North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 30 September 2020
9.45 am - 1.00 pm

Microsoft Teams - Microsoft Teams

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
BOD/2021/55	Patient Story	09:45	Information	Director of Strategy and Planning	
INTRODUCTION					
BOD/2021/56	Apologies for Absence	10:00	Information	Chairman	
BOD/2021/57	Declarations of Interest	10:00	Decision	Chairman	
BOD/2021/58	Minutes of Previous Meeting	10:00	Decision	Chairman	3 - 14
BOD/2021/59	Board Action Log	10:00	Assurance	Chairman	15 - 16
BOD/2021/60	Committee Attendance	10:00	Information	Chairman	17 - 18
BOD/2021/61	Register of Interest	10:05	Assurance	Chairman	19 - 20
STRATEGY					
BOD/2021/62	Chairman & Non-Executives' Update	10:10	Information	Chairman	
BOD/2021/63	Chief Executive's Report	10:15	Assurance	Chief Executive Officer	21 - 38
BOD/2021/64	Northern Ambulance Alliance Progress Report	10:20	For Discussion	Chief Executive Officer	39 - 44
BOD/2021/65	Review & Refresh of Trust Strategy and IBP	10:30	Decision	Director of Strategy and Planning	45 - 78
GOVERNANCE AND RISK MANAGEMENT					
BOD/2021/66	Policy Framework Update	10:40	Assurance	Director of Corporate Affairs	79 - 86
BOD/2021/67	Charitable Funds Committee Chair's Assurance Report - from meeting held on 29.07.20	10:50	Assurance	D Rawsthorn, Non-Executive Director	87 - 88
QUALITY AND PERFORMANCE					
BOD/2021/68	Integrated Performance Report	11:00	Assurance	Director of Quality, Innovation and Improvement	89 - 144
BOD/2021/69	Quality and Performance Committee Assurance Report - from meeting held on 21.09.20	11:10	Assurance	Prof A Chambers, Non-Executive Director	145 - 152
BOD/2021/70	IPC Board Assurance Framework	11:20	Assurance	Director of Quality, Innovation and Improvement	153 - 228
BOD/2021/71	Resources Committee Assurance Report - from meeting held on 25.09.20	11:30	Assurance	Mr M O'Connor, Non-Executive Director	229 - 238

BOD/2021/72	AQI Data Quality	11:40	Assurance	Director of Quality, Innovation & Improvement	239 - 250
BOD/2021/73	Research Strategy	11:50	Decision	Medical Director	251 - 278
BOD/2021/74	Learning from Deaths Q1 2020/21	12:00	Assurance	Medical Director	279 - 286
WORKFORCE					
BOD/2021/75	WRES, WDES and Gender Pay Reporting	12:10	Decision	Director of People	287 - 342
BOD/2021/76	Learning to improve our People Practices	12:20	Assurance	Director of People	343 - 352
BOD/2021/77	Flu Checklist	12:30	Assurance	Director of People	353 - 362
CLOSING					
BOD/2021/78	Any Other Business Notified Prior to the Meeting	12:40	Decision	Chair	
BOD/2021/79	Items for Inclusion on the BAF	12:45	Decision	Chair	
BOD/2021/80	Questions from the Public	12:50	For Discussion	Chairman	

Date and Time of Next Meeting 9.45 am Wednesday, 25 November 2020

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

NHS
North West
Ambulance Service
NHS Trust

Minutes
Board of Directors

Details: Wednesday 29th July 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
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
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 E Olasode	Corporate Governance Manager (Minutes)
Ms P Harder	Head of Corporate Affairs

Minute Ref:

BOD/2021/31 APOLOGIES FOR ABSENCE

No apologies for absence were received.

B0D/2021/32 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

BOD/2021/33 MINUTES OF PREVIOUS MEETING HELD ON 27TH MAY 2020

The minutes of the previous meeting held on 27th May 2020 were presented to members for review and approval.

The Board:

- Approved the minutes of the previous meeting held on 27th May 2020.

BOD/2021/34 ACTION LOG

The Board noted the action log and update.

BOD/2021/35 COMMITTEE ATTENDANCE

The Board noted the committee attendance presented for information.

BOD/2021/36 REGISTER OF INTEREST

The Board noted the 2020/21 register of interest presented for information and agreed it was a true and accurate record. Prof A Chambers advised an amendment was required to her declaration of interest which had been discussed with the Head of Corporate Affairs

BOD/2021/37 STAFF STORY

The Director of Strategy and Planning presented the Board of Directors with a short film relating to video consultation within NHS 111. Members were advised that NHS Digital and NHS England had contacted the Trust in March 2020 to become the first service to pilot video consultation. The film highlighted how video consultation worked, what the clinicians participating in the pilot thought of using video consultation within their clinical assessment process and how it benefited patients.

The Director of Strategy and Planning advised that clinicians involved in the pilot reported significant benefits in using video consultation and reported increased confidence in their clinical decision making, which helped the patient receive the most appropriate care for their needs, whether that was home management or by attending A&E.

He advised during the trial 45 patient video consultations were undertaken and that the majority of calls resulted in patients having their health concerns fully addressed without the need to have further face-to-face consultations with other health care professionals. In almost all the calls undertaken during the pilot, clinicians reported clinical assessments were completed almost 50% quicker than previously.

In terms of future plans, he reported that NHS England and NHS Digital are planning to roll out video consultation nationwide.

The Board commended the initiative however queried whether the quality of the video could be improved and if the Trust's digital infrastructure could support it. In addition, Prof R Thomson enquired whether video consultation could be incorporated into other parts of NWAS' services including the health and social care sector. The Director of Quality, Innovation and Improvement confirmed video consultation would be incorporated into other services provided by the Trust and stated the intention to include in the NHS 111 First business case.

Mr M O'Connor queried whether the Trust could record and store the video stream as evidence, in the event a patient's diagnosis deteriorated. The Director of Strategy and Planning agreed and advised IT and the digital team would undertake further work around this. He also reported NHS Digital were keen to work with the Trust and that the Director of Quality, Innovation and Improvement and the Director of Operations would present the outcome to a future Board Development Session.

The Director of Quality, Innovation and Improvement advised video consultation was within the Trust' Digital Strategy and noted the investment decision as two products were currently being tested within 111 and 999 service. She reported the data

protection impact assessment was being undertaken which would address every challenge.

The Board:

- Commended the video consultation pilot and the positive impact on patients.

BOD/2021/38 CHAIRMAN AND NON-EXECUTIVES DIRECTORS UPDATE

The Chairman advised the Board of Directors that he had met with Non- Executive Directors to undertake appraisals and set objectives for 2020/21. He reported he had held a number of regional calls and commented on the positive feedback received relating to the organisation's leadership.

Finally, he advised of his attendance to a Celebration Event at Furness General Hospital to celebrate the work of the volunteers at the hospital who delivered 300,000 meals during the coronavirus pandemic, which was an outstanding achievement.

The Board:

- Noted the update.

BOD/2021/39 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented a report to provide members with information on a number of areas since the last report to the Trust Board on 27th May 2020. The report covered (i) Performance, (ii) issues to note, and (iii) general updates.

The Chief Executive advised work was being undertaken across the sector in relation to COVID-19 and noted the organisation was progressing from response to recovery, with work being developed towards restoration of normality.

He reported that 22 May was the third anniversary of the Manchester Arena bomb attack and noted the actions taken by all emergency responders, especially of those from North West Ambulance Service would forever be remembered.

The Chief Executive was pleased to report that following a rigorous selection process on 3 July 2020, Lisa Ward was appointed to the post of Director of People. He referred to the unannounced CQC inspection and reported the Trust received a good overall rating and was delighted with the overall rating.

He advised the Board that violence and aggression towards the Trusts staff continued and that the Trust continued to explore how the working environment can be made safer for staff.

Members noted the work undertaken on race equality and noted the Equality, Diversity and Inclusion Annual Report was included on the agenda and highlighted the tremendous work undertaken by the Trust's People and Patient Engagement teams over the last 12 months.

The Chief Executive referred to the work undertaken during COVID-19 in relation to BME staff and the various support provided to staff during this period. He referred to his recent appointment as Chair of the Association of Ambulance Trust Chief Executives (AACE) which would raise the Trust's profile. Finally, he paid tribute to Malcolm McKune who passed away on 25th June 2020 and noted thoughts go out to his family at this sad time.

Prof R Thomson referred to the risk assessments and the low figures reported in comparison to BAME staff. The Director of People explained robust risk

assessments were in place from the outset and were required for all staff with an underlying health condition, which helped identify staff that could work from home, staff that needed to be medically suspended or provided with alternative duties. She advised the framework had been expanded to those at high risk to males aged 60+, which provided a further opportunity to risk assess 3,200 additional staff. She highlighted outputs were being reviewed in terms of i) staff lacking confidence in relation to PPE, ii) staff who may require mental health support and iii) identifying whether further risks factors. She referred to the report and the compliance rate at 22 July 2020 and noted the timescale for completion of the exercise was 31 July and the assumption that staff are confident around the process after the deadline.

Prof A Chambers congratulated the Chief Executive and Director of People on their recent appointments. She queried the level of confidence of the Trust around winter preparedness and questioned the availability of resources around routine treatments. The Chief Executive noted performance had been affected by the increase in demand and that he had met with the Director of Operations to identify how performance could be sustained during winter and stated he would be happy to meet with Prof A Chambers on this matter. Prof A Chambers welcomed a meeting to discuss progress.

The Chairman referred to the CQC rating and commended the Executive team for their hard work. He referred to the Chief Executives appointment with AACE and noted this was a positive appointment for the Trust and sector.

The Board:

- Received and noted the contents of the report.

BOD/2021/40 NORTHERN AMBULANCE ALLIANCE UPDATE

The Chief Executive provided the Board of Directors with an overview of progress against the key work streams being progressed by the Northern Ambulance Alliance (NAA) and advised that Ms. Carol Weir had been appointed as the Managing Director of the NAA.

Mr D Rawsthorn enquired whether there was a scope for a joint Non-Executive Director event. The Chief Executive advised a joint Chairs/Chief Executive away day had been held and noted the possibility of scheduling this in the future. The Chairman remarked that joint networking could be discussed with other Chairs and highlighted the work of the NAA is driven from the risks trusts face. He highlighted the need to understand governance processes and noted there could be no mixed messages around the role of the Chairs and the Chief Executives.

Dr D Hanley queried whether there would be an evaluation on the impact of the NAA work stream. The Chief Executive advised the Managing Director had not been requested to undertake this however this could be linked in to future work of AACE.

The Board:

- Noted the content of the report and the plans outlined to progress the NAA work stream.

BOD/2021/41 BOARD ASSURANCE FRAMEWORK 2020/21 & CORPORATE RISK REGISTER

The Director of Corporate Affairs presented a report to provide members with an opportunity to review the opening position of the 2020/21 Board Assurance Framework (BAF) and the Q1 position along with Corporate Risk Register. She advised that 21 risks were identified and following a full review of both controls and assurances across the BAF, the following changes were proposed:

- SR01 Opening Risk Score of 15
- SR02 Opening Risk Score of 25
- SR03 Opening Risk Score of 25
- SR04 Opening Risk Score of 16
- SR05 Opening Risk Score of 12
- SR06 Opening Risk Score of 8
- SR07 Opening Risk Score of 12
- SR08 Opening Risk Score of 15
- SR09 Opening Risk Score of 12
- SR11 Opening Risk Score of 20

She referred to the Q1 position of SR11 and noted the reduction in risk score from 20 to 15. The Board also noted SR06 had merged with SR10 and referred to the revised articulation to reflect the reputational impact. The Director of Corporate Affairs noted assurance would be evidenced through reports to Committees and tracked through the governance system.

The Chairman queried the rationale for SR01, the Director of Quality, Innovation and Improvement clarified that the wording was incorrect and agreed to amend.

The Chairman suggested a full review of the BAF and welcomed a meeting with the Director of Corporate Affairs and Senior Risk and Assurance Manager to discuss further in readiness for the Care Quality Commission.

Prof A Chambers and Dr D Hanley advised they had discussed SR03 with the Senior Risk and Assurance Manager relating to clarification of assurances to ensure triangulation at the Quality and Performance Committee. In terms of SR07, the Director of Quality, Innovation and Improvement advised review of the Digital Strategy would commence in September 2020 for completion by the end of Q3.

Mr D Rawsthorn suggested that the risk appetite statement is included as an appendix to the BAF and used to aid decisions made by the Board. The Director of Corporate Affairs noted the various conversations in relation to the BAF however stated the need to have a fundamental understanding of the BAF before moving to the next step and referring to the risk appetite statement. She advised that if levels of assurance are not provided, the Chair of the Committee must commission further assurance to ensure the expected level of assurance is delivered.

The Board of Directors:

- Agreed the 2020/21 Opening Position of the Board Assurance Framework
- Agreed the Q1 position of the Board Assurance Framework
- Agreed the decrease in risk score for SR11 from 20 to 15
- Agreed the revised articulation of SR06 to reflect the reputational impact
- Agreed the closure of SR10 pertaining to Trust perception.

BOD/2021/42 FREEDOM TO SPEAK UP REPORT Q1 2020/21

The Director of Corporate Affairs presented the Board with an overview of Freedom To Speak Up activity during Q1 2020/21. She noted there had been 84 concerns raised during Q1 2020/21, a significant increase compared to the previous year and referred to the analysis of concerns by theme, category and service line. She clarified the Board should refer to the recommendations provided in s5 of the report.

Prof R Thomson queried the triangulation of information relating to fraud and the reports received from the MIAA. The Director of Corporate Affairs advised the Audit Committee received these reports and that the Director of Finance was responsible

for this area. She advised a key element to take forward is to triangulate data to identify hot spots and is currently work in progress.

Mr M O'Connor referred to the outstanding cases and queried the actions being undertaken to ensure concerns are progressed. In response, the Board were advised a cluster of concerns all linked to a complex investigation and noted some of the delays are as a result of COVID-19 however should be closed off by the next meeting.

The Board also noted EOC had been impacted by COVID-19, with key staff on long-term sickness absence which affected investigations and that the situation was being monitored.

Prof A Chambers queried whether additional resource was required in order to resolve issues in a timely manner. The Director of People advised of the national agreement with the Trade Union to pause investigations and noted the need to consider/review how cases are dealt with in a timely manner.

Ms C Wade commented on the breakdown of cases around attitude and behaviours, she remarked that the cases were historical and queried the actions in place to tackle these issues and reduce numbers. The Director of People advised that the Freedom To Speak Up Guardian identified that had issues been managed effectively at local level, issues would not have been escalated to the Freedom to Speak Up route. She explained further that plans were in place to review workplace values, which would help drive cultural issues and identify how staff and managers work with each other.

Dr D Hanley commented that lessons learnt were around FTSU processes and referred to the need to evidence how the process impacts an organisation and its culture and queried when the Board would receive triangulation with other data to demonstrate the impact of the process. The Director of Corporate Affairs explained that this would be reflected in the work programme for this year to triangulate complaints data by sector and forecasted the availability of data by 2021/22. The Director of Quality, Innovation and Improvement agreed with the Director of Corporate Affairs and noted triangulation of FTSU with safeguarding and patient data would be a permanent feature from 2021/22.

The Chairman expressed his concerns relating to FTSU and increase numbers. He noted the issue with resource to resolve outstanding cases and how the Guardian is supported operationally. He requested the situation is resolved and that issues are discussed further with individuals, particularly to resolve the challenge around data triangulation. The Director of Quality, Innovation and Improvement commented that there should be an acknowledgement of existing capacity in terms of FTSU and the impact of COVID-19.

The Board:

- Noted the work of the Guardian.
- Noted the work of the Trust in response to some of the key themes emerging from cases.
- Noted the work to be undertaken to ensure the Guardian and the Trust can evidence learning from cases.
- Considered the risks and identified further actions.

BOD/2021/43 ANNUAL AUDIT LETTER

The Director of Finance presented members with the Annual audit letter 2019/20, which summarised the key issues from the external audit work carried out by KPMG. Members were advised all audit work was complete and the Annual Audit Letter would be published on the website by 31 July 2020.

Mr D Rawsthorn commented on the summary of information that was presented to the Board in June. He commended the Director of Finance and stated the results reflect well against CQC Well-led. The Chair commended the Director of Finance for excellent financial management.

The Board

- Noted the assurance provided**.**

BOD/2021/44 CHAIRS ASSURANCE REPORT - AUDIT COMMITTEE FROM THE MEETING HELD ON 10.07.20

Mr D Rawsthorn presented the Board with report form the Audit Committee meeting held on 10 July 2020. In terms of clinical audit, he reported that the organisation was in a favourable position to restart the programme, with outstanding actions completed after the next meeting.

The Board:

- Noted the assurance provided.

BOD/20201/45 INTEGRATED PERFORMANCE REPORT

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report to the Board. The report highlighted performance on Quality, Effectiveness, Finance, and Operational Performance and Organisational Health for the month of June 2020.

Mr R Groome referred to mandatory training and noted that compliance levels had reduced, the Director of Quality, Innovation and Improvement advised this mainly related to PTS during COVID-19 however there had been a gradual increase in compliance as the organisation returns to normality.

The Chairman queried the 9% performance relating to complaints and the underlying factors responsible for performance level. The Director of Quality, Innovation and Improvement advised of the directive from NHSE/I during COVID-19 to suspend complaints investigation and the redirection of the workforce to patient safety.

Dr D Hanley noted that whilst performance was good, expressed concern around sustainability of performance and referred to the gradual increase in sickness. The Director of People advised that COVID-19 had inflated sickness figures and advised the Trust was not in a position to progress sickness hearings however discussions had been held with the team to restart these. She advised that a targeted team to look at sickness may be required and accepted this as a key piece of work within the recovery phase.

Prof A Chambers noted the positive vacancy position however referred to sickness levels particularly within 111 and queried how confident the Trust were in maintaining staffing levels to achieve performance. The Director of People advised of the plans around the vacancy gap however noted challenges around the recruitment plan particularly in maintaining the balance in capacity across PES and PTS. The Director of Operations added the major challenge related to Think NHS 111, which required a significant number of staff and required focus, in order to sustain performance and noted the Quality and Performance Committee would receive further assurance.

The Chairman commended the work undertaken to deploy staff to the frontline to attend to patients. He noted the individual concerns relating to appraisals and

mandatory training with further assurance to be provided to Committees however acknowledged the great work that had been undertaken.

The Board:

- Noted the assurance provided.

BOD/2021/46 LEARNING FROM DEATHS

The Medical Director presented a report to the Board of Directors in order to meet the requirements of national guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from death in care as referenced in the Trust's Learning from Deaths policy.

He advised the Board that the first quarter to be published was Q4 2019/20 and noted work was being undertaken relating to the advanced methodology and identifying cases to review. He reported the delay in reporting was as a result of COVID-19 however a small team had been identified to undertake the reviews in conjunction with the Quality directorate.

In response to Dr D Hanley's question relating to the timescale for identification of learning, the Medical Director advised that themes would be identified which would lead to an improvement/action plan and would be presented to the Quality and Performance Committee in September 2020.

Ms C Wade noted that she was aware of the timeframe and knew the national lead and trainer for acute trusts however noted some assistance could be provided in relation to implementing the plans. The Medical Director welcomed the involvement.

Mr R Groome queried the information provided within the dashboard, the Medical Director advised that data collection had only just commenced and whilst difficult to interpret, provided assurance the methodology was being fulfilled and would become clearer over time. The Director of Corporate Affairs advised data should be easily interpreted with thought required on how data is presented. The Chief Executive added the CQC would review this as part of the Well-Led inspection and highlighted the need to ensure it meets all requirements.

The Chairman noted the requirement to clearly articulate the findings of the process. The Medical Director advised assurance would be provided once structured judgement reviews had been undertaken to identify those cases

The Board:

- Accepted the dashboard at Appendix A to be published within the public domain as evidence of the Trust's developing engagement with a formal process of learning from deaths.
- Accepted the limitations of the dashboard with the assurance that this is an iterative process and would develop over time.

BOD/2021/47 CQC UPDATE AND ACTION PLAN 2020.

The Director of Quality, Innovation and Improvement presented the Board of Directors with an update of current Care Quality Commission (CQC) related activity within the Trust and provided assurance that the Trust is addressing any current associated requirements.

Members were advised that work would be undertaken to focus on Emergency Care Framework and the first meeting in August 2020 would focus on the IPC BAF and

reiterated that there was no requirement to submit the IPC BAF to the CQC. In terms of the Trust's Well-Led inspection, she advised the Board that once the Emergency Care Framework had been worked through; it might follow in Q3 or Q4.

The Director of Quality, Innovation and Improvement referred to the areas of outstanding practice within the report, which would continue to be progressed and noted the areas of focus raised by the CQC had already been identified by the Trust. Prof A Chambers referred to Operation Outstanding and queried how the Trust could build on the successful pilots highlighted as outstanding by the CQC. The Director of Quality, Innovation and Improvement advised that Operation Outstanding had a work programme and through weekly meetings, ideas were shared across sectors. She also added commissioning arrangements were required to continue some of the pilots and would be aligned to the transformation and urgent and emergency care strategy.

The Chairman commended the Executive team in particular the Director of Quality, Innovation and Improvement and her team on the CQC ratings.

The Board:

- Noted the assurances provided in this report.
- Acknowledged the good work completed to achieve an overall CQC rating of 'Good' for the organisation, with an 'Outstanding' in the U&EC 'Responsive' domain.
- Noted that appropriate Committee of the Board would monitor the completion of the Trust's 'should do' action plan.

BOD/2021/48 CHAIRS ASSURANCE REPORT - QUALITY AND PERFORMANCE COMMITTEE FROM MEETINGS HELD ON 15 JUNE 2020 AND 20 JULY 2020

Mr R Groome presented the Chairs assurance report from the meeting held on 15 June 2020.

Prof A Chambers presented the assurance report from the meeting held on 20 June 2020 and reported the Committee discussed the BAF and were assured by the quality of papers and that actions were in place to mitigate risks. She referred to the work of Community First Responders and the Committee commended their contribution to NWAS during the ongoing pandemic.

Mr. D Rawsthorn commented on the noticeable change in assurance provided to the Board, the Chairman also noted it was good to see improvements against assurance rating and recognised the work of the Community First Responders.

The Board

- Noted the assurance provided in the report.

BOD/20201/49 CHAIRS ASSURANCE REPORTS - RESOURCES COMMITTEE FROM THE MEETING HELD ON 24 JULY2020

Mr M O'Connor presented the Board with the Chairs assurance report from the Resources Committee held on 24 July 2020. Members were advised that the Committee received assurance from the Board Assurance Framework that was presented and no significant risks were identified.

He noted the amber rating against finance, which related to the uncertain future of financial planning, the Director of Finance added this would be discussed further

within Part 2 of the Board meeting. Mr M O'Connor referred to the digital update and noted the Committee remarked on the positive progress made by the Trust.

The Board:

- Noted the assurance provided within the report.

BOD/2021/50 EQUALITY, DIVERSITY AND INCLUSION ANNUAL REPORT

The Director of People presented the Equality, Diversity and Inclusion Annual Report providing the Board with an overview of the work undertaken over the last 12 months in support of the equality diversity and inclusion agenda.

In terms of the work undertaken during COVID-19, she advised of challenges around representation within command structures and operational decision-making and reported that together with the Director of Operations, a debrief was being undertaken to look at equality issues and the representation within command structures. She advised a review of how the Trust used the Equality Impact Assessment during the pandemic would be distributed for comments in advance of the board of Directors meeting and reported through the Resources Committee.

The Director of People advised that the annual report celebrated the work undertaken across the Workforce and the Strategy and Planning teams. She reported on assessment of progress against quality objectives; workforce representation against bullying and harassment and highlighted the need to set new objectives. Work would be undertaken on areas to be prioritised and presented to the Board in September 2020.

In terms of leadership and governance, she noted the increased focus on executive visibility in order to support the development of ED&I work and the importance of representation across all directorates to make it more effective and embed within governance.

In response to Mr M O'Connor's question relating to how diversity and inclusion could be more prominent within the Trust, the Director of People advised that engagement work is critical and noted the importance of developing the networks, with Board champions to drive changes to support staff.

The Chairman stated the importance of leadership and support by the Board however noted the progress made and congratulated the team. Discussion followed regarding community engagement and it was agreed this would be discussed further at a future Board Development Session.

The Board:

- Noted the assurance regarding the progress of the equality, diversity and inclusion agenda.
- Approved the publication of the Annual Report on the Trust website, incorporating the EDS2 ratings.

BOD/2021/51 COMMUNICATIONS UPDATE

The Director of Strategy and Planning presented the Communications and Engagement dashboard for Q1 2020/21 and advised the team had adapted to support the COVID–19 response. He drew members attention to the Freedom of Information performance against the national target of 90% completion within 20 days which fell marginally below the target of 89% due to COVID-19 however noted the leniency provided by the Information Commissioners Office.

Mr D Rawsthorn queried whether information around Board visibility could be included on a future dashboard. The Director of Strategy and Planning this was currently under discussion in terms of how to capture information to present to the CQC however would discuss further with the Chairman.

The Chairman noted that opportunities are provided to the Non-Executive team to engage with staff and noted the Executive team had done so through social media. He noted all the good work undertaken by the Communications and Engagement team and commended the good work undertaken.
The Board:

- Received and noted the activity of the Communications and Engagement team during Q1 2020/21.

BOD/2021/52 WORKFORCE STRATEGY

The Director of People presented a report to the revised Workforce Strategy for approval by the Board following annual review.

Members were advised that the strategy refresh took into account the national drivers and changes to improvement goals and the impact of COVID-19 on workforce challenges. She reported that the revised appraisal target for the year had been approved by the Executive Leadership Committee and that the focus for appraisals for 2021/22 is to set a higher target and ensure that NWAS was in a good position to achieve the target with an overall focus on the recovery plan.

The Board:

- Approved the revised Workforce Strategy.

BOD/2021/53 ANY OTHER BUSINESS

There were no items of urgent business.

BOD/2021/54 ITEMS FOR INCLUSION ON THE BOARD ASSURANCE FRAMEWORK

There were no items identified.

BOD/2021/55 DATE, TIME AND VENUE OF NEXT MEETING

The next meeting of the Board of Directors will be held on Wednesday 29th September 2020 via Microsoft Teams

Signed: _____

Date: _____

This page is intentionally left blank

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
44	27/05/20	1920/26	Workforce and Wellbeing Covid -19 Response	A copy of the Equality Impact Assessment being completed for the workforce and wellbeing Covid 19 response, be circulated to members once it had been finalised.	LW	29.07.20		EIA in progress, updates awaited from some teams and final draft will be circulated prior to next Board. **Update 25.9.20:** EIA circulated for comment	
45	29/07/20	2021/42	FTSU	Triangulated workforce and complaints data to be reported to the Board.	MP/AW/LW	25.11.20		Trial to be reported in November Board Report	
46	29/07/20	2021/46	Learning From Deaths	Findings of the process and identified learning to be reported to the Board	CG	25.09.20		On agenda	
47	29/07/20	2021/39	CEO Reports	Review of requirements set out in WRES Briefing for Boards and COVID-19 Emergency Preparedness, Resilience and Response structures (EPRR) with presentation of review and any subsequent proposals to Quality and Performance Committee	GB	25.11.20			

This page is intentionally left blank

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		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
Ged Blezard	✔	✔	x	✔	✔	✔	✔	✔	✔	✔								
Prof Alison Chambers	✔	✔	✔	✔	✔	x	x	✔	✔	✔								
Salman Desai	✔	✔	✔	✔	✔	x	✔	✔	✔	✔								
Mick Forrest	✔	✔	✔	✔	✔	✔	✔	✔	✔	x								
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	✔	✔	x								
Richard Groome	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔								
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	✔	✔	✔	✔	✔	✔	✔	✔	✔								
Clare Wade	✔	✔	✔	✔	✔	✔	x	✔	✔	✔								
Lisa Ward	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔								
Angela Wetton	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔								
Peter White ©	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔								
Carolyn Wood	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔								

Audit Committee						
	17th April	22nd May	17th June	10th July	23rd October	23rd October
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	✔			
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	✔	✔						
Michael Forrest	✔	✔	✔	✔	✔						
Dr Chris Grant	✔	✔	✔	✔	✔						
Richard Groome	✔	✔	✔	✔	✔						
Dr David Hanley	✔	✔	✔	✔	✔						
Prof Maxine Power	✔	✔	✔	✔	✔						
Rod Thomson	✔	✔	✔	✔	✔						
Carolyn Wood	x	x									

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

Nomination & Remuneration Committee								
	14th April	27th May	3rd July	29th July	30th September	25th November	27th January	31st March
Prof Alison Chambers	✔	✔	✔	✔				
Richard Groome	✔	x	x	✔				
Dr David Hanley	x	✔	✔	✔				
Michael O'Connor	✔	✔	x	✔				
David Rawsthorn	✔	✔	✔	✔				
Prof Rod Thomson	✔	✔	✔	✔				
Clare Wade	x	x	✔	✔				
Peter White ©	✔	✔	✔	✔				

This page is intentionally left blank

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
			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.

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	30th September 2020			
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 Chief Executive's report to the Trust Board on 29 July 2020. The highlights from this report are as follows: **Performance** • NHS 111 First has gone live in Blackpool and Warrington • Cleric, the Single Patient Management system went live on 16 September. • The inquiry into the bombing of the Manchester Arena opened on 7 September			
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

- THIS PAGE IS INTENTIONALLY BLANK -

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 29 July 2020.

2. PERFORMANCE

2.1 **999**

During July and August NWAS witnessed activity levels return to pre-COVID levels. This coincided with the lifting of the national lockdown restrictions. With the restrictions being lifted activity quickly rose to the previous levels. It also meant the Universities re-opened and the Student Paramedics who were supporting PES and 111 returned to their studies thus reducing the availability of additional staffing. This has also been compounded by staff shielding and self-isolating.

The increase in activity and reducing resources saw NWAS performance return to the previous levels and only achieving one of the seven standards (C1 90th Centile).

A significant piece of work is nearing completion looking at the demand and the capacity that NWAS require to meet the national standards. ORH have been jointly commissioned with Blackpool CCG lead commissioners to undertake this review. The results are due late September and will indicate if investment is required and what efficiencies can be made.

The strategic winter plan has been produced and is ready to be submitted to NHSE/I.

111

During July and August 2020 NWAS 111 have been managing two significant projects, NHS 111 First and the new Single Patient Management System (SPMS), Cleric, whilst continuing to operate with the risks of COVID in the call centre and the population.

Calls offered in July 2020 (180,871) were 9% higher than in 2019, yet NWAS 111 delivered higher performance (83.2%). In the latter half of August 111 started to experience a resurgence in COVID related calls with the rise in community cases and limitations in the testing capacity. August 2020 calls offered was 202,449; 22% higher than August 2019. Unfortunately the combination of increased demand, staff extractions for Cleric training and increased new staff to support NHS 111 First performance in August was down at 69.6%.

NHS 111 First impacts have been experienced through rapid recruitment and training requirement of over 200 staff. This has stretched the 111 training team and required support from the 111 preceptor pool. Currently we are commencing new courses every 2 weeks and due to COVID delivering the training off site. As new Health Advisors commence taking live calls their inexperience leads to longer call lengths so 111 efficiency drops.

Due to the large expansion of the 111 team, work has been ongoing with the estates and Digital teams to review the internal estate and scope out the possibility of expansion into some vacant office space on the Middlebrook site.

Cleric, the Single Patient Management system, went live on the 16 of September 2020; with some 645 111 staff fully trained at the end of August and the Digital sub-group delivered assurance to the SPMS board through development and testing of the new system.

Within all our 111 call centres we continue to action our IPC (Infection Prevention and Control) plan, with maintaining social distancing continuing to be our greatest challenge.

Due to a recent outbreak we are now carrying out daily IPC audits and senior manager walk rounds to seek assurance all staff are adhering to the guidance.

PTS

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

As at August 2020 the overall year to date activity was 45% below contract baselines with Cumbria at 52% below, Greater Manchester at 41% below, Lancashire at 52% below and Merseyside at 36% below contracted baseline. Whilst activity is significantly below contracted baselines, outpatient activity has risen sharply since the last reporting period and it is expected to continue to grow into the Winter as the Integrated Care Systems attempt to restore their outpatient appointments across the North West.

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 means we cannot transport as many patients at the same time. As activity increases, and focus on the Trust's ability to respond to on the day discharge requests intensifies, it is becoming a greater challenge. PTS continues to support the delivery of the PES operation via the supply of staff and vehicles as previously mentioned.

3 ISSUES TO NOTE

3.1 Local Issues

Manchester Arena Inquiry

The Manchester Arena bomber who orchestrated the devastating atrocity which left 22 dead and hundreds more injured has been handed 24 life sentences with a minimum term of 55 years behind bars. The trust's condolences and heartfelt wishes go out to the families of the 22 people who tragically lost their lives as well as the many that were injured and/or affected by the terrible event.

Monday 7 September saw the start of the Manchester Arena Inquiry which is an independent public inquiry, established in October 2019 by the Home Secretary to investigate the death of the victims of the 2017 attack. The inquiry is a significant milestone for the trust and, of course, the families. We will do everything we can to support and engage in this very important process.

This month will see Sir John Saunders' opening remarks as Chair and the families' commemorative evidence. This will be a difficult time for many, not least those staff who were on duty at the time. Further dedicated Manchester Arena Inquiry bulletins will be sent out as the proceedings progress to keep staff fully informed of the process together with other information that may be needed from the trust's legal and communications teams. There will also be increasing amounts of media coverage which may bring back difficult memories for our staff. Resources have been made available which staff will be encouraged to make use of.

Apprenticeship Success

The trust was delighted to be able to celebrate the success of our colleague, Elena Winstanley, who joined the communications team as the very first communications apprentice in 2018. She heard the news that she had passed all elements of her studies and is now 'officially' a communications assistant.

To mark the occasion her colleagues in the team threw a surprise graduation ceremony on the lawn at Ladybridge Hall, complete with full degree regalia and a selection of gifts. It was a fun occasion organised as a one-off which everyone enjoyed, but it also makes an

important point; at NWAS we take our role seriously in terms of encouraging talent and providing opportunities right across the organisation for a new generation to flourish. We offer a number of apprenticeships across the trust and it is always a pleasure to play our part in their journey.

3.2 **Regional Issues**

COVID-19 Antibody Testing

I am very pleased to report that 89% of staff took up the opportunity to have this antibody test. My thanks to everyone who took the test and to everyone involved in facilitating testing via our healthcare partners across the region. Further testing will be the new normality for the trust and Maxine Power, Director of Quality, Innovation and Improvement and her team will continue to work on the trust's track and tracing programme, as well as our management of COVID-19 cluster outbreaks.

COVID-19 Trust Surveys

An element of our recovery planning is learning from our response to the pandemic and many staff took the time to share their experience and opinions in the first of the two recent trust surveys (for patient facing and non-patient facing staff). Some of the high level findings from the patient facing staff survey included positive feedback in relation to briefings, communications, PPE, vehicle cleaning and use of Card 36. In terms of how supported staff felt during the pandemic, 69% of staff felt supported with 31% reporting that they didn't feel fully supported, so the trust will pick this up and see what more we can do and where we can improve going forward.

Non patient facing staff rated homeworking, use of technology, realignment of roles and conversion of PTS ambulances to PES vehicles in support of our front line response very positively. Conversely around 80% of respondents in this survey felt they were well supported during the pandemic.

Overall, over 66% of respondents considered the trust responded to the pandemic either well or very well.

One of the recurring themes from the recent survey related to vehicle cleaning. Many were supportive of vehicle cleaning at emergency departments and wanted to see this continued. Throughout this period close to 25,000 vehicles were cleaned by the JPR Teams on behalf of our Fleet Team with a significant number of cleans related to our response to the pandemic. As the trust enters its recovery and restoration phase, we are looking at lessons learned and good practice which could be taken forward. Vehicle cleaning at emergency departments forms part of this review and is currently being looked at in more detail by a working group to fully evaluate its effectiveness and the benefit to the trust and our patients.

Pandemic Update

Additional localised restrictions relating to social gatherings have been placed on parts of the North West. Health Secretary, Matt Hancock, stated this was due to the increasing number of cases per 100,000 people in the area and data from Public Health England and the Joint Biosecurity Centre which suggests transmission among households is a key infection pathway in the area.

The trust are seeing increased numbers of 999 calls and growing numbers of COVID-19 related calls to the NHS 111 service. This is an important reminder that although we have moved to a recovery phase we are still responding to the virus and our recovery plans must be able to flex in order to deliver all essential services. Whilst our daily Executive calls and our Tactical and Strategic Commander Cells have been reduced or stood down, they can be

resumed very quickly. Equally we need to prepare for what may lay ahead this winter and this will continue to be a focus for the Executive Leadership Team together with the trust's testing strategy.

Workplace Safety and Wellbeing

The internal COVID-19 survey highlighted that many people welcomed the opportunity to work from home, some or all of the time.

As we move into the recovery phase of the pandemic, there will be greater numbers of staff returning to the workplace, either following a period of sickness absence, self-isolation, working from home or returning from shielding. Staff may be anxious about returning to the workplace after a period of time away, and may require additional support from the trust or other forms of help.

Whilst managers will be undertaking individual risk assessments to address concerns and signpost to the most appropriate form of peer, team and trust support, the Trust produced some short films to show people what trust sites now look like and the measures in place to keep them safe.

Additionally, in response to recent national guidance in relation to those who may be at a greater risk of developing more serious symptoms if they contract COVID-19, the trust invited all male staff and staff of white ethnicity who are over 60 years old to complete a short self-assessment.

Prioritising the physical and mental health of our workforce is essential to ensure we can continue to provide NHS services in the long-term.

NWAS Values

The trust are in the process of developing a set of values with associated behaviours that best represent NWAS, which are meaningful to all staff groups and are in line with the trust's aspirations. From all the feedback collated so far three key themes have emerged in terms of what is important: Being at Our Best; Working Together and Making a Difference

A series of focus groups were held to look at positive examples and experiences of what these themes look like in day-to-day work and through this engagement exercise we will create a set of values that are truly representative of all teams and the organisation as a whole.

NWAS appoints first ever dedicated NIHR Research Paramedic

The trust is pleased to announce that Betty Pennington has been appointed as a full-time, National Institute for Health Research (NIHR) research paramedic here at NWAS, a first for the trust.

After qualifying as a paramedic in 2008, Betty first started pursuing her interest in research by completing an MSc Professional Practice (Research & Development). She took up her first research paramedic secondment in 2012, working on the Head Injury Transportation Straight to Neurosurgery (HITS-NS) study, later supporting the Paramedic Acute Stroke Treatment Assessment (PASTA) trial.

She has since continued to deliver other NIHR research in her capacity as a part-time, research paramedic including the Pre-hospital Evaluation of Sensitive Troponin (PRESTO) study and is currently involved in one of the nationally prioritised COVID-19 Urgent Public Health studies, the PRINCIPLE Trial, that is taking place in our NHS 111 Service. Betty has a number of personal research achievements including securing funding from the College of

Paramedics to undertake her own study, being part of the current cohort of the NIHR Clinical Research Network North West Coast Early Career Researcher Development Pathway, training to become a certified Good Clinical Practice (GCP) Facilitator and winning the title of Research Practitioner of the Year at the Greater Manchester Clinical Research Awards in 2019.

Betty is now part of the Research & Development team and will be working alongside Consultant Paramedic and Research Lead, Steve Bell, and Research Support Manager, Sandra Igbodo, to promote, support and deliver NIHR research at NWAS.

NWAS Anti-Fraud Specialist (AFS)

Paul Bell has taken over the role of nominated AFS for NWAS on an interim basis. Paul is a Senior Anti-Fraud Manager employed by Mersey Internal Audit Agency (MIAA) in the Anti-Fraud Team.

MIAA works with a variety of NHS organisations across the North West to assist them in combating fraud, bribery and corruption. The MIAA Anti-Fraud Team focuses on helping organisations to prevent and detect fraud, bribery and corruption through the delivery of an Anti-Fraud Workplan with activities aligned to the NHS Standards for Providers, and is aimed at addressing and mitigating against fraud risk areas. The AFS should be the first point of contact with any issues or concerns relating to fraud, bribery and corruption.

Electronic Patient Records (ePR)

The trust has been talking about electronic patient records for some time, and providing all testing goes smoothly, the trust will be in a position to begin the pilot of the One Response ePR software this Autumn.

The ePR will enable us to create and view patient records to support assessment and decision making on the ground, vastly increasing our ability to deliver the right care in the right place at the right time. In short it is going to transform the working lives of operational staff. It will remove the need for paper patient report forms giving us increased security, confidentiality and invaluable information which will enable accurate reporting, monitoring and audit of our performance.

Launch of Health Wellbeing & Culture Audit

As the trust transitions to a new phase of working post pandemic, there seems no better time to pause and reflect on how we are feeling about our day to day working life. On the 1 September the trust launched the Health, Wellbeing and Culture Audit. It asks lots of questions about staff experience and feelings but it is completely anonymous, we have no way of tracking who has completed it. The responses will tell us what we are doing well, how we can protect that, and where we can make things better.

A Facebook Live session was held in conjunction with the launch where Michael Forrest (Deputy Chief Executive) and Lisa Ward (Director of People) were available to answer questions about the working culture at NWAS.

Since the last audit in 2014 we listened to staff views and implemented many support measures including: TRiM, a staff mobile phone app, and introduced a 24 hour employee assistance helpline.

3.3 **National Issues**

COVID-19 and NHS next steps

The Head of the NHS, Simon Stevens, has outlined the third phase of the national response to COVID-19, as patient numbers have fallen from the peak of 19,000 per day to around 900 per day.

The NHSEPRR level has been reduced from level 4 to level 3. However, COVID-19 is still very much in circulation. Sir Simon has emphasised the situation will be kept under close review and that the former alert level will be reinstated immediately if circumstances justify.

As well as redoubling efforts to fight the virus, now is the time for the NHS to look ahead to coming months and prioritise our biggest objectives. There is a huge drive for us all to meet the needs of both COVID-19 and non COVID-19 patients, as well as supporting the acceleration of elective activity.

It is vital that we also make preparations for winter and take into account lessons learned from the first two phases of response to the pandemic. Everything is now geared to planning for a future with COVID-19, and for getting systems ready to respond to what will be a challenging winter.

NHS 111 First

During the peak months of the coronavirus pandemic the number of people attending Emergency Departments (EDs) reduced dramatically. This presented an opportunity to change the way the public seek urgent care services and we have been invited to play a key role in helping to guide the public in making the right healthcare choices. The NHS 111 First programme builds on the existing NHS 111 service and aims to make it easier and safer for patients to get the right urgent care treatment when they urgently need it and prevent a return to previous overcrowding in EDs. With public use of NHS 111 already high, this is a great opportunity to implement this across the country to future proof UEC services.

Jackie Bell, Head of Service 111 and Abigail Harrison, Chief of Digital and Innovation, together with their respective teams, worked closely with NHS Digital and wider healthcare partners to enable two 'early mover' areas (Blackpool and Warrington) to offer their patients access to timed appointment slots in ED settings, where this is the most appropriate form of care. Greater Manchester is regarded as a 'fast follower' and the planned go live will be the middle of September. The intention is that all of the North West will implement this new model of care from the 1 December to support winter pressures and a potential further pandemic outbreak.

In the North West approximately 60% of emergency department attendances are self-presenting, walk-in patients, and the majority occur during the day and early evening, which has implications for managing social distancing in waiting rooms. The value of the NHS 111 service has been recognised during the pandemic and the NHS 111 First programme is being introduced to improve outcomes and patient experience in healthcare settings during COVID-19 and provide a long-term model of access to urgent and emergency care services. This will encourage people to call 111 or use 111 online services instead of turning up at EDs and focus on the benefits to them, their families and the NHS as a whole.

A major plan of communications and engagement activity, lead jointly by NHS England/Improvement and the trust's communications team, will support the initial pilot and wider roll out of the project. A recruitment campaign is also vital to provide the required level of resources as more areas link in with NHS 111 First.
This is a highly important national priority and one that I am delighted NWAS is leading on in the North West. It also speaks to the success and performance of the NHS 111 service during the pandemic.

New NHS Campaign - Your COVID-19 recovery

NHS England has launched a new national campaign which will be a great help to many of us across the trust, promoting support that is available to anyone who has been left with lasting health problems from coronavirus.

Patient facing staff in particular will find it a useful resource. Evidence shows that a proportion of post COVID-19 patients are likely to have significant ongoing health problems, notably breathing difficulties, tiredness and cough, reduced muscle function, the reduced ability to undertake physical activity and psychological symptoms such as PTSD and reduced mood status.

Your COVID Recovery https://www.yourcovidrecovery.nhs.uk is a new NHS website designed to help people recover from the long-term effects of Covid-19 and support them to manage their recovery. It includes information from rehabilitation experts about how to manage ongoing symptoms and health needs at home, and signposts to sources of support.

The website also includes information on returning to work, and a helpful section for family, friends and carers of people who are recovering.

New Normality

It is clear that COVID-19 and its impact will be with us now for some time to come so across the health care system we are moving from incident management mode to the new normal.

The North West has experienced the virus later and longer than other regions, and we are still experiencing outbreaks, meaning the hill we have to climb to get our non COVID-19 work back up towards last year's levels is steep. We must work together to support recovery of all our services.

We already know that the virus has had a disproportionate impact on certain sections of the population including those living in the most deprived neighbourhoods, people from Black, Asian and minority ethnic communities, older people, men and those who are obese and have long-term health conditions.

The trust recently announced the move from Resource Escalation Action Plan (REAP) level from Level 2 (moderate pressure) to Level 3 (major pressure) due to increased 999 call volumes and wider system pressures within acute trusts, resulting in handover delays. This allows us to focus our resources on essential services to meet the increased demand and ensure our performance is on track ahead of winter.

We also introduced new sickness reporting procedures for our staff, namely that everyone (including corporate and support services) should now report to the Carlisle Support Centre. This will provide us with a fuller picture of available resources and sickness levels as well as supporting our track and trace work.

NHS People Plan

The beginning of August saw the publication of the People's Plan for 2020/ 2021. It challenges us all to make the NHS a better place to work and this is our opportunity to take a huge step forward in creating an equal, inclusive and diverse NHS

The NHS People Plan, We Are The NHS: Action For All Of Us was published at the end of July. The Plan sets out an ambitious programme for change focused on the period 2020/21. It recognises the need to focus on key areas to support our NHS people through these current challenging times but at the same time aims to deliver a strong foundation on which to continue to build towards delivery of the NHS People Promise.

The 2020/21 People Plan focuses on four key areas:

- Looking after our people – with quality health and wellbeing support for everyone
- Belonging in the NHS – with a particular focus on inclusion
- New ways of working – capturing innovation, led by NHS people
- Growing for the future – how we recruit, train and keep our people, and welcome back colleagues who want to return.

The Plan sets out a range of key actions for individual Trusts, systems, Health Education England and NHSE/I to take in order to deliver improvements in these four important areas. As a trust we have mapped our current activity and practices against these requirements and there are many areas where we are already in a strong position with key actions already in place. This is particularly the case in the context of our Health and Wellbeing offer and our work around education and apprenticeships. There is further work identified to strengthen our approach to inclusion and to develop our existing flexible working practices but key actions have been identified and will be embedded into our recovery and workforce strategy plans to ensure that we can meet the requirements of the national People Plan.

This is a really important area of work to support our people and to create a compassionate and inclusive environment where our people feel safe, are supported and can achieve their potential

Detailed reports have already been submitted to the Executive Leadership Committee and the Resources Committee and assurance on progress in delivering the requirements of the plan will be monitored and reported to Board through the Resources Committee.

Emergency Services Day (999 Day) 9 September

999 day is a Government backed national day across the UK. It is a celebration of the work we all do and will help focus attention on volunteering options and career opportunities within the emergency services, as well as reminding the public how to use the emergency services correctly.

The day at headquarters began with Lisa Ward, Director of People, raising the NWAS flag at 9am on the 9th day of the 9th month. Lisa then led a two minute silence to remember everyone who works and volunteers for all the emergency services, particularly those colleagues who have sadly lost their lives in the last 12 months. More than two million people work and volunteer in the NHS and emergency services today, including 250,000 first responders

NWAS showed its commitment to 999 Day through its own social media activity, and by actively encouraging key regional figures to show their support through their own social media networks, thereby spreading the conversation about the day and our role to new

audiences. However, this year, due to COVID, the service had to be pre-recorded and I was proud, as Chair of AACE, to film a message of support.

My thanks to all those staff who contributed to spotlight features on social media and our website to promote the work of #TeamNWAS and the role of the emergency services.

World Suicide Prevention Day - 10 September

Champs Public Health Collaborative held a webinar via Microsoft Teams on World Suicide Prevention Day to celebrate the achievements of the Cheshire & Merseyside NO MORE Suicide Strategy five years on since its launch, including the prestigious Suicide Safer Community award. It will also mark World Suicide Prevention Day and look to the future with hope as we move forward during COVID-19.

National Ambulance Memorial Service – 16 September

The memorial service usually takes place at the National Arboretum in Staffordshire. Every two years, The Ambulance Service Charity (TASC) hosts a memorial service to remember and honour the members of the ambulance community who have died in service. However, this year, due to COVID, the service had to be pre-recorded and I was proud, as Chair of AACE, to film a message of support.

2019/20 was a year of growth and unprecedented challenges for TASC, and they are, quite rightly, incredibly proud of the life-changing work achieved during these difficult times. A key area of growth came from the introduction of their new physiotherapy service, where beneficiaries can receive up to ten sessions of physiotherapy with a local professional, which resulted in their team offering three times more rehabilitation sessions than last year. However mental health continued to be their largest service in 2019/20, accounting for 3 in 5 of the total interventions provided.

During the COVID outbreak, TASC continued to provide almost all services and even launched a few new ones. What is clear, is that there are more people in the ambulance community who need their support than they can currently help.

I was also contacted by Marie Fisher, Operations Manager at Estuary Point who has had the privilege of attending the Memorial Services over the years on behalf of NWAS, and was involved in the rededication of the Ambulance Service Memorial. She has also taken part in the readings inside the Chapel. Marie has done a lot of fund raising for TASC by way of selling large Poppy pin badges to NWAS, Police, Fire and Nursing, well done!.

4 GENERAL

Ambulance Programme

The final episode of the 5th series of Ambulance aired at the end of July. It has been a fantastic series once again, with around four million viewers tuning in every week. The response on social media has also been huge, with over 2.7 million impressions and the #Ambulance regularly trending in the top two on Twitter whilst on air. We have also had over 2.1 million impressions on Facebook. The positive comments from the public, NHS bodies and other ambulance services has been overwhelming

TV Ratings

- Ambulance is the highest rating factual programme on BBC One (averages over 20% audience).
- Series 5 in Merseyside had a series average of 4.4m, the highest audiences since S2 back in 2017. It has also been a strong performer among 16-34 and C2DE

audiences (three lower social and economic groups in a society), with these audiences also at their best levels since 2017.
- The series was particularly successful in the north, where it had a 22% audience share.
- The final episode of Series 5 had an audience of 4.9m, including 815k 16-34s, the highest ever audience for an Ambulance episode.

The trust are really proud of the series and want to thank everyone, not only the stars of this year's series, but all those who welcomed the production team, carried out their roles despite having a film crew around and those helped with the logistics. Finally thanks to the communications team who have liaised with Dragonfly throughout the whole process and managed all the social media.

The final episode highlighted not only the impact that COPD is having on the health of the people of Merseyside but also the emotional toll that practising life saving techniques like CPR can have on the minds of the crews and staff who have to deal with it day in and day out.

LGBTQ+ staff listening event

The diversity and inclusion team hosted an online listening event to look at the inequalities experienced by LGBTQ+ people and what can be done to tackle them and to shine a light on the experience of staff from a LGBTQ+ healthcare background within the context of COVID-19.

LGBT update

I had the pleasure of attending the LGBT network meeting with Chair, Peter White and hearing about the progress made over the last 12 months, in particular the development of training programmes, work on combatting violence and aggression and improved communications. The launch of the Rainbow Badge earlier this year was another high point for the group. To celebrate the 5th birthday of the National LGBT network, two new CPDme resources have been launched aimed at tackling health inequalities in the LGBT community.

Congratulations to Adam Williams for being elected to stay on as Chair; to Matheu Collins who is now the Deputy and thanks to Howard Coles for his time as Deputy, stepping down to concentrate on his studies. I look forward to seeing the network continue to advance over the next 12 months.

I would also like to congratulate everyone involved for the news that we've gained the silver award in the equality benchmarking process which we undertake with the Employers Network for Equality and Inclusion each year – clearly demonstrating the progress that has been made through this external benchmarking process.

Manchester Pride

Unfortunately the Manchester Pride event was cancelled due to COVID restrictions. I had the pleasure of joining our staff last year on the march, which I thoroughly enjoyed and was proud to be part of; hopefully 2021 will be much bigger and better.

Whilst we weren't able to enjoy the usual celebratory event, I recorded a short message to be included in a video message of support that was created featuring a number of colleagues from across the trust.

NWAS Trans Policy

It is nearly three years since NWAS published our first policy detailing how the trust will support staff who are transitioning. It also sets out the responsibilities of managers and colleagues in protecting new starters who are trans and the ongoing confidentiality of those who leave our employment. As a trust, we will be reviewing the policy with colleagues from the NWAS LGBT Network in the coming weeks; we recognise that language can change, so the various aspects of the policy will be looked at for up-to-date usage, as well as exploring any potential gaps in support. There is NWAS guidance for supporting managers of staff transitioning which will be revised at the same time

Equality & Inclusion Award

NWAS are members of the Employers Network for Equality & Inclusion (ENEI) which is a leading employer network across the public and private sector covering all aspects of equality and inclusion issues in the workplace; providing advice, benchmarking, training and research in the area of diversity.

The ENEI operates a benchmarking tool TIDE (Talent Inclusion & Diversity Evaluation) which assesses our approach and progression on diversity and inclusion across a range of areas. As well as providing an evaluation of areas of strength and improvement it also enables benchmarking across organisations with the best being categorised as bronze, silver or gold.

The Trust are proud to announce that we have now been awarded the Silver Award level which is a great achievement and recognises the hard work our staff are carrying out and the progress we continue to make in this area.

BAME Network

The Trust has continued to work with BAME colleagues through the Race Equality Forum and has been discussing how we support this group to develop into a fully-fledged network. There are now a core group of staff who are keen to develop a network and we are planning an event to support those staff to develop their ideas about what they want the network to offer staff, what its priorities should be and where they will need support to develop further. The trust is fully committed to providing the right infrastructure, development and executive sponsorship to help the network to develop and is excited about these next steps because as a Board we recognise the importance of having a strong voice from our staff to drive us to improve.

Mindfulness and the Health Implications within Prehospital care

Occupational stress is a substantial health issue affecting UK ambulance workers and a central theme identified in the Association of Ambulance Chief Executives' Employee Mental Health Strategy (AACE, 2018). By its very nature, the paramedic role lends itself to an unscheduled and often chaotic environment where individuals are expected to make rapid clinical decisions in the face of increasing public scrutiny. NWAS Advanced Practitioner, Chris Forster, recently completed an MSc dissertation study exploring the theme of mindfulness and the many associated health implications within prehospital care.

The study received excellent feedback and was nominated for PhD scholarship opportunity within Liverpool John Moores University for its potential to make a significant contribution to practice. As a result the article was published in a recent edition of the Journal of Paramedic Practice, to coincide with Mental Health Awareness Week. This is a huge achievement and highlights the excellent research into health and wellbeing that takes place within the trust.

Advanced practice in pre-hospital care

Recently our Clinical Leadership Team held a CPD event aimed at and delivered by NWAS clinicians. The team has delivered a number of similar events over the past few years, with

themes covered such as major incident management, major trauma and cardiac arrest. This time the focus was on advanced practice in pre-hospital care – an area in which, as a trust, we are already a national front-runner. A variety of topics were covered, including advanced practice surgical skills with HART AP Tim Byrom, and Associate Medical Director, Tim Smith being on hand to put everyone through their paces with a scalpel!

The event took place over two days and was held at Safety Central in Lymm. Safety Central has recently been built with emergency service training in mind, with state-of-the-art technology and sets such as train stations, canals and roads so that training scenarios can take place in the most realistic settings.

It was extremely encouraging to hear that both days were well attended by advanced paramedics and consultant paramedics, along with some senior paramedic team leaders aspiring to develop their careers within clinical practice. Medical Director, Chris Grant, spoke to the attendees on both days, discussing advanced practice from his perspective and closing each session with a strategic discussion and Q&A.

A big thank you to all those involved in delivering the event, and for the hard work that went into making it safe, educational and enjoyable for all those in attendance

Reporting abuse

I was contacted by a member of EOC last week who unfortunately informed me of a recent increase in number of instances where staff are on the receiving end of verbal abuse and racism. This should not be happening and I would encourage anyone, from any part of the trust, who experiences this abhorrent type of abuse to report it immediately. No-one should tolerate this type of behaviour and the trust will support all staff that highlight the issue.

The trust has a dedicated violence and aggression working group with representatives from across the organisation, and have peer supporters on hand who can offer a listening ear and help point in the right direction of any further support. Our Invest in Yourself microsite also has some really good tools and resources.

Stamping out Racism

In recent months the Black Lives Matter movement has shone a light on the worldwide problem of racism. Sadly we know that many of our staff and volunteers have experienced racism during the course of their work, and we as a trust do not condone or accept this type of behaviour, ever.

As Chair of AACE, I have, together with leadership teams across UK ambulance services, led a pledge to stamp out racism at all levels and promised to play a fundamental role in the achievement of positive and lasting change in this area, acting at both national and local levels.

As a Trust we recognise there is more work to be done. There is no quick and simple solution but we are listening and learning and we will do everything we can to protect anyone from any racist behaviour. As a trust, we have systems in place to report incidents of racism, whether verbal or physical. It is completely unacceptable for any of our staff to be treated poorly, and we want to know about it when it happens so that we can do what we can to prevent it from happening in the future.

Our Race Equality Forum continues to develop and is a platform for change and advocacy and as a trust we are refreshing our priorities and will work closely with the forum to ensure that we can make the changes needed to stamp out racism, and take positive action to support, encourage and improve staff experiences and opportunity.

Christian Ambulance Association

The Christian Ambulance Association (CAA) is a staff support group, which supports Christians in the ambulance service. The CAA is a staff-led organisation and currently has members across all role types and has a presence in each of the NHS trusts in the UK.

The CAA provides support to members who feel lonely or isolated; builds mutual recognition for Christians within the ambulance services; and enables members to be supported and supportive.

The Patient and Public Panel

Last year the Trust established its first Patient and Public Panel (PPP) to ensure we are listening to our patients and have meaningful ways to involve our communities in our work. The aim of the panel is to help support the delivery of safer services, improved patient and public experience and quality of care.

During the pandemic our panel members have continued to support the trust by attending forums, raising questions and local views and most recently taking part in a Q and A with the CEO and Chair.

The Patient Engagement (PE) team have recently been engaging with patients, public and community groups at online meetings where we have been asking attendees to share their experiences of using our service during the pandemic and their thoughts on the trust's response to COVID-19.

The team have taken part in ten virtual engagement sessions with different groups such as Healthwatch Cumbria, Age UK, Visual Impairment Forum and Brothers of Charity Learning Disability Group. Our communities have been sharing some interesting feedback with us. We have already seen recurring themes from our sessions including levels of Black and Minority Ethnic (BAME) confidence in using ambulance services during the pandemic, communication issues with the deaf community when staff members are wearing PPE and concerns from patients about social distancing when using Patient Transport vehicles.

Additional virtual engagement events will be held during September where the trust will invite patients, public and community groups to take part in ambulance learning discussions based on the themes that have been highlighted

Trust branded thermos

In line with the trust's commitment to find a sustainable alternative to plastic water bottles and prevent further impact on the environment, every member of staff has been given a trust branded green thermos bottle. Limited stocks of bottled water will still be available to staff in a major incident scenario

New Freedom to Speak Up (FTSU) Champions

The trust has recently recruited new FTSU Champions: Pam Morris, Datix System Manager; Sarah Morley, Communications Manager; Ian Mullineaux, e-Learning Co-ordinator and Oliver Cubitt, Paramedic at Brough Ambulance Station.

Achievements book

I am pleased to announce our latest Achievements Book is now available on the Green Room. The book provides a quick overview of the past year's achievements, of new initiatives, awards, partnership working, patient improvements and much more. Whilst it is

a summary of our accomplishments in 2019/20 it would be wrong not to also include the extraordinary demands of the pandemic and how we responded to one of the biggest challenges in our history.

Death of Staff Members – Graham White, Claire Winstanley and Lynne Rogers and former Staff Members - Mike Lowry, Sharon Ryan and John Nelson

It is with great sadness that I write to inform you of the death of our friends and colleagues, Regional Health Desk Coordinator, Graham White; Finance Assistant, Claire Winstanley and EMD, Lynne Rogers

Graham passed away on 22 July after a very short illness and leaves behind wife Bev, a former paramedic. Graham joined the trust in October 2013 and worked in the ROCC. Prior to this post he was employed as an emergency medical dispatcher at Parkway and as a health advisor at 111.

Claire passed away on 27 July after a very brave battle with cancer, she leaves behind her– mum Lynne, dad Stephen and 2 sisters Rachel and Heather. Claire joined the trust in April 2011 and worked in the finance department originally based at Highfield. Claire was a well loved and respected member of the finance family.

Lynne passed away on 13 August following a short illness and leaves behind her mum, 3 children and 3 granddaughters. Lynne has been part of the NWAS family since 2005 dedicating her career to dispatching ambulances for the Wigan area and was a UNISON rep and would not let up until she got problems resolved.

And also former friends and colleagues – Mike Lowry, Sharon Ryan and John Nelson

Mike passed away on 3 August. He joined Mersey Regional Ambulance Service in 1992 starting part time at Anfield station on PTS where he remained for his entire career.

Sharon passed away on 19 August after a short illness. She joined the trust in 2005 working in C&M as a resource co-ordinator, before moving to the GRS team where she remained until she retired in July.

John passed away on 8 September. John worked at Preston Ambulance Station before transferring to the Fylde group and then to Wesham station where he worked until his retirement at the end of March 2018. John became a PTS union steward and health and safety rep and played a major part in supporting both PTS and PES colleague

The trust sends sincere condolences to the families and friends of Graham, Claire, Lynne Mike, Sharon and John.

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.

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	30th September 2020			
Subject:	Northern Ambulance Alliance (NAA) programme update			
Presented by:	Daren Mochrie			
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 Trust; North East Ambulance Service NHS Foundation Trust; North West Ambulance 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 to progress the NAA work programme.			
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:	
Previously Submitted to:	
Date:	
Outcome:	

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

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 Trust; North East Ambulance Service NHS Foundation Trust; North West Ambulance Trust; and, Yorkshire Ambulance Service NHS Trust.

2. BACKGROUND

2.1 NAA Board

The NAA Board meets bi-monthly and met on 10.09.20. The work stream progress since March 2020 has been impacted by the need to focus resources on the covid-19 response. All NAA work streams were reviewed and re-started in June/July 2020 with the benefit of Microsoft Teams aiding collaboration.

2.2 NAA Work stream Updates – Key achievements and progress

2.2.1 Avoidable Conveyance/Telecare: Lead CE: Helen Ray, Lead Executive: Mick Forrest / Mark Newton (NWAS) (Author: Andrew Ormerod, Clinical Programme Lead, NAA)

Three groups (Falls and Frailty, Mental Health, Care Homes) share best practice to support achievement of work stream outcomes and benefits across all four Trusts. This work stream includes a telecare pilot. This is due to commence in November 2020 to test a decision support tool with telecare providers to assist them in identifying when a service user requires an NHS Ambulance Service response. It aims to support them in deciding when to transfer the call to the local NHS Ambulance Service or other locally defined pathway, the type of information needed and when to refer service users into locally agreed pathways of care. The implementation and impact will be evaluated and the learning shared across the NAA to support avoidable inappropriate conveyance.

2.2.2 Digital - Computer Aided Dispatch (CAD): Lead CE: Richard Henderson, Lead Executive: Will Legge (EMAS) (Author: Graham Norton, Chief Information Officer, NAA)

Computer Aided Dispatch (CAD)

The vision for the Common CAD project is, “Enabling better patient care thought the seamless control of 999, 111 and Patient Transport Services across the Northern Ambulance Alliance”. The Strategic Outline Case (SOC) for the Common CAD was approved by the NAA Board allowing the project to proceed to the development of a Full Business Case (FBC) by April 2021. A project manager commenced in post on 17.08.20 (until 31.03.21) to support the CAD FBC.

Digital

Support is continuing to be provided to the TRANMAN and Unified Communications projects.

A Gate Zero proposal was progressed for the NAA to provide a single focus for all four Trusts for the Ambulance Radio Programme (ARP) vehicle hardware roll out that will, in due course, be a key underpinning capability for ambulance digital transformation. The ARP national team are supportive of the proposal. The Gate Zero will now be expanded into a SOC for presentation to the next NAA Board in November 2020.

2.2.3 Quality Improvement (QI) Virtual Academy: Lead CE: Helen Ray, Lead Executive: Steve Page (YAS) (Author: Steve Page, Executive Director of Quality, Governance and Performance Assurance and Deputy Chief Executive, YAS)

Work is progressing on the NAA Board approved QI plan, with the key outputs of:

- The Leadership Council - the vehicle for development and delivery of the implementation plan, through the 3 work streams in the original proposal:
  1. staff engagement;
  2. QI training, and;
  3. Breakthrough Series Collaborative.
- The Advisory Board
- The launch event (now Spring 2021)

2.2.4 Sustainable Fleet: Lead CE Daren Mochrie, Lead Executive: Neil Maher (NWAS) (Author: Mark James, Project Manager NWAS)

Tranman

Delivery has been divided into two phases, with Phase One now complete. Phase Two has now commenced and requires a greater digital focus, as it concentrates on the delivery of key technical interfaces that will provide wider benefits beyond Trust Fleet Departments. These are: GRS for rostering information; Terrafix/Terratrack/VU for vehicle tracking system; and, reporting data warehouse which will allow the delivery of dashboards to meet internal and external business intelligence (BI) needs.

2.2.5 Corporate Services: Lead CE: Rod Barnes, Executive Leads: Human Resources- Christine Brereton (YAS), Kerry Gulliver (EMAS), Karen O'Brien (NEAS), Lisa Ward (NWAS); Legal, Governance and Risk-Angela Wetton (NWAS)

The four HR Directors have agreed to progress work around: maximising ESR benefits realisation; quality benchmarking; and talent management. Gate Zero proposals will be presented at the next NAA Chief Executives meeting.

The Legal Services work is in review across NAA colleagues and an updated paper will be presented to the November NAA Board meeting.

NEXT STEPS

2.4

The plan for the next quarter, based on stakeholder engagement, is to focus on:

- NAA team development, support, and delivery.
- Increasing the visibility of the NAA, sharing the vision and stakeholder engagement activities, including an Annual Report and NAA website to increase awareness and facilitate sharing of learning.

- Work stream delivery, progress and identification of new NAA opportunities, with monitoring, governance and accountability to achieve successful delivery of the benefits.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

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

4. RECOMMENDATIONS

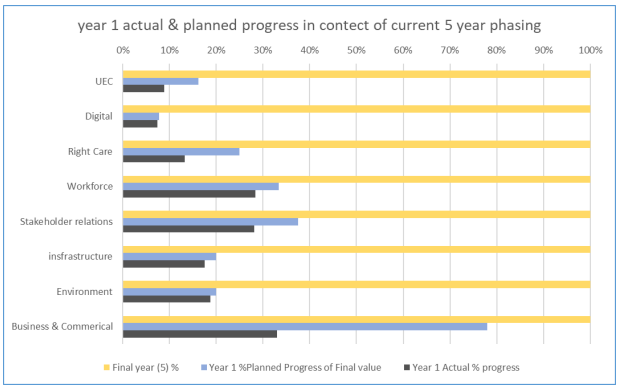
It is recommended that the NWAS Trust Board discuss and note the content of the report and plans outlined to progress the NAA work programme.

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	30 September 2020
Subject:	Strategic Planning – Trust Strategy and IBP milestone review and refresh
Presented by:	Salman Desai, Director of Strategy and Planning
Purpose of Paper:	For Decision
Executive Summary:	This paper presents the refreshed trust strategy together with the refreshed milestones from the 5 year integrated business plan. This refresh has taken place to ensure the strategy remains relevant and reflects the current operating environment and drivers for change, specifically the impact of Covid-19 and the challenges related to increased inclusivity and diversity. This work has confirmed that the trust vision has not changed – with the ambition remaining to be the Best Ambulance Service in the UK, by delivering the Right Care in the Right Place at the Right Time, Every Time. In addition, the trust strategic priorities remain unchanged; however, some of the associated milestones that will support the delivery of these strategic priorities have been refreshed and updated. Moreover, additional detail is now included for years 4 and 5 of the plan. The refreshed IBP has also been mapped against all the risks on the BAF to ensure they support their mitigation. **The IBP milestones maybe affected by the Covid-19 if there is a significant increase in demand resulting from a second peak coupled with a challenging winter.** Building on the refreshed milestones, this paper presents an approach to assessing our progress towards achieving our vision. The approach builds on the assumption that achieving all 8 strategic priorities will in turn achieve the vision; consequently, this approach looks at measuring progress in the delivery of the objectives and milestones related to each strategic priority. As described in the trust strategy, the vision will ultimately be measured in output terms – e.g. the CQC rating of outstanding, performance KPIs, however during the 5 year plan, the majority of milestones are described in terms of process rather than output. If the process changes are delivered,

	then the improvements in the output measures will follow. The proposal is to report progress toward achieving our vision using a methodology which will show the actual progress against planned for each year and then reflecting this against the planned end point for the 5 year period as it stands for that year. The annual refresh of the milestones influence the percentage progress made as there will be more and clearly defined milestones for the longer term. This change will be explicitly identified as part of each years refresh. The methodology uses the BRAGG scale to 'score' progress. **BRAGG** / **Status** / **Score** Blue / Completed / 4 Red / Off track - control measures required / 1 Amber / Off track – control measures in place / 2 Green / On track / 3 Grey / Not commenced (planned) / 0 • The IBP shows the planned milestones for the 5 years that together will achieve strategic priorities and therefore the vision • Each milestone is initially planned to be completed – therefore scoring 4 according the BRAGG scales • Actual progress for each milestone will be scored using the BRAGG scale • At the end of each year - this will produce a planned versus actual score which can be reported in percentage terms The graph below uses this method to report year 1 actual and planned progress against the final year 5 position 
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Approve the refreshed strategy and associated updates to the IBP with a view to sharing this widely with key internal and external stakeholders

	• Receive and note the year 1 progress				
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:	Equality Impact Assessment for Staff: Key to the 5 year integrated business plan is the improvement of staff representation from all groups with established deliverables and milestones. Equality impact assessment for our patients: In line with our national and local drivers, the IBP focuses on delivering population based care, reflecting the needs of the different groups, and levels of deprivation. The plan focuses on reducing variation in performance – delivering the Right Care at the Right Time in the Right Place – Every time* (* i.e. all our patients) This variation has been demonstrated by the impact of Covid-19 on the different groups
Previously Submitted to:	Executive Leadership Committee and Resources Committee
Date:	16th September 2020, 25th September 2020 respectively
Outcome:	Approved

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

This paper presents the proposed refreshed trust strategy, with the refreshed milestones from the 5 year Integrated Business Plan (IBP), together with a proposed approach to assessing our progress towards achieving our vision.

2. BACKGROUND

2.1 The board approved the trust strategy at their meeting in July 2019 with a launch event held in September 2019. The strategy included the trust vision to be the ***Best Ambulance Service in the UK, by delivering the right care in the Right Place at the Right Time, Every Time.***

The work underpinning the strategy resulted in the 8 strategic priorities as shown below:

2.2 In order to achieve our vision a set of SMART objectives, deliverables and milestones were produced aligned to each strategic priority – this formed the basis of the 5 year integrated business plan.

An initial review and refresh of the IBP took place in Q4 of 2019/20 to ensure we were in a position to start year 2 (2020/21) of the 5-year plan, however this work was paused due to the

2.3 Covid-19 pandemic. This current refresh builds on original refresh that commenced in February 2020 and which was subsequently paused due to Covid-19; and now includes the trust recovery plans, the impact of Covid-19, together with all other external and internal drivers.

3. External Drivers

3.1 The strategic planning process includes an assessment of the external drivers that influence the trust strategy and plans. There has been several significant national and external drivers with some common themes: Covid-19, and (Black Asian Minority Ethnic) BAME staff and patients.

3.2 Some of the drivers consider these themes together, whilst others look at these separately. For example much of the Covid-19 guidance presents information regarding the increased risk of the virus to staff and patients from BAME groups, whilst in other guidance and publications the issues of inclusivity, equality and accessibility regardless of the impact of the virus, is the main trust of the publication. The Black Lives Matter movement has also brought into sharp focus the issues and barriers faced everyday by our BAME staff, patients and communities which has also been reflected in the update.

3.3 The issues relating to race and inclusivity are reflected in the following publications

- AACE 5 promises to stamp out racism
- National Voices: Five principles for the next phase of the Covid-19 response
- 2020/21 People's Plan

3.4 The trust, alongside the rest of the NHS, has responded to numerous requirements from NHSI/E in relation to Covid-19. This has included staff testing – swab and antibody; and most recently on track and trace. Plus additional reporting and changes to the contracting and finance arrangements. The trust has also had to respond to the needs for tighter controls regarding infection prevention and control, staff health and wellbeing and mental health challenges.

