North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 26 January 2022
9.45 am - 12.20 pm

Microsoft Teams

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
BOD/2122/115	Staff Story	09:45	Information	Director of Strategy, Partnerships and Transformation	
INTRODUCTION					
BOD/2122/116	Apologies for Absence	10:00	Information	Chairman	
BOD/2122/117	Declarations of Interest	10:00	Decision	Chairman	
BOD/2122/118	Minutes of Previous Meeting held on 24th November 2021	10:00	Decision	Chairman	3 - 18
BOD/2122/119	Board Action Log	10:05	Assurance	Chairman	19 - 20
BOD/2122/120	Committee Attendance	10:10	Information	Chairman	21 - 22
BOD/2122/121	Register of Interest	10:10	Assurance	Chairman	23 - 24
STRATEGY					
BOD/2122/122	Chairman & Non-Executives' Update	10:15	Information	Chairman	
BOD/2122/123	Chief Executive's Report	10:20	Assurance	Chief Executive Officer	25 - 38
GOVERNANCE AND RISK MANAGEMENT					
BOD/2122/124	Q3 Board Assurance Framework Review	10:30	Decision	Director of Corporate Affairs	39 - 82
BOD/2122/125	Trust Corporate Calendar 2022/23	10:40	Decision	Director of Corporate Affairs	83 - 86
BOD/2122/126	Health, Safety and Security Policy Revision	10:50	Decision	Director of Quality, Innovation and Improvement	87 - 118
BOD/2122/127	Policy on Prevention and Reduction of Violence	11:00	Decision	Director of Quality, Innovation and Improvement	119 - 154
BOD/2122/128	Learning from Deaths Policy	11:10	Decision	Medical Director	155 - 178
BOD/2122/129	Audit Committee Assurance Report - from the meeting held on 21st January 2022	11:20	Assurance	Mr D Rawsthorn, Non-Executive Director	179 - 182

QUALITY AND PERFORMANCE					
BOD/2122/130	Integrated Performance Report	11:30	Assurance	Director of Quality, Innovation and Improvement	183 - 236
BOD/2122/131	Learning from Deaths Q2 Report	11:40	Assurance	Medical Director	237 - 248
BOD/2122/132	Quality and Performance Committee Assurance Report - from the meeting held on 22nd November 2021	11:50	Assurance	Prof A Chambers, Non-Executive Director	249 - 260
COMMUNICATIONS AND ENGAGEMENT					
BOD/2122/133	Communications and Engagement Team Dashboard	12:00	For Discussion	Director of Strategy, Partnerships and Transformation	261 - 272
BOD/2122/134	ICS and Stakeholder Engagement Update	12:10	Assurance	Director of Strategy, Partnerships and Transformation	273 - 284
CLOSING					
BOD/2122/135	Any Other Business Notified Prior to the Meeting	12:20	Decision	Chair	
BOD/2122/136	Items for Inclusion on the BAF	12:20	Decision	Chair	

Date and Time of Next Meeting 9.45 am Wednesday, 30 March 2022 via Microsoft Teams

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, 24th November 2021
Sir Tom Finney Suite, Lancashire FA, County Ground, Thurston Road, Leyland PR25 2LF

Mr P White	Chairman (Chair)
Prof A Chambers	Non-Executive Director
Mr G Blezard	Director of Operations
Mr S Desai	Interim Deputy CEO/Director of Strategy, Partnerships and Transformation
Prof A Esmail	Non-Executive Director (Clinical)
Dr C Grant	Medical Director
Mr R Groome	Non-Executive Director (via MS Teams)
Mr D Mochrie	Chief Executive Officer
Prof M Power	Director of Quality, Innovation and Improvement
Mr D Rawsthorn	Non-Executive Director
Prof R Thomson	Associate Non-Executive Director
Ms L Ward	Director of People
Ms A Wetton	Director of Corporate Affairs
Ms C Wood	Director of Finance

In attendance:

Ms D Earnshaw	Corporate Governance and Assurance Manager (Minutes)

Minute Ref:

BOD/2122/90 **Patient Story**

The Director of Strategy, Partnerships and Transformation presented the patient story.

He reported that the story had originated from the Trust's Emergency Operations Centre and a complaint made by the family of a patient called Laura, a young and vibrant army medic who had been swimming at her local pool and had collapsed on the pool side.

The story involved a film which included narrative from the family and described Laura's experience with NWAS. Laura had been attended by pool side first aiders who had administered CPR and subsequently dried her chest to commence resuscitation with a defibrillator. In the meantime, pool staff had called 999 and were advised not to use a defibrillator due to being at the pool side, they coded the call as fitting and subsequently as a cardiac arrest. It was reported that Laura never recovered and was later discovered that she had an unknown heart condition.

The Director of Strategy, Partnerships and Transformation advised that the Trust investigated the incident and subsequently responded to the family as a Duty of Candour which highlighted learning. He stated that learning was gained through early engagement with the family and it was found that findings were not just related to NWAS but nationally.

The Medical Director praised the courage of the family to speak up, he advised that although the Trust had addressed the call scripts concerned, the experience had been devastating for all involved.

The Chairman emphasised the importance of defibrillation training and added the need for consistent communication in relation to cardiac arrest situations.

Prof A Esmail queried the timelines for implementation of the key learning. The Medical Director advised that remedial actions had been implemented, however national scripts would take time to review and embed. He added that due to the severity of what had occurred he would expect the case to be given priority, although timescale was dependent on the national system.

The Chief Executive advised of the difficulty for call handlers and that NWAS would ensure learning was shared and implemented. He added that such scripting would require change at national level and NWAS would ensure changes were made.

Prof R Thomson referred to the communication of information to swimming pools. The Medical Adviser advised that the Duty of Candour process had involved the whole life guarding team and engagement with the National body for life guarding training. He added that through dialogue with the Resuscitation Council, training would be disseminated.

The Chairman recognised the national work that was ongoing and that the Trust had revisited call scripts and procedure in the interim. He acknowledged the very sobering story and admired the dignity of the family in extremely difficult circumstances. He added his thoughts were with them and noted their valuable work in promoting and obtaining further defibrillators in the community.

The Board:

- Welcomed and acknowledged the Patient Story.

BOD/2122/91 Apologies for Absence

Apologies for absence were received from Dr D Hanley, Non-Executive Director.

BOD/2122/92 Declarations of Interest

There were no declarations of interest to note.

BOD/2122/93 Minutes of the Previous Meeting

The minutes of the previous meeting held on 29th September 2021 were agreed as a true and accurate record of the meeting.

BOD/2122/94 Board Action Log

The Board noted the updates to the Board action log.

BOD/2122/95 Committee Attendance

The Board noted the Board and Committee Attendance Record.

BOD/2122/96 Register of Interest

The Board noted the 2021/22 Register of Interest presented for information.

BOD/2122/97 Chairman & Non Executives' Update

The Chairman reported that workload had significantly increased as ICS' were in the process of establishing themselves. He advised that a number of award ceremonies and ICS meetings had been held and regional workshops had taken place in Greater Manchester and Cheshire and Mersey areas.

He reported that an initial meeting had been held with Dr Amanda Doyle, North West Regional Director and he had attended a recent Women in Leadership Event.

He acknowledged Chair and Executives attendance at a H2 meeting with the ICS and also recent national and regional meetings to discuss the latest media coverage on the pressures. He added that governance, in relation to emergency preparedness and in light off the learning from the Manchester Arena Inquiry, had also been considered.

The Chairman advised he had chaired a National Health and Wellbeing Guardian meeting and emphasised the importance of the Covid-19 booster vaccination programme.

The Board:

- Noted the update from the Chairman.

BOD/2122/98 Chief Executive's Report

The Chief Executive presented a report to the Board of Directors providing information of a number of areas since his last report to Board on 29th September 2021.

He reported that the Trust had encountered challenging months with a continued increase in call volume and patient acuity. He advised the Trust had developed a six point improvement plan, which included hospital hand over delays and a BT duplicate call initiative, to reduce the amount of repeat calls received.

He stated that the Trust continued to cooperate with the Manchester Arena Inquiry and recognised the impact on families and staff as stories unfolded. He noted the recent incident at Liverpool Women's Hospital and NWAS' involvement which included deployment of commanders and the HART team.

In relation to the Trust's Service Delivery Model Review, he confirmed developments were ongoing and were linked into additional funding.

He reported that the Trust Board had undertaken a review of the organisational strategy and work was ongoing to refresh their approach in view of Covid-19. The Chief Executive acknowledged and appreciated recent face to face award ceremonies which he had attended. He added that during October he had met with individual paramedic students in various universities.

He went on to acknowledge that the organisation had been represented at Remembrance Day events which included the Royal Albert Hall.

In relation to Mental Health, he confirmed that Mr D Earley, Senior Paramedic Team Leader had been working closely with NHSE/I to create a BASIC STEP tool which facilitated conversations with staff and provided a process of assessment with a person experiencing mental ill-health; based on several risk factors.

He reported that the Trust's Unified Communications Programme (UCP) had reached a significant milestone, with call handlers from the emergency operations centres (EOC) moving onto the new platform to join EOC dispatchers, 111, PTS and support centre. He added that the programme had involved a full replacement of network and telephone switches within the data centres and included the introduction of the standardised telephony system, with associated tools including voice recording and wallboards for contact centres. He expressed huge thanks to the Director of Quality, Innovation and Improvement, Director of Operations and their teams for their hard work and efforts to ensure work was completed successfully.

He advised that a recent letter from NHSE/I confirmed that the Trust had remained on segment 2 of the Single Oversight System and NWAS would continue to work with NHSE/I in line with the new framework.

The Chief Executive advised that an AACE report was published on 15th November entitled Delayed Hospital Handovers: impact assessment of patient harm. He stated that the report had been commissioned on behalf of the national medical directors and quality group following serious concerns about harm to patients. He highlighted the report had received significant media attention and a communication plan had been produced with all aspects managed and co-ordinated by the Head of Communications at AACE in conjunction with the Chair, Managing Director and Deputy Managing Director of AACE. He added that NWAS continued to work hard, collaboratively with system partners to improve hospital handover delays.

He advised that a number of events had taken place in celebration of Black History Month and representatives from the Trust had attended a large event hosted by the Duke of Cambridge, in connection with the Royal Foundation, which supported emergency services and the mental health of staff and leaders.

The Chief Executive recognised the recent COP26 and stated that a session promoting a healthier planet and people had been hosted across the ambulance sector, with regard to carbon literary training.

He recognised the death of NWAS colleague Mark Stevens, following a short illness, and conveyed his thoughts to family and friends.

Prof A Chambers stated it had been good to hear that the mental health of colleagues continued to be a priority. The Chief Executive agreed and stated this was also a priority at regional and AACE level.

Mr D Rawsthorn stated he was pleased to see the progress made in relation to the Trust's Unified Communications Programme, which had been a huge project and a high risk area for the organisation.

The Chairman reported that the Non-Executive Directors had commenced visits to ambulance stations and advised that feedback forms would be completed following the scheduled visits. He advised that communication and wellbeing pressures had been a common theme to date.

The Chief Executive added that the Executive Directors were working with teams to increase compliance rates of appraisals and learning time for staff. He advised that staff were tired and it was imperative that the Trust addressed their basic needs and requirements.

The Board:

- Noted the Chief Executive's Report

BOD/2122/99 Q2 Board Assurance Framework Review

The Director of Corporate Affairs presented the Q2 Board Assurance Framework Review. She advised that the report presented the Board Assurance Framework (BAF) position at 30th September 2021 and was a late report due to the absence of a Board meeting in October 2021.

She referred to s4 of the report and the proposed new risk articulation of SR05 and SR06. She highlighted a typo in the new risk articulation of SR05, which should have read organisational culture change rather than organisational change.

She reported that following work with Non-Executive Directors, there had been a new risk identified, SR09. She stated this related to cyber security and would be included in the BAF from Q3 onwards. Mr D Rawsthorn thanked the Director of Corporate Affairs for the opportunity to engage in the identification of SR09, which had arisen through Board discussions related to the digital agenda. He added he was pleased to see this included in the BAF.

In terms of the overall position of the BAF, the Chief Executive noted the current risk score of 15 for SR01. He stated that as a lay person, with no clinical experience, the score may have been expected to be higher, however the score was based on Q2 performance.

Prof A Chambers and Prof A Esmail noted that the Quality and Performance Committee had accepted the risk score of SR01, following robust discussion with Executive Directors at the meeting held on Monday 22nd November 2021.

It was noted that minutes of the Quality and Performance Committee meetings provided detail of the work being achieved, although the Trust were seeing static performance due to increased volume and demand.

The Director of Quality, Innovation and Improvement highlighted that the BAF report reflected the position at 30th September 2021 and that the SR01 position would expect to increase following Q3 reviews. She added that the regulatory

compliance and performance strategic risks should be considered in context with the other BAF risks.

The Chief Executive agreed and added that the next BAF report, to be presented to the Board in January 2022, would provide an updated picture. He added that although there could be a slight improvement in some of the long tail waits, there was uncertainty around the winter pressure period.

The Chairman acknowledged that reporting of the BAF position would always be retrospective and behind that of the IPR report. He added he was encouraged by the actions being taken and noted that the next report would reflect the current position when presented to the Board in January.

The Board:

- Noted the content of the report.
- Agreed the proposed new risk articulation of SR05 and SR06
- Agreed the newly identified strategic risk SR09 pertaining to cyber security.
- Agreed the Q2 position of the Board Assurance Framework.

BOD/2122/100 Use of Common Seal Bi Annual Report

The Director of Corporate Affairs presented the Use of the Common Seal Bi Annual Report. She reported that the Use of the Common Seal was determined by section 8 of the Trust's Standing Orders and was presented for assurance as part of the governance process.

She stated that the Trust's Common Seal had been applied on 7 occasions during the period 1st April 2021 to 30th September 2021 for reasons associated with the Trust's Estate.

The Board:

- Noted the use of the Common Seal and compliance with s8 of the Standing Orders.

BOD/2122/101 Freedom to Speak Up Bi Annual Report

The Director of Corporate Affairs presented the Freedom to Speak Up (FTSU) Bi Annual Assurance Report on behalf of the FTSU Guardian.

She reported that the FTSU process continued to be managed in line with national best practice and there had been a decrease in the number of concerns reported, compared to the same period in 2020/21. She highlighted that the timing of the report had been in the middle of a Covid-19 lock down.

She added that the Trust were in line with national and regional trends and the FTSU continued to be promoted over the organisations digital platforms.

The Director of Corporate Affairs reported that the Chief Executive Officer, Director of People and Director of Corporate Affairs met with the FTSU guardian to review cases, including those with difficult content and that meetings with the Head of HR were also held; to identify where targeted support was required. She added that scheduled meetings with Dr D Hanley, Non-Executive Director, provided oversight that the process was being followed.

She reported that behaviours and bullying had been dominant in the themes of cases received, however there was no indication of systemic bullying in the organisation.

Prof R Thomson noted five anonymous referrals and queried if there had been any aspects, in the nature of the cases, which should be taken into account by the Board. The Director of Corporate Affairs confirmed she would direct the question to the FTSU guardian for follow up outside of the meeting.

The Chairman referred to the small number of cases related to patient safety. The Medical Director confirmed that this was a small number and there were no common or recurrent themes.

The Director of Corporate Affairs confirmed that the FTSU Guardian would be leaving the Trust to commence another post and that she would be supervising the process in the interim.

The Chairman thanked Ms Rachael Foot, FTSU Guardian for her 19 years' service at NWAS and stated he was grateful for all her hard work over the years.

The Board:

- Noted the content of the Report.
- Acknowledged a follow up of the five FTSU anonymous referrals to identify any action required of the Board.

BOD/2122/102 Charitable Funds Annual Report and Accounts 2020/21

The Director of Finance presented the Charitable Funds Annual Report and Accounts for 2020/21.

She reported that the Income for the year amounted to £354k and total expenditure during 2020/21 was £191k, of which the main element had been the planned purchase of medical equipment and staff welfare. She added that overall, the funds had increased by £163k.

The Director of Finance confirmed that the Report and Accounts had been submitted to the Charitable Funds Committee on 27th October 2021 and had undergone an independent examination which had been satisfactory.

She advised that a working Group had met to decide how best to use the funds and there would be a Board Development session held in December for further consideration.

The Board:

- Approved and adopted the Charitable Funds Annual Report and Accounts for 2020/21

- Approved the signing of the letter of representation and Statement of Trustees Responsibilities on behalf of the Corporate Trustee.

BOD/2122/103 Charitable Funds Committee Chairs Assurance Report from the meeting held on 27th October 2021

Mr D Rawsthorn, Non-Executive Director presented the Charitable Funds Committee Chairs Assurance Report from the meeting held on 27th October 2021. He reported that the meeting had focused on the Annual Report and Accounts for 2021/22 and business as described in the previous paper.

The Board:

- Noted the assurances provided in the report.

BOD/2122/104 Audit Committee Chairs Assurance Report from the meeting held on 22nd October 2021

Mr D Rawsthorn, Non-Executive Director presented the Audit Committee Chairs Assurance Report from the meeting held on 22nd October 2021. He reported that the amber rated item related to outstanding actions to address high risk and critical recommendations, however he advised that the Trust's overall position was good and in context; and progress of the outstanding actions continued to be monitored.

The Board:

- Noted the content and assurances provided in the report.

BOD/2122/105 Integrated Performance Report

The Director of Quality, Innovation and Improvement introduced the Integrated Performance Report for period October 2021. She advised that key metrics were monitored regularly by the Executive Team and detailed conversations were held and scrutiny provided at the Trust's Board Assurance Committees.

In terms of quality, she reported a higher number of complaints in the period from September to October 2021, with 201 complaints received against a 12 month average of 175 per month. She added that the delays with regard to the backlog had risen to 203 at the beginning of September and fallen to 108 at the end of October 2021.

She added that targets to further reduce the backlog had been discussed in full at the Quality and Performance Committee on 22nd November 2021.

The Director of Quality, Innovation and Improvement advised that the Trust had received 9 new safety alerts, of which 1 had been applicable and was being managed by the Trust's Executive Team.

She stated that in October 2021 1,128 internal and external safety incidents had been opened against a 12-month average of 1,383, with an additional 76 still to be scored. She confirmed that content analysis of safety incidents, by type, highlighted that the top two reasons were incidents associated with 111 services or staff welfare.

The Chairman welcomed the work undertaken to address the backlog and queried the lower closure rate in relation to Level 4/5 complaints.

The Director of Quality, Innovation and Improvement advised that the higher level complaints were reliant on input and statements from operational staff

and although work had been undertaken by senior managers to expedite the process, there were some complaints that could not be progressed without operational input.

The Medical Director confirmed that Level 4 and 5 complaints were reviewed by ROSE and there was no delay with reviews.

Prof A Chambers confirmed that members of the Quality and Performance Committee were assured through the Sub Committee Chairs Assurance Reports that ROSE continued to be managed effectively.

Prof A Esmail queried whether the revised approach to reviewing the lower level complaints had been embedded. The Director of Quality, Innovation and Improvement confirmed that the complaints team had reworked internal systems, which were co-ordinated on a daily basis, to allow for an earlier assessment of new complaints.

The Director of Strategy, Partnerships and Transformation reported that despite significant pressure, overall patient experience satisfaction levels had increased, however PES and 111 had decreased due to response times. He advised that PTS experience had increased on the previous year with feedback that staff had been polite and helpful. He added that waiting times and delays had caused poor ratings and work with Trust subcontractors had been carried out as part of the feedback process.

The Chairman praised all staff for their ongoing efforts and noted that when pressures impacted on response times this influenced the satisfaction ratings for PES and the 111 service.

The Director of Strategy, Partnerships and Transformation stated that a future communication strategy for the 111 service would be produced, to improve public understanding and perception.

In relation to the Ambulance Quality Indicators, the Medical Adviser advised that the reporting period was delayed and in view of the time lag, there would be a significant change in forthcoming reports which would reflect the ongoing significant pressures through the winter period.

The key trends were highlighted and included two areas in the North West had experienced increased cases of Avian Flu and Covid-19 patterns in younger children, particularly 5-9 year old rates, had rapidly increased; with an impact on staff with child care responsibilities.

In relation to the Trust's financial position, the Director of Finance reported that the year to date agency expenditure had increased due to recruitment via agency at speed, which had been predominantly for call handling in EOC and 111. She advised that as the H2 agreed financial plan was pending, the financial position was based on the Trust's experience of costs previously and what was known in terms of system funding. Mr R Groome, Chair of the Resources Committee confirmed robust conversation had taken place at the meeting on 19th November 2021.

The Director of Operations advised that September and October had been the most challenging months and the Trust had produced a number of plans to spend the additional resource of £6.23m on the areas specified. He confirmed spending included 59 new vehicles, increased EMD staffing by 25% and increased clinical hub resource by 40%.

He added that the Trust were seeking to resource additional nurses and paramedics outside of NWAS, with a target to recruit above establishment by the end of December. He stated that blue light driver training was scheduled for January 2022 and a business case would be prepared for a MACA request, to meet the increased demand and severe pressures.

He advised that ORH modelling was ongoing and stated that increasing Hear and Treat and Clinical Hub staff, reviewing where unproductive hours were lost and how to make productive hours more efficient, were included in the improvement work to be undertaken. He added that areas for the wider system included access to mental health services to reduce waiting times, access to community services including access to pertinent information and hospital turnaround times.

The Director of Operations confirmed that the Protocol 36 implemented for Covid-19 had been removed and had provided a positive impact to drive response times down. He noted that Cat 3 and Cat 4 performance had improved during November 2021.

The Chief Executive advised of the work undertaken to address long waits for mental health patients, which included improved access to crisis lines and daily huddles with mental health providers; to attempt to reduce calls held in the NWAS emergency call stack.

The Chairman referred to signposting patients to alternative care and the patients managed by signposting. The Medical Adviser stated that clinicians had been deployed to manage the risks associated with C2 waits.

Prof A Esmail referred to the timescales associated to the £6.23m additional resource. The Director of Strategy, Partnerships and Transformation stated that the Trust were reliant on the remainder of the health care system managing the position.

In relation to 111 pressures, the Director of Operations noted that patients would be given expected times for a response, in order to manage expectations. He advised that a robust recruitment plan for 111, prepared with the Director of People, included full time positions and comprehensive training courses.

The Director of Operations noted that system wide initiatives had included the suspension of protected learning time for GPs to increase primary care resource for patients.

Mr D Rawsthorn referred to the impact of the 111 First initiative. The Chief Executive advised that the service had been designed to take away pressures from emergency departments, however this had been counteracted by the service being used by patients who could not access their GP. He advised that as most patients calling in-hours had not been able to call their GP, improving the position via the 111 triage service was a priority, due to the high volume of patients calling the service.

The Director of People reported, that in terms of staffing, the situation in 111 and operational pressures had impacted significantly on the workforce indicators, particularly turn over. She advised there was a continued focus on mandatory training and appraisals compliance, with the challenge being capacity to release operational staff. She added that her team were working closely with the Operational teams, however targets were tight and posed a regulatory risk for the Trust.

In relation to sickness, she reported a challenge across the sector with the majority of Trusts experiencing similar levels. She confirmed that long term sickness rates had increased due to the impact of long Covid-19 and delays in elective surgery.

She advised that the Trust had mobilised additional resources to support service lines, with a focus on data and target interventions to address underlying themes and training. She added that keeping staff well and in work was a priority.

The Director of People reported that agency staff would be transferred onto full time contracts to address the challenge of turnover in EOC.

In terms of 111 she advised that immediate actions to address staff wellbeing including practical welfare support had been implemented to relieve some of the pressure. She added that NWAS were Involved in a national work stream with the Yorkshire Ambulance Service, to provide some resources to tackle immediate and long term actions and provide some flexibility.

She stated that the Resources Committee had instructed a deep dive into the 111 service and the workforce position.

Mr D Rawsthorn referred to recent station visits and the concerns within the service related to levels of sickness and the challenges of long Covid-19.

The Chairman emphasised the need to focus on safety during time of such pressures.

The Board:

- Noted the content and recommendations of the Integrated Performance Report.

BOD/2122/106 IPC Board Assurance Framework 6 monthly report

The Director of Quality, Innovation and Improvement introduced the Assistant Director of Nursing and Quality to present the IPC Board Assurance Framework 6 monthly report.

The Assistant Director of Nursing and Quality reported that the IPC Board Assurance Framework for the period 1st April to 30th September 2021 had been presented to the Quality and Performance Committee on 22nd November 2021 and the framework was presented in a new format provided by NHSE.

She advised that IPC risks had been identified against key lines of enquiry and all risks had been reviewed. She highlighted that there were four areas of non-compliance which are rated red on the RAG rating scale which had been discussed at Quality and Performance Committee. She added that gaps in control were articulated and a timeline to improve included, which would be a priority for the IPC team and the newly appointed IPC Consultant Nurse who joined the Trust on 1st December 2021.

The Assistant Director of Nursing and Quality stated that communications had been consistent throughout the pandemic and the Trust was working with the National IPC team to introduce a comprehensive communication process across the country.

The Chairman recognised IPC as an essential part of the work of the Trust and thanked the Assistant Director of Nursing and Quality for the report and for the ongoing hard work of the team

The Board:

- Noted the assurances provided by the IPC BAF 6 monthly report and the recommendations contained within the report.

BOD/2122/107 Emergency Preparedness Resilience and Response (EPRR) Annual Assurance Report 2021/22

The Director of Operations presented the Emergency Preparedness, Resilience and Response (EPRR) Assurance Report for 2021/22. He reported that the assurance report provided the NWAS submission approved by the Trust Accountable Emergency Officer as agreed with Blackpool CCG as Lead Commissioners.

The Chairman noted the significance of the report in the context of the Manchester Arena Inquiry.

The Director of Operations highlighted the outcome of the EPRR self-assessment requirement which resulted in an 89% compliance rate and an overall rating of Substantially Compliant. He reported that NWAS had been fully compliant in the majority of areas and the Trust were on track to deliver against new measures which were awaiting external guidance. He added that two large exercises were scheduled for January and February 2022 which would address outstanding actions.

The Chairman observed the risks related to the outstanding measures and noted the margin of achieving substantial compliance and welcomed further updates.
The Director of Strategy, Partnerships and Transformation noted that the document would be revisited following conclusion of the Manchester Arena Inquiry and a baseline assessment conducted for future assessment.

Prof R Thomson offered his assistance as an observer to the two large exercises scheduled for January and February 2022.

The Board:

- Noted the content of the EPRR Annual Assurance Report and the self-assessment templates and Statements of Compliance.

BOD/2122/108 NWAS Strategic Winter Plan 2021/22

The Director of Operations presented the NWAS Strategic Winter Plan 2021-22. He reported that the Winter Plan had been revised to reflect a number of related plans and outcomes of debriefs held during the previous year. He advised that the Plan was reflective of lessons learnt during 2020-21, including the seasonal pressures of winter demand and Covid-19.

The Plan had been previously approved by the Executive Leadership Committee and presented to the Quality and Performance Committee on 25th October 2021 for assurance.

The Chairman thanked the Director of Operations for the perennial report that covered all relevant areas.

The Board:

- Received assurance from the NWAS Winter Plan 2021/22.

BOD/2122/109 Quality and Performance Committee Assurance Report from held on 25th October 2021

Prof A Chambers, Non-Executive Director presented the Quality and Performance Committee Chairs Assurance Report from the meeting held on 25th October 2021. She highlighted the red assurance rating for the Integrated Performance Report which reflected the current performance position caused by significant demand and pressures on the service lines.

The Chairman acknowledged the volume of the work coming through the Committee and welcomed the scrutiny of the challenges.

The Board:

- Noted the content of the Quality and Performance Committee Chairs Assurance Report, from the meeting held on 25th October 2021.

BOD/2122/110 Resources Committee Chairs Assurance Report from the meeting held on 19th November 2021

Mr R Groome presented the Resources Committee Chairs Assurance Report from the meeting held on 19th November 2021. He acknowledged the red assurance rating in relation to Workforce Indicators report and the Committee's request for a deep dive into the 111 service.

The Board:

- Noted the content of the Resources Committee Chairs Assurance Report, from the meeting held on 19th November 2021.

BOD/2122/111 Health and Wellbeing Update

The Director of People presented a Health and Wellbeing Update. She reported the update provided an outline of the Trust's plans to provide a safe supportive environment for the holistic wellbeing of staff and highlighted three key areas of work which included a Wellbeing Guardian; a Health and Wellbeing Trailblazer and a Regional Wellbeing Pledge.

In terms of a Wellbeing Guardian she advised that a Staff and Learners Wellbeing review undertaken in 2019 had identified a lack of uniformity in Board level leadership in relation to workforce health and wellbeing. She added that one of the recommendations had included the appointment of a Wellbeing Guardian preferably a non-executive director of the Trust. As such, she confirmed that the Chairman had agreed to initially carry out the role and a set of 9 principles would form the areas of focus for the Guardian.

Furthermore she advised that centrally, running through the wellbeing framework, was a process of self-assessment and a new framework had been expanded to take a more holistic approach. She confirmed that NWAS had

been selected as one of two Trusts in the North West to act as a trailblazer for the framework. She added that the Trust would be using the revised diagnostic tool over the next 6 months to focus on the Trust's mental health offer.

The Director of People confirmed that the Resources Committee had expressed an interest in understanding the diagnostic tool at a future Board Development session during 2022/23.

She reported that Trust had also been working at regional level on the Regional Wellbeing pledge, alongside RAND Europe, to focus on the links between wellbeing, presenteeism and productivity in work.

She stated that focusing on keeping staff in work well, rather than a reactive approach to sickness was recognised as a priority and to provide managers with the time to train and develop the skills required.

Prof A Esmail welcomed the initiatives and queried how the Board identified initiatives that were working well. The Director of People advised that sickness and absence data was obtained alongside data from well-being audits and the staff survey, however there was a need to conduct more effective analysis of data via the use of the 6 month diagnostic tool. She confirmed the guidance would be shared with Board once completed.

Prof A Chambers highlighted the need for consistent communication on the initiatives available to staff across the organisation and queried what measures were in place to ensure this was the case.

The Director of People confirmed that it would be an independent provider that would conduct the well-being check ins with staff, which would provide valuable intelligence on whether they are accessing the offers in place or accessing services outside of the organisation.

The Chairman welcomed the role of the Wellbeing Guardian and acknowledged the robust level of assurance provided by the Trust's Director of People; he added the role would support the significant contribution already being made.

The Board:

- Noted and received assurance from the report.
- Noted the role of NWAS as a trailblazer for the revised national Health and Wellbeing Framework.
- Approved adoption of the Regional Wellbeing Pledge.
- Noted further detail of the diagnostic tool to be included on the Board Development Session programme for 2022/23.

BOD/2122/112 Communications and Engagement Team Dashboard Report

The Director of Strategy, Partnerships and Transformation presented the Communications and Engagement Team Dashboard Report. He reported the highlights and key outputs for Q2 to September 2021.

In terms of public engagement, he highlighted that patient and public panel targets remained ambitious and included the recruitment of more youth members for improved representation. He confirmed that the panel now had 18% youth representation against a 20% target and acknowledged the valuable ongoing contribution of the panel.

In terms of Press and Public Relations, he advised that the number of publications had increased significantly from Q1 and social media activity had rapidly risen due to the Ambulance BBC series.

An accessibility audit had been completed, with further improvements to be made in Q4 including enhancements and alternative formats for the presentation and format of data on the Trust's website. There had also been increased use of films and internal activity, including thank you messages sent to staff in relation to the documentary statistics.

Prof A Esmail referred to national campaigns and the use of communication channels to communicate regional and national messages for example in relation to 111.

The Director of Strategy, Partnerships and Transformation acknowledged the need for further communication on the 111 service but advised that national messages were driven by the NHS centrally and not by local Trusts.

The Chairman acknowledged the hard work of the team and work completed during the quarter.

The Board:

- Noted the content of the Quarter 2 Communications and Engagement Team Dashboard Report.

BOD/2122/113 Any other business Notified prior to the meeting

There was no other business notified prior to the meeting.

The Chairman welcomed the format of the meeting which had facilitated a hybrid attendance; face to face and remotely. He noted the level of scrutiny on the Executive Directors during the time of severe pressure and thanked the Board for the assurances received.

He acknowledged the ongoing resilience of all staff, senior managers and leaders and thanked them for their ongoing hard work and efforts.

At this point in the meeting, the Director of Strategy, Partnerships and Transformation referred to a question from the PPP related to a BT digital announcement which involved a change to the telephone system. The Director of Strategy, Partnerships and Transformation confirmed he was aware of the change and had spoken to the Trust's Director of Quality, Innovation and Improvement and Chief of Digital Innovation. He confirmed he would respond to the PPP directly following the meeting.

BOD/2122/114 Items for inclusion on the BAF

There were no items identified for inclusion in the BAF.

Date and time of the next meeting – 9.45am on 26th January 2022 venue to be confirmed.

Signed: _____Date:_____

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

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
61	24.11.22	101	Freedom to Speak Up Bi Annual Report	A follow up on the five FTSU anonymous referrals to identify if any action required by the Board.	AW	26.1.22			
62	24.11.22	111	Health and Wellbeing Update	Further detail of the Wellbeing Framework diagnostic tool to be shared at future Board Development Session.	LW/AW	2022/23			

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NWAS Board and Committee Attendance 2021/22

Board of Directors									
	28th April	26th May	11th June	30th June	28th July	29th September	24th November	26th January	30th March
Ged Blezard	✔	✔	✔	✔	✔	✔	✔		
Prof Alison Chambers	✔	✔	✔	x	✔	x	✔		
Salman Desai	✔	✔	✔	✔	✔	✔	✔		
Prof Aneez Esmail	✔	✔	✔	✔	✔	✔	✔		
Dr Chris Grant	✔	✔	x	✔	✔	✔	✔		
Richard Groome	✔	✔	✔	✔	✔	✔	✔		
Dr David Hanley	✔	x	✔	✔	✔	✔	x		
Daren Mochrie	✔	✔	✔	✔	✔	✔	✔		
Prof Maxine Power	✔	✔	✔	x	✔	✔	✔		
Gillian Singh	✔	✔	✔	✔	x				
David Rawsthorn	✔	✔	✔	✔	✔	x	✔		
Prof Rod Thomson	✔	✔	✔	✔	✔	✔	✔		
Lisa Ward	✔	✔	✔	✔	x	✔	✔		
Angela Wetton	✔	✔	✔	✔	✔	✔	✔		
Peter White (Chair)	✔	✔	✔	✔	✔	✔	✔		
Carolyn Wood	✔	✔	✔	✔	✔	✔	✔		

Audit Committee						
	23rd April	11th May	11th June	16th July	22nd October	21st January
Prof Alison Chambers	✔	x	✔	✔	✔	✔
Prof Aneez Esmail	✔	✔	✔	✔	✔	✔
David Rawsthorn (Chair)	✔	✔	✔	✔	✔	✔
Gillian Singh	✔	✔	✔	x		
Prof Rod Thomson	✔	✔	✔	✔	✔	✔

Resources Committee						
	21st May	23rd July	24th September	18th November	21st January	25th March
Ged Blezard	✔	x	✔	✔	Meeting Cancelled	
Salman Desai	✔	✔	✔	✔		
Richard Groome (Chair)	✔	✔	✔	✔		
Dr David Hanley	✔	✔	✔	✔		
Prof Maxine Power	✔	✔	✔	✔		
David Rawsthorn	✔	✔	x	✔		
Gillian Singh	✔	x				
Lisa Ward	✔	x	✔	✔		
Carolyn Wood	✔	✔	✔	✔		

Quality and Performance Committee									
	26th April	24th May	28th June	26th July	27th September	25th October	22nd November	24th January	28th March
Ged Blezard	✔	✔	Cancelled	✔	✔	x	✔		
Prof Alison Chambers (Chair)	✔	✔		✔	✔	✔	✔		
Prof Aneez Esmail	✔	✔		✔	✔	✔	✔		
Dr Chris Grant	✔	✔		✔	✔	✔	✔		
Dr David Hanley	✔	✔		✔	✔	✔	x		
Prof Maxine Power	✔	✔		✔	✔	✔	✔		
Prof Rod Thomson	✔	✔		✔	✔	✔	✔		
Angela Wetton	x	x		✔	x	✔	✔		

Charitable Funds Committee		
	28th April	27th October
Ged Blezard	✔	✔
Salman Desai	✔	✔
Richard Groome	✔	✔
Dr David Hanley	✔	✔
David Rawsthorn (Chair)	✔	✔
Lisa Ward	✔	✔
Angela Wetton	✔	✔
Carolyn Wood	✔	✔

Nomination & Remuneration Committee							
	30th June	28th July	29th September	24th November	15th December	26th January	30th March
Prof Alison Chambers	x	Meeting not held	x	Meeting not held	✔	Meeting not held	
Prof Aneez Esmail	✔		✔		✔		
Richard Groome	✔		x		✔		
Dr David Hanley	✔		✔		✔		
David Rawsthorn	✔		x		✔		
Gillian Singh	✔						
Prof Rod Thomson	✔		✔		x		
Peter White (Chair)	✔		✔		✔		

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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision is required within a meeting, in relation to the service line.
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
Aneez	Esmail	Non-Executive Director	Employed at the University of Manchester		√			Professor of General Practice		Present	N/A
			Work in GP Practice - Non Exec Chairman of Board	√	N/A	N/A	N/A	Position of Authority		Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Richard	Groome	Non-Executive Director	Director, Westbury Management Services Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Director of Avantage (Cheshire) Ltd	√				Position of Authority	Dec-20	Present	Withdrawal from any Cheshire Care Home related discussions.
			Chair, Fix360 (part of Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Deputy Chair , Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
David	Hanley	Non-Executive Director	Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care)		√			Position of Authority	Apr-19	Present	N/A
			Member of the Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A
			Member of NHSE/I Ambulance Review Implementation Board		√			Position of Authority	Sep-20	Present	N/A
			Board Member/Director - NHS Pathways Programme Board		√			Position of Authority	Mar-20	Aug-20	Appointment declined
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
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
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 – The Riverside Group	√				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	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
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.
Gillian	Singh (Resigned August 2021)	Associate Non Executive Director	Non Executive Director - The Riverside Group	√				Position of Authority	Jan-20		N/A

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26 January 2022
SUBJECT:	Chief Executive's Report
PRESENTED BY:	Daren Mochrie, Chief Executive

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☒	☒	☒

SR05	SR06	SR07	SR08	SR09
☒	☒	☒	☒	☒

PURPOSE OF PAPER:	For Assurance

EXECUTIVE SUMMARY:

The purpose of this report is to provide members with information on a number of areas since the last CEO's report to the Trust Board on 24 November 2021.

The highlights from this report are as follows:

Paramedic Emergency Services

- Continuing high activity throughout November and December
- 150 Military personnel to be deployed to help manage demand across the whole NHS in the North West
- New initiatives introduced for a hospital handover escalation process

NHS 111

- Performance continues to challenge the service
- Health Advisor recruitment campaign in December
- SMS for Self-Care project is now in progress

PTS

- PTS staff transfer to PES as Blue Light Drivers
- New regulations regarding access to nursing homes comes into force
- New service model for PTS being considered

The paper also provides an update on local, regional and national activities as well as outlining our approach to a number of areas such as Hospital Handover, Blue Light Together – a mental health approach and the IPC Survey from AACE

RECOMMENDATIONS:	The Board is requested to receive and note the contents of the report			
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Not applicable			
	Date:			
	Outcome:			

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1. PURPOSE

This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 24 November 2021

2. PERFORMANCE

2.1 Paramedic Emergency Services (PES)

Activity has continued at a high rate throughout November and December and the Trust has remained at REAP 4 throughout the period. We have also had the added pressure of the Omicron variant of Covid-19 which has had a significant impact of staff abstractions due to infection or isolation. At times Covid abstractions have been up to 20% and when added to normal sickness absences we have had at times 30% of the workforce absent which has had an impact on operational resources and in the control rooms.

The Trust has developed a six-point plan with our lead commissioner designed to jointly support actions to manage ongoing pressures. The annual winter plan has also been in place since 1 November and this has assisted in mitigating the impact of Covid-19, in particular the festive plan, where annual leave was reduced by 50%. The plan focused on increasing resources to meet increased demand, however due to Omicron resources were not has high as we would have liked, although they were above base line levels at peak. The combination of demand, Covid and abstractions has led to extended waiting times for patients which has been compounded by increased hospital handover times; an average of 39 minutes per hospital attendance and sometimes more at peak times.

During this period, we have focused on maximising the use of resources and making improvements in Hear & Treat and See & Treat, which has meant there has been a reduction in conveyances to hospital. A MACA (Military aid to the civil authorities) request was processed in late December as we predicted significant pressure and this request which has been approved, will see 150 military personnel deployed across the region from mid-January until late March. Attempts to increase private providers have been made but their numbers have reduced due to Covid-19 absences too.

Escalation processes have been revised, in particular hospital handover and the use of the patient safety check list, clinical oversight of the waiting stack has been constantly reviewed with early signs of success in reducing dispatches and increasing safety.

2.2 NHS 111

Performance for the headline KPI continues to challenge the service. Call demand throughout December and over the Christmas Period proved challenging, the busiest days being 27/28 December when calls offered peaked at 13,500. Pressure coming into the service at its peak resulted in up to 500 calls waiting to come into the Northwest 111 Service. This was not unique to the Northwest; challenges of this nature were evident across the country.

The national recruitment campaign ran throughout December, this has resulted in some additional interest in Health Advisor posts within 111; the team are currently

reviewing applicants and expect to fill planned courses throughout February and March.

Staff absence due to Covid rose exponentially throughout December and over the Christmas period, this impacted resourcing on the day and contributed to up to 15% loss of resource on the day.

NHSE have commissioned the national Covid Response Service (CRS) for a period to assist with pressures into 111, this was planned to go live 4/5th January and it is anticipated that this will take around 10% of the national pressure away from 111.

The Trust, working with our lead commissioner, has developed a six-point plan that is currently being delivered, a further project to deliver SMS messaging for self-care is now in progress with the support of colleagues in NHS Digital. It is anticipated that this project will deliver a reduction in average handling time as self-care advice will no longer be required if the patient is happy to receive a SMS message detailing this information, it is anticipated this will be deployed in February

2.3 Patient Transport Services (PTS)

43 PTS staff have now temporarily redeployed into PES as a Blue Light Drivers. Recruitment plans are progressing as planned and the impact of the temporary transfer of workforce is being managed via retention of additional levels of third-party support i.e. double crewed ambulance resources to help manage capacity challenges associated with social distancing measures which continue to impact utilisation of resource. Whilst the current direction is that IPC / social distancing measures will remain in place, discussions continue with NHSE/I, and commissioners locally, to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively. Over the reporting period activity remained at approximately 90% of pre Covid activity. The proportion of patients requiring an ambulance is regularly close to pre-Covid levels.

New regulation came into effect on 11 November 2021 meaning that only individuals who have received two vaccine doses are allowed to enter nursing homes and must be able to prove this on request. NWAS and private ambulance staff who have not received both vaccines have been identified and their records updated on the Cleric system to flag to the controller and prevent nursing home journeys being allocated to ineligible staff. No significant issues have been escalated.

3. ISSUES TO NOTE

3.1 Local Issues

Manchester Arena Inquiry

The closing statements from NWAS and the other emergency services were delivered to the Manchester Arena Inquiry.

The Inquiry will now be paused while the Chair completes Volume 2 of his report. It is this volume of the report that will conclude the effectiveness of the emergency service response and highlight any areas where learning and improvement is needed. The report is likely to be published in Spring 2022.

3.2 Regional issues

Hospital Handovers

Hospital handover delays continue to challenge us across the NWAS footprint and the extent of that harm is detailed within a recent report published by the Association of Ambulance Chief Executives; 'Delayed hospital handovers: impact assessment of patient harm'. The report shows that since April 2018 across the country an average of 190,000 handovers have missed the target of 15 minutes every month (accounting for around half of all handovers). In Sept 2021 over 208,000 exceeded the 15-minute target.

New initiatives to end handover delays and improve the patient flow at emergency departments can only help reduce unnecessary harm to patients and reduce the impact this has on ambulance staff and colleagues in the acute hospital sector, who are significantly affected when our patients experience delays and harm that can be prevented.

In the North West, our approach since the beginning of our Every Minute Matters collaborative, which began three years ago, has been to work on improvements together with hospital trusts.

The trust's heads of service and consultant paramedics met with the Improvement team to identify what else we can do to improve the situation and support frontline crews. There was universal acknowledgement that delays in handover pose clinical, professional and personal challenges. The group agreed that we will re-double our efforts to:

- Work with senior leadership teams in hospital trusts to ensure there is a shared understanding of the risks of handover delays and a lack of ambulance resources to respond to patients in the community.
- Revisit action cards for operational commanders.
- Thank all staff for the continued reporting of delays.

The reporting of patients delayed outside hospitals to the Regional Operations Control Centre (ROCC) is a vital part of the information we share with hospital leaders and wider NHS system.

It was also agreed that clear escalation processes need to be articulated in the event of treatment being initiated in the back of ambulances which should not be supported other than as an absolute last resort.

Covid-19 in the North West

The Covid-19 variant, Omicron, is thought to be more transmissible than previous strains of the virus and accordingly the Prime Minister announced the reintroduction of some restrictions, including mandatory mask wearing for most indoor public venues, on public transport and for individuals to work from home where possible.

The increased infection rate in the North West is continuing to place additional pressures on services and the NHS workforce. The effects of the pandemic are still being felt across the system, with a particularly challenging impact on accident and emergency departments and our own 999 and 111 services.

A number of system-wide improvements have been made to help the NHS in the North West manage demand over the winter, including: clinical streaming at the front door of A&E to direct patients to the most suitable service when they arrive; Same Day Emergency Care (SDEC) to increase the proportion of people who do not need to be admitted overnight in an emergency; a single multidisciplinary Clinical Assessment Service (CAS) within the NHS 111, ambulance dispatch and GP out of

hours services so people can be assessed by the most appropriate healthcare professional for their needs and an increase in bookable appointments for conditions that are not an emergency through NHS 111.

By April 2022, there will also be full regional coverage of community crisis response services, providing a community response to adults within two hours in their own homes if their health suddenly deteriorates or is in crisis. This will include individuals with underlying chronic conditions, with the aim of supporting their health needs within a community setting by multidisciplinary teams responding quickly to changes in their condition, hopefully reducing the need for an ambulance response or subsequent admission to hospital. This is a welcome addition to the community services already available in the region and should support our 999 service.

The trust is doing all we can to maximise resources, including (but not limited to): working with partners to improve hospital handover times; increasing our fleet with new and retained vehicles; and recruiting additional call handlers across 999 and 111.

Vaccinations

Dr Chris Grant, Medical Director, hosted a live MS Teams session on Thursday 20 January to answer questions from staff about the vaccination as a condition of employment and discussed the benefits to staff family and colleagues in advance of the law being introduced on 1 April 2022. As an organisation the trust needs to ensure that all those colleagues seeing patients face to face are double vaccinated which will become law later this year. This helps to support staff, their family and friends by staying well and helps protect the wider public and the vulnerable in our society

Military Partnership Arrangements (MACA)

Arrangements have been made for a partnership with the Ministry of Defence again, given this was so successful last year. This will see up to 150 military personnel working alongside us. This will allow us to maximise the number of resources we have available to respond to patients and bring additional support into the service at a time when we are experiencing whole system pressures, increased demand, and a high number of staff absences due to Covid-19 sickness and isolation.

Training commenced on 11 January, before the personnel were deployed across the region to assist NWAS colleagues with lower acuity 999 incidents and some interfacility transfers, which will not only support NWAS but the wider NHS system in the region as a whole.

This deployment will be similar to the arrangements in February and March 2021, when we welcomed the military in a very successful partnership. Personnel worked with paramedic emergency service (PES) and patient transport service (PTS) crews, aiding the wider healthcare system at a time of very high demand and supporting patients across the region. They were deployed to more than 4,600 999 incidents, including approximately 1,700 healthcare professional/inter-facility transfer requests – assisting with the safe transportation of patients between healthcare sites. Feedback from colleagues who worked with the military personnel was overwhelmingly positive.

All military personnel will follow a training package similar to the one undertaken by the PTS uplift staff who have been working with PES since the start of the pandemic. It will include a driving course and classroom training on topics such as kit familiarisation, manual handling, scene management and patient communication.

Our new colleagues will wear their military uniforms but will be provided with helmets and high-visibility jackets.

Requesting military assistance is not a decision we take lightly but, at this time of consistently high demand, system-wide pressures and now increasing levels of staff absence due to the Omicron variant of Covid-19, it's important we take action to ensure we are doing our best to support our staff and manage the ongoing demand challenges we're facing, not only at NWAS but across the NHS system.

It is an arrangement that is once again echoed with many other ambulance and hospital trusts seeking some type of external support either from the military or fire and rescue services.

We know every member of staff and volunteer is working incredibly hard to deliver the best possible service for patients and taking this step to increase our resources in partnership with the military will enable us to carry on doing that, while providing extra support for staff and for patients throughout this challenging period.

I would like to pay particular tribute to our Learning and Education teams who have pulled out all the stops to run courses, including driver familiarisation for our military colleagues.

Continuing to work together to manage demand

Since the start of the year, just after new year itself, we have seen a slight improvement in terms of demand and operational performance standards. There has been a small decrease in the number of incidents we are attending and 999 calls we have been receiving, and a similar pattern in NHS 111, with call volumes easing slightly.

This is welcome news and a trend we hope to see continue. However, we must be cautious and realistic, as we have seen activity levels fluctuate previously and overall demand is still high across the service. The regional NHS system continues to feel pressures, with capacity issues in many areas, so our focus will remain on making progress on steps to support staff and patients throughout this busy period.

The ongoing effort across the trust - but especially in 111, EOC and PTS contact centres and main office sites - to double down on infection prevention and control measures is having an impact, with fewer abstractions due to COVID-19 sickness or isolation.

In addition, I'm aware of some positive work among our senior paramedic emergency service clinicians, who have been exploring additional ways they can use their clinical skills, knowledge and experience to support colleagues and patients. Together, our cohort of consultant and advanced paramedics have identified an opportunity to have dedicated enhanced clinical response shifts for clinical activity only. During these shifts, advanced paramedics will focus on two main objectives:

- Supporting patients who have been waiting a long time, by assessing either remotely or face-to-face to manage and close incidents.
- Supporting colleagues who are attending complex incidents or have been on-scene for a long time, by being available for crew advice and monitoring incidents to identify those where they can offer additional clinical support.

These are roles our advanced paramedics often already carry out, but they also have many other duties that must be completed, including administration work, handling complaints and investigations. These agreed, dedicated enhanced clinical shifts will

allow our senior clinical resources to be as effective as possible in ensuring patients are safe and colleagues are supported and empowered to make appropriate decisions at times of high demand.

Advanced paramedic teams have been briefed locally about how these enhanced shifts will work in their areas and have been provided with supporting materials to assist them when carrying out these duties.

Meanwhile, PTS colleagues continue to play a vital role in supporting the wider NHS system by facilitating discharges and transfers from hospitals, helping trusts to manage their patient flow and assisting patients who need to attend important appointments.

I'd like to acknowledge the effort by a small team led by Director of People, Lisa Ward, who pulled together to make rapid arrangements for a mobile testing unit which was provided by NHS England and located on our Broughton site. Although only available for a few days the testing site allowed us to offer rapid Covid-19 LAMP tests, equivalent to a PCR, to staff, volunteers and family members. We know some staff struggled to get a PCR test booked and this was seen as a great opportunity to be able to offer some additional testing capacity to help staff avoid any unnecessary isolation.

3.3 National Issues

Emergency Department pressures

Following the Delayed hospital hand over report from AACE, a new report by the Royal College of Emergency Medicine 'Crowding and its Consequences' has found that at least 4,519 patients have died as a result of crowding and 12 hour stays in emergency departments in England in 2020-2021.

This report investigates the extent of harm that crowding causes and applies NHS England's own findings from the Getting It Right First Time (GIRFT) initiative, which found that one in 67 patients staying in an emergency department for 12 hours came to excess harm.

The ambulance sector continues to receive support from National and Regional NHS England & Improvement colleagues to do all we can to make and sustain improvements.

Infection prevention and control survey from AACE

The Association of Ambulance Chief Executives (AACE) is gathering feedback from staff about attitudes towards infection prevention and control, before and during the Covid-19 pandemic.

Many people have strong opinions on how effective IPC measures have been at various stages of the pandemic and what could potentially be done differently in the future. I have encouraged our staff to use this opportunity to share their experiences and views, as ultimately the survey aims to create better understanding of processes we need to protect together with areas where we can learn lessons to better prepare for future IPC concerns and pandemics.

Blue Light Together – Mental Health Support

In my AACE chair's role and as a member of The Royal Foundation's Emergency Responder Leaders Board, I recently supported and attended The Royal

Foundation's Emergency Services Mental Health Symposium, co-hosted by the Association of Ambulance Chief Executives and the other emergency services, where The Duke of Cambridge announced a new package of mental health support for emergency service workers.

Alongside me, our Chair and a number of NWAS Senior leaders and leaders from across all UK emergency services attended and we all committed to a uniform set of standards for supporting the mental health of staff. I was privileged and proud to sit alongside my police and fire counterparts, The Duke of Cambridge himself, and the Health Secretary, Sajid Javid, to make sure the ambulance sector is leading this work and being listened to.

We know our staff are our most valuable resource and by the nature of their role, their physical and mental health can be affected. Many staff put aside their own personal concerns to respond to highly pressurised, emotional, and physically challenging situations to save lives and care for patients, and this has been even more evident and difficult as a consequence of COVID. With the support of this new Blue Light Together initiative we hope to encourage more leaders and staff in UK ambulance services to speak up about their mental health.

Speaking at the event, The Duke of Cambridge highlighted this agreement is the first of its kind which sends a powerful message that mental health is, and will remain, a firm priority for UK emergency services. He went on to explain a set of standards for supporting mental health will be adopted and integrated into every workplace, a crucial step in ensuring all emergency responders are properly protected and supported.

We have committed to:

- Prioritise mental health in the workplace by developing and delivering a systematic programme of activity
- Proactively ensure work design and organisational culture drive positive mental health outcomes
- Promote an open culture around mental health
- Increase organisational confidence and capability
- Provide mental health tools and support
- Increase transparency and accountability through internal and external reporting

I was able to spend time with The Duke of Cambridge and we discussed several things, including the current demand. The main film at the event was The Duke of Cambridge meeting with ambulance colleagues in their home to discuss mental health and a senior leader from the East Midlands Ambulance Service talked to the audience about their own personal experiences of mental health.

I was also able to share a recent experience I had, when a colleague approached me when I was on a station visit to talk about their own mental health challenges, the likely tragic consequences had they not received help, and the support they had received from their line managers. I was humbled that this person felt able to openly discuss such a personal experience with me, over a brew in the mess room. We should all keep talking to each other about how we are feeling and ask for help whenever we need to.

At NWAS, we've always understood the importance of supporting the mental and physical wellbeing of our workforce, and it's a key element of our people plan. However, we welcome any additional resource and attention on this matter, which why it's so fantastic to have the backing of The Duke of Cambridge and collective commitment from emergency service leaders across the country.

4. GENERAL

Every member of Team NWAS, including Patient Transport, 999, 111, corporate and support services, has played their part in making sure we can continue to be there for patients throughout this demanding year. I recognise the immense pressure every part of the service has been facing and it isn't just within NWAS that our efforts are acknowledged, we often see kind words and gestures from members of the public showing that the work our colleagues do is appreciated, and at a national level, the Prime Minister wrote to the NHS to express thanks on behalf of the Government.

Disability Network launch

On 14 December 2021 the trust's new Disability Network launched with a virtual event, hosted by co-chair of the network, Adam Rigby, Special Operations Project Support Officer. It showcased some of our network members and will help us to learn, educate and support staff who have a disability. The network will provide a forum for staff to get together and discuss their working experiences in a confidential and safe space, and to highlight issues affecting staff with disabilities and long-term health conditions in order to improve them.

Freedom to Speak Up

Regular reports are presented to the Board with updates on Freedom to Speak Up (FTSU) activity.

FTSU is there to support anyone who wants to raise a concern, and make sure they feel safe and able to do so. We all have a responsibility to speak up about a risk, malpractice or wrongdoing at work which may affect patients, public, other staff or the organisation – including things such as risks to patient safety, breaches of patient confidentiality, or workplace fraud.

The trust's FTSU Guardian, Rachael Foot, left the trust 22 December 2021 and the Chair thanked her for all the work she has done to embed FTSU within the organisation. Angela Wetton, Director of Corporate Affairs, will cover the FTSU Guardian role on an interim basis until the end of the financial year when Medical Director, Chris Grant, will take on the oversight of FTSU.

Staff Surveys

The national staff survey, closed in November 2021. 36% of staff took the time to fill in the survey and provide feedback. This is just over a third of our total workforce, which is positive, but unfortunately, we were the ambulance trust with the lowest response rate in the country.

The findings from the survey will be used to identify key themes we can focus on as an employer to improve the experience of staff working for NWAS. Analysis of the staff survey results takes time, but we expect the findings to be available between February and March.

The national quarterly staff survey (NQPS) is now live for all staff to complete and is a shorter version of the annual staff survey and is open until the end of January. The NQPS runs during Q1, Q2 and Q4, with the annual national staff survey running during Q3. This allows a year-round opportunity for staff to share their views, experiences and feedback, and shape how we listen, respond, and make changes happen.

Climate Champions

The trust recently received four awards in the Health Care Climate Challenge as recognition for our climate work. The international organisation, Health Care Without Harm, works to transform health care worldwide to reduce is environmental footprint and award the trust two Gold in Greenhouse Gas Reduction and Climate Leadership and Silver in the categories of Renewable Energy and Climate Resilience

The recognition comes as we have been working on several initiatives to reduce our carbon footprint and support our Green Plan. The new Blackpool ambulance hub site will be our first new-build project to be designed to as near Net Zero standard as is practicable at this moment in time. We're also continuing the rollout of electric operational vehicles and their required infrastructure and became the first NHS organisation to use the carbon literacy ambulance toolkit training as a permanent feature on our training offer to staff. On Carbon Literacy Action Day in November, we held an open course for our ambulance service executives with participation from six ambulance services and NHS England and Improvement.

Outrun an Ambulance

The NWAS Charity together with five other regional NHS ambulance charities have joined together to deliver the 'Outrun an Ambulance' challenge. The challenge is a great way for people to focus on their health and wellbeing by fundraising to support NHS ambulance services. Outrun an Ambulance is a virtual challenge inviting people to conquer the mileage an ambulance covers on an average shift while responding to people in urgent need.

Participants are challenged to complete their selected distance, plus one mile. If they don't want to run they can walk, swim, scoot, hand-cycle, or ride anything that is self-propelled.

People can choose the distance they want to complete based on the mileage clocked up by crews during a typical shift. Fundraisers can choose their timeframe, up to a maximum of three months to 'outrun' the distance by at least one mile.

Funds raised for the NWAS Charity will help to support the welfare of our staff and volunteers and help to run life-saving CPR training for the public in local communities.

The charities that are participating are the South Western Ambulance Charity, East of England Ambulance Charity, London Ambulance Charity, North West Ambulance Charity, South Central Ambulance Charity and Yorkshire Ambulance Charity.

Further details can be found here: https://www.outrunanambulance.co.uk/

Welcome

The Estates and Fleet Team have recently welcomed Mike Crawford as the new Estates Manager (Capital) to improve our stations and sites.

Mike has worked in the care sector for 30 years, more recently as an accommodation project manager in a mental health setting. His primary focus is to improve the staff environment and deliver planned capital schemes and engage with teams on sites for delivery of schemes planned for 22/23. Mike is driven to transform the locations we operate from, creating spaces that we can be proud of.

Our thoughts are with South East Coast colleagues

You may be aware of the tragic road traffic accident that happened in Kent on Wednesday5 January, which involved a South East Coast Ambulance Service vehicle. A young paramedic sadly lost her life and two others were injured, while on duty. Alice Clark, 21, was a newly qualified paramedic and was just a few months into the job when she tragically died in the collision.

On behalf of all of us at NWAS, I have written to Chief Executive Philip Astle and David Astley, Chair to pass on our sincere condolences and send best wishes for a full and speedy recovery to those who were injured. I also spoke to a number of my former colleagues in SECAMB to offer my condolences and support.

When something like this happens within the ambulance service, it's bound to strike a chord with us and make us reflect on the dangers we sometimes face in our job, which we do to help keep others safe.

Death of staff members

It is with great sadness that I write to inform you of the death of our former colleague, Clive Heather who passed away on Sunday 12 December. Clive started his career in 1973 in the Cheshire area before he moved to Greater Manchester. Clive held various roles within the service, including being one of the first paramedics in the county. He later became a training manager and operational commander and retired from the trust in February 2017, serving over 47 years in the ambulance service.

Clive's daughter, Lisa Stanway, works for the trust as a community resuscitation development officer based in Greater Manchester.

The trust sends sincere condolences to the family, colleagues and friends of Clive and Lisa at this sad time.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

There are no legal implication contained within this report

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

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

7. RECOMMENDATIONS

The Board is requested to receive and note the contents of the report.

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 26 January 2022
SUBJECT:	Q3 Board Assurance Framework Review
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☒	☒	☒

SR05	SR06	SR07	SR08	SR09
☒	☒	☒	☒	☒

PURPOSE OF PAPER:	For Decision
EXECUTIVE SUMMARY:	The Corporate Risk Register can be seen in Appendix 1 and the proposed Q3 (as of 31 December 2021) of the Board Assurance Framework (BAF) with the associated Corporate Risk Register (CRR) risks scored ≥15 can be viewed in Appendix 2. The BAF Heat Maps for 2021/22 year to date can be viewed in Appendix 3. The Executive Leadership Committee (ELC) recommends the following Q3 changes (s4): • Increase in risk score of SR01 from 15 to 20 • Increase in risk score of SR04 from 12 to 16 • Decrease in risk score of SR06 from 20 to 15 It is proposed the following 2021/22 target risk scores are increased (s5): • SR01 from a target risk score from 10 to 20 • SR03 from a target risk score from 15 to 20 • SR04 from a target risk score from 8 to 12 • SR06 from a target risk score from 10 to 15 The revised and proposed target risk scores are deemed to be achievable and realistic given the current operational and systemic pressures placed on the organisation at present.
RECOMMENDATIONS:	The Board of Directors are requested to: • Agree the increase in risk score of SR01 from 15 to 20 • Agree the increase in risk score of SR04 from 12 to 16 • Agree the decrease in risk score of SR06 from 20 to 15 • Agree the increase in 2021/22 target risk score of SR01 from 10 to 20 •

<table>
<tr><td></td><td colspan="4">Agree the increase in 2021/22 target risk score of SR03 from 15 to 20
Agree the increase in 2021/22 target risk score of SR04 from 8 to 12
Agree the increase in 2021/22 target risk score of SR06 from 10 to 15
Agree the Q3 position of the Board Assurance Framework.</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☒ Financial/ VfM
☒ Compliance/ Regulatory
☒ Quality Outcomes
☒ Innovation
☒ Reputation</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Assurance Committees, ELC and Audit Committee</td></tr>
<tr><td>Date:</td><td colspan="3">Throughout Q3</td></tr>
<tr><td>Outcome:</td><td colspan="3">For Assurance</td></tr>
</table>

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1. PURPOSE

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

This paper provides an opportunity for the Board of Directors to review the 2021/22 Q3 position of the Board Assurance Framework (BAF) along with the Corporate Risk Register (CRR) risks scored 15 and above that are aligned to each BAF risk.

