AGENDA

NHS
North West Ambulance Service
NHS Trust

Board of Directors
Wednesday, 25th September 2024
9.45am – 12.20pm
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
PATIENT STORY				
BOD/2425/72	Patient Story	09:45	Information	Deputy Chief Executive
INTRODUCTION				
BOD/2425/73	Apologies for Absence	10:00	Information	Chair
BOD/2425/74	Declarations of Interest	10:00	Decision	Chair
BOD/2425/75	Minutes of the previous meeting held on 31st July 2024	10:00	Decision	Chair
BOD/2425/76	Board Action Log	10:05	Assurance	Chair
BOD/2425/77	Committee Attendance	10:10	Information	Chair
BOD/2425/78	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2425/79	Chair & Non-Executive Directors Update	10:15	Information	Chair
BOD/2425/80	Deputy Chief Executive's Report	10:20	Assurance	Deputy Chief Executive
BOD/2425/81	Digital Strategic Plan	10:30	Decision	Director of Quality, Innovation & Improvement
GOVERNANCE AND RISK MANAGEMENT				
BOD/2425/82	Charitable Funds Committee 3A Report from the meeting held on 11th September 2024	10:40	Assurance	Mr D Whatley, Non-Executive Director
BOD/2425/83	Resources Committee 3A Report from the meeting held on 20th September 2024	10:50	Assurance	Dr D Hanley, Non-Executive Director
BOD/2425/84	Trust Management Committee 3A Report from the meetings held on 18th September 2024	11:00	Assurance	Deputy Chief Executive
QUALITY AND PERFORMANCE				
BOD/2425/85	Integrated Performance Report	11:05	Assurance	Director of Quality, Innovation, and Improvement
BOD/2425/86	EPRR Annual Assurance Self-Assessment	11:25	Assurance	Director of Operations

BOD/2425/87	IPC Annual Report & Board Assurance Framework 2023/24	11:35	Assurance	Director of Quality, Innovation & Improvement
BOD/2425/88	Controlled Drugs Annual Report 2023/24	11:45	Assurance	Medical Director
BOD/2425/89	Learning from Deaths Q1 2024/25	11:55	Assurance	Medical Director
WORKFORCE				
BOD/2425/90	Flu Campaign 2024/25	12:05	Assurance	Director of People
CLOSING				
BOD/2425/91	Any other business notified prior to the meeting	12:15	Decision	Chair
BOD/2425/92	Risks Identified	12:20	Decision	Chair
DATE AND TIME OF NEXT MEETING				
9.45am on Wednesday, 27th November 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
North West
Ambulance Service
NHS Trust

Minutes
Board of Directors

Details: 9.45am Wednesday, 31st July 2024
Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chair
Dr A Chambers	Non-Executive Director / Deputy Chair
Mr S Desai	Deputy Chief Executive
Prof A Esmail	Non-Executive Director (via MS Teams)
Dr D Hanley	Non-Executive Director
Mr D Mochrie	Chief Executive
Dr M Power	Director of Quality, Innovation, and Improvement
Mrs L Ward	Director of People
Mrs A Wetton	Director of Corporate Affairs
Mr D Whatley	Non-Executive Director
Mrs C Wood	Director of Finance

In attendance:

Ms D Earnshaw	Corporate Governance Manager (Minutes)

Minute Ref:

Opening remarks

The Chair offered his heartfelt condolences to all impacted by the recent tragedy in Cheshire and Mersey. He recognised the pain of all people involved and thanked NWAS crews and emergency responders who dealt with the scene.

The Chief Executive stated he was extremely proud of the trust and the police response to the major incident and added that he had spent the day in Southport speaking with crews who had responded to the major incident.

He advised that he had met senior political and local leaders and visited staff who had dealt with the 999 calls and dispatch of NWAS resources. He stated that staff and commanders had undoubtedly saved lives.

He reflected on the overnight public disorder in the Southport area and that NWAS had supported the police and emergency colleagues, with a number of officers injured. He confirmed he had reached out to the Chief Constable to offer support.

Finally, he advised the trust would support NWAS operations and crews with specialist occupational health support, with a multi-agency debrief to establish any lessons to be learnt. He gave his condolences to all involved, particularly the families of the victims.

BOD/2425/43 Staff Story

The Deputy Chief Executive introduced the staff story featured Acting Senior Paramedic Team Leader (SPTL) Dean Cooper who took part in an initiative with Macclesfield Hospital, the HALO Project.

The HALO Project involved looking at how the traditional role of the Ambulance Liaison Officer (ALO) at hospitals could be improved.

The story highlighted Dean's role as an operational ALO based at Macclesfield Hospital, whilst also being available to respond to category one calls if required. He embedded himself in the A&E environment, attended meetings, shared information on how NWAS worked and suggested improvements to working practices, including effective cohorting, to enable NWAS crews to be released back onto the road, when clinically appropriate.

The HALO Project resulted in 143 staff hours being saved from waiting at Macclesfield Hospital due to cohorting patients, compared to 38 hours the previous year, with improvement to the collation of data on handover times. The project facilitated improved engagement between the hospital and the trust. The Board noted that the lessons learnt were being shared with Leighton Hospital to make similar improvements.

Mr D Whatley queried if a similar approach was being taken across other sites of the trust. The Deputy Chief Executive advised the work was specific to Macclesfield with the further work ongoing to deal with hospital handover delays to be discussed further in the meeting.

Dr A Chambers referred to the hospital handover collaborative work which had discontinued and queried the next phase of work to improve hospital handover times. Dr M Power updated the Board on the work ongoing with the region's integrated care boards and the different levels of working arrangements in place across the wider health care system.

She highlighted the significance of effective system working and the variances across the region.

The Chair acknowledged the significance of effective leadership and relationships within partnering organisations.

The Board:

- Noted the content of the story.

BOD/2425/044 Apologies for Absence

Apologies were received from Dr C Grant, Medical Director, Mrs C Butterworth, Non-Executive Director and Mr D Ainsworth, Director of Operations.

BOD/2425/045 Declarations of Interest

There were no declarations of interest to note.

BOD/2425/046 Minutes of the Previous Meeting

The minutes of the previous meeting, held on 29th May 2024 were agreed to be a true and accurate record of the meeting.

The Board:

- Approved the minutes of the meeting held on 29th May 2024.

BOD/2425/047 Board Action Log

The Board noted the updates to the action log.

BOD/2425/048 Committee Attendance

The Board noted the Committee Attendance.

BOD/2425/049 Register of Interest

The Board noted the Register of Interest presented for information.

BOD/2425/050 Chair & Non-Executives' Update

The Chair provided an update on system working and regional meetings in the three areas within the region. He referred to the difficult financial situation for the north west.

He referred to a recent visit to North Cumbria ambulance stations, where he had received feedback regarding the trust's Senior Leadership Review and observed good leadership and staff teams. He also referred to a recent apprenticeship event and excellent feedback from NWAS apprentices.

The Board:

- Noted the Chair and Non-Executives' Update.

BOD/2425/051 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 advised of good performance operationally and noted recent appointments to the post of Area Director for Greater Manchester and Director of Operations.

He referred to the recent General Election and the change in some MPs across the region. He noted a meeting with the new Health Minister.

He recognised a Research Award in memory of the late Betty Pennington and noted various PRIDE and disability events and meetings with north west executive networks.

In terms of Race Equality, he noted a recent successful event and good debate on the issues to tackle racism in the ambulance service.

Finally, he recognised a successful NHS Health and Social Care Apprenticeship Awards and thanked the Director of People and her team for their hard work.

The Director of People advised that the NWAS apprenticeship scheme had ranked 21 out of 100 NHS organisations and the Chair praised the teams on their hard work and the excellent achievement for the Trust.

The Board:

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

BOD/2425/052 People Strategy Refresh

The Director of People presented the Trust People Strategy. She reported that a refresh of the Trust Strategy, undertaken at the end of 2023/24, identified three key areas of focus in the strategy for 2024/25.

1. Urgent and Emergency Care recovery
2. Freedom to Speak Up
3. Ambulance Service Culture, with a particular focus on sexual safety.

She advised the recommendations to emphasise FTSU and Ambulance Service Culture directly impact the People Strategy and the refresh was expedited to ensure prompt alignment and focus. She added that the findings of the National Ambulance Service Culture review had been considered.

She provided an overview of the proposed changes in s2.4 of the report and confirmed that action plans were in place with progress and assurance to be reported to the Trust Management Committee (TMC), Resources Committee and Board of Directors where appropriate.

Dr D Hanley confirmed the Resources Committee non-executive members had met informally and supported the refresh of the strategy.

The Chair referred to the EDI priorities and queried if the refresh proposals had been discussed by the staff networks. The Director of People confirmed the refresh had not been consulted with the network, however the EDI priorities had been discussed with the network.

Prof A Esmail welcomed the approach to the refresh and the accessibility of the document.

The Board noted the excellent work of the Communications Department to produce the trust's strategy documents.

The Board:

- Approved the changes to the People Strategy outlined in s2.4.
- Noted the strategic planning team would be working with each Strategy lead to refresh the Strategic roadmaps.

BOD/2425/053 Board Assurance Framework Q1 2024/25

The Director of Corporate Affairs presented the Board Assurance Framework Q1 2024/25 position. She advised that as part of the review, the Trust Management Committee proposed the following Q1 changes:

- Increase of SR08 from 15 to 20.

Dr D Hanley recognised the completion date of improvement work to critical systems as September 2025. The Director of Quality, Innovation and Improvement confirmed work would be phased and could be finally completed by September 2025. She confirmed the nature of the risk and expected the risk score to vary throughout the year.

Dr D Hanley welcomed further discussion on the timescales at the next Resources Committee.

The Chair confirmed shortlisting had been undertaken to appoint an Associate Non-Executive Director to specialise in digital and would provide further expertise to the board in terms of seeking assurance, particularly in relation to cyber security.

The Board:

- Approved the Q1 2024/25 position of the Board Assurance Framework

BOD/2425/054 Amendment to Board Standing Orders

The Director of Corporate Affairs presented an amendment to the Board Standing Orders.

She reported that the Director of Operations commenced on 1st July 2024, and therefore the composition and voting rights of the Board of Directors had been updated to reflect these changes within the Standing Orders.

She noted s2 of the report detailed the amendments, for approval by the Board of Directors.

The Board:

- Approved the changes to the Board Standing Orders.

BOD/2425/055 Board Development Programme 2024/25

The Director of Corporate Affairs presented the Board Development Programme for 2024/25. She provided an overview of the work undertaken to produce the programme and the items scheduled for 2024/25, detailed in s2 of the report.

Dr D Whatley referred to the issue of artificial intelligence and future discussion either at Resources Committee or a Board Development session in the future. The Director of Quality, Innovation and Improvement agreed to consider options for a future board discussion on this.

The Deputy Chief Executive referred to the strategy development discussions required by Board, with scheduling to be considered alongside the Board Development programme.

The Board:

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

BOD/2425/056 Policy on Anti-Fraud, Bribery and Corruption

The Director of Finance presented the Policy on Anti-Fraud, Bribery and Corruption.

She reported the policy had been jointly reviewed and updated by the Anti-Fraud Specialist and the Deputy Director of Finance. She noted the updates included a clear definition of roles and responsibilities, to provide clarity for all relevant parties. She confirmed the Equality Impact Assessment (EIA) was included with the policy.

Mr D Whatley confirmed the Audit Committee supported the updated policy.

The Board:

- Noted the updated policy and confirmed approval of the Policy on Anti-Fraud, Bribery and Corruption.

BOD/2425/057 EPRR Assurance Report

The Deputy Chief Executive presented an EPRR Assurance Report. He provided an overview of the key progress made against the EPRR core standard requirements.

He referred to the actions in place to improve the position in terms of Joint Emergency Service Interoperability Programme (JESIP) training and the contributory factors, impacting on the attendance rates.

He advised the trust were currently achieving 87% compliance against the core standards, with some standards unlikely to be achieved due to resourcing, with discussions ongoing with commissioners.

In terms of Local Health Resilience Partnerships attendance, he noted that some delegation had been given for other attendees to attend on behalf of the trust, to improve the position.

Dr A Chambers felt assured that the trust had made good progress.

Mr D Whatley referred to peer assessment and queried the process for validation of the trust's self-assessment. The Deputy Chief Executive noted plans for an external peer assessment with a deep dive into cyber threats to be carried out internally.

Prof A Esmail praised the team on the work undertaken to improve the position.

Dr D Hanley referred to the progress however noted his disappointment in relation to training performance. The Director of People confirmed the trust had set a mandatory training compliance of 85% and referred to the plans to achieve the EPRR training standard of 90%.

The Chief Executive referred to the challenges of training course attendance, across fire, ambulance and police services however recognised the work required to improve the position.

The Deputy Chief Executive confirmed work was being undertaken to track individual members of staff who had not attended training courses. In addition to accessibility to documentation to ensure senior managers can monitor the position, to support improvement of the commander training position.

The Chair noted the additional resource allocated to the EPRR team, however noted the need for future reports to be clearer in terms of the compliance detail to provide more robust assurance. He offered to have a discussion outside of the meeting to discuss the requirements in more detail.

The Board:

- Noted the assurances provided.
- Further discussion to be held on the content of future EPRR assurance reports, to provide more robust assurance in terms of compliance.

BOD/2425/058 Health, Safety, Security and Fire Annual Report 2023/24

The Director of Quality, Innovation and Improvement presented a Health, Safety, Security and Fire Annual Report for 2023/24. She provided an overview of the report and highlighted key areas which included Health and Safety Executive compliance.

She noted the change in the management of serious incidents and health and safety arrangements from 1st April 2024/25.

Mr D Whatley clarified health and safety meeting governance arrangements. The Director of Quality, Innovation and Improvement confirmed the meetings in place and the new violence and aggression prevention assurance arrangements.

Dr D Hanley referred to the targets set in relation to violence prevention and reduction standards. The Director of Quality, Innovation and Improvement noted the challenges related to the disperse nature of the ambulance service, however confirmed the work undergoing to improve the position.

It was agreed that an assurance report would be presented to the Resources Committee in relation to the violence reduction and prevention standards.

The Board

- Noted the content of the Health, Safety, Security and Fire Annual Report 2023/24.

BOD/2425/059 Safeguarding Annual Report 2023/24

The Director of Quality, Innovation and Improvement presented the Safeguarding Annual Report for 2023/24. She provided an overview of the report and highlighted the work undertaken in the year.

She noted the reconfiguration of the integrated system safeguarding boards and the work by the team to liaise with the areas in the region. She referred to the oversight and monitoring systems in place and the assurance framework detailed at s11 in the report.

She advised of plans to move to a digital referral system and a training needs analysis review which recognised good training compliance.

The Director of Corporate Affairs referred to the Fuller Inquiry and queried the assurance requirements for the trust in relation to safeguarding and clinical

operations. The Director of Quality, Innovation and Improvement agreed to consider and report to the Quality and Performance Committee.

Prof A Esmail confirmed Quality and Performance Committee had reviewed the report and noted the referral process and learning for the trust. The Director of Quality, Innovation and Improvement outlined the referral process in relation to identifying early learning.

Mr D Whatley referred to the assurance provided and welcomed a discussion with the Director of Quality, Innovation and Improvement in relation to the scheduling of external and internal audits of safeguarding.

The Chair queried assurance processes in relation to private providers. The Deputy Chief Executive provided an overview of the arrangements in place.

The Chair and non-executives praised the work undertaken by the trust and the work of the team in relation to referrals.

The Board noted the following actions:

- The Director of Quality, Innovation and Improvement to consider the recommendations from the Fuller Inquiry and assess whether trust safeguarding processes, clinical practice processes and policies required review.
- Mr D Whatley to discuss external and internal audit scheduling of safeguarding with the Director of Quality, Innovation and Improvement.

BOD/2425/060 SIRO Annual Report 2023/24

The Director of Quality, Innovation and Improvement presented the SIRO Annual Report for 2023/24 and noted the cyber assurance processes and DSPT challenges.

Mr D Whatley confirmed the Audit Committee supported the report at the meeting on 19th July 2024 and noted the discussions held in relation to DSPT compliance and effectiveness of the monitoring arrangements in place.

The Director of People advised of changes made to the mandatory training process to improve compliance against training modules.

- Noted the content of the SIRO report 2023/24.

BOD/2425/061 Audit Committee 3A Report

Mr D Whatley presented the Audit Committee 3A reports for the meetings held on 19th June 2024 and 19th July 2024.

The Board:

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

BOD/2425/062 Trust Management Committee 3A Report

The Chief Executive presented the Trust Management Committee 3A reports from the meetings held on 19th June and 17th July 2024.

He referred to the alert items and noted further discussion in relation to resources would be held in the Board of Directors Part 2 meeting.

The Board:

- Noted the content of the Trust Management Committee 3A reports.

BOD/2425/063 Integrated Performance Report

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report. She provided an overview of the report and acknowledged performance challenges in the Cheshire and Mersey area.

Dr D Hanley recognised the increase in C2 long waits and queried if the level of harm to patients had increased. The Director of Quality, Innovation and Improvement outlined the trust's process to review and monitor category 2 call long waits.

The Deputy Chief Executive provided context in terms of the comparative monthly data, and the geographical significance of the performance reported.

Prof A Esmail recognised the improvements in the report, however referred to the static performance in relation to hear and treat and see and treat performance. He added the Cheshire and Mersey performance continued to be of concern.

The Chair acknowledged the ongoing difficulties in the Cheshire and Mersey area and noted the work ongoing to make improvements. In terms of hear and treat and see and treat, he requested some time to discuss the position at Board level.

The Deputy Chief Executive noted the improvement work ongoing to reduce conveyance and noted that improvement was dependent on the hospital handover delay position, which resulted in reduced capacity in the clinical hub.

The Chief Executive recognised the need to further explore the multifactorial issues with the Director of Operations and Medical Director.

Dr A Chambers queried the lack of movement in performance related to the clinical hub and warm transfers to a nurse. The Deputy Chief Executive provided an overview of the warm transfer position.

Dr D Hanley referred to the ongoing challenge of EOC turnover. The Director of People recognised the correlation in staff turnover and operational performance. She recognised the improvement work undertaken in 111 however noted that EOC turnover position remained a challenge.

In response to the discussion, the Chair requested the following actions:

- further discussion to be held by the Chief Executive, Deputy Chief Executive, Director of Operations and Medical Director on the issues impacting hear and treat and see and treat performance.

- a letter from the Trust Chief Executive to the Chair and Chief Executive of the Cheshire and Mersey ICB with a meeting to discuss the performance position.

The Board:

- Noted the contents of the report, the assurance provided and actions identified.

BOD/2425/064 Manchester Arena Inquiry Recommendations

The Deputy Chief Executive presented a report on the Manchester Arena Inquiry Recommendations. He updated the Board on progress against the 14 recommendations made, following the Manchester Arena Inquiry.

The Chair queried the assurance received by the legal team in terms of compliance against the recommendations.

The Director of Corporate Affairs confirmed the check and challenge processes in place, led by the Assistant Director of Legal, Resolution and PALS.

The Board:

- Noted the assurance provided.

BOD/2425/065 Learning from Deaths Report Q4 2023/24

The Director of Quality, Innovation and Improvement presented a Learning from Deaths Report for Q4 2023/24 on behalf of the Medical Director.

She outlined the Q4 report provided explanatory information in the year-end report to be presented to the September Board meeting.

Dr D Hanley referred to the dashboard and the inability to report on ethnicity data. The Director of Quality, Innovation and Improvement outlined the current position in relation to extraction of consistent data.

The Chair noted the challenges however emphasised the need to obtain EDI data, for further discussion in the EDI priorities item on the agenda.

The Board:

- Noted the content of the report.

BOD/2425/066 Quality and Performance Committee 3A Report

Prof A Esmail presented the Quality and Performance Committee 3A report from the meeting held on 24th June 2024.

He outlined the alert item related to controlled drug audit compliance and the need for continued monitoring via the Medical Director and Trust Management Committee.

The Chief Executive acknowledged the need to explore the issues and noted that the Controlled Drugs Annual Report would be presented to the next Board meeting for further discussion.

The Director of Quality, Innovation and Improvement noted the work ongoing by the trust's Chief Pharmacist and future reporting to the Quality and Performance Committee.

The Chair recognised the financial and resource discussions required, however noted the need to ensure the trust was compliant with all aspects of the Controlled Drugs Home Office License.

The Board:

- Noted the content of the Quality and Performance 3A report.

BOD/2425/067 Workforce Equality Data Monitoring Report

The Director of People presented the Workforce Equality Data Monitoring report. She provided an overview of the report and noted the links between the findings in the data monitoring report and the trust's draft Equality, Diversity and Inclusion (EDI) priorities.

In terms of the gender pay gap position she noted a reduced comparison of 3.5%, the lowest position seen since reporting. She noted the upper quartile of pay, which had shifted by 5%, and would assist to deliver improvements in terms of career progression.

She highlighted the actions detailed in the report clearly linked to the EDI priorities.

Prof A Esmail emphasised his concern in relation to challenges within concentrated areas of the trust, and the need for a thorough approach to equality, and the findings of the Too Hot to Handle report, and the significance of improvements across the whole organisation.

The Director of People welcomed the comments and noted the work to conduct a review to establish a baseline before focusing on targeted improvement areas.

The Chair welcomed the analysis approach explained, however noted the significance of specific challenges, and the value of work undertaken by other organisations that might assist the trust in establishing plans to make improvements.

The Director of People referred to the need to specifically challenge behaviours and management practices to make a difference to the position.

The Chair welcomed a balance of trust analysis of the position and that of external organisations to obtain learning and good practice.

The Board:

- Noted the content provided.

BOD/2425/068 EDI Priorities and Annual Plan

The Director of People presented the EDI Priorities 2024/26 and Annual Plan 2024/25. She explained the rationale for the set annual targets and noted that service line targets could be set to support the annual targets.

The Chair queried the most appropriate methodology for Board to assess improvement on an annual basis. The Director of People noted the links to annual plan reporting, and that objectives had been aligned to the regulatory requirements.

Prof A Esmail queried the resource committed to improving health inequalities and whether the trust had the required knowledge and expertise to conduct the necessary data analysis and utilise the information. The Director of People referred to the Annual Plan which identified actions to improve the data. She recognised the need to consider external data.

The Director of Quality, Innovation and Improvement outlined the process required in house, which included warehousing, extracting and manipulating data, to obtain the information required. She noted work in-year would progress the position, however there was a shorter-term action to make the most of data available and noted the work required with external partners.

Dr D Hanley reported that Resources Committee non-executives had requested further assurance in relation to EDI Priority 3.

The Chair noted the challenges and asked for further assurance to be presented to the Quality and Performance Committee and Resources Committee.

The Board:

- Approved the EDI Priorities and the Annual Plan.
- Noted EDI Priority 3 assurances would be presented to the Quality and Performance Committee.

BOD/2425/069 Communications and Engagement Dashboard

The Deputy Chief Executive presented the Communications and Engagement Dashboard.

The chair welcomed a good report and the amount of work undertaken.

The Board:

- Noted the contents of the report.

BOD/2425/070 Any Other Business Notified Prior to the meeting

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

BOD/2425/071 Items for inclusion on the BAF

There were no items identified for inclusion in the BAF.

Closing remarks

The Chair summarised the key points discussed during the meeting.

He referred to the items of further assurance and thanked the Deputy Chief Executive for an update on the Manchester Arena Inquiry recommendations.

He noted the need to continue to monitor Controlled Drug Audit compliance and the improvements highlighted in the gender pay gap reporting item.

Date and time of the next meeting –

9.45 am on Wednesday, 25th September 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
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	26.3.25			
123	31.07.24	57	EPRR Assurance Report	Discussion to be held on the content of future EPRR assurance reports, robust assurance in terms of compliance required.	Deputy Chief Executive and Director of Operations	25.09.24			
124	31.07.24	58	Health, Safety, Security and Fire Annual Report 2023/24	Assurance report to Resources Committee in relation to violence reduction and prevention standards.	Director of QII	27.11.09			
125	31.07.24	59	Safeguarding Annual Report 2023/24	Consideration of the recommendations from the Fuller Inquiry with assessment on whether trust safeguarding processes, clinical practice processes and policies required review.	Director of QII	25.09.24		MIAA Review scheduled October 2024	
126	31.07.24	59	Safeguarding Annual Report 2023/24	Mr D Whatley to discuss external and internal audit scheduling of safeguarding with the Director of Quality, Innovation and Improvement	Mr D Whatley & Director of QII	25.09.24		MIAA Review scheduled October 2024	
127	31.07.24	63	Integrated Performance Report	Further discussion to be held by Chief Executive, Deputy Chief Executive, Director of Operations and Medical Director on the issues impacting hear and treat and see and treat performance and report back to the Board.	Deputy Chief Executive	25.09.24			
128	31.07.24	63	Integrated Performance Report	A letter to be sent to Chief Executive to the Chair and Chief Executives of the Cheshire and Mersey ICB with a meeting to discuss the performance position.	Chief Executive	25.09.24			
129	31.07.24	68	EDI priorities and EDI Annual Plan	Assurance to be provided to the Quality and Performance committee on EDI Priority 3.	Medical Director	27.11.24		Medical Director to discuss with Chair of Committee.	

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				x				
Dr Alison Chambers	✔	✔	✔	✔				
Salman Desai	✔	✔	✔	✔				
Prof Aneez Esmail	✔	✔	x	✔				
Dr Chris Grant	✔	✔	x	x				
Dr David Hanley	✔	x	✔	✔				
Daren Mochrie	✔	✔	x	✔				
Dr Maxine Power	✔	✔	✔	✔				
Catherine Butterworth	✔	✔	✔	x				
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	✔		x			
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	x	✔		
Lisa Ward	✔	x		
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	✔	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.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 September 2024
SUBJECT	Deputy Chief Executive's Report to the Board of Directors
PRESENTED BY	Salman Desai
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 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 31 July. The highlights from this report are as follows: PES • Demand and response remain stable • Incident volume has increased vs August 2023 • Handover remains a challenge 111 • Fully established team • 95% of calls answered within 60 seconds • IUC national support arrangements remain in place PTS • Tender process extended, to be awarded in February 2025 • No increase in activity above contact baseline • PTS Improvement Group to be launched
PREVIOUSLY CONSIDERED BY	Not applicable

1. PURPOSE

This report seeks to provide a summary of the key activities undertaken and the local, regional and national issues of note in relation to the trust since the last report to the Trust Board on 31 July 2024.

2. PERFORMANCE

2.1 Paramedic Emergency Service

Overall demand for the 999 service has remained relatively stable in respect to emergency incidents. Incident volume has increased slightly when compared to August 2023 (0.5% increase) although emergency calls have reduced by 8k, compared to August 2023 and by around 10k calls compared to July 2024. The presenting acuity of patients has also reduced when compared to July 2024 with reduction in the percentage of incidents within the C1 and C2 cohorts. Handover remains a significant challenge with average handover being around 10 minutes higher than the previous year. Average handover times have improved when compared to July 2024. It should be noted that the increase in handover times is not proportionate across ICBs, with Cheshire and Mersey being responsible for the majority of the overall increase.

ARP response performance is stable. C1 mean response YTD stands at 07:41 and 07:29 for August 2024. C2 mean response stands at 24:44 and 21:03 for August 2024. NWAS continue to deliver against the C2 UEC standard of 30 minutes and response standards are currently ahead of trajectory. C3 and C4 responses have improved for the month of August 2024. NWAS are currently only delivering C1 90th ARP standard for the year-to-date position. Placing this into context NWAS performance against all ARP standards remain within the top 4 of all Ambulance Services, ranking especially well for C2 mean. Long waits continue to improve vs previous months and against the previous year position. As an illustration C2 long waits have reduced by 3,141 In August 2024 vs August 2023 (4,614 vs 1,473).

Call pick up continues to perform exceptionally well with a mean call answer of 0 seconds for August and 1 second YTD. NWAS rank first nationally for all call pick up metrics. Hear & Treat rates remain stable but have not improved in line with UEC trajectories. See & Treat also remains stable but again is not improving at the anticipated rates.

It should be noted that due to the significant variation in average handover across our ICB footprint, there is increasing variation in ARP response standards. As an illustration C2 mean YTD for Greater Manchester ICB stands at 20:59 vs Cheshire & Mersey ICB at 31:09.

This month sees the introduction of a new performance and efficiency delivery group, which will focus on C1 response, Hear & Treat and meal break compliance. In addition, a group focusing on improving conveyance rates has been commissioned. The leadership review has now moved into phase 3 with the remaining band 7 roles being filled through the next two months.

2.2 NHS NW 111

The IUC national support arrangements remain in place and their continuation has been confirmed for the remainder of the financial year. 111 has seen significant improvement across call pick up metrics and workforce indicators. For the month of August 2024, NHS 111 achieved both call pick up KPIs for the first time. Call answered in 60 seconds stood at 95.2% and calls abandoned at 0.6%. This places NHS 111 as the third best performing service nationally. Clinical KPIs have also improved across all measures.

It should be noted that there has been real progress in terms of workforce indicators through the past 18 months. Sickness rates have reduced from 20% to 9% and attrition rates have reduced from 46% to 15%. The workforce strategy, including rota review, team-based working, health and wellbeing initiative alongside the reduction in operational pressure have all contributed. This can also be observed in respect to establishment in front line roles. 111 are now fully established against the funded workforce position for all front-line roles.

2.3 Patient Transport Services

In the contract period, July is M 01 for PTS. The Contract year runs July to June. Overall activity during Month 4 (financial year) was 0% (490 Journeys) above contract baseline whilst the cumulative position is 0% (490 Journeys) above baseline.

Cumbria is 12% below baseline. Greater Manchester is 19% above baseline. Lancashire is 21% below baseline and Merseyside is 16% above baseline. This is consistent with contract year 2023/24. The financial position at M 01 is an overspend of £108k. Projected forward this is an overspend of £1.3m

Within Cumbria, planned arrivals achieved 85% against the Arrival KPI target of 90%. EPS achieved 87% against the Arrival KPI target of 90%. Lancashire, planned arrivals achieved 82% against the Arrival KPI target of 90%. EPS achieved 83% against the Arrival KPI target of 90%. Greater Manchester, planned arrivals achieved 71% against the Arrival KPI target of 90%. EPS achieved 67% against the Arrival KPI target of 90%. Merseyside, planned arrivals achieved 76% against the Arrival KPI target of 90%. EPS achieved 79% against the Arrival KPI target of 90%.

The PTS Improvement Group will be launched first week October, and a senior leadership review is ongoing.

3. ISSUES TO NOTE

3.1 Local Issues

Manchester Pride

On Saturday 24 August, some of our colleagues attended the Manchester Pride parade. We were part of the thousands of people who proudly marched, including firefighters, other NHS workers and many other organisations. The parade is the city's biggest where thousands of LGBTQ+ communities and their allies march for equality.

Lisa Ward, Director of People and our LGBT Network Executive Champion, was one of the colleagues who marched in the parade. Its humbling to see our staff being able to be open and celebrate who they are, as well as hearing the level of support from the crowds packing the streets.

It was therefore disappointing and disheartening to see so many unacceptable and homophobic comments on our Facebook posts and whilst these were outweighed by all the positive responses it is an important reminder that the society in which we deliver our services, does not always share out values and our staff continue to face the risk of discrimination and homophobia. We will continue to protect our staff and patients from exposure to such issues.

3.2 Regional Issues

Major Incident

On Monday 29 July the trust declared a major incident when reports of multiple stabbings at a property in Southport were received just before midday. The trust dispatched a number of resources to the scene, including 13 ambulance crews, HART, air ambulance and MERIT doctors. This was a very challenging incident involving many young children and two adults.

Sadly, three children were killed and many more were injured. Our thoughts and prayers are with the families of Bebe King, aged 6, Elise Dot Stancombe, aged 7 and Alice Dasilva Acuiar, aged 9.

The tragedy was then used as an excuse to incite violence and disorder across the country and a second major incident was declared in Southport due to the disturbances, where many NWAS resources were on scene treating 39 injured police officers. Utter chaos continued across the UK over the weekend and hundreds of police officers were injured in clashes, businesses, mosques and hotels which were thought to house asylum seekers, were attacked.

A number of our staff supported police officers at various incidents and the trust was very grateful for the commitment shown by everyone who worked hard to keep our communities safe.

Together with our Chair, Peter White, a letter of appreciation was sent to each individual member of staff involved in the emergency response and provided details of the welfare support available. The Ambulance Service Charity also confirmed that extra staffing had been arranged on the 24/7 staff crisis phone line which provides immediate and ongoing mental health care for UK ambulance staff.

The incident received, and continues to receive, extensive medica coverage, The Royal Family, Prime Minister Keir Starmer and Home Secretary Yvette Cooper all expressed their gratitude to the responding services.

There is absolutely no place for racism in our society and it will not be tolerated in our service. With the worst of humanity, we also saw the best of humanity. The outpouring of gratitude towards our service was phenomenal and our social media channels were

flooded with comments of support; the trust was inundated with letters and emails showing appreciation.

On Tuesday 20 August, His Majesty King Charles visited Southport Fire & Ambulance Station to meet survivors of the incident, together with their families, before greeting representatives from the fire, police and ambulance services and members of the community who rallied together in the aftermath.

There are so many different elements to responding to an incident of this nature and it was important that all the different roles within the trust had the opportunity to attend with colleagues from call centres, clinical staff, including on-scene Doctors, North West air ambulance and our specialist hazardous area response team (HART).

Patient Transport Service Contract

Following an initial commissioning timeline to complete the procurement of Non-Emergency Patient Transport Services (NEPTS) and mobilisation period by 31 March 2025, two legal challenges to the procurement process were received. After seeking legal advice, the commissioning team and ICB leads made a joint decision to rewind the procurement process to repeat the selection questionnaire stage. This decision was taken after reviewing what information had been shared about the criteria for pass/fail decision at the Selection Questionnaire selection stage.

As a result, a new process was launched and open to all previous bidders. Additional information on scoring was also issued and bidders given the option to revise their Selection Questionnaire submissions only.

In line with national requirements, the North West Ambulance Commissioning Team and the ICBs' Procurement Working Group issued a timetable (see below) which sets out the revised process and timelines against the re-procurement of the NEPTS services which reflects the changes as part of the rewind.

It is anticipated that the successful bidder will be formally awarded the contract in February 2025. There will then be a 12-month mobilisation period to 31 March 2026.

	Procurement Timetable
Tender Go-Live Point	**Late July 2024**
Tender Period Closure	**Late August 2024**
Evaluation / Moderation	**September to November 2024**
Authorisation	**December 2024**
Outcome communicated	**Mid-January 2025**
Award of Contract	**Early February 2025**
Mobilisation	**01/04/2025 – 31/03/2026 (12 months)**
Contract Go-Live	**01/04/2026**

REAP Level

On Wednesday 7 August, the trust's REAP level changed from Level 2 (moderate pressure) to Level 3 (major pressure). Escalating the REAP level is part of our response to manage system-wide pressures and the move to REAP 3 allows us to focus our resource on essential services to meet the increased demand. The trust has since returned to REAP Level 2, moderate pressure.

3.3 National Issues

Sexual harassment in UK Ambulance Services

A recent Sky News report detailed the experience of three female ambulance service employees who all faced sexual harassment at work.

The allegations in the report were shocking and deeply concerning and gave a troubling insight into what working life is like for some women within our service. There is no place for this kind of behaviour in society today and certainly not within a profession that provides itself on being caring to all, and free of discrimination.

Whilst the interviews were anonymised, we understand that the examples in the report do not relate to NWAS. There is a minority of people who think this behaviour is acceptable and there is still work to be done to eradicate it completely.

4 General

Trust Leadership

On Tuesday 19 August. the trust Chair announced that after 33 years within the ambulance sector and 36 years NHS overall, Daren Mochrie, Chief Executive, would be stepping down from his role as Chief Executive at the end of November to take up a new opportunity overseas.

Daren commented that it has been a privilege to lead NWAS and serve the communities of the northwest and despite the many challenges over the years the trust has a lot to be proud of and is well positioned to continue to deliver ongoing improvements and improved clinical care well into the future.

IT Outage

At the end of July there was a national major IT outage that hit industries across the globe, including parts of the NHS. The main issue in healthcare was with EMIS, an appointment and patient record system, which caused disruption to most of the GP practices in our area.

Although we had no problems with the systems in NWAS, the knock-on effect of the issues in the wider healthcare system meant that more people were calling us for help, particularly NHS 111. Patients were also waiting longer than they should for their follow up care because of the impact on referrals.

Rapidly growing queues for calls and clinical care are not what we like to see, but the Integrated Contact Centre team handled it superbly.

Trust Website

The trust website has been ranked first amongst all UK ambulance service websites for accessibility. We achieved 98% compliance with the Web Content Accessibility Guide which is an internationally recognised set of recommendations for improving website accessibility to make it easy for everyone to find and use, including those with impairments to their vision, hearing, mobility, understanding and thinking

ENEI

For the third consecutive year the trust has achieved the Gold Standard in the Employers Network for Equality & Inclusion's 'Talent Inclusion & Diversity Evaluation'. The trust is one of only 25 Gold Standard winners out of 185 global entries, from across 26 different sectors and with an overall score of 84% we are the third highest ranked organisation out of all entries this year.

NWAS Recognised as a better place to work

The trust was recently contacted by NHS England to recognise the positive improvements we saw in the results of the 2023 NHS Staff Survey. As an organisation we have improved across the themes of staff engagement and morale, together with all seven elements of the People Promise which includes: Compassionate & Inclusive, Recognise & Rewarded, A Voice that Counts, Safe & Healthy, Always Learning, Working Flexibly and We are a Team.

Being a brilliant place to work, investing in, and looking after, our people is absolutely one of our top priorities and seeing improvements in these areas is very encouraging.

Top Employer for apprenticeships

The trust has been ranked number 21 in the Top 100 Apprenticeship Employers in the UK.

This fantastic achievement comes a couple of weeks after we won 'Employer of the Year' at the NHS Apprentice Awards for a second time. A huge congratulations and well done to our People Directorate, and the Education Team in particular, who plays a key role in the training and development of our apprentices.

We currently have apprentices working in more than 20 roles at NWAS. This includes emergency medical technicians (EMTs), around 100 of which complete their course with us each year.

This recognition reflects the tireless work that goes into attracting apprentices at the start of their career and giving them the right support and development to make sure NWAS is a great place to work.

NHS Communication Initiative of the Year

Our communications team has been shortlisted in the NHS communications Initiative of the Year category at the HSJ Awards 2024.

The shortlist recognises the success of the winter communications campaign which aimed to help reduce non-emergency 999 calls and avoidable 111 calls by sharing educational and health related messages with the public

The team used data to identify areas where communications activity could have an impact – for example, one element of the campaign was a focus on reducing 111 calls for prescriptions by encouraging the public to arrange their medications sooner and educating them on how to do so. Another strand of the campaign was around falls prevention, which included community engagement work as well as a falls hazards film and social media activity.

The team will present to HSJ judges in October before the final winners are announced in November.

Patient Engagement Team shortlisted for three national awards

NWAS' Patient Engagement Team uses a range of ways to engage, listen and learn from our patients, public and wider community including traditional surveys, proactive engagement with specialist patient and cultural groups, and a programme of community listening and awareness days. This helps us get feedback on access and use of our services, which we use to make service improvements.

Some of the most recent improvements influenced by patient feedback include the successful rollout of the Insight app across PES and PTS to support language translation, the launch of the national BSL 999 video relay service to improve access for deaf patients accessing our services, and an increase in our engagement with hard-to-reach ethnic minority groups through our own series of community listening events and bespoke engagement.

We have also successfully achieved our Patient and Public Panel (PPP) membership target with 350 members of the public signed up. Since the launch of the PPP in September 2019, our members have been involved in a wide range of meetings and projects including the national ambulance dataset project with NHS England. The involvement and feedback from our members have influenced various changes within the trust as it allows us to shape our service from a patient perspective.

The vital work undertaken by our Patient Engagement team and PPP has been shortlisted in three national awards for Patient Experience Network National Awards (PENNA). PENNA are the first and only awards programme to recognise best practice in patient experience across all facets of patient experience. The team has been shortlisted in these categories:

- Team of the Year
- Patient Contribution
- Measuring, Reporting and Acting - Using Insight for Improvement

The results will be announced on 3 October 2024

HSJ – Mental Health Safety Improvement Award

The trust has won the Mental Health Safety Improvement Award at the HSJ Patient Safety Awards

Our initiative, the advanced questionnaire module (AQM) which allows for a timely upgrade and response to patients who have overdosed on high-risk drugs, stood out for its innovative approach to improving safety in mental health care. This collaborative approach between the Mental Health Team and ICC colleagues shows how working together can make a difference.

HCPC Standard of Conduct, Performance and Ethics

With effect from 1 September, the HCPC has revised their standards of conduct, performance and ethics and guidance on social media.

In general, theses standards set out how they expect registrants to behave, they outline what the public should expect from health and care professionals to help them make decisions about the character of professionals who apply to be registered, and they use those standards if a concern about a registrant's practice is raised.

The Darzi investigation into the NHS

Last week saw the publication of the Independent Investigation of the National Health Service in England, commissioned by the government to understand the performance of the NHS and inform the government's upcoming ten-year plan.

Surgeon and former health minister Professor Lord Darzi led the investigation. The full scope of his investigation was to:

- provide an independent and expert understanding of the performance of the NHS across England and the challenges facing the healthcare system.
- ensure that a new ten-year plan for health focuses on these challenges.
- stimulate and support an honest conversation with the public and staff about the level of improvement that is required, what is realistic and by when.

Lord Darzi's investigation found the NHS is in a 'critical condition' amid surging waiting lists and a deterioration in the nation's health. It points to four heavily interrelated drivers; austerity and constrained funding, the impact of the pandemic, a lack of patient voice and staff engagement and management structures and systems.

In particular, the report highlights a £37 billion capital spending shortfall over the past decade and a half, the negative impact of NHS reforms and stripping out management capacity. The result is described as a missed opportunity to prepare the NHS for the future, improve productivity and embrace the technologies that would enable a shift in the model from 'diagnose and treat' to 'predict and prevent'.

The report recognises that many of the factors that have contributed to the current challenges are outside NHS control, such as the Covid-19 pandemic and the declining health of the nation, not a failure of NHS staff or management.

It points to systemic and structural issues beyond the control of NHS leaders, including the failure to divert resources into more preventative care, the pressure on primary care, an oversized centre (including regulators) with a heavy burden of regulation and inspection, and a lack of consistency and clarity around the role of integrated care boards (ICBs). It concludes that a top-down reorganisation of NHS England and ICBs would be neither necessary nor desirable in supporting recovery.

Lord Darzi says that trust and confidence in the NHS can only be rebuilt if we are completely honest about where it stands now. He also said what I know to be true, that as colleagues we share 'passion and determination to make the NHS better for our patients'. This won't happen overnight, but is a key turning point for change.

Communications & Engagement Strategic Plan

The document for 2024-27 sets out the strategic direction for the communication, engagement and involvement activities of the trust. Our purpose is to help people when they need us most, but achieving this needs clear, consistent communication and meaningful engagement with all stakeholders, from patient and staff to healthcare partners and the wider community.

This strategic plan has been reviewed to ensure it remains up to date, reflecting the current environment, and adapts to the varying needs of the organisation. This includes increasing demand on ambulance services and an emphasis on urgent and emergency care recovery, changes to our infrastructure with the introduction of Integrated Contact Centres, a greater focus on digital technologies and a new operational leadership model.

Pay Uplift

The Government accepted the NHS Pay Review Body's recommendation of a 5.5% uplift for all staff on Agenda for Change contracts. The change to the pay system will be paid in October, backdated to April 2024.

Changes to the Band 8 and above pay points will be subject to ratification through the NHS Staff Council, but the indication is that this should be implemented from November.

Virtual Ambulance Leadership Forum

The date for the virtual Ambulance Leadership Forum has been announced as Tuesday 8th October 2024. The free, one-day virtual conference is open to all staff within UK ambulance services with the team 'Leaders at all Levels' and will cover key topics such as ambulance service culture, current operational landscape and what the future of healthcare looks like under the new government.

Great North Run

A huge thank you and well done to the NWAS runners who took part in this year's Great North Run. On Sunday 8 September, our team powered through the 13.1 miles from Newcastle to South Shields, to raise funds for the North West Ambulance Charity.

Our amazing team of 11 runners put in a huge amount of effort in terms of training and fundraising in the weeks and months leading up to the event. The cold and rainy weather on the day didn't dampen their spirits. Their dedication really paid off - with a total of £7,000 raised collectively so far!

In our Thoughts

It is with great sadness that I write to inform you of the death of our friend and colleague Alan Davey and former friends and colleagues, Peter Iliff and Keith Devereux.

Alan joined the trust in 2014 and was a bank ambulance care assistant in the East Lancashire sector, he passed away in July following an illness.

Peter's career within the ambulance service spanned five decades with his final role as Fleet Workshop supervisor at Bolton until his retirement in 2018. He passed away in August following a short illness.

Keith passed away very suddenly at his home earlier this month. He joined the service in April 1991 and retired last year from his role in Morecambe Bay Sector, as both a manager and a paramedic.

The trust sends sincere condolences to the family, colleagues and friends of Alan, Peter and Keith and has created an opportunity on the Green Room for digital condolences to be posted.

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, 25 September 2024
SUBJECT	Digital Strategic Plan (2024-2026)
PRESENTED BY	Maxine Power, Director of Quality, Innovation & Improvement
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; • Review and approve the contents of this strategic plan and recommend that it should be shared with and approved by the trust Board of Directors, and • Support the development of a long-term Digital Strategic Plan to commence from 2026.
EXECUTIVE SUMMARY	Strategic plans form part of the trust's strategy and outline how supporting functions would deliver the objectives of the trust strategies. Strategy, Planning and Transformation and members of our Digital teams began work in 2023/24 on developing a digital strategic plan to replace the Digital Strategy 2019-2024. During the development, it was identified that our current requirements are met by the existing digital strategy. The strategic themes from the existing strategy have been refreshed and included in this Digital Strategic Plan (2024-2026), updating and extending them for a further two years. The Digital Strategic Plan (2024-2026) will run for two years during which a longer-term digital strategic plan will be developed.
PREVIOUSLY CONSIDERED BY	Resources Committee
	Date: Friday, 20 September 2024

	Outcome	

1. BACKGROUND

The purpose of this paper is to the seek approval for the Digital Strategic Roadmap.

In June 2022, trust Board of Directors approved Our Strategy 2022-2025. In August 2022 Resources Committee agreed to begin production of four supporting strategies, which were approved in July 2023 and which would then be followed by strategic plans which would outline how supporting functions would deliver the objectives of the trust strategy and supporting strategies.

Strategy, Planning and Transformation and members of our digital teams began working together in quarter 3 2023/24 on developing a digital strategic plan which would replace the Digital Strategy 2019-2024 which expired in March 2024.

NHS England introduced the What Good Looks Like (WGLL) framework (August 2021) in response to the rapid deployment of digital technologies during the Covid-19 period. The WGLL framework provides clear guidance for NHS organisations on how to digitise, connect and transform services safely and securely.

The original intention was to look to create a strategic plan which would commence from 1st April 2024 and set out the principles for the next 3 years. In the process of developing the strategic plan it was identified that the current requirements are very similar to what was in the Digital Strategy 2019-2024 and that the existing strategy met the needs of the WGLL framework. Therefore, instead of fully redeveloping a new digital strategic plan, we have refreshed the strategic themes in the existing strategy and extended them for two years until 2026.

2. RISK CONSIDERATION

The Digital Strategic Plan (2024-2026) outlines our digital principles which will inform our digital work programmes for the next two years and which will reduce risks.

Risk appetite category	Implications
Compliance / regulatory	The strategic plan meets the requirements of the NHS England What Good Looks Like framework (August 2021).
Quality outcomes	Secure, resilient and effective digital systems will support the delivery of high-quality care. We will also ensure that we use our wealth of data to support quality improvement and improved outcomes.
People	To align with the WGLL framework, we will support our people to be able to work optimally with the data and equipment they need to do their jobs. We will also ensure that all of our systems and tools are fit for purpose and support our people to do their jobs well.

Financial / value for money	A proactive approach to internal system management and renewal will support proactive financial planning.
Reputation	The strategic plan aims to engender an overall improvement to the quality of our systems to ensure that we have modern, secure and resilient systems which people can be proud of and which will enhance our reputation as an employer and healthcare provider.
Innovation	The strategic plan sets out our aim to be digital pioneers, ensuring that we are using technology to perform our functions as effectively as we can. It also aims to make us an agile and responsive service able to meet the changing needs of our environment and which can cultivate and rapidly deploy innovation.

3. EQUALITY/ SUSTAINABILITY IMPACTS

Prior to final approval, we will complete an equality impact assessment and sustainability assessment on the strategic plan. The strategic plan includes consideration of sustainability and accessibility so it is not expected that there will be any negative impacts highlighted in either impact assessment. Any project or programme which implements elements of the strategic plan will have their own equality and sustainability impact assessments.

4. ACTION REQUIRED

The Board of Directors is asked to:

- Review and approve the contents of this strategic plan and recommend that it should be shared with and approved by the trust Board of Directors, and
- Support the development of a long-term Digital Strategic Plan to commence from 2026.

North West Ambulance Service NHS Trust

Digital Strategic Plan 2024-2026

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. Our supporting strategies outline what we will prioritise over the next three years to achieve our aims and ultimately, our vision.

Our current Digital Strategy was approved in 2019 to cover until the end of March 2024 and was designed through extensive engagement with stakeholders and aligned to support the delivery of the trust strategy. Since it was developed, NHS England introduced the What Good Looks Like (WGLL) framework (August 2021) in response to the rapid deployment of digital technologies during the Covid-19 period. The WGLL framework sets out seven success measures, applicable to all care settings, which provide clear guidance for NHS organisations on how to digitise, connect and transform services safely and securely. An assessment of the approved Digital Strategy identified that it met the needs of the WGLL framework. As such a refresh rather than a rework has been undertaken to the Digital Strategy, to create a Digital Strategic Plan (2024-2026). The rework has taken into consideration the current digital maturity of the trust and how to support the delivery of the strategy and supporting strategies.

In parallel to delivering the plan a programme will commence for a full detailed stakeholder engagement process to define how digital needs to support the trust in the future and create a more comprehensive digital strategic plan for 2026 onwards.

This Digital Strategic Plan (2024-26) will show what our principles will be for the next two years in digital transformation. It will show how these principles are aligned with our trust strategies and the WGLL framework.

Digital principles

Our digital principles are a continuation of the principles in the Digital Strategy 2019-2024. These principles are based on a significant programme of engagement with a wide range of stakeholders and have built a strong foundation for improving our digital maturity. There is more work to do, and we have key areas to improve upon in delivering the Digital Strategic Plan 2024-2026. The principles have been refreshed to reflect where we are in 2024. Each of our digital principles contain sub-themes which help us to understand how we will implement our digital principles.

Solving everyday problems

- We will ensure that our core business platforms, systems, devices, and solutions are fit for purpose to support our staff to do their jobs effectively.
- We will enhance the digital skills and capability of every member of staff and leaders will be empowered to utilise and champion digital enhancements.

One of the aims of our trust strategy 2022-25 is to be a brilliant place to work for all. We can help to solve everyday problems by providing the right tools, skills and environment needed to provide the best possible care. One of the fundamental aims of this strategic plan is to improve digital services and technological solutions so that they meet the needs of our staff, volunteers, and patients. If we can improve the quality and resilience of our digital services, we will in turn make NWAS a more accessible service for our patients and a great place to work.

We will implement this by:

1. Getting the basics right – Ensuring that our staff and volunteers have the right equipment, providing a timely response to problems, providing support and training and ensuring that our workforce is digitally connected.
2. Improving staff experience – Working closely with teams when designing and implementing digital solutions, ensuring that all staff and their requirements are considered in the design phase, there is diverse input in the testing and implementation phase.
3. Improving patient experience – Providing the right clinical information to our colleagues to ensure that patients are provided with the right outcome and support through all of the services NWAS provides.

4. Improving safety – Assessing the implementation of technology with consideration and assessment against the digital clinical standards, where relevant.
5. Improving digital skills – Ensuring that our staff have the skills and capability to use their equipment and systems as part of their role and by developing digital solutions which are intuitive and user-friendly.

Our digital journey

- Digital decisions are informed by digital knowledge but made by a multidisciplinary group led by clinical and operational leads.
- Operational governance within digital will be structured, transparent and collaborative.
- We will work on a portfolio designed to support the achievement of the trust's strategic aims which has been approved by clinical, operational, and corporate teams.

To fully realise the benefits of digital transformation, we must ensure that we have strong leadership and governance with defined roles and responsibilities. Our digital journey is focussed on making sure that we have the people and culture to embrace a 'digital first' approach that allows us to deliver benefits to patients, staff, and the wider system through the use of technology. We will also develop and sustain digital partnerships with our local partners, commissioners and national bodies which will help us to co-design digital transformation with our system and our patients in mind.

We will implement this by:

1. Promoting a 'digital first' culture – Working collaboratively to identify opportunities to solve problems and improve clinical and operational processes through the innovative utilisation of digital solutions.
2. Embedding collaborative leadership and governance – Developing and implementing clear structures to develop our digital portfolio which will ensure that we are working transparently towards achieving our strategic aims.
3. Improving our operating model – Creating a baseline and improvement plan for all functions within Digital to ensure good provision of services to our stakeholders.

4. Promoting digital partnerships – Working with partners across our footprint and with colleagues across the ambulance sector to maximise the opportunities for collaboration, learning and innovation.

Secure and joined up systems

- We will ensure cyber security standards, our systems, and our data infrastructure is safe and secure to protect our patients, staff, business continuity and resilience.
- We will ensure our internal systems are fully integrated to support a single integrated urgent and emergency care model.

Our technological systems must be secure, resilient, and effective to maintain business continuity and high-quality patient care. Our priority will always be to provide essential system maintenance and improvement to maintain business continuity. At the same time, we want to create the capacity within our digital structures for ongoing innovation through increased system interoperability and more intelligent data analytics.