3.5 The national planning guidance looks to 'system plans' with the 'system' being the Integrated Care System/STP. The system plans are required to focus on rapidly increasing elective and planned work, concentrating on key areas such as cancer and mental health, whilst managing the winter plans and prospect of a second wave.

3.6 The refresh has also considered the impact of the implementation of NHS111 First.

3.7 The trust strategy refresh has considered all these external drivers, with recommended updates to the narrative and IBP milestones, however the supporting strategies must also ensure they reflect these drivers, sometimes in much more detail due to the specific substance of the strategy.

4. Internal Drivers

4.1 The majority of internal drivers relate to the same key themes as the external drivers – i.e. our response to Covid-19 and to the need to increase diversity and opportunities for BAME staff; and to identify both staff and patients who are of higher risk to the virus.

4.2 Some of the headline theme include:

- Processes for track and trace
- Lessons learnt and recommendations from the antibody testing
- Changes to the sickness reporting processes
- Risk assessment of all staff
- Staff working environment with social distancing and cleaning equipment and temperature checked.

4.3 However there have been other factors to be considered as part of this refresh as they directly relate to the strategic priorities:

- lessons learnt from the response to the GPOOH invitation to tender
- increased flexible and remote working
- use of technology and MS teams
- the introduction of the Corporate Programme Board together with identification of the most significant projects

4.4 Finally there are been other changes relating to terminology and language e.g. The People Directorate and the green strategy.

5. Trust Values

5.1 The trust is in the process of introducing a new set of values.
It was the original intention to complete the values work in parallel with the refreshed trust strategy however due to the impact of Covid-19 this has not been possible.

5.2 It is anticipated that the trust values work will be completed by the end of October 2020 after which they will be incorporated into the trust strategy document.

6. Stakeholder Involvement and Engagement

6.1 Representatives from across the trust have contributed to this refresh of the strategy and the integrated business plan, with leads for each of the strategic priorities reviewing and refreshing the associated milestones.

6.2 This involvement is part of a wider aim to increase the engagement with our stakeholders in our strategic planning. This commenced a year ago, with the trust strategy launch event and continues this year. We have approval to recruit Partnership and Integration Managers who will be responsible for this engagement in each of the main areas of the North West, and the trust Communication and Engagement strategy is in the process of its annual refresh. This will include further details of stakeholder engagement.

7. Refreshed Trust Strategy

7.1 The refreshed strategy is attached in appendix 1.

8. 5 Year Integrated Business Plan

8.1 Earlier this year, the trust approved the introduction of the BRAGG scale as a method to

describe the progress made with the milestones and objectives, showing actual versus planned

BRAGG	Status	Score
Blue	Completed	4
Red	Off track - control measures required	1
Amber	Off track – control measures in place	2
Green	On track	3
Grey	Not commenced (planned)	0

8.2 Due to the impact of Covid-19, the progress made against the year 1 strategic priority milestones was not reported as planned in April 2020.

8.3 For this refresh, the lead for each of the strategic priorities reviewed the milestones for the 5-year period. With the aim to confirm agreement with the year 1 BRAGG colour and to increase the details and information relating to the future milestones –particularly those for year 3 to 5.

8.4 The refreshed IBP has been completed and as it contains a significant amount of detail, a summary of the number of milestones is shown below. They set of information be made available if required.

8.5 IBP Milestone Summary

Strategic Priority	Deliverables	Milestones
Workforce	10	23
Right Care	6	13
Stakeholder relationships	3	11
Digital	19	48
Urgent and Emergency care	3	16
Environment	2	4
Infrastructure	2	3
Business & commercial	1	2

8.6 These plans may be impacted is there is a significant resurgent of Covid-19 as a change in priorities would occur, resources are likely to be redeployed.

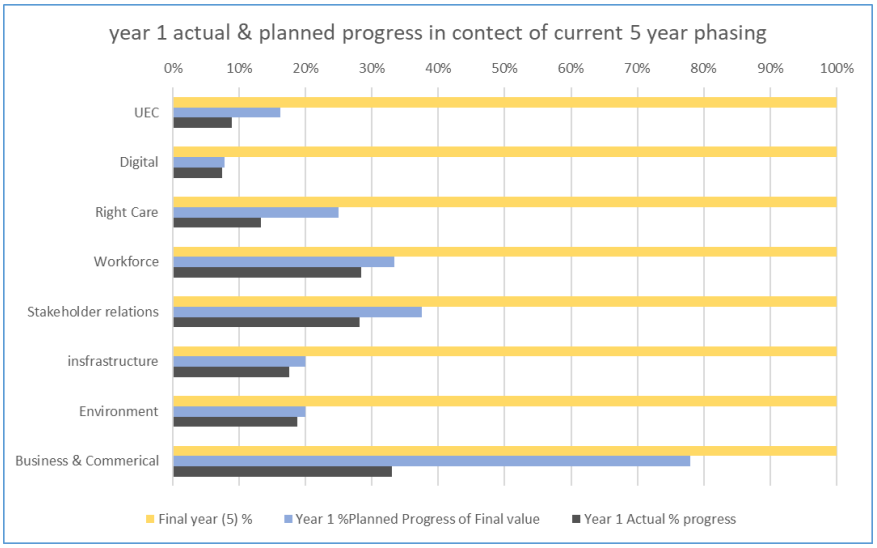
9 Vision Calculator

9.1 As described in the trust strategy, the vision will ultimately be measured in output terms – e.g. CQC rating of outstanding, achieving the performance KPIs etc, however during the 5 year plan the majority of milestones are described in terms of process rather than output. If the process changes are delivered, the improvements to the output measures will follow.

9.2 If we add a value (score) to each of the items on the BRAGG scale (see item 8.1) we can introduce a scoring mechanism. At the planning stage, each milestone should be planned to be complete therefore this will produce a planned score of 4 according to the BRAGG scale.

9.3 When we report progress, the actual score using the BRAGG scale will be captured for example if the milestone is Red - off track - control measures required, it will score 1. We can then compare the planned (4) versus the actual (1) for each milestones, totalling the amounts and converting this to a percentage if required.

9.4 On the graph below, each strategic priority aims to achieve 100% of its deliverables by the end of year 5. The graph also shows how much progress was planned in year 1 for each strategic priority and how much was actually achieved.



9.5 This can also be presented in numeric terms as shown below

Strategic Priority	Strategic Priority Description	Year 1 Planned BRAGG score	Year 1 Actual BRAGG score	Variation
UEC	Increased service integration, take the opportunity to lead and influence across the NW.	20	11	-9
Digital	Radically improve how we meet the needs of patient and staff every time they interact with our digital services	40	38	-2
Right Care	Deliver safe, effective and patient centred care for every patient	32	17	-15
Workforce	Engaging and empowering our leaders and staff to develop, adapt and embrace new ways of delivering the right care	20	17	-3
Stakeholder relationships	Achieve relationships that enable us to provide the right care, at the right time in the right place every	48	36	-12
infrastructure	Review estate and fleet to reflect the needs of the future service model	8	7	-1
Environment	Organisation's responsibilities to reduce emissions/carbon reduction, embrace new technology including electric vehicles	16	15	-1
Business & Commercial	Develop a cost neutral business and commercial function	56	24	-32
Total		240	165	-75

10. Considerations

10.1 This approach assumes all the strategic priorities have the equal value in terms of their contribution to the vision. Consultation was undertaken with a variety of senior management teams to assess the inclination for weighting the strategic priorities.

10.2 This resulted in a wide range of views and it was inconclusive with no consensus achieved. It

was felt the matter was too subjective and likely to change over the 5 year planning term.

10.3 It is therefore recommended that for the purpose to the vision calculator, all the strategic priorities should have equal value.

10.4 The annual refresh will impact on the calculations due to the likely addition of more detailed milestones. This impact will be clearly explained when completely this review and refresh.

11. Equality Impact Assessment

11.1 The Trust Board approved the trust strategy and the 5 year Integrated Business Plan (IBP) at their meeting in July 2019, with the proviso an Equality Impact Assessment was completed. The original EIA was approved by the Resources Committee in September 2019.

11.2 This EIA has been reviewed as the trust strategy has been refreshed together 5 year IBP milestones.

11.3 The Equality Impact Assessment document was shared at the Resources committee on 25th Sept 2020. It reflects the plans to have a positive impact on our patients and staff by including plans such as reducing variance in performance, increase staff representation from BAME groups and increased involvement of our patients and public. *This can be made available to the board if required.*

12. LEGAL and/or GOVERNANCE IMPLICATIONS

12.1 There are no legal or new governance implications to this paper

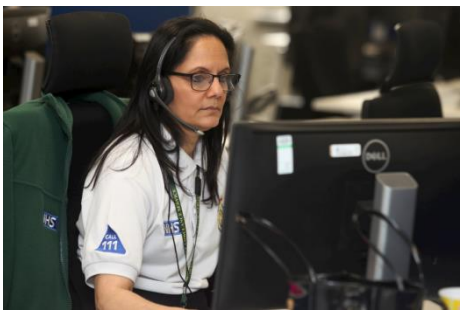
13. RECOMMENDATIONS

The Board of Directors is asked to:

- Approve the refreshed strategy and associated updates to the IBP with a view to sharing this widely with key internal and external stakeholders
- Receive and note the year 1 progress update

NHS
North West
Ambulance Service
NHS Trust

Our Strategy 2019 - 2024



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

Recommended by	Strategy and Planning
Approved by	Trust Board
Approval date	July 2019
Version number	1.0
Review date	September 2020 – delayed due to Covid19
Responsible Director/Senior Manager	Director of Strategy and Planning
For Use By	All trust employees

Change Record

Version	Date of change	Date of release	Changed by	Reason for change
2.0	September 2020	October 2020	C. Hall	Refreshed to ensure the strategy remains relevant and reflects the main drivers and changes in the environment. Details in the table below. The Vision has not changed

Page number	Details of Change
Page 5	Additional paragraph referencing Covid-19 , BAME staff and Black Lives Matter
Page 6	NWAS 'our work' – figures updated
Page 7	Additional item re: Covid-19
Page 11	To be updated with new values in October 2020
Page 12	Integrated clinical contact centre – tense changed to past 'we have'
Page 13	Reference to NHS111 First added
Page 13	PTS reference to new processes due to Covid-19
Page 15	The population – reference to Covid-19 added
Page 15	National drivers – reference to Covid-19, ACCE promises and Black Lives Matter, and key themes identified
Page 15	Additional paragraph relating to impact of Covid-19 on planning and impact on BAME staff and patients
Page 15	Service reconfiguration – reference to increase resources dedicated to stakeholder relationships
Page 16	Delivering our strategy – intro updated to reflect achievement in year 1 and the IBP updated to reflect new challenges
Page 17	Sentence re: NHS11 added to 1st paragraph
Page 17	Paragraph 'the UEC strategy' updated to reflect planned changes to UEC strategy
Page 17	Quality – reference to planned updates to strategy and these will include staff testing
Page 19	Finance plan – updated to reflect impact of Covid-19
Page 20	Estates strategy – additional paragraph re: safe working and social distancing
Page 22	Patients and communities and partners – updated to past tense and added reference to Covid-19
Page 24	New layout for 'strategy at a glance'

Contents

Welcome

At North West Ambulance Service (NWAS), our vision is to be the best ambulance service in the UK - but what do we mean by 'the best'?

We put patients at the heart of everything we do and we want to provide the best possible care to the people of the North West. We believe we will achieve our vision if we deliver the right care, at the right time, in the right place; every time.

This document explains our trust strategy - it shows which areas we want to concentrate on (our priorities - page 9) and how we will develop our services (page 11), all with the aim of achieving our vision.

To be the best, we recognise there are areas we will need to focus on which are priorities not only for us at NWAS, but for the NHS as a whole.

We have a central role to play in the development of urgent and emergency care in the North West. We are uniquely placed as a region-wide service, giving us an opportunity to influence and improve urgent and emergency care delivery across the whole area. The importance of this is outlined in the NHS Long Term plan which describes how the NHS will move to a new service model in which patients get better support and properly joined-up care at the right time in the optimal care setting.

Collaborating with our wider healthcare partners to develop a range of solutions and optimising opportunities to treat more patients by telephone, at scene and in community settings will help us reduce unnecessary conveyance to hospital - a better outcome for patients and the whole of the NHS system. As a key enabler of our trust vision, a specific Urgent and Emergency Care Strategy has been developed and describes in more detail how we will move towards a better integrated care model.

Another theme central to our strategy, which is also mentioned in the NHS Long Term Plan, is investment and improvements in digital. It is simply not possible to deliver the right care, at the right time, in the right place; every time in today's world without a progressive digital infrastructure. Our patients expect to be able to interact with us through email, phone, web or application and they expect us to have access to the best location software, their health record and information about past interactions with us. As such a vital enabler of the trust vision, a dedicated digital strategy has been developed which makes a commitment to pursue digital improvements for staff and patients at pace.

To be the best ambulance service in the UK we also need to support our committed, highly skilled and engaged staff to fulfil their potential. Our workforce strategy sets out how we will develop, engage and empower our staff to deliver services in the most effective and efficient way.

We have the opportunity to make NWAS a leader in shaping the future healthcare system for the North West, and an opportunity to make it an even greater place to work than it is today. It is our people who make our organisation outstanding and our patients who inspire us to continually improve, so none of this will be possible without your support and input. As such, there are parts of our strategy dedicated to our workforce development and patient involvement.

We review our strategy each year to ensure it remains up-to-date, reflecting the current environment, and adapts to the varying needs of the organisation. This is particularly relevant this year (2020/21) with the arrival of the COVID-19, its impact on our communities and staff, together with the important 'Black Lives Matter' movement and the welcome focus it placed on the support we give to our BAME friends, colleagues and patients.

We hope you enjoy reading this strategy and, more importantly, enjoy being part of our progressive and exciting future. We will endeavour to keep you up to date with progress against our plans and, as always, welcome comments and feedback. Thank you.

Daren Mochrie QAM
CHIEF EXECUTIVE

Peter White
CHAIRMAN

Context

We are emergency responders, patient transport providers and NHS 111 urgent care and advice givers. Here's more about our work:

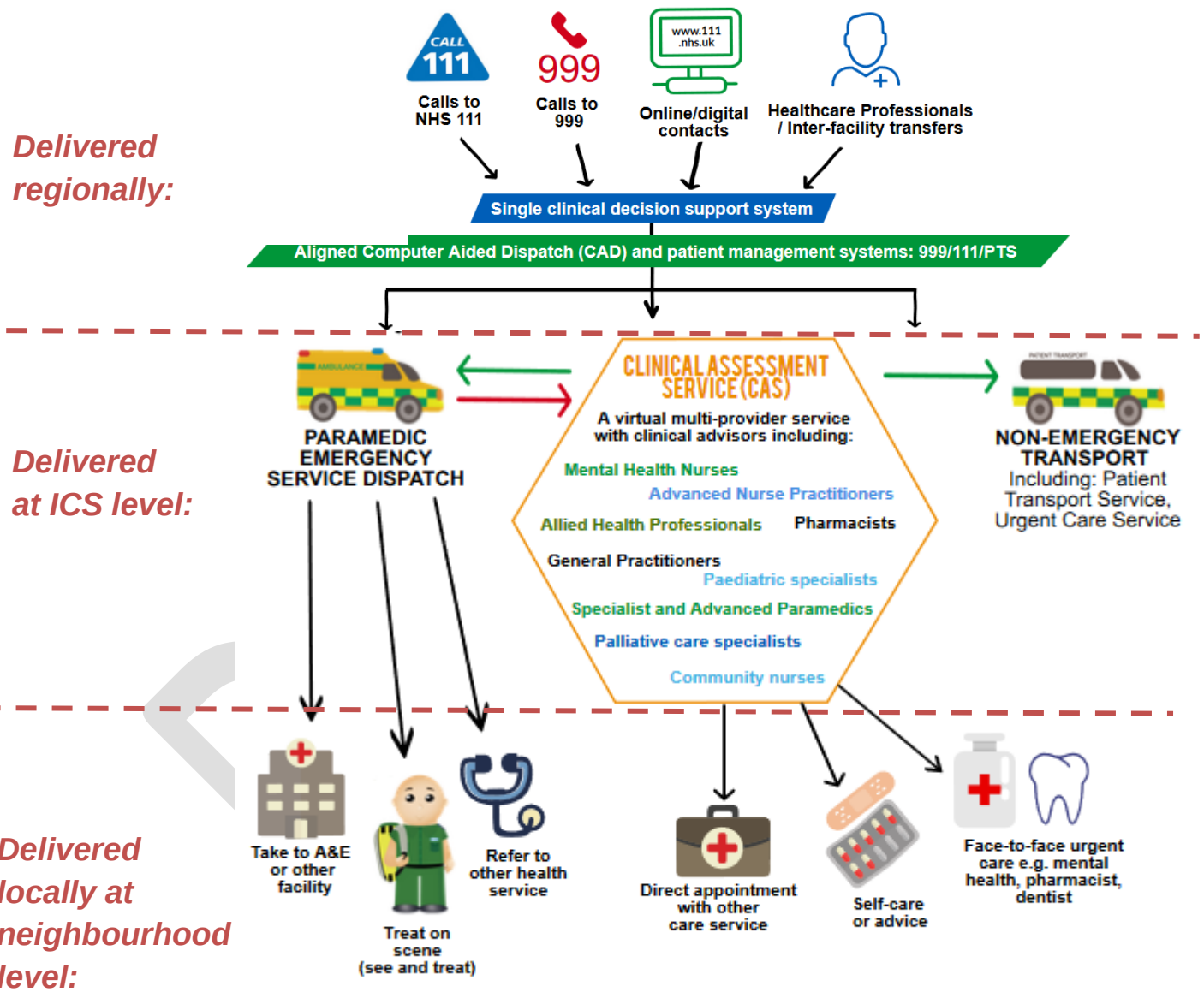
*As of Aug 2020

We provide care in a complex social and economic environment. Our strategy is responsive to this, ensuring our services are delivered in a way that best supports our diverse communities and contributes to the thriving economies in our region. Elements of it will be delivered regionally, while others will be tailored to a Sustainability and Transformation Partnership (STP) / Integrated Care System (ICS), or locally at a neighbourhood level.

Here's more about health and social care in the North West:

Our vision

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.



Measuring success

Achieving our vision will mean that we will:

- Achieve the highest standards of safe, effective and patient-centred care
- Achieve all operational performance standards for 999 U&EC, NHS 111 and PTS
- Ensure care is delivered in most appropriate setting for the patient and the system, safely reducing unnecessary conveyance to the emergency department
- Provide the appropriate workforce, resources and infrastructure enabling the achievement of our priorities every time to all our patients

Our priorities

To achieve our vision, we'll focus on eight **priorities**:

Urgent and emergency care (integrated)	Increasing service integration and leading improvements across the healthcare system in the North West.
Quality (Right Care)	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	Develop 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.

Our values

Our values form the foundation of the whole organisation, and drive us to lead by example and create the right culture and conditions for patients to receive safe care every time.

Working Together for Patients 	Patients are at the heart of everything we do. Through positive teamwork, we share our knowledge, experience and expertise, providing a well-mannered, professional service which is inclusive of all communities.
Commitment to Quality of Care 	We strive for excellence through being committed to quality and professionalism, providing suitable, sustainable and effective care to our patients. We welcome feedback to continually enhance and develop our service.
Respect and Dignity 	We show respect and dignity to every person we have contact with, demonstrated through our honesty, trust and good manners. We take personal responsibility for our behaviour, being accountable for the impact our actions and words may have on others.
Compassion 	We safeguard our patients, caring for and protecting them and acting on any concerns. We value each other and embrace our differences through listening, being supportive, sharing information and through collaborative working, knowing our diversity makes us stronger.
Everyone Counts 	Compassion, kindness and empathy are essential to the care we provide to our patients.
Improving Lives 	We acknowledge and learn from our mistakes to provide the best care we can.

Our services - now and in the future

Urgent and emergency care

Urgent and emergency care remains our core business. We have developed our Urgent and Emergency Care (Right Time and Right Place) Strategy which focuses on incorporating new, more integrated and flexible ways of working into our core urgent and emergency care offer.

Why?

Our 999 service (Paramedic Emergency Service) is central to our organisation. Saving lives and providing pre-hospital care gives us the opportunity to deliver the best patient care and compassion in the most stressful and demanding situations.

The Urgent and Emergency Care Strategy describes how we will ensure clinical decisions are made as early as possible in the patient journey. This will allow us to provide high quality patient centred care closer to home, in order to treat more patients, by telephone (hear and treat), at scene (see and treat), and in community settings; reducing unnecessary conveyance to hospital.

Integrated Clinical Contact Centre

As part of the Urgent and Emergency Care Strategy, we have reviewed how our contact centres are currently set up. This will enable us to provide a more integrated clinical contact centre, allowing NHS 111, GP and community services, 999, emergency departments and social care providers to work more closely together.

Why?

When a patient calls 999 or 111 their call is triaged to determine the level of response it requires. Calls are given codes based on their nature and where appropriate, certain codes are passed to the Clinical Hub. The call is then assessed and routed to the most appropriate service based on its nature. For example, if you are experiencing a mental health problem, a mental health practitioner will phone you back to conduct an assessment, if you have a medication query a pharmacist will be in touch, or if you have a chest infection then a GP may call you back. Developing the integrated clinical contact centre further will support this process of ensuring patients get the right care, at the right time, in the right place; every time.

NHS 111

We are the largest provider of NHS 111 nationally and we will continue to provide the NHS 111 service in the North West. It will develop as part of the Urgent and Emergency Care Strategy with a key role in a more integrated service model. In addition, we adapt and grow our service to deliver the national plans for NHS 111 First. This model has evolved as a result of the impact of COVID-19, and is focused on improving patient experience of urgent care by directing people to the right service for their needs and providing booked time slots to those who need to attend an emergency department, helping to manage flow through the ED and allow for social distancing in waiting areas.

Why?

Providing the NHS 111 service places us at the centre of the national plans in relation to IUC, and the changes brought about by COVID-19.

We continue to be committed to the development of the services related to this plan including online booking, access to alternative services and reducing the number of patients who are sent to emergency departments or to 999 by signposting them to more appropriate local services. Simultaneously expanding our service to deliver the increased activity resulting from the implementation of 111 First

Patient Transport Services (PTS)

We will continue to provide PTS and where appropriate, adapting to the new processes at our hospitals resulting from COVID-19, whilst look for further opportunities across the North West to support planned, non-urgent transportation of patients.

Why?

We are the largest provider of PTS across the country and we intend to continue to deliver high quality services in line with the contract specifications. This will benefit the whole patient journey from outpatient appointments to discharges. We will also make the most of our contact with patients by sharing health information and advice, and raising concerns to other support services if necessary.

Resilience

We have effective and valid emergency and contingency plans in place at all times. These plans allow us to mitigate and respond to risks

and hazards alongside our multi-agency partners, such as the fire and rescue service.

Why?

Our Resilience Team works alongside wider NHS partners in particular, supporting and driving the NHS Emergency Preparedness, Resilience and Response (EPRR) Programme. They achieve this through close working with our health partners in the Local Health Resilience Partnership (LHRP) structures.

Our challenges and opportunities

The population

The North West has areas of great deprivation. Rates of heart and circulatory diseases and respiratory conditions are high, plus there is wide variation in the health of people across our area. The number of people living with long-term health problems is increasing, and we expect a rise in the population aged over 75 to continue; obesity and other key societal factors will also affect the level and type of demand on the service. The North West has been affected particularly badly by COVID-19 with high infection rates in several of our communities.

National drivers

There are several external strategies that influence our strategy; these include the NHS Long Term Plan; Integrated Urgent Care Service Specification; National NHS Ambulance Digital Strategy; National Ambulance Commissioning Strategy; Carter Report and the People Plan. And now the response to the COVID-19 and the Black Lives Matter movement including the 'Promises' from the Association of Ambulance Chief Execs (AACE)

Key themes from these national drivers are increased use of technology; greater integration and interoperability; safe care closer to home; flexible workforce; efficiency and effectiveness; Test, track and trace; safe working; infection prevention and control; inclusivity and equality. The Long Term Plan in particular builds on increased integration with the further development of STPs and ICSs, with an element focused on expanding and reforming urgent and emergency care services.

It also places emphasis on the need to prevent people becoming ill in the first place, by helping them to make healthier lifestyle choices and treating avoidable illness early on. It highlights how maximising the opportunities that patient contact and hospital admissions bring can help people to improve their health - this is where the ambulance service has an important role to play.

The requirements arising from the impact of COVID-19 have affected the planning at trust and ICS level. The challenge is to balance increases in all activity (urgent and emergency care, elective and planned) from the low levels seen at the height of the pandemic, whilst ensuring all our staff and patients are safe. The virus has had a disproportion impact on the BAME community, and this combined with the Black Lives Matter movement, brought to the forefront the provisions for representation of the local community in our workforce and leaders within the trust.

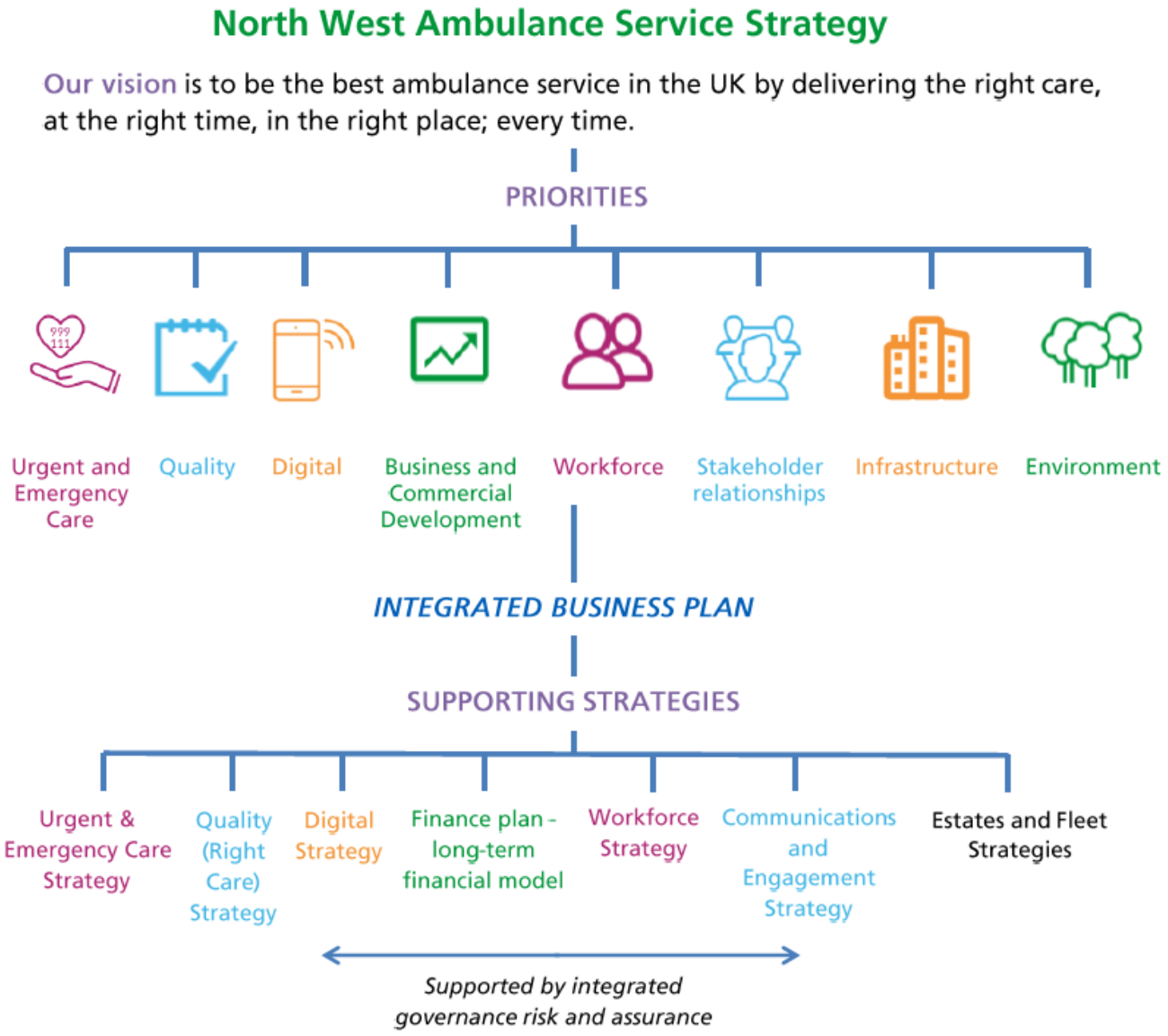
Service reconfiguration

Due to the size and complexity of the area we cover, there are a large number of planned service changes under each of the Sustainability and Transformation Partnerships (STPs) / Integrated Care Services (ICSs). These are at varied stages of development which presents unique challenges and opportunities. We have increased our resources dedicated to stakeholder relationships to ensure we have 'a place at the table' and can influence these plans.

Delivering our strategy

The plan for the delivery of this strategy is described in detail in our Integrated Business Plan (IBP), which was developed with input from all departments of the organisation and brings together a number of supporting strategies. The plan was updated to reflect the achievements in year one of the five year plan and to reflect the new challenges encountered. It details how we will achieve the vision, setting milestones to reach each year in order to stay on track.

The diagram below shows the multiple supporting strategies which contribute to the priority areas.



Urgent and Emergency Care (Right Time and Right Place) Strategy
Core to the Urgent and Emergency Care (UEC) Strategy is our ambition to move to a more integrated service model, with closer working for PES, NHS 111 and PTS**.** The introduction of 111 First reinforces the need for this integrated model

This will enable us to meet our primary objective: to ensure that patients with serious or life-threatening emergency needs receive timely, high quality care, to maximise their chances of survival and recovery.

We recognise that we are ideally placed to provide care closer to home, treating patients by telephone, at scene, and in community settings; thereby reducing unnecessary conveyance to hospital. We will work with the wider healthcare system to develop integrated urgent and emergency care solutions to ensure emergency resources are used effectively and able to provide a timely response; every time.

The UEC Strategy covers the following main areas: emergency care, urgent and emergency care delivery, integrated response model and reducing avoidable conveyance.

Quality (Right Care) Strategy
Our Quality (Right Care) Strategy describes how we will deliver our commitment to provide the right care through the provision of care that is:

- Safe - protecting our patients from avoidable harm
- Effective - reducing unwarranted variation in treatment and outcomes
- Patient centred - the best experience for patients and staff

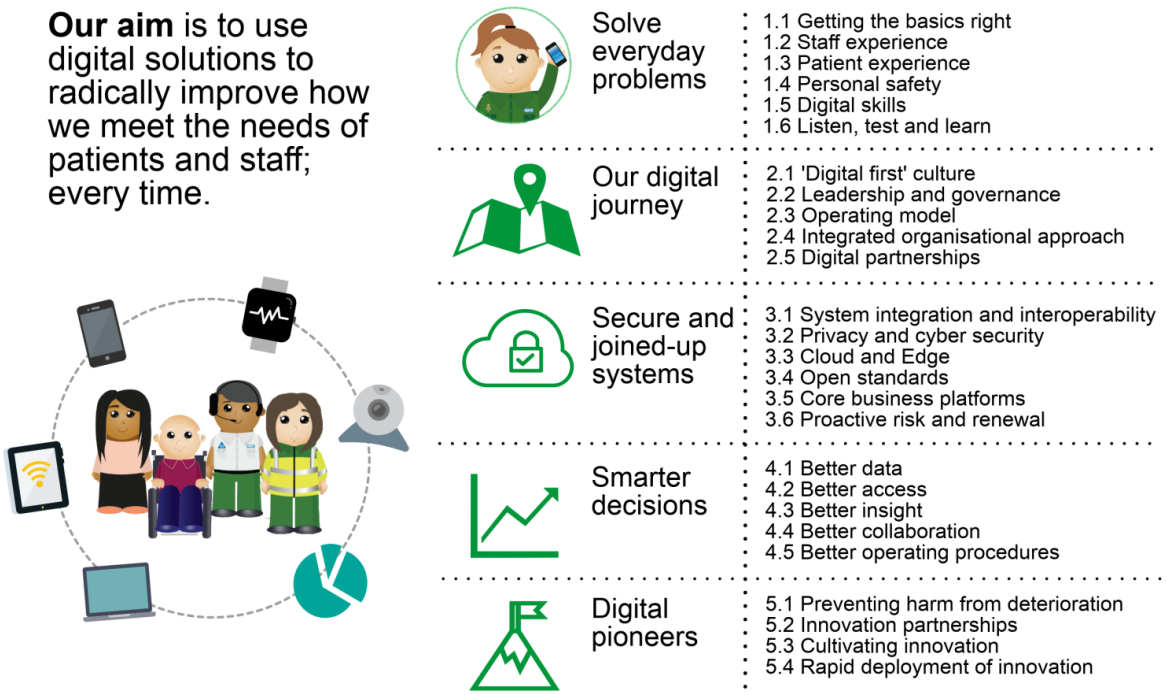
The Quality (Right Care) Strategy describes how quality improvement (QI) methodology is becoming increasingly embedded within the trust, supporting evidence-based improvements. It has a focus on developing ‘pillars of quality’ throughout the organisation:

- Complaints
- Incident Reporting (including Serious Incidents)
- Health, Safety & Security
- Safeguarding
- Infection Prevention & Control
- Medicines Management

The Quality Strategy will be updated to reflect the new responsibilities related to COVID-19 including, staff testing and track and trace; plus personal protective equipment (PPE) requirements.

Digital Strategy

Our Digital Strategy is key enabler to many of the other trust strategies. The digital vision is to radically improve how we meet the needs of patient and staff every time they interact with our digital services. The five year plan is focused on delivery of five strategic themes as outlined below:



Finance plan - long-term financial model

Effective financial management has always been important within the trust. Following the Government announcement of a five-year revenue budget settlement for the NHS from 2019/20 to 2023/24, alongside the publication of the NHS Long Term Plan, the trust developed a long-term financial plan that aligns with the NHS LTP and organisational strategies. However, COVID-19 again has affected this, with all financial arrangements changed to a much-simplified model. Dedicated funding ring-fenced for COVID-19 related spend was introduced. The financial and contracting arrangements are due to be review in the second half of 2020/21

Along with increases in NHS funding comes a demand for modernisation aimed at transforming services for the patients. Financial management is a fundamental building block for successful, high quality services. It is not just about recording and monitoring expenditure, having robust long term financial plans will help to: meet the challenges within the NHS LTP; understand how money is being spent and whether it is giving good value; improve productivity and efficiency; incentivise systems to work together to redesign patient care; improve how we manage demand effectively and make the best use of capital investment.

Workforce Strategy
Our staff are our greatest asset and central to our future success in providing patients with the right care, in the right place, at the right time; every time.

Our Workforce Strategy focuses on the following themes:

1. Develop - ensuring we attract and retain staff with the right skills and values, and enable them to fulfil their potential
2. Engage - ensuring that we create an inclusive culture, where our staff are actively engaged in shaping the future and where they feel supported and safe
3. Empower - enabling our leaders and staff to lead with confidence, to innovate and improve services and support staff to proactively respond to change.

Our vision can only be achieved through the continued development of a highly-skilled, fully-engaged and committed workforce; led by great leaders who can inspire, motivate and nurture our talent. We recognise the need to keep our staff safe and effectively support their mental and physical wellbeing so that they can deliver effective care to others. As our workforce develops to embrace different professions and ways of working, we need to support our staff to adapt, enable multi-professional working and develop flexible careers for the future.

Communications and Engagement Strategy
The Communications and Engagement Strategy supports the trust vision by focusing on educating, influencing, engaging and building trust with the public, patients and all other stakeholders.

We aim to ensure the voices of our patients and the public are heard and acted upon through our Patient and Public Panel, which provides an agreed framework to increase engagement and involvement between North West communities and the trust.

The Communications and Engagement Strategy also incorporates stakeholder involvement - as one of the biggest ambulance services in the country we have a number of stakeholders with whom we need to have effective relationships in order to deliver our vision, such as statutory bodies, commissioners, health and social care partners particularly the Sustainability and Transformation Partnerships (STPs) / Integrated Care Systems (ICSs) in the region.

We use a wide variety of communication methods, including face-to-face, electronic, social media and digital channels to ensure messages reach stakeholders.

Estates Strategy
The Estates Strategy is principally concerned with our usage of estate infrastructure and the capital investment over the next five years to ensure we can achieve our service objectives.
Lord Carter's report on ambulance service productivity advocates the hub and spoke model due to improved quality and performance. In addition there are potential savings by reducing the estate, centralising medicines management, reducing pool vehicles, reducing backlog maintenance and reducing stock via better stock control. Therefore, the aims of the strategy are to:

- Set the direction and priorities of the estate to have fewer but larger operational sites, hence having a planned strategic development rather than an opportunity driven one
- Identify the benefits and challenges in delivering the above
- Set the factors to consider when prioritising and locating hubs and spokes
- Learn from other trusts when delivering the hub and spoke model
- Refresh our understanding of the whole of our estate, its needs and future requirements.

The estates strategy will reflect the new challenges in relation to safe working, including the ability to socially distance and regular cleaning of equipment.

Fleet Strategy
Our fleet of vehicles is perhaps the most important of our organisation's physical assets.

The vehicles are the workplace for staff, they house sophisticated pieces of medical equipment and provide a caring, clinical environment for patients.

Future fleet requirements need to be considered in our planning of future resources. The Fleet Strategy aims to support the trust vision to become the best ambulance service in the UK, by providing the right care, at the right time, in the right place; every time, by:

- Procuring a fleet that supports the operational models for PES, PTS and the Hazardous Area Response Team (HART)
- Maintaining that fleet to a high standard of safety and availability
- Efficiently and safely disposing of fleet assets at the end of their operational life

The Fleet Strategy also refers to environmental considerations and exploring the use of alternative vehicles and designs to derive financial and environmental efficiencies from the fleet e.g. embracing technology and growing our fleet of electric vehicles.

Our patients, communities, volunteers and partners

Patients and communities

As mentioned in the welcome of this strategy document, at NWAS we put patients at the heart of everything we do. It is important to us that we provide an opportunity for patients, their families and carers, to give their feedback and be involved in any future service developments.

In addition to existing patient experience feedback channels and community engagement through events, we have introduced a Patient and Public Panel (PPP) to ensure effective patient and public involvement, making sure the voices of our patients and the public are heard and acted upon.

The PPP aims to:

- Strengthen our community engagement and structured patient and public involvement.
- Create the infrastructure to enable patients/the public to become involved at a level that suits them and in their selected area(s) of interest.
- Develop a work-plan for patient and public engagement and involvement.
- Provide meaningful opportunities for patients/the public to influence service planning and delivery and to develop service improvements using co-production methodology.
- Ensure patient and public representation can act as a critical friend for the trust's business.

Volunteers

We recognise that we cannot achieve our vision by working in isolation. We are fortunate to be supported by generous volunteers who work with us to ensure North West residents get the right care, at the right time, including: 360 volunteer car drivers and 850 community first responders (CFRs).

Partners

As mentioned throughout this document, we must integrate better - as services together within NWAS, and with external health and social care partners.

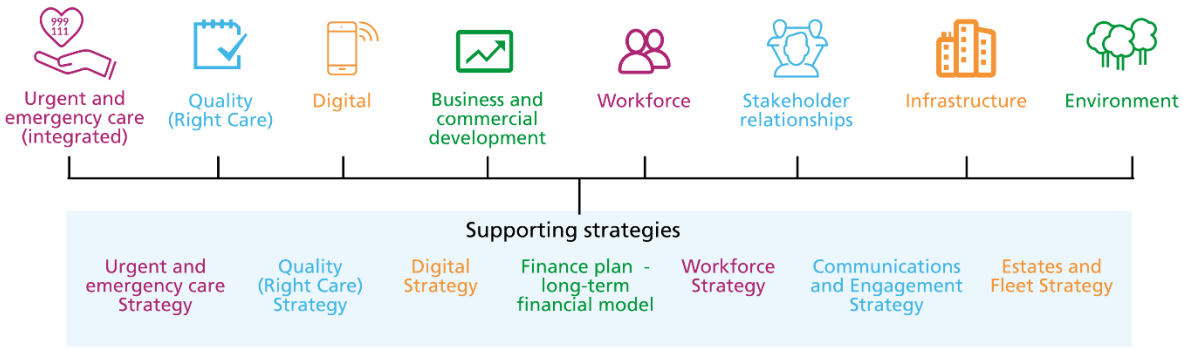
Building on the collaborative relationship with our commissioners, the local Clinical Commissioning Groups (CCGs), and other providers, we are undertaking a more structured approach to engagement and involvement with our local ICSs and continue to work together to further develop the urgent and emergency care available to the people of the North West. Close partnership working offers us the opportunity to influence and manage patient flow for unplanned and emergency care; support the delivery of planned patient care via our transport service, and ensure we are prepared the play our part in the management of any major incidents that may occur as recently demonstrated with the arrival of COVID-19.

NHS
North West
Ambulance Service
NHS Trust

Delivering our strategy in 2020/21

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.

STRATEGIC PRIORITIES



PROJECTS

There are many projects underway to develop our services and make them even better for patients and staff, helping us to work towards our vision. Here's an overview of current projects and how they will be progressed in 2020/21.

We need to ensure we are prepared to respond to a second wave of coronavirus and if that happens, some of these projects may be paused. In any event, we have identified three priority projects which will be our focus and will progress even if others are placed on hold.

Priority projects are marked with a star = ★

URGENT AND EMERGENCY CARE (UEC) STRATEGY

Single patient management system ★

From October 2020, NHS 111 and the clinical hub will use a new patient management system provided by software company, Cleric. This will replace the current Adastra system.

Clinical assessment service (CAS)

The CAS is a multi-disciplinary service which directs patients to the right place for their needs. It is delivered by different providers but works seamlessly together. Clinical hub and 111 clinicians are part of the CAS currently and the NWAS input into the CAS may develop further.

Contact centre review (CCR)

This applies to all 'contact centres' – emergency operations centres (EOCs), NHS 111 and patient transport service (PTS) control. The review will look at systems we use, estates (buildings and facilities) and career development opportunities across contact centres. This project includes plans to implement a single primary triage system.

Non-emergency transport service (NETs)

Exploring options for non-emergency transport and whether there is anything that could be introduced to help relieve pressure on emergency resources. This year we will build on the developments made during the coronavirus pandemic to progress closer working between emergency and non-emergency resources.

Reducing avoidable conveyance

This project will build on the great work already being done on increasing see and treat rates where clinically appropriate. The UEC Transformation Team will work with area teams to look at care pathways, triage tools, and support ideas for improvement.

NHS 111 First

A national programme which will encourage the use of NHS 111 to access urgent care including, for the first time, direct booking into emergency departments (EDs).

Building better rotas

The objective is to introduce new rotas which meet organisational demand. Most service areas have already gone live with new rotas with the EOC rotas to follow.

QUALITY (RIGHT CARE) STRATEGY

Safecheck

The Safecheck initiative will move the current paper-based vehicle check book to an app found on the Getac devices. There will be a number of local pilots and evaluation, with a view to trust-wide roll out.

DIGITAL STRATEGY

Electronic patient record (ePR) ★

ePR will transform the way clinicians work as it will enable us to work paperless at the point of care, avoiding the problems associated with paper records. A pilot is planned for Blackpool in September 2020, with a view to roll it out following this.

Unified communications programme (UCP) ★

We will replace the numerous systems across the trust with a single, unified telephony platform and replace existing ICT infrastructure. Training will be from August and go-live is in November.

Office 365

Replacement of the e-mail system with Office 365, allowing access to new features such as Microsoft Teams.

Emergency services mobile communications programme

This is a national programme to replace the current Airwave Radio Network and its associated radio systems.

Datix cloud IQ

The aim is to provide a patient safety and risk management system which meets all mandatory requirements. The project is to implement and introduce the new Datix Cloud IQ system, overtaking the use of Datix Web.

WORKFORCE STRATEGY

Rotational working

Looking at how we can embrace different professions and ways of working, while supporting our staff to adapt, enable multi-professional working and develop flexible careers for the future. We will be exploring opportunities to pilot rotational working.

ESTATES STRATEGY

Estates review

Estates will form part of the contact centre review project, looking at how we make the most of our buildings and facilities.

Hub and spoke models

Working from a central fully functioning 'hub' which acts as a reporting point for staff and vehicles located close to major hospitals, and a number of 'spokes' which are unmanned rest and welfare points.

TranMan

The fleet management system is one of the areas identified in which the Northern Ambulance Alliance can work together to procure a new system to effectively manage the vehicles and associated equipment.

Find the latest information about ongoing projects on the Green Room (search 'projects')

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	30 September 2020			
Subject:	Policy Framework Update – July to September 2020			
Presented by:	Director of Corporate Affairs			
Purpose of Paper:	For Assurance			
Executive Summary:	A robust Policy Framework is a key element of a corporate governance framework, recognising that out of date policies can leave the trust at risk. During the period 1st July to 16th September 2020, 10 policies/procedures were approved: • 6 had minor changes and were therefore approved by the relevant executive. • 2 were approved by the Executive Leadership Committee • 2 polices/procedures review dates were extended, with no identified risk At its meeting held on the 27th November 2019, the Board of Directors requested that an equality impact assessments (EIA) be completed for each policy. In addition, it was noted that assurance was required that out of date policies would not result in harm being caused. Members of the Board therefore requested that if a policy was under review, a risk assessment be carried out by the exec lead to highlight and mitigate against any risks: • 6 of the trust's policies/procedures are currently out of date. 5 have no completed risk assessments recorded. • 6 of the trust's policies/procedures are due to be reviewed in September 2020 • Of the 10 policies/procedures that have been approved, 1 has a completed EIA, 8 policies/procedures do not require an EIA and 1 EIA is outstanding.			
Recommendations, decisions or actions sought:	The Board of Directors is asked to: Note the policies and procedures approved during the period during 1st July 2020 – 16th September 2020 and to note that work is being carried out to review the policies that have expired review dates.			
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 required to be completed for each policy
Previously Submitted to:	Executive Leadership Committee
Date:	23 September 2020
Outcome:	Noted

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

The purpose of this report is to provide details of the policies and procedures approved by either the Executive Leadership Committee or individual Executive Directors during the period 1st July 2020 – 16th September 2020 The report also includes details of policies and procedures that have expired review dates.

2. BACKGROUND

At its meeting on the 9th May 2018, the Executive Management Team agreed a revised process for approving policies and procedures, to prevent overloading committees and Board meetings with policy approval.

At its meeting held on the 27th November 2019, the Board of Directors requested that an equality impact assessments (EIA) be completed for each policy. In addition, it was noted that assurance was required that out of date policies would not result in harm being caused. Members of the Board therefore requested that if a policy was under review, a risk assessment be carried out to highlight and mitigate against any risks.

Approval process for policies and procedures.

New Policies

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor. New policies may also be required as a result of the development of a new service or new way of working.

1. The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure. The aim should be to keep the number of policies to a minimum. The lead director should be able to provide a clear justification for the development of any new policy.
2. It is the responsibility of the lead Director for a policy to ensure that the document is appropriately consulted on during the development process with key stakeholders e.g. Unions; HR; Legal; etc.
3. The lead director is responsible for ensuring the policy is scheduled into an Executive Management Team meeting for approval.
4. Following approval – the corporate governance team will update the Policy Database
5. The lead director will be responsible for dissemination and training in relation to the policy and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation i.e. ensuring the approved document is uploaded to the intranet.

Amendments to Existing Policies

1. The lead director reviews the policy on the agreed cyclical basis and if nothing requires updating, signs off the policy with a new review date; ensures the new document is uploaded to the intranet and advises the corporate governance team so the database can be updated.
2. If changes are made but they are minor, e.g. job titles, then the lead director signs off the amended policy; ensures the new document is uploaded to the intranet and advises the corporate governance team so the database can be updated

3. If the changes needed are significant i.e. driven by legislative changes, then the lead director is responsible for ensuring that the revised document is consulted on with key stakeholders e.g. Unions; HR; Legal; etc.
4. The lead director is responsible for ensuring the policy is scheduled into an Executive Management Team meeting for approval.
5. Following approval – the corporate governance team will update the policy database
6. The lead director will be responsible for dissemination and training in relation to the policy changes and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation i.e. ensuring the approved document is uploaded to the intranet.

The Policy and Procedures Process has been reviewed in light of NHSI guidance stating that the Trust is required to have a Board approved Learning from Deaths Policy and was approved by the Executive Leadership Committee held on 20th November 2019.

3. APPROVED POLICIES AND PROCEDURES

During the period 1st July 2020 – 16th September 2020, 10 policies/procedures were approved:

- 6 had minor changes and were therefore approved by the relevant executive.
- 2 were approved by the Executive Leadership Committee
- 2 polices/procedures review dates were extended, with no identified risk

Policies/Procedures approved between 1st July 2020 – 16th September 2020

Policy	Approved by	Date	EIA	Comments
Jul-20				
Annual Leave and Public Holiday Procedure	DoP	01/07/20	Not req	Agreed at ELC to extend review date to September 2020
Public Health Plan 2017 - 2022	MD	21/07/20	Not req	Extended to review in September 2020 due to Public Health Dr starting on 1st September.
Aug-20				
Vehicle Fuel Card Guidance and Procedures	DoF	12/08/20	No Req	Revised procedure approved by ELC
Procedure on Vehicle Decommissioning and Disposal	DoF	4./08/20	Not Req	Revised procedure approved by DoF following minor amendments
Safeguarding Vulnerable Persons Procedures	DoP	05/08/20	Not Req	Policy Group agreed minor changes.
Sep-20				
Maternity Leave Procedure	DOP	01/09/20	Not Req	
Petty Cash Procedure	DoF	16/09/20		
ID Badge Procedure	Dof	16/09/20	Not Req	
SPP Policy	DOCA	01/09/20		Review date extended to November 2020
Smoke Free Policy	DoP	14/09/20		Agreed by Policy Group as no changes required. Updated EIA requested.

Of the 10 policies/procedures that have been approved, 1 has a completed EIA, 8 policies/procedures do not require an EIA and 1 EIA is outstanding.

4. POLICIES DUE FOR REVIEW

6 of the trust's policies/procedures are currently out of date. 6 of the trust's policies/procedures are currently due to be reviewed in September 2020.

Policy	Executive Lead	Review Date	Status
Frequent Callers Policy	Maxine Power	March 2020	Overdue
Duty of Candour	Maxine Power	July 2020	Overdue
Being Open Policy	Maxine Power	July 2020	Overdue
Incident Reporting Procedure	Maxine Power	July 2020	Overdue
Serious Investigations Procedure	Maxine Power	July 2020	Overdue
Investigations Policy	Maxine Power	Policy still under development. The Investigations Policy requires Board approval.	Overdue
Learning Framework	Maxine Power	September 2020	Due for review
NW Divert and Deflection Policy	Ged Blezard	September 2020	Due for review
Relief Staff Policy	Ged Blezard	September 2020	Due for review
Temporary Homeworking Policy in response to COVID-19	Lisa Ward	September 2020	Due for review
Annual Leave and Public Holiday Procedure	Lisa Ward	September 2020	Due for review
Public Health Plan	Chris Grant	September 2020	Due for review

Regular contact is made by the Corporate Governance Team with each policy owner to ensure that the latest position is recorded.

5. RECOMMENDATION(S)

The Board of Directors Committee is asked to:

(i) note the policies and procedures approved during the period during 1st July – 16th September 2020, and to note that work is being carried out to review the policies that have expired review dates

This page is intentionally left blank

North West Ambulance Service NHS Trust

Chairs Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Board of Directors
Date of Meeting:	29 July 2020	**Quorate (yes/no):**	Yes
Chair:	David Rawsthorn, Non-Executive Director	**Executive Lead:**	
Members present:	Mr R Groome, Non-Executive Director Dr D Hanley, Non-Executive Director Mr G Blezard, Director of Operations Mr S Desai, Director of Strategy & Planning Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs C Wood, Director of Finance	**Key Members not present:**	
Board Assurance Risks Aligned to Committee:	N/A		

Key Agenda Items	RAG	Key Points	Action/Decision
Charitable Funds Update Q1 2020/21		• Income for Q1 2020/21: £155k – £153k unrestricted – £2k restricted • The largest single donation was for £77.5k which was received from NHS Charities Together. • Expenditure: £70k • Total available resource: £885k – £606k unrestricted – £279 restricted • The largest item of expenditure was for a purchase of medical equipment mainly defibrillators.	Noted the assurance provided It was agreed a new NWAS Charitable Funds Strategy and Terms of Reference that reflected how the charity operated were needed. These would be presented to the next Committee meeting.

	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

		• An overview of the projects undertaken within Q1 was provided. In particular, the generous donations provided by Capt Tom Moore and Mrs Winifred Page and the action ongoing in terms of investing the funds to improve staff and volunteers health and wellbeing during COVID-19. • A refresh of the Charitable Funds Strategy was requested for submission to the next meeting, in addition to a refreshed version of the Charitable Funds Terms of Reference.	
NWAS Charitable Funds Accounts Assessment Proposal		• The Committee received a proposal for the annual accounts assessment of the Charitable Funds are independently examined than audited commencing 1 April 2020.	Approved the recommendation for NWAS Charitable Funds to be independently assessed.

	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 Trust

REPORT

Board of Directors	
Date:	30th September 2020
Subject:	Integrated Performance Report
Presented by:	Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	The Integrated Performance Report for September 2020 shows performance on Quality, Effectiveness, Finance, Operational Performance and Organisational Health during August 2020 unless otherwise stated. The highlights from this **AUGUST** report are as follows; **Quality** • The Trust is on track with its strategic goal of reducing complaints. The month average is 20 complaints per 1000 WTE staff, against a strategy goal of 31. • 66% of level 1-3 and 14% of level 4-5 complaints have been closed within the agreed standard. This is below the in year goal of 85% for level 1-3 and 80% for level 1-4. • 1352 incidents were reported, of which 36 were unscored (against a strategy goal of 25). • The 10 most common incident cateogries included: information (128) 111 assesment / advice / service (195), staff welfare (63), communication (50), threatening behaviour (49), verbal/ physical abuse (79) medicine management (45), missing equipement (46). • Incident closure rates have improved to 83% and 61% for Level1-3 and Level 4-5 respectively but have not yet reached the in year goal of 85 and 80% respectively. • 3 Serious Incidents were reported. • There were 9 new safety alerts which were all reviewed, actioned and closed.

Effectiveness

- Hear & Treat performance was 10%, a reduction from the peak of the covid pandemic comparable with pre-covid performance.
- See and Treat performance was 29.2%, significantly less than the peak of the covid pandemic when S&T rates increased.
- The investment in transformation programmes (clinical hub, GM CAS, EMT and paramedic upskilling with pathfinder and Manchester Triage system) have resulted in a systematic reduction in see and convey at 61%

Month	H&T	S&T	S&C
August	10.1%	29.2%	60.7%

- Ambulance quality indicators for cardiac arrest (ROSC, survival to discharge and acute stemi), and stroke for January 2020 show no special cause variation when compared with previous months despite activity increases over the seasonal period.
- Compliance with the care bundles for acute STEMI, stroke and sepsis were 75, 99 and 78% respectively.

Patient Experience

- FFT suspended nationally

Finance

- The Financial Risk Rating metrics have been suspended and will return when then new operating framework is launched after transition from the Covid-19 financial framework.

Patient Emergency Service (PES)

- Call Pick Up performance was 99.7%.
- Average hospital turnaround time was 28 minutes 33 seconds across the North West over 5 minutes below the commissioned standard of 34m.

ARP Performance

	Standard	Actual
C1 (Mean)	7:00	7:27
C1 (90th)	15:00	12:35
C2 (Mean)	18:00	27:37
C2 (90th)	40:00	59:30
C3 (Mean)	1:00:00	1:29:22
C3 (90th)	2:00:00	3:27:07
C4 (90th)	3:00:00	3:47:57

NHS 111

	Standard	Actual
Calls Within 60s	95%	69%
Average Time to answer		1min 40s
Abandoned Calls	<5%	6.75%
Call back Within 10 min	75%	17%
Average Call Back		1hour 19min
Warm Transfer to Nurse	75%	31%

PTS

- Activity in August for the trust was 44% below contract baselines, whilst the year to date position (July 2020 – August 2020) is performing at 10% above baseline. This is due to Covid-19.

Organisational Health

- **Sickness**: The overall sickness absence rate for the latest reporting month (July 2020) was 6.18%.
- **Turnover** was 7.60%.
- **Agency:** Despite the impact of Covid-19 agency costs at the trust stand at 0.4% in August.
- **Vacancy**: Positions across the trust are under establishment by 0.08%.
- **Appraisal:** The overall appraisal completion rate was 78.86% against a trust target of 76% this is lower than 95% due to the effect of Covid-19.
- **Mandatory Training:** The trust is 76% 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.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Note the content of the report • 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	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10	SR11
☒	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	Quality and performance (in part)
Date:	20th July 2020
Outcome:	Assurance

-THIS PAGE IS INTENTIONALLY BLANK -

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 August 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 August 2020, 126 complaints were received, against a 12 month average of 148 per month. 161 compliments were received this month.

A total of 107 complaints were closed in August 2020 (100 cases were risk scored 1-3 and 7 were risk scored 4-5). Overall, 66% of cases risk scored 1-3 were closed within the agreed timescales. 14% of level 4-5 complaints were closed within agreed timescales.

Q2 – Incidents

In August 2020, 1352 incidents were opened this compares to 12 month average of 1223. The increase in incident reports against the average attributable to the reporting of ALL staff with a positive Covid-19 result which is necessary to trigger the investigation required for RIDDOR reporting.

Q3 - Serious Incidents (SIs)

3 Serious Incidents (SIs) were reported in August 2020. 5 SI reports were due with the commissioners and 4 out of the 5 reports were submitted within the 60 day timescale.

Q5 - Safety Alerts and Health and Safety

There have been 9 new alerts in August 2020. The total number of CAS/NHS Improvement alerts received between September 2019 and August 2020 is 143, with 3 alerts applicable. 38 MHRA Medical Equipment Alerts have been received with 1 applicable alert. 65 MHRA Medicine alerts have been received, with no alerts applicable. 2 IPC alerts have been received, with 2 alerts applicable.

Effectiveness

E1 - Patient Experience

Due to the on-set of the pandemic in March 2020, NHS England suspended the FFT process at the end of Q4, hence no submission of March data was required from the April reporting window.

This suspension resulted in a substantive drop of 92.0% in PES FFT returns, from 25 in March to 2 in April 2020. This low rate of returns has continued, with August return of 2 being a 33.3% drop from July's return of 3. Satisfaction rates remain at 100%. Nationally, the trust previously held second position in terms of number of responses received – for both January and February. In addition, in terms of recommendation, were in 4th position having moved from 5th in the previous month (February 2020 data).

Currently there are no latest national figures to enable trust-ranking analysis. The trust's FFT implementation plan for April 2020 is in place awaiting the restart of the new national guidance.

The cessation also led to a substantive drop of 99.8% in returned PTS FFT responses, from 521 in March to just 1 in April 2020. This very low return rate continued, with a return of 2 for both July and August 2020. Satisfaction rates remained at 100%. On the national stage, in February and January, the trust previously held the second highest position in relation to number of responses submitted. In terms of satisfaction levels, February saw the trust drop into 2nd spot from 1st in the previous month of January (February 2020 data). There is still the requirement for national submissions for PTS FFT responses post April 2020.

E2 – ACQIs

In January, 7.4% of patients suffering an out of hospital cardiac arrest survived to hospital discharge (national mean 8.9%). The figure for the Utstein sub-group was 24.2% (national mean 30.2%). This performance saw the Trust ranked 10th and 9th respectively 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 48.5% (national mean 56.4%), ranking 11th nationally. For the overall group the rate was 35.8% (national mean 30.5%) ranking the Trust in 2nd position nationally. The Trust's Resuscitation Care Bundle score was 70.6% (national mean 72%) ranking the Trust 7th nationally. Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of 2h 14mins; the Trust's performance was 2h 21mins for these patients. Mean call to door time for patients suffering a hyper acute stroke was the exact same time as the national mean; the Trust's mean response to these patients was 1h 20mins. The STEMI care bundle result of 79.5% was ahead of the national mean of 78.2%. Care bundle data for stroke and sepsis was not published for January as is consistent with the NHSE reporting schedule.

E3 – H&T, S&T & S&C Outcomes

Hear & Treat Performance for August 2020 was 10.1% with the number of incidents with no face to face response totalling 9,672. NWAS continued to be one of the top performing ambulance Trust for Hear & Treat throughout the month of August, building on previous months of consistent delivery. As the first wave of COVID-19 subsided and the number of staff supporting Hear & Treat delivery reduces, there is a slow return to pre-covid performance levels. To support patient safety throughout the Trust the Clinical Hub continued to increase its support to the wider Emergency Operations Centre environments with initiatives such as the Clinical Coordination Desk trial. Throughout August the Greater Manchester Clinical Assessment Service (CAS) trial continued with its increased capacity which is helping to deliver strong hear & treat performance as in other areas with CAS provision.

See and Treat performance was 29.2%, significantly less than the peak of the covid pandemic when S&T rates increased.

See and Convey. The investment in transformation programmes (clinical hub, GM CAS, EMT and paramedic upskilling with pathfinder and Manchester Triage system) have resulted in a systematic reduction in see and convey at 61%

Finance

F1 – Finance

For the five 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 organisation s wherever possible, whilst maintaining a monthly data collection process.

The Financial Risk Rating metrics have been removed and we will add back once the new operating framework is launched after transition from the Covid-19 financial framework.

Operational

PES Activity

OP1 – Call Pick Up

For August 2020, call pick up in 5 seconds performance was at 97.7%. 2,167 calls took longer than 5 seconds to pick up. Special cause variation is seen in the control chart with 8 or more data points above the control limit. This a reflection of the increase in call volume, with activity returning to historic seasonal levels of activity. This can be attributed to an increase in incidents and an increase in secondary calls into the service. It is anticipated call volume will continue to increase as we move towards winter. It should also be noted that activity has the potential to spike upwards as the prevalence of COVID continues to increase across the NWAS footprint.

Calls with pick up

The Trust is seeing very low levels of variation across the previous four months data points. This can be attributed initially to a reduction in activity and an increase in call handling workforce. As activity continues to rise the EOC has continue to maintain high levels of call handling performance. This evident across all call handling metrics.

OP2 – Hospital Turnaround

Performance for the month of August shows a hospital turnaround time of 28 minutes 33 seconds across the North West. Key to the improvement in turnaround times for the trust is the Every Minute Matters programme. As a trust we have seen the benefit in reduced turnaround times from this programme of work. Currently this is pause due to Covid-19, however the trust is in dialogue with NHSE&I with a view to starting phase three.

OP3 – ARP Standards

	C1 Mean	C1 90th	C2 Mean	C2 90th	C3 Mean	C3 90th	C4 90th
August 2020	00:07:27	00:12:35	00:27:37	59:30	01:29:22	03:27:07	03:47:57
Target	00:07:00	00:15:00	00:18:00	40:00	01:00:00	02:00:00	03:00:00

OP4 – 111

Calls Answered within 60s for the month of August deteriorated from the previous months position. The causes of the decline in performance are multifactorial. These issues are Cleric migration training, 1111 First recruitment and Covid demand.

Cleric migration training - In order to achieve the deadlines of Cleric go live this had to be turned around at a pace. Over 600 staff within 111 have now been trained in the new Cleric system in readiness for go live on 16th September. This deployment of training was successfully delivered but did impact performance in 111 as approximately 18 staff per course were scheduled offline at any one time.

111 First recruitment - As required nationally the 111 service is now recruiting sufficient staff to be able to answer the extra demand following the launch of the '111 First' campaign. In order to meet 20% of the unheralded ED attendances recruitment is now planned across the next 4 months, this entails a new training course of staff commencing every 2 weeks between now and December. Resource to support recruitment is taken from front line, using 'super users' to support the delivery of training and the preceptorship of new staff after they have finished training.

Covid demand - Calls into the 111-service relating to Covid have significantly increased, August saw a 12% increase in calls offered compared to previous month, acknowledging the bank holiday in August

this is still a significant increase in demand. On review of activity trends it is apparent that activity is particularly volatile at present making forecasting even more of a challenge to plan for.

In addition to front-end demand pressure, staff absence relating to Covid Isolation has also significantly increased, this correlates with the identification of Bolton being a Covid hotspot and the service is seeing increasing numbers of staff absence due to Covid isolation.

OP5 – PTS Activity

Overall activity during August 2020 was 44% below contract baselines with Lancashire 51% below contract baselines whilst Merseyside is operating at -35% (-8844) Journeys below baseline. For the year to date position (July 2020 - August 2020) PTS is performing at 10% (12643 journeys) above baseline. Within these overall figures, Cumbria and Lancashire are operating at 4% and 4% below baseline whilst Greater Manchester and Merseyside are operating at 18% and 29% above baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 181% (5900 journeys above baseline) and 74% (1387 journeys) below 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 18% (231 journeys) and 57% (2643 journeys) below baseline.

During this reporting period the NHS has been responding to the level 4 COVID-19 emergency. Restricted hospital arrangements to ensure social distancing for all planned appointments continue to impact on activity levels.

Aborted activity for planned patients averaged 6% during August 2020 however Cumbria experiences 3%, Greater Manchester operates with 7% whilst Lancashire and Merseyside both experience 5% & 6% aborts respectively. There is a similar trend within EPS (renal and oncology) patients with an Trust average of 4% aborts whereas Cumbria has 1% and Greater Manchester 5% Lancashire and Merseyside operate with 2% and 4% respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average 14% (1 in 6 patients) with variances of 8% in Cumbria, 18% in Greater Manchester, 11% in Lancashire and 12% Merseyside.

Workforce

OH1 – Sickness

The overall sickness absence rates for July 20 were 6.18%. This includes COVID-19 related sickness of 0.67%. Overall sickness for the Trust shows underlying non-COVID sickness lower than the same time last year which was 6.10%. The overall Trust sickness level shows a special cause variation with the last data point being on the lower control limit. This is a positive indicator as it reflects a reduction in sickness absence greater than projected thereby increasing capacity in 111. Sickness absence in 111 in July was 7.16% (including COVID related sickness of 0.6%) which represents a significant reduction from the same time as last year which was 13.71%. PES sickness is at 6.24%, of which 5.54% is non COVID-19. This demonstrates a downward trend. PTS sickness was 7.36% in July 20 and is a stable position overall.

It should be noted that these figures relate to sickness recorded via ESR. COVID-19 self-isolating absences have been captured GRS.

OH2 – Turnover

Turnover is calculated on a rolling year average and does lend to some small variations between months with August 20 turnover being 7.60%. Overall the trend remain stable. Whilst the overall Trust position identifies that there is a special cause with the last three data points being below the lower control limit, this is unsurprising given the impact of COVID-19 and the impact this has had on the jobs market. Figure

Turnover in PTS also highlights special cause with the last two data points being below the lower control limit. As stated above, the likely explanation is the lack of job opportunities and reduction in movement overall. For 111 the downward trend in turnover pre-dates COVID resulting in a change to the control limits. Although the last few months will have been affected by the prevailing job market, the overall improvements are reflective of the significant work in 111 to reduce turnover over the last 12 months.

OH4 – Temporary Staffing

The current agency staffing position reflects the increased use of agency workers during the height of the pandemic in order to deploy additional resources. This was particularly the case in EOC, the Clinical Hub and 111. As a result of COVID-19 pandemic, both Bank and Agency costs increased between the period April - August 20. Under the current emergency budget arrangements the agency ceiling measure is currently paused.

The Trust will be looking where possible, to reduce Agency usage within 111 and EOC with the potential to move some staff on to fixed term contracts.

OH5 – Vacancy Gap

The vacancy position continues to remain positive. The baseline establishment includes all funded growth from 2019/20. This shows an over establishment in EOC of 4.55% in preparation for winter and 111 over established by 26.06%. The over establishment in 111 relates to the mobilisation of Think 111 First and the revised contract settlement which will be shown in establishment from October 1st.. Frontline PES vacancy position in August 20 is a good position at –0.80% in preparation for winter, although Paramedic graduates will only become available in Q4 this year. PTS have been impacted by the transfer of staff to support PES and bank recruitment is ongoing to support PTS delivery for the remainder of the year. ORH modelling outcomes may result in further establishment changes.

OH6 – Appraisals

Appraisal compliance overall has reduced as a result of the impact of Covid-19. Appraisals were paused in March 2020 in line with national guidance and as a result completion rates have decreased to 79% overall with PES rates at 84% and PTS at 77%. 111 compliance rates are currently low at 51%. This is impacted by recent high levels of recruitment and demand pressures. Work is ongoing to support 111 improvement. Following resumption in June 2020, a revised target as part of recovery planning is 85% for March 2021. Revised streamlined appraisal documentation approved by ELC in June should support completion.

OH7– Mandatory Training

The overall Trust mandatory training compliance position at the end of August 2020 is 76%. This takes into account all online and classroom training. In addition to the impact of COVID-19 overall compliance levels are impacted by the inclusion of new topics in this year's cycle of training which will show as non-compliant until completion.

The Trust had moved to competence-based reporting for mandatory training. The aim has been for staff to complete their classroom-based training and their online training before their competence expires, thus maintaining compliance across the year at 95%.

The cessation of training has impacted on this and now the 95% target will not be met fully until March 2021.

The current position is that PES classroom compliance is at 49% i.e. 49% of staff have received classroom training within the last 12 months and PTS are at 88%. However, both are on track against revised trajectories for classroom attendance.

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
- Clarify any items for further scrutiny through the appropriate assurance committee.

This page is intentionally left blank

Q1 COMPLAINTS

Figure Q1.1

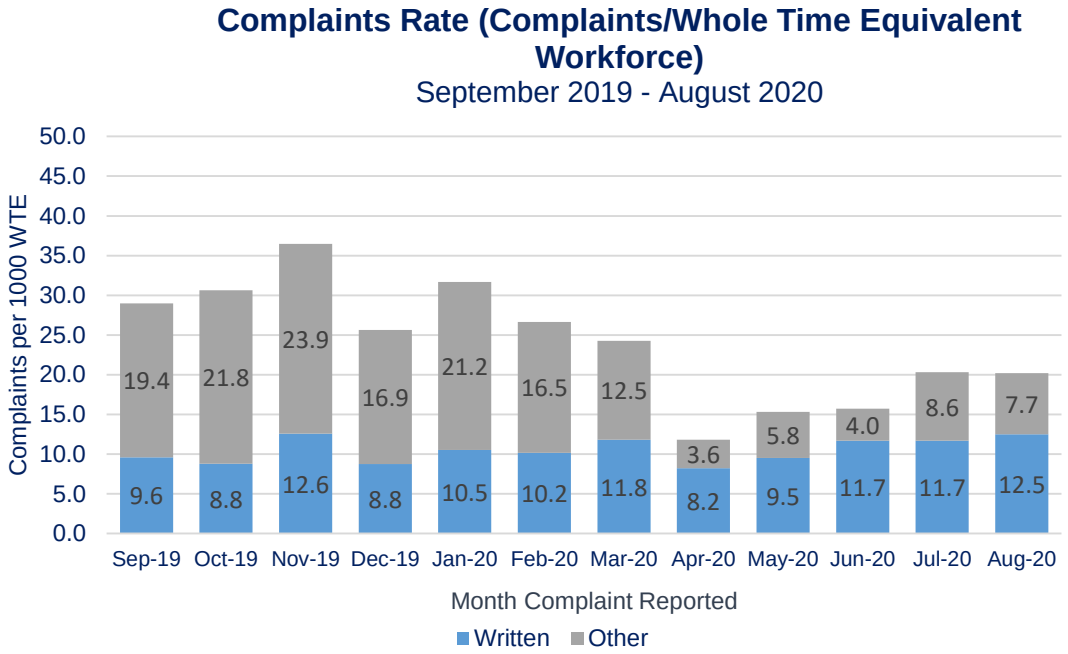


Table Q1.1: Complaints Opened by Month

Severity	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
1 - Minimum	15	10	15	11	12	7	5	9	7	5	9	7
2 - Minor	131	141	159	108	151	122	109	40	62	61	80	80
3 - Moderate	17	17	33	17	18	17	30	19	19	18	29	21
4 - Major	10	14	13	14	14	18	5	3	4	8	6	16
5 - Serious	2	6	6	8	1	1	1	2	3	5	3	2
Total	**175**	**188**	**226**	**158**	**196**	**165**	**150**	**73**	**95**	**97**	**127**	**126**
Compliments	127	146	123	113	148	76	138	142	121	117	128	161

Complaints & Compliments

In August 2020,

- 126 complaints were received, against a 12 month average of 148 per month.
- 161 compliments were received this month.
- The rate of complaints in August 2020 is 20 per 1000 WTE, which is below the strategy goal for 2020/21
- 66% of complaints with a risk score of 1-3 and 14% of complaints with a risk score of 4-5 were closed within the SLA against a goal of 85% and 80% respectively.

Right Care Strategy Goal:

2020/21 target to reduce the overall numbers of complaints per 1000 WTE staff by 20% (8) of the baseline* per 1000 WTE .