2. ASSURANCE PROCESS

The BAF and associated corporate risks are reviewed via the Integrated Governance Structure.

The evidenced based assurance information reported throughout the quarter via the assurance committees and identified via as review of Chair's Assurance Reports is collated on the Assurance Map. The assurance mapping has been utilised to support and inform discussions with Executive Directors and assist with the population of the assurance framework.

3. REVIEW OF THE CORPORATE RISK REGISTER

The review of the CRR takes place monthly at the Executive Leadership Committee (ELC) as well as via the Integrated Governance Structure. The CRR is available for review in Appendix 1.

4. REVIEW OF THE Q3 BAF POSITION

The Executive Leadership Committee has reviewed the Q3 position and recommends the following changes to the Board of Directors for approval:

SR01: There is a risk that the Trust may not deliver safe, effective, and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction

- Increase in current score for Q3 from 15 to 20

Opening Score 01.04.2021	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL	Prof M Power

The risk has increased in risk score following review, with the following rationale applied by the Executive Lead:

1. Continuing impact of delays in response times affecting quality, safety, and patient experience

2. There continues to be a focus on patient safety work and maintenance of quality to deliver our strategic intentions to be the best ambulance service in the UK in the context of COVID-19 recovery and current demands of winter
3. The pandemic has continued to highlight the importance of the correct clinical leadership structure
4. Ongoing focus will include delivering the milestones in the Right Care Strategy, strategy refresh and requirements of the new regulatory regime.

SR04: There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services

- Increase in current risk score for Q3 from 12 to 16

Opening Score 01.04.2021	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
12 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**16** 4x4 CxL	Ms L Ward

The risk has increased in risk score following review, with the following rationale applied by the Executive Lead:

1. The delivery of safe services has remained under pressure, although delivery of Q1, Q2 and Q3 recruitment plans have been maximised and robust plans in place for Q4
2. Increase in turnover across service lines, but within tolerance of pre-COVID levels except for NHS 111
3. End of Q3, the Trust has and continues to face significant challenges associated with the levels of abstractions from COVID and normal sickness
4. The legislative change to mandate COVID vaccination for patient facing staff could impact adversely on turnover and sickness absence
5. Robust plans to support and encourage COVID vaccination uptake are in place and anticipated to commence in Q4 with associated abstractions being mitigated by approval of the Trust's Military Aid to Civil Authorities (MACA) request.

SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action

- Decrease in current risk score for Q3 from 20 to 15

Opening Score 01.04.2021	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
		20 5x4 CxL	**15** 5x3 CxL	Prof M Power

The risk has increased in risk score following review, with the following rationale applied by the Executive Lead:

1. Mitigating actions taken to address aspects of the legislative and regulatory landscape in fire safety, mandatory training, complaints, incidents and infection, prevention, and control (IPC), with assurance provided via the Integrated Governance Structure
2. The 6-point winter plan has been developed by the system to assist with further improvements with hospital handover delays
3. It is anticipated that external demand and pressures may lead to further exacerbation of overall safety and workforce risks within Q4.

5. REVIEW OF 2021/22 TARGET RISK SCORE

Pat of the Q3 BAF Reviews included detailed conversations surrounding the realism of achieving the aspirational in-year 2021/22 target risk scores identified on the BAF.

ELC have reviewed and recommends the following changes to the 2021/22 target risk scores are increased:

- SR01 from a target risk score from 10 to 20
- SR03 from a target risk score from 15 to 20
- SR04 from a target risk score from 8 to 12
- SR06 from a target risk score from 10 to 15

Although there has been proactive assurance reporting during Q3, the increase in operational pressures and the response to the continuing COVID-19 pandemic has resulted in slippage of the strategic risk mitigation and management of the above BAF risks. The revised and proposed target risk scores are considered to be achievable and realistic given the current operational and systemic pressures placed on the organisation at present.

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

7. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

8. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the increase in risk score of SR01 from 15 to 20
- Agree the increase in risk score of SR04 from 12 to 16
- Agree the decrease in risk score of SR06 from 20 to 15
- Agree the increase in 2021/22 target risk score of SR01 from 10 to 20
- Agree the increase in 2021/22 target risk score of SR03 from 15 to 20
- Agree the increase in 2021/22 target risk score of SR04 from 8 to 12

- Agree the increase in 2021/22 target risk score of SR06 from 10 to 15
- Agree the Q3 position of the Board Assurance Framework.

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Appendix 1: Corporate Risk Register

**Extratced from Datix on 31 December 2021*

DX ID	Opened	Risk Description	Approval Status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Key Controls In Place	Likelihood (current)	Consequence (current)	Rating (current)	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
2507	01/02/18	There is a risk that the current Meal Break Policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	16	Treat - Implement controls and mitigating actions to reduce the risk.	01. Strategic Meal Break Dining Instructions. 02. Meal Break Management of Operational Resources within Meal Break Window memorandum. 03. Establishment of Meal Break Review Group to review current practices including review of the Policy. 04. Terms of Reference for Meal Break Review Group. 05. NWAS Strategic meetings taken place re Meal Break Management. (May 19 & 23 July 19). 06. MB Workshop took place (8th July), led by Strategic Head of EOC to discuss SMB etc. 07. Paper to be developed and presented back to Strategic Group by end of September 19 (DA). 08. Additional focus in C&M EOC re adherence to the meal break policy to take place for a four week period throughout December 2019. 09. Rota Review which may support meal break management due to stagger times implemented in GM and C&L. 10. Additional focus from the Covid-19 command cell re meal break management compliance (currently at 70%).	4	4	16	01. Review and Implement new Meal Break Policy - GB - March 21. 02. TU engagement and agreement to amend existing Policy 03. Meal Break Policy V11.5 04. Strategic Meal Break Guidance (EOC001) 05. Operational Meal Break Guidance V.1	01. Meal Break Reports submitted to SD SMT. 02. ORH and ACE to support NWAS model with recommendations made 03. Links with Trade Unions and have their agreement 04. Interim Head of Service for Cheshire & Merseyside reviewing Demand and Capacity 05. Daily measurement of meal break compliance. 06. Proposal to be sent to the Service Model Review Board November 2021	01. Gaps in compliance following MIAA Reporting re Meal Break Management. 02. Revised Meal Break Policy	4	07/12/21	07/01/22
3254	24/04/20	There is a risk that due to staff taking carried over leave accrued during the COVID-19 pandemic, operational resources will not meet demand resulting in delayed patient response and delivery of national ARP standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Maximum abstraction rates. 02. Option to carry some leave over into the next financial year. 03 Introduction of the NWAS annual leave buy back scheme. (8.47% of staff within PES took up the offer). 04. NHS Employers guidance re annual leave carry forward provision (2 years). 05. NWAS Operational Performance Calls. 06. Operational, Tactical and Strategic Management. 07. Performance Management Framework. 08. Overtime opportunities on selected shifts at selected times 09. Use of Third Party Providers and VAS. 10. Increase scope of Third Party Providers and VAS. 11. NWAS Patient Safety Plan. 12. Clinical Leadership Model. 13. ROCC Tactical and Strategic Commanders. 14. Deferring of Mandatory training. 15. PTS resources used in PES Support work. 16. NWAS COVID-19 Response Plan. 17. Agreed additional funding to increase PES workforce establishment. 18. ELC have agreed to extend the period of time in which annual leave can be taken (up to 20 days carried forward in line with National recommendation).	4	5	20	01.Number of operational staff opting to utilise the annual leave buy back scheme. 02.Use of Overtime and impact on Trust financial position 03.Increased use of PAS/VAS impacting on Trust's financial position 04.Sustainability of using non-PES clinical resources 05.Timescale of staff vaccination programme 06.Subsequent COVID-19 peaks/waves 07.Changing regional tier system and national/local lockdown restrictions. 08.Evolving guidance on higher risk individuals who should be shielding 09.Feedback on National ARP Standards. 10.Funding for additional resources. 11. Continued increases in staff sickness across Service Delivery.	01.Abstraction Reports. 02.NWAS Annual Leave Buy Back Scheme is being offered 03.National Performance Data 04.ORH Modelling Report 05.NWAS Integrated Performance Report 06.NWAS Performance Reporting to Commissioners 07.NWAS Performance Reporting to NHSE/I 08.NWAS Workforce Indicators Report 09. Return to Work process in place for those who have been shielding. 10. Confirmation on the amount of annual leave that can be carried over from HR.	01. Adherence to abstraction rates on abstraction reporting. 02. Sustainability of using University Students for PES Support 03. PTS Uplift staff working in PES Support roles 04. An additional days annual leave has been provided to staff across 2021/22 period	5	07/12/21	07/01/22

								19. Resources from MACA and eCFRs 20. Annual leave to be taken across the leave period 1 April 2021 - 31 March 2022.											
3445	17/11/20	There is a risk that due to the excessive handover delays at hospitals across the North West, there maybe increased numbers of patients being held on the back of ambulances and the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Local management engagement with hospitals within their Sector 02. NWAS Executive Management engagement with hospitals 03. Implemented HALOs at hospital sites to improve delays 04. Hospital Handover Project to reduce delays at hospitals 05. Installed Hospital Arrival Screens for all hospitals across the NW 06. A&E Delivery Board with NWAS representation 07. Attendance at National Calls regarding Hospital Handover 08. QI Approach to Hospital Handover 09. The Hospital Handover Safety Checklist is supported by the Medical and Quality Directorate and can be used in all Emergency Departments 10. Every Minute Matters Collaboration with Hospitals to improve handover times 11. Attendance at NHSE/I North West Winter Planning Meeting 12. Attendance at NHSE/I Hospital Handover Delays Review Meetings 13. Identification of Hospitals to participate in Every Minute Matters 14. NWAS concerns raised with AACE for National level discussion 15. Strategic Meeting Chaired by Prof. A Marsh to review delays 16. NHSE/I and Commissioners taking the Lead to reduce hosptial handover times 17. Escalations with Chief Executive Officers of appropriate Acute Trust 18. Hosptial Outliers escalated to the Regional Director of NHSE 19. Targeted Recovery Plans for Hospital Handover Improvements 20. Continued liaison between NWAS and Acute services (Gold Cell meetings in Cheshire and Mersey Region); 21. Monitoring is taking place between Acute and CQC 23 Joint monitoring arrangements between Lead Commissioners and NWAS. 22. National Handover meeting with AACE 23. Operational Orders being reviewed. 24. Hosptial Handover Action Cards to assist with managing a deteriorating patient 25. Commissioners are leading on working with Acutes and monitoring bi-weekly with NHSE	4	5	20	01. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration 02. Unpredictable increases in demand across the Service Directorate	01.NWAS Hospital Handover Performance Data to Commissioners and NW NHSE/I 02. NWAS Hospital Handover Safety Checklist developed and being rolled out across the NW. Two sites fully implemented 03.NWAS Integrated Performance Report 04.Hospital Handover Project Documentation 05.Every Minute Matters Project Docmentation 06. Right Care Closer to Home` allocated to SPTLs. 07. Acute Frailty Unit at Whiston Hospital as of September 2021 08. NHSE/I have a focused piece of work to reduce hospital handover delays. 09.Documents include Ambulance Handover Safety Checklist, and Handover Safety Checklist Resource Pack 10. Revised Divert and Deflection Policy (V12.3) 11. NWAS Hospital Handover Fit2Sit developed and being rolled out across the NW. One site fully implemented 12. NWAS Hospital Handover Process redesign developed and being rolled out across the NW. Four sites fully implemented 13. SDEC Pathways and ED avoidance being implemented 14. Resource packs received from Medical Director (Ambulance Handover Safety Checklist Pack & Resocurce Pacls)	01. Continued hospital presssures affect NWAS' ability to handover patients in a timely manner 02. Continued abstraction rates of PES staff remains challenging to provide extra vehicles 03. National Performance Data 04. National Hospital Handover Performance Data 05. NWAS Hospital Handover Process redesign not fully implemented the NW 06. NWAS Hospital Handover Safety Checklist not fully implemented across the NW 07. NWAS Hospital Handover Fit2Sit ongoing with Tameside	5	07/12/21	07/01/22
3447	17/11/20	There is a risk that due to increasing operational demand and call volumes, the health and wellbeing of our workforce may deteriorate leading to absenteeism negatively impacting on staff safety.	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Ged Blezard	16	Treat - Implement controls and mitigating actions to reduce the risk.	01.Local Health and Wellbeing Plans 02. Organisational Policies and Procedures 03. Staff Self-Referral Schemes to Occupational Health for advice and support 04. Health & Wellbeing initiatives 06. HR Business Partnering Team 07. Non- reocurring investment from Commissioners 08. Provision of Welfare Vehicles in Greater Manchester, Cheshire and Merseyside and Cumbria and Lancashire	4	4	16	01. Outcome of internal service delivery model review 02. Welfare vehicle provision isn`t 24/7 or consistent across all Sectors	01. Reinforcement of local level engagement and partnership with Trade Unions 02. Sickness and Data Officer position created to manage sickness. 03. Return to Work procedures taking place for those who have been shielding.	01. Receipt of commissioner funding following ORH review	4	07/12/21	07/01/22

					Corporate a			Treat - Implem	09. Additional funding approved by commissioners of £0.434m for expansion to the NWAS Mental Health Team 10. Voucher to be issued to all staff during the Festive period as a Thank You.										
3448	17/11/20	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	01.NWAS COVID-19 Response Plan 02.NWAS Bulletins (Operational and Clinical) 03.NWAS IPC Guidance across all sites 04.NWAS IPC Consumables available across all sites 05.NWAS Internal Test, Track & Trace Function 06.NWAS COVID-19 Cells; chaired by Exec Directors 07.BCM in place across Service Delivery areas 08.COVID-19 Staff Risk Assessments 09.COVID-19 Premises Risk Assessments 10.Home working options 11.Lockdown of EOCs/ NHS 111 & PTS Contact Centre's 12.Access to Occupational Health 13.Organisational Policies and Procedures 14.Alternative Duties are used to assist with other duties 15.HR Business Partnering Team for Advice & Support 16.Lateral Flow Tests are offered to all staff. 17.Lamp testing now available. 18. Test and Release change implemented following amendment to HM Government recommendations (August 2021) 19. HR wotrkring with Service Delivery to seek guidanbce on dealing with Long COVID cases and sheilidng due to COVID.	3	5	15	01. Reluctance by staff to comply with the wearing of PPE. 02. Definitive Guidance in relation to long term absence awaited from People Directorate 03. Clarification required as to employment status of staff affected by `long COVID` or awaiting elective surgery which is currently preventing full staffing 04. Absenteeism increased to 14.11% in October 2021 05. National Guidance on self isolation rules changed on the 12/12/2021 if there is contact with omicron variant for 10 day period, irrespecive of vaccination status.	11. Return to Work procedures taking place for those who have been shielding. 12. No current outbreaks across Service Delivery. 13. Staff vaccination hub `stood down` 04/05/2021. 14. Weekly review of Abstraction Levels with Head of Regional Planning 15. PES wide Daily Sit Rep Reports reviewed. 07.PTS report abstraction rates are reducing 08.PES report abstraction rates are reducing 09.Monitoring taking place via the Service Delivery Leadership Group 10.Communications Team to pick up isses with Media Visitors to EOC. 16. Circa 250 staff absent from COVID-19 related 01.NWAS Staff Abstraction Report 02.NWAS Workforce Indicators Report 03.NWAS Communication Bulletins 04.NWAS COVID-19 Response Plan 05.Local NWAS Staff Abstraction Report 06.Local NWAS Sickness Report	01. Uncertainty with Long COVID affecting absenteeism rates. 02. In August 2021 absenteeism was at 10%	5	13/12/21	13/01/22
		There is a risk that due to increases in operational demand, limited resource	S		mance	nsitive Risk Register			g actions to reduce the risk.	01.Shared learning via AACE and other NHS Ambulance Trusts 02.Preparatory workforce planning including overtime and recruitment opportunities 03. Senior operational representation at National level 04. NWAS representation on monthly conference calls 05. Implemented Pre-Determined Attendance (PDAs) part of ARP v2.3 and frequent reviews of PDAs 06. Implemented clinical leadership across all EOCs and Trauma cells 07. Auto-allocation to improve response times 08. Management of IFT/ HCP activity 09. DCA, RRV and ORH Modelling Review Building & Better Rota's Project 10. Fleet Replacement Programme 11. Operational Policies & Procedures and Operational Guidance 12. Operational, tactical and Strategic Management 13. Performance Management Framework 14. Additional resources utilised to support performance, e.g. use of Third Party Providers with increased scope of practice, use of CFRs and PTS supporting PES work				01.Confirmation of the receipt of additional finances from Commissioner 02.Delivery of Urgent and Emergency Care Strategy 03. Workforce Planning 04. Awaiting outcome of ORH review 05. Sustained REAP 4 since 08 Spetember	01.National Performance Data 02.National ARP Data 03.ORH Modelling Report 04.NWAS Integrated Performance Report 05.NWAS Performance Reports to Commissioners 06.NWAS Performance Reports to NHSE/I 07.NWAS Business Cases for Fleet Replacement 08.NWAS Workforce Indicators Report 09. National Hospital Handover Performance Data 10. NWAS Hospital Handover Performance Data to Commissioners 11. NWAS Hospital Handover Performance	01. AACE to simplfy the operating model.			

3452	17/11/20	operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	Approved Risk	Operational	Operational Perform	Corporate and Commercially Sen	Ged Blezard	25	Treat - Implement controls and mitigatin	15. NWAS Communications; use of social media 16. Clinical Leadership Model 17. NWAS Operational Performance Calls 18. ROCC Tactical Commanders & Strategic Commanders 19. Cancellation of mandatory training & appraisals 20. NWAS Winter Plan 21. Engagement with System Leaders & Acute Hospitals 22. Engagement with NHSE/I 23. Engagement with NWAS Lead Commissioner 24.Temporary suspension of Mandatory Training and Clinical supervision 25. Initiated Actions for REAP 3 and REAP 4 as agreed by ELC 26.Weekly review of strategic intentions with increases in pressures. 27. Additional 45 DCAs being utilised as part of Winter Plan 28. Additional 90 PTS staff being upskilled for PES up to 31 March 2022 29. Additional funding for 111 Service 30. Six Point Plan jointly devleoped with Commissioners to cover - Increase Resources, increase Hear and Treat, reduce loss of vehicle hours 31. Discussions with NHSE re `levelling up` investment	5	5	25	2021 due to external pressures. 06. Unpredictable escalations and de-escalations of REAP levels through the winter of 2021/22 07. Continued increases in abstraction rates across Service Delivery (circa 14.5% PES - 10% PTS) 08. Monthly monitoring by Lead Commisisoner to facilitate release of funding	11. NWAS Hospital Handover Performance Data to NW NHSE/I 12. NWAS Integrated Performance Report 13. Hospital Handover Project partly implemented across NW Acutes 14. Every Minute Matters Project Documentation 15. £6.23 m investment to cover short-term increase in resources from September 2021 - 31 March 2022 16. Commissioners and NHSE are engaged in improving ED hospital delays 17. Buddy system from NHS Ambulanbce Trusts to alleviate pressures on EOC when required 18. Financial Investment and Monitoring Winter Plan presentation (30/11/21) provides projections of exenditure	02. Continued hospital pressures 03. No confirmation for re-occuring funding levels for resourses from 01 April 2022	5	07/12/21	07/01/22
3455	17/11/20	There is a risk that across PES, resources will be limited or not available for effective and efficient utilisation across the region because of an increase in operational demand and patient acuity which may result in delayed responses to patients.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Operational, Tactical and Strategic Management 02. Performance Management Framework 03. Overtime opportunities 04. Recruitment opportunities 05. Use of Third Party Providers 06. Increased scope of practice for Third Party Providers 07. Additional resources utilised to support performance 08. NWAS Demand Management Plan 09. NWAS Communications; use of social media 10. Clinical Leadership Model 11. Trauma Cell in EOCs 12. Utilisation of Community First Responders 13. NWAS Operational Performance Calls 14. ROCC Tactical Commanders & Strategic Commanders 15. Cancellation of mandatory training & appraisals 16. PTS Resources being utilised for PES Support Work 17. Implementation of National Pandemic Card 36 18. NWAS COVID-19 Response Plan 19. NWAS Winter Plan 20. ORJ Modelling Review 21. Engagement with System Leaders & Acute Hospitals 22. Engagement with NHSE/I 23. Engagement with NWAS Lead Commissioner 24. BT Scripts for sub/duplicate calls into NWAS	4	5	20	01. Continued high abstraction rates of staff and limited resources. 02. Unpredictable changes in demand across the Service Delivery Directorate 03. Increased number of pre-alerts into Acute hospitals	01. Daily monitoring of resources 02. Agreed retention of 45 EAs to increase fleet until 31 March 2021 03. Agreed increase of additional personnel to crew the vehicles 04. Agreed increase of EOC Call handling staff	01. Inability to cover all abstractions 02. Confirmation of Commissioner funding to increase resources in line with ORH Demand and Capacity Review recommendations	5	07/12/21	07/01/28

									25. Agreed additional funding to increase PES workforce establishment											
3456	17/11/20	There is a risk that due to increasing numbers of 999 calls and patient acuity to EOCs, callers may experience call pick up delays resulting in increased emergency response times and negative impact on operational performance standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Agreed implementation of additional EMD Support Staff from April 2020 and additional staff from September 2021 02. Performance Management Framework 03. Call Pick Performance Data 04. Wallboards in EOCs to display call levles and EMD availability 05. NWAS Patient Safety Plan 06. EMD Training and Mentoring 07. Additional EMDs and EMD Support Staff recruited & operational 08. Reduction in duplicate calls 09. Additional workforce resources for EOCs being managed via NHSE/I 10. HI reporting enables planning for Building Better Rota's	4	5	20	01.NWAS' obligation to provide buddy support for other NHS Ambulance Services during periods of high demand 02. Unpredicted increased activity from members of the public due to follow-up calls 03. Increased pressures on the workforce 04. Increased acuity - Cat 1 and Cat 2 combined increased by 72% as of 08 November2021 05. Increase in call demand/ follow-up calls	01. National Performance Data 02. NWAS Integrated Performance Report 03. NWAS Performance Data to Commissioners 04. Performance Management Framework 05. Recruitment of 120 EMDs above base line by end of Q3 in 2021. 06. A number of Agency EMDs have been offered fixed term NWAS contracts until end September 2021 07.Additional recruitment supported by NHSE/I 08. EMD training will release 40 staff over three sessions to assist with resourcing and mentoring 09. EOC Procedure for Subsequent Calls (EOC0015) - reviewed September 2021 10. NWAS Medical Director approved use of Emergency Disconnect via Clinical SMT 11. Call handlers to be increased by 140 by January 2022 12. BT introduce Call scripts for screeening 999 calls for sub/duplicate calls from 28 October 2021 in an attempt to reduce call volume into EOC	01. Confirmation of attaining recruitment of 140 ECH's	5	07/12/21	08/01/22
3519	14/04/21	There is a risk that due to incompatible IT infrastructure at GMP HQ a multi-agency response to a major incident would be severely compromised.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially	Maxine Power	16	Treat - Implement controls and	Wifi provided by GMP (very limited) NWAS Infrastructure currently permits one user with limited or no access to systems other than email. GMP, HEADQUARTERS,4 NORTHAMPTON ROAD,, M40 5BR is due to get a network link upgrade to 50mb as part of WAN upgrade	4	4	16	Resilient NWAS IT infrastructure for multiple user access to NWAS systems across the 4 pods at GMP HQ – IT Request in place Resilient WIFI Systems as a backup for NWAS systems	Debrief Reports Incident Logs Incident Reporting	No design of requirements has been submitted and that C3 can only run on a sub 7ms latency network. Connectivity Report	4	01/12/21	28/01/22
3521	21/04/21	There is a risk that due to scheduled maintenance and replacement tasks not being progressed in a timely manner critical network communications will be lost resulting in failure of systems negatively impacting service delivery across the Trust.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Maxine Power	20	Treat - Implement controls and mitigating actions to reduce the risk.	Duplicate hardware providing resilience Monitoring current performance of memory leakage still valid Switch to be rebooted (completed April 2021) Switch core replacement procured and awaiting installation (Awaiting agreement of Date with EOC post COVID) Work starting on Business Impact Analysis of Trust systems in conjunction with the BCP Working group and board in place to undertake switch replacement in mid to late November Working group and board in place to undertake switch replacement in mid to late November Working group and board in place to undertake switch replacement in mid to late November	3	5	15	scheduled downtime for regular maintanace	MIAA business continuity and resilience audit - MODERATE ASSURANCE	no plan for delivery	5	14/10/21	31/12/21
										IT health dashboard enabling real time monitoring of assets, visibility of security threats and vulnerabilities, and assurance around completion of mitigation (e.g. patching and CareCERTs)										

3537	17/06/21	There is a risk, that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Maxine Power	15	Treat - Implement controls and mitigating actions to reduce the risk.	Cyber essentials Compliant assessment completed (2019 - 2020) Desktop central is utilised for maintaining software updates. Radically reduced the number of servers below 2012 - as of 17/06/2021 25 2008 servers are left Patching effectiveness is very high. Regular security updates deployed for the latest security patches New Cyber Security Manager recruited and in place (Oct 2020) New Firewalls were implemented at the end of 2020 offering better security and visibility Implementation of Mimecast email security service. Protecting NWAS from new and emerging threats through email Microsoft ATP implemented on all servers. providing protection and visibility. This is monitored by the Trust and NHSD Mobile Device Management in use to control services on some mobile devices Anti-virus protection (including malware protection) on both physical and virtual clients/server's Device encryption on all laptops and some mobile devices mobile devices to protect data Automated daily threat assessment in place for Windows 10 Business Continuity Plans Regular Audits undertaken by MIAA Regular Pen Tests undertaken Mandatory staff cyber training via ESR	3	5	15	Admin Accounts have internet access There is only 1 backup No MFA on backups High number of Global Admin accounts Out of support software No SIEM No Specific Cyber Incident Management Plan/Policy Lack of uptake in staff security awareness	ITHealth Dashboard - brithd01.northwestambulance.nhs.uk Cyber Essential Certificate Desktop Central - http://epdskc01.northwestambulance.nhs.uk:2581/homePage.do?actionToCall=homePageDetails Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of unsupported Operating Systems Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of patched/unpatched devices and servers Firewall alerts and dashboard Mimecast dashboard - https://login-uk.mimecast.com/u/login/?gta=apps&link=/home#/login ATP Dashboard - https://security.microsoft.com/endpoints/dashboard# MDM Intune portal - https://endpoint.microsoft.com/#@nwas.nhs.uk/dashboard/private/b259b43f-b7b8-47df-b8e0-a2109214d03a Malware protection dashboard - https://eptrnd01:4119/SignIn.screen BC plans are managed within continuity2 Yearly Staff Training figures reported to IG team Pen Test - External Vulnerability & DSPT Assessment (Internal) Feb 2021 Pen Test - External Vulnerability & DSPT Assessment (External) Feb 2021 Pen Test - External Vulnerability & DSPT Assessment (Safe check) Feb 2021 MIAA IT Continuity Audit Dec 2020 MIAA User Privilege Audit Dec 2020 New Cyber Security Manager recruited and in place (Oct 2020)	Lack of defined KPI's relating to Cyber Security & governance/assurance process Actions from NHS Digital, Pen Tests & MIAA assessments to be addressed &b monitored Lack of independent evaluation of security training re Social Engineering Lack of multiple and immutable backups	5	06/12/21	07/01/22
3595	23/11/21	There is a risk due to conflict with operational response priorities that operational staff will not be compliant with statutory and mandatory training requirements (85%), resulting in potential adverse impact on patient care/safety due to staff competence and also resulting in adverse regulatory scrutiny.	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Lisa Ward	20	Treat - Implement controls and mitigating actions to reduce the	01. Policy & Procedure in place 02. Recovery plan in place and revised trajectories 03. Weekly reports for PES on attendances and booking 04. Monthly reporting by service lines 05.Regular engagement with PES and PTS service line leads	4	4	16	01. Recovery plan for EOC 02. Recovery plan for Safeguarding level 3 03. Recovery plan for information governanance 04. Engagement with EOC service line leads	01.Monthly reporting to Board via IPR Dashboard 02. Quarterly Education Assurance Management Group - standing item 03. Monthly update to ELC compliance meeting 04. Substantial Assurance - from MIAA Internal Audit 05. Weekly reporting of bookings and uptake (PES)	01. Service line assurance of abstraction plans to meet 85%	8	24/12/21	31/01/22
3601	3/12/21	There is a risk that due to mandating the COVID-19 vaccine to all front line staff with patient contact will lead to a reduction in our workforce and have a	roved Risks	perational	People	orate and rcially Sensitive	sa Ward	16	- Implement and mitigating	01. Working group set up to work through the processes and implications of the mandate 02. Comms plan in place to support 03. Ongoing analysis of data to indentify those without a vaccination record	4	4	16	01. Currently the mandate has not been passed as legislation so cannot be clear with staff that it is mandated 02. current operational pressures may impact on the ability to hold meetings with	01. Working group in place to agree process with Staff Side and Ops Management 02. there are a number of non-patient facing vacancies in 111 and CHUB which may support redeployment considerations 03. Current workforce plan shows an over	01. Accurate numbers of staff not vaccinated are not yet clear and will require discussions with staff	4	4/12/21	1/01/22

	1	direct negative impact on patient care.	App	Op		Com Commer	Li	Treat controls	04. Process in place to understand the vaccination status of those with no vaccination recorded on the Ims data.			staff 03. If a number of staff refuse to have the vaccine this will require a formal hearing.	03. Current workforce plan shows an over establishment of EMT and Paramedics going inot Q1 of 2022/23					2	3		

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North West Ambulance Service NHS Trust

Board Assurance Framework 2021/22

BOARD OF DIRECTORS

WEDNESDAY 26 JANUARY 2022

nwas.nhs.uk

Q3 2021/22 Reporting Timescales:

Quality & Performance Cttee:	24/01/2022
Resources Cttee:	21/01/2022
Executive Leadership Cttee:	19/01/2022
Audit Cttee:	21/01/2022
Board of Directors:	26/01/2022

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

Director Lead:	
CEO	Chief Executive
DoQII	Director of Quality, Innovation & Improvement
MD	Medical Director
DoF	Director of Finance
DoOps	Director of Operations
DoP	Director of People
DoSPT	Director of Strategy, Partnerships & Transformation
DoCA	Director of Corporate Affairs

Board Assurance Framework Legend

Strategic Priorities	The 2018/2023 strategic priority that the BAF risk has been aligned to				
BAF Risk	The title of the strategic risk that threatens the achievement of the aligned strategic priority				
Rationale for Current Risk Score	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk				
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives				
Controls	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority				
Assurances	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk				
Evidence	This is the platform that reports the assurance				
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk				
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk				
Required Action	Actions required to close the gap in control(s)/ assurance(s)				
Action Lead	The person responsible for completing the required action				
Target Completion	Deadline for completing the required action				
Monitoring	The forum that will monitor completion of the required action				
Progress	A RAG rated assessment of how much progress has been made on the completion of the required action	Incomplete/ Overdue	In Progress	Completed	Not Commenced

OUR STRATEGY AT A GLANCE

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

Values:

WORKING TOGETHER.

We work together to understand and value every role in achieving our shared purpose. We live and breathe inclusivity, everyone matters.

BEING AT OUR BEST.

We challenge ourselves to be the best we can be. We are curious and push boundaries to improve everything we do.

MAKING A DIFFERENCE.

We make a difference through doing the right thing by our staff, patients, partners and communities. We act with compassion and kindness.

Priorities:

Urgent and Emergency Care

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

Quality

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

Digital

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

Business and Commercial Development

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

Workforce

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

Stakeholder relationships

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

Infrastructure

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

Environment

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

Supporting strategies:

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

BOARD ASSURANCE FRAMEWORK DASHBOARD 2021/22

BAF Risk	Committee	Exec Lead	01.04.21	Q1	Q2	Q3	Q4	2021/22 Target	Final Target
SR01: There is a risk that the Trust may not deliver safe, effective, and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 CxL	**15** 5x3 CxL	15 5x3 CxL	**20** 5x4 CxL		**20** 5x4 CxL	**5** 5x1 CxL
SR02: There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure	**Resources**	**DoF**	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL		**15** 5x3 CxL	**5** 5x1 CxL
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Quality & Performance**	**DoOps**	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL		**20** 5x4 CxL	**5** 5x1 CxL
SR04: There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**16** 4x4 CxL		**12** 4x3 CxL	**4** 4x1 CxL
SR05: There is a risk that organisational culture change does not sufficiently develop, impacting adversely on staff wellbeing and engagement with organisational changes, resulting in poor quality services and staff harm	**Resources**	**DoP**			**12** 4x3 CxL	**12** 4x3 CxL		**12** 4x3 CxL	**4** 4x1 CxL
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Quality & Performance**	**DoQII**			**20** 5x4 CxL	**15** 5x3 CxL		**15** 5x3 CxL	**5** 5x1 CxL
SR07: There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint	**Resources**	**DoSPT**			**12** 4x3 CxL	**12** 4x3 CxL		**8** 4x2 CxL	**4** 4x1 CxL
SR08: (**Commercially Sensitive Risk**)	**Resources**	**DoSPT**			**12** 4x3 CxL	**12** 4x3 CxL		**8** 4x2 CxL	**4** 4x1 CxL
SR09: There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm.	**Resources**	**DoQII**				**20** 5x4 CxL		15 5x3 CxL	**12** 4x3 CxL

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR01:
There is a risk that the Trust may not deliver safe, effective, and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction

Strategic Priority: Quality & Digital

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	15	15	15	20		20	5
	5x3	5x3	5x3	5x4		5x4	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q3 of this BAF has increased to a score of 20 due to the continuing impact of delays in response times which affects quality, safety, and patient experience. There is work to focus on patient safety and maintenance of quality to deliver our strategic intentions to be the best ambulance service in the context of COVID-19 recovery and in the current demands of winter. The pandemic has highlighted the importance of having the right clinical leadership structure, particularly preventing harm while waiting, ensuring clinical best practice, and learning when things go wrong. The biggest risk for 2021/22 continues to be the resource required to fund the proposed operational delivery model for both service delivery and corporate functions is yet to be secured due to the prolonged pause in financial planning. The ongoing focus will include delivering the milestones in the Right Care Strategy, refreshing the strategy, and delivering on the requirements of the new regulatory regime.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Quality Performance	**Level 2:** NWAS Quality Account	Reported to BoD
Quality and Operational Metric Surveillance	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Reportable Events Report	Reported to BoD (BoD/2122/105) Reported to BoD (BOD/ 2122/11)
Clincial Audit	**Level 2:** Clinical Audit Plan 2021/22 **Level 2:** Clinical Audit Q2 Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/15) Reported to Q&P Cttee (Q&PC/ 2122/136)
Quality Surveillance	**Level 2:** Quality Assurance Visit Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/87)
Right Care Strategy Implementation	**Level 2:** Quarterly Right Care Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/132)
CQC Transitonal Monitoring	**Level 2:** CQC Assurance Report & Action Plans	Reported to Q&P Cttee (Q&PC/ 2122/34)
Quality Systems and Process	**Level 2:** MIAA Quality Audit Plans	Reported to Audit Cttee (AC/ 2122/12)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework	Reported to BoD (BoD/2122/106)
DIGITAL		
Digital Strategy	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2122/89)
Data Security and Quality	**Level 3:** Data Secruty Protection Toolkit **Level 3:** MIAA Digital Audit Plans	Reported to Audit Cttee (AC/ 2122/10)
UCP Programme	**Level 2:** Implementation of a Stable 999 Telephony Platform	Reported to Resources Cttee (RC/2122/89) Reported to BoD (BOD/ 2122/98)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress

QUALITY					
Complaints & Incident Management	Develop and deliver a new operating model (stage 2) service line accountability for the management of complaints and incidents	Prof M Power	Q4	Q&P Cttee	In Progress
Midwifery Strategic Plan	Develop ~~and deliver~~ the Midwifery Strategic Plan	Dr C Grant	Q4	Q&P Cttee	In Progress
NHS Patient Safety Strategy	Develop a plan to implement appropriate elements of the NHS PS Strategy	Prof M Power	Q4	Q&P Cttee	In Progress
Electronic Quality Measurement Auditing/ Reporting Systems	Develop automated systems for non-clinical audits	Prof M Power	Q4	Q&P Cttee	In Progress
Digital Capture and Monitoring of Clinical Outcomes	Deliver EPR roll out and embed systems for automating clinical audit	Prof M Power	Q4	Q&P Cttee	In Progress
Quality Assurance & Improvement Plan	Draft the next iteration of the Right Care Strategy	Prof M Power	Q4	Q&P Cttee	In Progress
Safety Culture	Devise a plan to improve performance on safety culture & F2SU	Prof M Power	2022/23	Q&P Cttee	In Progress
Mental Health, Dementia, LD & Autism Strategic Plan	Develop ~~and delivery of~~ MH, Dementia, LD & Autism Strategic Plan Devise and embed appropriate pathways for patients	Prof M Power	2022/23	Q&P Cttee	In Progress
	Deliver MH, Dementia, LD & Autism Strategic Plan	Prof M Power	2022/23	Q&P Cttee	Not Commenced
Midwifery Strategic Plan	Deliver the Midwifery Strategic Plan	Dr C Grant	2022/23	Q&P Cttee	Not Commenced
DIGITAL					
Strategic Key Functionality of EPR	Development of Business Case to meet national strategic requirements	Prof M Power	Q3	Resources Cttee	Completed
Out of Hours Technical Resilience	Development of proposal in conjunction with operations	Prof M Power	Q4	Resources Cttee	In Progress
Single Primary Triage System	Migration to Single Primary Triage System	Prof M Power	Q4	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇔	5 Moderate
3448	Operational/ Operational Performance	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	20 Significant	20 Significant	⇔	5 Moderate
3519	Operational/ Emergency Preparedness	There is a risk that due to incompatible IT infrastructure at GMP HQ a multi-agency response to a major incident would be severely compromised.	16 Significant	16 Significant	⇔	3 Low
3521	Operational/ Patient Safety	There is a risk that due to scheduled maintenance and replacement tasks not being progressed in a timely manner critical network communication will be lost resulting in failure of systems negatively impacting service delivery across the Trust.	20 Significant	15 Significant	⇩	5 Moderate
3537	Operational/ Digital and Innovation	There is a risk, that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	15 Significant	15 Significant	⇔	5 Moderate
3601	Operational/ People	There is a risk that due to mandating the COVID-19 vaccine to all front line staff with patient contact will lead to a reduction in our workforce and have a direct negative impact on patient care.	16 Significant	16 Significant	New Risk	4 Moderate

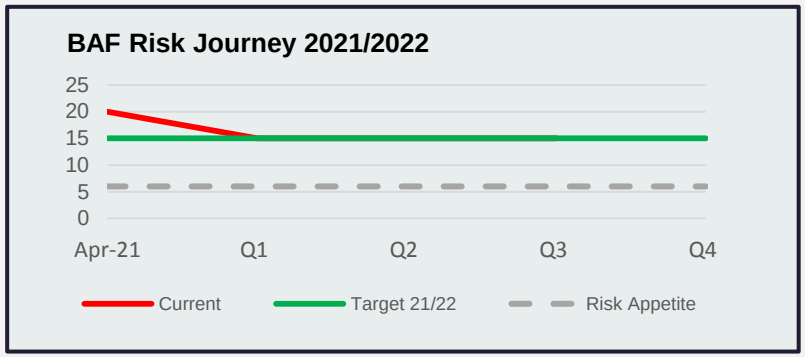
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR02:
There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure

Strategic Priority: ALL

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	20	15	15	15		15	5
	5x4	5x3	5x3	5x3		5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 of this BAF risk has maintained at a score of a 15 due to the Month 09 position which remains on plan and forecasting delivery of break even for H2. At the time of the BAF review, an agreed balanced plan for H2 has been developed and approved by Board. Detailed annual planning guidance for 2022/23 is still expected and working through the detail to review the financial impacts for the organisation.

CONTROLS	ASSURANCES	EVIDENCE
Financial Plans	**Level 2:** 2021/22 Financial Plans	Reported to BoD (BOD 2122/15)
Financial Controls	**Level 3:** MIAA Internal Audit – Key Financial Controls	Reported to Audit Cttee (AC 2021/114)
Significant Change Projects	**Level 2:** Business Cases with Financial Impact	Reported to ELC & CPB
2021/22 Capital Plan	**Level 2:** 2021/22 Captial Plan **Level 3:** NWAS 2021/22 Captial Plan	Reported to BoD (BOD/2122/15) (RC/2122/83) Reported to Lancashire & South Cumbria ICS Board
Annual Accounts/ VfM Statement	**Level 3:** Audit Completion Report (ISA 260) **Level 3:** Independent Auditors Report **Level 3:** Audited Annual Accounts 2020/21	Reported to BoD (BOD/2122/20) Reported to BoD (BOD/2122/21) Reported to BoD (BOD/2122/22)
Financial Performance	**Level 2:** M07 Financial Report	Reported to Resources Cttee (RC/2122/81)
H2 Financial Plan	**Level 2:** Assurance of H2 Financial Plans, including efficencies	Reported to Resources Cttee (RC/2122/81) Reported to BoD (BOD/2122/54)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2021/22 H2 Revenue Financial Plan	Approved 2021/22 H2 Revenue Financial Plan	Ms C Wood	November 2021	Resources Cttee	Completed
2021/22 H2 Efficiencies	Delivery of 2021/22 H2 Efficiency Savings	Ms C Wood	November 2021	Resources Cttee	Completed
2022/23 Planning Guidance	Receipt of 2022/23 Planning Guidance from NHSEI	Ms C Wood	January 2022	Resources Cttee	Not Commenced
2022/23 Financial Plan Revenue	Approval of 2022/23 Financial Plan (Revenue)	Ms C Wood	March 2022	Resources Cttee	Not Commenced
2022/23 Financial Plan Capital	Approval of 2022/23 Financial Plan (Capital)	Ms C Wood	March 2022	Resources Cttee	Not Commenced
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	2022/23	Resources Cttee	In Progress
DIGITAL					

Funding for key risk mitigation within the Digital portfolio	Develop proposal to mitigate data quality, clinical records governance, records management and development support	Prof M Power	September 2021	Resources Cttee	Completed
Funding for Digital Strategy Delivery	To source alternative funding models (ICS/ National)	Prof M Power	Q4	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

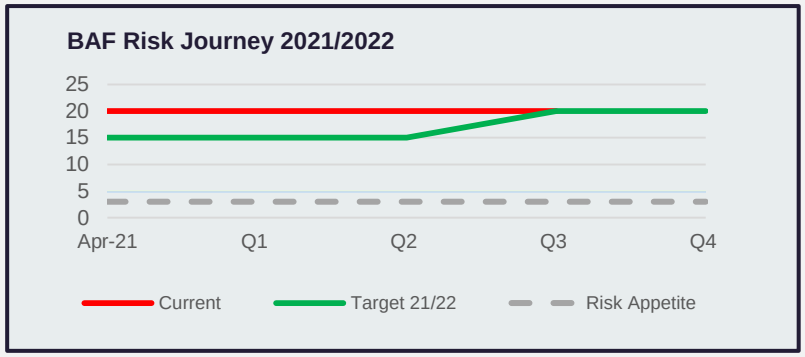
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR03:
There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care

Strategic Priority: Urgent & Emergency Care

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	20	20	20	20		20	5
	5x4	5x4	5x4	5x4		5x4	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q3 of this BAF risk has maintained a scored of a 20 due to sustained levels of operational pressures the Trust has seen across 999 and NHS 111 throughout Q3, resulting in remaining at REAP Level 4 throughout Q3. The Trust continues to apply appropriate mitigating measures to assist with the operational pressures, including the use of third-party providers, shift enhancements and PTS providing support to PES. ETA scripts have remained in place throughout Q3 to minimise the number of duplicate 999 calls. A Military Aid to Civil Contingencies (MACA) request has been submitted and approved. During Q3, NWAS received additional non-recurrent funding from the Government that will be used to assist with the current operational pressures. An escalation process has been developed for extended hospital handover times.

CONTROLS	ASSURANCES	EVIDENCE
Optima Independent Review of NWAS Resources	**Level 3:** ORH Demand and Capacity Review	Reported to Q&P Cttee (Q&PC 2021/145)
Operational Performance Surveillance	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BoD/2122/105)
Adverse Weather Planning	**Level 2:** NWAS Annual Heatwave Plan	Reported to Q&P Cttee (Q&PC 2122/69)
ARP Performance	**Level 2:** Deep Dive and thematic analysis into long waits and resource modelling	Reported to Q&P Cttee (Q&PC 2122/84)
Urgent & Emergency Care (UEC) Strategy Implementation	**Level 2:** Quarterly UEC Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/142)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operational Workforce Abstraction Rates	Request & approal of Military Aid to Civil Contigencies (MACA)	Mr G Blezard	January 2022	Q&P Cttee	Completed
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	March 2022	Q&P Cttee	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve patient care	Mr G Blezard	March 2022	Q&P Cttee	In Progress
Hospital Handover Delays	Develop escalation processes for extended handover delays	Mr G Blezard	January 2022	Q&P Cttee	In Progress
	Participation in local and national programmes to reduce delays	Mr G Blezard	March 2022	Q&P Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR03

Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
3254	Operational/ Performance	There is a risk that due to staff taking carried over leave accrued during the COVID19 pandemic, operational resources will not meet demand resulting in delayed patient response and delivery of national ARP standards.	20 Significant	20 Significant	⇔	5 Moderate
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇔	5 Moderate
3448	Operational/ Operational Performance	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	20 Significant	15 Significant	⇩	5 Moderate
3452	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 Significant	25 Significant	⇔	5 Moderate
3455	Operational/ Patient Safety	There is a risk that across PES, resources will be limited or not available for effective and efficient utilisation across the region because of an increase in operational demand and patient acuity which may result in delayed responses to patients.	20 Significant	20 Significant	⇔	5 Moderate
3456	Operational/ Performance	There is a risk that due to increasing numbers of 999 calls and patient acuity to EOCs, callers may experience call pick up delays resulting in increased emergency response times and negative impact on operational performance standards.	20 Significant	20 Significant	⇔	5 Moderate
3601	Operational/ People	There is a risk that due to mandating the COVID-19 vaccine to all front line staff with patient contact will lead to a reduction in our workforce and have a direct negative impact on patient care.	16 Significant	16 Significant	New Risk	4 Moderate
Commercially Sensitive Risk – FOI Act Section 22 – Intended for Future Publication						
3171	Reputational/ Emergency Preparedness	There is a risk that as the Manchester Arena Inquiry progresses, the Trust may be subject to reputational damage because of the details that emerges in the media outlining the role and response of NWAS during the incident, which may result in sustained negative publicity and reputation damage.	20 Significant	16 Significant	⇩	4 Moderate
Commercially Sensitive Risk – FOI Act Section 24 – Relation to National Security						
3409	Operational/ Emergency Preparedness	There is risk due to the National UK terror threat level increasing to 'Severe' there is an increasing likelihood of a terror attack within the NWAS geographical footprint which may impact on the delivery of urgent and emergency care and reduced ARP response times.	20 Significant	15 Significant	⇧	5 Moderate

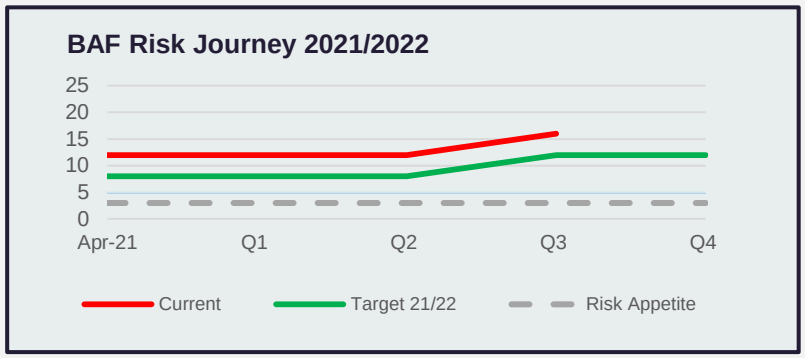
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR04:
There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	12	12	12	16		12	4
	4x3	4x3	4x3	4x4		4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded		Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q3 of this BAF has increased to a score of 16 due to the delivery of safe services has remained under pressure., Q1, 2 & 3 recruitment plans have been maximised and delivered and robust plans are in place for Q4. There has been some increase in turnover across service lines, but most areas are within tolerance of pre-COVID levels except for 111. However, at the end of Q3 the Trust is facing significant challenges associated with the levels of abstractions resulting from COVID and normal sickness. In addition, the legislative change to mandate COVID vaccination for patient facing staff could impact adversely on turnover and sickness absence during Q4. HR and managerial resources required to manage the process fairly and may have an adverse impact on the timeliness of managing of other HR processes. Robust plans to support and encourage vaccination uptake are in place and it is anticipated that during Q4 short term risks associated with abstractions will in part be mitigated by approval of the Trust's Military Aid for Civil Contingencies (MACA) request.

CONTROLS →	ASSURANCES →	EVIDENCE
PEOPLE		
Strategic People Plan	**Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/2122/91) Reported to BoD (BOD/ 2122/37)
Strategic Workforce Plan	**Level 2:** H1 Planning Submission **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** H2 Planning Submission	Reported to BoD (BOD/ 2122/10) Reported to Resources Cttee (RC/2122/69) Reported to Resources Cttee (RC/2122/87) & BoD (BOD/2122/54)
Diversity & Inclusion Plans	**Level 2:** Diversity & Inclusion Assurance Report **Level 2:** D&I Sub Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/ 2122/22) Reported to Resources Cttee (RC/2122/93)
People Metric Surveillance	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Report **Level 2:** Staff Survey and Culture Audit Deep Dive	Reported to BoD (BOD/2122/105) Reported to Resources Cttee (RC/2122/90) Reported to Resources Cttee (RC/ 2122/07)
Recruitment Plans	**Level 2:** Q2 Recruitment Plans	Reported to (RC/2122/90)
Vaccination	**Level 2:** Flu Plans and COVID booster roll out	Reported to Resources Cttee (RC/2122/66) Reported to Resources Cttee (RC/2122/68) Reported to BoD (BOD/2122/86)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
111 Retention	Development of an action plan to improve retention in 111	Ms L Ward	January 2022	Resources Cttee	In Progress
Vaccination	Delivery of target compliance of 85% for Flu and COVID booster	Ms L Ward	March 2022	Resources Cttee	In Progress
Vaccination as a Condition of Deployment (VCOD)	Implementation of legislative requirements	Ms L Ward	March 2022	Resources Cttee	In Progress
Recruitment Plans	Delivery of Q3 ~~& Q4~~ recruitment plans	Ms L Ward	March 2022	Resources Cttee	Completed

	Delivery Q4 recruitment plans	Ms L Ward	March 2022	Resources Cttee	In Progress
Attendance	Delivery of actions to improve attedance including AIT	Ms L Ward	March 2022	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3595	Operational/ People	There is a risk due to conflict with operational response priorities that operational staff will not be compliant with statutory and mandatory training requirements (85%), resulting in potential adverse impact on patient care/safety due to staff competence and also resulting in adverse regulatory scrutiny.	20 Significant	16 Significant	New Risk	8 High
3601	Operational/ People	There is a risk that due to mandating the COVID-19 vaccine to all front line staff with patient contact will lead to a reduction in our workforce and have a direct negative impact on patient care.	16 Significant	16 Significant	New Risk	4 Moderate

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR05:
There is a risk that organisational culture change does not sufficiently develop, impacting adversely on staff wellbeing and engagement with organisational changes, resulting in poor quality services and staff harm

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
			12	12		12	4
			4x3	4x3		4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite			Exceeded	Exceeded		Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q3 of this BAF has maintained at a score of 12 due to the Trust continuing to face significant number of changes, in a climate where pressures on staff and managers from demand, activity and COVID continues to be significant. There remains a good health and wellbeing offer in place. This is further strengthened through additional NHSEI funding which is being focused on addressing managerial burnout and proactive wellbeing calls for frontline staff. This builds on the implementation during this financial year of the refreshed values, treat me right campaign, increased focus on inclusion and steps to improve the just culture approach to HR casework. Whilst the climate reflects continuing pressures on staff and impacts are being seen on engagement.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
NHS People Plan	**Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/2122/91) & BoD (BOD/2122/110)
NWAS People Plan Implementation	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/2122/69) Reported to BoD (BoD2122/37)
Implementation of Revised Trust Values	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)
Appraisal Policy & Procedure	**Level 2:** Workforce Indicators Report & Integrated Performance Report **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/90) & BoD (BoD/2122/80) Reported to Resources Cttee (RC/2122/69)
Staff Survey Inc. Local Plans	**Level 1:** Local Wellbeing Plans **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)
Equality & Diversity Priorities	**Level 2:** WRES, WDES, Gender Pay Gap **Level 2:** EDI Annual Report **Level 2:** Diversity & Inclusion Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/67) & BoD (BoD/2122/85) Reported to Resources Cttee & BoD (BoD/2122/36) Reported to Resources Cttee (RC/2122/93)
Staff Networks	**Level 2:** Diversity & Inclusion Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/90)
Leadership Development Inc. BTD Leadership Recruitment	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)
Health and Wellbeing Provision	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2122/69) Reported to BoD (BOD/122/111)
CULTURE		
Culture & Wellbeing Audit	**Level 2:** Culture & Wellbeing Deep Dive	Presented to Resources Cttee (RC/2122/07)
Speaking Up Processes	**Level 2:** FTSU Annual Report **Level 2:** FTSU Action Plan	Reported to Resources Cttee & BoD (BoD/2122/101)
Just Culture Inc. Displinary & DAW Processes and Treat Me Right	**Level 2:** Workforce Indicators Report & Integrated Performance Report **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** Assurance on People Practices (Inc. Just Culture)	Reported to Resources Cttee (RC/2122/90) & BoD (BoD/2122/105) Reported to Resources Cttee (RC/2122/69) Reported to BoD (BoD/2122/55)
Culture Dashboards	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/69)

Just Culture Principles and Investigations Training	**Level 2:** Equalities, Diversity, and Inclusions Priorities Assurance Report	Reported to Resources Cttee: (RC/ 2122/66)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Leadership	Develop and Approval of a Leadership Framework	Ms L Ward	October 2021	Resources Cttee	Completed
Health and Wellbeing Guardian	Appointment of a Health & Wellbeing Guardian	Ms L Ward	November 2021	Resources Cttee	Completed
Operations and Medical Management Restructure	Implementation of Phase 1 Senior Management Restructure	Mr G Blezard Ms L Ward	March 2022	SDMR Project Board	In Progress
Additional H&WB Funding	Implementation of H&WB Plans associated with NHSEI Funding	Ms L Ward	March 2022	Resources Cttee	In Progress
EDI Priorities	Delivery of Year 1 Action Plans (Workforce Elements)	Ms L Ward	March 2022	Resources Cttee	In Progress
Trailblazer for National Health and Wellbeing Framework	Implementation of the National Health and Wellbeing Framework	Ms L Ward	March 2022	Resources Cttee	In Progress
FTSU Action Plan	Delivery of agreed actions	Ms L Ward Ms A Wetton	2022/23	Resources Cttee	In Progress
Fully embedding Just Culture Principles	Investigation training compliance	Ms L Ward	2022/23	Resources Cttee	In Progress
	Review of Disciplinary Procedure	Ms L Ward	2022/23	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	2022/23	Resources Cttee	Not Commenced
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	2022/23	Resources Cttee	Not Commenced
Evaluation of Trust Values	Undertake an evaluation on the impact on the Trust Values	Ms L Ward	2022/23	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2507	Operational/ Performance	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 Significant	16 Significant	⇔	4 Moderate
3447	Operational/ Workforce	There is a risk that due to increasing operational demand and call volumes, the health and wellbeing of our workforce may deteriorate leading to absenteeism negatively impacting on staff safety.	16 Significant	16 Significant	⇔	4 Moderate

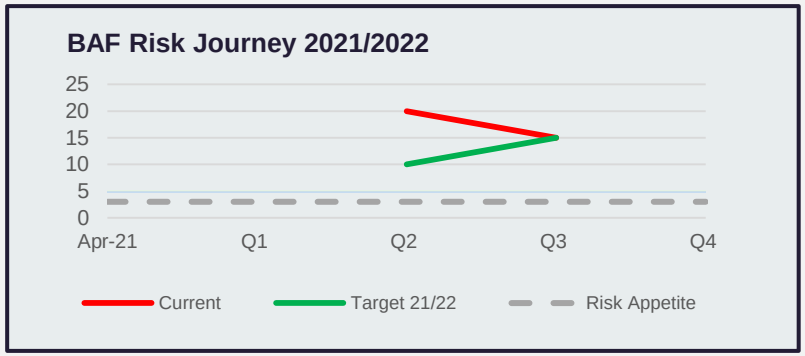
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR06:
There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
			20	15		15	5
			5x4	5x3		5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite			Exceeded	Exceeded		Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q3 of this BAF has decreased to a score of 15 due to the progress that has been made particularly in respect of the actions taken to mitigate risks in relation to fire safety, mandatory training, complaints, incidents metrics and Infection Prevention and Control (IPC), with assurance against the improvements being presented via the Integrated Governance Structure. In addition, the 6-point winter plan has been developed by the system to further improve hospital handover delays. Nevertheless, external demand and pressures may lead to further exacerbation of overall safety, and workforce risks, within Q4.

CONTROLS	ASSURANCES	EVIDENCE
PATIENT SAFETY		
CQC Overall Rating of 'Good'	**Level 3:** CQC Inspection Report	Reported to BoD (2020)
CQC Inspection Action Plan	**Level 2:** CQC Action Plan Assurance Report	Reported to Q&P Cttee (Q&PC 2122/13)
CQC Regulation	**Level 2:** CQC Regulation Assurance Report	Reported to Q&P Cttee (Q&PC 2122/34)
IPC Practices	**Level 2:** IPC Board Assurance Framework	Reported to Q&P Cttee (Q&PC 2122/135)
Right Care Strategy Implementation	**Level 2:** Quarterly Right Care Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/132)
Quality Assurance Processes	**Level 2:** Quality Assurance Visit Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/87)
PEOPLE		
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2122/90)
Speaking Up Processes	**Level 2:** FTSU Annual Report **Level 2:** FTSU Action Plan	Reported to Resources Cttee & BoD (BoD/2122/101)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
PATIENT SAFETY IMPROVEMENTS					
Response Model Inc. Long Waits & Handover Delays	Deliver Q3 & Q4 actions alongside regional 6 point winter plan	Dr C Grant	March 2022	Q&P Cttee	In Progress
Patient Safety Management (Incidents & Complaints)	Improve compliance with patient safety metrics	Prof M Power	March 2022	Q&P Cttee	In Progress
Non-Compliance with IPC & RPE	Improve compliance with IPC practices and RPE across the Trust	Prof M Power	March 2022	Q&P Cttee	In Progress
Clinical Audit Submissions	Development of APEX tool to ensure new e-PRF can be audited	Dr C Grant	Q4	Q&P Cttee	In Progress

Essential Checks (Vehicle)	Improve compliance by working with operational teams	Mr G Blezard	Q4	Q&P Cttee	In Progress
Essential Checks (Premises)	Improve compliance by working with the estates team	Ms C Wood	Q4	Resources Cttee	In Progress
Freedom to Speak Up Index	Review the detailed breakdown of all Index Indicator Scores	Prof M Power	2022/23	Q&P Cttee	In Progress
	Devise Corporate and Local Action Plans	Prof M Power	2022/23	Q&P Cttee	In Progress
PEOPLE					
HR Casework	Improving the timeliness of HR cases	Ms L Ward	March 2022	Resources Cttee	In Progress
Mandatory & Statutory Training Compliance	Achieve 85% compliance by March 2022	Ms L Ward	March 2022	Resources Cttee	In Progress
Appraisal Compliance	Achieve 75% compliance by March 2022	Ms L Ward	March 2022	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3445	Operational/ Patient Safety	There is a risk that due to the excessive handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	20 Significant	20 Significant	⇔	5 Moderate
3595	Operational/ People	There is a risk due to conflict with operational response priorities that operational staff will not be compliant with statutory and mandatory training requirements (85%), resulting in potential adverse impact on patient care/safety due to staff competence and also resulting in adverse regulatory scrutiny.	20 Significant	16 Significant	New Risk	8 High

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR07:
There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint

Strategic Priority: Stakeholder Relationships

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate

BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
			12	12		8	4
			4x3	4x3		4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite			Exceeded	Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q3 of this BAF has maintained at a score of 12 due to the new structures and work programmes being put in place by the Trust will help to ensure that the changes in place nationally for the ICS are mitigated. However, there is a degree of uncertainty going forward, whilst the legislation is turned into practice and implemented across the footprint has now been delayed until 01 July 2022. The Trust will work with the approval processes. The ICS has begun to implement some changes with Executives and Chairs now appointed. However, other positions need to be filled including a full Executive Team, this is expected by end February 2022. The ongoing issue remains around clarity on how the Ambulance Service will work and function with the various ICSs. The trust will utilise the extra time to embed processes and systems in place for effective engagement and influencing across the ICS areas.

CONTROLS	ASSURANCES	EVIDENCE
NWAS		
CEO via AACE Role Engagement with NHSE/I	**Level 2:** CEO Report	Reported to BoD (BOD/2122/97) & (BOD/2122/98)
Designated Executive Director Lead for each ICS	**Level 2:** Executive Portfolios	Reported to BoD (BOD/2122/87)
Partnership & Integration Team	**Level 2:** Established in September 2021	Reported to BoD (BOD/2122/87)
NWAS Manager Representation at Key Meetings	**Level 2:** Assessment to ensure the right expertise is in attendance	Reported to Board (BOD/2122/87)
Stakeholder Mapping	**Level 2:** Full mapping exercise is in place	Reported to BoD (BOD/21/22/87)
ICS		
Involvement in ICS Structures	**Level 2:** P&I Team involved in establishing relationships	Reported to BoD (BOD/2122/97) & (BOD/2122/98)
Working & monitoring national, regional & local groups	**Level 2:** Relevant NWAS Managers are part of these groups	Reporting to BoD (BOD/2122/87)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Information Sharing across Key Partners	Update and refresh the reconfiguration matrix	Mr S Desai	Q2	Resources Cttee	Completed
Knowledge Vault	Design, develop & implement so intelligence & information is shared	Mr S Desai	Q4	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

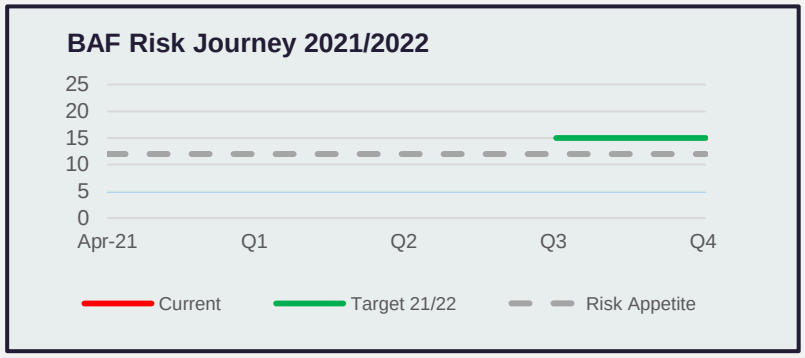
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR09:
There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Innovation – High



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
				20		15	12
				5x4		5x3	4x3
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite				Exceeded		Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q3 of this BAF has been opened at a score of 20 due to the significant progress in assurances and controls in place to protect us from cyber-attack. There is good visibility of our estate through the IT health dashboard and are making progress to patch as required and replace where required unsupported systems. Increases to resilience and expertise in the digital and innovation team and have new infrastructure; firewalls and security systems to protect our emails. However, there is significant volumes of attempted cyber breaches (locally, nationally & globally) which has increased during COVID. Our primary vulnerability lies in staff awareness, and not reaching the DSPT requirement for 95% of staff to have completed their information security mandatory training. A new vulnerability continues to pose a higher level of cyber threat globally, logj4. This has led to an increase in high severity CareCerts, and continue to monitor vulnerabilities that need to be patched.

