehicle check book system arrangements in operation.

She advised that in response, the trust had successfully implemented the electronic Safecheck system, which provided a robust digital alternative solution and the system had the potential for future developments. She added that the Quality and Performance Committee had received a presentation on the system at their meeting on 16th November 2020 and supported the system with a request to spend more time understanding the future development proposals at a future presentation.

The Director of Quality, Innovation and Improvement referred to appendix 1 which provided an overview of the CQC 'should do' action plan and reported good progress against the 10 actions. She added that a number of actions were ongoing and would be monitored up to the end of the financial year.

She highlighted that discussions were ongoing within the organisation and the CQC to balance the Covid-19 demands with maintaining performance against staff appraisals and mandatory safeguarding training.

In terms of CQC inspections, she advised that inspections have transitioned from a dormant position during the peak of the pandemic to themed reviews. She referred the Board to appendix 2, which included an assessment summary by the CQC of the trust's management of Infection Prevention and Control (IPC).

She reported that reviews of the IPC BAF continued, with the next review in December and a report due to the Board in January 2021 to provide assurance.

The Director of Quality, Innovation and Improvement noted that the trust had made a regulatory application to the CQC for a surgical procedures licence which reflected the enhanced work being undertaken by senior clinicians and air ambulance teams.

She advised that the trust would need to be prepared for the CQC's approach in the post Covid-19 environment and to gain an understanding of their expectations from providers. She added early indications reflected a focus on improvement innovation and sustainability of care through intelligence driven inspections by submission of information and with this, consideration to increased data requests would be required. She added that the CQC were defining a single view of what quality looks like across regulators and at internal effectiveness over the next 12 months.

The Director of Quality, Innovation and Improvement advised that further work with the Director of Corporate Affairs on the current position and future CQC requirements would be presented in the next update to the Board.

The Chief Executive added it was important to get the balance right with regard to patient safety and regulatory compliance, particularly through the winter period and further Covid-19 pressures.

The Director of Quality, Innovation and Improvement confirmed that early discussions with the CQC regarding the current pressures and training performance targets for 2021 indicated that revised targets would be acceptable and a proposal would be presented to the Board of Directors in January.

The Chairman welcomed the proposals to Board in January and confirmed patient safety and operational effectiveness was of paramount importance and asked if there had been an indication of any unannounced inspections.

The Director of Quality, Innovation and Improvement reported that CQC were involved in inspections of acute settings and A&E departments to address issues such as hospital handovers and although trust staff were operating in these environments the inspections were not targeted at NWAS. She advised that IPC was the current main concern of the CQC.

She added that the Trust continued to work closely with their CQC Relationship Manager to ensure their routine understanding of the organisations governance system and that trust data and information was available for any forthcoming inspection process.

The Chairman thanked the Director of Quality, Innovation and Improvement for the CQC report and update on recent developments.

The Board:

- Noted the assurances in the CQC update report.
- Noted that the Trust had made an application to add Surgical Procedures as a CQC regulated activity.

BOD/2021/111 NWAS VALUES REFRESH

The Deputy Chief Executive presented a report, which detailed the results of the work undertaken by Delve, external consultant provider, commissioned to produce staff values through the a process of extensive consultation with direct staff input.

He reported that the aim to move to a bespoke, set of values and behaviours, which were personal to the organisation and resonated with all staff irrespective of their role or directorate had resulted in three proposed values.

He added that although the intention had been to develop single word values, three short phrases emerged and ensured resonance. The values proposed were Being at our Best, Working Together and Making a Difference.

The Deputy Chief Executive advised that the findings identified that the words had impact on their own and the consultation had proved extremely meaningful for the organisation. He stated that the perceived view of patients of NWAS staff often related to being kind and compassionate however, in reality, upon consultation across the service lines, there was a strong message to ‘make me better’.

He reported that the findings resulted from over 700 people and this represented a critical mass that supported strong consideration of the proposed values.

Prof A Chambers supported the three short snappy sentences and congratulated the Deputy Chief Executive and the teams for the outcome of the work.

Dr D Hanley supported the values and stressed the need to ensure effective implementation in the work place. He added many corporate values fail because they focused on individual behaviour rather than how that relates to corporate behaviour. He recommended that as part of the implementation programme, the trust consider the link to corporate behaviour and policies to ensure they do not conflict, to ensure the three values are not lost in the organisation.

Mr D Rawsthorn welcomed the Values Refresh and suggested the work provided an opportunity to link the three values to the overall vision of the trust, to be the best ambulance service in the UK.

The Deputy Chief Executive welcomed the comments from the Non-Executive Directors and explained implementation of the values would involve a toolkit for leaders, focused on the need for managers and leaders to be leading by the underpinning behaviours, and emphasised that staff will be watching. He added the tool kit would be presented to a future Board meeting.

He agreed that behaviours at senior level would be required to support the values and stated that staff appraisals would include the underpinning behaviours and any inconsistencies identified through the appraisal and leadership conversations. He added that the Values Refresh was one of a number of pieces of work that the trust had undertaken in Q3/Q4 and accompanied the Culture Survey and Treat me Right Campaign.

The Chief Executive confirmed that the Values Refresh would link to the Trust's core vision and values to ensure a golden thread through the organisation and the tool kit would support implementation across the organisation. He added it was important to invest time in staff engagement to support the implementation process.

The Chairman highlighted it was always important to look at any results of an external consultation process to ensure they reflected and understood the strategic vision of the organisation. He added that the tool kit was an integral part of the process and an important paper for the Board. He emphasised implementation of the tool kit provided an opportunity for members to have further conversations with the workforce and that although there were current working environment restrictions, with Covid-19, the Board had a responsibility to make the links with the staff and ensure the values meant something to the whole of the organisation.

The Chairman thanked the Deputy Chief Executive for the report and the work of the team.

The Board:

- Supported the proposed values and supporting behaviours.
- Supported the next steps towards implementation.

BOD/2021/112 ANY OTHER BUSINESS NOTIFIED PRIOR TO THE MEETING

There was no items of other business.

BOD/2021/113 ITEMS FOR INCLUSION IN THE BAF

None

DATE, TIME AND VENUE OF NEXT MEETING

The next meeting of the Board of Directors will be held at 9.45am on Wednesday 27th January 2021 via Microsoft Teams.

Signed: _____

Date: _____

Status:	
Complete & for removal	
In progress	
Overdue	

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
49	30/09/20	2021/66	Policy Framework Update	Process for completion of EIAs to be reviewed.	AW/LW	25.11.20	27.1.21	Process reviewed and guidance to be updated. **Update January 2021:** The Policy on the Development and Management of Strategy, Policy & Procedure Documents has been reviewed. The EIA section of the policy has been strengthened.	
51	25/11/20	2021/90	Freedom to Speak Up Guardian Assurance Report Q2 2020/21	Noted the themes, trends, issues and learning identified in this report including a further briefing from the Director of People.	LW	27.1.21	27.1.21	A full briefing was provided following the meeting.	
52	25/11/20	2021/93	Integrated Performance Report	Supported a further scrutiny paper on the evaluation of serious incidents to Q&P Committee.	CG/MP	31.3.21	31.3.21	Evaluation of Serious Incidents included in the Q&P Work Plan and future assurance to Board via Q&P Chairs Assurance Report.	

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Board and Committee Attendance 2020/21

Board of Directors																				
	3rd April	6th May	27th May		3rd June	17th June	29th June	29th July		26-Aug-20	30th September		25th November		16th December		27th January		31st March	
	Part 2	Part 2	Part 1	Part 2	Part 2	Part 2	Part 2	Part 1	Part 2	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
Ged Blezard	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Prof Alison Chambers	✔	✔	✔	✔	✔	x	x	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Salman Desai	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Mick Forrest	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔				
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔				
Richard Groome	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	x	✔	✔	✔	✔				
Dr David Hanley	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Daren Mochrie	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Michael O'Connor	✔	✔	✔	✔	✔	x	✔	✔	✔	x	✔	✔	✔	✔	✔	✔				
Prof Maxine Power	x	✔	✔	✔	✔	x	x	✔	✔	Attendance at external meeting	✔	✔	✔	✔	✔	✔				
David Rawsthorn	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Prof Rod Thomson	x	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	x				
Clare Wade	✔	✔	✔	✔	✔	✔	x	✔	✔	✔	✔	✔								
Lisa Ward	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	x	✔				
Angela Wetton	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Peter White ©	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Carolyn Wood	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				

Audit Committee						
	17th April	22nd May	17th June	10th July	23rd October	15th January
Dr David Hanley	Cancelled due to COVID-19	✔	✔	✔	✔	✔
Michael O'Connor		✔	x	x	✔	✔
David Rawsthorn ©		✔	✔	✔	✔	✔
Prof Rod Thomson		✔	✔	✔	✔	✔

Resources Committee						
	18th May	24th July	25th September	20th November	22nd January	26th March
Ged Blezard	Cancelled due to COVID-19	x	✔	x	x	
Salman Desai		✔	✔	✔	✔	
Richard Groome		✔	✔	✔	✔	
Michael O'Connor ©		✔	✔	✔	✔	
Prof Maxine Power		✔	✔	✔	✔	
David Rawsthorn		✔	✔	✔	✔	
Lisa Ward		✔	✔	✔	✔	
Clare Wade		✔	✔			
Carolyn Wood		✔	✔	✔	✔	

Quality and Performance Committee											
	20th April	18th May	15th June	20th July	21st September	19th October	16th November	18th January	15th February	15th March	
Ged Blezard	✔	✔	✔	x	✔	✔	✔	✔			
Prof Alison Chambers ©	✔	✔	x	✔	✔	✔	✔	✔			
Mick Forrest	✔	✔	✔	✔	✔	✔	✔	x			
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	✔			
Richard Groome	✔	✔	✔	✔	✔	✔	✔	✔			
Dr David Hanley	✔	✔	✔	✔	✔	✔	✔	✔			
Prof Maxine Power	✔	✔	✔	✔	✔	✔	✔	✔			
Rod Thomson	✔	✔	✔	✔	✔	✔	✔	✔			
Carolyn Wood	x	x									

Charitable Funds Committee			
	29th April	29th July	28th October
Ged Blezard	Cancelled due to COVID-19	✔	x
Salman Desai		✔	✔
Richard Groome		✔	x
Dr David Hanley		✔	✔
David Rawsthorn ©		✔	✔
Lisa Ward		✔	✔
Angela Wetton		✔	✔
Carolyn Wood		✔	✔

Nomination & Remuneration Committee							
	14th April	27th May	3rd July	29th July	30th September	13th November	16th December
Prof Alison Chambers	✔	✔	✔	✔	✔	✔	✔
Richard Groome	✔	x	x	✔	x	✔	✔
Dr David Hanley	x	✔	✔	✔	✔	x	✔
Michael O'Connor	✔	✔	x	✔	✔	✔	✔
David Rawsthorn	✔	✔	✔	✔	✔	✔	✔
Prof Rod Thomson	✔	✔	✔	✔	✔	✔	x
Clare Wade	x	x	✔	✔	✔		
Peter White ©	✔	✔	✔	✔	✔	✔	✔

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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal	Indirect Interests		Apr-19	Mar-20	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision is required within a meeting, in relation to the service line.
Alison	Chambers	Non-Executive Director	Husband is CEO at Barking and Havering and Redbridge University Hospitals NHS Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governor at Wigan and Leigh College			√		Position of Authority	Apr-20	Present	N/A
			Pro Vice Chancellor, Faculty of Health and Social Care and Member of University Executive Group, Manchester Metropolitan University	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Salman	Desai	Director of Strategy and Planning	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Michael	Forrest	Deputy Chief Executive	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Richard	Groome	Non-Executive Director	Director, Westbury Management Services Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Director of Avantage (Cheshire) Ltd	√				Position of Authority	Dec-20	Present	Withdrawal from any Cheshire Care Home related discussions.
			Chair, Fix360 (part of Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Deputy Chair , Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
David	Hanley	Non-Executive Director	Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care		√			Position of Authority	Apr-19	Present	N/A
			Member of the Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A
			Board Member/Director - NHS Pathways Programme Board		√			Position of Authority	Marr-20	Aug-20	Appointment declined
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Aintree University Hospital NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Michael	O'Connor	Non-Executive Director	Partner in Addleshaw Goddard LLP	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Trustee of Central Manchester Concert Hall Ltd (Bridgewater Hall) (Charity)				√	Position of Authority	Apr-19	Present	N/A
			Chair, Festival Medical Services		√			Position of Authority	Apr-19	Present	N/A
			Company Secretary of Cartwright Care Balmoral Management Ltd 38 Montpelier Grove Ltd	√				Position of Authority	Apr-20	Present	N/A
			Company Secretary of Talia Lipkin Connor Ltd	√				Position of Authority	Apr-20	Present	N/A
			Non Executive Director and Trustee of Factory Youth Zone (Harpurhey) Ltd				√	Position of Authority	Apr-19	Present	N/A
			Director, 16 Princess Road, NW1 8JJ Freehold Limited	√				Position of Authority	Sep-19	Present	N/A
			Director, Lucinda Byre Limited	√				Position of Authority	Jun-20	Present	N/A
			Company Secretary. Lucinda Byre Ltd				√	Position of Authority	Jun-20	Present	N/A
			Company Secretary, Taylia Byre Ltd				√	Position of Authority	Jun-20	Present	N/A
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Member of Green Party			√		Other Interest	May-19	Present	Will not use NED position in any political way and will avoid any political activity in relation to the NHS.
			Member of Cumbria Wildlife Trust			√		Other Interest	Apr-19	Present	N/A
Rod	Thomson	Non-Executive Director	Visiting Professor at the Universities of Chester, Staffordshire and Liverpool John Moores University		√			Position of Authority	Sep-19	Present	No conflict
			Trustee of the mental health charity "listening ear". The charity is based in Merseyside and provides services in the NW region,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Volunteer at Severn Hospice, Shewsbury and do so as part of CPD requirements for NMC registration.		√			Volunteer	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governing Body Member, Royal College of Nursing		√			Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Locum Consultant in Public Health, Cheshire East Council	√				Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Fellow of the Royal College of Nursing and the Faculty of Public Health,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Clare	Wade	Associate Non-Executive Director (Digital)	Head of Patient Safety, Royal College of Physicians	√				Position of Authority	Jul-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Lisa	Ward	Interim Director of Organisational Development	Member of the Labour Party	N/A	N/A	√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
Peter	White	Chairman	Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Non-Executive Director – Riverside Housing	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director – Miocare Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Angela	Wetton	Director of Corporate Affairs	Husband is Operations Director of The Senator Group who supply the NHS, amongst many others, with office and hospital furniture.				√	Other Interest	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Carolyn	Wood	Director of Finance	Husband was Director of Finance at East Lancashire Hospitals NHS Trust				√	Other Interest	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27 January 2021
Subject:	Chief Executive's Report
Presented by:	Daren Mochrie, Chief Executive
Purpose of Paper:	For Assurance
Executive Summary:	The purpose of this report is to provide members with information on a number of areas since the last CEO's report to the Trust Board on 25 November 2020. The highlights from this report are as follows: **Paramedic Emergency Services** • PES continues to deal with the pressures of a global pandemic. The delivery of the winter/festive plan was successful and the Trust managed the Christmas & New Year pressures. • The focus for operations is to continue to maximise resources and to support staff and volunteers to continue to deal with the pandemic **NHS 111** • December, our busiest and usually most challenging month delivered a call pick up of 78.43%. • The new Avaya telephony system went live on 12 January, no issues to report • A significant amount of work has been undertaken to recruit additional staff and refining the Clinical Advice queue within Cleric to allow more efficient management of the queue and ultimately reduced waits for clinical call backs to patients **PTS** • PTS continues to support the delivery of the PES operation via the supply of staff and vehicle and supporting hospitals with discharges, transfers and flow. • Third party private ambulance resources have been sourced • Daily support is being provided to the Greater Manchester Nightingale Hospital

	The paper provides an update on local, regional and national activities as well as outlining our approach to a number of areas such as the vaccination programme, lateral flow testing, NHS 111 First and areas of regulatory compliance.
Recommendations, decisions or actions sought:	The Board is requested to receive and note the contents of the report

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☒	☒	☐	☒	☒	☒	☐	Closed	☒

Are there any Equality Related Impacts:	No
Previously Submitted to:	N/A
Date:	N/A
Outcome:	N/A

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1. PURPOSE

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 25 November 2020.

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

PES continues to deal with the global pandemic and remains under significant operational pressure. The pressures experienced from the second wave at the end of October and into the beginning of November recovered slightly although these have started to intensify over the past few weeks. As a consequence of this the Trust escalated to Resource Escalatory Action Plan 4 our highest level on Monday 12 January 21. This has allowed the Trust to put in place additional measures to manage the pressures. The delivery of the winter/festive plan over Christmas and New Year worked well. An increase in staff abstraction was noted due to Covid-19 however our forward planning of reduced annual leave, suspension of training and other actions over a two week period compensated for the loss and we were able to keep in place additional resources to meet the pressures. We continue to operate our Covid-19 command cells to ensure rapid decision making and risk management with a nominated Covid-19 commander on 24/7 and senior presence 7 days a week in the Regional Operations Control Centre (ROCC).

During this period the Trust was also able to support a number of other Ambulance Trusts as part of mutual aid arrangements and has dealt with multiple significant events due to adverse weather.

The focus for operations remains to maximise resources to deal with the pandemic and do all we can to support our staff and volunteers.

NHS 111

During November and December 2020 111 experienced a reduction in staff absence due to Covid-19 accompanied with increased staffing levels aligned to the ambitious recruitment plan for NHS 111 First which resulted in improved performance.

Calls Answered within 60 seconds in November delivered 63.1% performance and in December, our busiest and usually most challenging month, we achieved 78.43%. Performance into January remains strong.

NHS 111 service was unable to go live with the new Avaya telephony system in December as planned, however we utilised the delay to further develop and test the platform, to enable Go Live on 12 January 2021. This has now been completed successfully and thank you to everyone involved in this.

NHS 111 has continued through November 2020 to train the new staff for NHS 111 First programme to support the 20% unheralded ED activity demand, and have commenced more recruitment of Health and Clinical Advisors to answer the anticipated demand rising to 40% of the unheralded ED activity. Alongside the significant increases in staffing there has been recruitment to roles to support the additional staff.

Within all our 111 call centres we continue to action our enhanced IPC (Infection Prevention and Control) plan; maintaining social distancing where possible. Due to learning from ongoing outbreaks we are now carrying out daily IPC audits and senior manager walk rounds

to seek assurance that all staff are adhering to the guidance. New screening has been partially installed at Middlebrook, however due to a national shortage of aluminium the whole call centre cannot be completed until the end of January 2021.

Since the roll out of Cleric a significant amount of work has been undertaken refining the Clinical Advice queue to allow more efficient management of the queue and ultimately reduced waits for clinical call backs to patients.

PTS

The impact of Covid-19 has led to a significant change in the profile of PTS activity.

As at December 2020 the overall year to date activity was 39% below contract baselines with Cumbria at 45% below, Greater Manchester at 34% below, Lancashire at 46% below and Merseyside at 29% below contracted baseline. Whilst activity is significantly below contracted baselines, outpatient activity has risen sharply since June 2020 but plateaued between late October and mid-December prior to an expected reduction over the Christmas period.

Like other parts of the Trust, PTS has had to adapt to new ways of working to offset the impact of social distancing on vehicles which, as activity increases, and focus on the Trust's ability to respond to on the day discharge requests intensifies, is becoming a greater challenge. PTS continues to support the delivery of the PES operation via the supply of staff and vehicles. Additional third party private ambulance resources have been sourced.

Daily support is being provided to the Greater Manchester Nightingale Hospital with participation in daily strategic calls in addition to a PTS Manager being on site Monday to Friday 08:00 – 16:00. The 36 bed site is managing non-Covid-19 patients and has been set up to accommodate patients from Greater Manchester and Cheshire hospitals.

3 ISSUES TO NOTE

3.1 Local Issues

Nothing specific to report

3.2 Regional Issues

Covid-19 Vaccination

The trust continues to focus on Covid-19 vaccinations for staff and volunteers. Management of our Covid-19 vaccination programme is being undertaken by a Vaccination Cell, led by Pat McFadden and Lisa Ward as Executive lead. The cell includes operational representatives who are providing a single point of contact for the vaccination rollout in each area.

We have received tremendous support from NHS partners to allow our staff to access hospital vaccination hubs and we have also stood up our own internal vaccination centre supported by a number of staff and volunteers. This will ensure rapid delivery over the coming weeks and months.

Various bulletins have been issued explaining how the trust will receive the vaccines; when and where it will take place together with next steps.

All NHS organisations are using the National Immunisation Management System (NIMS) to support the booking process and report on uptake. As part of our early preparations, the trust are uploading existing staff data already recorded in ESR into the NIMS to ensure staff receive access to the vaccination as part of the first priority cohort. In addition, staff will need to upload their NHS number into Safecheck. This is the biggest national vaccination programme ever undertaken in this country and will be delivered in a number of phases as more vaccines become available and the associated vaccination sites, centres and teams are established.

Lateral flow test kits

Over 4500 members of staff have now collected the asymptomatic Covid-19 test kits (Lateral Flow Tests), with several positive results already captured. This shows the immense benefit of this exercise, as we have already helped stop asymptomatic colleagues from accidentally spreading the disease to families, patients and colleagues. The distribution is carrying on this week to get them out even wider across the trust, in a big team effort. Thanks to everyone involved in making this happen so quickly.

The kits are very easy to use, and are a good way of helping reassure all of us that we are Covid-19 free.

EPR roll out confirmed for February

We have passed a milestone in our rollout of the Electronic Patient Record, as the team have declared the pilot in Fylde a success and confirmed that its rollout will commence in other regions in February 2021 (subject to additional Covid-19 pressures). The rest of the Lancashire region will get it first, followed by Cumbria, Cheshire, Merseyside and Greater Manchester.

This will transform how we deliver care to our patients and how we interact with receiving locations. Well done and thank you to everyone involved in this long and complex project. Exciting times!

North West MPs

The trust issues regular stakeholder briefings to our North West MPs and other key stakeholders as well as offering them opportunities to meet to discuss changes in operating procedures, demand and activity both locally and across the region. Given our continued management of the pandemic and the onset of what is traditionally our busiest time of year, I have again offered virtual meetings with our Chairman, Peter White and myself.

I recently met with Andrew Stephenson, MP for Pendle and one of our community first responders in East Lancashire. Andrew has been responding for NWAS for since 2014 During the pandemic, he has helped with PPE packing at stations, and has recently completed the pre vaccination training for the South Cumbria and Lancashire integrated care service role out plan for the new vaccinations.

We discussed the role of the community first responder and the additional roles that first responders have undertaken to support the response to the Covid-19 virus. I thanked Andrew for all his support as a community first responder, especially during the pandemic, and talked about our plans for winter together with our response to the third wave of Covid-19. Andrew thanked everyone across the trust for their response to the pandemic.

I will be meeting with other North West MPs in the early part of 2021.

REAP Level (Resource Escalation Action Plan)

As outlined earlier in the paper, on 12 January the trust increased its REAP level from Level 3 (major pressure) to Level 4 (extreme pressure) due to increased operational demand and wider healthcare system pressures combined with the impact that Covid-19 is having on the workforce.

The escalation in REAP level enables the organisation to respond to, and address, the operational challenges being faced. The REAP level is in operation at all time and enables the trust to ensure that its service can be maintained when disruptive challenges occur in the local environment, such as increased activity, significant loss of staff, buildings or resources or pressures within the wider NHS. In general the trust will operate at lower levels when the service is operating within normal parameters and will escalate when pressures occur. REAP is designed to increase operational resource in line with demand in order to assist he service in coping with periods of high pressures whilst maintaining the quality of patient care.

In Moving to REAP Level 4 the trust carefully considered the actions to be taken and maximised all available resources with clinically trained staff responding in frontline roles and working closely with the trusts private transport providers and working with other healthcare organisations to safely signpost patients to other services as appropriate.

3.3 **National Issues**

NHS 111 First go live

The NHS 111 First service, which we deliver across the North West, went live on the 1 December and a widespread marketing campaign is beginning to encourage the public to contact 111 first instead of turning up to A&E themselves. This will include television advertisements, social medial messages and billboards

This is a national programme which builds on the existing integrated urgent care (IUC) service accessed through NHS 111. It encourages the use of the NHS 111 online and phone service to access a range of urgent care services including, for the first time, direct booking into emergency departments (EDs). This will also help to reduce the risk of transmission of Covid-19 between patients and to staff by reducing crowding in waiting areas across services.

We are live with direct booking into all emergency departments which is down to the hard work of Jane Higgs, Programme Director and Jackie Bell, Head of NHS 111, the programme board, our regional NHS system leaders and our 111 digital interoperability team.

Although this is a pilot scheme which will be evaluated in the months ahead, its introduction is testament to the value placed on NHS 111 and its ability to deliver, particularly during the first wave of the pandemic.

I**nternational Volunteers Day 2020**

We consider ourselves very lucky as for over 20 years, we have been supported by a large group of people across the North West who selflessly give their own time to help their local communities in many ways.

On Saturday, we took the opportunity to thank our army of volunteers; our community first responders (CFR), our voluntary car drivers (VCD), our patient and public panel (PPP) members and anyone who has helped their local communities, especially this year. The pandemic has magnified the community spirit we have always had and the commitment, passion and care our volunteers have demonstrated in their communities and in supporting our staff is to be commended.

In particular, I'd like to give a big thank you to Community First Responder Noel, Volunteer Car Driver, Ed and Patient Public Panel member, Adam, for taking part and sharing some of the important work they have been doing for this year's International Volunteer Day.

We are also very proud to hold the Investing in Volunteers UK quality standard, this is awarded for good practice in volunteer management which reflects the importance we place on our volunteers and the value of their contribution.

Race Equality Network Launch

The brand new Race Equality Network launches with an online event on Tuesday 26 January. The launch will be hosted by co-chairs of the network Asha Blake, Internal Accreditation & Quality Assurance Manager and Paramedic, Wesley Proverbs, and will feature guest speaker Dr Peggy Warren on the importance of lived experience in creating inclusive workplaces. The launch of the network is a positive step for NWAS, one that I, and the Board, are proud to support.

ICS consultation

NHS England and improvement published a consultation document on **Integrating Care:** *next steps to building strong and effective integrated care systems across England*. The document opens up a discussion about the ambition of Integrated Care Systems (ICSs) to support greater collaboration between health and care partners and how they could be embedded into legislation by April 2022. All NHS trusts were asked to comment and give their views on two potential options: Option 1 - where a new statutory ICS board would be created with an accountable officer. This would create a mandatory board and would allow partners to make decisions collectively. However, all NHS bodies – whether providers or commissioners – would remain, and all would also retain their existing accountable officers/chief executives. And option 2 – to create ICSs as new statutory bodies to secure health services for its population. This would mean replacing CCGs. Its board would include representatives of NHS providers, primary care and local government as well as a chair, chief executive and chief financial officer. NHS England commissioning functions would be delegated to the ICS.

The document proposed policy changes and different working arrangements and principles for the ICCs a number of these changes were around:

- Place based partnerships
- Provider collaboratives
- Clinical and professional leadership
- Financial frameworks
- Regulation and oversight
- Commissioning changes

NWAS and the Association of Ambulance Chief Executives (AACE) have provided a response to the initial consultation which closed on the 8 January 2021.

EUC A&E standards

The **Transformation of urgent and emergency care:** *models of care and measurement* was published in December 2020. The consultation document outlines the proposed changes to measuring urgent and emergency care, taking into account the learning from Covid-19 and the findings from the clinically-led review of standards to ensure they measure what matters most to patients. It makes a new offer to patients, and proposes a new set of standards for urgent and emergency care.

The main areas for Ambulance Services is around the changes to some of the metrics which are based on 4 principles:

1. Ensuring people with urgent care needs get the right advice in the right place, first time
2. Providing highly responsive, urgent care services that support avoidable attendance at EDs
3. Ensuring people with serious or life-threatening emergency care needs receive treatment in centres with the right expertise and facilities
4. Ensuring no patient stays in the ED longer than is necessary

For Ambulance Services/pre-hospital the proposals include the following new bundle of standards:

- Response times for ambulances
- Reducing avoidable trips (conveyance rates) to emergency departments by 999 ambulances
- Proportion of contacts via NHS 111 that receive clinical input
- Percentage of ambulance handovers within 15 minutes

The consultation period will run until the 12 February and as with the previous publication, NWAS will look to provide an individual and collective response via AACE.

4 GENERAL

CQC Regulation

The Care Quality Commission continue to regulate providers using a risk based model under their transitional regulatory approach (TRA). Following our Winter Pressures transitional monitoring approach (TMA) interview on 17th December 2020, we had a second TMA interview with the local inspector on 19th January 2021, following submission of a comprehensive assurance document covering all aspects of regulatory compliance and governance, from across the Trust. Thanks go to all that contributed and provided what we were informed was very good assurance. We will not receive anything more formally other than maybe an acknowledgement letter. The local CQC inspector re-iterated that they have no Regulatory concerns at the moment with NWAS. A number of follow up conversations will be organised over the next 2 weeks as part of our ongoing arrangement.

Ambulance Service of the Year Award

I am very pleased to confirm we have been awarded the coveted Ambulance Service of the Year award in the prestigious Health Business Awards. The award goes to the trust that has embraced change and demonstrated a decrease in response times, the ability to provide treatment at the scene of an accident, and the provision of outpatient services. This year the ceremony was of course virtual and was hosted by GP and TV presenter Dr Hilary Jones.

Our award predominantly relates to the East Lancashire Falls Response Service Team, the collaboration of a paramedic and an occupational therapist who respond to non-life threatening 999 calls for falls, so that patients can be treated at home without having to go to hospital or can be referred to an appropriate community service. My congratulations to Gail Smith, Andrew Ormerod and all those involved in this great initiative

Controlled Drugs

Controlled drugs (CDs) are medicines named in the Misuse of Drugs Act and are subject to strict legal controls and legislation. They can be subject to misuse or diversion and hence the strict regulatory environment. NWAS routinely use CDs in its paramedic emergency service and they form a critical part of our clinical service. NWAS had a strategic goal of

obtaining its own CD Home Office Licence within the Right Care (Quality) Strategy. The licence allows NWAS to possess (store) and supply CDs from its licensed site. Following appointment of our Chief Pharmacist, this objective can now be progressed. The recent withdrawal of our current supplier (Lloyds Pharmacy) from service provision has provided an additions impetus for this initiative

This licence allows the NWAS Medicines Supply Hub to store and distribute CDs throughout NWAS rather than relying on third party providers. This enables enhanced transparency, stock management and governance plus provides greater resilience for business continuity. This project will take approximately 6 months to complete.

Compliance with the requirements of the CD Home Office Licence will be audited on an ongoing proactive basis and assurance will be provided via Medicines Effectiveness Group and Quality and Performance Committee

Brexit

The UK exited the EU on 31 January 2020 and the transition period came to an end on 31 December 2020. This means that from 1 January this year, we separated from the EU and became an 'independent state'.

The UK Government has now reached an agreement with the EU as to the relationship following our exit, and this contains new rules for how the UK and EU will live, work and trade together. While the UK was in the EU, companies could buy and sell goods across EU borders without paying taxes and there were no limits on the amount of things which could be traded. The risk of disruption at the border is still a possibility and so NHS trusts have been asked to keep in place the plans and mitigations stood up for the end of the transition period until further notice.

The main areas of interest for the NHS include medicines, workforce, data, research and medical devices. NWAS, along with all other trusts, has been examining the impact of Brexit and taken steps to ensure risks are minimised as much as possible.

As NWAS is a mobile healthcare provider, one of our greatest considerations is that of fuel, vehicle and vehicle parts supplies. This has been a priority in the planning for Brexit and we have an ample supply in our reserves. Likewise, the Fleet team has ensured that our suppliers have mitigated all risks to the supply of parts and we are confident that there should be little impact now we have left the EU.

Manchester Arena Inquiry Proceedings

The Inquiry resumed on 18th January commencing with Chapter 10 which deals with the Emergency Response on the night.

The Inquiry Chairman has taken into consideration the views of all of those involved, including NWAS, and the decision was taken that the Inquiry will continue, however, the Chairman of the Inquiry understands the current demand levels the trust is facing and that the focus of our efforts and resources should be on providing our service to the public. In recognition of this, a number of changes have been made to the proceedings which includes a reduced schedule of 2.5 days per week and the number of people in the court room will be limited to four or five. Others, including the Chairman, will join virtually.

Death of Staff Members

It is with great sadness that I write to inform you of the death of our friends and colleague Ian Fawcett, Peter Sargeant, Ryan Booth, Bill Delaney and Bill McKenna

Ian commenced service in September 2001 as an Ambulance Care Assistant with the Greater Manchester Ambulance Service and worked in GM throughout his service with NWAS.

Peter was a PTS Team Leader and commenced service with Cumbria Ambulance Service in April 1992 at Kendal station. Throughout his 28 year career, Peter worked across many areas of Cumbria and more recently was based at Westmorland station. Peter was a team leader for more than half his service, managing the team across South Lakeland.

Ryan, aged 32, passed away on 11 December following an illness. He had been part of the NWAS family since 2011 and was a highly respected, well liked, friend, colleague and clinician.

Bill Delaney worked for urgent care services based at Fazakerley station and worked for the trust for 3.5 years after a lengthy career with Merseyside Police.

Bill McKenna was an EMT1 based at Wallasey ambulance station and worked for the trust for 7 years

The trust sends sincere condolences to the families and friends of Ian, Peter, Ryan, Bill and Bill

5 LEGAL IMPLICATIONS

5.1 There are no legal implications associated with the content of this report.

6. RECOMMENDATION(S)

6.1 The Board of Directors is recommended to:

- Receive and note the contents of the report.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27 January 2021			
Subject:	Northern Ambulance Alliance (NAA) programme update			
Presented by:	Daren Mochrie, Chief Executive			
Purpose of Paper:	For Discussion			
Executive Summary:	The paper provides the North West Ambulance Service (NWAS) Trust Board with an overview of Northern Ambulance Alliance (NAA) key work stream progress. The NAA consists of 4 Trusts: East Midlands Ambulance Service NHS Trust; North East Ambulance Service NHS Foundation Trust; North West Ambulance Service NHS Trust; and, Yorkshire Ambulance Service NHS Trust.			
Recommendations, decisions or actions sought:	It is recommended that the NWAS Trust Board discuss and note the content of the report and plans outlined regarding the current position and plans to progress the NAA work programme. It is recommended that the NWAS Trust Board notes the plans for future NAA strategy and planning, and supports the proposals for co-production in quarter 4, in particular socialising the plans with senior leadership teams.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	
Date:	
Outcome:	

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1.0 PURPOSE

The paper provides the North West Ambulance Service (NWAS) Trust Board with an overview of Northern Ambulance Alliance (NAA) key work stream progress.

2.0 BACKGROUND, CURRENT CONTEXT & PROGRESS

2.1 NAA Board

The NAA Board meets bi-monthly and last met on 12 November 2020. The CEOs last met on 23 November 2020. The most recent NAA Board meeting has been postponed from 14 January 2021 until 11 February 2021. This paper provides an update on actions and progress since the last NWAS Board.

2.2 Summary

- There has been continued positive progress across a number of NAA work streams despite Covid pressures.
- We continue to deliver on what can progress (e.g. Tranman) and contingency plans for other areas with adjusted timelines and understanding of risk and mitigation (e.g. Computer Aided Dispatch-CAD).
- There has been positive progress on completing the telecare work, with NWAS colleagues.
- NWAS Unified Communications roll-out to 111 was delivered on 6 January 2021.
- The plans to develop the NAA 3-5 year plan in Q4 remain on track.
- There are no major areas of concern.

2.3

Action 1: Review current position of work streams, plans and impact during Covid

There has been some significant progress since June/July up until October 2020. There has also been considerable work on the underpinning systems, structures and processes to support progress both now and in the future. Recognising that all the NAA services continue to experience unprecedented pressures it was agreed to review the work that can continue (at the same or a reduced pace) and the work that may need to be paused in light of capacity and prioritisation, recognising the associated risk and any mitigation. At 23 November 2020 meeting the NAA CEOs supported a plan for each of the work streams during quarter 3 and the plans to restart work in January 2021 (recognising there may be further unforeseen delay due to continued Covid and/or winter pressures).

Work streams are currently continuing or paused with risks managed within current structures. This has been reviewed with leads and key stakeholders and is detailed in Table 1 (see Appendix 1) for the most recent reporting period (December 2020).

2.4

Action 2: Launch of the NAA Website and Annual Report

The NAA Board agreed to communicate the position regarding work streams in the context of the challenges and priorities across member Trusts, aligned to the ongoing commitment to NAA work, plans for the future and launch of the NAA website and Annual Report. This has been delivered with Communications

colleagues across member Trusts in November / December 2020. A plan is in place to support regular website content updates.

2.5

Action 3: Progress the NAA strategy development proposals.

The proposal to develop a longer term (3-5 year) plan with defined 2021/22 impacts, outcomes and outputs from prioritised work streams, aligned with the learning from NAA work to date and complementing member trusts' transformation and business plans was approved at the CEOs Meeting on 23 November 2020. Co-production work with stakeholders is on track.

2.6

Action 4: NAA Legal Form

The November NAA Board agreed that all trusts would consider the Hill Dickinson Legal Options Paper (September 2020) and an update would be provided at the NAA Board meeting scheduled for 14 January 2021. The CEOs were requested to consider if they required further support / discussion to ensure the options and recommendations are discussed and endorsed at the Trust Boards for discussion at the NAA Board on 11 February 2021.

2.7

Further Developments

To support the development of the future NAA strategy and continuous improvement across the NAA work streams, the following underpinning activities are currently being progressed:

- Benefits Management Strategy
- Benefits realisation and continuous improvement on project closure supported by the Benefits Management Strategy
- Risk and Issues Management Strategy
- Quality impact assessments (QIA), equality impact assessments (EIA) and data protection impact assessments (DPIA)

3.0

NEXT STEPS

The strategy and plan development work as described above (Action 3) has progressed to the initial plan, with the next step to share the analysis of current NAA work, previous NAA plans and content analysis of member Trust plans back with each Trust Strategy lead separately and as a group (to sense check and identify opportunities). The NWAS Board are asked to support the plans for full co-production in this quarter (Q4), in particular socialising the plans with senior leadership teams.

4.0 LEGAL and/or GOVERNANCE IMPLICATIONS

There are no legal implications associated with the content of this report.

5.0 RECOMMENDATIONS

It is recommended that the NWAS Trust Board discuss and note the content of the report and plans outlined regarding the current position and plans to progress the NAA work programme.

It is recommended that the NWAS Trust Board notes the plans for future NAA strategy and planning, and supports the proposals for co-production in quarter 4, in particular socialising the plans with senior leadership teams.

Appendix 1:

Table 1: NAA Progress on a Page Report - December 2020

Project on track
Project progressing but minor/moderate risk or issues identified and affecting delivery
Project off track with major risks/issues that require escalation

NB-RAG status amended from Nov 2020 to include red, amber, green

										FORECAST
PROJECT	**ELEMENTS**	**CURRENT SUMMARY**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**
QUALITY IMPROVEMENT	**OVERALL PROJECT STATUS**	**Forecast reflects COVID impact. QI Council meeting cancelled in November 2020. A meeting is due to be held in January 2021 to re-establish progress with this programme (cancelled on 13.01.21)**	**RED**	**RED**	**GREEN**	**GREEN**	**GREEN**	**AMBER**	**AMBER**	**AMBER**
	TIME	**Capacity for QI Council to meet regularly is limited due to COVID-19 response and availability of core council members to move forward delivery plans**	**RED**	**RED**	**GREEN**	**GREEN**	**GREEN**	**AMBER**	**AMBER**	**AMBER**
	SCOPE	**No current issues**	**RED**	**RED**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**
	RISKS & ISSUES	**Capacity for QI Council to meet regularly is limited due to COVID-19 response and availability of core council members to move forward delivery plans**	**NA**	**NA**	**GREEN**	**GREEN**	**GREEN**	**AMBER**	**AMBER**	**AMBER**
TRANMAN	**OVERALL PROJECT STATUS**	**Slippage against timescales; project now on track. Phase 1a closure report completed. Phase 2 commenced. Updates to Project Board & DPB**	**RED**	**RED**	**RED**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**
	TIME	**No current issues; assurances given that phases 1b & 2 will be delivered in this financial year**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**
	SCOPE	**Project within original scope**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**
	RISKS & ISSUES	**Two strategic level risks: GRS interface will not integrate with our NHS systems impacting user expectation including benefits realisation. Escalated to Project Board and DPB – positive progress**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**GREEN**	**AMBER**	**AMBER**	**AMBER**

TELECARE DECISION SUPPORT TOOL	OVERALL PROJECT STATUS	Work paused due to sickness absence of lead. Agreed plan with NWAS, TSA & telecare providers. Plan to complete by end March 2021 with desktop research. New plan being developed.	RED	RED	RED	RED	GREEN	RED	RED	RED
	TIME	Slippage due to COVID-19 and current pause	RED	RED	RED	RED	GREEN	RED	RED	RED
	SCOPE	Tasks out of original scope. Project re-scoped.	RED	RED	RED	RED	GREEN	GREEN	GREEN	GREEN
	RISKS & ISSUES	Significant risk-will not achieve the objectives. Forecast reflects sickness absence of lead and further Covid delay. Predict completion by end March 2021.	RED	RED	RED	RED	GREEN	RED	RED	RED
AVOIDABLE CONVEYANCE	OVERALL PROJECT STATUS	Work paused due to sickness absence of lead & capacity of key stakeholders. Plan to revisit Jan 2021, complete March 2021. No significant risk or impact of pause.	RED	RED	RED	RED	GREEN	RED	RED	RED
	TIME	Slippage against key milestones due to COVID-19 and current pause	RED	RED	RED	RED	GREEN	RED	RED	RED
	SCOPE	Project within original scope	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
	RISKS & ISSUES	Significant risk-will not achieve the objectives. Forecast reflects sickness absence of lead.	RED	RED	RED	RED	GREEN	RED	RED	RED
COMMON CAD	OVERALL PROJECT STATUS	Delay due to COVID. SOC approved Sept 2020. OBC by July 2021. Forecast reflects Covid & other capacity impact. Continued resource/expertise from Mason Advisory has been agreed by NAA CE's to achieve the planned project timescales/objectives	GREEN	GREEN	GREEN	GREEN	RED	AMBER	AMBER	AMBER
	TIME	Project timescales have been re-baselined incorporating 3 months delay to account for limited User & Working Group capacity Oct-Dec 2020; this is dependent on User Group availability from Jan 2021	GREEN	GREEN	GREEN	GREEN	RED	AMBER	AMBER	AMBER
	SCOPE	Project within original scope	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
	RISKS & ISSUES	Major/strategic risks escalated to Digitisation Programme Board 15.12.20 including resource/SME availability. No change to risks/issues.	NA	NA	RED	RED	RED	RED	RED	RED

North West Ambulance Service NHS Trust

REPORT

Board of Directors											
Date:	Wednesday 27 January 2021										
Subject:	Q3 Board Assurance Framework Review & Corporate Risk Register (CRR)										
Presented by:	Angela Wetton, Director of Corporate Affairs										
Purpose of Paper:	For Decision										
Executive Summary:	The proposed Q3 position (as at 31st December 2020) of the BAF with the associated CRR risks scored ≥15 can be viewed in **Appendix 2**. The BAF Heat Maps for 2020/21 year to date can be viewed in **Appendix 3**. The Corporate Risk Register (CRR) can be seen in **Appendix 1**. In total, **58** mitigating actions are identified on the BAF: **21** actions have been completed during Q3 with no actions yet to be commenced or completed late. (s5) As part of the Q3 review with Director leads, no proposed changes have been identified. (s4)										
Recommendations, decisions or actions sought:	The Board of Directors are requested to: • Agree the Q3 position of the Board Assurance Framework										
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒							
	Right Place	☒	**Every Time**	☒							

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	None Identified
Previously Submitted to:	Assurance Committees, ELC and Audit Committee
Date:	Throughout Q3
Outcome:	For Assurance

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1. PURPOSE

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

This paper provides an opportunity for the Board of Directors to review the Q3 Board Assurance Framework (BAF) position along with the Corporate Risk Register (CRR) that contains risks scored ≥15 that are aligned to each BAF risk. In addition, themes and gaps identified by the Head of Risk and Assurance as part of the risk profiling work informs discussions with Directors and Senior Managers across the organisation.

2. RISK ASSURANCE PROCESS

The BAF risks are reviewed at each Board Committee meeting providing the opportunity to identify where assurances support potential mitigation of risks, commission where appropriate any additional assurance and identify any associated risks that may require escalating or de-escalating through the Chair's Assurance Reporting process. Risks identified on the CRR are mapped against the BAF risks and are included within the reports, providing sight of the progression of each risk. This in turn, supports the identification of any additional assurances that may need to be commissioned by the Chair as well as recognising where the achievement of risk mitigation may impact positively or negatively on the BAF risks.

To support the Q3 review of the BAF, the Head of Risk and Assurance has collated assurance information reported throughout the quarter onto the Assurance Map. The information has been identified through attendance at Board Committee Meetings and review of the Chair's Assurance Reports from both Management Groups and Board Committee meetings. The assurance mapping has been used to support discussions with Executive Directors and assist with updating the BAF risks.

3. REVIEW OF THE CORPORATE RISK REGISTER

The review of the CRR takes place at the Executive Leadership Committee (ELC) as well as the Board Committee meetings in the organisation. Here, assurance is sought that controls and mitigations are applied and actions are in place to ensure that the risk is being actively managed. The CRR can be viewed for information in **Appendix 1**.

4. REVIEW OF STRATEGIC RISKS Q3

The quarterly review process provides an opportunity for the Director Lead to meet with the Head of Risk and Assurance, to discuss the updates of their relevant risks. These meetings have taken place with either Director Leads or their nominated senior manager responsible for updating the BAF. Adjustments to the BAF risks has subsequently been undertaken. The proposed Q3 position for the BAF risks with associated Corporate Risk Register risks scored 15 and above can be viewed in

Appendix 2.

The Heat Maps for 2020/21 year to date can be viewed in **Appendix 3**.

Following a full review of the controls and assurances across the BAF, there are no changes proposed during this reporting quarter.

5. EXCEPTION REPORT ON MITIGATING ACTIONS IDENTIFIED ON THE BAF

In total, **58** mitigating actions are identified on the BAF: **21** actions have been completed during Q3 with no actions yet to be commenced or completed late.

Risk Description	Actions to be Completed	Exceptions
SR01: If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety	**21 action(s) to be completed** **18 action(s) In Progress** **7 action(s) Completed on Time**	Action: Improve the number of unscored incidents across the Trust *This action was completed during Q3; assurance was reported to the Quality and Performance Committee* Action: Assurance against the identified 10 'Should Do' CQC Recommendations *Assurance has been reported to the Quality and Performance Committee and also to the Board of Directors during Q3.* Action: Roll out of the electronic SafeCheck System Trust-wide *Assurance has been reported to the Quality and Performance Committee and also to the Board of Directors during Q3.*
SR02: If we do not have effective financial management, this may impact on the Trusts' financial position	**0 action(s) to be completed** **2 action(s) Completed on Time**	No exceptions to report at the time of report production.
SR03: If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care	**3 action(s) to be completed** **3 action(s) In Progress** **5 action(s) Completed on Time**	No exceptions to report at the time of report production.
SR04: If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of the Trusts' objectives	**7 action(s) to be completed** **7 action(s) In Progress** **2 action(s) Completed on Time**	No exceptions to report at the time of report production.
SR05: If we do not review our estate and fleet to reflect the needs of the future service model and commit to reduce emission,	**2 action(s) to be completed** **2 action(s) In**	No exceptions to report at the time of report production.

this may impact on the Trusts' infrastructure and achieving environmental efficiencies	**Progress** **1 action(s) Completed on Time**	
SR06: If we do not build and strengthen stakeholder relationships across systems, localities and neighbourhoods, this may impact on the Trusts' reputation and ability to achieve our vision to be the best ambulance service in the UK	**2 action(s) to be completed** **2 action(s) In Progress**	No exceptions to report at the time of report production.
SR07: If we do not improve and maintain our digital systems, this may impact on the delivery of secure IT systems and digital transformation	**14 action(s) to be completed** **14 action(s) In Progress** **7 action(s) Completed on Time**	7 actions have been completed during Q3 with assurance being presented to the Resources Committee.
SR08: If we do not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the Trusts' ability to complete and gain business and commercial opportunities that will generate income and protect our core service	**1 action(s) to be completed** **1 action(s) In Progress** **3 action(s) Completed on Time**	No exceptions to report at the time of report production.
SR09: If the organisation experiences further change at Board level during 2020/21, this may impact on relationships and ability to deliver the Trust's strategic objectives	**5 action(s) to be completed** **5 action(s) In Progress**	No exceptions to report at the time of report production.
SR11: If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21	**3 action(s) to be completed** **3 action(s) In Progress** **1 action(s) Completed on Time**	Action: Consideration to step-up arrangements to Winter/ Phase 2 of COVID-19 Pandemic *This action was completed during Q3 with a revised NWAS Strategic Winter Plan being presented for assurance at the Quality & Performance Committee.*

6. LEGAL and/or GOVERNANCE IMPLICATIONS

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

7. RECOMMENDATIONS

The Board of Directors are requested to;

- Agree the Q3 position of the Board Assurance Framework.

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Appendix 1: Corporate Risk Register

**Extracted from Datix on 30 December 2020*

Corporate Risk Register

DX ID	Opened	Risk Type	Risk Subtype	Risk Description	Lead(s)	Role Type	Rating (initial)	Key Controls in place	Likelihood (current)	Consequence (current)	Rating (current)	Risk Evaluation	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Forecast Completion Date	Last reviewed	Date of next review
2867	22/02/2019	Operational	Innovation	There is a risk of oversight or system issues, due to a high number of high impact projects linked to critical systems being delivered simultaneously, which could result in system failures.	Power, Maxine	QII - IM&T	16	1. Change Control process to ensure the change is robust, widely communicated and contingency plans are in place where possible. 2. Supplier engagement on high impact service changes 3. Key programmes have PMO support and individual risks 4. Corporate programme Board 5. Project support for Digital projects (SPMS) and aligned with key projects 6. CIO Role in post 7. Continuous reviews of plans 8. Structure review for additional resources to support projects agreed and progressing 9. Increased VDI infsatrcuture	4	4	16	Treat - implement controls and mitigating actions to reduce the risk.	Multiple training programmes being delivered symultaneously on and offsite Multiple projects running at same time -UCP, embedding SPMS, 111 First, ESMCP, infrastructure work Lack of detailed scoping of interdepndacies between changes to critical systems Firewall capacity may not be sufficent	CPB and DOF oversight - minutes System resilience measures	System resilience and continuity audit - underway with MIAA	8	26/02/2021	11/11/2020	23/12/2020
2920	01/04/2019	Operational	People	There is a risk that sufficient workforce resources are not in place across NHS 111 service leading to the inability to meet contracted KPIs which could result in comprised patient care and reputational damage to the Trust.	Blezard, Ged	SD - 111 Service	20	1. NHS111 Workforce Plan in place 2. Performance Management Framework in place monitoring all key metrics including attendance, training etc. 3. Senior Management in place to focus on resources and performance 4. FCMS contract in place with regular meetings to monitor performance 5. Additional monies provided in light of the corona virus impact on demand to deploy extra staff. 6. Contract negotiations have now started with commissioners. 7. Additional resources now in 111 due to covid-19. 8. Uplift in funding received	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	ORH report demonstrates that KPIs cannot be achieved at the current funding model. Increase in Covid-19 calls. Funding uplift received insufficient to meet KPI's. Sickness absence below target level. Staffing levels below required levels. Development of implementation plan for the U&E Care Strategy.	ORH demand. NHS 111 National Reporting. Staffing levels below required levels. NHS 111 performance reporting into Quality & Performance Committe. Performance Management Framework. NHS 111 workforce reporting into Resources Committe.	New rotas. Development and implementation of H&WB Plan.	4	30/09/2021	09/12/2020	10/01/2021
3027	03/07/2019	Operational	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	Ward, Lisa	PD - Human Resources	20	01. Increased numbers for direct entry and in-service conversion programmes for 2019/2020 starts. 02. 2019/20 in-service conversion rescheduled to maximise staff availability over winter periods (2019 and 2020) 03. National specification out to tender for paramedic apprenticeship (in-service conversion route from 2020 onwards). 04. Active recruitment 05. EMT approved 3 year transition to new skill mix July 2019 06. EMT approved increase in internal progression to 170 in July 2019, 165 starts. 07. Paramedic apprenticeship preferred supplier in place and contract award approved by Board. 08. Turnover remains stable. 09. Plans agreed with HEIs to prevent COVID from delaying completion of programmes 10. HCPC approval of UDC apprenticeship programme. 11. Recruitment to paramedic apprenticeships commenced 12. HEE funding secured for rotational working pilots and recruitment to infrastructure posts commenced 13. ELC approved key decisions for Paramedic apprenticeship, including supporting posts, cohort size and pay and conditions 14. Paper drfated for ELC to seek approval for he Trust to become a sponsor to allow the recruitment on non-UK citizens. Thsi would allow the recruitment of non-UK Paramedics already workign on other UK ambulance services.	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	01. Local Paramedic supply insufficient to meet potential demand 02. Impact of GP reform on retention unclear 03. Change in GP contract to band 7 funding for Paramedic posts. Further proposal also suggest Band 8A might be added to the ARRS. 04. Delay to rotational pilots as a result of COVID-19 05. PCN recruitment plans unclear	EMT1s on track to achieve the AAP qualification. 02. AACE and HRD oversight of impact of GP reforms 03. Prevoius paper to EMT approving over-establishment of paramedics and increases in provision 04. EMT paper July 2019 - agreed 3 year transition to increased skill mix 05. Agreed ToR and project plan for rotational working groups 06. ELC approval of Paramedic apprenticeship supplier - January 2020 07. Confirmation of HCPC validation of apprenticeship course. 08. Contract for apprenticeship awarded. 09. POC case to ELC 19/08/20 which identifies Pilot Schemes. 10. Develop trust offer for rotational paramedic working both internal and externally - model in place and advanced discussions. 11. Pilot Schemes identified 12. ELC report Nov 20, confirmed continuation of two pilot scheme 13. ELC report Nov 2020, assurance on Paramedic apprenticeship progress and key decision milestones 14. Resources Committee, assurance on Paramedic apprenitcesip and ORH plans 15. UEC Oversight Forum and CPB regular reporting on rotational working project 16. HEE fundin bid approved for rotational working infrastructure pilots 17. Intelligence from HEE suggests that the initial recruitment under the GP refrom may not be as high as intiially predicted for next year.	STP/ICS oversight of paramedic demand outside of ambulance trust Clear understanding about how the healthcare system is proposing to use paramedics to fill staffing gaps	4	31/03/2021	23/12/2020	29/01/2021

3062	13/08/2019	Clinical	Patient Safety	There is a risk that 999 call takers fail to identify key words and phrases relating to respiratory calls which could result in the wrong categorisation and/or delay the response leading to detrimental patient care, increase in complaints and reputational damage to the Trust.	Blezard, Ged	SD - Directorate Wide Risk	20	01. EMD & EMD Support Staff Training Programme 02. MPDS Certification 03. EMD & EMD Support Staff Mentoring Process 04. EOC Audit Team Monitoring Compliance 04. EOC Education & Learning Information; Bulletins, EMD CDE 05. Planned move to MPDS v13.1 06. EMD Training Planned for move to MPDS v13.1 07. Established T&F Group; Review of SI, Learning & Training 08. Engagement with other AMPDS Trust 09. Establish Best Practice and Shared Learning with other Trusts 10. HoS EOC raise concerns with L&D team around risk 11. Introduction of mandatory training module 12. MPDS v13.2 implemeneted across the Trust 13. MPDS v13.2 Briefings issued to EMDS 14. Audits post MPDS v13.2 demonstrate improved compliance 15. 1 hour training module developed; 2020/21 Mandatory Training 16. Established T&F Group to review 999 respiratory calls 17. Continued engagement with other NHS Ambulance Trusts 18. Reviewed new systems for auditing and leveling compliance 19. Recommedations from T&F Group reporting to EOC Gov Group 20. Joint discussions surrounding mitigations to the risk	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Inconsitent application of MPDS process Human Factors Recognised as a national risk within MPDS	Call Audits EMD Training Records EMD Briefings & Bulletins MPDS Certificates T&F Group ToR T&F Group Minutes Incident Report Forms Mandatory Training Module for EMDs Serious Incidents Serious Incident Reports NWAS Workforce Indicatos report	New Mandatory Training Module Compliance	5	31/03/2021	18/11/2020	18/12/2020
3156	11/10/2019	Operational	Performance	There is a risk that if consistent high rates of sickness and absenteeism occur across the 111 service line this could result in KPIs not being achieved so impacting on patient care and reputational damage to the Trust.	Blezard, Ged	SD - 111 Service	20	1. Adherence to NWAS Sickness Policy and Procedures by all levels of management across 111. 2. Return to work interviews carried out in line with NWAS Policy and Procedures. 3. NWAS, Directorate and Area reporting in place. 4. Performance Management Framework in place to monitor and focus on attendance across 111. 5. Introduction of CEO Accountability reviews which focus on all KPIs including attendance. 6. Introduction of HR master classes for team managers to focus on attendance. 7. New rotas now commenced, providing staff with work life balance. 8. Asymptomatic testing in place	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	ORH report demonstrates that KPIs cannot be achieved at the current funding model. Sickness absence below target level. Impact of isolationa nd other measures due to COVid 19	ORH demand. Workforce Reports. Performance Management Framework.	New rota patterns. Development of H&W Being Plan.	4	31/03/2021	08/12/2020	11/01/2021
3187	06/01/2020	Operational	Performance	There is a risk that the Trust could have poorly located sites due to the Trust not planning effectively for the future configuration of its estate which could result in a negative impact on operational performance (PES and PTS).	Wood, Carolyn	FIN - Estates & Facilities	10	1. Backing of Trust Board of Directors to implement the Estates Rationalisation programme. 2. Local involvement and accountability. 3. Project Initiation Document identifies links between interdependencies of other capital and revenue schemes. 4. New Estates Strategy was approved by Board in September 2018.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.		Area Project Group Meetings with Heads of Service Dedicated PMO Oversight Schemes have own Business Cases Estates Oversight Forum reporting to CPB established to replace Future Estates Programme Board		5	30/03/2021	24/12/2020	10/03/2021
3210	26/02/2020	Financial	Estates & Facilities	There is a risk that if inter-dependencies between other strategies such as EOC, training and medicines management which feed into and drive the Estates Strategy are not aligned in a timely manner this could result in delays and non-delivery of key elements of the Estates Strategy.	Wood, Carolyn	FIN - Estates & Facilities	20	1. Estates Contact Centre Programme Group 2. Trust IBP has links with all key Trust strategies 3. Corporate Programme Board has oversight of Estates Strategy progress 4. Oversight Forum established August 20	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Functional strategies from all key areas including estates elements Outcome of options from Estates Contact Centre Programme Group	Strategic Implementation Plan Through quarterly meeting reports to Resources Committee Meeting held with property management (Orbit) to gain their understanding and support EOF established Aug 20	Updates to the Trust Programme Board started September 20 PMO High Level Plan	5	31/01/2021	24/12/2020	22/01/2021

3236	07/04/2020	Operational	Performance	There is a risk that national ARP performance standards will not be achieved because of a lack of resources, increase in activity or hospital pressures which may result in compromised patient care, reputational damage to the Trust and an increase in patient complaints.	Blezard, Ged	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	25	1. Strategic, Tactical and Operational Management in place to focus daily on delivery of ARP standards. 2. Additional resources utilised to support performance delivery, ie PTS, Overtime and VAS. 3. ALOs in place at hospital sites to improve ambulance turnaround. 4. Performance Management Framework in place to focus on delivery of all associated key metrics, ie attendance, fleet etc. 5. Demand Management Plan in place to assist with activity/escalation management. 6. Frequent Caller Team in place to manage high frequency users. 7. Clinical Leadership in place in EOCs to support EMDs with call length reduction and upgrades/down grades. 8. Hospital Handover Programme in place to support hospital turnarounds. 9. Rota review complete and implemented in GM and C&L. 10. Covid-19 Strategic Command Cell in place to lead on related matters. 11. Increased focus from the ROCC Commander and Strategic Commander to manage performance particularly Cat 1 and Cat 2. 12. Modelling work commenced with ORH re PES resources and EOC Dispatch. 13. Preliminary findings and first draft report received from ORH. 14. C&M Revised Rota's live on 21/09/2020 15. ORH presented final report identifying resource gap. 16. Engaging with AACE to review operating model with a view to simplifying. 17. Procuring additional resources through 365 model - PAS/VAS 18. Increased PAS/VAS scope of practice 19. Reviewed Demand Management Plan 20. Patient safety Plan now live and replaced the DMP. 21. Reduction in duplicate calls.	4	5	20	Treat - Implement controls and mitigating actions to reduce the risk.	Sufficient resources to deliver performance.	National ARP Reporting. ELC, Quality & Performance Committee Reporting. Performance Reports, ie ARP, P1, Hospital Handover, AQI reports etc. Demand Management Plan. National Pandemic Card 36. Performance Management Framework & PES Dashboards. ROCC Procedures & Logs. Revised Rotas in GM, C&L and C&M following rota review.		5	31/03/2021	08/12/2020	11/01/2021
3237	07/04/2020	Operational	Performance	There is a risk that patient care could be comprised and national ARP performance standards not achieved because of excessive ambulance handover delays at hospital sites which may result in reputational damage to the trust, detrimental patient care and in increase in patients complaints.	Blezard, Ged	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	20	1. Executive and Operational Management engaged with hospitals to support handover delays. 2. ALOs in place at hospital sites to improve ambulance turnaround. 3. Hospital Handover Programme in place. 4. Hospital Handover reporting in place for all hospitals including HAS screens on site. 5. A&E Delivery Boards in place and attended by Executive/Senior Managers to focus on handover delays. 6. Demand Management Plan in place to focus on activity/escalation management. 7. Hospital handover currently being achieved at circa 30 minutes (ytd @ May 20) due to less activity/attendance at A&E. 8. DDPs attendance at national calls re handover. 9. Initial discussions taken place with DDOps and NWAS Head of Improvement re QI approach to hospital handover/appropriate conveyance. 10. Beginning of phase three of Every Minute Matters. 11. MP and SH presented on the 2 Sept at the North West Winter Planning Meeting chaired by NHSE/I North West relating to hospital handover and Every Minute Matters 12. Identified three Acutes to work with as part of the National ask from NHSE/I through the Hospital Handover DElays Review Meeting. ROLD, STEP and WHIST. 13. NWAS Concerns reviewed nationally by AACE through information collated daily by the NACC in-line with all English Ambulance Services. 14. bi-weekly strategic meeting chaired by Prof A Marsh to review all handover delays and report pressures to NHSE/I central team. Specific hospital outliers monitored by NHSE/I with escalation to respective CEO. 15. NWAS Concerns raised by Dir of Qual & Inov MP with NHSE/I North West Executives and lead Commissioners. Scoping review undertaken to identify most	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Consistent delivery of ambulance handover times.	Commissioner Reporting. ELC, Quality & Performance Committee Reporting. Hospital Handover Reporting. Performance Management Framework & PES Dashboards.	Consistent delivery of ambulance handover reporting.	5	31/03/2021	08/12/2020	11/01/2021
3238	07/04/2020	Operational	People	There is a risk that patient care could be comprised and national ARP Performance standards not achieved because of consistent high rates of sickness and absenteeism across PES which may result in detrimental patient care and reputational damage to the Trust.	Blezard, Ged	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	16	1. Adherence to NWAS Sickness Policy and Procedures by all levels of management across PES. 2. Return to work interviews carried out in line with NWAS Policy and Procedures. 3. NWAS, Directorate and Area reporting in place. 4. Performance Management Framework in place to monitor and focus on attendance across PES. 5. Development and Introduction of staff dashboard demonstrating staff self isolating due to covid-19. 6. Staff swabbing in place to identify covid-19 cases. 7. Ongoing discussions with HR and John Wray re risk assessment and support in the workplace for staff currently shielding. 8. Increased the number of support vehicles obtained on a daily basis from VAS/PAS providers. 9. Reviewed all abstraction rates and training implications with Head of W&OD CO and PES HoS incl Head of Regional Planning GL - to reduce any unnecessary staff release in order to maximise available resources. 10. Reviewed and amended the SPTL admin days to ensure additional frontline resource can be deployed. 11. Extended PTS uplift staff support until March 2021 12. Lateral Flow Testing	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	Covid-19 related sickness - self isolating, Track and Trace, additional shielding groups.	National Attendance Reporting. NACC reporting re covid-19. Workforce Committee reporting. ELC, Performance & Committee Reporting. Performance Management Framework & PES Dashboard.	Full compliance with attendance targets.	4	31/03/2021	08/12/2020	11/01/2021

3318	14/05/2020	Operational	People	There is a risk that COVID-19 has impacted on the delivery of the planned October 2020 paramedic apprenticeship cohort which could impact on the subsequent recovery plan for commencing the paramedic apprenticeship in February 2021 which would impact on longer term paramedic supply	Ward, Lisa	PD - Workforce Development	20	01. Programme validated by HCPC, all conditions met 02. UoC Programme lead appointed for NWAS programme 03. SCAS programme commencing in Oct 2020 04. NWAS/UoC programme and planning meetings 05. Recruitment of clinical lecturers 06. Recruitment of cohorts for Feb 2021 start	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	Unknown Covid 19 resource demand requirements may impact on programme starts in Feb 2021	Programme approved by HCPC on 25 September 2020 ELC Paper approved 18th November 2020 Two-weekly UoC/NWAS meetings Programme commenced delivery in SCAS for 25 students in October 2020 Paper to JPC on 14th December 2020	01. ELC Paper required to set out scope of programme 02. Confirmation of PES abstractions and numbers that can be supported for release	8	26/02/2021	16/12/2020	11/01/2021
3320	14/05/2020	Operational	People	There is a risk that the reduction in hearings will lead to conduct or capability matters not being effectively dealt with leading to impact on patient care	Ward, Lisa	PD - Human Resources	20	01. Any suspensions that were in place at the start of the pandemic are still in place and being regularly reviewed. 02. A small number of more serious cases have continued to be brought to conclusion. 03. A risk assessment process has been developed to flag a priority order when resuming investigations / hearings. 04. HRBP Team are looking at ways in whih cases can be expediated by reviewing and suggesting a temporary adjustment to the Scheme of Delegation. 05. Principles regards employee relations cases agreed with Trade Unions to commence.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	01. ET application responses from the Trust being delayed due to postal service delays and home working arrangements within the Team. 02. Lack of Operational and Clinical resources to pursue cases resulting in very lengthly investigations and potentially adverse impact on individual staff members. 03. The impact of the current situation with regards the Trusts strategic intentions around Just and Learning Culture and the associated review of the Disciplinary Procedure.	01. Temporary Scheme of delegation approved by ELC. 02. SPF document issued to Trusts to pause until 30/09 unless agreements reached. 03. Principles for managing ER cases agreed with local trade Unions. 04. HR Team prioritising cases in line with agreed principles. 05.ER tracker with ER cases now reported on a monthly basis to ELC.		5	31/03/2021	20/11/2020	31/01/2021
3324	14/05/2020	Operational	Performance	There is a risk that performance standards are not achieved because of the increased acuity of calls received into the 111 service due to the COVID-19 outbreak which may impact on patient safety	Blezard, Ged	SD - 111 Service	16	01. Strategic, Tactical and Operational Management in place 02. Performance Management Framework 03. Additional funding from NHSE to support maximum resources 04. FCMS Supporting NHS 111 Call Taking 05. Additional resources utilised to support performance delivery 06. Demand Management Plan in place to assist with activity/ escalation management 07. Clinical Leadership in place 08. NWAS escalated to REAP Level 3 to focus on performance 09. NHS 111 COVID-19 Command Cell in Place to manage response 10. Appraisals cancelled 11. Statutory & Mandatory Training cancelled 12. New flagging system on clinical queue to identify Non-COVID-19 Patients 13. Utilisation of all NHSP trained operatives from Audit, Training and Management 14. Daily Conference Calls with NHSE 15. Daily Conference Calls within NWAS 16. NWAS COVID-19 Response Plan 17. Recruitment and training of Y1 Uni Students for Call Taking Roles (111 and 999).	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	Corporate/Additional staffing now returned to normal duties. CRS due Oct 7th Capacity within 119 to manage demand.	111 Reporting. Performance Committee/ELC reporting. Commissioner/National reporting.	Not at this time.	4	31/12/2020	29/12/2020	29/01/2021
3372	16/07/2020	Compliance & Regulatory	Environmental	There is a risk that if the Trust continues to fail to segregate healthcare waste on vehicles they will remain non-compliant with the Hazardous Waste (England and Wales) Regulations 2005 which could result in financial penalties and prosecution.	Wood, Carolyn	FIN - Estates & Facilities	15	Task and Finish Group Draft Waste & Resources Strategy	5	3	15	Treat - Implement controls and mitigating actions to reduce the risk.	Current practice not fully compliant with legislation and department of health guidance. Insufficient resource for project delivery and loss of external consultancy support to implement the change required. Infection control have previously objected to this project Task and Finish Group is in its infancy, the first meeting was 16-Jul-20	Task and Finish working group set up to analyse requirements to impliment change. Action plan to be devised for delivery of service provision changes. Task Group to assess current failing and devise strategy for bridging the gaps Task Group to liaise with procurement to cover any changes within the waste contract currently being procured and with sufficient flexibility built in to absorb any potential future changes Task Group to run pilot scheme to gauge any succes and identify and remedy any issues flagged and roll out delivery of strategy Healthcare Waste Segregation working group met 20-Aug-20 and identified a number of challenges which are being documented to present as an update the next SSG Due to operational pressures and challenges associated with implementing healthcare waste segregation on vehicles, the SSG have approved deferring the trial implementation until spring 2021	Inadequate segregation system in place. Waste and Resources Strategy in draft format, scheduled for approval in October Task and Finish Group is in its infancy the first meeting was held 16-Jul-20	1	31/03/2021	29/12/2020	29/01/2021