We will implement this by:

1. Improving system integration and interoperability – Developing interoperable systems which enable us to act as a gateway to the wider urgent and emergency care system.
2. Improving privacy and cyber security – Adopting the best practice cyber security standards and ensuring our systems are safe and secure to protect our business continuity and the sensitive data we hold.
3. Using open standards – Complying with national open standards for integration and communication where relevant to ensure that our systems remain interoperable with other systems.
4. Reviewing core business platforms – Continuously reviewing our core business platforms to identify opportunities for improvement and efficiencies.
5. Proactive risk and renewal – Taking a proactive approach to internal system management and renewal, identifying early when systems will be due for renewal and planning financial investment and system requirements to ensure that we maintain the delivery of our services.

Smarter decisions

- We will provide through the development of relevant reports access to the right data. The prioritisation of the business intelligence roadmap will be driven by the trust priorities.
- We will support in building an informed and educated workforce who understand how to utilise the right data to support them in their roles.
- We will look to advance the analysis of data by combining data to provide meaningful insights, transforming data into information, enabling better decision making and improving the effectiveness and efficiency of the trust.

We hold a unique position in the North West England health and care system due to our geographical scale and number of patient contacts each year. This means we have a lot of information about our patients, the wider population, and the services available to support patient navigation. Our Sustainability Strategy aims to improve the utilisation of data which provides insights into population health and health inequalities. We must use and share our data securely and use data from across other health services in a more intelligent way. This information will help to inform clinical decision making by helping us to intelligently manage patient demand and resource allocation, predict and prevent deterioration in patients who are known to us as a service and, identify opportunities for innovation to improve service delivery.

We will implement this by:

1. Capturing better data – Ensuring that data we capture is high-quality, validated data from a range of internal and external sources and storing it in a central data warehouse. Supported by a programme of data quality work aligned to the Business Intelligence Roadmap, that works with colleagues to define best practice operating procedures.
2. Providing better access – Ensuring that our staff, and partners can access the appropriate information, to support making the right decisions at the right time through the delivery of the Business Intelligence Roadmap.
3. Gaining better insight – By creating an education programme to support staff at all levels to understand how to read data and utilise it. Enabling them to use our wealth of data to inform demand management, performance management, clinical decision-making, and system-wide improvement.

4. Improving collaboration – Working across the North West England health system to enable combining of data to support strategic objectives around health inequalities and improving patient outcomes.

Digital pioneers

- We will utilise digital skills and technologies to unlock the capability of digital transformation across our organisation and help our staff to do their jobs more effectively.
- We will increase the ability for our organisation to be agile and responsive to changes in environment by testing digital innovation cycles quickly.

Our Quality Strategy outlines an improvement approach provides a structured approach to continuous improvement which emphasises patient centred care, leadership, and organisational culture. We aim to be digital pioneers across the ambulance sector by cultivating innovation and deploying those innovations quickly as part of our continuous improvement approach.

We will implement this by:

1. Developing innovation partnerships – Working collaboratively with other ambulance trusts, academia, and other partners to identify opportunities for innovation.
2. Cultivating innovation –Developing the people, processes and infrastructure required to find and share ideas and incorporate those ideas into innovation cycles to test and implement them.
3. Rapidly deploying innovation – Working collaboratively with the trust to develop an innovation pipeline which is prioritised in line with our strategic aims, implements successful ideas and measures the organisational impact of those solutions.

Digital roadmap development

Starting in 2024-25 we will develop and maintain delivery roadmaps for our digital strategic plan which will show how we will implement the principles outlined in this strategic plan and continue to develop our digital maturity.

The roadmaps will be developed with consideration of our capital allocation, the wider need for change in the trust and a proactive assessment of risk and renewal of our systems. The roadmap will be developed by the digital teams and supported by the Strategy, Planning and Transformation Team.

References

NHS England What Good Looks Like framework

Appendix 1 - What good looks like framework

NHS England published the What Good Looks Like (WGLL) framework in August 2021. The programme was created following the fast adoption of technologies in response to COVID-19. The WGLL framework sets out seven success measures, applicable to all care settings, which provide clear guidance for NHS organisations to digitise, connect and transform services safely and securely.

The WGLL details how the seven success measures may be implemented by NHS organisations. The seven measures for the WGLL framework are:

1. Well led.
2. Ensure smart foundations.
3. Safe practice
4. Support people.
5. Empower citizens.
6. Improve care.
7. Healthy populations

Our Digital Strategic Plan 2024-2026 is aligned with the WGLL framework, and the table below explains the definition and shows how each measure maps to our strategic plan.

Success measure	Definition	NWAS digital principles
Well Led	Boards are equipped to lead digital transformation and collaboration. They own and drive the digitally enabled transformation journey, placing citizens and frontline perspectives at the centre.	• Our Digital Journey • Digital Pioneers

Success measure	Definition	NWAS digital principles
Ensuring Smart Foundations	Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Organisations have well-resourced teams who are competent to deliver modern digital and data services.	• Solve Everyday Problems • Smarter decisions • Secure & Joined-up Systems
Safe Practice	Organisations maintain standards for safe care. They routinely review digital and data systems to ensure they are safe, robust, secure, sustainable, and resilient. Digitally enabled outcome-driven transformation is at the heart of safe care.	• Solve Everyday Problems • Smarter decisions • Secure & Joined-up Systems • Digital Pioneers
Support People	Your workforce is digitally literate and are able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.	• Our Digital Journey • Solve Everyday Problems • Smarter decisions • Secure & Joined-up Systems • Digital Pioneers
Empower Citizens	Citizens are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Citizens can access and contribute to their healthcare information, taking an active role in their health and wellbeing.	• Our Digital Journey • Secure & Joined-up Systems • Digital Pioneers

Success measure	Definition	NWAS digital principles
Improve Care	Health and care practitioners embed digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place.	• Our Digital Journey • Smarter decisions • Digital Pioneers
Healthy Populations	Organisations use data to inform their own care planning and support the development and adoption of innovative ICS-led, population-based, digitally driven models of care.	• Our Digital Journey • Smarter decisions • Secure & Joined-up Systems • Digital Pioneers

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ESCALATION AND ASSURANCE REPORT

Report from the Charitable Funds Committee

Date of meeting	Wednesday, 11 September 2024		
Members present	Mr D Whatley, Non-Executive Director (Chair) Mr D Ainsworth, Director of Operations Mrs C Butterworth, Non-Executive Director Mr S Desai, Deputy Chief Executive/Director of Strategy, Partnerships & Integration Dr D Hanley, Non-Executive Director Mrs A Wetton, Director of Corporate Affairs Mrs C Wood, Director of Finance	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None identified.

ADVISE:

- Financial position of the NWAS Charity to 30th June 2024 £907k; £422k general funds and £485k restricted funds.

ASSURE:

- NWAS Charity risk register presented following quarterly review.
- Summary of the operational, strategic and charitable activity undertaken during Q1 2024/25 noted the use of restricted and unrestricted funds and updates in relation to the NHS Charities Together grants.
- A summary of the fundraising activities undertaken during Q1 2024/25 provided, together with fundraising plans scheduled for Q2 and Q3 2024/25.

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Friday, 20 September 2024		
Members present	Dr D Hanley, Chair Mr D Whatley, Non-Executive Director Mr S Desai, Deputy Chief Executive Officer Mr D Ainsworth, Director of Operations Mrs C Wood, Director of Finance Mrs L Ward, Director of People	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

Workforce Indicators Report

- A deep dive into the processes within EOC received however issues remain. There is a risk that if attrition does not stabilise and improve then there is a potential risk in maintaining performance.

Finance Report Month 05 2024/25

- Received assurance in relation to the financial performance indicators.
- Recurrent efficiency savings remain unrealised.

ADVISE:

Patient Level Costing (PLICS) 2023/24 Assurance:

- Received assurance that the NWAS 23/24 PLICS data collection was submitted in line with mandated requirements and in advance of submission deadline.
- Noted the currency tariffs, movements from 22/23 and the comparison with other ambulance trusts.
- Noted the development of the PLICS dashboard.

NHS England Financial Recovery

- Noted the work undertaken during August in relation to NHSE System Financial Recovery Investigation and Intervention.
- Noted the improved position against efficiency targets.

Trust Strategy Development

- Agreed to extend the existing Trust Strategy to the end of financial year 2025/25 to re-baseline timescales across all strategies.
- Noted the further work being undertaken to recommend the next steps for strategy design which will be reported to Committee in November.

ICC Retention Deep Dive:

- Received assurance that a clear evidence-based plan is in place however timeline for delivery is 6-12 months before it is understood whether the plan is effective.

Recruitment – Positive Action and Target Setting

- Received assurance in relation to diverse recruitment activity.
- Approved the recommended recruitment targets, further work to establish objectives at service line level.

ASSURE:

Agency Performance Report Q1 24/25:

- Received assurance the agency expenditure during 23/24 was within the Trust's agency expenditure ceiling.
- Received assurance there had been no breaches of agency price caps or procurement framework rules during 23/24 or year to date.

Private Ambulance Spend:

- Received assurance on private ambulance expenditure within the Paramedic Emergency Services directorate during 23/24.

Estates, Fleet and Facilities Management Assurance Report:

- Received assurance on the management of estates, fleet and facilities management activity.

Sustainability Update:

- Received assurance of the trust's work related to sustainability.

Driver Training Fleet 2024/25:

- Discussed the report and recommended to the Board of Directors for approval.

PES DCA Vehicle Replacement Programme 2025/26

- Discussed the report and recommended to the Board of Directors for approval.

Equipment Replacement Program – Carry Chairs

- Discussed the report and recommended to the Board of Directors for approval.

Strategy Assurance:

- Received assurance on the Trust's progress towards achieving the strategic aims through the delivery of supporting strategies to September 2024.
- Noted the development of a strategy dashboard during Q2.

Digital Strategy Plan:

- Discussed the report and recommended approval by the Board of Directors.
- Supported development of a long term Digital Strategic Plan commencing 2026.

Digital Strategy Update:

- Received assurance on delivery of the digital strategy.

Flu Campaign 2024/25

- Noted the approach to the 2024/25 flu campaign
- Endorsed the Board checklist for onward approval by the Board.

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, 18 September 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 Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs J Wharton, Chief Information Officer Ms S Rose, Interim Director of Integrated Contact Centres	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- 4 EPRR standards will be partially compliant upon submission, with an action plan in place
- Additional costs will be incurred for the training on the Schiller Defibrillators
- System required for visibility and booking of space across the estate required to reduce spend

ADVISE:

- The existing Trust Strategy will be extended to FY 2025-26 and timescales rebased
- NHSE Financial Recovery Phase 1 complete - Unmitigated forecast submitted to the ICB
- DCA Vehicle replacement programme increased to 79 vehicles per year
- The Clinical Safety Plan has been revised and updated
- Go live in GM with new defibrillators being considered

ASSURE:

- **The TMC discussed the following.**
  - **Item 117 –** Strategy Assurance Report
  - **Item 118 –** Strategy Development 2025-27

- **Item 119 –** Finance Report M5
- **Item 124 –** ICC Estates Update
- **Item 129 –** Analogue Lines at Ambulance Stations
- **Item 133 –** EPRR Annual Assurance Self Assessment

- Received the following Escalation & Assurance reports:
  - Sustainability Group
  - Clinical & Quality Group
  - People & Culture Group
  - Service Delivery Assurance Group
  - Diversity & Inclusion Group

RISKS

Risks discussed:

- The TMC approved the Corporate Risk Register as noted

New risks identified:

- No new risks identified

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 September 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 **August 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 non clinical incident. – Care and treatment continues to be the most frequently reported clinical incident. • Six Patient Safety Incident Investigations (PSII) have been submitted to NHS England for local review and learning. **Effectiveness**

- The STEMI care bundle has improved for the third reporting period. All other Ambulance Quality Care Indicators (ACQI) are stable.
- The H&T rate for August 24 was 14.1%, whilst the S&T rate was 27.1%, equating to a total non-conveyance rate of 41.2%. Nationally, the trust position sees a minimal shift from the previous period, ranking 5th for H&T, and 9th for S&T and 8th for S&C.

Operational Performance

- 999 call pick up mean, 90th, and 95th percentile of zero seconds.
- ARP standards were met for C1 90th, the remaining standards were not met, however, improvements in performance were noted particularly in C3 and C4 incidents.

Measure	Standard (hh:mm:ss)	August 24 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:07:29	3rd
C1 90th	00:15:00	00:12:47	3rd
C2 mean	00:18:00	00:21:03	2nd
C2 90th	00:40:00	00:40:08	2nd
C3 mean	01:00:00	01:17:25	5th
C3 90th	02:00:00	02:41:49	3rd
C4 90th	03:00:00	03:16:08	4th

- Turnaround performance is stable (35m:06s). Cheshire and Merseyside ICB (C&M) continue to record longer turnaround times; in August C&M turnaround (44m:38s) was 45% longer than other areas (30m:33s).
- Long waits for C1 and C2 are at the lowest levels for 3 years.
- Performance in 111 suggests improvement shown by national rankings and attaining national standards for calls answered and abandoned call rate. This is likely attributable to increased national contingency (now at 10%).

111 Measure	Standard	August 24	National Ranking
Answered within 60s	95%	95.2%	3rd/30
Average time to answer	--	12s	--
Abandoned calls	<5%	0.6%	2nd/30
Call-back within 20 min	90%	47.54%	--
Average call back	--	21m 58s	--
Warm transfer to nurse	75%	17.9%	--

- PTS activity is stable with operational and workforce improvement plans in progress.

	Finance • The trust has a surplus position attributable to additional bank interest received and a one-off benefit from a property sale. • Efficiency targets are ahead of plan and it is expected that the full year efficiency target will be met. **Organisational Health** There continues to be improvement in the workforce metrics specifically on • Sickness absence is indicating overall improvement despite the slight increase in July. • Turnover is signalling improvement, particularly 111 however EOC service line remains challenged at 22%. A deep dive was delivered to Resources Committee in September for assurance around plans. • Vacancy gap has reduced, plans remain ambitious but being closely monitored. • HR casework remains high but average case times maintained at 12.9 weeks.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 18 September 2024
	Outcome	

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 **August 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.

The review at TMC identified the following areas to highlight;

- Long Waits - For C1 and C2 are at the lowest levels for 3 years. With C2 long waits (n=1,473) decreased compared to the previous report (n=3,526).
- C2 – Achieving C2 mean of 21:03 in August which delivers against the C2 Urgent & Emergency Care Target of 30 minutes but exceeds the 18-minute ARP target.
- Acknowledgement of the challenges within C&M across key metrics which are impacting on the overall performance of the trust.

3. PERFORMANCE SUMMARY

QUALITY

Complaints: Owing to departmental changes this report displays complaints data in tabular form until there are sufficient data points for SPC.

In August n=143 PALS and n=13 Resolution complaints were received. Closure rates within service level agreement (SLA) for complaints were 83.2% for PALS complaints and 67.9% for Resolution complaints.

Incidents: Patient and safety incidents (including patient incident investigations) are reported in tabular form until enough data is present for SPC. Thirteen patient incidents were classified as 'severe harm' (an increase from 10 in the previous report) and 10 as 'fatal' (a decrease from 18 in the previous report).

Violence and aggression (n=235) remain the most common theme for non-patient incidents, and has increased 31.9% since the last reporting period. This is partially

attributable to the civil unrest following the Southport attack. Care and treatment (n=103) is the most common theme for patient incidents.

Most frequent non patient incidents:	**Most frequent patient incidents:**
Violence & Aggression (235)	Care and Treatment (103)
Medicines (71)	Call Handling (78)
Communication (48)	Communication (48)
Call Handling (45)	Medicines (36)
Accidents & Injuries (42)	Accidents and Injuries (25)

Incidents referred to NHSE: There were 6 Patient Safety Incident Investigations (PSII). Four were identified as a local priority under 'Prevention of deterioration to critically unwell patients with contributing harm' and two under 'Face to Face assessment managed down an incorrect pathway'.

Safety Alerts: No new safety alerts were received in August 2024.

EFFECTIVENESS

Patient experience

PES. The n=550 responses for August are 4.6% higher compared to the last reporting period (n=526), with comments showing a 6.11% increase (409 for June compared to 434 in August). The overall experience score for August of 91.5% is 1.2% higher than the 90.3% reported in June. Patient feedback examples from two mental health incidents this month, highlight the need for further staff training to improve skills and competencies to support patients in mental health crisis.

PTS. The 1,344 responses for August are 3.2% lower than for June's 1,388, with supporting comments higher by 0.18%, (1,109 for June compared to 1,111 for August). The overall experience score for August is 93.2%, a 2.5% increase from the 90.7% reported for June.

NHS 111. At the time of reporting, there are 85 returns for August, which is 54.8% lower than the 188 returns recorded for June. This reduction in returns is attributed to the time lag in returned surveys and the reporting timeframe. The new localised 111 survey is however starting to show positive returns with 223 being received in July. This is 21.1% higher than the highest return level in 2023 (184 for July 2023). The results thus far show a 90.6% likelihood of the 111 service being recommended; an increase of 5.5% percentage points compared to 85.1% reported for June.

Ambulance Clinical Quality Indicators (ACQI's)

Trust level cardiac ACQI submission has now been retrospectively submitted. Metrics are stable except for the STEMI bundle indicating improvement. Four of the 6 metrics are equal to or above the national average:

- Return of Spontaneous Circulation (ROSC) overall performance - last reported in April 24 (30.3%), above the national average of 27.3%.
- ROSC Utstein performance - last reported in April 24 (55.7%), above the national average of 53.0%.

- Survival at 30 days after discharge overall performance - last reported in April 24 (9.2%), below the national average of 10.0%.
- Survival at 30 days after discharge Utstein performance - last reported in April 24 (25.0%), below the national average of 32.4%.
- Stroke care bundle - last reported in February 24 (97.9%), equalling the national average of 97.9%.
- STEMI care bundle – last reported in April 24 (92.6%), above the national average of 80.2%.

The improvement in the STEMI care bundle is likely attributable improvements made by Clinical Audit and Clinical Informatics to the Electronic Patient Record and clinical leaders have been 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 August 24 was 14.1%, whilst the S&T rate was 27.1%, equating to a total non-conveyance rate of 41.2%. Nationally, the trust position sees a minimal shift from the previous period, ranking 5th for H&T, and 9th for S&T and 8th for S&C.

Since the broadening of the criteria in May the expected improvement in H&T from C2 segmentation is not yet observable and investigations are continuing to determine root causes. There have been positive actions including reduced abstraction and higher productivity of triaged calls. Factors such as a high rate of eligible calls returning to the dispatch stack are restricting potential increases. The performance of the clinician model is being carefully monitored to ensure the Trust is responsive to any changes.

OPERATIONAL PERFORMANCE

Paramedic Emergency Services (PES) Activity

Of the n=110,438 emergency calls received by the trust, 83.0% (n=92,000) became incidents. In comparison to the previous year, there are 7.2% fewer calls, and incidents have decreased 0.5%.

Manchester South (9,655), Manchester Central (n=9,545), and Mersey North (n=9,344) were the busiest sectors. Greater Manchester ICB contains the most incidents (n=36,186), accounting for 37% of PES activity.

PES Call Pick Up

The trust performed well for Call Pick Up (CPU). The mean, 90th, and 95th percentile were all zero seconds. Strong performance has been maintained through increased levels of 999 call handlers funded via UEC investment.

999 Ambulance Response (ARP) Performance

Measure	Standard (hh:mm:ss)	August 24 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:07:29	3rd

C1 90th	00:15:00	00:12:47	3rd
C2 mean	00:18:00	00:21:03	2nd
C2 90th	00:40:00	00:40:08	2nd
C3 mean	01:00:00	01:17:25	5th
C3 90th	02:00:00	02:41:49	3rd
C4 90th	03:00:00	03:16:08	4th

In August the trust recorded the second best C2 performance in sector for both mean and 90th. Both metrics are stable; the mean was 3 minutes over the standard which has reverted to 18 minutes. The trust was 8 seconds short of the C2 90th target of 40 minutes.

Regional variation exists - Cheshire and Merseyside ICB (C&M) have a 39% higher response time for C2 (26m06s) than the rest of the trust (18m44s) likely caused by a 45% (+14m) higher hospital turnaround time in the C&M area.

C3 and C4 performance placed third (C3 Mean), fourth (C4 90th), and fifth (C3 90th) nationally. North East & North Cumbria ICB met the 60 min target for C3 Mean this month (00:59:06). Response performance exceeded the standards in all metrics however August's performance was the smallest margin over the standard observed post pandemic.

Ongoing reviews of the response model are supporting further improvements including inter-facility transfers and healthcare professional (IFT/HCP) calls as well as urgent care response, on track for October 24 target completion date.

999 C1 & C2 long Waits

C1 long waits (n=450) decreased compared to the previous report (n=598). The percentage of C1 long waits of all C1s has decreased from 6.2% to 5.1%.

C2 long waits (n=1,473) decreased compared to the previous report (n=3,526). The percentage of C2 long waits of all C2s has decreased from 7.3% to 3.2%.

Long waits for C1 and C2 are at the lowest levels for 3 years.

Hospital Handover

Average turnaround time (35m:06s) is stable, however performance is still above the national standard of 30 minutes. Cheshire and Merseyside ICB (C&M) continue to record longer turnaround times; in August C&M turnaround (44m:38s) was 45% longer than other areas (30m:33s).

As part of local improvement plans the Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services (MHLDC) provider collaborative are

recruiting a UCR (Urgent Community Response) Navigator to divert patients at point of contact in NWAS ICC.

NHS 111

111 Measure	Standard	August 24	National Ranking
Answered within 60s	95%	95.2%	3rd/30
Average time to answer	--	12s	3rd/30
Abandoned calls	<5%	0.6%	2nd/30
Call-back within 20 min	90%	47.54%	--
Average call back	--	21m 58s	--
Warm transfer to nurse	75%	17.9%	--

Calls offered (n=134,959) were 5.8% lower than June 24 (n=142,627), displaying special cause, likely attributable to 15% national contingency that started in April 2024 (reducing to 10% from 29th July 2024). The 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 95.2%, delivering the best performance in 3 years and meeting the national standard of 95%.
- Call-back within 20 mins is showing improvement at 47.5% although short of the national standard of 90%.
- Average time to callback has improved to 21m:58s, the best performance over the last 3 years.

Other initiatives contributing to the improvements include:

- The Rota Review conducted throughout 2023 is now embedded
- Ongoing work to identify initiatives to improve staff health and wellbeing and work life balance.
- A newly established 'centralised' training team is now in place from Q3 23/24.

PTS

PTS activity remains stable. There is scope to improve the number of aborted journeys for same-day discharges, which are 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

Agency Expenditure

The year to date expenditure on agency is £0.459m which under the year to date ceiling of £1.057m and each area of NWAS coming in under the agency ceiling.

Financial Risk Rating

Overall performance for NWAS shows a surplus position primarily driven by additional bank interest received and a one-off benefit from a property sale in the year. Efficiency targets are ahead of plan and it is expected that the full year efficiency target will be met.

5. ORGANISATIONAL HEALTH

Sickness

Trust absence levels have continued to recover despite the slight rise in July, with the latest reported month (July 24) at 7.38%. The slight rise in July is indicative of previous years.

The improvement in sickness overall is reflected across all service lines. The 111 service line had the highest sickness rate previously however is signalling improvement (9.20%) but special cause variation remains in the July datapoint below the lower control limit. EOC sickness is continuing to rise.

The overall position is consistent with trends across the sector, and although we remain at the higher end, the gap is narrowing with NWAS only now 0.48% above national average. 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 August (10.17%) continued a downward (improving) trend with both July and August being at or below the lower control limit. This is driven by improvement in 111, however it remains challenged with the turnover rate at 22.7%. In contrast, EOC turnover remains at the upper control limit following a persistent upward trend at 22.3%. There is a focus in contact centres to support retention, and analysis is underway to understand emergency medical advisor (EMA) turnover. Initial indications show that internal movement (e.g. career change to start EMT course) and available external opportunities are causal factors.

At 6.1%, 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 0.2% pay bill, £150k below cap.

Vacancy

The trust vacancy position is –5.4% for August 24, reflecting an improved position. This reflects some establishment changes and improvements resulting from recruitment.

The PTS vacancy position has improved to 9.8%, but remains a challenge 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 –12.4%, driven by increased turnover in the call handler workforce. Recruitment plans are in place to maintain a stable position for the rest of the year. Some vacancies are being held to take account of expected efficiencies arising from the workforce management tool and pathways business cases.

PES show a slight under-establishment of –2.5%, 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 –3.9%, displaying special cause, with continuing small numbers of 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.

Appraisals

Overall appraisal completion has maintained at 87%, ahead of target and displaying special cause for consecutive months. PTS have improved from 85.7% to 87.6%. The 111 service line has reduced from 84.12% to 80.6% displaying special cause. Both PES and EOC have exceeded the target at 87% and 88% respectively.

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 89%, with all operational service lines meeting their targets. Corporate is achieving 94% 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=115 to n=123 between the reporting periods. The highest rate of live cases per staff (prevalence) occurs currently in PTS & PES (1.7%). Highest prevalence over the last 12 months has been n PTS and

111. Average case length has maintained at 12.9 weeks. Current levels of suspensions reflect the higher caseload.

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 is set to go live in C3 (999) upon completion of the patient marker update and governance work. 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

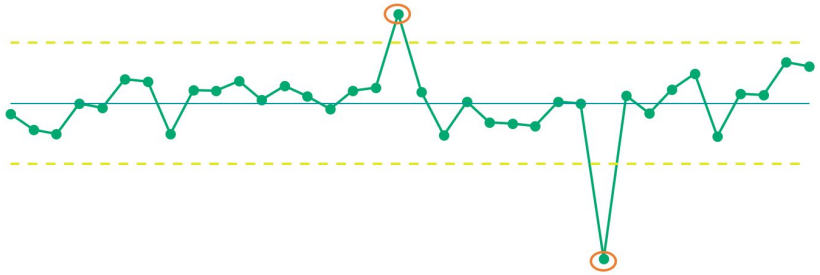
Integrated Performance Report

Board - September 2024

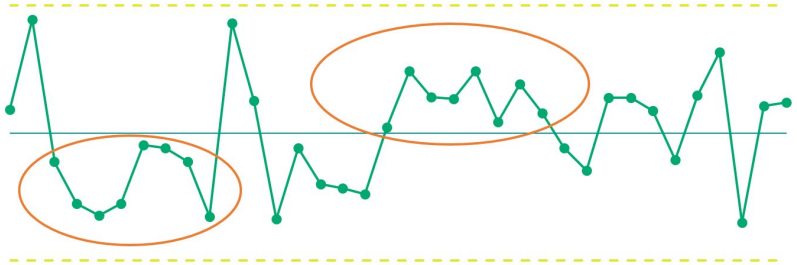
Rules for interpreting SPC Charts

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

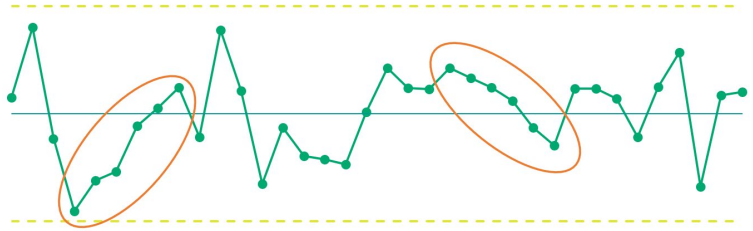
Rule 1: Single data point outside the control limits



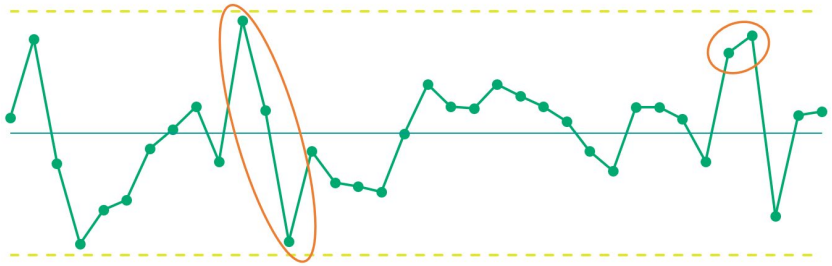
Rule 2: 8 or more consecutive data points above or below the centre line



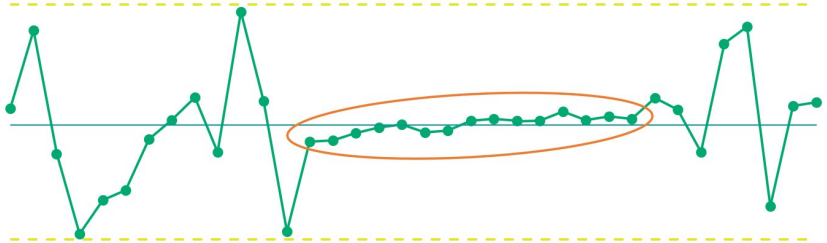
Rule 3: A trend of at least six consecutive points (up or down)



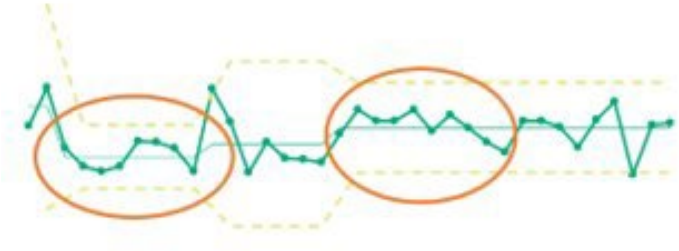
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



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)	Recieved	Complaints Closed	Closed In SLA %
1-2 (PALS)	143	155	83.2%
3-5 (Resolution)	13	28	67.9%

Figure Q1.2

Received by Service Line

Level (Team)	EOC	111	PTS	PES (GM)	PES (CAM)	PES (CAL)
1-2 (PALS)	15	13	70	18	14	13
3-5 (Resolution)	4		3	1	2	3

Data will be displayed monthly by SPC when datapoints are sufficient

Q2 Incidents

BAF

Figure Q2.1

Overview (August)

Incident Type	Received	Closed	Closed in SLA (%)
Non-Patient (1-3)	638	628	68.8%
Non-Patient (4-5)	2	4	75%
Patient (PSIRF)	538	599	N/A

PSIRF level of harm (August 24)	
None	405
Low	73
Moderate	37
Severe	13
Fatal	10

Data will be displayed monthly by SPC when datapoints are sufficient

Figure Q2.2

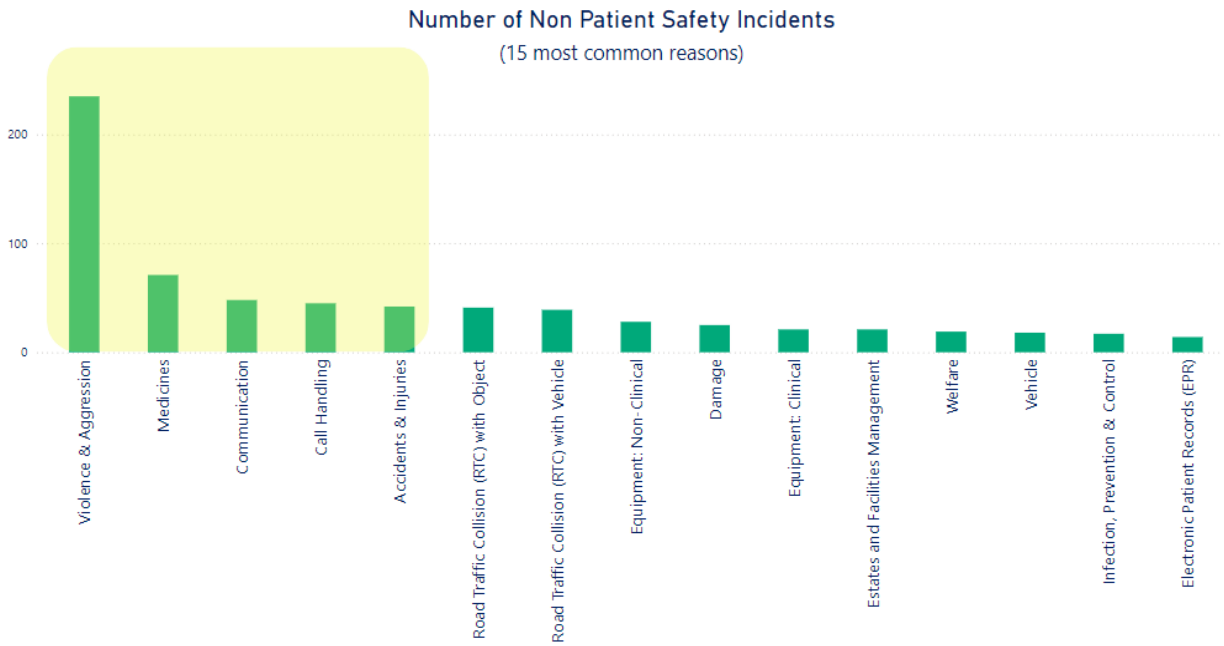
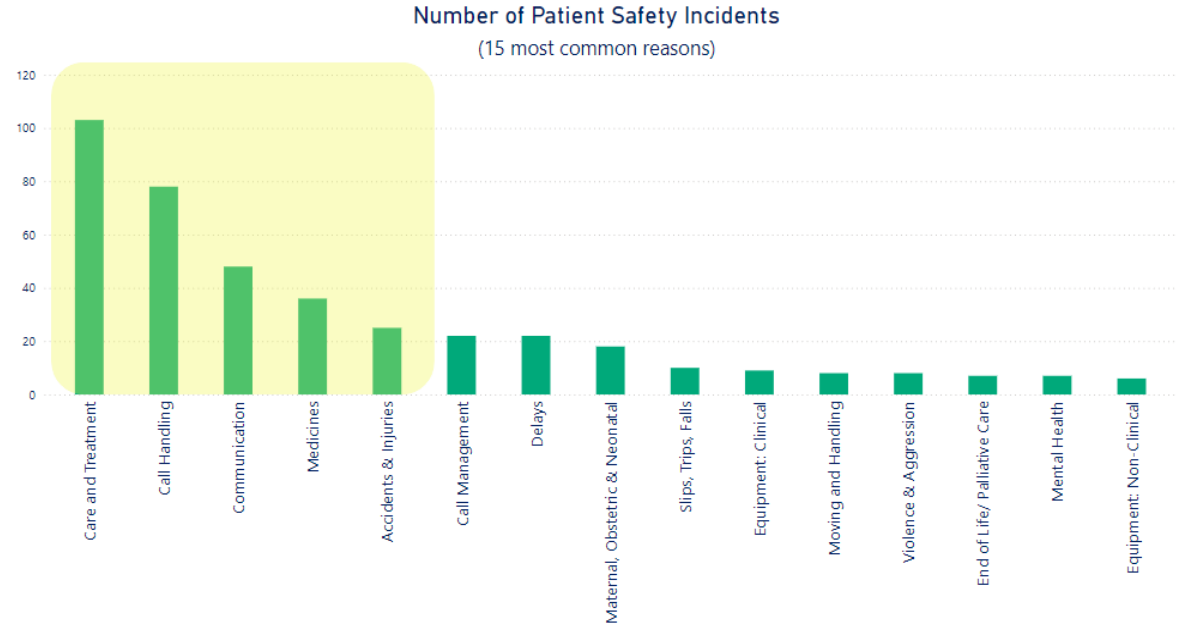
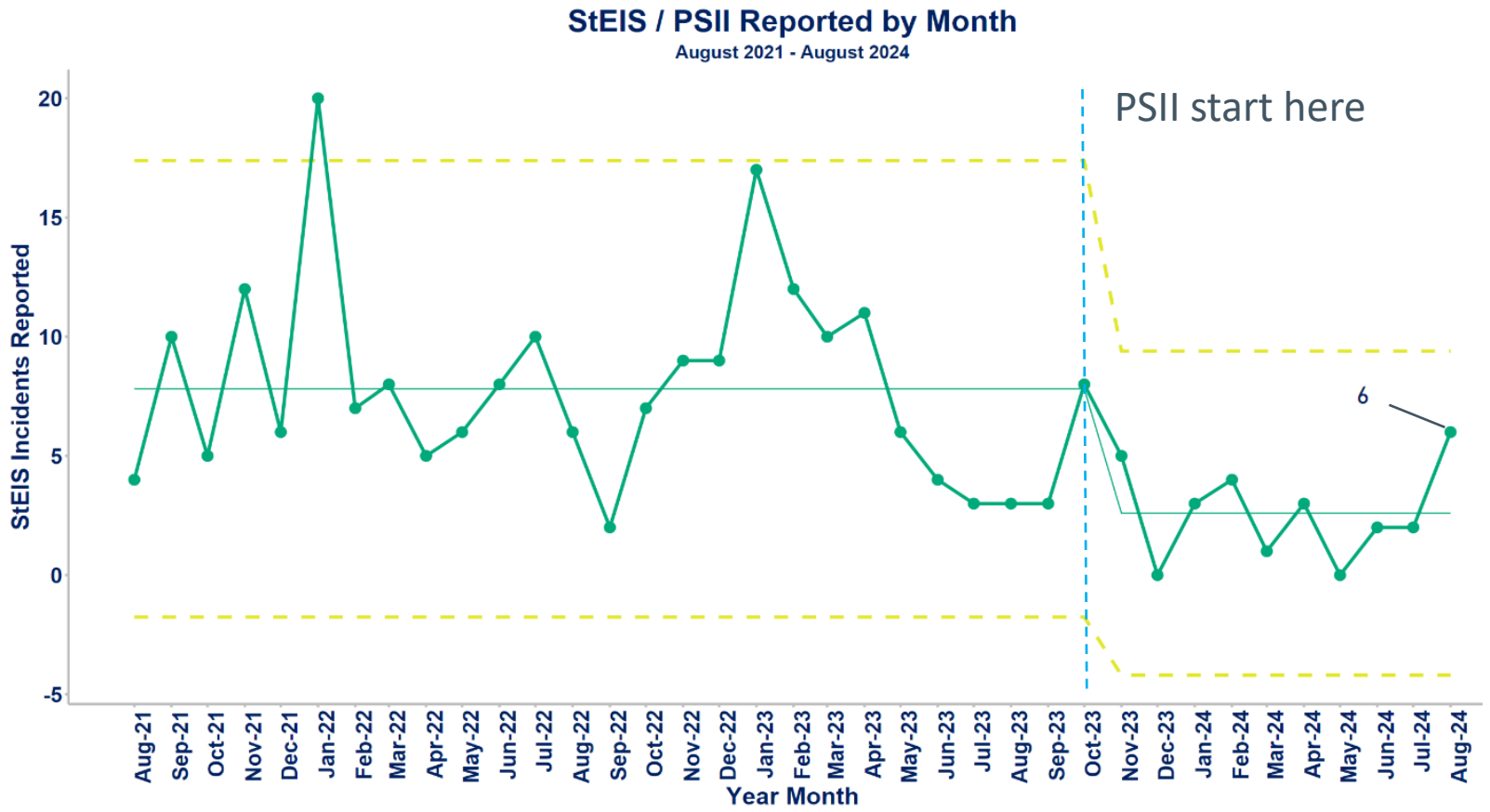


Figure Q2.3



Q3 Patient Safety Incident Investigations (PSII)

Figure Q3.1



Q5 SAFETY ALERTS

Table Q5.1

Safety Alerts	Alerts Received (Sep 23 – Aug 24)	Alerts Applicable (Sep 23 - Aug 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	
National Patient Safety Alert: DHSC	14	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	0	0	0	
CMO Messaging	3	0	0	
National Patient Safety Alert: MHRA	2	0	0	- 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	52	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

BAF

Figure E1.1

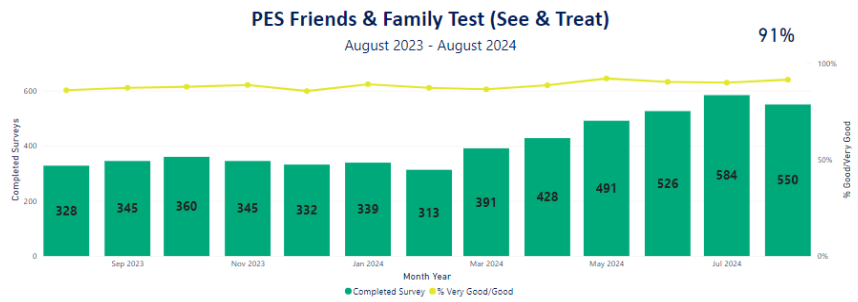
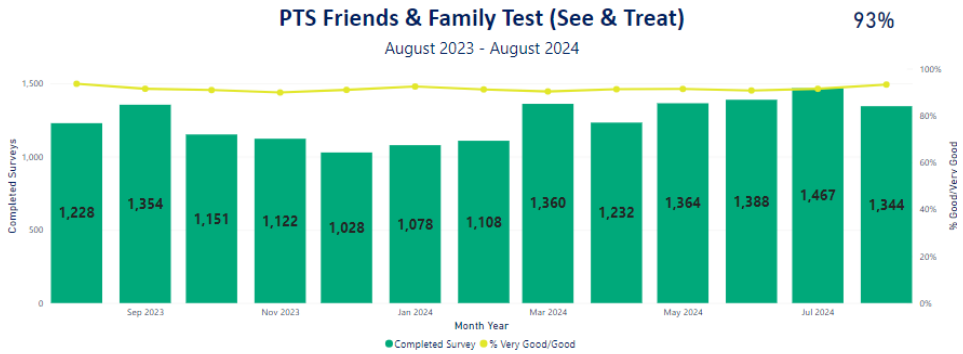


Figure E1.2



PES Positive

- *"They are, compassionate, non-judgemental, respectful, knowledgeable, explain what they are doing and why. Always assessing a person's needs and respond appropriately."*
- *"Both of the staff who attended were very professional and kind. Explained everything they did and the reason why. Very respectful to the person they visited a 93 year old."*
- *"Very knowledgeable, supportive, understanding and went above and beyond to ensure my husband's safety whilst respecting his wishes. Excellent service thank you."*

PES Negative

- *"They didn't know how to deal with mental health without being abusive , in the wrong job."*
- *"The staff didn't have a clue about mental health and treat my daughter like she was a naughty child rather than in crisis even asked why I called them."*
- *"Because waited nearly 8 hours for ambulance and then waited 24 hours in back of ambulance at A&E."*

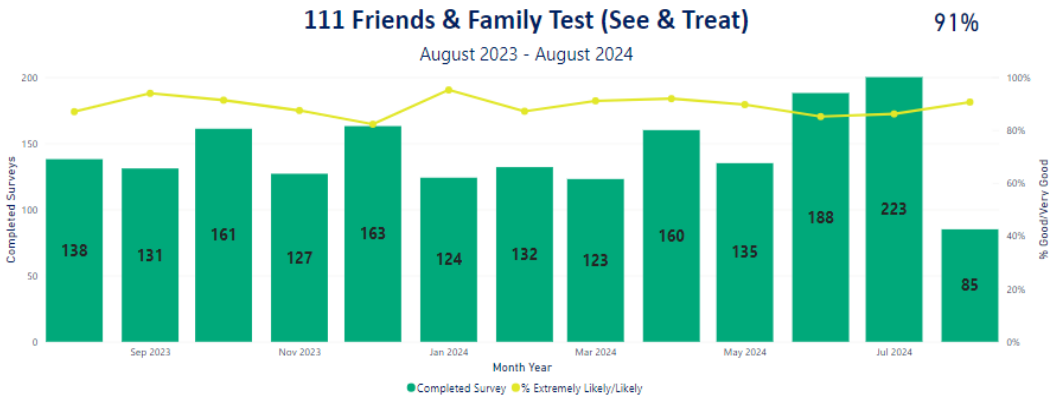
PTS Positive

- *"My Mum travels to and from dialysis by ambulance 3 times a week. She is 86 and quite frail and can get a bit confused. All of the ambulance crew have taken the time to get to know her well and they are all so kind, caring and professional in their dealings with her. They have a chat and a joke with her and she loves them all."*
- *"I am blind and 86 and your ambulance staff the most caring considerate helpful friendly people I have ever met. Nothing is too much trouble. I need every kind of help with mobility as I have no sight and they are brilliant at looking after me and keeping me safe. I have no fear of going to hospital now in their loving caring hands. They're excellent care each time cannot be improved on they are the best. Thank you."*

PTS Negative

- *"Patient was ready to come home at 3.30 after day surgery. Had to wait until 7pm for the ambulance to collect her. She is 92 years old and frail. By the time she got home she was in pain from the surgery, very tired and hungry."*
- *"The return ambulance people made my daughter walk to the ambulance and into the ambulance and out of the ambulance even though we told them my daughter was not weight baring as did the nursing staff. We asked for a wheelchair but they only got one out after my daughter struggled to get down the steps. They put her into a wheelchair to go up my drive. . She has a broken in two places of her ankle . The morning ambulance people were lovely. But the afternoon people*

Figure E1.3



NHS 111 Positive

- *"111 knew my husband needed help. They took control of his problem. They got an ambulance to take my husband to Urgent Care Centre, he was treated straight away, on monitors, admitted to hospital. I can't thank 111 enough, as I was panicking. They knew the situation and responded. Ambulance service, 111, all amazing. If it wasn't for 111, my husband would not be alive today. They took complete control and responded by saving my husband's life. We are eternally grateful."*
- *"I was away and my child developed a rash over his whole body. A doctor called asked for photos then gave advice. It was a great service as the rash looked awful but the doctor was very thorough and reassuring."*
- *"Immediate attention. 100%. Perfect care and understanding when I was in such pain. I am sole carer for husband and had to refuse hospital suggestion. Thank you for a fantastic service! Thank God I had you to turn to on that night."*

NHS 111 Negative

- *"I asked NHS 111 a question, the person at 111 said they were not medically qualified and put me through to my local chemist, who said it would probably be alright but advised me to ring the doctor. So I was back where I started when I rang the doctor and the receptionist said he was busy, and to ring NHS 111."*
- *"The amount of time wasted by the advisor asking questions which did not apply to my situation. I had a bad gash to my right leg calf which was bleeding badly and I had lost min of 750 ml of blood. As a double lung transplant patient I needed to get to A&E as soon as possible. All I wanted was the advisor to book me into A&E as my wife would drive me there."*
- *"My medical problem involved both my head and eye. The 111 operative would only accept one or the other, so that she could direct me to the 'right' place (walk in for migraine). I had shingles in my eye and head. My condition ended up being quite severe, it could have been diagnosed sooner."*

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

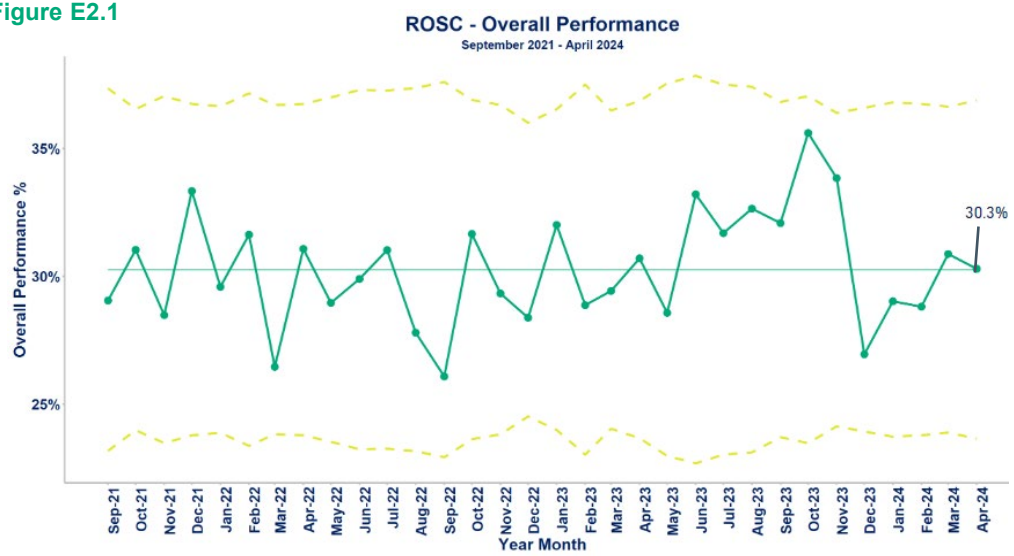


Figure E2.2

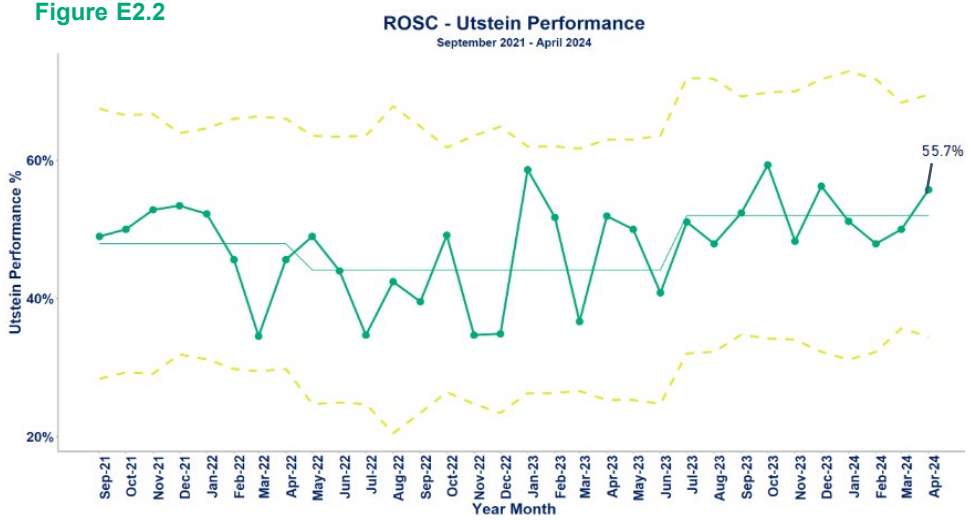


Table E2.3

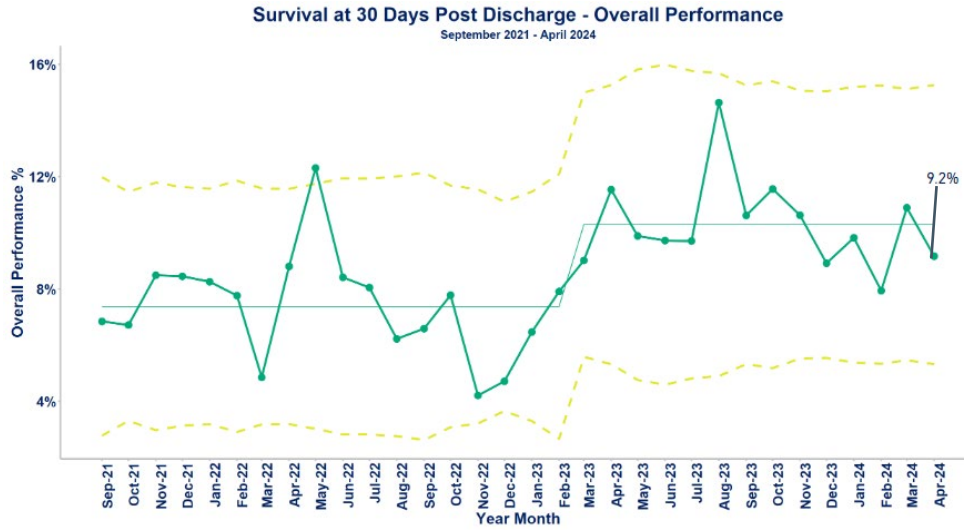


Figure E2.4

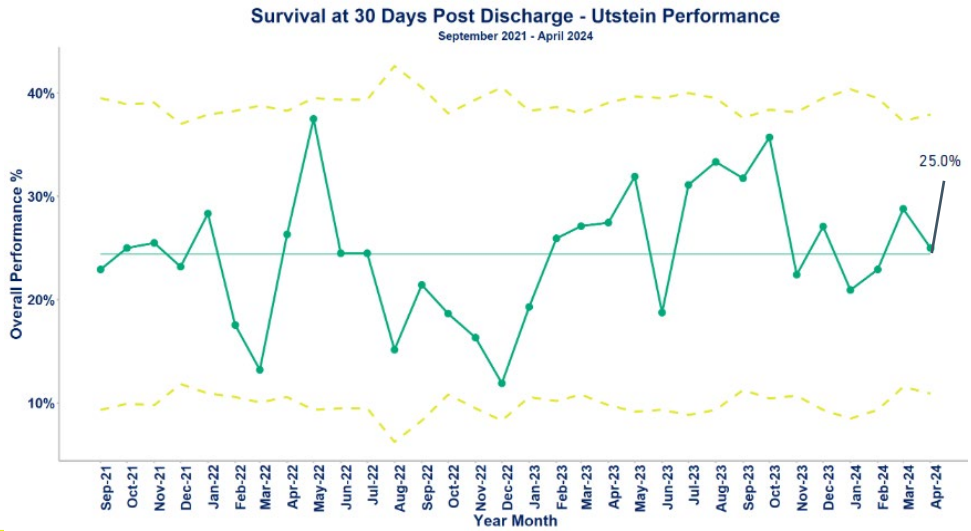


Figure E2.5

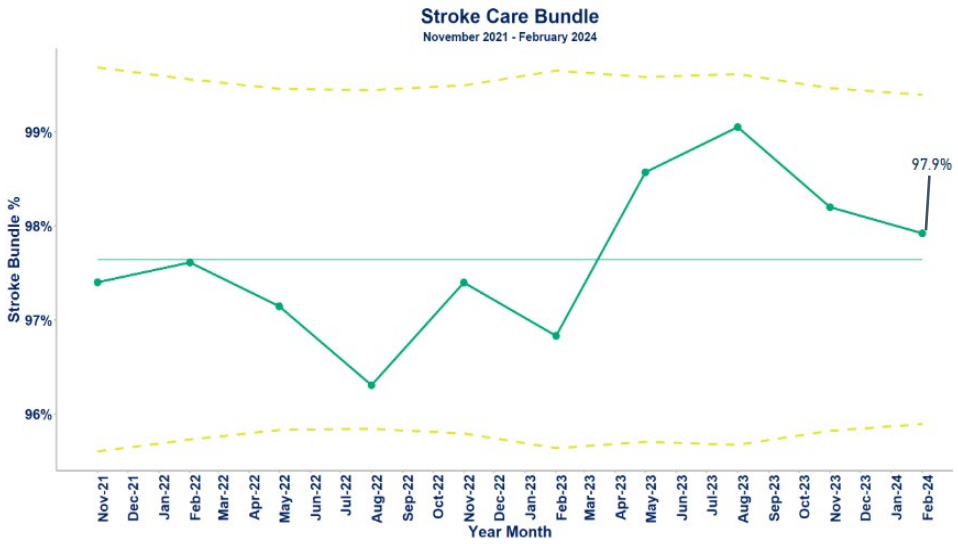


Figure E2.6

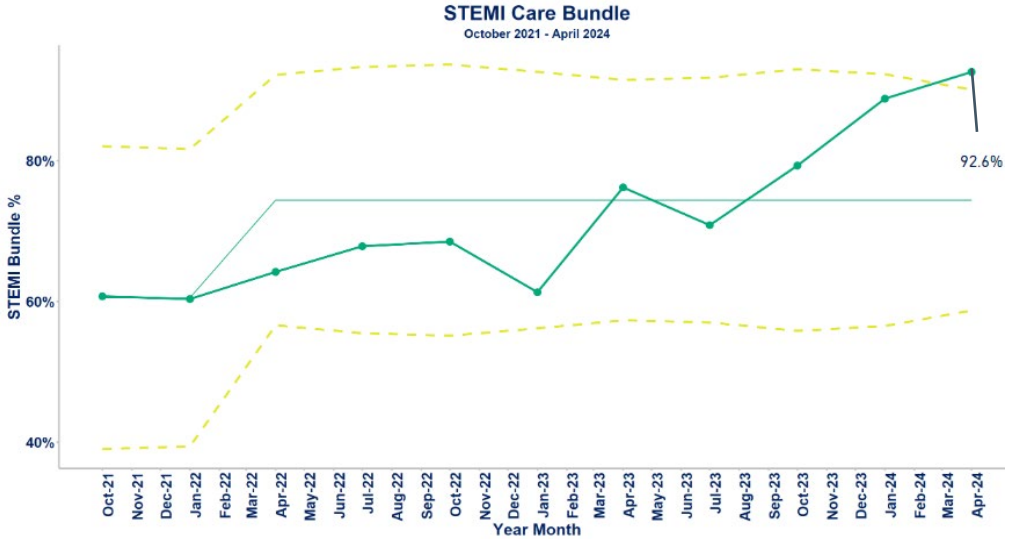


Figure E2.7

Month Year	STROKE Care Bundle %
Nov 2021	97.4%
Feb 2022	97.6%
May 2022	97.1%
Aug 2022	96.3%
Nov 2022	97.4%
Feb 2023	96.8%
May 2023	98.6%
Aug 2023	99.1%
Nov 2023	98.2%
Feb 2024	97.9%

