AGENDA

NHS
North West Ambulance Service
NHS Trust

Board of Directors
Wednesday, 29th January 2025
9:45am – 12:20pm
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
PATIENT STORY				
BOD/2425/116	Patient Story	09:45	Information	Chief Executive
INTRODUCTION				
BOD/2425/117	Apologies for Absence	10:00	Information	Chair
BOD/2425/118	Declarations of Interest	10:00	Decision	Chair
BOD/2425/119	Minutes of the previous meeting held on 27th November 2024	10:00	Decision	Chair
BOD/2425/120	Board Action Log	10:05	Assurance	Chair
BOD/2425/121	Committee Attendance	10:10	Information	Chair
BOD/2425/122	Register of Interest	10:10	Assurance	Chair
STRATEGY				
BOD/2425/123	Chair & Non-Executive Directors Update	10:15	Information	Chair
BOD/2425/124	Chief Executive's Report	10:20	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2425/125	Board Assurance Framework Q3 2024/25	10:30	Decision	Director of Corporate Affairs
BOD/2425/126	Corporate Calendar 2025-26	10:40	Decision	Director of Corporate Affairs
BOD/2425/127	Audit Committee 3A Report from the meeting held on 17th January 2025	10:50	Assurance	Mr D Whatley, Non-Executive Director
BOD/2425/128	Trust Management Committee 3A Report from the meetings held on 18th December 2024 and 15th January 2025	10:55	Assurance	Chief Executive
BOD/2425/129	Health & Safety Policy	11:00	Decision	Director of Corporate Affairs

QUALITY AND PERFORMANCE				
BOD/2425/130	Integrated Performance Report	11:10	Assurance	Director of Quality, Innovation, and Improvement
BOD/2425/131	Proposed PSIRF Priorities and Plan	11:30	Decision	Director of Quality, Innovation and Improvement
BOD/2425/132	Learning from Deaths Q2	11:40	Assurance	Medical Director
BOD/2425/133	EPRR Annual Assurance (Core Standards)	11:50	Assurance	Director of Operations
BOD/2425/134	Resources Committee 3A Report from the meeting held on 24th January 2025	12:00	Assurance	Dr D Hanley, Non-Executive Director
STRATEGY, PARTNERSHIPS AND TRANSFORMATION				
BOD/2425/135	Communications and Engagement Q3 2024/25 Report	12:05	Assurance	Interim Deputy Director of Strategy Planning & Transformation
CLOSING				
BOD/2425/136	Any other business notified prior to the meeting	12:15	Decision	Chair
BOD/2425/137	Risks Identified	12:20	Decision	Chair
DATE AND TIME OF NEXT MEETING				
9.45am on Wednesday, 26th March 2025 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.				

Minutes
Board of Directors

Details: 9.45am Wednesday, 27th November 2024
Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chair
Mr D Mochrie	Chief Executive
Mr S Desai	Acting Chief Executive
Mr D Ainsworth	Director of Operations
Mrs C Butterworth	Non-Executive Director
Prof A Esmail	Non-Executive Director
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director
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:

Mr J Price	Freedom to Speak Up Guardian (for item BOD/2425/104)
Mr J Mawrey	Deputy Chief Executive and Chief People Officer at Bolton NHS FT
Ms Margaret Nicholls	Patient and Public Panel
Mrs A Cunliffe	Corporate Governance Manager (Minutes)

Minute Ref:

BOD/2425/93 Staff Story

The Acting Chief Executive advised the video link to the film would be uploaded to the Trust website. The film featured Caroline, a Senior Paramedic based at Burnley station, who following time spent with the Urgent Community Response team, set up the collaborative 'East Lancashire Care Home Engagement' project with different external stakeholders and health organisations.

The Board:

- Noted the content of the story.

BOD/2425/94 Apologies for Absence

Apologies for absence were received from Dr A Chambers, Non-Executive Director.

BOD/2425/95 Declarations of Interest

There were no declarations of interest to note.

BOD/2425/96 Minutes of the Previous Meeting

The minutes of the previous meeting, held on 25th September 2024 were agreed as a true and accurate record of the meeting.

The Board:

- Approved the minutes of the meeting held on 25th September 2024

BOD/2425/97 Board Action Log

The Board noted the updates to the action log.

BOD/2425/98 Committee Attendance

The Board noted the Committee Attendance.

BOD/2425/99 Register of Interest

The Board noted the Register of Interest presented for information.

BOD/2425/100 Chair & Non-Executives' Update

The Chair advised that both he and the Acting Chief Executive attended the Northern Ambulance Alliance board meeting on the 28th October, where the upcoming changes of personnel were discussed. The chairmanship of the alliance will be taken by Martin Havenhand, Chair of Yorkshire Ambulance Service, and a refresh of how the Alliance operated was being planned.

He advised of his attendance at the Ambulance Community Day & Annual General Meeting held on 30th September at the Werneth Suite in Oldham, which was a great event, very well attended by more than 200 members of the public.

The Chair reported on his and Prof A Esmail's engagement in the NeXT Director Scheme development programme interviews and subsequent nominations.

He advised of his attendance at Non-Executive Directors network event held at Lancaster University on the 21st October.

The Chair referred to the latest Board Development Session held on the 30th October, regarding cyber security and described it as a good session covering an important topic.

In terms of internal affairs, the Chair advised all appraisals would be complete prior to his departure. The recruitment process to the role of Chief Executive was underway.

Mr D Whatley advised of his attendance with Dr A Chambers to a Listening Event in Kendal, which was an interesting event with significant representation from students and an interesting Q&A session.

The Board:

- Noted the Chair and Non-Executives' Update.

BOD/2425/101 Chief Executive's Report

The Chief Executive introduced the report, which covered activity undertaken since the previous Board meeting on the 25th September. He handed the presentation of the report to the Acting Chief Executive.

The Acting Chief Executive presented the report which provided detailed information on a number of areas, such as performance, regional issues, national issues and other general information. He updated the board members on key headlines of activity since the last meeting.

The Acting Chief Executive reflected on performance, which included some very strong areas as well as challenges.

In terms of 111, he noted continued strong performance and absence below 10%. He reported the additional call taking support would remain in place until February 2025.

Referring to Patient Transport Service (PTS) he reported activity was consistent with previous months, however, there was overspend of £301k. Activity was below baseline in Cumbria and Lancashire, which was indicative of low unplanned activity. Engagement with acute trusts was required to improve the number of aborted journeys.

In terms of regional updates, the Acting Chief Executive highlighted a letter received from Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care, who had visited Southport in the aftermath of the incident, offering his thanks for the Trust's response to the tragic events that unfolded that day.

He also noted the aforementioned Ambulance Community Day & AGM and reported it was great to see such good attendance from community and students with an interest in health care.

The Acting Chief Executive highlighted the Trust was selected as an NHS People Promise Exemplar. He advised NHS England had worked with NWAS

to deliver some of the ideas and interventions set out in the national People Promise, to make the organisation a brilliant place to work for all. The NHSE team visited the Trust and provided very positive feedback from their visit.

He reported on the latest Digital Maturity Assessment (DMA) from NHS England. A draft of the publication was expected in December with the intention to share it with the Executive team and review by the Resources Committee, before the formal publication in January.

Moving on to national updates, the Acting Chief Executive referred to Leadership Culture Event, which was attended by more than 100 senior leaders. Topics at the event included: generational differences and sexual safety. Notwithstanding the intention to cascade the learning from the event, there were plans to repeat the session in other to reach more people.

The Acting Chief Executive reported the Department for Health & Social Care had confirmed that the national eligibility criteria for the long service medal had been expanded to recognise emergency operational control room staff, including 999 call handlers and ambulance dispatchers and included staff with 30 and 40 years of service. It was a positive development, which had been lobbied for many years, however the eligibility still does not include PTS and 111 staff, which is continues to be advocated.

The Acting Chief Executive referred to the latest REAP escalation at level 4, due to increasing response times and extended and increasing hospital handover delays.

The Acting Chief Executive informed of the sad passing of former colleague Pete Greenwood, who dedicated 34 years to our service before retiring in 2019. On behalf of the Board, he offered sincere condolences to his family.

Prof A Esmail pointed to s2.1 referring to information on work to establish handover collaboratives with the acute trusts and the ICBs, supported by NHSE regional team. He requested more information regarding ECIST.

The Acting Chief Executive explained that Emergency Care Improvement Support Team (ECIST) was an improvement arm of NHSE, a clinically led national NHS team deployed to Cheshire & Mersey system.

Prof A Esmail referred to s2.3 on Patient Transport Services and queried the statement on the financial position at M02 being overspend of £301k, with projected forward overspend of £2.5m by end June 2025.

The Director of Finance offered clarification advising that the report related to the contractual position rather than in year financial position, with M02 being the contract month. She added there had been disparities in contract reporting pre and post Covid and the position reported was the contractual position.
The Board:

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

BOD/2425/102 Board Assurance Framework Q2 2024/2025

The Director of Corporate Affairs presented the updated Board Assurance Framework Q2 2024/2025 for approval.

She advised that as part of the review, the Trust Management Committee proposed the following Q2 changes:

- SR04 decrease in risk score from 12 to 8.

She referred to rationale for decrease in risk score, which was provided in s3 as applied by the Executive Lead.

The Director of Corporate Affairs highlighted a number of actions were due during Q4, some already complete and remaining being monitored.

The Chair referred to the operational risk aligned to SRO1 scored at 15 which stated the EOC/ICC leadership team were not adequately prepared to manage large scale, significant or major incidents, and requested information on mitigating actions.

The Director of Operations clarified the risk related to lack of EPRR national occupational standards, training, exercising, and subsequent competency assurance. The Trust was engaged in national work to develop the standards, as well as developing internal work plans and operational standards, including a bespoke programme for control room.

The Board:

- Approved the Q2 2024/25 position of the Board Assurance Framework.

BOD/2425/103 Bi-Annual Common Seal Report

The Director of Corporate Affairs presented the Common Seal Biannual Report.

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

She confirmed during the period the 1st April 2024 to 30th September 2024, the Trust's Common Seal was applied on 2 occasions, with details in s2 of the report.

The Board:

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

BOD/2425/104 Freedom to Speak Up Report

The Freedom to Speak Up (FTSU) Guardian presented the Freedom to Speak Up Assurance Report. He provided an overview of the report and highlighted the key headlines.

He noted activity remained consistent however whilst the volume of concerns remained stable, there were fewer concerns raised regarding organisational change due to the Service Delivery Model Review.

The Freedom to Speak Up Guardian advised several new metrics had been introduced to trend analysis, including tracking anonymous concerns, as per Figure 1 of the report. There was a static baseline level of anonymous concerns being raised with no correlation between the numbers of concerns, and the number of anonymous concerns being reported. This would be monitored for any changes.

He pointed to Figure 2 & 3 in the report, which evidenced that most concerns were raised within the PES service line and noted that 'inappropriate attitudes and behaviours' continued to be the most common theme. Broken down to granular level, the subthemes emerged as: management practices, working practices, incivility, followed by sexual safety.

The FTSU Guardian referred to Figure 4 and reported the average resolution times, with 4 days being the shortest and 45 being the longest resolution time, for complex, multifaceted cases. He reported FTSU training was mandated for all staff, with extended follow up modules for those in leadership roles.

The Board were advised the Trust would need a network of champions for our organisation. Alongside review of Q4, recommendations will be made to the Trust Management Committee.

Mr D Whatley referred to p5 of the report and the statement advising there were other routes for staff to raise concerns, however there was no current way of cross-referencing concerns raised by Datix or HR process to triangulate concerns across the organisation. He enquired about plans to change that.

The FTSU Guardian acknowledged this and advised correlation could be made between Staff Survey results and cultural matrix.

The Director of People advised such exercise had been done in the past on ad hoc basis and there was intention to take stock and triangulate information, for presentation to the Resources Committee as part of the update on progress in implementing recommendations from the culture review. She observed there was overlap between FTSU reporting and HR processes, so care needed to be taken about duplication of concerns.

Ms C Butterworth referred to the themes of the concerns raised and enquired whether benchmarking against other trusts could be carried out. She also noted that resolution times would be varied depending on the concern route and following process.

The FTSU Guardian referred to benchmarking and advised data was available through National Guardian Office, however there were differences in reporting methods and levels of transparency between trusts.

The Director of Quality, Innovation, and Improvement noted a low proportion of female staff reporting via FTSU (16.46%) in comparison to composition of NWAS staff with staff identifying as female being 54%.

The FTSU Guardian advised this was a new metric regarding protected characteristics proportions in FTSU concerns and acknowledged that the gender characteristic was an outlier. Anecdotally, women tended to be more confident to raise any concerns via regular management routes, however more understanding of this was needed and work with established networks will follow to understand any challenges. The Director of People added the Staff Survey results suggested women were more confident to speak up.

Prof A Esmail referred to s3 of the report and was pleased to note all cases were discussed at executive level at monthly executive assurance meetings. He referred to threading it through culture and strategy of the Trust and enquired about actions taken against those displaying inappropriate behaviours.

The Acting Chief Executive reaffirmed the Trust was explicit in that any unwanted sexual attention was not tolerated. Initially a conversation would be held with an individual to caution them, and if behaviour persisted, formal route would be taken. In terms of culture, there were multiple programmes in place including culture events and leadership review helping with raising awareness.

The Chair thanked the FTSU Guardian for a comprehensive and clear report. He welcomed the important discussion around triangulation of data between FTSU and HR processes. He enquired whether there was a benchmark to gauge what proportion of anonymous concern would be considered a healthy level.

The FTSU Guardian advised it had not been defined, however as the tracking of the anonymous concerns progresses, a downward trend would be positive, indicating staff nervousness around FTSU to be reducing.

The Medical Director added that although some concerns were anonymous, the FTSU Guardian had direct contact and conversations with those individuals who wished to remain anonymous, and through genuine focus on the issue rather than on an individual, provided reassurance and gratitude to those raising concerns.

The Board:

- Noted the content of the report and the assurance provided that FTSU systems and processes are working as intended.
- Noted the change in accountability of concerns and the routes of escalation to service line or area directors.
- Noted the plans for the forthcoming quarter.

BOD/2425/105 Audit Committee 3A Report from the meeting held on 18th October 2024

Mr D Whatley presented the Audit Committee 3A Report from the meeting held on 18th October 2024. The Committee received a number of reports, and no alerts were raised on this occasion.

He highlighted the Cyber Assessment Framework (CAF) / Gap Analysis, which received Moderate Assurance from MIAA review. He advised the CAF review had identified the required actions to develop an improvement plan in readiness for the final submission in June 2025.

The Board:

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

BOD/2425/106 Resources Committee 3A Report from the meeting held on 22nd November 2024

Dr D Hanley presented the Resources Committee 3A Report from the meeting held on 22nd November 2024.

He referred to alerts and advised whilst the Workforce Indicators were stable and improving, there was still an issue remaining regarding EOC turnover although performance was unaffected.

Dr D Hanley advised of the Finance Report, the Committee had received, which indicated a good financial position, however CIP targets had not been fully achieved.

The Board noted the Resources Committee received a deep dive presentation regarding BAME staff disciplinary processes. Whilst the Committee received assurance that formal disciplinary processes were being undertaken appropriately, there were still discrepancies around BME staff entering formal disciplinary process.

In response to the question posed by the Chair, Dr D Hanley advised that BAME colleagues were 2.5 times more likely to enter disciplinary process than British white staff.

The Director of People advised of plans to undertake a quantitative data exercise with the Operations Team, to explore the informal layer, prior to disciplinary process, for any inconsistencies.

Prof A Esmail observed that all data and reviews in the NHS repeatedly indicated the processes were not the issue and the challenge was to find out what happens in the informal space. He enquired about the actions that would be taken to explore this.

The Director of People advised that initial review had been undertaken to identify whether the cases had not been pushed to formal process too soon and the evidence indicated that all cases were carried out appropriately,

following informal process first. However what needed to be explored further was whether there should have been any individuals included in the process that were not.

The Director of Operations advised the questions would be answered through 111 system driven, quantitative analysis, which would provide data regarding age, gender, ethnicity triangulated with HR disciplinary processes to determine any discrepancies.

The Acting Chief Executive added the Equality and Diversity Group received the deep dive review as well. Further data was awaited to uncover discrepancies and take follow up actions.

The Chair summarised the discussion and would look forward to obtain the outcomes from the analysis as well as continued work around culture and leadership.

The Board:

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

BOD/2425/107 **Trust Management Committee 3A Report from the meetings held on 16th October 2024 and 20th November 2024**

The Acting Chief Executive presented the Trust Management Committee 3A report from the meeting held on 16th October 2024.

He brought attention to two alerts arising from the meeting – one regarding significant financial pressure across the system and latter referring to the fact that GM Mayor and co-chair of the Integrated Care Partnership had expressed ambition for GM Fire Rescue Service to provide assistance to NWAS. The Acting Chief Executive further reported the Chief Fire Officer would consult a range of stakeholders and report back to Deputy Mayor by the end of the year. The impact on the Trust would include a level of cost and Trade Union involvement.

The Acting Chief Executive provided an overview of the 16th October TMC agenda and items discussed.

Mr D Whatley referred to information on CQC discontinuing their newly introduced single assessment framework and enquired about the implications to the Trust.
The Director of Quality, Innovation, and Improvement advised there was no clarity regarding the framework that CQC would use for inspection, possibly reverting to the one used before single assessment framework and inspecting trusts if there was a concern.

Dr D Hanley referred to PLICS (Patient Level Costing) data management tool being developed and expressed his delight this was being progressed as recommended by the Resources Committee.

The Chief Executive referred to the GM Fire Rescue Service assistance programme and observed that whilst he supported this idea in principle, the Trust needed to ensure this was not undertaken at the cost of NWAS.

The Acting Chief Executive presented the Trust Management Committee 3A report from the meeting held on 20th November 2024. He provided an overview of items discussed and assurance received.

He drew attention to one alert regarding the Phishing exercise which had been completed. The Acting Chief Executive then referred to the latest information on Digital Maturity Assessment received from NHSE. When received, the publication will enable a review of the results against the Trust's digital strategic plan. In terms of Well Led review, the Acting Chief Executive advised the tender for external assessors would be recommenced. Referring to the roll out of new defibrillators, he advised all the outstanding issues had been resolved by the manufacturer.

The Board:

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

BOD/2425/108 Integrated Performance Report

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report with an overview of integrated performance to the month of October 2024. She provided an overview of the report, with executive summary drawing out the main points in terms of quality, effectiveness, operational performance, finance and organisational health.

The Director of Corporate Affairs presented an overview of complaints and incidents data. She advised complaints numbers were stable with a slight decrease in closure timescales, which was associated with the implementation of new structures. The team work closely with the new leads to provide support and it was expected that the usual levels would be back in January. In terms of safety alerts, all had been actioned and closed within the stipulated timeframe.

The Board noted that Friends and Family Test response rates increased in 999 service (PES) with 92% satisfied or highly satisfied. Satisfaction rates were lowest in 111 (74%) with patients commenting that pathways triage requires redundant and duplicate information. The outcomes were not always right for patients and could lead to re-direction and further delays. This will be looked into as the trends had been positive until now.

A discussion took place regarding patients' expectations versus Trust performance. The Board noted that despite decreased satisfaction in 111 service, performance was still high, and expectations needed to be managed to provide patients with good experience. The unmet primary care needs could impact on patients calling 111 and result in the unusual down trend.

Ms C Butterworth enquired whether there was a way to redevelop pathways taking into account the patients' experience and comments.

The Director of Operations advised there was a mechanism to feedback to pathways and also though audits. However the adjustment to pathways was more clinically driven rather than based on what was perceived to be experiential. There was always a balance to be considered between experience feedback and clinical results and performance.

In terms of effectiveness, the Director of Quality, Innovation and Improvement reported STEMI care bundle compliance had increased for the fourth quarter to 92.6%, which was the highest compliance to date.

Mr D Whatley queried the reasons why the STEMI care bundle relating to strokes was retired from the report.

The Medical Director advised that the reporting frequency and workplan for all care bundles were set nationally. The falls bundle was brought in recently as an additional area of focus, with other bundles being paused to create the capacity. The stroke metrics would continue to be monitored and should they deteriorate, would be brought back into the national reporting cycle.

Prof A Esmail observed the challenge was to ensure that stroke patients are conveyed to the right unit in time. The Medical Director advised there would be an NHSE regional meeting in January looking specifically at mechanical thrombectomy access across the North West.

The Director of Operations reported on the metrics and advised Hear and Treat (H&T) rate was 15% and See and Treat (S&T) rate was 27.3%, total non-conveyance rate was 42.3%. In terms of national position, the Trust was ranking 5th for H&T, 8th for S&T and 9th for S&C. He noted an improvement in H&T which was the highest since March 2024. He advised here was a number of pilot programmes seeking to establish optimal pathways of care.

Prof A Esmail referred to the variations in See & Convey between regions. The Director of Operations observed each of the ICBs took a different approach to resolving the issue of handover times and financial aspects were driving variations as well.

The Director of Operations reported on the operational performance of 999 service. Ambulance Response Programme (ARP) standards were met for C1 90th, the remaining standards were not met. C2 long waits had increased with an indication that more patients were waiting 2-3 hours for a response. Variation between Integrated Care Systems were evident in all ARP response times. The hospital handover times increased despite significant collaboration with urgent and emergency care systems and the regional leadership team (NHSE). Delays in handover were linked to C2 performance and long waits.

Dr D Hanley referred to a high number of patients waiting outside of A&E and enquired about the corresponding harm risk. The Medical Director advised that whilst this data could not be seen in real time and there were no direct cases

at the moment, as service was very reactive to each case individually, previous years' measures demonstrate increase in morbidity due to delays. The Trust as well as all partner organisations and the system were sighted on the situation with daily system calls in place.

The Director of Quality, Innovation and Improvement reported the Trust invited each ICS team to provide an update on their A&E improvement programmes and requested that they develop an improvement trajectory.

A discussion took place regarding access to care for stroke and cardiac patients. The Chief Executive Officer queried whether there was a way to speed up the process for stroke and cardiac patients in order not to miss the window of the necessary urgent care for them. The Medical Director advised the direct access continued to be discussed with the regional network in Cheshire & Merseyside. The Chair added he would raise awareness of these issues through the ICB level meetings, when an opportunity arises, as some previous meetings were cancelled.

The Chair advised it had to be acknowledged that A&E departments were under extreme pressures in terms of performance and finance and it was a pressure for the whole system, therefore our response needs to be balanced as we continue to look for joint solutions.

The Director of Operations reported a sustained improvement in 111 performance metrics. The Trust was 3rd in national ranking.

He then referred to PTS activity metrics and advised these were stable. He highlighted improvement plans were underway to address aborted activity, collection after treatment (planned and unplanned). This was key to future proofing services for the new contract.

The Director of Finance reported a healthy financial position, with significant improvement in agency spend as each NWAS area was below the agency spend ceiling.

The Director of People reported stable and improving position on organisational health, with sickness absence level reducing, turnover times continuing an improving trend and vacancy displaying an improved position.

The Director of People highlighted that HR casework was under pressure with an overall increase, which was caused partially by increased reporting in sexual safety cases resulting from the sexual safety campaign. She advised discussions continued at the steering group to raise awareness so that leaders and colleagues recognise and stop such cases from happening before escalation.

The Chair observed that increased reporting following sexual safety campaign was a positive development as more women coming forward. He encouraged his Non-Executive Director colleagues to have these conversations from leadership point of view with staff members, when they visit ambulance stations.

The Board:

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

BOD/2425/109 IPC Board Assurance Framework 2023/24

The Director of Quality, Innovation and Improvement presented the IPC Board Assurance Framework, previously received in detail at Quality and Performance Committee.

She reported there were 7 amber rated areas and no red rated areas in the IPC BAF and pointed to Appendix 1 for detailed information. The Board noted that gaps in control and mitigating actions were articulated in the report and a timeline to improve declared throughout the BAF.

The Director of Quality, Innovation and Improvement reported one new risk placed on the register, scored 9, in relation to the World Health Organisation declaration of a public health emergency of international concern in relation to a large outbreak of Mpox (Clade 1) in central Africa. Three other risks remained on the register.

The Board:

- Noted the content of the reports and assurances provided.
- Noted the ongoing arrangements for monitoring via the IPC BAF.
- Noted the key risks and mitigations.

BOD/2425/110 NWAS Winter Assurance 2024/25

The Director of Operations presented the NWAS Winter Plan 2024/2025 which had been informed by the annual winter letter provided by NHS England around the areas of focus and to ensure the NHS works effectively as a system and set out a similar direction to the previous year.

The Board noted the annual winter letter provided key messages and areas of focus to assist with whole system integration and risk mitigation. In addition to the key areas identified by NHS England, the NWAS Winter Planning Group focussed on the following areas to support the strategic winter plan: admission avoidance, UEC recovery funding, handover times and supporting people to stay well through winter.

The Director of Operations reassured the NWAS Winter Strategic Planning continued to operate and further work would continue across all service lines to formulate tactical plans and to enact delivery throughout the period of the plan.

The Board:

- Noted the assurance provided

BOD/2425/111 Quality & Performance Committee 3A reports from the meetings held on 23rd September 2024 and 28th October 2024

Prof A Esmail introduced the reports. He focused on the October report and noted that the alert areas were raised and discussed during the Integrated Performance Report item.

The Board:

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

BOD/2425/112 Strategy Development Options

The Acting Chief Executive presented the report. He provided background to the paper by advising that TMC had requested a detailed appraisal of the following options: to either develop a refreshed strategy for approval in March 2025 or to extend the current strategy by one year and implement a new strategy in 2026.

The Acting Chief Executive reported that SWOT and PESTLE analyses had been completed and concluded that the Trust's current strategy remained aligned with the external context and that with significant changes anticipated externally and internally, therefore it was prudent to delay the development of a new strategy to 2025/26. He confirmed the Resources Committee approved the extension of strategy for one year.

Prof A Esmail referred to s3.8 of the report stating feedback was received indicating lack of clarity around what health inequalities were and how we are working to tackle them through the delivery of our strategy. Whilst he supported the time extension to the new strategy development, he strongly advised work regarding health inequalities should continue in interim.

The Chief Acting Officer reassured that work would continue and this year of extension to the policy would be very busy with background work with key areas for development including population health, equality, diversity and inclusion, and embedding strategic priorities into everything we do.

The Chair welcomed the comprehensive report and supported the option to extend the existing strategy for a further year as we await the NHS 10-Year Plan due to be published in the Spring and we anticipate other internal and external changes, whilst work continues internally on the Trust aims.

The Board:

- Noted the content of the report.
- Approved option 2 to extend the existing strategy for a further year in line with the decision from the Resources Committee.

BOD/2425/113 Communications and Engagement Q2 2024/25 Report

The Acting Chief Executive took the Board through the key headlines from the report and provided an overview of the dashboard a quarterly summary of key outputs.

He highlighted the growth in numbers of the Patient and Public Panel to 346 members, with 32% youth representation, and 25% representation from diverse communities. He advised in Q2, members were actively involved in reviewing the equality, diversity and inclusion priorities.

The Acting Chief Executive referred to the FOI figures and reported 99% compliance with 20 working days response target.

He then noted significant activity across all social media platforms, with the biggest increase in engagement seen on X.

The Chair acknowledged the huge amount of ongoing communications work and praised the great presentation of data in Appendix 1.

The Board:

- Noted the content of the report and dashboard and assurances provided.

BOD/2425/114 Any Other Business Notified Prior to the meeting

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

BOD/2425/115 Risks identified

The Chair summarised the discussions and outcomes of the meeting and confirmed there was no additional risk identified for BAF.

Farewell to Daren Mochrie, Chief Executive Officer

On behalf of the Board, the Chair offered tribute to the outgoing Chief Executive. He thanked Daren for his great leadership and work for NWAS as well as raising the profile of ambulance trust nationally. The Chair expressed his heartfelt gratitude for the support and a positive working relationship they enjoyed. He noted that the outgoing Chief Executive would leave behind a legacy of the Trust being in a strong position in terms of finance, workforce and performance. He wished Daren all the best for the future.

Date and time of the next meeting –

9.45 am on Wednesday, 29th January 2025 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			

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	✔	✔	✔	✔	✔	x		
Salman Desai	✔	✔	✔	✔	✔	✔		
Prof Aneez Esmail	✔	✔	x	✔	✔	✔		
Dr Chris Grant	✔	✔	x	x	✔	✔		
Dr David Hanley	✔	x	✔	✔	✔	✔		
Daren Mochrie	✔	✔	x	✔	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	✔	✔	✔	✔	x	✔
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	✔	✔	✔	x		
Dr David Hanley	✔	✔	✔	✔		
Dr Maxine Power	✔	✔	✔	✔		
Angela Wetton	✔	✔	✔	✔		

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

Nomination & Remuneration Committee								
	3rd May	29th May	31st July	25th September	27th November	10th December	29th January	26th March
Catherine Butterworth	x	✔	x	✔	✔	x		
Dr Alison Chambers	x	✔	✔	✔	x	✔		
Prof Aneez Esmail	x	✔	✔	✔	✔	✔		
Dr David Hanley	✔	x	✔	✔	✔	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	Present	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	Present	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	Present	Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
Salman	Desai	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

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	
Maxine	Power	Director of Quality, Innovation and Improvement	Non Executive Director at AQUA - Improvement Agency based in the North West	√				Position of Authority	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-24		Declare an interest and withdraw from discussions as and when required.
			Son employed on NWAS admin bank contract			√		Non financial personal interest.	Aug-24	Sep-24	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	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	Sep-24	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.
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	Aug-24	N/A
			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

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
SUBJECT	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 several areas since the last report to the Trust Board dated 27 November 2024 The highlights from this report are as follows: PES • Overall demand and incident volume remains relatively stable • Handover continues to be a significant challenge with variation in areas • All new leadership structure roles are now live NHS 111 • Performance remains strong • Workforce is at full establishment • Support from Vocare will remain until February 2025 PTS • Current contract remains pending outcome of procurement exercise • Overall activity below contract baseline

	• Engaging with acute trusts and ICBs to reduce the number of aborted journeys for same day discharge	
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 27 November 2024

2. PERFORMANCE

2.1 Paramedic Emergency Service

Year to date, overall demand and incident volume for the 999 service has remained relatively stable in respect to emergency incidents in comparison to the same period in 2023. December 2024 saw similar numbers of emergency calls and incidents to December 2023. The presenting acuity of patients has reduced when compared to the same periods in 2023, with reduction in the percentage of incidents within the C1 cohort and a slight increase in the percentage in the C2 cohort. Handover remains a significant challenge with the year-to-date average handover being over 8 minutes higher than the same period the previous year. There is disparity in this increase across the three areas with Cumbria & Lancashire having a 6-minute increase, Greater Manchester having a 4 minute and 30 second increase, and Cheshire & Mersey seeing an increase of nearly 14 minutes. Late December and early January was a significant challenge for all three areas with handover averaging over 51 minutes, and 10 acute trusts having handover that was over one hour. Work continues in all three areas to embed handover collaboratives with the acute trusts and the ICBs, and the NHSE regional team are supporting work around setting trajectories for handover improvements with acute trusts. Work also continues to develop 'call before convey' models for all areas across the North West region, and ICBs are being pushed to evolve this into care coordination in line with the specification from NHSE. NWAS has been clear that benefits of these schemes are likely to be marginal, but that any assistance in reducing see and treat variation is welcome.

ARP response performance continues to be challenging as we move through winter. C1 mean response YTD stands at 07:47 and is 08:02 for December 2024. C2 mean response stands at 29:45 and is 42:21 for December 2024. NWAS is now behind the agreed year-to-date C2 UEC target of 29:23 and only just under the revised C2 standard of 30 minutes. C3 and C4 responses have also increased during this reporting period. NWAS are currently only delivering C1 90th ARP standard for the year-to-date position. Long waits increased in December for C1 and C2 calls. As an illustration C2 long waits slightly increased In December 2024 vs December 2023 (11,018 vs 10,634) but this was over 3000 more than the last reporting period in October 2024.

Call pick-up continues to perform exceptionally well with a mean call answer of 2 seconds for December and 2 second YTD. NWAS for December ranked first nationally for all call pick up metrics. Hear & Treat rates remain stable and improved but have not yet 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 23:36 vs Cheshire & Mersey ICB at 41:43 and this gap is widening. Both areas have seen a further deterioration in C2 performance

since October, but this is more pronounced in Cheshire & Mersey where it is over 5 minutes. In October Chesire & Mersey had a C2 mean of over 1 hour 7 minutes and saw 62% of the long waits for C2 calls across the NWAS footprint.

All the roles in the new leadership structure are now live, with the Senior Paramedics, Duty Officers, and Advanced Paramedic Practitioners starting on the 13 January 2025. Work is ongoing to induct everyone into their new role and provide role specific training for those who are new to command and advanced clinical posts. The transition from SPTLs working on rapid response vehicles to Paramedics providing that cover is underway, and this should have a positive effect on our category 1 performance. In the short term, additional Ambulance Liaison Officers have been seconded to support challenged hospital sites for handover.

2.2 NHS NW 111

Performance in the 111-service line has remained strong since the start of the financial year and December was no exception to this. For December calls answered in 60 seconds was 80%. It is also worthy of note that we now receive only very minimal support from agency staff.

For context, the below is a comparison with October 2023 which clearly demonstrates the significant improvement in these metrics.

	Dec-23	Dec-24
Number of abandoned calls	21871	4707
Abandoned calls as a %	12%	2.6%
Total number of calls answered in a 24-hour period	159047	176191
Total number of calls answered within 60 seconds	85966	141119
Total number of calls answered within 60seconds as a %	54%	80%

Continuation and review of recruitment processes to support a resilient workforce, review of mentoring process to provide additional support for new Call Handlers which is linked to attrition reduction in first 6 months of employment.

December position for sickness has increased slightly at 13.6%, this is in line with seasonal trends. The 111 workforce is now at full establishment.

FCMS have continued to provide a good level of support with their call handling provision, and we are now seeing provision of 90%+ month on month.

Support from Vocare will remain in place until February 2025 and the support ranges between 10-15% of total call volume.

2.3 Patient Transport Service

Report Date – Dec 2024, Contract Month 6

Cumulatively, Cumbria is -19% below baseline. Greater Manchester is 9% above baseline. Lancashire is -25% below baseline and Merseyside is 6% above baseline. This is broadly consistent with previous months, and indicative of low unplanned activity in Cumbria and lower planned activity in Lancashire.

PTS are currently operating under a block contract arrangement, and we continue to await the outcome of the PTS procurement exercise.

Cumbria -Planned achieved 86% against the Arrival KPI target of 90% (Consistent). EPS achieved 90% against the Arrival KPI target of 90%. (Improved)

Lancashire - Planned arrivals achieved 83% against the Arrival KPI target of 90%. (Improving). EPS achieved 85% against the Arrival KPI target of 90%. (improving).

Greater Manchester - Planned arrivals achieved 71% against the Arrival KPI target of 90%. (Improving). EPS achieved 68% against the Arrival KPI target of 90%. (Improving).

Merseyside - Planned arrivals achieved 76% against the Arrival KPI target of 90%. (Consistent). EPS achieved 77% against the Arrival KPI target of 90%. (Improving).

Overall activity during Month 6 (contract year) was -16% (-20,632 Journeys) below contract baseline whilst the cumulative position is -7% (-57,748 Journeys) below baseline.

The PTS service leads are engaging with acute trusts and ICB colleagues to improve performance through reducing the number of aborted journeys for same-day discharges. Work is also underway to strengthen the PTS senior leadership team in the areas of operational delivery and clinical governance and assurance through recruitment to key posts.

3. ISSUES TO NOTE

3.1 Local Issues

Staff Abuse

Colleagues from Parkway and Blackpool stations assisted the communications team with the production of a BBC news feature focussing on the violence and aggression our staff face on the phones, and out on the road.

The BBC broadcasted their feature on North West tonight on Tuesday 3 and Wednesday 4 December, focussing on our contact centres and station staff. It was supported with interviews, case studies and a BBC Radio feature to hopefully drive home the message that we are there to help, not to be abused. This special news feature was aired a week before we launched our own focus on violence and aggression on our social medical sites.

It has been reported by the Association of Ambulance chief Executives (AACE) that violence and abuse against ambulance workers will reach an all-time high by the end of the financial year. New figures show that every day at least 55 ambulance staff will be abused, or attacked, across the country and more than 20,0000 incidents of violence and

aggression are expected to be recorded across the fourteen UK ambulance services by the end of 2024-25 financial year. This will be the highest rate ever reported.

To help publicise the data, and highlight the issue, NWAS EOC Supervisor, James Shelley appeared on the BBC Breakfast sofa at the beginning of January alongside AACE Chair, Jason Killens. He talked about the homophobic abuse he received from a man who initially rang 999 for his mother and was later convicted and received a suspended prison sentence.

The trust has recently recruited new roles to tackles these issues, support staff who have faced abuse, and work with partner organisation to help staff stay safe.

Protecting our Emergency Workers

Assaults on emergency workers should never be considered 'part of the job'. Our campaign highlights the abuse faced by staff.

In six months, there have been over 1000 incidents of violence and aggression – an average of 165 per months, or 5 daily assaults, targeting ambulance crews and call handlers. These include verbal and physical abuse, with many incidents going unreported. To expose this reality, we're sharing on social media anonymised audio recordings from 111 and 999, highlighting the verbal assaults endured by staff.

Former detective Natalie Samuels joined the service in July as Head of Violence Prevention, Reduction and Security. With 15 years of policing experience, Natalie is leading efforts to ensure no abuse goes unchecked and commented that our service users need to be aware that they can't hide behind the phone, verbal abuse is not okay and they can, and will, be prosecuted. We also want to raise awareness and educate staff that any form of abuse should not be accepted and only by reporting these incidents can these offenders be punished for their abuse.

Natalie's work has already led to a 500% increase in reported incidents in our 111 service. Now, at least one verbal abuse incident is reported daily and many repeat offenders are undergoing prosecution or receiving formal judicial warnings, ensuring they only contact us for genuine medical reasons.

To strengthen support for staff, Natalie has expanded her team, appointing violence prevention and reduction specialist practitioners. These specialists provide advice and direct support to staff through the prosecution process, promote the use of body-worn cameras, risk map repeat offenders to proactively address potential threats, and implement support strategies aimed at preventing future offences.

Violence and aggression further featured in the press on the second week in January when a nurse was stabbed by a member of the public whilst working at a hospital in our region, reportedly leaving her with life-changing injuries. This dreadful, and frightening, incident is a stark reminder of the dangers that all NHS frontline workers face. Our thoughts are with he,r and her colleagues, and she tries to recover from this terrible ordeal.

Weather Conditions

The weather over the New Year period was horrendous and as a trust we saw many flood-related incidents in the 24 hours that followed.

The wet and freezing weather worsened the on-going pressure on the healthcare system, and we have seen some really significant hospital handover delays affecting service delivery in many areas. The impact on our staff and the patients who are waiting for us in the community, or stuck on a vehicle outside hospital, cannot be underestimated. We continue to highlight the scale of the problem and work closely with hospital colleagues to try to find solutions.

At a national level AACE has collaborated with The Guardian to highlight in a newspaper article the harm that handover delays can cause.

Southport Incident

The trial of Axel Rudakubana, the person accused of the knife attack in Southport in July last year was due to commence on 21 January. However, he has pleaded guilty and there will no longer be a trial. This was followed by an announcement from the government that there will be a public inquiry into the events leading up to the attack.

The horrendous attack, in which three young girls lost their lives, and many were injured, had a significant and lasting impact on everyone involved. This includes many NWAS colleagues - from those handling the 999 calls or attending the scene, to those affected by the aftermath of the event or the civil unrest that followed. The whole community felt the impact of the incident in the subsequent days, weeks and months and we can expect to see widespread media coverage and social media activity.

The sentencing is due to take place on Thursday which means we will continue to see and hear lots of news coverage about the incident and the involvement of various agencies. For anyone affected by the incident, especially those who were directly involved in the response, this coverage could be upsetting and the trust issued advice to all staff to take care over how much they choose to read and watch and noted that avoiding news programmes and removing news and social media apps from phone would be the quickest and easiest way to escape coverage of this nature.

The incident attracted huge attention on social media, with vast amounts of speculation and misinformation shared at the time. This contributed to community tensions. There is anticipation the trial will attract similar unwanted and unhelpful attention

My thoughts, and the thoughts of all of us at NWAS, continue to be with the families of Alice Dasilva Aguiar, Bebe King and Elsie Dot Stancombe.

3.2 Regional Issues

Pilot of New Procedure re End of Shift Protection

Effective 18 December 2024, the trust began the pilot of a new procedure to enhance support for emergency ambulance crews at the end of their shifts.

It is widely acknowledged that completing shifts on time is crucial for all staff. Frequently finishing late can have a negative effect on personal lives and well-being and can also create challenges for subsequent oncoming staff. Engagement groups will be held with staff to obtain feedback on the trial.

Electric Ambulances

Last week marked the arrival of the first of two fully electric ambulances for the trust. The vehicles will now enter a period of vehicle testing and formal certification, prior to handover to the trust.

The vehicles will initially be based at Blackpool and Central Manchester where preparations are well underway to install new rapid charging infrastructure at both sites.

3.3 National Issues

Christmas Carol Service at Westminster Abbey

I had the pleasure of attending the Princess of Wales' annual Christmas Carol Service at Westminster Abbey, alongside ambulance colleagues invited as part of the Royal Foundation. Families affected by the Southport attack were also amongst the 1600 guests at the event, where the message was 'showing solidarity for those in need'.

As part of the invitation letter, the Princess wrote about the importance of compassion; 'gentle words or a receptive ear, an arm round an exhausted shoulder, or silently being by someone's side' and 'the love that we show ourselves and the love we show others – love that listens with empathy, love that is kind and understanding, love that is forgiving and the love the brings joy and hope'.

It was a privilege to represent the trust at this special event, which was shown on ITV on Christmas Eve.

College of Paramedics New Patron

The Prince of Wales has become Patron of the College of Paramedics. Given his experience as an air ambulance pilot, the Prince has an in-depth knowledge and understanding of the work paramedics do and the difference they make to their patients' lives on a daily basis.

4 General

Trust Leadership

On 16 December, Peter White, Chair, announced that with effect from 1 January 2025, I have been appointed to the substantive position of Chief Executive, following the departure of Daren Mochrie. I've been proud to work for the ambulance service in the North West since I joined 27 years ago, and being appointed as Chief Executive is a true honour. We have an amazing team of dedicated, caring professionals who come to work every day to do their best for patients. I'm looking forward to leading this team and working with partner organisations to tackle healthcare system challenges together, continuing to improve the patient experience.

New Years Honours

Lisa Ward, Director of People, has been recognised in the 2024 King's New Year Honours list and will be awarded the prestigious King's Ambulance Medal. This recognition honours ambulance staff who demonstrate distinguished service, exemplary personal performance, and outstanding ability in their vocation.

Lisa's 23 years of service in the ambulance sector have been defined by her unwavering commitment to inclusion, representation, and advocacy. She has been a driving force behind the creation of our staff networks, ensuring underrepresented voices are heard and fostering a more inclusive and supportive environment within NWAS. The organisation we know today is brighter and more welcoming because of her leadership and influence.

Lisa also serves as the HR Director lead for the National Education Network for Ambulance Services, spearheading national education and training initiatives. She is a respected member of the Staff Council, advocating tirelessly for better pay and working conditions. Additionally, Lisa played a pivotal role in establishing the national LGBTQ network, and her decades of allyship were recognised with an award at the 2023 national LGBTQ conference.

It is particularly fitting that Lisa's relentless support for equity is now reflected in her own recognition. She is the first woman in NWAS to receive this honour, marking a historic moment for our organisation.

Another NWAS colleague, Steve Mannion, MERIT doctor, was recognised for his voluntary overseas work with the Feet First Foundation which makes a huge difference to the lives of children in Malawi and his volunteering work in war and disaster zones over the last 30 years. Steve received the very prestigious Companions in the Order of St Michael and St George (CMG) honour.

REAP

On 26 November, the trust's REAP level changed from Level 3 (major pressure) to level 4 (extreme pressure) due to increasing response times and extended, and increasing, hospital handover delays.

Staff Survey

The NHS staff survey closed at the end of November and this year we received our highest number of responses, 3560.

Our independent survey provider will collate all the responses so that they can share the anonymised results with us to enable our Staff Experience team to analyse the results, identify trends and themes, and importantly share the information with local sectors and teams so that it can be used to make improvements for our workforce. The results will be publicised in March 2025 and an action plan will be developed highlighting the areas we will be focussing on over the coming year.

National Quarterly Pulse Survey (NQPS)

The National Quarterly Pulse Survey launched on Wednesday 8 January and will be open throughout January for staff to complete.

The NQPS is an integral part of the NHS People Promise and provide a consistent and standardised approach for listening to NHS staff, both nationally and locally. We use the results from this survey, along with the finding from the annual NHS Staff Survey, to improve local working conditions and practices and to increase involvement and engagement with colleagues.

Speaking Up matters

Last year over 13,000 opportunities to speak up were taken across various channels, including Freedom to Speak Up, and HR, Processes. We know from staff survey data that staff are becoming increasingly confident in speaking up and have more confidence that the organisation will act upon concerns. Our focus remains to address any issues including management practices, working conditions, incivility as well as sexual safety and culture.

Additional guardians have been recruited who will focus on learnings from other trusts, refining our processes and improving satisfaction with the scheme.

Trust Strategy

The current trust strategy has been extended until March 2026 which allows us to maintain focus as we prepare for the leadership changes and align with the NHS 10-year Plan which is due to be published in the spring. Key areas for development include population health; equality, diversity and inclusion, and embedding our strategic priorities into everything we do.

Project 365

NWAS is currently one of the few NHS organisations not only using and migrating to the cloud, but also setting retentions, cleansing files as we migrate and focussing on user adoption and training.

There is national interest around how the digital Team are approaching the retention process with stakeholders and the overall approach to the project. The work has been described as trailblazing, and discussions are on-going to blueprint the project for other trusts to use.

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, 29 January 2025
SUBJECT	Board Assurance Framework Q3 2024/25 Position
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Agree the increase in score of SR01 from15 to 20. • Agree the decrease in score of SR02 from 16 to 12. • Agree the decrease in score of SR06 from 15 to 10 • Approve the Q3 2024/25 position of the Board Assurance Framework.	
EXECUTIVE SUMMARY	The proposed 2024/25 Q3 position of the BAF risks with associated CRR risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2024/25 year to date can be viewed in Appendix 2. As part of the Q3 review, the Trust Management Committee (TMC) recommend the following changes: • SR01 has increased in risk score from 15 to 20. • SR02 has decreased in risk score from 16 to 12. • SR06 has decreased in risk score from 15 to 10.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee & Audit Committee	
	Date	15th January 2025 and 17th January 2025
	Outcome	TMC recommended to Board for approval

1. BOARD ASSURANCE FRAMEWORK

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

2. RISK ASSURANCE PROCESS

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

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

3. REVIEW OF THE Q3 POSITION

Following a full review of the Board Assurance Framework, the following changes are proposed:

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

- Change in current risk score SR01 for Q3 from 15 to 20

Opening Score 01.04.2024	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL	**Dr C Grant**

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

- Continued pressure to achieve ARP performance standards, particularly C2 which resulted in long waits and deterioration in hospital handover times, predominantly within Cheshire and Mersey contributing to harm and poorer patient outcomes.

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

- Change in current risk score of SR02 for Q3 from 16 to 12

Opening Score 01.04.2024	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
16 4x4 CxL	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	C Wood

The risk has decreased in risk score because of the following rationale applied by the Executive Lead:

- M09 financial position better than year to date plan
- Shortfall on the delivery of recurrent efficiency significantly reduced during Q3

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

- Change in current risk score of SR06 for Q3 from 15 to 10

Opening Score 01.04.2024	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	Dr M Power

The risk has decreased in risk score because of the following rationale applied by the Executive Lead:

- Improvement in the Duty of Candour enactment, with training undertaken with Sector Clinical Leads during Q3.
- Quality audits being undertaken with area assurance meetings in place.

4. RISK CONSIDERATION

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

The Board Assurance Framework contains the application of the Trust's Risk Appetite Statement and has been reviewed as part of the Q3 BAF Review process.

5. ACTION REQUIRED

The Board of Directors is asked to:

- Agree the increase in score of SR01 from15 to 20.
- Agree the decrease in score of SR02 from 16 to 12.
- Agree the decrease in score of SR06 from 15 to 10.
- Approve the Q3 2024/25 position of the Board Assurance Framework.