* baseline is the financial year 2017/18

Figure Q1.2

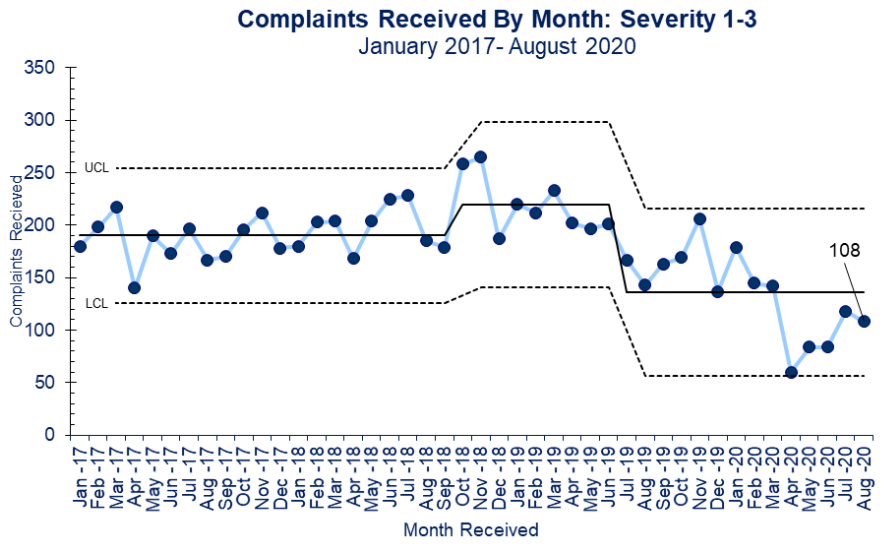


Figure Q1.3

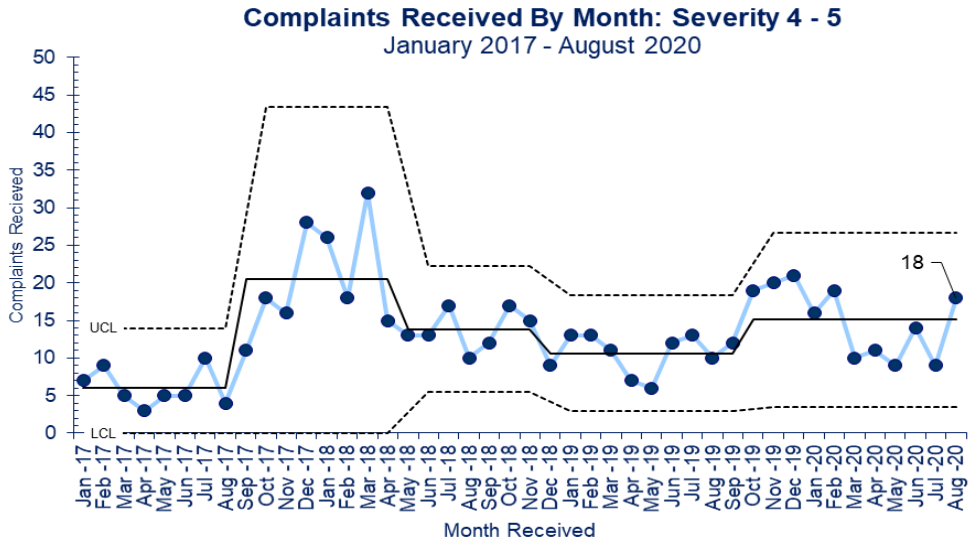


Figure Q1.4

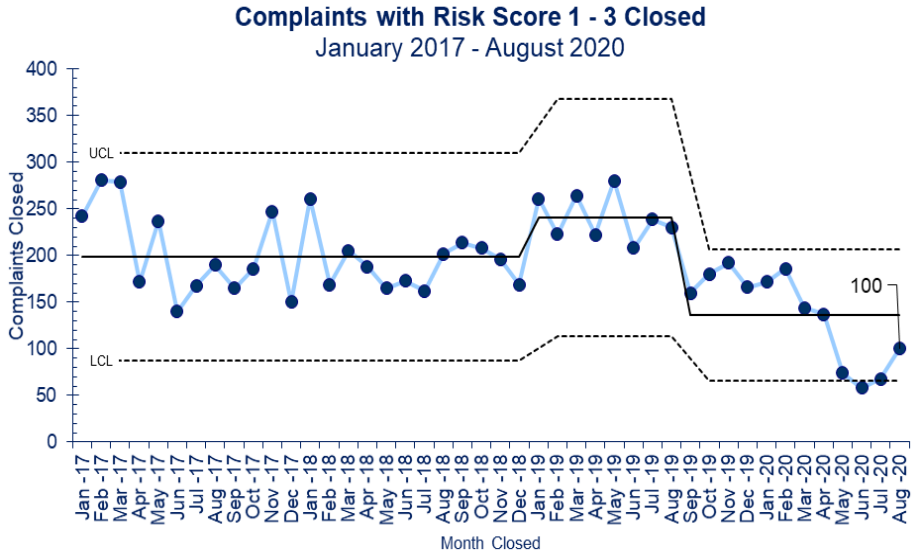


Figure Q1.5

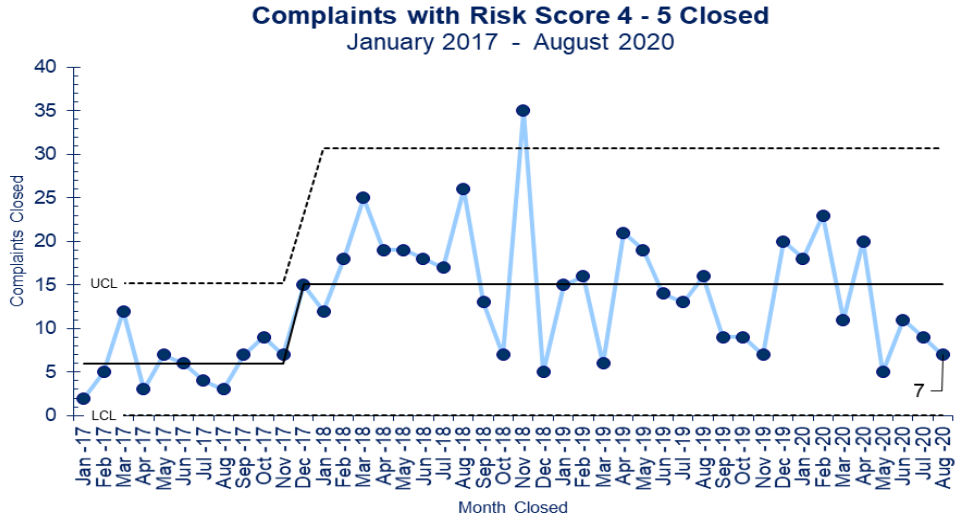


Figure Q1.6

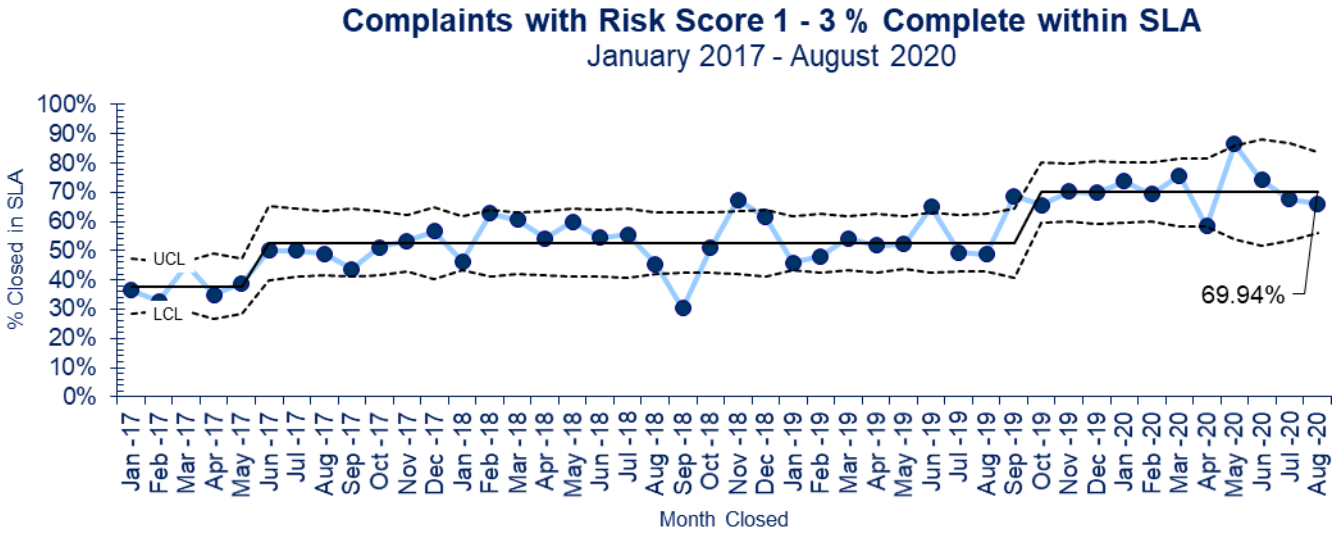
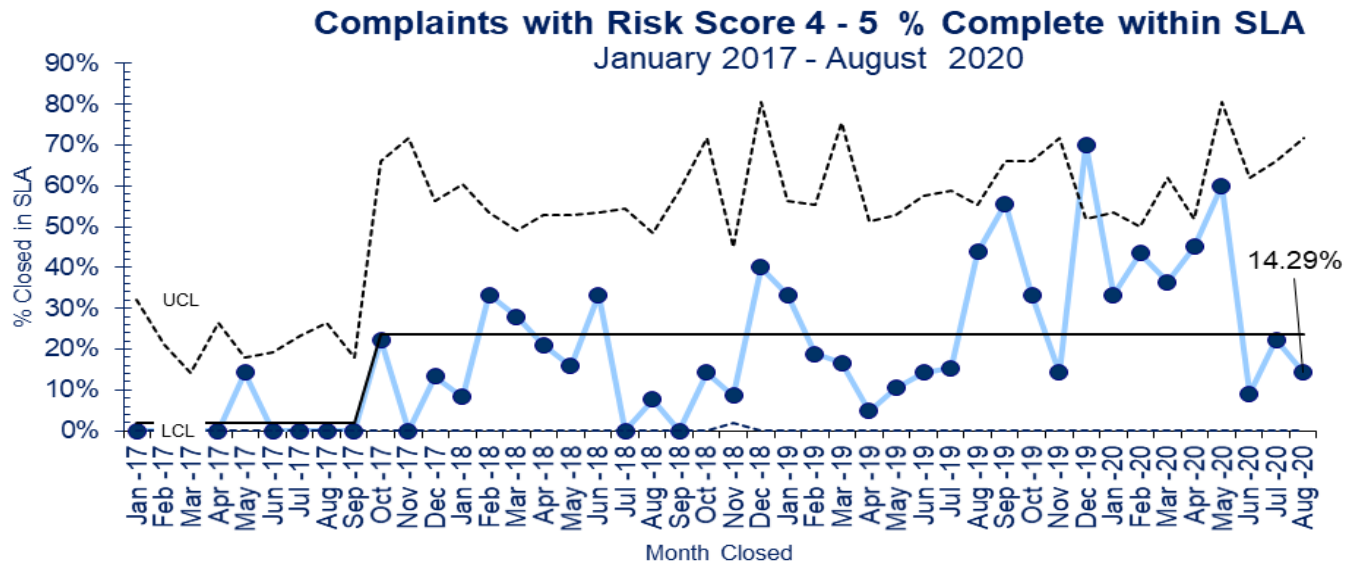


Figure Q1.7



Complaints Closure

A total of 107 complaints were closed in August 2020 (100 cases were risk scored 1-3 and 7 were risk scored 4-5).

Overall, 66% of cases risk scored 1-3 were closed within the agreed timescales.

14% of level 4-5 complaints were closed within agreed timescales.

Right Care Strategy Goals Performance:

1. 75% of complaints with a risk score of 1 to 3 will be closed within agreed timeframes by the end of 2020/21.

2. 75% of complaints with a risk score of 4 to 5 will be closed within agreed timeframes by the end of 2020/21.

.

Q2 INCIDENTS

Figure Q2.1

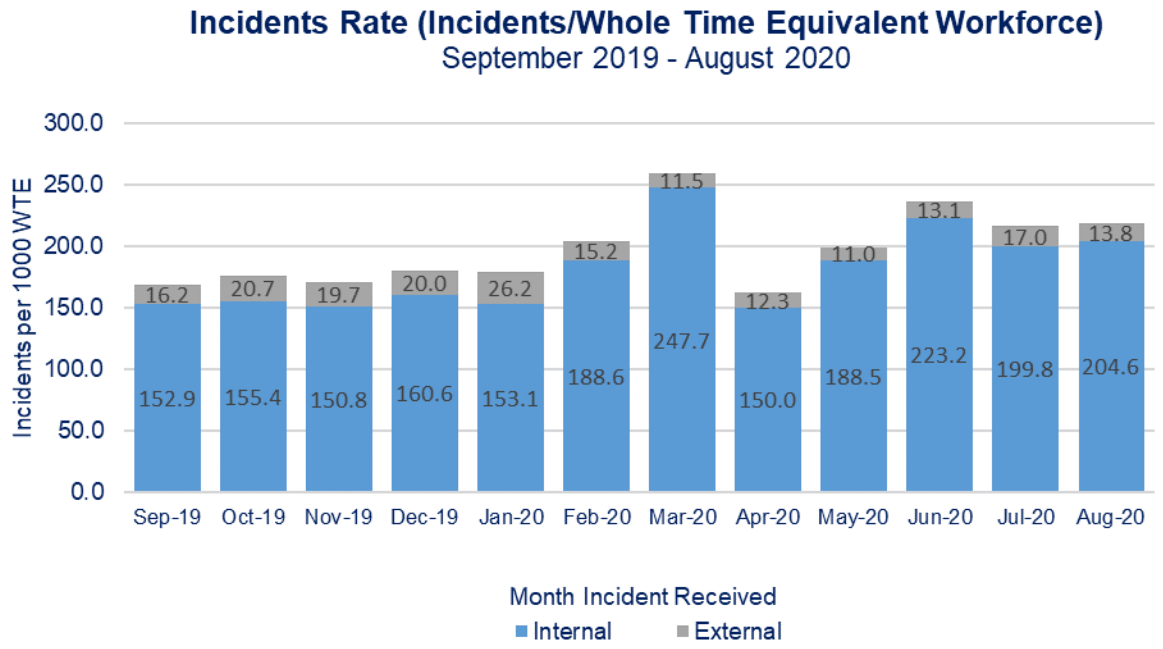


Table Q2.1

Severity	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
1. Insignificant	184	189	142	153	168	231	262	163	183	247	221	187
2. Minor	3	1	3	5	5	11	1	3	2	2	6	6
3. Moderate	640	708	704	695	707	776	1104	595	750	821	805	868
4. Major	174	152	173	219	202	210	198	204	265	368	272	243
5. Catastrophic	7	9	11	15	13	13	6	15	11	10	16	12
Unscored	10	16	19	22	12	19	23	17	22	20	29	36
Total	**1018**	**1075**	**1052**	**1109**	**1107**	**1260**	**1594**	**997**	**1233**	**1468**	**1349**	**1352**
Unscored %	0.98%	1.49%	1.81%	1.98%	1.08%	1.51%	1.44%	1.71%	1.78%	1.36%	2.15%	2.66%

Incidents

In September 2020 1352 internal and external incidents were opened, against a 12 month average of 1223.

Right Care Strategy Goals:
Reduce the reported unscored incidents in IPR to 25 unscored incidents in the previous month.

The trust has not met the strategy goal of 25 unscored incidents. The CS Team delivered a presentation on the importance of risk scoring incidents within timeframes at the Cheshire & Merseyside Area Briefing on 1st September. This received positive feedback from staff and provided clarity on the necessary actions required to be completed in datix. The CS Team continue to share unscored incident dashboards highlighting unscored incidents by area with operational teams.

Figure Q2.2

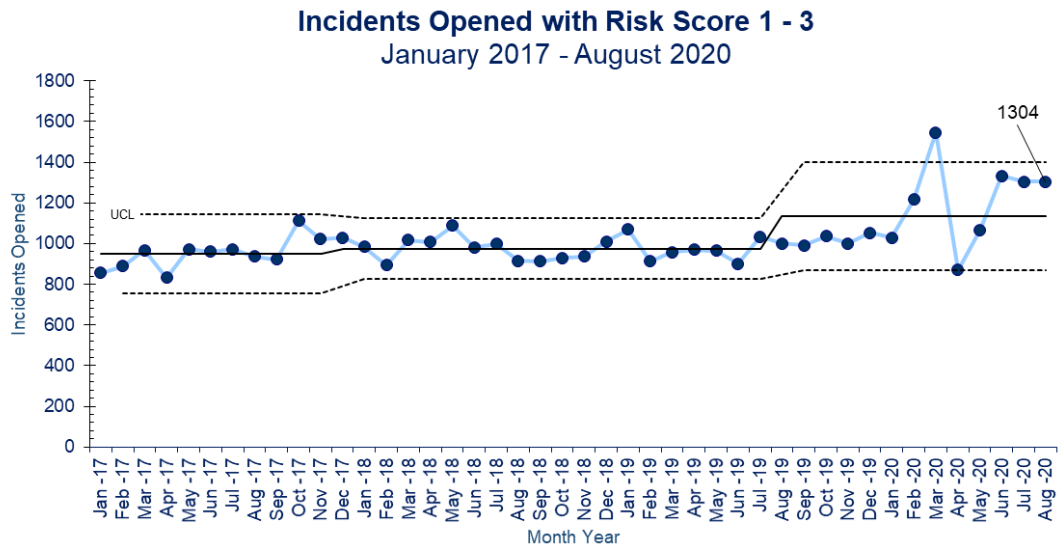


Figure Q2.3

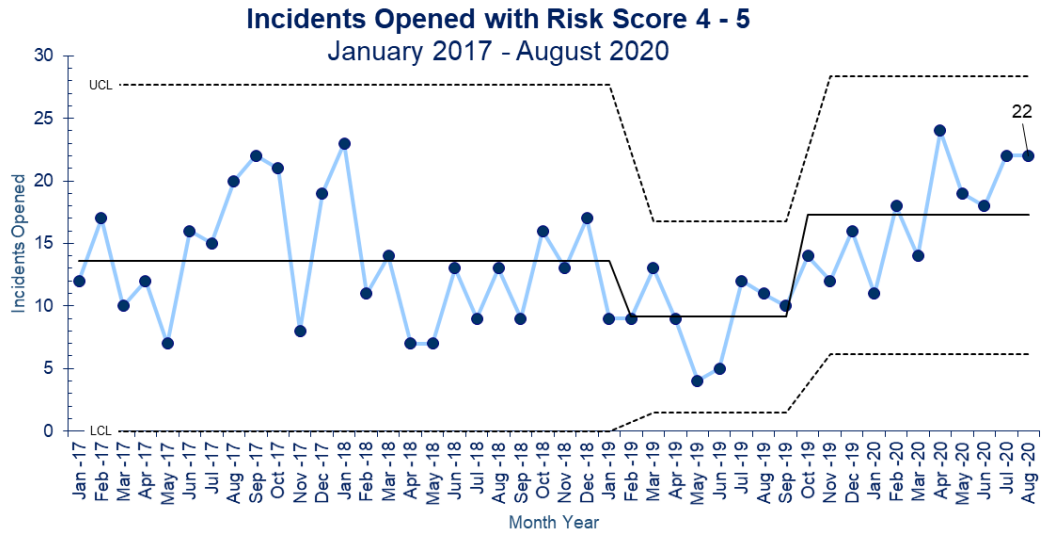


Table Q2.1 – Top 10 Incident Categories Opened in August 2020

Category	03/08/2020	10/08/2020	17/08/2020	24/08/2020	Total
Information	37	31	23	37	128
111 Assessment/Advice	20	28	34	30	112
111 Issue with other service	19	19	19	26	83
Staff Welfare	16	20	11	16	63
Communication	13	12	12	13	50
Threatening behaviour	10	14	14	11	49
Equipment Missing / Lost	15	11	7	13	46
Medicine Management	9	16	11	9	45
Verbal Abuse	12	10	11	10	43
Physical Assault	9	14	5	8	36

Figure Q2.5

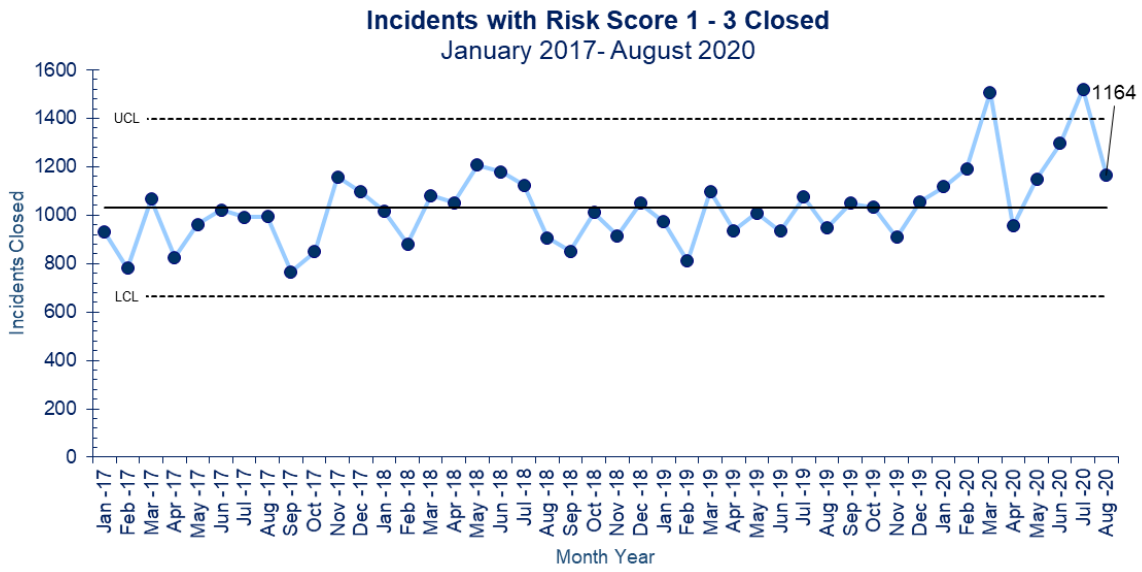
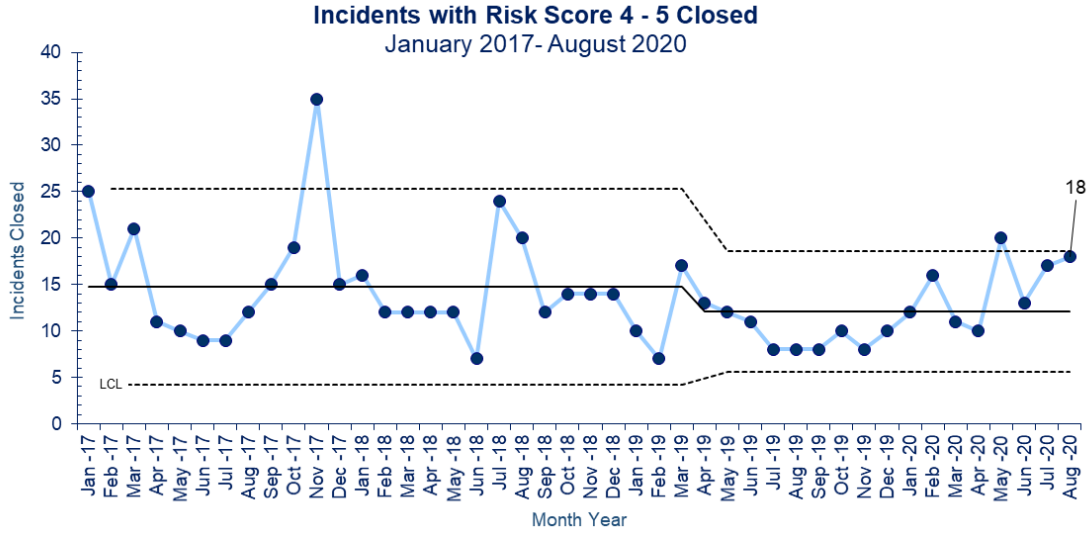


Figure Q2.6



Incidents Closure

In total, 1182 incidents (level 1-5) were closed during August 2020. Of these, 83% level 1-3 and 61% level 4-5 incidents were closed within the agreed standard.

Concerted efforts have been made by operational teams to review and close incidents.

Right Care Strategy Goals Performance:

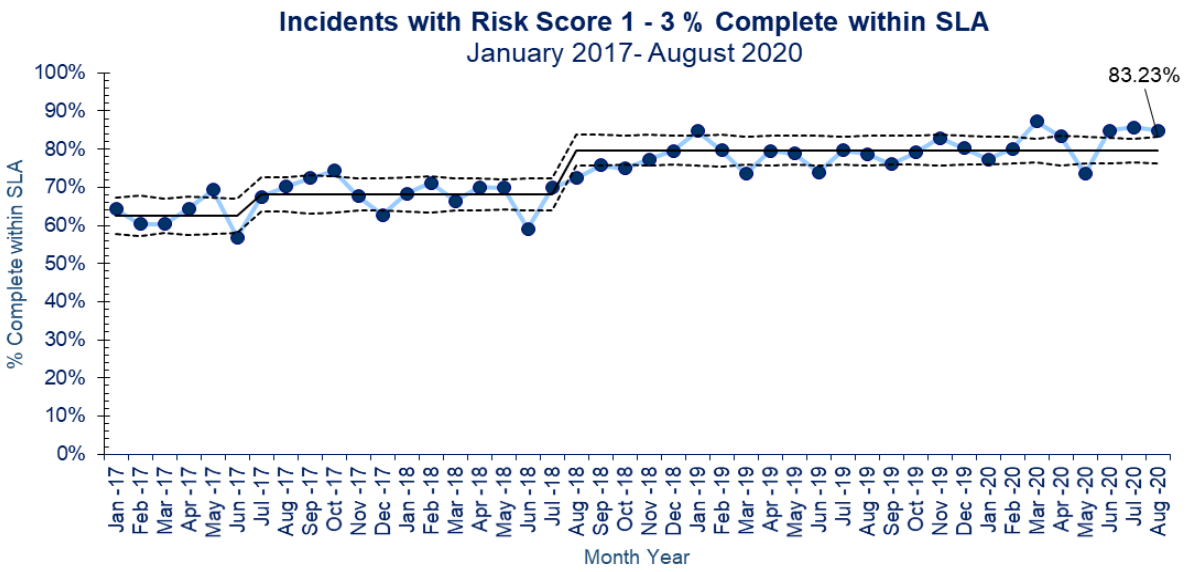
1. Increase closure within agreed timeframes to 85% by 2020/21 for severity 1-3 (**Figure Q2.7**)

The Trust has not been achieving their Strategy Goal (85%) for Risk 1-3 Incident Closures in the agreed timeframe as August performance shows performance at 83.23% however it is showing special cause variation.

2. Increase closure within agreed timeframes to 80% by 2020/21 for severity 4-5 (**Figure Q2.8**).

During August, the Trust has not achieved the Strategy Goal (80%) for risk scored 4-5 incidents within the agreed timeframe for closure with performance at 61.11%.

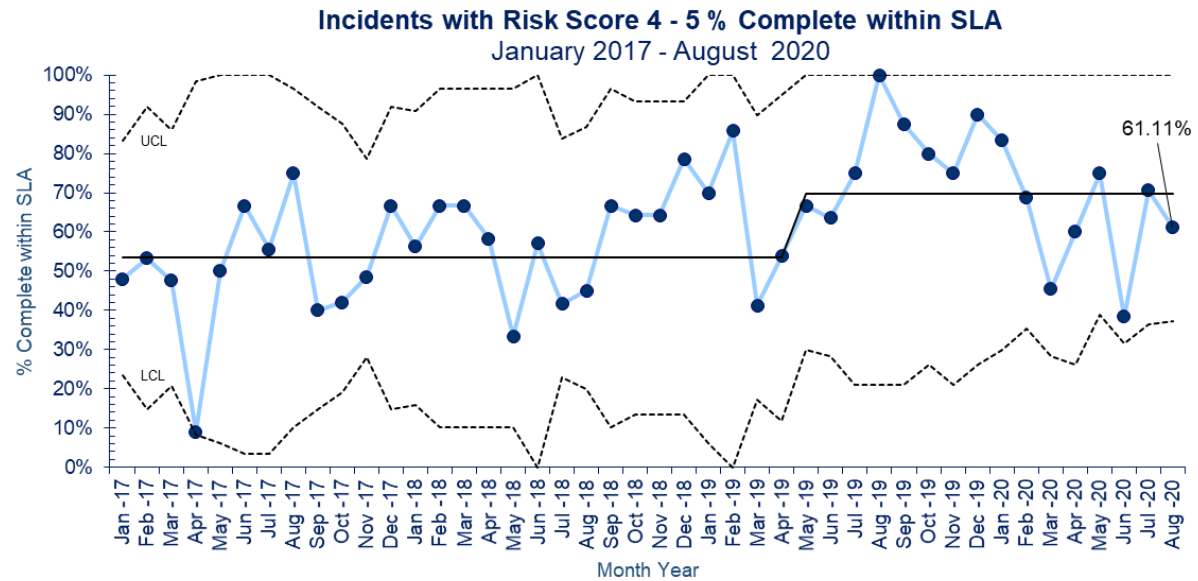
Figure Q2.7



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



Q3 SERIOUS INCIDENTS

Figure Q3.1

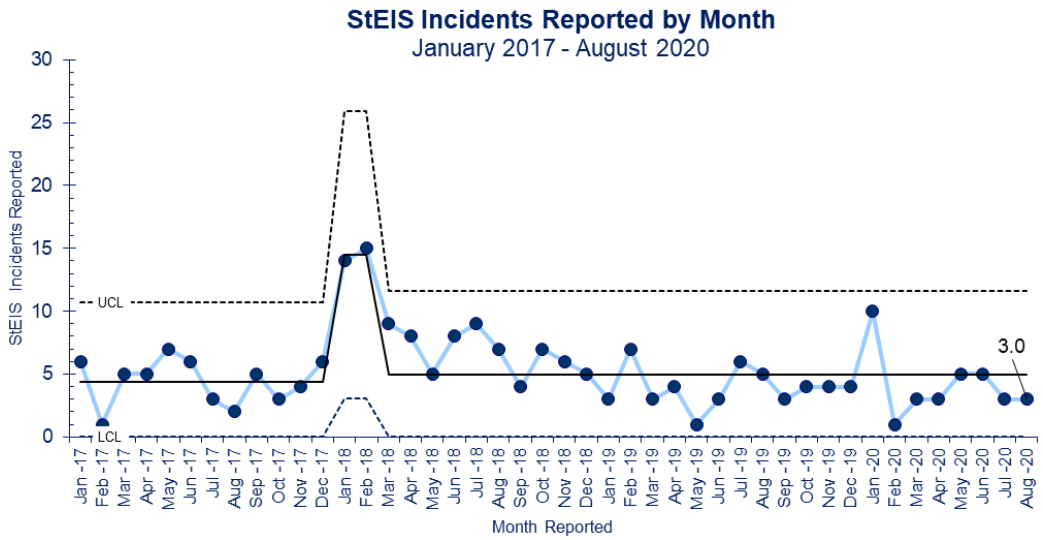


Table Q3.1: StEIS Incidents Opened in August 2020 by Source

Source	SD - Emergency Operations Centre	SD - Emergency Operations Centre	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	Total
111 Complaint/Steis	**1**			**1**
Complaint/StEIS				
External/StEIS				
IRF/StEIS		2		**2**
Legal/StEIS				
Total	**1**	**2**		**3**

Serious Incidents

3 Serious Incidents (SIs) were reported in September 2020.

5 SI reports were due with the commissioners in August 2020. 4 out of the 5 reports were submitted within the 60 day timescale. 1 report was submitted by the agreed extension date.

Right Care Strategy Goals:

1. Increase the proportion of cases where the notify-to-confirm interval is within the agreed timeframes to 85% by 2020/21.

1. The notify to confirm interval is completed within agreed timescales.

2. Increase the proportion of cases where the confirmation to report interval is within the agreed 60 day timeframe to 95% by 2020/21.

The SI review panel has been very positive with 80% of the reports submitted within timescales through August. Some reports have been returned prior to the scheduled due date.

Having already undertaken this SI review panel, any queries from BCCG are being responded to more efficiently.

BAF Risk: SR01.

Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received (Sept 19 – Aug 20)	Number of Alerts Applicable (Sept 19 – Aug 20)	Number of Open Alerts
CAS/ NHS Improvement	43	0	0
MHRA – Medical Equipment	36	1	0
MHRA - Medicine Alerts	65	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: LDonovan (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.

NWAS Response

There have been 9 new safety alerts in August 2020.

The total number of CAS/NHS Improvement alerts received between September 2019 and August 2020 is 146, with 3 alerts applicable.

36 MHRA Medical Equipment Alerts have been received with 1 alert being applicable.

65 MHRA Medicine alerts have been received, with 0 alert applicable.

2 IPC alerts have been received, with 2 alerts applicable.

BAF Risk: SR01.

E1 PATIENT EXPERIENCE

Figure E1.1

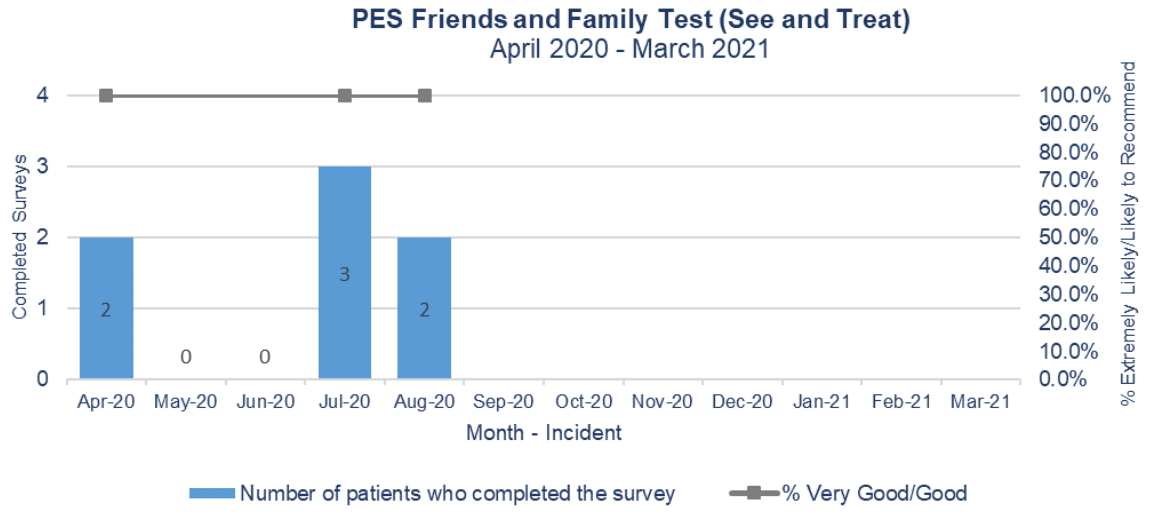
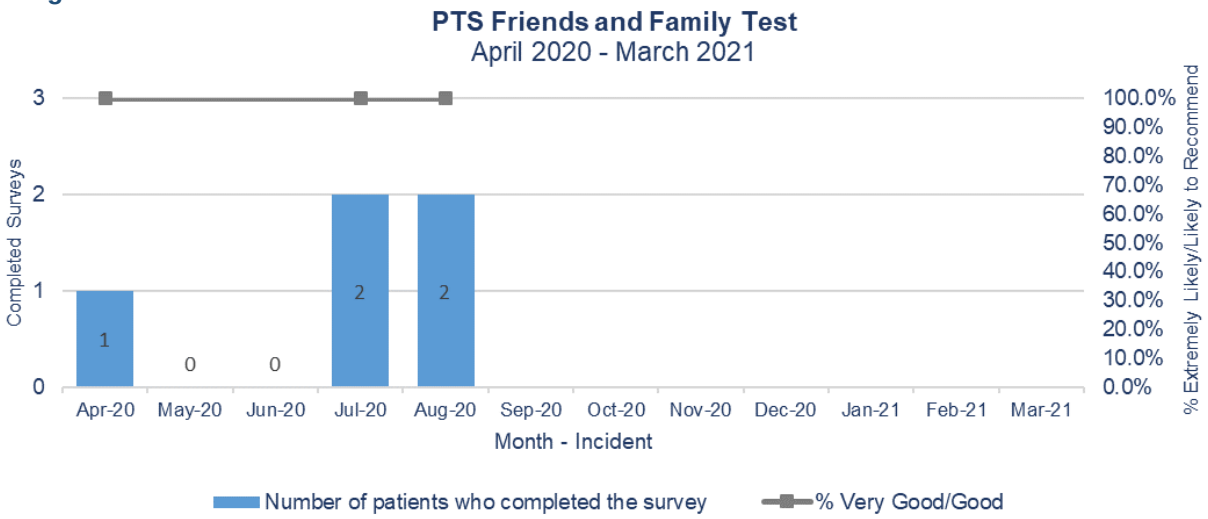


Figure E1.2



Patient Experience (PES)

Due to the on-set of the pandemic in March 2020, NHS England suspended the FFT process at the end of Q4, hence no submission of March data was required from the April reporting window. This suspension resulted in a substantive drop of 92.0% in PES FFT returns, from 25 in March to 2 in April 2020. This low rate of returns has continued, with August return of 2 being a 33.3% drop from July's return of 3. Satisfaction rates remain at 100%.

Nationally, the trust previously held second position in terms of number of responses received – for both January and February. In addition, in terms of recommendation, were in 4th position having moved from 5th in the previous month (February 2020 data). Currently there are no latest national figures to enable trust-ranking analysis. The trust's FFT implementation plan for April 2020 is in place awaiting the restart of the new national guidance.

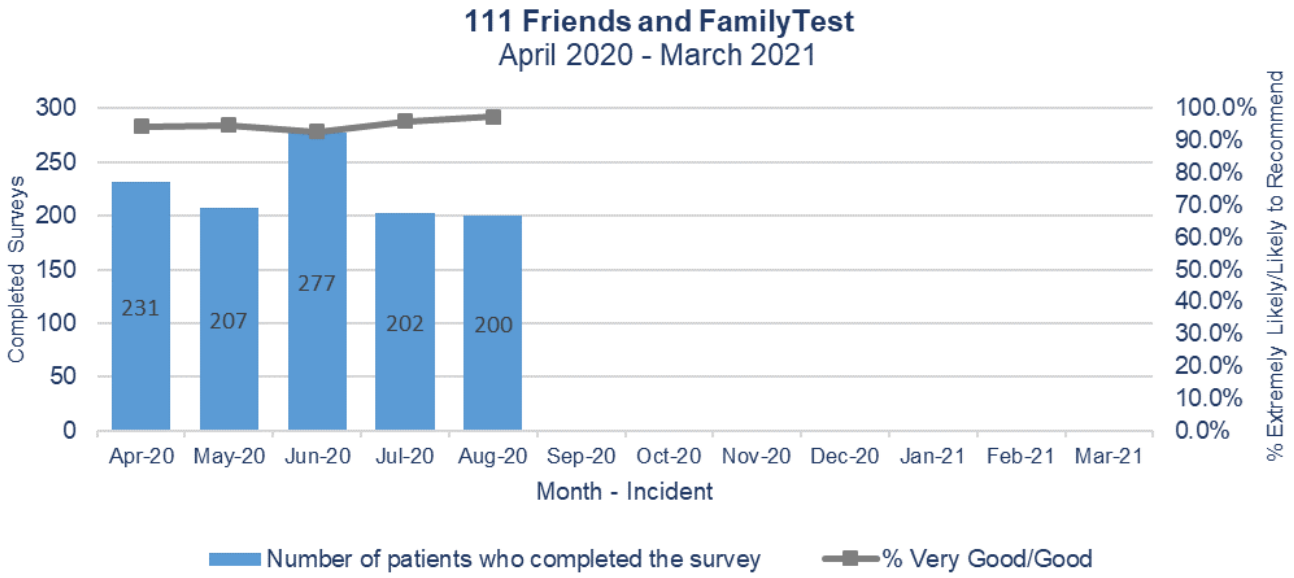
Patient Experience (PTS)

As above NHS England suspended the FFT process at the end of Q4, hence no submission of March data was required from April.

This cessation led to a substantive drop of 99.8% in returned PTS FFT responses, from 521 in March to just 1 in April 2020. This very low return rate continued, with a return of 2 for both July and August 2020. Satisfaction rates remained at 100%.

On the national stage, in February and January, the trust previously held the second highest position in relation to number of responses submitted. In terms of satisfaction levels, February saw the trust drop into 2nd spot from 1st in the previous month of January (February 2020 data).
There is still the requirement for national submissions for PTS FFT responses post April 2020.

Figure E1.3



Patient Experience (111)

The number of NHS 111 recommendation responses remained at 200 for both August and July, having seen a 27.0% drop from June returns of 277.

There was an increase of 1.5% in satisfaction levels from 96.0% in July to 97.5% in August.

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Table E2.1: ACQI January 2020

ACQI Indicator		YTD Performance (%)	Sample Size (Current Month)	January 20 Performance (% / hrs: mins)	December 19 Performance (%)*	January 20 Rank position	Rank movement	Performance Range % / hrs: mins (national mean)
Cardiac Arrest ROSC	Overall	33.0%	282	35.8%	29.9%	2	↑	23.6-43.8 (30.5)
	Utstein	54.9%	33	48.5%	56.3%	11	↓	48.5-63.6 (56.4)
	Resus Care Bundle	66.6%	119	70.6%	N/A	7	↓	27.5-93.2 (72.0)
Cardiac Arrest Survival to Discharge	Overall	9.2%	282	7.4%	9.0%	10	↓	3.9-25.0 (8.9)
	Utstein	28.7%	33	24.2%	33.3%	9	↔	19.0-66.7 (30.2)
Acute STEMI	PPCI (mean call to PPCI time)	N/A	139	2 hours 21 mins	2hrs 24 mins	9	↓	1hr 59 mins - 2hr 27 mins (2hr 14 mins)
	Care Bundle	74.7%	73	79.5%	N/A	5	↑	44.0-94.3 (78.2)
Stroke	Hyper acute (mean call to door time)	N/A	574	1hr 20 mins	1hr 28 mins	7	↔	1hr 18 mins - 1hr 47 mins (1hr 20 mins)
	Care Bundle	98.8%	N/A	N/A	N/A	N/A	N/A	N/A
Sepsis	Care Bundle	78.3%	N/A	N/A	N/A	N/A	N/A	N/A

ACQIs – January 2020

In January, 7.4% of patients suffering an out of hospital cardiac arrest survived to hospital discharge (national mean 8.9%). The figure for the Utstein sub-group was 24.2% (national mean 30.2%). This performance saw the Trust ranked 10th and 9th respectively 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 48.5% (national mean 56.4%), ranking 11th nationally. For the overall group the rate was 35.8% (national mean 30.5%) ranking the Trust in 2nd position nationally.

The Trust's Resuscitation Care Bundle score was 70.6% (national mean 72%) ranking the Trust 7th nationally.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of 2h 14mins; the Trust's performance was 2h 21mins for these patients.

Mean call to door time for patients suffering a hyper acute stroke was the exact same time as the national mean; the Trust's mean response to these patients was 1h 20mins.

The STEMI care bundle result of 79.5% was ahead of the national mean of 78.2%. Care bundle data for stroke and sepsis was not published for January as is consistent with the NHSE reporting schedule.

Cardiac Outcomes over time (SPC)

Figure E2.1

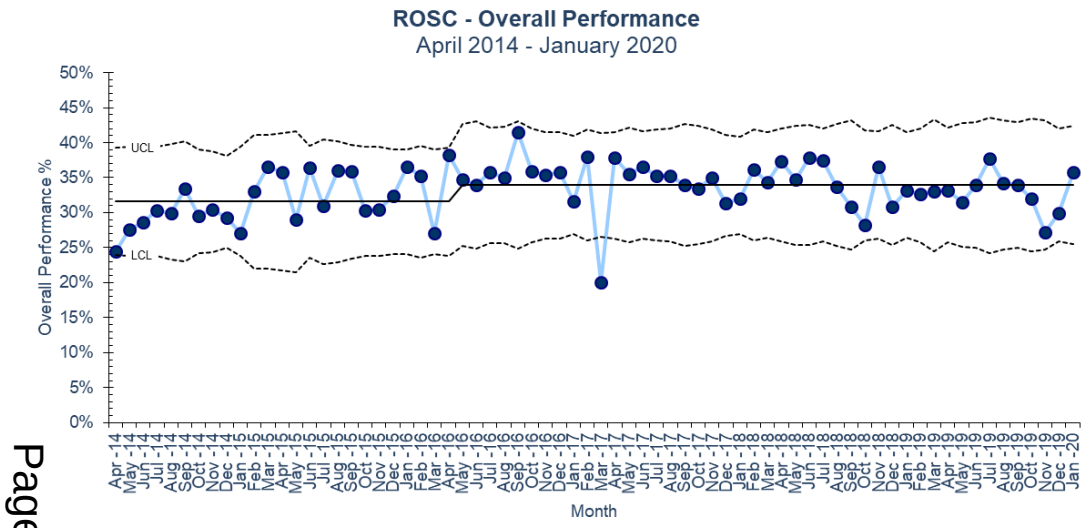


Figure E2.2

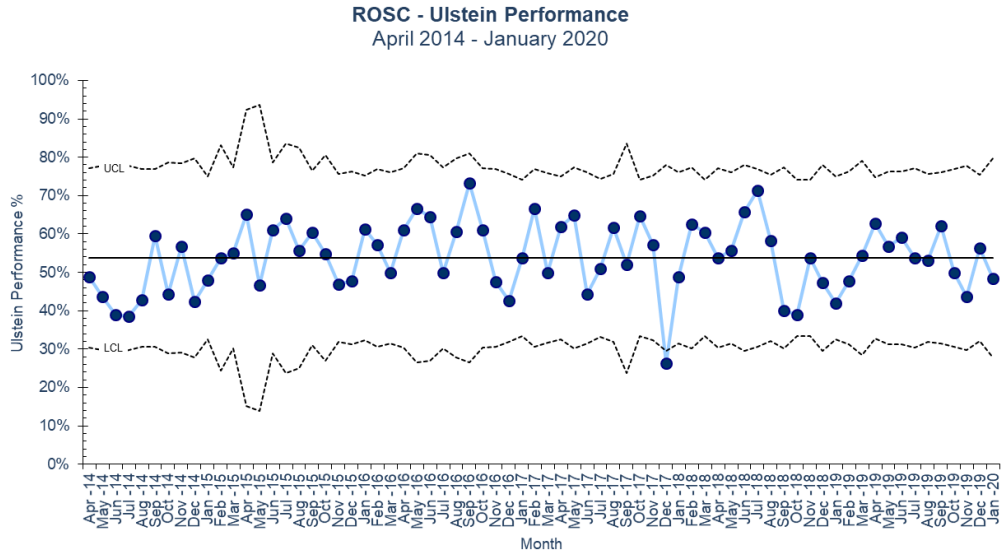


Figure E2.3

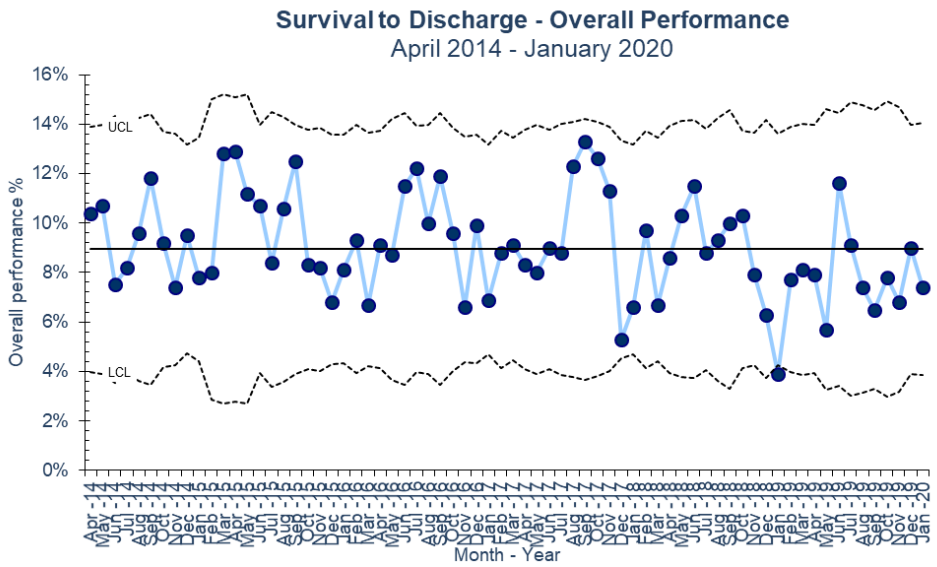
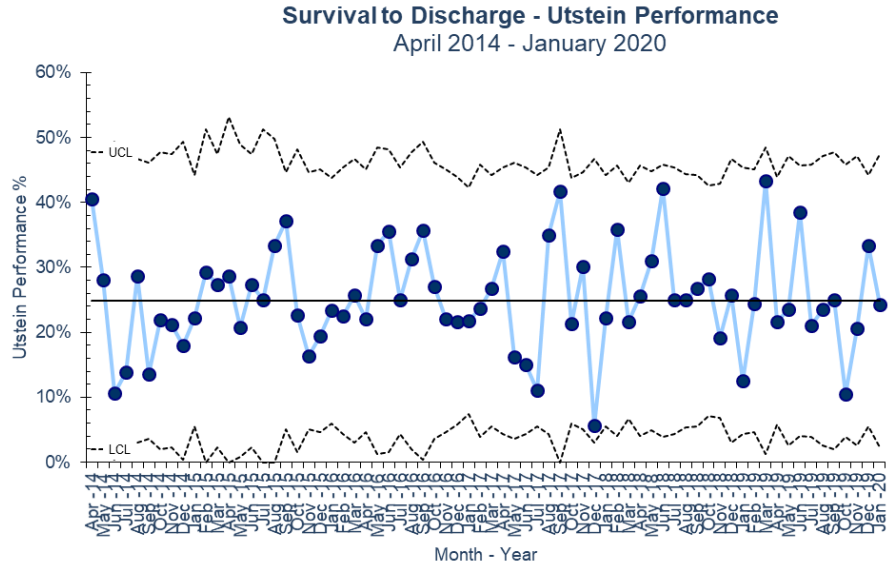


Figure E2.4



Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

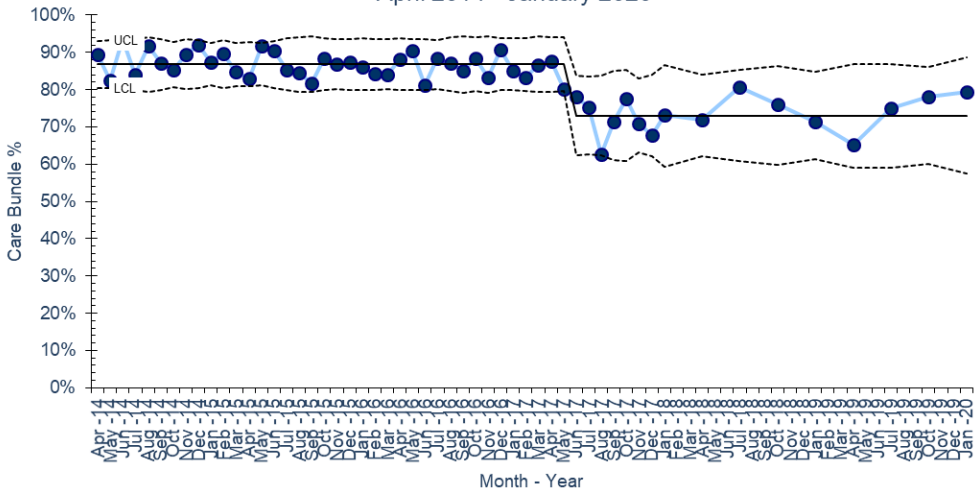
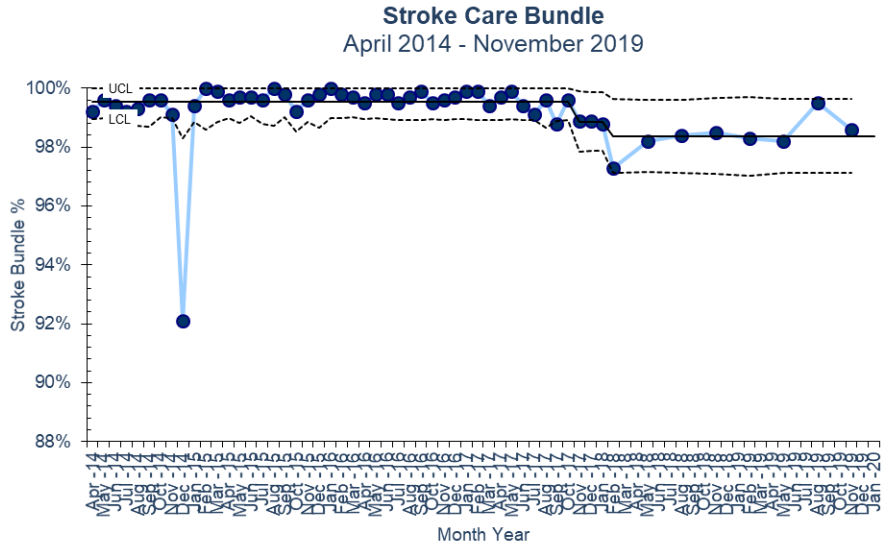


Figure E2.6



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).

E3 H&T, S&T, S&C OUTCOMES

Figure E3.1

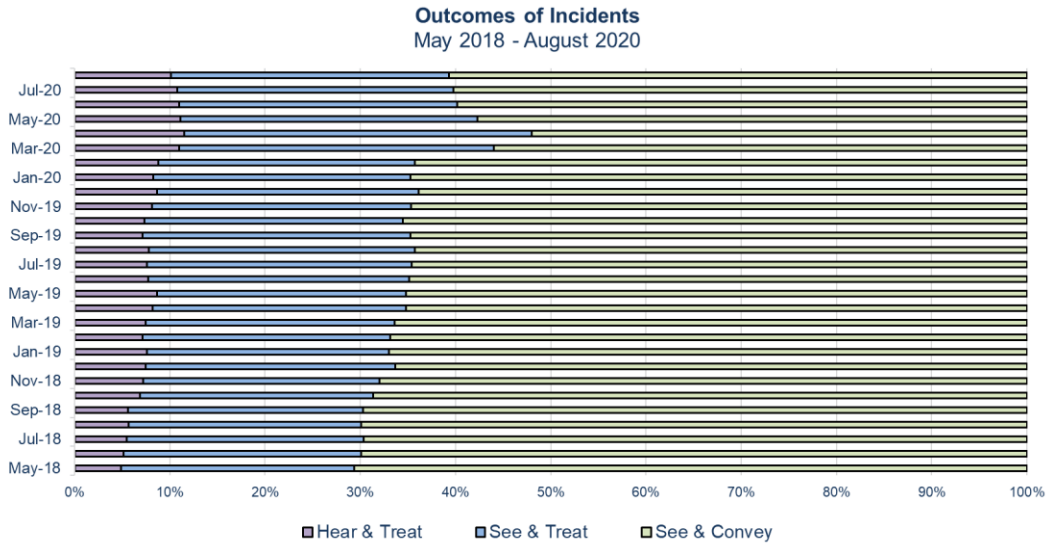


Table E3.1

Month/Yr	Incidents with no face to face response	Hear and Treat %	F2F Incidents with no transport	See & Treat %	F2F Incidents with transport	See & Convey %
Sep-19	6,782	7.1%	26,711	28.1%	61,423	64.7%
Oct-19	7,249	7.3%	26,863	27.2%	64,792	65.5%
Nov-19	8,101	8.1%	27,031	27.2%	64,357	64.7%
Dec-19	9,064	8.6%	28,779	27.5%	66,966	63.9%
Jan-20	8,170	8.3%	26,612	27.0%	63,873	64.7%
Feb-20	7,867	8.8%	24,033	26.9%	57,381	64.3%
Mar-20	10,602	11.0%	31,921	33.1%	54,002	55.9%
Apr-20	10,616	11.5%	33,586	36.5%	47,852	52.0%
May-20	10,216	11.1%	28,587	31.2%	52,933	57.7%
Jun-20	10,053	11.0%	26,606	29.2%	54,580	59.8%
Jul -20	10,422	10.8%	28,006	29.0%	58,101	60.2%
Aug - 20	9,672	10.1%	28,081	29.2%	58,381	60.7%

Outcomes

Hear & Treat Performance for August 2020 was 10.1% with the number of incidents with no face to face response totalling 9,672. NWAS continued to be one of the top performing ambulance Trust for Hear & Treat throughout the month of August, building on previous months of consistent delivery. As the first wave of COVID-19 subsided and the number of staff supporting Hear & Treat delivery reduces, there is a slow return to pre-covid performance levels. To support patient safety throughout the Trust the Clinical Hub continued to increase its support to the wider Emergency Operations Centre environments with initiatives such as the Clinical Coordination Desk trial.

Throughout August the Greater Manchester Clinical Assessment Service (CAS) trial continued with its increased capacity which is reflected in figure E3.2, which similarly indicates strong hear & treat performance in other areas with CAS provision.

Table E3.2

Provider	Hear & Treat
Isle of Wight	10.9%
North West	10.1%
South Central	9.8%
London	9.5%
Yorkshire	8.8%
East Midlands	8.5%
East of England	8.3%
South East Coast	7.2%
North East	7.0%
South Western	4.9%
West Midlands	4.0%

Table E3.3

Provider	See & Treat
South Western	39.0%
West Midlands	37.8%
South Central	34.6%
Isle of Wight	34.1%
South East Coast	33.7%
East of England	33.2%
East Midlands	31.0%
London	30.9%
North West	29.2%
Yorkshire	28.9%
North East	28.6%

Table E3.4

Provider	See & Convey
Isle of Wight	55.0%
South Central	55.6%
South Western	56.0%
West Midlands	58.3%
East of England	58.5%
South East Coast	59.1%
London	59.6%
East Midlands	60.5%
North West	60.7%
Yorkshire	62.4%
North East	64.4%

Figure E3.4

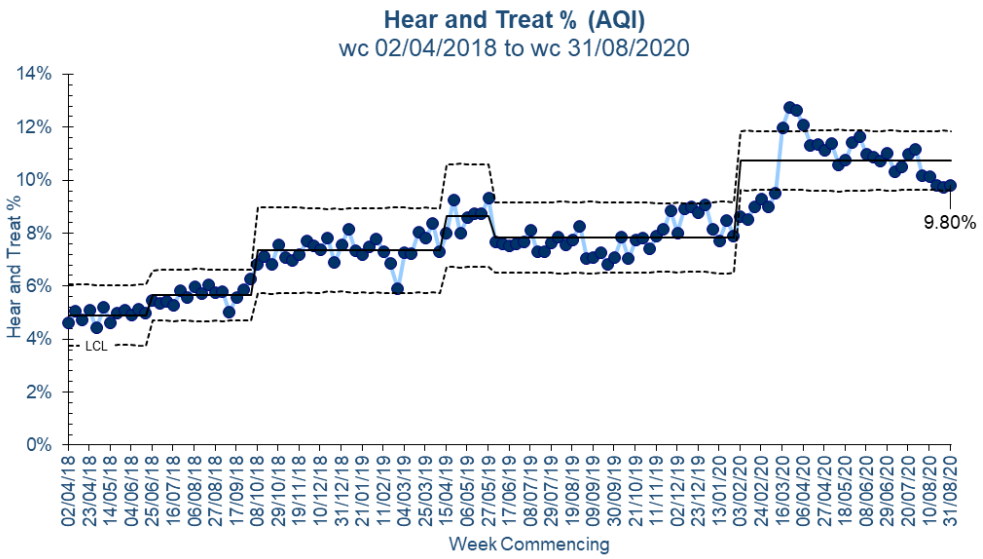


Figure E3.5

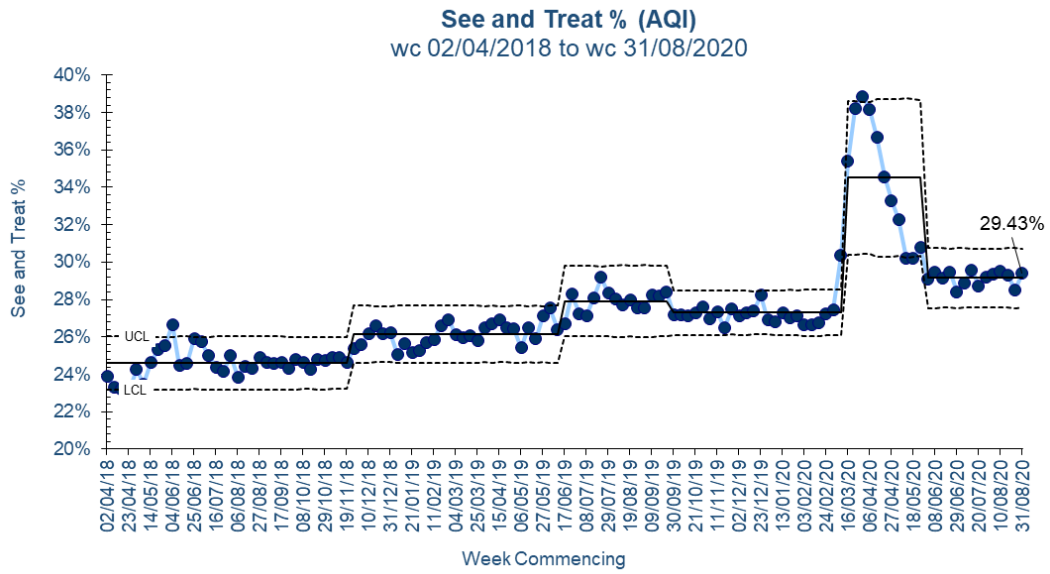
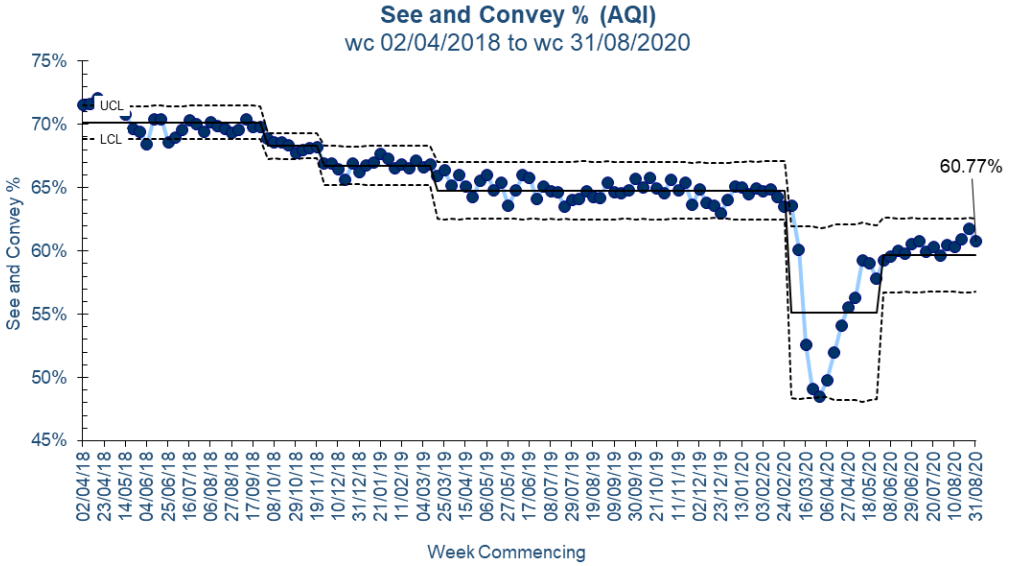


Figure E3.6



F1 FINANCIAL SCORE

Figure F1.1

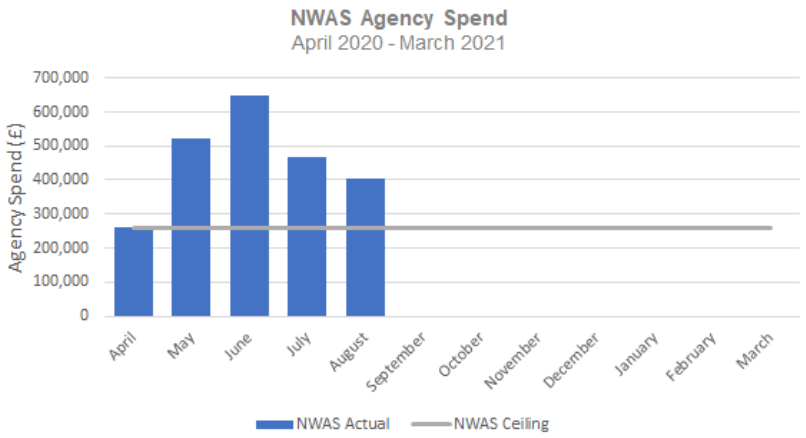


Figure F1.2

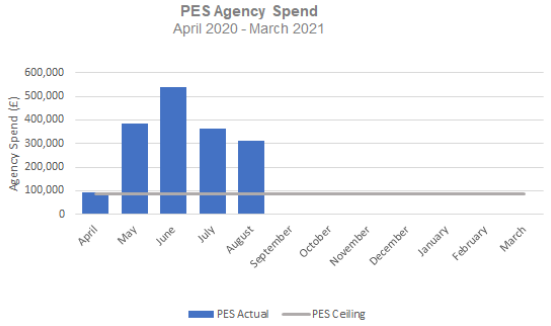


Figure F1.3

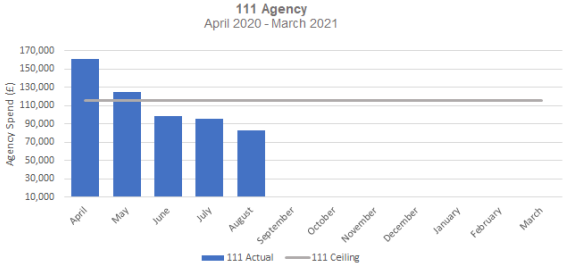


Figure F1.4

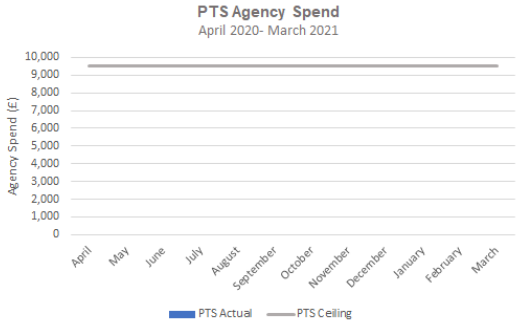
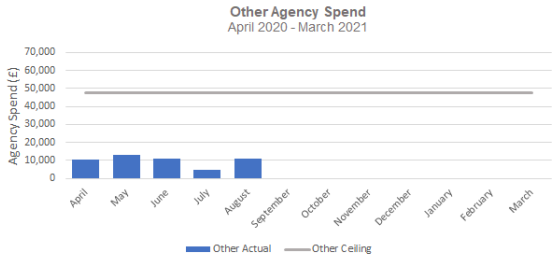


Figure F1.5



Finance Position – June 2019

Month 01 Finance Position:

Agency Expenditure

The year to date expenditure on agency is £2.303m which is £1.008m above the year to date ceiling of £1.296m.

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 five 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 we will add back once the new operating framework is launched after transition from the Covid-19 financial framework.

.

O1 CALL PICK UP

Figure O1.1

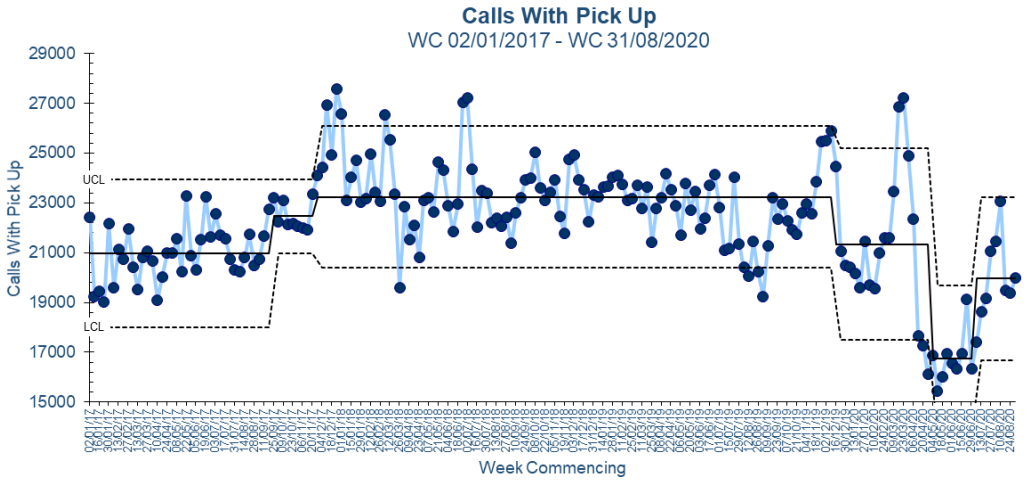
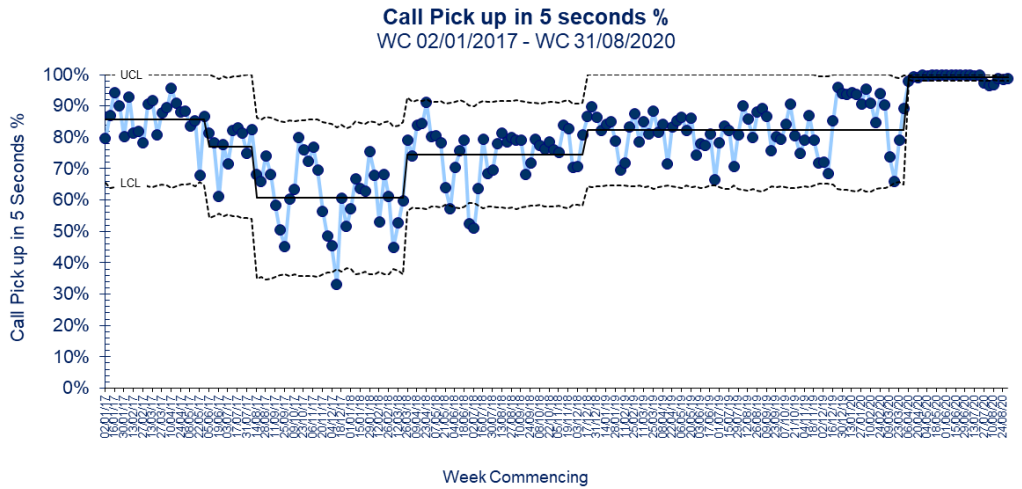


Figure O1.2



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: For August 2020, call pick up in 5 seconds performance was at 97.7%. 2,167 calls took longer than 5 seconds to pick up.

Figure 01.1 Increase in call volume, with activity returning to historic seasonal levels of activity. This can be attributed to an increase in incidents and an increase in secondary calls into the service. It is anticipated call volume will continue to increase as we move towards winter. It should also be noted that activity has the potential to spike upwards as the prevalence of COVID continues to increase across the NWAS footprint.

Figure 01.2 reflects very low levels of variation across the previous four months data points. This can be attributed initially to a reduction in activity and an increase in call handling workforce. As activity continues to rise the EOC has continue to maintain high levels of call handling performance. This evident across all call handling metrics.