Figure E2.8

Month Year	STEMI Care Bundle Performance
Oct 2021	60.7%
Jan 2022	60.4%
Apr 2022	64.2%
Jul 2022	67.9%
Oct 2022	68.5%
Jan 2023	61.3%
Apr 2023	76.2%
Jul 2023	70.9%
Oct 2023	79.3%
Jan 2024	88.8%
Apr 2024	92.6%

E3 ACTIVITY & OUTCOMES

Figure E3.1

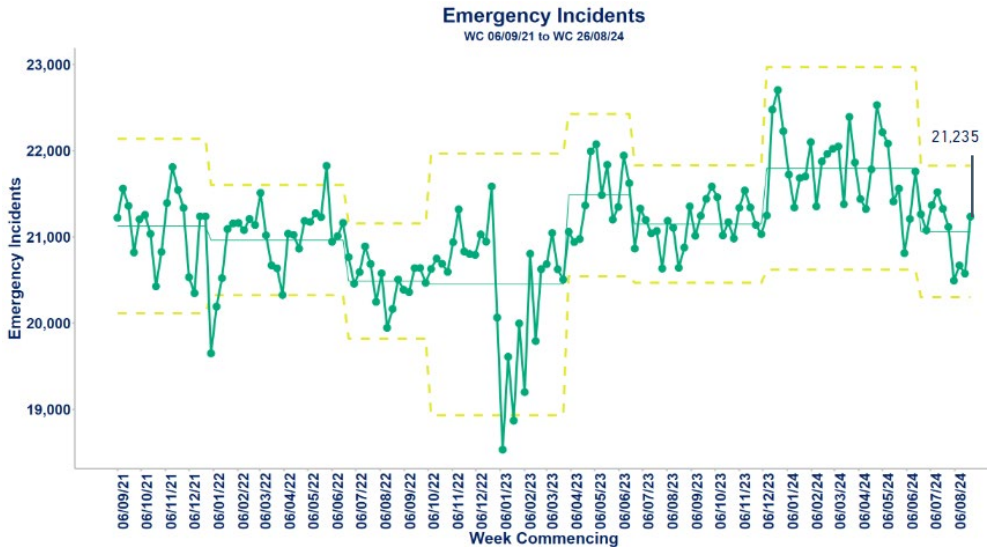


Figure E3.2

Figure E3.3

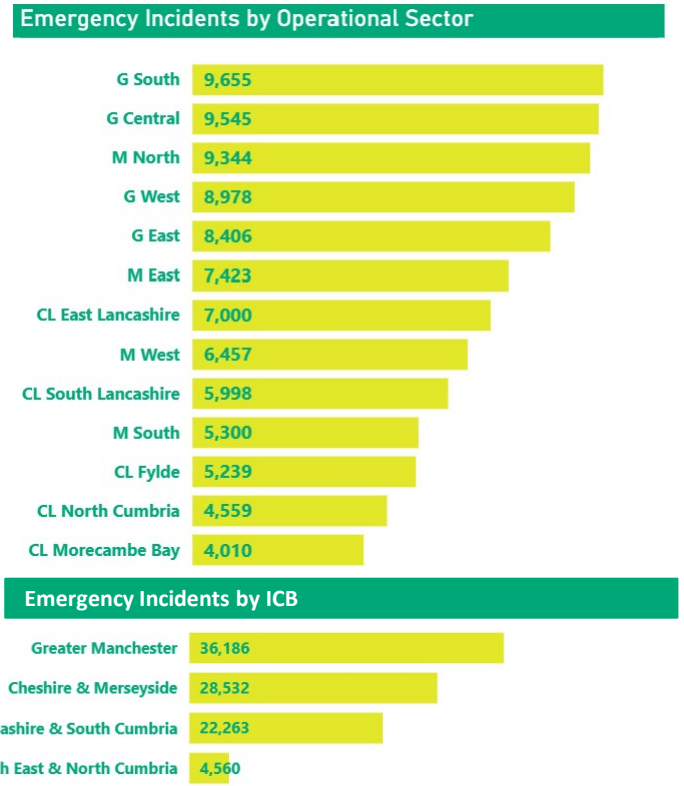


Figure E3.4

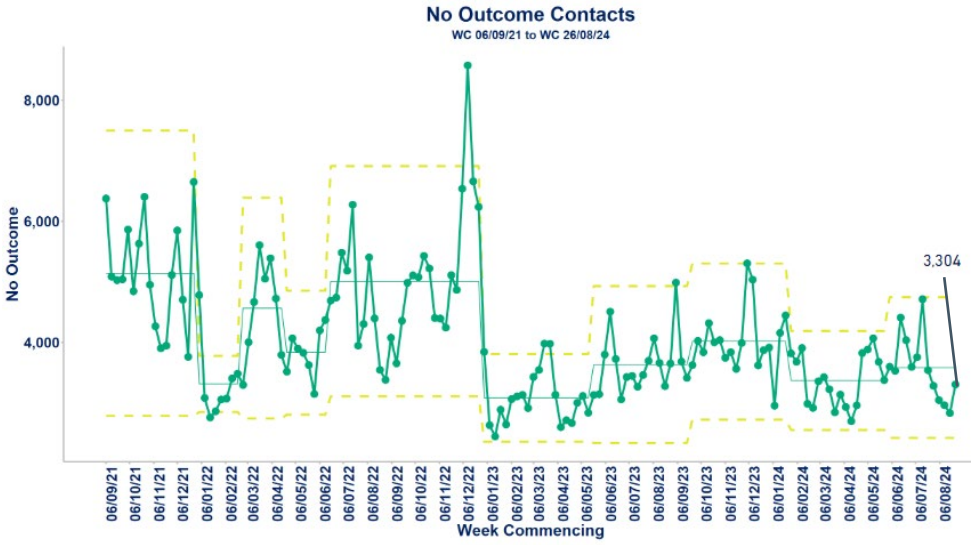


Figure E3.5

Calendar Year	Calls	% Change from Previous Year	Incidents	% Change from Previous Year
2021	141,603	+22.1%	93,369	-2.9%
2022	127,821	-9.7%	89,655	-3.7%
2023	118,713	-6.6%	92,315	+3.1%
2024	110,438	-7.2%	92,000	-0.5%

Figure E3.6

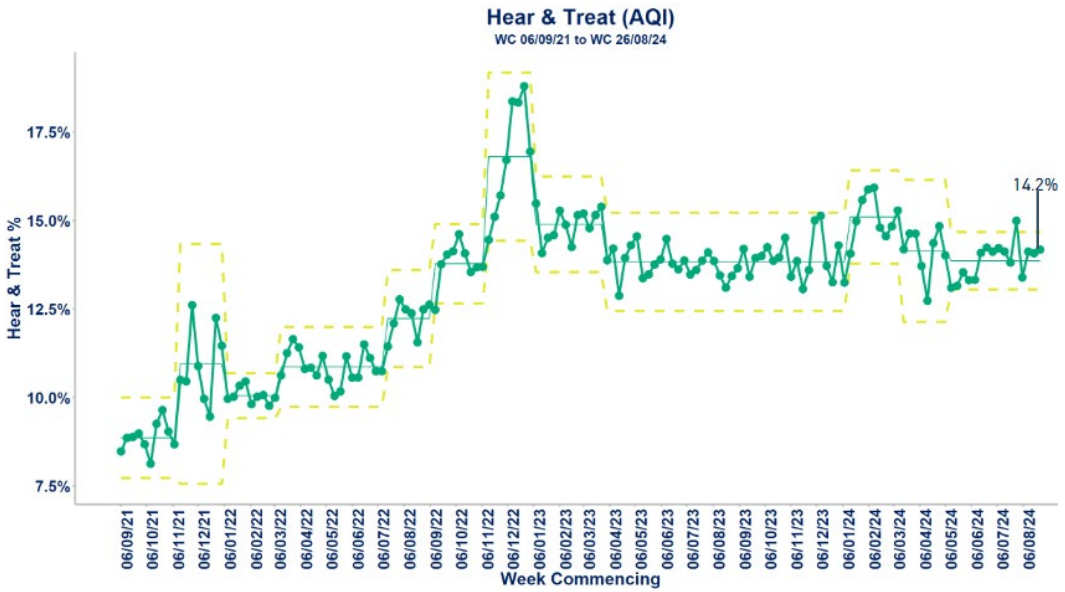


Figure E3.7

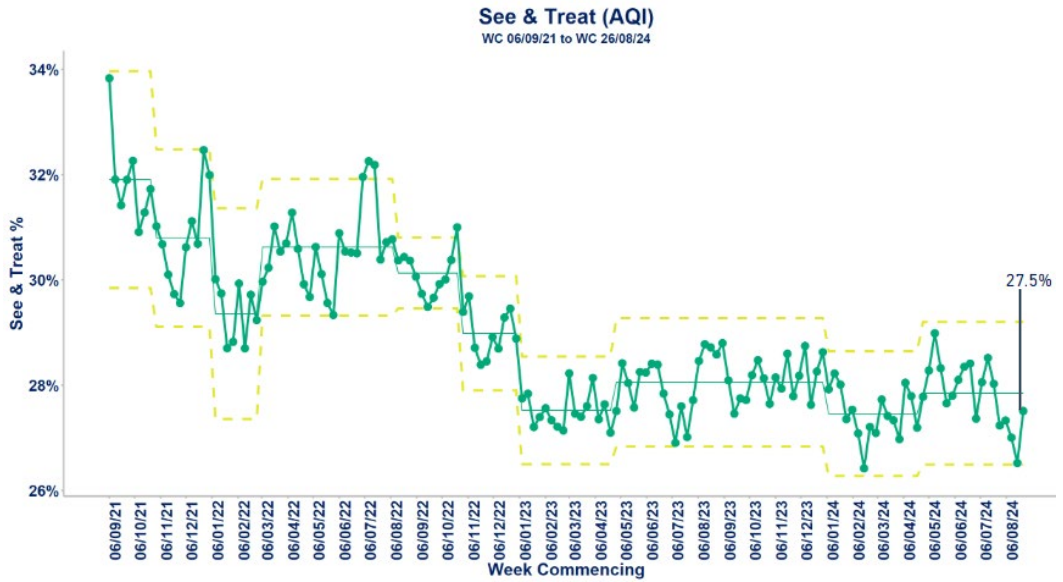


Figure E3.8

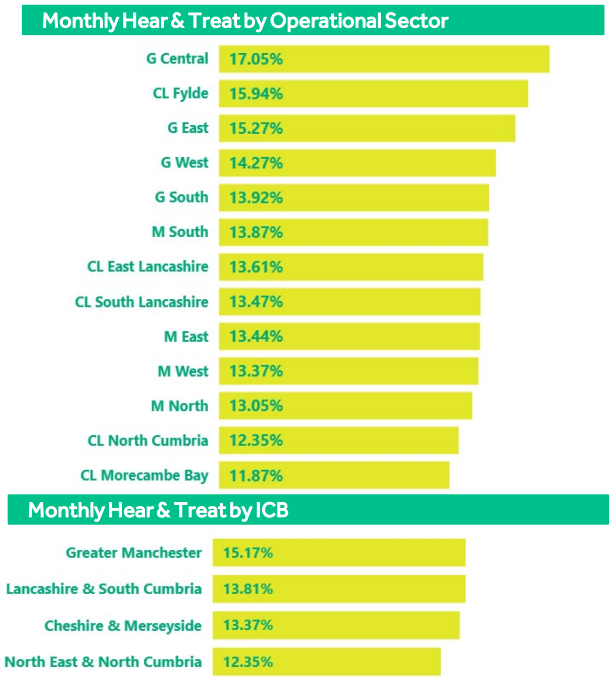


Figure E3.9

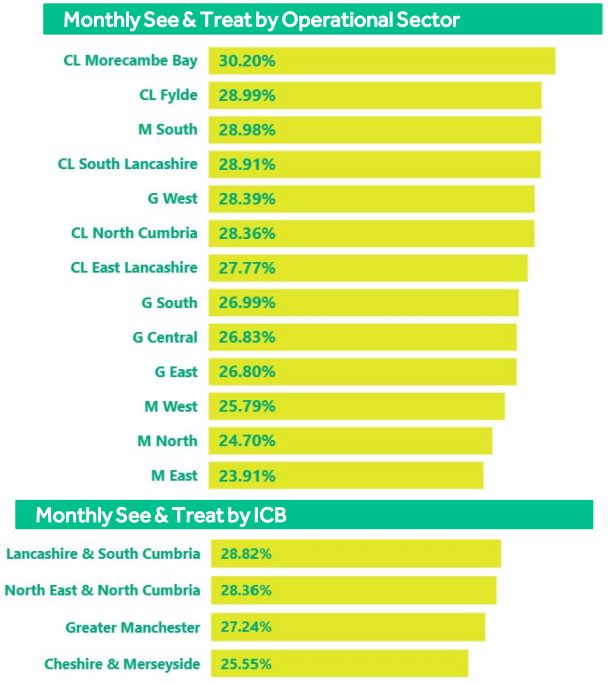


Figure E3.10

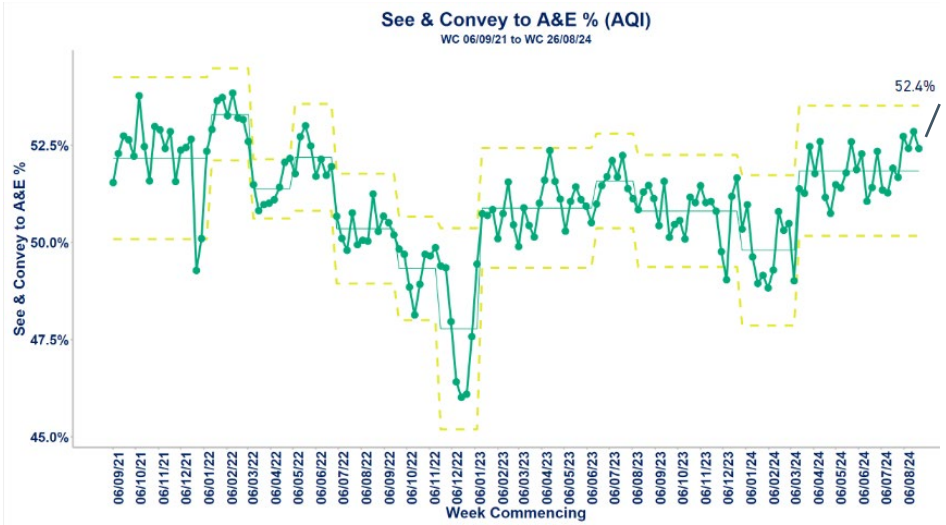


Figure E3.11

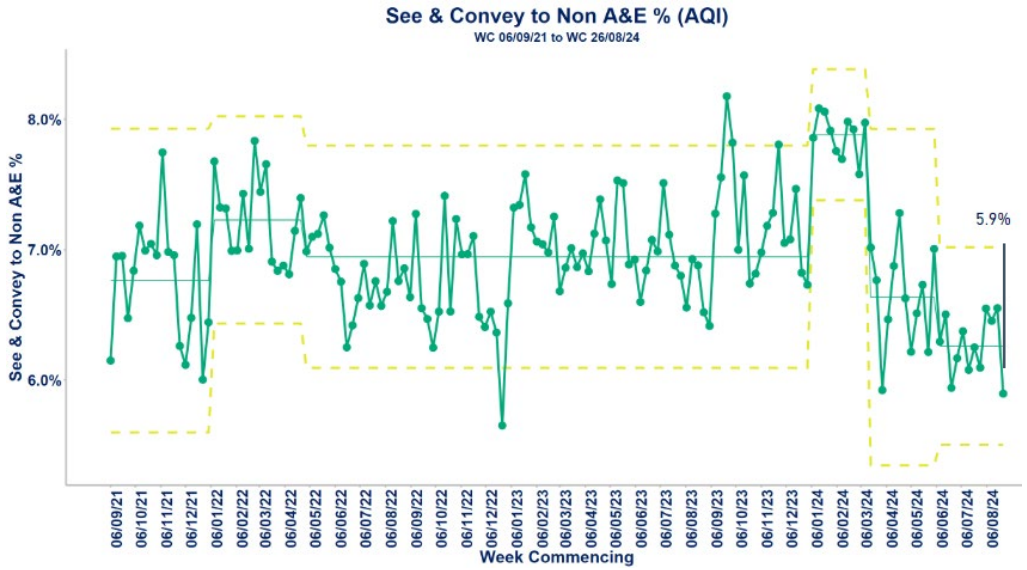
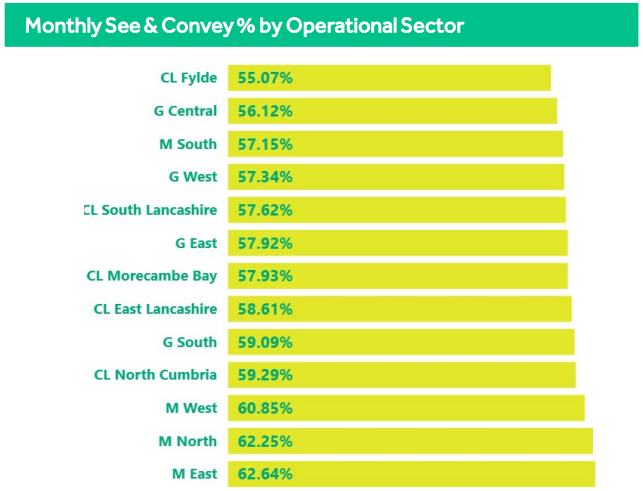


Figure E3.12



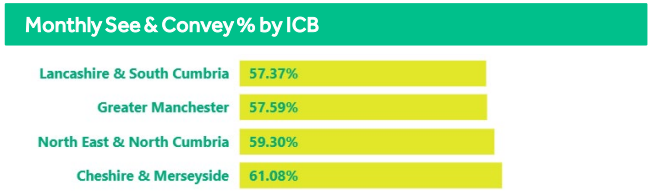
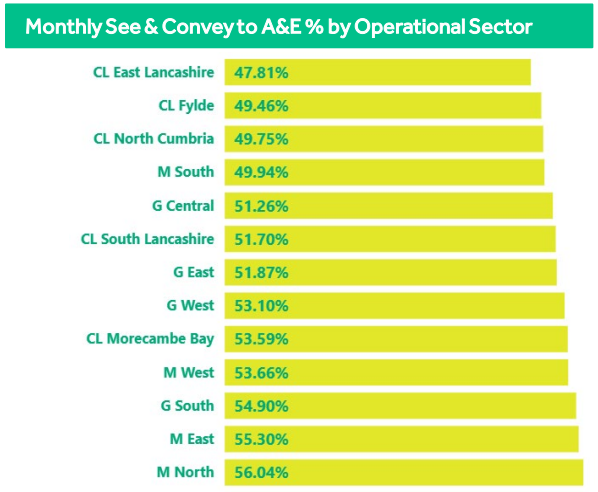


Figure E3.13



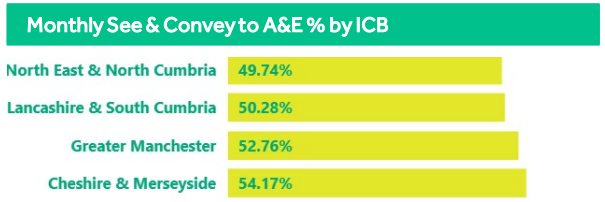
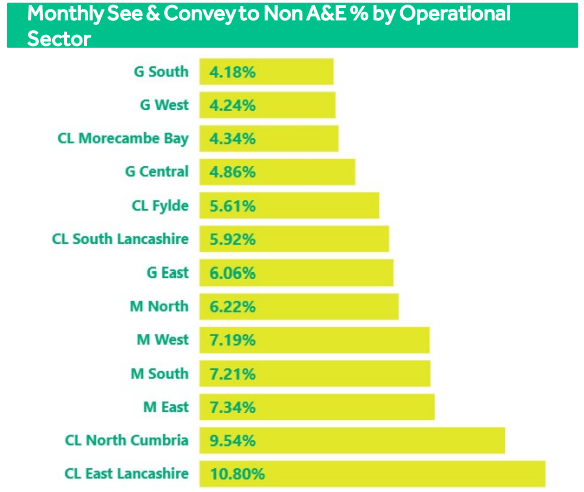


Figure E3.14



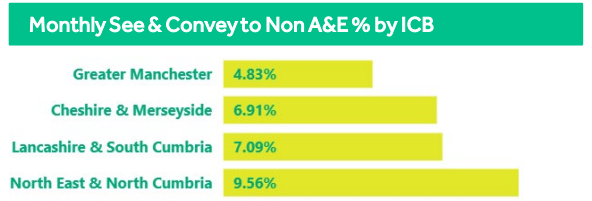


Figure E3.15

Rank	Trust	Hear & Treat	%
1	West Midlands		19.4%
2	London		19.0%
3	East Midlands		16.9%
4	Yorkshire		15.2%
5	North West		14.1%
6	South East Coast		13.9%
7	South Western		13.7%
8	South Central		12.7%
9	East of England		9.7%
10	Isle of Wight		6.4%
11	North East		6.2%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		36.6%
2	East of England		34.2%
3	Isle of Wight		32.9%
4	South Central		32.5%
5	South East Coast		30.9%
6	North East		30.2%
7	East Midlands		28.6%
8	London		27.1%
9	North West		27.1%
10	West Midlands		26.3%
11	Yorkshire		25.4%

Figure E3.17

Rank	Trust	See & Convey	%
1	South Western		49.6%
2	London		53.9%
3	West Midlands		54.4%
4	East Midlands		54.5%
5	South Central		54.9%
6	South East Coast		55.2%
7	East of England		56.1%
8	North West		58.7%
9	Yorkshire		59.4%
10	Isle of Wight		60.7%
11	North East		63.6%

Figure E3.18

Rank	Trust	See & Convey Non AE	%
1	North East		7.9%
2	East Midlands		6.8%
3	Yorkshire		6.5%
4	North West		6.3%
5	West Midlands		6.3%
6	South Western		4.3%
7	South Central		3.5%
8	East of England		3.1%
9	London		2.6%
10	South East Coast		2.0%
11	Isle of Wight		0.9%

Operational

O1 CALL PICK UP

Figure O1.1

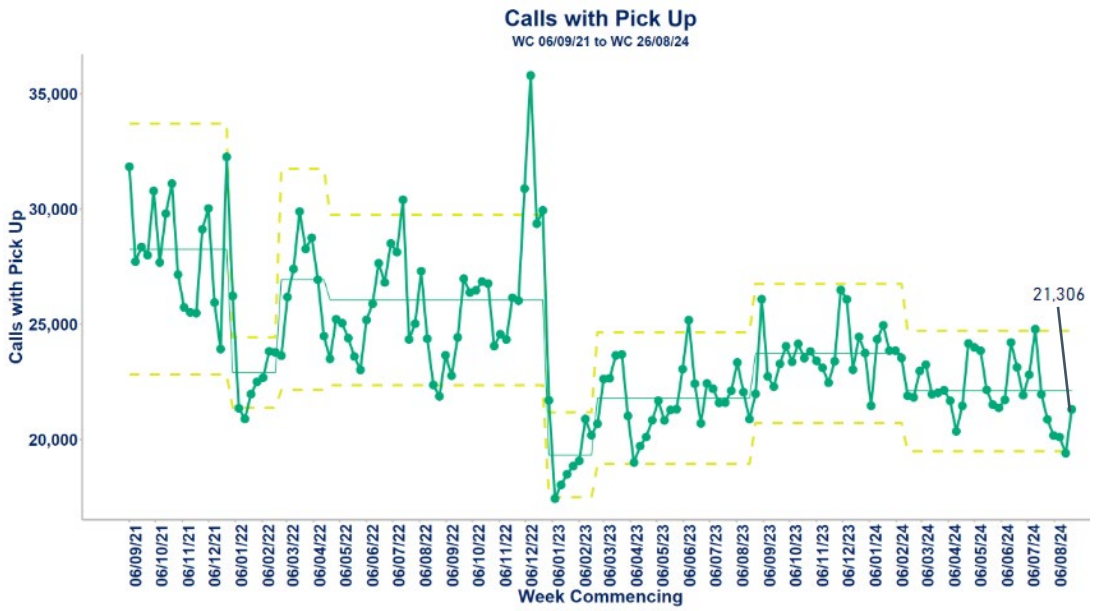


Figure O1.2

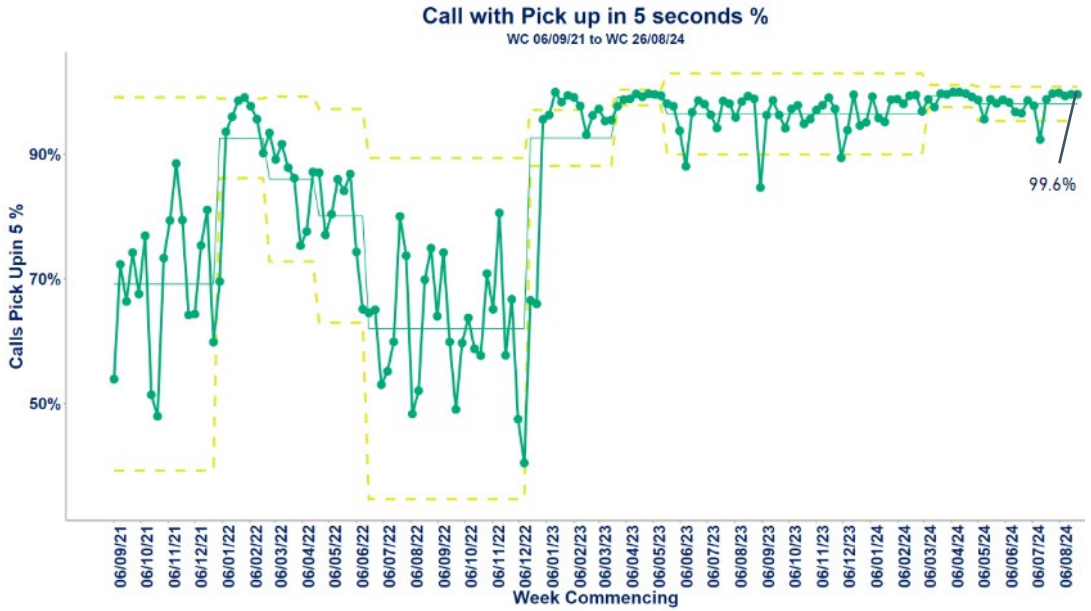


Figure O1.3

Call Pick Up Mean	
Aug 2024	0
YTD	1
Ranking	1st

Figure O1.4

Call Pick Up 90th Percentile	
Aug 2024	0
YTD	0
Ranking	1st

Figure O1.5

Call Pick Up 95th Percentile	
Aug 2024	0
YTD	0
Ranking	1st

O3 ARP RESPONSE TIMES

BAF

August 2024

Figure O3.1

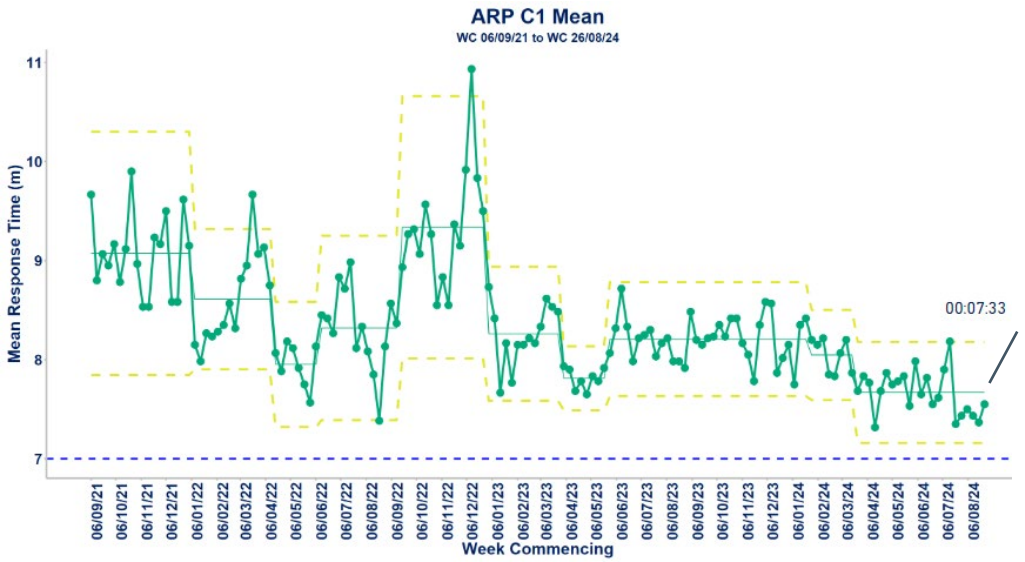


Figure O3.2

C1 Mean (Red =>7min)

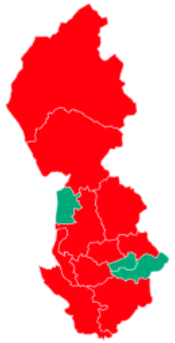


Figure O3.3

Figure O3.4

C1 Mean	
Target	7:00
Aug 2024	7:29
YTD	7:41
Ranking	3rd

Figure O3.5

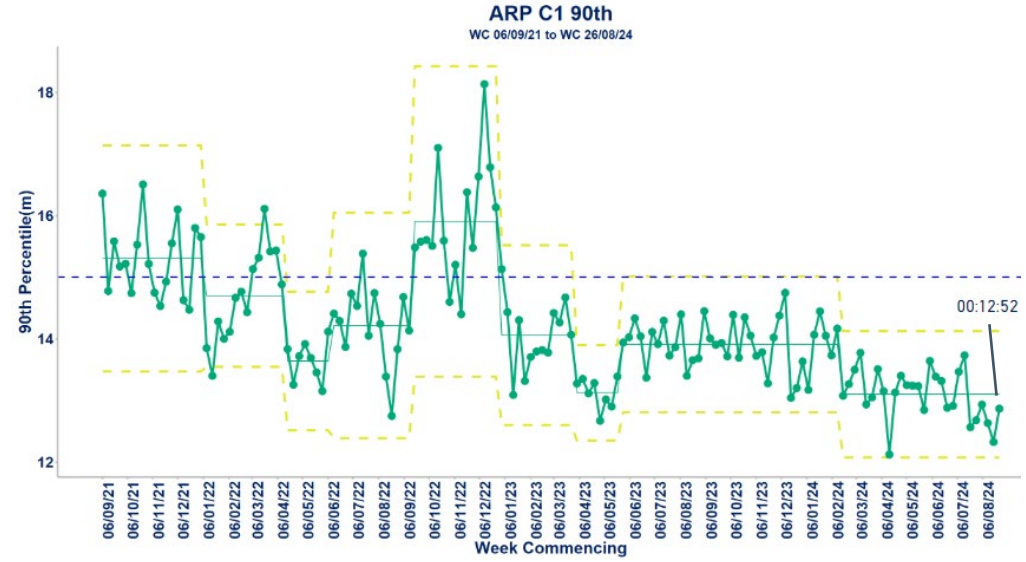


Figure O3.6

C1 90th (Red =>15m)

Figure O3.7

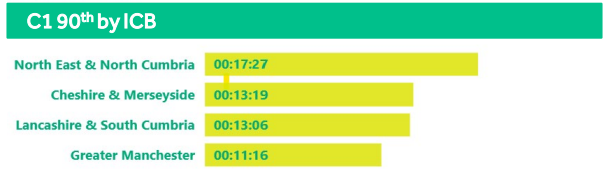


Figure O3.8

C1 90th	
Target	15:00
Aug 2024	12:47
YTD	13:05
Ranking	3rd

August 2024

Figure O3.9

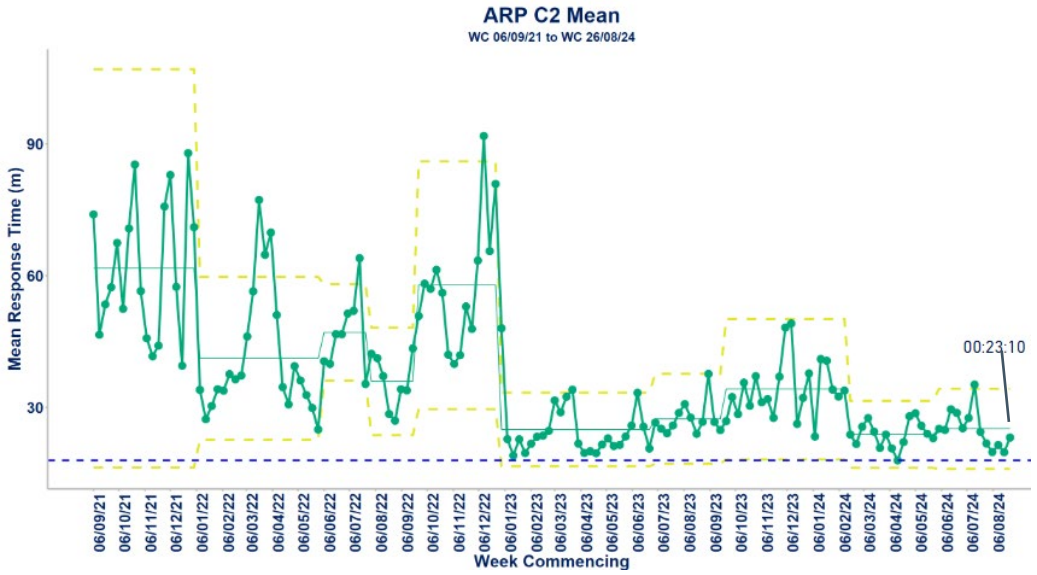


Figure O3.10

C2 Mean (Red =>18m)

Figure O3.11

C2 Mean by Operational Sector

C2 Mean by ICB

Figure O3.12

C2 Mean	
Target	18:00
Aug 2024	21:03
YTD	24:44
Ranking	2nd

Figure O3.13

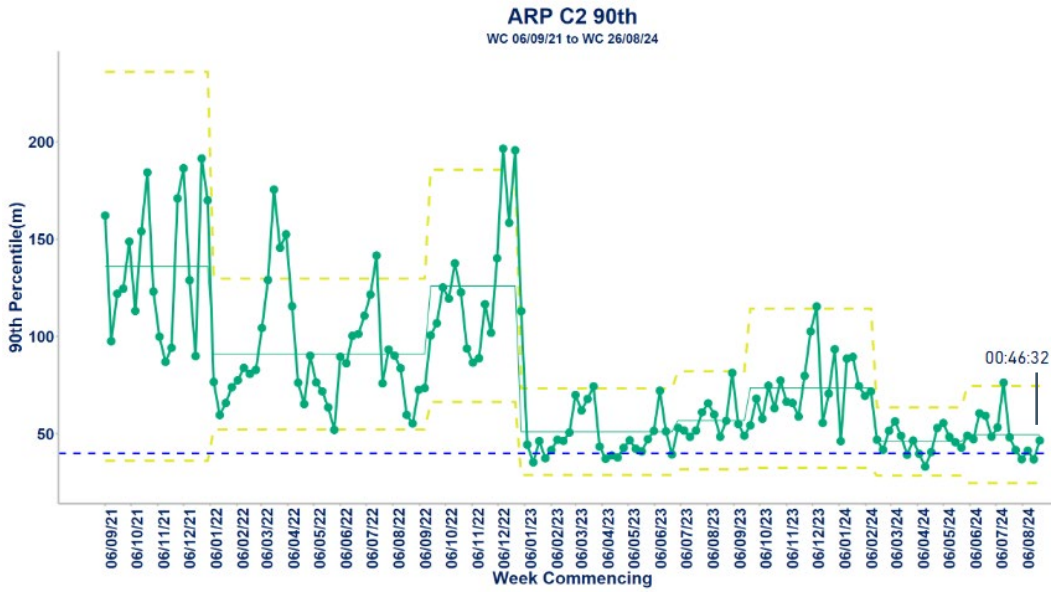
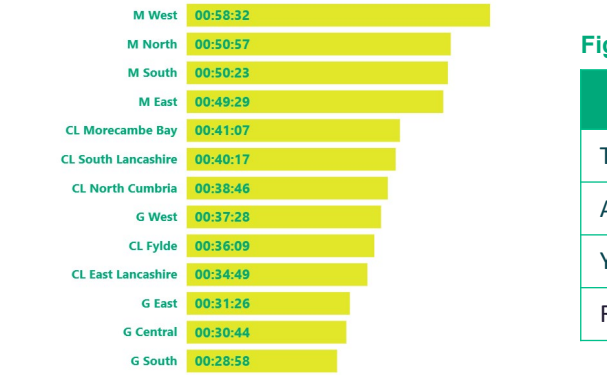


Figure O3.14

C2 90th (Red =>40m)

Figure O3.15

C2 90th by Operational Sector



C2 90th by ICB

Figure O3.16

C2 90th	
Target	40:00
Aug 2024	40.08
YTD	48:00
Ranking	2nd

August 2024

Figure O3.17

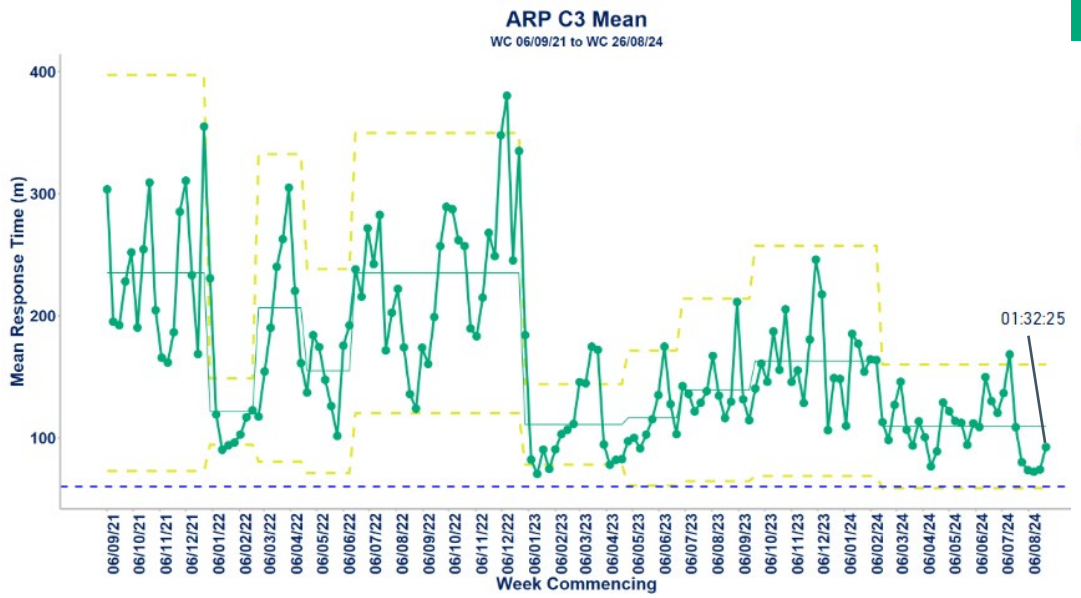


Figure O3.18

C3 Mean (Red =>60min)

Figure O3.19

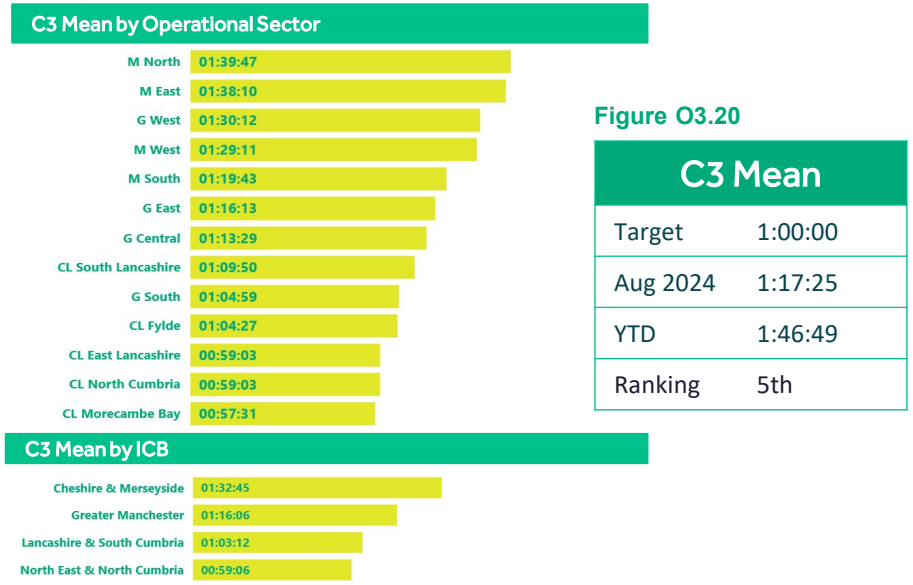


Figure O3.20

C3 Mean	
Target	1:00:00
Aug 2024	1:17:25
YTD	1:46:49
Ranking	5th

Figure O3.21

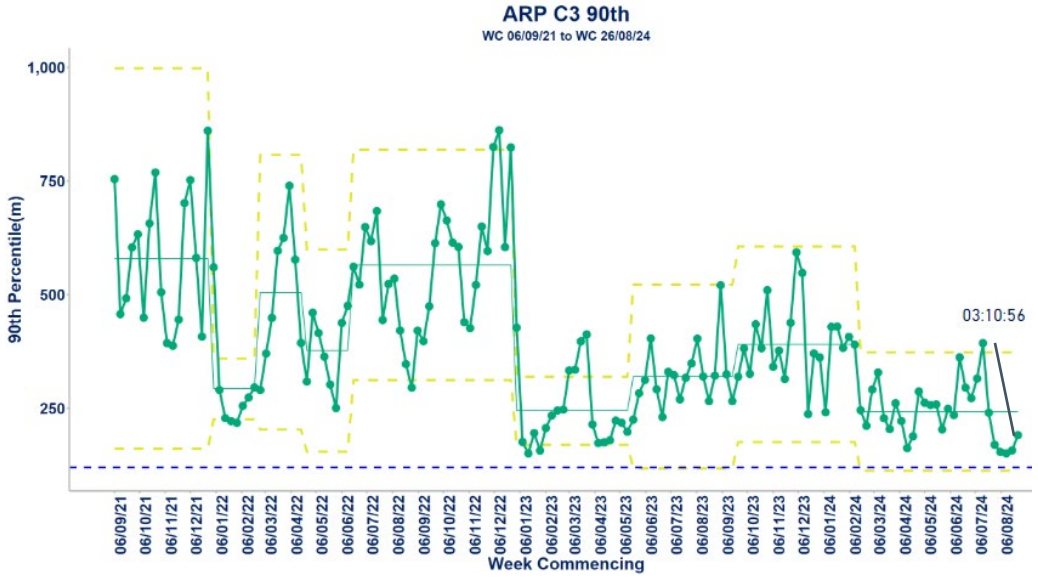


Figure O3.22

C3 90th (Red =>2h)

Figure O3.23

Figure O3.24

C3 90th	
Target	2:00:00
Aug 2024	2:41:49
YTD	3:59:36
Ranking	3rd

August 2024

Figure O3.25

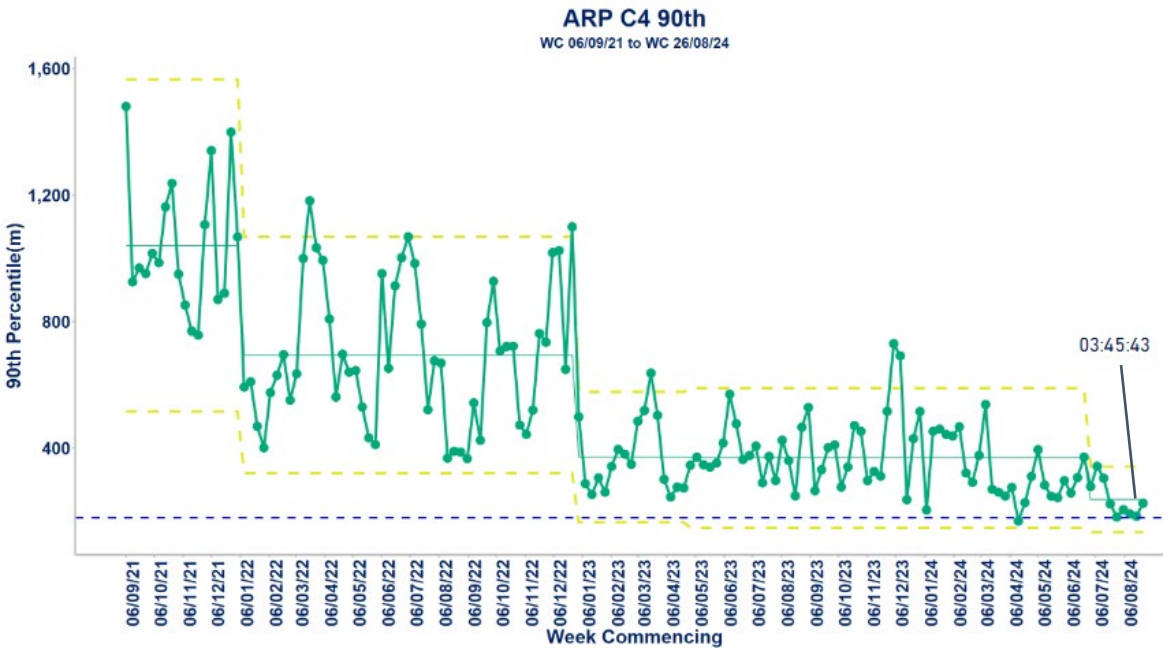


Figure O3.26

Figure O3.27

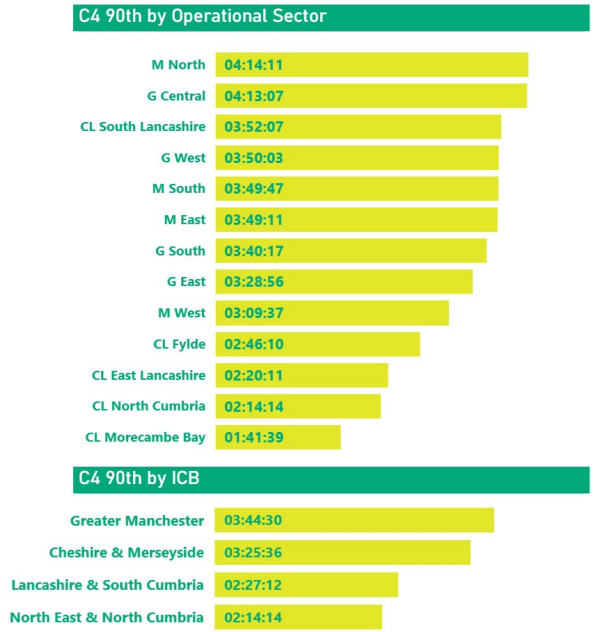


Figure O3.28

C4 90th	
Target	3:00:00
Aug 2024	3:16:08
YTD	4:15:29
Ranking	4th

O3 ARP Provider Comparison

Figure O3.25

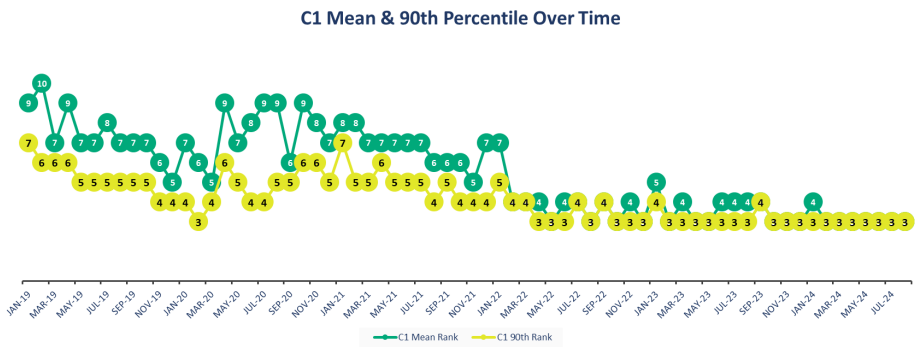


Figure O3.26

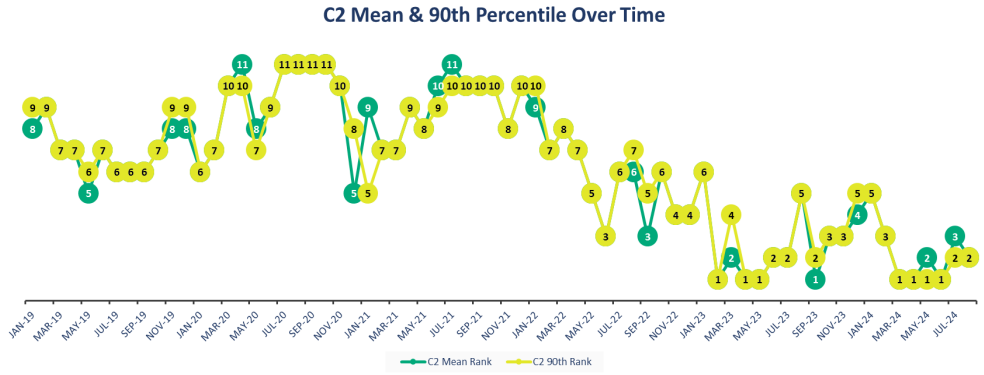


Figure O3.27

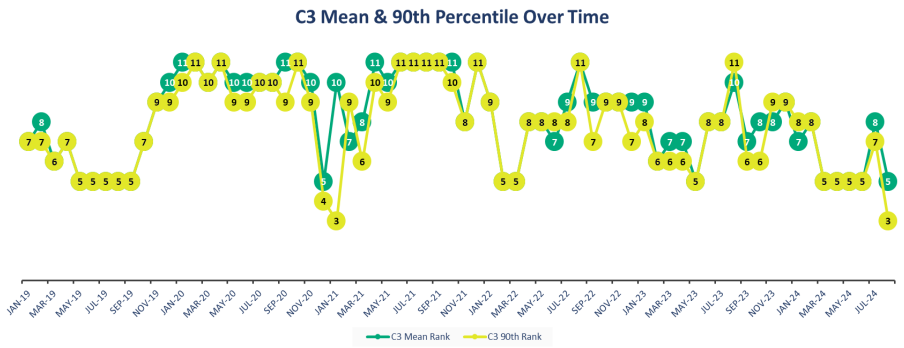
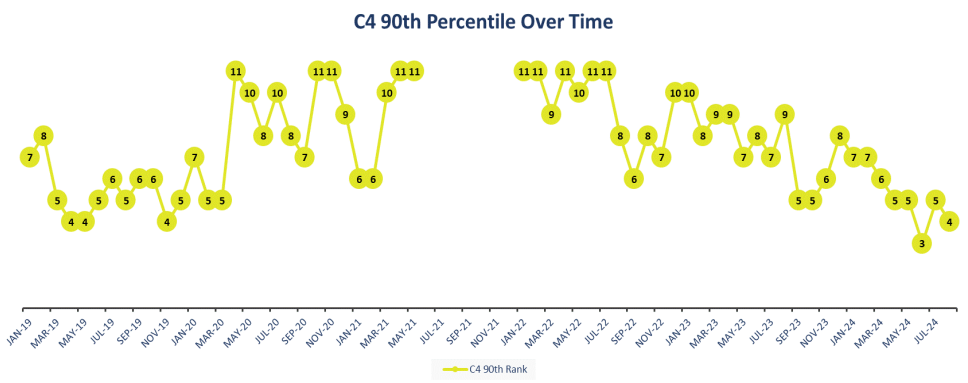


Figure O3.28



Rank	Trust	C1 Mean	Time
1	North East		06:27
2	London		07:00
3	North West		07:29
4	Yorkshire		07:44
5	West Midlands		07:56
6	South East Coast		08:19
7	East of England		08:40
8	East Midlands		08:46
9	South Central		08:53
10	Isle of Wight		09:11
11	South Western		09:38