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BOARD ASSURANCE FRAMEWORK 2024/25

Proposed Q3 Position

Board of Directors – Part 1

29th January 2025

Q4 Position Reporting Timescales:

Trust Management Cttee:	16/04/2025
Audit Cttee:	18/04/2025
Resources Cttee:	22/05/2025
Quality & Performance Cttee:	28/04/2025
Board of Directors:	30/04/2025

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

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

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


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

BOARD ASSURANCE FRAMEWORK DASHBOARD 2024/25

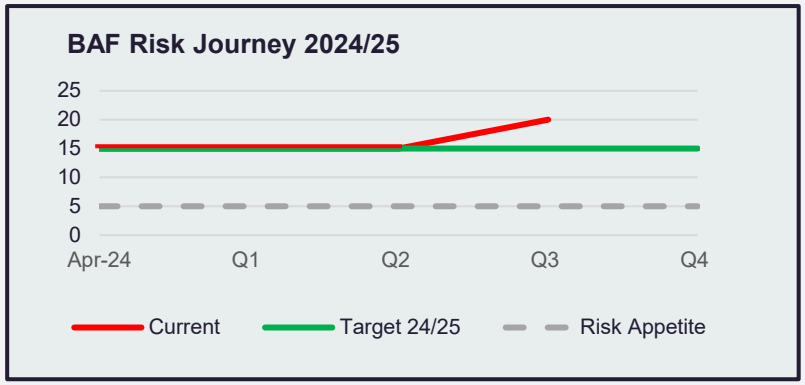
BAF Risk	Committee	Exec Lead	01.04.24	Q1	Q2	Q3	Q4	2024/25 Target	Risk Appetite Tolerance
SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 C&L	**15** 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL		**15** 5x3 CxL	**1-5**
SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver high quality (safe and effective) services	**Resources**	**DoF**	**16** 4x4 CxL	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL		**12** 4x3 CxL	**6-12**
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care and/or harm	**Quality & Performance**	**DoOps**	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL		**15** 5x3 CxL	**1-5**
SR04: There is a risk that the Trust will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualified staff impacting adversely on delivery of performance standards and patient outcomes	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**8** 4x2 CxL		**8** 4x2 CxL	**6-12**
SR05: There is a risk that the Trust does not improve its culture and staff engagement and this impacts adversely on retention and staff experience.	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL		**12** 4x3 CxL	**6-12**
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Quality & Performance**	**DoQII**	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL		**10** 5x2 CxL	**1-5**
SR07: There is a risk that the Trust does not work together with our partners in the health and social care system to shape a better future leading to poor effects on our communities and the environment	**Resources**	**DoSPT**	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL		**4** 4x1 CxL	**6-12**
SR08: There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm	**Resources**	**DoQII/ DoF**	**15** 5x3 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL		**15** 5x3 CxL	**1-5**
SR09: There is a risk that the Trust attracts negative media attention arising from long delays and harm leading to significant loss of public confidence	**Resources**	**DoSPT**	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL		**10** 5x2 CxL	**6-12**
SR10: (**Sensitive Risk**):	**Resources**	**DoSPT**	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL		**12** 4x3 CxL	**6-12**

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR RISK SCORE: The risk score for the Q3 position of this BAF risk has increased to a risk score of 20.This is as a result of continued pressure across all ARP standards, particularly C2, with a resultant increase in long waits. Whilst demand has remained largely within predicted levels, the significant deterioration in hospital handover is the primary rationale for this deterioration. However performance within 111 remains strong and call pick up has also been consistently maintained. The predominant risk remains within the Cheshire and Mersey PES area; C2 mean and long waits within the area are significant outliers and contribute to unavoidable harm and poorer patient outcomes. Work on call before convey is being piloted across all 3 ICSs looking to drive improvements in See and Treat. All ACQIs remain within expected range. The delivery of Duty of Candour and patient safety syllabus training continued to progress across the organisation, the Trust's Patient Safety Specialist has completed level 4 of the patient safety syllabus, with plans in place to train two further patient safety specialists. The first cohort of the Improvement Academy is now well established with graduation scheduled for March 2025. The recruitment process for Freedom to Speak Up Guardian roles has completed.

Projected Forecast Q4: Deteriorating
Stable
Improving

Rationale: Stable
The Trust will be in winter with weather and infectious diseases fully realised and hence sustained performance pressures will continue.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Progressing maturity of NHS Impact	**Level 2:** Improvement Academy **Level 2:** Trust Management Cttee Escalation and Assurance Report	Reported to Trust Management Cttee TMC/2425/044 Reported to Board of Directors BoD/2425/34
Patient Safety Strategy	**Level 2**: PSIRF Report Q1 24/25	Reported to Quality & Performance Cttee QPC/2425/046
Delays in responding to patients in mental health crisis	**Level 2:** Strategic Mental Health Plan 2024-2027 **Level 2**: Learning Disability & Autism (LDA) Plan Progress Report	Reported to Trust Management Cttee TMC/2425/131 Reported to Quality and Performance Committee QPC/2425/68
Safety Culture	**Level 2:** Freedom to Speak Up Guardians	Reported to Trust Management Cttee TMC/2425/17
Insight and Intelligence	**Level 2:** Data Insights and Intelligence Reporting Priorities (July - December 2024)	Reported to Trust Management Cttee TMC/2425/093
Freedom to Speak Up	**Level 2:** Freedom to Speak Up Report	Reported to Board of Directors BoD/2425/104
Variation in handover delays and process impacting patient safety	**Level 2:** Integrated Performance Report **Level 2:** Service Delivery Assurance Group 3A Report	Reported to Board of Directors BoD/2425/108 Reported to Trust Management Cttee TMC/2425/197
Implementation of Quality Strategy	**Level 2:** Annual Plan Assurance Report	Reported to Resources Ctte TMC/2425/73

DIGITAL					
Digital Strategic Plan	**Level 2**: Digital Strategic Plan 2024-2026	Reported to Board of Directors BoD/2425/81			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
CLINICAL					
Clinical Audit	Implement next generation of Clinical Audit Tool	Dr C Grant	March 2025	Q&P Cttee	In Progress
QUALITY					
Patient Safety Strategy	Further training required following service delivery model review (SDMR) to ensure specific roles are trained in PSIRF learning responses.	Dr M Power	March 2025	Q&P Cttee	In Progress
	Patient Safety Partner Policy approval awaiting approval	Dr M Power	January 2025	Q&P Cttee	In Progress
Implementation of the quality strategy	Service line plans for improvement of safety, effectiveness and experience	Dr M Power / Mr D Ainsworth	March 2025	Q&P Cttee	In Progress
Progressing maturity of NHS Impact	Deliver Programme of Improvement Academy (10 teams)	Dr M Power	March 2025	Q&P Cttee	In Progress
Insight and intelligence	Integrated quality and performance reporting for service lines and sectors	Ms J Wharton	March 2025	TM Cttee	In Progress
Delays in responding to patients in mental health crisis	Mental health strategic plan implementation	Ms E Orton /Mr D Ainsworth	March 2025	TM Cttee	In Progress
	RCRP task and finish group				
Avoidable conveyance to hospital & long waits at ED impacting resource availability and response	See and Treat Improvement Programme	Mr D Ainsworth	March 2025	TM Cttee	In Progress
Freedom to Speak Up	Scope plan to improve performance on FTSU	Dr C Grant	March 2025	TM Cttee	In Progress
Safety Education	Training needs analysis for safety training	Dr M Power/ Ms L Ward	January 2025	Q&P Cttee	In Progress
Variation in handover delays and process impacting patient safety	Specific work with the Cheshire and Mersey partnership to focus on excess delays	Mr D Ainsworth / Dr C Grant	March 2025	TM Cttee	In Progress

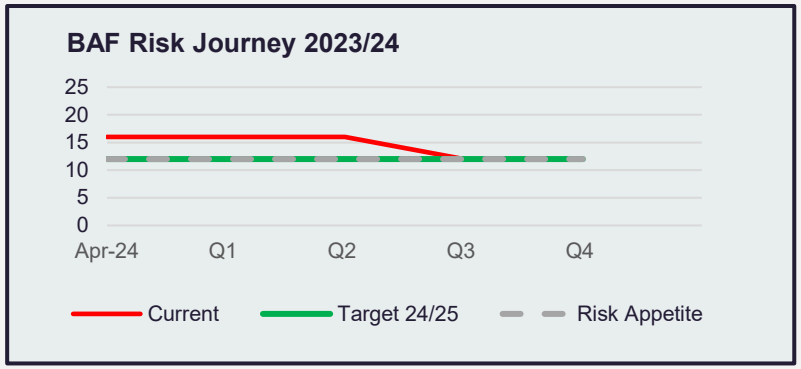
Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of EPRR national occupational standards, training, exercising, and subsequent competency assurance, the EOC/ICC leadership team are not adequately prepared to manage large scale, significant or major incidents, which may result in serious avoidable patient harm or death and cause significant reputational damage to the Trust.	15 High	15 High	⇔	5 Low
490	Operational/ Operational Performance	There is a risk that due to the roll-out speed of the of the UK Government's National Framework Agreement: Right Care, Right Person (RCRP), the necessary alternative services will not be available or lack sufficient capacity, leading to NWAS becoming the default organisation for all incidents involving people with mental health needs, resulting in pressure on NWAS capacity and NWAS receiving patients with needs that are not within our remit or skill set.	15 High	15 High	⇔	3 Low
507	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to the major incident which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to business as usual which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
At Q3 the risk score for the BAF risk has reduced to a score of 12. The actual month 9 financial position is better than the year to date plan, and whilst a significant proportion of the efficiency identified to date and projected, against the £15.5m target, is non-recurrent, the shortfall on the delivery of recurrent efficiency has reduced significantly during the last quarter, with only a small balance remaining to be identified (£0.3m).

Projected Forecast Q4:
Deteriorating
Stable
Improving

Rationale: Stable
With the improvement in Q3, the risk score will remain stable into Q4.

CONTROLS	ASSURANCES	EVIDENCE
2024/25 Financial Planning	**Level 2:** 2024/25 Financial Planning and Opening Budgets **Level 2:** Final 2024/25 Financial Plans	Reported to Board of Directors BoD/2324/082 Reported to Board of Directors PBM/2425/04
Financial Performance	**Level 2:** Finance Report Month 1 24/25 **Level 2:** Finance Report Month 2 24/25 **Level 2:** Integrated Performance Report **Level 2:** Finance Report Month 3 24/25 **Level 3:** Auditor's Annual Report 2023/24 **Level 2:** Finance Report Month 5 24/25 **Level 2:** NHSE System Financial Recovery **Level 2:** Finance Report Month 6 24/25 **Level 2**: Finance Report Month 7 24/25 **Level 2:** Finance Report Month 8 24/25	Reported to Resources Cttee RC/2425/010 Reported to Trust Management Cttee TMC/2425/061 Reported to Board of Directors BoD/2425/85, BoD/2425/108 Reported to Trust Management Cttee TMC/2425/84 & Board of Directors PBM/2425/34 Reported to Audit Cttee AC/2425/65 Reported to Resources Cttee RC/2425/33 Reported to Board of Directors PBM/2425/44 Reported to Trust Management Cttee TMC/2425/149 Reported to Trust Management Cttee TMC/2425/172 & Resources Cttee RC/2425/062 Reported to Trust Management Cttee TMC/2425/208

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

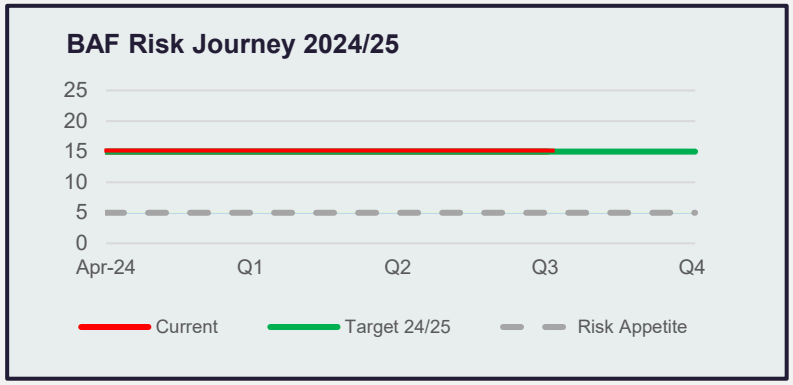
Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
Sensitive Risk – Section 43 – Commercial Interests						
317	Operational / People	**Sensitive Risk**	20 High	15 High	⇩	10 Moderate

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q3 position of this BAF risk remains at a risk score of 15 primarily as a result of the delivery of the national ARP standards, which remained significantly challenged with C1 90th standard being met regionally. Hospital handover remained above the system UEC agreed standards and there are challenges regarding vehicles being held outside EDs which worsened throughout December 2024, particularly in Cheshire & Mersey impacting on NWAS' ability to mitigate delay. The PTS contract award is still under extended standstill period, the PTS Improvement Group was established during Q3 to address performance. 111 continued to perform well against contract KPIs and continued to deliver against the IUC Q3 trajectories.

Projected Forecast Q4: **Deteriorating**
Stable
Improving

Rationale: **Deteriorating**
Q4 commenced in a challenged position due to various critical incidents being declared across the systems. The pressures experienced during December are likely to continue during January 2025, with priority of focus around working with the system and managing delays. Increased flu and norovirus within community and hospital setting is increasing pressures. As of January 2025, NWAS are not achieving the C2 30 minute standard due to increased handover delays, with the average handover 45% above agreed standards.

CONTROLS	ASSURANCES	EVIDENCE
Improve Hear and Treat Performance	**Level 2:** Integrated Performance Report **Level 2:** Service Delivery Assurance Group 3A Report	Reported to Quality & Performance Cttee QPC/24225/065 Reported to Board of Directors BoD/2425/108 Reported to Trust Management Cttee TMC/2425/197
Recruitment Plan Clinical Hub and Operational Staff (SR09)	**Level 2:** People and Culture Group 3A Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2425/195 Reported to Resources Cttee RC/2425/077 Reported to Board of Directors BoD/2425/108

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

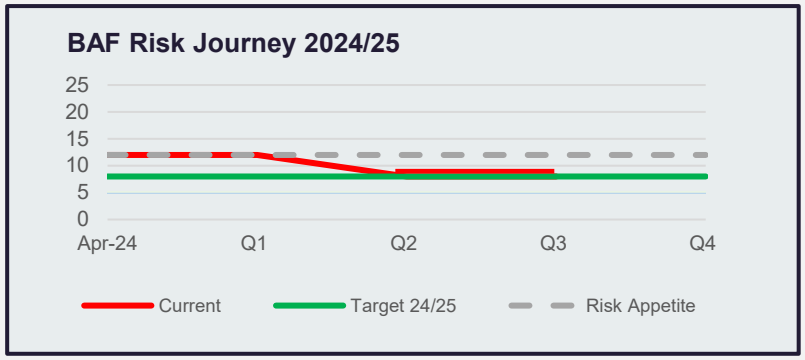
Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
507	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to the major incident which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	There is a risk that as a result of a major incident being declared, there are insufficient available resources to respond to business as usual which may lead to avoidable patient harm (quality outcomes).	20 High	15 High	⇩	5 Low

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The Q3 position of this BAF risk has reduced to a risk score of 8. Vacancy gaps are closing with significant improvements in both PES and 111. Sickness absence remains above sector average, although an improving position and continues to impact on resource availability. Where vacancy gaps remain in EOC and PTS these are not impacting on the safety of service provision. Turnover is improving across all service lines and plans are in place to improve this position and it is not impacting on safe staffing. The high turnover in EOC has now stabilised with early signs of improvement. The current score of 8 reflects the overall good position seen at the end of Q3 which indicates that safe staffing is being maintained. Current performance pressures are arising as a result of system issues and not staff shortages.

Projected Forecast Q4:
Deteriorating
Stable
Improving

Rationale: Stable
The deployment position in Operations is expected to continue to improve across Q4, with continued progress to be made in closing vacancy gaps. Continued improvements in attendance and turnover anticipated.

CONTROLS	ASSURANCES	EVIDENCE
Recruitment Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report **Level 2:** International Recruitment Learning Review	Reported to Resources Cttee RC/2425/077 Reported to Trust Management Committee TMC/2425/195 Reported to Resources Cttee RC/2425/078
Retention Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report **Level 2:** Deep Dive: ICC Retention	Reported to Resources Cttee RC/2425/077 Reported to Trust Management Committee TMC/2425/195 Reported to Resources Cttee RC/2425/047
Attendance Improvement Teams – Improvement Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report	Reported to Resources Cttee RC/2425/077 Reported to Trust Management Cttee TMC/2425/195
Flu Vaccination Programme	**Level 2:** 2024/25 Flu Campaign	Reported to Resources Cttee RC/2425/50 Reported to Board of Directors BoD/2425/90

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

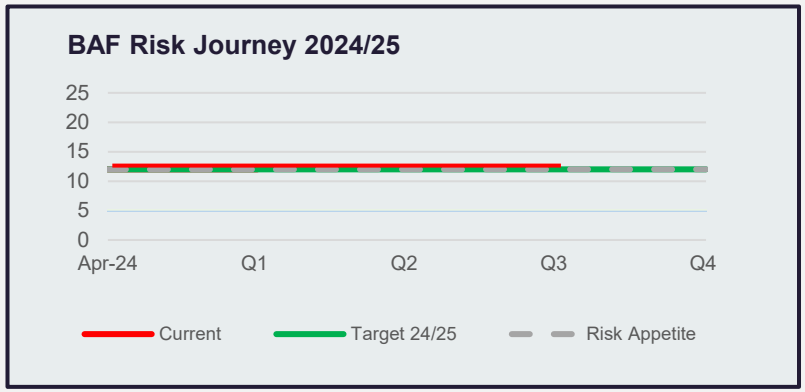
Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q3 position of this BAF risk remains at a score of 12. Whilst staff survey results indicate continued progress has been made across a range of indicators and that overall the Trust is average or slightly above average for the sector against the key People Promise themes, there are a range of challenges to staff experience identified through data and through the Ambulance Culture Review. Progress continues to be made in delivering planned improvements set out in the People Strategy and Annual Plans but these will take some time to deliver the changes required. Work is progressing to implement the leadership review with all appointments completed in Q3 and deliver planned leadership induction which follows in Q4; People Promise Manager has presented recommendations and workstreams mobilising for delivery; Disciplinary Policy evaluation and review complete; sexual safety campaign, partnership review and refresh of EDI priorities continuing. Wellbeing Hub launched and revised induction launched incorporating senior leadership input with all new starters. Culture focused leadership event held and four further events approved for Q4. 2024 staff survey response rate maintained at 48%, early results indicate stable position with improvement across a number of areas. The current score of 12 reflects that retention and staff experience feedback is in an improving position.

Projected Forecast Q4:
Deteriorating
Stable
Improving

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

CONTROLS	ASSURANCES	EVIDENCE
Culture Review	**Level 2:** Culture Review Assurance Report **Level 2:** Culture Events	Reported to Resources Cttee RC/2425/020 Reported to Trust Management Cttee TMC/2425/190
Fully Embedding Just Culture Principles	**Level 2:** Culture Review Assurance Report	Reported to Resources Cttee RC/2425/020
People Promise Exemplar Programme	**Level 2:** People and Culture Group 3A Report	Reported to Trust Management Cttee TMC/2425/195
EDI	**Level 2:** Equality, Diversity and Inclusion Annual Report 2023/24 **Level 2:** Diversity & Inclusion 3A Report **Level 2:** Recruitment – Positive Action and Target Setting **Level 2:** Deep Dive: BME Staff Informal Disciplinary Processes	Reported to Resources Cttee RC/2425/019 Reported to Trust Management Cttee TMC/2425/193 Reported to Resources Cttee RC/2425/049 Reported to Resources Cttee RC/2425/076
EDI Priorities	**Level 2:** Equality, Diversity and Inclusion Priorities 2024-26 and Annual Plan	Reported to Board of Directors BoD/2425/68
Wellbeing	**Level 2:** Health and Wellbeing Annual Report **Level 2**: Wellbeing and Absence Report	Reported to Resources Cttee RC/2425/018 Reported to Resources Cttee RC/2425/079
Staff Survey Plan	**Level 2**: People and Culture Group 3A Report **Level 2:** Staff Survey 2024 Plans	Reported to Trust Management Cttee TMC/2425/137 Reported to Trust Management Cttee TMC/2425/098
Sexual Safety Campaign	**Level 2:** Diversity and Inclusion Group 3A Report	Reported to Trust Management Committee TMC/2425/193
Leadership	**Level 2:** Developing Leaders Programme	Reported to Trust Management Cttee TMC/2425/189

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Delivery Leadership Review	Implementation of Operational & Clinical Management Restructure	Mr D Ainsworth	March 2025	Resources Cttee	In Progress

EDI Priorities	Delivery of year 1 action of plan	Ms L Ward	2024/25	Resources Cttee	In Progress
Partnership Agreement	Implementation of revised Partnership Agreement	Ms L Ward	March 2025	Resources Cttee	In Progress
Wellbeing	Implementation of mental health improvement plans	Ms L Ward	March 2025	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	March 2025	Resources Cttee	In Progress
Sexual Safety	Process to support learner safety	Ms L Ward	March 2025	Resources Cttee	In Progress
Staff Survey	Delivery of Staff Survey 2024	Ms L Ward	December 2024	Resources Cttee	Completed
Culture Review	Deliver identified actions and support national work programme	Ms L Ward	2024/25	Resources Cttee	In Progress
People Promise Exemplar Programme	Deliver improvements in identified priority areas: flexible working; staff engagement	Ms L Ward	2024/25	Resources Cttee	In Progress
Induction	Implement revised onboarding and induction	Ms L Ward	2024/25	Resources Cttee	In Progress

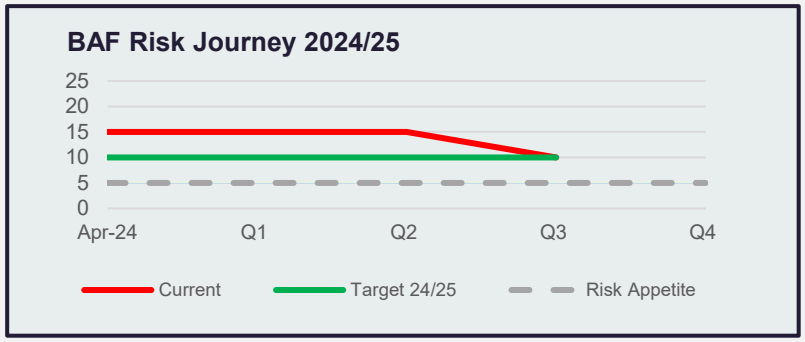
Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoQII

Risk Appetite Category: Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q3 position of this BAF risk has reduced to a risk score of 10. Regular engagement meetings continue with the CQC relationship manager. There has been improvement in the Duty of Candour enactment and the Trust is in a stable position. Duty of Candour training was undertaken for Sector Clinical Leads in October 2024. Quality audits are now being undertaken with area assurance meetings in place. Mandatory training and appraisal compliance is achieving targets. An internal audit review is scheduled for Q4 on the Patient Safety Incident Response Framework (PSIRF) and forms part of a regional audit. The risk associated with controlled drugs licensing remains at a risk score of 15.

Projected Forecast Q4: Deteriorating / Stable / Improving

Rationale: Stable
Although the Duty of Candour position is currently stable, there is concern due to winter pressures in relation to the volume of patient safety events currently being recorded and our ability to respond in a timely manner might be challenged.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Appraisal and Mandatory Training Compliance 2024/25	**Level 2:** 2024/25 Appraisal and Mandatory Training Plans **Level 2:** Integrated Performance Report **Level 2:** People and Culture Group 3A report **Level 2:** Workforce Indicators Report	Reported to Trust Management Cttee TMC/2425/22 Reported Board of Directors BoD/2425/108 Reported to Trust Management Cttee TMC/2425/195 Reported to Resources Cttee RC/2425/077
QUALITY & SAFETY IMPROVEMENTS		
Duty of Candour	**Level 2:** MIAA Progress Report **Level 2:** Internal Audit Follow Up Report **Level 2:** Clinical and Quality 3A Report	Reported to Audit Cttee AC/2425/12 Reported to Audit Cttee AC/2425/61 Reported to Trust Management Cttee TMC/2425/59
Medicines Management	**Level 2:** Medicines Management OBC Update **Level 2:** Controlled Drugs Annual Report 23/24 **Level 2:** Medicines Management Report Q1 24/25 **Level 2:** Medicines Management OBC	Reported to Corporate Programme Board: CPB/2425/059 Reported to Board of Directors BoD/2425/88 Reported to Quality & Performance Cttee QPC/2425/48 Reported to Trust Management Cttee TMC/2425/177
Information Governance	**Level 2:** Digital Strategy Update	Reported to Resources Cttee RC/2425/074
Essential Checks	**Level 2:** Service Delivery Assurance Group 3A Report	Reported to Trust Management Cttee TMC/2425/197

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Duty of Candour	Ongoing compliance monitoring and action plan to strengthen position with associated reporting for assurance transferred to service lines	Dr M Power/Mr D Ainsworth	March 2025	Q&P Cttee	In Progress
Essential Checks	Improve compliance of vehicle and equipment checks	Dr M Power / Mr D Ainsworth	March 2025	Q&P Cttee	In Progress
Medicines management	Business case and procurement of dedicated medicines management system	Dr C Grant	January 2025	Q&P Cttee	In Progress
Digital Clinical Safety	Creation and implementation of digital clinical safety procedures	Ms J Wharton	February 2025	Q&P Cttee	In Progress

	Completion of digital clinical safety process on Electronic Patient Record	Ms J Wharton	February 2025	Q&P Cttee	In Progress
	Assessment of all systems to determine systems requiring application of digital clinical safety	Ms J Wharton	February 2025	Q&P Cttee	In Progress
Information Governance	Compliance on mandatory training to 95%	Dr M Power / Ms L Ward	March 2025	Resources Cttee	Completed
PEOPLE					
Appraisal Compliance 2024/25	Achieve 85% compliance	Ms L Ward	March 2025	Resources Cttee	Completed
Mandatory Training Compliance 2024/25	Achieve 85% compliance	Ms L Ward	March 2025	Resources Cttee	Completed

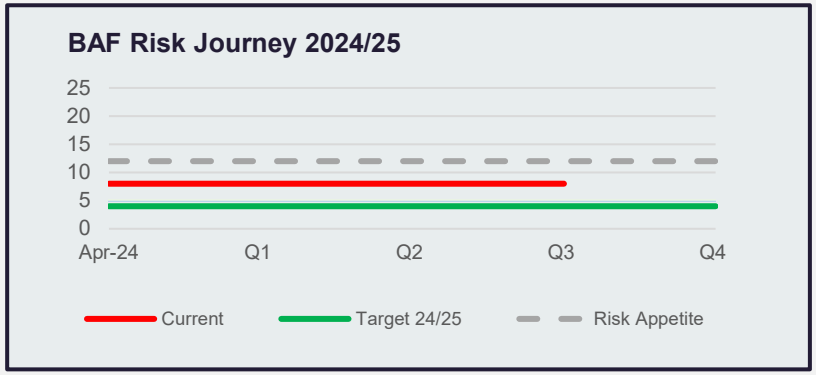
Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low
474	Strategic/ Estates & Facilities Management	There is a risk that a fire on NWAS premises involving a lithium-ion battery may present a serious threat of harm to staff and catastrophic damage to the premises.	15 High	15 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for Q3 position of this BAF risk remains at a score of 8. Work continues with all Service Delivery areas regarding external engagement. A mapping exercise has been completed and shared with areas about the meetings taking place in their areas with the required representation. Uploads to the Knowledge Vault (KV) has increased. Monthly statistics are shared which show the engagement being recorded in the KV.

Projected Forecast Q4:
Deteriorating
Stable
Improving

Rationale: Improving
Renewed focus on external engagement and relationship management will continue as it has in Q3 and more emphasis on evidencing and assuring external engagement.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Knowledge Vault	Ongoing improvement for utilisation of the KV by all three areas of the Trust	Mr S Desai	Q3 – Q4	Resources Cttee	In Progress
External Engagement Assurance	Service Delivery areas to provide evidence that important external meetings are being attended	Mr S Desai	Q1 – Q4	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07

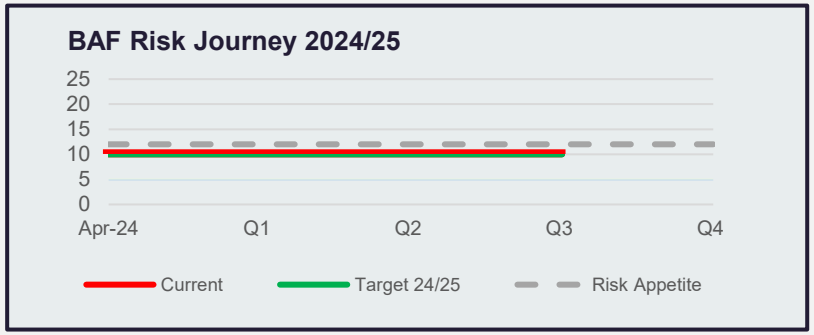
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q3 position of this BAF risk remains at a score of 10 due to hospital handover delays that continue to attract negative media attention. The negativity arising from long delays and potential harm is a constant risk that requires annual communications plans and approaches that can respond to seasonal and other circumstantial demands. Our aim is to keep the risk at a moderate and managed level.

Projected Forecast Q4:
Deteriorating
Stable
Improving

Rationale: Stable
Whilst delays at hospitals impact our ability to respond to 999 calls, this has heightened during the winter period and is expected to continue into Q4, due to winter weather and seasonal conditions such as influenza, respiratory conditions and norovirus, which may lead to greater media interest and adverse coverage.

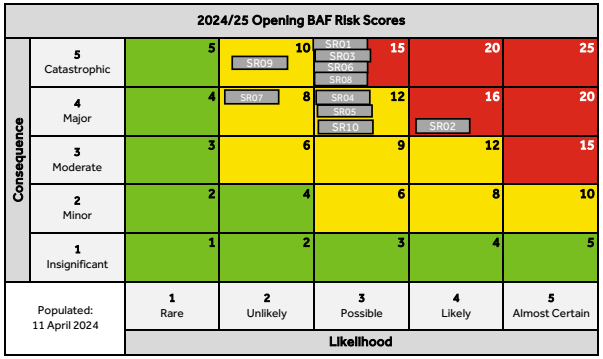
CONTROLS	ASSURANCES	EVIDENCE
Communications and Engagement Dashboard	Level 2: Q2 2024-25 Assurance	Reported to Board of Directors BoD/2425/113
Recruitment Plan Clinical Hub and Operational Staff (SR09)	**Level 2:** People and Culture 3A Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2425/195 Reported to Resources Cttee RC/2425/077 Reported to Board of Directors BoD/2425/108
Winter Plan	**Level 2:** NWAS Strategic Winter Plan	Reported to Trust Management Cttee TMC/2425/187 & Quality & Performance Cttee QPC/2425/069

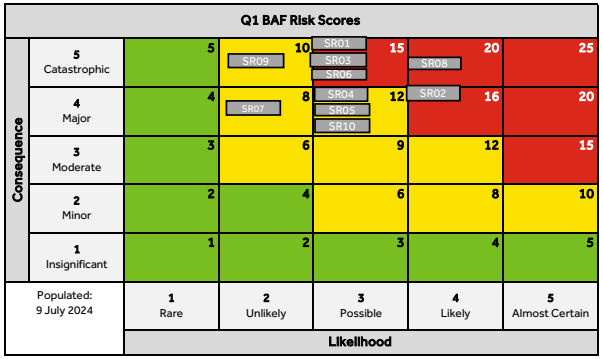
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Delivery Leadership Review	Delivery of SDLR to improve working practices	Mr D Ainsworth	March 2025	Resources Cttee	In Progress
	Maximise resources to the most efficient level	Mr D Ainsworth	March 2025	Resources Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff	Robust recruitment plan to be delivered	Mr D Ainsworth/ Mrs L Ward	March 2025	Resources Cttee	In Progress

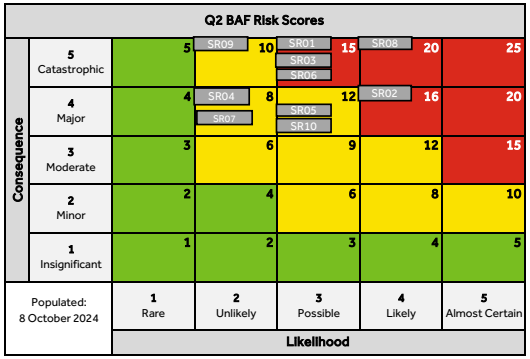
Operational Risks Scored 15+ Aligned to BAF Risk: SR09

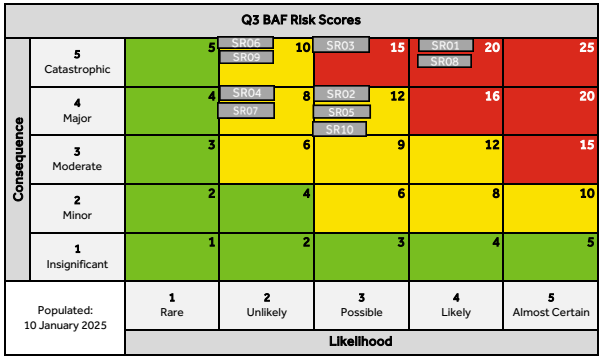
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

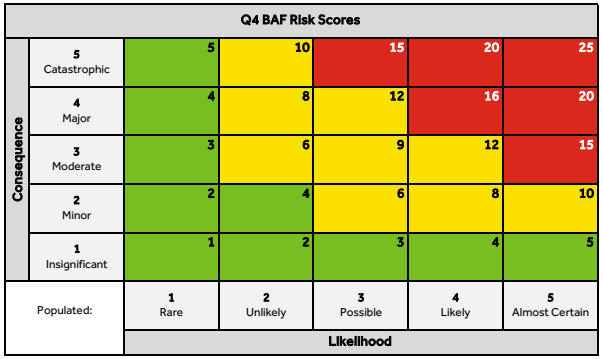
Appendix 2:
2024/25 Board Assurance Framework (BAF) Heat Maps
Q3 Position

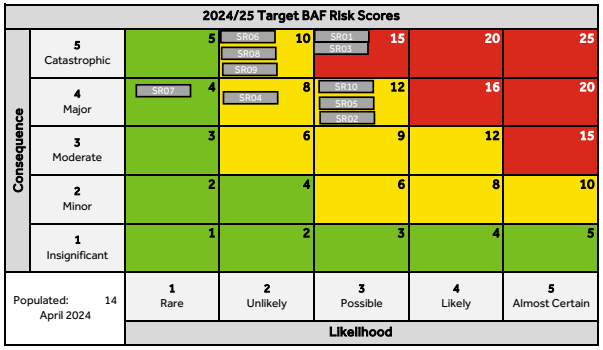


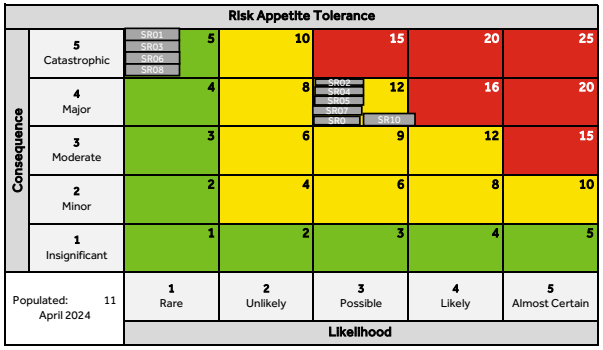












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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
SUBJECT	Board and Committee Calendar 2025/26
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors is requested to approve the Corporate Calendar 25/26.	
EXECUTIVE SUMMARY	The proposed meeting dates for the Board of Directors and its Committees for 25-26 can be seen in s2 of the report. The dates have been shared with Committee Chairs and Executive colleagues for agreement prior to presenting to Board. The Resources Committee meetings for 25-26 have been scheduled to take place on a Thursday morning, the rationale for this is provided within s2.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 29 January 2025
	Outcome	Recommended to Board for approval

1. BACKGROUND

Following submission of the proposed dates to the Trust Management Committee and Committee Chairs, the Corporate Calendar for 25/26 is presented to the Board of Directors for approval.

2. CORPORATE CALENDAR 25/26

Meeting	Date
Board of Directors 9.45 am – 3.00 pm Bi monthly	30th April 28th May 18th June (Year End) 30th July 24th September 26th November 28th January 25th March
Board Development 9.30 am – 4.30 pm Bi monthly	30th April (PM only) 25th June 29th October 10th December 25th February
Charitable Funds Committee 10.00 am – 11.30 am Quarterly	14th May 23rd July 22nd October 18th February
Nominations & Remuneration Committee 9.00 am – 9.45 am Bi monthly	28th May 30th July 24th September 26th November 28th January 25th March
Audit Committee 10.00 am – 12.00 pm Quarterly	25th April 23rd May 18th June 18th July 24th October 16th January
Quality and Performance Committee 1.00 pm – 4.00 pm (Bi monthly)	28th April 30th June 1st September 27th October 15th December 23rd February
Resources Committee 10.00 am – 1.00 pm (Bi monthly)	22nd May 24th July 18th September 20th November 22nd January 19th March

Trust Management Committee 1.00 pm – 4.30 pm (Monthly)	23rd April 21st May 18th June 23rd July 20th August 17th September 22nd October 19th November 17th December 21st January 18th February 18th March

Resources Committee meetings have been scheduled for Thursday morning rather than the previous Friday mornings as they coincided with the submission, collation and distribution of agendas and papers for the Board of Director meetings – this change helps to alleviate pressure for both the corporate team and executive colleagues.

Membership of Committees will be reported to the Board of Directors in March 2025. Diary invites have been distributed to all Board Members for all meetings based on the current membership and will be updated accordingly in the event of any changes.

3. RISK CONSIDERATION

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

4. EQUALITY/ SUSTAINABILITY IMPACTS

None identified.

5. ACTION REQUIRED

The Board of Directors is asked to approve the Corporate Calendar for 2025/26.

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ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Friday, 17 January 2025		
Members present	Mr D Whatley, Non-Executive Director (Chair) Mrs C Butterworth, Non-Executive Director Dr A Chambers, Non-Executive Director Prof A Esmail, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None identified.

ADVISE:

- The Internal Audit progress report detailed reviews completed and in progress ahead of the Head of Internal Audit Opinion being presented at the end of the financial year.
- The Anti-Fraud progress report detailed the work undertaken during Q3 24/25.
- The External Auditors progress report was noted by the Committee.
- Losses and Compensation for Q3 2024/25 totalled £196k.
- Six waivers were approved during Q3 24/25.

ASSURE:

- Internal Audit reported four reviews were completed during Q3 24/25.
  - Management of Controlled Drugs - Substantial Assurance
  - Safeguarding – Substantial Assurance
  - Risk Management Core Controls – High Assurance
  - EPRR – Moderate Assurance

  The Director of Operations attended to provide a progress update against the recommendations identified within the EPRR review including a high priority recommendation related to commander learning portfolios being consistently completed.
- The Q3 24/25 Board Assurance Framework position was presented, prior to approval by the Board of Directors on 29th January 2025. Committee members considered the report within the context of their role as Audit Committee.
- 3A Reports were received from the Quality and Performance Committee meetings held on 23rd September 2024 and 28th October 2024 and the Resources Committee meeting held on 22nd November 2024.

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 December 2024		
Members present	Mr S Desai, Acting CEO (Chair) Mr D Ainsworth, Director of Operations Mr M Cooper, Area Director, Lancashire & Cumbria Dr C Grant, Medical Director Mr I Moses, Area Director, Cheshire & Mersey Prof M Power, Director of Quality, Innovation & Improvement Ms S Rose, Interim Director of Integrated Contact Centres Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs J Wharton, Chief Information Officer Ms S Wimbury, Area Director, Greater Manchester Mrs C Wood, Director of Finance	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- No alerts to record

ADVISE:

- Capital is being made available by NHSE to support replacement of emergency ambulances in 25/26
- Operational Planning Guidance is due Thursday 19 December
- Chief Information Officer presented a paper on the proposed structure changes within Digital and noted the requirement to realign the ICC systems team to the digital function together with the DoS team and Clinical & Digital Information team, all of whom have a significant cross over in roles and responsibilities
- The AACE Violence Prevention & Reduction Hub, funded primarily by NHSE, will cease at the end of March 2025

ASSURE:

- **The TMC discussed the following:**
  - 2425/174 Finance Report Month 8

RISKS

Risks discussed:

- None

New risks identified:

- None

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee			
Date of meeting	Wednesday, 15 January 2025		
Members present	Mr S Desai, CEO (Chair) Mr D Ainsworth, Director of Operations 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 A Ormerod, Interim Deputy Director of Strategy, Partnerships & Transformation Prof M Power, Director of Quality, Innovation & Improvement Ms S Rose, Director of Integrated Contact Centres Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs J Wharton, Chief Information Officer Ms S Wimbury, Area Director, Greater Manchester Mrs C Wood, Director of Finance	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- Additional scrutiny and reconciliation required on increased taxi spend
- Outcome of the PTS tender has been pushed back to 31 January 2025
- Further investment in Body Worn Video Cameras will be required in 2026/27 if the decision to proceed is agreed, although the trial has not produced any evidence

ADVISE:

- L&SC ICB providing additional £3m of capital – two pre-approved programmes will be brought forward from 2025/26 – Defibrillator replacements and DCA replacements
- National Occupational Standards Framework compliance at 90%
- Awaiting a response from the UKHSA regarding clearly defined roles and responsibility (lead/advise/inform) for incident management when an incident span multiple geographic areas
- Statutory and mandatory Training targets for operational service lines increased to 90%

ASSURE:

- **The TMC discussed the following reports:**
  - 2425/221 Finance Report Month 8
  - 2425/222 Financial Planning 2025/26
  - 2425/239 National Occupational Standards Framework (NOS)
  - 2425/242 Strategic Debrief TB case in Ambulance Worker
  - 2425/243 HR Casework Q3

- **Received the following Escalation & Assurance reports**:
  - Health, Safety, Security & Fire Group
  - People & Culture Group
  - Service Delivery Assurance Group
  - Sustainability Group

RISKS

Risks discussed:

- None

New risks identified:

- Potential risk in relation to Fire Code / compliance – to be assessed
- ICC trainer risk to be added to register
- Risk relating to unvalidated taxi spend
- Concerns regarding the Police response to natural death in GM – to be added to risk register

NHS
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NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
SUBJECT	Health & Safety Policy
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Health and Safety Policy.	
EXECUTIVE SUMMARY	The previous H&S Policy was due for review this month, however, following transfer of the health & safety function to the corporate affairs directorate on 01 April 2024, a whole review and rewrite of the policy has taken place. The new H&S policy details the framework by which NWAS will effectively manage health and safety across its activities and how the trust will approach and discharge its legal duties. The new H&S policy can be viewed in Appendix 1.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee (TMC) Health, Safety, Security & Fire Group	
	Date	Wednesday, 15 January 2025
	Outcome	Supported onward reporting to Board

1. BACKGROUND

From 01 April 2024, the health & safety function transferred to the corporate affairs directorate and subsequently a new Health and Safety Policy has been created.

2. PURPOSE OF THE HEALTH AND SAFETY POLICY

The Health and Safety Policy sets out a framework for managing health and safety across NWAS, following the framework laid down in the Health and Safety Executives (HSE) HS(G)65 'Managing for Health and Safety.' The framework is based around the plan, do, check, act cycle. It sets out clear definitions, responsibilities, and process requirements to enable legal compliance with health and safety related legislation.

The process requirements detailed within the policy will support health and safety principles to be applied consistently throughout the organisation.

The new Health and Safety Policy can be viewed in Appendix 1.

3. POLICY GOVERNANCE

The Head of Integrated Governance, Risk and Assurance authored a draft version of the policy which was shared with a wide-ranging group of stakeholders, including Execs, senior managers and the Health and Safety Trade Union Representatives. Feedback was received and where appropriate, this was incorporated into the policy document.

The Health and Safety Policy:

- Will replace the legacy Health, Safety, Security & Fire Policy.
- Brings together existing working practices into a formal policy document.
- Has been created in line with legislation.
- Has been reviewed and taken specialist advice from key stakeholders.
- Has been subject to consultation with key stakeholders.

The Health and Safety Policy was presented to the Trust Management Committee (TMC) on 15 January 2025, and the Health, Safety, Security & Fire Group on 21st January 2025 – both forums agreed for recommendation to the Board of Directors (29 January 2025) for approval.

4. RISK CONSIDERATION

Health and Safety forms part of the trust's integrated governance and risk management arrangements and supports the Board of Directors in meeting its statutory duties.

5. EQUALITY/ SUSTAINABILITY IMPACTS

An Equality Impact Assessment (EIA) has been completed by the Policy Lead, and approved by the Equality, Diversity & Inclusion (EDI) Team.

The EIA is designed to ensure that the policy, practices, events and decision-making processes arising from the policy are fair and do not present barriers to participation or disadvantage any protected groups from participation.

This document can be seen attached to the policy in appendix 1.

6. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Health and Safety Policy.

North West Ambulance Service NHS Trust

Policy on Health and Safety

Policy on Health and Safety		Page:	Page **1** of **20**
Author:	Head of Integrated Governance, Risk and Assurance	Version:	0.1
Date of Approval:	TBC	Status:	Draft
Date of Issue:	TBC	Date of Review	January 2028

Document Control	
Policy Title	Health and Safety Policy
Policy Reference Number	
Version number	0.1
Approval date	
Approved by	Board of Directors
Date for Review	January 2028
Executive Sponsor	Director of Corporate Affairs
Policy Lead	Head of Integrated Governance, Risk & Assurance
For use by	All individuals working for or on behalf of the trust

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	November 2024		J Taylor	New policy

Policy on Health and Safety

Contents	

HEALTH AND SAFETY STATEMENT OF INTENT

The Board of Directors at North West Ambulance Service NHS Trust (NWAS) is committed to providing a safe environment for all its people and others who are involved or affected by the activities of the trust, so far as is reasonably practicable, in accordance with the Health and Safety at Work Act 1974 and associated legislation.

The trust will take the necessary steps to ensure regulatory compliance with relevant health and safety legislation and will access competent advice to assist with this. The trust will ensure a safe system of work to prevent work related injuries, ill health, protection of its people, property, and assets by promoting safe working practices.

Working together, the trust is committed to address identified risks in a proactive manner. As far as is reasonably practicable the trust aims to avoid exposure to risk by the promotion of an effective, proactive safety culture by clear identification of roles and responsibilities of all our people, ensuring they receive suitable and sufficient advice, guidance, supervision, support and training.

The Board of Directors recognises that financial investment is required to ensure compliance with its statutory duties. This policy and supporting health and safety procedures will endeavour to ensure the necessary resources are made available.

The trust acknowledges that effective health and safety management contributes to the organisation's success and monitors health and safety performance in several ways as described in this policy.

Our Health and Safety Policy will be monitored to ensure compliance and will be reviewed, and revised as necessary, on a regular basis or in response to organisational and/or legislative changes.

PETER WHITE
Chair

SALMAN DESAI
Chief Executive Officer KAM

1. Introduction

This policy details the framework by which North West Ambulance NHS Trust (the trust) will effectively manage health and safety across its activities.

This policy sets out how the trust will approach and discharge its legal duties under the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999 and all other relevant statutory provisions including current best practice/ requirements from within the wider NHS.

All individuals working for or on behalf of the trust have legal responsibilities under the Health and Safety at Work Act 1974. This policy sets out the actions necessary to fulfil these responsibilities.

The implementation of good health and safety management is not just a legal responsibility, it can benefit an organisation financially by helping to reduce the costs associated with accidents and incidents.

2. Purpose

This policy sets out a process for how the trust will manage health and safety with the aim of ensuring legal compliance with health and safety related legislation.

It is a legal requirement for all organisations with five or more employees to have a written health and safety policy.

The objectives of this policy are:

- To establish the trust's approach and commitment to health and safety management.
- To detail the processes for establishing a health and safety management system.
- To integrate health and safety management into the trust's culture and everyday practice.
- To define the elements of the trust's health and safety management system.

3. Definitions

Competent Advice/ Nominated Competent Person
The Management of Health and Safety at Work Regulations require an employer to appoint a competent person to assist them with fulfilling their statutory health and safety responsibilities. The competency level set by the trust is Chartered Safety and Health Practitioner status.

Health and Safety Management System
A health and safety management system is a framework for organising and recording the trust's health and safety arrangements and activities. The trust is using the framework detailed in the Health and Safety Executive (HSE) document 'Managing for Health and Safety – HS(G)65 which is used by HSE inspectors when auditing organisations arrangements for managing health and safety.

Health and Safety Risk Assessment

A health and safety risk assessment is a careful examination of what could cause harm to people whilst at work, so that a decision can be made on whether enough precautions have been taken to prevent harm or if more are needed.

Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)
RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. This legislation requires the trust to report certain types of incidents to the Health and Safety Executive (HSE).

So far as is reasonably practicable
This means that you must take action to control the health and safety risks in a workplace except where the cost (in terms of time and effort as well as financial) of doing so is "grossly disproportionate" to the reduction level of the risk.

Trade Union Health and Safety Representative
This is a staff member nominated in writing by their Union to undertake this role after suitable training via the Trade Union Congress (TUC) accreditation programme. They are appointed in line with the Safety Representatives and Safety Committee Regulations 1977 to carry out functions as specified in the regulations.

4. Duties

The Board of Directors has overall responsibility for health and safety management. The Trust Board requires the Chief Executive Officer (CEO), the Executive Directors and their staff to implement the requirements of this policy within all service lines covered by their portfolio.

The Health and Safety at Work Act 1974 states that everyone has a responsibility to protect the health and safety of themselves and others whilst conducting their day-to-day activities within the organisation.

The **Board of Directors** has overall responsibility for all aspects of health and safety within NWAS. The Board of Directors are responsible for the approval of the strategic direction for health and safety management, including compliance with the requirements of this policy and will make adequate provisions in the annual budget to allow appropriate health and safety commitments to be met.

The **Chief Executive Officer (CEO)** has overall accountability for the health and safety of all employees and other affected by the trust's activities. The CEO will ensure that health and safety management requirements are included in the portfolio of all Executive Directors employed by NWAS.

The **Director of Corporate Affairs** is the Board level lead for health and safety, and is the Chair of the Health, Safety, Security and Fire Group. The Director of Corporate Affairs is also responsible for:

- Ensuring that the trust has access to competent health and safety advice as required by the Management of Health and Safety at Work Regulations 1999.
- Providing health and safety advice to the Board of Directors, Chief Executive Officer, and Executive Directors.
- Working with the Trust Management Committee (TMC) to ensure appropriate health and safety management objectives are set for their areas of responsibility.

The **Director of Finance** is responsible for:

- Ensuring that premises, equipment and vehicles are provided and maintained in a safe condition.
- Ensuring adequate resources are available to provide the trust with competent fire safety advice as required by the Health Technical Memorandum 05-01: Managing Healthcare Fire Safety.
- Ensuring that the trust complies with the Regulatory Reform (Fire Safety) Order 2005.
- Ensuring assurance reports for fire safety are submitted via the NWAS Integrated Governance Structure.

The **Director of People** is responsible for:

- Ensuring adequate arrangements are in place regarding Occupational Health Services (OHS).
- Ensuring that suitable health and safety training, including induction, is delivered as necessary.
- Ensuring that suitable driver training, including high speed driver training is delivered.