Figure O1.3: Source - CAD calls

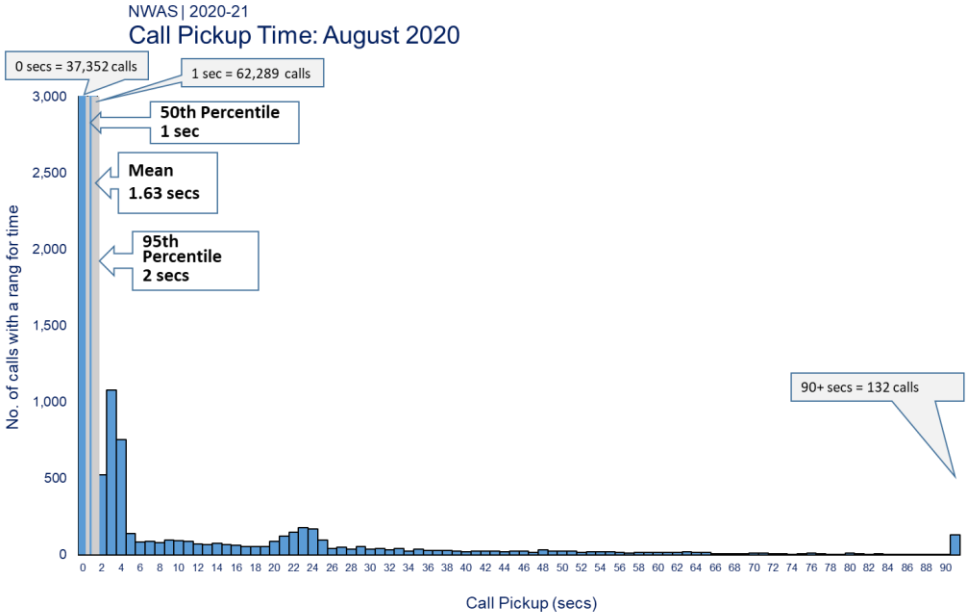


Table O1.1: Calls and Call Answer Times (Source – AQI)

			Call answer times (seconds)				
Month/Yr	Contact Count	Calls answered	Total	Mean (Switch)	Median (50th centile)	95th centile	99th centile
Sep – 19	126,328	104,445	1,153,070	11	1	70	130
Oct - 19	134,676	120,721	1,120,257	9	1	64	120
Nov - 19	140,609	126,698	1,583,850	13	1	78	127
Dec – 19	146,720	130,786	1,548,068	12	1	76	124
Jan - 20	125,079	103,307	471,336	5	1	19	87
Feb - 20	117,409	98,259	531,953	5	1	36	69
Mar - 20	142,039	123,743	1,504,031	12	1	74	133
Apr - 20	116,584	96,542	196,505	2	1	1	52
May- 20	105,814	83,256	53,010	1	1	1	1
Jun - 20	107,860	84,608	52,592	1	1	1	1
Jul - 20	114,801	90,806	73,021	1	1	1	1
Aug - 20	121,982	105,185	143,121	1	1	1	1

O2 A&E TURNAROUND

Figure O2.1

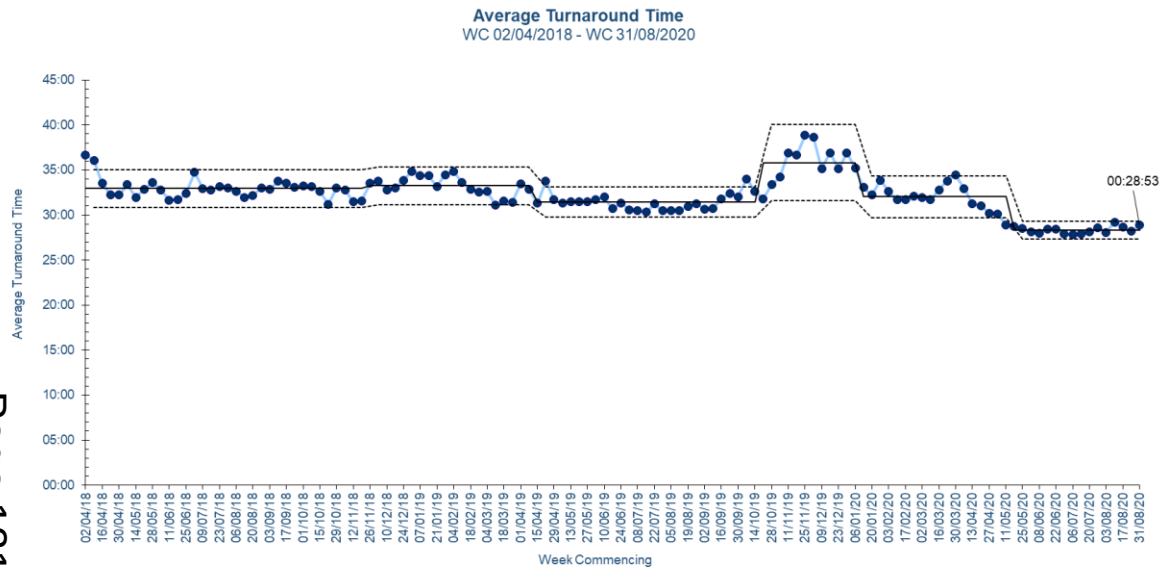


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Sep-19	55,724	31:31	20:13	11:09
Oct-19	58,933	32:34	21:31	11:03
Nov-19	57,735	34:39	23:39	10:48
Dec-19	61,304	37:22	26:42	10:42
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

A&E Turnaround Times

The average turnaround for August 2020 was 28 minutes 33 seconds across the North West.

The 5 hospitals with the longest turnaround times during August 2020 were:

Cumberland Infirmary	36:11
Royal Oldham	32:15
Stepping Hill	31:46
Macclesfield General	31:20
Wythenshawe	30:29

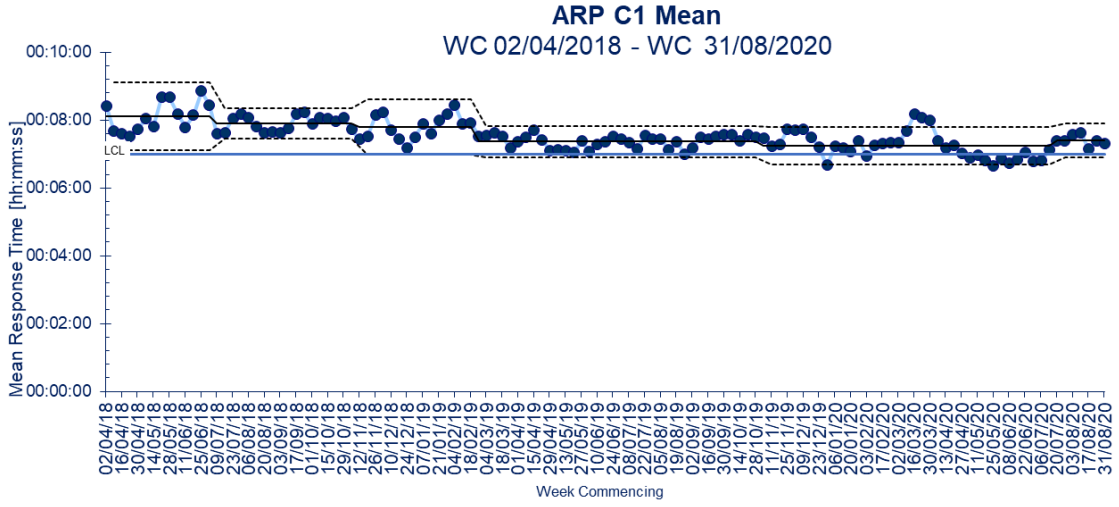
Key to the improvement in turnaround times for the trust is the Every Minute Matters programme. As a trust we have seen the benefit in reduced turnaround times from this programme of work. Currently this is pause due to Covid-19, however the trust is in dialogue with NHSE&I with a view to starting phase three.

O3 ARP RESPONSE TIMES

Table O3.1 - Incidents with a response

Month/Yr	C1	C2	C3	C4
Sep-19	9,870	49,579	20,051	3,870
Oct-19	10,615	52,552	17,951	2,854
Nov-19	10,787	53,795	15,992	3,438
Dec-19	11,276	57,593	14,551	4,738
Jan-20	9,803	52,929	14,070	5,244
Feb-20	8,879	47,867	12,456	4,360
Mar-20	9,855	51,929	13,151	4,095
Apr-20	7,476	42,643	17,779	3,697
May-20	6,423	43,931	17,881	4,790
Jun-20	6,688	45,477	16,507	4,195
Jul-20	7,642	48,575	17,245	3,352
Aug-20	8,528	49,476	16,503	2,990

Figure O3.1



Activity

Activity during August has seen an increase in proportion within Category 1 and Category 2. Along with an increase in demand there has been a change to some codes which has seen them moved from Category 3 to Category 2 and one code from Category 2 to Category 1.

ARP Response Times

Both Mean and 90th Percentile for C2, C3 and 90th percentile only for C4 have had a phase change during the last 20 days. With both metrics showing quicker response times over that period when compared to the time period directly preceding. An increase in operational resource through a reduction in COVID19 abstractions and additional private providers has been key to this improvement.

C1 Performance

C1 Mean
Target: 7 minutes

NWAS
August 2020: 7:27
YTD: 7:10

Figure O3.2

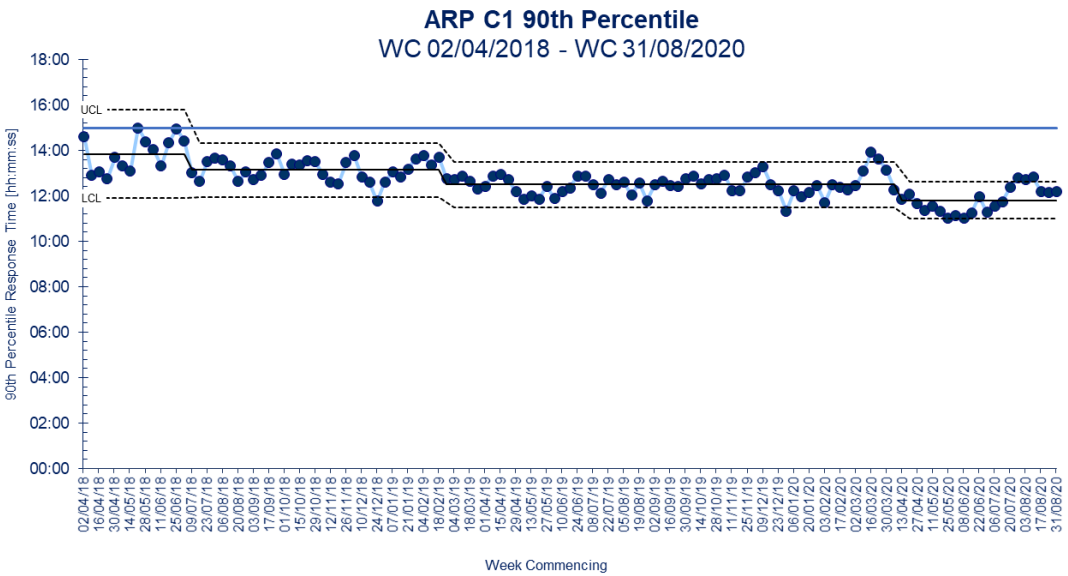
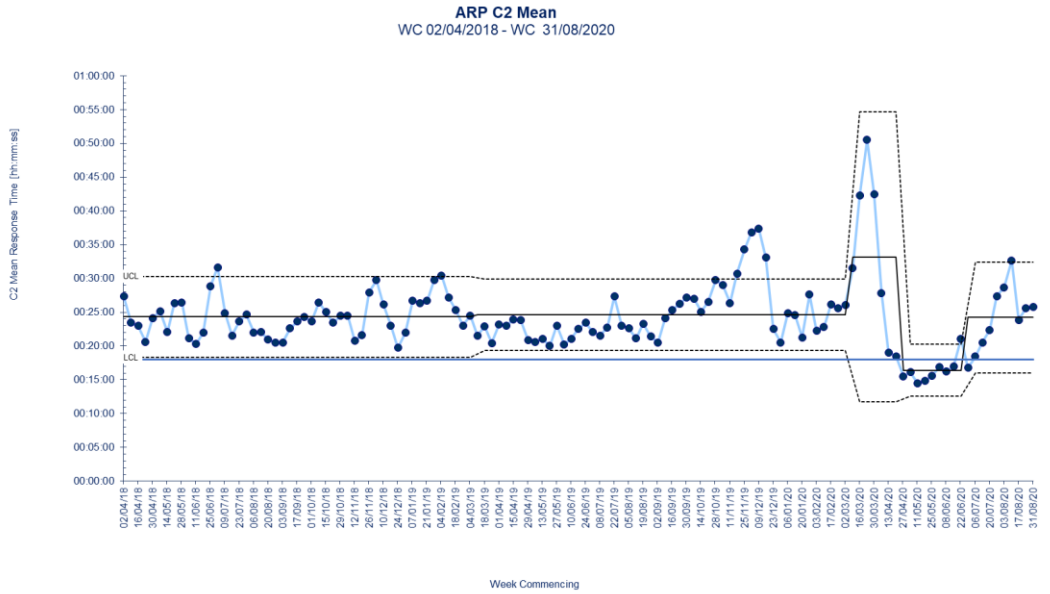


Figure O3.3



C1 90th Percentile

Target: 15 Minutes

NWAS
August 2020: 12:35
YTD: 11:58

C2 Performance

C2 Mean

Target: 18 minutes

NWAS:
August 2020:27:37
YTD: 21:22

Figure O3.4

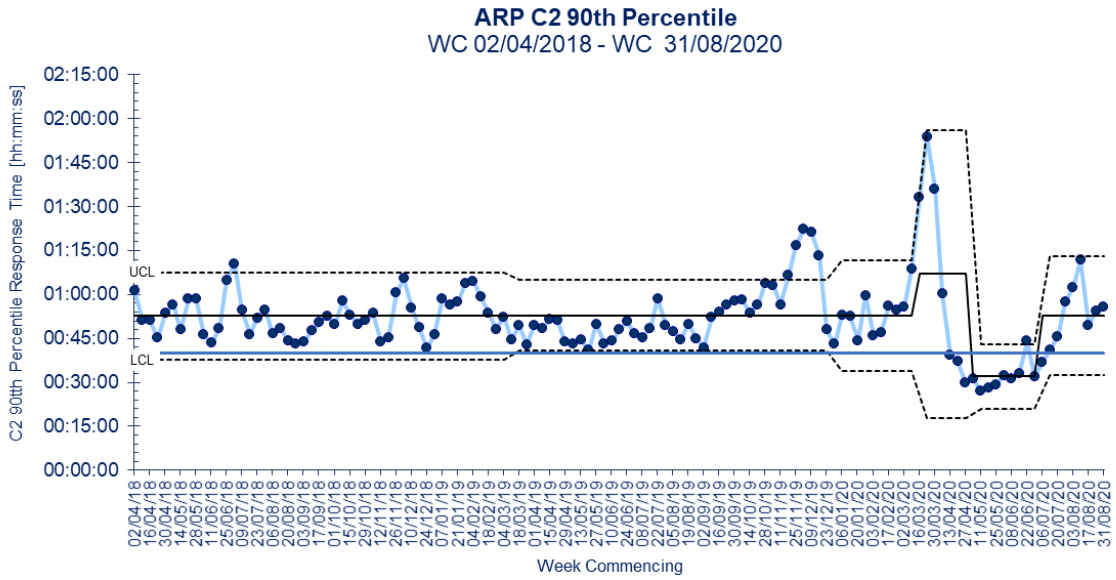
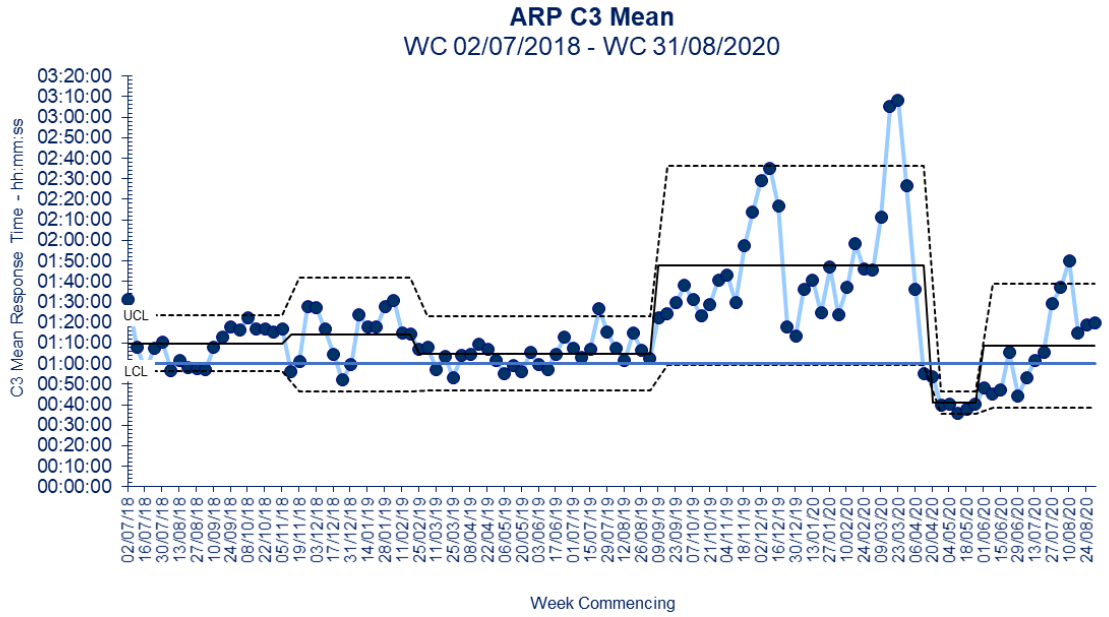


Figure O3.5



C2 90th Percentile

Target: 40 Minutes

NWAS
August 2020: 59:30
YTD: 43:57

C3 Performance

C3 Mean

Target: 1 Hour

NWAS:
August 2020: 1:29:22
YTD: 1:03:05

Figure O3.6

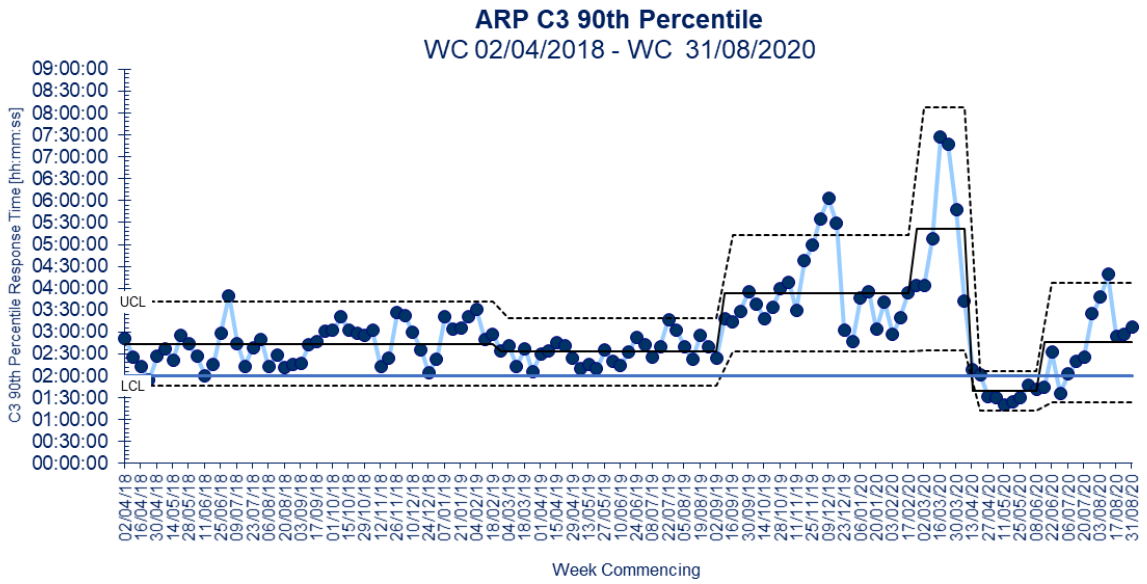
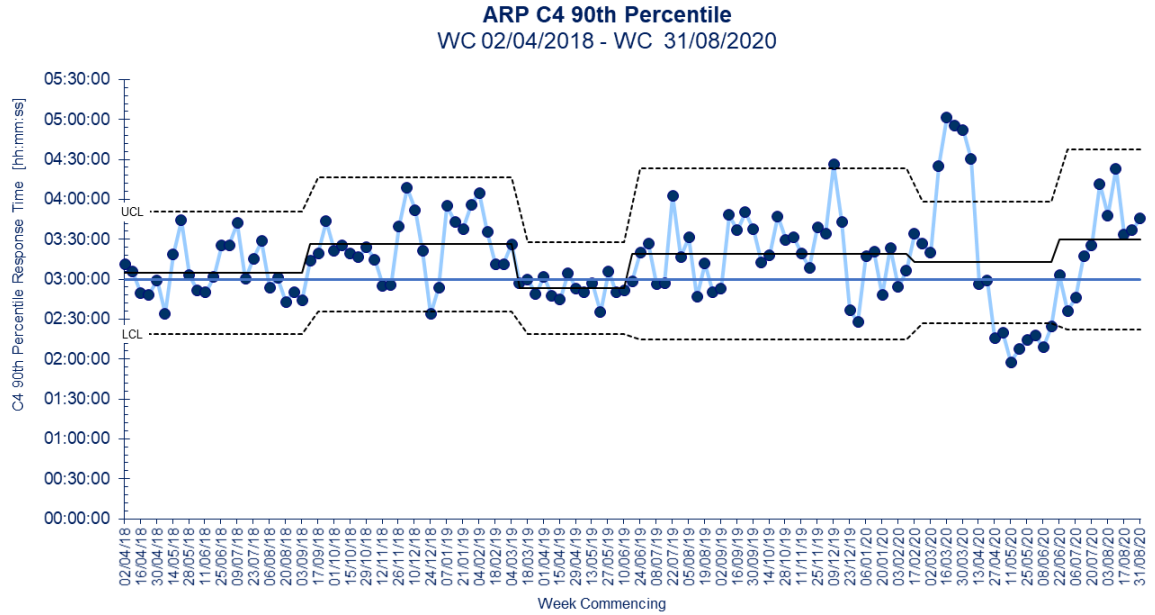


Figure O3.7



C3 90th Percentile
Target: 2 Hours

NWAS
August 2020: 3:27:07
YTD: 2:25:35

C4 Performance

C4 90th Percentile
Target: 3 Hours

NWAS
August 2020: 3:47:57
YTD: 2:57:51

.

ARP Provider Comparison Figures August 2020

Table O3.3 - C1

Provider	C1 Mean	C1 90th
London	6:22	10:49
North East	6:28	11:09
South Central	6:29	12:05
West Midlands	6:56	12:09
East of England	7:08	13:22
East Midlands	7:13	12:56
South Western	7:23	13:58
Yorkshire	7:24	12:44
North West	7:27	12:35
South East Coast	7:53	14:50
Isle of Wight	9:40	19:20

Table O3.4 - C2

Provider	C2 Mean	C2 90th
West Midlands	12:09	22:21
London	14:12	27:00
South Central	17:06	34:08
Yorkshire	18:29	38:00
South East Coast	18:57	34:57
East of England	22:25	46:46
East Midlands	22:39	46:20
North East	23:28	48:04
South Western	24:17	49:33
Isle of Wight	26:25	58:18
North West	27:37	59:30

Table O3.5 - C3

Provider	C3 Mean	C3 90th
West Midlands	0:29:15	1:02:22
London	0:35:58	1:21:15
Yorkshire	0:39:55	1:34:56
South Central	0:54:55	2:08:18
East of England	0:55:39	2:14:03
East Midlands	1:01:54	2:30:09
North East	1:04:39	2:36:02
South Western	1:10:58	2:52:44
Isle of Wight	1:19:45	3:11:03
North West	1:29:22	3:27:07
South East Coast	1:34:11	3:31:37

Table O3.6 - C4

Provider	C4 90th
West Midlands	1:34:53
London	2:25:10
North East	2:29:36
Yorkshire	2:42:23
East of England	2:49:31
East Midlands	3:06:17
South Central	3:07:46
North West	3:47:57
South Western	3:58:17
Isle of Wight	4:22:32
South East Coast	5:01:24

O4 111 PERFORMANCE

Figure O4.1

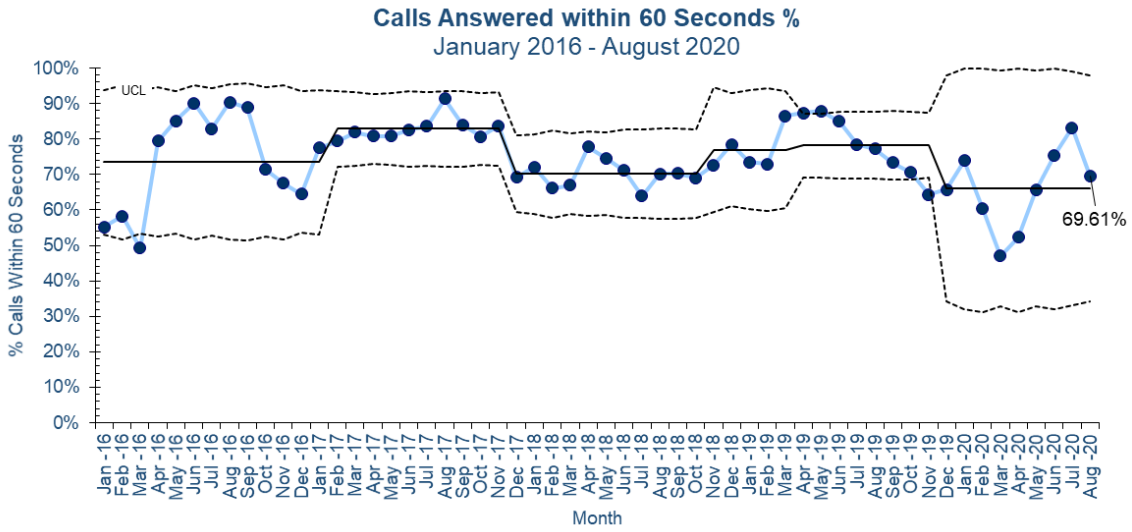
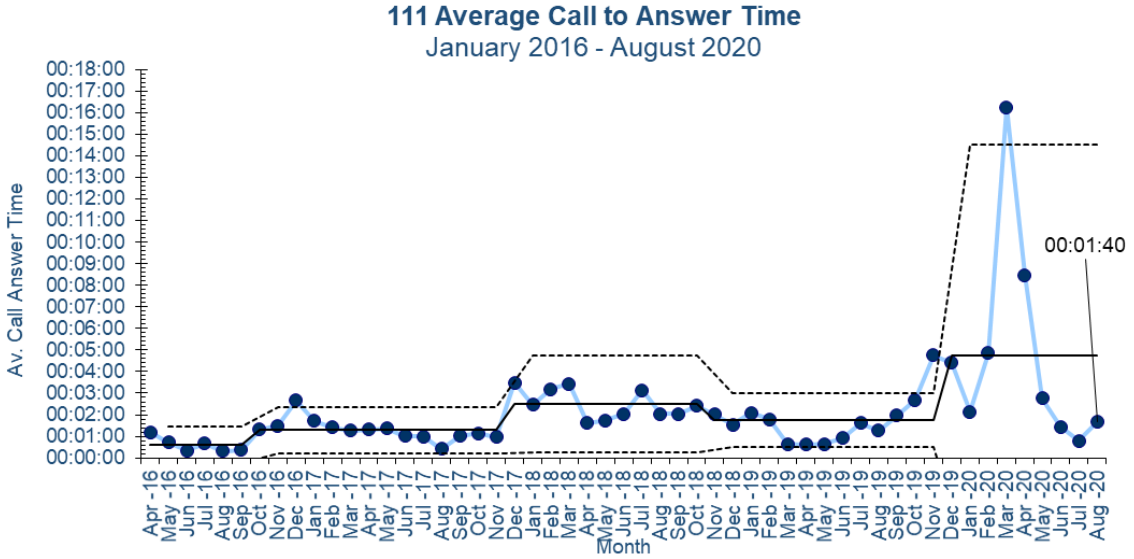


Figure O4.2



111 Performance

Calls Answered within 60 seconds %

Target: 95%

NWAS
August 2020: 69.61%
YTD: 69.52%

National 84.1%

Calls Answered within 60s for the month of August deteriorated from the previous months position. The causes of the decline in performance are multifactorial and described below:

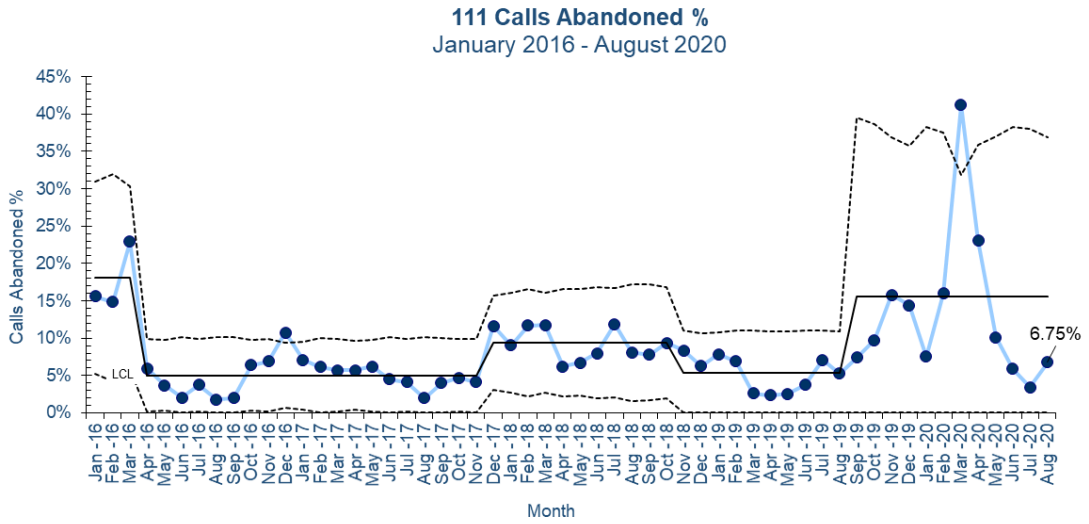
Cleric migration training - In order to achieve the deadlines of Cleric go live this had to be turned around at a pace. Over 600 staff within 111 have now been trained in the new Cleric system in readiness for go live on 16th September. This deployment of training was successfully delivered but did impact performance in 111 as approximately 18 staff per course were scheduled offline at any one time.

111 First recruitment - As required nationally the 111 service is now recruiting sufficient staff to be able to answer the extra demand following the launch of the '111 First' campaign. In order to meet 20% of the unheralded ED attendances recruitment is now planned across the next 4 months, this entails a new training course of staff commencing every 2 weeks between now and December. Resource to support recruitment is taken from front line, using 'super users' to support the delivery of training and the preceptorship of new staff after they have finished training.

Covid demand - Calls into the 111-service relating to Covid have significantly increased, August saw a 12% increase in calls offered compared to previous month, acknowledging the bank holiday in August this is still a significant increase in demand. On review of activity trends it is apparent that activity is particularly volatile at present making forecasting even more of a challenge to plan for.

In addition to front-end demand pressure, staff absence relating to Covid Isolation has also significantly increased, this correlates with the identification of Bolton being a Covid hotspot and the service is seeing increasing numbers of staff absence due to Covid isolation.

Figure O4.3:



Calls Abandoned %

Target: <5%

NWAS

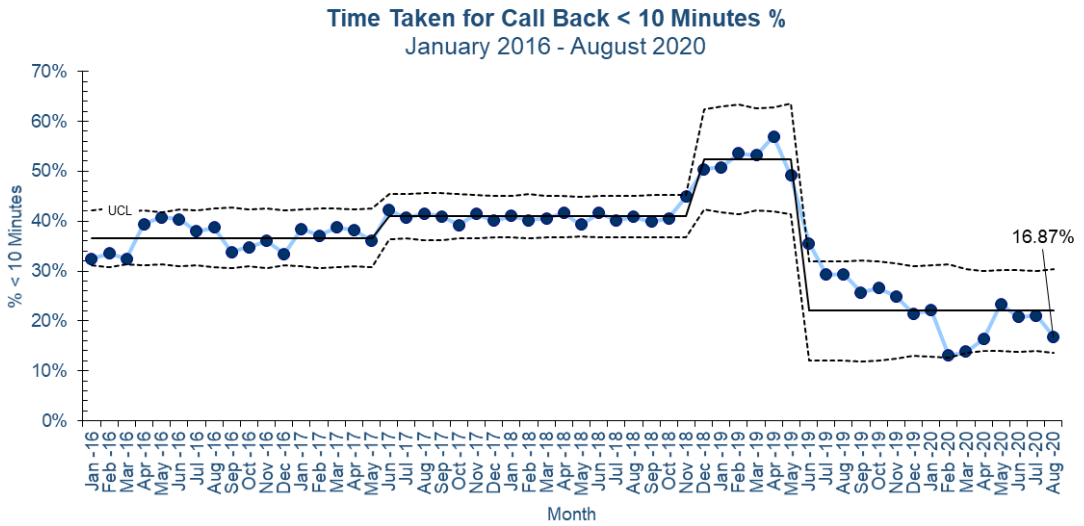
August 20: 6.75%

YTD: 10.35%

National 4.8%

Calls abandoned is a direct correlation to calls answered performance, see previous section for detail.

Figure O4.4



Call Back < 10 Minutes %

Target: 75%

NWAS

August 20: 16.87%

YTD: 19.71%

National 37.3%

As described in previous section demand saw an increase in August which impacted on calls answered in 60, this impact is also seen in the timeliness of calls backs in 10. Work is ongoing at present to identify opportunities to improve this position. Clinical Hub colleagues continue to support where they have available capacity in the form of 'Strategy calls'.

Figure O4.5

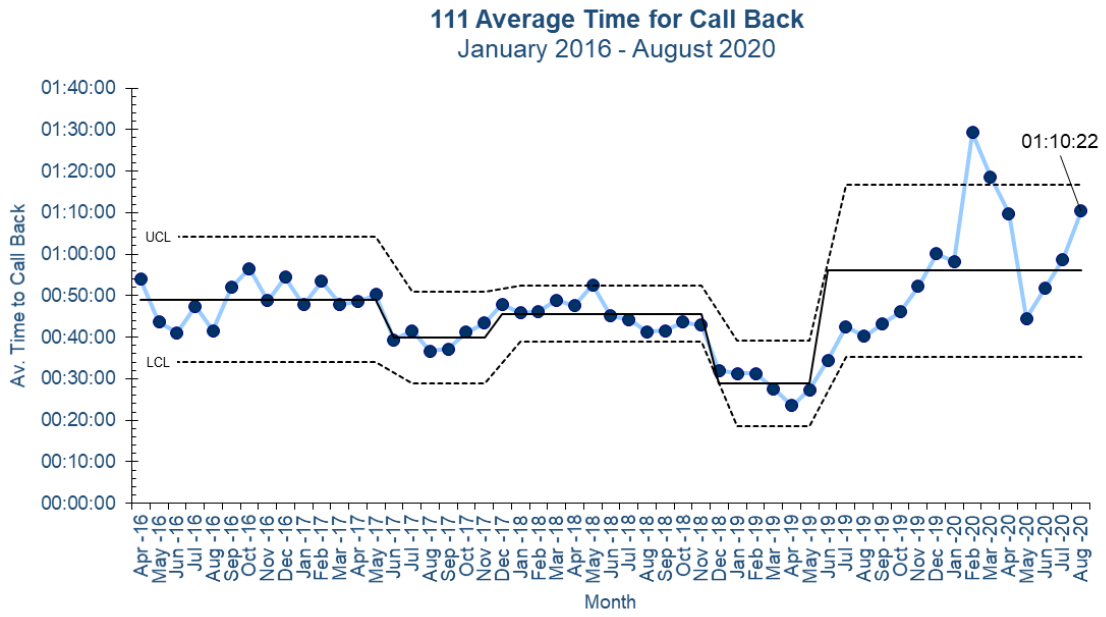
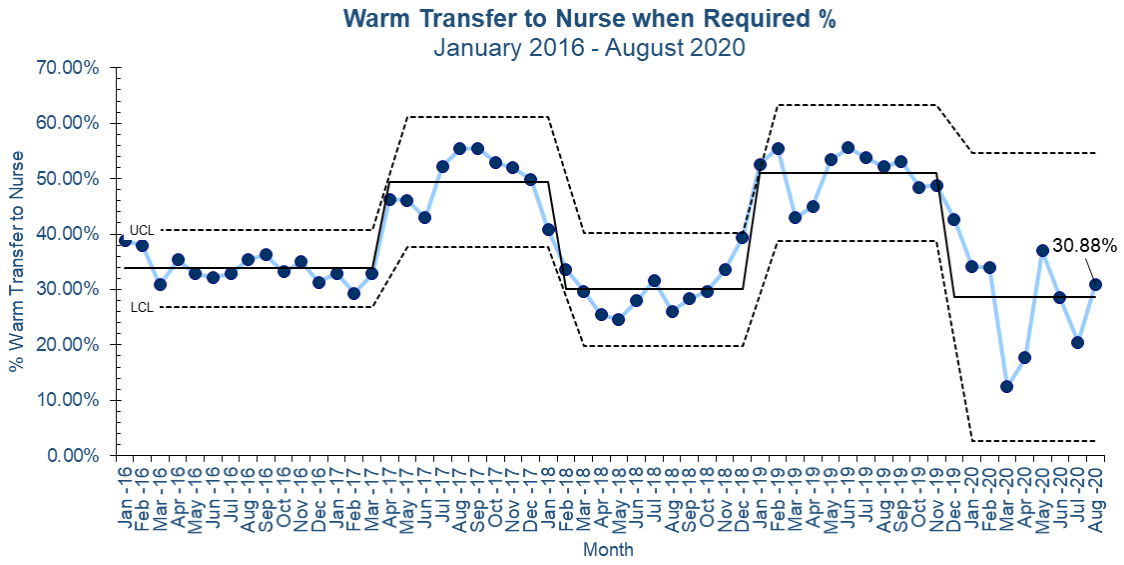


Figure O4.6



Warm Transfer to Nurse when Required%

Target:	75%

NWAS

August 20:	30.88%
YTD:	26.80%

See previous page for detailed explanation around service pressures and performance.

111 Provider Comparison Figures August 2020

Table O4.1

Provider	Of calls offered, abandoned after at least 30 seconds
West Midlands Ambulance Service	0.1%
London Ambulance Service	0.2%
Integrated Care 24	0.2%
London Central & West Unscheduled Care Collaborative	0.3%
Herts Urgent Care	0.6%
Yorkshire Ambulance Service	1.0%
Derbyshire Health United	1.0%
South East Coast Ambulance Service	2.0%
Care UK	2.0%
South Central Ambulance Service	2.9%
Isle of Wight NHS Trust	3.5%
Vocare	3.8%
Medvivo	4.5%
Kernow Health	6.7%
North West Ambulance Service	6.8%
North East Ambulance Service	11.8%
Dorset Healthcare	15.4%
Devon Doctors Ltd.	15.6%

Table O4.2

Provider	Of calls answered, calls answered in 60 seconds
West Midlands Ambulance Service	99.2%
London Ambulance Service	98.3%
London Central & West Unscheduled Care Collaborative	97.8%
Integrated Care 24	96.5%
Herts Urgent Care	93.9%
Derbyshire Health United	92.2%
Isle of Wight NHS Trust	89.3%
Yorkshire Ambulance Service	88.0%
Care UK	85.2%
South East Coast Ambulance Service	83.9%
South Central Ambulance Service	81.7%
Vocare	77.4%
North East Ambulance Service	76.4%
Medvivo	74.1%
Kernow Health	74.1%
North West Ambulance Service	69.6%
Devon Doctors Ltd.	63.3%
Dorset Healthcare	47.8%

Table O4.3

Provider	Of call backs, call backs in 10 minutes	Provider	Of call backs, call backs in 10 minutes
Derbyshire Health United	66.8%	North East Ambulance Service	25.8%
London Central & West Unscheduled Care Collaborative	50.2%	Yorkshire Ambulance Service	21.4%
Isle of Wight NHS Trust	47.4%	Medvivo	20.1%
West Midlands Ambulance Service	40.6%	Devon Doctors Ltd.	18.0%
Herts Urgent Care	38.0%	North West Ambulance Service	17.0%
Care UK	34.4%	South East Coast Ambulance Service	16.3%
Vocare	32.8%	South Central Ambulance Service	15.8%
Integrated Care 24	31.9%	Kernow Health	14.8%
London Ambulance Service	29.3%	Dorset Healthcare	7.3%

O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: August 2020					Year to Date: July 2020 – August 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	6,767	(7,257)	(52%)	14,024	13,423	(601)	(4%)
Greater Manchester	526,588	43,882	26,557	(17,325)	(39%)	43,882	51,801	7,919	18%
Lancashire	589,181	49,098	23,983	(25,115)	(51%)	49,098	47,253	(1,845)	(4%)
Merseyside	300,123	25,010	16,166	(8,844)	(35%)	25,010	32,181	7,171	29%
NWAS	1,584,182	132,015	73,473	(58,542)	(44%)	132,015	144,658	12,643	10%

UNPLANNED ACTIVITY									
	Current Month: August 2020					Year to Date: July 2020 – August 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	718	(529)	(42%)	1,247	1,478	231	18%
Greater Manchester	39,178	3,265	4,356	1,091	33%	3,265	9,165	5,900	181%
Lancashire	56,132	4,678	3,545	(1,133)	(24%)	4,678	7,321	2,643	57%
Merseyside	22,351	1,863	1,545	(318)	(17%)	1,863	3,250	1,387	74%
NWAS	132,630	11,053	10,164	(889)	(8%)	11,053	21,214	10,162	92%

ABORTED ACTIVITY									
	August 2020								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	112	3,312	3%	59	701	8%	34	2,731	1%
Greater Manchester	661	9,034	7%	760	4,209	18%	706	12,948	5%
Lancashire	471	9,969	5%	387	3,485	11%	258	10,352	2%
Merseyside	324	5,695	6%	180	1,518	12%	314	8,854	4%
NWAS	1,568	28,010	6%	1,386	9,913	14%	1,312	34,885	4%

PTS Performance

Overall activity during August 2020 was 44% below contract baselines with Lancashire 51% below contract baselines whilst Merseyside is operating at -35% (-8844) Journeys below baseline. For the year to date position (July 2020 - August 2020) PTS is performing at 10% (12643 journeys) above baseline. Within these overall figures, Cumbria and Lancashire are operating at 4% and 4% below baseline whilst Greater Manchester and Merseyside are operating at 18% and 29% above baseline respectively.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 181% (5900 journeys above baseline) and 74% (1387 journeys) below 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 18% (231 journeys) and 57% (2643 journeys) below baseline.

During this reporting period the NHS has been responding to the level 4 COVID-19 emergency. Restricted hospital arrangements to ensure social distancing for all planned appointments continue to impact on activity levels.

Aborted activity for planned patients averaged 6% during August 2020 however Cumbria experiences 3%, Greater Manchester operates with 7% whilst Lancashire and Merseyside both experience 5% & 6% aborts respectively. There is a similar trend within EPS (renal and oncology) patients with an Trust average of 4% aborts whereas Cumbria has 1% and Greater Manchester 5% Lancashire and Merseyside operate with 2% and 4% respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average 14% (1 in 6 patients) with variances of 8% in Cumbria, 18% in Greater Manchester, 11% in Lancashire and 12% Merseyside.

OH1 STAFF SICKNESS

Figure OH1.1

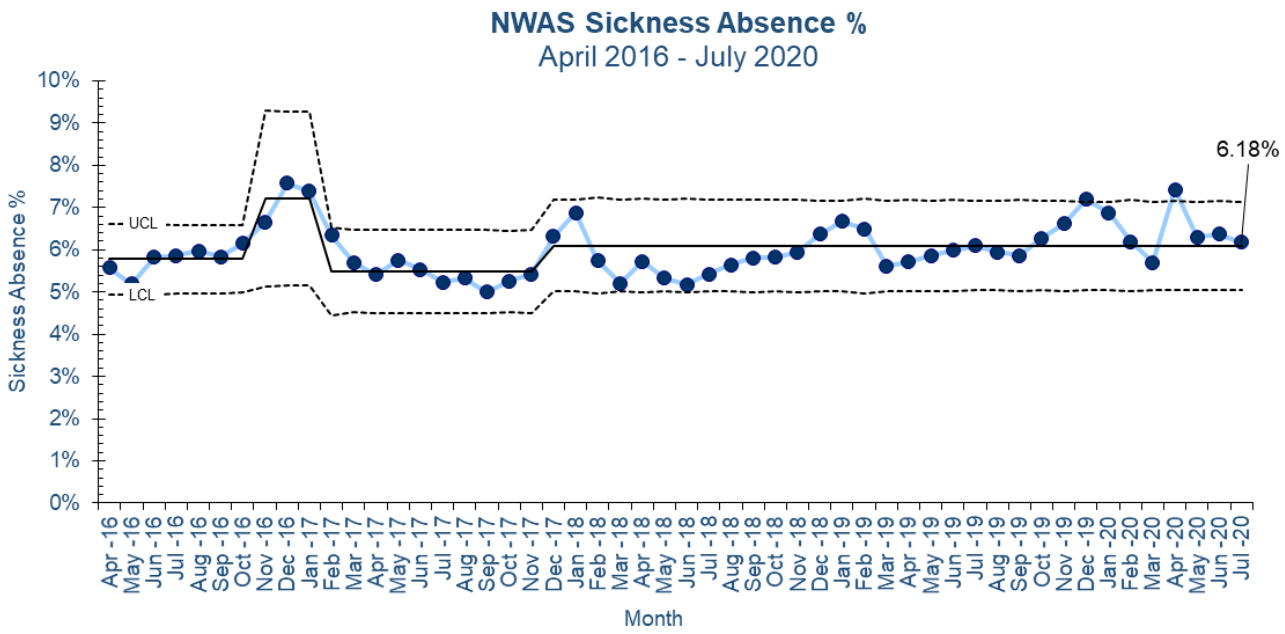


Table OH1.1

Sickness Absence	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
NWAS	5.94%	5.86%	6.27%	6.61%	7.19%	6.88%	6.20%	5.70%	7.42%	6.30%	6.38%	6.18%
Amb. National Average	5.78%	5.65%	5.85%	6.01%	6.60%	6.38%	5.93%	6.75%	7.40%			

Staff Sickness

The overall sickness absence rates for July 20 were 6.18%. This includes COVID-19 related sickness of 0.67%. Figure OH1.1 shows sickness within control limits with underlying non-COVID sickness lower than the same time last year which was 6.10%.

0H1.5 highlights a special cause variation with the last data point being on the lower control limit. This is a positive indicator as it reflects a reduction in sickness absence greater than projected thereby increasing capacity in 111. Sickness absence in 111 in July was 7.16% (including COVID related sickness of 0.6%) which represents a significant reduction from the same time as last year which was 13.71%. This improvement in underlying sickness can be seen in OH1.10.

PES sickness is at 6.24%, of which 5.54% is non COVID-19. This demonstrates a downward trend.

PTS sickness was 7.36% in July 20 and is a stable position overall.

It should be noted that these figures relate to sickness recorded via ESR. COVID-19 self-isolating absences have been captured GRS.

BAF Risk: SR04.

Figure OH1.2:

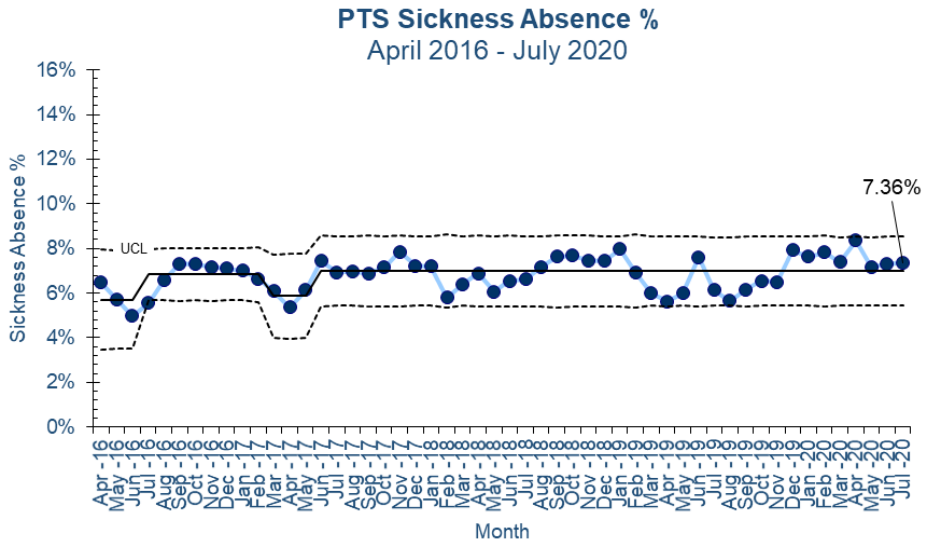


Figure OH1.3:

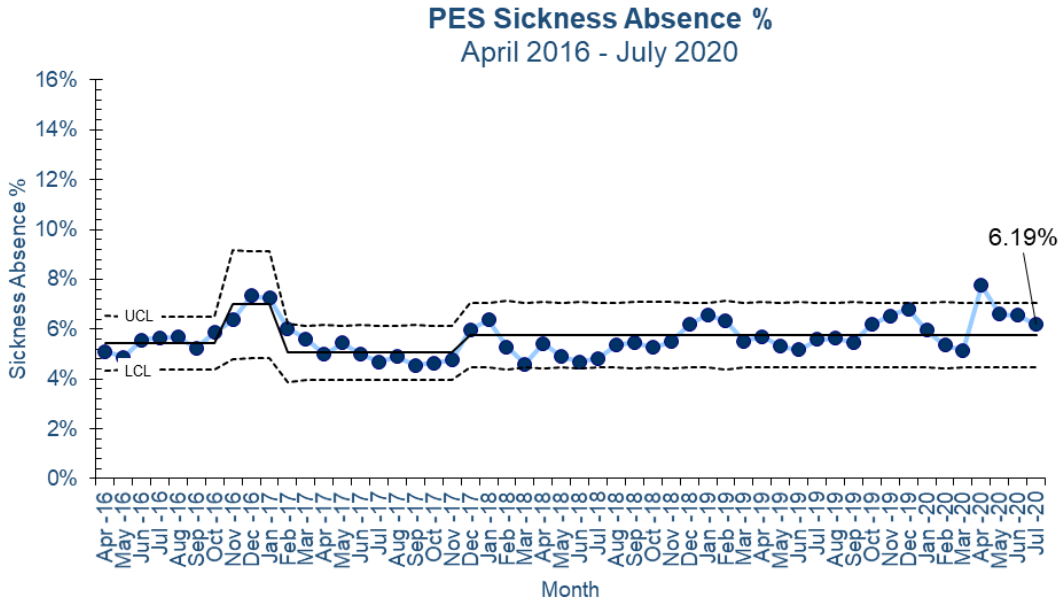


Figure OH1.4:

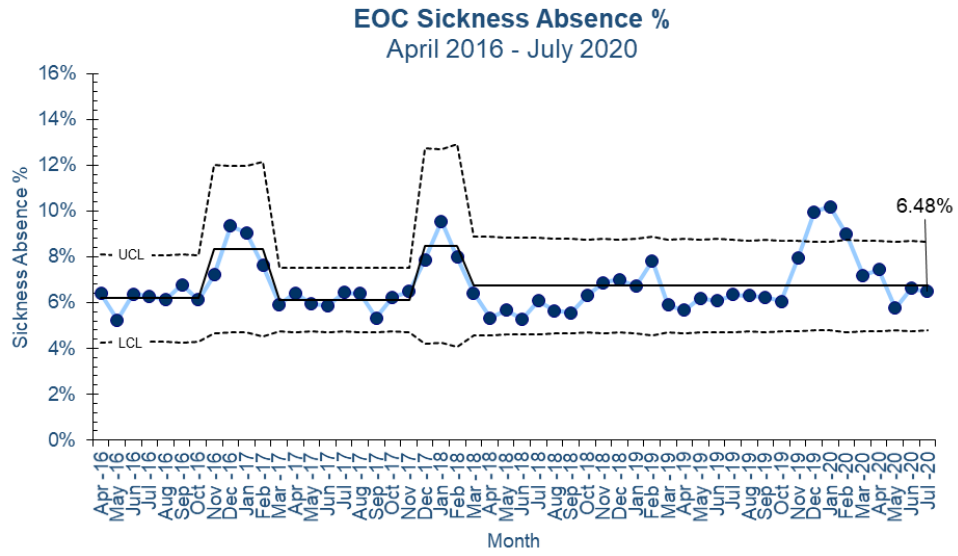


Figure OH1.5:

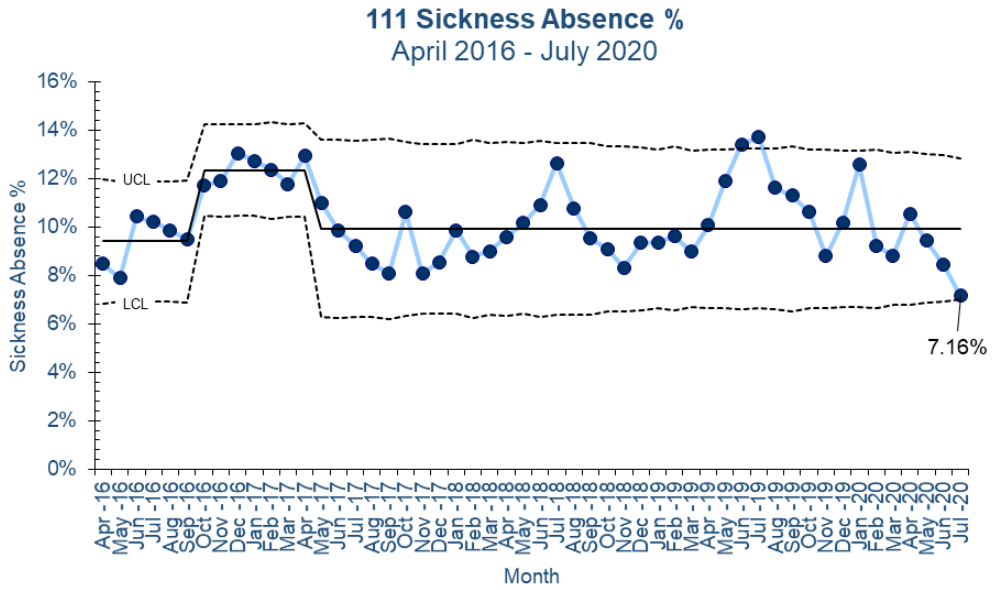


Figure OH1.6:

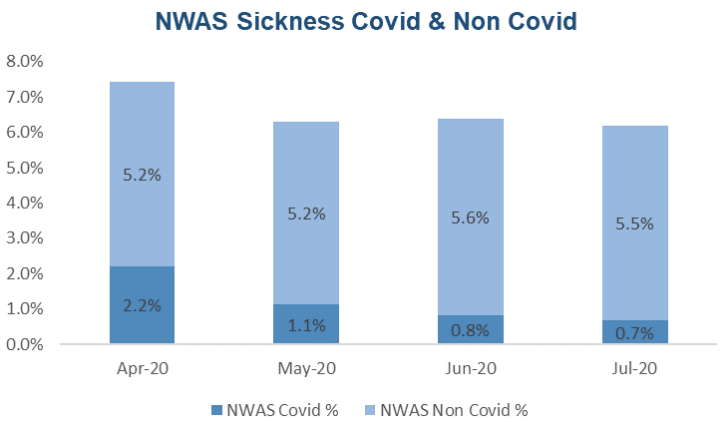


Figure OH1.7:

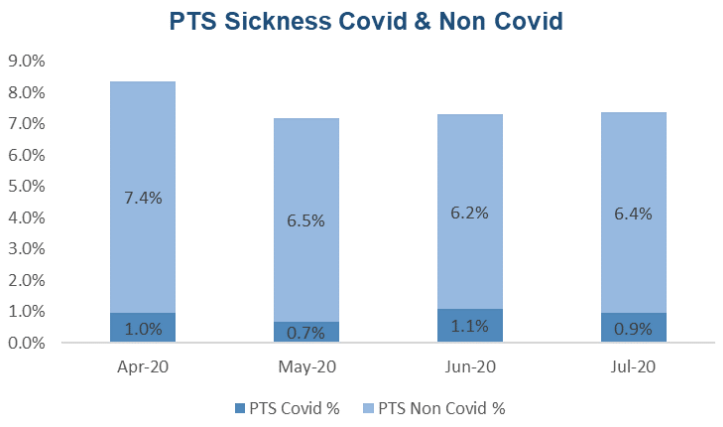


Figure OH1.8:

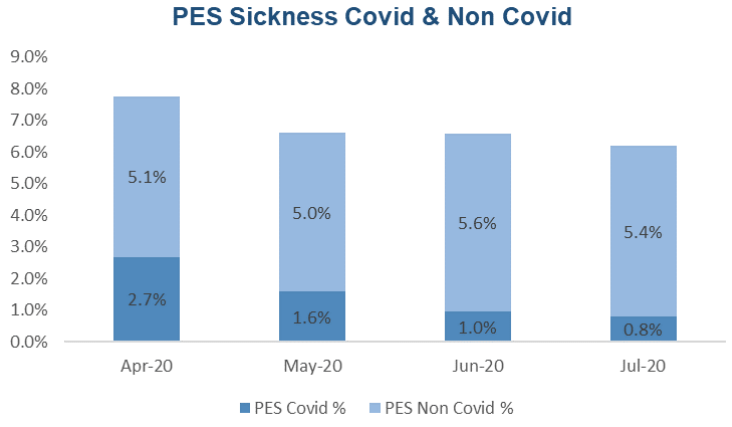


Figure OH1.9:

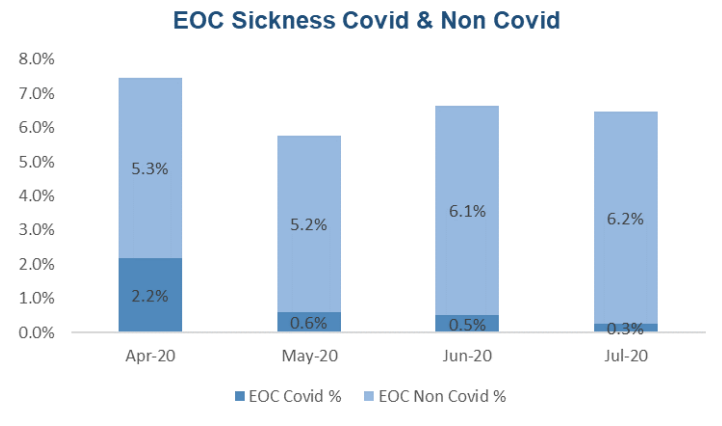


Figure OH1.10:

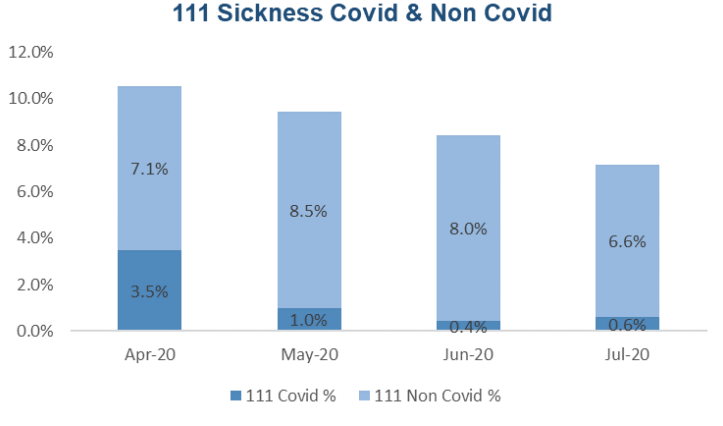
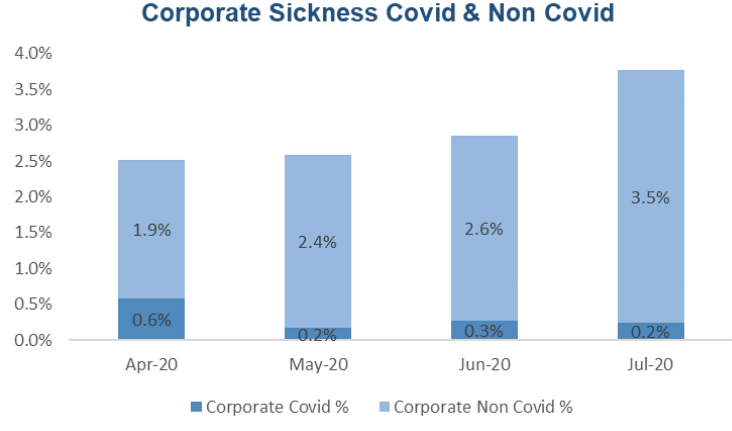


Figure OH1.11:



OH2 STAFF TURNOVER

Figure OH2.1

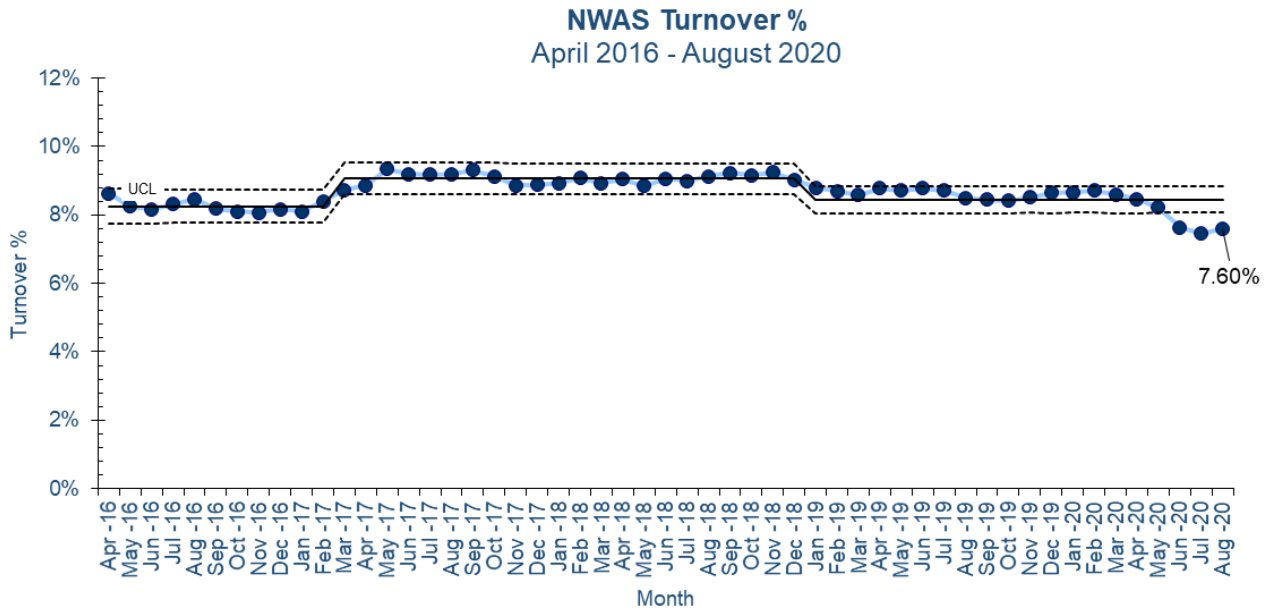


Table OH2.1

Turnover	Sep - 19	Oct - 19	Nov – 19	Dec - 19	Jan – 20	Feb - 20	Mar - 20	Apr - 20	May - 20	Jun - 20	July-20	Aug-20
NWAS	8.45%	8.41%	8.51%	8.65%	8.66%	8.72%	8.60%	8.46%	8.22%	7.63%	7.46%	7.60%
Amb. National Average	9.14%	9.21%	9.20%	8.92%	9.08%	9.12%	9.12%	8.94%	8.98%			

Staff Turnover

Turnover is calculated on a rolling year average and does lend to some small variations between months with August 20 turnover being 7.60%. Overall the trend remain stable.

Whilst figure 0H2.1 identifies that there is a special cause with the last three data points being below the lower control limit, this is unsurprising given the impact of COVID-19 and the impact this has had on the jobs market.

Figure 0H2.2 also highlights that there is special cause with the last two data points being below the lower control limit. As stated above, the likely explanation is the lack of job opportunities and reduction in movement overall.

In Figure 0H2.5 the downward trend in turnover pre-dates COVID resulting in a change to the control limits. Although the last few months will have been affected by the prevailing job market, the overall improvements are reflective of the significant work in 111 to reduce turnover over the last 12 months.

BAF Risk: SR04.

Figure OH2.2

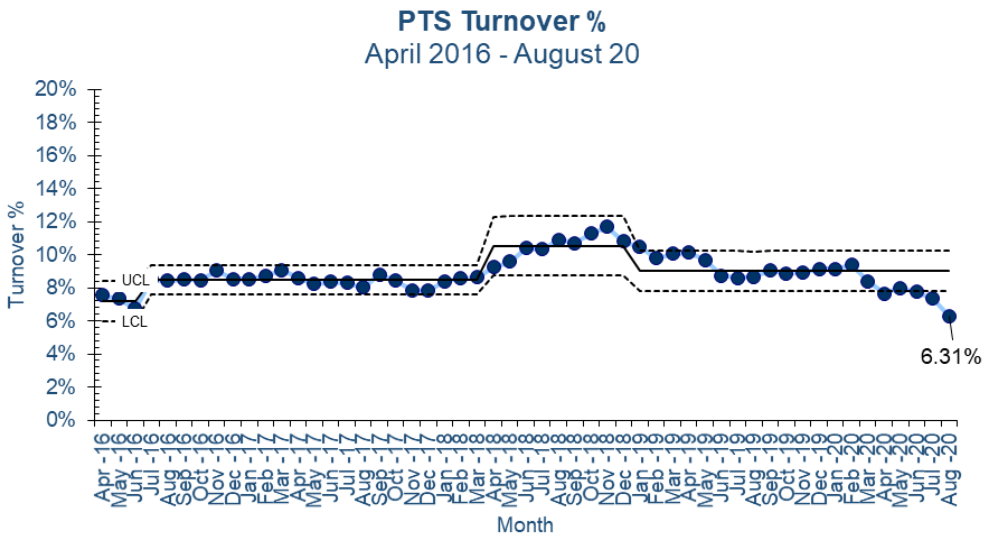


Figure OH2.3

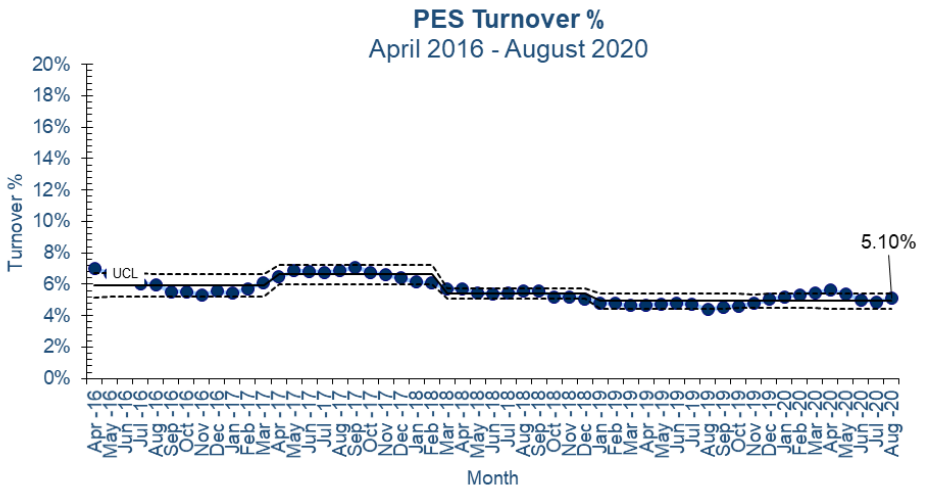


Figure OH2.4

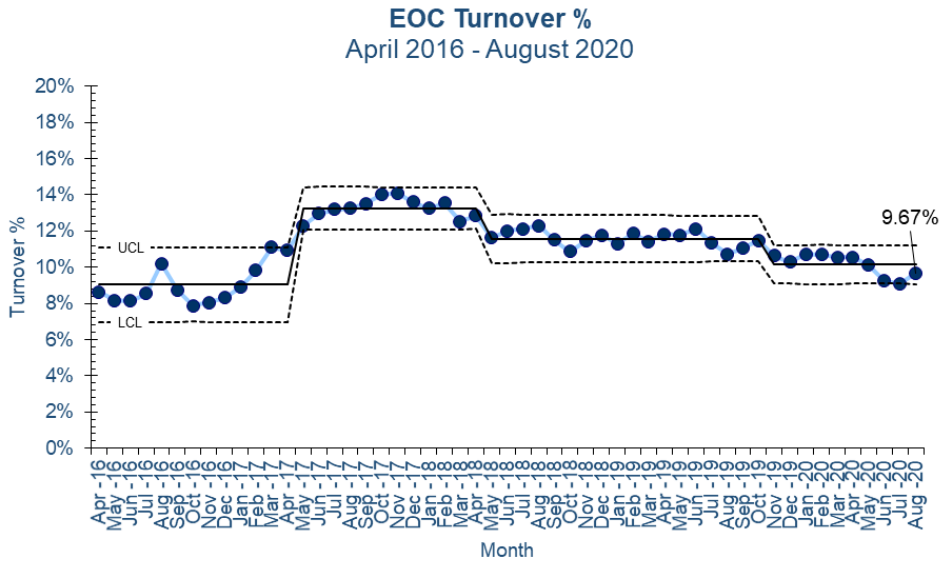
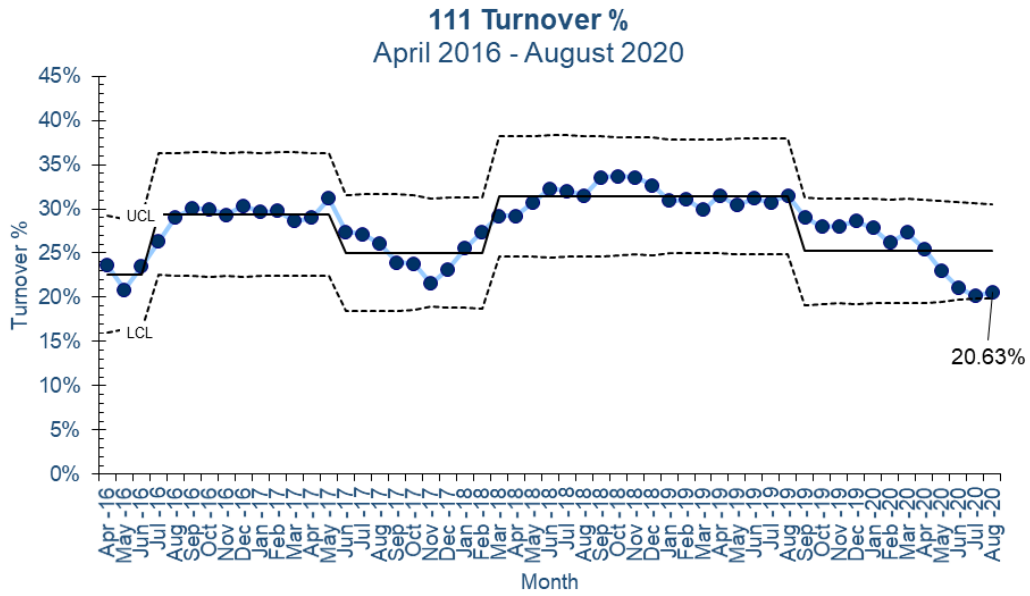
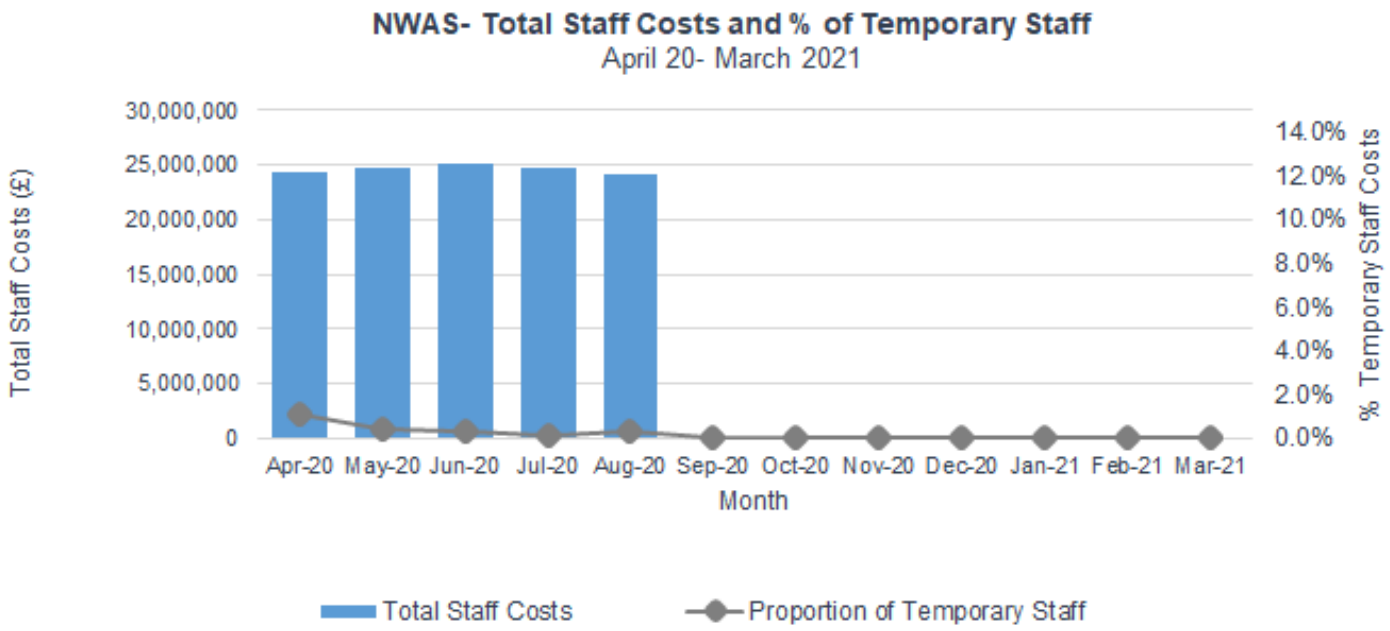


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

The current agency staffing position reflects the increased use of agency workers during the height of the pandemic in order to deploy additional resources. This was particularly the case in EOC, the Clinical Hub and 111. This is reflected in graphs OH4.2 and OH 4.3 which show a reducing trend overall.

As a result of COVID-19 pandemic, both Bank and Agency costs increased between the period April - August 20. Under the current emergency budget arrangements the agency ceiling measure is currently paused.

The Trust will be looking where possible, to reduce Agency usage within 111 and EOC with the potential to move some staff on to fixed term contracts.