Rank	Trust	C1 90th	Time
1	North East		11:23
2	London		11:54
3	North West		12:47
4	Yorkshire		13:30
5	West Midlands		14:09
6	East Midlands		15:26
7	South East Coast		15:31
8	South Central		15:58
9	East of England		16:24
10	Isle of Wight		16:29
11	South Western		18:23

Rank	Trust	C2 Mean	Time
1	West Midlands		0:18:36
2	North West		0:21:03
3	North East		0:22:01
4	South East Coast		0:26:11
5	Isle of Wight		0:26:38
6	Yorkshire		0:26:39
7	South Central		0:30:18
8	East Midlands		0:30:34
9	London		0:30:53
10	South Western		0:32:29
11	East of England		0:33:38

Rank	Trust	C2 90th	Time
1	West Midlands		0:37:42
2	North West		0:40:08
3	North East		0:44:57
4	South East Coast		0:55:17
5	Isle of Wight		0:55:39
6	Yorkshire		0:58:02
7	South Central		1:00:51
8	East Midlands		1:04:47
9	London		1:06:27
10	South Western		1:08:10
11	East of England		1:12:23

Rank	Trust	C3 Mean	Time
1	North East		00:47:42
2	London		01:06:15
3	West Midlands		01:09:56
4	Yorkshire		01:16:22
5	North West		01:17:20
6	South Western		01:20:45
7	South Western		01:22:42
8	East of England		01:45:51
9	East Midlands		01:54:14
10	South East Coast		02:09:17
11	South Central		02:20:24

Rank	Trust	C3 90th	Time
1	North East		01:48:55
2	London		02:29:09
3	North West		02:41:43
4	West Midlands		02:47:25
5	Yorkshire		02:56:25
6	South Western		03:14:01
7	Isle of Wight		03:14:07
8	East of England		04:06:51
9	East Midlands		04:23:20
10	South East Coast		04:49:09
11	South Central		05:17:23

Rank	Trust	C4 90th	Time
1	North East		02:25:22
2	West Midlands		03:07:44
3	South Western		03:14:33
4	North West		03:16:04
5	Yorkshire		03:22:29
6	Isle of Wight		03:38:48
7	East Midlands		03:50:25
8	London		04:24:07
9	South East Coast		05:07:12
10	South Central		05:45:14
11	East of England		06:25:57

O3 LONG WAITS

BAF

Table O3.29

Year Month	Total No. of C1 long waits
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	598
Jul-24	582
Aug-24	450

Figure O3.29

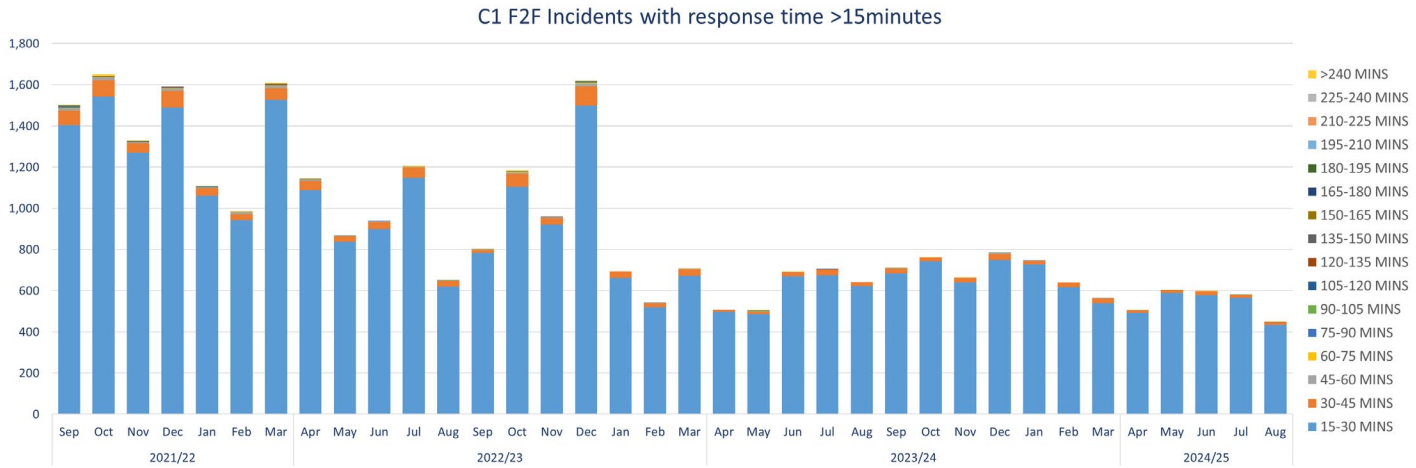


Figure O3.30

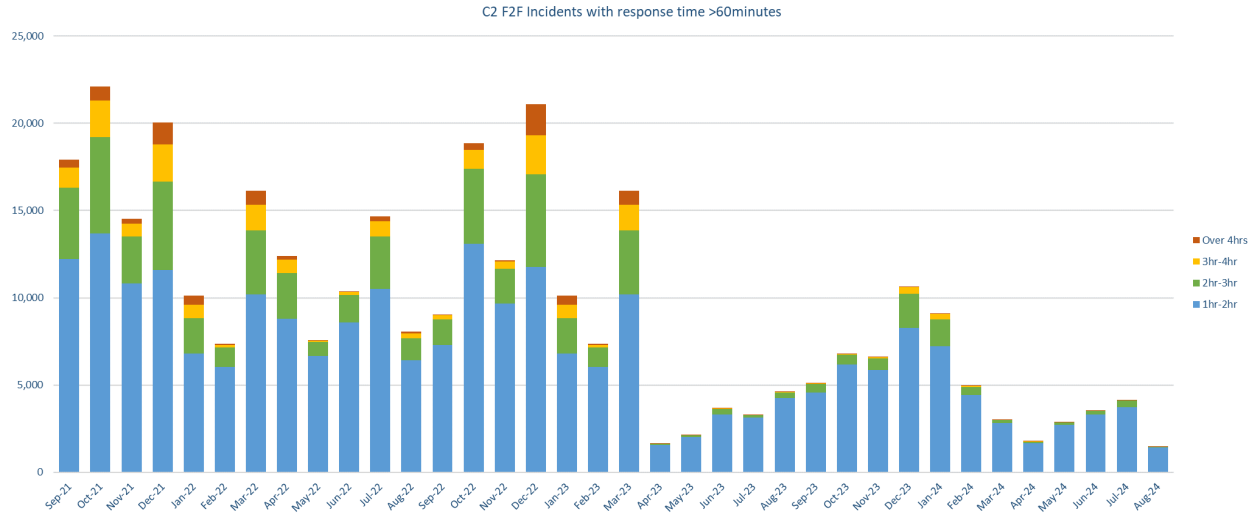


Table O3.30

Year Month	Total No. of C2 long waits
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	4,631
Feb-23	2,048
Mar-23	6,132
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	3,526
Jul-24	4,121
Aug-24	1,473

O3 A&E TURNAROUND

BAF

Figure O3.1

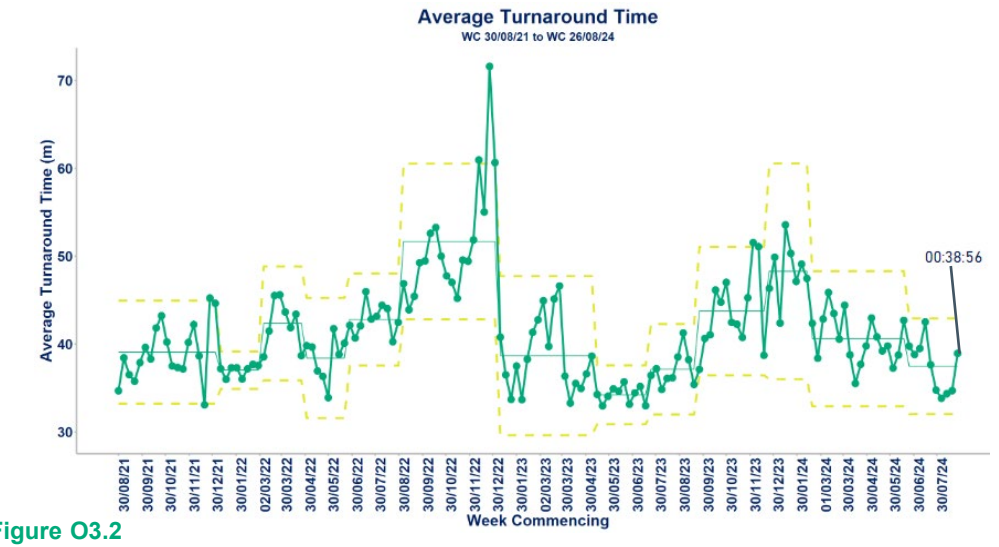


Figure O3.2

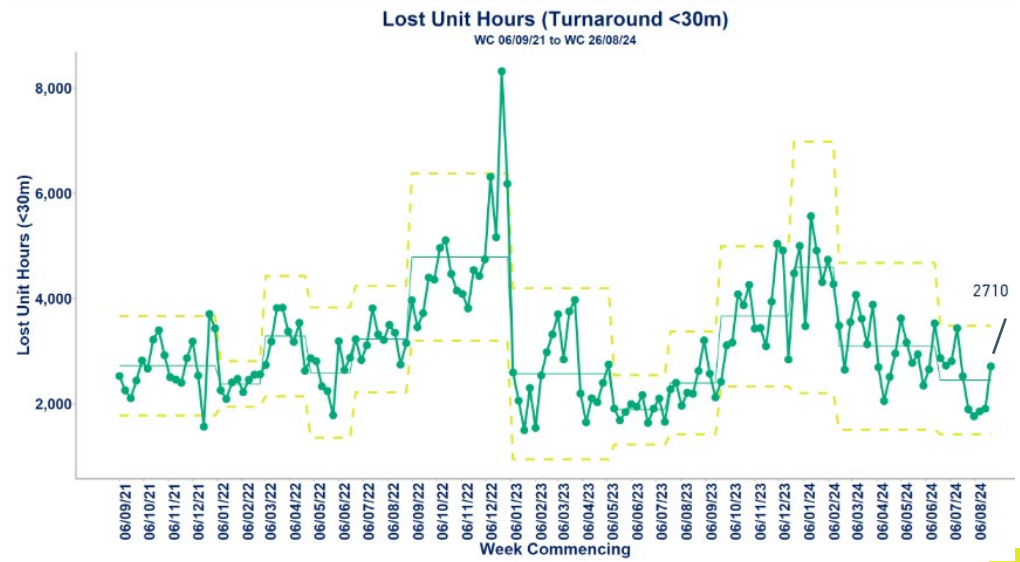


Table O3.1

Month	Hospital Attendances	Average Turnaround Time(hh:mm:ss)	Average Arrival to Handover Time (hh:mm:ss)	Average Handover to Clear Time(hh:mm:ss)
Aug 2023	47,381	00:36:19	00:24:56	00:11:26
Sep 2023	46,290	00:37:52	00:26:18	00:11:24
Oct 2023	47,591	00:43:24	00:32:47	00:11:28
Nov 2023	46,613	00:43:05	00:31:40	00:11:00
Dec 2023	48,751	00:46:25	00:35:22	00:10:59
Jan 2024	47,972	00:49:13	00:38:36	00:11:03
Feb 2024	44,943	00:44:53	00:34:59	00:10:21
Mar 2024	49,092	00:42:39	00:32:50	00:10:15
Apr 2024	48,305	00:39:29	00:29:57	00:09:46
May 2024	50,238	00:40:33	00:31:29	00:09:18
Jun 2024	47,255	00:39:23	00:30:34	00:09:01
Jul 2024	48,914	00:39:19	00:30:34	00:08:57
Aug 2024	48,434	00:35:06	00:26:24	00:08:53

Table O3.2

Top 5 Trusts: Lost Unit Hours

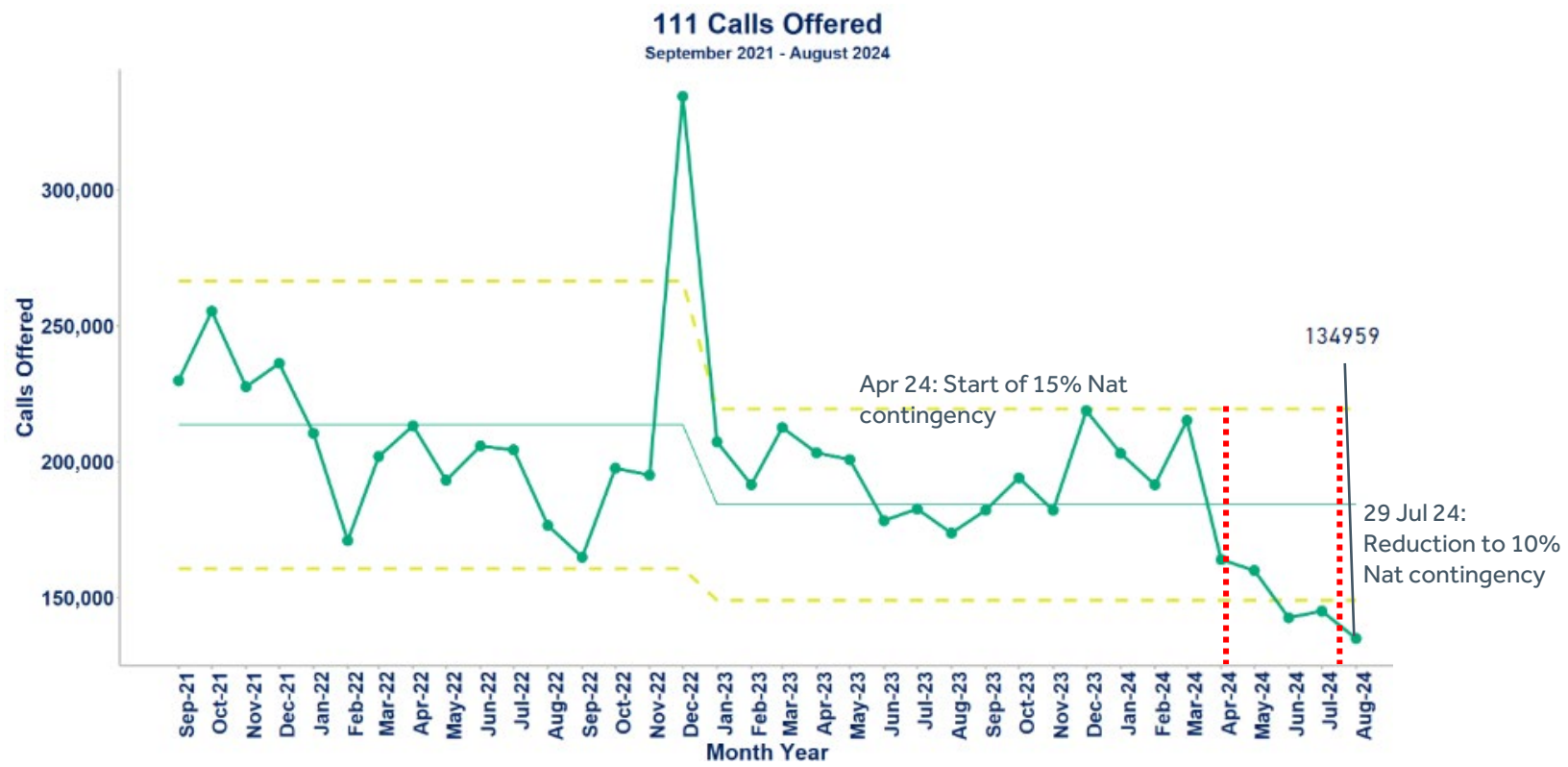
Hospital Name	Operational Area Name	Hospital Attendances to AE	Lost Time Turnaround >30m (h)	Average Turnaround Time(hh:mm:ss)	Average Arrival to Handover Time(hh:mm:ss)	Average Handover to Clear Time(hh:mm:ss)
Whiston	Cheshire & Merseyside	2,293	985.76	00:51:29	00:41:03	00:11:04
Arrowe Park	Cheshire & Merseyside	2,049	879.90	00:49:50	00:41:49	00:08:46
Aintree University	Cheshire & Merseyside	2,212	849.73	00:48:17	00:37:25	00:11:40
Countess of Chester	Cheshire & Merseyside	1,341	636.77	00:54:56	00:46:15	00:08:28
Royal Liverpool University	Cheshire & Merseyside	2,346	530.53	00:40:10	00:29:28	00:11:09

Table O3.3

Month	No. of patients waiting outside A&E for handover
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
Jul-24	1851
Aug-24	989

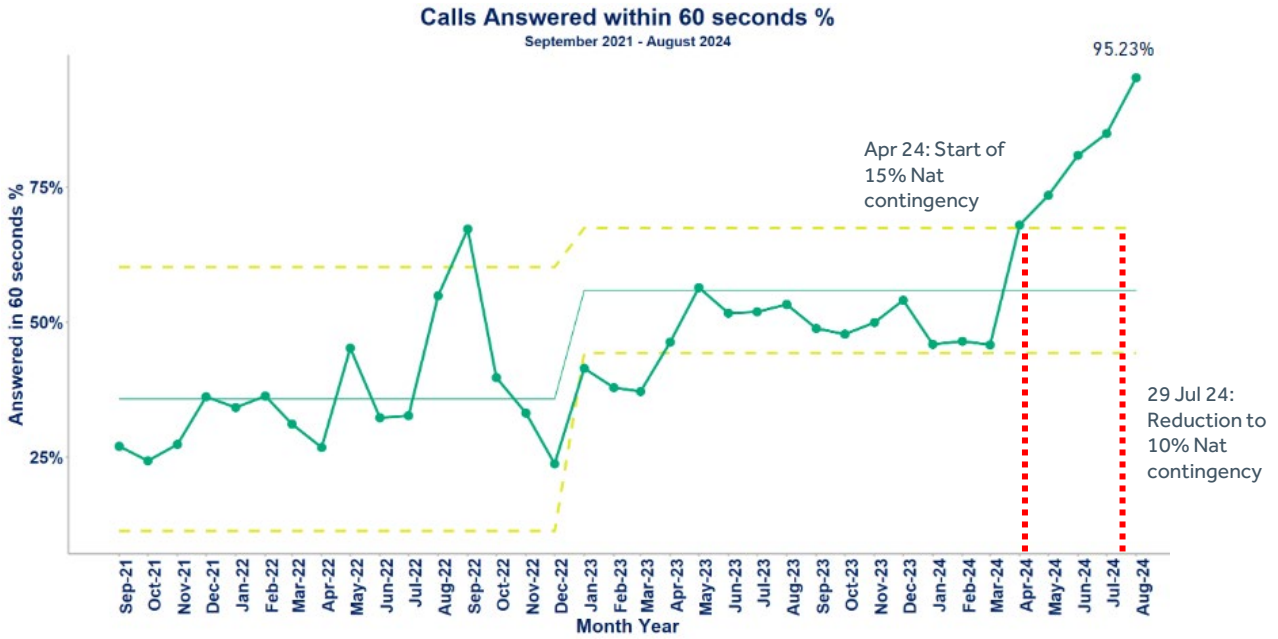
O4 111 ACTIVITY & PERFORMANCE

Figure O4.1



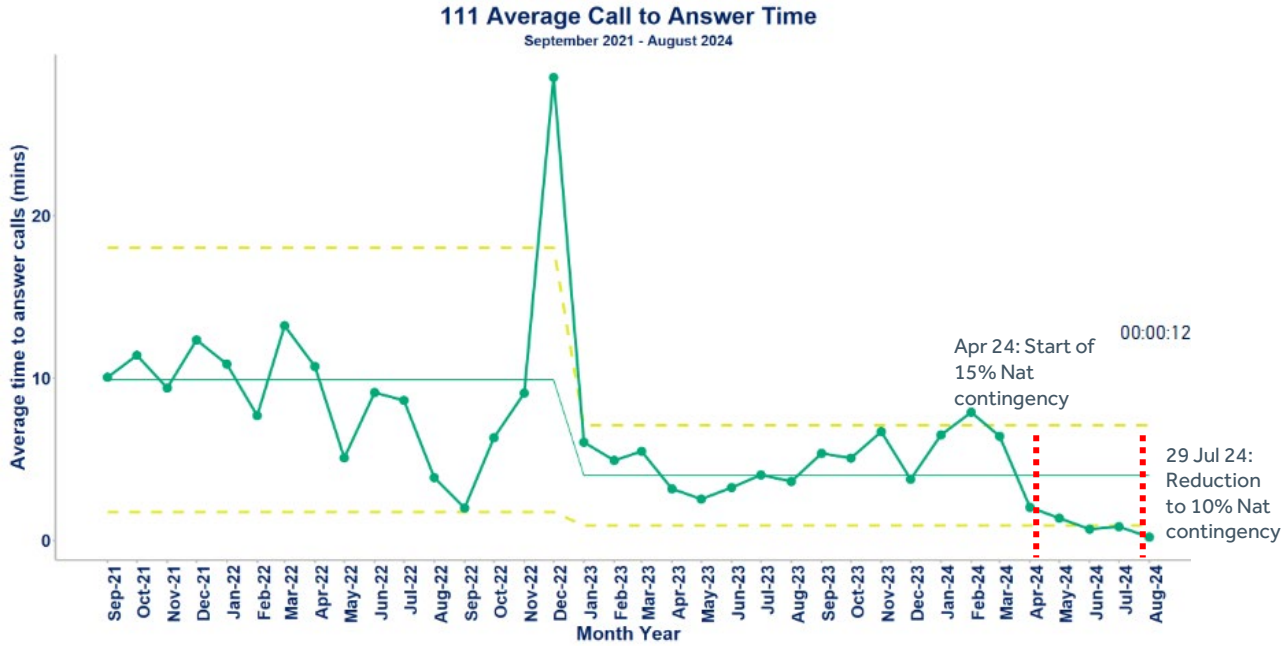
Calls Offered	
Aug 2024	134,959
YTD	746,621

Figure O4.2



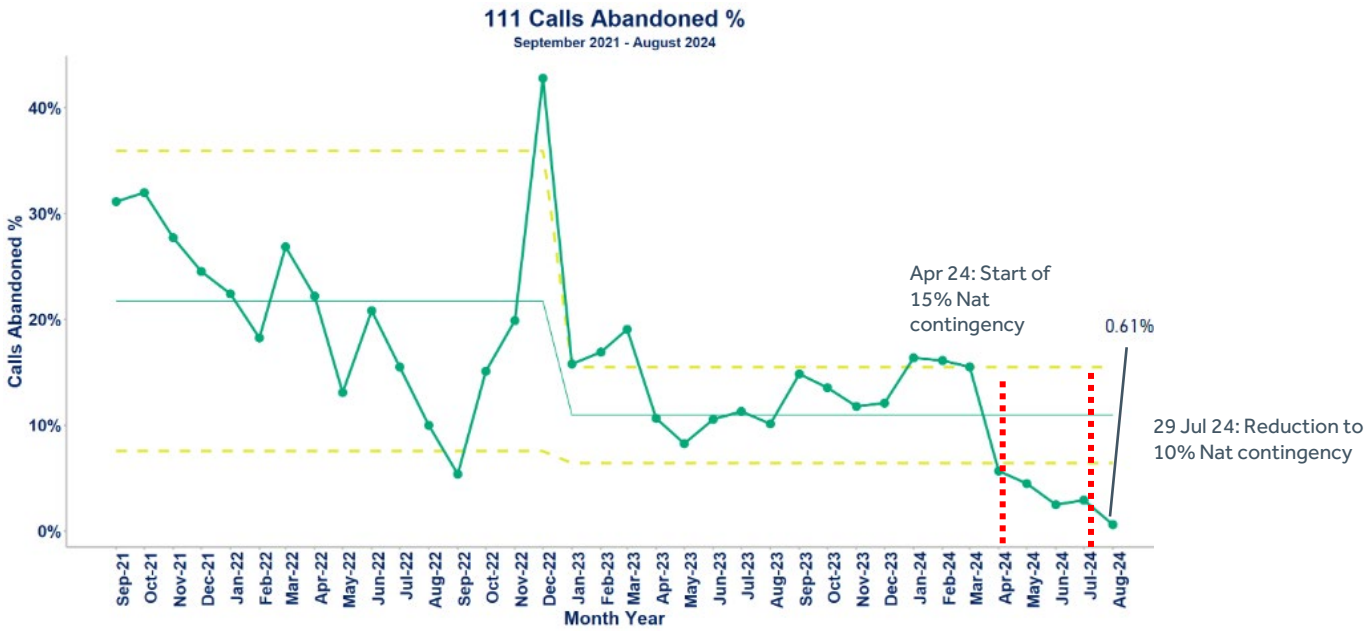
Calls Answered within 60 Seconds %	
Target	95%
Aug 2024	95.2%
YTD	80.6%
National	87.1%
Ranking	3rd/30

Figure O4.3



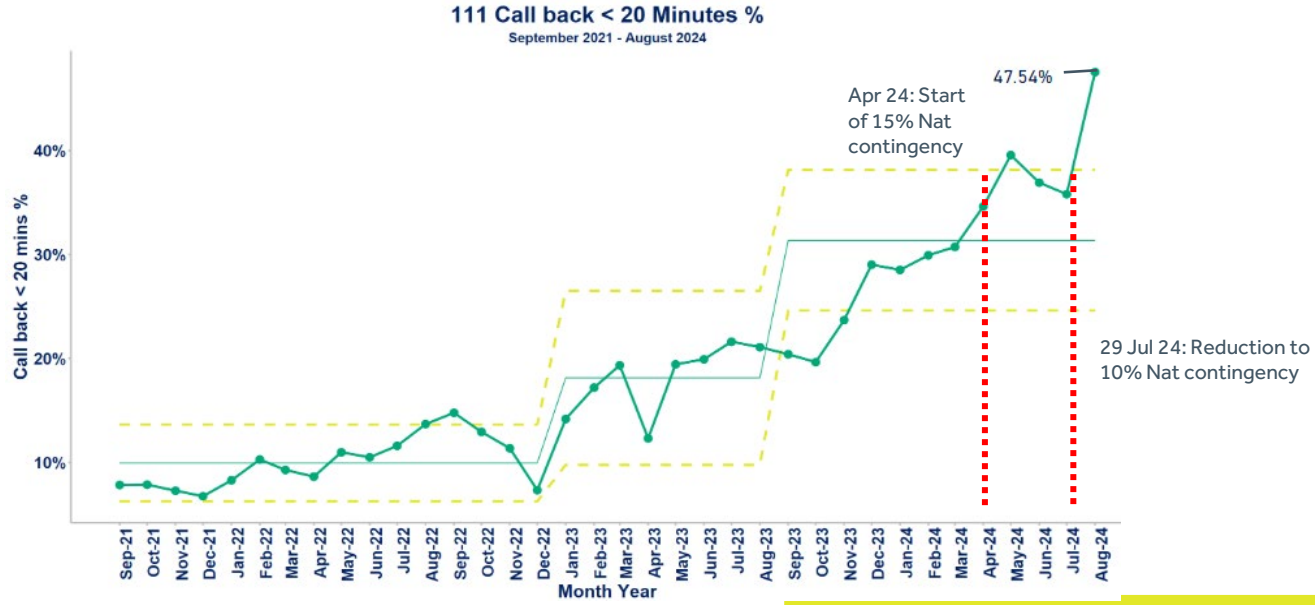
Average Call to Answer time (seconds)	
Target	<20
Aug 2024	12
YTD	85
National	36
Ranking	3rd/30

Figure O4.4



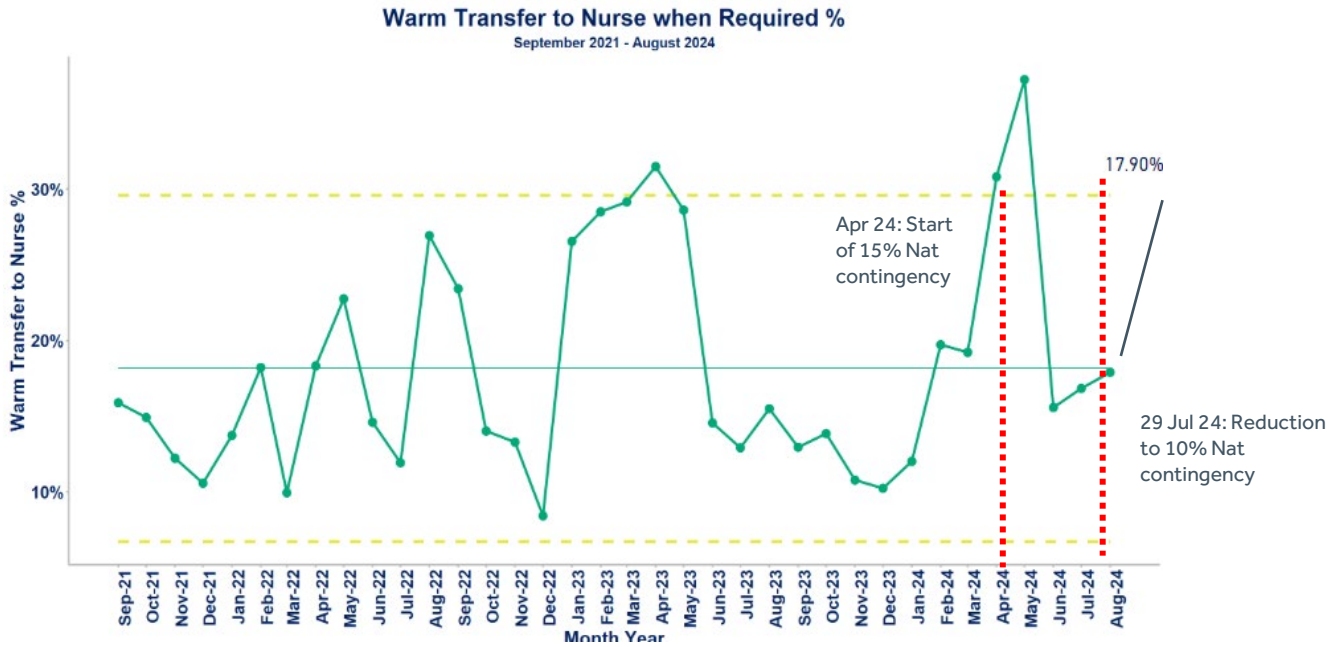
Calls Abandoned %	
Target	<5%
Aug 2024	0.6%
YTD	3.4%
National	2.4%
Ranking	2nd/30

Figure O4.5



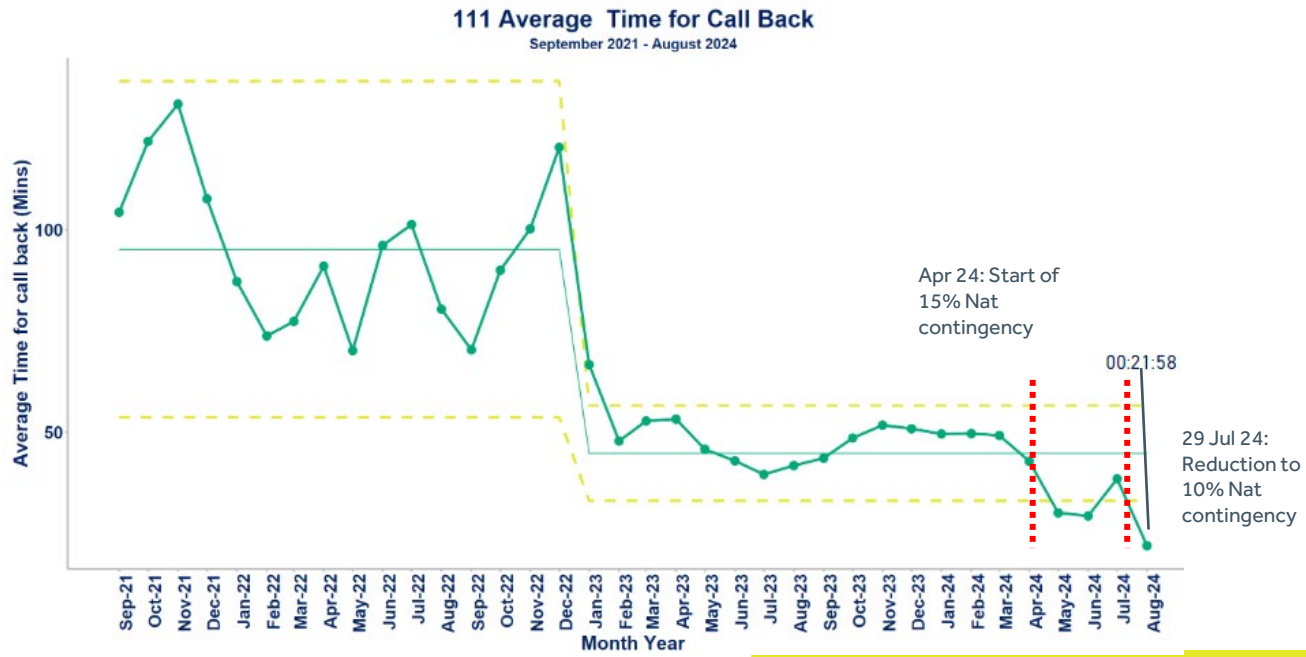
Calls Back <20 Mins	
Target	90%
Aug 2024	47.5%
YTD	41.7%

Figure O4.6



Warm Transfer %	
Target	75%
Jun 2024	17.9%
YTD	23.7%

Figure O4.7



O5 PTS ACTIVITY & TARIFF

Figure O5.1

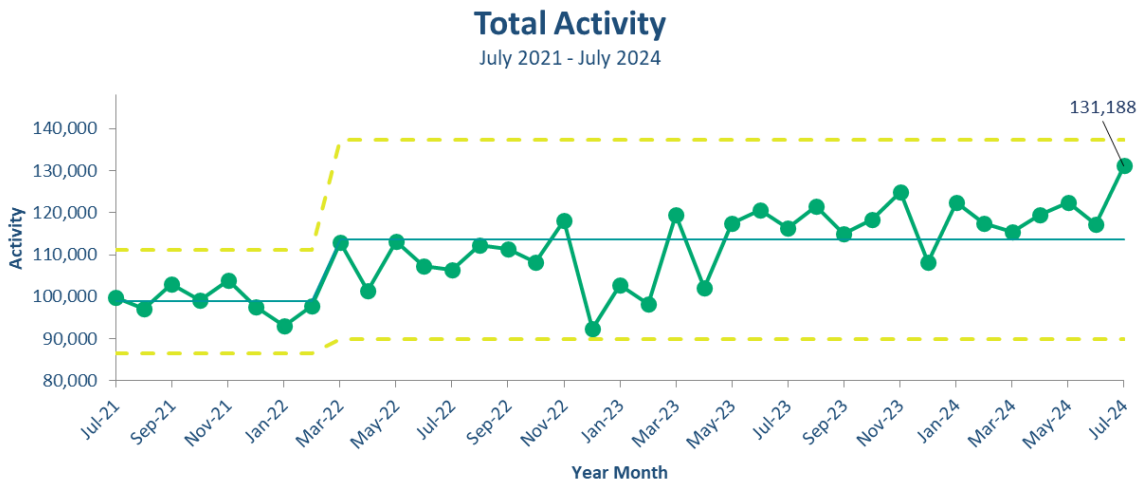


Figure O5.2

Contract	Total Activity
Greater Manchester	51,543
Lancashire	38,605
Merseyside	28,771
Cumbria	12,269

Total Activity	
Plan	132,015
Actual	132,505
YTD Plan	132,015
YTD Activity	132,505

Figure O5.3

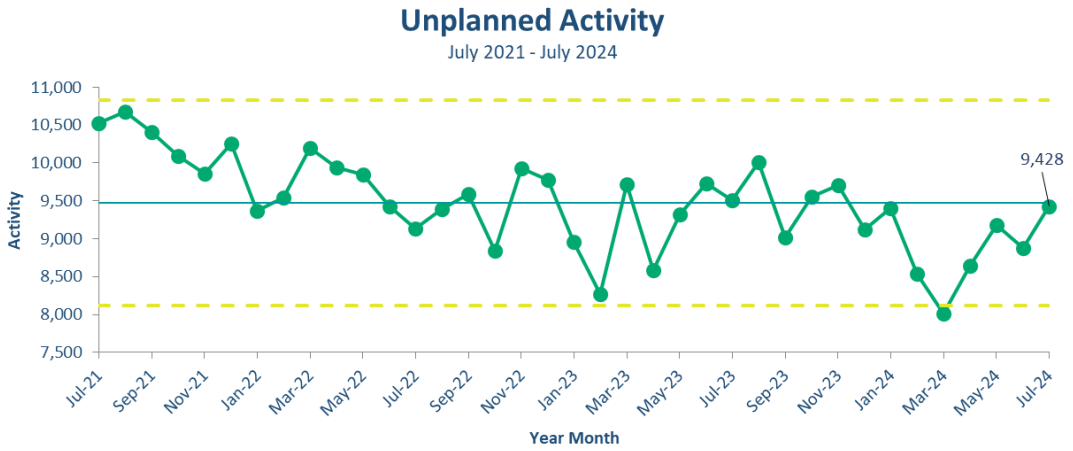


Figure O5.4

Contract	Unplanned Activity
Greater Manchester	3,699
Lancashire	3,325
Merseyside	1,960
Cumbria	444

Unplanned Activity	
Plan	12,107
Actual	9,726
YTD Plan	12,107
YTD Activity	9,726

Figure O5.5

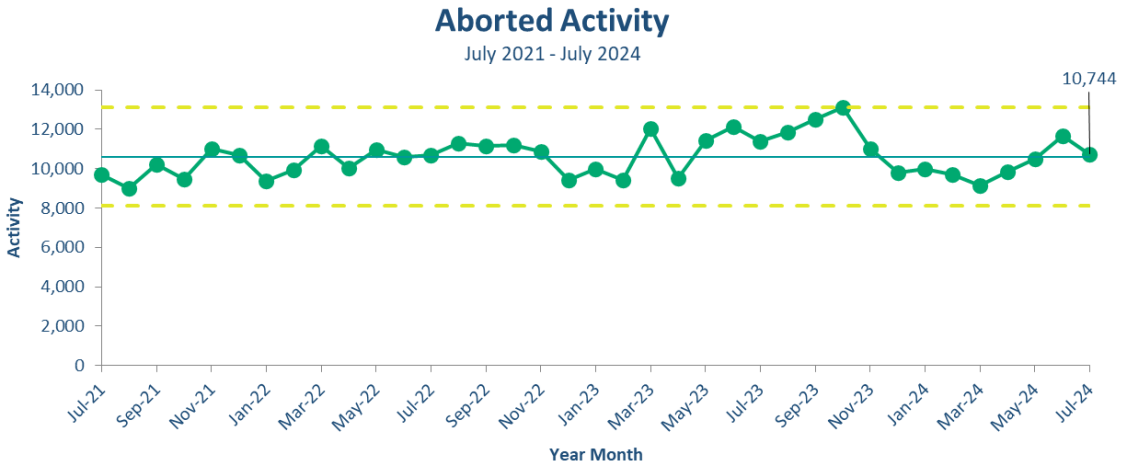


Figure O5.6

Contract	Aborted Activity
Greater Manchester	5,637
Lancashire	2,519
Merseyside	2,209
Cumbria	379

Finance

F1 – FINANCIAL SCORE

Figure F1.1

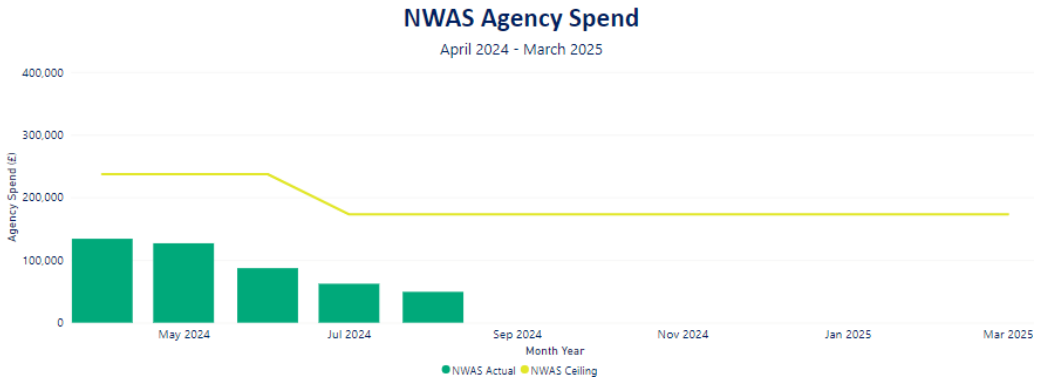


Figure F1.2

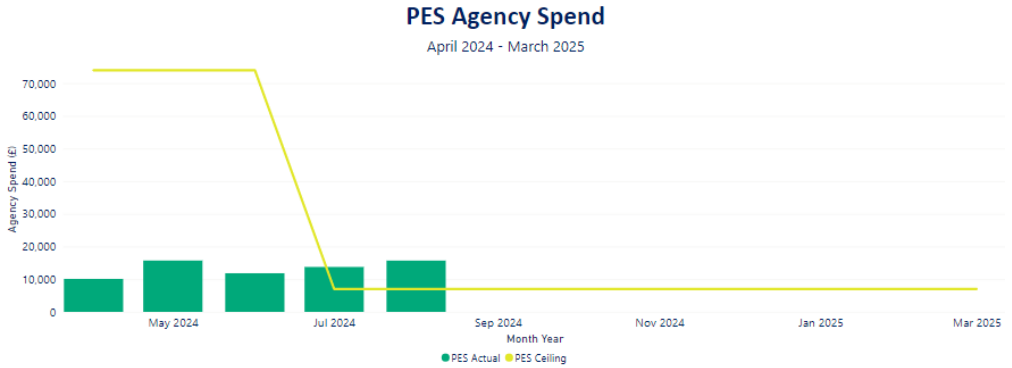


Figure F1.3

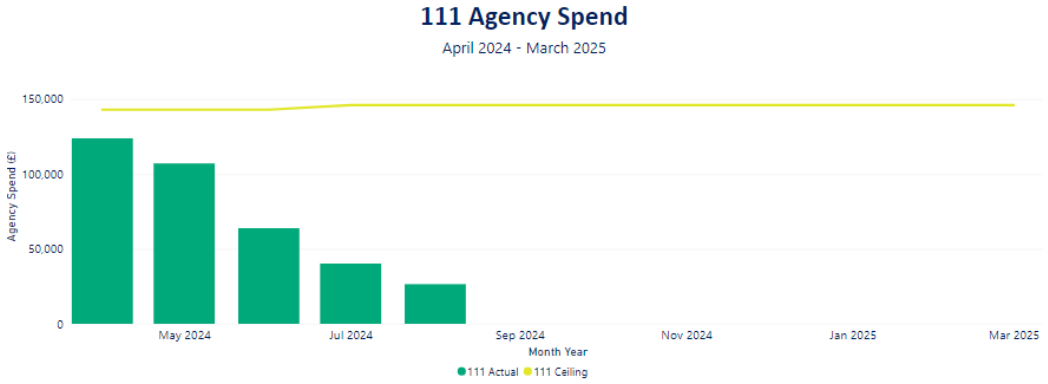


Figure F1.4

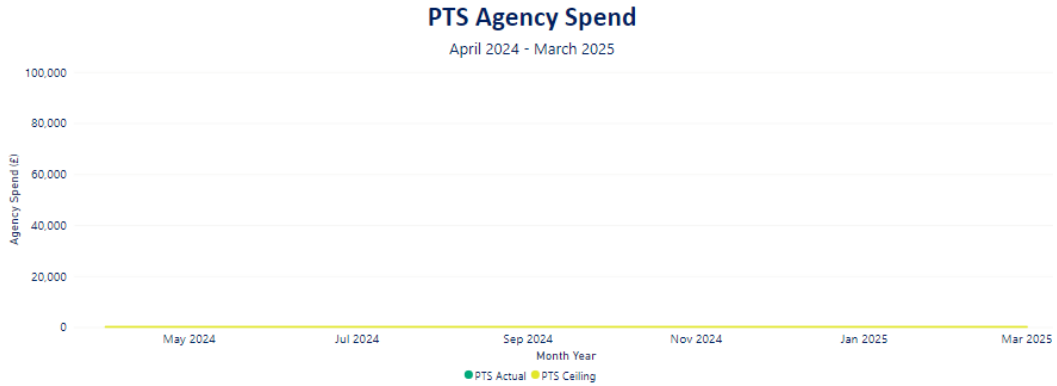
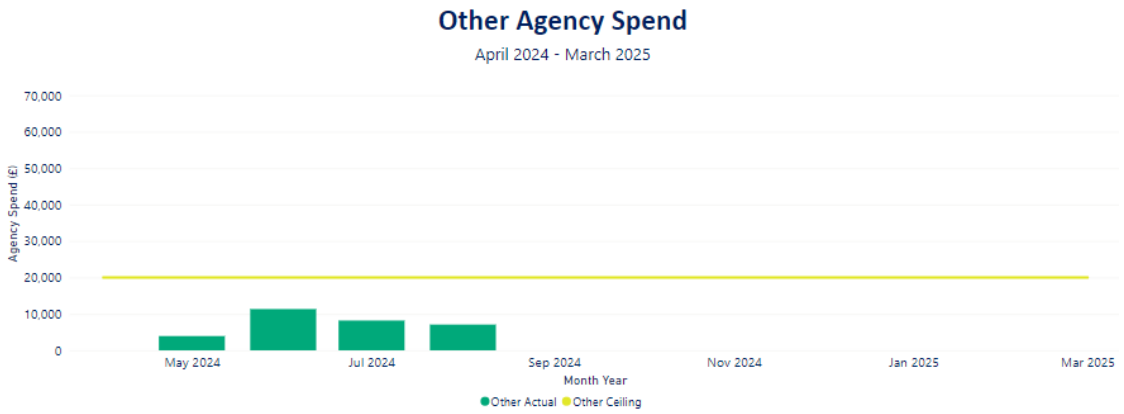


Figure F1.5


Other Agency Spend
April 2024 - March 2025
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Agency Spend (£)
May 2024
Jul 2024
Sep 2024
Nov 2024
Jan 2025
Mar 2025
Month Year
Other Actual
Other Ceiling

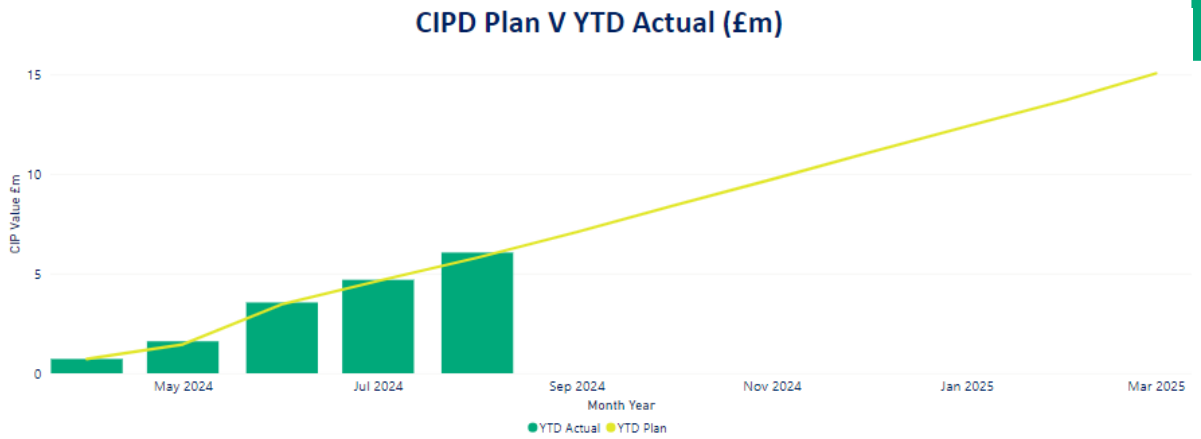

CIPD Plan V YTD Actual (£m)
15
10
5
0
CIP Value £m
May 2024
Jul 2024
Sep 2024
Nov 2024
Jan 2025
Mar 2025
Month Year
YTD Actual
YTD Plan

Figure F1.7

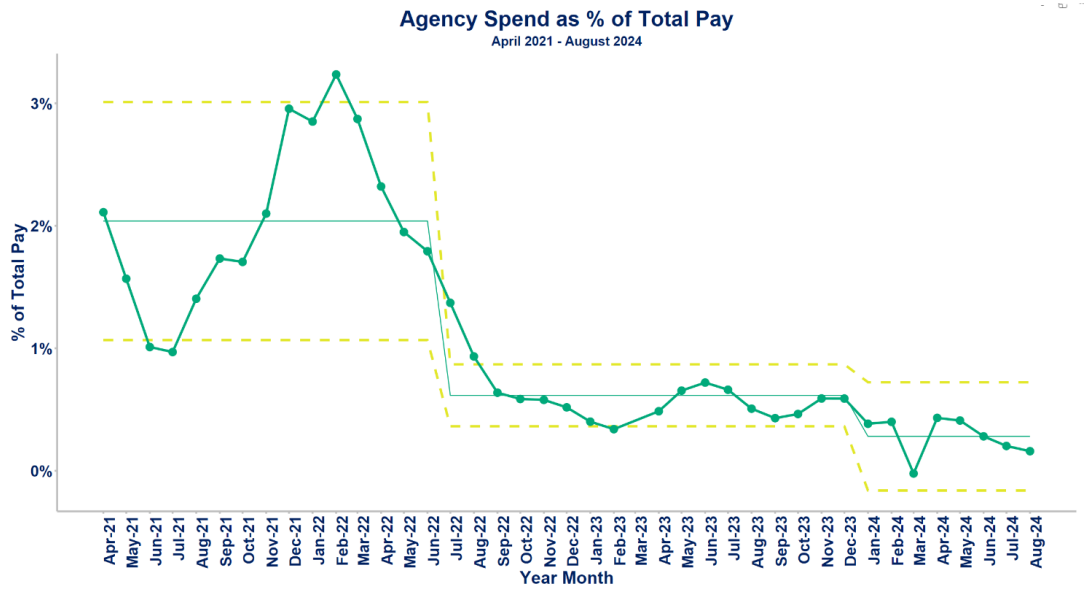


Figure F1.8

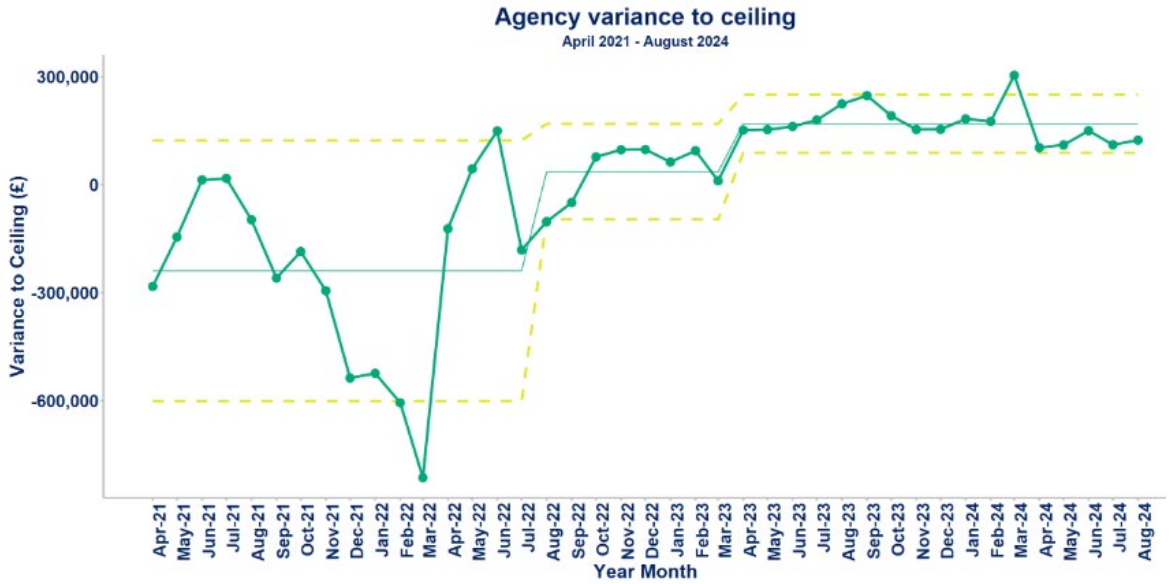
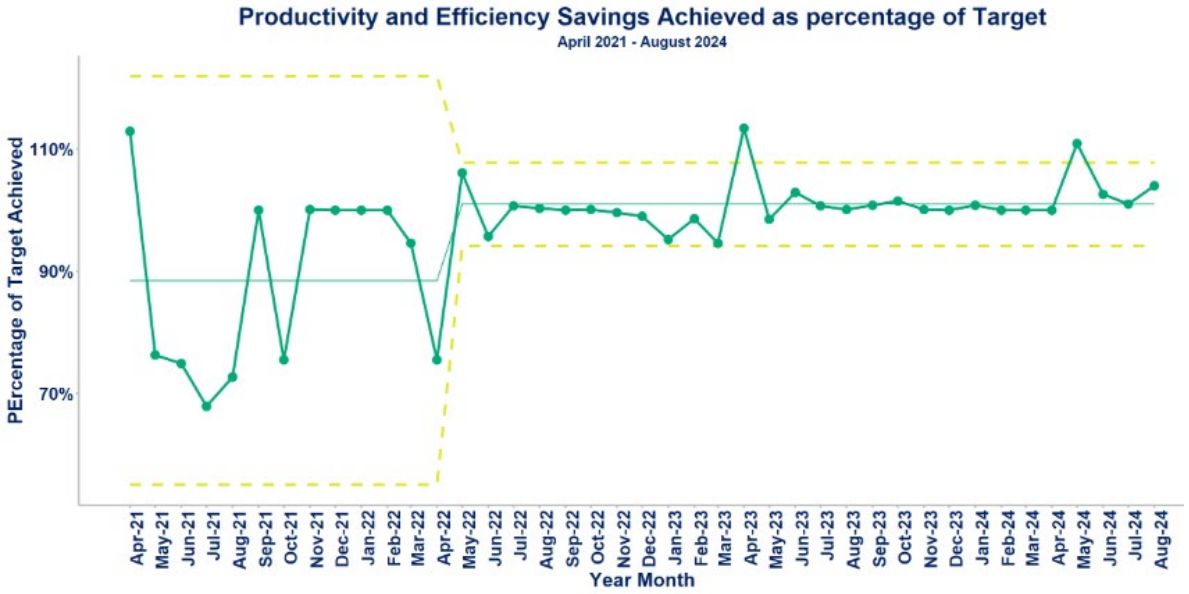