CONTROLS	ASSURANCES	EVIDENCE
Data Security Protection Toolkit	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/89)
CareCert Compliance	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/89)
Patching	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/89)
Penetration Testing	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/89)
Monitoring and Surveillance	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/89)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Additional Back-ups	Completion of external audit	Prof M Power	December 2021	Resources Cttee	Completed
	Identify and implement additional back-ups required	Prof M Power	March 2022	Resources Cttee	In Progress
	Implement additional training within team	Prof M Power	March 2022	Resources Cttee	In Progress
Cyber Security Strategy	Devise a new cyber security strategy	Prof M Power	March 2022	Resources Cttee	In Progress
Patching	Reach 85% systems patches in the last month	Prof M Power	March 2022	Resources Cttee	In Progress
	External scanning for vulnerabilities	Prof M Power	2022/23	Resources Cttee	In Progress
	To ensure logj4 vulberabilities are patched	Prof M Power	2022/23	Resource Cttee	In Progress
	Enable monthly failover & patching opportunities	Prof M Power	2022/23	Resources Cttee	In Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Prof M Power	2022/23	Resources Cttee	In Progress

Out of Hours Resilience	Develop business case for 24/7 support	Prof M Power	2022/23	Resources Cttee	In Progress
	Work with Business Continuity Team to desktop worst case scenario	Prof M Power	2022/23	Resources Cttee	In Progress
	Implement recommendations from desktop worst case scenario	Prof M Power	2022/23	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3537	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	15 Significant	15 Significant	⇔	5 Moderate

Appendix 3:

2021/22 Board Assurance Framework (BAF) Heat Maps

Quarter 3 Position

NHS North West Ambulance Service NHS Trust

2021/22 Opening BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01	20 SR02 SR03	25
4 Major	4	8	12 SR04	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 01 April 2021

Likelihood

Q1 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01 SR02	20 SR03	25
4 Major	4	8	12 SR04	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 07 July 2021

Likelihood

Q2 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01 SR02	20 SR03 SR06	25
4 Major	4	8	12 SR04 SR05 SR07 SR08	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 07 October 2021

Likelihood

Q3 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR06	20 SR01 SR03 SR09	25
4 Major	4	8	12 SR07 SR08	16 SR04	20
3 Moderate	3	6	9	12 SR05	15 SR02
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 13 January 2022

Likelihood

Q4 BAF Risk Scores

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

Populated:

Likelihood

2021/22 Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10 SR02 SR06 SR09	15 SR01 SR03	20	25
4 Major	4	8 SR07 SR08 SR05 SR04	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 01 April 2021 Updated: 13 January 2022

Likelihood

Final Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	SR01 SR02 SR03 SR06 SR04 SR05 SR07 SR08 5	10	15 SR09	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 01 April 2021

Likelihood

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th January 2022				
SUBJECT:	Board and Committee Calendar 2022/23				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☒	☒	☒	☒	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The report details the proposed meetings dates for 2022/23 for the board of Directors and Committees.				
RECOMMENDATIONS:	The Board of Directors are requested to approve the Corporate Calendar 2022/23.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:					
	Date:				
	Outcome:				

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1. PURPOSE

The purpose of this report is to present the proposed Board of Directors and Committee dates for 2022/23 for approval.

2. BACKGROUND

Following circulation of the draft dates in December 2021, the Corporate Calendar for 2022/23 has taken into consideration any feedback received from Board members.

3. CORPORATE CALENDAR 2022/23

Meeting	Dates
Board of Directors 9.45 am – 3.00 pm Bi-Monthly	27th April 2022 25th May 2022 17th June 2022 (Year End) 27th July 2022 26th September 2022 30th November 2022 25th January 2023 29th March 2023
Board Development 9.30 am – 4.30 pm Bi-Monthly	27th April 29th June 26th October 14th December 22nd February
Charitable Funds Committee 3.00 pm – 4.00 pm (Bi-Annual)	27th April 26th October
Nominations and Remuneration Committee 9.00 am – 9.45 an Bi-Monthly	25th May 27th July 28th September 30th November 25th January 29th March
Audit Committee 10.00 am – 12.00 pm Quarterly	22nd April 12th May (3.00 pm) 17th June (Year End) 21st July 21st October 20th January
Quality and Performance Committee 1.00 pm – 4.00 pm Monthly	25th April 23rd May 27th June 25th July 26th September 24th October 28th November 23rd January 27th February 27th March

Resources Committee 10.00 am – 1.00 pm Bi-Monthly	20th May 22nd July 23rd September 25th November 20th January (1.00pm – 4.00 pm) 24th March

Membership of Committees will be reported to the Board of Directors in March 2022. Diary invites have been distributed to all Board Members for all meetings based on the current membership and will be updated accordingly in the event of any changes.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to approve the Corporate Calendar 2022/23.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26 January 2022				
SUBJECT:	Health, Safety and Security Policy Revision				
PRESENTED BY:	Director of Quality Improvement and Innovation				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	
	☒	☐	☐	☐	
	SR05	**SR06**	**SR07**	**SR08**	**SR09**
	☐	☒	☐	☐	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The Health and Safety at Work Act 1974, along with subsequent regulations and guidance aims to protect employees and others affected by the employer's undertaking, so far as is reasonably practicable, from harm whilst at work. The health, safety and security policy has been reviewed and updated to reflect the trust current organisational structure and has been strengthened as a result of key stakeholder feedback. There have been some significant changes to the current policy and these have been summarised in section 4.1 of the paper; and describes the proposed implementation process.				
RECOMMENDATIONS:	The BoD is asked to • note the review process undertaken • note the summary of changes and their impact • support the proposed implementation process • accept the revised health, safety and security policy				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☒ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐	

PREVIOUSLY CONSIDERED BY:	HSSSC, ELC and Q&P	
	Date:	18/01/22 19/01/22 24/01/22
	Outcome:	

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1. PURPOSE

1.1 The purpose of the paper is to present the revised Health, Safety and Security Policy (appendix 1) to the Board of Directors (BoD). It is requested the BoD accept the revised policy for implementation in the trust.

2. BACKGROUND

2.1 The Health and Safety at Work Act 1974, along with subsequent regulations and guidance aims to protect employees and others affected by the employer's undertaking, so far as is reasonably practicable, from harm whilst at work. The responsibility for this protection is shared between the employer and employee. Each owes the other a duty of care to maintain a working environment that is, so far as is reasonably practicable, free from hazards and risk of injury to persons working there or to others who may be affected by the work activity.

It is not practical however to eliminate all risks from the workplace and therefore it is the employer's responsibility to provide adequate protection, advice, information and / or training to reduce risks that cannot be eliminated. Equally, employees must comply with these arrangements.

The purpose of this policy is to clearly set out the trust's commitment to the health, safety and security of staff and others alike, to define responsibilities and to assist all employees to understand the complex nature of safety and security management. The Health, Safety & Security A – Z tool kit compliments this policy with detailed procedures for different aspects of health and safety.

Through this policy the trust aims to promote a safety and security conscious culture in all activities and the commitment to health, safety and security must go beyond merely reading this policy and associated procedures within the Health, Safety & Security A – Z tool kit and must be translated into effective action.

3. REVIEW PROCESS

3.1 The policy was reviewed in several stages:
Stage 1: The current policy was shared at the Health Safety and Security Sub-committee for consultation and feedback was requested from the members.

Stage 2: The feedback received from members of the sub-committee was reviewed by the Health, Safety and Security Manager and the policy annotated.

Stage 3: The annotated policy was shared with the Senior Clinical Quality Manager who undertook a further review and shared with the Chief of Regulatory Compliance and Assurance and the Director of Quality, Innovation and Improvement.

Stage 4: The feedback from key stakeholders was used to improve the content of the policy for sign off at the Health, Safety and Security sub-committee.

4. SUMMARY OF CHANGES

4.1 The changes to the health safety and security policy have on this occasion been significant and these have been summarised in the table below.

Ref No	Section title	Summary of Change	Significant or minor impact
	Statement of Commitment	Expanded to include explicit statement of responsibilities of all line managers and the estates and facilities team	significant
4.1	Board of Directors	Include a commitment to wear appropriate protective equipment where necessary	minor
4.3	Director of Quality Innovation & Improvement	Act as Chair for the Health, Safety and Security Sub-committee	minor
4.6	Assistant Director (Estates and Fleet)	Named as responsible person for fire safety across NWAS managed premises and liaise closely with the landlords of shared sites. Responsible for specific areas of health and safety processes for workshops and contracting of services to ensure annual processes for specific areas of testing and assurance such as portable equipment, fire extinguishers and ventilation.	significant
4.8	Chief of Regulatory Compliance & improvement	Renamed and revised to include undertaking the lead relationship building with the Health and Safety Executive in the North West. To act as deputy chair for the health, safety and security sub-committee.	significant
4.9	Head of Quality Compliance and Assurance	New role and responsibilities including the design, facilitation and evaluation of the health safety and security training programmes and the delivery of specialist safety training.	significant
4.10	Health, Safety and Security Manager	Strengthened statement of the role of specialist advisor. Developing and maintaining relationships with external agencies	minor
4.11	Health, Safety and Security Practitioners	Renamed and revised to include the maintenance of relationships with external agencies	minor
6.2	Health, Safety, Security and Fire Incidents	Describes the monitoring procedures in place	minor
6.3	Health, Safety, Security and Fire Audits	Describes the audit processes in place	minor
6.4	Learning from Incidents and Audits	Describes how learning is shared and risks managed.	minor
9.	Key References and Bibliography	Summary of reference materials	minor

5. IMPLEMENTATION PROCESS

5.1 The proposed implementation process is as follows:

- All named officers to receive an electronic copy of the policy with the summary of the changes(4.1, 4.3, 4.6, 4.8, 4.9, 4.10 and 4.11)
- Current health, safety and security policy removed from the intranet
- Approved policy to be added to the intranet
- Short item in the regional bulletin advising the revised policy is available on the intranet

Under ‘for information’ at Level 3 meetings or equivalent to advise of the availability of the policy on the intranet.

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

6.1 The health, safety and security policy has been reviewed with consideration to:

- Health & Safety at Work Act 1974
- Management of Health & Safety at Work Regulations 1999
- Health & Safety (Consultation with Employees) Regulations 1996
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
- Safety Representatives and Safety Committees Regulations 1977
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Dangerous Substances Explosive Atmosphere Regulations 2002 (DSEAR)
- https://www.hse.gov.uk/ last accessed 14/12/2021

7. EQUALITY OR SUSTAINABILITY IMPLICATIONS

7.1 Equality Impact Assessment: The review of the policy, despite the significant changes, suggest the statement for equality impact assessment remains neutral (appendix 2).

8. RECOMMENDATIONS

8.1 The Board of Directors is asked to

- note the review process undertaken
- note the summary of changes and their impact
- support the proposed implementation process
- accept the revised health, safety and security policy

North West Ambulance Service NHS Trust

Policy on Health, Safety and Security

Recommended by	Executive Leadership Committee
Approved by	Trust Board of Directors
Approval date	
Version number	8.0
Review date	
Responsible Director	Director of Quality, Innovation and Improvement
Responsible Manager (Sponsor)	Chief of Regulatory Compliance and Improvement
For use by	All trust employees and volunteers

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

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
x 1	March 2008	April 2008	F Buckley	Board of Directors approval
X 1.2	May 2011	September 2011	F Buckley	Sent to the Health and Safety Sub Committee for consultation
X2.0	August 2011	September 2011	F Buckley	Amended to ensure NHSLA requirements. Presented to Health, safety and security Management Group for approval
X2.0	August 2011	September 2011	F Buckley	Presented to the EMT for approval
X2.0	September 2011	September 2011	F Buckley	Presented to the Board of Directors for approval
X3.0	November 2012	March 2013	F Buckley	Presented to Health and Safety Management Group for consultation
X3.0	April 2013	June 2013	F Buckley	Approved by Health and Safety Management Group. Presented to Executive Management Team for approval
X3.0	April 2013	June 2013	F Buckley	Approved by Executive Management Team. Presented to Board of Directors for approval
X3.0	April 2013	June 2013	F Buckley	Approved by the Board of Directors
X4.0	June 2015		F Buckley	Presented to Health and Safety Management Group for consultation
X4.0	October 2015		F Buckley	Recommended for approval by the Health and Safety Management Group
X4.0	December 2015		F Buckley	Presented to and approved by the Executive Management Team
X5.0	September 2018		F Buckley	Presented to Health and Safety Management Group for consultation
X5.0	November 2018	February 2019	F Buckley	Approved by Health and Safety Management Group
X5.0	January 2019	February 2019	F Buckley	Approved by Board of Directors
X5.0	May 2019	May 2019	F Rose	Change of CEO
X6.0	April 2021	September 2021	F Rose	Review by HSSSC
X7.0	September 2021	December 2021	M Peters	Review by key stakeholders
X8.0	December 2021	January 2022	M Peters	Review by HSSSC and ELC
X9.0	January 2022		M Peters	

Contents

Statement of Commitment

The Board of Directors of the North West Ambulance Service N.H.S. Trust (NWAS) recognise and accept responsibility as an employer to provide a safe environment for all its employees and others who are affected by the trust's undertaking, so far as is reasonably practicable in accordance with Health and Safety at Work Act 1974 and associated legislation and guidance.

The trust is committed to ensuring a safe system of work approach to health, safety and security and in order to achieve this will put in place the organisational arrangements necessary to fulfil its statutory and mandatory obligations as a minimum and seeks to prevent work place/related injuries, ill health and protection of staff, property and assets by promoting good working practices.

Working together with staff, the trust is committed to addressing identified risks in a proactive way. As far as is reasonably practicable the trust aims to avoid exposure to risk by the promotion of an effective, progressive safety and pro-security culture by clear identification of the roles and responsibilities of staff at all levels, ensuring they receive suitable and sufficient training, information, supervision and support.

The Board of Directors recognises that financial investment is required in order to ensure compliance with its statutory duties and this policy and will endeavour to ensure that the necessary resources are made available.

The Health, Safety and Security team are responsible for the development of health, safety and security policies in line with best practice and changes in regulatory and legislative requirements. The Health, Safety and Security team are responsible for the design and oversight of audit of processes against these policies across the organisation. The Health, Safety and Security team are responsible for the identification of actions to resolve non-compliance and safety issues and the provision of expertise and advice to line managers.

All line managers across NWAS are responsible for the management of health, safety and security and implementation of this policy and associated policies, procedures, risk assessments within their own areas of responsibility and ensuring that there a local systems for safe working. They should also ensure that their own personnel are made aware of their statutory requirements under current health and safety legislation. Line managers are responsible for local audit of compliance against the policies (for example via health and safety audits) and for local partnership working with Trade union representatives and staff to ensure staff and patient safety. Line managers and local teams are responsible for ensuring the timely completion of actions identified via risk assessment of audit to ensure safe, working environments.

The estates and facilities team are responsible for ensuring that specific safety risks and actions resulting from audits related to fleet and estate are actioned in a timely manner to ensure safe systems of working for all staff. The estates and facilities team are also responsible for specific areas of health and safety processes for workshops, and the contracting of services to ensure annual processes for specific areas of testing and assurance such as portable equipment testing, fire extinguishers and ventilation.

All staff are responsible for ensuring that they follow policies and procedures to keep themselves and their colleagues and patients safe at work.

A copy of this Statement of Commitment will available from the Health, Safety and Security Team and on the Intranet. This policy is subject to a triennial review unless determined otherwise. The Board may also refer to independent reviews and assessment to gain assurance on the effectiveness of the measures within the policy.

Evidence of compliance with the policy will be collated by the appropriate directorates and presented to the appointed Board Committee, as required. All employees will on acceptance of their contract be required to ensure compliance with their responsibilities as listed in this policy.

As Chief Executive I will ensure that the Board of Directors commits to continually improve and promote health, safety, security and welfare as a priority for all involved in the delivery of the service we provide. This will create a working environment in which health, safety and security is ingrained into the culture and lives of all.

Health, safety and welfare must be the primary concern of every employee within NWAS.

Please read the Policy and think safety, plan safety and work safely, at all times. Be Safe; Do the Right Thing

Chief Executive
DAREN MOCHRIE QAM

1. Introduction

The Health and Safety at Work Act 1974, along with subsequent regulations and guidance aims to protect employees and others affected by the employer's undertaking, so far as is reasonably practicable, from harm whilst at work. The responsibility for this protection is shared between the employer and employee. Each owes the other a duty of care to maintain a working environment that is, so far as is reasonably practicable, free from hazards and risk of injury to persons working there or to others who may be affected by the work activity.

It is not practical however to eliminate all risks from the workplace and therefore it is the employer's responsibility to provide adequate protection, advice, information and / or training to reduce risks that cannot be eliminated. Equally, employees must comply with these arrangements.

The purpose of this policy is to clearly set out the trust's commitment to the health, safety and security of staff and others alike, to define responsibilities and to assist all employees to understand the complex nature of safety and security management. The Health, Safety & Security A – Z tool kit compliments this policy with detailed procedures for different aspects of health and safety.

Through this policy the trust aims to promote a safety and security conscious culture in all activities and the commitment to health, safety and security must go beyond merely reading this policy and associated procedures within the Health, Safety & Security A – Z tool kit and must be translated into effective action.

2. Aims and Objectives

The North West Ambulance Service NHS trust (NWAS) aims to fulfil its duties to employees and others affected by their undertaking by:

- Assessing all work activities by identifying and evaluating risks so that effective control measures can be implemented
- Creating, as far as is reasonably practicable, a work environment that is safe and secure acknowledging that the trust does not have complete control over the situations staff may find themselves in or the patients they may deal with
- Encouraging all staff to take care of their own safety and security and that of others who may be affected by their acts or omissions
- Ensuring that all staff receive appropriate and timely induction, training, information, instruction and / or supervision
- Ensuring the health, safety, security and welfare management systems are properly implemented and performing to requirements in all locations and spheres of operation within the trust
- Providing a comprehensive Occupational Health service including health surveillance where necessary
- Implementing a monitoring and audit procedure to maintain effective health, safety and security management
- Making arrangements for the co-ordination, co-operation and dissemination of information to non-trust employees who may be required to work on trust premises
- Integrating health, safety and security responsibilities into everyday working practices and line management responsibilities
- Developing and embedding a culture that recognises the importance of health, safety and security
- Providing staff with clear procedures and systems of work, where possible

- To minimise unavoidable risks by the use of physical control measures and issue of personal protective equipment
- Providing safe arrangements for the use, handling, storage and transport of articles and substances
- Reducing risks through the provision of suitable plant, vehicles, equipment, accommodation and facilities
- Involving and promoting commitment from staff side representatives and by consulting with all employees
- Supporting staff and volunteers who are involved in safety and security incidents

3. Scope of Policy

This policy applies to all health, safety and security matters and is applicable to all employees, volunteers, contractors and non-employees who we come into contact with.

4. Responsibilities

It is the responsibility for all employees, volunteers, contractors and non-employees to promote a safety and security culture in all activities. This includes interacting appropriately with regulators such as the Care Quality Commission and the Health and Safety Executive.

4.1 Board of Directors

As the corporate body of the trust, the Board of Directors is responsible for the health, safety, security and welfare of all NWAS NHS Trust employees and that of others who may be affected by the trust's undertakings.

The Board of Directors will:

- Formally accept its collective role in providing health, safety, security and welfare leadership for the trust
- Ensure each member of the Board accepts their individual role in providing health, safety and security leadership within the trust and that health, safety and security intentions are reflected in their decisions
- Ensure that health, safety and security responsibilities are reflected in job descriptions
- Recognise its role in the active participation of staff in improving health, safety, security and welfare for all staff, patients and others who are affected by the trust's activities
- Appoint an executive director to be responsible for Health, Safety and Security
- Appoint a lead non-executive director with responsibility for holding the Executive to account
- Devolve oversight responsibility to the Quality and Performance Committee through their work plan
- Maintain an up to date knowledge of health, safety and security legislation and duties
- Ensure appropriate resources and funding is allocated so that controls to continually improve the health, safety, security and welfare management system can be implemented
- Monitor annually and where necessary by exception the health, safety and security arrangements through reports from the Director of Quality, Innovation and Improvement to whom responsibility has been designated.
- Setting a personal example when visiting sites by wearing appropriate protective equipment where necessary.

4.2 Chief Executive

In accordance with the Health, Safety and Security Policy Statement of Commitment, the Chief Executive assumes overall responsibility within the trust for fulfilling the policy of the trust and to engender a pro-active safety and security culture throughout North West Ambulance Service NHS trust.

In doing so, the Chief Executive will ensure that:

The trust has in place the appropriate structures for the management and organisation of health, safety and security (including fire) arrangements and for advising the Chair and Board of Directors of such. These are detailed in the following paragraphs.

There are sufficient resources available to ensure, so far as is reasonably practicable, the health, safety and security of all staff and others who are affected by the trust's undertaking.

The areas of responsibility are:

- All personnel employed by the trust
- All personnel not employed by the trust though are affected by the trust's undertaking
- All third party contractors employed by the trust
- All work activities and systems performed within the trust
- All trust premises and any shared accommodation with another employer
- All property in the form of vehicles, equipment, supplies, furnishings etc. which are used in the performance of the trust's activities

In practical terms, the Chief Executive will delegate the health, safety and security responsibilities to the Director of Quality, Innovation and Improvement supported by the Finance Director, the Director of People and onto all managers within the trust.

4.3 Director of Quality, Innovation and Improvement

The Director of Quality, Innovation and Improvement has delegated responsibility to act on behalf of the Chief Executive for:

- Ensuring that the Board appointed committee receive regular reports and where necessary by exception health, safety and security reports. The Executive Management Team will also receive reports where necessary.
- Co-ordinating, developing, maintaining and monitoring an efficient health, safety and security function, including fire arrangements, across the trust
- Ensuring that employees are fully aware of the trust's health, safety and security policies and procedures and at the earliest opportunity is brought to the attention of all new entrants
- Ensuring that suitable and sufficient health, safety and security risk assessments are undertaken in co-ordination with the health, safety and security team so that appropriate controls can be put in place
- Ensuring the preparation within the trust of such preventative and protective procedures, organisation and arrangements as are necessary to meet statutory and mandatory obligations
- Arranging effective consultation with recognised trade unions and their Safety Representatives on all matters relating to health, safety and security at work and that the appropriate consultation routes are established and functioning

- Ensuring that there are sufficient numbers of trained competent persons within the trust, as defined by the Management of Health and Safety at Work Regulations 1999.
- Ensuring the trust has a suitable system for reporting incidents both internally and externally to statutory bodies
- Ensuring that where the trust shares a workplace with another employer(s) there is a mutual co-operation in order that statutory duties are complied with and all reasonable steps are taken to inform other employers of the risks their staff may face
- Ensuring that where trust activities overlap or affect the activities of other trusts, or any other person that specific arrangements are made to ensure the health, safety and welfare of those persons
- Ensuring that the safety policies, lines of accountability and safety procedures are monitored and reviewed on a regular basis.
- To act as Chair for the Health, Safety and Security Sub-committee

Ensuring that within the organisation and arrangements of the trust, that so far as is reasonably practicable:

- Safe systems of work, safe procedures and safe processes are devised, observed and maintained
- All relevant information, instruction, training and supervision necessary to complete the job safely are provided
- Plant and equipment provided for use is supplied and maintain to a suitable standard and are without risks to safety and / or health when used, cleaned or maintained
- Arrangements are in place to ensure the transportation of personnel minimises risk and furthermore that the handling, use and storage or articles or substances does not constitute a hazard
- Effective procedures are to be followed in the event of serious and imminent danger to staff or others, including the nomination of competent persons to implement any evacuation procedures and restrict access to any areas of danger

4.4 Director of Finance

The Director of Finance is responsible for:

- Ensuring that the all premises, accommodation and vehicles are provided and maintained in a suitable manner

4.5 Director of Operations

The Director of Operations is responsible for:

- Ensuring that the trust suitably manages its third party contractors so that they comply with both legal requirements and of the trust in terms of health, safety and security.
- Ensuring processes are in place to ensure the testing, assurance and maintenance of operational technical equipment is undertaken at appropriate intervals.

4.6 Director of People

The Director of People is responsible for

- Ensuring that a suitable Occupational Health service is accessible for staff and managers and includes appropriate health surveillance as dictated through the risk assessment process

- Ensuring the trust had identified the health, safety and security training and development needs of employees and that such training is provided where necessary
- Ensuring that employees are fully aware of the trust's Health, Safety and Security policy and procedures and at the earliest opportunity is brought to the attention of all new entrants, through the induction process

4.7 Assistant Director (Estates & Fleet)

The Assistant Director (Estates & Fleet) is responsible for:

- Ensuring the estates function maintains the physical infrastructure of buildings.
- The facilitation of users (i.e. the delegated leads for that building / function) in the provision and maintenance of physical security measures such as swipe readers, digilocks, CCTV and safes but the users must retain responsibility for their use and application.
- Acting as the responsible person for fire safety across NWAS managed premises, and liaise closely with the landlords of shared sites, (hard) estate infrastructure.
- Ensuring that specific safety risks and actions resulting from audits related to fleet and estate are actioned in a timely manner to ensure safe systems of working for all staff
- Specific areas of health and safety processes for workshops, and the contracting of services to ensure annual processes for specific areas of testing and assurance such as portable equipment testing (general office equipment), fire extinguishers and ventilation
- Ensuring the fleet department have suitable and sufficient arrangements in place to ensure maintain and assure the safety of all vehicles.

4.8 Line Managers

All line managers shall ensure that:

- The health, safety, security and welfare of the staff and others, who are affected by their activities, within their area of responsibility is appropriately managed
- Managers are responsible for ensuring functional consistency of practice and ensuring that their staff receive and understand relevant procedures
- All relevant information, instruction, training and supervision necessary to complete the job safely is provided and maintained, particularly for young or inexperienced workers Sufficient resources are identified to enable safe working
- Developing and implementing effective "risk assessment" and safety system of work where needed Safe systems of work, identified by risk assessments, are implemented and monitored, via incident data analysis, to reduce the risk of injury to all employees and any other persons who may be affected
- All incidents and near-misses are reported, graded and investigated in accordance with trust procedures
- Routine health and safety workplace inspections are undertaken and any remedial actions completed
- Structured meetings are held with local safety representatives where appropriate, review reports and carry out identified actions
- Adequate arrangements are in place for controlling emergencies that affect the health, safety and security of staff or others
- Safety rules and procedures are adhered to including any statutory or legal responsibilities
- Any specific safety technical information is acted upon
- Ensure that all issues raised within health, safety & security risk assessment audits or reports are attended to with a degree of urgency that merits the situation

- Health, safety, security and welfare issues are raised at the appropriate level within the trust
- All staff are aware of first aid facilities available
- Setting a personal example by wearing appropriate protective equipment were necessary and being seen to take positive intervention when deficiency have been identified,
- Cohesive working with the Health, Safety and Security Team

4.9 Chief of Regulatory Compliance and Improvement

The trust conforms to the requirements of Regulation 6 of the Management of Health and Safety at Work Regulations 1999 by appointing competent safety advice. Advice is made available to the trust through the following roles within the organisation.

The Chief of Regulatory Compliance and Improvement shall be responsible for:

- Advising the Board of Directors, Executives and Managers on all matters relating to health, safety, security and welfare, within the trust
- Participating in consultation with the recognised trade unions and their safety representatives on matters relating to health, safety, security and welfare with the aim of securing a progressive approach in such matters
- Preparing, revising, publicising and monitoring compliance with codes of practice, policies and procedures relating to safety issues in order to meet the minimum, statutory requirements and trust standards
- In conjunction with the training department assist with the design, facilitation and evaluation of the health, safety and security training programmes as well as ensuring all new members of staff receive adequate induction in health, safety and security
- Undertaking the role of lead relationship building with the Health and Safety Executive in the North West.
- Ensuring NWAS is assured the Health and Safety Executive is informed of all notifiable injuries, diseases and dangerous occurrences as required under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- To act as deputy chair for the health, safety and security sub-committee

4.10 Head of Quality Compliance and Assurance

The Head of Quality Compliance and Assurance shall be responsible for:

- Advising the Board of Directors, Executives and Managers on all matters relating to health, safety, security and welfare, within the trust
- The development and oversight of all health, safety and security policies and procedures in the trust
- Supporting the Chief of Regulatory Compliance and Regulation in the development and maintenance of relationships with the Health and Safety Executive in the North West
- Ensuring the Health and Safety Manager informs the Health and Safety Executive are informed of all notifiable injuries, diseases and dangerous occurrences as required under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- Engaging and developing relationships with the wider ambulance sector on all aspects of Health, Safety and Security ensuring the Chief of Regulatory Compliance and Regulation is informed of activities undertaken and impact of those upon NWAS

- Ensure the trust meets all health, safety and security (including fire safety) legislative requirements, so far as is reasonably practicable through a well-designed programme of audit and assurance visits
- Participating in consultation with the recognised trade unions and their safety representatives on matters relating to health, safety, security and welfare with the aim of Securing a progressive approach in such matters
- Responsible for the development and implementation of identified Health, Safety and Security plans.
- In conjunction with the training department assist with the design, facilitation and evaluation of the health, safety and security training programmes as well as ensuring all new members of staff receive adequate induction in health, safety and security
- Deliver specialist safety training, as required.
- Work proactively with the Estates and Fleet team to ensure that the trust is providing safe places of work, so far as is reasonably practicable.
- Work proactively with Service Delivery teams to ensure that the trust is providing safe systems of work, so far as is reasonably practicable
- Acting as a point of contact for regulatory officials, enforcement inspectors, fire safety officials and others for trust wide matters
- Develop and participate processes to share learning from safety issues across the organisation and with external partners
- Ensuring accurate and reliable health and safety data systems and processes of work to provide audit and assurance to the health, safety and security sub-committee
- Act as the trust's appointed Local Security Management Specialist developing both proactive and reactive initiatives in relation to security management work
- Ensuring that violence and aggression statistics are produced on a regular basis to ascertain any trends that may develop and act on them accordingly
- Developing and maintaining excellent working relationships with partner external agencies (e.g. police / local authorities / NHS) to promote appropriate sanctions following acts of violence and aggression against staff

4.11 Health, Safety and Security Manager

The Health, Safety and Security Manager shall be responsible for:

- Advising line managers on all matters relating to health, safety, security and welfare, within the trust
- Ensuring compliance with all statutory requirements, regulations, codes of practice and Health & Safety Executive (HSE) guidance and they are implemented in line with trust policy
- Support the development and maintenance of health, safety and security policies, procedures and audits
- Ensuring that all policy, procedural (including A – Z toolkit) documents are publicised and available as required
- Ensuring that the Health and Safety Executive are informed of all notifiable injuries, diseases and dangerous occurrences as required under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
- In conjunction with the training department assist with the design, facilitation and evaluation of the health, safety and security training programmes as well as ensuring all new members of staff receive adequate induction in health, safety and security. Ensure evaluation data is collected.
- Participating in consultation with the recognised trade unions and their safety representatives on matters relating to health, safety, security with the aim of securing a progressive approach in such matters

- Completing specialist risk assessments where necessary and ensuring that identified control measures are put into place and effectively monitored
- The collation of all trust wide security incident statistics, including for violence and aggression; performing trend analysis and reporting to facilitate the trust understanding its risks and learning from incidents
- Developing and maintaining excellent working relationships with partner external agencies (e.g. police / local authorities / NHS) to promote appropriate sanctions following acts of violence and aggression against staff

4.12 Health, Safety and Security Practitioners

The Health and Safety Security Practitioners are responsible for:

- Ensuring compliance with all statutory requirements, regulations, codes of practice and Health and Safety Executive guidance and they are implemented in line with trust policy
- Offering competent advice, guidance and to practical support all staff / mangers / Safety Representatives on health, safety (incl. fire safety) and security issues including devising and implement initiatives in response to identified risks and issues.
- Ensuring appropriate risk assessments, including specialist or individual assessments, are carried out in a timely manner as the designated competent person and identifying control measures. Also ensuring that control measures identified by the risk assessment process are implemented and their effectiveness monitored
- Overseeing health, safety and security incident investigations carried out locally to ensure consistency and best practice and assisting local managers and safety representatives in the completion of more complicated / higher risk incidents
- Ensuring that incident statistics are produced on a regular basis to ascertain any trends that may develop and act on them accordingly
- Ensuring that inspections and audits are initiated and the results monitored and any corrective actions acted upon
- Ensuring appropriate security and fire risk assessments are carried out in a timely manner as the designated competent person and identifying control measures. Also ensuring that control measures identified by the risk assessment process are implemented and their effectiveness monitored
- Informing the Health and Safety Executive of all notifiable injuries, diseases and dangerous occurrences as required under the RIDDOR Regulations
- Delivering specialist health, safety and security training as required

4.13 All Employees

All employees (including non-executives directors and volunteers) of the North West Ambulance Service NHS Trust must have due regard for the duties placed upon them by the Health and Safety at Work etc. Act 1974 and associated legislation.

This means that all employees must:

- Take reasonable care for their own health, safety and security and of other persons who may be affected by their acts or omissions
- Co-operate with the trust so far as is necessary to enable them to fulfil their duty under relevant legislation

- Not intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare
- Make themselves familiar with and conform to the trust's Health, Safety and Security Policy along with any associated policies and procedures
- Report all incidents and near misses whether persons are injured or not to their Line Manager in line with the incident reporting procedure and complete the appropriate documentation
- Report any damage or defects to premises, equipment or vehicles immediately to the supervisor/local manager and complete the appropriate paperwork
- Follow all the safe systems of work and information, training, instruction and supervision received
- Complete dynamic risk assessments in line with agreed training standards as appropriate
- Use protective clothing/equipment as required by the outcome of risk assessments, as appropriate to the work activity
- Make themselves familiar with the local fire procedures
- Challenge unsafe behaviour that may affect staff, volunteers or patients
- Declaring of any medical condition or disability that is liable to involve risk to them or others when carrying out their tasks as soon as they become aware of it

5. Arrangements

The process for monitoring the effectiveness of the management of the health, safety, security and welfare of staff and patients and others will be through a variety of processes including, but not exhaustively:

5.1 Each relevant function will have a process for ensuring appropriate health, safety and security consultation takes place. Reporting will be via the trust's Health, Safety and Security Sub-Committee, which in turn will report to the Quality and Performance Committee of the Board. The Health, Safety and Security Sub-Committee will comprise of both staff side and management representatives and will be chaired by the Director of Quality, Innovation and Improvement or nominated deputy. The trust will also consider safety advice through other Committees of the Board and associated sub-groups.

5.2 All staff will receive induction training on joining the trust and this will be appropriate to their role and legislation. All staff will receive training on health, safety and security, including basic fire safety and where appropriate specialist training for example moving and handling people, the movement of very heavy patients, hazardous substances or blue light driving dependent on role. Staff will be required to attend further training as necessary for updates on both clinical and non-clinical skills.

5.3 Staff will receive supervision whilst working. The level of supervision will depend on role and experience.

5.4 The trust will identify and provide suitable equipment for use in the workplace and will take cognisance of design improvements by suppliers.

5.5 The trust will ensure that the vehicles provided will be suitable for the activities undertaken and that the health, safety, security and welfare of staff and patients will be taken into consideration in the purchase and design of vehicles.

5.6 The trust will ensure that both stations and vehicles are subject to regular inspections and that any remedial actions arising out of the inspections are acted upon within appropriate timescales.

5.7 In order to protect both staff and patients and others the trust will ensure that safe systems of work are developed for all normal activities. Staff are also provided with the training to undertake dynamic operational risk assessments in order to manage day to day activities and unusual incidents. Safe systems of work will be detailed procedures, work instructions and training bulletins.

5.8 Generic risk assessments have been developed for the main staff groups and activities, identifying control measures which are appropriate and acted upon recognising the potential financial implications. These are completed by the Health, Safety and Security Practitioners, supported by the Health, Safety and Security Manager. Local teams and line managers are asked to use the generic risk assessments as a template to inform local context specific risk assessments. The following list defines the main generic assessments:

- Paramedic Emergency Service
- Patient Transport Service
- Contact Centres
- Community Paramedic
- Rapid Response Vehicles
- Community First Responders / Volunteers
- Resilience, including Hazardous Area Response Teams
- Cycle responders
- Stations / offices
- Workshops and Transport
- Events
- Observers
- Staff responders
- Merit, Helimed and Basics
- COVID19

5.9 Further hazards, activities, equipment, vehicles, events and where necessary individuals will also be subject to the risk assessment process as determined by the local Health Safety and Security Practitioner supported by the Health, Safety and Security Manager.

5.10 All premises will also be subject to fire and security assessment which will be reviewed in line with the agreed review timescales according to the level of risk.

5.11 Local risk assessments for staff or other legislative reasons as determined by the local manager will be carried out with support from the Health, Safety and Security team where needed.

5.12 Risk assessments will be reviewed in accordance with the Management of Health, Safety and at Work Regulations: Approved Code of Practice 1999.

5.13 The trust will ensure that emergency procedures are in place for dealing with on-site emergencies as well as for crews attending major incidents. A copy of major incident plans for COMAH sites, sporting grounds, hospitals and other significant locations will be easily accessible from the appropriate Emergency Operations Centre.

5.14 The trust will support this policy with a number of detailed procedures and guidance notes and the Health, Safety & Security A - Z Tool kit that will be communicated to all staff via bulletins, be available through the intranet and where necessary through the mandatory training programme.

6. Monitoring and Review

6.1 Equality Impact Assessment

An Equality Impact Assessment (EIA) has been completed for this policy and is available from the Health, Safety & Security Manager. The EIA is a live and working document which is updated as changes are made to this policy. The current EIA has advised that the implementation of this policy does not have a negative impact upon persons with protective characteristics overall.

6.2 Health, Safety, Security and Fire Incidents

The trust has in place systems for the reporting and recording of clinical and non-clinical incidents. Staff are informed how and what to report and all incidents are reviewed by local managers. Reports on incident trends are reviewed at the local health, safety and security meeting. The severity of the incident or the injury will determine the level of investigation required. All investigations will take place in line with the Complaints, Incidents and Investigation Policy and Investigations Good Practice Guide.

This policy is subject to a triennial review but maybe amended earlier in light of changes in legislation or changes in organisational responsibilities. The Board of Directors will also refer to independent reviews and assessment to gain assurance on the effectiveness of the measures within the policy.

6.3 Health, Safety, Fire and Security Audits

The trust has in place systems for the audit and assurance of processes against health, safety, security and fire procedures. These comprise of:

- Workplace inspections
- Snap shot visits
- Focused Audits
- Safe check system

An agreed frequency of audit has been designed. These are carried out by different disciplines within the Trust. The results and actions from these audits should be documented for assurance. These are monitored by the different governance arrangements within the Trust.

Audits and actions resulting from audits are reported to the Compliance unit and tracked through the integrated action tracker to ensure that actions are completed in a timely manner. Actions are managed and reviewed through the local Health, Safety and Security consultative groups with safety audit progress and action status reported to the Health, Safety and Security Sub-Committee.

6.4 Learning from Incidents and Audits

The learning identified from health, safety and security incidents and audits are shared at the trust non-clinical incident learning forum. Identified risks are managed through the trust incident management system and referenced and monitored through the Board Assurance Framework.

7. NHS Constitution

The NHS Constitution establishes the principles and values of the NHS. It includes staff pledges, which state what the NHS expects from its staff and what staff can expect from the NHS. We view this as part of our commitment to being a good employer, making our staff feeling valued. NWAS will ensure that all engagement activities comply with the underlying principles of the Constitution.

8. Functions of Safety Representatives

The Safety Representatives and Safety Committees Regulations 1977, concern safety representatives appointed in accordance with section 2(4) of the Health & Safety at Work Act 1974 and cover:

- Prescribed cases in which recognised Trade Unions may appoint safety representatives from amongst the employees.
- Prescribed functions of safety representatives.
- In addition to his/her function under section 2(4) of the HSWA 1974, each representatives function is to investigate potential hazards and dangerous occurrences, investigate complaints by any employee, make representations to the employer with regards any hazards or unsafe practices, carry out health, safety and security inspections, represent the employees they were appointed to represent in consultation at the workplace either with Inspectors of the HSE or any other enforcing authority, and to attend meetings of safety committees, where they attend in their capacity as an appointed safety representative in connection with any of the above functions.

Regulation 4A of the Safety Representatives and Safety Committees Regulations 1977 require the employer to consult safety representatives on the following:

- The introduction of any policy or procedure at the workplace that may substantially affect the health, safety and security of the employees the concerned safety representative represents.
- The arrangements for appointing or, as the case may be, nominating persons in accordance with regulations 6(1) and 7(1)(b) of the Management of Health, safety and security at Work Regulations 1992 (Amended 1999).
- Any health, safety and security information they are required to provide to employees the safety representative concerned represents, by or under the relevant statutory provisions.
- The planning and organisation of any health, safety and security training required for employees the safety representatives concerned represent
- The health, safety and security consequences for the employees the safety representatives concerned represent of the introduction of new technologies into the workplace.
- The employer shall provide such facilities and assistance as safety representatives may reasonably require for the purpose of carrying out their functions under section 2(4) of the 1974 Act and under these regulations.

- The trust also recognises the Health, safety and security (Consultation with Employees) Regulations 1996.

9. Key references and bibliography

Health & Safety at Work Act 1974

Management of Health & Safety at Work Regulations 1999

Health & Safety (Consultation with Employees) Regulations 1996

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

Safety Representatives and Safety Committees Regulations 1977

Control of Substances Hazardous to Health Regulations 2002 (COSHH)

Dangerous Substances Explosive Atmosphere Regulations 2002 (DSEAR)

https://www.hse.gov.uk/ last accessed 14/12/2021

Equality Impact Assessment Report

Name of Policy, Service or Function Health, Safety and Security Policy
Equality Impact Assessment carried out by F Buckley, F Rose, M Peters
Date of Equality Impact Assessment April 2008: Updated September 2011: Updated June 2013: Updated February 2019; Updated May 2019; Updated October 2021

Step 1: Description and Aims of Policy, Service or Function

Overall aims

The purpose of this policy is to clearly set out the trust's commitment to the health, safety and security of staff and others alike, to define responsibilities and to assist all employees to understand the complex nature of safety and security management. The Health, Safety & Security A – Z tool kit compliments this policy with detailed procedures for different aspects of health and safety.

Key elements of policy, service, process

The policy states what the statutory requirements for Health, Safety and Security, the aims and objectives, scope and responsibilities. It identifies the monitoring and review process and functions of safety representatives.

Who does the policy, service or function affect?

The policy affects all employees of the Trust, patients, and members of the public, contractors and commissioners, internal and external stakeholders.

How do you intend to implement the policy or service change (if applicable?)

The proposed implementation process is as follows:

- All named officers to receive an electronic copy of the policy with the summary of the changes
- Current health, safety and security policy removed from the intranet
- Short item in the regional bulletin advising that revised policy is available on the intranet.
- Under 'for information' the local level 3 meetings to advise of the availability of the policy on the intranet.

Copies will be circulated to all Assistant Directors for onward dissemination as appropriate within their directorate. Hard copies will be made available to all relevant internal and external stakeholders.
If requested, copies of this policy document can be made available in languages other than English, or in a format that suits the requestor.

The policy will be implemented through the use of an annual audit plan that identifies the rationale, objectives and the resource requirements for each audit.

Step 2: Data Gathering

Summary of data available and considered

Health & Safety at Work Act 1974. Regulations arising from the Act, Approved Codes of practice and relevant guidance provided by The Health and Safety Executive (www.hse.gov.uk). Management of Health, Safety and at Work Regulations: Approved Code of Practice 1999.

Outcomes of data analysis

Equality Group	Evidence of Impact
Gender	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Gender related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Race/Ethnicity	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Race related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Disability	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Ability related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Sexual Orientation	It is not anticipated that implementation of this policy will be an issue within the realm of this characteristic
Religion or belief	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Belief related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable
	General risk assessments must consider all persons to whom

Age	NWAS owes a duty of care under health and safety law. Age related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
General (Human Rights)	NWAS owes a duty of care under health and safety law to all persons.

Step 3: Consultation

Summary of consultation methods

The policy has been developed via consultation with staff side representatives, health and safety team, health safety and security sub-committee.

The content of the policy will be further developed by the dynamic consultation with relevant and interested internal and external stakeholders.

Outcomes of consultation

Equality Group	Evidence of Impact
Gender	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Gender related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Race/Ethnicity	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Race related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Disability	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Ability related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Sexual Orientation	It is not anticipated that implementation of this policy will be an issue within the realm of this characteristic
Religion or belief	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Belief related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable
Age	General risk assessments must consider all persons to whom NWAS owes a duty of care under health and safety law. Age related

	issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
General (Human Rights)	The Health and Safety at Work etc. Act places a statutory duty on NWAS to ensure the health and safety of all those affected by its undertaking. By undertaking suitable and sufficient localised risk assessments, all equality issues should be identified and adequately mitigated.

Step 4 & 5: Impact Grid

Relevant Equality Area	Areas of impact identified	Is the impact positive or negative?	Key issues for action [Will form basis of action plan]
Gender	It is anticipated that there will be neutral impact to these protected characteristics	Neutral	----
Race/Ethnicity	It is anticipated that there will be neutral impact to these protected characteristics	Neutral	----
Disability	It is anticipated that there will be neutral impact to these protected characteristics. However in terms of the policy document itself there may be a negative impact	Neutral/Negative	Provide alternative formats
Sexual Orientation	It is anticipated that there will be neutral impact to these protected characteristics	Neutral	----
Religion or belief	It is anticipated that there will be neutral impact to these protected characteristics	Neutral	----
Age	It is anticipated that there will be neutral impact to these protected characteristics	Neutral	----
General (Human Rights)	It is anticipated that there will be neutral impact to these protected characteristics	Neutral	----

Step 6: Action Plan

Name of Policy or Service: Health Safety and Security Policy					
Issue identified and equalities group or communities affected	**Action to be taken**	**By When**	**Who By**	**Expected outcome**	**Progress**
Difficulties in reading the policy by visually impaired users	Produce a large print version in accordance with the principles of RNIB 'clear print' guidelines	On request	The author of the policy	Large print version produced	No requests to date
Difficulties in reading the policy by users with conditions such as dyslexia	As dyslexia has many variations, requests for alternative versions will be accommodated on request	On request	The author of the policy	Alternative version produced	No requests to date

Summary of decisions and recommendations

1. Make available large print version, in accordance with RNIB 'clear print' guidance; or other alternative versions on request.

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26 January 2022
SUBJECT:	Policy on Prevention and Reduction of Violence
PRESENTED BY:	Director of Quality Improvement and Innovation

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☐	☐	☐

SR05	SR06	SR07	SR08	SR09
☐	☒	☐	☐	☐

PURPOSE OF PAPER:	For Decision
EXECUTIVE SUMMARY:	The North West Ambulance Service NHS Trust (NWAS) finds deliberate violence and aggression towards our staff (from those who use our services), unacceptable. The purpose of the policy is to clearly define the expectations of the Trust and provide policy guidance which the organisation can use to set standards and behaviours. It sets out the rationale, monitoring arrangements and mechanisms that provide a framework within the trust where all staff can participate in the prevention and reduction of violence and aggression, and was developed in line with the national violence prevention and reduction standard 2020. The policy content describes the trust intent, duties and the trust high level position in management of violence and aggression and its commitment to supporting staff. It is anticipated that a series of supporting procedures will be developed through the violence prevention and reduction group (formerly the violence and aggression group) to support managers and staff involved in such incidents.
RECOMMENDATIONS:	The BoD is asked to: • Note the development process undertaken • Note the policy attached at appendix 1 • Support the proposed implementation process • Accept the violence prevention and reduction policy
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☒ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation

	☐ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	HSSSC ELC and Q&PC			
	Date:	18/01/22 19/01/22 24/01/22		
	Outcome:			

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1. PURPOSE

1.1 The purpose of the paper is to present the Prevention and Reduction of Violence policy to the Board of Directors. It is requested the BoD accept the policy for implementation.

2. BACKGROUND

2.1 Definition:
The World Health organisation defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or a community that either result in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.' (Global status report on violence prevention, 2014).

2.2 The North West Ambulance Service NHS Trust (NWAS) finds deliberate violence and aggression towards our staff (from those who use our services), unacceptable. Where violent or aggressive behaviour may occur due to clinical and or medical factors, all possible primary and preventative measures should be used to reduce risk of harm.

The purpose of the policy is to clearly define the expectations of the Trust and provide policy guidance which the organisation can use to set standards and behaviours. The policy sets out the rationale, monitoring arrangements and mechanisms that provide a framework within the trust where all staff can participate in the prevention and reduction of violence and aggression.

3. DEVELOPMENT PROCESS

3.1 The policy was developed in several stages:
Stage 1: The draft policy was developed based on the violence prevention and reduction standard released in December 2020 by the Head of Quality Compliance and Assurance.

Stage 2: The draft policy was shared at the health, safety and security sub-committee for consultation and feedback was requested from the members.

Stage 3: The feedback received from members of the sub-committee was reviewed by the Health, Safety and Security manager and the draft policy annotated.

Stage 4: The annotated draft policy was shared with the Senior Clinical Quality Manager who undertook a further review and shared with the Chief of Regulatory Compliance and Assurance and the Director of Quality, Innovation and Improvement.

Stage 5: The feedback from key stakeholders was used to improve the contact of the policy for sign off at the Health, Safety and Security sub-committee.

4. CONTENT

4.1 *Duties*

Describes the responsibilities of all employees with regard to the prevention and reduction of violence experienced by staff. The section describes the responsibilities of all staff and additional accountability for named roles.

4.1.1 *Violence Prevention and Reduction Group*

The policy refers to a key stakeholder group who will participate in the assessment against the security standards. The group (formerly known as the violence and aggression group) has reviewed its terms of reference and submits them under separate cover for approval by the health, safety and security sub-committee.

4.2 *Violence Prevention and Reduction Standard*

The violence prevention and reduction standard provides as risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

NWAS is required to review the standards and undertake compliance assessments at least twice a year, and the process of governance for this is described policy. The assessment will inform the violence prevention and reduction of the work plan to be undertaken by the appropriate stakeholders across the trust.

4.3 *Prevention*

Describes the intent for staff to attend the relevant personal safety or violence reduction training necessary for their role and work environment. The section touches upon the model of relational security as a form of primary prevention; by ensuring staff and services are doing everything they should do consistently and well, the net effect should be overall reductions in violence and challenging behaviour, both directly and indirectly.

4.4 *Management of Violence and Aggression*

States the choice of intervention must always represent the least intrusive option to meet the immediate need; informed by an appraisal of the environment and the risks associated with the patients' health presentation.

4.5 *Training*

Describes the training received by staff according to role, and the requirement for managers and supervisors to carry out risk assessments where advice can be sought from the health, safety and security team.

4.6 *Risk Assessments*

Risk assessments on all identified violence and aggression matters are to be carried out by the appropriate manager and, where necessary, with assistance from the trust health, safety and security practitioners. This will ensure that the health and safety of staff, volunteers, community first responders, students and visitors to site are protected as far as is reasonably practicable.

5. IMPLEMENTATION PROCESS

5.1 The proposed implementation process is as follows:

- All named officers to receive an electronic copy of the policy
- Approved policy to be added to the intranet
- Short item in the regional bulletin advising policy is available on the intranet
- Under 'for information' at Level 3 meetings or equivalent to advise of the availability of the policy on the intranet.

5.2 It is anticipated current trust procedures aligned to this policy will be reviewed and developed further with the support of the violence prevention and reduction group (VPRG). Similarly, VPRG is likely to remain the main forum for the development of additional procedures as required; which will be sent through to this committee for support and sign off.

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

6.1 The violence prevention and reduction policy has been developed with consideration to:

- Health and Safety at Work Act 1974 (HASAWA)
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultations with Employees) Regulations 1996
- Assaults on Emergency Workers (Offenses) Act 2018
- Violence prevention and reduction standard 2020

7. EQUALITY OR SUSTAINABILITY IMPLICATIONS

7.1 The development process of the policy suggest the statement for equality impact assessment is positive (appendix 2).

8. RECOMMENDATIONS

8.1 The Board of Directors is asked to:

- Note the development process undertaken
- Note the policy attached at appendix 1
- Support the proposed implementation process
- Accept the violence prevention and reduction policy

North West Ambulance Service NHS Trust

Policy on Prevention and Reduction of Violence

Recommended by	
Approved by	
Approval date	
Version number	
Review date	
Responsible Director	
Responsible Manager (Sponsor)	
For use by	

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

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	April 2021	April 2021	T Carter	First Draft
0.2	May 2021	May 2021	F Rose	Consultation Feedback
0.3	December 2021	January 2021	M Peters	Document Review
0.4	January 2021		M Peters	HSSC and ELC feedback

Policy on Prevention and Reduction of Violence

Contents

1. INTRODUCTION

The North West Ambulance Service NHS Trust (NWAS) finds deliberate violence and aggression towards our staff (from those who use our services), unacceptable. Where violent or aggressive behaviour may occur due to clinical and or medical factors, all possible primary and preventative measures should be used to reduce risk of harm.

2. PURPOSE

The purpose of this policy is to clearly define the expectations of the Trust and provide policy guidance which the organisation can use to set standards and behaviours.

NWAS is committed to:

- Create a supportive and safe environment for staff to work in.
- Provide positive and proactive care to the people who use our services
- Reduce the occurrence of violence and aggression across the trust by implementing reduction and prevention of violence standards
- Provide appropriate training and guidance for staff in the recognition, avoidance, prevention and management of situations of potential or actual violence,
- Provide individualised follow-up support for staff who have been involved in an incidence of violence or aggression.

The policy sets out the rationale, monitoring arrangements and mechanisms that provide a framework within the trust where all staff can participate in the prevention and reduction of violence and aggression.

The key objectives for the trust in this respect are to:

- Take all actions possible to reduce or eliminate the prevalence of violence and aggression.
- Provide all staff, including bank and agency staff and volunteers with clear responsibilities and guidance on the prevention and management of risk.
- Commit to a human rights respecting approach that is consistent with national legislation and the trust values.
- Encourage the reporting of both incidents and near misses and feedback to staff on the learning and actions taken to prevent further occurrences.

- Ensure serious incidents are dealt with promptly by local management and reported to the Health, Safety and Security (HSS) team and/or Police
- The HSS and legal teams will work with law enforcement to advise and support staff who wish to prosecute under the Assaults on Emergency Workers (Offenses) Act 2018.
- Provide personal, individualised support to staff following a violent or aggressive incident (TRiM, Counselling, Blue Light Minds etc).

3. DEFINITION

The World Health organisation defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or a community that either result in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.' (Global status report on violence prevention, 2014).

4. DUTIES

4.1 *Employers:*

Have a general duty of care to protect from threats and violence at work. Five pieces of health and safety legislation cover violence at work:

- Health and Safety at Work Act 1974 (HASAWA)
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultations with Employees) Regulations 1996

Under the NHS Standard Contract all NHS Commissioners and all providers of NHS funded services are required to meet the violence prevention and reduction standard. It is mandated that organisations are required to review their status against the standard and provide board assurance that the standards have been met, twice a year.

The violence and reduction standard provides a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence. This policy is aligned with these standards as requires corporate and local action plans to be developed for assurance purposes (appendix A).

4.2 *Trust Board:*

Will ensure there are suitable and sufficient arrangements and adequate resources for the identification, assessment and management and control of risks to staff and others who work for or on behalf of the trust.

4.3 *Chief Executive:*

Has overall responsibility for:

- The effective implementation of this policy within the trust
- Ensuring the allocation of sufficient resources to maintain an efficient and effective health and safety arrangements providing as far as reasonably practicable a safe workplace.
- Ensuring policies are reviewed to secure compliance with existing legislation and any changes to this legislation.
- Ensuring there is organisational capability and capacity to deliver the violence prevention and reduction standards.

4.4 *Executive Directors:*

Have a responsibility to identify a designated Security Management Director (SMD) who is responsible for ensuring:

- Workplace health, safety and welfare procedures are regularly reviewed including those for the management of violence and aggression.
- There are arrangements for liaising with the Health and Safety Executive (HSE) and NHS England and NHS Improvement.
- Board Assurance on the NHSE violence prevention and aggression reduction standards
- The Trust Board are informed of the number of violence and aggression incidents reported by staff.
- The Trust Board are informed of relevant new legislation and guidance in order to ensure on-going compliance with that new legislation and guidance.

The SMD is the Director of Quality, Innovation and Improvement.

4.5 *Chief of Regulatory Compliance and Improvement*

Has responsibility to the SMD to ensure:

- Effective policies and procedures are in place
- An annual violence prevention and reduction work plan is in place
- An annual violence prevention and reduction report is received as part of the health, safety and security annual report.
- Implementation of the violence prevention and reduction standard and action plans take place
- Assurance is received at the board assurance committees (biannual) on progress and risk management.

4.6 *Head of Quality Compliance and Assurance*

Has responsibility for the:

- Development of effective policies and procedures to assist in providing a safe and secure environment for staff, patients volunteers, students and contractors
- Annual security prevention and reduction work plan
- Annual security prevention and reduction report as part of the Health, Safety and Security annual report
- Creation and development of a pro-security culture
- Implementing the violence prevention and reduction standards and action plan
- Updating of the board assurance committees (biannual) on progress and risk management
- Chair of the Violence Prevention and Reduction Group

4.7 *Health, Safety and Security Practitioners*

Will undertake the roles of the local safety management specialists in support of the Head of Quality Compliance and Assurance. The practitioners will:

- Provide advice and guidance to the trust on prevention and reduction of violence and aggression whilst promoting a pro-security culture with other key stakeholders such as the Estates and Facilities team.

- Liaise with colleagues and review all notified cases of serious physical assault, or where a staff member who following an assault is absent from work (or are incapacitated from doing their normal job) for over seven days as part of the RIDDOR process.

- Liaise with agencies such as the Police and Crown Prosecution Service to seek sanctions and redress against individuals who either engage in criminal activity against the Trust or who assault Trust employees as referenced in the Assaults on Emergency Workers (Offenses) Act 2018.

4.8 *Managers and Supervisors:*

Are responsible for:

- Ensuring the provision of high quality, compassionate and personalised care.

- Attending any training to enable them to fulfil their responsibilities outlined in this policy

- Bring the policy to the attention of staff within their area of responsibility

- Delivery of the violence reduction and prevention standards and action plans

- Ensuring that all staff within their area of responsibility comply with this management of violence and aggression policy and any associated protocols and procedures. Where applicable, each area should have their own protocols and procedures, which includes standard operating procedures.

- Encouraging all staff within their area of responsibility to report all incidents of violence and aggression including any near misses, using the trust's incident reporting system.

- Ensuring members of staff are given all necessary support and advice in the event of an assault (TRiM, Occupational Health and counselling).

- Encouraging all staff who are subjected to violence and aggression whilst at work to report the matter to the Police.

- Ensuring that appropriate investigations are carried out following all incidents of violence and aggression, and staff are informed of the result of those investigations.

- Ensuring the Health, Safety and Security team is notified of any:

- Serious physical assault
- Staff member who following an assault at work is absent from work (or are incapacitated from doing their normal job) for over seven days (RIDDOR).

- Carrying out or assisting with risk assessments on preventing staff and others from being subject to violence and aggressions ensuring:
  - All identified controls are put in place and communicated to staff
  - Risks are escalated appropriately
- Seek advice on violence and aggression matters as appropriate with the Health, Safety and Security team.

4.9 *All Staff*

Have the following responsibilities to:

- Make themselves fully aware of the contents of this policy
- Follow the trust and the site specific procedures and protocols regarding the security of people, property, information and premises.
- Ensure any visitors to the trust premises have the correct authorisation. Politely challenge visitors to sites from a distance to avoid the possibility of violence, escalating concerns to a manager.
- Comply with any training, instruction or information in order to carry out their work safely with the aim of avoiding any incidence of violence or aggression where possible.
- Take reasonable care for their own health and safety and that of others who may be affected by their acts or omissions.
- Use any equipment (phones/radios etc) provided to ensure their safety and report defects through the support centre in Carlisle.
- Adhere to safe systems of working and safe operating procedures.
- Report any incidence of violence or aggression, including near misses arising from carrying out their work using the trust incident reporting system

4.10 *Head of Education*

Is responsible for the:

- Implementation and provision of appropriate training
- Provision of information confirming staff numbers who have completed training at least twice a year to the Violence Prevention and Reduction Group.

4.11 *Emergency Operations Centres (EOCs)*

Procedures will ensure that:

- Crews receive all relevant information available to ensure an appropriate risk assessment can be carried out
- Lone workers/ First Responders will not be mobilised to potentially violent incidents (see lone working policy)
- Operational staff will be alerted when attending incidents where violence or caution markers are present.
- Delivery of the violence prevention and reduction standards and action plans takes place
- Following a request from operational staff for additional operational and or police support, they will endeavour to arrange this by deploying additional resources and or requesting police attendance.

4.12 *Patient Transport Service Contact Centres (PTS)*

Procedures will ensure that:

- Relevant information received from the healthcare professional / patients where the safety of staff concerns are raised are entered onto the journey notes and escalated to the contact centre management team as appropriate.
- All bookings that have an ‘at risk’ indicated must be accepted by the control team and displayed on the MDT used by the operational resource.
- Delivery of the violence prevention and reduction standards and action plans take place

4.13 *Estates Department*

Is responsible for ensuring all trust premises have effective means of being locked and secured. The Estates Department is responsible for arranging the:

- Installation, repair and replacement of defective locks
- Issue of security keys
- Installation, repair or replacement of signage around trust premises
- Repair and replacement of lighting at sites (including external lighting and any security lighting within the curtilage of trust property.
- Repair or replacement of perimeter fencing around trust premises
- Installation of any alarm systems in trust premises
- Maintenance of close circuit television recording systems
- Arranging for contractors to attend trust premises.

4.14 *Violence Prevention and Reduction Group*

Has the following responsibilities:

- Receive, from the operational leadership teams the summary actions and learning points from the outcome of incident investigations for wider dissemination across the trust.
- Management and progression of actions identified on the violence and aggression action log.
- Carry out specific tasks on behalf of the Health, Safety and Security sub committee
- Make recommendations for changes to trust policies associated with violence and aggression
- Feedback into the health, safety and security sub-committee via a Chair report on a bi monthly basis.
- Review themes and as appropriate deep dive of incidents resulting in violence and aggression to develop learning and resources to promote prevention of violence and aggression.

5. VIOLENCE PREVENTION AND REDUCTION STANDARD

The violence prevention and reduction standard provides as risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression and violence.

NWAS is required to review the standards and undertake compliance assessments at least twice a year, and the process of governance for this is described in figure 1 below. The assessment will inform the violence prevention and reduction of the work plan to be undertaken by the appropriate stakeholders across the trust. The work plan will be managed through the governance structures as described in figure 1.

The violence and reduction standard employs the Plan, Do, Check, Act (Deming cycle) approach, which is an iterative four-step management method, to validate, control and achieve continuous improvement of processes.