3391	14/08/2020	Operational	Performance	There is a risk that national ARP performance standards may not be sustained due to the inability to continue with all supportive measures activated through COVID-19 response, which may result in reputational damage to the trust.	Blezard, Ged	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	20	1.Multiple daily ARP reports detailing actual performance. 2.Daily reporting on delayed response. 3.Commitment made for August and September to procure additional 3rd Party Provider shifts through the '365' marketplace. 4.ELC agreement that PTS Support will continue until the end of the financial year (Mar 2021). 5.Strategic, Tactical and Operational Management in place to focus daily on delivery of ARP standards. 6.ALOs in place at hospital sites to improve ambulance turnaround. 7.Performance Management Framework in place to focus on delivery of all associated key metrics, ie attendance, fleet etc. 8.Demand Management Plan in place to assist with activity/escalation management. 9.Frequent Caller Team in place to manage high frequency users. 10.Clinical Leadership in place in EOCs to support EMDs with call length reduction and upgrades/down grades. 11.Hospital Handover Programme in place to support hospital turnarounds. 12.Rota review complete and implemented in GM and C&L. 13.Covid-19 Strategic Command Cell in place to lead on related matters. 14.Increased focus from the ROCC Commander and Strategic Commander to manage performance particularly Cat 1 and Cat 2. 15.Modelling work commenced with ORH re PES resources and EOC Dispatch. 16.Preliminary findings received from ORH. 17. Management of staff shielding to maximise staffing levels. 18. Development of paper to NHSE/I to establish additional funding. 19. C&M Rota review completed and live on 21/09/2020 20. ORH Final Report delivered 21. PTS Support continues to 31 March 21 - review in January	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Risk of second wave of the COVID-19 pandemic	National ARP Reporting ELC, Quality & Performance Committee Performance Reporting; ARP, CPU, Hospital Handover, AQI Demand Management Plan (DMP) National Pandemic Card 36 Performance Management Frameworks and PES Dashboards ROCC Procedures and daily occurrence logs Revised rota's in three PES areas folliwng rota review		5	31/03/2021	08/12/2020	11/01/2021
3394	14/08/2020	Operational	Performance	There is risk that operational resource levels will not match demand/activity due to increased Covid-19 shielding arrangements/guidance which may result in delayed patient care and ability to deliver national ARP standard's	Blezard, Ged	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	20	1. Undertaking of risk assessments for individuals highlighted by the survey. 2. Use the risk assessment for those shielding since March. 3. Social distancing in place across all Trust sites where possible. 4. Office assessments taken place to encourage social distancing. 5. Face masks available when social distancing not possible. 6. Hand sanitisers available in all locations 7. Desk cleaning products are available in all locations. 8. Individual risk assessments for those higher risk. 9. Potential to redeploy staff to lower risk areas such as 111 or CHUB. 10. Wider opportunity for all staff to complete their own risk assessment to highlight any vulnerabilities. 11. Reviewed commercial cleaning contracts to increase at appropriate sites 12. Lateral Flow Testing across the organisation available to all staff. 13. Relaxation of national shielding arrangements.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Potential of second/further waves of COVID-19 R-Rate increase in the community - resulting in staff absence or increased demand New NHSE/I guidelines published	Establishment of dedicated HR Cell providing SPOC for specialist advice Trust COVID-19 Updates published by the Comms team to ensure staff remain informed ORH Final Report of activity and Resourcing NWAS COVID-19 Response Plan		5	31/12/2020	08/12/2020	11/01/2021
3407	10/09/2020	Compliance & Regulatory	Clinical	There is a risk that Learning from Deaths (a regulatory requirement upon the Trust) may not be embedded across the Trust due to a lack of resources and suitable trained subject matter experts to perform the structured judgement reviews which may impact on compliance to National standards.	Grant, Chris	MED - Medical Operations	16	1. Learning from Deaths Coordinator post temporarily in place until 31/03/2021 2. As from September data SJRs (November 2020) a named clinician cohort have been in place to undertake elements 2-4 of stage 1 SJRs.	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	Named subject matter access for EOC dispatch and coding review yet to be identified meaning SJRs are currently only partially completed	SJR Panels and work schedule in place for 2020/21		8	31/03/2021	16/12/2020	11/01/2021
3409	11/09/2020	Operational	Emergency Preparedness	There is risk due to the National UK terror threat level increasing to severe, increasing likelihood of a terror attack within the NWAS geographical footprint which may impact on the delivery of urgent and emergency care	Blezard, Ged	SD - Directorate Wide Risk	20	01. Major Incident Response Plan 02. Action Cards within the MIRP for dedicated roles 03. Major Incident training for all operational staff at induction 04. Command and Control System in operation 24/7 05. Dedicated NILO role 24/7 06. Annual refresher training for On Call Commanders 07. HART Teams located in Liverpool and Manchester 08. Established staff role of Ambulance Intervention Team (AIT) 09. Commanders trained to deploy in an MTA Incident 10. Training of Commanders to deploy staff in an MTA Incident 11. NWAS Cascade System 12. Business Continuity Plans 13. Internal movement of resources (Strategic Redeployment) 14. National MoU with other UK Ambulance Trusts for mutual aid 15. Attendance in Local Resilience Forums (LRFs) 16. NWAS Communications Bulletin; Increase in current threat level 17. All Major Incident Fleet checked by Resilience Manager & HART 18. Collaboration with other Emergency Services & Agencies 19. National funding approved for UK Ambulance Service focused specifically on MTA	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.		Mass Casualty Dispersal Plan BCM Plans Major Incident Response Plan	BCM Plans	5	31/03/2021	08/12/2020	11/01/2021

3432	19/10/2020	Operational	Patient Safety	There is a risk that staff abstractions will significantly increase due to COVID-19 infection rates within the EOC & CHUB environment and associated isolation procedures. This could result in a significant inability for the trust to operate call-handling, dispatch and remote triage functions.	Blezard, Ged	SD - Emergency Operations Centre	20	1. NWAS COVID-19 Response Plan 2. IPC Guidance and consumables available at all sites 3. Regular COVID-19 specific comms messages to all NWAS staff. 4. NWAS Track and Trace team 5. EOC COVID-19 Cell 6. HR COVID-19 Cell operational 7. BC Plans in place at all sites. 8. Support home working where practical 9. EOC Lockdown - no unauthorized access 10. Lateral Flow Testing distributed to approx 3300 staff - this will identify asymptomatic COVID-19 affected staff.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	R Rate Increases in the community – resulting in staff absence or increased demand Potential of second/further waves of COVID-19 Lack of IM&T Infrastructure to support homeworking Staff compliance to IPC guidance	Organisational ESR reporting and sickness absence reporting procedure. Establishment of dedicated HR Cell providing SPOC for specialist advice Trust COVID-19 Updates published by the Comms team to ensure staff remain informed ORH Final Report of activity and Resourcing NWAS COVID-19 Response Plan	Enforcement of face coverings in the workplace	5	31/03/2021	08/12/2020	11/01/2021
3433	26/10/2020	Financial	Financial	There is a risk that NWAS are recruiting staff and committing funds associated to Estates, IMT & support staff structures in relation to NHS 111 First without any agreed recurrent funding in place which may result in NWAS carrying a large financial risk in to 2021/22 and beyond.	Wood, Carolyn	FIN - Management Accounts	16	1, The Director of Finance presented a paper to the Regional Leadership Group on 14th October, which outlined the 2020/21 and recurrent funding required. 2020/21 funding was agreed but there has been no agreement yet on recurrent funding. 2, NHSE/I, commissioners and the Regional Leadership Group are all aware of the recurrent financial impact for NWAS. 3, Ongoing dialogue between Finance and 111 Operations to minimise the recurrent impact as possible without impacting on service provision. 4, 111 Operations, Finance and HR are in regular dialogue regarding the trajectory of recruitment to mitigate the recurrent impact.	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	No confirmed recurrent funding information available as the phase 3 financial regime covers 1st October 2020 to 31st March 2021	Reported to the Regional Leadership Group on 14th October	Phase 4 planning guidance not yet received (due mid-December).	4	31/03/2021	15/12/2020	31/12/2020
3435	30/10/2020	Operational	Business / Continuity Planning	There is a risk that if the number of Covid related cases and outbreaks continue to rise within the second wave of the pandemic and business continuity plans need to be enacted, the plans may be insufficient and therefore services may be adversely affected which can result in patient harm.	Power, Maxine	QII - Clinical Safety	20	Enhanced IPC support - temporary Outbreak executiveled trust- wide reporting meeting structure Early escalation of issues Tactical/strategic command structure re- established Improved data reporting mechanisms via informatics/MIAA Reap Level controls	4	5	20	Treat - Implement controls and mitigating actions to reduce the risk.	limited ipc staff - currently temp staf being used to support team - not substansive outbreak manaagement requires further operational support limited TTT support Continuinty plans not yet enacted - consider REAP review	weekly oversight by ELC weekly oversight by IPC and 111 on current position NSE/I and commissioners oversight and reporting local operational report to weekly trust outbreak group	consideration of increasing reap to address potential failire of BCP trust wide action plan to plan for worst case scenario in relation to covid outreaks	5	31/03/2021	29/12/2020	29/01/2021
3437	03/11/2020	Financial	Financial	There is a risk that the H2 draft planned financial deficit is not achieved because of the Covid-19outbreak which may increase the Trust financial pressure, and further compromise achievement of Trust statutory financial duties and requirements.	Wood, Carolyn	FIN - Management Accounts	15	Phase 3 financial plans have been resubmitted to ICS (18th Nov 20) which identify a projected deficit of £4m, with the following included:- 01.Additional expenditure forecast of £4.7m funding for 111 First, funded by £2.9m SDF and £1.8m supported by the NW system. 02. Projected £14.9m additional costs and income from L&SC Covid-19 allocation, based on the resources put in place for Covid-19response Wave 1 03. £2.3m additional 111 core contract extension funding 04. £1.25m efficiencies have been included in the plan, based on run rate savings identified in H1 05. Projected £0.9m additional costs linked to winter pressures 06. NHSE/I have continued the Monthly Block Contract arrangements based on £29.6m, this has been reconciled and agreed by Finance 07. Cash flow will continue to be closely monitored to ensure there is no negative impact on the Trust due to this new NHS finance regime	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Awaiting formal approval of the submitted Phase 3 plans for L&SC ICS from NHSE/I.	2020/21 Phase 3 (M7-M12) financial plan paper presented to ELC on 11/11/2020 and Resources Committee on 20/11/20 Income and expenditure forecast will be regularly monitored and reported, with formal reports of actual financial position against plan to ELC, Resources Committee and Board.	National approval has not yet been received.	10	31/12/2020	14/12/2020	31/12/2020

1181	30/01/2014	Operational	Innovation	There is risk that the Trust's Critical Telephone System (999) and/or the Voicemail messaging service fails which could result in an inability to appropriately respond and treat patients within agreed target timescales.	Power, Maxine	QII - IM&T	20	1. Robust National 999 Network 2. Constantly monitored by National Operator Centre 3. Full Business Continuity plans developed in partnership with all telecom providers. 4. Resilient telephone system and network design including diverse routing. 5. NWAS operate a virtual regional network 6. 24/7 specialist support from NWAS staff and Third party suppliers 7. There is constant liaison with the core provider 999 liaison teams who will monitor and advise of any threat that may interrupt the service. 8. SMT Team meetings to review system updates/ outages 9. Change request process in place and meets weekly as part of a formal CAB 10. A back up voicemail server is being purchased to enable a swap out in the event of failure, greatly reducing downtime. 11.Unified Communications Programme has submitted a business case to replace all telephony and the voicemail solution which will eliminate this risk. 12. Unified Communications Business case approved and work underway.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Current telephony systems are end of life and are no longer supported by Avaya with only limited support from BT available. Full Business Continuity plans need to be reviewed and tested in partnership with the providers and EOC Avaya are no longer providing any security patching or updates after April 19 The Voicemail server is end of life ,vulnerable to cyber attack and sits on the NWAS LAN, any outages would result in no messages being heard and dropped call rates Due to increased capacity of home workers due to COVID-19 the CISCO infrastructure may exceed capacity	BT providing interim maintenance and support Any system downtime reported to ICT SMT meetings Changes to telephony are strictly monitored and controlled via CAB	Report from third party to show preventative maintenance outcome	5	02/11/2020	11/11/2020	31/12/2020

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North West Ambulance Service NHS Trust

Appendix 2

Board Assurance Framework 2020/21

Board of Directors
Wednesday 27 January 2021

Data Extracted from Datix: 30 December 2020

Q3 2020/21 Reporting Timescales:

Quality & Performance Cttee:	18/01/2021
Resources Cttee:	22/01/2021
Executive Leadership Cttee:	20/01/2021
Audit Cttee:	15/01/2021
Board of Directors:	27/01/2021

Delivering the right care, at the right time, in the right place; every time

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

Director Lead:	
CEO	Chief Executive
DCEO	Deputy Chief Executive
DoQII	Director of Quality Innovation & Improvement
MD	Medical Director
DoF	Director of Finance
DoOps	Director of Operations
DoP	Director of People
DoSP	Director of Strategy & Planning
DoCA	Director of Corporate Affairs

Board Assurance Framework Legend

Strategic Priorities	The 2018/2023 strategic priority that the BAF risk has been aligned to
BAF Risk	The title of the strategic risk that threatens the achievement of the aligned strategic priority
Rationale for Current Risk Score	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk
Operational Risk Exposure	The key areas of operational risks scored 15 and above that align with the BAF risk and have the potential to impact on the score
Controls	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority /
Assurances	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk
Evidence	This is the platform that reports the assurance
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk
Required Action	Actions required to close the gap in control(s)/ assurance(s)
Lead	The person responsible for completing the required action
Target Completion	Deadline for completing the required action
Monitoring	The forum that will monitor completion of the required action
Progress	A RAG rated assessment of how much progress has been made on the completion of the required action — Incomplete/ Overdue | Action In Progress | Completed Late | Completed on Time

OUR STRATEGY AT A GLANCE

Our vision is to be the best ambulance service in the UK by delivering the right care, at the right time, in the right place; every time.

Values:

Working Together for Patients

Commitment to Quality of Care

Respect and Dignity

Compassion

Everyone Counts

Improving Lives

North West Ambulance Service - Our Strategy 2019 - 2024

Priorities:

Urgent and Emergency Care

Increasing service integration and leading improvements across the healthcare system in the North West.

Quality

Delivering appropriate care, which is safe, effective and patient centered for each individual.

Digital

Radically improving how we meet the needs of patients and staff every time they interact with our digital services.

Business and Commercial Development

Developing skills and capability to explore business opportunities for current and new viable contracts, services or products.

Workforce

Engaging and empowering our leaders and staff to develop, adapt and embrace new ways of delivering the right care.

Stakeholder relationships

Building and strengthening relationships that enable us to achieve our vision.

Infrastructure

Reviewing our estates and fleet to reflect the needs of the future service model.

Environment

Committing to reduce emissions by embracing new technology including electric vehicles.

Supporting strategies:

- Urgent and Emergency Care Strategy
- Quality (Right Care) Strategy
- Digital Strategy
- Finance plan - long term financial model
- Workforce Strategy
- Communications and Engagement Strategy
- Estates and Fleet Strategies

BOARD ASSURANCE FRAMEWORK DASHBOARD 2020/21

BAF Risk	Committee	Exec Lead	01.04.20	Q1	Q2	Q3	Q4	2020/21 Target	Final Target
SR01: If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety	**Quality & Performance**	**DoQII**	**15** 5x3 CxL		**15** 5x3 CxL	**15** **5x3** **CxL**		**10** 5x2 CxL	**5** 5x1 CxL
SR02: If we do not have effective financial management, this may impact on the Trusts' financial position	**Resources**	**DoF**	**25** 5x5 CxL		**20** 5x4 CxL	**20** 5x4 CxL		**15** 5x3 CxL	**10** 5x2 CxL
SR03: If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care	**Quality & Performance**	**DoOps**	**25** 5x5 CxL		**20** 5x4 CxL	**20** 5x4 CxL		**15** 5x3 CxL	**5** 5x1 CxL
SR04: If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of the Trusts' objectives	**Resources**	**DoP**	**16** 4x4 CxL		**16** 4x4 CxL	**16** 4x4 CxL		**12** 4x3 CxL	**8** 4x2 CxL
SR05: If we do not review our estate and fleet to reflect the needs of the future service model and commit to reduce emission, this may impact on the Trusts' infrastructure and achieving environmental efficiencies	**Resources**	**DoF**	**12** 3x4 CxL		**12** 3x4 CxL	**12** 3x4 CxL		**9** 3x3 CxL	**3** 3x1 CxL
SR06: If we do not build and strengthen stakeholder relationships across systems, localities and neighbourhoods, this may impact on the Trusts' reputation and ability to achieve our vision to be the best ambulance service in the UK	**Board of Directors**	**DoSP**	**8** 4x2 CxL		**12** 4x3 CxL	**12** 4x3 CxL		**8** 4x2 CxL	**4** 4x1 CxL
SR07: If we do not improve and maintain our digital systems, this may impact on the delivery of secure IT systems and digital transformation	**Resources**	**DoQII**	**12** 4x3 CxL		**12** 4x3 CxL	**12** 4x3 CxL		**12** 4x3 CxL	**8** 4x2 CxL
SR08: If we do not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the Trusts' ability to compete and gain business and commercial opportunities that will generate income and protect our core services	**Resources**	**DCEO**	**15** 5x3 CxL		**15** 5x3 CxL	**15** 5x3 CxL		**10** 5x2 CxL	**5** 5x1 CxL
SR09: If the organisation experiences further change at Board level during 2020/21, this may impact on relationships and ability to deliver the Trusts' strategic objectives	**Board of Directors**	**CEO**	**12** 4x3 CxL		**12** 4x3 CxL	**12** 4x3 CxL		**8** 4x2 CxL	**4** 4x1 CxL
SR10: If the UK Government leaves the EU during the transitionary period with a no deal may impact on our ability to provide the service at the required levels resulting in inflated costs, disruption to supplies and loss of workforce	**Board of Directors**	**DoSP**			**12** 3x4 CxL	**6** 3x2 CxL		**6** 3x2 CxL	**3** 3x1 CxL
SR11: If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21	**Board of Directors**	**CEO/ DCEO**	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL		**10** 5x2 CxL	**5** 5x1 CxL

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR01: If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trust's compliance with regulatory requirements for quality and safety

LEAD DIRECTOR: DoQII

Compliance/ Regulatory/ Quality Risk Appetite: Low

STRATEGIC PRIORITY: Quality

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Impact of COVID-19 pandemic on front line resources and demand
- Resources vs demand levels affecting operational performance
- Increased length of time taken to close Serious Incidents
- Increased length of time taken to close Complaints

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
15		15	15		10	5
5x3		5x3	5x3		5x2	5x1
CxL		CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has maintained at a score of 15 due to the continued risk that the Trust may not deliver appropriate, safe, effective and patient-centred care due to the increased demand, as detailed in SR03. This is potentially catastrophic for the Trust as it would lead to patient and/or staff harm and/or multiple breaches in our statutory duties and subsequent prosecution from one or more regulatory bodies. The likelihood of this occurring is possible, as the Trust potentially moves into a second wave of COVID and winter pressures. However, it should be recognised that despite this, good progress has been made during Q3 against the identified gaps in controls and assurances surrounding medicines management, completion of COVID-19 Premises Risk Assessments, IPC BAF, establishment of a COVID-19 Test, Track and Trace Service; which will potentially surface an additional high level risk of outbreaks, provision and distribution of RPE, completion of 12 monthly QAVs across the Trust, improved number of unscored incidents, assurance against the 10 CQC 'Should Do' recommendations and the roll out of SafeCheck.

CONTROLS	ASSURANCES	EVIDENCE
Incident Reporting		
Level 4 & 5 Incident Scruitiny & Review at ROSE	**Level 2:** Reportable Events Report	Reported to BoD (BOD/2021/26)
Serious Incidents		
NHSE Serious Incident Framework	**Level 2:** Serious Incidents Bi-Annual Assurance Report	Reported to Q&P Cttee (Q&PC/2021/95)
Complaints		
Complaint Management	**Level 2:** Complaints Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/10)
Level 4 & 5 Complaint Scuitiny & Review at ROSE	**Level 2:** Reportable Events Report	Reported to BoD (BOD/2021/26)
Health, Safety & Security		
Health and Safety Management	**Level 2:** Health, Safety & Security Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/31)
Working Safely During COVID-19	**Level 2:** COVID-19 Premises Risk Assessments	Reported to Q&P Cttee (Q&PC/2021/102a)
Safeguarding		
Safeguarding Practices & Processes	**Level 2:** Safeguarding Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/37)
Safeguarding Serious Case Reviews	**Level 2:** Reportable Events Report	Reported to BoD (BOD/2021/26)
Infection, Prevention & Control		
NWAS Internal IPC Audits	**Level 2:** IPC Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/32)

NWAS IPC Practices	**Level 2:** IPC Board Assurance Framework	Reported to BoD (BOD/2021/70)			
Medicines Management					
Medicine Administration & Management Practices	**Level 3:** MIAA Audit Medicine Management – Events (2019/20)	Reported to Audit Cttee			
NWAS Internal Medicines Audits	**Level 2:** Medicines Management & CD Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/34)			
Safety/ Compliance					
Quality Assurance Visits	**Level 2:** Annual Programme of Trust-wide QAVs	Reported to Q&P Cttee (Q&PC/2021/94)			
Effectiveness					
Major Trauma Care & Enhanced Pre-Hospital Care	**Level 3:** North West Major Trauma Operational Delivery Networks Peer Review	Reported to Q&P Cttee (Q&PC/ 2021/97)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Serious Incidents					
Actions Arising from Serious Incident Investigations	Timely completion of actions arising from SI investigations	Ms C Wade	March 2021	Q&P Cttee	In Progress
Timely Submission of Reports within 60 days	Increase completion of SI Reports to Commissioners	Ms C Wade	March 2021	Q&P Cttee	Completed On Time
Learning from Serious Incidents	Embed learning identifed from SIs across the Trust	Ms C Wade	March 2021	Q&P Cttee	In Progress
Complaints					
Learning from Complaints	Embed learning identifed from complaints across the Trust	Ms C Wade	March 2021	Q&P Cttee	In Progress
Timely Closure of high level Complaints	Level 4 & 5 Complaints are closed within timeframe	Ms C Wade	March 2021	Q&P Cttee	In Progress
Safeguarding					
Rejections of Safeguarding Concerns	Devise and embed alternative pathways for Mental Health patients	Ms A Hansen	March 2021	Q&P Cttee	In Progress
Child Protection Information Sharing in 999	Roll out of national Child Protection Information Sharing system	Ms A Hansen	March 2021	Q&P Cttee	In Progress
Infection, Prevention & Control					
Compliance with IPC Performance Metrics/ Standards	Improved compliance against performance metrics across the Trust	Ms A Hansen	March 2021	Q&P Cttee	In Progress
Medicines Management					
CD Licence Inc. CD Procurement and Supply	Devise a Strategic Plan detailing options for CD storage & supply	Ms R Fallon	January 2021	Q&P Cttee	Completed On Time
Systems & Governance of Safe and Secure Handling of Medicines	Review & enhance safe & secure handling of medicines	Ms R Fallon	January 2021	Q&P Cttee	Completed On Time
Compliance with NICE PGD Guidance	Review Medicines Policy to reflect NICE guidance	Ms R Fallon	January 2021	Q&P Cttee	Completed On Time
Expired Medicines	Reduction in expired medicine pouches in circulation	Ms R Fallon	January 2021	Q&P Cttee	In Progress

CD Station and Vehicle Audits	Improve compliance in quality indicators for medicine audits	Ms R Fallon	January 2021	Q&P Cttee	In Progress
PGD Medicines Management	Complete actions identified by MIAA Internal Audit	Ms R Fallon	January 2021	Q&P Cttee	Completed On Time
Safety/ Compliance					
CQC Action Plan	Assurance against the identified 10 'Should Do' Recommendations	Mr N Barnes	January 2021	Q&P Cttee	Completed On Time
SafeCheck	Roll out of electronic SafeCheck System Trust-wide (PES)	Mr N Barnes	January 2021	Q&P Cttee	Completed On Time
Effectiveness					
Timely Response to Patients to Prevent Harm	Commence the trail of the Clinical Coordination Desk in EOC	Dr C Grant	January 2021	Q&P Cttee	In Progress
Learning from Deaths	Ensure learning from deaths aligns to lessons learned	Dr C Grant	January 2021	Q&P Cttee	In Progress
Safety Netting Patients	Implementation of Safe Care Closer to Home Audits to assure clinicians are ending care safely	Dr C Grant	March 2021	Q&P Cttee	In Progress
Timely Response to Patient to Prevent Harm	Evaluation of the Clinical Coordination Desk trail in EOC	Dr C Grant	March 2021	Q&P Cttee	In Progress
Just Culture Organisation	Creation of an implementation plan to embed 'Just Culture' across the organisation	Dr C Grant Ms L Ward	March 2021	Q&P Cttee	In Progress

Risks Scored 15+ Aligned to BAF Risk: SR01					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3062	Service Delivery	There is a risk that 999 call takers fail to identify key words and phrases relating to respiratory calls which could result in the wrong categorisation and/ or delay the response leading to detrimental patient care, increase in complaints and reputational damage to the Trust	**20 Significant**	**15 Significant**	5 Moderate
3407	Medical	There is a risk that Learning from Deaths (a regulatory requirement upon the Trust) may not be embedded across the Trust due to a lack of resources and suitable trained subject matter experts to perform the structured judgement reviews which may impact on compliance to National standards	**16 Significant**	**16 Significant**	8 High
3435	Quality	There is a risk that if the number of Covid related cases and outbreaks continue to rise within the second wave of the pandemic and business continuity plans need to be enacted, the plans may be insufficient and therefore services may be adversely affected which can result in patient harm	**20 Significant**	**20 Significant**	5 Moderate
3466	Quality	There is a risk that there is currently no consistent approach, across the Trust, to the reporting and management of level 1 to 3 internal and external incidents, which will result in missed opportunities for managing identified harm, potentially identifying higher levels of harm, learning and the prevention of reoccurrence	**15 Significant**	**15 Significant**	5 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR02: If we do not have effective financial management, this may impact on the Trust's financial position	**LEAD DIRECTOR:** DoF	**Financial/ VfM Risk Appetite:** Moderate

STRATEGIC PRIORITY: ALL

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- M7-12 Financial Operating Plans
- 2020/21 Cost Improvement Programmes

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
25		20	20		15	10
5x5		5x4	5x4		5x3	5x2
CxL		CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has remained at a score of 20 due to financial plans for the second half of the financial year have been submitted via the ICS, but the ICS and regional plans are yet to be agreed as a financial gap remains for the last six months of the year. A final submission by the ICS is expected early in January 2021. There is also an inherent 1% efficiency requirement within the funding envelope.

CONTROLS	ASSURANCES	EVIDENCE
Financial Position		
Financial Management & Performance	**Level 2:** 2020/21 M09 Financial Report	Reported to Resources Cttee (RC/2021/63)
Code of Conduct and Accountability	**Level 2:** Standing Financial Instructions, Standing Orders & Scheme of Delegation	Reported to Audit Cttee & BoD
Financial Plans	**Level 2:** 2020/21 Financial Plans for Capital Programmes **Level 2:** M7-12 Finanical Plans	Reported to BoD Reported to Resources Cttee & BoD
Significant Change Project(s)	**Level 2:** Business Cases with Financial Impact	Reported to ELC & CPB
Financial Systems Key Controls	**Level 3:** MIAA Audit Financial Systems Key Controls (2019/20)	Reported to Audit Cttee
Charitable Funds	**Level 3:** MIAA Audit Charitable Funds (2019/20)	Reported to Audit Cttee
Agency Expenditure		
Internal Monitoring of Agency Costs against 2019/20 NHSI Ceiling	**Level 2:** Financial Performance Report	Reported to Resources Cttee
Procurement		
Procurement Strategy	**Level 2:** Procurement Assurance Report	Reported to Resources Cttee (RC/2021/37)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
2020/21 Cost Improvement Programmes	Producing financial plans inline with ICS requirements	Ms C Wood	October 2020	Resources Cttee	Completed On Time
M7-12 Financial Operating Plans	Producing financial plans inline with ICS requirements	Ms C Wood	November 2020	Resources Cttee	Completed On Time

Risks Scored 15+ Aligned to BAF Risk: SR02					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3433	Finance	There is a risk that NWAS are recruiting staff and committing funds associated to Estates, IMT & support staff structures in relation to NHS 111 First without any agreed recurrent funding in place which may result in NWAS carrying a large financial risk in to 2021/22 and beyond	**16 Significant**	**16 Significant**	4 Moderate
3437	Finance	There is a risk that the H2 draft planned financial deficit is not achieved because of the Covid-19 outbreak which may increase the Trust financial pressure, and further compromise achievement of Trust statutory financial duties and requirements	**15 Significant**	**15 Significant**	10 High

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR03: If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care

LEAD DIRECTOR: DoOps

Compliance/ Regulation/ Quality Risk Appetite: Low
Financial/ VfM Risk Appetite: Moderate

STRATEGIC PRIORITY: Urgent & Emergency Care

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
25		20	20		15	5
5x5		5x4	5x4		5x3	5x1
CxL		CxL	CxL		CxL	CxL

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Workforce Vacancies
- Service Performance
- Contract Performance
- COVID-19

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has remained at a score of 20 due to COVID-19 remains as a significant cause for staff abstractions, elongated job cycle times and increasing hospital handovers across the region. NHS 111 performance has improved with the introduction of additional staffing for 111 First. We have now successfully delivered the Cleric system upgrade and also delivered the new telephony system in NHS 111, which will assist in the delivery of performance. PTS continues to support 999 with staff and vehicles. PTS performance is in line with national arrangements is not being monitored. There is a reduction in PTS capacity on vehicles due to social distancing. PTS have reached their maximum capacity and are delivering well against standards, even though these are being monitored. On the 02 November 2020, the Trust declared an internal major incident due to demand out-stripping capacity, this was predominately in the Greater Manchester area, where we experienced a significant increase in activity and acuity of patients over a sustained period. As a result of this, the Trust reviewed its Demand Management Plan, this was refocused as the Patient Safety Plan and new triggers were implemented. The early indications identify that this has had a positive impact on patient safety. The Directorate has appointed a dedicated resource to be responsible for the management of both operational risk and governance.

CONTROLS	ASSURANCES	EVIDENCE
Strategy		
Urgent and Emergency Care Strategy	**Level 2:** Strategy Progress Assurance Report	Reported to Q&P Cttee (Q&PC/ 2021/179)
Performance		
Increased Workforce (PES and NHS 111)	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)
ORH Modelling	**Level 2:** ORH Modelling Report	Reported to Q&P Cttee (Q&PC/ 2021/145)
Utilisation of PTS Workforce & Student Paramedics	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)
Increased Operational Resources	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)
Hospital Handover	**Level 2:** Hospital Handover Report	Reported to Q&P Cttee (Q&PC/ 2021/30)
Enhanced Clinical Stack Management Maximising H&T Outcomes	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/175)
Greater Manchester Clinical Assessment Service	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/175)
Engagement with NHS Providers – Reduction in PTS Aborted Journies	**Level 2:** PTS Performance Assurance Report	Reported to Q&P Cttee (Q&PC/ 2021/176)
Activity		
Contingency Planning	**Level 2:** 2020/21 Heat Wave Plan **Level 2:** 2020/21 Strategic Winter Plan	Reported to Q&P Cttee & BoD (Q&PC/ 2021/144) Reported to Q&P Cttee & BoD (Q&PC/ 2021/128)
NWAS Operating Level	**Level 1:** REAP Level	Reported to ELC (Weekly)

Demand Management Plan	**Level 1:** ELC Performance Reports	Reported to ELC (Weekly)			
Mutual Aid Framework	**Level 3:** National Agreement	Reported to ELC/ Q&P Cttee/ BoD			
National Agreement for Protcol 36	**Level 3:** Agreement at NDOG/ NASMED/ AACE	Reported to BoD (PBM/2021/05)			
Resources					
Increased Operational Resources	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)			
Utilisation of Private Providers	**Level 2:** Directorate Service Provision Paper	Reported to ELC (ELC/ 2021/04c)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
2020/21 Winter Plan	Devise NWAS Winter Plan	Mr G Blezard	October 2020	Q&P Cttee	Completed on Time
Optima Review	Completion of Optima Tools on Resourcing	Mr G Blezard	October 2020	Q&P Cttee	Completed on Time
Independent Review of Resources	Complete ORH Modelling to establish Required Resources to Deliver Performance	Mr G Blezard	October 2020	Q&P Cttee	Completed on Time
Commissioner Funding to Deliver Performance	Engagement with Commissioners following the ORH Modelling to fund the gap in resources in order to deliver performance	Mr G Blezard	November 2020	Q&P Cttee	Completed On Time
Commissioner Engagement	Engagement with Commissioners surrounding Capacity Review	Mr G Blezard	November 2020	Q&P Cttee	Completed On Time
Simplify the Resource Model	Undertake a review with AACE to streamline the process	Mr G Blezard	March 2021	Q&P Cttee	In Progress
Staff Abstractions due to Track and Trace	Ensure adherance to IPC Standards across the Directorate and utilisation of Private Providers when abstractions are high	Mr G Blezard	March 2021	Q&P Cttee	In Progress

Risks Scored 15+ Aligned to BAF Risk: SR03					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2920	Service Delivery	There is a risk that insufficient workforce resources are not in place across NHS 111 Service leading to inability to meet contracted KPIs which could result in comprised patient care and reputational damage to the Trust	**20 Significant**	**16 Significant**	4 Moderate
3027	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand	**20 Significant**	**16 Significant**	4 Moderate
3156	Service Delivery	There is a risk that if consistent high rates of sickness and absenteeism occurs across the 111 Service line this could result in KPIs not being achieved so impacting on patient care and reputational damage to the Trust	**20 Significant**	**16 Significant**	4 Moderate
3187	Finance	There is a risk that the Trust could have poorly location sites due to the Trust not planning effectively for the future configuration of its estate which could result in a negative impact on operational performance for PES and PTS	**25 Significant**	**15 Significant**	5 Moderate
3236	Service Delivery	There is a risk that national ARP performance standards will not be achieved because of a lack of resources, increase in activity or hospital pressures which may result in compromised patient care, reputational damage to the Trust and an increase in patient complaints	**25 Significant**	**20 Significant**	5 Moderate
3237	Service Delivery	There is a risk that patient care could be comprised and national ARP performance standards not achieved because of excessive ambulance handover delays at hospital sites which may result in reputational damage to the trust, detrimental patient care and in increase in patients complaints	**20 Significant**	**15 Significant**	5 Moderate
3238	Service Delivery	There is a risk that patient care could be comprised and national ARP Performance standards not achieved because of consistent high rates of sickness and absenteeism across PES which may result in detrimental patient care and reputational damage to the Trust	**16 Significant**	**16 Significant**	4 Moderate
3324	Service Delivery	There is a risk that performance standards are not achieved because of the increased acuity of calls received into the NHS 111 Service due to the COVID-19 Pandemic which may impact on patient safety	**16 Significant**	**16 Significant**	4 Moderate
3391	Service Delivery	There is a risk that national ARP performance standards may not be sustained due to the inability to continue with all supportive measures activated through the COVID-19 response which may result in reputational damage to the Trust	**20 Significant**	**15 Significant**	5 Moderate
3394	Service Delivery	There is a risk that operational resource levels will not match demand/ activity due to increased COVID-19 shielding arrangements/ guidance which may result in delayed patient care and ability to deliver national ARP standards	**20 Significant**	**15 Significant**	5 Moderate
3409	Service Delivery	There is risk due to the National UK terror threat level increasing to severe, increasing likelihood of a terror attack within the NWAS geographical footprint which may impact on the delivery of urgent and emergency care	**20 Significant**	**15 Significant**	5 Moderate
3432	Service Delivery	There is a risk that staff abstractions will significantly increase due to COVID-19 infection rates within the EOC & CHUB environment and associated isolation procedures. This could result in a significant inability for the trust to operate call-handling, dispatch and remote triage functions	**20 Significant**	**15 Significant**	5 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR04: If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of the Trust's objectives

LEAD DIRECTOR: DoP

Compliance/ Regulatory/ Quality Risk Appetite: Low

STRATEGIC PRIORITY: Workforce

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Mandatory Training & Appraisals Recovery
- Impact of ORH Growth & GP Contract Reform on Paramedic Workforce
- COVID-19
- Manchester Arena Inquiry

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
16		16	16		12	8
4x4		4x4	4x4		4x3	4x2
CxL		CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has remained at a score of 16 due to Q3 seeing a high impact on resource availability from COVID-19 and a further pause to mandatory training and appraisals. Although positive work has been undertaken to recover student programmes, mobilising for NHS 111 First, recommencing the culture audit and values work, as well as achieving improved flu vaccination levels and mobilising for COVID vaccination, challenges have continued throughout Q3 in respect of sufficiency of resources.

CONTROLS	ASSURANCES	EVIDENCE
Strategic		
Workforce Strategy	**Level 2:** 3 Year Implementation Plan/ Bi-Annual Progress Report	Reported to BoD (BoD/2021/52)
COVID-19 Recovery	**Level 2:** Recovery Plan **Level 2:** MIAA Workforce Assurance Self-Assessment	Reported to Resources (RC/2021/16)
National People Plan	**Level 2:** NWAS Implementation Plan	Reported to Resources Cttee (RC/2021/46)
Recruitment and Retention		
Recruitment Inc. Criminal Records & Clinical Registration	**Level 2:** Clinical Registration & Revalidation Assurance Report **Level 3:** MIAA Audit Staff Responders (2019/20) **Level 3:** MIAA Audit Driving Licence Checks (2020/21)	Reported to Resources Cttee (RC/2021/45) Reported to Audit Cttee Reported to Audit Cttee (AC/2021
Safer Staffing Assessment	**Level 2:** Completion of National Safe Staffing Requirements	Reported to Resources Cttee
Staff Retention	**Level 3:** NHSI Retention Plan	Reported to Resources Cttee
Workforce Planning	**Level 2:** Phase 3 Planning Submission **Level 2:** ORH Demand and Capacity Report	Reported to Resources Cttee (RC/2021/51) Reported to Resources Cttee (RC/2021/88)
Developing Potential		
Mandatory Training & Appraisals	**Level 2:** Workforce Indicators Report **Level 2:** Integrated Performance Report **Level 2:** Developing Potential Annual Report	Reported to Resources Cttee (RC/2021/75) Reported to BoD (BOD/2021/75) Reported to Resources Cttee (RC/2021/77)
CQC Action Plan for Mandatory Training & Appraisals	**Level 2:** CQC Workforce Action Plan Assurance Report	Reported Resources Cttee (RC/2021/61)
Perceptorships	**Level 3:** MIAA Audit Newly Qualified Paramedics (2019/20)	Reported to Audit Cttee & Resources Cttee
Apprenticeships	**Level 2:** Apprenticeship Annual Report **Level 3:** OFSTED Inspection **Level 3:** Accredited on Register of Apprenticeship Training Providers **Level 3:** Future Quals Accredition	Reported to Resources Cttee (RC/ 2021/76) Reported to Resources Cttee & BoD
Wellbeing		

Absence Management	**Level 2:** Workforce Indicators Report & Quarterly Sickness Audits **Level 3:** NHSI Action Plan	Reported to Resources Cttee (RC/2021/75) Reported to Audit Cttee
Staff Survey Action Plan	**Level 2:** Localised Engagement Plan **Level 3:** 2019/20 Staff Survey Results	Reported to Resources Cttee (RC/2021/42) Reported to Resources Cttee (RC/2021/79)
Health & Wellbeing Initiatives	**Level 2:** Workforce Inidicators Assurance Report **Level 2:** Risk Assessments **Level 2:** Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2021/75) Reported to BoD (BoD/2021/27) Reported to Resources Cttee (RC/2021/79)
NHSI Health & Wellbeing Diagnostic Tool	**Level 2:** Completed Diagnostic Self-Assessment	Reported to Resources Cttee/ NHSI
2020/21 Flu Vaccination Programme	**Level 2:** Flu Assurance Report **Level 2:** Publication of National Best Practice Checklist **Level 2:** Workforce Indicators Report	Reported to Resources Cttee (RC/2021/43) Reported to BoD (BOD/2021/75) Reported to Resources Cttee (RC/2021/75)
Zeal Culture Audits	**Level 2:** Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2021/79)
Inclusion		
WRES & WDES Measures	**Level 2:** Annual WRES & WDES Reports & Action Plans **Level 2:** EDI Annual Report **Level 3:** Employed Network for Equality & Inclusion Silver Award	Reported to Resources Cttee (RC/2021/44) Reported to BoD (BOD/2021/75)
Gender Pay Gap (Improved Position for 2020)	**Level 2:** Monitoring & Reporting of Action Plan **Level 3:** NW HPMA Award for 'We Look After Our Talent'	Reported to Resources Cttee (RC/2021/44) Reported to BoD (BOD/2021/75)
Equality & Diversity System Assessment 2	**Level 2:** Completed Self-Assessment & External/ Staff Assessment **Level 2:** Annual Equality & Diversity Plan	Reported to Resources Cttee (RC/2021/19) Reported to BoD (BOD/2021/50)
Staff Networks & Exec Champions	**Level 2:** Infrastructure for Networks	Reported to ELC
Reservists	**Level 3:** Gold Standard Accredition Recognition	Reported to Resources Cttee & BoD
Leadership		
Board Succession Planning	**Level 2:** Shadow Board Development Plan	Reported to Resources Cttee
Talent Management Tool	**Level 3:** NW HPMA Award for 'We Look After Our Talent'	Reported to Resources Cttee & BoD
Leadership Framework Inc. Recruitment & Induction	**Level 2:** Leadership Assurance Paper **Level 3:** CMI Accredited Centre	Reported to Resources Cttee & BoD
Organisational Values Project	**Level 3:** External Organisation Leading on Project	Board Development Session
Improvement and Innovation		
Policy Framework	**Level 2:** Policy Progress Assurance Report **Level 3:** Partnership Agreement Review with ACAS	Reported to BoD (BOD/2021/66) Reported to Resources Cttee & BoD
Projects & Programmes Inc. Rota Review & Rotational Working	**Level 2:** Project Progress Reports Inc. POC & PID **Level 3:** Funding Approved by HEE	Reported to CPB
HR & Financial Systems	**Level 3:** MIAA Audit ESR (HR/ Payroll Interface) (2018/19)	Reported to Audit Cttee

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Organisational Values Refresh	Completion of Values Refresh	Ms L Ward	November 2020	Resources Cttee	Completed On Time

NQP Audit	Delivery of Recommended Actions in NQP Audit	Ms L Ward	December 2020	Resources Cttee	Completed on Time
Freedom to Speak Up	Complete actions identified by MIAA Internal Audit	Ms L Ward Ms A Wetton	March 2021	Resources Cttee	In Progress
Recovery of Appraisals	Agreement of recovery trajectory and revised targets for appraisals	Ms L Ward	March 2021	Resources Cttee	In Progress
Recovery of Mandatory Training	Delivery of agreed recovery trajectory for mandatory training	Ms L Ward	March 2021	Resources Cttee	In Progress
Zeal Outstanding Culture	Delivery of Zeal Outstanding Culture Project through to Action Plan	Ms L Ward	March 2021	Resources Cttee	In Progress
HR Financial Systems	MIAA Internal Audit – HR/Payroll Systems (Q4)	Ms L Ward	March 2021	Audit Cttee	In Progress
Policy Group	Mobilisation of the Policy Group during Q4	Ms L Ward	March 2021	Resources Cttee	In Progress
Organisational Values Launch	Launch implementation plan of the values refresh	Ms L Ward	March 2021	Resources Cttee	In Progress

Risks Scored 15+ Aligned to BAF Risk: SR04					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2920	Service Delivery	There is a risk that sufficient workforce resources are not in place across NHS 111 service leading to the liability to meet contracted KPIs which could result in comprised patient care and reputational damage to the Trust	**20 Significant**	**16 Significant**	4 Moderate
3027	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand	**20 Significant**	**16 Significant**	4 Moderate
3318	People	There is a risk that COVID-19 has impacted on the delivery of the planned October 2020 paramedic apprenticeship cohort which could impact on the subsequent recovery plan for commencing the paramedic apprenticeship in February 2021 which would impact on longer term paramedic supply	**20 Significant**	**16 Significant**	8 High
3320	People	There is a risk that the reduction in hearings will lead to conduct or capability matters not being effectively dealt with leading to impact on patient care	**20 Significant**	**15 Significant**	5 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR05: If we do not review our estate and fleet to reflect the needs of the future service model and commit to reduce emission, this may impact on the Trust's infrastructure and achieving environmental efficiencies

LEAD DIRECTOR: DoF

Compliance/ Regulatory Risk Appetite: Low
Financial/ VfM Risk Appetite: Moderate

STRATEGIC PRIORITY: Environment & Infrastructure

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- National Restraints on Capital Funding
- Capacity to Deliver the Estate Strategy
- Interdependencies between Work Streams
- ORH Modelling
- Climate Change

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
12		12	12		9	3
3x4		3x4	3x4		3x3	3x1
CxL		CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has remained at a score of 12 due to compliance within the estate is monitored and reviewed using a Statutory Compliance Audit Tool and the Trust has commissioned an independent professional assessment of the condition of the estate and will inform prioritisation of capital schemes to undertake remedial works. Several Hub and Spoke developments have been initiated with progress being reported to the Resources Cttee. The Trust is actively involved, and a key ambulance lead, with both NHSI ERIC and NHSI Ambulance Teams to develop ERIC and the model ambulance. Vehicle replacement programmes are in progress and on target.

CONTROLS	ASSURANCES	EVIDENCE
Strategic		
Estate & Fleet Strategies	**Level 2:** Strategy Progress Assurance Report **Level 2:** Estate Strategy Review	Reported to Resources Cttee & BoD (2018/19) Reported to Resources Cttee (RC/ 2021/72)
Estates		
Estate Maintenance	**Level 2:** Estate & Fleet Assurance Report **Level 3:** Oakleaf completed Facet Surveys (2020)	Reported to Resources Cttee (RC/2021/71) Reported to Resources Cttee (RC/ 2021/74)
Estate Performance Measurement & Benchmarking	**Level 3:** DHSC Annual Estates Returns Information Collection (ERIC)	Reported to Resources Cttee
Green Plan	**Level 2:** Delivering Green Plan Assurance Report **Level 2:** Green Plan Annual Report **Level 2:** SDAT Submissions	Reported to Resources Cttee (RC/2021/36)
Funding Committed Expenditure (Exisiting Captial Programme)	**Level 2:** 2020/21 Captial Programme & Costings	Reported to Resources Cttee
Estate Business Cases Fully Implemented to enable Strategy	**Level 2:** Annual Capital Receipts for Re-Investment	Reported to ELC/ Resources Cttee
Joint Partnerships with Services in line with Estates Strategy	**Level 2:** Joint Partnership Agreements for Estates	Reported to Resources Cttee & BoD
Management of Clinical Waste	**Level 2:** Waste Assurance Report	Reported to Resources Cttee
New Buildings Designed to Comply with Green Plan & NHS Delivering a Net Zero Health Service	**Level 3:** Energy Performance of Estate	Reported to Resources Cttee
Fleet		
Fleet Maintenance	**Level 2:** Fleet Assurance Report	Reported to Resources Cttee
Vehicle Replacement Programmes & National Ambulance Spec.	**Level 2:** National Procurement of DCA Report **Level 2:** Vehicle Replacement Programme 2020/21 Level 2: Major Incident Vehicle Replacement Programme 21/22	Reported to Resources Cttee (RC/ 2021/69) Reported to Resources Cttee (RC/ 2021/70)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Detailed Plan for Ongoing Estate Maintenance	Creation of a Backlog Maintenance Improvement Plan for Exisiting Estate Based on Facet Survey Report (2020)	Ms C Wood	November 2020	Resources Cttee	Completed On Time

Operational Requirements to Reflect Estate based on ORH Modelling	To Map and Develop Estate based upon Optima Modelling to assure ARP Provides Prime Focus	Ms C Wood	March 2021	Resources Cttee	In Progress
Operational Requirements to Reflect Fleet based on ORH Modelling	To Map and Develop Fleet profiles based upon Optima Modelling to assure peak fleet requirements	Ms C Wood	March 2021	Resources Cttee	In Progress
Utilisation of Model Ambulance	NWAS Contribution to NHSI Working Measures to Deliver Model Ambulance	Ms C Wood	March 2021	Resources Cttee	In Progress

Risks Scored 15+ Aligned to BAF Risk: SR05					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3187	Finance	There is a risk that the Trust could have poorly located sites due to the Trust not planning effectively for the future configuration of its estate which could result in a negative impact on operational performance for PES and PTS	10 High	**15 Significant**	5 Moderate
3210	Finance	There is a risk that if inter-dependencies between other strategies such as EOC, training and medicines management which feed into and drive the Estates Strategy are not aligned in a timely manner this could result in delays and non-delivery of key elements of the Estates Strategy	**20 Significant**	**15 Significant**	5 Moderate
3372	Finance	There is a risk that if the Trust continues to fail to segregate healthcare waste on vehicles they will remain non-compliant with Hazardous Waste (England and Wales) Regulations 2005 which could result in financial pressures	**15 Significant**	**15 Significant**	1 Low

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR06: If we do not build and strengthen relationships across systems, localities and neighbourhoods, this may impact on the Trust's reputation and ability to achieve our vision to be the best ambulance service in the UK	**LEAD DIRECTOR:** DoSP	**Reputation Risk Appetite:** Moderate

STRATEGIC PRIORITY: Stakeholder Relationships

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- System Integration and Partnership Structure Implementation
- Manchester Arena Inquiry

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
8		12	12		8	4
4x2		4x3	4x3		4x2	4x1
CxL		CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q2 has remained at a 12 due to stakeholder relationships not being renewed due to COVID-19 and the Manchester Arena Inquiry which commenced on 07 September 2020 which will look into the emergency services response from January 2021 onwards and specifically the actions of NWAS. We have seen a number of significant headline since the start of the Inquiry across both digital and broadcast media. The implementation of the new System Integration and Partnership structure is scheduled for completion by end of March 2021, currently consultation is taking place with existing staff.

CONTROLS	ASSURANCES	EVIDENCE
Stakeholder Relationships		
Representation and attendance at key meetings	**Level 2:** Stakeholder Engagement Assurance Reports	Reported to BoD
Designated Excecutive Lead for each ICS/ STP footprints	**Level 2:** Executive Director Portfolio Reviews	Reported to BoD
Sharing Intelligence	**Level 2:** Stakeholder Engagement Assurance Report	Reported to BoD
Changes to Commissioning Landscape	**Level 2:** Optima Utilisation to establish collective impact	Reported to BoD
Information Sharing across Key Partners	**Level 2:** Reconfiguration Matrix	Reported to SPB/ ELC
Nominated Senior Manager Leads	**Level 2:** Service Development Team Restructure Paper	Report to ELC (ELC/ 2021/204)
Reputation		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Development Team	Implementation of agreed Structure	Mr S Desai	January 2021	Resources Cttee	In Progress
Stakeholder & Relationships Assurance Report	Bi-annual Assurance Reporting to Board of Directors	Mr S Desai	March 2021	Board of Directors	In Progress

Risks Scored 15+ Aligned to BAF Risk: SR06					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks on the Corporate Risk Register scored 15+ pertaining to this BAF Risk					

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR07: If we do not improve and maintain our digital systems, this may impact on the delivery of secure IT systems and digital transformation

LEAD DIRECTOR: DoQII

Innovation Risk Appetite: Moderate

STRATEGIC PRIORITY: Digital

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Critical Telephone Systems Require Replacing
- Robust Asset Ownership of Hardware and Software; Including IAO Training and Full Risk and Renewal Road Map
- Quarterly Programme of System Resilience Testing for Critical Systems
- Unsupported Software & Hardware (Inc. 2008 Servers)
- Understanding and Management of Data Consumption
- Resilience of On Call Service for Specialist Support
- Multiple high impact changes to critical systems being undertaken simultaneously

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
12		12	12		12	8
4x3		4x3	4x3		4x3	4x2
CxL		CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has remained at a score of 12 as progress continues to be made and the EPR implementation is going well, the Critical Telephony System requires replacement and the Unified Communications Programme is experiencing delays caused by late delivery of the product and insufficient time for testing. Multiple critical system transformation programmes continue simultaneously with Cleric upgrades, continued roll out of EPR, increasing call taking capacity for 111 First, the telephony replacement and implementing office 365. Asset ownership meetings have been difficult to progress due to the pressure operational teams are experiencing although the digital asset register is in place. System resilience measures are being monitored frequently, progress has been made in replacing unsupported hardware and software and the desktop replacement is almost complete to ensure we have a fully supported environment. IT health dashboard is operational with real time monitoring. Work to implement the DSPT as standard practice and implementation of a data consumption monitoring tool which will enable policy development.

CONTROLS	ASSURANCES	EVIDENCE
Leadership & Governance		
Interdependancies and Prioritisation	**Level 2:** Interdependancies Review of Large Scale Digital Programmes	Reported to Corporate Programme Board
Governance Structures	**Level 2:** Terms of Reference for CPB and DOF	Reported to Resources Cttee
Digital First Culture/ Solving Everyday Problems		
Digital Design Forum	**Level 1:** Digital Strategy Assurance Report	Reported to Corporate Programme Board & Resources Cttee
Electronic Patient Record Project Plan	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)
Clinical Leadership; Chief Clinical Information Officer & Heads of Clinical Digital Innovation	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)
Secure & Joined Up Systems		
Prioritisation of Unsupported Critical Systems	**Level 2:** Critical Systems Recovery Plan	Reported to Resources Cttee (RC/2021/47)
Supported Environment	**Level 2:** Agreed Microsoft Email Licensing	Reported to Board of Directors
Asset Management	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2021/81)
Remote Access & Management to NWAS Digital Systems	**Level 3:** MIAA Audit 3rd Party Remote Access & Mngmt (2019/20)	Reported to Audit Cttee
Data Security and Protection Toolkit	**Level 3:** MIAA Audit Data Security and Protection Toolkit (2019/20)	Reported to Audit Cttee
External Penetration Testing and Social Engineering	**Level 3:** External Audit Report	Reported to IG Management Group
Critical System Transformation		

Unified Communications Programme; Business Case, PID & Plan	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee
Supported CAD Infrastructure	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)
NAA Review of CAD Replacement	**Level 2:** NAA Feasibility Study	Reported to Resources Cttee (RC/2021/47)
SPMS Programme	**Level 2:** Digital Strategy Assurance Report **Level 3:** SPMS External Review	Reported to Resources Cttee (RC/2021/47)
Technical Project Support	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)
System Resilience	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2021/81)
Smarter Decisions		
999 Data Warehouse	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)
Power BI	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)
Digital Pioneers		
Safecheck	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Leadership & Governance					
Digital Strategy Review	Undertake a review of the Digital Strategy and addition of measures	Ms A Harrison	January 2021	Resources Cttee	In Progress
Digital First Culture/ Solving Everyday Problems					
Measurement of Digital Culture and Confidence	Establish a baseline of Digital Culture	Ms A Harrison	November 2020	Resources Cttee	Completed On Time
Data Consumption	Realign contract to current usage, use wandere to manage usage, plan forward for increased data consumption	Ms A Harrison	November 2020	Resources Cttee	Completed On Time
Connectivity	Review connectivity and identify problem areas	Ms A Harrison	January 2021	Resources Cttee	Completed On Time
Ambulance Station Infrastructure	Secure funding and implementation of upgrades	Ms A Harrison	March 2021	Resources Cttee	In Progress
Secure & Joined Up Systems					
Digital Asset Register	Creation of a Digital Asset Register	Ms A Harrison	November 2020	Resources Cttee	Completed On Time
Clinical Safety Risk Assessments for Digital Systems	Clinical Safety Officer to undertake training and assessment for Critical Systems	Ms A Harrison	November 2020	Resources Cttee	Completed On Time
End of Life Telephony	Implementation of Unified Communications Programme, including firewall replacement	Ms A Harrison	January 2021	Resources Cttee	In Progress
Alignment of RA Function	Reviwew of current functionality and proposal aligned to 2021/22 Digital Structures	Ms A Harrison	January 2021	ELC	In Progress
System Resilience, Continutity and User Privileges	Completion of MIAA Internal Audit	Ms A Harrison	January 2021	Audit Cttee	In Progress

Information Asset Owner Training	Ensure 80% of Information Asset Owner training completed	Ms A Harrison	March 2021	Resources Cttee	In Progress
DSPT – Information Security Mandatory Training Uptake	Implemetation of Action Plan with OD; 100% criteria met for DSPT	Ms A Harrison	March 2021	Resources Cttee	In Progress
Full 24/7 Support Service	Review of On Call and Support Model Consideration of 24/7 Support Model	Ms A Harrison	March 2021	Resources Cttee	In Progress
Quarterly System Resilience and Failover Tests	Plan to be developed and implemented	Ms A Harrison	March 2021	Resources Cttee	In Progress
Critical System Transformation					
Multiple Large Scale Critical Systems Changing Simultaneously	Enhanced monitoring via System Resilience Measures	Ms A Harrison	December 2020	Resources Cttee	Completed On Time
Management of Interdependancies	Mobilise project resources and working with PMO and transformation to map interdependancies	Ms A Harrison	March 2021	Resources Cttee	In Progress
Smarter Decisions					
Lack of Data Quality Function	Review requirements for Data Quality Create proposal and secure funding	Ms A Harrison	March 2021	Resources Cttee	In Progress
Power BI Roadmap	Agreement of priorities with CPB and develop warehouse roadmap and implement	Ms A Harrison	March 2021	Resources Cttee	In Progress
Digital Pioneers					
Intellectual Property Agreement for SafeCheck	Work with Innovation Agency to get IP in place. Q&A System and get Kite Mark	Ms A Harrison	November 2020	Resources Cttee	Completed On Time
Development Team	Recruitment to roles and set up team & Secure funding for 2021/22	Ms A Harrison	January 2021	Resources Cttee	In Progress
Digital Maturity Assessment & Benchmarking	Work with NAA to agree approach	Ms A Harrison	March 2021	Resources Cttee	In Progress

Risks Scored 15+ Aligned to BAF Risk: SR07					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
1181	Quality	There is a risk that the Trust's Critical Telephone System (999) and/or the Voicemail messaging service fails which could result in an inability to appropriately respond and treat patients within agreed target timescales	**20 Significant**	**15 Significant**	5 Moderate
2867	Quality	There is a risk of oversight or system issues, due to a high number of high impact projects linked to critical systems being delivered simultaneously, which could result in system failures	**16 Significant**	**16 Significant**	8 High

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR09: If the organisation experiences further change at Board level during 2020/21 it may impact on relationships and ability to deliver the Trust's strategic objectives	**LEAD DIRECTOR:** CEO	**Compliance/ Regulatory Risk Appetite:** Low **Reputation Risk Appetite:** Moderate

STRATEGIC PRIORITY: Workforce

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Independent Well-Led Review
- Non-Executive Director End of Terms
- Board Level Vacancies

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
12		12	12		8	4
4x3		4x3	4x3		4x2	4x1
CxL		CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has remained at a score of 12 due to at least 3 vacancies that will need to be recruited to between October 2020 and the end of financial year, March 2021. The Board of Directors are committed to developing a more representative Board of Directors which will be an integral part of the recruitment process. Following the Deloitte Well-Led Review, a number of outstanding actions that require completion and assurance reporting to the Board of Directors. The Board of Directors will continue with a programme of further development in order to ensure it has the correct level of capacity to assist the Trust in reaching its strategic objectives.

CONTROLS	ASSURANCES	EVIDENCE
Fit and Proper Persons	**Level 3:** MIAA Audit Fit & Proper Persons (2019/20)	Reported to Audit Cttee
Board Development	**Level 2:** 2020/21 Board Development Programme	Reported to BoD
Independent Well-Led Review	**Level 3:** Deloitte Well-Led Review	Reported to BoD

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Executive Induction Programme	Devise an Executive Induction Programme for new Executives	Mr M Forrest	January 2021	BoD	In Progress
Executive Team Development	Devise a programme for development opportunities for Executives	Mr M Forrest	January 2021	BoD	In Progress
Non-Executive Director Development	Devise a programme for development opportunities for NEDs	Chairman	January 2021	BoD	In Progress
Actions from the Independent Well-Led Review	Delivery of actions identified following the Deloitte Well Led Review	Ms A Wetton	January 2021	BoD	In Progress
Non-Executive Director(s) End of Terms	Recruit to the number of NED position(s) Devise a Succession Management Plan for NEDs Increase BME Representation at the Board of Directors	Chairman	January 2021	BoD	In Progress

Risks Scored 15+ Aligned to BAF Risk: SR09					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks on the Corporate Risk Register scored 15+ pertaining to this BAF Risk					

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR11: If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21	**LEAD DIRECTOR:** CEO/ DCEO	**Compliance/ Regulatory/ Quality Risk Appetite:** Low

STRATEGIC PRIORITY: ALL

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Localised Restrictions across the NW
- Staff Abstractions & Shielding
- Operational Performance; PES, 111, EOC and CHUB
- Localised COVID-19 Outbreaks
- COVID Vaccination Programme

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
20	15	15	15		10	5
5x4	5x3	5x3	5x3		5x2	5x1
CxL	CxL	CxL	CxL		CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q3 has remained at a score of 15 due to the response provided by the Trust in terms of the COVID-19 Pandemic. The Trust has continued to respond to the significant pressures during the ongoing COVID-19 Pandemic and the primary focus remains on the operational response to sustain the level of resources to the end of the financial year. The Trust continues to remain compliant with associated regulation and legislative requirements with assurance being provided to the Quality & Performance Cttee. The Trust has continued to be responsive in providing PPE, supplies and vehicles, Face Fit Testing and a establishing a Track and Trace System. The Trust has commenced staff testing and is preparing for a COVID vaccination implementation plan for roll out during Q4.

CONTROLS	ASSURANCES	EVIDENCE
Regulatory Compliance/ Safety		
COVID-19 Incident Management	**Level 2:** Directorate Service Provision Paper	Reported to ELC (ELC/ 2021/04c)
COVID-19 Infection Prevention Control Practices	**Level 2:** PPE for Cardiac Arrest Paper	Reported to ELC (ELC/ 2021/20)
Staff Testing Inc. Swab & Antibody	**Level 2:** COVID-19 Staff Testing	Reported to ELC (ELC/ 2021/135c)
Additional Third Party Provider Inspections	**Level 2:** Directorate Service Provision Paper	Reported to ELC (ELC/ 2021/04c)
IPC & Social Distancing Guidance	**Level 2:** NWAS Stations IPC Guidance & Social Distancing Paper	Reported to ELC (ELC/ 2021/95c)
Patient Safety/ Clinical		
Single Regional Trauma Cell & Dispatch Senior Clinician Role	**Level 2**: Trauma Cell Reconfiguration & Dispatch Paper	Reported to ELC (ELC/ 2021/12)
Self Care Pathways used by Pathfinder Qualified EMT1s	**Level 2:** EMT1 SCP Use Paper	Reported to ELC (ELC/ 2021/13)
Implementation of Early Recognition of Futile Resuscitation in EOCs	**Level 2:** Early Recognition of Futile Resuscitation Paper	Reported to ELC (ELC/ 2021/14)
Move to JRCALC Clinical Guidelines for Cardiac Arrests	**Level 2:** JRCALC Resuscitation Guidelines Paper	Reported to ELC (ELC/ 2021/15)
Closure of Uncontacted 'Elective Testing' COVID-19 Incidents	**Level 2:** COVID-19 Testing/ Swabbing Calls in ADASTRA Paper	Reported to ELC (ELC/ 2021/16)
Temporary Stand Down of GoodSAM Responders	**Level 2:** GoodSAM Temporary Stand Down within the NW Paper	Reported to ELC (ELC/ 2021/17)
Purchase Mechanical CPR Devices	**Level 2:** Mechanical CPR Devices Paper	Reported to ELC (ELC/ 2021/18)
Unchanged Auto-Allocation & PDA Process for 999 calls	**Level 2:** Auto Allocation and PDA Paper	Reported to ELC (ELC/ 2021/19)
Implementation of Card 36 Protocol	**Level 2:** MPDS Protocol 36 Monthly Assurance Paper	Reported to ELC (ELC/ 2021/58d)
Finance, Fleet & Logistics		

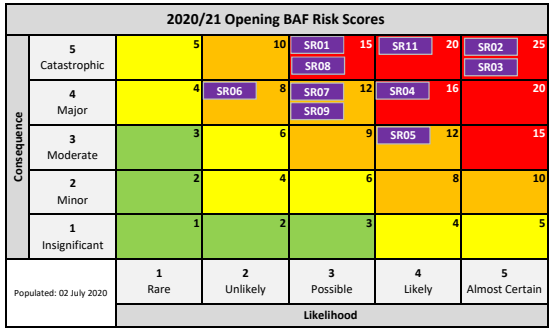
PPE and Safety Equipment Installation of Screens in Contact Centres	**Level 2:** PPE and Safety Equipment Paper **Level 2:** Supply and Installation of Plastic Screens Paper	Reported to ELC 9ELC/ 2021/79c) Reported to ELC (ELC/ 2021/75e)
Emergency Budget	**Level 2:** 2020/21 Emergency Financial Plan	Reported to BoD (BoD/ 2021/28)
Recovery of M1 COVID-19 Costs	**Level 2:** Month 1 Financial Position Paper	Reported to BoD (BoD/ 2021/27)
PTS Vehicle Conversions	**Level 2:** COVID-19 PTS Vehicle Conversions Assurance Paper	Reported to ELC (ELC/ 2021/114e)
Increased Capacity for Additional Call Takers	**Level 2:** Estate Reconfiguration Paper	Reported to ELC (ELC/ 2021/ 88)
Working Safely During COVID-19	**Level 2:** COVID-19 Premise Planning Recovery Paper	Reported to ELC (ELC/ 2021/ 161f)
Operations		
Increased Operational Resources (Inc. Emergency Ambulances)	**Level 2:** Weekly Performance Reports (ELC)	Reported to ELC (ELC/ 2021/04a)
Increased Call Taking Capacity in Contact Centres	**Level 2:** COVID-19 Workforce & Wellbeing Update	Reported to ELC (ELC/ 2021/04b)
PTS supporting PES Operations	**Level 2:** PTS Assisting Emergency Service Paper	Reported to BoD (BoD/ 2021/15)
Increased Utilisation of Third Party Providers & Taxi Providers	**Level 2:** Operational Response Paper	Reported to ELC (ELC/ 2021/75a)
Workforce & Wellbeing		
Increased Workforce Capacity Inc. Returners	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Utilisation of University Students & Associated Training	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Introduction of Family Liaison Officers & Action Cards	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Upskilling Training Programmes	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Staff Risk Assessments Inc. BME	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Homeworking Arrangements Inc. Clinical and Corporate Staff	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
National Agreement on Terms and Conditions	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Q1 Annual Leave Buy Back Scheme	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Break in Learning for Apprenticeships	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Health and Wellbeing Initatives Inc. Mental Health & Financial	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Trade Union Engagements	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
National Social Partnership Forum Agreement: Ceasing Hearings & Investigations	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Communications & Engagement		
COVID-19 Communications Inc. Engagement with Stakeholders	**Level 2:** COVID-19 Communciations Plan	Reported to ELC (ELC/ 2021/037h)

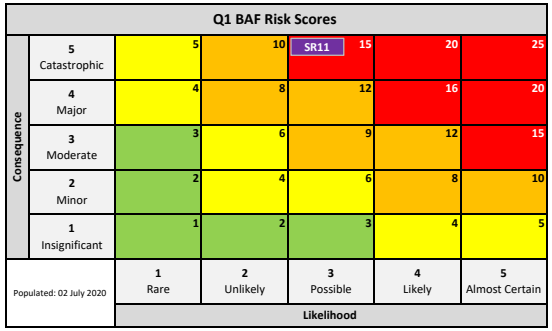
Digital					
Review of Projects	**Level 2:** Project Prioritisation During COVID-19 Activity Report	Reported to ELC (ELC/ 2020/50)			
BCP/ Restoration of Normality					
NWAS COVID-19 Recovery Briefing Document	**Level 2:** Restoration Plan Framework	Reported to BoD (BoD/2021/13)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Recovery					
Responding to the Pandemic	Consideration to step-up arrangements to Winter/ Phase 2 of COVID	Mr G Blezard	November 2020	Q&P Cttee	Completed On Time
Staff Testing	Roll out of Lateral Flow Testing for Staff	Prof M Power	January 2021	Q&P Cttee	In Progress
COVID-19 Vaccination	Production of a Staff COVID-19 Vaccination Plan	Ms L Ward	January 2021	Resources Cttee	In Progress
Sustainability of Resources	Ensure additional resources are sustained to meet performance	Mr G Blezard	March 2021	Q&P Cttee	In Progress

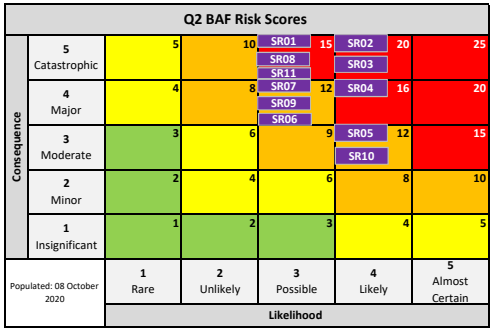
Risks Scored 15+ Aligned to BAF Risk: SR11					
RISK ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3318	People	There is a risk that COVID-19 has impacted on the delivery of the planned October 2020 paramedic apprenticeship cohort which could impact on the subsequent recovery plan for commencing the paramedic apprenticeship in February 2021 which would impact on longer term paramedic supply	**16 Significant**	**16 Significant**	8 High
3324	Service Delivery	There is a risk that performance standards are not achieved because of the increased acuity of calls received into the NHS 111 Service due to COVID-19 pandemic which may impact on patient safety	**16 Significant**	**16 Significant**	4 Moderate

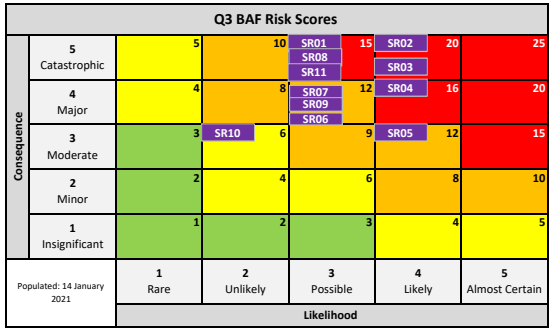
Appendix 3:
Board Assurance Framework (BAF) 2020/21 Heat Maps
Quarter 3 Position

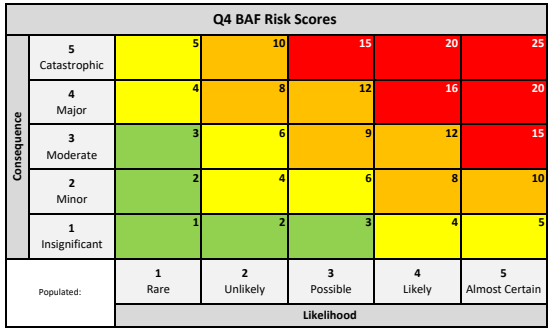
NHS North West Ambulance Service NHS Trust

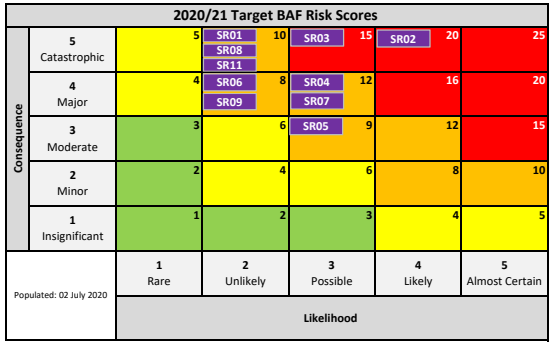


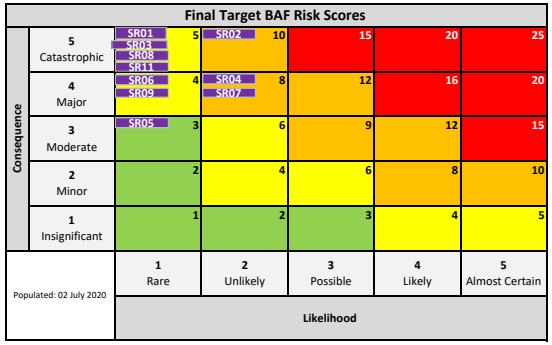












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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	20th January 2021			
Subject:	Corporate Calendar 2021/22			
Presented by:	Angela Wetton, Director of Corporate Affairs			
Purpose of Paper:	For Decision			
Executive Summary:	The report details proposed meeting dates for 2021/22 for the Board of Directors and Committees.			
Recommendations, decisions or actions sought:	It is recommended that the Board of Directors approve the Corporate Calendar for 2021/22.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	N/A
Previously Submitted to:	Executive Leadership Committee
Date:	20th January 2021
Outcome:	Supported for onward recommendation to the Board of Directors

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1. PURPOSE

The purpose of this report is to present the proposed Board and Committee dates for 2021/22.