The **Head of Integrated Governance, Risk and Assurance** is responsible for:

- External reporting compliance and the building, maintaining relationships with external regulators.
- Promoting the business benefits of good health and safety management.
- Ensuring that trust-wide health and safety objectives are set and incorporated into relevant plans.
- Ensuring that trust-wide health and safety performance information is incorporated into relevant reports.
- Ensuring the trust has a health and safety plan in place.
- Ensuring adequate resources are available to provide the trust with competent health and safety advice as required by the Management of Health and Safety at Work Regulations 1999.
- Ensuring assurance reports are submitted via the NWAS Integrated Governance Structure.

The **Director of Operations** is responsible for ensuring that health and safety arrangements are incorporated into the operational activities of the trust.

The **Head of Health and Safety**, fulfils the role of the ***nominated competent person***. The Head of Health and Safety will provide advice and practical assistance in all matters relating to health and safety across the trust. Their responsibilities include:

- Providing advisory support to the Director of Corporate Affairs and the Head of Integrated Governance, Risk and Assurance on all health and safety matters.
- Providing advisory support to the trust and its managers on all health and safety matters.
- Positive promotion of good health and safety management, including the importance of near-miss and incident reporting.
- Production of the annual health and safety plan.
- Production of health and safety performance information at a trust-wide level.
- Development and coordination of the trust's health and safety management system.
- Production and maintenance of an appropriate health and safety policy.
- Production and maintenance of associated health and safety procedures.
- Liaison with the Education and Training Department to ensure provision of appropriate health and safety training.
- Liaison with nominated Trade Union Health and Safety Representatives.
- Maintenance of suitable monitoring and recording arrangements.

- Co-operation with health and safety audit arrangements.
- Liaison with the trust's nominated Health and Safety Executive (HSE) Inspector.
- Reporting of incidents in line with Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) requirements.
- Maintaining Chartered Safety and Health Practitioner status through continuous professional development (CPD) with the Institute of Occupational Safety and Health (IOSH).
- Ensuring adequate consideration of health and safety is incorporated into the inspection and improvement processes.

Trade Union Health & Safety Representatives are recognised by their trade union and accepted by the trust to carry out health and safety functions in line with the requirements of the Safety Representatives and Safety Committee Regulations 1977.

The Board of Directors, via appropriate Executive Directors, will ensure that the Safety Representatives are:

- Involved in health and safety monitoring and inspections carried out by the trust.
- Consulted on health and safety matters affecting our people.
- Able to attend the Health, Safety, Security and Fire Group meetings in sufficient number to ensure proportional representation.
- Provided with sufficient information to effectively represent others.
- Able to investigate RIDDOR reportable accidents at work and discuss these with managers.
- Able to participate in premise inspections, risk assessments, or any work to introduce new equipment, vehicles or procedures.
- Able to carry out independent premise inspections in line with the Safety Representatives and Safety Committee Regulations 1977.
- Able to represent staff in consultation at the workplace with inspections from the HSE and of any other enforcing authority.
- Able to receive health and safety information from Inspectors.

Recognised trade union representatives will represent the interests of all NWAS staff regardless of union affiliation.

Area Directors/ Deputy Directors/ Assistant Directors/ Associate Directors are responsible for:

- Achieving health and safety management objectives set by their Executive Director by incorporating them into their area of responsibility.
- Ensuring health and safety responsibilities are adequately reflected in job descriptions for all employees and volunteers working on behalf of NWAS.

The **Head of Violence, Prevention, Reduction (VPR) & Security**, fulfils the role of the ***Local Security Management Specialist (LSMS)*** and is specifically responsible for providing competent advice to the trust regarding violence and aggression issues that may affect staff safety.

The **Infection, Prevention and Control (IPC) Specialist Lead** is specifically responsible for providing competent advice to the trust regarding IPC related issues that may affect staff safety.

The **Head of Estates** is specifically responsible for ensuring the trust has access to competent advice regarding fire safety and will also, where necessary, seek external assistance relating to asbestos, legionella, electrical safety, construction, and other relevant estates related compliance.

The **Head of Fleet and Logistics** is specifically responsible for the trust has access to competent advice regarding vehicle and workshop safety. The Head of Fleet and Logistics is responsible for equipment safety, including maintenance, servicing and the management of defective equipment.

All **managers** are responsible for:

- Ensuring that the health and safety policy and associated procedures are adhered to within their area of responsibility.
- Ensuring the health and safety of their staff and other persons affected by operations under their control is adequately managed.
- Conducting risk assessments and developing safe operating procedures for activities under their control.
- Ensuring health and safety concerns/ issues that arise from activities under their control are assessed and reduced so far as reasonably practicable.
- Determining the training needs of staff under their supervision to enable them to carry out their roles safely.
- Providing a suitable level of supervision for staff when necessary to ensure safe working.
- Co-ordinating and monitoring all aspects of health and safety, and reporting matters of concern to the appropriate responsible person, or their line manager.
- Positive promotion of the importance of incident and near-miss reporting.
- Investigating incidents and near-misses that occur within their area of responsibility and providing appropriate feedback to staff on the outcomes and learning from investigations in a timely manner.
- Communicating health and safety messages to staff on a regular basis particularly relating to actions taken following an incident or near-miss, or part of lessons learned.
- Promoting a positive and proactive approach to health and safety, encouraging speaking up about concerns and promoting learning.

Every **employee** has a personal responsibility for health and safety and has a duty to:

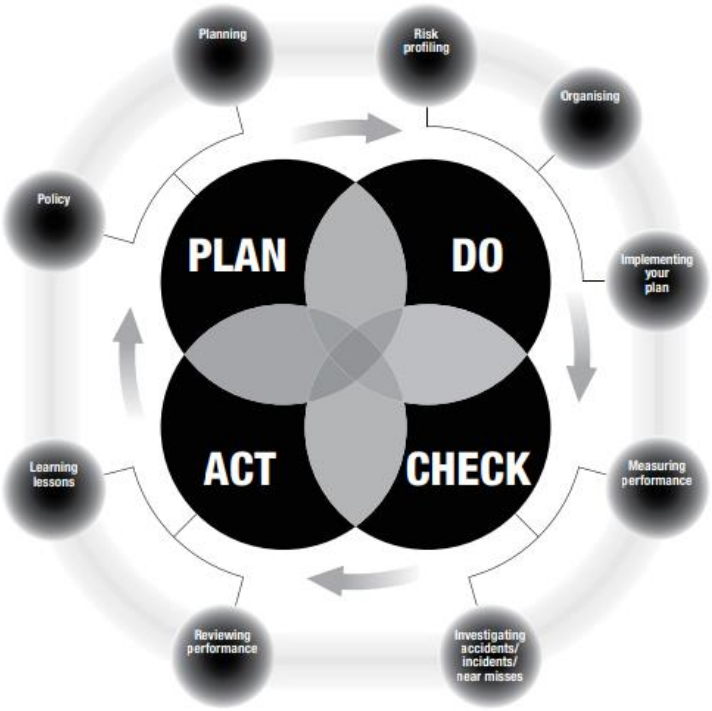
- Take reasonable care of their own health and safety and has a duty of care toward other persons affected by their acts or omissions.
- Co-operate with managers in reviewing regulations regarding health and safety in their department and for making them effective.
- Report all incidents, near-misses, hazards, work related illnesses or injuries, however minor, initially using the Datix Cloud IQ (DCIQ) system, as well as informing their line manager, ensuring these are documented properly.
- Correctly use personal protective equipment (PPE) provided by the trust.
- Correctly use equipment or items provided in the interest of health and safety management.
- Follow procedures and apply any relevant training provided to them.

The trust requires all **Contractors** that it employs to:

- Comply with the trust's health and safety policies and procedures by working safely and not exposing persons in and around their work area to risk.
- Ensure that their employees or sub-contractors meet their statutory responsibilities and adhere to the health and safety information received by the trust.

5. Process

The trust's process for managing health and safety follows the framework laid down in the Health and Safety Executive's HS(G)65 'Managing for Health and Safety'. The framework is based around the plan, do, check, act, cycle, as illustrated below.



"Managing for Health and Safety" HS(G)65 – Third Edition. Health and Safety Executive. 2013. Accessed via www.hse.gov.uk

6. Plan

Policy

"An important part of achieving effective health and safety outcomes is having a strategy and making clear plans."

The development and maintenance of this policy fulfil the first element of the 'plan' stage by setting out the trust's approach to health and safety.

Planning for implementation

"An effective system for health and safety management requires organisations to plan to 1) control risks, 2) react to changing demands and 3) sustain positive health and safety attitudes and behaviours."

Controlling risk

The health and safety policy is supported by several health and safety procedures which detail the arrangements for ensuring compliance with specific health and safety legislation. These health and safety procedures are, if necessary, translated into standard operating procedures within departments.

Reacting to changing demands

The trust has in place a Risk Management Policy. The policy includes the maintenance of a risk register which captures all different types of risk to the organisation. The processes for risk management are detailed in the trust's Risk Management Policy.

Health and safety risks can be added to the risk register by any department. This process allows for the proactive identification, assessment and treatment of trust-wide health and safety risks as they arise in any area of the trust.

Health and safety risks scored 12 and above are reviewed on a bi-monthly basis by the Health, Safety, Security, Fire Group. The Head of Health and Safety also develops an annual workplan. This is based on the trust's strategic objectives together with any identified gaps in the trust's health and safety management system, changes in legislation or any other risks identified through the risk management process.

Sustaining positive health and safety attitudes and behaviours

The trust is working to improve health and safety awareness. Information and awareness of the most common hazards associated with the ambulance sector are already built into our staff training, for example, manual handling, slips, trips, and falls, and occupational road risk. However, the trust is working towards raising awareness of other less common hazards, including those encountered in high-risk operational situations, for example, work near water, work on railways.

In addition, the trust employs a dedicated health and wellbeing team. Collectively, they are working to improve staff attitudes towards maintaining their own health both physically and mentally.

7. Do

Risk Profiling

"A risk profile examines the nature and levels of threats faced by an organisation. It examines the likelihood of adverse effects occurring, the level of disruption and costs associated with each type of risk and the effectiveness of the control measure in place."

As detailed in the previous section, the trust has in place a Risk Management Policy which is used to profile all risks to the organisation. The risk registers record the elements detailed above, for example, likelihood, consequence, costs and gaps in controls.

Risk assessment is a specified legal requirement for many health and safety related issues and is therefore incorporated into the trust's health and safety related procedures. The trust also has a specific procedure for the management of trust health and safety risk assessments.

Organising

"Organising for health and safety is the collective label given to activities in four key areas that together promote positive health and safety outcomes."

Control

This policy sets out the health and safety duties of all roles within the trust and ensures that health and safety objectives are integrated into the trust's overall management processes.

Competence

Health and safety training is provided to staff via the People Directorate and is integrated into staff training programmes as appropriate.

The Management of Health and Safety at Work Regulations 1999 require an employer to appoint a competent person to assist them with fulfilling their statutory health and safety responsibilities. The competency level set by the trust is Chartered Safety and Health Practitioner status.

Cooperation and communication

The trust has a Health, Safety, Security and Fire Group which meets bi-monthly. The Group is attended by management representatives from appropriate trust departments. The Group members are defined in the Group's Term of Reference.

The Group is also attended by recognised Trade Union Health and Safety Trade Union Representatives and provides a forum for co-operation and communication between the trust and staff on health and safety. The trust has other local Health and Safety Forums which can refer issues to the Health, Safety, Security, and Fire Group.

The trust has an agreed working arrangement involving Health and Safety Trade Union Health and Safety Representatives which is intended to maximise collaboration working and cover non-union affiliated employees.

There are other specific health and safety groups that are formed as necessary, depending on the needs of the trust.

Implementing your plan

"Workplace precautions will be easier to implement if risk control systems and management arrangements have been well designed."

The trust's health and safety related documentation, for example, policy, procedures, guidance etc, detail the trust's practical risk control and management arrangements. The documentation details relevant health and safety legislative requirements and then translates this into practical action for trust managers. Where the implementation of a health and safety process may vary across departments.

8. Check

Measuring performance

"Monitor before events, investigate after events."

The Health, Safety, Security and Fire Group is the corporate function for measuring health and safety performance with several reports/ documents being submitted to the Group for consideration and a number then sent from the Group to the Trust Management Committee (TMC), and the Board of Directors for assurance and oversight.

Active monitoring

The trust's Health, Safety, Security and Fire Group which meets bi-monthly. As part of its regular business is to monitor progress against the annual health and safety plan to seek assurance that objectives are being met. The Group also discusses health and safety related risks that are recorded on the risk register at every meeting and considers any new risks for inclusion or escalation.

An escalation and assurance report is presented to the Trust Management Committee (TMC) following each Health, Safety, Security and Fire Group. Assurance reports are presented to Committees and Board of Directors, as required, to provide assurance on effective management of health and safety.

Health and Safety Workplace Inspections are incorporated into the annual health and safety workplan, which aims to inspect premises utilising a risk-based approach. These inspections are aligned to health and safety legislation and the trust's compliance.

Health surveillance is carried out where necessary by the trust's Occupational Health Service.

Reactive monitoring

A report containing trust and staff related incident and near-miss data is submitted to the Health, Safety, Security, and Fire Group, which occurs bi-monthly. The report provides details of staff related incident figures including any incidents that have been reported to the HSE in accordance with RIDDOR regulations. The report also provides the trust a way of monitoring its health and safety incidents, analysis to identify any themes or trends in accidents which may need capturing as part of the trust's risk management process.

The incident and near-miss report submitted to the Health, Safety, Security, and Fire Group contains equipment and security incidents.

Investigating accidents/ incidents and near-misses

"Effective investigation requires a methodical, structured approach to information gathering, collation and analysis."

All incidents and near-misses reported within the trust are managed in accordance with the trust's incident reporting and management policy which includes reporting (utilising the trust's risk management system, Datix Cloud IQ system), and investigation.

9. Act

Reviewing performance

"Tells you whether your system is effective in managing risk and protecting people."

An annual health and safety assurance report is produced and presented to the trust's Health, Safety, Security, and Fire Group for consideration and learning, to the Trust Management Committee (TMC), and Board of Directors for assurance.

The annual report details the trust's health and safety performance for the year including analysis of employee incident data to identify themes and trends. The report also looks at any HSE intervention, the completion of the health and safety annual workplan and the completion of any specific health and safety related projects.

Auditing is carried out as part of the wider NHS arrangements, such as internal audit and inspections from the Care Quality Commission (CQC).

Learning lessons

"Learning lessons involves acting on findings of accident investigations and near-miss reports and organisational vulnerabilities identified during monitoring, audit and review processes."

Analysis and lessons learnt from incident and near-miss data on a wider scale, not just from staff related incidents is covered in the trust's Learning from Non-Patient Safety Policy.

All managers in the trust are integral in providing feedback to staff on the outcomes from incidents, near-misses, and the outcomes of investigations, including any learning from investigations. Directorates are required to review their own data and learn from such incidents and near-misses.

The trust's Health, Safety, Security, and Fire Group has a fundamental role to play in learning lessons as it is the main forum for the review of trust-wide health and safety data. It also has sight of the results from other health and safety audits and review processes and has the authority to delegate actions to managers across the trust to address and rectify issues identified.

10. Training

The trust undertakes regular training needs analysis which captures health and safety training requirements. It has produced a training programme for all identified training needs, which contains various types of statutory and mandatory training.

Training will be provided in a variety of formats, for example, in-house, external, work-based, team briefings or e-learning. The training programme outlines which staff are required to receive what training and how often. This will include training in relation to this policy and associated health and safety procedures.

The trust will ensure that all staff have the appropriate level of training and education to fulfil their duties in respect of health and safety awareness. The trust will continue to support staff in undertaking

appropriate health and safety training to promote a transfer of knowledge and provide for business continuity/ succession planning.

11. Policy implementation

This policy has been agreed with the members of the trust's Health, Safety, Security and Fire Group, submitted to the Trust Management Committee (TMC), and Board of Directors for approval. This policy is available on the trust's green room site. The Head of Health and Safety will ensure that the most up to date version is available to all staff via this route. After each policy review, this policy will be brough to the attention of all staff via the appropriate trust communication methods.

Associated health and safety procedures will be agreed by the trust's Health, Safety, Security and Fire Group. These procedures will be available on the trust's green room site. Any key changes to associated procedures will be brough to the attention of staff via the appropriate trust communication methods.

Any ad hoc health and safety communication regarding specific hazards will be done through the trust's corporate communications team utilising existing communication channels.

12. Monitoring compliance with this policy

The processes in place for monitoring compliance are detailed in section 8 of this policy. The annual health and safety workplan forms an integral part of this process and is reviewed at each of the trust's Health, Safety, Security, and Fire Group.

Compliance monitoring on an annual basis is carried out by the Head of Health and Safety using the key performance indicators (KPIs) listed below and the results are detailed in the annual health and safety report which is submitted to the trust's Health, Safety, Security and Fire Group, Trust Management Committee (TMC), and Board of Directors.

The results of the above monitoring will be used to inform the next financial year annual health and safety workplan.

Key Performance Indicators (KPIs)

The key elements of the trust's health and safety management systems are listed below along with the KPIs that show the trust has the elements in place.

Plan

- In date Health and Safety Policy on the green room and public facing website
- In date Health and Safety Policy signed by the Chief Executive Officer (CEO)
- Maintenance of Chartered Safety Practitioner status by the Head of Health and Safety
- Development and maintenance of health and safety procedures
- Capture of health and safety risks via risk management processes
- Development of an annual health and safety workplan.

Do

- Completion of risk assessments
- Compliance with health and safety training
- Frequency of the trust's Health, Safety, Security and Fire Group
- Attendance at the trust's Health, Safety, Security and Fire Group as per the terms of reference
- Sufficient Health and Safety Trade Union representation at the trust's Health, Safety, Security and Fire Group.

Check

- Annual health and safety workplan reviewed at each Health, Safety, Security and Fire Group
- Risk register review at each Health, Safety, Security and Fire Group
- Escalation and assurance reports from the trust's Health, Safety, Security and Fire Group to the Trust Management Committee (TMC)
- Completion of health and safety workplace inspections
- Health surveillance completed in line with risk assessments
- Health and safety incidents and near-misses reports to the trust's Health, Safety, Security and Fire Group.

Act

- Completion of the annual health and safety assurance report submitted to the trust's Health, Safety, Security and Fire Group, Trust Management Committee (TMC) and Board of Directors
- Compliance with the Care Quality Commission (CQC) standards.

13. References

Legislation

The Health and Safety at Work Act 1974
The Management of Health and Safety at Work Regulations 1999
The Safety Representatives and Safety Committees Regulations 1977

Guidance

Managing for Health and Safety, HS(G)65, 3rd Edition. Health and Safety Executive. 2013.

APPENDIX 1: EQUALITY IMPACT & RISK ASSESSMENT

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

Directorate:	Team:
Corporate Affairs	Health and Safety
Name of policy/procedure or strategy:	**EIA lead/author:**
Policy on Health and Safety	Head of Integrated Governance, Risk and Assurance
Date of completion:	**Date of review:**
25-Nov-24	30-Jan-28

Brief overview of the proposals (policy/procedure or strategy) being assessed, and intended outcomes	**The Health and Safety Policy details the processes by which NWAS will effectively manage health and safety across its activities. The policy sets out how the trust will approach and discharge its legal duties under the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999, and all other relevant statutory provisions including current best practice/ requirements from within the wider NHS. All individuals working for or on behalf of the trust have a legal responsibility under the Health and Safety at Work Act 1974. The policy sets out the actions necessary to fulfil these responsibilities. The implementation of good health and safety management is not just a legal responsibility, it can benefit an organisation financially by helping to reduce the wide range of costs associated with accidents and incidents.**

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

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *If you have indicated 'yes' for any questions, please briefly explain*
1	**Is this a new policy/procedure or strategy?**	Y	This is a new policy, it replaces the legacy Health, Safety, Security and Fire Policy.
2	**Is the policy/procedure or strategy proposing significant changes to current ways of working?**	N	No significant changes to current ways of working are made. The new policy brings together existing working practices into a formal policy document.
3	**Does the policy/procedure or strategy relate to service users?**	Y	Accidents and injuries to service users whilst in the care of NWAS, may result in the incident being reported to the Health & Safety Executive (HSE). This is a positive impact as reporting such incidents in accordance with RIDDOR regulations, provides reactive monitoring of health and safety incidents and analysis to identify any themes or trends in accidents. These incidents are reported utilising the trust's risk management system. Analysis and lessons learnt from reported incidents to improve safe systems of working for all individuals working for or on behalf of the trust.
4	**Does the policy/procedure or strategy relate to NWAS staff? If so, please outline which staff groups**	Y	This new policy will impact all individuals working for or on behalf of the trust. This is a positive impact as it sets out the process for how the trust will manage health and safety with aim of ensuring legal compliance with health and safety related legislation. The policy is clear and easy to follow.
5	**Does the policy/procedure or strategy have an impact on the way service users access NWAS services?**	N	No impact on the way service users access NWAS services.
6	**Does the policy/procedure or strategy impact on the ways of working for staff?**	N	No impact on the ways of working for staff.
7	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab* This new policy considers all individuals working for or on behalf of the trust, to whom NWAS owes a duty of care under health and safety laws. As such, protected characteristics such as age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, or sexual orientation related issues are an inclusive part of health and safety activities and require the implementation of suitable and sufficient arrangements to reduce the likelihood of any harm so far as is reasonably practicable.

EQUALITY RISK		Enter Y or N	Rationale *If you have indicated 'yes' for any questions, please briefly explain*
8	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	Y	This new policy has been created in line with legislation. This is a positive impact as the policy provides the trust with clear processes for how the trust will manage health and safety with the aim of ensuring legal compliance with health and safety related legislation.
9	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	Y	Specialist advice has been taken from a diverse group of stakeholders, including Executive Directors, Area Directors, H&S Trade Union Representatives, Finance, Fleet, Estates, Health and Safety, Violence, Prevention & Reduction (VPR), Security, Infection, Prevention & Control (IPC), when reviewing this policy.
10	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	Y	Considerations showed sufficient due regard under the Public Sector Equality Duty.
11	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	Y	No potential negative effects will occur to protected characteristics groups.
12	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	Liaised and consulted with various stakeholders for comment on this new policy, prior to the policy approval process.
13	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	Y	Liaised and consulted with various stakeholders for comment on this new policy, prior to the policy approval process.

HUMAN RIGHTS IMPACT		Rationale
14	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**	No, the policy does not impact the human rights of any patient, carer or staff.
Human Rights: **A2 Right to Life** **A3 Prohibition of torture, inhuman or degrading treatment** **A4 Prohibition of slavery and forced labour** **A5 Right to liberty and security** **A6 Right to a fair trial** **A7 No punishment without law** **A8 Right to respect for private and family life** **A9 Freedom of thought, conscience and religion** **A10 Freedom of expression** **A11 Freedom of assembly and association** **A14 Prohibition of discrimination** **P1A2 Right to education**		A3: Prohibition of torture, inhuman or degrading treatment has been reviewed and no discrimination found at the EIA review. A14: Prohibition of discrimination has been reviewed and no discrimination found at the time of the EIA review.
Are you intending on proceeding to complete a Stage 2 EIA? ***If no, please provide a rationale***		Stage 2 is not required due to no negative impact on any patient, carer or staff.

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

Comments from the ED&I Team			
04/12/2024 - WM - 1st Review: feedback/comments added (Review > Show Comments), once information added/revised, then please resubmit for further review 12/12/2024 - WM - 2nd Review: Approved, this EIA stage 1 shows sufficient due regard as required under the Public Sector Equality Duty. If in the future any new information/data comes to light then revisit and refresh this EIA stage 1 and resubmit for further review to the inclusion.workfore inbox. The next step is to add this approved EIA as an appendix to the policy.			
Reviewed by:	WM - 1st Review WM- 2nd Review	**Date**	04/12/2024 - WM 12/12/2024 - WM

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
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 assurance against the core Single Oversight Framework 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 **December 2024**. The report shows the historical and current performance on Quality, Effectiveness, Operational Performance, Finance and Organisational Health. The key areas to highlight by exception are: **Quality** • All safety alerts have been actioned and closed within the stipulated timeframe. • Care and treatment (n=330) is the most common theme for patient incidents and the highest overall reported incident. 'Delays' have inadvertently been incorporated within this theme following a revision to the categorisation of incidents in October 2024. This is expected to be rectified by the next reporting period.

Effectiveness

- STEMI care bundle compliance is 12.9 percentage points above the sector average.
- Hear and Treat (H&T) rate was 15.6% and See and Treat (S&T) rate was 28.0%, total non-conveyance rate was 43.6%.
- The H&T rate was highest since December 2022, likely attributable to a focus on clinical hub productivity.
- Nationally, the trust ranked 5th for H&T, 8th for S&T and 7th for S&C to ED.

Operational Performance

PES (999)

- We answered 133,150 calls and responded to 97,653 incidents. Compared to December 2023 calls were 0.03% up whilst incidents increased 1.1% indicating increased capacity. Greater Manchester has proportionately the highest number of incidents.
- Call pick up mean was 1 second, and 90th, and 95th percentile were zero seconds for 999 calls.
- Ambulance Response Programme (ARP) standards were met for C1 90th; the remaining standards were not met. The C2 mean (*) has an Urgent & Emergency Care (UEC) recovery target of 30 minutes that was not met. The year to date performance (29m:45s) is within target, however there is a risk the annualised recovery target may not be met.

Measure	ARP Standard (hh:mm:ss)	December 24 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:08:02	3rd
C1 90th	00:15:00	00:13:40	3rd
C2 mean*	00:18:00	00:42:21	6th
C2 90th	00:40:00	01:30:58	5th
C3 mean	01:00:00	02:40:18	5th
C3 90th	02:00:00	06:05:12	5th
C4 90th	03:00:00	05:42:49	3rd

- C2 long waits (n=11,019) have increased and are 3.6% higher than December 2023.
- Variation is evident in all ARP response times between Integrated Care Systems. This has been discussed in assurance meetings.
- Hospital turnaround continues to exceed the 30 minute standard. Average turnaround time has increased by 4 mins to 51m:07s compared to previous report (47m:07s) and is 4m:42s longer than December 2023 (46m:25s). Median turnaround is

24m:51s suggesting the distribution is skewed, i.e. there are long handover delays (from specific locations) that affect overall trust performance.

- The UEC system agreed target for handover is now 50% above trajectory (plan 25m:37s vs actual 38m:17s). This is directly impacting our C2 mean UEC target.
  Hospital handover and Category 2 performance are causally linked (correlation coefficient circa r=0.8). This is demonstrated by the table below:

	Dec-24	
Integrated Care Board (ICB)	**C2 mean (hh:mm:ss)**	**Average Turnaround (hh:mm:ss)**
Cheshire & Merseyside	01:07:34	01:12:50
Lancashire & South Cumbria	00:33:10	00:53:36
Greater Manchester	00:31:36	00:35:46
North Cumbria	00:24:32	00:26:49

- Performance has worsened despite significant collaboration with urgent and emergency care systems and the regional leadership team (NHSE).
- Handover performance is subject to scrutiny and executive oversight with plans in place to work with senior leadership teams as part of their urgent and emergency care recovery.

111

- Despite a notable increase in calls received in December (n=180,898), the service sustained its recent improvement in performance, with only one metric (average time to callback patient) showing a significant increase.
- 111 has continued to receive national call handling support (15% of calls offered). NW 111 did answer an additional 17k calls in December 24 vs December 23, due to the fully established call handling workforce.

111 Measure	Standard	December 24	National Ranking
Answered within 60s	95%	80.1%	11/31
Average time to answer	<20s	56s	13/31
Abandoned calls	<5%	2.6%	3/31
Call-back within 20 min	90%	29.8%	--
Average call back	--	01h:02m:41	--
Warm transfer to nurse	75%	4.15%	--

	Patient Transport Services (PTS) • PTS activity metrics are stable. Operational and workforce improvement plans are in progress to address aborted activity, collection after treatment (planned and unplanned) which are currently below the 90% contract standard. **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** • Sickness absence is stable at 7.71%. Increases are in line with expected seasonal variation and lower than December in previous years. • Turnover is reducing with most service lines (except PTS) indicating improvement and below last year's rates. • The trust vacancy position has improved. This reflects establishment changes and improvements resulting from recruitment. • Appraisal compliance is stable at 85.8% and continues to sustain its improvement in 2024. • Mandatory training compliance is exceeding target across all service lines. • The human resources casework has remained at 1.7 cases per 100 staff. The average case time remains under 12 weeks at 11.83 weeks. • Eight staff were dismissed during December; 4 Gross misconduct cases and 4 long term sickness (LTS). • The current uptake rate of the Flu vaccination across the trust is 42.23%, compared 48.47% at the same time last year. Data from November suggests our uptake is in the upper quartile for the North West region and average for the ambulance sector.
PREVIOUSLY CONSIDERED BY	Trust Management Committee
	Date: Wednesday, 15 January 2025
	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 **December 2024**. The report shows the historical and current performance on Quality, Effectiveness, Operational performance, Finance and Organisational Health. It also includes information about sector performance 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 review at TMC identified the following areas:

- The performance within C2 being impacted on by the increasing length of time for hospital handovers. This has led to further review of the data and expansion of the narrative within this report.

3. PERFORMANCE SUMMARY

QUALITY

Complaints: PALS and complaints are shown in SPC format as enough data-points have accumulated since recent revisions. Totals for opened, closed, and service level agreement (SLA) performance are all stable.

Incidents: Categories and sub-categories within DCIQ for reporting patient and non-patient incidents were revised from October 2024 therefore historical comparison is not possible. For example, 'Delays' is now incorporated into 'Care and Treatment' and is therefore not observable but is expected to be revised for next reporting period. Level of harm for patient incidents is unchanged.

Care and treatment (n=330) is the most common theme for patient incidents and the highest overall reported incident. Violence and aggression (n=159) is the most common theme for non-patient incidents. Twenty four patient incidents were classified as 'severe harm' (an increase from 16 in the previous report and highest recorded in 2024) and 18 as 'fatal' (an decrease from 19 in the previous report, above the median (n=17)).

Most frequent non-patient incidents:	Most frequent patient incidents:
Violence & Aggression (159)	Care and Treatment (330)
Road Traffic Incident (RTI) (98)	Call Handling (151)
Medicines (87)	Accidents and Injuries (39)
Accident and Injuries (44)	Dispatch (36)
Equipment (39)	Medicines (31)

Incidents referred to NHSE: Nil

Safety Alerts: Safety alerts have been actioned and closed within the stipulated timeframe. No applicable safety alerts were received in December 2024.

EFFECTIVENESS

Patient experience

PES. The 748 responses for December are 11.8% higher compared to the last reporting period of 669. The overall experience score for December was stable at 91.6%.

PTS. The 1,262 responses for December are 3.5**%** lower than the last reporting period of 1,308. The overall experience score for December was stable at 93.5%.

NHS 111. At the time of reporting, we have 86 returns so far for December, which is decrease of 48.8**%** compared to the updated 168 returns for the last reporting period. The reduction is attributed to the time lag in returned surveys over the festive period. Satisfaction rates reported thus far were 83.7%.

Ambulance Clinical Quality Indicators (ACQI's)

Metrics are stable and above the sector average except Survival at 30 days (Utstein). The STEMI care bundle is 12.9 percentage points above the sector average. In summary:

- Return of Spontaneous Circulation (ROSC) overall performance - last reported in August 24 (35.1%), above the national average of 28.9%.
- ROSC Utstein performance - last reported in August 24 (52.2%), above the national average of 51.2%.
- Survival at 30 days after discharge overall performance - last reported in August 24 (12.9%), above the national average of 10.4%.
- Survival at 30 days after discharge Utstein performance - last reported in June 24 (28.8%), below the national average of 30.8%.
- STEMI care bundle – last reported in July 24 (89.6%), above the national average of 76.7%.

The stroke care bundle is no longer reported; in future months this will be replaced by the Falls care bundle.

Hear & Treat (H&T), See & Treat (S&T), See & Convey (S&C)

The H&T rate for December 24 was 15.6%, whilst the S&T rate was 28.0%, equating to a total non-conveyance rate of 43.6%. Nationally, the trust position is largely unchanged from the previous period, ranking 5th for H&T, 8th for S&T and 7th for S&C.

H&T was the highest since December 2022. Initiatives include the implementation of adherence managers and a focus on Advanced Practitioner (UEC AP) productivity.

OPERATIONAL PERFORMANCE

Paramedic Emergency Services (PES) Activity

Of the n=133,150 emergency calls received by the trust, 73.3% (n=97,653) became incidents. In comparison to the previous year, there are 0.03% more calls, and incidents increased 1.1%, indicating improved capacity.

Manchester South (10,457), Manchester Central (n=10,124), and Mersey North (n=9,832) were the busiest sectors. Greater Manchester ICB contains the most incidents (n=37,952), accounting for 39.6% of PES activity, unchanged from the previous report.

PES Call Pick Up

The trust performed well for Call Pick Up (CPU). The mean was 1 second, while both the 90th, and 95th percentile were zero seconds. Strong performance has been maintained through increased levels of 999 call handlers funded via UEC investment. Calls with pick up indicates change, however this is likely attributable to winter pressures and is expected to decrease in Q4.

999 Ambulance Response (ARP) Performance

Measure	ARP Standard (hh:mm:ss)	December 24 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:08:02	3rd
C1 90th	00:15:00	00:13:40	3rd
C2 mean*	00:18:00	00:42:21	6th
C2 90th	00:40:00	01:30:58	5th
C3 mean	01:00:00	02:40:18	5th
C3 90th	02:00:00	06:05:12	5th
C4 90th	03:00:00	05:42:49	3rd

*UEC Recovery Standard is 30mins over the year.

C1 and C2 ARP standards were stable, although only one ARP standard was met (C1 90th). The trust is achieving the UEC Recovery standard for Category 2 of 30-minute average (annualised), with the year-to-date position of 29m:45s (2023/24 year-to-

date comparative: 28m:20s). However, with the current annualised position within 15 seconds of the target there is some risk that the target may not be achieved.

Variation between ICBs is evident in all ARP response times. Cheshire and Merseyside ICB (C&M), experienced a 113% higher response time for C2 (01h:07m:34s) than the rest of the trust (31m:40s), causally linked to hospital turnaround time in the C&M area.

The Trust placed third for both C1 mean and C1 90th nationally, 6th for C2 mean and 5th for C2 90th. The decrease in national standings for C2 are consistent with winter pressures 2023/24. Further analysis will be undertaken to explore the impacting factors behind this.

Response to lower acuity incidents (C3 and C4) displayed a similar trend to C1 and C2, however C4 90th showed instability, likely owing to the smaller totals in that category (n=806 face to face incidents) affecting percentiles. The Trust's national position was unchanged; 5th for C3 mean and C3 90th and 3rd for C4 90th.

Ongoing reviews of the response model are supporting further improvements such as a review of inter-facility transfers and healthcare professional (IFT/HCP) calls and a refreshed pre-alert process. Results of both are expected in Q4.

999 C1 & C2 long Waits

Long waits were consistent with the pattern observed in 2023:

C1 long waits (n=736) increased compared to the previous report (n=682), however displayed a 6.2% decrease from December 23.

C2 long waits (n=11,019) increased compared to the previous report (n=7,752), a 3.6% increase from December 2023.

Hospital Handover

Average turnaround time has increased by 4 mins to 51m:07s compared to previous report (47m:07s) and is 4m:42s longer than December 2023 (46m:25s). The metric continues to exceed the 30-minute standard despite significant collaboration with urgent and emergency care systems and the regional leadership team (NHSE). Median turnaround is 24m:51s suggesting the distribution is skewed, i.e. there are long handover delays from specific locations that affect overall trust performance.

Delays in handover are causally linked to Category 2 performance (correlation coefficient circa r=0.8). Therefore, a region with delayed handover performance is highly likely to have an increased C2 response time, as demonstrated in the below table:

	Dec-24	
Integrated Care Board (ICB)	C2 mean (hh:mm:ss)	Average Turnaround (hh:mm:ss)
Cheshire & Merseyside	01:07:34	01:12:50
Lancashire & South Cumbria	00:33:10	00:53:36
Greater Manchester	00:31:36	00:35:46
North Cumbria	00:24:32	00:26:49

Specific initiatives to support handover include the Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services (MHLDC) provider collaborative who are progressing several key actions in support of improvement in the Cheshire and Mersey area.

NHS 111

Calls offered (n=180,898) displayed special cause, likely owing to the time of year. Recent improvements in performance were sustained throughout December, displaying common cause variation, except for average time to call back which increased (worsened) to 01:02:41.

111 Measure	Standard	December 24	National Ranking
Answered within 60s	95%	80.1%	11th/31
Average time to answer	<20s	56s	13th/31
Abandoned calls	<5%	2.6%	3rd/31
Call-back within 20 min	90%	29.8%	--
Average call back	--	01:02:41	--
Warm transfer to nurse	75%	4.15%	--

PTS

PTS activity is stable. Operational and workforce improvement plans are in progress to address aborted activity as well as collection after treatment (planned and unplanned) which are currently below the 90% contract standard.

4. FINANCE

Agency Expenditure

The year to date expenditure on agency is £0.435m which is under the year to date ceiling of £1.749m, with each area of NWAS coming in under its agency ceiling.

The monthly position is negative owing to a one-off benefit linked to charges from previous years that did not materialise. This has also affected the variance to ceiling

calculations, with both figures showing special cause. This is expected to return to common cause by January 2025.

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 rate (7.71%) is stable and service lines sustained their recovery (new phase) throughout 2024.

The overall position is consistent with seasonal trends across the sector, and we are closer to the sector average than we have been in previous years. Current rates show the trust is within 1.0% percentage point (pp) of the sector average, compared to previous years being 1.5-2.0% pp. The Attendance Improvement Team (AIT) continues to support management of attendance.

Turnover

Turnover for December 2024 was 9.17%, reducing steadily over the last 12 months and below the lower control limit, indicating improvement. Most service lines (except PTS) are indicating improvement (special cause) and are below last year's rates.

Temporary Staffing

The position for temporary staffing shows continuing agency usage at a similar rate to previous months. The monthly temporary staff % cost position is negative owing to a one-off benefit linked to charges from previous years that did not materialise.

Vacancy

The trust vacancy position has improved to –3.98% for December 24, displaying special cause. This reflects some establishment changes and improvements resulting from recruitment.

The PTS vacancy position has improved to -6.28%, again displaying special cause. PTS turnover remains challenging, due to staff moving into PES and retirements. However, PTS have robust bank arrangements in place to bridge their vacancy position.

The EOC vacancy gap has increased (worsened) to -11.31% and is displaying special cause. Recruitment plans are in place to ensure stability for the remainder of the year. Some vacancies are being held to take account of expected efficiencies arising from the pathways business cases.

PES show an under-establishment of –1.12%, 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 improved (special cause) to –2.71%, with vacancies remaining in the Health Advisor and Clinical Advisor roles. Whilst turnover is improving, the recruitment market is proving challenging for call handler positions.

Appraisals

Appraisal compliance is stable at 85.8% and has sustained its improvement (new phase) in 2024 due to the significant improvement in PTS. The 111 rate was 87.5% after displaying special cause in November. Both PES and EOC have exceeded the 85% target at 85.7% and 85.4% 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 at 91%, with all operational service lines meeting their targets. Corporate is achieving 97% against a target of 95%, despite an additional 5 online modules being added to the programme at the start of the year.

Case Management

Employee relations casework has remained at 1.7 cases per 100 staff. The highest rate of live cases per staff (prevalence) occurs currently in PTS and Corporate (2.0 per 100). Average case length has maintained at under 12 weeks at 11.83 weeks. Current levels of suspensions reflect the higher caseload as there has been an increase seen in the complexity and seriousness of cases, partly reflective of the impact of the Trust sexual safety campaign.

Flu vaccination uptake

The current uptake rate of the Flu vaccination across the trust is 42.23%. Uptake rate at the same time last year was 48.47%. Data from November suggests that our uptake is in the upper quartile for the North-West region and average for the ambulance sector.

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 Group 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

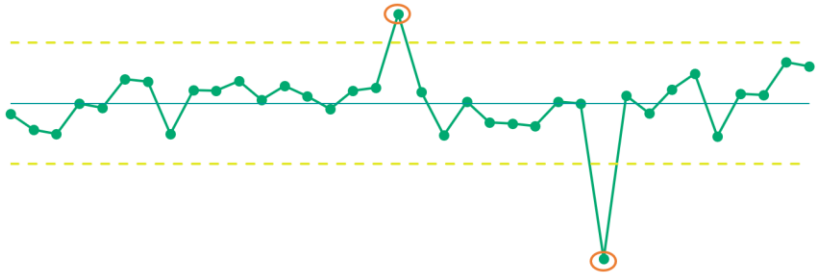
Integrated Performance Report

Board- January 2025

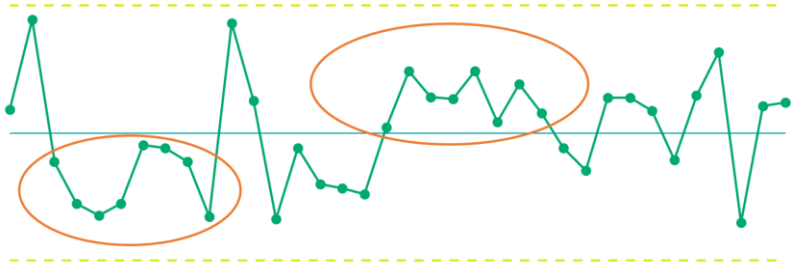
Rules for interpreting SPC Charts

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

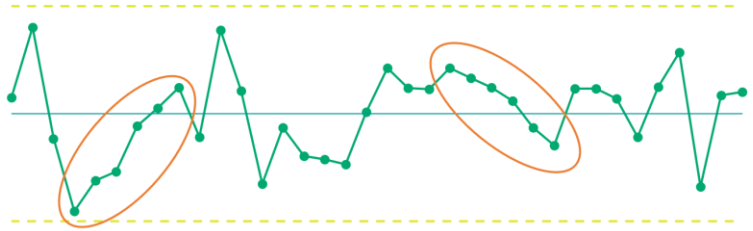
Rule 1: Single data point outside the control limits



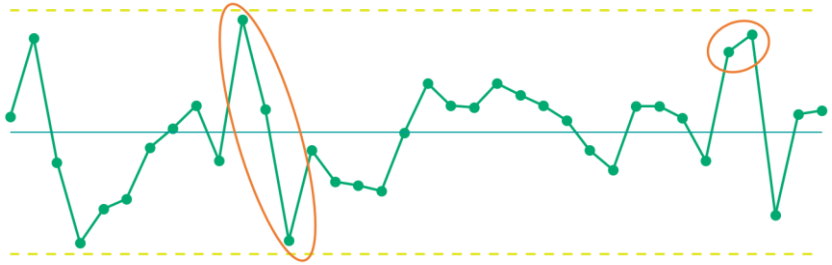
Rule 2: 8 or more consecutive data points above or below the centre line



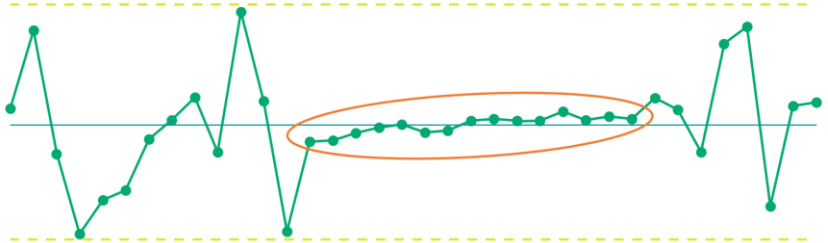
Rule 3: A trend of at least six consecutive points (up or down)



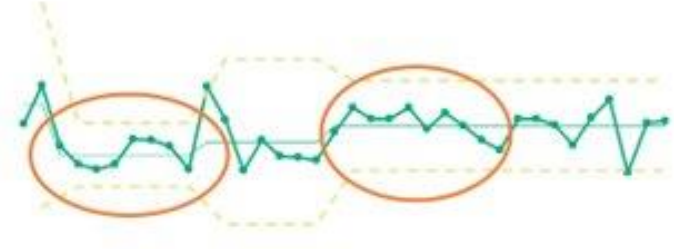
Rule 4: 2 out of 3 consecutive data points near a control limit (outer third)



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

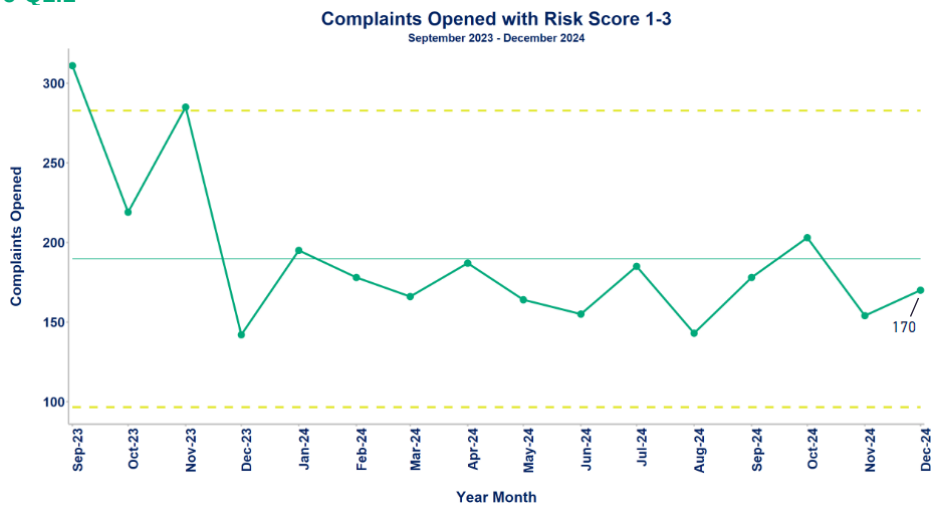


Figure Q1.2

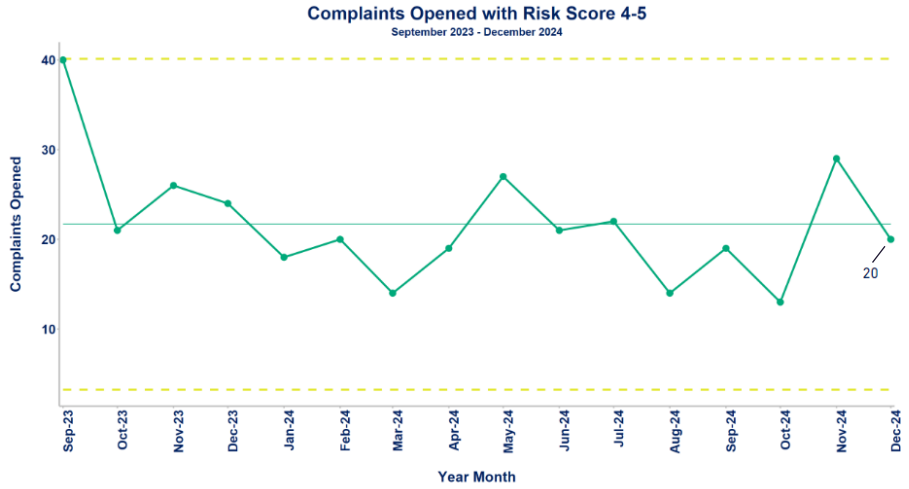


Figure Q1.3

Figure Q1.4

Figure Q1.5

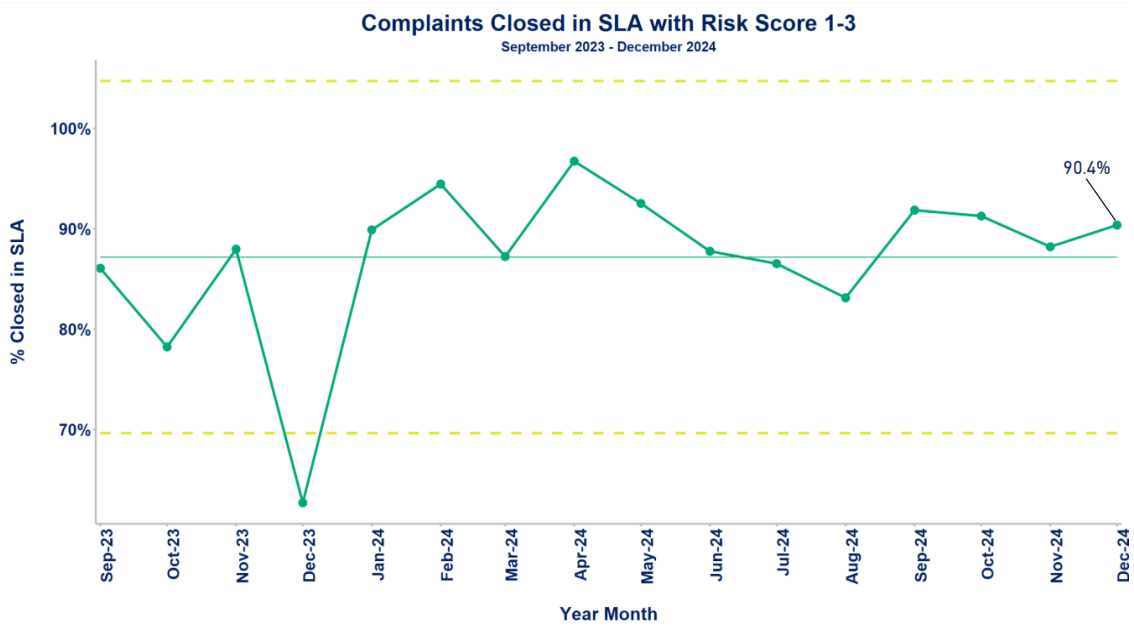


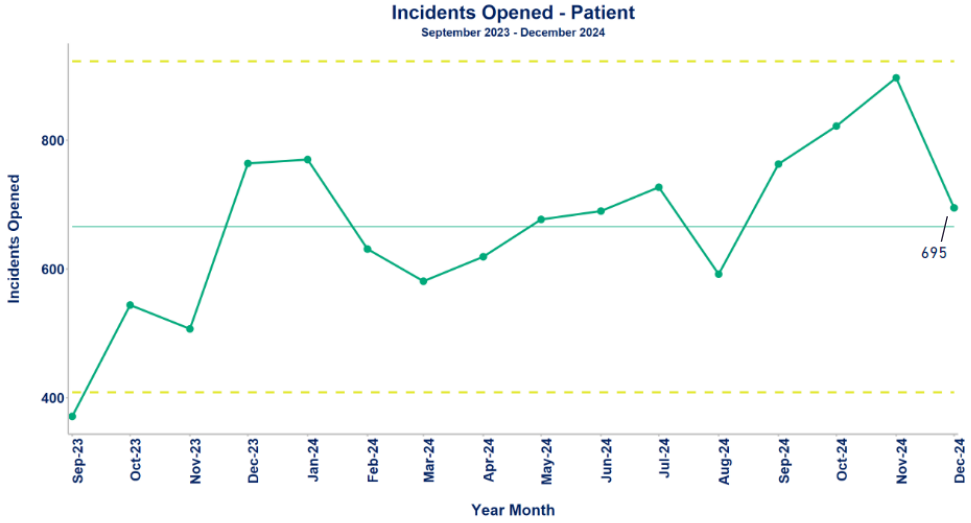
Figure Q1.6

Q2 Incidents

Figure Q2.1

Figure Q2.2

Figure Q2.3



PSIRF level of harm (December 24)	
None	552
Low	61
Moderate	40
Severe	24
Fatal	18