Figure F1.9



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

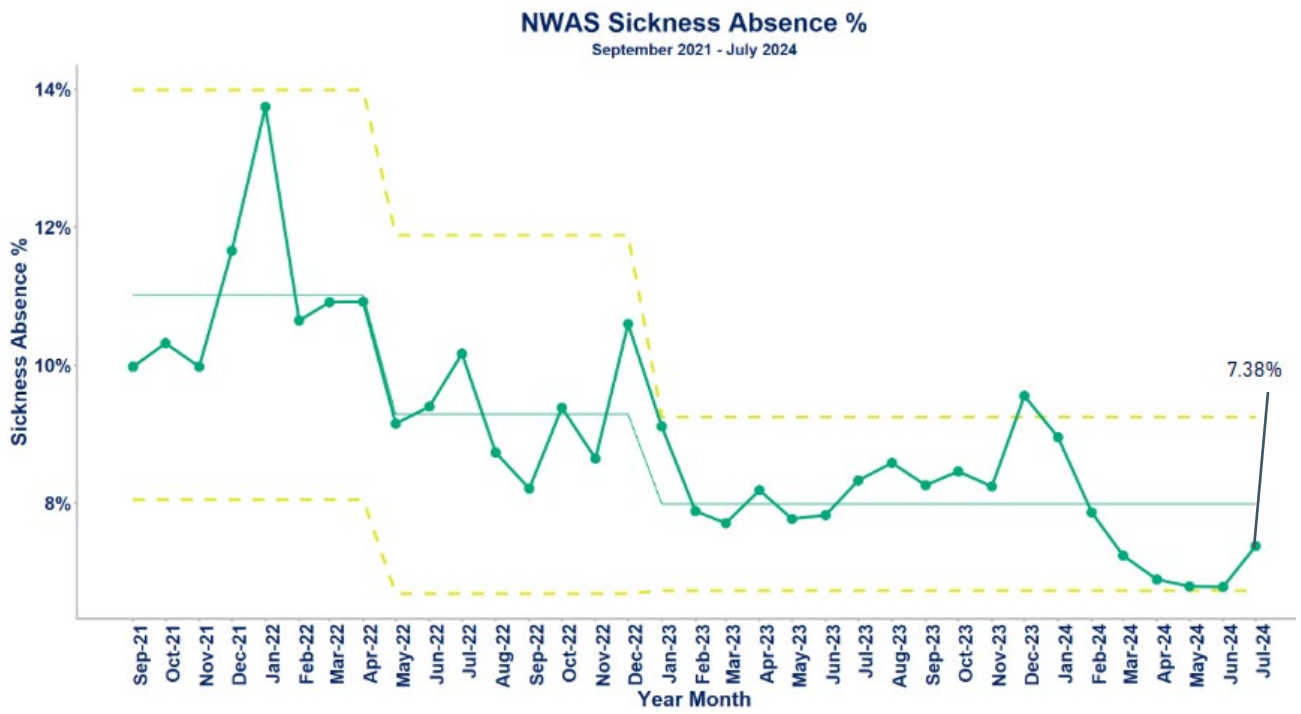


Table OH1.1

Month	NWAS	Amb. National Average
Aug 2023	8.58%	6.90%
Sep 2023	8.26%	6.60%
Oct 2023	8.46%	6.80%
Nov 2023	8.24%	6.80%
Dec 2023	9.55%	7.90%
Jan 2024	8.95%	7.30%
Feb 2024	7.86%	6.90%
Mar 2024	7.24%	6.60%
Apr 2024	6.89%	6.30%
May 2024	6.79%	6.20%
Jun 2024	6.78%	6.30%
Jul 2024	7.38%	

Figure OH1.2

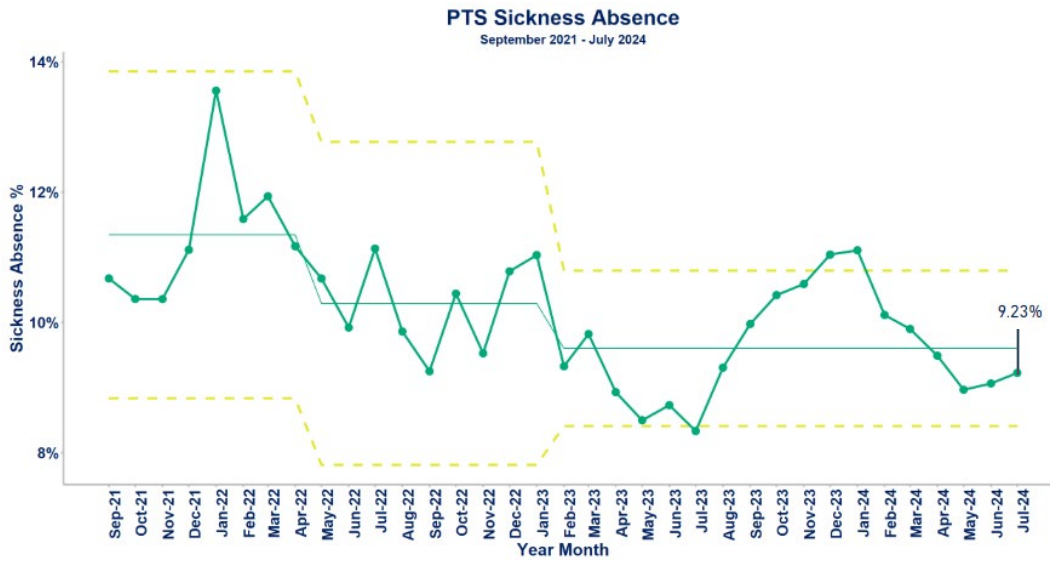


Figure OH1.3

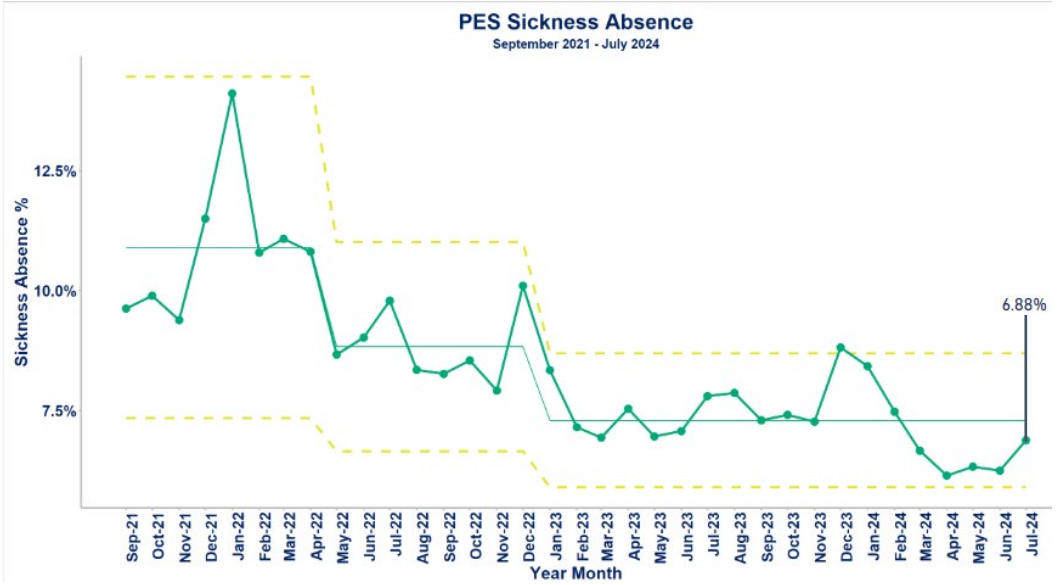


Figure OH1.4

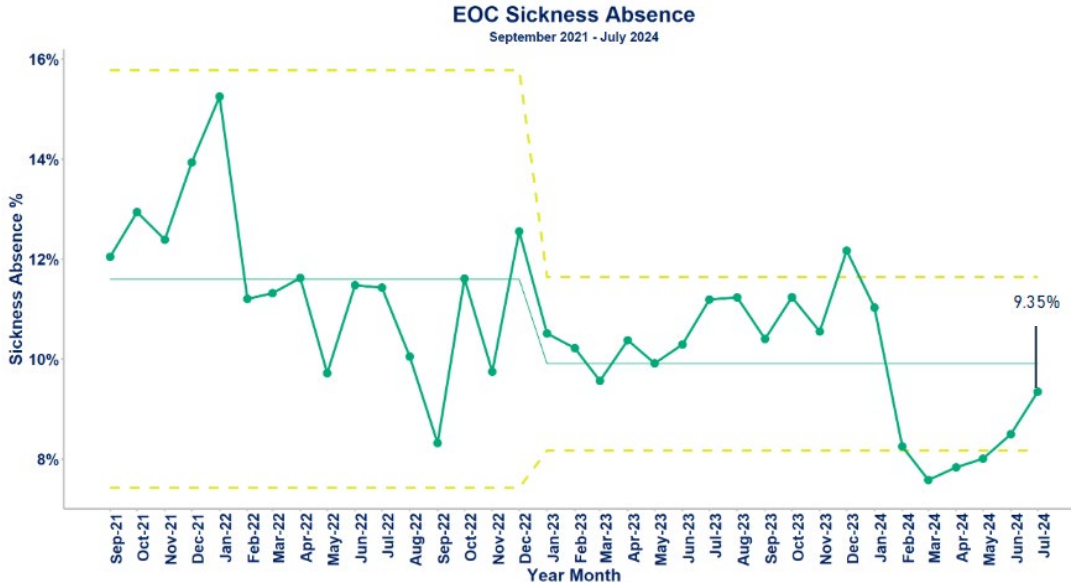
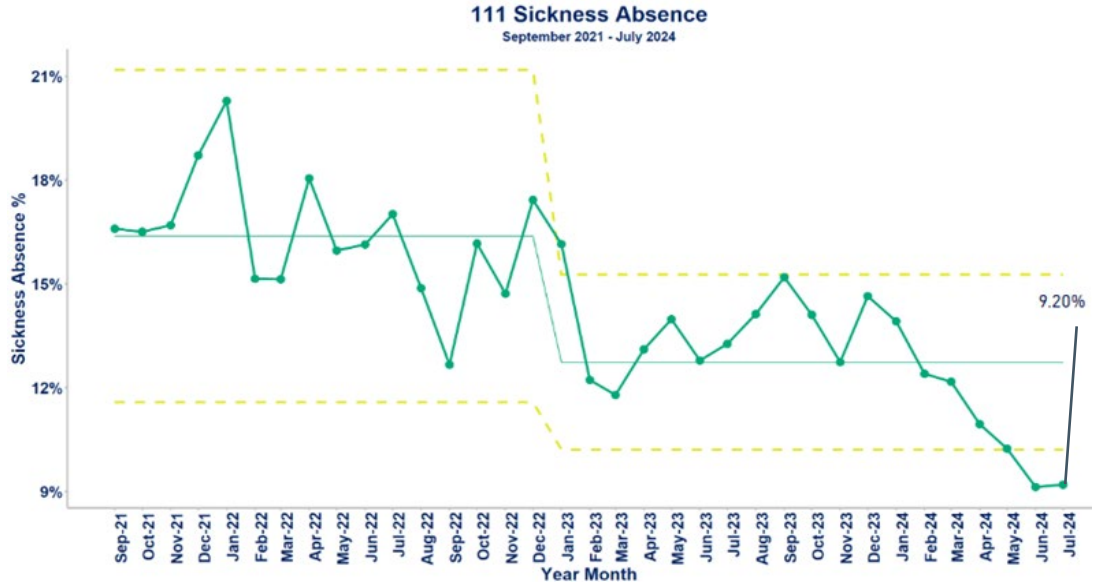


Figure OH1.5



OH2 STAFF TURNOVER

Figure OH2.1

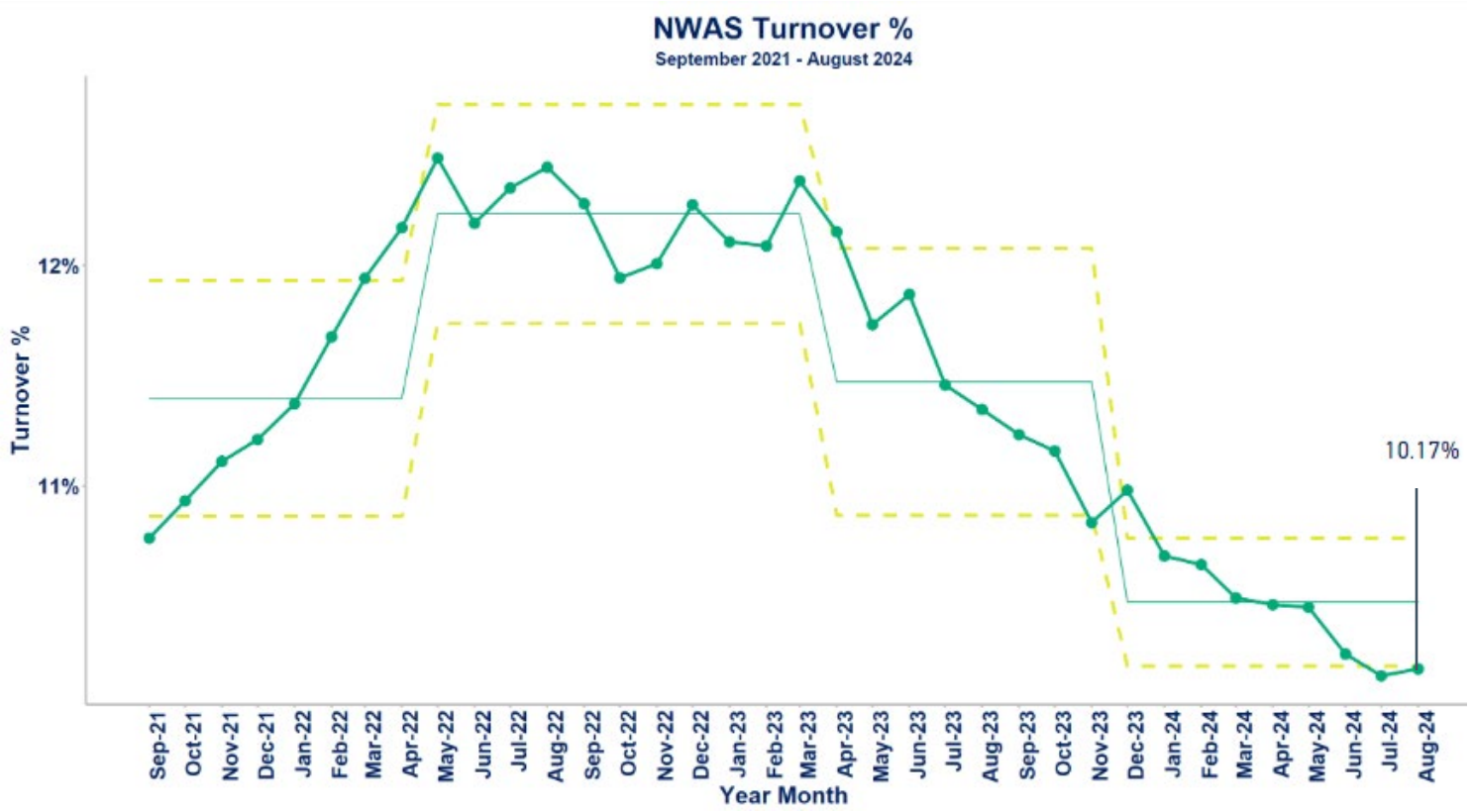


Table OH2.1

Month	NWAS	Amb. National Average
Aug 2023	11.35%	11.20%
Sep 2023	11.23%	10.99%
Oct 2023	11.16%	10.96%
Nov 2023	10.83%	10.87%
Dec 2023	10.98%	10.59%
Jan 2024	10.68%	10.46%
Feb 2024	10.64%	10.27%
Mar 2024	10.49%	9.50%
Apr 2024	10.46%	9.50%
May 2024	10.45%	9.40%
Jun 2024	10.24%	
Jul 2024	10.14%	

Figure OH2.2

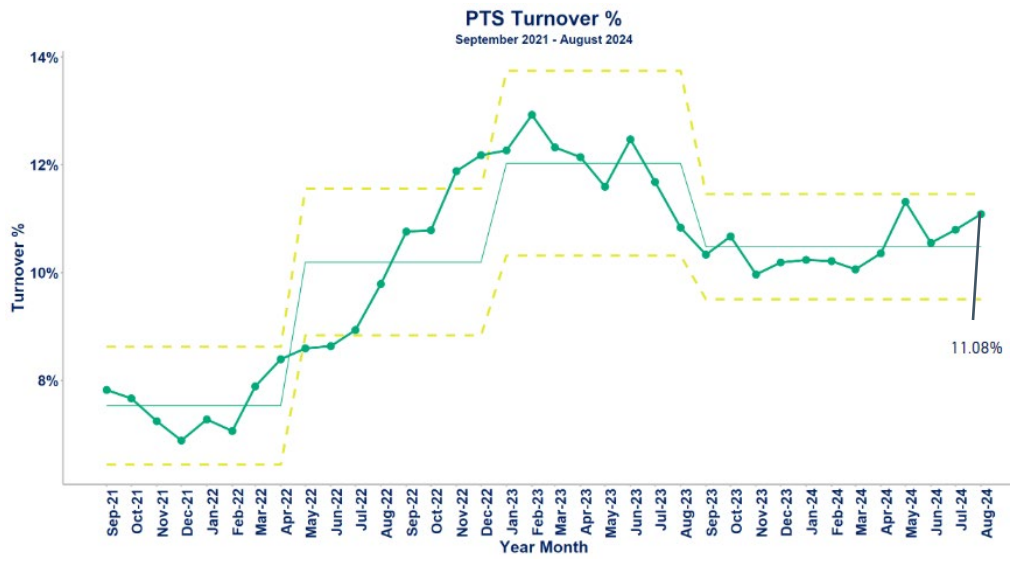


Figure OH2.3

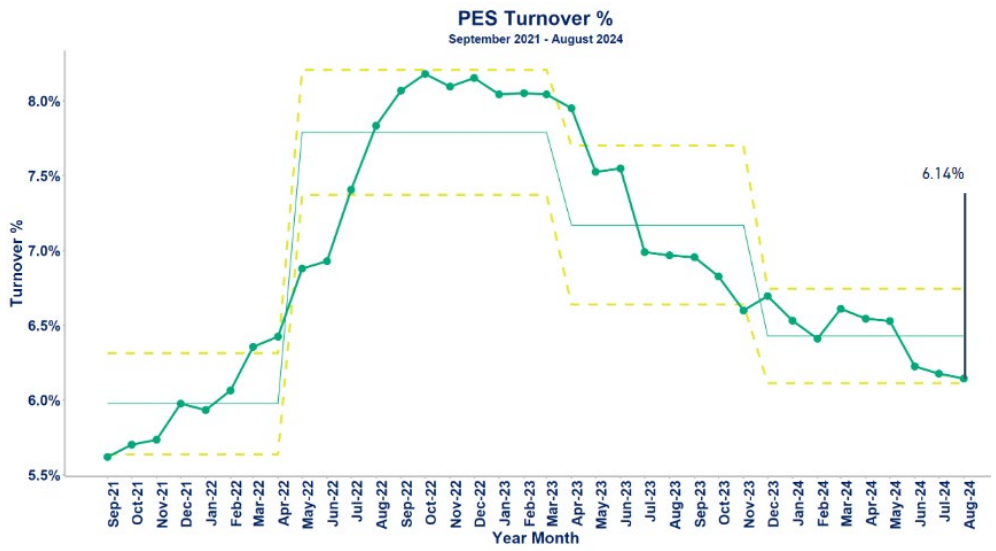


Figure OH2.4

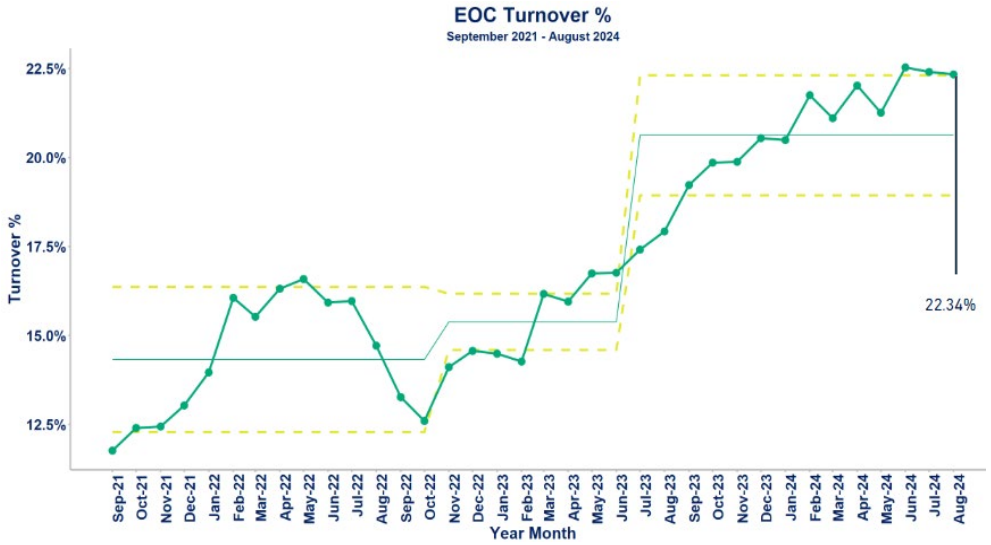
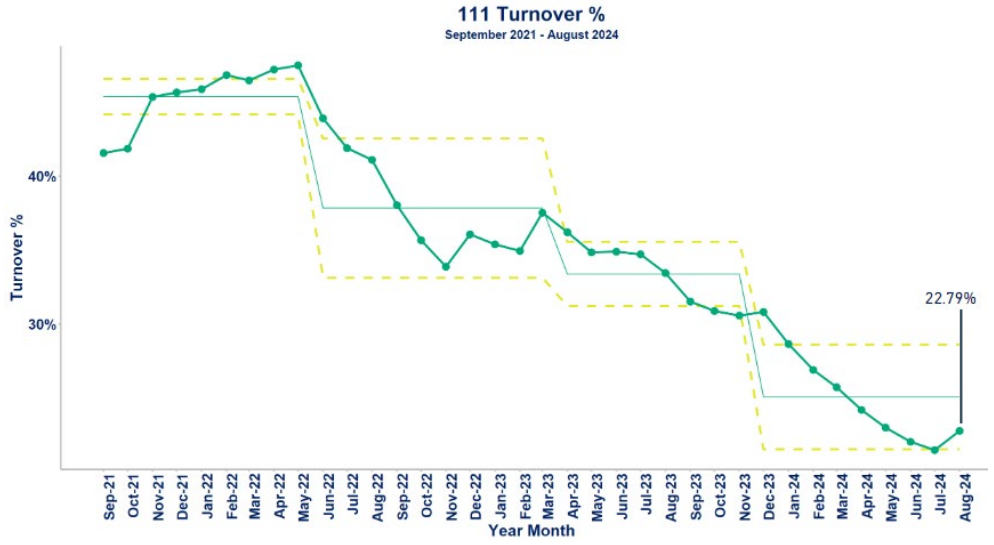


Figure OH2.5



OH4 TEMPORARY STAFFING

BAF

Figure OH4.1

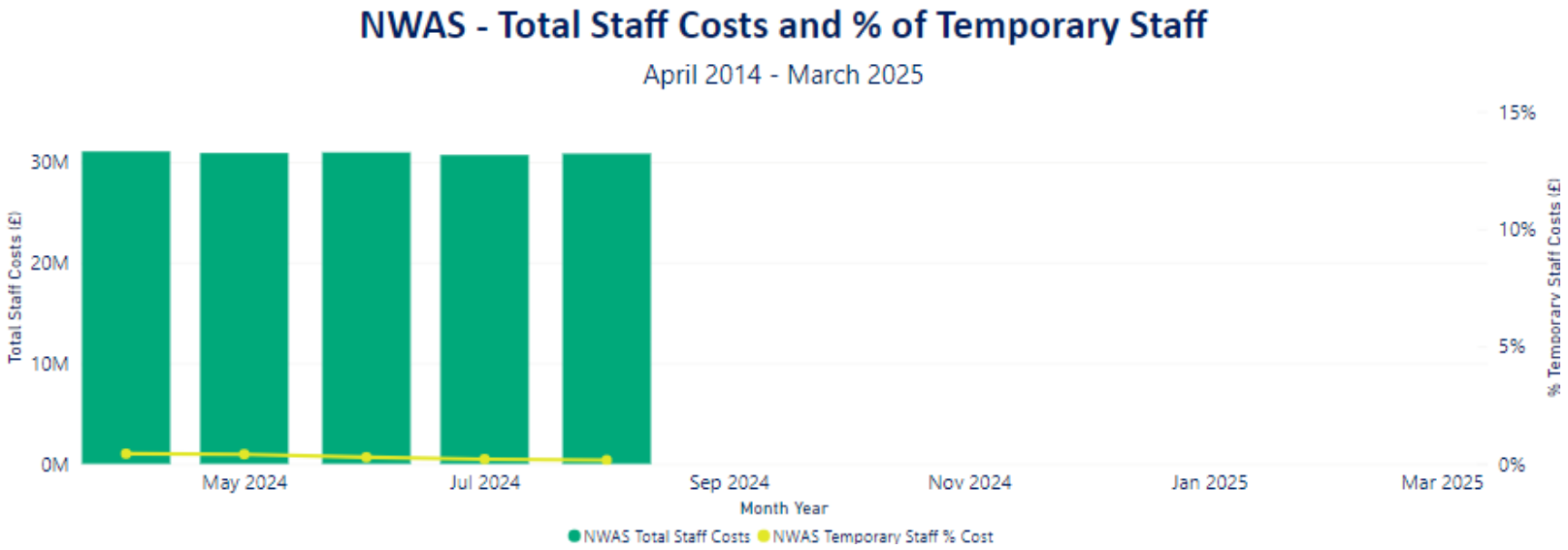


Table OH4.1

Month	NWAS Agency Staff Costs	NWAS Total Staff Costs	NWAS Temporary Staff % Cost
Sep 2023	£124,670	£29,022,514	0.43%
Oct 2023	£136,633	£29,479,928	0.46%
Nov 2023	£174,789	£29,620,537	0.59%
Dec 2023	£174,325	£29,568,340	0.59%
Jan 2024	£114,353	£29,779,636	0.38%
Feb 2024	£121,308	£30,352,345	0.40%
Mar 2024	-£6,855	£30,481,294	-0.02%
Apr 2024	£133,948	£31,045,969	0.43%
May 2024	£126,729	£30,884,497	0.41%
Jun 2024	£87,010	£30,946,651	0.28%
Jul 2024	£62,166	£30,692,369	0.20%
Aug 2024	£49,243	£30,829,513	0.16%

Figure OH4.3

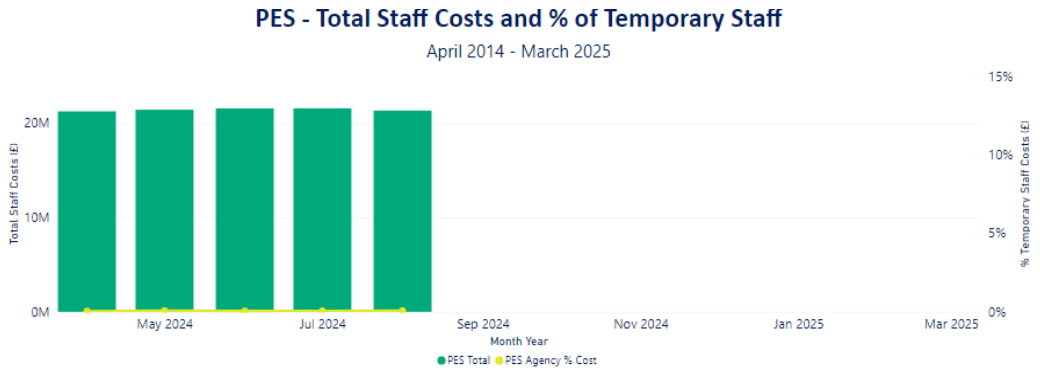
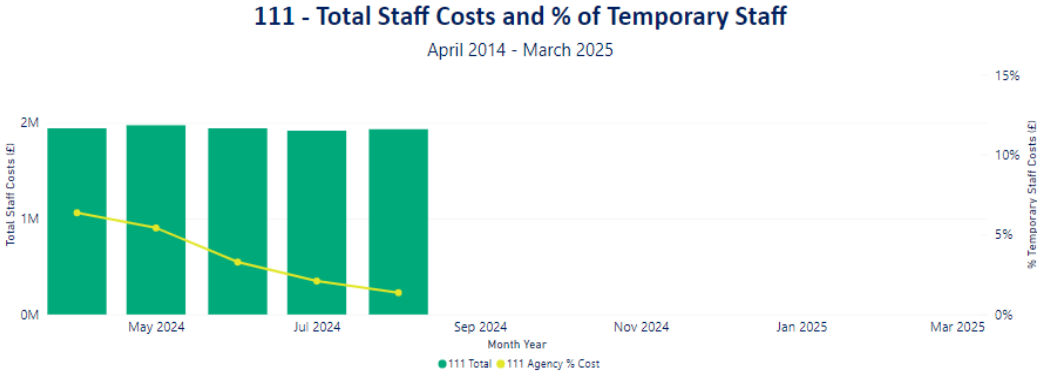


Figure OH4.2

Figure OH4.4



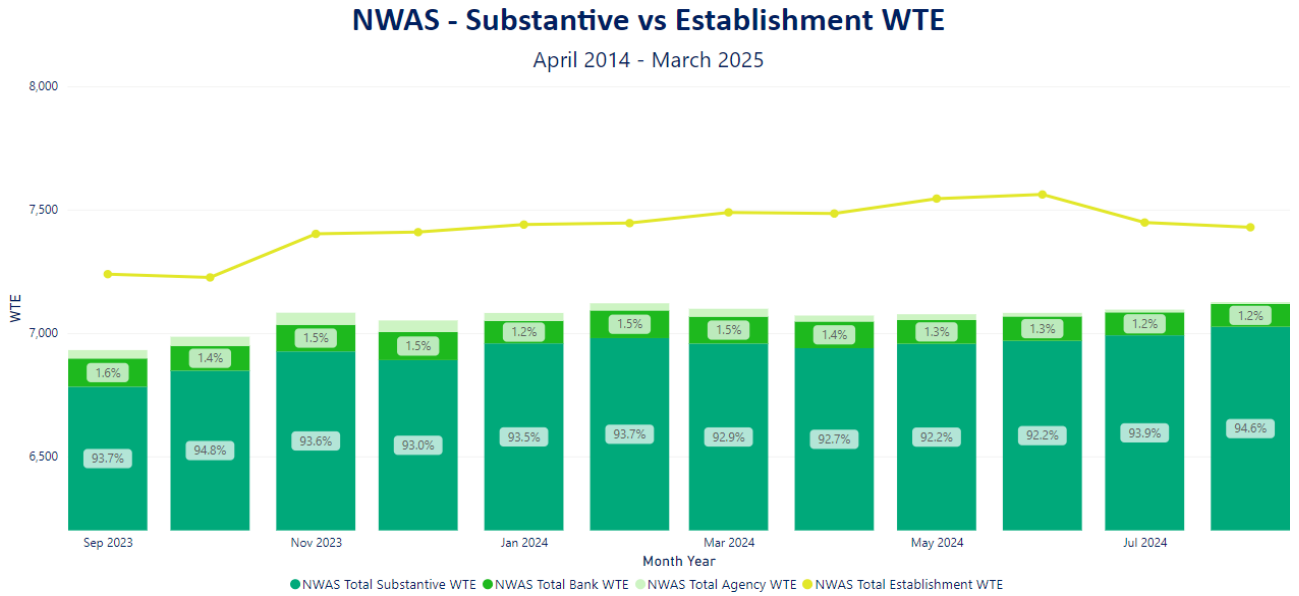
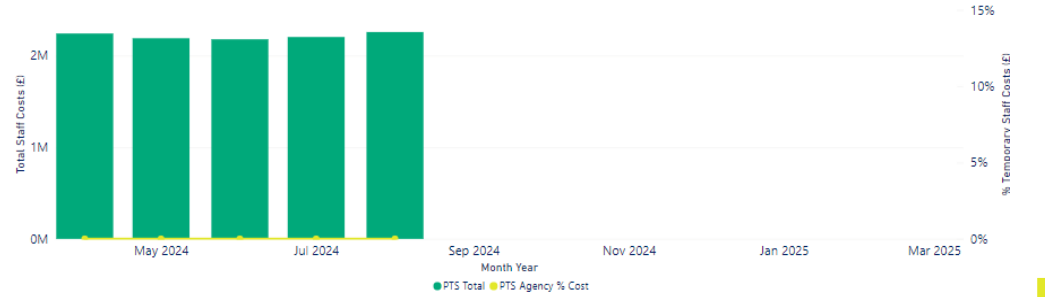


Figure OH4.5



OH5 VACANCY GAP

Figure OH5.1

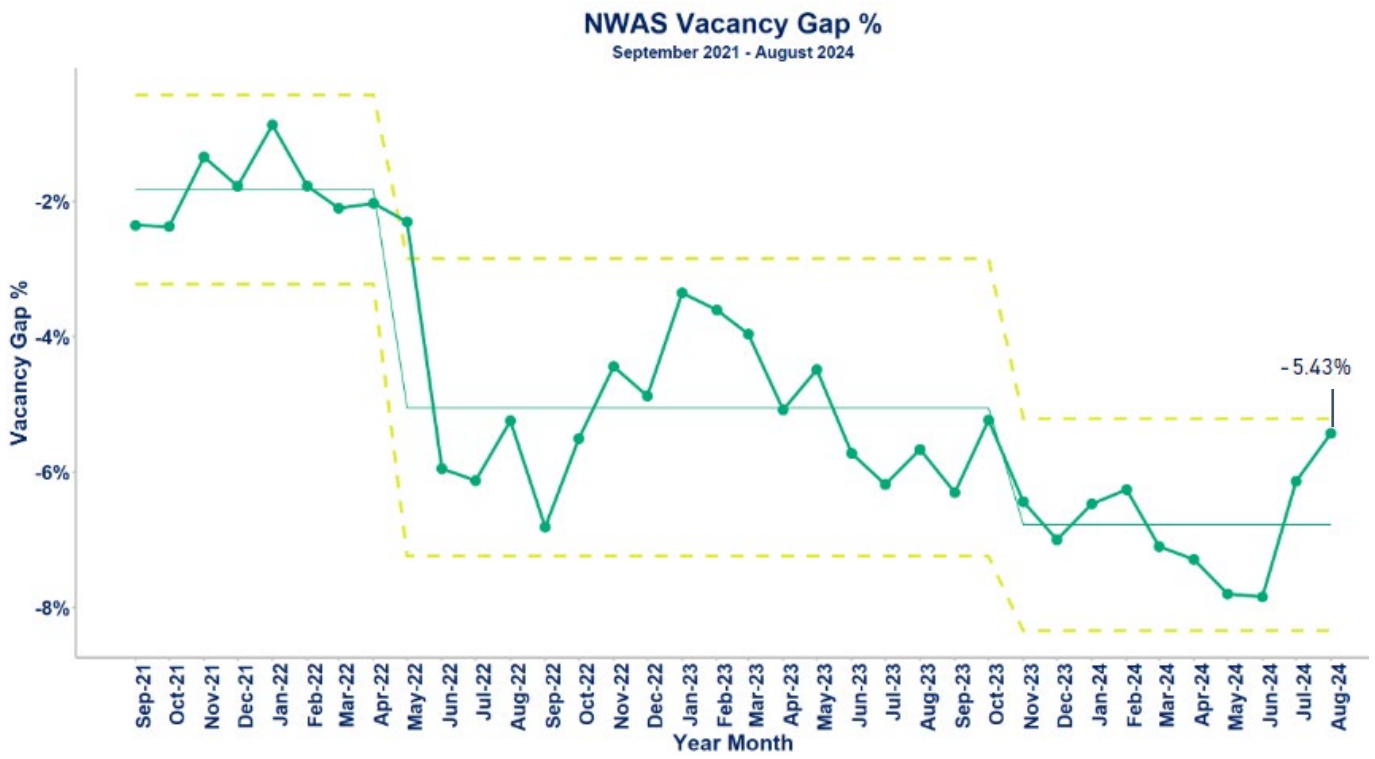


Table OH5.1

Month	NWAS
Aug 2023	-5.67%
Sep 2023	-6.30%
Oct 2023	-5.23%
Nov 2023	-6.44%
Dec 2023	-7.00%
Jan 2024	-6.47%
Feb 2024	-6.26%
Mar 2024	-7.10%
Apr 2024	-7.29%
May 2024	-7.80%
Jun 2024	-7.84%
Jul 2024	-6.14%

Figure OH5.2

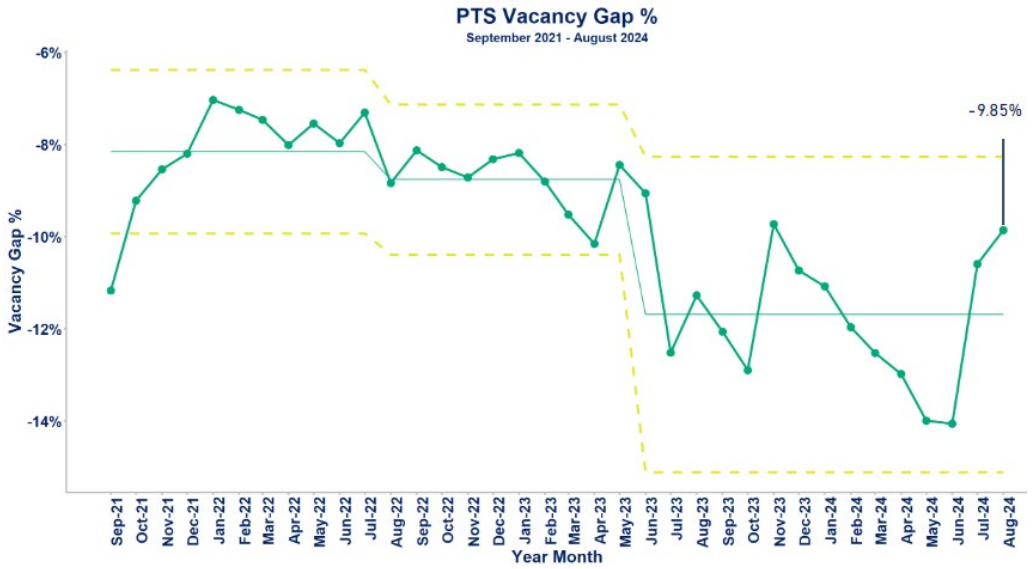


Figure OH5.3

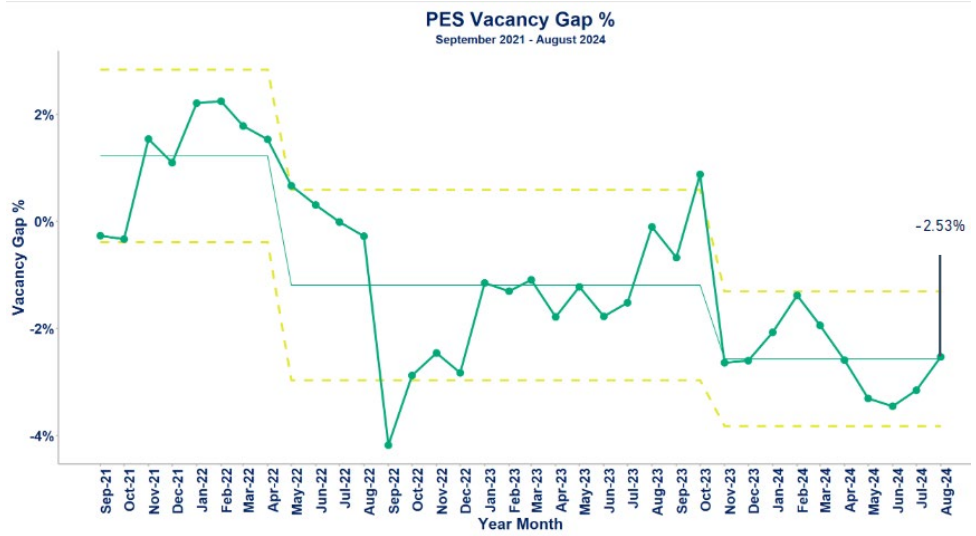


Figure OH5.4

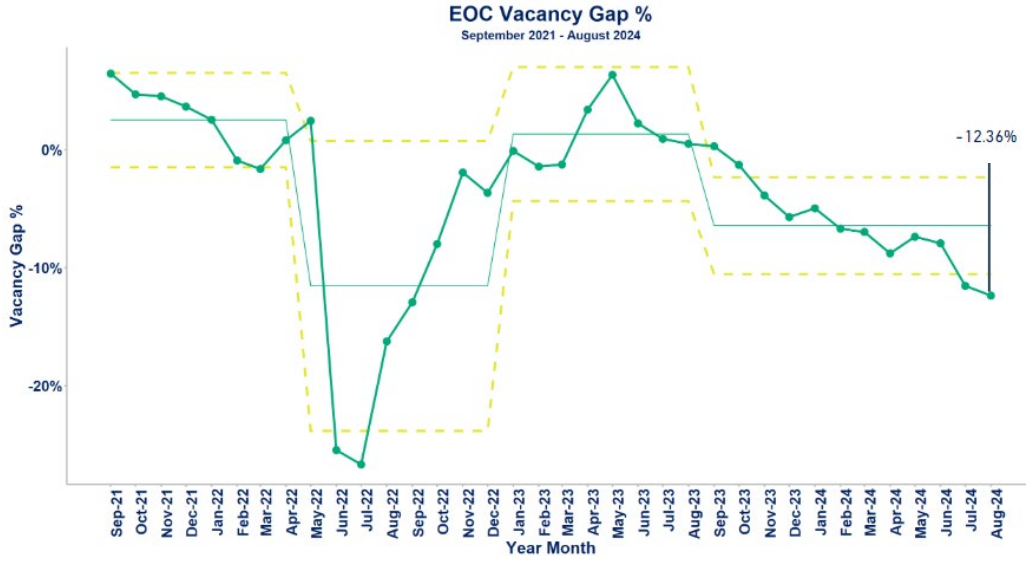
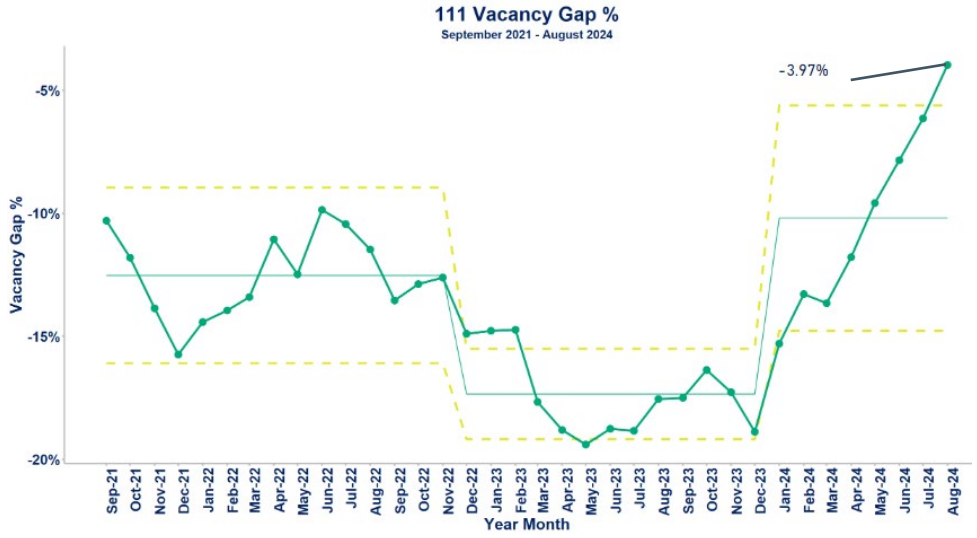


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

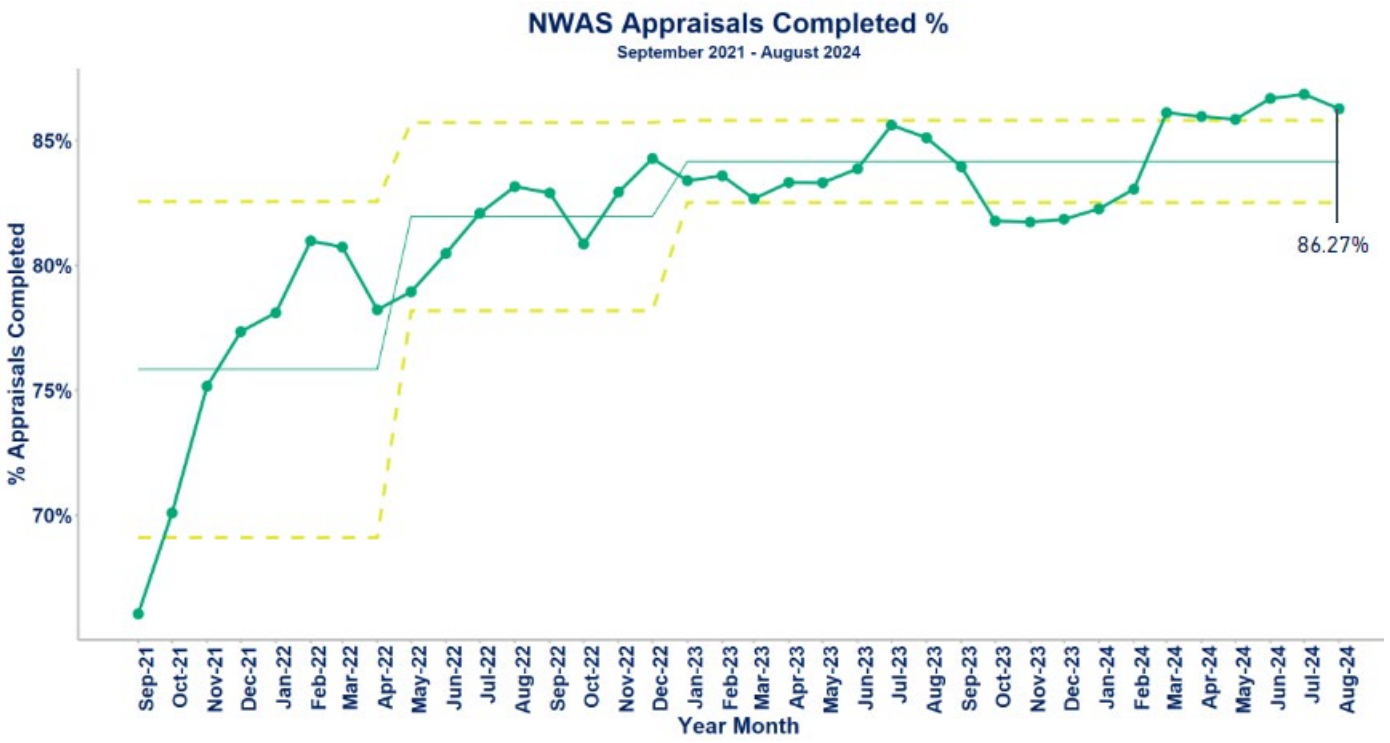


Table OH6.1

Month	NWAS
Aug 2023	85.11%
Sep 2023	83.95%
Oct 2023	81.78%
Nov 2023	81.73%
Dec 2023	81.85%
Jan 2024	82.26%
Feb 2024	83.05%
Mar 2024	86.11%
Apr 2024	85.96%
May 2024	85.84%
Jun 2024	86.68%
Jul 2024	86.85%

Figure OH6.2

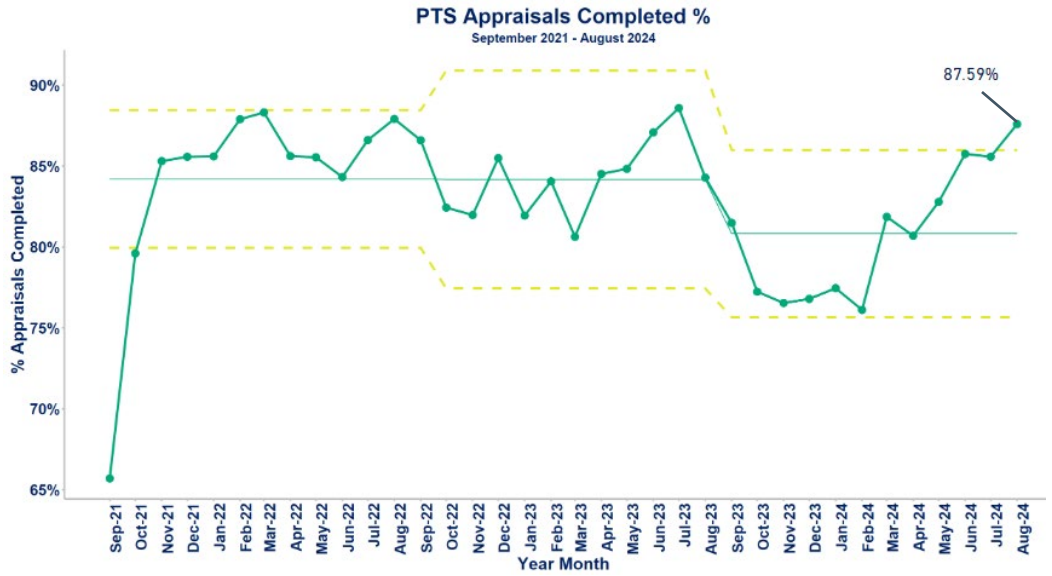


Figure OH6.3

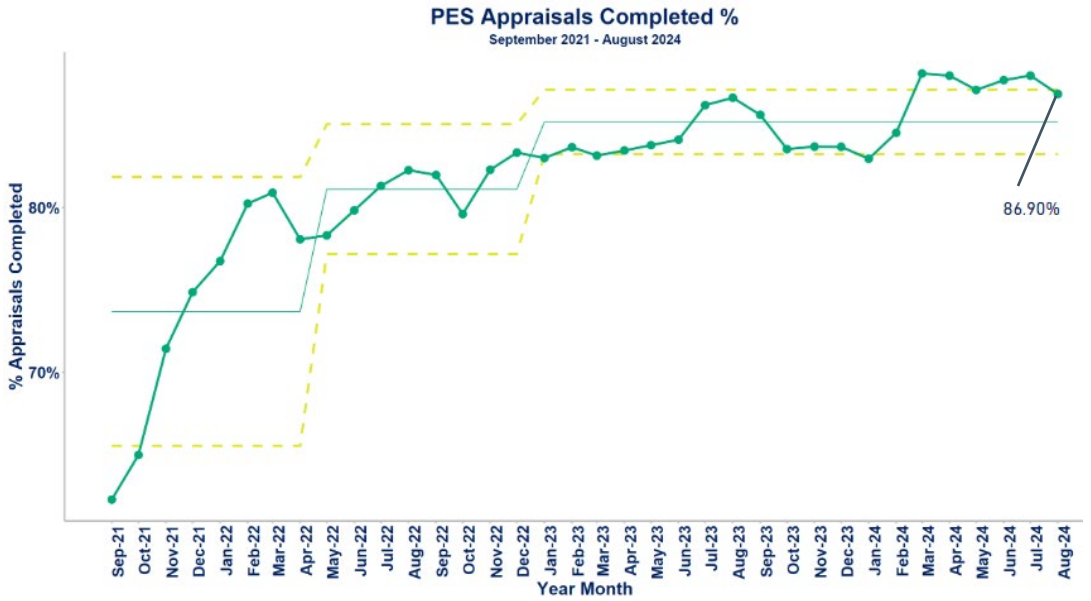


Figure OH6.4

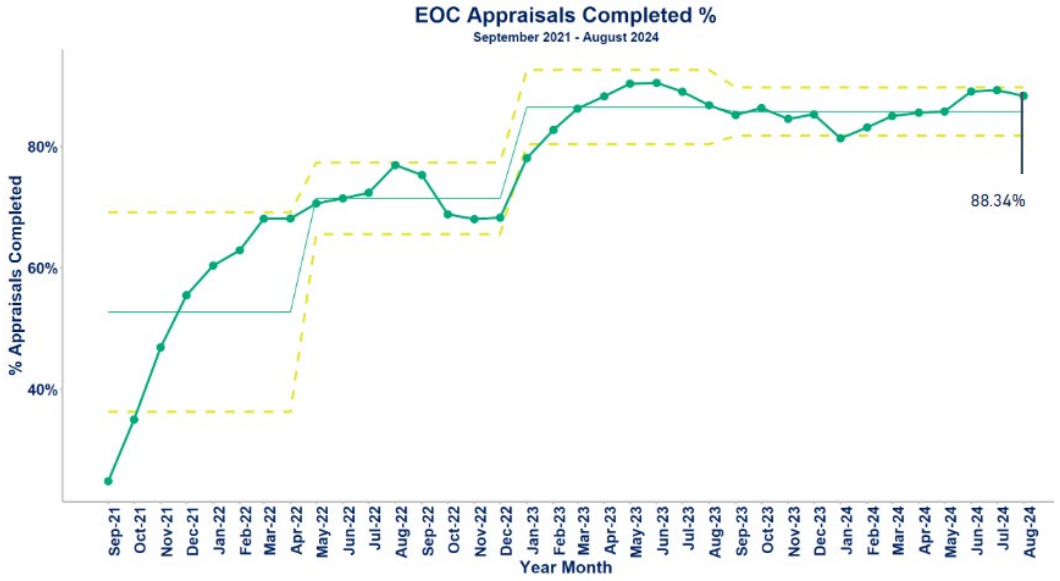
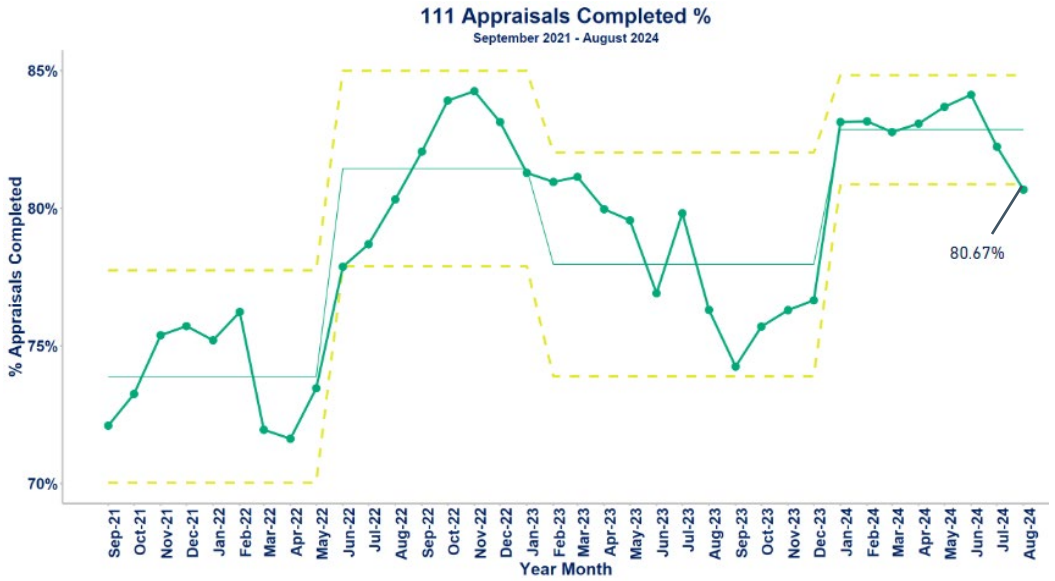