2. BACKGROUND

Following circulation of the draft dates in December 2020, the revised Corporate Calendar for 2021/22 has taken into consideration feedback received from Board members.

3. 2021/22 CORPORATE CALENDAR

Committee	Dates	Membership
Board of Directors 9.45am-3.00pm (Last Wednesday) (Bi-monthly) **Meeting to commence at 9.00 am, prior to Board Development Session*	**2021** 28th April* 26th May 11th June (Year End) 28th July 29th September 24th November **2022** 26th January 30th March	All Board Members
Board Development 10.00am-4.00pm (Last Wednesday) (Bi-monthly)	**2021** 28th April 30th June 25th August 27th October 15th December **2022** 23rd February	All Board Members
Audit Committee 10.00am – 12 noon (Friday)	**2021** 23rd April 11th June (Year End) 22nd October **2022** 22nd January	David Rawsthorn (Chair) Prof Alison Chambers Prof Rod Thomson Clinical NED Associate NED (Digital)
Nominations & Remuneration Committee (Prior to Board Meetings)	**2021** 28th April 26th May 28th July 29th September 24th November **2022** 26th January 30th March	Peter White (Chair) David Rawsthorn Dr David Hanley Prof Alison Chambers Prof Rod Thomson Richard Groome Clinical NED Associate NED (Digital)
Quality and Performance Committee 1.00pm – 4.00pm (4th Monday) (Monthly)	**2021** 26th April 24th May 28th June 26th July	Prof Alison Chambers (Chair) Dr David Hanley Richard Groome Clinical NED

	27th September 25th October 22nd November **2022** 24th January 28th February 28th March	Prof Rod Thomson Dr Chris Grant Prof Maxine Power Ged Blezard Carolyn Wood
Resources Committee 10.00am - 1.00pm (3rd Friday) (Bi-monthly)	**2021** 21st May 23rd July 24th September 26th November **2022** 21st January 25th March	Richard Groome (Chair) Dr David Hanley David Rawsthorn Associate NED (Digital) Carolyn Wood Ged Blezard Lisa Ward Maxine Power Salman Desai
Charitable Funds Committee 3.00pm -4.00pm (Last Wednesday) (Bi-Annual)	**2021** 28th April 27th October	David Rawsthorn (Chair) Richard Groome Dr David Hanley Carolyn Wood Ged Blezard Lisa Ward Salman Desai Angela Wetton

4. LEGAL and/or GOVERNANCE IMPLICATIONS

There are no specific legal implications, however, there are governance implications in terms of the establishment and membership of Board committees.

Membership of the Board and Committees is set in conjunction with the Trust's Standing Orders and Reservation of Powers and Terms of Reference have been established for each committee.

5. RECOMMENDATIONS

It is recommended that the Board of Directors approve the Corporate Calendar for 2021/22.

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	Wednesday 27 January 2021			
Subject:	Risk Management Policy			
Presented by:	Angela Wetton, Director of Corporate Affairs			
Purpose of Paper:	For Decision			
Executive Summary:	The Risk Management Policy has been through a full review and refresh. The Risk Management Strategy was approved by the Board of Directors in November 2020 and subsequently, the Risk Management Policy has been revised to define the approach taken by the organisation in applying risk management practices in a consistent manner across the Trust. Risk management is a statutory requirement and an indispensable element of good governance. The Risk Management Policy can be viewed in **Appendix 1**.			
Recommendations, decisions or actions sought:	The Board of Directors are requested to: • Approve the Risk Management Policy for the Trust			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	EIA Completed (Contained within Policy Document)
Previously Submitted to:	Audit Committee
Date:	Friday 15 January 2020
Outcome:	Recommendation to the Board of Directors for Approval

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1. PURPOSE

The purpose of the report is to provide the Board of Directors with the revised Risk Management Policy.

2. BACKGROUND

The Trust's ambition is to be the best ambulance service in the UK, delivering right care, at the right time, in the right place, every time. The Risk Management Strategy was approved by the Board of Directors in November 2020 and subsequently, the Risk Management Policy has been revised to define the approach taken by the organisation in applying risk management consistently across the Trust.

Risk management is a statutory requirement and an indispensable element of good governance.

Good risk management is integral to the effectiveness of all the Trust's activities and as such must be integrated into all functions' day-to-day practice, and embedded within the culture of the organisation so that appropriate risk-based decisions are made by managers and staff at all levels.

An effective policy enables the Board of Directors to determine the extent of risk exposure it currently faces with regard to the achievement of its objectives. As a key component of the internal control framework, regular review and routine monitoring of the Risk Management Policy will also inform the Chief Executive's Annual Governance Statement which is included in the Annual Report.

3. PURPOSE OF THE RISK MANAGEMENT POLICY

The main objective of this policy is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

The Risk Management Policy is applicable to all areas of the Trust and all levels.

It is expected that all risk management activities in the Trust will follow the process described within the Risk Management Policy, to ensure a common and robust approach is adopted to risk management.

The full Policy can be viewed in **Appendix 1**.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

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

5. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the Risk Management Policy for the Trust.

North West Ambulance Service NHS Trust

Policy on Risk Management

Policy on Risk Management		Page:	Page **1** of **30**
Author:	Head of Risk and Assurance	Version:	0.1
Date of Approval:	January 2021	Status:	Draft
Date of Issue:		Date of Review	January 2022

Recommended by	Audit Committee
Approved by	Board of Directors
Approval date	
Version number	0.1
Review date	27 January 2022
Responsible Director	Director of Corporate Affairs
Responsible Manager (Sponsor)	Head of Risk and Assurance
For use by	All staff and volunteers

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	December 2020		J Taylor	New Policy

Policy on Risk Management

Contents

1. Introduction

Risk management is both a statutory requirement and an indispensable element of good management. It is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health and social care community, as a provider of health services to the public and as an employer of staff.

The activities associated with caring for patients, employing staff, providing facilities and services and managing finances are all, by their nature, activities that involve risk. These risks are present on a day-to-day basis throughout the organisation and whilst it may not always be possible to eliminate these risks, they can be managed to an acceptable level.

Good risk management is integral to the effectiveness of all of the Trust's activities and as such must be integrated into all functions day-to-day practice and embedded within the culture of the organisation so that appropriate risk-based decisions are regularly made by managers and staff at all levels.

An effective Risk Management Policy enables the Board of Directors to determine the extent of risk exposure it currently faces with regard to the achievement of its objectives. As a key component of the internal control framework, regular review and routine monitoring of this policy will also inform the Trust's Annual Governance Statement.

2. Purpose

The purpose of this Risk Management Policy is to define the approach taken by North West Ambulance Service NHS Trust (The Trust) in applying risk management to its decision making at all levels.

The main objective of this policy is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

It is the policy of the Trust that risk management is everyone's responsibility and that the principles of effective risk management should form an integral component of decision making at all levels.

The principles and techniques of risk management as defined in this policy should be fully integrated within the formal governance arrangements and decision making processes of the organisation.

All Trust staff are responsible for making sure that they are aware of the organisation's objectives, and are empowered to make decisions to manage risks to the achievement of those objectives so long as those decisions are within the scope of their role and level of authority.

Where a risk is identified but cannot be managed without some significant change to the way the organisation operates, it must be escalated through the relevant line management structure.

The Risk Management Policy applies to all areas of the Trust and at all levels. It defines the basic principles and techniques of risk management that the organisation has decided to adopt and forms the basis of all risk-based decision making.

It is expected that all risk management activities in the Trust will follow the process described within this document to ensure a common and robust approach is adopted to risk management.

3. Roles & Responsibilities

This section details those groups and individuals within the Trust that have specific responsibilities with regard to the Risk Management Policy.

The **Board of Directors** is responsible for providing strategic leadership to risk management throughout the organisation, which includes:

- Maintaining oversight of strategic risks through the Board Assurance Framework (BAF)
- Leading by example in creating a culture of risk awareness

The **Chief Executive** as the ***Accountable Officer*** is responsible for ensuring an effective system of internal control is maintained to support the achievement of the Trust's strategic objectives. This includes:

- The establishment and maintenance of effective corporate governance arrangements
- Ensuring that this Risk Management Policy is applied consistently and effectively throughout the Trust
- Ensuring that the Trust is open and communicates effectively about its risks, both internally and externally
- Retaining sufficient professional risk management expertise to support the effective implementation of this Policy

The **Director of Corporate Affairs** is accountable to the Board of Directors and Chief Executive for the Trust's Governance and Risk Management activities. With Executive responsibility for Corporate governance and risk management the Director of Corporate Affairs (with support from the Head of Risk and Assurance) provides a clear focus for the management of organisational risks and for coordinating and integrating all of the Trust's risk management arrangements on behalf of the Board of Directors.

Members of the **Executive** and **Directorate Senior Management Teams** are responsible for the consistent application of this Policy within their areas of accountability, which includes:

- Maintaining an awareness of the overall level of risk within the organisation
- The management of specific risks that have been assigned to them, in accordance with the criteria set out in this policy
- Promoting a risk aware culture within their teams and in the course of their duties

Heads of Service are responsible for the consistent application of this Policy within their areas of accountability, which includes:

- Making active use of the Trust risk register and the processes described in this Policy to support the management of their service
- The management of specific risks that have been assigned to them in accordance with the criteria set out in this policy
- Promoting a risk aware culture within their teams and in the course of their duties
- Ensuring that as far as possible risk assessments carried out within their service are based on reliable evidence

Every member of staff is responsible for identifying and managing risks within their day to day work, which includes:

- Maintaining an awareness of the primary risks within their service
- The identification and as far as possible the management of risks that they identify in the course of their duties
- Bringing to the attention of their line manager any risks that are beyond their ability or authority to manage

4. Risk Management Approach

The basic principle at the heart of the Trust's risk management approach is that an awareness and understanding of risk should be used to inform decision making at all levels.

This requires not only the active engagement of all staff with risk management activity in practice, but also the integration of risk management principles and techniques within the formal governance arrangements of the organisation.

This will ensure that major strategic, policy and investment decisions are made with a full and reliable appreciation of the risks associated with them as well as any existing risks that those decisions may serve to mitigate.

5. Risk Management Process

The risk management process, which can be seen in Figure 1 below, involves the identification, analysis, evaluation and treatment of risks. More importantly, the process provides iterative steps, which when taken in a coordinated manner can support recognition of uncertain events which could lead to a negative outcome and therefore allows to put actions in place to minimise the likelihood (how often) and consequence (how bad) of these risks occurring.

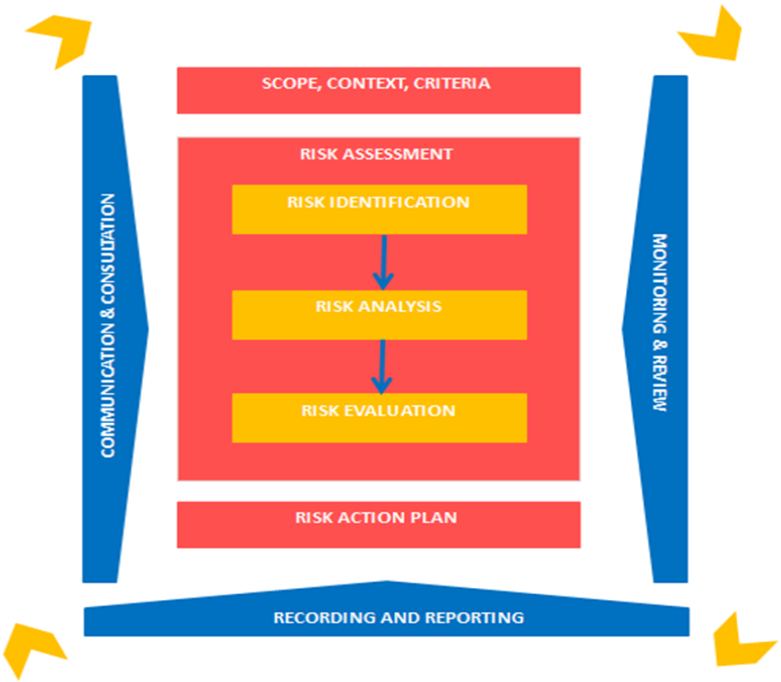

Figure 1: *ISO 3100:2018 Risk Management Process*

5.1 Scope, Context and Criteria

The Trust Strategy sets out how the organisation will become the best ambulance service in the UK, which is broken down into 8 Strategic Priorities. These are:

- Quality
- Urgent and Emergency Care
- Workforce
- Infrastructure
- Environment
- Stakeholder Relationships
- Digital
- Business and Commercial Development

Risks are linked to the strategic priorities because failing to control risks may lead to non-achievement of our strategic goals and priorities.

5.2 Risk Assessment

Risk assessment is an objective process and where possible, staff should draw upon evidence or qualitative data to aid assessment of risk. Where evidence or data is not available, assessors will be required to make subjective judgement.

Risk vs Issue

It is important to understand the difference between a risk and an issue/ incident. The fundamental difference between a risk and an issue/incident is that an issue/incident has **already happened**, there is no uncertainty, and it is a matter of fact. A risk is an uncertain event that has **not yet happened**, but if it did, it could affect the achievement of an objective.

Risk	**Issue/ Incident**
An uncertain even that **HAS NOT** happened	An unplanned event that **HAS** happened

Risk Articulation

In order to assist the risk management process, it is essential that risks are described in a way that allows them to be understood by all who read them. Articulating a risk in this way will enable effective controls, assurances and action plans to be put in place to mitigate the risk.

A risk should be described with three components:

Cause (Source of Risk)	**Risk (Uncertain Event)**	**Consequence (Impact)**
What has caused the risk? Where has the risk originated from?	The uncertain event (risk) that may happen if we do nothing	What would be the impact if the risk materialised?
Risk descriptions must tell a convincing story		
As a result of/ due to/ because of… *existing condition* **Present Condition**	*An uncertain event…* may occur **Uncertain Future**	Which would lead to… *effect on objectives* **Conditional Future**

Risk Identification
New risks and factors which increase a known risk may be identified at any time and by anyone within the organisation and can take many different forms.

Some risks can be managed effectively by the person identifying them taking appropriate action themselves or within their immediate team. This is particularly true with types of safety risk, where identification and removal of the hazard will often be sufficient to manage the risk.

Staff should initially consider what their main areas of work are and how these relate to their local objectives, and the objectives of the Trust. Every work activity that has a significant hazard should be assessed for risk. Identification using a systematic approach is critical, because a potential risk not identified at this stage will be excluded from further analysis.

All risks, whether under the control of the Trust or not, should be included at this stage. The aim is to generate an informed list of events that might occur. Key sources that will inform this exercise include (but are not limited to):

- Compliance requirements with regulators and stakeholders such as the CQC, HSE, NHSE/I, and Clinical Commissioning Groups (CCGs)
- Recommendations from recent internal / external audit reports
- Root cause analysis of incidents, inquiries, complaints, claims and inquests
- Performance data
- Quality Assurance Audits
- Quality Impact Assessments
- Safety Alerts
- Trend and forecasting analysis
- Risks associated with the achievement of corporate objectives
- Other methods of horizon scanning.

Business Continuity Exercises
Recommendations from business continuity exercises are captured within the risk management process to ensure the delivery of actions to reduce risk of failure in the event of an actual incident.

All staff play a vital role in the identification of risk. All new risks should be reported and discussed with your line manager in the first instance, who will consider the best approach to manage the risk; this could be actions to immediately eliminate the risk, signposting of the risk to the appropriate person to manage the risk or inclusion of a risk register with an action plan in place.

5.3 Risk Analysis
The purpose of analysing and scoring a risk is to estimate the level of exposure which will then help inform how the risk should be managed.

When analysing a risk, you will need to:

- Identify who is affected and what is the potential consequence/ impact should the risk occur
- Estimate the likelihood (how often) the risk may possibly occur
- Assess and score the level of exposure to that risk using the risk scoring process below.

Risk Analysis Process

Risks are analysed using the Trust Risk Matrix. The Trust has adopted a 5x5 matrix with the risk scores taking account of the consequence and likelihood of a risk occurring.

The scoring of a risk is a 3 step process:

Step 1: Evaluate the consequence of a risk occurring. The consequence score has five descriptors:

Score	Consequence Descriptor	Consequence Description
1	Insignificant	Please see **Appendix 2** for Consequence Descriptions
2	Minor	
3	Moderate	
4	Major	
5	Catastrophic	

Step 2: Analysing the likelihood (how often) a risk may occur. The table below gives the descriptions of the likelihood of a risk occurring:

Score	Likelihood Descriptor	Likelihood Frequency	Likelihood Probability
1	Rare	Not expected to occur in years	May only occur in exceptional circumstances
2	Unlikely	Expected to occur at least annually	Unlikely to occur
3	Possible	Expected to occur at least monthly	Reasonable chance of occurring
4	Likely	Expected to occur at least weekly	Likely to occur
5	Almost Certain	Expected to occur at least daily	More likely to occur

Step 3: To calculate the risk score, multiply the consequence score with the likelihood score:

CONSEQUENCE score x **LIKELIHOOD** score = **RISK** score

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

5.4 Risk Evaluation

Once the risk analysis process has been completed, the risk score should now be compared with the level of risk criteria below which enables the Trust to measure the potential level of risk exposure and proceed to identify appropriate actions and management plans.

Level of Risk
1 - 3 (Low)
4 - 6 (Moderate)
8 - 12 (High)
15 - 25 (Significant)

Each risk will be assigned 3 risk scores; initial, current and target. The risk scoring process above will be carried out three times for each score using the guidance below.

1. **Initial Risk Score**
   The initial risk score is when the risk is first identified, the risk analysis process for initial risk scores should be a measure of the consequence and likelihood before any controls/ mitigating actions are proposed. The initial risk score will not change for the lifetime of the risk.

2. **Current Risk Score**
   The current risk score, the risk analysis process for current risks should be a measure of the consequence and likelihood once controls and mitigating actions are in place, taking into account the effectiveness of the controls added.

3. **Target Risk Score**
   The target risk score, the risk analysis process for the target risk should be a realistic measure of the consequence and likelihood once improved mitigating actions have been achieved and improved controls added.

5.5 Risk Management

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified, analysed and that appropriate controls and responses are in place.

Risk Treatment

Risk treatment a process to modify risk and the selection and implementation of measures to treat the risk. This includes as its major element, risk control/ mitigation, but extends further to the appropriate selection of a risk treatment option, these are outlined in the table below.

Tolerate (Accept)	**Can we accept the risk as it is i.e. without further controls? Would the cost of controlling the risk outweigh the benefits to be gained?** Where the ability to do anything about certain risks may be limited or the cost of taking any further action may be disproportionate to the potential benefit gained. In these cases, the response is to manage the risk to as low as reasonable practicable (ALARP) then tolerate the risk. This option can also be

	supplemented by contingency planning for handling the consequences that may arise, if the risk is realised. Where the status of the risk is to tolerate, the risk must be monitored and reviewed by the risk owner at least annually. All risks tolerated, will be subject to review by the Corporate Risk Team and a decision made by the Executive Leadership Committee if the risk should be tolerated or not.
Treat (Reduce or Remove)	**Can we put controls in place to reduce the likelihood of the risk occurring or its impact?** Treat is the most widely used approach and will be the course of action to take for the majority of risks within the Trust before any other course of action is considered.
Terminate (Suspend the risk situation/ activity)	**Can we avoid or withdraw from the activity causing risk? Can we do things differently?** A decision will be made by the Executive Leadership Committee if the risk should be terminated or not.
Transfer (Responsibility)	**Can we transfer or share, either totally or in part, by way of partnership, insurance or contract?** This course of action should only be taken following consideration and decision by the Executive Leadership Committee.

Identifying Controls and Gaps
Controls are arrangements that are already in place to mitigate or manage the risk and these can include policies and procedures, monitoring and audit.

Every control should be relevant to the risk that has been described, it should be clear that the control directly impacts on managing the risk and the strength of the control should be considered when deciding the influence this will have on the risk score.

Despite having identified controls, where the service has established a risk exists, it is the uncontrolled issues that are articulated as gaps. Gaps are issues which are not controlled and directly affect our mitigation of the risk. Gaps require clear and proportionate actions to address them.

Action Plans
The purpose of risk action plans is to document how the chosen treatment options will be implemented.

Information should include:

- A description of what the planned action is
- Expected benefit(s) gained
- Responsibilities (risk owners and action owners)
- Reporting and monitoring requirements

- Resourcing requirements
- Timing and scheduling

Differentiating between Controls, Gaps and Actions

To summarise:

- Controls are things that are already in place to manage or monitor the risk
- Gaps are the issues that we need to address to control the risk fully
- Actions describe how you will address the gaps to reduce the risk identified.

Contributory Factors

Contributory factors are the influencing and casual factors that contribute to the identified risk. These factors affect the chain of events and can be positive as well as negative, and they may have mitigated or minimised the outcome of the risk materialising. More than one contributory factor can be selected.

Risk Monitoring and Review

The monitoring process should provide assurance that there are appropriate controls in place. The frequency of ongoing monitoring and review depends upon the seriousness of the risk. As a **minimum**, this must be:

Current Risk Score	Review Timescales
1 - 3 (Low)	Annually
4 - 6 (Moderate)	6 Monthly
8 - 12 (High)	Quarterly
15 - 25 (Significant)	Monthly

6 Risk Registers

The Datix Cloud IQ system is used by the Trust to record, manage and monitor risks throughout the organisation. Where risks cannot be immediately resolved, these risks should be recorded onto the Directorate Risk Register.

The purpose of the risk register is to:

- Provide a summary and overview of potential risks to each Directorate
- Evaluate the level of existing internal control in place to manage the risk
- Be an active live system to record and report risks using the risk management process.

Risk registers must:

- Be fully complete
- Be updated and reviewed regularly
- Have measureable controls added for all live risks
- Have action plans must be in place
- Be discussed and reported to Directorate SMT Meetings at least quarterly.

7 Risk Escalation

The Trust aims to support staff throughout the organisation to manage risk at the most appropriate level in the organisation whilst ensuring that there is a clear process for risk to be escalated when necessary to ensure discussion, action, advice and support can be provided.

All staff can escalate a risk for discussion, action, advice and support. The table below shows the Operations to Board escalation route.

Corporate Directorates

Escalation From	Escalation To
Team/ Department	Directorate Senior Management Team
Directorate Senior Management Team	Executive Leadership Committee
Executive Leadership Committee	Board of Directors

Service Delivery Directorate

Escalation From	Escalation To
Level 1 Meeting	Level 2 Meeting
Level 2 Meeting	Level 3 Meeting
Level 3 Meeting	Level 4 Meeting
Level 4 Meeting	Directorate Senior Management Team
Directorate Senior Management Team	Executive Leadership Committee
Executive Leadership Committee	Board of Directors

The diagram below defines the 'Assurance and Escalation Pyramid' and demonstrates the route of assurance and escalation takes.

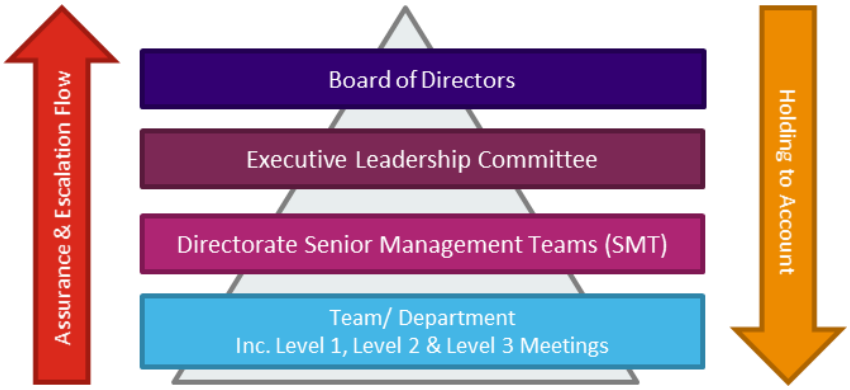

Figure 2: *NWAS Assurance and Escalation Pyramid*

8 Executive Oversight

All risks held on the Datix Cloud IQ system scored 15 and above are automatically reviewed by the Corporate Risk Team and the below steps are followed to ensure the Executive Leadership Committee have oversight of all risks which are deemed as significant to the organisation.

- All risks scored 15 and above are reviewed and analysed by the Corporate Risk Team weekly
- Risks are discussed with Risk Owners and Executive Lead to explore the risk in further detail and ensure risk scoring is accurate
- Corporate Risk Register is submitted to Executive Leadership Committee monthly for review and discussion

9 Risk Management Governance Structure

Risks are overseen at various levels throughout the Trust as per the table below:

Meeting	Type of Risk	Report Type	Risk Cycle
Board of Directors	Risks identified against delivery of strategic objectives	Quarterly Board Assurance Framework Corporate Risk Register Commercially Sensitive Risk Register	4 times per financial year
Board Committees	Risks identified against delivery of strategic objectives relevant to their area of focus	Committee Board Assurance Framework Report	At least 6 time per financial year
Audit Committee	Risks identified against delivery of strategic objectives	Quarterly Board Assurance Framework	4 times per financial year
Executive Leadership Committee	New risk(s) scored 15 and above which indicate a significant/ increased risk or where support is requested by the Directorates in the management of risk Trust-wide profile of risk Enterprise Risk Management Report	Quarterly Board Assurance Framework Corporate Risk Register Commercially Sensitive Risk Register Trust-wide Risk Management Report Enterprise Risk Management Lessons Learnt Report	4 times per financial year Monthly Monthly Monthly At least 4 times per financial year

Management Groups	Visibility of risks scored 15 and above relating to the management groups area of focus	Management Group Board Assurance Framework Report	At least 4 times financial per year
Directorate Senior Management Team Meetings	Risks identified on the Directorate Risk Register	Directorate Risk Management Report	At least 4 times per financial year

10 Risk Reporting and Assurance Diagram

The risk reporting and assurance diagram highlights how the Trust aims to assure, scrutinise, escalate and inform on risk management from floor to Board.

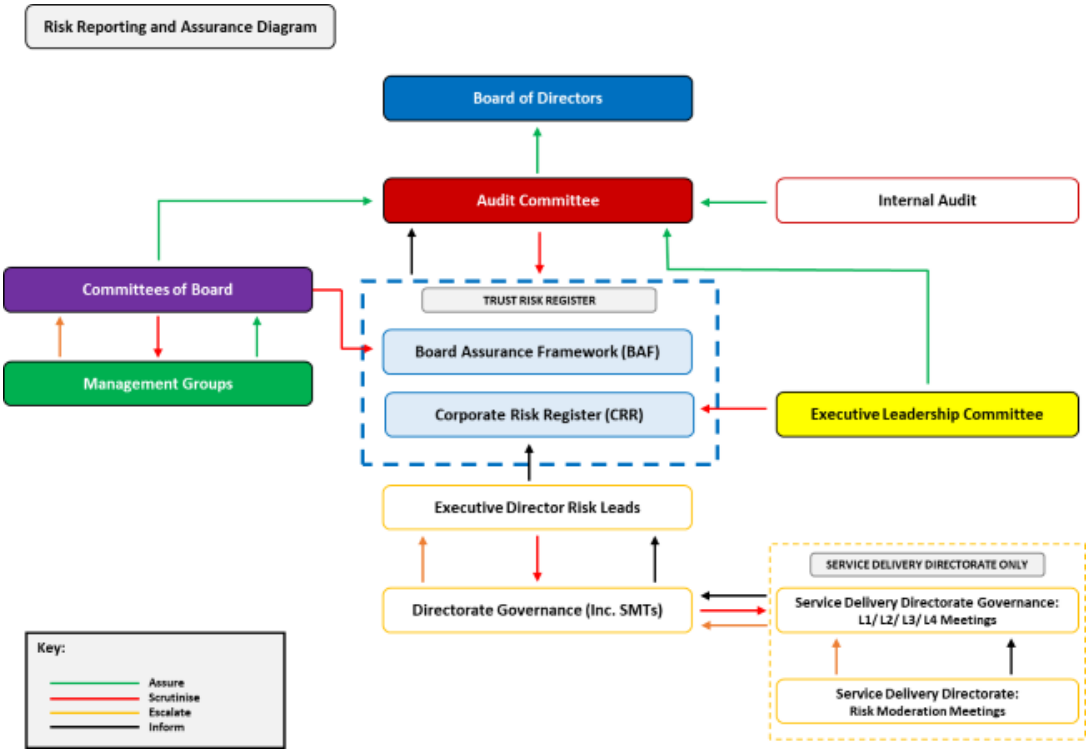

Figure 3: *North West Ambulance Service NHS Trust; Risk Reporting and Assurance Diagram*

11 Assurance

A key element of the Trust's risk management system is providing assurance. Assurance provides evidence that risks are effectively managed by ensuring the effectiveness of controls and actions being put in place are making a positive impact and mitigating risks appropriately.

12 Risk Registers

A risk register is a centralised repository of identified risks that may threaten the delivery of services. A risk register should be live, dynamic and populated through the risk assessment and evaluation process. Risks are recorded using the Datix system; Risk Register module.

13 Corporate Risk Register

The Corporate Risk Register allows the Executive Leadership Committee to have oversight of particular risks where:

- Risk owners have communicated the need for additional support;
- The risk has a current risk score of 15 and above; and/or;
- The risk indicates a significant/ increased risk;
- The risk has the potential to significantly impact a strategic objective

Risks held on the Corporate Risk Register continue to be managed at their current level, with input and support from the Executive Leadership Committee where appropriate.

14 The Board Assurance Framework (BAF)

The Board Assurance Framework is a key document used to record and report the Trust's key strategic objectives, risks, controls and assurances to the Board of Directors. The Board Assurance Framework takes in account the recommendations from Audit, Executive Leads and Committees of the Board as to what should be included, amended or removed. The Board Assurance Framework is updated and approved by the Board of Directors four times per year.

15 Annual Governance Statement

The Chief Executive is responsible for 'signing off' the Annual Governance Statement, which forms part of the statutory Annual Report and Accounts.

To provide this statement, the Chief Executive needs to demonstrate that the Board of Directors has been properly informed via the corporate governance framework of the totality of risks carried by the Trust, not just financial, and the Chief Executive has arrived at their conclusion based on all the evidence presented. The organisation's Board Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk based plan of work, agreed with senior managers of the Trust and approved by the Audit Committee, which should provide a reasonable level of assurance. The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. As such, it is one source of assurance that the Chief Executive takes into account when making their Annual Governance Statement.

16 Clinical Risk Management

Clinical risk management can be defined as:
"The continuous improvement of the quality and safety of healthcare services by identifying the factors that put patients at risk of harm and then acting to control/ prevent those risks."

Clinical risk is identified through the analysis of patient safety incidents, clinical negligence claims, and complaints, identified areas of sub-optimal care, clinical audit and non-compliance with clinical policies, guidance and training.

17 Risk Governance and Internal Audit

The Executive Leadership Committee and the Audit Committee continually review and monitor all aspects of the Trust's risk management system and play a key role in the standardisation and moderation of risks that are added to the Trust-wide risk register.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) provides an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisations' risk management, control and governance processes.

18 Training and Support

Risk management training, guidance and advice is provided through the Corporate Risk Management Function.

Risk management training is made available for staff as per the below table.

Staff/ Group	Type of Training	Type of Delivery	Frequency of Training
All staff	Risk Awareness Training	E-Learning	3 Yearly
All staff who require access Risk Register Module	DatixWeb Risk Register Module Training	E-Learning	Once
First line, Middle & Senior Managers	Risk Management Training	Face to Face/ Virtually	3 Yearly
Board of Directors	Risk Management and Assurance Training (Board Development)	Face to Face/ Virtually	Annually

19 Implementation

Taking into consideration the implications associated with this policy, it is considered that a target date of *01 March 2021* is achievable for communications about changes in this Policy, with any specific training being implemented on an ongoing basis. This will be monitored by the Executive Leadership Committee and the Audit Committee through the review process. If at any stage there is an indication that the target date cannot be met, then the Policy author will implement an action plan.

20 Equality and Diversity

The Trist is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. The Equality Impact Assessment can be viewed in **Appendix 3**.

21 Monitoring Compliance

Monitoring of compliance with this policy will be undertaken on a day to day basis by the Corporate Risk Management Function, discussing any issues with the relevant team/ department/ Directorate and, if necessary, reporting to the Director of Corporate Affairs and relevant Executive Director Leads. The monitoring matrix can be viewed in **Appendix 4** for further information.

22 Consultation and Review

This is an existing policy which has had major changes that relate to operational and/ or clinical practice therefore requires a full consultation process. The Head of Risk and Assurance has consulted with the Director of Corporate Affairs, Internal Audit and Local Counter Fraud to invite any comments or suggestions with regard to this policy.

The policy will be presented to the Executive Leadership Committee, Audit Committee; as the assurance committee for Trust-wide risk management for ratification and onward reporting to the Board of Directors for approval.

23 References

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APPENDIX 1: Risk Management Definitions

APPENDIX 2: Consequence Scoring Table

APPENDIX 3: Equality Impact Assessment

APPENDIX 4: Monitoring Compliance

Appendix 1: Risk Management Definitions

Term	Definition
Action	A response to control or mitigate risk
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted
Assessment	Means by which risks are evaluated and prioritised by undertaking the 4 stage risk assessment processes
Assurance	Confidence based on sufficient evidence that internal controls are in place, operating effectively and objectives are achieved
Board Assurance Framework	A document setting out the organisations strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available
Consequence (Impact)	The effect on the Trust if a risk materialises
Control	Action taken to reduce the likelihood and or consequence of a risk
Gaps in Control	Action to be put in place to manage risk and achieve objectives
Frequency	A measure of rate of occurrence of an event
Internal Audit	An independent, objective assurance and consulting activity designed to add value and improve organisations' operations
Initial Risk	The score on identification before any controls are added
Likelihood	Evaluation of judgement regarding the changes of a risk materialising, established as probability or frequency
Mitigation	Actions taken to reduce the risk or the negative impact of the risk
Current Risk Score	The score with controls/ actions in place
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives
Risk Matrix	A grid that cross references consequence against likelihood to assist in assessing risk
Risk Owner	The person responsible for the management and control of all aspects of individual risks
Risk Rating	The total risk score worked out by multiplying the consequence and likelihood scores on the risk matrix
Risk Register	The tool for recording identified risks and monitoring action plans against them
Risk Tolerance	The degree of variance from the Risk Appetite that the Trust is willing to tolerate
Strategic Risk	Risks that represent a threat to achieving the Trusts' Strategic Objectives
Operational Risk	Risks which are a by-product of the day to day running of the Trust

Appendix 2: Consequence Scoring Table

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Adverse Publicity/ Reputation/ Public Confidence	Rumours No public/ political concern	Local media area interest – short-term reduction in public confidence Local public/ political concern Elements of public expectation not being met	Local media interest – reduction in public confidence Damage to reputation Extended local/ regional media interest Regional public/ political concern	Regional/ national media interest with less than 1 day service well below reasonable public expectation Loss of credibility and confidence in organisation Independent external enquiry Significant public/ political concern Significant damage to reputation	National media interest with more than 1 day service well below reasonable public expectation MP concerned (questions in Parliament) Full public enquiry Total loss of public confidence in organisation Major damage to reputation
Business Programmes/ Projects	Temporary defects causing minor short term consequences to time and quality	Poor project performance shortfall in area(s) of minor importance (Performance may be related to time, cost & quality – either singularly or in combination of)	Poor project performance shortfall in area(s) of secondary importance (Performance may be related to time, cost & quality – either singularly or in combination of)	Poor performance in area(s) of critical or primary purpose (Performance may be related to time, cost & quality – either singularly or in combination of)	Significant failure of the project to meet its critical or primary purpose
Confidentiality/ Security	Patient information or other confidential information left unattended or was visible to unauthorised staff Computer left logged into a person account but no one was using the computer NWAS network receive minor 'hacking' attempts that are safely blocked	Staff involved in a patient care overheard in a public area on Trust grounds speaking about a patient using the patients name Staff communicated excessive patient information to a third party as part of the care of that person, consent not having been specifically denied by the patient Computer logged into an account, but being used by a person other than the account holder. No patient information data entry, email usage or internet usage was performed	Staff communicated confidential and/ or sensitive information to other members of the Trust as part of 'gossip' Patient record is missing and cannot be found within a week Trust site security is breached and intruders could have had access to confidential information Computer logged into an account, being used by a person other than the account holder. Patient information data entry, email usage or internal usage was performed	Inappropriate/ accidental communication of obviously confidential information by staff to a third part unaware that the patient or the Trust specifically denied consent to disclose Multiple patient records go missing due to deliberate actions of intruders on Trust sites Trust networks security is breached but no confidential information or email account were accessible Diaries/ laptops/ computers with confidential information staff or patient are lost, stolen or missing	Deliberate disclosure to third party by a staff member who was aware that the patient or the Trust specifically denied consent to disclose Publication of any patient information or confidential information that was not specifically authorised by the patient or the Trust Trust network security is breaches and confidential or email accounts were accessible

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Clinical Audit *(Provision of Clinical Information)*	No or limited/ single disruption to the provision of timely and accurate clinical information across NWAS Meets local clinical audit standards	Minor disruption to the provision of timely and accurate clinical information on an individual CBU/ business area Minor discrepancy with local clinical audit standards	Reduction in the provision of timely and accurate clinical information in CBU's/ business areas Moderate discrepancy with meeting local clinical audit standards	Inconsistent production of timely and accurate clinical information across all CBU's/ business areas Non-compliance with local clinical audit standards agreed by NWAS Delay in participation with national and local quality frameworks	Failure to produce clinical information or participate within any local or national quality frameworks Non-compliance with national clinical and standards
Clinical: Medication Error	Incorrect medication dispensed but not taken	Wring drug or dosage administered, with no adverse effects	Wrong drug or dosage administered with potential adverse effects	Wrong drug or dosage administered with adverse effects	Unexpected death or permanent incapacity Incident leading to ling-term health problems
Delayed Response	Response Inside Long Wait Criteria: Cat 1: 15 minutes Cat 2: 60 minutes Cat 3: 180 minutes Cat 4/5: 240 minutes With clinical review whilst waiting with minor or no consequence to patient outcome Late transport causing minimal disruption Referral to incorrect PCS with no consequences	Response meets Long Wait Criteria: Cat 1: 15 minutes Cat 2: 60 minutes Cat 3: 180 minutes Cat 4/5: 240 minutes With clinical review whilst waiting with minor or moderate consequence to patient outcome Delayed PCS response (speak to/ contact within 6 hour disposition < 60 mins) Late transport causing distress and/ or loss of appointment Non-arrival of transport leading to missed appointment	Response meets Long Wait Criteria: Cat 1: 15 minutes Cat 2: 60 minutes Cat 3: 180 minutes Cat 4/5: 240 minutes Without clinical review whilst waiting with minor or moderate consequence to patient outcome Delayed PCS response (speak to within 1 hour/ contact within 2 hour disposition < 60 mins Delayed PCS response (speak to/ contact within 6 hour dispositions > 60 mins	Response meets Long Wait Criteria: Cat 1: 15 minutes Cat 2: 60 minutes Cat 3: 180 minutes Cat 4/5: 240 minutes With clinical review whilst waiting with severe consequence to patient outcome Delayed PCS response (speak to within 1 hour/ contact within 2 hour dispositions > 60 mins	Response meets Long Wait Criteria: Cat 1: 15 minutes Cat 2: 60 minutes Cat 3: 180 minutes Cat 4/5: 240 minutes Without clinical review whilst waiting with severe consequence to patient outcome
Environmental Impact	Minimal or no impact on the environment (Small spillage or escape of non-clinical or non-harmful material on Trust premises)	Minor impact on environment (Spillage or escape of clinical or toxic waste with effects contained within unit or department)	Moderate impact on environment (Spillage or escape of clinical or toxic waste affecting an entire building)	Major impact on environment (Significant spillage or escape of clinical or toxic waste with effects contained to Trust property)	Catastrophic impact on environment (Significant discharge or escape of clinical or toxic waste with widespread effects beyond Trust property
Financial Inc. Claims	Small loss Risk of claim remote (£0-£5,000)	Loss of 0.1-0.25% of budget Claim less than (£5,000-£10,000)	Loss of 0.25-0.5% of budget Claim(s) between (£10,000-£100,000)	Uncertain delivery of key objective Loss of 0.5-1.0% of budget Claim(s) between (£100,000-£1 million) Purchase failing to pay on time	Non-delivery of key objective Loss of >1% of budget Failure to meet specification/ slippage Claim(s) (>£1 million) Loss of contract/ payment by results

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Infection Control and/ or Ill Health	Exposure to blood/ body fluids/ other sources of infection with no risk	Exposure to blood/ body fluids/ other sources of infection with minimal risk/ no sickness Outbreak involving 3 or more people Physically unwell – GP treatment or treated by staff	Exposure to blood/ body fluids/ other sources of infection resulting in short term sickness (minimum 3 days) Outbreak causing disruption to service or short term closure (days/ weeks) Physically unwell – planned admission/ attendance at A&E (not blue light) or transfer to general medical ward Inoculation contamination with no infection	Exposure to blood/ body fluid/ other sources of infection resulting in very serious infection, long term sick leave Outbreak causing medium term closure (weeks/ months) Physically unwell – emergency admission to general hospital Inoculation contamination from infected person	Sudden or unexpected death (including where evidence may be related to exposure to infection) Outbreak causing long term closure or termination of service Inoculation contamination causing life threatening disease or death
Information Risks	Minimal or no loss of records containing person identifiable data. No significant reflection on any individual or body Media interest very unlikely Only a single individual affected	Loss/ compromised security of one record (electronic or paper) containing person identifiable data Damage to a team's reputation/ some local media interest that may not go public Serious potential breach and risk assessed high. For example, unencrypted clinical records lost – up to 20 people affected	Loss/ compromised security of 2-100 records (electronic or paper) containing confidential/ person identifiable data Damage to a services reputation/ low key local media coverage	Loss/ compromised security of 101+ records (electronic or paper) containing confidential/ person identifiable data Serious breech with particular sensitivity Damage to organisation's reputation/ local media coverage	Compromised security of a local application/ system/ facility holding person identifiable data (electronic or paper) Compromised security of an organisation/ Trust wide application/ system/ facility holding person identifiable data (electronic or paper) Damage to NHS reputation/ national media coverage Serious breech with potential for ID theft or over 1000 people affected.
Moving/ Manual Handling Inc. Slips, Trips & Falls	Malfunction/ fault with equipment Slipping, falling with no injuries	Minor injury as a result of moving or handling Short term staff sickness/ absence (less than 3 days off work) Slipping, falling with minor injuries requiring first aid only Short term staff sickness/ absence (less than 3 days off work)	Moderate injury to staff as a result of moving or handling Staff sickness – more than 7 days off work (RIDDOR reportable) Slip/ trip/ fall resulting in injury such as a sprain, requiring medical attention Staff sickness – more than 7 days off work (RIDDOR reportable)	Serious injury to staff resulting in long term damage Long term staff sickness (RIDDOR reportable) Slip/ trip/ fall resulting in injury such as dislocation/ fracture/ head injury, requiring medical attention and hospitalisation Long term staff sickness (RIDDOR reportable)	Unexpected death or permanent incapacity Incident leading to long-term health problem Unexpected death or permanent incapacity Incident leading to long-term health problem

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Patient Safety *(Harm to patients and/ or public, including physical and/or psychological harm)*	Minimal injury requiring no/ minimal intervention or treatment. For example, delay in routine transport for patient Minor injury not requiring first aid or no apparent injury	Minor injury or illness, requiring minor intervention Increase in length of hospital stay or treatment by 1-3 days Minor injury or illness, first aid treatment needed 1-2 people affected	Moderate injury requiring professional intervention. For example, vehicle carrying patient involved in RTC Increase length of hospital stay or treatment by 4-15 days An event which impacts on small number of patients Some permanent harm up to a year 3-15 people affected Possible RIDDOR/ MHRA/ StEIS Reportable Incident	Major injury leading to long-term incapacity/ disability Increase in length of hospital stay or treatment by >15 days Serious mis-management of patient care with long-terms effects 16-50 people affected Potentially StEIS reportable	Death/ life threatening harm Serious mis-management of patient care leading to death/ lfe threatening harm/ permanent injuries/ long term incapacity or disability or irreversible health effects A significant event which impacts on a large number of patients – more than 50 people affected StEIS reportable
Physical Violence/ Aggression **Inc. Hostage Situation**	Minimal or no impact	Physical attack/ assault such as pushing, shoving, pinching, slapping, hair pulling etc. Causing minor injury (not requiring immediate medical assessment or treatment) Threats to prevent staff member leaving property but is persuaded and allows exit	Assault on patients, public or staff which may have physical health/ psychological implication on the victim Injury may require A&E or GP assessment but no further treatment Deliberate delay in the departure of staff using minor threats or physical obstruction	Serious assault resulting in physical injuries that require hospital treatment Deliberate delay in the departure of staff using significant threats or physical obstruction	Homicide or attempted homicide resulting in death or serious prolonged injury or disability Staff member held hostage using physical force
Service/ Business Interruption	Loss of ability to provide services (Interruption of >1 hour)	Loss of ability to provide services (Interruption of >8 hours)	Loss of ability to provide services (Interruption of >1 day)	Loss of ability to provide services (Interruption of >1 week)	Permanent loss of service or facility
Staff Competence	Staff are adequately equipped with the appropriate skills, knowledge and competence to undertake their duties Staff attendance at mandatory/ key training Insignificant effect on delivery of service objectives due to failure to maintain professional registration (less than 10 staff)	Minor error due to a lack of appropriate skills, knowledge and competence to undertake duties Insignificant staff attendance at mandatory/ key training (Within 5%) Minor effect on delivery of service objectives due to failure to maintain professional development or status (between 11-50 staff)	Moderate error due to limited skills, knowledge & competence to undertake duties Poor staff attendance for mandatory/ key training (6 – 10%) Moderate effect on delivery of service objectives due to failure to maintain professional developments or status (between 51-100 staff)	Serious error or due to limited skills, knowledge & competence to undertake duties Regular poor/ low attendance at mandatory/ key training (11 – 20%) Major effect on delivery of service objectives due to failure to maintain professional development or status (between 101-250 staff)	Critical error due to limited skills, knowledge & competence to undertake duties Significant/ inconsistent low uptake of attendance at mandatory/ key training (>21 or 2 months+) Significant effect on delivery of service objectives due to failure to maintain professional development or status (more than 250 staff)

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Staff Safety *(Harm to staff and/or contractors, including physical and/or psychological harm)*	No time off work Minor injury not requiring first aid or no apparent injury	Minor injury, illness, Mental Health issue or first aid treatment needed Requiring intervention Short term staff sickness/ absence (less than 3 days off work)	Moderate injury, illness, Mental Health issue requiring hospital treatment/ outpatient appointments/ assessment of social care needs Staff sickness – more than 7 days off work Possible RIDDOR/ MHRA/ StEIS reportable incident	Major injury, illness, Mental Health issue requiring long term treatment or community care intervention Long term staff sickness More than 15 staff affected Post-traumatic stress disorder	Death Life threatening injury or illness or harm Permanent injury/ damage/ loss of limb/ long term incapacity or disability StEIS
Staffing Levels	Short-term low staffing levels that temporarily reduces service quality (less than 1 day)	Low staffing levels that reduces the service quality (1-5 days)	Late delivery of key objective/ service due to lack of staff/ capacity Unsafe staffing level (1-2 weeks) Staff Turnover	Uncertain delivery of key objective/ service due to lack of staff Unsafe staffing level (more than a month) Loss of key staff Staff Turnover	Non-delivery of key objective/ service due to lack of staff Constant ongoing unsafe staffing levels or competence Loss of several key staff
Statutory Duty/ Inspection	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

NHS
North West
Ambulance Service
NHS Trust

North West Ambulance NHS Trust
Equality Impact Assessment Form (EIA) - Policies & Procedures

Name of policy or procedure being reviewed: **Risk Management**

Equality Impact Assessment completed by: **Head of Risk and Assurance**

Initial date of completion: **24 December 2020**

It is anticipated that this EIA will be reviewed throughout the lifecycle of the policy or guidance. Relevant documentation should be maintained relating to the review. Please also record any stakeholders who input into this now or in the future. There is a longer version of this form for assessing the impact of strategy and major plans.

Section 1 – Overview

What kind of policy/procedure is this – eg clinical, workforce?

This 'Corporate' policy is to ensure a structured and systematic approach to risk management is implemented throughout the Trust.

Who does it affect? (Staff, patients or both)?

This policy is intended to cover ALL employees of the Trust, bank staff, and agency staff, all self-employed NHS Professionals, trainees, student placements working for NWAS (herein known as NWAS staff). In addition, all volunteers are expected to adhere to this policy.

How do you intend to implement it? (Trust wide communications plan or training for all staff)?

The policy will be placed on the Green Room for all staff to access.

Section 2 – Data and consultation

In order to complete the EIA it may be useful to consider the following:-

- What data have you gathered about the impact of policy or guidance on different groups?
- What does it show?
- Would it be helpful to have feedback from different staff or patient groups about it?

Please document activity below:

Equality Group	Evidence of Impact
Age	The policy includes litigation risks; this will incorporate any risks in relation to Equality legislation and other standards relating to the needs of people with protected characteristics. The Trust has staff and systems in place to identify equality related risks.
Disability – considering visible and invisible disabilities	

Gender	
Marital Status	
Pregnancy or maternity	
Race including ethnicity and nationality	
Religion or belief	
Sexual Orientation	
Trans	
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	

Section 3: Impact Grid

Having considered the data and feedback through consultation, please detail below the impact on different groups (Age, Disability – considering visible and invisible disabilities, Gender, Marital Status, Pregnancy or maternity, Race including ethnicity and nationality, Religion or belief, Sexual Orientation, Trans, Any other characteristics for patient or staff e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee):

Equality Group	**Evidence of Impact**	**Is the impact positive or negative?**
All groups	This is a corporate policy relating to the application of Risk Management across the Trust for all staff equally.	Neither

Section 4 – Action plan

At this point, you should prepare an action plan which details the group affected, what the required action is with timescales, and expected progress. You may still be seeking further information as part of your plan. You can use the table 3 above to detail any further action.

Section 5 – Monitoring and Review

You should document any review which takes place to monitor progress on the action plan or add any information through further data gathering or consultation about the project. It is sensible for the review of this to be built into any plans. More information about resources can be found on the greenroom.

Further information about groups this policy may affect can be found here pages 10-11.
https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Appendix 4: Monitoring Compliance

Monitoring	Monitoring Lead	Reported to Person/ Group	Monitoring Process	Monitoring Frequency
Identifying Risk *Effective use of Datix risk form*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on Datix	Monthly
Assessing Risk *All new risks will be reviewed for completeness and quality of information against guidance in Policy*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Weekly review of risks on Datix	Monthly
Assessing Risk *All risks will be scored and graded according to consequence and likelihood using the Trust Risk Matrix*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on Datix	Monthly
Managing Risk *New risks with a current risk score of 15 and above will be discussed, managed and presented to Executive Leadership Committee on a monthly basis*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Weekly review of risks on Datix	Monthly
Reviewing Risk *Risks will be reviewed by Directors consistently against guidance in Policy*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on Datix	Monthly
Reviewing Risk *All tolerated/ accepted risks will be reviewed annually*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on Datix	Monthly
Reviewing Risk *Strategic risks will be reviewed each quarter with the appropriate Executive Director and recorded on the BAF*	Head of Risk and Assurance	Director of Corporate Affairs/ Board of Directors	Board Assurance Framework	Quarterly

Risk Management Process *Annual review of the Trust risk management process undertaken by Internal Audit*	Head of Risk and Assurance	Director of Corporate Affairs/ Audit Committee	Internal Audit Review	Annually
Risk Management Process *Annual review of the BAF process undertaken by Internal Audit*	Head of Risk and Assurance	Director of Corporate Affairs/ Audit Committee	Internal Audit Review	Annually

North West Ambulance Service NHS Trust

REPORT

Board of Directors					
Date:	27th January 2021				
Subject:	Anti-Fraud, Bribery and Corruption Policy				
Presented by:	Carolyn Wood, Director of Finance				
Purpose of Paper:	For Decision				
Executive Summary:	The Anti-Fraud, Bribery and Corruption Policy has been jointed reviewed and updated by the Anti-Fraud Specialist and Deputy Director of Finance. The aim of the Policy is to provide a guide for employees as to what fraud is in the NHS and to emphasise that it is everyone's responsibility to prevent fraud, bribery and corruption and to provide guidance on how to report it. The main updates from the Policy review for the Board of Directors to note are: • The aims and objectives have focused on ensuring that the four key principles of tackling fraud in the NHS are clear. • Compliance with the NHS Counter Fraud Authority's standards. • The Roles and Responsibilities section to provide further clarity for all relevant parties, including additions for the Fraud Champion and Freedom to Speak-Up Guardians				
Recommendations, decisions or actions sought:	The Board of Directors is asked to note the contents of the updated policy and to approve the revised Anti-Fraud, Bribery and Corruption Policy.				
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☐	
	Right Place	☐	**Every Time**	☒	

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11

☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	None
Previously Submitted to:	Audit Committee
Date:	15th January 2021
Outcome:	Small change requested, then approved

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1. PURPOSE

The purpose of this report is to present the updated Anti-Fraud, Bribery and Corruption Policy to the Board of Directors for approval.

2. BACKGROUND

The aim of the Policy is to provide a guide for employees as to what fraud is in the NHS and to emphasise that it is everyone's responsibility to prevent fraud, bribery and corruption and to provide guidance on how to report it.

The previous Policy was last reviewed and approved in January 2018, with just an amendment in October 2020 to reflect the appointment of a new Anti-Fraud Specialist.

The main updates from the Policy review for the Board of Directors to note are:

- The aims and objectives have focused on ensuring that the four key principles of tackling fraud in the NHS are clear.
- Compliance with the NHS Counter Fraud Authority's standards.
- The Roles and Responsibilities section to provide further clarity for all relevant parties, including additions for the Fraud Champion and Freedom to Speak-Up Guardians

3. LEGAL and/or GOVERNANCE IMPLICATIONS

In line with NHS Counter Fraund standards and relevant UK legislation.

4. RECOMMENDATIONS

The Board of Directors is asked to note the contents of the updated policy and to approve the revised Anti-Fraud, Bribery and Corruption Policy.

North West Ambulance Service NHS Trust

ANTI-FRAUD, BRIBERY AND CORRUPTION POLICY AND RESPONSE PLAN

This document explains the North West Ambulance Service NHS Trust Anti-Fraud Bribery and Corruption policy and the steps that must be taken where Fraud, Bribery or Corruption is suspected. All employees should be aware of the existence of this policy document, while managers must make staff aware of its content. Any member of staff who becomes aware of any Fraud, Bribery and Corruption or other illegal act and does not follow this policy could be subject to disciplinary action.

Recommended by	Director of Finance
Approved by	Audit Committee
Approval Date	15 January 2021
Version Number	2.8
Review Date	January 2023
Responsible Director	Director of Finance
Responsible Manager (Sponsor)	Deputy Director of Finance
For use by	All Trust Employees (permanent and temporary) including volunteers, executives and non-executives

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

CHANGE RECORD FORM

Version	Date of change	Date of release	Changed by	Reason for change
1.1	December 2008	26 Feb 2009	P Howard	Amendment of existing policy
1.2	January 2010	16 April 2010	P Baulcombe	Update of existing policy
1.3	February 2011	6 April 2011	P Baulcombe	Review of existing policy
1.4	October 2011		P Baulcombe	Update of existing policy
2.0	30 November	30 November	P Buckingham	Approval by Audit Committee
2.1	September 2013		J Hurst/ LCFS	Review of existing policy and updated against national NHS Protect template document July
2.2	December 2013	December 2013	P Buckingham	Approval by Audit Committee
2.3	September 2014		J Hurst/LCFS	Review of existing policy and updated against NHS Protect
2.4	November 2014	November 2014	P Buckingham	Approval by Audit Committee
2.5	October 2015	March 2016	J Hurst/AFS	Annual review of existing policy
2.6	January 2018	March 2018	Cath Robson (AFS)	Reflect the changes regards the launch of the NHS CFA and the newly appointed AFS
2.7	July 2020	July 2020	M.Brooks	Updated AFS name and contact details
2.8	December 2020	January 2021	Andy Wade (AFS) / M.Brooks	Reflect changes and the newly appointed AFS

CONTENTS

1. Introduction

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

The North West Ambulance Service NHS Trust ("The Trust") is committed to reducing the level of fraud, bribery and corruption within the NHS to an absolute minimum and keeping it at that level, freeing up public resources for better patient care. The Trust does not tolerate fraud, bribery or corruption and aims to eliminate all such activity as far as possible.

The Trust at its most senior level wishes to encourage anyone having a reasonable suspicion of fraud, bribery or corruption to report them. For the purposes of this policy "reasonable held suspicions" shall mean any suspicions other than those which are totally groundless (and/or raised maliciously).

It is the Trust's policy that no employee will suffer in any way as a result of reporting these suspicions. This protection is given under the provisions of the Public Interest Disclosure Act and other related legislation / regulations which the Trust is obliged to comply with.

The Trust will take all necessary steps to counter fraud, bribery and corruption in accordance with this policy, with the NHS Counter Fraud standards, NHS contractual requirements and with regard to the policies, directions, instructions and guidance as issued by the NHS Counter Fraud Authority (NHSCFA), as well as in accordance with relevant UK Legislation.

The Trust will seek the appropriate disciplinary, regulatory, civil and criminal sanctions (as well as a referral to professional bodies, where appropriate) against fraudsters and where possible to recover losses.

Each Trust is required to appoint its own dedicated Anti-Fraud Specialist (AFS), also known as the Local Counter Fraud Specialist (LCFS), who is accredited by the NHSCFA and accountable to them professionally for the completion of a range of preventative anti-fraud, bribery and corruption work, as well as for undertaking any necessary investigations. Locally, the AFS is accountable on a day-to-day basis to the Trusts Director of Finance and also reports, periodically to the Trust's Audit Committee.

All instances where fraud, bribery and/or corruption is suspected are thoroughly investigated by suitable accredited personnel. Any investigations will be undertaken in accordance with the NHSCFA investigatory toolkit requirements.

(NB for staff awareness, **theft issues** are usually dealt with by local security management (LSMS) not the AFS. However, the AFS will be mindful of any potential criminality identified in the course of any investigation and will, with the agreement of the Director of Finance notify the appropriate investigating authority).

1.1 Aims and Objectives

The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption.

The aim of this policy is to provide a guide for employees as to what fraud is in the NHS, to emphasise that it is everyone's responsibility to help prevent fraud, bribery and corruption and to provide guidance on how to report it.

Tackling fraud in the NHS is guided by four key principles:

- **Inform and Involve:** raise awareness of fraud against the NHS, and work with NHS staff with stakeholders and the public to highlight those risks and the consequences of fraud against the NHS.
- **Prevent and Deter:** provide solutions to identify fraud risks, discourage individuals who may be tempted to commit fraud against the NHS and ensure that opportunities for fraud to occur are minimized.
- **Investigate, sanction and seek redress:** investigate allegations of fraud thoroughly and to the highest professional standards, and where appropriate

and seek the full range of civil, criminal and disciplinary sanctions, seeking redress where possible.

- **Continuously review and hold to account:** fraud is constantly evolving, and continuous re-evaluation and improvement is needed to ensure that we keep ahead of the problem. Where this does not take place, or where there is a reluctance to do so, then organizations must be held to account for their inaction.

The overall requirement underpinning these principles is effective strategic governance, strong leadership and a demonstrable level of commitment to tackling fraud from senior management within organisations.

1.2 Scope

This policy has been produced by the Trust's AFS and is intended to provide a guide for all employees (regardless of position or employment status), contractors, consultants, vendors and internal and external stakeholders who have a professional or business relationship with the Trust, on what fraud and corruption are within the NHS; what everyone's responsibilities are to prevent fraud, bribery and corruption; and also how to report concerns/suspicions with the intention of reducing fraud to a minimum within the Trust.

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to employees who may identify suspected fraud, bribery and/or corruption. It provides a framework for responding to suspicions of fraud, corruption and bribery advice and information on various aspects of fraud, bribery and corruption and implications of investigations. It is not intended to provide a comprehensive approach to preventing and detecting fraud, bribery and corruption.

2. Definitions

2.1 NHS Counter Fraud Authority

The NHS Counter Fraud Authority (NHSCFA) is a special health authority which has the responsibility for the detection, investigation and prevention of fraud and economic crime within the NHS. Its aim is to lead the fight against fraud affecting

the NHS and wider health service, by using intelligence to understand the nature of fraud risks, investigate serious and complex fraud, reduce its impact and drive forward improvements.

2.2 Counter Fraud Standards

A requirement of the NHS standard contract is that providers and commissioners of NHS services must take the necessary action to comply with the NHSCFA's counter fraud standards. Other's should have due regard to the standards. The contract places a requirement on providers/commissioners to have policies, procedures and processes in place to combat fraud, corruption and bribery to ensure compliance with the standards. The NHSCFA carries out regular assessments of health organisations in line with the counter fraud standards

2.3 Fraud

The Fraud Act 2006 introduced an entirely different way of investigating and prosecuting fraud, which can relate to money, property or other benefits of value. Previously the word 'fraud' was an umbrella term used to cover a variety of criminal offences falling under various legislative acts. It is no longer necessary to prove that a person has been deceived or for fraud to be successful. The focus is now on the dishonest behaviour of the suspect and their intent to make a gain for themselves or another; to cause a loss to another; or expose another to a risk of loss,

There are several specific offences under the Fraud Act 2006; however, there are three primary ways in which it can be committed that are likely to be investigated by the AFS.

The offence of fraud can be committed in three ways:

- **Fraud by false representation (s.2)** – lying about something using any means, e.g. falsifying a CV or NHS job application form
- **Fraud by failing to disclose (s.3)** – not saying something when you have a legal duty to do so, e.g. failing to declare a conviction, disqualification or commercial interest when such information may have an impact on your

NHS role, duties or obligation and where you are required to declare such information as part of a legal commitment to do so.

- **Fraud by abuse of a position of trust (s.4)** – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation, e.g. a carer abusing their access to patients monies or an employee using commercially confidential NHS information to make a personal gain

It should be noted that all offences under the Fraud Act 2006 occur when the act or omission is committed dishonestly with the intent to cause gain or loss. The gain or loss does not have to succeed, so long as the intent is there. Successful prosecutions under the Fraud Act 2006 may result in an unlimited fine and/or a potential custodial sentence of up to 10 years.

2.4 Bribery and Corruption

The Trust adopts a 'zero tolerance' attitude towards bribery and does not and will not pay or accept bribes or offers of inducement to or from anyone, for any purpose.

The Trust is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery.

The Bribery Act 2010 reformed the criminal law of bribery, making it a criminal offence to:

- Give, promise or offer a bribe (s.1) and/or
- Request, agree to receive or accept a bribe (s.2)

Corruption is generally considered to be an 'umbrella' term covering such various activities as bribery, corrupt preferential treatment, kickbacks, cronyism, theft or embezzlement. Under the 2010 Act, however bribery is now a series of specific offences.

Generally, bribery is defined as: ***an inducement or reward offered, promised or provided to someone to perform their functions or activities improperly in***

order to gain a personal, commercial, regulatory and/or contractual advantage.

Examples of bribery in an NHS context could be a contractor attempting to influence a procurement decision-maker by giving them an extra benefit or gift as part of a tender exercise; or, a medical or pharmaceutical company providing holidays or other excessive hospitality to a clinician in order to influence them to persuade their Trust to purchase that company's particular clinical supplies.

A bribe does not have to be in cash; it may be the awarding of a contact, the provision of gifts, hospitality, sponsorship, the promise of work or some other benefit. The persons making and receiving the bribe may be acting on behalf of others – under the Bribery Act 2010, all parties involved may be prosecuted for a bribery offence.

All staff are reminded to ensure that they are transparent in respect of recording any gifts, hospitality or sponsorship and they should refer to the separate Trust policy, the 'Conflict of Interest Policy' covering:

- Acceptance of gifts and Hospitality
- Declaration of Interests
- Sponsorship.

The Bribery Act 2010 applies to (and can be triggered by) everyone "associated" with the Trust who performs services for us, on our behalf, or who provides us with goods. This includes those who work for us and with us, such as employees, agents, subsidiaries, contractors and suppliers (regardless of whether they are incorporated or not). The term 'associated persons' has an intentionally wide interpretation under the Bribery Act 2010.

Sanctions following a successful prosecution, are similar to those of the Fraud Act 2006.

3. Roles and Responsibility

Through our day-to-day work, we, i.e. all staff are in the best position to recognise any specific risks within our own areas of responsibility. We also have a duty to ensure those risks -however large or small – are identified and eliminated. Where you believe and opportunity for fraud, corruption or bribery exists, whether because of poor procedures or oversight, you should report it to the AFS or the NHS Fraud and Corruption reporting Line and/or online Fraud Reporting Form.

This section states the roles and responsibilities of employees and other relevant parties in reporting fraud or corruption.

3.1 Chief Executive

The Trust's Chief Executive, as the organisations accountable officer, has the overall responsibility for securing funds, assets and resources entrusted to it, including instances of fraud, bribery and corruption.

The Chief Executive must ensure adequate policies and procedures are in place to protect the organisation and the public funds it receives. However, responsibility for the operation and maintenance of controls falls directly to line managers and requires the involvement of all Trust employees. The Trust therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support in order to carry out their responsibilities. Therefore, the Chief Executive and Director of Finance will monitor and ensure compliance with this policy.

3.2 Board of Directors

The Trust's Board of Directors has a duty to provide adequate governance and oversight of the Trust to ensure that it's funds, people and assets are adequately protected against criminal activity, including fraud, bribery and corruption.

The Board of Directors provides clear and demonstrable support and strategic direction for counter fraud, bribery and corruption work. They review the proactive management control and the evaluation of counter fraud, bribery and corruption work. The Board of Directors scrutinise NHSCFA assessment reports, where applicable, and ensure that the recommendations are fully actioned.

3.3 Director of Finance

The Director of Finance (DoF) has the power to approve financial transactions initiated by the directorates across the organisation.

They prepare, document and maintain detailed financial procedures and systems and apply the principles of separation of duties and internal checks to supplement those procedures and systems.

The DoF will report annually to the Board of Directors on the adequacy of internal financial controls and risk management as part of the board's overall responsibility to prepare a statement of internal control for inclusion in the annual report.

They also act as the Executive Lead for the organisation's counter fraud arrangements, liaising closely with the Anti-Fraud Specialist.

The DoF will, depending on the outcome of initial investigations, inform appropriate senior management of suspected cases of fraud, bribery and corruption, especially in cases where the loss may be above an agreed limit or where the incident may lead to adverse publicity.

3.4 Audit Committee

The role of Audit Committee is in reviewing, approving and monitoring counter fraud workplans, receiving regular updates on counter fraud activity, monitoring the implementation of action plans, providing direct access and liaison with those responsible for counter fraud, reviewing annual reports on counter fraud, and discuss NHSCFA quality assessment reports. Reference the NHS Audit Committee handbook 2018 https://www.hfma.org.uk/publications?Type=Guide

3.5 Internal and External Audit

The role of internal and external audit includes reviewing controls and systems and ensuring compliance with financial instructions. They have a duty to pass on any suspicions of fraud, bribery or corruption to the Anti-Fraud Specialist (AFS)

3.6 Human Resources

Human resources (HR) plays a role in relation to employees in suspected cases of fraud, bribery and corruption, including liaison with the AFS and the conduct of any investigation, and instigating the necessary disciplinary action against those who fail to comply with the polices, procedures and processes. HR work with the AFS to ensure the appropriate parallel sanctions are applied (in accordance with the NHSCFA Anti-Fraud Manual) where fraud, bribery or corruption is proven against employees. Appropriate joint working protocols exist to detail this relationship.

3.7 Anti-Fraud Specialist

The AFS is responsible for taking forward all anti-fraud work locally in accordance with national standards and reports directly to the DoF.

Adhering to NHSCFA fraud standards is important in ensuring that the organisation has appropriate counter fraud, bribery and corruption arrangements in place and that the AFS will look to achieve that highest standard possible in their work.

The AFS will work with key colleagues and stakeholders to promote counter fraud work, apply preventative measures and investigate allegations of fraud and corruption.

The AFS will conduct risk assessments in relation to their work to prevent fraud, bribery and corruption.

The AFS has responsibility for investigating any allegations of fraud and corruption within the organisation.

3.8 Fraud Champion

Where a Fraud Champion has been appointed, their role and duties include:

- Promoting awareness of fraud, bribery and corruption within their organisation,
- Understanding the threat posed by fraud, bribery and corruption and,
- Understanding the best practice on counter fraud.
- They do not have any remit to investigate allegations of fraud and corruption.

3.9 Freedom to Speak-Up Guardians ('Whistleblowing')

Speak-Up Guardian has a responsibility to report allegations they receive relating to fraud or corruption against the organisation to the AFS (whilst protecting the identity of the referrer, if necessary).

3.10 Managers

All Managers are responsible for ensuring that policies, procedures and processes within their local area are adhered to and kept under constant review.

Managers have a responsibility to ensure that staff are aware of fraud, bribery and corruption and understand the importance of protecting the organisation from it. Managers will also be responsible for the enforcement of disciplinary action for staff who do not comply with policies, and processes.

Managers must report any instances of actual or suspected fraud, bribery or corruption brought to their attention to the AFS immediately. It is important that managers do not investigate any suspected financial crimes themselves.

Other responsibilities managers have include conducting risk assessments and mitigating identified risks.