The specific assessment criteria are located in Appendix A, and the associated risk scoring matrix is located at Appendix B.

5.1 *Plan*

NWAS is required to review our current status against the standard and identify their requirements, to understand what needs to be completed and how, who will be responsible for what and what measures will be used to judge success. This phase of the process includes developing or updating strategies, policies and plans to deliver the aims.

5.2 *Do*

NWAS must:

- Assess and manage risks
- Organise and implement processes, and communicate plans to involve NWAS staff and key stakeholders in their delivery.
- Provide adequate resources and training.

5.3 *Check*

NWAS is required to ensure the plans are implemented successfully, assess how well the risks are controlled and determined through the use of audit measures for example, if the aims have been achieved. Routine assessment of gaps will take place primarily at the VPRG Group who will identify actions for correction.

5.4 *Act*

The VPRG group will undertake the review of performance against the standards and advise/enable the senior management teams to direct and inform changes to policies, or plans in response to any localised lessons learnt and incident data collected in respect of violence prevention and reduction. NWAS will share critical findings with internal and external stakeholders.

5.5 *Compliance*

This process ensures the responses to the evaluation are valid and any organisational actions are endorsed at senior management level in consultation with key stakeholders via the internal governance routes (figure 1). The evidence showing the criteria have been met for each indicator or not will be made available to all essential stakeholders

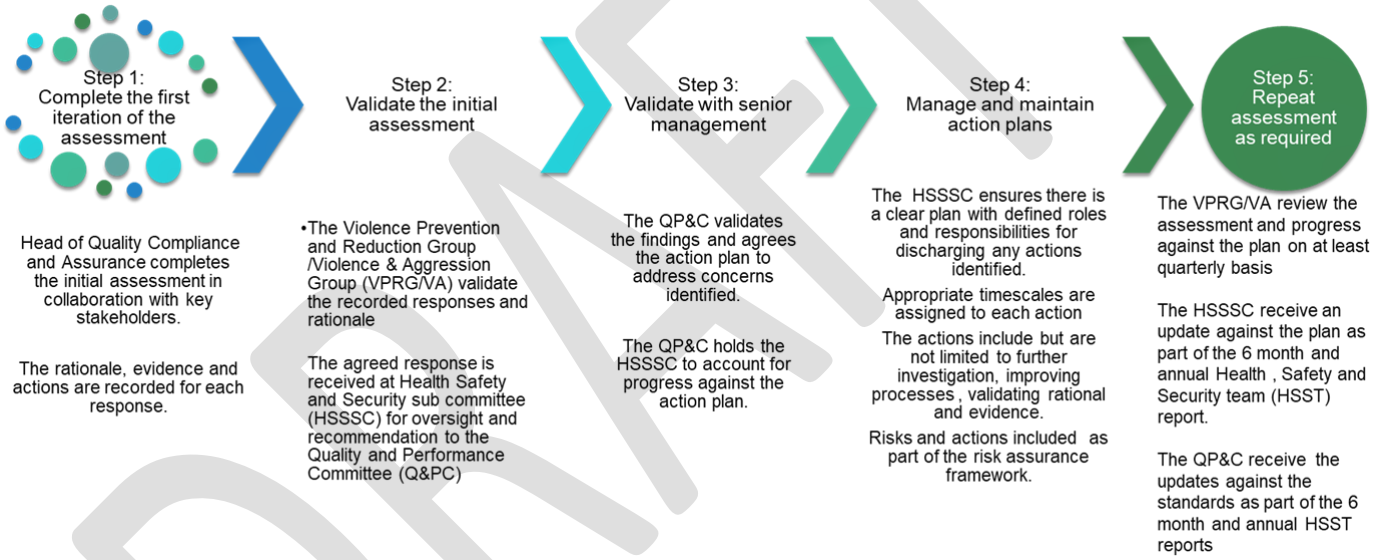


Figure 1: Violence Prevention and reduction standard assessment process.

6. PREVENTION

The primary measures to support and reduce the behaviours that challenge are the most essential factor to prevent violence and aggression. All staff who meet individuals who may exhibit aggression or violence that could jeopardise their own or another's safety will need to understand strategies used in the prevention of such behaviours. To this end staff will attend the relevant personal safety or violence reduction training necessary for their role and work environment.

Risk assessments of workplaces, tasks and the control measures to manage and identify risks will be up to date and available.

There is not always a cause of clinically related challenging behaviour, even if it is not evident at the time. A holistic approach looks to prevent distress by identifying, categorising and understanding its reasons that should reduce the likelihood of these potentially unforeseen events occurring.

6.1 *Relational Security*

'Relational security is the knowledge and understanding we have of the patient and of the environment, and the translation of that information into appropriate responses and care' (Allen, 2015). It is not only about having 'good relationships' between people. Effective relationships need to be professional, therapeutic, and purposeful and with understood limits. The environment needs to feel safe to enable patients and staff to participate positively in the activities of the service.

Relational security is a form of primary prevention as per the World Health Organisation public health model. Its effectiveness in this regard can be achieved by 'ensuring that staff and services are doing everything they should do consistently and well.' The net effect of this should be overall reductions in violence and challenging behaviour, both directly and indirectly.

7. MANAGEMENT OF VIOLENCE AND AGGRESSION

When confronted with violent, aggressive, risky or challenging behaviour, the choice of intervention must always represent the least intrusive option to meet the immediate need. It should always be informed by an appraisal of the environment and the risks associated with the patients' health presentation (dynamic risk assessment/DORA).

Physical interventions should only be used to manage an emergency; be proportionate and where there is an immediate apparent risk to health, safety and well-being of the staff member. Managing behaviour by using any restrictive practice should only be done when it is likely that greater harm would occur if no intervention is made.

Any physical intervention used must be:

- Reasonable, necessary, and proportionate to the risk posed by the patient
- Used for only as long as is necessary
- Be carried out by staff who have received appropriate training, wherever possible.

It is important that any intervention is seen within the overall continuum of approaches for managing violence and aggression. De-escalation or disengagement from a violent or potentially violent situation is always the preferred option.

8. TRAINING

Managers and staff receive training with the trusts training needs analysis and its statutory and mandatory training programme. Mandatory conflict resolution training will be provided to all patient facing staff. Refresher conflict resolution training should be provided three years after receiving the initial training.

Staff in the call centres and volunteers will be provided with appropriate training in accordance with their role.

Managers and supervisors who have to carry out risk assessments on preventing violence and aggression can seek advice from the health, safety and security team.

9. RISK ASSESSMENTS

All identified violence and aggression matters relating to staff, volunteers, students and contractors shall be subjected to the risk assessment process. Suitable and sufficient risk assessments shall be carried out. These risk assessments on all identified violence and aggression matters will be carried out by the appropriate manager and, where necessary, with assistance from the trust health, safety and security practitioners. This will be done to ensure that the health and safety of staff, volunteers, community first responders, students and visitors to site are protected as far as is reasonably practicable.

The risk assessments should identify hazards and the existing controls in place (if any) to protect staff and others from those hazards - and from this evaluate the level of risk. The level of risk should be reduced to the lowest level as far as is reasonably practicable. Therefore it may be necessary to introduce further measures to manage and control the risks effectively.

The risk assessment should be reviewed annually to check and ensure all of the controls in place are working effectively. The assessment should be reviewed and revised following any significant changes to the assessment for instance if there is a change in working practices or changes to the workplace / working environment.

9.1 *Dynamic Risk Assessments*

Every incident attended by ambulance staff is different and must therefore be subject to a dynamic operational risk assessment (DORA). In an emergency operational setting there will be two phases to this.

- Phase 1: Operations Centres

  Call takers will assess and consider the information they receive from the caller and if they have concerns about the safety of staff they will enter their concerns into the system and if necessary they will liaise with the duty manager.

  The duty manager will ensure that any information is passed to the attending crew so it can assist in their DORA on scene. If a crew decide they want police assistance then the Operation Centre will make the contact and request attendance.

  Lone workers / first responders will not, in accordance with operational procedures, be mobilised to potentially violent incidents (lone working policy).

  Dispatchers will alert operational staff who are attending to incidents where individuals are present and there is a violence or caution marker present on the property.

- Phase 2: Operational Staff

  Using all the information received from the Operations Centres, the crew may carry out a DORA based on information received en-route and may choose to stand off. A decision to stand off can be made by the crew following a suitable risk assessment. If there is the potential for violence and aggression operational staff may withdraw to a safe position informing the Operations Centres, and requesting police and or other assistance as required.

10. EQUALITY IMPACT ASSESSMENT STATEMENT

It was found that the Prevention and Reduction of Violence policy has a positive assessment, as it sets out the trust position to prevent and reduce of violence and aggression incidents against its employees paying particular attention to staff members with protected characteristics.

Monitoring and reporting of hate crime / misogyny / vulnerability of any individuals with protected characteristics will be managed at local level with associated monitoring and actions. The aggregated information with themes and summary of actions taken received at the VPRG as part of that groups work plan; and will form part of the chair report at Health and Safety sub-committee.

11. POLICY REVIEW

The Prevention and Reduction of Violence policy will be reviewed every three years; however, should national guidance or legislation change then the policy may be reviewed earlier.

As part of the policy review process, the effectiveness of the policy and its application will be assessed. Information and results from information systems, adverse incidents, user and stakeholder feedback will be used to inform this assessment.

12. BIBLIOGRAPHY AND REFERENCES

Assaults on Emergency Workers (Offences) Act 2018

Equality Act 2010

Health and Safety (Consultation with Employees Regulations) 1996

Health and Safety at Work Act 1974

Management of Health and Safety at Work Regulations 1999

Offences against the person legislation

Protection from Harassment Act 1997

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

Safety Representatives and Safety Committees Regulations 1977

Section 39 Criminal Justice Act 1988

The Corporate Manslaughter and Corporate Homicide Act 2007

Violence prevention and reduction standard 2020

APPENDIX A: *Violence Prevention and Reduction* *Assessment Criteria*

PLAN

	Indicators	Compliant	Evidenced (how)
The board (non - exec and exec members) endorses the Violence prevention and reduction policy	The organisation has developed a violence prevention and reduction strategy which has been endorsed by the board and is underpinned by the relevant legislation and government guidance.	Yes/No	
	The organisation has developed a violence prevention and reduction policy which has been endorsed by the board and is underpinned by workforce and workplace risk assessments.	Yes/No	
	The organisation has engaged with key stakeholders, including trade unions, health and safety representatives and other appropriate stakeholders.	Yes/No	
	The organisational risks associated with violence have been assessed and shared with appropriate stakeholders in the sustainability and transformation partnership (STP) or integrated care system (ICS).	Yes/No	
	The senior management (the chief executive and the board) is accountable for the violence prevention and reduction strategy and policy, and this is clearly set out in both documents.	Yes/No	
	Senior management is informed about any disparity trends for violence and aggression against groups with protected characteristics, and a full equality impact assessment has been developed and made available to all stakeholders.	Yes/No	
Clearly defined objectives and Performance criteria	The violence prevention and reduction objectives and expected performance criteria outcomes have been incorporated into the policy	Yes/No	
	There are practical and efficient methods for measuring status against the objectives identified and agreed by the senior management team in consultation with key stakeholders.	Yes/No	
	The organisation is compliant with relevant health and safety legislation and any other applicable statutory legislation, and this has been validated, i.e. via the organisation's auditors	Yes/No	
	Inequality and disparity in experience for any staff groups with protected characteristics have been addressed, and this is clearly referenced in the equality impact assessment.	Yes/No	
Violence prevention and reduction plans recorded,	Plans have been developed and documented for achieving violence prevention and reduction objectives, and the outcomes are clearly set out in the policy	Yes/No	
	The plans are updated and maintained to consider improvements, lessons learnt and updated risk assessments, annually as a minimum schedule.	Yes/No	

	Indicators	Compliant	Evidenced (how)
implemented and maintained	Risk assessments are available to managers, their staff, trade union representatives and other relevant stakeholders.	Yes/No	
	The plans are reviewed in consultation with subject matter experts pertaining to the Equality Act 2010.	Yes/No	

DO

	Indicators	Compliant	Evidenced (how)
Board members approve resources	The senior management assesses and provides the resources required to deliver the violence prevention and reduction objectives.	Yes/No	
	A designated board-level (director) manages the violence prevention and reduction work-stream and ensures appropriate and sufficient resources are allocated to the function (which is underpinned by an organisational risk assessment).	Yes/No	
Regular workforce engagement	The senior management team regularly provides accessible communications on the violence prevention and reduction objectives and priorities.	Yes/No	
	Communications cover all staff groups and functions within the organisation	Yes/No	
	The recognised trade unions are consulted and involved in the development of violence prevention and reduction objectives.	Yes/No	
	A diversity lens is applied to objectives development, to provide due diligence for Public Sector Equality Duty, and this is validated by the subject matter expert pertaining to the Equality Act 2010.	Yes/No	
Clear roles, responsibilities and training	The organisational roles and responsibilities across all levels are clearly set out in a violence prevention and reduction policy.	Yes/No	
	A training needs analysis (violence) informed by the risk assessment has been undertaken, and suitable and sufficient training and support are accessible and provided to all staff.	Yes/No	
Regular risk assessment	Violence prevention and reduction workforce and workplace risk assessments are managed and reviewed as part of an ongoing process and documented in the appropriate organisational risk registers.	Yes/No	
	Violence risks are co-ordinated across the organisation, and are accessible and shared with senior management and all appropriate stakeholders.	Yes/No	
	Identified violence risks and their mitigations/controls are communicated to all staff in regular bulletins.	Yes/No	

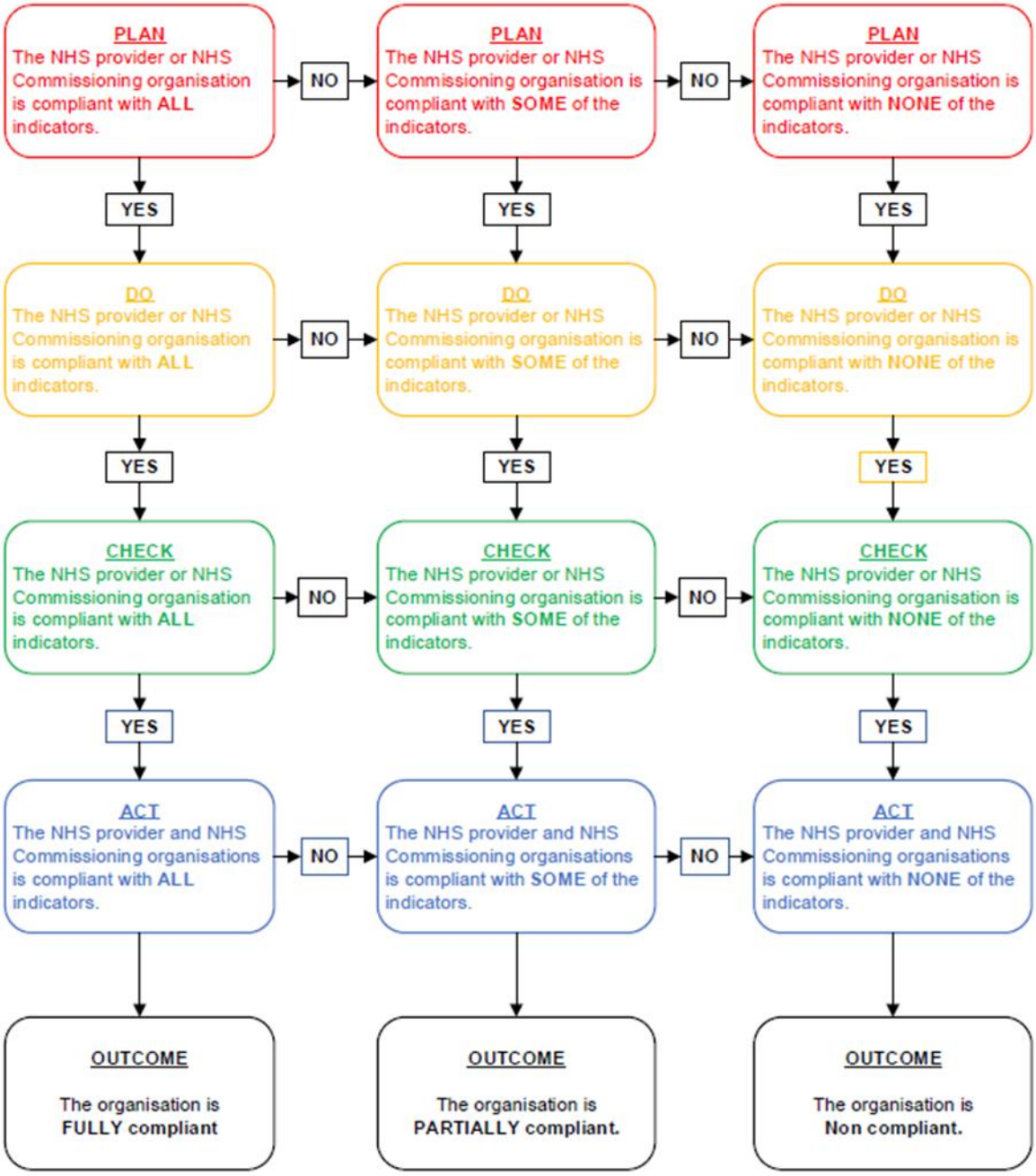
CHECK

	Indicators	Compliant	Evidenced (how)
Process to assess violence prevention and reduction performance	The efficiency and effectiveness of the violence prevention and reduction plans and processes are assessed and reviewed as a minimum every six months or following organisational changes or serious incidents.	Yes/No	
	The senior management is directly accountable for ensuring that the system is working effectively and providing assurance that the violence prevention and reduction objectives are being achieved.	Yes/No	
	Staff members are actively encouraged to report all incidents, including near misses.	Yes/No	
Data is traceable retrievable and accessible	Violence data is managed in accordance with the General Data Protection Regulations (GDPR)	Yes/No	
	Violence data is frequently analysed using primary metrics to support the violence prevention and reduction assessments and inform the audit process.	Yes/No	
	Violence data is analysed using the demographic make-up of the workforce, including age, sex, ethnicity, disability and sexual orientation.	Yes/No	
	The protection and storage of data about violence follows the organisation's information governance policies.	Yes/No	
	Data collected about violence assures that the processes are effective and identifies where lessons can be learnt and that the policy objectives are being achieved.	Yes/No	
Established audit and assurance process for violence prevention and reduction	A process exists for auditing violence prevention and reduction performance and ensuring that associated systems are effectively managed and assessed regularly.	Yes/No	
	The audit outcomes inform a regular senior management review held at least twice a year.	Yes/No	
Process for corrective and preventative actions for violence prevention and reduction	All incidents are logged, reviewed, assessed and any corrective actions are recorded within acceptable timeframes, and where this may be prolonged by investigations and or staff support, this is recorded and communicated to senior management, relevant staff and stakeholders	Yes/No	
	The violence prevention and reduction risk registers are updated accordingly.	Yes/No	

ACT

	Indicators	Compliant	Evidenced (how)
Process to assess violence prevention and reduction performance	A senior management review is undertaken twice a year and as required or requested to evaluate and assess the violence prevention and reduction programme, the findings of which are shared with the board.	Yes/No	
	Inputs to the process include: - local risk management system (data about violent incidents) - risk registers - audit and governance reports that include violence performance - lessons learned (STP and ICS level) - review of the violence prevention and reduction processes - risk assessments (workplace and workforce) - triangulated with WRES and WDES - staff experiences (causation themes, impact on health and wellbeing, consequences, etc) - Serious Incidents - NHS Staff Survey, local or pulse surveys - local HR intelligence (staff recruitment and leavers rates, absenteeism or retention rates) - key stakeholders. - trade union concerns raised through the health and safety committee - meetings with chief constable or designated representative, police and crime commissioners, etc.	Yes/No	
Violence prevention and reduction policy updated with lessons learned	Following the senior management review (twice a year) the violence prevention and reduction lead updates as necessary the objectives, policy, plans and supporting processes required to deliver the outcomes.	Yes/No	
Informed decisions at senior management level	Senior management has enough information from the violence prevention and reduction performance inputs to make informed decisions about the violence prevention and reduction policy, and this information is based on credible intelligence and risk assessments.	Yes/No	
	Violence prevention and reduction forms part of the overall organisational strategy and workforce planning process and is closely aligned to the STP and ICS planning arrangements.	Yes/No	
	Staff receive timely responses to incident investigations, and where this may be prolonged by process requirement, this is recorded and communicated to staff, senior management and relevant stakeholders.	Yes/No	

APPENDIX B: *Violence Prevention and Reduction Standard Risk Scoring Matrix*



Equality Impact Assessment Report

Name of Policy, Service or Function Violence prevention and reduction policy
Equality Impact Assessment carried out by M Peters
Date of Equality Impact Assessment October 2021, December 2021

Step 1: Description and Aims of Policy, Service or Function

Overall aims

The purpose of this policy is to clearly define the expectations of the Trust and provide policy guidance which the organisation can use to set standards and behaviours. The policy sets out the rationale, monitoring arrangements and mechanisms that provide a framework within the trust where all staff can participate in the prevention and reduction of violence and aggression.

Key elements of policy, service, process

- Take all actions possible to reduce or eliminate the prevalence of violence and aggression.
- Provide all staff, including bank and agency staff and volunteers with clear responsibilities and guidance on the prevention and management of risk.
- Commit to a human rights respecting approach that is consistent with national legislation and the trust values.
- Encourage the reporting of both incidents and near misses and feedback to staff on the learning and actions taken to prevent further occurrences.
- Ensure serious incidents are dealt with promptly by local management and reported to the Health, Safety and Security (HSS) team and/or Police
- The HSS and legal teams will work with law enforcement to advise and support staff who wish to prosecute under the Assaults on Emergency Workers (Offenses) Act 2018.
- Provide personal, individualised support to staff following a violent or aggressive incident (TRiM, Counselling, Blue Light Minds etc).

Who does the policy, service or function affect?

The policy affects all employees of the Trust, patients, and members of the public, contractors and commissioners, internal and external stakeholders.

How do you intend to implement the policy or service change (if applicable?)

The proposed implementation process is as follows:

- All named officers to receive an electronic copy of the policy with the summary of the changes
- Short item in the regional bulletin advising the new policy is available on the intranet.
- Under 'for information' the local level 3 meetings to advise of the availability of the policy on the intranet.

Copies will be circulated to all Assistant Directors for onward dissemination as appropriate within their directorate. Hard copies will be made available to all relevant internal and external stakeholders.
If requested, copies of this policy document can be made available in languages other than English, or in a format that suits the requestor.

The policy will be implemented through the violence prevention and reduction standard assessment cycle that identifies the rationale, objectives and the resource requirements for the policy.

Step 2: Data Gathering

Summary of data available and considered

- Health and Safety at Work Act 1974 (HASAWA)
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultations with Employees) Regulations 1996

Outcomes of data analysis

Equality Group	Evidence of Impact
Gender	Gender related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Race/Ethnicity	Race related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Disability	Ability related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Sexual Orientation	Sexual orientation related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.

Religion or belief	Belief related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable
Age	Age related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
General (Human Rights)	NWAS owes a duty of care under health and safety law to all persons.

Step 3: Consultation

Summary of consultation methods

The policy has been developed via consultation with staff side representatives, health, safety and security team, health safety and security sub-committee, Chief of Regulatory Compliance and the Security Management Director (Director of Quality, Improvement and Innovation).

The content of the policy will be further developed by the dynamic consultation with relevant and interested internal and external stakeholders.

Outcomes of consultation

Equality Group	Evidence of Impact
Gender	Gender related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Race/Ethnicity	Race related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Disability	Ability related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Sexual Orientation	Sexual orientation related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable.
Religion or belief	Belief related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood of any perceived harm so far as is reasonably practicable
Age	Age related issues are an inclusive part of this process and require suitable and sufficient arrangements made to reduce the likelihood

	of any perceived harm so far as is reasonably practicable.
General (Human Rights)	The Health and Safety at Work etc. Act places a statutory duty on NWAS to ensure the health and safety of all those affected by its undertaking.

Step 4 & 5: Impact Grid

Relevant Equality Area	Areas of impact identified	Is the impact positive or negative?	Key issues for action [Will form basis of action plan]
Gender	It is anticipated that there will be positive impact to these protected characteristics	Positive	----
Race/Ethnicity	It is anticipated that there will be positive impact to these protected characteristics	Positive	----
Disability	It is anticipated that there will be positive impact to these protected characteristics. However in terms of the policy document itself there may be a negative impact	Positive/Negative	Provide alternative formats
Sexual Orientation	It is anticipated that there will be positive impact to these protected characteristics	Positive	----
Religion or belief	It is anticipated that there will be positive impact to these protected characteristics	Positive	----
Age	It is anticipated that there will be positive impact to these protected characteristics	Positive	----
General (Human Rights)	It is anticipated that there will be positive impact to these protected characteristics	Positive	----

Step 6: Action Plan

Name of Policy or Service: Health Safety and Security Policy					
Issue identified and equalities group or communities affected	**Action to be taken**	**By When**	**Who By**	**Expected outcome**	**Progress**
Difficulties in reading the policy by visually impaired users	Produce a large print version in accordance with the principles of RNIB 'clear print' guidelines	On request	The author of the policy	Large print version produced	No requests to date
Difficulties in reading the policy by users with conditions such as dyslexia	As dyslexia has many variations, requests for alternative versions will be accommodated on request	On request	The author of the policy	Alternative version produced	No requests to date

Summary of decisions and recommendations

1. Make available large print version, in accordance with RNIB 'clear print' guidance; or other alternative versions on request.

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th January 2022
SUBJECT:	Policy on Learning from Deaths - Review
PRESENTED BY:	Dr C Grant, Medical Adviser

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☐	☐	☐

SR05	SR06	SR07	SR08	SR09
☐	☒	☐	☐	☐

PURPOSE OF PAPER:	For Decision
EXECUTIVE SUMMARY:	The Board of Directors has the accountability for the ownership of Learning from Deaths via the approval of this policy and the commitment to ensuring sufficient resource is available to facilitate learning across the organisation. A scheduled review has been undertaken by the Trust's Consultant Paramedic (Medical Directorate) with minor amends and updates identified, to reflect changes to the Trust's Corporate Governance Structure and process. The amended Policy (**attached**) has been approved by the Trust's Clinical Effectiveness Sub Committee and Quality and Performance Committee at the meeting on 24th January 2022.
RECOMMENDATIONS:	The Board of Directors are requested to – • Note the minor updates to the Trust's Policy on Learning from Deaths. • Approve the updated Trust Learning from Deaths Policy.
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☐ Innovation ☐ Reputation

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Clinical Effectiveness Sub Committee Quality and Performance Committee			
	Date:	18th January 2022 24th January 2022		
	Outcome:	Approved		

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1. PURPOSE

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

2. BACKGROUND

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

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

3. REVIEW OF POLICY

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

The amended Policy (**attached**) has been approved by the Trust's Clinical Effectiveness Sub Committee and Quality and Performance Committee at the meeting on 24th January 2022.

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

No equality or sustainability implications have been identified.

5. RECOMMENDATIONS

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

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North West Ambulance Service NHS Trust

Policy on

Learning from Deaths

Safe, Effective and Patient Centred Care, Every Time

Recommended by	Quality & Performance Committee
Approved by	Board of Directors
Approval date	27th November 2019
Version number	1.1
Review date	December 2023
Responsible Director	Executive Medical Director
Responsible Manager (Sponsor)	Consultant Paramedic (Medical Directorate)
For use by	All Trust employees and volunteers

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

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	September 2019	November 2019	Consultant Paramedic (Medical Directorate)	Document creation
0.2	November 2019	November 2019	Consultant Paramedic (Medical Directorate)	Amends following review by Clinical Effectiveness Management Group (CEMG); Sections 8, 9 & 10.
0.3	November 2019	November 2019	Consultant Paramedic (Medical Directorate)	Addition of Section 11 following Head of Legal Services review
1.0	November 2019	December 2019	Consultant Paramedic (Medical Directorate)	Policy finalisation following Committee review. No significant change
1.1	December 2021	January 2022	Consultant Paramedic (Medical Directorate)	Scheduled review. Minor amends and updates reflecting changes to Corporate Governance Structure and process

Policy on Learning from Deaths

Contents

1. Introduction

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

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

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

2. Executive Summary

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

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

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

3. Scope

This policy applies to all Trust staff, including volunteers.

4. Duties and Responsibilities

Board of Directors

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

Chief Executive

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

Executive Medical Director

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

Executive Directors

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

Consultant Paramedic (Medical Directorate)

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

All Senior Clinicians and Managers

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

All Employees

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

5. Our Approach to Learning From Deaths

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

We have adopted a process of structured judgement review in order to systematically and consistently scrutinise the care provided to patients. We continue to commit to a programme of education and training for key senior clinicians in the methodology associated with structure judgement reviews and use the opportunity to increase safety and reliability as well as promote the adoption of improvement methodology to make real changes to practice.

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

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

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

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

6. Determining Deaths in Scope for Review

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

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

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

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

7. Determining Which Deaths Should be Reviewed

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

The national guidance stipulates that the Trust must review **all** deaths where ambulance service personnel, other health and care staff, and / or families or carers have raised a concern about the care provided, including concerns about end of life care. This includes any concern raised that cannot be answered fully at the time or anything not answered to the satisfaction of the person raising the concern.

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

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

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

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

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

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

Additional Reporting Requirements:

- **Deaths of Patients with Learning Disabilities**

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

- **Maternal and Neonatal Deaths**

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

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

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

- **Paediatric Deaths**

The Child Death Review Statutory and Operational Guidance outlines the Trust's statutory duties with regards to notification and information gathering. The Trust will participate in child death review meetings, including Child Death Overview Panel (CDOP) meetings, whenever

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

- **Safeguarding Concerns**

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

- **Deaths in Custody**

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

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

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

8. Case Record Reviews

NWAS utilises a structured method of case review for those deaths identified for inclusion utilising a standard methodology based upon an adaptation of the Royal College of Physicians'

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

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

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

9. Learning from Reviews

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

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

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

10. Serious Investigations

This Learning from Deaths Policy enhances and does not replace the Trust's existing policies on Serious Investigations.

Any concerns with care identified at any stage of the Learning from Deaths process should be reported as a high risk (4 or 5) incident on the Datix system. Incidents assessed at this risk score are escalated to the Review of Serious Events (ROSE) Group for consideration for reporting as a Serious Incident. This is now a well-established process that facilitates compliance with Serious Incident National reporting requirements including database submissions. This process is separate from the Learning from Deaths case review and wherever possible, duplication in case review should be avoided.

Where concerns are identified from the Learning from Deaths process of structured judgement review, the Consultant Paramedic (Medical Directorate) has the responsibility for the escalation of these concerns to senior clinicians within the Trust for consideration against the Serious Incident Framework.

The Trust will ensure that any staff involved in the investigation are treated in a consistent, constructive and fair way throughout the process and that all are conducted in accordance with the Investigation Policy and other associated professional standards.

11. Coronial Engagement

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

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

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

12. Bereaved Families and Carers

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

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

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

13. Supporting Our Staff

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

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

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

14. Reporting and Monitoring Arrangements

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

The Trust will produce an annual summary of learning from deaths within its Quality Account (from June 2021). This will provide a consolidation of the quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these.

References

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

NHS England (2015) ‘Serious Incident Framework’. London: NHS England

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

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

National Quality Board (2019) ‘National Guidance for Ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care’. London: National Quality Board

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

North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Audit Committee			
Date of Meeting:	21st January 2021	**Chair:**	David Rawsthorn
Quorate:	Yes	**Executive Lead:**	Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs
Members Present:	Prof A Chambers, Non-Executive Director Prof A Esmail, Non-Executive Director Prof R Thomson, Associate Non-Executive Director	**Key Members Not Present:**	
Link to Board Assurance Framework (Strategic Risks): No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.			

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating
Clinical Governance-Quality and Performance Chair's Assurance Reports	The Committee received the Chairs Assurance Reports from the meetings held on 27th September 2021 and 25th October 2021 and items relating to Clinical Governance.	Noted the assurance provided within the reports.	
Clinical Audit Q2 2021/22 Progress Report	The Medical Director presented the Clinical Audit Q2 2021/22 update to the Committee.	Noted the assurance provided.	

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

Data Quality Update	The Committee received an update in relation to the work completed and planned to improve overall Data Quality within the Trust.	Noted the assurances provided. Consideration is to be given to regular reporting to all committees to give assurance on data quality.	
Critical and High Risk Recommendations	MIAA continued to follow up recommendations. It was noted 2 high risk recommendations remain outstanding. Freedom to Speak Up has one partially implemented with the completion date extended to September 2022 and a superseded recommendation.	Noted the update provided.	
Internal Audit Progress Report Q3 2021/22	The Committee noted the assurance reviews completed within Q3: Lessons Learnt – High Assurance Project Management Office – Substantial Assurance	Noted the assurances provided.	
Internal Audit Follow Up	The Committee noted the good progress within the reporting period and that 8 recommendations were completed during the period.	Noted the assurance provided.	
Anti-Fraud Progress Report	The Committee received the Anti-Fraud Progress Report outlining the wide range of activities undertaken in relation to Strategic Governance; Inform and Involve; Prevent and Deter and Hold to Account since the last meeting.	Noted the assurance provided.	
External Audit Progress Report and Technical Update	Progress to date on preparation for the audit was noted.	Noted the assurances provided.	

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

Audit Strategy Memorandum	The Committee received the report summarising the audit approach and highlighting the significant audit risks and areas of key judgements for the year ending 31 March 2022.	Noted the assurances provided.	
Board Assurance Framework Q3 2021/22	The Committee received the updated BAF prior to submission to the Board of Directors for approval on 26th January 2022. Committee members considered the report within the context of their role as Audit Committee.	Noted the assurances provided. Further maturity work to be undertaken with the Board to ensure that the BAF gives a clear position of the current position on each strategic risk.	
Waiver of Standing Orders Q3 2021/22	A total of three waivers were approved during Q2 2021/22.	Noted the assurances provided.	
Chairs Assurance Report – Resources Committee	The Committee received the report from the meeting held on 24th September 2021.	Noted the assurances provided.	

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

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th January 2022
SUBJECT:	Integrated Performance Report
PRESENTED BY:	Director of Quality, Innovation and Improvement

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☐	☒	☐

SR05	SR06	SR07	SR08	SR09
☐	☐	☐	☐	☐

PURPOSE OF PAPER:	For Assurance

EXECUTIVE SUMMARY:

The Integrated Performance Report for January 2022 shows performance on Quality, Effectiveness and Operational Performance during **December 2021** unless otherwise stated.

PES (999)

- We received 143,568 calls of which 92,249 became incidents. Compared with December 2019, we have seen a 7% increase in calls and a 12% decrease in incidents**.** The decrease in incidents is due to the use of signposting to self-transport or other services.
- An increase in duplicate calls and staff abstractions have affected call pick up performance which was 68.6% against a target of 95%.
- Overall we achieved 10.9% Hear and Treat, 30.9% See and Treat resulting in an aggregate non-conveyance of 41.8%.
- Response time targets were not met for any ARP category. Increased abstraction rates, increasing turnaround times and an increase in acuity of patients have contributed to performance challenges.
- Turnaround continues to be above the National standard of 30:00 with a turnaround time of 39:22. 5,582 attendances (11.7%) had a turnaround time of over 1 hour. 1,520 hours were lost to delayed admissions.

- The number of C2 long waits remains high with 20,038 patients waiting more than 60 minutes. This is a significant patient safety concern and measures are in place to continuously review patients who are waiting through the clinical control desk.

- Despite increased clinical oversight, we have seen an increase in level 4-5 incidents and during November and December there were 18 serious safety incidents reported on the StEIS database (12 in November and 6 in December). The rise in incidents and serious incidents is directly linked to performance and high waiting times.

The trust has taken a number of measures to improve performance and maintain patient safety including:

- A robust winter plan has been implemented with 95% of planned resources realized despite COVID abstractions
- In December we put out 2474 additional operational resource hours
- An agreed 6-point plan (jointly with commissioners and the 4 ICS footprints) has continued to be implemented.
- Enactment of MACA which will see 150 army personnel deployed to increase operational resource.
- Rapid COVID testing has been introduced and controls in place on NWAS premises are containing outbreaks to very small numbers of individuals.
- Continued work with those most challenged trusts to support handover including testing and implementation of the delayed handover crew and managers escalation action card.

NHS 111

Call volume remains high and the gap between activity and resource continues to be as high as 50% at various points of the day. Staff absence rose during December and contributed to up to 15% loss of resource during the day.

The increase in demand on the 111 service has directly impacted the size of the Clinical advice queue. Time taken for a call back continues to be well above the target. Safety measures are in place. Increased demand during out of hours operation are leading to increased call volume and conversations between CCGs and OOH provides are taking place. The 111 service are looking to implement self-care advice via SMS to enables a reduction in call times.

PTS

PTS performance is reported one month in arrears. Activity in November for the Trust was 20% below contract baselines.

	Finance As at month 9 (December) the trust is recording a surplus position for the year to date. It is expected that the trust will finish the year in a break even position due to cost pressures expected in the January to March period. **Organisational Health** The overall sickness absence rate for the latest reporting month (November 2021) was 9.97% including COVID related sickness of 1.53 % Turnover has increased to 11.21% with a significant increase across. The main increases are in call centres which mirrors national trends. The overall appraisal completion rate improved to 74.54% against a revised trust target of 75%. We are currently off track for Mandatory Training at 68% against the target of 87%. A recovery plan for classroom training has been implemented and this will run in parallel with a focus on recovery of online completion. 565 staff have tested positive for Covid-19 in December 2021 .At the end of this reporting period, there were 10 open outbreaks on Trust sites.
RECOMMENDATIONS:	The Board of Directors is asked to: • Note the increased demand across all service lines and the impact of this demand on quality, performance and workforce. • Note the ongoing work to maintain patient safety and regulatory compliance and mitigate the impact of increased demand and long waits. • Note the continued high performance on the patient reported friends and family test across all service lines. • Note the partnership delivery of a whole system 6 point improvement plan to optimise performance. • Note the controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively. • Clarify any items for further scrutiny through the appropriate assurance committee
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation

	☐ Reputation			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☒
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	24/01/2021		
	Outcome:	Not known at time of submission		

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1. PURPOSE

1.1 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 **October 2021**. 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. SUMMARY

2.1 Quality

- 168 complaints were received, against a 12 month average of 181 per month.
- 66% of complaints risk scored 1-2, 63% of level 3 and 22% of level 4-5 complaints were closed within the agreed time frames.
- A revised plan is being put in place to address the complaints backlog which fell to 79 at the end of November and rose to 122 at the end of December.
- During November and December 2021 there were 18 serious safety incidents reported on the StEIS database (12 in November and 6 in December).
- In December 2021, 1,296 internal and external safety incidents were opened against a 12-month average of 1,323, with an additional 121 still to be scored.
- Content analysis of safety incidents by type shows that the top two reasons (by volume) are incidents associated with 111 services or staff welfare.

2.2 Effectiveness

- **Patient experience:** PES and PTS have seen an increase in returns (3.6% and 4.8% respectively) with 111 having seen a decrease in returns of 62.2%. 111 have seen a 7.3% decrease in satisfaction levels compared to last month.
- This report contains a high level summary of the experience of patients using NHS 111 First, which shows a decrease in responses (112 to 105) but a marginal decrease in satisfaction (85.3% to 84.5%) in December compared to November.

2.3 Ambulance Clinical Quality Indicators (ACQI's):

- August 2021's data see us within normal limits and close to the mean across all indicators with the exception of ROSC which is below mean performance although within limits. The lag in data publication impacts upon the ability to assess or understand reasons behind this as well as the ability to evaluate the impact of any recent work undertaken to improve in these areas.

Cardiac Outcomes

- **Return of spontaneous circulation (ROSC)** achieved for the Utstein group was 38.1% (national mean 46.8%). For the overall group the rate was 24% (national mean 25.8%).
- **Survival to Discharge** rates in August 2021 were at 7.2%.
- In August 25.6% of patients in the Utstein group survived to hospital discharge. The national mean at 28.6%. .
- Mean call to PPCI time in August for patients suffering a myocardial infarction was slightly outside of the national mean of 2h 27mins; the Trust's performance was 2h 39mins.
- Mean call to hospital time in August for patients suffering a hyper acute stroke the same as the national mean of 1h 43mins.
- The stroke care bundle was the same as the national the mean of 97.8%.
- The Stemi Care Bundle performance was not reported for August in line with the NHSE schedule.

H&T, S&T, S&C

- For December we achieved 10.9% Hear and Treat and ranked 6th nationally. Some weeks in December saw special cause with hear and treat rates increasing over 12%. See & Treat is at 30.1% within normal limits and we are ranked 9th nationally. In total there was an aggregate non-conveyance of 41.8%.

Patient Emergency Service (PES)

2.4

- **Activity:** In December 2021, the Trust received 143,568 calls of which 92,294 became incidents. Compared with December 2019, we have seen a 7% increase in calls and a 12% decrease in incidents. The decrease in incidents is due to the increased use of signposting to self-transport or other services.
- **Call volume:** call volume is 31% above the equivalent month for 2020 and 7% above against 2019.
- **Duplicate calls** rose to 42,005 (29.3%) during December and continue to add complexity and reduce CPU performance.
- **Call Pick Up** has been adversely affected by staff abstractions and performance was 68.6% (target 95%). and has deteriorated from the previous month.
- **Acuity:** over recent months we have seen increasing acuity of our patients. C1 calls have risen from 9% to 16%, C2 calls have risen from 52% to 55%. This means that 77% of all our incidents are in the highest categories and reduce our opportunities for Hear & Treat and See & Treat. NWAS are working with AACE to understand the increase in acuity. All trusts have seen an increase but not to the same extent as NWAS.

2.5 **Ambulance Response (ARP) Performance**

	Standard	Actual
C1 (Mean)	7:00	9:14
C1 (90th)	15:00	15:33
C2 (Mean)	18:00	1:07:42
C2 (90th)	40:00	2:28:44
C3 (Mean)	1:00:00	4:06:33
C3 (90th)	2:00:00	10:27:54

- For December, response time targets were not met for any ARP category.
- Increased abstraction rates (Covid positive, Isolation and non covid sickness) have contributed to poor performance during December. In order to support staff to return to work quickly we have deployed rapid covid testing for the trust. COVID outbreaks are contained and linked to community prevalence and individual lack of compliance with PPE. The controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively with outbreaks limited to very small numbers of individuals at each site.
- The trust has taken a number of measures to improve performance and maintain patient safety including the deployment of a robust winter plan and an agreed 6-point plan (jointly with commissioners and the 4 ICS footprints) focused on reduction in lost hours, reduction in conveyances to hospitals, reduced handover times, improvements in community access and access to mental health services. The aim of this plan is to optimise operational resource. This is being supplemented with additional investment of £6.2m in additional staff, vehicles and winter schemes. Details are included in this report.
- In addition to the implementation of the Trusts 6-point plan NWAS has now enacted MACA. MACA will see 150 army personnel deployed to increase operational resource. This will increase DCA production and improve response times to lower acuity patients (C3 & C4). The deployment will comment from 17th January 2022.

Handover

2.6

- Average turnaround time has increased and continues to be above the National standard of 30:00 with a turnaround time of 39:22. This is the seventh consecutive month the trust has been above the standard and the eighth time in 2021. 5,582 attendances (11.7%) had a turnaround time of over 1 hour, with 491 of those taking more than 3 hours. 1,520 hours were lost to delayed admissions in December up from 1,320 in November.
- The trust continues to work with those most challenged trusts and is also ensuring a focus on patient safety while the system is challenged. During December the trust has started to test and implement the delayed handover crew and managers escalation action card.

2.7 **C1 & C2 Long Waits**

- The number of C2 long waits has risen sharply in December with 20,038 patients waiting more than 60 minutes. This is higher than November with 14,518 but lower October with 22,113 patients waiting more than 60 minutes. This is a significant patient safety concern and measures in place to continuously review patients who are waiting through the clinical control desk which are helping but not eliminating the risk.

2.8 **NHS 111**

	Standard	Actual
Calls Within 60s	95%	24.33%
Average Time to answer		11m 24s
Abandoned Calls	<5%	31.98%
Call back Within 10 min	75%	4.69%
Average Call Back		2 hour 2min
Warm Transfer to Nurse	75%	0.71%

- Call volume remains high. The gap between activity and resource continues to be as high as 50% at various points of the day.
- Staff absence rose during December contributing to 15% loss of resource on the day .
- A national recruitment campaign ran throughout December and has generated some additional interest with the team reviewing applications with a plan to fill vacancies during February and March.
- The increase in demand on the 111 service has directly impacted the size of the Clinical advice queue. Time taken for a call back continues to be well above the target. Safety measures are in place. Increase demand during out of hours (OOH) operation are leading to increased call volume and conversations between CCGs and OOH provides are taking place. The 111 service are looking to implement self-care advice via SMS, this will enable the call handler to reduce call time by sending a message rather than reading out lengthy scripts, the timeframes for this project to go live are indicatively by the end of February.

2.9 **PTS**

- Due to reporting timing issues PTS performance is reported one month in arrears.

- Activity in December for the Trust was 20% below contract baselines, whilst the year to date position (July 2021 – December 2021) is performing at 22% below baseline.

2.10 **Finance**

- The year to date expenditure on agency is £4.103m which is £1.771m above the year to date ceiling of £2.332m.
- As at month 9 (December) the trust is recording a surplus position for the year to date. H2 (October to March) income has been agreed along with additional top up elements for Covid & winter pressures, spend related to these top ups is monitored and we are bringing in additional staff as appropriate to help operational performance. It is expected that the trust will finish the year in a break even position due to cost pressures expected in the January to March period.
- The Financial Risk Rating metrics have been removed and will be added back once the new operating framework is launched after transition from the Covid-19 financial framework.

2.11 **Organisational Health**

- **Sickness:** The overall sickness absence rate for the latest reporting month (November 2021) was 9.97% including COVID related sickness of 1.53%. Additional resource has been identified to provide additional focus on managing attendance and wellbeing. The impact of the Omicron variant will show in the next report.
- The top 5 reasons for absence are Mental health, Covid, Injury and MSK and back problems.
- **Turnover** was 11.21% with the main increases arising in call centres which mirrors national trends. This is showing special cause variation for EOC, 111 and PES with all being above the upper control limit.
- **Agency:** Due to the impact of Covid-19 agency costs at the trust stands at 3% in December.
- **Vacancy**: Positions across the trust are under establishment by 1.78%. This is mainly as a result of establishment changes and turnover in 111 and vacancies in PTS following the use of PTS staff on PES. EOC are over-established by 3.65% and PES are fully staffed.
- **Appraisal**: The overall appraisal completion rate was improved at 75.54% against a revised trust target of 75% by March 2022 for the service lines and to 85% by March 2022 for Corporate and band 8a and above.
- **Mandatory Training:** A new cycle of mandatory training started in April with additional online topics included and a new classroom cycle. The starting Trust compliance position was 60% in April 21 as a result new topics being added. This rate will build during the year but has been impacted by pauses in mandatory training at Reap 4. We are currently off track at 68% against the agreed ELC target of 87% overall by March 2022. This target is made up of 85% for service lines and 95% Corporate services by March 2022. A recovery plan for classroom training has been implemented and this will run in parallel with a focus on recovery of online completion.

2.12 **COVID 19**

- 565 staff have tested positive for Covid-19 in December 2021 . At the end of this reporting period, there were 10 open outbreaks on Trust sites.
- The outbreaks are contained and linked to community prevalence and individual lack of compliance with PPE. The controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively with outbreaks limited to very small numbers of individuals at each site.
- Rapid testing has been implemented to support staff to return to work.

3. LEGAL, GOVERNANCE AND/OR RISK 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. EQUALITY OR SUSTAINABILITY IMPLICATIONS

4.1 The data in this report are presented at an aggregate level for the trust and so any issues related to equality and diversity are not highlighted. An initial review of the potential to understand EDI measures against the friends and family test has demonstrated that although data are available, it is complex and requires further work to define correctly, in order to drive meaningful information. We are also looking to add EDI measures into the complaints process. This work has been delayed but is now progressing. A digital sprint has begun to improve our data sharing across NWAS services / systems of patient ethnicity. This will enable us to view our ACQIs by ethnicity and understand if quality of outcomes is different for different groups.
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The effectiveness measures related to ‘hear and treat’ and ‘see and treat’ have the potential to impact on our carbon emissions however this is not explored in the report.

5. RECOMMENDATIONS

5.1 The Board of Directors is recommended to:

- Note the increased demand across all service lines and the impact of this demand on quality, performance and workforce.
- Note the ongoing work to maintain patient safety and regulatory compliance and mitigate the impact of increased demand and long waits.
- Note the continued high performance on the patient reported friends and family test across all service lines.
- Note the plans in place to close recruit more staff across all service lines.
- Note the partnership delivery of a whole system 6 point improvement plan to optimise performance.
- Note the controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively.
- Clarify any items for further scrutiny through the appropriate assurance committee

Q1 COMPLAINTS

Figure Q1.1

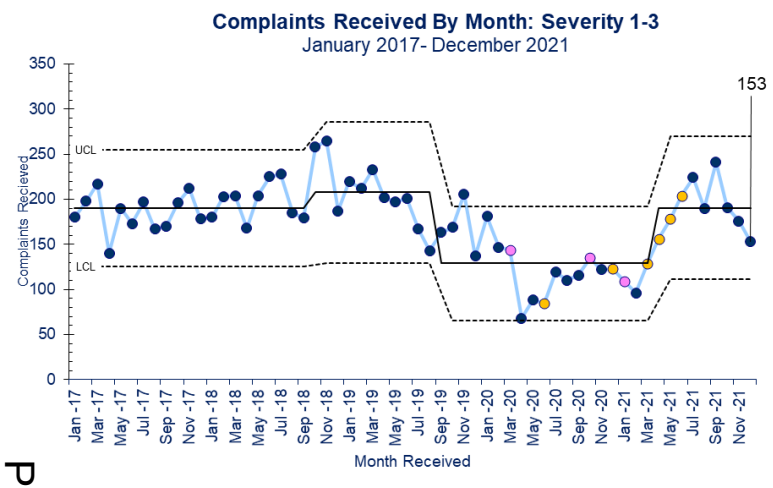


Figure Q1.2

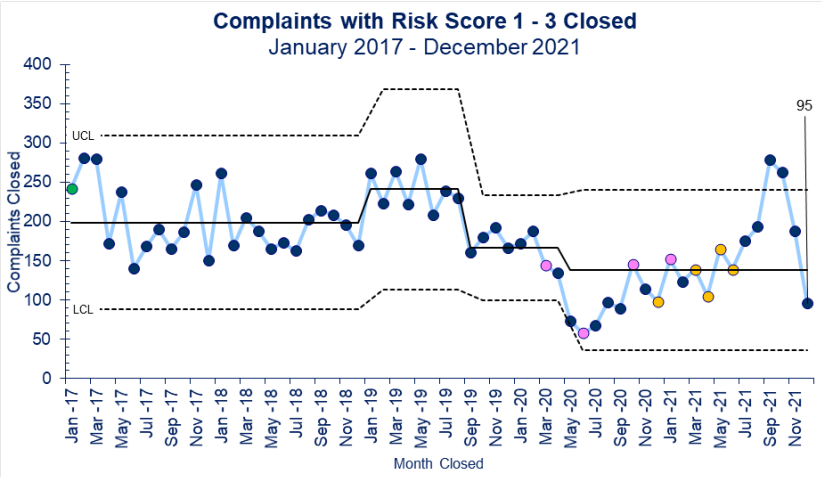


Figure Q1.3

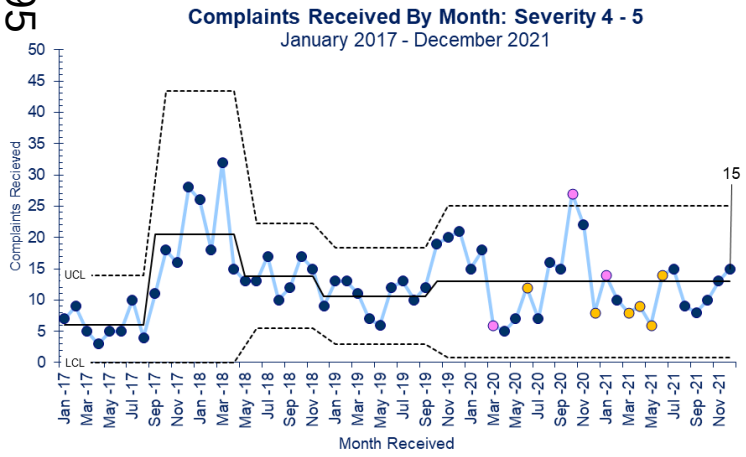
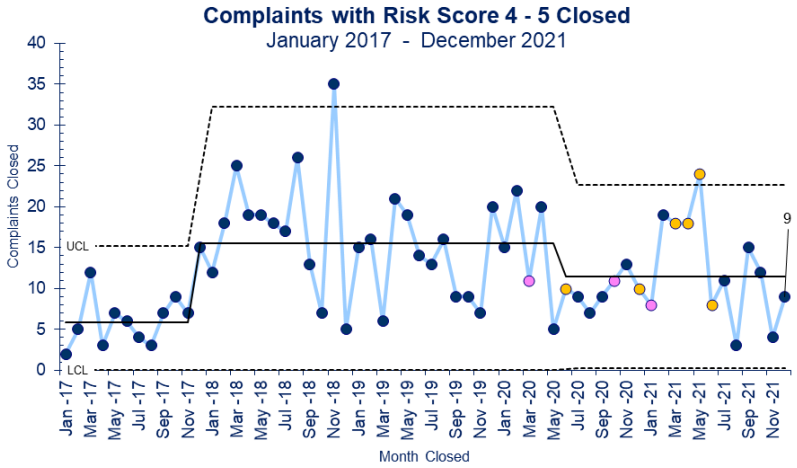


Figure Q1.4



* *Lockdown* *Easing of Restrictions*

Complaints & Compliments

In December, **168 complaints** were received (figures Q1.1 & Q1.3), against a total 12-month average of **181** per month.

71 compliments were received this month which is significantly lower than October and November (**153** and **128** respectively) but similar to December with **73**.

The rate of complaints in December 2021 was **27 per 1000 WTE**. The average for the fiscal year (1 April 2021 – 30 April 2022) is **29** per 1000 WTE. The rate for both the month of December and the year to date are above the strategy goal for 2021/22 of **27**.

A total of **104** complaints were closed in December 2021 (**95** were risk scored 1-3 Q1.2 and **9** were risk scored 4-5 Q1.4).

The process for rapid closure of complaints risk scored 1-2 and 3 was trialled and implemented in November.

This process was impacted in December due to staff abstractions in the risk scored 1-2 peer group, resulting in higher caseloads for individuals. There is a plan in place to work collaboratively across the team throughout January to alleviate pressures from individuals with larger caseloads and implement smarter working processes moving forward.

Figure Q1.5

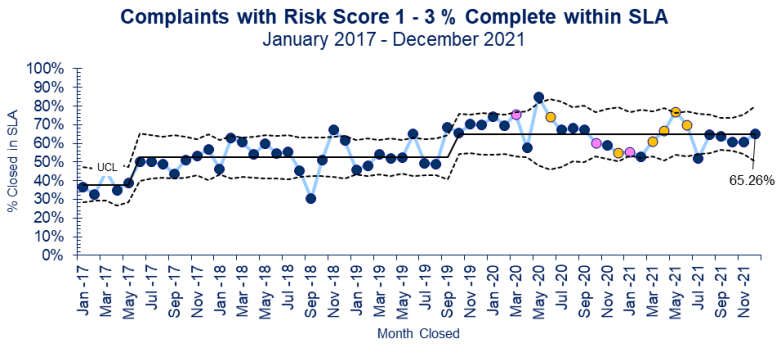


Figure Q1.6

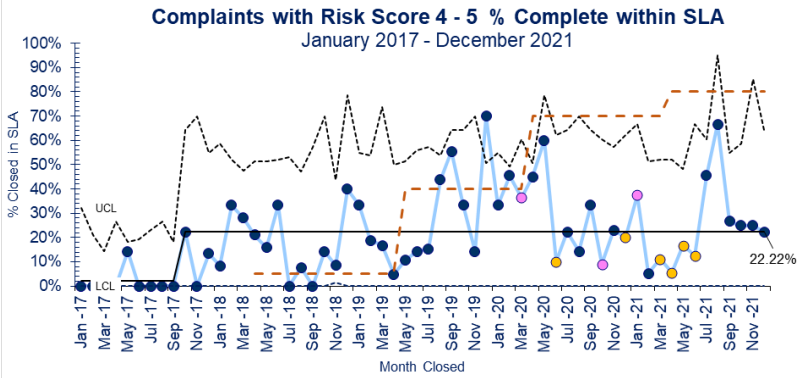
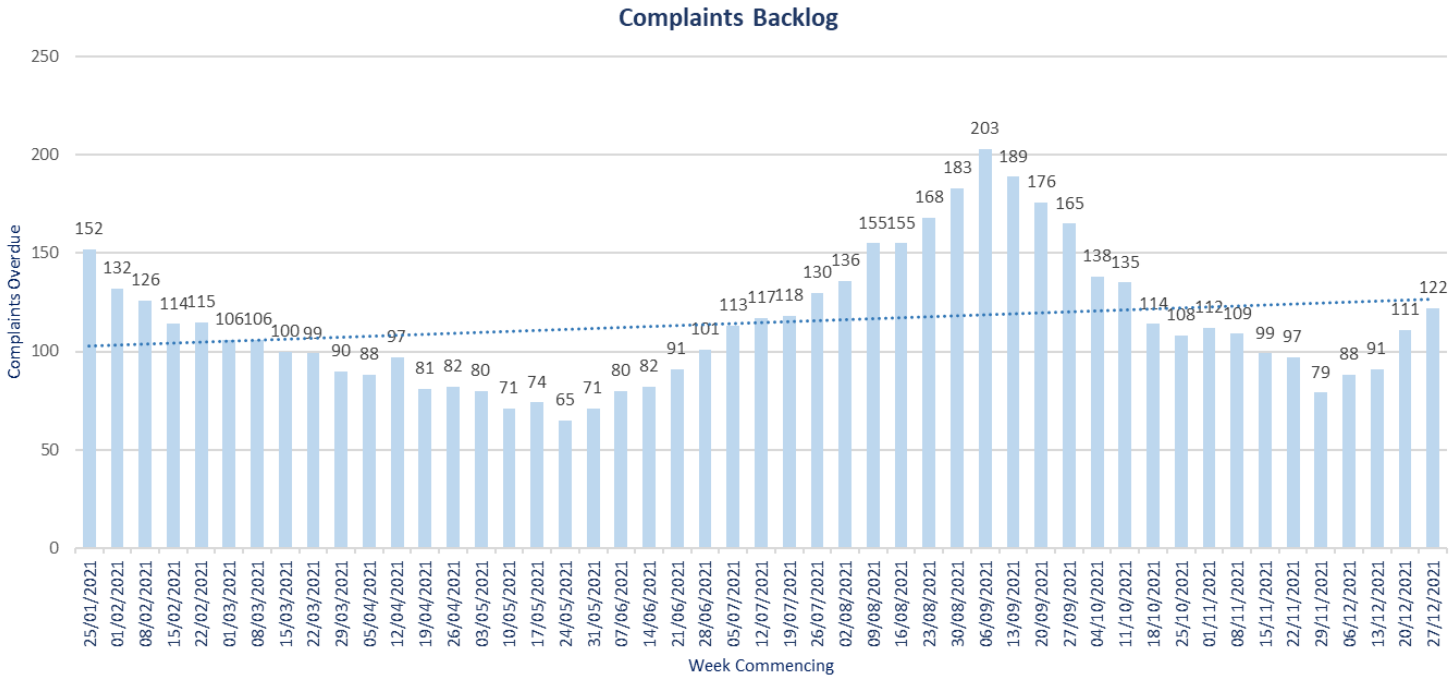


Figure Q1.7



Complaints Closure

Overall, **65%** of cases risk scored 1-3 were closed within the agreed timescales (Q1.5).

The updated Right Care strategy goals break down complaints with a score of 1-2, 3 and 4-5 rather than 1-3 and 4-5.

66% of level 1-2 complaints were closed within agreed timescales against a right care strategy goal of **75%** by the end of 21/22

63% of level 3 complaints were closed within agreed timescales against a right care strategy goal of **70%** by the end of 21/22

22% of level 4-5 complaints were closed within agreed timescales (Q1.6) against a right care strategy goal of **80%** by the end of 21/22.

The decrease in complaints scored 4-5 closed in SLA is due to resource issues due to Covid abstractions , general sickness and leave. Also, availability of operational staff for specialist reviews and investigation due to REAP 4.

The backlog of complaints has been rising since May but had seen a fall from **203** at the start of September to **79** for WC 29th November. The backlog has started to increase again since the introduction of REAP 4 (Q1.7). Overall, the backlog has moved to **c54%** of the total volume of complaints. A trajectory and improvement plan had been agreed with the Executive Leadership Team where assurance was provided that the backlog was to be back to low levels **c30** by mid-November. This trajectory was not met due to unfilled vacancies and staff abstractions. New trajectories will be agreed with Executive Leadership Team.

Q2 INCIDENTS

Figure Q2.1

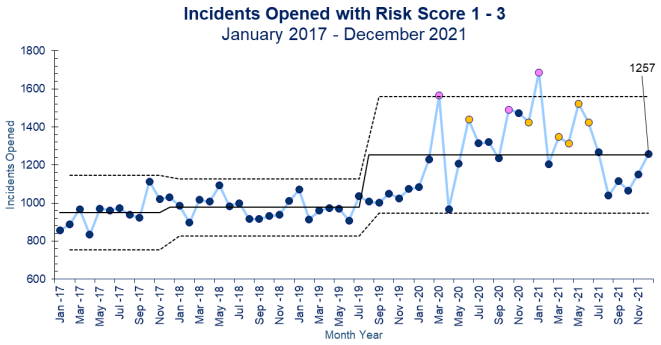


Figure Q2.3 - Highest number of safety incidents October 2021 by subcategory are from 111

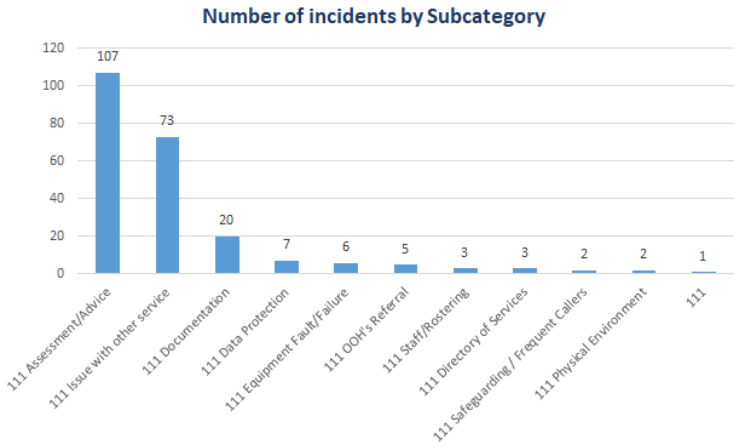


Figure Q2.2

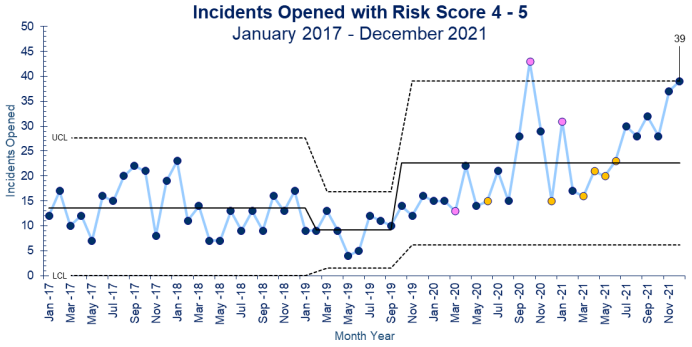
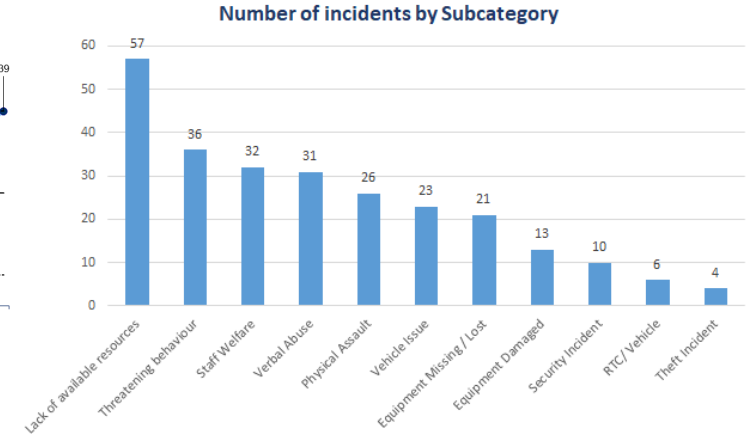


Figure Q2.4 - Second highest number of safety incidents October 2021 by subcategory are staff welfare



* Lockdown Easing of Restrictions

Reporting: In December 2021, **1,296** internal and external safety incidents were opened (Q2.1 and Q2.2) against a 12-month average of **1,323**, with an additional **121** still to be scored. The number of safety incidents with a risk score of 4-5 is showing special cause variation and is directly attributable to the poor response times in December. High levels of reporting are important and considered a marker of a positive culture where staff feel able to speak up.