Figure Q2.4

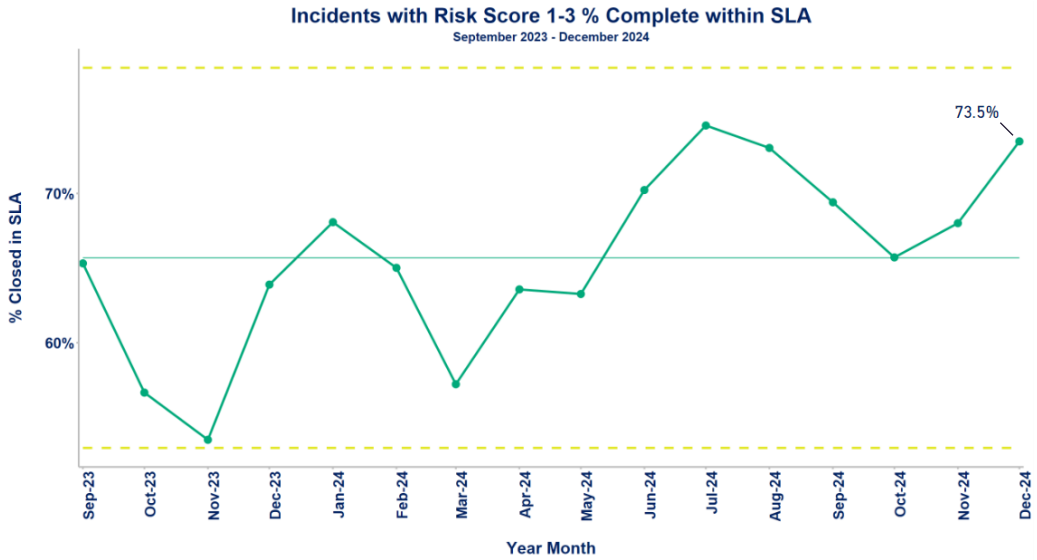


Figure Q2.5

Figure Q2.6

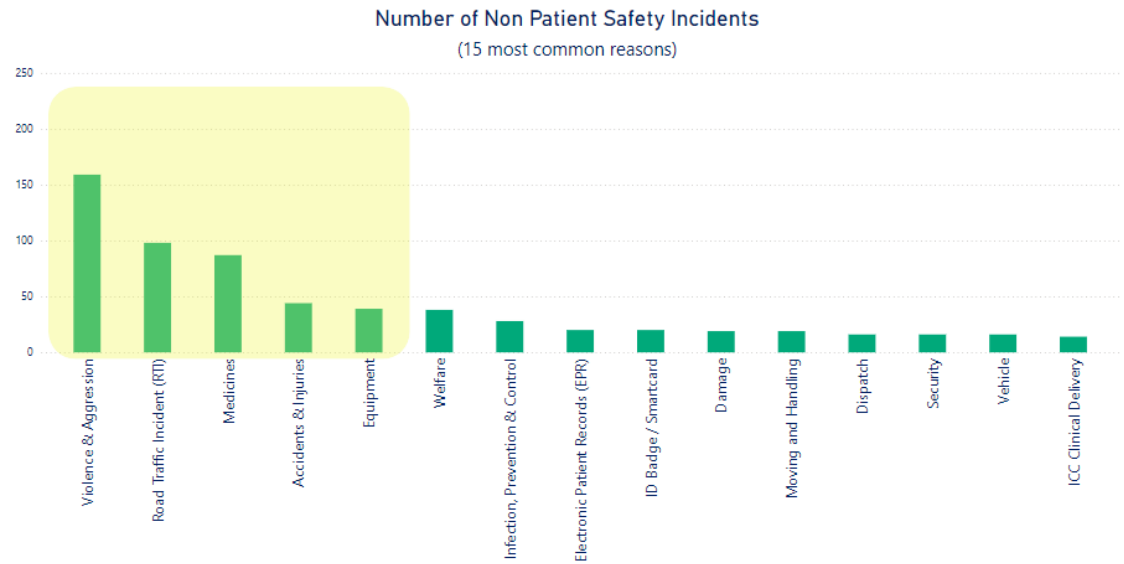
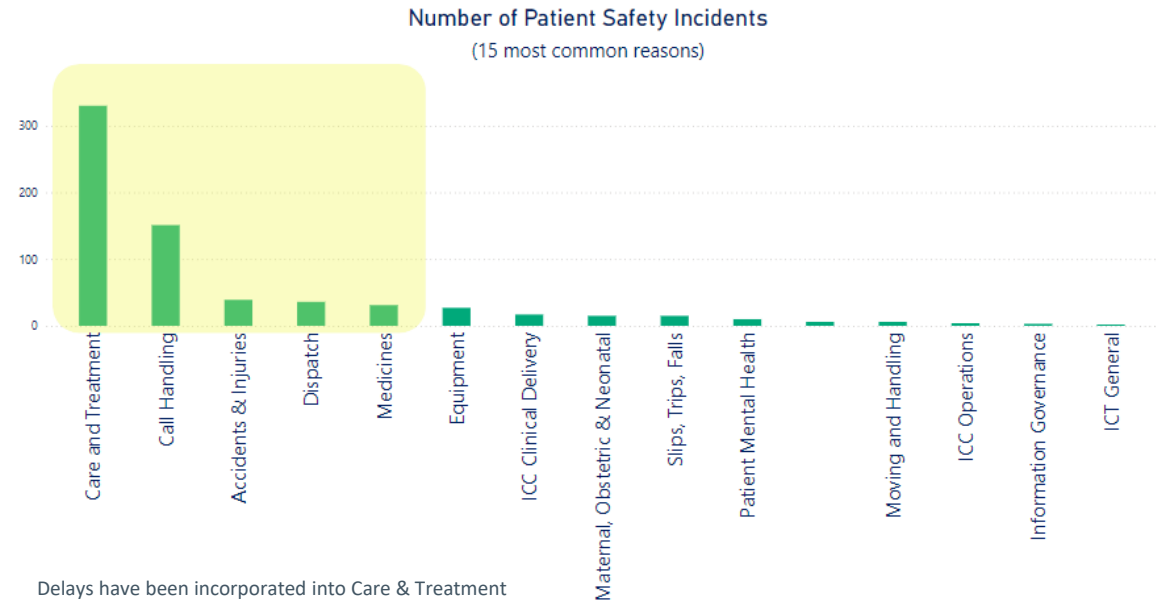
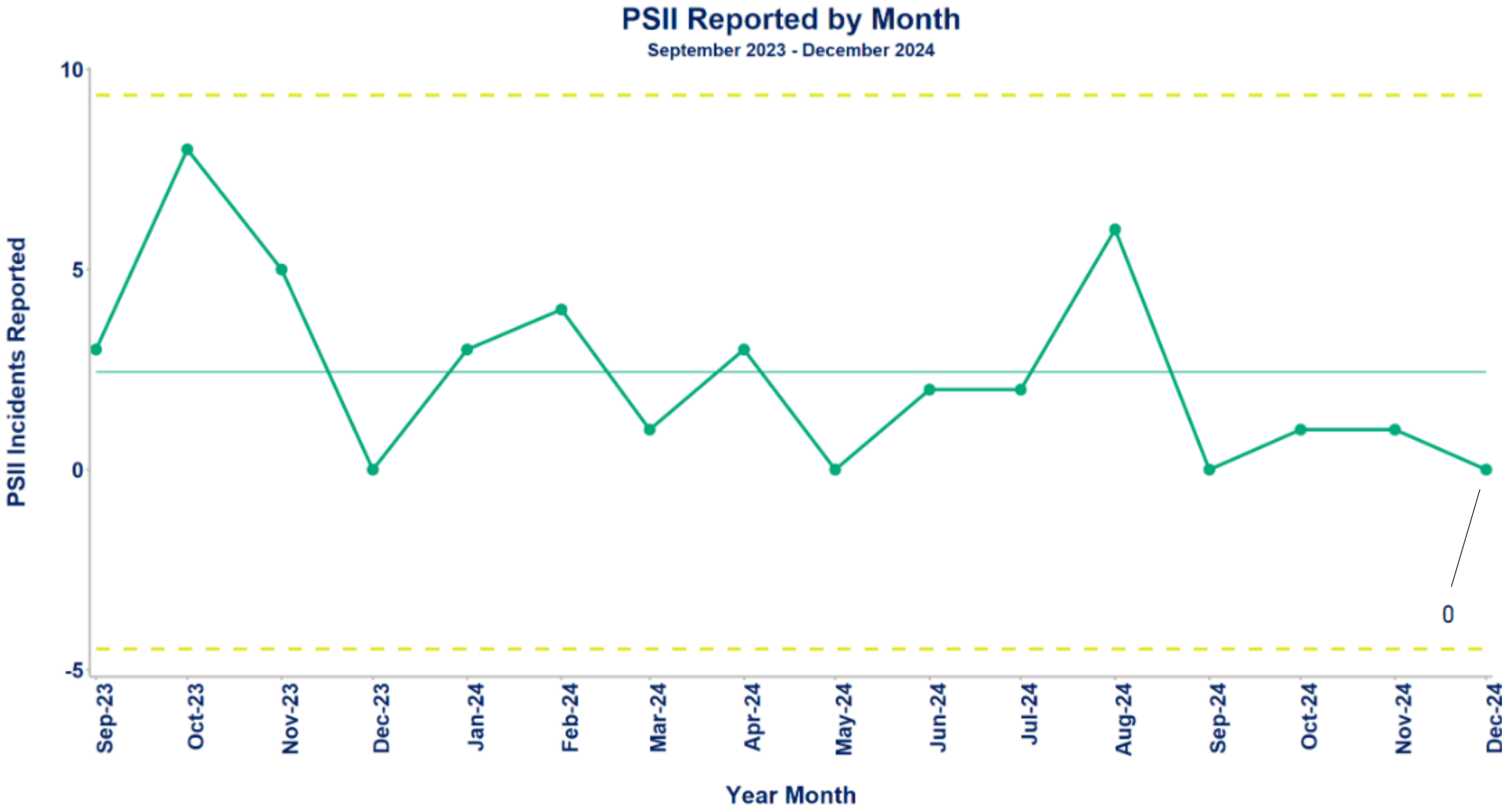


Figure Q2.7



Delays have been incorporated into Care & Treatment since October 2024 and will be amended for next report

Figure Q2.2


PSII Reported by Month
September 2023 - December 2024
PSII Incidents Reported
10
5
0
-5
0
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Year Month

Q5 SAFETY ALERTS

Table Q5.1

Safety Alerts	Alerts Received (Jan 24 – Dec 24)	Alerts Applicable (Jan 24 - Dec 24)	Alerts Open	Notes
CAS Helpdesk Team	0	0	0	
Patient Safety Alert: UKHSA	0	0	0	
National Patient Safety Alert: NHS England	2	0	0	
National Patient Safety Alert: DHSC	10	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	1	0	0	- NATPSA/2024/004/MHRA. Reducing risk for transfusion-associated circulatory overload (TACO) Issued 8/4/24. Deadline 4/10/24. **Action Complete**
Medicine Alerts: MHRA	63	0	0	MHRA alerts have been checked to ensure they are not applicable to the trust.
IPC	0	0	0	
National Patient Safety Alert: NHS England Patient Safety	1	0	0	

E1 PATIENT EXPERIENCE

Figure E1.1

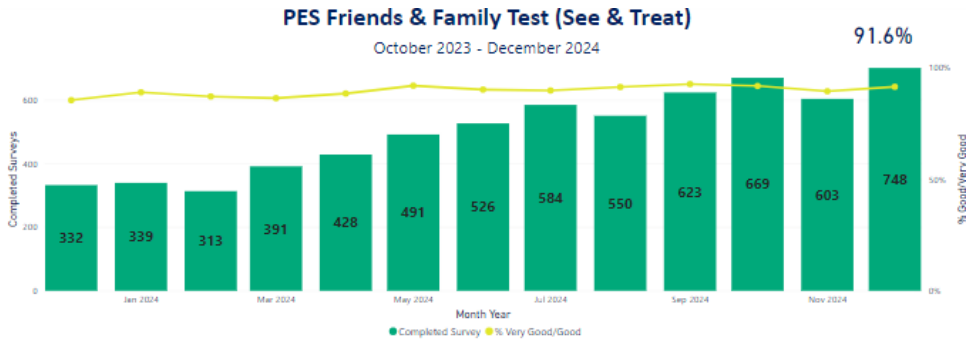
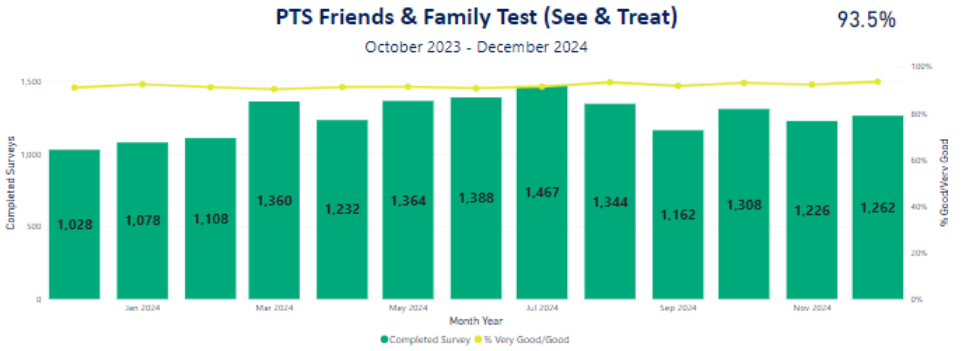


Figure E1.2



PES Positive

- *"Quick arrival of paramedics, good interim advice from call centre, paramedics asked what else we were concerned about. Highly professional and friendly staff."*
- *"They were extremely calm , efficient and had my husband's best interests at heart and treated him with respect. They gave him the treatment he required at home as he was too vulnerable to take to hospital and gave us information on different services available in the future. Very impressed."*
- *"Responded quickly, provided support over phone, went out to check on patient I was concerned about and contacted doctor to provide observations report. Doctor has now been out and moved things forward with patients' medication and health, thank-you."*

PES Negative

- *"Was told needed an assessment by paramedics, would be approx 3 hours 45 minutes. Waited for 15 hours, no updates provided throughout that period, I had to call 999 myself again to finally get attendance."*
- *"85 year old man had fallen he had been on floor 5 hours in agony. He was left at home. When brought to casualty later that day he had 4 fractured ribs. Blood clot and many other issues. He should have been brought in on the ambulance at the time. If I hadn't have brought him to casualty, I was told he could have died. He's been in hospital for 4 days now."*
- *"Did not listen to my concerns, treated me in a patronising dismissive manner."*

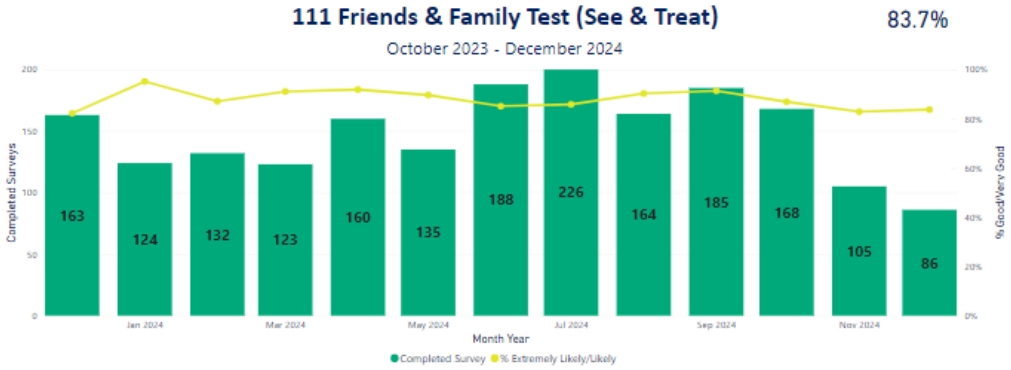
PTS Positive

- *"My husband has had appointments at 3 different hospitals within the last week which without your service we wouldn't have been able to get to. All of your staff that we have encountered from the initial telephone booking system to the drivers who have taken us and brought us back home again have been excellent. They are all so helpful and have gone out of their way to ensure that we are in the right place for the appointments at the right time. We are very grateful for such a wonderful service. Thank you all."*
- *"The people volunteering as drivers for PTS in my experience have been kind, empathetic, patient, caring and compassionate towards all patients. I also observe this in them with how they are with other patients on shared journeys. Very grateful for the service. Thank you."*
- *"The crew were excellent and assisted me in and out of the vehicle with the utmost care and respect. I was able to hold a conversation and have a laugh! 10/10."*

PTS Negative

- *"Twice in one week I missed appointments due to them. Staff majorly unhelpful and dismissive. Would definitely never recommend this service. Telling you driver is on the way when clearly not the case. Your appointments are not pre booked by them. Absolute joke of a service!"*
- *"Yes taxi did not turn up. I had to drive to Wigan hospital. Left at 7.20 am. Had to be there for 8 am. Driver turned at 7.58 am. Fuming I got there for 8.45. Imagine if I would have waited. I had to leave car there overnight because I cannot drive for a week, so my daughter on her day off from work had to go up there. Could not get in touch with you because you don't start till 8am. Can not get in touch with anyone. Very poor."*
- *"I've got spinal injuries and the drive going took the longest route and when we went over speed sleepers it was very painful and the driver didn't go over slowly. Coming home I had to wait for 4 hrs for the journey home. The receptionist had to keep phoning to ask when we could expect the ambulance. Very exhausting especially when one's not feeling good."*

Figure E1.3



NHS 111 Positive

- *"Speed of answering. Clear questioning. Number of options available to me. Appointment with health professional within 2hrs. The confidence it gave me and ease of access."*
- *"An easily accessible service for advice particularly out of hours rather than trying to get to A E or even urgent care centre where often wait times in their areas are practically a day which is extremely debilitating in itself when patient is already on palliative care."*
- *I was very happy that they contacted the out of hours service for me and arranged for me to see a doctor as soon as possible, within 3 hours on a Saturday night."*

NHS 111 - Negative

- *"Told to contact district nurse but given phone number of a treatment room which was not manned until several hours later when we were informed that all of the appointments with all services had now been taken."*
- *"I was advised that I was referred to Urgent Care. This was not the case. I was sent to A&E and endured an 8-9 hour wait. I was not transferred to a local Urgent Care Centre (Burnley) where the wait was 1-2 hrs instead."*
- *"My daughter had a stomach ache for 4 weeks which we suspected might be appendicitis. She was due to go on holiday with the school to Iceland. Primary care could not see her before her trip so we used 111 who wrongly diagnosed the problem and offered the incorrect treatment."*

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Figure E2.1

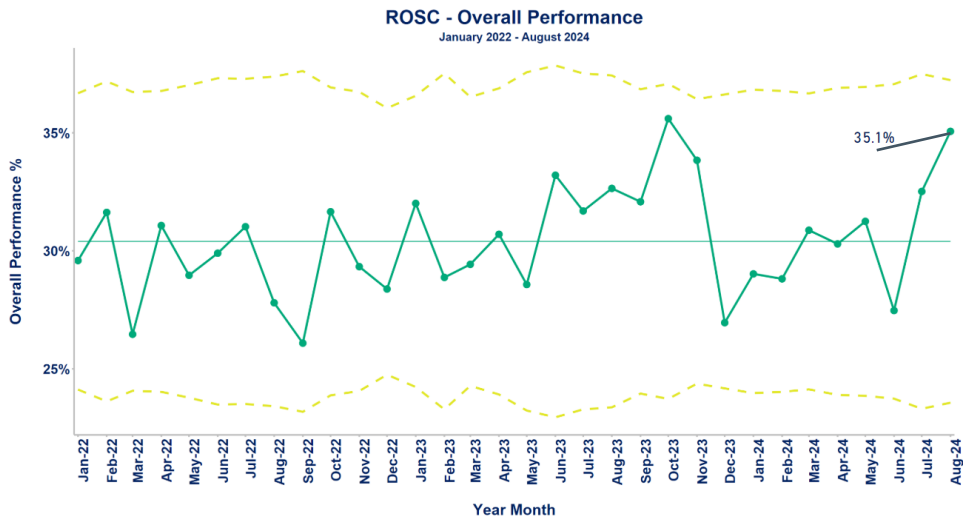


Figure E2.2

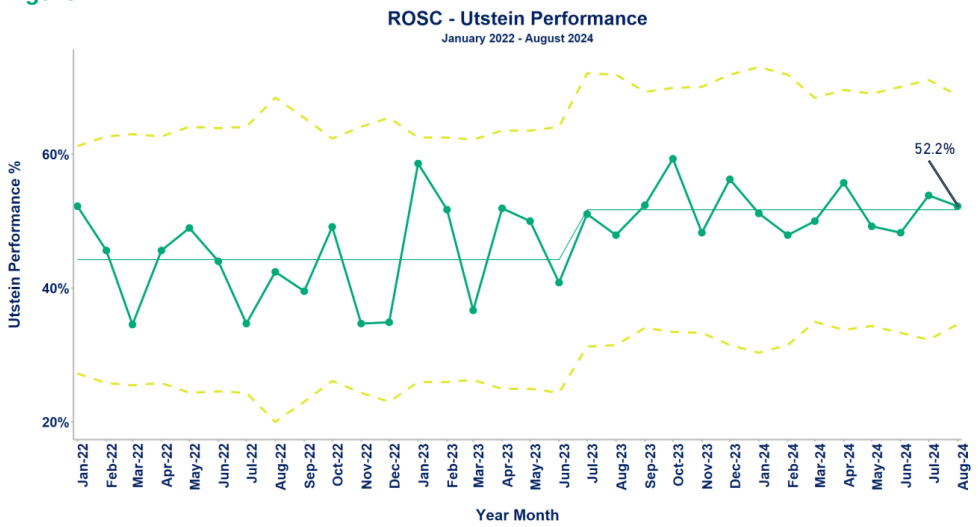


Figure E2.3

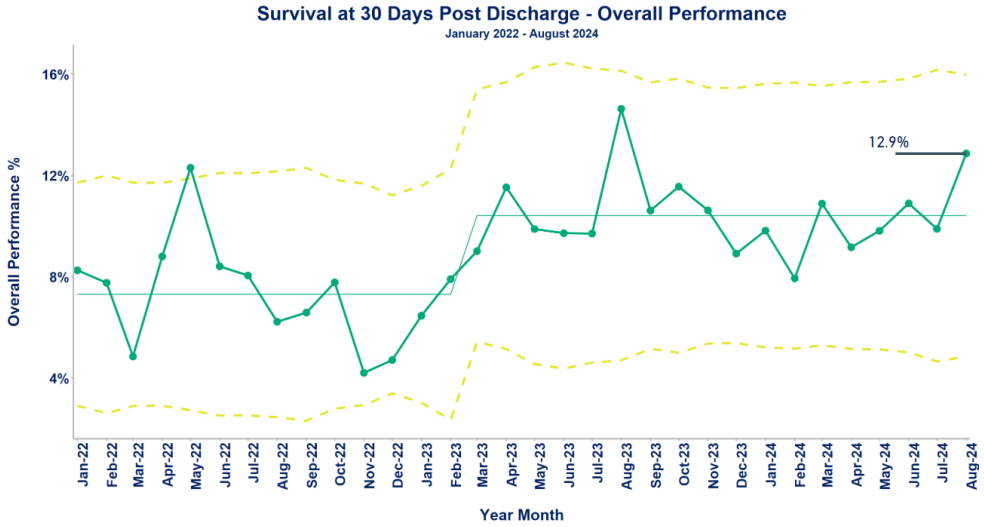


Figure E2.4

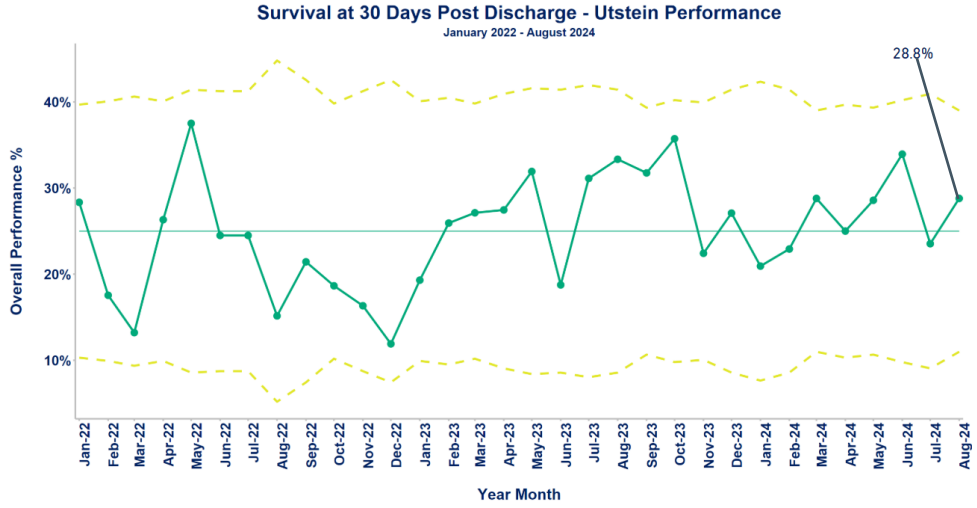


Figure E2.5

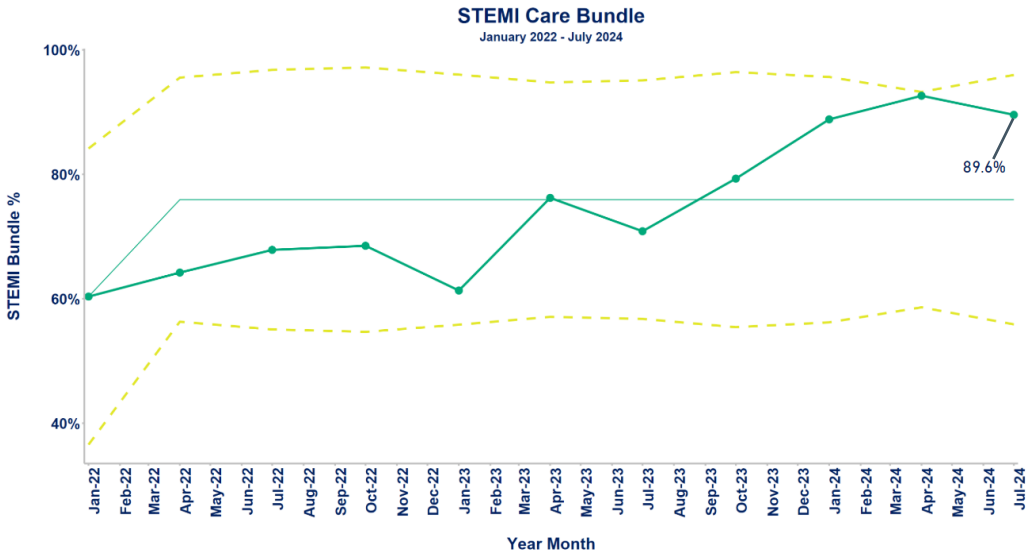


Figure E2.6

Month Year	STEMI Care Bundle Performance
Jan-22	60.4%
Apr-22	64.2%
Jul-22	67.9%
Oct-22	68.5%
Jan-23	61.3%
Apr-23	76.2%
Jul-23	70.9%
Oct-23	79.3%
Jan-24	88.8%
Apr-24	92.6%
Jul-24	89.6%

E3 ACTIVITY & OUTCOMES

Figure E3.1

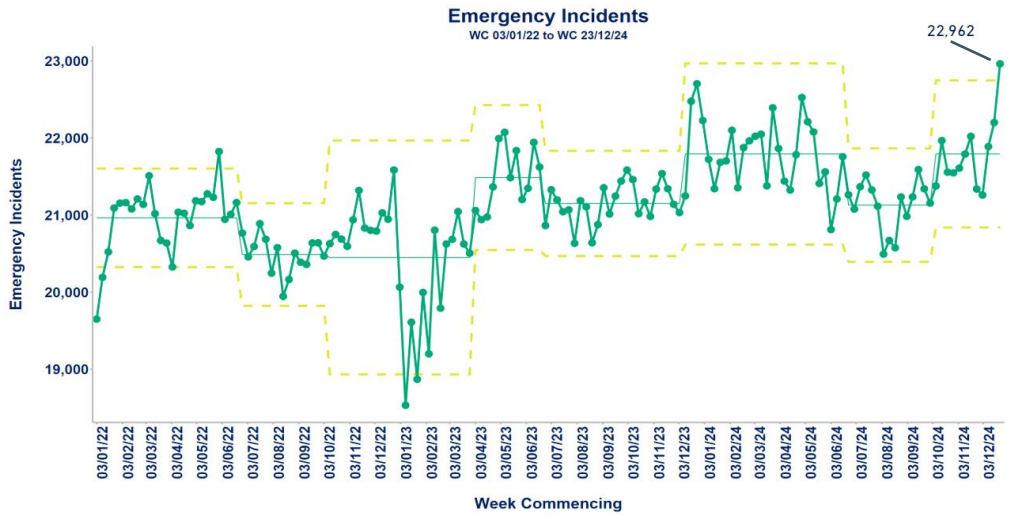


Figure E3.2

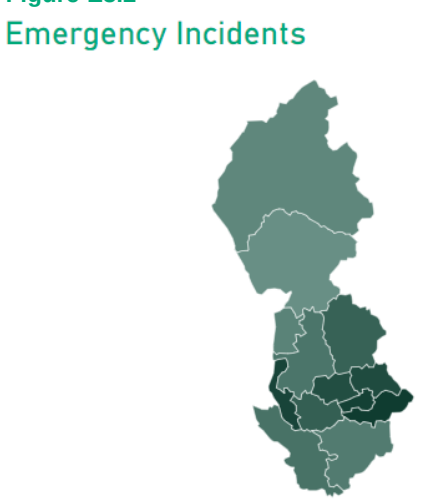


Figure E3.3

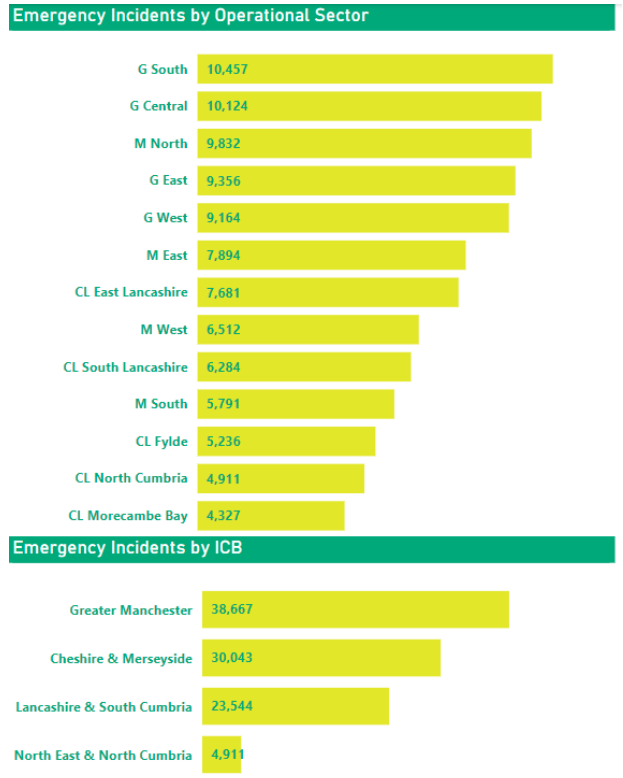


Figure E3.4

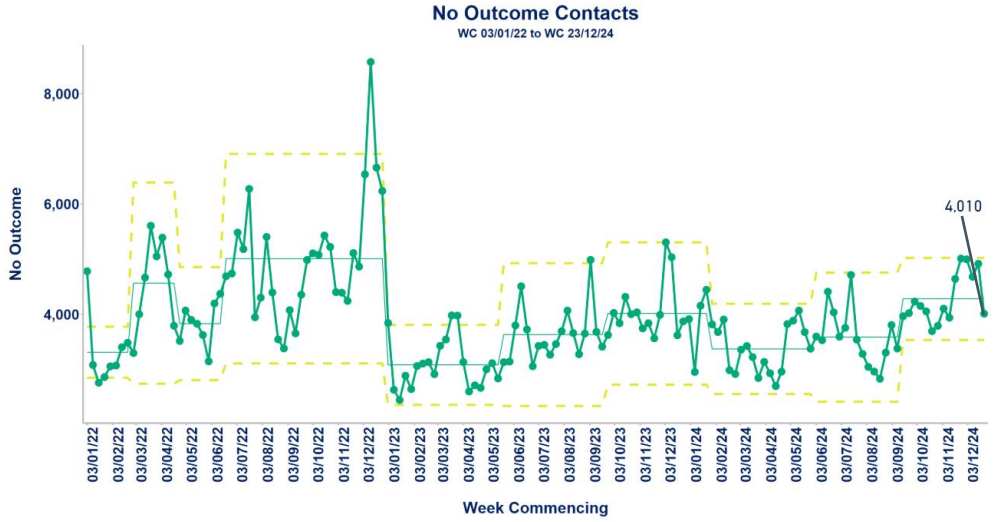


Figure E3.5

Dec	Calls	% Change from previous year	Incidents	% Change from previous year
2021	143,568	29.80%	92,317	-7.40%
2022	156,347	8.90%	92,997	0.74%
2023	133,105	-14.87%	96,581	3.85%
2024	133,150	0.03%	97,653	1.11%

Figure E3.6

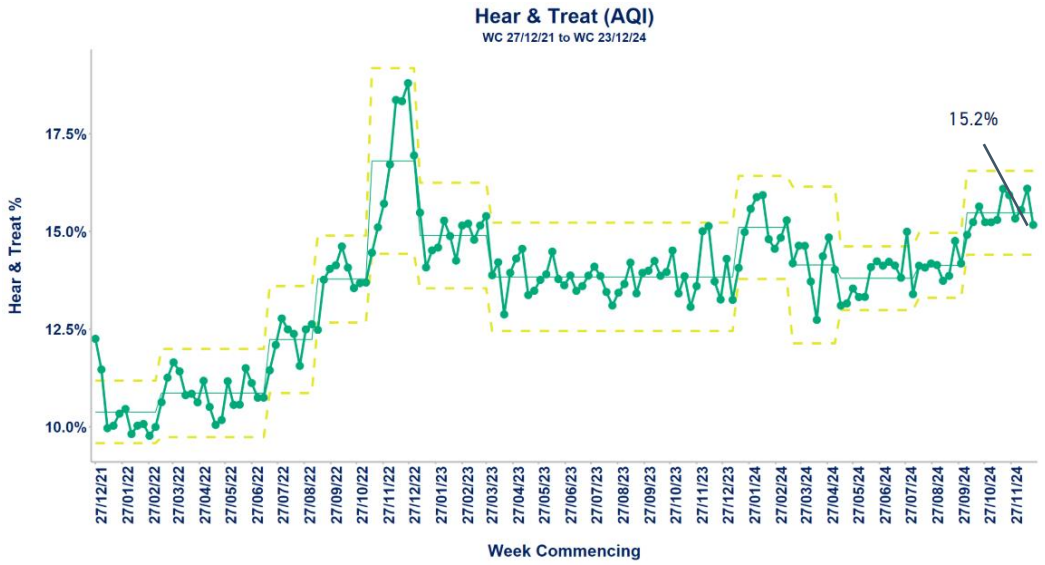


Figure E3.7

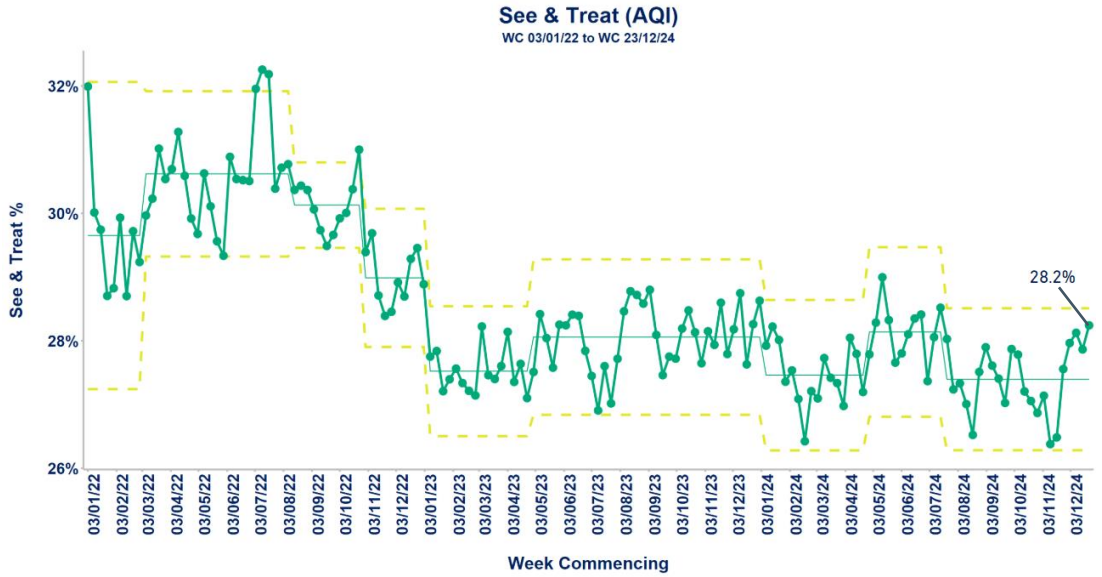


Figure E3.8

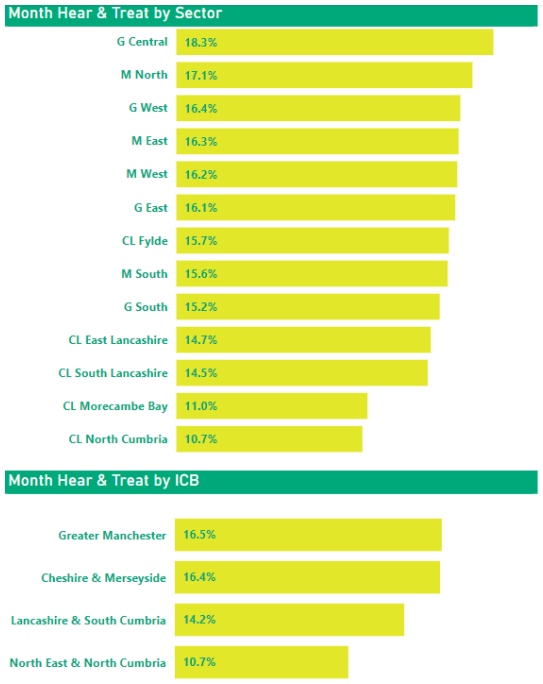


Figure E3.9

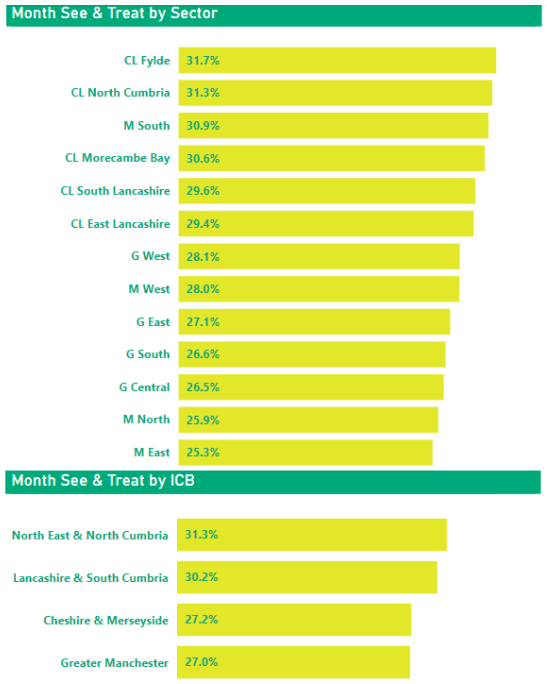


Figure E3.10

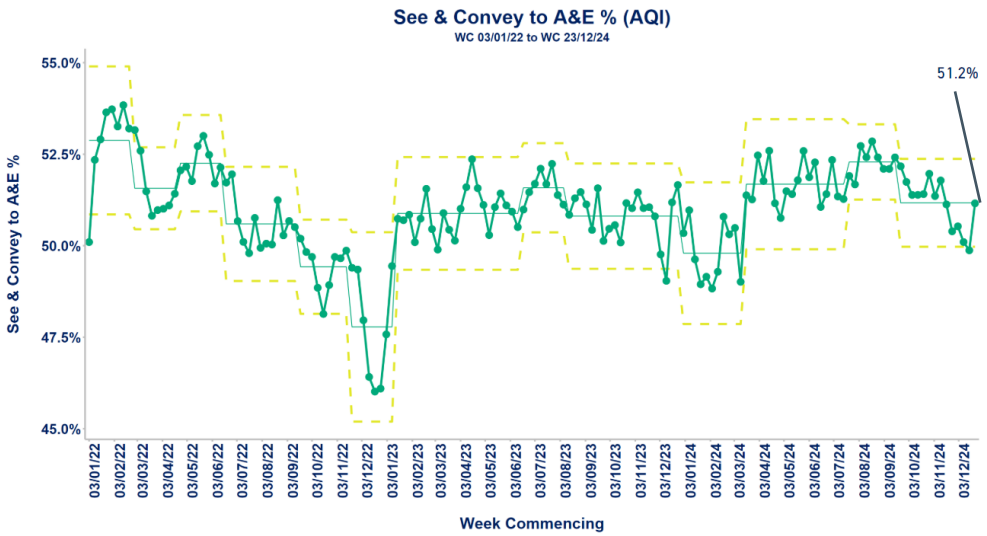


Figure E3.11

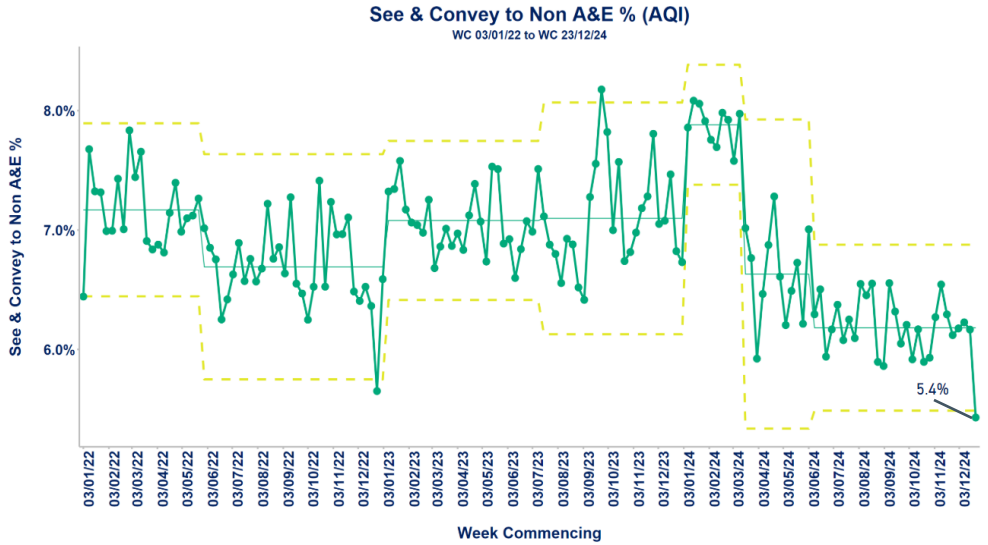


Figure E3.12

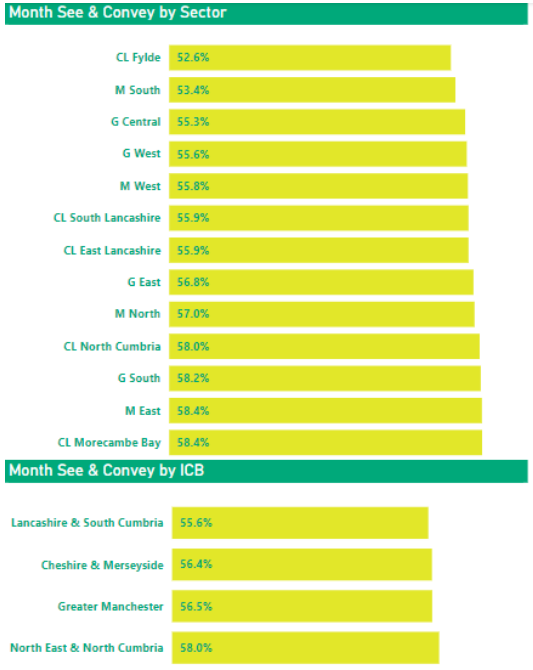


Figure E3.13

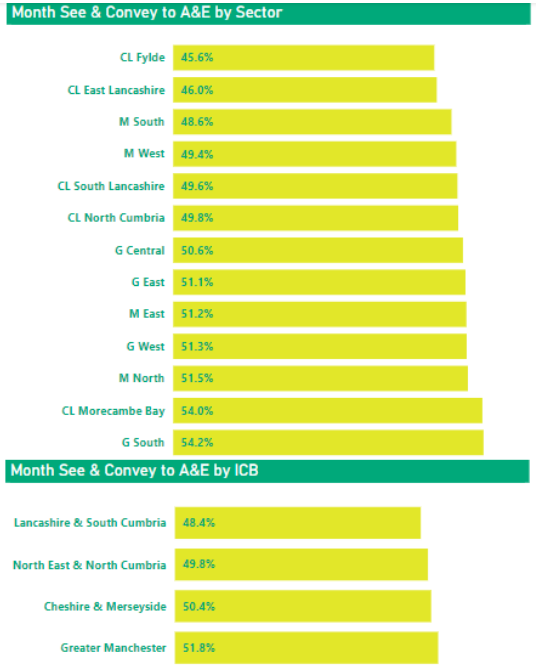


Figure E3.14

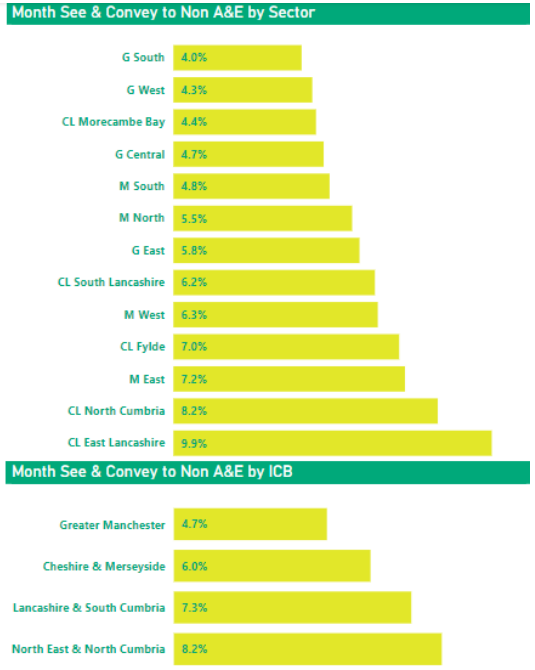


Figure E3.15

Rank	Trust	Hear & Treat	%
1	West Midlands		25.2%
2	East Midlands		23.2%
3	London		22.2%
4	Yorkshire		17.3%
5	North West		15.6%
6	South Western		15.5%
7	South Central		14.9%
8	South East Coast		14.4%
9	East of England		12.2%
10	North East		10.9%
11	Isle of Wight		8.2%

Figure E3.16

Rank	Trust	See & Treat	%
1	South Western		37.0%
2	East of England		35.8%
3	Isle of Wight		35.3%
4	South Central		32.8%
5	South East Coast		31.0%
6	North East		30.4%
7	East Midlands		28.4%
8	North West		28.0%
9	London		26.3%
10	Yorkshire		25.9%
11	West Midlands		24.9%

Figure E3.17

Rank	Trust	See & Convey	%
1	East Midlands		42.3%
2	South Western		43.1%
3	West Midlands		44.5%
4	London		49.0%
5	South Central		49.0%
6	East of England		49.3%
7	North West		50.4%
8	Yorkshire		50.8%
9	North East		52.4%
10	South East Coast		52.7%
11	Isle of Wight		54.8%

Figure E3.18

Rank	Trust	See & Convey Non AE	%
1	North East		6.3%
2	East Midlands		6.2%
3	Yorkshire		6.0%
4	North West		5.9%
5	West Midlands		5.3%
6	South Western		4.3%
7	South Central		3.3%
8	East of England		2.8%
9	London		2.5%
10	South East Coast		1.9%
11	Isle of Wight		1.7%