3.11 All Employees

Employees are required to comply with the organisation's policies, procedures and processes and apply best practice in order to prevent fraud, bribery and corruption (for example in areas or procurement, personal expenses and ethical business behaviour). Staff should be aware of their own responsibilities in accordance with the organisation's standards of behaviour and in protecting the organisation from these crimes.

Employees who are involved in or manage internal control systems should be adequately trained and supported in order to carry out their responsibilities.

If an employee suspects that fraud, bribery or corruption has taken place, they should ensure it is reported to the AFS and/or to the NHSCFA as explained below.

3.12 Information Management and Technology

The Head of Information Security (or equivalent) will contact the AFS immediately in all cases where there is suspicion that the Trust ICT (Information and Communications Technology) is being used for fraudulent purposes in accordance with the Computer Misuse Act 1990. Similarly, the Head of Information Security or equivalent will liaise closely with the AFS to ensure that a subject's access (both physical and electronic) to Trust ICT resources is suspended or removed where an investigation identifies that it is appropriate to do so.

4 The Response Plan

4.1 Bribery and Corruption

The AFS undertakes and annual fraud and bribery risk assessment, in conjunction with the organisation conducting periodic assessments (in line with Ministry of Justice guidance) to assess how bribery and corruption may affect it. Proportionate procedures and measures have been put in place to mitigate identified risks. The organisation also has a policy and procedure in place in relation to the completion of declarations of interest, declarations of secondary employment and the hospitality/gifts register. The relevant policy and procedures are accessible via https://greenroom.nwas.nhs.uk/library/standards-of-business-conduct-policy-of-gifts-and-hospitality and staff are required to comply with these arrangements. Instances of non-compliance may be referred to the AFS for further investigation.

The AFS has primary organisational responsibility for investigating allegations of fraud and corruption against or with the organisation.

2 Reporting Fraud, Bribery or Corruption

This section outlines the action to be taken if fraud, corruption or bribery is discovered or suspected.

All genuine suspicions of fraud, bribery and corruption must be reported directly to the AFS-

Name: - Andrew Wade

Telephone: - 07824 104209

Email:- andrew.wade@miaa.nhs.uk / andrew.wade3@nhs.net

If the referrer believes that the Director of Finance or AFS is implicated, they should notify whichever party is not believed to be involved who will the inform the Chief Executive and Audit Commission Chairperson.

An employee can contact any executive or no-executive director of the Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the AFS or Director of Finance.

Details of a suspected fraud, bribery or corruption may also be reported though the MHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60, (powered by Crimestoppers 24/7) or online at https://cfa.nhs.uk/reportfraud in addition to the AFS or the organisation's Director of Finance.

The AFS and/or NHSCFA will undertake an investigation and seek to apply criminal and civil sanctions, where appropriate. Any investigation would follow our set investigation procedures.

Investigations may also include police involvement, where appropriate.

All NHS bodies including private providers, commissioners and trusts refer to the Home Office's bribery and corruption assessment template in order to assess their response to bribery and corruption.

Whistleblowing

To support the reporting of fraud using the NHS CFA fraud reporting process (as outlined above), all employees should be aware of NHS Improvement and NHS England's: Freedom to speak up: raising concern's (whistleblowing) policy for the NHS, April 2016 and NHS England's Freedom to speak up in Primary Care: Guidance to primary care providers on supporting whistleblowing in the NHS, these form the minimum standard to help normalise the raising of concerns in the NHS for the benefit of all patients in England.

4.3 Disciplinary Action

Disciplinary procedures, in the context of fraud allegations will be initiated where an employee is suspected of being directly involved in a fraudulent or illegal act, or where their negligent action has led to fraud being perpetrated. The organisation's disciplinary policy can be located here https://greenroom.nwas.nhs.uk/library/disciplinary-policy-and-procedure

4.4 Sanctions and Redress

This section outlines the sanctions that can be applied and the redress that can be sought against the individuals who commit fraud, bribery and corruption against the organisation.

The Trust's approach to pursuing sanctions in cases of fraud, bribery and corruption is that the full range of possible sanctions – including criminal, civil, disciplinary and regulatory – should be considered at the earliest opportunity and any or all of these may be pursued where and when appropriate. The consistent use of an appropriate combination of investigative processes in each case demonstrates this organisation's commitment to take fraud, bribery and corruption seriously and ultimately contributes to the deterrence and prevention of such actions.

Briefly, the types of sanction which the organisation ma apply when a financial offence has occurred include:

Civil – civil sanctions can be taken against those who commit fraud, bribery and corruption to recover money and/or assets which have been fraudulently obtained, including interest and costs.

Criminal – The AFS will work in partnership with the NHSCFA, the police and/or the Crown Prosecution Service to bring a case to court against an alleged offender. Outcomes can range from a criminal conviction to fines and imprisonment.

Disciplinary – Disciplinary procedures will be initiated where an employee is suspected of being involved in a fraudulent or illegal act. The organisation's disciplinary policy can be located here https://greenroom.nwas.nhs.uk/library/disciplinary-policy-and-procedure

Professional Body Disciplinary – If warranted, staff may be reported to their professional body as a result of a successful investigation/prosecution

The organisation will seek financial redress wherever possible to recover losses to fraud, bribery and corruption. Redress can take the form of confiscation and compensation orders, a civil order for repayment, or a local agreement between the organisation and the offender to repay monies lost.

5 Review

5.1 Monitoring and auditing of policy effectiveness

Monitoring is essential to ensuring that controls are appropriate and robust enough to prevent or reduce fraud. Monitoring arrangements include reviewing system controls on an ongoing basis and identifying weaknesses in processes.

Where deficiencies are identified as a result of monitoring, appropriate recommendations and action plans are developed and implemented.

5.2 Dissemination of the policy

This policy will be brought to the attention of all employees and will form part of the induction process for new staff.

North West Ambulance NHS Trust
Equality Impact Assessment Form (EIA) – Strategy and Major Project

Name of strategy and major project being reviewed:	**Anti-Fraud Bribery and Corruption Policy**
Equality Impact Assessment completed by:	**Michelle Brooks, Deputy Director of Finance**
Initial date of completion:	**22nd December 2020**

It is anticipated that this EIA will be reviewed throughout the lifecycle of the policy or guidance. Relevant documentation should be maintained relating to the review. Please also record any stakeholders who input into this now or in the future. There is a shortened version of this form for assessing the impact of policies and procedures.

Section 1 – Overview

Outline of the strategy or project being reviewed

This policy is to guide and advise staff on the subject of Anti-Fraud, Bribery and Corruption in the NHS. This document outlines how to protect public money from the risk of fraud in a non-discriminatory, fully open, fair and transparent manner. This ensures compliance to both the latest NHS CFA guidance and regulatory legislation.

Who does it affect? (Staff, patients or both)?

All employees and volunteers

How do you intend to implement it? (Trustwide communications plan or training for all staff)?

The policy requires approval by the Board of Directors. It will made available on the intranet and staff and on the Trust's website for others. Regular training is provided on the subject via the mandatory training programme.

Section 2 – Data Gathering

In order to complete the EIA it may be useful to consider the following:-

- What data have you gathered about the impact of this strategy or project on different groups?
- What does it show?
- Would it be helpful to have feedback from different staff or patient groups about it?

The policy will be used by staff and managers so in terms of equality, the policy aims to make sure the diversity of staff and patients is considered as part of this policy.

Please document activity below:

Equality Group	Findings of the data
Age	There is data available within the Trust about the age ranges of staff.
Disability – considering visible and invisible disabilities	Just over 3.5% of staff within NWAS have disclosed a disability on ESR but approximately 20% of staff survey respondents have disclosed a disability or long-term condition. There is no data about the percentage of patients we respond to with disabilities or long-term health conditions.
Gender	No data has been collated about the policy with reference to gender.
Marital Status	No data has been collated about the policy with reference to marital status.
Pregnancy or maternity	No data has been collated about the policy with reference to pregnancy or maternity.
Race including ethnicity and nationality	We are able to request information about the ethnicity of staff from a company we work with.
Religion or belief	We have data about staff demographics relating to religion and belief. There is no data available to us as this time relating to patients.
Sexual Orientation	We collate data on sexual orientation relating to staff.
Trans	There is no data available to us re staff who are trans. This group is supported by the LGBT network, as per 'sexual orientation' above.
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	

Section 3: Consultation

Having considered the data above:-
- ✓ Can you or must you consult with different groups?
- ✓ What else should you be considering?

Please document the outcome of consultation below:

Equality Group	Feedback from groups
Age	We don't propose to circulate the policy to staff and stakeholders specifically with regards to age.
Disability – considering visible and invisible disabilities	We don't propose to circulate the policy to staff specifically with disability in mind. However we do engage with staff via the Disability Forum as appropriate.
Gender	We do not seek to share this with staff or stakeholders specifically re gender.
Marital Status	We do not seek to share this policy specifically relating to marital status.

Pregnancy or maternity	We do not seek to share this policy specifically relating to pregnancy or maternity.
Race including ethnicity and nationality	We do not seek to share this policy specifically relating to race.
Religion or belief	We haven't shared the policy with the Religion and Belief Forum within NWAS as it is still developing.
Sexual Orientation	There is scope to share this policy with the LGBT network if requested.
Trans	We do not seek to share this policy specifically relating to trans.
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	

Section 4: Impact Grid
Having considered the data and feedback through consultation, please detail below the impact on different groups:

Equality Group	**Evidence of Impact**	**Is the impact positive or negative?**
Age	No indication that this policy will impact on staff or patients of particular ages.	Neutral
Disability – considering visible and invisible disabilities	The team links in with the Disability Forum for feedback from staff.	Neutral
Gender	There is no indication that the policy will negatively impact on staff or patients re gender.	Neutral
Marital Status	There is no indication staff of particular marital status will be affected.	Neutral
Pregnancy or maternity	There is no indication that the policy will impact on staff or patients in relation to pregnancy or maternity.	Neutral
Race including ethnicity and nationality	There is no indication that staff or patients from particular ethnic groups will be affected. Different attitudes and approaches to bribery and corruption do exist within different countries and cultures. The definitions cited in 2.3 and 2.4 of the policy clearly state the expectations for any staff new to working in the UK.	Neutral
Religion or belief	There is no information to indicate that the policy will not be able to respond to individual patient or staff needs about religion.	Neutral
Sexual Orientation	There is no indication that the policy will impact on staff or patients in relation to sexual orientation.	Neutral

Trans	There is no indication that the policy will impact on staff or patients in relation to trans.	Neutral
Any other characteristics for patient or staff e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee		

Section 5 – Action plan
At this point, you should prepare an action plan which details the group affected, what the required action is with timescales, and expected progress. You may still be seeking further information as part of your plan. You can use the tables above to form the relevant plan and attach to this.

This EIA has been reviewed by the HR Advisor for Workforce and Equality.

Section 6 – Monitoring and Review
You should document any review which takes place to monitor progress on the action plan or add any information through further data gathering or consultation about the project. It is sensible for the review of this to be built into any plans.

Resources and support

You may:
- discuss your project or request feedback from a relevant staff network
- link in with the Patient Engagement team to discuss the potential impact on patient groups
- link in with a colleague within HR to discuss the potential impact on different staff groups
- consider the data available within the Trust about the current workforce or patient groups
- consider the full list of vulnerable groups as cited in EDS2 framework documents – page 10-11 of this link: https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf
- consider increasing the diversity of views and characteristics within the project group

North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Name of Committee/Group:	**Audit Committee**	**Report to:**	**Board of Directors**
Date of Meeting:	**15th January 2021**	**Quorate (yes/no):**	**Yes**
Chair:	**David Rawsthorn, Non-Executive Director**	**Executive Lead:**	**Director of Finance / Director of Corporate Affairs**
Members present:	**Prof Rod Thomson, Associate Non-Executive Director Dr David Hanley, Non-Executive Director Michael O'Connor, Senior Independent Director**	**Key Members not present:**	
Board Assurance Risks Aligned to Committee:	**No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.**		

Key Agenda Items	RAG	Key Points	Action/Decision
Clinical Governance- Quality and Performance Chair's Assurance Reports		• The Committee received assurance reports relating to Clinical Governance from the meetings held on: 19th October 2020 and 16th November 2020. • The Director of Quality, Innovation and Improvement attended the meeting for this agenda and provided clarification around specific items.	Noted the assurance provided within the reports.
Data Quality		• The Head of Digital Intelligence attended the meeting to present an update in on the plan to improve the robustness of data quality processes..	Noted the assurance provided within the report.
Critical and High Risk Recommendations		• MIAA have continued to follow up recommendations. It was noted 2 high risk recommendations remain outstanding for completion by March 2021.	Noted the update provided.
Internal Audit Progress Report Q3 2020/21		• The Committee noted the assurance reviews completed within Q3: – Risk Management – Substantial Assurance – Key Financial Controls – High Assurance – 111 Working from Home – Substantial Assurance	Noted the assurance provided.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
		– Assurance Framework – Stage 2 • The Committee noted the good progress against the audit plan.	
Internal Audit Follow Up		• The Committee noted the progress within the reporting period with 9 recommendations implemented.	Noted the assurance provided.
Third Party Assurances		• Completion of the self-assessment exercise against the NHS Audit committee Handbook checklist had identified a need to consider whether 'the committee receives assurance from third parties who deliver key functions to the organisation'. The Committee received a report detailing where third party assurances are aligned to within the Committee structure.	Noted the assurance provided and the alignment of assurances to appropriate Committees. The report is to be passed on to the Resources and Q&P committees so they can satisfy themselves they are receiving the appropriate assurance in relation to the third party services they are responsible for.
Review of MIAA Covid-19 Checklists against NAO Guidance		• The Committee received a report providing an overview of the COVID-19 checklists provided by MIAA against the National Audit Office guidance to ensure there were no gaps. • It was noted the Trust had considered all of the areas within MIAA COVID-19 checklists against the NAO Code with the exception of a small gap relating to financial reporting which would be considered during the production of the financial statements for the year ending 31 March 2021.	Noted the assurance provided.
External Quality Assessment		• MIAA presented the Committee with the outcome of the Public Sector Internal Audit Standards Assessment, an external quality assessment process undertaken every 5 years. • The Committee noted that MIAA were fully compliant with the standards.	Noted the assurance provided.
Anti-Fraud Progress Report		• The Committee received the Q3 2020/21 Anti-Fraud Progress outlining the wide range of activities aligned to the NHS CFA's Standards for Providers undertaken by the anti-fraud specialist (AFS).	Noted the assurance provided.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
NWAS Anti-Fraud, Bribery and Corruption Policy		• The Committee received the updated Anti-Fraud, Bribery and Corruption Policy following review with the Anti-Fraud Specialist.	Subject to one minor amendment, supported the recommendation to submit to the Board of Directors for approval.
External Audit Progress Report and Technical Update		• The Committee received an update relating to the progress of the 2020/21 external audit. • The Committee noted the national publications released during the period.	Noted the assurance provided.
Audit Strategy Memorandum		• The Committee received a report summarising the external audit approach and the significant audit risk and areas of key judgement. • It was noted that a significant change arising from the new Code of Practice was that the auditor would need to deliver an Auditor's Annual Report	Noted the assurance provided.
Board Assurance Framework (BAF) Q3 2020/21		• The Committee received the updated BAF prior to submission to the Board of Directors for approval on 27 January 2021. • It was noted that the Q3 position was incomplete and was due for review by the Executive Leadership Committee. • Committee members considered the report within the context of their role as Audit Committee.	Noted the assurance provided.
Risk Management Policy		• The Risk Management Policy was presented to the Committee following a full review and refresh. • The Chair of the Committee noted he had requested changes to; s3 to specify the role of the Audit Committee and its responsibility for the risk management process and to s14 to provide clarity in relation to the different role of the Audit Committee from the Board Assurance Committees.	Subject to the agreed changes, recommended the Risk Management Policy to the Board of Directors for approval.
Provision of Internal Audit and Counter Fraud Services		• The Committee received a proposal to allow a legally compliant contract to be awarded for the provision of internal audit and counter fraud services from 1st April 2021.	Supported the direct award of 2+1+1+1 contract to MIAA as the preferred supplier for internal audit and counter fraud services.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision

Legal Services Report Q3 2020/21		• The Committee received a report detailing the work undertaken by Legal Services during Q3 2020/21:
		  • No Regulation 28 PFD Report
		  • 15 new claims
		  ○ 10 are Clinical Negligence claims
		  ○ 4 are Employer's Liability claims
		  ○ 1 is a Property Damage claim
		  • 80 Subject Access Requests were processed
		  • 24 requests connected with Care Proceedings
		• The report included common themes found relating to contentious/potentially contentious inquests. It was agreed to request the Quality and Performance Committee to review whether ROSE have the ability to deal with issues at a thematic level.
			Noted the assurance in the report. Chair of the Quality and Performance Committee to request a review on whether ROSE have the ability to deal with issues at a thematic level.

Waiver of Standing Orders Q3 2020/21		• 11 waivers were received during Q3.	Noted the assurance provided.
Review of meeting effectiveness		• The meeting was considered to have been effective.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

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REPORT

Board of Directors	
Date:	27th January 2021
Subject:	Integrated Performance Report
Presented by:	Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	The Integrated Performance Report for January 2021 shows performance on Quality, Effectiveness, Finance, Operational Performance and Organisational Health during December 2020 unless otherwise stated. The highlights from this **December** report are as follows; **Quality** • 132 complaints were received, against a 12 month average of 133 per month. The Trust is on track with its strategic goal of reducing complaints. 86 compliments were received. • 53% of complaints risk scored 1-3 and 27% of level 4-5 complaints were closed within SLA. This signals a reduction in the complaints completed within SLA from previous months and is due to a number of reasons including operational pressures and a backlog. • 1474 internal and external incidents were opened, against a 12 month average of 1352. Although the numbers of incidents has increased we are still managing to close them within the agreed standard. • 4 Serious Incidents (Sis) occured in December. Six SI reports were submitted within the 60-day timescale. • There were 6 new safety alerts which were all reviewed, actioned and closed. **Effectiveness** • **Patient experience:** In November 2020, national collection of FFT data recommenced and the number of returns has increased across all service lines. These high return rates are due to changes in the way data are collected. Satisfaction levels remain high. • **ACQIs:** Overall we are seeing no change in our data for the clinical quality indicators. Rankings in comparison to other ambulance services change from month to month but overall there is no significant change (common cause variation). • **H&T, S&T, S&C:** The proportion of incidents with Hear and Treat has increased in December to 10% (although within the control limits as common cause variation) and is being sustained at high levels. See & Treat has also remained steady at 30% resulting in an aggregate non-conveyance of 40%. **Finance**

- The year-to-date expenditure on agency is £4.204m which is £1.872m above the 19/20 ceiling of £2.332m which is due to be updated.
- The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

Patient Emergency Service (PES)

- Call Pick Up performance was 96.1%.

ARP Performance

	Standard	Actual
C1 (Mean)	7:00	7:36
C1 (90th)	15:00	12:44
C2 (Mean)	18:00	26:29
C2 (90th)	40:00	55:49
C3 (Mean)	1:00:00	1:17:46
C3 (90th)	2:00:00	3:02:47
C4 (90th)	3:00:00	5:54:57

- The only response time target met is for C1 90th. The primary reason for not reaching targets is a mismatch between demand and resource levels and the additional impact of COVID 19 abstractions.
- NWAS performance on C4 90th centile has been challenged with a significant lengthening of respose times compared with our previous performance.
- Although targets have not been met, C2 mean, C2 90th, C3 mean and C3 90th are all stabilising at a new lower mean time. The Trust has continued to focus on maintaining an effective response to life threatening calls.
- **Handover:** Despite the average handover time remaining at around 31 minutes versus a national standard of 30 minutes 2564 attendances (4.8%) had a turnaround time of over 1 hour with 63 of those taking more than 3 hours. 527.8 hours were lost to delayed admissions in December.

NHS 111

	Standard	Actual
Calls Within 60s	95%	78.43%
Average Time to answer		1min 19s
Abandoned Calls	<5%	5.32%
Call back Within 10 min	75%	9.85%
Average Call Back		1hour 15min
Warm Transfer to Nurse	75%	13%

- Performance throughout December has shown significant improvement in all measrures apart from call back within 10

	minutes with work underway to improve this metric in the coming months. **PTS** • Activity in December for the trust was 37% below contract baselines, whilst the year to date position (July 2020 – December 2020) is performing at 49% below baseline. This is due to Covid-19. **Organisational Health** • **Sickness**: The overall sickness absence rate for the latest reporting month (November 2020) was 9%. • **Turnover** was 7.35%. • **Agency:** Due to the impact of Covid-19 agency costs at the trust stands at 1.6% in December. • **Vacancy**: Positions across the trust are under establishment by 3.44%. This is mainly as a result of establishment changes in 111 • **Appraisal:** The overall appraisal completion rate was 69.87% against a reviesed trust target of 85% this is lower than 95% due to the effect of Covid-19. • **Mandatory Training:** The trust is 80% compliant against a target of 95%. This is due to the impact of Covid-19 and the addition of new topics for the current years cycle of training. The target of 95% will be met by March 2021, a plan is in place to achieve this. • **COVID 19:** There have been 165 instances of staff that have tested positive for Covid-19 in December 2020 with 948 instances since July 2020. There have been 61 outbreaks on trust sites from July until the end of December of which 22 are now closed. Outbreak management is a key objective and is overseen by a weekly executive management group.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Note the content of the report • Note the impact on performance of COVID-19 staff abstractions • Clarify any items for further scrutiny

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety	☐
SR03	If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	
Date:	
Outcome:	

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1. PURPOSE

The purpose of this report is to provide the Board of Directors with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of December 2020. The report shows the historical and current performance on Quality, Effectiveness and Operational performance. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

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

2. INTEGRATED PERFORMANCE SUMMARY

Quality

Q1 – Complaints and Compliments

In December 2020, 132 complaints were received, against a 12 month average of 133 per month. 86 compliments were received this month. The Trust is on track with its strategic goal of reducing complaints. The month average is 21 complaints per 1000 WTE staff, against a strategy goal of 31.

A total of 111 complaints were closed in December 2020 (100 cases were risk scored 1-3 and 11 were risk scored 4-5). Overall, 53% of cases risk scored 1-3 were closed within the agreed timescales against a right care strategy goal of 85% for the end of 20/21. 27% of level 4-5 complaints were closed within agreed timescales against a right care strategy goal of 75% by the end of 20/21.

The data signal a significant increase in completion within SLA in May (special cause can be seen with the data point above the upper control limit). This was due to the Ombudsman stopping lower level complaints between March to May. Since June, the data signal that less complaints have been completed within SLA with December's data point in Q1.5 showing a significant change (with the data point on the lower control limit). There are a number of reasons why we have seen a reduction, including:

- Operational pressures impacting on staff' ability to respond to complaints
- Parliamentary and Health Service Ombudsman (PHSO) have stopped the reporting of complaints during the first wave causing a backlog
- Some processes within the patient safety team that require improvement

The team, led by our new Patient Safety specialist (Clare Wade), have a plan being implemented from 18th January to improve response times. This will be monitored by safety management group and Quality and Performance Committee.

Q2 – Incidents

In December 2020 1474 internal and external incidents were opened, against a 12 month average of 1352. The number of opened incidents is back within the normal range having previously increased in October and November. With increase in demand on the service there has also been associated delays in the timely risk scoring of opened incidents within timeframe. A high proportion are related to 111 and this is being investigated to understand the cause.

In November, 25 incidents were unscored which aligns to the Right Care Strategy goal of 25 unscored incidents in the previous month reported in the IPR.

In total, 1335 incidents (level 1-5) were closed during December 2020 . There have been improvements in both the 1-3 and 4-5 incident closure rates during December.

85% level 1-3 were closed within agreed standard against the right care strategy goal of 85%. The data signal a significant change with special cause variation with a data point above the upper control limit and we are one data point away from seeing an upward shift, resetting our mean to reach our strategy goal.

77% of level 4-5 incidents were closed within the agreed standard against a right care strategy goal of 80% for the end of 20/21.

The data demonstrate that although the numbers of incidents being closed has moved up we are still managing to close them within the agreed standard.

Q3 - Serious Incidents (SIs)
4 Serious Incidents (SIs) were reported in December 2020. 6 SI reports were due with the commissioners in December 2020. All 6 were submitted within the 60-day timescale.100% of the SI's reports due in December 2020 were submitted within the timescales and we are on track with our right care strategy goals. We are now seeing the benefits of the introduction of the serious incident review panel and are continuing with the trial. The data do not signal any increase which demonstrates that although the number of incidents risk scored 4-5 has increased we are not seeing this translate into an increase in Serious Incidents.

Q5 - Safety Alerts and Health and Safety
There have been 6 new safety alerts in December 2020. The total number of CAS/NHS Improvement alerts received between January 2020 and December 2020 is 34, with 1 alerts applicable. 21 MHRA Medical Equipment Alerts have been received with 1 alert being applicable. 64 MHRA Medicine alerts have been received, with 0 alerts applicable. 2 IPC alerts have been received, with 2 alerts applicable.

Effectiveness

E1 - Patient Experience
Because of the COVID-19 pandemic, NHS England suspended the FFT process at the end of Q4 2019/20, resulting in no submission of data from the April reporting window with submission recommencing in November.

Prior to this, the only responses received during 2020 in relation to FFT were through the trust's online digital surveys. These were introduced in the summer of 2020 and the lack of direct contact to individual patients receiving our services, reflect the low return rate.

Since November we have reinstated contacting patients to ask the FFT question via SMS text message– this allows us to contact those patients that we know have recently used the service directly to ask about their experience. Response levels tend to be much higher as patients receive this question directly to their mobile phones and it is tailored to only ask the question and follow up demographics. As we can see, this has led to a large uptake in return rates since we have reinstated using this method. (combined figures for November and December 2020 are 369, 899, and 297 for PES, PTS and 111 respectively).

Despite all the additional pressures that NWAS currently face - satisfaction levels remain high across all service lines.

National reporting on FFT is due to recommence with December's data required for submission on the 1st February 2021.

It should also be noted that whilst postal surveys and face to face patient experience and engament work have been mainly put on hold during the pandemic, the trust has continued to listen to and engage with patients, community groups and the general public through its engagement framework implementation plan with these stakeholders in addition to its programme of work with the patient and public panel.

Quarterly updates on this work are provided to the Quality and Performance Committee and trust Board.

E2 – ACQIs

Effectiveness

Overall we are seeing no change in our data for the clinical quality indicators. Rankings in comparison to other ambulance services change from month to month but overall there is no significant change (common cause variation).The lag in data make it difficult to understand the impact of any recent work to improve in these areas and supplementary measures to give us a more recent picture are being explored.

In August, 9.4% of patients suffering an out of hospital cardiac arrest survived to hospital discharge (national mean 10.2%). Performance was within control limits; This performance saw the Trust ranked 6th and 3rd for both categories for English ambulance trusts.

The rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group was 55.6% (national mean 53%), ranking 4th nationally. For the overall group the rate was 30.5% (national mean 29.4%) ranking the Trust in 5th position nationally.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of 2h 18mins; the Trust's performance was 2h 45mins for these patients. Mean call to door time for patients suffering a hyper acute stroke was worse better that the national mean of 1h 22mins; the Trust's mean response to these patients was 1h 23mins.

The Stroke care bundle result of 98.0% was fractionally behind the national mean of 98.3%. Care bundle data for acute STEMI and sepsis was not published for August as is consistent with the NHSE reporting schedule.

E3 – H&T, S&T & S&C Outcomes

The proportion of incidents with Hear and Treat has moved up in December to 10% (although within the control limits as common cause variation) and is being sustained at high levels. See & Treat has also remained steady at 30% leading to an aggregate non-conveyance of 40%.

Our rankings over time show no change for See and Treat and See and Convery (E3.8 and E3.9) but for Hear and Treat we see a move to 5th.

Finance

F1 – Finance

The year-to-date expenditure on agency is £4.204m which is £1.872m above the year-to-date ceiling of £2.332m. (Please Note: The agency ceiling is based on 2019/20 ceiling figures and will be updated as soon as we have the information). For the nine months of the Covid-19 framework, the 2020/21 monthly financial returns have been redesigned to collect a minimum dataset to reduce the burden on organisations wherever possible, whilst maintaining a monthly data collection process.

The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

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Operational

PES Activity

OP1 – Call Pick Up

For December 2020, call pick up in 5 seconds performance was at 96.1%. 3,396 calls took longer than 5 seconds to pick up. Mean call answering has deceased to 2 seconds.

Activity has fluctuated with regularity from 19000-23000 calls per week. Our ability to answer the phone in a timely manner has been consistently within normal limits.

Since December 2020 the EOC has begun "wave 2" of agency recruitment. This process will see 123 further emergency call handlers (ECH) introduced into the workforce to support 999 call answering. This is scheduled to be delivered by the end of February 2021, and is currently on tracker for a confirmed delivery.

NWAS has also been working alongside NARU, AACE and all other UK Ambulance Trusts to help support the on-going national call answering effort. Many other Trusts have seen large numbers of staff abstractions, in particular London Ambulance Service (LAS). NWAS has been supporting this work whilst maintaining the safety of patients of the North West.

OP3 – ARP Standards

	C1 Mean	C1 90th	C2 Mean	C2 90th	C3 Mean	C3 90th	C4 90th
Dec 2020	00:07:36	00:12:44	00:26:29	55:49	01:17:46	03:02:47	05:54:57
Target	00:07:00	00:15:00	00:18:00	40:00	01:00:00	02:00:00	03:00:00

For December the only response time target met is for C1 90th. Modelling work has been commissioned from ORH to inform future commissioning. The additional impact of COVID 19 abstractions has resulted in challenges in delivering more double crewed ambulances to meet demand. Handover delays have also contributed as described previously.

Although targets have not been met, C2 mean, C2 90th, C3 mean and C3 90th all see the data signalling that performance is stabilising at a new lower mean time. NWAS performance on C4 90th centile has been challenged with a significant lengthening of respose times compared with our previous performance.

The Trust has continued to focus on maintaining an effective response to life threatening calls. In support of this, high level actions to maximise the availability of NWAS responding resources have been developed:

- Increased DCA (Double Crewed Ambulance) numbers by reduction of RRV (Rapid Response Vehicle) fleet.
- Increase number of DCA profiled each day
- Increased use of third party resources
- Increased scope of practice for third party resources
- Use of complimentary resources to increase clinical decision making on scene – through HART and SPTL structure
- PTS resources providing support to PES where safe to do so.
- Redeployment of suitably trained staff to enhance frontline service delivery.
- Clinical Coordination Desk within EOC supporting enhanced decision making and reviewing long waits.
- Additional call handling capacity within EOC's.
- Continue to engage locally, regionally and nationally regarding Hospital Handover challenges.
- Patient Safety Plan
- Pandemic Protocol Card 36 (EOC Procedure)

OP2 – Hospital Turnaround

The average turnaround for December 2020 was 31 minutes 54 seconds across the North West. . This is only 5 seconds longer than November's average turnaround time of 31 minutes and 49 seconds,

despite 3,893 more hospital conveyances. It is also 38 seconds shorter than the October average of 32 minutes and 32 seconds despite higher numbers of patients taken to hospital in December.

Nevertheless, despite the average handover time remaining at around 31 minutes versus a national standard of 30 minutes, this is the average performance. 2564 attendances (4.8%) had a turnaround time of over 1 hour during December with 63 of those taking more than 3 hours.

In addition, Since August 2020 delayed admissions to hospitals have become an increasing problem for trust. In December, 415 cases of delayed admissions were reported. During w/c 28th December alone there was 154 occurrences of delayed admission (highest volume in week since data collection commenced in August 2020). 527.8 hours were lost to delayed admissions in December 2020.

The top 5 sites where delayed admissions are occurring by volume are:

- Royal Bolton Hospital (81; 20%)
- Fairfield General Hospital (69; 17%)
- Royal Preston Hospital (67; 16.5%)
- Royal Oldham Hospital (37; 9%)
- Blackpool Victoria (36; 9%)

Whilst the Every Minute Matters improvement collaborative has paused to support the pandemic response the Trust continue to work with NW NHSEI and acute hospital partners across the region to address the increase in hospital handover times and associated safety and patient experience risks.

OP4 – 111

In December, performance continues to improve within 111 as it did in November compared to September and October. This is aligned to the significant increase in recruitment of Health Advisors and Clinicians to support the 111 First campaign. This is aligned to the significant increase in recruitment of Health Advisors and Clinicians to support the 111 First campaign.

Despite the increase in staffing, performance at present is not fully optimised due to constraints with Estate and Telephony.

Estate - Work is underway preparing the additional estate within Middlebrook. The planned go live date for this is currently the end of March 2021. Call Handlers that have been recruited between December and March will be done so on fully flexible shift patterns until there is available estate to seat them in. Once Estate capacity is realised (circa 75 desks) call handlers will then be rostered to shift patterns to optimise performance.

Telephony – The UCP is now live within 111. The original planned go live date for the UCP project was 17th December. This was delayed due to significant issues presenting in the Soft Launch period. Prior to UCP go live the 111 Service had a limited number of Cisco phones and therefore a further constraint in putting recruited staff onto shifts optimised to achieve performance. With additional telephony capacity now in place, temporary additional desks have been secured at Lady Bridge Hall for evening and weekend call taking. The operational team are now in the process of setting up and testing this area before mobilising the capacity which will support performance further, estimated go live for this is week commencing 12th January 2021.

Further investigation is underway to understand the drop in the proportion of patients with a call back in 10 minutes which is signalled in the data with a data point outside the control limits.. Initial analysis suggests this is linked to the roll out of the new Patient Management System Cleric.

Since the roll out of Cleric a significant amount of work has been undertaken refining the Clinical Advice queue to allow more efficient management of the queue and ultimately reduced waits for clinical call backs to patients, this should show further improvements for this KPI next month.

OP5 – PTS Activity

Overall activity during December 2020 was 37% below contract baselines with Lancashire 44% below contract baselines whilst Merseyside is operating at -27% (-6826) Journeys below baseline. For the year

to date position (July 2019 - December 2020) PTS is performing at -39% (-307053 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at 45% and 46% below baseline whilst Greater Manchester and Merseyside are operating at 34% and 29% below baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 37% (7172 journeys) and -12% (-1383 journeys) above baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges in achieving contract KPI performance. Cumbria and Lancashire are -51% (-3796 journeys) and -24% (-6824 journeys) below baseline.

In terms of overall trend analysis, Greater Manchester has experiencing upward activity movement for the 12 months up to around October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also plateauing whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity.

Aborted activity for planned patients averaged 6% during December 2020 however Cumbria experiences 3%, Greater Manchester operates with 8% whilst Lancashire and Merseyside both experience 5% & 5% aborts respectively. There is a similar trend within EPS (renal and oncology) patients with a Trust average of 4% aborts whereas Cumbria has 1% and Greater Manchester 5% Lancashire and Merseyside operate with 3% and 4% respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average 16% (1 in 6 patients) with variances of 9% in Cumbria, 17% in Greater Manchester, 15% in Lancashire and 15% Merseyside.

Workforce

OH1 – Sickness
The overall sickness absence rates for November 2020 were 9% with all service lines showing increases apart from 111. This overall trust sickness rate includes COVID-19 related sickness of 3%. The underlying Non-COVID-19 sickness remains consistent.

All service lines show sickness above 9%. Both PES and 111 have Covid related sickness at 3.58% and 3.3% respectively.

In addition to sickness reported via ESR, COVID-19 self-isolating absences have been captured by GRS, Telipoti and Marvel. This data is reported externally.

OH2 – Turnover
Turnover is calculated on a rolling year average and this does lend to some small variations between months with December 2020 turnover being 7.35% consistently lower than in previous years.

Staff turnover has in the main been positively affected by COVID-19 and the changed job market. 111 has seen the most significant reduction in turnover since COVID-19 although a slight increase in December to 20.52% but overall the Trust turnover remains low compared to the historical positon of over 30%.

OH4 – Temporary Staffing
As a result of COVID-19, the Trust Agency usage and expenditure is projected to exceed the Agency ceiling, although this does not form part of the reporting under the emergency arrangements.

Agency staff have been used to support the Trust's response to the Pandemic and have been utilised primarily in the Contact Centre environment.

ELC approved the recruitment of an additional 123 Agency staff in EOC for the period up to the end of the financial year, so levels are expected to remain higher than previous years. An exit strategy to reduce agency levels through fixed and permanent contracts is in place to reduce this by April reporting

The increase in November and December 2020 are impacted by Wave 2 & 3 of the Pandemic.

OH5 – Vacancy Gap
There has been a worsening of the vacancy position since October but this reflects the significant change in establishment implemented in month in 111 as a result of the agreed contract extension and 111 First.

Recruitment plans for 111 are on track. There were no new starters planned for December which has resulted in a slight increase in the vacancy position to 13.85% (OH5.5). The Health Advisor vacancy position is 5% and plans expect this to be reduced further in Q1.

The vacancy position in PES is positive and very stable within 1% of establishment. This excludes the continuing use of PTS and VAS resource to supplement resources (OH 5.3). The increase in PTS vacancies in December reflects the permanent appointment of some of these staff onto the EMT1 apprenticeship.

There is an over establishment at the end of December 2020 in EOC at 2.28% (OH 5.4), although this shows a reducing position, this is being supplemented by new agency recruitment of over 120 additional staff to support COVID delivery and to prepare for Single Primary Triage project implementation.

OH6 – Appraisals
As a result of the impact of COVID-19, appraisals were paused in March 2020 in line with national guidance. They were recommenced in June and improvement can be seen until the commencement of the second wave. The last 4 months have shown a worsening of the position. Appraisals were formally paused again for frontline staff on October 21st as a result of demand and high levels of abstractions.

As a result completion rates are currently 69% overall.

Following resumption in June 2020, a revised target was set as part of recovery planning of 85% and a review of the target and recovery plans is cunnently under consideration.

OH7– Mandatory Training
Mandatory training for frontline staff was paused in March 2020. Classroom training for PTS resumed in May 2020 with reduced capacity. EOC and 111 resumed online training in June 2020. PES mandatory training resumed in August but finished in October 2020 ahead of the scheduled plan (November) due to operational pressures.

The training cycle has been extended from January 2021 to March 2021 as part of the recovery actions. Classroom training for PTS is on track against the revised trajectory however PES is currently behind trajectory with a further delay to resumption now planned for February 2020.

A review of the mandatory training target and recovery plans are currently being considered.

The Trust moved to competence-based reporting for mandatory training which combines classroom and online module completion. The overall Trust mandatory training compliance position at the end of December is 80% against a 95% compliance target and has maintained a stable position for the last 3 months

Covid-19
There have been 165 instances of staff that have tested positive for Covid-19 in December 2020 with 948 instances since July 2020.

There have been 61 outbreaks on trust sites from July until the end of December. The largest outbreak has been at Middlebrook where the call centre for 111 is based. The largest 5 outbreak sites account for 24% of confirmed covid cases. In December there were 27 new outbreaks and 22 outbroeaks closed.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

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

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to:

- Note the content of the report
- Note the additional inclusion of ranking over time for ACQI, Outbreak (H&T, S&T & S&C) and 111 performance
- Note the inclusion of COVID 19 positive staff and outbreaks
- Clarify any items for further scrutiny through the appropriate assurance committee.

Q1 COMPLAINTS

Figure Q1.1

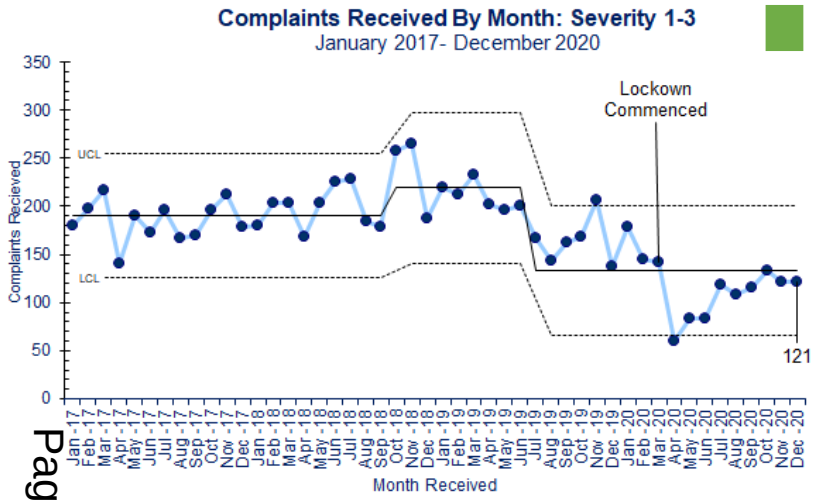


Figure Q1.2

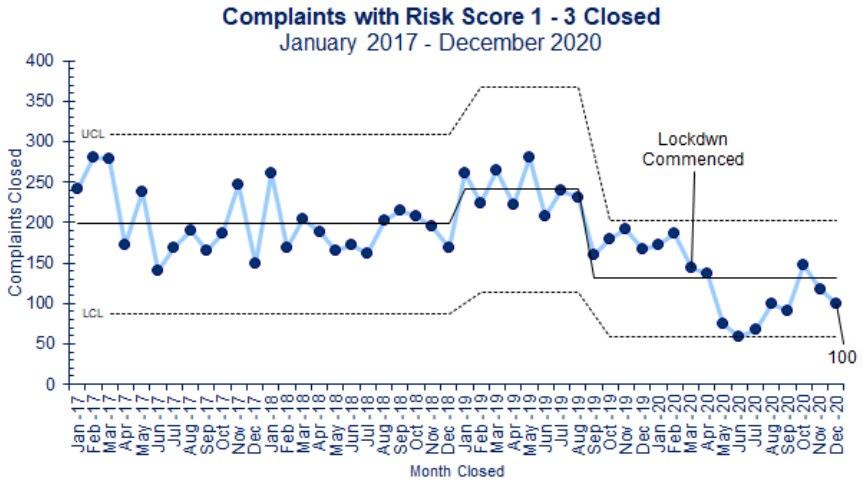


Figure Q1.3

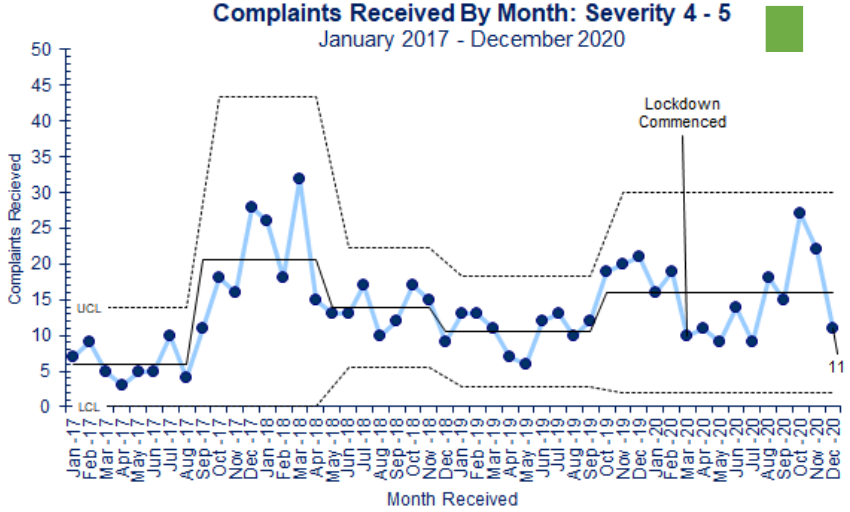
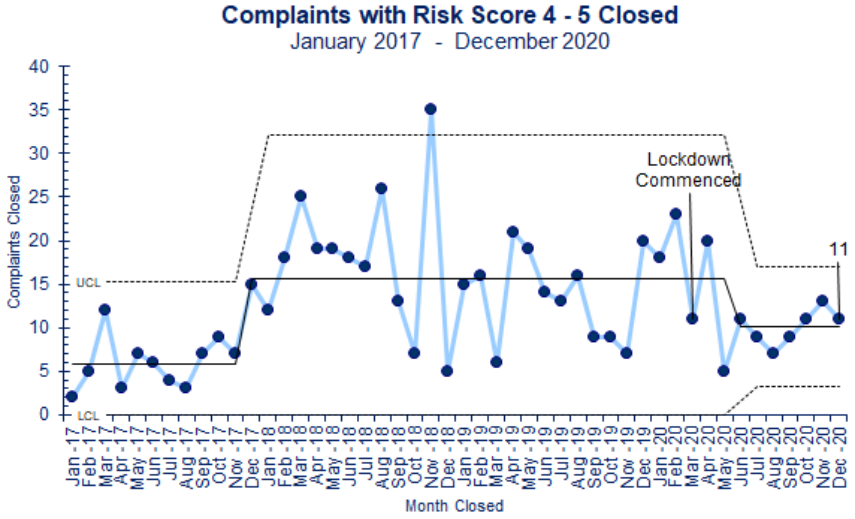


Figure Q1.4



Complaints & Compliments

In December 2020,

132 complaints (figures Q1.1 & Q1.2) were received against a 12 month average of 133 per month.

86 compliments were received this month.

The rate of complaints in December 2020 is 21 per 1000 WTE, which is below the strategy goal for 2020/21 of 31.

The average for the fiscal year (1 April 2020 – 31 December 2020) is 19.3 per 1000 WTE which is significantly below the target. This reduction in complaints is attributed to the current COVID-19 pandemic where we saw a reduction in lower-level complaints due to the following reasons:

- Improved performance in the early and mid stages of the first wave of COVID-19.
- Reduced PTS journeys which typically generate a high number of lower-level complaints
- More tolerance from the public for minor concerns.

measures are meeting expectations

measures are below expectations

* baseline is the financial year 2017/18

Figure Q1.5

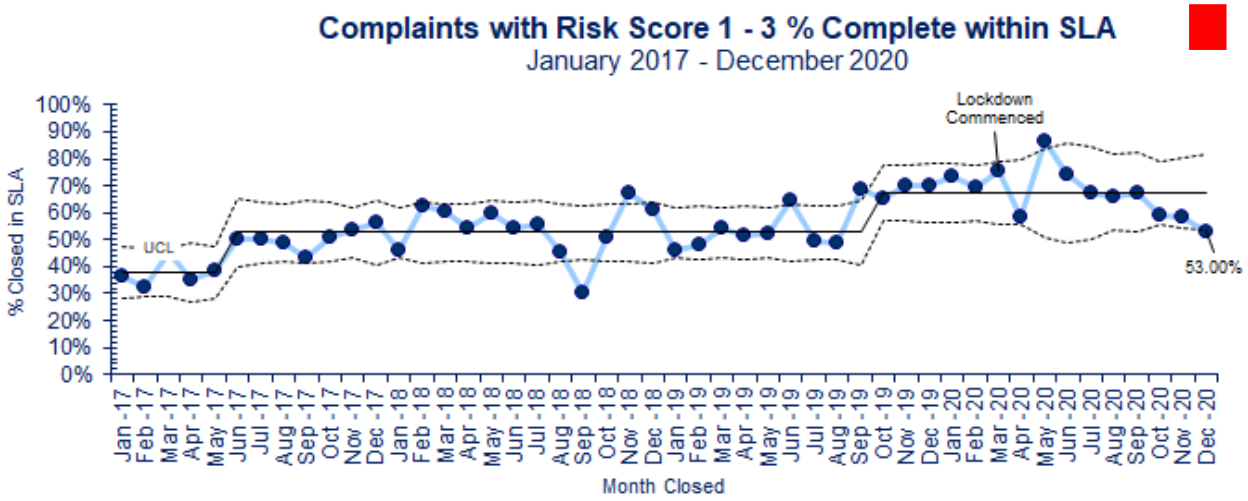
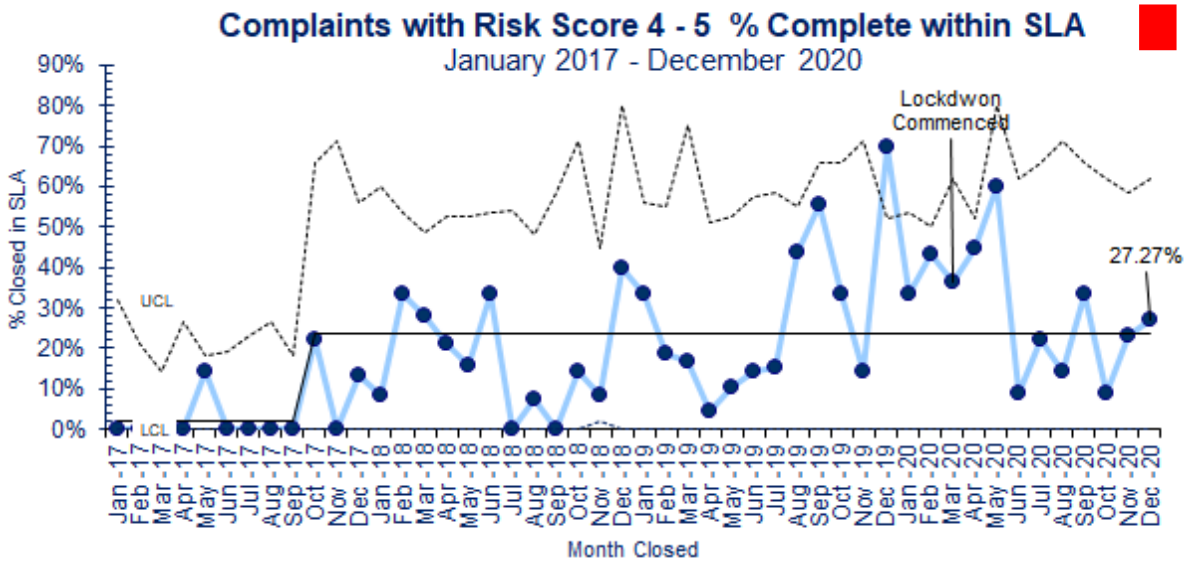


Figure Q1.6



Complaints Closure

A total of 111 complaints were closed in December 2020 (100 were risk scored 1-3 and 11 were risk scored 4-5).

Overall, 53% of cases risk scored 1-3 were closed within the agreed timescales (Q1.5) against a right care strategy goal of 85% for the end of 20/21.

27% of level 4-5 complaints were closed within agreed timescales (Q1.6) against a right care strategy goal of 75% by the end of 20/21.

The data signal a significant increase in completion within SLA in May (special cause can be seen with the data point above the upper control limit). This was due to the Ombudsman stopping lower level complaints between March to May.

Since June, the data signal that less complaints have been completed within SLA with December's data point in Q1.5 showing a significant change (with the data point on the lower control limit).

There are a number of reasons why we have seen a reduction, including:

- Operational pressures impacting on staff' ability to respond to complaints
- Parliamentary and Health Service Ombudsman (PHSO) have stopped the reporting of complaints during the first wave causing a backlog
- Some processes within the patient safety team that require improvement

The team, led by our new Patient Safety specialist (Clare Wade), have a plan being implemented from 18th January to improve response times.

Q2 INCIDENTS

Figure Q2.1

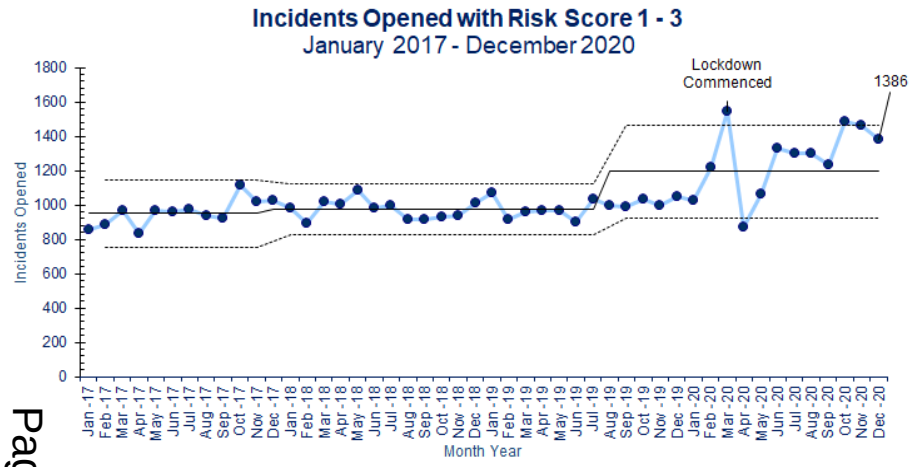


Figure Q2.2

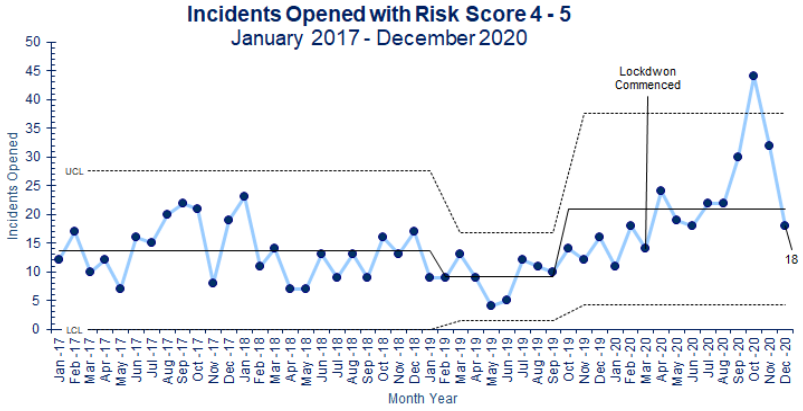


Table Q2.2 – Top 10 Incident Categories Opened in December 2020

Category	30/11/2020	07/12/2020	14/12/2020	21/12/2020	28/12/2020	Total
111 related	105	74	102	69	96	446
Infection Control	35	34	26	37	61	193
Staff Welfare related	28	25	36	49	36	174
Information	29	28	26	17	28	128
Communication	11	25	13	6	13	68
Equipment Missing / Lost	16	11	18	11	10	66
Unknown	8	12	14	10	9	53
Slips, Trips or Falls	4	6	13	2	15	40
Manual Handling	11	19	5	3	1	39
Equipment Damaged	8	8	9	8	6	39

Incidents

In December 2020 1474 internal and external incidents were opened (Q2.1 and Q2.2), against a 12 month average of 1352.

The number of opened incidents (Q2.1 and Q2.2) has moved back within the expected limits having previously signalled a change with higher numbers opened in October and November. Changes in staffing levels over the Christmas period will have affected the numbers of opened incidents and the reduction is likely to be due to this. With increase in demand on the service there has also been associated delays in the timely risk scoring of opened incidents within timeframe.

Table Q2.2 shows a breakdown of incident categories. A high proportion are related to 111 and this is being investigated to understand the cause.

In November, 25 incidents were unscored which aligns to the Right Care Strategy goal of 25 unscored incidents in the previous month reported in the IPR.

BAF Risk: SR01.

Figure Q2.5

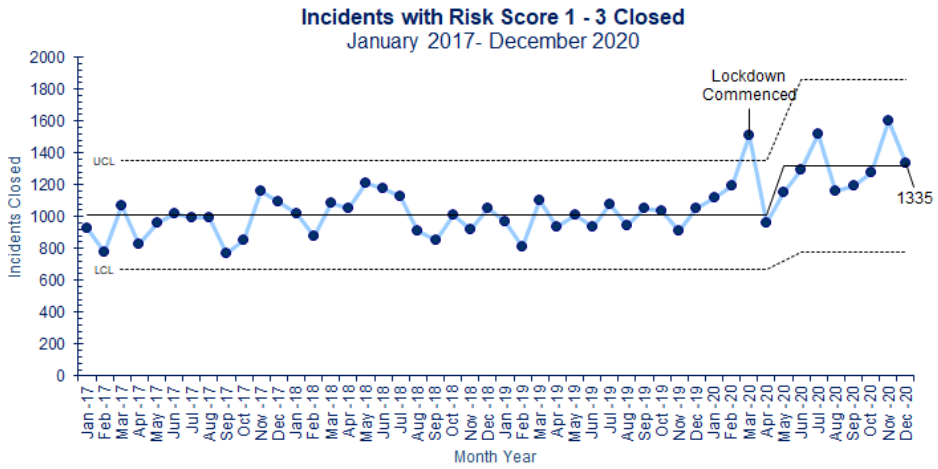
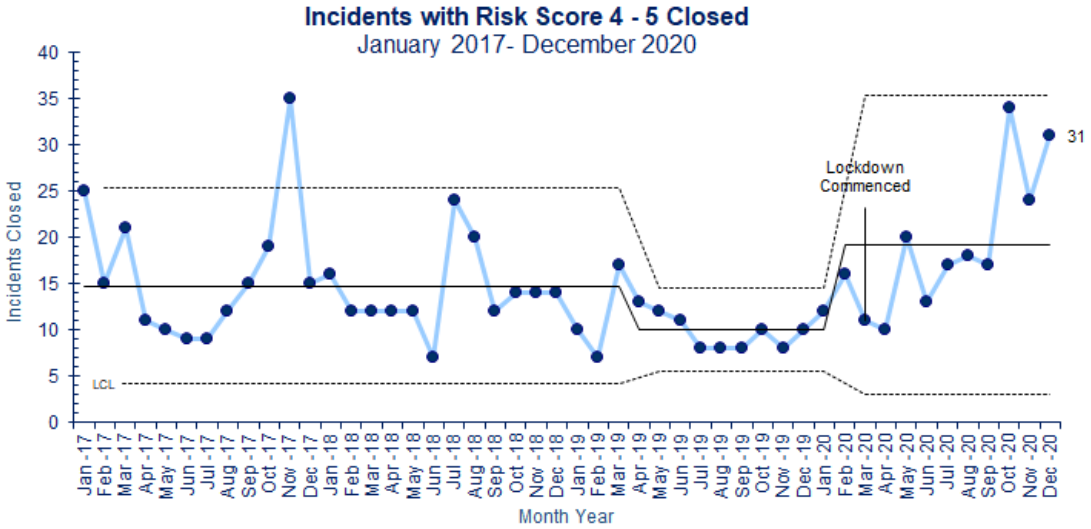


Figure Q2.6



Incidents Closure

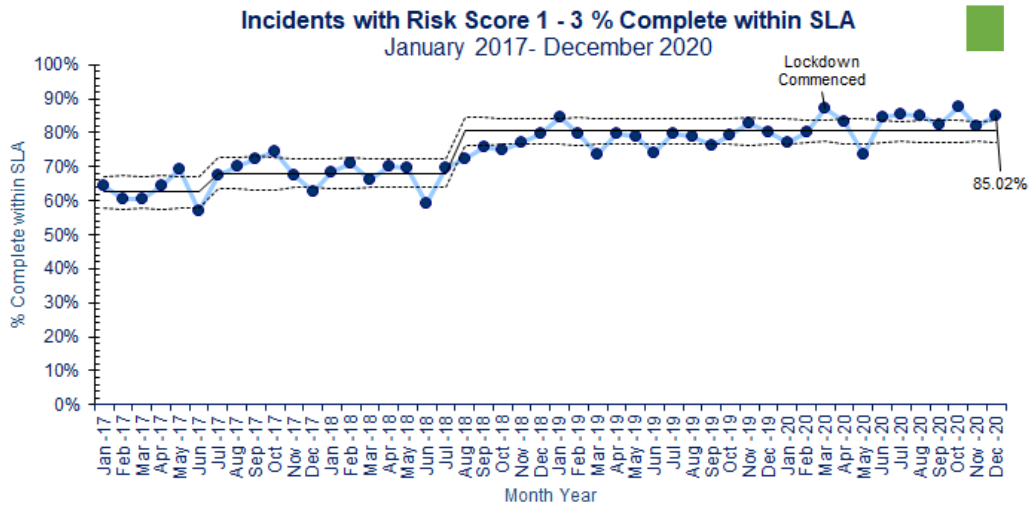
In total, 1335 incidents (level 1-5) were closed during December 2020 (Q2.5 & 2.6). Incidents risk scored 1-3 closed (Q2.5) demonstrates a change in the data with an increase in the mean starting in April 20. Incidents risk scored 4-5 closed also signals a change with a shift of the mean from January 20 and data points near the upper control limit for October and December.

85% level 1-3 were closed within agreed standard (Q2.7) against the right care strategy goal of 85%. The data signal a significant change with special cause variation with a data point above the upper control limit and we are one data point away from seeing an upward shift, resetting our mean to reach our strategy goal.

77% of level 4-5 incidents were closed within the agreed standard (Q2.8) against a right care strategy goal of 80% for the end of 20/21.

The data demonstrate that although the numbers of incidents being closed has moved up (Q2.5 and Q2.6) we are still managing to close them within the agreed standard (Q2.7 and Q2.8).

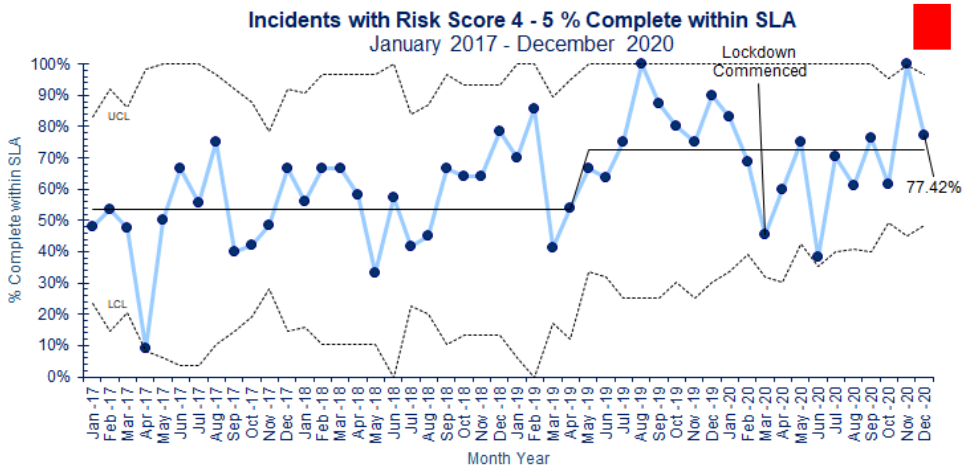
Figure Q2.7



SLAs are calculated using the following measures/ targets.
No exceptions are taken into account:

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

Figure Q2.8

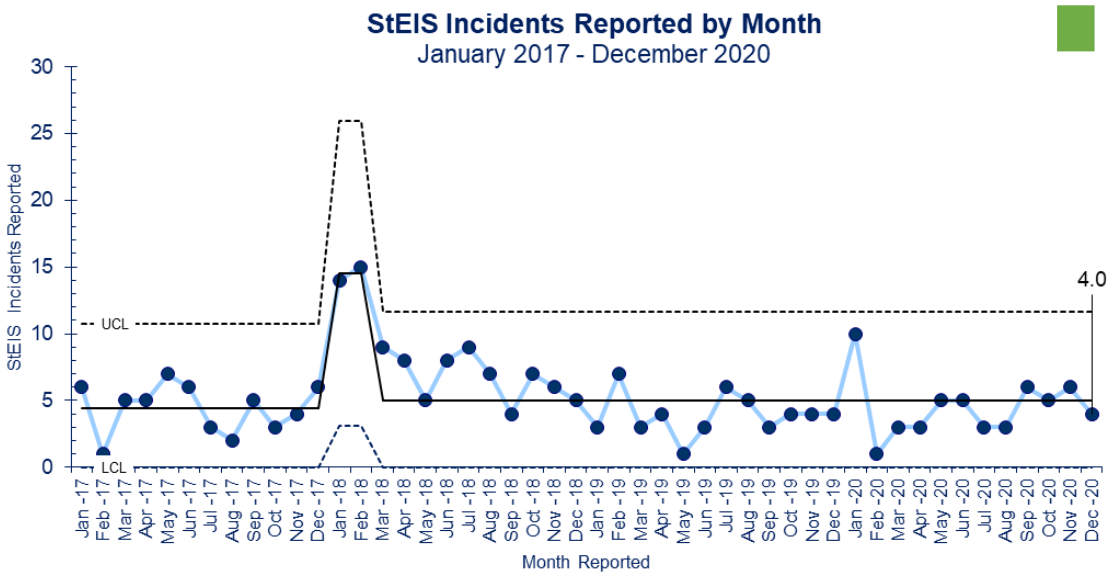


measures are meeting expectations

measures are below expectations

Q3 SERIOUS INCIDENTS

Figure O3.1



Serious Incidents

4 Serious Incidents (SIs) were reported in December 2020.

6 SI reports were due with the commissioners in December 2020. All 6 were submitted within the 60-day timescale.

100% of the SI's reports due in December 2020 were submitted within the timescales and we are on track with our right care strategy goals. We are now seeing the benefits of the introduction of the serious incident review panel and are continuing with the trial.

The data (Q3.1) do not signal any increase which demonstrates that although the number of incidents risk scored 4-5 has increased (Q2.6) we are not seeing this translate into an increase in Serious Incidents.

measures are meeting expectations

measures are below expectations

BAF Risk: SR01.

Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received (Jan 20 – Dec 20)	Number of Alerts Applicable (Jan 20 – Dec 20)	Number of Open Alerts
CAS/ NHS Improvement	34	1	1
MHRA – Medical Equipment	21	1	0
MHRA - Medicine Alerts	64	0	0
IPC	2	2	0

IPC – Alerts Applicable

1. Measles - 5 cases 1 NWAS staff member and 4 public cases throughout the period of January and February 2020 . Actions: Staff member contained and vaccinated who finished the incubation period on 18/01/2020. Contact staff members referred to occupational health staff that may pose a risk to patients and staff have removed from working. Patient contact of infected member of staff , 02/01/2020 warn and inform letters sent out to them,08/01/2020. Comms information and advisory bulletin sent out. 09/01/2020 .NWAS working alongside Public Health England and other Health care organisations. LEAD: L Donovan (Clinical Safety practioner lead GM) Fran Dreniw (Sector Manager South) Senior management informed and monitoring.
2. Coronavirus is a viral disease (Covid-19). Coronavirus has been spreading throughout the world therefore it has been declared as a national pandemic and is still ongoing. There is a multi faceted action plan that operates across the trust, this includes HR, Procurement, Communications, Operations and the quality teams. This is being discharged via A Hansen (LEAD and DiPC) and the Executive Leadership Committee (ELC).
3. Type IIR masks that are in use in some Trusts are not fit for purpose and should be destroyed. All PPE hubs in the trust were checked and there were none in the Trust.
4. Foreign body aspiration during intubation, under review with Medical director.

NWAS Response

There have been 6 new safety alerts in December 2020.

The total number of CAS/NHS Improvement alerts received between January 2020 and December 2020 is 34, with 1 alerts applicable.

21 MHRA Medical Equipment Alerts have been received with 1 alert being applicable.

64 MHRA Medicine alerts have been received, with 0 alerts applicable.

2 IPC alerts have been received, with 2 alerts applicable.

BAF Risk: SR01.

E1 PATIENT EXPERIENCE

Figure E1.1

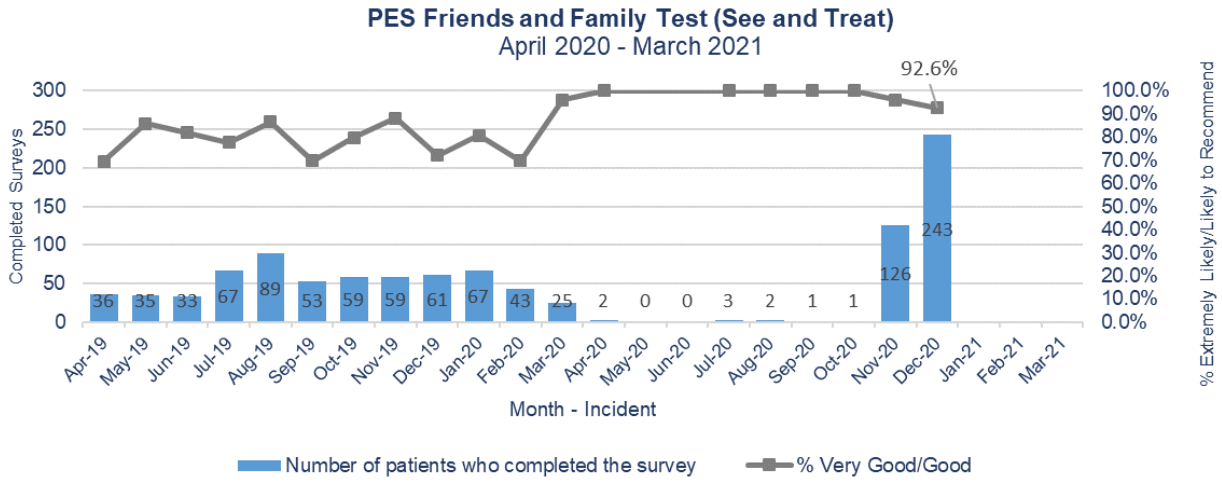
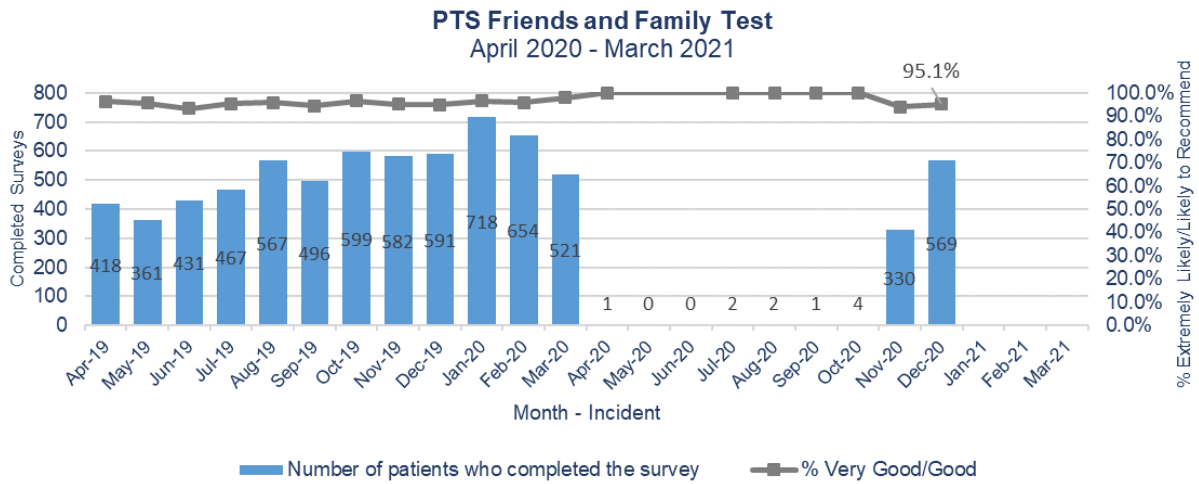


Figure E1.2



Patient Experience

Because of the COVID-19 pandemic, NHS England suspended the FFT process at the end of Q4 2019/20, resulting in no submission of data from the April reporting window with submission recommencing in November.

Patient Experience (PES)

The suspension resulted in a drop in the number of PES FFT returns from 25 in March to 2 in April 2020 (92%) and this low rate of return continued throughout the period of cessation.