BAF Risk: SR04; SR11

Table OH4.1

NWAS	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan -20	Feb-20	Mar-20	Apr-20	May-20	June-20	Jul-20	Aug-20
Agency Staff Costs (£)	102,471	83,441	82,553	79,503	57,922	80,913	153,153	261,425	523,449	647,832	465,485	405,091
Total Staff Costs (£)	21,460,515	21,982,878	21,758,192	21,083,687	21,613,064	22,646,658	21,904,103	24,361,995	24,812,375	25,181,809	24,737,935	24,176,859
Proportion of Temporary Staff %	0.5%	0.3%	0.1%	0.2%	0.6%	0.2%	0.4%	1.1%	0.4%	0.4%	0.2%	0.4%

Figure OH4.2:

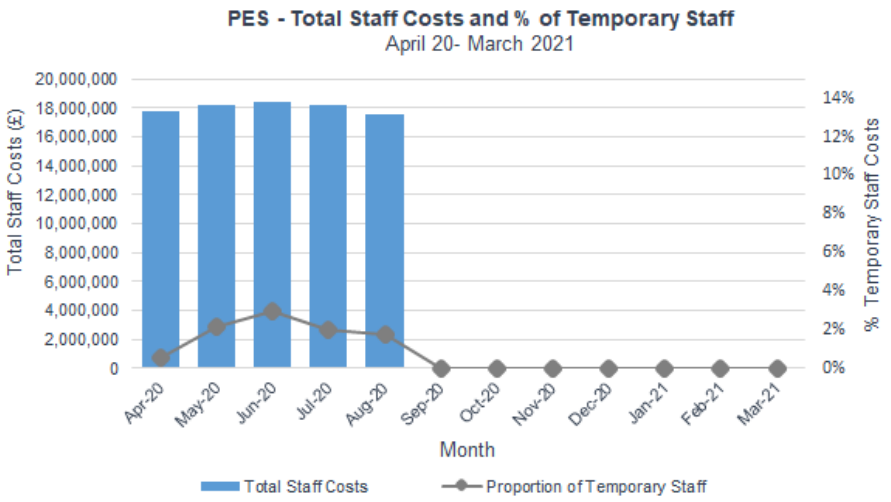


Figure OH4.3:

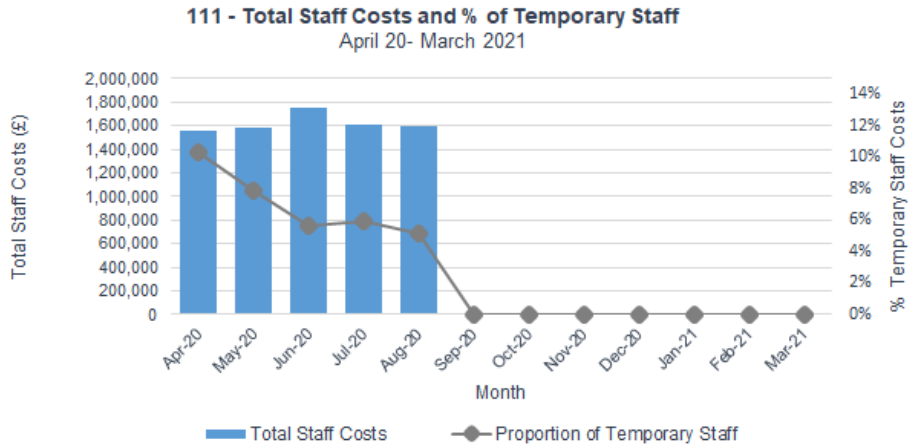


Figure OH4.4:

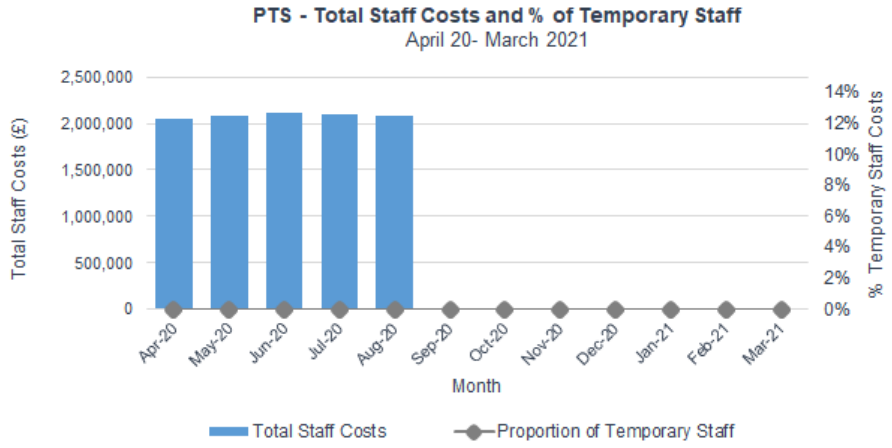
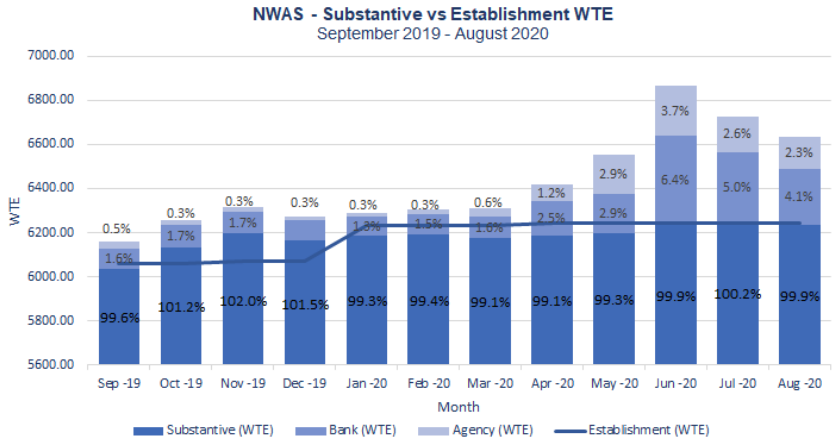


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

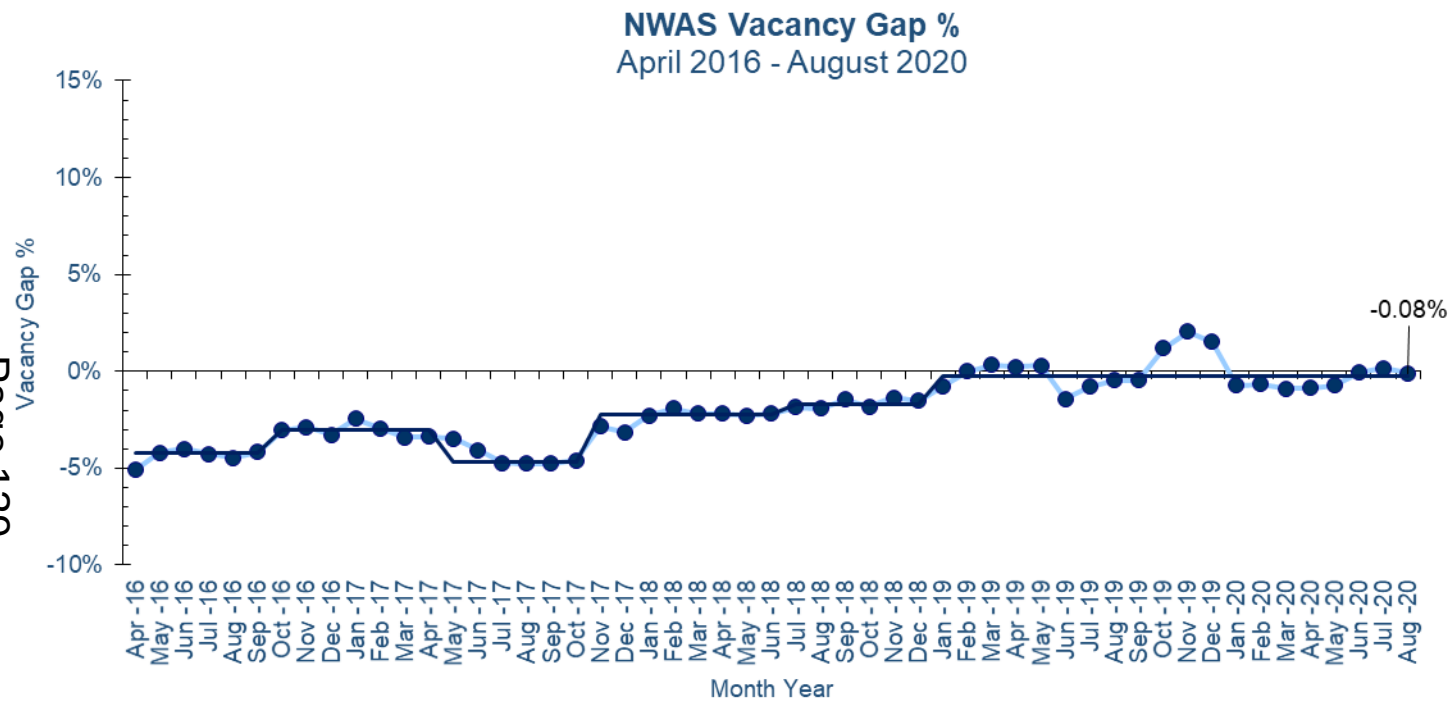


Table OH5.1

Vacancy Gap	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	July-20	Aug-20
NWAS	-0.45%	1.20%	2.05%	1.51%	-0.72%	-0.64%	-0.90%	-0.86%	-0.72%	-0.07%	0.17%	-0.08%

Vacancy Gap

The vacancy position continues to remain positive. The baseline establishment includes all funded growth from 2019/20.

This shows an over establishment in EOC of 4.55% in preparation for winter and 111 over established by 26.06%. The over establishment in 111 relates to the mobilisation of Think 111 First and the revised contract settlement which will be shown in establishment from October 1st..

Frontline PES vacancy position in August 20 is a good position at –0.80% in preparation for winter, although Paramedic graduates will only become available in Q4 this year.

PTS have been impacted by the transfer of staff to support PES and bank recruitment is ongoing to support PTS delivery for the remainder of the year.

ORH modelling outcomes may result in further establishment changes.

BAF Risk; SR04; SR11

Figure OH5.2

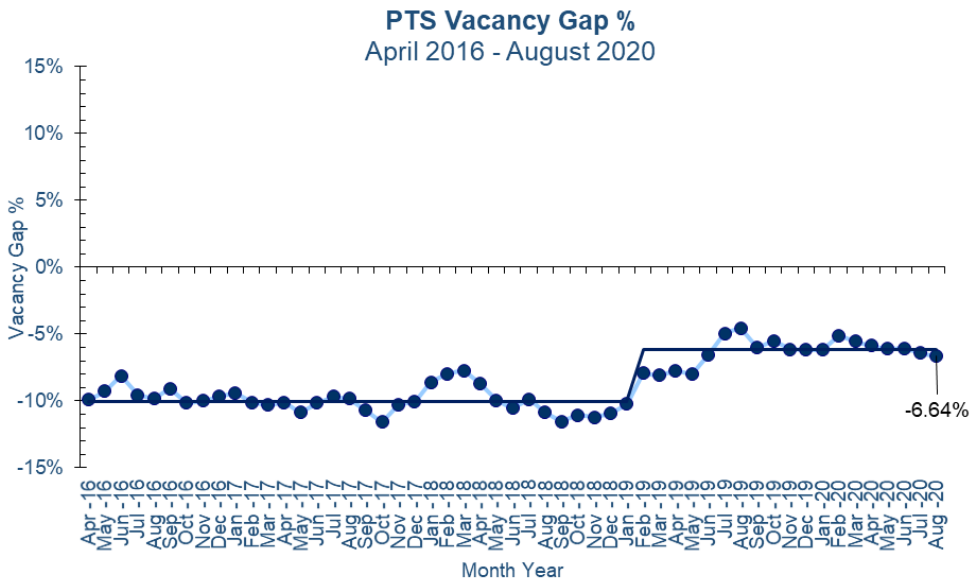


Figure OH5.3

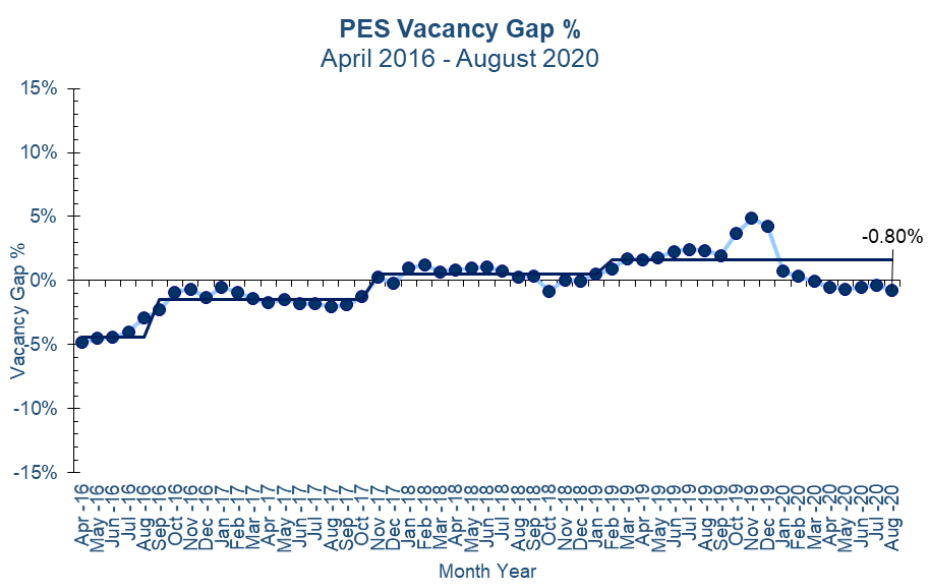


Figure OH5.4

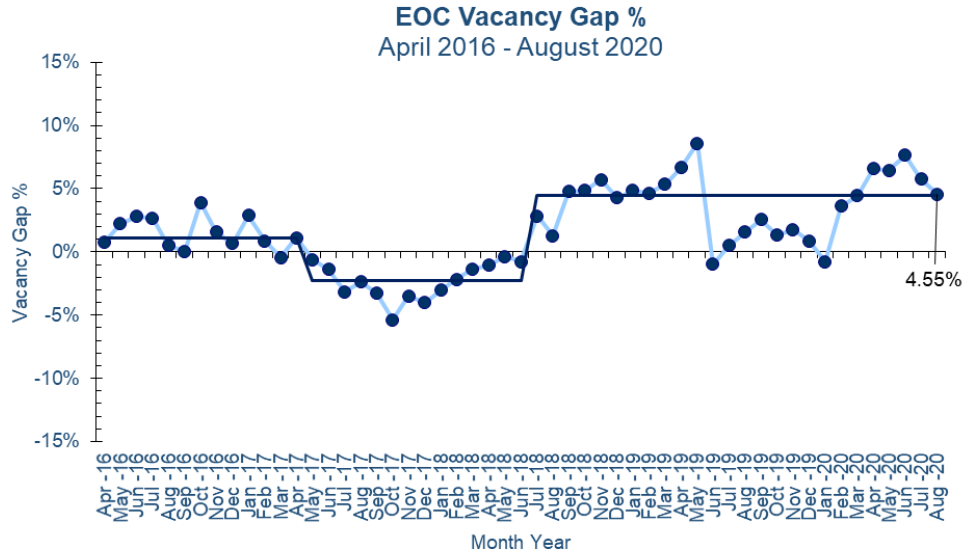
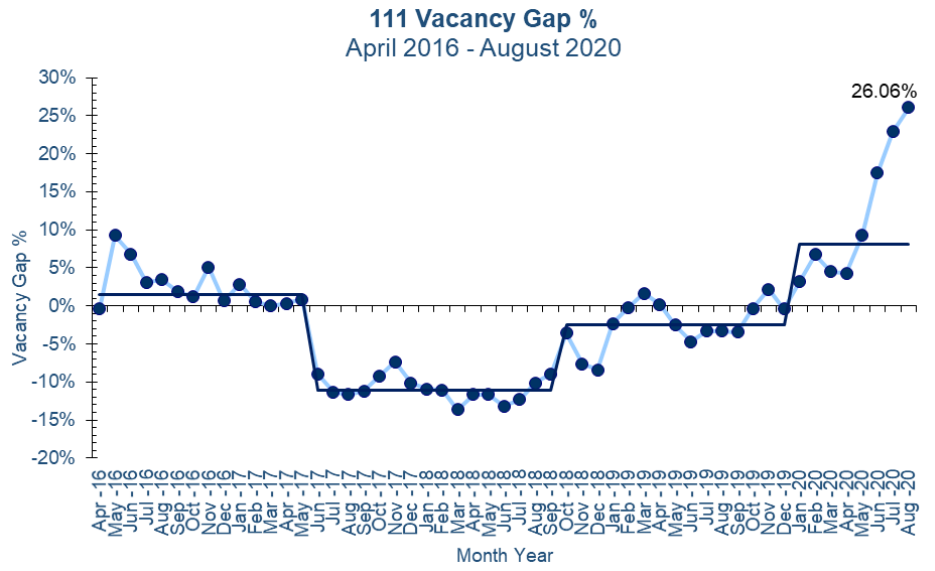


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

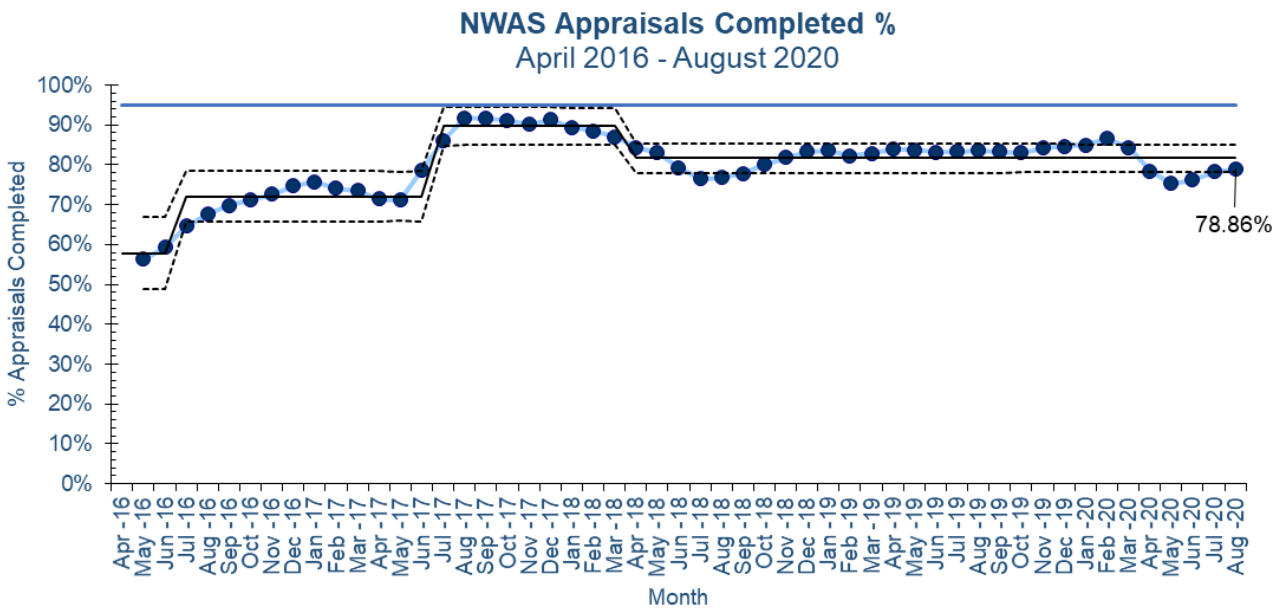


Table OH6.1

Appraisals	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb -20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
NWAS	83%	83%	84%	85%	85%	87%	84%	78%	75%	76%	78%	79%

Appraisals

Figures 0H6.1,2,4,5 all show special cause variation with the recent data points being around or below the lower control limit. The reason for the special cause is as a result of the impact of COVID-19.

Appraisals were paused in March 2020 in line with national guidance and as a result completion rates are currently 79% overall, which is an improved position from the previous 2 months.

PES rates are at 81% and PTS at 77%.

111 compliance rates are currently low at 51%. This is impacted by recent high levels of recruitment and demand pressures. Work is ongoing to support 111 improvement.

Following resumption in June 2020, a revised target as part of recovery planning is 85% for March 2021.

Revised streamlined appraisal documentation approved by ELC in June should support completion.

BAF Risk: SR04; SR11

Figure OH6.2

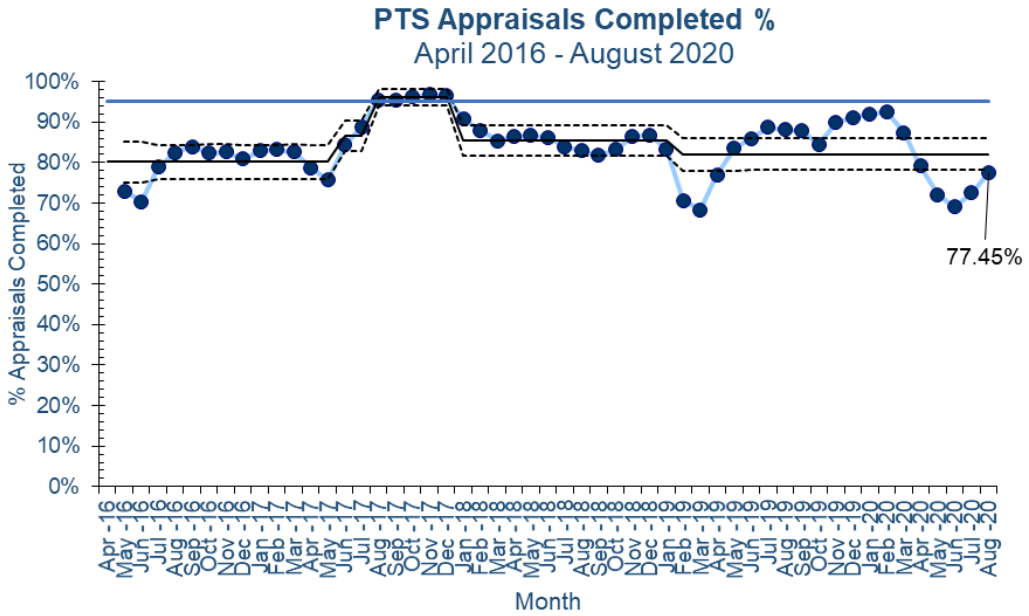


Figure OH6.3

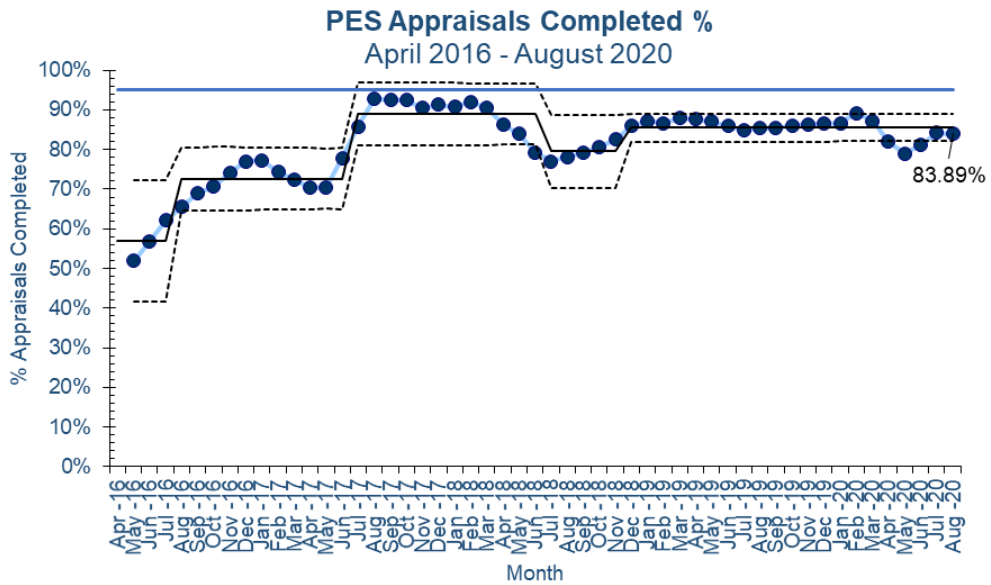


Figure OH6.4

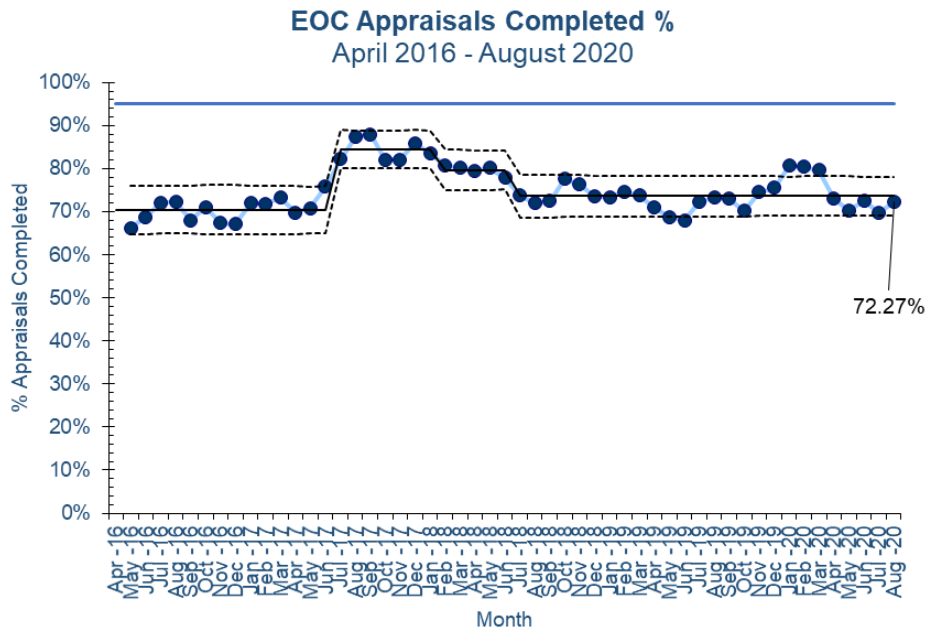
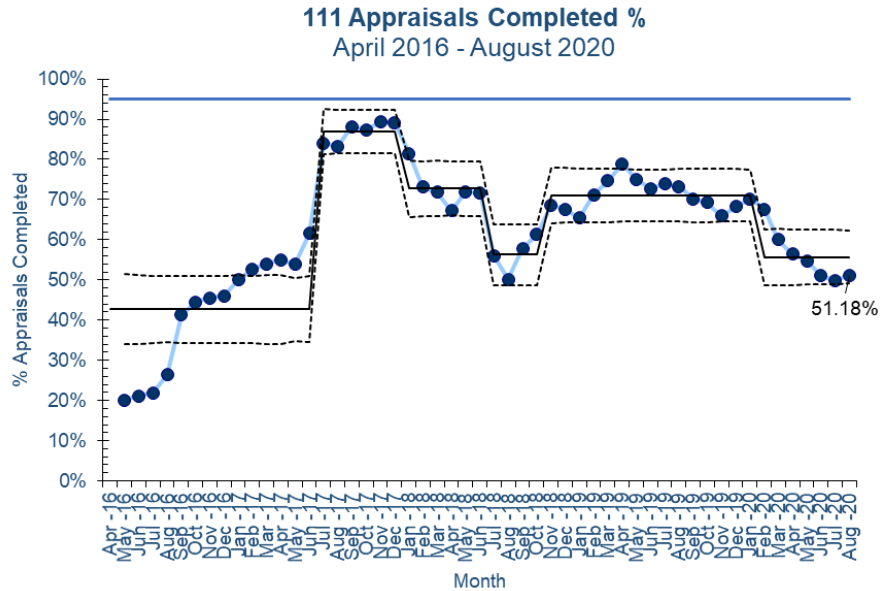


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

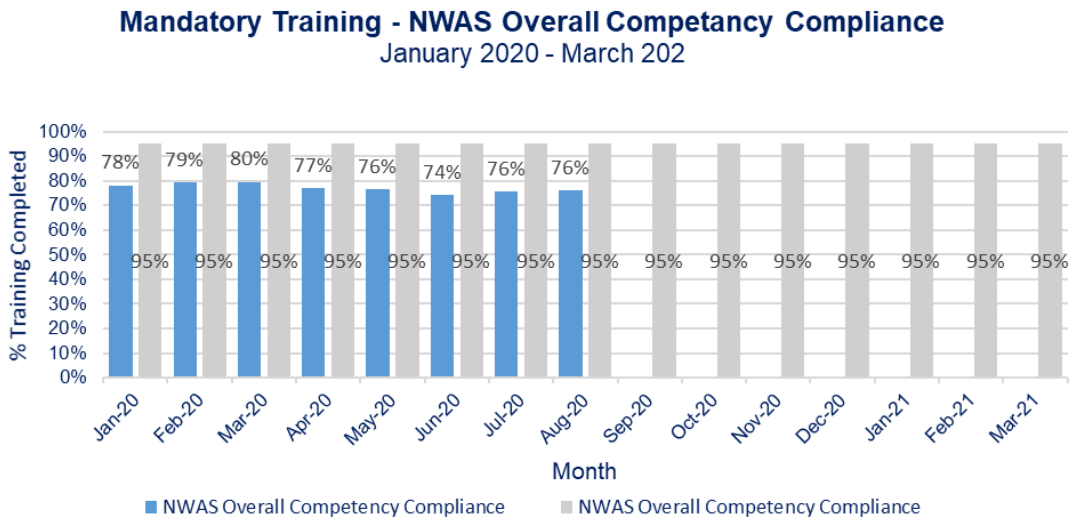
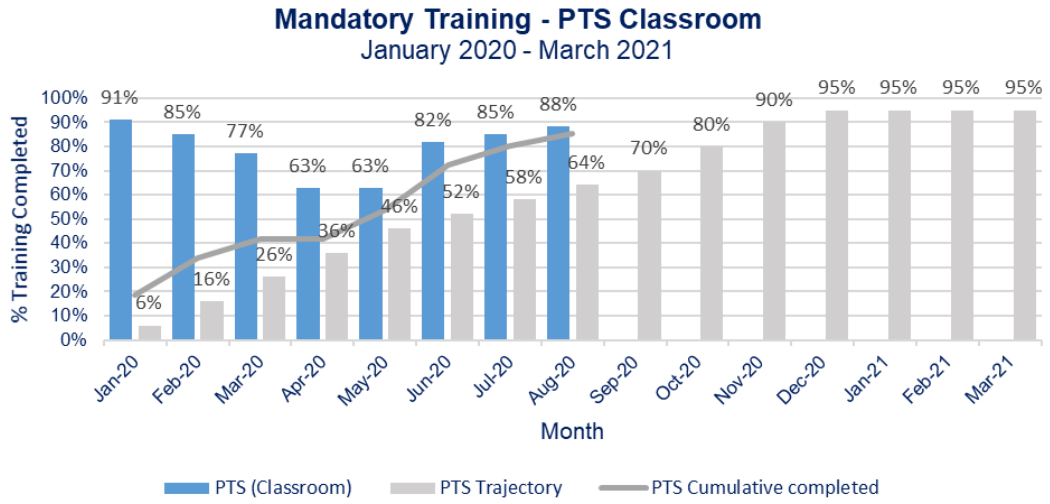


Figure OH7.2



Mandatory Training

The overall Trust mandatory training compliance position at the end of August 2020 is 76%.

This takes into account all online and classroom training. In addition to the impact of COVID-19 overall compliance levels are impacted by the inclusion of new topics in this year's cycle of training which will show as non-compliant until completion.

The Trust had moved to competence-based reporting for mandatory training.

The aim has been for staff to complete their classroom-based training and their online training before their competence expires, thus maintaining compliance across the year at 95%.

The cessation of training has impacted on this and now the 95% target will not be met fully until March 2021.

The current position is that PES classroom compliance is at 49% i.e. 49% of staff have received classroom training within the last 12 months and PTS are at 88%. However, both are on track against revised trajectories for classroom attendance as shown in OH7.2 and OH7.3.

BAF Risk: SR04, SR11

Figure OH7.3

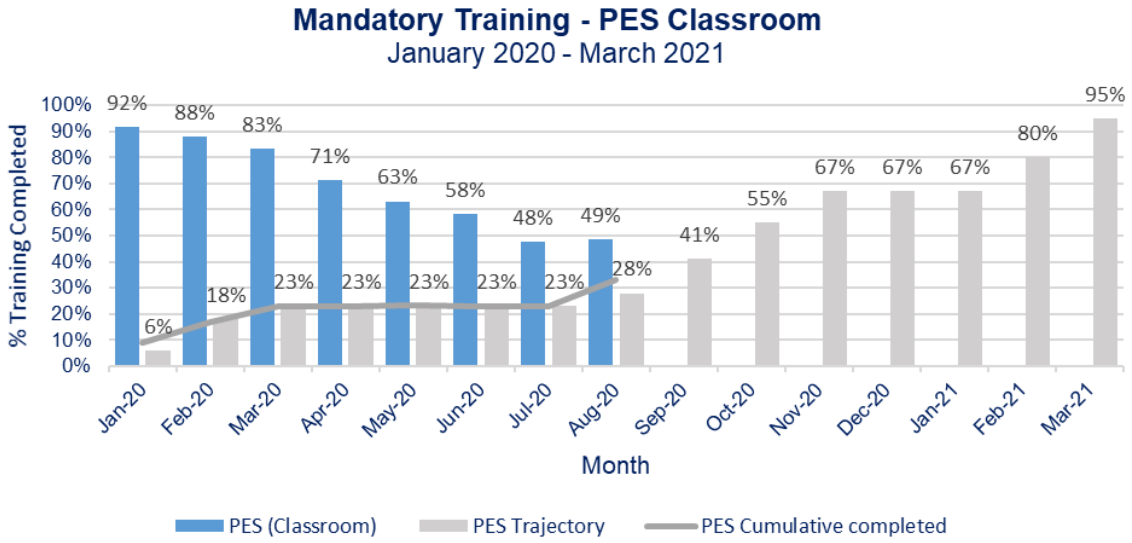


Figure OH7.4

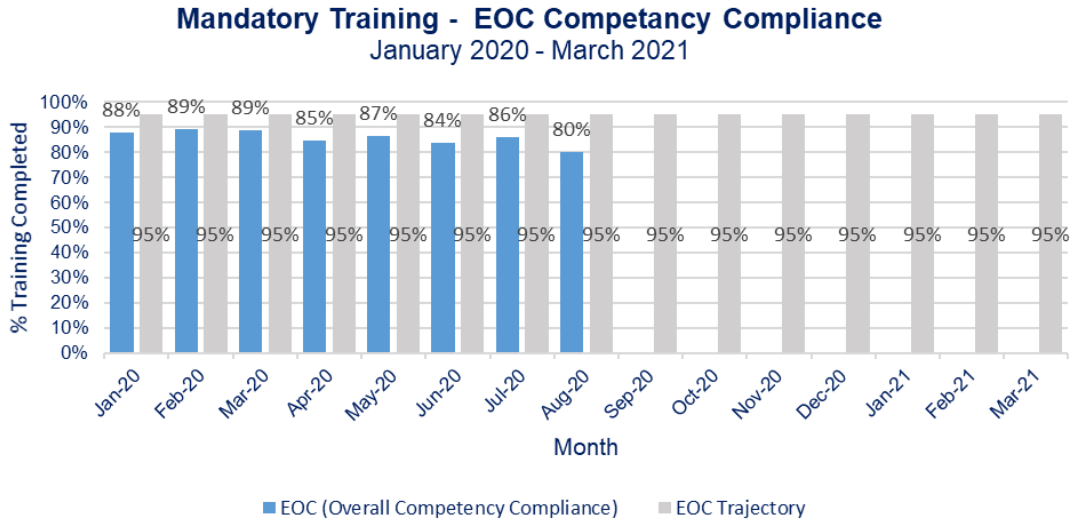


Figure OH7.5

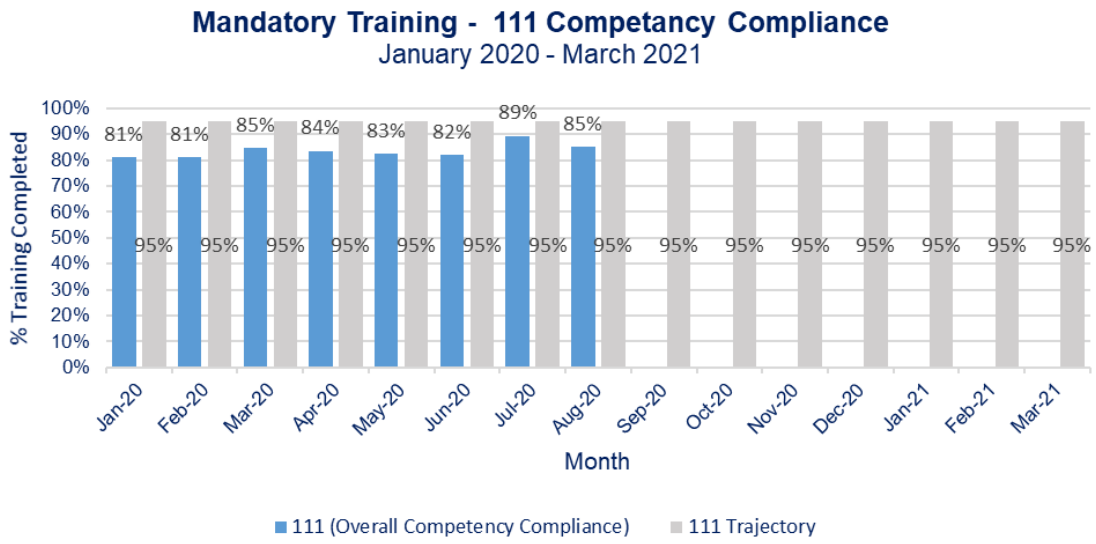
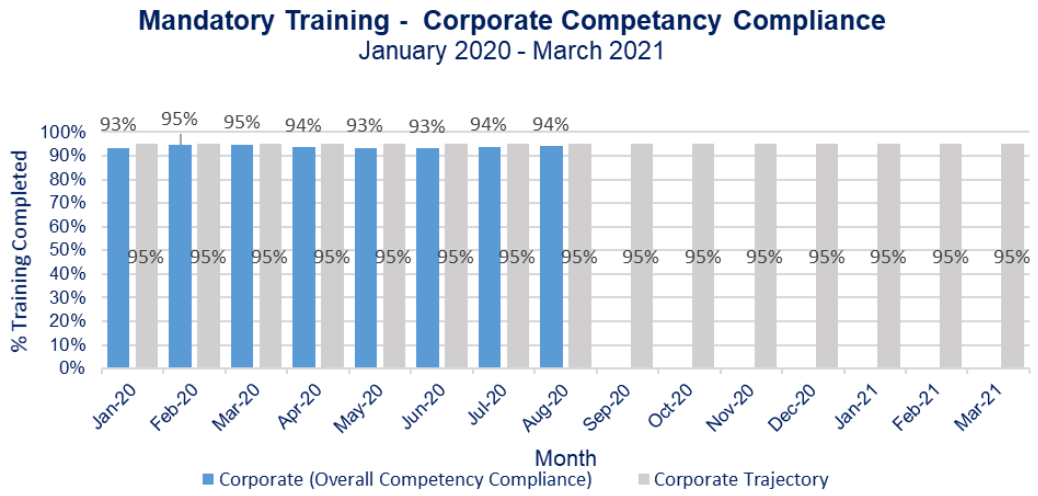


Figure OH7.6



Chairs Assurance Report

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	21 September 2020	**Quorate (yes/no):**	Yes
Chair:	Prof. A Chambers	**Executive Lead:**	Prof. M Power *Director of Quality, Improvement and Innovation* Dr C Grant *Medical Director* Mr G Blezard *Director of Operations*
Members present:	Prof. A Chambers, Non-Executive Director Mr R Groome, Non-Executive Director Dr D Hanley, Non-Executive Director Prof. R Thomson, Associate Non-Executive Director Prof. M Power, Director of Quality, Improvement and Innovation Dr C Grant, Medical Director Mr G Blezard, Director of Operations Mr M Forrest, Deputy Chief Executive	**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 performance standards through transition to an integrated serviced model within the funding envelope, this may impact on providing timely patient care.		

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance Framework		Since the previous Committee; • 4 new risks have emerged; (3379) Absence of professional leadership for midwifery, (3391) ARP	Noted and received assurance from the Board Assurance Framework.

	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

		standards not being sustained due inability to continue with supportive measures activated during COVID-19, (3394) Operational resource levels not matching demand due to increased shielding, (3397) Absence of a Patient Safety Specialist. • 3 risks have increased in risk score; (2750) Uncertainty over the supply of controlled drugs, (2931) Staff release not being scheduled appropriately for projects, (3236) Delivery of ARP standard during the current financial year. • In total 31 mitigating actions are identified on the BAF for SR01 and SR03. 23 actions are to be completed for SR01 and 6 for SR03. 10 actions have a target completion during Q3.	Gained assurance that each BAF risk was managed effectively.
Integrated Performance Report (IPR)		• Overall several measures have moved back towards pre-COVID levels • Increased call takers has delivered a high standard of response in answering the increased call volume with a mean call answering of 1 second • Both Mean and 90th Percentile for C2, C3 and 90th Percentile only for C4 have had a phase change; with performance metrics demonstrating quicker response times • Despite increased activity, less patients are being conveyed to ED due to good Hear and Treat and See and Treat performance • Draft report of the ORH Independent Review has been received by the Trust • NHS 111 First has been introduced in Blackpool and Warrington; call volume is higher than anticipated • Key Performance Indicators (KPIs) for Patient Transport Service (PTS) are still suspended	Noted and received moderate assurance from the report. Noted the assurance that actions were in place to improve performance. ORH Independent Review Report to be reported to Committee Further assurance requested Emerging Risks Identified: • Patients waiting in excess of 1 hour for handover at hospital

	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

			• Social distancing having the potential to impact on PTS performance
Right Care Strategy 2020/21 Q1 Assurance Report		• During Q1 COVID-19 has impacted on the progression of the Right Care Strategy • Completion of risk assessments to reduce the workplace risk of contracting COVID-19 and implementation of social distancing measures recommended by AACE guidelines • Medicines Team working closely with project team for SAFECHECK to incorporate this into vehicle checks • Controlled drugs expiries are being monitored by a digital solution • Draft guidance for managing suicide in the workplace • The Hub of Hope App has been agreed • Limited progress in developing a work plan for 'preventing harm to patients who wait for our services' • Based on the advice from NHSE/I the patient engagement programme and the national friends and family test has been paused to COVID-19 • COVID-19 has impacted on the progress against the Pillars of Quality • All quality improvement activity related to the Right Care Strategy was paused during Q1 due to the redeployment to the NHS Test, Track and Trace	Noted and received moderate assurance from the report. NWAS NHS Test, Track and Trace Plan to be reported to Committee NWAS Recovery Plans to be reported to Committee Safety Management Group have been commissioned to improve the progress of the pillars of quality Clinical Effectiveness Management Group have been commissioned to improve the progress of the clinical effectiveness programme Requested the format of reporting is revisited to highlight quarterly progress against key milestones against targets.

	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

Infection, Prevention and Control (IPC) Board Assurance Framework		• Compliance self-assessment with NHSE/I and Public Health England COVID-19 IPC guidance • The IPC BAF includes 10 key questions for NWAS to consider providing assurance and identifying any areas of risk to the organisation • The IPC BAF Action Plan will be managed by the Executive Leadership Committee • The IPC BAF was a key discussion point with the CQC as part of the Emergency Support Framework • IPC was a key theme identified as part of the Quality Assurance Visits and expectation that these issues will be addressed via the IPC BAF	Noted and received assurance from the report Committee welcomed assurance on the progress of the actions as part of the IPC reporting arrangements to Committee Noted that the CQC were assured the Trust had the appropriate systems and processes to manage IPC Approved the IPC BAF and onward reporting to the Board of Directors
Clinical Audit Plan 2020/21 Q1		• NHSE published the 'Reducing the Burden' document to manage the COVID-19 • National clinical audit activity from April to June 2020 was suspended • Identification of a risk surrounding the lack of resource and may impact on the annual clinical audit plan	Noted and received moderate assurance from the report Welcomed a revised Clinical Audit Plan for 2020/21 Escalated to the Audit Committee
Learning from Deaths 2020/21 Q1		• Q1 dashboard identified 17 deaths in the cohort and 8 of these incidents have been identified as contributing to the death of a patient • 4 of the contributing cases were due to problems in clinical assessment or a lack of resource • Learning was identified relating to EOC/ EMD procedures resulting in reflection and re-training	Noted and received moderate assurance from the report Clinical Effectiveness Management have been commissioned to ensure Learning from Deaths is embedded across the Trust

	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

		• Identification of a risk surrounding the lack of dedicated resource leading to no Structured Judgement Reviews (SJR) have been conducted	Escalated to the Board of Directors
NWAS Working Safely During COVID-19		• Station and Premises Recovery Working Group was established to agree a framework for compliance with published guidance • Collaborative working with internal colleagues and an external organisation to develop a signage package • Facilities Management Team visited 135 sites to install the packs and support managers in undertaking risk assessments and 135 sites have been issued with a COVID Safe Certificate	Noted and received assurance from the report Notify the Chair of the Resources Committee of the positive assurances received

Quality Assurance Visits (QAVs)		• A presentation relating to the progress made in relation to i) undertaking Quality Assurance Visits (QAVs) across the Trust, ii) the Trust's current position and iii) the next steps was received.
		• All NWAS front line premises (incl. PES, EOC, HART, PTS, PTS Control, NWAA and 111) have been subjected to a Quality Assurance Visit (QAV) during 2020/21 and are audited through a standard toolkit.
		• The QAV process has become embedded in 'Operation Outstanding' which is a mind-set to support the Trust in its ambition of a CQC 'Outstanding' rating by 2022.
		• As at 1 September 2020:
		  ○ All QAVs to front line premises were complete, with the exception of 1 PES station within the Cheshire and Mersey area and 6 QAV reports were outstanding.
		  ○ 2,504 improvement actions had been identified as a result and over 2,178 (875) are now complete
			Noted and received assurance from the presentation 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

		and 326 (13%) remain incomplete (delayed, on target or require continuous monitoring). ○ Incomplete actions are categorised under 3 themes (Estates, IPC and Health, Safety and Security) however noted the priority of these incomplete actions are medium or low.	
ROSE Bi-Annual Assurance Report		• For the reporting period of 01 April and 31 August 2020, 166 cases have been considered at ROSE • 19 cases met the Serious Incident Framework • Increased number of cases discussed at ROSE is due to the increasing volume of activity in 999, NHS 111 and PTS as well as an improved reporting culture • There has been a reduction in the number of overall cases identified as SIs • Common theme remains 'harm arising from delays in treatment' • GM and EOC remain high reporting areas of SIs • No SIs from PTS • 3 SIs originated from NHS 111	Noted and received assurance from the report Clinical Effectiveness Management Group have been commissioned to triangulate the themes identified
Major Trauma Care Provision Peer Review Report 2020		• The North West Major Trauma Operational Delivery Networks (NWTODN) undertook a review of pre-hospital trauma care services provided by NWAS, including the regions enhanced pre-hospital care services provided by NWAA in January 2020 • The Trust was benchmarked against Pre-Hospital Care Standards for Major Trauma Care 2019 and was the first time since 2015 the Trust has been reviewed • Outcome of the review upgraded the compliance with the standards in comparison to the self-assessment completed by NWAS • NWTODN congratulated the Trust and the NWAA on the high compliance	Noted and received assurance from the report

	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

Research Strategy 2020-2025		• NWAS has made progress in driving the research agenda and as a result the Trust has grown its research capacity and capability • The revised Strategy aligns to the refreshed position of the Trust and considers the evolving leadership landscape, the vision, values and Trust Strategy to enable research activity	Noted the Research Strategy 2020-25 and recommended to the Board of Directors for approval
AQI Data Quality		• ORH identified during the work to model performance that the time stamp for calls transferred from other services including NHS 111 to 999 are incorrect • The clock start time has been delayed and gives additional time of 30 seconds for Category 1 calls and 4 minutes for Category 2 • The issues are two-fold (i) CAD incorrectly starting the clock and (ii) Informatics reports being linked to the incorrect time • A refresh and rebuild is in progress dating back to 1 April 2020 • C1 Mean and 90th Percentile are unaffected • C2 will extend by ~+17seconds and 90th Percentile by ~+21 seconds • C3 and C4 will extend but proportionally less due to the longer response times for these call categories • The impact of the error to last year's position has been estimated and although increased are identified, none of the impacts took any of the measures below a target line at the NWAS Level or Sub-regional level • Resubmission of the data to NHSE/I will be made once the data has been corrected • Independent Review of the alignment of AQIs will be commissioned	Noted and received moderate assurance from the report AQI Independent Review Report to be reported to Committee Notify the Chair of the Resources Committee regarding the AQI Data Quality and moderate assurance on Data Quality Noted onward reporting to the Board of Directors

	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

Chairs Assurance Report: Learning Forum held on 10 August 2020		• Committee were advised on the areas of assurance • Lessons learnt newsletters were received and reviewed	Noted and received assurance from the report
Chairs Assurance Report: Clinical Effectiveness Management Group held on 01 September 2020		• Limited assurances received on the Chairs Assurance Report • Controlled drug supply issue was escalated to ELC • Disconnect between risks identified on the BAF and the content of the Chairs Assurance Report; Midwifery and Obstetrics	Noted and received moderate assurance from the report Chairs Assurance Report to contain more detail
Chairs Assurance Report: Safety Management Group held on 01 September 2020		• Committee were advised on the areas of assurance • A detailed analysis to be undertaken by the Mental and Health and Dementia Lead for suicidal calls where the patient is deceased on the arrival of NWAS	Noted and received moderate assurance from the report

	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 Trust

REPORT

Board of Directors						
Date:	30th September 2020					
Subject:	Infection Prevention and Control Board Assurance Framework					
Presented by:	Maxine Power – Director of Quality, Innovation and Improvement					
Purpose of Paper:	For Assurance					
Executive Summary:	This IPC Board Assurance Framework (BAF) summarises our self-assessment with compliance to NHSE/I and Public Health England COVID-19 infection prevention and control guidance. This 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. Using this framework is not a regulatory requirement; however, it will help us to maintain quality standards and provide assurance to the NWAS Trust Board that organisational compliance has been systematically reviewed. A draft version was presented to ELC 15/07/2020. Due to the cross cutting nature of the information contained within the BAF, ELC recommended a task and finish group to review the draft and finalise the BAF. The task and finish group met on two occasions and a revised framework was presented to ELC for approval on the 12th August. This was also presented to the Safety Management group on the 1st September for information and was presented to the Quality and Performance Committee on 21st September and recommended for onward approval to board.					
Recommendations, decisions or actions sought:	The Board of Directors is asked to: 1. Approve content of IPC Board Assurance Framework 2. Support the development of risk gap analysis/action plan 3. Agree monitoring / reporting structure					
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:	• Executive Leadership Committee • Quality and Performance Committee
Date:	• ELC - 5th July 2020 and 12th August 2020 • Quality and Performance - 21st September 2020
Outcome:	• ELC – Approved • Quality and Performance – Approved for onward consideration by board

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

To present to the Board of Directors 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 and for the patients and service users themselves in a healthcare setting. 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.

Using this framework is not compulsory; however, 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 addition to the framework we have developed an evidence log, risk log and action log.

The draft framework was previously presented to the Executive Leadership Committee on the 15th July 2020. This has since been updated following a review by a task and finish group consisting of key managers who have within their sphere of responsibilities areas specified within the framework. This has also been cross referenced with the Covid Risk Register and an evidence log completed.

Following approval of final draft at ELC 12/08/2020 the framework will now also be shared with the Non-Executive Directors as requested by the chair of the Quality & Performance Committee on 20/07/2020.

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 IPC Board Assurance Framework and action plan will be owned by 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 Board of Directors are asked to note and approve the content of the revised draft framework and approve content of IPC Board Assurance Framework

4.2 Support the development of risk gap analysis/action plan

4.3 Agree monitoring / reporting structure

Infection Prevention and Control Board Assurance Framework – COVID 19

Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in evidence- based way to maintain the safety of patients, service users and staff.

NWAS has developed this framework in alignment to the national PHE framework to help assess the organisation against the guidance as a source of internal assurance that quality standards are being maintained. This will assist us identify any areas of risk and show the corrective actions taken in response. The tool therefore will also provide assurance to our Trust Board that organisational compliance has been systematically reviewed.

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 that are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

This document together with associated appendices of evidence, risk and action logs provide assurance that NWAS is meeting these regulatory requirements.

Infection prevention and control board assurance framework

Version 1.0 Approved 12/8/2020/		Last Updated: 24/8/2020	
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			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
1.1 **Infection risk is assessed at the front door and this is documented in patient notes**	a)Documented in patient administration systems (CAD, ADASTRA & CLERIC) for PES, 111 & PTS respectively on every call	a) At present it is only COVID 19 that is routinely recorded. This does not happen routinely for all infectious diseases unless stated in initial call.	a) IPC status/risk is added to calls at PTS booking and via NHS Pathways/ AMPDS coding routes. This is set at national level.
1.2 **Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission**	a) Hear and Treat and See and Treat rates remain high and are monitored in the IPR to ensure home care pathways are optimised b) H & T and S & T reported regularly through the CEMG Committee	a) Specific monitoring of patients with known COVID-19 or infectious diseases are not currently reported as part of the Hear and Treat data.	a) Hear and Treat and See and Treat data is regularly reported. Covid Incidents reported through IRF are reviewed weekly.
1.3 **Compliance with the national guidance around discharge or transfer of COVID- 19 positive patients**	a) Discharge and transfer of patients policy, CV051 (Staff Bulletin)	a) Potential for policy not to be followed.	a) Information on policy breaches gathered by IRF system and reviewed weekly.
1.4 **All staff (clinical and non-clinical) are trained in putting**	a) Mandatory training for all staff on IPC	No gaps identified	Not applicable

on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	b) Donning and Doffing e-learning module established as mandatory competency for all patient facing staff c)PPE hubs and distribution established d) stock supplies monitored daily PPE reciprocal arrangements established with other trusts e) Daily Executive COVID 19 command cell escalation if required		
1.5 **National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way**	a) National Ambulance Coordinating centre (NACC) cascade IPC guidance to commanders daily b) QGARD IPC subgroup cascade IPC updates to IPC leads via email c) IPC team act as a central coordination / dissemination in hours and strategic command coordinate out of hours d) Bulletins and guidance are issued via the Green room (on line), trust communications and reinforced on strategic calls / via staff side	a-b) The interval between guidance changes and dissemination can be lengthened by frequency of issue (by PHE) and lack of senior IPC personnel to process the change.	a- c) Temporary IPC support contracted during COVID 19 pandemic.

	Communication channels used for CFRs		
1.6 **Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted**	a) CEO and DIPC (Chief Nurse) receive direct communications from PHE and NHSI b) CEO & DIPC meet with Director of Quality Innovation and Improvement monthly to identify risks / gaps in assurance c)Safety alerts (including IPC) are reported to the board via the integrated performance report (IPR) d) Risks and Mitigations; the 2020/21 BAF contains a specific strategic risk pertaining to COVID that is reported to the Board of Directors. In addition any significant risks are also reported to the Board and the full COVID-19 Risk Register	a) As highlighted in 1.5 b) Potential to guidance not being picked up and risks not identified	b) Risks are collated from incidents and reported to the IPC forum and Safety Management Group / Quality & Performance Committee
1.7 **Risks are reflected in risk registers and the board assurance framework where appropriate**	a) The Trust has a risk register on Datix which includes specific COVID 19 risks. b) The Board Assurance	a - b) Risk owners review and own the risk environment but the frequency of risk review may not keep pace with the rapidly changing risk profile seen during a pandemic	a) Robust monitoring of risks a) Operations and Corporate joint working established via Tactical Command Group / Strategical Command Group. Senior Risk

	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.		and Assurance Manager to continue attendance at both groups a) Risks discussed at SMT and in addition, risks are reporting to Board Assurance Committees, Audit Committee and Board of Directors. The Board of Directors had visibility of the COVID-19 risks on the Trust risk register
1.8 **Robust IPC risk assessment processes and practices are in place for non COVID 19 infections and pathogens**	a) Specific policies and procedures are in place for the management of communicable diseases & IPC risk for patients e.g. Communicable Disease Policy b) Risk assessments in place for all sites in NWAS: EOC, stations, corporate for risk assessment for staff c) Completion of risk assessments monitored via operation outstanding d) Compliance with IPC policies & procedures monitored via audit locally and via Clinical Safety and H&S team audits	b) Operational and IPC resource needs to be identified to monitor via on site audits frequently Real time data on compliance not yet available	b) Risk Assessment Process standardised and fully implemented in all stations, offices and control centres. This is monitored by operational Managers and reported via Operation Outstanding”

1. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
2.1 Designated teams with appropriate training are assigned to care for and treat patients in COVID 19 isolation or cohort areas	a) All frontline clinical staff trained in latest IPC guidance. Guidance and bulletins are published regularly to ensure staff are kept up to date with latest information via trust intranet and the JRCALC application. Contact shifts (x3 per year) for PES staff.	a) No central records of whether staff have read and understood the update PHE guidance	a) Communications are currently in discussion with an external provider (Granicus) in exploring an email communications platform that allows for 'open' and 'read' rates. IRF procedure in place for reporting incidents related to care of Covid patients (IPC team & operational managers) Complaints monitoring would identify any patient issue (patient experience team)
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to stations and premises	a) Clinical staff are trained in decontamination of vehicles in line with policies and procedures. This is supplemented via mandatory training and information bulletins. b) Contracted cleaning team (JPR) trained in	a) Limited auditing of staff between contact shifts. b) Training records & audits for contractors available for	a) Audit schedule in place by CSP – one sector per month. b) No mitigation currently in place. Captured on IPC BAF

	decontamination of premises and vehicles in line with policies and procedures; mandatory training and tool box talks, monitored through standard contract management processes c) Vehicle, contact centres and station audits are undertaken by Clinical Safety team (ad hoc and planned)	review but no corporate visibility for assurance c) Limited resources to undertake timely audits at all hospital sites, stations and vehicles	action log. c) Audit schedule in place – one sector per month.
2.3 Decontamination of premises and vehicles is carried out in line with PHE and other national guidance	a) Working party reviewing cleaning schedules on sites - dedicated email for premises cleaning b) Deep cleaning of vehicle schedule monitored by Estates and Fleet following national guidance reported via SMG c) Additional deep cleaning in place as part of outbreak plan	No gaps identified No gaps identified c) No records of enhanced cleaning by 3rd party providers (PTS etc.)	Not applicable Not applicable c) No mitigation currently in place. Captured on IPC BAF action log.
2.4 Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	a) Vehicle cleaning in line with PHE guidance, cleaning all contact areas after each patient – more than recommended frequency b) Enhanced cleaning of all areas following AGP patients in line with national guidance (App 1, 2.4) c) auditing of vehicles and stations as part of observational audits and Quality Assurance Visits	No gaps identified No gaps identified c) Limited resources to undertake timely audits at all hospital sites, stations and vehicles	Not applicable Not applicable c) Audit schedule in place – one sector per month. QAVs recommenced.

2.5 **Attention to the cleaning of toilets/bathrooms, as COVID 19 has frequently been found to contaminate surfaces in these areas**	a) Toilets and bathrooms cleaned in accordance with guidance – EOC/contact centre schedules increased. Guidance for contact centres published. Station and corporate areas cleaning guidance issued and managed as part of cleaning contract	a) No cleaning on stations on weekends. Larger stations and all contact centres are cleaned during bank holidays. b) Actions arose from the Middlebrook sector level visit re. Cleaning practices and schedules.	a) Head of Facilities in the process of undertaking a Trust wide review all cleaning regimes across estate. b) fed back to cleaning company – picked up at Premises Recovery Group Clinical Safety Practitioners auditing EOC/111 contact centres every month.
2.6 **Cleaning is carried out with natural detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance.** **If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to**	a) Cleaning of vehicle is included within basic training b) Cleaning procedures in place for crews and for cleaning teams (SOPS) in line with guidance c) Chlorine solution is used on vehicles by cleaning teams and crews in accordance with manufacturers' instructions and PHE guidance d) Products supplied by procurement meet standards required	No gaps identified b) There is a risk that cleaning consumables are not available via the NHS Supply Chain our current provider due to demands across the NHS and shortages in stocks. d) In addition the PPE dedicated service created by the NHS	Not applicable b-d) The Procurement Team have identified alternative routes to procure and products should they be required. The "Safety Equipment Cell" is used should alternatives need to be reviewed. Escalations can be made for certain products with the National Supply Disruption Response (NSDR). There is also the possibility of mutual aid with neighbouring NHS Trusts.

ensure that this is effective against enveloped viruses		during COVID 19 dictates the items/brands/quantities and frequency in which items are "pushed" to Trusts.	
2.7 Manufacturer' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/ products as per national guidance	a) Contact time guidance available within good practice guidance b) Staff trained in manufacturers' guidance as part of induction	No gaps identified b) Products supplied via the "push" stock system or alternatives that have been sourced may differ to those used by staff.	Not applicable b) IRF system – Potential to identify any issues or breaches Staff would be expected to check/familiarise themselves if they had new/alternative products.
2.8 Frequently touched surfaces, e.g. door/toilet handles	a) Frequent touch points cleaned after each patient on a vehicle. Stretchers cleaned thoroughly between patients b) Frequent touch points in non-clinical settings cleaned regularly throughout the day and workstations at the beginning and end of each shift c) Guidance for all areas provided including reminders and visual prompts for additional cleaning	a) Monitoring undertaken daily by local managers but no visibility of evidence available for assurance b) As above c) As above	a) Implementation of observational audits to demonstrate compliance by SPTL Limited mitigation currently in place across some sites. Captured on IPC BAF action log. As above
2.9 Electronic equipment e.g. mobile phones,	a) Guidance on cleaning of surfaces issued including visual prompt cards, cleaning products minimum twice a day at start and end of each shift	a) No central records	a) Trust 'working group' established to audit adherence to guidance and signs

desk phones, tablets, desktops and keyboards should be cleaned at least twice daily			Local management monitoring ongoing adherence to cleaning standards and reporting through "operations outstanding" management teams audits are completed and available at each 111 site
2.10 **Rooms/ areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)**	a) PPE removed at hospitals in accordance with local procedures b) PPE removed in vehicle after patient transfer and vehicle clean in accordance with guidance c) CFR remove PPE at incident in accordance with guidance	a) Staff may not be aware of local hospital procedure for donning and doffing areas	a) Operational managers ensure there are clear signages or instructions at each hospital site and liaise with hospital if issues identified.
2.11 **Linen from possible and confirmed COVID- 19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken**	a) Linen managed with in accordance with Trust Linen Policy Dispersible laundry bags for home use are available for staff. b) Local arrangements in place for linen swap at hospitals c) Linen supply available on stations	a) Staff may not be aware or not follow linen policy b) Staff may not be aware of local hospital procedure for donning and doffing areas and linen management.	a) All policies and procedures are on trust website and linen management part of training. IRFs system in place for issues that arise. b) Operational managers ensure there are clear guidelines for staff at each hospital site for linen disposal and liaise with hospital if issues identified.
2.12	a) The trust has a range of single use	a) Single use items may not be	a) PPE "push" stock through

Single use items are used where possible and according to single use policy	medical items/consumables and PPE these are used in line with guidance and overall usage monitored by procurement b) Infection Prevention Procedures contains information on single use PPE	available in the event of national PPE shortage. For example FFP3 Masks. b) The move to the dedicated "push" channel for PPE created concerns and anxiety amongst staff, particularly as standard PPE items were no longer available e.g. aprons with sleeves and alternatives were being push to us. In addition to alternative products, emergency guidance such as reusing face visors.	dedicated PPE Channel. b) From the start of the pandemic Procurement worked to source appropriate PPE wherever possible from commercial suppliers in order to supplement the bulk PUSH deliveries. c) Mutual Aid system in place from other trusts if necessary d) Stock recorded at station level (JOT Forms) and reported via Regional (Advice Inc.) and nationally (Foundry) portals. e) When required escalations were raised with National Supply Disruption Response (NSDR).
2.13 Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	a) SOPS in place for reusable items include FFP3 half masks, eye protection goggles and RPE (used only in HART) SOPS in place for reusable medical items and equipment such as stretchers/defibrillators.	a) No local or corporate monitoring of local adherence to procedures- presumed competent at sign off of SOPs and monitored by line manager	a) No mitigation currently in place. Captured on IPC BAF action log.

2.14 Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Estates oversees air conditioning across sites	Staff spoken to who are shielding or working from home due to medical reasons have commented that due to their health condition being lung related they are concerned about air conditioning.	All 111 centres have had recent air conditioning services which has been recorded on the Covid-19 recovery plan assessment.

2. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
3.1 Arrangements around antimicrobial stewardship are maintained	a) NWAS only use one antimicrobial. This medicine is administered under the Human Medicine Regulations-schedule 17 exemption for paramedics for the treatment of meningitis b) Evidence based guidelines for the use of antimicrobial are in place and all staff have access to them c) A medicines formulary is in place. Approval for any new medicines needs to go through a robust application process via the Medicines Effectiveness Group d) No prescribing or supply of antimicrobials takes place	No gaps identified	Not applicable
3.2 Mandatory reporting requirements are	a) Incident report forms and yellow card submissions are monitored by the Medicines team. Incidents are themed and	No gaps identified	Not applicable

adhered to and on boards continue to maintain oversight	reported quarterly to the Medicines Effectiveness Group where learning can be identified where possible b) Medicines team monitors antimicrobial usage		
3. 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			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
4.1 Implementation of national guidance on visiting patients in a care setting	a) PES have suspended all escorts to care settings unless identified in vulnerable patient group which includes children b) PTS will only permit escorts for pre identified vulnerable patient group and this is prescribed within the contract. Taxis are allocated only to patients who can travel alone unassisted Discussed with patient on booking.	a) No specific information with regards to this is available on NWAS public website b) No specific information on NWAS public website with regards to COVID for patients on how to use our service safely for planned journeys	a) IPC Guidance drafted to go on website to cover escorts b) The communication team are in touch with PTS management regarding a form of words for the website.
4.2 Areas in which suspected or confirmed COVID 19 patients are being treated are clearly marked with appropriate signage and have restricted access.	a) Handovers are undertaken in accordance with the logistic plans at each care setting	a) Amendments to plans not always communicated. Crews who are out of area or new to NWAS may not be aware of restricted areas	a) Operational managers ensure there are clear guidelines and signage for staff on each hospital site – any local issues are addressed through liaison with the hospital.
4.3 Information and guidance on COVID	a) Information on the trust's website refers people to the gov.uk coronavirus page so that the latest information is always up to	Information is available but always looking to improve the number of easy to read	Not applicable

19 on all trust websites with easy read versions	date. This information includes easy read versions. b) The news page on the public NWAS website is refreshed as updates are received from PHE. This information includes easy read versions. c) NWAS shares up-to-date information on social media in line with government and national NHS messages and guidelines as well as any issues affecting trust service. - Regular trust stakeholder briefings and newsletters are published on the website. d) Recite Me is an accessibility function which is incorporated onto the external website and is automatically available to all users. This comes with a range of tools to make pages more accessible to all.	versions. No further gaps identified	
4.4 **Infection status is communicated to the receiving organisation or department when a possible confirmed COVID 19 patient needs to be moved**	a) Care settings are informed via pre alert for all suspected and confirmed COVID 19 patients	a) EOC not always fully informed re: patients infection status	a) IRF process in place if notification process is not followed or communicated

4. 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

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating Actions
5.1 **Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed symptoms and to segregate them from non COVID 19 cases to minimise the risk of cross-infection, as per national guidance**	a) Pathways are in place to triage patients at source 999/111/PTS to ascertain COVID 19 status (at our front door – call centre) and reduce need for conveyance where safe to do so include hear and treat and see and treat b) Audited as part of MDT compliance on an ongoing basis c)Reported via the integrated performance report (H&T and S&T)	No gap identified	Not applicable
5.2 **Mask usage is emphasized for suspected individual**	a) Guidance in place to ensure all patients to wear masks when being transported (PES, PTS and Taxi)	a) Lack of guidance on Trust website	a) - Information on the trust's website refers people to the gov.uk coronavirus page so that the latest information is always up to date. The news page on the public NWAS website is refreshed as updates are received from PHE. This information includes easy read versions. NWAS shares up-to-date information on social media in line with government and national NHS messages and guidelines as

			well as any issues affecting trust service. Work is currently being undertaken by our Patient Engagement team to understand patient experience during the pandemic and identify way to improve access to services e.g. the deaf community have found face masks challenging as they are unable to lip read and as a result the team are working with Procurement to purchase clear face masks for use with this community. The communication team are in touch with PTS management regarding a form of words for the website.
	b) Masks are provided for all patients. Staff are required to implement the wearing of masks, including the application of exemptions when it may be difficult for some patients e.g. those requiring oxygen	b). There may be limited reporting of non - compliance	b) IRF process in place to monitor any issues
5.3 **Ideally segregation should be with separate spaces, but there is potential to use**	a) All public facing areas and stations have social distancing measures in place b) Risk assessments undertaken for all sites Screens have been installed in contact	a) limited monitoring or reporting of compliance to social distancing in stations b) awaiting installation date for floor 1 replacement at	a) Monitoring/audit system has been implemented (Operational Managers/Facilities) b) CSP and Estates team are auditing estate sites monitoring

screens e.g. to protect reception staff	centres c) Good practice guidance implemented in contact centres. Compliance audit implemented	Middlebrook and PTS Carlisle c) No gaps identified	any issues that need to be resolved. c) Not applicable
5.4 **For patients with new on-set symptoms, it is important to achieve isolation and instigation of contact tracing as soon as possible**	a) Guidance on self- isolation provided by 999 and 111 services for all COVID 19 patients as part of the call script b) 111 offer contract tracing pathway for patients to follow c) Call handlers are audited on an ongoing basis and compliance monitored d) Contact tracing for patients is not managed by NWAS	No gaps identified	Not applicable
5.5 **Patients with suspected COVID 19 are tested promptly**	Not applicable	Not applicable	Not applicable
5.6 **Patients who test negative but display or go on to develop symptoms of COVID 19 are segregated and promptly re-tested and contact traced**	Not applicable	Not applicable	Not applicable

5.7 **Patients who attend for routine appointments and who display symptoms of COVID 19 are managed appropriately**	a) All patients are treated as if they have COVID with appropriate PPE as per NWAS and national guidance Staff are required to implement the wearing of masks for patients, consideration is given to the application of exemptions as masks may be prove difficult for some patients e.g. those requiring oxygen.	a) There may be limited symptomatic patients who may refuse to wear a mask – requirement for staff to understand actions on refusal There may be limited reporting of non - compliance	a) IRF process in place to monitor any issues

5. 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			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
6.1 **All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe**	a) IPC/H&S training for all is included within induction and mandatory training Compliance monitored via ESR IPC and H&S are delivered annually, PPE Donning and Doffing e-learning modules and competency introduced for all staff in March 2020 b) Education Department monitor training records monthly. Compliance reported in IPR and monitored via Q&P Recovery plan for all directorates for mandatory training overseen workforce recovery cell c) Environment risk assessments for all areas are undertaken by Local Managers. Supported by IPC/ H&S teams. Checklist	a) Mandatory training was paused due to COVID 19. This has restarted for all groups, with PES due to recommence in August 2020.	a) Recovery plan for all directorates for mandatory training overseen by workforce recovery cell.

	available to support managers d) Guidance published on the green room re: processes to reduce risks. Safety checkpoints established These include temperature checking upon entry to buildings. Face masks to be readily available	c) Estate is not always conducive to support recommended 2 metre social distancing d) Reporting structure to provide assurance not yet established	c) Local auditing and monitoring of sites via estates and supported by CSP and H&S teams to monitor compliance and issues. d) Current processes being monitored via Operation Outstanding and Compliance unit.
6.2 **All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it**	a) PPE guidance is available (My ESR) Title: 242 NWAS Clinical COVID 19- PPE 1.3 Staff Bulletin on E learning: CV065 b) Mandatory training logs to show staff have completed module. c) Donning and Doffing e-learning module is mandatory for all patient facing staff d) Fit checking is included in fit test	a) Limited assurance to confirm staff have read and understood up to date information provided in bulletins and other communications. No gaps identified c) Process to evidence competency assessments not yet in place trust wide. d) Only pertains to point in time	a) Communications are currently in discussion with an external provider (Granicus) to explore the possibility of an email communications platform that allows for 'open' and 'read' rates. Clinical supervision is provided via SPTL observation shifts c) Donning and Doffing practical assessment currently being piloted includes fit check assessment d) as above
6.3 **A record of staff training is**	a) Completion of PPE e-learning is recorded on ESR and reported monthly.	a) no gap	a) not applicable

maintained	b) Records of fit testing status for all eligible staff maintained c) Records of fit testers competency fully maintained d) Fit testing meetings have been in place since April 2020 to review and provide assurance on process	b) Process in place but not fully aligned to ESR for a central ESR record c) Process to evidence ongoing competency not in place d) No gap identified	b) Area based records are in place and have been cross-matched to ESR records. c) No mitigation currently in place. Captured on IPC BAF action log. d) Not applicable
6.4 **Appropriate arrangements are in place so that any use of PPE in line with the CAS alert is properly monitored and managed**	System in place 24/7/365 via the strategic commanders in the regional operations centre (ROCC) System supported by clinical audit and H&S team in hours Procedures approved by safety management group and Q&P committees	No gap identified	Not applicable
6.5 **Any incidents relating to the re-use of PPE are monitored and appropriate action taken**	a) Limited use of reusable PPE. Cleaning and decontamination guidance is updated and communicated via green room NWAS policy dictates that PPE is not reused other than in extreme circumstances for e.g. national shortages. Regular updates on PPE availability to TCG/ SCG	a) Staff may purchase and reuse their own PPE without management consent	a) Clear guidance has been issued to support managers to address with individual staff members
6.6 **Adherence to PHE national guidance on the use of PPE is regularly audited**	**a)** Weekly and monthly review of IRF's monitored by H&S and IPC leads b) Findings reported to Executive Leadership Committee	Leadership required from within operations to monitor compliance with PPE policy and procedures on a day to day basis	Clinical supervision is provided via SPTL observation shifts Limited mitigation further actions captured on IPC BAF action log.

	c) IRF Thematic review reported to Safety Management Group d) Incidents reported where suspected occupations exposure (RIDDOR)	d) staff may wear inappropriate PPE and expose themselves to Covid	d) Director of Operations leading audit of all staff who participate in an AGP
6.7 **Staff regularly undertake hand hygiene and observe standard infection control precautions**	a)IPC Standard policies and procedure b) Hand hygiene audits reported quarterly to SMG c) Observation audits/ contact shifts	a-c) Only pertains to a point in time	a-c) Covert auditing is included in Clinical Safety Practitioners audit cycle
6.8 **Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hand should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per**	a) Hand driers have been taken out of service and replaced with supply of paper towels	a) Not all areas have paper towel dispensers – paper towels are just left on the side of the basin. b) No paper towel dispensers at Middlebrook due to being advised that paper towels were not required by facilities management on 08/07/2020 due to changed HM Government guidance & previous incidents of paper towels being used and blocking toilets – this goes against national IPC & COVID guidance.	a) Facilities/ Estates Lead are sourcing and installing dispensers for all NWAS sites. b) No mitigation currently in place. Captured on IPC BAF action log.

national guidance			
6.9 **Guidance on hand hygiene including drying should be clearly displayed in all public toilet areas as well as staff areas**	a) Hand hygiene posters are clearly displayed in all toilets and staff areas - Part of IPC audit tool to check in place and intact	No gaps identified	Not applicable
6.10 **Staff understand the requirements for uniform laundering where this is not provided on site**	a) Uniform guidance has been issued. Dispersible bags to facilitate home laundering safely are readily available (bulk orders placed and stock held for stations to request).	a) Not all stations have adequate changing facilities or adequate storage space for spare uniform b) Agreed staff uniform allocation may not support increased frequency of change. Although all staff should have sufficient garments, occasionally some may not and should submit requests.	a) Lockers and changing facilities included within estate/ refurbishment plans b) BAU processes include emergency uniform at EOC's for staff to access. The Uniform store has been open throughout the pandemic dealing with requests for uniform. Procurement engaged with the National Uniform Supplier to ensure they could meet any increased demand (considering they were in lock down with limited staff). COVID-19 Daily Briefing - 15 May 2020 Provided staff with advice on cleaning, availability of laundry bags and the

	a) Domestic washing machines in use on some stations	a) Non adherence with H&S governance requirements	provision of additional uniform and how to order it. a) No mitigation currently in place. Captured on IPC BAF action log.
6.11 **All staff understand the symptoms of COVID -19 and take appropriate action in line with PHE and other national guidance if they or a member of their household displays any of the symptoms**	a) COVID information communicated regularly to all staff Letters sent to vulnerable staff b) staff welfare cell established. HR monitoring weekly reporting to ELC - Weekly welfare check system in progress	a) Reliant upon regular reporting	a) IRF system in place for staff to raise any concerns
6. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
7.1 **Patients with possible or confirmed COVID 19 are isolated in appropriate facilities or designated areas where appropriate**	a) All transportation guidance followed. Teams undertake hospital to hospital transfers in line with Infection Disease Unit processes. PES transport single patients only. PTS transport maximum of two patients at any time as per guidance. Procedure in place	a) Reliant on correct information being passed to team and approval by partner organisations	a) Local issues addressed at sources. IRF system in place for reporting of issues.
7.2 **Areas used to**	a) Ambulances compliant with guidance regarding environmental requirements i.e.	No gaps identified	Not applicable

cohort patients with possible or confirmed COVID 19 are compliant with the environmental requirements set out in the current PHE national guidance	closed bulk head/ cleaning regimes		
7.3 Patients with resistant/ alert organism are managed according to local IPC guidance, including ensuring appropriate patient placement	a) Standard IPC policies and procedures in place for all patients	a) Not always aware of IPC status of patient if patient or caller does not disclose	a) CSP continue to receive incident reports on lack of information and address issues where required

7. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
8.1 Testing is undertaken by competent and trained individuals	a)NWAS does not test patients for infectious diseases this is carried out by local healthcare providers	Not applicable	Not applicable

8.2 Patient and staff COVID 19 testing is undertaken promptly and in line with PHE and other national guidance	a) Staff testing for COVID 19 is carried out by the national and local testing centres	a) No MOU agreement exists for NWAS staff tested at local test centres	a) No mitigation currently in place. Captured on IPC BAF action log.
8.3 Screening for other potential infections takes place	a) Occupational health contract available to advise all staff with suspected infectious disease	Risk that staff may be exposed to infectious disease and require treatment do not go through occupational health	RIDDOR reporting of occupational exposure to COVID 19 or other communicable disease

8. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms	a) NWAS policies and procedures in place & updated for all IPC practices and communicable disease management.	a) No evidence of staff reviewing and understanding changes to policy and procedure	a) communication team Communications are currently in discussion with an external provider (Granicus) to explore the possibility of an email communications platform that allows for 'open' and 'read' rates. SPTL observational contact shifts assess staffs understanding of policies and procedures Contact centre audits in place to

	b) Training annually as part of mandatory training programme delivered and monitored by Education department in conjunction with advice and support from the Clinical Safety team. c) Clinical Safety practitioners attend L2 and L3 meetings; sector quality visits and support tier 3 audit feedback d) Local risk assessments for social distancing in place across all sites	b) Paused mandatory training due to COVID 19 pandemic and Increased REAP level c) Workload of Clinical Safety Practitioners is unmanageable and requires capacity / demand review d) Staff side, IPC and H&S representation at every assessment is not possible.	identify issues. b) PPE donning & Doffing module completed as a mandatory requirement. Mandatory training has restarted for all groups, with PES due to recommence in August 2020 Recovery plan for all directorates for mandatory training is in place and reported to the Resources Committee. Operation outstanding focusing on regulatory compliance and mandatory training c) Practitioners attend where possible and there is regular communication between area leads in relation to IPC issues d) Safety Management Group oversight and H&S review of services (Operation Outstanding)
9.2 **Any changes to the PHE national guidance on PPE are quickly identified and effectively**	a) National Ambulance Coordinating centre (NACC) cascade PHE guidance to commanders daily QGARD IPC subgroup cascade PHE updates to IPC leads IPC team act as a central coordination /	a) The interval between guidance changes and dissemination is lengthened by frequency of issue (by PHE) and lack of senior IPC personnel.	a) CS team work office hours, any additional information coming out of hours is identified and actioned through the ROCC and on call command structure. Limited mitigation currently in

communicated to staff	dissemination (in hours) & strategic command coordinate (out of hours) b) Bulletins and guidance are issued via the green room (on line), trust communications and reinforced on strategic calls and/ or via staff side		place. Captured on IPC BAF action log.
9.3 **All clinical waste related to confirmed or possible COVID 19 cases is handled, stored and managed in accordance with national guidance**	a) Clinical waste guidance in standard operating procedures for dealing with COVID 19 waste.	a) Sector quality visit programme suspended due to COVID 19 so no level 3 assurance	a) Operation Outstanding QAV restarted in July 2020
9.4 **PPE Stock is appropriately stored and accessible to staff who require it**	a) Push stock delivered to a central location and issued to 3 main PPE stores (GM, C&L, C&M) for distribution. In addition stocks sent to EOC's and corporate sites. Monitored daily by ROCC	a) Limited visibility of expected "Push" stock of FFP3 masks requires availability/access to fit testing provision across the Trust.	a) Respiratory Protective Equipment management group and RPE leads in each area Mutual aid moving FFP3 masks between Trusts has taken place. From the start of the pandemic Procurement worked to source appropriate PPE wherever possible from commercial suppliers in order to supplement the bulk PUSH deliveries. The Transport Depot was mobilised into a secure Store with 24/7 cover to accept deliveries at any time.