Operational

O1 CALL PICK UP

Figure O1.1

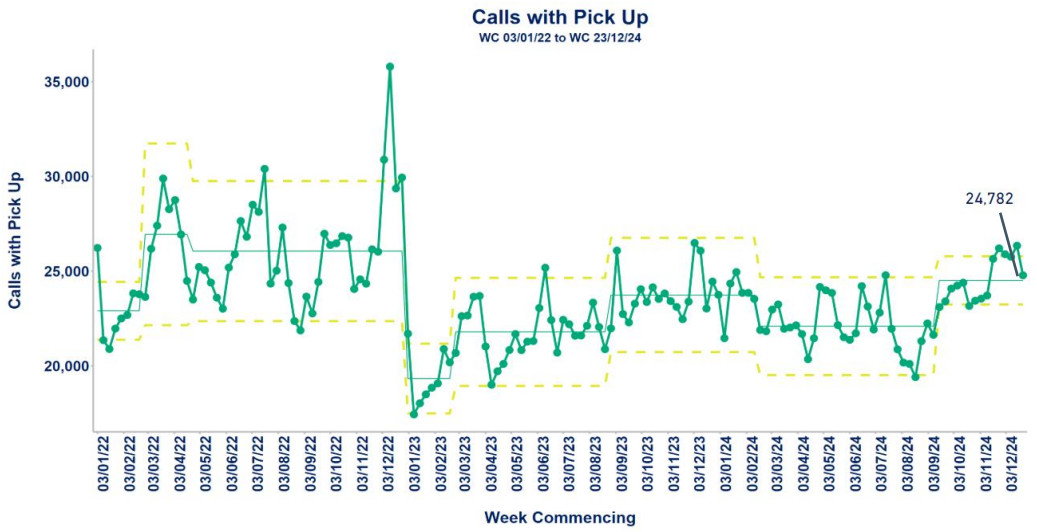


Figure O1.2

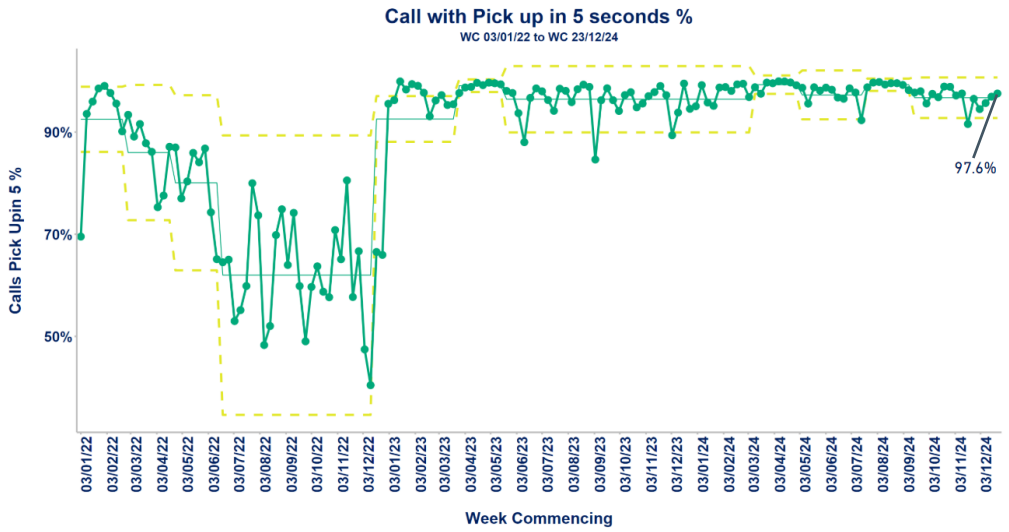


Figure O1.3

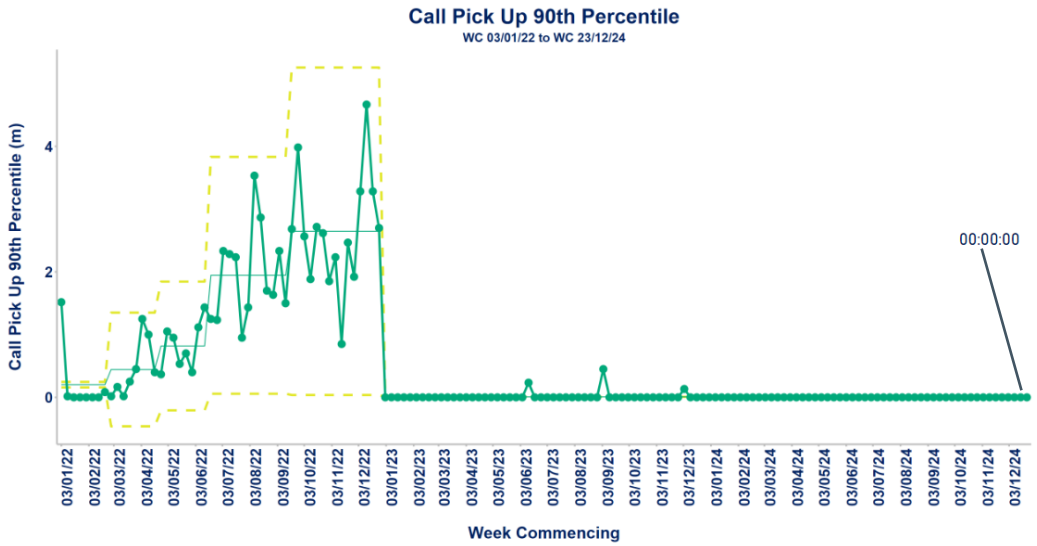


Figure O1.4

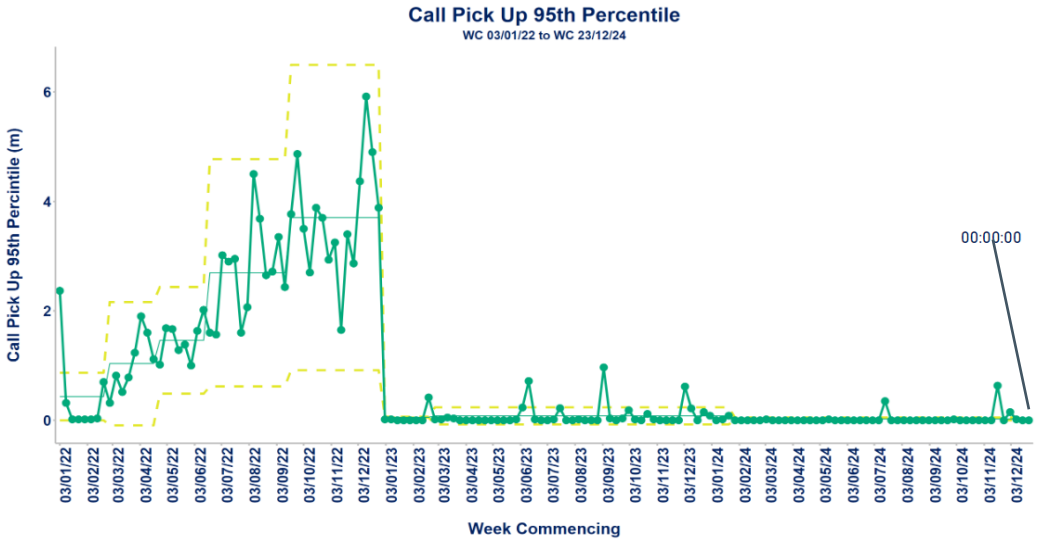


Figure O1.5

Call Pick Up Mean	
Dec 2024	1
YTD	1
Ranking	1st

Figure O1.6

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

Figure O1.7

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

O3 ARP RESPONSE TIMES

December 2024

Figure O3.1

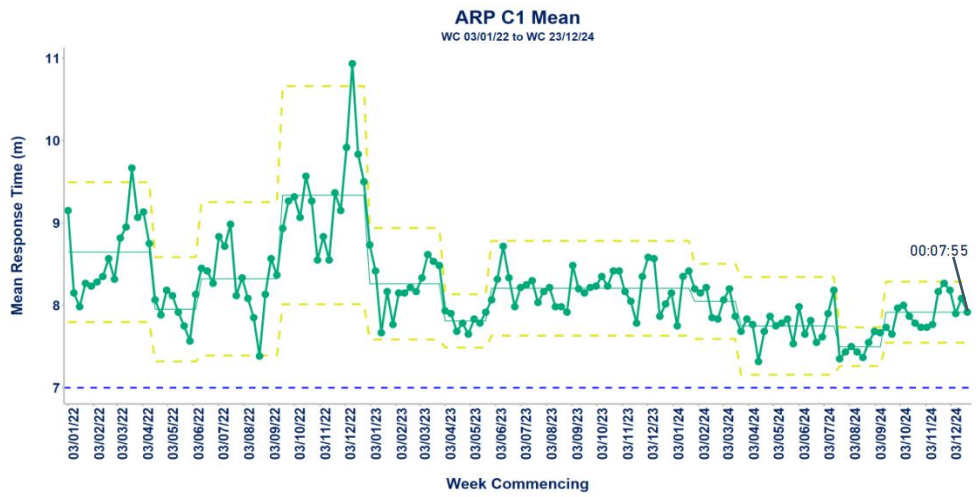


Figure O3.2

C1 Mean (Red =>7min)

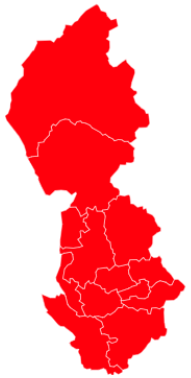


Figure O3.3

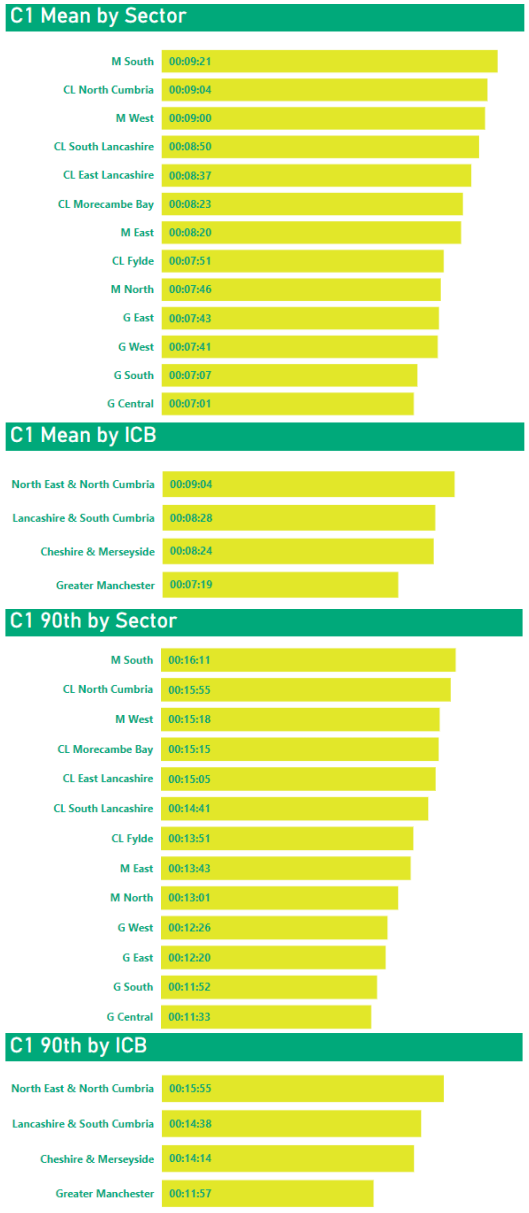


Figure O3.4

C1 Mean	
Target	7:00
Dec 2024	8:03
YTD	7:47
Ranking	3rd

Figure O3.5

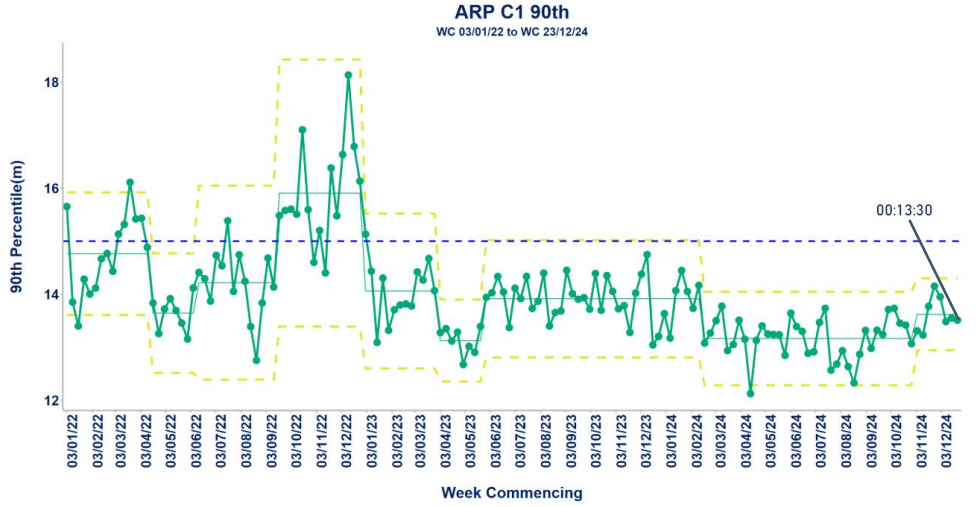


Figure O3.6

C1 90th (Red =>15m)

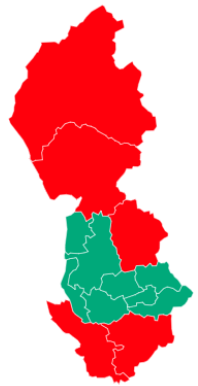


Figure O3.8

C1 90th	
Target	15:00
Dec 2024	13:40
YTD	13:15
Ranking	3rd

December 2024

Figure O3.9

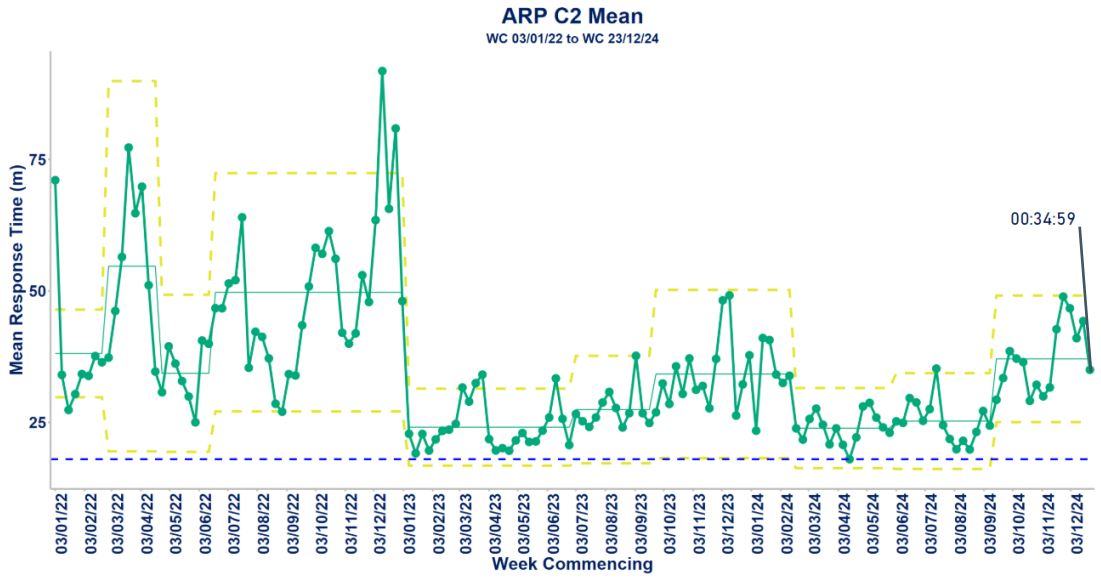


Figure O3.10

C2 90th (Red =>40m)

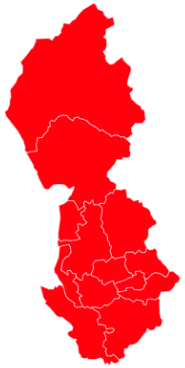


Figure O3.11

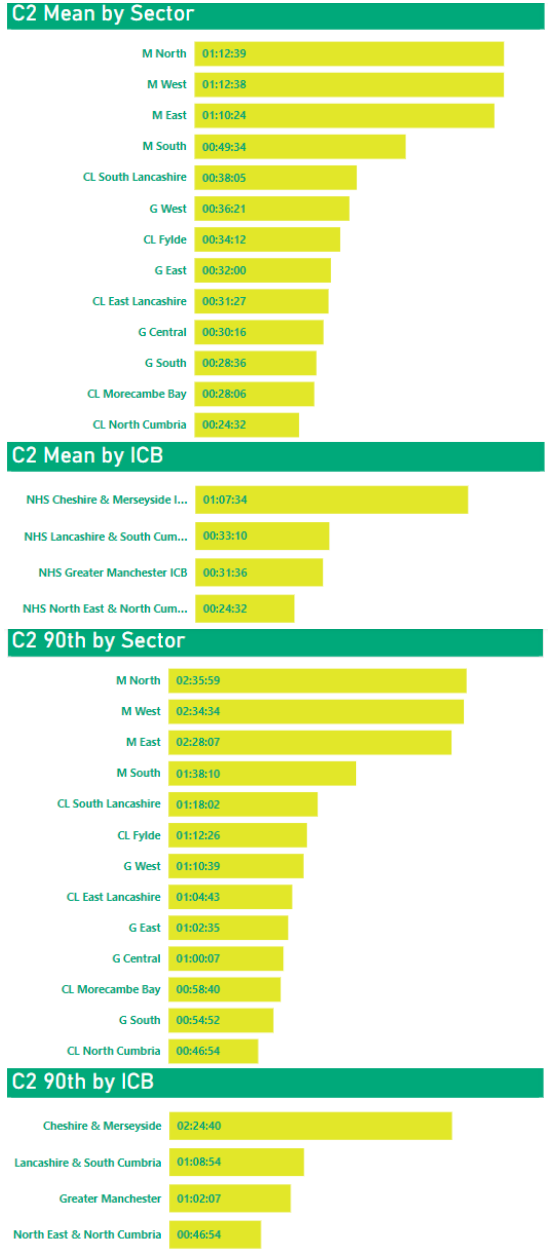


Figure O3.12

C2 Mean	
Target(ARP)	18:00
Target(UEC)	30:00
Dec 2024	42:21
YTD	29:45
Ranking	6th

Figure O3.13

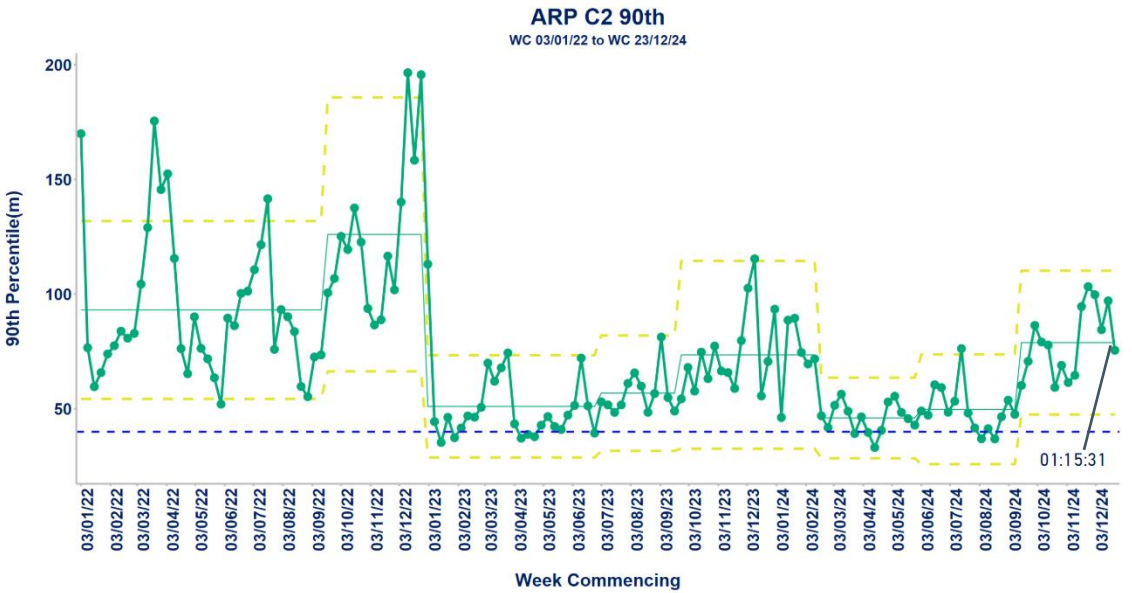


Figure O3.14

C2 Mean (Red =>18m)

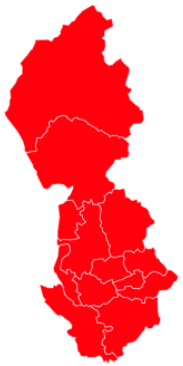


Figure O3.16

C2 90th	
Target	40:00
Dec 2024	1:30.58
YTD	1:00:46
Ranking	5th

December 2024

Figure O3.17

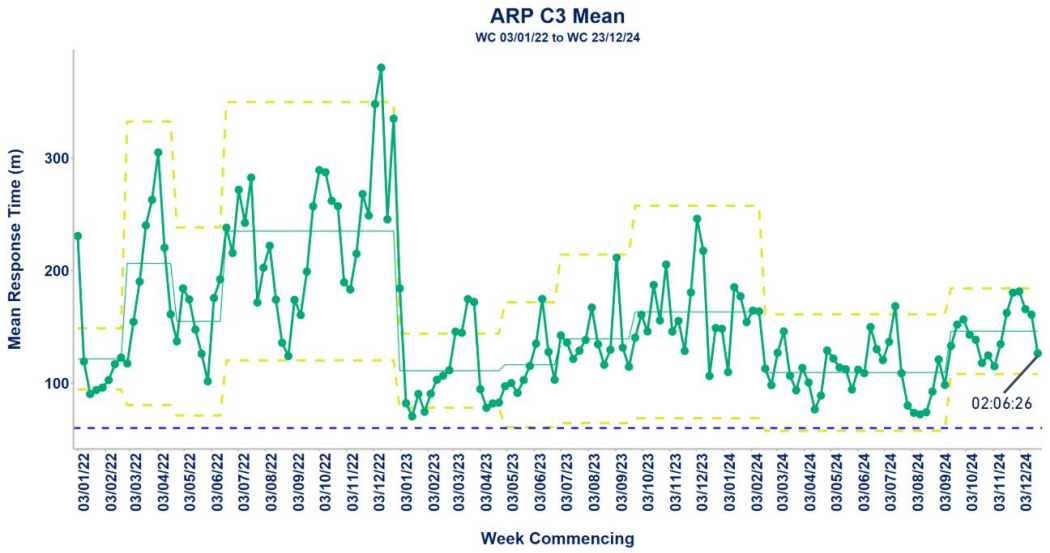


Figure O3.18

C3 90th (Red =>2h)

Figure O3.19

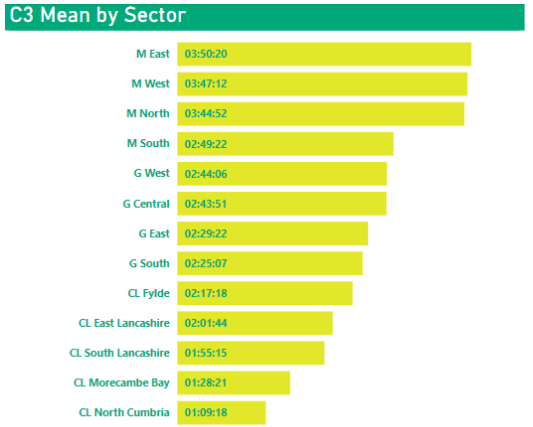


Figure O3.20

C3 Mean	
Target	1:00:00
Dec 2024	2:40:18
YTD	2:01:04
Ranking	5th

Figure O3.21

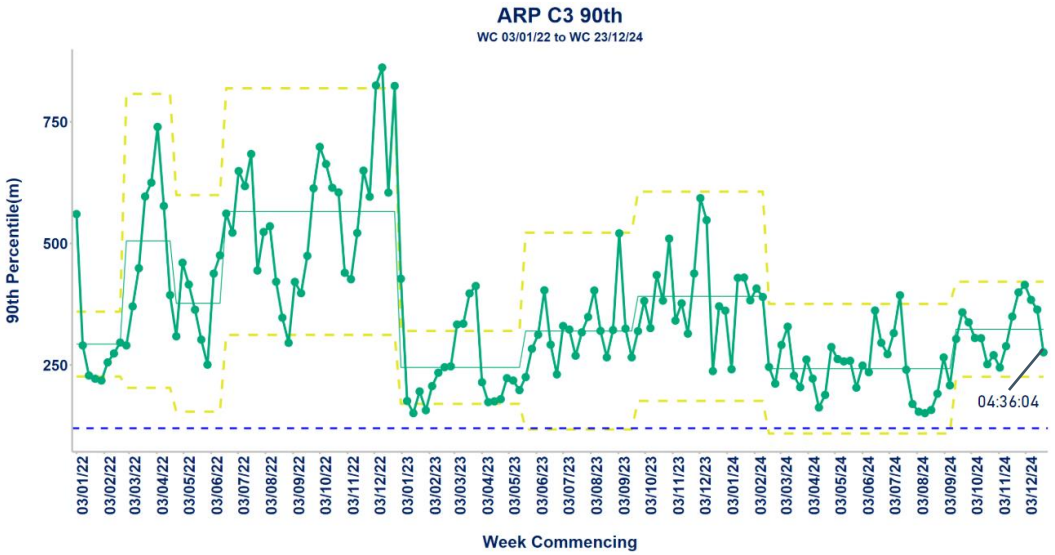


Figure O3.22

C3 Mean (Red =>60min)

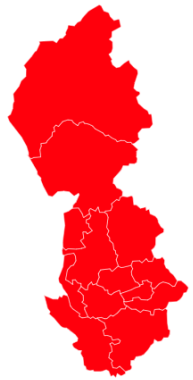
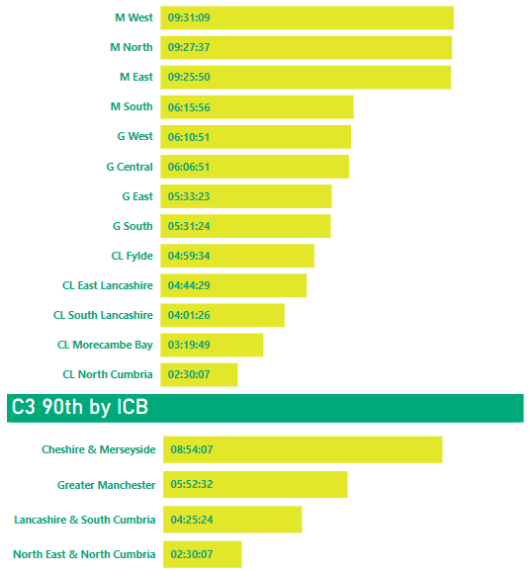


Figure O3.24



C3 90th	
Target	2:00:00
Dec 2024	6:05:12
YTD	4:29:36
Ranking	5th

December 2024

Figure O3.25

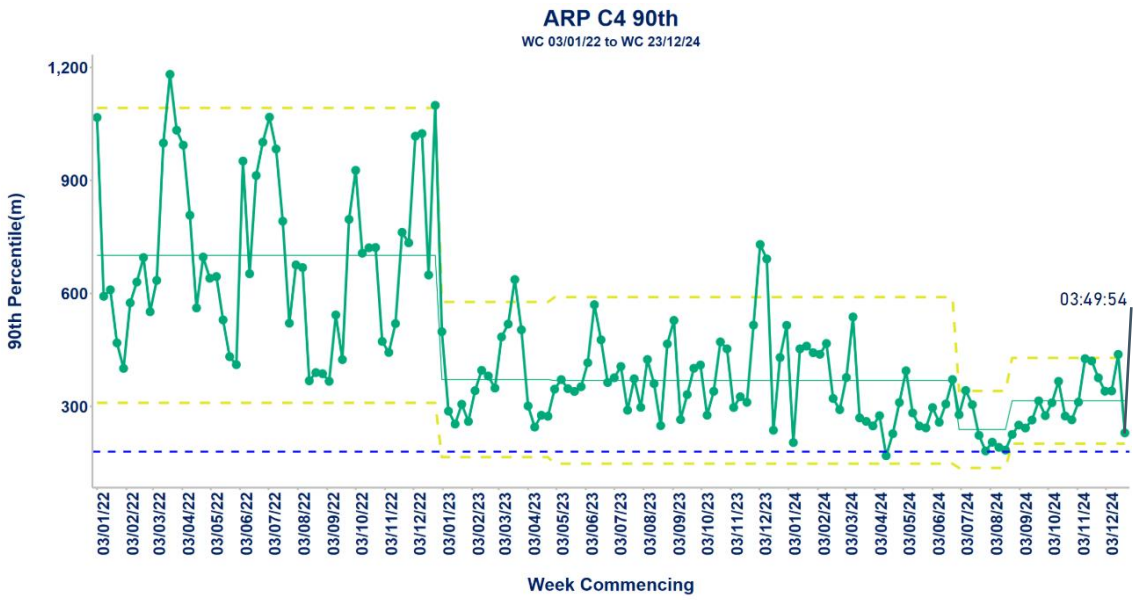


Figure O3.26

C4 90th (Red =>3h)

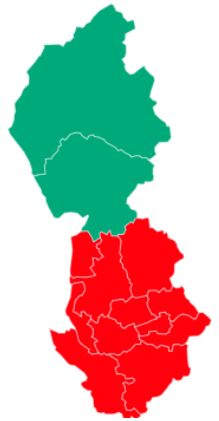


Figure O3.27

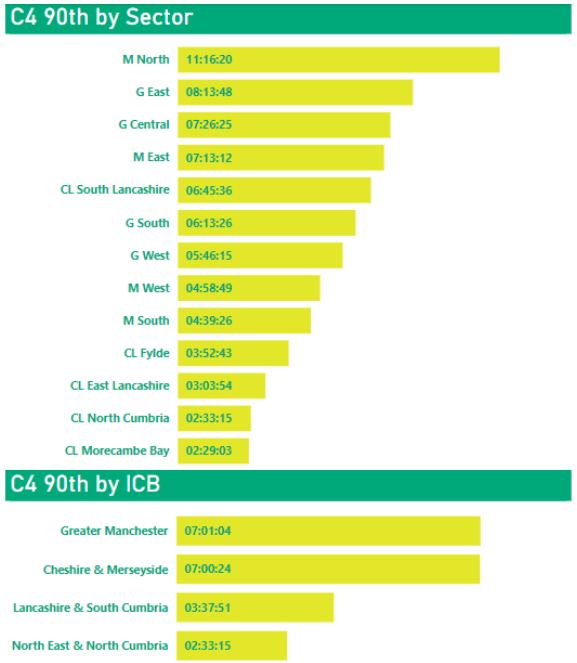


Figure O3.28

C4 90th	
Target	3:00:00
Dec 2024	5:42:49
YTD	4:38:25
Ranking	3rd

O3 ARP Provider Comparison

Figure O3.25

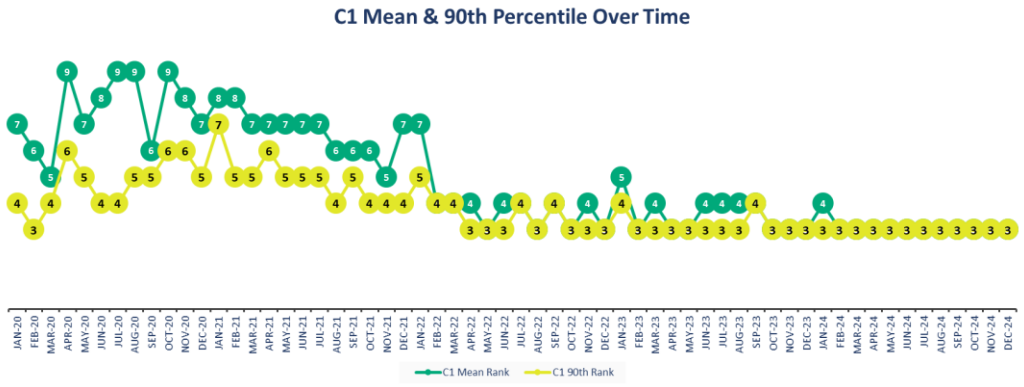


Figure O3.26

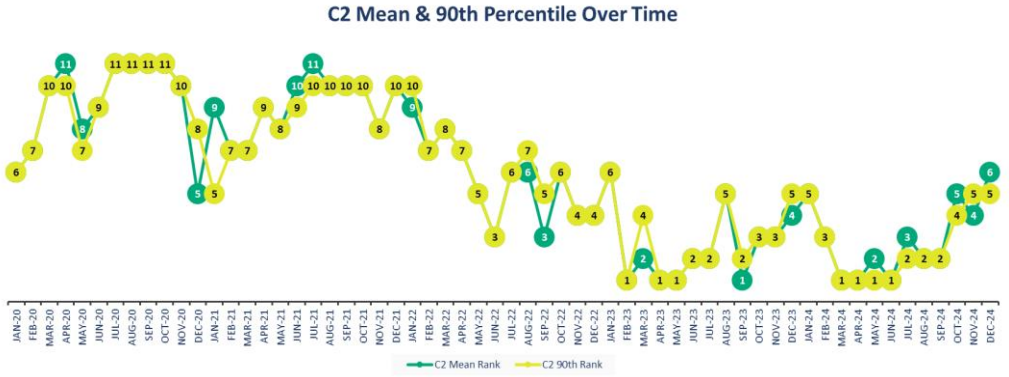


Figure O3.27

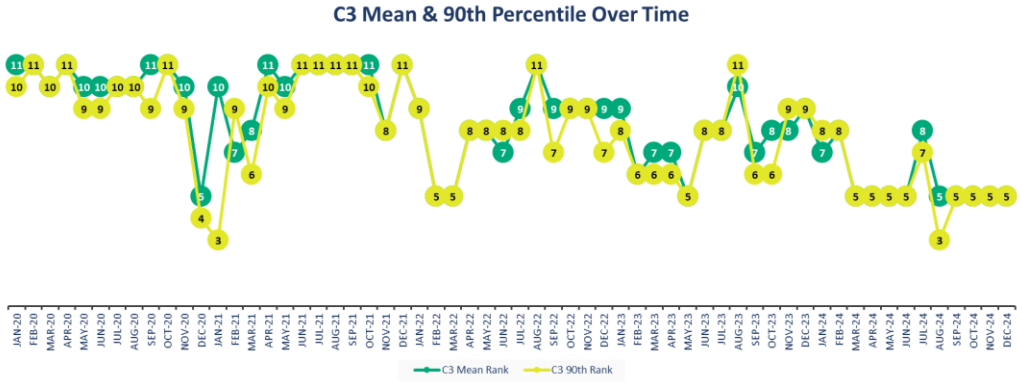
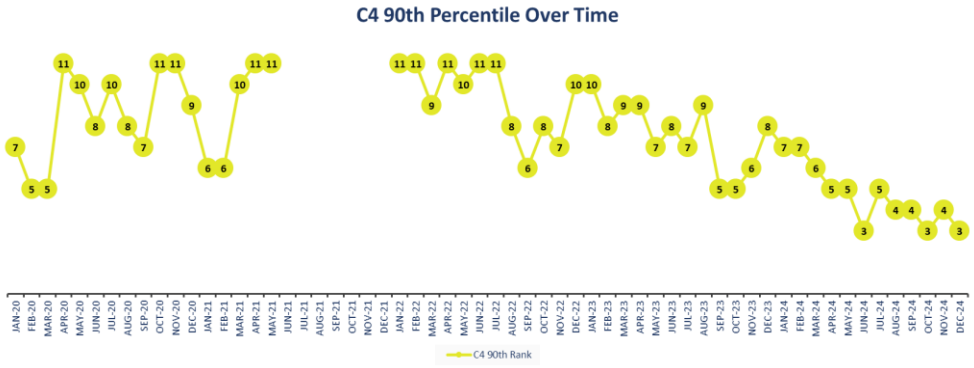


Figure O3.28



Rank	Trust	C1 Mean	Time
1	North East		06:55
2	London		07:49
3	North West		08:03
4	Yorkshire		08:11
5	West Midlands		08:34
6	Isle of Wight		08:38
7	South East Coast		08:41
8	South Central		08:53
9	East of England		09:47
10	East Midlands		09:48
11	South Western		09:57

Rank	Trust	C1 90th	Time
1	North East		11:45
2	London		13:27
3	North West		13:40
4	Yorkshire		14:14
5	West Midlands		15:23
6	South East Coast		15:58
7	South Central		16:07
8	East Midlands		17:14
9	Isle of Wight		17:17
10	East of England		18:16
11	South Western		18:28

Rank	Trust	C2 Mean	Time
1	Isle of Wight		0:27:35
2	South East Coast		0:32:12
3	South Central		0:33:34
4	North East		0:37:50
5	Yorkshire		0:41:06
6	North West		0:42:21
7	West Midlands		0:44:08
8	London		0:49:50
9	East of England		0:57:20
10	South Western		1:00:32
11	East Midlands		1:06:15

Rank	Trust	C2 90th	Time
1	Isle of Wight		0:59:36
2	South Central		1:05:28
3	South East Coast		1:06:04
4	North East		1:15:48
5	North West		1:30:58
6	Yorkshire		1:32:31
7	West Midlands		1:42:03
8	London		1:45:00
9	East of England		2:04:09
10	South Western		2:10:38
11	East Midlands		2:20:34

Rank	Trust	C3 Mean	Time
1	Isle of Wight		01:14:29
2	Yorkshire		02:05:31
3	London		02:11:54
4	North East		02:36:38
5	North West		02:39:33
6	South East Coast		02:48:22
7	South Central		03:05:29
8	West Midlands		03:20:40
9	East of England		03:30:02
10	South Western		04:00:16
11	East Midlands		04:15:48

Rank	Trust	C3 90th	Time
1	Isle of Wight		02:44:38
2	Yorkshire		04:38:52
3	London		05:22:49
4	North East		05:51:48
5	North West		06:03:37
6	South East Coast		06:39:45
7	South Central		07:01:00
8	East of England		08:42:56
9	West Midlands		09:01:49
10	South Western		09:42:28
11	East Midlands		11:00:38

Rank	Trust	C4 90th	Time
1	Isle of Wight		03:31:13
2	North East		04:26:30
3	North West		05:40:57
4	South East Coast		06:01:16
5	Yorkshire		06:08:00
6	London		07:32:54
7	South Central		08:31:24
8	West Midlands		09:19:22
9	South Western		11:10:53
10	East of England		12:05:25
11	East Midlands		15:25:46

O3 LONG WAITS

Table O3.29

Year Month	Total No. of C1 long waits
Jan 2022	1,109
Feb 2022	985
Mar 2022	1,609
Apr 2022	1,145
May 2022	869
Jun 2022	940
Jul 2022	1,207
Aug 2022	653
Sep 2022	804
Oct 2022	1,186
Nov 2022	959
Dec 2022	1,619
Jan 2023	694
Feb 2023	543
Mar 2023	708
Apr 2023	509
May 2023	504
Jun 2023	693
Jul 2023	707
Aug 2023	643
Sep 2023	712
Oct 2023	760
Nov 2023	665
Dec 2023	785
Jan 2024	748
Feb 2024	641
Mar 2024	565
Apr 2024	507
May 2024	604
Jun 2024	595
Jul 2024	582
Aug 2024	450
Sep 2024	566
Oct 2024	682
Nov 2024	692
Dec 2024	736

Figure O3.29

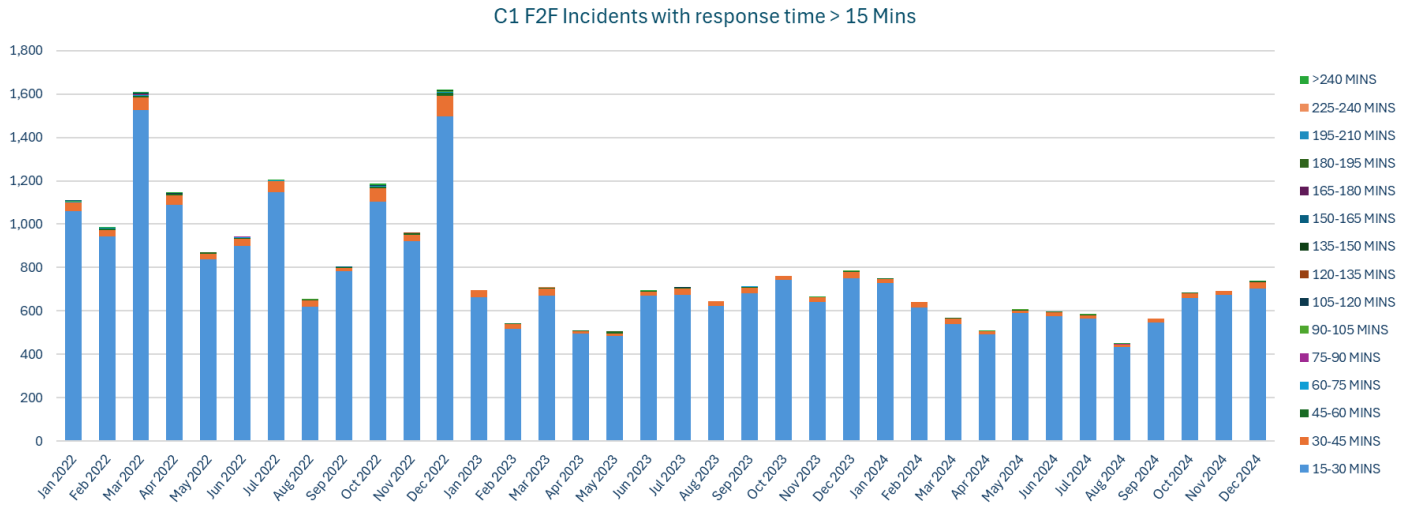


Figure O3.30

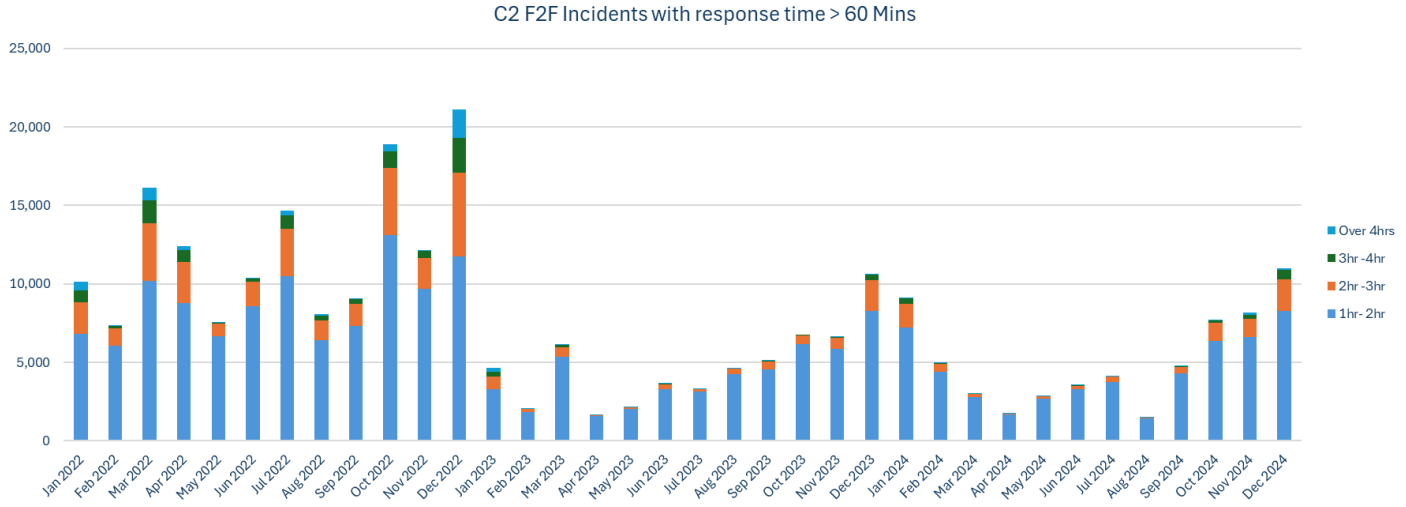


Table O3.30

Year Month	Total No. of C2 long waits
Jan 2022	10,127
Feb 2022	7,349
Mar 2022	16,135
Apr 2022	12,400
May 2022	7,564
Jun 2022	10,374
Jul 2022	14,649
Aug 2022	8,051
Sep 2022	9,057
Oct 2022	18,870
Nov 2022	12,153
Dec 2022	21,089
Jan 2023	4,631
Feb 2023	2,048
Mar 2023	6,132
Apr 2023	1,649
May 2023	2,141
Jun 2023	3,667
Jul 2023	3,294
Aug 2023	4,613
Sep 2023	5,088
Oct 2023	6,754
Nov 2023	6,608
Dec 2023	10,636
Jan 2024	9,112
Feb 2024	4,975
Mar 2024	2,998
Apr 2024	1,761
May 2024	2,860
Jun 2024	3,526
Jul 2024	4,121
Aug 2024	1,473
Sep 2024	4,740
Oct 2024	7,748
Nov 2024	8,162
Dec 2024	11,019

O3 A&E TURNAROUND

Figure O3.1

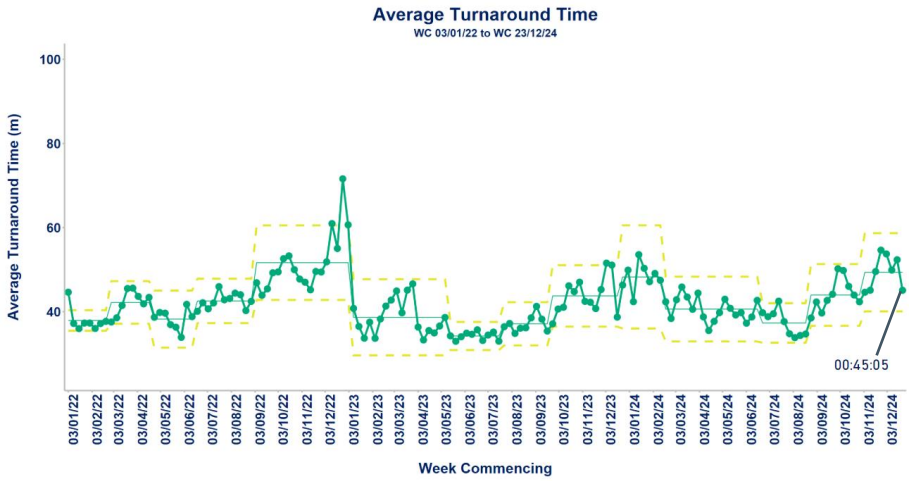


Figure O3.2

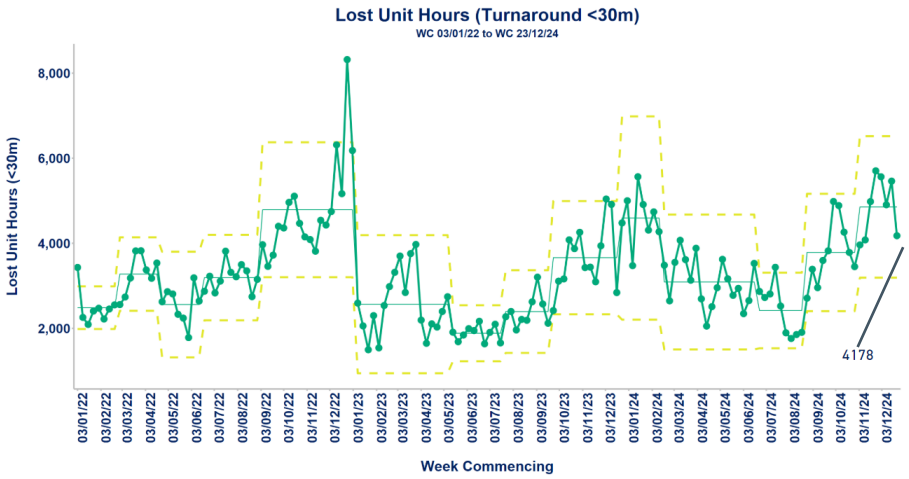


Table O3.1

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)
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	00:39:22	00:30:34	00:09:01
Jul 2024	48,915	00:39:19	00:30:34	00:08:57
Aug 2024	48,434	00:35:06	00:26:24	00:08:53
Sep 2024	47,618	00:42:19	00:33:27	00:09:04
Oct 2024	49,288	00:47:07	00:38:23	00:08:58
Nov 2024	47,834	00:47:13	00:38:39	00:08:55
Dec 2024	49,453	00:51:07	00:42:22	00:08:59

Table O3.2

Top 5 Trusts with most lost unit hours

Destination Short Name	Operational Area Name	Hospital Attendances to AE	Lost Time Turnaround >30m (h)	Mean at Hospital to Clear Time(hh:mm:ss)	Mean at Hospital to Handover Time(hh:mm:ss)	Mean Handover to Clear Time(hh:mm:ss)
Whiston	Cheshire & Merseyside	2,275	2931.95	01:37:36	01:25:03	00:11:39
Aintree University	Cheshire & Merseyside	2,183	2621.29	01:32:09	01:18:21	00:14:36
Blackpool Victoria	Cumbria & Lancashire	2,374	2136.26	01:12:49	01:02:44	00:09:43
Arrowe Park	Cheshire & Merseyside	1,917	1662.03	01:13:59	01:07:06	00:08:44
Royal Liverpool University	Cheshire & Merseyside	2,229	1358.12	01:03:18	00:52:23	00:11:29

Table O3.3

Month	No. of patients waiting outside A&E for handover
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
Sep-24	1877
Oct-24	2681
Nov-24	2432
Dec-24	2392