In November 2020, national collection of FFT PES data recommenced and the number of returns increased significantly, exceeding levels prior to suspension, with 126 returns in November and 243 in December (an increase of 92.9%). These high return rates are due to changes in the way data is collected - daily access to PES 'see and treat' data now enables FFT questions to be sent out more frequently via SMS, close to the time the patient used the service, Restarting use of SMS has improved response rates.

An increase in returns has led to more variance in the responses but satisfaction levels remain high, (a drop of 3.4% from November to 92.6% in December).

Currently there are no national figures to enable trust-ranking analysis. Previously the trust held second place in terms of number of returns – for both January and February 2020.

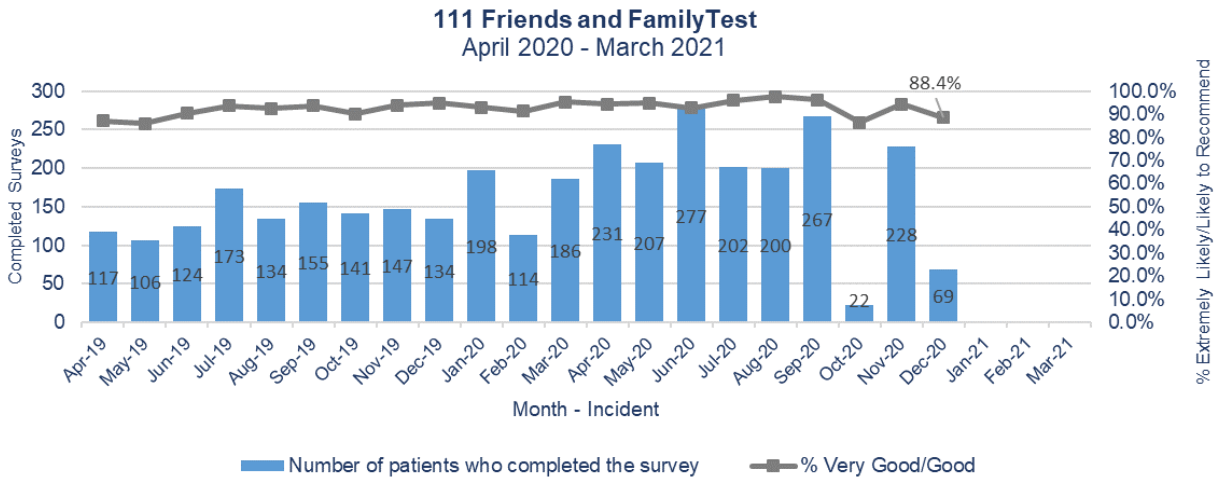
Patient Experience (PTS)

As reported above, the cessation of FFT nationally led to a drop in returned PTS FFT responses, from 521 in March to just 1 in April 2020 and this low rate of return continued throughout the period of cessation, up to October 2020.

In November 2020, national collection of FFT PTS data was restarted and returns increased substantially with 330 returns in November and 569 in December, (an increase of 72.4%).

While there are currently no figures available to allow for comparisons with other trusts, previously the trust held second place in relation to satisfaction with similar figures.

Figure E1.3



Patient Experience (111)

NHS 111 surveys have continued to be nationally mandated throughout the pandemic.

The number of NHS 111 recommendation responses decreased by 71.6% to 69 in December from 228 in November.

The drop in December returns was due to the lag in postal returns and the effect of the festive break.

There was a drop of 5.9% in satisfaction levels from 94.3% for November to 88.4% in December.

BAF Risk: SR01
Quality of care through implementation of the Right Care Strategy

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Cardiac Outcomes over time (SPC)

Figure E2.1

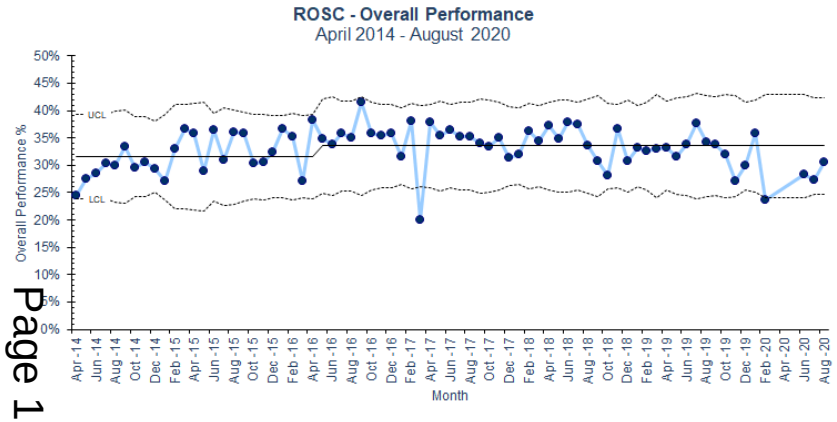


Figure E2.2

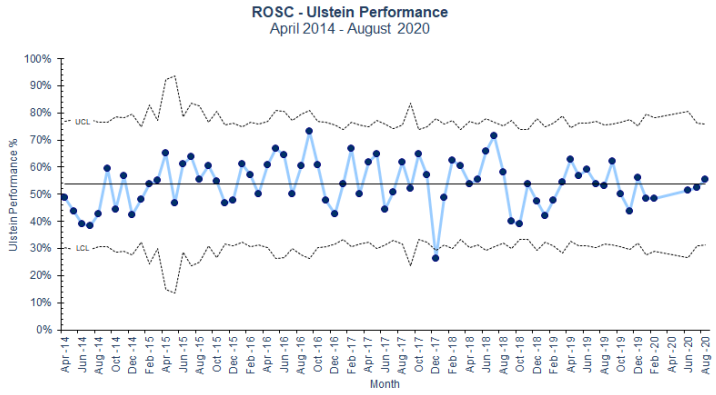


Figure E2.3

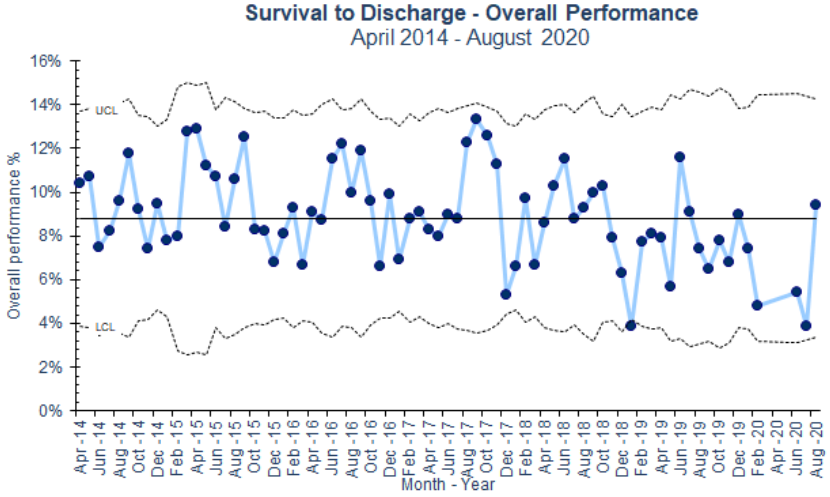
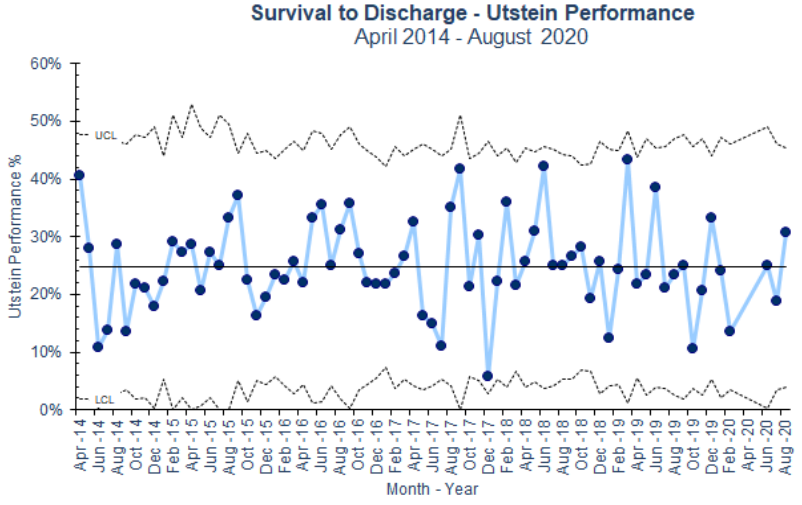


Figure E2.4



ACQIs (up to AUGUST 2020)

Overall, we are seeing no change in our data for the clinical quality indicators. Rankings change from month to month but overall there is no significant change (common cause variation). The lag in data make it difficult to understand the impact of any recent work to improve in these areas and supplementary measures to give us a more recent picture are being explored.

In August, 9.4% of patients suffering an out of hospital cardiac arrest survived to hospital discharge (national mean 10.2%). This performance ranked the Trust in 6th position for English ambulance trusts. The figure for the Utstein sub-group was 30.8% (national mean 28.9%) which saw the Trust ranked 3rd for English ambulance trusts.

The rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group was 55.6% (national mean 53%), ranking 4th nationally. For the overall group the rate was 30.5% (national mean 29.4%) ranking the Trust in 5th position nationally.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of 2h 18mins; the Trust's performance was 2h 45mins for these patients. This ranked the Trust in 10th place nationally.

Mean call to door time for patients suffering a hyper acute stroke was marginally outside that of the national mean of 1h 22mins; the Trust's mean response to these patients was 1h 23mins; 7th place nationally.

The Stroke care bundle result of 98% was fractionally outside of the national mean of 98.3%.

Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

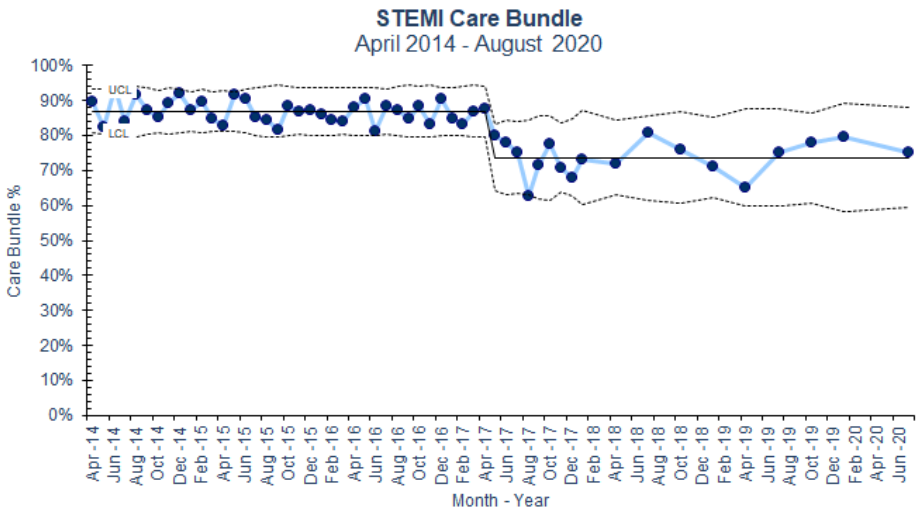
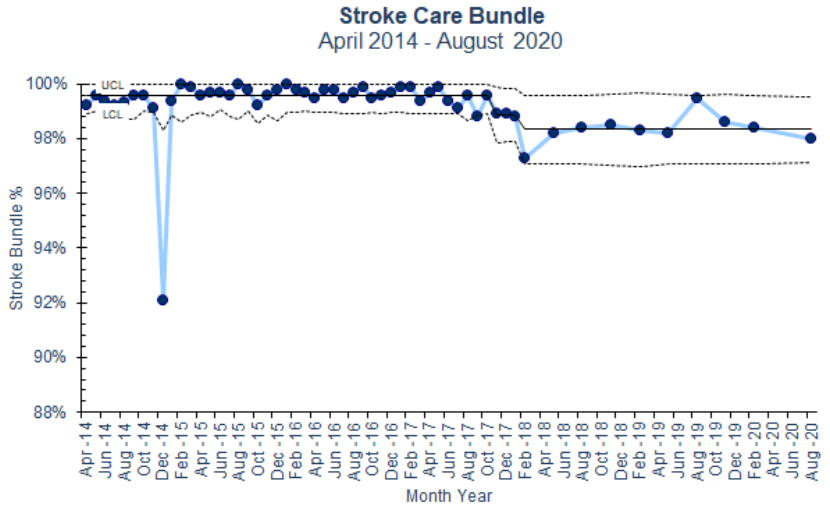


Figure E2.6



N.B. **Stroke CB data now published nationally 1 month in 3: February, May, August and November (data produced internally on monthly basis).**
STEMI CB now published nationally 1 month in 3: January, April, July and October (data produced internally on monthly basis).

Figure E2.7

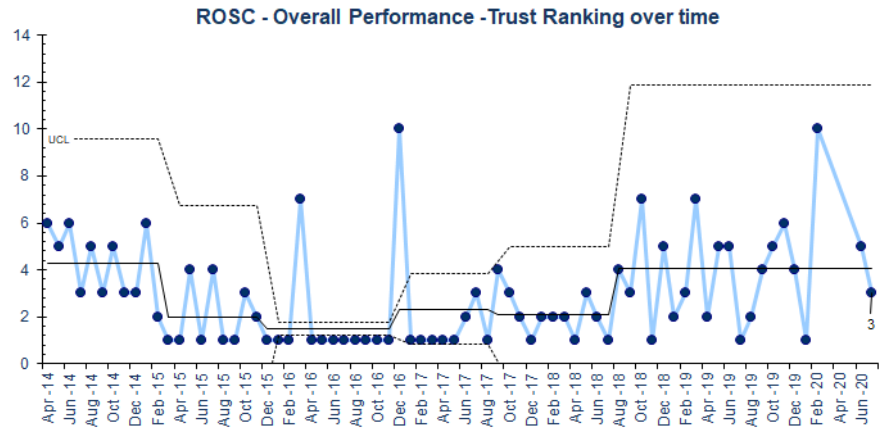
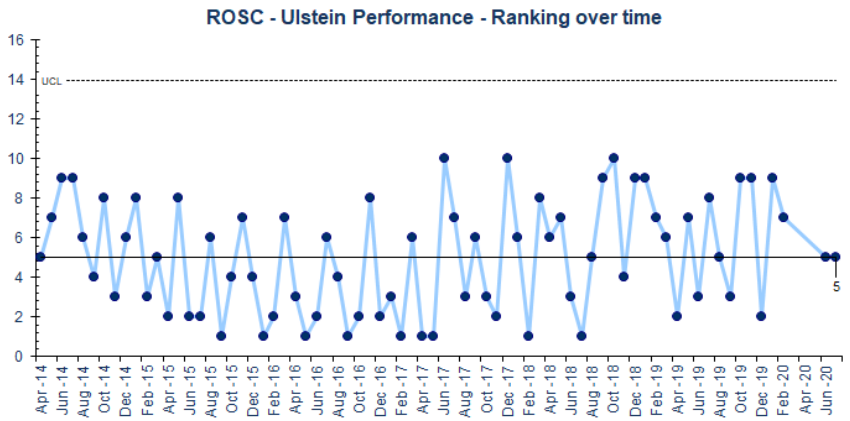


Figure E2.8



***NEW CHART** – this shows our change in the national ranking tables since June 14 on key metrics (1 is best, 10 is worst)

Figure E2.9

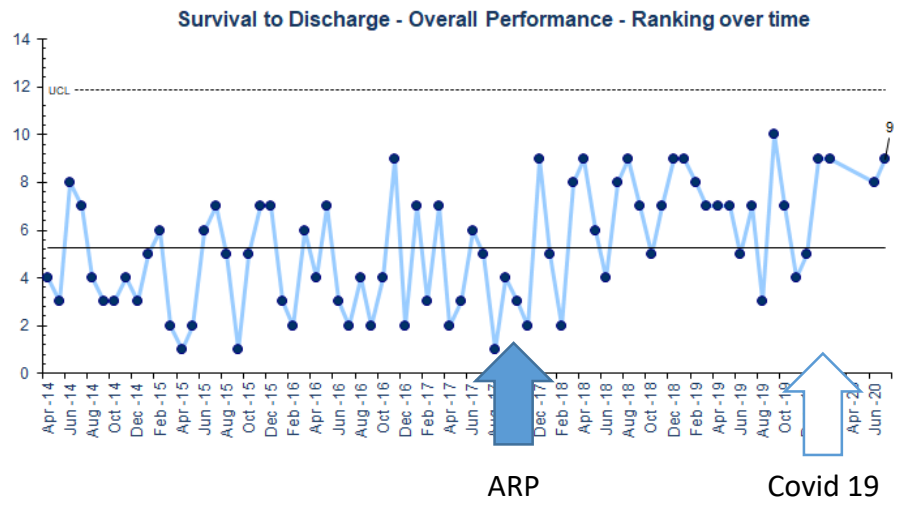


Figure E2.10

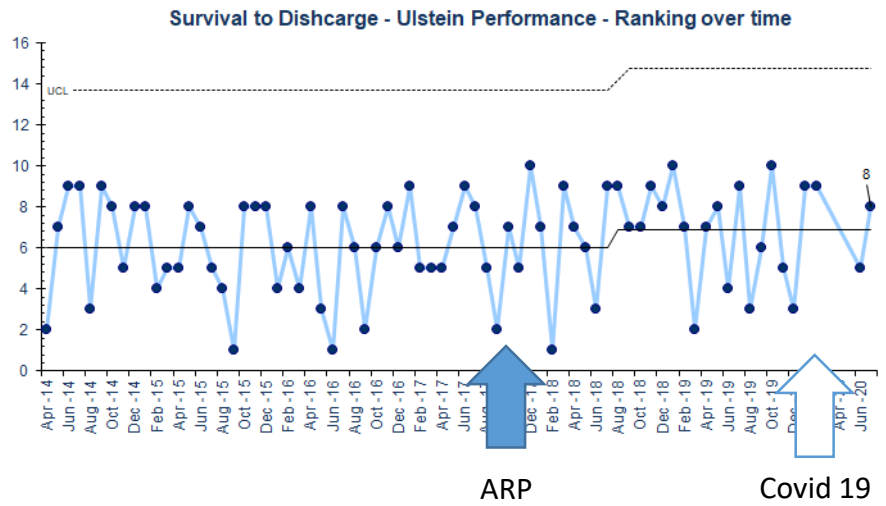


Figure E2.11

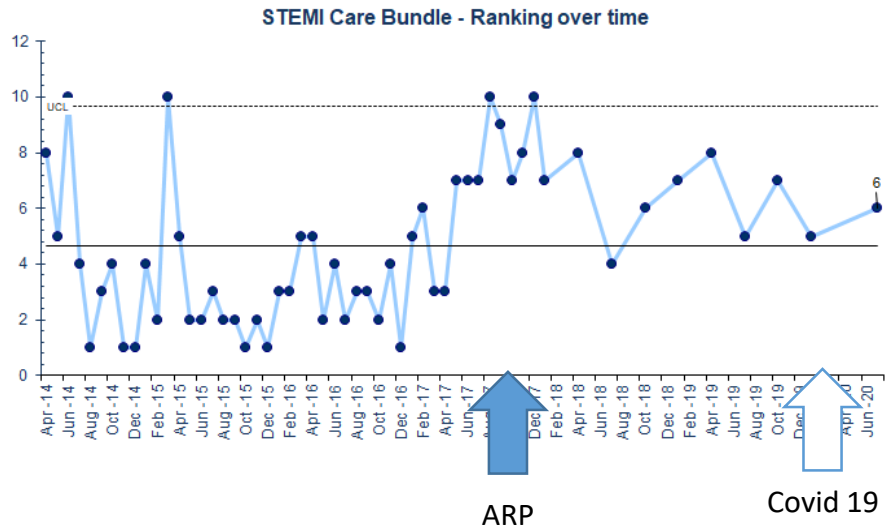
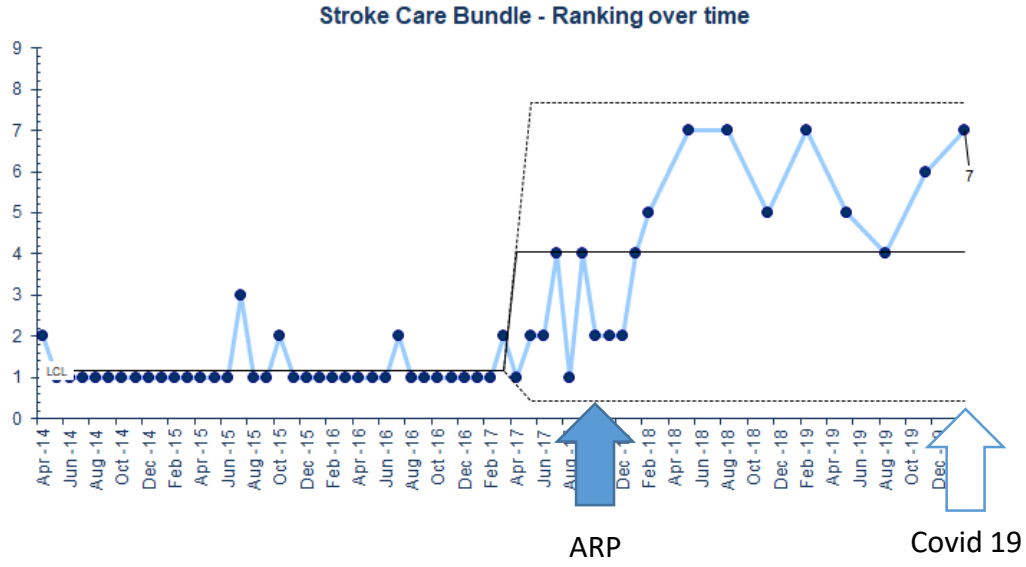
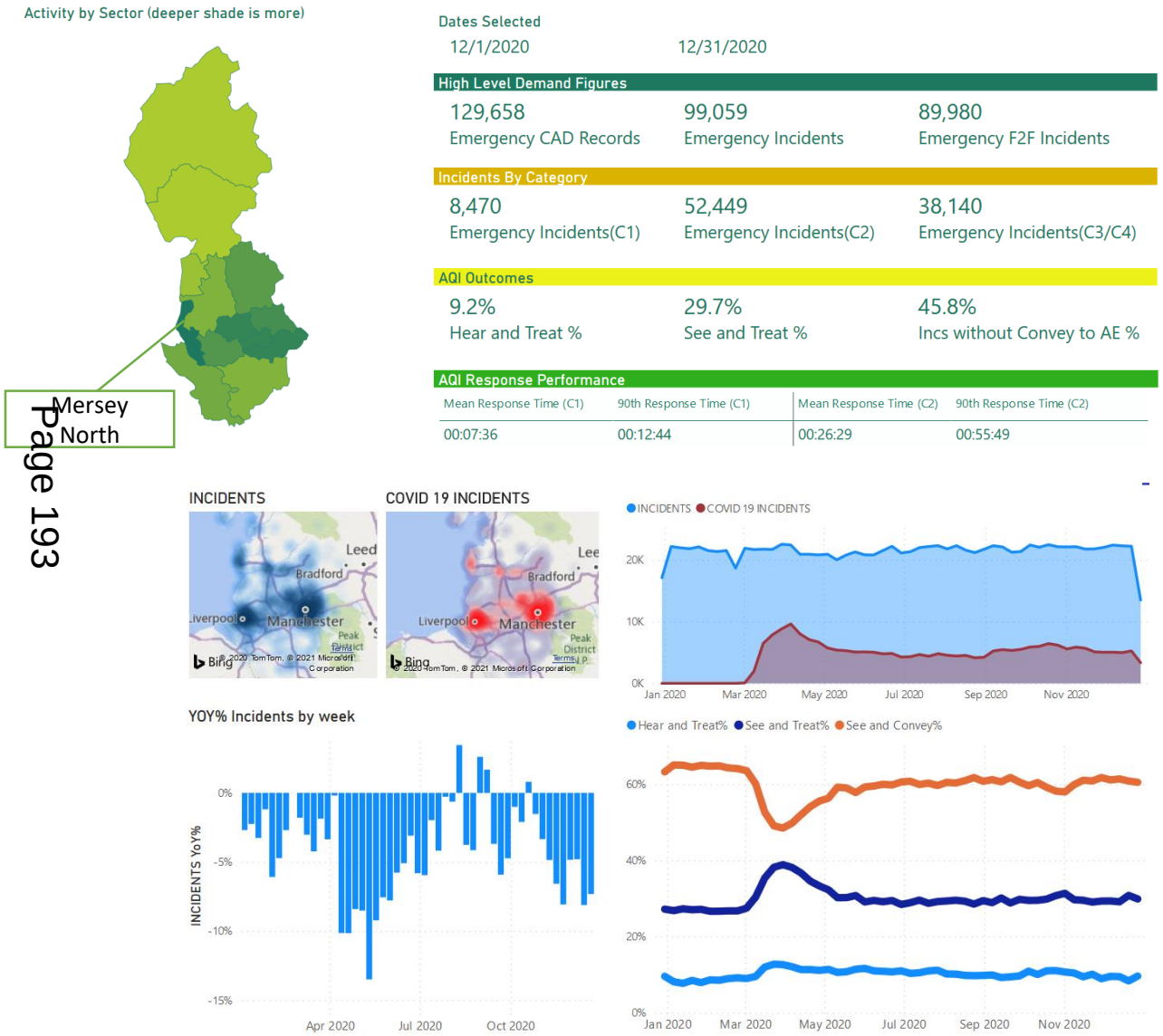


Figure E2.12



E3 H&T, S&T, S&C OUTCOMES

Figure E3.1



H&T, S&T, S&C Outcomes

The proportion of incidents with Hear and Treat (E3.4) has moved up in December (although within the control limits as common cause variation) and is being sustained at high levels. See & Treat (E3.5) has also remained steady at c 31% leading to an aggregate non-conveyance at 40% (E3.6).

Our rankings over time see no change for See and Treat and See and Convery (E3.8 and E3.9) but for Hear and Treat we see a move to 5th.

The development of the NHS 111 First initiative has resulted in the establishment of Clinical Assessment Services (CAS) and Locality Clinical Assessment Services (LCAS) functions. Capacity has been modelled against an expected NHS 111 First demand of 20% of previously unheralded walk-in ED activity. This has not materialised as yet, and therefore in December CAS functions were able to absorb additional low acuity 999 activity into their clinical pools. This has led to increases in H&T being sustained at high levels, especially in Greater Manchester where CAS services are well-established.

The Trust is working to increase the levels of See & Treat through its reducing avoidable conveyance programme as our ability to work efficiently across frontline resources is predicated on freeing up ambulances from those patients who can be managed more effectively in the community.

As we move further into wave 3 of COVID we will see increased use of specific pandemic protocols. These are highly sensitive to symptoms but often result in See & Treat outcomes once crews have arrived on scene. We should expect to see increase.

Figure E3.4

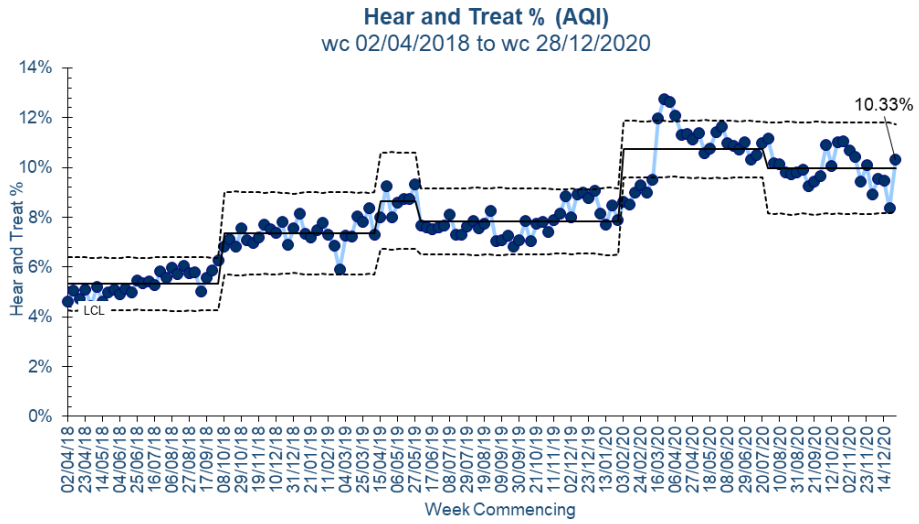


Figure E3.5

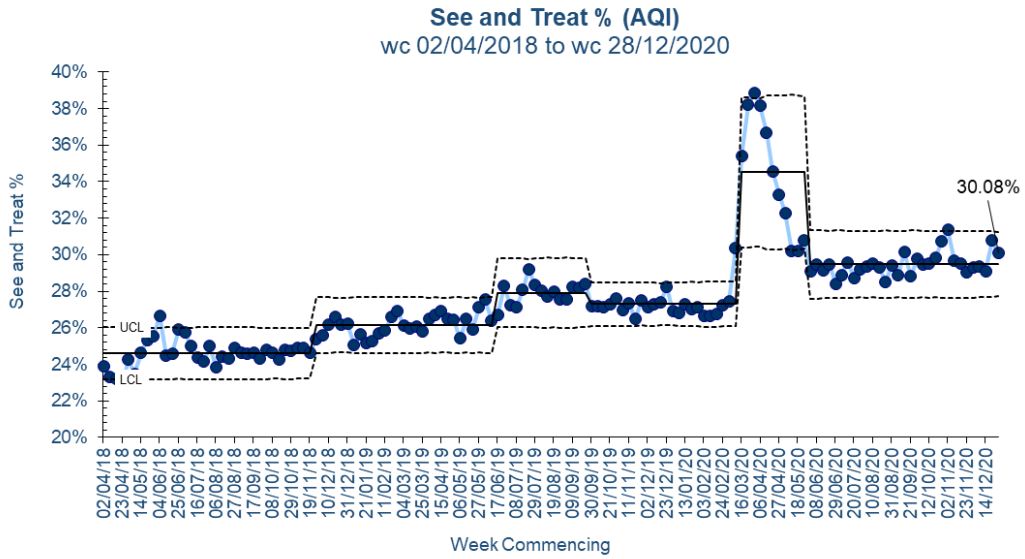


Figure E3.6

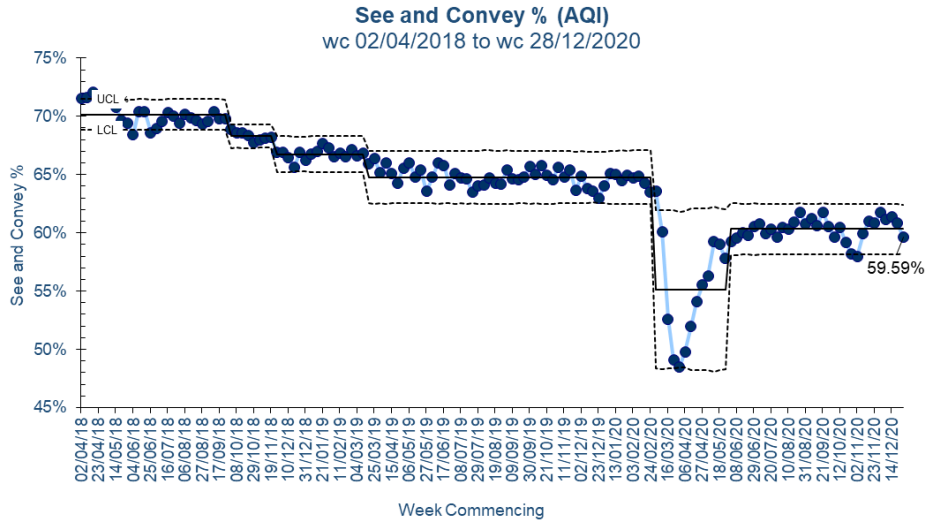
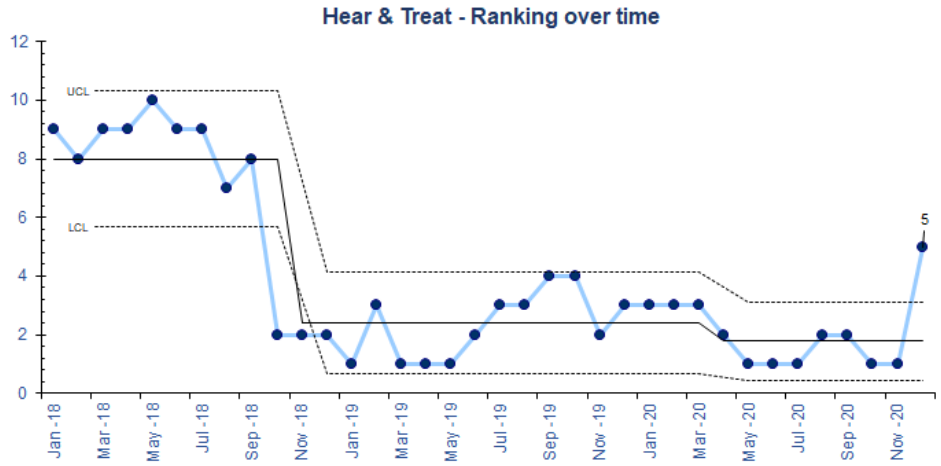


Figure E3.7



FigureE3.8

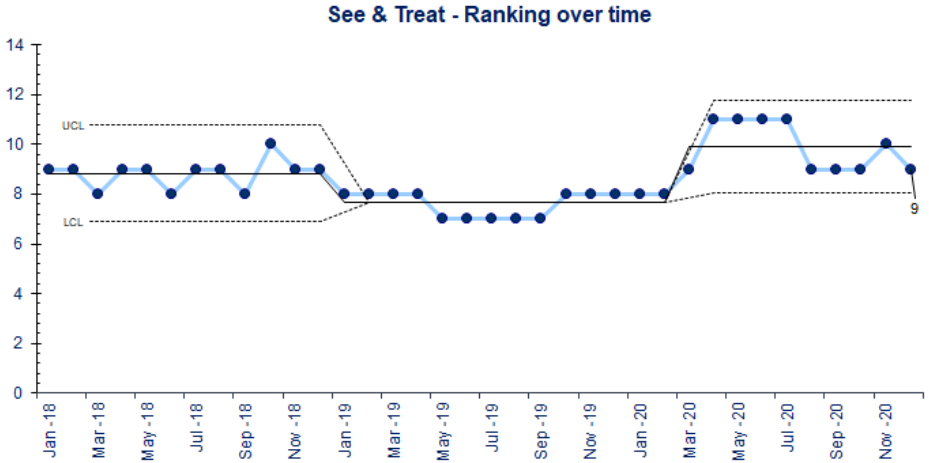
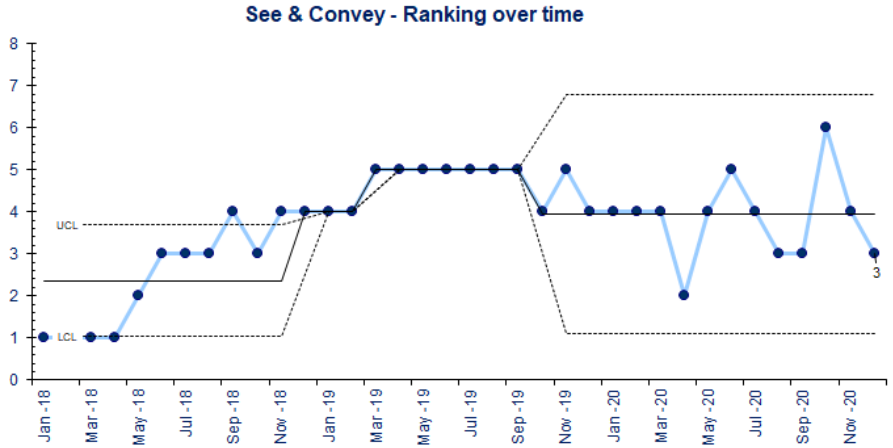


FIgure E3.9



F1 FINANCIAL SCORE

Figure F1.1

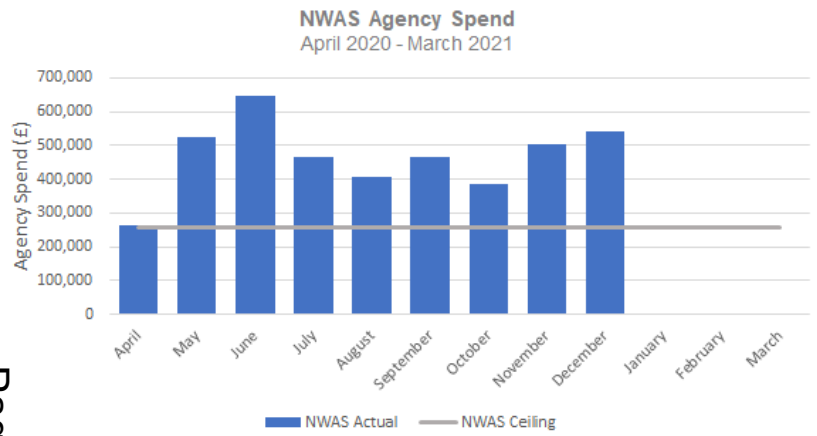


Figure F1.2

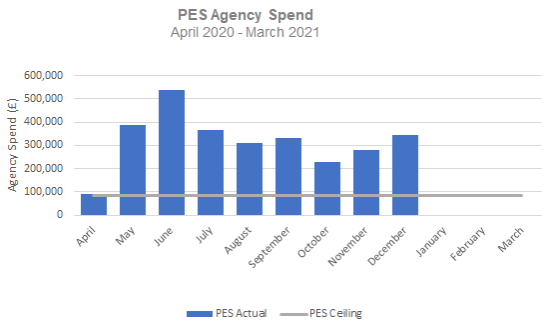


Figure F1.3

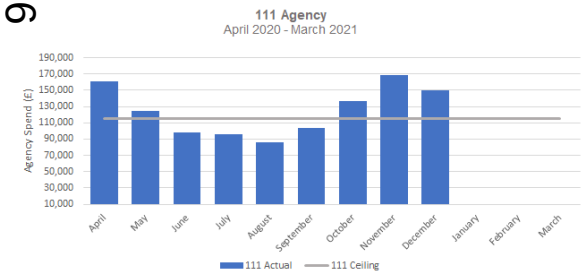


Figure F1.4

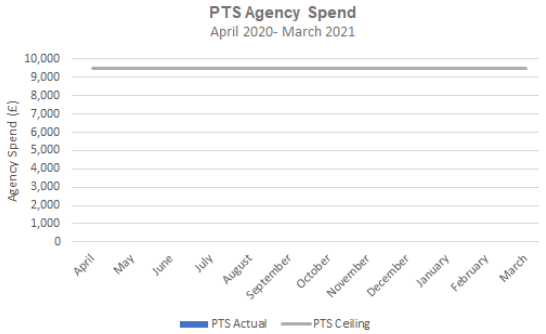


Figure F1.5

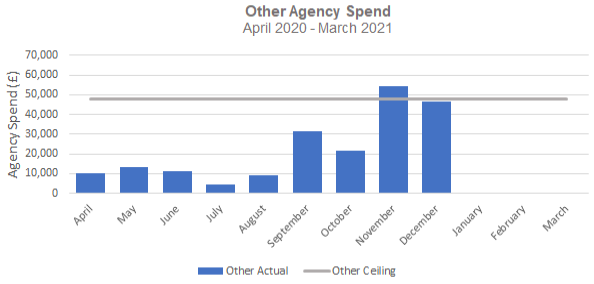
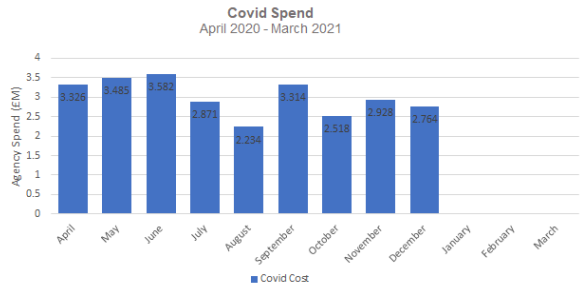


Figure F1.6



Finance Position – December 2020

Month 09 Finance Position:

Agency Expenditure

The year-to-date expenditure on agency is £4.204m which is £1.872m above the year-to-date ceiling of £2.332m.

Please Note: The agency ceiling is based on 2019/20 ceiling figures and will be updated as soon as we have the information.

Risk Rating

For the nine months of the Covid-19 framework, the 2020/21 monthly financial returns have been redesigned to collect a minimum dataset to reduce the burden on organisations wherever possible, whilst maintaining a monthly data collection process.

The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

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O1 CALL PICK UP

Figure O1.1

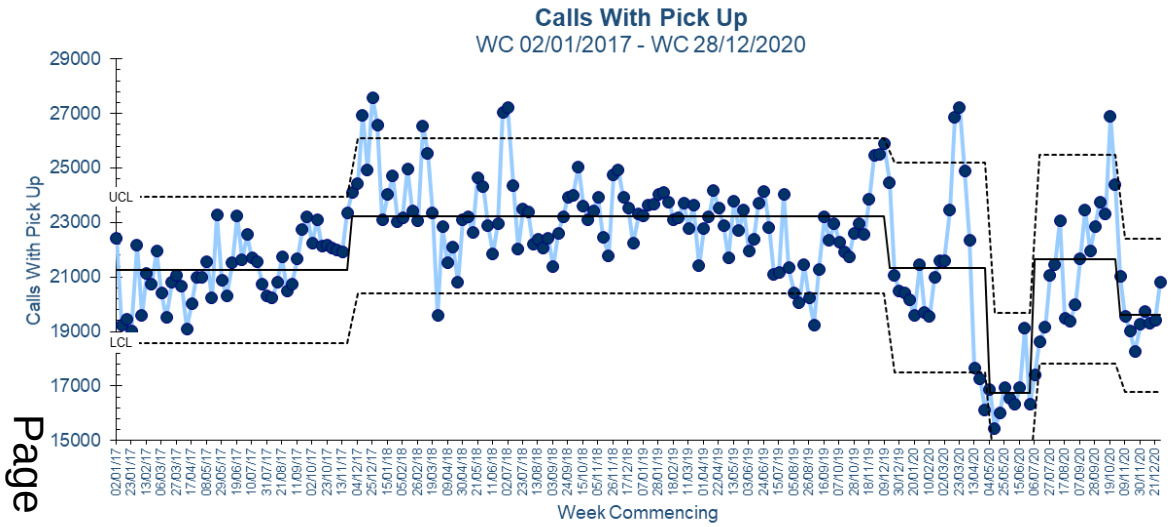
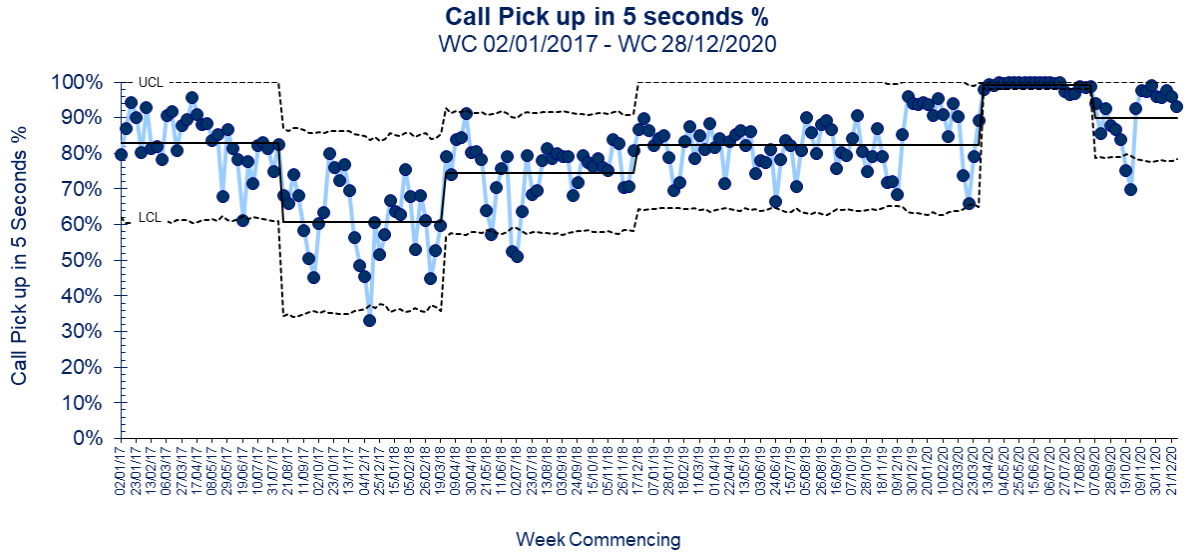


Figure O1.2



Call Pick Up

Definition: The percentage of emergency calls recorded in the CAD system and answered with 5 seconds, excluding 111 direct entries. Call pick up is not a national standard but is widely used by ambulance trusts to monitor call handling performance with a target of 95%.

Performance: Activity has fluctuated from 19000-23000 calls per week. The data signal that we have a new stable position with less calls since November (signalled by the reset mean which moves down from November (Q1.1)). This represents less calls than we saw through July to October and less calls than we saw at the same time period for the last two years. Aligned to this, call pickup in 5 seconds (Q1.2) is achieving high performance with the data signalling a change with multiple data points above the mean and near the upper control limit in November and December.

Since December 2020 the EOC has begun "wave 2" of agency recruitment. This process will see 123 further emergency call handlers (ECH) introduced into the workforce to support 999 call answering. This is scheduled to be delivered by the end of February 2021, and is currently on tracker for a confirmed delivery.

NWAS has also been working alongside NARU, AACE and all other UK Ambulance Trusts to help support he on-going national call answering effort. Many other Trusts have seen large numbers of staff abstractions, in particular London Ambulance Service (LAS). NWAS has been on the front foot supporting this work and to date has taken over 2000 calls for LAS and helped save the lives of patients in the capital, whilst maintaining the safety of the patients of the North West.

EOC are still currently using the Lightfoot SFN platform to access forecasts of demand at short, medium and long term. This allows for effective deployment of staff, in line to meet performance demand.

O2 A&E TURNAROUND

Figure O2.1

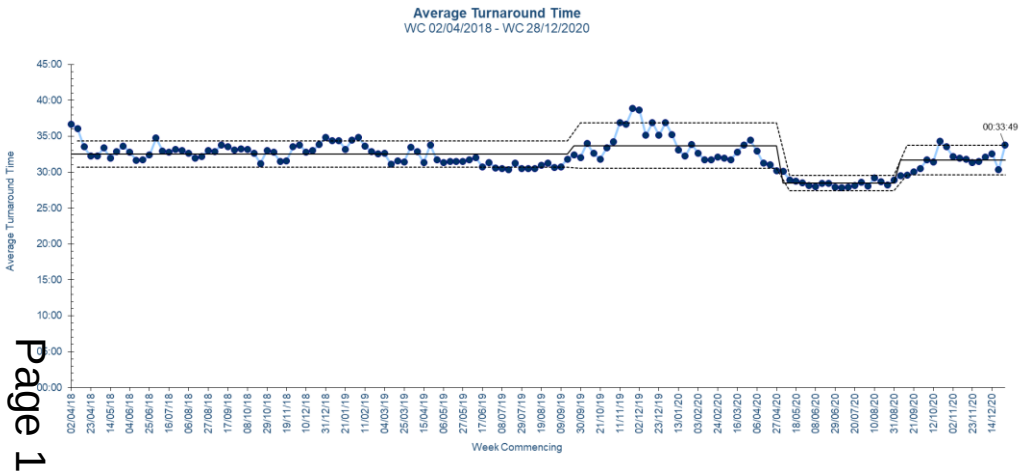


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Jan-20	58,150	34:08	23:12	10:53
Feb – 20	52,392	32:08	20:51	11:07
Mar-20	49,419	32:37	20:54	11:26
Apr-20	41,267	31:58	19:45	12:06
May-20	47,637	29:10	17:08	11:47
Jun-20	49,207	28:14	16:43	11:21
Jul-20	52,551	28:05	16:44	11:10
Aug-20	52,059	28:33	17:28	10:52
Sep-20	49,946	29:37	18:45	10:53
Oct-20	51,452	32:32	21:47	11:04
Nov-20	49,941	31:49	20:31	11:08
Dec-20	53,780	31:54	20:55	10:56

Figure O2.2

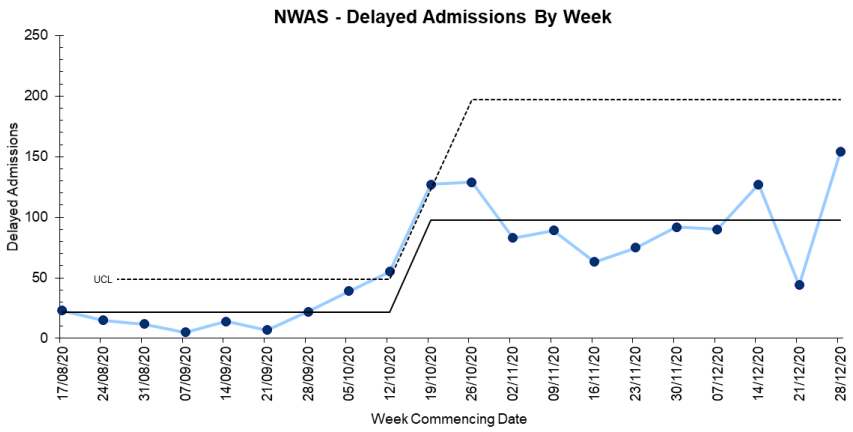


Table O2.2

Week Commencing	No. of Delayed Admissions
17/08/2020	23
24/08/2020	15
31/08/2020	12
07/09/2020	5
14/09/2020	14
21/09/2020	7
28/09/2020	22
05/10/2020	39
12/10/2020	55
19/10/2020	127
26/10/2020	129
02/11/2020	83
09/11/2020	89
16/11/2020	63
23/11/2020	75
30/11/2020	92
07/12/2020	90
14/12/2020	127
21/12/2020	44
28/12/2020	154

A&E Turnaround Times

The average turnaround for December 2020 was 31 minutes 54 seconds(Table O2.1) across the North West. . This is only 5 seconds longer than November's average turnaround time of 31 minutes and 49 seconds, despite 3,893 more hospital conveyances. It is also 38 seconds shorter than the October average of 32 minutes and 32 seconds despite higher numbers of patients taken to hospital in December.

Nevertheless, despite the average handover time remaining at around 31 minutes versus a national standard of 30 minutes, 2564 attendances (4.8%) had a turnaround time of over 1 hour during December with 63 of those taking more than 3 hours.

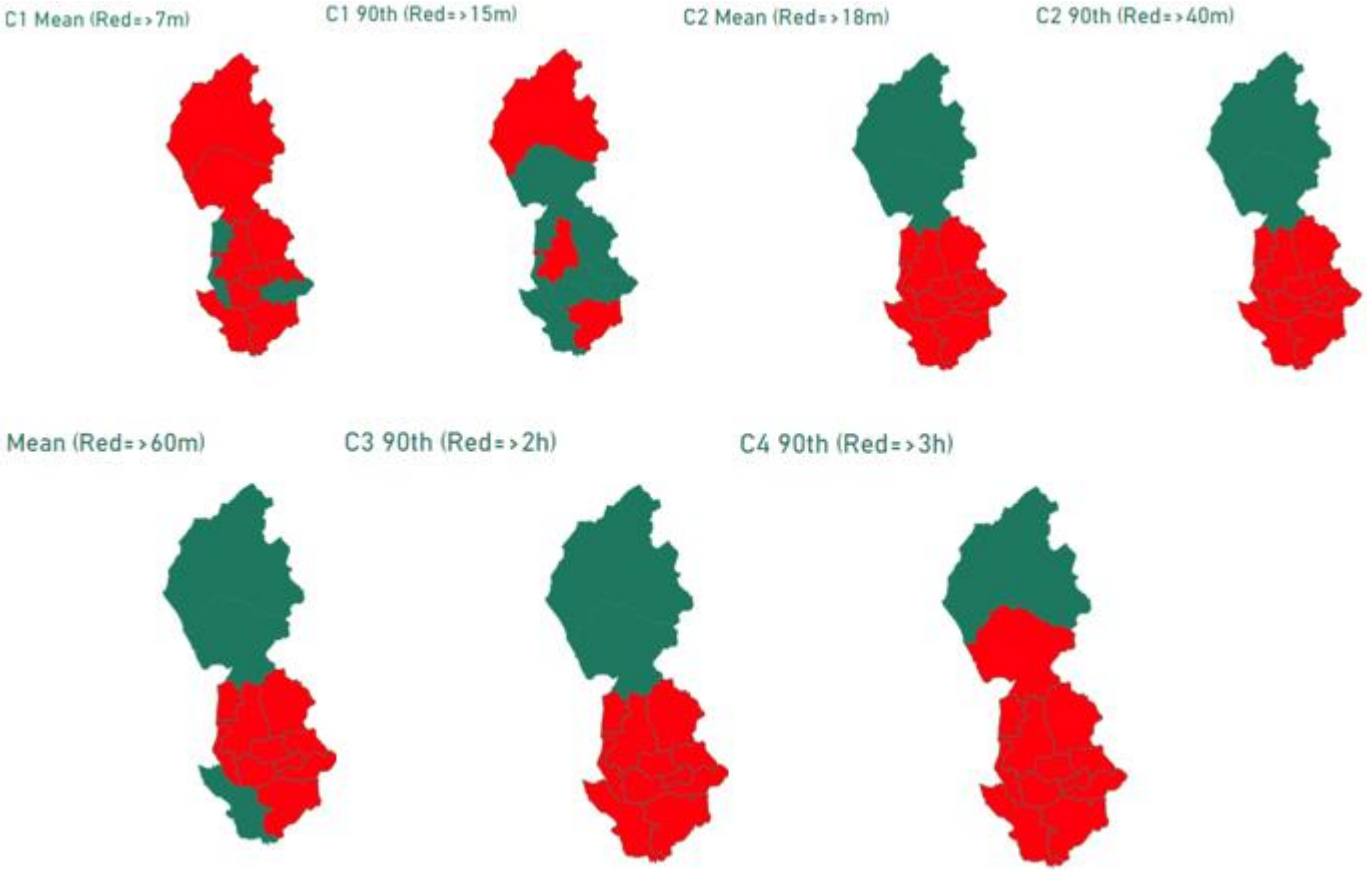
In addition, Since August 2020 delayed admissions to hospitals have become an increasing problem for the trust. In December, 415 cases of delayed admissions were reported. During w/c 28th December alone there was 154 occurrences of delayed admission (highest volume in week since data collection commenced in August 2020). 527.8 hours were lost to delayed admissions in December 2020.

The top 5 sites where delayed admissions are occurring by volume are:

•Royal Bolton Hospital (81; 20%)
•Fairfield General Hospital (69; 17%)
•Royal Preston Hospital (67; 16.5%)
•Royal Oldham Hospital (37; 9%)
•Blackpool Victoria (36; 9%)

Whilst the Every Minute Matters improvement collaborative has paused to support the pandemic response the Trust continue to work with NW NHSEI and acute hospital partners across the region to address the increase in hospital handover times and associated safety and patient experience risks.

O3 ARP RESPONSE TIMES



Activity: ARP Response Times

For December the only response time target met is for C1 90th (Q3.2). The primary reason for not reaching targets is a mismatch between demand and resource levels. Resource levels have been inadequate for a number of years, with the exception of 2 months this year, and the additional impact of COVID 19 abstractions has resulted in challenges in delivering more double crewed ambulances to meet demand. Handover delays have also contributed as described previously.

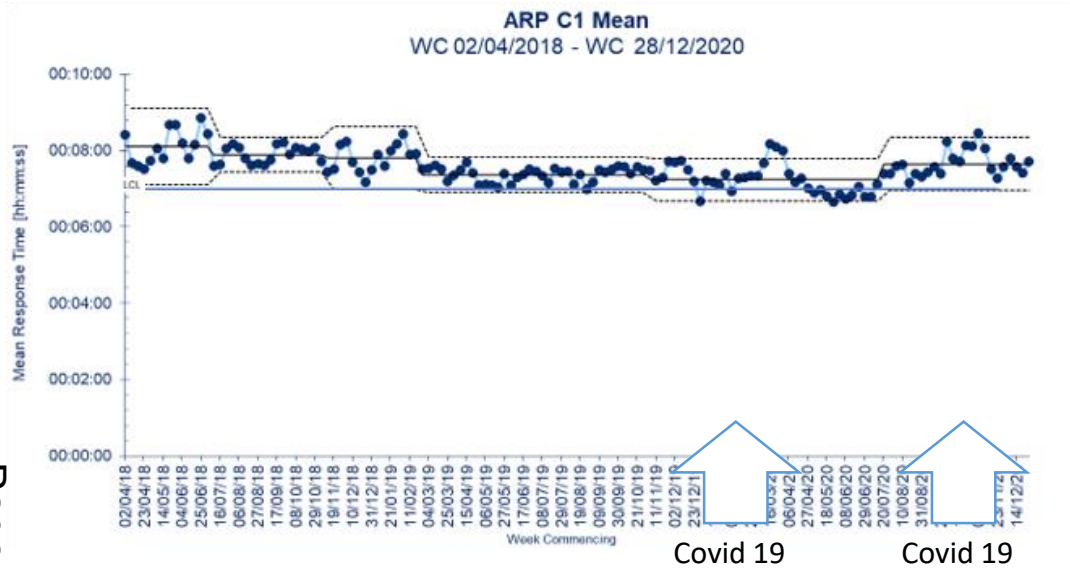
Although targets have not been met, C2 mean (Q3.3) , C2 90th (Q3.4) , C3 mean (Q3.5) and C3 90th (Q3.6) all see the data signalling that performance is stabilising at a new lower mean time (with a new phase from November).

The Trust has continued to focus on maintaining an effective response to life threatening calls. In support of this, high level actions to maximise the availability of NWAS responding resources have been developed:

- Increased DCA (Double Crewed Ambulance) numbers by reduction of RRV (Rapid Response Vehicle) fleet.
- Increase number of DCA profiled each day
- Maintain use of third party resources and increase scope of practice
- Use of complimentary resources to increase clinical decision making on scene – through HART and SPTL structure
- PTS resources providing support to PES where safe to do so.
- Redeployment of suitably trained staff to enhance frontline service delivery.
- Clinical Coordination Desk within EOC supporting enhanced decision making.
- Additional call handling capacity within EOC's.
- Continue to engage locally, regionally and nationally regarding Hospital Handover challenges.
- Patient Safety Plan
- Pandemic Protocol Card 36 (EOC Procedure)

BAF – SR03

Figure O3.1



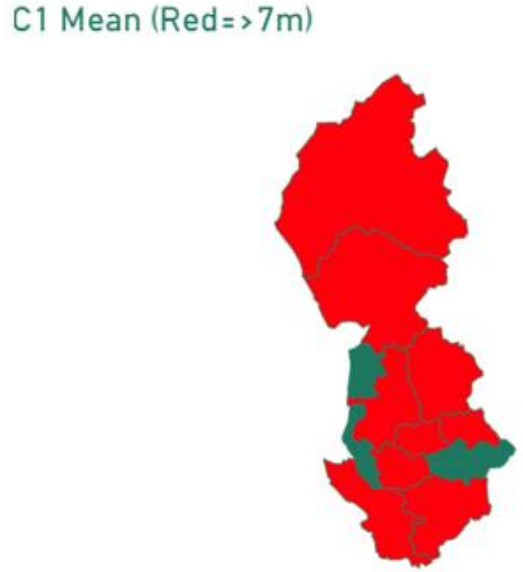
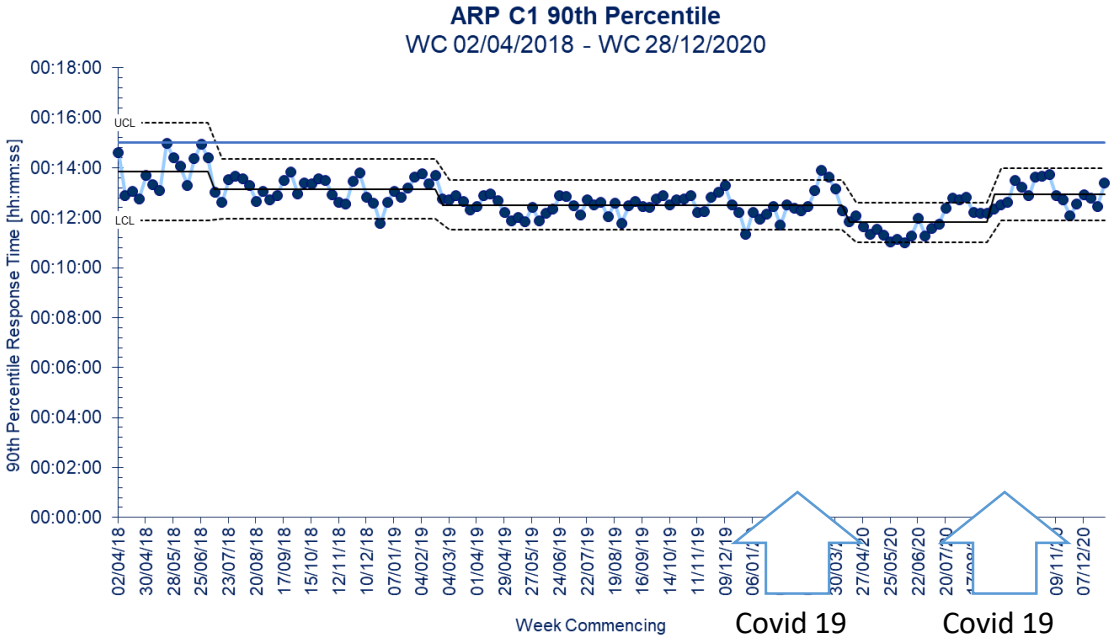
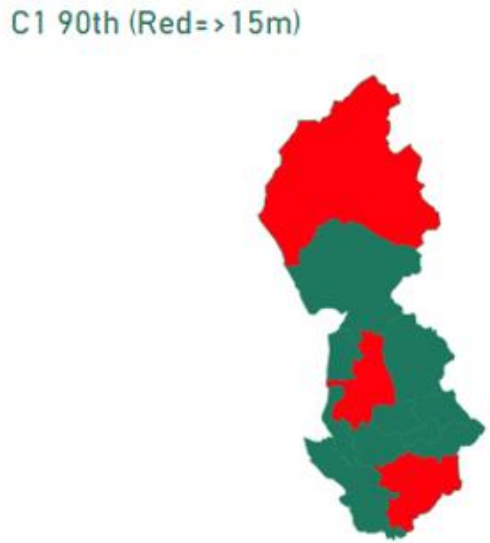


Figure O3.2





C1 Performance

C1 Mean

Target: 7 minutes

NWAS
December 2020: 7:36
YTD: 7:26

C1 90th Percentile

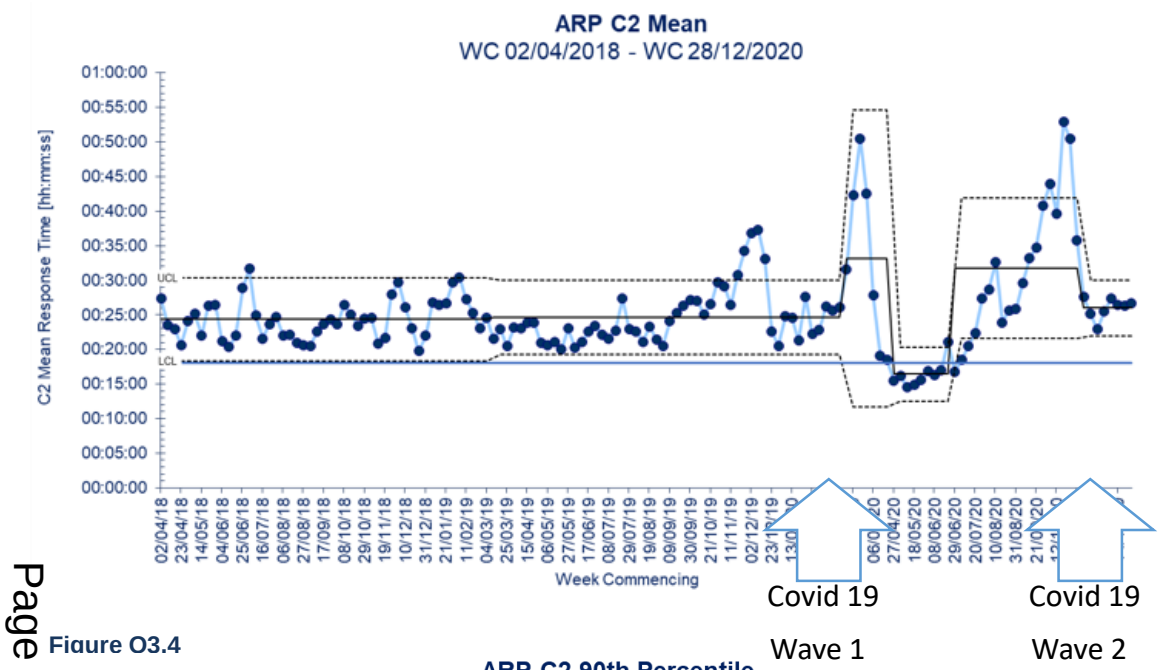
Target: 15 Minutes

NWAS
December 2020: 12:44
YTD: 12:26

measures are meeting expectations

measures are below expectations

Figure O3.3



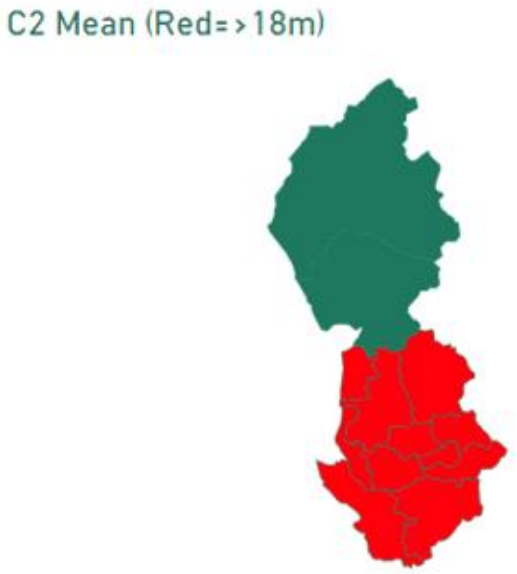
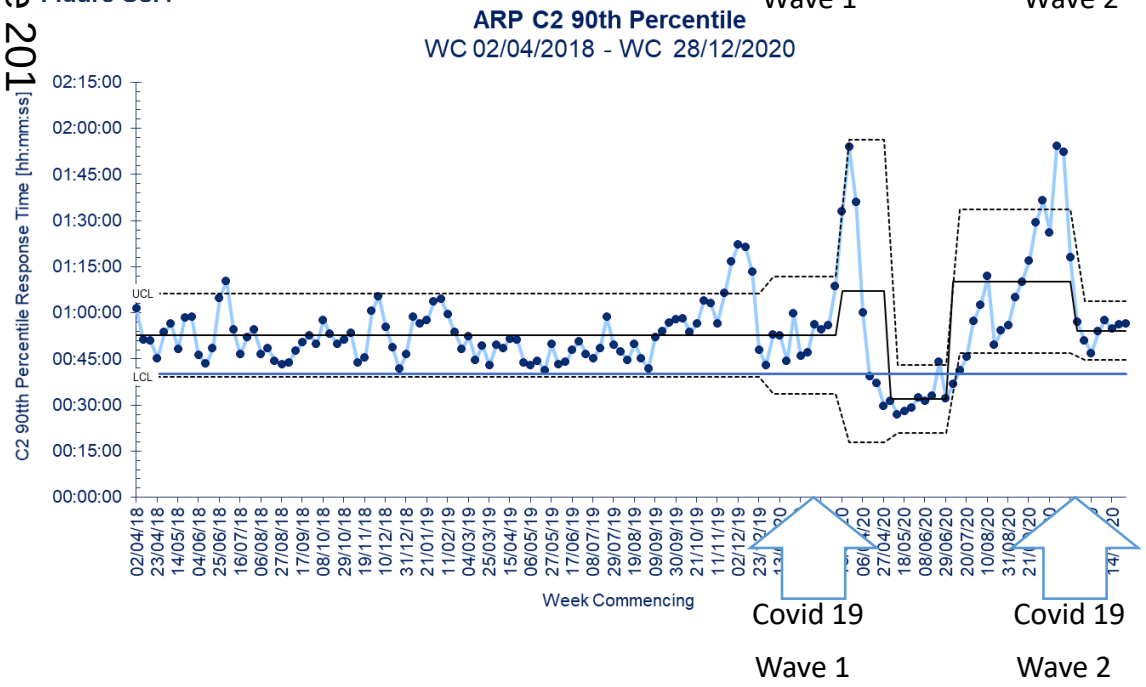
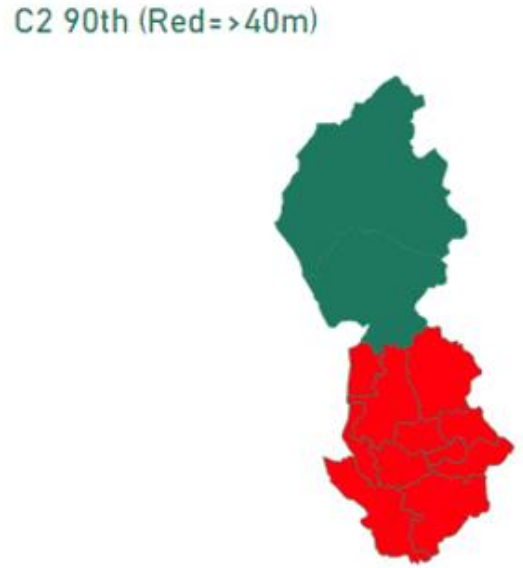


Figure O3.4





C2 Performance

C2 Mean

Target: 18 minutes

NWAS:
December 2020: 26:29
YTD: 27:07

The data signals a change with a new phase from 9/11/2020 lowering our mean position. This new phase within the data can be attributed to the actions detailed in the summary.