			PPE was not held centrally; as soon as it arrived it was split and issued to the 3 sites ASAP to ensure it was available to frontline staff. Collaboration with GM PPE Sourcing Team provided us temporary access to storage with GM Fire. When required escalation is raised with National Supply Disruption Response (NSDR).
	b) Stock levels monitored locally and reported to PPE hub(s) procurement daily as part of the escalation and response systems in place for mutual aid between areas/ service lines JOT Form daily stock submitted by stations and used to report Regionally and Nationally to the NHS to inform "push" stock requirements. Escalated to ROCC if issues requiring escalation. c) Mutual aid agreements with NHS ambulance and GM providers d) H&S and IPC specialist advice on quality and storage of materials creation of the Safety Equipment Cell to support product decision making for alternatives and any donations.	b) The move to the dedicated "push" channel for PPE created concerns and anxiety amongst staff, particularly as standard PPE items were no longer available e.g. aprons with sleeves and alternatives were being push to us. No gaps identified No gaps identified	b) Daily audit if all staff are present at high risk incidents where AGP's are carried out to highlight immediate actions for PPE stocks and staff safety Not applicable Not applicable

9. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
10.1 Staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported	a) Risk assessments for at risk staff completed (including staff who are vulnerable and shielding and BAME staff)	a) Review may not be completed on time due to social distancing and increased home working	a) Oversight from senior HR management, staff welfare cell and reporting to NHSI regional team
10.2 Staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance	FFP3 reusable half masks are only used by HART staff. HART staff are trained re usage and maintenance. Respiratory hoods are being introduced into NWAS. Guidance with regards to usage and maintenance of masks is provided RPE training as part of E learning package on My ESR.	No gaps identified	Not applicable
10.3 Consistency in staff allocation is maintained, with reductions in the movement of staff	Not applicable	Not applicable	Not applicable

between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance			
10.4 **All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a face mask and in non-clinical areas**	a) Social distancing risk assessments completed on all sites b) Temporary signage in place in all settings c) Good practice guidance issued to all stations and non-clinical areas and available on the trust intranet. Working Safely document in place d) Middlebrook have re-assessed kitchen facilities with support of facilities management and installed social distancing measures – with a suggested option for use of meeting rooms downstairs. The use of	No gaps identified b) Full NWAS social distancing site kits (posters, signage, floor signs) tested at 3 sites only c) Compliance is reliant on implementation by local management teams d) Compliance is reliant on implementation by local management teams.	No gaps identified b) Estates working group leading procurement / Operation outstanding focus on social distancing Roll out via plan led by Head of Estates and Facilities c) Quality Assurance Visits have restarted from July 1st 2020 d) Communications will be issued called ` Continued Covid-19 safety measures - the little things make a big difference' to 111 colleagues to explain the

	kitchen facilities and seating areas will continue to be monitored by operational management on duty over the weekend.		IPC measures in place and asking for colleagues' support in continuing to ensure we are working safely during Covid-19 in 111 contact centres . Due for issue 10/07/20 – awaiting approval.
10.5 Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	a) Working safely guidance issued for all sites includes advice re: meal breaks / dining - i.e. staggering breaks at contact centres	a) Compliance is reliant on implementation by local management teams.	a) Quality Assurance Visits have restarted from July 1st 2020
10.6 Staff absence and well -being are monitored and staff who are self-isolating are supported and able to access testing	a) Welfare team in place to monitor staff absence and provide advice and support b) GRS reporting on a daily basis to HR Teams to ensure that welfare calls are undertaken. c) All contact with staff is recorded on the GRS system. d) Staff provided with a range of information and support / counselling services available to staff. e) No detriment to staff who are self-isolating in terms of pay and conditions, normal sickness triggers not applied.	a) The return to BAU requires resources to be identified to support staff who are abstracted with COVID 19, test track and trace and staff welfare b) Testing encouraged but no ability to enforce refusers - consequences with pay/contract	a) Data collection system is in development for tracking COVID 19 cases as part of the Trust Test and Trace cell. b) Supported by local managers and welfare checks in place encouraging staff testing.

10.7 **Staff who test positive have adequate information and support to aid their recovery and return to work**	a) Guidance exists on the green room for staff who test positive for COVID 19 (self-isolation) All contact with staff is recorded on the GRS system. Staff provided with a range of information and support / counselling services available to staff. No detriment to staff who are self-isolating in terms of pay and conditions, normal sickness triggers not applied. Welfare & checks remains the overall responsibility of the line manager the staff welfare cell will support any health and well-being issues supported by Occupational health	a) Reliant on the national testing system and there could potentially be delays in identifying positive staff and commencement of TTT	a) Establishment of an in house TTT service with supporting welfare is now underway. Approval of longer term plan for TTT agreed. Sickness reporting centralised via Carlisle support centre

Appendix 2 – IPC BAF Evidence

North West Ambulance Service
Infection Prevention and Control Assurance Framework – Covid-19
Evidence Log

Key Lines of Enquiry	Evidence/ Reference
1.1 Risk assessed front door	1.1 MPDS protocol 36 bulletin https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV037-030420-MPDS-Protocol-36.pdf 1.1 Regular bulletins to update case definition i.e. CL772 https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CI772-Coronavirus-COVID-19-case-definition-130320.pdf
1.2 Patients not moved unless essential	1.2 as above 1.2 Hart transfers – C|V013 https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV013-230320-confirmed-case-transfers-1.pdf
1.3 Discharge & Transfer	1.3 Discharge and Transfer of Patients Staff Bulletin : CV051 (Staff Bulletin) – Non-emergency transport of suspected or positive COVID-19 patients (15 April 2020) 1.3 CV026 PTS discharge https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV026-300320-PTS-discharge-coordination-hub-.pdf
1.4 All staff trained in PPE & Access to PPE	1.4.1. CV048 (Staff Bulletin) – PPE Updated Guidance (13 April 2020) 1.4 .1 CV051 (Staff Bulletin) – Non-emergency transport of suspected or positive COVID-19 patients (15 April 2020)

	1.4 .1 CV072 (Staff Bulletin) – COVID-19: PPE (30 April 2020) 1.4.1 PPE guidance for Volunteers:  Volunteer ppe procedure.docx 1.4 .1: CV071 (Staff Bulletin) – Level 3 PPE: Clinical grade labels (29 April 2020) 1.4.2 Donning and Doffing Procedure: https://greenroom.nwas.nhs.uk/library/ipc-dressing-and-undressing-procedure-2/ 1.4 FFP3 face mask testing https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV069-240420-FFP3-face-mask-fit-testing.pdf 1.4.1 PPE E-learning https://greenroom.nwas.nhs.uk/bulletins_briefings/cv065-ppe-e-learning-programme/ 1.4.7 Command cell update (PPE distribution) Email example  01.07.2020 CV19 Strategic Commander
1.5 National Guidance regularly checked.	1.5 Access to greenroom and all national guidance :https://greenroom.nwas.nhs.uk/resources/coronavirus-covid-19/ 1.5 All guidance based on national ambulance https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts
1.6 Risks reflected in risk register	1.6.1 Datix Risk Register: http://datixweb.northwestambulance.nhs.uk/Datix/live/index.php?action=dashboard

	1.6.2 Covid Risk Register COVID19 RR 270520.pdf 1.6.2 NWAS Risk Covid risk assessment 30/1/2020: Risk Assessment - WN COV v0.1.docx
1.7 Risk assessment process	1.7.2 Risk assessment for stations: Covid 19 specific Risk Assessment - Final V1
2.1 Designated teams to care for and treat Covid patients	2.1 Staff trained in IPC guidance: Example on PPE E-Learning - Staff Bulletin on E-Learning: CV065 2.1.1 PPE training on NWAS Learning Zone 2.1.1 Infection Prevention Procedures PPE section : https://greenroom.nwas.nhs.uk/content/uploads/2019/07/Infection-Prevention-Control-Procedures-V7.1-July-2019.pdf 2.1.2 Access to green room – all information up to date on here :https://greenroom.nwas.nhs.uk/resources/coronavirus-covid-19/
2.2 Designated cleaning team	2.2.1 Cleaning Guidance for Staff in national guidance https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts 2.2.2 Emergency Department Cleaning Standard Operating Procedure

	COVID ED cleaning SOP v1.4.pdf
2.3 Decontamination and terminal decontamination deep clean	2.3.2 Deep cleaning https://greenroom.nwas.nhs.uk/bulletins_briefings/cv004-deep-cleaning/ 2.3.3 Outbreak action plan –For stations 01.07.2020 CV19 Strategic Commander
2.4 Increased Frequency of cleaning	2.4.1. Vehicle Cleaning - CV074 (Staff Bulletin) – ED Vehicle Cleaning Support (30 April 2020) 2.4.1 Vehicle Cleaning - CV078 (Staff Bulletin) – Vehicle Cleaning (6 May 2020) 2,4,1 Vehicle cleaning PTS https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV021-260320-PTS-vehicles.pdf 2.4.2 Vehicle Cleaning (AGP) - CI769 (Clinical Information) – COVID-19 and cleaning of vehicles (13 March 2020) 2.4.2 Vehicle Cleaning (AGP) : CV004 (Staff Bulletin) – COVID-19: Deep Cleaning (19 March 2020) 2.4.2 Pod Decontamination Pod decontamination Final v1.1.docx
2.5 Attention to high use areas	2.5.1 Contact Centre Guidance

	 Contact Centre IPC Guidance (3) (3).doc 2.5.1 Contact Centre Audit  Control Centre IPC Audits Report - 26.04 2.5.1 Guidance for 111 https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV068-240420-Infection-prevention-and-control-–-update-for-111-contact-centres.pdf
2.6 Cleaning with Detergent and disinfectant (chorine)	2.6.2 Cleaning guidance –section 7 https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts 2.6.2 NWAS FAQ bulletin CI766 https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CI766-COVID-19-FAQs-110320.pdf 2.6.3 Chlorine Guidance – as above
2.7 Following manufacturers guidance	2.7. As above
2.8 Frequent touch point cleaning	2.8.1 – Cleaning after each patient https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts

	2.8.2 – non clinical area guidance https://greenroom.nwas.nhs.uk/library/working-safely-during-covid-19-in-ambulance-service-non-clinical-areas/ 2.8.2 CV049 NWAS workstation cleaning bulletin https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV049-130420-Workstations-IPC-guidance.pdf
2.9 Electronic Equipment Cleaning	2.9.1 As above in 2.8.2
2.10 Removal of PPE room decontamination	2.10 hospital PPE removal – section 6 https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts
2.11 Linen management	2.11.1 Linen Policy 2.11.2 – Infectious Disease Uniform bag – Covid Bulletin CV048 https://greenroom.nwas.nhs.uk/content/uploads/2020/05/CV084-150520-Uniforms-guidance-and-support.pdf
2.12 Single use items policy	2.12.2 Single use items: Infection Prevention Procedures 2.12.2 PPE Guidance: CV048 (Staff Bulletin) – PPE Updated Guidance(13 April 2020)
2.13 Reusable Equipment Decontamination	2.13– Guidance on reusable masks  3M Reusable half face masks May 202(2.13 – Cleaning and Disinfecting guidance for half masks

	
2.14 -ventilation	Not applicable
3. Antimicrobial stewardship	Not applicable
4.1 Visitors and escorts	4.1.1 Guidance on escorts https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV003-190320-Clincal-FAQs.pdf https://greenroom.nwas.nhs.uk/bulletins_briefings/cv027-latest-faqs/
4.2 Clearly identified areas for treatment of Covid19 patients	4.2 Handover at hospitals staff awareness – section 5 https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts
4.3 Information and guidance on trust websites	4.3.3 ref to Government websites https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts 4.3.3 Access to Information : COVID-19 Green Room Page
4.4 Information status communicated to hospitals	4.4 Pre alert message for Covid19 in cardiac arrest https://greenroom.nwas.nhs.uk/content/uploads/2020/06/C1795-Cardiac-Arrest-and-Pre-alert-update.pdf 4.4 Pre-alert at hospitals https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV003-190320-Clincal-FAQs.pdf
5.1 Front door ‘triaging’	5.1 MPDS protocol 36 bulletin https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV037-030420-MPDS-Protocol-36.pdf

	5.1 Regular bulletins to update case definition i.e. CL772 https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CI772-Coronavirus-COVID-19-case-definition-130320.pdf
5.2 Mask usage for patients	5.2 Mask usage for patients: Bulletin CV048 https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV048-120420-PPE-updated-guidance.pdf
5.3 Public facing segregation to protect staff	5.3 Social distancing and screens – non clinical area guidance https://greenroom.nwas.nhs.uk/content/uploads/2020/06/Working-safely-during-COVID-19-16th-June-2020-v2.0-002.pdf
5.4 Isolation and instigation of contact tracing for patients	No gaps identified – not applicable
5.5 Patient Testing	Not applicable
5.6 Patient contact tracing	Not applicable
5.7 Routine patients managed appropriately	5.7 All patients treated as if they have Covid 19 – Bulletin https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV048-120420-PPE-updated-guidance.pdf
6.1 Training on Personal safety and work environment	6.1 Access to Information : COVID-19 Green Room Page 6.1 PPE E-Learning guidance (My ESR) Title: 242 NWAS Clinical COVID 19- PPE 1.3 6.1 Staff Bulletin on E learning: Staff Bulletin on E-Learning: CV065 6.1.2 Risk assessments for areas https://greenroom.nwas.nhs.uk/library/covid-19-risk-assessment/
6.2 Donning and Doffing of PPE	6.2 As above

6.3 Staff training records	6.3. MT training records – My ESR for PPE https://greenroom.nwas.nhs.uk/bulletins_briefings/cv065-ppe-e-learning-programme/
6.4 Reuse of PPE	6.4 Reuse and cleaning of goggles bulletin : https://greenroom.nwas.nhs.uk/bulletins-and-briefings/?filter_keyword=coronavirus&bulletin_category=0&bulletin_year=0&sort_filter=updated&page_no=4
6.5 Reuse off PPE - Incidents	6.5 FAQ for IRF https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV003-190320-Clincal-FAQs.pdf
6.6 Adherence to PPE -audit	6.6. Adherence to AGP – Follow up https://greenroom.nwas.nhs.uk/content/uploads/2020/05/CV087-220520-AGP-audit.pdf 6.6 Covid Bulletin CV072 – se of own PPE https://greenroom.nwas.nhs.uk/content/uploads/2020/04/CV072-300420-Self-purchased-donated-PPE-004-3.pdf 6.6 IPC report PPE IRF S:\Medical\Clinical Safety\Clinical Safety Team Reports\ELC Reports\ELC Analysis COVID-19 Related Incidents May 2020.docx
6.7 Hand hygiene and IPC standards	6.7 HH information for staff Bulletin CV089 https://greenroom.nwas.nhs.uk/content/uploads/2020/05/CV089-270520-Hand-hygiene-1.pdf 6.7 Hand Hygiene Audit Data May 2020  Hand hygiene audits (Jun 2019-May 2020).

6.8 Hand dryers/ paper towels	6.8 Removal of hand dryers/ paper towels – guidance page 25 https://greenroom.nwas.nhs.uk/content/uploads/2020/06/Working-safely-during-COVID-19-16th-June-2020-v2.0-002.pdf
6.9 Hand hygiene posters	6.9 Hand hygiene posters distributed as part of working safely plan and Intranet guidance https://greenroom.nwas.nhs.uk/content/uploads/2020/05/CV089-270520-Hand-hygiene-1.pdf
6.10 Uniform laundering	6.10 uniform guidance CV064 (Staff Bulletin) – Uniforms: Infection Prevention and Control Cleaning Quick Reference Guide (21 April 2020)  Risk Assessment for Laundering uniform 2 Dress code Policy: https://greenroom.nwas.nhs.uk/content/uploads/2019/07/Dress-Code-Policy-Dec-20.pdf IPC Procedures (section 6 Uniform): https://greenroom.nwas.nhs.uk/content/uploads/2019/07/Infection-Prevention-Control-Procedures-V7.1-July-2019.pdf CL770 FAQ – Uniform question https://greenroom.nwas.nhs.uk/bulletins_briefings/ci770-latest-faqs-on-coronavirus-covid-19/?swpmtx=47a5dfa1703ccc725ff8cfe770c836ae&swpmtxnonce=e7b02d8b38 CV084- uniform Guidance bulletin https://greenroom.nwas.nhs.uk/bulletins_briefings/cv084-uniforms-guidance-and-support/?swpmtx=b4b2fb5b846212f7fdeff439f67f3745&swpmtxnonce=4653f54cf1
6.11 Staff action if symptomatic	6.11 C1771 clinical bulletin CI771 (Clinical Information): COVID-19 Case definition

	6.11 CV050 Covid guidance for staff https://greenroom.nwas.nhs.uk/bulletins_briefings/cv050-covid-19-staff-and-family-testing-arrangements/
7.1Patients isolated in appropriate facilities	7.1 Transfer of patients ; Covid-19-hart-transfers-of-confirmed-cases 7.1 pathway guidance : Pathway guidance for Covid:  EOC0070a - Coronavirus (COVID- 7.1 EOC confirmed and suspected COVID-19 PTS Discharge coordination 7.1 Covid divert and deflection. North West Divert & Deflection Policy CV013: COVID-19 Transfers of confirmed cases (23 March 2020) 7.1 PTS social distancing CV017 https://greenroom.nwas.nhs.uk/bulletins_briefings/cv017-social-distancing-on-pts-vehicles/
7.2 Covid area environmental compliancy	Closed bulkhead cleaning – national guidance document section 5.1 https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts
7.3 Patients IPC status management	7.3 IPC Policy : Iinfection Prevention and Control Policy https://greenroom.nwas.nhs.uk/library/infection-prevention-control-policy/ 7.3 IPC Procedures : Infection prevention and control procedures https://greenroom.nwas.nhs.uk/content/uploads/2019/07/Infection-Prevention-Control-Procedures-V7.1-July-2019.pdf 7.2 Communicable Disease Policy : Communicable disease policy https://greenroom.nwas.nhs.uk/content/uploads/2019/07/Communicable-Diseases-Policy-v4.1-FINAL.pdf

8.1 Laboratory report testing	Not applicable
8.2 Staff Covid19 testing	8.2 Swabbing Procedure and Community testing : Drive through Swabbing Procedure Community Testing SOP 8.2 staff testing bulletin CV075 – COVID-19 Staff Testing (1 May 2020)# 8.2 Examples of antibody testing for staff: https://greenroom.nwas.nhs.uk/bulletins_briefings/cv113-antibody-testing-at-liverpool-university-hospitals/ https://greenroom.nwas.nhs.uk/bulletins_briefings/cv109-antibody-testing-process-greater-manchester/
8.3 Screening for other infections	8.3 Occupational health support- IPC procedures and Communicable disease policy – see 9.1.1
9.1 Staff support in IPC policies and Procedures	9.1.1 IPC Policy : Iinfection Prevention and Control Policy https://greenroom.nwas.nhs.uk/library/infection-prevention-control-policy/ 9.1 .1 IPC Procedures : Infection prevention and control procedures https://greenroom.nwas.nhs.uk/content/uploads/2019/07/Infection-Prevention-Control-Procedures-V7.1-July-2019.pdf 9.1 .1 Communicable Disease Policy : Communicable disease policy https://greenroom.nwas.nhs.uk/content/uploads/2019/07/Communicable-Diseases-Policy-v4.1-FINAL.pdf
9.2 Changes on national guidance effectively communicated	9.2 all latest information on greenroom :https://greenroom.nwas.nhs.uk/resources/coronavirus-covid-19/
9.3	9.3 NWAS Waste Policy

Clinical waste management	https://greenroom.nwas.nhs.uk/library/waste-management-policy/ 9.3 Clinical Waste CollectionCV020 https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV020-260320-Clinical-waste.pdf
9.4 PPE stock storage and monitoring	9.4 IRF for PPE issues – Bulletin FAQ https://greenroom.nwas.nhs.uk/content/uploads/2020/03/CV003-190320-Clincal-FAQs.pdf 9.4 Command cell update (PPE distribution) Email example  01.07.2020 CV19 Strategic Commander
10.1 Staff at risk groups managed and supported.	10.1 risk assessments for risk groups.  Risk Stratification Document NWAS  Risk discussion pro-forma - Covid19. 10.1 At risk group information https://greenroom.nwas.nhs.uk/bulletins_briefings/cv112-phe-england-report-on-bame-communities-and-covid-19/ 10.1 Guidance on shielding https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19 10.1 Wellbeing and support Health and Wellbeing: COVID-19 Greenroom Page

	https://www.collegeofparamedics.co.uk/COP/News/Covid-19/Guidance_for_managers_psychosocial_support_and_mental_wellbeing_of_ambulance_personnel_in_a_pandemic.aspx
10.2 Reusable FFP3 mask training	10.2 RPE FAQ CV101 https://greenroom.nwas.nhs.uk/bulletins_briefings/cv101-sundstrom-respiratory-kit-faqs/ 10.2 Reusable mask SOP  3M Reusable half face masks May 202(10.2. MT training records – My ESR for PPE https://greenroom.nwas.nhs.uk/bulletins_briefings/cv065-ppe-e-learning-programme/
10.3 Staff allocation	Not applicable
10.4 Social distancing and wearing of face masks	10.4.1 Risk assessments of sites –bulletin CV103 https://greenroom.nwas.nhs.uk/content/uploads/2020/06/CV103-160620-NWAS-working-safely-during-COVID-19.pdf 10.4.1 Risk assessment https://greenroom.nwas.nhs.uk/library/covid-19-risk-assessment/ 10.4.2 Signage https://greenroom.nwas.nhs.uk/library/working-safely-during-covid-19-in-ambulance-service-non-clinical-areas/ 10.4.3 Working safely documentation – stations/ contact centres and non-clinical areas. (as above in 10.4.2)

	 Station Infection Prevention & Contrc 10.4.3 safe working information: https://greenroom.nwas.nhs.uk/content/uploads/2020/06/CV110-240620-Further-guidance-on-safe-working-during-COVID.pdf 10.4.3 FAQ on masks. https://greenroom.nwas.nhs.uk/content/uploads/2020/06/CV111-240620-FAQs-on-wearing-masks-as-part-of-safe-working-during-COVID.pdf 10.4.3 Social Distancing Guidance bulletin CV086 https://greenroom.nwas.nhs.uk/content/uploads/2020/05/CV086-210520-Guidance-on-social-distancing.pdf
10.5 Staggering breaks	10.5 Working safely document page 18. https://greenroom.nwas.nhs.uk/content/uploads/2020/06/Working-safely-during-COVID-19-16th-June-2020-v2.0-002.pdf
10.6 Staff absence and access to testing	10.6 Staff testing bulletin: CV075 – COVID-19 Staff Testing (1 May 2020) 10.6 Absence support https://greenroom.nwas.nhs.uk/about-us/invest-in-yourself/your-health-and-wellbeing-covid-19/ 10.6 Track and Trace bulletin CV102 https://greenroom.nwas.nhs.uk/bulletins_briefings/covid-19-track-and-trace/
10.7 Staff testing positive – information and support	10.7 Self isolation guidance green room –blog https://publichealthmatters.blog.gov.uk/2020/02/20/what-is-self-isolation-and-why-is-it-important/ 10.7 CV099 – Accommodation for self-isolation https://greenroom.nwas.nhs.uk/bulletins_briefings/cv099-covid-accommodation-update-faqs/

	10.7 FAQ on staff testing and support https://greenroom.nwas.nhs.uk/content/uploads/2020/05/CV085-190520-Staff-FAQs.pdf

Appendix 3 – Risk Mitigation Log

North West Ambulance Service
Infection Prevention and Control Assurance Framework – COVID19-19
Risk Mitigation Log

Key Lines of Enquiry	Risk Mitigation Action	Risk	Risk Score
1.1 Risk assessed front door	1.1 General IPC status needs to be added to all calls for all service lines (Head of EOC, 111) if not already in place.	3326 – workforce exposure to COVID19	10
1.2 Patients not moved unless essential	1.2 COVID19 19 dashboard to be completed by informatics to include H&T and S&T rates (Informatics)	As above 3327- pressure within the IT system 3290 – potential downgrading of 999 calls	10 12 12
1.3 Discharge & Transfer	1.3 Monitoring by incident reporting (internal and external). No level 2 or 3 assurance - Still gathering information on policy breaches	3299 Risk of delay in IRF reporting.	6
1.4	1.4 IPC & learning and development working together to review	2714	6

All staff trained in PPE & Access to PPE	mandatory training, Simulation training required to determine future provision. (CN/L&D)	Lack of Fit testing training 2715 –not adhering to PPE 3219 exposure to staff due to lack of PPE 3275 – timely availability of PPE	 12 3 8
1.5 National Guidance regularly checked.	1.5 Temporary IPC support contracted during COVID19 19 pandemic now ceased - Review of IPC infrastructure required to deliver safe & timely service. (CN) Risks are collated from incidents and reported to the IPC forum and safety management group / Quality committee. (CN/HOCS) Guidance dependent on timely updates	3246 Lack of out of hours support 2716 Insufficient audits and IPC support 3350 – potential communication delays	9 12 12
1.6 Risks reflected in risk register	1.6.1 - Robust monitoring of risks? Operations and Corporate joint working well through TCG/SCG – reduction in operation may increase risk monitoring. Senior Risk & Assurance Manager on TCG/SCG Risks discussed at ELC. Assurance framework risk may need adding to risk register (HOCS/RM)	2716 Insufficient audits and IPC support	12

1.7 Risk assessment process	1.7 IPC audit data needs to be included in the work plan (roadmap) for Safe-checks (CN/HODI) Safe-checks data report needs to be developed to enable daily compliance.(CN/HODI)	2716 Insufficient audits and IPC support	12
2.1 Designated teams to care for and treat COVID19 patients	2.1.1 IRF procedure in place for reporting of incidents related to care of COVID19 patients (IPC team & operational managers) 2.1.1 Complaints monitoring would identify any patient issues. (patient experience team) 2.1.3 Review the central records system within JRCALC, ESR & Green room to devise a system for recording views & understanding (HR & Communications & Medical Directorate)	3299 Risk of delay in IRF reporting. 3298 – delay in complaints handling	6 12
2.2 Designated cleaning team	2.2.1 restart MT at reap 3 and monitor through HR recovery cell (HR and Operations) 2.2.2 reporting structure to be developed to ensure visibility at corporate level - (CN & HOFE) 2.2.3 as above 2.2.4 IPC structure capacity review (CN)	3276 – availability of cleaning products 3337 – unsuitable long term solution to cleaning sites 2716 Insufficient audits and IPC support	4 16 12
2.3	2.3.3. To include enhanced cleaning in review of all 3rd party providers as	3337 unsuitable	16

Decontamination and terminal decontamination deep clean	part of standard proforma (PTS & IPC)	long term solution for cleaning sites 3309 – access of PPE for 3rd party providers	 3
2.4 Increased Frequency of cleaning	2.4 To include enhanced cleaning in review of all 3rd party providers as part of standard proforma (PTS & IPC)	As above 3219 – access to PPE and cleaning products 3196-PTS non-compliance of standards 3275 – timely availability of cleaning products	3 3 3 8
2.5 Attention to high use areas	2.5.1 Head of Facilities to review all cleaning regimes across estate. 2.5.1 Clinical Safety Practitioners auditing EOC/111 contact centres every two weeks	2716 Insufficient audits and IPC support 3356 – lack of consistency across sites	12 10
2.6 Cleaning with Detergent and disinfectant (Chlorine)	2.6 No gaps identified.	NA	NA

2.7 Following manufacturers guidance	2.7.1 IRF system –potential to identify any issues or breaches	3299 Risk of delay in IRF reporting	6
2.8 Frequent touch point cleaning	2.8.1 Implementation of observational audits to demonstrate compliance by SPTL. 2.8.1 Senior leadership walk rounds	2716 Insufficient audits and IPC support 3219 – exposure of staff from lack of PPE and cleaning	12 3
2.9 Electronic Equipment Cleaning	2.9.1 Trust 'working group' established to audit and monitor adherence to guidance and signs. 2.9 Senior leadership walk rounds	As above 3341 – none adherence to social distancing	9
2.10 Removal of PPE room decontamination (hospitals)	2.10.1 Operational managers to ensure there are clear guidelines for staff on each hospital site and shared on green room to be accessed by EOC dispatchers (Director of Operations & Head of EOC's)	3299 Risk of delay in IRF reporting 3356 – lack of consistency across sites	6 15
2.11 Linen management	2.11.1 Operational managers to ensure there are clear guidelines for staff on each hospital site for linen disposal and shared on green room to be accessed by EOC dispatchers (Director of Operations & Head of EOC's)	2715 Non adherence to IPC standards 3356 – lack of consistency	12 10

		across sites	
2.12 Single use items policy	2.12.1 Push stock through procurement- swap shop in place from other trusts if necessary. 2.12 numbers monitored as part of procurement cell.	3299 Risk of delay in IRF reporting 3275 – timely availability of PPE 3322 – quality of push stock 3233 – risk of tiger eye goggles 3257 – risk of reuse of PPE	6 8 4 12 6 closed
2.13 Reusable Equipment Decontamination	2.13.1 Implementation of observational audits to demonstrate compliance by SPTL.	As above	6
2.14 ventilation	Not Applicable	NA	NA
3. Antimicrobial stewardship	No gaps identified	NA	NA
4.1 Visitors and escorts	4.1No specific information with regards to this available on NWAS public website. 4.1.1 Communication team to liaise with PES and PTS to include this. (HOC)	3350 –potential communication delays	12
4.2	4.2.1 Operational managers to ensure there are clear guidelines for staff	2715 – non	12

Clearly identified areas for treatment of COVID1919 patients	on each hospital site and shared on green room to be accessed by EOC dispatchers (Director of Operations & Head of EOC's)	adherence to IPC standards 3219 –Exposure of staff to COVID19 from lack of PPE & Cleaning products	 3
4.3 Information and guidance on trust websites	Procurement team to explore procurement of clear face masks. Communication team to ensure the key messages and information required is shared on NWAS website and/or in other formats in an accessible way.	3275 – timely availability of PPE 3350 – potential communication delays	8 12
4.4 Information status communicated to hospitals	IRF process in place if notification process is not followed or communicated.	3299 delayed IRF reporting 3219 –Exposure of staff to COVID19 from lack of PPE & Cleaning products	6 3
5.1 Front door 'triaging'	No gap identified	NA	NA
5.2 Mask usage for patients	5.2.1 Information for the public is available on the PHE and government websites and part of public campaigns IRF process in place to monitor any issues Leadership walk rounds/ staff forum to ask questions of staff re: compliance	3299 delayed IRF reporting 3219 –Exposure of staff to COVID19 from lack of PPE &	6 3

		Cleaning products 3275 – timely availability of PPE 3350 – potential communication delays	 8 12
5.3 Public facing segregation to protect staff	5.3 Monitoring/audit system to be implemented (Operational Managers/ Facilities)	2715 Non adherence to IPC standards 3356 – lack of consistency across sites	12 10
5.4 Isolation and instigation of contact tracing for patients	No Gaps identified	NA	NA
5.5 Patient Testing	No Gaps identified	NA	NA
5.6 Patient contact tracing	No Gaps identified	NA	NA
5.7 Routine patients managed appropriately	5.7 Auditing of staff adherence to PPE as part of management supervision (HOS)	2715 Non adherence to IPC standards	12

		3219 –Exposure of staff to COVID19 from lack of PPE & Cleaning products	3
6.1 Training on Personal safety and work environment	6.1.1 Learning and Development Department monitor training records monthly. Compliance reported in IPR and monitored via Q&P Recovery plan for all directorates for mandatory training overseen by HR recovery cell 6.1.2 Guidance published on the green room re: processes to reduce risks. These include temperature checking upon entry to buildings. Face masks to be readily available Reporting Structure to be implemented and monitored via Operation Outstanding and Compliance unit.	3315 – cessation of MT 3314-staff returning to roles not MT compliant 3243 – lack of social distancing 3341 none adherence to working safely guidance	12 8 12 9
6.2 Donning and Doffing of PPE	6.2.1 Clinical supervision is provided via SPTL observation shifts Sign off/ recording process to evidence staff receipt of information To be implemented (L&D) 6.2.2 L&D/ Chief Nurse to ensure records are reconciled 6.2.3To be included in Clinical Safety Practitioners audit cycle	2715 non adherence to PPE 2716 Insufficient audits and IPC support	12 12
6.3 Staff training records	6.3.1 On agenda to be managed through RPE meetings scheduled monthly from 9th July	3306 – Fit testing assurance	9

	6.3.2 To be implemented (Chief Nurse/L&D)	3305 – not adhering to BSI standards	9
6.4 Reuse of PPE	6.4 Senior Clinical Quality manger to ensure revised CAS Alert process approved/ implemented	3257 – reuse of PPE	6 closed
6.5 Reuse off PPE - Incidents	6.5.1 Clear guidance has been issued to support managers to address with individual staff members Director of Operations leading audit of all staff who participate in and AGP	3332 – use of non-agreed PPE 3219 –Exposure of staff to COVID19 from lack of PPE & Cleaning products 3326 – workforce exposure to COVID19 3345 – risk of HSE involvement if RIDDOR not followed	10 3 10 4 closed
6.6 Adherence to PPE -audit	6.6 Clinical supervision is provided via SPTL observation shifts Consultant Paramedics to develop observational IPC/PPE audit to be carried out on a minimum of 10 staff per week and reported to Operation Outstanding	2715 non adherence to PPE	12

	Clarity for managers on management of non-compliance with PPE policy (HR)		
6.7 Hand hygiene and IPC standards	6.7 Covert auditing to be included in Clinical Safety Practitioners audit cycle	2716 insufficient audit and IPC support	12
6.8 Hand dryers/ paper towels	6.8 Facilities/ Estates Leads to source and install dispensers for all areas	3219 –Exposure of staff to COVID19 from lack of PPE & Cleaning products 3326 – workforce exposure to COVID19 3276 availability of cleaning products 3356 – lack of consistency across sites	3 10 4 10
6.9 Hand hygiene posters	6.8 Facilities/ Estates Leads to source and install for all areas	As above	10

6.10 Uniform laundering	6.10.1 Lockers and changing facilities to be included within estate/ refurbishment plans 6.10.1 Procurement of additional uniform for staff to ensure staff have enough to wear a clean set every day 6.10.2 Health and Safety Lead/ Director of Operations to address	3349 – lack of lockers and changing facilities 3346 – lack of uniform 3348 – washing machines on stations	9 9 9
6.11 Staff action if symptomatic	6.11 IRF system in place for staff to raise any concerns	3299 Risk of delay in IRF reporting	6
7.1 Patients isolated in appropriate facilities (hospitals)	7.1.1 Operational managers to ensure there are clear guidelines for staff on each hospital site and shared on green room to be accessed by EOC dispatchers (Director of Operations &Head of EOC)	3356 – lack of consistency across sites 3326 – workforce exposure to COVID19	10 10
7.2 COVID19 area environmental compliancy	7.2 No Gaps identified	NA	NA
7.3 Patients IPC status management	7.3 CSP continue to receive incident reports on lack of information	3299 Risk of delay in IRF reporting 3326 – workforce exposure to	6 10

		COVID19	
8.1 Laboratory report testing	No gaps identified	NA	NA
8.2 Staff COVID1919 testing	8.2 Service level agreements to be drawn up and agreed with local providers (Operations and HR)	3310- demand on Occy Health 3362 sustainability of testing cell	8 6 closed
8.3 Screening for other infections	8.3 RIDDOR reporting of occupational exposure to COVID19 19 or other communicable disease	3345 Potential risk of HSE involvement if RIDDOR not followed	4 closed
9.1Staff support in IPC policies and Procedures	9.1.1 Implementation for recording of evidence required 9.1.2 Recovery plan for all directorates for mandatory training overseen by HR recovery cell Operation outstanding focusing on regulatory compliance and mandatory training 9.1.3 IPC staffing review required (CN) 9.1.4 Safety Management Group oversight & H&S review of services (Operation outstanding)	3315 – cessation of MT 3314-staff returning to roles not MT compliant 2716 insufficient audit and IPC support	12 8 12
9.2 Changes on national guidance effectively communicated	9.2.1 IPC staffing review & IPC management group role and terms of reference	As above 3246 –no ooh support of IPC	9

		3350 – potential communication delays	12
9.3 Clinical waste management	9.3.1 Monitoring of policies. Re-start operation outstanding and SLQV from July 1st 2020	3278 – increase in clinical waste 2715- non adherence to IPC policies	8 12
9.4 PPE stock storage and monitoring	9.4.1 Respiratory Protective Equipment management group and RPE leads in each area needed. 9.4.2 Daily audit if all staff are present at high risk incidents where AGP's are carried out to highlight immediate actions for PPE stocks and staff safety	3322 quality of push stock 3332 –purchase own PPE 3333 – donation off PPE 3323 – risk with tiger eye goggles 3358 – risk with KN95 face masks	4 10 5 closed 3 closed 3 - closed
10.1 Staff at risk groups managed and supported.	10.1 Oversight from senior HR management, staff welfare cell and reporting to NHSI regional team	3339 – detrimental impact on BAME groups	10
10.2 Reusable FFP3 mask	10.2 To be developed and included in Induction and Training	3305 – Fit testing	9

training		accreditation 3306 – assurance for fit testing 3257 – reuse of PPE	 9 6 closed
10.3 Staff allocation	No gaps identified	NA	NA
10.4 Social distancing and wearing of face masks	10.4.1 Re-start SLQV from July 1st 2020 10.4.1 Compliance is reliant on implementation by local management teams. No level 3 assurance process in place due to suspension of SLQV – re-start 1/7/2020	3342 – adherence to SD guidance 3243 Working safely not followed	16 12
10.5 Staggering breaks	10.5. Compliance is reliant on implementation by local management teams 10.5.1 Re-start SLQV from July 1st 2020	As above 3356 – lack of consistency across trust of guidance	12 10
10.6 Staff absence and access to testing	10.6.1 Data collection system needs to be established under executive leadership for tracking COVID19 19 cases TTT steering group to be established urgently	3341 –risk of further outbreaks due to not following guidance 3281 – risk to workforce with self-isolation EOC	9 8

		3283 – risk to workforce with self-isolation - Corporate services 3325 risk to workforce with self-isolation – PES 3280 risk to workforce with self-isolation – 111 3282 – risk to workforce with self-isolation - PTS	8 10 9 8
10.7 Staff testing positive – information and support	10.7.2 All staff need to be supported if they develop COVID19 19 so that support can be offered and TTT commence 10.7.2 Sickness reporting centralised via Carlisle support centre 10.7.2 Establishment of a TTT service with supporting welfare offer needs to be established urgently	3329 – staff burnout 3362 sustainability of Testing cell	10 6 closed

Updated 24/8/2020

Appendix 4 – Action Plan

Covid 19 Infection Prevention and Control BAF Action Plan

KLOE	Evidence Gap	Actions	Lead	Target Completion Date	Update	RAG Status
1.2 Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Specific monitoring of patients with known COVID-19 or infectious diseases are not currently reported as part of the Hear and Treat data.	COVID 19 dashboard to be completed by informatics to include Hear and Treat and See and Treat rates	A Harrison	Dec 20	On-going	
1.5 National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	Lack of senior IPC personnel to process the change.	Review of IPC infrastructure required to deliver safe and timely service	A Hansen	Nov 20	Directorate structure under review. On-going currently in development	
1.8 Robust IPC risk assessment processes and practices are in place for non COVID 19 infections and pathogens	Compliance with IPC policies & procedures monitored via audit locally and via Clinical Safety and H&S team audits	IPC audit data needs to be included in the work plan (roadmap) for Safe-checks Safe-checks data report needs to be developed to	M Dugdale/ D Bullock	Nov 20	Initial discussions had and on safe check development plan	

		enable daily compliance monitoring				
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to stations and premises	Clinical staff are trained in decontamination of vehicles in line with policies and procedures. This is supplemented via mandatory training and information bulletins. Limited auditing of staff between contact shifts and lack of evidence that information has been read and understood	Review the central records system within JRCALC, ESR & Green room to devise a system for recording views & understanding (HR / Communications/ Medical Directorate) – Communications are currently in discussion with an external provider (Granicus) to implement an email communications platform that allows for 'open' and 'read' rates. However this is dependent on our own IT permissions and has been raised at the trust's Digital Design Forum	J Treharne	Oct 20	On-going - in discussions currently	
2.2 Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to stations and premises	Limited resources to undertake timely audits at all hospital sites, stations and vehicles	IPC structure capacity review (Chief Nurse)	A Hansen	Nov 20	Directorate structure under review.	
2.3 Decontamination of premises and vehicles is carried out in line with PHE and other national guidance	No records of enhanced cleaning by 3rd party providers (PTS etc.)	To include enhanced cleaning in review of all 3rd party providers as part of standard proforma (PTS &	D Bullock	Dec 20	To be included on as part of audit schedule – as part of safecheck	

		IPC)			audit plan – still under development	
2.8 Increased frequency of cleaning of Frequently touched surfaces, e.g. Door/toilet handles	Monitoring undertaken daily by local managers but no visibility of evidence available for assurance	Include as part of QAV and leadership walk arounds	N Barnes	Sept 20	QAV process being reviewed	
2.13 Reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	No local or corporate monitoring of local adherence to procedures- presumed competent at sign off of sops and monitored by line manager	Implementation of observational audits to demonstrate compliance by SPTL Clinical Safety Team to amend audit tool to capture this	D Bullock	Sept 20	Currently audit tool being amended for implementation via Safecheck – discuissions at RPE group	
4.1 Implementation of national guidance on visiting patients in a care setting	No specific information with regards to this is available on NWAS public website No specific information on NWAS public website with regards to COVID for patients on how to use our service safely for planned journeys	IPC team to provide communications with information to be included on the website. Information to be included in 'our services' section as well as on dedicated COVID-19 page. Communication team to liaise with PTS service to include this – ongoing to get the correct information. Information to be included in 'our services' section as well as on dedicated COVID-19 page. Also raised via patient	D Bullock J Treharne	Aug 20 Aug 20	Completed Completed	

		engagement is that patients may be concerned about sitting in close proximity to other patients which will also be addressed. ACTION				
5.3 Ideally segregation should be with separate spaces, but there is potential to use screens e.g. To protect reception staff	Awaiting installation date for floor 1 replacement at Middlebrook and PTS Carlisle	To confirm with facilities management	N Maher	Aug 20	On-going monitoring as part of site audits	
5.7 Patients who attend for routine appointments and who display symptoms of COVID 19 are managed appropriately	There may be limited symptomatic patients who may refuse to wear a mask – requirement for staff to understand actions on refusal	Guidance for staff on non-adherence by patients.	C Grant/ G Blezard	Sept 20	On-going	
6.2 All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it	Limited assurance to confirm staff have read and understood up to date information provided in bulletins and other communications. Process to evidence competency assessments not yet in place trust wide.	Sign off/ recording process to evidence staff receipt of information To be implemented To be included in Clinical Safety Practitioners audit cycle 2020	J Treharne D Bullock	Oct 20 Sept 20	On-going discussions In development	
6.3 A record of staff training is maintained	Process in place for fit testing but not fully aligned to ESR for a central ESR record	Development of fit testing policy and procedure	D Bullock	Sept 20	Currently going through approval process.	

	Process to evidence ongoing competency not In place	Develop audit tool and audit schedule			On work plan and process under discussion	
6.6 Adherence to PHE national guidance on the use of PPE is regularly audited	Leadership required from within operations to monitor compliance with PPE policy and procedures on a day to day basis	Consultant Paramedics to develop observational IPC/PPE audit to be carried out on a minimum of XX staff per week and reported to Operation Outstanding Clarity for managers on management of non-compliance with PPE policy (HR)	M Jackson G Blezard	Dec 20 Aug 20	On-going On-going	
6.8 Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hand should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per National guidance	No paper towel dispensers at Middlebrook. Advised that paper towels were not required by facilities management on 08/07/2020 due to changed HM Government guidance & previous incidents of paper towels being used and blocking toilets – this goes against national COVID guidance.	Ensure Paper towel dispensers and waste paper bins are provided at Middlebrook	A El-garidi / J Bell	Sept 20	On-going – requires confirmation of completion	
6.10 Staff understand the	Domestic washing machines	Health and Safety Lead/	G Blezard	Dec 20		

requirements for uniform laundering where this is not provided on site	in use on some stations – non adherence with H&S governance requirements	Director of Operations to address	N Barnes		On-going	
8.2 Patient and staff COVID 19 testing is undertaken promptly and in line with PHE and other national guidance	No MOU exists for NWAS staff tested at local test centres	MOU to be drawn up and agreed with local providers (Operations and HR)	J Furnival L Ward	October 20	On-going	
9.1 Staff are supported in adhering to all IPC policies, including those for other alert organisms	Workload of Clinical Safety Practitioners is unmanageable and requires capacity / demand review Staff side, IPC and H&S representation at every station assessment is not possible.	IPC staffing review required Ensure enough notice is given for visits. Have schedule in place	A Hansen N Barnes	Nov 20 Aug 20	Directorate structure under review. Schedule in place – dependent on notice period given – dates distributed to wider teams	
9.2 Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	The interval between guidance changes and dissemination is lengthened by frequency of issue (by PHE) and lack of senior IPC personnel.	Development of prompt process for bulletin approval	A Hansen/ J Treharne	Sept 20	Ongoing	

Updated 8/9/2020

Blue – Complete	**Red – Delayed**	**Amber – potential to be delayed**	**Green – on track**

This page is intentionally left blank

Chairs Assurance Report

Name of Committee/Group:	Resources Committee	**Report to:**	Board of Directors
Date of Meeting:	25 September 2020	**Quorate (yes/no):**	Yes
Chair:	Mr M O'Connor	**Executive Lead:**	Ms C Wood *Director of Finance* Ms L Ward *Director of People* Prof. M Power *Director of Quality, Innovation and Improvement*
Members present:	Mr M O'Connor; *Chair* Mr D Rawsthorn; *Non-Executive Director* Mr R Groome; *Non-Executive Director* Ms C Wade; *Associate Non-Executive Director (Digital)* Ms C Wood; *Director of Finance* Ms L Ward; *Director of People* Prof. M Power; *Director of Quality, Innovation & Improvement* Mr G Blezard; *Director of Operations* Mr S Desai; *Director of Strategy and Planning*	**Key Members not present:**	
Board Assurance Risks Aligned to Committee:	**SR02** – If we do not have effective financial management, this may impact on the Trusts' financial position **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 **SR05** – If we do not review our estate and flee 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		

	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

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

Key Agenda Items	RAG	Key Points	Action/Decision
Board Assurance Framework		Since the previous Committee; • 2 new risks have emerged; (3372) Absence of professional leadership for midwifery and (3397) Absence of a Patient Safety Specialist • 2 risks have increased in risk score; (2867) Oversight or system issues due to number of high projects linked to critical systems and (3027) Paramedic shortfall due to combined outcome of ORH demand analysis • In total 37 mitigating actions are identified on the BAF risk aligned to the Committee. 23 actions are to be completed for SR01 and 6 for SR03. 11 actions have a target completion during Q3.	Noted and received assurance from the Board Assurance Framework. Gained assurance that each BAF risk was managed effectively.
CQC Action Plan		• Appraisals and safeguarding mandatory training have been impacted by a cessation of activity as a result of COVID-19 • The appraisal compliance target for 2020 has been reviewed and agreed as 85% by March 2021 • 2019/20 mandatory training compliance was met, a drill down in PES identified that safeguarding compliance had not been met • Review of safeguarding training in 2020/21 to be aligned to the revised intercollegiate documents and	Noted and received moderate assurance from the report

	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

		all training this year will cover the required Level 3 Safeguarding outcomes • Mandatory training compliance is on track against the revised delivery trajectory	
Month 5 Financial Report		• Month 5 (August 2020) is a breakeven position against the emergency plan • Income is over recovered by £12.859m • Pay is overspent by £8.741m and non-pay is overspent by £4.118m • Assumption of additional income from NHSE/I of £1.709m for August as per national guidance for retrospective top-up payments as a result of; (i) £2.234m additional expenditure incurred due to responding to COVID-19, (ii) £0.634m cost pressures/ inflation and (iii) £1.159m offset of areas underspending against historical run rates • Financial risk rating metrics have been removed under COVID-19 financial framework • YTD Capital Expenditure is £2.339m against current forecast of £18.232m • Trust has achieved the Better Payment Practice Code target for August 2020	Noted and received assurance from the report
Sustainability (Green Plan) Assurance Report		• The Sustainable Development Management Plan (SDMP) has been renamed to the Green Plan, in line with NHSE/I requirements • The Sustainability Steering Group has been established and is fully active • The Sustainable Development Assessment Tool requires updated at 6 monthly intervals to allow measurement of progress and continuous improvement; the Trust score has increased to an overall 60% from 54% at the last update	Noted and received assurance from the report

	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

		• There are a number of initiatives being undertaken by the Trust to enhance its sustainability commitment and progression including; carbon literacy, electric vehicles, water supply, LED lighting, hydrogen fuel cells, ceasing plastic bottled water and single use plastics	
Procurement Report		• Trust's Procurement Strategy is actively progressing; the final status of the 89 projects on the 2020/21 procurement work plan • Completion of the MIAA COVID-19 Procurement Governance and have been presented to the Audit Committee in September • 17 contracts will expire in 2020, 11 of which require replacement contracts • 37 waivers expire during 2020; 25 are to be replaced and have been added to the 2020/21 procurement work plan or have already been retendered. The remaining waivers are for one off or specialist provision	Noted and received assurance from the report
Purchase of Land		• Specification was presented to Committee	Recommended to the Board of Directors for approval
Advanced Paramedic Vehicle Replacement Programme		• Specification was presented to Committee	Recommended to the Board of Directors for approval
Phase 3 Financial Planning 2020/21		• Verbal update was presented to Committee	
Key Workforce Indicators Assurance Report		• Appraisals were paused in March 2020 as a result of the COVID-19 impact and in line with national guidance. Completion rates are 79% overall; PES rates are at 81%, PTS at 77%, NHS 111 are most challenged at 51%. Revised target as part of the recovery planning is 85% for March 2021	Noted and received moderate assurance from the report

	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

		• Mandatory training was also paused in March 2020; but has now been resumed. The training cycle has been extended from January 2021 to 31 March 2021 as part of the recovery actions, bringing all mandatory training in line with the same cycle. Classroom training for PES and PTS is on track for achieving the revised trajectory in March 2021 • Transition to competency based reporting for mandatory training. Overall Trust mandatory training compliance at the end of August 2020 is 76% • Bespoke e-learning packages have been developed to assist with IPC knowledge for donning and doffing PPE; 89.30% of staff had completed this e-learning package. A updated programme was released with practical assessments of donning and doffing competencies at Level 2 and Level 3 • Sickness for July 2020 was reduced slightly to 6.18%; including COVID-19 related sickness of 0.67%. Good improvements seen in NHS 111 in comparison to last year. PTS sickness was 7.36% and PES sickness is at 6.24% of which 5.54% is non-COVID-19 related • Vacancy position is positive; over-establishment in EOC (4.55%) and NHS 111 (26.06%) • Staff turnover has been positively affected by COVID-19 with exception to frontline operations where a slight increase in turnover has been seen • HR case management position shows high numbers as a result of pausing casework during COVID-19. 362 outstanding cases, 267 are sickness related, 278 cases has been closed since July 2020	
Staff Survey Update		• NHSE have made it clear that there will no expectation on organisations to improve their	Noted and received assurance from the report

	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

		response rates compared to previous years due to the impact on COVID-19 • NWAS has launched the Health, Wellbeing and Culture Audit in partnership with Zeal Solutions, with findings to inform people plans • NWAS have engaged Picker through an approved procurement route to manage the national survey and the majority will be accessible online • No incentive scheme will be attached to this campaign due to no evidence to suggest encouragement or an increased response rate in the previous year • This years' data will enhance the triangulation of workforce and Freedom to Speak Up data	
Flu Campaign Progress Report		• Flu campaign for 2020/21 commenced pre-launch activities since July 2020 • Completion of a healthcare worker (HCW) Flu Vaccination Best Practice Management Checklist to provide assurance and published nationally for public assurance in December 2020 • Delivery scheduled have been publicised and will be staggered over an 8 week period; allowing management of vaccine distribution and vaccinator coverage effectively • Vaccinator cohort continues to be developed and training commenced early September 2020 • Identified risks are reviewed, managed and monitored via the People Directorate SMT • Senior leadership visibility is integral in illustrating the uptake • This years' aim will be to utilise 'Get a Jab, Give a Jab' incentive through Unicef to encourage the	Noted and received assurance from the report

	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

		uptake and replace the previous personal voucher incentives	
Workforce Equality Assurance Report – Race, Disability, Gender		• WRES data shows a mixed picture of results with some positive improvements in representation (286 to 304 staff) and staff experience but some areas for continued focus in recruitment, disciplinary processes and training. Action will be managed through the WRES working group • WDES data shows a mixed picture of movement in levels of representation with higher staff representation in clinical than non-clinical roles overall. Work in this area is less mature and key areas of activity through the Disability Forum to improve these metrics • Gender equality data confirms a sustained level of improvement in addressing representation of NWAS. Data shows an ongoing increase in the number of female staff to 48.91% of the workforce and highest paid quartile of staff; female representation has also increased from 34% to 36.7% • The pay gap using mean calculation has dropped from 8.9% to 8.79% and pay gap using the median calculation has also dropped from 8.3% to 7.16% • The Trust has proposed a 12 month plan to address the gender equalities, specifically focusing on leadership and management progression and flexible working	Noted and received moderate assurance from the report
Clinical Registration and Revalidation Assurance Report		• ESR provides the interface between the clinical registration council and highlights any deregistered or suspension from the professional register	Noted and received assurance from the report

	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

		• The Trust's procedure provides an overarching framework of how professional registration of the Trust's clinicians is managed within the Trust. • To date, there are no outstanding issues for clinical registration of our staff during the last year • A log of registration issues is kept and in the last year there were 16 cases of registration issues with the HCPC and were dealt with promptly and appropriately • No issues were identified for GMC, NMC or Pharmacist registrants	
People Plan Requirements and Plans		• Delivery against the NHS People Plan will be included in future CQC 'Well Led' assessments • The Trust is well placed to respond to the NHS People Plan and particularly in respect of health and wellbeing has a strong foundation in place to meet the required actions • Key areas of challenge including actions around Equality, Diversity and Inclusion and Flexible Working • Focus on system accountability will create challenges for a regional organisation; especially in relation to HEE funding flow and effective engagement at system level to ensure the risks and opportunities are managed • Work has already been carried by the Director of People and Chief Executive to ensure appropriate engagement and influence at regional, HEE and ICS level	Noted and received assurance from the report
Digital Strategy Assurance Report		• A review of the Digital Strategy is in progress • Appointment of a substantive Chief Technology Officer • 45 out of 75 asset owners have completed their asset owner training	Noted and received moderate assurance from the report

	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

		• Governance framework for clinical safety risk assessments are in place • Progress is being made in relation to Digital First Culture • There are a large number of ongoing large scale digital transformation projects • The procurement of a single CAD as part of the NAA CAD programme has picked up pace • Projects are on track with an overall rating of amber due to extremely tight timescales and some third party supplier issues • New Single Patient Management System went live in September 2020 • Power BI COVID dashboard is being utilised by operations • Achievement of a trademark for Safecheck and production of a non-disclosure agreement enabling discussions with external parties and working with the Innovation Agency and Trustech to commercialise the product	
Trust Strategy and IBP Refresh		• Refresh taken place to ensure the Strategy remains relevant and reflects the current environment and drivers for change, primarily the impact of COVID-19 • The Trust vision has not changed • The Trust strategic priorities remain unchanged; some milestones to support delivery have been refreshed and updated • The refreshed IBP has been mapped against all the risks on the Board Assurance Framework to ensure they support their mitigation	Noted and received assurance from the report
Strategic Planning - Achieving Our Vision		• Assumption that achieving all 8 strategic priorities will achieve the vision of the Trust and measuring the	Noted and received assurance from the report

	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

		progress towards this using a hybrid model will evidenced actual progress against plan for each and reflecting this against the planned end point for the 5 year period • Annual refresh of the milestones will influence the percentage made as they will be better defined milestones for longer term. • The method has been named the Vision Calculator uses the BRAGG scale to 'score' progress	
Directorate Plans and Objectives		• A new approach to directorate planning by the inclusive of a directorate business plan using a standardised template for consistency	Noted and received assurance from the report
Phase 3 – System Plan Submission		• NWAS are required to submit information via Lancashire and South Cumbria ICS and share with other North West ICSs for planning purposes • NWAS are required to provide an activity and workforce trajectory for the remaining 6 months of the financial year • There are no formal financial submissions required nationally; the Trust has provided indicative figures for the remainder of the year to enable the ICS to report on the forecast gap in available finances and forecast spend	Noted and received assurance from the report

	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 Trust

REPORT

Board of Directors	
Date:	30th September 2020
Subject:	AQI Data Quality
Presented by:	Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	This paper outlines an error that has been found with the data quality of one of our Ambulance Quality Indicators, specifically clock start times for direct transfer calls to 999. It puts forward a summary of the impact on our performance data and outlines next steps. Ambulance Quality Indicators (AQI) look at the quality of care provided as well as the speed of response to patients and are reported to NHS E/I on a monthly basis. A full audit of AQI metrics was commissioned by the Association of Ambulance Chief Executives (AACE) and coordinated by WMAS in early 2018. In regards to clock starts, the audit found NWAS to be compliant for all categories and 111 direct transfer incidents. On two occasions ORH have undertaken analysis on NWAS data. In 18/19 no errors were found. This year however, ORH found that the time stamp for calls transferred from other services including 111 to 999 is incorrect. The clock start time has been delayed and gives additional time (30s Cat 1, 4 minutes Cat 2). Latest AQI guidance specifies for incidents transferred through a direct transfer message using the interoperability toolkit (ITK) the performance clock starts on transfer to the EOC CAD. On investigation it was found that in the Trust's data warehouse and the CAD these incidents have the normal 999 clock start logic applied. The issue is two-fold: 1. the CAD incorrectly starting the clock and 2. Informatics reports being linked to the incorrect time. This could have been avoided if the CAD had the correct clock start time or if reporting logic was based to a different field.

	We are now in a position to refresh and rebuild the reporting data going back to April 1st. This requires a change to the CAD system parameter and a rebuild of the data warehouse going back to 1ST April 2020. We have calculated the difference this will make: the C1 mean and 90th are unaffected. The C2 mean will extend by ~+17s, and the 90th will extend by ~+21s C3 and C4 measures also extend, however proportionally less, due to the normally longer response times expected for these categories anyway. We have also estimated the impact the error would have made to last years position. Although there are increases none of these impacts took any of the measures below a target line at the NWAS Level or Sub-regional level. Once we correct the data to the 1st of April a number of key communications and actions should be followed including resubmission to NHS E/I and an independent review of alignment to AQIs. We have flagged our lack of ability to systematically cross reference and reconcile our data outputs with the CAD as a risk (DX ID 2469) and have recognised our need to develop a systematic approach to data quality which is not yet in place. A data quality function will be proposed as part of the digital structures for 21/22.
Recommendations, decisions or actions sought:	The Board is recommended to note the issue as described and take assurance from the proposed next steps and action plan.

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
☐	☐	☒	☐	☐	☐	☒	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	Executive Leadership Committee Quality and Performance Committee
Date:	09.09.20 21.09.20

Outcome:	• ELC: To add in estimated impact to last years' position and report to Q+P and the Board of Directors • Q+P Committee: to discuss at Resources Committee and ensure plans are in place to do immediate data quality checks and deliver on data quality requirements in the long term

- THIS PAGE IS INTENTIONALLY BLANK -

1 PURPOSE

This paper outlines an error that has been found with the data quality of one of our Ambulance Quality Indicators, specifically clock start times for direct transfer calls to 999. It puts forward a summary of the impact on our performance data and outlines next steps.

2 BACKGROUND

Ambulance Quality Indicators (AQI) were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients. The AQIs are ambulance specific and are concerned with patient safety and outcomes. These measures are reported on a monthly basis to NHS E/I.

When ARP was introduced, the Trust began to develop a new reporting environment and data warehouse based on guidance that was frequently changing. This resulted in reporting logic constantly changing and being re-written to conform to the latest guidance.

In regards to reporting, if the C3 CAD is not fully compliant with the AQI guidance, Informatics are required to calculate performance metrics, including clock start/stop time, outside of the CAD to ensure that the Trust is reporting in compliance with the latest guidance.

A full audit of AQI metrics was commissioned by the Association of Ambulance Chief Executives (AACE) and coordinated by WMAS in early 2018. The aim of the audit was to provide assurances that all Trusts were reporting performance in accordance with the new national AQIs that had been released following the Ambulance Response Programme (ARP) Spring review. In regards to clock starts, the audit found NWAS to be compliant for all categories and ITK incidents.

We have flagged our lack of ability to systematically cross reference and reconcile our data outputs with the CAD as a risk (DX ID 2469) and have recognised our need to develop a systematic approach to data quality and seeking out system and reporting errors which is not yet in place.

Latest AQI guidance specifies for incidents transferred through a direct transfer message using the interoperability toolkit (ITK) the performance clock starts on transfer to the EOC CAD. On two occasions ORH have undertaken analysis on NWAS data. In 18/19 no errors were found. This year however, ORH during their work to model performance, have found that the time stamp for calls transferred from other services including 111 to 999 is incorrect. The clock start time has been delayed and gives additional time (30s Cat 1, 4 minutes Cat 2). On investigation by NWAS it was found that in the Trust's data warehouse and the CAD these incidents have the normal 999 clock start logic applied.

The identified issue is two-fold: 1. the CAD incorrectly starting the clock and 2. Informatics reports being linked to the incorrect time. This could have been avoided if the CAD had the correct clock start time or if reporting logic was based to a different field.

A full explanation of the issue with an example can be seen in appendix 1.

Since the issues was first found and investigated on the 1st of July a number of actions have been completed:

- We provided ORH with a corrected data set on 7th July.
- An incident was raised detailing the reporting error.
- Informatics undertook necessary work to correct reporting based on the correct clock start time for 111 ITK incidents. This involved making the correction and quality assuring the change and was completed by Friday 10th July 2020. From that point on the ongoing feed of data were correct. This is a fix in the reporting and the CAD remains incorrect.
- In order to submit July's AQI's we performed a rebuild dating back to 1st July 2020 to ensure as accurate as possible data was used to submit July's position.

3 IMPACT ASSESSMENT

Between April and July 2020 we have calculated the following impacts and expect the corrective action to result in the following approximate variances.

APR-JUL 2020	AS REPORTED:			EXPECTED AFTER ADJUSTMENT:			VARIANCE		
CATEGORY	F2F Records	Average Response	90th Response Time	F2F Records	Average Response	90th Response Time	F2F Records	Average Response	90th Response Time
C1	28230	00:07:04	00:11:47	28230	00:07:05	00:11:47	0	00:00:00	00:00:00
C2	180625	00:19:39	00:39:26	180625	00:19:56	00:39:47	0	+00:00:17	+00:00:21
C3	69413	00:56:50	02:10:15	69413	00:57:04	02:10:42	0	+00:00:15	+00:00:26
C4	16034	01:25:50	02:49:27	16034	01:26:11	02:49:59	0	+00:00:21	+00:00:32

This means that the C1 mean and 90th are unaffected. The C2 mean will extend by ~+17s, and the 90th will extend by ~+21s

C3 and C4 measures also extend, however proportionally less, due to the normally longer response times expected for these categories anyway.

We have estimated based on these exact calculations the difference this would make to our year end position or 19/20. This is a whole year total and a more detailed review on a month by month basis will be presented to the next meeting.

	2019/20 Reported Outturn	EST. FIX IMPACT(*)	EST. OUTTURN
Emergency Incidents	**1,176,962**		**1,176,962**
C1 Mean	00:07:23	No change	00:07:23
C1 90th Percentile	00:12:30	No change	00:12:30
C2 Mean	00:26:00	17s	00:26:17
C2 90th Percentile	00:56:27	21s	00:56:48
C3 Mean	01:22:42	15s	01:22:57
C3 90th Percentile	03:15:32	26s	03:15:58
C4 90th Percentile	03:18:07	32s	03:18:39

(*) These estimated impacts assume equivalent proportions of direct passes and subsequent overrides and closure outcomes during 19/20 as April-July 2020.

It is important to note that none of these impacts took any of the measures below a target line at the NWAS Level or Sub-regional level.

4 NEXT STEPS

We are now in a position to refresh and rebuild the reporting data going back to April 1st 2020. This requires a rebuild of the data warehouse going back to 1ST April 2020. Following this, quality assurance of the data will be completed ready for any resubmission for the 02nd October.

We are also now ready following work with MIS to change to the CAD system parameter so that it is correct.

Following this there are a number of steps we have considered including communications with NHS E/I and an independent review of data quality which are included in the action plan in Appendix 2.

5 LEGAL and/or GOVERNANCE IMPLICATIONS

We have a requirement to share performance data with NHS England / Improvement. Our annual report which is submitted to NHS E /I is a legislative requirement.

