AGENDA

NHS
North West Ambulance Service
NHS Trust

Board of Directors
Wednesday, 31st July 2024
9.45am – 1.10pm
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2425/43	Staff Story	09:45	Information	Deputy Chief Executive
INTRODUCTION				
BOD/2425/44	Apologies for Absence	10:00	Information	Chair
BOD/2425/45	Declarations of Interest	10:00	Decision	Chair
BOD/2425/46	Minutes of the previous meetings held on 29th May 2024	10:00	Decision	Chair
BOD/2425/47	Board Action Log	10:05	Assurance	Chair
BOD/2425/48	Committee Attendance	10:10	Information	Chair
BOD/2425/49	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2425/50	Chair & Non-Executive Directors Update	10:10	Information	Chair
BOD/2425/51	Chief Executive's Report	10:15	Assurance	Chief Executive
BOD/2425/52	People Strategy Refresh	10:25	Decision	Director of People
GOVERNANCE AND RISK MANAGEMENT				
BOD/2425/53	Board Assurance Framework Q1 2024/25	10:35	Decision	Director of Corporate Affairs
BOD/2425/54	Amendment to Board Standing Orders	10:45	Decision	Director of Corporate Affairs
BOD/2425/55	Board Development Programme 2024/25	10:50	Assurance	Director of Corporate Affairs
BOD/2425/56	Policy on Anti-Fraud, Bribery and Corruption	10:55	Decision	Director of Finance
BOD/2425/57	EPRR Assurance Report	11:00	Assurance	Deputy Chief Executive
BOD/2425/58	Health, Safety, Security and Fire Annual Report 2023/24	11:10	Assurance	Director of Quality, Innovation, and Improvement
BOD/2425/59	Safeguarding Annual Report 2023/24	11:20	Assurance	Director of Quality, Innovation, and Improvement

BOD/2425/60	SIRO Annual Report 2023/24	11:30	Assurance	Director of Quality, Innovation, and Improvement
BOD/2425/61	Audit Committee 3A Reports from the meetings held on 19th June 2024 and 19th July 2024	11:40	Assurance	Mr D Whatley, Non-Executive Director
BOD/2425/62	Trust Management Committee 3A Report from the meetings held on 19th June 2024 and 19th July 2024	11:50	Assurance	Chief Executive
QUALITY AND PERFORMANCE				
BOD/2425/63	Integrated Performance Report	11:55	Assurance	Director of Quality, Innovation, and Improvement
BOD/2425/64	Manchester Arena Inquiry Recommendations	12:10	Assurance	Deputy Chief Executive
BOD/2425/65	Learning from Deaths Q4 2023/24 Report	12:20	Assurance	Director of Quality, Innovation, and Improvement
BOD/2425/66	Quality and Performance Committee 3A Report from the meeting held on 24th June 2024	12:30	Assurance	Prof A Esmail, Non-Executive Director
WORKFORCE				
BOD/2425/67	Workforce Equality Data Monitoring	12:40	Assurance	Director of People
BOD/2425/68	EDI Priorities and Annual Plan	12:50	Decision	Director of People
STRATEGY, PARTNERSHIPS AND TRANSFORMATION				
BOD/2425/69	Communications and Engagement Dashboard	13:00	Assurance	Deputy Chief Executive
CLOSING				
BOD/2425/70	Any other business notified prior to the meeting	13:10	Decision	Chair
BOD/2425/71	Risks Identified	13:10	Decision	Chair
DATE AND TIME OF NEXT MEETING				
9.45am on Wednesday, 25th September 2024 in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton				
Exclusion of Press and Public: In accordance with Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				

NHS
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Minutes
Board of Directors

Details: 9.45am Wednesday, 29th May 2024
Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chair
Mrs C Butterworth	Non-Executive Director
Dr A Chambers	Non-Executive Director / Deputy Chair
Mr S Desai	Deputy CEO / Chief Operating Officer
Prof A Esmail	Non-Executive Director
Dr C Grant	Medical Director
Mr D Mochrie	Chief Executive
Dr M Power	Director of Quality, Innovation, and Improvement
Mrs L Ward	Director of People
Mr D Whatley	Non-Executive Director
Mrs C Wood	Director of Finance

In attendance:

Mr G Pacey	Freedom to Speak Up Lead (Item 030)
Mr U Nawaz	Head of Inclusion and Engagement (Item 039)
Ms D Earnshaw	Corporate Governance Manager (Minutes)

Minute Ref:

BOD/2425/018 **Patient Story**

The Deputy Chief Executive introduced the Patient Story which featured Edwina Ion, a 64-year-old patient who suffered a heart attack and a near fatal cardiac arrest.

The story detailed the emergency calls to 999 and the action taken by the Trust, with Edwina only able to answer a couple of the call handler's questions before the line dropped out due to poor connection. Fortunately, the service were able to deploy resource to her home.

The crew spent less than 20 minutes at the scene before transferring Edwina to the Liverpool Heart and Chest Hospital. Edwina was treated in the Catheter lab at the hospital within one hour of her 999 call. The crew remained with

Edwina until she received two stents fitted. Edwina was discharged following three days in hospital and underwent 10 weeks of cardiac rehabilitation.

The story highlighted the lessons learnt by NWAS, which included the positive patient outcomes delivered, through an understanding of the speediness and the range of skills required.

The Chair recognised and praised the excellent work of the crew and the call handling team.

Mrs C Butterworth queried the process from call to deployment of the crew.

The Deputy Chief Executive confirmed that an emergency resource was deployed in response to the first 999 call and he confirmed the protocol for emergency calls which were cut off or unclear.

The Chief Executive reflected on the changes and improvements made in the organisation over the years, particularly in relation to diagnostic equipment and faster acting referral processes.

The Medical Director praised the diagnostic capability on the front line and the collaborative work of the teams.

The Deputy Chief Executive confirmed that some patient stories were used in mandatory training modules and that Edwina's story would be used for this purpose. He also referred to NWAS statistics, the average time on scene, and the further work required to interrogate data to address health inequalities and ensure care is consistent across communities.

Mr D Whatley referred to his own personal experience of using the emergency service for a cardiac condition and praised the organisation for their work, and referred to a current trial ongoing within the trust, to make further improvements.

The Medical Director confirmed the nature of the trial being undertaken to improve pathway changes.

The Director of Quality, Innovation and Improvement referred to the use of trust patient stories and queried whether these would be useful to share with system partners, the Integrated Care Board (ICB).

The Chair supported this suggestion and commended the story which highlighted good practice and exemplified the core purpose of the Trust.

The Board:

- Noted the content of the story.

At this point the Chair recognised the forthcoming general election and acknowledged that the trust was in a period of Purdah.

BOD/2425/019 Apologies for Absence

Apologies were received from Dr D Hanley, Non-Executive Director and Mrs Angela Wetton, Director of Corporate Affairs.

BOD/2425/020 Declarations of Interest

There were no declarations of interest to note.

BOD/2425/021 Minutes of the Previous Meeting

The minutes of the previous meeting, held on 27th March 2024. The Director of Finance noted an amendment to page 8 and the finance commentary contained within the Integrated Performance Report, to be amended prior to approval.

Subject to the above amendment, the minutes of the previous meeting held on 24th April 2024 were accepted as a true record.

The Board:

- Approved the minutes of the meeting held on 27th March 2024 and 24th April 2024.

BOD/2425/022 Board Action Log

The Board noted the updates to the action log.

BOD/2425/023 Committee Attendance

The Board noted the Committee Attendance.

BOD/2425/024 Register of Interest

The Board noted the Register of Interest presented for information.

BOD/2425/025 Chair & Non-Executives' Update

The Chair reported recent activity.

He referred to a recent Iftar dinner held by the trust and congratulated the team on an excellent event. He praised an enjoyable evening and noted the sense of community. He praised the trust's Head of Inclusion and Engagement for co-ordinating the event.

He updated the Board on recent Chair meetings and noted a series of visits to trust ambulance stations, including Manchester Central. He referred to some ongoing concern amongst staff in relation to the trust's leadership review, which he'd conveyed to the relevant Executive Directors.

He confirmed the Trust had appointed a Director of Operations to commence 1st July 2024.

He acknowledged recent and successful Board Development Sessions and Northern Ambulance Alliance meetings, as well as the annual board member appraisals, undertaken since his last update. He reflected on a successful year for the trust and congratulated Executive directors on their performance throughout the year.

Mrs C Butterworth referred to the Northern Ambulance Alliance and welcomed future information on the remit of the Alliance.

The Chief Executive confirmed developments were ongoing with options being explored.

The Board:

- Noted the Chair and Non-Executives' Update.

BOD/2425/026 Chief Executive's Report

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

He noted a continued improvement of PES and call pick up performance throughout April.

In terms of 111, he noted improved performance with more detail to follow in the integrated performance report agenda item.

Regarding Patient Transport Services (PTS) he noted work ongoing and the pending decision in relation to the contract tender award.

He referred to the opening of the new Co-op Live venue in Manchester, and the collaborative work of the trust with emergency partners.

He reported recent digital vehicle innovations and a recent visit to Estuary Point, to host a meeting with Graham Urwin, CEO of Cheshire, and Merseyside ICB. He noted a good discussion on hospital handover delays and the positive working relationships.

He referred to recent station visits, a successful network event, and thanked all teams for their efforts. He also referred to the successful Iftar dinner.

Regarding Freedom to Speak Up (FTSU), he recognised the ongoing work to understand further ways to strengthen FTSU processes. He noted the launch of a new trust campaign to promote sexual safety - Stop. Speak. Support. and referred to the trust's Health and Well Being Hub.

He highlighted that NWAS continues with sustainability plans to meet the climate change and sustainability agenda.

Finally, he sadly reported the death of Julie Lea who worked for NWAS from 2011 to 2023, and stated his thoughts were with Julie's family and friends at this time.

Dr A Chambers praised the improved performance of 111 and queried the joint working plans in place for the new Co-Op Live venue in Manchester.

The Chief Executive explained the joint working arrangements with the Greater Manchester Resilience Forum and confirmed the trust is aware of the local venue plans in place.

She went on to praise the CMI qualification celebrations for corporate staff.

The Chair referred to the use of social media by trust staff and the procedures in place.

The Director of People confirmed the trust had a Social Media Activity Policy and referred to the initiatives and campaigns in place, linked to the Policy.
The Deputy Chief Executive referred to the learning processes used, in response to any issues linked to use of social media by staff.

The Board:

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

BOD/2425/027 Trust Strategy Refresh

The Deputy Chief Executive presented the Trust Strategy Refresh.

He outlined the process used to conduct the annual refresh, since approval of the 3-year trust strategy in 2022. He reported the 2024/25 refresh resulted in no substantial changes being required to the strategy.

He referred to the areas of analysis and progress made and noted the actions still to be completed with narrative in the report to explain contributory factors. He acknowledged the pending decision of the PTS tender which had impacted on the progress and achievement of some objectives.

He advised that s4 of the report illustrated the steps taken to reframe and refocus some of the actions, for inclusion in 2024/25 where necessary.

Mr D Whatley referred to discussion at the Resources Committee and queried the preparedness of the forthcoming dashboard, to monitor performance against annual progress.

The Deputy Chief Executive confirmed the work ongoing with the digital team to deliver the dashboard.

The Director of People referred to the culture review and the review of the EDI priorities, with some changes required to the People Strategy to reflect the work required.

Prof Aneez Esmail referred to the economic and environmental impact factors and queried the trust's monitoring plans, in terms of health inequalities.

Mrs C Butterworth noted a discussion at Resources Committee which highlighted the value of a future Board Development Session to understand priorities and plans to address health inequalities.

The Director of Quality, Innovation and Improvement queried whether there was sufficient strategic content in the Strategy regarding health inequalities.

The Deputy Chief Executive confirmed the action taken in the refresh process and confirmed the health inequalities priorities, included in the 3-year Strategy.

The Director of Finance referred to the supporting Sustainability Strategy and the work of the Executive Led Sustainability Group. She added that sustainability updates were routinely reported to the Resources Committee.

The Chair welcomed future discussion and a coherent joined up approach to health inequalities at a national and local level in terms of plans and strategies.

The Board:

Supported the recommendations in the report –

- Emphasising "Urgent and emergency care recovery," "Freedom to Speak up," and "Ambulance Service Culture, with a particular focus on sexual safety" as key areas of focus in the Trust strategy for 24/25.

- Updating of the internal and external intranet pages to highlight the areas of focus on the "landing page" where the Trust Strategy document is available for download.

- Conducting a light-touch refresh of the supporting strategies to ensure continued alignment to the Trust Strategy.

BOD/2425/028 Trust Annual Plan

The Deputy Chief Executive presented the Trust Annual Plan.

He confirmed the review process undertaken with trust directorates, resulting in a reduction of deliverables, from 175 included in the previous plan to 65 for 2024/25. He added the reduction supported achievability and considered the Trust Risk Appetite Statement.

Prof A Esmail welcomed the plan on a page approach and queried whether the progress was monitored in staff appraisals.

The Deputy Chief Executive confirmed the work of the planning team to work with the directorates during the year, with quarterly progress reports presented

to the Trust Planning Board, Trust Management Committee and Resources Committee.

He noted the check and challenge process in place and the RAG rating system used, to provide oversight and support monitoring of the deliverables.

The Chair referred to Trust's Equality Impact Assessments (EIAs) and the EIA framework. He queried if executive board members were assured on the robustness of the arrangements in place.

The Deputy Chief Executive advised of the EIA process and the assurance received in the production of the annual plan.

The Board:

- Reviewed and approved the Trust Annual Plan 2024/25.

BOD/2425/029 Common Seal Biannual Report

The Deputy Chief Executive presented the Common Seal Biannual Report on behalf of the Director of Corporate Affairs.

He advised use of the Common Seal is determined by Section 8 of the Trust's Standing Orders and Clause 8.4 of Section 8 requires the occasions of use to be reported to the Board on a biannual basis.

He confirmed during the period 1st October 2023 to 31st March 2024 the Trust's Common Seal was applied on 14 occasions, with details in s2 of the report.

The Board:

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

BOD/2425/030 Freedom to Speak Up Annual Report 2023/24

The Freedom to Speak Up Guardian presented the Freedom to Speak Up (FTSU) Annual Report 2023/24.

He noted the impact of the local case of Lucy Letby which had attracted huge media attention within the NHS and that speaking up around sexual safety and cultural issues has become prevalent in the ambulance sector.

He summarised the key headlines in the report and highlighted -

- NHS England have this year completed their culture review of English ambulance services which has drawn more scrutiny to the cultures within the sector.

- This year the trust staff survey results displayed a further increase in the confidence of our staff in speaking up, more over there is a greater

confidence that the organisation will act on both clinical and non-clinical concerns.

- Staff survey results highlight a need to listen to staff and how the trust can improve accountability.

- An increase of 54% in the number of concerns raised on the previous year. In 2023/24 the Freedom to Speak Up Guardians received 154 concerns.

- An increase in the number of anonymous concerns from 18% to 29%. Noted the implementation of an online reporting system rolled out to all mobile devices, which made speaking up anonymously easier.

- A slight increase in the number of staff feeling secure to raise concerns about unsafe clinical practice from 66% to 67%.

Prof A Esmail queried the issue of staff not feeling confident that something would be done about their concern. He also referred to the issue of inappropriate behaviours and the high number of concerns which related to corporate departments.

The FTSU lead advised of the process and the need to provide confidentiality and a safe space for concerns to be raised. In terms of inappropriate attitudes and behaviours he referred to the issue of micro aggression which had been attributed to the higher number of staff working remotely, caused by a breakdown in communication.

Mrs C Butterworth welcomed the increase in the number of staff using the FTSU process and queried if the different routes for people to speak up created confusion in terms of signposting concerns.

The FTSU Lead referred to the challenges of duplication and noted the various routes for FTSU, which included Datix and discussions at staff appraisals.

She also referred to the trust staff survey results and queried whether the next annual report could include other voices in the report, such as the networks and the trade unions, to provide a more complete picture.

The FTSU lead welcomed the comments and advised of the working arrangements in place with the staff networks. He agreed these views could be reflected in the next annual report.

The Director of People advised of the strengthened working relationships in place and noted the shift in the recent staff survey results which highlighted significant improvement is some areas.

She acknowledged the need to develop work across the demographics to provide assurance that more vulnerable groups were able to raise concerns.

Dr A Chambers welcomed a good report and recognised the need for triangulation in terms of the other methods used for staff to speak up in the organisation.

The Chair welcomed sight of triangulation on a page, in future versions of the report.

He expressed his concern at the level of staff feeling secure to raise concerns about unsafe clinical practice, which had risen slightly to 67%.

The Director of Finance and FTSU Guardian advised that the data could be skewed by responses from corporate staff. She noted by the nature of their roles, corporate staff would be unclear on what unsafe clinical practice looked like.

The Medical Director referred to the so what question, and a recent supporting paper taken to the Trust Management Committee on FTSU Guardian plans for 2024/25. He referred to the national requirements and some restrictions in terms of scope for flexibility. However, he supported and recognised improvements that could be made to support triangulation learning.

The Chair recognised the need for the process to maintain its independence along with the need for triangulation. He added it would be useful at Board level to understand the supervision and oversight and scrutiny of clinical practice in relation to the Lucy Letby case and the findings from the annual report for 2023/24.

The Director of Quality, Innovation and Improvement referred to the trust's plans for Safety Culture Surveys and a full NWAS Safety Culture Programme, to include improvement and provide support for staff, which would involve the NWAS FTSU Guardian and Patient Safety Specialist.

The Chair looked forward to receiving future updates on the ongoing work and the need to ensure board members site visits to sites included consideration of the trust's FTSU processes.

The Board:

- Noted the content of the report and the assurance provided in relation to speaking up arrangements within the trust.
- Requested future annual reports to include -
  (i) feedback from other parties such as trade unions and staff networks, to receive more robust assurance on the effectiveness of the process and
  (ii) triangulation of learning.
- To receive future assurance, to understand the supervision, oversight, and scrutiny of clinical practice that's in place in the trust.

BOD/2425/031 Fit and Proper Persons Requirements Annual Declaration

The Director of People presented the Fit and Proper Persons Requirements (FPPR) Annual Declaration.

She introduced the Chair's annual declaration and noted a recent report represented the Board on the changes in the FPPR process and that the new framework strengthened appointments of directors.

She confirmed the required checks had been completed and submitted to the Regional Director for sign off.

The Chair thanked the team for their hard work and recognised the robust process in place to complete the required checks.

The Board:

- Recorded that the Fit and Proper Persons Test has been conducted for the period 2023/2024 and that all Board members satisfy the FPPT requirements.

BOD/2425/032 Audit Committee 3A report

Mr D Whatley, Non-Executive Director presented the Audit Committee 3A Report from the meetings held on 19th April 2024 and 17th May 2024.

He clarified Q4 data in the report and outlined the activity discussed at the meetings which included annual governance documents. He referred to the Committee's receipt of the annual accounts and the Annual Governance Statement.

The Board:

- Noted the content of the Audit Committee 3A Reports.

BOD/2425/033 Charitable Funds Committee 3A Report

Mr D Whatley, Non-Executive Director presented the Charitable Funds Committee 3A Report from the meeting held on 8th May 2024.

He noted the good position of the charity and a positive year one and acknowledged the underpinning resources and systems put in place for year two.

He referred to the recent Charity Newsletter and forthcoming planned activities, along with the charity donations made to the Trust Hardship Fund.

The Chair welcomed the report and referred to the number of applications received in relation to the Hardship Fund.

The Director of People referred to the nature of the Hardship Fund and the trust's financial well-being offer in place, which ranged from education support to salary sacrifice and financial loans, along with access to other initiatives and charitable support available.

The Board

- Noted the content of the Charitable Funds 3A Report.

BOD/2425/034 Trust Management Committee 3A Report

The Chief Executive presented the Trust Management 3A Report, from the meetings held on 17th April 2024 and 15th May 2024.

He highlighted the key points to alert, advise and provide assurance from the meetings.

Prof A Esmail referred to the value of the RAG ratings used in previous reports, which provided a visual view of assurance.

The Chief Executive confirmed the purpose of the 3A reports, which were in line with the new governance structure and intended to prompt non-executives to commission, monitor and scrutinise any areas of concern.

Prof A Esmail, as Chair of the Quality and Performance Committee meetings, welcomed sight of TMC alerts, and the need to ensure issues were not lost in between the scheduled bi monthly meetings.

The Chair welcomed the transparency of issues discussed by the new Trust Management Committee.

The Deputy Chief Executive welcomed comments on the report which would mature and evolve to support the trust governance structure.

In response to the alert items reported, the Chair asked the Chair of the Quality and Performance to follow up and seek assurance on Schiller Defibrillators and the Board would continue to monitor RIDDOR compliance via future TMC assurance reports.

The Board:

- Noted the content of the 3A reports.
- Acknowledged further assurance on Schiller Defibrillators to be sought by the Chair of the Quality and Performance Committee.
- To monitor RIDDOR compliance via future TMC reports presented to the Board.

BOD/2425/035 Integrated Performance Report

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

She confirmed the Trust Management Committee had reviewed the data in May and that s2 of the report highlighted issues raised, for inclusion in the board report.

She noted a change to the presentation of complaints data and explained the data over time had been stood down, to allow time for data to be collected on the new complaints management process.

The Deputy Chief Executive provided an update on complaints data and acknowledged the work to be completed on closing multi complex complaints which involved more than one service line. He confirmed the new process involved the PALS team managing level 1-2 complaints and the Resolution team level 3-5 complaints.

The Chair referred to the impact of the changes to reporting, related to the new PSSIs and previous SIs.

The Medical Director confirmed that although PSSI and SI meetings and investigations differed, the trust were seeing a similar number of incidents being presented. He confirmed NWAS continued to apply a Duty of Candour to all cases when assessing harm and any potential harm, without any retirement of transparency and openness of learning.

The Director of Quality, Innovation and Improvement confirmed plans for a Board Development Session on Patient Safety and PSIRF reporting in 2024/25 to provide assurance on the change in process and reporting.

Prof A Esmail confirmed the data had not been scrutinised by the Quality and Performance Committee due to the rescheduling of bi monthly meetings.

The Deputy Chief Executive referred to patient experience and the responses received during the period. He recognised the positive figures of the service lines and the outcomes of the online surveys.

The Medical Director referred to the time lag in reporting data and the work being undertaken in relation to cardiac arrest.

Prof A Esmail referred to the Effectiveness section and the narrative and queried why the changes made have not materialised in see and treat figures.

The Deputy Chief Executive advised of the nature and factors associated with see and treat figures.

In terms of call pick up, the Deputy Chief Executive noted a good position and some increase in activity in the Mersey areas. He referred to good performance in Cat 1 and Cat 2 responses and that the lower acuity Cat 3 and Cat 4 responses also signalled some improvement, reflective of an improved national position.

The Director of Quality, Innovation and Improvement referred to the inclusion of Blackburn Acute Trust in the data table for the first time.

The Chair acknowledged the strategic significance of this for the trust and acknowledged that NWAS were working with the Trust to understand the change in performance.

The Chair welcomed the report and the improvements made in call category performance and response. He congratulated all teams on their hard work to reduce long waits and improve overall performance.

Dr A Chambers referred to the improvement in call activity, however queried the warm transfer data.

The Deputy Chief Executive described the challenges and referred to the unpredictable nature of performance against the national standard and the further work required. In relation to Patient Transport Service (PTS) he reported that improvement work continued.

The Director of Finance reported the financial position and productivity and efficiency performance.

The Chair acknowledged the continued monitoring of the efficiencies position required by the Resources Committee.

The Director of People summarised performance against the workforce indicators, she referred to staff turnover and the work underway to learn from initiatives taken in 111 to improve staff turnover, to be applied to Emergency Operating Centres (EOCs) to make the required improvements.

She noted the vacancy position across the service lines, with a 7% improvement, however noted the overall work still required to close vacancy gaps. She referred to ambitious plans for 2024/25 with a specific focus on PTS, along with actions to strengthen management support.

The Chair referred to PTS and the awareness amongst staff of the current uncertainties. He acknowledged the overall encouraging performance, aligned to the workforce indicators.

The Board:

- Noted the content and recommendations detailed within the Integrated Performance Report.

BOD/2425/036 Complaints Annual Report 2023/24

The Deputy Chief Executive presented the Complaints Annual Report 2023/24.

He provided an overview of the complaints received during the year and the cases received, reported in accordance with NHSE guidance on categorisation and against required timescales.

He reported that during 2023/24 NWAS received 2,250 complaints in total and 90% of these complaints were managed as low-level complaints, incorporating the guidance on early resolution and everyday conversations.

He added that 82% of low-level complaints are being managed within the Trust's agreed timeframes. He referred to the number of cases not upheld, and the further recourse available to families. He noted care and treatment was attributed to 930 of complaints received and the report provided a breakdown of the care and treatment category.

Mrs C Butterworth referred to the level of justifiable complaints and the number not founded and queried the trust's resources to focus on the residual cases.

The Deputy Chief Executive referred to structure of the PALS and Resolution teams when dealing with low level complaints and confirmed learning would be taken from the new process and improvements made.

Mrs C Butterworth welcomed inclusion of the learning in a future report.

The Chair supported the suggestion of a future report and a discussion at Board on the outcomes and lessons learnt from Complaints during 2023/24.

The Board:

- Noted the assurance provided.
- Requested a future discussion report at Board on the outcomes and lessons learnt from Complaints during 2023/24.

BOD/2425/037 Quality and Performance Committee Chairs Assurance Report and 3A Report

Prof Aneez Esmail presented the Quality and Performance Committee Chairs Assurance Report from the meeting held on 25th March 2024 and the 3A report from the meeting held on 24th May 2024.

The Board:

- Noted the content of the Quality and Performance Committee 3A reports.

BOD/2425/038 Resources Committee 3A Report

Mrs C Butterworth presented the Resources Committee 3A report from the meeting held on 24th May 2024.

She provided key highlights from the meeting and the points of alert, advice, and assurance with any further actions identified.

The Director of Quality, Innovation and Improvement noted the suggestion of a future deep dive into digital and recommended aligning the deep dive with the outcome of the trust's submission against the national initiative - What Good Looks Like.

The Board:

- Noted the content of the Resources Committee 3A Report.

BOD/2425/039 Equality, Diversity, and Inclusion Annual Report 2023/24

The Director of People presented the Equality, Diversity, and Inclusion Annual Report 2023/24.

She highlighted the key areas of the report which included the work undertaken during the year and the good practice identified. She added that the Resources Committee had discussed the report at their meeting on Friday, 24th May 2024.

She recognised the leadership work, board development discussion and EDI initiatives deployed over the last 12 months. She noted the critical piece of work underway to review the EDI priorities and a plan to present the draft priorities to the July meeting of the Board.

Prof A Esmail welcomed a very good report. He stated that he found the examples uplifting and the report reflected the changes required.

The Director of People noted the time it takes to make improvements.

The Director of Quality, Innovation and Improvement praised the work during the year and referred to the trust's gender pay gap of 10.6% and the median, which was the higher than figures reported in recent years.

She queried if executive colleagues were confident that the action identified to make improvements could be achieved.

The Director of People recognised the areas of challenge for executives, in improving the gender pay gap. She outlined the trust's initiatives, such as the aspiring leader's programme and recognised the need to improve internal opportunities such as acting up and internal development, with the need to ensure an equal spread of informal arrangements.

The Director of Quality, Innovation and Improvement recognised the responsibility of the whole board to improve the position.

Dr A Chambers acknowledged the work of the networks and the work to improve recruitment processes for diverse groups.

The Director of People noted the work undertaken to improve development pathways and the range of supporting measures to prepare staff for apprenticeships, with work still to do on recruitment processes.

The Chair welcomed the report and the comments made by board members on the trust's gender pay gap performance. He reflected on the progress made over the years and the importance of self-reflection, which was everyone's responsibility.

The Board:

- Received assurance from the contents of the EDI Annual Report 2023/24.
- Approved the publication of the Annual Report through internal and external communications channels.

BOD/2425/040 Communications Q4 2023/24 Update

The Deputy Chief Executive presented the Communications Q4 2023/24 Update.

He outlined the key highlights of the report.

Mrs C Butterworth referred to the work of the health and wellbeing hub and welcomed the improvements made, stating the trust's offer was tangible in terms of the culture review.

The Chair thanked the team for their work and the assurance it provided. He referred to the Patient and Public Panel and praised the current representation of the members. He thanked members of the team and the PPP for their hard work and commitment during 2023/24.

The Board:

- Discussed and noted the content of the report.

BOD/2425/041 Any Other Business Notified Prior to the meeting

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

BOD/2425/042 Items for inclusion on the BAF

There were no items identified for inclusion in the BAF.

Date and time of the next meeting –

9.45 am on Wednesday, 31st July 2024 in the Oak Room, Ladybridge Hall, Trust HQ.

Signed _____

Date _____

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

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
118	24.04.24	15	Quality and Performance Committee Annual Report 2023/24	To provide an assurance paper on the bi monthly PSIRF reporting arrangements to the Q&P Committee.	Director of Quality, Innovation & Improvement			29.5.24 - To be presented to the Q&P Committee on 23.9.24	
121	29.05.24	30	Freedom to Speak Up Annual Report	Future annual reports to include - * feedback from trade unions and staff networks * triangulation of learning	FTSU Guardian	26.3.25			
122	29.05.24	30	Freedom to Speak Up Annual Report	Future assurance report for Board to understand the supervision, oversight and scrutiny of clinical practice that's in place in the trust	Medical Director	TBC			
120	29.05.24	34	TMC 3A Reports	Q&P Committee to seek assurance on the alert item related to Schiller Defibrillators and Board to monitor RIDDOR compliance via future TMC reports.	Prof A Esmail	31.7.24		Discussed at Q&P Committee on 24th June, assurance paper to be presented to the Committee on 23.9.24	
119	29.05.24	36	Complaints Annual Report 2023/24	Requested a future discussion report at Board on the outcomes and lessons learnt from Complaints during 2023/24.	Director of Corporate Affairs	31.7.24	25.9.24	AW - Learning from complaints/concerns is seen on a quarterly basis at Q&P Committee via the quarterly assurance report which is reported to Board via Q&P 3A Report and themes for learning are also considered at the Exec-led Clinical and Quality Group and the Regional Clinical Improvement Forum. However, learning will be included in the 2024/25 Complaints Annual Report and a separate report on learning for 2023/24 can be presented to the September Board for assurance.	

NWAS Board and Committee Attendance 2024/25

Board of Directors								
	24th April	29th May	19th June	31st July	25th September	27th November	29th January	26th March
Daniel Ainsworth								
Dr Alison Chambers	✔	✔	✔					
Salman Desai	✔	✔	✔					
Prof Aneez Esmail	✔	✔	x					
Dr Chris Grant	✔	✔	x					
Dr David Hanley	✔	x	✔					
Daren Mochrie	✔	✔	x					
Dr Maxine Power	✔	✔	✔					
Catherine Butterworth	✔	✔	✔					
Lisa Ward	✔	✔	✔					
Angela Wetton	✔	x	x					
David Whatley	✔	✔	✔					
Peter White (Chair)	✔	✔	✔					
Carolyn Wood	✔	✔	✔					

Audit Committee						
	19th April	17th May	19th June	19th July	18th October	17th January
Dr Alison Chambers	✔	✔	✔	x		
Dr Aneez Esmail	✔	✔	✔	✔		
David Whatley (Chair)	✔	✔	✔	✔		
Catherine Butterworth	✔	✔	✔	✔		

Resources Committee						
	24th May	26th July	20th September	22nd November	24th January	21st March
Daniel Ainsworth						
Salman Desai	✔					
Catherine Butterworth	✔					
Dr David Hanley (Chair)	✔					
Lisa Ward	✔					
David Whatley	✔					
Carolyn Wood	✔					

Quality and Performance Committee						
	22nd April	24th June	23rd September	28th October	27th January	24th February
Daniel Ainsworth						
Dr Alison Chambers	x	✔				
Salman Desai	✔	✔				
Prof Aneez Esmail (Chair)	✔	✔				
Dr Chris Grant	✔	✔				
Dr David Hanley	✔	✔				
Dr Maxine Power	✔	✔				
Angela Wetton	✔	✔				

Charitable Funds Committee				
	8th May	11th September	13th November	12th February
Daniel Ainsworth				
Salman Desai	✔			
Catherine Butterworth	✔			
Dr David Hanley	✔			
Lisa Ward	✔			
Angela Wetton	✔			
David Whatley	✔			
Carolyn Wood	✔			

Nomination & Remuneration Committee							
	3rd May	29th May	31st July	25th September	27th November	29th January	26th March
Catherine Butterworth	x	✔					
Dr Alison Chambers	x	✔					
Prof Aneez Esmail	x	✔					
Dr David Hanley	✔	x					
David Whatley	✔	✔					
Peter White (Chair)	✔	✔					

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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
Daniel	Ainsworth	Director of Operations	Partner is a Team Manager at NWAS in 111 service	N/A	N/A	√	N/A	Personal interest	Jul-24	Present	N/A
Catherine	Butterworth	Non-Executive Director	HR Consultant (no live commissions) for NLaG Acture Trust and Beacon GP Care Group				√	Position of Authority	Apr-22	Present	Agreed with Chairman not to accept or start any NHS HR contracts without his prior approval and support.
			Non Executive Director - 3 x Adult Health and Social Care Companies owned by Oldham Countil				√	Position of Authority	Apr-22	Present	Withdraw from decision making process if the organisations listed within the declaration were involved.
			Director / Shareholder for 4 Seasons Garden Companies: 4 Seasons Garden Maintenance Ltd 4 Seasons Gardens (Norden) Ltd 4 Seasons Design and Build Ltd 4 Seasons lawn treatments Ltd CFR HR Ltd (not currently operating) - removed 25th May 2022				√	Position of Authority	Apr-22	Present	4 Seasons garden maintenance Ltd has secured and operates NHS Contracts for grounds maintenance and improvement works at other NW NHS Acute Trusts but these pre date and are disassociated with my NED appointment at NWAS. To withdraw from the meeting and any decision making process if the organisations listed within the declaration were involved.
Alison	Chambers	Non-Executive Director	Self Employed, A&A Chambers Consulting Ltd	√				Self employment	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Trustee at Pendle Education Trust		√			Position of Authority	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Non Executive Director Pennine Care Foundation Trust				√	Position of Authority	Jul-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
Salman	Desai	Deputy Chief Executive	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Board member of Charity Dignity in Dying			√		Board member	May-22	Present	
Chris	Grant	Medical Director	NHS Consultant in Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			A member of Festival Medical Services, a 'not for profit' registered charity staffed by volunteers, delivering professional medical services at events throughout the country. NWAS does not sub-contract events nor does FMS operate any significant activity in the North West.		√			Non Financial Professional Interest.	Jul-22	Present	If FMS run events in the North West, these would be undertaken via usual NWAS command functions and EPRR planning and I would remove myself from any interactions and engage with the NWAS Deputy Director should involvement be required from the Medical Directorate.
David	Hanley	Non-Executive Director	Lay Representative Royal College of Physicians			√		Non Financial Professional Interest.	May-24	Present	No conflict.
			Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	Present	No conflict.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Member of the JESIP Ministerial Board, HM Government		√			Position of Authority	Jan-22	Present	No conflict.
			Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A

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	
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care)		√			Position of Authority	Apr-19	Present	N/A
			Member of the NW Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A
Maxine	Power	Director of Quality, Innovation and Improvement	Non Executive Director at AQUA - Improvement Agency based in the North West	√				Non Executive Director	May-24	Present	All interactions will be discussed at one to ones and any conflicts or hospitality declared as appropriate.
			Daughter employed at NWAS as Service Delivery Programme Assurance Manager in PES.			√		Non financial personal interest.	Sep-23	Present	Declare an interest and withdraw from discussions as and when required.
			Advisor (Associate Specialist) to The Value Circle - a specialist agency providing advice to NHS organisations		√			Advisory role	Dec-23	Present	All advice provided out of working hours and not linked to my role at NWAS. Benefits to be declared if applicable.
Lisa	Ward	Director of People	Member of the Labour Party			√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
			Member of Chartered Institute of Personnel and Development		√			Non financil professional interest	Jun-23	Present	Declare an interest and withdraw from discussions as and when required.
			Daughter employed at DHSC as economic analyst			√		Non financial personal interest.	Sep-21	Sep-23	Declare an interest and withdraw from discussions as and when required.
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Whatley	Associate Non Executive Director	Trustee Pendle Education Trust		√				Mar-23	Present	Withdrawal from the decision making process if the organisations listed within the declarations were involved.
			Governor, Nelson and Colne College Group		√				Mar-23	Present	
			Independent Member of Audit Committee, Pendle Borough Council		√				Mar-23	Present	
			Wife is employed at Manchester Teaching Hospitals NHS FT as a Biochemist				√		Mar-23	Present	
Peter	White	Chairman	Chair of Lancashire Teaching Hospitals NHS Foundation Trust	√				Second Trust Chair Position in another NHS organisation	Aug-23	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	No Conflict
Carolyn	Wood	Director of Finance	Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Chief Executive's Report to the Board of Directors
PRESENTED BY	Daren Mochrie, Chief Executive
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Receive and note the contents of the report
EXECUTIVE SUMMARY	The purpose of this report is to provide members with information on a number of areas since the last CEO's report to the Trust Board dated 29 May 2024. The highlights from this report are as follows: PES • Achieving the governmental standard of YTD C2 mean • Performing well on all ARP standards • Handover, particularly in C&M, remains a challenge 111 • National call handling support to continue to at least end Q2 • Good results for 111 'Press 2', for patients in mental health crisis • Improved sickness absence PTS • Tender outcome still awaited • Strengthened PTS leadership structure being developed • All areas experiencing gradual increases in activity

PREVIOUSLY CONSIDERED BY	Not applicable	

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 29 May 2024.

2. PERFORMANCE

2.1 Paramedic Emergency Service

June's ARP response standards remain relatively stable compared to previous months. UEC Recovery Plans continue to focus on C2 mean response below 30 minutes. As at end of June NWAS continue to deliver the government standard with YTD C2 mean at 24:42. For June NWAS ranked first within the sector for C2 mean response. All ARP response standards remain stable and NWAS continues to perform well against the sector. Call pick-up also continues to perform well with a mean CPU of 00:01 and NWAS ranked first within the sector. From an activity perspective, calls and incidents remain equivalent to the previous June.

Handover continues to be a significant challenge. For June, arrival to handover is 8 minutes higher than the previous June. Handover to clear has improved by just over 2 minutes, with overall handover around 5 minutes longer than June 2023. It should be noted that handover varies significantly by ICB, with Cheshire and Mersey's handover being 41% higher than the rest of the north west. This in turn is delivering significant variation in respect to response standards. Non-conveyance both H&T and S&T remains stable, but behind the national average. Focus on productivity and improvement is being applied to both of these metrics.

2.2 NHS NW 111

Recent months has shown significant improvement in call answering KPI's within 111. Since the start of the financial year in April, our SLA for calls answered within 60 seconds is up to 81%. This is, by comparison to the whole of 2023/24 at 50%, showing an improvement of 31% so far this year. Our abandonment rate has also improved significantly and now sits at 2.5% against the target of 3%. The vacancy gap is continuing to close with a sustained and robust recruitment strategy led by the head of service for call handling.

The IUC arrangements currently provide 15% national call handling support which has reduced inbound call demand. This arrangement will remain in place until at least the end of Q2. Further discussions nationally, dependant on NW 111 delivery of the IUC plan, will commence in early Q2. In addition, NW 111 has seen the launch of '111 press 2' for patients presenting in mental health crisis. The results indicate a reduction in referrals made to mental health services from within NWAS, indicating patients are routing correctly through to their neighbourhood mental health teams.

Further improvements have been made in staff related figures such as attrition and sickness absence, with both metrics showing their lowest figures in over a year. The wellness of colleagues within 111 is regularly around 90%, indicating a sickness rate of 10%. Work continues to enable further reductions and share best practice both internally and externally across contact centres.

2.3 Patient Transport Services

The PTS contract tender award outcome is still awaited. Activity during May 2024 (Contract Month 11) was 6% below contract baselines with Lancashire 23% below contract baselines whilst Merseyside is operating at 5% (1133) Journeys above baseline. For the year-to-date position (July 2020 - May 2024) PTS is performing at -9% (-137611 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are operating at 22% and 25% below baseline whilst Greater Manchester and Merseyside are operating at 6% and 1% above baseline, respectively.

In terms of overall trend analysis, all areas are experiencing gradual increases in activity, mainly in the core (outpatient) areas.

Unplanned activity, cumulative positions within Greater Manchester and Merseyside are -4% (-1580 journeys) and 0% (15 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.

Planned arrival performance varies by area with the best performance in Cumbria where we achieved 84% against the arrival KPI target of 90%. During Month 11, May 2024, planned arrivals achieved were Greater Manchester 73%, Lancashire 53% and Merseyside 78%.

Enhanced Priority Service (EPS) performance, against the arrival KPI target of 90%, achieved Cumbria 84%, Greater Manchester 69%, Lancashire 82% and Merseyside 80%.

Aborted activity for planned patients averaged 8% during May 2024 however Cumbria experiences 4%, Greater Manchester operates with 11% whilst Lancashire and Merseyside both experience 6% and 6% aborts respectively. There is a similar trend within EPS (renal and oncology) patients with a trust average of 6% aborts whereas Cumbria has 2% and Greater Manchester 8% Lancashire and Merseyside operate with 4% and 7% respectively. Unplanned (on the day) activity experiences the largest percentages of aborts with an average 29% (1 in 6 patients) with variances of 13% in Cumbria, 37% in Greater Manchester, 23% in Lancashire and 26% Merseyside.

The PTS senior leadership team are developing a strengthened leadership structure and an improvement group encompassing all NWAS business lines to evaluate all areas of perceived

operational and financial efficiency challenges. Should NWAS ultimately be successful in the future business bid, then this group will naturally evolve into a mobilisation oversight group.

3. ISSUES TO NOTE

3.1 Local Issues

Appointment of Area Director for Greater Manchester

In August, we will welcome a new Area Director for Greater Manchester, Sian Wimbury, who will join the trust from Greater Manchester Mental Health NHS Foundation Trust, where she held the role of Deputy Chief Operating Officer.

Sian has more than 20 years' experience in senior management roles in mental health and community services trusts and commissioning.

Her knowledge, skills and expertise really stood out during the competitive recruitment process and I'm confident she will do well in the role.

The Area Director for Greater Manchester became vacant after Joanne Clague left her role of Area Director for Cheshire and Mersey and Ian Moses moved across from Greater Manchester to fill that position.

Once Sian has commenced in role, the Area Directors will be:

- Greater Manchester – Sian Wimbury
- Cheshire and Merseyside – Ian Moses
- Cumbria and Lancashire – Matt Cooper

3.2 Regional Issues

Executive Director of Operations Appointment

Dan Ainsworth, former Director of Integrated Contact Centres, has been appointed to the position of Director of Operations, effective 1 July 2024, following a competitive external recruitment process.

Dan has been part of Team NWAS since 2013, when he joined in the role of NHS 111 Operations Manager. For the five years prior, Dan had worked for NHS Direct, where he started his career as a Health Advisor. Dan held various senior management positions within NHS 111 before becoming Head of Emergency Operations Centres (EOCs) in April 2018. He started his most recent role of Director of Integrated Contact Centres in May 2022.

Dan was responsible for EOCs throughout the COVID-19 pandemic and some of our most challenging periods of demand in recent years. Under his leadership, we've recruited hundreds of new call handlers and successfully recovered our performance, making us among the best ambulance services in the country for call pick-up times.

Most recently, Dan and his team have led the start of our journey to an integrated contact centre, bringing together 999, 111 and PTS teams, systems and processes to enable us to work more closely together as one team.

Sally Rose, Assistant Director of Integrated Contact Centres, will take on the role of Interim Director of Integrated Contact Centres for the next few months. During this time, a full recruitment process will be undertaken to appoint to the role on a permanent basis.

I would like to thank Salman for his valuable contribution over the past few months as Chief Operating Officer following the retirement of Ged Blezard at the end of September 2023. With his support, we have been able to continue to provide the highest quality of patient care and experience to the communities we serve. Salman will now continue to focus on his duties as Deputy CEO and Director of Strategy, Partnerships and Transformation.

Clinical Audits

The trust's clinical audit teams are visiting stations to talk to staff about the importance of completing a good patient record in honour of Clinical Audit Awareness Week.

Clinical audits are a way to find out if health services are meeting local and national standards and targets. They let care providers and patients know what their service is doing well, and where there could be improvements. The work of clinical audit teams is essential, both as drivers of improvement in their own organisations, and their contribution to national audit data collection that allows appropriate scrutiny of our health and social care system.

By generating reliable data, clinical audits help to improve the care our patients receive. They provide evidence to show when we're getting it right, but also help us to identify areas where we need to improve

3.3 National Issues

Retirement of Steve Irving, Executive Officer at AACE

The Association of Ambulance Chief Executives has announced the formal retirement of its long-serving Executive Officer, Steve Irving, following a distinguished 40-year career in the NHS ambulance sector which included the organisation of the annual Ambulance Leadership Forum event.

Steve has made a tremendous contribution to the ambulance service in London, where he began his career as a trainee, and then in his various national roles.

National Quarterly Pulse Survey

The National Quarterly Pulse Survey (NQPS) supports an integral part of the NHS People Promise and runs for the month of July.

By completing the short survey, we can help build an understanding of colleagues' experiences working for NWAS, including what's working well and where improvements are needed; the honest insights are vital and valuable as we strive to make the organisation the best place to work.

NQPS and the National Staff Survey (NSS) both provide a consistent and standardised approach to listening to staff sentiment at regular intervals.

4. GENERAL

The General Election

The trust issued guidance to staff regarding the pre-election period and the restrictions on the activity of public bodies, civil servants and local government officials, including ourselves and noted that communication either in the form of announcements or activities by the trust should be avoided if they could influence, or be regarded as influencing, the outcome of any of the elections.

The General Election took place on 4 July resulting in a change of government with labour winning the general election and Sir Kier Starmer becoming the country's Prime Minister. He then announced his cabinet, containing a record 11 women, and including a number of MPs from our region; Lucy Powell as Leader of the House of Commons, Angela Rayner as Deputy Prime Minister, Jonathan Reynolds, Business and Trade Secretary and Lisa Nandy as Culture Secretary. The Secretary of State for Health and Social Care has been confirmed as Wes Streeting who has been Shadow Health Secretary since 2021.

The election also meant lots of changes within the North West, with new MPs in many of the constituency areas we cover.

For the NHS, a new government brings new opportunities to tackle some of the issues we have been facing. In its manifesto, Labour promised 40,000 more healthcare appointments every week, steps to address the workforce crisis, improving care options closer to home, and modernising our systems; the improvements needed will take a significant amount of time and money. Together with our Deputy Chief Executive, Salman Desai, we will continue

to work at a senior level with our colleagues from the Association of Ambulance Chief Executives (AACE) and NHS England to make sure the ambulance service challenges the government, and opportunities are made clear.

The conclusion of the election also means the end of the pre-election period and we are now able to resume all normal activities and will be working to engage with new MPs in our region and creating new relationships with them.

At the State Opening of Parliament on 17 July, King Charles outlined the government's priorities for the coming legislative year and reiterated the government's commitment to the NHS "as a service for all, providing care on the basis of need regardless of the ability to pay. It will seek to reduce the waiting times, focus on prevention and improve mental health provision for young people".

International Paramedics Day

July 8 was International Paramedics Day. The aim of the day is to celebrate the profession and build a better understanding of the breadth and depth of the work carried out by paramedics around the world.

This year's theme is the "Difference We Make." Staff join the ambulance service to help people and hopefully make a positive impact on their lives, not just saving lives but often also providing comfort and reassurance for people in challenging times.

We all have the shared purpose of helping people when they need us most, and that includes everyone from frontline clinicians to the behind-the-scenes teams that keep the service running.

Body Worn Video Cameras (BWVC)

A man has recently been charged with assault on an emergency worker and sentenced to a twelve-month custodial sentence after attacking Paramedic, Elli Tayburn, in August last year.

Elli had been treating the patient and had taken him to Royal Blackburn Hospital when he kicked her in the back. The kick was that brutal, it caused her severe pain, kidney problems and forced her to take six weeks off work.

The judge was very supportive of the emergency services and referred to the fact that suffering from mental health issues did not excuse the attackers' actions.

Fortunately, the police had accompanied Elli and her crewmate to the hospital and were able to restrain the attacker immediately following the assault. The footage from the

officer's body worn video camera was crucial in obtaining a conviction. Since then Elli's own body worn video camera has captured another attack on one of her colleagues.

Body worn video cameras are now available across the entire trust for colleagues to use as a form of protection whilst on duty should they so wish.

Sexual Safety Roadshow

Members of our sexual safety steering group recently spoke to over 50 members of staff across PES and PTS at Wigan, Bolton and Chorley emergency departments as part of our sexual safety roadshows. The group also engaged with private provider staff and the police to promote our mission to make NWAS a safe place to work.

The roadshows will continue across the summer months with members travelling across the entire footprint to talk to as many staff as possible. Our Stop, Speak, Support campaign reminds us to pause and look at our own behaviour, speak out to challenge the behaviours of others, and support anyone we know has been affected. This is what our members are discussing at the roadshows as well as asking about staff experiences and what more we can do to support them.

Positive progress for staff health and wellbeing

The NWAS Health and Wellbeing annual report was recently published and summarises the progress made over the last 12 months to put better support in place for everyone across the organisation, including:

- Development of a Workforce Wellbeing Team, with a dedicated workforce wellbeing officer for each area of the trust. The officers are a visible presence engaging with staff and providing information, advice and guidance.
- The launch of the Wellbeing Hub, a one-stop-shop for health and wellbeing resources and a phone line for anyone who needs a conversation about the range of support available.
- A programme of initiatives including: a wellbeing festival; confidential support calls to staff; a therapy dogs partnership; and new and improved support groups, resources and services.
- NWAS Charity-funded projects, such as the hardship fund for people experiencing financial difficulties, and enhancements to staff sites and facilities.

National Staff Survey responses in 2023 showed improved results for wellbeing-focused questions The priorities for the year ahead are outlined in the annual report and include expanding the wellbeing support and training resources available.

Access to Work Mental Health Support Service

A new mental health support service is now available to all staff following a successful trial period in 111.

The Maximus Access to Work Mental Health Support Service, delivered on behalf of the Department for Work and Pensions, provides nine months of tailored mental health support, free of charge, to employees who are experiencing depression, anxiety or stress to help them stay in, or return to, work and offers personalised wellbeing support plans, suggests workplace adjustments, and provides practical advice and guidance.

National Institute for Health & Care INSIGHT Programme

The National Institute for Health and Care are working with the University of Central Lancashire to offer a programme to help professionals develop their research skills. The Inspiring Students into Research Scheme (INSIGHT) programme is a four-year scheme for 30 students from various NHS organisations, local authorities and community bodies.

As a regionwide healthcare organisation, we are pleased to collaborate with our NHS partners and higher education institutions across the North West to offer students the opportunity to engage with research at an early stage in their careers. The INSIGHT programme will help create a skilled research workforce who will help address the complex health and care challenges of the future.

Inaugural Betty Pennington Research Award

The Betty Pennington Research Award was designed by our Research and Development Team to commemorate their colleague, Betty Pennington, who sadly passed away in 2023. This research award offers a small grant to support people early in their career to undertake a research study.

The winner of the award was Alex Diffley, Research Paramedic for Yorkshire Ambulance Service and was presented by Betty's husband at the College of Paramedics dinner, held on Wednesday 22 May 2024.

We hope to continue our collaboration with the College of Paramedics and offer the opportunity annually so that we may maintain Betty's legacy.

Addressing Health Inequalities

I attended the NHS Confed Expo held in Manchester; an opportunity for leaders across the healthcare system nationwide to share learning and best practice. A topic of particular

relevance was ambulance services working with integrated care systems (ICSs) to address health inequalities.

Health inequalities are preventable, unfair and unjust differences in health between groups, populations or individuals. They are usually caused by wider social and economic factors such as housing, employment and education.

In a region as diverse as the north west, we unfortunately see stark health inequalities. Our trust strategy outlines our role and commitment to helping to tackle health inequalities, by working with health and social care partners and making sure our services are accessible for everyone.

As an ambulance service, we are in a unique position. We have valuable insight into the real impact of health inequalities. When we interact with a patient, we not only identify an individual's medical condition or immediate health needs, but also see first-hand the conditions and circumstances they live in.

We have a Public Health Team working across several projects, one of which is focused on improving knowledge and understanding among staff in relation to population health and health inequalities, and action we can take to help make improvements. There were hundreds of responses to a recent survey asking for staff experiences, the team will be using these to shape a new training offer.

Pride Month

Pride Month is a global celebration to highlight and celebrate the LGBT+ community and is celebrated throughout the month of June. As allies, we can strengthen LGBT+ voices, advocating for their rights and wellbeing, and highlight issues impacting our LGBT+ community.

Disability Pride

Disability Pride Month, celebrated every July, is a time to raise awareness about disabilities, start positive conversations, and celebrate the diversity within the disabled community.

The month is about helping others find the support they need to achieve self-acceptance of their disabilities and make their voices heard. Many people who don't have a disability fear using the wrong language or upsetting people, but it's about showing you care by actively trying to learn the correct language and understanding how to help.

Tackling racism in the ambulance service

I recently attended the National Ambulance Black and Minority Ethnic (BME) Forum Conference in London where representatives from services across the country got together to discuss how we make systematic change to tackle racism.

I gave a welcome talk, in which I spoke about the drivers for change. There is plenty of data and reporting that shows us the need for change including the NHS workplace race equality standard (WRES) reports, freedom to speak up cases and statistics, and the recent reviews into ambulance service culture.

The rest of the day was packed with workshops, sharing of best practice, and powerful and thought-provoking personal experiences from people who have experienced racism in the workplace. These served as a constant reminder of the importance of discussing these issues and finding ways to do better.

We had speakers from NWAS on the agenda. Director of People, Lisa Ward, was part of a panel for a session on international recruitment, and Wasim Mir, Equality, Diversity and Inclusion Advisor, led a workshop on 'beat the burnout', about increasing resilience.

The trust's Race Equality Network (REN) was also well represented, with several members in attendance. The work of our REN is vital in helping us understand the barriers and inequalities faced by some groups of staff and patients.

Celebrating Excellence

The trust was shortlisted for Employer of the Year with ten of our apprentices being recognised in the NHS Health & Social Care Apprenticeship Awards 2024 and out of the eleven award categories our colleagues were shortlisted in five.

The trust, nominated by the university of Cumbria, won the Employer of the Year Award making this the second time in three years that we have received this award. One of our apprentices was Highly Commended in the non-clinical apprentice of the year category and one won the rising Star T-Level Award out of three colleagues shortlisted.

This success builds on the achievements of our 2023/24 apprentices, who were celebrated for their exceptional skills, knowledge, and commitment at an event held at Bolton Stadium in June. The event recognised those who completed their apprenticeships over the past year.

Plastic Free July - The fight against plastic pollution

The trust's Sustainability Team encouraged staff to be part of the solution to plastic pollution and help reduce plastic waste.

By 2050, it is estimated that there will be more plastic in the oceans than fish by weight. Plastic waste has devastating consequences for marine life, it damages and poisons soil and groundwater and can cause serious health impacts. Through small swaps, or complete plastic elimination, we can all contribute to the solution. Every small change collectively makes a massive difference to our communities.

Community Engagement

Each year the Patient Engagement Team host a series of community engagement events, with one event in each county area. Members of the public are invited to attend to find out more about their local ambulance service, careers and volunteering opportunities.

5. EQUALITY/ SUSTAINABILITY IMPACTS

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

6. ACTION REQUIRED

The Board is recommended to:

- Receive and note the contents of this report

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	People Strategy Refresh
PRESENTED BY	Ward, Lisa
PURPOSE	Decision

LINK TO STRATEGY	People Strategy									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☐	**SR03**	☐	**SR04**	☒	**SR05**	☒
	SR06	☐	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☐

ACTION REQUIRED	The Board is asked to: • Approve the recommended changes to The People Strategy as outlined in 2.4. • The Strategic Planning Team will be working with each Strategy lead to refresh the Strategic Roadmaps.
EXECUTIVE SUMMARY	The Trust Strategy refresh was undertaken at the end of FY 23/24 to determine whether the strategy is still relevant within the context and to identify key areas of focus for the next financial year. The outcome of the Trust Strategy refresh process was the recommendation to emphasise three key areas of focus in the Trust strategy for 24/25; 1. Urgent and emergency care recovery, 2. Freedom to Speak up (FTSU), 3. Ambulance Service Culture, with a particular focus on sexual safety. The analysis and recommendations were presented to TMC, Resources Committee and Board of Directors in May 2024 and were approved. In approving the recommendations presented in the Trust Strategy refresh, there is a need to conduct subsequent refreshes on the four supporting strategies.

	The recommendations to emphasise FTSU and Ambulance service culture directly impact The People Strategy and therefore, the People Strategy refresh has been expedited to ensure prompt alignment and focus. To ensure The People Strategy aligns to the refreshed key areas of focus in the Trust Strategy, a review of The People Strategy document has been completed. The review found that the priorities within the strategy are well aligned to the Trust Strategy and the refreshed key areas of focus however, there were some additions needed to the context of the document to make sure ambulance service culture and FTSU are appropriately emphasised. The review highlighted that the language included within the equality, diversity and inclusion (EDI) priorities was not reflective of the 24/25 refreshed priorities and therefore the EDI priorities were updated to be reflective of the most current language. A summary of the recommended changes is outlined in 2.4	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 17 July 2024
	Outcome	Recommended for approval
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	Friday, 26 July 2024
	Outcome	Paper circulated to members for comment as meeting stood down. Any matters will be raised verbally at Board.

1. BACKGROUND

1.1 The Trust Strategy refresh was undertaken at the end of FY 23/24 to determine whether the strategy is still relevant within the context and to identify key areas of focus for the next financial year.

1.2 The Trust Strategy refresh required analysis of the current context and changes upon the horizon as well as progress against year two of the strategy. These analyses were considered to answer the following questions:

- Has the strategy had the impact intended?
- Does the strategy fit within the current context?
- Will the strategy continue to add value?

1.3 The outcome of the Trust Strategy refresh process was the recommendation to emphasise three key areas of focus in the Trust strategy for 24/25;

4. Urgent and emergency care recovery,
5. Freedom to Speak up (FTSU),
6. Ambulance Service Culture, with a particular focus on sexual safety.

1.4 The analysis and recommendations were presented to TMC, Resources Committee and Board of Directors in May 2024 and were approved.

1.5 In approving the recommendations presented in the Trust Strategy refresh, there is a need to conduct subsequent refreshes on the four supporting strategies: The People Strategy, The Quality Strategy, The Sustainability Strategy and, the Service Delivery Strategy.

1.6 The supporting strategies outline what we commit to prioritise to achieve the aims of the Trust Strategy and ultimately, our vision: To deliver the right care, at the right time, in the right place, every time. The supporting strategy refreshes are necessary to make sure the strategies are aligned to the key areas of focus in the Trust Strategy for 24/25.

1.7 The recommendations to emphasise FTSU and Ambulance service culture directly impact the People Strategy and therefore, the People Strategy refresh has been expedited to ensure prompt alignment and focus. The three remaining supporting strategies will be refreshed collectively and presented through TMC, Resources Committee and Board of Directors in September 2024.

2. PEOPLE STRATEGY REFRESH

2.1 To ensure The People Strategy aligns to the refreshed key areas of focus in the Trust Strategy, a review of the strategy document has been completed.

2.2 The review found that the priorities within the strategy are well aligned to the Trust Strategy and the refreshed key areas of focus however, there were some additions needed to the context of the document to make sure ambulance service culture and FTSU are appropriately emphasised.

2.3 The review highlighted that the language included within the equality, diversity and inclusion (EDI) priorities was not reflective of the 24/25 refreshed priorities and therefore the EDI priorities were updated to be reflective of the most current language.

2.4 A summary of the changes recommended as part of The People Strategy refresh are as follows:

Page	Previous wording	Refreshed wording
5	None	**Culture review of ambulance trusts** In 2023, NHS England commissioned an independent review of culture within the ambulance service to be conducted by Siobhan Melia, Chief Executive, Sussex Community NHS Foundation Trust. The findings of the review were published in February 2024 and the following six key recommendations have been made to improve ambulance service culture: 1. Balance operational performance with people performance at all levels. 2. Focus on leadership and management culture and develop the ambulance workforce. 3. Improve the operational environment, line management and undergraduate training. 4. Translate the NHS equality, diversity, and inclusion improvement plan into a bespoke plan for the sector. 5. Target bullying and harassment, including sexual harassment and enable freedom to speak up. 6. Prioritise, support and develop human resources and organisational development functions. These recommendations will influence national and regional improvement plans which NWAS is committed to support and delivery to make sure our culture provides a fair, safe and inclusive environment where everyone is supported to be at their best.
6	Following the publication of the recent 'Listening to Workers' report into Ambulance Services, the Trust will be implementing a range of measures to improve culture, safety and Speaking Up in the Sector.	**Freedom to Speak Up (FTSU)** In 2023, the National Guardian's office published a "speak up review" of ambulance trusts in England. The review found that ambulance service culture was having a negative impact on people's ability to speak up. At NWAS, we recognise that speaking up is critical to enable improvement in our organisational culture. The Trust will be implementing a range of measures to improve culture, safety and Speaking Up in the Sector.

7	**Making sure our current employees and future talent have fair job and career progression opportunities which will improve diversity and representation at all levels of the organisation.** • Targeting an improvement in representation from ethnic minority communities to 8% of the workforce through better attraction, fairer recruitment and positive action • Delivering equitable representation at all management levels through a focus on fair career progression • Improving the gender pay gap and other measures of staff experience for protected groups	**We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels.** • To increase attraction rates from under-represented groups • To improve the fairness of our internal and external recruitment processes • To provide improved access to career pathways • To improve retention of under-represented groups
7	Educating and developing our leaders and people to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients. • Developing our leaders to being able to lead inclusively • Continuing to support our staff networks to give voice to staff experience and to challenge how we are doing • Developing talent management programmes for under-represented groups. • Improving respect and civility in the workforce	We will educate and empower our workforce and leaders to promote a positive culture, and help support a reduction in the experience of bullying, harassment and discrimination • To build the confidence and competence of managers to create healthy workplace cultures • To reduce levels of unwanted behaviour of a sexual nature, bullying and harassment from colleagues • To improve the experience of students • To further enhance the effectiveness of staff networks • To make progress towards being an intentionally anti-racist organisation

3. NEXT STEPS

3.1 Action plans are in place with progress and assurance through TMC, Resources Committee and Trust Board where appropriate.

4. RISK CONSIDERATION

4.1 The recommended changes to The People Strategy are in response to the changes in the context and are necessary for NWAS to achieve its people priorities and subsequently its vision, as outlined in the Trust Strategy.

4.2 The recommended changes to The People Strategy and subsequent improvement action to be taken directly links to the controls aligned to strategic risks SR04 and SR05.

Risk appetite category	Implications
Compliance / regulatory	The People Strategy includes priorities which will improve staff experience and contribute to the 'Well Led' domain in the CQC regulatory framework. The areas which focus on equality and inclusion will support the delivery of the Public Sector Equality Duty
Quality outcomes	It is expected that by improving staff experience, we will see an improvement in the quality of care delivered to patients. The People Strategy maintains a focus on being an excellent place to work.
People	The People Strategy is focussed on improving the working environment for our people.
Financial / value for money	The People Strategy includes aims to improve and simplify processes which should deliver efficiency improvements and improved value for money.
Reputation	Improving the working experience of our people will enhance our reputation and reduce the likelihood of reputational damage.

5. EQUALITY/ SUSTAINABILITY IMPACTS

5.1 The recommended changes aim to have a positive impact on equality and inclusion. The review of The People Strategy reminds us of the risk that, if the strategy is not delivered, NWAS misses the opportunity to positively impact communities and staff groups who currently face disadvantage.

6. ACTION REQUIRED

6.1 The Board is asked to:

- Approve the recommended changes to The People Strategy as outlined in 2.4.
- The Strategic Planning Team will be working with each Strategy lead to refresh the Strategic Roadmaps.

North West Ambulance Service NHS Trust

People Strategy

2023 - 2026

Contents

Introduction

Our Trust Strategy 2022-2025 sets our vision for the future;

To provide the right care, at the right time, at the right place, every time.

To achieve this vision, we have three aims; provide high-quality, inclusive care, be a brilliant place to work for all, and work together to shape a better future. This People Strategy is one of four supporting strategies which outlines what we will prioritise over the next three years to achieve our aims and ultimately, our vision.

Our People

Since our last strategy, our people tell us that we are doing better at supporting them whether this is through health and wellbeing, reasonable adjustments, or appraisals. This support extends to our planning and recruitment which means in the main our vacancy gaps and turnover are low compared with the wider NHS.

Our people consistently tell us that their immediate line managers are improving every year in the support they offer to their teams. Our learners, new starters and those completing mandatory training tell us that the education they receive and their support in the workplace is high quality. Our people are proud of the care they are supported to give to patients.

"Our People are our greatest asset. By looking after our People and improving their experience of work, we directly improve the care of our patients. It is only by fostering an inclusive and compassionate culture that allows people to bring their whole self to work, that we can fully develop our talent and release the potential of our people for the benefit of patients."

Lisa Ward, Director of People

However, this strategy is designed to look forward and to focus on the areas we need to improve. Our People tell us that we don't always get everything right.

Our staff survey results tell us that our people experience negative behaviours in work from patients, colleagues and managers more frequently than they should. It also tells us that several staff lack confidence to speak up about these experiences. Our people also tell us they lack confidence in the fairness of some of our processes and are frustrated about how support is difficult to navigate.

Our workforce measures, such as attendance, recruitment, and retention, also tell a story about where we need to focus our priorities. They tell us that we need to do more to support the mental and physical wellbeing of our staff. That we have great talent that we lose from our organisation that we need to work harder to retain.

Our staff networks provide a safe environment for people to share their lived experiences, but they also challenge us to do more to create an inclusive environment to improve experiences for all our people.

The Culture and Organisation Review carried out in 2021 helped us to understand what was important to our people in their experience of work and where to focus improvement to have the greatest impact. This work continues into this strategy.

Our People Strategy in context

The People Strategy is a supporting strategy which underpins the wider Trust strategy. It aims to develop the culture and leadership environment to facilitate the delivery of the overall organisational goals. In developing the priorities within this strategy, alignment is made with both regional and national policy outlined below;

National People Context

The seven pillars of the NHS People Promise sets out ambitions for what people working in the NHS will say about their experience of work in the future. These ambitions alongside the NWAS values underpin the NWAS People Strategy.

The People Promise is supported with national programmes of work which aim to provide a framework for improvement in individual Trusts. Examples include:

- Management and leadership – aiming to provide standardised approaches to leadership development, staff induction and appraisal based on the recommendations of the Messenger Review
- NHS Equality, Diversity and Inclusion Improvement Plan

This works informs the NWAS People Strategy.

The HROD Futures Programme sets out a vision of how Human Resources and Organisational Development services will be delivered by 2030 focussing on the 8 key themes. These aim to transform the way People Services are delivered with a focus on areas such as developing the People Profession, improved use of digital and improving productivity and collaboration.

Culture review of ambulance trusts

In 2023, NHS England commissioned an independent review of culture within the ambulance service to be conducted by Siobhan Melia, Chief Executive, Sussex Community NHS Foundation Trust. The findings of the review were published in February 2024 and the following six key recommendations have been made to improve ambulance service culture:

1. Balance operational performance with people performance at all levels.
2. Focus on leadership and management culture and develop the ambulance workforce.
3. Improve the operational environment, line management and undergraduate training.
4. Translate the NHS equality, diversity, and inclusion improvement plan into a bespoke plan for the sector.
5. Target bullying and harassment, including sexual harassment and enable freedom to speak up.
6. Prioritise, support and develop human resources and organisational development functions.

These recommendations will influence national and regional improvement plans which NWAS is committed to support and delivery to make sure our culture provides a fair, safe and inclusive environment where everyone is supported to be at their best. The People Strategy is already closely aligned with the findings from this review.

Freedom to Speak Up (FTSU)

In 2023, the National Guardian's office published a "speak up review" of ambulance trusts in England. The review found that ambulance service culture was having a negative impact on people's ability to speak up. At NWAS, we recognise that speaking up is critical to enable improvement in our organisational culture. The Trust will be implementing a range of measures to improve culture, safety and Speaking Up in the Sector.

Other National Drivers

The Urgent and Emergency Care Recovery Plan seeks to increase front line capacity and improve Category 2 Ambulance Response times through additional capacity and improvements to health and wellbeing. This impacts strongly on the first year of the People Strategy.

Association of Ambulance Chief Executives

A range of workstreams specific to the Ambulance Sector have been developed between the Association of Ambulance Chief Executives (AACE) and NHS England with People Directors leading key projects linked to Recruitment & Retention, Culture & Leadership, Digital, Health, Wellbeing & Suicide prevention.

Our commitment to equality, diversity and inclusion

To create an inclusive culture, we must develop an environment where diversity is truly valued. If we are to deliver our vision we must recognise that discrimination exists in society, in our workplaces and in healthcare, and take proactive steps to address inequalities. Our commitment to equality and inclusion feeds into everything we do and is a responsibility shared by everyone at NWAS.

Our commitment to inclusion is reflected through all our supporting strategies but it is fundamental to the People Strategy and the environment we want to create for our People.

The existing high impact priorities related to our people and committed to by the Trust Board are embedded in the People Strategy.

We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels

- To increase attraction rates from under-represented groups
- To improve the fairness of our internal and external recruitment processes
- To provide improved access to career pathways

We will educate and empower our workforce and leaders to promote a positive psychologically safe culture, to support a reduction in the experience of bullying, harassment, discrimination and an improvement in retention

- To build the confidence and competence of managers to create healthy workplace cultures
- To reduce levels of unwanted behaviour of a sexual nature, bullying and harassment from colleagues
- To improve the experience of students
- To further enhance the effectiveness of staff networks
- To make progress towards being an intentionally anti-racist organisation
- To improve retention of under-represented groups

We have already commissioned a review of the inclusiveness of our recruitment and progression processes by the Employers Network for Equality and Inclusion (ENEI) to help us in focusing on the actions which will have greatest impact.

This strategy is driven by the overall aims set out within Trust Strategy and is primarily aligned to the aim to be a “brilliant place to work for all” by;

- Looking after our People
- Investing in our People
- Leading our People Compassionately

The priorities within our People Strategy are also driven by our People and what they tell us about their experience of working for NWAS. These are the most important voices in shaping what we want to achieve over the next 3 years.

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

The People Strategy plan on a page

The People Strategy is a supporting strategy which underpins the wider, Trust strategy and contributes to achieving our vision; **To deliver the right care, at the right time, in the right place; every time.**

The People Strategy outlines what we will prioritise over the next three years to become a brilliant place to work.

NHS North West Ambulance Service NHS Trust

The people strategy primarily focusses on this aim from the Trust strategy…	…and will deliver against the following measures by 2026	…through a focus on the following priorities over the next 3 years	…which will be delivered by
Be a brilliant place to work for all We will create an environment where our people feel happy and safe, have access to equal opportunities and are supported to be at their best.	**Improved retention rates**	**Our people are safe, happy and healthy.**	• Proactive support for people to be healthy and in work • Improve violence prevention • Improve ways of working including meal breaks, relief arrangements, end of shift, etc. • Reduced stigma and improved support for mental health issues in our workforce • Develop innovative approaches to flexible working
	Improved attendance	**Our people approach is flexible, responsive and accessible.**	• Simplify HR processes ensuring consistent application and reduced errors • Induction processes which welcome staff, embed values and create a sense of belonging • Effective use of technology to improve experience • Listening to staff and manager experiences about improving services • Policies and procedures reflect the needs of the changing workforce and society.
	Improve staff views of career progression **Improvement in key staff survey responses**	**Our people are diverse, valued and respected.**	• Improve representation across the workforce at all levels • Staff work in an inclusive environment where they feel sexually safe and free from discrimination • Embedding a fair and just learning culture • Encouraging speaking up and developing the ways we engage, listen, respect and value staff • Being a clearly anti-racist organisation
	Improved diversity indicators and representation	**Our leadership is compassionate.**	• Deliver a core leadership and essential management skills programme to all managers to enable consistent and fair leadership • Commanders are recruited and developed in line with EPRR requirements • Develop a coaching community to support and improve leadership/management practices • Developing managers to collaborate confidently and effectively across internal and external systems
	Improvement in quality of processes	**Our people reach their potential.**	• Fair and transparent promotion and progression with visible and accessible development pathways • Everyone has the digital capability required for role • Learner feedback tells us we deliver high quality training supporting induction, preceptorship, CPD and annual training needs • Learning environments are fit for purpose for a modern and progressive ambulance trust • Talent management and succession planning

Our people are safe, happy and healthy

Life and work can have an emotional and physical impact on our people. The wellbeing of our staff is our priority. We want to create a psychologically safe environment where we get the basics right and where staff are confident, they will get support when they need it. We will achieve this by:

- Proactive support for people to be healthy and in work through improving Wellbeing and Occupational Health provision, enabling self-help and developing managers to focus on prevention.
- Improving violence reduction through collaborative work with partners, working with staff on preventative measures, a strong line on prosecution, improved support and targeted work on sexual safety and hate crime.
- Improve ways of working including meal breaks, relief arrangements, end of shift times by listening to staff, undertaking policy reviews, and implementing best practice.
- Reducing stigma and improved support for mental health issues in our workforce through proactive wellbeing conversations, suicide prevention, embedding the Mental Health Pledge and ensuring Managers are trained and competent to support this work.
- Developing innovative approaches to flexible working by taking best practice nationally and across the Ambulance Sector to improve options for staff.

By 2026, we aim to:

Improve staff survey results on H&WB

Improve meal break and end of shift compliance

Improve retention through better flexible options

Reduce sickness absence

Improve results on NWAS being a great place to work

Have fewer incidents of violence and aggression

Enhance line manager support through training around mental health support at work

Our people approach is flexible, responsive and accessible

Feedback from our people is that the way we deliver people services is not always easy to access. The Trust will learn from staff and management experiences to ensure our people approach is responsive and able to adapt to changing needs through better use of technology. We will achieve this by:

- Simplifying HR processes ensuring consistent application and reduced errors through end-to-end process reviews and the introduction of digital solutions such as interfaces between rostering and payroll systems. Delivering reductions in payroll errors and improved transactional processes.
- Ensuring induction processes welcome staff, embed values and create a sense of belonging through developing induction competencies for all staff, the design of induction pathways capturing staff groups and the roll out of Civility Saves Lives.
- Effective use of technology to improve experience through a Workforce Digital Roadmap ensuring that solutions add value and reduce burden.
- Listening to staff and manager experiences about improving our people services and proactively seeking feedback on aspects of our work.
- Ensuring Policies and Procedures are simplified, easily accessible and reflect the needs of the changing workforce and society focussing on social and economic issues around cost of living and social values.

By 2026, we aim to:

Have transformed our end to end pay process

Simplify policies and procedures to ensure greater access

Reduce under and overpayments

Measuring our services through metrics and stakeholder feedback

Increased productivity through greater use of digital solutions

Improve staff sense of belonging by improving the recruitment and induction processes

Our people are diverse, valued and respected

An inclusive working environment where everyone feels safe, which is kind and respectful and where we care for each other as we care for our patients, is a core and basic requirement for us all. We want to enable people to speak up, to call out inappropriate behaviour and where diversity is celebrated. We will achieve this by:

- Improving representation across the workforce at all levels through Positive Action and implementing the recommendations from the ENEI review of recruitment processes.
- Working proactively to improve the inclusivity of the working environment. We will work proactively on matters of sexual safety with policy reviews, improved complaint handling, engagement and training to ensure that staff work in an environment where they feel sexually safe and free from discrimination. We will deliver programmes to develop cultural competence of the organisation through embedding health inequality issues through our clinical and induction training, and supporting a programme of development interventions in conjunction with our networks.
- Embedding a fair and just learning culture through the implementation of a revised Disciplinary Policy with training for Managers.
- Develop new ways to engage with staff ensuring that we listen, respect and value everyone's contribution. We will enhance support for speaking up and ensure all staff have a regular appraisal conversation that recognises their value and contribution, supports their aspirations for development and embeds the NWAS values
- We will ensure that we are a clearly anti-racist organisation by taking visible action to address racism, taking action to identify and remove barriers, building allyship and using reverse mentoring to develop understanding.

By 2026, we aim to:

Improve WRES / WDES indicators.

Fully embedded the new Disciplinary Procedures – Increasing organisational learning, reducing case time.

Reduce the number of staff experiencing inappropriate sexual behaviour.

Improved diversity of representation at all levels.

Increase the number of staff feeling safe to report concerns.

Improved internal and staff survey measures on appraisal quality.

Complete Beyond Bias/Civility Saves Lives roll out.

Have embedded a Reverse Mentoring Programme which adds value.

Our leadership is compassionate

Our people have told us that their line manager has the single biggest influence on their experience of work so it is critical that we enable our leaders to deliver support to our people compassionately, fairly and effectively. We will achieve this by:

- Delivery of a core leadership and essential management skills programme to all managers through the Making a Difference programme and the development and design of essential learning for Leaders.
- Ensuring that Commanders are recruited and developed in line with national EPPR requirements and learning the lessons from the Manchester Arena Enquiry.
- Developing a coaching community to support and improve leadership/management practices on a day-to-day basis in their support of staff, to enable development and to provide constructive support and challenge.
- Developing managers to collaborate confidently and effectively across internal and external systems by providing them with the skills to support effective collaboration and the opportunities to engage in system wide development.