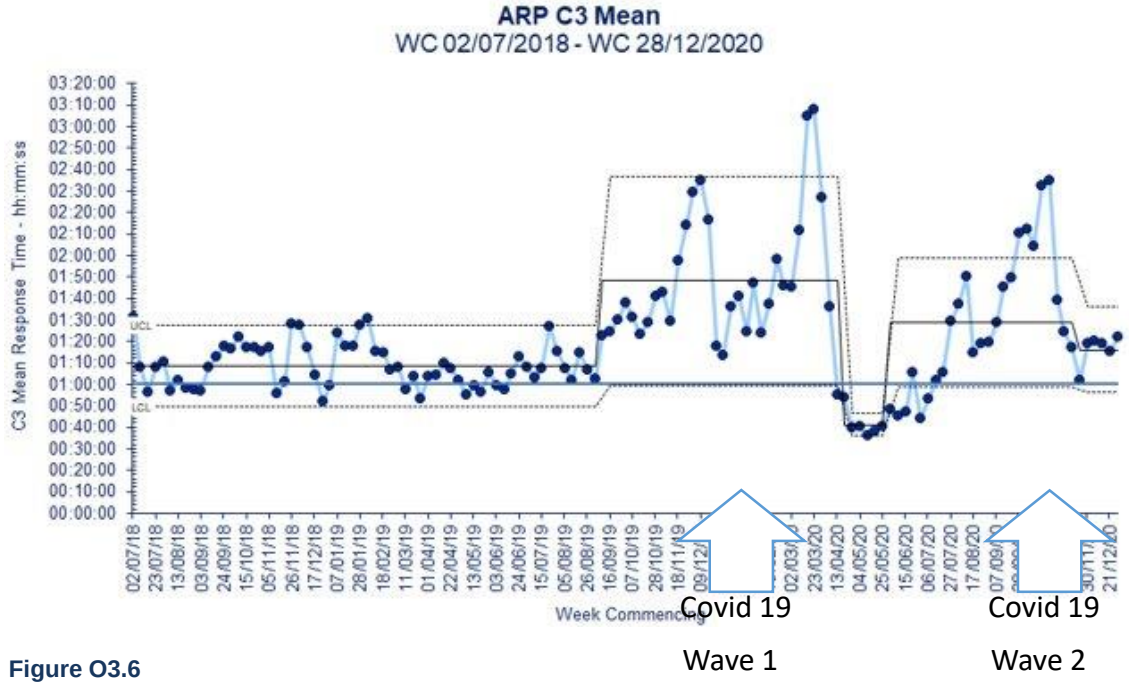
C2 90th Percentile

Target: 40 Minutes

NWAS
December 2020: 55:49
YTD: 59:02

The data signals a change with a new phase from 9/11/2020. This new phase within the data can be attributed to the actions detailed in the summary.

Figure O3.5



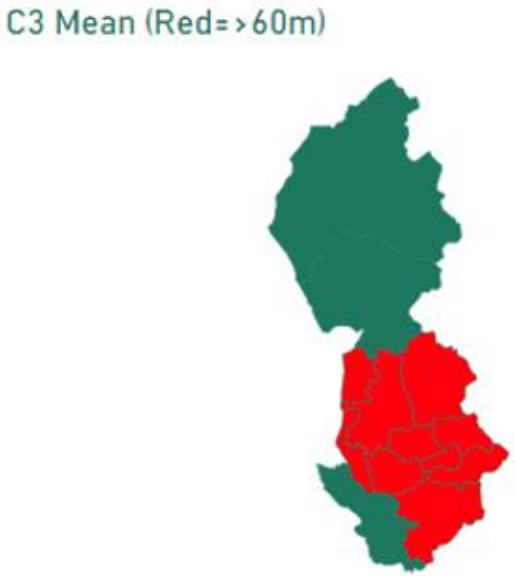
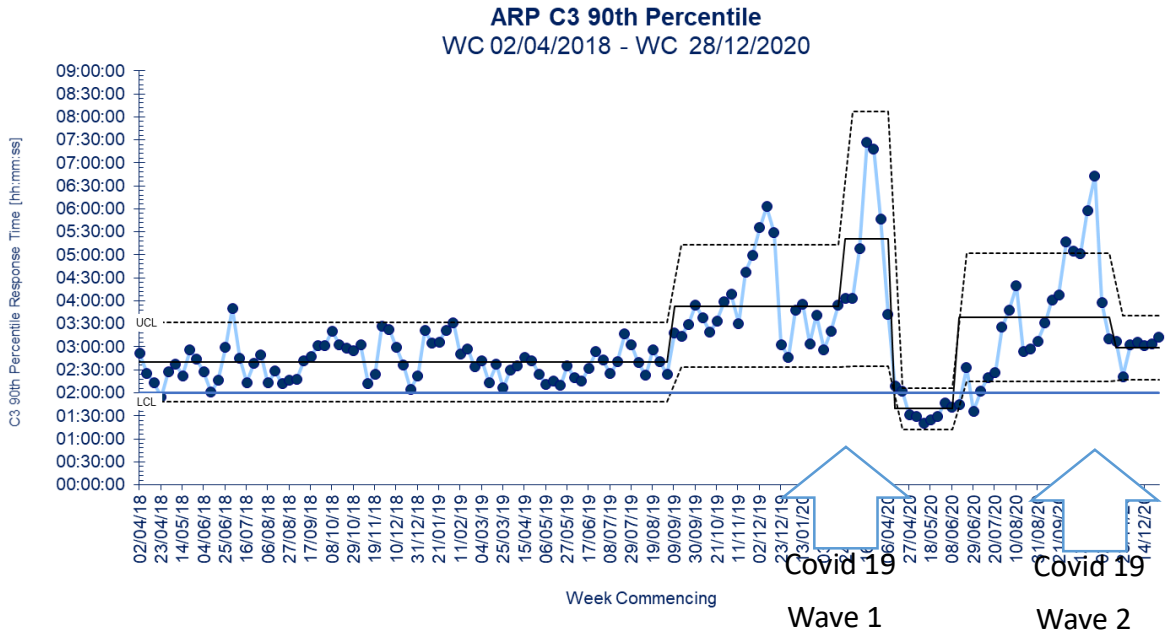
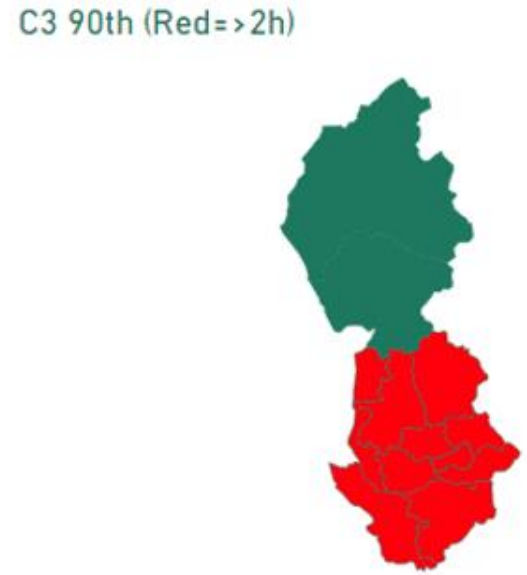


Figure O3.6





C3 Performance

C3 Mean

Target: 1 Hour

NWAS:
December 2020: 1:17:46
YTD: 1:18:30

The data signals a change with a new phase from 16/11/2020. This new phase within the data can be attributed to the actions detailed in the summary.

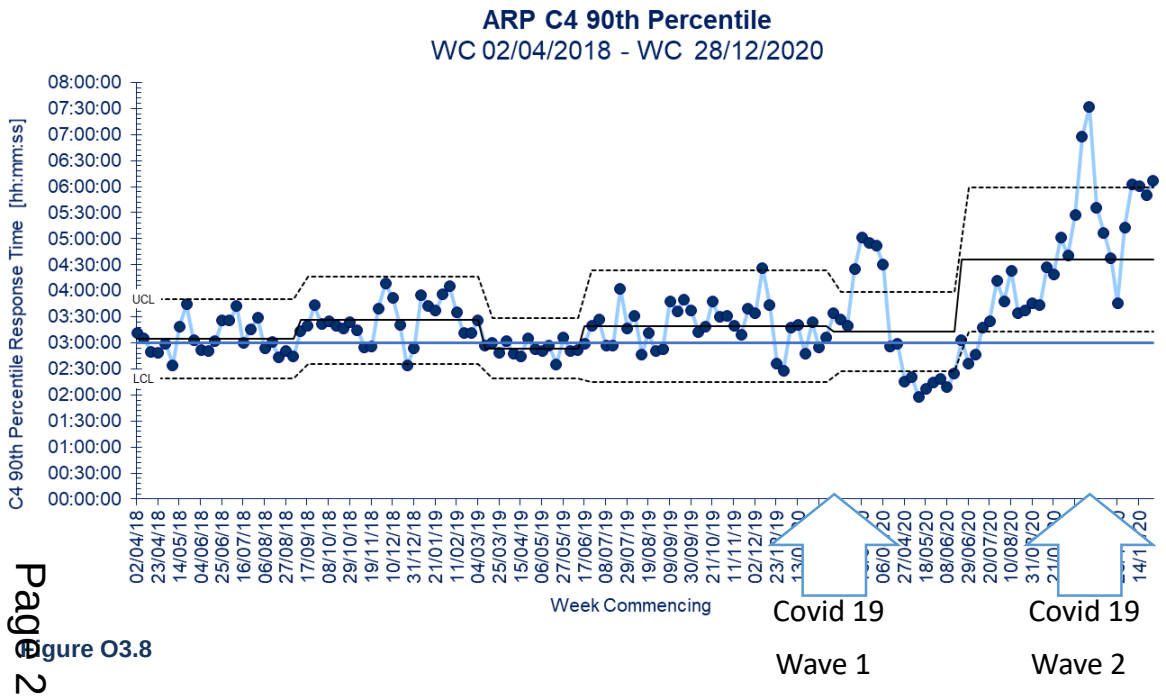
C3 90th Percentile

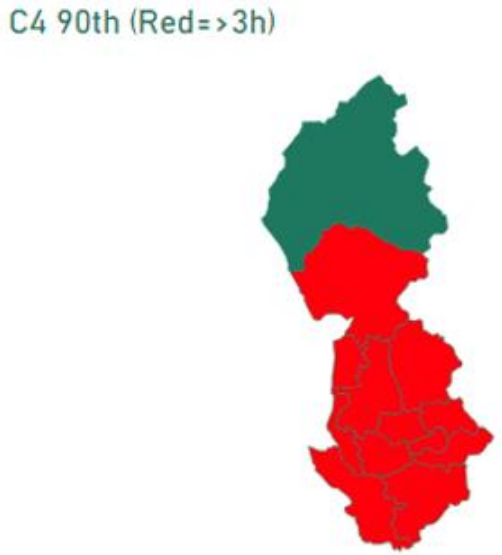
Target: 2 Hours

NWAS
December 2020: 3:02:51
YTD: 3:06:49

The data signals a change with a new phase from 16/11/2020. This new phase within the data can be attributed to the actions detailed in the summary.

Figure O3.7





C4 Performance

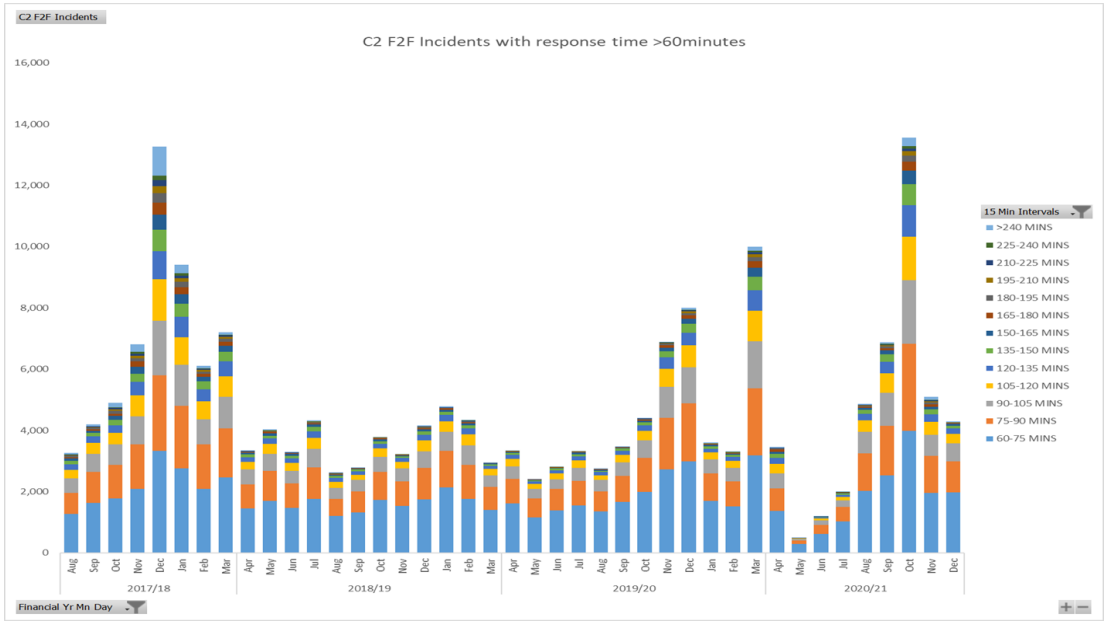
C4 90th Percentile
Target: 3 Hours

NWAS
December 2020: 5:55:30
YTD: 3:54:19

The data signal a significant change with 3 data points above the upper control limit (special Cause variation). As a consequence of applying focus on higher acuity calls, those calls of a less urgent nature have seen waiting times extended. The contributing factors include:

•Pandemic Protocol Card 36 (Nationally agreed)
•Patient Safety Plan – Includes the option of 'No Send' to lower acuity calls when higher levels of the plan are triggered.

Figure O3.8



C2 Long Waits

The increased C2 long waits seen in the peak of the pandemic (March and October 2020) have not occurred in November and December. Measures are in place within the emergency operations centres to ensure clinical review of patients waiting for an emergency response.

C1

Table O3.1

Provider	C1 Mean	C1 90th
North East	6:35	11:32
South Central	6:37	12:16
West Midlands	6:57	12:07
East of England	7:18	13:31
East Midlands	7:25	13:15
London	7:30	12:24
North West	7:36	12:44
Yorkshire	8:03	13:54
South Western	8:16	15:15
South East Coast	8:23	15:07
Isle of Wight	8:38	15:30

Rank 8/11

C2

Table O3.2

Provider	C2 Mean	C2 90th
West Midlands	14:46	28:01
South Central	19:02	37:47
Isle of Wight	21:56	42:36
Yorkshire	24:03	50:47
North West	26:29	55:49
East of England	26:36	56:15
East Midlands	26:42	54:40
South East Coast	26:49	51:55
South Western	27:02	55:19
North East	32:04	5:34
London	44:45	48:03

Rank 5/11

C3

Table O3.3

Provider	C3 Mean	C3 90th
West Midlands	0:47:41	1:50:30
Yorkshire	1:02:28	2:34:31
South Central	1:02:36	2:23:34
South Western	1:16:50	3:09:41
North West	1:17:46	3:02:47
East Midlands	1:22:02	3:14:50
Isle of Wight	1:22:20	3:23:08
East of England	1:24:36	3:32:40
London	1:41:45	4:12:09
North East	1:42:46	4:18:28
South East Coast	2:35:13	5:51:35

Rank 5/11

C4

Table O3.4

Provider	C4 90th
West Midlands	2:25:19
East Midlands	3:04:24
South Central	3:09:56
North East	3:14:51
Yorkshire	3:45:37
East of England	3:56:00
South Western	3:56:55
Isle of Wight	4:15:10
North West	5:54:57
London	6:34:32
South East Coast	7:42:55

Rank 9/11

O4 111 PERFORMANCE

Figure O4.1

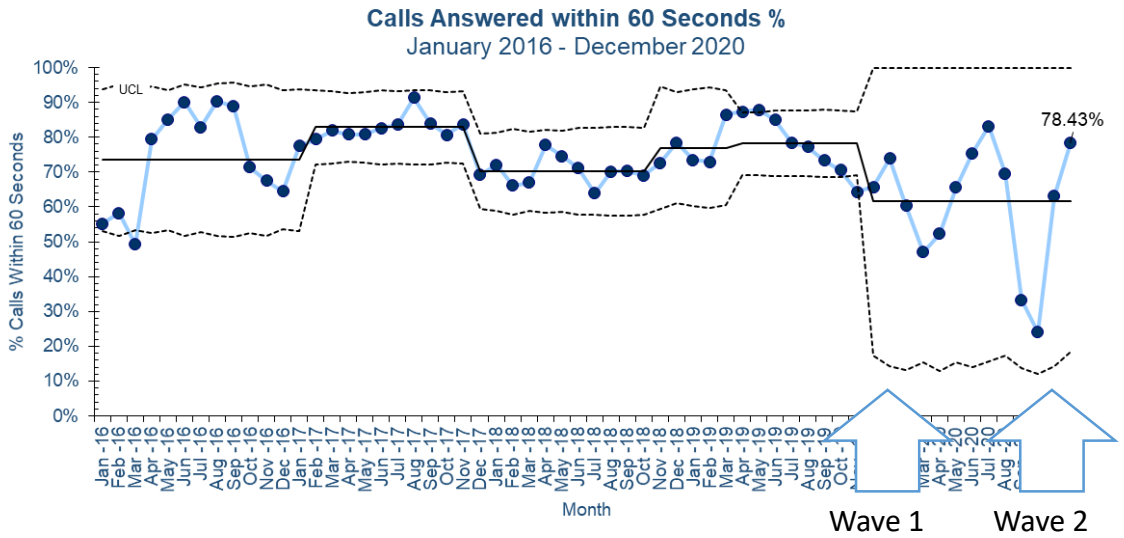
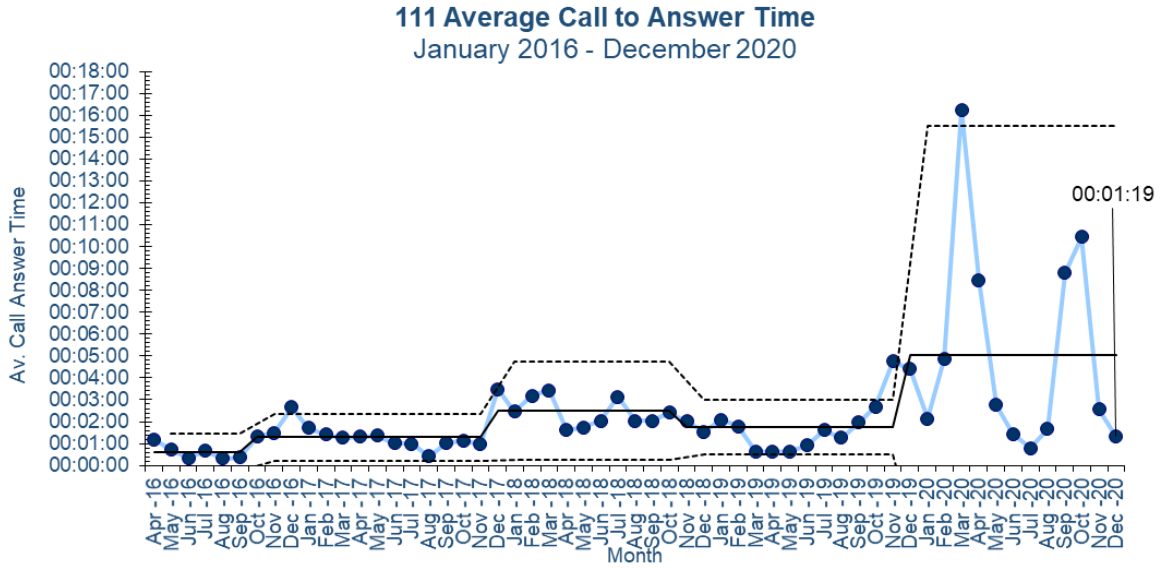


Figure O4.2



111 Performance

Calls Answered within 60 seconds %

Target: 95%

NWAS
December 2020: 78.43%
YTD: 61.67%

National 80.5%

Performance continues to improve within 111 compared to September and October. This is aligned to the significant increase in recruitment of Health Advisors and Clinicians to support the 111 First campaign.

Despite the increase in staffing, performance at present is not fully optimised due to constraints with Estate and Telephony.

Estate - Work is underway preparing the additional estate within Middlebrook. The planned go live date for this is currently the end of March 2021. Call Handlers that have been recruited between December and March will be done so on fully flexible shift patterns until there is available estate to seat them in. Once Estate capacity is realised (circa 75 desks) call handlers will then be rostered to shift patterns to optimise performance.

Telephony – The UCP is now live within 111. The original planned go live date for the UCP project was 17th December. This was delayed due to significant issues presenting in the Soft Launch period. Prior to UCP go live the 111 Service had a limited number of Cisco phones and therefore a further constraint in putting recruited staff onto shifts optimised to achieve performance. With additional telephony capacity now in place, temporary additional desks have been secured at Lady Bridge Hall for evening and weekend call taking. The operational team are now in the process of setting up and testing this area before mobilising the capacity which will support performance further, estimated go live for this is week commencing 12th January 2021.

Figure O4.3:

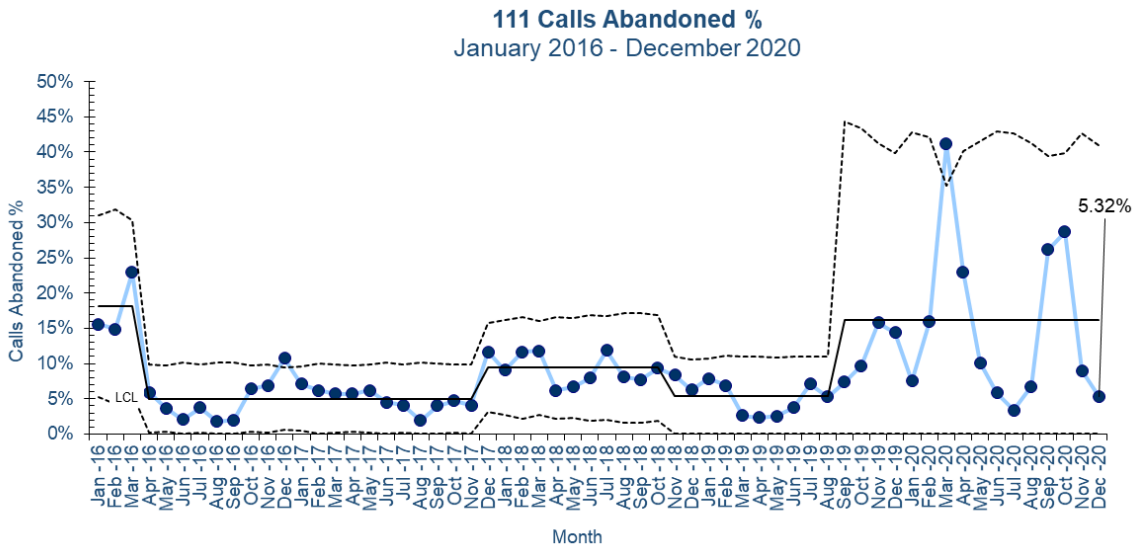
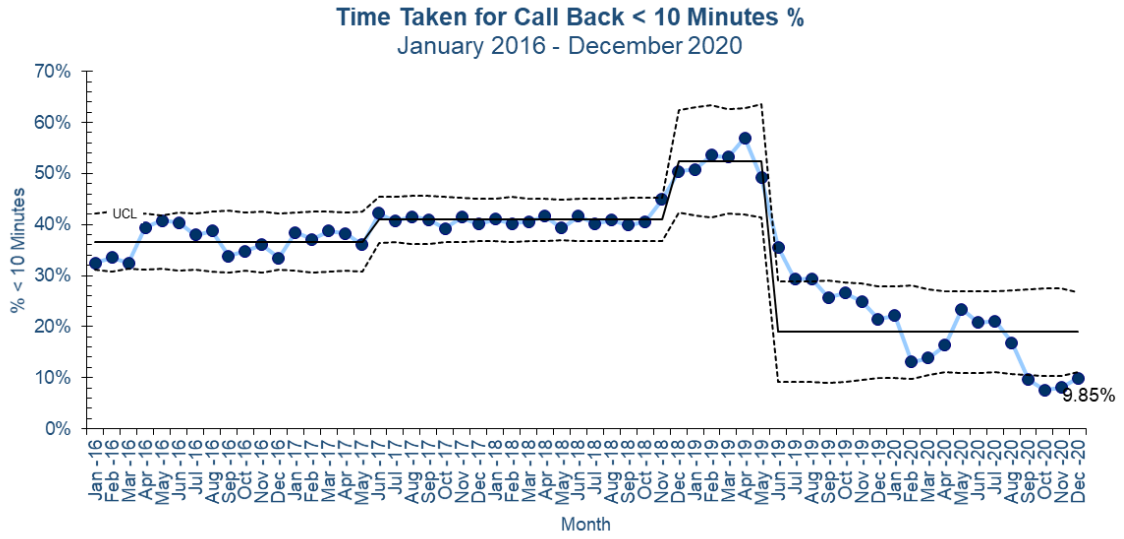


Figure O4.4



Calls Abandoned %
Target: <5%

NWAS
December 20: 5.32%
YTD: 13.94%

National 5.7%

Call Back < 10 Minutes %
Target: 75%

NWAS
December 20: 9.85%
YTD: 15.05%

National 34%

Further investigation is underway to understand the drop in the proportion of patients with a call back in 10 minutes which is signalled in the data with a data point outside the control limits.. Initial analysis suggests this is linked to the roll out of the new Patient Management System Cleric.

Since the roll out of Cleric a significant amount of work has been undertaken refining the Clinical Advice queue to allow more efficient management of the queue and ultimately reduced waits for clinical call backs to patients, this should show further improvements for this KPI next month.

Figure O4.5

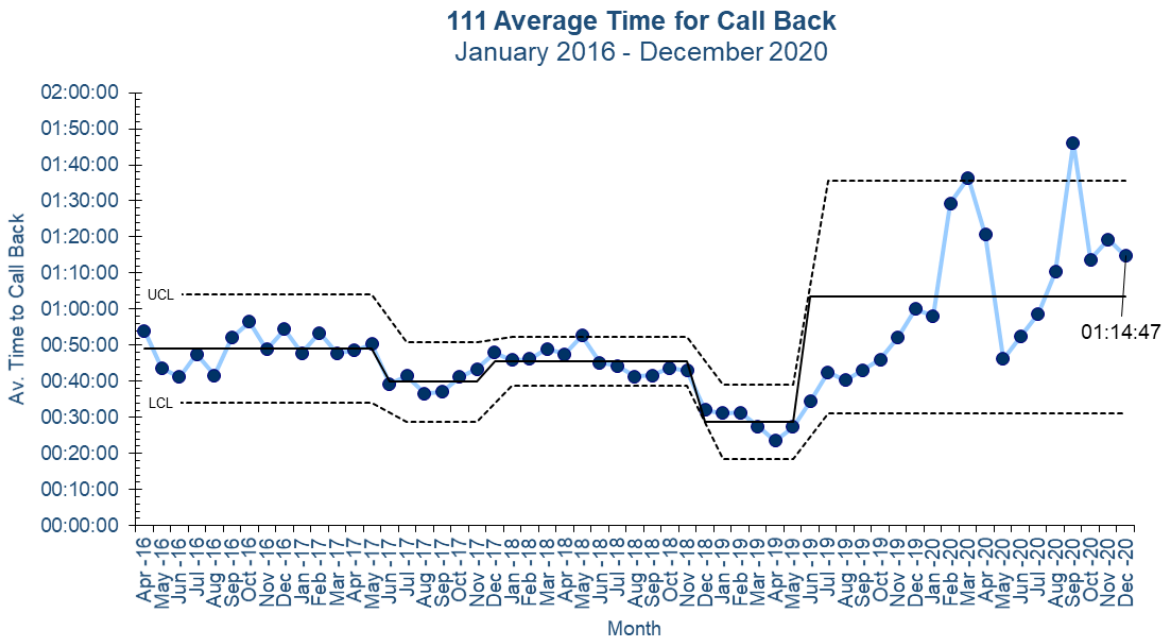
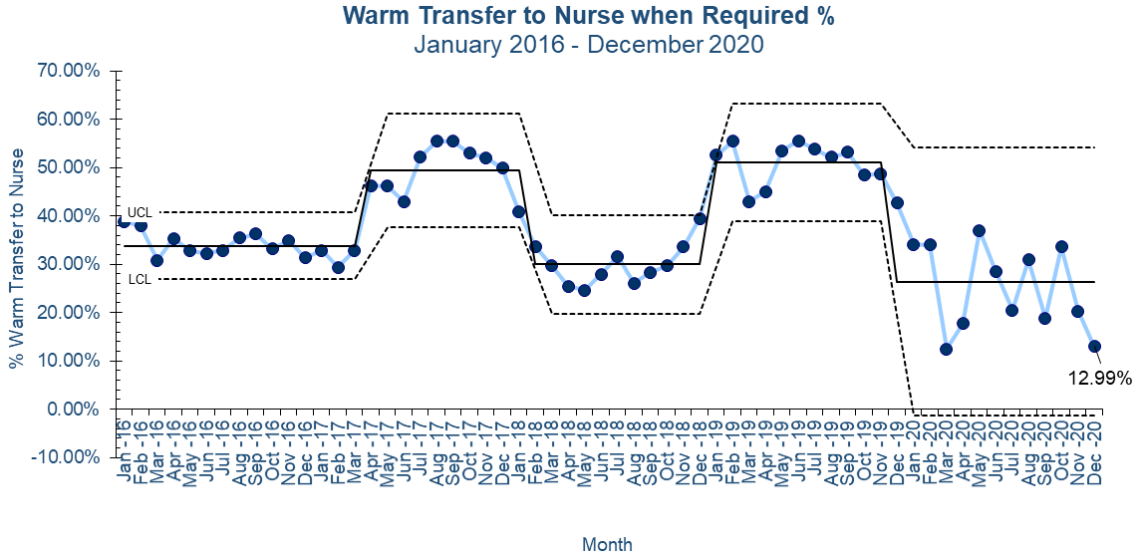


Figure O4.6



Warm Transfer to Nurse when Required%

Target:	75%

NWAS

December 20:	12.99%
YTD:	24.26%

***NEW CHART** – this shows our change in the national ranking tables since January 18 on key metrics (1 is best, 25 is worst)

Figure O4.7

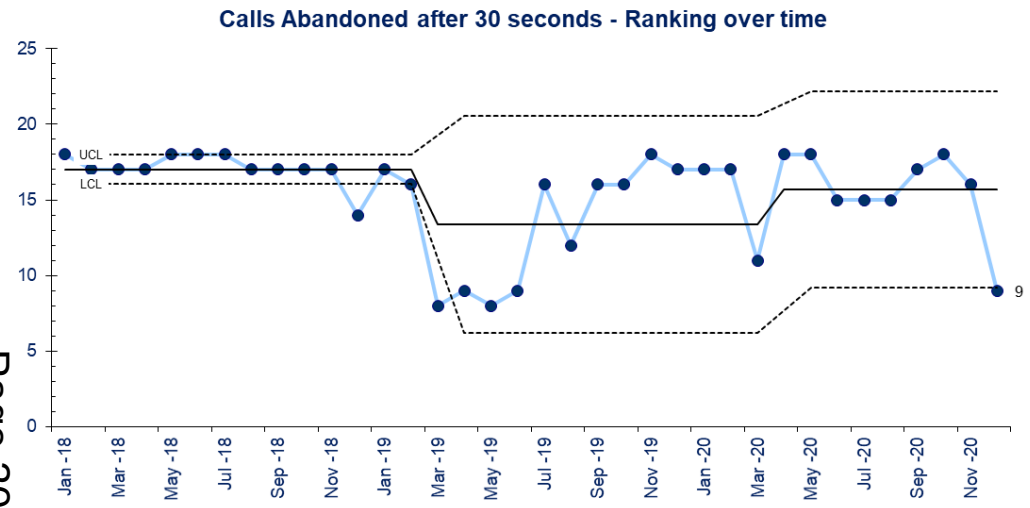


Figure O4.8

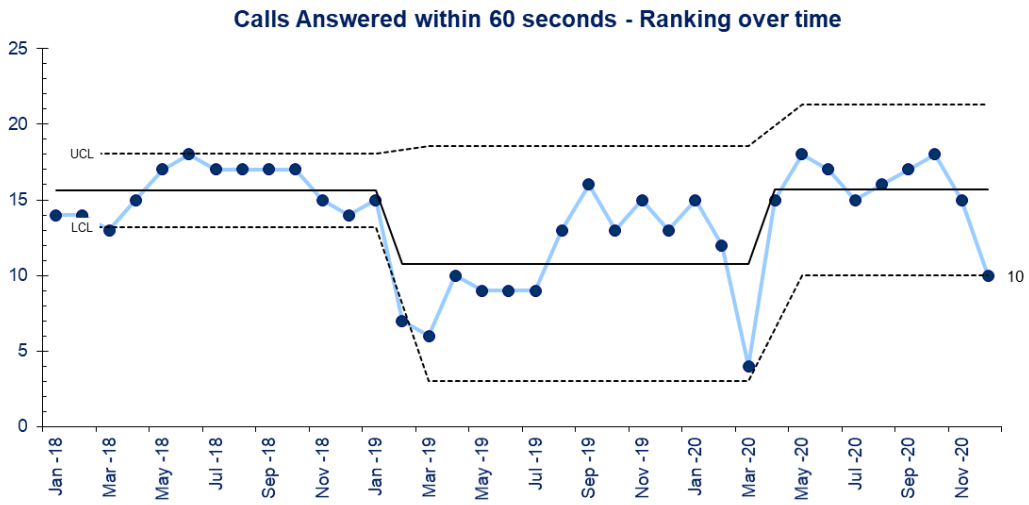
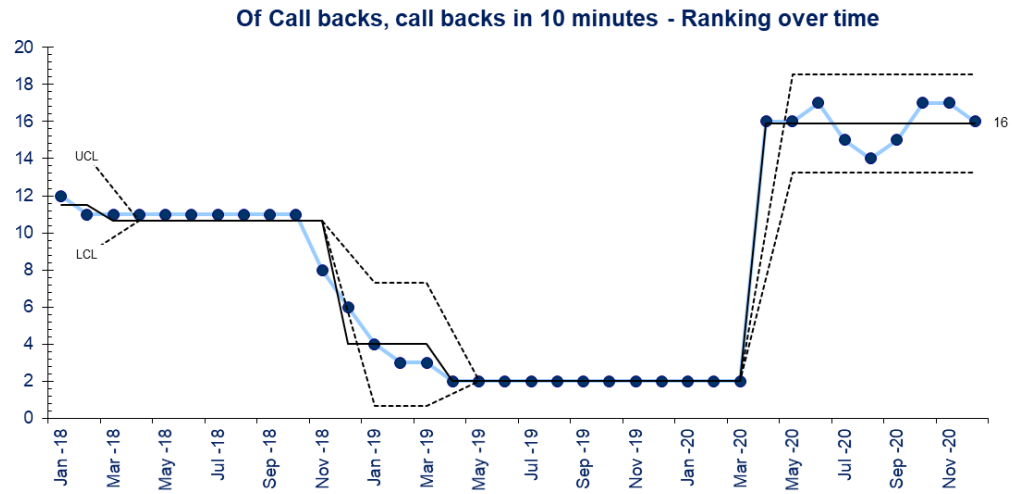


Figure O4.9



O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: December 2020					Year to Date: July 2019 – December 2020			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity	Current Month Activity	Year to Date Baseline	Year to Date Activity	Year to Date Activity	Year to Date Activity
Cumbria	168,290	14,024	7,970	(6,054)	(43%)	84,145	45,937	(38,208)	(45%)
Greater Manchester	526,588	43,882	29,807	(14,075)	(32%)	263,294	173,732	(89,562)	(34%)
Lancashire	589,181	49,098	27,508	(21,590)	(44%)	294,591	158,321	(136,270)	(46%)
Merseyside	300,123	25,010	18,184	(6,826)	(27%)	150,062	107,048	(43,014)	(29%)
NWAS	1,584,182	132,015	83,469	(48,546)	(37%)	792,091	485,038	(307,053)	(39%)

UNPLANNED ACTIVITY									
	Current Month: December 2020					Year to Date: July 2019 – December 2020			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity	Current Month Activity	Year to Date Baseline	Year to Date Activity	Year to Date Activity	Year to Date Activity
Cumbria	14,969	1,247	433	(814)	(65%)	7,485	3,689	(3,796)	(51%)
Greater Manchester	39,178	3,265	4,044	779	24%	19,589	26,761	7,172	37%
Lancashire	56,132	4,678	3,173	(1,505)	(32%)	28,066	21,242	(6,824)	(24%)
Merseyside	22,351	1,863	1,489	(374)	(20%)	11,176	9,793	(1,383)	(12%)
NWAS	132,630	11,053	9,139	(1,914)	(17%)	66,315	61,485	(4,830)	(7%)

ABORTED ACTIVITY									
	December 2020								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	141	4,557	3%	41	432	9%	37	2,837	1%
Greater Manchester	836	10,953	8%	695	4,131	17%	811	14,808	5%
Lancashire	663	12,411	5%	486	3,240	15%	315	11,678	3%
Merseyside	329	6,630	5%	222	1,502	15%	385	10,677	4%
NWAS	1,969	34,551	6%	1,444	9,305	16%	1,548	40,000	4%

PTS Performance

Overall activity during December 2020 was 37% below contract baselines with Lancashire 44% below contract baselines whilst Merseyside is operating at -27% (-6826) Journeys below baseline. For the year to date position (July 2019 - December 2020) PTS is performing at -39% (-307053 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at 45% and 46% below baseline whilst Greater Manchester and Merseyside are operating at 34% and 29% below baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 37% (7172 journeys) and -12% (-1383 journeys) above baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges in achieving contract KPI performance. Cumbria and Lancashire are -51% (-3796 journeys) and -24% (-6824 journeys) below baseline.

In terms of overall trend analysis, Greater Manchester has experiencing upward activity movement for the 12 months up to around October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also plateauing whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity.

Aborted activity for planned patients averaged 6% during December 2020 however Cumbria experiences 3%, Greater Manchester operates with 8% whilst Lancashire and Merseyside both experience 5% & 5% aborts respectively. There is a similar trend within EPS (renal and oncology) patients with a Trust average of 4% aborts whereas Cumbria has 1% and Greater Manchester 5% Lancashire and Merseyside operate with 3% and 4% respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average 16% (1 in 6 patients) with variances of 9% in Cumbria, 17% in Greater Manchester, 15% in Lancashire and 15% Merseyside.

OH1 STAFF SICKNESS

Figure OH1.1

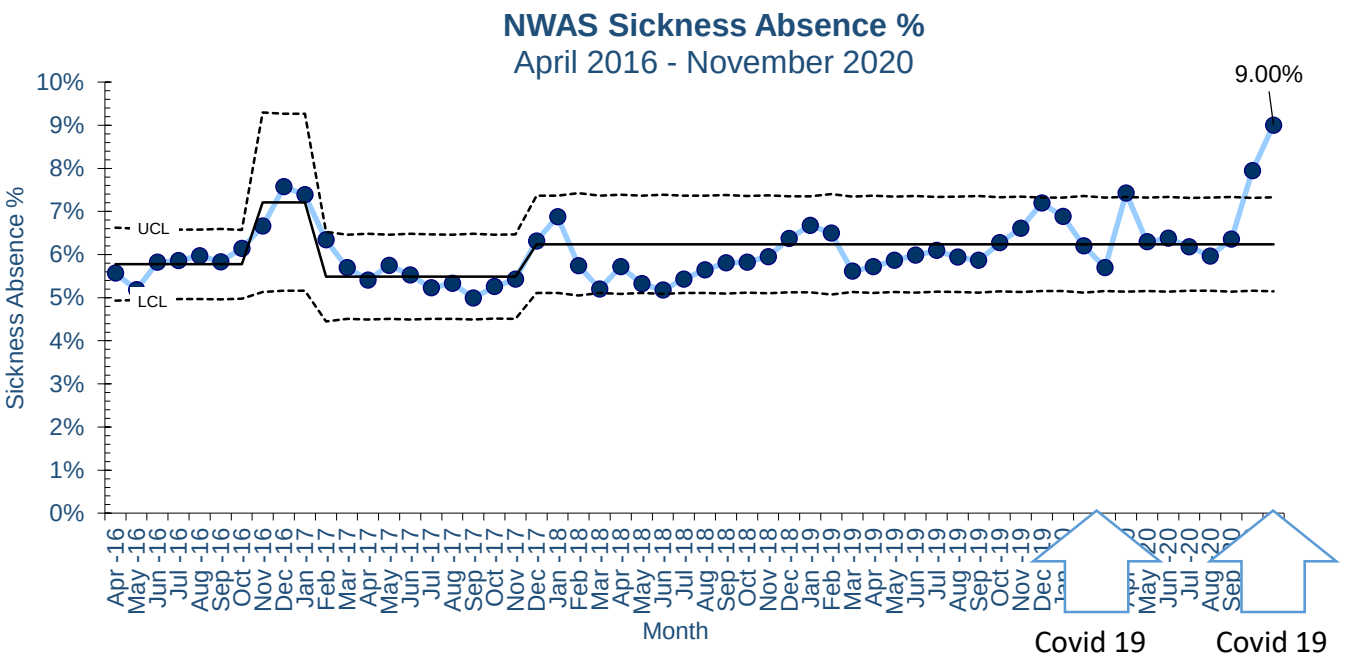


Table OH1.1

Sickness Absence	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20
NWAS	7.19%	6.88%	6.20%	5.70%	7.42%	6.30%	6.38%	6.18%	5.96%	6.35%	7.94%	9.00%
Amb. National Average	6.60%	6.38%	5.93%	6.75%	7.40%	5.38%	4.65%	4.75%	5..24%			

Staff Sickness

The overall sickness absence rates for November 2020 were 9% with figure OH1.1 displaying an upward position and outside of upper control limits. The impact of COVID-19 related sickness is evident with 3%(OH1.6) of the sickness absence in November now COVID related. This was an increase from the previous report at 2.12% COVID-19 sickness.

Underlying non-COVID sickness remains within control limits.

All service lines have sickness absence levels above 9%, both PES(OH1.3) and 111(OH1.5) have the highest COVID-19 sickness at 3.85% and 3.3% respectively which is consistent with the outbreak and self- isolation position.

Whilst 111 sickness has increased, it is within control limits.

In addition to sickness reporting via ESR, COVID-19 self-isolating have been captured by GRS, Teliopti and Marvel. This data is reported externally.

BAF Risk: SR04.

Figure OH1.2:

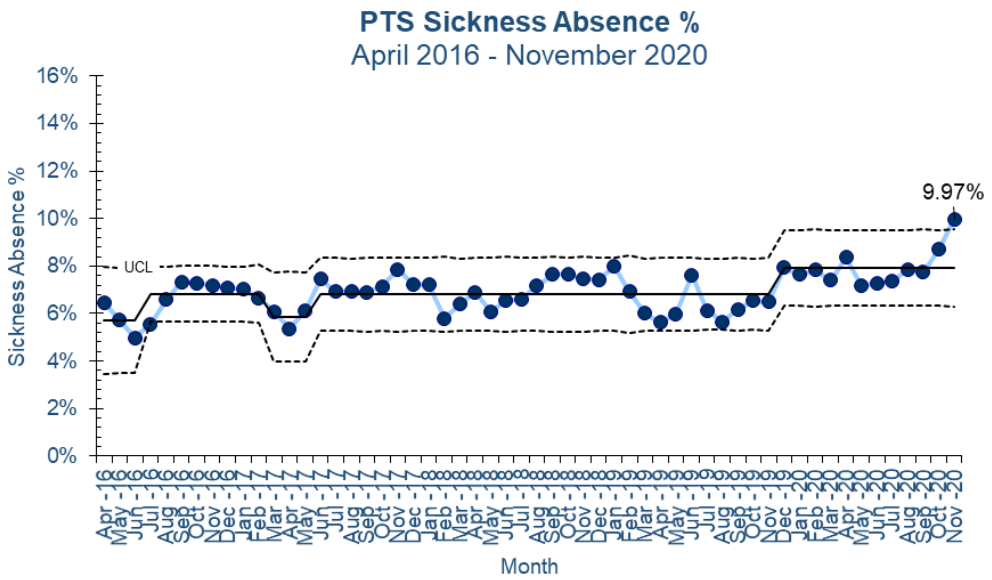


Figure OH1.3:

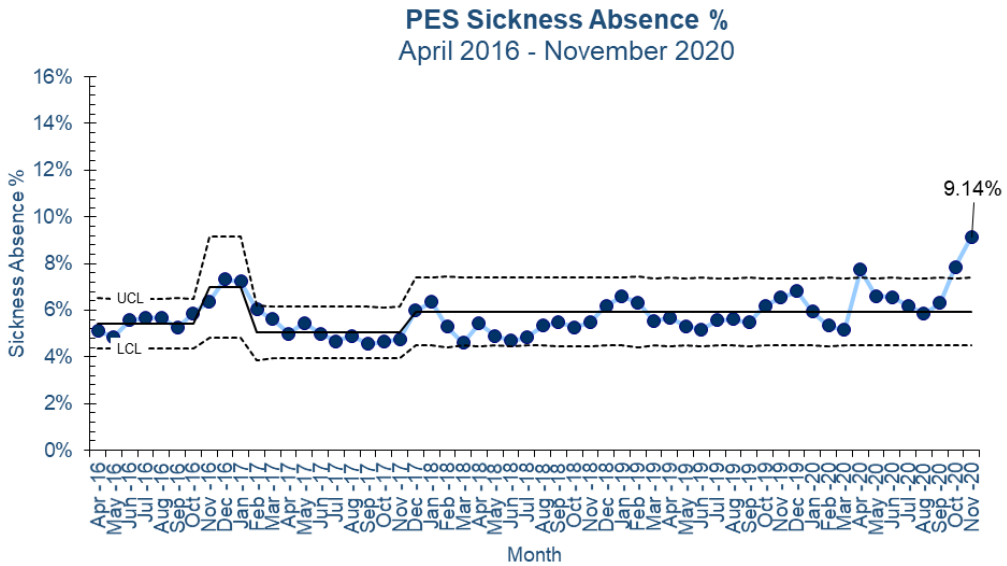


Figure OH1.4:

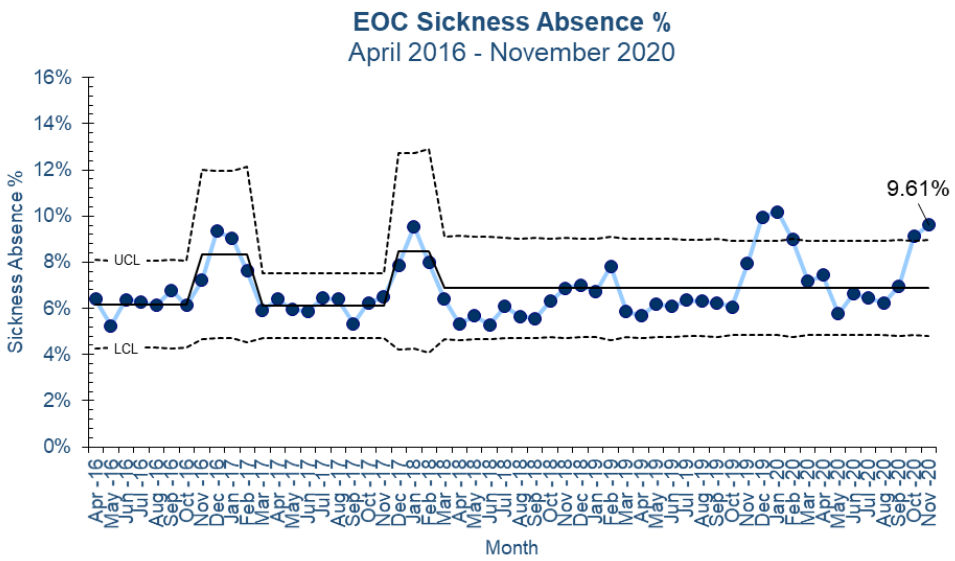
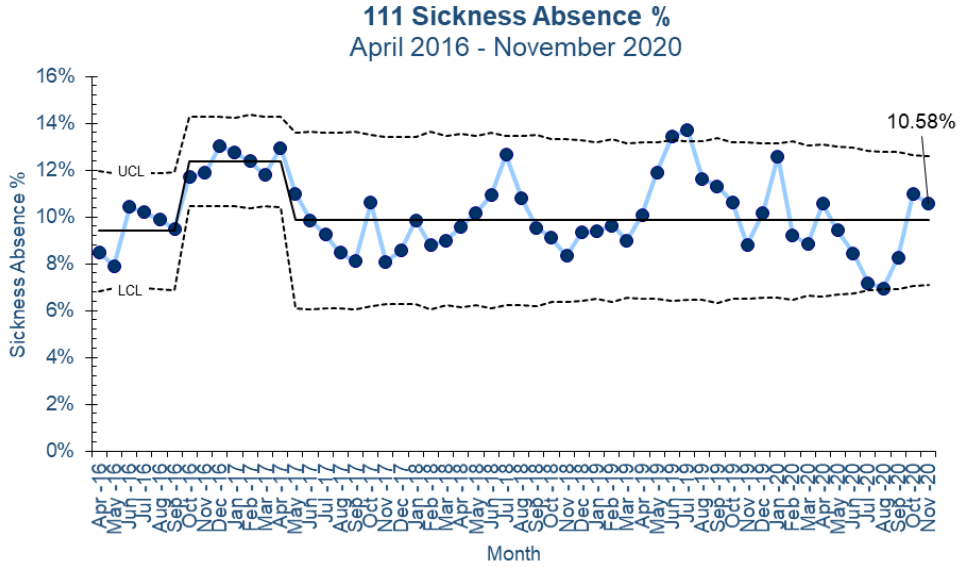


Figure OH1.5:



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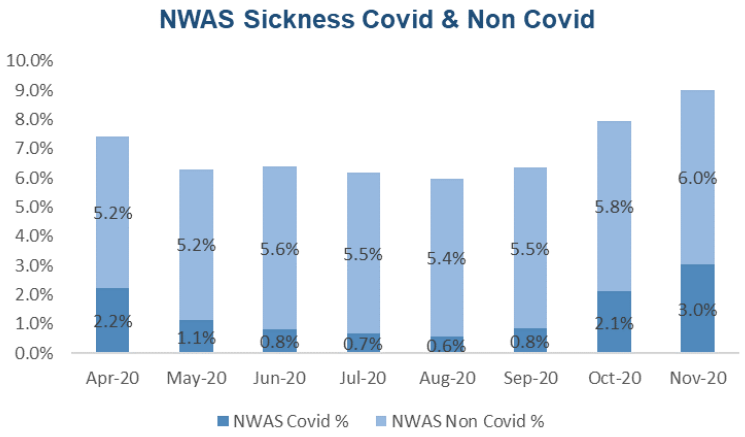

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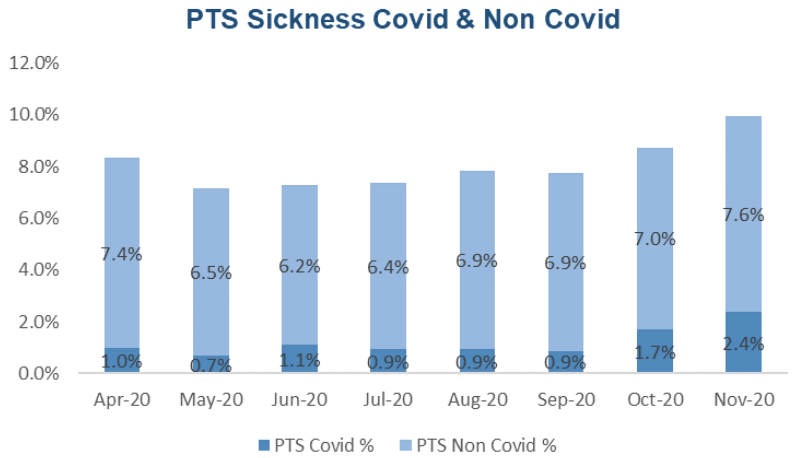

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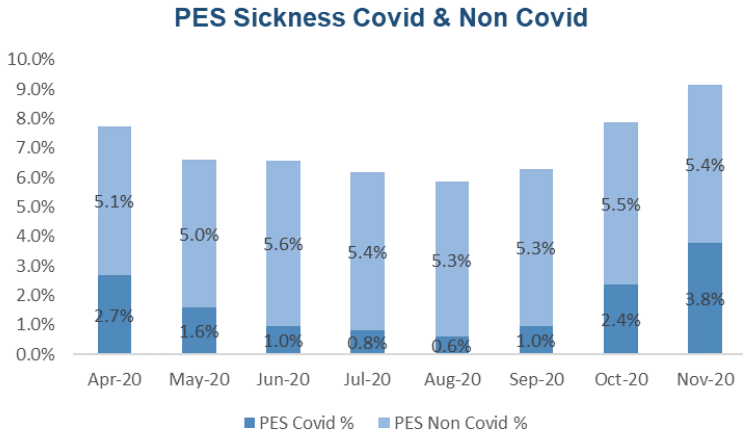

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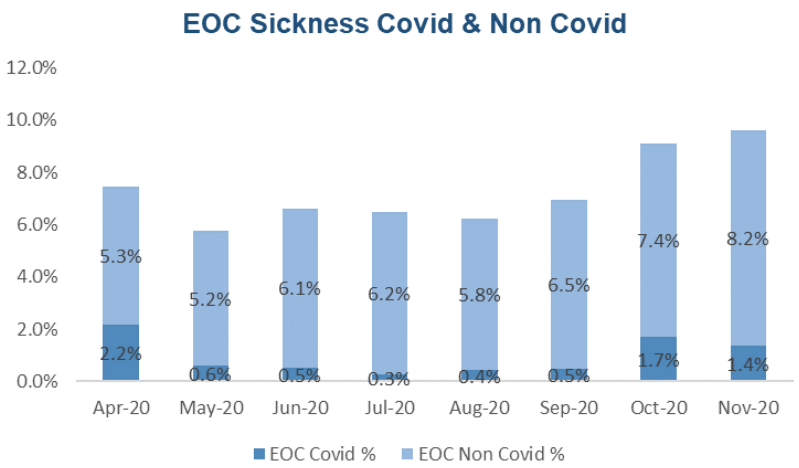

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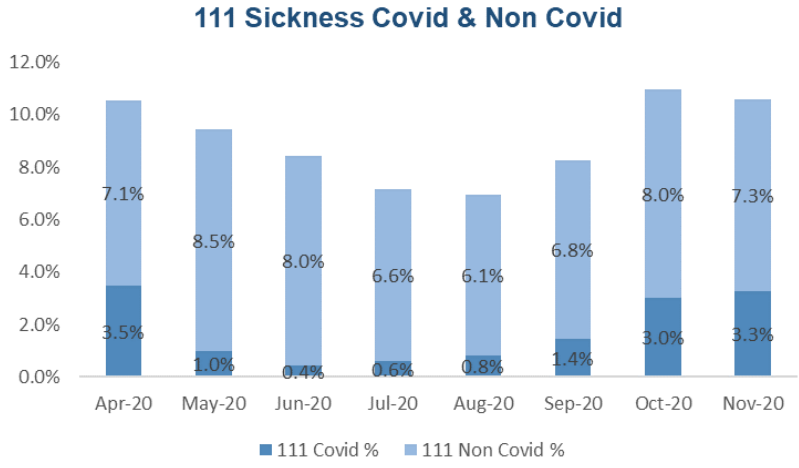
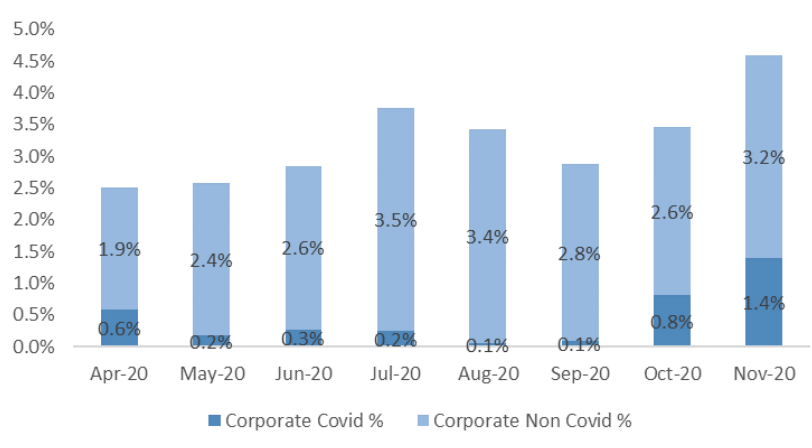


Figure OH1.11:



OH2 STAFF TURNOVER

Figure OH2.1

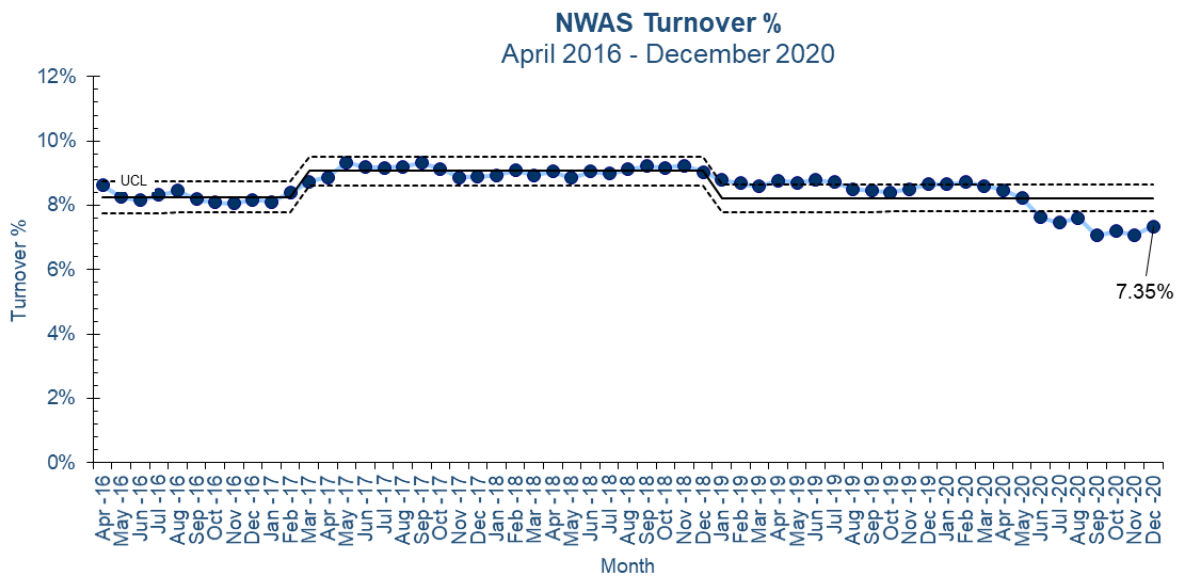


Table OH2.1

Turnover	Jan – 20	Feb - 20	Mar - 20	Apr - 20	May - 20	Jun - 20	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
NWAS	8.66%	8.72%	8.60%	8.46%	8.22%	7.63%	7.46%	7.60%	7.07%	7.19%	7.08%	7.35%
Amb. National Average	9.08%	9.12%	9.12%	8.94%	8.98%	8.69%	8.52%	8.21%	8.08%			

Staff Turnover

Turnover is calculated on a rolling year average and this does lend to some small variations between months with December 2020 being 7.35%.

Figure OH2.1 is showing special cause variation with the last five data points below the lower control limit. However, in this scenario it is a positive position. All service lines are close to the lower control limit and fairly stable, although there are some signs in the 111 and PTS service lines of an increasing trend which will be monitored.

Staff turnover has in the main been positively affected by COVID-19 and the changed job market. 111 has seen the most significant reduction in turnover since COVID although a slight increase in December 2020 to 20.52%(OH2.5), it is much lower than the historical position of over 30%.

BAF Risk: SR04

Figure OH2.2

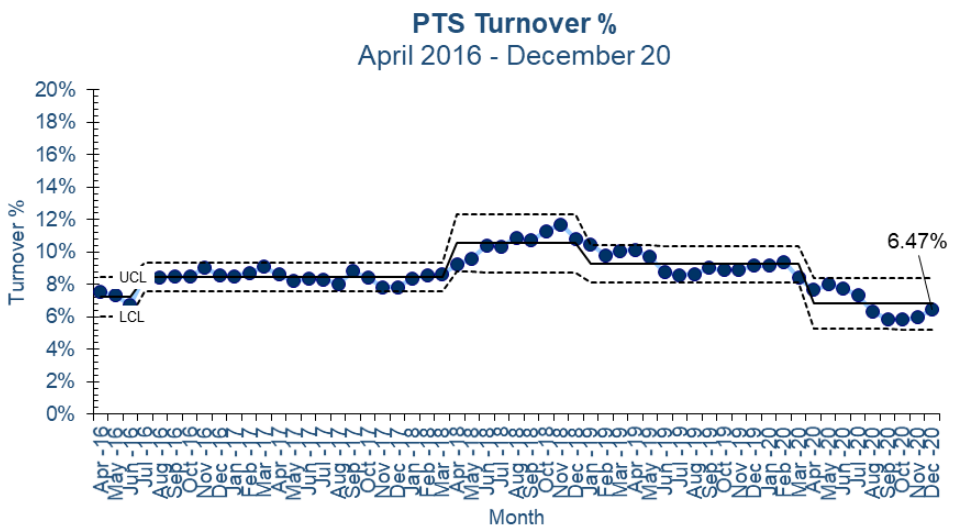


Figure OH2.3

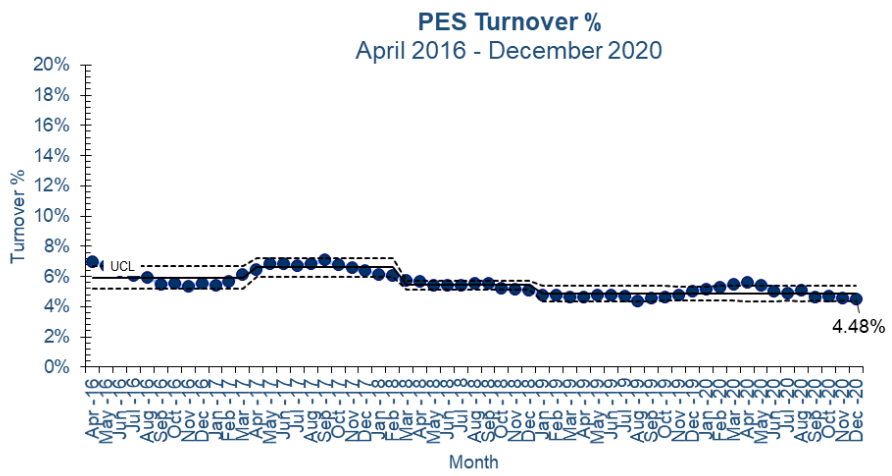


Figure OH2.4

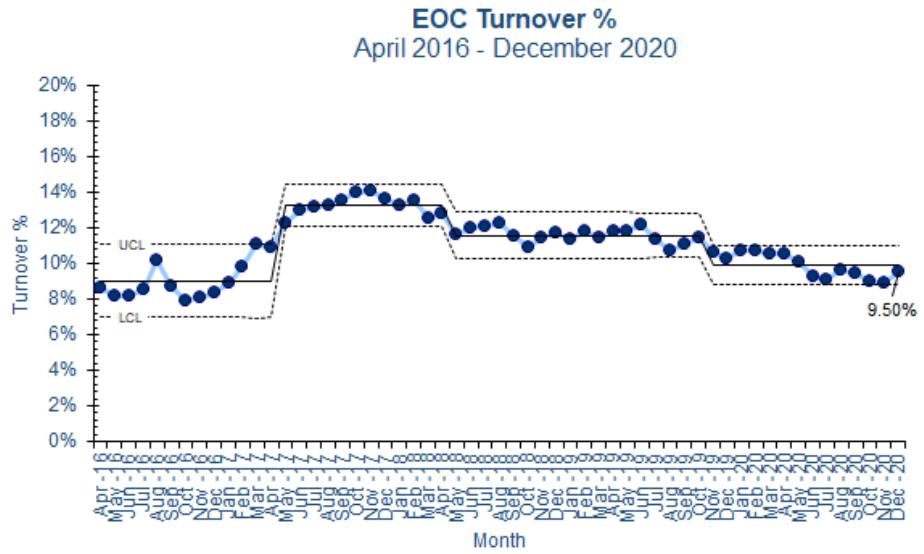
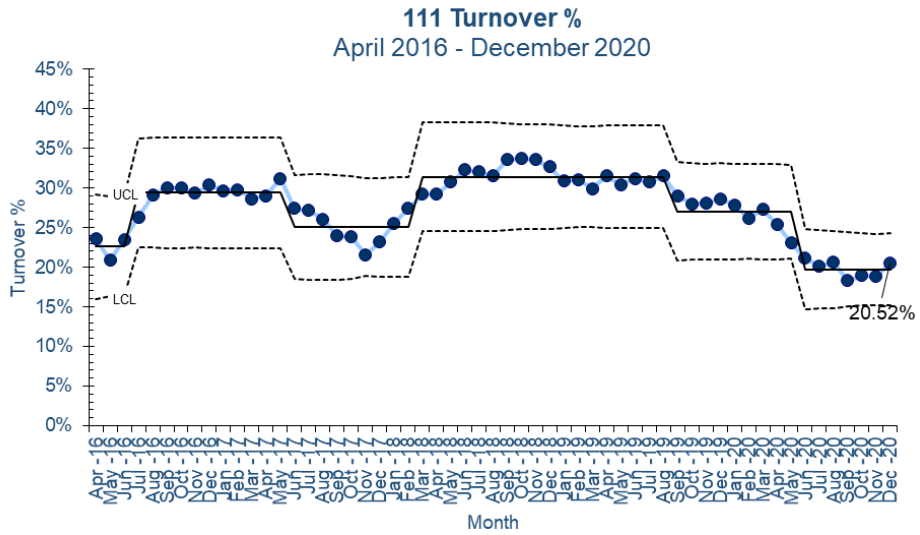
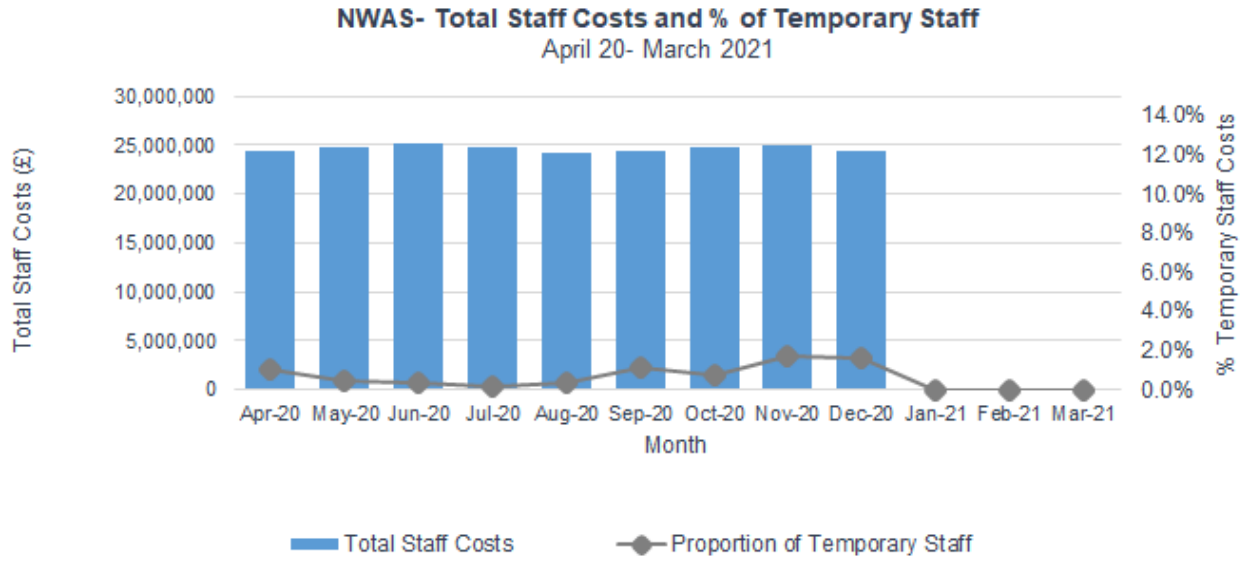


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

As a result of COVID-19, the Trust Agency usage and expenditure is projected to exceed the Agency ceiling, although this does not form part of the reporting under the emergency arrangements.

Agency staff have been used to support the Trust's response to the Pandemic and have been utilised primarily in the Contact Centre environment.

ELC approved the recruitment of an additional 123 Agency staff in EOC for the period up to the end of the financial year, so levels are expected to remain higher than previous years. An exit strategy to reduce agency levels through fixed and permanent contracts is in place to reduce this by April reporting.

The increase in November and December 2020 are impacted by Wave 2 & 3 of the Pandemic.