Unscored Safety Incidents (RCS): In December, **22** safety incidents during November were unscored which is below the end of year Right Care Strategy goal of **25** unscored safety incidents in the previous month reported in the IPR. The scoring and management of safety incidents in a timely way is monitored via the clinical effectiveness meeting and plans are in place to ensure the end of year target is achieved.

Safety Incidents by Type: Content analysis of incidents by type shows that the top two reasons (by volume) are safety incidents associated with *111 services* or *staff welfare*. Figures 2.3 and 2.4 show the subcategories within these two themes and help to explain the reasons for the themes.

111: It is important to frame the total number of safety incidents in 111 against the total number of calls received (**229** safety incidents from **236,233** calls). Many of these safety incidents are raised by healthcare professionals who want clarity on outcome decisions. All calls are audited and action taken where concerns are upheld. The majority of 111 safety incidents have been raised because of concerns about the assessment or advice given (n=**107**), because we have had issues with another NHS service (n=**73**), for documentation or data protection issues (n=**20+7**) or for out of hours referrals (n=**5**). Around **15% -20%** of safety incidents raised within 111 can be resolved locally

Staff Welfare Safety Incidents: Two of the most common reasons for reporting are; violence and aggression towards staff, which includes threatening behaviour, verbal abuse and physical assault, and resource or equipment issues. The Trust has an active Violence and Aggression working group (a sub-group of the Health, Safety and Security sub-committee) with work streams to reduce assaults on staff and to assist in increasing appropriate prosecutions. A lack of available resources has also continued to be a key concern for staff in December.

Figure Q2.5

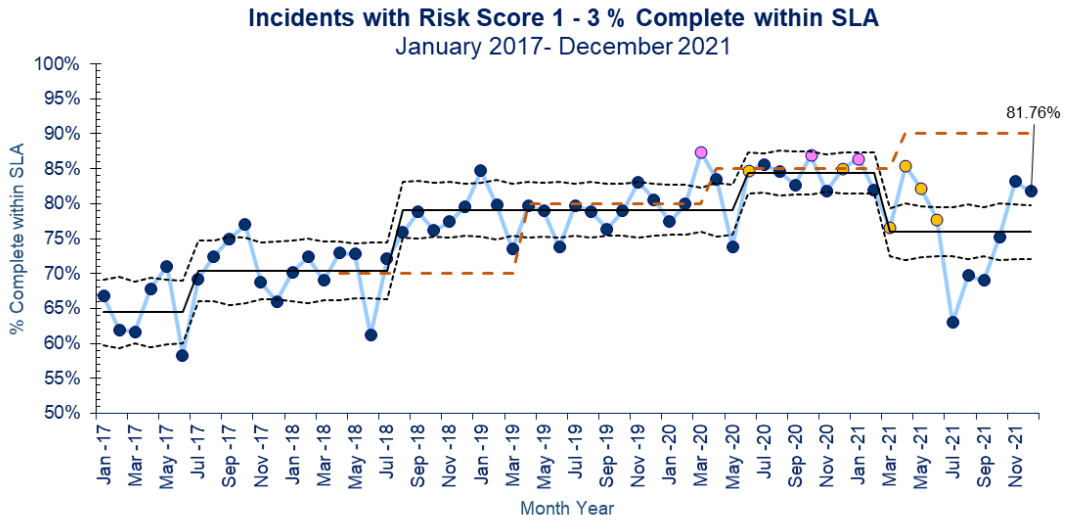
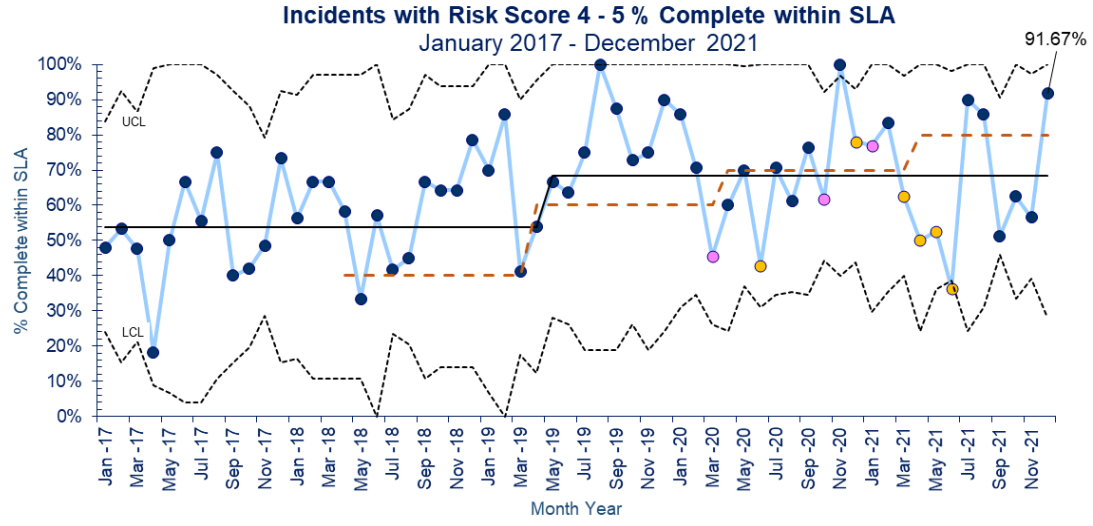


Figure Q2.6



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

* Lockdown Easing of Restrictions Right care strategy goal

Incidents Closure

In total, **1,114** safety incidents (level 1-5) were closed during December 2021.

82% level 1-3 were closed within agreed standard (Q2.5) which is currently showing as special cause variation to the good being above the upper control limit, this is however below the right care strategy goal of **90%**.

92% of level 4-5 safety incidents were closed within the agreed standard (Q2.6) against a right care strategy goal of **80%** for the end of 2021/22.

Closure rates continue to be affected by periods of REAP Level 4 which impacts on the ability of front line staff to produce the required statements and investigation reports to close off these safety incidents. As well as the availability of senior management teams for approval of investigations. The Patient Safety team have implemented new processes to support this as much as they can during periods of REAP level 4.

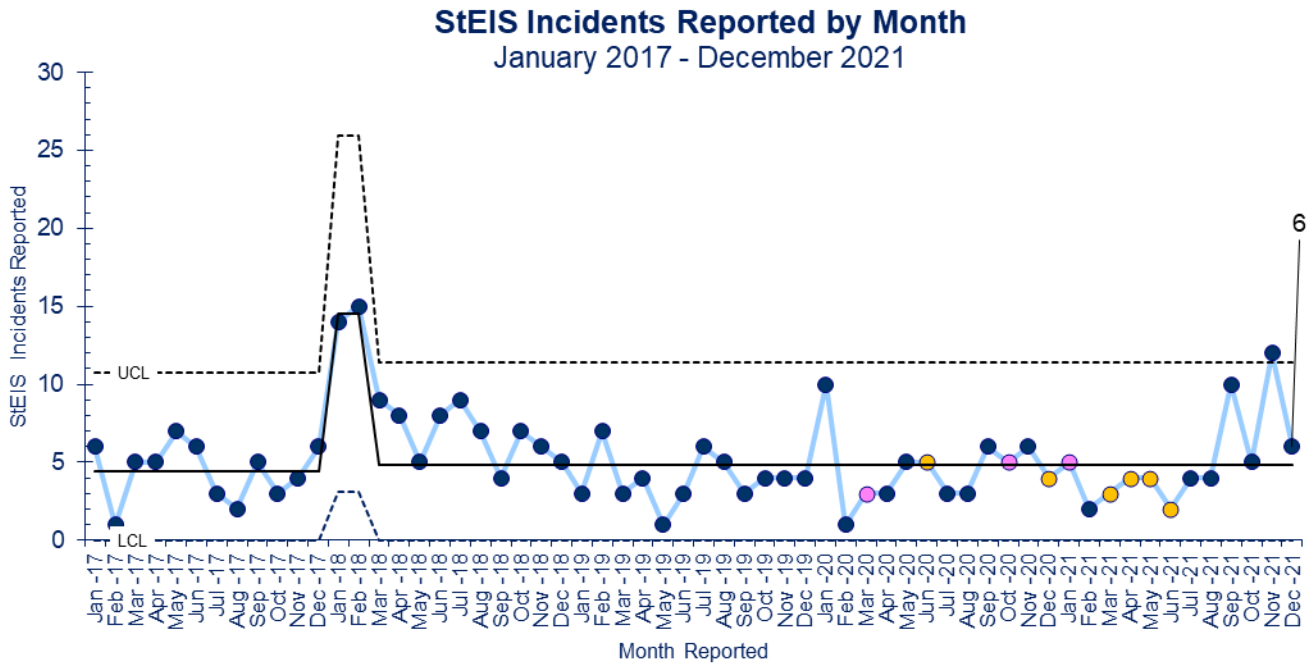
The risk scoring, management and learning from safety incidents remains a priority. The patient safety management team meet with each area and head of service on a regular basis to discuss a plan for recovery of their back log and a goal to get safety incidents scored and closed in a timely manner. Establishing a collaborative approach to investigations and complaint closures has been key moving through December and continues in to 2022.

The Patient Safety Team have completed recruitment of a case worker for the risk 1-2 complaints, but still await approvals for vacancy lines across the team. Furthermore, staff abstractions were high in December due to the Omicron variant and annual leave over the festive period.

The closure of incidents in a timely manner continues to be a goal moving in to 2022 and will be reported via Quarterly right care strategy updates to the Quality and Performance Committee.

Q3 SERIOUS INCIDENTS

Figure Q3.1



* Lockdown Easing of Restrictions

Serious Safety Incidents

6 Serious safety Incidents (SIs) were reported in December 2021. in recent months the variation in the number has increased with November showing special cause variation being over the upper confidence limit.

9 SI reports were due with the commissioners in December 2021. 5 were submitted within the 60 day timescale. A further 1 which had an extension was submitted within the extended timeframe.

3 where submitted after their due date.

Significant work has been undertaken to ensure quality and safety, learn from previous serious incidents and ensure clinical support within the EOC.

This work is described in more detail in the recently published Quality Account : Quality Account 20/21 – NWAS Green Room

Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received (Jan 21 – Dec 21)	Number of Alerts Applicable (Jan 21 – Dec 21)	Number of Open Alerts	Notes
CAS/ NHS Improvement	28	0	0	

Safety Alerts	Number of Alerts Received (Jan 21 – Oct 21)	Number of Alerts Applicable (Jan 21 – Oct 21)	Number of Open Alerts	Notes
MHRA – Medical Equipment	3	0	0	

Safety Alerts	Number of Alerts Received (Jan 21 – Dec 21)	Number of Alerts Applicable (Jan 21 – Dec 21)	Number of Open Alerts	Notes
MHRA - Medicine Alerts	49	0	0	

Safety Alerts	Number of Alerts Received (Jan 21 – Dec 21)	Number of Alerts Applicable (Jan 21– Dec 21)	Number of Open Alerts	Notes
IPC	1	1	0	Coronavirus is a viral disease (COVID-19). The Delta variant (Indian variant) is the prominent variant in the UK and there is an increase of cases in the North West. 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 by L Yeomans (Lead and DIPC) and the Executive Leadership Committee (ELC).

NWAS Response

There has been **7** new safety alerts in December 2021.

The total number of CAS/NHS Improvement alerts received between November 2020 and October 2021 is **28**, with no alerts applicable.

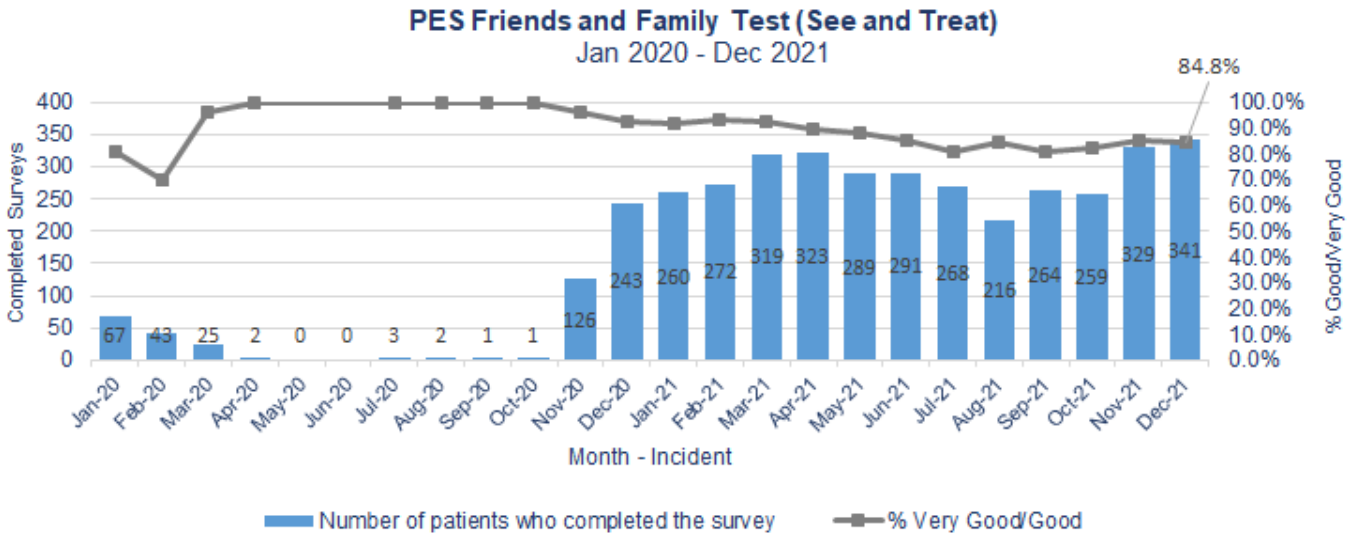
3 MHRA Medical Equipment Alerts have been received with no alerts applicable.

49 MHRA Medicine alerts have been received, with no alerts applicable.

1 IPC alert have been received, with **1** alert applicable.

E1 PATIENT EXPERIENCE

Figure E1.1



Patient Experience

The service line narratives and data below relates to all our patient respondents' feedback. We have started to explore any variation in the data related to equality, diversity and inclusion measures and more detail together with associated charts will be reported in future reports. In addition, potential service improvements are also being discussed with service line improvement ambassadors on a monthly basis.

Patient Experience (PES)

Returns for December, **341** were **3.6%** greater than that for November 2021, at **329**, with comments matched (**242** for November and December). The satisfaction level is **84.8%** for December.

Where respondents indicated **'very good/good'**, the corresponding themes continue to be around; speed of response, being treated with kindness; dignity and respect, the empathy, reassurance provided both on the phone and by the paramedics, teamwork and professionalism of the paramedics and explanation of what was being done and why.

Comments included:

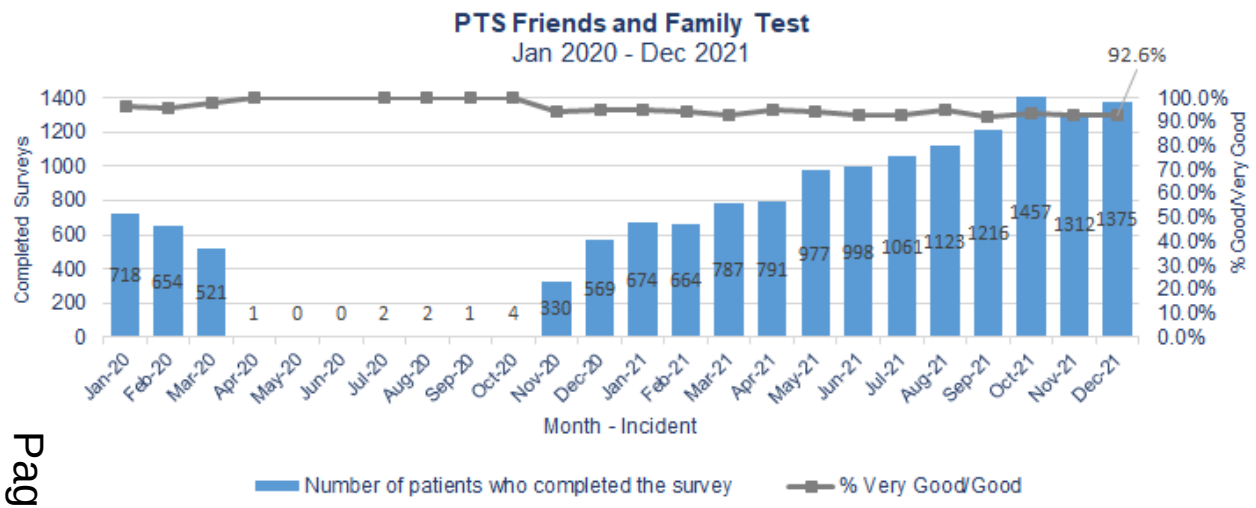
- *"The two ladies who came were very kind, caring & extremely efficient. They could not have done more to put my mind at ease, plus they had the nightmare of getting through to my Dr for me & managed to get a prescription over the phone from Hertfordshire to Crewe."*
- *"Excellent came within half an hour & stayed with patient also getting him care with the district nurse, & sorting his needs very impressed with the service , as i had found him lying in porch for over a couple days."*
- *"Very patient with my hard of hearing dad, very respectable, knowledgeable but also made everyone feel at ease."*

Where respondents indicated '**poor/very poor**', the corresponding themes were around response times, poor attitude, lack of empathy and poor patient care.

Comments included:

- *"Having first phoned for help at 10:00 in the morning.. I received a call to say how sorry they were the length of time it's taken for the ambulance... That call came at 7:40 that night.... Ambulance did turn up at 3:30 the next morning..."*
- *"Waiting 9 hours is ridiculous, I would have happily gone to hospital or out of hours, if advised at first point of call. Issue not with the wonderful staff but the ridiculous processes in place."*
- *"I waited over 9hours for an ambulance to come out to my son he had COVID-19."*

Figure E1.2



Patient Experience (PTS)

There were **1,375** returns for December, **4.8%** more than that of **1,312** for November. Comments also saw an increase, **6.2%**; (**1,120** for December and **1,051** for November). The overall satisfaction level for December is **92.6%**

Where respondents indicated '**very good/good**', the corresponding themes continue to be around polite, friendly and helpful staff, efficient and excellent service, timely pick up, being treated with dignity and respect, patient comfort and safety, along with professionalism. Comments included:

- *"The driver was exemplary in every way. She was punctual, road worthy, law abiding driving exactly to the speed limit. Further, she was polite, friendly, helpful and she escorted me to the reception desk and collected me promptly. I was unwell after my procedure and unsteady on my feet, so she took me back to her car in a wheelchair. I cannot speak highly enough of this lady,, she is a credit to your service. Thank you."*
- *"It's always a pleasure to ride on a stretcher with patient transport I feel safe, happy & relaxed by the time I reach my appointment. Absolutely amazing staff. I could list a multitude of reasons why I've given the highest number. Please pass on how I've appreciated everyone they have been amazing!!"*
- *"Easy to book. Driver on time, friendly and polite. Car was clean and comfortable and good safe driver."*
- *"Crew, absolutely brilliant they looked after me & were very friendly but very professional & even remembered me from years ago and asked was my cat still alive!! Yes!"*

Where respondents indicated '**poor/very poor**', themes included booking problems, equipment and taxis. Comments included:

- *"Twice they sent the wrong transport with no seat for Carer when it was booked for Carer waited in waiting room 2 1/2 hours with 79-year-old who had no lunch no hot drink and no dinner time medication due to this mix up, the first transport said they would let control know that they needed a different vehicle to allow for a Carer, this obviously didn't happen as another one arrived without an extra seat."*
- *"Accepted 92-year-old dementia client unescorted, and she was waiting from 3pm to be collected when she was still there 7pm ALONE! Family member had to travel 30mile to collect her and return her to care home."*
- *"The 1st ambulance that came could not take me because the winch wasn't working and in a very impolite manner said we couldn't push me on because it's not acceptable and if we fell, she didn't want to go to coroners court. She made me feel very uncomfortable and we feel she was very rude and unprofessional."*
- *"Was sent a taxi to the hospital and he refused to drive round the back, so I was left at main entrance. I had to walk all the way. I said I needed a wheelchair when I booked. The walk caused unbearable pain.."*
- *"Pick up to go to hospital was fine, but to wait several hours following appointment, which was at 2pm, meant it was 7.25pm before I got home. I was tired, stiff and hungry as well as quite upset by mix up with taxis."*

Figure E1.3

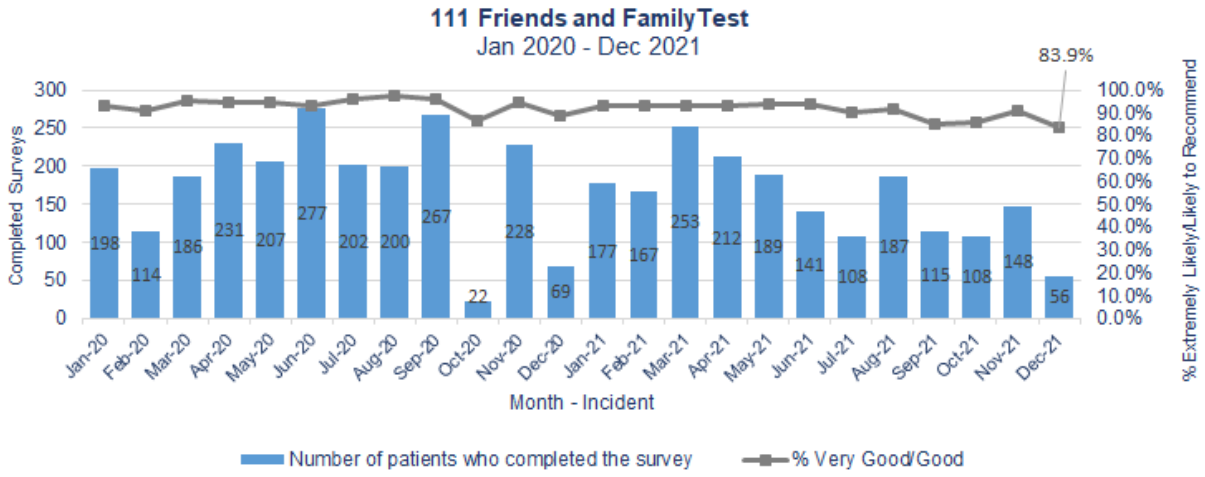
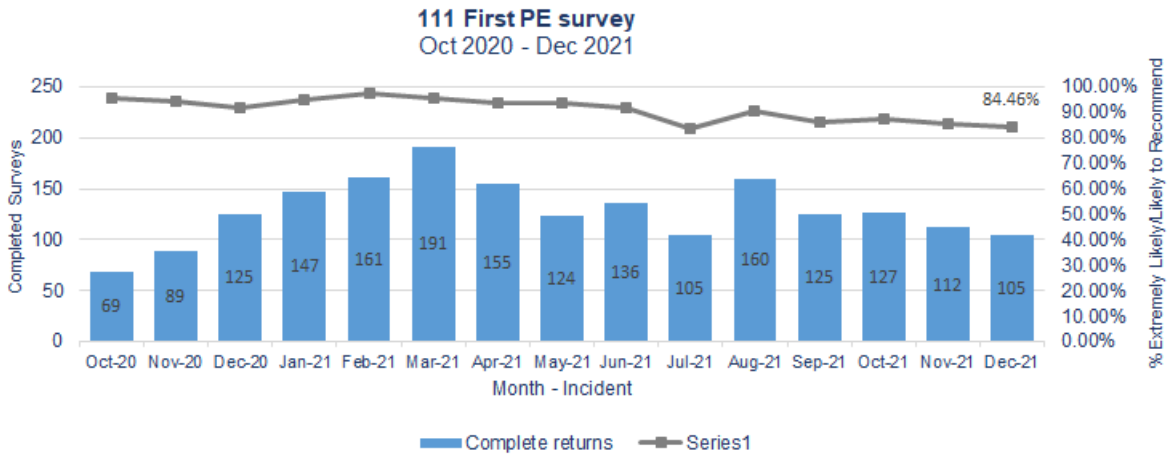


Figure E1.4



NHS 111 First

The above high level summary table shows the number of returns and the levels of overall patient satisfaction. Cumulatively since the service commenced last August, 91.39% (previously 92.28%) of patients describe their experience as '**very good/good'** and 94.53% (previously 95.01%) of patients felt their need for calling the service was met.

Patient Experience (NHS 111)

There was a **62.2%** reduction in returns for December of **56** compared to **148** for November. *(This is attributed to the time lag between sent and return as these are sent out weekly, hence this data only shows returns from service users from week 1 and 2 of December.)* With the low level of returns, we see an **83.9%** likelihood of recommending the service, a drop of **7.3%** compared to the previous month of November at **91.2%**.

Where respondents indicated they were '**extremely likely/likely**' to recommend the service, themes included: clear advice and helpfulness, reassurance and empathy, professionalism, hospital/GP referral and booking process and speed of response. Comments included:

- *"I couldn't get an app with my GP and was told to call 111. They then booked me an appointment with my own GP.*
- *"The person I spoke to was very pleasant, knowledgeable and clear in what was going to happen next. I was told I was going to receive a call from a health care professional at a certain time and I did."*
- *"The person I spoke to was clinically knowledgeable (unlike GP receptionist). They couldn't have been more helpful. They were professional but also very understanding. As my problem is an ongoing one, I was also given advice on how to access further medical help, if necessary, via NHS 111. Your staff are a credit to the NHS."*
- *"Very calm. Understanding of the problem. Reassurance, everything would be OK."*
- *Non-judgemental practitioner. Clear advice. Calm and friendly. Honest."*

Only 6 respondents indicated they were '**extremely unlikely/unlikely**' to recommend the service during this period, sample comments included:

- *"Initial call was too scripted and did not really give flexibility to take into account specific issues. Eventually NHS 111 advised I would get a call back for assessment. 5 hours later I received a call apologising that health professional still not available. At this point initial call was cancelled."*
- *"Keeping you on the phone for hour not good enough."*
- *"What is the purpose of this number? No help or advice provided called for antibiotics and no help was given."*

Table E1.1

2021 - 2022 Patient Engagement Surveys Summary of Key Demographic Data (Q1 - Q2)		PTS (URL Link)*	PES (URL Link)*	UCD (URL Link)*	PTS FFT (SMS Text)	PES FFT (SMS Text)	111 (Postal)	111 First (Postal)
Patient Age	Under 16 yrs	2.3%	0.0%	2.7%	1.4%	0.8%	3.4%	8.8%
	Over 45+ yrs	90.1%	76.8%	64.9%	91.9%	65.5%	71.5%	64.8%
	Over 75+ yrs	19.1%	29.0%	29.7%	29.5%	10.5%	20.7%	16.9%
	Over 85+ yrs	5.7%	10.8%	13.5%	7.9%	3.9%	No data	4.2%
Patient Gender	Female	53.8%	54.8%	64.9%	53.3%	61.9%	61.1%	61.1%
	Male	44.7%	45.2%	32.4%	46.7%	34.2%	37.3%	38.1%
	Prefer not to say	1.5%	0.0%	2.7%	0.1%	3.9%	1.6%	0.8%
Patient Declared Condition	Limiting illness	n/a	n/a	n/a	n/a	n/a	37.4%	n/a
	None	14.9%	38.6%	43.2%	9.1%	52.7%	58.1%	46.9%
	Mobility	60.3%	32.4%	16.2%	51.6%	14.2%	n/a	10.8%
	Hearing	13.4%	15.1%	2.7%	1.0%	1.6%	n/a	7.6%
	Visual	8.4%	5.0%	0.0%	4.0%	0.7%	n/a	1.8%
	Mental Health	9.9%	17.8%	21.6%	2.0%	8.2%	n/a	6.1%
	Dementia	n/a	n/a	n/a	0.7%	2.3%	n/a	1.5%
	Learning	4.6%	3.1%	5.4%	0.8%	1.0%	n/a	2.4%
Patient Ethnicity	(Black & Minority Ethnic Communities)	3.8%	3.1%	2.7%	5.5%	9.0%	6.0%	3.9%
	Prefer not to say	2.3%	0.8%	8.1%	2.2%	2.9%	0.0%	1.5%
Demographic Data Request	No response	0.0%	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%

EDI

Table E1.1 shows percentage breakdown of respondents by demographics for our PES, PTS, NHS 111 and NHS 111 First surveys as well as where we have received FFT feedback via SMS on our PES and PTS service lines. Some key headlines show

- Over **90%** of PTS respondents are over 45 years of age.
- Over **60%** of NHS 111 respondents are female.
- Nearly **85%** of PTS respondents declared their disability.
- An average **5%** of all respondents were from ethnic minority communities.
- Just **2.5%** of all respondents preferred not to declare their ethnicity.

The next step is to understand if our response rates represent the communities proportionally and to understand if there is a difference in patient experience score for different groups.

We are working to improve our capturing of ethnicity data and have begun a digital sprint to enable the sharing of ethnicity data cross our systems – for example pulling it from cleric in to our EPR as we are much more likely to have the information captured in 111.

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Cardiac Outcomes over time (SPC)

Figure E2.1

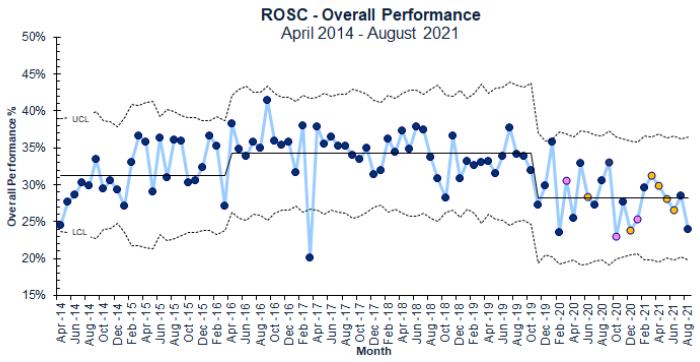
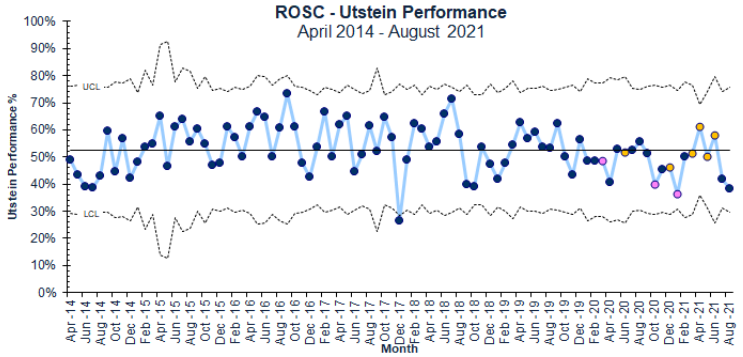


Figure E2.2



* Lockdown Easing of Restrictions

Figure E2.3

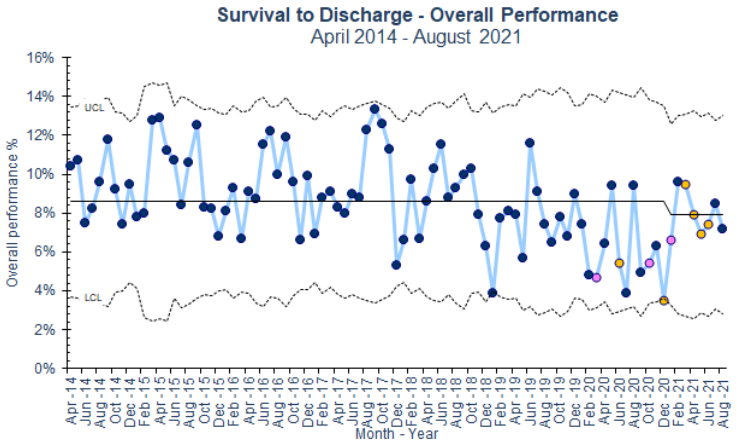
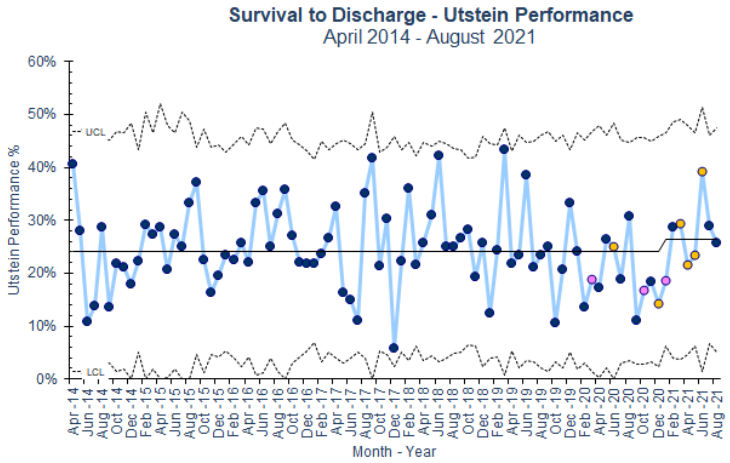


Figure E2.4



ACQIs (Last data point: August 2021)

August 2021's data see us within normal limits and close to the mean across all indicators with the exception of ROSC which is below mean performance although within limits, signalling no significant change overall. The lag in data publication impacts upon the ability to assess or understand reasons behind this as well as the ability to evaluate the impact of any recent work undertaken to improve in these areas.

E2.1 ROSC & E2.2 ROSC (Utstein)

The ROSC achieved for the Utstein group was 38.1**%** (national mean **46.8%**), For the overall group the rate was **24%** (national mean **25.8%**). This indicator is predominantly influenced by pre-hospital factors.

E2.3 ROSC Survival to Discharge & E2.4 ROSC (Utstein) Survival to Discharge

Survival to Discharge rates overall in August 2021 were at **7.2%**. representing no significant change.

In August 25.6**%** of patients in the Utstein group survived to hospital discharge; the national mean was **28.6%.** This remains within the control limits.

This indicator can be considered as a 'system indicator' and is influenced by in-hospital factors, overall system pressures as well as pre-hospital performance.

Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

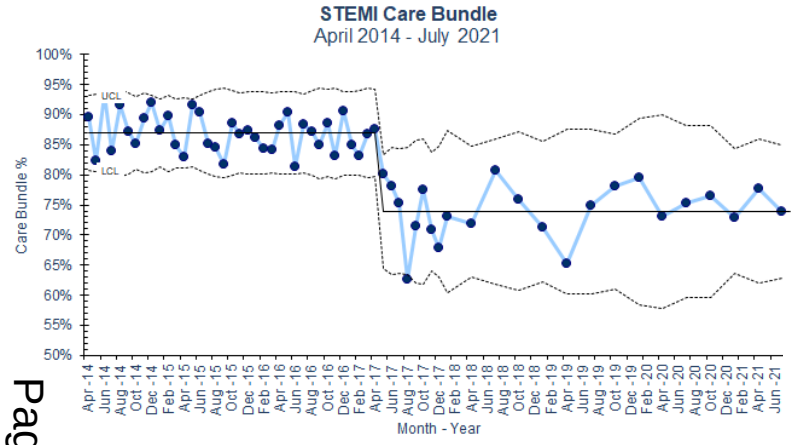
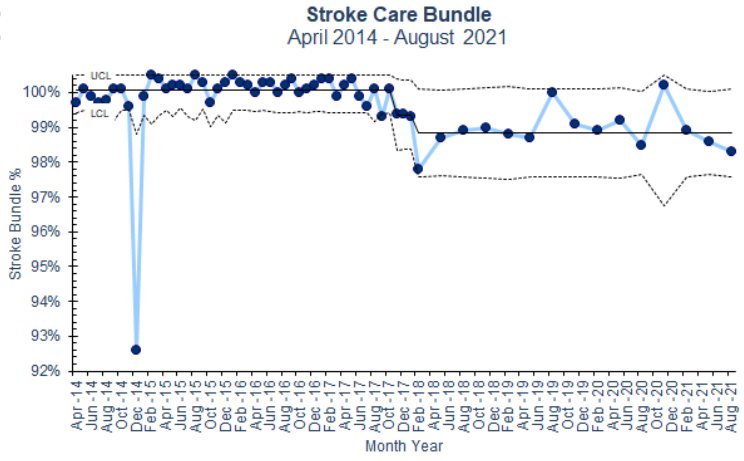


Figure E2.6



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).

Care Bundles

STEMI (2.5): STEMI care bundle performance was not reported for August 2021 as is consistent with the NHSE schedule.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of **2h 27mins**; the Trust's performance was **2h 39mins.**

Component of STEMI care bundle	Exceptions
Aspirin given	• Patient refusal • Contraindication to the drug • Cautions if clear reasons provided
Glyceryl trinitrate (GTN) given	• Patient refusal • Contraindication to the drug • No Chest Pain
Two pain scores recorded	• Patient refusal • Patient unable • Patient unconscious
Appropriate analgesia given –options available are Morphine, Entonox and Paracetamol	• Patient refusal • Patient not in pain • Contraindication to the drug(s) • Cautions if clear reasons provided

STROKE (2.6): Stoke care bundle performance for August 2021 was 97.8% (national mean also 97.8%).

Mean call to hospital arrival for stroke was **1h:43min** in August 2021, exactly the same as the national mean time (**1h 43min)**.

Component of stroke diagnostic bundle	Exceptions
FAST assessment recorded	• Patient refusal • Patient unable
Blood glucose recorded	• Patient refusal
Systolic and diastolic blood pressure recorded	• Patient refusal

The audit process will be undergoing a transition with the implementation of the EPR. NHS E/I have been informed of any associated potential disruption to the returns

F1 FINANCIAL SCORE

Figure F1.1

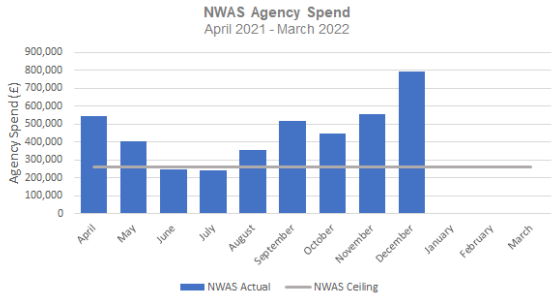


Figure F1.2

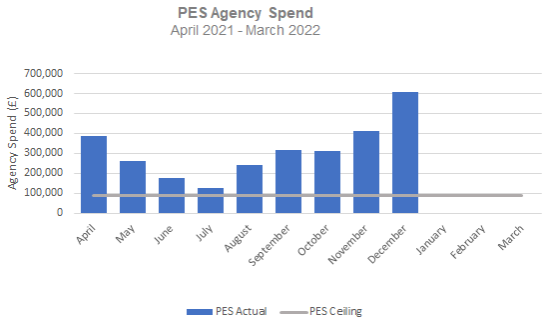


Figure F1.3

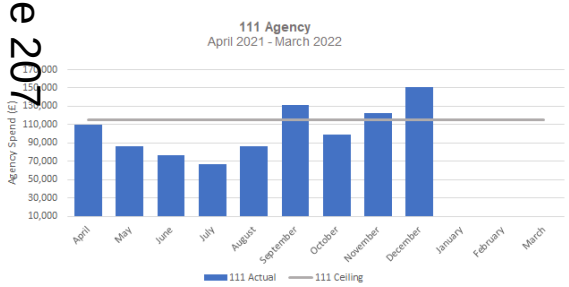


Figure F1.4

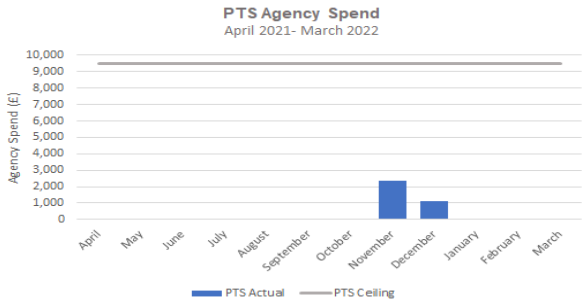


Figure F1.5

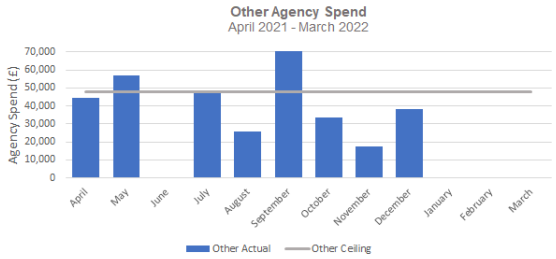
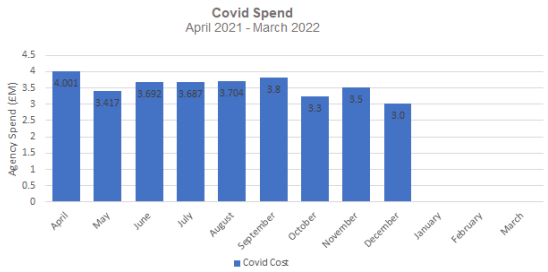


Figure F1.6



Finance Position

Month 9 Finance Position

As at month 9 (December) the trust is recording a surplus position for the year to date. H2 (October to March) income has been agreed along with additional top up elements for covid & winter pressures, spend related to these top ups is monitored and we are bringing in additional staff as appropriate to help operational performance. It is expected that the trust will finish the year in a break even position due to cost pressures expected in the January to March period.

Agency Expenditure

The year-to-date expenditure on agency is **£4.103m** which is **£1.771m** above the year-to-date ceiling of **£2.332m**.

Please Note: The agency ceiling is based on 2019/20 ceiling figures, no further updated has been received from NHSE/I.

Risk Rating

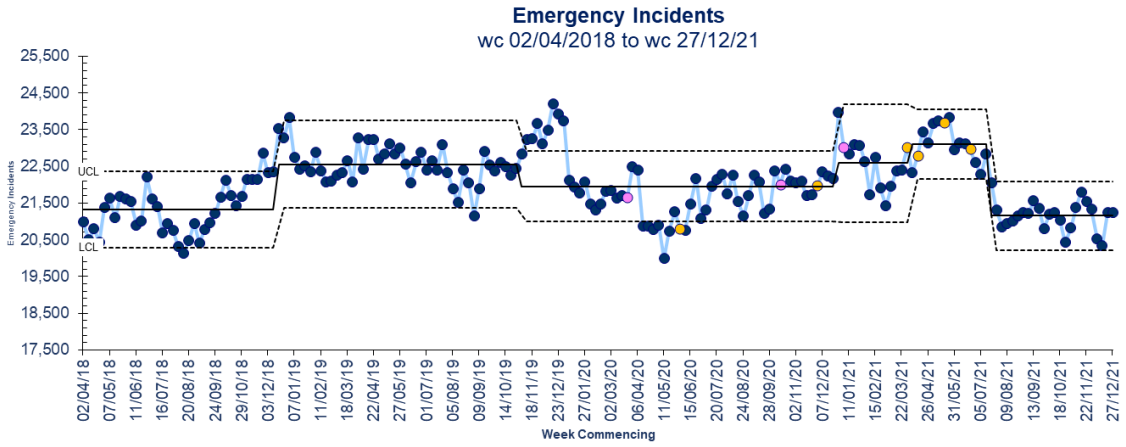
The COVID-19 financial framework in place for H1 (1 April 2021-30 September 2021) and the redesigned monthly financial returns collect a minimum dataset to reduce the burden on organisations wherever possible, has remained in place for H2 (1 October 2021 - 31 March 2022).

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.

E3 ACTIVITY & OUTCOMES

Figure E3.1 Activity by Sector (Deeper shade is more)

Figure E3.2



* Lockdown Easing of Restrictions

Activity:

In December 2021 the Trust received **143,568** calls of which **92,294** became incidents. Compared with December 2019, we have seen a **7%** increase in calls and a **12%** decrease in incidents. The data are signalling special cause variation in the number of incidents with the data being on the lower confidence limit for both WC 6th and 13th of December(Figure E3.2). This is due to the use of signposting (self transport or other services).

Dec	Calls	% Change from 2019	Incidents	% Change from 2019
2019	134,607		104,810	
2020	109,842	-18%	99,062	-5%
2021	143,568	7%	92,294	-12%

Figure E3.1 shows the regional footprint of NWAS with the borders of each sector delineated. The deeper the shade of green the more activity in that sector. We can see from the sector map for December that Manchester South has the greatest volume of incidents with Mersey North and GM Central, GM West and GM East also showing high levels of incidents compared with other sectors. This correlates with the incident heat map and the city regions of Manchester and Liverpool. This is aligned to population density and where the majority of resource will be based.

H&T, S&T, S&C Outcomes

For December we achieved **10.9%** Hear and Treat and ranked 6th nationally. See & Treat marginally increased to **30.1%** but is within normal limits and we are ranked 9th nationally. In total there was an aggregate non-conveyance of **41.8%**.

Figure E3.4

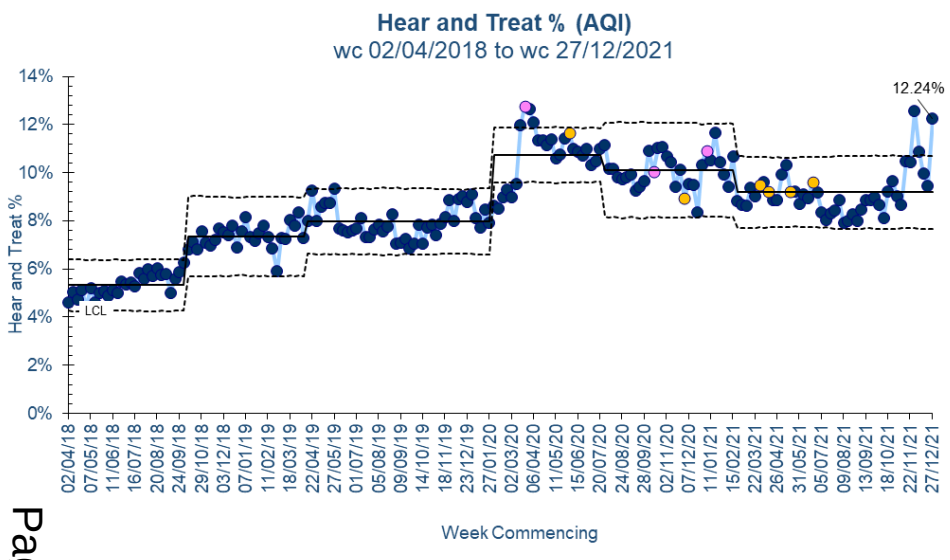


Figure E3.5

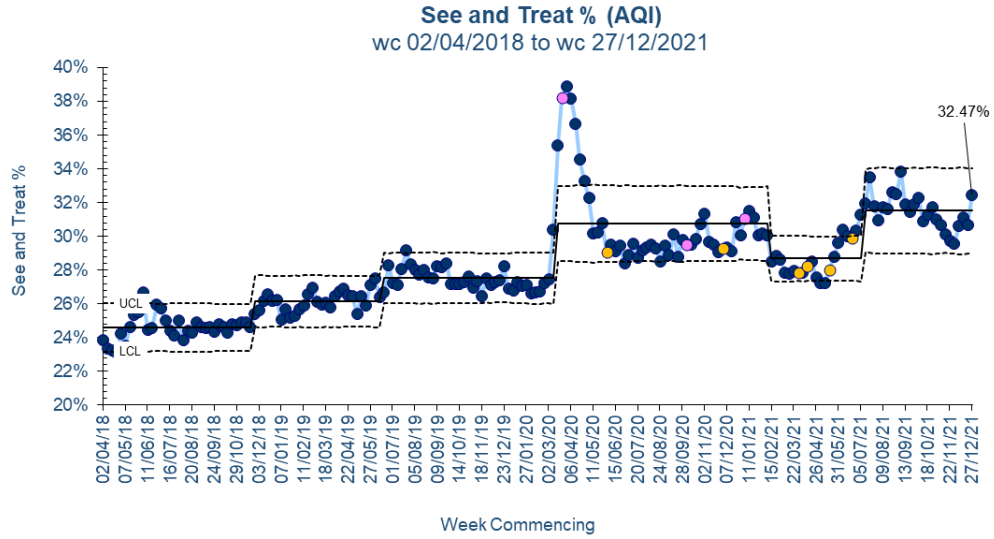
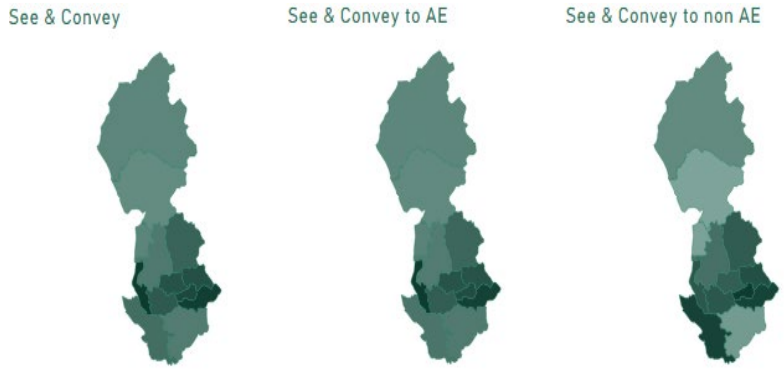


Figure E3.6



**the darker the colour the higher the level of activity*

* Lockdown Easing of Restrictions

- **Hear and Treat rates** had been consistent since June at around **9%**. On 17th December 2021 a new process went live in EOC/Clinical Hub for call C3/C4 Validation. The process enables C3/C4 incidents to be 'hidden' from Dispatch until Clinically validated by a Clinical Navigator. This has enabled smarter working allowing clinicians time to review incidents before an ambulance is allocated. Since this change there has been a stepped increase in performance, averaging around **12%**. The Clinical Hub continues to split its focus between patient safety, Crew Advice and Hear & Treat.

- **See and Treat rates** vary between sectors and are contingent on primary care and out of hospital commissioned services responding promptly to requests for clinical consultation. We have seen the percentage of calls triaged into higher acuity categories is increasing however on face-to-face assessment patients are not necessarily as acutely unwell as the initial triage would suggest therefore we are maintaining higher levels of S&T despite an increase in acuity.

- **See and Convey rates** The maps in E3.6 show this variation by sector and it is possible to see that areas like Morecambe Bay, Fylde and South Manchester have lower 'see and convey' rates than for other sectors within NWAS. The reason for their success is being reviewed and learning shared through the Right Care at Home Collaborative. However, this is still in pilot and will need time to mature and significant focus to have widespread impact across NWAS. The transformation team, community paramedics, frequent caller team and mental health team are also focussed on these efforts.

Outcome Provider Comparison Figures December 2021

Figure E3.7

Provider	Hear & Treat
	17.1%
	15.9%
	12.7%
	12.5%
	11.9%
North West	10.9%
	10.7%
	9.5%
	9.4%
	9.4%
	8.3%

6/11

FigureE3.8

Provider	See & Treat
	39.1%
	34.5%
	33.0%
	32.9%
	32.9%
	32.5%
	31.8%
	31.4%
North West	30.9%
	28.3%
	26.6%

9/11

Figure E3.9

Provider	See & Convey
	51.1%
	51.4%
	52.6%
	53.0%
	55.1%
	57.7%
	58.1%
North West	58.2%
	58.9%
	60.7%
	61.0%

8/11

- **HEAR & TREAT**: The Trust has improved its performance on Hear and Treat when compared with the rest of the ambulance sector and is in **6th** place. This is due to the increase in C1 and C2 incidents, the introduction of the C3/C4 validation process and the re-direction of clinicians within our clinical hub to stack management and patient safety. The trust is working closely with clinical assessment service providers to increase the number of calls closed through the clinical assessment service and this is likely to improve H&T throughout Q4. As part of the winter initiatives, we are also increasing the number of clinicians within contact centres.

- **SEE & TREAT: The Trust is preforming 9th in the national rankings.** In August 2020 we moved to **9th** and remained in that position moving to **5th** in October and November before moving to **7th** in November and **9th** in December. The RIGHT care at Home Improvement Programme is working with 3 health economies (with the most challenged A&E systems) to increase See and Treat Rates. These are multiagency improvement programmes which are overseen by the Chief of Regulatory Compliance and Improvement and the Director of Quality, Innovation and Improvement.

- **SEE & CONVEY:** See and Convey rankings were steadily improving between Jan 2018 and September 2019 but since October 2019 we have been ranked **9th** out of 11 ambulance services apart from September and December 2021 when the trust was ranked **8th**.

NOTE: There is a robust improvement plan in place to increase both hear and treat and see and treat rates, supported by commissioners and regulators.

O1 CALL PICK UP

Figure O1.1

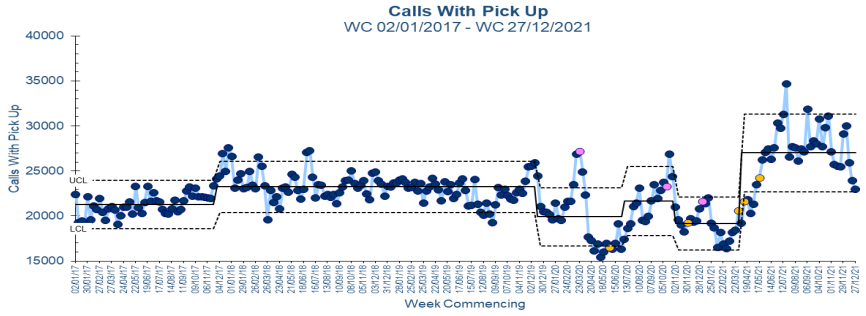


Figure O1.2

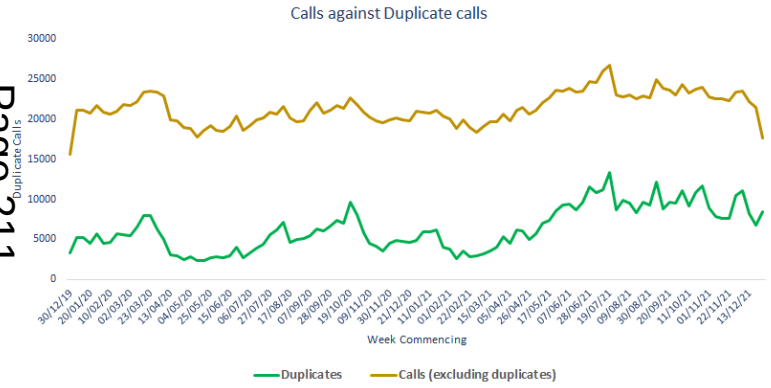
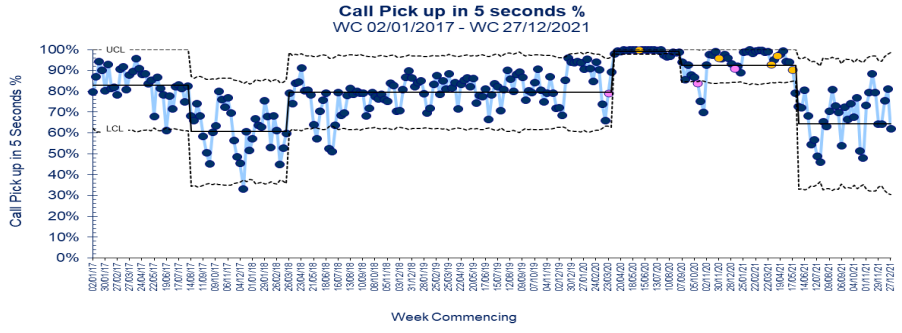


Figure O1.3



* *Lockdown* *Easing of Restrictions*

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: Call pick up performance for December 2021 has deteriorated vs November 2021 but has improved across all measures compared to October 2021.

Mean call answer 28 seconds
90th centile call answer 1 min 30 seconds
95th centile call answer 2mins 16 seconds
Percentage of calls answered within 5 seconds 68.64%

National Context: The deterioration is also reflected across the ambulance sector compared to November 2021. Two-minute delays increased by **2,880** nationally for December 2021 against November 2021. Both months represent an improved position against October 2021. Nationally and specific to NWAS the factors influencing call pick are common. Demand remains high and variable across the sector, which creates complexity in respect to workforce planning. From around the 20th of December abstractions of staff (specifically related to COVID) became the predominant challenge. Across NWAS's EOC the rate of COVID positive staff increase **900%** between December 22nd and December 30th. This trend was broadly mirrored nationally. Despite these challenges and not delivering CPU performance to the indicated standards, NWAS continues to perform well when compared to English Ambulance Trusts. NWAS was the second-best performing Trust for national 999 mean call handling performance.

Figure O1.1 reflects the increase in call volume NWAS continue to face. However, for the month of December we have observed activity returning to previous control limits. Daily and intraday activity remains highly variable with no true pattern of demand. Inevitably weekend activity has increased as we moved towards the festive period. The current indicators suggest activity will reduce or certainly not return to levels observed through the autumn period. In reality, activity is less of a challenge currently, abstractions rates are the primary pressure.

Figure O1.2 reflects the pressure created by duplicate calls. BT introduced a filter process where calls that are purely for ETAs (vs worsening presentation) in November. This both for NWAS and nationally has delivered limited benefit. Less than **1%** of call at peak are deflected via this process. As operational abstractions increase and response times also increase, the pressure of duplicates follows the same trend. Duplicates continue to add complexity and reduce CPU performance.

NWAS has delivered a significant uplift in call handling staff and has maintained the planned recruitment trajectory. This has ensured NWAS continues to perform well vs the sector. This has not delivered the anticipated improvements in CPU due to demand and abstractions.

O2 A&E TURNAROUND

Figure O2.1

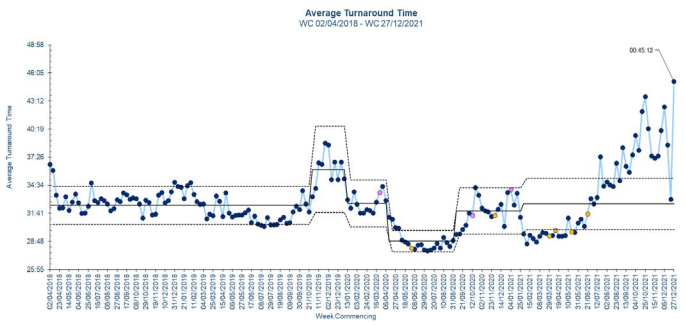


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Jan-21	53,179	33:00	21:58	11:08
Feb-21	47,620	29:09	17:47	11:17
Mar-21	54,174	29:25	17:57	11:42
Apr-21	53,552	29:26	18:14	11:18
May-21	57,212	29:56	18:46	11:17
Jun-21	52,324	31:20	20:11	11:24
Jul-21	51,396	34:16	23:12	11:20
Aug-21	49,377	35:06	23:45	11:32
Sep-21	47,467	36:49	25:26	11:41
Oct-21**	38,181	39:27	27:56	11:25
Nov-21	48,412	38:29	27:28	11:34
Dec-21	47,723	39:22	27:58	11:18

Figure O2.2

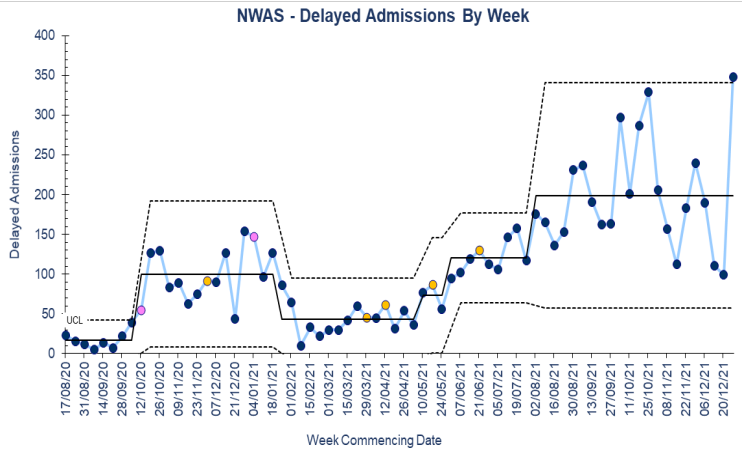


Table O2.2

Month	No. of Delayed Admissions
Aug-20*	38
Sep-20	46
Oct-20	355
Nov-20	347
Dec-20	406
Jan-21	528
Feb-21	129
Mar-21	182
Apr-21	196
May-21	282
Jun-21	491
Jul-21	585
Aug-21	674
Sep-21	902
Oct-21	1156
Nov-21	739
Dec-21	824

*Data only started being collated from 17/08/2020
Increased data capture made possible from October 2020 due to use of Call+ to record Delayed Admissions

** Data for WC 25/10/21 missing due to data issue

A&E Turnaround Times

Average turnaround time was **39:22** (Table O2.1). This is the seventh consecutive month that the trust has not met the standard of 30 minutes and the 8th time in 12 months that the standard has not been met. The increase is primarily in the arrival to handover time which has increased from **18.46** in May to **27:58** in December (Table O2.1)

5,582 attendances (11.7%) had a turnaround time of over 1 hour, with **491** of those taking more than 3 hours. We have seen an 11% increase with comparison to Novembers' figures. In December, **824** cases of delayed admissions were reported – up from **739** reported in November (Table O2.2). In December we lost **1,520** hours to delayed admissions - up from **1,320** hours in November. Below are tables showing both the 5 trusts with the highest mean arrival to handover time and the most hours lost due to delayed admissions.