By 2026, we aim to:

Increased numbers of staff accessing coaching.

Positive feedback from stakeholders.

Be delivering a full range of essential learning for managers from induction to full role competency.

Full compliance with Making a Difference programme.

Embedded commander recruitment processes & maintenance of competence.

Improved staff survey results in relation to immediate line managers.

Our people reach their full potential

We have amazing talent amongst our people but we need to identify and nurture that talent more effectively. When our people join us we want them to be able to see their future career and be confident of their route to realise their potential, supported by high quality learning and Continuing Professional Development to help them achieve their goals. We will achieve this by:

- Ensuring our promotion and progression processes are fair and transparent with visible career pathways for our core roles supported by clear development opportunities.
- Everyone having the digital capability required for role through the design and delivery of core skills required for all roles, supporting technological changes and offering flexible support options to build confidence and capability.
- Developing the way in which we listen to our learners and use their feedback to ensure high quality training supporting induction, preceptorship, CPD and annual training needs are met.
- Learning environments are fit for purpose for a modern and progressive ambulance trust through a review of current facilities and that new opportunities are explored. Embracing the opportunities presented by technology to enhance learning.
- Embedding a fair process to identify and develop our talent and succession planning for senior and aspiring clinical, operational and educational leaders. Ensuring transparent access, consistent development support, positive action and collaborative working to develop our talent.

By 2026, we aim to:

Have a clear framework and development

Have embedded a pre-apprenticeship route for PTS and contact centre staff.

Have a talent and succession plan.

Implemented the ENEI Recruitment audit

Improved learner feedback.

Improved retention rates.

Have clear and transparent Career Pathways for all roles across the organisation.

Improved staff survey scores on fairness of career progression.

What does this mean for me?

Upon delivery of our People Strategy, we will have improved many elements of the lifecycle of our people as they join and develop during their time with us. We will have also made improvements in the diversity of our workforce and will have developed cultural competence to make sure our diverse workforce works in a way which is inclusive of all. This is what the delivery of our People Strategy will mean for you:

What does this mean for Staff?

- I will have a warm welcome to the organisation and feel a sense of belonging throughout my career with NWAS
- I will work as part of a diverse team
- I will have access to more and better options to help support me to be healthy at work
- I will have more options to work flexibly.
- I will feel proud to work at NWAS and will recommend it to family and friends as an employer and provider of care

What does this mean for Managers?

- I will be confident in supporting all staff at any point in their time at NWAS.
- I will have a better understanding and more options to help staff and teams develop.
- I will have refreshed leadership training and will feel confident to embed Just & Learning Culture within my Team.
- I will have fewer members of my team needing help with everyday “basics” such as pay discrepancies.

What does this mean for NWAS?

- More people will be happy and feel supported leading to a positive and productive work environment.
- The organisational culture will become more accepting and understanding of individual differences and staff and patients will have better experiences as a result.
- The talented individuals who work for NWAS will develop, grow and succeed.

Glossary

FTSU	Freedom to Speak Up
HROD	Human Recourses Organisational Development
NHS People Promise	The seven pillars of the NHS People Promise sets out ambitions for what people working in the NHS will say about their experience of work in the future.
The HROD Futures Programme	A range of improvement projects across the People Profession the NHS.
Turnover (people or staff)	Number of staff leavers calculated over a rolling 12 month period.
Vacancy gap	The number of staff in post against the funded establishment.
WRES	Workplace Race Equality Scheme
WDES	Workplace Disability Equality Scheme

References and acknowledgements

Trust Strategy

NHS People Plan

NHS People Promise

Future of NHS Human Resources and Organisational Development report

Urgent and Emergency Care Recovery Plan

Messenger Review

Organisation and Culture report – Zeal solutions

Listening to Workers Report

NHS equality, diversity and inclusion improvement plan

Employers Network for Equality and Inclusion review of recruitment processes

Culture review of ambulance trusts

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Board Assurance Framework Q1 2024/25 Position
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Q1 2024/25 position of the Board Assurance Framework.
EXECUTIVE SUMMARY	The proposed 2024/25 Q1 position of the BAF risks with associated CRR risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2024/25 year to date can be viewed in Appendix 2. As part of the Q1 review, the Trust Management Committee (TMC) recommend the following changes for Q1: • Increase of SR08 from 15 to 20.
PREVIOUSLY CONSIDERED BY	Trust Management Committee & Audit Committee
	Date: Wednesday, 17 July 2024 and Friday, 19 July 2024
	Outcome: TMC recommended to Board for approval

1. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework (BAF) identifies the strategic risks which may threaten the achievement of the Trust's strategic objectives/aims.

2. RISK ASSURANCE PROCESS

The Board Assurance Framework (BAF) identifies the strategic risks and ensuring that systems and controls are in place are adequate to mitigate any significant risk which may threaten the achievements of the strategic objectives.

Whilst the Board of Directors delegates authority to its Board Assurance Committees to monitor assurance against its strategic risks, it is ultimately responsible for the oversight of the BAF and the Board Assurance Committees are expected to escalate any significant assurance issues as they arise.

3. REVIEW OF THE Q1 POSITION

Following a full review of the Board Assurance Framework, the following change is proposed:

- Change in current risk score SR08 for Q1 from 15 to 20

BAF RISK SR08: There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm

Opening Score 01.04.2024	Q1 Risk Score	Exec Lead
15 5x3 CxL	**20** 5x4 CxL	Maxine Power

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

- Recent breach at a large NHS organisation demonstrates the continued threat and sophistication of a significant cyber incident.

4. RISK CONSIDERATION

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.

The Board Assurance Framework contains the application of the Trust's Risk Appetite Statement and has been reviewed as part of the Q1 BAF Review process.

5. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Q1 2024/25 position of the Board Assurance Framework.

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK 2024/25

Q1 Position Review

Part 1 - Board of Directors

31st July 2024

Q1 Position Reporting Timescales:

Trust Management Cttee:	17/07/2024
Audit Cttee:	19/07/2024
Resources Cttee:	26/07/2024
Board of Directors:	31/07/2024
Quality & Performance Cttee:	23/09/2024

BOARD ASSURANCE FRAMEWORK KEY

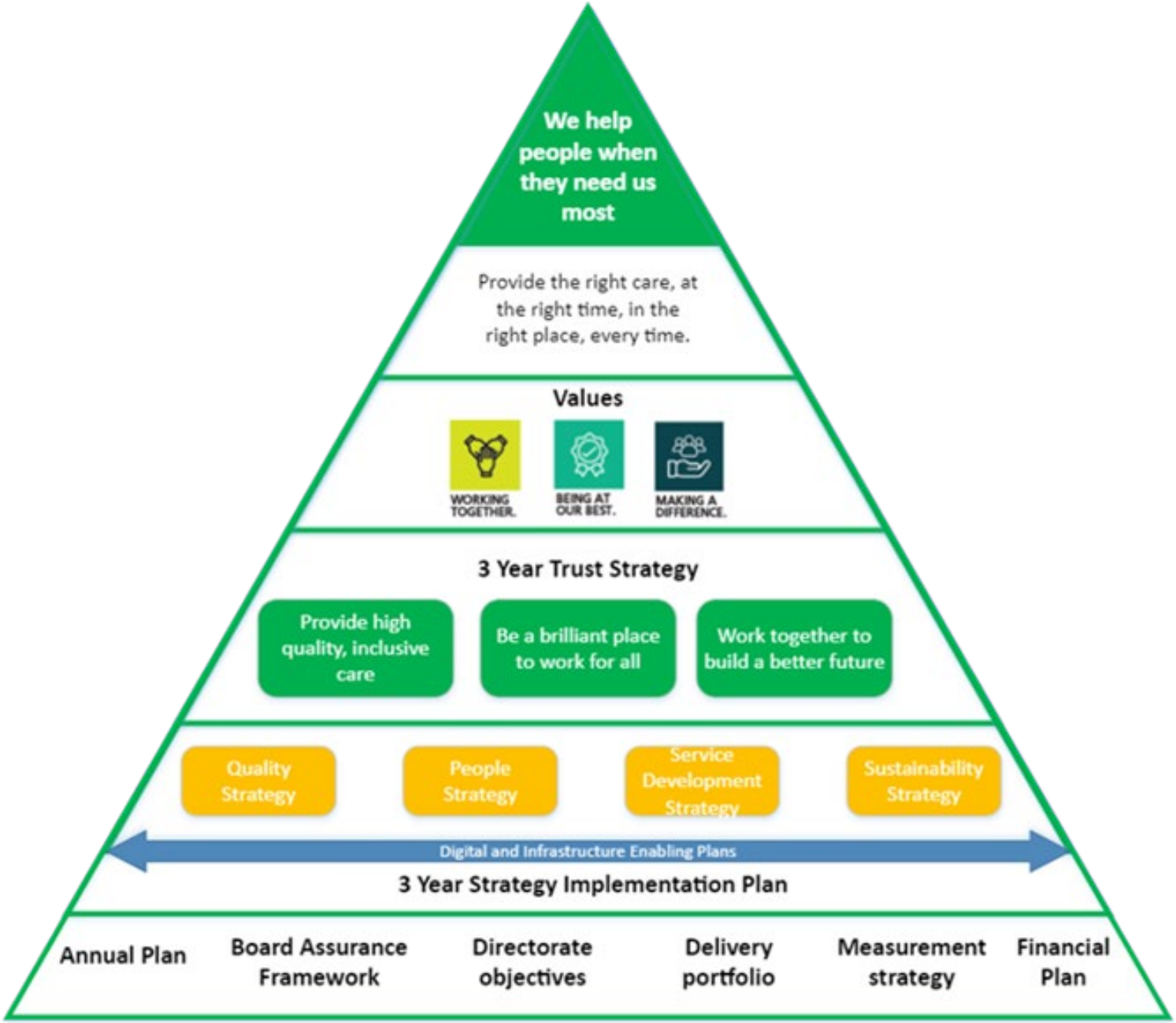
Risk Rating Matrix (Likelihood x Consequence)

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

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

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


We help people when they need us most
Provide the right care, at the right time, in the right place, every time.
Values
WORKING TOGETHER.
BEING AT OUR BEST.
MAKING A DIFFERENCE.
3 Year Trust Strategy
Provide high quality, inclusive care
Be a brilliant place to work for all
Work together to build a better future
Quality Strategy
People Strategy
Service Development Strategy
Sustainability Strategy
Digital and Infrastructure Enabling Plans
3 Year Strategy Implementation Plan
Annual Plan
Board Assurance Framework
Directorate objectives
Delivery portfolio
Measurement strategy
Financial Plan

BOARD ASSURANCE FRAMEWORK DASHBOARD 2024/25

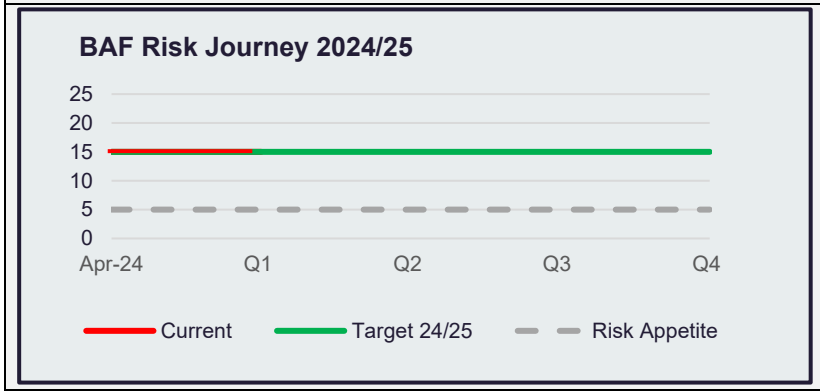
BAF Risk	Committee	Exec Lead	01.04.24	Q1	Q2	Q3	Q4	2024/25 Target	Risk Appetite Tolerance
SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 C&L	**15** 5x3 CxL				**15** 5x3 CxL	**1-5**
SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver high quality (safe and effective) services	**Resources**	**DoF**	**16** 4x4 CxL	**16** 4x4 CxL				**12** 4x3 CxL	**6-12**
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care and/or harm	**Quality & Performance**	**DoOps**	**15** 5x3 CxL	**15** 5x3 CxL				**15** 5x3 CxL	**1-5**
SR04: There is a risk that the Trust will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualified staff impacting adversely on delivery of performance standards and patient outcomes	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL				**8** 4x2 CxL	**6-12**
SR05: There is a risk that the Trust does not improve its culture and staff engagement and this impacts adversely on retention and staff experience.	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL				**12** 4x3 CxL	**6-12**
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**	**15** 5x3 CxL	**15** 5x3 CxL				**10** 5x2 CxL	**1-5**
SR07: There is a risk that the Trust does not work together with our partners in the health and social care system to shape a better future leading to poor effects on our communities and the environment	**Resources**	**DoSPT**	**8** 4x2 CxL	**8** 4x2 CxL				**4** 4x1 CxL	**6-12**
SR08: There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm	**Resources**	**DoQII**	**15** 5x3 CxL	**20** 5x4 CxL				**15** 5x3 CxL	**1-5**
SR09: There is a risk that the Trust attracts negative media attention arising from long delays and harm leading to significant loss of public confidence	**Resources**	**DoSPT**	**10** 5x2 CxL	**10** 5x2 CxL				**10** 5x2 CxL	**6-12**
SR10: (**Sensitive Risk**):	**Resources**	**DoSPT**	**12** 4x3 CxL	**12** 4x3 CxL				**12** 4x3 CxL	**6-12**

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR01:
There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15	15				15	1-5
	5x3	5x3				5x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Exceeded	

RATIONALE FOR RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a score of 15 due to persistent challenges delivering statutory ARP and hospital turnaround times remaining high. However, the Trust is in a strong national standing for C1 and C2 performance. 111 performance is stable but remains challenged in delivering the national standards. Whilst NWAS performance remains strong compared to sector, significant challenges remain within the Cheshire and Mersey area. C2 mean and long waits within the area are significant outliers and contribute to avoidable harm and poorer patient outcomes. All ACQIs are now consistently above national average. The delivery of Duty of Candour and patient safety syllabus training progresses across the organisation.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Improving
The Trust has moved out of winter season and would expect to see improved performance during summer months, with an expectation of decreased demand and improving hospital handover delays.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Progressing maturity of NHS Impact	**Level 2:** Improvement Academy **Level 2:** Trust Management Cttee Escalation and Assurance Report	Reported to Trust Management Cttee TMC/2425/044 Reported to Boad of Directors BoD/2425/34
Patient Safety Strategy	**Level 2:** PSIRF Q4 2023/24 Assurance Report **Level 2**: NHS Patient Safety Strategy (2019) Progress Update	Reported to Quality & Performance Cttee QPC/2425/09 Reported to Quality & Performance Cttee QPC/2425/029
Delays in responding to patients in mental health crisis	**Level 2:** Mental Heath Annual Report 2023/24 **Level 2**: Mental Health Strategic Plan 2024-2027	Reported to Quality & Performance Cttee QPC/2435/13 Reported to Trust Management Cttee TMC/2425/067
Safety Culture	**Level 2:** Freedom to Speak Up Guardians	Reported To Trust Management Cttee TMC/2425/17
DIGITAL		
Digital Strategic Plan	**Level 2**: Digital Strategic Plan 2024-2026	Reported to Trust Management Cttee TMC/2425/070

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLINICAL					
Clinical Audit	Implement next generation of Clinical Audit Tool	Dr C Grant	March 2025	Q&P Cttee	In Progress
QUALITY					
Patient Safety Strategy	Further training required following service delivery model review (SDMR) to ensure specific roles are trained in PSIRF learning resonses.	Dr M Power	March 2025	Q&P Cttee	In Progress
	Patient Safety Partner Policy approval required.	Dr M Power	September 2024	Q&P Cttee	In Progress
Implementation of the quality strategy	Service line plans for improvement of safety, effectiveness and experience	Dr M Power / Mr D Ainsworth	September 2024	Q&P Cttee	In Progress

Progressing maturity of NHS Impact	Deliver Improvement Academy (10 teams)	Dr M Power	September 2024	Q&P Cttee	In Progress
Insight and intelligence	Integrated quality and performance reporting for service lines and sectors	Ms J Wharton	September 2024	TM Cttee	In Progress
Delays in responding to patients in mental health crisis	Mental health strategic plan implementation	Ms E Orton /Mr D Ainsworth	September 2024	TM Cttee	In Progress
	RCRP task and finish group				
Avoidable conveyance to hospital & long waits at ED impacting resource availability and response	See and Treat Improvement Programme	Mr D Ainsworth	March 2025	TM Cttee	In Progress
Freedom to Speak Up	Scope plan to improve performance on FTSU	Dr C Grant	September 2024	TM Cttee	In Progress
Safety Education	Training needs analysis for safety training	Dr M Power/ Ms L Ward	December 2024	Q&P Cttee	In Progress
Variation in handover delays and process impacting patient safety	Specific work with the Cheshire and Mersey partnership to focus on excess delays	Mr D Ainsworth / Dr C Grant	March 2025	TM Cttee	In Progress
DIGITAL					
Digital Strategic Plan	Complete and seek Board approval	Dr M Power	July 2024	BoD	In Progress

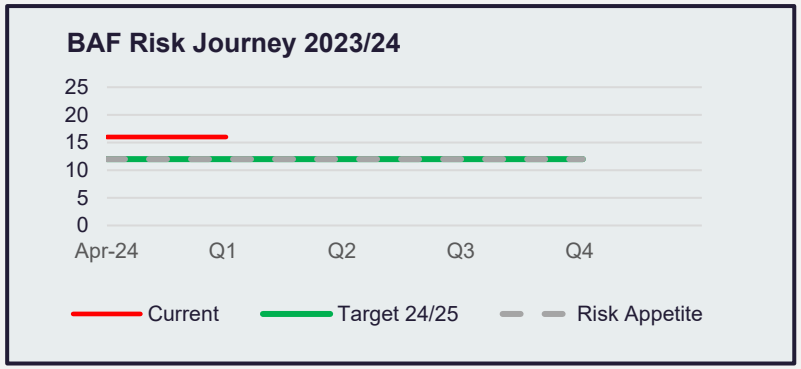
Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of national standards, training, exercising, and subsequent competency assurance, the EOC/ICC leadership team are not adequately prepared to manage large scale, significant or major incidents, which may result in serious avoidable patient harm or death and cause significant reputational damage to the Trust.	15 High	15 High	⇔	5 Low
490	Operational/ Operational Performance	There is a risk that due to the roll-out speed of the of the UK Government's National Framework Agreement: Right Care, Right Person (RCRP), the necessary alternative services will not be available or lack sufficient capacity, leading to NWAS becoming the default organisation for all incidents involving people with mental health needs, resulting in pressure on NWAS capacity and NWAS receiving patients with needs that are not within our remit or skill set.	15 High	15 High	⇔	3 Low
575	Operational/ Patient Safety	There is a risk that patients ringing 999 with a Mental Health need will experience a disparity in triage/assessment/response due to high call volume and lack of mental health practitioner expertise in EOC, which could result in long waits, patient deterioration and self harm which may lead to serious injury or death.	20 High	20 High	⇔	5 Low
604	Operational/Clinical Effectiveness	There is a risk that due to the multiple and varied incidents reported with Schiller Touch 7 defibrillator, that the devices will not defibrillate when the clinician expects defibrillation to occur, which would lead to patient harm.	20 High	16 High	⇩	4 Low
329	Operational/Patient Safety	There is a risk that NWAS will face regulatory enforcement, potential financial penalties and loss of public confidence due to not meeting the statutory requirement for duty of candour	20 High	16 High	⇩	4 Low

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR02:
There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver high quality (safe and effective) services

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	16	16				12	6-12
	4x4	4x4				4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Within	

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q1 position of the BAF risk remains at a score of 16, based on the draft balanced financial plan which still required the ICS income values to be agreed and contract variations were not signed. The final plan approved did result in a further reduction in the contract income, linked to convergence, with a final efficiency requirement of £15.5m. Whilst overall the actual Month 3 financial position is better than the year-to-date plan, a significant proportion of the efficiency identified to date and projected, against the £15.5m target. is non-recurrent.

Projected Forecast Q2: Deteriorating / Stable / Improving

Rationale: Stable
The risk score will remain stable whilst the recurrent CIP schemes continue to be developed.

CONTROLS	ASSURANCES	EVIDENCE
2024/25 Financial Planning	**Level 2:** 2024/25 Financial Planning and Opening Budgets **Level 2:** Final 2024/25 Financial Plans	Reported to Board of Directors BoD/2324/082 Reported to Board of Directors PBM/2425/04
Financial Performance	**Level 2:** Finance Report Month 1 24/25 **Level 2:** Finance Report Month 2 24/25 **Level 2:** Integrated Performance Report	Reported to Resources Cttee RC/2425/010 Reported to Trust Management Cttee TMC/2425/061 Reported to Board of Directors BoD/2425/35

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2025/26 Financial Planning	Receipt of 2025/26 planning guidance from NHSE	Ms C Wood	January 2025	Resources Cttee	Not Commenced
	Draft 2025/26 Financial Plan (Revenue & Capital)	Ms C Wood	March 2025	Resources Cttee / BoD	Not Commenced
	Approval of 2025/26 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2025	Resources Cttee / BoD	Not Commenced

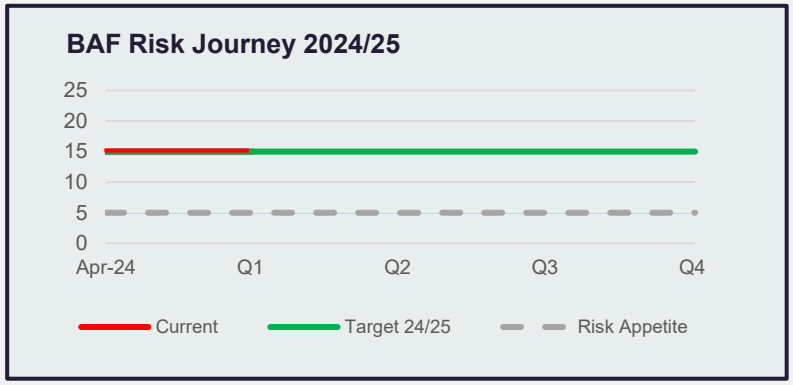
Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk.						

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15	15				15	1-5
	5x3	5x3				15x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a score of 15 primarily because delivery of the national ARP standards remains challenged with only one of the seven standards currently being met. Hospital handover remains above the system UEC agreed standard, particularly in Cheshire & Mersey, which is significantly above the agreed plan. The PTS contract award is still under extended standstill period, however further improvement required against the planned arrivals and enhanced priority service KPIs. In 111, KPIs continue to deliver the IUC trajectories with significant improvement in all performance standards for Q1.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Stable
The delivery of the UEC recovery plan continues to progress well with most of the recruitment and deployment of additional resources in place. PTS continues to take forward an ambitious improvement plan in to 24/25 and similarly NHS 111 are on target in Q2 for no vacancies in frontline workforce however at this stage no agreement for national support post Q2.

CONTROLS	ASSURANCES	EVIDENCE
Improve Hear and Treat Performance	**Level 2:** Integrated Performance Report	Reported to Board of Directors BOD/2425/35

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Improve Hear and Treat Performance	Improve Hear and Treat Performance from 15% to 16.4%	Mr D Ainsworth	March 2025	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff (SR09)	Robust recruitment plan to be delivered to maximise resources to the most efficient level	Mr D Ainsworth/ Mrs L Ward	November 2024	Q&P Cttee	In Progress
Service Delivery Leadership Review (SR09)	Delivery of SDLR to improve working practices	Mr D Ainsworth	September 2024	Q&P Cttee	In Progress
ICC Integration and Restructure	Delivery of Phase 2 and 3 of ICC Restructure	Mr D Ainsworth	March 2025	Q&P Ctte/Resources Cttee	In Progress

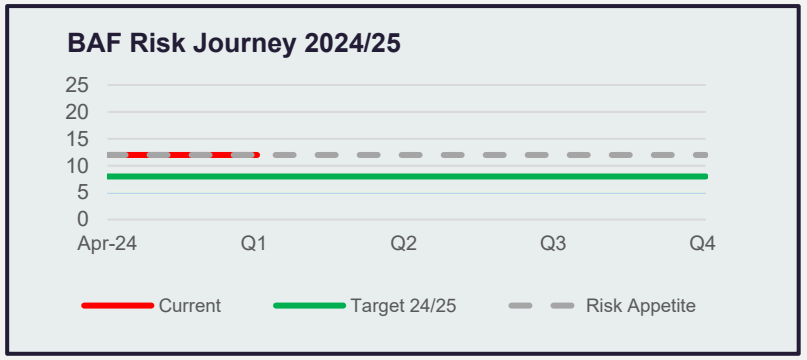
Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk.						

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR04:
There is a risk that the Trust will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualified staff impacting adversely on delivery of performance standards and patient outcomes

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	12	12				8	6-12
	4x3	4x3				4x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within	Within				Below	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a score of 12. Whilst the opening vacancy position across emergency operations is strong, there remain a high number in training with some issues with course fill over summer programmes. There are persistent challenges in closing vacancy gaps in PTS. Previously high vacancy challenges in 111 are improving. Turnover is stable overall but there are challenges in EOC call handling. Sickness absence remains above sector average, although an improving position and continues to impact on resource availability. The score of 12 reflects these ongoing risks and the need for further action to mitigate in some areas but recognises that current performance indicates that safe staffing is being maintained

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Improving
The deployment position in Operations is expected to improve across Q1 and progress to be made in closing vacancy gaps in 111 and PTS. Continued improvement in attendance anticipated.

CONTROLS	ASSURANCES	EVIDENCE
Recruitment Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report	Reported to Resources Cttee RC/2425/017 Reported to Trust Management Committee TMC/2425/050
Retention Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report	Reported to Resources Cttee RC/2425/017 Reported to Trust Management Committee TMC/2425/050
Attendance Improvement Teams – Improvement Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report	Reported to Resources Cttee RC/2425/017 Reported to Trust Management Cttee TMC/2425/050

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of recruitment plans	Ms L Ward	March 2025	Resources Cttee	In Progress
Retention Plans	Delivery of EOC Retention Plans	Ms L Ward	March 2025	Resources Cttee	In Progress
Flu Vaccination Programme	Delivery of 2024/25 Campaign	Ms L Ward	February 2025	Resources Cttee	In Progress
Attendance Improvement Teams – Improvement Plans	Continued implementation of improvement plans	Ms L Ward	March 2025	Resources Cttee	In Progress

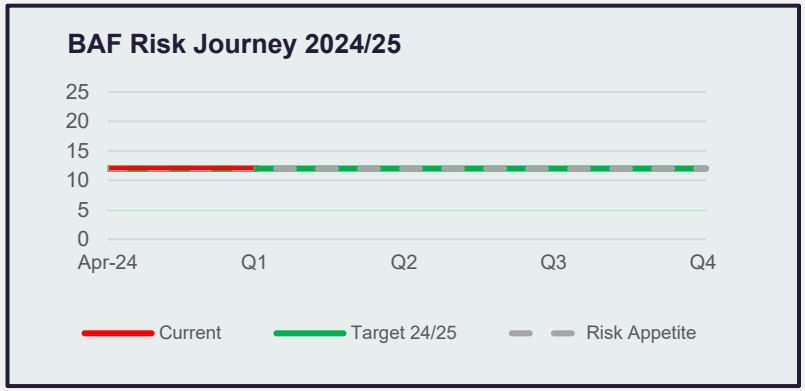
Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR05:
There is a risk that the Trust does not improve its culture and staff engagement, and this impacts adversely on retention and staff experience

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	12	12				12	6-12
	4x3	4x3				4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within	Within				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a score of 12. Whilst 2023 staff survey results indicate continued progress has been made across a range of indicators and that overall the Trust is average or slightly above average for the sector against the key People Promise themes, there are a range of challenges to staff experience identified through data and through the Ambulance Culture Review. Progress continues to be made in delivering planned improvements set out in the People Strategy and Annual Plans but these will take some time to deliver the changes required. Work is progressing to implement the leadership review and deliver planned leadership induction; People Promise Manager has started in post; Disciplinary Policy evaluation and review complete; sexual safety campaign, partnership review and refresh of EDI priorities continuing. Wellbeing Hub launched and revised induction in pilot phase. The current score of 12 reflects that retention and staff experience feedback is in an improving position.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Stable
There are clear plans in place to progress improvements in culture and staff experience but these are expected to take time to achieve a step change in experience so the position is expected to remain stable.

CONTROLS	ASSURANCES	EVIDENCE
Culture Review	**Level 2:** Culture Review Assurance Report	Reported to Resources Cttee RC/2425/020
Fully Embedding Just Culture Principles	**Level 2:** Culture Review Assurance Report	Reported to Resources Cttee RC/2425/020
People Promise Exemplar Programme	**Level 2:** People and Culture Group 3A Report	Reported to Trust Management Cttee TMC/2425/050
EDI	**Level 2:** Equality, Diversity and Inclusion Annual Report 2023/24	Reported to Resources Cttee RC/2425/019
Wellbeing	**Level 2:** Health and Wellbeing Annual Report	Reported to Resources Cttee RC/2425/018
Staff Survey Plan	**Level 2**: People and Culture Group 3A Report	Reported to Trust Management Cttee TMC/2425/050
Sexual Safety Campaign	**Level 2:** Diversity and Inclusion Group 3A Report	Reported to Trust Management Committee TMC/2425/71

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Delivery Leadership Review	Implementation of Operational & Clinical Management Restructure	Mr D Ainsworth	September 2024	Resources Cttee	In Progress
EDI Priorities	Refresh of EDI priorities	Ms L Ward	July 2024	Resources Cttee	In Progress
	Delivery of year 1 action of plan	Ms L Ward	2024/25	Resources Cttee	In Progress
Partnership Agreement	Implementation of revised Partnership Agreement	Ms L Ward	September 2024	Resources Cttee	In Progress
Wellbeing	Implementation of mental health improvement plans	Ms L Ward	March 2025	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	August 2024	Resources Cttee	In Progress

Sexual Safety Campaign	Delivery of Campaign	Ms L Ward	September 2024	Resources Cttee	In Progress
Staff Survey	Delivery of Staff Survey 2024	Ms L Ward	December 2024	Resources Cttee	In Progress
Culture Review	Deliver identified actions and support national work programme	Ms L Ward	2024/25	Resources Cttee	In Progress
People Promise Exemplar Programme	Deliver improvements in identified priority areas: flexible working; staff engagement	Ms L Ward	2024/25	Resources Cttee	In Progress
Induction	Implement revised onboarding and induction	Ms L Ward	2024/25	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR05

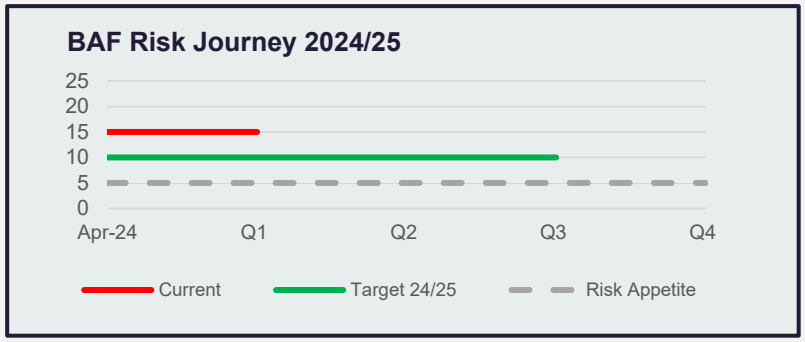
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoQII

Risk Appetite Category: Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15	15				10	1-5
	5x3	5x3				5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a score of 15, Regular engagement continued into Q1 with our new CQC relationship manager. Planning continues to transition to the CQC single assessment framework and changes have been made to the NWAS quality assurance visit assurance processes. Stage 2 of the HSE inspectorate visits have been concluded and feedback is scheduled late July. Quarterly Duty of Candour quality audits now being undertaken with area assurance meetings in place. Work ongoing to improve quality of enactment and ensure learning is captured. The risk associated with controlled drugs licensing remains. Mandatory training and appraisal compliance on track.

Projected Forecast Q2: Deteriorating / Stable / Improving

Rationale: Stable
Whilst progress is being made some of the identified inspections, gaps in controls and actions will not be completed until Q2 2024/25.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Appraisal Compliance 2023/24	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Resources Cttee: (RC/2425/17) Reported to Board of Directors: (BoD/2425/35)
Mandatory Training Compliance 2023/24	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Resources Cttee: (RC/2425/17) Reported to Board of Directors: (BoD/2425/35)
Appraisal and Mandatory Training Compliance 2024/25	**Level 2:** 2024/25 Appraisal and Mandatory Training Plans **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee (TMC/2425/22) Reported Board of Directors (BoD/2425/35)
QUALITY & SAFETY IMPROVEMENTS		
Duty of Candour	**Level 2:** MIAA Progress Report **Level 2:** Internal Audit Follow Up Report	Reported to Audit Cttee: (AC/2425/12) Reported to Audi Cttee: (AC/2425/13)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Duty of Candour	Ongoing compliance monitoring and action plan to strengthen position with associated reporting for assurance transferred to service lines	Dr M Power/Mr D Ainsworth	March 2025	Q&P Cttee	In Progress
Essential Checks	Improve compliance of vehicle and equipment checks	Dr M Power / Mr D Ainsworth	March 2025	Q&P Cttee	In Progress
Medicines management	Business case and procurement of dedicated medicines management system	Dr C Grant	September 2024	Q&P Cttee	In Progress
Digital Clinical Safety	Creation and implementation of digital clinical safety procedures	Ms J Wharton	September 2024	Q&P Cttee	In Progress
	Completion of digital clinical safety process on Electronic Patient Record	Ms J Wharton	September 2024	Q&P Cttee	In Progress
	Assessment of all systems to determine systems requiring application of digital clinical safety	Ms J Wharton	September 2024	Q&P Cttee	In Progress
Information Governance	Improve compliance on mandatory training to 95%	Dr M Power L Ward	July 2024	Resources Cttee	In Progress

PEOPLE					
Appraisal Compliance 2024/25	Achieve 85% compliance	Ms L Ward	March 2025	Resources Cttee	In Progress
Mandatory Training Compliance 2024/25	Achieve 85% compliance	Ms L Ward	March 2025	Resources Cttee	In Progress

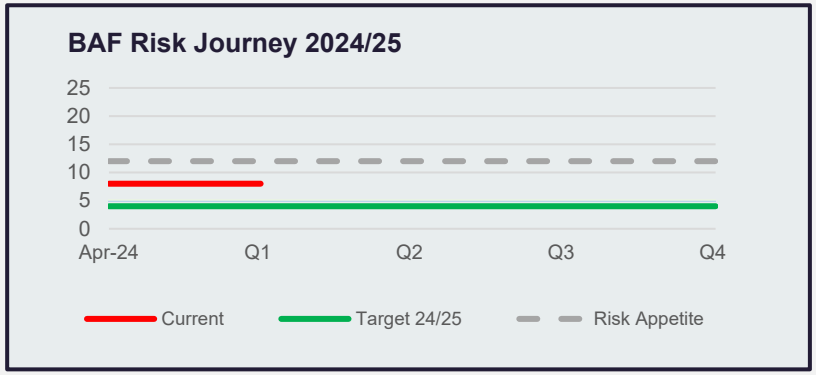
Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low
474	Strategic/ Estates & Facilities Management	There is a risk that a fire on NWAS premises involving a lithium-ion battery may present a serious threat of harm to staff and catastrophic damage to the premises itself.	15 High	15 High	⇔	5 Low
329	Operational/Patient Safety	There is a risk that NWAS will face regulatory enforcement, potential financial penalties and loss of public confidence due to not meeting the statutory requirement for duty of candour	20 High	16 High	⇩	4 Low

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR07:
There is a risk that the Trust does not work together with our partners in the health and social care system to shape a better future leading to poor effects on our communities and the environment

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	8	8				4	6-12
	4x2	4x2				4x1	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within	Within				Below	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for Q1 position of this BAF risk remains at a score of 8. Work has been ongoing with the incoming Director of Operations regarding external engagement from the three areas. A mapping exercise has been completed across the three areas and the Partnerships and Integration team will work with areas to ensure that external engagement is documented and assured. A process has been agreed regarding mapping and attendance at meetings, which will lead onto monitoring of engagement uploads onto the Knowledge Vault and is supported by the Director of Operations. All areas including the Director of Operations have been provided with refresher training on the Knowledge Vault.

Projected Forecast Q2: Deteriorating / Stable / Improving

Rationale: Improving
Renewed focus on external engagement and relationship management will continue to improve in all areas.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Knowledge Vault	Utilisation of the KV by all three areas of the Trust	Mr S Desai	Q2	Resources Cttee	In Progress
External Engagement Assurance	Service Delivery areas to provide evidence that important external meetings are being attended	Mr S Desai	Q1 – Q4	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07

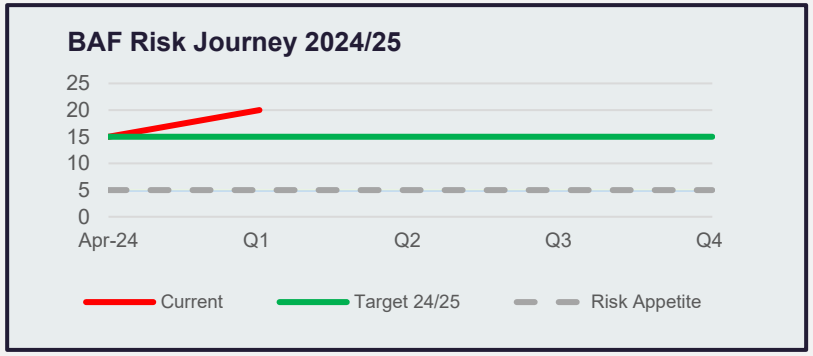
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR08:
There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm

Executive Director Lead: DoQII

Risk Appetite Category: Compliance/Regulatory - Low



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15	20				15	1-5
	5x3	5x4				5x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk has increased to a score of 20 due to the persistent threat of cyber attacks and global unrest, the recent breach at a large NHS organisation has demonstrated the threat is real. Our digital systems are expanding rapidly and with that comes an increasing risk of attack based on the 'expansion of the threat surface'. The expansion is necessary for us to achieve our strategic goals and continue to monitor the impact of changes through the governance process. We have digital monitoring systems in place which require continual updates to maintain their safety based on a continuous flow of intelligence (alerts) from agencies such as NHSE. We must maintain high levels of training compliance and carry out simulation to ensure our staff understand how their actions impact on system safety. Cascading this through information asset owners is partially complete.

Projected Forecast Q2: **Deteriorating**
Stable
Improving

Rationale: Deteriorating
Based on the recent NHS cyber incident it is considered that that global environment we are operating in is becoming more hostile and may lead to an increase in the likelihood of a significant cyber incident.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Digital Strategic Plan	Define the process for creating the digital strategic plan	Dr M Power	September 2024	Resources Committee	Not Commenced
Cyber Assurance Framework	Implement Multi factor authentication on all required systems	Dr M Power	September 2024	Resources Cttee	In Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Dr M Power	March 2025	TM Cttee	In Progress
	Critical system mapping completed	Dr M Power	September 2025	TM Cttee	In Progress
	Information Asset Register completed with data flow mapping	Dr M Power	March 2025	Resources Cttee	In Progress
Out of Hours Resilience	Implement recommendations from desktop worst case scenario	Dr M Power	September 2024	Resources Cttee	In Progress
EPRR resilience and response	Conduct a mock cyber incident session with operational and clinical colleagues	Dr M Power	September 2024	Resources Committee	Not started
Information Asset Owner Assurance	Define a assurance process for IAO to follow	Dr M Power	September 2024	TM Cttee	Not started

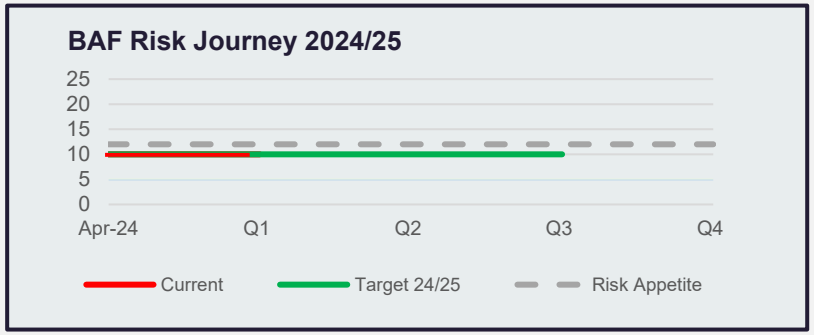
Operational Risks Scored 15+ Aligned to BAF Risk: SR08						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
330	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	15 High	15 High		5 Low
331	Operational/ Digital and Innovation	There is a risk that due to digital expansion/interoperability increasing the Trust's attack surface which in turn increases overall risk to the Trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	12 Moderate	16 High		4 Low

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR09:
There is a risk that the Trust continues to attract negative media attention arising from long delays and harm leading to significant loss of public confidence

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	10	10				10	6-12
	5x2	5x2				5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Below	Below				Below	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q1 position of this BAF risk remains at a score of 10 due to industrial action and hospital handover delays that continued to attract negative media attention. The negativity arising from long delays and potential harm is a constant risk that requires annual communications plans and approaches that can respond to seasonal and other circumstantial demands. Our aim is to keep the risk at a moderate and managed level.

Projected Forecast Q2:
Deteriorating
Stable
Improving

Rationale: Stable
Whilst there are still delays at hospitals impacting on our ability to respond to 999 calls, resources and demand has remained stable. However this could change at any time due to seasonal spikes, industrial action and harm to patients, which may lead to greater media interest and adverse coverage.

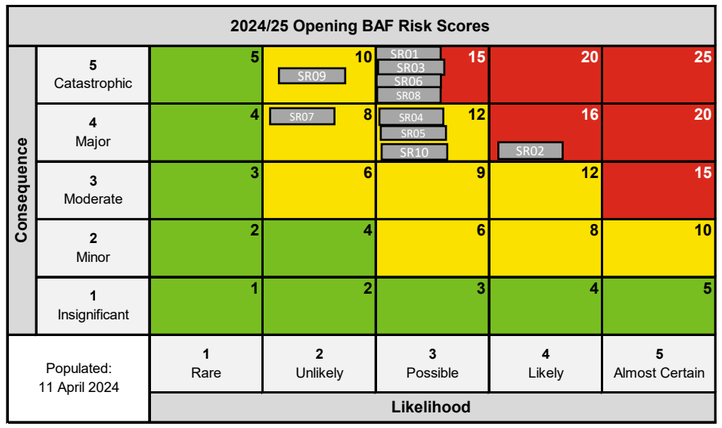
CONTROLS	ASSURANCES	EVIDENCE

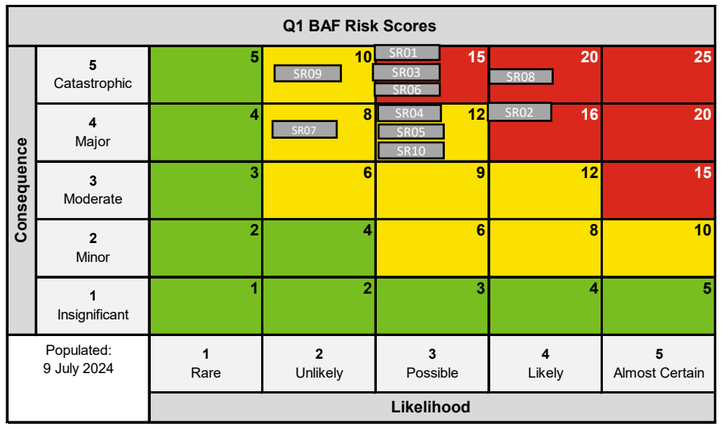
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Delivery Leadership Review	Delivery of SDLR to improve working practices	Mr D Ainsworth	September 2024	Resources Cttee	In Progress
	Maximise resources to the most efficient level	Mr D Ainsworth	September 2024	Resources Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff	Robust recruitment plan to be delivered	Mr D Ainsworth/ Mrs L Ward	November 2024	Resources Cttee	In Progress

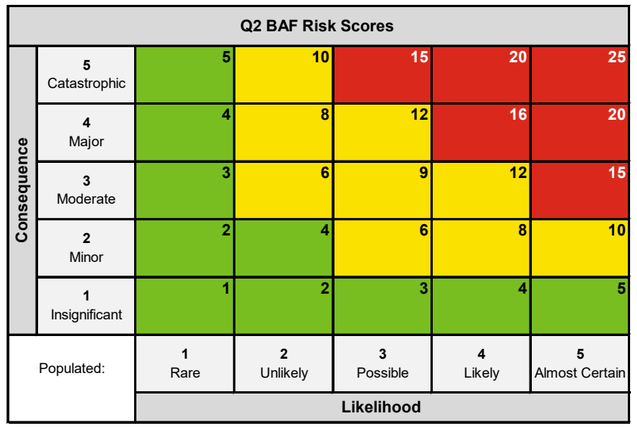
Operational Risks Scored 15+ Aligned to BAF Risk: SR09

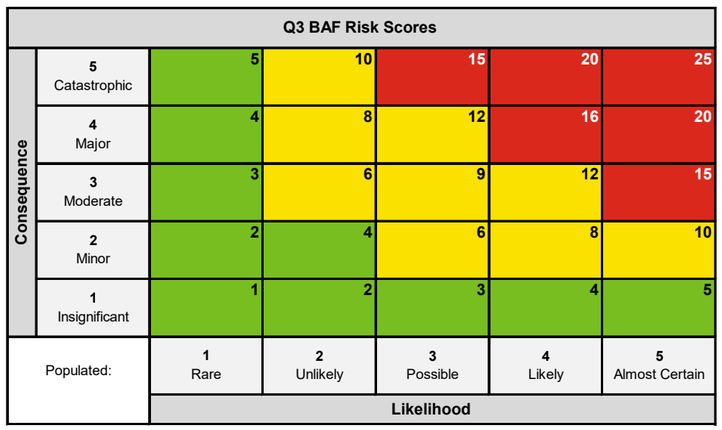
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

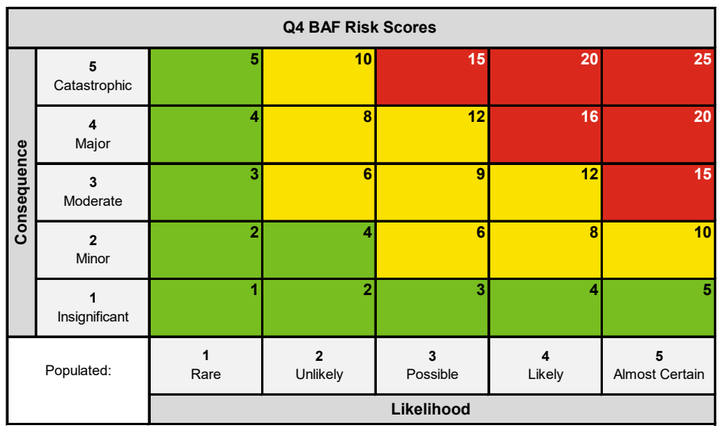
Appendix 2:
2024/25 Board Assurance Framework (BAF) Heat Maps
Opening Position

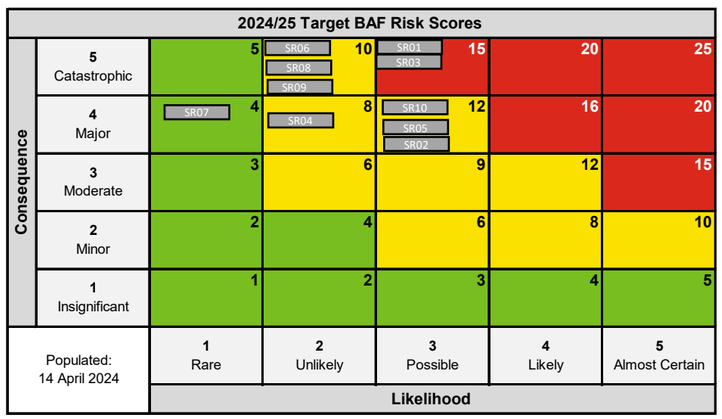


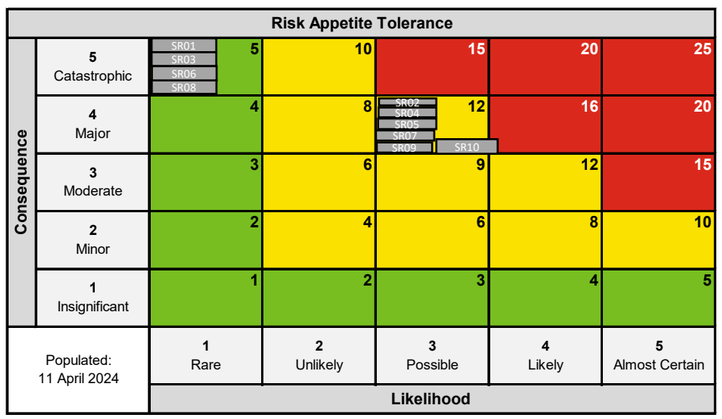












NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Amendment to Board Standing Orders
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to approve the changes to the Standing Orders.	
EXECUTIVE SUMMARY	The Executive Director of Operations commenced on 1st July 2024, therefore the composition and voting rights of the Board of Directors has been updated to reflect these changes within the Standing Orders. The amendments can be identified within Section 2 of the Standing Orders **(Appendix 1)**.	
PREVIOUSLY CONSIDERED BY	Not Applicable	
	Date	Not Applicable
	Outcome	Not Applicable

1. BACKGROUND

In September 2023, the Board approved a temporary change to the Standing Orders to reflect the interim arrangements following the retirement of the former Executive Director of Operations on 30th September 2023.

The interim post of Chief Operating Officer/Deputy Chief Executive assumed the voting rights until a substantive Executive Director of Operations was recruited.

2. COMPOSITION OF THE BOARD

Following the recruitment process, the substantive Executive Director of Operations commenced on 1st July 2024 and consequently the composition and voting rights of the Board of Directors has been updated.

The amendments can be identified within Section 2 of the Standing Orders **(Appendix 1)**.

3. RISK CONSIDERATION

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted.

4. ACTION REQUIRED

The Board of Directors is asked to approve the changes to the Standing Orders.

North West Ambulance Service NHS Trust

Standing Orders, Reservation of Powers & Scheme of Delegation

Approved by the Board of Directors: 24 April 2024

Record of amendments

Number	Section	Date
1	Updated document issued for implementation	1 July 2006
2	Updated following Board approval, 27 September 2006	1 October 2006
3	Annual review, July 2007	25 July 2007
4	Annual review, September 2008	1 October 2008
5	Annual review, September 2009	30 September 2009
6	Annual review, November 2010	24 November 2010
7	Annual review, January 2012	25 January 2012
8	Annual review, January 2013	27 February 2013
9	Annual review, September 2014	24 September 2014
10	Annual review, September 2015	30 September 2015
11	Temporary amendment to the Composition of the Trust	24 February 2016
12	Annual Review, September 2016	28 September 2016
13	Change in Voting Rights and Board Membership General Review and Refresh	31 October 2017
14	Temporary Change in Voting Rights during Interim Period	26 September 2018
15	Annual Review, March 2019	24 April 2019
16	Annual Review, March 2020	27 May 2020
17	Annual Review, March 2021	28 April 2021
18	Annual Review, March 2022	27 April 2022
19	Annual Review, March 2023	26 April 2023
20	Temporary Change to Voting Rights and Board Membership	27 September 2023
21	Annual Review, March 2024	24 April 2024
22	Change in Voting Rights and Board Membership	31 July 2024

CONTENTS

STANDING ORDERS

RESERVATIONS OF POWERS TO THE BOARD OF DIRECTORS

1. Introduction

1.1 Statutory Framework

1.1.1 North West Ambulance Service NHS Trust ('the Trust') is a statutory body which came into existence on 1 July 2006, under (Establishment) Order No 2006/1622.

1.1.2 The principal place of business of the Trust is:

Ladybridge Hall,
Chorley New Road,
Bolton,
BL1 5DD.

1.1.3 NHS Trusts are governed by statute, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999 and the Health and Social Care Act 2012. The statutory functions are conferred by this legislation.

1.1.4 As a statutory body, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care.

1.1.5 The Membership and Procedure Regulations (1990) as amended requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.6 These Standing Orders apply to the North West Ambulance Service NHS Trust and its statutory elements.

1.2 Interpretations

The Chair of the Trust is the final authority in the interpretation of Standing Orders (on the advice of the Chief Executive and Director of Corporate Affairs).

1.3 Definitions

Terminology	Definition
Accountable Officer	Is the officer responsible and accountable for funds entrusted to the Trust; and is responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive, or their appointed replacement, is the Accountable Officer for this Trust
Board of Directors	The Board of Directors means the Chair; Non-Executive Directors and both voting and non-voting Executive Directors.
Chair of the Board of Directors	Is the person appointed by the Secretary of State for Health and Social Care to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall, if the Chair is absent from the meeting or otherwise unavailable, be deemed to include the Vice-Chair of the Trust, or other Non-Executive Director.
Chief Executive	The Accountable Chief Officer of the Trust
Committee	A committee appointed by the Board of Directors

Terminology	Definition
Committee Members	Formally appointed by the Board of Directors to sit on, or to chair specific committees
Directors	Are the Non-Executive Directors and Executive Directors (including non-voting Directors)
Director of Finance	The Chief Financial Officer of the Trust
The Trust	North West Ambulance Service NHS Trust
Funds held on Trust	Are those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
Motion	A formal proposition to be discussed and voted on during the course of a Board of Directors or Committee meeting
Nominated Officer	An Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust
Secretary	A person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the Law, Standing Orders and Department of Health guidance
Vice Chair	The Non-Executive Director appointed by the Trust to take on the chair's duties is the Chair is absent for any reason

All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

1.4 NHS Framework

1.4.1 In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter. The majority of these can be found on the department of health website.

1.4.2 The Code of Accountability for NHS Boards requires that, *inter-alia*, Boards draw up a schedule of decisions reserved to the Board known as the 'Reservation of Powers to the Board' and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives through a Scheme of Delegation. The Code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Code of Conduct for NHS Boards makes various requirements concerning possible conflicts of interest of members of the Board.

1.4.3 The Code of Practice on Openness in the NHS or the Freedom of Information Act 2000 and sets out the requirements for public access to information on the NHS.

1.5 Delegation of Powers

1.5.1 The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions by Delegation (SO5), the Board is given powers to 'make arrangements for the exercise, on behalf of the Trust, of any of their functions by a Committee, Sub Committee or Joint Committee appointed by virtue of SO4 or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust sees fit or as the Secretary of State for Health and Social Care may direct'. Delegated powers are included within these Standing Orders and (Reservation of Powers to the Board and Scheme of Delegation). The Standing Financial Instructions is a separate document. These documents have effect as if incorporated into these Standing Orders.

1.6 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will ensure decision-making is informed by intelligent information. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. The Board of Directors: Composition of Membership, Tenure and Role of Members

2.1 Composition of the Board of Directors

2.1.1 In accordance with the Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) the voting membership of the Board of Directors shall comprise the Chair and five Non-Executive Directors, together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent Non-Executive Directors.

In addition to the Chair, the Non-Executive Directors shall normally include:

- one appointee nominated to be the Deputy or Vice-Chair
- one appointee nominated to be the Senior Independent Director
- up to three non-voting Associate Non-Executive Directors

The Voting Executive Directors shall include:

- Chief Executive
- Executive Director of Operations
- Executive Director of Quality, Innovation and Improvement
- Executive Director of Finance
- Executive Medical Director

The Board may appoint additional Directors, to be non-voting members of the Trust Board, these currently include:

- Deputy Chief Executive/Director of Strategy, Partnerships and Transformation
- Director of People
- Director of Corporate Affairs

2.2 Appointment of Chair and Executive Directors/Directors

2.2.1 The Chair and Non-Executive Directors of the Trust are appointed by NHSE, on behalf of the Secretary of State for Health and Social Care.

2.2.2 Associate Non-Executive Directors are appointed by the Trust.

2.2.3 The Chief Executive is appointed by the Chair and the Non-Executive Directors.

2.2.4 Other Executive Directors/Directors shall be appointed by a committee comprising the Chair and the Non-Executive Directors, under recommendation from the Chief Executive.

2.2.5 Where more than one person is appointed jointly to an Executive Director post in the Trust, those persons shall become appointed as an Executive Director, jointly. Where the post has voting rights attached, the joint appointees will have the power of one vote; and shall count as one person.

2.3 Terms of Office

2.3.1 The regulations governing the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office of the Chair and Non-Executive Directors are contained in the Membership and Procedure Regulations and as directed by NHSE, under its delegated authority from Secretary of State for Health and Social Care.

2.3.2 In line with NHS England's Code of Governance for NHS Provider Trusts, Chairs and Non-Executive Directors should not remain in post beyond nine years from the date of their first appointment and any decision to extend a term beyond nine years should be subject to rigorous review and consideration of progressive refreshing of the Board should be taken into account. In exceptional circumstances, terms may be extended for a limited time beyond nine years however should be subject to annual re-appointment by NHS England. Serving more than nine years could be relevant to the determination of a non-executive's independence.

2.4 Appointment and Powers of Vice-Chair

2.4.1 To enable the proceedings of the Trust to be conducted in the absence of the Chair, the Board of Directors may elect one of the Non-Executive Directors to be Vice-Chair, for a period that does not exceed the remainder of their appointed term as a Non-Executive Director of the Trust.

2.4.2 Any Non-Executive Director so elected may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The appointment as Vice-Chair will end with the termination for any reason of that Non-Executive Director's period of office as a director. On such resignation or termination the Board of Directors may then appoint another Non-Executive Director as Vice-Chair, in accordance with the provision of this Standing Order.

2.4.3 When the Chair is unable to perform their duties due to illness or absence for any reason, his duties will be undertaken by the Vice-Chair who shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties.

2.4.4 In order to appoint the Vice-Chair, nominations will be invited by the Chair. Where there is more than one nomination, a vote will be conducted and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this being acceptable to the Directors present, the Board will be requested to confirm that person as Vice-Chair at the meeting in which the nomination is made.

2.5 Role of Members

2.5.1 The Board will function as a corporate decision-making body, Officer and Non-Officer members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

Executive Members
Executive Members shall exercise their authority within the terms of these Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Chief Executive
The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

Director of Finance
The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Members
The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair
The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall work closely with the Chief Executive and ensure that key and appropriate issues are discussed by the Board in a timely manner, together with all necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

Senior Independent Director

The Senior Independent Director shall be available to hear any issues or concerns that individuals feel unable to raise with the Chair or any Executive Director.

2.5.2 In line with NHS England's Code of Governance for NHS Provider Trusts, where directors have concerns about the operation of the Board or the management of the trust that cannot be resolved, these should be recorded in board minutes. In the case of the resignation of a Non-Executive Director, any such concerns should be provided in a written statement to the Chair for circulation to the Board.

2.6 Corporate Role of the Board

2.6.1 All business shall be conducted in the name of the Trust.

2.6.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.6.3 The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided in SO3.

2.7 Schedule of Matters reserved to the Board and Scheme of Delegation

2.7.1 The Board has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Reservation of Powers to the Board and are incorporated into the Standing Orders. Those powers which it has delegated to individuals and other bodies are contained in the Scheme of Delegation.

3. Meetings of the Trust

3.1 Ordinary Meetings of the Trust Board

3.1.1 All ordinary meetings of the Board of Directors shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

3.1.2 Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may from time to time determine. A minimum of six meetings shall be held each year.

3.1.3 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

'That representatives of the press and other members of the public be 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'

as required under s.1(2) of the Public Bodies (Admission to Meetings) Act 1960.

3.1.4 The Chair (or person presiding at the meeting) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

'That, in the interests of public order, the meeting adjourn for [the period specified] to enable the Board to complete business without the presence of the public'

as required under s.1(8) of the Public Bodies (Admission to Meetings) Act 1960.

3.1.5 The Board of Directors or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting, shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the Board of Director meetings without express permission of the Board of Directors.

3.1.6 Nothing in these Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 *Regular meeting of the Trust*

Agendas will be sent to members at least five days before the meeting. Supporting papers, whenever possible, shall accompany the agenda and will in any event be despatched no later than three clear days before the meeting, except in an emergency.

3.2.2 *Exceptional meetings of the Trust*

A notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer of the trust authorised by the Chair to sign on their behalf, shall be delivered to every Director, so as to be available to them at least three clear days before the meeting.

3.2.3 *Meetings called by Directors*

In the case of a meeting called by Directors in the event that the Chair has not called the meeting, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.2.4 *Public notice*

Before each meeting of the Board, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting, as required under s.1(4)(a) of the Public Bodies (Admission to Meetings) Act 1960.

3.3 Setting the Agenda

3.3.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

3.3.2 A Director may request that a matter is included on an agenda. This request should be made in writing to the Chair and Director of Corporate Affairs at least seven clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than seven days before a meeting may be included on the agenda at the discretion of the Chair.

3.3.3 Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board meeting.

3.4 Annual Public Meeting

The Trust will publicise and hold an annual public meeting in accordance with the NHS Trusts (Public Meetings) Regulations 1991. The meeting shall take place no later than 30 September each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting.

3.5 Chair of the Meeting

3.5.1 The Chair shall preside at any meeting of the Trust Board, if present. In their absence, the Vice Chair shall preside.

3.5.2 If the Chair and Vice-Chair are absent, the directors present, who are eligible to vote shall choose a Non-Executive Director who shall preside. An Executive Director may not take the chair.

3.5.3 The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and the Chair's interpretation of the Standing Orders shall be final. In this interpretation the Chair shall be advised by the Director of Corporate Affairs and in the case of Standing Financial Instructions the Chair shall be advised by the Director of Finance.

3.6 Voting

3.6.1 It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

3.6.2 Where it is necessary to take a vote to determine an issue, the decision shall be determined by a majority of the votes of the directors present and eligible to vote. If the result of the vote is equal, the Chair of the meeting shall have a second or casting vote.

3.6.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may be held, if a majority of the directors present and eligible to vote, so request. Unless specifically agreed beforehand, the voting record of each individual director will not be made public, or recorded

3.6.4 The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors present and eligible to vote so request.

3.6.5 If a director so requests, his vote will be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded

3.6.6 Under no circumstances may an absent director vote by proxy.

3.6.7 An officer who has been appointed formally by the Trust to act up for an Executive Director during a period of incapacity, or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of that Executive Director. An officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence, but without formal acting up status, may not exercise the voting rights of that Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.6.8 Where the office of a director who is eligible to vote is shared jointly by more than one person:

- either or both of those persons may attend and take part in the meetings of the Trust Board.
- if both are present at a meeting they will cast one vote if they agree.
- in the case of disagreement no vote will be cast.
- the presence of either or both of those persons will count as the presence of one person for the purpose of establishing a quorum.

3.6.9 Where necessary, a director may be counted as present when available constantly for discussions through an audio or video link and may take part in voting on an open basis.

3.7 Quorum

3.7.1 No business shall be transacted at a meeting of the Board unless at least six of the Directors who are eligible to vote (including at least three Executive and three Non-Executive Directors with voting powers) are present.

3.7.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.7.3 A director will not count towards the quorum on a matter where he is ruled to be ineligible to participate in the discussion, or vote, due to the declaration of a conflict of interest. If a quorum is not available for the passing of a resolution on any matter, that matter may be discussed further at the meeting, but no resolution can be made. That position shall be recorded in the minutes of the meeting.

3.8 Record of Attendance

3.8.1 The names of the directors and others invited by the Chair present at the meeting, shall be recorded in the minutes.

3.8.2 If a director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

3.9 Minutes

3.9.1 The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

3.9.2 There should be no discussion on the minutes, other than as regards their accuracy, unless the Chair considers discussion appropriate.

3.9.3 Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

3.10 Notices of Motion

3.10.1 Subject to the provision of Standing Order 3.11 and 3.13 a director of the Trust desiring to move a motion shall give notice of this in writing, to the Chair, at least seven working days before the meeting. The Chair shall insert all such notices that are properly made in the agenda for the

meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.11 Motions: Procedure at and During a Meeting

3.11.1 When a motion is under debate, no motion may be moved other than:

- an amendment to the motion
- the adjournment of the discussion, or the meeting
- that the meeting proceed to the next business
- that the question should now be put
- the appointment of an ad-hoc Committee to deal with a specific item of business
- that a member/Director be not further heard
- a motion under Section 1(2) or Section 1(8) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public including the press

3.11.2 The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the seconder and the consent of the Trust Board.

3.12 Rights of reply to motions.

3.12.1 The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment to it.

3.13 Motion to Rescind a Decision of the Trust Board

3.13.1 Notice of a motion to rescind any decision of the Board of Directors (or general substance of any decision) which has been passed within the preceding six calendar months, shall bear the signature of the director who gives it and also the signature of four other directors who are eligible to vote.

3.13.2 When the Board of Directors has debated any such motion, it shall not be permissible for any director, other than the Chair to propose a motion to the same effect within a further period of six calendar months.

3.14 Suspension of Standing Orders

3.14.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the directors of the Trust are present and the majority of those present, vote in favour of suspension.

3.14.2 In this instance:

- a decision to suspend Standing Orders shall be recorded in the minutes of the meeting
- a separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors
- no formal business may be transacted while Standing Orders are suspended
- the Audit Committee shall review every decision to suspend Standing Orders

3.15 Variation and Amendment of Standing Orders

3.15.1 These Standing Orders shall be amended only if:

- a notice of motion under SO 3.10 has been given; and
- no fewer than half of the appointed Non-Executive Directors vote in favour of the amendment; and
- at least two-thirds of the Directors who are eligible to vote are present; and
- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State for Health and Social Care

4. Committees

4.1 Appointment of Committees

4.1.1 Subject to such directions as may be given by the Secretary of State for Health and Social Care, the Board of Directors may appoint committees of the Trust.

4.2 Applicability of Standing Orders to Committees

4.2.1 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees established by the Trust. In which case the term 'Chair' is to be read as a reference to the Chair of other Committees as the context permits and the term 'member' is to be read as a reference to a member of other Committees also as the context permits. There is no requirement to hold meetings of Committees established by the Trust in public.

4.3 Terms of Reference

4.3.1 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State for Health and Social Care. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.3.2 Approved Terms of Reference for all Board Committees shall be held by the Director of Corporate Affairs.

4.4 Delegation of Powers by Board Committees

4.4.1 The Board of Directors shall authorise any delegation of powers to be exercised by its formally constituted Committees. The Board of Directors shall approve the terms of reference of these committees and any specific powers.

4.5 Approval of Appointments to Committees

4.5.1 The Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Board determines and regulations permit that persons, who are not Directors, shall be appointed to a Committee, the terms of such appointment shall be determined by the Board.

4.6 Appointments for Statutory Functions

4.6.1 Where the Trust is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Secretary of State for Health and Social Care, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State for Health and Social Care.

4.7 Minutes

4.7.1 Minutes, or a representative summary of the issues considered and decisions taken, of any Committee appointed under this Standing Order are to be formally recorded. The Chair of such Committees are to provide a representative summary of the issues considered and any decisions taken to the next Board of Directors meeting.

4.8 Statutory and Mandatory Committees

The mandated committees to be established by the Board are:

4.8.1 Audit Committee

The Board of Directors shall appoint a committee to undertake the role of an audit committee. This role shall include providing the Board of Directors with an independent and objective review of the financial systems and of general control systems that ensure the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with laws, guidance and regulations and codes of conduct governing the NHS. The Committee will comprise of a minimum of three Non-Executive Directors of which one must have significant, recent and relevant financial experience. This Committee will pay due regard to good practice guidance, including, in particular the NHS Audit Committee Handbook.

The Terms of Reference of the Audit Committee shall be approved by the Board of Directors and will be reviewed on a periodic basis.

4.8.2 Audit Panel

The Board of Directors shall nominate its Audit Committee to act as its Audit Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

The Audit Panel's functions are to advise the Board of Directors on the selection and appointment of the External Auditor. This includes the following:

i. Agree and oversee a robust process for selecting the External Auditors in line with the organisation's normal procurement rules.
ii. Make a recommendation to the Board of Directors as to who should be appointed.
iii. Ensure that any conflicts of interest are dealt with effectively.
iv. Advise the Board of Directors on the maintenance of an independent relationship with the appointed External Auditor.
v. Advise the Board of Directors on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
vi. Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed External Auditor.
vii. Advise the Board of Directors on any decision about the removal or resignation of the External Auditor.

4.8.3 Nominations & Remuneration Committee

In line with the requirements of the 1990 Membership and Procedure Regulations, Regulations 17-18, a Remuneration Committee will be appointed and constituted to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Very Senior Managers including:

- All aspects of salary (including any performance related elements)
- Provisions for other benefits, including pensions and cars
- Arrangements for termination of employment and other contractual terms

4.8.4 Charitable Funds Committee

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

4.8.5 **Non-Mandatory Committees**

The Board of Directors shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

These are subject to change at the discretion of the Board of Directors. All new or amended non-mandatory committees will have the same standing and will be subject to the same standing orders.

5. Arrangements for the Exercise of Functions by Delegation

5.1 Introduction

5.1.1 Subject to Reservation of Powers to the Board, the Scheme of Delegation and such directions as may be given by the Secretary of State for Health and Social Care, the Board of Directors may delegate any of its functions to a committee appointed by virtue of SO4, or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the Board thinks fit.

5.2 Emergency Powers and Urgent Decisions

5.2.1 The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair acting jointly and after having consulted with at least two Non-Executive Directors and two Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

5.3 Delegation to Committees

5.3.1 The Board of Directors shall agree from time to time to the delegation of specific powers to be exercised by committees, which it has formally constituted. The Board of Directors shall approve the constitution and terms of reference of these committees and their specific powers.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust, which have not been retained as reserved by the Board of Directors or delegated to a committee of the Trust Board, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust Board.

5.5 Schedule of Decisions Reserved for the Board of Directors

5.5.1 The Board of Directors shall adopt a Schedule of Decisions Reserved for the Board of Directors setting out the matters for which approval is required by the Trust Board.

5.5.2 The Board of Directors shall review such Schedule at such times as it considers appropriate; and shall update after each review.

5.5.3 The Schedule of Decisions Reserved for the Board of Directors shall take precedence over any terms of reference or description of functions of any committee established by the Trust Board. The powers and functions of any committee shall be subject to and qualified by the reserved matters contained in that Schedule.

5.6 Scheme of Delegated Authorities

5.6.1 The Board of Directors shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them.

5.6.2 The direct accountability, to the Board of Directors, of the Director of Finance and other Executive Directors to provide information and advise the Board of Directors in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities

5.7 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance, shall be reported to the next formal meeting of the Board for action or ratification by the Director of Corporate Affairs. All members of the Board and all staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. Declarations of Interest and Register of Interests

6.1 Declaration of Interests

6.1.1 In addition to the statutory requirements relating to pecuniary interests, the Trust's Standards of Business Conduct Policy requires Board members to declare interests annually, or as and when they arise, which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as relevant and material are:

- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
- Shareholdings and ownership interests in any publicly listed, private or not might reasonably be expected to do business with the organisation
- A position of authority in another NHS organisation, commercial, charity, voluntary, professional, statutory or other body which could be seen to influence your role within the organisation
- A position on an advisory group or other paid or unpaid decision making forum that could influence how the organisation spends taxpayers money
- Are or could be involved in the recruitment or management of close family members and relatives, close friends and associates and business partners
- Any connection with a private, public, voluntary or other organisation contracting for NHS services
- Any other commercial interest relating to any relevant decision to be taken by the organisation
- Research funding/grants that may be received by an individual or their department.

6.1.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Director of Corporate Affairs.

6.1.4 At the time that Directors' interests are declared they should be recorded in the Board minutes and the Register of Interests. Any changes in interests should be declared at the next Board meeting following the change occurring and will be recorded in the minutes of that meeting.

6.1.5 During the course of a Board meeting, if a conflict of interest is established, the Director(s) concerned should declare such likely conflict of interest and withdraw from the meeting unless requested to remain by the Board members present. The Director should play no part in the relevant discussion or decision.

6.2 Register of Interests

6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally, declarations of interest of the Board. In particular the register will include details of all Directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in SO 6.1.2.

6.2.2 The Register of Interests shall be published on the website and shall be reviewed at least on an annual basis.

6.3 Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest

6.3.1 Subject to the following provisions of this Standing Order, which is taken from the Membership Procedure Regulations 1990 (as amended), if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or any other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement, disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.3.2 The Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which that person has a pecuniary interest is under consideration.

6.3.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the NHS (Consolidation) Act 2006 Schedule 3 Part 1 Paragraph 10, NHS Act 1997 Schedule 5A Paragraph 11(4) or the 1999 Act Schedule 1 (pay and allowances) shall not be treated as pecuniary interest for the purpose of this regulation.

6.3.4 Subject to SO 6.3.3 and any conditions imposed by the Secretary of State for Health and Social Care, the Chair or a Director shall be treated for the purpose of this regulation as having indirectly a pecuniary interest in a contract, proposed contract or other matter if:

- The Director, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, which has a direct pecuniary interest in the other matter under consideration; or
- The Director is a partner of, or is in the employment of, a person with whom the contract was made, or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.
- In the case of married persons or persons living together as partners, the interest of one spouse/cohabitee shall, if known to the other, be deemed to be also the interest of that spouse/cohabitee.

6.3.5 For the purpose of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- *'Spouse'* shall include any person who lives with another person in the same household. (Any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse).
- *'Contract'* shall include any proposed contract or other course of dealing.

6.3.6 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- Of their (or a person connected to them) membership of a company or other body if they have no beneficial interest in any securities of that company or other body.
- Of an interest in any company, body or person with which they are connected, as detailed in SO 6.3.2, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of, or in voting on, any question with respect to that contract or other matter.
- The total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the lower, provided however, that the person shall nevertheless be obliged to disclose/declare their interest in accordance with SO 6.1.2.

6.4 Powers of the Secretary of State for Health and Social Care

The Secretary of State for Health and Social Care may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability shall be removed.

6.5 Committee Responsibilities

This regulation applies to a Committee of the Trust as it applies to the Board and applies to any member of any such Committee (whether or not they are also a Director of the Trust) as it applies to a Director of the Trust.

7. Standards of Business Conduct

7.1 Policy

7.1.1 All staff must comply with the national guidance contained in HSG(93)5 'Standards of Business Conduct for NHS Staff'. The following provisions should be read in conjunction with that guidance and staff should also refer to the Trust's Standards of Business Conduct; Policy on Managing Conflicts of Interest, Gifts & Hospitality and Sponsorship.

7.1.2 It is the responsibility of all Trust staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their official duties.

7.1.3 It is an offence under the Bribery Act 2010 for an employee of the Trust to accept corruptly any inducement or reward for doing, or refraining from doing, anything in their official capacity, or corruptly showing favour or disfavour in the handling of contracts.

7.1.4 It is the responsibility of the Trust to ensure that its Officers are aware that breach of the provision of the Act renders them liable to prosecution and may also lead to the termination of their contracts of employment and superannuation rights within the NHS.

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of a Director or an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or Director of Corporate Affairs of the fact that he is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer must also declare to the Chief Executive any other employment or business or other relationship of their partner, or of a co-habiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.2.3 The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.3 Canvassing of and Recommendations by Directors in Relation to Appointments

7.3.1 Canvassing of Directors of the Trust or members of any Committee of the Trust directly or indirectly, for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Orders shall be included in application forms or otherwise brought to the attention of candidates.

7.3.2 A Director of the Trust shall not solicit for any person, any appointment under the Trust or recommend any person for such an appointment. But this paragraph of Standing Orders shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.3.3 Unsolicited informal discussions outside appointment panels or Committees should be declared to the panel or Committee.

7.4 Relatives of Directors or Officers

7.4.1 Candidates for any staff appointment shall when making an application, disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to dismissal.

7.4.2 The Chair and every Director or Officer of the Trust shall disclose to the Board any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or holder of any office under the Trust.

7.4.4 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, the Standing Order headed 'Exclusion of Chair and Members in Proceedings on Account of Pecuniary Interest ' (SO 6.3) shall apply.

8. Custody of Seal and Sealing of Documents

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Director of Corporate Affairs in a secure place.

8.2 Sealing of Documents

8.2.1 The Seal of the Trust shall only be attached to documents where the sealing has first been approved by the Trust Board, or the Chief Executive and the Director of Finance, or their designated acting replacement in accordance with the Scheme of Delegated Authorities

8.2.2 The seal shall be affixed in the presence of the signatories.

8.4 Register of Sealings

The Director of Corporate Affairs shall keep a register of sealings. An entry of every sealing shall be made and a report of all sealings shall be made to the Board at least bi-annually.

9. Partnership Arrangements – Memorandum of Understanding (MoUs)

9.1 The Trust will from time to time, establish partnership arrangements (MoUs) with external organisations or groups (NHS or non NHS) with the aim of achieving identified benefits for the parties involved in the partnership.

9.2 For governance purposes, it is imperative that such partnership arrangements are subject to formal approval by the Trust Management Committee prior to any commitment to join the partnership.

9.3 The anticipated outcomes and duration of partnership arrangements will be measured and monitored by the relevant lead Officer. The Director of Corporate Affairs will maintain a register of partnership arrangements which will be presented to the Board for scrutiny on a 6 monthly basis.

9.4 For the avoidance of doubt, the definition of a Partnership is as follows:

'A relationship established between the Trust and an external organisation for the furtherance or development of the Trust's activities, which aim to deliver identified benefits to the satisfaction of all Partners in the relationship. Such relationships would be in addition to the purchaser/provider or client/customer relationships which arise through the Trust's normal business activities.'