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

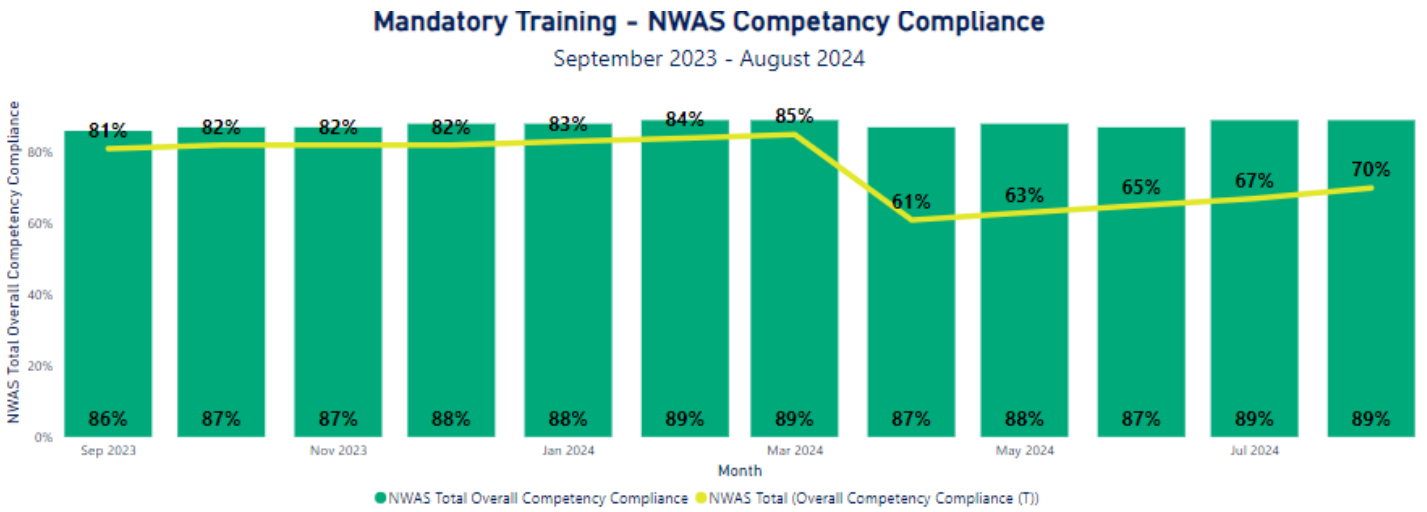


Figure OH7.2

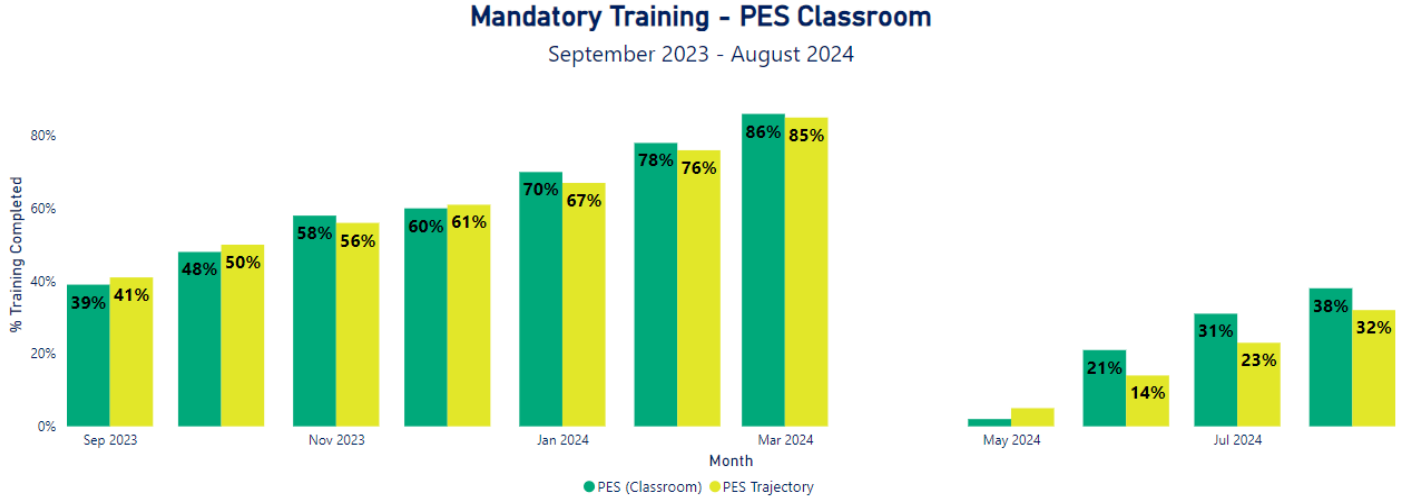


Figure OH7.3

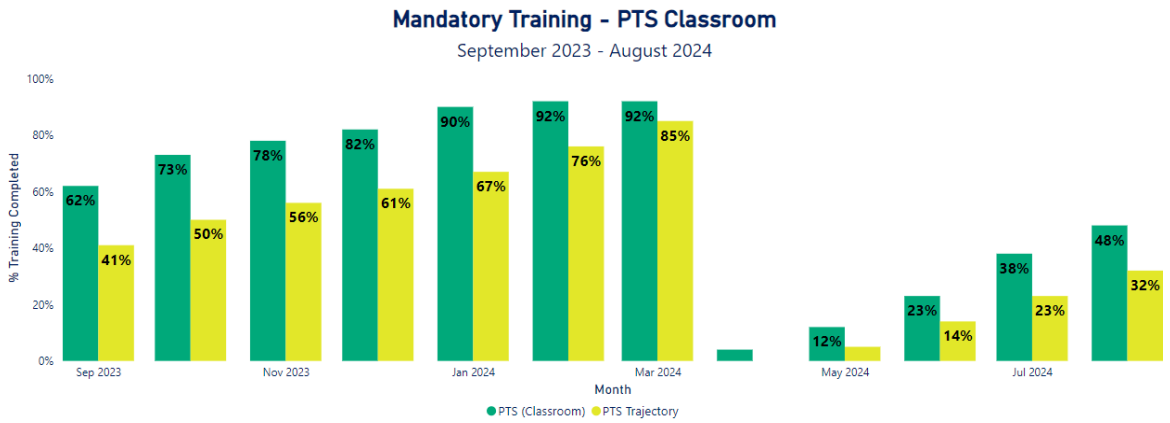
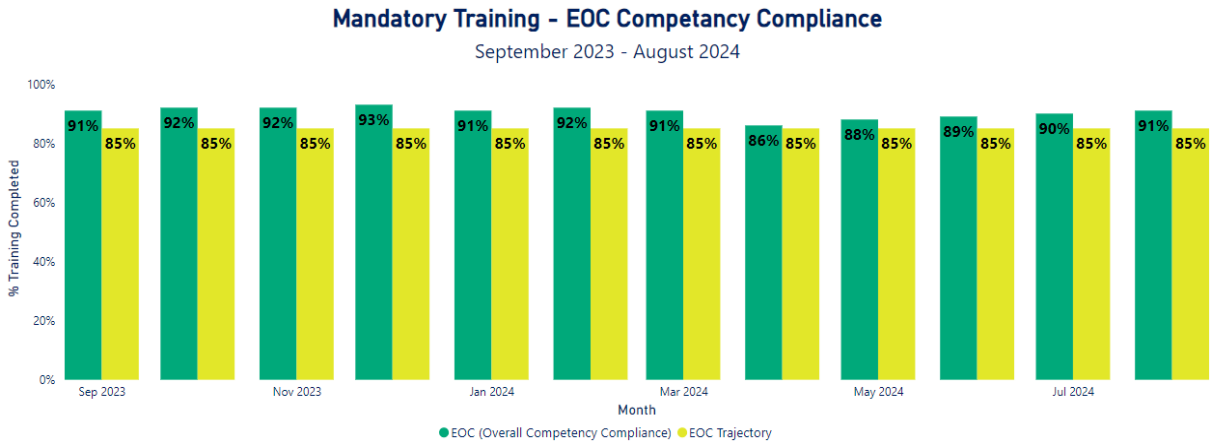


Figure OH7.4



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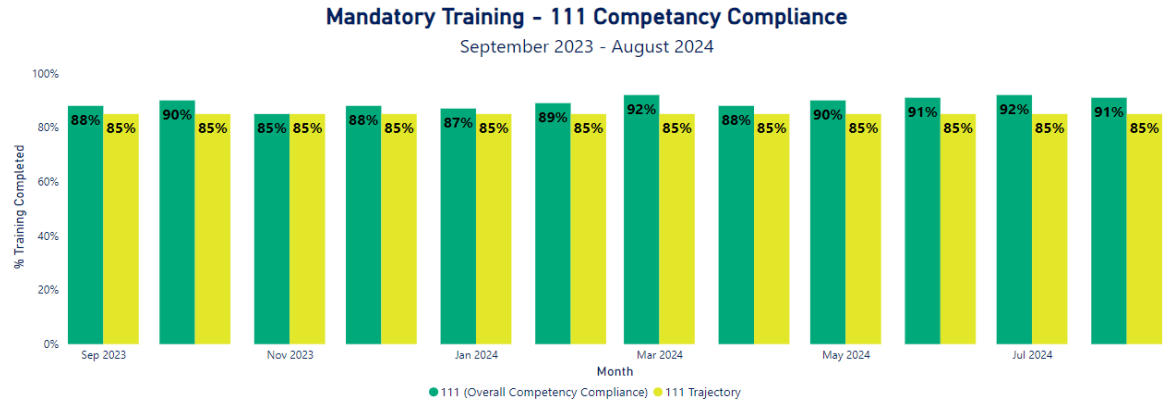
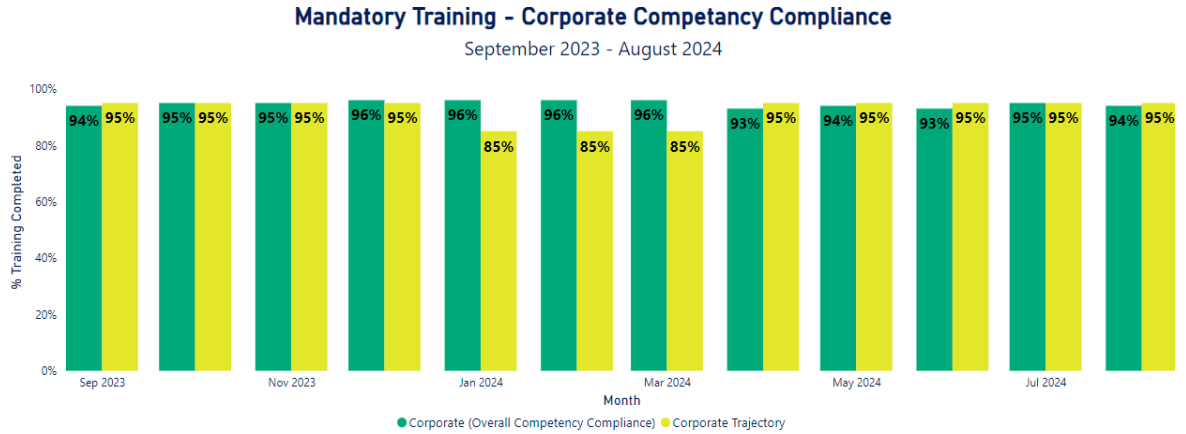


Figure OH7.6



OH8 CASE MANAGEMENT

BAF

Figure OH8.1

Board Reportable Events relating to Employee Relations as August 2024

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	71.00	1.7	189.00	4.5	15.78
CAM PES	17.00	1.3	71.00	5.3	13.61
CAL PES	25.00	1.9	63.00	4.8	15.49
GM PES	26.00	1.8	52.00	3.6	18.11
Operations ~ EOC	15.00	1.3	60.00	5.1	16.49
Operations ~ 111	8.00	1.2	88.00	12.7	6.39
Operations ~ PTS	17.00	1.7	115.00	11.5	10.28
Operations ~ Resilience	1.00	0.6	1.00	0.6	2.14
Corporate	9.00	2.1	42.00	6.6	16.34
Other	2.00		0.00		
NWAS Summary	123.00	1.6	495.00	6.3	12.94

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	15	77	13.40
Disciplinary	60	124	26.11
Fact Finding	34	180	6.10
Grievance	14	114	9.09
Case Summary	**123**	**495**	**12.94**

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	9	4	1	1
Disciplinary	29	21	7	3
Fact Finding	25	7	2	0
Grievance	12	2	0	0
Case Total	**75**	**34**	**10**	**4**

Top 5 Reasons for opening Disciplinary cases in the past 12 months

Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	20
Failure to follow reasonable management instructions/procedures	14
Fraud	8
Lateness	8
Poor patient care	8
NWAS Summary	**58**

*table shows a rolling 12 months so can go down as well as up

Case Dismissals July-August 2024

Service Line	Case Type	Information Category
Operations ~ PTS	Sickness	Ill health
Operations ~ PES	Sickness	Ill health
Operations ~ PES	Sickness	Ill health
Operations ~ PTS	Sickness	Ill health
Operations ~ EOC	Sickness	Ill health
Operations ~ PES	Disciplinary	Theft or Unauthorised or Unlawful possession of Property
Operations ~ PES	Disciplinary	Conviction of a Criminal Offence
Operations ~ PES	Disciplinary	Any actions that bring the Trusts reputation into disrepute
Operations ~ PES	Performance	Capability
Operations ~ 111	Probation	Capability

New Litigation cases August 2024

Service Line	Case Type	Case Sub Type	Information Category	Received Date
Operations ~ EOC	Litigation	Unfair dismissal	Disability	01-Aug-24
Operations ~ PES	Litigation	Unfair dismissal	N/A	06-Aug-24

Suspended	Alternate Duties
14	1

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 September 2024
SUBJECT	EMERGENCY PREPAREDNESS RESILIENCE RESPONSE (EPRR) Annual Assurance
PRESENTED BY	Dan Ainsworth, Director of Operations (AEO)
PURPOSE	Assurance

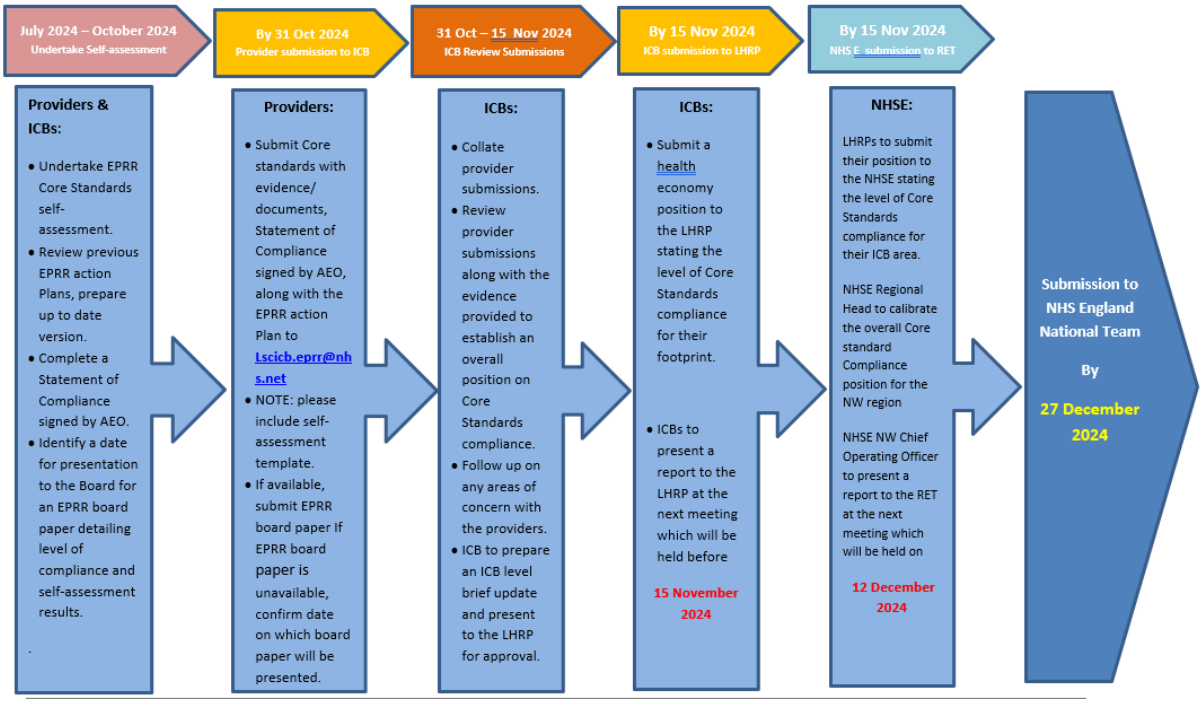
LINK TO STRATEGY	Choose an item.									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☒	**SR04**	☒	**SR05**	☐
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☐

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

ACTION REQUIRED	The Board is asked to: • Note the items in the ALERT section with associated actions. • 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 sets out the background to the self-assessment process, previous and current positions with rationale and actions, and a description of the plans NHS England have to refresh the process going forward. **ALERT** There are 4 standards that are partially compliant and will remain so at submission by 31st October. There is an action plan for 3 of them, one is dependant on funding being made available either by commissioners or nationally. **ADVISE** There are 9 standards that are partially compliant, 5 are anticipated to be compliant by submission which will give the Trust a substantial compliance rating (93%). There are 7 interoperability standards listed as partially compliant giving the Trust a substantial compliance rating (95%). It is not anticipated this will change as they are longer term pieces of work. **ASSURE** NWAS are meeting with the commissioning Integrated Care Board (ICB) on 7th and 11th October to go through the statements and evidence in detail prior to submission. Updates will be provided through the normal NWAS governance structure.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 18 September 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. 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*'
	NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintaining the ability to remain resilient and continue to deliver critical services. This is achieved through the EPRR (Emergency Preparedness, Resilience and Response) Annual Assurance process. NHS England requires that this assurance process identifies any areas of limited or non-compliance (as well as highlighting areas of full compliance) of arrangements against the EPRR core standards and that any deficiencies in particular areas inform an individual Action Plan. This plan will demonstrate the intention of each Trust to address any outstanding issues and give an indication of priority and timescale for resolution. Lancashire and South Cumbria(L&SC) Integrated Care Board (ICB) have requested regular updates for inclusion in their reports to the LHRP. The NHS Core Standards for EPRR (the 'Core Standards') are the basis for the assurance process and are the minimum requirements commissioners and providers of NHS-funded services must meet. They are based on robust delivery of duties under the Civil Contingencies Act (2004). The Core Standards cover 10 core domains applicable to all NHS services, the standards within the domains are filtered to ensure they are applicable to the Trust completing the review. In 2022/2023 PTS and NHS 111 was introduced as a core standard for EPRR Annual Assurance, and this continues as part of the process for 2023/2024. An additional domain for Ambulance is Interoperable Capabilities. This is assessed and scored but is not included in the overall score for the Service, nor is it covered in the check and challenge. Therefore the 2 areas for self-assessment as part of the EPRR Annual Assurance for the trust is as follows: • EPRR Core Standards (inc PTS and 111) • Interoperability Capabilities The NHS core standards for EPRR cover 10 core domains: • Governance • Duty to risk assess • Duty to maintain plans • Command and control • Training and exercising • Response • Warning and informing • Cooperation • Business continuity • Hazmat and Chemical Biological Radiological Nuclear (CBRN)

	The Interoperable Capabilities section contains: • Hazardous area response teams (HART) • Special operations response teams (SORT) • Mass casualty vehicles (MCV) • Command and control (C2) • Implementation of the joint emergency services interoperability principles (JESIP) The 2024/25 EPRR annual deep dive focuses on cyber resilience. This will not contribute to the overall organisational EPRR assurance rating.
2.	**Assessment Methodology**
	NHS England published the letter of notification on their website dated 15th July 2024 for Accountable Emergency Officer (AEO) and EPRR Leads. There was a delay in NWAS receiving notification from the ICBs although the Resilience Team had been made aware of the site update and moved proactively. This year, the standards are described as moving back to more self-assessment with peer review from the commissioning ICB who may then be challenged to produce rationale by NHS England. The timeline for NWAS is: **2024-25 Lancashire and South Cumbria ICB Core Standards for EPRR: Summary of Local Timeline of NHS Assurance Process**  **Maximum deadline for submission is 31st October 2024** but there has been a request to submit sooner so they have more time to process and report to NHS England. Head of Contingency Planning is in regular contact with Lancashire and South Cumbria ICB Head of EPRR and can ask questions ad hoc, formal assessment meetings between the two Heads of Contingency Planning/EPRR will take place on **7th and 11th October** to go through all of the standards, plus a more in-depth look at 6 standards of the ICBs choice.

The spreadsheet provided by NHS England and the evidence from NWAS is uploaded on an NWAS Teams channel and can be shown to the ICB. An action tracker is also available.

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

NHS England require presentation and discussion of the outcomes at a public Board meeting prior to submission and published in the annual report within the organisation's own regularly reporting requirements.

3.	**EPRR COMPLIANCE AGAINST THE CORE STANDARDS – 2023/2024 submission and progress**
	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. 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 while unaware 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 necessary prioritisation but progress is still being made. **By the end of June 2024, the Trust was at 83% compliance** with the EPRR Core Standards (starting position was 41%). This is in the **partially compliant** category. Substantial compliance starts at 89%. At the same assessment point, **Interoperability standards were now 95.6% compliant (classed as substantially compliant).**
4.	**EPRR COMPLIANCE AGAINST THE CORE STANDARDS – 2024/2025**
	Lancashire and South Cumbria (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 for both ambulance providers and interoperability.
	ALERT The Board should be aware that 4 standards will not be compliant in this cycle, 2 of which should be considered for non-compliance: • Standard 5 – EPRR resource. Funding from commissioners for MR20 has not been received. If there is no plan to gain the funding in the next 12 months, this should move to non-compliant. • Standard 37 – Local Health Resilience Partnership (LHRP) attendance, executive level health group. The Trust has been represented at all meetings in the last 12 months but has been represented by a Head of Service or Sector Manager on several occasions. **ACTION** – This has been addressed but there are not enough meetings tabled to have compliance for this submission. • Standard 38 – Local Resilience Forum (LRF) attendance, executive level multiagency group. The Trust has been represented at all meetings in the last 12 months but has been represented by a Head of Service or Sector Manager on several occasions. **ACTION** – This

has been addressed but there are not enough meetings tabled to have compliance for this submission.

- Standard 51 – Business Continuity audit. **ACTION** - External audit anticipated in Q3/Q4 but not prior to submission. If a robust audit cannot be anticipated in the next 12 months, this should move to non-compliant.

ADVISE

Current compliance – EPRR Core Standards

As of report submission, there are some pieces of work nearing completion but for transparency, the compliance rating should it be submitted at this time is:

EPRR Core Standards – 85% (Partially compliant)

It should be noted there are 9 standards in the EPRR section are currently rated as **partially** compliant:

Standard	23/24 rating	Status
5 – EPRR Resources	Partial	**See ALERT**
10 – Incident response	Compliant	The Incident Response Plan is under review and going to EPRRG in October when it will move it to compliant
12 – Infectious diseases	Partial	Policy expected to be signed off by 18th September which will change to compliant.
16 – Evacuation and shelter	Partial	Requires approval of guidance currently in draft (going to EPRRG in October), and assurance regarding Personal Emergency Evacuation Plans
37 – LHRP engagement	Compliant	**See ALERT**. Attendance at AEO or AD is recognised, and attendance is being monitored. If an area only has 3 meetings per year, all need to be attended by an AD or AEO.
38 – LRF engagement	Compliant	**See ALERT**. Some areas only have 2 meetings per year so both need to be attended by an Area Director or AEO
51 – BC Audit	Partial	**See ALERT**
Acute Trust Support 71 (train the trainer) and 73 training sessions	Partial	The lack of consistency between NHS England regions in their expectation of the ambulance services remit to design and deliver this training has been raised at the national ambulance EPRR Group and escalated to the National Directors of Operations Group to request clarity. NWAS are delivering training and have a workplan and training records. A letter will go on behalf of the AEO to the ICBs in lieu of an MOU, stepping out what we will do in alignment with contracts and core standards.

Expected compliance (by 31st October 2024)

4 standards will remain partially compliant (6.8%)
3 pieces of work awaiting final stages of completion/sign off (5.1%)
2 ATS standards require a formal letter/MOU (3.4%)
Possible total – 93% compliance (substantial).

Current compliance – Interoperability Core Standards

Interoperability – 95% (substantially compliant)

Standard	23/24 rating	Status
H8 – Six operational HART staff on duty		Funding has been made available but the lack of course availability will mean achieving teams of 7 is unlikely in the next 18 months.
H16 – record of compliance with response time standards		NWAS Digital team, in conjunction with ICC, have been asked to consider use of MIS HART module. This system is in place across other Trusts, as are processes that link to the PRO-CLUS interface. Work continues to explore means of accurate reporting; however, no end date is in place.
H32 – capital estate provision		Elm Point and Ashburton Point is being built at the moment; this will remain open until they are completed.
S25 – HAZMAT/CBRN plan		This plan is under review.
S29 – SORT response time		NWAS have SORT deployment plans in place to achieve the required standard, but more data needs to be gathered to test if deployment is possible with the given numbers at all times of day and year across the patch. This is part of a testing regime. It is recognised nationally to be challenging.
J8 – Command course (JESIP) attendance		From the list of 66 commanders that are currently in post, 9 have not completed a JESIP command course given us a compliance percentile of 88% as at 31 August 2024.
J11 – Command participation in exercises		Most exercises NWAS participate in are multiagency. From the list of 66 commanders that are currently in post, 11 have not completed an exercise in 3 years.
J13 – 90% staff JESIP aware		Figures remain around 80% compliance for ESR completion which can be see on the ESR dashboard. Work is underway to establish if other methods of awareness (e.g. SORT course attendance) are recorded and deconflicted against these figures.

Deep Dive

The outcome of the deep dive will be used to identify areas of good practice and further development and as in previous years it is expected that organisations will use their self-assessment to guide the development of local arrangements. The Resilience Team had already engaged with Digital in anticipation of questions, and a multi-departmental exercise is planned for 2nd October 2024.

Content includes:

- How Cyber security and IT Teams support the organisations EPRR activity and their inclusion in the workplan;
- Plans in place for mitigation/response/recovery in line with a risk assessment;
- Communications with stakeholders and media during a cyber incident;
- Exercising/testing/learning processes;
- Training in line with a training needs analysis;
- Assessment and recovery of critical functions and interoperability including business continuity.

	Future Methodology
	
	NHS England are currently reviewing the EPRR assurance process to ensure that it continues to develop and support continual improvement. The NHS core standards for EPRR will continue to be reviewed and updated every 3 years. Each new updated set of standards will be published no less than 12 months ahead of them being used for assurance purposes.
	
	The reviewed process will see changes from 2025/26 which will include:
	
	• Ensuring ICBs are empowered and supported to take the lead with regards to local delivery of the EPRR agenda (in line with the NHS England operating framework, seeking further opportunities to embed new ways of working in all our activities);
	  • This includes ICBs being responsible for gaining the NHS EPRR assurance.
	• Compliance rating from their providers of NHS funded care, under the terms of the NHS Standard Contract.
	• NHS England developing its relationship with related regulatory bodies to share and secure a common understanding regarding assurance outcomes, ensuring that compliance is achieved through a single mechanism:
	  • These organisations include the Care Quality Commission and the Health and Safety Executive.
	• Identifying any unconditional compliance requirements of the NHS core standards for EPRR.
	• NHS England annually self-assessing its EPRR compliance as a single organisation, including all relevant departments and regions.
	• Evaluating options for a digital solution to facilitate delivery of the overall assurance process.

	ASSURE Submissions will go to the following groups: 18th September – TMC 23rd September – Quality and Performance Committee 25th September – Board 14th October – EPRR Group (verbal update from meetings with ICB) 16th October – TMC 28th October – Quality and Performance Committee 31st October – FINAL SUBMISSON TO ICB 20th November – TMC 27th November – Board (update of final submission) 13th January – EPRR Group (update from submission by ICB to NHS England) 27th January – Quality and Performance Committee (update from submission by ICB to NHS England) 29th January – Board (update from submission by ICB to NHS England) There may be a discrepancy between the data that goes to each group as it will be the most up to date version provided. **Final submission will take place between 18th and 31st October** due to the ICB meeting dates.
5.	**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.
6.	**EQUALITY/ SUSTAINABILITY IMPACTS**
	None.
7.	**ACTION REQUIRED**
	The Board is asked to: • Note the items in the ALERT section with associated actions. • 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.

Appendix 1

Core standards table

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	8	3	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	5	3	2	0
Business Continuity	11	10	1	0
Hazmat/CBRN	1	1	0	0
CBRN Support to acute Trusts	7	5	2	0
Total	58	49	9	0

Interoperability standards table

Interoperable capabilities	Total standards applicable	Fully compliant	Partially compliant	Non compliant
HART	32	29	3	0
SORT	40	39	1	0
MassCas	14	14	0	0
C2	36	36	0	0
JESIP	13	10	3	0
Total	135	128	7	0

Deep dive – cyber

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	2	9	0
Total	11	2	9	0

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NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 September 2024
SUBJECT	Infection Prevention & Control Annual Report and Board Assurance Framework FY 2023/24
PRESENTED BY	Maxine Power, Director of Quality, Innovation and Improvement
PURPOSE	Assurance

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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 asked to: • Note the content of the reports. • Note the assurances it provides. • Note the arrangements for ongoing monitoring via the IPC BAF. • Note the key risks and mitigations.
EXECUTIVE SUMMARY	The purpose of this paper is to introduce the IPC annual report for 2023/2024 and the IPC BAF (see appendix 1) for reporting period 1st January 2024 to 30th June 2024. This report is a summary of the efforts and challenges the Trust has faced and overcome moving from the global pandemic and transitioning into 'business as usual' whilst acknowledging lessons learned. The Trust has adopted new national guidance to ensure there remains a significant focus on IPC to maintain both staff and patient safety and have considerable preparedness for any emerging infectious diseases. Assurance on the delivery of IPC within the Trust is monitored through the updated IPC Board Assurance Framework (BAF), which is presented to the Quality and

	Performance Committee, as well as The Board of Directors. The annual report aligns assurance and provides an understanding of the risks to the organisation during the reporting period. **Risks:** There are currently three risks aligned to IPC: • Risk ID – 236 There is a risk that due to not all staff being Filtering Face Piece (FFP3) fit tested and Sundstrom hoods not suitable for all scenarios, staff are unable to respond safely to Aerosol Generating Procedures (AGPs) leading to risk to personal safety of staff. • Risk ID – 255 There is a risk that due to lack of awareness or capacity, 20% of sharps boxes found in sharps bins aren't correctly labelled and / or with temporary safety lock correctly activated, resulting in no auditable trail and discarded sharps bins leading to harm or injury to both North West Ambulance Service (NWAS) staff and external clinical waste collection staff. • Risk ID - 605There is a risk due to increased prevalence of Measles in the community, staff who are not immunised or wearing the correct Personal Protective Equipment (PPE) will be exposed and at risk of contracting Measles resulting in further transmission in both the community and colleagues, leading to absence from work. The report also outlines all other activities that the IPC team lead on, collaborative working with other Trust services and provides a summary of any mandatory reporting.	
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	Monday, 23 September 2024
	Outcome	

1. BACKGROUND

NWAS Infection Prevention and Control (IPC) Annual Report) provides a comprehensive overview of IPC activity throughout the financial year and assurance that policies, procedures, system, processes, and training are in place to minimise the risk of transmission of infection to service users, patients, and staff. It also identifies gaps in assurance, IPC risks and mitigations. The report outlines the significant progress and achievements that have been made in delivering effective staff and patient safety.

The Annual Report is presented annually to the Quality and Performance Committee prior to the Board of Directors. The Annual Report has been discussed at IPC Working Group and has been circulated to all IPC Working Group members.

The IPC annual workplan and resulting activities centre around the gaps identified in the IPC Board Assurance Framework to ensure that the Trust minimises the risk of onward transmission of infection to staff and patients.

One new risk has been identified during the reporting period; 3 risks remain on risk register – one score has been decreased from a 12 to an 8. Risks regularly reviewed and managed, and action undertaken.

The IPC team have been extremely responsive in communicating information out to staff in response to revised national guidance on emerging infectious diseases - they have been a specialist resource and have improved visibility to ensure that staff are supported in the workplace. The IPC team have also spent a significant amount of time revising and streamlining policies and procedures and producing action cards to provide a quick reference for staff. QR codes have been produced for all documents to enable staff to access the necessary information in a timely manner and from any location.

IPC audits continue to be inputted via Safecheck. The IPC practitioners have been working closely with the Safecheck and Power BI team and assurance can be presented at the IPC sub- committee. Integrated Contact Centre audits have been developed by the IPCT and results are captured on a Teams questionnaire.

2. RISK CONSIDERATION

Infection, Prevention and Control (IPC) is a statutory requirement placed on NHS trusts. This assurance report is a requirement to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.

3. EQUALITY/ SUSTAINABILITY IMPACTS

There are no equality or sustainability impacts.

4. ACTION REQUIRED

The Trust Board is asked to:

- Note the content of the reports.
- Note the assurances it provides.
- Note the arrangements for ongoing monitoring via the IPC BAF.
- Note the key risks and mitigations.

North West Ambulance Service NHS Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2023/2024

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1.	**STATEMENT BY THE DIRECTOR OF INFECTION, PREVENTION & CONTROL**
1.1	This report demonstrates that the Trust has continued to make substantial progress towards achieving the Trust's key priorities for IPC. We continue to be committed to promoting best practice in IPC and to maintain our clinical standards. The IPC team are responsible for developing, implementing, and monitoring practices and procedures to prevent and control infections within the Trust, and continue to collaborate with internal and external stakeholders to provide advice, support, and training to ensure we maintain our compliance with the Health and Social Care Act (2008). The IPC team also play a critical part in safeguarding patient and staff health, reducing the risk of healthcare-associated infections, and ensuring a safe environment. National guidance and initiatives have been key drivers for elements of our annual work programme, and this evolving work stream will continue into 2024/25. IPC is the responsibility of everyone, and success is achieved when everyone works together. This annual report shows how we are performing, where we do well and where we plan to innovate and continuously improve our services.
2.	**PURPOSE**
	The purpose of this report is to present the achievements and challenges of the IPC team for NWAS. This report will focus on many different aspects of IPC activity and our ongoing response to emerging infectious diseases and outbreaks including concerns such as Measles and Scabies. The reporting period is 1 April 2023 until 31 March 2024.
3.	**BACKGROUND**
	Effective systems for the management of IPC are essential for all NHS providers. NWAS has a legal duty to comply with the Health and Social Care Act 2008, specifically the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. Our approach to IPC is taken from the guidance published by United Kingdom Health and Security Agency (UKHSA) who remain the trusted NHS authority on the implementation of research evidence into NHS practice. We are guided by the National IPC Manual (NIPM) which is supported through the Association of Ambulance Chief Executives (AACE). The IPC Manual is located on the NWAS Green Room and supplemented with several procedural documents for key areas of IPC practice specific to the ambulance service. These policies have been reviewed this year in line with national guidance and have been approved at the IPC Sub Committee. The IPC team monitor compliance to IPC policies, procedures, and training via a series of audits which are conducted locally, by IPC Practitioners, the IPC Manager, and external assessors such as UKHSA, Environmental Health and NHS England (NHSE). During the year we have continued to collaborate with digital teams to update systems to improve

	IPC Audits and how they are reported through a Power BI dashboard. This allows all service lines to review audit data and monitor their progress in real time. The dashboard also forms assurance reports which are presented to the IPC Sub Committee. To reflect the new corporate governance reporting structure from the 1st of April 2024 the IPC Sub Committee will be replaced by the IPC Working Group & will report directly to the Clinical & Quality Group. The IPC team monitor any infection related issues by reviewing IPC incidents through the Trust's incident management system, Datix Cloud IQ (DCIQ). The IPCT have a dashboard that has been developed that summarises all IPC incidents that have been reported. Themes from incidents occurring in each area are used alongside audit data to inform our intelligence about which systems need to be improved, where additional training is required, or where risk management systems need to be put in place.
4.	**COMPLIANCE WITH REGULATORY CQC**
4.1	**CQC Assurance** In 2023/24 the Care Quality Commission (CQC) continued to regulate providers using a risk-based model whilst moving towards their new regulatory model, with staggered rollouts nationwide of the new Single Assessment Framework (SAF). In Q4 2023/24, the SAF went live in the Northwest. Their approach during 2023/24 included ongoing routine engagement meetings and enquiries. On an annual basis, NWAS undertake Quality Assurance Visits (QAV) across all service lines. The purpose of QAVs is to provide assurance to the Trust about the quality and safety of our operational premises, vehicles and services at sector level and provide internal second line assurance and information in relation to key lines of enquiry from the CQC. The IPC team participates in the QAVs outlined above to provide a specialist oversight on the visit. Non-adherence to IPC policies and procedures are identified and inputted onto the Trust Integrated Action Tracker (IAT) for services to rectify, with the support of the team if required. Any non-compliance is monitored by a follow up IPC audit to ensure all actions have been addressed. We actively review any feedback and concerns that may have been raised in relation to IPC. Any recommended changes to our policies or procedures are fully considered and implemented when appropriate. This interactive and close collaboration with the CQC is showing a reduction in the amount of formal CQC enquiries. The CQC's regulatory mode has recently changed, to keep up with the regulatory requirements and improve our internal assurance, we have redesigned our QAV framework according to CQC's SAF. The IPC Specialist Lead has worked with the Accreditation and Assurance Manager to ensure that the internal assurance systems related to IPC are aligned to CQC's new Quality Statements which have replaced the key lines of enquiry and prompts.
4.2	**Estates and Facilities Management** The Estates and Facilities team conduct compliance audits on all NWAS owned properties to ensure the sites remain safe, clean, well maintained and all associated equipment is in a safe operational condition. The team ensures that appropriate maintenance and inspection records are held centrally and comply with statutory legislation.

	The Head of Estates has a number of safety groups in operation to provide assurance in relation to HSE legislation to include, but not limited to, the management of; asbestos, water safety, gas and 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. Compliance reports are provided to the HSSF Group and other Trust Committees. The IPC Specialist Lead is a member of the Water Safety Group that commenced this year in line with the requirement in the Health and Social Care Act. A Trust Water Safety plan has been developed and approved by the group. Results of regular monitoring of water samples are reported to the group and any anomalies are recorded on a central database which is monitored by the Estates and Facilities department and action taken accordingly to address any issues identified which are out of normal parameters. The IPC team participate in the planning stage of refurbishment and new buildings across the organisation. The team ensure that these plans include facilities so that the organisation is compliant with national guidance on the safe disposal of waste, safe disposal of sharps, to store clean linen, have adequate storage for sterile, single use items and that all areas are fitted with surfaces that are able to be cleaned easily with the required cleaning materials.
5.	**IPC GOVERNANCE ARRANGEMENTS**
5.1	In NWAS the corporate responsibility for IPC sits with the Assistant Director of Nursing and Quality, who is also the Director of Infection Prevention & Control (DIPC). The DIPC provides assurance to the Board and the wider Executive Team through assurance reports, the annual work plan, and the IPC BAF. The DIPC is responsible for the IPC team. The team consists of 1 x IPC Specialist Lead, 1 x IPC Manager, 3 x IPC Practitioners, and 1 x IPC Administrator who provides support to the DIPC and the IPC team. The team sits within the Quality, Improvement and Innovation directorate and is overseen by the Assistant Director of Nursing and Quality & DIPC.
5.2	 Chart 1 demonstrates the structure of the IPC team.
5.3	**Progress Against BAF Key Lines of Enquiry** The IPC BAF has been revised in line with the code of practice (the code) on the prevention and control of infections under the Health and Social Care Act 2008 (H&SCA 2008). This

	act sets out the overall framework for the regulation of health and adult social care activities by the CQC. The revised BAF is also a reflection of the updated national guidance in terms of the NIPCM and the requirement to return to 'business as usual' following the pandemic. Part 2 of the code sets out the 10 criteria against which the CQC will judge a registered provider on how it complies with the IPC (including cleanliness) requirements, which are set out in the BAF. To ensure that consistently high levels of IPC (including cleanliness) are developed and maintained, it is essential that all providers consider the whole document and its application in the appropriate sector and not just selective parts. A number of sections have been highlighted as 'Not Applicable' for ambulance services as they relate to Antimicrobial Stewardship, Inpatient isolation facilities and access to pathology services. Assurance is provided by providing evidence against each criterion and mitigating actions where the criteria are not fully met. The BAF was reviewed in November 2023 and presented to both the Quality and Performance Committee and Trust Board for assurance. NWAS is rated green for 26 criteria, there are no red rated criteria, and 9 amber rated key lines of enquiry. 18 of the criteria are not applicable for the ambulance service as they refer to isolation facilities, access to a pathology laboratory and surveillance of infections. Mitigating actions for these amber rated criteria are included in the document – which include fit testing and standards of cleanliness (which we are awaiting a national document for cleanliness specifications particular to the ambulance service to benchmark). The IPC risks are reviewed monthly, and the IPC BAF will be reviewed 6 monthly at the IPC Sub Committee – or sooner as required in line with national guidance.
5.4	**Provide and Maintain a Clean Environment** During the year 2023/24 environmental cleaning continued for non-clinical areas in line with national cleanliness standards. Escalation measures are re-instated in line with national guidance if any outbreaks are declared. Vehicles continued to be cleaned daily and in between patients. Enhanced cleaning continued to be undertaken for suspected or confirmed infection cases and where AGP's had been undertaken within the vehicle. All Trust vehicles undergo a 6 weekly deep clean carried out – deep clean audit data is presented at the IPC Sub Committee for assurance. The IPC team also carry out unannounced audit on vehicles after a deep clean prior to the vehicle going back out on the road. Any issues identified are then escalated to the Fleet Logistics Manager who is responsible for monitoring the contract.
5.5	**Provide Suitable Information on Infections for Staff and Patients** Any updated national guidance and local operating processes were disseminated regularly to staff via bulletins, social media, internal intranet, and the IPC Sub Committee. All training materials for staff and volunteers were reviewed throughout the reporting period and amended to reflect changes in national guidance.

	Local risk assessments, guidance and procedures remain in place to ensure that patients are appropriately triaged and assessed for level of risk prior to transportation where possible. Liaison with other health care providers in relation to patients with transmissible infections ensures the risk of onward transmission of infection is minimised by ensuring that patients are placed in the most appropriate setting. The IPC team work closely with IPC teams in all health care organisations and so are aware of any increase in prevalence of infections in the community and as a result will inform staff working in that area to be aware. The IPC team also work closely with UKHSA to identify care facilities that have reported an outbreak. UKHSA sends the information via email to the IPC inbox, the team will then review that information, liaise with the NWAS Gazetteer team who will put a marker on the address which will inform attending crews of the outbreak. The markers are removed when the outbreak is declared closed.
6	**ASSURANCE**
6.1	The NWAS BAF includes a strategic risk related to the safe delivery of high-quality care which is articulated as follows: 'If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety'.
6.2	**IPC Risk Management** During 2023/24 risks in relation to IPC have been aligned, managed, and monitored as part of the IPC BAF, in addition to the organisational BAF and the Corporate Risk Register (CRR). This BAF was developed to monitor NWAS standards against key healthcare criteria and provided evidence and assurance surrounding the management of any risks identified. Risks are continually reviewed, re-assessed, and added to the organisational risk register. The BAF continues to be reviewed on a quarterly basis and when updated nationally. BAF updates are presented to the Quality and Performance Committee for assurance, prior to the Board of Directors. The Executive Leadership Committee monitors the organisational management of the BAF. All risks are reported on DCIQ: There are currently three risks that are aligned to IPC: • Risk number – 236 There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods not suitable for all scenarios, staff are unable to respond safely to Aerosol Generating Procedures (AGPs) leading to risk to personal safety of staff. • Risk number - 255 There is a risk that due to lack of awareness or capacity 20% of sharps boxes found in sharps bins aren't correctly labelled and / or with temporary safety lock correctly activated resulting in no auditable trail and discarded sharps bins leading to harm or injury to both NWAS staff and external clinical waste collection staff. • Risk number - 605 There is a risk that due to increased prevalence of Measles in the community, staff who are not immunised or wearing the correct PPE will be exposed and at risk of contracting Measles resulting in further transmission in both

	the community and colleagues leading to absence from work. These 3 risks have been reviewed monthly and updated as further actions and mitigations have been put in place, this is reported via the IPC Sub Committee for assurance. Of these three risks, only one risk has a risk rating of 12 by the end of March 2024 which is the risk around Measles and has only been added to the risk register in March 2024. All three risks identified are in relation to areas highlighted in the report, including areas of improvement and additional assurances.
6.3	**Risks Scoring >12** A new risk was added in March 2024 (ID 605). There is a risk that due to increased prevalence of Measles in the community, staff who are not immunised or wearing the correct PPE will be exposed and at risk of contracting Measles resulting in further transmission in both the community and colleagues leading to absence from work. Mitigating actions include close liaison with Occupational Health to ensure we have accurate vaccination records for staff, working with communications to cascade information to staff to ensure that they are aware of the correct PPE to wear and to develop resources for staff to advise on necessary actions should they have been exposed to a Measles case. Risk ID 236, scoring 8, is a risk due to not all staff being FFP3 face fit tested and Sundstrom hoods are not suitable for all scenarios. Staff are unable to respond safely to AGPs leading to a risk to personal safety of staff. During 2023/24 this risk has reduced from a 12 to an 8 due to a successful business case which was presented to the Executive Leadership Committee to recruit three Face Fit Test Assistants to the IPC team. The fit testers started in post in quarter two and attended the accredited fit testing course. They are each directly line managed by the IPC Practitioner for that area and also work closely together as a team to identify and address any low compliance areas. The funding from the business case also allowed other members of the IPC team, and some staff in the training department, to also attend the accredited course and carry out fit testing on staff across the organisation to help with compliance rates. A Microsoft Teams form has been developed to be completed at the fit test to record if staff pass or fail the test and which mask. The data on the forms is then inputted onto ESR so the Trust now has a robust centrally recorded system to monitor compliance. Staff are also given written information to inform them when they need to be retested and which mask they need to use. Compliance with fit testing has increased significantly hence the risk score being reduced. Risk ID 255, identified as score 8, is a risk due to the lack of awareness or capacity that 20% of sharps boxes found in sharps bins are not correctly labelled and/or with temporary safety lock correctly activated resulting in no auditable trail and discarded sharps bins leading to harm or injury to both NWAS staff and external clinical waste collection staff. Work is ongoing to address these issues, the practitioners are working with the areas to raise awareness of sharps safety, and the team are working with the sales company that manufacture the sharps container to develop a bespoke receptacle for the ambulance service.

6.4	**Mitigated Risks (Closed) During 2023/24** Risk ID 322 was placed on the risk register, with a score of 8, in July 2022 due to ongoing issues with the audit data collection tool. There is a risk due to the inaccuracies within the Safecheck audit tool that the IPC team are unable to gain adequate assurance on compliance with the IPC policies and procedures leading to an unsafe environment for patients and staff. This risk was closed in January 2024 after work had been completed on Safecheck, a trial data was completed to ensure the information was accurate prior to closing the risk.
6.6	**Private Provider Group** Over the past 12 months the IPC team have been involved and supporting the private provider group who have ownership of commissioning and management of the private providers for PTS and PES. The support has ranged from IPC Practitioners undertaking spot check audits on vehicles at Emergency Departments, basic IPC education, offering IPC specialist advice and visiting sites for commissioning and audit purposes.
6.7	**Peer Review** In June 2023 the IPC Team at NWAS engaged in a national peer review programme between ambulance services. This was lead nationally through AACE and each trust was assigned another ambulance trust to conduct a peer inspection review and provide feedback to the ambulance trust inspected. The Head of Safety and IPC and a senior IPC Specialist from the Yorkshire Ambulance Service (YAS) conducted a full peer inspection review. They provided a very positive feedback report which highlighted some key achievements. • Motivated IPC Team keen to develop and progress – this is a relatively new team comprising of an experienced IPC Team Manager and IPC Practitioners who had been paramedics previously. • IPC Team re-structured and has introduced a new IPC Specialist Lead role that provides sound clinical knowledge and experience. • Fit Testing and assurance of RPE checks is now managed by IPC team. This is now managed by the Trust in house, so we have better access to data and compliance is improving. • Policies have been reviewed and process in place to update them. • Cleaning regimes now in place for frontline staff to clean their vehicles. • Deep Clean contract went through a tendering process to establish a provider that better suits NWAS requirements.
7.	**POLICES AND PROCEDURES**
7.1	The IPC Specialist Lead attends the monthly National Ambulance Service Infection Prevention and Control Group (NASIPCG) and contributes to AACE guidance prior to approval. Once the AACE guidance is approved the IPC team work closely with the Communications team in NWAS to ensure an updated bulletin is distributed to inform staff of any changes and the IPC team also support the Heads of Service in implementing the necessary changes. The Trust IPC policies and procedures are regularly reviewed and updated to ensure they are aligned to national best practice guidance. The IPC team work with the

	Communications team to also ensure that new policies and procedures are available on the IPC pages on the Greenroom. The team then work closely with Heads of Service, when new or updated policies are available, to ensure all staff are made aware and to improve Trust compliance. This year we have reviewed and updated our IPC policies and procedures, and we have ensured that the national standard of good practice from the NIPCM is incorporated into Trust policy. NWAS also has responsibility to keep its internal policy and procedures in place in line with the Health and Social Care Act – the current policies that are in place include: • National Infection Prevention and Control Manual • Communicable Diseases Policy • Wound Care Policy • Peripheral Intravenous Cannulation Policy • Linen Policy • Aseptic Non-Touch Technique Policy • Respiratory Protective Equipment Fit Testing Policy The IPC team monitor compliance to our policies, procedures, and training via a series of audits which are carried out locally, by IPC Practitioners and by external assessors, such as UKHSA, Environmental Health, NHS Improvement (NHSEI) and NHSE. We have continued to develop our IPC audit dashboard which allows all service lines to digitally input audit data and review progress in real time. We also learn about IPC practices from when things go wrong by reviewing IPC incidents through our incident management system, DCIQ. The themes from incidents occurring in each area are used alongside audit data to inform our intelligence about which systems need to be improved, where additional training is required or where risk management systems need to be put in place.
8.	**GOVERNANCE**
8.1	The Trust's IPC Sub Committee convenes bi-monthly to ensure ongoing adherence to regulatory compliance. Initially, the IPC Sub Committee's terms of reference were the monitoring of COVID-19, Respiratory Protective Equipment (RPE) usage, and conducting audits of RPE up until the government changed the guidelines in April 2023. Even though the government guidelines were revised, the inclusion of the IPC Sub Committee became a permanent fixture as it is used to provide and present assurance reports. All staff members were required to notify the Carlisle Support Centre of any absences related to COVID-19, whilst reporting sickness absences. This reporting protocol facilitated NWAS in generating various reports based on the collected data allowing the IPC team to monitor COVID-19. This information was provided daily which enabled the IPC team to assess the necessity of declaring an outbreak. However, this practice ceased on 25 April 2023 as staff members were no longer obliged to undergo Lateral Flow Device (LFD)

	testing. If staff exhibited symptoms and felt unfit for duty, they reported their unfitness as any other sickness through the regular channels.
8.2	**Outbreak Management** Outbreaks are declared by an IPC Practitioner and are defined as instances where two or more cases of a communicable disease are linked in either time or place. Within the ambulance service, this could entail cases linked to specific stations, offices, fleet services, call centres, or between crew members. The IPC team have a responsibility to monitor the outbreak to ensure an efficient and coordinated response to the outbreaks within NWAS, from the initial detection phase to the formal closure and review of lessons learned. It encourages a uniform approach across all levels of NWAS and includes a set of response standards for a declared outbreak. During the period covered in the report there has been no outbreaks reported in the Trust.
9.	**Personal Protective Equipment (PPE)**
9.1	From April 2023, NHSE and UKHSA guidance on COVID-19 was updated and the previous restrictions were relaxed. There was no further need for physical distancing, mandatory face mask wearing or for health care staff to undertake lateral flow testing. Risk assessments were undertaken to ensure staff and patient safety within the Trust. PPE guidance was also changed, and the previous PPE requirements known as 'PPE levels' were replaced with Transmission Based Precautions (TBP) and the staff member chose the appropriate PPE based on what transmission route was need i.e. contact, droplet or airborne. These updates have been reflected in all training packages.
9.2	**PPE Stock Ordering and Distribution** NWAS procurement team take full responsibility for the ordering and supply of PPE in NWAS. There was a requirement for the Trust to procure PPE for stock distribution from NHSE/I who continued to adopt a 'push stock' system. NWAS' stock was replenished regularly. Stocks continue to be held regionally at central stations across each geographical region. Although the demand for PPE stock reduced after the COVID-19 pandemic, PPE stocks are held across the Trust. The 'push stock' system ended 31st March 2024.
9.3	**PPE Recalls and Safety Alerts** The MHRA issues notice of safety alerts from the Central Alerting System (CAS). The NWAS Board of Directors are notified via the Integrated Performance Report of safety alerts received. During 2023/24 NWAS did not receive any IPC related safety alerts or PPE recalls.
9.4	**Respiratory Protective Equipment** The FFP3 respirator mask covers the mouth and nose to protect against particulate hazards, such as airborne infectious viruses and is an essential part of PPE for clinical staff who carry out AGP's. An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route. The only AGP likely to be completed by NWAS staff is the suctioning of a tracheostomy on a patient with a suspected or confirmed respiratory condition. There are also other infectious diseases where the requirement for respiratory protection is essential. These include Middle Eastern Respiratory Virus (MERS), Avian flu, Monkey Pox (MPox) and other high consequence infectious diseases. Respiratory protective equipment must also be worn if there is a risk of exposure to asbestos.