O3 A&E TURNAROUND ICB

Figure O3.4

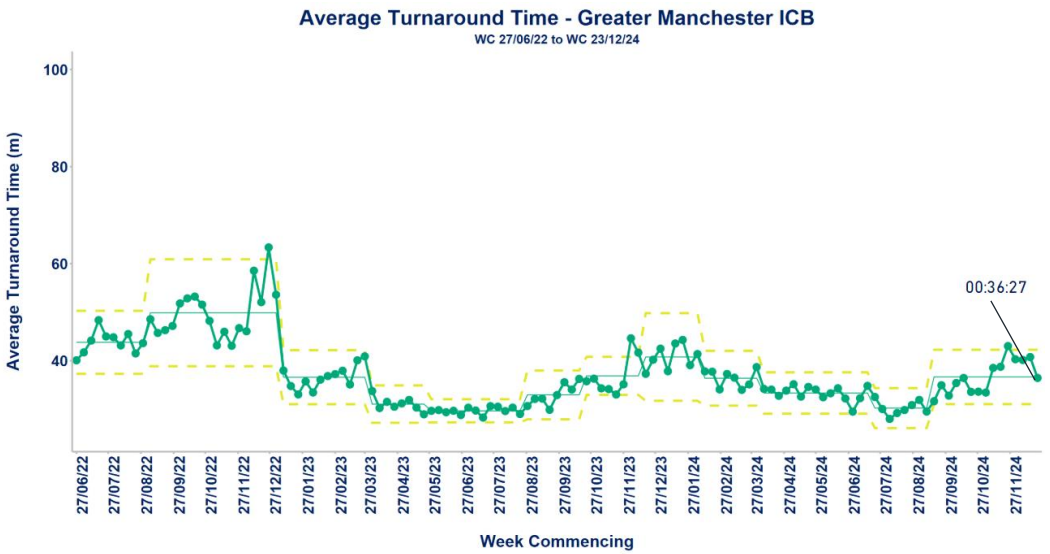


Figure O3.5

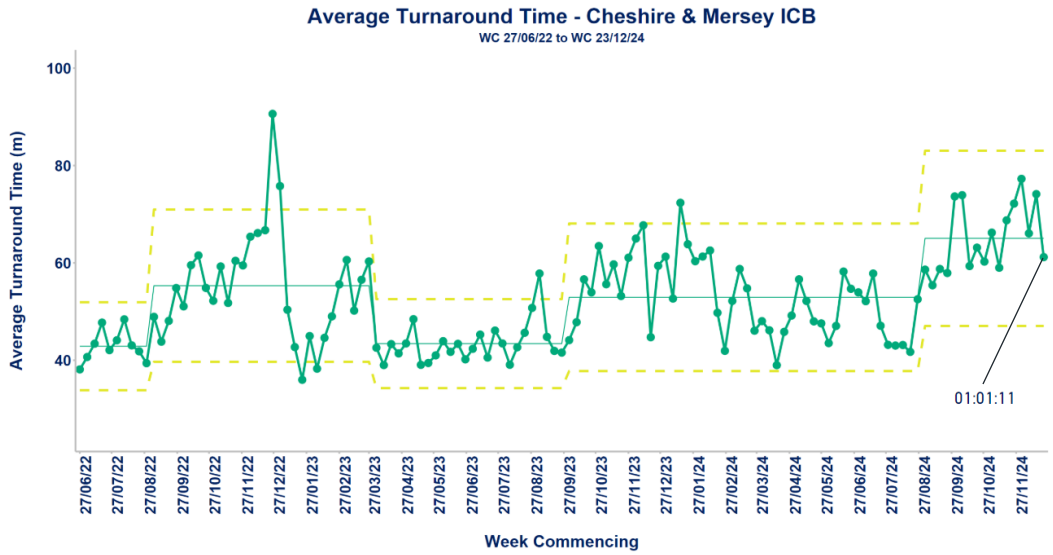


Figure O3.6

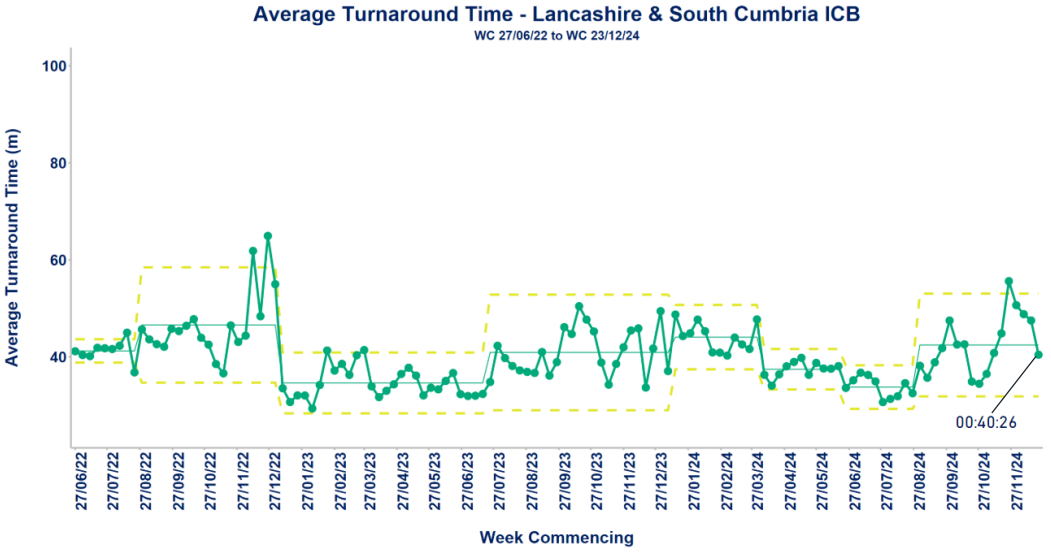
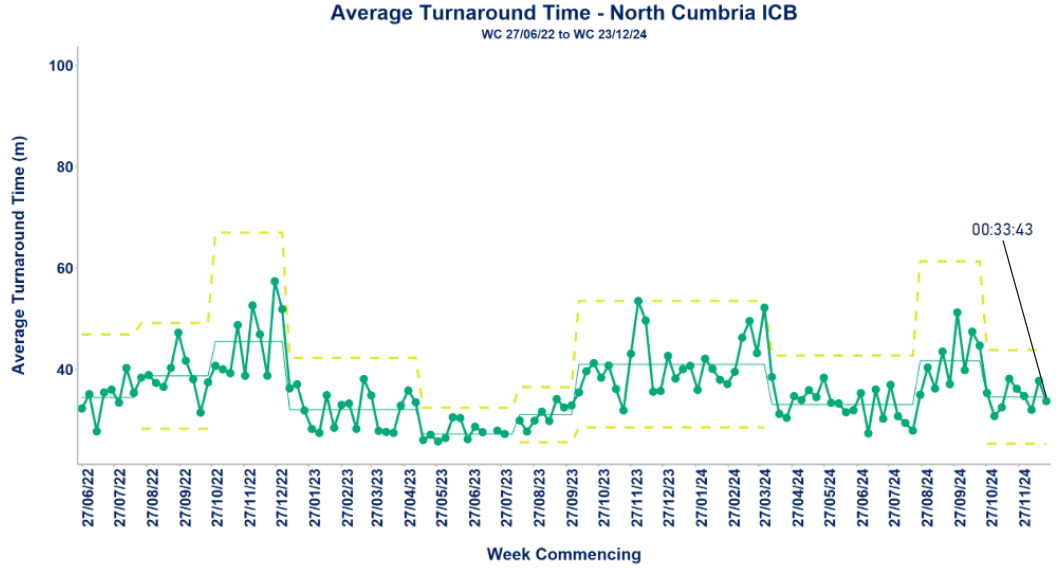
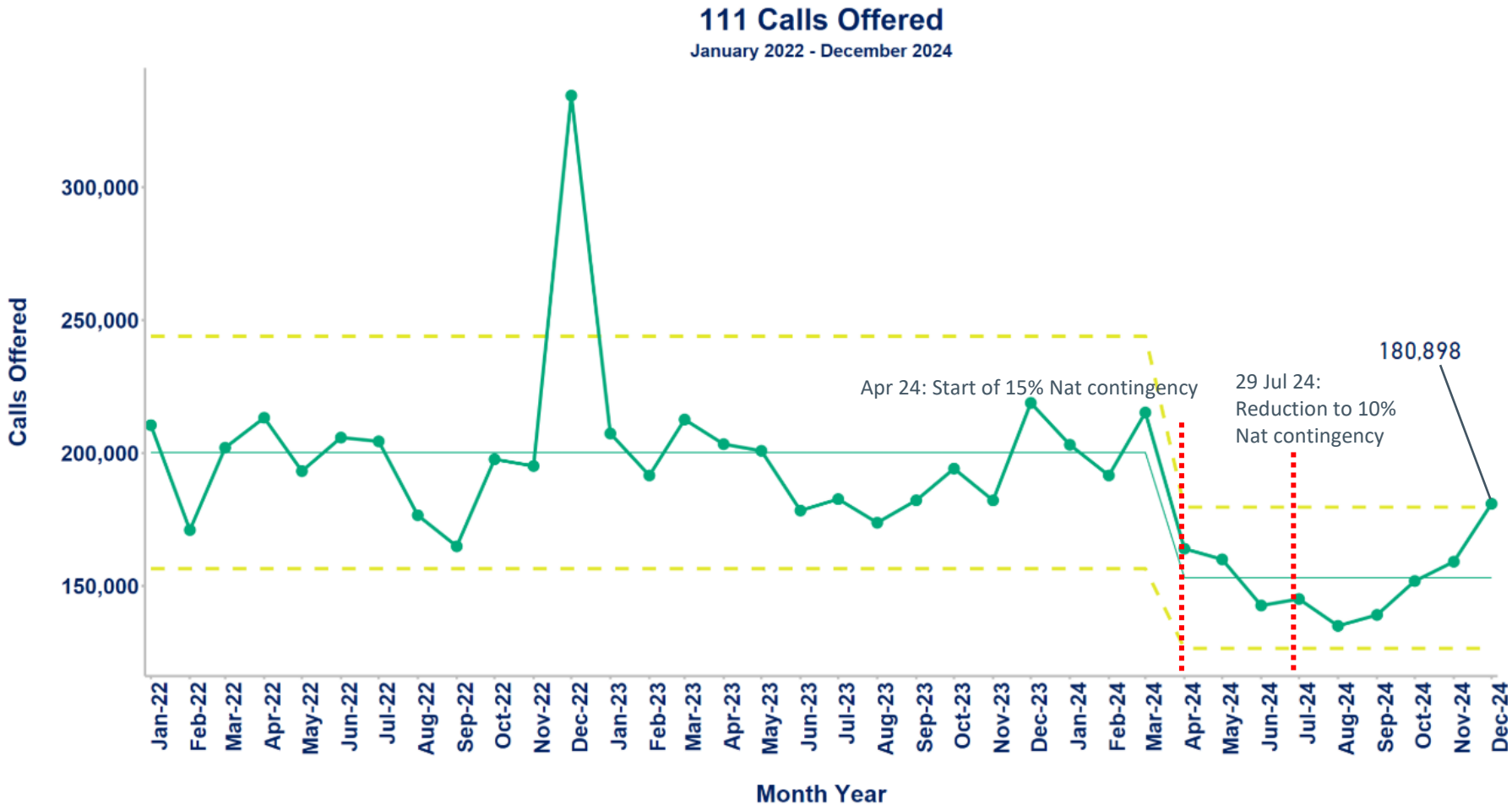


Figure O3.7



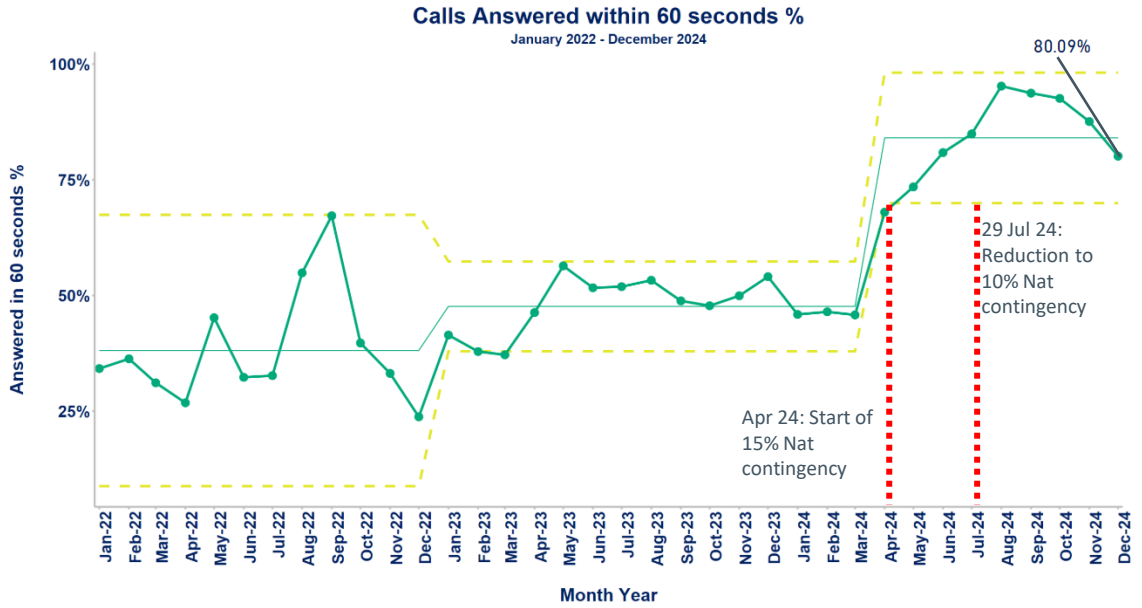
O4 111 ACTIVITY & PERFORMANCE

Figure O4.1



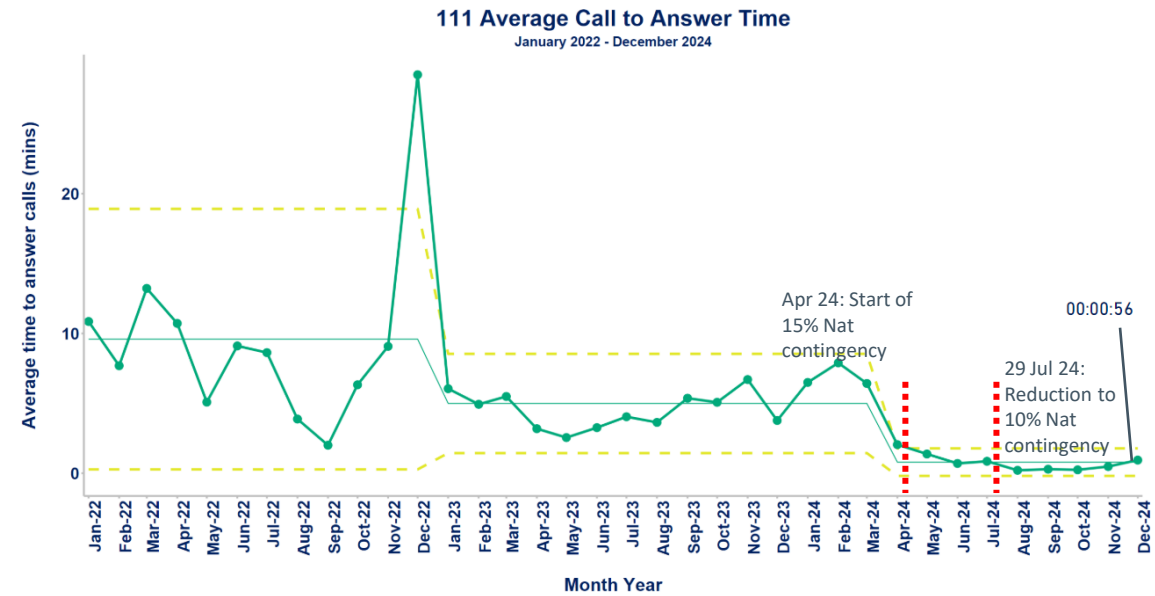
Calls Offered	
Dec 2024	180,898
YTD	1,987,421

Figure O4.2



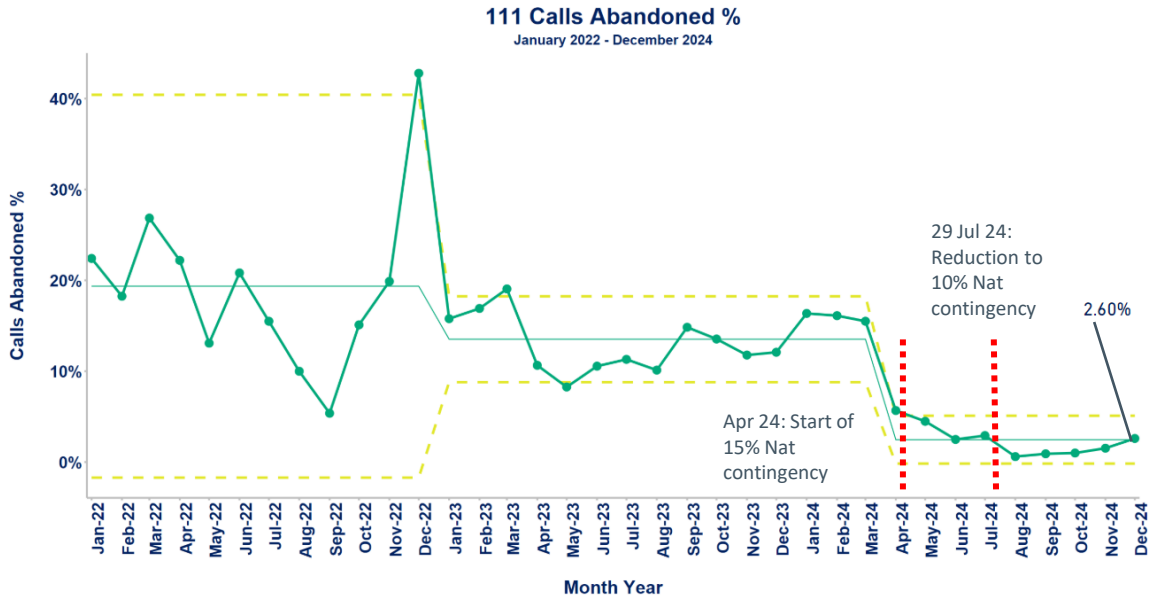
Calls Answered within 60 Seconds %	
Target	95%
Dec 2024	80.09%
YTD	83.83%
National	77.4%
Ranking	11th/31

Figure O4.3



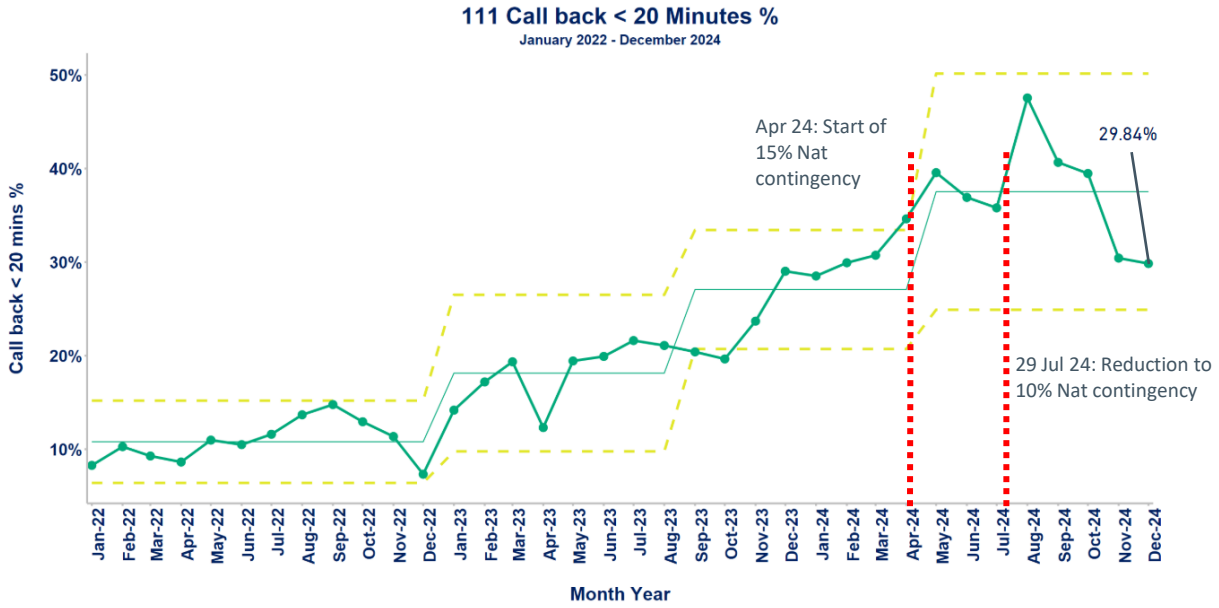
Average Call to Answer time (seconds)	
Target	<20
Dec 2024	56
YTD	56
National	70
Ranking	13th/31

Figure O4.4



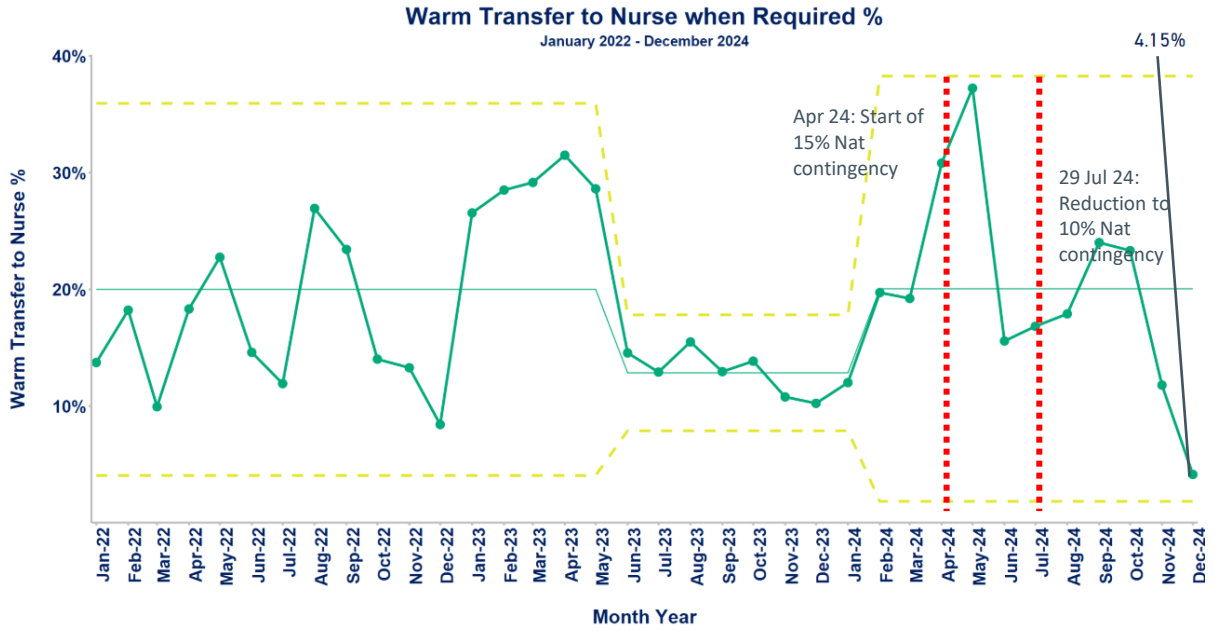
Calls Abandoned %	
Target	<5%
Dec 2024	2.6%
YTD	2.5%
National	3.5%
Ranking	3rd/31

Figure O4.5



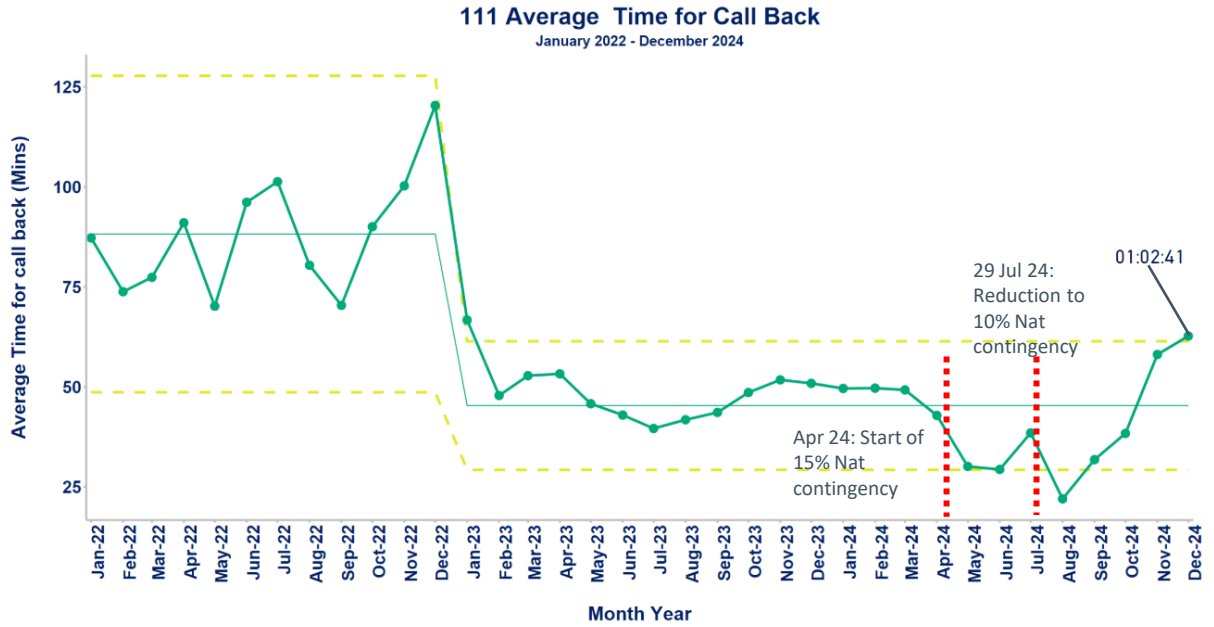
Calls Back <20 Mins	
Target	90%
Dec 2024	29.8%
YTD	30.1%

Figure O4.6



Warm Transfer %	
Target	75%
Dec 2024	4.15%
YTD	20.18%

Figure O4.7



O5 PTS ACTIVITY & TARIFF

Figure O5.1

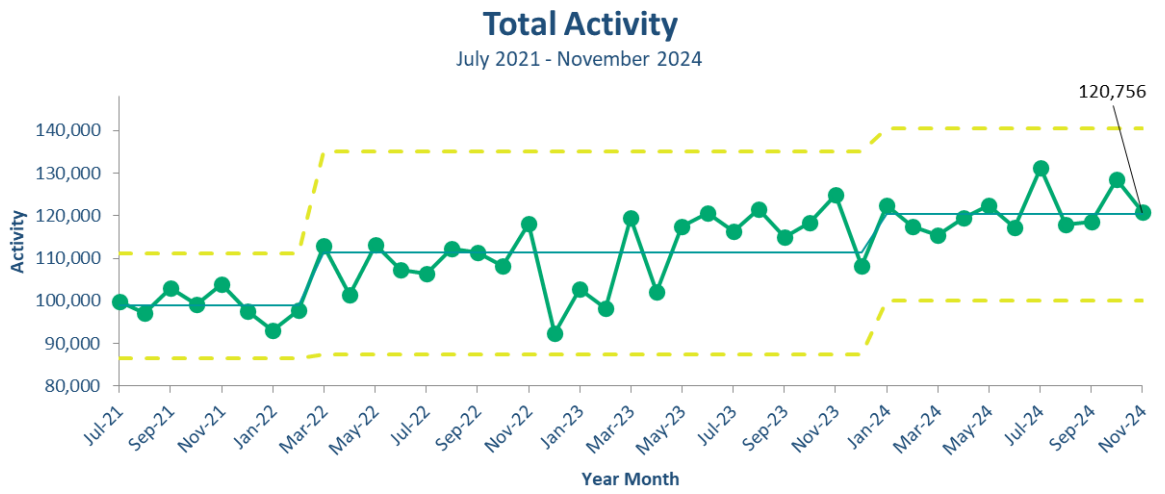


Figure O5.2

Contract	Total Activity
Greater Manchester	46,822
Lancashire	37,062
Merseyside	25,742
Cumbria	11,130

Total Activity	
Plan	132,015
Actual	120,756
YTD Plan	660,076
YTD Activity	622,960

Figure O5.3

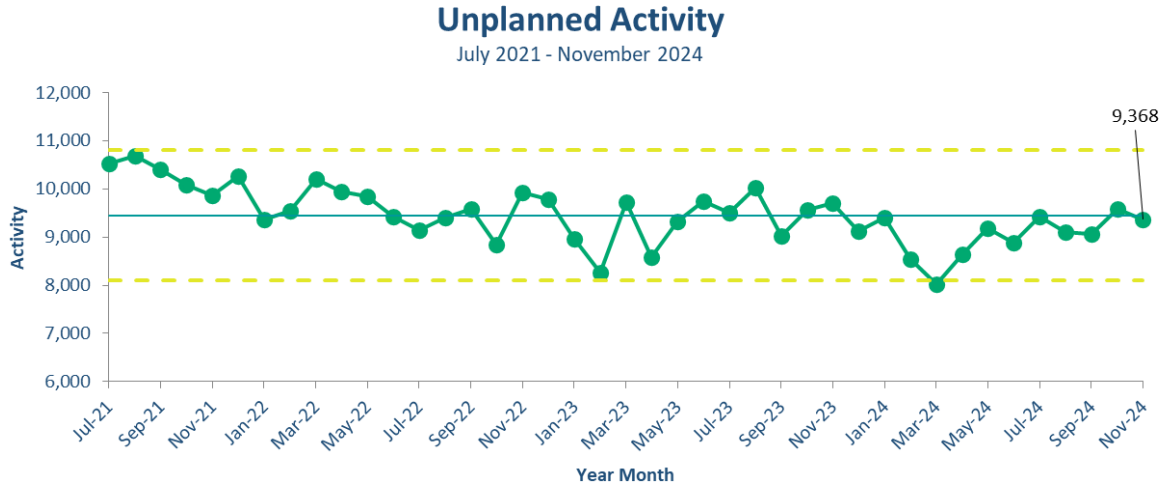


Figure O5.4

Contract	Unplanned Activity
Greater Manchester	3,728
Lancashire	3,482
Merseyside	1,769
Cumbria	389

Unplanned Activity	
Plan	12,107
Actual	9,368
YTD Plan	60,534
YTD Activity	48,006

Figure O5.5

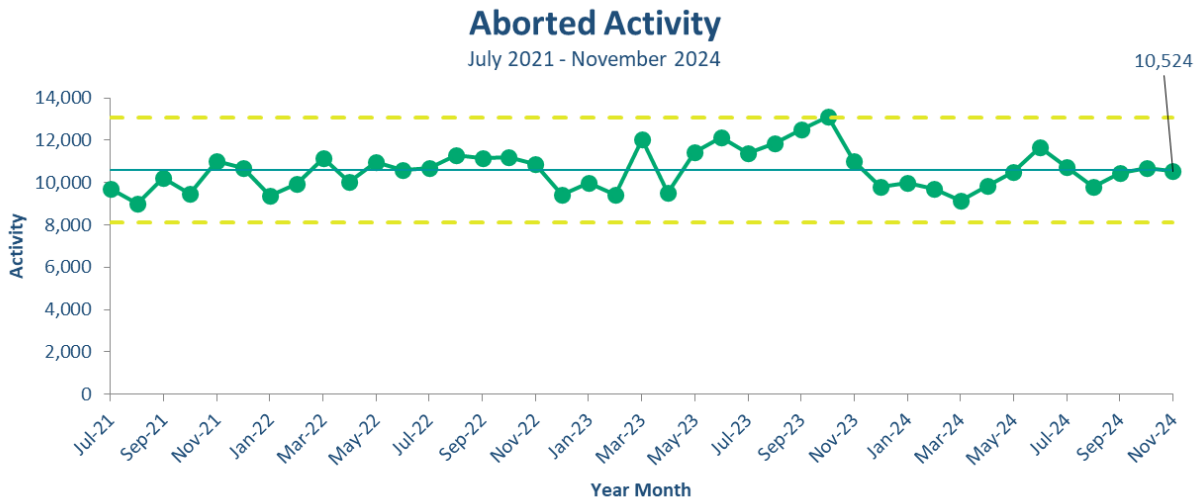


Figure O5.6

Contract	Aborted Activity
Greater Manchester	5,498
Lancashire	2,747
Merseyside	1,879
Cumbria	400

Figure O5.7

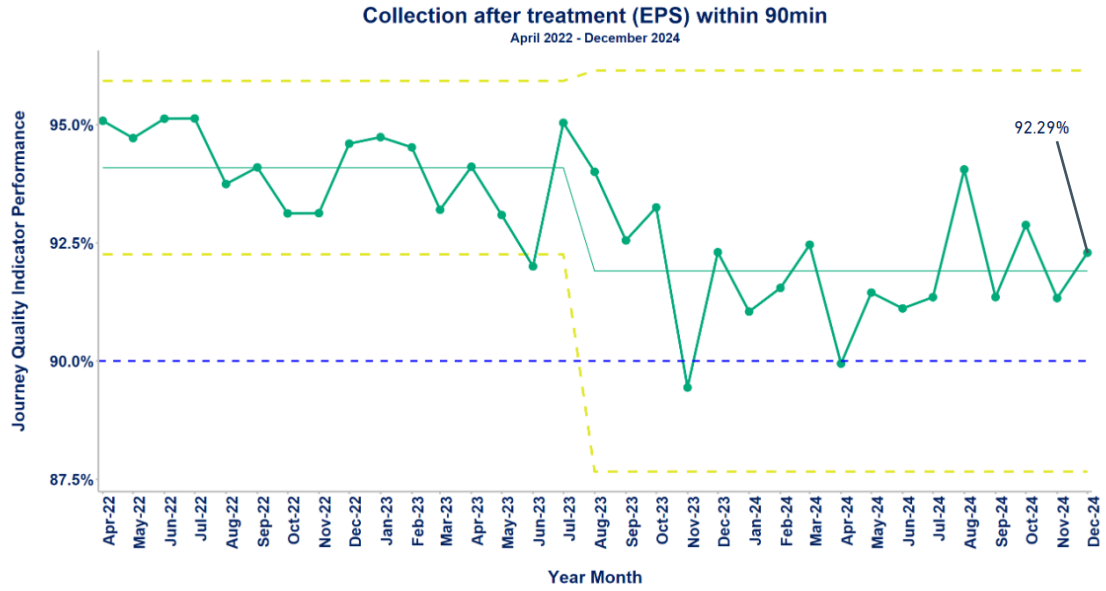


Figure O5.8

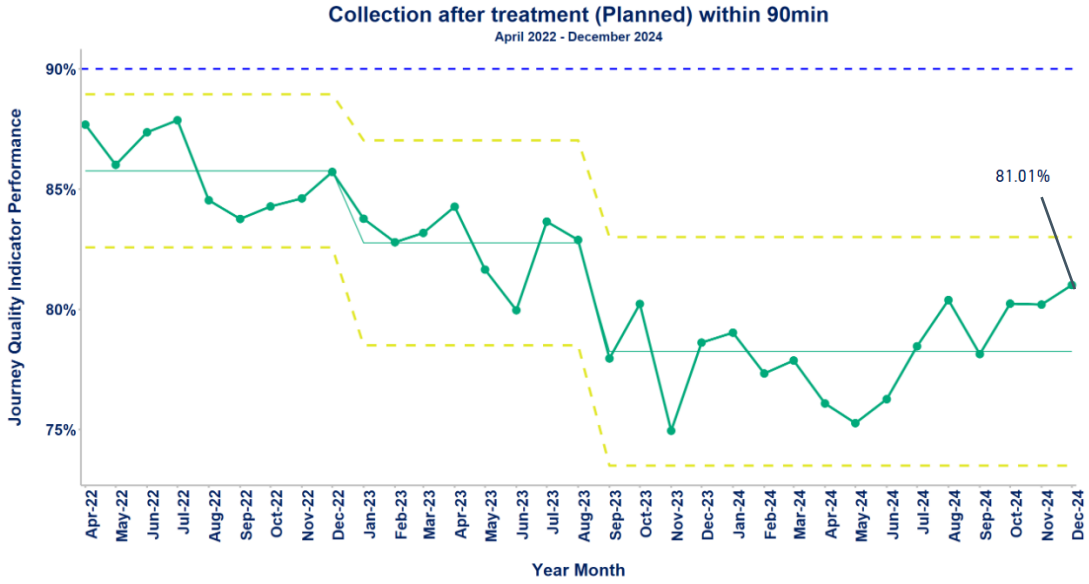
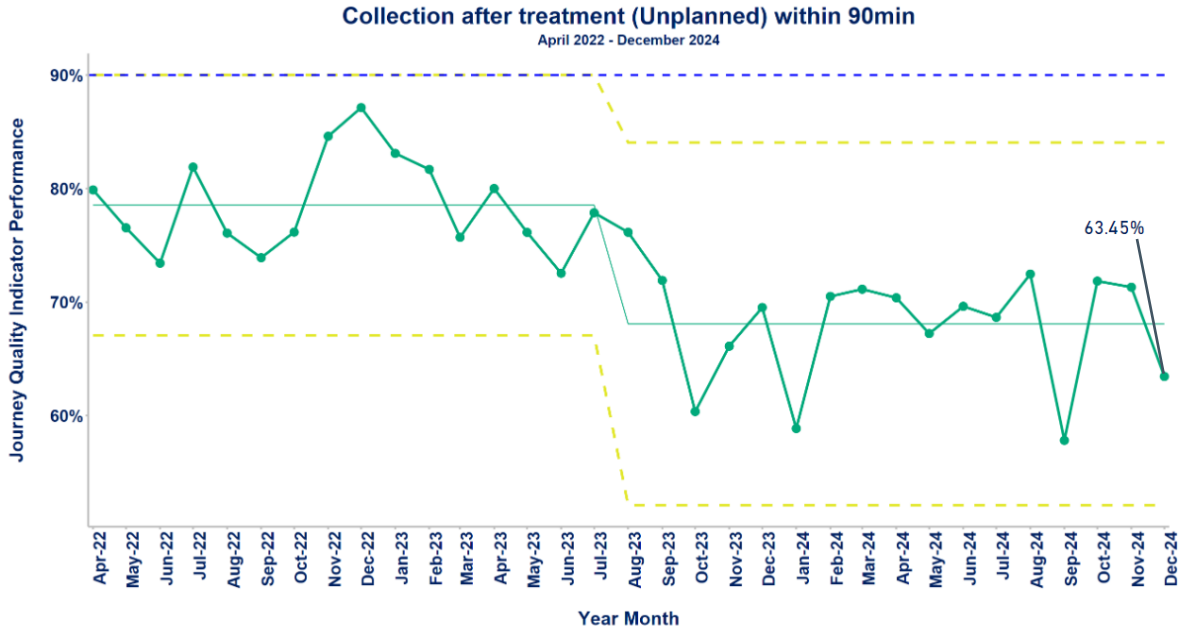


Figure O5.9


Collection after treatment (Unplanned) within 90min
April 2022 - December 2024
Journey Quality Indicator Performance
90%
80%
70%
60%
63.45%
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Year Month

Finance

F1 – FINANCIAL SCORE

Figure F1.1

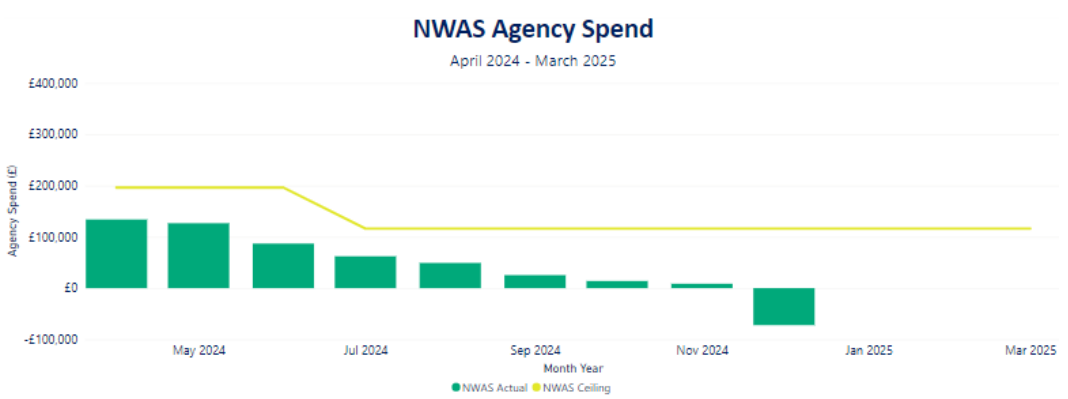


Figure F1.2

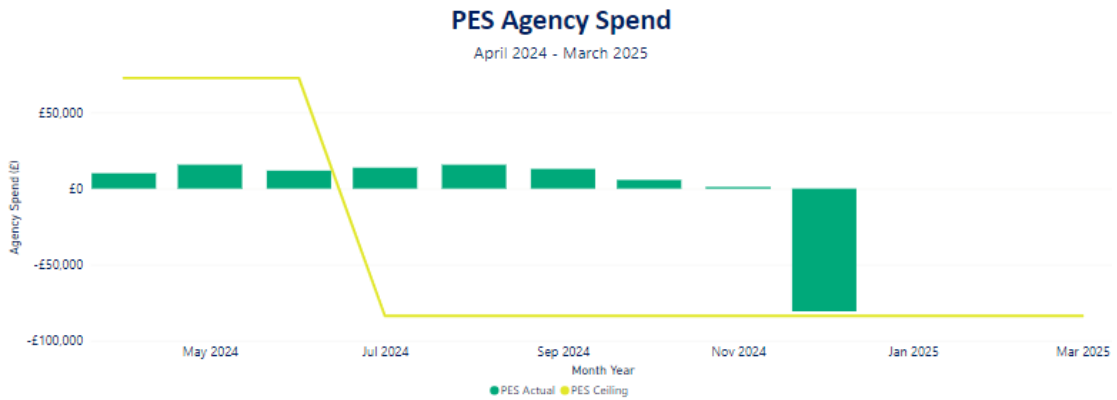


Figure F1.3

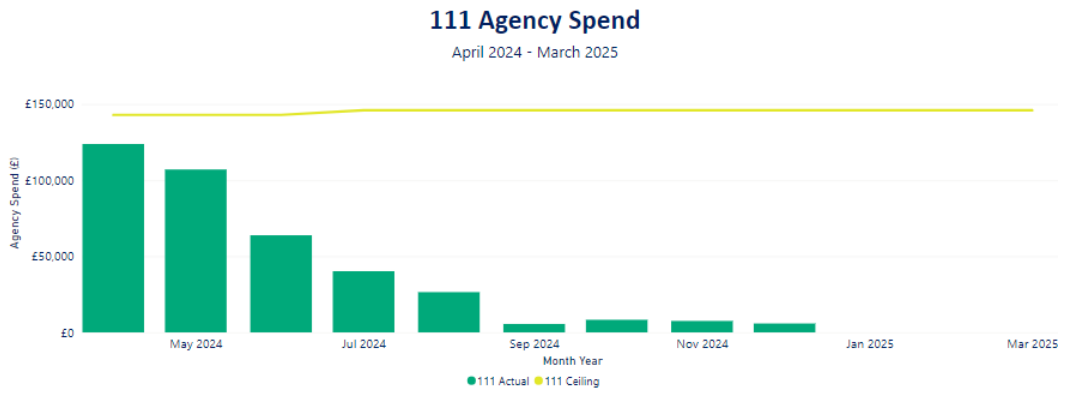


Figure F1.4

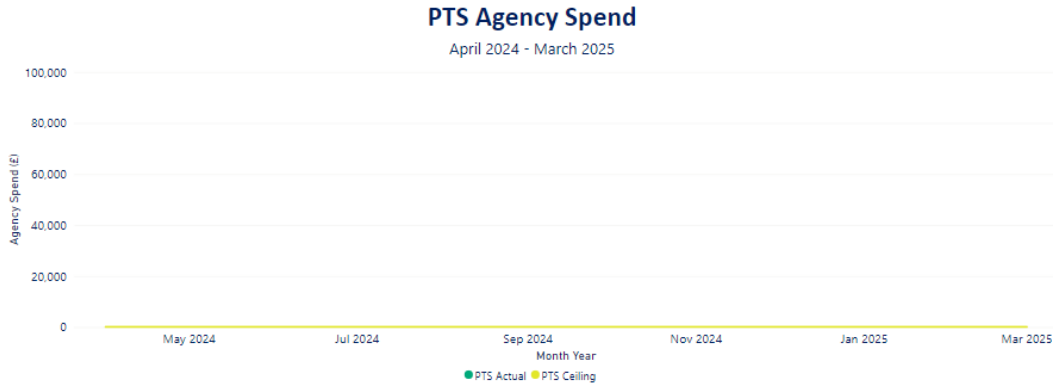
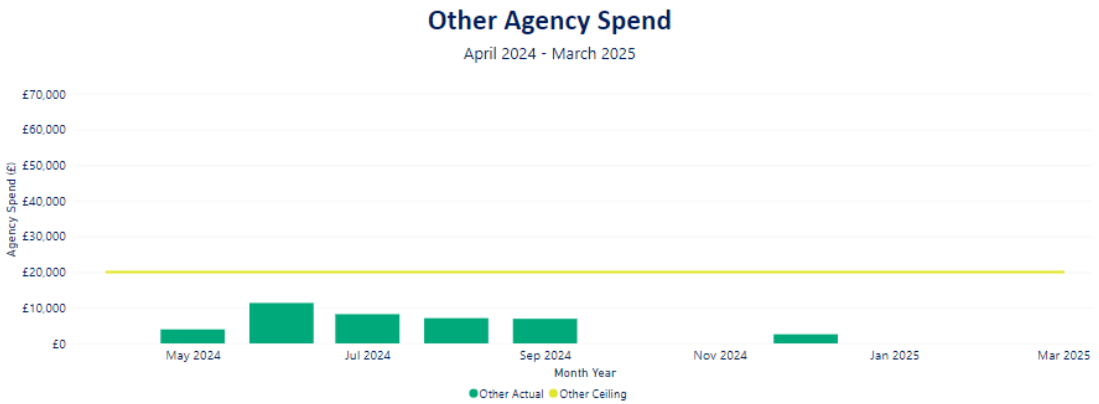


Figure F1.5


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

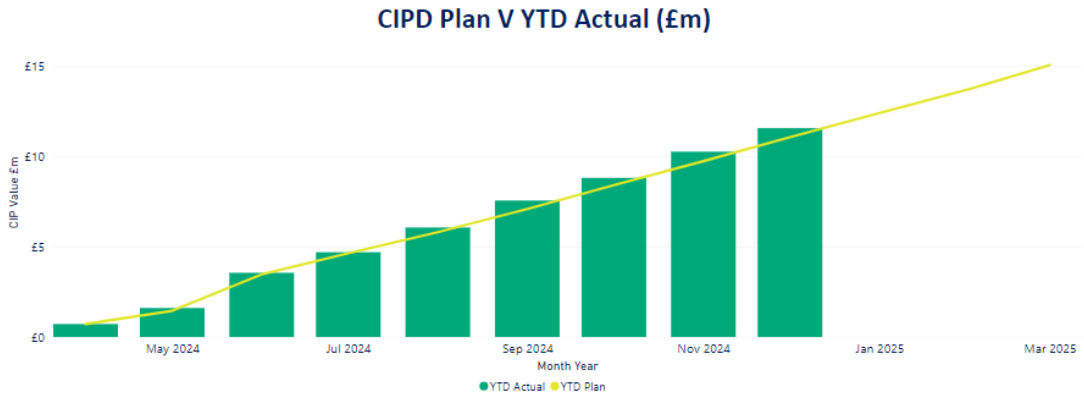

CIPD Plan V YTD Actual (£m)
£15
£10
£5
£0
CIP Value £m
May 2024
Jul 2024
Sep 2024
Nov 2024
Jan 2025
Mar 2025
Month Year
YTD Actual
YTD Plan