Reservation of Powers to the Board

1. Introduction

1.1 Standing Order 1.6 requires that the Trust must adopt a Reservation of Powers and Scheme of Delegation which define the powers retained by the Board. Those powers so determined are detailed below.

2. General enabling provision

2.1 The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

3. Powers reserved to the Board

3.1 Regulations and control

3.1.1 Approval of Standing Orders, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

3.1.2 Suspension of Standing Orders.

3.1.3 Approve variations or amendments to the Standing Orders, schedule of matters reserved to the Board and Standing Financial Instructions.

3.1.4 Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO5.2.

3.1.5 Approval of a scheme of delegation of powers from the Board to committees and officers.

3.1.6 Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.

3.1.7 Require and receive the declaration of officers' interests that may conflict with those of the Trust.

3.1.8 Approve arrangements for dealing and responding to complaints.

3.1.9 Receive reports from committees, including those that the Trust is required by the Secretary of State for Health and Social Care or other regulation to establish, and take appropriate action.

3.1.10 Confirm the recommendations of the Trust's committees where the committees do not have executive powers.

3.1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

3.1.12 Establish terms of reference and reporting arrangements for all committees and sub-committees that are established by the Board.

3.1.13 Receive reports on instances of use of the seal.

3.1.14 Ratify, or otherwise, instances of failure to comply with Standing Orders or Standing Financial Instructions brought to the Chief Executive's attention in accordance with SO5.7.

3.2 Appointments and dismissals

3.2.1 Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

- Appoint the Chief Executive
- Appoint the Executive Directors

Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests.

3.2.2 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements of the Trust's Standing Orders.

3.2.3 Approve the disciplinary procedure for officers of the Trust.

3.3 Strategy, plans and budgets

3.3.1 Define the strategic aims and objectives of the Trust.

3.3.2 Approve all Trust strategies

3.3.3 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State for Health and Social Care.

3.3.4 Approve the Trust's policies and procedures for the management of risk.

3.3.5 Approve Final Business Cases for Capital Investment schemes where the value exceeds £1,000,000.

3.3.6 Approve the Trust's annual revenue and capital budgets.

3.3.7 Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

3.3.8 Approve PFI proposals.

3.3.9 Approve the opening of bank accounts.

3.3.10 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 during the duration of the contract.

3.3.11 Approve proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses and special payments) previously approved by the Board.

3.4 Policy determination

3.4.1 Approve the process for approval, dissemination and implementation of policies.

3.4.2 Approval of policies is delegated to the Executive Directors however the Board shall maintain responsibility for approving the following policies:

- Health, Safety and Security Policy
- Risk Management Policy
- Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak Up Policy
- Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts, Hospitality & Sponsorship
- Complaints Investigation Policy
- Learning from Deaths Policy
- Policy on Prevention and Reduction of Violence

3.5 Audit Arrangements

3.5.1 Approve the appointment (and where necessary dismissal of External Auditors recommended by the Audit Panel).

3.5.2 Approve external auditors' arrangements for the separate audit of funds held on Trust, and submission of reports to the Audit Committee meetings which will take appropriate action.

3.5.3 Receive the Auditors Annual Report from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

3.6 Annual report and accounts

3.6.1 Receive and approve the Trust's Annual Report and Annual Accounts

3.6.2 Receive and approve the Annual Report and Accounts for funds held on trust

3.6.3 Receive and approve the Trust's Quality Account.

3.7 Monitoring

3.7.1 Receive Escalation and Assurance Reports from Chairs of Committees in respect of their exercise of delegated powers. The remit of each Committee is specified within the relevant Committee Terms of Reference available via the Trust's website and staff intranet.

3.7.2 Continuous appraisal of the affairs of the Trust by means of the provision to the Board of reports from directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care and the Charity Commission shall be reported, at least in summary, to the Board.

3.7.3 Receive reports from the Director of Finance on financial performance against budget.

4. Review

4.1 This Reservation of Powers to the Board document will be reviewed on an annual basis in conjunction with the annual review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Board Development Programme 2024/25
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Note the proposed Board Development Programme for 2024/25.
EXECUTIVE SUMMARY	Development of the Board of Directors remains an important element to support the overall effectiveness of the Board and to build a cohesive Board team with resilient relationships - this might include formal training; briefings, or sessions to help Board members think collectively from a strategic perspective The Board Development Programme for 2024/25 as detailed in s2 has been devised and set in conjunction with the Chair and Chief Executive Officer and remains fluid with time held to accommodate any matters arising during the year.
PREVIOUSLY CONSIDERED BY	N/A
	Date: N/A
	Outcome: N/A

1. BACKGROUND

Alongside arrangements for individual development of both Executive and Non-Executive Directors at NWAS, based on identified needs, development of the Board of Directors as a whole remains an important element to support the overall effectiveness of the Board and to build a cohesive Board team with resilient relationships.

NWAS takes board development to mean anything which helps the Board undertake their role more effectively and this might include formal training; briefings, or sessions to help Board think collectively from a strategic perspective.

Currently, the Trust corporate calendar includes bimonthly board development days and whilst the programme is devised and set in conjunction with the Chair and Chief Executive Officer it remains fluid with time held to accommodate any matters arising during the year.

2. BOARD DEVELOPMENT PROGRAMME 2024/25

Meeting Date	Topic	Lead
24th April 2024	Strategy Deliverables (Annual Plan) 2024/25 Care Quality Commission Review of previous well-led assessment Introductions to CQC team and CQC Single Assessment Framework – Presentation	Deputy Chief Executive Director of Quality Innovation & Improvement
26th June 2024	Directors Responsibilities Under the Civil Contingencies Act (2004) (NARU) EPRR Self-Assessment and Journey to Full Compliance	Deputy Chief Executive
30th October 2024	Patient Safety covering: 1) Board level patient safety syllabus 2) An introduction to the safety dashboard 3) One year of PSIRF - learning / changes / how patient safety incidents are managed when they don't meet PSII priorities NCSC Assured Cyber Security Board Training	Director of Quality, Innovation and Improvement
11th December 2024	Health & Safety Corporate Directors and Board Legal and Regulatory Responsibilities	Director of Corporate Affairs
26th February 2025	Strategy Review & Refresh Annual Plan and Financial Plan (Budget) 2025/26 Risk Appetite Statement 2025/26 Board Assurance Framework 2025/26	Deputy Chief Executive Director of Finance Director of Corporate Affairs

3. ACTION REQUIRED

The Board is asked to:

- Note the proposed Board Development Programme for 2024/25.

NHS
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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Policy on Anti-Fraud, Bribery and Corruption
PRESENTED BY	Carolyn Wood, Executive Director of Finance
PURPOSE	Decision

LINK TO STRATEGY	Choose an item.									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☒	**SR03**	☐	**SR04**	☐	**SR05**	☐
	SR06	☐	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☐	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Note the contents of the updated policy and confirm approval of the policy on Anti-Fraud, Bribery and Corruption.
EXECUTIVE SUMMARY	The Anti-Fraud, Bribery and Corruption Policy has been jointly reviewed and updated by the Anti-Fraud Specialist and Deputy Director of Finance. The aim of the Policy is to provide a guide for employees as to what fraud is in the NHS and to emphasise that it is everyone's responsibility to prevent fraud, bribery and corruption and to provide guidance on how to report it. The review of the Policy has ensured that: • The aims and objectives focus on ensuring that the four key strategic pillars of tackling fraud in the NHS are clear. • Compliance with the NHS Counter Fraud Authority's standards. • The duties section clearly identifies the roles and responsibilities to provide further clarity for all relevant parties.
PREVIOUSLY CONSIDERED BY	Audit Committee
	Date: Friday, 19 July 2024
	Outcome: Recommended for approval

1. BACKGROUND

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

The Policy was previously updated and approved, in October 2023, by the Audit Committee to reflect changes to NHS Counter Fraud Authority (CFA) for its updated strategy for 2023-2026.

The biannual review of the Policy has been completed by Andy Wade, MIAA Anti-Fraud Specialist and Michelle Brooks, Deputy Director of Finance and Fraud Champion for the Trust.

The review of the Policy has ensured that:

- The aims and objectives focus on ensuring that the four key strategic pillars of tackling fraud in the NHS are clear.
- Continued compliance with the NHS Counter Fraud Authority's standards.
- The duties section clearly identifies the roles and responsibilities to provide further clarity for all relevant parties.

2. RISK CONSIDERATION

Compliance/ regulatory	NWAS will take all the necessary steps to counter fraud, bribery and corruption in accordance with this Policy and with regard to the policies, directions, instructions and guidance as issued by the NHS Counter Fraud Authority (NHS CFA), as well as in accordance with relevant UK legislation. This risk is mitigated by the Trust contracting for specialist Anti-Fraud support and management, currently provided from Mersey Internal Audit Agency. They are accredited by the NHS CFA and accountable to them professionally for the completion of a range of preventative anti-fraud, bribery and corruption work, as well as for undertaking any necessary investigations. Locally accountable to the Director of Finance and reports to the Audit Committee.
People	It is key that all staff within the Trust understand their responsibilities within this Policy. Most people who work in the NHS conduct themselves in an honest and professional manner and support anti-fraud activities and believe it is wholly unacceptable.

	Staff are in the best position to recognise any specific fraud risks within their areas, and the risk is that staff do not report it. Within the Policy it is clear they have a duty to ensure that those risks are identified, reported and eliminated as much as possible. There is a risk around staff not complying with the Trust's SFIs, policies and procedures which may increase the Trust's exposure to fraud. This Policy, along with adequate training and support, reduces this risk and makes staff aware of their own responsibilities
Financial/ value for money	The risk of financial loss across the NHS from fraud remains high. In line with the Policy, the Trust will adopt a zero-tolerance approach to fraud, bribery or corruption through the maintenance of an anti-fraud culture, investigating all reported instances and following disciplinary and criminal proceedings.
Reputation	One of the basic principles of public sector organisations is the proper use of public funds. NWAS is committed to reducing the level of fraud, bribery and corruption and aims to eliminate all such activity as far as possible, as ultimately it leads to the reduction in the resources available for patient care and has a negative reputational impact.

3. EQUALITY / SUSTAINABILITY IMPACTS

The equality impact assessment has been completed and there are no issues to highlight to the Board in relation to the Policy review.

4. ACTION REQUIRED

The Board of Directors is asked to:

- Note the contents of the updated policy and confirm approval of the Policy on Anti-Fraud, Bribery and Corruption.

North West Ambulance Service NHS Trust

Policy on Anti-Fraud, Bribery and Corruption and Response Plan

Policy on Anti-Fraud, Bribery and Corruption		Page:	Page 1 of 12
Author:	Anti-Fraud Specialist	Version:	3.1
Date of Approval:	31/07/2024	Status:	Final
Date of Issue:	July 2024	Date of Review	July 2026

Document Control	
Policy Title	Anti-Fraud, Bribery and Corruption and Response Plan
Policy Reference Number	BOD05
Version number	3.1
Approval date	31/07/2024
Approved by	Board of Directors
Date for Review:	July 2026
Executive Sponsor	Director of Finance
Policy Lead	Deputy Director of Finance
For use by	All Trust employees (permanent and temporary) including volunteers, executives and non-executives

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
2.8	December 2020	January 2021	Andy Wade (AFS)	Reflect changes and the newly appointed AFS
2.9	April 2021	July 2021	Andy Wade (AFS)	Introduce the new Government standards to the document
3.0	October 2023	October 2023	Andy Wade (AFS)	Reflect changes to NHS Counter Fraud Authority (CFA) for its updated strategy for 2023-2026.
3.1	July 2024	July 2024	Andy Wade (AFS) / Michelle Brooks	Review of existing Policy

Policy on Anti-Fraud, Bribery and Corruption and Response Plan

1. Introduction

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

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

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

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

The Trust will take all necessary steps to counter fraud, bribery, and corruption in accordance with this policy, with the Government Functional Standard GovS 013: Counter Fraud (NHS Requirements), NHS contractual requirements and with regard to the policies, directions, instructions, and guidance as issued by the NHS Counter Fraud Authority (NHSCFA), as well as in accordance with relevant UK legislation.

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

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

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

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

2. Purpose

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

Tackling fraud in the NHS is guided by 2023-26 which details how the NHSCFA works collaboratively with the health sector to understand, find, and prevent fraud in the NHS. They have developed four strategic pillars of activity to facilitate this:

1. **Understand**: Understand how fraud, bribery and corruption affect the NHS.
2. **Prevent**: Ensure the NHS is equipped to take proactive action to prevent future losses from occurring.
3. **Respond**: Ensure the NHS is equipped to respond when a fraud occurs.
4. **Assure**: Provide assurance to key partners, stakeholders and the public that the overall response to fraud across the NHS is robust.).

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

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

3. Definitions

NHS Counter Fraud Authority (NHSCFA) is a special health authority which has the responsibility for the detection, investigation and prevention of fraud and economic crime within the NHS. Its aim is to lead the fight against fraud affecting the NHS and wider health service, by using intelligence to understand the nature of fraud risks, investigate serious and complex fraud, reduce its impact, and drive forward improvements.

NHSCFA also maintains a national **NHS Counter Fraud Strategy** which sets out the strategic approach and direction, key challenges and opportunities, and the priority areas identified for tackling fraud and corruption in the NHS. The Trust/CCG's local approach to tackling fraud and corruption, through the work of the Anti-Fraud Specialist, organisational resources, and the annual risk-assessed counter fraud work-plan, fully acknowledges and aligns itself to the priorities set out in the national strategy.

Government Functional Standard GovS 013: Counter Fraud (NHS Requirements). A requirement in the NHS standard contract is that providers and commissioners of NHS services must take the necessary action to comply with the NHSCFA's counter fraud standards. Other's should have due regard

to the standards. The contract places a requirement on providers / commissioners to have policies, procedures and processes in place to combat fraud, corruption and bribery to ensure compliance with the standards. The NHSCFA carries out regular assessments of health organisations in line with the counter fraud standards.

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

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

- **Fraud by false representation (s.2)** – lying about something using any means, e.g., falsifying a CV or NHS job application form.
- **Fraud by failing to disclose (s.3)** – not saying something when you have a legal duty to do so, e.g., failing to declare a conviction, disqualification, or commercial interest when such information may have an impact on your NHS role, duties, or obligation and where you are required to declare such information as part of a legal commitment to do so.
  Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation, e.g., a carer abusing their access to patients' monies, or an employee using commercially confidential NHS information to make a personal gain.

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

Bribery and Corruption: The Trust adopts a 'zero tolerance' attitude towards bribery and does not, and will not, pay or accept bribes or offers of inducement to or from anyone, for any purpose. The Trust is fully committed to the objective of preventing bribery and will ensure that adequate procedures, which are proportionate to our risks, are in place to prevent bribery.

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

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

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

Generally, bribery is defined as: ***an inducement or reward offered, promised, or provided to someone to perform their functions or activities improperly in order to gain a personal, commercial, regulatory and/or contractual advantage.***

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

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

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

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

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

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

4. Duties

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

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

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

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

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

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

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

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

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

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

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

The role of **Audit Committees** is in reviewing, approving, and monitoring counter fraud workplans, receiving regular updates on counter fraud activity, monitoring the implementation of action plans, providing direct access and liaison with those responsible for counter fraud, reviewing annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

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

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

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

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

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

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

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

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

- Promoting awareness of fraud, bribery, and corruption within their organisation.

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

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

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

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

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

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

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

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

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

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

5. Policy information section – The Response Plan

5.1 Bribery and Corruption

The AFS undertakes an annual fraud and bribery risk assessment, in conjunction with the organisation conducting periodic assessments (in line with Ministry of Justice guidance) to assess how bribery and corruption may affect it. Proportionate procedures and measures have been put in place to mitigate identified risks.

The organisation also has a policy and procedure in place in relation to the completion of declarations of interest, declarations of secondary employment and the hospitality/gifts register. The relevant policy and

procedures are accessible via https://greenroom.nwas.nhs.uk/library/standards-of-business-conduct-policy-of-gifts-and-hospitality and staff are required to comply with these arrangements. Instances of non-compliance may be referred to the AFS for further investigation.

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

5.2 Reporting Fraud, Bribery or Corruption

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

All genuine suspicions of fraud, bribery and corruption must be reported directly to the AFS – Andy Wade.

Email – andrew.wade@miaa.nhs.uk

Tel – 07824 104209

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

An employee can contact any executive or non-executive director of the Trust to discuss their concerns if they feel unable, for any reason, to report the matter to the AFS or Director of Finance.

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

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

Investigations may also include police involvement, where appropriate.

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

To support the reporting of fraud using the NHSCFA fraud reporting process (as outlined above), all employees should be aware of NHS England's: Freedom to speak up: raising concern's (whistleblowing) policy for the NHS, April 2016. This provides the minimum standard to help normalise the raising of concerns in the NHS for the benefit of all patients in England.

5.3 Disciplinary Action

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

5.4 Sanctions and Redress

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

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

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

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

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

Disciplinary – Disciplinary procedures will be initiated where an employee is suspected of being involved in a fraudulent or illegal act, as per Section 4.3 of this policy.

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

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

5.5 Monitoring and auditing of policy effectiveness

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

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

5.6 Dissemination of the policy

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

This policy will be disseminated Trust wide for all employees to understand and be made aware of via awareness presentations, the Trust's Bulletin's and on the Trust's Anti-Fraud intranet page https://greenroom.nwas.nhs.uk/about-us/who-we-are/finance-directorate/finance-department/

It is important that staff understand and are aware of this policy.

6. References

https://cfa.nhs.uk/about-nhscfa/corporate-publications

Fraud Act 2006 1-4 https://www.legislation.gov.uk/ukpga/2006/35/contents and Bribery Act 2010 https://www.legislation.gov.uk/ukpga/2010/23/contents

NHS Audit Committee handbook 2018 https://www.hfma.org.uk/publications?Type=Guide

https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-guidance.pdf

Home Office Bribery and corruption assessment template https://www.gov.uk/government/publications/bribery-and-corruption-assessment-template

NHS Improvement and NHS England's Freedom to speak up: raising concern's (whistleblowing) policy for the NHS, April 2016 https://improvement.nhs.uk/documents/27/whistleblowing_policy_final.pdf

EQUALITY IMPACT & RISK ASSESSMENT SCREENING TOOL (STAGE 1)
Policies, Procedures and Strategies

Directorate:	**Team:**
Finance	Finance
Name of policy/procedure or strategy:	**EIA lead/author:**
Anti-Fraud Corruption and Bribery Policy	Michelle Brooks
Date of completion:	**Date of review:**
10th July 2024	Jul-26

Brief overview of the proposals (policy/procedure or strategy) being assessed, and intended outcomes	**The Trust is committed to taking all necessary steps to counter fraud, bribery, and corruption. The aim of this policy is to provide a guide for employees as to what fraud is in the NHS, to emphasise that it's everyone's responsibility is to prevent fraud, bribery, and corruption and to provide guidance on how to report it.**

GENERAL GUIDANCE
Please use the rationale box to provide more information, particularly in relation to responses which turn 'red'. The tool will provide an indication of whether a Stage 2 EIA is required. The reccomendation can be discussed with the ED&I Team before proceeding.

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *If you have indicated 'yes' for any questions, please briefly explain*
1	**Is this a new policy/procedure or strategy?**	N	This is a review of the existing Anti-Fraud Policy
2	**Is the policy/procedure or strategy proposing significant changes to current ways of working?**	N	This is the biannual review of the existing Policy, and no significant changes have been made to the guidance within it, therefore neutral impact on staff equality. Interim updates were made to the Policy in October 2023 to reflect the changes to the NHS Counter Fraud Authorities updated strategy, this was by the Audit Committee.
3	**Does the policy/procedure or strategy relate to service users?**	N	This Policy is not for service users
4	**Does the policy/procedure or strategy relate to NWAS staff? If so, please outline which staff groups**	Y	Relates to all staff groups. The Trust will ensure that all persons that are subject of a fraud, bribery or corruption investigation, in line with this Policy, will be treated fairly and without discrimination.
5	**Does the policy/procedure or strategy have an impact on the way service users access NWAS services?**	N	This Policy is not for service users
6	**Does the policy/procedure or strategy impact on the ways of working for staff?**	N	The Policy does directly impact the way of working for staff, clearly advising on the way staff conduct themselves in relation to reducing the risk to the Trust from fraud, bribery of corruption.
7	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab* All allegations will be investigated without different treatment stemming from personal characteristic defined on the Equality Act 2010. At this time there are no required mitigations or negative impacts on these protected groups.
	EQUALITY RISK	**Enter Y or N**	**Rationale** *If you have indicated 'yes' for any questions, please briefly explain*
8	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	Y	According to estimates fraud costs the NHS £1.29bn a year. This is taxpayers money that is taken away from patient care and the NHS is the victim. When fraudsters target the NHS and succeed, this results in a loss of resources intended for patient care, and all staff and patients bear the cost when the NHS loses money to fraud (source NHS CFA). The Fraud Act 2006 is a key piece of legislation used to prosecute fraud. The Fraud Act 2006 defines fraud as an offence that could be committed in one of three ways, by false representation; by failing to disclose information; or by abuse of position - these 3 categories are at the centre of the Act. This impacts on staff, NWAS has a responsibility to educate staff on what constitues fraud and how to spot it and report it. This data has a neutral impact on equality.
9	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	Y	Specialist Advice from Anti-Fraud Specialist at MIAA, Andy Wade and from the guidance issued from the NHS Counter Fraud Authority
10	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	Y	The proposals within this policy do not contravene the PSED. The Policy has had due regard to equality and does not discriminate against people with protected characteristics.
11	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	Y	There are no negative effects on protected characteristics groups at the time of completing this assessment.
12	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	This has no impact on patient care therefore not engaged, staff are the main stakeholder group
13	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	N	This is a long standing Policy withing the Trust, with the biannual review resukting in minimum changes, thereore no engagement has been done with staff due to neutral impact from changes.
	HUMAN RIGHTS IMPACT		**Rationale**
18	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**		No impact on human rights from the NWAS Policy. In deciding the application of the Human Rights Act 1988 to civil procedures for dealing with fraud cases, the Act gives legal protection of your human rights, such as your right to a fair trail - but this Policy is in relation to Anti-Fraud practices to be followed, the NHS CFA is the special health authority tasked with identifying and investigating fraud, bribery and corruption, not NWAS.
	Human Rights: **A2 Right to Life** **A3 Prohibition of torture, inhuman or degrading treatment** **A4 Prohibition of slavery and forced labour** **A5 Right to liberty and security** **A6 Right to a fair trial** **A7 No punishment without law** **A8 Right to respect for private and family life** **A9 Freedom of thought, conscience and religion** **A10 Freedom of expression** **A11 Freedom of assembly and association** **A14 Prohibition of discrimination** **P1A2 Right to education**		
	Are you intending on proceeding to complete a Stage 2 EIA? ***If no, please provide a rationale***		No, as no major changes have been made to the Policy and based on the answers provided throughout the EIA screening tool.

Please send this completed EIA Screening Tool to the Equality, Diversity & Inclusion Team for review: inclusion.workforce@nwas.nhs.uk

Comments from the ED&I Team

12/07/2024 - WM - 1st Review: Comments/Queries added (Review>Show Comments) once amended, send back to inclusion.workforce inbox for further review
17/07/2024 - WM - 2nd Review: Approved, this EIA stage 1 at this time shows sufficient due regard as required under the Public Sector Equality Duty. This EIA should now be added as an appendix to the Anti Fraud Policy. If in the future any new information/data comes to light then please refresh this EIA and resubmit to the inclusion.workforce inbox for further review

Reviewed by:	WM - 1st Review WM - 2nd Review	**Date**	12/07/2024 - WM 17/07/2024 - WM

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Emergency Preparedness Resilience Response (EPRR)
PRESENTED BY	Salman Desai Deputy Chief Executive
PURPOSE	Assurance

LINK TO STRATEGY	Choose an item.									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☒	**SR04**	☒	**SR05**	☐
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☐
	Financial/ Value for Money	☐	Reputation	☒	Innovation	☐

ACTION REQUIRED	The Board is asked to: • Receive assurance from the Accountable Emergency Officer (AEO) discharging their responsibilities against the EPRR work programme in line with its duties under the NHS Standard Contract 30, and as required in line with its EPRR Annual Assurance Core Standard 3.
EXECUTIVE SUMMARY	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. The NHS England Annual Assurance Core Standard 3 states that '*The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.* *The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements*'

This report provides a summary of:

- training and exercises undertaken by the organisation
- summary of any business continuity, critical incidents and major incidents experienced by the organisation
- lessons identified and learning undertaken from incidents and exercises
- the organisation's compliance position in relation to the latest NHS England EPRR assurance process.

ALERT

The Trust has been working on the NHS England Annual Core Standards Assurance taking a systems approach and updating processes to improve assurance. This is ongoing and the systems will mature over time. The submission to NHS England in November 2023 was 41% (non-compliant), and by the end of June 2024 it achieved 83% (partially compliant). Work continues to progress in areas of partially compliance to move the trust to substantially compliant prior to submission to Board in September 2024 on the EPRR Annual Assurance self-assessment for 2024/2025.

ADVISE

The Board should be alert to the addition of risks to the corporate register which are linked to the National Risk Register and National Security Risk Assessment. The scoring is the initial scoring while control measures are tested and reviewed. These risks will remain on the Trust risk registers to align with the Cabinet Office risk processes and regular national and local reviews.

Collaboration continues with multiagency partners within Local Resilience Forum Areas, and is increasing internally through work with Paramedic Emergency Service (PES), Integrated Contact Centres (ICC), Learning and Development, and Quality/Patient Safety.

There is a change of methodology in terms of implementation of the Emergency Planning Cycle. This will emphasise the importance of risk assessment, working into planning, training, and communication. It will also grow the Trust's learning culture, decreasing departmental silo working and strengthening the identification and tracking of lessons identified from internal and external sources.

ASSURE

The Resilience team will commence the EPRR Annual Assurance self-assessment on receipt of the required correspondence from NHS England for the 2024/2025 cycle.

The Interoperability section of the Core Standards has reached 95.6% (substantially compliant).

The second Commander training cycle is underway, delivered by the new Command and Resilience Education Team. The team have also pioneered the use of a digital app, Parafolio (part of Parapass) for tracking National Occupational Standard compliance. They are presenting the progress to

	other ambulance services which has been well received. This digital development will be presented to NARU in August 2024 for consideration to be used across the sector. Attendance at courses and on exercises is now tracked through ESR which allows reports to be extracted for data collection against compliance. This data is reported to EPPR Group and subsequently to the Quality and Performance Committee.	
PREVIOUSLY CONSIDERED BY	N/A	
	Date	Click or tap to enter a date.
	Outcome	

1.	**BACKGROUND**
	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. The NHS England Annual Assurance Core Standard 3 states that: '*The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.* *The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements*' This report provides a summary of: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises (continuous improvement) • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.
2.	**TRAINING AND EXERCISES**
	Training for response preparedness and on-staff readiness is part of the NHS England Core Standards. This requires a training needs analysis which is, in part, driven by National and Minimum Occupational standards set out by NHS England and the National Ambulance Resilience Unit (NARU). JESIP (interoperability group) also monitor compliance against the national doctrine and training. **<u>JESIP eLearning</u>** The NHS England Core Standards (J10 in interoperability) states that a minimum of 90% of staff involved in incident response should have annual awareness updates of JESIP and interoperability. The Trust hosts the awareness videos on ESR so viewing can be tracked. Data taken from ESR shows the Trust are currently 75% compliant. Area Directors are publicising the need for and benefits from completion, the content and reports from ESR are being reviewed for accuracy. JESIP is also covered in mandatory training in the face-to-face sessions, and on SORT courses. The data sources need to be combined and cleansed, but it is expected that the total will be higher than 75%.

Initial Operational Response (IOR)

IOR is the process of identifying the presence of hazardous materials, managing exposure, and treating/managing persons affected. The JOL action note (see section 4) required All responders, control room staff and commanders are to receive training/briefings on IOR.

A briefing was published on the Green Room (NWAS Intranet) in May 2023, Commanders had an awareness session, and the eLearning session was added to mandatory training in the 2023-2024 cycle. It is not possible to tell how many staff read the briefing. The report pulled from ESR in December showed that 84.11% of staff had completed the IOR module, by the end of May this had risen to **91%.**

Staff who attend the NWAS induction and EMT1 courses cover IOR through a video and classroom simulation which means the newer staff will have had the training. If this skill and knowledge set is not mandated going forwards, the knowledge may deteriorate through lack of practice.

In-person JESIP courses

Commanders are required to attend face to face JESIP courses every 3 years as part of their portfolio. In the North West, over the last 3 years there have been 83 classes, 452 staff have attended.

The data taken from ESR shows that **89% of the Trust on call commanders have completed a face-to-face JESIP course** in the last 3 years as mandated. 100% of CAL commanders are compliant, 75% of CAM and 91% of GM.

		JESIP in date			
AREA	ON CALL	N	Y	Grand Total	Percentage in date
C&L	Operational		12	12	100
	Strategic		6	6	100
	Tactical		6	6	100
			24	**24**	100
C&M	Operational	2	7	9	78
	Strategic	1	5	6	83
	Tactical	2	3	5	60
		5	**15**	**20**	75
GM	Operational	2	9	11	82
	Strategic		5	5	100
	Tactical		6	6	100
		2	**20**	**22**	91
Grand Total		**7**	**59**	**66**	89

There are ongoing discussions with ICC linked with their service line review, to identify which role are classed as commanders, and to create a training needs analysis for those roles.

Commander training

The Command, Resilience and Education (CARE) team were formed to ensure NWAS commanders have support with the completion of the National Occupational Standard, and the opportunity to further their knowledge, understanding, and practice.

Cycle 1 took place between January 2024 and March 2024, cycle 2 started in June 2024 and will run until September 2024. Cycle 3 is under development. The CARE team have been

working closely with the Learning and Development team to ensure training standards are met and training carried into mandatory training.

Cycle 1 attendance:

Role/function	Cumbria and Lancashire	Greater Manchester	Cheshire and Merseyside
Operational Commanders	92%	67%	100%
Tactical Commanders	67%	67%	100%
Strategic Commanders	100%	100%	100%
Executive	100%		
NILO	100%		
EOC	94%	63%	82%
HART Team Leader	NA	71%	40%
MERIT	83%		
ROCC Commanders	100%		

This shows there is room for improvement in terms of attendance. Area Directors are responsible for ensuring their staff are compliant with the training and evidence portfolios, including compliance aligned to their National Occupational Standards. NWAS has set a standard of compliance including courses, exercises they need to undertake within specified timescales. The Resilience team ahs also developed a NWAS National Occupational Standards Framework to ensure clarity is made on the requirements of all commanders, and support commanders. The Resilience team will work in partnership with NARU and AACE to establish occupational standards for EOC commanders.

2024 Mandatory Training

The figures for NWAS PES classroom attendance at 30 June 2024 for the cycle starting April 2024 are:

- 4118 required
- 862 attended
- 20.93% attended
- Target for end Jun 24 – 14% attendance

This does not include PTS.

The rolling 12 months figure for PES classroom (i.e. those compliant / attended in last 12 months) is 85.72%.

The Command & Resilience Education Team assisted with providing the content of the Resilience aspect of the training which focussed on the role of the First Resource on Scene by using a video of a Train and Vehicle RTC and the actions that are to be conducted in line with the Trust Incident Response Plan and Action Cards.

Exercises

As part of the Commander CPD portfolio, commanders are mandate to attend an exercise everyone 18 months as a minimum. Attendance is now recorded on ESR. 82% of NWAS

commanders are compliant with this standard. Future reports will include trends for comparison over time.

AREA	ON CALL	N	Y	Grand Total	Percentage compliance
C&L	Operational	1	11	12	92
	Strategic		6	6	100
	Tactical	1	5	6	83
C&L Total		2	22	24	92
C&M	Operational	2	7	9	78
	Strategic	2	4	6	67
	Tactical		5	5	100
C&M Total		4	16	20	80
GM	Operational	3	8	11	73
	Strategic	1	4	5	80
	Tactical	2	4	6	67
GM Total		6	16	22	73
Grand Total		12	54	66	82

The Manchester Arena Inquiry recommendation R20 states:

'*North West Ambulance Service should ensure that non-specialist ambulance personnel are involved in multi-agency exercising.'*

EPRR Core Standard 5 asks if the Trust/Board believe they have enough resources to carry out their duties in response. This standard sits at partially complaint as funding has been requested locally and nationally to support delivery of training to non-specialists while maintain business as usual.

In the rolling 12-month period to June 2024, 3 EOC and 51 PES staff (non-specialists) are recorded as having attended exercises. It should be recognised that exercises are often run locally with agreement with other local services. These exercises are not designed or tracked by the Resilience Team, so objectives are not recorded. Data regarding attendance is not included on the ESR reports.

3. INCIDENTS

The Trust record the occurrence of incident declarations in several places, this is being reviewed to improve accuracy and reporting.

Internally, 1 critical incident has been declared in connection with capacity, and several Business Continuity incidents have been declared within the Integrated Contact Centres (ICC). A Business Continuity Incident was declared on the 19/07/2024 following the Global Outage Incident.

The trust has a clear process in place for declaration of a Major Incident and Critical Incident but further work required to support all decision makers on declaration of a Business Continuity Incident. The process for a BCI to action the notification required by NHS England and the ICBs is in progress and anticipated to be in place from August 2024.

An alerting system is being trialled to establish if it would be advantageous for internal and external notifications. The current process of the Regional Operational Coordination Centre (ROCC) contacting stakeholders and receiving hospitals is time consuming and could

	potentially lead to deals in stakeholders being prepared. The pilot is anticipated to be complete in Q4 2024/2025. **National Interagency Liaison Officers (NILO)** The Manchester Arena Recommendations included holding a rota with good geographical cover. NWAS now have a 6 line rota with 2-3 staff per line covering the region. By the end of 2024 there are expected to be 22 NILOs in place. The rota is designed to balance subject knowledge, location, and experience. The Resilience Team are gathering information from the NILOs via a MS Teams form completed after each activation to look at how and when they are utilised, and what type of incidents they are used for so it can be included in continuous professional development. The data recorded shows that around 80% of incidents only require 1 NILO and they are utilised mainly during week days.
4.	**CONTINUOUS IMPROVEMENT (core standard 6)**
	Emergency Planning cycle With the development of risks taken from the NRR and brought into the Trust, this is the first step of improving the NWAS approach to the emergency planning cycle. A process for writing plans, exercises, setting up and running debriefs, identification and tracking of lessons, and pulling lessons from outside of the organisation is also in progress. This will be continuously tested and developed over time to improve the assurance around 'closing the loop' in terms of learning. It will also drive what plans are required, how they are communicated and tested. These processes will become a supporting document to the EPRR Policy. Business Continuity will also align. **Joint Organisational Learning (JOL)** The Trust also subscribe to the JOL process where organisations (including police and fire and rescue service plus others) can upload lessons and good practice for national scrutiny. If significant lessons are identified, organisations receive an 'action note' which they are obliged to complete. They usually prescribe the removal of out of date documents, addition of new toolkits or terminology into processes, training of staff, and provision of action plans. NWAS have received 4 action notes this year and fed back on 3. The final one is due to be submitted in August 2024. All refer to updated national documentation and processes. • 2023-01 Initial Operational Response • 2023-02 MTA Joint Operating Procedures • 2024-01 JESIP Doctrine v3.1 • 2024-002 Dealing with Persons in Crisis **Debriefs** The trust has a debrief policy in place and continues to imbed debriefs post specific incidents as defined through the policy. The process to undertake a debrief is being reviewed to enhance the process further, to support learning. Updates will be presented through the EPRR Group.
5.	**EPRR COMPLIANCE AGAINST THE CORE STANDARDS**
	NHS England set of the Core Standards which commissioned organisations are expected to comply with. They align with duties under the Civil Contingencies Act and delivery of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework 2022.

Each year, commissioned organisations perform a self-assessment and provide evidence of that assessment to NHS England. In 2022 they did a deep dive into several organisations which showed a disconnect with what the organisations deemed to be compliant and what NHS England interpreted to be correct. This process was repeated nationally in 2023. A letter was received by the NWAS Accountable Emergency Officer (AEO) in May 2023 setting out the requirements, submission was set for the end of September 2023.

Compliance for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Full and partial compliance of a standard does not have a sliding scale, for example if a plan is in place but has not been tested, or if it was in draft at time of submission, this would be partial compliance.

Organisational rating is defined as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

2023 cycle and progress

During the review period, discussions took place between NWAS, NHS England, and Lancashire and South Cumbria ICB (NWAS Commissioners) to gauge their perspective. Using these conversations to understand the ask, **NWAS final submission in November 2023 was 41% (non-compliant), interoperability was 87% (partial compliance).**

The report submitted to the EPRR Group at the beginning of July 2024 shows that progress has been made through a review of systems and processes, and collaborative working. Some

	items were noted as having evolved over time but not while aware of interdependencies. This is being improved by better communication and collaboration outside of the traditional channels. Organisational change within the leadership structure has slowed some of the progress due to prioritisation but progress is still being made. **<u>Final position within this cycle</u>** **The Trust is at 83% compliance** with the EPRR Core Standards (starting position was 41%). This is in the **partially compliant** category. Substantial compliance starts at 89%. Interoperability standards are now 95.6% compliant (classed as substantially compliant). **<u>EPRR Annual Assurance 2024/2025 cycle</u>** The assessment and accompanying letter for 2024 has not been received by NWAS, but multiagency working groups leads the Trust to understand Lancashire and South Cumbria Integrated Care Board (ICB) will be doing a peer-type assessment this year. NWAS are also working closely with the Northern Ambulance Alliance (North East and Yorkshire Ambulance Services) in addition to national working groups to share approaches and good practice. Assessment for 2024 is expected to be robust and in the 'substantial compliance' category. The Board should be aware that 3 standards are unlikely to be compliant in the next cycle: • Standard 5 - EPRR resource. Funding from commissioners for MR20 has not been received. • Standard 37 – Local Health Resilience Partnership (LHRP) attendance, executive level health group. The Trust has had good representation at all the groups in terms of attendance, 1 area has provided a lower level manager on several occasions. This has been addressed but not early enough to have compliance for this submission. • Standard 51 – Business Continuity audit. External audit anticipated in Q3/Q4 but not prior to submission. Annually, a 'deep dive' takes place which is subject specific. The topic for 2024 is Cyber security. The Resilience Team have already engaged with Digital in anticipation of questions, and an exercise is in the early stages of development.
6.	**RISK CONSIDERATION**
	The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the CCA (2004), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998. NWAS Resilience is also a key component of the NHS Ambulance Standard Contract and is governed by the NHS England & Improvement Emergency Preparedness, Resilience and Response (EPRR) Core Standards which are revised annually.
7.	**EQUALITY/ SUSTAINABILITY IMPACTS**
	None
8.	**ACTION REQUIRED**

	The Board is asked to: • Receive assurance from the Accountable Emergency Officer (AEO) discharging their responsibilities against the EPRR work programme in line with its duties under the NHS Standard Contract 30, and as required in line with its EPRR Annual Assurance Core Standard 3.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Health, Safety, Security and Fire Annual Report 2023/24
PRESENTED BY	Maxine Power, Director of Quality, Innovation and Improvement
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is recommended to: • Acknowledge and thank the HSSF staff side representatives for their commitment to supporting staff to stay safe during 2023/24 • Recognise the achievements made in the year by the HSSF team. • Note the assurances within this HSSF annual report 2023/24. • Accept the annual report as an accurate reflection of HSSF activity in 2023/24.
EXECUTIVE SUMMARY	The report at Annex 1 is to provide the Board of Directors with a summary of assurance received from the health, safety, security, and fire activity undertaken in 2023/24. The Health and Safety at Work Act 1974 requires workplaces to provide: 1. adequate training of staff to ensure health and safety procedures are understood and adhered to 2. adequate welfare provisions for staff at work 3. a safe working environment that is properly maintained and where operations within it are conducted.

	During 2023/24: 1. Staff injury incident rate per 1,000 staff 16.9 2. Staff injury incident rate per 1,000 journeys 0.05 3. Top three non-clinical incident themes identified: a. Moving and Handling/slips trips and falls:213 b. Accident and Injuries: 832 c. Violence and aggression incidents: 1,419 Key assurance points to note: 1. 62% of RIDDOR incidents reported to HSE within 15 days of notification. 2. Deep dive analysis identified 62 manual handling incidents were reported to the HSE. The mitigation in place to prevent harm is through online training or face to face training. All NWAS employees receive manual handing training. 3. Seven, procedures were fully reviewed and approved at the Health, Safety, Security and Fire sub-committee. 4. Several guidance documents were published by the HSSF team: • RIDDOR Guidance (updated) • Violence and Aggression incident reporting flowchart • Muscular Skeletal Disorder associated with driving guidance 5. MIAA audit that NWAS is complying with its Health, Safety & Security Policy (including H&S checks) offered Significant Assurance. 6. Note that a feedback meeting with the HM Inspector of Health and Safety is scheduled for the 23/7/24. We have been advised that the meeting will provide verbal feedback only as no breaches of Health and Safety Law have been identified. A verbal update on this will be provided to the Board of Directors. The management of the Health Safety Security and Fire Team has moved to the Director of Corporate Affairs from 1st April 2024.
PREVIOUSLY CONSIDERED BY	Trust Management Committee
	Date: Wednesday, 19 June 2024
	Outcome: HSSF Annual Report Accepted.

1. BACKGROUND

xxx

2. SUB HEADER

xxx

3. SUB HEADER

xxx

4. RISK CONSIDERATION

xxx

5. EQUALITY/ SUSTAINABILITY IMPACTS

xxx

6. ACTION REQUIRED

The xxx is asked to:

- xxx
- xxx
- xxx

North West Ambulance Service NHS Trust

Health, Safety and Security Annual Report 2023/2024

Recommended by	
Approved by	Board of Directors
Approval date	
Version number	
Review date	n/a
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 report 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 0.1			T Shonick	First draft
X 0.2	12/06/2024		T Shonick	Following feedback M Peters
X 0.3	13/06/2024		M Peters	Following feedback M Power

Contents

Introduction

NWAS staff operate across a range of settings and in many instances are performing their daily work in unpredictable and high-risk environments. We are continuously working towards a culture where health, safety, security, and welfare are the primary concern of every employee within NWAS.

The Board of Directors recognise and accept responsibility as an employer to provide a safe environment for employees and those 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 board undertake regular health, safety, and security training. They receive information and assurance on Health and Safety via the Executive Director of Quality, Innovation, and Improvement.

We seek to prevent workplace related injuries, ill health and protection of staff, property, and assets by promoting good working practices. We promote a progressive safety and security culture by clear identification of the roles and responsibilities of staff at all levels, ensuring they receive training, information, supervision, and support. Working together with staff and trade unions, NWAS is committed to addressing identified risks in a proactive way; actively encouraging staff to speak up and report incidents.

All line managers across NWAS are responsible for the management of health, safety and security. They are the first line in implementation of Health Safety and Security policies, procedures, and risk assessments within their own areas of responsibility. Managers ensure their staff are made aware of their statutory requirements under current health and safety legislation and have a safe system of work in their local setting. Line managers are responsible for local audit of compliance against the policies (for example via health and safety workplace inspections) and for local partnership working with Trade Union representatives and staff. 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 Health, Safety, Security and Fire (HSSF) team are responsible for the identification of actions to resolve non-compliance and safety issues and for the provision of expertise and advice to line managers. The HSSF team also provide assurance to the Trust Board via the Health, Safety and Security sub-committee, identifying themes for improvement from incident reports. The top three themes in this year's report include:

- Violence and Aggression
- Accident and Injury
- Moving and Handling.

The Estates, Fleet and Facilities Management (EFFM) 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 EFFM 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.

Think safety, plan safety, and always work safely. Be Safe; Do the Right Thing

1. Regulatory Compliance

The Health and Safety at Work Act, (HSWA), 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 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.

This report provides a high-level summary of the Health, Safety, Security and Fire, (HSSF), activity carried out across NWAS from 01 April 2023 to 31 March 2024; our compliance with the standards set in the HSWA 1974.

1.1 Regulatory Bodies

NHS Trusts Health Safety and Security systems are regulated by:

Care Quality Commission (CQC): It is an executive non-departmental public body of the Department of Health and Social Care established in 2009 to regulate and inspect health and social care services in England and works closely with the HSE with both regulators taking lead for certain issues across NHS trusts. In England, where providers are registered with them, the CQC is the enforcing authority for patient and service user health and safety.

Health and Safety Executive (HSE): The HSE is the national independent regulator for health and safety in the workplace. This includes private or publicly owned health and social care settings in Great Britain. The HSE works in partnership with co-regulators in local authorities to inspect, investigate and where necessary take enforcement action.

Medicines and Healthcare products Regulatory Agency (MHRA): The MHRA is an executive agency of the Department of Health and Social Care; responsible for ensuring that medicines and medical devices work and are acceptably safe.

Home Office: The Home Office is the lead government department whose responsibilities include fire prevention and rescue. The Regulatory Reform (Fire Safety) Order 2005 applies to all on-domestic premises in England and Wales.

2. Health and Safety Executive

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

RIDDOR places responsibilities on employers, the self-employed and people in control of work premises to report certain serious workplace accident, occupational diseases and specified dangerous occurrences (near misses) against clear guidelines.

In NWAS, the timely reporting of RIDDORs following an incident is the responsibility of the HSSF team. RIDDOR reported incident activity and high-level analysis is received at the Health, Safety and Security subcommittee. The Board of Directors receive a bi-monthly update through the reportable events paper.

2.1.1 RIDDOR reporting rates in ambulance services.

National RIDDOR reporting requires the activity to be reported using the methodology of number of incidents per 1,000 staff. The number of staff employed as at 31/3/2024 is 7851; and the number of staff injury RIDDORs reported in the 12 months to 31 March 2024 is 133. The total number of journeys (PTS (1,069,180) and PES (1,446,701)) combined is 2,515,881 for the same period. National RIDDOR reporting requires the activity to be reported as incidents per 1000 staff members. The number of staff injury RIDDOR reported in the 12 months to 31 March 2024 is 133.

- The rate of incident per 1000 staff is 16.9, a slight increase in rate from 2022/23 (16.1).
- The incident rate is per 1000 ambulance journeys is 0.05, a slight increase in rate from 2022/23 (0.04)

2.2 Health, Safety, Security & Fire (HSSF) incident activity

The number of patient and staff non-clinical incidents reported in the 12 months to 31 March 2024 is 3,119.

Service Line	Category	Total
Finance	Accidents & injuries	3
	Fire	1
	Welfare	1
	Total	5
Medical	Accidents & injuries	1
	Equipment: non-clinical	1
	Security	1
	Slips, trips, falls	1
	Total	4
People	Accidents & injuries	2
	Slips, trips, falls	1
	Welfare	1
	Total	4
Quality, Innovation & Improvement	Accidents & injuries	1
	Equipment: non-clinical	1
	Violence & aggression	1
	Total	3
Service Delivery	Accidents & injuries	825
	Equipment: non-clinical	158
	Fire	7
	Moving and handling	212
	Security	82
	Slips, trips, falls	193
	Violence & aggression	1,419
	Welfare	207
	Total	3,103
Overall total		3,119

Non-clinical incidents by directorate. Data source: DCIQ last accessed 04/04/2024.

There has been a reduction in health, safety, security and fire incident reporting since the COVID pandemic, from 10,052 in 2021/22 to 7,034 in 2022/23. In the reporting period for this report to 31 March 2024, there has been 3,119 incidents reported which signifies a further drop.

There are two key factors why non clinical incident reporting has dropped:

- Health, Safety, Security & Fire incident reporting increased significantly during the COVID19 pandemic years, and this is a return to non-pandemic reporting levels.
- We have transitioned to a new incident reporting system DCIQ which has refined the recording of incidents to make the categorisation more accurate.

Work is ongoing to ensure that health, safety security and fire incident reporting is reviewed, and the data shared with Trust Management Committee. Each directorate is expected to review the nature of these incidents at the appropriate level of scrutiny and themes fed through as learning and as part of the Directorate chair report to the Health, Safety, Security and Fire subcommittee.

2.2.1 Non-clinical incident themes

Analysis of the themes from non-clinical incidents arising in the year to 31 March 2024. The top three health, safety, security and fire incident themes are:

- Accident and injuries: 841
- Moving and Handling 217
- Slips trips and falls:197
- Violence and aggression incidents reported: 1,423

2.3 Violence prevention and reduction activity

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).
NWAS finds deliberate violence and aggression towards our staff or people 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 the prevalence and risk of harm.

2.3.1 Security Standards

The NWAS Violence Prevention and Reduction policy seeks to provide:

- Positive and proactive care to the people who use our services, and
- Create a supportive and safe environment for staff to work in.

The standards describe the activities that will support the reduction of violence and commits to keep staff safe in the workplace. There are 57 security standards that if compliant, evidence the commitment to prevention and reduction of violence in the workplace. The November 2023 Health, Safety, security and Fire subcommittee received an assurance report NWAS demonstrating high compliance (74%). The NWAS self-assessment of compliance was peer reviewed and therefore we can be confident of the current compliance position.

It should be noted due to a change in management personnel, resulting in a reduction of capacity the group has not met since Q3 2023/24 with a residual impact that the activities required to complete compliance with the

standards have not progressed as anticipated. A corresponding risk was identified and held on the directorate risk register. A mitigation plan has been developed including the recruitment of a dedicated VPR team.

2.3.2 Violence and aggression markers

Violence and aggression markers are attached to patient records where staff have reported an incident of concern. We use these markers to inform staff attending the patients are alert to the potential of harm. The presence of a marker does not negate the need to undertake a dynamic operational risk assessment (DORA) of the incident staff are attending. Similarly, the absence of a marker does not mean a DORA should not take place.

The markers accuracy and status is managed by the HSSF team. On 31 March 2024 the number of patients with an active violence and aggression marker was 1,070, and a further 387 patients had temporary violence and aggression in place whilst more information is gathered to inform the marker length and description of severity.

During the year the patients whose violence and aggression markers have been in place for 12 months are reviewed to determine if the marker should be extended for another 12 months - this is in addition to patients being identified in year as potentially violent and aggressive. 1,006 patients with violence and aggression markers in place were reviewed to determine if the marker can be made redundant or extended for 12 months.

3. Regulatory reform (fire safety) order 2005 assurance (FSA)

The Regulatory Reform (Fire Safety) Order 2005 (FSO) is the main piece of legislation governing fire safety in buildings in England and Wales. The FSO applies to all workplaces. It places legal duties on anyone in control of these premises to undertake a fire risk assessment and put in place and maintain general fire precautions. safety risk assessments (FSAs). In law there are no specific time periods for how often fire risk assessments (FRA) must be done or reviewed. It states that the ‘responsible person for assessments in your building must review it 'regularly' to make sure it's up to date. There are three levels of fire risk assessment that take place at site level:

- The Health, Safety, Security, and Fire (HSSF) team undertake fire risk assessment reviews at each NWAS site on behalf of the trust. Current risk assessment schedule means that in a three year cycle each site will receive at least one FRA review.
- Up to three times each year every operational site receives a workplace inspection (WI) of health, safety and security which includes a simplified assessment of fire risk which exceeds the minimum safety questions as described in 5 step fire safety risk assessment as issued by the Home Office https://www.gov.uk/workplace-fire-safety-your-responsibilities/fire-risk-assessments.
- Additionally, Quality Assurance Visits (QAV) take place annually at each operational site. The content of the QAV, includes elements of the FRA and where standards are not met actions are identified and included in the summary report.

The actions identified from the WIs, FRAs and QAVs are collated onto the integrated action tracker (IAT) and Estates system Concerto (where applicable). The new reporting system tracks issues within the organisation. It is a user-friendly tool specifically designed to simplify the reporting process for staff.

3.1 Risk mitigation on fire.

There are six risks relating to fire that are in the Trust Risk registers. All have mitigation in place with work ongoing work to strengthen that mitigation.

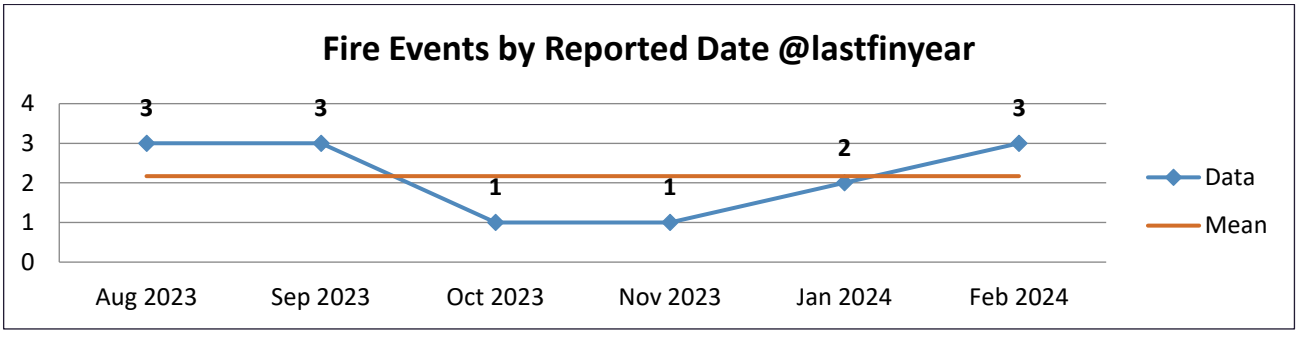
Two of these relate to an emerging national increase in fires involving lithium-ion batteries and electric vehicles. This risk was raised by NWAS Operational Commanders who had received intelligence on the subject as part of their Continuous Professional Development. From an NWAS perspective these have been themed as Lithium-Ion Battery fires that may affect our premises or vehicles and a second risk that identifies the dangers that our responding staff may face when responding to any incident that involves lithium-ion battery such a Road Traffic Collision which is a daily occurrence.

There is a risk that due to inconsistencies in the checking and recording of fire checks as required by the Fire Safety Order, the organisation will not receive assurance leading to a breach in the Fire Safety legislation, potentially resulting in harm to staff, visitors and loss of assets. Efforts are underway to standardise and improve systems and processes to reduce this risk.

3.1.1 Fire Safety Review

During 2023/24, there were 0 fire near-misses reported. There were **13** fire related incidents reported this is compared with 10 during the same period for 2022/23:

- **5** incidents related to fire: detection,
    - 2 at Broughton EOC, during estate works
    - 1 at an ambulance station due to poor housekeeping
    - 1 at Haydock workshop in the battery room
    - 1 at Estuary Point, a lit cigarette as found in the bin within a toilet cubicle.
- **5** incidents related to fire: extinguishing equipment
    - 2 incidents - NWAS crews have assisted with a non-NWAS vehicles on fire
    - 3 incidents, fire extinguishers knocked and set off in the vehicle cab
- **3** incidents related to the fire alarm sounding on ambulance stations and required evacuation.



Fire Risk Assessments:

- Currently, there is 3 year rolling programme of a formal Fire Risk Inspection being undertaken by a Senior Health, Safety, Security & Fire Practitioners, 48 sites were audited during the report period
- Work is continuing to improve the frequency and standardisation of the undertaking and recording of our statuary weekly fire checks which are undertaken by Operational and Corporate Teams.
- The Fire Risk Assessments identified some common themes for non-compliance of the weekly fire checks including:
    - Fire evacuation drills not being conducted, across both Corporate and Service Delivery sites.
    - Failure to perform fire alarm checks, fire extinguisher checks.
    - damaged fire doors or fire doors being held open by fire extinguishers.
    - electrical equipment being charged amongst combustible material.
    - a lack of assurance on the annual checks of fire alarm.

General Advice Provided:

- **Emergency Procedures:** NWAS must continue to test emergency procedures through regular drills and ensure the trust has the appropriate number of competent people to assist in evacuation of the premises.
- **Staff Training:** NWAS must ensure that the training that is given to staff is repeated periodically in line with recommendations of the FRA.

4. MHRA: Central Alerting System

The MHRA issues notices of safety alerts from the Central Alerting System (CAS). The alerts are managed centrally by the nominated CAS officer who as appropriate assigns them to the responsible manager. Safety alerts received by the trust are notified to the NWAS Board of Directors through the integrated performance report.

CAS: Safety Alert Originating Authority	Number of Alerts received	Number of Alerts applicable
CMO Messaging	2	0
National Patient Safety Alert: DHSC	7	1
National Patient Safety Alert: MHRA	5	1
National Patient Safety Alert: NHSEI	1	0
National Patient Safety Alert: UKHSA	1	0
National Patent Safety Alert: Office for Health Inequalities	1	1
National Patient Safety Alert: Patient Safety	1	
Total	18	3

Safety alerts received through Central Alerting System correct to 31/03/2033 last accessed 30/04/2024.

4.1 National Patient Safety Alert ref: *NatPSA/2023/010/MHRA*

Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from falls or entrapment.

Recommendation 1: Updating policies and procedures on procurement, provision, prescribing, servicing and maintenance of these devices in line with the MHRA's updated guidance on management and safe use of

bedrails. Fleet reviewed policies to confirm any gaps with updated MHRA guidance. Procurement confirmed their policies focus on compliance with BS EN 1789

Recommendation 2: Develop a plan for all applicable staff to have training relevant to their role within the next 12 months with regular updates. All training should be recorded: NWAS Mandatory training lead, has been provided with the information on trollies etc included in induction training to look at incorporating into manual handling mandatory training slides. Union representatives supported the review. Additional questions are to be added to DORA regarding patients being placed back into 'hospital' beds at home with bedrails – risk assessing safe positioning, safe environment etc, any safeguarding concerns.

Recommendation 3: Review medical device management system for your organisation for devices, including those which have been provided to a community setting. Keep this system up to date. Fleet have provided evidence of asset register. Work in progress around maintaining the register and tracking equipment.

Recommendation 4: Implement maintenance and servicing schedules for the devices in the inventory/database, in line with the manufacturer's instructions for use. Prioritise devices which have not had regular maintenance and servicing. Copy of e-form and servicing schedule provided.

Recommendation 5: Review patients who are children or adults with atypical anatomy as a priority. Ensure the equipment they have been provided with is compliant with BS EN 50637:2017 unless there is a reason for using a non-compliant bed. Record this on the risk assessment and put in place measures to reduce entrapment risks as far as possible. This is divergent due to the nature of the business. The procurement team have confirmed the stretchers in use and future purchases are compliant with EN-1789 (Medical vehicles and their equipment: Road ambulances).

Recommendation 6: Review all patients who are currently provided with bed rails or bed grab handles to ensure there is a documented up-to-date risk assessment. Complete risk assessments for patients where this has not already been done and for each patient who is provided with bed rails or bed grab handles.

Recommendation 7: Implement systems to update risk assessments where the equipment or the patient's clinical condition has changed (for example, reduction/improvement in weight or mobility), and at regular intervals.

Mitigation in place is limited. Generally, the patients are not left unattended on an ambulance trolley, and when on the hospital corridor received 121 or 221 supervision.

Additionally, three risks have been identified and are managed through the Trust incident management system. In brief:

- 598: Cohorting of patients and risk assessments
- 599: Third party provider compliance
- 600: PTS exposure to beds in the community.

4.2 National Patient Safety Alert ref: *NatPSA/2023/009/OHID*

Potent synthetic opioids implicated in heroin overdoses and deaths. Several actions were taken.

- Stock levels monitored through liaison with Regional Procurement Pharmacist
- Liaison with Emergency Operational Control Managers to ensure shared understanding is in place regarding the rapid deterioration of patients

- Regional NWAS bulletin issued to communicate process of diagnostic operational risk assessments are enacted and that equipment such as atomisers are available for intranasal administration of medicines.
- Actions shared with third party providers and the NWAS lead for North West Air Ambulance.

4.3 National Patient Safety Alert ref: *NatPSA/2024/003/DHSC*

Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials. Actions taken include:

- Engagement with local and national pharmacy teams – some stock is ringfenced for ambulance use.
- Reminder to staff to consider the use of the patients own inhaler to manage mild and moderate asthma as per ambulance guidance in JRCALC.
- If the patient treatment is compromised due to stock levels staff are reminded to contact the Complex Incident team for advice and support.

5. Estate and Facilities Management

5.1 Provide and maintain a clean environment

The Facilities and infection prevention and Control (IPC) teams monitor the cleanliness of sites and vehicles through a series on regular audit. The IPC team involved in the planning of new buildings and the refurbishment of existing premises to ensure that they meet IPC requirements.

To support staff there are policies and procedures in place to inform staff of their responsibilities in relation to cleaning and decontamination. In addition, there is a six-week regular cycle of deep cleaning of all vehicles.

5.2 Ventilation

The Estates, Fleet and Facilities management (EFFM) team hold responsibility for assessing and ensuring appropriate ventilation is in place for NWAS Estate and vehicles. Ventilation assurance has been central to providing a safe working environment for NWAS staff, and is carried out in line with national guidance. The EFFM team were charged to provide an annual assurance report to NWAS Health, safety and security sub-committee as a feature of the 2023/24 workplan.

5.2.1 Ventilation: Non-clinical staff face fit testing

The Fleet workshop team have the potential to be exposed to substances hazardous to their health. The actions workshop team, led by a trained assessor, has ensured staff members have access to appropriate respirators through regular face fit testing. Every member of the fleet team has access to appropriate respiratory protection. A regular cycle of face fit testing for non-clinical staff take place for those who require respiratory protective equipment for their role. There are 60 eligible staff, including six new starters who are currently awaiting testing. The overall compliance on 31 March 2024 is 88%. This will be 100% within quarter one of 24/25.

5.2.2 Ventilation: Estate

The Environment and Modelling Group of the Scientific Advisory Group for Emergencies (SAGE-EMG) assessed the ‘Role of ventilation in controlling SARS –CoV-2 transmission’. Evidence continues to suggest that in poorly ventilated indoor spaces airborne aerosols are a possible transmission route and precautionary advice remains valid. The HSE issued guidance in support of this. Professional CO_2 Testing Devices have been purchased in year and Estates Managers use these to test the air quality in call centres to ensure the air conditioning system

is working efficiently. The Estates, Fleet and Facilities management (EFFM) team undertook audits to assess the carbon dioxide concentrations at high-risk sites and were able to provide positive outcome audit and assurance statements to the Health Safety and Security sub-committee as required during 2023/24.

5.2.3 Ventilation: Vehicles

The EFFM team central log of vehicles in use across the trust, describes the ventilation system in each. EFFM in conjunction with operational leads across PTS and PES has issued guidance to support staff in ensuring the vehicle is ventilated whether in the saloon or the cab. The guidance explains the heating and ventilation methods as they are different depending on vehicle type.

All NWAS PES double crew ambulances (DCA) are fitted with air exchange systems that exchange the air in the saloons over 40 times per hour whilst in operation. This is significantly higher than the CEN regulations which require an air exchange 20 time per hour within the saloon. For assurance, these systems are checked by fleet every 8 weeks on safety check maintenance.

5.3 Estates and Facilities Compliance

The Estates and Facilities team carry out compliance audits on all NWAS owned properties to ensure the sites remain safe, clean, well maintained and all associated equipment are in a safe operational condition. The team ensures that appropriate maintenance and inspection records are held centrally and complies with statutory legislation.

The main areas covered in relation to HSE legislation include but are not limited to the management of; asbestos, water safety, gas & electrical safety, portable appliance testing, air conditioning and air monitoring safety with planned preventative maintenance in addition to reactive maintenance undertaken in line within current contract specifications. The Estates Team are currently carrying out a facet survey of the owned and long-lease properties of the Trust. This work (to be completed during Q1) will assess the physical condition of the Estate. A report will be produced for each property that will show the level of repairs needed to bring the property to an acceptable standard and the remaining life of the key elements of the property. This information will help the Estates team to target capital spending into the most appropriate properties. The information will also be useful to the finance team when developing business cases for re-location of services and new buildings.

6. Hazardous Area Response Team: National Ambulance Resilience Unit

Hazardous Area Response Teams (HART) are comprised of specially recruited personnel who are trained and equipped to provide the ambulance response to high-risk and complex emergency situations. The teams work alongside the police and fire and rescue services within the inner cordon of a major incident. The team role is to triage and treat casualties in extreme and challenging circumstances.
To provide a safe and robust response to patients caught in such environments, requires three elements: a Standard Operating Procedure (SOP) to work to, training in the discipline being employed and appropriate equipment, serviced and maintained to industry standards.

To that end the Head of Special Operations provides assurance on a quarterly basis to the sub committees for Emergency Planning, Resilience and Response (EPRR) and Health Safety and Security (HS&S) that the capabilities are managed, trained, and equipped appropriately.

6.1 HART Learning from incidents: vehicle incident / failure resulting in a Road traffic Collision (RTC)

The learning from a HART vehicle failure was shared both nationally as it had the potential to occur across the country and locally to establish if we could improve our processes. In January 2024 an RTC occurred between two Primary Response Vehicles (PRV) whilst travelling on a motorway to an emergency call. Initial reports suggested the vehicle in front reduced speed quickly in lane 3 for no apparent reason, causing the vehicle behind to drive into the rear of the first vehicle. The driver of the first vehicle reported a complete loss of power causing the vehicle to lock up and slow down. Once hit from the rear the vehicle started again. Thankfully staff were uninjured and the damage to the vehicles was minor. Fleet dept. commenced an investigation but could not replicate the fault reported. The vehicle was subsequently returned to HART a week later.

Two weeks later a similar event was reported on a different vehicle at the other station. Again, thankfully there were no injuries or an RTC on this occasion. A second incident report initiated an urgent case conference between HART Ops Management and Fleet management. It was agreed to withdraw the PRVs from service and operate a different response model while the incidents could be investigated further.

As the HART fleets are consistent around the country, a National Safety Alert was issued by NWAS to all Ambulance Trusts via NARU informing them of the issues. All six PRVs were immediately referred to main dealers for full diagnostic assessment. Over the next 8-day period all vehicles were assessed.

A report was received within the week outlining their diagnostic findings. A bracket and connection on the battery linking much of the specialist equipment requiring power on the PRV had been found to have loosened. The original incident was believed to have rectified itself when the vehicle was hit from the rear hence not being able to replicate it. To ensure no repeat, all PRVs had now had their connections secured but it was recommended that they were checked as part of the regular servicing.

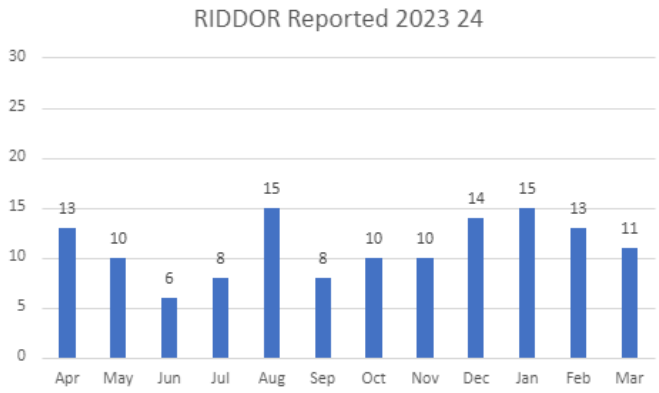
The findings and recommendations were sent to NARU to allow for an updated National Safety Alert to be issued to all Ambulance Trusts. All Trusts were able to assess their own PRVs (circa 60+ nationally) to mitigate any potential risk and future reoccurrence.

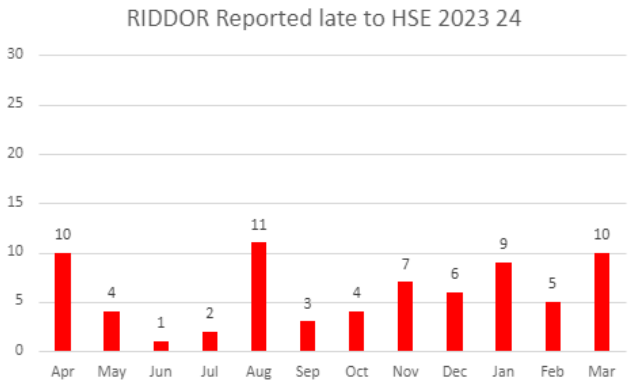
7. Quality Strategy Assurance

7.1 Objective 1: RIDDOR Reporting

RIDDOR incident reports are completed **within 15 days of knowing about the incident** via Datix.

The number of RIDDOR (non-disease) incident reports received in 2023/24 was 133, and of these 61 were reported to the HSE within 15 days of the incident lodged in DCIQ.

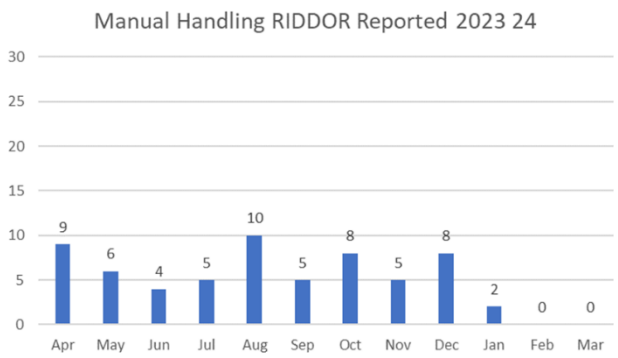


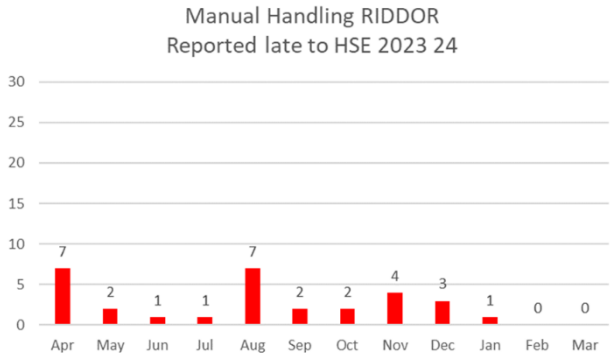


Outcome: Without exception the delayed reporting under RIDDOR was due to the late reporting of the incident within the incident reporting system and therefore to the HSSF team.

7.2 Objective 2: Deep Dive audit on manual handling during 2023/24.

The 2023/24 manual handling incident analysis took place in January 2024 and 62 incidents were reported to the HSE.





Analysis identified that whilst there were late reports of incidents meeting the RIDDOR threshold were made, these were predominantly delayed by one or two days. The themes arising from the reports are as follows:

- Human: cumulative back issue, difficult extraction, patient movement.
- Equipment: use of aids, lifting defibrillators, lifting response bags
- Environmental: confined spaces

Training is the primary mitigation in place for manual handling issues. Corporate ‘desk based’ staff are required to undertake moving and handling learning programmes via ESR modules and to regularly update DSE assessments for both work and home working as appropriate. Each service line holds a generic risk assessment. In addition to the corporate training – fleet staff receive additional training about the ramp replacement programme. Operational staff members receive in addition to the ESR modules, face to face training on induction and as part of the annual training programme.

Reactive support is also available to staff members in the form of easily accessible welfare offers – located on the NWAS intranet site or through occupational health intervention and support.

The manual handling audit identified several recommendations including:

- Focus on preventative injury through manual handing training
- Complex needs and bariatric training for frontline staff as part of mandatory programme
- Regular manual handling training for 'hidden services':
    - Fleet teams: Engineers and technicians,
    - Logistic teams: including couriers and warehouse/stores
    - Medicine hub
- Additional manual handling equipment investment for frontline services, particularly in the patient transport service.

8. Resourcing and Engagement

8.1 Team Resourcing

Between April and June 2023 3 HSSF Officers were appointed. There were still outstanding vacancies for a Senior HSSF Practitioner overseeing CAM, a specialist Manual Handling Practitioner and the Head of HSSF.

Despite these issues, the HSS team have continued to provide support and advice for staff to maintain their health, wellbeing and safety whilst meeting their key objectives for the year whilst at the same time developing and improving relationships with staff-side, TU colleagues and Estates etc.

8.2 HSS Engagement: Sector Partnership (SPG) and Service Line HSS meetings

The team, in addition to their active responsibilities in site audits, RIDDOR management, violence and aggression marker review and general HSSF advice they attend local level (SPG meetings – three times a year) and service line HSSF meetings (PES, PTS, Estates, Fleet and Facilities Management et al). Despite the current unfilled vacancies in the team, they have continued to provide virtual advice and support to their colleagues across NWAS.

8.3 Trade Union Engagement: Joint Statement

The HSSF corporate team would once again like to thank our join trade unions for the supporting the safety agenda through undertaking workplace inspections. The support we received this year was significant and we would not be assured of the high level of site and staff safety without your help.

The joint trade unions within NWAS are committed to ensuring a safe and healthy working environment and that any risks are properly controlled. Although NWAS as an employer is legally responsible for ensuring a safe workplace, we all have a part to play. It is vital that any near misses or untoward incidents are reported. As well as raising concerns via the DCIQ system, staff are encouraged to discuss any issues with their union health & safety representative.

The joint trade unions and NWAS health and safety team are committed to continuing our excellent partnership working to ensure the safest possible environment for our staff and patients.

8.4 Guidance and Policy Review

In the 12 months to 31 March 2024, the following documents were reviewed and updated:

- Security Procedure

- Generic Risk Assessment 016 Merit
- DSE Procedures
- Generic Risk Assessment 001 Ambulance Stations
- Generic Risk Assessment 004 Integrated Contact Centres
- Generic Risk Assessment 006 Offices
- COSHH Assessment for Nitrous Oxide

All HSSF policies and guidance are subject to open consultation, historically as part of the standing agenda item at the health, safety, and security sub-committee; the practice being the papers come first for notice of consultation and six months later for sign-off.

Additionally, several guidance documents were developed by the HSSF Officers, and these were also received and approved at the HSSF sub-Committee:

- RIDDOR Guidance (updated)
- Violence and Aggression incident reporting flowchart
- Muscular Skeletal Disorder associated with driving guidance

8.4.1 Independent Audit: Merseyside Internal Audit Assurance MIAA

MIAA were commissioned with the overall objective to provide assurance that the Trust is complying with its Health, Safety & Security Policy (including H&S checks) and it is being operated consistently across the organisation. The auditors reached the conclusion that there was substantial assurance in there is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

8.5 HSE Inspection

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

9. Governance

The Quality and Performance Committee established the Health, Safety and Security subcommittee to provide assurance on matters relating to health, safety, and security on behalf of NWAS. The subcommittee's duties include:

- Obtaining and providing assurance that standards of HSSF as a minimum comply with legal requirements and NWAS policy. That these standards are established and maintained.
- Overseeing HSSF arrangements including those regarding the management of violence and aggression.
- Receiving reports, obtaining, and providing assurance there is a proactive approach to the management of HSSF in all locations where NWAS staff operate.

- Receiving reports from safety representatives, specialist advisors, management, HSE and local authority inspectors where required, such as but not limited to those associated with COSHH, RIDDOR, Fire Safety and Buildings, moving and handling, and security (violence and aggression).
- Reviewing risks identified on the Corporate Risk Register pertaining to HSSF. Providing assurance in relation to areas of high-level safety

A key element of the HSS subcommittee effectiveness is the partnership working with the joint trade unions. The subcommittee has been in place for 12 months and its membership has undertaken an effectiveness self-assessment. The results were favourable overall, responders acknowledged there are improvements still to be made, in terms of assurances received from HSS groups and clarity of responsibility between corporate and local operational teams. Positive comments include all attendees being given a voice and listened to in the meeting, and the continuous improvement of the HSSF assurance reports received.

10. Direction for 2024/25

The direction for 2024/24 and the associated forward plan will be provided at a later point by the current Head of Health, Safety, Security and Fire, with support from the Corporate Affairs Director.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Monday, 24 June 2024
SUBJECT	Safeguarding Annual Report 2023/24
PRESENTED BY	Emma Orton, Assistant Director of Nursing and Quality
PURPOSE	Assurance

LINK TO STRATEGY	Choose an item.									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☐
	Financial/ Value for Money	☐	Reputation	☒	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Receive the assurance that NWAS safeguarding activity during 2023-24 continues to meet our statutory requirements.
EXECUTIVE SUMMARY	This Safeguarding Annual Report provides an overview of safeguarding activity within the Trust in 2023/24. Key assurance points to note: **Safeguarding activity** has remained consistent throughout this financial year. A total of 33,298 safeguarding and early help referrals were made during 2023/24 compared to 42,227 in 2022/23. Safeguarding referral numbers have decreased over the last year, likely to be attributable to a number of different factors, including a review of the safeguarding training needs analysis (TNA) which resulted in more staff aligned to level 3 and the introduction of mental health and social prescribing pathways.

Assurance in relation to the quality of NWAS referrals is now monitored in two ways:

- We report on referrals rejected by our Local authorities via the Cleric system. The referral rejection rate remains less than 3% of all referrals made. Further analysis is provided within the body of this report.
- Following an audit of referrals rejected by the Support Centre, we have strengthened our quality assurance processes. The audit identified the potential for missed opportunities to make a safeguarding referral, which is reflected on the Risk Register (#635). From June 2024, Support Centre staff will record all referrals on a Cleric form, with those deemed not to meet the safeguarding threshold to be passed electronically to the Safeguarding Team for additional oversight.

Safeguarding Audits Safeguarding audits are carried out for repeat safeguarding children's concerns and domestic abuse. Information is escalated to multi agency partners where necessary.

Safeguarding Training – A full review of the Safeguarding Training Needs Analysis has now been undertaken to ensure that newer roles are aligned with the Safeguarding Children and Young People: Roles and Competences for Health Care Staff and Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Documents. At 31.3.24, the Learning and Development Team report overall safeguarding training compliance as >90%. Further analysis is provided within the body of this report.

The need to provide bespoke, participative training to our Integrated Contact Centres (ICC) and corporate staff to ensure full, trust-wide compliance is reflected on the Risk Register (#636). Roll out of these sessions is planned for Q2 2024/25.