BAF Risk: SR04; SR11, SR02

Table OH4.1

NWAS	Jan -20	Feb-20	Mar-20	Apr-20	May-20	June-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-19	Dec-20
Agency Staff Costs (£)	57,922	80,913	153,153	261,425	523,449	647,832	465,485	407,651	466,727	386,841	502,967	541,395
Total Staff Costs (£)	21,613,064	22,646,658	21,904,103	24,361,995	24,812,375	25,181,809	24,737,935	24,176,859	24,352,743	24,669,105	24,985,757	24,466,230
Proportion of Temporary Staff %	0.6%	0.2%	0.4%	1.1%	0.4%	0.4%	0.2%	0.3%	1.2%	0.7%	1.7%	1.6%

Figure OH4.2:

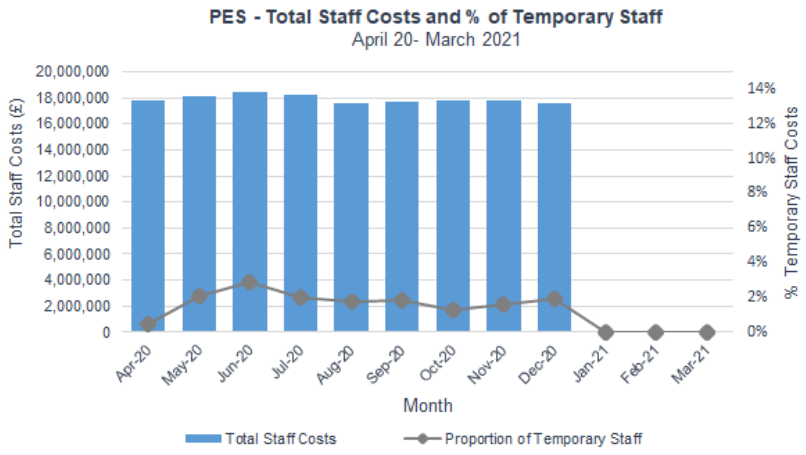


Figure OH4.3:

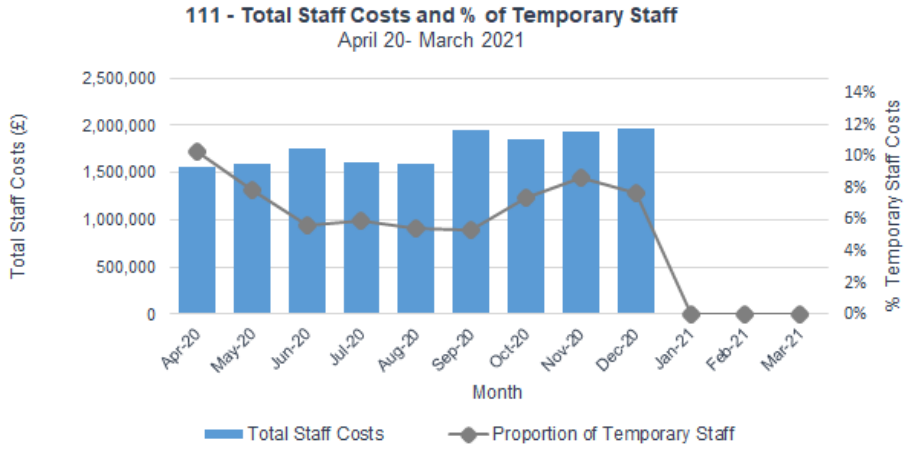


Figure OH4.4:

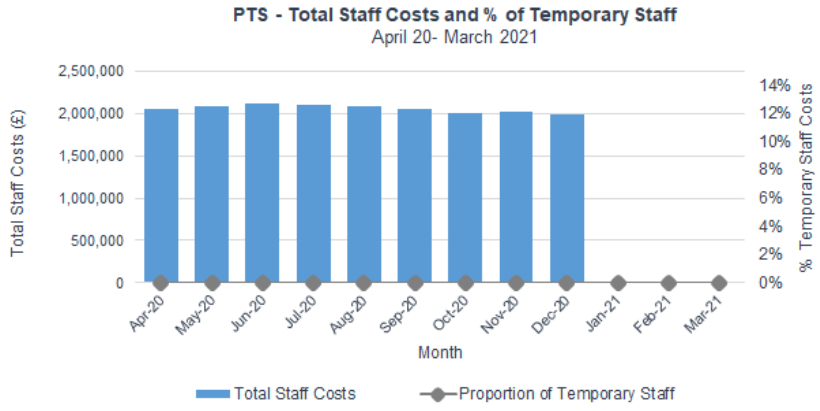
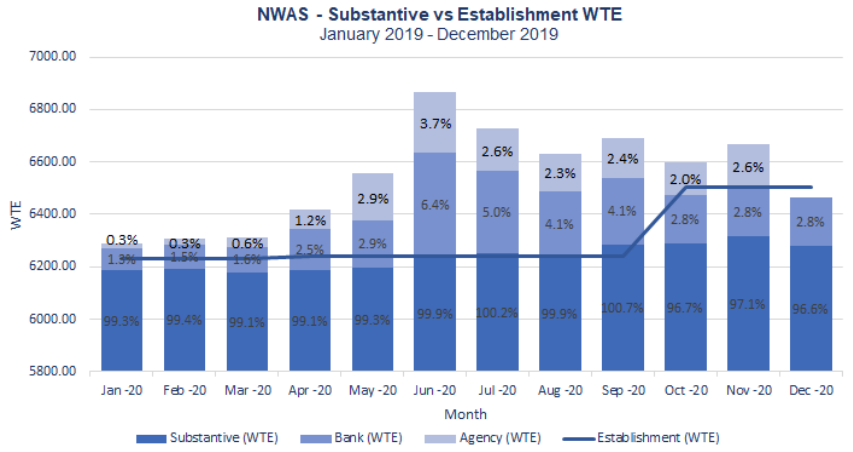


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

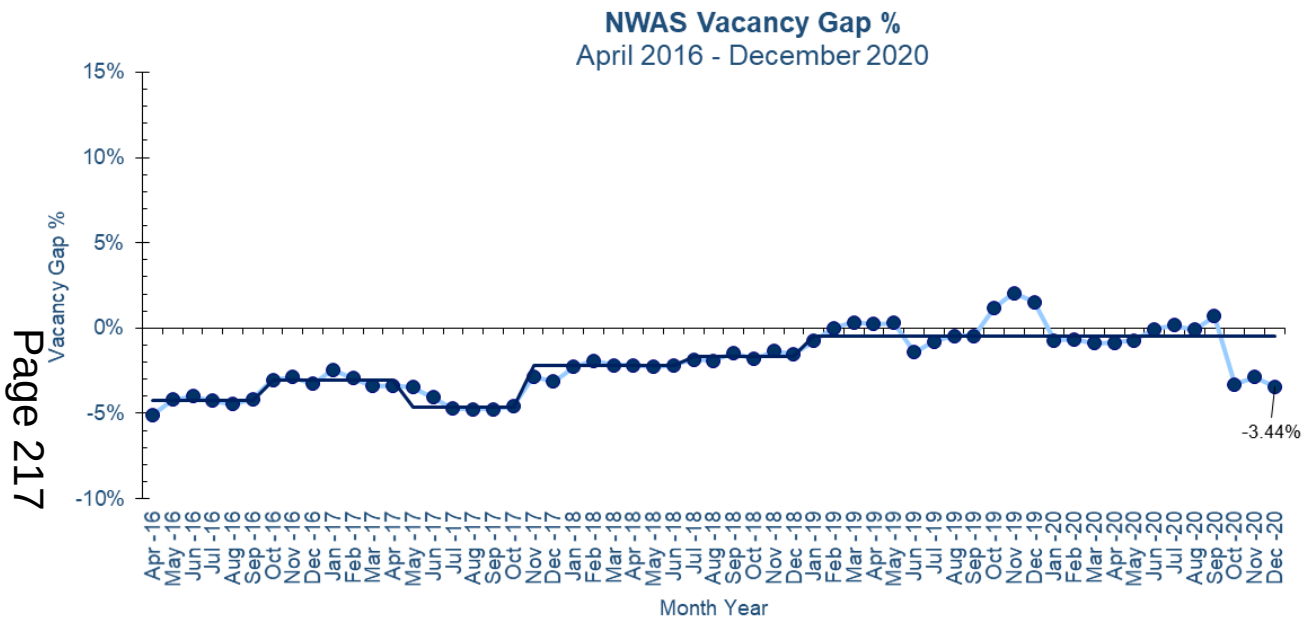


Table OH5.1

Vacancy Gap	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	July-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
NWAS	-0.72%	-0.64%	-0.90%	-0.86%	-0.72%	-0.07%	0.17%	-0.08%	0.69%	-3.31%	-2.88%	-3.44%

Vacancy Gap

Chart OH5.1 shows a slight worsening of the vacancy position, but this reflects the significant change in establishment implemented in 111 as a result of the agreed contract extension and 111 First and the fact that recruitment plans generally limit new starters in the Christmas period.

Recruitment plans for 111 are on track. There were no new starters planned for December which has resulted in a slight increase in the vacancy position to 13.85% (OH5.5). The Health Advisor vacancy position is 5% and plans expect this to be reduced further in Q1.

The vacancy position in PES is positive and very stable within 1% of establishment. This excludes the continuing use of PTS and VAS resource to supplement resources (OH 5.3). The increase in PTS vacancies in December reflects the permanent appointment of some of these staff onto the EMT1 apprenticeship.

There is an over establishment at the end of December 2020 in EOC at 2.28% (OH 5.4), although this shows a reducing position, this is being supplemented by new agency recruitment of over 120 additional staff to support COVID delivery and to prepare for Single Primary Triage project implementation.

BAF Risk; SR04; SR11

Figure OH5.2

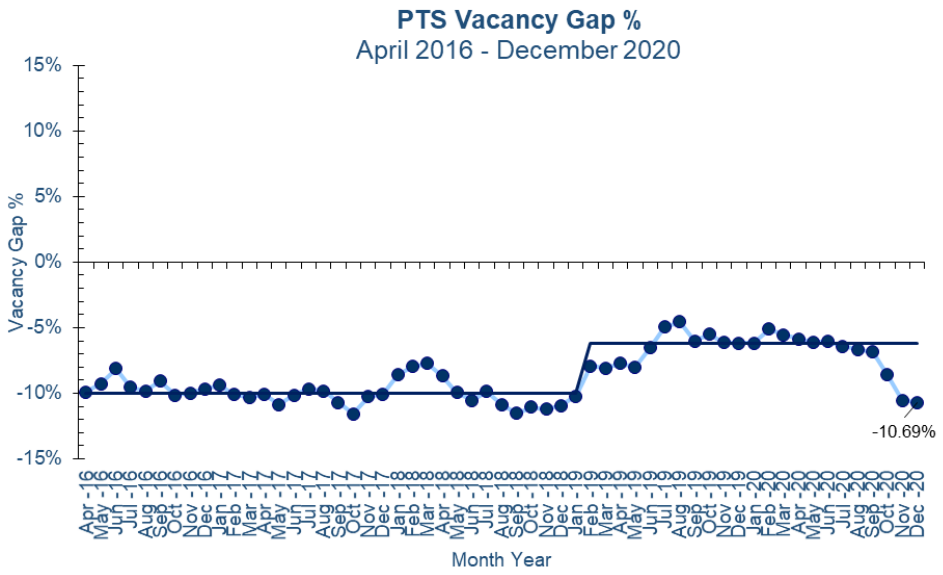


Figure OH5.3

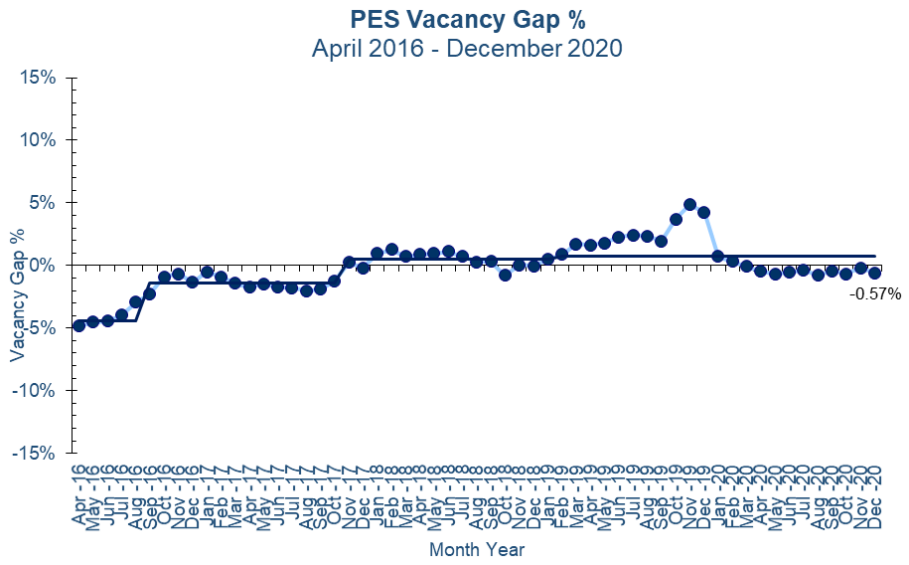


Figure OH5.4

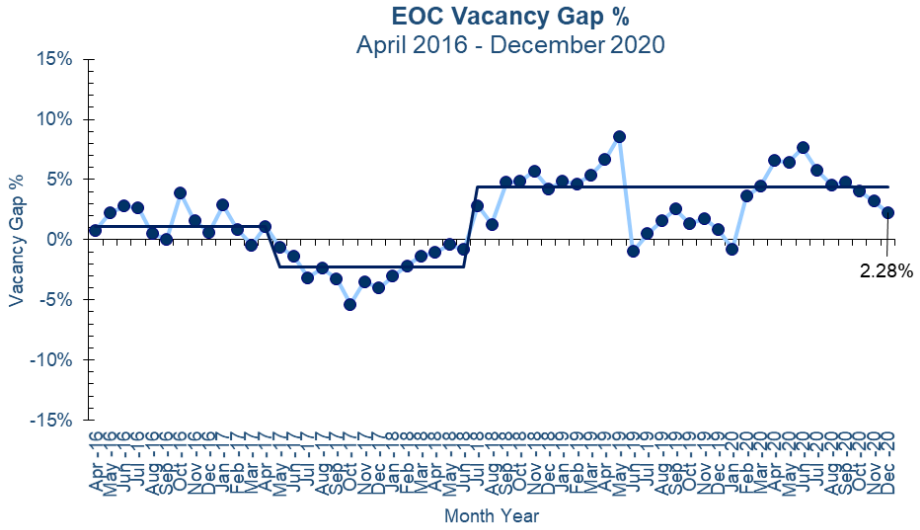
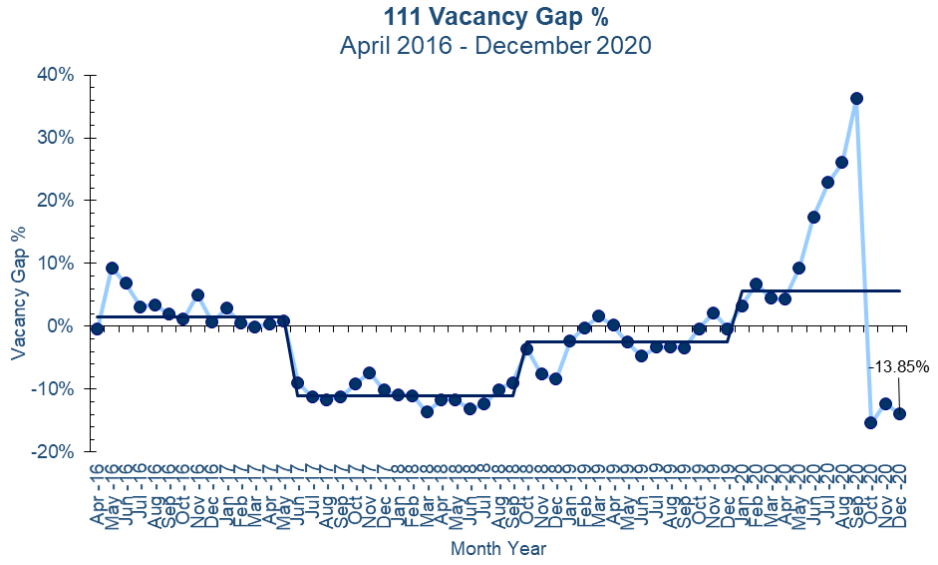


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

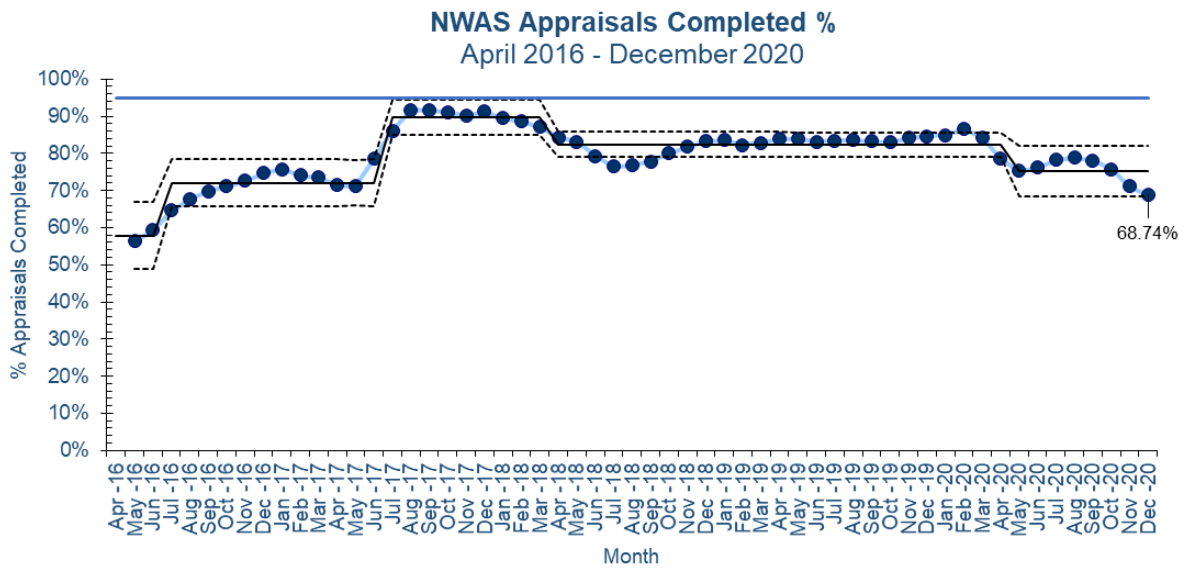


Table OH6.1

Appraisals	Jan-20	Feb -20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
NWAS	85%	87%	84%	78%	75%	76%	78%	79%	78%	76%	71%%	69%

Appraisals

As a result of the impact of COVID-19, appraisals were paused in March 2020 in line with national guidance. They were recommenced in June and improvement can be seen in OH 6.1 until the commencement of the second wave. The last 4 months has shown a worsening of the position.

Appraisals were formally paused again for frontline staff on October 21st as a result of demand and high levels of abstractions. Abstractions remain a significant challenge.

As a result completion rates are currently 69% overall.

PES rates are at 73% (OH6.3) and PTS at 74% (OH6.2). 111 have the most challenging rates at 43%(OH6.5). EOC is currently at 56%(OH6.4) which is outside of the lower control limit.

Following resumption in June 2020, a revised target was set as part of recovery planning of 85%.

A review of the target and recovery plans is currently under consideration.

BAF Risk: SR04; SR11

Figure OH6.2

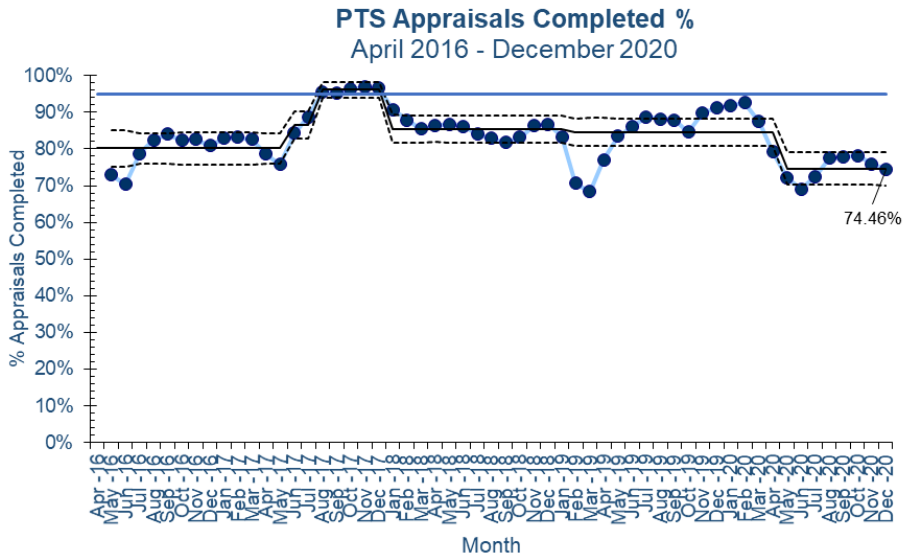


Figure OH6.3

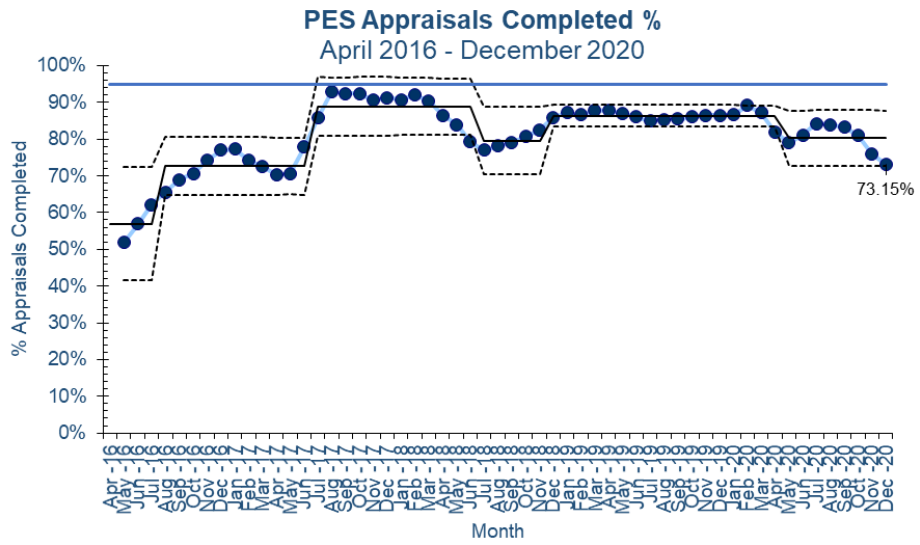


Figure OH6.4

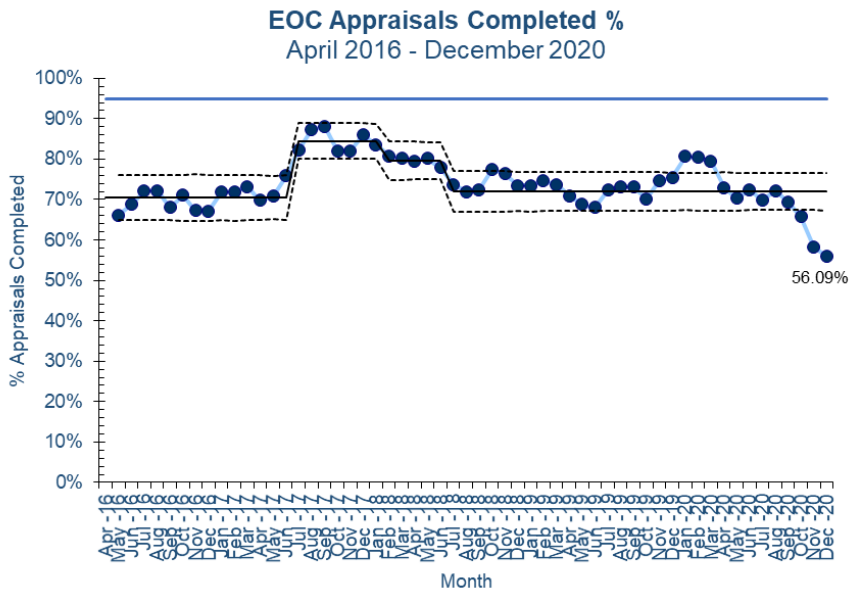
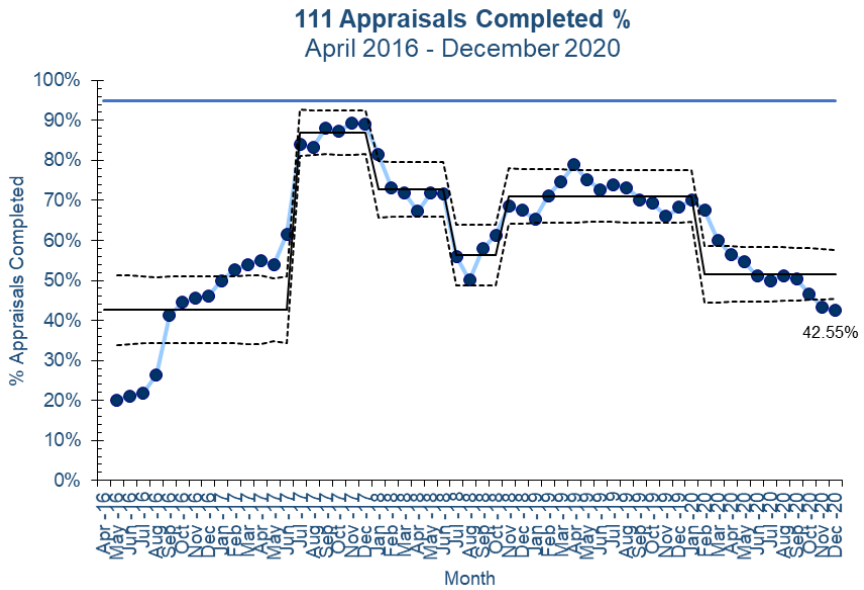


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

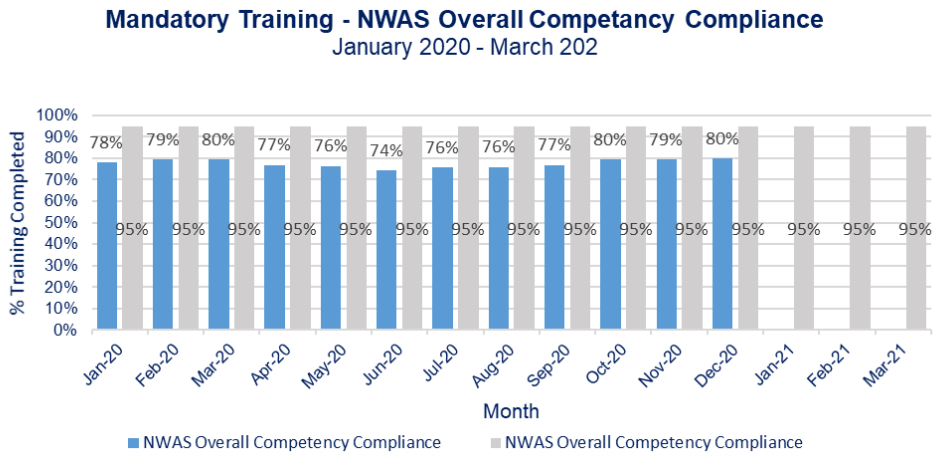
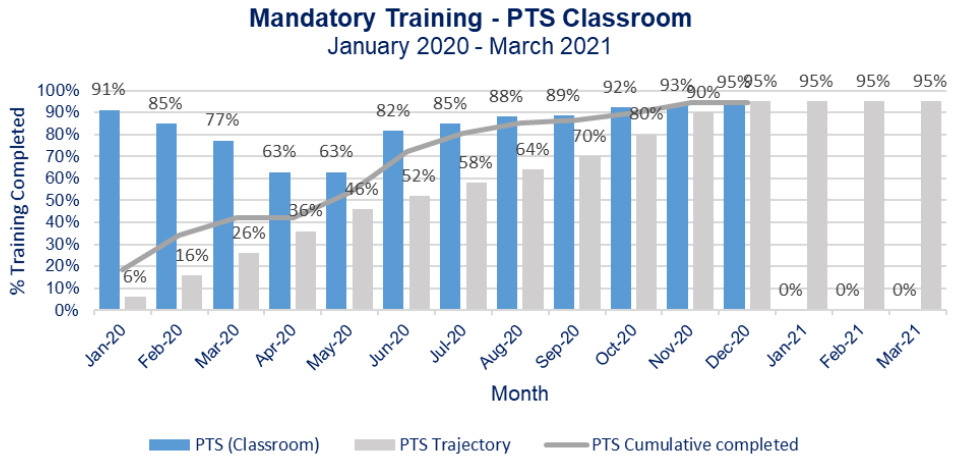


Figure OH7.2



Mandatory Training

Mandatory training for frontline staff was paused in March 2020. Classroom training for PTS resumed in May 2020 with reduced capacity. EOC and 111 resumed online training in June 2020. PES mandatory training resumed in August but finished in October 2020 2 weeks ahead of the scheduled plan (November) due to operational pressures.

The training cycle has been extended from January 2021 to March 2021 as part of the recovery actions. Classroom training for PTS is on track against the revised trajectory however PES is currently behind trajectory with a further delay to resumption now planned for February 2020.

A review of the mandatory training target and recovery plans are currently being considered.

The Trust moved to competence-based reporting for mandatory training which combines classroom and online module completion. The overall Trust mandatory training compliance position at the end of December is 80% against a 95% compliance target and has maintained a stable position for the last 3 months

BAF Risk: SR04, SR11

Figure OH7.3

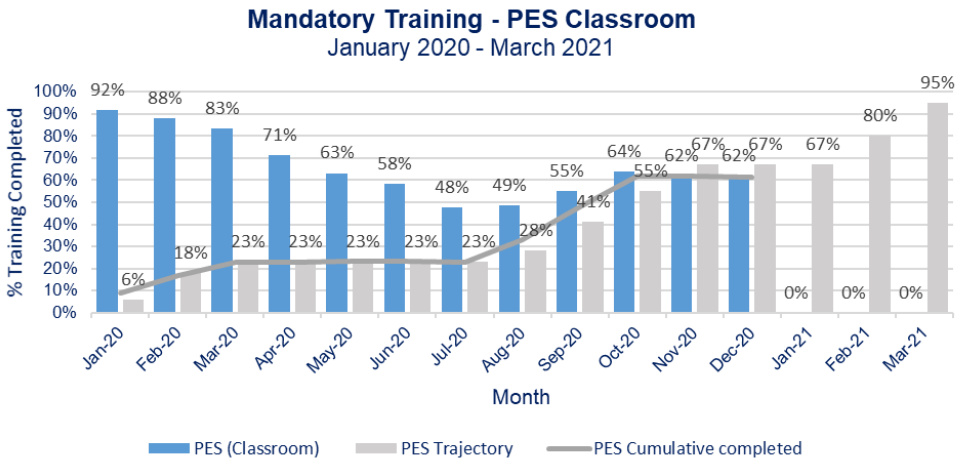


Figure OH7.4

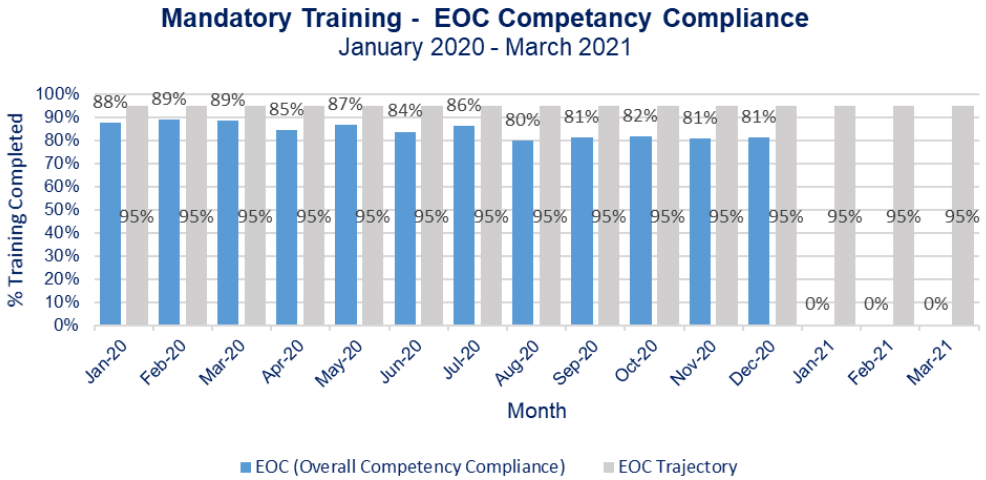


Figure OH7.5

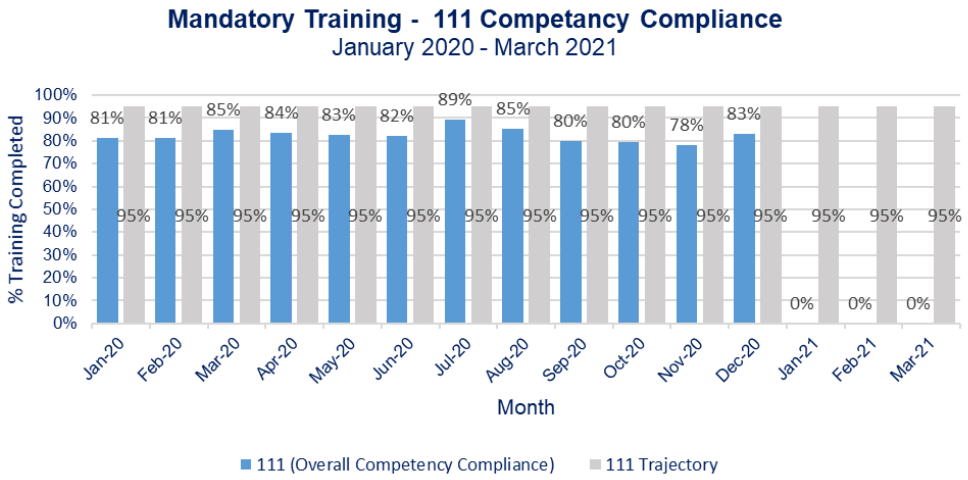
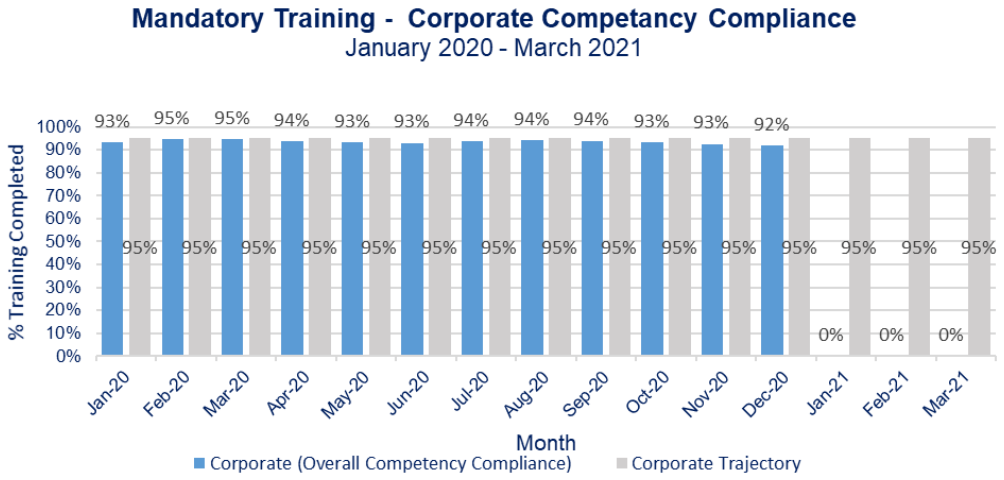


Figure OH7.6



COVID 19

Figure CV19.1 - Number of Staff tested positive and new isolators by week

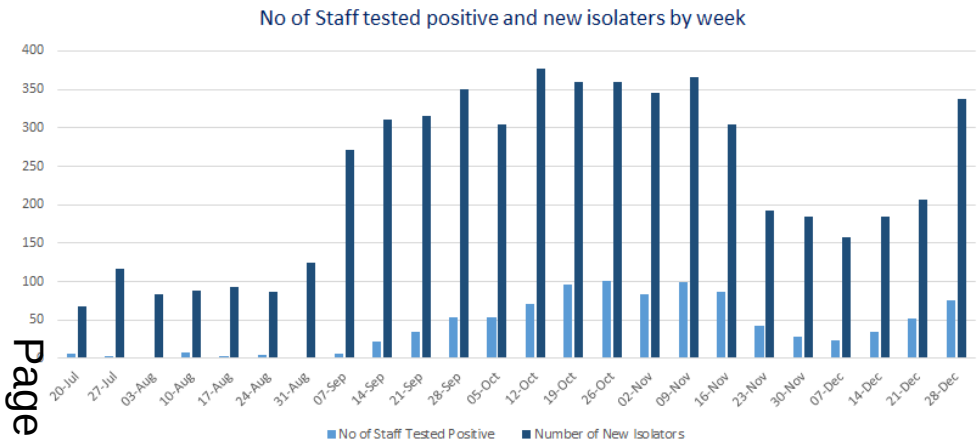
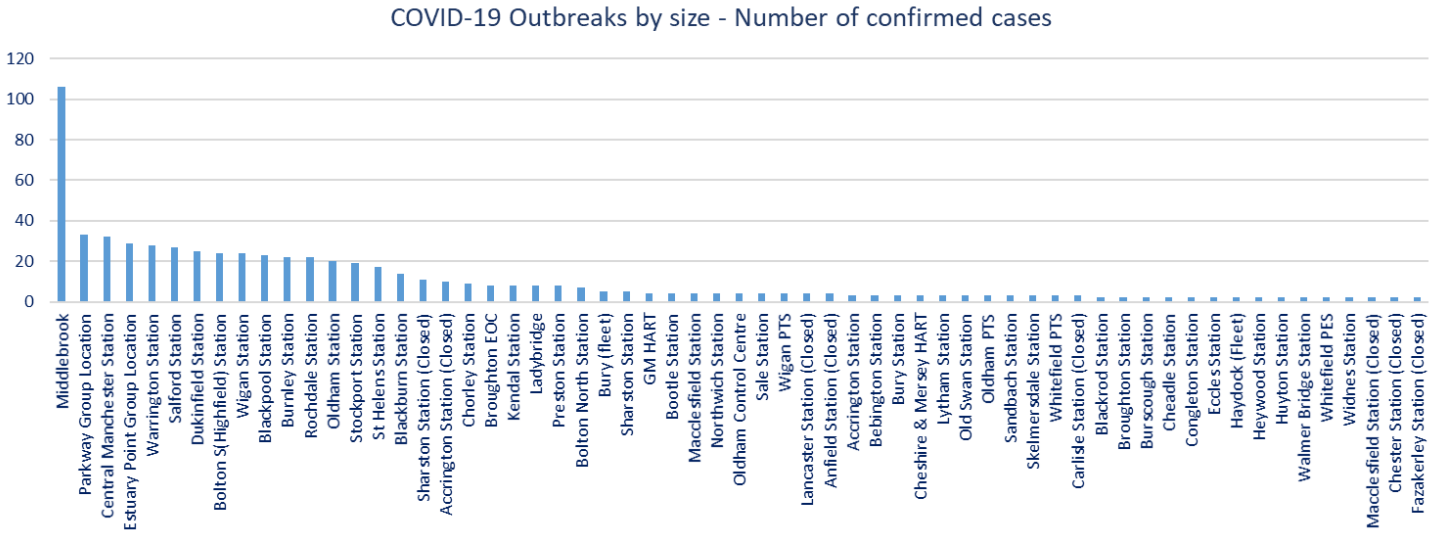


Figure CV19.2 - Outbreaks by size (number of confirmed cases)



COVID-19

There have been 165 instances of staff that have tested positive for Covid-19 in October 2020 with 948 instances since July 2020.

There have been 61 outbreaks on trust sites from July until the end of December. The largest outbreak has been at Middlebrook where the call centre for 111 is based. The largest 5 outbreak sites account for 24% of confirmed COVID-19 cases.

In December there were 27 new outbreaks and 22 outbreaks closed.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27th January 2021
Subject:	Infection Prevention and Control Board Assurance Framework- Update
Presented by:	M Power, Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	NWAS IPC Board Assurance Framework (BAF) provides assurance that policies, procedures, system, processes and training are in place to minimise the risk of COVID – 19 transmissions to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. The Framework is organised under 10 Key lines of enquiry, each with a series of questions which need to be addressed. The full IPC BAF and the accompanying action plan and risk log was approved by the Trust in September 2020. The action plan, includes cross cutting actions for the whole trust and is monitored by the IPC team and reported via the IPC Forum and SMG. Since September the IPC action plan has been reviewed at the following: 1. IPC Forum (9th November 2020/ 11th January 2021) 2. Safety Management Group (11th January 2021) 3. RPE Steering group (relevant parts) (16th November 2020) 4. Quality and Performance Committee (18th January 2021) On presentation of the IPC BAF to Trust Board in September 2020 it was agreed that the IPC actions and risks should be presented quarterly to the Executive Leadership Committee (ELC) who provide assurance to the Quality and Performance Committee and Board. This report provides the Trust Board with a brief update on achievements and risks against the 10 KLOEs for the reporting period October – December 2020. Also included in this report is the NHSI/E 10 key actions for boards (November 2020) which asked organisations to consider additional questions related to the management of COVID-19. Of these five are relevant to the ambulance sector.

Recommendations, decisions or actions sought:	The purpose of this report is to: 1. Update the Board of Directors on published revisions of the framework. 2. Provide the Board of Directors with an updated position on the outstanding IPC risks and actions from the original IPC BAF and the revised board guidance.

Link to Strategic Goals:	**Right Care**	☒		**Right Time**	☒
	Right Place	☒		**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**NA**	
Previously Submitted to:	Quality and Performance Committee	Executive Leadership Committee
Date:	18th January 2021	13th January 2021
Outcome:	Approved	Approved

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1. PURPOSE

To present to the Board of Directors an update on the Infection Prevention and Control Board Assurance Framework developed by NHSE/I to support providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance. The framework is used to identify any gaps in assurance risks and show the corrective actions taken in response.

2. BACKGROUND

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff. Where it is not possible to eliminate risk, organisations must assess and mitigate risk, and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

The IPC Board Assurance Framework document includes 10 key questions (KLOEs) for NWAS to consider providing assurance and identifying any areas of risk.

IPC BAF Questions
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7. Provide or secure adequate isolation facilities
8. Secure adequate access to laboratory support as appropriate
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

For each KLOE there is a requirement to provide evidence, identify any gaps in assurance and provide a high level overview of mitigating actions. This report

provides an update (Appendix 1) against the achievements made and risk status against the initial 10 KLOEs.

Whilst using this framework is not compulsory; it is recognised by our regulators as a reliable source of assurance. The framework can be used to provide evidence, assess measures taken in line with the current guidance, and as an improvement tool to optimise actions and interventions. In order to support the Framework evidence, risk and action logs have been developed.

The framework was previously presented and approved by the Trust Board on the 30th September 2020. In October 2020 NHSE/I published a revised version of the framework. This has been reviewed and the additional KLOEs have been incorporated in the IPC BAF. In addition to this further inclusions have been added following our CQC compliance self-assessment submission and a series of peer review visits by NHSE/I in November 2020. These have been cross referenced with the Covid Risk Register and an evidence log completed. An update inclusive of these additions will be provided when the next IPC BAF quarter position is reported.

The IPC BAF COVID-19 risk register has been reviewed and updated, 21 of the original COVID-19 identified risks have been closed and 30 remain. These have been updated to reflect the current scoring of the risk. Whilst the majority of the risks have reduced or remained the same four of these have increased. These risks are all associated with the increased risk to staff resources due to self-isolation across the Trust and potential outbreaks.

The IPC BAF has been reviewed, evidenced and updated regularly. This report was approved at the ELC on 13th January 2021 and at the Quality and Performance Committee on the 18th January 2021.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

3.1 The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. The framework has been structured around the existing 10 criteria set out in Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

3.2 The Health and Safety at Work Act 1974 places wide-ranging duties on NWAS, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others and to co-operate with employers to ensure compliance with health and safety requirements.

3.3

The management of the IPC Board Assurance Framework and action plan is the responsibility of the Director of Infection Prevention and Control (DIPC) and monitored through the following groups and committees:

- Infection Prevention and Control Forum Bi- monthly
- Safety Management Group Bi- monthly
- Quality and Performance Committee Bi- annually

4. RECOMMENDATIONS

4.1 The purpose of this report is to:

1. Update Board of Directors on published revisions of the framework.

2. Provide the Board of Directors with an updated position on the outstanding IPC risks and actions from the original IPC BAF and the revised board guidance.

Appendix 1.

IPC BAF KLOE	Questions	Risks Q3 (12 or above)	BRAGG
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users	8	3326 - Workforce resources (15) 2716 - Insufficient IPC audits and support – (12)	
KLOE 1: Q3 Achievements • IPC guidance re-issued for adherence to national guidance, social distancing and the use of facemasks, introduction of new 'Working Safely' guidance and outbreak management of covid19 at NWAS sites. • 126 IPC Tier 3 audits conducted at call centres and stations between September and December 2020. • 2.0 WTE IPC practitioners appointed to fill vacancies (previously clinical safety practitioners) • 2.0 WTE IPC specialist practitioners (agency) appointed (FT until March 2021) • IPC Training Programme introduced for IPC Practitioners • External assurance peer review visits conducted by NW regional IPC specialists • Risk assessment process standardised and fully implemented in all stations, offices and control centres • Risk assessments reviewed after any outbreak and every 90 days.			
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	14	3298 - delays in complaint handling (12) 2715 - Non-adherence to IPC Practices (12)	
KLOE 2: Q3 Achievements • Review of Covid-19 secure risk assessments on each NWAS site • Additional cleaning facilities introduced on site at 16 emergency departments/sites. Rollout to further sites continues with 2 further sites identified for February. • Continued review of cleaning to support outbreak management • Competed review of organisational cleaning allocations • Review of PPE storage by H&S team • Safety Check points reviewed and hands free thermal imaging installed at Estuary Point and Middlebrook • Audit schedule revised and implemented			
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	2	No risks identified	
KLOE 3: Q3 Achievements • N/A			
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with	4	2715 - non-adherence to IPC practice (12)	

providing further support or nursing/medical care in a timely fashion			
KLOE 4: Q3 Achievements • Hospital handover guidance for staff with new action cards developed • Liaison with hospitals on delays • Robust IRF process in place with regular monitoring • Updated national guidance disseminated to staff • Reviewed training materials for staff and volunteers • Fit testing Train the Trainer programme implemented			
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	8	2715 non-adherence to IPC practice (12)	
KLOE 5: Q3 Achievements • TTT service fully operational • Working Safely document for staff introduced – screens and barriers fitted • Social distancing in vehicles aligned with new PTS guidance • All patients provided with appropriate masks			
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	11	3315 - pause of mandatory training (16) 3243 - lack of social distancing (12) 2716 - lack of audits and IPC support (12) 3326 - Workforce exposure to Covid (15)	
KLOE 6: Q3 Achievements • Updated guidance regularly published on greenroom. Weekly bulletins. • Donning and Doffing videos for staff developed compliance monitored on ESR and monitored via RPE steering group • Lateral Flow Testing introduced for staff • Completion of rollout of fit testing and RPE Hoods • Fit testing policy approved • Uniform guidance issued. Dispersible bags to facilitate home laundering safely made readily available			
7. Provide or secure adequate isolation facilities	3	3326 - workforce exposure to Covid (15)	
KLOE 7: Q3 Achievements • Hospital handover action cards developed			
8. Secure adequate access to laboratory support as appropriate	3	No risks above 12	
KLOE 8: Q3 Achievements • Lateral Flow tests introduced for all staff- 4,900 distributed • Safecheck logging system introduced			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control	4	3315 - Pause of mandatory training (16)	

infections		3243 - lack of social distancing (12) 2716 - lack of audits and IPC support (12)	

KLOE 9: Q3 Achievements

- Updated guidance to reflect new national changes
- Working safely instigated with regular monitoring via IPC cell
- Outbreak management procedure in place
- Introduction of local and strategic outbreak team meetings
- Audits of all high risk areas completed – (Contact centres)
- IPC team supported by 2 additional specialist practitioners (to March 2021)
- Training programme to support IPC Practitioners introduced
- AGP audits undertaken and reported to ELC
- PPE stock levels monitored locally via PPE hubs reported via RPE steering group
- Heavier gauge aprons provided following staff feedback
- Cab stickers produced to support mask wearing in vehicles
- Introduction of barrier screens in high risk areas i.e. contact centres

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	14	3342 - adherence to social distancing (12) 3242- risk to staff health if working safely not followed (12) 3325- risk to workforce due to self-isolation of staff PES (15) 3280 - risk to workforce due to self-isolation of staff 111 (12) 3282- risk to workforce due to self-isolation of staff PTS (9)	

KLOE 10: Q3 Achievements

- Vulnerable staff and shielding staff review of risk assessment
- Alternative duties for staff as appropriate
- Development of Covid-19 vaccination hub progressing expected Jan 21
- Test, track and trace team in place
- Outbreak Management team in place
- Lateral Flow testing now in place.

Additional Questions for Boards
1. Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day – once or twice a day is insufficient.
NWAS follow the national PHE guidance and AACE guidance for ambulance trusts on Covid-19 standard operating procedures. Since the onset of the pandemic this message has been reiterated many times to all service lines and directorates. Information is available as links to all relevant policies and procedures on our NWAS intranet (the Greenroom) where we have a special Covid section where all bulletins and guidance is stored. Posters and stickers have been produced to support this guidance. Clinical staff are trained in decontamination of vehicles in line with policies and procedures. This is supplemented via mandatory training and information bulletins. Acute cleaning is undertaken by crews and teams at hospitals in between patients. Vehicle cleaning is in line with PHE guidance, cleaning all contact areas after each patient, more than the recommended frequency. Enhanced cleaning of all areas following AGP patients is in line with national guidance. Cleaning of premises is undertaken via a managed service contract. Standards have been reviewed, guidance sought from NHSE, in light of Covid and an enhanced regime applied. Contracted cleaning team (JPR) trained in decontamination of premises and vehicles in line with policies and procedures; mandatory training and tool box talks, monitored through standard contract management processes. Vehicle, contact centres and station audits are undertaken by Clinical Safety team (ad hoc and planned). NWAS have gone above the minimum PHE standards for cleaning of vehicles and established dedicated cleaning teams at some main hospital sites. The vehicles are cleaned by cleaning teams whilst crews are handing over the patients. This helps with the turnaround time of vehicles and ensures that the vehicle is cleaned appropriately after each patient. During Covid the deep cleaning of vehicles has been managed well and has been maintained at the set target of every vehicle every six weeks despite pressures within the system. (95.3. % of all vehicles have been cleaned within target during the Covid period). All services have been maintained throughout. Cleaning procedures are in place for crews and for cleaning teams throughout the trust (SOPS) in line with guidance for all vehicles and sites. This includes non-clinical areas, corporate buildings, and contact centres. Modelling was done by Facilities Management in all contact centers. We were able to identify the hours of cleaning required in keeping with the footfall within those areas. As a result some areas have had enhanced cleaning schedules implemented. The modelling we have undertaken has been shared with the national heads of Estates where membership includes all ambulance services across England.
2. Staff maintain social distancing in the workplace, when travelling to work (including avoiding car sharing) and to remind staff to follow public health guidance outside of the workplace.
NWAS follow the national PHE guidance and AACE guidance for ambulance trusts on Working Safely (Covid-19). Significant amount of work has been undertaken to ensure staff adhere to this guidance with an enhanced communications plan, weekly IPC cell meetings and outbreak management meetings at all levels of the organisation to ensure that this message is maintained and procedures are followed. At all NWAS sites, all staff and visitors /bank/agency staff need to report to the main reception at each site, and the Covid-19 safety checkpoint station, where any visitor to the building will be enabled to check their temperature and be informed of IPC measures at that site. The introduction of 'working safely document' required the Trust to introduce Covid19 risk assessments at all sites. The Trust to date has undertaken 100% of all risk assessments and has also audited all 136

	sites. Any actions identified are monitored to completion by Facilities Management and the Head of Service. There have been 134 installations of equipment including barrier screens, working safely signage and safety checkpoints to support the working safely agenda. Any risks identified that require trust wide action are monitored through the Covid Cells, IPC forum and the Safety Management Group. NWAS staff have received many bulletins in relation to specific IPC measures regarding social distancing, mask wearing and working safely. These recently include: CV150 travel between sites, CV149 Mask wearing and social distancing, CV 146 Mask wearing FAQ, CV 134 mask wearing and social distancing. CV 124 IPC control at sites.
3.	Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings.
	NWAS follow the national PHE guidance and AACE guidance for ambulance trusts on Covid-19 standard operating procedures and the working safely guidance. As per current national guidance level 2 PPE is worn for all patient contacts and escalated to level 3 for AGPs. Staff guidance in relation to individual and household isolation in the event of Covid-19 symptoms/ positive results or notification of contact via track and trace is in place to minimise risk of staff to patient and staff to staff transmission. Ambulance sector Working Safely guidance has been implemented with risk assessments undertaken in all areas this includes the provision of PPE where required including surgical face masks in non-clinical settings. These are provided at all entrances and safety checkpoints for staff to use. Donning and Doffing e-learning modules and video have been established as mandatory competency for all patient facing staff. All frontline Paramedic Emergency service clinical staff have been fit tested for FFP3 masks and provided with personal respiratory protective equipment (hoods). Numerous bulletins on PPE and mask wearing have been produced including CV128 Donning and Doffing PPE, CV 139 AACE poster on mask wearing, CV116 fit testing and ffp3.
4.	Patients are not moved until at least two negative test results are obtained, unless clinically justified.
	Not applicable to ambulance services.
5.	Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of reviews is available.
	NWAS submit a daily outbreak data sheet to NHSE/I overseen by the Chief Nurse which includes updates on the number of staff who have tested positive, the number self-isolating and the area in which they work. NWAS are not required to submit any further information. The Board Assurance Framework contains the 11 strategic risks as approved by the Board by Directors; the risks scored 15 and above on the Corporate Risk Register are linked to each relevant BAF risk. Directorate Risk Registers are reviewed at Directorate SMT meetings. The Corporate Risk Register is reviewed at the Executive Leadership Committee on a monthly basis and reported to the Board of Directors on a quarterly basis. Risks aligned to the Board Assurance Framework are reported to Board Assurance Committees, the Audit Committee and Board of Directors. The Board of Directors has had visibility of the Covid-19 risk register and the Strategic COVID-19 risk. There is a separate IPC Covid Board Assurance Framework which has been shared at the Quality and Performance Committee, Executive Leadership Committee and the Trust Board. This IPC BAF includes

evidence logs associated with the key lines of enquiry, a risk log and an action plan. This is to be presented to board twice a year and its associated action plans monitored through the Safety Management Group and Executive leadership Committee.
6. Where bays with high numbers of beds are in use, these must be risk assessed, and where 2m can't be achieved, physical segregation of patients must be considered, and wards are effectively ventilated.
Not applicable to ambulance services.
7. Staff testing: a. Twice weekly lateral flow antigen testing for NHS patient facing staff is implemented. Whilst lateral flow technology is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing. b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control team. Such cases must be appropriately recorded, managed and reported back.
Staff testing has been undertaken by the Trust as part of the management of outbreak procedures. This has predominantly been in relation to the Test, track and trace system that we have established which signposts "at risk" staff for testing. We have also undertaken some asymptomatic testing at a couple of larger outbreak sites. TTT data is formally reported to PHE and NHSE on a daily basis. The new lateral flow antigen testing has been introduced across the Trust. Recent bulletins include CV 153 lateral flow testing, CV 156 Track test and trace, CV 152 Asymptomatic testing.
Patient testing: a. All patients must be tested at emergency admission, whether or not they have symptoms. b. Those with symptoms of COVID-19 must be retested at the point symptoms arise after admission. c. Those that test negative upon admission must have a second test 3 days after admission, and a third test 5-7 days post admission. d. All patients must be tested 48 hours prior to discharge directly to a care home and must only be discharged when their test result is available. Care home patients testing positive can only be discharged to CQC-designated facilities. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them. e. Elective patient testing must happen within 3 days before admission and patients must be asked to self-isolate from the day of the test until the day of admission.
Not applicable to ambulance services.
8. Assure themselves, with commissioners that a trust's infection prevention and control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered.
Not applicable to provider organisations – targeted at Integrated Care Systems.
9. Review system performance and data; offer peer support and take steps to intervene as required.
Not applicable to provider organisations – targeted at Integrated Care Systems.

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27/01/2021			
Subject:	Approval of Complaints, Incidents & Investigations Policy			
Presented by:	Dr Maxine Power			
Purpose of Paper:	For Decision			
Executive Summary:	Whilst a number of procedures exist within the Trust for the management and progression of complaints, incidents, & serious incident investigations, it was identified that there was no overarching policy to ensure consistency in line with national strategy and guidance. This policy aims to provide assurance that all of the current Trust procedures are following this guidance and that the Trust is adhering to the NHS Complaints legislation and Parliamentary & Health Service Ombudsman guidance on Investigation best practice.			
Recommendations, decisions or actions sought:	The Board is recommended to support the approval of the Complaints, Incidents & Investigations Policy for use.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	**Q&P Committee**
Date:	**18/01/2021**
Outcome:	**Approved**

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North West Ambulance Service NHS Trust

Complaints, Incidents and Investigation Policy

North West Ambulance Service NHS Trust

Recommended by	Executive Leadership Committee
Approved by	
Approval date	
Version number	5.0
Review date	October 2022
Responsible Director	Executive Director of Quality, Innovation and Improvement
Responsible Manager (Sponsor)	Patient Safety Specialist
For use by	All Staff

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change record form

North West Ambulance Service NHS Trust

Version	Date of change	Date of release	Changed by	Reason for change
x 1.0	18th August 2014		F Buckley	Document created
x 1.0	August 2014		F Buckley	Presented to Health and Safety Management Group for consultation
X2.0	June 2017		F Buckley	Policy reviewed, incident reporting removed and incorporated into procedure
X2.0	July 2017		F Buckley	Presented to Health and Safety Management Group for consultation
X2.0	October 2017		F Buckley	Approved by Health and Safety Management Group.
X2.0	November 2017		F Buckley	Sent to Quality Committee for approval
X3.0	March 2018		J Walsh	Revised to coincide complaint procedure and investigation 'good practice guide'
X4.0	May 2019		J Walsh	Minor amends completed. Approved by Director of Quality, Innovation and Improvement
X5.0	June 2020		J Walsh	Reviewed and minor amendments made ahead of approval by ELC
X5.0	11th June 2020		J Walsh	Approved by Quality SMT
X5.0	July 2020		G Drummond	Reviewed and amended
5.0	November 2020	November 2020	G Drummond A Hansen	Reviewed and amended for approval at ELC

CONTENTS

1. Introduction

1.1 This policy describes the overarching principles enacted through the following procedures;

- Serious Incident Procedure
- Complaints and External Incident Procedure
- Duty of Candour Procedure
- Redress Policy

1.2 Underpinning this policy and associated procedures is the Investigation 'good practice guide' (Part 1 and Part 2). The 'good practice guide' provides practical advice for investigators and highlights the principles of good investigation.

2. Purpose & Scope

2.1 The purpose of this policy is to highlight the roles and responsibilities of all staff in adopting the collective policies and procedures that underpin good incident management and investigative practice.

Implementation of this policy and the associated procedures will ensure fair, open, proportionate and timely incident and investigation management.

2.2 This policy applies to all employees conducting or contributing to investigations.

2.3 Adherence to this policy will help patients and/or carers and staff to feel confident in the Trust's investigative processes. The provision of information will also help professionals feel supported.

3. Policy Statement

3.1 This policy meets the requirements of:

- The Health and Social Care Act 2010
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (hereafter referred to as the Regulations)

- The NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Services.
- The Care Quality Commission: Essential Standards of Quality and Safety 2010
- The Care Quality Commission: Regulation 16: Receiving and acting on complaints
- The Parliamentary and Health Service Ombudsman: Principles of good complaint handling, 2009
- The Department of Health: Listening, Responding and Improving, 2009
- The Patient Safety Agency Safer Practice Notice 10: Being open when patients are harmed, 2009.
- Current data protection legislation

- The Information Governance Alliance Records Management Code of Practice for Health and Social Care 2016
- The Serious Incident Framework 2015

4. Aims and Objectives

- To ensure that investigations are fair and transparent, identifying contributory factors together with systemic and individual learning.
- To ensure the trust complies with current legislation and national guidelines.
- To ensure proportionate and timely investigations are undertaken by staff who possess the requisite skills and competence in undertaking robust and proportionate investigations.
- To identify themes and trends from investigations and any areas of risk leading to effective risk management plans.
- To ensure that employees who are involved incident investigation have the right level of knowledge, skills and experience.
- To Identify and share learning both within and outside the organisation as needed.

5. Roles and Responsibilities of Key Personnel

5.1 Board of Directors

The Board of Directors has the overall responsibility to ensure that investigations are conducted to the standards identified in this policy and associated procedures.

The Board monitors and reviews:

- Reportable events (defined as serious incidents, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents, Information Commissioner's Office (ICO) reportable incidents, serious case reviews, domestic homicide reviews, safeguarding adult reviews, contentious coroner's cases, Parliamentary and Health Service Ombudsman (PHSO) findings disciplinary dismissals, and employment tribunals.
- The quality and timeliness of investigations.
- The implementation of learning from incidents.

5.2 Chief Executive

NHS chief executives are responsible for clinical standards in their organisations with the duty of quality set out in the Health and Social Care Act 2010. This responsibility includes learning from when things go wrong. The Chief Executive has overall statutory responsibility for having robust and effective investigation processes in place within the trust and for meeting all statutory internal and external reporting requirements. The Chief Executive is accountable for the proper and effective management of risk within the Trust and is responsible for ensuring the safety of patients, visitors and staff.

The Chief Executive's responsibilities include ensuring that:

- There are robust systems in place to identify trends and themes from investigations.
- Patients, staff and visitors are safe.
- There are robust systems in place to share learning across the organisation and between organisations.

The Complaints Regulations section 4.4 state that the 'Responsible Person' in the case of an NHS authority should be the Chief Executive, section 14.2 states that a response should be sent to the complainant signed by the 'Responsible Person'.

5.3 Director of Quality, Innovation and Improvement

It is the responsibility of the Director of Quality, Innovation and Improvement to:

- Assume ownership of this policy on behalf of the Chief Executive
- Ensure that any changes in legislation or national guidance relating to this policy are made known to the Executive Leadership Committee (ELC) and the Board of Directors via the Quality and Performance Committee
- Promote a Just Culture within the organisation.
- Ensure fair and proportionate investigations are undertaken and all possible learning is identified and effectively communicated with healthcare partners / commissioners / patients and their representatives.
- Ensure that policies, lines of accountability and procedures are monitored and reviewed on a regular basis.

5.4 Executive Directors

It is the responsibility of the Executive Directors to;

- Promote a Just Culture within the organisation

- To ensure that all incidents, involving their directorate staff are investigated in line with this policy and associated procedures.

- To receive and approve Serious Incident investigations pertaining to their area of responsibility through arranged serious incident panels / systems of approval as and when required.

- To monitor all investigations ensuring that any recommendations regarding corrective actions and learning are effectively implemented.

- Ensure that sufficient resources are available to support the implementation of this policy and associated procedures.

5.5 Medical Director

It is the responsibility of the Medical Director to:

- Promote a Just Culture within the organisation.

- Chair and oversee the weekly Review of Serious Events meeting.

- Oversee Serious Incident reports and investigations.

- Ensure fair and proportionate investigations are undertaken and all possible learning is identified.

- Provide senior clinical (specialist) advice for the purposes of investigations as and when required.

- Provide executive level approval of Serious Incident Investigation reports.

- Act in the role of Caldicott guardian, to protect the confidentiality of the health and care information of those involved in investigation.

5.6 Patient Safety Specialist

It is the responsibility of the Patient Safety Specialist to:

- Promote a Just Culture within the organisation.

- Oversee serious incident reports and investigations

- Ensure fair and proportionate investigations are undertaken and all possible learning is identified
- Provide executive level approval of Serious Incident Investigation reports.
- Provide professional advice and guidance to all levels of management with regard to investigations and ensure that suitable learning outcomes are reached.
- Oversee complex investigations and ensure the findings are reported to the appropriate Quality and Performance Committee

5.7 Quality Directorate Senior Management Team

It is the responsibility of the Quality Directorate Senior Management Team (SMT) to:

- Promote a Just Culture within the organisation.
- To support the implementation of this policy across the trust.
- To enable and support fair and proportionate investigations.
- Receive thematic incident reports and make recommendations to improve patient care and support staff in delivery of care or execution of the duties.
- Inform when necessary the relevant Head of /Data Protection Officer of incidents that may require external reporting (e.g. MHRA / NPSA / StEIS /Coroner /ICO)

5.8 Head of Clinical Safety

It is the responsibility of the Head of Clinical Safety to:

- Promote a Just Culture within the organisation.
- Contribute to compiling, reviewing and ensuring implementation of this policy.
- Provide professional advice and guidance to all levels of management in relation to investigations and continuous learning from investigations.
- Administer the learning process.
- Advise the Board of Directors, Executive Leadership Committee and Managers on all matters relating to incidents and investigation processes.

5.9 Senior Patient Safety Manager.

It is the responsibility of the Senior Patient Safety Manager to:

- Promote a Just Culture within the organisation
- Comply with all local and national statutory requirements, regulations, codes of practice and guidance.
- Collaborate with the Education, Learning and Development team; assist with the design, facilitation and evaluation of learning programmes for investigation training.
- Complete specialist investigations where necessary and ensure that learning is identified and effectively monitored.
- Oversee the monitoring and revision of investigation policies, procedures, good practice guides and learning requirements.
- Ensure that relevant risks are highlighted onto the appropriate risk registers, as necessary.
- Oversee written responses resulting from investigative processes and approve where appropriate.
- Deliver investigation training in accordance with this policy and best practice.
- Apply the principles of the investigations good practice guide.

5.10 Patient Safety Managers.

It is the responsibility of the Patient Safety Managers to;

- Promote a Just Culture within the organisation.
- Provide specialist advice and support to managers who are completing investigations.
- Ensure that relevant risks are escalated and highlighted onto the appropriate risk registers, as necessary.
- Ensure compliance with all local and national statutory requirements, regulations, and good practice.
- Be the primary point of contact for the Parliamentary Health Service Ombudsman, when necessary

- Collaborate with the Education, Learning and Development Team; assist with the design, facilitation and evaluation of learning programmes for investigation training.

- Complete specialist investigations where necessary and ensuring that learning is identified and effectively monitored.

- Oversee and approve complaint responses.

- Conduct regular investigation audits and monitor compliance with policy and procedures and the investigation 'good practice guide'.

- Be responsible for ensuring statutory information returns, locally and nationally in line with areas of responsibility.

- Apply the principles of the investigations good practice guide.

5.11 Health, Safety and Security Manager.

It is the responsibility of the Health, Safety and Security Manager to:

- Promote a Just Culture within the organisation.

- Monitor all Health, Safety and Security incidents, their investigations, learning outcomes and recommendations

- Provide specialist health, safety and security advice and assistance with management investigations including, where appropriate complex investigations and the provision of specialist advice to managers.

- Ensure that relevant health, safety and security risks are highlighted onto the appropriate risk registers.

- Apply the principles of the investigations good practice guide.

- Report, where appropriate incidents to the Health and Safety Executive (HSE).

5.12 Health, Safety and Security Practitioner (s).

It is the responsibility of the Health, Safety and Security Practitioners to:

- Promote a Just Culture within the organisation.

- Monitor all Health, Safety and Security incidents, their investigations, learning outcomes and recommendations.
- Provide where required specialist advice and support to managers in relation to investigations involving health, safety and security concerns.
- Report Health, Safety and Security themes from incidents in line with legislative requirements.
- Report, where appropriate incidents to the Health and Safety Executive (HSE).
- Apply the principles of the investigation good practice guide.

5.13 Senior Clinical Quality Manager

It is the responsibility of the Senior Clinical Quality Manager to;

- Promote a Just Culture within the organisation.
- Monitor all medicine management incidents, their investigations, learning outcomes and recommendations.
- Provide where required specialist clinical advice and support to managers in relation to investigations.
- Report medicine management incidents and investigations and to identify learning outcomes for recommendation to the Clinical Governance Management Group.
- Apply the principles of the investigation good practice guide.

5.14 Information Governance Manager.

It is the responsibility of the Information Governance Manager to:

- Promote a Just Culture within the organisation
- Monitor all data breaches, their investigations, learning outcomes and recommendations.
- Provide where required specialist information governance advice and support to managers in relation to investigations.
- Report data breaches and investigations and to identify learning outcomes for recommendation to the Information Management Group.
- Apply the principles of the investigation good practice guide.

5.15 Clinical Safety Team, Patient Safety Team, 111 Clinical Governance Team and Information Governance Team.

It is the responsibility of these teams to:

- Comply with all statutory requirements, regulations, codes of practice and ensure that concerns guidance is implemented in line with Trust policy
- Provide (where required) specialist advice and support to managers in relation to investigations.
- Report themes from clinical incidents/complaints and investigation outcomes to the Clinical Effectiveness Management Group.
- Report themes from non-clinical incidents and investigation outcomes to the Safety Management Group.
- Support and work with local managers and staff to implement, local, trust wide and national learning.
- Monitor and co-ordinate the investigation of incidents/complaints.
- Co-ordinate incident investigations.
- Investigate incidents/complaints.
- Liaise with external stakeholders including patients and their carers/relatives.
- Assist in the delivery of investigation training.
- Prepare investigation reports and responses to external stakeholders
- Apply the principles of the investigation good practice guide
- Liaise with the Trusts Legal Team when a complaint is also the subject of a coroner's inquest or claim.

5.16 Legal Team.

It is the responsibility of the Legal Team to:

- Provide expert advice on investigations that have associated claims and/or coronial/police involvement.

- Support managers and staff involved in investigation which have associated claims and/or coronial/police involvement.

5.17 Health & Safety Representatives

In accordance with the Safety Representatives and Safety Committee Regulations (SRSC) 1977 and the Health & Safety (Consultation with Employees) Regulations 1996, a recognised Health & Safety Representative will be notified of a major injury incident.

Where appropriate they may be included as a specialist advisor for an investigation.

It is also recognised that Health & Safety Representatives have a right to investigate incidents, however wherever possible the trust will seek to conduct a joint investigation into an incident with the agreement of the staff member.

5.18 Data Protection Officer

In accordance with the current data protection legislation the Trust's appointed Data Protection Officer will be involved in all matters relating to data protection in a timely manner; this includes notification of data breaches.

It is also recognised that the Data Protection Officer acts independently and is able to offer advice to the Trust. Wherever possible the trust will seek to conduct a joint investigation into an incident with the agreement of the staff member.

5.19 Head of Communications

Is responsible for ensuring the handling of any media enquiries and to advise the Trust on public and stakeholder communications to support the application of this policy and associated procedures.

5.20 Freedom 2 Speak Up Guardian

The Freedom 2 Speak Up Guardian is responsible for promoting a culture where staff feel able to speak up on patient and staff safety issues without fear of suffering detriment.

5.21 All Managers.

It is the responsibility of all managers providing supervision and undertaking investigation to:

- Promote a Just Culture within the organisation.

- Ensure that fair and proportionate investigations are completed and where necessary immediate remedial action is taken to address identified risks.

- Ensure this policy and associated procedures are implemented within their area of responsibility as a manager.

- Ensure that all staff and visitors, within their area of responsibility, are familiar with this policy.

- Participate fully with the investigation of all incidents/complaints in a timely manner.

- Ensure that any Incident Report Forms (IRF) are inputted into the risk management system, Datix within 48 hours of the incident occurring and afforded an accurate risk score within the defined timeline.

- Provide feedback to their staff on the progress of an investigation. Where low risk incidents are being used for trend analysis only, the staff member should also be made aware of the incident.

- Provide assurance to their management team on the progression and quality of incident investigations.

When investigating to:

- Risk score all incidents as soon as practicable (preferably within 24 hours) using the approved Trust risk matrix

- Apply the principles of the investigation good practice guide

- Review Incident Report Forms and take any appropriate remedial action recording all actions on Datix.

5.22 All Employees, students, volunteers and third party providers:

It is the responsibility of all employees, volunteers and third party providers to:

- Co-operate in any investigation.

- Report adverse incidents promptly and in line with the Trust's reporting processes

- Implement learning that has been approved and agreed and feedback or participate in the review of efficacy of any changes implemented following investigations.

- Know what actions to take on receipt of any concern.

- Adopt the values of the organisation when interacting with patients, representatives, members of the public and other professionals.

6. Role of supporting forums/groups/meetings.

6.1 Clinical Effectiveness Management Group, Safety Management Group, and Information Management Group.

These groups will monitor themes and trends arising from clinical and non-clinical incidents and complaints. The group will provide assurance to the Board, through the Quality and Performance Committee that the procedures associated with this policy and the Learning from Experience Policy is working effectively.

6.2 Review of Serious Events (ROSE) Group

The ROSE Group meets weekly and is responsible for reviewing all high-risk incidents and complaints. They are the decision making panel for reporting incidents on the Strategic Executive Information System (StEIS).

When the ROSE group declare an incident is reportable they will undertake the following actions;

- Assure allocation of an appropriate investigator
- Assure allocation of an appropriate Duty of Candour lead
- From the information presented as ROSE, highlight specific items for the investigation Terms of Reference

6.3 Learning Forums

Learning Forums will receive, review, synthesise and share the learning identified from investigations. The forums will make recommendations for inclusion of identified risks onto the appropriate risk register(s) and make recommendations for wider organisational learning.