	During 2023/24 FFP3 masks were available free of charge to all NHS trusts via the Central Governments push stock. NWAS were able to choose from a list of approved FFP3 masks of which the supply was guaranteed. A selection of 5 masks are available that staff can be fit tested on which provide an option for various face shapes and sizes. Anyone who failed on all 5 of these masks had the powered respiratory hoods (Sundstrom) that are supplied as personal issue to every patient facing member of staff. During 2022/23, fit testing was undertaken by NHSE funded external provider Ashfield, however this stopped at the end of March 2023. In April 2023, the IPC Specialist Lead, IPC Manager and IPC Practitioners undertook accreditable quantitative fit tester training in order to continue fit testing operational staff in the absence of external fit testers. In addition, Clinical Education Practitioners completed the training to fit test new operational and trainee staff whilst in their induction or training period. Recruitment of a dedicated NWAS Fit Test team was undertaken and three staff members joined the team, one for each area – Cheshire and Merseyside (CAM), Cumbria and Lancashire (CAL) and Greater Manchester (GM). These RPE fit test assistants began fit testing operational staff across the Trust in October 2023, as well as university Paramedic students who have their placements with NWAS. All fit test records are currently held centrally on ESR to allow auditing and to ensure individual staff members are aware of their own fit test status. Current compliance: PES staff that have been offered a fit test – GM 87% CAL 82% CAM 63% The variance in figures is due to the amount of fit testing that was available in 2022/23 where CAM had little fit testing completed due to challenges with the external fit test provider Ashfield. The challenges still remain with staff availability for fit testing due to operational pressures. Mitigations are in place for any PES staff who have not been fit tested or have failed a fit test. All staff who may be required to perform AGP's or attend an incident with an infectious patient are provided with an individual issue powered respiratory hood.
9.5	**Respiratory Hoods** NWAS continue to issue powered respiratory hoods as RPE as personal issue to all emergency service patient facing staff. The powered respiratory hood which the Trust uses is the Sundstrom SR 520 Hood with the SR700 Fan unit.

This Powered Air Purifying Respirator (PAPR) comprises of a small motor unit that sits on an IPC compliant belt, in the small of the back. A corrugated hose runs up the wearers back to a hood. The motor unit sucks air in, via two filters, filter it, blows it up the hose and into the hood creating positive pressure. This enables staff with beards, stubble, spectacles, and facial disfigurement to wear the equipment. There is no need for fit testing, however, the user does need to be trained in how to test and wear the equipment.

There is a requirement for the Sundstrom hood filtering units to be serviced on an annual basis, to ensure compliance with the Control of Substances Hazard to Health (COSHH) regulations. The filter units are serviced by Sundstrom trained Oxylitre service engineers.

Compliance Auditing of RPE Preparedness

The IPC Team has developed audit systems for monitoring operational compliance of our staff regarding preparedness to attend an incident requiring RPE. This audit is carried out by a Senior Paramedic Team Leader (SPTL) during their clinical contact shifts with front line operational staff. This should happen on three occasions a year. This audit measures whether the staff member is in date for their FFP3 fit test and if not if they have their Sundstrom hood with them.

10. VACCINATION

10.1 Flu Vaccination Programme

The Trust managed its annual flu vaccination programme for 2023/24 with a similar model as with previous years. The IPC Specialist Lead for the Trust was responsible for coordinating the vaccination of corporate staff within NWAS. Several of the IPC team completed the necessary training to administer the flu vaccine - they then organised and conducted vaccination clinics around the trust liaising with operations managers, emailing corporate staff and booking appointments. The IPC vaccinators vaccinated a number of PTS staff as they had no vaccinators and also attended numerous educational settings vaccinating new starters to the Trust. The IPC team managed to vaccinate over 450 staff members which equated to 14% of the total vaccinated. The team had numerous discussions with staff members to support and reassure them of the vaccination process and alleviate any reluctancy.

The Trust officially concluded its campaign at the end of February 2024 and the final uptake of the flu vaccine was 3172 vaccinated at NWAS and 524 members of staff vaccinated

	elsewhere which equates to 48.63% of staff. The total number of staff vaccinated is slightly higher than last year and in terms of benchmarking with other Trusts, NWAS performed better than of previous years. Across the NHS uptake of the influenza vaccine was lower this year than previous campaigns. The IPC team will be fully supporting the flu vaccination program for 2024/2025 with mobile flu clinics around the Trust footprint.
10.2	**Staff Welfare - Supporting staff and families** NWAS remains committed to prioritising the health and well-being of its over 8000 employees and volunteers. During the pandemic, NWAS conducted one-to-one risk assessments with staff to understand individual difficulties and risks, ensuring appropriate support measures. These assessments were regularly updated to reflect personal circumstances or national guidance changes. Support mechanisms included regular welfare texts, stress risk assessments, signposting to therapy or agencies, highlighting well-being resources on the intranet, and modifying duties or work arrangements. Although COVID-19 is no longer a significant factor, the welfare of staff remains a priority. To continue supporting staff well-being, NWAS has introduced several welfare support platforms, including a comprehensive well-being app. This app encompasses various aspects of staff welfare, enhancing the employee support network. Key features of this app include: • Ambulance Staff Crisis Phone Line: A dedicated helpline for immediate crisis support • Employee Assistance Provision: Access to resources and support for a wide range of personal and professional issues • Counselling and Occupational Health: Professional counselling services and Occupational Health support • Every Mind Matters: Mental health resources and tools to support well-being • Well-being Apps: A selection of recommended apps focused on mental and physical health • The Hub of Hope: A national mental health database bringing help and support together in one place • Chaplaincy Support: Spiritual support and guidance for staff of all faiths and none • TRM Assessments: Trauma Risk Management assessments to support staff exposed to traumatic incidents • TASC: The Ambulance Staff Charity which provides additional support and resources The introduction of this app demonstrates NWAS's commitment to enhancing the health and well-being of its staff, providing a readily accessible, comprehensive support system to address a wide range of needs. This initiative is part of NWAS's ongoing efforts to ensure a supportive and responsive working environment for all its employees.
11.	**FACILITIES MANAGEMENT**
11.1	**Review of Cleaning Regimes Across All Sites** The NHS published the National Standards of Healthcare Cleanliness in April 2021, mandatory for all healthcare settings except for ambulance services trusts. NHSE formed a national working group to develop the standard specific for the ambulance sector and the Head of Facilities Management (FM) and FM Regional Officer, who manages the Trust's

	cleaning provider, are members of this group. Work continues to develop this version with NWAS at the forefront creating the specification supported by the IPC Lead. No publication date has been set, but this is expected to be during 2024 with a 12-month implementation period following. In anticipation of the publication, and with the insight afforded from being a part of the working group, FM has reviewed the current cleaning provision and developed a matrix containing new specifications, all elements that require cleaning and the frequency of clean, which will ensure that the Trust has a solid foundation to meet the new standards once these are released. The matrix will also be used as the basis of the new premises cleaning contract which will be retendered during 2024 and used to measure performance and cleanliness of our sites with the contractor. In further readiness for the new national standards, FM have commenced a Trust wide review of cleaning provisions; the sluice and storage facilities provided in premises that enable effective cleaning at stations and premises. The results of this review will be collated in July 2024 and early findings indicate that a commensurate space will be needed in many stations together with investment in shelving and sluice sinks. IPC are supporting this review, and the practitioners are involved in reviewing the premises with members of the FM team.
11.2	**Decontamination** Through 2023, following the removal of all social distancing measures, there was no requirement to use this facility in respect of the cleaning of premises. However, the decontamination service for workstations and premises remains available to call on as and when necessary or the Trust through the contractor.
11.3	**Premises Cleaning and Increase to Cleaning Provision** The enhanced provision at the contact centres and large stations is now stable and well embedded. The review of the provision continues to take place as required in line with any changes to the Trust's operational delivery plans or, as the estate portfolio is increased or reduced.
11.4	**Clinical Waste** The clinical waste stream within the Trust is managed and monitored by the Fleet Logistic Team and the contract at present sits with Stericycle. The Trust has robust systems in place for disposing safely and effectively of clinical waste. Due to the increased usage of PPE / clinical waste during the pandemic, it was necessary to increase the amount of clinical waste collections, however, this is in the process of being reduced, resulting with annual savings of FY 21/22 £9K, FY 22/23 £15K, FY 23/24 £9K as a consequence of reducing the frequency of collections with Stericycle. The Trust has an initiated the first pilot of Alternative Treatment (Orange bag) waste disposal at Blackpool station in April 2024 for all vehicles within the hub. This will shortly be followed by extending the pilot within CL South and Wigan station for introduction in June 2024. The service delivery provided by Stericycle in the provision of clinical waste disposal is managed and reviewed on a monthly basis during contact management

	meetings, which is managed by the Fleet team in collaboration with the Trust Energy and Sustainability Manager and Procurement team.
11.5	**Vehicle Cleaning** All ambulances interiors and equipment are cleaned and disinfected after every patient contact with clear guidance provided within the IPC Procedures which is in line with national guidance. Ambulance vehicle exteriors are cleaned regularly and when as required. An additional Deep Clean service across the entire fleet (PES / PTS / RRV), is in place and provided by Churchills Ltd. Every vehicle (emergency, patient transport, urgent care, and all solo response vehicles) receives a `Deep Clean' every six weeks, delivered through a combination of fixed and mobile sites across the Trust footprint. This service continues to enhance operational availability, patient safety, and staff welfare in the improved cleanliness of each vehicle. To maintain service delivery against performance, an assurance regime monitors all Deep Cleans conducted against a randomised 10% audit program, this is further underpinned by additional unannounced audits carried out by the IPC Team. Deep clean audit results are presented at the IPC Sub Committee for assurance.
11.6	**Deep Clean Tender Contract** The IPC Specialist Lead was involved in the tendering process for a provider of deep clean/make ready services for the Trust in August. The lead worked with procurement and fleet (who oversees the contract) to ensure that the new provider of the services going forward were able to provide assurance that they followed national guidance on IPC and that their products used were suitable for cleaning both the equipment and the vehicles.
11.7	**Cleaning Innovation** The IPC team were approached by a local company named Metis who manufacture cleaning equipment for the health care sector. They were keen to understand the issues around ambulance contamination with the aim to improve their in-development misting machine. This was being designed to rapidly decontaminate ambulances without the use of ultraviolet light or toxic hydrogen peroxide. The team facilitated access to one of the NWAS emergency vehicles so they could see the layout and the type of equipment carried on the vehicle. With the research they carried out, Metis were able to demonstrate their misting machine which can decontaminate an ambulance in 6 minutes – much quicker than hydrogen peroxide which can take around 30 minutes. Product development is ongoing.
12.	**TRAINING**
12.1	IPC is a crucial element within the mandatory training programme that all staff members must undertake. It requires the completion of two modules at the time of recruitment, followed by an annual update. To ensure that this critical topic is effectively conveyed, a presentation has been developed by the IPC team that outlines the IPC guidelines for new front-line starters. The presentation complies with the new national IPC manual and ensures it meets the requirements of the UK core skills training framework and mandatory training. This is presented by the IPC team and its goal is to ensure that all staff members

	have a comprehensive understanding of the IPC practices and protocols. The presentation encompasses the following. • systems and procedures relating to IPC. • legislation and policies relating to IPC. • definitions of a Healthcare Associated Infection and how to reduce them. • the importance of good personal hygiene in IPC in line with UKHSA guidance. • roles and responsibilities in IPC. • how to clean and decontaminate vehicles and equipment. • the management of Sharps and linen. • handwashing techniques in IPC. • the importance of risk assessment concerning IPC The IPC team works closely with the mandatory training team to ensure that all clinical staff completes the mandatory IPC training and are also dedicated to improving local training based on audit findings, which entails ongoing assessments of current practices and protocols to identify areas that require improvement.
13.	**COMMUNICATION AND ENGAGEMENT**
13.1	**IPC Team** The IPC team continue to work hard to maintain their visibility across the Trust. Attendance at locality meetings and forums to share information on IPC is a regular occurrence and the IPC Practitioners act as integral support to the QAV processes across the Trust. In addition to the internal engagement, the IPC team have formed strong infrastructures with IPC leads at other health care providers, UKSHA IPC leads and NHSE IPC Leads. The IPC team have also developed good relationships with company representatives to develop ambulance specific products such as hand wipes and bespoke sharps containers. The recruitment of three fit testers, one in each area, has increased the visibility of IPC whilst fit testing operational staff across all stations in the Northwest. The IPC team would like to raise awareness of IPC matters across the Trust and continue to be more visible and supportive to all staff members working within a modern-day ambulance service. Work will continue during 2024/25 to gain points of contact within the Integrated Care Systems.
13.2	**IPC Communications** The IPC team continually review their Trust internet pages to allow staff the most up to date information. The IPC team have developed an informative internet page with the support from the patient public panel, for members of the public to view and learn what NWAS do to protect patients and staff from infection. This project is newly developed and will hopefully grow in further months. The IPC team regularly publishes staff bulletins through the Trust Communications team, and these are disseminated via email and displayed at station sites via the Hubara screens supporting sustainability by removing posters from sites. In addition, information is communicated through operational team managers who disseminate directly to frontline staff through meetings. The IPC team also utilise social media platforms such as Facebook and Twitter through the Trust Communications team which helps the team to communicate with as many staff as we can reach.

13.3	**Unplanned Activity** **Measles** The UKHSA declared the Measles outbreak in England a national incident, and therefore the guidance on Measles for healthcare workers was updated on 2nd January 2024. One of the key elements of the guidance was to increase uptake of the MMR vaccine as this is the most effective method of reducing spread. The IPC team worked closely with the Occupational Health providers to ensure vaccination records were available for frontline staff, and in areas of work at higher risk of outbreaks i.e. Integrated Contact Centres, the MMR vaccine was promoted. Measles is a highly contagious infectious disease and is spread through respiration (contact with fluids from an infected person's nose and mouth, either directly or through aerosol transmission). It may lead to serious problems including pneumonia, blindness, seizures and is a particular concern during pregnancy. Being in close proximity in the ambulance saloon to an infected person for a period in excess of 15 minutes without wearing PPE is considered as being high risk of infection. A clinical bulletin was issued and distributed widely in in the Trust to advise staff of the signs and symptoms of measles, what PPE should be worn if in contact with a known or suspected Measles case and what precautions should be taken after exposure. Flowcharts were developed and put on the Greenroom alongside other resources for staff. **Group A Streptococcus** In the past 12 months, there has been a notable rise in the number of patients in the care/nursing home environment within the Northwest area, which is reflective of the national increase in Group A Streptococcus cases (GAS) in the community. The IPC team have been informed of a number of cases/outbreaks in these care settings where residents have tested positive for IGAS (invasive group A streptococcus) and NWAS crews have had contact with these patients. This situation has posed challenges as there is often a delay in being informed about these cases, resulting in the need to trace staff members, check the amount of contact they had with the patient, schedule appointments with occupational health for risk assessment and potentially offer prophylactic treatment. The IPC team have collaborated closely with the UKSHA, hospital departments, and Occupational Health to implement measures aimed at preventing the further spread of IGAS. Clinical bulletins from UKHSA and advice on preventing the transmission of GAS have been cascaded to staff via communications bulletins and operations managers. **Clostirdium Difficile North West Collaborative** In response to the increased C. Difficile rates in the North West, a collaborative meeting was held by Bolton NHS Trust in June 2023 to try and address any identified key themes and pull together an action plan with the aim of reducing rates. This was aimed primarily at figures for the Royal Bolton; however, partner organisations IPC Leads and NHSE were invited to the meeting to incorporate any successful interventions implemented and also to

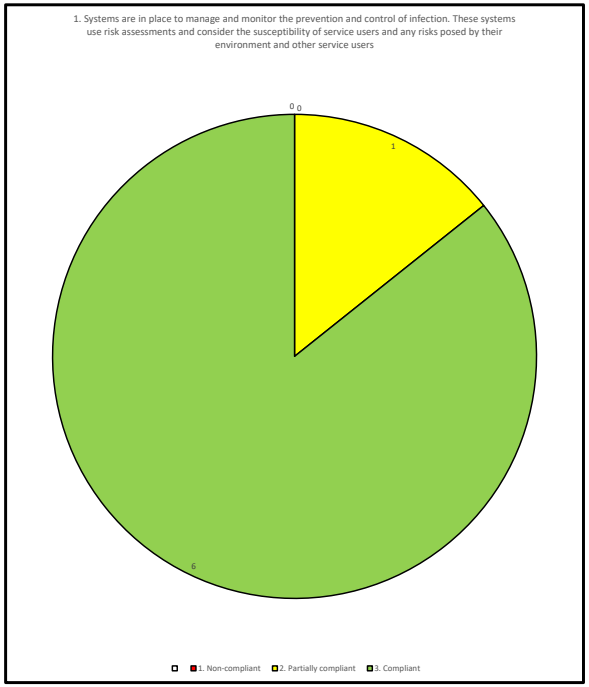
	seek out further improvements. The IPC Specialist Lead from NWAS was invited to share any views/issues encountered by the ambulance sector.
14.	**INNOVATION**
14.1	The IPC team are working on having all the IPC audit data captured on Safecheck. The move to Safecheck meant that all the Trust audits are housed on one system, the system is designed to encourage staff to complete audits in a format which is familiar to them and is easy to pull reports from. The improvement project has developed an information system which will ensure the Trust can improve its analysis of IPC data and compliance and provide broader comparative data from all audits. This data is then presented at the IPC Sub Committee in the form of a dashboard which allows the user to see an overarching view of the Trust's compliance with IPC policies and procedures and also the ability to identify a number of parameters including each station's compliance and overarching compliance to each question in the audit. The data can be formatted to be displayed in a number of ways. The IPC Practitioners are currently working with PTS colleagues to support and develop PTS specific audits which will be used on the Safecheck platform. The IPC Practitioners strive in developing new ways of working to provide a safer working environment for NWAS staff and safe places to be treated for our patients. In 2024/25, the IPC Practitioners will be working on the following. • Reviewing the storage of PPE. • Trialling new head blocks. • Developing ambulance and specialist vehicle specific IPC audits. • Reviewing the process and compliance of audits for IPC.
14.2	**IPC COMMITMENTS 2024/25** NWAS will continue to maintain its regulatory compliance for infection prevention and control in line with the Health & Social Care Act, in addition to this the IPC team will align closely to the IPC annual workplan which includes the following ambitions: • Recruitment and retention of IPC Guardians across the Trust. • Maintain high compliance with face fit testing across NWAS. • Assurance in relation to PAPR. The team will liaise with the manufacturers to ensure compliance with their guidance on the equipment. • Further development of compliance processes with the NWAS Aseptic Non-Touch Technique (ANTT). The team will work with the Trust's Chief Pharmacist to ensure any resources available to staff are in line with aseptic technique. • The IPC Specialist Lead will oversee the Staff Flu Vaccination Campaign for 2024/25 for the Trust. Close working relationships will be developed with key stakeholders including Medicines Management, HR, Communications and Operations staff to plan and deliver an effective campaign to maintain staff safety. • Attend regional IPC collaboratives to facilitate close working relationships with other IPC teams and to ensure our practice is in line with other organisations. To force relationships with IPC teams in acute trusts to ensure patient safety when cohorting

	in EDs. • Participate in the national peer review programme for other IPC services in the ambulance sector, as set out by the Association of Ambulance Chief Executives national IPC group. • Collaborative working with the Contracts Manager, Facilities Management, and cleaning contractors to ensure robust processes are in place to maintain high standards of cleanliness. • Continue to strengthen relationships with partners outside of NWAS – this year a representative from United Kingdom Health and Security Agency (UKHSA) and Occupational Health for NWAS will be invited to attend and provide assurance reports for the IPC Working Group. • Develop further our digital solutions to support IPC Audits and analysis. Continue to move towards the goals set within the Right Care strategy and the pillars of quality goals.
15.	**The Board of Directors is asked to:** • Note the content of the report • Note the assurances it provides • Note the arrangements for ongoing monitoring via the IPC board assurance framework • Note the key risks and mitigations

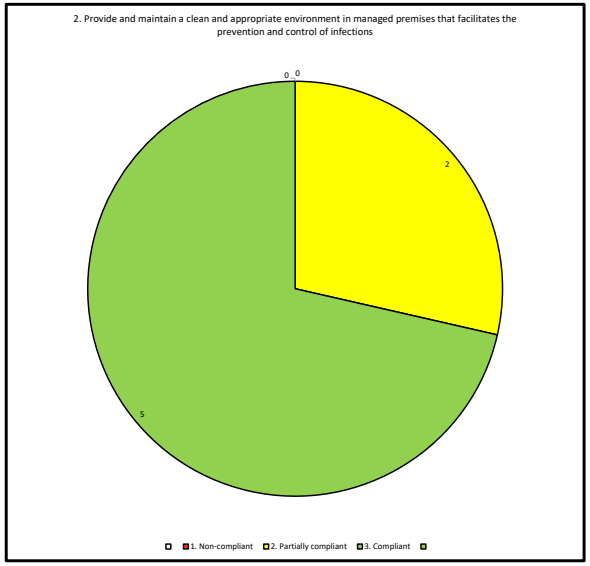
See Appendix 1 – IPC BAF for reporting period 1st April 2023 to 31st March 2024

Infection Prevention and Control board assurance framework v0.1

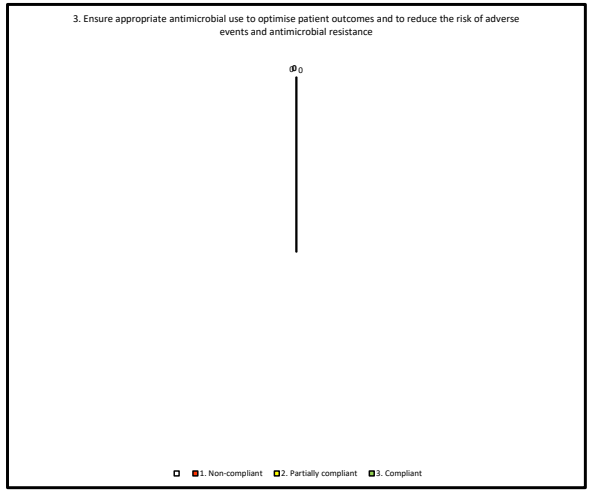
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	- DIPC (Chief Nurse), bi-monthly IPC Working Group reporting to Q+P, IPC Specialist Lead in post, IPC policy, functioning IPCT. Annual IPC report presented to Board. IPC task & finish groups developed from gaps in assurance report to IPC Working Group.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Staff infections reported through OH. Outbreaks reported to IPCT (various sources - Carlisle Support centre/direct from Managers/HR reports). IPCT responsible for managing outbreaks and reporting, as required, to NHSE. Will work with partners if any patient infections as part of a PIR. OH & UKHSA providing reports to bi-monthly IPC Working Group.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Incident reporting widely promoted at NWAS. IPC incidents form part of area assurance reports that are presented at IPCWorking Group. Key themes analysed by IPCT and any necessary mitigating actions are put in place. FTSU guardian widely promoted in the Trust. IPC present at Area learning forums. Lessons learned from incidents incorporated into IPC training and comms bulletins. Some joint audits being completed now with H+S. Developing links with patient safety with respect to IPC & PSIRF	Work alongside other specialities (eg H+S) to ensure effective working in relation to incidents, key themes & actions taken as a result.	Plans to work closer with H+S to complete audits and prepare joint reports.		2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPC station completed 12 monthly by practitioners to capture adherence to NIPCM. Target of 10 vehicle audits per month per area. Ops managers carry out monthly audits. HH and clinical practice monitored on contact shifts. All audits inputted onto safecheck & presented on dashboard. Link to NWAS policies & procedures are included in IPC manual.				3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Mandatory surveillance for infectious agents not required for Ambulance Services. Mandatory reporting of COVID staff outbreaks reporting to NHSEI and summary of outbreaks presented at IPC sub-committee	N/A	N/A	N/A	0. Not applicable
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPC station completed 12 monthly by practitioners to capture adherence to NIPCM. Target of 10 vehicle audits per month per area. Ops managers carry out monthly audits. HH and clinical practice monitored on contact shifts. All audits inputted onto safecheck & presented on dashboard. Link to NWAS policies & procedures are included in IPC manual. Face Fit Testers ensure compliance with health & safety executive for face fit testing.				3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All Trust staff, including those employed via temporary staffing and contractors receive IPC induction. All clinical staff require annual IPC training, non-clinical staff have bi-annual training. IPCT are also available to provide ad-hoc training as required. All training packages are updated annually or as required with changes in guidance to reflect best practice. The IPCT has its own Trust intranet/public facing webpage where staff can access information, policies, leaflets, hand decontamination posters, and other helpful resources.				3. Compliant



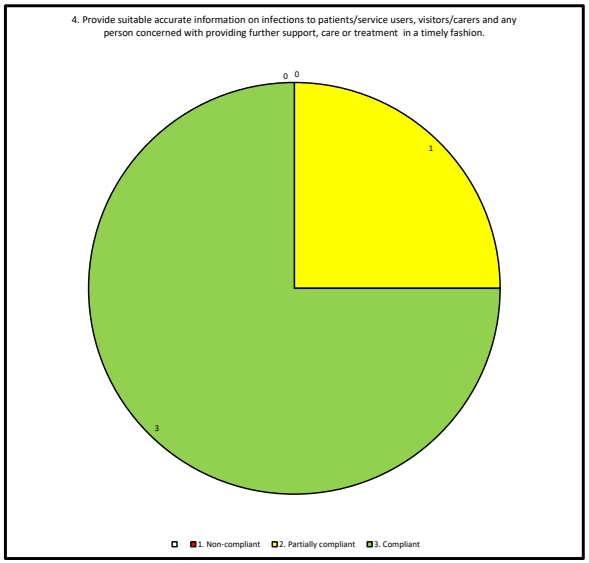
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	staff can contact IPC during office hours via email, teams or mobile numbers. Outside of these hours staff can contact their managers/ operational managers for IPC support. ONcall tactical advisors are also available to provide necessary IPC guidance. ICC have access to A-Z of communicable diseases. Advacnced paramedics are contactable out of hours for advice. There are policies, procedures and guidance on the Green Room page which all trust staff have access to.				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Awaiting National Standards of cleanliness for ambulance service. Cleanliness is monitored and audited with locally agreed protocols and via IPC audits. NWAS have a cleaning contractor who is monitored by the facilities manager. Audits are carried out by the contractor, NWAS staff and IPC team for assurance of standards on stations. IPC are involved in any contract tenders related to station/vehicle cleaning	National Standards of cleanliness for ambulance service still not published - June 24. Awaiting implementation date from NHSE	IPC specialist Lead working with Facilties Manager to scope provision of cleaning stores and storage facilities. Scoping exercise to be completed by end of Q4. Business case to be developed to ensure all meet required standard - to be completed by end of Q1. Progress to be monitored via the IPCSC		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	N/A	N/A	N/A	N/A	0. Not applicable
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Policies and procedures are in place to inform staff of responsibilities in relation to cleaning and decontamination. National cleaning standards are still not published for ambulance services. Where applicable the National cleaning standards are being applied to NWAS.Reusable equipment is cleaned after patient use Vehicle audits provide evidence of cleaning - these are reported though the IPC SC. IPC do unannounced audits on the 6 weeekly deep clean of vehicles completed by a private provider.	Difficulty completing required number of audits after deep clean due to operational demands. Still awaiting final publication of National Standards of Cleanliness for Ambulance Service.	Increase freqeuncy of audits to try & capture more vehicles. IPC to work closely with new provider of deep clean services to ensure standards of cleanliness are maintained. Joint audits to be completed		2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Water Safety Group meets every 6 months and provides assurance to the health,safety and security sub committee via the Estates, Fleet + Facilities management health, safety and security committee. Ventialtion testing is carried ut in line with national guidance. The Water Safety Group receives reports of anomolies of any water testing carried out at NWAS sites completed by the contractor. Policies and procedures are in place in relation to water safety and ventilation systems.				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	IPCT are involved from the planning stage of new builds and refurbishments. IPCT are invited to meetings and site walkabouts throughout the refurbishment period and IPC have to sign off works prior to staff working from the premises.				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Minimal linen is stored on vehicles, used linen is disposed of at hospital sites when conveying a patient. Linen which is on the vehicle at the time of service/ scheduled deep clean is removed, bagged and put into carts to be disposed of by local agreement at a local trust.				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Policies and procedures are in place in line with national guidance. Waste management overseen by facilities. IPC monitor compliance through audit. Correct waste disposal is included in all teaching sesssions and resources are also available on the Green Room.Waste collection carried out by a private contractor.				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	All reusable equipment is decontaminated between use. Any surgical instruments are single use. Decontamination certificates are used when equipment sent for servicing/repair.				3. Compliant



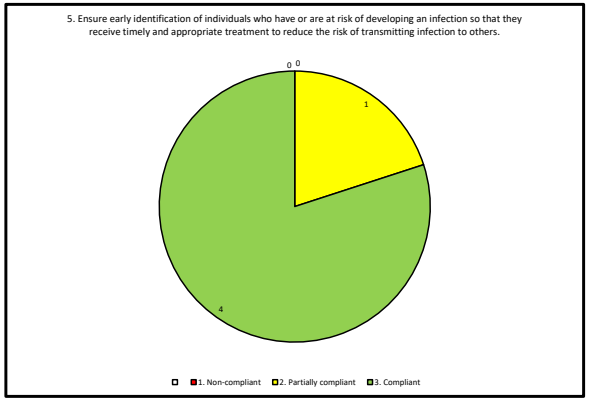
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	N/A - there is no food provision for patients within NWAS	N/A	N/A	N/A	0. Not applicable
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	No antibiotics are prescribed - administered under PGD and in line with JRCALC. Only 2 antibiotics are used within the Trust. They are for emergency use and are a one off dose. Paramedics follow PGD for antibiotic use. AMS lead is in the DIPC role supported by the Chief Pharmacist	N/A	N/A	N/A	0. Not applicable
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	PGD compliance monitoring as part of audit plan - reported into Medicines Optimisation Group which feeds into Clinical Effecftiveness Sub Committee. Audit includes frequency of administration, if compliant with guidance & any related incidents.	N/A	N/A	N/A	0. Not applicable
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	Director of quality, innovation and improvement - delegates responsibility to the DIPC	NA	NA	NA	0. Not applicable
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.					0. Not applicable
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.					0. Not applicable
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)					0. Not applicable

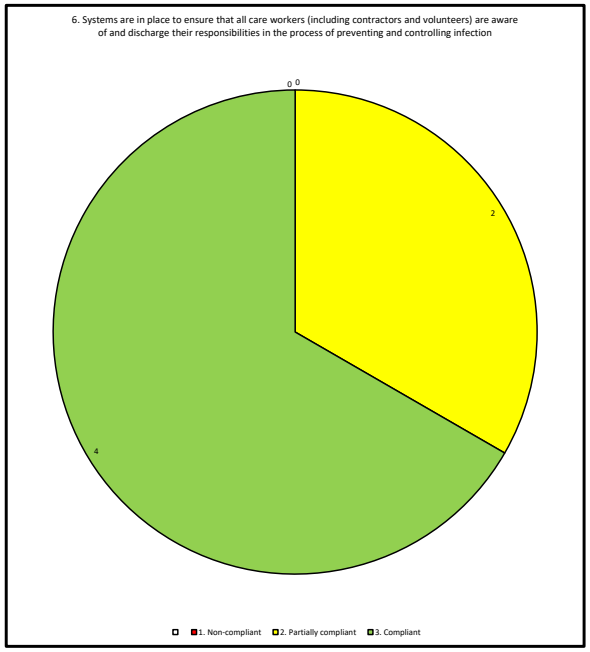


4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Service user input for the trust is obtained from the engagement team. All information which is in the public domain on the Trust website/ available to the public will be checked by comms. Staff have access to language line to promote communication with patients. Information about minimising risk of infection for patients (PPE etc) is available on vehicles. Engaged with religious partners via EDI team with respect to PPE/RPE. Representative from UKHSA attends IPC Working Group to present local demographic reports for infectious diseases.	Not clear defined relationships with PPIG. Liaise with medical director to identify any further actions in relation to public health and IPC.			2. Partially compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Service user input for the trust is obtained from the engagement team. All information which is in the public domain on the Trust website/ available to the public will be checked by comms. Staff have access to language line to promote communication with patients. Information about minimising risk of infection. Posters displayed if outbreak on any site to inform visitors for patients (PPE etc) is available on vehicles.				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	All information which is on Trust website is reviewed regularly and updated in line with local and national guidelines. Information is available digitally.				3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Patients and escorts will be asked to wear a mask if it has been risk assessed it is appropriate to do so by the crew or if local/national guidance states so. Outbreak management is undertaken by the IPC team in liaison with ops managers, risk assessments to be carried out to identify necessary actions and implement mitigations - information to be communicated to relevant staff within NWAS. vaccination programme is co ordianted by occupational health. Flu Vaccinations offered to staff - other necessary vaccinations provided by OH. Hand hygiene wipes available on vehicles. New national guidance on emerging infectious diseases casecaded to staff via different communications channels				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users. This is N/A for NWAS however please see information in columns for mitigating actions taken	NWAS rely on information from patient/person reporting incident and also accurate handover for transfers from hospital staff when conveying a patient in terms of infection status. PTS have booking system available which will assess risk of infection status and also identify those patients at risk of infection. Infectious status (if known) would be recorded on PRF.	Invasive device passports not always used/ used in all trusts. Infectious status of the patient not always communicated	Staff are aware of implementation of SICPS and how to risk assess for appropriate PPE and decontamination. This is also on mandatory training and e learning packages		0. Not applicable

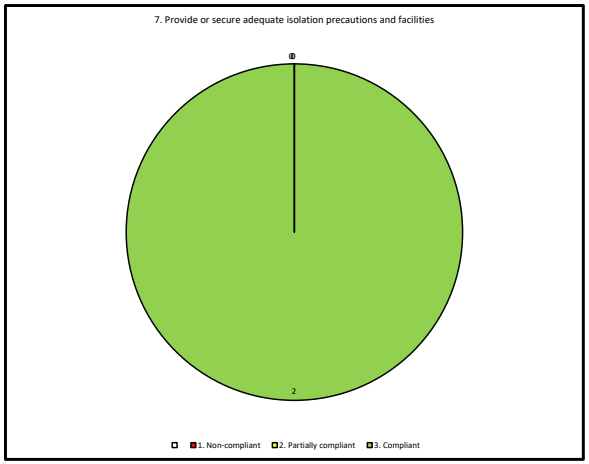


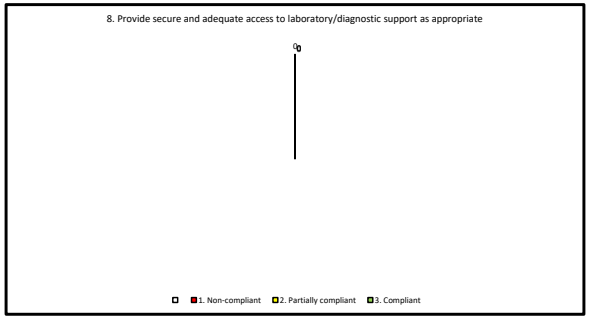
5.	**Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.**					
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	NWAS do not have any inpatient areas. Staff are aware of IPC measures to put in place to reduce the risk of picking up an infection from a patient. Crews will alert receiving ED/ID unit to ensure patient is placed in an approriate facility to minimise risk of onward transmission.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Crews will identify if patient potentially has infection and will pass this information on to receiving care facility to ensure patient is cared for in an environment that minimisies risk of onward transmission of infection.				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Crews will inform receiving department if infectious status known & will be documented on PRF.				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	NWAS do not have any settings where patients are in-situ. Safety stations (masks, wipes & alcohol hand gel) remain in place at the entrance to all buidings.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	NWAS outbreak policy identifes 2 or more staff will trigger an outbreak - these are reported externally to NHSE. Outbreaks are investigated by the IPCT and managers, extra IPC measures are implemented in the setting. Outbreaks are reported monthly to TMC and also to IPC working group. Safety stations remain in place at entrance to all NWAS premises.	Reliant on managers informing IPCT that they have staff off sick. No longer asymptomatic testing in place so uncertain if cases of illness are caused by same pathogen.	Regular visists to all settings from IPCT to raise awareness. IPC have implemented weekly audits to be completed by Ops managers within ICC's and have started to attend their regular Quality Business Group meetings to update on new guidance/rates of community prevalence of infection		2. Partially compliant
6.	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	All training reviewed annually and updated and is in line with the National IPCM. Staff responsibilities documented in the IPC policy. Any new national guidance in incorporated into training packages.				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Training needs analysis completed by the Education Department to ensure staff receive appropriate training for their role. Staff responsibilities documented in the IPC policy.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	IPC training programmes are reviewed regularly and are updated with any changes in national guidance. Compliance with Mandatory Training is monitored closely by the Education Department. IPC monitor MT compliance as part of assurance reports presented at IPC working group.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	All covered in mandatory training. Resources also available on the Green Room - this includes flow charts and videos showing staff how to correctly don + Doff PPE. Training videos on use of RPE and all new starters on their induction are shown how to use the equipment correctly.				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff are fit tested to 2 masks as per requirements. Quantitative fit testing method being used within NWAS in line with health & safety executive guidance. All staff are also provided with a respiratory powered hood on commencing with NWAS. Training is delivered on how to use the hood correctly. Fit testing recorded centrally on ESR. Fit testers have now been in post since September 2023 & overall fit testing compliance is at 79% for the Trust	Not all power units are being serviced as per manufactureres guidance	IPCT liaising with fleet to ensure that powered motor units are being serviced as per manufacturers recommendations		2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	NWAS staff are trained in aseptic technique and medical device insertion whilst in training at University. Staff are monitored for clinical competencies during contact shifts. Policies in place to support aseptice technique.	No further aseptic technique competency checking completed.	Included in IPC annual workplan to roll out ANTT training. Resources have been developed and to discuss with ops staff as to how this can be delivered effectively.		2. Partially compliant



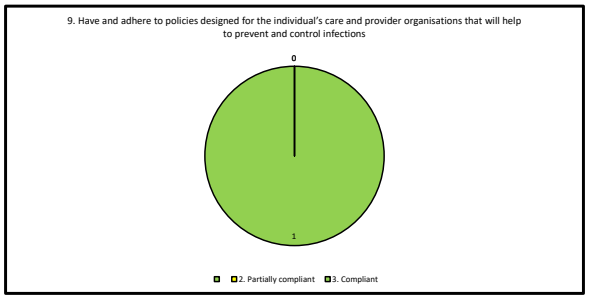


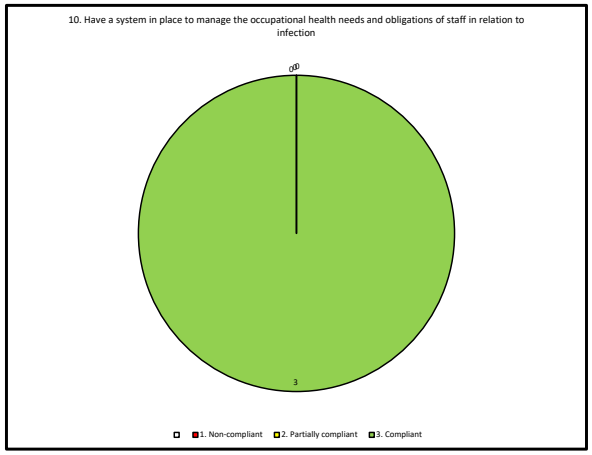
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking which will determine how they are transported. PPE available for both staff and patients on vehicles.				3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • If there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID	N/A	N/A	N/A	0. Not applicable
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking . Signage N/A.				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID	N/A	N/A	N/A	0. Not applicable
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	N/A NWAS do have access to a microbiologist if required via OH. OH also able to advise for staff with infections. IPCT work closely wwith UKHSA & health protection teams as necessary for contact tracing and any necessary prophylactic treatment of staff	N/A	N/A	N/A	0. Not applicable
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	N/A	N/A	N/A	N/A	0. Not applicable
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	N/A	N/A	N/A	N/A	0. Not applicable
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	N/A	N/A	N/A	N/A	0. Not applicable
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	N/A	N/A	N/A	N/A	0. Not applicable
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	N/A	N/A	N/A	N/A	0. Not applicable





9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Training provided to all staff in line with the national IPC manual. IPC resources are available on the Trust intranet site. Staff can readily contact IPC for advice via phone, email or microsoft teams. Policies are in place and accessible on the intranet site. Safety stations remain in place at all sites, signage and the implementation of IPC measures available in event of an outbreak. Spcific outbreak policy in place. Outbreak reporting to NHSE is in place as required and all outbreaks are internally monitored by the IPCT and reported to the IPC working group. Communcations sent out via bulletins to inform staff of any local outbreaks.				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Staff are referred to OH and are also risk assessed by their line mananger to ensure are not put at risk in the workplace. Risk assessment in place for staff who are pregnant. Managers responsibility to complete risk assessments. Alternative duties available for staff at risk				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Staff are referred to OH and are also risk assessed by their line mananger to ensure are not put at risk in the workplace. Risk assessment in place for staff who are pregnant. Managers responsibility to complete risk assessments. Alternative duties available for staff at risk				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	This is completed by OH pre employment and as necessary dependant on risk assessment. GP's also provide some vaccinations. Vaccinations are recorded on NIVS.				3. Compliant





NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 September 2024
SUBJECT	Controlled Drugs Annual Report 2023/2024
PRESENTED BY	Dr Chris Grant – Executive Medical Director
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 is asked to: • Note the assurance provided and the achievements and improvements made in 2023/24. • Note work planned to address challenges and risks.
EXECUTIVE SUMMARY	The report details the following key notes of assurance, and the achievements and improvements made in 2023/24: • A dedicated Controlled Drug (CD) Sub Group allowing the appropriate level of scrutiny on CD management. • Involvement of the CD Accountable Officer and Medicines Team in several investigations relating to CDs. • Reporting into NHSE CD governance arrangements • CD reporting remains strong, demonstrating a good reporting culture. • Data on CD breakages now available to the CD Sub Group. • Implementation of a medicine's dashboard including CDs. • Assurance that CD doses administered to patients are within NWAS guidance.

	• Ordering and receipt of CDs for the NW Air Ambulance is now overseen by the Medicines Team. • Receipt of CDs for Mass Casualty Vehicles now overseen by the Medicines Team. • CD Policy - full review completed. • Procedure for use of medicines at events developed. • All CD procedures are up to date. • All frontline clinicians have received updated CD training The report notes the workplan for 2024/25: • Lack of digital pharmacy stock management system and electronic CD register – outline business case being developed. • Site security and CDs – recommendations made to the Executive Leadership Committee and a Task and Finish Group set up. • CD licence renewal with the Home Office – escalated through national governance structures.	
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	Monday, 24 June 2024
	Outcome	Approved

This annual report is intended to update the Trust and provide assurance around controlled drug (CD) management for the financial year 2023-24.

It is a national requirement for Trusts to employ a CD Accountable Officer (CDAO), who must produce an annual report for the Board of Directors or its delegated committee. The CDAO at NWAS is Executive Medical Director, Dr Chris Grant.

The management of medicines, including CDs, forms part of the Care Quality Commission inspection.

This report covers:

2.1 Control Drugs Arrangements
2.2 Reactive Assurance
2.3 Proactive Assurance
2.4 Achievements and Obstacles

This report complements the Medicines Management Annual Report and provides more detail on CD management.

2.1 CONTROL DRUGS ARRANGEMENTS:

2.1.1 Controlled Drugs Used:

Controlled drugs used at NWAS as listed in Figure 1. A new addition this year was morphine orodispersible tablets 1mg and 5mg. Supplies of ketamine for HART Specialist Paramedics was also made available this year.

Figure 1: Controlled Drugs Used

Controlled Drug	Schedule	Profession	Restrictions
Diazepam 10mg/2ml injection	4 (part 1)	Doctor & Paramedic	N/A
Diazepam rectal 5mg tubes	4 (part 1)	Doctor & Paramedic	N/A
Fentanyl 500micrograms/10ml pre-filled syringe	2	Doctor	NWAA Doctor only
Fentanyl 500micrograms in 10ml ampoule	2	Doctor	NWAA Doctor only
Ketamine 200mg/20ml	2	Doctor & Paramedic	NWAA Doctor, Consultant Paramedic, Advanced Paramedic, Critical Care Paramedic and HART Specialist Paramedic
Ketamine 200mg/20ml pre-filled syringe	2	Doctor	NWAA Doctor only
Ketamine 500mg/10ml vial	2	Doctor	NWAA Doctor only

Midazolam 5mg/5ml injection	3	Doctor & Paramedic	NWAA Doctor, Consultant Paramedic, Advanced Paramedic and Critical Care Paramedic
Morphine 10mg in 1ml Injection	2	Doctor & Paramedic	N/A
Morphine 1mg and 5mg orodispersible tablets	2	Doctor & Paramedic	N/A

2.1.2 Controlled Drug Supplies:

CDs are received via various routes, improvements made in the oversight arrangements for CDs:

- NWAS stocks are procured by the Medicines Supply Hub and received into the Medicines Supply Hub.
- NWAA stocks are procured from Lancashire Teaching Hospitals and receipted to NWAA. This arrangement stopped in Dec 2023/Jan 2024, so all supplies are now ordered by the Medicines Supply Hub and received into the Medicines Supply Hub. This provides an improvement in the CD oversight arrangements.
- NARU Mass Casualty Vehicle stocks are ordered at a national level and delivered via Movianto to the ambulance station hosting the Mass Casualty Vehicles. This receipting arrangement changed in 2023/24 to receipt into the Medicines Supply Hub with the Medicines Team being part of the official communications about orders being received. This provides an improvement in the CD oversight arrangements.

Suppliers check that NWAS has a Home Office CD licence in place prior to supply and delays in obtaining a renewed licence has caused difficulties in continuity of supply. Such issues are raised via the Association of Ambulance Chief Executives, NHSE and CQC governance channels as this is an issue across the ambulance sector.

A Pharmacy Stock Management System is required to track all these different supplies in an auditable digital system. In addition, an electronic digital CD register would support enhanced governance of CDs once issued from the Medicines Supply Hub. There are over 650 places stocking and recording CDs in NWAS. A strategic outline case has been developed which has received support from the Executive Leadership Committee and an outline business case will be progressed in 2024/25.

2.1.3 Controlled Drug Financial Costs and volumes:

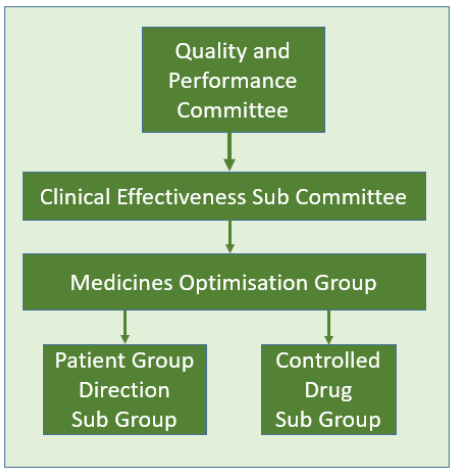
NWAS spend on CDs has increased by £16,264 in the last year to a total of £39,859. This was largely due to the introduction of morphine tablets. Full details on this can be found in the Medicines Management Annual Report.

2.1.4 Controlled Drug Governance Arrangements:

Since 2022, there has been a dedicated Group overseeing the CD governance arrangements in NWAS, the CD Sub Group. This group reports to the Medicines Optimisation Group (MOG) via a Chair's Assurance Report.

Figure 2 shows how the governance arrangements fit within NWAS.

Figure 2: Organogram of medicines governance arrangements



NB - The Clinical and Quality Group has now replaced Clinical Effectiveness Sub Committee

2.1.5 Controlled Drug Home Office Licence:

The Trust holds a Home Office CD licence which permits supply and possession of Schedule 2 to 5 CDs. To hold such a licence, there is a requirement to meet a range of standards covering procurement, receipt, storage, security, supply and destruction of CDs.

The Home Office issued NWAS with a low contravention (8351905 and 8238548) in relation to diazepam 10mg/2ml ampoules x 2 ampoules and morphine sulphate 10mg/1ml ampoule x1 ampoule respectively on 14/12/22. Two actions were required to be completed, and a response provided by NWAS on the 14/02/23. No subsequent correspondence has been received in 2023/24.

Following an investigation into unaccounted for morphine 10mg injection losses that was concluded in Jan 2023, the Home Office wrote to NWAS on 15/12/23 and issued a medium contravention (re 8440428) which remains on file for 5 years and issued three actions for completion by 29/12/23. These actions were completed, and a response provided with no further correspondence received.

In 2022, it was evident via the Local Intelligence Network that Home Office licences were not being issued prior to expiry and the date to apply had increased to 16 weeks prior. NWAS applied within this deadline and in October 2023 NWAS licence expired. The Home Office has acknowledged that the licensing process is in progress for NWAS. The Home Office then subsequently changed NWAS licence arrangements. This shifted from holding one licence with all other sites on the annexe to subsequently holding four licences and a maximum 10 sites on each annexe. This led to a programme of four inspections. After two inspections, the Home Office agreed that NWAS could revert to one licence and the other two inspections were cancelled. There remains an outstanding issue concerning the destruction of CDs. These challenges are well understood by both the Care Quality Commission and NHSE. The length of time taken to amend a licence is a risk for NWAS and has been escalated via the AACE governance

route. We currently have one ambulance station that was co-located with the fire service that we were given notice to vacate. The resultant station move renders it unable to hold CDs as they have no covering licence. This may lead to further operational complexities.

2.2 REACTIVE ASSURANCE:

2.2.1 Incident Management:

Medicines related incidents must be reported on the Trust incident reporting tool, Datix. These incidents are viewed by the Medicines Team regularly to provide support to the operational team for any investigation or follow up. A quarterly report is provided to the Medicines Optimisation Group and the Controlled Drug Sub Group. All Level 3 incidents and above have additional narrative information provided. If the incident is classed as a serious incident (as determined by the Review of Serious Events weekly meeting) the Medicines Team are involved in the investigation and the full report is reviewed by the Medicines Optimisation Group. This has now progressed to PSIRF, with similar processes followed.

The Medicines Team has a dedicated email address, where any concerns around the use of CDs within NWAS or in the wider health economy, can be escalated. Awareness of how to report concerns about CDs have been increased with the use of posters in all NWAS stations, and reminders to staff at each learning opportunity about how to report including a new mandatory training module all clinicians completed in 2023. This is an important aspect of the governance framework for CDs and over the last year has been a route staff have used to escalate concerns.

If an incident is reported that has occurred outside of NWAS, these are followed up by the Medicines Team with the relevant personnel, primarily the Medicines Safety Officers for hospitals and the Community Pharmacy Contract Leads for community pharmacies.

2.2.2 Incidents reporting to NHSE:

NHS England require declaration of any CD related incident that falls into specific categories. NWAS has reported the following:

- Real or perceived staff diversion of controlled drugs x 1.
- Real or perceived staff substance misuse of controlled drugs x 3 (one of these led to a NHSE alert being issued).
- Patients with drug seeking behaviours that might require an NHSE alert to be issued to health and care settings x 5.
- Severe harm issues x 1 (the paediatric Level 4 incident described in section 2.2.3).

The four staff concerns of diversion or substance misuse have been followed up as appropriate. The Medicines Team work closely with the People Directorate and Service Delivery as well as the Regional CD Team (part of NHSE) and the CD Liaison Officers. Two of the cases highlighted the importance of CCTV in assisting investigations.

2.2.3 Controlled Drug Incidents:

CD incidents reported are higher compared to the previous year (492 compared to 293) which is a rate of 5 reports per 10,000 face to face patients attended. The increase is due to a change to how incidents are reported. The majority of incidents are low or no harm. There have been zero never events, no Level 5 incidents and two Level 4 incidents relating to CDs.

These were:

- Q3: Patient administered 10mg of morphine instead of the intended 2.5mg due to miscommunication between paramedic and a newly qualified paramedic. Patient's GCS fell to 11 (from 15) and so was administered naloxone, GCS returned to 15 during journey to hospital.
- Q4: Incorrect dose of morphine intramuscular (IM) injection administered to a paediatric patient. Intended dose was 1mg (0.1ml) but dose was administered as 10mg (1ml) using a 3ml syringe. Initially patient had no ill effects but deteriorated whilst in hospital resus and it was unclear if due to morphine (burns patient) but became hypoxic and respiratory rate reduced. Error detected during disposal process. Hospital and patients' family fully informed. Full investigation took place and staff were supported throughout. Review felt staff had not differentiated between intravenous (IV) and IM volumes (1mg/ml = 1ml IV versus 1mg IM = 0.1ml). Learning took place with paramedic around pain management, medication preparation, administration practices and the 6 rights of medicines administration.

Figure 3 shows a breakdown by type of incident and Figure 4 shows a comparison between the types of incidents for this year compared to last. The amount of missing CDs reported has decreased. Although there were 25 reports, upon investigation there were only 5 incidents truly unaccounted for (see Figure 5), these were all very small amounts and triangulation of the data is always undertaken. A CD is considered missing when the CD record book in the vehicle or ambulance station does not reflect the balance of the CD safe. This is usually due to a documentation error and the record book is updated retrospectively when the item is accounted for. All of the unaccounted-for CDs were reported to the police and NHSE.