Prevent Training – At 31.3.24, the Learning and Development Team report overall safeguarding training compliance with Prevent Basic Awareness as 91%. Compliance with Level 3 Prevent training is reported as 81%, requiring additional focus during Q1 2024/25.

Safeguarding case reviews – The Safeguarding Team continue to meet our statutory duties in relation to Safeguarding Adult Reviews (SAR's), Local Child Safeguarding Practice Reviews (LCSPR's) and Domestic Homicide Reviews (DHR's). Further analysis is provided within the body of this report.

Allegations Against Professionals – the policy has been reviewed and updated. A dedicated email inbox is now in place to receive all referrals. Collaboration with Human Resources, Operational Leads and the Freedom to Speak Up Guardian, allows us to share intelligence appropriately and to complete joined up risk assessments on a case-by-case basis. Further analysis is provided within the body of this report.

Project Emerald - The Safeguarding Team continue to monitor the Cleric referral system and to ensure continued, positive engagement with social care partners. Phase two of the project is underway and we are working with the Business Intelligence (BI) Team to create a safeguarding dashboard which will enhance our reporting ability.

Private Providers – The Safeguarding Assurance Framework (SAF/Section 11) document was issued to all private ambulance providers at the end of 2023 and the requirement to complete this and to submit the appropriate evidence is reflected in private provider contracts. Work is currently underway to quality assure the submissions and agree action plans as required. Going forward, the submission will be requested from our private providers on an annual basis.

Communication – There is now a dedicated Safeguarding "landing page" on the Green Room aimed at providing our staff with easily accessible safeguarding information and support. This resource will also be added as an additional iPad app for our crews.

Partnership Working - During 2023/24, NWAS engaged with two separate Joint Area Targeted Inspections (JTAI's) into Serious Youth Violence (SYV) in Manchester City Centre and the Lancashire region. Inspection findings were that while NWAS has a significant, reactive response to SYV, our ability to participate in proactive system working is limited due to our large geographical footprint.

	Safeguarding Interface with Key NWAS Workstreams - Collaborative working with the NWAS Patient Safety Incident Response Team (PSIRF) has seen safeguarding oversight increasingly embedded within patient safety processes. The Safeguarding Team now have access to all patient safety events and are thus involved in all aspects of the process from initial event reporting, through to attendance at the Complex Case Review Group (CCRG) and Patient Safety Event Committee (PSEC). This affords up the opportunity to consider a patient safety event through the safeguarding lens and to identify any missed opportunities to safeguard children and adults at risk.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee and Quality and Performance Committee	
	Date	19th June 2024 and 24th June 2024
	Outcome	Approved for onward submission to Board of Directors

2.1 THE SAFEGUARDING TEAM

The team currently comprises the Head of Safeguarding, four Safeguarding Practitioners who cover specific areas across the NWAS geographical footprint, as well as providing safeguarding support to our Integrated Contact Centres (ICC). A secondment post to cover maternity leave, initially to February 2024 is currently extended until June 2024. There are also two Administration Support Officers (1.8 whole time equivalent) within the team. Safeguarding referrals by NWAS staff continue to be made via the Support Centre in Carlisle and are sent electronically to the appropriate local authority using the Cleric referral system.

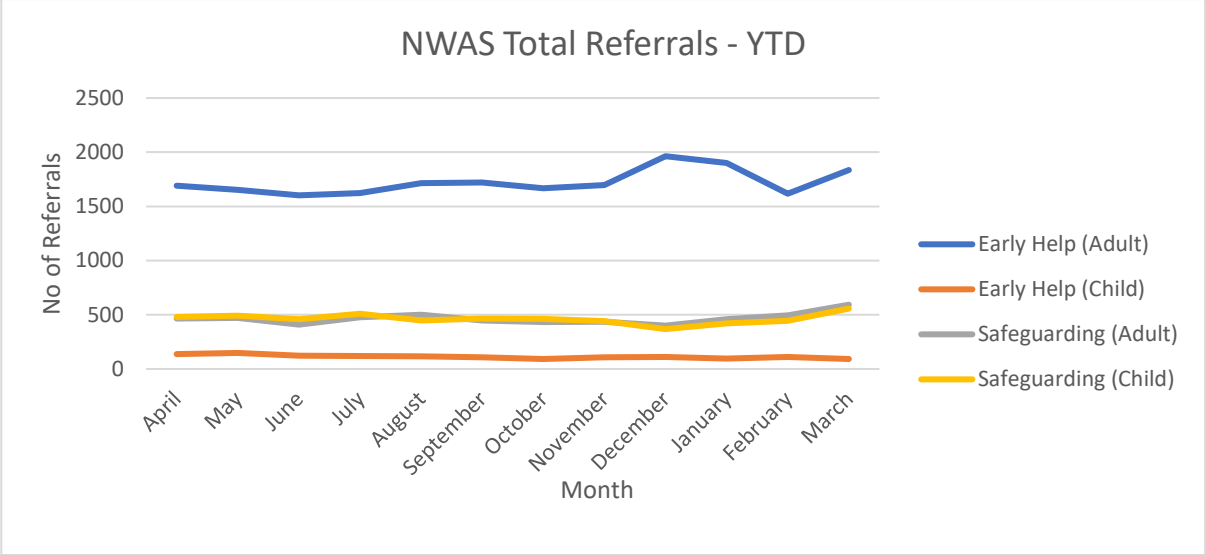
2.2 SAFEGUARDING ACTIVITY

The team currently comprises the Head of Safeguarding, four Safeguarding Practitioners who cover specific areas across the NWAS geographical footprint, as well as providing safeguarding support to our Integrated Contact Centres (ICC). A secondment post to cover maternity leave, initially to February 2024 is currently extended until June 2024. There are also two Administration Support Officers (1.8 whole time equivalent) within the team. Safeguarding referrals by NWAS staff continue to be made via the Support Centre in Carlisle and are sent electronically to the appropriate local authority using the Cleric referral system.

NWAS makes safeguarding referrals to 27 local authorities within the geographical footprint. Referrals are made electronically via our Support Centre in Carlisle to the appropriate local authority. During 2023/24, NWAS made 33,298 Safeguarding and Early Help referrals. This is a decrease of 8,939 compared to 2022/23, likely to be attributable to a number of different factors, including a review of the safeguarding training needs analysis (TNA) which resulted in more staff aligned to level 3, thus potentially improving safeguarding knowledge and confidence. There is now a greater understanding of mental health pathways and this along with the introduction of the social prescribing pathway, provides alternative routes to access the most appropriate support for our patients.

The number of referrals rejected by local authorities is less than 3%, indicating that the safeguarding information we share is of a high quality.

The tables below detail the referral activity for 2023/24.



Referral Activity 2023/24

	Adult SG	Adult EH		Child SG	Child EH		Total
Apr 23	463	1689		480	138		**2770**
May 23	472	1652		491	145		**2760**
June 23	415	1618		467	126		**2626**
July 23	478	1568		509	121		**2676**
Aug 23	500	1714		448	114		**2776**
Sept 23	448	1720		465	106		**2739**
Oct 23	443	1698		468	95		**2704**
Nov 23	434	1697		442	109		**2682**
Dec 23	400	1963		368	110		**2841**
Jan 24	473	1973		432	99		**2977**
Feb 24	495	1618		444	113		**2670**
Mar 24	593	1835		557	92		**3077**
Grand Total							**33298**

Assurance in relation to the quality of NWAS referrals is now monitored in two ways:

- We report on referrals rejected by our Local authorities via the Cleric system. The referral rejection rate remains less than 3% of all referrals made, with most rejected referrals requiring redirection to a different local authority.

- Following an audit of referrals rejected by the Support Centre, we have strengthened our quality assurance processes. The audit identified the potential for missed opportunities to make a safeguarding referral, which is reflected on the Risk Register. From June 2024, Support Centre staff will record all referrals on a Cleric form, with those deemed not to meet the safeguarding threshold to be passed electronically to the Safeguarding Team for additional oversight. This process will also enable identification of themes and areas of the organisation requiring specific safeguarding support and will give the Safeguarding Team the opportunity to provide meaningful feedback to our workforce.

2.3 TRAINING

Safeguarding training compliance is monitored closely by the Safeguarding Team on an ongoing basis. At 31.3.24 the Learning and Development Team report overall safeguarding training compliance (levels1-3) to be >90%. See table 2 below.

Table 2 Safeguarding Training Compliance 2023/24

	Level 1	Level 2	Level 3
Safeguarding Adults	95.29%	92.94%	94.18%
Safeguarding Children	95.22%	91.67%	95.32%
Prevent Basic Awareness	91%	N/A	81%

Level 1 & Level 2 safeguarding is delivered through e-learning packages which are accessed via My ESR. The induction training package for Level 1 – 3 has been reviewed this year and can be utilised across all service lines.

Level 3 safeguarding training is delivered across multiple platforms. Those staff who have been identified as requiring level 3 safeguarding training on the training needs analysis, are required to complete 13 hours of training over a three-year cycle. Patient facing staff receive their level 3 training via the mandatory training programme.

Level 4 training: The Head of Safeguarding, Assistant Director of Nursing and Quality and the Safeguarding Practitioners are all compliant with level 4 training this year.

Safeguarding training for ICC staff was historically supported face-to-face by the Safeguarding Team. However, as the service (and subsequently the workforce) has increased, this has become more challenging both in terms of releasing staff for face-to-face sessions and also due to limited capacity within the Safeguarding Team to train sufficient numbers of ICC staff. A review of the training needs analysis has therefore been undertaken to ensure that newer roles are aligned with the Safeguarding Children and Young People: Roles and Competences for Health Care Staff and Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Documents.

In agreement with the Learning and Development Team and ICC operational leads, additional E-Learning for Health (ELfH) safeguarding modules are now accessible to ICC staff via ESR, which provides 50% of overall compliance. Moving forward, we are working with Learning and Development Team, ICC Operational Leads and our Communications Team to develop additional, participative training sessions required to ensure that full compliance is achieved. Roll out of these sessions is planned for Q2 2024/25. This is reflected on the Trust Risk Register.

2.4 PREVENT TRAINING

Due to the mandatory, rigid data set required by NHS Digital, the Q2 Prevent Duty Return was, in agreement with Lancashire and South Cumbria ICB, submitted based on approximations. In collaboration with the Learning and Development Team, this has now been resolved and from Q3 onwards, we have been in a position to submit returns of a high quality. At 31.3.24, the Learning and Development Team report overall safeguarding training compliance with Prevent Basic Awareness as 91%. Compliance with Level 3 Prevent training is reported as 81%, requiring additional focus during Q1 2024/25.

During 2022-2023 the Trust has made 12 PREVENT referrals to the regional anti-terrorism teams, a reduction from the 17 referrals the previous year. Feedback has been received for some of the referrals made, and this has been sent out to the Trust staff who raised the referral.

2.5 PROJECT EMERALD

The Safeguarding Team continue to monitor the Cleric referral system and to ensure continued, positive engagement with Social Care partners. Phase two of the project is underway and we are working with the BI Team to improve our data reporting ability and to create a safeguarding dashboard which to support identification of themes and trends, by abuse type and geographical area.

2.6 SAFEGUARDING AUDITS

The Safeguarding Team currently carry out two audit cycles a year, focussing on repeat children's safeguarding concerns and domestic abuse. These audits are carried out on a weekly basis by the team to explore any cases where we have multiple concerns raised regarding the same children to ensure that all the necessary services are provided.

The children's audit provides oversight and assurance of collaborative working between Children's Social Care and NWAS. Repeat child concerns are raised when there are three or more concerns raised within a year for a child under the age of 18. When a child is identified as a having had repeat safeguarding concerns raised for them, the Safeguarding Practitioners contact the relevant social care team or the child's social worker and discusses the NWAS contacts and the safeguarding concerns that are raised. This discussion allows planning processes to be agreed between the Trust and the responsible social care organisation. These cases are raised with Children's Social Care to ensure that they are known to services and are being supported appropriately. If they are known in the system, this is highlighted so that we can be assured that the child is being supported and a 'flag' can be removed.

The domestic abuse audit is carried out to ensure that there have been no missed opportunities to raise concerns for the person at risk. It is to provide assurance that staff are reporting appropriately through onward communication with Social Care or the Police and that when domestic violence is witnessed or disclosed then a safeguarding concern has been raised. It also provides the team with the opportunity to review more in-depth cases and to educate staff where needed. These audits also provide assurance that where cases of domestic violence are raised, safeguarding concerns for any children in the family are also raised jointly.

Both audits require the analysis of data and the contacting of the relevant multi agency partners, which for these specific audits would usually be Social Care and the Police.

2.7 SAFEGUARDING POLICIES AND PROCEDURES

Safeguarding policies and procedures have been reviewed and are now available for staff to access on the Safeguarding Resource section of the Green Room.

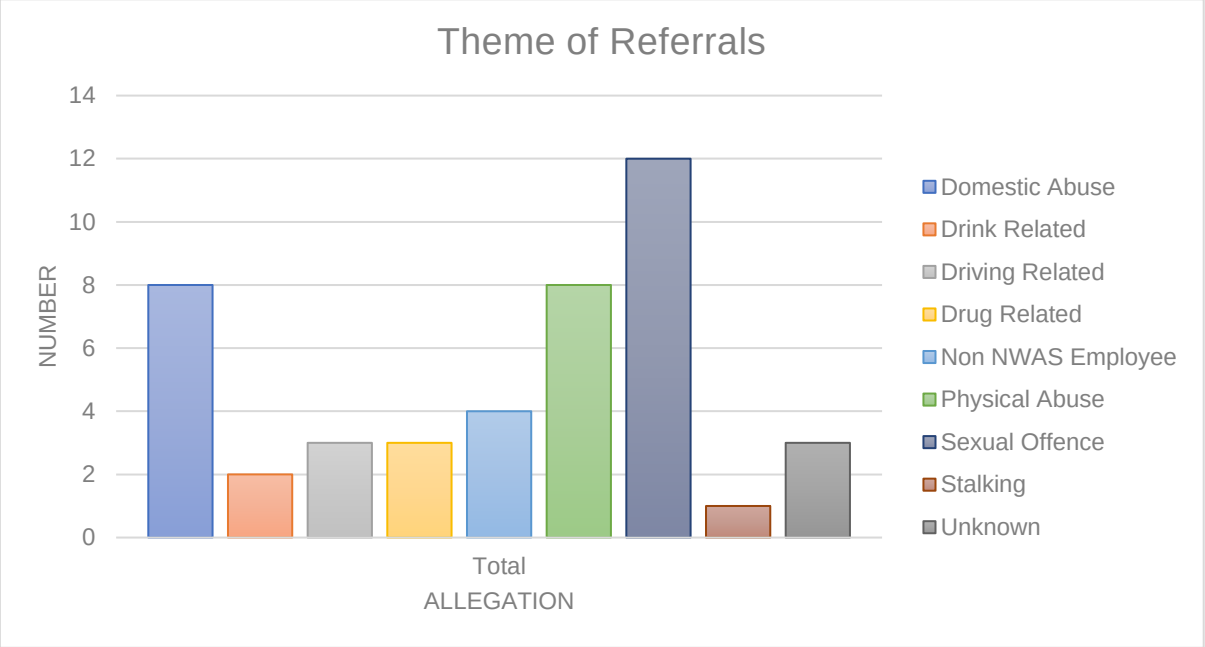
The Allegations Against Professionals policy has been reviewed and the process to manage allegations has been strengthened. A dedicated E-mail inbox is now in place for the Safeguarding Team to receive all referrals and this has been communicated to all operational leads across the Trust. Collaboration with Human Resources, Operational Leads, and the Freedom to Speak Up Guardian allows us to share intelligence appropriately and to complete joined up risk assessments on a case-by-case basis.

We are now able to produce an analysis report in relation to allegations against our staff. This allows us to scrutinise the data to collate themes and trends by geographical area and by service line. Cases are shared with Human Resources as well as the Head of Service for the relevant service line and are also escalated within the Trust as appropriate. All actions are guided by supporting policies and are proportionate to the level of risk to patients and to NWAS staff.

In 2023/24, 44 notifications have been received by the NWAS Safeguarding Team of which 31 have been closed in agreement with the Local Authority Designated Officer (LADO) or Person in a Position of Trust (PiPOT), due to no further safeguarding action required and/or in favour of HR processes. 13 cases currently remain open.

The table below details the themes identified. Allegations of a sexual nature remain the most common referral type, followed by concerns relating to domestic abuse.

Referral Themes



2.8 SAFEGUARDING ASSURANCE FRAMEWORK

The Safeguarding Assurance Framework (SAF) is an assurance document which the Trust is required to complete and return to Commissioners. The SAF asks specific questions of the safeguarding arrangements which are in place within the Trust. The document once agreed, is shared with the 46 safeguarding boards. The safeguarding boards use the NWAS response to form part of their overall multi-agency section 11 report.

Lancashire and South Cumbria ICB have been leading on a piece of work to agree a new set of Safeguarding Key Performance Indicators, to be shared across all five of the ICB's across the NWAS geographical footprint. The first submission is likely to be requested at the end of Q1 2024/25.

2.9 PARTNERSHIP WORKING

During 2023/24, the Trust has engaged in 169 statutory reviews: these are broken down as 96 Safeguarding Adult Reviews, 33 Domestic Homicide Reviews and 40 Local Child Safeguarding Practice Reviews. There has been no significant learning for NWAS from completed reviews although attendance at learning events has generated broad, system-wide learning aimed at overall quality improvement.

The notification of these cases is received from external partners. Greater Manchester remains the area with the most safeguarding activity generated.

In 2023/24, NWAS engaged with two separate Joint Targeted Area Inspections (JTAI's) into Serious Youth Violence (SYV) in Manchester City Centre and the Lancashire region. Inspection findings were that while NWAS has a significant reactive response to SYV, our ability to participate in proactive system working is limited. A recommendation was made following the Lancashire JTAI as follows:

"The contribution of the North West Ambulance Service (NWAS) to the multi-agency response to serious youth violence is negatively affected by their limited capacity and by high demand. The NWAS safeguarding team is unable to support the work of the Violence Reduction Network or the Community Safety Partnership due to the large geographical area they cover. This risks inequitable liaison and joint work and limits the opportunity for NWAS to add value to the partnership."

NWAS engagement with system-wide safeguarding activity remains a challenge due to the large geographical area we cover. In order to make the most effective and equitable use of the resource within the Safeguarding Team, we are working closely with our ICB's to develop leaner ways of working and to ensure that our contributions are meaningful and proportionate.

Each Safeguarding Board/Partnership Board is formally written to on an annual basis by the Head of Safeguarding to inform them of our commitment to engage with the Safeguarding Boards, and to establish good working relationships in each area. A copy of the Trust annual safeguarding report is also shared.

The Safeguarding Team participates with the following panels and sub-groups:

- Child Death Overview Panel
- Rapid Response meetings
- Alternative Life-Threatening Event meetings
- Brief Learning Reviews
- Serious Case Review groups
- Safeguarding Adults Review groups
- Domestic Homicide Reviews
- Front line visits with local board members
- Wider stakeholder meetings
- Multi-agency review meetings following the Sudden Unexplained Death of a Child (SUDC)

- Section 42 enquiry meetings.
- High Risk Patients review meetings.

2.10 SAFEGUARDING INTERFACE WITH KEY NWAS WORKSTREAMS

Collaborative working with the NWAS Patient Safety Incident Response Team (PSIRF) has seen safeguarding oversight increasingly embedded within patient safety processes. The Safeguarding Team now have access to all patient safety events and are thus involved in all aspects of the process from initial event reporting, through to attendance at the Complex Case Review Group (CCRG) and Patient Safety Event Committee (PSEC). This affords us the opportunity to consider a patient safety event through the safeguarding lens and to identify any missed opportunities to safeguard children and adults at risk. Our ability to identify themes/areas of our workforce requiring bespoke, safeguarding support has benefitted from this collaborative working and reduces the risk of duplication in investigative processes, ensuring that patient safety investigations give due regard to statutory safeguarding processes and vice versa.

The Head of Safeguarding is now a member of the NWAS Sexual Safety Steering Group which has ensured that the Allegations Against Professionals Policy is appropriately considered within the process to manage sexual safety concerns. Likewise, the Head of Safeguarding attends the Right Care Right Peron Steering Group, in order to ensure that as work continues with the Police and other agencies to realign roles and response expectations, that any emerging safeguarding themes are highlighted to the safeguarding boards appropriately.

2.11 PRIVATE PROVIDERS

The Safeguarding Assurance Framework (SAF/Section 11) document was issued to all private ambulance providers at the end of 2023.The requirement to complete this and to submit the appropriate evidence has been reflected in private provider contracts. The Head of Safeguarding continues to work closely with the Patient Transport Service Compliance Manager to coordinate this piece of work and to collate compliance data. The Safeguarding Team are currently quality assuring the submissions and creating action plans for each provider as required. Going forward, the submission will be requested from our private providers on an annual basis.

2.12 PROJECT EMERALD

The Safeguarding Team continue to monitor the Cleric referral system and to ensure continued, positive engagement with social care partners. Phase two of the project is underway and we are

working with the Business Intelligence Team to create a safeguarding dashboard which will enhance our reporting ability.

2.13 NATIONAL AMBULANCE SAFEGUARDING GROUP

The Head of Safeguarding attends the National Ambulance Safeguarding Groups (NASaG). Engagement with NASaG ensures the Trust are informed of any changes to the national safeguarding policy, safeguarding standards, or regulatory framework. They liaise and work with other ambulance trusts to share and learn information.

2.14 SAFEGUARDING FLAGS

Safeguarding flags are placed on addresses where it has been identified that an individual who is at high risk of harm or abuse resides. Flags are placed for short periods and are reviewed to ensure that they do not incorrectly remain in place, flags are reviewed by the professional who places them onto the system to ensure they are current and relevant. Maternity alerts are also placed onto the Cleric system. Maternity alerts are placed upon the request of maternity professionals, these alerts are usually placed when the unborn child is at immediate risk following birth, or if the child is to be removed at birth and the mother is avoiding maternity services.

2.15 SAFEGUARDING ACHIEVEMENTS 2023/24

- Review of the organisation-wide Safeguarding Training Needs Analysis and more roles subsequently aligned to Level 3.
- Training compliance report by service line now produced monthly by the Safeguarding Team for oversight.
- Review of the Allegations Against Professionals policy and development of a robust process to manage referrals.
- Accurate Prevent data submissions to NHS Digital.
- Revised process for Safeguarding Team oversight of referral rejections by the Support Centre.
- Process in place to quality assure Private Provider safeguarding activity.
- Dedicated Safeguarding Resource page now on the Green Room.
- Safeguarding is now embedded throughout the PSIRF process.
- Safeguarding input to Sexual Safety and Right Care Right Person Steering Groups.

2.16 AMBITIONS 2024/25

- Embed Safeguarding Supervision within the Trust appraisal process.
- Delivery of bespoke, participative safeguarding training for ICC and Support Centre staff.
- Completion of phase 2 of the Safeguarding Cleric system, including development of the safeguarding dashboard.
- Explore the potential for NWAS crews to make safeguarding referrals electronically.
- Continued engagement with ICB's to streamline assurance requirements and to provide a conduit to safeguarding boards/partnership boards.
- Continue to develop easily accessible safeguarding resources for our workforce.
- Development of safeguarding champions/link staff within our Integrated Contact Centres.

3. RISK CONSIDERATION

The Trust appetite for risk in relation to quality outcomes is low and the action taken to provide additional scrutiny by the Safeguarding Team, of referrals rejected by the Support Centre, will enhance assurance in relation to NWAS safeguarding activity.

The Trust has a statutory duty to comply with:

- The Children's Act (1989; 2004)
- The Care Act (2014)
- Working Together to Safeguard Children (2018)
- The Serious Crimes Act (2015)
- Mental Capacity Act (2005)
- Mental Health Act (1983; 2007)
- Deprivation of Liberty Safeguards: Codes of Practice (2008).
- Health & Social Care Act (2008)
- Care Quality Commission's Registration Standards.
- Modern Slavery Act (2015)
- Female Genital Mutilation Act (2003; 2015)
- Learning from Deaths Report (2018)
- Domestic Abuse Act (2021)

Safeguarding assurance is reported within the Trust via bi-annual reports to the Trust Management Committee.

4. EQUALITY/ SUSTAINABILITY IMPACTS

N/A

5. ACTION REQUIRED

The Board of Directors is asked to:

- Receive the assurance that NWAS safeguarding activity during 2023-24 continues to meet our statutory requirements.

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Senior Information Risk Owner Report
PRESENTED BY	Maxine Power, Executive Director of Quality, Innovation & Improvement
PURPOSE	Assurance

LINK TO STRATEGY	Quality Strategy									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐
	SR06	☐	**SR07**	☐	**SR08**	☒	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Review the report and take assurance from the information provided that there are appropriate controls in place to maintain the security of information. • Support a Trust-wide campaign to prompt all staff to complete the Information Governance and Data Security mandatory training module on Electronic Staff Record (ESR).
EXECUTIVE SUMMARY	The Senior Information Risk Owner presents a summary of our information governance (IG) for the financial year and compliance with regulatory and contractual standards. Information Governance (IG) is the framework for handling information in a secure and confidential manner that allows organisations and individuals to manage patient, personal and sensitive information legally, securely, efficiently and effectively in order to deliver the best possible healthcare and services. There are several legal requirements, standards and best practice that apply to the handling of patient, personal and sensitive information. The key items of legislation and standards covered are • UK Data Protection Act 2018 • UK General Data Protection Regulation 2016 (GDPR)

- Access to Health Records Act
- Computer Misuse Act
- Records Management Code of Practice 2021
- Caldicott Principles
- Network and Information Systems (NIS) regulations 2018

To demonstrate compliance against these key legal requirements and standards and other items the trust reports against key areas which are reported through the Information Governance Subcommittee (IGSC).

DATA SECURITY PROTECTION TOOLKIT (DSPT)

For the DSPT 2022/23 it was submitted on 30th June 2023, the trust achieved "Approaching Standards" as a key evidence requirement was not achieved. The evidence requirement that was not achieved was,

3.2.1: 95% of all staff must complete their annual mandatory Data Security Awareness training

The trust at the point of submission on 30th June 2023 had achieved 83% of staff having completed their training.

Mersey Internal Audit Agency (MIAA) are required to undertake an internal audit each year on the evidence submitted by the trust on the DSPT across a section of assertions. The audit for the 2022/23 DSPT covered 13 assertions and the outcome was "Substantial Assurance".

There is a risk of not achieving standards met for the DSPT 2023/24 due to the Information Governance training compliance being below the standard of 95%, at the end of March 2024 it was 77%. An improvement is required before submission in June 2024.

INFORMATION ASSETS

An information asset is a body of information, defined and managed as a single unit so it can be understood, shared, protected and exploited effectively. The trust is responsible for creating and maintaining an Information Asset Register (IAR), this has been created in 2023/24 and 160 assets have been identified.

As part of the IAR creation there is a requirement to identify the Information Asset Owners (IAO) and Information Asset Administrators (IAA) and ensure that they are clear on their roles and responsibilities. 85% of identified IAO's and IAA's being trained by the end of 2023/24.

DATA BREACHES

During 2023/24 financial year (1st April 2023 to 31st March 2024), 139 breaches were reported.

Four incidents where externally reported, after meeting the criteria for notification to the Information Commissioners Office (ICO), with no action taken against the Trust.

The requirement to report any externally reportable data breaches to the ICO within the 72-hour timescale has not been met due delays for one incident in September 2023.

SUBJECT ACCESS REQUESTS (SARs)
The Individual Rights team process SARs, Access to Health Requests, and general requests for information from across the trust.
A total of 2,657 requests were received by the trust between 1st April 2023 and 31st March 2024.
Key Performance Indicators (KPI) for SARs and Access to Health requests have been met.

FREEDOM OF INFORMATION REQUESTS
Key Performance Indicators (KPI) for Freedom of Information Requests (FOI) have been met.

THE DATA PROTECTION OFFICER
The DPO has received 12 complaints which have all been addressed and closed.

DATA PROTECTION IMPACT ASSESSMENTS
There have been 4 approved Data Protection Impact Assessments (DPIA) in 2023/24:

- Manchester United event cover
- Schilling Defibrillators
- Global Rostering System (GRS)
- Mobile Data Vehicle Systems (MDVS)

DATA QUALITY
The Data Quality team remains relatively immature with the main roles only being appointed to in 2023/24. The initial programme of work has been aligned to the priorities for the trust but also considerate of the new status of the team. The Data Quality team have undertaken audits on HART calls and an additional audit at the end of March 2024 was being worked through with MIAA (Mersey Internal Audit Agency) on the 111 service for 2 key performance indicators.

AMBULANCE DATA SET
The Ambulance Data Set (ADS) phase 1 is the extraction of specified data items from the 999 system (CAD) to be shared with NHS England. In the final quarter following rework on the extraction and transform process as well as amendments to the data fields within the CAD, data has been extracted meeting NHS England's requirements. The business intelligence teams are now re-processing the data to be able to share back an updated version to complete the requirements of Phase 1, this is due to be completed in May 2024.

CYBER ASSURANCE
The report sets out the performance against the 11 fundamental controls recommended by the National Cyber Security Centre. It highlights that at the end of 2023/24 there was substantial assurance against 6 controls and moderate for 5 controls.

	RISKS The Information Governance Subcommittee (IGSC) through 2023/24 has been overseeing the risks associated with information governance and cyber. At the end of March 2024 there were 14 active risks.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 19 July 2024
	Outcome	Approved

1. BACKGROUND

1.1 Data is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. Information Governance and data protection are concerned with the way NHS organisations handle information about patients/service users and employees, in particular personal and special category information.

1.2 There are several legal requirements, standards and best practice that apply to the handling of patient, personal and sensitive information. The key items of legislation and standards covered are,

- UK Data Protection Act 2018
- UK General Data Protection Regulation 2016 (GDPR)
- Access to Health Records Act
- Computer Misuse Act
- Records Management Code of Practice 2021
- Caldicott Principles
- Network and Information Systems (NIS) regulations 2018

To demonstrate compliance against these key legal requirements and standards and other items the trust reports against key areas through the Information Governance Subcommittee (IGSC).

1.3 The Trust Senior Information Risk Officer (SIRO) is accountable for Information Governance within the trust and is supported by the Medical Director, who is the Caldicott Guardian. The Caldicott Guardian is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

1.4 The SIRO chaired in 2023/24 the Information Governance Subcommittee (IGSC). IGSC provided assurance for the Board of Directors through the Audit Committee. The work programme for the Committee aligned to the assertions set out in the Data Security Protection Toolkit (DSPT). In addition, there has been a continued focus on cyber assurance, improvements to data quality including the work on the Ambulance Data Set.

1.5 For the new financial year (2024/25) the SIRO will chair the Information Governance & Cyber group, which will provide assurance through to the Trust Management Committee (TMC)

2. DATA SECURITY AND PROTECTION TOOLKIT PERFORMANCE

2.1 The Data Security and Protection Toolkit (DSPT) is designed to provide assurance on the local implementation of the ten data security standards as set out in the National Data Guardian's (NDG) 2016 review and compliance with data protection legislation. The ten security standards are broken down into assertions with mandatory evidence requirements against which the trust is required to submit evidence to demonstrate achievement.

2.2 NHS England expects organisations to achieve "standards met" in the DSPT which is defined as compliance with all mandatory evidence requirements. Organisations' statuses are published with the aim of providing assurance to business partners and to patients of the standard of information management within NHS Trusts.

2.3 The submission process for the DSPT is to complete an interim submission in March and then a final submission in June. In the period of this report the final submission was completed in June 2023 which covered 2022/23. For the 2022/23 period there were 35 assertions broken down into 113 mandatory evidence requirements against which evidence was submitted, the trust was able to meet evidence requirements for 112.

2.4 The evidence requirement that was not achieved was,
3.2.1: 95% of all staff must complete their annual mandatory Data Security Awareness training
The trust at the point of submission on 30th June 2023 had achieved 83% of staff having completed their training. An improvement plan was submitted to demonstrate how the trust aimed to improve the compliance in 2023/24.

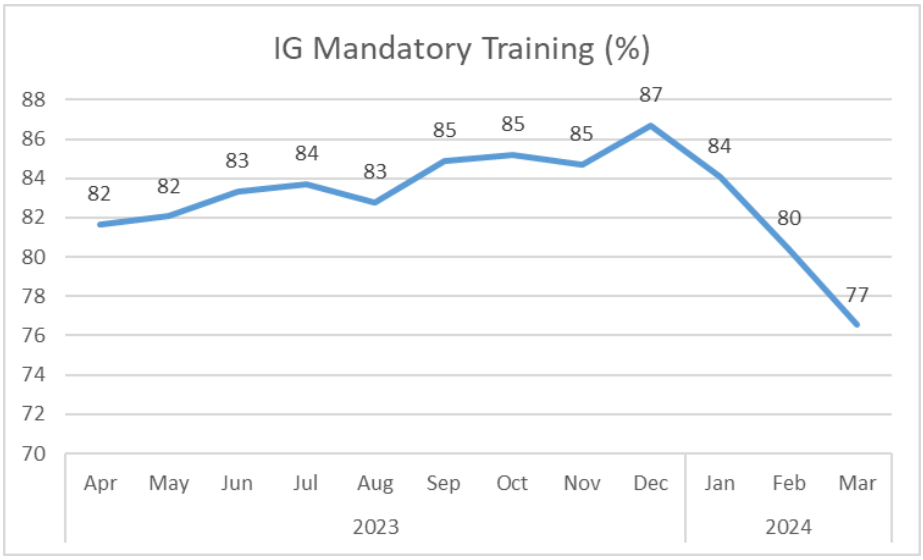
2.5 The completion of 112 of 113 mandatory evidence requirements meant that the trust was awarded the status of "Approaching Standards" by NHS England.

2.6 Mersey Internal Audit Agency (MIAA) are required to undertake an internal audit each year on the evidence submitted by the trust on the DSPT across a section of assertions. The audit for the 2022/23 DSPT covered 13 assertions and the outcome was "Substantial Assurance".
As a result of the assessment of the evidence, an overall assurance across all 10 NDG's standards of "Substantial Assurance" was given. This was calculated by MIAA by using the guidance from the independent assessment guidance.

2.6 For the DSPT for 2023/24 the baseline submission was submitted on 1st March 2024, of 108 mandatory evidence requirements the trust completed submission for 99 requirements.
The final submission will be completed on 29th June 2024 and a MIAA audit will also be undertaken before the submission. There is a risk of not achieving standards met due to the Data Security Awareness training compliance being below the standard of 95%, at the end of March 2024 it was 77%.

2.7 Data Security Awareness Compliance was at 77% at the end of 2023/24, the highest compliance level achieved in 2023/24 was 87% in December 2023. Information Governance are working closely with Learning & Development to improve completion rates. The increase in the number of data breaches highlights the importance of all staff being aware of their role and responsibility in relation to data security.

There needs to be additional support from across the trust leadership teams, to support the campaign for completing the Information Governance and Data Security training.



3 INFORMATION ASSETS

3.1 An information asset is a body of information, defined and managed as a single unit so it can be understood, shared, protected and exploited effectively. Information assets have recognisable and manageable value, risk, content and life cycles. The trust is responsible for creating and maintaining an Information Asset Register (IAR).

3.2 The IAR is a database which holds details of all the Information Assets (IA) within the trust. This includes physical assets such as paper files and computer systems (hardware) as well as software. Through the year the Information Governance team have worked with colleagues across the trust to identify 160 assets which are now recorded on the IAR.

3.3 As part of the IAR creation there is a requirement to identify the Information Asset Owners (IAO) and Information Asset Administrators (IAA) and ensure that they are clear on their roles and responsibilities. To support this in 2023/24 the trust has invested in face-to-face training from Exemplar Execs, which are accredited for cyber security training by NHS England. Additional investment has been made in Exemplar Execs online training which is now being provided to all new IAO's and IAA's. This has resulted in 85% of identified IAO's and IAA's being trained by the end of 2023/24.

3.4 As part of the IAR there is a requirement to ensure that each asset has the following

- An approved Data Protection Impact Assessment (DPIA) if applicable
- System Level Security Policies (SLSP)
- Backup Process Documentation
- Data Flow Documentation

The work against the 160 assets in 2023/24 has identified several gaps with the DPIA and SLSP which were expected to be in place. The backup process documentation and data flow documentation are new requirements that have been identified through the creation of the IAR. This will be a priority within the workplan for the Information Governance and Cyber Assurance team for 2024/25.

4. DATA BREACHES

4.1 The Trust effectively uses the RLDatix System, DCIQ, to capture data breaches by all levels of staff via the incidents module.

During the 2023/24 financial year (April 2023 to March 2024), 139 breaches relating to Information Governance were reported.

Four incidents where externally reported, after meeting the criteria for notification to the Information Commissioners Office (ICO), with no action taken against the Trust.

4.2 The Key Performance Indicator (KPI) for data breaches is to report any externally reportable data breaches within a 72-hour timescale. This has not been met due to the need of an internal investigation the details for one incident in September 2023.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Data Breaches	To report any externally reportable data breaches within the 72-hour timescale.	100% (1)	0% (1)	100% (3)	100% (0)	75%

5. SUBJECT ACCESS REQUESTS

5.1 The Individual Rights team has received SARs, Access to Health Requests, and numerous redirections of requests across the trust.

A total of 2,657 requests (including SARs, Access to Health requests, and redirections) came into the trust between April 2023 and March 2024.

This shows an increase of 478 requests more compared to the previous financial year.
The KPI for SARs has been achieved for the period 2023/24.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Subject Access Requests (SARs)	To respond to 85% of requests without undue delay and at the latest, within one month.	98.82%	97.16%	99.52%	99.18%	98.65%

6. FREEDOM OF INFORMATION REQUESTS

6.1 Under the Freedom of Information Act 2000 individuals can make a request to the trust to seek information that it holds. The trust is required to respond to these promptly and a target of responding within 20 days for 90% of requests has been set. For 2023/24 this has been achieved for the year and in each quarter.

The number of requests received in the year was 434.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Freedom of Information	To respond to 90% of requests within 20 working days.	100%	98.18%	93.18%	100%	98.16%

Request (FOI)						

7. DATA PROTECTION (Body Worn Video Cameras)

7.1 BWVC Incidents

V&A = Violence & Aggression. CMI = Complex / Major Incidents

Apr 23		May 23		Jun 23		Jul 23		Aug 23		Sep 23		
V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	
1	0	3	0	5	0	9	1	5	0	9	1	
Oct 23		Nov 23		Dec 23		Jan 24		Feb 24		Mar 24		
V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	Totals
8	7	14	10	23	5	16	9	24	4	14	2	V&A / CMI
												131 / 39

Police Request for Footage

V&A = Violence & Aggression. CMI = Complex / Major Incidents

Apr 23		May 23		Jun 23		Jul 23		Aug 23		Sep 23		
V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	
0	0	0	0	0	0	0	0	0	0	0	0	
Oct 23		Nov 23		Dec 23		Jan 24		Feb 24		Mar 24		
V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	V&A	CMI	Totals
0	0	0	1	4	0	1	0	2	0	1	0	V&A / CMI
												8 / 1

8. DATA PROTECTION OFFICER

8.1 The DPOs assists the Trust to monitor internal compliance, and advise on data protection obligations, also provide advice regarding Data Protection Impact Assessments (DPIAs) and acts as a contact point for data subjects and the Information Commissioner's Office (ICO).
The DPO is independent, an expert in data protection, adequately resourced, and reports to the highest management level. The Trust procure the DPO service from Mersey Internal Audit Agency MIAA).

The DPO has received 12 complaints which have all been addressed and closed.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Data Protection Requests	To respond to 85% of requests within 40 working days	92.34%	100%	100%	100%	97.94%

9. DATA PROTECTION IMPACT ASSESSMENTS

9.1 Over the past year the IG team's focus has been on ensuring that new information assets, changes to existing assets and changes in procedures involving personal identifiable data, are risk assessed in compliance with the UK GDPR, article 35 'Data Protection Impact Assessment'. The Trust has introduced a comprehensive assessment which is facilitated by the IG team and involves internal and external stakeholders with knowledge of the information asset and purposes of information processing.

9.2 The team have screened 20 information asset introductions or changes during the year, with 10 of these progressing to a full data protection impact assessment or a Data Sharing Agreement (DSA).

Approved Data Protection Impact Assessment (DPIA) :

- Manchester United event cover
- Schilling Defibrillators
- Global Rostering System (GRS)
- Mobile Data Vehicle Systems (MDVS)

10. DATA QUALITY

10.1 The Data Quality team remains relatively immature with the main roles only being appointed to in 2023/24. The initial programme of work has been aligned to the priorities for the trust but also considerate of the new status of the team.

10.2 The Data Quality team have developed reports across key data points within data warehouse and the electronic patient record (EPR). These reports act as a tool to enable IAO and IAAs to review and resolve issues within their systems to improve the quality of data. There is a programme to monitor the development of additional reports within core systems within the trust.

10.3 In addition to the report development the Data Quality team have undertaken audits on HART calls and an additional audit at the end of March 2024 was being worked through with MIAA (Mersey Internal Audit Agency) on the 111 service for 2 key performance indicators.

11 AMBULANCE DATA SET

11.1 The Ambulance Data Set (ADS) phase 1 is the extraction of specified data items from the 999 system (CAD) to be shared with NHS England. There have been difficulties through the year in extracting the data in the required format for NHS England. In the final quarter following rework on the extraction and transform process as well as amendments to the data fields within the CAD, data has been extracted meeting NHS England's requirements. The business intelligence teams are now re-processing the data to be able to share back an updated version to complete the requirements of Phase 1, this is due to be completed in May 2024.

11.2 Phase 2 of ADS is to take specific data items from the Electronic Patient Record (EPR) and share those with the CAD data to NHS England to enable them to be combined with Emergency Care Data Set (ECDS) obtained from acute providers. Work is underway on the validation of the data within the EPR and identification of any changes required to the configuration to meet NHS England's requirements. This phase is not expected to complete until September 2024, in line with NHS England's timeline.

12 CYBER ASSURANCE

12.1 Cyber security is a key element of protecting the data we store and utilise to provide patient care and look after our staff. Cyber security's core function is to protect the data and information assets including devices, infrastructure, networks and software. There is increasing challenge from a cyber perspective of maintaining our security position with there being an increasing prevalence of cyber-attacks across the globe. This has been reflected in the updates to the Board Assurance Framework Risk which outlines the gaps, controls and progress that has been undertaken to mitigate the risks.

12.2 At each meeting a report is presented providing an update on the areas of control that have been identified as fundamental by the National Cyber Security Centre (NCSC). The assurance report provides an update on the maintenance and improvement work being undertaken by the technical teams. The position as at the end of the financial year against each of the eleven controls is shown below

12.3

Control	Policy Compliance	Risk	Trend ◄► / ▼ / ▲	Assurance
Perimeter – Firewalls, Internet Gateways & Websites	Partially Compliant	Low	◄►	Moderate
User Devices & Servers including encryption & end point protection	Partially Compliant	Low	◄►	Substantial
User Access including privileged accounts	Partially Compliant	Low	▲	Substantial
Patch Management – Endpoints & Servers	Partially Compliant	Medium	▲	Substantial
Risk Management	Partially Compliant	Low	▲	Substantial
User Education & Awareness	Partially Compliant	Medium	▲	Moderate
Removeable Media Controls	Partially Compliant	Low	◄►	Substantial
Secure Configuration	Partially Compliant	Medium	▲	Substantial
Incident Management	Partially Compliant	Medium	▲	Moderate
Monitoring	Partially Compliant	Medium	◄►	Moderate
Home & Mobile Working	Partially Compliant	Medium	▲	Moderate

12.4 Key highlights of the work undertaken by the teams in maintaining our cyber security are

- All servers are enrolled in the Microsoft Defender software on the NHS England tenancy providing enhanced protection including Cyber Security Operations Centre oversight.
- Removal of 2008 Windows Server from our estate

- Separation of on premise administration accounts and cloud administration accounts, with cloud administrator accounts only being accessible from a trust owned device
- Maintenance of patch compliance across our servers
- At end of March 2024 there were no outstanding High Severity Alerts (previously CareCERTs)
- Completion of desktop cyber incident exercises have been undertaken in year and learning included in the revised business continuity plans

14. RISK CONSIDERATION

The IGSC reviews all information governance and cyber risks each meeting, there continue to be several key risks within the committee's remit. The work programme is set to provide assurance on the controls and the gaps in controls for those risks.

At the end of March 2024 the following relevant risks were in place and being monitored through the IGSC

Risk No	Description	Current Score
331	There is a risk due to digital/expansion/interoperability increasing the trust's surface which in turn increases the overall risk to the trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	16
330	There is a risk that due to gaps in controls end 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
119	There is a risk due to expiration of Vendor support for existing systems and increase in cyber security threats which may result in costly last minute updates and loss of systems.	12
188	There is a risk that, due to gaps in controls and user education/awareness the Trust may be subject to accidental/deliberate mishandling of data resulting in a misuse of confidential data causing a regulatory data breach.	12
292	There is a risk that without an established and embedded System Security Testing Programme the Trust is vulnerable to cyber attack resulting in a loss of critical systems, business disruption or exfiltration of confidential data.	12
384	There is a risk that due to the lack of clear governance, centralised oversight, and retention schedules in place for clinical and corporate records, the Trust is not meeting the regulatory compliance required for the management of all records held within the Trusts digital and paper systems, which may result in incorrect use of personal information, reputational damage, or litigation.	12
445	There is a risk that as a result of the OneResponse system not following some of the updated cyber security best practices, that	12

	unauthorised access to the application may occur, which may lead to exfiltration of sensitive data, changed to be made to the system, the creation or deletion of users, or the system being taken offline.	
485	There is a risk of data breaches, operational disruption, successful phishing attacks and malware infiltration due to the lack of a robust Web Security/Proxy solution.	12
516	There is a risk that due to ICB inbound requests the network team are required to make changes to the firewall, meaning the PORT443 is open to the Trust CAD provider, MIS Computer Systems and ICBs causing increased vulnerability to cyber attack.	12
518	There is a risk that due to NWAS having no formal processes in place for the accessing and release of CCTV from Trust sites, the rights and freedoms of the data subject may be compromised, which could lead to a breach in Data Protection Legislation and a complaint to the Information Commissioner's Office, resulting in reputational damage to the Trust..	12
553	There is a risk of unplanned downtime resulting in service disruption and appointment cancellations; data breach, including patient details; reputational damage; and significant financial impact of mitigating a successful cyber-attack which could lead to patient safety implications; due to targeted phishing / vishing / phishing (e.g. to facilitate other fraud such as mandate) or major cyber-attack removing/delaying access to NHS computer systems and information, including Ransomware / system takeover.	12
578	There is a risk due to no clearly defined process, templates or guidance that the trust may implement digital products without following the requirements of DCB0129 and DCB0160. These standards demonstrate that the implementation of digital products have considered any potential clinical safety hazards and have the appropriate controls in place to implement products safely. This could lead to failure to comply with the required legislation and could lead to patient safety issues.	12
245	There is a risk that due to the legacy completion of paper PRFS and the current business continuity process of EPR that reverting back to paper PRFS could result in the inability to retrieve paper clinical records for coroners, claims and complaints, subject access requests, internal investigations and Police requests leading to breaches in law, reputational damage and financial penalty.	6
196	There is a risk that due to a lack of a place of deposit the Trust is not compliant with the Public Records Act 1958 resulting in a regulatory breach and increase in IG related complaints plus the potential for further legislative breaches such as the Freedom of Information Act and Data Protection Legislation, leading to significant financial cost and reputational damage.	4

15. EQUALITY/ SUSTAINABILITY IMPACTS

There are no specific equality and sustainability impact from the content of this assurance report.

16. ACTION REQUIRED

The Board of Directors are asked to:

- Review the report and take assurance from the information provided that there appropriate controls in place to maintain the security of information.
- Data Security Awareness Compliance is currently at 82% (April 2024) but at the end of 2023/24 compliance was 77%. Information Governance is working closely with Learning & Development to improve completion rates. Support is needed from the Committee to endorse a Trust-wide campaign to prompt all staff to complete the Information Governance and Data Security module on ESR.

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ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Wednesday, 19 June 2024		
Members present	Mr D Whatley, Non-Executive Director (Chair) Dr A Chambers, Non-Executive Director Mrs C Butterworth, Non-Executive Director Prof A Esmail, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None identified.

ADVISE:

- The External Auditors presented the Audit Completion Report and provided an overview of the key areas of interest.
- The audited annual accounts were presented and produced in line with the DHSC Group Accounting Manual 2023/24. The Committee recommended the annual accounts for adoption by the Board of Directors.
- The annual report 2023/24 was presented and prepared in accordance with the mandatory requirements set out within the DHSC Group Accounting Manual 2023/24. The Committee recommended the annual report 2023/24 to the Board of Directors for approval.
- The management letter of representation was recommended to the Board of Directors for signing.

ASSURE:

- None identified.

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Friday, 19 July 2024		
Members present	Mr D Whatley, Non-Executive Director (Chair) Mrs C Butterworth, Non-Executive Director Prof A Esmail, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None identified.

ADVISE:

- The SIRO Annual Report 2023/24 provided a summary of the work relating to information governance and compliance with regulatory and contractual standards. The Committee noted the initiatives being adopted and supported the work being undertaken to improve mandatory training compliance.
- The revised Anti-Fraud, Bribery and Corruption Policy was recommended to the Board of Directors for approval.
- The Auditor's Annual Report 2023/24 was presented to confirm the findings from the external audit of the 2023/24 Annual Report and Accounts. The report will be published on the Trust's website.
- The Q1 2024/25 Board Assurance Framework position was presented, prior to approval by the Board of Directors on 31st July 2024. Committee members considered the report within the context of their role as Audit Committee.
- Losses and Compensation for Q1 2024/25 totalled £255k.
- The outcome of the Committee self-assessment against HFMAs checklists:
  - Committee Processes: Confirmed the committee effectively discharges its responsibilities.
  - Committee Effectiveness: Responses received from members and Executive Leads of the Committee were largely positive. The survey identified some areas for further discussion by Committee members and Executive leads to agree actions to address.

ASSURE:

- The Anti-Fraud progress report detailed the work undertaken during Q1 2024/25. The Counter Fraud Functional Standard Returned submitted in May 2024 achieved an overall rating of green and across all standards.
- Internal Audit reported four reviews were completed during Q1 2024/25.
  - Data Quality (23/24 review) – Substantial Assurance
  - Data Security and Protection Toolkit – Substantial Assurance
  - Complaints – Substantial Assurance
  - Fit and Proper Persons Test – High Assurance
- Seven waivers were approved during Q1 2024/25

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 19 June 2024		
Members present	Mr Salman Desai, Deputy Chief Executive (Chair) Mr D Ainsworth, Integrated Contact Centre Director Mr M Cooper, Area Director, Lancashire & Cumbria Dr C Grant, Medical Director Mr M Jackson, Chief Consultant Paramedic Mr I Moses, Area Director, Cheshire & Mersey Mr M Newton, Interim Area Director, GM Mrs E Orton, Asst Director of Nursing & DIPC Prof M Power, Director of Quality, Innovation, and Improvement Mrs L Ward, Director of People Mrs J Wharton, Chief Information Officer Mrs C Wood, Director of Finance	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Item 60: PTS –** additional leadership support agreed to help with the operational challenges the service continues to face
- **Item 62: Corporate Risk Register –** new risk, 603, relating to gaps in provision of the on-call rota with confirmation required whether this risk is area specific or trust-wide

ADVISE:

- **Item 61: Finance Report –** the National Model ambulance Team have flagged areas for improvement and focus – to be presented to TMC in September
- **Item 66 – Safeguarding Annual Report** – data requires triangulation before presentation to Board
- **Item 67: Mental Health Strategic Plan** – sub-group to be formed to determine priorities and to co-ordinate delivery of the plan

ASSURE:

The TMC discussed the following.

- **Item 61 - Finance Report** Month 2 update
- **Item 63 - The integrated Performance Report (IPR)** – supporting narrative used to inform Quality & Performance and Board submissions
- **Item 64 - Health, Safety, Security & Fire Annual Report 2023/24** - end of year assurance
- **Item 69 - Cyber Incident** update presented for assurance
- **Item 70 - Digital Strategic Plan 2024/26** – supported for onward reporting to Resources Committee and Board
- Received the following Escalation & Assurance reports:
  - Diversity & Inclusion Group
  - EPRR Group
  - Sustainability Group

RISKS

Risks discussed:

- The TMC approved the Corporate Risk Register.

New risks identified:

- No new risks identified

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 17 July 2024		
Members present	Mr S Desai, Deputy Chief Executive (Chair) Mr D Ainsworth, Integrated Contact Centre Director Mr M Cooper, Area Director, Lancashire & Cumbria Dr C Grant, Medical Director Mr M Jackson, Chief Consultant Paramedic Mr I Moses, Area Director, Cheshire & Mersey Mrs E Orton, Asst Director of Nursing & DIPC Prof M Power, Director of Quality, Innovation, and Improvement Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs J Wharton, Chief Information Officer Mr M Newton, Interim Area Director, GM Ms S Rose, Interim Director of Integrated Contact Centres	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Item 84: Finance Month 3 Report –** efficiency target forecasting achievement in-year but further work required on recurrent elements
- **Item 84 – Finance Month 3 Report** – The NHSE I&I programme has commenced, with all three northwest systems

ADVISE:

- **Item 91:** Dress Code Policy – further engagement and consideration needed.
- **Item 93:** Manchester Arena Inquiry – 13 of the recommendations moved into BAU, 1 recommendation regarding the opportunity for all operational staff to attend command exercise will remain open and ongoing partially compliant
- **Item 94 – National Occupational Standards Framework** – further assurance is required on the escalation process and implications regarding non-compliance

ASSURE:

- **The TMC discussed the following.**

  - **Item 83 - Annual Plan 2024/25 –** Q1 Assurance
  - **Item 85: Huyton Ambulance Station**
  - **Item 87- Corporate Risk Register**
  - **Item 88 – Board Assurance Framework –** Q1 2024/25
  - **Item 92 – Data Insights & Intelligence Reporting Priorities**
  - **Item 96 – HR Casework Update**
  - Received the following Escalation & Assurance reports:
    - Planning Group
    - EPRR Group
    - Health, Safety, Security & Fire Group
    - Clinical Quality Group
    - Information & Cyber Governance Group
    - People & Culture Group
    - Service Delivery Assurance Group

RISKS

Risks discussed:

- The TMC approved the Corporate Risk Register as noted
- Risk 603 will remain as a regional risk rather than area specific

New risks identified:

- No new risks identified

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Integrated Performance Report
PRESENTED BY	Director of Quality, Innovation, and Improvement
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors are requested to note: • The contents of the report and take assurance against the core Integrated Performance Report (IPR) metrics. • Identify risks for further exploration or inquiry by assurance committees of the board.
EXECUTIVE SUMMARY	The purpose of this report is to provide the Board with an overview of integrated performance to the month of **June 2024**. The report shows the historical and current performance on Quality, Effectiveness, Operational performance, Finance and Organisational Health. The key areas to highlight are: **Quality** • Safety incident reporting tells us: – Violence and aggression toward staff continues to be the most frequently reported incident. – Care and treatment continues to be the most frequently reported patient safety related incident. • 2 Patient Safety Incident Investigations (PSII) have been transferred to NHS England

Effectiveness

- The STEMI care bundle is indicating improvement (special cause). Clinical Audit and Clinial Informatics teams have made improvements to the Electronic Patient Record and clinical leaders have promoted the care bundle which may have caused the improvement. These changes are being monitored to determine if this improvement will remain.
- All other Ambulance Quality Care Indicators (ACQI) are stable.
- Nationally, the trust position is largely unchanged from the previous period, ranking 6th for H&T, 9th for S&C and 8th for S&T.
- Work is continuing to understand the effect of C2 segmentation implementation and the trust's Hear and Treat rate relative to the sector. Initial assessment is that the contribution of C2 segmentation to the Trust's H&T is between 3.0% – 3.5% currently.

Operational Performance

Operationally the trust performed well in June 2024 but with some areas for improvement, key elements of performance are:

- A 999 call pick up mean of 1 second and 90th and 95th percentile of zero seconds.
- The best C2 performance in sector for the fourth consecutive month (Mean: 26:53, 90th: 53:02), however this was a deterioration in average performance from the previous report (Mean: 21:48, 90th: 41:25). The C2 mean performance also exceeds the ARP standard, which has now reverted to the 18-minute standard, by 8.53 minutes.
- Maintaining third place nationally for C1 mean and C1 90th and achieving the standard for C1 90th (13:15).
- Category 3 response is stable and placed 5th nationally, however it is over double the required standard for mean and 90th response time.
- Turnaround performance is stable (39:23), although still above the 30-minute target and with regional variation. Cheshire and Merseyside ICB recorded an average turnaround of 55:47 which is 41.4% (16:24) higher than the rest of the trust.
- Performance in 111 continues to improve as shown by national rankings and attaining the national standard for abandoned call rate.
- PTS activity is stable with operational and workforce improvement plans in progress.

Finance

- The year-to-date expenditure on agency is £0.348m which is under the year-to-date ceiling of £0.711m.
- At Month 03 productivity and efficiency target has been exceeded by £0.090m.

	Organisational Health There continues to be improvement in the workforce metrics specifically on • Sickness absence is indicating improvement (special cause). • Turnover is signalling improvement, particularly 111 displaying special cause, however the service line remains challenged at 22%. • In contrast, EOC turnover has worsened to 22.5%. A deep dive will be conducted at Resources Committee in September. • Vacancy gap reflects establishment changes but is starting to reduce with delivery against recruitment plans.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 17 July 2024
	Outcome	Approved (comments included)

1. BACKGROUND

The purpose of this report is to provide the Board with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of **July 2024**. The report shows the historical and current performance on Quality, Effectiveness, Operational performance, Finance and Organisational Health. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

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

Data are presented over time using statistical process control charts (SPCs). Statistical rules are applied to determine whether something significant has happened which needs to be flagged to committee.

2. TRUST MANAGEMENT COMMITTEE REVIEW

The Trust Management Committee (TMC) receive the Integrated Performance Report (IPR) monthly to review and understand performance prior to the submission to the Board of Directors. The new process is iterative and will refine over upcoming reports.

Over the last two months review TMC identified the following areas to highlight:

- **Hear & Treat and See & Treat:** There was an in depth discussion around the performance on H&T and S&T not improving and remain nationally in the lower ranking positions. Through the discussion it was identified the need for a new table showing the national ranking for S&C to a Non-accident & emergency location. This has been included as figure E3.18.
- **Category 2 Segmentation:** Several changes have been made to category 2 segmentation, but it is not translating to a change, with the H&T and S&T rates remaining relatively stable. This will be a focus for the operational leads.
- **A&E Turnaround**: Feedback from Greater Manchester Area Director in June highlighted that there had been a negative change in turnaround without a clear understanding of the reasons. There is work ongoing with the acute sector on how to improve the turnaround performance and reduce conveyance to emergency departments

3. PERFORMANCE SUMMARY

QUALITY

Complaints: This report continues to display complaints data in the updated format to reflect departmental changes (in tabular form until there are sufficient data points for SPC). The revised structure sees The Patient Advice and Liaison Service (PALS) team resolve complaints with relatively minor implications (classified as 'low' complexity) whereas the Resolution team investigate complaints with higher risk or complexity, classified as 'medium to high'.

In June n=154 PALS and n=20 Resolution complaints were received. Closure rates within service level agreement (SLA) for complaints were 87.8% for PALS complaints and 53.8% for

Resolution complaints. This is a reduction on the position reported in the previous report, 96.7% for PALS complaints and 65.5% for Resolution complaints.

Incidents: Patient and safety incidents (including patient incident investigations) are stable. Closure within SLA for incidents with risk score 1-3 has stabilised, whilst incidents with risk score 4-5 are strongly indicating improvement with 6 of the previous 7 data-points at the upper control limit.

In June, 10 patient incidents were classified as 'severe harm' (a decrease from 12 in the previous report) and 18 as 'fatal' (an increase from 14 in the previous report).

Violence and aggression (n=160) is the most common theme for non-patient incidents and Care and treatment (n=107) is the most common theme for patient incidents. Communication incidents are present in the top 5 most common themes in both lists (n=77 and n=45 respectively).

Most frequent safety incidents:	**Most frequent patient safety incidents:**
Violence & Aggression (160)	Care and Treatment (107)
Communication (77)	Call Handling (95)
Medicines – all (75)	Delays (54)
Accidents & Injuries (50)	Communication (45)
Road Traffic Collision with Vehicle (47)	Call Management (28)

Incidents referred to NHSE: There were 2 Patient Safety Incident Investigations (PSII):

- 2024/5687 - Identified through Patient Safety Event Case group (PSEC) to match local priority 'Prevention of deterioration to critically unwell patients with contributing harm'.
- 2024/5873 - Identified through PSEC to match national priority 'Death of person with learning disabilities or autism'. The PSII is likely to be stood down due to ongoing Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) review.

Safety Alerts: No new safety alerts were received in June 2024.

EFFECTIVENESS

Patient experience

PES. The n=526 responses for June are 22.9% higher compared to the last reporting period (n=428), with comments showing a 23.2% increase (409 for June compared to 332 from April). The overall experience score for June of 90.3% is 1.7% higher than the 88.6% reported in April.

PTS. The 1,388 responses for June are 12.7% higher than for April's 1,232, with supporting comments higher by 13.9%, (1,109 for June compared to 974 from April). The increase is attributed to the additional 25% of PTS patients offered the opportunity to provide feedback via a link to the online patient experience survey. The overall experience score for June of 90.7%, a 0.5% decrease than the 91.2% reported for April.

NHS 111. At the time of reporting, there are 160 returns for June, matching the 160 returns recorded for April. This number is expected to significantly increase with the commencement of the additional, shorter 111 localised survey being offered to patients. The results thus far show an 84.4% likelihood of the 111 service being recommended; a decrease of 7.5% percentage points compared to 91.9% reported for April.

Ambulance Clinical Quality Indicators (ACQI's)

Trust level cardiac ACQI submission has now been retrospectively submitted. Metrics are stable apart from the STEMI bundle indicating improvement. Two of the 6 metrics are above the national average:

- Return of Spontaneous Circulation (ROSC) overall performance - last reported in February 24 (28.8%), below the national average of 29.0%.
- ROSC Utstein performance - last reported in February 24 (47.9%), below the national average of 51.5%.
- Survival at 30 days after discharge overall performance - last reported in February 24 (7.9%), below the national average of 9.6%.
- Survival at 30 days after discharge Utstein performance - last reported in February 24 (22.9%), below the national average of 29.9%.
- Stroke care bundle - last reported in February 24 (97.9%), above the national average of 97.9%.
- STEMI care bundle – last reported in January 24 (88.8%), above the national average of 80.2%.

The improvement in the STEMI care bundle maybe associated with the improvements made by the Clinical Audit and Clinial Informatics to the Electronic Patient Record and clinical leaders have promoting the care bundle. These changes are being monitored to determine if this improvement will remain.

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

The H&T rate for July 24 was 13.8%, whilst the S&T rate was 28.2%, equating to a total non-conveyance rate of 42.0%. Nationally, the trust position is largely unchanged from the previous period, ranking 6th for H&T, 9th for S&C and 8th for S&T.

Expected increases in H&T through broadening of C2 segmentation eligibility criteria have not fully materialised owing to abstractions for training and backfill of roles resulting from UEC AP recruitment. Work is in progress to manage abstractions through additional clinicians trained in the clinical advice hunt-group role and Avaya software for homeworkers to increase capacity for roles such as CAS coordinator to be carried out remotely.

Identifying the impact of C2 segmentation to date remains challenging, due to the iterative changes to specifications/eligibility criteria as well as complexities in data capture. However, the contribution of C2 segmentation to the Trust's H&T is hovering between 3.0% - 3.5% currently. Preliminary investigations comparing sector performance with our own are in progress.

OPERATIONAL PERFORMANCE

Paramedic Emergency Services (PES) Activity

Of the n=118,635 emergency calls received by the trust, 77.0% (n=91,322) became incidents. In comparison to the previous year, calls are unchanged, and incidents have decreased 1%.

Manchester South (9,668), Manchester Central (n=9,616), Mersey North (n=9,404) were the busiest sectors. Greater Manchester ICB contains the most incidents (n=36,634), accounting for 40% of PES activity.

PES Call Pick Up

The trust performed well for Call Pick Up (CPU). The mean was 1 second whilst the 90th and 95th percentile were zero seconds. Strong performance was delivered through increased levels of 999 call handlers funded via UEC investment.

999 Ambulance Response (ARP) Performance

Measure	Standard (hh:mm:ss)	June 24 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:07:44	3rd
C1 90th	00:15:00	00:13:15	3rd
C2 mean	00:18:00	00:26:53	1st
C2 90th	00:40:00	00:53:02	1st
C3 mean	01:00:00	02:02:37	5th
C3 90th	02:00:00	04:40:58	5th
C4 90th	03:00:00	03:52:53	3rd

In June 24 the trust recorded the best C2 performance in sector for the fourth consecutive month but was a deterioration from the performance in the previous report (Mean: 21:48, 90th: 41:25). The C2 mean performance also exceeds the ARP standard which has now reverted back to the 18-minute standard.

Improvement initiatives have led to a reduction in regional variation however response times in Cheshire and Merseyside ICB (CAM) are persistently higher, likely caused by a 41% (+16:24) higher hospital turnaround time in the CAM area.

Category 3 (C3) response has displayed a stable national position (5th) whilst Category 4 (C4) national position has improved. Despite the positive national position, the trust exceeded C3 response standards by 100%.

Ongoing reviews of the response model are supporting further improvements. This includes a review of inter-facility transfers and healthcare professional (IFT/HCP) calls with a measurement/timescale meeting planned for August, as well as a review of Urgent Care response (on track for October 24 target completion date).

999 C1 & C2 long Waits

C1 long waits (n=600) increased compared to the previous report (n=507). The percentage of C1 long waits of all C1s has increased from 5.7 to 6.2%.

C2 long waits (n=3,526) increased compared to the previous report (n=1761). The percentage of C2 long waits of all C2s has increased from 3.6 to 7.3%.

Long waits have increased following a period of decline. Extreme long waits for C2 (2hr+) were n=228 (0.5% of C2), and for C1 (30m+) there were n=21 (0.2% of C1).

Hospital Handover

Average turnaround time (39m:23s) is stable. However, performance is still above the national standard of 30 minutes and 5 minutes higher than the June 2023 position (34m:17s). Cheshire and Merseyside ICB (C&M) continue to record longer turnaround times; in June C&M turnaround (51m:24s) was 41.4% longer than other areas (36m:21s).

As part of local improvement plans the Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services (MHLDC) provider collaborative continues to focus on improving utilisation of 2-hour Urgent Care Response to promote ED avoidance and ensure that patients receive appropriate and timely care. Learning from the pilot has informed a re-development of the initiative, which will see the focus move from diverting patients to exploring ways of increasing referrals from clinicians on scene. The impact of this will be measured as the initiative develops.

NHS 111

111 Measure	Standard	June 24	National Ranking
Answered within 60s	95%	80.9%	8th /30
Average time to answer	--	42s	--
Abandoned calls	<5%	2.49%	4th /30
Call-back within 20 min	90%	36.9%	--
Average call back	--	29m 20s	--
Warm transfer to nurse	75%	15.6%	--

Calls offered (n=142,627) were 14% lower than February 24 (n=163,990), displaying special cause, likely attributable to 15% national contingency that started in April 2024 (up from 10%). The increase in national contingency is also likely a causal factor for other improvements in 111 since April 24 including:

- Calls answered in 60 sec has improved to 80.9%, delivering the best performance in 3 years and approaching the national standard of 95%.
- Call-back within 20 mins is strongly indicating improvement at 36.9% although short of the national standard of 90%.
- Average time to callback has improved to 29m:20s, the best performance over the last 3 years.

PTS

Owing to a lag in PTS reporting, performance is reported one month in arrears. PTS operational performance is stable, however there is scope to improve the number of aborted journeys for same-day discharges, which are often inefficient and negatively affect other performance standards. Work is underway to strengthen the PTS senior leadership team in the areas of operational delivery and clinical governance and assurance. The financial recovery plan is progressing, including reducing spend on third party providers.

4. FINANCE

- The year-to-date expenditure on agency is £0.348m which is under the year-to-date ceiling of £0.711m.
- The trust is ahead of plan at the end of Month 3, the forecast remains to achieve the breakeven plan by the end of the year.
- The efficiency and productivity target (£3.463m) has been over achieved year-to date by £0.090m.

5. ORGANISATIONAL HEALTH

Sickness

Trust absence levels have continued to recover, with the latest reported month (May 24) at 6.79%, displaying special cause.

The improvement in sickness is reflected across all service lines. The 111 service line has the highest sickness rate (10.24%) however is signalling improvement with special cause variation in the May datapoint.

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

The UEC recovery funding has delivered further investment in attendance coaching support, wellbeing coordination to improve access and navigation of the available support, and specialist MSK and violence and aggression support.

Turnover

Turnover for June (10.2%) continued a downward (improving) trend. This is driven by improvement in 111, showing special cause (below lower control limit), however it remains challenged with the turnover rate at 22.05%. In contrast, EOC turnover continues an upward (worsening) trend at 22.5% and has surpassed 111 as the service line with highest turnover. There is a focus in contact centres to support retention, and analysis is underway to understand emergency medical dispatcher (EMD) turnover. Initial indications show that internal movement (e.g. career change to start EMT course) and available external opportunities are causal factors.

At 6.2%, PES turnover is stable and the best performing service line.

Temporary Staffing

The position for temporary staffing shows continuing agency usage at a similar rate to previous months at a level equivalent to 0.3% pay bill, £150k below cap.

Vacancy

The trust vacancy position is –7.84% for June 24, reflecting establishment changes from the UEC recovery funding and challenges in PTS and 111 recruitment.

The PTS vacancy position has worsened to –14.05%, reflecting relatively high turnover, including staff moving to PES. However, PTS have robust bank arrangements in place to bridge their vacancy position.

The EOC position has worsened to –7.93%, driven by increased turnover in the dispatch workforce. Recruitment plans are in place to maintain a stable position for the rest of the year.

PES show a slight under-establishment of –3.45%, primarily owing to an under-establishment within the EMT1 workforce. Recruitment plans are being delivered, with interventions to ensure that the EMT1 courses are fully populated.

The current 111 vacancy position has significantly improved to –7.84% with vacancies in the Health Advisor and Clinical Advisor roles. Whilst turnover is improving, the recruitment market is proving challenging for call handler positions. The trust is also engaging in an international recruitment pilot for Clinical Advisors.

Plans for recruitment to an integrated call handler role (under the Integrated Contact Centre programme of work) have commenced with large scale advertising in Quarter 4 2024/25.

Appraisals

Overall appraisal completion has improved to 87% ahead of target and displaying special cause for consecutive months. PTS have improved from 81% to 85.7%. The 111 service line is 84.12% displaying special cause and indicating improvement. Both PES and EOC have exceeded the target at 87.7% and 89.07% respectively, with PES displaying special cause.

The targets for 2024/25 are:

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

Mandatory Training

Overall compliance is ahead of the target (85%) at 87% and all service lines are ahead of target apart from Corporate who are achieving 93% against a target of 95%. An additional 5 online modules were added to the programme, at the start of the year but underlying strong performance means that overall compliance has been maintained.

Case Management

Employee relations casework has increased from n=109 to n=115 between the reporting periods. The highest rate of live cases per staff (prevalence) occurs in 111 (2.2%) and this mirrors the prevalence rates over the last 12 months. Average case length has decreased slightly to 12.9 weeks since the last report although this had shown a prior increase due to high volume and increased complexity of cases.

6. RISK CONSIDERATION

The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

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

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.

7. EQUALITY/ SUSTAINABILITY IMPACTS

The Diversity and Inclusion sub-committee are reviewing the trust's protected characteristics data to understand and improve patient experience. Formerly, patient experience data was presented demographically, however challenges in reporting ethnicity preclude our ability to draw conclusions. With a much higher proportion of ethnicity data completion in 111, a development to enable data sharing across NWAS systems is now completed and expected to go live in C3 (999) during this quarter. Updates on this development are reported into the Diversity and Inclusion sub-committee.

8. ACTION REQUIRED

The Board of Directors are requested to note:

- The contents of the report and take assurance against the core Integrated Performance Report (IPR) metrics
- Identify incidents for further exploration or inquiry by assurance committees of the board.