Top 5 Trusts with the highest Arrival to Handover time	
Trust	Mean Arrival to Handover time
Royal Oldham	00:42:18
Royal Albert Edward Infirmary	00:41:23
Fairfield General	00:38:56
Royal Bolton	00:35:03
Whiston	00:35:00

Top 5 Trusts with most hours lost due to delayed admissions	
Trust	Hours lost to delayed admissions
Royal Oldham Hospital	320.2
Fairfield General Hospital	310.6
Royal Preston Hospital	190.8
Blackpool Victoria Hospital	180.3
North Manchester General Hospital	142.9

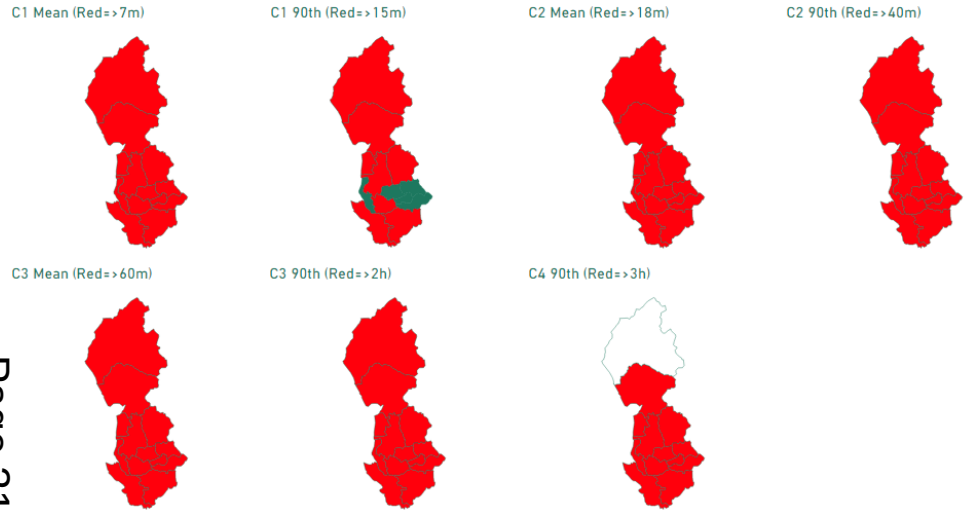
Over the last seven months we have seen overall turnaround time exceed the standard of 30 minutes (Table O2.1) and this has increased each month apart from November. This is challenging for the trust and the wider system, however the results remain consistent within a tight distribution with a number of trusts who have high turnaround times. The system has started to see increased staff abstractions due to the omicron variant. The trust continues to work with those most challenged trusts and is also ensuring a focus on patient safety while the system is challenged.

The number of delayed admissions has been deteriorating month by month peaking at **1,156** in October. In November and December we have seen the number reduce with **739** and **824** delayed admissions respectively. Despite the peak being during October there is a general upward trend over time and the highest weekly number of delayed admissions occurred in WC 27/12/2021 (Figure 02.2)

Whilst performance for turnaround is outside the standard we are seeing similar performance around the country for other ambulance trusts. The increase is of high priority as seen by the head of NHS England & Improvement writing to acute trust to ask for improvement in this area. During December the trust has started to test and implement the delayed handover crew and managers escalation action card.

O3 ARP RESPONSE TIMES

December 2021



The heat maps show the sectors within NWAS where the standards are being met. It is important to note that:

1. **C1 mean: No** sector met the standards for C1 mean
2. **C1 90th: Five** sectors (Mersey North, , Manchester West, Manchester East, Manchester Central and Manchester South) met the standards
3. **C2 Mean: No** sector met the standard
4. **C2 90th: No** sector met the standard
5. **C3 Mean: No** sector met the standard
6. **C3 90th: No** sector met the standard
7. **C4 90th: No** sector met the standard

measures are meeting standard

measures are below standard

Activity: ARP Response Times

For December, response time targets were not met for any ARP measures. This continues the position from November. This is the third time since January 2018 that the trust has not met the standard of 15mins for C1 90th. The majority of ARP standards are showing special cause variation, this is due to a number of factors that are covered below.

There are a number of reasons for worsening performance:

- A further significant increase in delayed admissions with average turnaround time continuing to be above the 30m standard and increasing month on month. This has increased significantly over the past few weeks, contributing to the deterioration in response standards.
- Continuous high call levels which has partly been driven through an increase in duplicate calls.
- During recent months we have seen increasing acuity of our patients. C1 calls have risen from 9% to 16%, C2 calls have risen from 52% to 55%. This means that 77% of all our incidents are in the highest categories and reduce our opportunities for Hear & Treat and See & Treat.
- Increased abstraction rates (Covid positive, Isolation & non covid related sick) have directly contributed to performance during the month.
- High sickness rates in the care sector are leading to Acute Trusts being unable to discharge patients when they are medically able to.

The trust has taken a number of measures to improve performance and maintain patient safety including an agreed 6 point plan (jointly with commissioners and the 4 ICS footprints) focused on reduction in lost hours, reduction in conveyances to hospitals, reduced handover times, improvements in community access and access to mental health services.

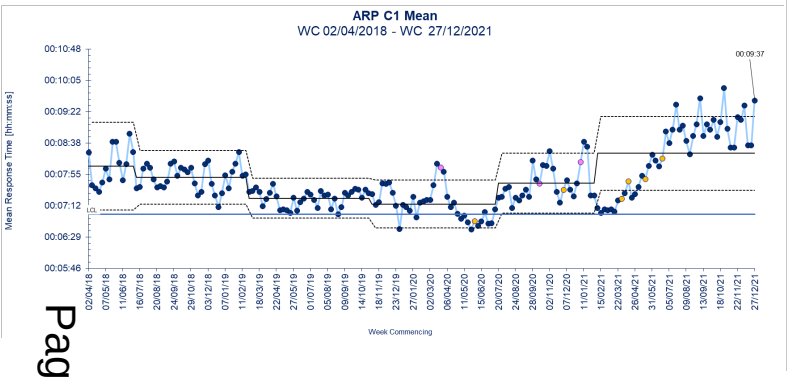
The £6.2M for increase for winter is being used for

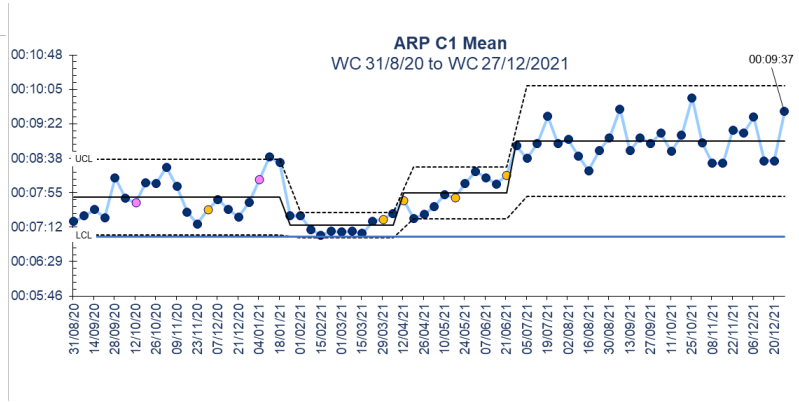
- Increase in 999 call handlers
- Expanded capacity for crews on the road
- Additional clinical support
- Extended HALO (Hospital Ambulance Liaison Officer) cover
- Retention of Emergency Ambulances to increase the fleet for winter

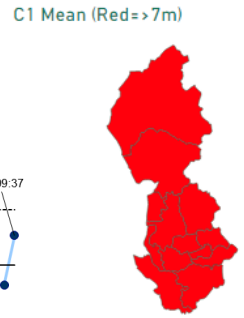
In addition to the implementation of the Trusts 6 point plan NWAS has now enacted MACA. MACA will see 150 army personnel deployed to increase operational resource. This will increase DCA production and improve response times to lower acuity patients (C3 & C4). The employment will comment from 17th January 2022. We have also Increased internal access to rapid covid testing to support people returning to work.

We continue to focus on patient safety with a particular focus on long waits to ensure we avoid patient harm. We have not seen an increase in serious incidents reports (section Q3). We are also seeing patient satisfaction levels remaining constant (section E1).

Figure O3.1

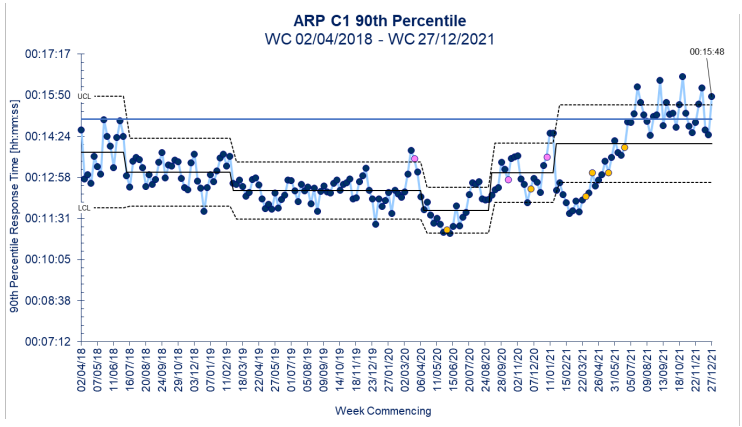


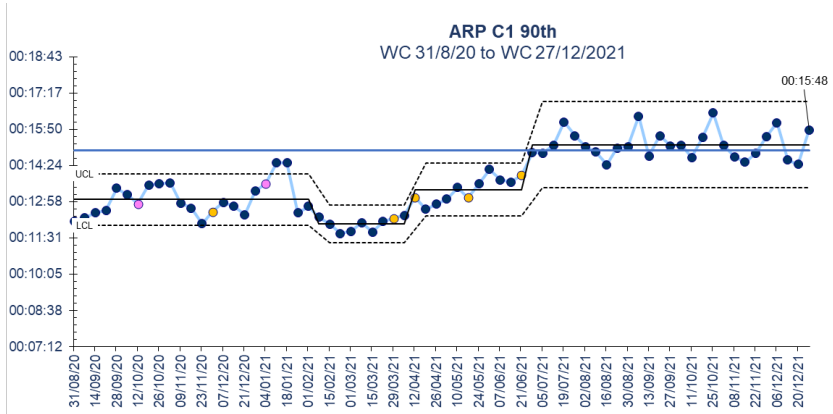




Green sectors

Figure O3.2





Green sectors

M North, , G West, G East, G Central, G South,

* Lockdown Easing of Restrictions

C1 Performance

C1 Mean

Target: **7 minutes**

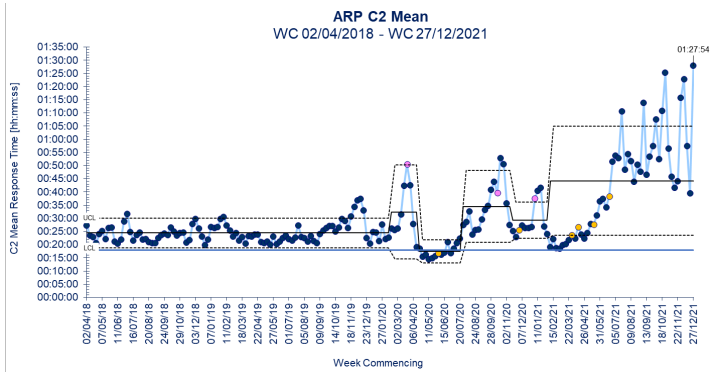
NWAS
December 2021: **9:05**
YTD: **8:42**

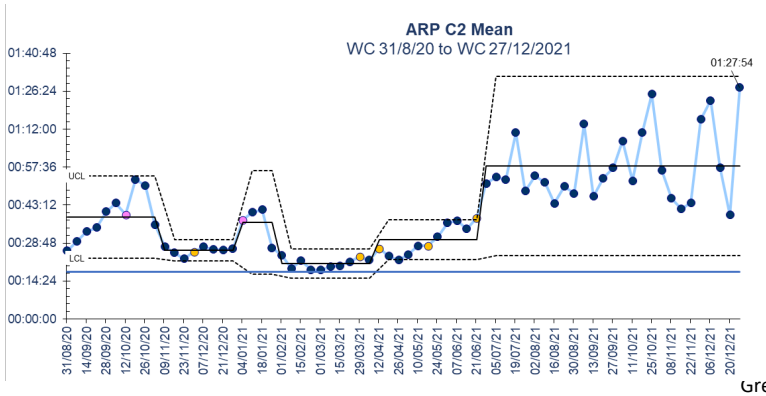
During the second half of 2022 the trust has seen increasing variation for all the ARP measures.

C1 90th Percentile

Target: **15 Minutes**
NWAS
December 2021: **15:17**
YTD: **14:45**

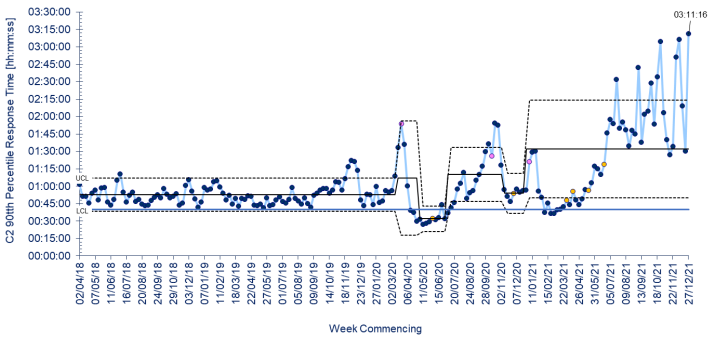
Figure O3.3

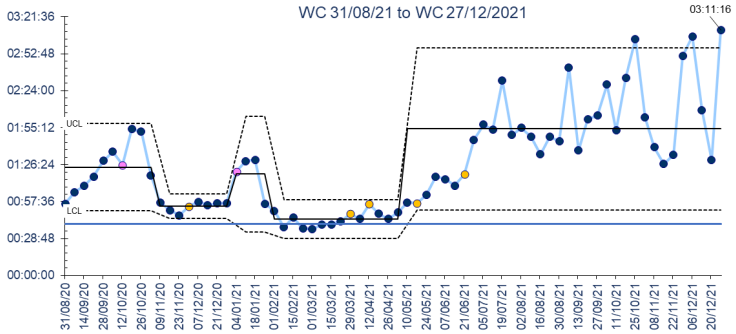




Green sectors

Figure O3.4





Green sectors

C2 Performance

C2 Mean

Target: **18 minutes**

NWAS:
December 2021: **1:06:43**
YTD: **48:07**

C2 response times for both mean and 90th are showing as the longest in over 3 and a half years and are also showing a process with less control, with data points showing greater divergence since summer 2021.

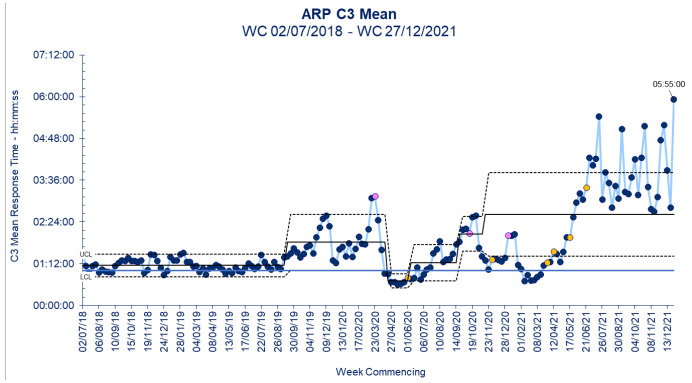
Additional focus is being placed on long waits ensuring incidents are responded to in order of acuity, ensuring we minimise any patient harm.

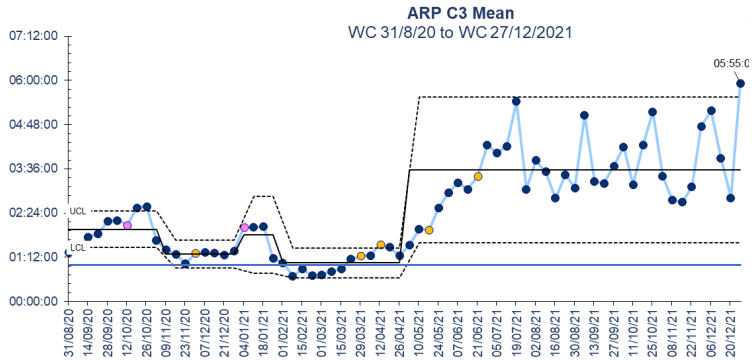
C2 90th Percentile

Target: **40 Minutes**

NWAS
December 2021: **2:33:58**
YTD: **1:44:26**

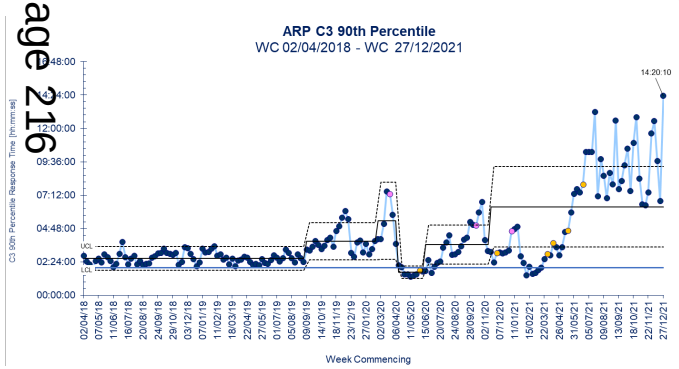
Figure O3.5

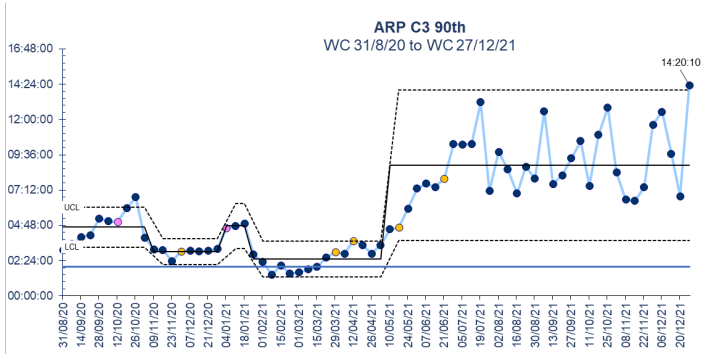




Green sectors

Figure O3.6





Green sectors

C3 Performance

C3 Mean
Target: **1 Hour**

NWAS:
December 2021: **4:15:39**
YTD: **3:03:54**

C3 response times for both mean and 90th are showing the as the longest in over 3 and a half years and is also showing a process with less control, with data points showing greater divergence since summer 2021.

C3 90th Percentile
Target: **2 Hours**

NWAS
December 2021: **10:57:11**
YTD: **7:33:56**

C4 90th Percentile

Target: **3 Hours**

NWAS
December 2021: **19:10:59**

C4 data over time has not been included. A system change has taken place on December 5th 2022 which has now corrected reporting. There is now work ongoing to correct the retrospective data which will be included in the next report. NHS E/I agreed this approach. The heat map shows that not enough data was available to produce a C4 90th for North Cumbria.

Figure O3.8

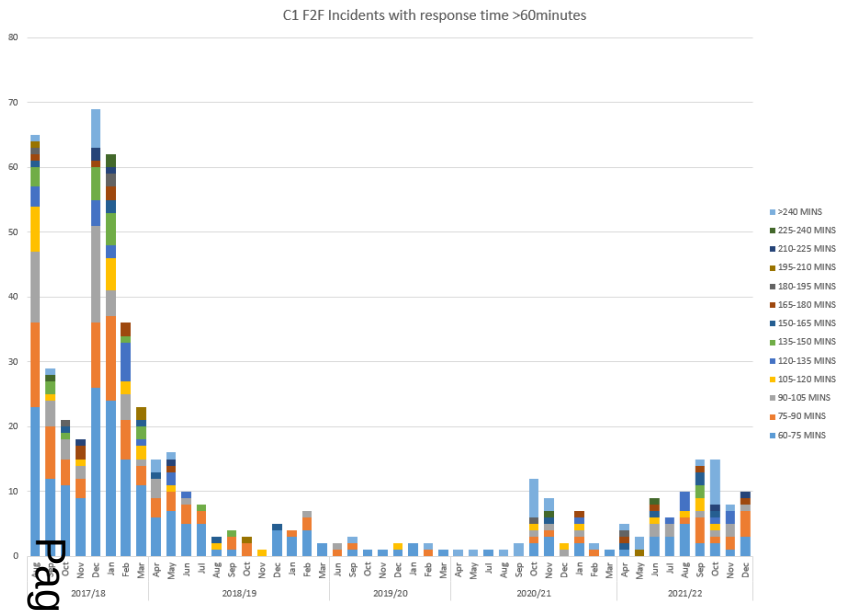


Figure O3.9

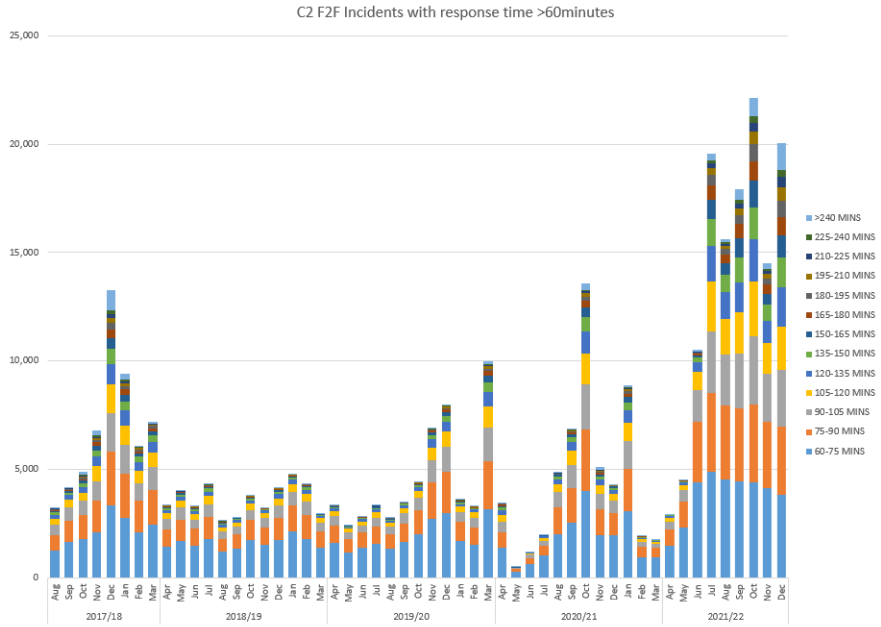


Figure O3.10

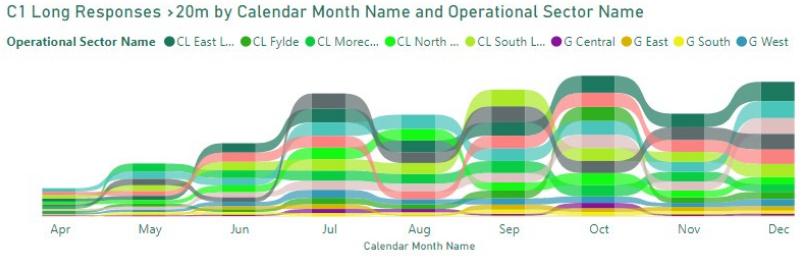
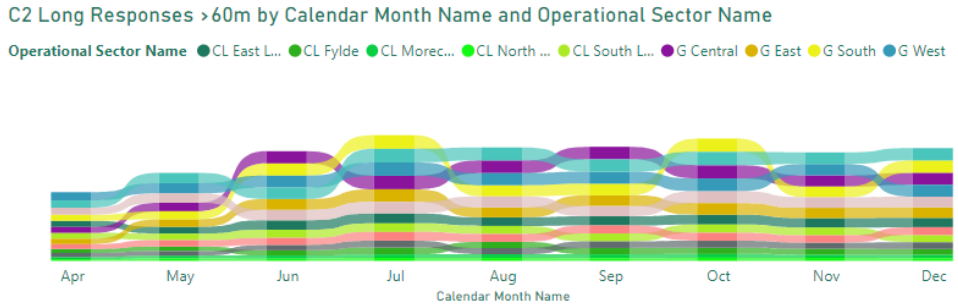


Figure O3.11



C1 & C2 Long Waits

An increase in the long waits for both C1 and C2 occurred in December after a fall for both in November. This corresponds with the overall increase in activity in C1, with a small fall in activity in C2 over the same period. As would be expected the increase is lower in C1 than C2.

The number of C2 long waits has been significantly high since June. This is a major patient safety concern and there are measures in place to review patients through the clinical control desk which are helping but not eliminating the risk.

ARP Provider Comparison Figures October 2021

Figure O3.8

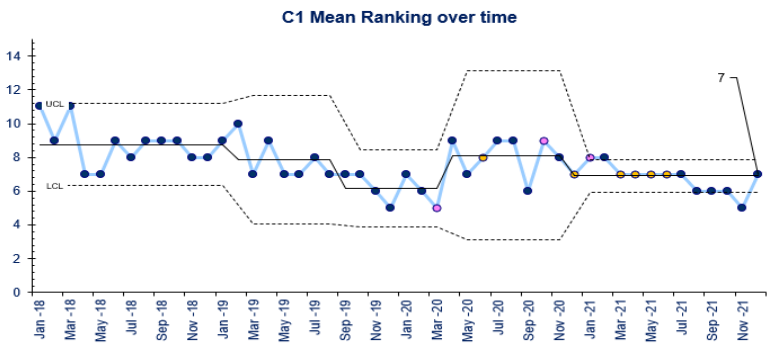


Figure O3.9

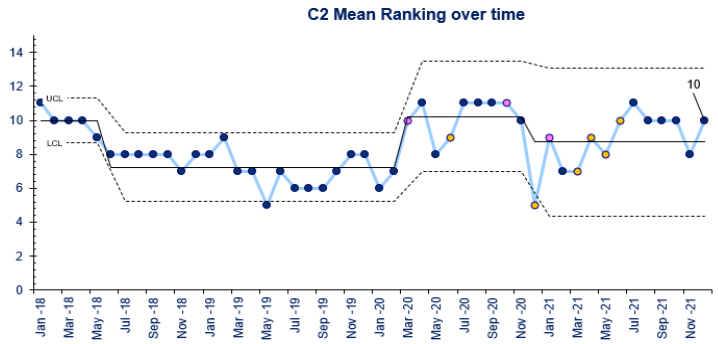


Figure O3.10

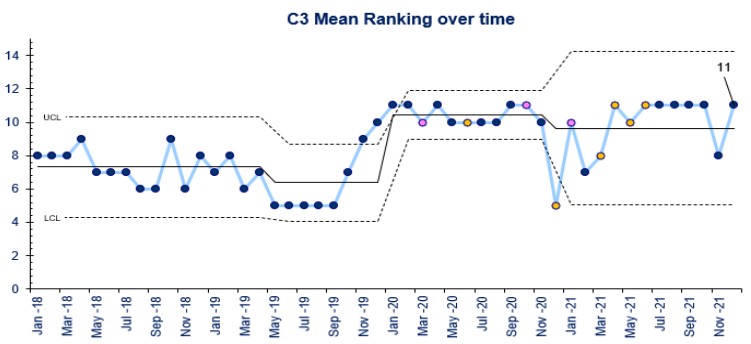


Figure O3.11

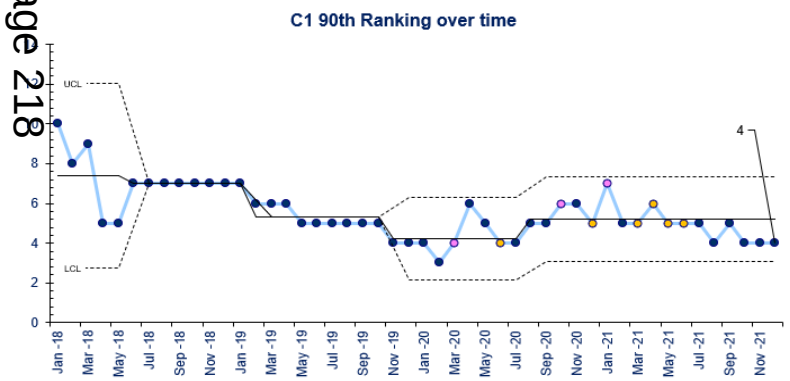


Figure O3.12

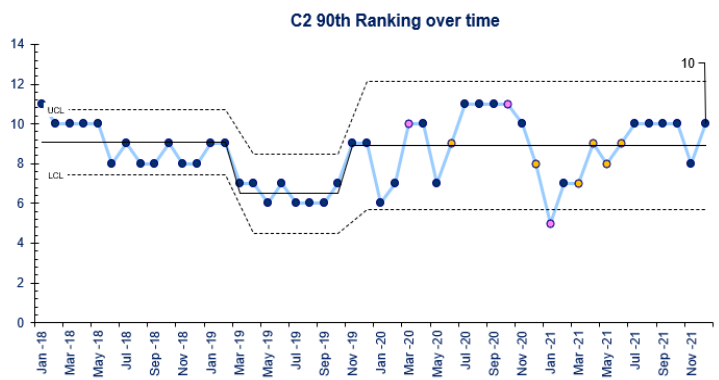
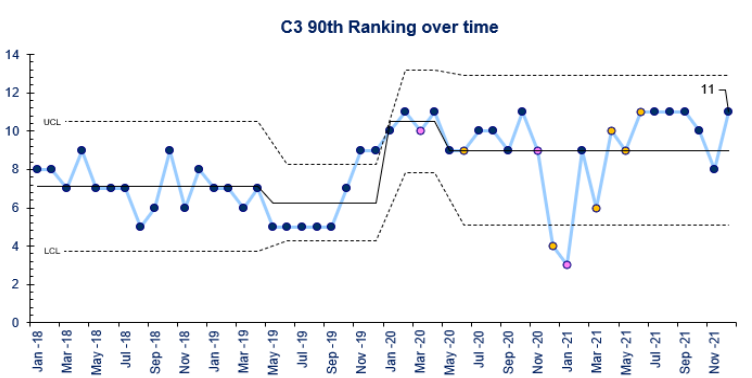


Figure O3.13



Provider	C1 Mean
North West	09:05

Provider	C1 90th
North West	15:17

Provider	C2 Mean
North West	1:06:43

Provider	C2 90th
North West	2:33:58

Provider	C3 Mean
North West	04:15:39

Provider	C3 90th
North West	10:57:11

O4 111 PERFORMANCE

Figure O4.1

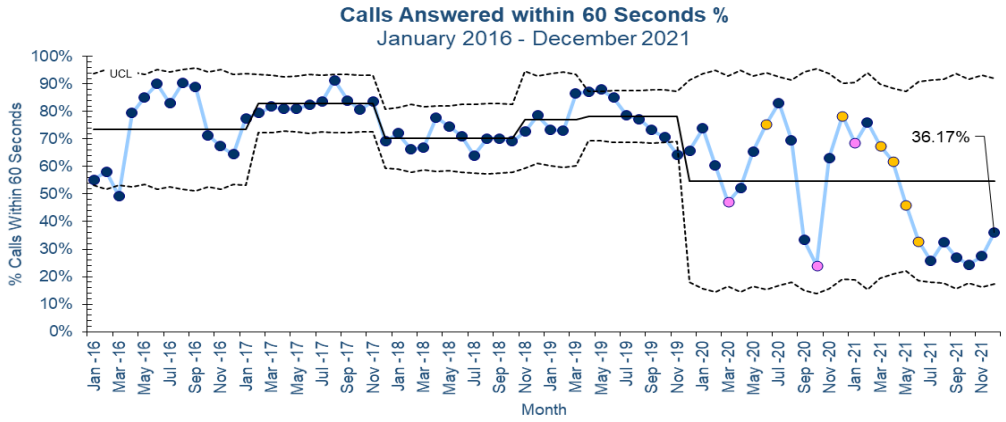
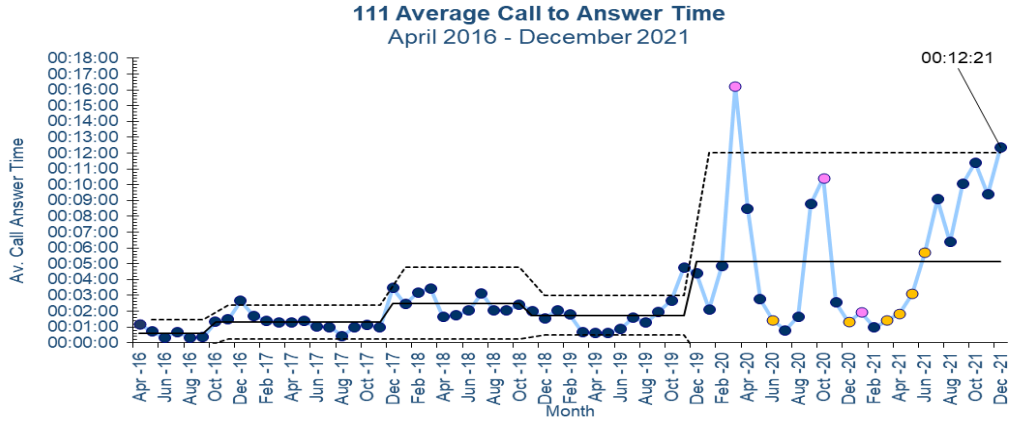


Figure O4.2



* Lockdown Easing of Restrictions

111 Performance

Calls Answered within 60 seconds %

Target: **95%**

NWAS

December 2021: **36.17%**

YTD: **35.93%**

National **38.2%**

Performance for the headline KPI continues to challenge the service.

Calls Answered within 60s, Average Call To Answer Time and Calls Abandoned directly relates to available resource (Q4.1).

Call demand throughout December over the Christmas Period proved challenging, the busiest days being 27th and 28th December where calls offered peaked at **13,500**. Pressure coming into the service meant at times up to 500 calls were waiting to come into the Northwest 111 Service. This was not unique to the Northwest; challenges of this nature were evident across the country.

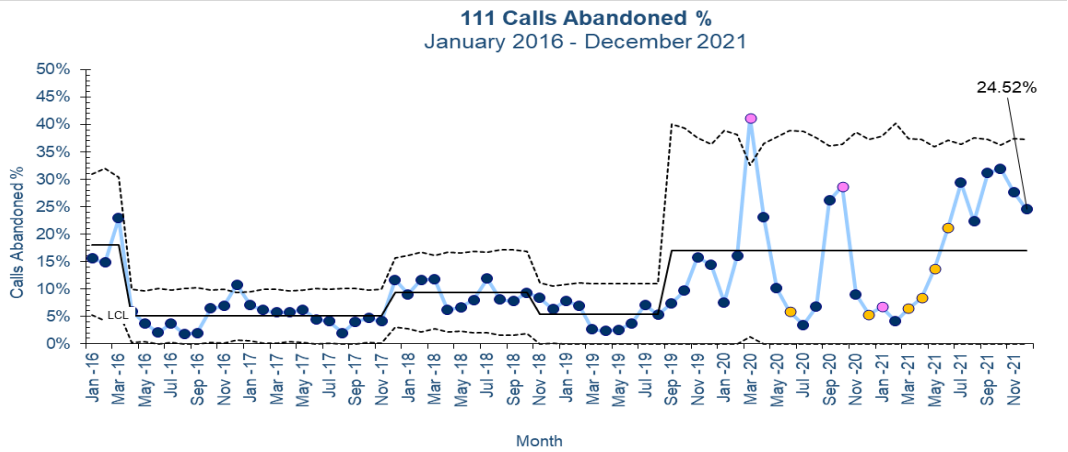
The national recruitment campaign ran throughout December, this has sparked some additional interest in Health advisor posts within 111, the team are currently reviewing applicants and expect to fill planned courses through February and March.

Staff absence due to Covid rose exponentially throughout December and over the Christmas period, this impacted resourcing on the day and contributed to up **15%** loss of resource on the day.

NHSE have commissioned the national Covid Response Service (CRS) for a period to assist with pressures into 111, it is anticipated this will go live 4/5th January and it is anticipated that this will take around 10% of the national pressure away from 111, this was announced on a Provider call on 17th December, further official confirmation that this service is live is awaited.

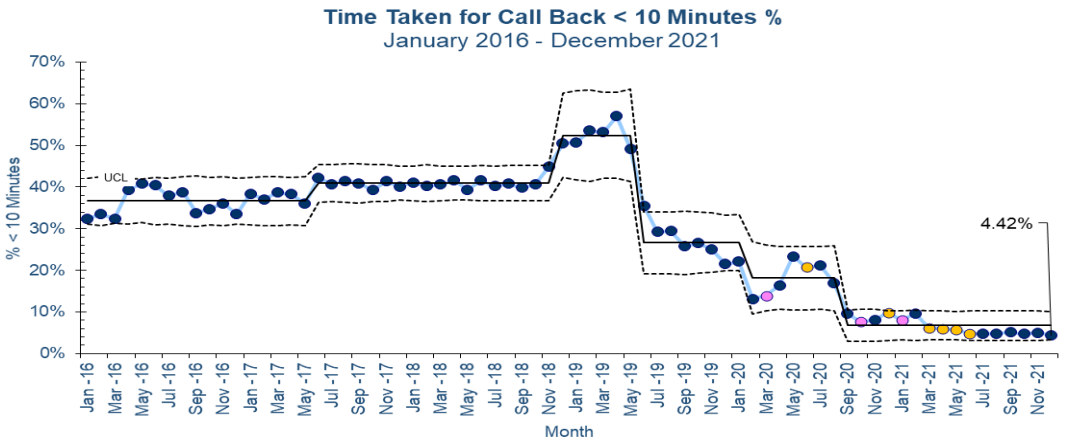
Alongside the 6-point plan that is currently being delivered, a further project to deliver SMS for Self-Care is now in progress with the support of colleagues in NHSD. It is anticipated that this project will deliver a reduction in AHT as self-care advice will no longer be required if the patient is happy to receive an SMS message with this on.

Figure O4.3:



** From April 2021 the method of calculating abandoned calls has changed, the difference between the two methods means that the figure for April is 0.5% higher than would have been under the old method*

Figure O4.4



* Lockdown Easing of Restrictions

Calls Abandoned %
Target: **<5%**

NWAS
December 21: **24.52%**
YTD: **23.39%**

National **23.4%**

Call Back < 10 Minutes %

Target: **75%**

NWAS
December 21: **4.42%**
YTD: **5.03%**

As with previous comments call abandoned directly correlates with the answered in 60 KPI.

Time taken for a call back (10 mins). The increase in demand on the 111 service has directly impacted the size of the clinical advice queue. This has resulted in much larger queues and therefore fewer calls being called back within 10 minutes. The CAQ is managed 24/7 by the Clinical Duty Manager (CDM) and any calls of concerns are flagged for Clinicians to pick up as a priority. December was the second month that percentage of calls abandoned fell.

Figure O4.5

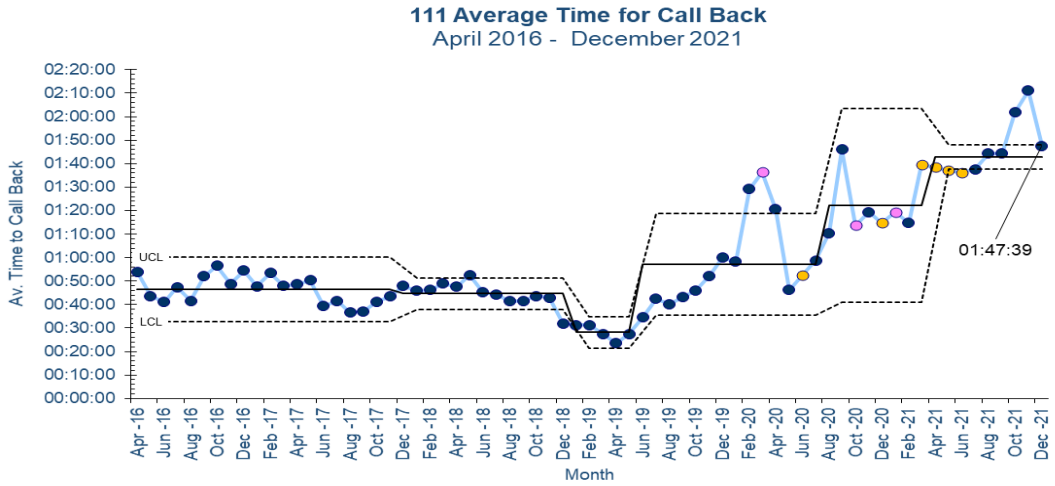
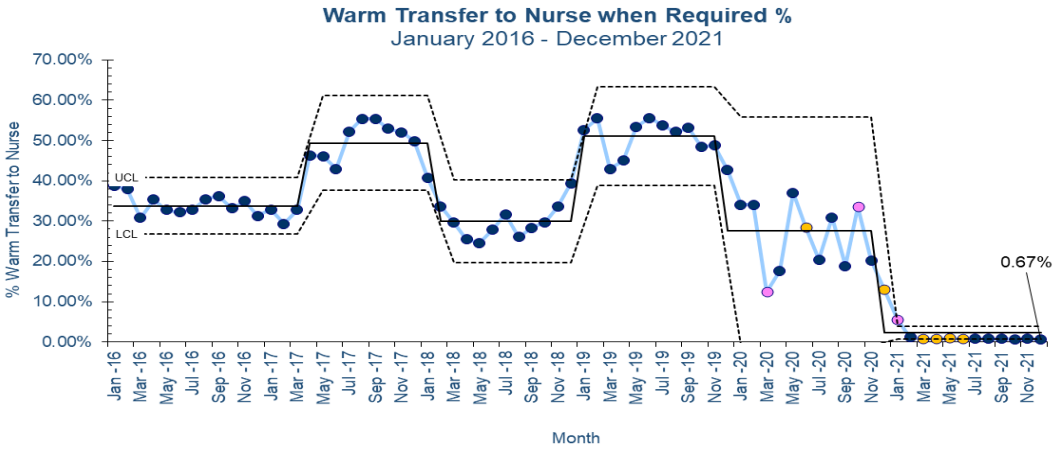


Figure O4.6



* Lockdown Easing of Restrictions

Warm Transfer to Nurse when Required%
Target: **75%**

NWAS
December 21: **0.67%**
YTD: **0.82%**

As per previous commentary due to the increase in demand warm transfer to Clinicians has been affected.

This has resulted in a 'bottle neck' with health advisors being on hold for prolonged periods of time waiting to get through to the next available clinician.

Many of these calls are now checked with the Clinical Duty Manager and were appropriate are then placed on the Clinical advice queue to be called back.

This then releases the HA to take another incoming call. The CDM will monitor the CAQ and assign any calls of concern to a clinician to pick up as their next call.

O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: November 2021					Year to Date: July 2021 - November 2021			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,290	14,024	10,126	(3,898)	(28%)	70,121	47,458	(22,663)	(32%)
Greater Manchester	526,588	43,882	38,492	(5,390)	(12%)	219,412	185,935	(33,477)	(15%)
Lancashire	589,181	49,098	34,531	(14,567)	(30%)	245,492	168,758	(76,734)	(31%)
Merseyside	300,123	25,010	22,345	(2,665)	(11%)	125,051	109,479	(15,572)	(12%)
NWAS	1,584,182	132,015	105,494	(26,521)	(20%)	660,076	511,630	(148,446)	(22%)

UNPLANNED ACTIVITY									
	Current Month: November 2021					Year to Date: July 2021 - November 2021			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	531	(716)	(57%)	6,237	2,827	(3,410)	(55%)
Greater Manchester	49,133	4,094	4,332	238	6%	20,472	22,513	2,041	10%
Lancashire	58,829	4,902	3,334	(1,568)	(32%)	24,512	17,593	(6,919)	(28%)
Merseyside	22,351	1,863	1,658	(205)	(11%)	9,313	8,620	(693)	(7%)
NWAS	145,282	12,107	9,855	(2,252)	(19%)	60,534	51,553	(8,981)	(15%)

ABORTED ACTIVITY									
	November 2021								
Contract	Planned Aborts	Planned Activity	Planned Aborts %	Unplanned Aborts	Unplanned Activity	Unplanned Aborts %	EPS Aborts	EPS Activity	EPS Aborts %
Cumbria	233	6,229	4%	49	531	9%	70	3,366	2%
Greater Manchester	1,425	18,065	8%	907	4,332	21%	1,038	16,093	6%
Lancashire	995	18,690	5%	600	3,335	18%	402	12,514	3%
Merseyside	531	9,293	6%	252	1,657	15%	633	11,389	6%
NWAS	3,184	52,277	6%	1,808	9,855	18%	2,143	43,362	5%

PTS Performance

Due to timetable issues PTS will always report a month behind other operational areas.

Activity during November 2021 was 20% below contract baselines with Lancashire 30% below contract baselines whilst Merseyside is operating at -11% (-2,665) Journeys below baseline. For the year to date position (July 2020 - November 2021) PTS is performing at -22% (-148,446 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at 32% and 31% below baseline whilst Greater Manchester and Merseyside are operating at 15% and 12% below baseline respectively.
In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 10% (2041 journeys) and -7% (-693 journeys) against 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 achieving contract KPI performance. Cumbria and Lancashire are -55% (-3410 journeys) and -28% (-6919 journeys) below baseline.
In terms of overall trend analysis, all areas are experiencing gradual increases in activity, mainly in the core (outpatient) areas.

Aborted activity for planned patients averaged 6% during November 2021 however Cumbria experiences 4%, Greater Manchester operates with 8% 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 5% aborts whereas Cumbria has 2% and Greater Manchester 6% Lancashire and Merseyside operate with 3% and 6% respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average 18% (1 in 6 patients) with variances of 9% in Cumbria, 21% in Greater Manchester, 18% in Lancashire and 15% Merseyside.

43 PTS staff have now temporarily redeployed into PES as a Blue Light Drivers. Recruitment plans are progressing as planned and the impact of the temporary transfer of workforce is being managed via retention of additional levels of third party support i.e. double staffed ambulance resources to help manage capacity challenges associated with social distancing measures which continue to impact utilisation of resource. Whilst the current direction is that IPC / social distancing measures will remain in place discussions continue with NHSE/I, and commissioners locally, to discuss ways in which demand can be managed in such a way that maintains standards of patient safety whilst enabling the service to sustainably operate effectively. Over the reporting period activity remained at approximately 90% of pre covid activity. The proportion of patients requiring an ambulance is regularly close to pre-Covid levels.

New regulation came into effect on 11 November 2021 meaning that only individuals who have received two vaccine doses are allowed to enter a nursing homes and must be able to prove this on request. NWAS and private ambulance staff who have not received both vaccines have been identified and their records updated on Cleric to flag to the controller and prevent nursing home journeys being allocated to ineligible staff. The most notable issue with respect to the new regulation was escalated by DHSC by Barchester Care Group in relation to the provision of evidence of staff being fully vaccinated however, this was resolved quickly. No significant issues have been escalated since.

Received 2nd jab 86.63%

Discussions continue with commissioners and colleagues internally with respect to a new service model(s) for PTS with a view to the procurement of a new service due to commence in April 2023 and as reported previously outputs from these discussions are reported at the UEC Oversight Forum.

OH1 STAFF SICKNESS

Figure OH1.1

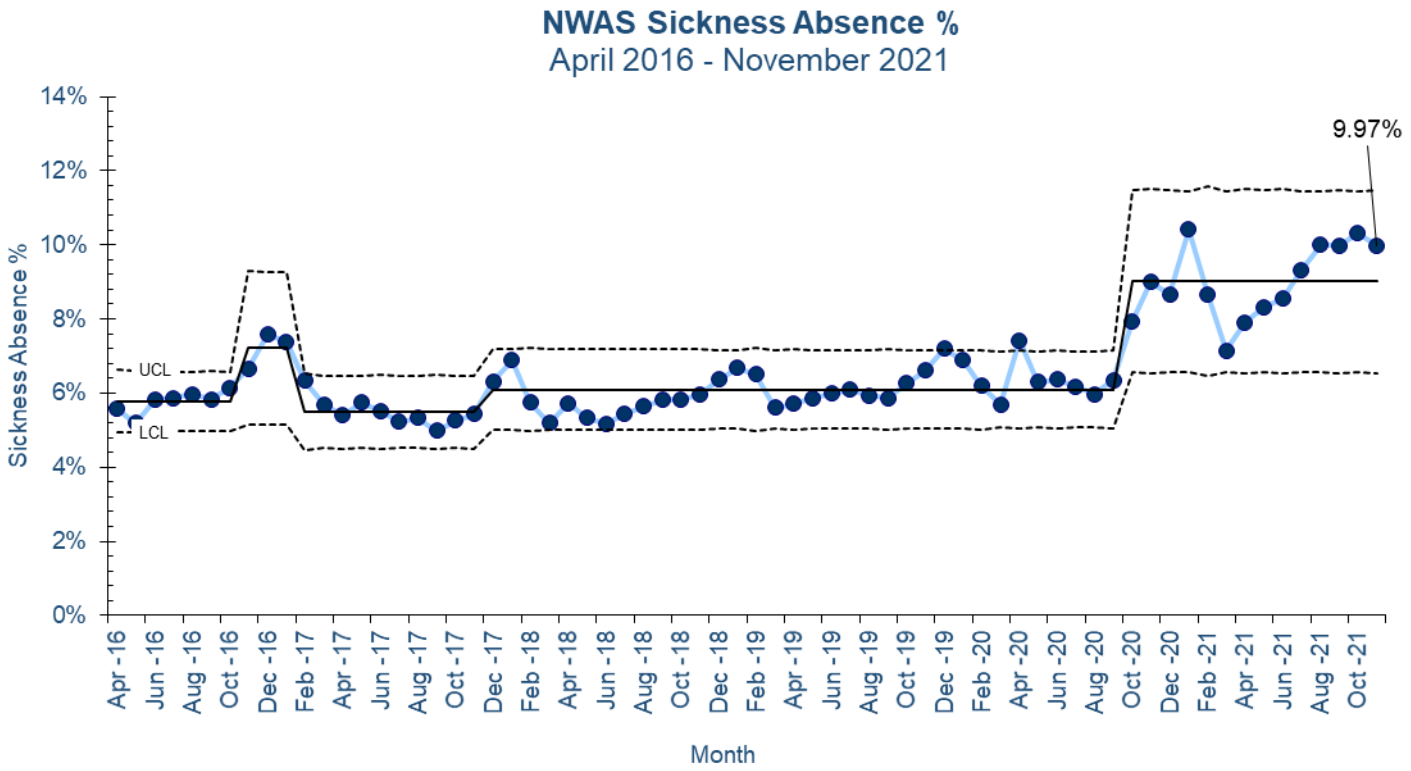


Table OH1.1

Sickness Absence	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
NWAS	8.66%	10.41%	8.65%	7.15%	7.90%	8.32%	8.55%	9.33%	10.00%	9.97%	10.32%	9.97%
Amb. National Average	6.75%	9.37%	7.03%	6.06%	6.36%	6.59%	6.98%	7.73%	8.17%			

Staff Sickness

The overall sickness rates for November 2021 were **9.97%** (OH1.1). The current position being within the control limits but above the Trust target of **0.5%** reduction on previous year which would be **5.7%**. Sickness had increased over 6 consecutive months since February but showed signs of stabilising.

The impact of COVID related sickness has increased slightly to **1.53%** in November (OH1.2). The underlying non-COVID position is **8.4%** which is higher than the same period last year which was **6.35%.**

Data analysis shows the top 5 reasons for absence being Mental Health, Covid, Injury, MSK and Back problems.

Long Term sickness (LTS) absence has been impacted by long COVID and extended LTS as a result of national terms and conditions. The balance between short and long term sickness absence in PES and PTS remains broadly equal with both at raised levels. Short-term sickness in 111 and EOC is high which is likely to be as a result of sustained demand on the service. The full impact of the Omicron variant and the additional sickness and isolation will only start to show next month.

In addition to sickness reported via ESR, COVID 19 self-isolating absences have been captured by GRS, Teliopi and Marval.

The People directorate have identified additional resources to establish a dedicated Team to focus on supporting operational teams to improve attendance management and wellbeing. Progress may be impacted by the VCOD work over the coming months.

Figure OH1.2:

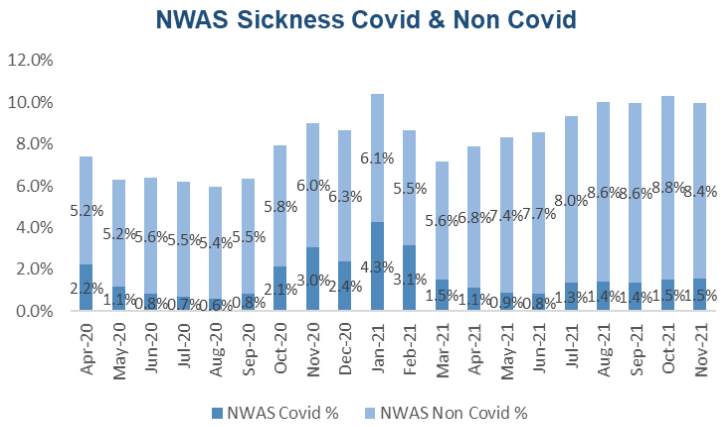


Figure OH1.3:

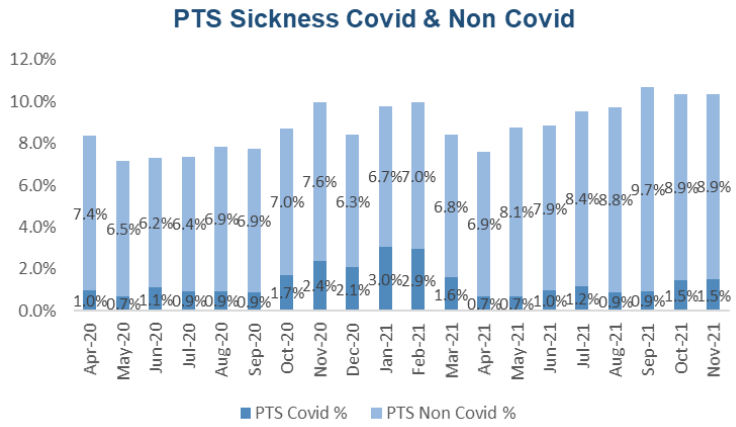


Figure OH1.4:

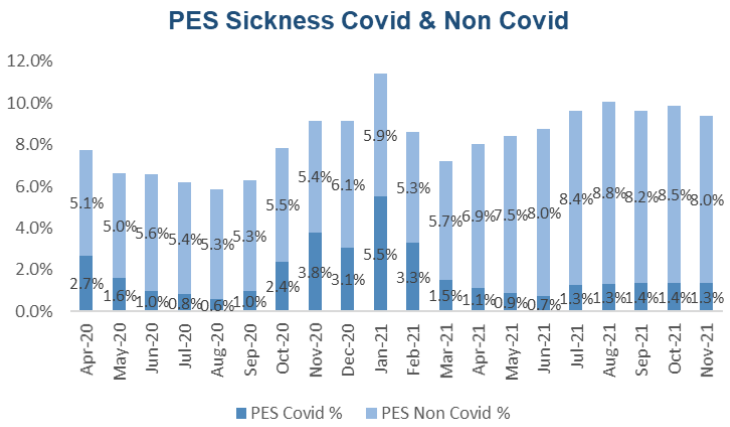


Figure OH1.5:

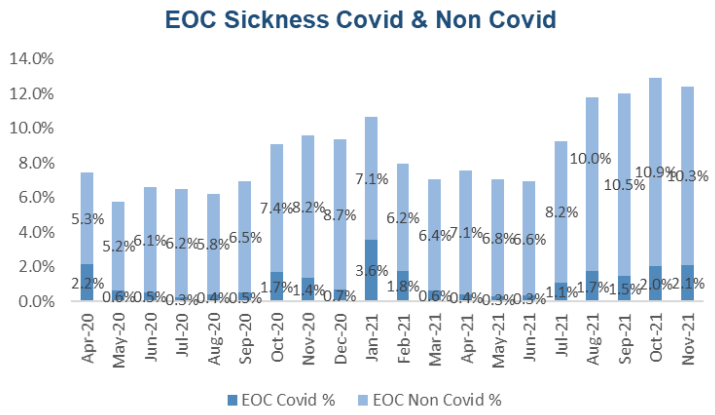


Figure OH1.6:

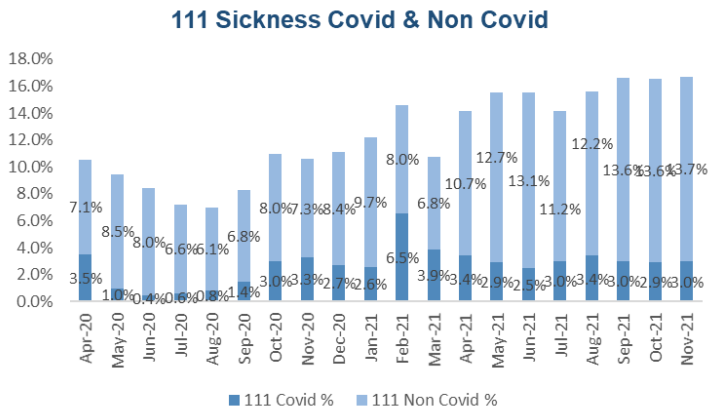
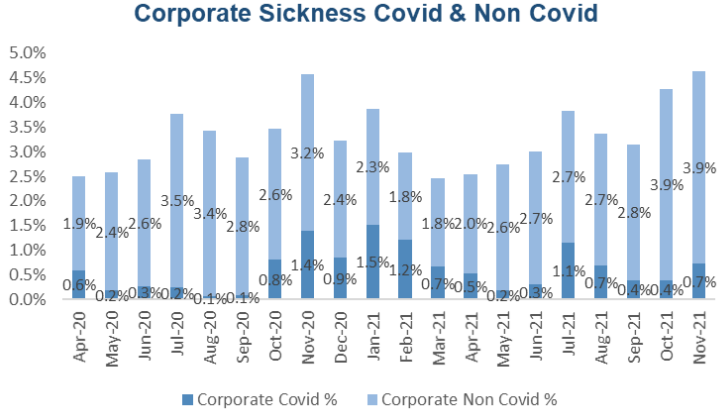


Figure OH1.7:



OH2 STAFF TURNOVER

Figure OH2.1

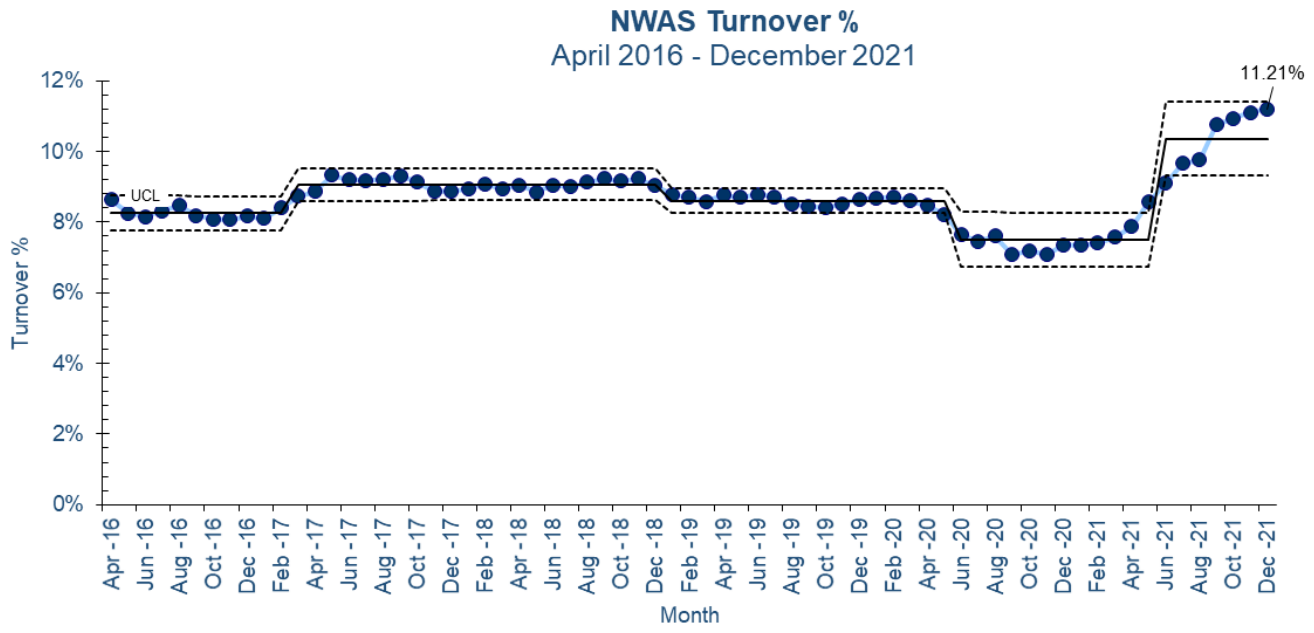


Table OH2.1

Turnover	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
NWAS	7.34%	7.41%	7.57%	7.87%	8.56%	9.10%	9.67%	9.77%	10.76%	10.93%	11.11%	11.21%
Amb. National Average	7.58%	7.41%	7.35%	7.57%	7.52%	8.07%	8.44%	8.85%	9.25%			

Staff Turnover

Staff turnover for November is **11.21%**. This is calculated on a rolling year average.

Staff turnover has shown a steady increase in the last 7 months and is at the upper control limit. 111 turnover is showing a significant upward trend to **45%** in November 2021 which is outside of the upper control limit (OH2.5)

Detailed work is being undertaken on 111 retention both locally and at a national level. A deep dive on 111 retention is being presented to January Board.

EOC has also seen an increase with November turnover at **13.04%** (OH2.4), it is slightly up on previous months. Some of this reflects the loss of fixed term staff seeking permanent positions. Initial review of leavers exit interviews and data does not indicate a particular theme. EOC staffing position is stable moving into the winter period given the level of over recruitment and training.

PES turnover is showing a small upward trend, however, this is broadly in line with pre-COVID levels. Overall the Trust has not seen the anticipated loss of Paramedics to PCNs in Q2 and Q3.

Overall Trust turnover is now above the sector average but the trend seen in contact centres is being mirrored nationally.