We have a risk on the corporate risk register (risk ID 2469) which outlines our lack of ability to systematically cross reference and reconcile our data outputs with the CAD. We have also highlighted a systematic approach to data quality with supporting resources as a gap in the Board Assurance Framework.

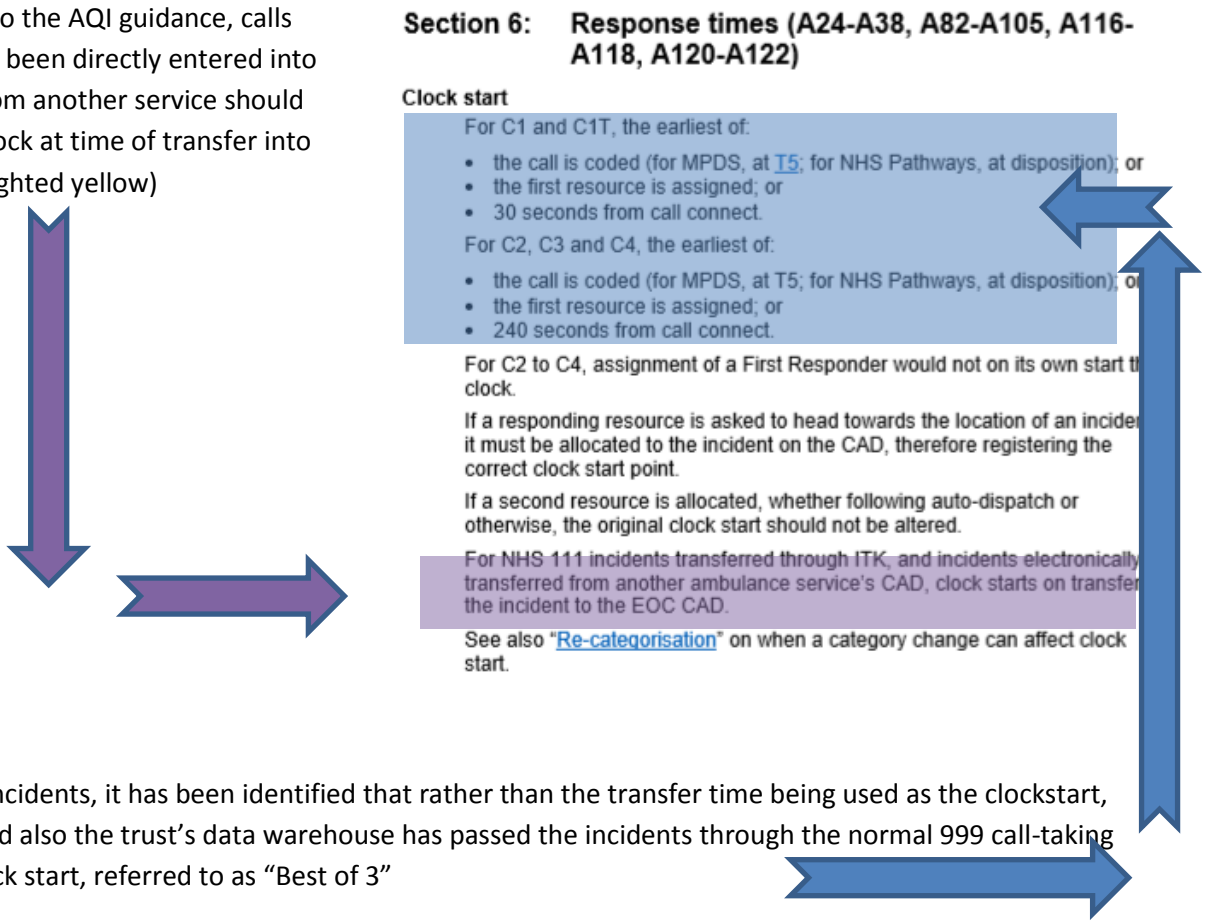
6 RECOMMENDATIONS

The Board of Directors are asked to note the issue as described and take assurance from the proposed next steps and action plan.

APPENDIX 1

Summary of data quality issue on direct transfers

According to the AQI guidance, calls which have been directly entered into the CAD from another service should start the clock at time of transfer into CAD (highlighted yellow)



Section 6: Response times (A24-A38, A82-A105, A116-A118, A120-A122)

Clock start

For C1 and C1T, the earliest of:

- the call is coded (for MPDS, at T5; for NHS Pathways, at disposition); or
- the first resource is assigned; or
- 30 seconds from call connect.

For C2, C3 and C4, the earliest of:

- the call is coded (for MPDS, at T5; for NHS Pathways, at disposition); or
- the first resource is assigned; or
- 240 seconds from call connect.

For C2 to C4, assignment of a First Responder would not on its own start the clock.

If a responding resource is asked to head towards the location of an incident it must be allocated to the incident on the CAD, therefore registering the correct clock start point.

If a second resource is allocated, whether following auto-dispatch or otherwise, the original clock start should not be altered.

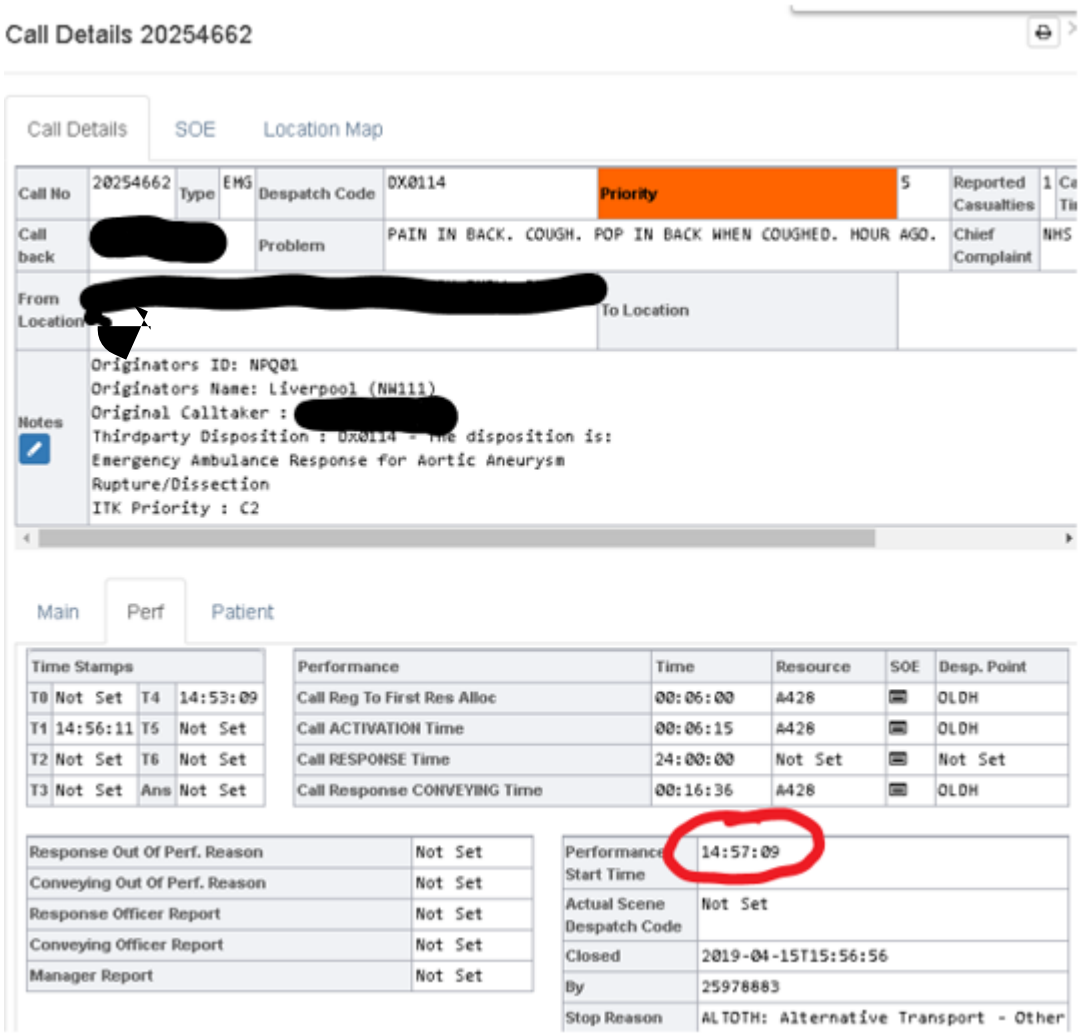
For NHS 111 incidents transferred through ITK, and incidents electronically transferred from another ambulance service's CAD, clock starts on transfer the incident to the EOC CAD.

See also "Re-categorisation" on when a category change can affect clock start.

For these incidents, it has been identified that rather than the transfer time being used as the clockstart, the CAD and also the trust's data warehouse has passed the incidents through the normal 999 call-taking logic of clock start, referred to as "Best of 3"

This means that for these calls, C1's clocks have been started a **maximum of 30s** too late, and all other categories, a **maximum of 240s** too late.

The following screenshot is taken from the CAD's C3WEB reporting system and demonstrates the issue.



Call Details 20254662

Call Details | SOE | Location Map

Call No	20254662	Type	EMG	Despatch Code	DX0114	Priority	5	Reported Casualties	1	Ca Ti
Call back	[redacted]			Problem	PAIN IN BACK. COUGH. POP IN BACK WHEN COUGHED. HOUR AGO.			Chief Complaint	NHS	
From Location	[redacted]					To Location				

Notes

Originators ID: NPQ01
Originators Name: Liverpool (NW111)
Original Calltaker : [redacted]
Thirdparty Disposition : DX0114 - The disposition is:
Emergency Ambulance Response for Aortic Aneurysm
Rupture/Dissection
ITK Priority : C2

Main | Perf | Patient

Time Stamps			
T0	Not Set	T4	14:53:09
T1	14:56:11	T5	Not Set
T2	Not Set	T6	Not Set
T3	Not Set	Ans	Not Set

Performance	Time	Resource	SOE	Desp. Point
Call Req To First Res Alloc	00:06:00	A428		OLDH
Call ACTIVATION Time	00:06:15	A428		OLDH
Call RESPONSE Time	24:00:00	Not Set		Not Set
Call Response CONVEYING Time	00:16:36	A428		OLDH

Response Out Of Perf. Reason	Not Set
Conveying Out Of Perf. Reason	Not Set
Response Officer Report	Not Set
Conveying Officer Report	Not Set
Manager Report	Not Set

Performance Start Time	14:57:09
Actual Scene Despatch Code	Not Set
Closed	2019-04-15T15:56:56
By	25978883
Stop Reason	ALTOTH: Alternative Transport - Other

Both the CAD and the trust's WH have selected 240s (4minutes) after the transfer time into the CAD as the clock start.

The clock start should have been 4 minutes earlier, meaning the response time should have been measured as 4 minutes longer

APPENDIX 2

Communication and action plan

Action	Context / further info	Owner	Deadline
Rebuild the data warehouse from 1st April 2020 and undertake quality assurance	This is a significant piece of work. It was agreed with the Director of ops that we should only seek to retrospectively change / correct data for year 2020/21. Although we have estimated the difference the correction would make to our 19/20 position	**Abigail Harrison, Chief of Digital and Innovation**	**01.10.20**
Make CAD parameter change	The work has been scoped and agreed with critical systems and MIS and a change control produced in preparation	**Abigail Harrison, Chief of Digital and Innovation**	**30.09.20**
Submit resubmission to NHS E/I	Re-submissions are standard as retrospective data do change although this would be a more significant change than usual	**Abigail Harrison, Chief of Digital and Innovation**	**02.10.20**
Write to NHS E/I explaining the issue	As the change is more significant a letter from exec level to explain would be appropriate. We may want to seek advice on further communications required.	**Ged Blezard, Executive Director of Operations**	**02.10.20**
Write to Commissioners explaining the issue and providing refreshed data	We have not posted any contractual performance data to commissioners since April, due to COVID19 pause and also the pause in contractual negotiations. The lead commissioners do receive the daily 'P' reports which once adjusted will show as longer performance times	**Ged Blezard, Executive Director of Operations**	**02.10.20**
Consider communication with the CQC	To be considered whether this should happen at the same time as communications above or once we have the full analysis of the impact to data last year	**Maxine Power, Director of Quality, Innovation and Improvement**	**TBC**
Mini competition followed by commission of an independent review of CAD parameters and warehouse / reporting to ensure compliance with AQIs	This has previously been carried out by West Midlands Ambulance service. We have other partners who deliver similar services.	**Abigail Harrison, Chief of Digital and Innovation**	**16.10.20**

Detailed monthly position for 19/20 to be calculated	The current data in the paper for 19/20 is only an estimate. For the next Q+P committee we will provide a more detailed monthly breakdown	**Abigail Harrison, Chief of Digital and Innovation**	**Next Q+P November (date tbc)**
Complete assessment of data quality requirements and put proposal to ELC	This is already flagged in our risks and BAF as a gap. Funding will be required and it will be included in an overarching plan to digital requirements for 21/22	**Abigail Harrison, Chief of Digital and Innovation**	**01.01.21**
Agree with ops a schedule of sample record reviews against AQIs	This would form part of the long term data quality plan and be delivered between informatics and ops	**Abigail Harrison, Chief of Digital and Innovation**	**16.10.20**
Continue to implement asset ownership / management programme	Part of the assets review should include a conversation where the digital teams give assurance about data quality to asset owners	**Abigail Harrison, Chief of Digital and Innovation**	**Ongoing**

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors						
Date:	30 September 2020					
Subject:	Research Strategy 2020-2025					
Presented by:	Dr Chris Grant, Executive Medical Director					
Purpose of Paper:	For Decision					
Executive Summary:	Since the launch of the inaugural Research Strategy in 2016, North West Ambulance Service NHS Trust has made strides in driving the research agenda forward. The Trust has grown its research capacity and capability; increased the number of opportunities for staff, patients and the public to participate in research; and improved research performance on a national level. The scheduled review of the existing Research Strategy allowed us to consider the evolution of our organisation over the last four years, developing priorities that align with the Trust's refreshed vision, values and strategies. This report presents the background and rationale for the suggested changes.					
Recommendations, decisions or actions sought:	The Board of Directors is invited to: • Review the Research Strategy 2020-25; and • Approve the Research Strategy based upon the recommendation of the Clinical Effectiveness Management Group, Executive Leadership Committee and Quality & Performance Committee.					
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:	**Yes – EIA included (Annex II)**
Previously Submitted to:	**Quality & Performance Committee 21-Sept-2020** **Executive Leadership Committee 09-Sept-2020** **Clinical Effectiveness Management Group 01-Sept-2020**

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

The purpose of this paper is to describe the rationale and benefits of updating the Research Strategy, version 1.1 dated December 2019, to version 2.3 dated September 2020 **(Annex I).**

The Board of Directors is invited to approve the Research Strategy following review by the Quality & Performance Committee, Clinical Effectiveness Management Group and Executive Leadership Committee.

2. BACKGROUND

The inaugural Research Strategy for North West Ambulance Service NHS Trust was published in 2016. Since then, the Trust has made strides in in embedding research across our organisation with our staff, patients and the public all given the opportunity to take part in the research we host.

We continue to be committed to conducting high quality research that expands the evidence base both within the ambulance sector and the wider field of health and social care, leading to advances in the services we deliver and improving the current and future health of the population we serve.

In 2018, the Trust appointed a Research Support Manager to facilitate the growth of research activity at the organisation under the direction of the Research Lead. This investment in our research infrastructure has returned a number of tangible improvements and benefits:

1. Fundamental work to develop and implement research management and governance policies and procedures got underway to embed good practice and robust processes, enabling the delivery of research that adheres to both national regulation and local guidelines;
2. For the second year in succession, we successfully attracted additional income from our local National Institute for Health Research Clinical Research Network (NIHR CRN), which saw an improvement of 860% to our core funding allocation since FY 2017-18. These monies permitted the appointment of our first ever fixed-term, Research Paramedic who delivers and promotes NIHR research throughout the Trust;
3. NIHR Research Capability Funding to the value of £20k was triggered for the first time in the history of the Trust due to our exceptional research performance;
4. Engagement and participation of our staff in research increased substantially. 53% of paramedics within the Greater Manchester area were involved in supporting one of our largest NIHR clinical trials, the PRESTO Study. Our committed staff voluntarily undertook training to be able to deliver the research protocol in accordance with Good Clinical Practice, demonstrating their clear enthusiasm for supporting clinical research;
5. Involvement in research improved across service lines with the Paramedic Emergency Service, Patient Transport Service, Community First Responders, Informatics, Human Resources and Clinical Audit to name a few, all supporting and delivering studies;
6. In 2019/20, we achieved a 975% improvement against our research participant recruitment total for the preceding financial year;
7. Staff were helped to act as Principal Investigators and Local Collaborators for NIHR

CRN Portfolio studies and as leads for their own research or service improvement projects;

8. Support was provided for researcher development. Our Research Paramedic was successfully accepted onto the Early Career Researcher Development Pathway Programme hosted by NIHR CRN North West Coast and also won the title of 'Research Practitioner of the Year' at the NIHR CRN Greater Manchester Awards in 2019;
9. Research events were held;
10. Research opportunities, successes and achievements were publicised both internally and externally;
11. We expanded our research network by becoming an official partner of two, local NIHR Applied Research Collaborations through which we engage with health and social care providers, academia and other external stakeholders to cultivate research collaborations; and
12. We acted as a co-applicant for NIHR research grant bids.

The benefits gained within this short period from this increase to our operational capacity and augmentation of our in-house expertise demonstrates that with precise strategic planning, support and action, we have the impetus to emerge as a vibrant, research-active organisation. Not only can we be the collaborator of choice, but we also have the potential to become a leader within the pre-hospital research arena, generating new evidence that supports the delivery of first-rate urgent and emergency care.

The revised Research Strategy responds to the refreshed position of the Trust and considers the evolving research landscape. It includes priorities that align with our organisation's existing vision, values and strategies and will enable our research activity, performance and reputation to continue on an upward trajectory over the next five years.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

The Research Strategy has been developed with reference to the following organisational strategies:

- Our Strategy 2019-2024
- Quality (Right Care) Strategy 2018-23
- Urgent and Emergency Care Strategy 2019-24

It also considers the legal and governance frameworks as outlined in the Trust's Research Management Policy, version 1.0 dated 23 October 2019.

A separate Strategy Implementation Plan will be developed to supplement the Research Strategy. The plan will be developed in consultation with relevant stakeholders to ensure that it is achievable. Measurable improvement outcomes will be identified where appropriate such as an increase to NIHR CRN Portfolio research participant recruitment targets and consistently triggering NIHR Research Capability Funding at defined time points. The plan will be monitored and adjusted throughout the delivery period with the legal and governance implications identified for each activity and outcome reviewed at regular intervals.

A query was raised at the Clinical Effectiveness Management Group held on 01 September 2020 in relation to whether the document may be classified as a 'strategy'. The document

has been submitted by the Sponsor to the Director of Strategy and Planning for assessment (awaiting outcome) and the title will be amended if appropriate.

4. RECOMMENDATIONS

The Board of Directors is invited to approve:

1. Research Strategy, version 2.3 dated 10 September 2020.

The benefits of the document are:

1. Establishing a vision and mission statement for research for NWAS;
2. Aligning of the Research Strategy and priorities to those of the Trust;
3. Communicating the benefits of taking part in research for patients, staff and the organisation;
4. Stating clear priorities with corresponding attainable objectives; and
5. Providing the foundation for the development of a supporting strategy implementation plan.

Annex I

NHS
North West
Ambulance Service
NHS Trust

Research Strategy

2020-2025

Recommended by	Research Support Manager
Approved by	TBC
Approval date	TBC
Version number and date	2.3 10 September 2020
Review date	TBC
Responsible Director	Medical Director
Responsible Manager (Sponsor)	Consultant Paramedic – Medical Directorate
For use by	All Trust Employees and External Stakeholders

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
2.0	07-Feb-2020	N/A	Sandra Igbodo	Creation of document
2.1	23-Jun-2020	N/A	Sandra Igbodo	Minor changes following review by Sponsor including **Item 2** *(Renumbering);* and, *(amendment to "1.5 Establish research advocates across the organisation who promote engagement with research" to "Establish research advocates across the organisation within all service lines who will promote engagement with research."*
2.2	24-Jun-2020	N/A	Sandra Igbodo	Minor changes to wording throughout following review by Sponsor; addition to **Item 3** *(3.7 Enable the Trust to act as a sponsor responsible for the initiation and management of research)*
2.3	10-Sept-2020	N/A	Sandra Igbodo	Changes made following review by Director of Strategy and Planning: addition of **Item 1.2** (Strategic Objective); addition of **Item 1.3** *(Strategy Implementation Plan)*; and addition of **Annex I** *(Equality Impact Assessment)*

Research Strategy 2020-2025

Contents

1. Introduction

1.1. Research at North West Ambulance Service NHS Trust

North West Ambulance Service NHS Trust strives to be the best ambulance service in the United Kingdom by providing the right care, at the right time, in the right place; every time. We are dedicated to providing high quality care to our patients by meeting not only their immediate healthcare needs, but also having a positive impact on their future health and wellbeing.

Research is essential to expanding the evidence base in health and social care and an aim of the NHS Long Term Plan is to "increase the number of people registering to participate in health research to one million by 2023/24"[1].

As a Trust, we actively uphold the NHS Constitution for England[2] through our "commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population." We fulfil our responsibility of providing our patients, staff and the public with the opportunity to participate in health care research.

Our mission is to embed a culture of research excellence and to be at the vanguard of generating new evidence that supports the delivery of first-rate, urgent and emergency care.

Our vision is to enhance the health and wellbeing of the communities we serve by translating high quality research into exceptional service provision and outstanding clinical practice.

1.2. Strategic objective

Over five years, we will host and develop research that will continue to enhance the quality of the urgent and emergency care we deliver. We will seek to ensure that our communities have equitable access to our clinical services, improving health outcomes for all of our patients.

The three, Strategic Priorities (**Item 2)** will provide the framework for the Strategy Implementation Plan by which the objectives will be delivered.

[1] National Health Service (2019) *The NHS Long Term Plan.* Available at https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ (Accessed: 07 February 2020).

[2] Department of Health and Social Care (2015) *The NHS Constitution for England.* Available at https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england (Accessed: 07 February 2020).

1.3. Strategy implementation plan

Progress against the Strategy Implementation Plan will be monitored and reported to the Board via the Clinical Effectiveness Management Group.

All research activity will be conducted in accordance with the Research Management Policy.

The Equality Impact Assessment **(Annex I)** will be reviewed throughout the lifecycle of the strategy and its implementation.

1.4. The research effect

> "Trusts that are more research active have been shown to benefit from the 'research effect': they provide a better care experience, deliver improved outcomes for patients, and find it easier to recruit and retain staff."[3] *(Figure 1)*

The Research Effect: Benefits		
For patients	**For trusts**	**For staff**
✓ Improved survival rates	✓ Improved recruitment and retention of staff	✓ Reduced level of burnout / emotional exhaustion
✓ Improved sense of value through taking part in research	✓ Meeting CQC inspection standards	✓ Better morale and job satisfaction
✓ Better overall care, as represented in higher CQC ratings	✓ Cost-effective innovations and savings, and translation of research intro practice	✓ Building transferable skills and developing new networks

Figure 1, The Research Effect: Benefits for Patients, Trusts and Staff

The importance of research in the development and delivery of better health care and its overall positive effect is recognised by the Care Quality Commission (CQC). As of 2018, NHS trusts are subject to inspection under the 'well-led framework' and are assessed on how well clinical research is integrated into their organisation.

Trusts now face questions about whether their vision and strategy incorporates plans for supporting clinical research activity as a key contributor to best patient care; how patients and carers are given the opportunity to participate in or become actively involved in clinical research studies; or their internal reporting systems for their research activity.

The inclusion of clinical research in the CQC inspection provides a clear incentive for all

[3] Royal College of Physicians, 'Benefiting from the 'research effect': The case for trusts supporting clinicians to become more research active and innovative', https://www.rcplondon.ac.uk/projects/outputs/benefiting-research-effect-case-trusts-supporting-clinicians-become-more-research (Accessed: 07 February 2020).

NHS organisations to develop practical ways of embedding research as a core activity.

1.5. Research within the pre-hospital setting

Carrying out clinical research in the pressurised setting of an ambulance service can be challenging. Patient needs are heterogeneous, often more complex and with an increased level of uncertainty; ambulance service personnel must make urgent yet informed decisions to achieve the highest standards of safe, effective and patient-centred care.

The quality of the pre-hospital care we provide is paramount. Our front-line staff not only carry out critical interventions in emergency situations but deftly evaluate increasingly multifarious patient needs to make sure that their care is delivered in the most appropriate setting.

As an NHS organisation, our staff continually endeavour to enhance the quality of our services and it is vital that we provide them with the means to advance patient care through, not only having the opportunity to deliver the research that we host, but to also be offered the prospect of developing their own research that aligns with and implements Trust strategy.

1.6. Supporting research: from prevention to treatment

As an NHS ambulance trust, we serve more than seven million people across approximately 5,400 square miles in the communities of Cumbria, Lancashire, Greater Manchester, Merseyside, Cheshire and Glossop in Derbyshire.

The region has areas of great deprivation, high rates of heart and circulatory diseases and respiratory conditions, elevated instances of alcohol and smoking related illnesses, an increasing number of people living with long-term health conditions and a continuing rise in people aged over seventy-five.

Health inequality is prevalent across the North West of England with avoidable differences in the health status of our communities that are determined by broad social and economic factors.

Our organisation is uniquely placed as a region-wide service with the capability to effectively challenge and address health inequality and improve patient outcomes across the North West. We will align our research to the needs of our population and the areas with the greatest health needs.

We have a chance to not only be a leader in the treatment of health conditions within the pre-hospital arena nationally, but to also contribute to the prevention of illness, the promotion of the healthy lifestyle and the progression of health literacy.

Every patient contact counts.

1.7. Our research journey

Since the launch of the inaugural Research Strategy in 2016, the Trust has continued to drive the research agenda forward.

Our organisation invested in a dedicated Research Support Manager to facilitate the growth of research activity under the direction of our Consultant Paramedic (Medical Directorate) in their capacity as Research Lead.

We successfully attracted research income to continue to build capacity and capability, including securing an extension of National Institute for Health Research (NIHR) funding for a full-time, trust-based Research Paramedic who delivers and promotes research throughout the organisation – a first for the organisation.

We expanded our research network by becoming an official partner of two, local NIHR Applied Research Collaborations and engaged with health and social care providers, universities and academics to cultivate research collaborations. We attended local and national research events to interact with the wider research community and we are an enduring and active member of the National Ambulance Research Steering Group. The links we forged provided us with the opportunity to act as a co-applicant for two NIHR research funding bids as well as develop joint research projects.

We have promoted the trust as being research active through internal and external stakeholder engagement and publicised our achievements and awards. In 2019, our Research Paramedic won the title of 'Research Practitioner of the Year' at the NIHR Clinical Research Network Greater Manchester Awards and we delivered events to endorse our research activity and disseminate research findings to our staff.

The creation of a Research Management Policy initiated fundamental work to develop supporting procedures that will embed good practice and robust processes to enable the delivery of high quality research. Our committed staff have been trained and taken part in the delivery of clinical research protocols in accordance with Good Clinical Practice.

We have improved the number of NIHR Clinical Research Network (NIHR CRN) Portfolio studies and student research projects being approved annually. We have also increased the number of participants taking part in research.

We will continue to build on these achievements to further embed research as a core activity, strengthening the culture of evidence-based practice so that we can continue to

deliver safe, effective and patient-centred care.

2. Strategic Priorities

Priority 1 Ensure that research is visible and supported throughout the whole organisation	
Research is everyone's business and a core part of delivering excellent clinical care through the application of evidence based practice. Our leadership structure must champion research to foster a culture of critical enquiry and provide the foundation for a vibrant research culture. **Research needs to be acknowledged as being integral to the work of the organisation and should be strategically and operationally integrated into the core business of the Trust. Our research should be aligned with the Trust vision, values and strategies and correlate with the needs of the communities we serve.** **The benefits of research to patients, staff and the Trust should be understood across all tiers of management and by all staff at the organisation so that they may effectively engage with the research agenda.**	
1.1	Raise awareness with our executive and senior leadership teams about how research benefits our patients, staff and the organisation and how our research activity aligns with the Trust's strategic plans
1.2	Sustain engagement with our executive and senior leadership teams to continually inform and inspire the collective endeavour to promote an organisational culture which values and endorses research activity
1.3	Include research as part of the Trust's corporate and clinical inductions to establish research as core business
1.4	Raise awareness of how research activity links to the Care Quality Commission standards relating to the quality and safety of patient care
1.5	Establish research advocates across the organisation within all service lines who will promote engagement with research
1.6	Enhance the visibility of research roles and describe the value that they bring to the Trust
1.7	Continued communications to ensure that opportunities to develop, deliver and support research are made known to all
1.8	Promote and facilitate opportunities for dissemination of research findings
1.9	Maintain a digital signposting resource to keep staff informed of research activity, policies, procedures, guidance, training and events

Priority 2
Expand our research networks and facilitate research collaborations

Through collaborative working, we will enhance our reputation as an emerging, research-active organisation proficient in delivering high quality studies.

We will continue to build upon our existing research partnerships while exploring new opportunities to engage with academia, industry, charities and the NHS, with an emphasis on cultivating locally-led research and supporting national studies that are advantageous to our patient population and our organisation.

We will focus our research on priority areas and nurture alliances that will maximise our research potential through the joint development of grant bids, attracting income for financial reinvestment and facilitating growth of our research expertise and activity.

2.1	Sustain our existing relationships with the National Institute for Health Research, NHS organisations, higher education institutions and research support networks such as the Council for Allied Health Professions Research
2.2	Identify the Trust's research priorities so that we may forge partnerships based on mutual research interests that will successfully address areas of greatest need
2.3	Expand our research networks and establish new links that will diversify our research portfolio
2.4	Engage with industry to attract commercial research opportunities
2.5	Facilitate networking of staff, research students and academics to foster a environment for knowledge exchange and collaboration
2.6	Seek out opportunities to act as a co-applicant for research grants to reinforce our expertise in developing research bids
2.7	Focus on our strengths so that we can maximise the impact of our research
2.8	Build on our reputation to make us the collaborator of choice

Priority 3
Increase our research capacity and capability

Every clinician in the NHS should be research active. We endeavour to be an organisation that acts as an incubator for all staff aspiring to undertake research. We must nurture our workforce by giving them access to resources that will equip them with the knowledge and skills to design and carry out their own research.

We must expand our research infrastructure so that we can effectually design, initiate, manage and monitor research, and guide and advise our staff through the full research lifecycle.

3.1	Through talent management, attract, retain and develop our own research professionals
3.2	Recognition of research career development in job plans, appraisal systems and career pathways
3.3	Equip our staff with the skills and knowledge to design and deliver their own research
3.4	Continue to attract research income that provides funding for dedicated research roles within the Trust
3.5	Trigger NIHR Research Capability Funding to allow us to act flexibly and strategically to maintain research capacity and capability to support the appointment, development and retention of key staff undertaking or supporting people and patient-based based research.
3.6	Formalise processes to access support from internal teams and departments to streamline study set-up, increasing the capacity of the core Research & Development team to deliver research across the organisation
3.7	Expand our research infrastructure to augment our in-house expertise and to increase our operational capacity
3.8	Enable the Trust to act as a sponsor responsible for the initiation and management of research

3. References

Benefiting from the 'Research Effect', https://www.rcplondon.ac.uk/projects/outputs/benefiting-research-effect-case-trusts-supporting-clinicians-become-more-research

Care Quality Commission, https://www.cqc.org.uk

College of Paramedics Post-Registration Career Framework 4th Edition, https://collegeofparamedics.co.uk/COP/ProfessionalDevelopment/post_reg_career_framework.aspx

College of Paramedics Strategy 2019-2024, https://www.collegeofparamedics.co.uk/COP/About_us/Strategy/COP/Strategy.aspx

Delivering Research for All: Expectations and Aspirations for the NHS in England, https://www.rcplondon.ac.uk/guidelines-policy/delivering-research-all-expectations-and-aspirations-nhs-england

Enabling NHS Staff to Contribute to Research: Reflecting on Current Practice and Informing Future Opportunities, https://www.rand.org/pubs/research_reports/RR2679.html

Health Equity in England: The Marmot Review 10 Years On, https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

The Health of the Nation: A Strategy for Healthier Longer Lives, https://appg-longevity.org/events-publications

Health Profile for England: 2018, https://www.gov.uk/government/publications/health-profile-for-england-2018

Health Profile for England: 2019, https://www.gov.uk/government/publications/health-profile-for-england-2019

LCRN Contract Support Document Targeting Research According to Health Needs, Offline Document

Multi-Professional Framework for Advanced Clinical Practice in England, https://www.nhsemployers.org/your-workforce/plan/workforce-supply/education-and-training/advanced-clinical-practice

NIHR Dissemination Centre Themed Review - Care at the Scene: Research for Ambulance Services, https://content.nihr.ac.uk/nihrdc/themedreview-000827-CS/Care-at-the-scene-final-for-web.pdf

National Institute for Health Research (NIHR), https://www.nihr.ac.uk

North West Ambulance Service NHS Trust: Our Strategy 2019-2024, https://www.nwas.nhs.uk/publications/2018-2023-strategy-document

North West Ambulance Service NHS Trust: Quality (Right Care) Strategy 2018-2023, https://greenroom.nwas.nhs.uk/library/right-care-quality-strategy-2018/

North West Ambulance Service NHS Trust: Urgent and Emergency Care Strategy 2019-24, https://www.nwas.nhs.uk/publications/nwas-urgent-and-emergency-care-strategy-2019-24-2

The NHS Constitution for England, https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

NHS England's Research Needs Assessment 2018, https://www.england.nhs.uk/publication/nhs-englands-research-needs-assessment-2018

The NHS Long Term Plan, https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan

Transforming health through innovation: Integrating the NHS and academia, https://acmedsci.ac.uk/file-download/23932583

What makes us healthy?: An introduction to the social determinants of health, https://www.health.org.uk/sites/default/files/What-makes-us-healthy-quick-guide.pdf

Annex I

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

Name of strategy and major project being reviewed: Research Strategy

Equality Impact Assessment completed by: Sandra Igbodo, Research Support Manager

Initial date of completion: 14-Aug-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

Since the launch of the inaugural Research Strategy in 2016, North West Ambulance Service NHS Trust has made strides in driving the research agenda forward. The Trust has grown its research capacity and capability; increased the number of opportunities for staff, patients and the public to participate in research; and improved research performance on a national level.

The scheduled review of the existing Research Strategy allowed us to consider the evolution of our organisation over the last four years, developing priorities that align with the Trust's refreshed vision, values and strategies

The revised Research Strategy outlines three priorities areas for action to enhance research activity at the Trust:

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

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

Staff and patients

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

Trust wide communications plan; training; and engagement with internal and external stakeholders

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?

Please document activity below:

The EIA has been developed under the guidance of the HR Equality Lead who recommends bi-annual review of the document. The EIA will evolve throughout the implementation of the Research Strategy and adjusted as and when required.

At present, the Trust mostly hosts research rather than developing its own studies to address specific needs. The aim of Research Strategy is to remedy this, increasing our in-house capacity and capability to be able to design research that focuses on priority areas that are advantageous to our patient population and our organisation.

The research we support always aims to be inclusive and is reviewed by either the NHS Health Research Authority, which includes review by an NHS Research Ethics Committee (REC), or a university Research Ethics Committee. The role of the REC is to protect the dignity, rights, safety and wellbeing of people who take part in research.

Item 3.2.3 of the 'Governance Arrangements for Research Ethics Committees: 2020 Edition' states:

"The benefits and risks of taking part in research, and the benefits of research evidence for improved health and social care, should be distributed fairly among all social groups and classes. Selection criteria in research protocols should not unjustifiably exclude potential participants, for instance on the basis of economic status, culture, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. RECs should take these considerations into account in reviewing the ethics of research proposals, particularly those involving under-researched groups."

Every research study we support is subject to this independent review and REC approval granted prior to being authorised to take place at the Trust. For HRA Approval studies, there is a national mandate that these assurances are accepted by host NHS organisations:

"HRA Approval is the new process for the NHS in England that comprises a review by a NHS Research Ethics Committee (REC) (where required) as well as an assessment of regulatory compliance and related matters undertaken by dedicated HRA staff. In England, it replaces the need for local checks of legal compliance and related matters by each participating NHS organisation…HRA Approval will provide assurance that the study complies with required legislation and guidance and, where applicable for the study type, that a favourable opinion from an independent ethical review is in place." Item 2.6, Assess, Arrange and Confirm: Clarifications on HRA Terminology, v2.0, November 2015

The HRA recognised that there was a burden to research teams in having to create an individual application for each participating NHS organisation. The need for local checks of legal compliance and ethical matters by each participating NHS organisation created great variability in standards and expectations at each site. The single, overarching review and issuing of HRA Approval allows participating NHS organisations to focus resources on assessing, arranging and confirming their capacity and capability to deliver research rather than scrutinising ethical and legal matters that have already been assessed at a national level by the NHS HRA.

Additional reference documents in relation to the completion of this EIA include:

- Annual Equality, Diversity and Inclusion Report 2018-2019, North West Ambulance Service NHS Trust;
- Annual Report on Workforce Disability Equality Standard, September 2019, North West Ambulance Service NHS Trust;
- Our Strategy 2019-2024, North West Ambulance Service NHS Trust
- Patient Engagement Annual Report 2018/19, North West Ambulance Service NHS Trust;
- Workforce Race Equality Standard Data 2018/19 Publication, Summer 2019, North West Ambulance Service NHS Trust;
- Workforce Strategy 2020–2023, July 2020, North West Ambulance Service NHS Trust;
- Making the difference: diversity and inclusion in the NHS, December 2015, The King's Fund
- NHS Staff Survey Results 2019
- Toolkit for Increasing Participation of Black Asian and Minority Ethnic Groups in Health and Social Care Research, December 2018, Professor Azhar Farooqi, OBE et al.

Equality Group	**Evidence of Impact**
Age	**Staff:** The NHS Staff Survey Results 2019 for NWAS showed that of the staff who responded, 1% was between 16 and 20 years of age; 17% between 21-30; 26% between 31-40; 30% between 41-50; and 26% between 51 to 65. There were no employees aged 66+. As researchers, the age of staff is not recorded or monitored. **Patients:** ONS data shows that in the UK, the population aged 65 years and over is growing faster than other age groups. The ageing population across the North West Coast region is acknowledged as a challenge and an opportunity in both the Trust Strategy and the Research Strategy. Research participant's personal data is not accessible by the Trust therefore cannot be reported. The condition being investigated and the staff/patients under investigation influence the inclusion criteria, including

	minimum/maximum age where applicable. **Strategy impact:** The Trust currently and will continue to support research that involves participants of all ages from 0 years old +. Although we can identify individual research studies to evidence that we capture participants of all ages, this study inclusion criterion for each research study is not currently monitored. It is recognised that where possible, the age inclusion criterion may be recorded for the purpose of monitoring against this standard for patients to ensure that research opportunities are available to our whole patient population. The Trust's clinical priorities include older people/frailty and children. There has been engagement with internal and external stakeholders to explore areas of collaboration in relation older people and ageing research including falls. Increased investment is required in exploring opportunities to involve paediatric cohorts of participants. Internal consultation recommended to inform the strategy implementation plan.
Disability – considering visible and invisible disabilities	**Staff:** The NHS Staff Survey Results 2019 for NWAS showed that 22% of our respondents considered themselves to have a physical or mental health condition, disability or illness that has lasted or are expected to last for 12 months or more (although the most recent NWAS Annual Report on Workforce Disability Equality Standard published in 2019 metrics referenced percentages again a total number/percentage of staff who do/do not consider themselves to have a disability, these figures were not included in the report). The 2015 **'**Making the difference: diversity and inclusion in the NHS' report by The King's Fund highlighted **Patients**: Data is not routinely collected about the disability status of patients. **Strategy impact:** The EIA has highlighted that at present, we do not host any research that focusses on disabilities so this is an area for improvement and consideration when undertaking research priority setting as part of the strategy implementation plan. The Trust has a Disability Forum for staff with disabilities and long term health conditions, staff who care for someone with a disability and colleagues who want to learn more about disability. The Trust has a Disability Forum that may be consulted if necessary.

Gender	**Staff:** The NWAS Annual Equality, Diversity and Inclusion Report 2018-2019 reported that 52% identified as male and 48% female. Of the 32 research studies submitted for approval in 2019/20, 9 were internal applicants. Of the applicants who were NWAS staff, 56% were male and 44% female. The 2015 **'**Making the difference: diversity and inclusion in the NHS' report by The King's Fund highlighted that staff in ambulance trusts are more than twice as likely as those in acute hospital settings to report discrimination on the basis of gender, with more women reporting discrimination than men. This may reflect the gender balance in the workforce as men constitute 56 per cent of the staff in ambulance trusts. **Patients:** Data to be supplied by HR Equality Lead. **Strategy impact:** The EIA has not highlighted any significant disparities in relation to gender at this stage.
Marital Status	**Staff and patients:** Data is not routinely collected about staff or patient marital status. **Strategy impact:** The EIA has not highlighted any significant impact in relation to marital status at this stage.
Pregnancy or maternity	**Staff:** Data to be supplied by HR Equality Lead. **Patients:** Data to be supplied by HR Equality Lead. **Strategy impact:** Maternity is one of the Trust's clinical priorities. Improved focus is required in exploring opportunities in this area. Internal consultation recommended to inform the strategy implementation plan.
Race including ethnicity and nationality	**Staff:** The NWAS Workforce Race Equality Standard Data 2018/19 reported that of the 6356 employees, 286 were of black and minority ethnic (BME) background accounting for 4.5% of the workforce. **Patients:** Approximately 9.2% of the population in North West England is BME. **Strategy impact:** The COVID-19 pandemic has highlighted racial inequality with BME communities disproportionately affected. The EIA has highlighted a gap in the research the Trust supports in relation to race, ethnicity and nationality. The Trust has a Race Equality Forum that may be consulted if necessary.

Religion or belief	**Staff:** The NHS Staff Survey Results 2019 for NWAS reported that 41% of our respondents did not have a religious affiliation; 49% considered themselves Christian; 1% Muslim; and 2% any other religion. **Patients:** Data is not routinely collected about the religion or belief of patients. **Strategy impact:** The EIA has not highlighted an impact in relation to religion or belief at this stage.
Sexual Orientation	**Staff:** The NHS Staff Survey Results 2019 for NWAS showed that 5% of our respondents considered identified as homosexual and 1% as bisexual. **Patients:** Data is not routinely collected about the sexual orientation of patients. **Strategy impact:** The EIA has not highlighted an impact in relation to sexual orientation at this stage. The Trust has an LGBT Forum that may be consulted if necessary.
Trans	**Staff and patients:** Data is not routinely collected about whether staff or patients identify as trans. **Strategy impact:** The EIA has not highlighted any significant impact in relation to individuals who identify as trans at this stage.
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	**Staff and patients:** Data is not routinely collected about these characteristics. **Strategy impact:** The EIA has highlighted that no research is currently being undertaken with most of these cohorts. The Trust has an Armed Forces Network that may be consulted if necessary. Improved focus on marginalised groups such as homeless, refugees etc. has already been identified during the strategy development.

Section 3: Consultation

We will consider consultation with different groups during the design of the Strategy Implementation Plan. We will look towards the Trust's Patient and Public Panel to inform and advise appropriate activities and outcomes.

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	Evidence of Impact
Age	Review ongoing.
Disability – considering visible and invisible disabilities	Unknown: the Trust does not currently collate these data locally or formally measure impact in relation to this equality group.
Gender	Review ongoing.
Marital Status	Unknown: the Trust does not currently collate these data locally or formally measure impact in relation to this equality group.
Pregnancy or maternity	Review ongoing.
Race including ethnicity and nationality	Review ongoing.
Religion or belief	Review ongoing.
Sexual Orientation	Review ongoing.
Trans	Review ongoing.
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	Review ongoing.

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		
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		

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.

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

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	30 September 2020
Subject:	Learning from Deaths: Quarter 1 2020/21
Presented by:	Dr Chris Grant, Executive Medical Director
Purpose of Paper:	For Assurance
Executive Summary:	Following publication of the 'National guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care' the Trust is required to publish on its public accounts a quarterly and then annual summary of learning; this is the second quarterly report to be published. The Q1 dashboard attached in Appendix A identifies that across the two modules (Incidents and Patient Experience), 17 deaths in the cohort have been closed and eight of these incidents have been identified as potentially contributing to the death of a patient. In half of these contributing cases, it was due to concerns with clinical assessment or a lack of available resources. Using the associated documents/reports on the Patient Experience module has allowed some learning themes to be established. Six incidents across the Datix breakdown had learning relating to Emergency Operational Centre/Emergency Medical Dispatcher procedures.. Other notable actions from learning include the development of a new Standard Operating Procedure (SOP), new system configurations and response code re-categorisation. To date, the lack of dedicated clinical resource (due to COVID constraints) has meant that no structured judgement reviews (SJRs) have been conducted. Hence, this element of the dashboard remains unanalysed. The dashboard remains an iterative process and so this element will develop once resource is established in October .
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Note the dashboard in Appendix A is the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths. • Note the limitations of the dashboard, with the assurance this is an iterative process which will develop over time. Clinical resources have been identified and SJRs will commence in October

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:	**Safety Management Group Clinical Effectiveness Management Group: Executive Leadership Committee: Quality and Performance Committee**
Date:	**1 September 2020: 14 September 2020: 16 September 2020**
Outcome:	**Approve to Board consideration**

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

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

The document attached in Appendix A is a summary dashboard of the Q1 2020/21 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts, following the paper being received by the Board of Directors on 30 September 2020, in accordance with the national framework and trust policy.

It is acknowledged the attached document remains an iterative reporting process which will become more sophisticated and informative as the year progresses. The content of the current dashboard has been affected due to a lack of a dedicated resource to conduct the structured judgement reviews (SJRs), which has meant that none have been conducted. The Trust has described the risk in the Board Assurance Framework and mitigation is in place. Dedicated and protected clinical resource has been established and SJRs will commence in October.

2. BACKGROUND

2.1 Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement.

2.2 The guidance proposes to review those described in the scope, which includes:

- Any patient who dies while under the care of the ambulance service (from call handling to before handover concludes)
- Any patient who dies after handover (where informed)
- Any patient who dies within 24 hours of contact with the ambulance service where a decision was taken to initially not convey them to hospital

2.3. The methodology to produce the information described in Appendix A is as follows:

2.3.1 Phase 1.

Identify all deaths where a concern was raised be that by ambulance personnel, other health and care staff and / or families or carers about the care received.
A combination of data sources were used to identify these incidents and this included cases recorded on the Incidents module and on the Patient Experience module in Datix.

2.3.2 Phase 2.

A sample of between 40 and 50 from:

- *Deaths where Cat 1 and Cat 2 responses had a delayed* ambulance response*
- *Deaths of patients assessed as requiring Cat 3 and Cat 4 responses*

- *Deaths that occur following handover to an NHS acute, community or mental health trust or to a primary care provider when this information is known by way of notification to NWAS*
- *Deaths of patients who were not initially conveyed to hospital and who then had re-contact with NWAS within 24 hrs*

*A delayed response is defined as one that is double the 90th centile response time, as set out in the NHS England (2013) New ambulance standards: >30 minutes for category 1 calls and >80 minutes for category 2 calls.

2.3.3 This sample data is provided by Health Informatics reports that have been mapped to the criteria. All deaths (Cat 1 and Cat 2) where there was a delayed ambulance response be included in the sample for review. The rest is selected through random-sampling.

2.3.4 In future iterations, the dashboard will develop to include the learning from structured judgement reviews (SJRs). The SJR is a validated research methodology which is able to create an overall care score and will be undertaken by named senior clinicians and other subject matter experts to ensure a standardised audit methodology.

3. DISCUSSION

3.1 The number of patients whose deaths were identified as being in scope for this review was 80 (40 Datix incidents and 40 sampled).

3.2. *Datix Cohort Discussion*

Of the 40 patient deaths;

- 22 patients were identified through the Incidents module only
- 13 patients were identified through the Patient Experience module only
- 5 patients were identified as having records on both the Incidents module and Patient Experience module

A total of 17 deaths were identified as reviewed and closed, eight of which (47%) have been identified as potentially contributing to the death of a patient. In half of these contributing cases this was categorised as due to concerns in clinical assessment or a lack of available resources (figure 8).

3.2.1 Figures 9 to 11 demonstrate that of the 13 deaths reported in the Patient Experience module only, the most common theme was concern raised by relative/ external health care professional. At the time of writing, the action themes show that these are still in the early stages of review, so it is unknown if the care was in line with best practice. The learning details section in figure 11 illustrates the learning opportunity is mainly around documentation and adherence to known procedures. The most common actions in this category are reflection and re-training. Other notable actions include new system configuration to avoid reoccurrence (to commence September 2020) and emphasis on using the Clinical Hub for advice.

3.2.2 Of the five deaths reported in both the Patient Experience module and Incidents module, it was found that EOC/EMD procedures and communication were the main themes for learning (figures 12 to 14). Again reflection and re-training are a common action theme. Other actions include the development of a new standard operating procedure regarding police cancellations, priority code re-categorisation (escalation)

and EOC environment and equipment reviews (headset reviews to ensure background noise is heard on calls).

3.3 *Sample Cohort Discussion*

Of the 40 patients identified:

- 20 patients were not initially conveyed and then the service was re-contacted within 24 hours*
- 17 patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- Three deaths occurred where the they were initially coded as Cat 1 or Cat 2, and were subjected to a long wait

**The results should not be correlated to the results of the Safe Care Closer to Home audit due to the significant differences in audit methodology.*

It has not been possible to perform any SJRs of these patient deaths due to the availability of suitable qualified senior clinician(s) to perform a review.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 There are no legal implications associated with the content of this report and the data gathered to produce the dashboard has been managed with attention to the Data Protection Act 2018.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the dashboard in Appendix A is the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.

- Note the limitations of the dashboard, with the assurance this is an iterative process which will develop over time. Clinical resources have been identified and SJRs will commence in October
  .

Appendix A: Quarter 1 2020-2021 Learning from Deaths Report Dashboard

NWAS Learning From Deaths Dashboard Quarter 1 2020-2021 (April-June)

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

Total Number of Deaths in scope (Sample cohort and Datix incidents [Incidents and Patient Experience module])*		Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April	32	8	25.0%	3
May	24	5	20.8%	2
June	24	4	16.7%	3
This Quarter	80	**17**	**21.3%**	**8**
This Financial Year	80	17	21.3%	8

*** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quaily of care provieded where the patient died under the care of the ambulance service (from call to handover), after handover or within 24 hours of inital contact where the decision was to not convey the patient. The sample must contain incidents across the categories outlined in the document.**

Figure 1.

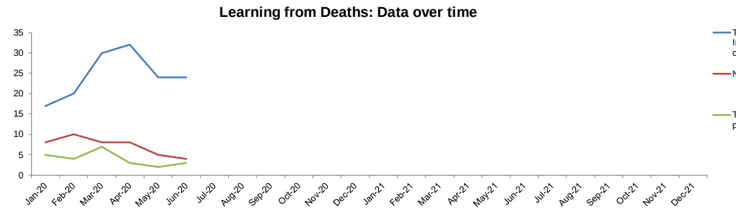


Figure 2.

Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Number of Learning from Death requests by other trusts	
April	0
May	1
June	0

Figure 3.

Number of patients NWAS informed of by other Trusts who died after handover		Number of these deaths reviewed
April	0	N/A
May	0	N/A
June	0	N/A

Figure 4.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 03/08/2020.

Datix Cohort Breakdown

Datix Cohort Description: This Dashboard describes those outlined in the guidance as 'must review'. The 'must review' category includes those that have been raised to the organisation and recorded via Datix as being deaths that occured in our care where there has been concern has been raised about the quality of care provided. This has been broken down into those where an incident has been raised with concern for care (Incidents module), those that have been escalated to the Patient Experience Module and where an incident appears on both modules. For the Patient experience incidents these are included where they are Risk scored 4/5 and death has occured. For Datix, the reviews are considered as complete when the incident is closed. For the incidents module data, it is considered as death caused by the incident when 'Degree of harm' is 'Death- Caused by the incident'. For the incidents module data, it is considered as death caused by the incident when the incident is closed and 'Reason for SI' Unexpected /Potentially avoidable death'.

Incidents Module only

Total Incident module Deaths in scope		Incident Grade		
		1 or 2	3	4 or 5
April	11	2	2	7
May	4	1	2	1
June	7	3	0	4
Total	22	6	4	12

Figure 5.

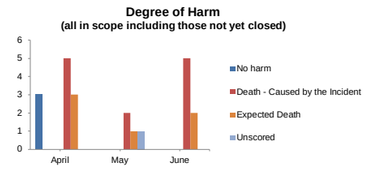


Figure 6.

Month	Number of Deaths Closed on Incidents module	Of those closed, Number of Deaths considered as caused by the incident	Lessons Learned complete for those closed and considered caused by the incident
April	8	3	2
May	4	2	0
June	4	3	1
Total	16	8	3

Figure 7.

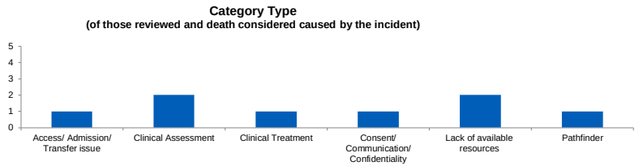


Figure 8.

Data source: Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter - Listing Report' both last extracted on 03/08/2020. Information recorded on these incidents last accesed 11/08/2020.

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
April	4	0	0
May	3	0	0
June	6	0	0
Total	13	0	0

Figure 9. (Note- This is the month the incident occured, not when the notification of raised concern for care was received)

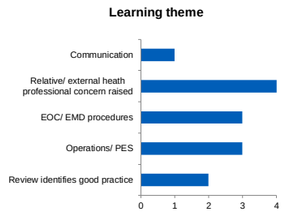


Figure 10.

Learning Theme	Learning Detail	Action Themes (may have multiple)
Review identifies good practice	Reviewed as safe outcome (1)	· Reflection and/or feedback
	Good recognition of condition, treatment and clinical interventions (1)	· Reflection and/or feedback
Operations/ PES	Correct outcome but lacked pre-alert (1)	· None yet, still under review
	Lack of sufficient documentation (2)	· Reflection and/or feedback · Improve documentation skills · Emphasis of using Clincal Hub
EOC/ EMD procedures	Procedure not adhered to (2)	· Reflection and/or feedback · Re-training / re-reading procedures
	Resource monitoring/ management (1)	· Reflection and/or feedback · Re-training / re-reading procedures
Relative/ External heath professional concern raised	Patient safety concern (2)	· None yet, still under review
	No Learning yet (2)	· None yet, still under review
Communication	Internal Communication Messages (1)	· New system configuration to avoid reoccurance (to commence September 2020)

Figure 11.

Data source:Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted on 04/08/2020. Information recorded on these incidents last accesed 11/08/2020.

Incidents on both Patient Experience Module and Incidents Module

Month	Relevant incidents on both modules	Incidents Closed on both modules	Number closed and death considered caused by the incident
April	1	0	0
May	3	1	0
June	1	0	0
Total	5	1	0

Figure 12. (Note- This is the month the incident occured, not when the notification of raised concern for care was received)

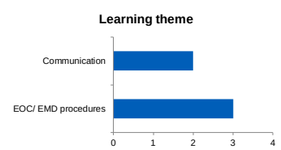


Figure 13.

Learning Theme	Learning Detail	Action Themes
EOC/ EMD procedures	EMD Ineffective breathing recognition (2)	· Reflection and/or feedback · Re-training / re-reading procedures · Review EOC enviroment · Change in Code categorisation · Review Equipment (headsets)
	Procedure not adhered to (1)	· Re-review process · Re-training / re-reading procedures
Communication	Communication with other services (1)	· Development of new SOP around Police cancellations
	Technonology/ Communication (CPAD) (1)	· None yet, still under review

Figure 14.

This is an outline of the deaths recorded on the Incidents module and/or Patient Experience module that fit the cohort. The information is provided from the reviews and associated documents.

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted on 04/08/2020. Information recorded on these incidents last accesed 10/08/2020. Datix Incidents query 'Inc: LfD (DoH Expected Death or Death) Listing Report - Incident Date @lastquarter' and 'Inc: Wild Card Search (death/dead/deceased/died) Incident Date @lastquarter - Listing Report' both last extracted on 03/08/2020.

Sample Cohort Breakdown

Sample Data Description: A random sample of 40 incidents using the specified criteria from the national guidance. This includes deaths that were classified as requiring a Category 1 or Category 2 response, Category 3 and Category 4 incidents that resulted in deaths and deaths of patients that were not initally conveyed and the ambulance service was re-contacted within 24 hours. For the sample, when the incident has had a structured judgement review (SJR) it is considered as reviewed.

Incidents used for the Sample criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
April	16	0	0
May	14	0	0
June	10	0	0
Total	40	0	0

Figure 15.

Quarter 1 2020-2021 Sample Data Breakdown			
Month	C1 and C2	C3 and C4	24 hr Re-contact Deaths
April	1	8	7
May	0	7	7
June	2	2	6

Figure 16.

Currently, there have been no reviews of the sample cohort due to a lack of dedicated staff resource. Therefore we have no completed reviews for Quarter 1.

Data source: Informatics queries 874893 (April and May) run on 16/06/2020, and 854372 run on 03/07/2020.

This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	30th September 2020
Subject:	Regulatory and statutory equality reporting – WRES, WDES and Gender Pay Gap
Presented by:	Lisa Ward, Director of People
Purpose of Paper:	For Decision
Executive Summary:	The paper provides an overview of the annual gender pay gap data, Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Each of these areas have annual action plans to seek to address and progress the Trust's position. A summary of the end of year positions relating is provided along with 2019/20 high level plans for the next 12 months. **WRES** - Appendix 1 details the themes of the nationally set WRES metrics and progress against the 2019 action plan with an end of year position, up to summer 2020. Progress has been made against each theme. Appendix 2 details the WRES data as at 31st March 2020. Overall the WRES data shows a mixed picture of results with some positive improvements in representation and staff experience but some areas for continued focus in recruitment, disciplinary processes and training. The paper outlines the position against each metric and areas have been identified for focus on this year's action plans. The data shows an increase in representation and numbers of BME staff within NWAS from 286 to 304 staff, which is a shift from 4.5% to 4.6%, this has further improved since March to 4.9%. The metrics in relation to likelihood of appointment from shortlisting and likelihood of entering the formal disciplinary process have shown a small worsening of position. Both of these will have further data analysis and scrutiny through the planned review of recruitment required under the People Plan and the planned review of the disciplinary process. 2019 staff survey results continued to show improvements in staff experience and the narrowing of the gap with white staff. in particular experience of bullying, harassment and abuse from patients and colleagues no longer shows a difference of experience.

	Key priorities for action include a review of recruitment and disciplinary processes; positive action initiatives; development of the Race Forum into a network, continued focus on bullying and harassment and the outputs from the culture survey. The actions will be managed through the WRES working group which has cross functional representation. This will allow specific and targeted actions on a service line and functional basis. **WDES -** This is only the second year of reporting for WDES and Appendix 3 details the themes of the nationally set WDES metrics. It also identifies the activity which was planned 12 months ago, key stakeholders and an end of year position, up to summer 2020. Progress has been made against each theme. Appendix 4 details the WDES data 2020. The data shows a mixed picture of movement in levels of representation with higher staff representation in clinical than non-clinical roles overall. The issue of non-disclosure remains a challenge for this data especially as staff can become disabled during their employment lifetime and this is an area of focus to enable us to establish a clearer picture of representation across the workforce. Overall the experience of disabled staff as reflected through recruitment data, performance management data and staff experience shows a greater gap in experience between non-disabled and disabled staff than we see for other protected groups. Work in this area is less mature and key areas of activity, through the Disability Forum are planned in order to start to make some inroads in improving these metrics. Similar to Race, priorities will focus on recruitment and performance management processes as well as continued work on bullying and harassment. Undertaking a data cleanse to better understand the disabled workforce and enhancing engagement t be able to target interventions are key along with continuing to embed the Work and Disability passport to address concerns regarding reasonable adjustments. **GENDER EQUALITY** - Appendix 5 details the themes of activity NWAS has been working to, in order to address the gender inequalities in the highest paid roles within the Trust. It also identifies the activity which was planned 12 months ago, key stakeholders and an end of year position, up to summer 2020. This plan responds to the data collated for the gender pay gap report. Appendix 6 shows the data collated for the following gender pay gap submission. This data is collated as at 31st March 2020. NWAS was within timeframes for publishing this data to meet statutory requirements.

	Overall the data confirms a sustained level of improvement in addressing representation in NWAS. The data shows an ongoing increase in the number of female staff to 48.91% of the workforce, up nearly 2% from the previous year. With regards to the highest paid quartile of staff, female representation has also increased from 34% to 36.7%. The pay gap using the mean calculation has dropped from 8.9% to 8.79%. The pay gap using the median calculation has also dropped from 8.3% to 7.16%. The data also includes an analysis against gender of the bonuses awards to staff on VSM contracts. The mean calculation is impacted by efforts to increase overall representation and the main entry routes are into lower graded roles but the median has shown a significant improvement on the previous year and this is a better indicator of the impact of activities to support fairer progression. Although not required for national reporting, a snapshot of some key staff survey data has been provided to give an indication of the experience on female staff. This overwhelmingly indicates that male experience tends to be less positive than female staff Appendix 7 is the proposed plan for the next 12 months for the Trust to address the gender inequalities, specifically focusing on leadership and management progression and flexible working, the latter of which aligns closely with the People Plan priorities. Overall the paper seeks to provide assurance of the continued focus on work to address workforce equality in the Trust.
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Note the outcomes of the WRES, WDES and gender pay gap analysis • Note planned race, disability and gender activities for next 12 months • Approve the WRES, WDES and gender data for external publication

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 work being carried out is to reduce inequalities faced by particular staff groups within our workforce. The activities which are planned support positive action, not

	positive discrimination, and we also work to ensure any policies and procedures related to this work are inclusive as standard.
Previously Submitted to:	Executive Leadership Committee/ Resources Committee
Date:	23rd September 2020/ 25th September 2020
Outcome:	To be provided verbally

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

The purpose of this paper is to provide the Board of Directors with the most recent data in relation to race, disability and gender which is required to be published as a statutory or contractual requirement.

2. BACKGROUND

2.1 The Trust has a legal responsibility to publish its gender pay gap data on an annual basis. In addition, there is a contractual requirement under the NHS Contract to publish annual data in respect of the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Working to address inequalities shows compliance with the Equality Act 2010 and the Public Sector Equality Duty.

2.2 This paper provides an overview of this data along with an end of year position relating to these three areas of workforce equality – race, disability and gender. High level plans for the next 12 months in response to the data are also shared for consideration and scrutiny. Although further data analysis will be required in order to fully identify areas for intervention.

2.3 It should be noted that several areas of work were paused in order to respond to the coronavirus pandemic. This has naturally affected the ability to carry out all the activities to address workforce inequalities as planned.

2.4 All of this activity supports the Workforce Strategy. It has explicit links to the Engage section of the strategy, supporting the Inclusion strand. However, the activity also spreads across the other strands of the strategy, for example training sits under the 'development' section of the strategy, and there is a key theme of training in the activity on race, disability and gender which are to be considered.

2.5 The work also supports the activity under the EDS2 framework, used to monitor progress on equality. Much of this work fits under the overarching themes of 'A representative and supportive workforce' and 'Inclusive leadership'.

2.6 Each of these areas of work contribute to the Well Led Domain of the CQC requirements. As above, this work impacts across all other areas of the CQC priorities though, as staff experience undoubtedly impacts on patient experience.

2.7 Nominated operational representatives have engaged with the action plan meetings on race, disability and gender in NWAS. Work has been ongoing to ensure service line ownership of objectives under the action plans. Feedback has indicated that a clear objective for each service line will support progress on the agreed objectives. Teams have also been encouraged to add their specific targets to their existing local health and wellbeing plans, although this planning was interrupted by COVID-19.

2.8 There has also been engagement with relevant networks and staff forums to share the data and engage with them over viable solutions.

2.9 The outputs of these data gathering exercises will also inform the strategic priorities for diversity and inclusion being considered by the Executive Leadership Committee.

3. WORKFORCE RACE EQUALITY STANDARD (WRES)

3.1 Appendix 1 details the themes of the nationally set WRES metrics and progress against the 2019 action plan with an end of year position, up to summer 2020.

3.2 Progress has been made against each theme. Areas to note include the promotion of a range of courses and opportunities which are available to staff, either targeting BME staff specifically or about the topics of race and development. Also the work taking place in several parts of the Trust on the themes of speaking up and challenging poor behaviour. This includes the Freedom to Speak Up Guardian attending the Race Equality Forum to hear more about staff experience and efforts to ensure that Freedom to Speak Up Champions are diverse. The 'Is it really banter?' workshop has been well received. Additional dates were delayed due to covid-19 but this will form part of future plans.

3.3 Appendix 2 details the WRES data for summer 2020. The data relates to the period up until the end of March 2020 and was submitted to NHS England on time before end August 2020. It also includes the 2019 staff survey data, which NHS England will have already received earlier in the year. Overall the WRES data shows a mixed picture of results with some positive improvements in representation and staff experience but some areas for continued focus in recruitment, disciplinary processes and training.

3.2 The data shows an increase in the number and representation of BME staff within NWAS from 286 to 304 staff, which is a shift from 4.5% to 4.6%. There is a higher BME representation in non-clinical than clinical roles. This data is at March 2020 and representation has continued to rise and now stands at 4.9%. This is in the context of overall growth in the workforce.

3.3 Metric 2 assesses the likelihood of appointment from shortlisting. This is the first WRES submission in several years which indicates that BME candidates are less likely than White staff to be appointed from shortlisting. Previous years have shown a positive position in respect of BME staff progression at recruitment. Further data analysis is being undertaken to breakdown this data to understand and address any issues of potential discriminatory practice. This will particularly focus on differences between service lines and analysis of where BME candidates are being lost from the process.

3.4 This data analysis will also inform the review of recruitment practices which is required to be completed by all NHS Trusts by the end of October under the People Plan. This review is intended to make sure that staffing reflects the diversity of the community, and regional and national labour markets and will enable the setting of more detailed recruitment and progression targets across a range of diversity factors.

3.5 The disciplinary metric has moved from 1.32 to 1.89 with 1 being the target indicating equal experience. Overall the numbers of staff affected remain relatively small with 11 BME staff subject to formal disciplinary processes, however, there remains a disparity of experience which requires focus. Given the small numbers, individual case reviews

can be conducted to try to identify themes and ensure appropriateness of action. The Trust is also intending to resume its overall review of disciplinary and investigation processes which was paused as a result of COVID and the disproportionate experience of BME staff will be a feature in this review.

3.6 The training metric shows an improving position towards a more equal experience in the likelihood of BME staff and white staff accessing non-mandatory or CPD training. Overall total numbers accessing training have increased. This data is always impacted by the high proportion of CPD activity funded for registered professionals as this is a group where there is under-representation of BME staff. This metric is being closely monitored by the Education and Learning teams to ensure equity of access and plans to improve this metric will continue into 2021.

3.7 The metrics associated with staff experience show continuing improvements and although there remain differences in experience to be addressed, in the main these metrics show positive progress. The experience of staff in relation to harassment from patients has improved by 11% over the last two years whilst for white staff experience has only improved by 2%. The experience of BME staff compares very favourably with that of white staff with 35% of BME staff saying they have experienced harassment from patients in comparison with 48% of white staff. Reporting of bullying and harassment from other staff is now reported equally by white and BME staff with no differential in experience.

3.8 There remains a clear difference in the views of BME and white staff on the equity of career progression opportunities. Whilst this gap has narrowed and staff views have improved over the last two years, it is clear that this remains an area for work to be undertaken and it is hoped that the review of recruitment referenced above, combined with targeted work on progression opportunities will contribute to narrowing this gap further.

3.9 There also remains a differential in the experience of BME staff in respect of perceived discrimination at work. Again although there has been a 10% improvement in experience of BME staff over the last two years and a narrowing of the experience gap with white staff, there are still improvements to be made in this area.

3.10 The metric relating to Board membership is more representative this year than it has been previously. This is potentially due to a reduction in the number of Board members for whom the ethnicity was unknown previously and is now known. However, it should be noted that due to the small numbers, the data indicates that a change in this for one individual can have a large impact on the percentage reported.

3.11 Detailed action plans are in development and will be managed through the WRES working group which has cross functional representation. This will allow specific and targeted actions on a service line and functional basis. The Race Equality Forum is continuing to develop in terms of staff numbers and activity. There is a named representative from the Race Equality Forum who is attending the WRES Action plan meetings from September 2020. In time, it is hoped that the Forum can play a greater role in identifying Trust priorities relating to race inequality too.

3.12 Key priorities and areas of work arising from the WRES are as follows:

- Recruitment review in line with the requirements of the People Plan, developing targeted actions to eliminate discrimination, improve representation and progression. This will be completed by the end of October.
- More detailed target setting for recruitment and progression
- Positive actions programmes to support progression
- Development of the Race Forum into a network to help drive interventions and programmes of work
- Continued work on bullying and harassment including the Treat Me Right campaign
- Outcomes of the culture survey which will be analysed by demographics enabling more detailed analysis of BME staff experience
- Analysis of disciplinary cases and specific focus on differential experience in the review of the disciplinary policy and procedure

4 WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

4.1 This is only the second year of reporting for WDES. It should be noted that actions to address inequalities relating to staff with disabilities had been taking place prior to this contractual requirement for reporting on WDES. Appendix 3 details the themes of the nationally set WDES metrics. It also identifies the activity which was planned 12 months ago, key stakeholders and an end of year position, up to summer 2020. This completes the first 12 months of Trust activity in support of the WDES metrics.

4.2 Progress has been made against each theme. Areas to note are activity of the 'Treat Me Right' campaign of which the 'Is it really banter?' workshop is a key part and will continue into the next 12 months. The Disability Forum has given a voice to staff and it remains open for anyone in the Trust to come and learn more about disability in the workplace. The 'Work and Wellbeing Passport' is now being piloted in Fylde Sector in Cumbria and Lancashire following progress in summer 2020 after COVID initially delayed implementation. There are improved links with Operational Teams about WDES which stands NWAS in good stead for continuing to improve the experience of disabled staff in NWAS.

4.3 Appendix 4 details the WDES data for summer 2020. It consists of the data collected as at the end of March 2020 and submitted to NHS England on time before end August 2020.

4.4 The information on levels of representation of disabled staff in the workforce is clustered in the WDES report. The data shows a mixed picture of movement in levels of representation with higher staff representation in clinical than non-clinical roles overall. The data remains mixed with further analysis required about the barriers to staff with disabilities from progressing into Band 8 and above roles and of staff in those roles disclosing disabilities. The issue of non-disclosure remains a challenge for this data especially as staff can become disabled during their employment lifetime and this is an area of focus to enable us to establish a clearer picture of representation across the workforce. Staff survey data and the recent risk assessment processes demonstrate that we have a high level of under-reporting.

4.5 Data in relation to recruitment has shown an increase in the raw number of disabled candidates appointed from shortlisting from the previous year, but as the number of candidates not declaring disability also increased, the likelihood calculation shows a slightly poorer experience for disabled candidates. Further work to encourage candidates to declare their disability status is required and the recruitment review outlined above will also consider the experience of disabled staff.

4.6 Metric 3 looks at staff entering the formal performance process, this excludes sickness capability processes and focuses on performance management only. The figure indicates staff with disabilities are more likely to enter the formal performance process than staff who have not disclosed a disability. It should be noted that the overall number of staff who do enter this process is small when reviewing the raw data but clearly there appears to be a significant disparity. This data was not mandated last year so we do not have comparative figures available. The small numbers enable us to review individual cases to identify themes and areas for improvement.

4.7 Metrics 4 to 8 are staff survey scores and Metric 9 is an engagement score, calculated using several scores together. The staff survey 2019 results with regards to disability have been shared in a Board report earlier in 2020 and are also shown in Appendix 5 again for clarity. The staff experience of disabled staff was again poorer on each factor than for non-disabled staff apart from the results again showing disabled staff being more likely to report incidents.

4.8 The responses contributing to Metric 4 show some positivity, with fewer staff having experienced bullying and harassment from managers over the previous 12 months. A higher percentage of staff advised that they had reported incidents over the previous 12 months too, with greater growth from staff with disabilities, which indicates an increased confidence in reporting. Areas of concern include the experiences of disabled staff with other colleagues and experiences with members of the public.

4.9 There was an improvement overall in the views of staff within the Trust about equal opportunities for career progression, with a larger positive increase in that view by staff with disabilities but again there is a significant disparity. This relates to Metric 5.
The data collated for Metric 6 indicates an improvement in experience for all staff relating to feeling under pressure from their manager to come into work. However there remains a 10% difference in the experience of staff with disabilities, on the side of being more likely to feel pressure.

4.10 There was also an overall improvement in the views of staff feeling that the Trust values their work. Again staff with disabilities were less positive but showing an improvement from the previous year. This data can be found in Metric 7.

4.11 Overall the results indicate that there is much more work to do to address and support disabled staff in the workplace. Although there are some positive signs of improvement, these are much less marked than they have been for race but the Trust is at an earlier stage of its engagement and targeted work with disabled staff.