North West Ambulance Service NHS Trust

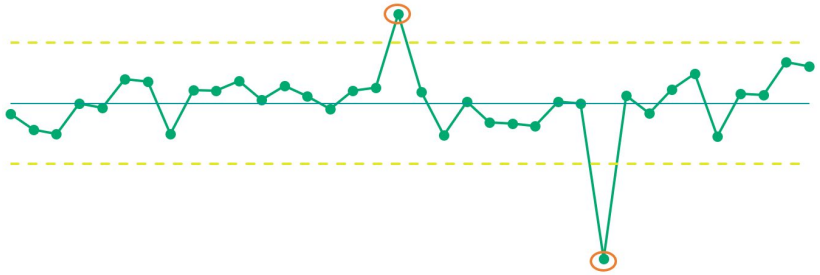
Integrated Performance Report

Board - July 2024

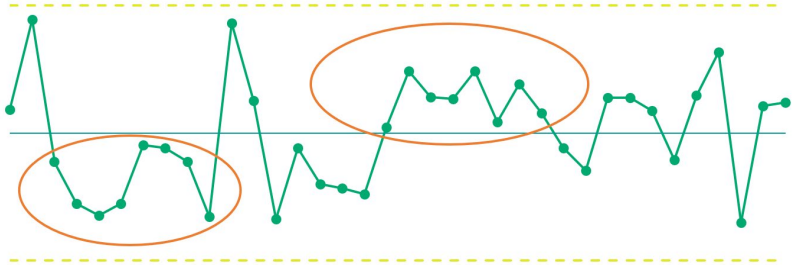
Rules for interpreting SPC Charts

Most charts contained in the report are SPC (Statistical Process Control). SPC charts follow the rules shown below to determine when something statistically significant has happened. Once these rules are triggered the control limits - dotted lines above and below the mean (centre line) are adjusted around the new data – this is known as resetting the limits

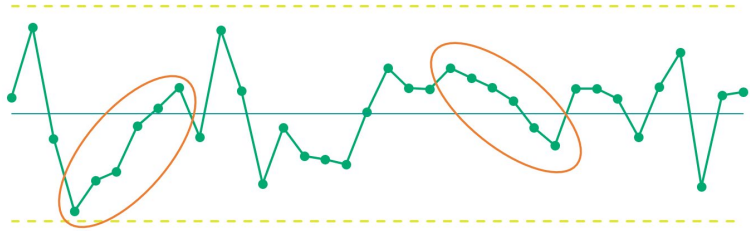
Rule 1: Single data point outside the control limits



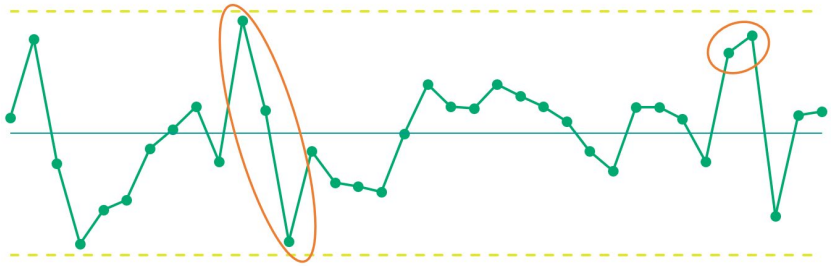
Rule 2: 8 or more consecutive data points above or below the centre line



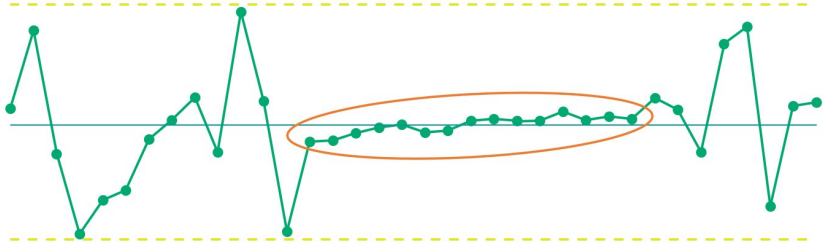
Rule 3: A trend of at least six consecutive points (up or down)



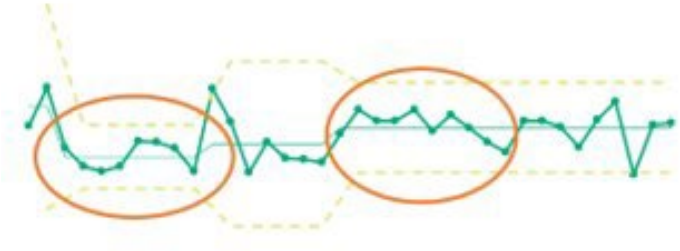
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



Rule 5: At least 15 consecutive data points "hugging" the centre line



Example of Limits reset following special cause



Quality & Effectiveness

Q1 COMPLAINTS

Figure Q1.1

Overview

Level (Team)	Received	Closed	Closed in SLA (%)
1-2 (PALS)	154	148	87.8%
3-5 (Resolution)	20	13	53.8%

Figure Q1.2

Received by Service Line

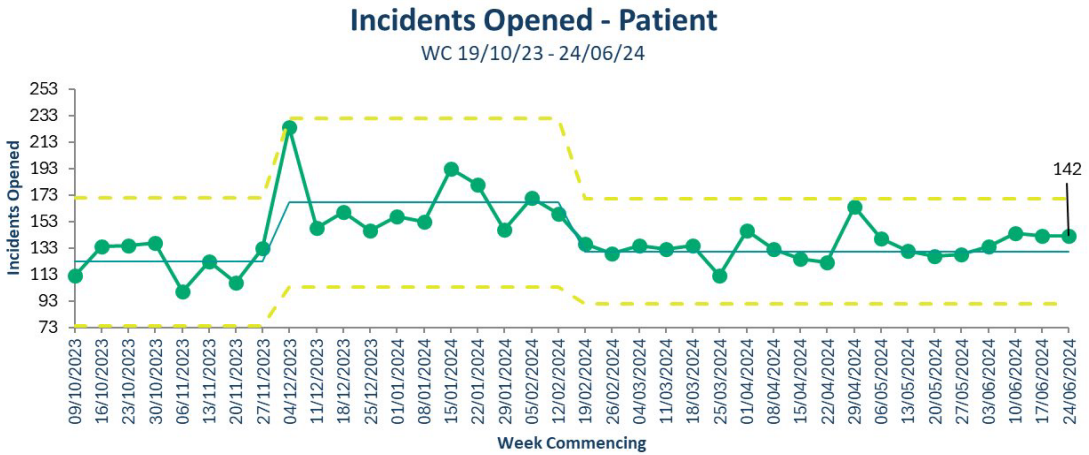
Level (Team)	EOC	111	PTS	PES (GM)	PES (CAM)	PES (CAL)
1-2 (PALS)	12	18	78	15	17	14
3-5 (Resolution)	2	0	3	4	9	2

Q2 Incidents

Figure Q2.1

Figure Q2.2

Figure Q2.3



PSIRF level of harm (June 24):

None (n=451)
Low (n=53)
Moderate (n=49)
Severe (n=10)
Fatal (n=18)

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

Figure Q2.4

Figure Q2.5

Figure Q2.5

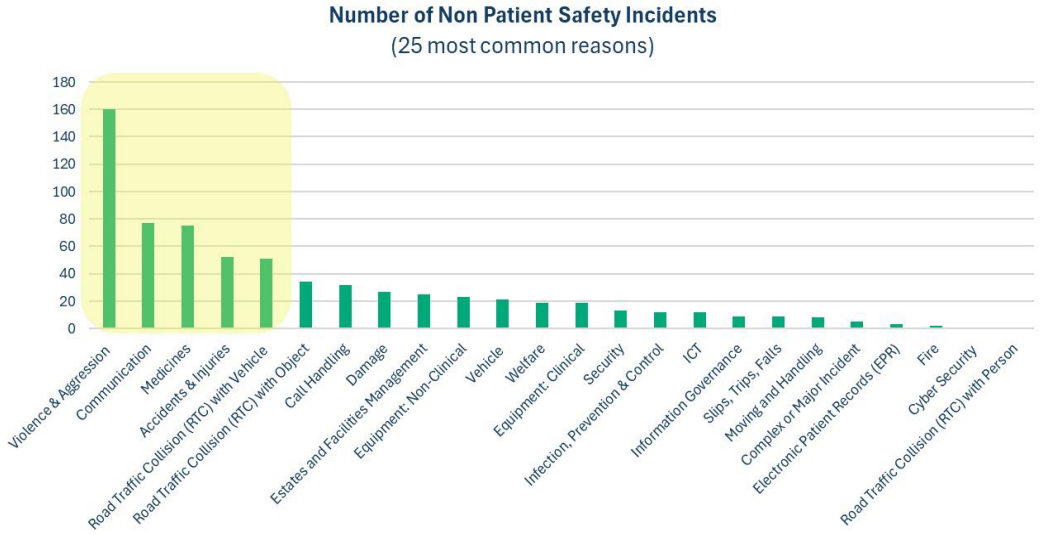
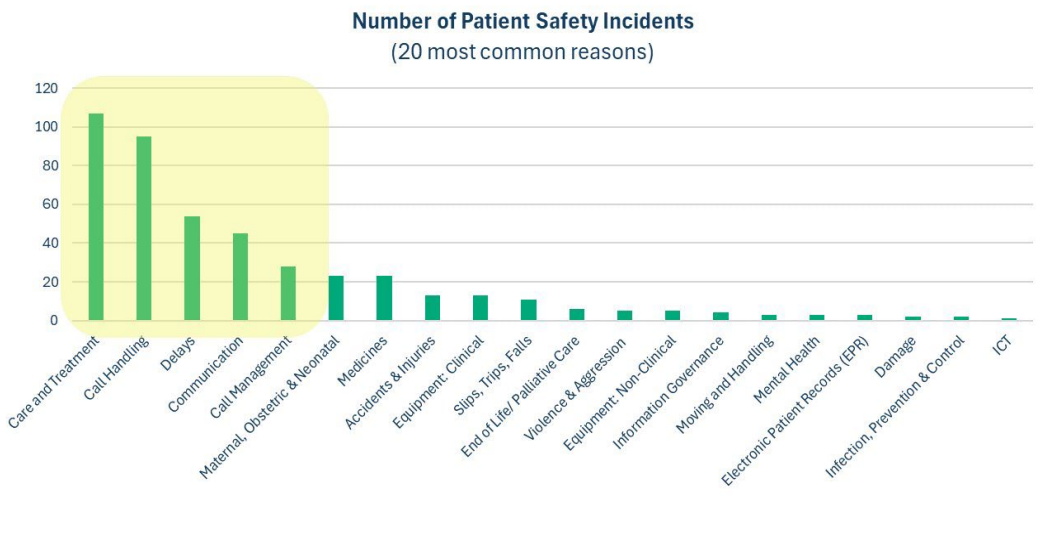


Figure Q2.6

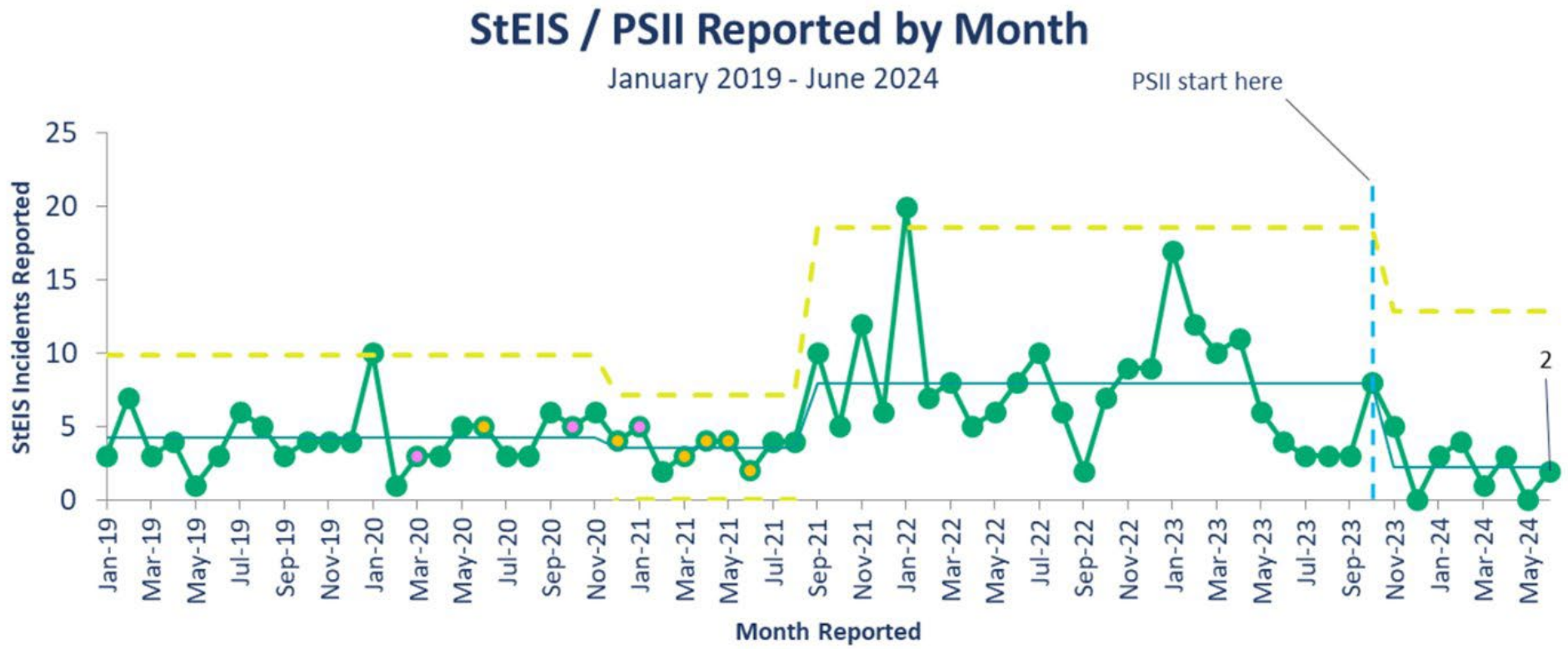


Incident SLA (no exceptions are taken into account):

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

Q3 Patient Safety Incident Investigations (PSII)

Figure Q3.1



Q5 SAFETY ALERTS

Safety Alerts	Alerts Received (Jul 23 – Jun 24)	Alerts Applicable (Jul 23 - Jun 24)	Alerts Open	Notes
CAS Helpdesk Team	0	0	0	
Patient Safety Alert: UKHSA	1	0	0	
National Patient Safety Alert: NHS England	1	0	0	- NatPSA/2023/014/NHSPS. Identified safety risks with the Euroking maternity information system. Issued 07/12/23 Deadline 07/06/24. Acknowledged and with maternity lead for review.
National Patient Safety Alert: DHSC	9	1	0	- NatPSA/2024/003/DHSC_MVA. Shortage in Salbutamol Nebuliser. Bulletin CI1023 gives guidance to clinicians in managing the risk. Issued 26/2/24. Deadline 8/3/24. **Action Complete.**
National Patient Safety Alert: OHID	1	1	0	NatPSA/2023/003/OHID. Patient synthetic opioids implicated in heroin overdose/deaths. Issued 26/7/23. Deadline 04/08/23. Bulletins issued by Medical Director. **Action Complete**
CMO Messaging	3	0	0	
National Patient Safety Alert: MHRA	3	2	1	- NATPSA/2023/010/MHRA. Medical Beds etc, risk of death from entrapment. Issued 31/8/23. Deadline 31/3/24. Reviewed at MDOG. **Action Complete** - NATPSA/2024/004/MHRA. Reducing risk for transfusion-associated circulatory overload (TACO) Issued 8/4/24. Deadline 4/10/24.
Medicine Alerts: MHRA	50	0	0	MHRA alerts have been checked to ensure they are not applicable to the trust.
IPC	0	0	0	
National Patient Safety Alert: NHS England Patient Safety	1	0	0	

E1 PATIENT EXPERIENCE

Figure E1.1

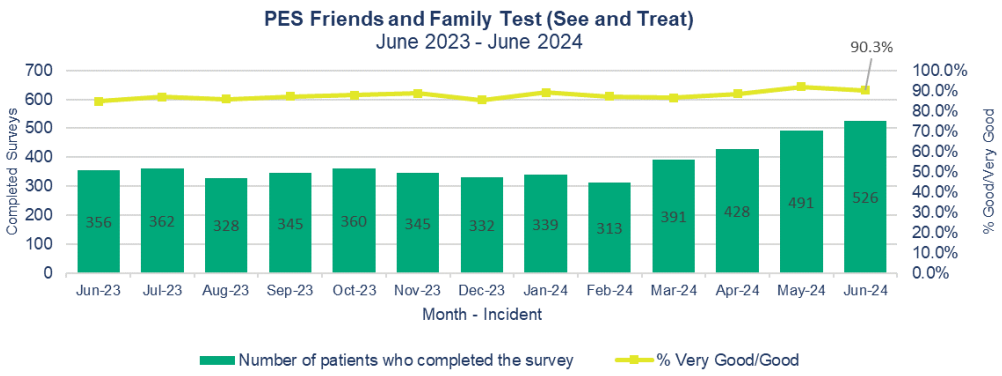
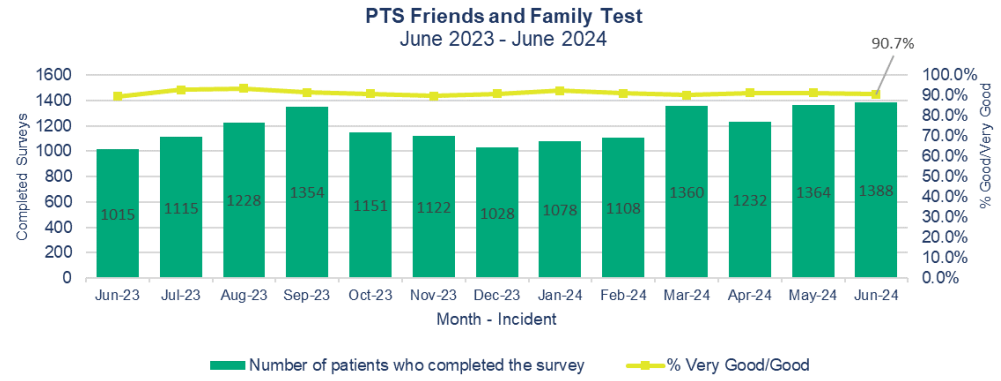


Figure E1.2



PES Positive

- *"The paramedics were so kind and professional. They reassured our 5 year old grandson who was having a sleepover with us who woke up coughing and couldn't breathe. The ambulance was with us within 20 minutes, and they gave him treatment to help open his airway. They took time to explain everything they were doing and why and even took time to speak to Daniels parents in Stockport to reassure them too. We can't thank them enough - the team were Emma and a male colleague whose name I can't remember due to stress of the situation at the time. They stayed with us until they were 100% happy that Daniel was ok. (they were amazing with us grandparents too)."*

PES Negative

- *My mum hadn't passed water. She was very ill. The next day, we had to get another ambulance they took her straight to the hospital, and we were told she could die. She was in kidney failure and heart failure. Then we were told she had pneumonia. She is still in hospital. That is why I gave them that score. We could have lost our mum because of their decision."*
- *"Paramedics refused to take my mother to hospital stating her confusion and symptoms were a UTI. She ended up in hospital as she had in fact had a stroke."*

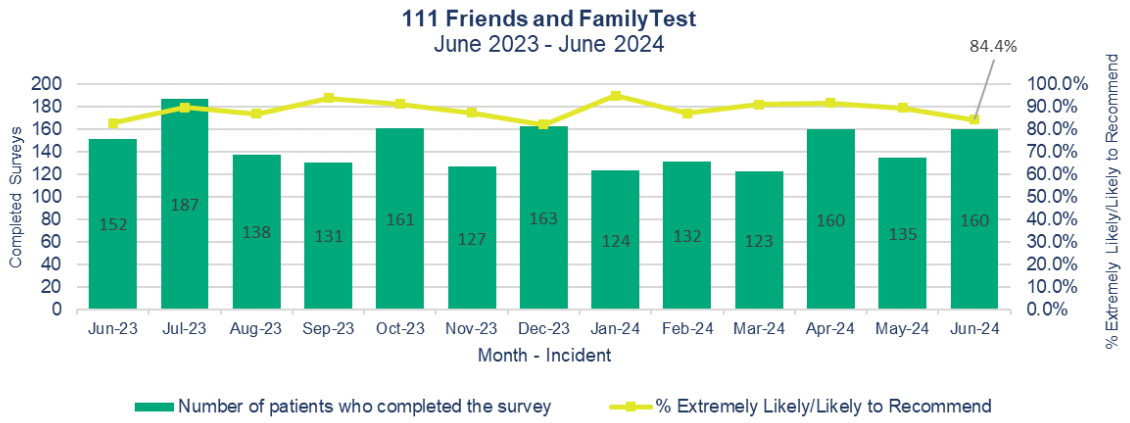
PTS Positive

- *"I call them my heroes because they are always so caring, and I am stretcher only and couldn't get to and from important appointments. They have helped so much in keeping me alive and they make me feel safe."*
- *"When booking the transport, the gentleman I spoke to was very efficient. I got to my appointment on time. The drivers were very polite and I only had to wait less than an hour for transport home. I'm very grateful for the service. Thanks."*

PTS Negative

- *"Some of the drivers tried to put my guide dog into the boot of the car, I told them that I needed the front seat and front well for my guide dog, the driver said it was too small for me and my guide dog but, he would not even let me try the space. In the end the hospital sent him away and asked you to provide another car and driver, this driver needs his licence to work with you revoked, as he refused me any help whatsoever."*
- *"Transport was 2 taxis neither felt safe when in a wheelchair."*

Figure E1.3



NHS 111 Positive

- *" The speed with which I had contact with someone. From call to my GP practice (10:21am) to calling 111 (10;26am), speaking to nurse (?) and being told I would have a telephone consult by 10:45 - to a lovely lady who called at 10:46am. Also, the genuine concern shown by both."*
- *" The ability to email a photo of the injury and have a nurse call me back about it. It's sometimes hard to explain things over the phone so it's very useful to be able to get advice based on a picture. Especially in an evening where a young child is injured."*
- *"The first ever call to 111, I was so ill. Very helpful and understanding young man (very impressed). Living alone with no family near plus my age, the service was a 'life saver'."*

NHS 111 Negative

- *"Went to Northwich Vin first then rang 111 who directed me to open pharmacy, who not able to deal with, passed it back to 111 @ 11:40-ish, 111 rang back at 20:40ish. Far from happy, won't use again."*
- *"I was very dissatisfied . The person I spoke to sent me to Piccadilly Train Station Boots. When I got all the way there, they had no idea what I was talking about."*
- *"I was offered very generic advice which I already knew and could seek online. I was advised of a call back within 2 hours. This did not happen, and the call was received 12 hours later. This was not helpful. I was asked specific questions to establish a life or death situation and felt fobbed off and it seemed to be a box ticking exercise only. My call was a waste of time."*

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

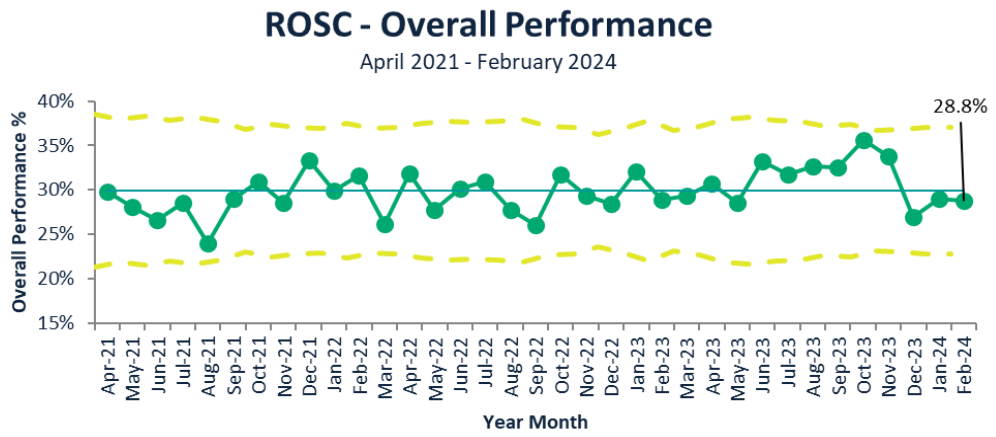


Figure E2.2

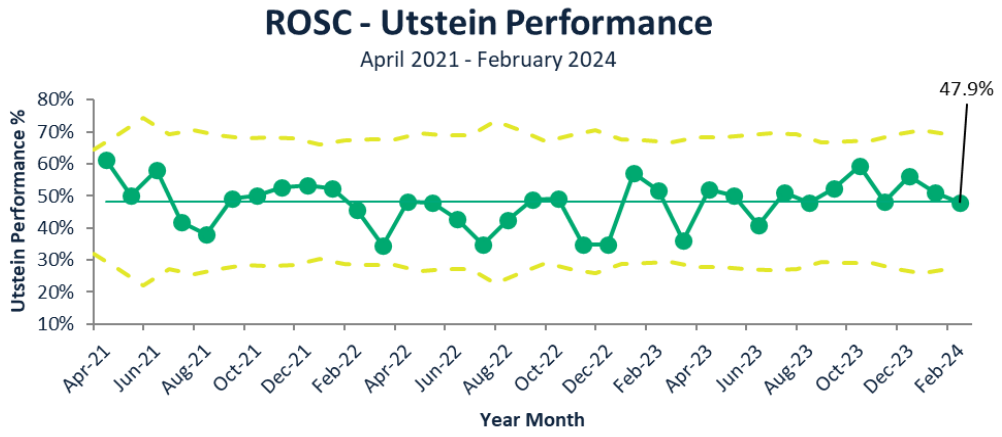


Table E2.3

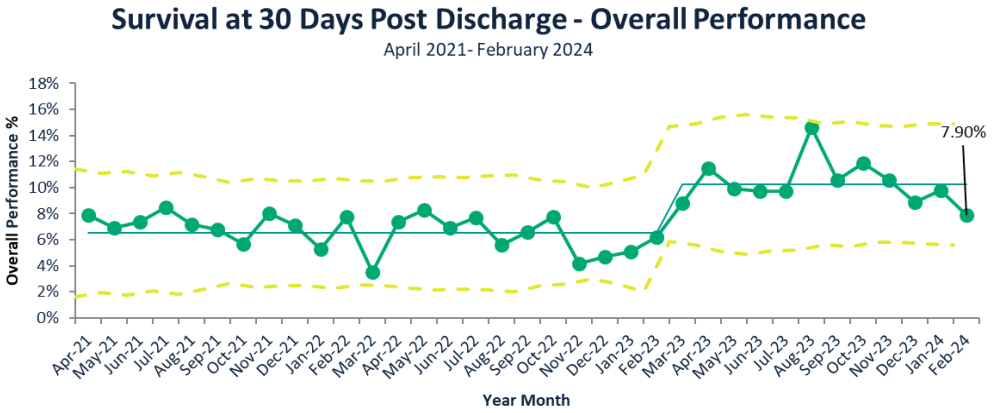


Figure E2.4

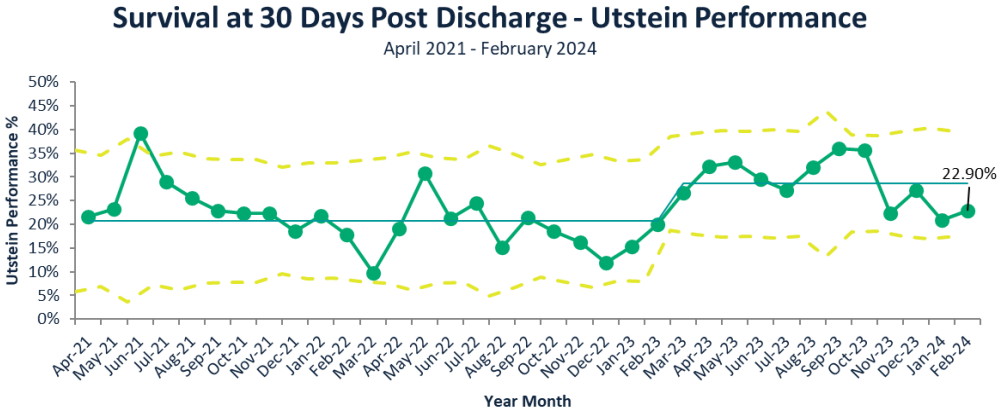


Figure E2.5

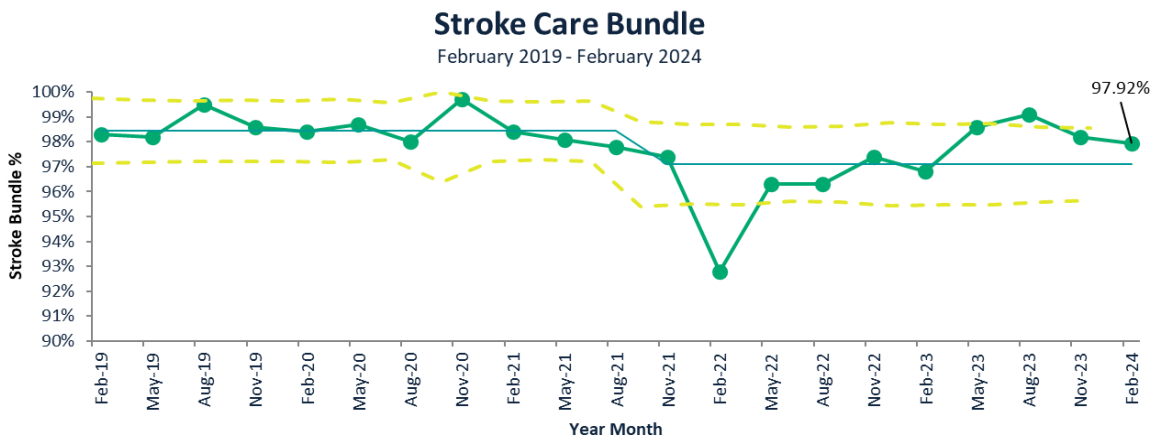


Figure E2.6

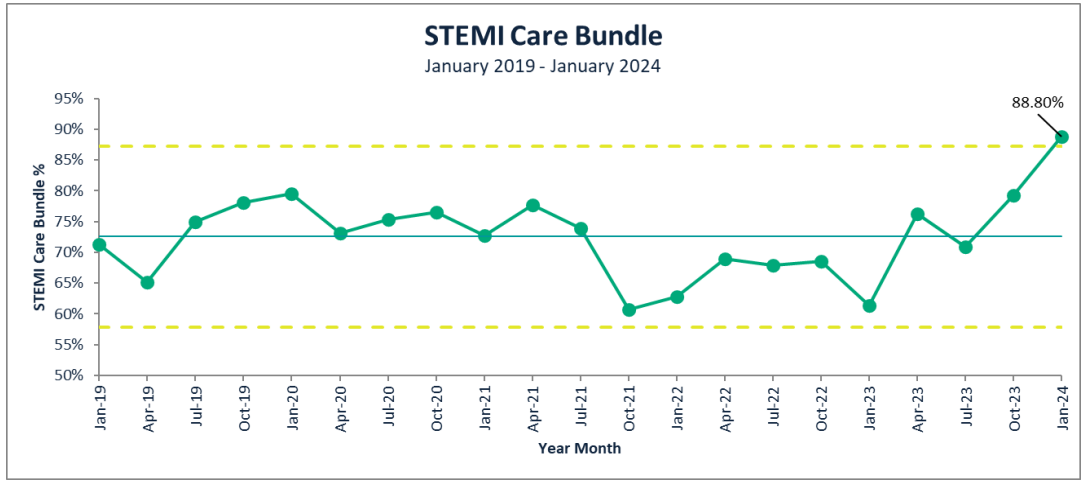


Figure E2.7

Month Year	Stroke Care Bundle Performance
Feb-19	98.3%
May-19	98.2%
Aug-19	99.5%
Nov-19	98.6%
Feb-20	98.4%
May-20	98.7%
Aug-20	98.0%
Nov-20	99.7%
Feb-21	98.4%
May-21	98.1%
Aug-21	97.8%
Nov-21	97.4%
Feb-22	92.8%
May-22	96.3%
Aug-22	96.3%
Nov-22	97.4%
Feb-23	96.8%
May-23	98.6%
Aug-23	99.1%
Nov-23	98.2%
Feb-24	97.9%

Figure E2.8

Month Year	STEMI Care Bundle Performance
Jan-19	71.3%
Apr-19	65.2%
Jul-19	75.0%
Oct-19	78.1%
Jan-20	79.5%
Apr-20	73.1%
Jul-20	75.3%
Oct-20	76.5%
Jan-21	72.8%
Apr-21	77.7%
Jul-21	73.9%
Oct-21	60.7%
Jan-22	62.8%
Apr-22	68.9%
Jul-22	67.9%
Oct-22	68.5%
Jan-23	61.3%
Apr-23	76.2%
Jul-23	70.9%
Oct-23	79.3%
Jan-24	88.8%

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

E3 ACTIVITY & OUTCOMES

Figure E3.1

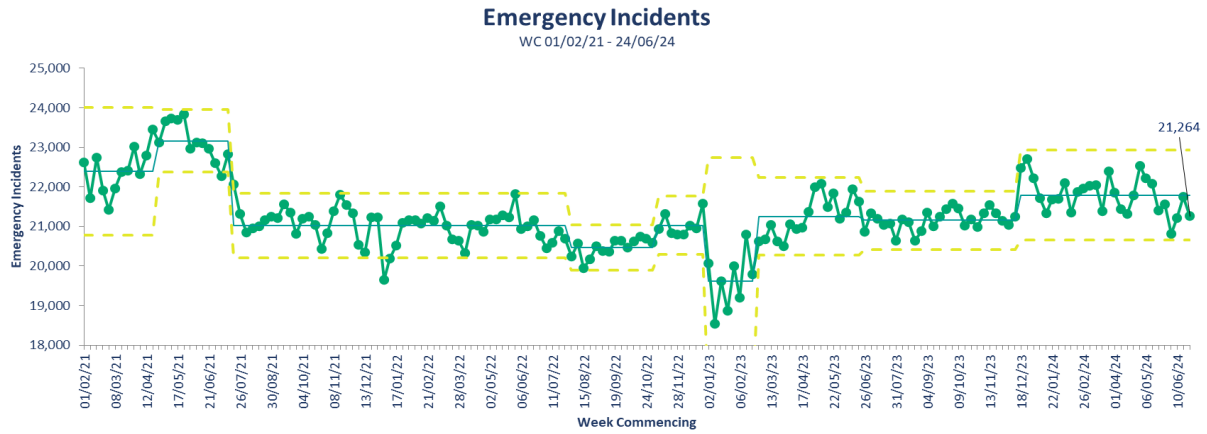


Figure E3.2

Figure E3.3

Sector	No. of Emergency Incidents
G South	9,668
G Central	9,616
M North	9,404
G West	8,844
G East	8,506
M East	7,284
CL East Lancashire	7,064
M West	6,219
CL South Lancashire	5,753
M South	5,326
CL Fylde	4,905
CL North Cumbria	4,566
CL Morecambe Bay	4,100
ICB	**No. of Emergency Incidents**
Greater Manchester	36,634
Cheshire & Merseyside	28,233
Lancashire & South Cumbria	21,822
North East & North Cumbria	4,566

Figure E3.4

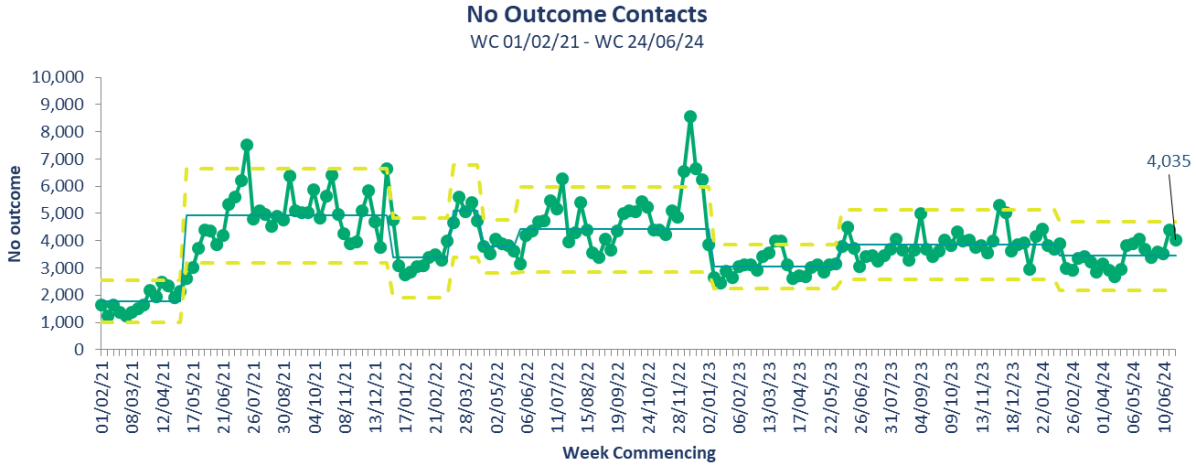


Figure E3.5

Jun	Calls	% Change from previous year	Incidents	% Change from previous year
2021	143,074		98,524	
2022	131,065	-8%	90,923	-8%
2023	118,947	-9%	91,932	1%
2024	118,635	0%	91,322	-1%

Figure E3.6

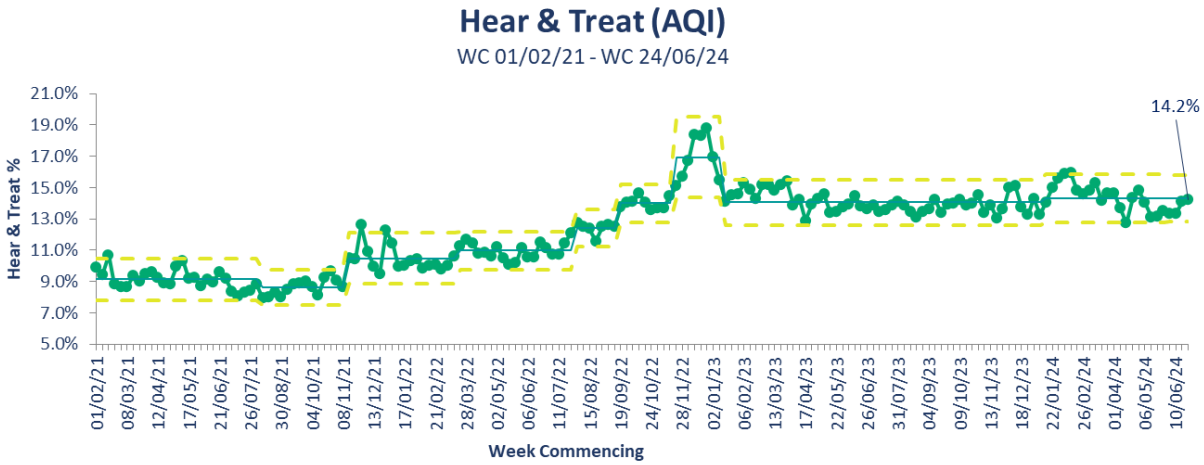


Figure E3.7

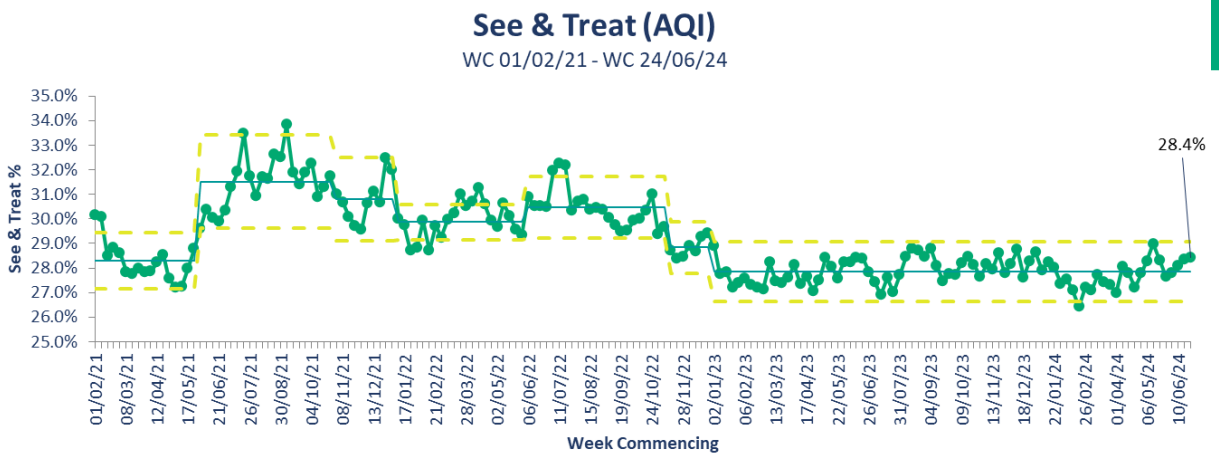


Figure E3.8

Sector	Monthly Hear & Treat	%
G Central		17.02%
G East		15.69%
CL Fylde		14.37%
M East		13.95%
CL East Lancashire		13.72%
G West		13.66%
CL South Lancashire		13.59%
G South		13.30%
M North		12.81%
M South		12.43%
M West		12.22%
CL North Cumbria		12.07%
CL Morecambe Bay		11.02%

ICB	Monthly Hear & Treat	%
Greater Manchester		14.97%
Lancashire & South Cumbria		13.33%
Cheshire & Merseyside		12.90%
North East & North Cumbria		12.08%

Figure E3.9

Sector	Monthly See & Treat	%
CL Morecambe Bay		32.07%
CL North Cumbria		31.60%
M South		31.22%
CL South Lancashire		29.74%
CL Fylde		29.60%
G West		29.44%
CL East Lancashire		29.23%
G East		27.87%
G Central		27.70%
G South		27.17%
M North		26.39%
M West		26.16%
M East		23.90%

ICB	Monthly See & Treat	%
North East & North Cumbria		31.59%
Cheshire & Merseyside		29.99%
Lancashire & South Cumbria		28.08%
Greater Manchester		26.61%

Figure E3.10

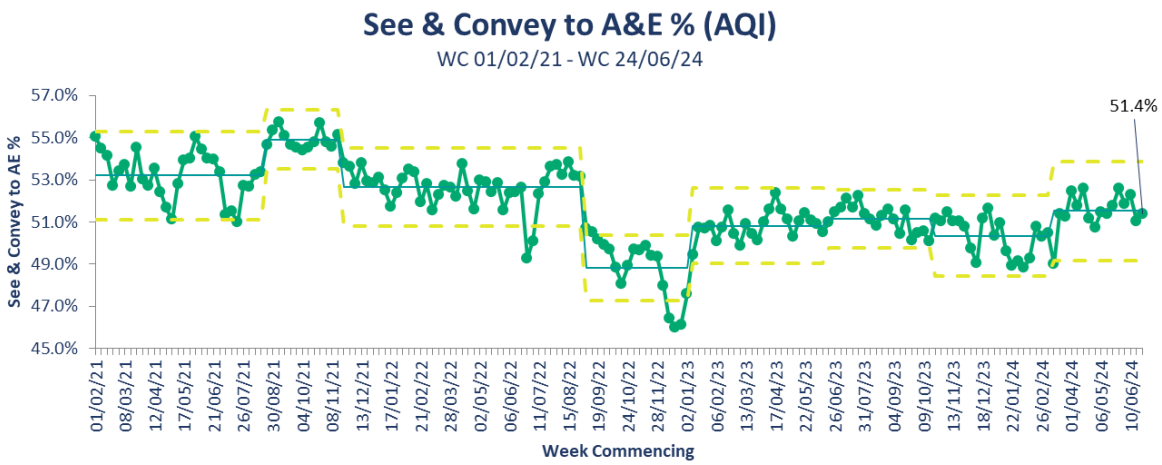


Figure E3.11

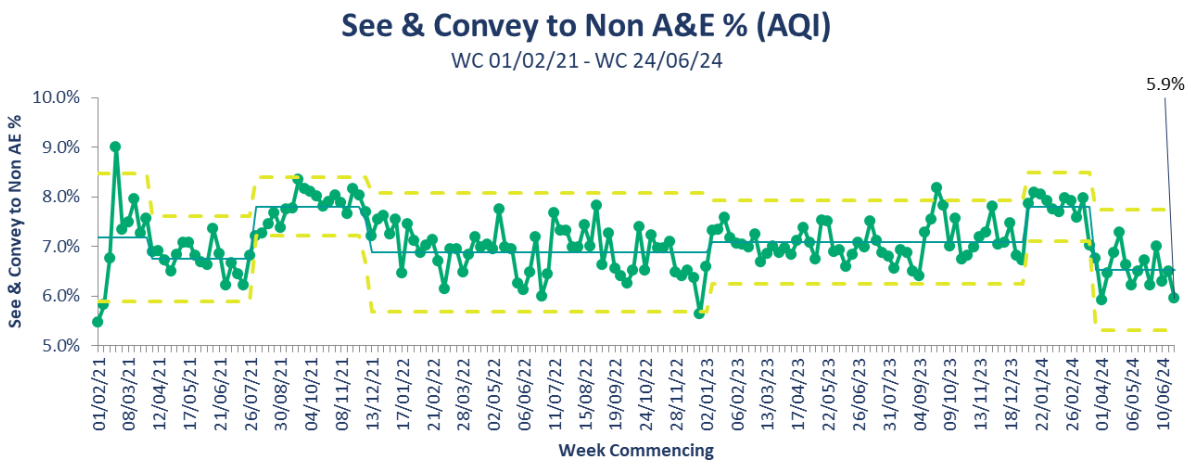


Figure E3.12

Sector	Monthly See & Convey	%
G Central		55.27%
CL Fylde		56.02%
CL North Cumbria		56.33%
M South		56.35%
G East		56.43%
CL South Lancashire		56.67%
G West		56.90%
CL Morecambe Bay		56.90%
CL East Lancashire		57.05%
G South		59.53%
M North		60.79%
M West		61.62%
M East		62.15%

ICB	Monthly See & Convey	%
North East & North Cumbria		56.33%
Lancashire & South Cumbria		56.68%
Greater Manchester		56.95%
Cheshire & Merseyside		60.48%

Figure E3.13

Sector	Monthly See & Convey to AE	%
CL East Lancashire		45.71%
CL North Cumbria		47.77%
G Central		49.92%
CL Fylde		50.66%
M South		50.77%
G East		50.88%
CL South Lancashire		50.90%
CL Morecambe Bay		51.90%
G West		52.42%
M East		54.16%
M West		54.17%
M North		54.55%
G South		54.76%

ICB	Monthly See & Convey to AE	%
North East & North Cumbria		47.75%
Lancashire & South Cumbria		49.35%
Greater Manchester		51.91%
Cheshire & Merseyside		53.65%

Figure E3.14

Sector	Monthly See & Convey to Non AE	%
G West		4.48%
G South		4.77%
CL Morecambe Bay		5.00%
G Central		5.36%
CL Fylde		5.36%
G East		5.55%
M South		5.58%
CL South Lancashire		5.77%
M North		6.24%
M West		7.44%
M East		7.99%
CL North Cumbria		8.56%
CL East Lancashire		11.34%

ICB	Monthly See & Convey to Non AE	%
Greater Manchester		5.04%
Cheshire & Merseyside		6.84%
Lancashire & South Cumbria		7.33%
North East & North Cumbria		8.58%

Figure E3.15

Rank	Trust	Hear & Treat	%
1	West Midlands		19.8%
2	London		19.3%
3	East Midlands		17.5%
4	Yorkshire		15.3%
5	South Western		14.9%
6	North West		13.8%
7	South East Coast		13.4%
8	South Central		13.1%
9	Isle of Wight		9.3%
10	East of England		8.9%
11	North East		6.8%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		36.3%
2	Isle of Wight		35.6%
3	East of England		34.9%
4	South Central		33.1%
5	North East		30.8%
6	South East Coast		30.6%
7	East Midlands		28.3%
8	North West		28.2%
9	London		27.3%
10	West Midlands		27.1%
11	Yorkshire		25.8%

Figure E3.17

Rank	Trust	See & Convey	%
1	South Western		48.9%
2	West Midlands		53.1%
3	London		53.3%
4	South Central		53.8%
5	East Midlands		54.1%
6	Isle of Wight		55.2%
7	South East Coast		56.0%
8	East of England		56.2%
9	North West		57.9%
10	Yorkshire		58.9%
11	North East		62.4%

Figure E3.18

Rank	Trust	See & Convey Non AE	%
1	North East		7.6%
2	East Midlands		6.6%
3	North West		6.3%
4	Yorkshire		6.3%
5	West Midlands		5.6%
6	South Central		4.6%
7	South Western		4.1%
8	East of England		3.2%
9	London		2.6%
10	South East Coast		2.0%
11	Isle of Wight		0.7%

Operational

O1 CALL PICK UP

Figure O1.1

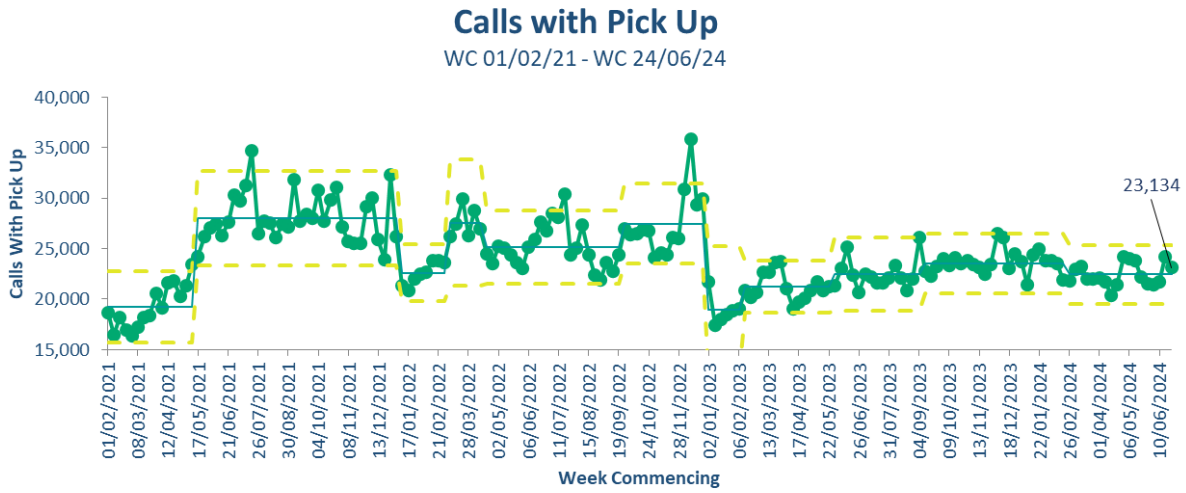


Figure O1.2

Call Pick Up Mean	
Jun 2024	1
YTD	0
Ranking	1st

Figure O1.3

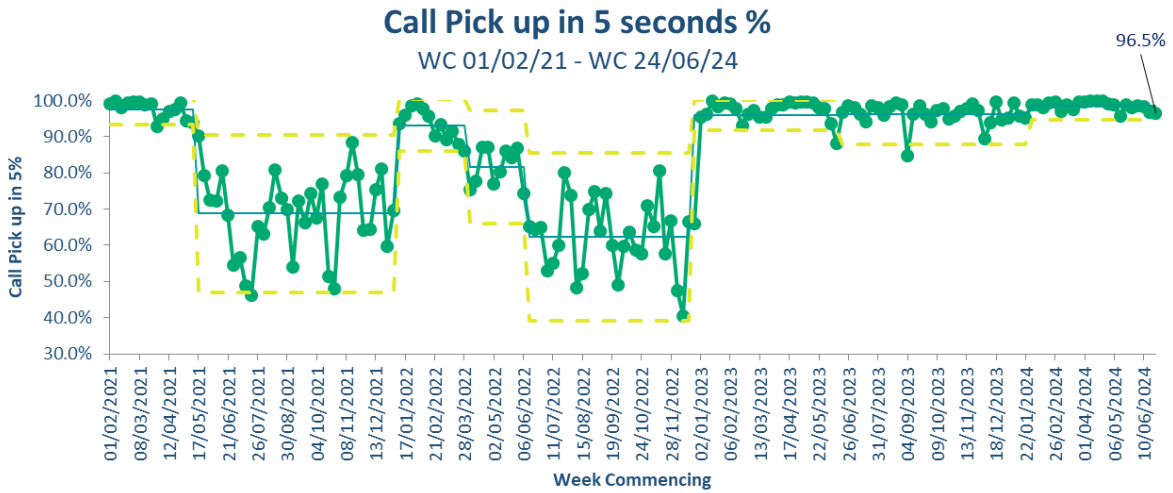


Figure O1.4

Call Pick Up 90th Percentile	
Jun 2024	0
YTD	0
Ranking	1st

Figure O1.5

Call Pick Up 95th Percentile	
Jun 2024	0
YTD	0
Ranking	1st

O3 ARP RESPONSE TIMES

June 2024

Figure O3.1

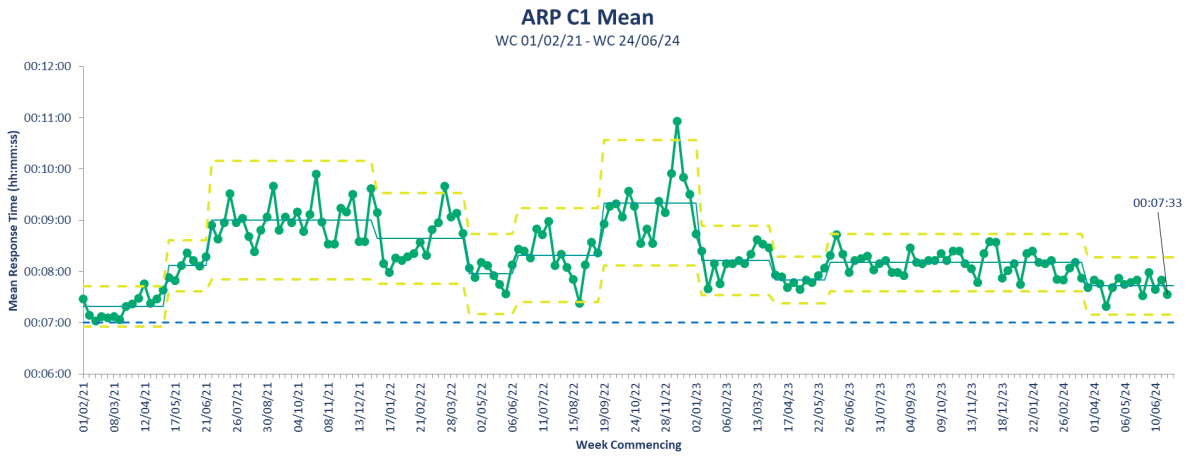


Figure O3.2

Figure O3.3

Sector	C1 Mean	Time
G Central		00:06:34
G South		00:07:01
G West		00:07:06
M North		00:07:07
G East		00:07:17
CL Fylde		00:07:39
CL East Lancashire		00:07:51
M East		00:07:56
CL Morecambe Bay		00:08:28
M West		00:08:37
CL North Cumbria		00:08:53
CL South Lancashire		00:09:04
M South		00:09:59
ICB	**C1 Mean**	**Time**
Greater Manchester		00:06:56
Cheshire & Merseyside		00:08:06
Lancashire & South Cumbria		00:08:13
North East & North Cumbria		00:08:53

Figure O3.4

C1 Mean	
Target	7:00
Jun 2024	7:44
YTD	7:43
Ranking	3rd

Figure O3.5

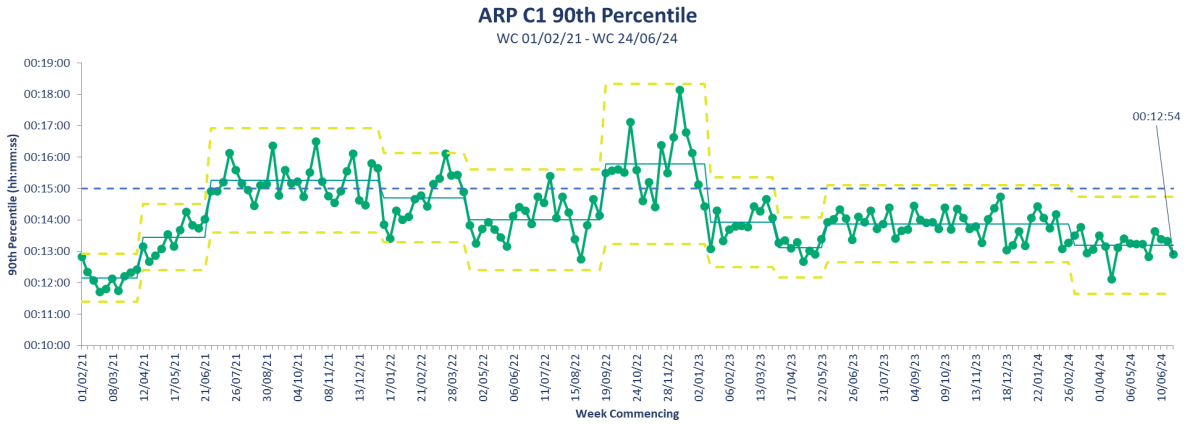


Figure O3.6

Figure O3.7

Sector	C1 90th	Time
G Central		00:10:49
G South		00:11:20
G East		00:11:34
M North		00:11:40
G West		00:11:41
CL East Lancashire		00:13:31
M East		00:13:36
CL Fylde		00:13:50
M West		00:15:06
CL South Lancashire		00:15:13
CL Morecambe Bay		00:16:14
CL North Cumbria		00:16:51
M South		00:17:21
ICB	**C1 90th**	**Time**
Greater Manchester		00:11:13
Cheshire & Merseyside		00:14:08
Lancashire & South Cumbria		00:14:32
North East & North Cumbria		00:16:51

Figure O3.8

C1 90th	
Target	15:00
Jun 2024	13:15
YTD	13:09
Ranking	3rd

June 2024

Figure O3.9

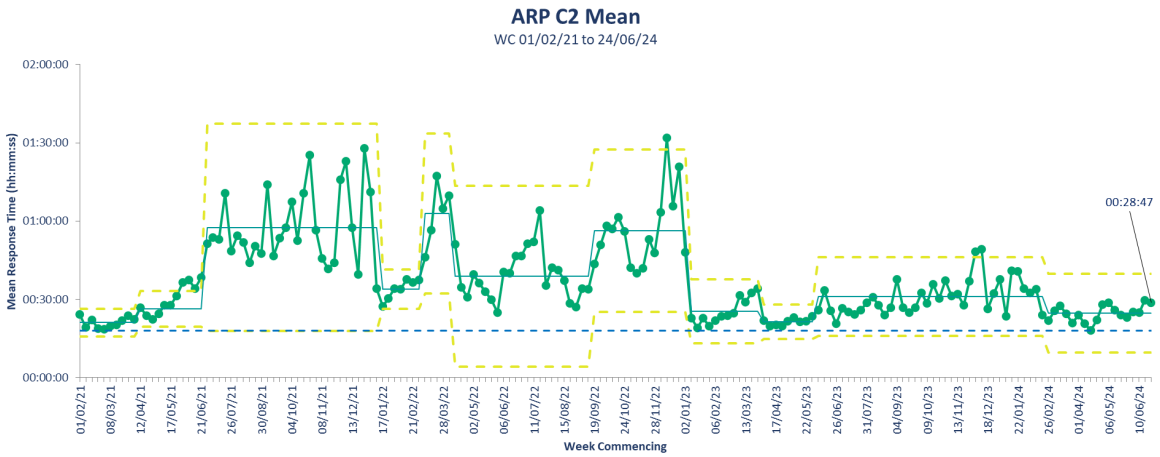


Figure O3.10

C2 Mean (Red=>18m)

Figure O3.11

Sector	C2 Mean	Time
G South		00:20:02
CL North Cumbria		00:21:08
G Central		00:21:34
G East		00:22:16
CL East Lancashire		00:22:53
CL Morecambe Bay		00:23:36
CL Fylde		00:24:11
G West		00:25:34
CL South Lancashire		00:26:03
M South		00:35:15
M North		00:35:18
M East		00:35:58
M West		00:36:28

ICB	C2 Mean	Time
North East & North Cumbria		00:21:08
Greater Manchester		00:22:14
Lancashire & South Cumbria		00:24:08
Cheshire & Merseyside		00:35:43

Figure O3.12

C2 Mean	
Target	18:00
Jun 2024	26:53
YTD	24:52
Ranking	1st

Figure O3.13

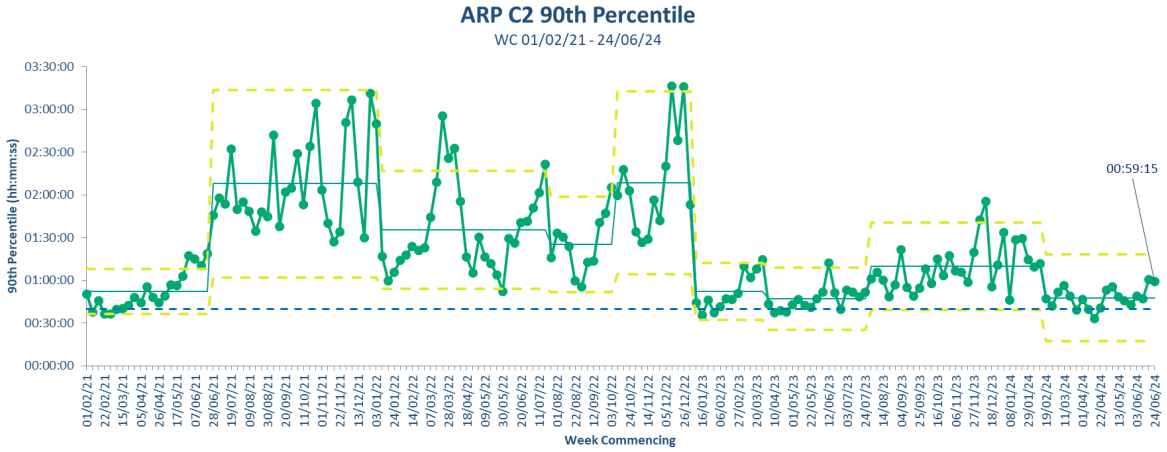


Figure O3.14

C2 90th (Red=>40m)

Figure O3.15

Sector	C2 90th	Time
G South		00:36:56
CL North Cumbria		00:39:11
G Central		00:39:11
G East		00:40:48
CL East Lancashire		00:41:54
CL South Lancashire		00:47:36
CL Morecambe Bay		00:47:39
G West		00:48:16
CL Fylde		00:48:38
M South		01:09:44
M East		01:11:40
M North		01:14:01
M West		01:16:47

ICB	C2 90th	Time
North East & North Cumbria		00:39:11
Greater Manchester		00:41:11
Lancashire & South Cumbria		00:45:54
Cheshire & Merseyside		01:13:26

Figure O3.16

C2 90th	
Target	40:00
Jun 2024	53:02
YTD	48:01
Ranking	1st

June 2024

Figure O3.17

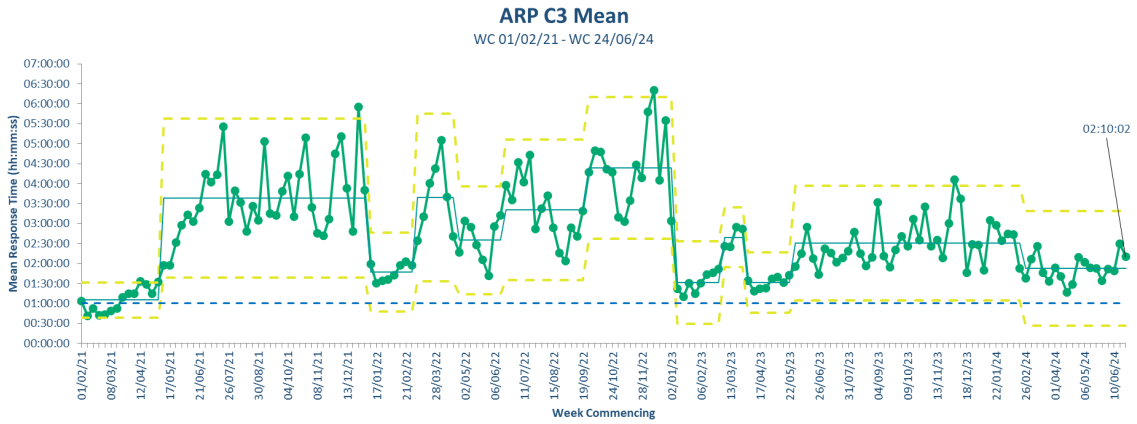


Figure O3.18

Figure O3.19

Sector	C3 Mean	Time
CL North Cumbria		01:01:40
CL Morecambe Bay		01:15:41
CL East Lancashire		01:30:01
CL Fylde		01:32:27
G South		01:50:46
CL South Lancashire		01:52:45
G East		01:58:22
G Central		02:11:51
M South		02:12:45
G West		02:15:51
M West		02:33:44
M North		02:34:53
M East		02:41:59
ICB	**C3 Mean**	**Time**
North East & North Cumbria		01:01:40
Lancashire & South Cumbria		01:34:04
Greater Manchester		02:04:29
Cheshire & Merseyside		02:31:32

Figure O3.20

C3 Mean	
Target	1:00:00
Jun 2024	2:02:37
YTD	1:50:55
Ranking	5th

Figure O3.21

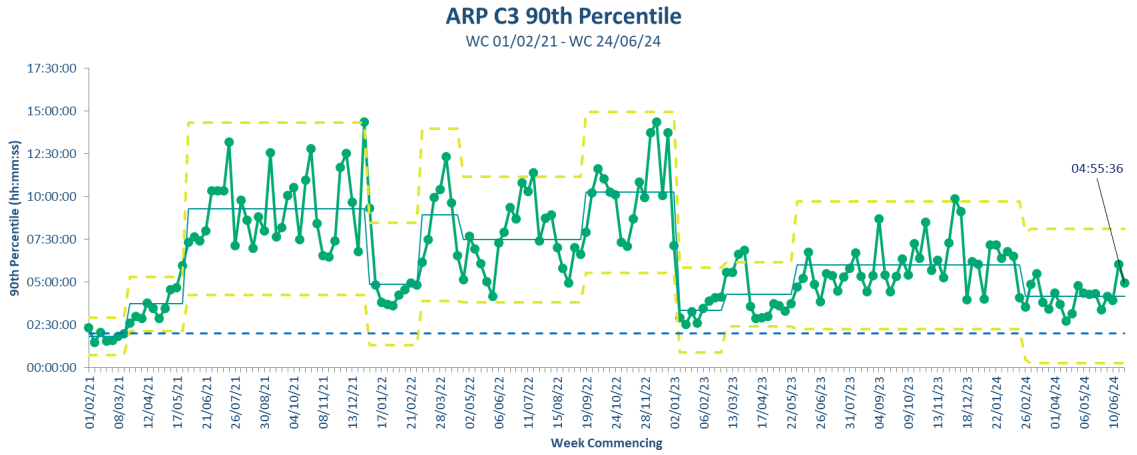


Figure O3.22

Figure O3.23

Sector	C3 90th	Time
CL North Cumbria		02:11:57
CL Morecambe Bay		02:55:52
CL East Lancashire		03:15:31
CL Fylde		03:37:47
G South		04:01:10
CL South Lancashire		04:11:47
G East		04:34:55
M South		04:58:46
G Central		05:01:13
G West		05:06:01
M West		05:48:24
M East		06:05:30
M North		06:21:52
ICB	**C3 90th**	**Time**
North East & North Cumbria		02:11:57
Lancashire & South Cumbria		03:36:28
Greater Manchester		04:38:04
Cheshire & Merseyside		05:48:33

Figure O3.24

C3 90th	
Target	2:00:00
Jun 2024	4:40:55
YTD	4:09:59
Ranking	5th

June 2024

Figure O3.25

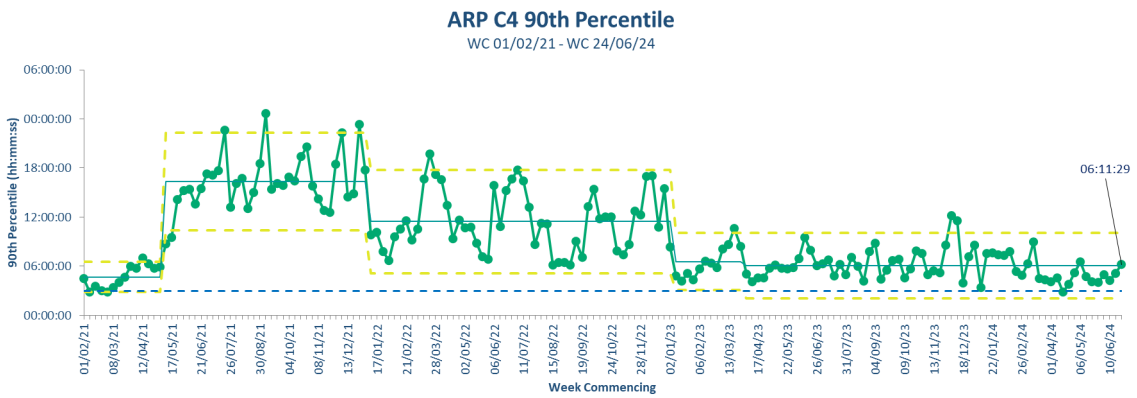


Figure O3.26

Figure O3.27

Sector	C4 90th	Time
CL North Cumbria		02:01:21
CL Morecambe Bay		02:37:48
M East		03:27:30
CL East Lancashire		03:30:46
M West		03:33:08
G Central		04:13:28
CL Fylde		04:14:47
CL South Lancashire		04:22:03
G South		04:48:01
M South		04:56:10
G East		06:04:30
G West		06:19:04
M North		07:34:29

ICB	C4 90th	Time
North East & North Cumbria		02:01:21
Lancashire & South Cumbria		03:31:18
Cheshire & Merseyside		04:42:29
Greater Manchester		05:24:50

Figure O3.28

C4 90th	
Target	3:00:00
Jun 2024	4:37:55
YTD	4:27:26
Ranking	3rd

O3 ARP Provider Comparison

Figure O3.25

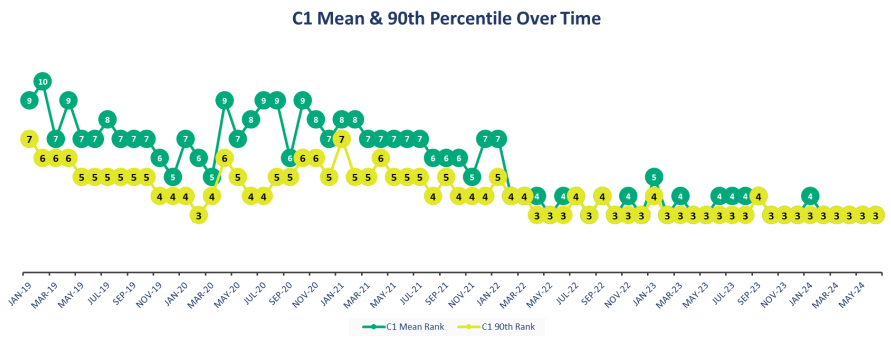


Figure O3.26

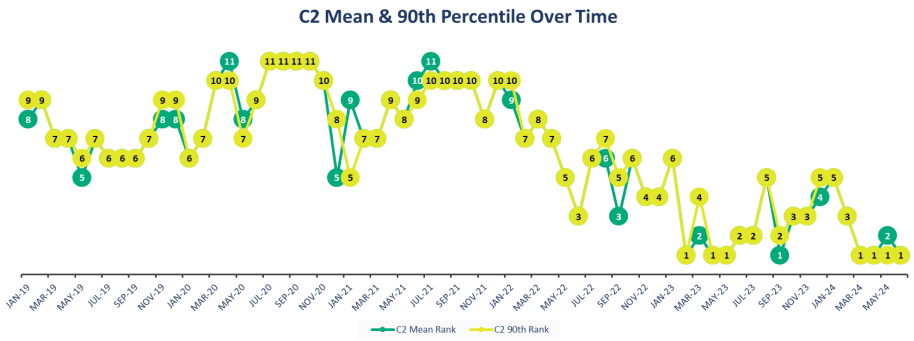


Figure O3.27

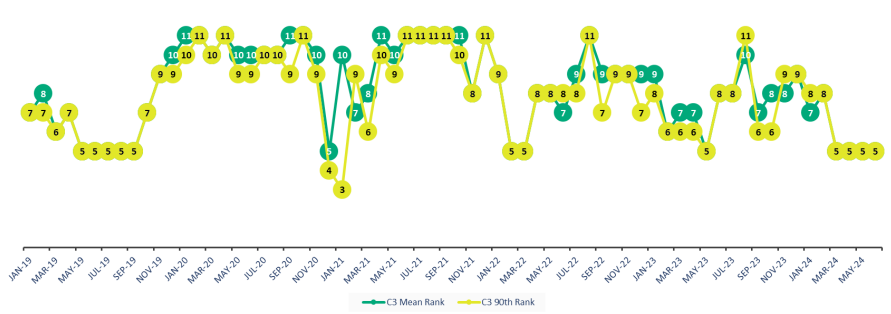
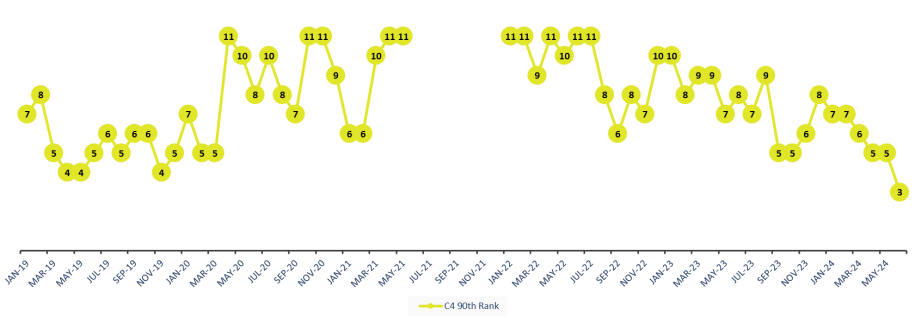


Figure O3.28



Rank	Trust	C1 Mean	Time
1	North East		06:48
2	London		07:27
3	North West		07:44
4	Yorkshire		07:58
5	West Midlands		08:15
6	South East Coast		08:24
7	South Central		09:05
8	East Midlands		09:09
9	Isle of Wight		09:15
10	East of England		09:19
11	South Western		09:40

Rank	Trust	C1 90th	Time
1	North East		11:46
2	London		12:35
3	North West		13:15
4	Yorkshire		13:53
5	West Midlands		14:27
6	South East Coast		15:30
7	East Midlands		16:16
8	South Central		16:44
9	East of England		17:31
10	Isle of Wight		17:40
11	South Western		18:18

Rank	Trust	C2 Mean	Time
1	North West		0:26:53
2	North East		0:27:11
3	West Midlands		0:28:30
4	South Central		0:29:50
5	South East Coast		0:30:00
6	Yorkshire		0:30:43
7	Isle of Wight		0:31:51
8	East Midlands		0:38:04
9	London		0:39:44
10	South Western		0:43:18
11	East of England		0:45:11

Rank	Trust	C2 90th	Time
1	North West		0:53:02
2	North East		0:55:12
3	South Central		0:58:28
4	Isle of Wight		1:01:34
5	South East Coast		1:01:50
6	West Midlands		1:02:28
7	Yorkshire		1:08:41
8	East Midlands		1:20:29
9	London		1:27:39
10	South Western		1:30:49
11	East of England		1:37:43

Rank	Trust	C3 Mean	Time
1	North East		01:04:51
2	London		01:22:35
3	Yorkshire		01:28:24
4	Isle of Wight		01:35:31
5	North West		02:02:37
6	South Western		02:07:40
7	West Midlands		02:19:18
8	South Central		02:19:58
9	South East Coast		02:20:59
10	East of England		02:30:50
11	East Midlands		02:33:20

Rank	Trust	C3 90th	Time
1	North East		02:35:09
2	London		03:14:04
3	Yorkshire		03:25:10
4	Isle of Wight		03:34:57
5	North West		04:40:55
6	South Central		05:05:33
7	South Western		05:09:33
8	South East Coast		05:27:18
9	East of England		05:55:02
10	East Midlands		06:05:34
11	West Midlands		06:19:58

Rank	Trust	C4 90th	Time
1	North East		02:53:52
2	Yorkshire		03:10:19
3	North West		04:37:35
4	London		04:41:53
5	East Midlands		04:46:35
6	Isle of Wight		05:07:44
7	South Western		05:19:44
8	South East Coast		06:07:57
9	South Central		06:33:53
10	West Midlands		09:05:58
11	East of England		09:25:15

O3 LONG WAITS

Table O3.29

Year Month	Total No. of C1 long waits
Apr-20	329
May-20	186
Jun-20	196
Jul-20	274
Aug-20	437
Sep-20	394
Oct-20	586
Nov-20	447
Dec-20	455
Jan-21	663
Feb-21	340
Mar-21	358
Apr-21	489
May-21	734
Jun-21	971
Jul-21	1,534
Aug-21	1,226
Sep-21	1,501
Oct-21	1,650
Nov-21	1,329
Dec-21	1,590
Jan-22	1,109
Feb-22	985
Mar-22	1,609
Apr-22	1,145
May-22	869
Jun-22	940
Jul-22	1,207
Aug-22	653
Sep-22	804
Oct-22	1,186
Nov-22	959
Dec-22	1,619
Jan-23	694
Feb-23	543
Mar-23	708
Apr-23	509
May-23	505
Jun-23	693
Jul-23	706
Aug-23	643
Sep-23	713
Oct-23	761
Nov-23	665
Dec-23	785
Jan-24	748
Feb-24	641
Mar-24	565
Apr-24	507
May-24	604
Jun-24	600

Figure O3.29

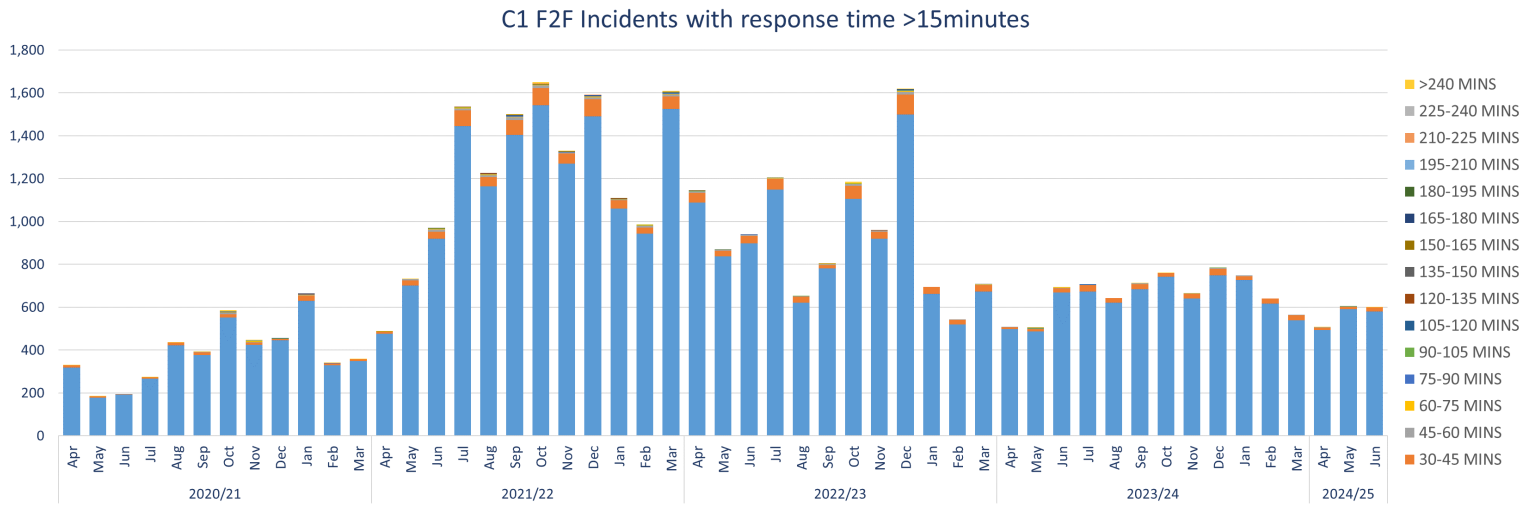


Figure O3.30

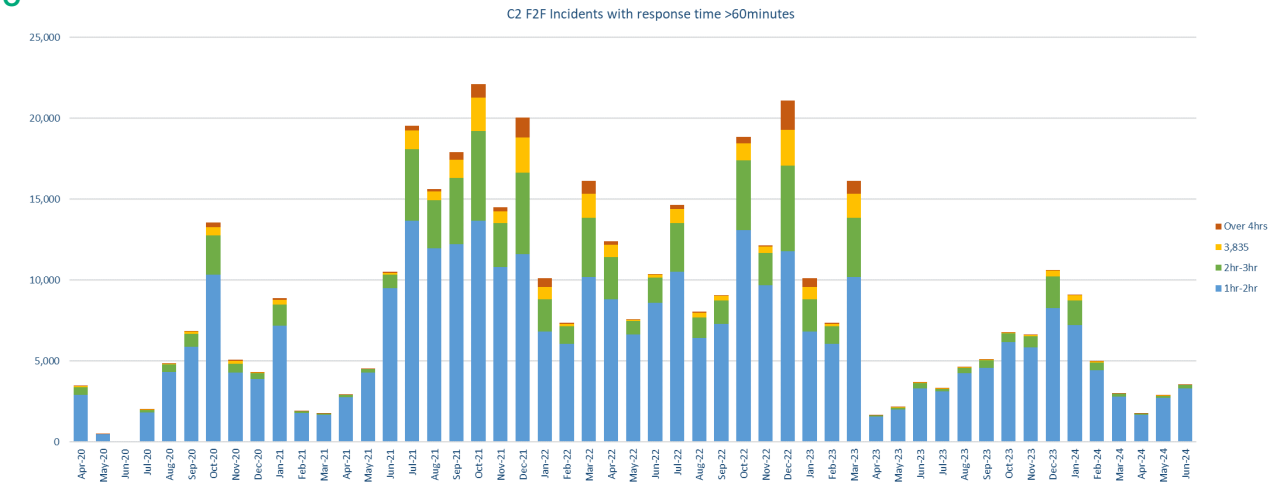


Table O3.30

Year Month	Total No. of C2 long waits
Apr-20	3,458
May-20	483
Jun-20	1,193
Jul-20	2,003
Aug-20	4,860
Sep-20	6,874
Oct-20	13,563
Nov-20	5,090
Dec-20	4,290
Jan-21	8,889
Feb-21	1,908
Mar-21	1,739
Apr-21	2,918
May-21	4,523
Jun-21	10,503
Jul-21	19,540
Aug-21	15,612
Sep-21	17,922
Oct-21	22,113
Nov-21	14,517
Dec-21	20,037
Jan-22	10,127
Feb-22	7,349
Mar-22	16,135
Apr-22	12,400
May-22	7,564
Jun-22	10,374
Jul-22	14,649
Aug-22	8,051
Sep-22	9,057
Oct-22	18,870
Nov-22	12,153
Dec-22	21,089
Jan-23	10,127
Feb-23	7,349
Mar-23	16,135
Apr-23	1,650
May-23	2,142
Jun-23	3,670
Jul-23	3,294
Aug-23	4,614
Sep-23	5,089
Oct-23	6,758
Nov-23	6,611
Dec-23	10,636
Jan-24	9,113
Feb-24	4,975
Mar-24	2,999
Apr-24	1,761
May-24	2,860
Jun-24	3526