Figure 3: CD incident types reported per area 2023/24

Controlled Drug Incident Breakdown by Area 2023/24							
Datix Subcategory / MMQI coding	**CL**	**CM**	**GM**	**HART**	**NWAA**	**EOC/111**	**TOTALS**
CD Administration Error	8	8	7	0	0	0	23
CD Adverse Reaction	0	0	4	0	0	0	4
Any Other CD problems	7	4	11	0	0	0	22
CD Damaged	18	27	36	0	4	0	85
CD Missing	9	12	4	0	0	0	25
CD Safe Access Problem	17	8	10	0	1	0	36
CD Stock Problem	22	35	24	0	2	0	83
CD Documentation Error	52	82	75	0	5	0	214
Suspected Misuse	0	0	0	0	0	0	0
Total	**133**	**176**	**171**	**0**	**12**	**0**	**492**

Figure 4: Comparison of CD incidents reported in 2020/21, 2021/22, 2022/23 and 2023/24

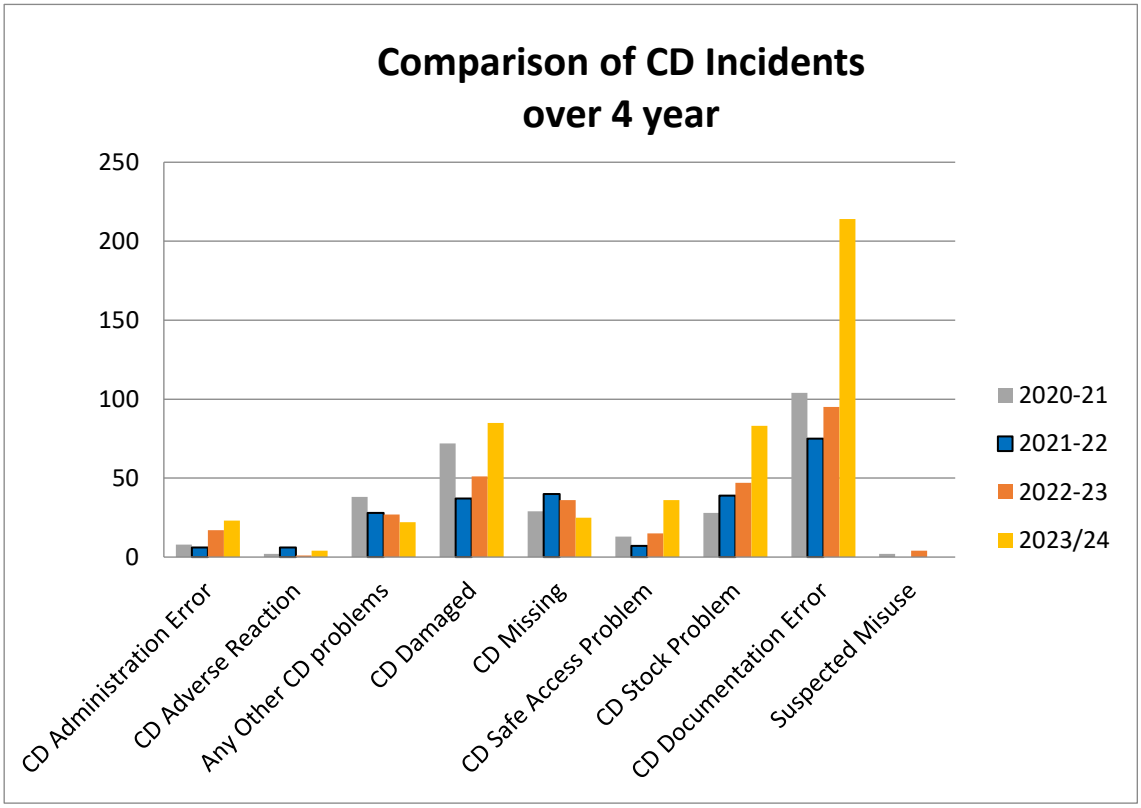


Figure 5: Unaccounted for CDs

Controlled drug	Area
Diazepam 5mg rectal tube x 1	C&L
Morphine 10mg ampoule x 1	C&M
Morphine 10mg ampoule x 1	GM
Morphine 10mg ampoule x 1	C&L
Morphine 10mg ampoules x 2	C&L

Breakages of CDs are to be reported as incidents and these are monitored by the Medicines Team. Overall, 85 items have been broken. See Figure 6 for the summary data. This is an increase from the previous year (51). This is likely due to an increase awareness of the requirement to report any CDs found damaged or damaged during handling following the training conducted by the Medicines Team with Senior Paramedics. Of the 85 damages/ breakages, 48 were morphine 10mg injection, 3 orodispersible morphine tablets, 28 diazepam 10mg injection, 3 diazepam 5mg rectal tubes and 3 midazolam 10mg injection. This data is now provided quarterly to the CD Sub Group.

Figure 6: CD breakages reported 2023/24

Total Controlled Drug damages/breakage reported 2023/24													
Area	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Totals
GM	3	1	1	2	2	7	5	0	4	5	3	3	36
CM	2	3	0	0	3	3	4	3	3	2	2	1	26
CL	0	1	0	2	1	1	2	4	5	2	0	1	19
NWAA	0	0	0	0	0	0	0	2	0	1	1	0	4
HART	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	5	5	1	4	6	11	11	9	12	10	6	5	**85**

2.3 PROACTIVE ASSURANCE:

2.3.1 Controlled Drug Use Monitoring:

As a CD designated body, it is a requirement that we monitor the use of CDs to ensure this is safe and appropriate. A CD dashboard has been developed by the electronic patient record team to enable the Medicines Team to monitor the use of CDs. This allows a quarterly report to be produced which is reported to the CD Subgroup for scrutiny. The report provides the following:

- Total doses of CDs used by areas – total doses for morphine and diazepam have been consistent with more variation (as expected) for use of ketamine and midazolam.
- Number of patients receiving CDs – these have been consistent month on month.
- Average doses used – these have been consistent and within expected ranges.
- Top 5 indications per CD used – indications have been consistent and as expected.

Flags are put into the database to allow further review of data that falls outside of normal ranges and this is further scrutinised. Where further scrutiny cannot provide a plausible explanation for the deviation, it is escalated to the relevant Consultant Paramedic who provides a review and response. This information is monitored by the CD Sub Group. Reasons for outliers have included:

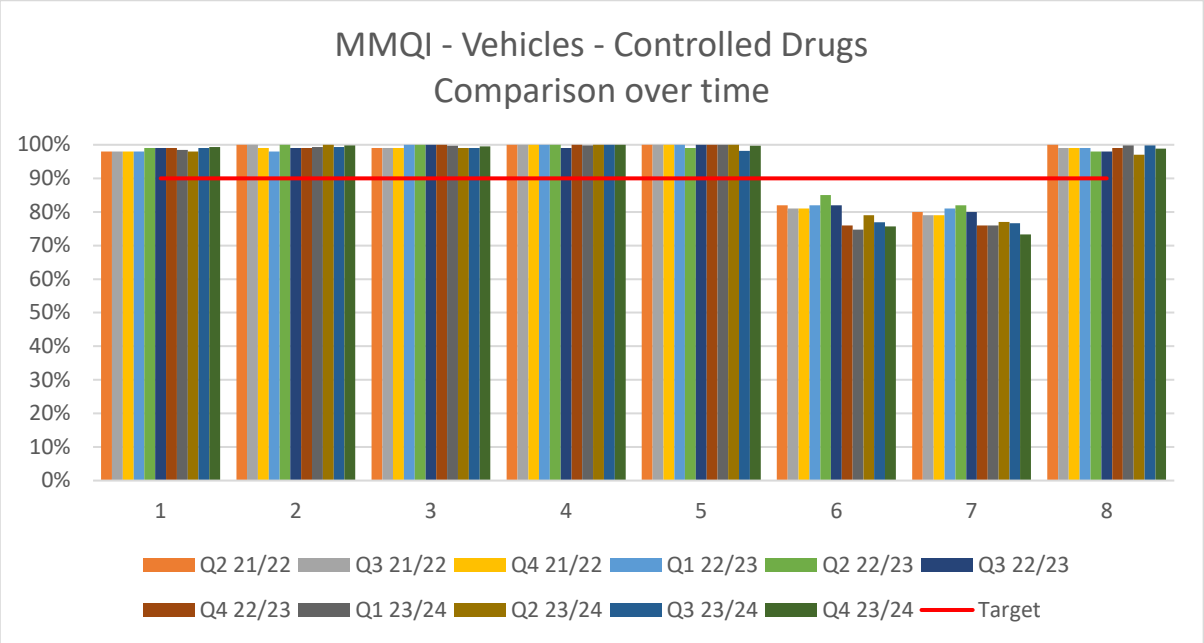
- Documentation errors into EPR (e.g. 100mg instead of 10mg)
- Patient's own medication used and taken by patient but witnessed and documented by paramedic.
- Higher doses being authorised by a doctor on scene or, in the case of morphine, a second paramedic has administered the additional dose with authorisation from the clinical hub.
- In the case of some of the outliers, action was required (e.g. DATIX entry, update to a JRCALC entry) or there was a learning need, and this was fed back to relevant teams. As this process has been embedded into practice the numbers of outliers has reduced which demonstrates improved documentation and clarity of the processes to be followed (e.g. for doses of morphine greater than 20mg).

The data provides assurance that doses of CDs administered to patients are in line with guidance set by NWAS.

2.3.2 Controlled Drug Vehicle Audit

CD audit of vehicles was conducted each quarter with a high level of compliance with the numbers of vehicles being audited. Full details are provided in the Medicines Management Annual Report. Figure 7 shows the results over time. This shows excellent compliance with the majority of the standards with the exception of the weekly CD checks of the CD safe and the seizure pouch.

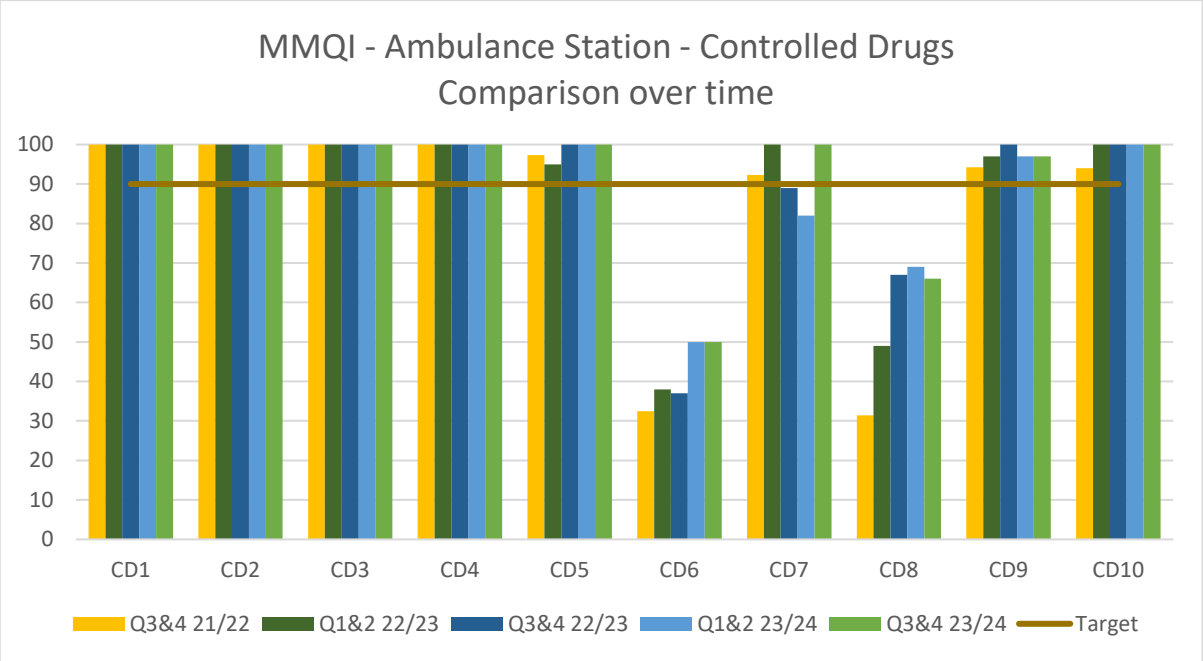
Figure 7: MMQIs CD Vehicles over time



2.3.3 Controlled Drugs Ambulance Station Audit

CD audit of ambulance stations was conducted 6 monthly, 100% of ambulance stations were audited by the Medicines Team in each cycle. Full details are provided in the Medicines Management Annual Report. Figure 8 shows the results over time. This shows excellent compliance with the majority of the standards with the exception of the daily and weekly CD checks. These are now subject to an improvement plan.

Figure 8: MMQIs CD Vehicles over time



2.3.4 Designated Body Assurance and Improvement Framework

The Regional CD Team have introduced an Assurance and Improvement Framework. The CDAO of each Designated Body is requested to complete a survey detailing their confidence in CD related systems and processes. The survey was completed and submitted in February 2024. Actions that were put in place include:

- CDs included in mandatory training, including how to raise concerns.
- Updated Drug and Alcohol Policy referencing the CD Accountable Officer and the Medicines Team.
- Questions relating to CDs in the Quality Assurance Visits (QAVs).
- Authorised witness training developed and implemented.
- HR Business Manager Lead and Chief Pharmacist meetings.
- NWAS Clinical Induction reviewed – now includes how to raise concerns and the role of the CD Accountable Officer.
- E-learning module for the use of morphine tablets.
- Approval of the medicines dashboard allowing monitoring of CD use.

2.3.5 Changes in legislation and policy

Changes to legislation in 2023/24 included:

- Paramedics now allowed to prescribe CDs (from Dec 2023) which includes: morphine sulfate, diazepam, midazolam, lorazepam and codeine phosphate and excludes: fentanyl or ketamine. This does not directly affect NWAS as we do not have non-medical prescribers.
- Nitrous oxide change in status from a pharmacy medicine to a Schedule 5 CD medicine from 8/11/23. This change in legislation was not aimed at changing access for healthcare purposes.

- Codeine linctus reclassified from a pharmacy only to Prescription Only Medicine in February 2024. This does not directly affect NWAS.

There is expected changes to the legislation on naloxone possession and supply. NWAS has commented on this consultation.

2.3.6 CQC CD Annual Report

This report is reviewed by the CD Sub Group and any points noted and any actions followed up. Risks around staff self-sourcing CDs was highlighted due to storage of CDs in their own homes. NWAS does not allow personal possession of CDs when a member of staff is not signed on duty. The report articulates the concern about non patient facing staff unable to get disclosure and barring checks completed, a concern raised by NWAS. It outlined some of the risks of transitioning to electronic CD systems which will be borne in mind when developing business cases at NWAS. It should be noted that the Trust Chief Pharmacist is a member of the CQC CD National Sub Group.

2.3.7 Local Intelligence Network Activity

During 2023/34, a member of the NWAS Medicines Team has attended all six Local Intelligence Network (LIN) meetings. One meeting was a national CD Accountable Officer virtual education event. A summary of each meeting is presented at the CD Sub Group meeting where any learning or points relevant to NWAS can be discussed. The benefits of CCTV when conducting investigations has repeatedly been identified.

2.3.8 Policy and procedures

The CD policy has been completely reviewed and updated. The new version went live in May 2024.

A suite of CD procedures have been developed and approved for the NW Air Ambulance to use. A new procedure has been implemented for how medicines should be managed at events (e.g. football matches), which includes CDs. All other CD procedures have been kept up to date.

2.3.9 Training

During 2023/24, all paramedic staff, EMTs and nurses were asked to complete a module on ESR titled ‘Medicines Management Module’. Part 1 of this training was CD focussed and included updates on CD checks, the 3Ws (Words, Witness and Waste) and CD security. By year end 2023/34, 96% of paramedics had completed this training and 89% of EMT staff.

Clinical induction for all new starters was updated for the medicines management element by the Medicines Team, including CDs.

Training on CDs was provided by the Medicines Team on 8 occasions at Senior Paramedic Team Leader away days. This focussed on the 3Ws, reminders on the governance of CDs and how and when to be curious about CD documentation.

2.3.10 Risk Register

The following risks are on the risk register relating to CDs:

- Pharmacy stock management system and electronic CD register – a strategic outline case has been approved by the Executive Leadership Committee. The next step is to develop an outline business case.
- CDs and Site Security – 10 recommendations were made and a task and finish group has been set up to oversee completion of the recommendations.

2.3.11 Projects

SMART key cabinets and paramedic personal possession digital CD keys are being implemented following the development of procedures, communications and training to aid implementation. This project is being led by the Project Management Office.

3. RISK CONSIDERATION

This report demonstrates a robust approach to governance and development of systems to monitor how medicines are managed.

Controlled Drugs (CDs) are regulated by a number of legislative instruments, including but not limited to:

- the Misuse of Drugs Act 1971,
- the Misuse of Drugs Regulations 2001 and
- the Controlled Drugs Regulations 2013.

4. EQUALITY/ SUSTAINABILITY IMPACTS

Nil

5. ACTION REQUIRED

The Board is asked to:

- Note the assurance provided and the achievements and improvements made in 2023/24.
- Note work planned to address challenges and risks.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 September 2024
SUBJECT	Learning from Deaths summary report and dashboard Q1 2024/25
PRESENTED BY	Dr C Grant, Executive Medical Director
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 Trust Board is recommended to: • Support the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths. • Note the recent developments around call handling and the Trust continues to be fully compliant with the Learning from Deaths framework. • Acknowledge the impact of the SJR process in identifying opportunities for improving care. • Support the dissemination process as described in Section 4

EXECUTIVE SUMMARY	The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning. The Q1 dashboard (appendix A) describes the opportunities to learn from deaths. The main concerns raised internally and externally identified in DatixCloudIQ (DCIQ), were attributed to problems in ICC and PES, specifically around the emergency response and treatment/management plan. Of the concerns closed, there were no incidents where causal factors were identified by the investigator. The peer review process now encompasses ICCs and as a result the Trust is now compliant with the national framework. The key areas for improvement reflect similar themes from the previous quarter. This includes 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 Pathways. The quality of patient records has remained high this quarter, with only 13% receiving a poor or very poor rating. This figure has remained consistent for this and the previous two quarters and is a vast improvement from 47% seen in Q1 23/24. There were two patient records that received a good rating for quality, which is a slight decrease from seven in the previous quarter. The panel continues to welcome observers to help raise awareness of the project and embed learning from the peer reviews. The Learning from Deaths programme has faced some challenges over this quarter which have affected the number of cases reviewed, and therefore reduced the number reported on in this paper. The introduction of PSIRF to the trust along with changes made to the way incidents are raised in DCIQ has potentially resulted in fewer DCIQ concerns falling under the Learning from Deaths framework. We are in regular contact with the DCIQ team to try to investigate and minimise any issues that may be present in this data. There have also been challenges seen with the availability of panel members now that the SDMR re-structure process is nearing its completion. Many of the panel members from both PES and ICC teams have been and continue to be personally affected by the process, and this has resulted in fewer cases being able to be presented at the panels. We are hopeful that these logistical challenges will begin to be resolved over the coming months as the restructure comes to an end.
PREVIOUSLY CONSIDERED BY	1. Clinical & Quality Group 2. Quality & Performance Committee
	Date: Tuesday, 03 September 2024 Monday, 23 September 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 Q1 2024/25 Learning from Deaths review, and it is proposed this document is published on the Trust's public accounts by 30th September 2024 in accordance with the national framework and trust policy. The Q1 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q1. 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 66 (43 concerns raised in Datix and 23 sampled for SJR).

3.2 Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 11/07/2024. 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:

- 32 internal concerns were raised through the Incidents module (Events).
- 11 external concerns were raised through the Patient Experience module (Feedback).

3.2.1 Internal Concerns

Of the 32 internal concerns, 13 were reviewed and closed. There were no cases in which the investigation concluded the Trust had contributed in some way to that patient death.

3.2.2 External Concerns

Of the 11 external concerns that have been reported, 9 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. Two concerns have been closed with no causal factors identified.

3.2.3 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

14 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). 9 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

Five cases were identified as needing second stage review following Stage 1. The second stage review concluded that two deaths were not avoidable, and three 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) and the Infographic (appendix B). A summary of the themes includes:

ICC:

- Poor communication with patient/family
- Missed opportunity to upgrade a low acuity incident
- Incorrect coding of call

PES:

- Limited information regarding clinical assessment/examination
- Failure to recognise potential seriousness & complexity of condition
- No referral to AVS/GP when appropriate to do so.
- Correct hospital/community pathway not followed
- Quality of EPR.

Trust:

- Delays in allocation - demand outstripped resources

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 Q1 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
- 12 Lead ECG not done for a patient who has fallen
- No patient medications listed on EPR
- Crews consulted patient on wishes in the event of a cardiac arrest, and discussed with family/GP to put plans in place
- Crews documenting clear and detailed worsening advice

ICC:

- Training ongoing for EMAs regarding both under and over probing during Pathways triage
- EMAs continue to demonstrate good use of the Non-Clinical Advice Hunt for complex calls and concerns
- EMAs continue to highlight red-flag symptoms where they are concerned that the response may not be sufficient

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 Q1 Learning from Deaths infographic (Appendix B) will be shared with the clinical leadership team.

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 the quarterly dashboard (appendix A) as the report to be published on the Trust public account as evidence of the Trust's developing engagement with a formal process of learning from deaths.
- Note the recent developments around call handling/dispatch and the Trust is now 100% compliant with the Learning from Deaths framework.
- Acknowledge the impact of the SJR process in identifying opportunities for improving care.
- Support the dissemination process as described in Section 4.

NWAS Learning from Deaths Dashboard Q1 23/24 - Q1 24/25

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.

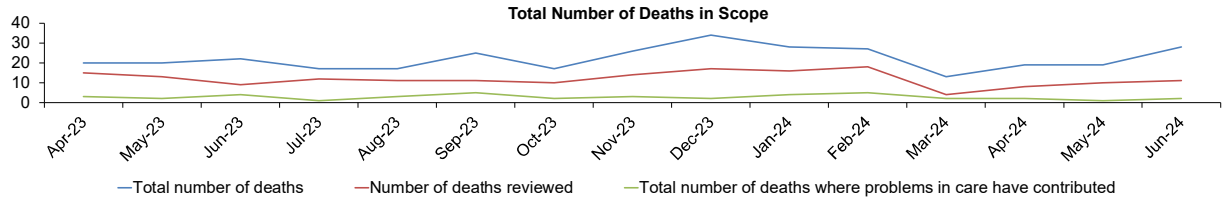


Figure 1

Concerns Raised in DCIQ

Internal Concerns

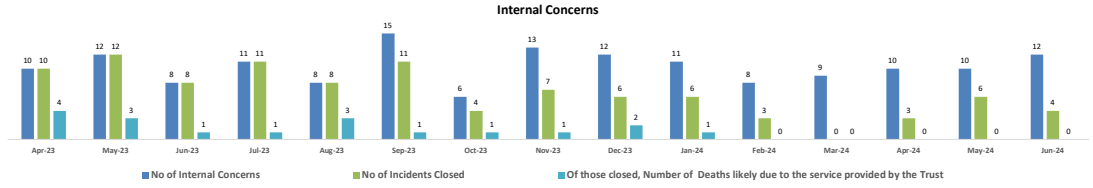


Figure 2

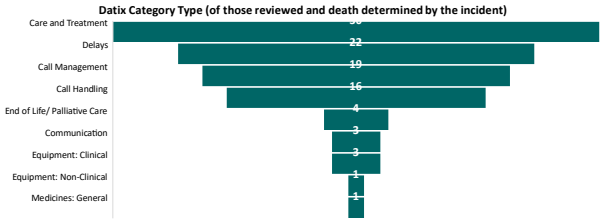


Figure 3

External Concerns

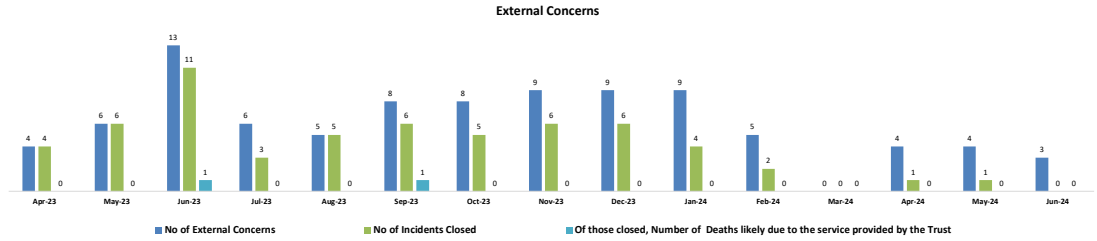


Figure 4

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

Problem with Communication:
-Poor communication with patient/family

Table 1

Learning themes: Trust

Delays in allocation: Demand outstripped resources

Table 2

Learning themes: ICC

Problem with call taking/response allocation:
-Missed opportunity to upgrade low acuity incident
-Incorrect coding of call

Problem with communication:
-Poor communication with patient/family

Table 3

Internal and External Concerns

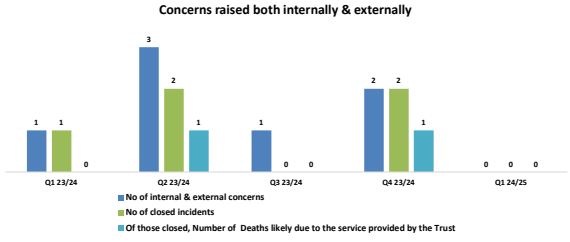


Figure 5

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

Table 4

NWAS Learning from Deaths Dashboard Q1 2024/25

Structured Judgement Review (SJR) Sample

Reporting Year	Incidents used for the sample criteria		Number of Deaths Reviewed	Total number of deaths where care is deemed to be less than adequate
23/24	Q1	18	16	9
	Q2	19	15	8
	Q3	27	26	7
	Q4	24	21	9
24/25	Q1	23	14	5
	Total	**111**	**92**	**38**

Table 5

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

SJR Stage 1 Overall Care Assessment for Year

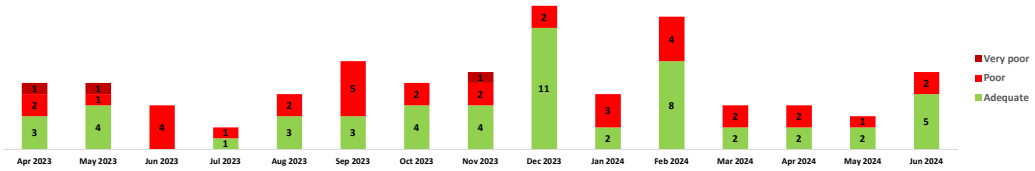


Figure 6

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	1	13	0
Right Care	Patient Assessment Rating	1	13	0
	Management Plan/Procedure Rating	3	11	0
Right Place	Patient Disposition Rating	1	13	0

Table 6

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	2	7	0
Right Care	Patient Assessment Rating	0	9	0
	Management Plan/Procedure Rating	0	9	0
Right Place	Patient Disposition Rating	0	9	0

Table 7

SJR Learning Themes - Q1 2024/25

Evidence of Poor/Very Poor Practice

Poor learning themes

Problem with patient assessment:
-Limited information regarding clinical assessment, examination & outcome

Problem with treatment/management plan:
-MTS not applied correctly
-No repeated observations recorded post treatment

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 (x2)

Table 8

Evidence of Poor/Very Poor Practice

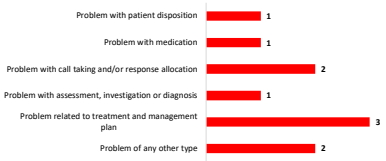


Figure 7

Evidence of Good/Very Good Practice

Evidence of Good/Very Good Practice

Figure 8

Good learning themes

Any other category:
-Good quality of EPR (x2)

Table 9

NWAS Learning From Deaths Demographics Dashboard for Q1 2024-2025

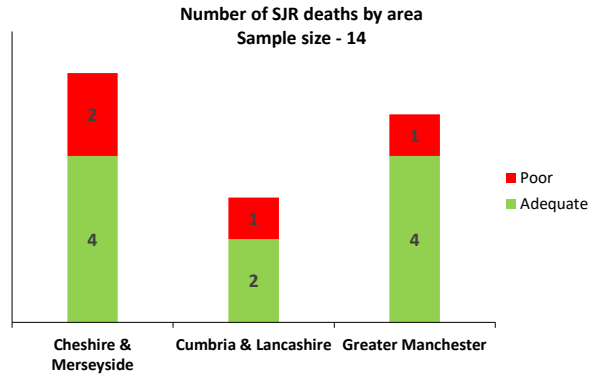


Figure 1

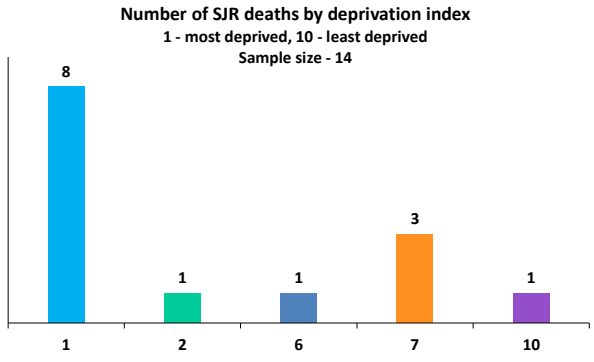


Figure 2

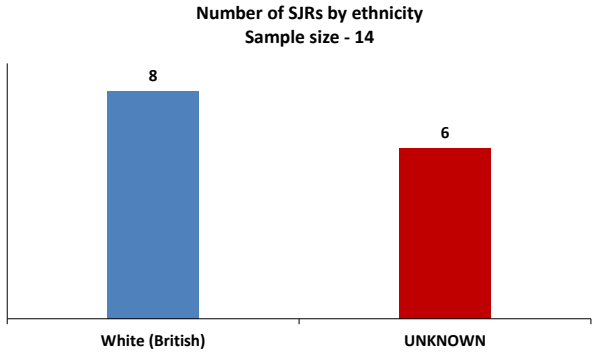


Figure 3

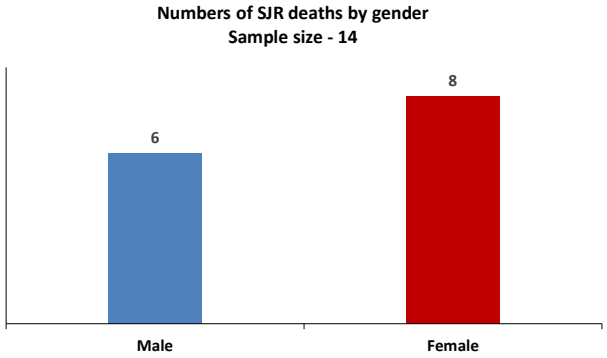


Figure 4

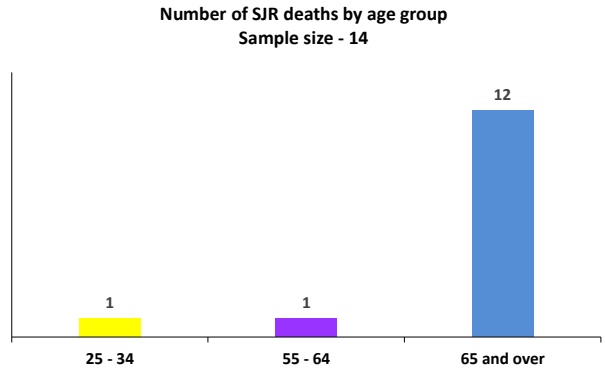


Figure 5

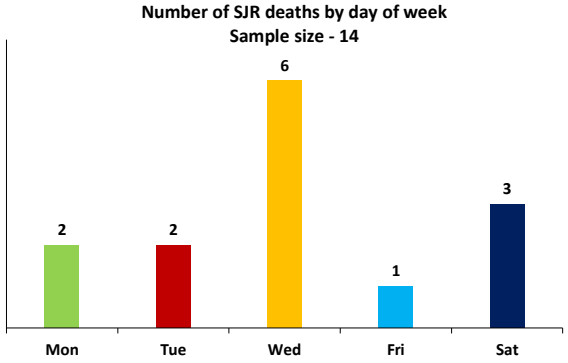


Figure 6

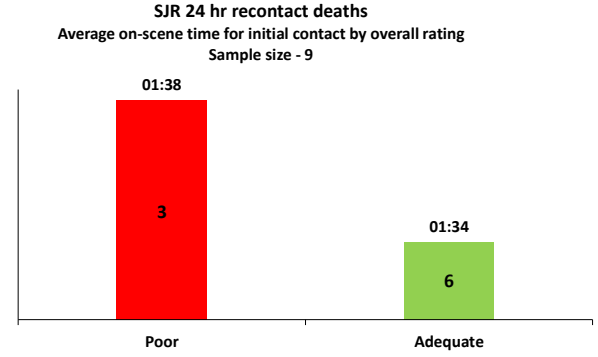


Figure 7

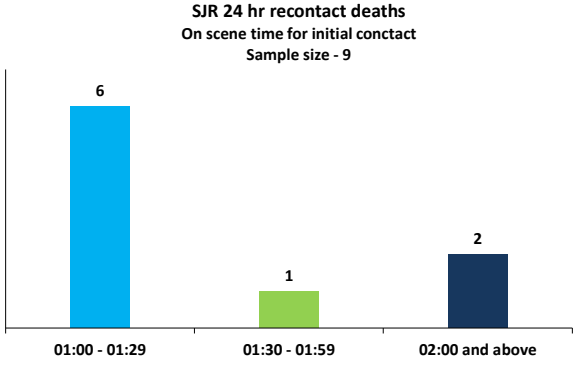


Figure 8

LEARNING FROM DEATHS

NHS North West Ambulance Service NHS Trust

Q1 2024/25 REPORT

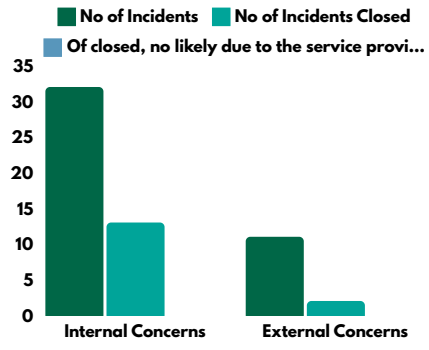
DEATHS WITH CONCERNS RAISED IN DATIX

Internal Concerns 32

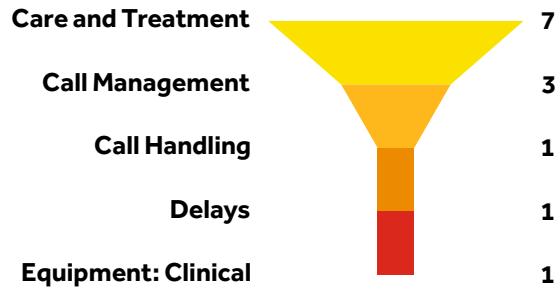
External Concerns 13

Internal & External 0

Concerns with no casual factors



Top themes from internal concerns from closed incidents



Learning from Paramedic Emergency Service (PES)

Problem with treatment & management plan:

- Failure to recognise potential seriousness and complexity of condition

Problem with patient disposition:

- Correct hospital/community pathway not followed

Problem with Communication:

- Poor communication with patient/family

Key learning from ICC

Call categorised incorrectly (n=3)

Missed opportunity to upgrade (n=1)

Poor communication with patient (n=1)

New themes from externals

- Poor communication between ICC & Hospitals
- Incorrect coding of call
- Limited assessment of patient

Structured Judgement Reviews (SJRs)

Patient Demographics

57% Female

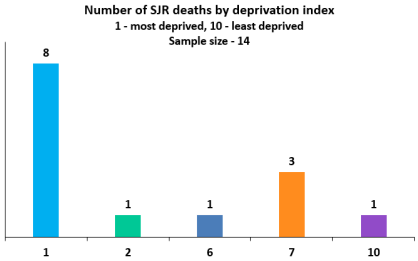
43% Male

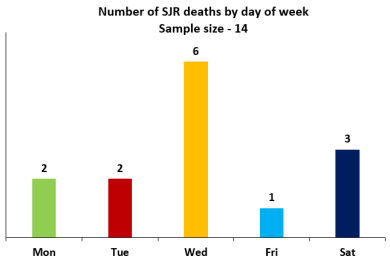
57%

More than 1/2 of patients ethnicity recorded as White (British)

86% of the sample were over 65 years old

Incident Demographics





More information contact: Learning.FromDeaths@nwas.nhs.uk

Structured Judgement Reviews (SJRs)

Deaths in Scope

Re-contact within 24hrs
16

Category 3/4 Deaths
4

Category 1/2 Delays
3

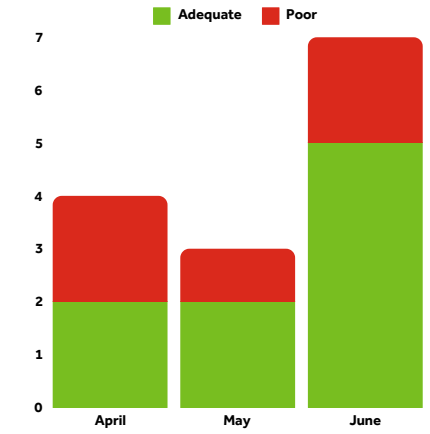
Deaths Reviewed

Total sample
N = 23

Excluded from review
Not moderated = 9

Included for review
n = 14

SJR Stage 1 Care Assessment



Stage 2 = 5 incidents

No causal factors identified
3

Uncertain poor practice led to harm
2

Poor practice led to harm
0

SJR - PES Themes

- Problem with call taking/response allocation
- Problem with patient assessment
- Problem with treatment & management plan
- Problem of any other category (Quality of EPR)

Top PES Themes

Problem related to treatment & management plan:

- No repeated observations recorded following treatment
- MTS not applied correctly
- O2 not administered despite patient having low SpO2 levels

SJR - ICCs Themes

Poor call handling elements:

- Cat1 pre-alert missed due to entering Y to 'patient breathing' instead of N for patient in cardiac arrest
- Incorrect address input into C3 - caused the crew a delay when attending the property

SJR GENERAL LEARNING THEMES

PES

- GP not notified when patient passes away at scene
- Asystole ECG strip not uploaded to media for DOA/TOR
- 12 Lead ECG not done for a patient who has fallen
- No patient medications recorded on EPR
- Patient consulted on wishes in the event of cardiac arrest - resulting in the patient passing how they wanted
- Clear & detailed history documented
- Holistic decision making noted for very unwell patients

ICCs

- Training ongoing for EMAs regarding both under and over probing during Pathways triage
- EMAs continue to demonstrate good use of the Non-Clinical Advice Hunt for complex calls and concerns
- EMAs continue to highlight red-flag symptoms where they have concerns

SJR ACTIONS

- Incident passed to 111 audit colleagues to review call
- Feedback to be provided to crew regarding learning around recording of capacity/CC1 forms
- External Out raised to OOHGP/AVS to highlight learning regarding delays in their services
- Clinical colleagues to raise learning points regarding administration of fluids for unwell patients
- Duty of Candour (DOC) to be considered

SJR IMPROVEMENTS

- To continue to maintain and improve the Quality of EPR/clinical documentation
- To work with the DCIQ team to continue to improve the LfD DCIQ module
- To continue to circulate learning points from Learning from Deaths to all staff networks and learning forums
- To continue to perform thematic analysis of the LfD dataset to narrow leaning gaps and celebrate good practice

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 September 2024
SUBJECT	2024/25 Flu Campaign
PRESENTED BY	Lisa Ward, Director of People
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 asked to: • Note the approach to the Flu campaign for 2023/24 • Provide senior commitment to offer all frontline staff a flu vaccination • Approve the Board checklist.
EXECUTIVE SUMMARY	The 24/25 Flu Vaccination programme letter issued by NHS England outlines the expectation for providers to deliver a 100% offer to eligible healthcare workers and this mirrors the expectation for the 23/24 campaign. The letter sets out the expectation to equal or improve uptake rates from 2023/24 in 2024/25. Last year's campaign was overseen by the People Directorate but was led by the Infection Prevention & Control Specialist Lead In the Quality Directorate. The report outlines the learning from last year's campaign which resulted in a total of 3172 staff being vaccinated, which was a slight decrease for the 22/23 campaign where 3659 were vaccinated. This was equivalent to 48.6%. The Trust has procured 4000 Seqirus vaccines which is a single vaccine, suitable for all ages and is egg free. The Quality Directorate will take a lead role in the campaign, and this will be led by the Infection, Prevention and Control Specialist lead who will work closely with the Medical Management Team, along with the Chief Pharmacist to support the overall leadership and

	governance of the project. The Corporate HR team also take responsibility on fulfilment of national reporting requirements. The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model. The Trust is using a Written Instruction (WI) as used in last year's campaign. An appropriate budget has been set to support the campaign. The national flu programme commences on 1 October 2024 and the Trust will also start the campaign on this date. An earlier start date is not possible as the Written Instruction which is used in place of the PGD is effective from 1 October 2024. The communications plan will largely reflect last year's plan with social media and visual messages. It is proposed that as with previous years, the Trust Board are able to show visible support of the campaign in the form of social media and bulletin features. This will be profiled for the Board dates in October or November. The HCW Flu Vaccination Best Practice Management Checklist is included at appendix 1 and demonstrates that the Trust's programme has these core components in place for the 2024/25 programme. Frontline health and social care workers are eligible for a COVID booster from 3 October 2024 and staff will be able to access the vaccination via pharmacies and potentially GPs. There is no capability to deliver this booster in-house. Regular communications will go out to staff over the coming weeks to encourage them to take up the offer of the COVID-19 booster. It should be noted however, that the Trust does not have detailed oversight of uptake of the COVID booster until regional statistics are published and then we are only provided with an overall uptake figure. This makes direct management of uptake very difficult.	
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	Friday, 20 September 2024
	Outcome	Assurance received

1. BACKGROUND

1.1 Influenza (flu) vaccines are offered free to all NWAS staff as part of the national flu vaccination programme. NWAS has historically participated in the national vaccination programme which is led by the People Directorate. The flu vaccination campaign for 2023/24 officially commenced in mid-September 2023 and ended in February 2024.

1.2 The 24/25 Flu Vaccination programme letter issued by NHS England outlines the expectation for providers to deliver a 100% offer to eligible healthcare workers and this mirrors the expectation for the 23/24 campaign. The letter sets out the expectation to equal or improve uptake rates from 2023/24 in 2024/25.

2. OVERVIEW OF LAST YEAR'S CAMPAIGN

2.1 Last year's campaign was based upon learning from previous Flu campaigns. Whilst oversight was provided through the People Directorate, it was operationally led by the Infection Prevention & Control Specialist Lead in the Quality Directorate and delivered through a multi-functional project team. Delivery was through peer vaccinators providing vaccinations at a local level or through targeted flu clinics.

2.2 For the first time NWAS adopted the use of the National Written Instruction to replace Patient Group Directions (PGDs). A Written Instruction allows medicines to be provided by occupational health vaccinators under exemption in Schedule 17 of the Human Medicines Regulations 2012. The use of a Written Instruction is not subject to the same legislated framework required for PGDs. It is an arrangement between the named registered vaccinator and the authorising doctor (Medical Director in NWAS) and following a legislation changes became available for use by Paramedics for the first time in 2023/24. It is a more straightforward way to ensure staff are legally covered to administer vaccinations.

3. 2023/24 FLU CAMPAIGN DATA

3.1 A total of 3172 staff were vaccinated either within or external to NWAS. This is a slight decrease for the 22/23 campaign where 3659 were vaccinated. The total overall figure available to vaccinate was 7600 which did not include volunteers and students eligible under the inclusion criteria of the written instruction.

Table 1: NWAS staff vaccine uptake 2023/24

3.2

	Received at NWAS	Received elsewhere	Declined	Referred	Deferred
No. of staff	3172	524	3776	34	94
% of staff	41.7%	6.9%	49.7&	0.4%	1.2%

3.3 National targets for employers of NHS staff to target vaccinations for flu campaigns is set for frontline staff only. The target of uptake was set at 75% for frontline healthcare staff. Across the North West region a reduced uptake of the flu vaccine by healthcare workers was reported, nationally the uptake of the vaccine declined from 49.4% in 2022/23 to 42.8% of frontline healthcare staff in 2023/24. NWAS uptake exceeded the national average by 6.2%

4. 2024/25 FLU CAMPAIGN

4.1 The national flu programme commences on 1 October 2024 and the Trust will also start the campaign on this date. As with last year, the Trusts is using a Written Instruction (WI) as opposed to a PGD and this national WI is effective from 1 October 2024. To commence this year's campaign, the Trust has procured 4000 Seqirus vaccines. This is a single vaccine and is suitable for all ages and is egg free.

4.2 The approach for this year's campaign is based on the learning outlined from last year's campaign of which two main issues have been identified. Firstly, Medicines Management are ensuring that the calibration of fridges is completed as early as possible as this delayed the start of the campaign in a couple of areas last year. In addition, the need for some additional administration at the beginning of the campaign is required to ensure all vaccinators have completed the relevant modules and are set up on Flumis and NIVS. An administrator is now in place until the end of September to support the overall set up of the campaign.

4.3 The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model. This involved the area flu leads identifying a group of vaccinators who then travel to offer and administer the vaccine to all staff in scope within their area. The flu leads take responsibility for reviewing the data around uptake and identifying key sites or staff groups where further targeting of the vaccination is required. The model is best described as a 'roaming model' and relies on vaccinators travelling to deliver vaccinations to staff.

4.4 For staff who are in site-based roles such as in our contact centres, corporate sites, the existing approach of advertising flu clinics will remain in place. In the past we have also put specific clinics into place for PTS staff, and particularly those in GM who are not necessarily on the same sites as PES staff. It is proposed that a similar approach for PTS is taken for this year's campaign.

4.5 The Quality Directorate will take a lead role in the campaign, and this will be led by the Infection, Prevention and Control Specialist lead who will work closely with the Medical Management Team, along with the Chief Pharmacist, to support the overall leadership and governance of the project. The Corporate HR team also take responsibility on fulfilment of national reporting requirements.

4.6 Appropriate funding is in place to support the project both in terms of short term administrative support, equipment and vaccines and flexibility to maximise vaccinator flexibility.

4.7 Support will also be provided by the Communication Team to ensure that staff are fully aware of the campaign and the benefits of the vaccine.

4.8 Following discussions with this year's flu team, there is a recognition that the offering of the vaccine to staff needs to occur early on in the campaign for two main reasons. Firstly, as last year's data shows, uptake of the vaccine is at its highest within the first two months of the campaign. Secondly, there is a significant impact on frontline resources through the delivery of a peer led campaign. As a result, ensuring that the majority of vaccines are administered ahead of the start of winter pressure will minimise the impact on front line resources.

5 GOVERNANCE AND RECORDING OF VACCINATIONS

5.1 As with last year, there is a national directive to ensure that all vaccinations were also recorded in the National Immunisation and Vaccination System (NIVS). As with last year, it is proposed that the vaccinators will input onto both Flumis and NIVS at the point of care (POC). There is a requirement to ensure that all information is inputted onto NIVS within 7 days. As such it is prudent to ensure that the accuracy and timeliness of input is maintained by training vaccinators to input onto both systems.

5.2 As frontline staff all have access to iPads this will support this approach. In case of a loss of IT access, paper forms will be available for used, but will require vaccinators to input onto both Flumis and NIVS at the earliest opportunity.

5.3 Training and access to both Flumis and NIVS will be provided to designated vaccinators ahead of the start of the campaign.

6. COMMUNICATION AND ENGAGEMENT

6.1 The communications plan has been developed and is in line with previous years reflecting a focus on social media and visual messages. It is proposed that as with previous years, the Trust Board are able to show visible support of the campaign in the form of social media and bulletin features. Vaccinations will be offered to Board at either the October or November dates.

6.2 Based on learning from previous years and from other Trusts, the best approach to engage staff to have a vaccination comes from their management teams. It is therefore proposed that there is clear engagement from management teams to support the flu leads and directly encourage staff to have the flu vaccine.

7. THE HCW FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST

7.1 In July 2024, the Health Care Workers (HWC) vaccination letter was published and this has a clear focus on encouraging staff to access both the flu and COVID 19 vaccinations on offer.

7.2 The Flu Vaccination Best Practice Management Checklist is included at appendix 1 and demonstrates that the Trust's programme has these core components in place for the 2024/25 programme.

7.3 The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. This is supported by a comprehensive communications plan. Whilst, like all ambulance services, the vaccination delivery model for our dispersed workforce presents challenges, the flu team have worked hard to ensure appropriate flexibilities and options are in place to maximise vaccination rates

8. COVID 19

8.1 The 2023/24 COVID booster vaccination campaign has launched nationally with an aim to maximise and extend protection during the winter and through the period of greatest risk in December 2023 and early January 2024

Frontline health and social care workers are eligible for a booster

8.2 From 3 October, COVID-19 vaccinations will be available for frontline health care workers with the ability to start booking COVID-19 vaccinations in advance in pharmacies from 23 September, with appointments running until 20 December. Staff may also be able to access the booster via their GP

8.3 Regular communications will go out to staff over the coming weeks to encourage them to take up the offer of the COVID-19 booster

8.4 It should be noted that the Trust will not have access to real time information on Covid vaccine uptake as it is not a vaccination provider. As a result data only becomes available when regional statistics are published and then only at a Trust wide level making targeted communications and management of uptake extremely difficult to achieve.

9. RISK CONSIDERATION

9.1 There is a risk that the Trust will not equal or improve flu vaccination uptake rates in 2024 to 2025. The campaign will be carefully managed to ensure that all staff are offered a vaccine and that this is completed at an early stage in the campaign. There are no financial consequences to this risk but the impact could be reputational or on the level of sickness absence across teams resulting from low uptake.

10. EQUALITY/ SUSTAINABILITY IMPACTS

10.1 The flu vaccine procured by the Trust is egg free and should therefore address potential concerns arising from religious, ethical or life style choices. The campaign will consider any specific advice and guidance linked with pregnancy, age or underlying health conditions.

11. ACTION REQUIRED

The Trust Board is asked to:

11.1
- Support the proposed delivery model for the 24/25 flu campaign
- Provide senior commitment to offer all frontline staff a flu vaccination
- Approve the Board checklist.

Appendix 1

Healthcare Worker Flu Vaccination Best Practice Management Checklist

A	Committed Leadership	Trust Self Assessment
A1	Board records their commitment to achieving the ambition of vaccinating all frontline healthcare workers	Commitment recorded through September public board meeting.
A2	Link with Medical Directors and Directors of Nursing to promote key messages and get strategic buy-in	Full engagement with the Chief Nurse and Medical Director around communication messages to staff to encourage take up of the vaccine.
A3	Trust order and provide suitable vaccine for all healthcare workers	The Trust has ordered 4000 vaccines which can be delivered to the majority of our staff taking into account age and religious belief.
A4	Board receive an evaluation of the previous year's flu programme including data, success, challenges and lessons learnt	Both Resources Committee and the Board of Directors have received an evaluation of learning from the 2023/24 flu programme and plans for the 2024/25 programme. Presented to September meetings.
A5	Agree a board champion for flu	The Director of People will be the champion for the Flu campaign.
A6	Publicise board members receiving their flu vaccine	Plans will be put in place once the campaign commences to ensure the opportunity for take up by Board and this forms a clear part of the communications campaign.

A7	Flu team formed with representatives from all directorates and staff groups to advocate and lead by example	Cross functional flu team has been established. Strengthened this year by a clinical lead. Trade Unions briefed at JPC September and involved in campaign.
A8	Flu team meet regularly from September to March	Regular meetings already commenced.
A9	Monitor uptake across all areas and seek to understand the reasons for low uptake in departments and offer support to increase uptake	Weekly flu reports will be sent out once the campaign commences. The flu team will review take up and reasons for low uptake to target areas for promotion.
A10	In low uptake areas a list of staff is made available, and these are targeted with public health messages and information. Managers to support unvaccinated staff in getting the vaccine and arrange flu clinics for these areas	Lists are sent to flu leads who will then take a strategic approach to low uptake with communication messages and targeted flu clinics.
B	**Communications Plan**	
B1	Order and use/share national staff-facing materials/resources	Materials have been ordered.
B2	Rationale for flu vaccination programme and facts to be published	The rationale and facts around the flu campaign will form part of the Trusts wide communications plan.
B3	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Range of communications methods included in the plan.
B4	Content showing board and staff members having their vaccine	The communications plan include the promotion of the vaccine with picture of the Board and other staff, including the Staff Networks, receiving their vaccination.

B5	Flu vaccination programme and access to vaccination on induction and large meetings/events	Dates for induction programmes and mandatory training sessions to form part of the vaccination plan.
B6	Vaccination programme to be publicised on screensavers, posters and social media	The vaccination programme will be promoted via the bulletin and station based wall boards. Promotion in the ICC's is also undertaken via their SharePoint sites.
B7	Weekly feedback of percentage uptake for directorates, teams and professional groups. Consider 'Jabathon'	Weekly reports published weekly with percentage uptake split by Sectors and Service lines.
C	**Flexible Accessibility**	
C1	Concentrating on high-risk areas first	All staff are encouraged to access the vaccine as part of the campaign. Specific focus is made on front line staff, including the ICC's.
C2	Peer vaccinators in clinical areas to be identified, trained, released to vaccinate and empowered to encourage others	The Trust uses a peer led vaccination model.
C3	Schedule for easy access drop-in clinics agreed or online booking systems	Local clinics are advertised, and flu vaccinators take a flexible approach to vaccinating based on local requirements.
C4	Schedule for 24-hour mobile vaccination clinics to be agreed with vaccinations available across all shift patterns, days, evening, nights and weekends	Flu vaccinators are paramedics who work a range of shifts.
C5	Link with ward managers/matrons to ascertain the best times to visit in order not to disturb the normal working shift	Not applicable – but this engagement takes place on sites with high density such as ICCs
C6	Hub and spoke models in larger Trusts	Not applicable
C7	Pop-ups and roving models in community providers in recognition of multiple sites across a large geography	Roaming model forms core of delivery model

D	Incentives	
D1	Board to agree on incentives and how to publicise this	Agreement that incentives do not form part of the campaign.
D2	Success to be celebrated weekly	Vaccination uptake is published and celebrated weekly during the campaign.