Figure F1.7

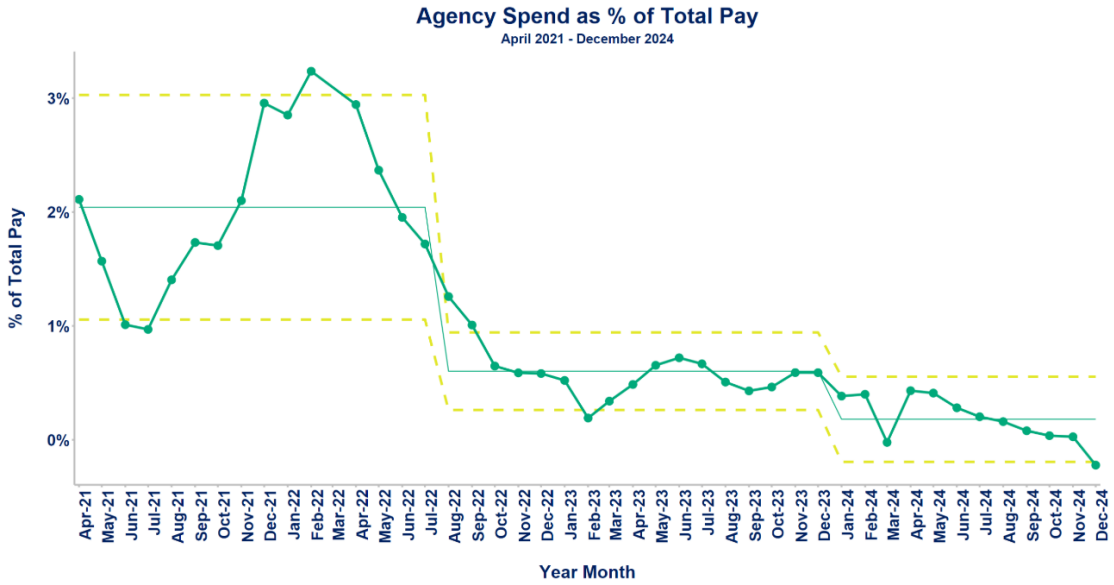


Figure F1.8

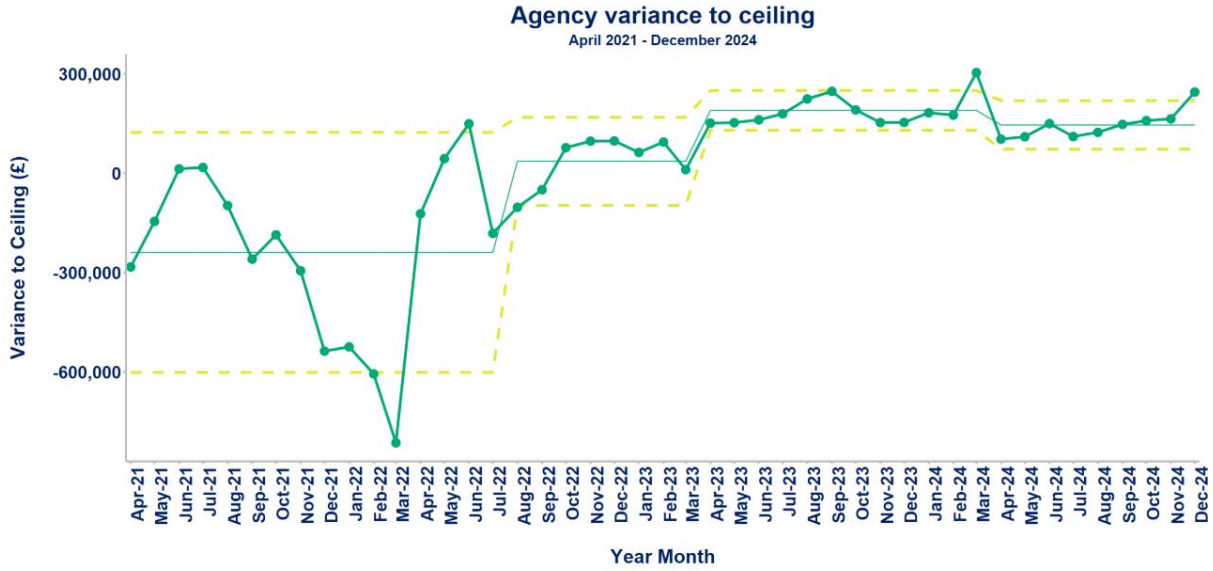
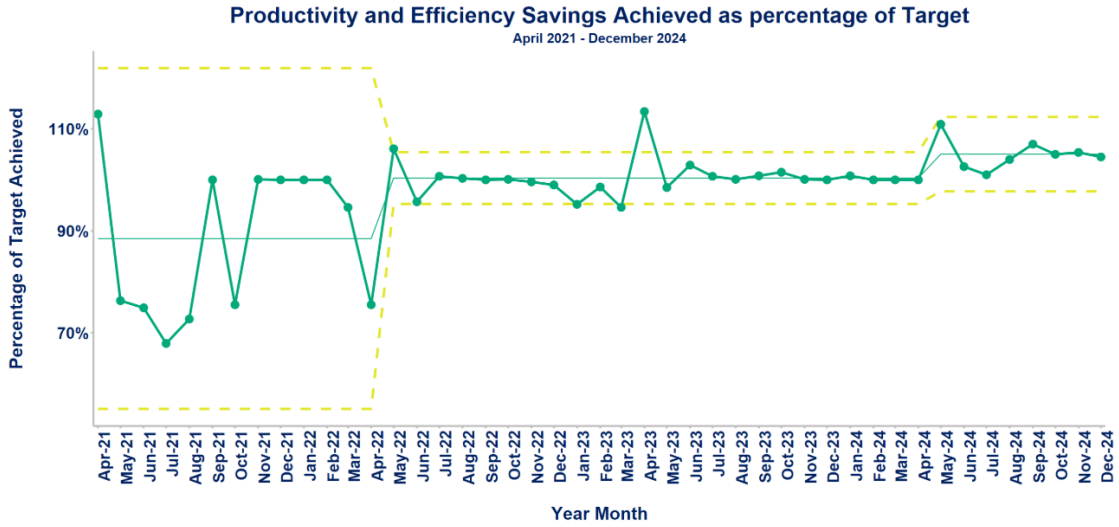


Figure F1.9



Organisational Health

OH1 STAFF SICKNESS

Figure OH1.1

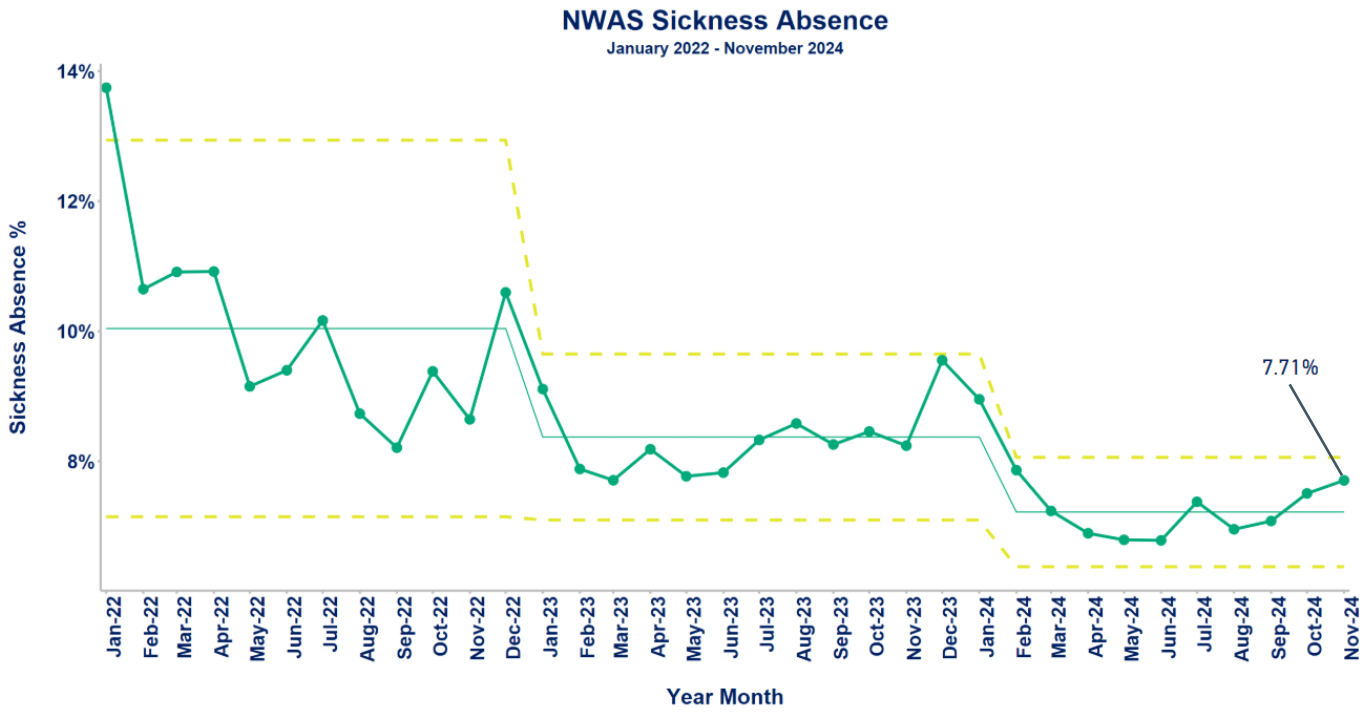


Table OH1.1

Month	NWAS	Amb. National Average
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%	6.80%
Aug 2024	6.95%	6.40%
Sep 2024	7.08%	6.50%
Oct 2024	7.50%	6.80%
Nov 2024	7.71%	

Figure OH1.2

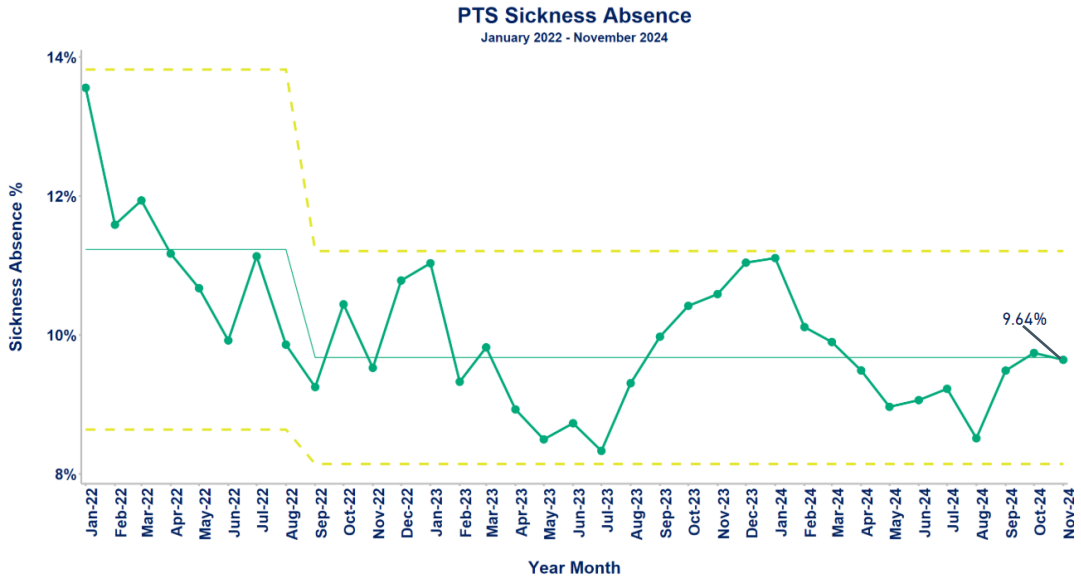


Figure OH1.3

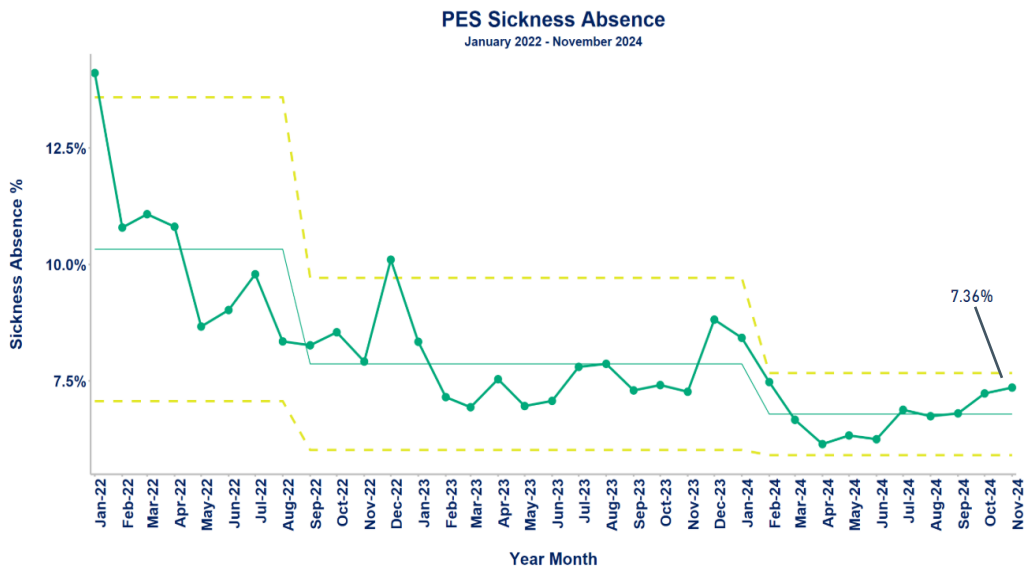


Figure OH1.4

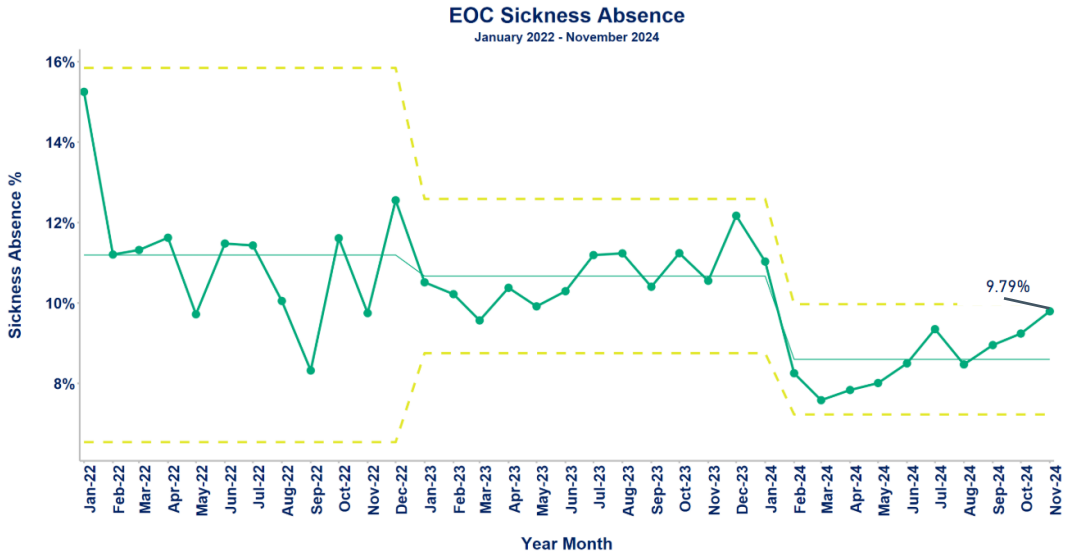
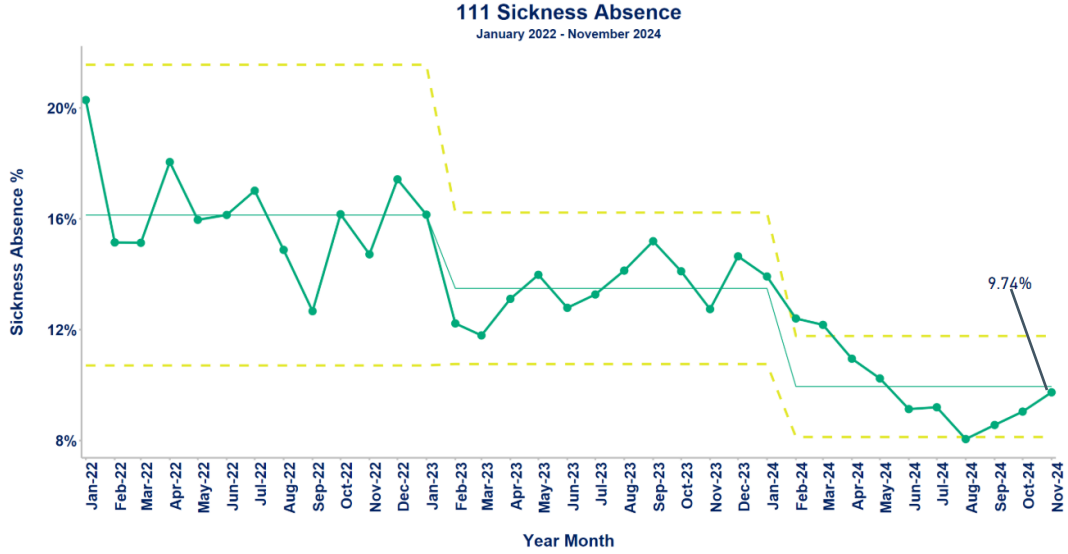


Figure OH1.5



OH2 STAFF TURNOVER

BAF SR05

Figure OH2.1

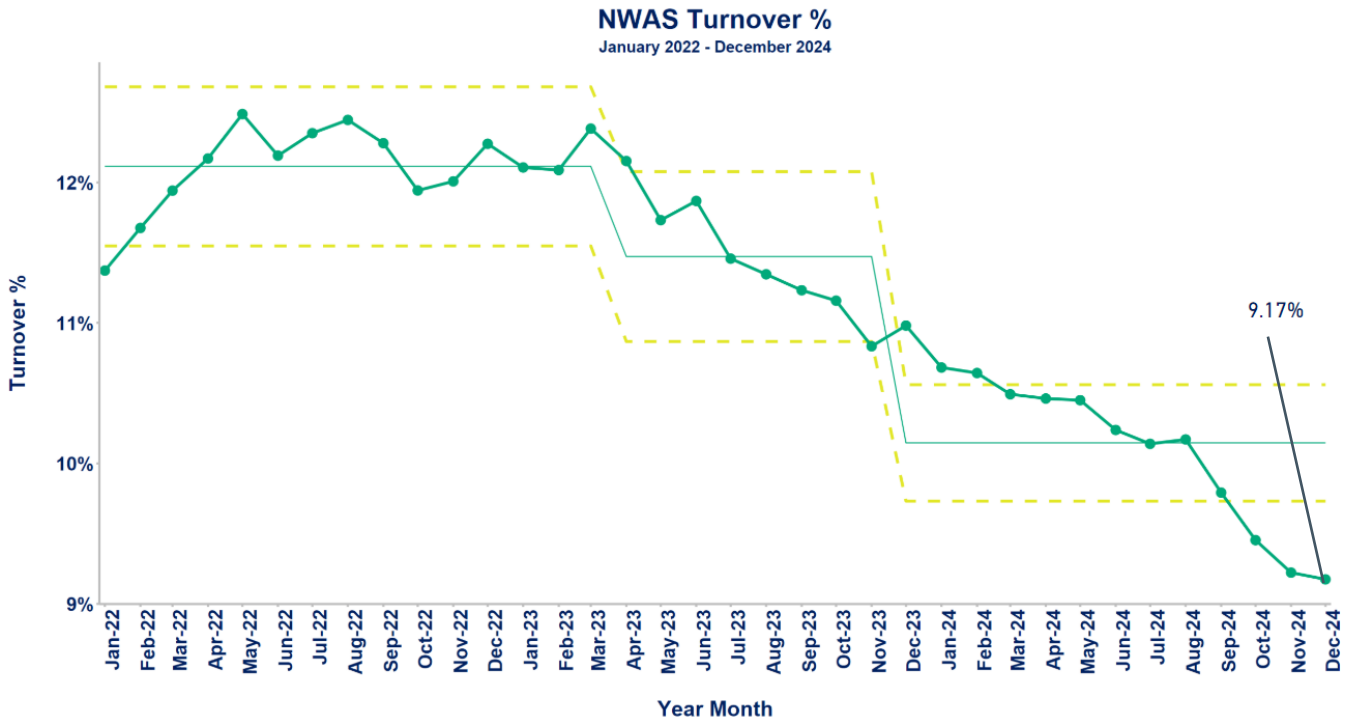


Table OH2.1

Month	NWAS	Amb. National Average
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%	9.24%
Jul 2024	10.14%	9.13%
Aug 2024	10.17%	9.13%
Sep 2024	9.79%	
Oct 2024	9.45%	
Nov 2024	9.22%	
Dec 2024	9.17%	

Figure OH2.2

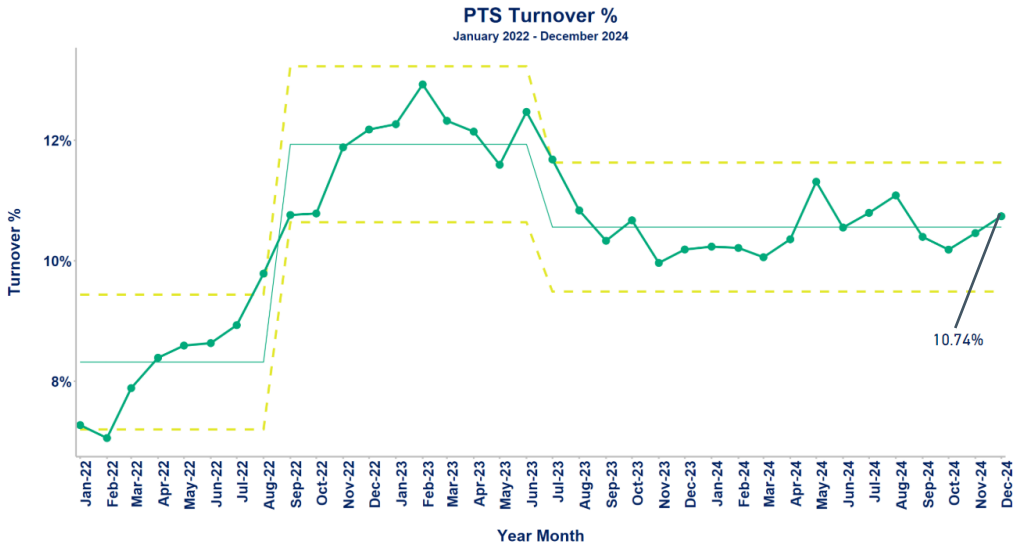


Figure OH2.3

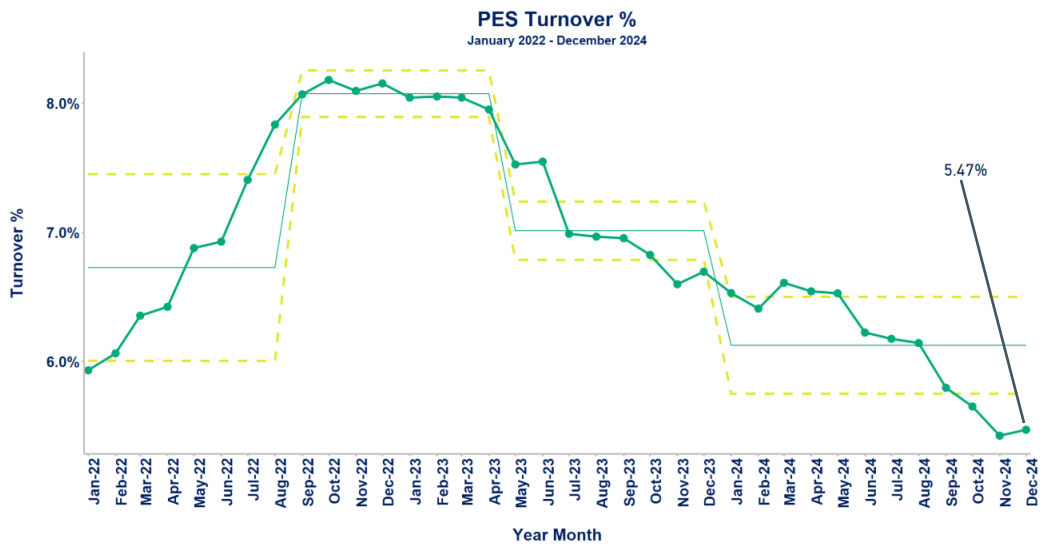


Figure OH2.4

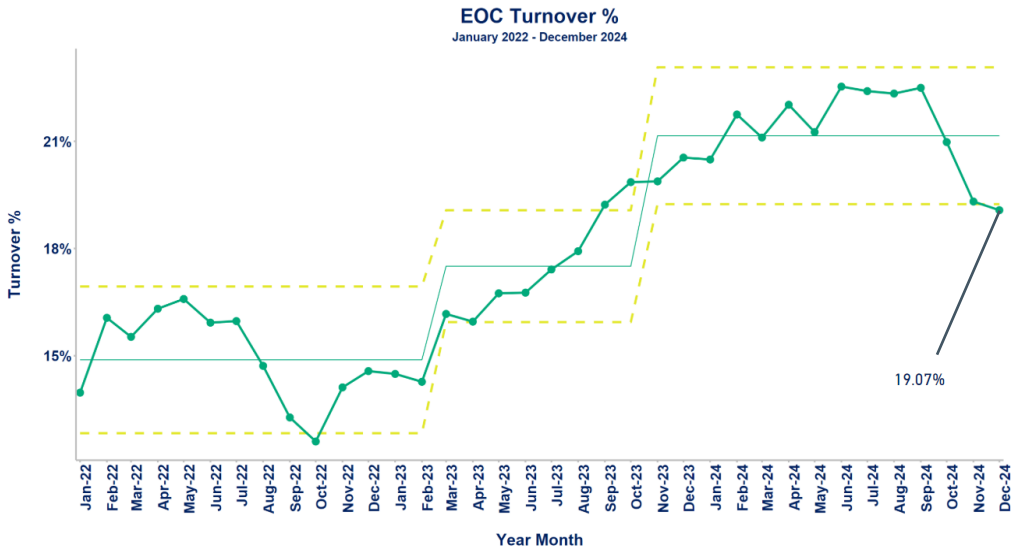
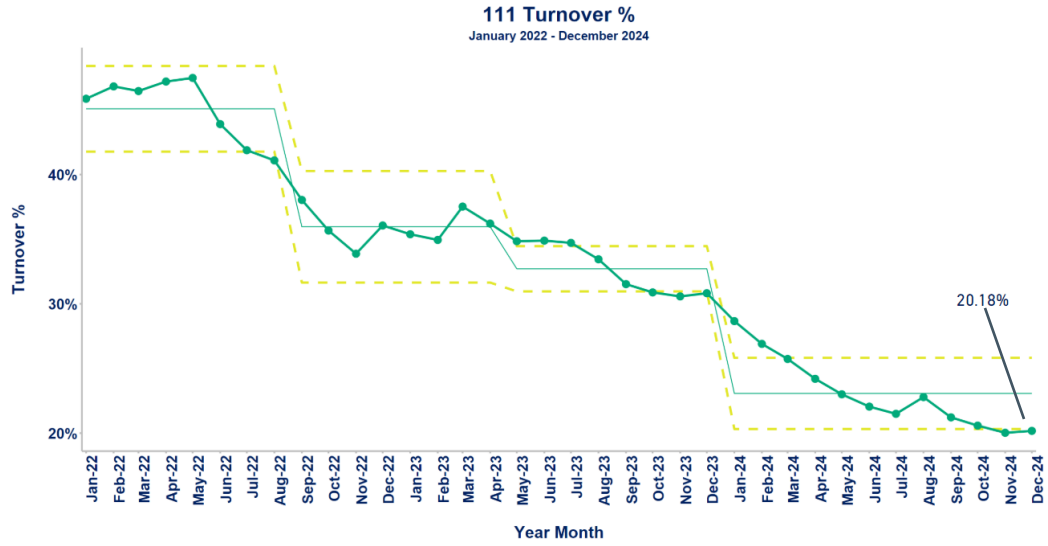


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1

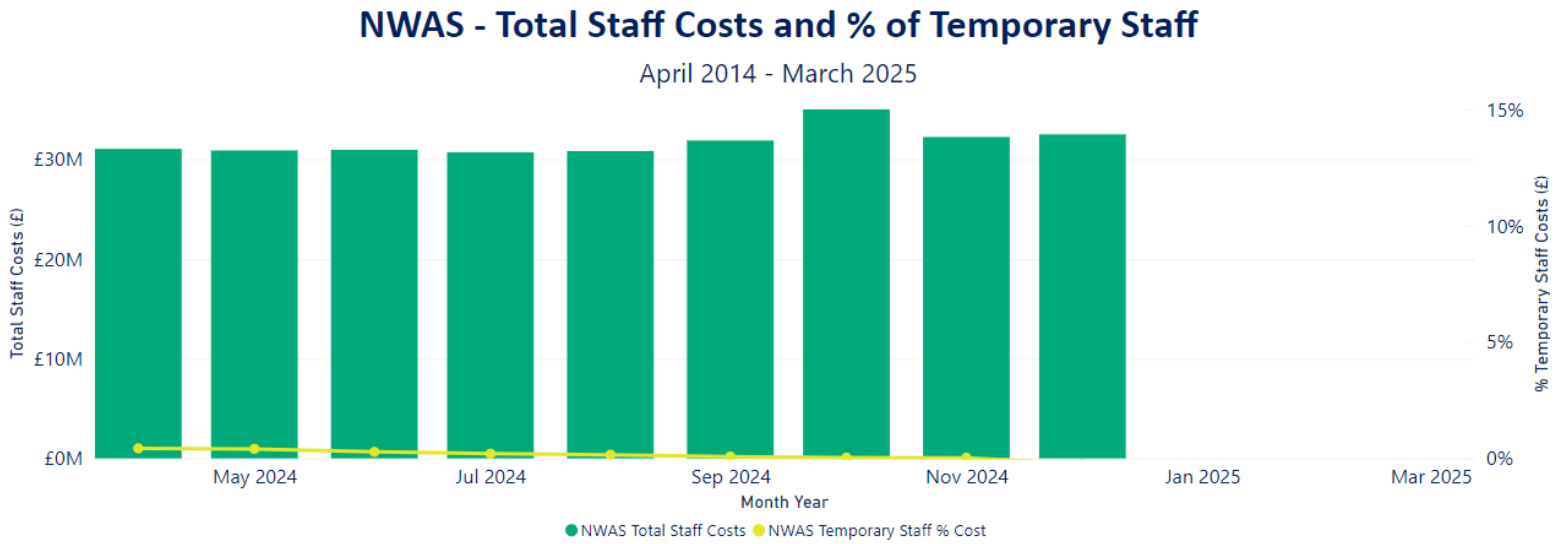


Table OH4.1

Month	NWAS Agency Staff Costs	NWAS Total Staff Costs	NWAS Temporary Staff % Cost
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%
Sep 2024	£25,394	£31,878,937	0.08%
Oct 2024	£14,004	£38,393,469	0.04%
Nov 2024	£8,611	£32,227,169	0.03%
Dec 2024	-£72,234	£32,498,419	-0.22%

Figure OH4.3

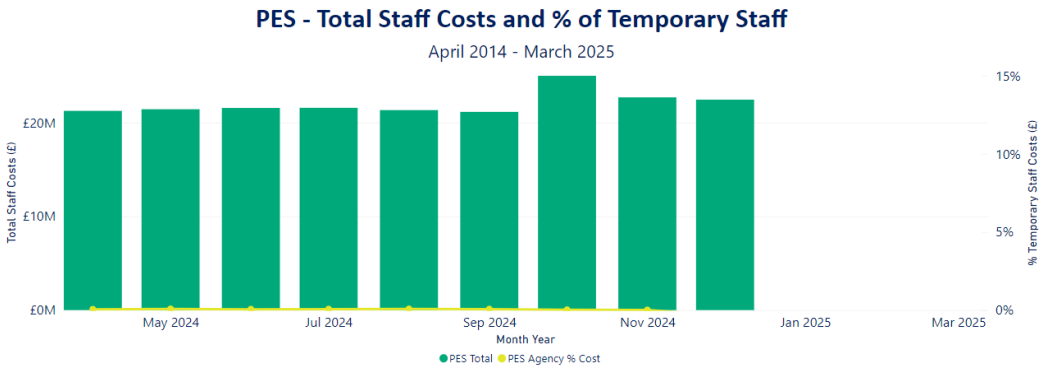


Figure OH4.2

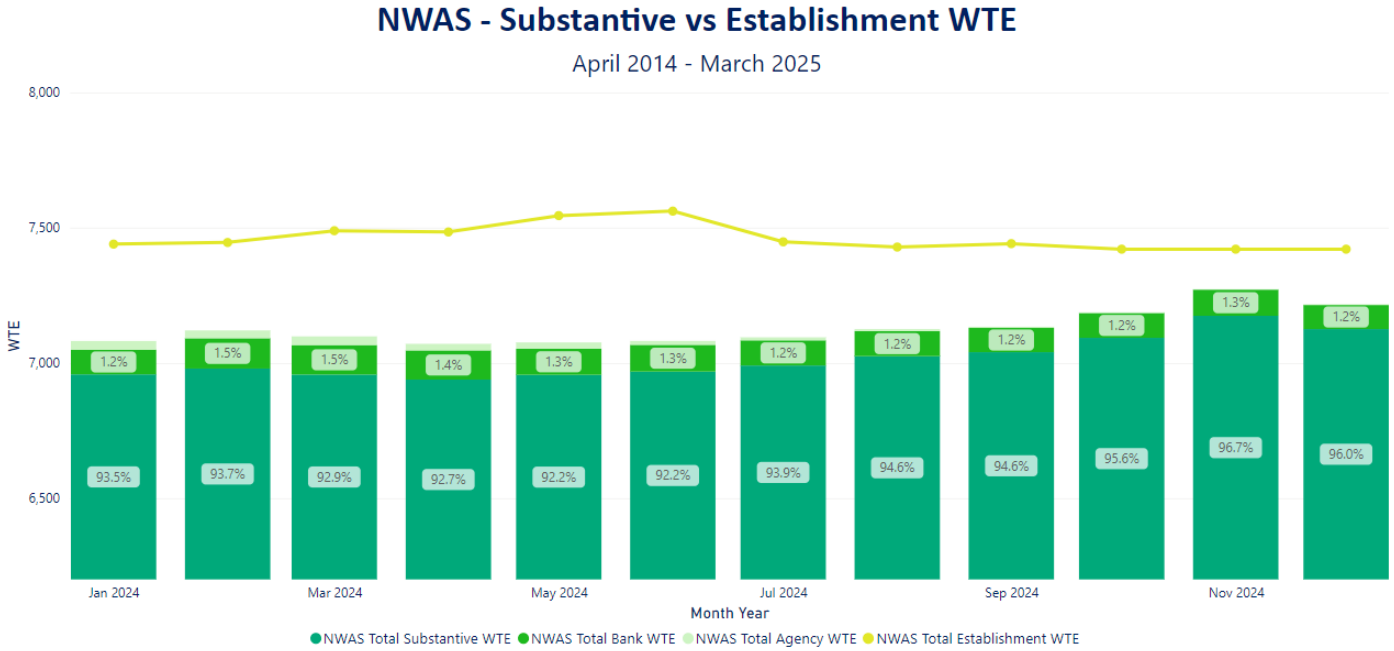


Figure OH4.4

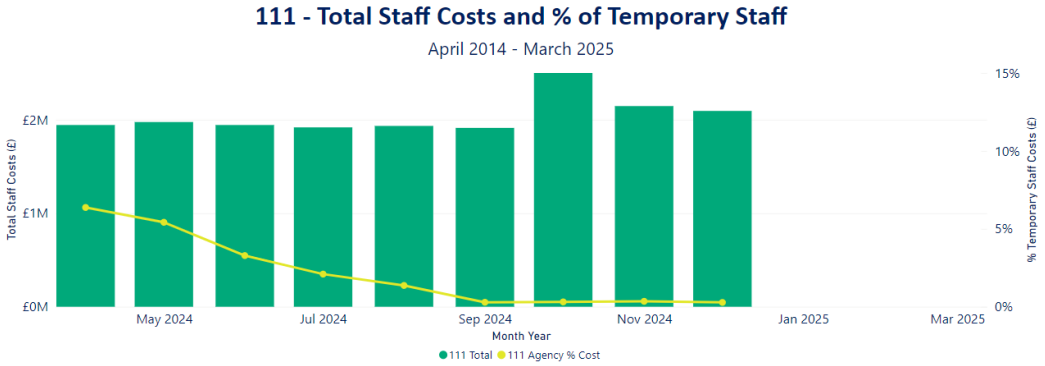
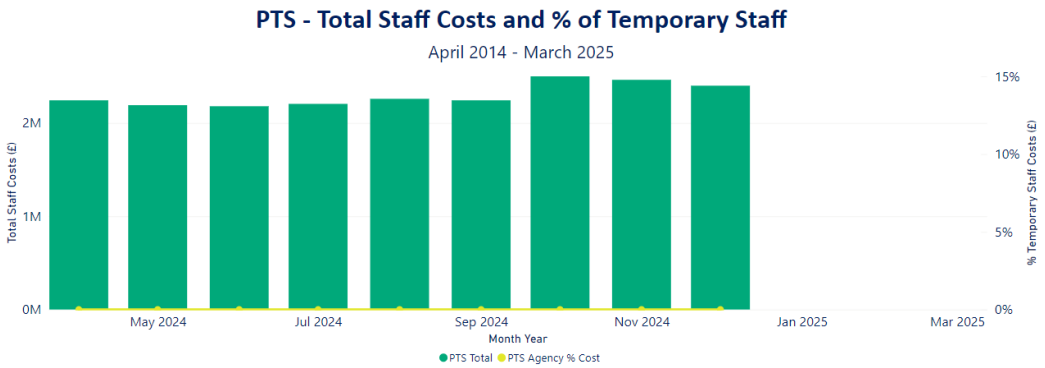


Figure OH4.5



OH5 VACANCY GAP

Figure OH5.1

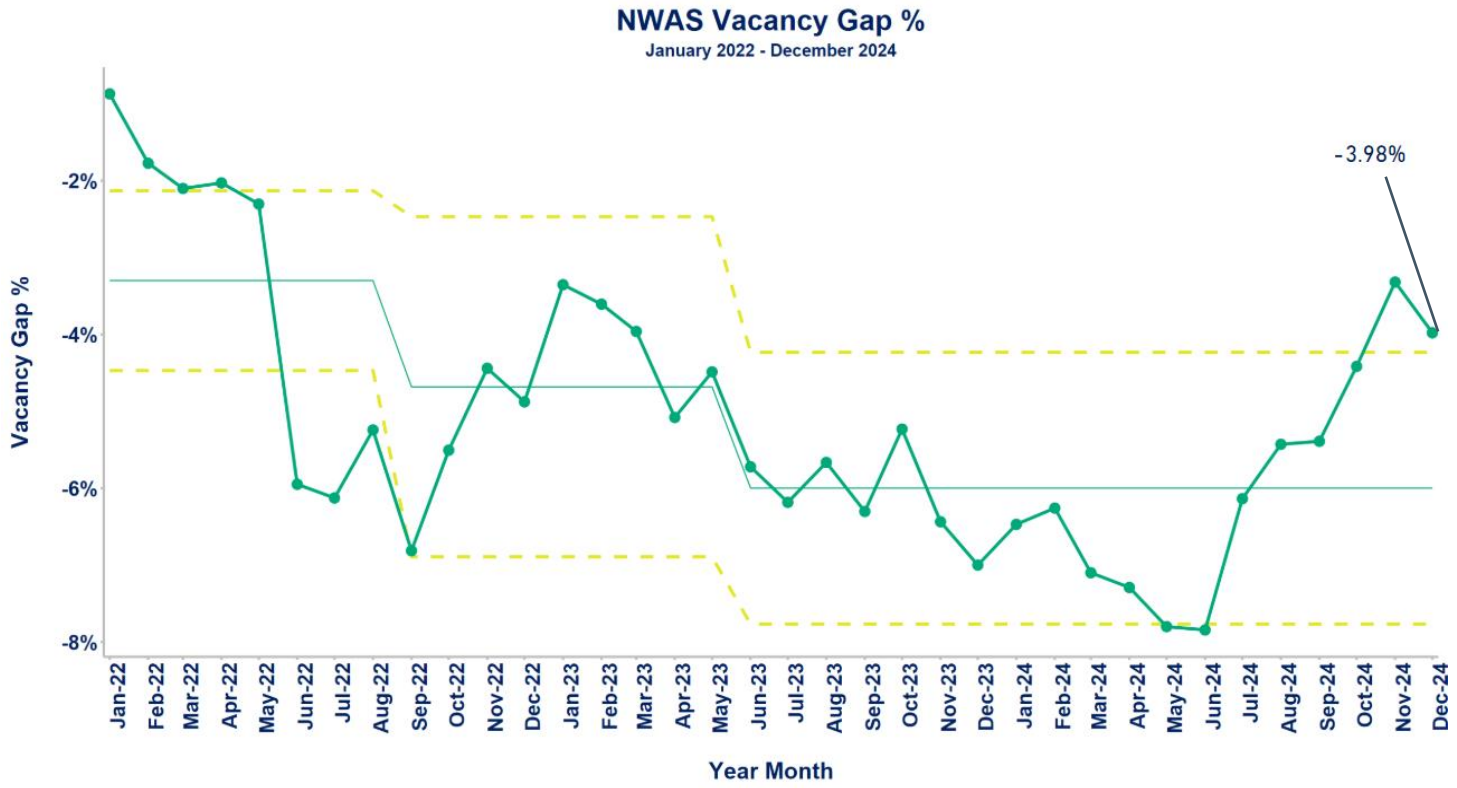


Table OH5.1

Month	NWAS
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%
Aug 2024	-5.43%
Sep 2024	-5.39%
Oct 2024	-4.42%
Nov 2024	-3.32%
Dec 2024	-3.98%

Figure OH5.2

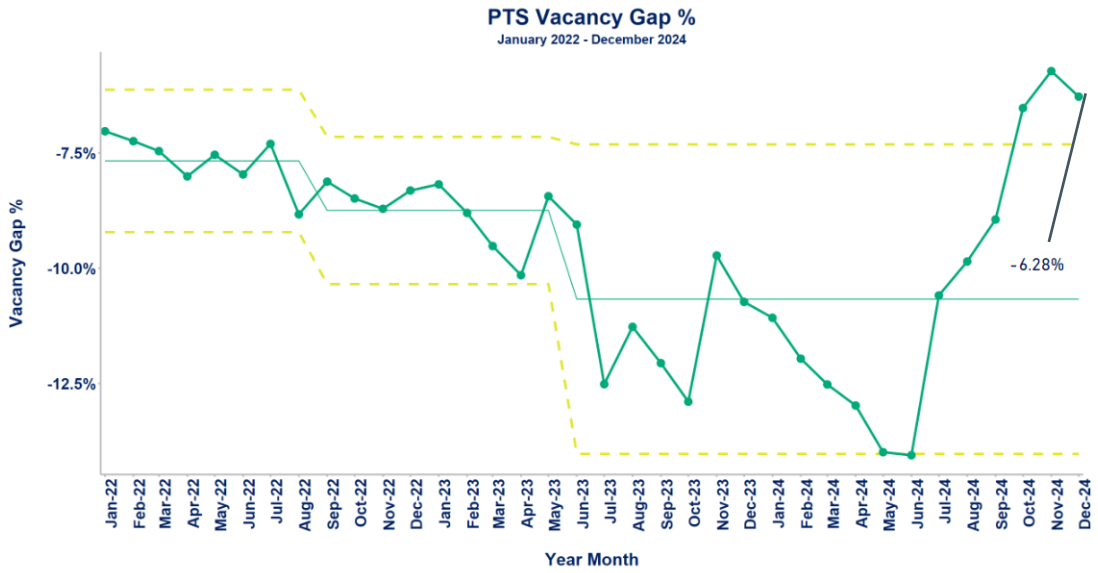


Figure OH5.3

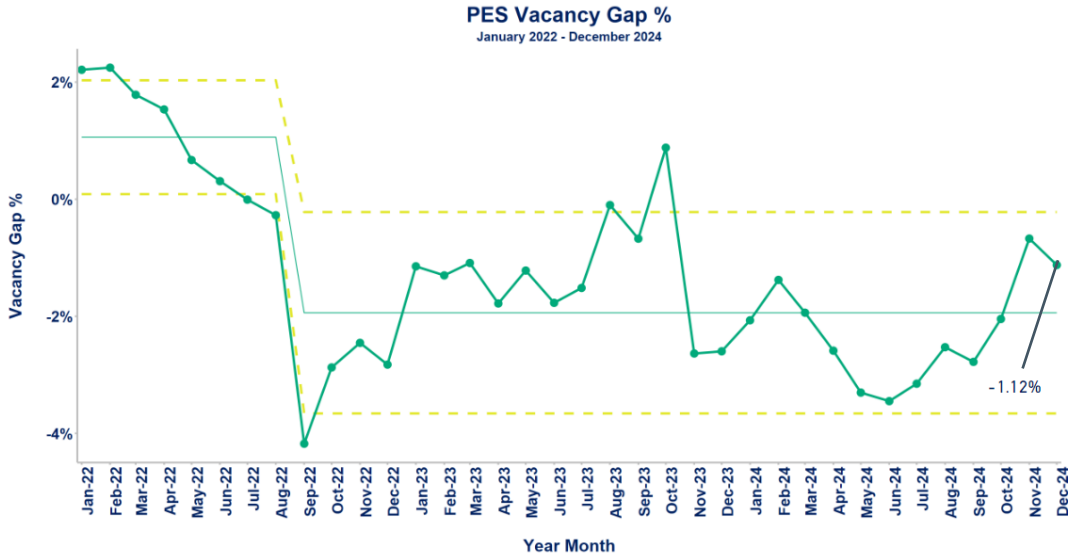


Figure OH5.4

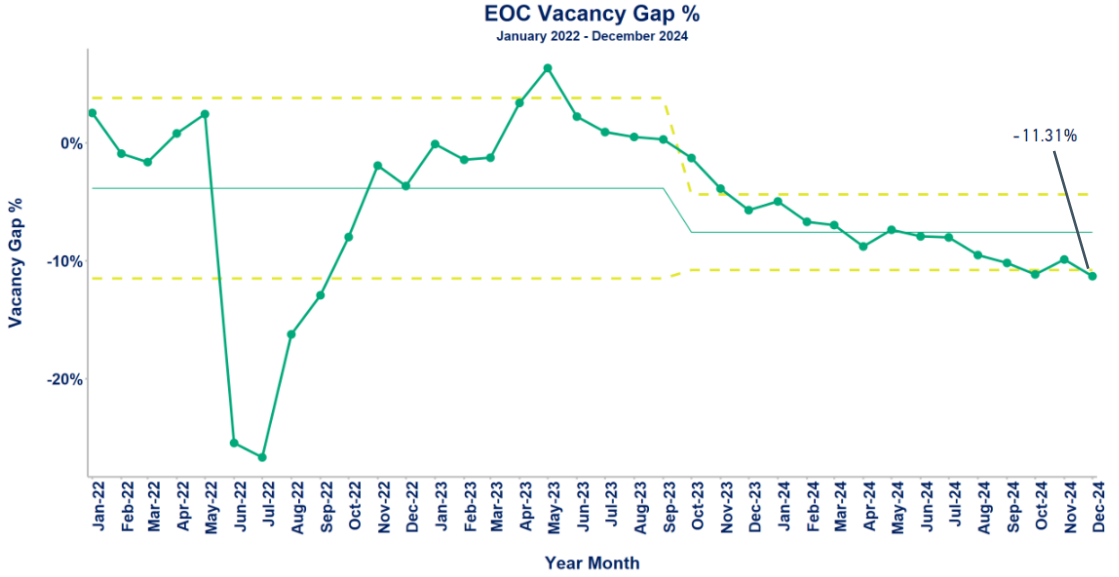
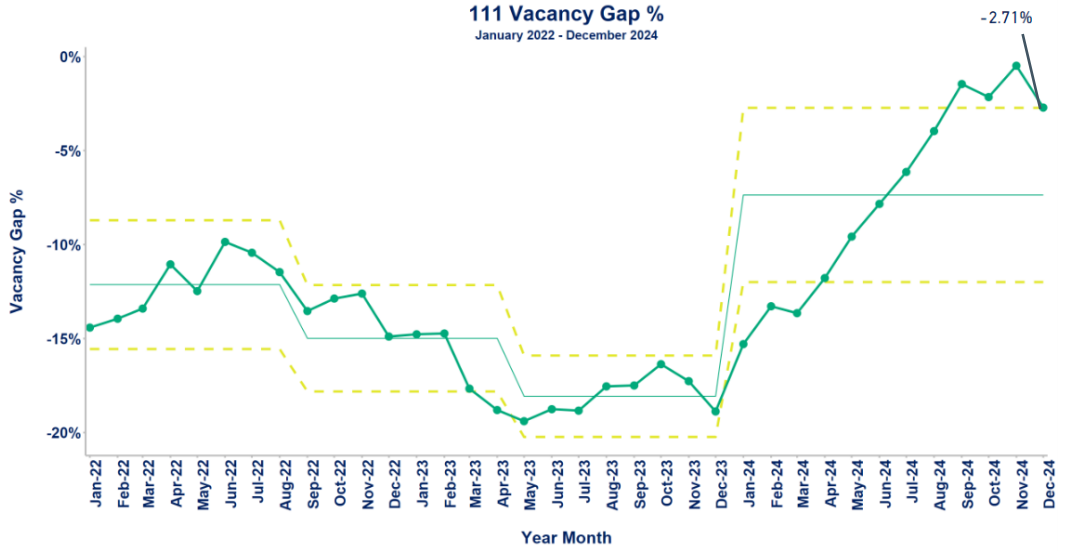


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

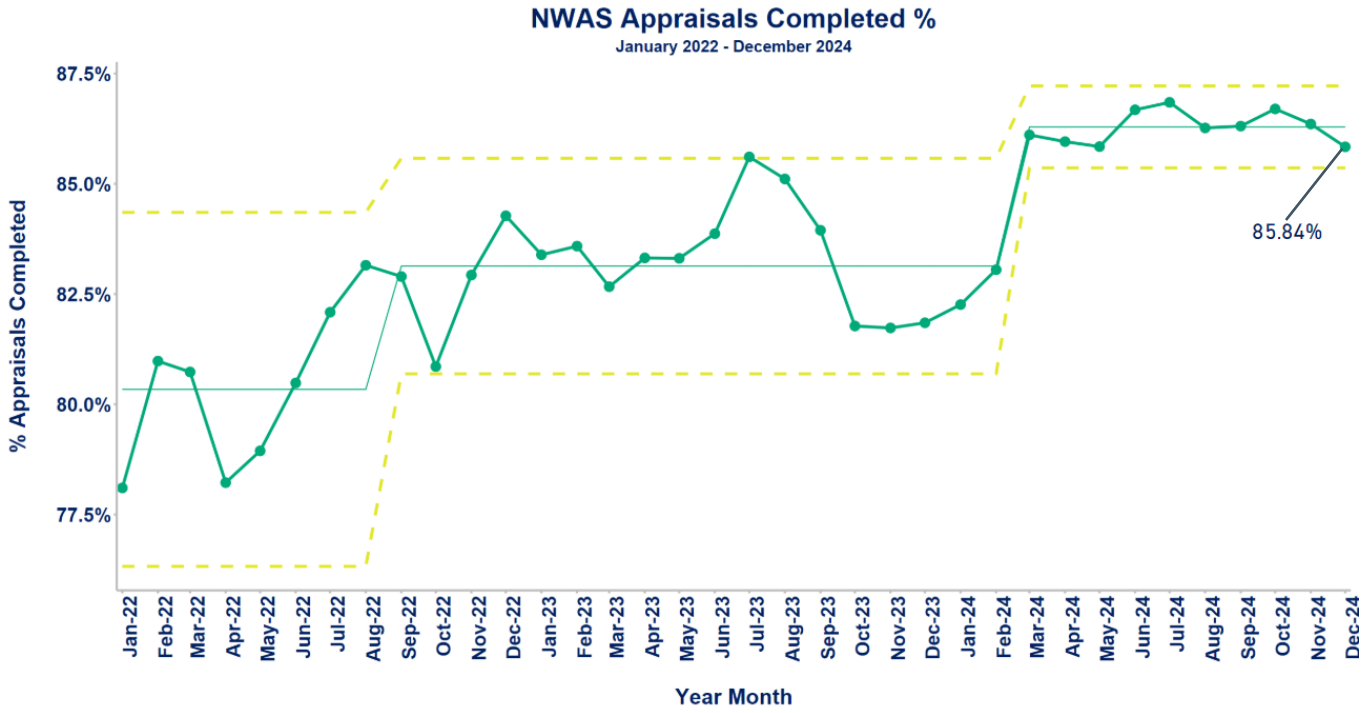


Table OH6.1

Month	NWAS
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%
Aug 2024	86.27%
Sep 2024	86.31%
Oct 2024	86.70%
Nov 2024	86.35%
Dec 2024	85.84%