NHS turnover is typically between 10% & 12% according to NHS SBS. (Shared Business Services)

Figure OH2.2

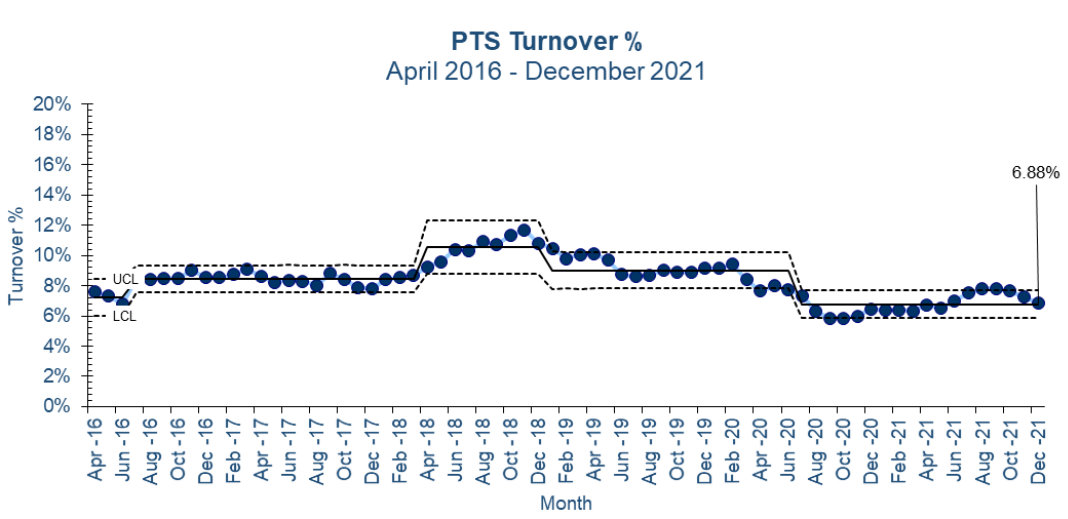


Figure OH2.3

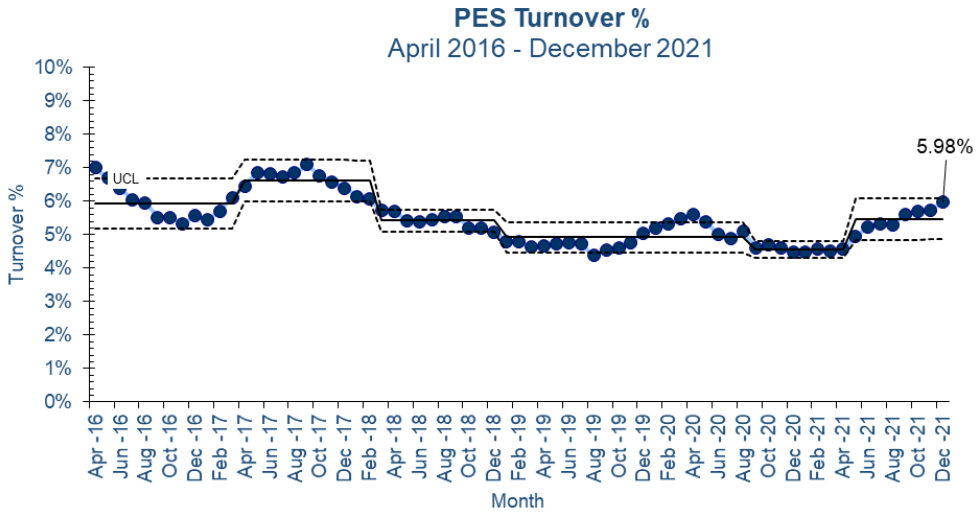


Figure OH2.4

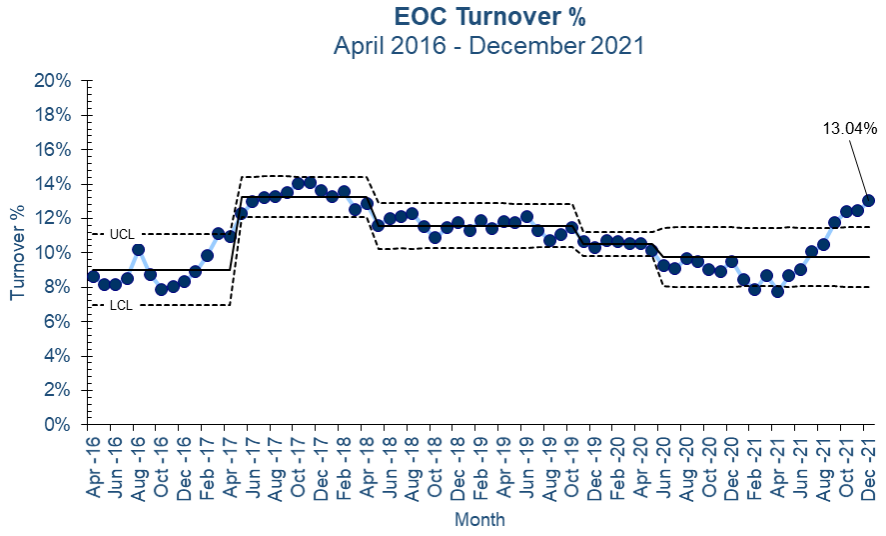
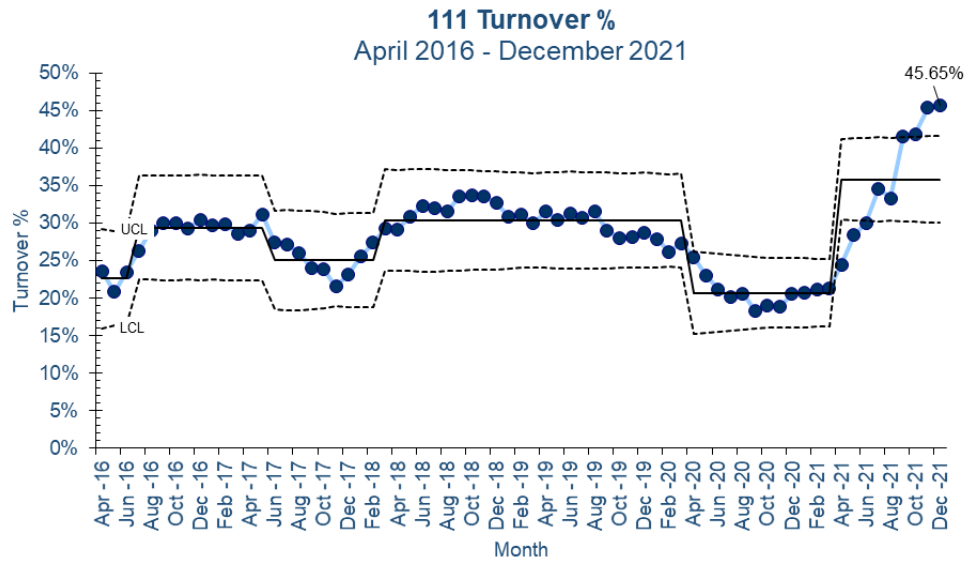
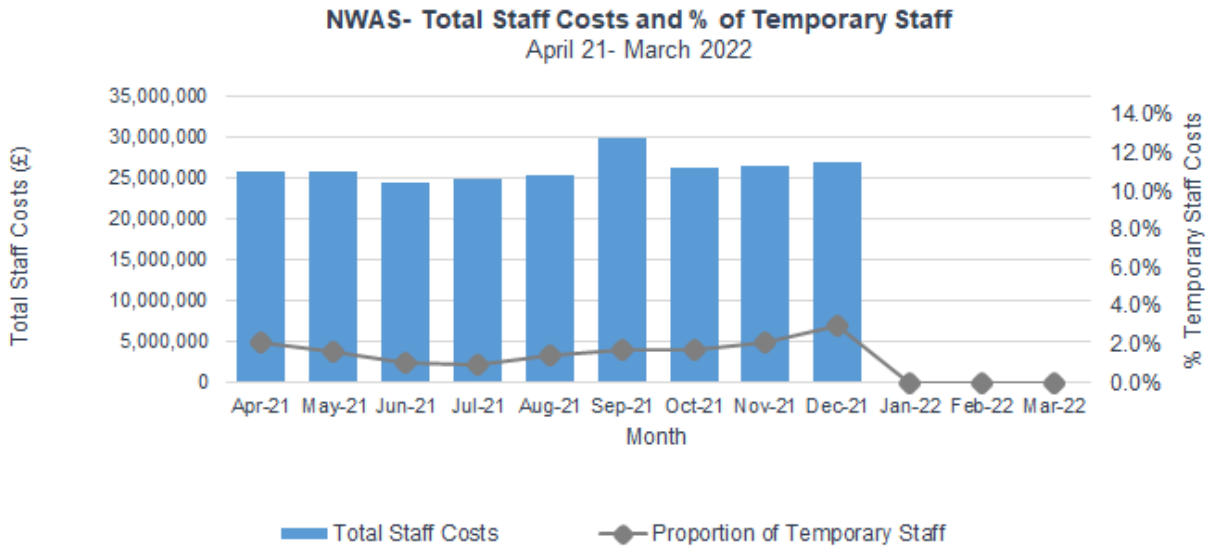


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

As a result of COVID-19 the Trust Agency usage and expenditure is projected to exceed the Agency ceiling, although this does not form part of the reporting under the emergency arrangements. The agency ceiling is a maximum amount of agency spend allowable.

Agency staff have continued to support the Contact Centre environment.

Due to the impact of Self Isolation and Covid sickness associated with Omicron and the additional Christmas bank holidays, EOC and 111 were given approval to pay Agency staff overtime which has resulted in an increase in Agency spend in December.

111 have also had temporary funding to recruit into Service Advisor posts for a 3 month period. To support ongoing recruitment, these Agency staff will then be considered at the end of the 12 week period to transfer on to a Trust contract to support vacancy gaps overall.

Current agency usage is therefore anticipated to continue across Q4.

Table OH4.1

NWAS	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Agency Staff Costs (£)	636,447	478,564	647,483	541,873	404,321	245,748	241,475	356,466	518,275	444,941	553,502	796,039
Total Staff Costs (£)	25,444,774	25,353,362	48,192,045	25,673,168	25,780,966	24,317,963	24,909,469	25,379,411	29,910,317	26,091,860	26,356,720	26,930,619
Proportion of Temporary Staff %	2.5%	1.9%	1.3%	2.1%	1.6%	1.0%	1.0%	1.4%	1.7%	1.7%	2.1%	3.0%

Figure OH4.2:

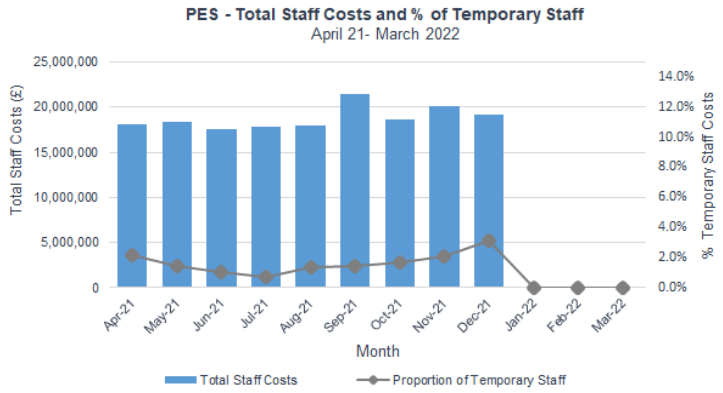


Figure OH4.3:

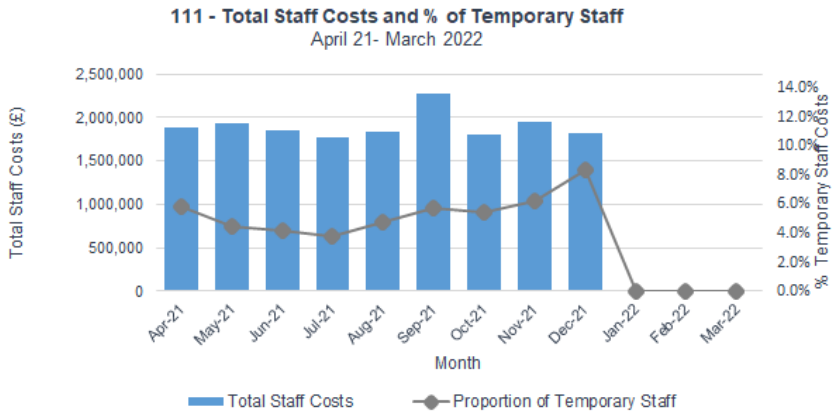


Figure OH4.4:

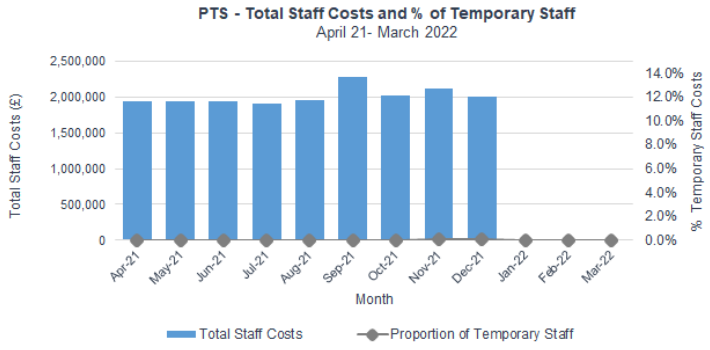
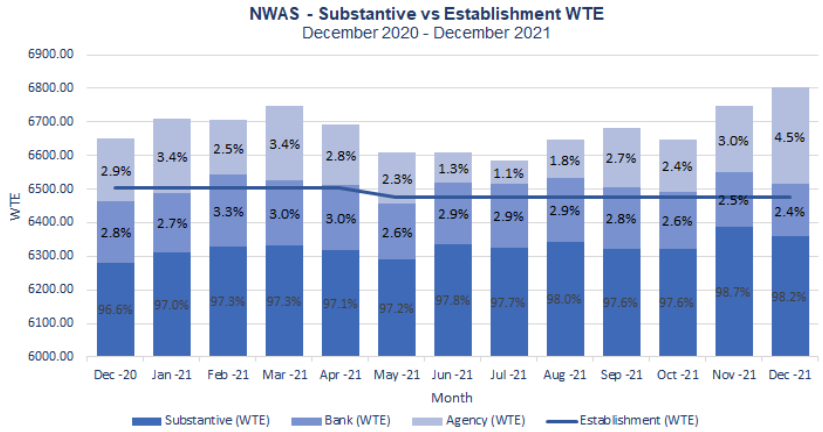


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

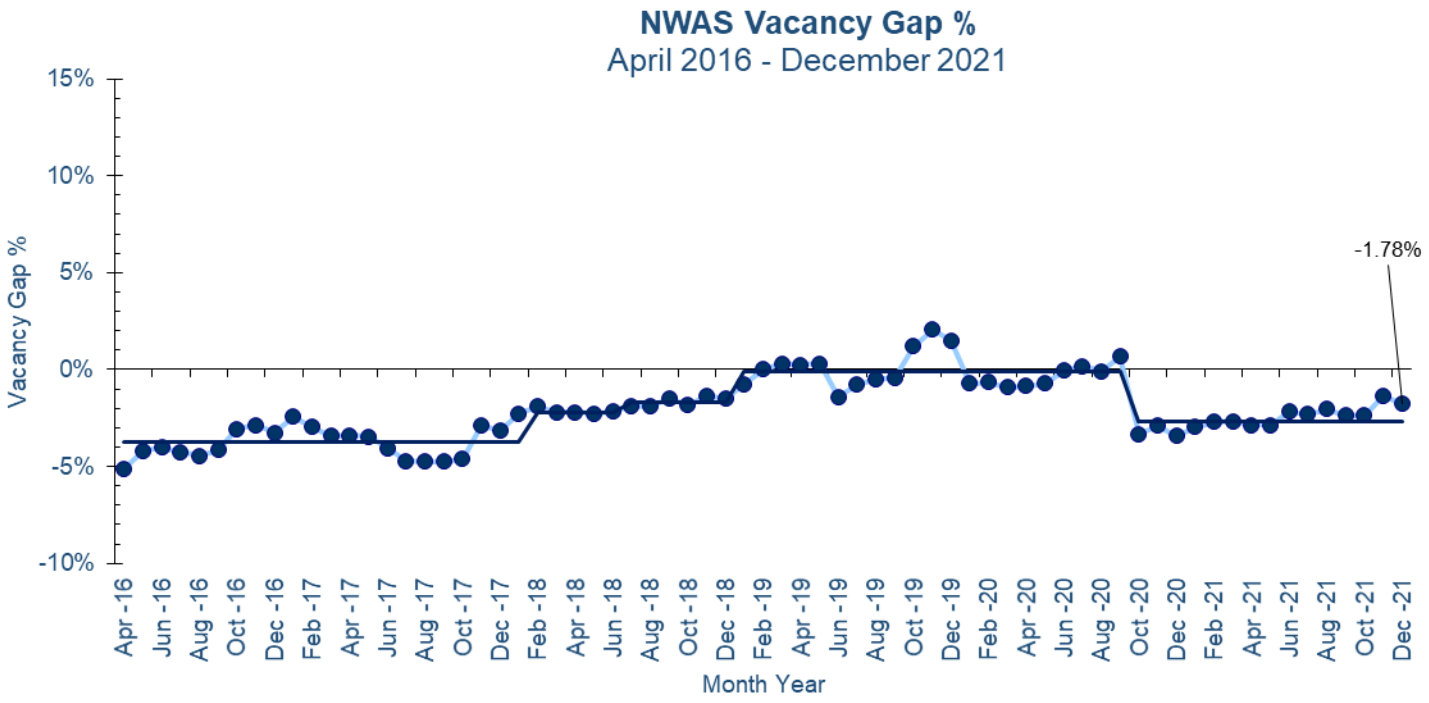


Table OH5.1

Vacancy Gap	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
NWAS	-2.88%	-3.44%	-2.97%	-2.68%	-2.67%	-2.86%	-2.85%	-2.16%	-2.30%	-2.03%	-2.36%	-2.37%	-1.35%	-1.78%

Vacancy Gap

Chart OH5.1 shows the vacancy gap at **–1.78%** reflecting overall a positive position.

Although recruitment plans for 111 are on track the vacancy position is a gap of **15.74%** (OH5.5). This is mainly the result of increased turnover which has moved the service into a deficit position. The recruitment plan focuses on maximising Health Advisor and Clinical Advisor recruitment. Additional Agency staff are also being recruited for an initial 12 week period with a view to being move onto Trust contracts after this period. The risk is mitigated by the use of agency and bank staff across frontline positions, for example bank and agency was equivalent to 45 WTE for call handling in December against a vacancy position of 69 WTE.

The PTS vacancy position (OH5.2) shows a reducing gap resulting from robust recruitment plans to replace PES upskill staff taking up apprentice EMT1 positions. This also includes the impact of the further 50 PTS staff moved to support PES blue light driving.

PES position (OH5.3) shows the positive impact of plans to maximise recruitment into PES during Q3 and are **1.1%** over-established.

EOC position remains very stable at **3.65%** above establishment due to ELC approving the continued recruitment at risk to maintain and improve frontline staffing. This excludes agency recruitment with the current position including **104** agency staff being **24.4%** above establishment

Figure OH5.2

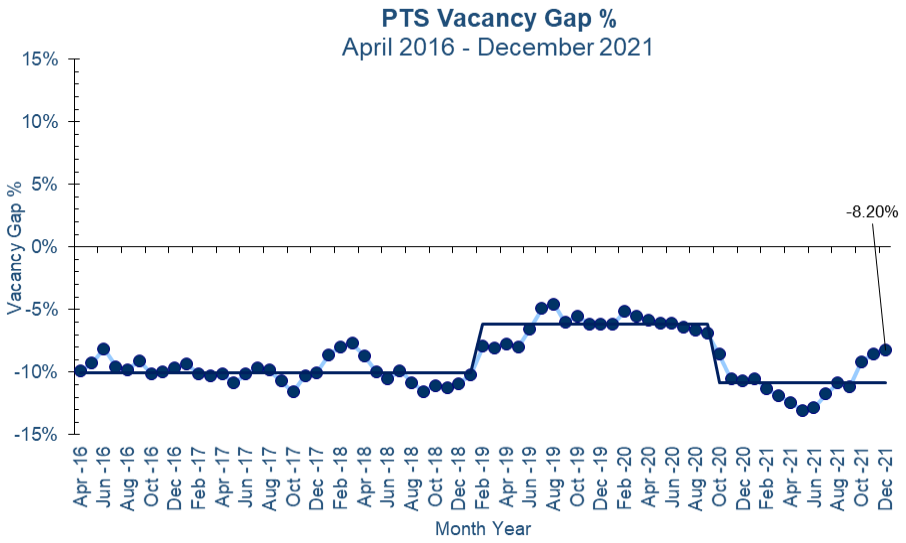


Figure OH5.3

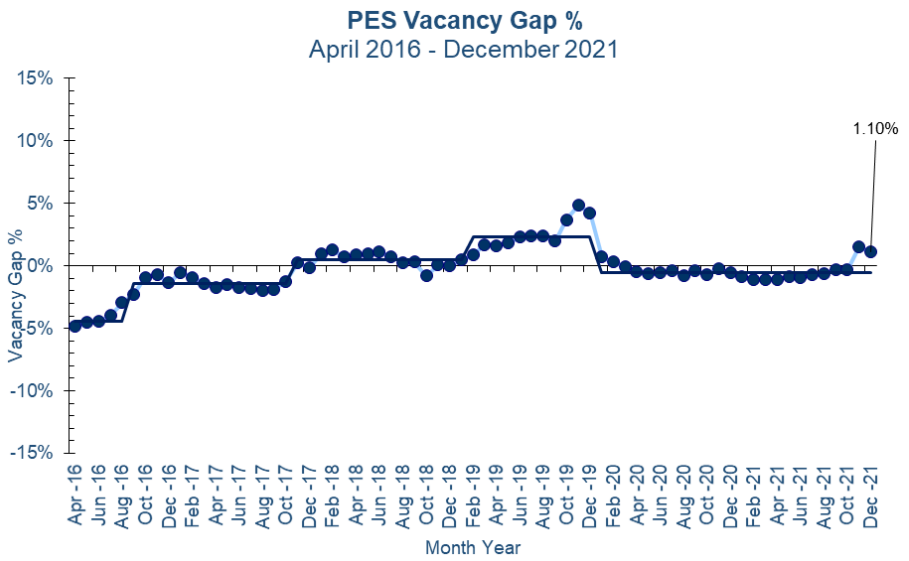


Figure OH5.4

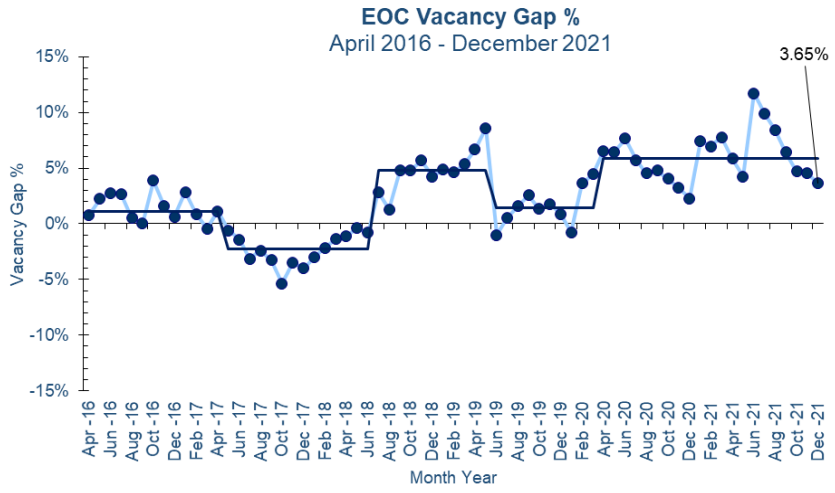
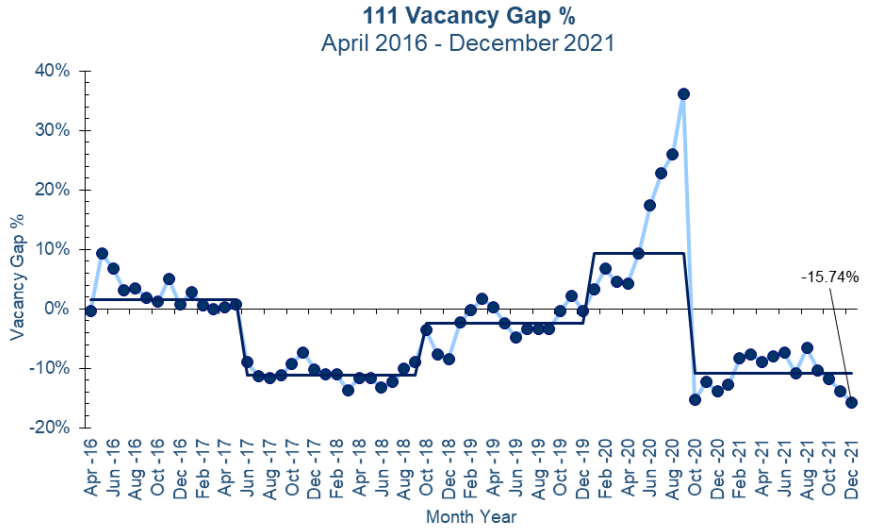


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

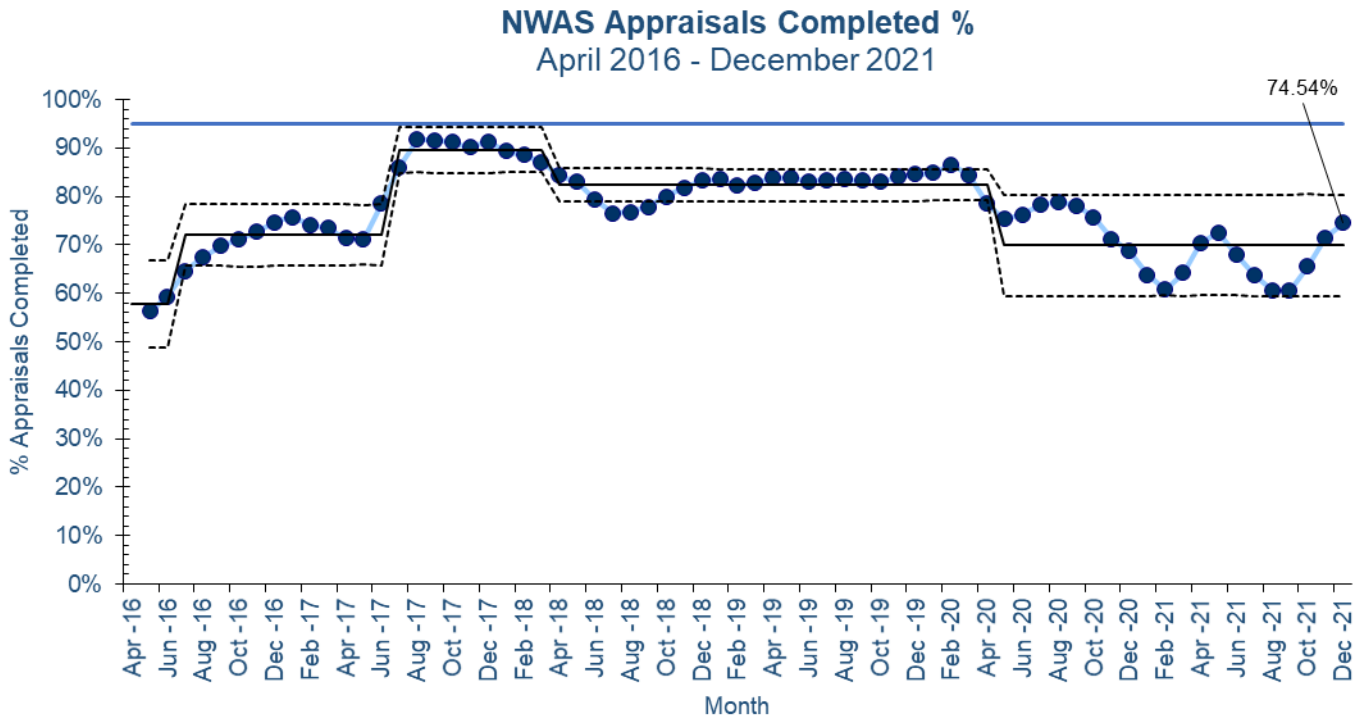


Table OH6.1

Appraisals	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
NWAS	64%	61%	64%	70%	73%	68%	64%	61%	59%	65%	72%	75%

Appraisals

Appraisal completion rates are at **75%** for December 21 (OH6.1) which meets the revised target set earlier this year.

The impact of operational pressures since June and the move to Reap 4 has impacted on compliance but good progress has been seen.

A revised process has set a minimum expectation for staff check-in conversations with a focus on

- Health, wellbeing, safety, and any support that may be needed
- Personal and professional resilience in the current operating environment, and
- Identification of any development needs that may arise out of the previous discussion points

EOC, 111 and PTS are above the upper control limits which reflects recovery plans and the focused work of teams. EOC (OH6.4) had been identified as a risk area but have improved position by **30%** since September.

The current pressures are likely to impact on compliance. Whilst ther eis no formal pause staff abstractions will make progress difficult but managers will continue to take appropriate opportunities for appraisals. However, the strong position at December should enable delivery of **75%** by end of March.

Figure OH6.2

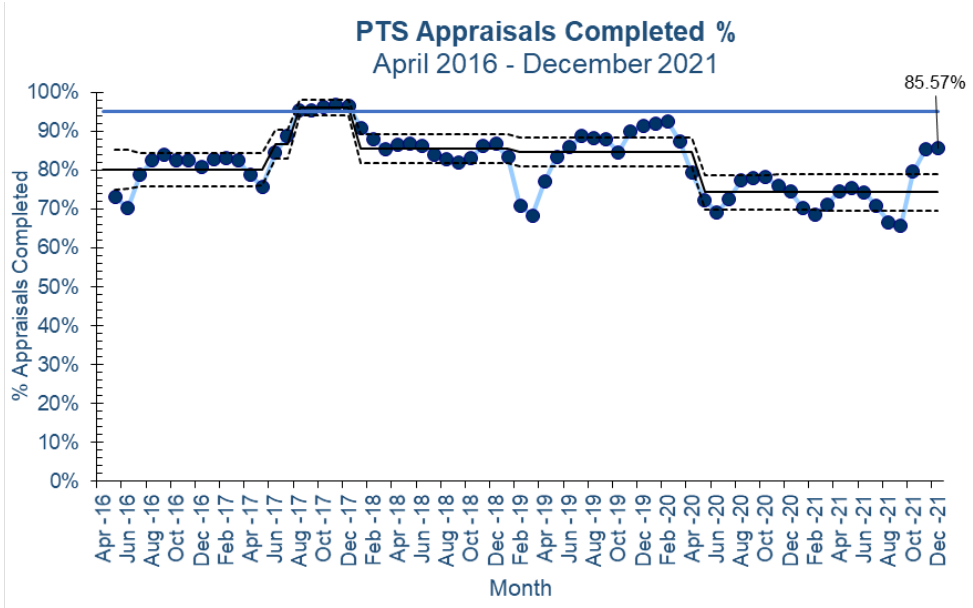


Figure OH6.3

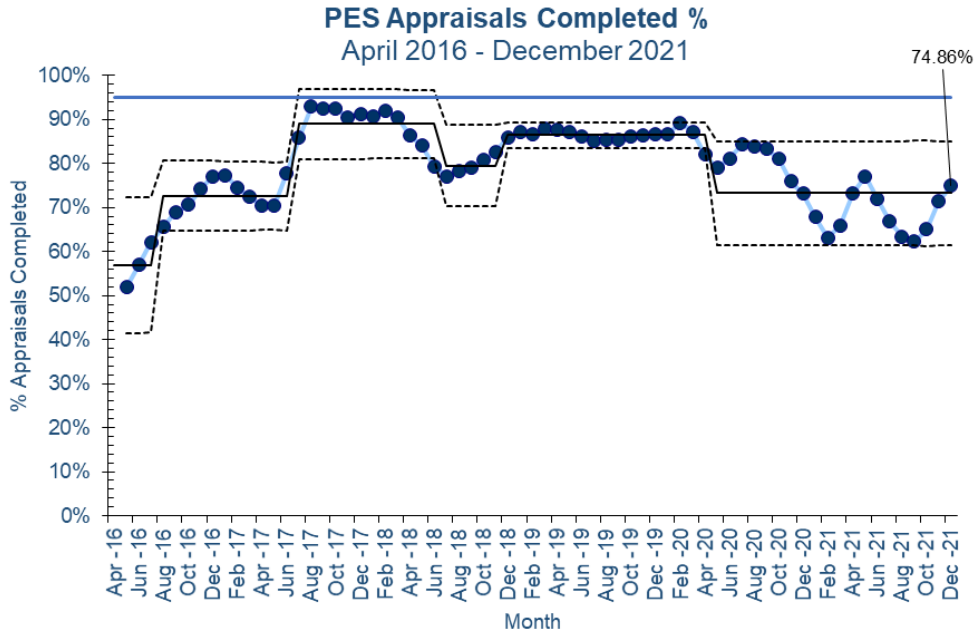


Figure OH6.4

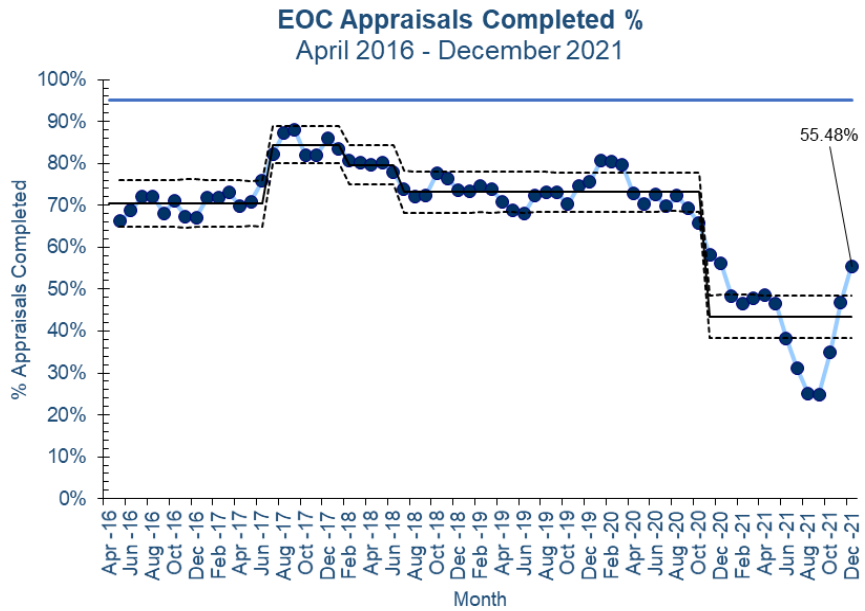
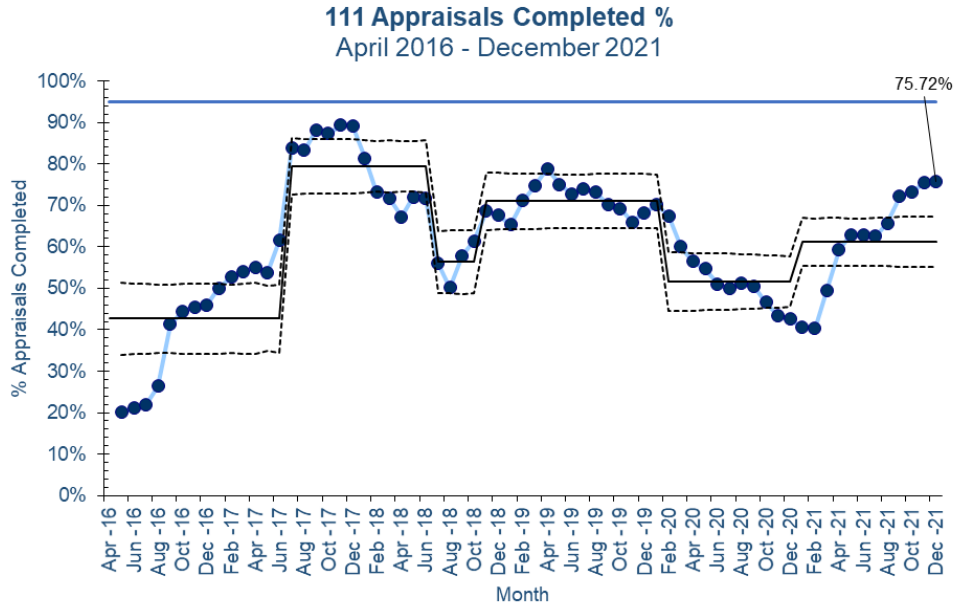


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

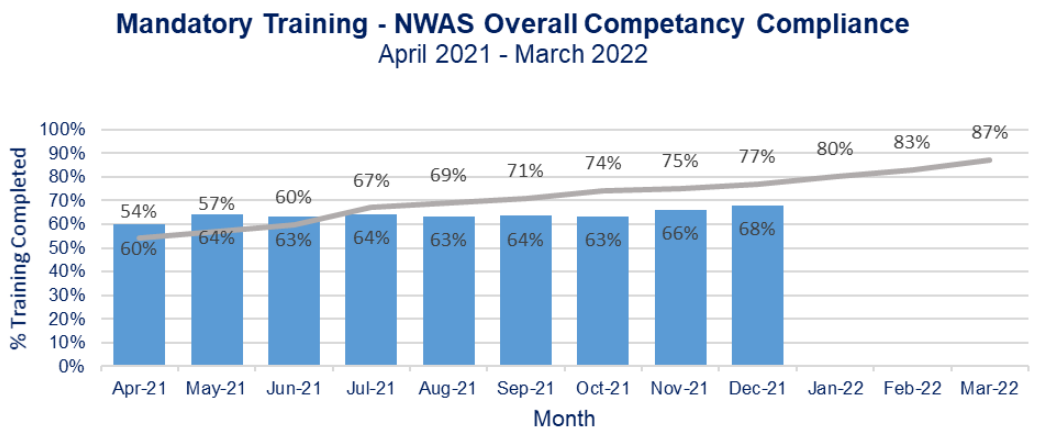
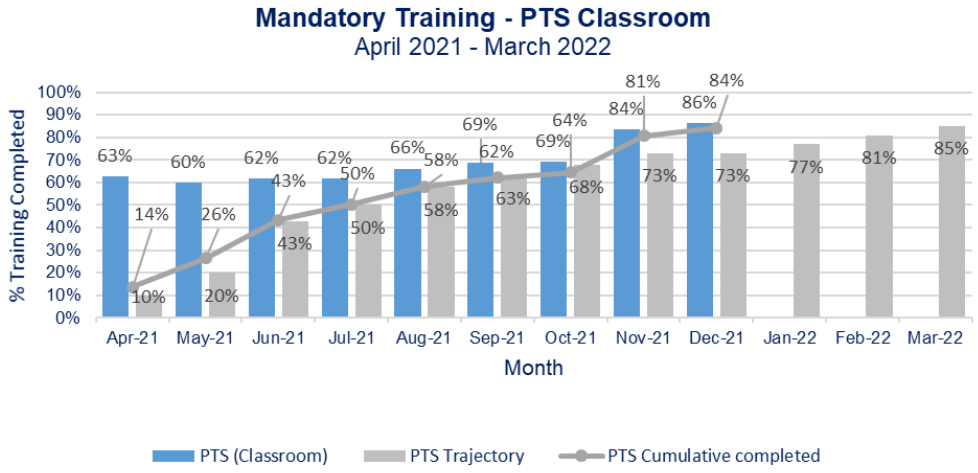


Figure OH7.2



Mandatory Training

The mandatory training cycle for 2021/22 commenced in April 2021 and runs across the financial year. The target for 2021/22 was to achieve **95%** compliance. However, as a result of REAP 4 , ELC have agreed a revised target of **85%** compliance for all Service Lines apart from Corporate Services remaining at **95%** compliance.

PTS are ahead of trajectory for both classroom and online compliance with overall compliance already at target **85%**.

111 (OH7.5) are also on track with trajectory to deliver the **85%** target and are currently at **79%**.

Corporate teams (OH7.6) have not met the **95%** target set for December given increasing pressures but at current compliance of **87%** the target should be met by March.

The key risk areas are PES and EOC. Classroom mandatory training has been paused in January for PES and PTS in order to facilitate training for the army deployment. PES classroom attendance was at trajectory at pause but online completions are also behind plan leaving overall compliance for PES at **62%**. EOC(OH 7.4) are **8%** behind trajectory at December.

The classroom pause will be reviewed at the end of January, however, additional abstractions would be required across February and March to reach the target, along with a focus on online completions.

ELC are reviewing individual module completions alongside the overall progress. Further work is also being undertaken to recover Level 3 Safeguarding training for those missing classroom training last year, this is being moved online , due to commence February for targeted completion in Q4.

Figure OH7.3

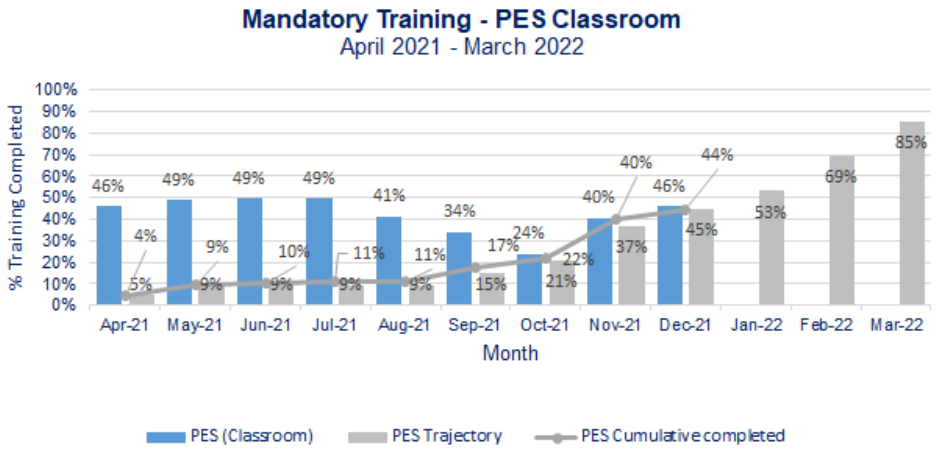


Figure OH7.4

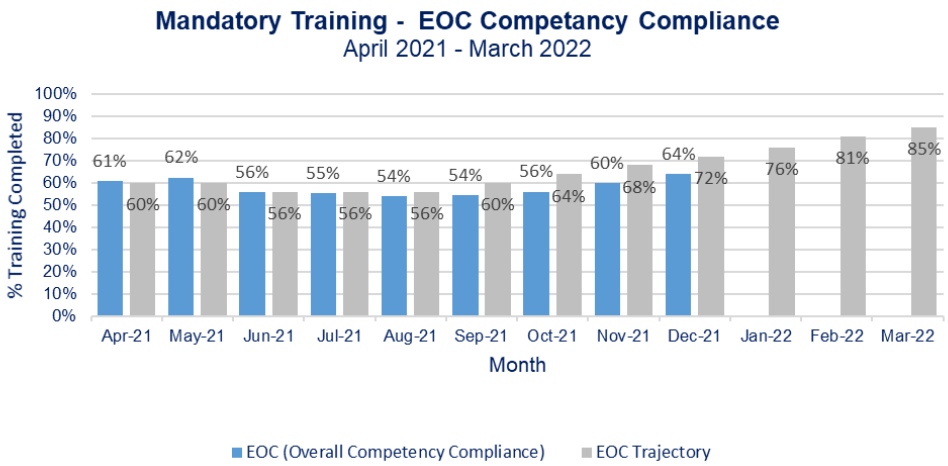


Figure OH7.5

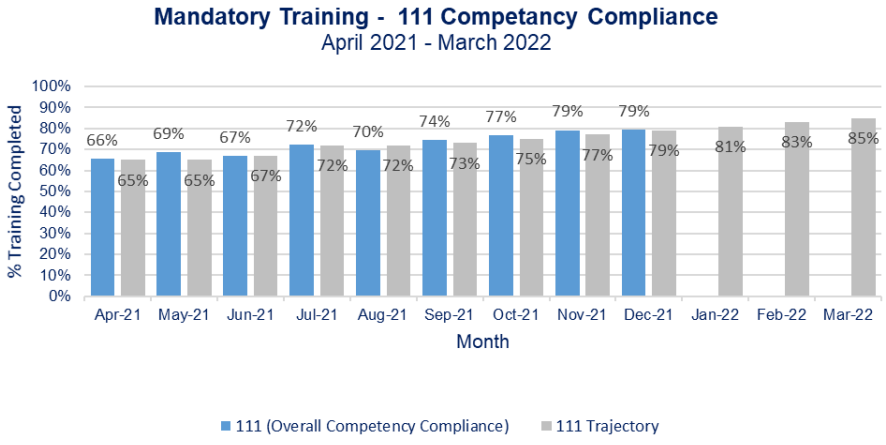
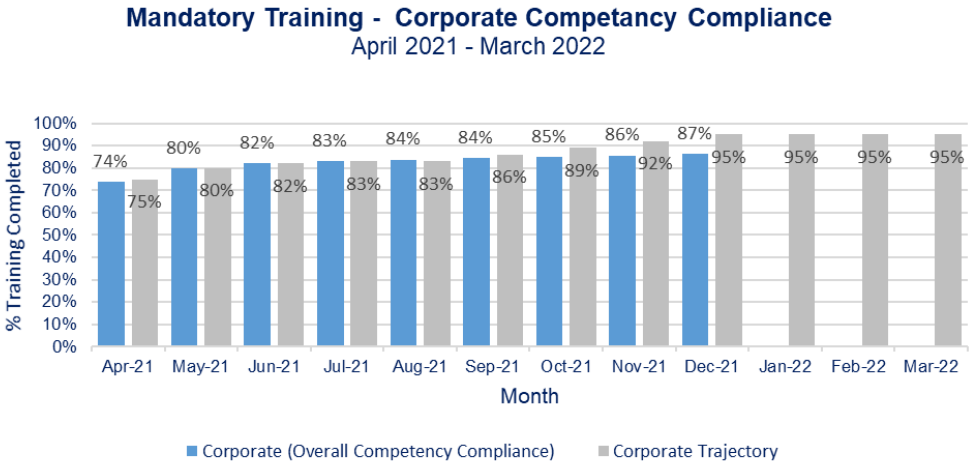


Figure OH7.6



OH8 CASE MANAGEMENT

Employee Relation Dashboard @ 18 January 2022 All information related to Dignity at work, Disciplinary, Fact Finding/Investigation and Grievance cases only

NWAS Summary

Service Line	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	36	130	12.06
Operations ~ EOC	6	22	12.89
Operations ~ Resilience	0	0	12.70
Operations ~ 111	3	36	8.45
Operations ~ PTS	3	31	12.66
Corporate	4	8	17.48
Other*	8	36	12.44
NWAS Summary	60	263	11.48

* In ER data base, where more than one employee is grouped under any particular case then they couldn't be identified under one particular department and hence they are grouped under other.

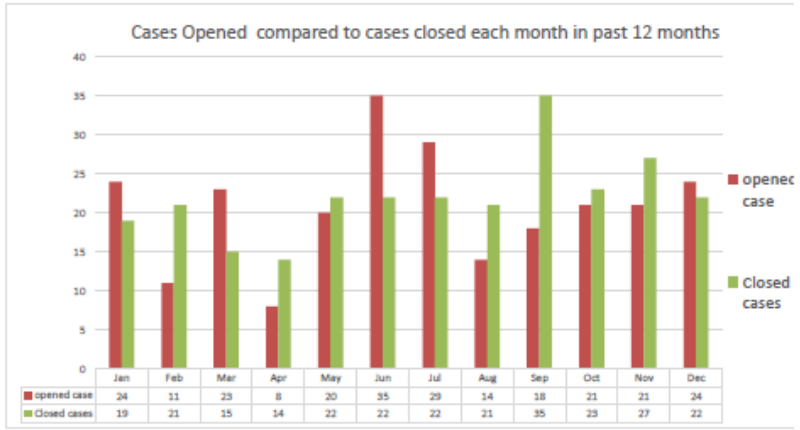
Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	12	46	12.55
Disciplinary	6	74	25.91
Fact Finding/Investigation	27	57	10.73
Grievance	15	86	17.17
Case Summary	60	263	11.48

Reason for opening Disciplinary cases in the past 12 months

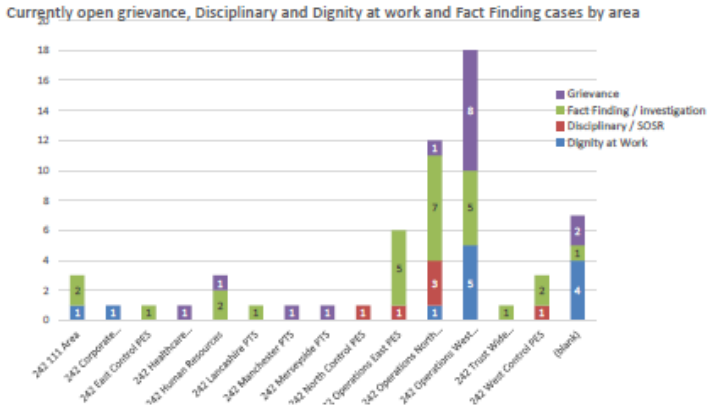
Opening reason	Number of cases in 12 months
Any action that brings the trust in disrepute	2
Assault/Threatening behaviour	1
Carelessness in the use of equipment or resources	1
Clinical Error	5
Conviction of a Criminal Offense	1
Discriminatory Behaviour	1
Fraud	3
Inappropriate/Unprofessional Behaviour	14
Negligent Behaviour	1
On-Going lateness	1
Poor Patient Care	2
Unauthorised absence	1
Failure to follow reasonable Management instructions/procedures	1
Victimisation/Bullying and Harrassment	1
NWAS Summary	35

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



Length of current live cases

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	7	2	2	1
Grievance	13	0	2	0
Fact Finding/Investigation	16	4	7	1
Disciplinary / SOSR	3	1	1	0
Case Total	39	7	12	2



Human Resources Case Management

The Trust is developing its data and oversight of case management. Details of casework are regularly reported to Resources Committee and ELC as part of Recovery planning.

The overall number of open cases and timeliness has been impacted by COVID-19 with several periods where there were limitations on progressing investigations and hearings. This has had a particular impact on the levels of sickness absence casework and on overall timeliness, so the Trust remains in a recovery period.

Overall the data shows higher or the same levels of case closure compared with new cases since August and this is also impacting positively on timeliness. The length of current live cases also shows a significant reduction in cases between 3-6 months which is indicative of earlier closure of new cases. There remains some challenges in closure of some longstanding cases often linked with long term sickness absence, level of complexity or involvement of external parties such as police.

There has been 10 pre-investigation review panels considering over 60 cases ensuring appropriateness of entry into formal process, welfare support and resources required for investigation. This is reducing the number of cases entering formal processes with 40% of cases have been deflected to informal conclusion, learning or no further action.

A recovery plan is in place to improve this position however it should be noted that the Mandating Covid Vaccination as a condition of deployment (VCOD) will have a significant impact on the HRBP Team and managers in the coming months. A significant number of informal and formal hearing will need to be scheduled.

COVID 19

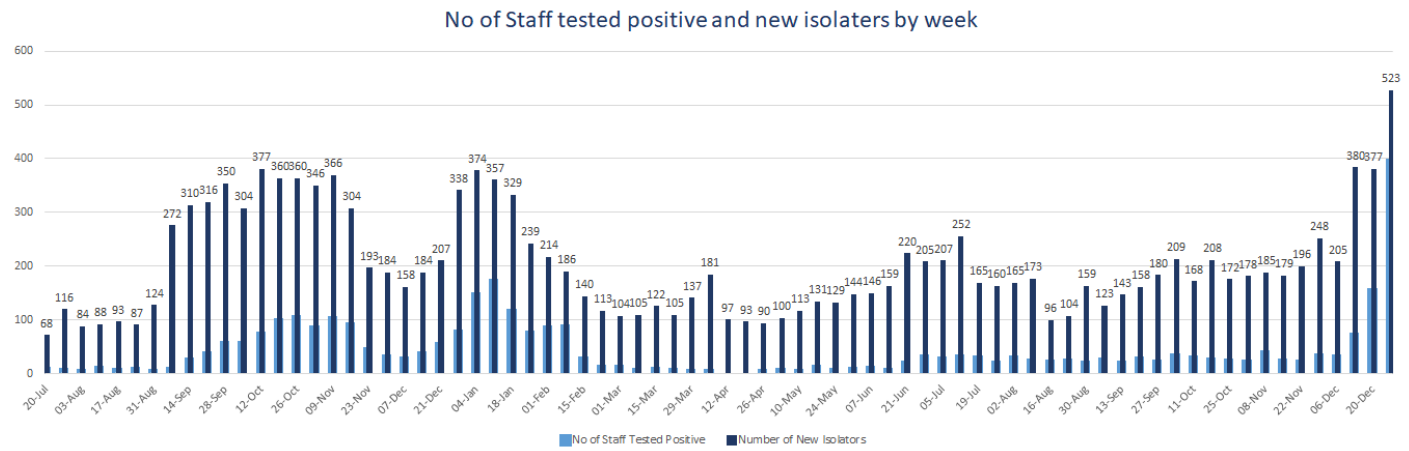
Table CV19.1 – Number of staff tested positive by week

Week Commencing	No of Staff Tested Positive	Week Commencing	No of Staff Tested Positive
20-Jul	6	12-Apr	0
27-Jul	3	19-Apr	0
03-Aug	1	26-Apr	1
10-Aug	7	03-May	4
17-Aug	3	10-May	2
24-Aug	5	17-May	8
31-Aug	2	24-May	4
07-Sep	6	31-May	5
14-Sep	22	07-Jun	7
21-Sep	34	14-Jun	4
28-Sep	53	21-Jun	17
05-Oct	54	28-Jun	28
12-Oct	71	05-Jul	24
19-Oct	96	12-Jul	29
26-Oct	101	19-Jul	26
02-Nov	83	26-Jul	17
09-Nov	99	02-Aug	26
16-Nov	87	09-Aug	21
23-Nov	42	16-Aug	19
30-Nov	28	23-Aug	20
07-Dec	24	30-Aug	17
14-Dec	34	06-Sep	22
21-Dec	52	13-Sep	17
28-Dec	75	20-Sep	24
04-Jan	144	27-Sep	18
11-Jan	168	04-Oct	30
18-Jan	113	11-Oct	27
25-Jan	72	18-Oct	23
01-Feb	83	25-Oct	21
08-Feb	84	01-Nov	19
15-Feb	24	08-Nov	35
22-Feb	9	15-Nov	20
01-Mar	9	22-Nov	19
08-Mar	3	29-Nov	30
15-Mar	6	06-Dec	28
22-Mar	4	13-Dec	69
29-Mar	1	20-Dec	152
05-Apr	2	27-Dec	393

Table CV19.1 – Number of staff tested positive and Isolating by Month

Month	No of Staff Tested Positive	Number of New Isolators
July 2020	8	166
August 2020	17	408
September 2020	86	1151
October 2020	346	1555
November 2020	326	1280
December 2020	166	894
January 2021	536	1448
February 2021	200	653
March 2021	22	481
April 2021	4	530
May 2021	18	524
June 2021	48	735
July 2021	107	871
August 2021	97	611
September 2021	82	648
October 2021	108	823
November 2021	101	808
December 2021	565	1523

Figure CV19.1 – Number of staff tested positive and isolating by week



Covid-19

Trust Position

In the Trust there have been **565** instances of staff that have tested positive for Covid-19 in December 2021 with **2,837** instances since July 2020 (Table CV19.1). This is the highest during the pandemic.

Weekly breakdowns are shown in both Table CV19.1 and Figure CV19.1.

Outbreaks

As at the end of December 2021 there were **10** outbreaks on trust sites.

There have been **118** outbreaks since reporting began with **109** outbreaks closed.

The outbreaks are contained and linked to community prevalence and individual lack of compliance with PPE. The controls in place to contain COVID 19 outbreaks in NWAS premises are working effectively with outbreaks limited to very small numbers of individuals at each site.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th January 2022			
SUBJECT:	Learning from Deaths summary report and dashboard Q2 2021/22			
PRESENTED BY:	Dr C Grant, Medical Director			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☐	☐
	SR05	**SR06**	**SR07**	**SR08**
	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	The Trust is required to publish on its public accounts, a quarterly and then an annual summary of learning; this is the fourth quarterly report to be published. The Q2 dashboard (appendix A) describes the opportunities to learn from deaths. In summary, the contributory factors to patient deaths, where identified, were attributed to problems with EOC procedures (specifically calls being incorrectly categorised) and lack of available resources. The peer review process identified most patients received appropriate care, but where failings occurred these included the failure to record observations, Manchester Triage System (MTS) being used inappropriately, and/or lack of a comprehensive PRF. The peer review identified areas of good practice. This included recognition of patients approaching end of life where no End of Life Care package or DNACPR was in place. Another example was organising and engaging with MDTs comprised of carers/GP/family members and external providers to ensure best interests of the patient were met. A further area of good practice was exemplary behaviour when treating a patient who had self-harmed, ensuring they were thoroughly safety-netted with safeguarding, the police, the patient's GP and the Emergency Duty Team. A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums and individual frontline staff. DCIQ Mortality module completed testing in Q2 with the module going live in November 2021. The subsequent			

<table>
<tr><td></td><td colspan="4">reports for this year will use data and findings from the new module.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board of Directors is recommended to:

• Support the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.

• Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.

• Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.

• Acknowledge the good practice identified including:

○ Recognising when a patient is approaching end of life and liaising with the patient, family and GP to ensure their best interests are met

○ Showing exemplary behaviour, emotional and informational support to a patient approaching End of Life, ensuring the patient did so with dignity by going above and beyond what we expect from our clinicians.

• Support the dissemination process as described in 3.4

• Note the progress of the DCIQ Mortality module going live.</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee
Clinical Effectiveness Sub Committee</td></tr>
<tr><td>Date:</td><td colspan="3">24th January 2022
18th January 2022</td></tr>
<tr><td>Outcome:</td><td colspan="3">Received assurance</td></tr>
</table>

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1. PURPOSE

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

Appendix A is a summary dashboard of the Q2 2021/22 Learning from Deaths review; and it is proposed this document is published on the Trust's public accounts by 31st January 2022 in accordance with the national framework and trust policy. The Q2 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs), for Q2. The learning from the panels is discussed later in this paper.

The next phase of dashboard development will require dedicated EOC subject experts to undertake the dispatch and triage review.

It is acknowledged the attached document remains an iterative reporting process which will continue to become more sophisticated and informative as 2021/22 progresses.

2. BACKGROUND

2.1 Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the Clinical Audit Team at Learning.FromDeaths@nwas.nhs.uk

3. LEARNING FROM DEATHS DASHBOARD Q2 2021/22: APPENDIX A

3.1 The number of patients whose deaths were identified as in scope for review was 100 (58 Datix incidents and 42 sampled - *table 1, Fig.1*).

3.2 ***Datix Cohort Discussion***

Of the 58 patient deaths;

- 42 patients were identified through the Incidents module
- Ten (10) patients were identified through the Patient Experience module
- six (6) patients were identified as having records on both the Incidents and the Patient Experience module

3.2.1 ***Incident Module: Tables 2 and 3, figures 2 and 3***

Of the 42 patients, 18 were reviewed and closed. In eight (8) cases the investigation concluded the Trust had contributed in some way to that patient death.

- A lack of available resources was cited as the main contributing factor to the patient's death

3.2.2 ***Patient Experience Module: Tables 4 and 5 and figure 4***

Of the ten (10) patients reported, six (6) are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. For the four (4) cases that have been closed, all of those deaths were considered to have been caused by the incident. The content of the reviews so far suggest the learning themes and therefore opportunities for improvement are:

- EOC and EMD procedures
    - Call incorrectly categorised with a missed opportunity to manually upgrade the call
    - Significant delay in responding to a falls patient, resulting in cardiac arrest
    - Significant delay in responding to a chest pain patient, resulting in cardiac arrest
- Communication
    - 111 did not convey sufficient information to EOC/EMD
- Relative/external health professional concern raised
    - Relative concerned that patient was not prioritised by call handlers
    - HCP concerned delay in conveying a patient for emergency neurosurgery resulted in that patient's death
    - HCP concerned delay in conveying a renal patient by PTS resulted in death due to lack of resus status and lack of CPR

3.2.3 ***Investigation and Patient Experience Modules: Tables 6 and 7 and figure 5.***

Six (6) patient deaths were recorded on both modules – note this is a different incident from those referenced separately in the incident and patient experience modules. None of the incident investigations have been closed though themes emerging from the investigations include:

- EOC and EMD procedures:
    - ECH did not recall Sudden Silence Procedure, resulting in incorrect call categorisation for the incident
    - EMD did not send caller for a public access defibrillator when one was available due to no defibrillator icon appearing on the call system
    - Calls incorrectly categorised with missed opportunities to manually upgrade the incidents
    - ECH did not recall the Ineffective Breathing Procedure, resulting in an incorrect category for the incident

3.3 ***Sample Cohort Discussion: tables 8, 9 and fig 6.***

Of the 42 patient deaths:

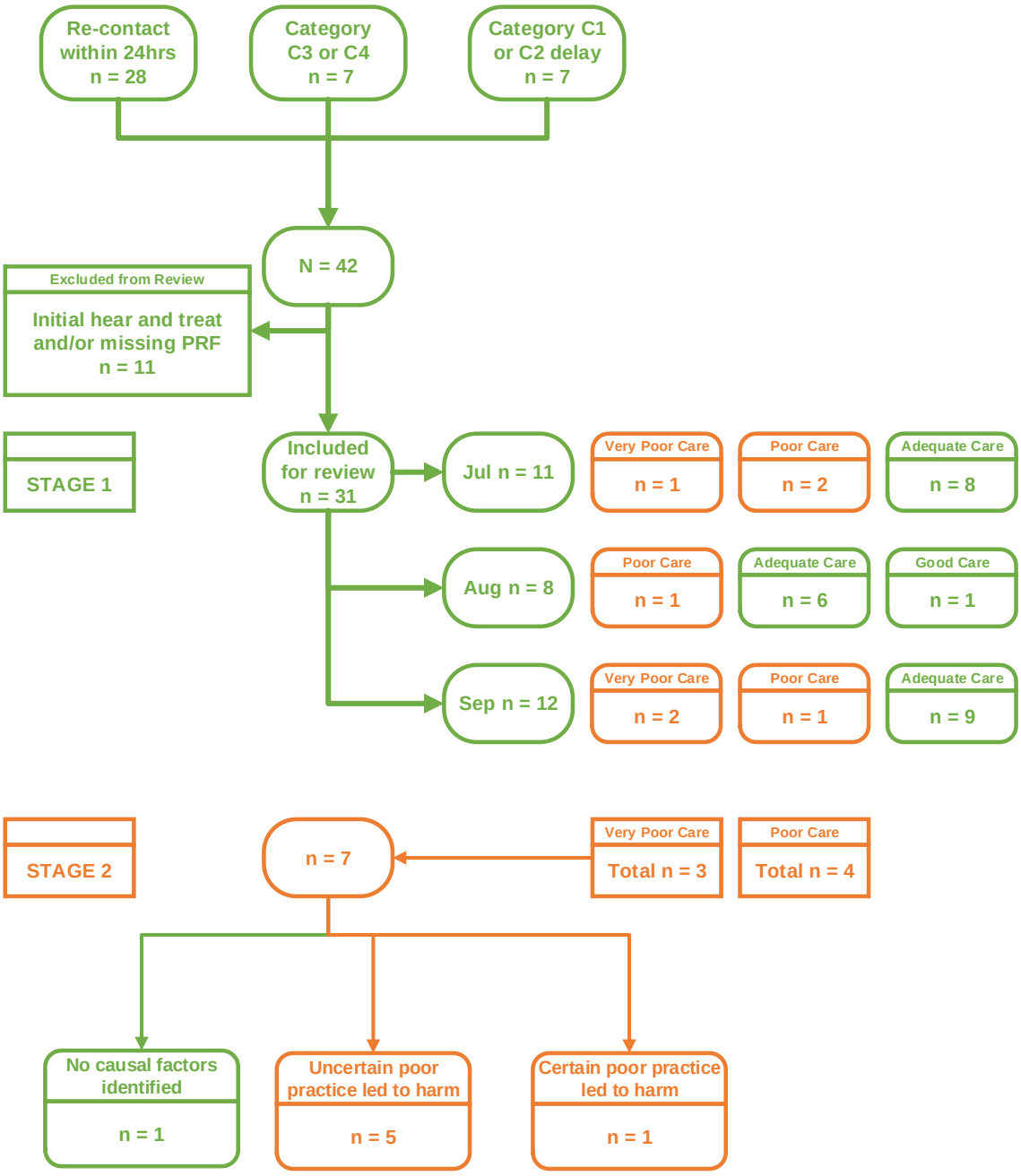
- 28 patient deaths occurred where patients were not initially conveyed and the service was re-contacted within 24 hours*
- Seven (7) patient deaths occurred where the incident was coded as Cat 3 or Cat 4
- Seven (7) deaths occurred where they were initially coded as Cat 1 or Cat 2, and were subjected to a long wait.