O3 A&E TURNAROUND

Figure O3.1

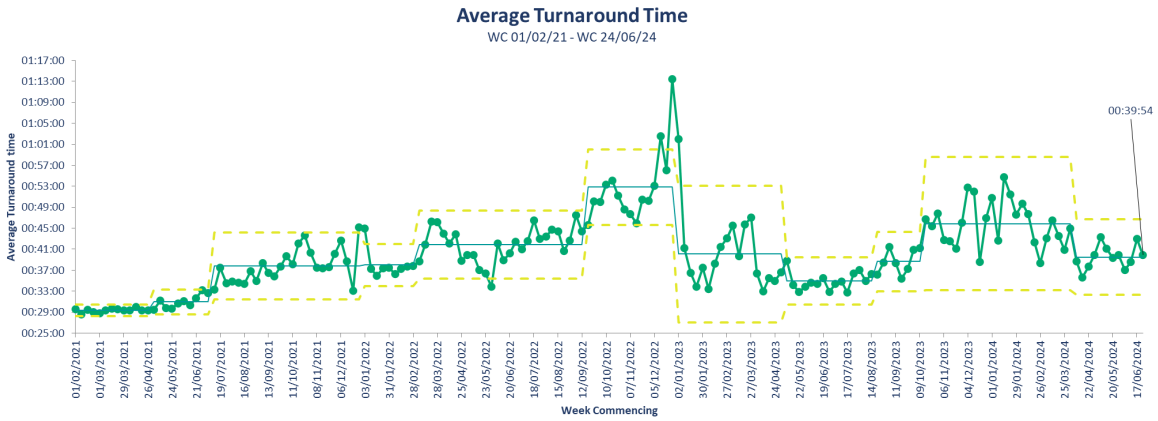


Figure O3.2

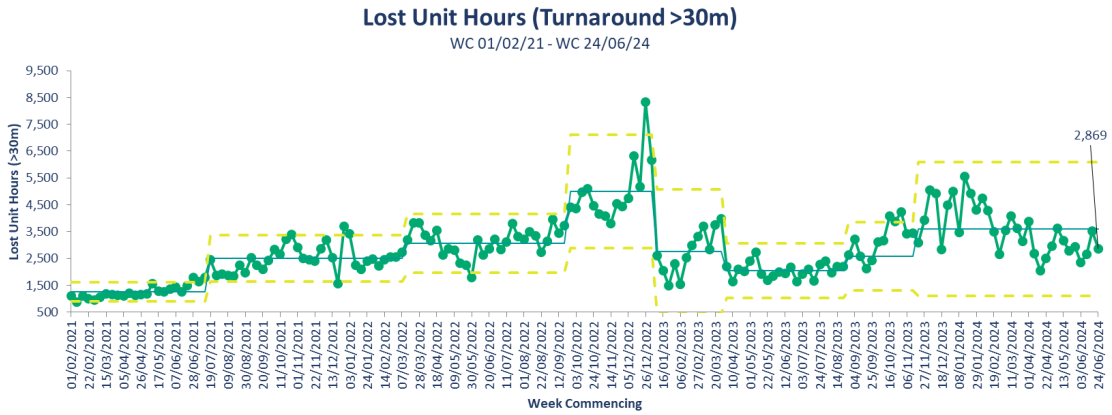


Table O3.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Jun-23	46,866	0:34:17	0:22:25	11:29
Jul-23	48,412	0:34:46	0:22:55	11:28
Aug-23	47,374	0:36:21	0:24:43	11:23
Sep-23	46,282	0:37:56	0:26:05	11:24
Oct-23	47,585	0:43:51	0:32:40	11:28
Nov-23	46,594	0:43:32	0:31:28	11:03
Dec-23	48,733	0:47:03	0:35:21	11:06
Jan-24	47,951	0:50:04	0:38:36	11:14
Feb-24	44,937	0:45:10	0:34:40	10:31
Mar-24	49,091	0:42:52	0:32:27	10:25
Apr-24	48,748	0:39:38	0:29:33	10:06
May-24	50,239	0:40:48	0:31:13	09:36
Jun-24	47,245	0:39:23	0:30:10	09:19

Table O3.2

Top 5 Trusts with most lost unit hours		
Trust	Area	Lost Unit Hours
Whiston Hospital	Cheshire & Merseyside	1,390
Arrowe Park Hospital	Cheshire & Merseyside	1,051
Countess of Chester Hospital	Cheshire & Merseyside	1,047
Aintree University Hospital	Cheshire & Merseyside	1,025
Blackpool Victoria Hospital	Cumbria & Lancashire	919

Table O3.3

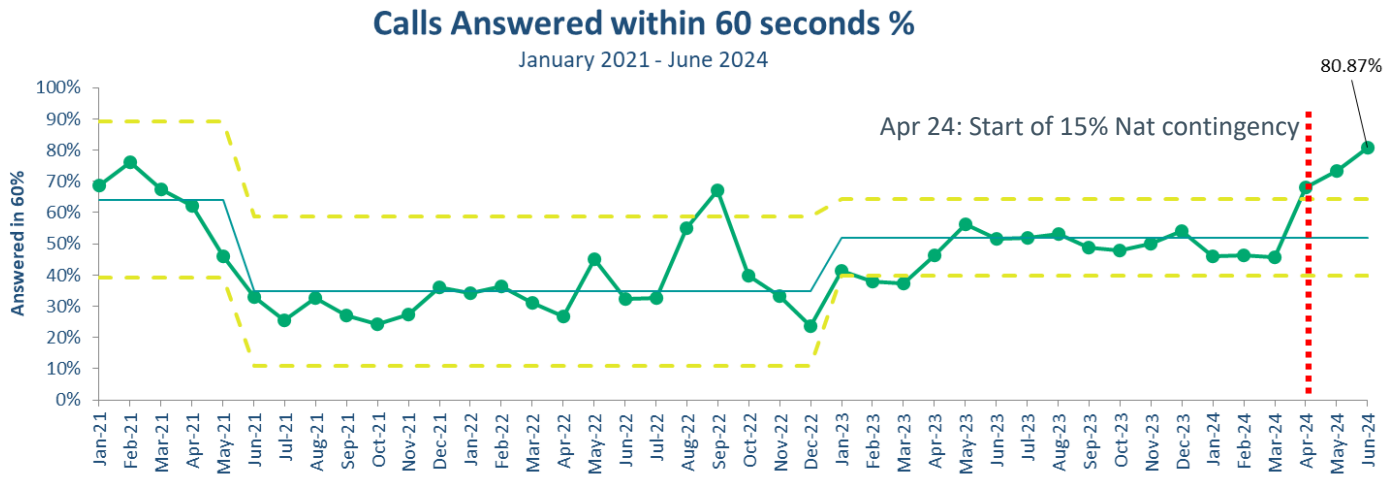
Month	No. of patients waiting outside A&E for handover
Jan-21	528
Feb-21	129
Mar-21	182
Apr-21	196
May-21	282
Jun-21	491
Jul-21	585
Aug-21	674
Sep-21	902
Oct-21	1156
Nov-21	739
Dec-21	824
Jan-22	708
Feb-22	590
Mar-22	936
Apr-22	1057
May-22	891
Jun-22	926
Jul-22	975
Aug-22	1099
Sep-22	1490
Oct-22	2319
Nov-22	1283
Dec-22	1775
Jan-23	862
Feb-23	514
Mar-23	1113
Apr-23	538
May-23	898
Jun-23	545
Jul-23	577
Aug-23	943
Sep-23	1004
Oct-23	1746
Nov-23	1414
Dec-23	2121
Jan-24	2397
Feb-24	1946
Mar-24	1524
Apr-24	1062
May-24	1579
Jun-24	1594

O4 111 ACTIVITY & PERFORMANCE

Figure O4.1

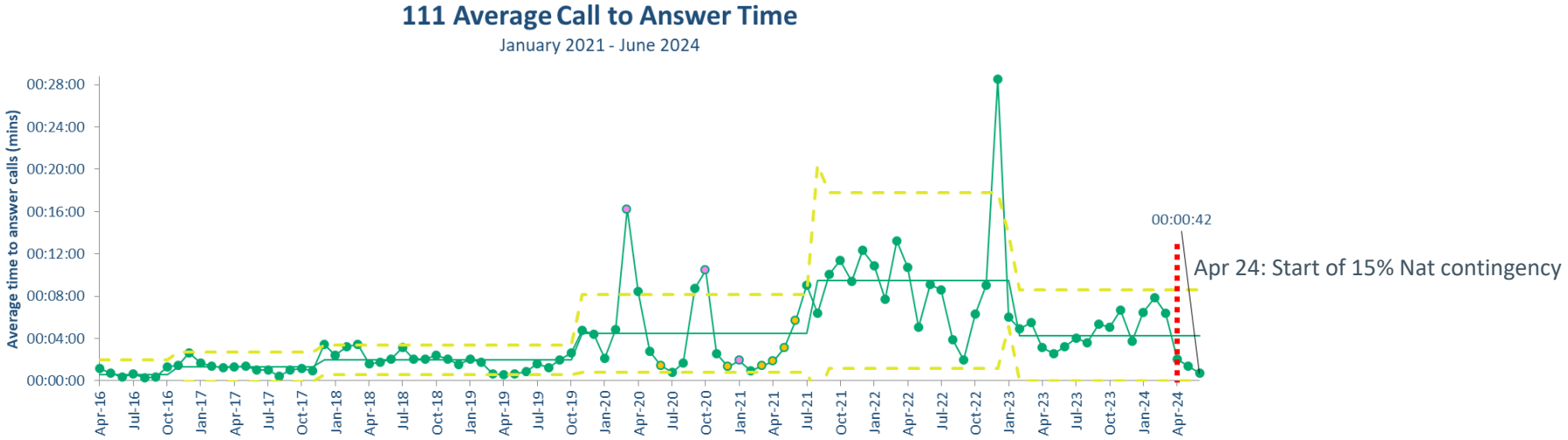
Calls Offered	
Jun 2024	142,627
YTD	466,590

Figure O4.2



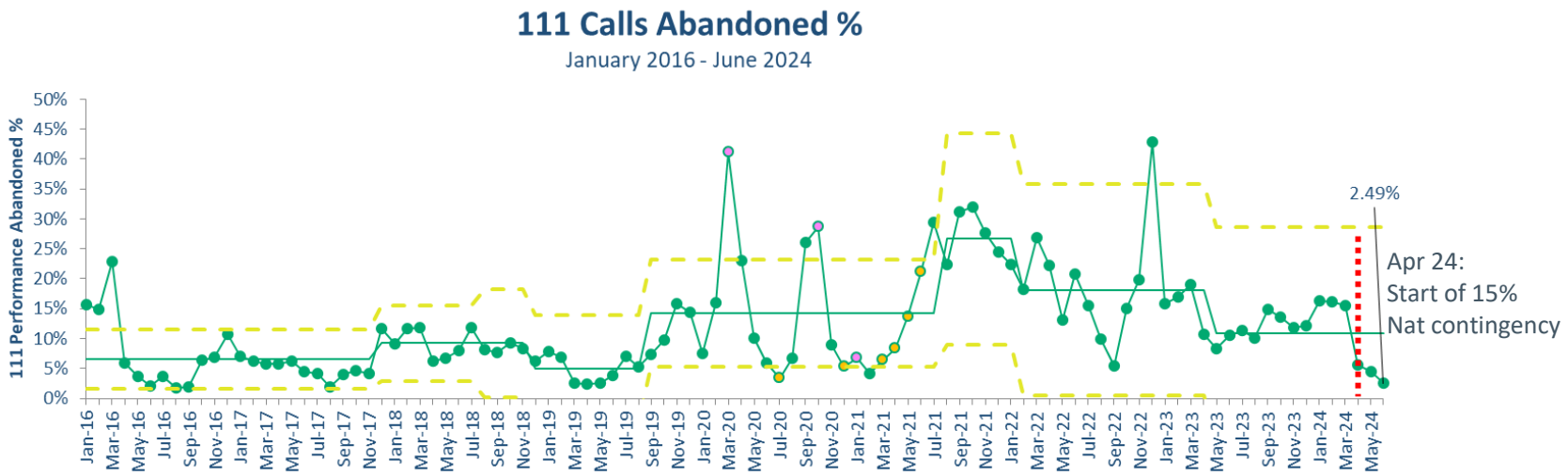
Calls Answered within 60 Seconds %	
Target	95%
Jun 2024	80.87%
YTD	74%
National	78.1%
Ranking	8th / 30

Figure O4.3



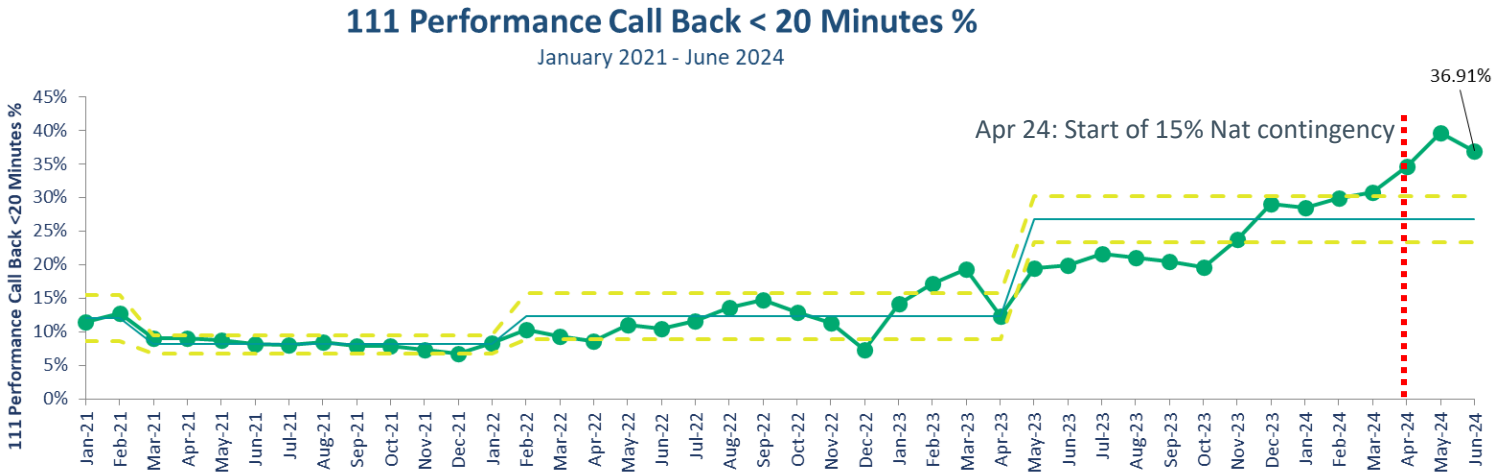
Average Call to Answer time (seconds)	
Target	<20
Jun 2024	42
YTD	85
National	65
Ranking	8th / 30

Figure O4.4



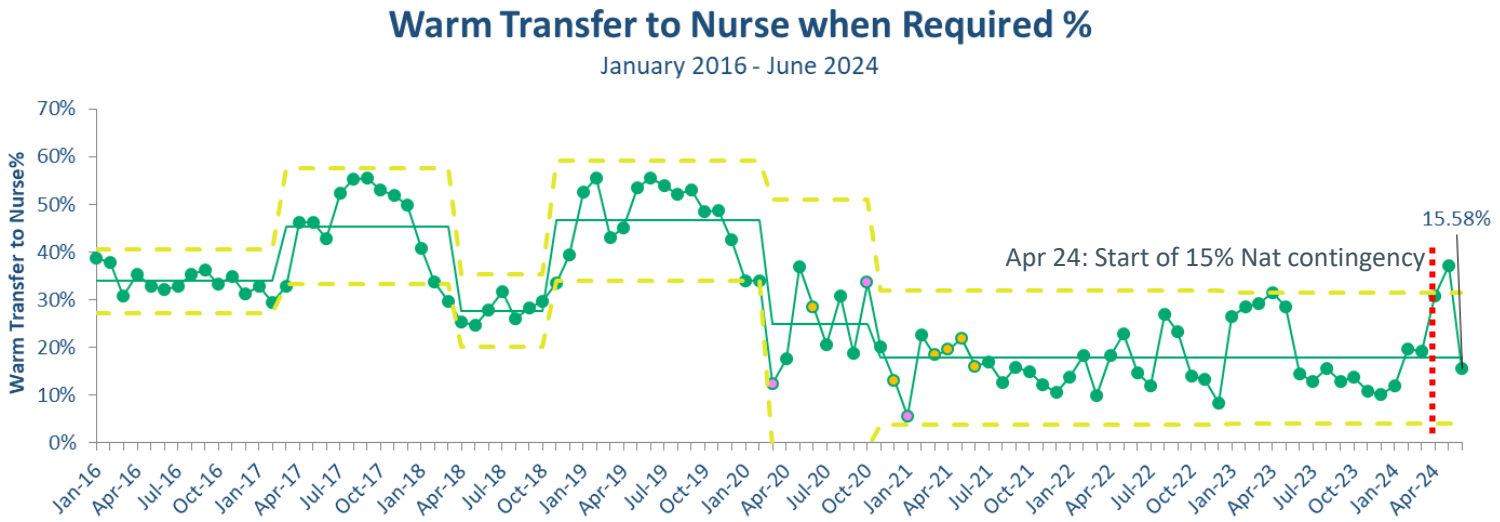
Calls Abandoned %	
Target	<5%
Jun 2024	2.49%
YTD	4.29%
National	4.0%
Ranking	4th / 30

Figure O4.5



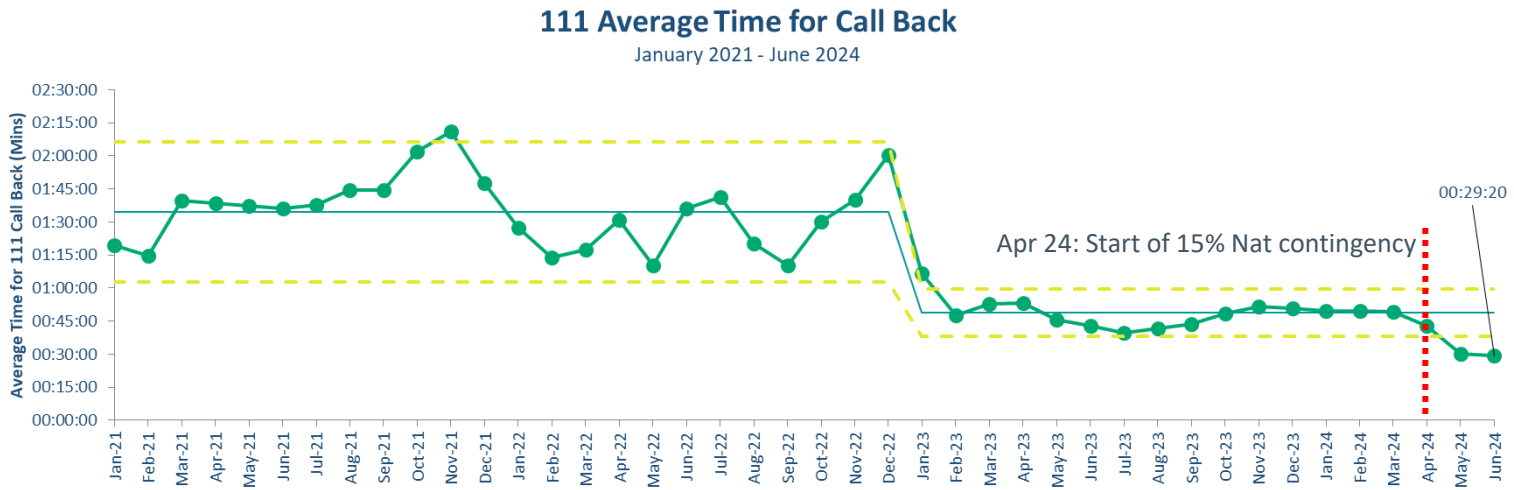
Calls Back <20 Mins	
Target	90%
Jun 2024	36.91%
YTD	37.3%

Figure O4.6



Warm Transfer %	
Target	75%
Jun 2024	15.58%
YTD	27.8%

Figure O4.7



O5 PTS ACTIVITY & TARIFF

Figure O5.1

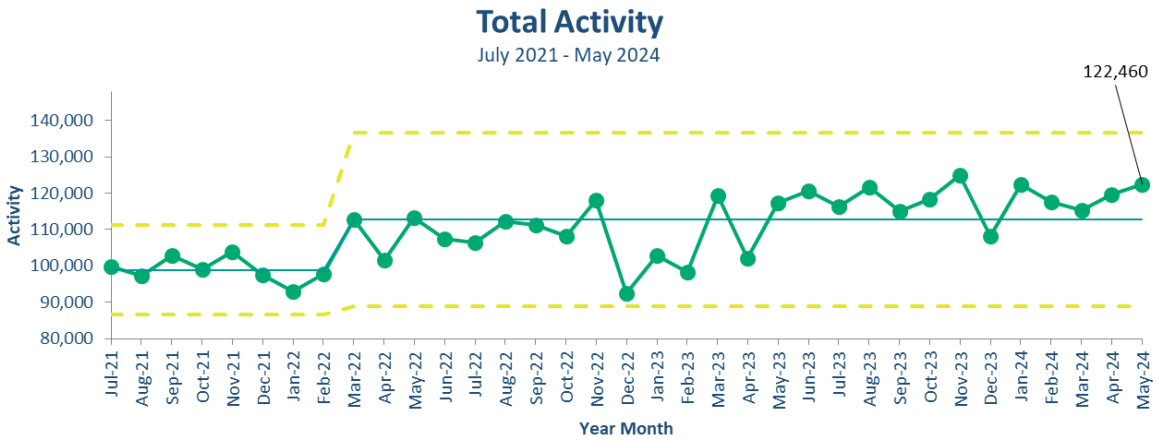


Figure O5.2

Contract	Total Activity
Greater Manchester	47,417
Lancashire	37,310
Merseyside	25,869
Cumbria	11,864

Total Activity	
Plan	132,015
Actual	123,804
YTD Plan	1,452,167
YTD Activity	1,314,556

Figure O5.3

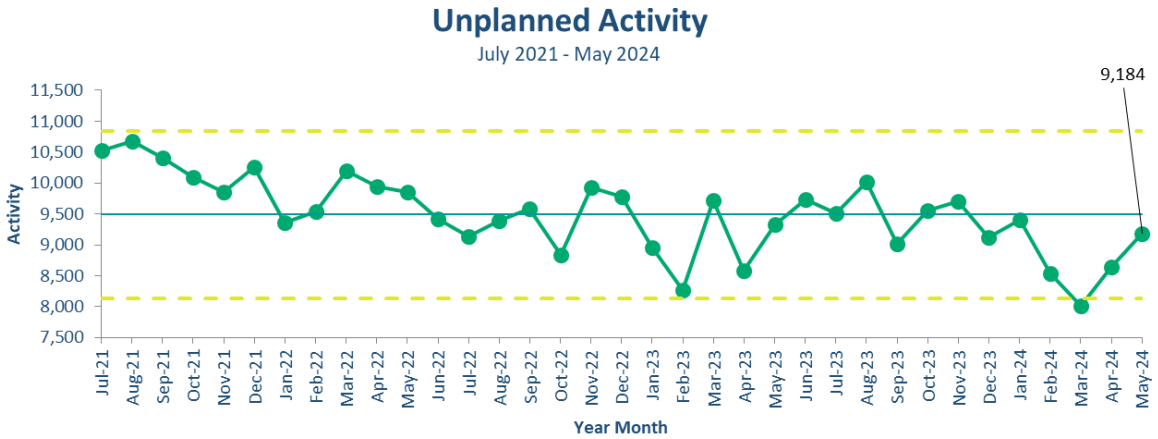


Figure O5.4

Contract	Unplanned Activity
Greater Manchester	3,919
Lancashire	2,950
Merseyside	1,935
Cumbria	380

Unplanned Activity	
Plan	12,107
Actual	9,184
YTD Plan	133,172
YTD Activity	101,587

Figure O5.5

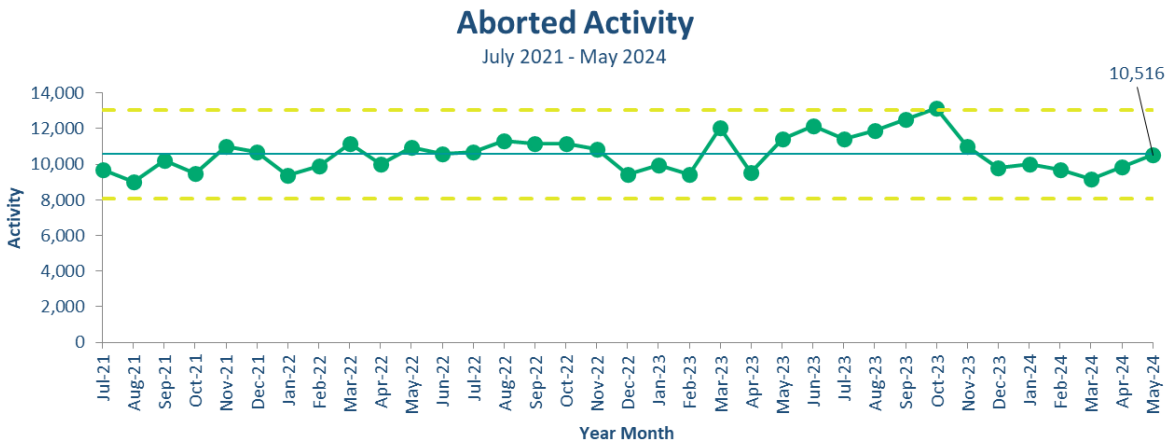


Figure O5.6

Contract	Aborted Activity
Greater Manchester	5,542
Lancashire	2,548
Merseyside	1,968
Cumbria	458

Finance

F1 – FINANCIAL SCORE

Figure F1.1

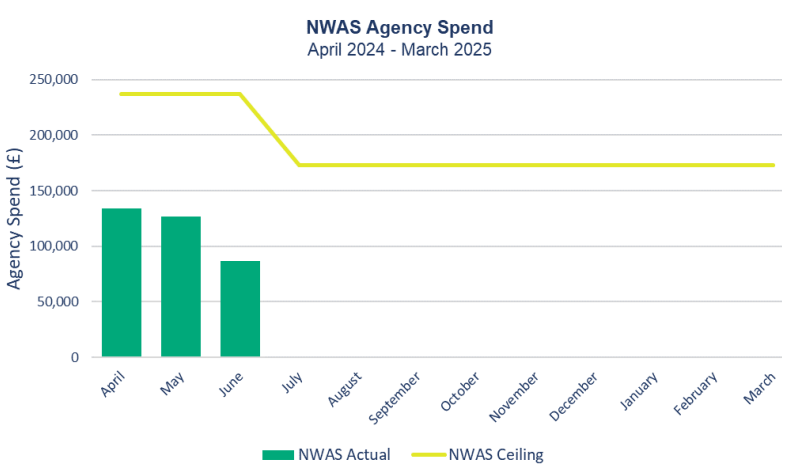


Figure F1.2

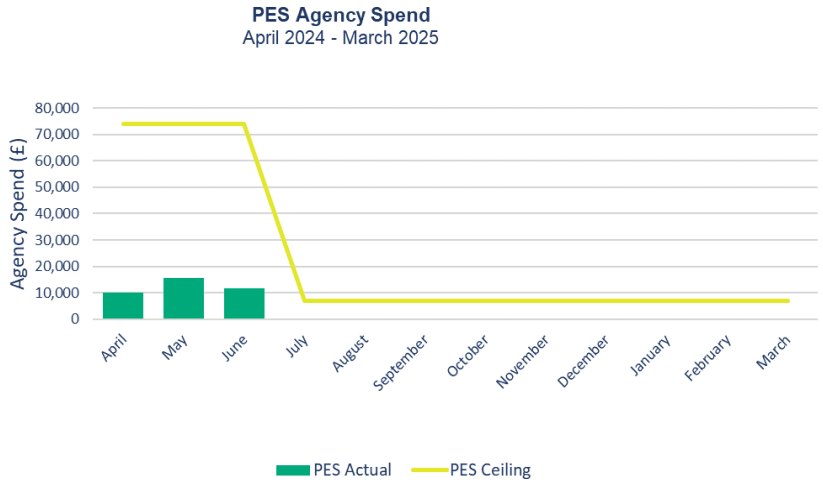


Figure F1.3

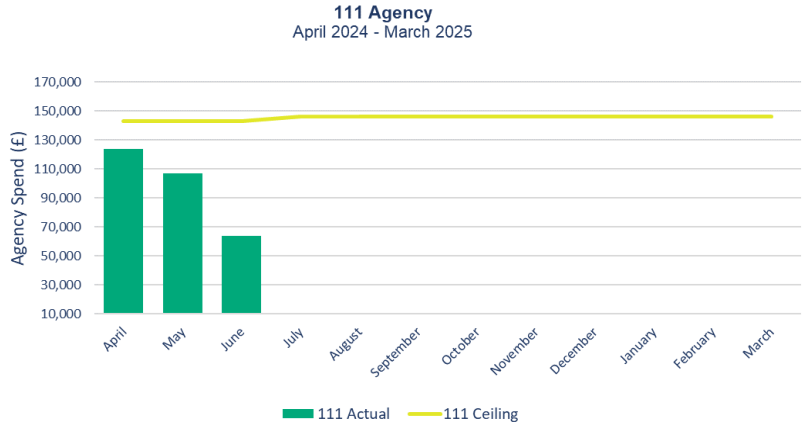


Figure F1.4

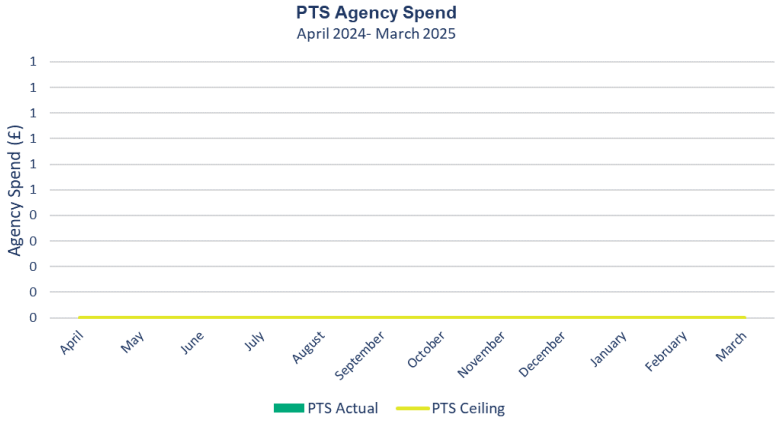


Figure F1.5

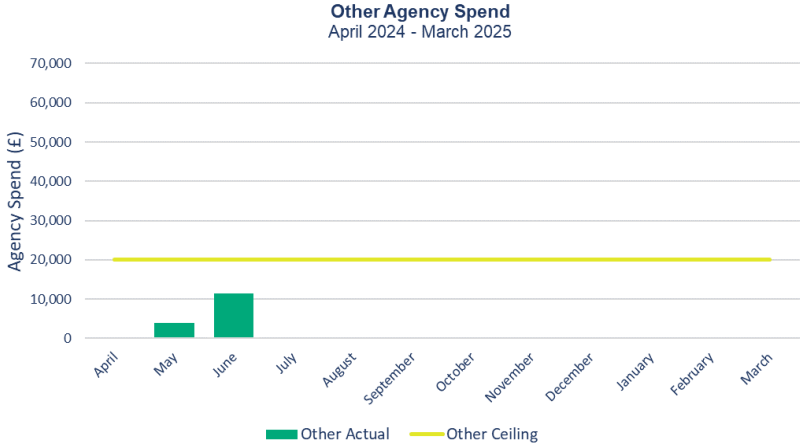


Figure F1.6

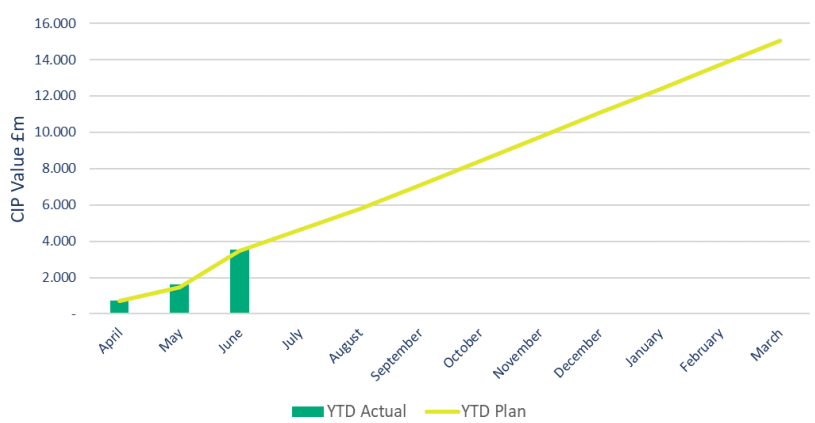


Figure F1.7

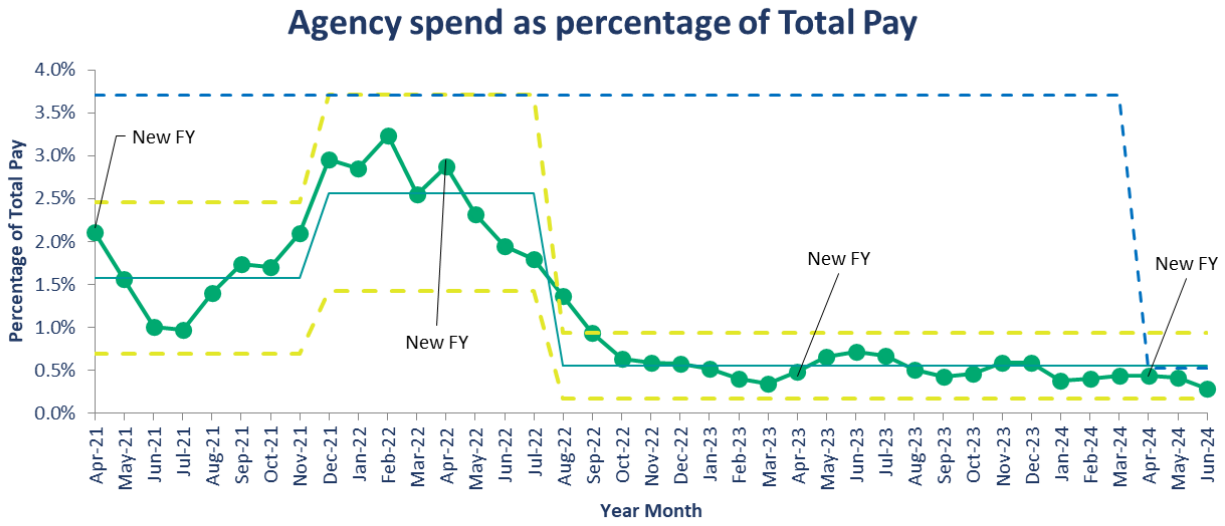


Figure F1.8

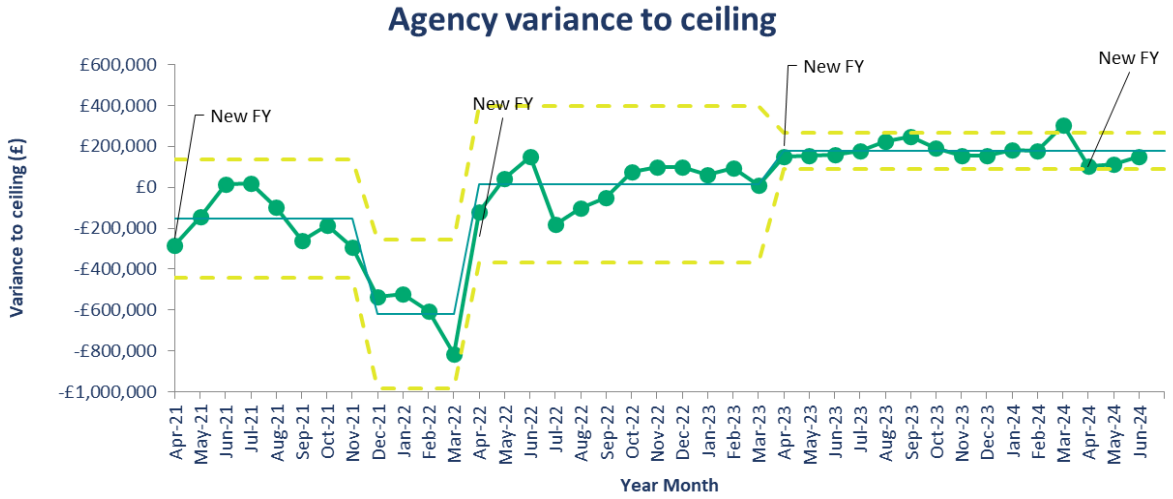
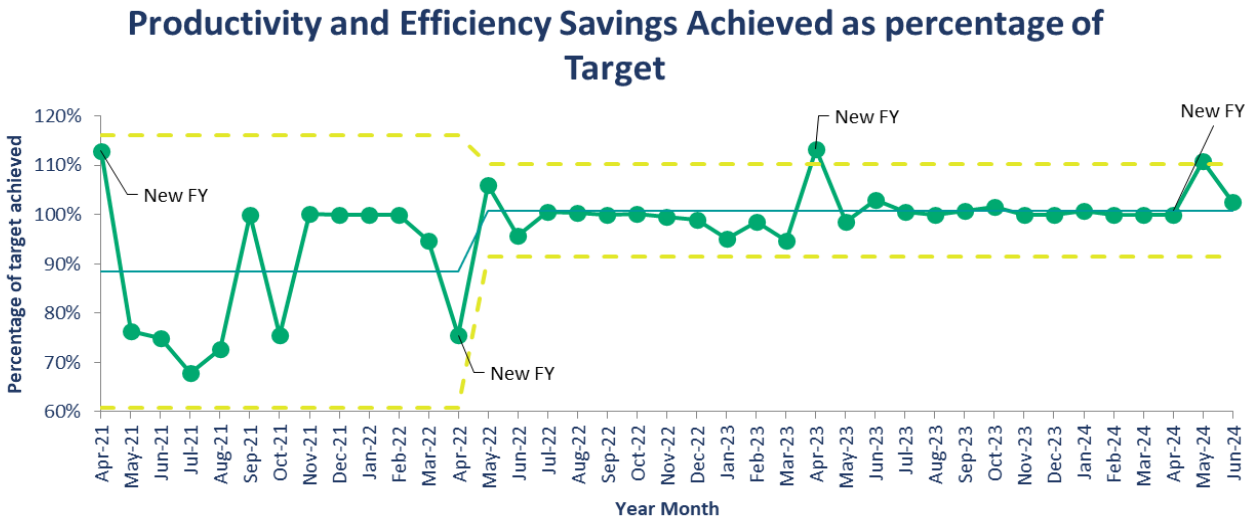


Figure F1.9



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

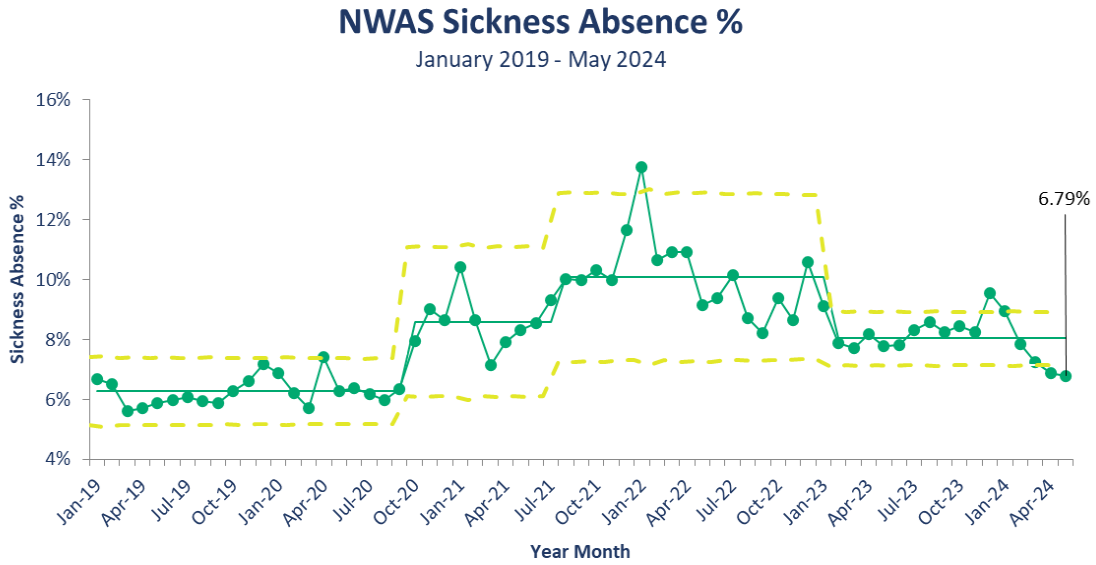


Table OH1.1

Sickness Absence	Jun-23	Ju-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
NWAS	7.82%	8.33%	8.58%	8.26%	8.46%	8.24%	9.55%	8.95%	7.86%	7.24%	6.89%	6.79%
Amb. National Average	6.6%	6.8%	6.9%	6.6%	6.8%	6.8%	7.9%	7.3%	6.9%	6.6%	6.3%	

Figure OH1.2

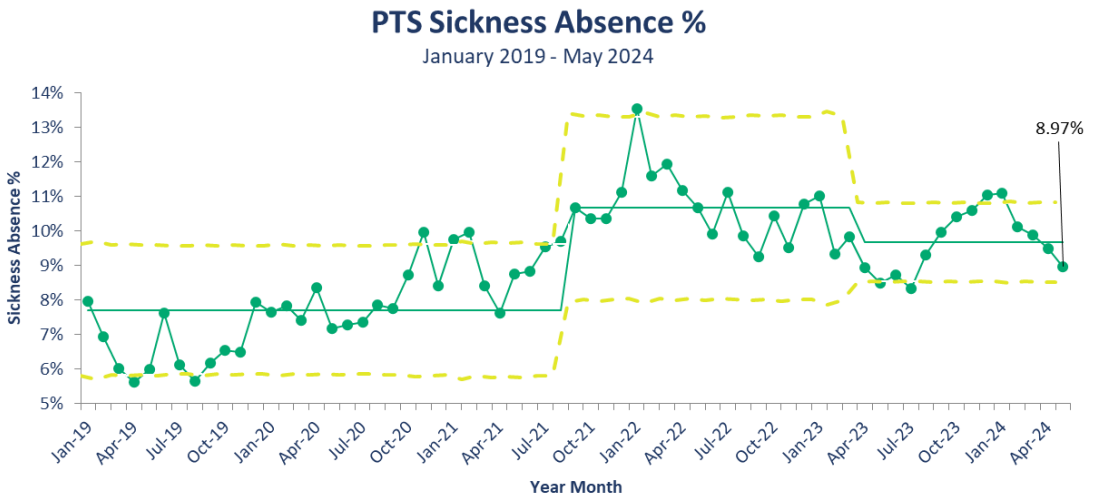


Figure OH1.3

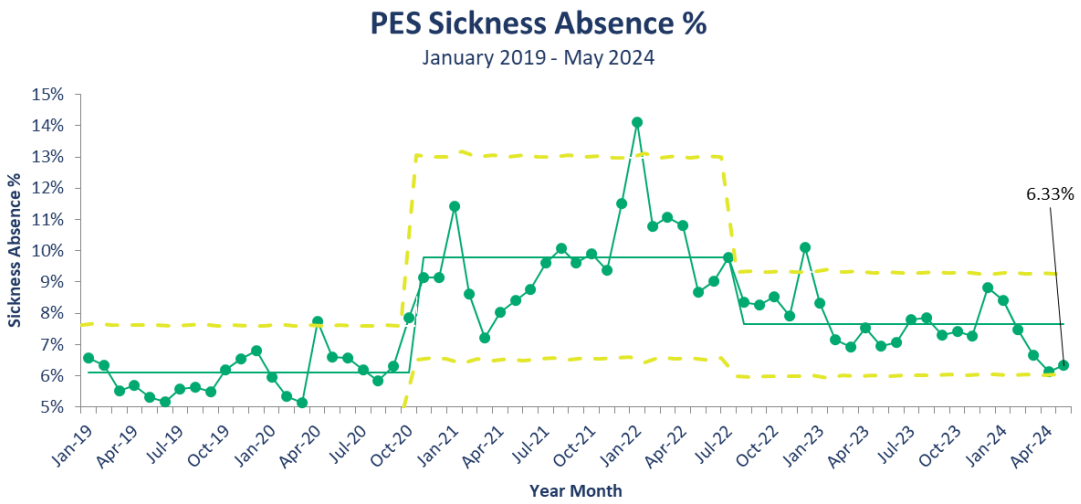


Figure OH1.4

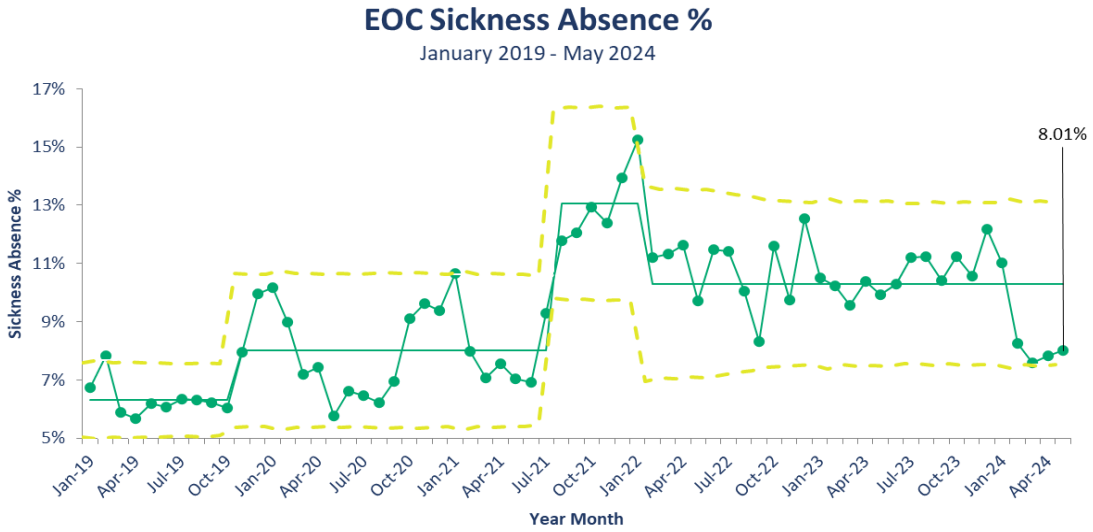
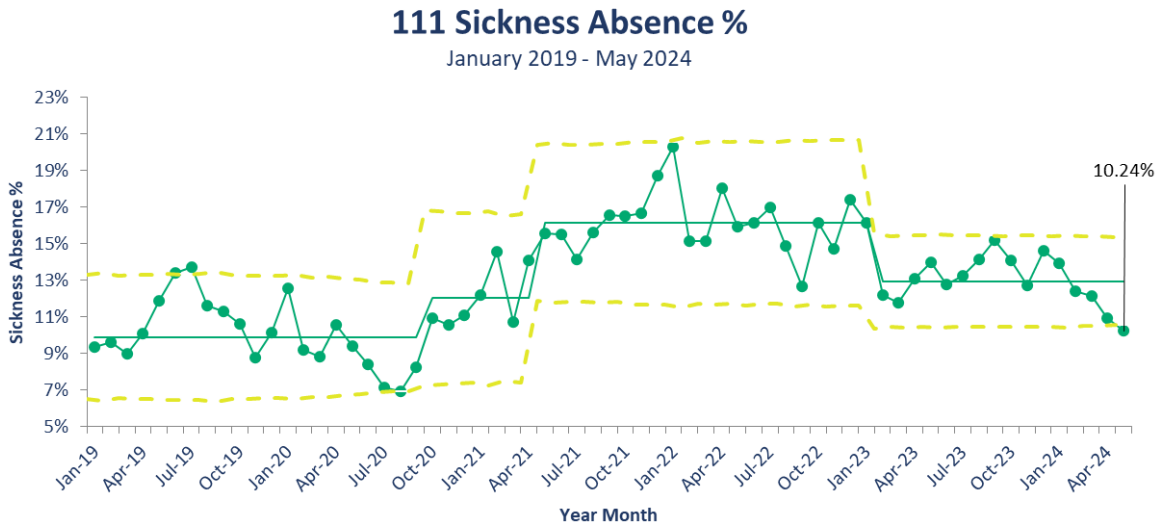


Figure OH1.5



OH2 STAFF TURNOVER

Figure OH2.1

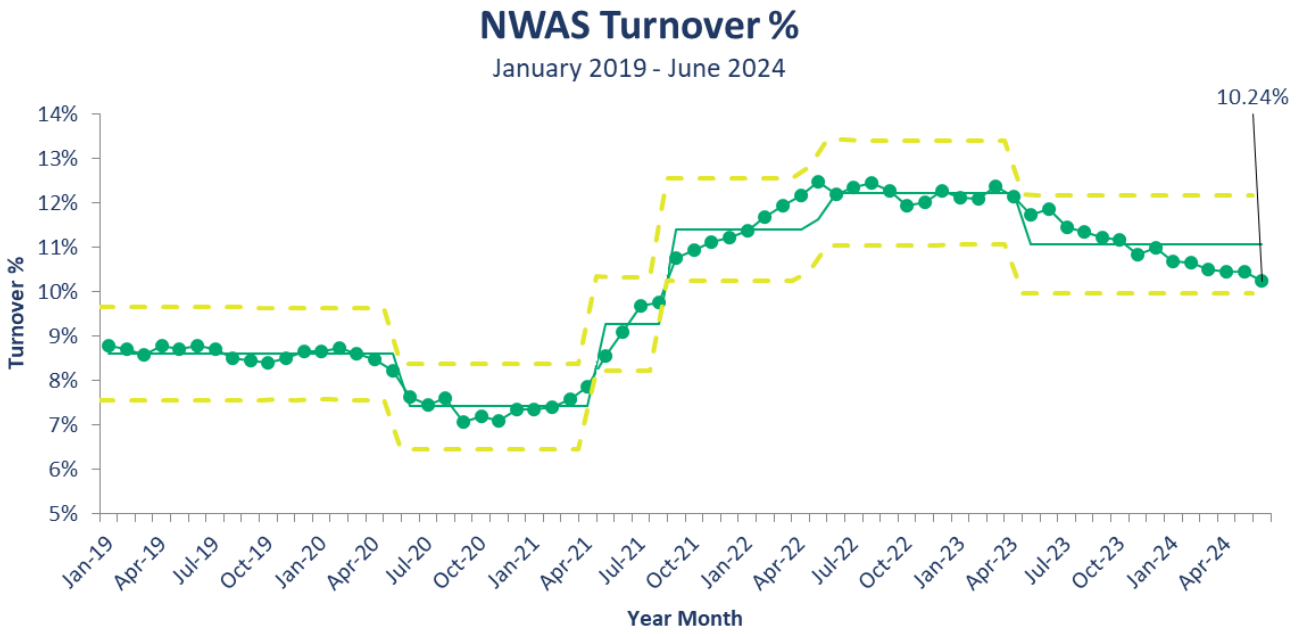


Table OH2.1

Turnover	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
NWAS	11.46%	11.35%	11.23%	11.16%	10.83%	10.98%	10.68%	10.64%	10.49%	10.46%	10.45%	10.24%
Amb. National Average	11.49%	11.20%	10.99%	10.96%	10.87%	10.59%	10.46%	10.27%	9.5%			

Figure OH2.2

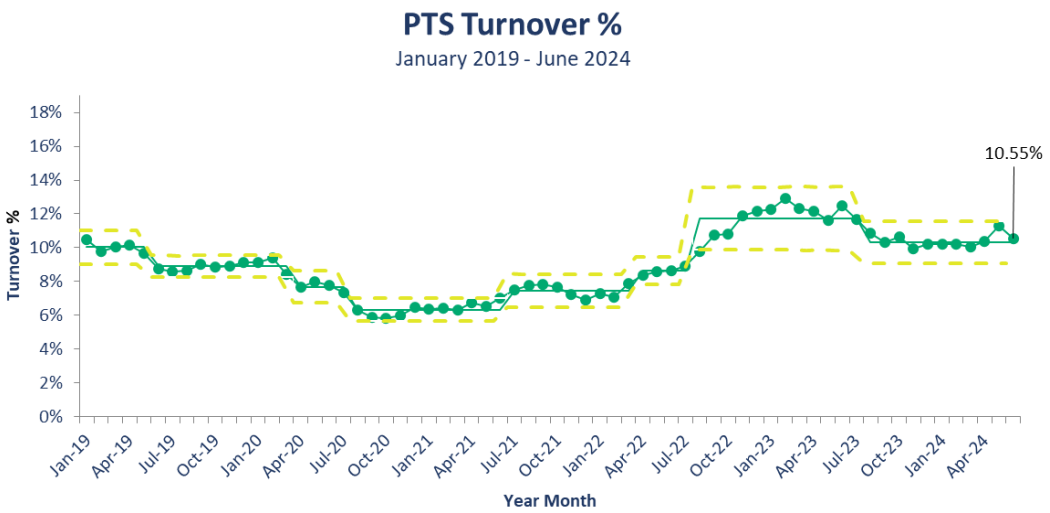


Figure OH2.3

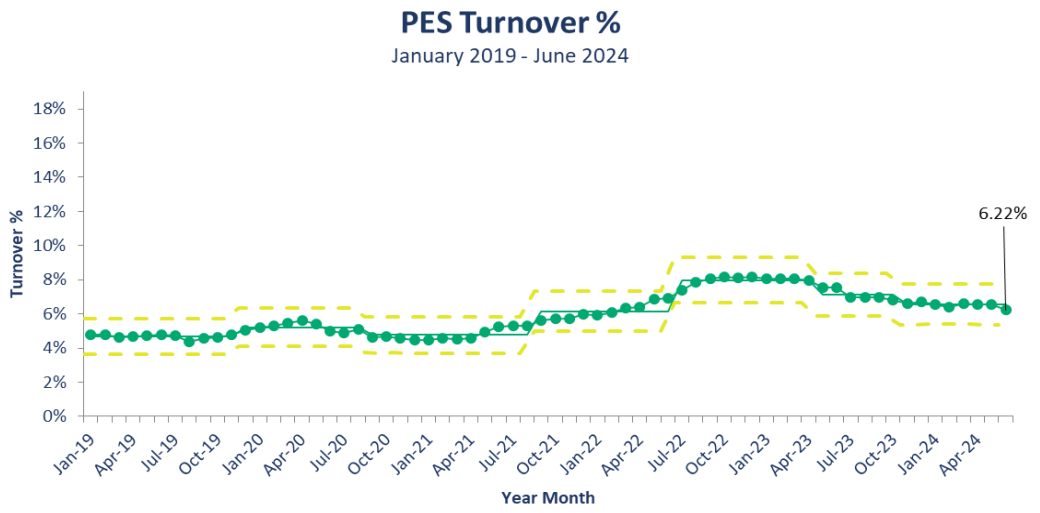


Figure OH2.4

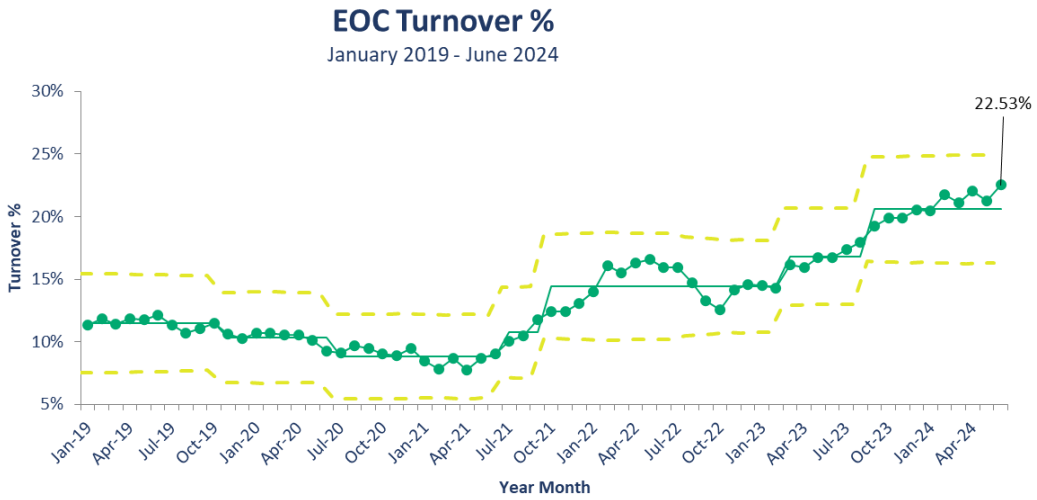
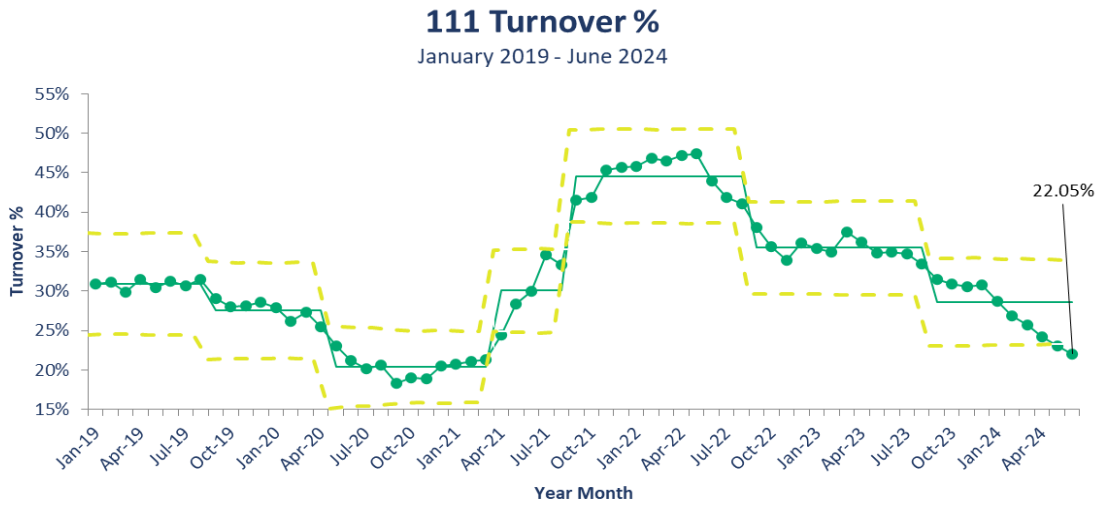


Figure OH2.5



The scale on the 111 and EOC Turnover % is different to the others. 15%-55% for 111 , 5% to 30% for EOC and 5% to 18% for the others.

OH4 TEMPORARY STAFFING

Figure OH4.1

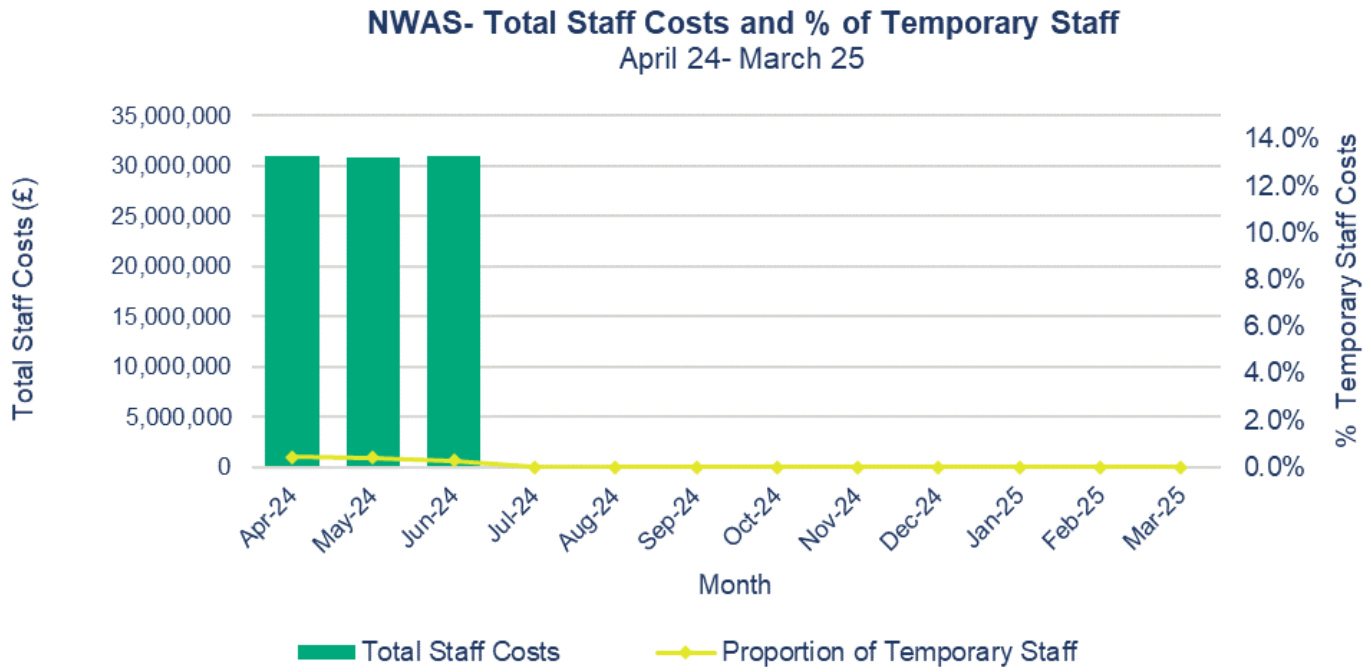


Table OH4.1

NWAS	Ju-23	Aug -23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Agency Staff Costs (£)	192,594	147,684	124,670	136,633	174,789	174,325	114,353	121,308	133,805	133,948	126,729	87,010
Total Staff Costs (£)	28,871,609	29,127,865	29,022,514	29,479,928	29,620,537	29,568,340	29,779,636	30,352,345	30,481,294	31,045,969	30,884,497	30,946,651
Proportion of Temporary Staff %	0.7%	0.5%	0.4%	0.5%	0.6%	0.6%	0.4%	0.4%	0.4%	0.4%	0.4%	0.3%

Figure OH4.3

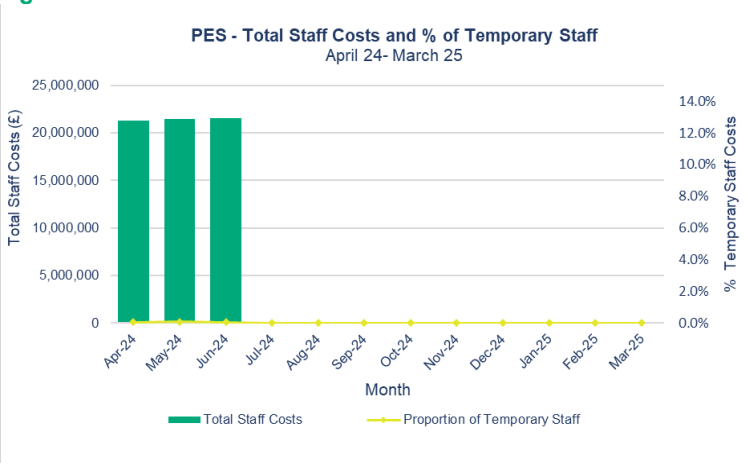


Figure OH4.4

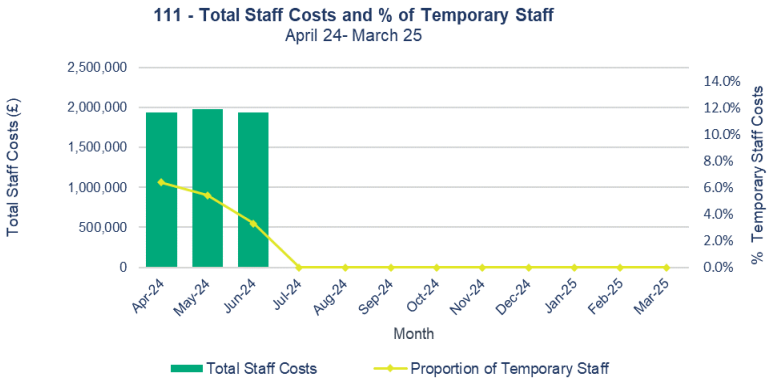


Figure OH4.5

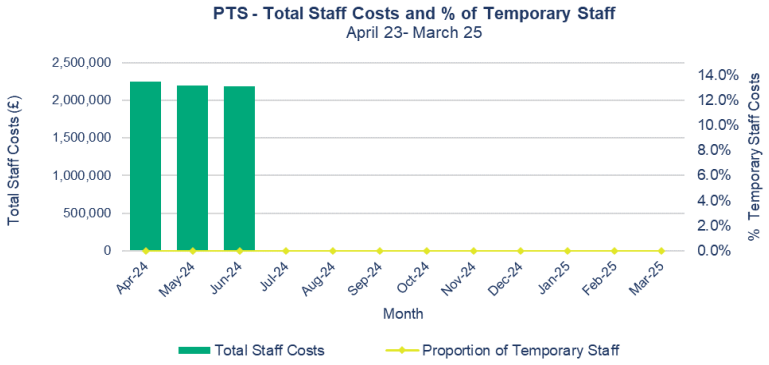
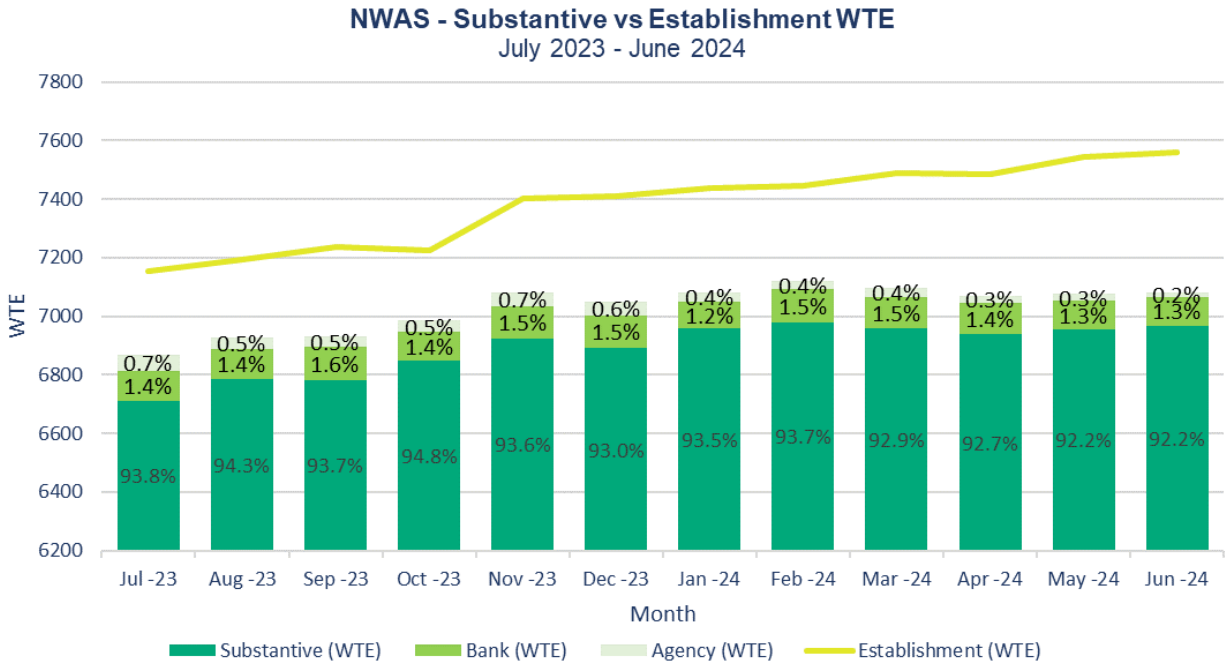


Figure OH4.2



OH5 VACANCY GAP

Figure OH5.1

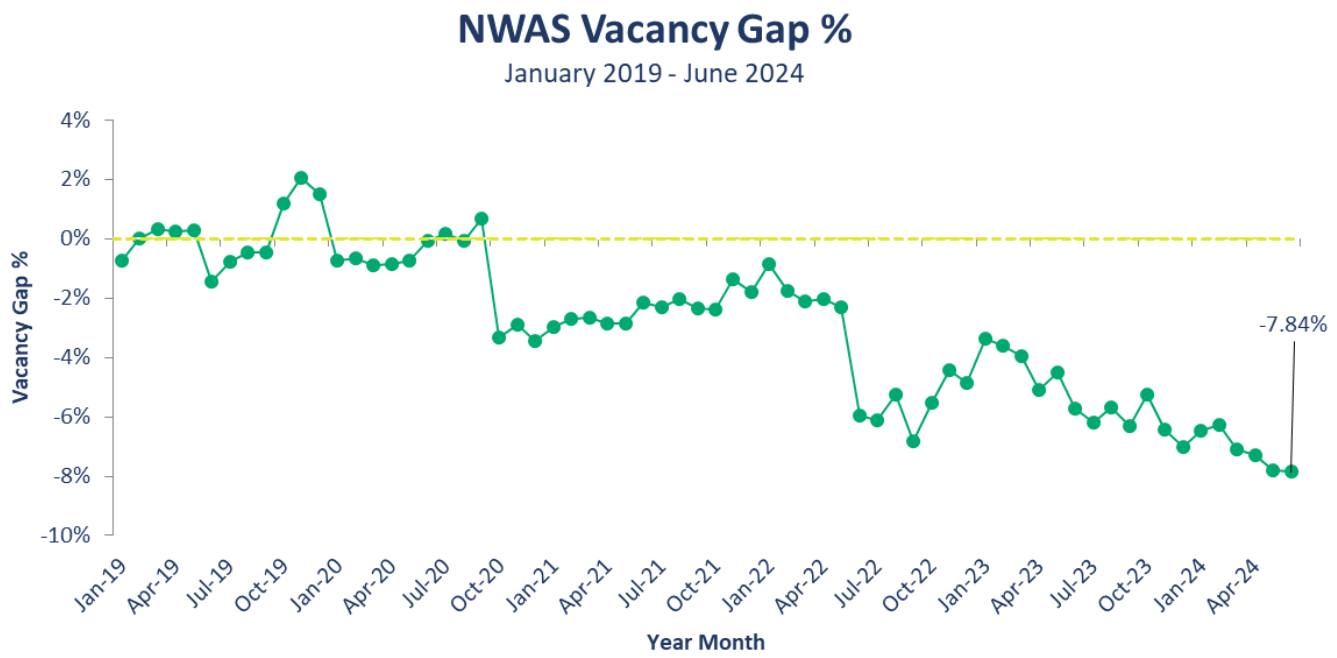


Table OH5.1

Vacancy Gap	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
NWAS	-6.18%	-5.67%	-6.30%	-5.23%	-6.44%	-7.00%	-6.47%	-6.26%	-7.10%	-7.29%	-7.80%	-7.84%

Figure OH5.2

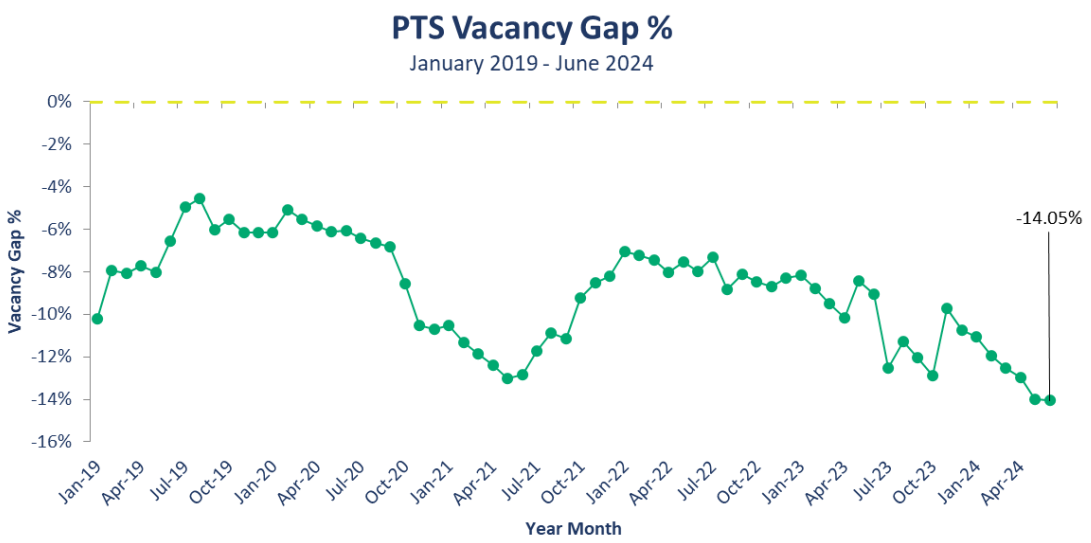


Figure OH5.3

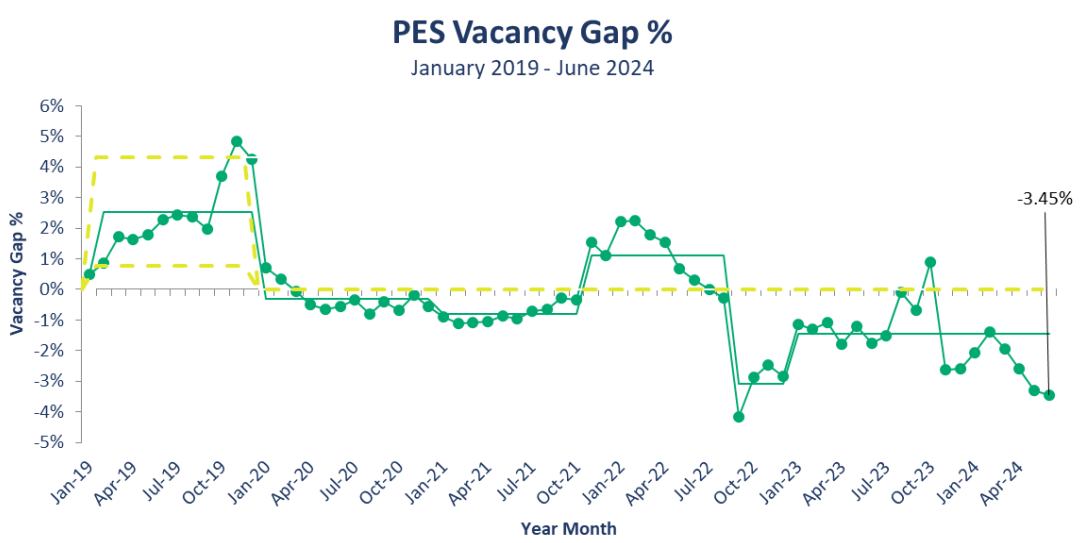


Figure OH5.4

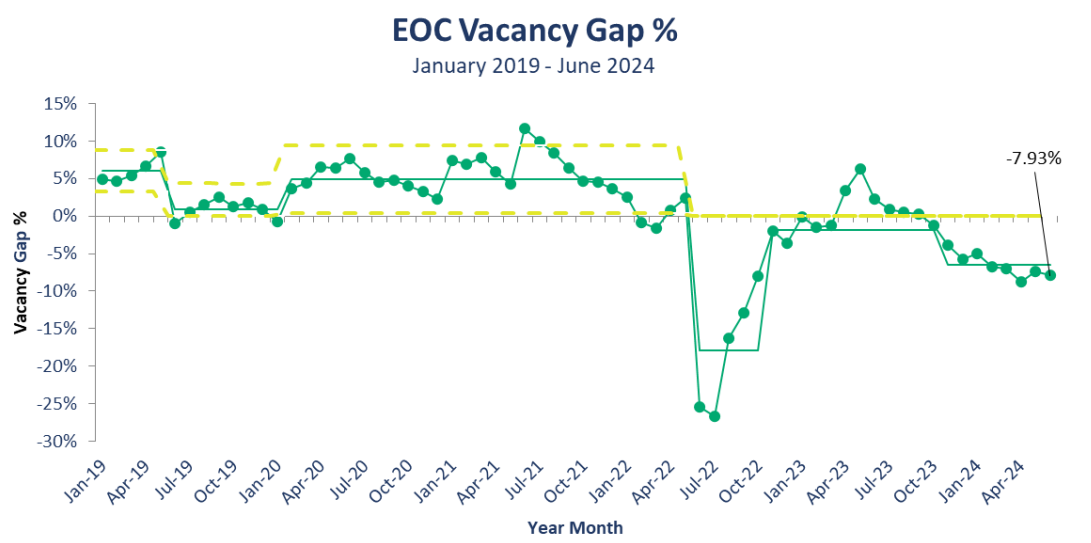
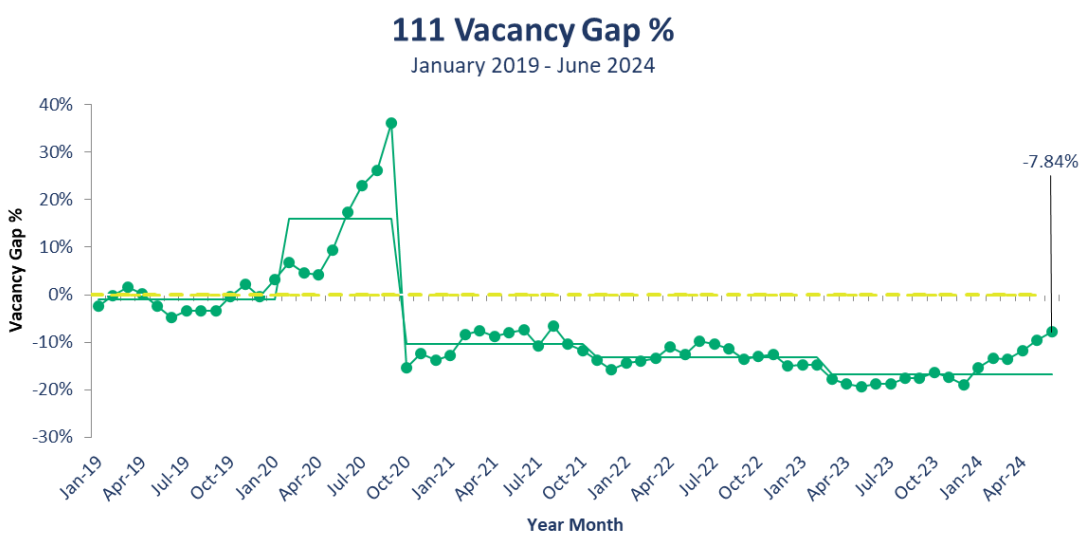