4.12 There has been a small drop in the percentage of staff with disabilities who feel that the Trust has made adequate adjustments for them in their role. Since that survey was completed last autumn, there has been a lot of activity in support of this metric with the

Disability Forum. More recently there has been work on the Work and Wellbeing passport and this will carry on into the action plan for the next 12 months.

4.13 The overall engagement score has increased for disabled staff, reducing the difference in experience when compared with staff who haven't declared a disability. This is a positive indicator for the Trust. NWAS has also advised 'yes' about making sure the voices of disabled staff can be heard. This is facilitated through the Disability Forum and that is also an opportunity for staff to learn more about disabilities in the workplace.

4.14 As last year, there remains underrepresentation for disabled people when considering the make-up of the Board overall, for those members who vote and in the wider executive team. There are no Board members who have disclosed a disability on ESR. Work will be undertaken to ensure that this data is accurate and gaps in reporting are addressed.

4.15 Detailed action plans are in development and will be managed through the WDES working group which has cross functional representation. This will allow specific and targeted actions on a service line and functional basis. The Disability Equality Forum is continuing to develop in terms of staff numbers and activity and they continue to contribute to plans and act as a key engagement forum as proposals and solutions develop.

4.16 Key priorities and areas of work which will form the basis of the action plan are:

- Recruitment review in line with the requirements of the People Plan, developing targeted actions to eliminate discrimination, improve representation and progression. This will be completed by the end of October.
- More detailed target setting for recruitment and progression
- Continued work on bullying and harassment including the Treat Me Right campaign
- Data cleanse of disability status to provide more accurate recording of disability and ongoing self-declaration
- Continuation of roll out of the Work and Disability Passport following current pilot
- Development of the Disability Forum into a network to help drive interventions and programmes of work
- Outcomes of the culture survey which will be analysed by demographics enabling more detailed analysis of disabled staff experience
- Analysis of performance management cases, identifying themes and key actions

5. GENDER EQUALITY

5.1 Appendix 5 details the themes of activity NWAS has been focused on since the last gender pay gap report, in order to address the gender inequalities in the highest paid roles within the Trust. It also identifies the activity which was planned 12 months ago, key stakeholders and an end of year position, up to summer 2020. This plan responds to the data collated for the gender pay gap report.

5.2 Appendix 6 shows the data collated for the gender pay gap submission. This data is collated as at 31st March 2020. NWAS is within timeframes for publishing this data to meet statutory requirements.

5.3 The data shows an ongoing increase in the number of female staff to 48.91% of the workforce, up nearly 2% from the previous year. With regards to the highest paid quartile of staff, female representation has also increased from 34% to 36.7%. These headlines show a sustained level of improvement in addressing representation in NWAS, which shows our activity to address inequalities are working. The data also includes an analysis against gender of the bonuses awards to staff on VSM contracts.

5.4 The pay gap using the mean calculation has dropped from 8.9% to 8.79%. The pay gap using the median calculation has also dropped from 8.3% to 7.16%. Again, this suggests that Trust activity is starting to take effect. Many of the activities are long-term cultural changes and dependent on staff turnover in senior roles. The mean calculation will be impacted by efforts to increase representation at recruitment as many of our entry points are into lower graded roles, however there has been a significant shift in the median calculation which is an indicator of progression into higher paid roles and better representation in the higher quartiles of pay.

5.5 Appendix 7 is the proposed plan for the next 12 months for the Trust to address the gender inequalities, specifically focusing on the leadership and management roles in the organisation.

5.6 Unlike the WRES and WDES metrics, the gender pay gap report only looks at where female staff work within an organisation. The data does not capture the experience of female staff as collated in the staff survey. This was identified as a gap in how we approach inequalities for staff by gender and as such the proposed gender equality action plan for the next 12 months will consider staff responses in more detail than has taken place previously.

5.7 Although more detailed analysis is required to inform interventions for 2020/21, the responses to key questions in the 2019 staff survey, do indicate that on the whole female experience on a range of wellbeing indicators is more positive than it is for men. The following gives an indication of responses from 2019:

Staff survey question	**Female (%)**	**Male (%)**
Opportunities for flexible working (satisfied & very satisfied)	41	27
Experience of B&H from managers	12	15
Experience of B&H from colleagues	16	17
The Trust acts fairly in respect of career progression	81	70
Experience of discrimination from manager	9	12

6 LEGAL and/or GOVERNANCE IMPLICATIONS

6.1 As stated above, the WRES and WDES metrics and action plans are to be published in line with the commitments of the NHS Contract. The submission and publication of gender pay gap information is a legal requirement for an organisation of more than 250 staff.

6.2 This activity supports our commitment to ensure compliance with the Equality Act 2010 and with the Public Sector Equality Duty.

6.3 The work contributes to the Well Led domain of the CQC priorities, but the impact is felt across all areas.

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to:

- Note the outcomes of the WRES, WDES and gender pay gap analysis
- Note planned race, disability and gender activities for next 12 months
- Approve the WRES, WDES and gender data for external publication

Appendix 1 - Workforce Race Equality Standard – Final end of year position of Agreed Action Plan September 2019 for the period 2019-2020

Metric	Action	Lead stakeholder	Progress as at end November 2019	End of year position summer 2020
1 – Workforce by Band	- Data cleanse exercise of those with 'ethnicity unknown' on ESR record	- HR Hub	- On local workplan	- Reduction in unknown ethnicity from 1.4% to 1.26% (from 89 to 83 staff)
	- Increase awareness of WRES data across the Trust	- Corporate HR Team and Managers	- Ongoing. Race included in quarterly Equality updates which are sent to all managers. Request that these are included on new intranet from now onwards too. Item submitted to 'Be Inspired' about NA BME conference held October 2019.	- Information presented at Race Equality Forum October 2019. Ongoing development of forum will continue. Presentations to Board, PTS Operations and Training Teams have taken place.
2 – Recruitment	- Continue to attend recruitment in areas of diversity across the NWAS footprint	- HR Hub with Widening Access Team and Recruitment Positive Action Officer	- Number of events attended shared at each update meeting. Targeting certain areas.	- Many events held previously and full list is detailed in Equality and Inclusion annual report 2019-2020. More recently events have stopped due to covid-19 but contacts in communities sustained through technology.

	- Continue to promote range of roles and opportunities available within NWAS - Collate data for this WRES metric on a quarterly basis - Continue to promote NWAS as inclusive employer through social media presence	- HR Hub with Widening Access Team and Recruitment Positive Action Officer - HR Hub and Workforce Manager - Communications	- Range of roles promoted at recruitment events - Recruitment data for first 6 months shared at meeting in November 2019. - Tweets from NWAMB_Inclusion about events attended.	- As above. - Completed. Information shared by HR Hub quarterly at WRES meetings. - Work also completed on 2 diverse recruitment videos to be launched autumn 2020
3 – Disciplinary	- Review the recently published national guidance and share with the Investigations and Disciplinaries Working Group for consideration and action planning	- HR BP Team	- Working Group not fully established but guidance shared with colleagues in HR BP Team	- Cases have been looked at to identify any potential themes and shared at NWAS meeting. Working group not yet established.
4 – Accessing non-mandatory and CPD training	- Continue to improve recording of all non-mandatory and CPD across the Trust particularly through working with staff and managers delivering locally advertised - Continue to promote courses targeting BME staff, whether	- Education and L&D Teams	- Data being collated and reviewed so targeted training and CPD can be considered for the future.	- Data collation has improved with increase in number of staff recorded as having had CPD/non-mandatory training.

	external such as through NW Leadership Academy or sessions arranged internally	- L&D and Education Teams	- Stepping Up programme to be advertised by L&D Team. RECAP programme was advertised with 2 staff invited onto the first cohort starting January 2020.	- NWAS representation on Stepping Up and RECAP (cohort 1) programmes. Staff supported to attend National Ambulance BME conference in Brighton.
5 – % staff experiencing abuse from patients	- Violence and Aggression Working Group to consider this WRES metric when action planning Trust approach	- Violence and Aggression Working Group	- Chair of V&A group to attend Race Forum January 2020 to hear directly from staff about violence, aggression and harassment in the workplace.	- Improved links between V&A group and WRES work.
6 – % staff experiencing abuse from staff	- Bullying and Harassment Working Group to consider this WRES metric when action planning Trust approach	- HR BP Team	- Agreed at most recent meeting that this should sit with work of V&A group in metric 5.	- B&H mentioned at V&A group although remit of the group is on patient/public abuse. - Development of Treat Me Right campaign, but some progress stalled due to Covid. 'Is it really banter' workshop took place with positive evaluation so further sessions to be planned. Closer working between HR and F2SU guardian

				too, including sharing letter from national F2SU and WRES leads.
7 – % staff believing Trust offers equal opportunities for career progression	- Continuous revision of selection processes	- HR Hub	- Inclusive Recruitment toolkit from National Ambulance BME Network shared with HR Hub Manager for consideration. Staff on RECAP programme to focus on inclusive recruitment.	- RECAP project work stalled during covid-19.
	- Review of progression data	- HR Hub and L&D Teams	- Agreed that the review of progression data sits best with Workforce, L&D and Training Teams. Corporate HR Team has approached to discuss further with these teams.	- To form part of 20/21 plans.
8 – % staff experiencing discrimination from manager/colleague	- Evaluate pilot of 'Is it banter?' training and consider approach to making this a permanent training opportunity	- L&D Team and HR BP Teams	- Pilot has been evaluated. Bespoke session arranged January 2020 as requested by managers.	- January 2020 session took place with positive evaluation. Revision of slides during summer with further dates to be arranged.
	- Review of Be Think Do and other programmes to ensure diversity and inclusion is embedded	- Corporate HR Team with L&D and Education Teams	- Invite to L&D to recent Equality training session and further discussion to take place December 2019 about next steps for further embedding ED&I into training programmes	- To be included on 20/21 plan.

9 – Board Representation	- All of the Board and Executive Team members will be asked to update all of their personal monitoring information and asked to discuss any concerns they may have about this directly with the Interim Director of OD or HR Advisor for Equality and Workforce. - Board Development session on Inclusion scheduled for December 2019 will include discussion about race in the workplace	- Corporate Governance - Corporate HR Team	- To be flagged at Board Development session 10th December 2019 - Presentation prepared with Programme Manager on Diversity for AACE to present as a guest speaker	- Request made December 2019. - Completed. Senior leaders have also asked to be updated on Race Equality Forum and indeed attended a Forum summer 2020.

Appendix 2 – WRES data summer 2020 collation

1 - Workforce data – percentage of staff BME / White categories

	Data as at 31 March 2019	**Data as at 31 March 2020**
Total workforce	6356	6598
Number of BME staff	286	304
% BME staff in total workforce	4.5%	4.6%

2. Recruitment data

Likelihood of BME staff being appointed from shortlisting is 1.29.

The target figure is 1.0 which would indicate no difference in experience in likelihood of being appointed.

3: Likelihood of BME staff entering formal disciplinary process compared with White staff:

	2019	**2020**
Likelihood	1.32	1.89

4: Likelihood of BME staff accessing non-mandatory training and CPD as compared with White staff:

	2019	**2020**
Likelihood	1.45	1.31

5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months:

	Staff survey 2017	**Staff survey 2018**	**Staff survey 2019**
White	49.8%	47.00%	48%
BME	45.7%	38.00%	35%

6: Percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months:

	Staff survey 2017	**Staff survey 2018**	**Staff survey 2019**
White	27.5%	25.80%	24.5%
BME	30.9%	27.50%	25%

7: Percentage of staff believing that Trust provides equal opportunities for career progression or promotion

	Staff survey 2017	Staff survey 2018	Staff survey 2019
White	69.1%	74.30%	76%
BME	45.5%	56.50%	57%

8: Percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues

	Staff survey 2017	Staff survey 2018	Staff survey 2019
White	13.4%	10.60%	11%
BME	23.2%	12.80%	14%

9: Percentage difference in board voting membership and overall workforce:

(This metric had previously collated data relating to the local population; it now looks at the current workforce).

	2019	2020
White	-17.2%	-5.9%
BME	3.2%	1.3%
Ethnicity unknown/NULL as per ESR	14.0%	4.6%

Appendix 3 – Workforce Disability Equality Standard – Action Plan for the period 2019-2020 – end of year position summer 2020

Metric	Action	Lead stakeholder	End of year progress as at end summer 2020
1 – Workforce Information	Continue data cleanse exercise Promote self-declaration on ESR	HR Hub Corporate HR Team	Reduction in number of staff for who information about disabled status is unknown from 952 to 777 (15.0% to 11.8%) Recent discussions focused on development of disability passport first with this piece of work to follow so propose this action carried into next action plan
2 – Recruitment	Continue to promote NWAS as an inclusive employer	HR Hub and Recruiting Managers	HR Hub liaises with Recruiting Managers with regards to responsibilities for supporting reasonable adjustments. Disability Confident information on NWAS site which is available on the link straight from NHS Jobs. Staff attending external events aware of NWAS aims to recruit diverse candidates.
3 – Capability	Continue to support disabled and non-disabled staff though the performance and sickness policies through individualised bespoke management support. Review the national information and guidance about this metric when published.	HR BP Team and Managers HR BP Team	This takes place as a 'business as usual' approach within the HR BP Team with managers, offering support as required, National guidance about the sickness capability aspect of this guidance was not released during 2019-2020.
4 – Staff survey	Bullying and Harassment working group to consider and progress this metric during action planning.	B&H working group	It was initially thought that as the B&H working group ceased, this work would be taken on by the V&A group, yet much of their work is responding to abuse from patients and the public. However work undertaken has included design, delivery and evaluation of two 'Is it really banter?' sessions with staff/managers; development of 'Treat me right'

	Seek feedback from the Disability Forum about the issues affecting disabled staff with regards to bullying and harassment.	Corporate HR	campaign; promotion of health and wellbeing support at Disability Forum and presence of Freedom to Speak Up Lead at Disability Forum too. B&H was to be discussed at April 2020 Disability Forum which didn't take place due to Covid. As above – range of reporting and support methods have been promoted to staff and data about this metric has also been shared with the group.
5 – Career progression	Continuous revision of selection processes Review of progression data	HR Hub and L&D L&D Team	Be Think Do assessment centres have been active since September 2019. Due to COVID-19 and social distancing requirements these were on hold Mar 20 – Jun 20 but starting up again Jul 20 Evaluation of the Be Think Do assessment centres taking place Jul 20 – Aug 20, involving recruiting managers and candidates, to understand the effectiveness of current practices
6 – Attending work	Continuous review of management of sickness absence Continuous review of Be Think Do and other programmes to ensure compassionate leadership is reflected in the training content	HR BP Team L&D Team	This is a 'business as usual' part of the HR BP Team work in line with workforce strategy. Plans in place for the forthcoming review of the sickness policy to include HR Advisor for Workforce and Equality re input on staff with disabilities. Training Managers and L&D Managers invited to equality awareness training session November 2019 and February which included section on disability. Due to COVID-19 most L&D workshops have been on hold (exceptions being CMI and appraisals). Virtual workshops are being developed.

7 – Feeling valued	Continuous review of Be Think Do and other programmes to ensure recognition and valuing staff are key feature of the training content Range of recognition schemes and initiatives available to managers	L&D Team Communications Team	As above, Be Think Do evaluation taking place summer 2020. Also appraisal paperwork refreshed Jun 20 with the start of the appraisal being a H&WB conversation. Any identified support is to be added to the individual's PDP Comms team promote staff recognition in a variety of ways – which has become 'business as usual'.
8 – Reasonable adjustments	Promoting disability as an asset though Trust wide communications and events open to all Reviewing support available to managers as individuals and as a group Improving portability of reasonable adjustments for staff transferring within the organisation	Corporate HR Team HR BP Team Corporate HR Team	Again this has become 'business as usual' between Corporate HR Team, Comms and L&D Teams promoting case studies, tweeting information, advertising relevant webinars etc about disability in the workplace. Intranet section on Disability Forum now set up. This is part of the ongoing work within the HR BP Team about reflecting on the support offered to individual managers and as a wider group. Specifically to disability, there has been regular attendance from the HR BP Team at Disability Forums too which can help inform the support offered. Input from group into Work and Wellbeing passport too. Progress on the Disability Passport stalled due to Covid but progress made again summer 2020 with first conversations of now-called Work and Wellbeing passport scheduled September 2020. Trade union involvement in planning the pilot for this too.
9 – Staff engagement	Disability Forum to be held quarterly	Corporate HR Team	Sessions held July 2019, October 2019, January 2020 but April one did not go ahead due to Covid. Forum staff were written

			to in May 2020. Document detailing achievements of first 12 months of Forum available on intranet. Range of speakers about different conditions attended and outcomes of the sessions included Procurement Flowchart and representative of Forum attending WDES action plan meetings from March 2020 onwards.
10 – Board Representation	All of the Board and Executive Team members will be asked to update all of their personal monitoring information and asked to discuss any concerns they may have about this directly with the Interim Director of OD or HR Advisor for Equality and Workforce. Board Development session on Inclusion scheduled for December 2019 will include disability	Corporate Governance Corporate HR Team	Completed – requested after Board Development session December 2019. Completed. This has led onto further discussions about the inclusive and visible leadership on a range of equality issues including disability.

Appendix 4 – Workforce Disability Equality Standard Data as at 31st March 2020

For publication summer 2020

(Red if 2019 and need updating)

Metric 1 – Workforce information

	Percentage of disabled staff 2019	**2020**
Non clinical staff – Cluster Bands 1 - 4	5%	4.7%
Non clinical staff – Cluster Bands 5-7	2%	3.5%
Non clinical staff – Cluster Bands 8a-8b	3%	0%
Non clinical staff – Cluster Bands 8c-9 and VSM	3%	2.6%
Clinical staff – Cluster Bands 1-4	3%	3.65%
Clinical staff – Cluster Bands 5-7	4%	4.05%
Clinical staff – Cluster Bands 8a-8b	2%	3.70%
Clinical staff – Cluster Bands 8c-9 and VSM	8%	7.69%

Metric 2 – Recruitment

Likelihood of 1.1 compared with 1.0 the previous year.

This metric looks specifically at the likelihood of being appointed from shortlisting. The outcome is a figure of 1.0 and means that disabled candidates are no more or less likely to be appointed from shortlisting than candidates who have not declared a disability. A figure of 1.0 reflects well on the fairness of current recruitment processes.

Metric 3 – Formal Performance Process

Likelihood is 5.52

This metric was voluntary and not reported by NWAS last year. As for recruitment, a figure of 1.0 is desired as this would indicate staff with disclosed disabilities are no more or less likely to enter into a formal capability process with the Trust than staff without disclosed disabilities. Only the Performance policy is used by NWAS to calculate this figure, in line with the technical guidance; it does not include sickness capability processes.

Metric 4 – Staff Survey

This metric collates the data from four staff survey questions relating to bullying, harassment, abuse, discrimination and reporting such behaviours.

Metric 4 – This metric uses information from four separate staff survey questions on the theme of harassment and bullying.

The first question in this metric relates to the % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	45.8%	45%
Disabled	52.0%	56%

The second question relates to the % of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	13.2%	12%
Disabled	25.8%	23%

The third question relates to the % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	15.6%	15%
Disabled	26.5%	27%

The final question which forms part of Metric 4 relates to the % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	38.3%	44%
Disabled	40.1%	49%

Metric 5 – Equal opportunities for career progression

The data from this metric also comes from the staff survey. It showed that 65% of disabled staff felt that the organisation provided equal opportunities for career progression compared with 77% of non-disabled staff feeling that there were equal opportunities.

	Staff survey 2018	**Staff survey 2019**
Non-disabled	76.5%	77%
Disabled	61.4%	65%

Metric 6 – Attending work

The staff survey question relating to this metric asks about staff feeling under pressure to come into work from their manager when they don't feel well enough to perform their duties.

	2018	2019
Non-disabled	32.6%	31%
Disabled	45.3%	44%

Metric 7 – Feeling Valued

This question asks about staff feeling satisfied with the extent to which the organisation values their work. The data showed that 29% staff with a disability felt satisfied with the extent to which the organisation values their work; this compares to 40% of non-disabled staff.

	Staff survey 2018	Staff survey 2019
Non-disabled	36.7%	40%
Disabled	25.3%	29%

Metric 8 – Reasonable Adjustments

This question asks staff with a disability to advise whether the organisation has made adequate adjustments to enable them to carry out their work.

	Staff survey 2018	Staff survey 2019
Disabled	60.3%	58%

Metric 9 – Staff engagement

This metric provides an engagement score, calculated from 9 specific questions from the staff survey. There remains a gap between the engagement score for staff with and without disabilities in staff survey responses, but the gap has narrowed slightly according to these results.

Engagement score:

	2018	2019
Non-disabled	6.4	6.4
Disabled	5.7	5.8

This metric also asks whether the organisation has taken action to facilitate the voices of disabled staff to be heard, to which NWAS has said 'Yes'.

Metric 10 – Board representation

The data again shows an overall underrepresentation of disabled people on the Board, voting membership and executive membership when compared with the overall workforce. This is due to no Board members having declared a disability which has been recorded on ESR; there are 3 Board members who have not advised of their disabled status.

NWAS narrative in response to Metric 9 is as follows:

NWAS has held several Disability Forums to hear the voice of disabled staff. There have been different guest speakers to explain the experiences of having different conditions and how these can affect staff in the workplace. Proactive work has included the development of a Procurement Flowchart in response to queries about difficulties in understanding the process of purchasing equipment as part of a reasonable adjustment. The achievements of the first 12 months of the Disability Forum are available on the intranet. The Freedom to Speak Up lead has attended and spoken at a session.

Appendix 5 - Gender Equality Action Plan for the period 2019-2020

Theme	Action	Lead stakeholder	End of year position July 2020
Recruitment	- Review of assessment for managerial/leadership posts to incorporate Be Think Do approach	- HR Hub and Learning and Development Teams	- Assessment centres effective from September 2019. Job descriptions, adverts and VCP forms updated to reflect this. Evaluation of the BTD assessment centres taking place July to August 2020, involving recruiting managers and candidates, to understand the effectiveness of current practices.
	- Consideration of gender in recruitment and selection process	- HR Hub	- The HR Hub challenges recruiting managers about the make-up of recruitment and selection panels as appropriate. -
Career progression	- Completion of first cohort of Empowering Women programme. Receive feedback through the programme and complete final evaluation after completing cohort one.	- Learning and Development Team	- Final evaluation completed for cohort one and feedback disseminated to HR.
	- Draft Aspiring Women programme for consideration, targeting paramedics for Senior Paramedic Team Leader roles	- Learning and Development Team	- This work has gone on hold pending recruitment of Head of L&D/OD position.
	- Review how development opportunities are offered	- OD Directorate – various stakeholders for internal and external development opportunities	- Teams have worked collaboratively to promote a range of roles and opportunities. Work on specifically targeting groups about particular opportunities will carry over to next year.

Flexible working – reflecting culture supportive to differing staff needs through course of employment cycle	- Rota review to be completed - Flexible working policy review completed - Ongoing promotion of inclusive culture through guidance and policy review	- HR BP Team - HR BP Team - Corporate HR Team	- The rota review is continuing so this activity will carry into next year's plan. An Equality Impact Assessment was undertaken for the project. - Complete - This is undertaken through Corporate HR Team involvement with Policy Group to promote inclusion and a review in the last 12 months of the Equality Impact Assessment paperwork for policies, strategies and projects. Specific policy revision includes working with Trust LGBT Network in revising the Trans policy.

Appendix 6 - Gender Pay Gap Data as at 31st March 2020

The NWAS Gender Pay Gap data is as follows:

The mean gender pay gap is 8.79%.

The median gender pay gap is 7.16%.

Bonus payments

Bonus payments are eligible to the Trusts staff on Very Senior Manager (VSM) contracts. Out of this group there are 7 eligible staff

Proportion of males and females who got bonus payments

Bonuses are only available to very senior roles.

0% of eligible males received a bonus and 67% of eligible female received a bonus.

Mean gender pay gap in bonus payments

Mean amount of bonus pay for women is £1796.37

Median gender pay gap in bonus payment

Median is the mid-point of the bonus payment.

Median bonus payment is £2694.56

The pay quartile information is as follows:

Quartile	Female	Male	Female %	Male %
Low - 1	909.00	736.00	55.26%	44.74%
2	882.00	762.00	53.65%	46.35%
3	770.00	875.00	46.81%	53.19%
High - 4	604.00	1040.00	36.74%	63.26%

Appendix 7 – Proposed Gender Equality Action Plan for the period 2020-2021

Theme	Action	Lead stakeholder (and teams)
Recruitment	- Review of assessment for managerial/leadership posts to incorporate Be Think Do approach (carried over from last year). Specifically looking at recruiting manager and candidate experiences by gender.	- Head of L&OD with L&D Team
	- Revision of HR Recruitment and Selection masterclass with regards to gender – including candidate experience, interview and selection methods	- Sarah Moss (and HR Hub)
	- Targeted promotion of the HR Recruitment and Selection masterclass with regards to gender	- Head of L&OD with L&D Team
Career progression	- Review of NWAS bespoke female development programme and consider further programme	- Head of L&OD
	- Facilitating informal mentoring between previous candidates of Empowering Women programme and other female staff within the organisation to offer bespoke personalised support	- Head of L&OD and Deputy Director of Operations
	- Continue to promote external development opportunities targeting female applicants	- Head of L&OD and Operational Managers
	- Monitoring and tracking of gender mix of apprentices and paramedic applications	- Head of Education and Consultant of Paramedic Education
	- Exploration of staff survey data on career progression for female staff and relevant finding shared. Next steps considered at that point by all stakeholders.	- Steph Chadwick to look at career progression question with findings shared through HR BP Team to Operational Managers and People

		Directorate. Operational manager to work with corporate colleagues to develop actions.
Flexible working – reflecting culture supportive to differing staff needs through course of employment cycle; further exploration of staff survey information about flexible working	- Rota review to be completed (carried over from previous year) - Flexible working policy review to be completed (carried over from previous year) - Exploration of staff survey data on flexible working for female staff and relevant findings shared. Next steps considered at that point by all stakeholders	- Joanne Jones as HR BP representative - Joanne Jones as HR BP representative - Steph Chadwick to look at career progression with findings shared through HR BP Team to Operational Managers and People Directorate. Operational manager to work with corporate colleagues to develop actions.

This page is intentionally left blank

Appendix 1 - Workforce Race Equality Standard – Final end of year position of Agreed Action Plan September 2019 for the period 2019-2020

Metric	Action	Lead stakeholder	Progress as at end November 2019	End of year position summer 2020
1 – Workforce by Band	- Data cleanse exercise of those with 'ethnicity unknown' on ESR record	- HR Hub	- On local workplan	- Reduction in unknown ethnicity from 1.4% to 1.26% (from 89 to 83 staff)
	- Increase awareness of WRES data across the Trust	- Corporate HR Team and Managers	- Ongoing. Race included in quarterly Equality updates which are sent to all managers. Request that these are included on new intranet from now onwards too. Item submitted to 'Be Inspired' about NA BME conference held October 2019.	- Information presented at Race Equality Forum October 2019. Ongoing development of forum will continue. Presentations to Board, PTS Operations and Training Teams have taken place.
2 – Recruitment	- Continue to attend recruitment in areas of diversity across the NWAS footprint	- HR Hub with Widening Access Team and Recruitment Positive Action Officer	- Number of events attended shared at each update meeting. Targeting certain areas.	- Many events held previously and full list is detailed in Equality and Inclusion annual report 2019-2020. More recently events have stopped due to covid-19 but contacts in communities

				sustained through technology.
	- Continue to promote range of roles and opportunities available within NWAS	- HR Hub with Widening Access Team and Recruitment Positive Action Officer	- Range of roles promoted at recruitment events	- As above.
	- Collate data for this WRES metric on a quarterly basis	- HR Hub and Workforce Manager	- Recruitment data for first 6 months shared at meeting in November 2019.	- Completed. Information shared by HR Hub quarterly at WRES meetings.
	- Continue to promote NWAS as inclusive employer through social media presence	- Communications	- Tweets from NWAMB_Inclusion about events attended.	- Work also completed on 2 diverse recruitment videos to be launched autumn 2020
3 – Disciplinary	- Review the recently published national guidance and share with the Investigations and Disciplinaries Working Group for consideration and action planning	- HR BP Team	- Working Group not fully established but guidance shared with colleagues in HR BP Team	- Cases have been looked at to identify any potential themes and shared at NWAS meeting. Working group not yet established.
4 – Accessing non-mandatory and CPD training	- Continue to improve recording of all non-mandatory and CPD across the Trust particularly through working with staff and	- Education and L&D Teams	- Data being collated and reviewed so targeted training and CPD can be considered for the future.	- Data collation has improved with increase in number of staff recorded as having had CPD/non-

	managers delivering locally advertised - Continue to promote courses targeting BME staff, whether external such as through NW Leadership Academy or sessions arranged internally	- L&D and Education Teams	- Stepping Up programme to be advertised by L&D Team. RECAP programme was advertised with 2 staff invited onto the first cohort starting January 2020.	mandatory training. - NWAS representation on Stepping Up and RECAP (cohort 1) programmes. Staff supported to attend National Ambulance BME conference in Brighton.
5 – % staff experiencing abuse from patients	- Violence and Aggression Working Group to consider this WRES metric when action planning Trust approach	- Violence and Aggression Working Group	- Chair of V&A group to attend Race Forum January 2020 to hear directly from staff about violence, aggression and harassment in the workplace.	- Improved links between V&A group and WRES work.
6 – % staff experiencing abuse from staff	- Bullying and Harassment Working Group to consider this WRES metric when action planning Trust approach	- HR BP Team	- Agreed at most recent meeting that this should sit with work of V&A group in metric 5.	- B&H mentioned at V&A group although remit of the group is on patient/public abuse. - Development of Treat Me Right campaign, but some progress stalled due to covid. 'Is it really banter' workshop took place with

				positive evaluation so further sessions to be planned. Closer working between HR and F2SU guardian too, including sharing letter from national F2SU and WRES leads.
7 – % staff believing Trust offers equal opportunities for career progression	- Continuous revision of selection processes - Review of progression data	- HR Hub - HR Hub and L&D Teams	- Inclusive Recruitment toolkit from National Ambulance BME Network shared with HR Hub Manager for consideration. Staff on RECAP programme to focus on inclusive recruitment. - Agreed that the review of progression data sits best with Workforce, L&D and Training Teams. Corporate HR Team has approached to discuss further with these teams.	- RECAP project work stalled during covid-19. - To form part of 20/21 plans.
8 – % staff experiencing discrimination from manager/colleague	- Evaluate pilot of 'Is it banter?' training and consider approach to making this a permanent training opportunity - Review of Be Think Do and	- L&D Team and HR BP Teams - Corporate HR Team	- Pilot has been evaluated. Bespoke session arranged January 2020 as requested by managers. - Invite to L&D to recent	- January 2020 session took place with positive evaluation. Revision of slides during summer with further dates to be arranged. - To be included on

	other programmes to ensure diversity and inclusion is embedded	with L&D and Education Teams	Equality training session and further discussion to take place December 2019 about next steps for further embedding ED&I into training programmes	20/21 plan.
9 – Board Representation	- All of the Board and Executive Team members will be asked to update all of their personal monitoring information and asked to discuss any concerns they may have about this directly with the Interim Director of OD or HR Advisor for Equality and Workforce. - Board Development session on Inclusion scheduled for December 2019 will include discussion about race in the workplace	- Corporate Governance - Corporate HR Team	- To be flagged at Board Development session 10th December 2019 - Presentation prepared with Programme Manager on Diversity for AACE to present as a guest speaker	- Request made December 2019. - Completed. Senior leaders have also asked to be updated on Race Equality Forum and indeed attended a Forum summer 2020.

This page is intentionally left blank

Appendix 2 – WRES data summer 2020 collation

1 - Workforce data – percentage of staff BME / White categories

	Data as at 31 March 2019	**Data as at 31 March 2020**
Total workforce	6356	6598
Number of BME staff	286	304
% BME staff in total workforce	4.5%	4.6%

2. Recruitment data

Likelihood of BME staff being appointed from shortlisting is 1.29.

The target figure is 1.0 which would indicate no difference in experience in likelihood of being appointed.

3: Likelihood of BME staff entering formal disciplinary process compared with White staff:

	2019	**2020**
Likelihood	1.32	1.89

4: Likelihood of BME staff accessing non-mandatory training and CPD as compared with White staff:

	2019	**2020**
Likelihood	1.45	1.31

5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months:

	Staff survey 2017	**Staff survey 2018**	**Staff survey 2019**
White	49.8%	47.00%	48%
BME	45.7%	38.00%	35%

6: Percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months:

	Staff survey 2017	**Staff survey 2018**	**Staff survey 2019**
White	27.5%	25.80%	24.5%
BME	30.9%	27.50%	25%

7: Percentage of staff believing that Trust provides equal opportunities for career progression or promotion

	Staff survey 2017	Staff survey 2018	Staff survey 2019
White	69.1%	74.30%	76%
BME	45.5%	56.50%	57%

8: Percentage of staff personally experiencing discrimination at work from manager/team leader or other colleagues

	Staff survey 2017	Staff survey 2018	Staff survey 2019
White	13.4%	10.60%	11%
BME	23.2%	12.80%	14%

9: Percentage difference in board voting membership and overall workforce:

(This metric had previously collated data relating to the local population; it now looks at the current workforce).

	2019	2020
White	-17.2%	-5.9%
BME	3.2%	1.3%
Ethnicity unknown/NULL as per ESR	14.0%	4.6%

Appendix 4 – Workforce Disability Equality Standard – Action Plan for the period 2019-2020 – end of year position summer 2020

Metric	Action	Lead stakeholder	End of year progress as at end summer 2020
1 – Workforce Information	Continue data cleanse exercise Promote self declaration on ESR	HR Hub Corporate HR Team	Reduction in number of staff for who information about disabled status is unknown from 952 to 777 (15.0% to 11.8%) Recent discussions focused on development of disability passport first with this piece of work to follow so propose this action carried into next action plan
2 – Recruitment	Continue to promote NWAS as an inclusive employer	HR Hub and Recruiting Managers	HR Hub liaises with Recruiting Managers with regards to responsibilities for supporting reasonable adjustments. Disability Confident information on NWAS site which is available on the link straight from NHS Jobs. Staff attending external events aware of NWAS aims to recruit diverse candidates.
3 – Capability	Continue to support disabled and non-disabled staff though the performance and sickness policies through individualised bespoke management support. Review the national information and guidance about this metric when published.	HR BP Team and Managers HR BP Team	This takes place as a 'business as usual' approach within the HR BP Team with managers, offering support as required, National guidance about the sickness capability aspect of this guidance was not released during 2019-2020.
4 – Staff survey	Bullying and Harassment working group to consider and progress this metric during action planning.	B&H working group	It was initially thought that as the B&H working group ceased, this work would be taken on by the V&A group, yet much of their work is responding to abuse from patients and the public. However work undertaken has included design, delivery and evaluation of two 'Is it really banter?' sessions with staff/managers; development of 'Treat me right' campaign; promotion of health and wellbeing support at Disability Forum and presence of Freedom to Speak Up Lead at Disability Forum too.

	Seek feedback from the Disability Forum about the issues affecting disabled staff with regards to bullying and harassment.	Corporate HR	B&H was to be discussed at April 2020 Disability Forum which didn't take place due to covid. As above – range of reporting and support methods have been promoted to staff and data about this metric has also been shared with the group.
5 – Career progression	Continuous revision of selection processes	HR Hub and L&D	Be Think Do assessment centres have been active since September 2019. Due to COVID-19 and social distancing requirements these were on hold Mar 20 – Jun 20 but starting up again Jul 20
	Review of progression data	L&D Team	Evaluation of the Be Think Do assessment centres taking place Jul 20 – Aug 20, involving recruiting managers and candidates, to understand the effectiveness of current practices
6 – Attending work	Continuous review of management of sickness absence	HR BP Team	This is a 'business as usual' part of the HR BP Team work in line with workforce strategy. Plans in place for the forthcoming review of the sickness policy to include HR Advisor for Workforce and Equality re input on staff with disabilities.
	Continuous review of Be Think Do and other programmes to ensure compassionate leadership is reflected in the training content	L&D Team	Training Managers and L&D Managers invited to equality awareness training session November 2019 and February which included section on disability. Due to COVID-19 most L&D workshops have been on hold (exceptions being CMI and appraisals). Virtual workshops are being developed.
7 – Feeling valued	Continuous review of Be Think Do and other programmes to ensure recognition and valuing staff are key feature of the training content	L&D Team	As above, Be Think Do evaluation taking place summer 2020. Also appraisal paperwork refreshed Jun 20 with the start of the appraisal being a H&WB conversation. Any identified support is to be added to the individual's PDP
	Range of recognition schemes and initiatives available to managers	Communications Team	Comms team promote staff recognition in a variety of ways – which has become 'business as usual'.
8 – Reasonable	Promoting disability as an asset though Trustwide	Corporate HR	Again this has become 'business as usual' between Corporate

adjustments	communications and events open to all	Team	HR Team, Comms and L&D Teams promoting case studies, tweeting information, advertising relevant webinars etc about disability in the workplace. Intranet section on Disability Forum now set up.
	Reviewing support available to managers as individuals and as a group	HR BP Team	This is part of the ongoing work within the HR BP Team about reflecting on the support offered to individual managers and as a wider group. Specifically to disability, there has been regular attendance from the HR BP Team at Disability Forums too which can help inform the support offered. Input from group into Work and Wellbeing passport too.
	Improving portability of reasonable adjustments for staff transferring within the organisation	Corporate HR Team	Progress on the Disability Passport stalled due to Covid but progress made again summer 2020 with first conversations of now-called Work and Wellbeing passport scheduled September 2020. Trade union involvement in planning the pilot for this too.
9 – Staff engagement	Disability Forum to be held quarterly	Corporate HR Team	Sessions held July 2019, October 2019, January 2020 but April one did not go ahead due to covid. Forum staff were written to in May 2020. Document detailing achievements of first 12 months of Forum available on intranet. Range of speakers about different conditions attended and outcomes of the sessions included Procurement Flowchart and representative of Forum attending WDES action plan meetings from March 2020 onwards.
10 – Board Representation	All of the Board and Executive Team members will be asked to update all of their personal monitoring information and asked to discuss any concerns they may have about this directly with the Interim Director of OD or HR Advisor for Equality and Workforce.	Corporate Governance	Completed – requested after Board Development session December 2019.
	Board Development session on Inclusion	Corporate HR	Completed. This has led onto further discussions about the

	scheduled for December 2019 will include disability	Team	inclusive and visible leadership on a range of equality issues including disability.

Appendix 5 – Workforce Disability Equality Standard Data as at 31st March 2020

For publication summer 2020

(Red if 2019 and need updating)

Metric 1 – Workforce information

	Percentage of disabled staff 2019	**2020**
Non clinical staff – Cluster Bands 1 - 4	5%	4.7%
Non clinical staff – Cluster Bands 5-7	2%	3.5%
Non clinical staff – Cluster Bands 8a-8b	3%	0%
Non clinical staff – Cluster Bands 8c-9 and VSM	3%	2.6%
Clinical staff – Cluster Bands 1-4	3%	3.65%
Clinical staff – Cluster Bands 5-7	4%	4.05%
Clinical staff – Cluster Bands 8a-8b	2%	3.70%
Clinical staff – Cluster Bands 8c-9 and VSM	8%	7.69%

Metric 2 – Recruitment

Likelihood of 1.1 compared with 1.0 the previous year.

This metric looks specifically at the likelihood of being appointed from shortlisting. The outcome is a figure of 1.0 and means that disabled candidates are no more or less likely to be appointed from shortlisting than candidates who have not declared a disability. A figure of 1.0 reflects well on the fairness of current recruitment processes.

Metric 3 – Formal Performance Process

Likelihood is 5.52

This metric was voluntary and not reported by NWAS last year. As for recruitment, a figure of 1.0 is desired as this would indicate staff with disclosed disabilities are no more or less likely to enter into a formal capability process with the Trust than staff without disclosed disabilities. Only the Performance policy is used by NWAS to calculate this figure, in line with the technical guidance; it does not include sickness capability processes.

Metric 4 – Staff Survey

This metric collates the data from four staff survey questions relating to bullying, harassment, abuse, discrimination and reporting such behaviours.

Metric 4 – This metric uses information from four separate staff survey questions on the theme of harassment and bullying.

The first question in this metric relates to the % of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	45.8%	45%
Disabled	52.0%	56%

The second question relates to the % of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	13.2%	12%
Disabled	25.8%	23%

The third question relates to the % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	15.6%	15%
Disabled	26.5%	27%

The final question which forms part of Metric 4 relates to the % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.

	2018 survey score	**2019 survey score**
Non-disabled	38.3%	44%
Disabled	40.1%	49%

Metric 5 – Equal opportunities for career progression

The data from this metric also comes from the staff survey. It showed that 65% of disabled staff felt that the organisation provided equal opportunities for career progression compared with 77% of non-disabled staff feeling that there were equal opportunities.

	Staff survey 2018	**Staff survey 2019**
Non-disabled	76.5%	77%
Disabled	61.4%	65%

Metric 6 – Attending work

The staff survey question relating to this metric asks about staff feeling under pressure to come into work from their manager when they don't feel well enough to perform their duties.

	2018	2019
Non-disabled	32.6%	31%
Disabled	45.3%	44%

Metric 7 – Feeling Valued

This question asks about staff feeling satisfied with the extent to which the organisation values their work. The data showed that 29% staff with a disability felt satisfied with the extent to which the organisation values their work; this compares to 40% of non-disabled staff.

	Staff survey 2018	Staff survey 2019
Non-disabled	36.7%	40%
Disabled	25.3%	29%

Metric 8 – Reasonable Adjustments

This question asks staff with a disability to advise whether the organisation has made adequate adjustments to enable them to carry out their work.

	Staff survey 2018	Staff survey 2019
Disabled	60.3%	58%

Metric 9 – Staff engagement

This metric provides an engagement score, calculated from 9 specific questions from the staff survey. There remains a gap between the engagement score for staff with and without disabilities in staff survey responses, but the gap has narrowed slightly according to these results.

Engagement score:

	2018	2019
Non-disabled	6.4	6.4
Disabled	5.7	5.8

This metric also asks whether the organisation has taken action to facilitate the voices of disabled staff to be heard, to which NWAS has said 'Yes'.

Metric 10 – Board representation

The data again shows an overall underrepresentation of disabled people on the Board, voting membership and executive membership when compared with the overall workforce. This is due to no Board members having declared a disability which has been recorded on ESR; there are 3 Board members who have not advised of their disabled status.

NWAS narrative in response to Metric 9 is as follows:

NWAS has held several Disability Forums to hear the voice of disabled staff. There have been different guest speakers to explain the experiences of having different conditions and how these can affect staff in the workplace. Proactive work has included the development of a Procurement Flowchart in response to queries about difficulties in understanding the process of purchasing equipment as part of a reasonable adjustment. The achievements of the first 12 months of the Disability Forum are available on the intranet. The Freedom to Speak Up lead has attended and spoken at a session.

Appendix 7 - Gender Equality Action Plan for the period 2019-2020

Theme	Action	Lead stakeholder	End of year position July 2020
Recruitment	- Review of assessment for managerial/leadership posts to incorporate Be Think Do approach	- HR Hub and Learning and Development Teams	- Assessment centres effective from September 2019. Job descriptions, adverts and VCP forms updated to reflect this. Evaluation of the BTD assessment centres taking place July to August 2020, involving recruiting managers and candidates, to understand the effectiveness of current practices.
	- Consideration of gender in recruitment and selection process	- HR Hub	- The HR Hub challenges recruiting managers about the make-up of recruitment and selection panels as appropriate.
Career progression	- Completion of first cohort of Empowering Women programme. Receive feedback through the programme and complete final evaluation after completing cohort one.	- Learning and Development Team	- Final evaluation completed for cohort one and feedback disseminated to HR.
	- Draft Aspiring Women programme for consideration, targeting paramedics for Senior Paramedic Team Leader roles	- Learning and Development Team	- This work has gone on hold pending recruitment of Head of L&D/OD position.
	- Review how development opportunities are offered	- OD Directorate – various stakeholders for internal and external development opportunities	- Teams have worked collaboratively to promote a range of roles and opportunities. Work on specifically targeting groups about particular opportunities will carry over to next year.

Flexible working – reflecting culture supportive to differing staff needs through course of employment cycle	- Rota review to be completed	- HR BP Team	- The rota review is continuing so this activity will carry into next years plan. An Equality Impact Assessment was undertaken for the project.
	- Flexible working policy review completed	- HR BP Team	- TBC – checking with Jo Jones
	- Ongoing promotion of inclusive culture through guidance and policy review	- Corporate HR Team	- This is undertaken through Corporate HR Team involvement with Policy Group to promote inclusion and a review in the last 12 months of the Equality Impact Assessment paperwork for policies, strategies and projects. Specific policy revision includes working with Trust LGBT Network in revising the Trans policy.

Appendix 8 - Gender Pay Gap Data as at 31st March 2020

The NWAS Gender Pay Gap data is as follows:

The mean gender pay gap is 8.79%.

The median gender pay gap is 7.16%.

Bonus payments

Bonus payments are eligible to the Trusts staff on Very Senior Manager (VSM) contracts. Out of this group there are 7 eligible staff

Proportion of males and females who got bonus payments

Bonuses are only available to very senior roles.

0% of eligible males received a bonus and 67% of eligible female received a bonus.

Mean gender pay gap in bonus payments

Mean amount of bonus pay for women is £1796.37

Median gender pay gap in bonus payment

Median is the mid-point of the bonus payment.

Median bonus payment is £2694.56

The pay quartile information is as follows:

Quartile	Female	Male	Female %	Male %
Low - 1	909.00	736.00	55.26%	44.74%
2	882.00	762.00	53.65%	46.35%
3	770.00	875.00	46.81%	53.19%
High - 4	604.00	1040.00	36.74%	63.26%

This page is intentionally left blank

Appendix 9 – Proposed Gender Equality Action Plan for the period 2020-2021

Theme	Action	Lead stakeholder (and teams)
Recruitment	- Review of assessment for managerial/leadership posts to incorporate Be Think Do approach (carried over from last year). Specifically looking at recruiting manager and candidate experiences by gender.	- Head of L&OD with L&D Team
	- Revision of HR Recruitment and Selection masterclass with regards to gender – including candidate experience, interview and selection methods	- Sarah Moss (and HR Hub)
	- Targeted promotion of the HR Recruitment and Selection masterclass with regards to gender	- Head of L&OD with L&D Team
Career progression	- Review of NWAS bespoke female development programme and consider further programme	- Head of L&OD
	- Facilitating informal mentoring between previous candidates of Empowering Women programme and other female staff within the organisation to offer bespoke personalised support	- Head of L&OD and Deputy Director of Operations
	- Continue to promote external development opportunities targeting female applicants	- Head of L&OD and Operational Managers
	- Monitoring and tracking of gender mix of apprentices and paramedic applications	- Head of Education and Consultant of Paramedic Education
	- Exploration of staff survey data on career progression for female staff and relevant finding shared. Next steps considered at that point by all stakeholders.	- Steph Chadwick to look at career progression question with findings shared through HR BP Team to Operational Managers and People Directorate. Operational manager to work

		with Corporate colleagues to develop actions.
Flexible working – reflecting culture supportive to differing staff needs through course of employment cycle; further exploration of staff survey information about flexible working	- Rota review to be completed (carried over from previous year) - Flexible working policy review to be completed (carried over from previous year) - Exploration of staff survey data on flexible working for female staff and relevant findings shared. Next steps considered at that point by all stakeholders	- Joanne Jones as HR BP representative - Joanne Jones as HR BP representative - Steph Chadwick to look at career progression with findings shared through HR BP Team to Operational Managers and People Directorate. Operational manager to work with Corporate colleagues to develop actions.

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	30th September 2020
Subject:	Learning Lessons to Improve our People Practices – update
Presented by:	Lisa Ward, Director of people
Purpose of Paper:	For Assurance
Executive Summary:	Baroness Dido Harding, Chair of NHSI, wrote to all NHS Trusts on 24 May 2019 sharing an overview of the findings of an independent inquiry commissioned by Imperial College Healthcare NHS Trust into the management of their Trust's disciplinary process. Following on from the inquiry's findings, a task and finish Advisory Group was set up by NHSI involving professionals from the NHS and external bodies to establish whether the failings were unique or prevalent across NHS Trusts. This exercise identified a number of key themes similar to those identified by the inquiry and this informed new additional guidance on the management and oversight of local investigation and disciplinary procedures, based on 7 key actions. A report was submitted to Board in July 2019 which set out the review of current disciplinary cases which had been undertaken in the Trust, the key themes emerging and the next steps in addressing the recommendations contained within Baroness Harding's letter. This report provides an update on progress. In order to frame further work in relation to investigations and associated processes across the Trust, work was undertaken between the Medical, Quality and People directorates to develop a set of core principles based on best practice and in particular the NHS Resolution paper 'Being Fair'. These principles were consulted widely in early 2020 and are attached at Appendix 1. It was felt that this was a necessary precursor to a broader review of policies and processes as it sets a clear framework for the approach to be adopted. Appendix 1 also sets out a driver diagram identifying the key areas of work to be reviewed in light of the framework. Unfortunately this work was paused as a result of the pandemic and in particular the review of the disciplinary policy and processes at the heart of the work has not concluded but is due to recommence in phase 3 of the recovery. Despite this there are key areas of work which have been undertaken in order to deliver improvements to the Trust's processes and to embed the just culture guide and principles.

	• Mandatory investigations training was in place for managers with compliance at 76% for level 1 and 69% at level 2 which equates to over 600 managers trained in investigative good practice and the just culture guide • Training has been supported by the development of best practice toolkits • Additional training in HR masterclasses has been refreshed with 94 managers completing training in the 12 months prior to the pandemic • More detailed guidance on the key factors in ensuring the independence of investigators has been implemented • Guidance has also been refreshed for those undertaking consistency reviews of investigations to ensure that investigations, outcomes and recommendations are proportionate and robust before any further action is taken. • Welfare support continues to be provided with welfare officers having access to a range of support for staff affected by investigations • The principles outlined in appendix 1 have been applied practically through ROSE in the approach taken to serious clinical incidents. Work has also been undertaken to improve the data available on case management and although it is recognised that further work is required to improve the sophistication of this data, it is now regularly reported to both Executive Leadership Committee and to Resources Committee, providing regular oversight. The next step is to triangulate this data more fully and a leadership and culture dashboard is in development to achieve this aim.
Recommendations, decisions or actions sought:	The Board of Directors is recommended to : • Note progress in addressing the issues raised in Baroness Harding's letter • Remit the Resources Committee to continuing monitoring of progress through their workplan

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:	Data from the WRES and WDES indicates a greater likelihood of staff from a BME or disabled background entering formal disciplinary and performance management processes. A review of individual cases is being undertaken and any emerging themes will be used to inform the disciplinary policy review.
Previously Submitted to:	
Date:	
Outcome:	

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

1.1 The purpose of this paper is to provide Board with an update and assurance on the progress is addressing actions arising from the 'Learning Lessons to Improve our People Practices' letter issued nationally by the Chair of NHS Improvement, Dido Harding in 2019.

2. BACKGROUND

2.1 Baroness Dido Harding, Chair NHSI, wrote to all NHS Trusts on 24 May 2019 sharing an overview of the findings of an independent inquiry commissioned by Imperial College Healthcare NHS Trust into the management of their Trust's disciplinary process and the dismissal of employee Amin Abdullah. Tragically Amin took his own life prior to his appeal hearing.

2.2 The inquiry identified a number of number of serious procedural errors that had been made during the investigation and disciplinary process and concluded that Amin was treated very poorly throughout the process and this had impacted severely on his mental health.

2.3 Following on from the inquiry's findings, a task and finish Advisory Group was set up by NHSI involving professionals from the NHS and external bodies to establish whether the failings were unique or prevalent across NHS Trusts. This exercise identified a number of key themes similar to those identified by the inquiry and this informed new additional guidance on the management and oversight of local investigation and disciplinary procedures, based on 7 key actions.

2.4 A report was submitted to Board in July 2019 which set out the review of current disciplinary cases which had been undertaken in the Trust, the key themes emerging and the next steps in addressing the recommendations contained within Baroness Harding's letter. This provided immediate assurance that the Trust had a robust and proportionate approach to conduct related casework and investigations but identified some further actions that it intended to pursue. This report will provide a progress update, noting that some actions have been paused as a result of the COVID pandemic.

3. CURRENT POSITION

3.1 <u>Just Culture principles</u>

3.1.1 In order to frame further work in relation to investigations and associated processes across the Trust, work was undertaken between the Medical, Quality and People directorates to develop a set of core principles based on best practice and in particular the NHS Resolution paper 'Being Fair'. These principles were consulted widely in early 2020 and are attached at Appendix 1.

3.1.2 It was felt that this was a necessary precursor to a broader review of policies and processes as it sets a clear framework for the approach to be adopted. The principles are designed to provide a framework within which complaints, incidents and other

issues of concern highlighted within the trust can be investigated and addressed. They are intended to guide action without being prescriptive, whilst also setting clear accountabilities for individuals and the organisation.

3.1.3 The framework recognises the principle of their being a second victim, who is the individual under investigation, and to ensure that the position of that individual as an employee and someone impacted by the process is recognised and that welfare is supported in line with the Trust's value irrespective of the issue at the heart of the investigation.

3.1.4 Appendix 1 also provides a driver diagram which sets out the key areas of work needed to embed the principles. This identifies key areas within project scope and areas which will be influenced by the work but where the principles are to a large degree already embedded. For example, the principles are already well reflected in the Be Think Do leadership framework and there is also already a good framework of Health and Wellbeing in place within the Trust which can be linked to this work.

3.1.5 Further work on this, and in particular the review of the disciplinary policy and supporting processes which sits are the heart of this work, was paused as a result of COVID-19 but it is intended to recommence this work as part of the phase 3 recovery. The framework has not yet been published in the Trust.

3.1.6 It should be noted that the Just Culture guide and the principles outlined in Appendix 1 have been applied regularly through the approach to serious incidents managed through ROSE meetings which has helped to shape the positive approach taken to investigating serious clinical incidents within the Trust.

3.2 <u>Other progress</u>

Although some of the work outlined above has been paused as a result of COVID, significant progress had been made in other areas identified in the original report to Board and identified as appropriate to address key themes identified in the initial review.

3.2.1 *Investigations*

All managers and staff who have a responsibility to undertake investigations have investigation training incorporated into their mandatory training. This training was refreshed with the aim of delivering a step change in the quality of investigations and also incorporating the recommended Just Culture guide which, although focused primarily on patient safety incidents, offers managers a framework to assess the extent of individual or system contribution to incidents.

The training is delivered at two levels, depending on the complexity of incidents that a manager is likely to investigate. Immediately prior to the pandemic compliance levels were at 76% of required managers had completed Level 1 training equating to 600 staff and 69% of those requiring Level 2 were complaint equating to 180 staff. Again this training had to be paused but a review and options for completion are due to be presented to the Executive Leadership Committee shortly.

In support of the best practice approach to investigations underpinning the training, toolkits have been developed to provide additional tools, best practice and

techniques to support managers in the practical application of the skills and methods trained

3.2.2 *Other training*

In addition to investigations training there is are range of HR masterclasses available designed to develop managers understanding of the relevant policies and procedures applicable for managing staff appropriately through processes. During the 12 months prior to the pandemic 94 managers attended masterclasses.

3.2.3 *Independence of investigators*

One key area highlighted in the original review and also highlighted through Freedom to Speak Up investigations was the independence of investigators. Clear guidance has now been developed on the issues to consider when deciding on the appropriateness of an investigating officer. This is based on the detailed guidance from the ACAS Code of Practice on workplace investigations and also outlines the responsibility of investigators to highlight and consider their own ability to maintain independence and objectivity.

Although independence has always been an explicit requirement set out in policy, a measure of independence had not been articulated and this now provides a robust framework in which to assess the appropriateness of investigators and their independence in approach. The opportunity for individuals to raise concerns regarding the independence of investigators has also been reflected in the Freedom to Speak Up policy review but is being used across investigations to ensure confidence in processes.

3.2.4 *Wellbeing support*

The Trust has robust arrangements in place to provide support to those who are subject to or associated with investigations. A welfare officer is routinely appointed to support staff who is separate to the investigation and able to provide welfare signposting and practical support and guidance. The welfare officers have access to a range of interventions through the wellbeing offer, HR teams and occupational health to provide the necessary support.

3.2.5 *Consistency Reviews*

Each potential conduct investigation is reviewed by a consistency panel, comprising of a senior HR manager and senior manager. The purpose of these panels is to ensure the robustness of the investigation and to assess the recommendations for fairness, appropriateness in light of the just culture guide and consistency of approach in respect of similar cases. This process acts as an objective check on process and the guidance and necessary documentation for these reviews has been refreshed to ensure that the principles set out in Baroness Harding's letter are adequately reflected.

3.3 **Data**

3.3.1 At the time of the report to Board in 2019, data on HR cases was not routinely reported and the Trust had only recently implemented a HR case management system. The data available from the system still needs to be refined to provide improved trend data but regular reporting has been implemented in the following areas:

- ELC receives a monthly report on open and closed cases by type and service line and the length of HR processes by type
- Resources Committee receives case management data in the Workforce Indicators report on a bi-monthly basis
- Board receives data on dismissals and tribunal cases through the Part 2 Reportable Incidents Report

3.3.2 This is providing improved oversight of caseload within the Trust but it is recognised that further work is required to use this data intelligently to drive change and identify areas of concern. The next step is to develop the first draft of a Leadership and Culture dashboard which will aim to triangulate data from a range of sources including case management, Freedom to Speak Up, staff survey results combined with more usual workforce indicators such as sickness, appraisal, mandatory training and apprenticeship progress. This is currently in development.

3.4 Ongoing monitoring

Continued progress in respect of the issues raised in this report will be reported through the Resources Committee who can provide future assurance to Board.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 Inappropriate application of HR processes could lead to Employment Tribunal cases or breach of employment law. The matters covered within this report may contribute to the CQC well led KLOE.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to :

- Note progress in addressing the issues raised in Baroness Harding's letter
- Remit the Resources Committee to continuing monitoring of progress through their workplan

This page is intentionally left blank

JUST & LEARNING CULTURE - #BEFAIR

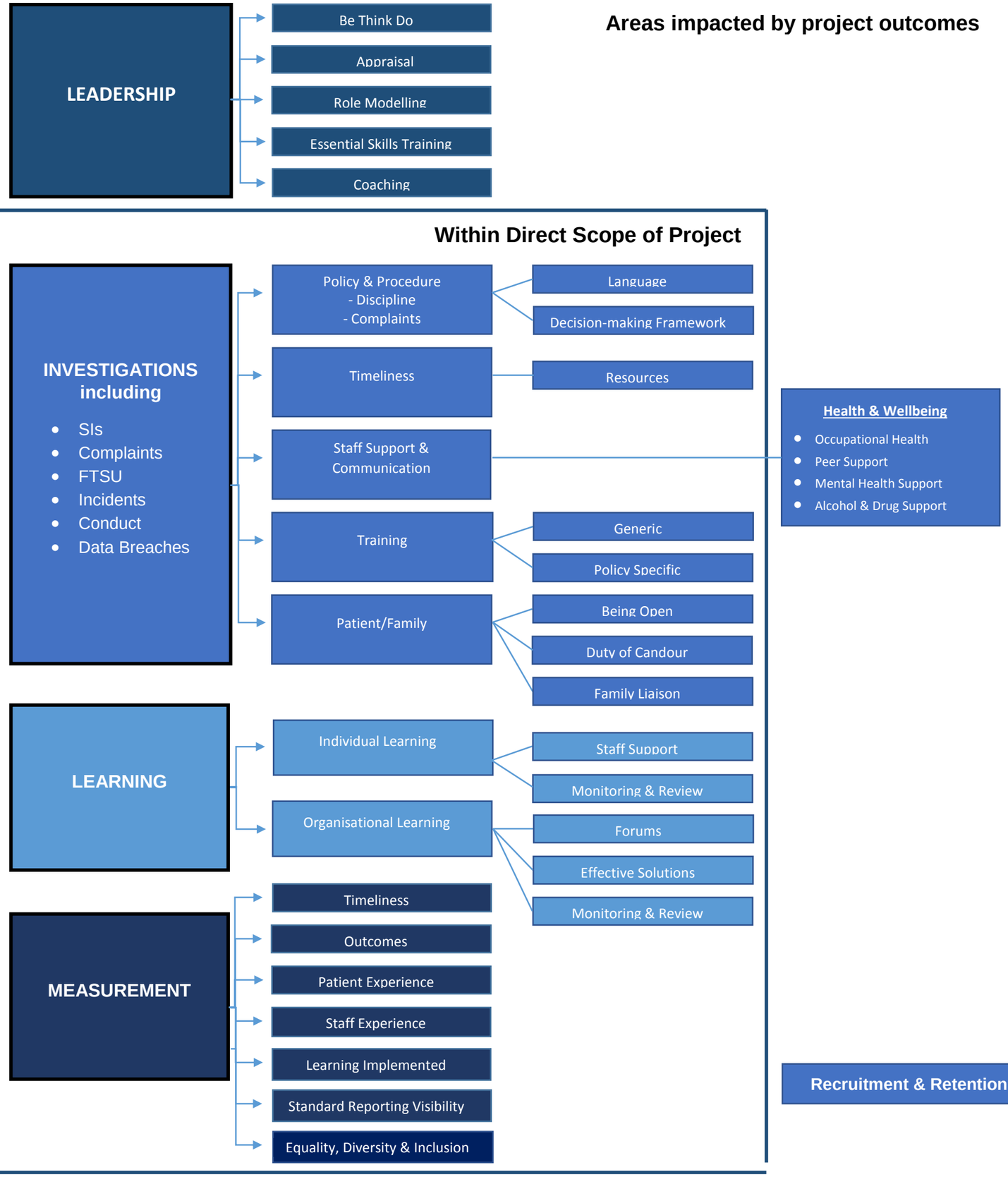
- Behaviours in the Trust should encourage honesty, openness and learning.
- The primary focus of investigations is to learn by identifying what happened, the circumstances leading to actions, decisions made and the outcome.
- There is a shared responsibility to be open about what has happened, in order to work out why it happened with both the organisation and individual learning from the incident.
- Clinical and other incidents have a real and deep impact on people's lives. Patients and relatives have a right to an explanation and an apology where things have gone wrong and staff involved have a right to compassionate and effective support. Staff wellbeing is a foundation for working safely.
- Our processes and systems should be designed to ensure the safety of our staff and patients. When things go wrong, this is usually as a result of choices and unintentional acts.
- Processes should be impartial and timely. They should enable the consistent, constructive and fair evaluation of the decision making actions of staff.
- To remove the blame from failure or mistakes whilst retaining accountability.

OBLIGATIONS OF STAFF

- To honestly disclose their role in an incident.
- To recognise the impact of their decisions and actions on those affected
- To take responsibility, be prepared to learn and put things right

OBLIGATIONS TO STAFF

- To offer support for all those affected.
- To ask honestly 'what' not who was responsible.
- To investigate incidents on the premise that staff come to work to do a good job and are honest.
- To identify and implement learning.



This page is intentionally left blank

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	30 September 2020
Subject:	Flu Campaign 2020/2021 - HCW Flu Vaccination Best Practice Management Checklist
Presented by:	Lisa Ward – Director of People
Purpose of Paper:	For Assurance
Executive Summary:	An update was issued in relation to the Flu Vaccination Programme jointly by the Department of Health and Public Health England on 5th August 2020. This set out the clear ambition to maximise vaccination uptake by ensuring that 100% of frontline healthcare workers are offered a vaccine by their employer. Boards are asked to confirm their public commitment to this ambition. The HCW Flu Vaccination Best Practice Management Checklist included at appendix 1 provides an overview of the self-assessment NWAS has undertaken against the national best practice checklist which has been developed based on five key components of developing an effective flu vaccination programme. Appendix 1 demonstrates that the Trust's programme has these core components in place for the 2020/21 programme. The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. This is supported by a comprehensive communications plan and a shift from individual incentives to a charity incentive. There are challenges in how the offer is presented and delivered to staff this year given COVID-19 but the flu team have worked hard to ensure appropriate flexibilities and options are in place to maximise vaccination rates. A risk has been placed on the corporate risk register and is currently scored at 12. The corporate risk is underpinned by a comprehensive campaign risk register. There are some challenges with the 2020 campaign. Although offer rates were high last year (90-95% of PES staff) the ask to deliver a compete 100% offer to all frontline staff is a challenge. In addition, the Trust needs to target refusal rates which were at 21% in 2019 to achieve good levels of uptake and protection across winter. The Trust

	has ordered sufficient vaccines to meet expected demand taking into account refusal rates but if supply were to come under pressure, the indications are that additional vaccines would be hard to procure. Whilst the impact of COVID-19 may be positive in terms of encouraging uptake, it also poses some challenges to the way the campaign is run with a reduced reliance on drop in clinics and a greater focus on individual vaccinators being allocated identified groups of staff to target. Vaccination will be supported by appropriate standard operating procedures and PPE. Senior leadership visibility is an integral component of the Communication strategy and the senior management will be provided with regular reports throughout the campaign illustrating uptake and refusal rate. Board are also asked to show their visible commitment to vaccination.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Note the assurance on plans for the 20/21 Flu campaign providing in the national checklist. • Confirm Board commitment to seeking to offer 100% of Healthcare workers a flu vaccine opportunity.

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 main vaccine purchased is egg based and this may prevent uptake from some religious groups, but we do have an alternative supply available this year which can address this issue. Analysis from last year indicated that uptake from BME groups was lower than from white counterparts, engagement with the Race Forum has commenced to try to understand the reasons for this and target communications as necessary.
Previously Submitted to:	**Resources Committee**
Date:	**September 2020**
Outcome:	**To be confirmed at Board**

- THIS PAGE IS INTENTIONALLY BLANK -

1. PURPOSE

1.1 The purpose of the paper is to provide the Board of Directors with assurance that all appropriate plans are in place to deliver the 2020/21 Flu campaign as confirmed through the demonstrated compliance with national HCW Flu Vaccination Best Practice Management Checklist.

2. BACKGROUND

2.1 This year, largely triggered by the COVID19 pandemic, the NHS will see the most comprehensive flu programme in UK history. There will be an unprecedented drive nationally and the Trust is expected to target 100% of staff with a minimum of 75% uptake.

2.2 The Trust initiated pre-launch activities for its Flu Campaign 20/21 in July 20. Two detailed reports have been submitted to Resources Committee. The July report set out the analysis and learning from the 2019/20 campaign which was the most successful in the Trust to date and gave an outline of developing plans. The September report provided detailed assurance on plans and also presented the HCW Flu Vaccination Best Practice Management Checklist for consideration. As the Resources Committee meeting takes place following the submission of Board papers, a verbal update will be provided at Board.

2.3 The Trust must complete a HCW Flu Vaccination Best Practice Management Checklist. The purpose of this is to demonstrate the Board's public commitment to the aim to achieve 100% offer of the vaccine to frontline healthcare workers. Whilst this does not have to be published nationally for public assurance until December 20, appendix 1 within this report illustrates how the checklist pointers are being met and provides assurance that the best practice recommendations have been adopted in the Trust's approach.

3. ASSURANCE

3.1 An update was issued in relation to the Flu Vaccination Programme jointly by the Department of Health and Public Health England on 5th August 2020. This set out the clear ambition to maximise vaccination uptake by ensuring that 100% of frontline healthcare workers are offered a vaccine by their employer. Boards are asked to confirm their public commitment to this ambition.

3.2 The HCW Flu Vaccination Best Practice Management Checklist included at appendix 1 provides an overview of the self-assessment NWAS has undertaken against the national best practice checklist which has been developed based on five key components of developing an effective flu vaccination programme. Appendix 1 demonstrates that the Trust's programme has these core components in place for the 2020/21 programme. The programme will formally launch on 1st October but vaccinations will commence with the arrival of the first vaccines from 21st September.

3.3 The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. This is supported by a comprehensive communications plan and a shift from individual incentives to a charity incentive. There are challenges in how the offer is presented and delivered to staff

this year but the flu team have worked hard to ensure appropriate flexibilities and options are in place to maximise vaccination rates.

3.4 A risk register has been developed by the Flu Team and an overall risk placed on the risk register which currently scores at 12. There has been significant learning from the 2019/20 campaigns including improvements in vaccine distribution, tracking and disposal.

3.5 Although the Trust has all the best practice components in place as advised by the national checklist. There are some areas of challenge with this year's campaign that Board should note.

3.6 Additional vaccines to normal have been ordered and this should enable the Trust to deliver expected levels of demand for the vaccine. In 2019/20 the Trust made significant progress in achieving a high offer rate with PES areas offering between 90-95% of staff a vaccine, although refusal rates were 21.28%. Further work will be required during 2020/21 to hit the required 100% offer rate and to drive the refusal rate down. The vaccines available (which include a portion of non-egg based vaccines to cater for allergy, religious and dietary concerns) should be sufficient to meet overall demand but if any further are required to meet demand, there may be challenges in procuring additional vaccines. This has been included in the campaign risk register.

3.7 COVID-19 will have a significant impact on the way the campaign is managed. A number of actions have been taken to prepare and address this. In particular, the Standard Operating Procedure has been revised to incorporate additional PPE requirements and vaccinators will be prepared through training and kit pervasion to operate safely in the current environment. In addition, there will reduced reliance on drop in clinics. Instead staff are being encouraged to pre-book and vaccinators will be given a targeted group of staff for whom they will take responsibility for contact, offer and vaccination.

3.8 COVID-19 also poses challenges for the normal communications' campaign as it will make it more difficult to gather photos of key staff receiving vaccinations. Commitment is sought from Board however, to role model having the flu vaccine and we will engage with Board members to ensure that we are able to capture and promote this important statement of support.

4. LEGAL and/or GOVERNANCE IMPLICATIONS

4.1 There are no legal implications from this report, although any incentives will need to meet HMRC requirements.

5. RECOMMENDATIONS

5.1 The Board of Directors is asked to:

- Note the assurance on plans for the 20/21 Flu campaign providing in the national checklist.
- Confirm Board commitment to seeking to offer 100% of Healthcare workers a flu vaccine opportunity.

Appendix C: Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December – 2020

A	Committed Leadership	Trust self- assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	The Director of People and Medical Director continuously champion the flu campaign. Board receives regular updates on the status of the uptake. Communications plan includes messages to staff from Board members. Commitment presented at Board September 2020.
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Ordered and due to receive vaccinations from w/c 21/09/20.
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learned	Resources Committee received 19/20 campaign overview with lessons learnt in July, reported to Board through Committee reports. Interim updates to be provided throughout the campaign.
A4	Agree on a board champion for flu campaign	Director of People and Medical Director will jointly champion campaign
A5	All board members receive flu vaccination and publicise this	A date for vaccinating the Board is in the flu plan with appropriate communications planned.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Flu lead team has representatives from key directorates. The Trade Unions are not currently part of the team but input and commitment to the campaign has been managed through the Joint Partnership Council.
A7	Flu team to meet regularly from September 2020	Flu leads team meets regularly and commenced meeting in July 2020 and will continue to meet throughout the campaign.
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published -sponsored by senior clinical leaders and trades unions	Rationale for the vaccination programme will be endorsed by senior clinical managers with appropriate communications. The campaign will also request that the Staff Side leads include endorsement for the campaign in their communication to their members. Trade Union leads have confirmed their willingness to actively support the campaign including through photographs of them receiving the jab.

B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Due to social distancing flu leads will respond to demand based on local activity reports whilst cross referencing with staff lists. For frontline staff, EOC and 111it is intended that there will be a 24 hour service. Flu vehicles are being identified to proactively target staff
B3	Board and senior managers having their vaccinations to be publicised	Board and senior managers are scheduled to have their vaccinations and this will be reported in bulletins and social media by the Communication team.
B4	Flu vaccination programme and access to vaccination on induction Programme's	The flu team are linked in with core induction programme leads to ensure new starters are offered a vaccine.
B5	Programme to be publicised on screensavers, posters and social media	Publicity of the campaign is to be communicated by film, social media, bulletins and briefs.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	A weekly uptake report will be provided by the Corporate HR Team to ELC and senior managers.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	The Flu Lead team have mapped their flu vaccinators in terms of clinical areas to determine any gaps. The aim is to have at least one peer vaccinator in each area identified, trained and released to vaccinate.
C2	Schedule for easy access drop in clinics agreed	Restrictions due to COVID-19 will prevent drop in clinics. However, the strategy for vaccinators will include leads to respond to demand based on local activity reports whilst cross referencing with staff lists. Vaccinators will have identified groups of staff to target for vaccination and will take responsibility for ensuring a complete offer.
C3	Schedule for 24 hour mobile vaccinations to be agreed	The flu lead team are identifying gaps in service areas to ensure vaccinators are in place round the clock.

D	Incentives	
D1	Board to agree on incentives and how to publicise this	Incentives have been agreed by ELC and instead of staff receiving a personal incentive, the Trust is operating the UNICEF 'Get a jab, give a jab' for this year's campaign.
D2	Success to be celebrated weekly	Through weekly flu reporting, the Corporate HR Team will publish a league table to celebrate uptake increases. Celebration of progress will be communicated through normal channels.

This page is intentionally left blank