**The results should not be correlated to the results of the Safe Care Closer to Home audit due to significant differences in audit methodology.*

The flow chart below provides a summary of which of the cases identified were reviewed and how the numbers referred to in tables 8 and 9 and fig 6 of the Q2 dashboard change.
There are two reasons why the whole cohort identified are not reviewed:

1. Without a patient report form the review cannot be undertaken

2. Where a 24hr re-contact incident is initiated as a 'hear and treat' and subsequently as a see and treat; the 'hear and treat' element review cannot be undertaken without the EOC Clinical Hub specialist



Flow chart to describe sample cohort attrition and treatment Q2 2021/22

3.3.1 ***Structured judgement review methodology***

The process requires the reviewing frontline staff to make explicit statements upon the practice under review using the 'Sequence of Events' (SoE) and 'Patient Report Form' (PRF) as the data source.

The explicit statements of care can be one of five categories ranging from very good to very poor and it is possible in use each of the statements multiple times in a single review.

The review comprises of Stage1: review of clinical practice and call handling/ resource allocation. Where less than adequate overall care is identified a Stage 2 review of the patient death to identify if any causal factors (systemic) problems in care have led to harm.

3.3.2 ***Outcome: Q2 Review: Stage 1.***

31 patient deaths were reviewed by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the table below.

Month	Very Poor	Poor	Adequate	Good	Very Good
July 21	1	2	8		
Aug 21		1	6	1	
Sept 21	2	1	9		

Moderation Panels held on 14/09/2021, 12/10/2021, & 16/11/2021

It should be understood the mid-range statement of 'adequate' practice is defined as the expected practices and procedures in compliance with guidance. Any practice identified as beyond expected practice is defined as 'good'. Any practice identified as not reaching expected practice is defined as 'poor'.

3.3.3 ***Q2 Review: Stage 2.***

Seven (7) cases were identified as needing second stage review following Stage 1. It was identified that in one (1) case no other causal factors were identified as contributing to harm and simply the care experienced by the patient in terms of assessment, management plan and disposition were below expected levels one might reasonably expect.

In one (1) case it was identified that the factors identified did contribute to the death. The second stage review for the five (5) remaining patients remained as uncertain whether poor practice had led to harm.

3.3.4 ***Learning Outcomes: Tables 11 -12***

Poor Practice: Table 11 fig 7.

The panel identified areas for improvement were to

- Increase observations and/or investigations recorded
- Apply MTS/Pathfinder appropriately and correctly, ensuring that decisions are recorded
- Ensure the patient is appropriately safety-netted
- Ensure SOS/red flag/worsening advice is given and recorded
- Make appropriate referrals to AVS, primary care or alternative providers when appropriate to do so.
- Ensure Mental Health Assessments are carried out on patients when appropriate to do so
- Ensure when dealing with high-intensity users that unconscious bias does not enter decision making

Other learning which was identified through the review but not leading automatically to a stage 2 review was the variable quality of the patient record itself in terms of legibility, its comprehensiveness and use of appropriate language – leading to the more specific learning identified above.

Escalation and Learning
Five (5) case have been escalated for a further review but unfortunately due to the current demands on EOC and local operational teams, these are delayed.

Good Practice: Table 12 fig 8.
The panel review identified numerous positive examples of practice over and above expected practice. This included

- Recognising when a patient was approaching end of life and liaising with the patient and their family to ensure their best interests were met
- PES staff showing exemplary behaviour to a patient approaching End of Life by attending a local Hospice to provide the patient with bed pans as well as providing emotional and informational support to the spouse above and beyond what is expected
- PES Staff performing additional investigations and assessments beyond expected practice.

3.4 ***Dissemination Process***
A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the area learning forums (ALFs) and individual frontline staff.

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

There is an intention to commend individuals who through their care and professionalism have supported families and patients to experience a good death, and this will be a key element of the Learning from Deaths communication plan.

3.5 ***Report Development***
DCIQ: Mortality Module

The project team for DCIQ has worked with the Clinical Audit Team and Consultant Paramedic (Medical) to develop the structured judgement review process in Datix. As of November 2021 the DCIQ Mortality Module is live. The LfD SJR process is now held on the DCIQ system with two full cycles of SJR review having taken place as of time of writing. This now means all of our LfD data and findings are now hosted on one secure platform allowing for a more efficient process of review and reporting.

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

There are no legal implications associated with content of this report and the data gathered to produce the dashboard has been managed in accordance to the Data Protection Act 2018.

4.1 ***Risks***
Two on-going risks have been identified regarding the LFD project and they remain:

DX3408: *(risk score 12)* There is a risk that the lack of resource will mean the competing priorities to perform additional high risk defined audits (such as the Learning from Deaths audit) will not be undertaken in their entirety and this will have a negative impact upon the annual clinical audit plan resulting in a failure to provide assurance to the trust and regulatory bodies.

It is not possible to complete the 'call' element of the review without a dedicated EOC subject expert. Until this is resolved, all SJRs can only be 75% complete. Findings from each of the SJR panels held have highlighted this element as crucial towards identifying potential risks in practice.

DX3477: *(risk score 12)* There is a continued risk that NWAS will cease to be able to deliver the nationally mandated co-ordinated Learning from Deaths programme because of a failure to resource the co-ordinator position. Since 31st March 2021 cover has ceased and without a fully funded resource this will result in a failure to meet the national statutory requirement placed upon the trust going into 2021-2022.

5. EQUALITY OR SUSTAINABILITY IMPLICATIONS

No equality or sustainability implications (other than those identified as risks) have been raised as a concern from this report.

6. RECOMMENDATIONS

The Board of Directors is recommended to:

- Support the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the developing formal process of learning from deaths.
- Note the risks associated with the development of the Learning from Deaths process notably the continued absence of the call handling/dispatch and triage review.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care and identification of serious incidents previously unknown to the trust.
- Acknowledge the good practice identified including:
    - Recognising when a patient is approaching end of life and liaising with the patient and family to ensure their best interests are met
    - Thorough safety-netting of mental health self-harm patients through multiple agencies
    - Thorough safety-netting of patients at risk of dying who refuse conveyance and/or are violent to our clinicians
- Support the dissemination process as described in 3.4
- Note the progress in developing the DCIQ Mortality module.

NWAS Learning From Deaths Dashboard Quarter 2 2021-2022 (July - September)

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

	Total Number of Deaths in scope (sample cohort and Datix incidents)*	Total Number of Deaths Reviewed	% Deaths Reviewed	Total Number of Deaths where problems in care have contributed
July	31	18	58.1%	7
August	36	19	52.8%	7
September	33	16	48.5%	5
This Quarter	**100**	**53**	**53.0%**	**19**
This Financial Year	168	99	58.9%	38

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality 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.*

Table 1.

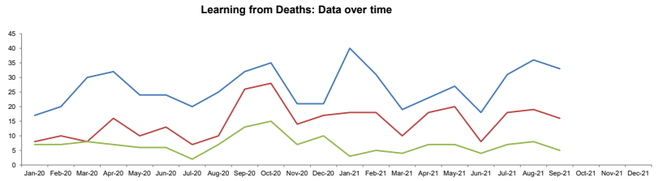


Figure 1.

Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Data source:An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below. Last accessed 15/12/2021.

Datix Cohort Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised to the organisation and recorded via Datix as 'deaths that occured in our care where there has been concern has been raised about the quality of care provided'. Patient experience module, records are included where Risk score is 4/5 and death has occured; the review is considered complete when the record is closed. Incidents module data, it is considered as a death in cohort where 'Degree of harm' is 'Death- Caused by the incident'. Patient Experience module data, is included in the cohort where the incident is closed and 'Reason for SI: Unexpected /Potentially avoidable death'.

Incidents Module

Total Datix Death incidents in scope		Risk grading		
		1 or 2	3	4 or 5
July	13	0	4	9
August	17	2	4	11
September	12	0	1	11
Total	**42**	**2**	**9**	**31**

Table 2.

Month	Number of Deaths Closed on Datix	Of those closed, Number of Deaths considered as caused by the incident	Lessons Learned complete for those closed and considered caused by the incident
July	5	2	1
August	9	4	2
September	4	2	1
Total	**18**	**8**	**4**

Table 3.

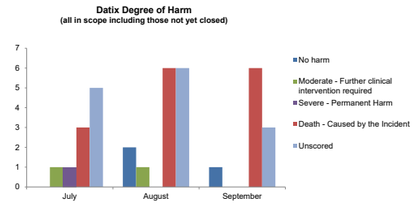


Figure 2.

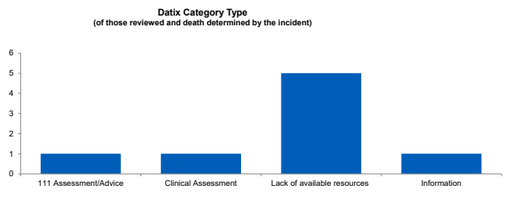


Figure 3.

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. Last extracted 02/12/2021. Last accessed 15/12/2021

Patient Experience Module only

Month	Relevant Patient Experience module incidents	Incidents Closed on Pat. Exp.	Number closed and death considered caused by the incident
July	2	2	2
August	5	2	2
September	3	0	0
Total	**10**	**4**	**4**

Table 4.

(Note- This is the month the incident occured, not when the notification of raised concern for care was received)

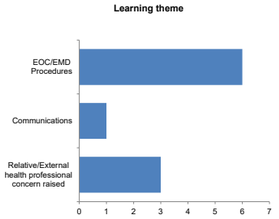


Figure 4.

Learning Theme	Learning Detail	Frequency	Action Themes (may have multiple)
EOC/EMD procedures	Call incorrectly categorised, opportunity to manually upgrade was missed	4	Reflection and/or feedback; refresher training to be undertaken for sudden silences/sudden arrest
	Significant delay in responding to a falls patient leading to cardiac arrest	1	Demand outstripped resources; guidance issued on principles of dispatch; HART to be included in review of Trust Meal & Rest Break policy
	Significant delay in responding to a chest pain patient	1	Demand outstripped resources; resourcing levels were not appropriate anywhere across the Trust on night of incident; commendation to dispatcher for effective monitoring of incident
Communication	111 did not convey sufficient information to EOC/EMD	1	Reflection and/or feedback; refresher training to be undertaken; still under review
Relative/external health professional concern raised	Relative concerned patient was not prioritised by call handlers	1	Complaint not upheld; Call handled correctly; Incident monitored safely
	HCP concern delay in conveying patient for emergency neurosurgery resulted in death	1	Complaint not upheld; demand outstripped resources;
	HCP concern delay in conveying renal patient by PTS resulted in death due to lack of resus status and lack of CPR	1	Complaint not upheld; no mismanagment from NWAS perspective; concern from NWAS as to suitability of patient for transfer

Table 5.

Data source: Datix Patient Experience search 'Risk Score: 4 & 5' Incident Date @lastquarter, last extracted using PE Listing report on 02/12/2021. Last accesed 15/12/2021.

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
July	2	0	0
August	1	0	0
September	3	0	0
Total	**6**	**0**	**0**

Table 6.

(Note- This is the month the incident occured, not when the notification of raised concern for care was received)

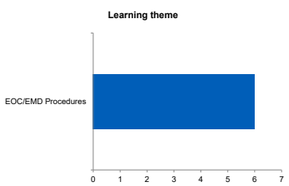


Figure 5.

Learning Theme	Learning Detail	Frequency	Action Themes
EOC/EMD Procedures	ECH did not recall Sudden Silence Procedure, resulting in incorrect category for incident	1	Reflection and/or feedback; re-training/re-reading procedures; conduct an incident learning review; refresher training to be undertaken for sudden silences/sudden arrest
	EMD did not send caller for Defibrillator as no defibrillator icon appeared	1	Reflection and/or feedback; re-training/re-reading procedures; instruction to send someone for defib should still have been given as per IAED
	Call incorrectly categorised, opportunity to manually upgrade was missed	3	Reflection and/or feedback; re-training/re-reading procedures; review of Patient Safety Plan; escalate incident to EOC learning forum
	ECH did not recall Ineffective Breathing Procedure, resulting in incorrect category for incident	1	Reflection and/or feedback; re-training/re-reading procedures; raise issue of ineffective breathing at EOC Learning Forum

Table 7.

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 02/12/2021. Information recorded on these incidents: last accessed 15/12/2021. 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': last extracted on 02/12/2021. Last accessed 15/12/2021

Sample Cohort Breakdown

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

Structured Judgement Review

Incidents used for the Sample criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
July	14	11	3
August	13	8	1
September	15	12	3
Total	**42**	**31**	**7**

Table 8.

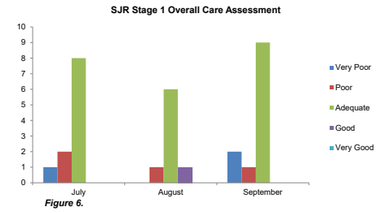


Figure 6.

Quarter 2 2020-2021 Sample Data Breakdown			
Month	C1 and C2 Long waits	C3 and C4 Deaths	24 hr Re-contact Deaths
July	2	3	9
August	3	2	8
September	2	2	11
Total	7	7	28

Table 9.

	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	N/A	N/A	N/A	**N/A**	
Right Care	Patient Assessment Rating	5	24	2	**26 patients out of 31 patient cohort**	**84%**
	Management Plan/Procedure Rating	6	23	2	**25 patients out of 31 patient cohort**	**81%**
Right Place	Patient Disposition Rating	6	24	1	**25 patients out of 31 patient cohort**	**81%**

Table 10.

† SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards; **Poor/Very Poor:** Care that is lacking and/or does not meet expected standards;
Good/Very Good: Care that shows practice above and/or beyond expected standards

Definitions taken from the National Quality Board, "National Guidance for Ambulance Trusts on Learning from Deaths", July 2019

‡ EOC subject matter expert required to undertake the call handling/resource allocation element of the SJR.

Structured Judgement Review Highlighted Learning Themes from Stage 1 (Review of 31 patients)

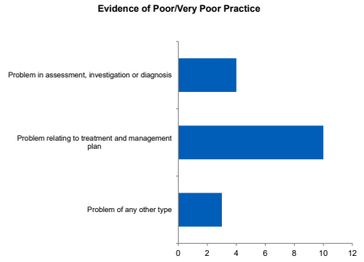


Figure 7.

Learning Theme	Learning Detail	Frequency (n=31 patients)
Problem in assessment, investigation or diagnosis	Lack of observations or investigations performed	4
Problem relating to treatment and management plan	MTS/Pathfinder incorrectly/not used	5
	Lack of patient safety-netting undertaken	2
	No SOS/red flag/worsening advice given	1
	No referral to AVS/GP/alternative providers when approriate to do so	1
	Lack of Mental Health Assessment	1
Problem of any other type	Incomprehensive PRF	2
	Unconscious clinician Bias when dealing with high intensity users	1

Table 11.

Figure 8.

Learning Theme	Learning Detail	Frequency (n=31
Additional assessments, investigations or diagnosis	Assessment of patient with additional investigations and assessments beyond expected practice	2
Additional treatment and management plans	Crew made multiple attempts to gain entry to a Mental Health Self Harm patient's property with excellent escalation before requesting permisaion to force entry when no answer from patient. Detailed description of recent police search & seize records as well as general scene.	1
	Patient recognised to be approaching EoL; crew liaised with patient, family members and GP to ensure best interests were met	1
	Crew showed exemplary behviour and treatment towards a patient approaching EoL. Crew attended local Hospice to obtain bed pans for patient and discuss supporting patient's spouse. Crew also provided emotional and informational support to patient, spouse and caregivers	1

Table 12.

The SJR Completion is an iterative process. All three months have been reviewed across three elements of the Stage 1 review process. Due to PRFs being unavailable and a lack of EOC subject experts for the SJR process, 31 reviews took place, 9 less than the minimum random sample size of 40 required.

Data source: Informatics Learning from Deaths SSRS Feed last run on 05/10/2021, SJR data source: Learning from Deaths SJR Database, last accessed on 15/12/2021.

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North West Ambulance Service NHS Trust

CHAIRS ASSURANCE REPORT

Quality & Performance Committee			
Date of Meeting:	22nd November 2021	**Chair:**	Prof A Chambers
Quorate:	Yes	**Executive Lead:**	Prof M Power, Director of Quality, Innovation and Improvement Mr G Blezard, Director of Operations Dr C Grant, Medical Director
Members Present:	Prof A Chambers Prof A Esmail Prof R Thomson Mr G Blezard Prof M Power Dr C Grant Ms A Wetton	**Key Members Not Present:**	Dr D Hanley, Non-Executive Director Mr N Barnes, Deputy Director of Quality, Innovation and Improvement

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☒	☐	☒	☐	☐	☒	☐	☐

Agenda Item	Assurance Points	Action(s) and Decision(s)	Assurance Rating

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

Board Assurance Framework	• Discussed the outstanding actions on the BAF and target completion dates for those in progress. • The Director of Operations reported challenges in relation to SR03 and staffing resource. Reported that recruitment plans were on track although short term nature of additional funding provided a level of uncertainty. • Noted that BAF narrative prepared by Executive Leads should reflect the impact of local and wider health care system on the Trust. • Recognised that the Trust had taken a transparent approach with the CQC to ensure that NWAS were judged in context with the wider system. • Acknowledged that the hard work by staff was not always recognised due to the overall performance level. • Received assurance that the Sub Committees continued to provide monitoring and robust discussion of the operational risks. • The final Q2 position would be presented to the Board of Directors on 24th November 2021.	• Received assurance that BAF risks were being managed effectively.	

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

Integrated Performance Report	• In terms of Quality, reported that the complaints backlog continued to be a priority and had reduced from 203 to 108 at the end of September 2021. • Reported that progress and plans to recover the position were monitored and scrutinised monthly by the Executive Leadership Committee. • The remainder of complaints to be closed were more complex cases that were more difficult to close due to the level of operational input required; which was currently impacted by the pressures of demand on the service. • ACQIs cardiac outcomes were preserving clinical care and care bundles were stabilised. • Discussed comparative data and most appropriate Trusts to benchmark NWAS activity against. • In relation to PES, noted that the Trust had received 152,673 calls during October 2021, a 24% increase compared to October 2019. • Delays had increased with a 6 point plan to achieve 999 and 111 trajectories. Noted that a review of productivity was being undertaken to establish the level of unproductive hours.	• Received assurance that work continued to maintain patient safety. • Noted the level of performance caused by operational pressures, due to significant demand on resources.	

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

	• In terms of 111 noted increased level of staff turnover and call volume remained high, reported a 50% gap between activity and resource. • Noted that the call profile had shifted and had impacted on the service. • Acknowledged the safety measures in place with regard to the clinical advice queue and ETA scripts introduced to provide realistic timescales to patients. • In relation to PTS, noted the service continued to provide high standard of service and continued to support PES.		
Progress Against the Right Care Strategy Q2 Update	• Received an update on progress against the Right Care Strategy Goals. • Acknowledged that progress had been impacted by the overall level of performance. • Recognised that Quality Assurance Visits had been completed during Q2 to support internal assurance processes. • Discussed amber RAG ratings in relation to progress made and noted the continued emphasis placed on patient safety.	• Received moderate assurance from the report.	
Health, Safety & Security Bi Annual Report	• The bi annual report reported mid-year position against metrics.	• Received moderate assurance from the report.	

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

	• Noted substantial sickness within the department which had impacted on risk score, however plans to mitigate the risk would make a positive difference during end of Q3 onwards. • Positive progress noted in relation to development of Safe check data and dashboard. • Violence and aggression incidents towards staff were discussed and the uptake amongst staff of Body Worn Cameras; which had been discussed at length at the Trust's Resources Committee. • Noted that an increased number of fire visits had been undertaken to mitigate risk and the recovery position was on track for the end of the year. • Highlighted the risk associated to mandatory training compliance, including manual handling. • Recognised the consequences of the level of demand on the service in terms of maintaining the required levels of mandatory training. • Mandatory training targets and recovery plans continued to be monitored by the Executive Leadership Committee and reported to the Resources Committee.		

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

Safeguarding Bi Annual Report	• Acknowledged the key developments made by the safeguarding team which included focus on safeguarding in 111, EOC and the Clinical Hub via the introduction of a dedicated Safeguarding Practitioner. • Noted the risk associated to safeguarding training had been reviewed and continued to be monitored by the Executive Leadership Committee. • Lessons learnt from safeguarding referrals and incidents was discussed. Suggested that future reports include detail of the learning themes. • Acknowledged that further detail was provided bi monthly to the Part 2 meeting of the Board of Directors for scrutiny.	• Received moderate assurance from the report.	
IPC Board Assurance Framework Q2 Update	• Received an updated and reformatted BAF report from the Assistant Director of Nursing and Quality. • Robust narrative on progress of IPC risks was noted. • A new IPC Specialist had been appointed to join the Trust on 1st December 2021 with focus on IPC BAF areas which required further assurance.	• Received assurance from the report.	

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

	• Four areas of priority identified with work plan to monitor progress, which would be included in the next report to the Committee. • The IPC team were currently reviewing face fit testing compliance and auditing which included work with the National IPC team. • Noted that a compliance toolkit, based on national guidance, would be progressed by the IPC specialist. • The Director of Quality, Innovation and Improvement noted the hard work and achievements made by the IPC team to reach the current BAF position.		
Clinical Audit Q2 2021/22 Report	• Progress in Clinical Audit during Q2 included introduction of a number of stretched targets. • Outcomes of Safer Care Closer to Home care bundles and learning from deaths audits discussed. • Confirmed the audit methodology process for learning from deaths cases and learning included the need for improved narrative regarding care plans. • AGP audit methodology compliance was noted and recognised that levels varied across the Trust which highlighted the challenges of balancing	• Received assurance from the report.	

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

	audit requirements with day to day pressures. • Noted the overall positive considering the pressure on the service. • Noted the ongoing development of the ePR Clinical Audit Tool.		
Clinical Effectiveness Sub Committee Chairs Assurance Report, from the meeting held on 2nd November 2021	• Highlighted the improvement in 111 in terms of clinical audit, reporting of risks and required mitigations. • Noted that MOUs had been approved in relation to Direct Access to Urgent Treatment Centres and Mental Health Crisis Lines. • The conveyance of paediatric patients audit data shared following outcome of a serious incident. Outcome of audit identified the need to review the governance framework and articulate the Trust's position; to be reported to future Q&P Committee. • Audits in EOC planned but current pressure on resource was impacting on learning requirements, position continued to be monitored. • Assurance reports received from service lines. • Initiatives completed by the Medicines Optimisation Group.	• Received assurance from the report.	

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Health, Safety & Security Sub Committee Chairs Assurance Report from the meeting held on 2nd November 2021	• Noted sickness levels within the team which had impacted on timeliness of reporting mechanisms. • Risks continued to be monitored. • Recognised that resource had been identified to rectify the position. • Noted that some written assurance reports had not been received due to pressures. • Acknowledged attendance level by service lines which was being addressed.	• Received moderate assurance from the report.	
Patient Safety Sub Committee Chairs Assurance Report from the meeting held on 2nd November 2021	• Noted that work continued to develop in line with the work plan. • New appointment of the Patient Safety Specialist would provide increased focus of safety culture work which would be measured alongside the Freedom to Speak Up Index. • Safeguarding Forum Assurance Report deferred to the January meeting.	• Received moderate assurance from the report.	
IPC Chairs Assurance Report from the meeting held on 9th November 2021	• Reported that scheduling of the subcommittee had been adjusted to support attendance levels. • Assistance had been received from the Head of Risk and Assurance to develop the structure and future reporting requirements	• Received moderate assurance from the report.	

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Non Clinical Learning Forum Chairs Assurance Report from the meeting held on 8th November 2021	• Noted that learning publications had been made and continued to support non-clinical learning within the Trust, despite operational pressures. • Work plan continued and directorate representatives on track with reporting requirements.		
Third Party Assurance Annual Report	• Received assurance from the governance arrangements in place to manage 111 and PTS third party contracts. • Noted the process for monitoring and reviewing performance which included monthly contract review meetings with a focus on clinical safety. • Terms of reference and robust meeting arrangements supported reporting requirements. • Performance levels against contract requirements were satisfactory and levels of quality compliance evidenced staff held the required clinical competencies. • The benefit of audit learning from third party 111 provider was discussed, however noted the challenge in releasing NWAS staff due to current operational pressures.	• Received assurance from the report.	

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Urgent & Emergency Care Assurance Report	• Received assurances in relation to progress against objectives of the Urgent and Emergency Care strategy. • Outcomes supported the overall aims and were aligned to the 3 year implementation plan. • ORH modelling work continued to support the remit of the Strategy. • The objectives included related to the UEC Delivery Model Programme; Integrated Response Model and Reducing Avoidable Conveyance with green and blue RAG ratings. • Quarterly assurance report would continue to be monitored by the Committee as plans progressed.	• Received assurance from the report.	

Key		
	Not Assured/ Limited Assurance	Could have a significant impact on quality, operational, workforce or financial performance
	Moderate Assurance	Potential moderate impact on quality, operational, workforce or financial performance
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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	26th January 2022
SUBJECT:	Communications and Engagement Team Dashboard Report – Q3 (October-December) 2021/22
PRESENTED BY:	Mr S Desai, Director of Strategy, Partnerships and Transformation

LINK TO BOARD ASSURANCE FRAMEWORK:

SR01	SR02	SR03	SR04
☒	☐	☐	☐

SR05	SR06	SR07	SR08	SR09
☐	☐	☐	☐	☐

PURPOSE OF PAPER:	For Discussion
EXECUTIVE SUMMARY:	The Communications and Engagement Team provides a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. For quarter 3 (Q3 – October - December 2021), statistical content and themes are provided on: **Patient and public engagement** A summary of our patient and public engagement activity for Q3. It includes the number of virtual engagement opportunities attended and feedback gathered, and information about our patient surveys. For example, this quarter: • 16 virtual community engagement opportunities were attended or facilitated. • Feedback was gathered about service accessibility and patient transport service eligibility which will be passed on through regular attendance at PTS meetings. • 57% more patient surveys were issued – the second consecutive increase in surveys sent out – due to the continuation and expansion of a pilot where SMS text messages prompt survey completion for PES and PTS patients. • Response rates increased and are hoped to increase further with the continuation of the trial of the SMS prompts. • Satisfaction with services declined for the third quarter in a row, based on survey responses: - 88% were likely to recommend the service to friends and family, down 2% from Q2. - 85% were very or fairly satisfied with the overall service they received, down 2% from Q2. - 92% agreed they were cared for with dignity, compassion and respect, down 1% from Q2.

Patient and public panel (PPP)
A summary of the Q3 activity for the PPP, including up-to-date figures for panel recruitment and performance against objectives for the year. For example, this quarter:

- 20 new panel members were confirmed and inducted to the trust
- 198 panel members in total, a 9% increase from Q2
- 30 new expressions of interest in Q3
- 15 new requests for panel involvement in Q3, up 67% from Q2
- Exceeded a target of 20% for youth representation on the panel by end of the year by reaching 22% in Q3
- Reached 14% against a target of 20% for diverse community representation on the panel by the end of the year
- Exceeded the target for 15 opportunities for panel involvement.

Press and public (patient) relations
A summary of our media relations activity for Q3. This includes the number of incident check calls and some highlights of the media relations work that has been undertaken this quarter. In Q3:

- 440 incident check calls.
- 27 proactive web or media stories, a 37% decrease after a very busy Q2.
- 49 statements prepared in response to press enquiries. This is an increase of 23%, and the second consecutive increase after a huge 122% jump from Q1 to Q2, demonstrating how busy the press office has been this year.
- The increase in statements is due to media enquiries broadly about high demand - causing delays in responding to patients, issues with hospital handovers and staff absences.
- These issues led to an increased amount of press coverage that we would categorise as negative, but it is important to highlight that we respond to each enquiry with a balanced statement from NWAS to ensure we are represented in any article.

Social media: Facebook, Twitter and Instagram
A summary of our social media statistics for this quarter.

The report highlights our:

- **Audience** – which has grown by 2.9% across our channels in Q3, with a combined following of more than 147,000 people.
- **Engagement** – which shows our 865 social media posts potentially reached more than 10 million people in Q3 and achieved an engagement rate of 5.4% (very high compared to an industry standard of 2.5%).
- **Content** – a brief description and analysis of our 'quality over quantity' approach to content creation. While we post less than some other ambulance trusts, our

engagement rates are much higher which is a more valuable measure of successful social media use.

Green Room
A summary of statistics for the Green Room – our staff intranet - including page views and visitor numbers. In Q3, staff accessed the Green Room more than 360,000 times.

Thanks to effort from the team, the 'news' page of the Green Room is becoming increasingly popular, with a 50% increase in views in Q3.

The report also includes details of new Green Room features for Q3 – a pilot of a comments feature for news stories.

Website
A summary of statistics for our website, accessed by members of the public and partner organisations. In Q3, the website was visited almost 210,000 times.

The most popular pages were careers, patient transport service, and 'contact us'. The majority of people found our website by searching on Google, typing in the web address or clicking through from social media.

There is an update about an accessibility audit taking place in Q4 to ensure our website and Intranet are following best practice and meeting accessibility standards.

FOI performance
An update on the FOI performance against the national target of 90% completion within 20 days. 78 FOIs were completed in Q3 (up 4% from Q2) and 96% were within the 20 working day target, maintaining performance from Q2.

Stakeholder communications
A summary of stakeholder activity for Q3, including the number of MP letters written and bulletins issued, along with any other activity. For example, this quarter included:

- 2 stakeholder bulletins and 2 autumn/winter watch newsletters
- 6 MP letters

Internal projects and campaigns
Highlights and figures about the main internal communications projects and campaigns from Q3, including:

- Flu vaccination
- Community calendar
- Disability Network launch
- NHS 111
- Service delivery model review
- NHS Pathways
- Festive messages
- Ideas Room – strategy refresh
- New email solution

	- Awards - iPads **Internal bulletins and the Staff App** Figures showing how many internal communication bulletins have been issued and up-to-date statistics on the staff app. For example, in Q3 there were: • 10 CEO bulletins • 20 Clinical bulletins • 49 Operational bulletins • 591 staff app downloads **Films produced in-house** A summary of in-house videography activity. 22 films were completed this quarter, 22% more than Q2 and an increase for the second consecutive quarter, with an average of seven films filmed or edited per month. They included: a flu jab film, clinical review of 999 calls announcement, a patient story, 2 x films to support the Disability Network launch and 2 x 'proud to be' films for Black History Month. **Focus on…** • **Restart a heart -** three public CPR demonstration events were held online as part of Restart a Heart Day. More than 330 people joined to learn CPR and the success has led to plans for a follow up session. • **Staff survey** – a summary of communications activity that helped to achieve a response rate of 36.2% - above the 35% target – including posters, bulletin articles, social media activity, app notifications and a CEO message. • **Winter plan** – an update on winter plan activity in Q3, including: radio adverts which were aired more than 1,000 times across North West stations reaching almost 1 million people; and an information booklet to support people in the community.
RECOMMENDATIONS:	For discussion, noting and the provision of any comments.
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation

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

PREVIOUSLY CONSIDERED BY:	N/A	
	Date:	
	Outcome:	

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1. PURPOSE

To provide the Board of Directors with a summary of key outputs and associated highlights on the work of the combined Communications and Engagement Team for Q3 (October - December 2021).

2. BACKGROUND

The Communications and Engagement Team has created a dashboard providing high level statistical content and themes from Q3 activity on:

- Patient and public engagement
- Patient and public panel
- Press and public (patient) relations
- FOI performance
- Stakeholder communications
- Social media: Facebook, Twitter and Instagram
- Website and Green Room
- Internal projects and campaigns
- Internal communications including the staff app
- Films produced in-house

Each report also goes into more detail on some priority pieces of work. This quarter's dashboard provides an overview of our Restart a Heart Day activity, winter plan progress and staff survey support.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

All of the trust's communication and engagement activities adhere to the following legislation:

- Freedom of Information Act 2000
- Health and Social Care Act 2006 (to involve and consult with patients and the public in the way it develops and designs services).
- Department of Health's Code of Practice for promotion of NHS Services 2008.

NHS England Patient and Public Participation Policy 2015 (listening to and involving communities, their representatives and others, in the way we plan and provide our services).

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

All the trust's communications and engagement activities seek to promote equality and diversity and ensure information is accessible to all. This dashboard includes reference to an accessibility audit which is underway to ensure we meet accessibility standards across our digital channels.

5. RECOMMENDATIONS

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.

Communications and engagement dashboard

Q3 2021/22: Oct - Dec

NHS North West Ambulance Service NHS Trust

PATIENT AND PUBLIC ENGAGEMENT

16 virtual engagement opportunities with groups including: Cumbria Deaf Association, Lancashire Visual Impairment Forum, Cheshire East Carer's forum, Sefton Older Person's forum and Salford Mental Health forum.

- At the Lancashire Visual Impairment Forum there was positive feedback about our website and the good accessibility features.
- Slightly less positive examples were shared about problems the deaf community may have had accessing the service.
- The Patient Engagement Team will continue to share information about the emergency video relay service (accessing 999 via BSL interpreters) which should be in place by April 2022 via the operator.
- Questions were asked about PTS eligibility criteria and alternatives for those not eligible. PPE concerns were also raised by patients who travelled with third party providers.
- The Patient Engagement Team will be attending PTS meetings on a regular basis to share monthly dashboards with patient feedback themes so this can be cascaded to all PTS staff.

17,283 surveys sent ▲ 57%

1,245 surveys returned ▲ 25%

We usually send out patient experience surveys to cover 1% of each service line's activity. In Q3, as part of an ongoing pilot to send surveys via SMS text message, we doubled this and sent survey links to 2%, to measure the impact this has on return rates.

88% were likely to recommend the service to friends and family ▼ 2%

85% were very or fairly satisfied with the overall service they received ▼ 2%

92% agreed they were cared for with dignity, compassion and respect ▼ 1%

For a third consecutive quarter, there is a decline against the response measures.

PATIENT AND PUBLIC PANEL (PPP)

30 new expressions of interest in Q3

20 new panel members in Q3

198 panel members now in total ▲ 9%

15 new requests for panel involvement in Q3 ▲ 67%

20 structured and/or task orientated involvement opportunities delivered

5 ad hoc opportunities (virtual only) offered for panel members in Q3

PERFORMANCE AGAINST OBJECTIVES:

- Increasing youth representation – target is to have **20%** of the PPP made up of young people (16-24 years old) by the end of the year. During Q3, we reached **22%** - exceeding the target.
- Ensuring we represent our diverse communities – target is to increase the representation of panel members from our diverse communities by **20%** by end of this year. In Q3, this increased to **14%** from 10% a year ago.
- A minimum of 15 opportunities for PPP involvement - exceeded in Q3.
- Enhance two-way communication with PPP -in Q3, during PPP work plan sessions, a few members raised they sometimes feel overwhelmed with heavy email traffic. However, others said they preferred how emails are sent now. A weekly round-up bulletin with all PPP information and opportunities is being trailled to replace non-urgent emails.

PRESS AND PUBLIC (PATIENT) RELATIONS

440 'Incident checks' handled

27 proactive website and media articles ▼ 37%

49 statements in response to press enquiries ▲ 23%

14 broadcast media interviews arranged

After a very busy Q2, we saw a slight drop in the number of proactive news stories issued but another increase in the number of statements we provided to the press. This is mostly due to continued interest in our performance, particularly our reaction to hospital handover delays and many queries about delays in responding to patients.

We arranged for Medical Director Chris Grant to give a number of broadcast interviews about current pressures.

Also in Q3, one of our emergency medical technicians (EMTs) featured in a BBC TV programme, Blackburn Sings Christmas With Gareth Malone. We supported his involvement in the show, along with the required promotional interviews.

225 pieces of media coverage ▲ 43%

103 were reports of incidents including a mention of NWAS with details provided by our press office about what resources were there, number of patients and nature of injuries. This is considered 'neutral' coverage as the story itself about an incident may be considered positive or negative, but the information about NWAS is factual and neutral in tone.

44 pieces were considered negative. These are stories that overall, reflect negatively on NWAS, but will include a statement from us in response to a situation. This amount of negative coverage is higher than usual and is proportionate to the increase in work preparing statements for the second consecutive quarter. The negative coverage includes pieces about high demand causing delays and reporting from the Manchester Arena Inquiry.

The remaining coverage was positive and included stories about award wins and new, greener ambulances in the fleet.

NOTES: This is coverage available online and may not include all mentions of NWAS in local publications or on broadcast media outlets, although most broadcast outlets also publish online stories which will be captured.

SOCIAL MEDIA - FACEBOOK, TWITTER AND INSTAGRAM

AUDIENCE

71,570 Facebook page likes

61,210 Twitter followers

15,081 Instagram followers

2.9% Overall audience growth in Q3

ENGAGEMENT

865 posts published across all channels (around 9 per day)

10,374,311 Impressions

558,313 engagements (comments, likes, retweets, shares etc)

5.4% overall engagement rate

9.3% in engagement rate from Q2

CONTENT

Our quality over quantity approach:

We post less than other ambulance services but with better engagement results - as a comparison, on Facebook during Q3, we published 189 posts compared with an average of 234 posts by our competitors, with one trust posting more than double the amount. However, we lead the way with engagement - with a whopping 99,216 engagements on Facebook posts, compared with a competitor average of 18,041.

NOTES:

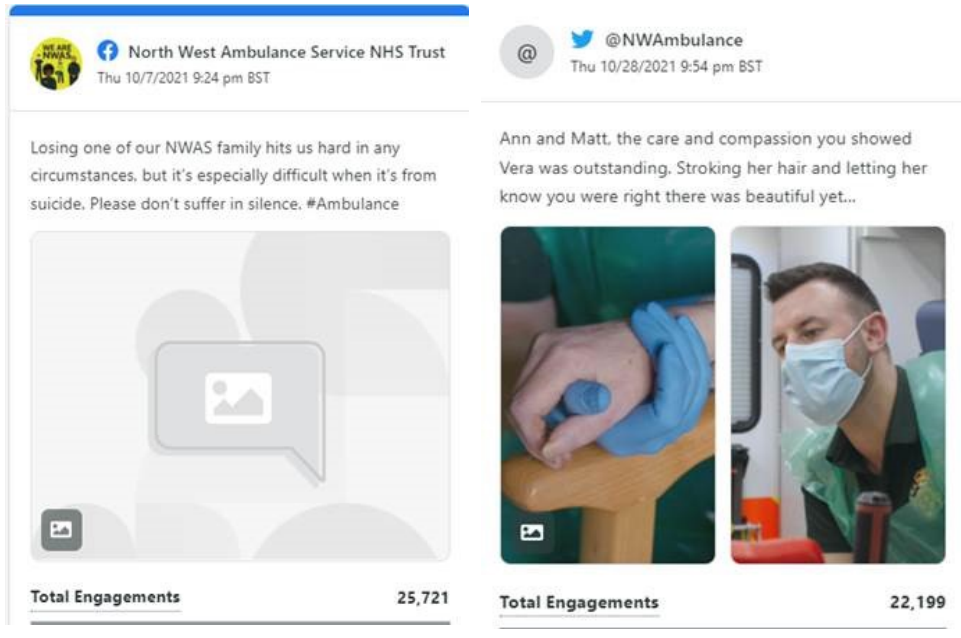
'Impressions' means a post has appeared on someone's social media feed. It is the number of times our content may have been seen by a member of the public.

'Engagements' is when someone engages with our content e.g. clicks a link, reacts to it by clicking 'like', or shares or retweets it.

'Engagement rate' shows us how many people engage, for example for every 1,000 people who see our post, 54 engage.

According to social media industry experts, the average engagement rate is less than 0.5% for Facebook, 2.5% for Twitter and 1.5% for Instagram, making our engagement very high.

BBC Ambulance posts still featured heavily in this quarter with the top performing posts in terms of engagement:



THE GREEN ROOM (INTERNAL)

361,395 visits in Q3 - the number of times staff members have used it

1,109,264 page views - meaning every time a person visits, they view approx 3 pages

HIGHLIGHTS:

50% increase in views to the 'news' section, for the second consecutive quarter, with 16,693 visits (almost 300% increase on this period last year). This makes it a valuable communication channel, letting us focus on the more significant stories for the weekly email bulletin.

NEW

We're currently testing a comments feature on Green Room news stories to increase interactivity. Before publicising trust-wide, we've soft launched in order to establish how staff use the feature and to iron out any potential issues.

NWAS WEBSITE (EXTERNAL)

209,538 visits in Q3 - the number of times people have visited our website

435,948 page views - meaning every time someone visits, they view approx 2 pages

MOST VIEWED:

- Careers – 205,136 views
- Patient Transport Service – 50,087 views
- Contact us – 20,909 views

ROUTE IN:

- Search (Google etc) – 132,082 visits (63%)
- Direct (typing in URL) – 38,301 visits (18%)
- Social – 34,078 visits (16%)
- Referral from other site – 5,077 visits (3%)

HIGHLIGHTS:

- External factors heavily influence daily visits – on 23 November site visits peaked at **14,876** due to a social media post about EMT apprenticeships. On that day social media referrals accounted for **82%** of visits.
- Top news story this quarter was about our 'Learn how to save a life' virtual sessions for Restart a Heart Day – helping to generate **334** attendees at the sessions.

COMING SOON: In Q4, accessibility audits are taking place to make sure we are following best practice and so action can be taken to ensure both sites meet the AA accessibility standards.

FREEDOM OF INFORMATION (FOI)

78 FOIs completed ▲4%

96% within 20 working day target =

96% year to date on 20 working day target =

Topics included:

- Call outs to locations
- Ambulance responses from traffic calming measures
- Hospital handovers
- Number of calls

NOTES:

FOIs: We have a statutory duty to reply to FOIs within 20 working days. The national target is 90% for this and we set an internal stretch target of 95%. Q3 was busy with an increase in the number of FOIs completed for the second consecutive quarter. Performance against targets was maintained.

STAKEHOLDER COMMUNICATIONS

2 Stakeholder bulletins
Covering topics including: winter preparedness, COVID-19 in the North West and a Manchester Arena Inquiry update.

2 Autumn/Winter Watch
A monthly summary of our activity with comparisons to the previous year's activity. It is shared to keep stakeholders informed of the demand for our services.

6 MP letters
Covering topics including: road access, ambulance delays, response times, cycle lanes and traffic calming measures in Stockport.

FILMS

22 completed ▲22%
5 underway

- Why it's important to get your flu jab
- Clinical review of 999 calls
- Learn how to restart a heart with BSL
- Beat The Burnout: meditation
- 4 x Health, Wellbeing and Culture Audit (Zeal)
- Patient Story: Laura's story
- Team Talk Live: November
- 2 x films to support Disability Network launch
- Christmas Card and Chair's Christmas message
- 2 x Proud to Be films to mark Black History Month

NOTES:

Videos are filmed and/or edited in-house using team skills and equipment.

An average of 7 films per month were filmed or edited in Q3, one of our busiest ever periods.

INTERNAL (STAFF) BULLETINS

This quarter, we issued:

10 CEO bulletins **20** Clinical bulletins **49** Operational bulletins

plus 50 others, including Manchester Arena Inquiry, HR, 111, digital and PTS bulletins.

Topics included:

- Manchester Arena Inquiry updates
- iPad roll out updates
- Access to emails on personal phones instructions
- Care home COVID-19 guidance

591 staff app downloads in Q3, most used for accessing GRS, ESR and Green Room.

14 push notifications to staff mobiles about about staff survey, disability network launch and emails.

INTERNAL (STAFF) ACTIVITY

Flu vaccination campaign

- Ran from the end of September as a short, sharp eight-week campaign.
- A communications plan aimed to share key messages about the vaccine and reasons for getting it.
- With support from a design agency, produced posters, social media assets, hand sanitisers and stickers.
- Regular messaging featured across our internal channels.
- A dedicated Green Room page was regularly updated with upcoming clinics.
- Case studies with 'Influencers' covered why they were having the vaccine to encourage colleagues to do the same.

Disability Network Launch

- Supported the launch of the Disability Network during Disability History Month.
- Assisted with the schedule and structure of the event, producing scripts for speakers, videos for the launch and promotional materials to attract interest.
- More than 45 people attended, with further views afterwards on our YouTube channel.

NHS 111

- Issued 12 shift enhancement bulletins
- Promoted the wellbeing champions and the results of the survey to see what benefit they are providing.

Service Delivery Model Review

- Standalone bulletins issued giving updates on all working groups and the associated leadership review.

NHS Pathways (Single Primary Triage)

- Updated comms plan and reviewed FAQs for external organsations.

Community calendar

- Teamed up with the Health and Wellbeing Team to give our annual Community Calendar a whole new look.
- The calendar celebrates our diversity and inclusivity marking various religious celebrations as well as a number of special inclusion dates.
- Photographs of our diverse workforce are included each month along with quotes from staff from all areas of the organisation.
- A digital copy is available on our website and intranet and printed copies are being sent to all trust sites. Additional copies have been offered to our community contacts and stakeholders.

Festive messaging

- Supported messages to staff including a Christmas Eve message from our Chair and New Year message from our Chief Executive as well as letters to each service line from their Head of Service.
- Issued Christmas card and gift voucher to all staff.
- For a bit of light-hearted communications, we asked staff for pet photos for our Christmas calendar, posted on our staff Facebook page. We received great interest from colleagues with 35 photos sent in of pets dressed in outfits, tearing open presents and climbing the Christmas tree.

INTERNAL (STAFF) ACTIVITY continued...

Ideas Room - Strategy refresh

- Used the Ideas Room to gather staff views on the proposed trust strategy refresh.
- Ran two sessions - one focused on purpose and vision, the second focused on strategic priorities.
- There were more than 40 contributions which were used to inform the next stage of the strategy refresh.

New email solution

- Scoped options for a new corporate comms email distribution platform to provide staff with accessible and responsive design, as well as reminders for important clinical information.
- Rollout will commence in Q4.

Awards

- Evaluated both the long service and Star awards to influence future plans.
- A task and finish group for long service will be set up in Q4.
- Plan for Super Star Awards was drafted to be implemented in Q4.

iPads

- Supported launch of iPad rollout to frontline staff with dedicated 'how to get an ipad' web page, which had **985** views by the end of Q3 and Green Room support page, which had **575** views by the end of Q3.
- A segmented email with key messages and information, poster for all sites and further support comms planned for next quarter.

FOCUS ON...Restart a heart

- We successfully hosted three public online CPR demonstration events as part of Restart a Heart Day.
- More than **330** people joined us on the session to learn CPR.
- There was a fierce appetite for the event/topic on social with posts generated amazing interest and support - on Facebook the four supporting posts reached **431,343** users and generated **14, 475** engagements (number of times that users engaged with your post during its lifetime).
- A follow up session is looking at being planned for paediatric CPR based on feedback gathered from the sessions.

FOCUS ON...staff survey

- The annual NHS Staff Survey launched on Monday 4 October and ran for seven weeks.
- A comprehensive communications plan was formulated with specific objectives and actions using various internal channels.
- Teaser messages were sent out across bulletins and in the staff Facebook group followed by weekly bulletin articles and regular staff app notifications.
- An incentive to be entered into a weekly draw to win Love 2 Shop vouchers was promoted and featured winners as case studies.
- Posters were distributed across all sites which highlighted positive changes as a result of staff sharing their views.
- We kept a consistent flow of messaging using all channels to target as many staff as possible and supported managers and senior leaders to encourage take up amongst their teams.
- We involved Trade Union colleagues to further embed the key messages and share with staff the importance of completion.
- The final response rate was **36.2%**. HR's target was **35%**.

FOCUS ON...winter plan

In addition to a schedule of social media content and accommodating appropriate media interview requests, during Q3, radio commercials were produced advising the public to only call us in an emergency. These were aired on Hits Radio group covering all North West regions from 15 December.

1,042 **adverts aired**

970, 810 **people reached according to radio figures**

A winter booklet was produced with what expect when you call 999, what to call us for and what to expect in terms of a response. It also included some advice and helpline numbers.

It was produced in collaboration with the Patient and Public Panel, who gave feedback on the content and language, to ensure it was suitable for a wide public audience.

The booklet is available to download or request as a printed copy via the website. It has also been issued to all North West Healthwatch groups and a number of the Patient and Public Panel members.

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
DATE:	26 January 2022			
SUBJECT:	ICS and Stakeholder Engagement Update			
PRESENTED BY:	Director of Strategy, Partnerships and Transformation			
PURPOSE OF PAPER:	For Assurance			
LINK TO BOARD ASSURANCE FRAMEWORK	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☐	☐	☐
	SR05	**SR06**	**SR07**	**SR08**
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EXECUTIVE SUMMARY:	The paper provides an update on the progress and timetable of Integrated Care Systems now the date has been delayed from April 2022 to July 2022 and the interim arrangements across the wider NHS in terms of responsibilities. The paper also provides a stakeholder engagement update as well as progress of the key identified areas for the Partnerships and Integration team for the remainder of 2021/22 in particular: • Developing and strengthening relationships with Integrated Care System (ICS) structures • Stakeholder relationship maturity • Engagement • Trust wide Knowledge Vault • ICS System Profiles The intention is to build a support and infrastructure around managers to be equipped with the right information, and have the necessary capacity and capability to deliver external engagement which is consistent and comprehensive across all areas. The remaining period up to the end of the financial year will see a trust wide Knowledge Vault come on-line. The trust was well positioned in the work with ICS colleagues for an implementation date of 1 April 2022. The extra time of 1 July allows the continued build-up of			

	relationships, and taking part in the discussions and debates with its wider NHS partners. It also allows a number of pieces of work to be embedded which will enable the Trust to improve representation, messaging, speaking consistently and with authority at external meetings, supported by appropriate and timely information and intelligence. Partnerships and Integration Managers will continue to build on their work with ICS colleagues and contribute to better and more appropriate stakeholder engagement and relationship management.			
RECOMMENDATIONS, DECISIONS OR ACTIONS SOUGHT:	The Board are asked to: • Note the update and reassurance provided in this paper • Note the work of the P&I team across the three areas and in particular the roll out of the Knowledge Vault across the trust			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality	☐	Sustainability	☐
PREVIOUSLY SUBMITTED TO:				
DATE:				
OUTCOME:				

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1. PURPOSE

The purpose of this paper is to inform the Board of the progress and timetable of Integrated Care System (ICS) in the North West, including the implications of the change of target date from 1 April 2022 to 1July 2022.

The paper will give an overview of the progress to date and the timetable to July 2022.

The Partnerships and Integration team were fully in place by the start of Q3 2021/22, a list of deliverable objectives were in in place for the team for the remainder of 2021-22 to ensure that the trust was ready to meet the opportunities that the ICS structures would present.

The paper will also cover briefly the progress around the areas of:

- Developing and strengthening relationships with Integrated Care System structures
- Stakeholder relationship maturity
- Engagement
- Trust wide Knowledge Vault
- Integrated Care System Profiles

Governance will be covered in a separate paper in Part 2 of Board.

2. BACKGROUND

The ICSs in the North West are made up of five areas, with North Cumbria and Glossop covered by ICSs outside the regional footprint.

ICSs have been developing plans in line with national guidance, as it becomes available. Guidance has been received through Q2 and Q3 this includes papers such as:

- Working Together at Scale: Guidance on Provider Collaboratives
- Integrated Care Board functions and governance
- The transfer of CCG staff and functions as well as Direct Commissioning.
- ICS digital and data, working with people and communities/ leadership and Thriving
- Places (place-based partnerships)

3. INTEGRATED CARE SYSTEMS UPDATE

The CEO and Chair appointments across the ICS areas have taken place, Greater Manchester currently has an interim CEO in place.

Two of the Greater Manchester non-executive directors are expected to be in place from 1 February. The closing date for the CEO was 21 January with interviews due to take place by 14 February. The closing date for the three statutory ICB director roles is 31 January with interviews to take place in early March, allowing the designate CEO to take part.

For the other ICS areas the remaining executive team appointments should be completed by March 2022.

ICSs will formally replace CCGs in July 2022 (previously April 2022), the developments around ICS, and the changes taking place in the North West areas will gather pace as time evolves. The ICSs in the north west are at different stages of development, and this allows the trust to be involved with each ICS across the footprint and to be part of the changes taking place.

The delayed implementation date from April to July 2022 allows sufficient time for the remaining parliamentary stages to take place, as well as affording the NHS to focus on the immediate priorities in the pandemic response. The establishment of the statutory ICS arrangements is subject to the passage of the Health and Care Bill which is being considered by Parliament. The new date of 1 July reflects the time needed for this to happen.

The work ongoing will continue in the wider NHS and specifically during the period 1 April to 1 July 2022:

- CCGs will remain in place as statutory organisations, retaining all existing duties and functions and conduct business through existing governing bodies
- CCG leaders will also work with the designate Integrated Care Board leaders on key decisions, especially around commissioning and contracting
- NHSE&I will continue with direct commissioning responsibilities

The ICS timetable is shown below:

The trust was well positioned in the work with ICS colleagues for an implementation date of 1 April 2022, however, the extra time of 1 July allows the Trust to continue building its relationships with its wider NHS partners.

It also allows a number of pieces of work to be embedded which will enable the Trust to improve representation, narrative, consistent messaging backed by appropriate and timely information and intelligence.

4. PARTNERSHIP AND INTEGRATION (P&I) UPDATE

Initial key areas were identified for the P&I team for the remainder of 2021-22.

The Partnership and Integration 2021-22, (shown in **Appendix 1**) gives more details around these key areas, these being:

- Partnerships
- Relationship Management
- Information Exchange

To ensure the trust is in the best position possible with the ICS, a number of key work areas are being progressed as shown below:

- Developing and strengthening relationships with ICS structures
- Stakeholder relationship maturity
- Engagement
- Trust wide Knowledge Vault
- ICS Profiles

Developing and strengthening relationships with ICS structures

The P&I team have regular meetings with the key contacts in the ICS areas in order to form relationships and be part of the discussions going forward.

This has allowed greater understanding of the needs of the ICS structures across the North West and enabled the trust to have a place and voice at meetings across the footprint.

As the ICS executive teams are fully recruited this will continue. Executive leads as well as Heads of Service are working with the P&I team to share information and intelligence at regular meetings to ensure that the narrative / messaging is consistent across the Trust.

The P&I team are attending Level 3 Service Delivery meetings in each of the areas to further embed the changes / information/ intelligence across senior managers around progress and narrative.

Stakeholder relationship maturity

It is important that the trust meets the recommendations in the Deloitte review of December 2019 which stated that our partners wanted to both see more of the trust and for the trust to be actively involved in the discussions.

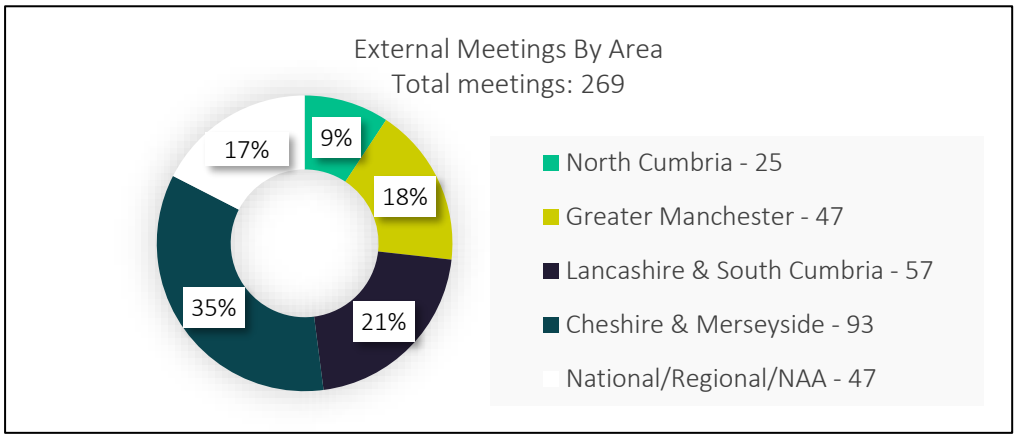
Work is currently ongoing to assess our external relationship maturity with our partners and wider NHS organisations, and to gauge what our engagement has been like. This will enable the trust to use the feedback received to put in place systems and process which allow the trust to engage in a better way with it's partners.

When improvements are in place, the intention is re-do the exercise later this year with the same stakeholders / partners to get an understanding of how the engagement and relationships have developed and matured, as well as building in the engagement principles within the 4OC report of May 2021 - 'NWAS Engaging effectively with ICS Partnerships".

This will enable the trust to go on the improvement journey of building better relationships with partners.

Engagement

A mapping exercise was conducted in Q2 of the external engagement and this was shared with Board in September 2021. The purpose was to see which meetings were attended and how the trust were represented in order to determine who the most appropriate person for attendance was. At the time, although not an exhaustive response, the following chart showed the meetings across the areas.



The P&I team have been working both internally and externally to ensure that the trust has a list of the critical meetings identified as the new structures for the ICS take place that the trust has the right representation at the right meeting, sharing the right message.

Other work ongoing around the Knowledge Vault and the NWAS Link briefings will enable the identified managers who attend these meetings to pick up the critical information and intelligence, in order to be able to take part and influence the discussions taking place.

As the Service Delivery structures take shape, there will be named manager/roles within these structures, both in the interim and in the new structures aligned to the meetings taking place. The P&I team will take a critical role in developing, supporting and managing this process.

It is the intention to build support and infrastructure around managers to ensure they have the relevant information and intelligence to enable them to take an active and constructive part in external meetings. Further details of this are provided in the report to Part 2 of the Board.

In terms of building capacity and equipping managers with the latest information, Partnerships and Integration Managers put together a fortnightly briefing document across all three areas called **"NWAS Link"** which tailors the key information across the trust

enabling managers to use this as part of their external engagement. This is also available on the Green Room for reference.

Trust wide Knowledge Vault (KV)

This is a critical piece of work to which will enable a lot of the other strands of external engagement work to take place.

The KV will allow information and intelligence to be utilised in the most appropriate way, to inform better information sharing and decision making. Leading on from the above, once the trust has the right representation at the right meeting, information and intelligence from external meetings can be uploaded into the KV and used to inform dialogue with external partners.

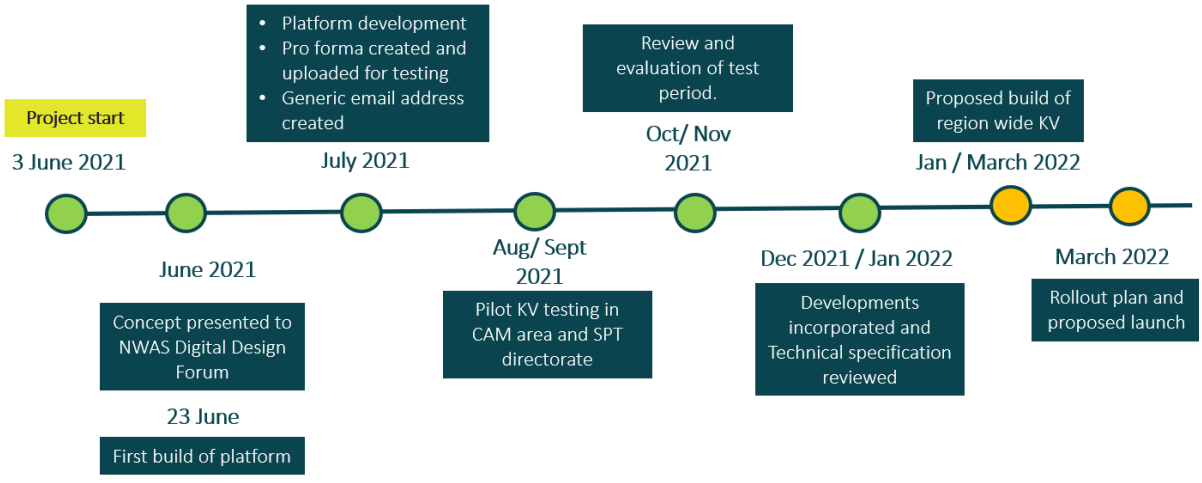
It will show ICS partners that managers attending external meetings across the footprint, are equipped with the information and intelligence, as well as the authority to make meaningful contributions to the discussions and debates taking place. The KV will enable managers to be fully involved, rather than just an attendee at meetings.

The KV was piloted in Cheshire and Mersey Area with Service Delivery in August and September 2021, there has been a significant investment of time between the P&I and Digital team to develop the KV to ensure any issues and improvements identified in the pilot were incorporated into the technical specification for the full build.

Senior colleagues have had sight and use of the prototype KV. A full build of the KV is in progress with the Digital team. An implementation plan will be in place from March 2022 for rollout of the KV across the region, which will cover all aspects of communications, familiarisation and usage across each area through the Service Delivery directorate initially, and then across other directorates.

A significant amount of time and resources has gone into the KV. If the KV is used proactively across the trust, it has the potential to make a significant impact, and add value in our relationship and reputation management with external partners.

The timeline for the KV is shown below



ICS Profiles

ICS profiles for the three main ICS areas as well as North Cumbria and Glossop were completed in November 2021. These allow managers to be aware of the key data and subsequent challenges / opportunities of their respective ICS areas.

The ICS profiles have been circulated to executive directors and senior managers and are also available on the Green Room for reference

The ICS profiles cover:

- Key system information / Population overview
- Health statistics including co-morbidities (against national average)
- Pre-pandemic trends
- Index of deprivation in area
- Ethnicity and Disability
- Who's who in the ICS, Acute and Local Authorities

The trust has developed and put in place systems and process, such as NWAS Link, information sharing meetings with executive leads; identification of representation at current and future meetings; and the design, development and impending build of the Knowledge Vault, which will all contribute to better and more appropriate stakeholder engagement and relationship management.

The delay of ICS implementation affords the trust additional time to further embed these new systems and processes in place.

Support and infrastructure around managers engagement will enable external engagement to be consistent and comprehensive, as shown below.

5. LEGAL, RISK and/or GOVERNANCE IMPLICATIONS

On the board assurance framework for 2021-22 risks SR07 and SR08 apply, with the work currently being undertaken across the ICS areas these risks are being managed and mitigated.

The change in implementation date for ICS structures is reflected within the relevant strategic risk.

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

There are no equality or sustainability implications.

7. RECOMMENDATIONS

The Board are asked to:

- Note the update and reassurance provided in this paper
- Note the work of the P&I team across the three areas and in particular the roll out of the Knowledge Vault across the trust

Appendix 1 - **Partnerships and Integration 2021/22**

Building effective stakeholder relationships through dialogue, debate, discussion and decision making with our partners.

We will achieve this by:

1.PARTNERSHIPS

Working together with partners to coordinate, manage, monitor and review actions to get things done.

OBJECTIVE

Consistency of: message, narrative, ask, offer and representation.

DELIVERABLES

1.1 Being clear on our ask and offer to partners

1.2 Integration of external services changes within the trust

2. RELATIONSHIP MANAGEMENT

Ensuring we have long lasting and effective relationships with organisations across the footprint which strengthen our working together arrangements.

OBJECTIVE

Ensuring we are central to decision making across the region and to develop and deliver services going forward.

DELIVERABLES

2.1 Engage with the new ICS/ICP structures, at the appropriate level

2.2 Stakeholder engagement mapping across the trust footprint

3. INFORMATION EXCHANGE

Establishing an online Knowledge Vault which will enable a better way of using information and intelligence with partners to inform decision making

OBJECTIVE

We will make appropriate and timely decisions through information and intelligence via the Knowledge Vault.

DELIVERABLES

3.1 Design and develop the Digital Knowledge Vault for use across the trust

3.2 Equipping directorates and managers to ensure they have the right information at the right time

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