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

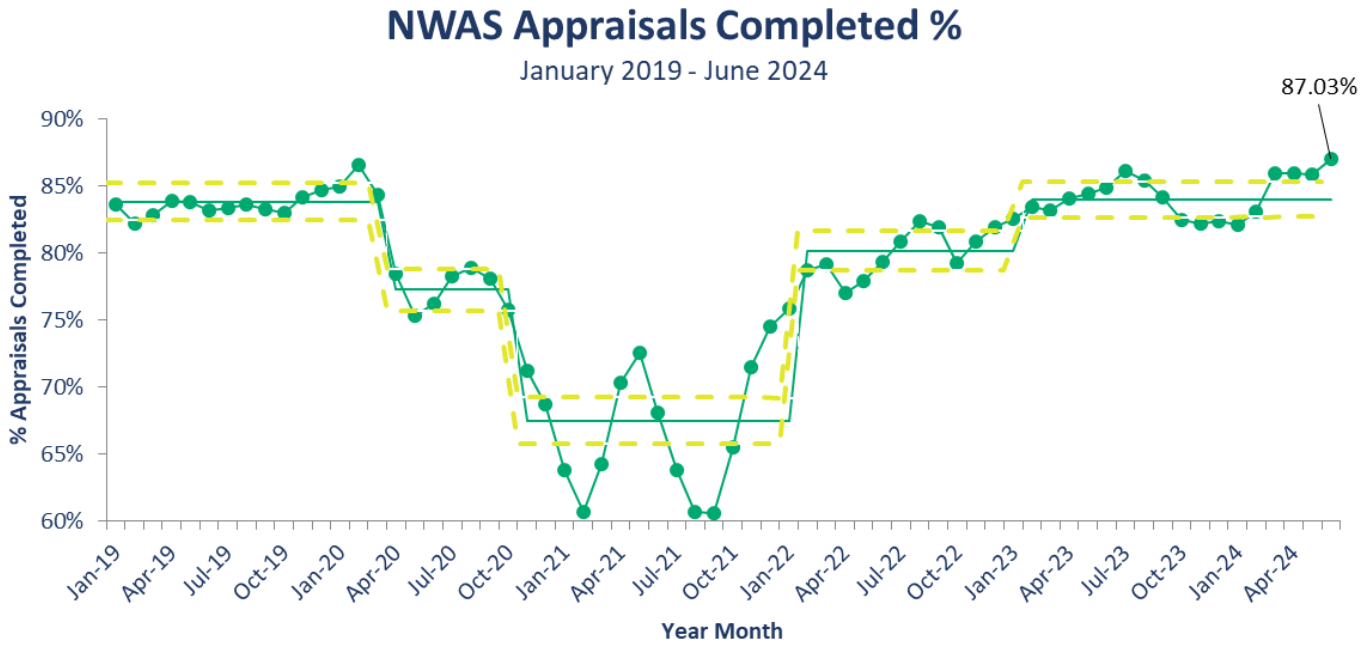


Table OH6.1

Appraisals	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
NWAS	86%	85%	84%	82%	82%	82%	82%	83%	86%	86%	86%	87%

Figure OH6.2

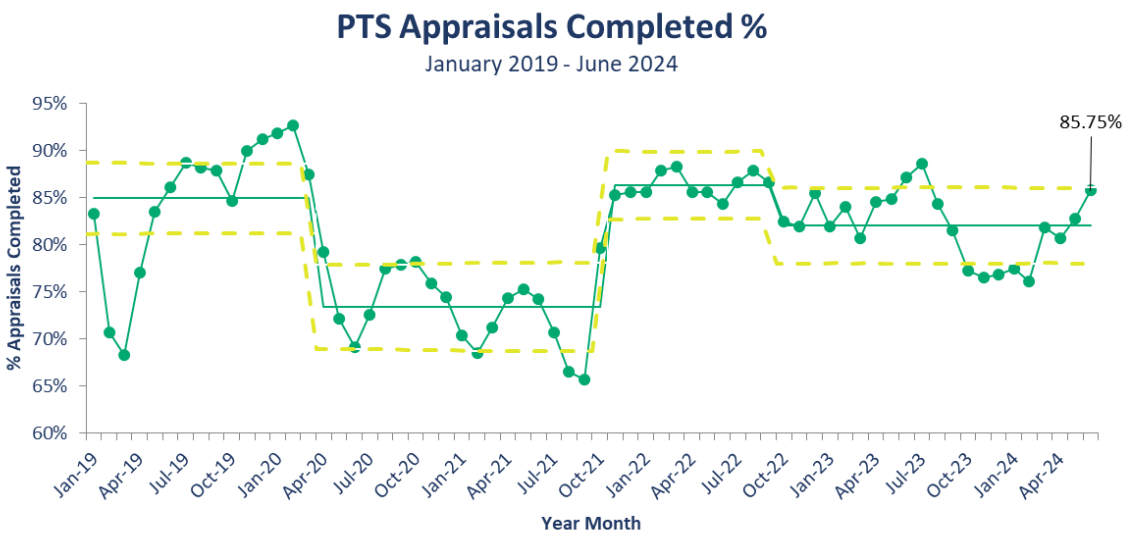


Figure OH6.3

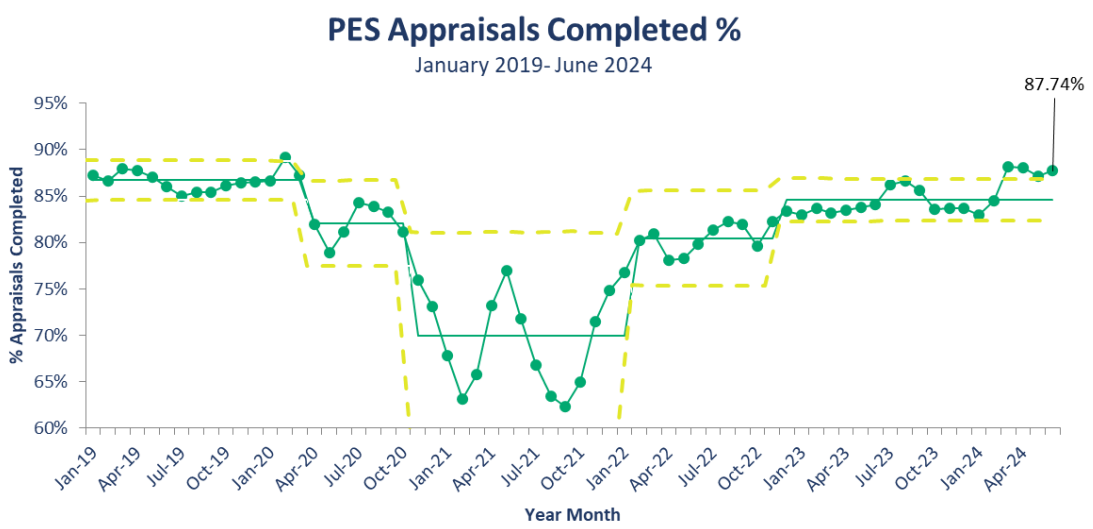


Figure OH6.4

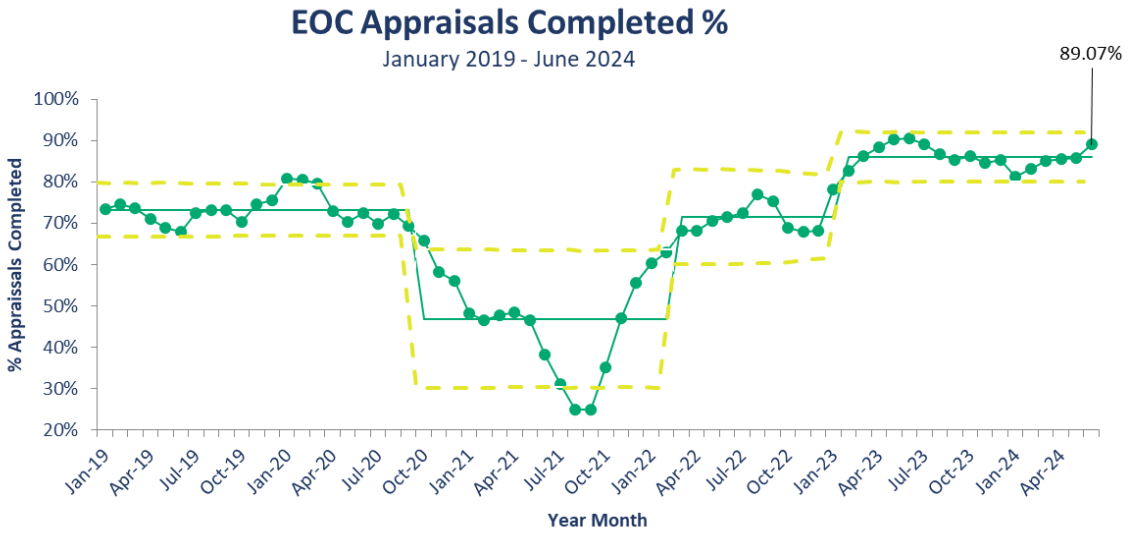
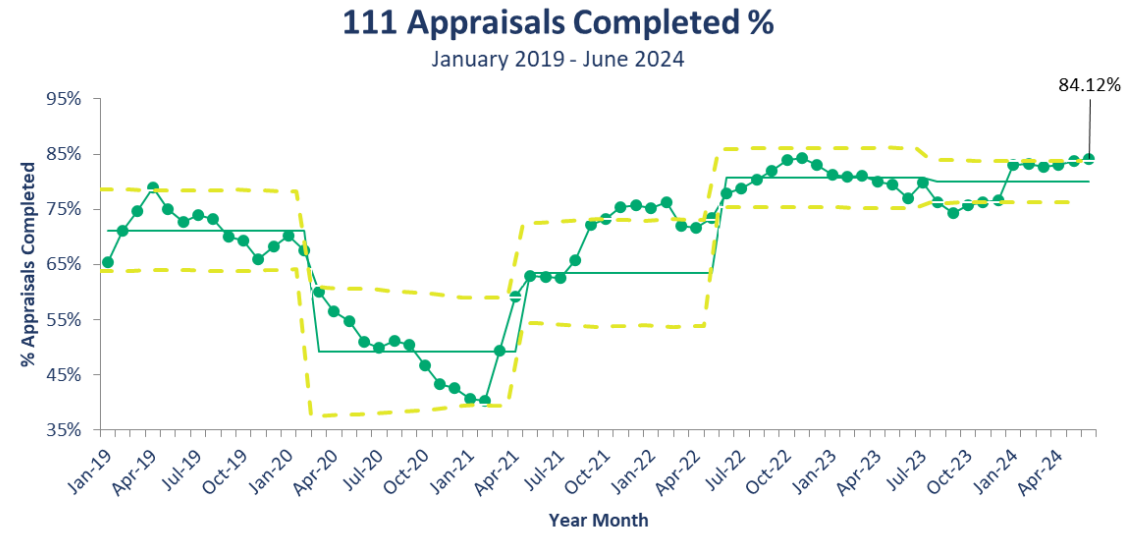


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

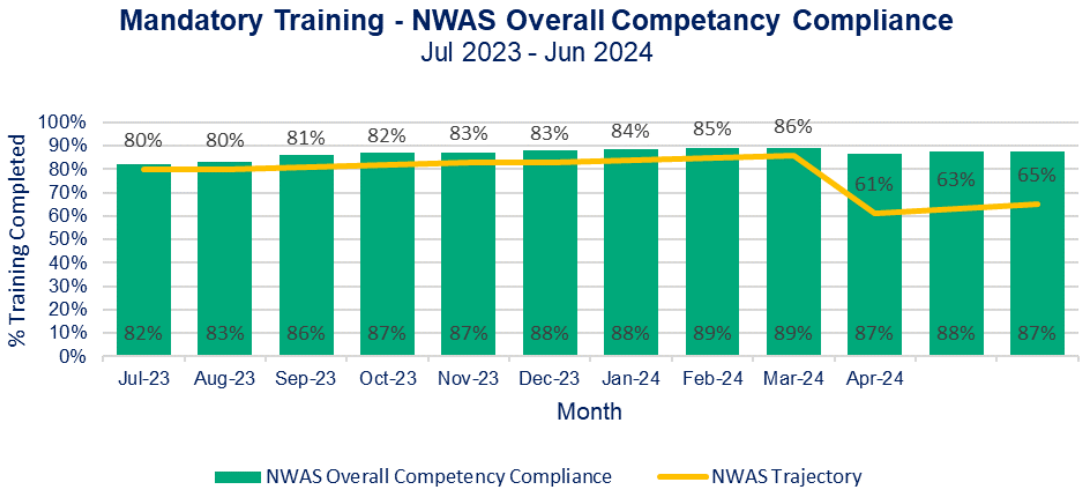


Figure OH7.2

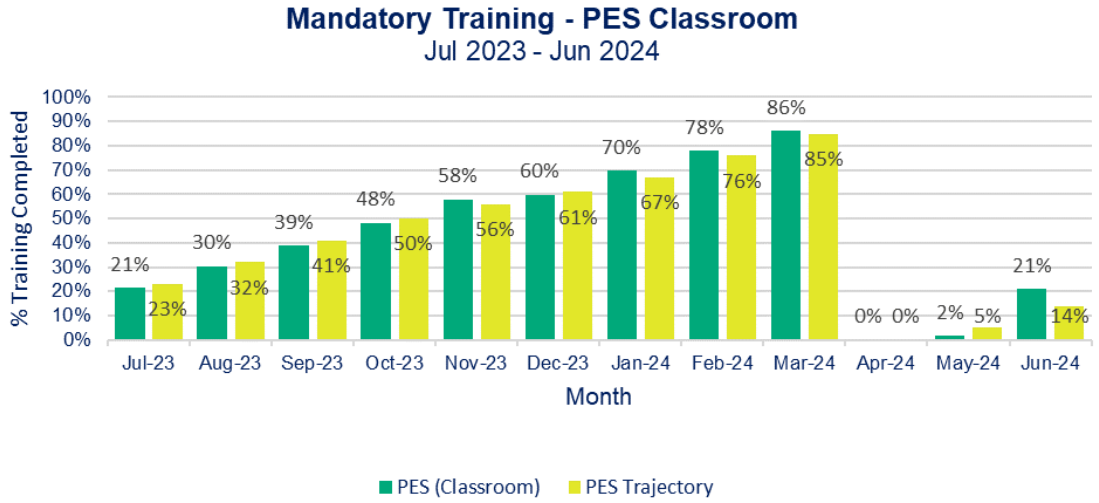


Figure OH7.3

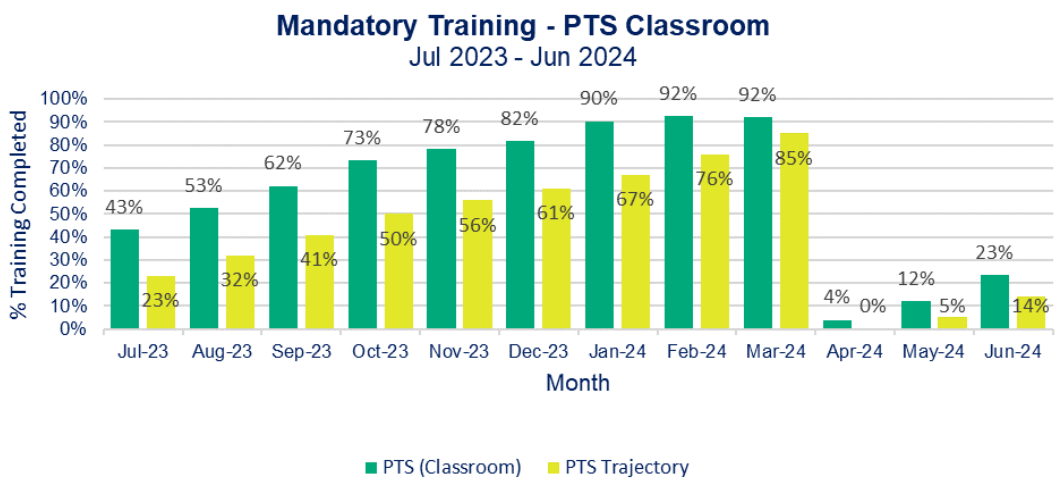


Figure OH7.4

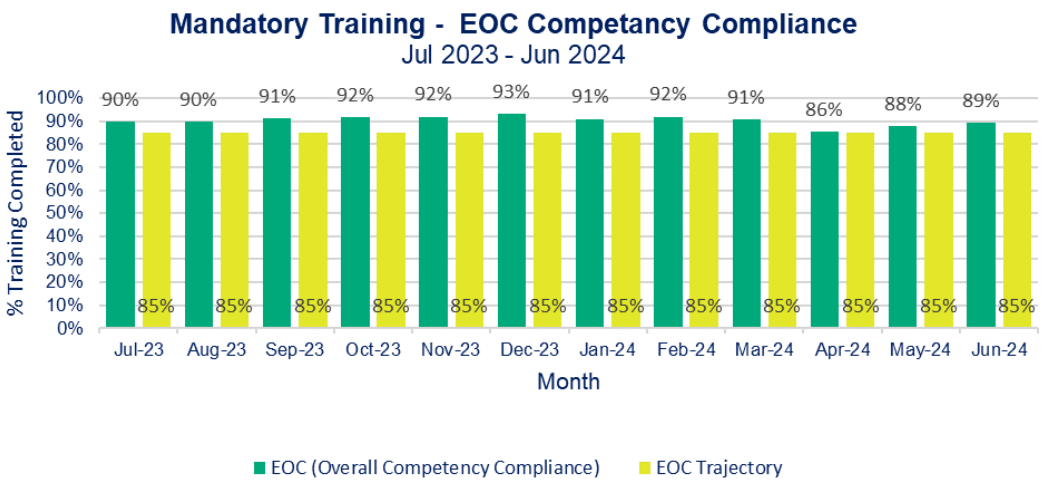


Figure OH7.5

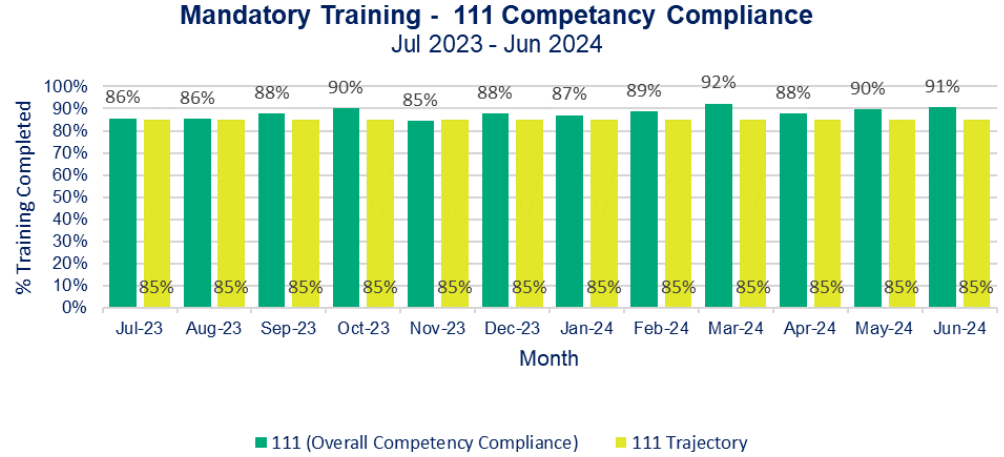
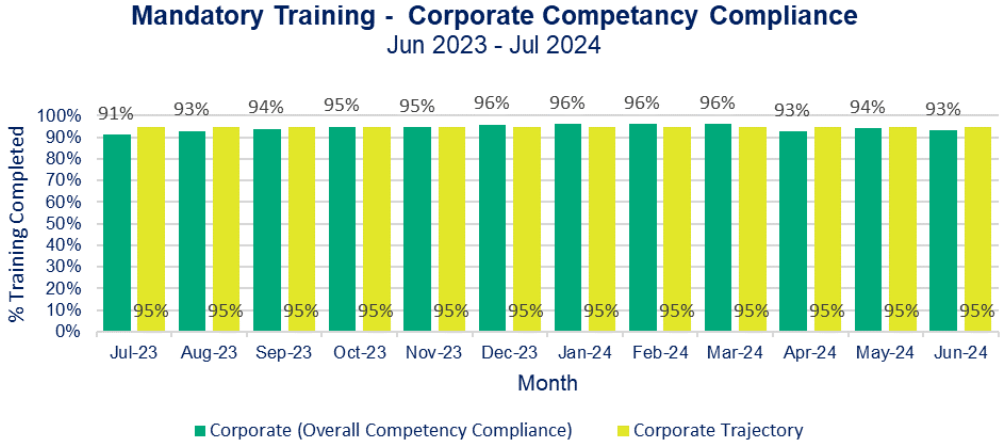


Figure OH7.6



OH8 CASE MANAGEMENT

Figure OH8.1

Board Reportable Events relating to Employee Relations as @5th July 2024

All information related to Dignity at work, Disciplinary, Fact Finding and Grievance cases only

NWAS Summary split by service line and sector

Service Line	Number of Live cases	Prevalence Live cases (numbers per hundred staff)	Number of cases closed in last 12 months	Prevalence closed cases in last 12 months (numbers per hundred staff)	Average length of time (weeks) taken to close ER cases in last 12 months
Operations ~ PES	57.00	1.4	179.00	4.3	
CAM PES	22.00	1.7	62.00	4.7	14.47
CAL PES	13.00	1.0	63.00	4.7	15.14
GM PES	19.00	1.3	53.00	3.6	17.74
Operations ~ EOC	15.00	1.3	58.00	5.0	14.58
Operations ~ 111	14.00	2.2	75.00	11.9	6.91
Operations ~ PTS	21.00	2.0	113.00	10.8	10.73
Operations ~ Resilien	1.00	0.7	1.00	0.7	2.14
Corporate	6.00	1.4	44.00	6.9	15.18
Other	1.00		0.00		
NWAS Summary	115.00	1.5	470.00	6.0	12.87

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

Figure OH8.2

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	16	72	13.84
Disciplinary	56	109	27.76
Fact Finding	30	173	6.15
Grievance	13	116	8.29
Case Summary	**115**	**470**	**12.87**

Length of current live cases by case type				
Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	7	7	2	0
Disciplinary	21	21	11	3
Fact Finding	25	4	1	0
Grievance	6	5	2	0
Case Total	**59**	**37**	**16**	**3**

Top 5 Reasons for opening Disciplinary cases in the past 12 months	
Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	13
Failure to follow reasonable management instructions/procedures	12
Poor patient care	11
Any actions that bring the Trusts reputation into disrepute	8
Lateness	7
NWAS Summary	**51**
*table shows a rolling 12 months so can go down as well as up	

Gross misconduct/Ill health/Performance Dismissals May to June 2024		
Service Line	Case Type	Information Category
Operations ~ PES	Disciplinary	sexual misconduct
Operations ~ PES	Disciplinary	assault/threatening behaviour
Operations ~ PES	Performance	serious poor performance
Operations ~ PES	Performance	
Operations ~ PES	Termination Other	
Operations ~ PES	Long Term Sick	ill health capability
Operations ~ PES	Long Term Sick	ill health capability
Operations ~ PTS	Long Term Sick	ill health capability
Operations ~ EOC	Long Term Sick	ill health capability
Operations ~ PTS	Long Term Sick	ill health capability
Operations ~ PES	Long Term Sick	ill health capability
Operations ~ 111	Long Term Sick	ill health capability
Operations ~ EOC	Long Term Sick	ill health capability
Operations ~ 111	Long Term Sick	ill health capability
Operations ~ 111	Long Term Sick	ill health capability

New Litigation cases May - June 2024			
Service Line	Case Type	Information Category	Received Date
Operations ~ PTS	Litigation	N/A	25-Jun-24

Suspended	Alternate Duties
9	1

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Manchester Arena Inquiry Recommendations
PRESENTED BY	Salman Desai, Deputy Chief Executive
PURPOSE	Assurance

LINK TO STRATEGY	Service Development Strategy									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☒	**SR04**	☐	**SR05**	☐
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☒	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Receive assurance on the delivery of 13 of the 14 Monitored Recommendations 'Emergency Response' published 3rd November 2022. • Note the alert on the outstanding monitored recommendation (R20) • Note the movement of all monitored recommendations are now embedded into business as usual within Service Delivery, and more specifically in the Resilience service line. • Note the Trust Management Committee will continue to receive assurance against EPRR Core standards aligned to the monitored recommendations.

EXECUTIVE SUMMARY	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. On the 3 November 2022, The Chair of the Manchester Arena Inquiry (MAI) published volume 2, 'Emergency Response' which presented 14 Monitored Recommendations for the Trust. **Alert** • Out of the 14 NWAS Monitored Recommendations, 1 recommendation it still outstanding: *MR20: North West Ambulance Service should ensure that non-specialist ambulance personnel are involved in multi-agency exercising.* This recommendation has been escalated through to Board, Commissioners, and NHS England. **Advice** • Key senior individuals including the Accountable Emergency Officer (AEO – Salman Desai) from NWAS met with Weightmans Legal team to undertake a 'check and challenge' on the trusts reported position against the 14 monitored recommendations. All present supported the reported position of 13 recommendations as complete and to be imbedded within the workplan of the EPRR Group. It was confirmed the 1 recommendation outstanding has been escalated to Board, Commissioners and NHSE. • The EPRR Group revised its workplan (March 2024) to ensure updates and assurance is provided aligned to the MAI recommendations. **Assurance** • 13 of the 14 NWAS Monitored Recommendations from the Manchester Arena Inquiry volume 2, Emergency Response are complete and have now been moved in to 'business as usual' within Service Delivery, and specifically the Resilience service line. The EPRR Group workplan has been reviewed and provides requirements for assurance reports to be presented and aligned to the recommendations from the MAI.

PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 17 July 2024
	Outcome	Noted.

1. BACKGROUND

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022.

On the 3 November 2022 The Chair of the Manchester Arena Inquiry (MAI) published volume 2, 'Emergency Response' which presented 14 Monitored Recommendations for the Trust. The Trust through the Resilience service line established a workplan to deliver against the recommendations, and to support other recommendations across the sector and other local, regional and national workstreams

2. CURRENT POSITION

A report was submitted to the EPRR Sub Committee on the 22nd January 2024 stating 12 of the 14 NWAS Monitored Recommendations were complete. Due to the EPRR SC not quorate it was rescheduled to the 11th March 2024.

On the 8th February 2024 a meeting took place between NWAS and Weightmans to 'check and challenge' the current reported position against the 14 monitored recommendations. Present at the meeting were:

- Deputy CEO (& Accountable Emergency Officer) (SD)
- Director of Corporate Affairs (AW)
- Head of Legal Services (ES)
- Assistant Director of Resilience (SH)
- Head of Contingency Planning (JH)
- Greater Manchester Resilience Manager (NB)
- Associate Director of Operational Transformation (GB)
- Weightmans Legal Team (JS & ME)

A detailed discussion took place against each monitored recommendation led by the Assistant Director of Resilience and his team providing detailed updates on the work caried out on each monitored recommendation and its status. The Resilience Team presented 12 of the 14 monitored recommendations as complete. The two monitored recommendations reported as 'amber' were as follows:

MR20: *North West Ambulance Service should ensure that non-specialist ambulance personnel are involved in multi-agency exercising.*

MR26: *North West Ambulance Service should review its procedures with local NHS trusts to ensure that it has effectives policies in place for quickly dispatching patients injured in a Major Incident to an appropriate hospital.*

Through detailed discussions it was agreed that **MR26** would move to be reported as complete considering a review had taken place and an updated Mass Casualty Distribution Plan covering the North West region had been published initially in July 2023 v1.4 available through the greenroom, and

reviewed in June 2024 as part of an annual review and approved (v2.0) by the NWAS Medical Director 1st July 2024.

With regards MR20 it was agreed this should remain non-compliant despite the work NWAS had undertaken to address the recommendation. A letter on behalf of the CEO was submitted to the lead commissioners on the 26 May 2023 as indicated in recommendations R105 and R106:

Resources

R105: *Ambulance service trusts should review their capacity to respond to a mass casualty incident. That should include an assessment of whether they have an adequate number of trained specialist personnel to respond effectively to a mass casualty incident.*

R106: *Having carried out that review, the trust should make recommendations to their NHS commissioners about the additional and / or different resources they require in order to ensure that they are able to respond effectively to a mass casualty incident in the numbers required.*

A letter was received from the land commissioners dated 27th September 2023 in response the initial CEO letter and covering a proposed way forward (see appendix 1).

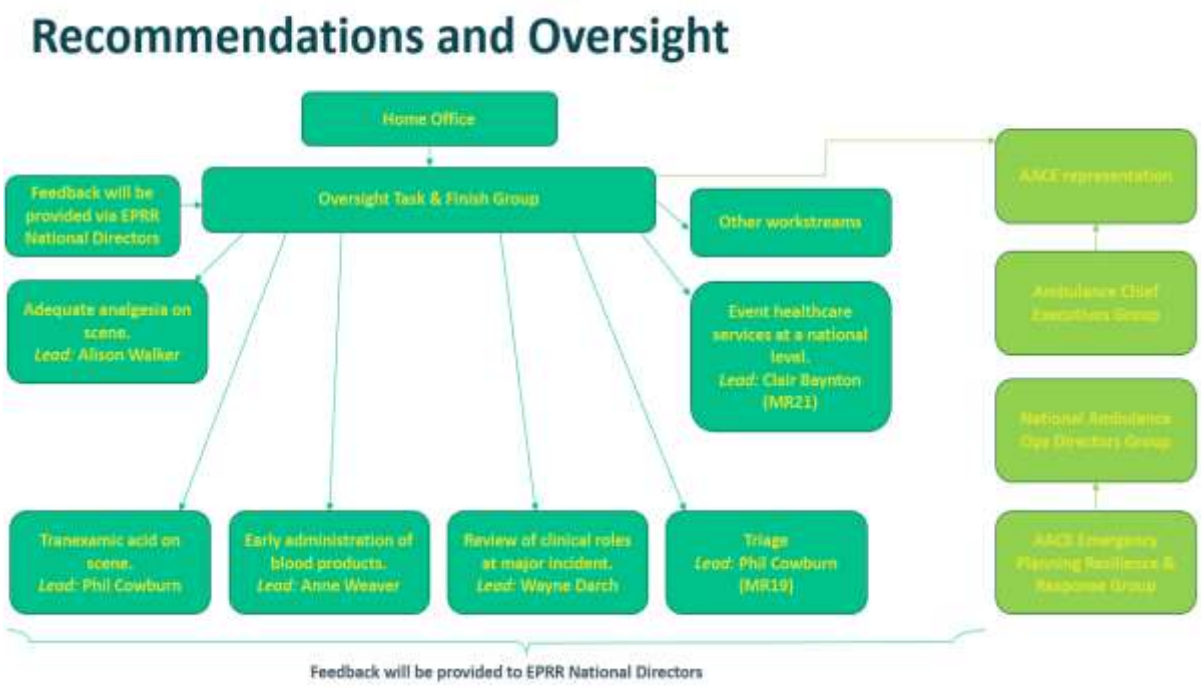
The conclusion and agreed position of the 'check and challenge' meeting held in February 2024 was to approve 13 of the monitored recommendations as complete (R14, 15, 16, 17, 18, 19, 21, 22, 23, 24, 25, 26, 27) and one recommendation, R20, to remain outstanding (Table 1). It was also agreed all parts of the recommendations including those outside the NWAS monitored recommendations be moved into business as usual within Service Delivery and aligned to the Resilience discipline.

No	Recommendation	RAG
R14	Review Major Incident Plan and include a pre-determined attendance for Major Incidents	
R15	Speed up mobilisation, it should provide pre-determined attendances for the all-specialist response	
R16	Up-to-date site-specific plans for all large, complex or high-risk locations within its area	
R17	Sharing plans with other Category 1 responders	
R18	Develop a policy that sets out the circumstances in which an Operational Commander may be relieved	
R19	Train the Operational Commanders in the new policy (R18)	
R20	Include non-specialist ambulance personnel are involved in multi-agency exercising	
R21	Achieved situational awareness from the first response on scene	
R22	Train its commanders in the use of operational discretion	
R23	Review its policies for mobilising the Hazardous Area Response Team resource	
R24	Review rosters for NILO ensuring geographical coverage	
R25	Increase the number of NILO both generally and on call	
R26	Effective policies in place for quickly dispatching patients including the Mass Casualty Distribution Plan	
R27	Improve and reflect on its approach to record-making	

Table 1.

3. MANCHESTER ARENA INQUIRY RECOMMEDNATIONS OVERSIGHT

The following table covers the national oversight, including the sector against the Manchester Arena Inquiry Recommendations.



4. RISK CONSIDERATION

The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the CCA (2004), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998.

NWAS Resilience is also a key component of the NHS Ambulance Standard Contract and is governed by the NHS England & Improvement Emergency Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance.

5. EQUALITY/ SUSTAINABILITY IMPACTS

None.

6. ACTION REQUIRED

The Board of Directors is asked to:

- Receive assurance on the delivery of 13 of the 14 Monitored Recommendations 'Emergency Response' published 3rd November 2022.

- Note the alert on the outstanding monitored recommendation (R20).
- Note the movement of all monitored recommendations are now embedded into business as usual within Service Delivery, and more specifically in the Resilience service line.
- Note the Trust Management Committee will continue to receive assurance against EPRR Core standards aligned to the monitored recommendations.

Lancashire and South Cumbria
Integrated Care Board

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27th September 2023

Daren Mochrie QAM, MBA, Hon DHC, Dip IMC, RCSEd, MCPara
Chief Executive
North West Ambulance Service
Ladybridge Hall
399 Chorley New Road
Bolton
BL1 5DD

Dear Daren

Re: Manchester Arena Inquiry Recommendations

Thank you for your letter 26th May 2023, addressed to Chris O'Neill and please accept my sincere apologies for the delay in responding to you.

Commissioners recognise the points that you raise in your letter regarding ambulance services reviewing their capacity to respond to major incidents and having undertaken that review, making recommendations to NHS Commissioners about the additional / different resources needed to respond to mass casualty events.

I note that the Trust has undertaken a needs analysis for 2023/24 and beyond, which amounts to £40m in 2023/24 (including £33m of recurrent funding) and capital investment of £4m. The needs analysis also identifies an additional £15m in year 2024/25 on top of the recurrent amount.

Clearly, we are in a time of significant pressure in the NHS on several fronts including recovering from the COVID-19 pandemic, responding to new structures from the introduction of Integrated Care Systems and Integrated Care Boards, the need to deliver financial stability across the north west systems and the onset of, what we expect, will be another difficult winter all alongside significant workforce pressures.

Commissioners are aware of the on-going pressures seen by the Trust relating to demand and acuity, and of how this continues to be impacted by continued pressure from hospital handover delays and the need to deliver improved performance against the C2 requirement set out in the UEC Recovery Plan.

We are also aware that other ambulance trusts have written to their local commissioners on the back of the recommendations from Sir John Saunders's reports and I have discussed the approaches that have been made with both regional EPRR colleagues and with the National Ambulance Commissioners Network.

Commissioners believe that we need to collectively review the needs analysis and that this requires underpinning with a significant level of additional detail, which may include considering different ways of working going forwards recognising the difficulties the Trust faces through workforce recruitment and retention. This will include considering how the plans submitted earlier in the year to the national team related to the additional £23.5m funding for UEC recovery dovetail into the needs analysis. Commissioners across the region and myself would be keen to support you in this.

Commissioners also believe, given the scale of the issues raised in Sir John's reports, the impact on ambulance trusts nationally and the impact on other organisations including NARU, co-responding organisations, regional and national EPRR, the DHSC and Home Office, that a much wider discussion is needed to deliver sustainable solutions. Steve Hynes described to me the oversight arrangements and steering groups that have been established to respond to the recommendations and I think it is important that we jointly stay close to what is being discussed in these forums. In this respect I am writing to Julian Mark in his role as Medical Advisor on the National Ambulance Team to seek guidance on what is clearly a national issue.

Through winter planning, ICBs have committed to retaining a focus on reducing handover delays and this is now one of the three key deliverables of the Operational Delivery Group that we agreed at the Strategic Partnership & Transformation Board in September in tackling poor handover, recognising the link this has with capacity and the achievement of the C2 target.

I propose, given the detailed understanding that is needed to progress this difficult issue, that a sub group of the Strategic Partnership & Transformation Board is formed to consider the content of the needs analysis and determine a way forwards. I look forward to further discussion with you and your team in this regard.

Yours sincerely

Professor Craig Harris
Chief of Strategy, Commissioning & Integration
Chair of Strategic Partnership & Transformation Board

cc: Chris O'Neill – Associate Director for Ambulance and NHS 111 Commissioning (North West)
Kevin Lavery – Chief Executive, Lancashire & South Cumbria ICB
Graham Urwin – Chief Executive, Cheshire & Merseyside ICB
Mark Fisher – Chief Executive, Greater Manchester ICB
Tom Quartley – Deputy Director of Emergency & Planned Care, NHS England (North West)
Paul Dickens – Regional Head of EPRR, NHS England (North West, North East & Yorkshire)
ICB Ambulance and NHS 111 Leads

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Learning from Deaths - Summary Report and Dashboard Q4 2023/24
PRESENTED BY	Maxine Power - Director of Quality, Innovation and Improvement
PURPOSE	Assurance

LINK TO STRATEGY	Quality Strategy									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐
	SR06	☐	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Trust Board is recommended to:
	• Support publication of the quarterly dashboard (Appendix A)
	• Note the recent developments around call handling and the Trust continues to be fully compliant with the Learning from Deaths framework.
	• Acknowledge the good practice identified including:
	  ○ Patient centred decisions involving frailty, comorbidities, and social history.
	  ○ Clear involvement of those important to the patient when making treatment and management decisions.
	  ○ Holistic decision making recorded in EPR.

EXECUTIVE SUMMARY	The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning. The Q4 dashboard (Appendix A) describes the opportunities to learn from deaths. The main concerns raised internally and externally identified in DatixCloudIQ (DCIQ), were attributed to the timeliness of the emergency response and treatment and management plans enacted. Of the concerns closed, there were two incidents where causal factors were identified by the investigators. The peer review process now encompasses Integrated Contact Centres and as a result the Trust is fully compliant with the national framework. The key areas for improvement include making a clear management plan for the patient, including more detail in a patient assessment, making a referral to AVS/GP services when appropriate to do so and ensuring calls are triaged correctly using NHS Pathways. The quality of patient records has remained high this quarter, with only 14% of EPR receiving a "poor" or "very poor" rating. To give context, this is a significant improvement from 47% similarly scored in Q1 23/24. The peer review also identified areas of good practice: patient centred decisions involving frailty, comorbidities, and history; holistic decision making with excellent recognition of the patient dying and clear involvement of those important to the patient. There were seven patient records that received a "good" rating for quality. The panel continues to welcome observers to help raise awareness of the project and embed learning from the peer reviews.	
PREVIOUSLY CONSIDERED BY	Clinical & Quality Group	
	Date	Tuesday, 02 July 2024
	Outcome	Accepted

1. PURPOSE

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

Appendix A is a summary dashboard of the Q4 2023/24 Learning from Deaths review, and it is proposed this document is published on the Trust's public accounts by 31st July 2024 in accordance with the national framework and trust policy. Appendix B is the annual dashboard which also requires publication. The Q4 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q4. Learning from the panels is discussed later in this paper.

2. BACKGROUND

2.1 Learning from Deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the Clinical Audit Team at Learning.FromDeaths@nwas.nhs.uk

3. LEARNING FROM DEATHS COHORT SUMMARY

3.1 The number of patients whose deaths were identified as in scope for review was 68 (44 concerns raised in Datix and 24 sampled for SJR).

3.2 Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 04/04/2024. Please note that due to the complexity, the granular updates for the previous quarters will be received within other patient safety reports and the thematic analysis will be captured within the annual learning from deaths report.

The breakdown of concerns raised:

- 28 internal concerns were raised through the Incidents module (Events).
- 14 external concerns were raised through the Patient Experience module (Feedback).
- 2 concerns were raised both internally and externally.

3.2.1 Internal Concerns

Of the 28 internal concerns, 9 were reviewed and closed. There was one case in which the investigation concluded the Trust had contributed in some way to that patient death.

3.2.2 External Concerns

Of the 14 external concerns that have been reported, 8 are still in the early stages of review. Six concerns have been closed with no causal factors identified.

3.2.3 Concerns raised both internally & externally

Of the 2 incidents which were raised both internally and externally, both are closed on both modules. One incident was concluded that the trust had contributed to that death.

3.2.4 Outcomes from concerns raised

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

3.3 SJR Stage 1 Outcomes

21 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the dashboard (appendix A). 12 patients received appropriate care. The mid-range statement of 'adequate' practice is defined as the expected practices and procedures in compliance with guidance. Any practice identified as beyond expected practice is defined as 'good'. Any practice identified as not reaching expected practice is defined as 'poor'.

3.3.1 SJR Stage 2 Outcomes

Nine cases were identified as needing second stage review following Stage 1. The second stage review concluded that five deaths were not avoidable, and four cases were uncertain whether poor practice had led to harm. The care experienced by these patients in terms of call handing/categorisation/resource allocation, patient assessment and management plan were below expected levels.

3.3.2 SJR & Concerns - Learning Themes

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

ICC:

- Poor communication.
- Missed opportunity to upgrade.
- Lack of probing by EMA.

PES:

- Limited information regarding clinical assessment/examination.
- MTS not used or not applied correctly.
- No referral to AVS/GP when appropriate to do so.
- No documentation of plan, worsening or SOS advice

Trust:

- Demand outstripped resources – hospital handover delays

Additional learning themes were also identified within the reviews that received an 'Adequate' rating. Whilst these were not necessarily 'Poor' or 'Good' themes, they were recurrently seen in reviews throughout Q4 and demonstrate where additional learning can be found, as well as highlighting more good practice. These include:

PES:

- GP not being notified when patient passes away at scene
- Capacity to consent 'ticked' but no detail noted within the EPR
- Crews were quick to escalate concerns for very unwell patients to either an NWAS local team or the patients GP
- Crews showed additional compassionate management of family following a patient passing away

ICC:

- Ongoing learning required for EMAs regarding confirmation of a DNACPR and how to triage this down NHS Pathways
- More probing required by EMAs for complex calls
- EMAs continue to demonstrate good use of the Non-Clinical Advice Hunt for complex calls and concerns

4. OUTCOME OF LEARNING THEMES

A commitment to disseminating and promoting good practice has been made by the Consultant Paramedic (Medical) through the regional and local 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.

5. RISK CONSIDERATION

There are no legal implications associated with content of this report and the data gathered to produce the dashboard has been managed in accordance with the Data Protection Act 2018.

6. EQUALITY/ SUSTAINABILITY IMPACTS

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

7. ACTION REQUIRED

The Trust Board is recommended to:

- Support publication of the quarterly dashboard (Appendix A)
- Note the recent developments around call handling and the Trust continues to be fully compliant with the Learning from Deaths framework.
- Acknowledge the good practice identified including:

- Patient centred decisions involving frailty, comorbidities, and social history.
- Clear involvement of those important to the patient when making treatment and management decisions.
- Holistic decision making recorded in EPR.

NWAS Learning From Deaths Dashboard - Q4 of 2023 - 2024 (January - March)

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
Jan-24	28	16	57.1%	4
Feb-24	27	18	66.7%	5
Mar-24	13	4	30.8%	2
This Quarter	**68**	**38**	**55.9%**	**11**
This Financial Year	266	145	54.5%	34

** Criteria as specified in the 'National guidance for ambulance trusts on Learning from Deaths' (2019) - Where concern raised on quality of care provided where the patient*

Table 1

Data source: An amalgamation of both the Datix cohort and the Sample cohort data sources detailed below.

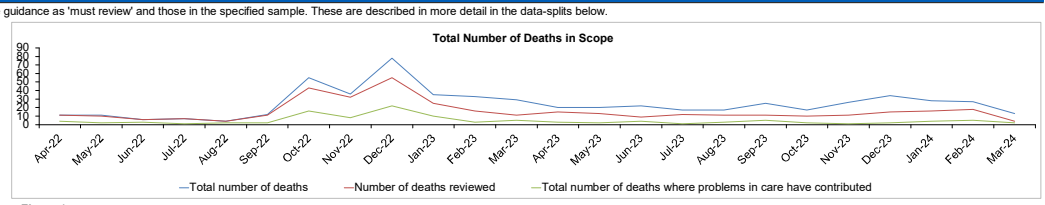


Figure 1

Those in scope must have died under the care of the ambulance service (from call handling to before handover concludes), after handover (if notified by other trusts of these) or within 24 hours of contacting the service and the decision was not to be conveyed to hospital. This report draws on learning from the previous quarter and remains an iterative process.

Concerns raised in Datix Breakdown

Datix Cohort Description: The 'must review' category includes incidents raised internally and exernally to the organisation and recorded via Datix as 'deaths that occurred in our care where there has been a concern about the quality of care provided'. Records are included where death has occurred; the review is considered complete when the record is closed.

Internal Concerns - Incidents (including SIs)

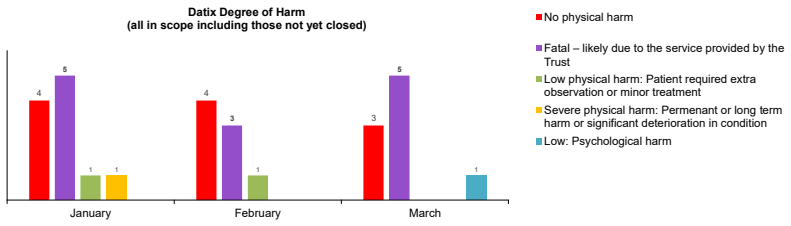


Figure 2

Total Datix Death Incidents in Scope		Number of Deaths Closed on Datix	Of those closed, Number of Deaths likely due to the service provided by the Trust	Lessons Learned complete for those closed and Deaths likely due to the service provided by the Trust
January	**11**	6	1	1
February	**8**	3	0	0
March	**9**	0	0	0
Total	**28**	**9**	**1**	**1**

Table 2

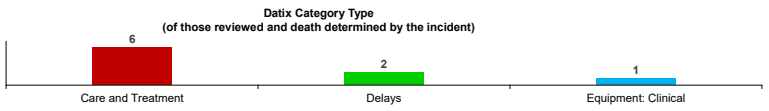


Figure 3

External Concerns

Number of Complaints		Incidents Closed on Pat. Exp.	Number closed and Deaths likely due to the service provided by the Trust
January	9	4	0
February	5	2	0
March	0	0	0
Total	**14**	**6**	**0**

Table 3

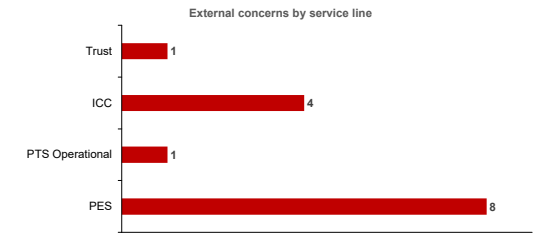


Figure 4

Department	Concern Raised	Cause and Actions	Total
PES	Problem of any other type	Crew did not act appropriately; Still under review	1
	Problem related to treatment and management plan	Failure to recognise potential seriousness and complexity of condition; Still under review	1
		Failure to recognise potential seriousness and complexity of condition; Not upheld; No actions	1
	Problem with communication	Poor communication; Staff feedback and/or reflection	1
		Poor communication; Not upheld; No actions	1
	Problem with patient disposition	Correct pathway not followed; Still under review	1
	Problem with any other type not fitting the categories	Hospital handover delays; Still under review	1
	Problem with equipment	Issues with Sat-Nav plotting address incorrectly; Partly upheld; No actions	1
PTS Operational	Problem with call taking and/or response allocation	Demand outstripped resources; Partly upheld; No actions	1
ICC	Problem of any other type	No causal factors; No Action	2
	Problem with call taking and/or response allocation	Still under review; Still under review	1
		No causal factors; Not upheld; No actions	1
Trust		Demand outstripped resources; Partly upheld; No actions	1

Table 4

Internal and External Concerns - Incidents and Complaints

Number of concerns that have been raised internally and externally		Incidents Closed on both modules	Number closed and Deaths likely due to the service provided by the Trust
January	1	1	0
February	1	1	1
March	0	0	0
Total	**2**	**2**	**1**

Table 5

Department	Concern Raised	Cause and Actions	Total
PES	Problem with patient disposition	Incorrect destination; Not upheld; No actions	**1**
Trust	Problem with call taking and/or response allocation	Demand outstripped resources; Hospital handover delays; Staff feedback and/or reflection	**1**

Table 6

Data last exported 04/04/2024; Data last cleansed 28/05/2024

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

Structured Judgement Review Sample (SJR) Breakdown

Sample Data Description: A random sample of 40 incidents minimum using the specified criteria from the national guidance reviewed using the SJR process.

Structured Judgement Review

Incidents used for the Sample Criteria		Number of Deaths Reviewed	Total Number of Deaths where problems in care have contributed
January	7	5	3
February	13	12	4
March	4	4	2
Total	**24**	**21**	**9**

Table 7

SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards
Poor/Very Poor: Care that is lacking and/or does not meet expected standards
Good/Very Good: Care that shows practice above and/or beyond expected standards

Definitions taken from the National Quality Board, "National Guidance for Ambulance Trusts on Learning from Deaths", July 2019

Initial Contact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	2	19	0	**19/21 patients**	**90%**
Right Care	Patient Assessment Rating	3	17	1	**18/21 patients**	**86%**
	Management Plan/Procedure Rating	3	15	3	**18/21 patients**	**86%**
Right Place	Patient Disposition Rating	1	19	1	**20/21 patients**	**95%**

Table 8

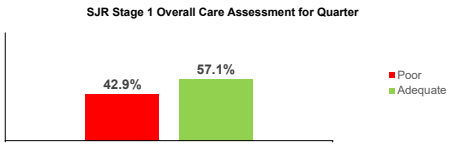


Figure 5

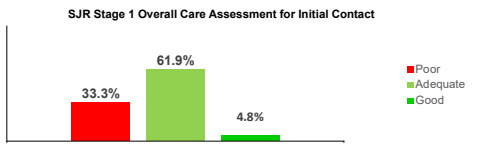


Figure 6

Recontact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)†	4 or 5 - Good or Very Good	% Patients receiving Adequate or Good Care	
Right Time	Call Handling/Resource Allocation‡	3	11	0	**11/14 patients**	**79%**
Right Care	Patient Assessment Rating	1	13	0	**13/14 patients**	**93%**
	Management Plan/Procedure Rating	1	12	1	**13/14 patients**	**93%**
Right Place	Patient Disposition Rating	2	12	0	**12/14 patients**	**86%**

Table 9

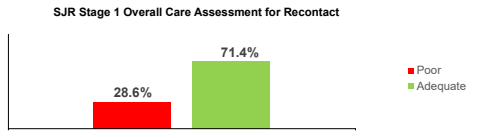


Figure 7

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

Evidence of Poor/Very Poor Practice

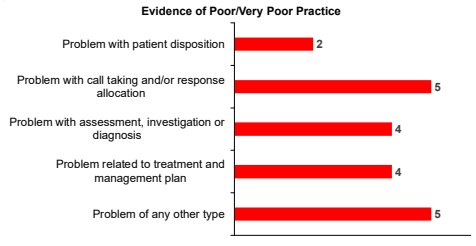


Figure 8

Department	Learning Theme	Learning Detail	Total
PES	Problem with assessment, investigation or diagnosis	Limited information recorded regarding clinical assessment, examination and outcome	4
		No physical examination documented	1
		No medication recorded	1
	Problem related to treatment and management plan	MTS not applied correctly	3
		No documentation of plan, worsening advice or SOS advice	2
		No referral to AVS/GP/alternative providers when appropriate to do so	3
		Capacity to consent assessed but no details provided	1
	Problem of any other type	Quality of EPR	5
	Problem with patient disposition	Safety netting not documented	1
		Incorrect DOD procedure followed for expected death	1
ICC	Problem with call taking and/or response allocation	Call not triaged correctly	5

Table 10

Evidence of Good/Very Good Practice

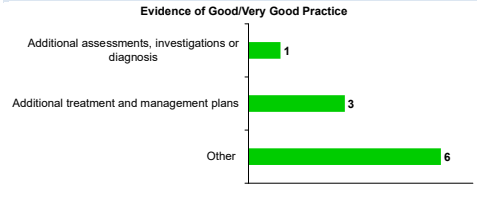


Figure 9

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

Table 11

Data last accessed 14/05/2024

NWAS Learning From Deaths Demographics Dashboard for Q4 2023 - 2024 (January - March)

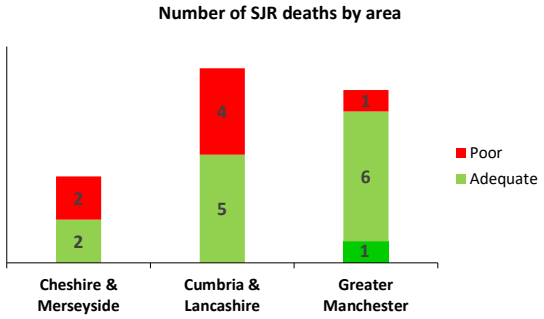


Figure 1

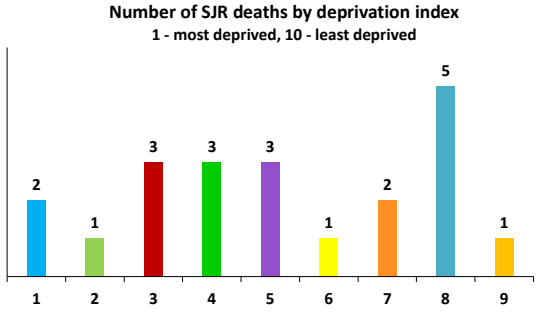


Figure 2

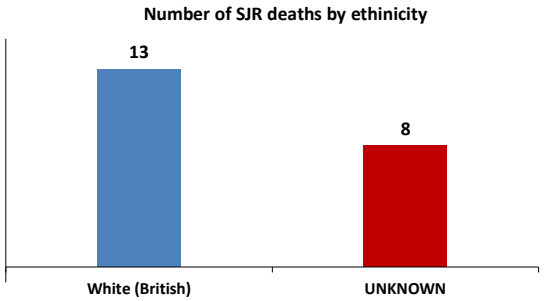


Figure 3

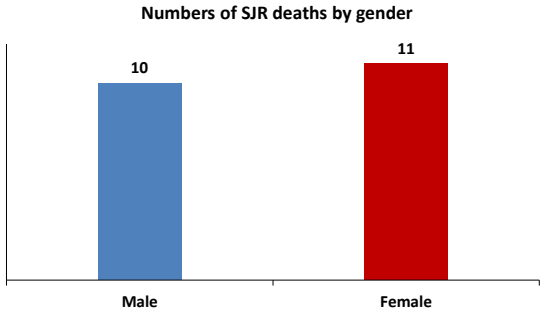


Figure 4

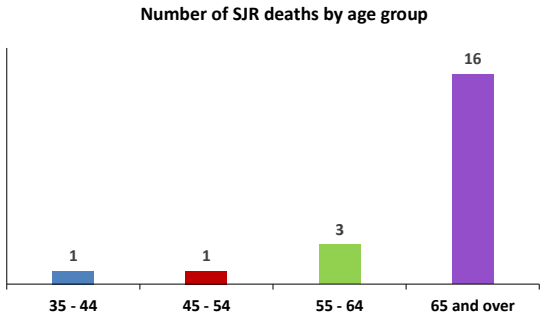


Figure 5

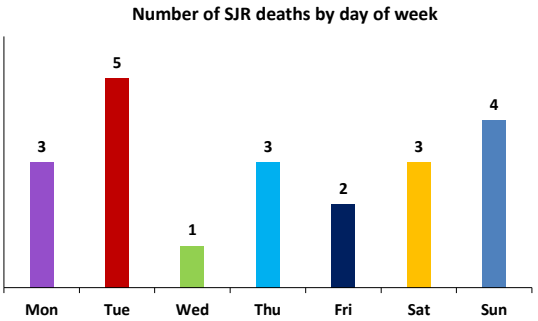


Figure 6

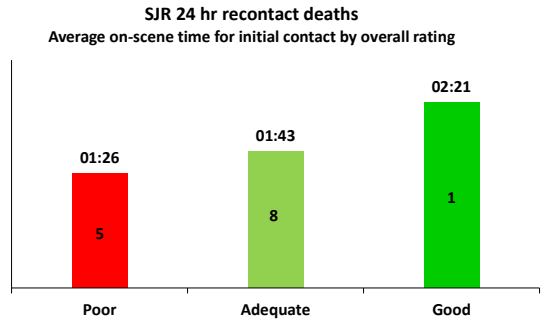


Figure 7

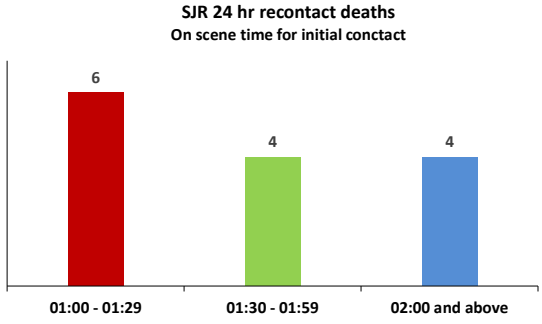
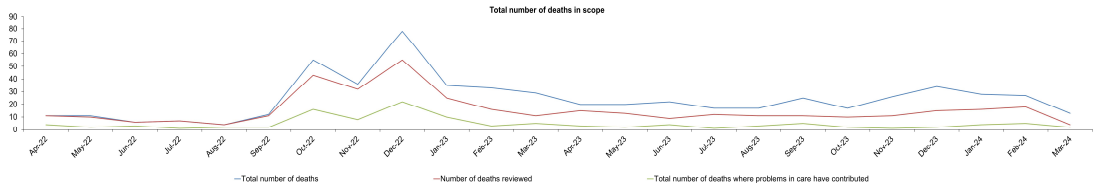


Figure 8

Data last accessed 29/04/2024

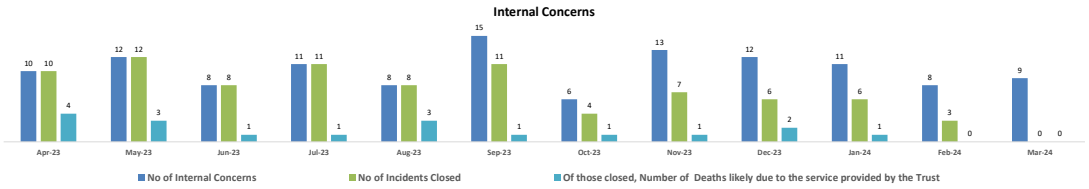
NWAS Learning from Deaths Dashboard Annual 2023 - 2024

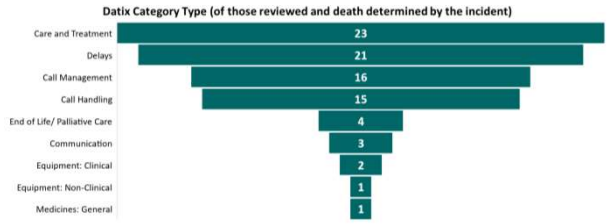
Overall Dashboard Description: This is a systematic dashboard that is a combination of those outlined in the guidance as 'must review' and those in the specified sample. These are described in more detail in the data-splits below.



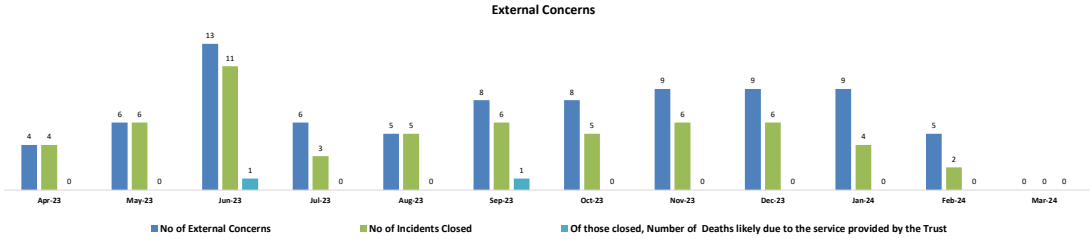
Concerns Raised in DCIQ

Internal Concerns





External Concerns



Learning themes: PES

Problem with treatment & management plan:
-failure to recognise potential seriousness & complexity of condition

Problem with Patient Disposition:
-correct hospital/community pathway not followed
-lack of appropriate safety-netting

Problem with Communication:
-Poor communication with patient/family

Learning themes: Trust

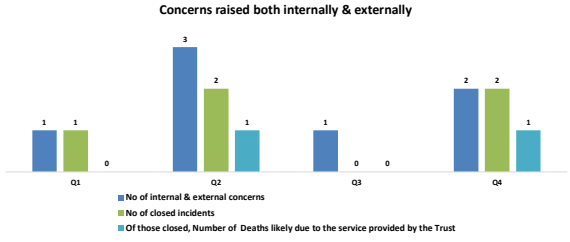
Demand outstripped resources:
-Hospital handover delays
-Inappropriate resourcing levels across the trust at the time of the incident

Learning themes: ICC

Problem with call taking/response allocation:
-Call categorised incorrectly
-Missed opportunity to upgrade low acuity incident
-Missed opportunity to divert Ambulance

Problem with communication:
-Poor communication with patient/family
-Correct hospital pathway not followed

Internal and External Concerns



Learning themes: PES/ICC/Trust

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

Problem with call taking/response allocation:
-Missed opportunity to allocate ambulance

Demand outstripped resources:
-Hospital handover delays

NWAS Learning from Deaths Dashboard Annual 2023 - 2024

Structured Judgement Review (SJR) Sample

Incidents used for the sample criteria		Number of Deaths Reviewed	Total number of deaths where care is deemed to be less than adequate
Q1	18	16	9
Q2	19	15	8
Q3	27	26	7
Q4	24	21	9
Total	88	78	33

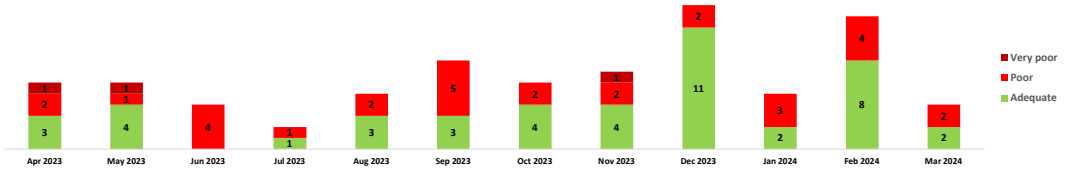
SJR Scoring Key:

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

SJR Stage 1 Overall Care Assessment for Year



Initial Contact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good
Right Time	Call Handling/Resource Allocation	10	68	0
Right Care	Patient Assessment Rating	13	58	7
	Management Plan/Procedure Rating	14	57	7
Right Place	Patient Disposition Rating	12	61	5

Recontact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good
Right Time	Call Handling/Resource Allocation	7	46	0
Right Care	Patient Assessment Rating	1	52	0
	Management Plan/Procedure Rating	1	51	1
Right Place	Patient Disposition Rating	2	51	0

SJR Learning Themes

Evidence of Poor/Very Poor Practice

Poor learning themes

Problem with patient assessment:
-Limited information regarding clinical assessment, examination & outcome
-No medical model used

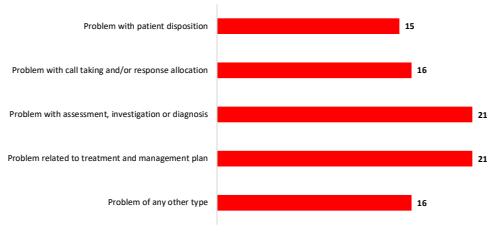
Problem with treatment/management plan:
-MTS not used
-Lack of clear management plan

Problem with patient disposition:
-No referral to AVS/GP when appropriate to do so

Problem with call taking/response allocation:
-Call not triaged correctly

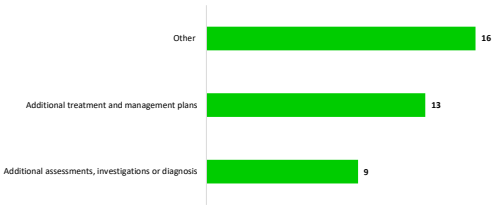
Problem of any other category:
-Poor quality of EPR (x16)

Evidence of Poor/Very Poor Practice



Evidence of Good/Very Good Practice

Evidence of Good/Very Good Practice



Good learning themes

Additional assessments, investigations & diagnosis:
-Extensive patient assessment
-Patient centred decisions around frailty, co-morbidities and history
-Involvement of those important to the patient, with holistic conversations noted

Additional treatment & management plan:
-Holistic decision making reported
-Excellent recognition of a patient dying
-Multiple sets of observations and discussed patient's condition with GP and family

Any other category:
-Good quality of EPR (x16)

NWAS Learning From Deaths Demographics Dashboard for 2023 - 2024

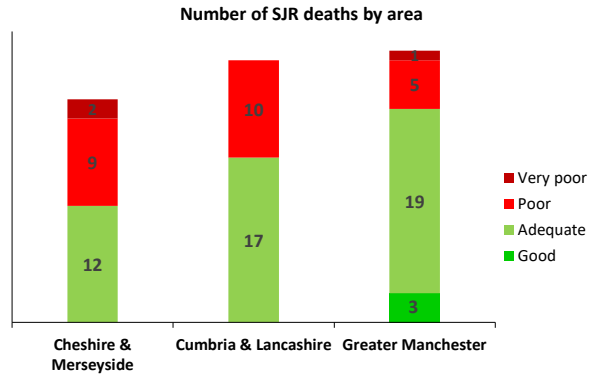


Figure 1

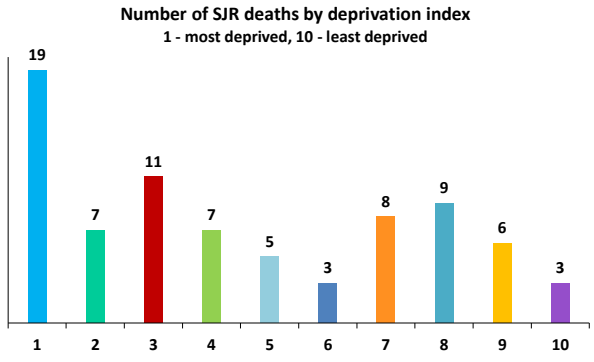


Figure 2

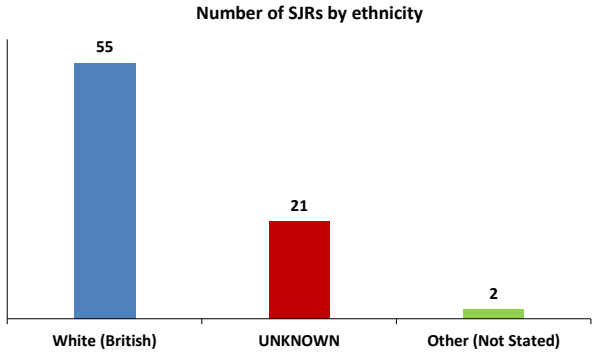


Figure 3

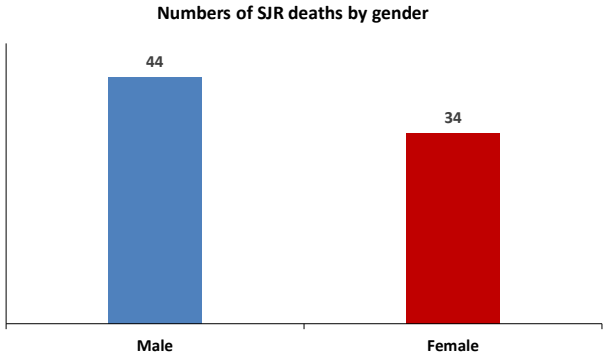


Figure 4

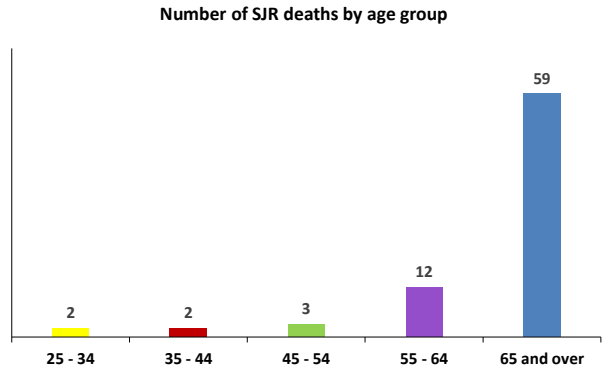


Figure 5

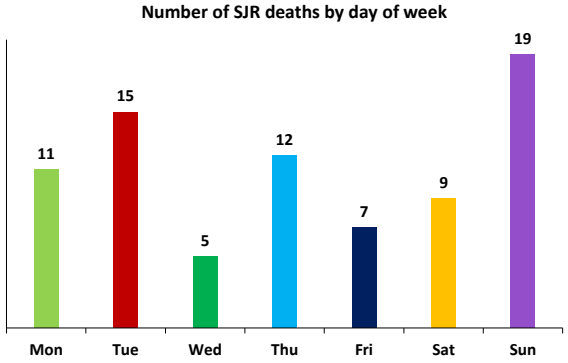


Figure 6

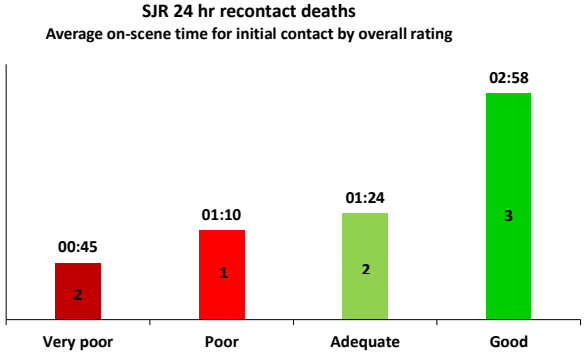


Figure 7

Data last accessed 28/05/2024

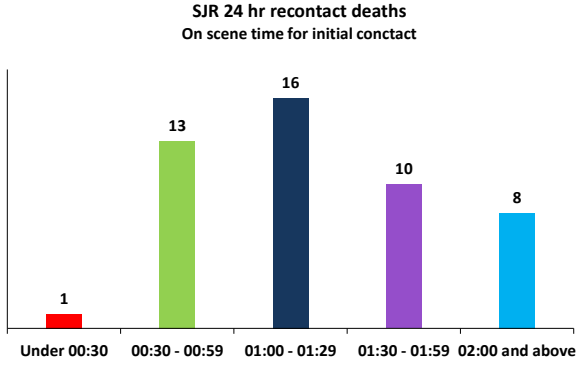


Figure 8

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ESCALATION AND ASSURANCE REPORT

Report from the Quality & Performance Committee

Date of meeting	Monday, 24 June 2024		
Members present	• Prof A Esmail, Chair • Dr D Hanley, Non-Executive Director • Dr A Chambers, Non-Executive Director • Mr S Desai, Chief Operating Officer & Deputy CEO • Dr M Power, Dir. of Quality, Innovation, and Improvement • Mrs A Wetton, Director of Corporate Affairs • Dr C Grant, Medical Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

Item 2425/030: Medicines Management & Controlled Drugs Annual Reports 2023/24 –

- Some Controlled Drug Audits static at 70% compliant with improvements identified.
- Noted the ongoing improvement work planned and the oversight provided by the Medical Director.
- **Action**: Requested continued monitoring of the compliance position via Clinical and Quality Group to the Trust Management Committee to Board.

ADVISE:

Item 2425/027: Q&P Dashboard –

- Noted the ongoing work of the complaints team and the effective processes in place to manage the low level and higher-level complaints by the PALS team.
- Discussed hear and treat and see and treat activity and further details related to the variations across the trust to be provided to members of the Committee.
- Considered 111 and primary care data and the requirement for a future deep dive to the Committee to be considered by the Chair.
- Noted overall good AQI performance.

Item 2425/028: Safeguarding Assurance Report –

- Received a comprehensive report, however queried if the paper answered the so what question.
- Discussed the challenges faced by the trust to manage the various safeguarding expectations across the wider health care system.
- Recommended the paper for presentation to the Board of Directors on 31st July 2024.

Item 2425/029: NHS Patient Safety Strategy Update

- Received a comprehensive update on the work undertaken in respect of Patient Safety Strategy and Framework.
- Chair continues to meet with the Patient Safety Specialist at regular intervals for patient safety updates

Item 2425/031: NWAS Adverse Weather Plan –

- Noted and received assurance from the Draft Adverse Weather Plan.

ASSURE:

Item 2425/025: Updated Terms of Reference

- Approved updated terms of reference, to include the Director of Operations in the Committee membership from 1st July 2024.

Item 2425/026: Board Assurance Framework:

- Received assurance from the report and discussed the progress of key outstanding mitigating actions.

RISKS

Risks discussed:

- Strategic Risks aligned to the Committee SR01, SR03, SR06.

New risks identified:

- None identified.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Workforce Equality Data Monitoring
PRESENTED BY	Lisa Ward, Director of People
PURPOSE	Assurance

LINK TO STRATEGY	People Strategy									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☐	People	☒
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board is asked to: • Review and consider the workforce equality data reports • Approve publication of the reports via NWAS website.
EXECUTIVE SUMMARY	The purpose of this paper is to introduce the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) data reports. Reports for all three data sets are appended to this cover paper. A brief summary of significant findings from the data is presented in this paper, but colleagues are asked to consult the attached reports for more detail. In the main, there are a number of positives which emerge from the data including, an increase in the numbers of BME and disabled staff, and greater female representation in the upper quartiles of pay. This latter position has resulted in a significant narrowing of the average pay gap between men and women in the organisation which has reduced by 3.5% and is the lowest since we commenced reporting. These improvements have not been replicated in the median gap which has slightly widened as a result of the growing balance of recruitment towards female staff. On the whole the staff survey related elements of the WRES and WDES have improved with the WDES figures showing that more disabled staff feel valued in the organisation compared to the previous year.

	The most significant finding across the data however relates to the relative likelihood of BME staff entering the formal disciplinary process compared to White staff, which has identified an area of significant concern. The data in this Indicator shows that BME staff are over two-and-a-half times more likely to enter the formal disciplinary performance compared to their White colleagues. The likelihood of appointment from shortlisting for WRES and WDES indicates a continuing requirement for further work to close these gaps. A number of actions have been identified in section 5 (with more detail in the reports) which aim to improve the experiences of staff, and positively impact the metrics for next year.	
PREVIOUSLY CONSIDERED BY	Diversity and Inclusion Group	
	Date	Friday, 12 July 2024
	Outcome	Noted the outcomes and assured that the relevant actions were translated to the EDI Annual Plan which is being presented separately to Board.
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 17 July 2024
	Outcome	Noted the outcomes and assured that the relevant actions were translated to the EDI Annual Plan which is being presented separately to Board. Confirmed support for actions to address BME disciplinary gaps.
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	26 July 2024
	Outcome	RC did not meet in July but the report was circulated virtually to members.

1. BACKGROUND

1.1 The purpose of this paper is to introduce the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) data reports.

1.2 Reports for all three data sets are appended to this cover paper. A brief summary of significant findings from the data is presented below, but colleagues are asked to consult the attached reports for more detail.

2. WRES SIGNIFICANT FINDINGS

2.1 WRES figures show a consistent increase in the number of BME staff in the organisation since 2019. There were 100 more BME staff in the organisation on 31 March 2024, compared to the same date in March 2023.

2.2 Overall, the experiences of BME staff as seen through the WRES indicators have improved. This is particularly apparent through the data extracted from the NHS Staff Survey which saw considerably more responses from BME staff in 2023 compared to 2022.