7. Risk Identification

7.1 A thematic analysis of incidents, external incidents, complaints and claims may also initiate an investigation. Risk registers will be updated accordingly.

7.2 Risk mitigation actions will be implemented, to ensure that these risks are managed.

8. Recommendations following investigations

8.1 During the investigation process, all associated documents and communication are attached to the investigation record in Datix. Local actions to prevent or reduce the risk of recurrence should be undertaken immediately or as soon as reasonably practicable. Confirmation any actions are documented within the Datix record.

8.2 Please refer to the Learning from Experience Policy for further guidance on the implementation of recommendations and completion of actions.

9. Serious Incidents

9.1 Risk scoring an incident or complaint 4 or 5, ensures that the incident/complaint will be discussed at the weekly, Review of Serious Events (ROSE) meeting, which is chaired by the Medical Director or Chief Paramedic. All incidents that are agreed by the ROSE panel to meet the threshold in the Serious Incident Framework are reported on the Strategic Executive Information System (StEIS) database.

9.2 For further information see the Investigation 'good practice guide' and Serious Incident Procedure or contact the Patient Safety Team at serious.incident@nwas.nhs.uk.

10. Confidentiality

Confidentiality is paramount during the investigative process unless there are professional or statutory obligations that make it imperative that information is shared i.e. for safeguarding purposes, for example.

11.1 Complaints and External incidents

When a patient takes the positive action to raise a complaint the Trust will access their records to investigate that complaint using implied consent under the Common Law duty of confidentiality. The legal basis for doing so under data protection legislation is recorded in the Trust records of processing held by the Data Protection Officer.

For more information about the handling of complaints and external incidents, please see the Procedure for the management of Complaints and External Incidents.

11.2 Internal incidents

More often than not the Trust is notified of incidents by employees.

The Trust has a duty to undertake open, honest and proportionate investigations when incidents are reported. In these circumstances, the Trust is committed to disclosing investigation findings to those who are able to demonstrate that they have a justifiable interest in the investigation outcome.

11.3 Duty of Candour

When moderate or severe patient harm has occurred the Trust are committed to enacting Duty of Candour. This includes sharing investigation findings with patients, their families and / or representatives. Please refer to Duty of Candour Procedure for more guidance.

12. Externally led Investigations

There are occasions when the investigation will be led and conducted by an external agency, these include;

- Police – where the incident may be as a result of a criminal act
- Health and Safety Executive (HSE) – where the incident is reportable under the RIDDOR Regulations and they commence an investigation into the circumstances of the event
- Healthcare Safety Investigation Branch (HSIB) – when a independent investigation of patient safety concerns in NHS-funded care is required.
- Information Commissioner's Office (ICO) – when an investigation of a potential infringement of the Data Protection Act and regulations is required
- Coroner – making enquiries and / or investigating when the cause of death is unknown.

Other organisations – where the investigation falls under the remit of highly complex or sensitive.

13. Training

13.1 Training is provided to all staff involved in conducting investigations to equip them with the skills necessary to conduct an open, fair and proportionate investigation. Including, implementing Duty of Candour.

13.2 The training provision is based on part 1 and part 2 of the investigation 'good practice guide'.

13.3 A record of who has undertaken the training is held by the Trusts Education, Learning and Development Team.

14. Record Keeping

14.1 All complaint, incident and non-employment investigation records are retained on Datix.

14.2 All such information held on trust systems will be kept in accordance with the current data protection legislation and the Information Governance Alliance Records Management Code of Practice for Health and Social Care 2016 and any other information security arrangements applied within the Trust.

14.3 Individuals and their appointed representatives have the right to see any information held by the Trust relating to them, however appointed representatives must have a signed authority.

Copies of information given to any member of staff, staff representative, patient or patient representative (next of kin or carer) must be clearly marked as such and recorded and retained on trust systems.

15. Communications

15.1 Where an incident is reported, the individual making the report will be provided with feedback on the outcome of the investigation by their line manager; this can be done through the Datix system.

15.2 The results of an investigation will also be notified to the pertinent Business Groups and Learning Forums.

15.3 Where action or learning has identified a change in working practices this will be communicated through Forums and Business Groups to trust employees e.g. revised risk assessments, safety notices, training memos, training, updated policy/procedures, newsletters, intranet, etc.

16 Policy Implementation

This document will be available on the Trust internet and through the Green Room and available in hard copy for members of the public on request.

17. Monitoring and Review

The Trust will ensure that this Policy is reviewed every two years, as a minimum. When reviewing the policy the Trust will consider:

- User feedback on the policy.
- Experiences of staff and managers using the policy.
- Reviewing the quality of learning.

- Any external reviews or audits of the policy.
- Newly published national guidance or evidence considered relevant.

North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Quality and Performance Committee

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	18th January 2021	**Quorate (yes/no):**	Yes
Chair:	Prof A Chambers	**Executive Lead:**	Dr Chris Grant, Medical Director Maxine Power, Director of Quality, Innovation and Improvement Ged Blezard, Director of Operations
Members present:	Prof A Chambers (Chair) Mr R Groome, Non-Executive Director Prof R Thomson, Associate Non-Executive Director Dr D Hanley, Non-Executive Director Dr C Grant, Medical Director Mr G Blezard, Director of Operations Prof M Power, Director of Quality, Innovation and Improvement Ms L Ward, Director of People (for agenda item 172)	**Key Members not present:**	
Board Assurance Risks Aligned to Committee:	**SR01:** If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety. **SR03:** If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care		

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance framework		• Since the previous Committee: – 2 new risks had emerged; (3407) Learning from Deaths may not be embedded across the Trust and (3466) lack of consistent approach to reporting and management of level 1-3 internal and external incidents. – 1 risk already on the Corporate Risk Register had increased in risk score; (3435) Covid-19 related cases and outbreaks continue to rise and business continuity plans need to be enacted. – 2 risks had decreased in risk score but continue to remain on the corporate risk register and feature on the BAF (3236) achievement of ARP performance standards and (3238) high levels of sickness and absenteeism across PES. – 9 risks had decreased in score and de-escalated off the Corporate Risk Register onto Directorate Risk Registers. – 1 risk had been closed off the Corporate Risk Register due to duplication. • In total 24 mitigating actions are identified on the BAF for completion by the end of the financial year 2020/21. • The root and branch review of the service delivery risks would be completed by end of January 2021.	Gained assurance that each BAF risk was managed effectively and noted the continued work to manage the increased risks in Service Delivery.
BAF Risk SR01 & SR03 Integrated Performance Report		• PES Call pick up in 5 seconds was back in control following special concern due to increased activity and increased staff abstractions due to Covid19 in October. • ARP C2, C3 Mean and C2, C3 and C4 90th saw significant increase (with data outside of the control limits) for 1 day	Received moderate assurance from the report. Noted the assurance that actions were in place to improve performance.

	No assurance – could have a significant impact on quality, operational or financial performance;
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Chairs Assurance Report

		on the 27th December due to a significant increase in activity that day. • Covid19 related staff absence started to rise in December which hampered resourcing, despite that the Trust has maintained resourcing just below 400 double crewed ambulance a day. • Average turnaround time shows a significant increase during the weeks in December (with data points above the control limit). Hospital Handover continues to be challenging in a number of sites. 527.8 hours were lost to delayed admissions in December, 2020. • Performance continues to improve within 111. This is aligned to the significant increase in recruitment of Health Advisors and Clinicians to support the 111 First campaign. • The PTS service continued to support PES during Covid-19 pressures.	
BAF Risk SR03: ORH Demand and Capacity Review		• A verbal update on progress relating to work of ORH. • The options and recommendations would be presented to a future Q&P Committee.	Noted the assurance provided.
BAF Risk SR03: Test, Track and Trace		• An update was provided on the work of NWAS TTT service during Q3. • Ongoing monthly reports to be presented to future Q&P Committee meetings during the Covid-19 pandemic. • Developments of the service and lessons learnt continued to be progressed.	Noted the assurance provided.
BAF Risk SR03: IPC BAF Refresh		• An update on the IPC BAF, including the 10 KLOEs, action log and risk log for October to December 2020 was provided.	Noted the assurance provided.

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Chairs Assurance Report

BAF Risk SR03: Medicines Management Q3 Update		• The Q3 position and work undertaken by the Medicines Management was noted and included – providing support to the Covid-19 vaccination programme – transition to new Controlled Drug supplier – development and approval of business case to allow for NWAS to apply for CD licence. – Implementation of a new digital temperature monitoring system to support handling of vaccines. – Bar coding and audit placed on hold due to Covid-19 pressures.	Noted the assurance provided.
BAF Risk SR03: Signposting Update Assurance Report		• A report on the Patient Safety Plan, formerly the Trust's Demand Management Plan (DMP) detailed the revised call triggers in response to the Major Incident. • The signposting process model had been approved by the ELC and involved a clear review of all patients signposted including a follow up by a clinician.	Received assurance from the actions implemented following a review of the Trust's DMP and the Trust's signposting process.
BAF Risk SR01: Workforce Governance Structure		• Received a report proposing establishment of a Diversity and Inclusion Assurance Management Group to strengthen the governance and assurance processes around workforce matters. • The Group would report to the Resources Committee and Q&P Committee to provide focus on patient related matters. • Terms of reference included Deputy Chief Executive Officer as Chair of the Group. • The Group would operate in shadow form for remainder of 2020/21 with reporting throughout 2021/22 and a 12 month evaluation.	Supported the establishment of the Diversity and Inclusion Assurance Management Group.

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Chairs Assurance Report

BAF Risk SR01: Learning from Deaths Q2		• The committee noted the activity and data which highlighted – – two contrasting methodologies used to learn from deaths – the process involved input from clinicians – immediate concerns were flagged to ROSE – future learning themes to be reported to CEMG and Q&P Committee – Structured Judgement Reviews would inform the themes and reported during 2021/22. – Peer reviews took place and recurring themes and learning disseminated through operational teams and shift team leaders	Received moderate assurance. Noted the new risk (3407) and resources available for the Learning from Deaths process due to current pressures. Noted future reports to Q&P Committee.
BAF Risk SR01: Clinical Audit Report Q3 (including AQI data)		• A Q3 update on AQIs and clinical outcomes was received and noted – • Following a deep dive, the Trust had maintained a target service to MI patients. • The increase in PPE time, due to Covid-19, had increased the on scene times across the service and recognised that formalised support was required for AGP audit and EOC live call backs. • Further formal support required for staff who repeatedly failed to wear PPE. • Supported the proposal to establish a clinical audit and improvement forum. • Quality Improvement Plans would be implemented over the next 6 months.	Received moderate assurance due to the impact of Covid-19 and PPE demands across the service.
BAF Risk SR01: Complaints, Incidents and Investigations Policy		• The committee received the Complaints, Incidents and Investigations Policy which aimed to provide overarching assurance and ensure consistency in line with national strategy and guidance.	Supported approval by the Board of the Complaints, Incidents and Investigations Policy.

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Chairs Assurance Report

		• Noted future reports to the Q&P Committee on developments of trust wide strategies.	
BAF Risk SR01: Chairs Assurance Report form the Clinical Effectiveness Management Group (CEMG) held on 12th January 2021		• The highlights from the latest CEMG meeting reported moderate assurance in relation to ineffective breathing and Task and Finish Group recommendations that had been delayed. • Safeguarding training and audit plan had both been suspended and delays caused by Covid-19 pressures. • NHS 11 First service had He highlighted there had been positive assurances in relation to NHS 111 and an increase in staff including a Consultant Paramedic appointed to the service.	Received moderate assurance.
BAF Risk SR01: Chairs Assurance Report from the Safety Management Group (SMG) held on 12th January 2021.		• The highlights from the latest SMG meeting reported compliance against the IPC BAF. • The green waste report to be reported in 2021/22. • The Health and Safety Review had progressed and an interim report had been produced. • The patient story highlighted the continued risk of Hospital Handover delays. • The work of the suicide prevention group was ongoing, but not at the same pace, due to resources currently devoted to operational pressures.	Received moderate assurance.
BAF Risk SR01: Chairs Assurance Report from the Non Clinical Learning Forum held on 9th November 2020.		• The highlights from the latest NCLF meeting reported a delay in updated learning trackers and this was being addressed by the forum. • A case study on a frequent caller and actions implemented from lessons learnt. • Continuation of the lessons Learnt Newsletters.	Noted the assurance provided.

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Chairs Assurance Report

Name of Committee/Group:	Resources Committee	**Report to:**	Board of Directors
Date of Meeting:	22.1.21	**Quorate (yes/no):**	Yes
Chair:	Mr M O'Connor	**Executive Lead:**	Carolyn Wood, Director of Finance Lisa Ward, Director of People Prof M Power, Director of Quality, Innovation and Improvement
Members present:	Mr M O'Connor, Non-Executive Director (Chair) Mr R Groome, Non-Executive Director Mr D Rawsthorn, Non-Executive Director Ms C Wood, Director of Finance Ms L Ward, Interim Director of Organisational Development Mr S Desai, Director of Strategy and Planning Prof M Power, Director of Quality, Innovation and Improvement (part)	**Key Members not present:**	Mr G Blezard, Director of Operations Mr M Forrest, Deputy CEO
Board Assurance Risks Aligned to Committee:	**SR02:** If the Trust does not maintain efficient financial control systems then financial performance will not be sustained and efficiencies will not be achieved leading to failure to achieve its strategic objective. **SR04:** If the Workforce Strategy is not delivered, then the Trust may not have sufficient skilled, committed and engaged staff and leaders to deliver its strategic objectives. **SR05:** If the Trust does not deliver the benefits of the Estates Strategy then the Trust will not maximise its estate to support operational performance leading to failure to create efficiencies and achieves its strategic objectives. **SR07:** If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity. **SR08:** If the Trust does not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the Trusts' ability to complete and gain business and commercial opportunities that will generate income and protect our core services.		

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Chairs Assurance Report

Key Agenda Items		Key Points	Action/Decision
Board Assurance Framework		• 1 new risk had emerged 3431 – Draft planned financial deficit is not achieved. • 0 risks had increased in score. • 5 risks had decreased in current risk score 3338 - Heavy use of agency staff in EOC/NHS 111 3360 – Improvement programmes 20/21 not being fully mobilised due to resourcing constraints 3374 - Implementing internal NWAS Test, Track and Trace Service due to resourcing constraints 3379 - Absence of a professional lead for midwifery 3393 - Absence of senior operational leads due to the Manchester Arena Inquiry • 1 risk had been closed 3397 - Absence of a Patient Safety Specialist	• Noted and received assurance form the report.
BAF RISK SR02: Financial Performance Month 09 2020/21		• The financial position for the year to 31st December 2020 reported a deficit of £0.540m, which is £0.226m better than the planned deficit of £0.766m. Income is over recovered by £16.581m, pay is overspent by £8.537m and non-pay is overspent by £7.817m. • The financial plans for the period October 2020 to March 2021 (H2) were submitted to NHSE/I on the 18th of November. Income is planned at £206m, with the expenditure plan projected at £210.0m resulting in a deficit of £4.0m for the period. • Noted that the latest forecast outturn position is a deficit of £2.3m which is an improvement of £1.7m compared to the H2 plan of £4.0m deficit. This is due to additional system growth funding of £1.3m being allocated to the Trust from the ICS and a £0.4m reduction in the Trust's forecast expenditure position for the year.	• Noted the Month 09 2020/21 reported financial position.

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		• The deficit of £2.3m is due to the projected shortfall against the recovery of the non-NHS income of £1.8m and an assumption in the plans of £0.5m in relation to the impact of outstanding annual leave. Further guidance is awaited in relation to the two items.	
BAF Risk SR02: Procurement Report		• Received progress of the Trust's Procurement Strategy. • Noted that work is actively progressing and included the current status of the 103 projects on the 2020/21 procurement work plan. • The project priorities were outlined and recent audit of the tenders and waivers process completed with an appraisal of the waivers process to be reported to Resources Committee in March 2021.	• Received assurance from the report
BAF Risk SR04: Appraisals and Compliance		• Received an update on Trust's performance against the revised target of 85% for appraisal compliance agreed by the Board of Directors in July 2020. • Whilst performance peaked at 87% in February 2020 it was noted this had steadily reduced due to the operational pressures and staff abstractions caused by the pandemic and the decision taken to pause appraisals in March and October 2020 for frontline operations. The current appraisal compliance position was reported at 68%. • Although there is no CQC recommended minimum target set for appraisal, the CQC minimum threshold for mandatory training is 75% and proposed the Trust apply the same threshold for appraisal compliance. • Recommendations to manage the appraisal compliance position, with view to supporting incremental recovery towards 95% by 31st March 2023, with milestone targets of 75% by September 21 and 85% by March 22 noted.	• Noted the current appraisal position. • Approved the recommendations to recover and reset appraisal targets from January 2021 to March 2023.

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BAF RISK SR04: Mandatory Training - Covid-19 Impact		• Reported that due to Covid-19 pressures the Trust had agreed a change to a 75% mandatory training competency compliance target, in line with the CQC recommended minimum threshold. • At 31st December 2020, Trust competency compliance was 79.85%, with all service lines meeting or exceeding 75%. Noted that if no further mandatory training modules are completed, by the end of March 2021 both PES and EOC will fall below the revised 75% target. • PES classroom training will not resume in this cycle but a range of interventions to maintain overall competence levels at the 75% target in place. Level 3 Safeguarding and Resuscitation training in PES focused area for recovery plan targets.	• Approved to adjust the mandatory training competency compliance target to that of the CQC recommended minimum threshold of 75%. • Noted the risks and mitigations identified in section and approve the proposed solutions.
BAF Risk SR04: Covid-19 Vaccination Assurance Report		• Following approval of the Oxford Astra- Zeneca vaccine and a national directive on 30th December 2020 to expand the Covid-19 vaccination programme to all health and social care staff, NWAS employees in patient facing roles including volunteers, call centre staff, students, agency and third party providers would be offered the vaccine as priority. • Trust had established a staff vaccination hub at Broughton station, with the aim of delivering 200 vaccines per day over a 7 day period. • The report highlighted that additional funding would not be made available for vaccination hub set up. • NWAS focus of the project has been to minimise costs where possible with the extensive use of volunteers and light duties staff. • The costs for set up are £30k with weekly running costs projected to be between £12-29k. These will be absorbed in running costs but create a cost pressure in the organisation.	• Noted and received assurance from the report.

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BAF Risk SR07: Digital Strategy Update Q3		• Reported an overall risk rating for SR07 of 12 for Q3. Unable to reduce risk 1181 due to the delay in the unified communications programme. • Risk 2867 remains at 15 and linked to the multiple system changes occurring simultaneously although with some major projects now moving into Business As Usual support, should reduce in Q4. • The only deliverable on the Board Assurance Framework now delayed was the implementation of the new telephony platform in 999 which was originally planned for December and is now re-planned for March 2021. • The report highlighted that Good progress was being made against the National Ambulance Digital Strategy Priorities agreed by ACCE. • Acknowledged that the Trust had been the first Ambulance Service to achieve call passing capabilities with all UK Ambulance Services. • Projects were being managed well, with overall rating for digital projects as Green. • The first phase of the Unified Communications Programme in the 111 service had been delivered successfully.	• Noted assurance from the Q3 Digital Strategy update.
BAF RISK SR08: Annual Planning - Q3 Progress Position Must Do Objectives		• Reported that ELC agreed on a simplified approach to the annual planning process for 2020/21 due to the impact of Covid-19. • Recovery plan objectives to be set as directorate objectives for Q1 and Q2 plus a set of must do objectives for Q3 and Q4. • BRAGG rating applied to identify priority and controls. • 1 objective was identified as off track with control measures required - to 'Improve the management of complaints across the Trust, by 31 March 2021 and timeframes had been set for delivery.	• Received assurance from the report.

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		• Noted that 93% of the objectives were completed or on track by the end of Q3 and recommended to remove objectives which referred to Business As Usual with the exception of the objective related to mandatory training and appraisals.	

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27th January 2021
Subject:	Workforce Governance Structure
Presented by:	Angela Wetton, Director of Corporate Affairs / Lisa Ward, Director of People
Purpose of Paper:	For Decision
Executive Summary:	Whilst workforce assurance reporting is visible at Board level and via the Resources Committee, there is currently no underlying governance structure for workforce matters. In order to strengthen the governance and assurance processes around workforce matters, it is proposed that Resources Committee establishes a Strategic Workforce Management Group to provide assurance to the Resources Committee that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives. This Group will review and oversee the implementation of the key provisions in the NHS People Plan that relate to NWAS, other national strategic plans/guidance and the NWAS Workforce Strategy. In order to assist the work of this Group it will be supported by the following Groups that will oversee and provide assurance around key elements of the workforce agenda: • Education Assurance Management Group • Health, Wellbeing & Culture Assurance Group Existing recruitment and workforce planning groups which review the progress of approved workforce plans will also feed into the Group. In addition, it is proposed to establish an Equality, Diversity and Inclusion Assurance Group which will report jointly to the Resources Committee on workforce and public engagement related matters and to the Quality and Performance Committee on patient related matters. The initial proposal is that the Groups run in shadow form for the remainder of this financial year, with full reporting commencing from April 2021. The structure will be evaluated during its first full year of operation.

	All Terms of Reference can be seen at Appendix 1.
Recommendations, decisions or actions sought:	The Board of Directors is requested to: • Agree the establishment of a Strategic Workforce Management Group reporting into the Resources Committee • Approve the establishment of an Equality, Diversity and Inclusion Assurance Group reporting into both Resources Committee and Quality & Performance Committee • Note the intention to run the structure in shadow form for the remainder of the financial year before commencing formal reporting, with evaluation taking place during the first 12 months of operation

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	The creation of an EDI Assurance group which will have a seat for staff network representatives will improve both the oversight of equality, diversity and inclusion work across the Trust and strengthen the voice of staff from protected groups. This is expected to have a positive impact on equality.
Previously Submitted to:	Resources Committee/ Quality & Performance Committee
Date:	20th November 2020/ 18th January 2021
Outcome:	Recommended to Board of Directors

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1. PURPOSE

1.1 Good governance at NWAS should be supported by a clear structure, providing simplicity of reporting and escalation of information; encouraging evidence based assurance at each stage within the hierarchy.

2. BACKGROUND

2.1 Whilst workforce assurance reporting is visible at Board level and via the Resources Committee, there is currently no underlying governance structure for workforce matters and whilst there is no desire to create meetings that don't add value, working together the Director of People and Director of Corporate Affairs have identified an opportunity to strengthen the governance and assurance process and ultimately streamline elements of reporting to Resources Committee. It is important to note that, as with certain Quality reports, some elements will continue to need Board oversight.

2.2 The proposed structure will assist with workforce related risk management as aligned risks can feature in the work of the groups.

3. PROPOSED WORKFORCE GOVERNANCE ARRANGEMENTS

3.1 The proposal is that Resources Committee establishes a Strategic Workforce Management Group. The purpose of this Group, as can be seen in the full Terms of Reference in the appendix, is to provide assurance to the Resources Committee that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives. This Group will review and oversee the implementation of the key provisions in the NHS People Plan that relate to NWAS and other national strategic plans/guidance. The Assurance will be provided in the form of a Chair's Assurance Report to the Committee.

3.2 In order to assist the work of this Group it will be supported by the following Groups that will oversee and provide assurance around key elements of the workforce agenda:

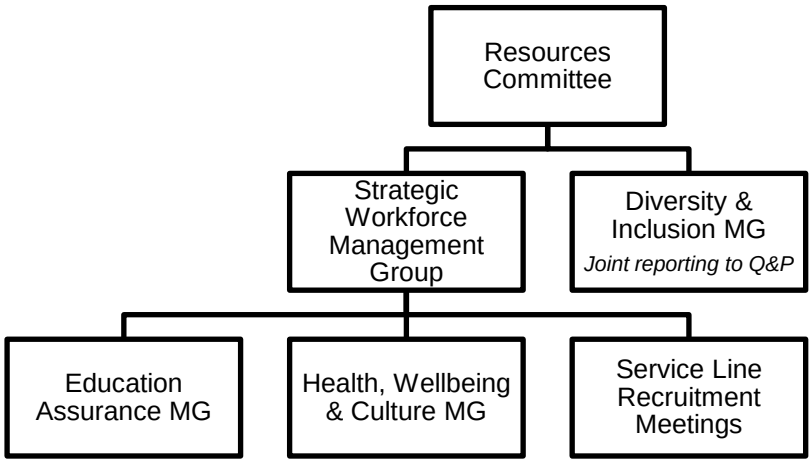
- Education Assurance Group
- Health, Wellbeing & Culture Assurance Group
- Service line recruitment groups

3.3 The service line recruitment groups currently operate within service lines reviewing the implementation of the agreed workforce plans and associated recruitment and training plans. Representation on the Strategic Workforce Management Group from the Head of HR Corporate Services will provide reporting from all the relevant recruitment groups.

3.4 In addition, it is proposed to establish an Equality, Diversity and Inclusion Assurance Group which will report jointly to the Resources Committee on workforce and public engagement related matters and to the Quality and Performance Committee on patient related matters.

3.5 The initial proposal is that the Groups all meet on a quarterly basis and that they will run in shadow form for the remainder of this financial year, with full reporting commencing from April 2021. The structure will be evaluated during its first full year of operation.

3.6 The Terms of Reference for all the Groups (with the exception of the Service Line recruitment meetings) can be seen in the Appendix and a visual representation of the structure can be seen below:



3.7 The proposals set out in thie paper have been reviewed through Resources Committee and Quality & Performance Committee and are recommended to the Board of Directors for approval.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 There are no legal implications. It is anticipated that governance will be strengthened through these proposals.

5. RECOMMENDATIONS

5.1 The Board of Directors is requested to:

- Approve the establishment of a Strategic Workforce Management Group reporting into the Resources Committee
- Approve the establishment of an Equality, Diversity and Inclusion Assurance Group reporting into both Resources Committee and Quality & Performance Committee
- Note the intention to run the structure in shadow form for the remainder of the financial year before commencing formal reporting, with evaluation taking place during the first 12 months of operation

NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE – STRATEGIC WORKFORCE MANAGEMENT GROUP

CONTENTS

1. ROLE AND PURPOSE

The Strategic Workforce Management Group has been established as a formal group of the Resources Committee. The Strategic Workforce Management Group *(hereinafter referred to as 'the Group')* no executive powers, other than those specifically delegated within these terms of reference.

The purpose of the Group is to provide assurance that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives.

The Chair of the Group will report in writing to the Resources Committee a summary of the business that has been transacted and basis for any recommendations made.

2. MEMBERSHIP

The Group shall comprise of the following membership:

- Director of People (Chair)
- Deputy Director of People (Deputy Chair)
- Assistant Director of Workforce & Organisational Development
- Head of HR Corporate Services
- Deputy Director of Operations
- Head of 111
- Head of PTS

There is an expectation that members will attend a minimum of 3 out of 4 Group meetings during each financial year.

Other Officers of the Trust shall attend at the request of the Group in order to present and provide clarification on agenda items and with the consent of the Chair will be permitted to participate in the debate.

The quorum necessary for the transaction of Committee business shall be either the Chair or Deputy Chair and at least 3 members.

3. ACCOUNTABILITY

The Committee's authority is as set out in the NWAS Scheme of Delegation.

4. REVIEW ARRANGEMENTS

The Committee will identify annual objectives of the Group, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Group's terms of reference and a review of the effectiveness of the Group. Any changes to the Terms of Reference must be recommended to the Resources Committee for approval.

Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance Department.

5. WORKING METHODOLOGY

Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

The Group will normally meet on a quarterly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given.

The Group shall be supported administratively by the Corporate Governance department, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Group on pertinent areas.

6. DUTIES AND INTERRELATIONS

The Group shall:

i. provide assurance to the Resources Committee that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives

ii. review and oversee the implementation of the key provisions in the NHS People Plan and Trust Workforce Strategy

iii. support, challenge and advise on leadership, talent management and development arrangements to ensure they will deliver a step change improvement in talent management

iv. determine and monitor the Workforce Annual Plan which shall be presented formally to Resources Committee

v. receive assurance that staff engagement and satisfaction levels are improving through delivery of wellbeing and initiatives to improve culture

vi. review Key Workforce Performance Indicators including sickness absence, bank/agency usage and expenditure, education and development, payroll performance, HR case management, appraisal and staff turnover and ensure agreed targets are being met

vii. seek assurance that education, training and development approaches are effective

viii. seek assurance that workforce related regulatory requirements are being met, including actions arising from CQC inspections, Ofsted requirements and apprenticeship delivery.

ix. review workforce related risks identified on the Corporate Risk Register and seek assurance in relation to risk mitigation and future activity/plans.

7. DELEGATED AUTHORITY

The Committee is authorised by the Resources Committee to:

i. investigate any activity within its terms of reference
ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Group.

8. INWARD REPORTING ARRANGEMENTS

The Management Group will receive Chair's Assurance reports from:

- Education Assurance Management Group
- Health, Wellbeing and Culture Assurance Group
- Service line recruitment groups

NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE – DIVERSITY & INCLUSION ASSURANCE GROUP

CONTENTS

1. ROLE AND PURPOSE

The Diversity and Inclusion Assurance Group has been established as a formal assurance group of both the Resources Committee and the Quality and Performance Committee. The Diversity and Inclusion Assurance Group *(hereinafter referred to as 'the Group')* has no executive powers, other than those specifically delegated within these terms of reference.

The purpose of the Group is to maintain a strategic overview of the Trust's activities in the area of diversity and inclusion, either aligned to the Workforce Strategy, the Right Care Strategy or the national People Plan, helping to guide, steer and challenge progress in delivery of the Trust's EDI strategic objectives.

This is with a view to assessing the adequacy of progress in creating a representative workforce and working environment where all staff are protected and able to reach their potential and ensuring that we are delivering high quality care to our patients in a culturally competent way. In addition, seeking assurance as to compliance with statutory and regulatory requirements including but not limited to Equality Delivery System performance (EDS), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Accessible Information Standard (AIS) and statutory equality duties.

The Chair of the Group will report in writing to the relevant Committee a summary of the business that has been transacted and basis for any recommendations made.

2. MEMBERSHIP

The Group shall comprise of the following membership:

- Deputy Chief Executive (Chair)
- Director of People (Deputy Chair)
- Executive Medical Director or senior representative
- Deputy Director of Operations
- Senior 111 representative
- Senior EOC representative

- Senior PTS representative
- Senior Quality representative
- Senior Finance representative
- Director of Strategy and Planning or senior representative (patient engagement)
- Race Equality Network Representative
- LGBT Network Representative
- Disability Forum Representative
- Patient and Public Panel representative
- Trade Union equality representative

Directorate representatives are expected to lead on the relevant EDS goals and objectives within their directorates and will be expected to provide evidence and assurance of progress.

There is an expectation that members will attend a minimum of 3 out of 4 Group meetings during each financial year.

Other Officers of the Trust shall attend at the request of the Group in order to present and provide clarification on agenda items and with the consent of the Chair will be permitted to participate in the debate.

The quorum necessary for the transaction of Group business shall be at least 6 members.

3. ACCOUNTABILITY

The Group's authority is as set out in the NWAS Scheme of Delegation.

4. REVIEW ARRANGEMENTS

The Group will identify annual objectives of the Group, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Group's terms of reference and a review of the effectiveness of the Group. Any changes to the Terms of Reference must be recommended to the Resources Committee and/or Quality & Performance Committee for approval.

Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance Department.

5. WORKING METHODOLOGY

Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

The Group will normally meet on a quarterly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given.

The Group shall be supported administratively by DCEO Executive Business Support Officer, whose duties shall include: agreement of the agenda with the Chair and collation of papers;

producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Group on pertinent areas.

The Chair and Deputy Chair may in an emergency, following consultation with at least one other member of the Group, exercise the functions of the Group jointly. A full report shall be prepared as for the Group and a signed authorisation appended. The exercise of such powers, together with the report, shall be submitted to the next formal meeting for ratification.

6. DUTIES AND INTERRELATIONS

The Group shall:

i. Act as advocates and allies in actively promoting diversity and inclusion across the Trust, receiving assurance on senior visibility and activity on the diversity agenda

ii. Provide assurance to the relevant Committee that diversity and inclusion approaches for staff and patients are effective

iii. Oversee data analysis, development and monitoring of strategies and plans in relation to diversity including:

- Progress in relation to the Inclusion goal of the Workforce Strategy to Resources Committee ;
- Progress in relation to diversity aspects of the Right Care Strategy
- Progress in relation to the Trust's published Equality objectives and plans to the relevant Committee;
- Progress in relation to the Workforce Race Equality Standard (WRES); Workforce Disability Equality Standard (WDES) Gender pay gap and Accessible Information Standard
- Progress in relation to strategic plans for community and patient engagement and resulting learning and action;
- Progress in relation to statutory equality duties

iv. Receive data and analysis on a range of indicators relating to workforce representation and experience; patient access and experience, undertaking deep dives where necessary, with a view to assuring Committees of progress or that suitable plans have been developed to address areas of concern

v. Provide active support to staff networks, receiving reports on progress of action plans, removing barriers, championing their work and supporting their development.

vi. Actively seek out lived experience of staff and patients to enhance understanding of the experience of staff and patients and using this to drive improvements.

vii. Receive assurance on the equality impact assessment process

7. DELEGATED AUTHORITY

The Group is authorised by the Resources Committee and Quality & Performance Committee to:

i. investigate any activity within its terms of reference

ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Resources or Quality and Performance Committees.

8. INWARD REPORTING ARRANGEMENTS

The Group will receive assurance from the following groups:

- Staff Networks
- Gender Pay Gap working group
- WRES working group
- WDES working group

NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE – EDUCATION ASSURANCE MANAGEMENT GROUP

CONTENTS

1. ROLE AND PURPOSE

The Education Assurance Management Group has been established as a formal group of the Strategic Workforce Management Group. The Education Assurance Management Group *(hereinafter referred to as 'the Group')* has no executive powers, other than those specifically delegated within these terms of reference.

The purpose of the Group is to maintain a strategic overview of the Trust's workforce education, training and development activities with a view to assessing the adequacy to provide a positive working environment for staff, to enable the provision of high quality care and good clinical outcomes for patients.

The Chair of the Group will report in writing to the Strategic Workforce Management Group a summary of the business that has been transacted and basis for any recommendations made.

2. MEMBERSHIP

The Group shall comprise of the following membership:

- Associate Director of Workforce and Organisational Development (Chair)
- Head of Education (Deputy Chair)
- Consultant Paramedic education
- Head of L&OD
- Union Learning Representatives x 4 (unison, unite, GMB and RCN)
- PTS service line rep
- 111 service line rep
- EOC service line rep
- PES service line rep
- Finance
- Senior Education Managers x3
- 111 Education lead

There is an expectation that members will attend a minimum of 3 out of 4 Group meetings during each financial year.

Other Officers of the Trust shall attend at the request of the Group in order to present and provide clarification on agenda items and with the consent of the Chair will be permitted to participate in the debate.

The quorum necessary for the transaction of Group business shall be at least 8 members.

3. ACCOUNTABILITY

The Group's authority is as set out in the NWAS Scheme of Delegation.

4. REVIEW ARRANGEMENTS

The Group will identify annual objectives, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Group's terms of reference and a review of the effectiveness of the Group. Any changes to the Terms of Reference must be recommended to the Strategic Workforce Management Group for approval.

Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance Department.

5. WORKING METHODOLOGY

Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

The Group will normally meet on a quarterly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given.

The Group shall be supported administratively by the People Directorate, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Group on pertinent areas.

The Chair and Deputy Chair may in an emergency, following consultation with at least one other member of the Group, exercise the functions of the Group jointly. A full report shall be prepared as for the Group and a signed authorisation appended. The exercise of such powers, together with the report, shall be submitted to the next formal meeting for ratification.

6. DUTIES AND INTERRELATIONS

The Group shall:

i. provide assurance to the Strategic Workforce Management Group that recommendations and requirements of professional bodies and regulators relating to standards and quality of professional education and training are met.

ii. provide assurance to the Strategic Workforce Management Group that education, training and development approaches are effective and oversee implementation of the Workforce Strategy themes of Leadership and Developing Potential.

iii. oversee development and monitoring of strategies and plans in relation to education including:

- undergraduate and postgraduate education of healthcare professionals;
- professional development of non-clinical staff;
- apprenticeship programmes as an employer and as an employer-provider
- succession planning and talent management
- staff appraisal
- Statutory and mandatory training
- leadership and management development.
- NQP consolidation of learning programme

iv. Identify, monitor and control risks relating to the delivery of high quality education and learning activities.

v. Monitor and facilitate compliance against external education performance standards, good practice and guidance

vi. Set out and support the implementation of an annual quality plan designed to improve the quality and effectiveness of education and learning activities

vii. oversee development and monitoring of strategies and plans in relation to the national library and knowledge service for ambulance service in England (LKS ASE)

7. DELEGATED AUTHORITY

The Group is authorised by the Strategic Workforce Management Group to:

i. investigate any activity within its terms of reference

ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

8. INWARD REPORTING ARRANGEMENTS

The Management Group will receive Chair's Assurance reports from:

- Mandatory Training Assurance sub-group
- Apprenticeship Assurance sub-group

NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE – HEALTH, WELLBEING AND CULTURE ASSURANCE MANAGEMENT GROUP

CONTENTS

1. ROLE AND PURPOSE

The Health, Wellbeing and Culture Assurance Management Group has been established as a formal group of the Strategic Workforce Management Group. The Health, Wellbeing and Culture Assurance Management Group *(hereinafter referred to as 'the Group')* has no executive powers, other than those specifically delegated within these terms of reference.

The purpose of the Group is to maintain a strategic overview of the Trust's Workforce Health and Wellbeing with a specific emphasis on improving culture, through leadership of the staff engagement and health and well-being plans to deliver the Trust's values in practice. The Group will develop and manage overarching Health and Wellbeing Plans to ensure that the Trust can evidence its progress, providing assurance to the Workforce Strategic Management Group and / or Resources Committee.

The Chair of the Group will report in writing to the Strategic Workforce Management Group a summary of the business that has been transacted and basis for any recommendations made.

2. MEMBERSHIP

The Group shall comprise of the following membership:

- Deputy Director of People (Chair)
- Strategic HR Manager (Deputy Chair)
- Corporate HR Health and Wellbeing lead
- Education and Training representative
- Learning and Development team representative
- PTS service line representative
- HR Business Partnering Team Representative
- F2SU Guardian
- 111 service line representative
- EOC service line representative
- PES service line representative

- Trade Unions reps (Unite, GMB, UNISON, RCN)

There is an expectation that members will attend a minimum of 3 out of 4 Group meetings during each financial year.

Other Officers of the Trust shall attend at the request of the Group in order to present and provide clarification on agenda items and with the consent of the Chair will be permitted to participate in the debate.

The quorum necessary for the transaction of Group business shall be at least 6 members.

3. ACCOUNTABILITY

The Group's authority is as set out in the NWAS Scheme of Delegation.

4. REVIEW ARRANGEMENTS

The Group will identify annual objectives, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Group's terms of reference and a review of the effectiveness of the Group. Any changes to the Terms of Reference must be recommended to the Strategic Workforce Committee for approval.

Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance Department.

5. WORKING METHODOLOGY

Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

The Group will normally meet on a quarterly basis. The Chair may, however, call a meeting at any time provided that notice of the meeting is given.

The Group shall be supported administratively by the People Directorate, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Group on pertinent areas.

The Chair and Deputy Chair may in an emergency, following consultation with at least one other member of the Group, exercise the functions of the Group jointly. A full report shall be prepared as for the Group and a signed authorisation appended. The exercise of such powers, together with the report, shall be submitted to the next formal meeting for ratification.

6. DUTIES AND INTERRELATIONS

The Group shall:

i. provide assurance to the Strategic Workforce Management Group that the Trust has appropriate and effective strategies and plans relating to workforce health and wellbeing and the development of an inclusive, compassionate culture, so as to enable the Trust to meet its Strategic Objectives

ii. review and oversee the implementation of the key provisions in the NHS People Plan relating to wellbeing and culture

iii. Review and oversee the implementation of Trust Workforce Strategy in the Wellbeing theme, including foundations of success and key improvement goals and any projects/implementation plans

iv. Provide assurance to the Strategic Workforce Management Group that the National Ambulance Sector health and wellbeing framework is being adopted in the following key areas:

- Universal Prevention Supportive Culture
- Preparing the future workforce
- Enhance support for early care Paramedics and front line staff
- Targeted prevention
- Postvention
- Family Support

v. Identify, monitor and control risks relating to the delivery of high quality health and wellbeing interventions and activities.

vi. Monitor and facilitate compliance against external frameworks and standards, good practice and guidance

vii. oversee planning for the annual staff survey and any localised culture audits, including development and monitoring of strategies and plans in relation to the outcomes

viii. Review appropriate data to provide assurance on progress including triangulation of data.

ix. Oversee the planning and delivery of annual flu vaccination campaign

7. DELEGATED AUTHORITY

The Group is authorised by the Strategic Workforce Management Group to:

i. investigate any activity within its terms of reference

ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

8. INWARD REPORTING ARRANGEMENTS

There are no inward reporting arrangements.

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27th January 2021
Subject:	EDI Report
Presented by:	Lisa Ward, Director of People
Purpose of Paper:	For Discussion
Executive Summary:	The Trust has made demonstrable progress in narrowing the gaps in staff experience for different protected groups. Inclusion is a key improvement goal within the Workforce Strategy. However, our staff survey results still show differences in the experience of some of our protected groups, especially BAME and disabled staff and Board has previously challenged ELC on the level of ambition shown in planned improvements to representation and progression. The differential impact of COVID on BAME communities, combined with the Black Lives Matter movement following the death of George Floyd in the US, have highlighted the impact of sustained racism in society on the experience of BAME communities and staff. This has provided additional momentum to review the Trust's approach to diversity and inclusion. This momentum is also reflected in the People Plan which includes specific objectives to review recruitment and disciplinary processes and to more effectively embed staff networks in decision making. The creation of the BAME Assembly in the North West has also challenged organisations to be positively anti-racist, recognising that racism is frequently about unconscious, unintentional and institutional actions and processes that need to be confronted and addressed. Over the course of the pandemic the Trust has already taken a number of actions to start to improve leadership, governance and accountability. In particular, the following changes have been made: • **Governance** - Proposal for a Diversity and Inclusion Assurance Group reporting to both Resources and Quality & Performance Committees. This group, with senior representation, will monitor progress on regulatory compliance, support delivery of staff

network plans and hold service lines to account for their delivery against the Trust's diversity objectives.

- **Staff Voice** – the Trust has approved an infrastructure to support staff networks, including release for core members and budget allocation. Progress has also been made in developing networks. The LGBT Network continues, with the Race Equality Network launched at the end of January and work ongoing to develop the existing Disability forum into a network.
- **Executive Champions** – Directors have taken on Executive Champion roles aligned with networks or particular equality strands. Champions will be accountable for supporting network objectives, acting as allies and advocates and for bringing the perspective of their equality strands to ELC debate and decision making
- **Command Structures** – the Race Equality Network now has a sub-group which is supporting the Trust in reviewing its decision making in respect of the COVID response.

Plans are in place to support Board Development in the area of anti-racism and diverse leadership and to implement the Reciprocal Mentoring for Inclusion programme for senior leaders following our successful bid for support from the Leadership Academy.

Evidence suggests that organisations with a compelling vision around diversity and inclusion and with a focus on a small set of ambitious objectives are able to make more significant progress. To this end ELC have debated and agreed three key priority areas which are as follows:

1. **We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.**

2. **We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.**

3. **We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities.**

Further work is required on measurement, particularly around patient data, but the view taken by ELC was that this should represent our ambition for a step change.

From a workforce perspective the closure of existing gaps in staff experience measured through the staff survey should be an aim and in terms of BAME representation ELC have committed to an increase to 8% over the next three years which represents 20% of future new

	entrants being from a BAME background. Similar progression targets will be developed. These key priorities will sit within the context of our other work to improve and change culture which provides the foundation on which these priorities can be achieved. This includes our Culture and Wellbeing Audit; Just Culture work; Values refresh and our Leadership framework. The priorities are presented to Board for discussion and confirmation. They will also be published as our statutory Equality Objectives for the next three years. Assuming Board are comfortable with this approach, work will then be undertaken to share and consult on these proposals with network groups, both to check that these areas are the right priorities but also to seek feedback on the actions we will need to take to deliver on these commitments. Work will be undertaken to develop a strategic action plan, similar in approach to the mental health strategic action plan, which can sit under associated strategies, primarily Workforce and Right Care. A project structure to establish and deliver implementation plans will then report through to the Equality, Diversity and Inclusion Assurance Group. Existing WRES, WDES and gender pay gap working groups will be reviewed to ensure dedicated focus to these priority areas.
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Discuss and approve the diversity and inclusion key priorities for further work • Note the work already undertaken to improve leadership and governance of diversity and inclusion

Link to Strategic Goals:	**Right Care**	☒		**Right Time**	☐
	Right Place	☐		**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	The paper sets out some of the Trust's work in the area of Diversity and Inclusion and also key priority areas aiming to deliver improvements in staff representation, health inequalities and staff experience. These should support delivery of statutory and regulatory requirements for protected groups.
Previously Submitted to:	Executive Leadership Committee
Date:	6 &13 January 2021
Outcome:	Key priority areas approved and recommended to Board

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1. PURPOSE

1.1 The purpose of the paper is to provide an overview of the strategic reset of the Trust's Diversity and Inclusion approach.

1.2 The paper will discuss the context and drivers for the reset, the work already undertaken and the paper also outlines the proposed priority areas for the Trust that aim support the delivery of a step change in the experience of our staff and patients from protected groups.

2. BACKGROUND

2.1 The argument for creating an inclusive culture is clear. Where staff feel valued and welcomed for the diversity they bring to their role and where the organisation around them reflects the diversity of the communities we serve, individuals will reach their potential and there will be a positive impact on the working environment, innovation and quality of patient care.

2.2 Our staff survey results show a clear disparity in the experiences of some of our staff from diverse groups, particularly those from BAME and disabled backgrounds, and this is seen in their experiences of bullying and harassment, discrimination and their views of the fairness of career progression opportunities. Although the indicators in our WRES show improvements in narrowing the gaps in areas such as recruitment and access to training, this does not adequately reflect in the day to day experiences of our staff and more drive is required to create a fully inclusive environment for our staff and to make a significant change for our staff.

2.3 The Workforce Strategy has inclusion as one of its key improvement goals and has a supporting set of workforce indicators to measure progress. The ELC has been challenged by Board as to whether these represent sufficient ambition, particularly in addressing under-representation.

2.4 Almost all of the activity around the ED&I agenda has been delivered through the People Directorate and focused on Workforce activity, which can be seen through the incremental progress in key workforce indicators. However, there is a recognition that we need to improve ownership and accountability for the agenda across the organisation if we are to make a step change in delivery and address health inequalities.

3. CONTEXT AND EXTERNAL DRIVERS

3.1 The impact of the pandemic, alongside world events highlighting the ongoing disproportionate impact of racism and discrimination, has caused many organisations to pause and reflect on the experiences that BAME colleagues face on a daily basis. In turn this has led the Trust to reflect on our own efforts to support and progress the diversity and inclusion agenda.

3.2 Alongside our own internal efforts and measurement of progress, there are external drivers inducing an enhanced focus. The NHS People Plan published this summer set out a need for Trusts to create an organisational culture where everyone feels they belong and with this to improve the experience of BAME employees. More than ever,

organisations are being asked to look inwardly at the impact of their current efforts. In particular the People Plan sets objectives for organisations to overhaul their approach to recruitment, enhance staff voice as a whole and through command structures and to address BAME experience of disciplinary processes.

3.3 In response to the disproportionate impact of COVID 19 and Black Lives Matter movement, a strategic advisory committee, the North West BAME Assembly, has been established in the region to lead on positive action on racism. The Assembly seeks to work with Trusts to be positively anti-racist, with the expectation that this will lead to real and sustained change, which will be noticed at all levels of the NHS from board level to the frontline. In taking an anti-racist stance the Assembly is looking to organisations to recognise that racism is frequently about unconscious, unintentional and institutional actions and processes that need to be confronted and addressed.

3.4 They have set out three main themes to support this work:

1. Minimise the risks posed by Covid-19 to our Black, Asian and Minority Ethnic colleagues
2. Address underlying racism within our structures through:
    a. setting improvement trajectories for representation at each grade
    b. Nurture the understanding of all colleagues of the depth of equality and inclusion issues
3. Tackle the inequalities of access, which mean that our Black, Asian and Minority ethnic communities have poorer health and health outcomes

3.5 The Trust has responded to the assembly, welcoming the strength that it will bring to support the Trust's commitment to improve the position on Diversity and Inclusion. There is also an acknowledgement by the Trust of the work required to make the shift from being an organisation that supports diversity and inclusion to being actively anti-racist. The Trust has also confirmed to the assembly the commitment to continuing to evolve our leadership practice at a Board level to positively develop our leadership of the diversity and anti-racist agenda.

3.6 Alongside the commitment to support the intentions of the assembly, the Trust has been engaged with AACE's Project D since its launch in 2019. The outputs of this work has led to the development of the AACE promises that will form part of a national campaign in Q4 of 20/21 focussed on stamping out racism across the sector. The intention of the Trust is to combine the vision of the assembly with the AACE Anti-Racism Promises to develop a framework for our Diversity and Inclusion objectives. As such, there is demonstrable commitment in place by the Trust ensure that external strategic intentions form part of the Trust strategic objectives.

4. STRATEGIC APPROACH – PROGRESS TO DATE

4.1 Despite the pandemic work has already been undertaken to start to improve leadership, governance and accountability across the agenda. The following section outlines some of the key areas of work already undertaken.

4.2.1 **Governance**

A separate report is being presented to Board to strengthen governance and accountability around EDI. This aims to establish a management assurance group reporting both to Resources and Quality and Performance Committees.

4.2.2 The group has been formed with a purpose to create a strategic overview of work aligned to the Workforce Strategy, the Right Care Strategy or the national People Plan with an intention to guide, steer and challenge progress in delivery of the Trust's EDI strategic objectives.

4.2.3 The group will have oversight of the key statutory and regulatory reporting requirements, as well as providing a forum to support delivery of network objectives. It will also monitor the newly developed Diversity and Inclusion priorities for the Trust and oversee the accompanying action plan. As such, the Chair of the group will have a role in holding managers to account on their progress against their service line's actions. The group reports jointly to the Resources Committee on workforce and public engagement related matters and to the Quality and Performance Committee on patient related matters.

4.3.1 **Staff Voice**

The importance of having an effective staff voice cannot be underestimated. Staff networks can provide an internal consultancy approach with their insight and opinion on how the Trust operates from the perspective of being a minority group. These views can help to shape the diversity landscape in the organisation.

4.3.2 Research by NHSE indicates that staff networks facilitate the need for a safe space where staff can share the challenges they face and identify practical and constructive solutions. The development of the staff networks needs to harness this perspective as it provides a unique forum in which staff can discuss their perspective with the mind-set of wanting to evoke change within the organisation. Staff networks are therefore a key stakeholder to help shape and then support the work required to realise the strategic intentions of the organisation.

4.3.3. Following approval from ELC in October 2020, the Trust has moved to a formalised infrastructure to support staff networks. Approval has been given for formal release of network chairs and core group members, along with a small budget to support the progress of annual activities and initiatives. The intention is that each group will have a clear work plan, where progress can be monitored and reported into the Diversity and Inclusion Assurance Group. In addition, the group will also provide the networks with proactive support and championing of their agenda.

4.3.4 Within the NHS People Plan there is an intention that by December 2021 all NHS organisations should have reviewed their governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes. The infrastructure and governance changes help us to deliver against this objective.

4.3.5 <u>Network progress</u>

The LGBT Network has been established for some time and this is reflected in the network having a more strategic focus within their action plan. The priority over the next twelve months includes increased visibility of the network, trans awareness, career

progression and external public-facing engagement. Over the last 12 months, the Trust has supported the network with the launch of the rainbow badge scheme and led on the revision of the Trans policy for staff with input from the network. Partnership working with the National Ambulance LGBT Network is proactive and positive. This includes regular Network attendance at committee meetings and the sharing of resources and support as appropriate.

4.3.6 The formal launch of the Race Equality Network takes place this month, marking the transition from a Corporate HR run forums to a staff run network. The formalisation of the group with aligned Executive Champions will enable a tangible and clear focus for the organisation on BAME issues for staff, clearly aligned to the Trust priorities.

4.3.7 The network's action plan includes a focus on:

- increasing education and awareness of race equality
- improving attraction to our service from applicants in our BAME communities
- supporting our BAME talent to progress in our organisation
- celebrating our diversity more
- targeting patient and community engagement

4.3.8 The Disability Forum has evolved throughout the pandemic. The facilitation of video conferencing facilities has ensured a consistently healthy attendance at meetings and with this an increased energy from the group to progress forward their work programme. This remains a group organised and run by the Corporate HR team. The group has a number of actions it is seeking to progress but over the next 12 months consideration will be given on how to transform it to a more formal network in line with the Race Equality and LGBT networks.

4.4 **Command structures**

4.4.1 There is an awareness and appreciation that the command structure in place does not adequately address specific BAME issues. As a result the Race Equality Network has created a sub group to review any policies or procedures related to the current management of the COVID response to provide advice on any specific BAME issues. The group are currently reviewing the COVID-19 wave 2 response plan with a view to making comments/recommendations.

4.4.2 Whilst it is not possible at this time to create a more diverse command structure as key commander roles are associated with job roles, it is the intention that the Trust's commitment for a more diverse and representative workforce should help to address this in time. However, the specific focus on BAME issues will provide the Trust with assurance that issues and decisions made by the command structure will now be made taking account of the impact on BAME staff and patients.

4.5 Leadership

4.5.1 All of the evidence based research confirms that visible and sustained senior leadership of the inclusion agenda is critical to delivering a step change in diversity, inclusion and culture. One element of that is visible advocacy for diverse groups.

4.5.2 Following the ED&I Board development session in late 2019, there was a commitment within the Board to identify Executive Champions to support the progress of staff

networks. Each Director has now taken on an executive champion role either aligned with a network or supporting a particular strand of diversity e.g. gender equality.

4.5.3 Executive Champions are committed to show visible support and provide advocacy to support the aims of their network. The role includes supporting the development of the network and encouraging Trust wide engagement from staff at all levels of the organisation. The role has the added benefit of supporting the development of Directors who may not always have confidence in the area of inclusion, providing a safe relationship in which to develop greater understanding of staff experience from diverse groups.

4.5.4 The introduction of Executive Champions also allows the Trust to make progress in respect of the inclusive leadership goal under the EDS2 framework:

4.1: Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.

4.5.5 The Trust has also identified the Medical Director as the ED&I lead for Patient Care. Again this is a positive step in ensuring the Board is closely aligned to all aspects of care delivery and health inequalities.

4.5.6 The introduction of Executive Champions is an important step in the reset of the Trust's strategic intent to the Diversity and Inclusion agenda. NHSE best practice guidance around the development of successful networks suggests that involvement at an executive level in networks 'can serve as a cultural competency engine to fuel better intelligence for the executive team'(Improving Through Inclusion; Supporting Staff Networks for Black and Minority Ethnic Staff in the NHS' (NHSE 2017).

4.5.7 Inclusive cultures depend on inclusive leaders and it is important to ensure that invest time to develop our Board in Diversity and Inclusion. The immediate next steps to be taken include:

- Board development in the area of anti-racism and diverse leadership in Q4
- Implementation of Reciprocal Mentoring for Inclusion programme following our successful bid for support from the Leadership Academy
- Setting of targets for Board and senior leadership representation
- Formal launch of Race Equality Network
- Implementation of AACE 'Stamp out Racism' campaign

5. ORGANISATIONAL FOCUS AND AMBITION

5.1 The responsibility of the Trust to make improvements in equality, diversity and inclusion is set out in law through the Equality Act and Public Sector Equality Duty and in the regulatory framework through the NHS contract (which required compliance with WRES, WDES and EDS) and CQC standards. In this regard the Trust does not currently have published Equality Objectives which is a statutory requirement. The last objectives expired in 2020 and need to be refreshed.

5.2 The disproportionate impact of COVID 19 and the Black Lives Matter movement on BAME communities has highlighted the disparity in the experience of BAME staff and the severe health inequalities experienced in BAME communities. This has prompted

an increased focus at both a national and regional level on progress in reducing inequalities for BAME staff and patients.

5.3 As a Trust we have recognised the need to change our approach to Diversity and Inclusion. Whilst acknowledging that good incremental progress has been made over recent years to improve representation and staff experience, it is recognised that there is a need to increase our ambition and provide a clear and resourced commitment to make a step change in the experience of staff and patients.

5.4 The approach to ED&I is set within the context of the work already in progress to start to shift the culture of the organisation towards a more compassionate and inclusive culture. This work will provide a critical foundation on which to build further work on diversity and inclusion. In particular, the work already being progressed through:

- *The Culture and Wellbeing Audit* – this will provide a more detailed understanding of the experience of staff, including those from diverse groups, helping to identify positive interventions which can build on the existing psychological capital within the organisation.
- *The Values refresh* – as previously shared with Board the revised values and underpinning behaviours will provide an opportunity to reset expectations of behaviour in the workplace with respect and inclusion fundamentally embedded within the desired behaviours
- *Just Culture* – with core processes and approaches to investigation and conduct being reviewed in the context of an agreed set of just culture principles
- *Leadership Framework* – The Be Think Do framework continues to provide a sound set of leadership principles linked to compassionate leadership.

5.5 The Kings Fund research 'Making a Difference: Diversity and Inclusion in the NHS' identifies that the creation of a compelling vision and set of values, combined with clarity of objectives is critical to delivering sustained improvement in diversity and inclusion. The report also identifies the value in focusing on a small number of fully resourced key priorities in what can be a broad and challenging agenda.

5.6 In light of this the ELC have committed to the development and delivery of key objectives. The proposed priority areas recognise three key elements which ELC believe are critical to delivering a step change in the experience of our staff and patients:

1. better representation in the workforce creating role models and visibility which changes the dynamic of discussion and diversity of thinking
2. the need to embed core values and challenge where those are not being lived, supported through education and a willingness to have the difficult conversations about discrimination, particularly in respect of race
3. the importance of staff and patient voice in driving real change

5.7 As a result the following priorities have been developed:

We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.

5.8 This priority recognises the fact that increasing representation overall within the workforce and in leadership positions is key to driving a change in culture and improving understanding in our delivery of care.

5.9 Measurement

This priority will be supported through a series of targets for improved representation covering both recruitment and progression. These will be worked through in more detail prior to final approval but will reflect an appropriate level of ambition. These will further be disseminated to service line level with senior leaders accountable for delivery.

5.10 Progression targets will look at representation across a range of protected characteristics but recruitment targets will be focused on under-representation of individuals from BAME communities and in principle the following measures were discussed and agreed by ELC at the meeting on 6th January.

> The Trust aims to improve representation in the workforce from BAME communities to 8% by 2024.

5.11 This represents an equivalent annual increase of 1% per year and will require us to ensure 20% of our new recruits each year are from BAME backgrounds. This is a significant challenge and will require a shift in our approach to recruitment and operational support in community engagement.

5.12 ***We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.***

5.13 Implementation will consider:

- How we enable honest and open discussions about race
- How we equip our leaders to challenge inappropriate behaviour, to engage with diverse staff and to drive improvements locally
- How we develop allies and advocates who proactively engage and challenge
- How we challenge our staff's thinking, increase their cultural competence and increase their awareness of how their unconscious bias impacts on their decision making and therefore the quality of care delivered.
- How we enable a strong staff and patient voice in support of change

5.14 The priority recognises that being proactive and challenging in our approach to developing staff understanding is critical both in terms of the experience of staff working in the organisation but also in changing the approach of staff in delivery of care. This work is intrinsically linked with the plans we already have around culture and the implementation and full embedding of the refreshed values provide the baseline on which to build effective change.

5.15 Measurement

From a workforce perspective, the ambition will be to eliminate the gaps in staff experience measured through key staff survey indicators.

5.16 From a patient perspective, measurements will be developed as we have a limited baseline currently but will be expected to include both quantitative and qualitative measures associated with clinical audit and patient experience.

5.17 ***We will improve our use of patient data and patient experience to drive improvements in access and health inequalities, for patients from diverse communities***

5.18 This priority recognises the importance of making better use of patient data and experience to drive learning and improvement with the aim of having a positive impact on patient experience and outcomes. It reflects the need to enhance our use of data which will become much easier with EPR but also the need to extend and target some of our community engagement work, with services lines engaging more directly with uses from harder to reach communities.

5.19 Measurement

Measurements to support this priority will need to be worked through but will be evidenced through evaluation of changes and improvements made as a result of data analysis and feedback.

6. Next steps

6.1 The next steps for progressing these areas will be to share and consult on these proposals with network groups. This will serve to both check that these areas are the right priorities but also to seek feedback on the actions we will need to take to deliver on these commitments.

6.2 Work will be undertaken to develop a strategic action plan, similar in approach to the mental health strategic action plan, which can sit under associated strategies, primarily Workforce and Right Care. A project structure to establish and deliver implementation plans will then report through to the Diversity and Inclusion Assurance Group. Existing WRES, WDES and gender pay gap working groups will be reviewed to ensure dedicated focus to these priority areas.

6.3 The strategic action plan will be brought back to a future Board for final approval.

7. LEGAL and/or GOVERNANCE IMPLICATIONS

7.1 The establishing and delivery of key priorities for Equality, Diversity and Inclusion will support the Trust in meeting its statutory and regulatory obligations under the Equality Act, Public Sector Equality Duty, NHS contract and CQC regulations.

8. RECOMMENDATIONS

8.1 The Board of Directors is recommended to:

- Discuss and approve the diversity and inclusion key priorities for further work
- Note the work already undertaken to improve leadership and governance of diversity and inclusion

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27 January 2021
Subject:	Values: Implementation Plan
Presented by:	Lisa Ward, Director of People
Purpose of Paper:	For Assurance
Executive Summary:	The NWAS Values have been refreshed based on feedback from staff on what is important to them at work towards providing the best possible patient care and supporting NWAS to become the best ambulance service, nationally. These were shared with the Board of Directors in December. NWAS is now at a stage where the newly refreshed values are ready for organisation-wide implementation. Given the current global pandemic context and related guidance with regard to maintaining social distancing and PPE vigilance, an implementation plan has been developed to accommodate the COVID-19 recovery environment. It is proposed that the formal launch of the values takes place in March with ongoing activities forming part of the implementation plan over the following 12 months. Five approaches are proposed to introduce, embed and implement the newly refreshed values into the organisation to include: 1) Raising Trustwide staff awareness around the refreshed values through a vibrant virtual Communications campaign 2) Implementing a bespoke education programme to support staff to understand the mission, purpose and application of the Values in everyday business as usual towards providing improved patient and staff experience 3) Aligning and integrating organisation wide systems, processes and policies to the newly refreshed Values so they are streamlined into core business functionality 4) Aligning all corporate branding to the newly refreshed values to enable their reflection in the NWAS corporate identity and 5) Delivery of a bi-annual and annual evaluation survey to determine the effectiveness of integration of the newly refreshed value into business as usual with view to informing any future reconfiguration of approach. Evaluation of progress will be reported through the Resources Committee.

Recommendations, decisions or actions sought:	The Board of Directors is recommended to • Receive assurance on the proposed approach taken to introduce, embed and implement the newly refreshed Values into the organisation.

Link to Strategic Goals:	**Right Care**	☐		**Right Time**	☐
	Right Place	☐		**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	Monitoring and reporting of the implementation of the values will specifically cover WRES and WDES reporting and any wider cultural metrics that touch on staff experience
Previously Submitted to:	
Date:	
Outcome:	

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1. PURPOSE

1.1 This paper outlines the approach taken by the organisation to introduce, embed and implement the refreshed values across all service lines and into business as usual activity in support of the People Plan, NHS England, 2020 and the Workforce Strategy.

2. BACKGROUND

2.1 It is the expectation of NWAS that the entirety of the employee lifecycle is underpinned by the values, to be routinely evidenced in the behaviours, actions and approach of every member of staff, at all times. It is important that the values of the organisation therefore, are current, contextual and relevant to staff toward enabling NWAS to become the best ambulance service nationally.

2.2 To that end, a bespoke Project was commissioned in 2019, recruiting a competitively tendered provider (Delve) to support the refresh of the NWAS values in partnership with the organisation and its staff across the spectrum of clinical and non-clinical roles.

2.3 The three new values define what it means to be a member of the NWAS family;

1. Working together
2. Making a difference and
3. Being at our best.

2.4 These refreshed values are a direct product of collaborative co-design with staff, reflecting what is important to us collectively in the workplace so that we can consistently be at our best, maintaining high levels of employee engagement and morale for improved performance and work based enjoyment.

3. IMPACT FACTORS

3.1 Numerous impact factors have been taken into consideration in the development of an implementation plan to introduce the refreshed values into the organisation, to include:

a) Capacity: The COVID-19 third wave and the impact of a further National lockdown on the workforce, ranging from staff morale and resilience levels to service line operational pressures and capacity to engage with a refresh of values at this time
b) Business as usual limitations: An analysis of any limitation imposed by the pausing of business as usual activity during COVID -19 wave 3 that would have generated opportunities to socialise the refreshed values such as Leadership and wider learning and development courses / training
c) Communication Team's schedule to undertake a full review of the NWAS corporate branding portfolio (inclusive of values) scheduled for March 2021.

4. IMPLEMENTATION PLAN

4.1 Cognisant of the impact factors described above, an implementation plan has been developed to mainstream the 3 refreshed values into business as usual through the effective introduction, embedding and integration of the values into the everyday working lives of NWAS staff to include:

1. Introducing a programme of activity to raise staff awareness of the refreshed NWAS values, to commence in March 2021
2. Developing an education programme to enable staff to understand and translate the role of values in achieving personal and professional success at NWAS by September 21
3. Aligning the organisation's systems, processes and policies to the newly refreshed values with view to mainstreaming them into business as usual by March 22
4. Reflecting the values in the NWAS corporate brand and corporate identity in line with the scheduled corporate branding review scheduled for March 21
5. Routinely monitoring and reviewing the impact of NWAS values on improving employee engagement, employee morale and employee performance metric through bi–annual pulse surveys.

4.2 The activity behind this approach has been mapped out in more granular detail in Appendix A, attached to this report.

4.3 It is proposed that the formal launch of the values takes place in March with ongoing activities forming part of the implementation plan over the following 12 months.

5. MONITORING AND PROGRESS REPORTING

5.1 Monitoring and reporting against the progress of the implementation plan for refreshing the NWAS values will be achieved through bi annual reporting on progress including routine examination and analysis of the existing cultural metrics used to determine organisational performance in relation to staff experience including:

a) an analysis of the annual staff survey results,
b) employee relation data,
c) sickness absence data,
d) patient complaints,
e) WRES and WDES reporting and any wider cultural metrics that touch on staff experience.

Assurance will be provided to Resources Committee on progress in implementing the revised values.

5.2 Pulse Surveys will be further introduced to provide bespoke monitoring of the effect and impact of the Values on staff engagement and morale.

6. LEGAL and/or GOVERNANCE IMPLICATIONS

6.1 There are no legal and/or governance implications associated with the production of this report.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to

- Receive assurance on the proposed approach taken to introduce, embed and implement the newly refreshed Values into the organisation.

APPENDIX A:

Values Refresh Implementation Plan: March 21 – March 22

NHS North West Ambulance Service NHS Trust

Theme	Actions / proposed initiatives	Timeframes	Responsibility
Staff awareness	**The NWAS Way.** An online launch of the NWAS values through a comms campaign including a) Introduction of the new values framework presented as a staff charter into the organisation b) Video introducing the staff charter c) Posters of the staff charter across all 109 NWAS sites d) Social media campaign: twitter, facebook and Instagram showcasing the NWAS staff charter e) Campaign to engage commitment to the staff charter by inviting and showcasing a month of pledges from across service lines f) Campaign with patients to support the staff charter and NWAS staff to be at their best g) Development of 'Value Staff Values' – virtual living library of staff for Green Room, telling how their story of how bringing the values to life in practice has positively impacted teams / staff / services / patients. h) Integrate 3 values into email signatures, wage slips, staff bulletins, weekly comms etc	March 21 – June 21	Comms Team L&OD Team
Education programme	**NWAS: A learning organisation** • Introduce the 'Values toolkit' development programme to enable managers to instil the values into their teams and individual performance	May 21 to March 22	Delve L & OD Team

APPENDIX A:

	• **Integrate and embed refreshed values across all Leadership and Management offers hosted by the Leadership and Management Faculty** • **Introduce 3 leadership circles per annum, each focused on a specific value to enable reflective practice on navigating staff engagement with a values driven organisation** • **Support all staff networks to develop a bespoke programme to connect underrepresented groups to NWAS values in relevant ways** • **Embed values into mandatory training modules where possible**		**Staff Networks**
Systems and Processes	**NWAS: a values driven organisation** • **Embed refreshed values into local and corporate induction and on boarding processes** • **Embed refreshed values into appraisal process and paperwork** • **Embed refreshed values into HR Employee Relations policies and processes** • **Embed refreshed values into all recruitment processes and practices from advertising to JDs, PSs and application processes to selection.** • **Map refreshed values to Health and Wellbeing offer** • **Map refreshed values to EDI offer** • **Introduce values approach to managing and chairing meetings to be reflected in agenda templates** • **Introduce *promotion, praise, promise* initiative to drive approach to reward and recognition, anchored to refreshed values**	**June – March 22**	**HR Teams** **L&OD Team**

APPENDIX A:

Corporate Branding	**NWAS: a values driven organisation** • **Develop a refreshed values brand (logo) that is reconciled with current NWAS branding for BTD and wider corporate branding** • **Translate branding onto all NWAS letterheads and corporate stationary** • **Translate branding onto the Green room and all corporate comms** • **Ensure all email signatures are branded with the refreshed values logo** • **Map and translate values into all NWAS promotional material ie drinking bottles** • **Update all corporate posters with refreshed values brand** • **Embed refreshed values brand into all Board papers, strategy papers and any further papers available for public release**	**March 21 – Sept 21**	**Delve /Comms Team** **Comms Team**
Evaluation	**The NWAS way** **An opportunity to regularly review the impact of values based work on organisational development, ranging from staff engagement and morale to improved HR metrics and wider relevant organisational performance indicators:** • **Pulse survey driving a 6 month review of the impact of refreshed values on staff experience** • **Evaluation report detailing impact of refreshed values on organisational performance metrics (to be agreed)** • **Action plan to respond to outcomes of above two evaluation pieces at 6 months and 12 months**	**Nov 21** **May 22**	**L&OD Team**

APPENDIX A:

The implementation plan marks a 12 month programme to launch, embed and mainstream the refreshed NWAS values into the hearts and minds of staff to shape, direct and align the workforce to the organisation's journey to become the best ambulance service in the country. The 12 month evaluation report will support shaping the priorities for the next phase of development towards sustaining NWAS as a values driven organisation.

APPENDIX A:

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