2.3 Figures in Indicator 5 -7 show fewer BME staff experiencing bullying, harassment or abuse from the public or colleagues, and more BME staff feeling that organisation acts fairly in terms of career progression. It is also encouraging to see that improvements in figures are helping narrow the gap in experience between BME and White staff.

2.4 However, recruitment data shows that White staff are more than one-and-a-half times more likely to be appointed compared to BME applicants – which is a worsening of the previous year's position. This is despite significantly more BME applicants being shortlisted, and an increase in the number of BME staff being appointed.

2.5 Indicator 3 relating to the relative likelihood of BME staff entering the formal disciplinary process compared to White staff has identified an area of significant concern. The data in this Indicator shows that BME staff are over two-and-a-half times more likely to enter the formal disciplinary process compared to their White colleagues.

2.6 An exploration of the disciplinary data found that out of less than 100 formal disciplinary cases in 2023/24, around 15 related to BME staff and are largely concerned with lower-level incidents. While these numbers are low when compared to the overall BME and White staff total, the BME cases equated to 16% - when the proportion of BME staff in the organisation is only 6%.

3. WDES SIGNIFICANT FINDINGS

3.1 We have continued to see an increase in the numbers of staff declaring that they have a disability or long-term condition. At the end of March 2024, 7.8% of all staff had declared they had a disability – an increase from 6.5% in 2023 and 5.0% in 2022.

3.2 Figures around the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process further deteriorated from the previous year's score, meaning that that disabled staff are over one-and-a-half times more likely to enter the capability process compared to non-disabled staff. Numbers of staff affected are however in single figures.

3.3 Whilst the actual experience of negative behaviours has decreased for disabled staff, there has been a notable increase in the proportion of disabled staff reporting negative experiences when they occur. On the whole, NHS Staff Survey results since 2018 consistently show that a greater percentage of disabled staff report their experiences of bullying, harassment or abuse compared to non-disabled staff.

3.4 Around 1 in 3 disabled staff reported feeling satisfied with how the organisation values their work, and this is the highest positive response since reporting on this metric started in 2018. Additionally, the difference between disabled and non-disabled staff has significantly narrowed on this question in comparison to the previous year.

4. GPG SIGNIFICANT FINDINGS

4.1 Female representation in the NWAS workforce has consistently continued to increase over a number of years. As of 31 March 2024, 53.13% of staff were female (52.14% in 2023, 51.60% in 2022). Additionally, the majority of the workforce (55.43%) in the Operations directorate were female, and women account for half of all staff across the corporate directorates.

4.2 The percentage of women in the lower and lower middle quartiles has fallen for the first time, while increasing in the upper middle and upper quartiles. The most sizable increase was in the upper quartile, where female representation now stands at 44.06% - an increase of 5% on the previous year.

4.3 The hourly mean/average pay gap has continued to narrow and is now at 7.27%. While still a significant gap, this is however the lowest average figure since we started reporting. This will reflect the increasing representation in the higher pay quartiles and the impact of work around progression. On the other hand, the median hourly gap increased to 11.17%. In contrast to the average gap, this figure represents the largest gap since reporting started. This is largely because of the higher proportion of female than male staff in the entry pay bands.

5. ACTIONS

5.1 The WRES, WDES and GPG data reflects the ongoing work to support all our staff groups and address inequalities in the workplace. While there have been some improvements across a number of key areas, it is important to recognise that there remains a considerable difference in the experiences of BME, disabled and female staff in the organisation.

5.2 In response to WRES Indicator 3, we will undertake a review of disciplinary cases relating to BME staff to better understand the data and consider improvements to the application of disciplinary policy to ensure it is being used appropriately and fairly.

5.3 In 2024/25, to support improvements for WDES Metric 2 (recruitment), we are aiming to complete the refresh of the recruitment and selection policy with the input of a wide range of stakeholders, including the Disability Network. This refresh will take into account learning from the Inclusive Recruitment Audit referenced in the report earlier.

5.4 Finally, with the launch of Developing Leaders programme in 2024/25, we aim to support more colleagues from who are currently underrepresented in leadership roles by providing them with the skills and knowledge to progress in the careers.

5.5 Overall, the outputs from this data will continue to inform the annual plans supporting the EDI priorities.

6. RISK CONSIDERATION

6.1 Data emerging from the WRES, WDES and GPG will be considered in the development of EDI-related risks.

6.2 There are statutory and regulatory requirements associated with progress in improving equality, diversity and inclusion.

7. EQUALITY/ SUSTAINABILITY IMPACTS

7.1 Collation and assessment of WRES, WDES and GPG data is essential to help improve the experiences of all our staff.

8. ACTION REQUIRED

8.1 The Board is asked to:

- Review and consider the workforce equality data reports
- Approve publication of the reports via NWAS website.

North West Ambulance Service NHS Trust

Workforce Race Equality Standard (WRES) Data Report

Covering the period of
1 April 2023 – 31 March 2024

Introduction

This report sets out the 2023/24 annual workforce data in relation to race which the trust is required by NHS England to publish.

Working to address inequalities identified by workforce data demonstrates our compliance with the Equality Act 2010 and the Public Sector Equality Duty. Monitoring workforce equalities data is also central to ensuring that we are delivering on our equality, diversity and inclusion priorities:

1. We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.
2. We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.

Workforce Race Equality Standard (WRES)

The WRES is a set of nine specific measures (indicators) which enables NHS organisations to compare the workplace and career experiences of Black and Minority Ethnic (BME) staff. We use the data to inform the development of projects and initiatives to improve NWAS for BME staff. Year on year comparison enables us to demonstrate progress against the indicators of race equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers.

This data in this report relates to the period of 1st April 2023 – 31st March 2024. In line with the nationally mandated timeframe, the data was submitted to NHS England in May 2024.

This is the sixth year of reporting for WRES, and as with previous years, the data includes results from the National Staff Survey.

Indicator 1: Workforce information

Percentage of BME staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of BME staff in the overall workforce

Overall	31/03/ 2019	31/03/ 2020	31/03/ 2021	31/03/ 2022	31/03/ 2023	**31/03 2024**
Total workforce	6356	6598	6807	6815	7073	**7421**
BME staff	286	304	342	325	365	**444**
% BME staff in total workforce	4.5%	4.6%	5.0%	4.8%	5.2%	**6.0%**

Agenda for Change bandings	2024 Non-clinical Staff	2024 Clinical Staff
Cluster 1: Bands 1 - 4	8.5%	7.1%
Cluster 2: Bands 5-7	10.8%	4.1%
Cluster 3: Bands 8a-8b	6.5%	3.3%
Cluster 4: Bands 8c-9 and VSM	6.8%	0

Figures show a consistent increase in the number of BME staff in the organisation since 2019. There were 100 more BME staff in the organisation on 31 March 2024, compared to the same date in March 2023.

Less than 1% of all staff have not declared their ethnicity. Colleagues are regularly reminded to update their details on the Electronic Staff Record and we will be working to reduce the number of non-declarations.

Indicator 2: Recruitment

Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants

The target outcome is a figure of 1.0 – meaning that BME candidates are no less likely to be appointed from shortlisting than candidates who are White. A figure of 1.0 reflects well on the fairness of recruitment processes.

	2020	2021	2022	2023	**2024**
Likelihood	1.29	1.51	1.98	1.26	**1.61**

The figures show that white staff are more than one-and-a-half times more likely to be appointed compared to BME applicants – which is worsening of the previous year's position. This is despite significantly more BME applicants being shortlisted, and an increase in the number of BME staff being appointed.

In 2023/24:

- Out of 14000+ applications for trust roles, more than 4000 came from BME applicants.
- 1,046 BME applicants were shortlisted (602 in 2022/23, 349 in 2021/22).
- 134 BME staff were appointed (102 staff in 2022/23, 48 in 2021/22).

While we still have a way to go to improve the score, it is encouraging to see the increased numbers of BME applicants applying for, and being appointed to trust roles. These increases are likely due to a range of factors including the delivery of positive action recruitment initiatives, promotion of communications campaigns using diverse imagery, and review of inclusive language in job adverts. Additionally, the Beyond Bias training module for managers and leaders has helped enable greater awareness around managing bias when undertaking recruitment. More information on our inclusive recruitment work can be seen in the Equality, Diversity and Inclusion Annual Report 2023-24.

Considering the data emerging from this indicator and a similar metric in the Workforce Disability Equality Standard (WDES), in summer 2023 we completed an audit of our end-to-end recruitment and selection processes through an external and independent consultancy. The audit undertook a deep dive in to the data and explored a range of issues impacting applicants who are disabled, and those from black and minority ethnic backgrounds. It identified potential solutions and provided recommendations to effectively address the challenges and improve access to employment opportunities in the trust. Many of the recommendations emerging from the audit are now being taken forward by a recently established Inclusive Recruitment Group.

A point on data

It should be noted that on our recruitment portal (Trac), a campaign is considered completed when all appointees from a campaign have commenced in post. This means that for example, if there is a vacancy that opens on 1 March 2024, but the successful individual(s) does not commence in post until 15 April 2024, this recruitment will not be counted in the data. This issue with the data is a particular challenge for us, as the trust manages several mass recruitment campaigns each year, and at times, these may cross over from one financial year to the other. The portal only closes a vacancy once every individual with an offer starts in the position.

In the case of mass recruitment campaigns this could lead to distorted data, as often there can be up to twelve months between a campaign opening and the last individual commencing on a training course. As a result, the data that is presented for the WRES submission, while correct at the time, does not accurately reflect our actual position.

Indicator 3: Formal Disciplinary Process

Relative likelihood of BME staff entering the formal disciplinary process compared to White staff

A figure of 1.0 or below is desired, as this would indicate BME staff are no more or less likely to enter the formal disciplinary process than White staff.

	2019	2020	2021	2022	2023	**2024**
Likelihood	1.32	1.89	1.70	2.23	1.86	**2.59**

The data in this Indicator shows that BME staff are over two-and-a-half times more likely to enter the formal disciplinary performance compared to their White colleagues. This represents the most significant disparity between the two staff groups, since we started reporting.
Out of less than 100 formal disciplinary cases in 2023/24, around 15 related to BME staff. While these numbers are low when compared to the overall BME and White staff total, the BME cases equated to 16% - when the proportion of BME staff in the organisation is only 6%.

When reviewing the themes related to disciplinary cases involving BME staff, data shows that they cumulatively relate to lower level incidents. The disproportionality in the figures may therefore suggest that there could be a greater propensity to progress issues into the formal disciplinary process for these types of cases.

The majority of BME staff in NWAS are based within our Contact Centres. To help further understand and explain the data, engagement will be undertaken with HR and Management Teams, especially in the 111 service line as a priority.

Indicator 4: Non-mandatory training and CPD

Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff

The target outcome is a figure of 1.0 – meaning that BME staff are no less likely to be able to access non-mandatory training and CPD that White staff.

	2019	2020	2021	2022	2023	**2024**
Likelihood	1.45	1.31	1.34	1.01	1.01	**1.11**

For the two preceding years, the data showed virtually no difference in experience between BME and White staff. However, 2023/24 data shows a slight advantage for White staff in accessing training and CPD. Over the course of this year, 313 BME staff accessed non-mandatory and CPD training opportunities, compared to 5406 White staff.

The data in the following indicators (5 – 8) is based on responses from NHS Staff Survey 2023.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

	National Staff Survey Year						
	2017	2018	2019	2020	2021	2022	**2023**
White	49.8%	47.0%	47.9%	43.5%	40.0%	38.1%	**39.5%**
BME	45.7%	38.0%	34.6%	38.2%	37.1%	34.4%	**33.3%**
Difference	4.1%	9.0%	13.3%	5.3%	2.9%	3.7%	**6.2%**

A third of BME staff had experienced negative behaviours from the public, compared to 1 in 4 White staff. While BME responses on this question have continued to show a positive trend since 2021, responses from White staff were more negative compared to 2022.

The responses to this question will be monitored carefully in 2024 Staff Survey to see if the rollout of Body Worn Video Cameras to all sectors has an impact on figures.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

	National Staff Survey Year						
	2017	2018	2019	2020	2021	2022	**2023**
White	27.5%	25.8%	24.5%	25.7%	23.6%	22.2%	**20.9%**
BME	30.9%	27.5%	25.0%	24.2%	29.5%	23.7%	**22.4%**
Difference	-3.4%	-1.7%	-0.5%	1.5%	-5.9%	-1.5%	**-1.5%**

There are positive reductions in the percentage of BME and White staff experience negative behaviours from colleagues. However, for both staff groups, it remains the case that around 1 in 5 continue to experience abuse from colleagues.

The Civility Saves Lives training has continued to be delivered and promoted, and the Freedom to Speak Up function has expanded to make it easier for staff to engage with, to report negative behaviours and concerns.

Indicator 7: Percentage of staff believing that their trust provides equal opportunities for career progression or promotion

	National Staff Survey Year						
	2017	2018	2019	2020	2021	2022	**2023**
White	47.6%	52.6%	52.7%	51.3%	47.8%	50.4%	**52.0%**
BME	30.5%	36.8%	38.8%	39.1%	33.6%	36.8%	**37.9%**
Difference	17.1%	8.5%	19.1%	12.2%	9.0%	13.6%	**14.1%**

Responses from BME staff have improved on this question compared to the previous year. However, the gap between BME and White staff has increased year on year. It remains that over 6 in 10 BME staff believe the organisation does not act fairly in terms of career progression compared to almost 5 in 10 White staff.

We are continuing efforts to improve retention of talent, as well as support career progression and development opportunities for staff. This work is taking in to account the experiences of staff with protected characteristics, and the barriers they may face in their professional development and career progression.

Metric 8: Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues

	National Staff Survey Year						
	2017	2018	2019	2020	2021	2022	**2023**
White	13.4%	10.6%	10.6%	10.1%	10.0%	11.1%	**10.8%**
BME	23.2%	12.80%	13.6%	8.6%	22.4%	14.0%	**14.0%**
Difference	-9.8%	-2.2%	-3.0%	1.5%	-12.4%	-2.9%	**-3.2%**

Responses to this question from BME staff remained stable in 2023 when compared to the previous year. However, the difference in experience between BME and White staff has slightly widened.

Experiences of discrimination may relate to recruitment and development opportunities, feeling around inclusion within a team or relationships with colleagues and managers. We are working towards becoming an anti-racist organisation and committed to nurturing positive environments for all staff – and through this process we aim to reduce the incidences of discrimination and feelings of exclusion.

Since October 2022, we have been delivering the 'Beyond Bias' training module, as part of the NWAS Making a Difference leadership programme. This module examines how bias, discrimination, and prejudice affect the workplace. At the end of May 2024, around 850 leaders and managers had participated in the training, with the overwhelming majority reporting that they found the programme to be useful and insightful.

A refreshed training module developed internally with the input of Staff Networks will launch in mid-2024, titled Leading with Inclusivity, building on Beyond Bias to continue to improve the cultural; competency of our managers and leaders.

Indicator 9: Representation of BME people among board members

Percentage difference between the organisation's board voting membership and overall workforce, disaggregated by:

- *Voting membership of the Board*
- *Executive membership of the Board.*

While slightly lower than the previous year, proportionally however, there is still a higher percentage of BME representation on the Board than there is in the overall NWAS workforce (6%). The percentage of Board members who have not declared their ethnicity remains at 6%.

NWAS overall 31/03/2024	6.0%	**Board overall 31/03/2024**	14.2%
Voting Board Members	18.2%	**Non-Voting Board Members**	0
Executive Board Members	14.2	**Non-Executive Board Members**	14.2

The table below shows the percentage difference when comparing the total Board number to the overall workforce.

	2019	2020	2021	2022	2023	**2024**
White	-17.2%	-5.9%	-5.5%	-17.1%	-15.2%	**-14%**
BME	3.2%	1.3%	0.9%	10.6%	9.1%	**8%**
Ethnicity unknown	14.0%	4.6%	4.6%	6.4%	6.1%	**6%**

Trust-wide actions

The WRES data along with the Workforce Disability Equality Standard (WDES), and Gender Pay Gap data (set out in separate reports) reflects the ongoing work to support all our staff groups and address inequalities in the workplace. While there have been some improvements across a number of key areas, we recognise that there remains a significant difference in the experiences of BME and white staff. We will continue to explore the reasons for this and put in place actions to help improve the employee experience of our BME colleagues.

In 2024/25, to support improvements in Indicator 2, we are aiming to complete the refresh of the recruitment and selection policy and will be embedding applicant tracking in to all large-scale recruitment campaigns, not just EMT recruitment as has been the case to date. We will also be launching a new training module for manager around leading inclusively, and we will continue to work with universities to improve diversity of students on Paramedic degree programmes – aiming to impact the academic year starting in 2025.

In response to Indicator 3, we will undertake a review of disciplinary cases relating to BME staff to better understand the data, and consider improvements to the application of disciplinary policy to ensure it is being used appropriately and fairly.

Through the introduction of the Developing Leaders programme, we aim to support more colleagues from underrepresented background into leadership roles by providing them with the skills and knowledge to progress in the careers. We are aiming to positively impact Indicator 7 through this work.

A full set of actions are set out in our EDI Action Plan.

North West Ambulance Service NHS Trust

Workforce Disability Equality Standard (WDES) Data Report

Covering the period of 1st April 2023 – 31st March 2024

Introduction

This report sets out the 2023/24 annual workforce data in relation to disability which the trust is required by NHS England to publish. Working to address inequalities identified by workforce data demonstrates our compliance with the Equality Act 2010 and the Public Sector Equality Duty. Monitoring workforce equalities data is also central to ensuring that we are delivering on our equality, diversity and inclusion priorities:

1. We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.
2. We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.

Workforce Disability Equality Standard (WDES)

The WDES is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. We use the metrics data to develop and publish an action plan, building on high impact actions as set out in the EDI improvement plan. Year on year comparison enables us to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers.

This data in this report relates to the period of 1st April 2023 – 31st March 2024. In line with the nationally mandated timeframe, the data was submitted to NHS England in May 2024. This is the sixth year of reporting for WDES, and as with previous years, the data includes results from the NHS Staff Survey.

Metric 1: Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

The following two tables provide a breakdown of representation of disabled staff within the NWAS non-clinical and clinical workforces.

	Non-clinical Staff					
	2019	2020	2021	2022	2023	**2024**
Cluster 1: Bands 1 - 4	5%	4.7%	6.7%	10.7%	10.4%	**13.3%**
Cluster 2: Bands 5-7	2%	3.5%	5.8%	6.2%	8%	**10.5%**
Cluster 3: Bands 8a-8b	3%	0%	0.0%	4.7%	3.6%	**4.8%**
Cluster 4: Bands 8c-9 and VSM	3%	2.6%	5.1%	5.0%	14%	**10.2%**

	Clinical Staff					
	2019	2020	2021	2022	2023	**2024**
Cluster 1: Bands 1-4	3%	3.65%	4.5%	4.5%	6.1%	**7.4%**
Cluster 2: Bands 5-7	4%	4.05%	4.5%	5.0%	6.4%	**7.5%**
Cluster 3: Bands 8a-8b	2%	3.70%	5.2%	6.9%	14.3%	**16.7%**
Cluster 4: Bands 8c-9 and VSM	8%	7.69%	13.3%	11.1%	0%	**0%**

The data shows that there has been an increase in the proportion of disabled staff in Bands 1 – 8b across both clinical and non-clinical staff groups. However, there has been a notable decrease of 3.8% in the most senior non-clinical staff cohort (8c-9 and VSM). The likely reason for this is that as this is a relatively smaller cohort of staff, any change in headcount (increase or decrease) makes a significant impact.

On the whole, we have continued to see an increase in the numbers of staff declaring that they have a disability or long-term condition. At the end of March 2024, 7.8% of all staff had declared they had a disability – an increase from 6.5% in 2023 and 5.0% in 2022.

The sustained increase in declaration rates may be the result of a number of important factors, including the promotion of internal communications campaigns aimed at encouraging staff to update their disability status on the Electronic Staff Record (My ESR). Additionally, Workforce Wellbeing Officers and the Disability Network have also been undertaking initiatives to engage staff around disability declaration and promoting the newly created reasonable adjustments policy. We have also introduced a policy to support neurodiverse employees which is having a positive impact.

Additionally, we joined the Hidden Disabilities Sunflower scheme during National Hidden Disabilities Week in 2023. The Sunflower Scheme aims to raise awareness of and assist individuals with hidden disabilities which are not immediately apparent to others. In addition to promoting the Sunflower lanyard and wristbands, we also rolled out an e-learning package for staff to increase their understanding of hidden disabilities and the scheme.

There are still 475 members of staff who have a ‘null’ or ‘disability unknown’ entry in their ESR profile, but this is another significant decrease from 541 in 2023 (642 in 2022, 805 in 2021). Building on the types of actions referenced above, we will continue to encourage all colleagues to keep their disability status up to date. Of those who are yet to declare, we aim to particularly focus on the following staff cohorts:

Clinical

- Band 3 — 5.4% - 88 people — (2023, 6.4%, 111 people) — Medium Impact Percentage / High Number of People
- Band 6 — 10.4% - 198 people — (2023, 11.7%, 230 people) — High Impact Percentage / High Number of People
- Band 7 — 6.7% - 36 people — (2023, 8.5%, 50 people) — Medium Impact Percentage / High Number of People

Non-Clinical

- 8d — 15.4% — (2023, 13.3%) — High Impact Percentage
- VSM — 31.3% — (2023, 18.2%) — High Impact Percentage

Metric 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

The target outcome is a figure of 1.0 – meaning that disabled candidates are no less likely to be appointed from shortlisting than candidates who have not declared a disability. A figure of 1.0 reflects well on the fairness of current recruitment processes.

	2019	2020	2021	2022	2023	**2024**
Likelihood	1.0	1.1	1.39	1.56	1.26	**1.29**

The data in this metric has not significantly shifted since 2023, with non-disabled applicants still being 1.3 times more like to be appointed. However, this is lower than the peak in 2022 when non-disabled candidates were more than one-and-a-half times more likely to be appointed.

Between April 2023 and March 2024, **703 disabled applicants** were shortlisted for trust roles (561 in 2023/23, 250 in 2021/22). **108 disabled staff were appointed** in this period (92 staff in 2022/23, and 42 in 2021/22).

While we still have a way to go to improve the metric score, the increased numbers of disabled applicants applying for and being appointed to trust roles is encouraging. These improved figures may be reflective of inclusive language and imagery being used in recruitment adverts, promotion of the trust being a Disability Confident Leader, highlighting work of the Disability Network externally, and development of compassionate and inclusive management through training such as Beyond Bias.

In response to the data emerging from this metric and a similar metric in the Workforce Race Equality Standard (WRES), in summer 2023 we completed an audit of our end-to-end recruitment and selection processes through an external and independent consultancy. The audit undertook a deep dive in to the data and explored a range of issues impacting applicants who are disabled, and those from black and minority ethnic backgrounds. It identified potential solutions and provided recommendations to effectively address the challenges and improve access to employment opportunities in the trust. Many of the recommendations emerging from the audit are now being taken forward by a recently established Inclusive Recruitment Group.

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure

As with recruitment, a figure of 1.0 or below is desired, as this would indicate disabled staff are no more or less likely to enter into the formal capability process than non-disabled staff. This metric is based on data from a two-year rolling average of the current year and the previous year and looks at capability on the grounds of performance only, rather than ill health.

	2020	2021	2022	2023	**2024**
Likelihood	5.52	2.71	0.00	1.47	**1.63**

This metric was voluntary and not reported by NWAS in 2019.

The figure in 2024 has further deteriorated from the previous year's score, meaning that that disabled staff are over one-and-a-half times more likely to enter the performance process compared to non-disabled staff. The number of overall staff in the formal performance process is low, and the actual number of disabled staff in the performance process in 2023/24 was lower still, in single figures. However, it is important to understand and ascertain why the disproportionality exists, and work will continue to be undertaken through the HR Business Partnering Team to explore this further.

The data in the following Metrics (4 - 9) is based on responses in the NHS Staff Survey.

In 2023, we achieved our highest ever response rate in the NHS Staff Survey. More than 3400 NWAS staff participated in the survey, equating to nearly 50% of the workforce. Around 30% of all respondents indicated that they had a disability or long-term condition. This is a substantially higher figure when compared to disability declaration rates on the ESR. However, NWAS is not unique in this position, as NHS organisations across the country report higher rates of disability declaration in the staff survey in comparison to ESR. While it is difficult to know exactly why this is the case, there could be a number of reasons including, the way in which the question about disability is asked in the Staff Survey compared to ESR, concerns that a declaration on ESR may lead to negative presumptions from managers/colleagues, and concerns about confidentiality.

Metric 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- **4.1: Patients/Service users, their relatives or other members of the public**

The proportion of disabled staff experiencing these negative behaviours has reduced from the previous year and is significantly lower than the 2019 peak. However, it remains the case that a considerably higher percentage of disabled staff indicated experiencing these behaviours in comparison to non-disabled staff, with the difference between to the groups rising to nearly 20%.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	45.8%	45.0%	42.1%	37.8%	34.1%	**26.8%**
disabled	52.0%	56.2%	47.0%	45.9%	47.2%	**45.1%**
difference	6.2%	11.2%	4.9%	8.1%	13.1%	**18.3%**

- **4.2: Managers**

Responses to this question have remained largely stable for disabled staff from 2021 to 2023. There difference in experience between disabled and non-disabled staff has been consistently narrowing over the last five years.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	13.2%	11.8%	14.5%	11.3%	10.1%	**10.1%**
disabled	25.8%	23.2%	22.1%	18.6%	16.8%	**16.1%**
difference	12.6%	11.4%	7.6%	7.3%	6.7%	**6%**

4.3: Other colleagues

The results for this question continue to show that around 1 in 5 disabled staff experience abuse from colleagues, which is significantly higher than non-disabled staff. The difference between disabled and non-disabled staff has however reduced to its lowest level of 5.6%, and shows a downward trend overall since 2021.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	15.6%	14.5%	15.5%	14.1%	14.0%	**13.4%**
disabled	26.5%	26.7%	23.0%	23.6%	21.8%	**19%**
difference	10.9%	12.2%	7.5%	9.5%	7.8%	**5.6%**

- **4.4: Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

There has been a notable increase in the proportion of disabled staff reporting negative experiences. On the whole, results since 2018 consistently show that a greater percentage of disabled staff report negative experiences compared to non-disabled staff. However, more than half of all staff (disabled and non-disabled) still indicated they have not reported the experiences they had.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	38.2%	43.7%	43.4%	43.8%	45.1%	**46%**
disabled	39.9%	49.1%	49.3%	46.3%	44.7%	**48.7%**
difference	1.7%	5.4%	5.9%	2.5%	-0.4%	**2.7%**

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

The response from disabled staff has improved on this question compared to the previous year, and with the highest % since 2018, it has helped narrow the gap between disabled and non-disabled staff. However, the data show that more than half of disabled staff believe the organisation does not act fairly in terms of career progression.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	53.9%	53.7%	52.0%	49.7%	51.9%	**52.2%**
disabled	43.3%	45.5%	44.9%	39.4%	45.1%	**48.7%**
difference	-10.6%	-8.2%	-7.1%	-10.3%	-6.8%	**-3.5%**

We are continuing efforts to improve retention of talent, as well as support career progression and development opportunities for staff. This work is taking in to account the experiences of staff with protected characteristics, and the barriers they may face in their professional development and career progression.

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Just over a third of disabled staff reported that they felt pressure to come to work when not feeling well enough, compared to 1 in 4 non-disabled staff. For both staff groups, these figures are the most improved since 2018 and do indicate a gradual improvement.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	32.6%	30.8%	29.5%	28.6%	27.2%	**24.8%**
disabled	45.3%	44.0%	38.9%	40.6%	38.3%	**35%**
difference	12.7%	13.2%	9.4%	12.0%	11.1%	**10.2%**

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Around 1 in 3 disabled staff reported feeling satisfied with how the organisation values their work, and this is the highest positive response since reporting on this metric started in 2018. Additionally, the gap in experience between the disabled and non-disabled staff has significantly narrowed in comparison to the previous year.

However, it is important to note that 70% of disabled staff and around two-thirds of non-disabled staff did not respond positively to this question.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	36.7%	39.5%	35.2%	32.9%	33.6%	**35.7%**
disabled	25.3%	29.1%	29.1%	27.5%	23.9%	**31.1%**
difference	11.4%	9.6%	6.1%	5.4%	9.7%	**4.6%**

Metric 8: Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.

Positive responses to this question have continued to increase since 2021, with nearly two-thirds of disabled staff in 2023 saying that reasonable adjustments had been made for them.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
disabled	60.3%	58.6%	71.0%	57.8%	63.0%	**65.2%**

In December 2023, we launched the Procedure for Requesting and Managing Reasonable Adjustments setting out guidance for staff and managers, with a new reasonable adjustments

application form. We also recently completed a refresh of the Wellbeing Passport and introduced a Carers Passport too. These resources are now being promoted to staff across the trust.

The Trust continues to provide equipment and support to staff to ensure they have all they need to work from home where operationally suitable, while at the same time ensuring safe work environments on trust sites.

Metric 9: Staff engagement score for calculated from nine specific questions in the NHS Staff Survey

The 2023 staff engagement score shows that the gap between disabled and non-disabled staff has narrowed from 0.6 to 0.4, with the scores showing improvements for both staff groups.

	NHS Staff Survey Year					
	2018	2019	2020	2021	2022	**2023**
non-disabled	6.5	6.5	6.4	6.2	6.2	**6.3**
disabled	5.7	5.8	6.0	5.6	5.6	**5.9**
difference	0.8	0.7	0.4	0.6	0.6	**0.4**

This metric also asks whether the organisation has taken action to facilitate the voices of staff with disabilities to be heard, to which NWAS has said 'Yes' and added the following note:

"The Disability Network is open to all staff with disabilities and long-term health conditions, staff who care for someone with a disability and colleagues who want to learn more about disability. The network promotes equality across the trust and aims to open up conversations about the barriers facing people with disabilities, to give staff a voice to improve understanding of disabilities, raise awareness more generally and provides the opportunity to influence organisational change."

Metric 10: Representation of disabled people among Board members

Percentage difference between the organisation's board voting membership and overall workforce, disaggregated by:

- *voting and non-voting membership of the board*
- *executive and non-exec membership of the board.*

The data shows that the proportion of total board members declaring a disability has remained at around 14%, but disability declarations in the workforce overall have increased to 7.8%.

Disability declarations

NWAS overall	7.8%	**Board overall**	14.2%
Voting Board Members	10%	**Non-Voting Board Members**	25%
Executive Board Members	25%	**Non-Executive Board Members**	0

The table below shows the percentage difference when comparing the total Board number to the overall workforce.

	2024
Disabled	7%
Non disabled	-29%
Disability unknown	22%

Trust-wide actions

The WDES data along with the Workforce Race Equality Standard (WRES), and Gender Pay Gap data (set out in separate reports) reflects the ongoing work to support all our staff groups and address inequalities in the workplace. While there have been some improvements across a number of key areas, we recognise that there remains a significant difference in the experiences of disabled and non-disabled staff. We will continue to explore the reasons for this and put in place actions to help improve the employee experience of our colleagues with disabilities.

In 2024/25, to support improvements for Metric 2 (recruitment), we are aiming to complete the refresh of the recruitment and selection policy with the input of a wide range of stakeholders, including the Disability Network. This refresh will take into account learning from the Inclusive Recruitment Audit referenced in the report earlier.

In order to develop a clearer understanding of the data in Metric 3, we will be undertaking a deep dive into the performance process to explore and understand the potential reasons for disabled staff being one-and-a-half times more likely to be subject to the performance process, compared to non-disabled staff.

Additionally, through delivery of training programmes such as Civility Saves Lives and Leading with Diversity & Inclusion, we are aiming to see improvements in the data in Metric 4 (negative experiences). With the expansion of the Freedom to Speak Up function across the trust, we will be looking to see an increase in the proportion of disabled who feel confident in reporting any negative experiences.

With the launch of Developing Leaders programme in 2024/25, we aim to support more colleagues from underrepresented backgrounds into leadership roles by providing them with the skills and knowledge to progress in the careers. We are aiming to positively impact Metric 5 through this work.

A full set of actions are set out in our EDI Action Plan.

North West Ambulance Service NHS Trust

Gender Pay Gap Data Report

Covering the period of 1st April 2023 – 31st March 2024

Published: **June 2024**

Introduction

This report sets out the 2023/24 annual workforce data in relation to the gender pay gap, which the trust is required to publish as per Schedule 2 of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The data in this report is taken on 31 March 2024 (snapshot date).

The purpose of the gender pay gap is to show any difference between the hourly wage of male and female employees. The figure is affected by how many females are at a given grade/band and their position on the pay scale. It shows the difference in the average pay between male and female employees.

Gender pay gap is not the same as equal pay. Equal pay looks at the difference in pay of men and women doing the same or similar job, or a job of equal value.

Monitoring of the workforce equalities data from a race (WRES), disability (WDES) and gender (GPG) perspective is central to ensuring that we are delivering on our equality, diversity and inclusion priorities:

1. We will ensure our current employees and future talent have fair opportunities and access to jobs and career progression resulting in improved representation of diverse groups at all levels of the organisation, including Board.
2. We will educate and develop our leaders and staff to improve understanding of racism, discrimination and cultural competence to deliver a step change in the experience of our staff and patients.

Gender Pay Gap Data

Female representation in the NWAS workforce has consistently continued to increase over a number of years. As of 31 March 2024, 53.13% of staff were female (52.14% in 2023, 51.60% in 2022). Additionally, the majority of the workforce (55.43%) in the Operations directorate were female, and women account for half of all staff across the corporate directorates.

2024 Gender Split by Quartile

The table below shows that female representation has fallen in both lower quartiles for the first time, while increasing in both upper quartiles. The most significant increase was in the upper quartile, where female representation now stands at 44.06% - an increase of 5% on the previous year.

There continue to be more women than men in the two lower quartiles, and a majority of staff (albeit by a smaller margin) in the upper middle quartile are female.

Quartile	Female	Male
Lower pay quartile	**57.63%** (58.78%, 2023)	**42.37%** (41.22%, 2023)
Lower middle quartile	**60.29%** (60.63%, 2023)	**39.71%** (39.37%, 2023)
Upper middle quartile	**50.54%** (50.11%, 2023)	**49.46%** (49.89%, 2023)
Upper quartile	**44.06%** (39.05%, 2023)	**55.94%** (60.95%, 2023)

Historic gender split by quartile for comparison

Quartile	2018 F	2018 M	2019 F	2019 M	2020 F	2020 M	2021 F	2021 M	2022 F	2022 M
LQ	51.8%	48.2%	54.85%	45.15%	55.26%	44.74%	60.95%	39.05%	55.1%	44.9%
LMQ	50.4%	49.6%	51.15%	48.85%	53.65%	46.35%	56.04%	43.96%	58.5%	41.5%
UMQ	46.8%	53.2%	47.13%	52.87%	46.81%	53.19%	47.43%	52.57%	49.4%	50.6%
UQ	33.5%	66.5%	34.18%	65.82%	36.74%	63.26%	37.23%	62.77%	37.8%	62.2%

2024 Hourly Pay Gap

The hourly mean/average pay gap has continued to narrow and is now at 7.27%. While still a significant gap, it is an improvement of 3.5% on last year's figure and is reflective of the improvement in representation in the upper quartile of pay. This is also the lowest average figure since we started reporting.

On the other hand, the median hourly gap has increased to 11.17%. In contrast to the average gap, this figure represents the largest gap since reporting started. While the reasons for this require further investigation, a key factor may be the levels of representation in different quartiles of pay. For example, proportionately more female staff are represented in the two lower quartiles of pay, therefore the median figure will be in the lower middle quartile. Whereas less than 50% of men are in the lower quartiles, therefore the median for males will be in the Upper middle quartile. Another factor could be longevity of service, which on average will be higher for men, and they are therefore more likely to be paid at the top of their pay band.

Gender	Average Hourly Rate	Median Hourly Rate
Male	£19.14	£18.12
Female	£17.75	£16.09
Difference	£1.39	£2.02
Pay Gap %	**7.27%**	**11.17%**

Historic hourly pay gap for comparison

	2020	2021	2022	2023
Average hourly pay gap	8.79%	10.89%	9.80%	10.77%
Median hourly pay gap	7.2%	9.26%	8.66%	10.54%

Bonus Pay

Bonus pay includes any rewards related to:

- profit sharing
- productivity
- performance
- incentive
- commission
- long service awards with a monetary value (cash, vouchers or securities)

For 2024, based on the above criteria, no bonus payments were made this year.

Trust-wide actions

The trust applies the national NHS terms, conditions of service, and uses the national job evaluation system to determine job bandings. These systems have been equality impact assessed and are jointly reviewed by trade unions and managers in partnership at a national level. We believe these systems provide a non-discriminatory set of conditions which meet the requirements of equal pay for work of equal value. We remain committed to working to close the gender pay gap through improvements in representation in the upper quartiles of pay.

To support the progression of women within the organisation into the higher pay quartiles, we will continue to focus on improving the inclusiveness of our recruitment processes, facilitate fair, equal career progression opportunities, and enhance flexible working arrangements.

We will continue to increase awareness of our gender pay gap, and what impacts it.

Through the introduction of the Developing Leaders programme launching in mid-2024, we aim to support more female staff into leadership roles by providing them with the skills and knowledge to progress in the careers.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Equality, Diversity and Inclusion Priorities 2024-26 and Annual Plan 2024/25
PRESENTED BY	Lisa Ward, Director of People
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☒	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☐	Reputation	☒	Innovation	☐

ACTION REQUIRED	The Board is asked to: • Approve the three Equality, Diversity and Inclusion Priorities for 2024-26. • Note the contents of the EDI Annual Plan for 2024/25.
EXECUTIVE SUMMARY	This purpose of this brief paper is to provide an overview of the trust's refreshed Equality, Diversity and Inclusion Priorities and accompanying annual plan. A draft of the refreshed EDI priorities has been consulted on with various groups and networks and is recommended for adoption following consideration by the Diversity & Inclusion Group in May and July 2024. The priorities can be seen in Appendix 1 and annual plan in Appendix 2. Each priority has a clear statement of intent and an identified SRO who will take accountability for delivery and reporting. For each priority, several improvement goals, a set of deliverables and measures of success have been identified. In order to monitor progress against the priorities, an annual plan has been developed which sets out comprehensively the actions which will be taken to effect improvements in each of the three areas. Each action in the plan has an identified lead and an indication has been added to illustrate alignment with equality monitoring requirements i.e. WRES,

	WDES, EDS. This alignment will help with reducing the duplication of EDI-related action plans and will streamline reporting.	
PREVIOUSLY CONSIDERED BY	Diversity and Inclusion Group	
	Date	Friday, 12 July 2024
	Outcome	The draft priorities had been previously considered in May as part of the consultative process and feedback was incorporated. The final draft was presented to the Group in July and is recommended for approval to Resources Committee and the Board of Directors.
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	Friday, 26 July 2024
	Outcome	RC did not meet in July but the report was circulated virtually to members.

1.	**BACKGROUND**
1.1	This purpose of this paper is to provide an overview of the trust's refreshed Equality, Diversity and Inclusion Priorities and accompanying annual plan.
1.2	Under the Public Sector Equality Duty, we are required to produce and publish EDI objectives at least every four years. The development of our EDI priorities meets this requirement.
2.	**EDI PRIORITIES**
2.1	The full set of priorities can be seen in Appendix 1. They have been developed taking into account the following: • Feedback from the Board of Directors • Existing strategy commitments • Best practice guidance such as the NHS EDI Improvement Plan • Data outputs from staff survey, WRES, WDES and Equality Delivery System
2.2	Each priority has a clear statement of intent and an identified SRO who will take accountability for delivery and reporting. For each priority, several improvement goals, a set of deliverables and measures of success have been identified.
2.3	The priorities reflect a similar approach in previous years with the first two being concerned with workforce equalities, and the third being focused on population health inequalities.
2.4	Feedback on the priorities was sought from the People and Culture Group, Clinical & Quality groups and has been discussed in detail through the Diversity and Inclusion Group, who are recommending adoption. Additionally, members of staff networks had an opportunity on the Staff Networks Development Day to contribute to the priority development. Trade Union colleagues were consulted on the revised priorities at the Joint Partnership Council in June.
2.5	Members of the Patient and Public Panel were also engaged to provide their feedback on the draft priorities, at a specially convened online session in July with 15 PPP members in attendance.
2.6	Feedback from PPP members on the priorities was overwhelmingly positive, with the group noting that the priorities appeared to be "very well thought through" and had the right focus.
2.7	With regards areas for further improvement, some members suggested that the success measures could be more effective if they were more specific i.e. not just stating "improvement", but "improvement by certain %". Members also queried how collation of patient feedback can be made better, and also identified that the ambition set out in Priority 3 should reflect that it would require a multi-organisational partnership (to reduce health inequalities).
2.8	It was explained that an annual plan will underpin the priorities each year, and feedback such as that shared above is helpful in shaping the way in which we deliver on the priorities.
3.	**SINGLE EDI ANNUAL PLAN**

3.1	In order to monitor progress against the priorities, an annual plan (Appendix 2) has been developed which sets out comprehensively the actions which will be taken to effect improvements in each of the three areas.
3.2	Each action in the plan has an identified lead and an indication has been added to illustrate alignment with equality monitoring requirements i.e. WRES, WDES, EDS, High Impact Actions. This alignment will help with reducing the duplication of EDI-related action plans and will streamline reporting.
3.3	This annual plan will also inform the workplan of the D&I Group, and delivery of actions will be monitored through the Group.
4.	**RISK CONSIDERATION**
4.1	There are a number of risks associated with this work: • The work continues to be challenging in terms of the overall cultural context, but also the ability to deliver effective impact from the outputs. Close consideration of success measures and evaluation will be built into plans. • The delivery of plans requires organisational wide commitment and clear contribution from across directorates, and without this progress may continue to be slower than desired. • There are regulatory risks associated with this work. The new CQC single inspection framework has diversity and inclusion running through it as well as specific requirements for progressing the agenda for both staff and patients. The priorities and supporting plans will support the Trust in evidencing their commitment but will need to be supported by corresponding evidence of action. In reaching the decision to recommend approval of the priorities D&I Group should consider the risk appetite statements as outlined below:

Compliance/regulatory	Low	The publication of the priorities will enable the Trust to meet its statutory requirements under the Public Sector Equality Duty to have published equality objectives. The supporting annual plans as also mapped to other contractual and regulatory requirements such as EDS/WRES/WDES which will enable us to demonstrate responsiveness to these requirements and reduce the risk of regulatory scrutiny. It will also positively contribute to CQC Well Led by providing evidence against the EDI quality statement.
Quality outcomes	Low	The priorities include a specific priority focused on health inequalities which has been strengthened and the delivery of the supporting action should enable us to contribute positively to quality of care.
People	Moderate	Both priority 1 and priority 2 are primarily focused on the experience of staff in work and the delivery of supporting actions should therefore mitigate

			risks of poor staff experience leading to retention challenges.
	Reputation	Moderate	Publication of the priorities should have a positive impact on reputation.

5.	**EQUALITY/ SUSTAINABILITY IMPACTS**
5.1	Delivery of the priorities and associated actions should lead to an improvement in the experience of protected groups within the workforce, as well as within patient groups. The priorities and plans support the Trust in demonstrating its compliance with the Public Sector Equality Duty.
6.	**ACTION REQUIRED**
6.1	The Board is asked to: • Approve the three Equality, Diversity and Inclusion Priorities for 2024-26. • Note the contents of the EDI Annual Plan for 2024/25.

NHS North West Ambulance Service NHS Trust

NWAS EQUALITY, DIVERISTY & INCLUSION PRIORITIES 2024 - 2026

The EDI Priorities reflect the organisation's ambitions and commitments to delivering inclusively for our people and communities. To enable delivery against each of the Priorities, improvement goals have been identified which represent the areas of focus over the next three years.

A Single EDI Plan (updated annually) based on learning from staff surveys, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), pay gap data and other diversity indicators has been developed to incorporate the deliverables listed below.

Priority 1: We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels	**SRO: Director of People**

We will focus on the following improvement goals:	**These will be delivered by:**	**Measures of success:**
a) To increase attraction rates from under-represented groups b) To improve the fairness of our internal and external recruitment processes c) To provide improved access to career pathways	• Implementing recommendations from the inclusive recruitment review • Improving reach of positive action recruitment activities internally and externally • Increasing ethnic minority representation on pre-employment courses • Working with HEIs to improve BME representation on Paramedicine courses • Delivering an Aspiring Leaders programme • Embedding pre-apprenticeship programmes • Reviewing operational recruitment and acting up processes • Improving visibility and enabling fair access to career pathways and educational opportunities • Collating feedback from applicants for trust roles	• Improvement in relative likelihood of appointment from shortlisting (WDES/WRES) • Improved perception of fairness of career progression (staff survey) • Year on year improvement in ethnic minority representation (workforce & supply) • Year on year improvement in disparity ratios • Year on year improvement in representation in upper quartiles of pay • Increase in number of applications from under-represented groups • Increase in number of staff appointed following positive action / widening access support

Priority 2: We will educate and empower our workforce and leaders to promote a positive psychologically safe culture, to support a reduction in the experience of bullying, harassment, discrimination and an improvement in retention	**SRO: Director of People**

We will focus on the following improvement goals:	**These will be delivered by:**	**Measures of success:**
a) To raise awareness and enhance the understanding of managers and staff in relation to the impact of poor behaviours, and the importance of active allyship b) To build the confidence and competence of managers to create healthy workplace cultures c) To reduce levels of unwanted behaviour of a sexual nature, bullying and harassment from colleagues d) To improve the experience of students e) To further enhance the effectiveness of staff networks f) To make progress towards being an intentionally anti-racist organisation g) To improve retention of under-represented groups	• Mandating and delivering leadership for inclusion training • Ensuring senior and middle leaders all have diversity objectives • Developing an anti-racism baseline and action plan • Developing leaders as allies • Embedding Civility Saves Lives in to the refreshed induction process • Embedding sexual safety campaign • Delivering bystander training to staff • Continuing to develop a culture of speaking up accessible to all • Improving our understanding of the impact of HR work on different protected groups • Implementation of recommendations from the maternity review conducted in 2023/24 • Further development of the reverse mentoring programme • Working to improve the experience of students through a bespoke reverse mentoring project and other feedback mechanisms • Continuing to promote and support the work of Staff Networks • Taking action to improve retention where leavers from under-represented groups are higher than average • Annual board development • Developing resources for CPD Hub	• Reduction in experience of bullying and harassment from managers/colleagues (staff survey) • Reduction in experience of unwanted behaviour of a sexual nature from colleagues (staff survey) • Number of managers completing inclusion training • Improvements in retention post maternity leave Bullying and harassment score metric (NETS) • Disaggregated data on HR processes e.g. disciplinary; wellbeing • Improved learner feedback

Priority 3: We will reduce health inequalities for our patients	SRO: Medical Director

We will focus on the following improvement goals:	These will be delivered by:	Measures of success:
a) To ensure clinical audit activity actively integrates health inequalities and demographic indicator data b) To improve the collection, analysis and utilisation of our data to support population health improvement and reduction of health inequalities c) To develop core clinical education and training which is culturally aware d) To ensure clinical guidelines and practice actively considers the impact of health inequalities and cultural needs. e) To use patient experience from diverse groups to drive improvements to our services clinical education and training is developed to be culturally aware	• Reporting against demographic and health inequalities indices across national AQI returns. • Reporting against demographic and health inequalities indices Learning from Deaths (LfDs) case reviews. • Inclusion of demographic and health inequalities indices in all new audit activity. • Integration of audit data into public health dashboard output. • Developing a population health dashboard to provide demographic profile and relative demand of the population we serve (age, sex, ethnicity and deprivation), and to provide information on health inequalities observed across services and clinical activity. • Delivering training to support interpretation of the dashboard and the integration of insights to inform work plans and equity impact assessments. • Establishing mechanisms to share relevant insights internally and externally with appropriate partners to drive improvement work. • Actively monitoring and drive improvement work to fill gaps in ethnicity data. • Review education and training programmes for cultural competence, including assessment of equipment • Develop access to further resources to improve knowledge and understanding of culturally competent patient care • Embedding overt review of health inequality and cultural impact in all new clinical guidelines and procedures utilising EIA approach. • Development of a CPD module for clinicians on the principles of Making Every Contact Count (MECC) • Using demographic data to improve learning from patient feedback, complaints and incidents • Ensuring Patient and Public Panel membership is representative of NW communities and used to support service development. • Continuing to improve communication options for patients • Promotion of new communication aids leaflet to patient group • Annual programme of community engagement to support improved access and communications	• Incorporation of demographic and health inequalities data into AQI reports. • Incorporation of demographic and health inequalities data into LfDs reports. • Integration of demographic and health inequalities reporting requirements into new audit proposals. • Development of population health dashboard. • Integration of health inequalities data in all service delivery and clinical reports to the Board. • Health inequalities insights supporting equality impact assessments • Uptake of MECC CPD module across clinical groups • Increase feedback from patients from diverse groups • Positive satisfaction rates for dignity, care and respect and overall satisfaction • Maintain diversity of PPP representation at 25% or more • Minimum 25% PPP involvements to include diverse representation

NHS North West Ambulance Service NHS Trust

EQUALITY, DIVERSITY AND INCLUSION ANNUAL PLAN 2024/25

This plan has been developed in line with the Board approved EDI Priorities. The actions listed below represent the key areas of focus for EDI and reflect:

- Our trust strategies
- Staff survey responses
- NHS EDI Improvement Plan High Impact Actions (HIA)
- NW BAME Assembly Anti-Racism Framework
- Workforce Race Equality Standard (WRES) data
- Workforce Disability Equality Standard (WDES) data
- Pay gap data
- Equality Delivery System 22 data

Priority	Action		Measure	Alignment with EDI reporting	Lead
1. We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels.	1.1	Increase offer of pre-employment courses in support of improving ethnic minority representation	• Number pre-employment courses • Increase in proportion of BME representations	WRES Indicator 2	Danielle Soens-Hughes
	1.2	Learning ambassadors are representative of communities that we serve	• Increase in proportion of learning ambassadors from BME backgrounds	WRES Indicator 4	Danielle Soens-Hughes
	1.3	Continue implementation of the ENEI Inclusive Recruitment Audit recommendations, including review and refresh of the Recruitment and Selection Policy and increasing capacity of Positive Action Team	• Improvement in WRES/WDES shortlisting to appointment measure	WRES Indicator 2 HIA 2	Usman Nawaz
	1.4	Design and deliver a pilot cohort of the Developing Leaders programme	• Programme representative of workforce	WRES Indicator 1 WDES Metric 1 HIA 2 and 3	Danielle Soens-Hughes
	1.5	Produce visible career and development pathways readily accessible to all new and existing staff	• Feedback from staff • Improvement in staff survey fairness of career progression score	HIA 2 WRES Indicator 1 WDES Metric 1	Carol Offer
	1.6	Coordinate delivery of the ParaMEdic Project 2024 in partnership with the College of Paramedics and Edge Hill University	• Number of BME young people participating	[redacted]	Carol Offer

Priority	Action		Measure	Alignment with EDI reporting	Lead
2. We will educate and empower our workforce and leaders to promote a positive psychologically safe culture, to support a reduction in the experience of bullying, harassment, discrimination and an improvement in retention.	2.1	We will refresh the Trust's EDI priorities, develop clear action plans, and use this to support ongoing development of staff and leaders	• Approval of priorities • Progress against 24/25 plans	HIA 1	Usman Nawaz
	2.2	Develop the plan to become an anti-racist organisation	Approval of plans	WRES Indicator 8 HIA 6 Anti-racism Framework	Usman Nawaz
	2.3	Produce specific anti-racism statement as part of review of EDI Policy	Implementation		
	2.4	Complete delivery of the Beyond Bias programme, and facilitate rollout of the new diversity training module for all managers - embedding in future leadership induction	• Successful completion of Beyond Bias programme • Completion of new Leading D&I module • % compliance for existing managers • Evaluation of programmes •	WRES Indicator 8 WDES Metric 7	Daneille Soens-Hughes
	2.5	Consolidate learnings from the Reverse Mentoring pilot cohort, and deliver the second cohort of the programme	• Application of learning by senior leaders involve in first cohort • Increased number of mentors and mentees	HIA 6	Carol Offer
	2.6	Continue delivery of the sexual safety campaign through development of a toolkit, roadshows, and collation of case studies	• Improvement in speaking up scores in staff survey • Improvement in staff experience of unwanted sexual behaviour in staff survey	HIA 6 WRES Indicator 8 WDES Metric 9	Lorraine McConnell
	2.7	Deep dive of BME entry to formal disciplinary processes, taking steps to improve disparity	Reduction in WRES disparity measure	WRES Indicator 3	Carla Marshall
	2.8	Implement a clear procedure to support ICC staff dealing with racist abuse and sexual behaviour	• Procedure implemented • Staff feedback	WRES Indicator 5 HIA 6	TBC - ICC Manager
	2.9	Implement recommendations from the maternity review conducted in 2023/24	• Improvements in retention post maternity leave • Improved staff feedback	Gender Pay Gap	Carla Marshall

Priority	Action		Measure	Alignment with EDI reporting	Lead
3. We will reduce health inequalities for our patients	3.1	Embed diversity monitoring and learning into complaints and patient safety incidents	Diversity metrics regularly reported	EDS Domain 1	Emma Shiner / Carly Manning
	3.2	Equality assess EMT1 apprenticeship modules to ensure clinically and culturally diverse	Completion of review	EDS Domain 1 WRES Indicator 8	Carol Offer
	3.3	Work with national LGBT network to make CPD resources available on NWAS learning platform	• Launch of modules • Number of staff engaging with resources access	EDS Domain 1	Carol Offer
	3.4	Learning from Deaths (LfD) quarterly report to include demographic and deprivation data to by Q1	Incorporation of demographic and health inequalities data into LfD reports.	EDS Domain 1	Jon Price
	3.5	Demographic and deprivation to be integrated in to national Ambulance Quality Indicator (AQI) reports by end of Q4	Incorporation of demographic and health inequalities data into AQI reports.	EDS Domain 1	Jon Price
	3.6	Include health inequality and demographic data capture into procurement specification for clinical audit tool tender	Integration of demographic and health inequalities reporting requirements into new audit proposals.	EDS Domain 1	Jon Price
	3.7	Deliver a 999 service-level population health dashboard, which will provide a high-level view of activity volumes classified by final impression, broken down by protected characteristics (age, sex and ethnicity) and by population health deprivation data, by Q4	• Dashboard development • Integration of health inequalities data in all service delivery and clinical reports to the Board.	EDS Domain 1	Steve Bell / Claudia Soiland-Reyes
	3.8	Participate in the 2024/25 NWAS QI Academy to develop methodology and resources for the application and integration of a population health approach to projects / workstreams	Development of resources and trust specific methodology relating to data insights; reviewing evidence to identify multi-partner solution; developing interventions; evaluation; implementation of solution at scale.	EDS Domain 1	Steve Bell / Claudia Soiland-Reyes

Priority	Action		Measure	Alignment with EDI reporting	Lead
	3.9	Implementation of Making Every Contact Count (MECC) CPD module by Q3	Uptake of MECC CPD module across clinical groups	EDS Domain 1	Steve Bell / Claudia Soiland-Reyes
	3.10	Deliver a quality improvement project in autumn 2024 aiming to increase feedback from patients from diverse communities. This will also consider how patients from diverse communities can be encouraged to provide demographic data to help improve experience of services.	• Increased feedback from patients from diverse groups - via a range of different methods and sample groups e.g. increasing NHS 111 feedback from diverse patients from 5% to 15%. • Increased understanding of barriers to providing demographic data.	EDS Domain 1	Julie Treharne
	3.11	Develop an updated version of the pictorial handbook for PTS, promote new patient communications aids (e.g. ability to share a photo with 111 service to assist in triaging, use of Insight App etc) and further publication easy read/plain English documents on our website	• Production of PTS pictorial handbook and easy read documents for all key services • Delivery of Programme of publicity of communication aids	EDS Domain 1	Julie Treharne/ Olivia Jones
	3.12	Deliver annual programme of community engagement, with an increased focus on Jewish and Chinese communities this year, exploring experiences of accessing services	Targeting engagement with 15 groups, with a minimum of 5 to be from Jewish and Chinese communities	EDS Doman 1	Julie Treharne/ Yunus Mogra
	3.13	Increase diversity of PPP through continued engagement in diverse communities and deliver a development programme to support current Panel members	• Maintain diversity of PPP representation at 25% or more • Minimum 25% PPP involvements to include diverse representation		Julie Treharne/ Elena Church

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 31 July 2024
SUBJECT	Communications and Engagement Dashboard
PRESENTED BY	Salman Desai, Deputy Chief Executive
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐
	SR06	☐	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to note the contents of this report and discuss the impact of its content.	
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. The dashboard demonstrates how activity aligns with the aims and objectives of the trust strategy, and the positive impact it has on staff, patients, and partners.	
PREVIOUSLY CONSIDERED BY	Not Applicable	
	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

This report provides the Board of Directors with a summary of key outputs, impact and associated highlights on the work of the combined Communications and Engagement Team for quarter one of the financial year 2024/25 (April – June 2024).

It demonstrates how the activity of the team contributes to the strategic aims and objectives of the trust strategy.

2. REPORT

The dashboard demonstrates how activity aligns with the aims and objectives of the trust strategy, and the positive impact it has on staff, patients, and partners.

Key points to note are:

Aim 1 – Provide high quality, inclusive care
Objective – Identify opportunities to improve clinical practice and patient experience.

Statistical content and narrative is provided to outline patient engagement activity that meet this aim and objective.

For Q1, this includes:

- 1,280 patient feedback surveys returned with 90% of respondents likely to recommend the service to family and friends. Although returns are down 12%, this is nothing to be concerned about as there is a natural fluctuation dependent on the number of weeks in the month/quarter.
- 12 community events and six engagement opportunities aimed at diverse communities, including Preston Health Mela, Bolton Eid Extravaganza, Stepping Stones Deaf Active Group and Kashmir Youth Project.
- Growing the Patient and Public Panel to 338 members, with members actively involved in reviewing the 2023/24 Quality Account, PTS pictorial handbook and Mental Health and Dementia Plan.

Examples of the impact of this work are included in the report:

- A new 111 specific survey has launched to focus attention on feedback from this specific group of patients. The survey is entirely digital; patients are sent a text with a link to complete the survey online, giving us instant access to results.
- Our panel members provided feedback during the development of a pictorial e-book which is now available for all frontline staff to view on their iPads. The book supports effective communication with patients who have language or other communication barriers.
- The patient story filmed by our in-house videographer for the Board of Directors meeting is also being used to support clinical training for our staff.

Aim 2 – Be a brilliant place to work for all
Objective – Improve the health, wellbeing and safety of our people

Statistical content and narrative is provided to outline communications activity that meet this aim and objective.

For Q1, this includes:

- Network support – extensive comms activity in support of various network events and the launch of the free sanitary products for women scheme.
- STEMI Quality Improvement Project - working closely with clinical audit and operational team members, a project was launched to raise awareness of the benefits of facilitating early reperfusion for our patients. Using April as 'STEMI Awareness Month', resources were created including a video featuring Cardiologist Dr VJ Karthikeyan, two patient stories, Rapid Recap, a minutes matter poster, and information about the new STEMI ECG recognition mandatory training module.
- Sexual Safety – promoted a new roadshow and used real-life stories in our communication to encourage staff to share their stories.

Examples of the impact of this work are included in the report:

- STEMI Quality Improvement Project - Following STEMI Awareness Month, the audit team saw an 11% improvement in performance for the STEMI care bundle, which means our campaign has had a positive impact on patient care.

Aim 3 – Work together to shape a better future
Objectives – Improve sustainability, productivity and efficiency; Design a sustainable operational model and implement in line with the UEC recovery priorities.

Statistical content and narrative is provided to outline communications activity that meet this aim and objective.

For Q1, this includes:

- Summer campaign launch in June to coincide with the Euros (football) – a CPR training video with a football link was produced with 35.7k views along with a CPR reel viewed 187k times.
- 24 pieces of positive media coverage, including several patient reunion stories.
- A number of publications produced or contributed to, including Your Call magazine, Our Year in Action and the Annual Report.
- Social media activity – our engagement rate stands at 4.4% which is well above industry average and a 12% increase on the previous quarter despite a reduction in posts due to the pre-election period. Notably, our top post featured a PTS vacancy.

The report also captures other areas of communications and engagement activity which cut across the three aims:

- Website and Green Room – we have seen an increase in visits to the website as a result of the continuing work on the Careers with Heart campaign. The Green Room's most popular pages were managers on duty, HR Portal and our locations where staff can get addresses for our various sites.
- Accessibility – work continues to improve accessibility of NWAS information. Our current position is 35 converted documents, with 15 remaining. 120 do not need to be converted. This includes board papers, annual reports, and over £25k spend reports.
- FOI figures – we received 14% fewer FOIs in Q1 than Q4. Our 20-working day response target of 90% sits at 98%.
- Stakeholder communications – Q1 saw minimal correspondence with MPs and key stakeholders. This was due to the pre-election period during which proactive communication was restricted in order to remain impartial.

In relation to the significant decrease in posts on social media, but a positive engagement rate* of over four percent, it should be noted that many factors were at play which influenced this. Much of our content related to the Euros in June using the #Euro24 hashtag which will have influenced the relevance of our content to a wider audience than usual. We also coupled Euros messages with a lot of posts/Reels (films) on how to do CPR with football-related backgrounds. Film typically generates a higher engagement rate but is more time consuming to produce.

*Engagement rate - a metric used to calculate, as a percentage, the total number of interactions (likes, comments, shares, etc.) divided by the number of people who saw the post. A high engagement rate indicates that the content is relevant, interesting, and valuable to the audience. In the social media industry, a good engagement rate is considered between 1% to 5%.

3. EQUALITY/ SUSTAINABILITY IMPACTS

All of the trust's communications and engagement activities seek to promote equality and diversity and ensure information is accessible to all.

4. ACTION REQUIRED

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 Q1 2024/25 (April, May, June)

All communications and engagement activity is planned and undertaken to support the aims of the trust strategy, and the accompanying strategic objectives. Our dashboard details examples of how we've achieved this in Q1 2024/25, before summarising other highlights from our activity.

MAKING A DIFFERENCE.

The 'making a difference' value icon is used to highlight how our activity has a positive impact on staff, patients or partner organisations.

NHS North West Ambulance Service NHS Trust

Provide high quality, inclusive care

Objective: Identify opportunities to improve clinical practice and patient experience

Patient experience surveys

14,150 surveys sent

1280 surveys returned ▼ 12%

90% were likely to recommend the service to friends and family ▲ 2%

88% were very or fairly satisfied with the overall service they received ▲ 1%

93% agreed they were cared for with dignity, compassion and respect ▼ 1%

12 community events attended ▲ 6

which helped us to achieve our priority targets with diverse members of the community. Examples of these include

- Preston Health Mela
- African Cultural event
- Bolton Eid Extravaganza.

6 engagement opportunities

with patient/community groups including:

- Greater Manchester Jewish Community
- Stepping Stones Deaf Active group
- Kashmir Youth Project.

We expect an increase in engagement in Q2 due to the busy summer events schedule.

In Q1, planning and preparation commenced for the first of NWAS' community events - planned for Cheshire in July.

Patient and Public Panel (PPP)

23 new expressions of interest

29 new panel members

338 total panel members ▲ 9%

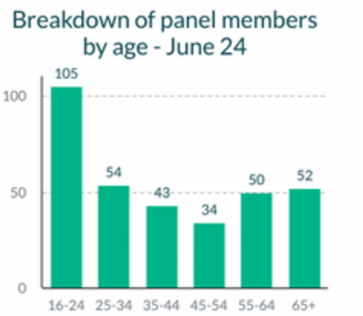
Surpassing our target of 300 members!

17 new requests for panel Involvement

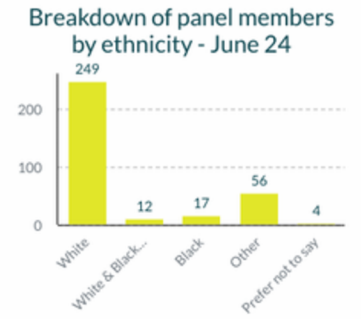
5 involvement opportunities delivered

Areas of involvement included: reviewing 2023/24 Quality Account, PTS pictorial handbook review and Mental Health and Dementia Plan review.

We have scaled down PPP recruitment in place of a new focus on developing our existing PPP membership.



Youth representation is at 30.07% against a stretch target of 40%.



Representation from diverse communities is at 25.15% against a stretch target of 50%.

Patient story

This quarter the Board of Directors heard a story from 64-year-old Edwina who had spent 41 years in the NHS working as a haematology nurse.

In January 2023, she suffered a heart attack and near-fatal cardiac arrest. The quick care, treatment and transportation by the ambulance crew to the nearest specialist hospital, along with an early pre-alert, ensured Edwina was able to get the life-saving treatment she needed and reduce any adverse outcomes on her future quality of life.

Making a difference

- A new digital survey launched for our NHS 111 patients to allow us to focus on feedback from this specific patient cohort.
- Engagement events and opportunities to gain feedback are on the up! Typically, the events calendar is busy in spring and summer, and we will see this continue into Q2 with several university freshers fairs in the diary. Feedback from these events is shared with service lines and informs our annual engagement report and recommendations.
- Our PPP members provided feedback during the development of a pictorial e-book which is now available for all frontline staff to view on their iPads. The book supports effective communication with patients with language or other communication barriers.
- The patient story filmed by our in-house videographer for the Board of Directors meeting is also being used to support clinical training for our staff.

Be a brilliant place to work for all

Objective: Improve the health, wellbeing and safety of our people

Internal bulletins

During this quarter, we shared:

9 CEO bulletins **10** Clinical bulletins **24** Operational bulletins

Plus **23** others including weekly bulletins, HR, Leadership Review, and In Our Thoughts.

321 staff app downloads

Topics:

- General election guidance
- Audio recording and filming by patients
- Cyber security
- MHRA national patient safety alert

Staff app

Views – 272,593
User engagement – 172,714
Sessions – 67,036
Active users this period – 2,455

Top tiles:

- Rostering
- ESR
- Careers

3 editions of 'Better Health, Better You'

A publication produced in collaboration with the staff wellbeing team. In this quarter, editions covered autism awareness, diabetes and mental health. All featured real staff experiences.

3,295 staff read the newsletter each month on average

380 interactions (link clicks)

The previous quarter received the highest number of interactions to date, so this quarter's number of interactions is lower. This could suggest the topics have appealed to a smaller pool of people. Going forward, we will review links to ensure strong calls to action are included in link text.

Film

12 underway **10** completed

Our filming projects have continued to be centred around welcoming new starters to the trust. We have also used film as part of our Sexual Safety at Work campaign and supporting awareness around STEMI incidents.

Project support

Leadership Review

- Continued to support leadership review with regular bulletins to staff - keeping them updated on the implementation of the new structure and opportunities to attend recruitment support sessions.
- Plan to communicate new structure/roles more widely in Q2, once recruitment processes complete.

Integrated Contact Centres (ICCs)

- Updated Green Room with information about ICCs, including the ICC leadership review.
- Progressed with new 'Contact Centre News' newsletter for issue in Q2.
- Promoted the new dual clinician role and recruitment support sessions.

Sexual Safety

- Launched the roadshow and promoted the locations and dates. Shared photos and feedback from the first events.
- Used real-life quotes provided by the Association of Ambulance Chief Executives (AACE) in our internal channels to evidence the need for this campaign and encourage people to come forward to share their experiences.
- Highlighted the relevance of this campaign by linking it to the launch of Q1's National Quarterly Pulse Survey and the results from the NHS Staff Survey.

Network support

- Attended the Network Development Day - a summary of the event was shared on our internal and external platforms with links to the network pages.
- Attended the Armed Forces annual conference. A summary of the event was shared on our internal and external platforms, with links to the AFN Green Room page.
- Promoted the launch of the Women's Network's free sanitary product launch.
- Shared information of the Disability Network's upcoming meetings.

Health and wellbeing

- Launched The Wellbeing Hub which included a case study from one of the workforce wellbeing officers who will be answering the phoneline and a dedicated manager's briefing.

STEMI Quality Improvement Project

- Working closely with clinical audit and operational team members, a project was launched to raise awareness of the benefits of facilitating early reperfusion for our patients.
- We used April as 'STEMI Awareness Month'.
- We created resources including a video featuring Cardiologist Dr VJ Karthikeyan, two patient stories, Rapid Recap, a minutes matter poster, and information about the new STEMI ECG recognition mandatory training module.

Other projects:

- MDVS; training webinar information, how to report issues, staff case studies showcasing the new system's benefits and charging/usage reminders.
- Turn off the Lights school competition and an update on our green spaces.
- NWAS Action Cards: Significant illness, injury, suicide attempt, suicide or death in service (member of staff). This was to ensure a consistent approach across all areas.
- GM Long service awards - producing the film, presentation, and brochure design.

Making a difference

Staff app - careers is a new entry into the top tiles, so this shows the new recruitment campaign has had a positive effect.

Body worn cameras - the sharing of staff stories via trust communications channels has led to more people contacting us to share their stories about the benefits of wearing a camera when they have unfortunately been the victims of violence and aggression.

STEMI Quality Improvement Project - Following STEMI Awareness Month, the audit team saw an 11% improvement in performance for the STEMI care bundle, which means our campaign has had a positive impact on patient care.

Work together to shape a better future

Objectives: Improve sustainability, productivity and efficiency; design a sustainable operational model and implement in line with the UEC recovery priorities.

Press and public relations

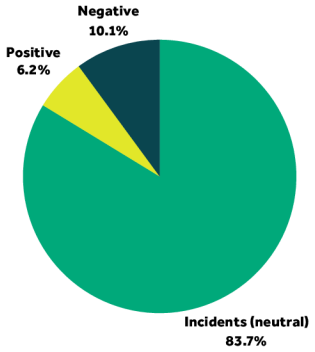
Press office activity / output

168	incident checks handled	▶
21	statements prepared in response to media enquiries	▲ 11%
9	positive broadcast media opportunities secured	▼ 60%
24	proactive stories issued, against our target of **16**	

We arranged several reunions where a patient reunited with our staff to say thank you. Media were invited to attend and photos were sent out afterwards, resulting in positive press coverage.

There was the usual coverage on waiting times and response times, and a few stories on a viral video of a call handler doing a headstand at work. This received a mixed reaction from the public, with many comments in support of the worker.

Resulting media coverage



To give us a picture of NWAS in the media, we log all news coverage available online. This will not include every mention in local press or broadcast media, but allows us to see the overall sentiment of reporting.

- The majority is about incidents, including a mention of NWAS with details provided by our press office, which is factual and neutral in tone.
- Negative coverage overall reflects negatively on NWAS, but usually includes a statement from us in response.
- Positive coverage usually comes as a direct result of the proactive press activity carried out by our press office that quarter.

Summer campaign

The summer months are traditionally less operationally pressured than during winter. However, in terms of 999 calls, data from recent years show little to no variance in between seasons meaning that it's still important to ensure the public is well-educated on using services wisely. Our summer campaign to support operational demand launched in June, to coincide with the Euros.

Highlights include:

- Produced an updated CPR training video which features on our web and social media. It has had **35.7k** views online already.
- Produced supporting CPR Reels of people learning CPR and showcasing staff, these combined with Euro24 warning and informing Reels total **186,869** video views.
- Summer leaflets reprinted to distribute face-to-face at summer events
- Toolkit for internal and external with warning and informing messages to support operational demand created and shared with partner organisations.
- Summer giveaways ordered and have started to be given to the public.
- A cardiac arrest reunion and media opportunity arranged with high profile ex-footballer for start of Q2.

Publications

Your Call magazine was released in April. This edition:

- included stories on emergency maternity care in the ambulance service, the journey of a 999 call, Corrie's Tanisha Gorey on becoming an on-screen paramedic, helping neurodivergent children feel part of society and endometriosis.
- Your call has been read **1,825** times so far, with readers spending an average of **3 minutes 28 seconds** browsing the edition.

'Our Year In Action'- a booklet summarising our achievements for 2023/24 against the trust strategic aims was produced in Q1. It is available online and printed copies will be distributed to NWAS sites and stakeholders in Q2.

We worked with colleagues to produce the Annual Report, Quality Accounts, and Equality and Diversity Annual Report. As well as contributions about the impact of our activities for all publications, this work included proof reading and editing to ensure the content met our Plain English writing and accessibility standards.

Stakeholder communications

During this quarter, we had two pre-election periods which restricted the amount of proactive stakeholder engagement we were able to undertake.

Likewise, due to the dissolution of Parliament in the run-up to the general election, there was only one MP reactive letter produced and no stakeholder briefings.

However, the following have been issued:

- Brief for Alston Parish Council on the future of the ambulance response car
- Issue of Quality Account draft to all councils in the region
- Several condolence and best wishes letters.

Freedom of Information (FOI)

128 received ▼ 14%

81 completed

98% compliance year-to-date against 20 day target

Topics included:

- Assaults on staff
- Agency spend
- Contracts

NOTES
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%.

Making a difference

Much of the proactive external communications was curtailed by general and local elections. However, this meant there was a renewed focus on the NHS and ambulance response times, which required our response to give context. Often the media wanted to focus on the longest wait times, our briefings tried to persuade them this was not a fair way to assess the performance of the trust.

Despite the pre-election period's limitations, we continued our warning and informing agenda to get good coverage from press releases about a heat warning; facilitating several interviews with local broadcasters.

Social media - Facebook, X (Twitter) and Instagram

Audience

84,236	Facebook followers	
68,719	X (Twitter) followers	Audience growth
19,402	Instagram followers	▲ 1%
9,136	LinkedIn followers	

Engagement

449 posts published on all channels ▼40%

3,447,631 impressions ▼42%

150,489 engagements (comments, likes, retweets, shares etc) ▼34%

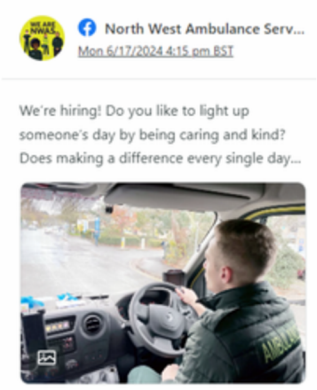
4.4% engagement rate ▲12%

460,663 video views ▲34%

The reduction in posts and impressions was expected as we poster fewer times in the pre-election period.

TOP POST

PTS job advert
11,207 engagements



TOP REEL

Football CPR demo
23.2k views

'Impressions' 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 eg clicks a link, reacts to it by clicking 'like', or shares or retweets it

'Engagement rate' shows us the number of interactions our content receives per follower

According to industry experts, the average engagement rate is less than 0.5% for Facebook, 2.5% for X and 1.5% for Instagram, making our engagement extremely high

'Reels' are short, entertaining videos with audio tracks

NOTES

A 'user' is a person who has an engaged session. An 'engaged session' is when a user is engaged for longer than 10 seconds, performs an action, or views at least 2 pages. This discounts visits where users immediately move onto another site.

Website

317,170 users ▲19%

450,450 page views ▼2%

Most viewed

Vacancies (132,449 views)
Apprenticeships (20,783 views)
Our locations (20,556 views)

Green Room

22,194 users ▼4%

632,503 page views ▲11%

Most viewed

Managers on duty (98,684 views)
HR Portal (17,935 views)
Our locations (16,216 views)

How did visitors find our website?

Direct (searched/typed NWAS web address)
- 154,604 users – 53%

Organic (searched on Google or other)
- 114,657 users – 39.2%

Social media
– 19,612 users – 7.8%

Accessibility

- We are continuing to work through turning all PDF publication documents that need to be converted into HTML web pages to meet accessibility requirements.
- Our current position is 35 converted documents, with 15 remaining.
- 120 do not need to be converted. This includes board papers, annual reports, and over £25k spend reports.

Developments

In the next Q we plan to improve the 'thank you' cards recognition scheme, promote our buy sell swap staff area, and review our documents library.

We are working with website developers to make improvements to the managers on duty page. Currently we are awaiting design mock-ups, but coding updates are scheduled for w/c 29 July.

Making a difference

Unusually, the top performing social media posts for engagement were about PTS - usually top performing posts tend to be about 999. We are always looking at the best ways to promote all services and the simple image paired with the recruitment message drew attention in this instance and helped attract 303 applications for the role, with 161 shortlisted.

LinkedIn - we have increased our following on this platform by 24% since the same period last year, with more focus going into posting on it since the changes to X (formerly Twitter). All audiences on all our other platforms are dominated by females, but according to YouGov, LinkedIn has a higher percentage of male users (at 54%) making it a great tool to get messages out to this demographic.

Web users increased by a fifth on top of last quarter's 107% increase; our campaign Careers With Heart and regular vacancy posts on social media are the main factors influencing the consistent growth.

The most visited Green Room pages are the same as the previous Q, but all have seen increases. Managers on duty continues to be a popular and useful page for staff. Similarly, the HR portal and the bulletins continue to be important for staff to keep up to date with crucial information.

Communications and engagement plans for Q2

- Our strategic Communications and Engagement Plan for 2024 - 2027 will be finalised.
- Our 2024/25 round of community engagement events hosted by NWAS will begin. These offer the community a voice through interactive activities, whilst providing an opportunity for us to educate the public about what to expect from our service.
- We'll also host a community event alongside our AGM.
- Public affairs and stakeholder relationship building will ramp up as many new members of parliament begin their new roles after the general election.
- Supporting the ongoing review of the operational leadership structure, there will be internal communication to embed the changes and help colleagues understand the new roles.