Figure OH6.2

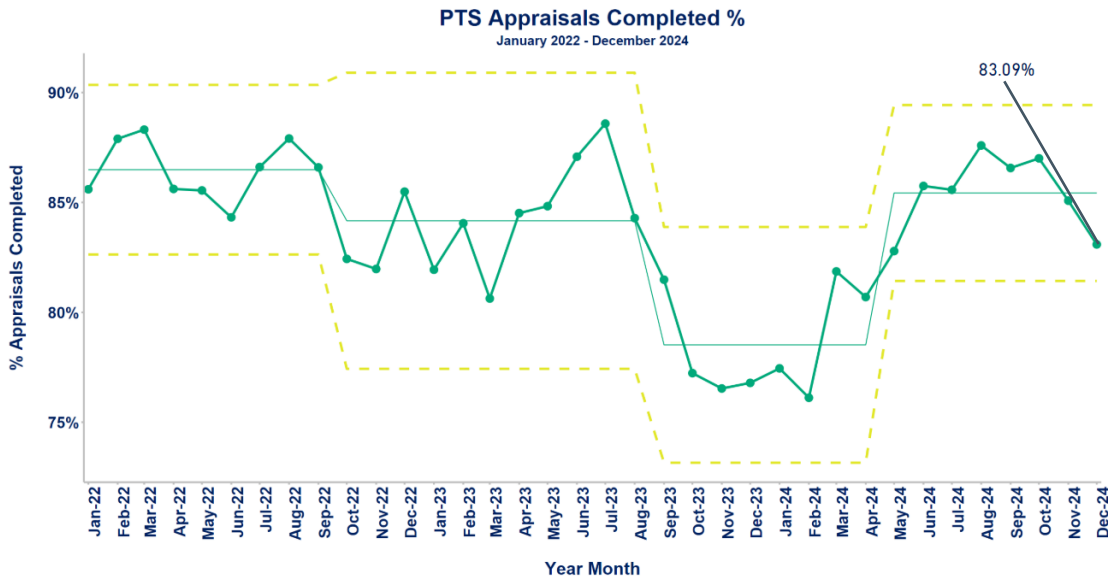


Figure OH6.3

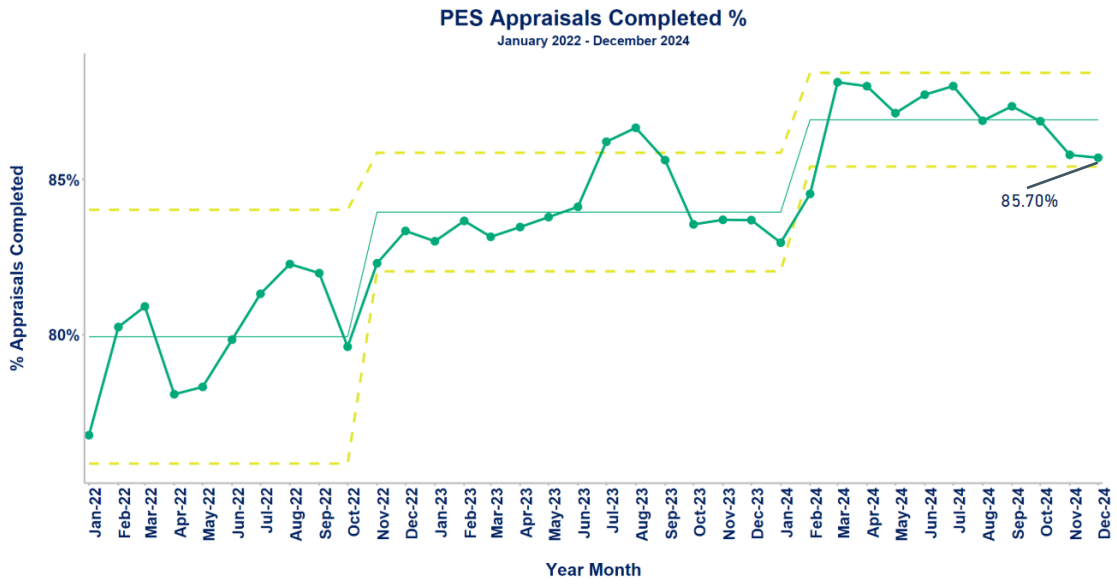


Figure OH6.4

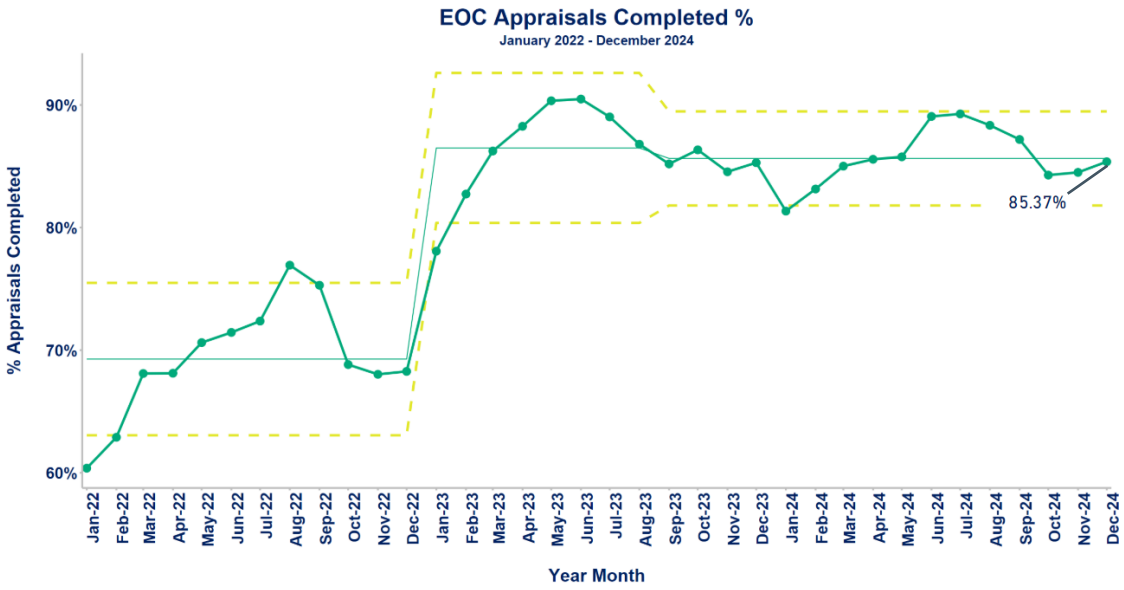
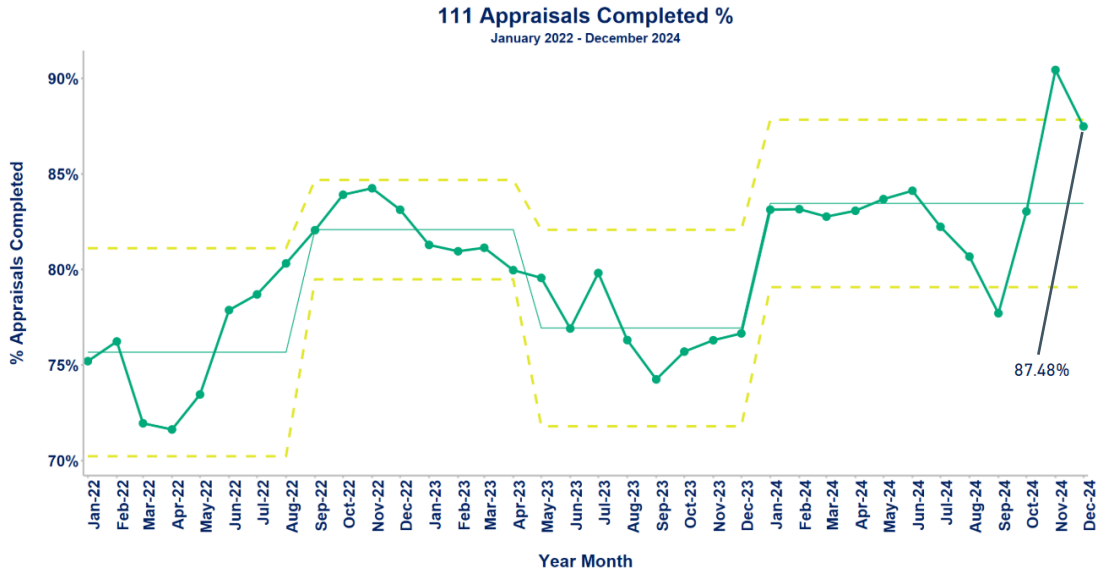


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

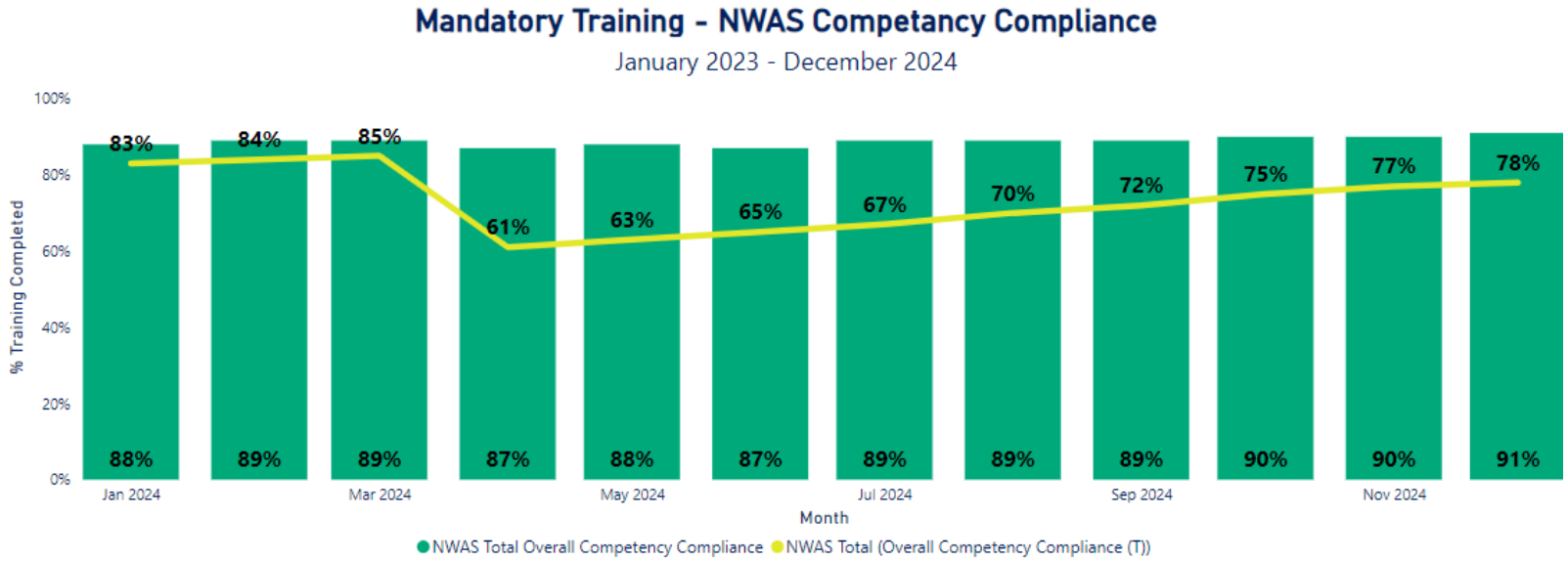


Figure OH7.2

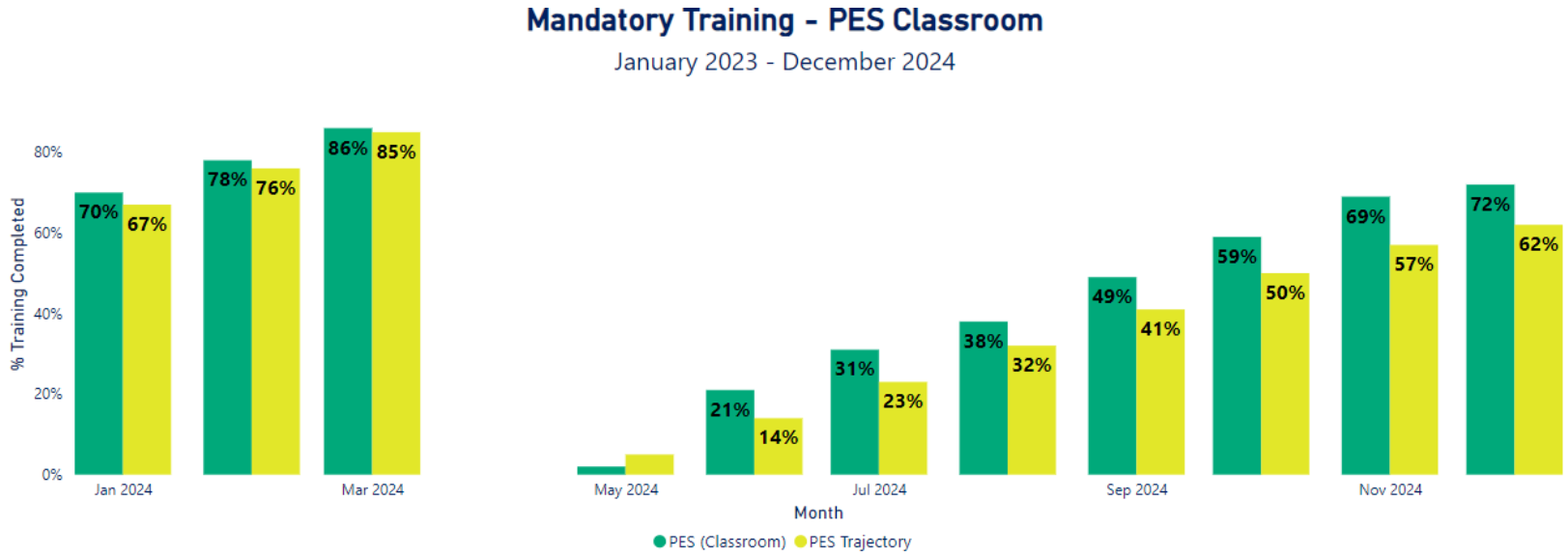


Figure OH7.3

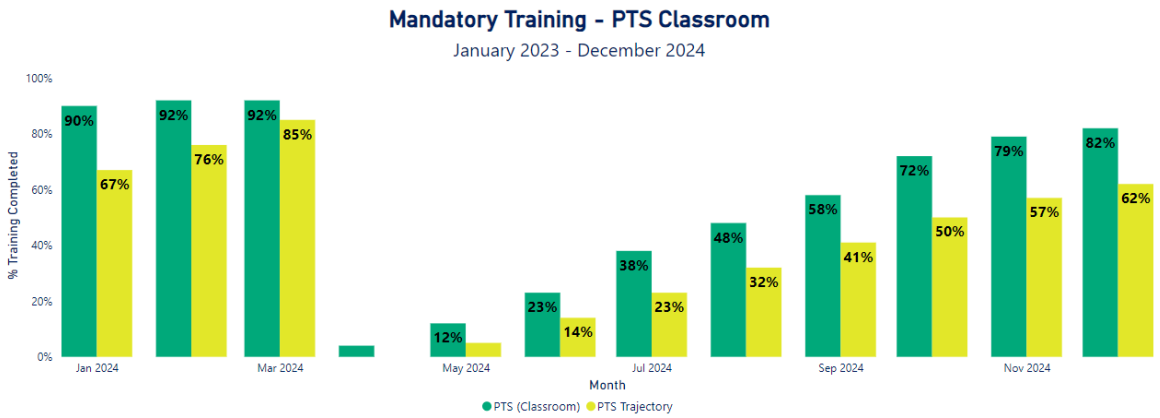
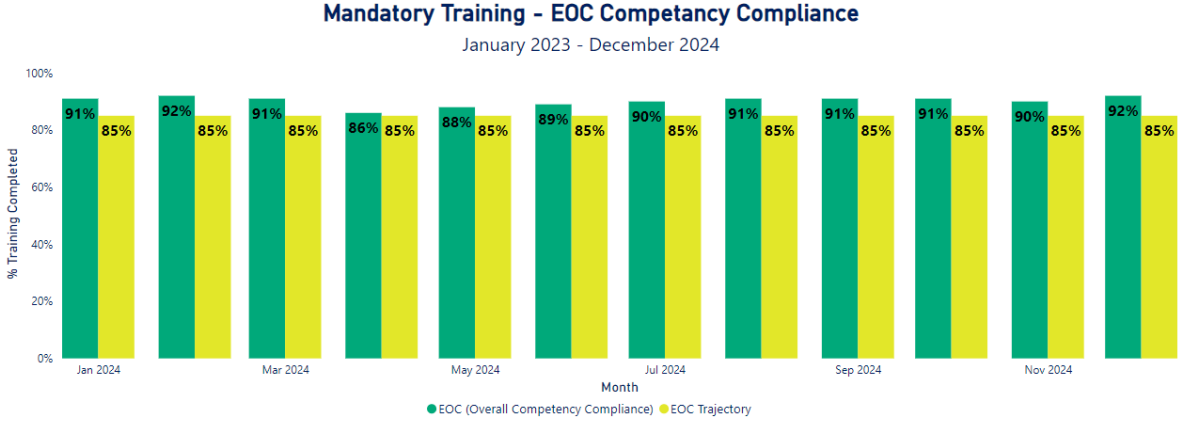


Figure OH7.4



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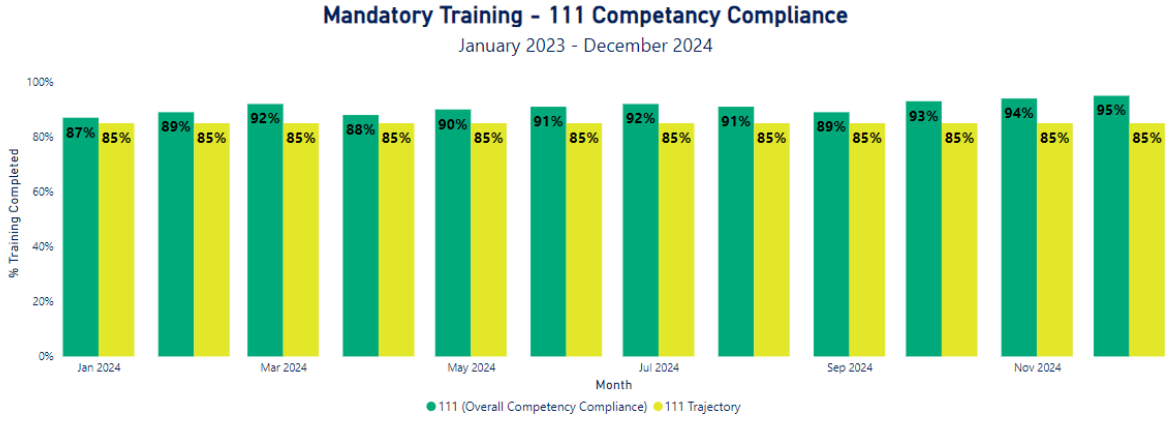
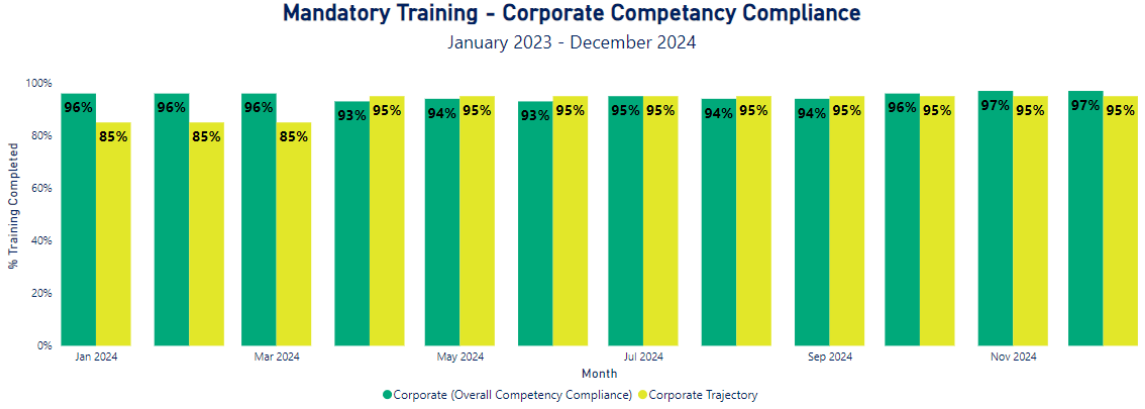


Figure OH7.6



OH8 CASE MANAGEMENT

Figure OH8.1

Board Reportable Events relating to Employee Relations as 9th January 2025

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	219.00	5.3	14.20
CAM PES	26.00	1.9	78.00	5.8	12.25
CAL PES	18.00	1.4	77.00	5.9	14.14
GM PES	25.00	1.7	60.00	4.1	15.68
Operations ~ EOC	15.00	1.3	51.00	4.4	15.81
Operations ~ 111	12.00	1.7	88.00	12.3	5.70
Operations ~ PTS	20.00	2.0	87.00	8.6	10.46
Operations ~ Resilience	0.00	0.0	2.00	1.3	7.86
Corporate	9.00	2.0	34.00	5.2	10.26
Other	3.00		0.00		
NWAS Summary	**130.00**	**1.7**	**481.00**	**6.1**	**11.83**

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	20	60	11.97
Disciplinary	67	145	22.22
Fast Track	1	36	10.9
Fact Finding	27	172	5.61
Grievance	16	104	7.58
Case Summary	**130**	**481**	**11.83**

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	10	6	3	1
Disciplinary	28	30	6	3
Fact Finding	20	6	1	0
Grievance	12	2	2	0
Case Total	**70**	**44**	**12**	**4**

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

Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	85
Failure to follow reasonable management instructions/procedures	40
Poor patient care	18
Sexual misconduct	17
Breach of social media policy	16
NWAS Summary	**176**

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

Case Dismissals December 2024

Service Line	Case Sub Type	Information Category
C&L Control PES	Sickness	
PES GM	Sickness	Back problems
PTS Management	Sickness	Anxiety/ stress/ depression/other psychiatric illnesses
PES GM	Sickness	Other musculoskeletal problems (exclude back - inc neck)
PES GM	Gross misconduct	Police Investigation
Cumbria PTS	Gross misconduct	Police Investigation
PES GM	Gross misconduct	Withholding live/spent convictions
Control West PTS	Gross misconduct	Conviction of a Criminal Offence
111 Area		

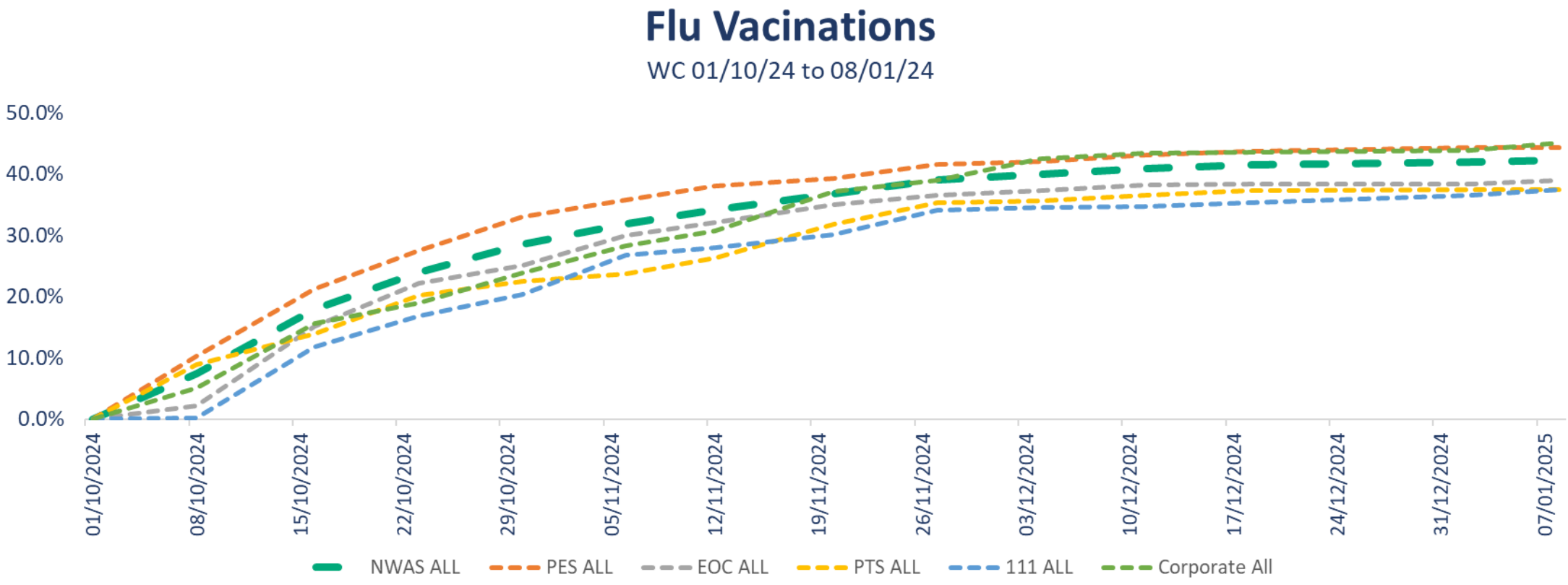
New Litigation cases September 2024

Service Line	Case Type	Case Sub Type	Information Category	Received Date
PES C&M	Litigation	Failure to comply with stati	N/A	06/12/2024

Suspended	Alternate Duties
15	0

OH9 Flu Vaccination

Figure OH9.1



*Week Commencing is a Tuesday for Flu Vaccinations

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
SUBJECT	Patient Safety Incident Response Framework (PSIRF) – Proposed Refresh of Local Priorities
PRESENTED BY	Maxine Power – Executive Director of Quality, Innovation and Improvement
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors are asked to: • Review and approve the proposed local priorities and note subsequent actions required to develop PSIRF plan
EXECUTIVE SUMMARY	On 1st October 2023, North West Ambulance Service transitioned from the Serious Incident Framework (SIF) to Patient Safety Incident Response Framework (PSIRF). PSIRF is best considered as a learning and improvement framework, with an emphasis placed on the culture and systems that support continuous improvement in patient safety. Under PSIRF, each organisation internally determines the types of events that will require exploration based upon risks, trends and priorities for highest impact. The Patient Safety Team have collated almost 3 years of triangulated data (2024/2025 is a partial year due to timing of review) which considers insights such as patient safety events, complaints, inquests and claims. In addition to the collation of data, we have reviewed safety risks across the organisation and held a series of collaborative workshops with internal and external stakeholders to ensure we can gain context from our teams that deliver care, subject matter experts and the patient voice. The methodology used as part of this process can be seen in Appendix One. The proposal for our refreshed local priorities are: 1) Management of cardiac arrest to include: - Airway management

	-Medicines administration during advanced life support - Issues occurring during defibrillation (including equipment) -Cardiopulmonary resuscitation is not commenced where it is indicated to do so 2) Clinical assessment and treatment which is managed outside of JRCALC guidelines/policy during maternity care 3) Likely Harm relating to patient refusal where there is an absence of documented informed consent/refusal/mental capacity assessment There will also be consideration of areas of risk identified through the data, and mechanisms of informing improvement in these areas including delayed response/delayed hospital handover, moving & handling and management of ST elevation myocardial infarction through thematic review. Existing national priorities will not change currently.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 15 January 2025
	Outcome	Approved

1. BACKGROUND

1.1

Patient Safety Incident Response Framework (PSIRF) is a nationally mandated framework (replacing the Serious Incident Framework) which sets out the approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning. The four key aims of PSIRF are:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement

North West Ambulance Service went live with PSIRF on the 1st October 2023.

2. PREVIOUS PRIORITIES

2.1

Prior to go live in October 2023 the organisation agreed the following three local priorities:

- Prevention of deterioration to critically unwell patients
- Errors in 999 and 111 call handling which led to a delay with contributing harm
- Face to face or telephone assessment which is managed down an incorrect pathway contributing to harm.

From October 2023 to October 2024 the organisation has undertaken twenty six Patient Safety Incident Investigations, with a further three relating to system pressures which were integrated into thematic reviews. Forty five After action reviews were undertaken along with other Level two learning responses both internally and held jointly with system partners.

2.2 Learning generated by previous learning responses has fed into local improvement plans and is ongoing. These improvement plans will be monitored through both local and organisational governance routes for efficacy. Any new risk identified prior to the next review will be managed via risk registers and responded to as appropriate.

3. PROPOSED LOCAL PRIORITIES

3.1

Following a review of organisational data, along with consultation with a range of stakeholders (methodology can be seen in Appendix One), Table 3 describes the proposed local priorities and the anticipated response/improvement route.

3.2

Table One: Proposed Locally Defined Priorities

Event	Learning Response	Anticipated Improvement Route
1) Management of cardiac arrest to include: - Airway management -Medicines administration during advanced life support - Issues occurring during defibrillation (including equipment) -Cardiopulmonary resuscitation is not commenced where it is indicated to do so	PSII – we will commit to a minimum of 1 per year After Action Review SWARM Huddle Multi-disciplinary team meeting (MDT) Thematic Analysis Appreciative Inquiry	Local and organisational safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
2) Clinical assessment and treatment which is managed outside of JRCALC guidelines/policy during maternity care	PSII - we will commit to a minimum of 1 per year After Action Review SWARM Huddle Multi-disciplinary team meeting (MDT) Thematic Analysis Appreciative Inquiry	Local and organisational safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
3) Likely Harm relating to patient refusal where there is an absence of documented informed consent/refusal/mental capacity assessment	PSII– we will commit to a minimum of 1 per year After Action Review SWARM Huddle Multi-disciplinary team meeting (MDT) Thematic Analysis Appreciative Inquiry	Local and organisational safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group

3.3

Table Two: IP&C Incidents for Consideration Under The Framework

Event	Learning Response	Anticipated Improvement Route
Lapse in policy or procedure resulting in	PSII After Action Review SWARM Huddle	Local and organisational safety improvement plans which will feed into Quality

High Consequence Infectious Disease (HCID) Lapse in policy or procedure resulting in significant outbreak which impedes trust ability to provide safe service	Multi-disciplinary team meeting (MDT) Thematic Analysis Appreciative Inquiry	Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group

The priorities have been selected based triangulated data across a range of insights, further cross referenced with risk registers. Priorities have been selected where contributory factors may not be well known, and limited improvement work is underway. Some events in healthcare require a specific type of response which is set out in policy or regulation. These responses are a locally led patient safety incident investigation (PSII) or a referral to another body or team. The nationally defined priorities remain the same as previously and can be seen in Appendix Two.
In addition to the above priorities, a programme of thematic analysis will be undertaken which will generate insights for improvement work

3.4 Table Three: Proposed Programme of Thematic Reviews to Inform Continued Improvement

Time Period (Q)	Event	Learning response	Anticipated improvement route
Q1 2025/26	Management of ST elevation Myocardial infarction	Thematic analysis	Organisational safety plan/annual planning
Q2 2025/26	Moving and handling issues relating to equipment including availability (equipment to include vehicle ramp, stretchers, harnesses, and equipment used to move patient between areas	Thematic analysis	Organisational safety plan/annual planning
Q3 2025/26	Winter safety review – focus on delays in care	Thematic analysis	Organisational safety plan/annual planning

3.5 Table Four: Process for Managing Patient Safety Events Not Meeting a Local or National Criteria

Event category	Response to be undertaken

Patient event resulting in no harm/low physical or psychological harm	Local review Being open conversation Consideration of parallel processes Appreciative inquiry
Patient event resulting in moderate physical or psychological harm	Review via Patient Safety Governance Meeting Local review Chronology Coroner report Statutory duty of candour enacted Consideration of parallel processes Appreciative inquiry
Patient event resulting in severe physical or psychological harm	Review via Patient Safety Governance Meeting Local investigation Chronology Coroner report Statutory duty of candour enacted Consideration of parallel processes Appreciative inquiry
Fatal	Review via Patient Safety Governance Meeting Local investigation Chronology Coroner report Statutory duty of candour enacted Consideration of parallel processes Appreciative inquiry

4. FURTHER ACTION REQUIRED:

4.1 Following the review of the priorities, there are further actions needed:

- Currently, the guidance around how we establish " deaths thought more likely than not due to problems in care" relies on the Learning from Deaths (LfD) process. This has led to significant variation in the number of PSII's being undertaken in this category across the sector. The national policy is currently being reviewed and may increase the amount of PSII's we must complete (for example, London Ambulance Service completed circa 40 PSII's in this category last year).
- A resource analysis is required to ensure we commit the correct number of resources to our agreed plan, and that we can maintain our statutory and contractual requirements
- Agree process with Integrated Care Board for sharing of patient safety incidents that are identified by NWAS but relate to delayed hospital handover
- Establish existing programmes of audit, and improvement to ensure PSIRF aligns and compliments these, thus minimising duplication.
- Update policy and plan to reflect the above and approval of the new proposed priorities, along with a completed quality impact assessment for priorities

5. EQUALITY AND SUSTAINABILITY IMPACTS

5.1 Patient Safety Incident Response Framework (PSIRF) prompts consideration of inequalities in the development of patient safety incident response policies and plans. In addition, the tools proposed (eg. Patient Safety Incident Investigation, After Action Review, Thematic Analysis) in addition to learning from Duty of Candour/engagement conversations prompt consideration of inequalities during the learning response and the development of safety improvement plans. Identified inequalities will be woven into our improvement plans, which will be supported by internal and external stakeholders with insights into these areas, including patients and families.

6. ACTION REQUIRED

6.1 The Board of Directors are asked to

- Review and approve the proposed local priorities and note subsequent actions required to develop PSIRF plan

APPENDIX ONE: METHODOLOGY USED TO REVIEW PRIORITIES

Stage 1

Initially, the Patient Safety Team commenced data gathering from a variety of sources:

Data Types	Time Period
Contentious/ Potentially Contentious Inquests	2022/2023 2023/2024 2024/2025 (to date)
Claims	2022/2023 2023/2024 2024/2025 (to date)
Learning from Deaths	2022/2023 2023/2024 2024/2025 (to date)
Complaints	2022/2023 2023/2024 2024/2025 (to date)
Serious Incidents	2022/2023 2023/2024 (partial year)
Incidents	2022/2023 2023/2024 2024/2025 (to date)
Freedom to Speak Up	2023/2024 2024/2025 (to date)
Staff Survey Results	2023/2024

In addition, other sources of information were collated from a variety of specialisms, including:

- End of Life/Palliative Care

- Safeguarding
- Mental Health
- Medicines
- Maternity
- North West Air Ambulance (NWAA) & Resilience
- NWAS Harm Review undertaken for December 2023 and January 2024
- Risks held on the Risk Register.

This initial process focused on gathering quantitative information in preparation for qualitative multidisciplinary team discussions with internal stakeholders through a series of workshops.

Stage 2

The Patient Safety Team hosted a series of virtual workshops to present the quantitative data and have qualitative discussions with a view to seek and understand inequalities in patient safety.

The following stakeholders have been consulted with:

- Consultant Paramedics
- Clinical Support Managers
- Sector Clinical Leads
- Executive Director Quality, Innovation and Improvement
- Assistant Director of Quality & Nursing (Chief Nurse)
- Professional Lead Nurse
- Patient Safety Team
- Chief Pharmacist
- Maternity Team
- IP&C Team
- Mental Health & Safeguarding Teams
- Patient Safety Partners
- Head of Legal & Resolution
- Integrated Care Board/Ambulance Commissioning Team
- Clinical Audit Team
- End of Life Lead
- Quality Improvement Team

During the workshops, data was presented to the group to assist with understanding. This exercise concluded, and a second thematic review took place to identify recurring themes, which was cross referenced with risk registers to ensure our focus was on the most significant risk across the organisation.

Learning was identified pertaining to:

- Data quality around health inequalities is improved from previous position, but still needs refinement
- Challenges in understanding granular detail of sub-groups in themes

Stage 3

Following the review of data and series of workshops a draft version of proposed priorities was shared by Patient Safety Specialists with Consultant Paramedics on 8th January 2025.

The draft priorities were presented along with rationale, alongside qualitative discussions to understand the contributory factors and improvement work that has been completed, in progress, or soon to be commencing.

The group came to a consensus of three potential local priorities which along with the unchanged national priorities allow for focused improvement. In addition, there are some potential areas we hope to explore further to inform future improvement and will be managed via an annual thematic analysis. Any new risks identified will also be added to the risk register.

Stakeholders all agreed the importance of maintaining visibility around risks associated with delayed response and delayed handovers, therefore cases identified that fall into one of the priority categories will be managed via that route, but continued conversations are taking place to ensure the ICB are taking a co-ordination role to incidents identified which need review by another organisation. The aim is to reduce administrative burden in these cases where there is limited opportunity for NWAS learning, and information needs to feed into wider system conversations.

The proposed process also gives assurance around events that do not feature as one of the national/local priorities but where something is thought to have gone wrong, or harm has occurred, with a clear process for local review and enactment of duty of candour/being open conversations.

Stage 4

The proposed priorities will now go through governance committees, and if approved will require ongoing discussions around the links to annual planning. The PSIRF plan and policy will need to be updated on approval of new priorities, to include a resource analysis, summary of current organisational improvement programmes and a dynamic safety improvement plan.

APPENDIX TWO: NATIONAL PRIORITIES

Table One: Nationally Defined Priorities Requiring Locally Led Patient Safety Patient Safety Incident Investigation (PSII):

Event	Learning Response	Anticipated Improvement Route
Deaths thought more likely than not due to problems in care (incidents meeting the Learning from deaths criteria for PSII) *	Locally Led PSII	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
Incidents that meet the criteria set in the Never Events List 2021 (or its replacement)	Locally Led PSII	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group

Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies and there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	Locally Led PSII	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group

*unless the death falls in a more specific category detailed in Table 2, in which case that response must be followed

Table Two: Nationally Defined Priorities Requiring Referral to Other Team or Body/ and Locally Led PSII

Event	Learning Response	Anticipated Improvement Route
Mental health related homicide by persons in receipt of mental health services or within 6 months of discharge	Referral to NHS England Regional Independent Investigation Team (RIIT) for consideration for independent PSII Locally led PSII	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
Maternity and neonatal incidents meeting the " each baby counts criteria" and maternal deaths Maternity and neonatal incidents whereby severe brain injury occurs Maternity and neonatal incidents: Severe brain injury, perinatal and maternal deaths	Referral to Health Services Safety Investigations Body (HSSIB) Referral to NHS Resolutions Early Notification Scheme Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries Across the UK (MBRRACE) Locally led PSII may also be required	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
Child Deaths (under 18 years of age)	Referral to Child Death Overview Panel (CDOP Locally led PSII may be required	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement

		Group/Improvement Delivery Group
Death of persons with learning disabilities	Referral to LeDeR Locally led PSII may be required	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
Safeguarding incidents in which: • Babies, children or young people on a child protection plan or looked after plan are victims of wilful neglect or domestic abuse/violence • Adults (over 18 years) are in receipt of care & support needs from local authority • Incident relates to FGM, Prevent, modern slavery, human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead and organisational named professional for adult/child safeguarding Organisation must contribute to domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews as required to do so	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
Incidents in NHS screening programmes	Refer to Public Health England	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group
Death in custody (prison, police custody or probation) where healthcare is or was NHS funded	Refer to Prison & Probation Ombudsman (PPO)or Independent Office for Police Conduct (IOPC) Healthcare organisations must support investigations where required to do so	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group

Domestic Homicide	Healthcare organisations must support investigations by Community Safety Partnerships (CSP)	Locally created safety improvement plans which will feed into Quality Strategy via Regional Clinical Learning & Improvement Group/Improvement Delivery Group

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
SUBJECT	Learning from Deaths summary report and dashboard Q2 2024/25
PRESENTED BY	Dr C 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 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. • 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 Q2 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 care & treatment. Of the concerns closed, there were six 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, documenting all refusal and safety netting details and ensuring calls are triaged correctly using Pathways. The quality of patient records has dropped this quarter,

	with 29% receiving a poor or very poor rating. This figure has dropped slightly from the previous three quarters but is a still an improvement from 47% seen last year. There was one patient record that received a good rating for quality, which is a decrease from two 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. The Clinical & Quality Group 2. Quality & Performance Committee
	Date: Tuesday, 21 January 2025 Monday, 27 January 2025
	Outcome:

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 Q2 2024/25 Learning from Deaths review, and it is proposed this document is published on the Trust's public accounts by 31st January 2025 in accordance with the national framework and trust policy. The Q2 dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q2. 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 62 (43 concerns raised in Datix and 19 sampled for SJR).

3.2 Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 11/12/2024. 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:

- 27 internal concerns were raised through the Incidents module (Events).
- 14 external concerns were raised through the Patient Experience module (Feedback).
- 2 concerns raised both internally and externally

3.2.1 Internal Concerns

Of the 27 internal concerns, 14 were reviewed and closed. There were four cases in which the investigation concluded the Trust had contributed in some way to that patient death.

3.2.2 External Concerns

Of the 14 external concerns that have been reported, 6 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. Seven concerns have been closed with no causal factors identified.

3.2.3 Concerns raised internally and externally

Of the 2 concerns raised internally and externally, two are closed. One investigation concluded that the trust had contributed towards the death.

3.2.4 Outcomes from concerns raised

The outcomes and actions from outstanding concerns will be reported by the patient safety team once the investigations are complete. The themes identified from the closed concerns can be found in section 3.3.2 below.

3.3 SJR Stage 1 Outcomes

17 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). 8 patients received appropriate care. The mid-range statement of 'adequate' practice is defined as the expected practices and procedures in compliance with guidance. Any practice identified as beyond expected practice is defined as 'good'. Any practice identified as not reaching expected practice is defined as 'poor'.

3.3.1 SJR Stage 2 Outcomes

Nine cases were identified as needing second stage review following Stage 1. The second stage review concluded that four deaths were not avoidable, and four cases were uncertain whether poor practice had led to harm. One case was concluded that poor practice 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
- Possible missed allocation
- Incorrect coding of call

PES:

- Limited information regarding clinical assessment/examination
- Failure to recognise potential seriousness & complexity of condition
- Potential missed diagnosis on scene
- Potential missed opportunity to start resus
- Lack of clear management plan
- Quality of EPR

Trust:

- Delays in allocation on category 2 and category 3 calls

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 Q2 and demonstrate where additional learning can be found, as well as highlighting more good practice. These include:

Areas for improvement:

- Patient not referred to primary care when appropriate
- Only one set of observations documented
- Crews using 'Unwell Adult' MTS card when more appropriate cards available
- No detailed worsening advice

Good practice:

- Additional management of patient's family following patient passing away
- Good use of 'GP Connect' to support decision making on scene

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 Q2 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.
- 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 Q2 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.

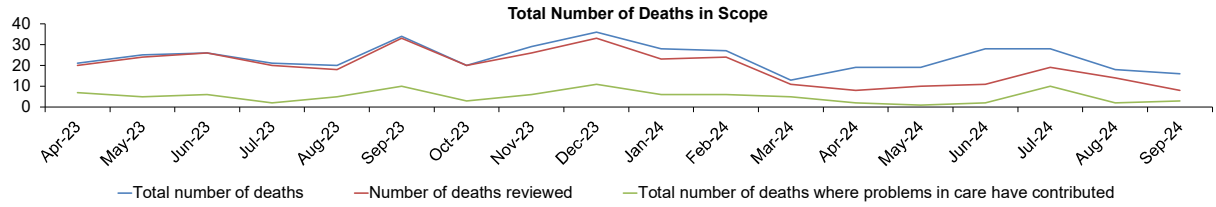


Figure 1

Concerns Raised in DCIQ

Internal Concerns

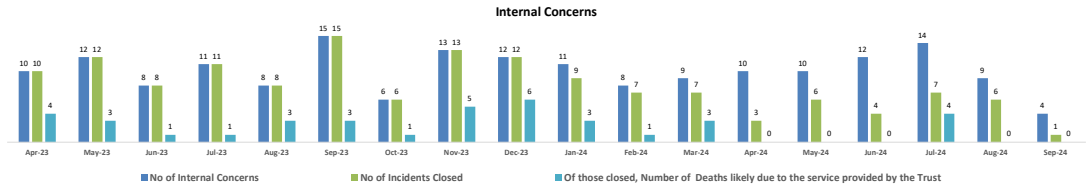


Figure 2

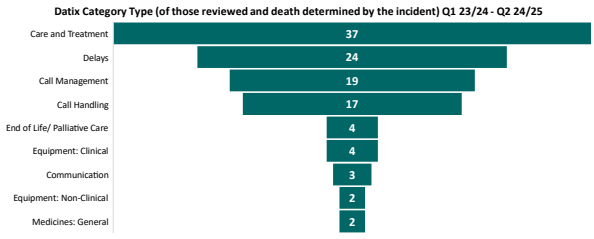


Figure 3

Trends Identified from Internal Concerns raised in DCIQ

PES:

Care & Treatment
- Recontact within 12hrs - patient passed away on re-contact
- Potential missed opportunity to start BLS/ALS in line with guidance
- Potential missed diagnosis on scene

Equipment
- Lifepak defib failed to shock - issue with leads/pads
- Oxygen tank tubing broke/snapped

ICC:

Call Handling
- Call coded incorrectly (x2)

Dispatch
- Possible missed allocation (x2)

Trust:

Delays
- 1hr30/2hr delay on Cat 2 calls (x2)
- 1hr-6hr delays on Cat 3 calls (x6)

Table 1

External Concerns

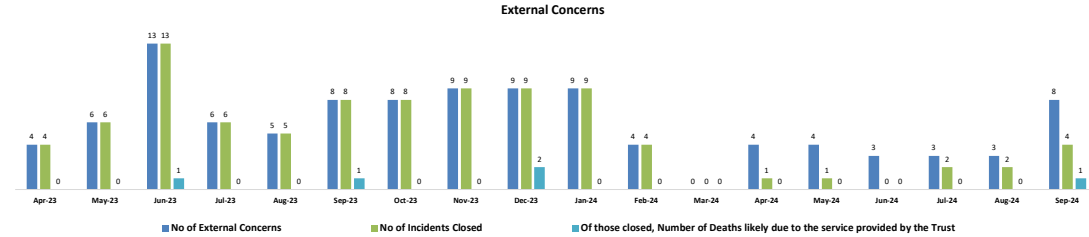


Figure 4

Learning themes: PES

Problem with treatment & management plan:
- Failure to recognise potential seriousness and complexity of condition

Problem with Communication:
- Poor communication with patient/family

Problem with Clinical Monitoring:
- Patient airway not fully monitored while arriving at hospital

Table 2

Learning themes: ICC/CHUB

Key learning from ICC

Problem with communication:
- Poor communication with patient (x2)

Key learning from CHUB

Problem with patient disposition:
- Inappropriate disposition due to failure to recognise potential seriousness and complexity of condition (x2)

Table 3

Other Learning Opportunities

Trust themes in Q2
- Delays in allocation due to demand outstripping available resources

New themes identified in Q2
- Problem with patient disposition following Telephone Triage Assessment (TTA)
- Poor communication from both PES and ICC

Table 4

Internal and External Concerns

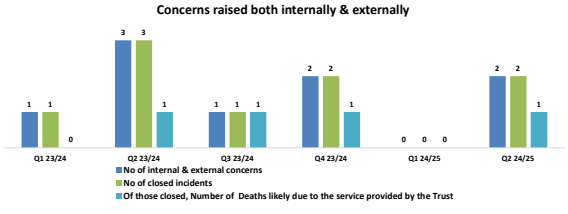


Figure 5

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:
- Incorrect coding of call which resulted in delays in allocation

Demand outstripped resources:
- Hospital handover delays

Table 5

Data last exported: 27/11/2024; Data last cleansed: 11/12/2024

NWAS Learning from Deaths Dashboard Q2 24/25

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
	Q2	19	17	9
	Total	111	92	38

Table 6

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

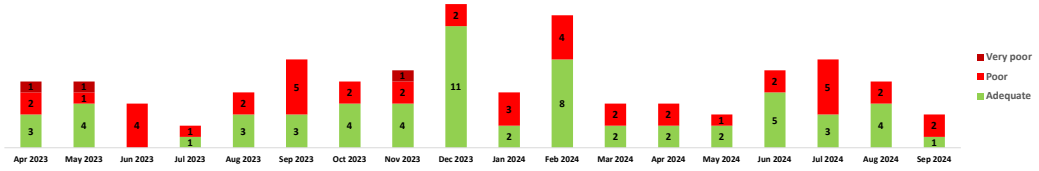


Figure 6

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	3	14	0
Right Care	Patient Assessment Rating	4	13	0
	Management Plan/Procedure Rating	5	12	0
Right Place	Patient Disposition Rating	3	14	0

Table 7

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	10	0
Right Care	Patient Assessment Rating	0	12	0
	Management Plan/Procedure Rating	1	11	0
Right Place	Patient Disposition Rating	0	12	0

Table 8

SJR Learning Themes

Findings identified from 'Poor' ratings

Problem with patient assessment:
- Clinical examination poorly documented
- Limited information regarding clinical assessment/examination/diagnosis

Problem with treatment/management plan:
- MTS not applied correctly
- Lack of clear management plan
- Patient capacity documented but with no detail

Problem with patient disposition:
- Safety netting not documented
- Risk associated with refusing ED not described

Problem of any other category:
- Poor quality of EPR (x5)

Problem with call taking/response allocation:

Call not triaged correctly (x5)
- EMA could have probed more before transferring call
- 'Early exit' used due to 3 not sure answers - caller had given enough detail to answer questions
- Call downgraded by EMA - not enough information to downgrade call
- EMA should have revisited breathing assessment questions following more information given at the end of the call
- EMA didn't follow opening script - omitted 'Tell me exactly what's happened'

Table 9

Evidence of Poor/Very Poor Practice

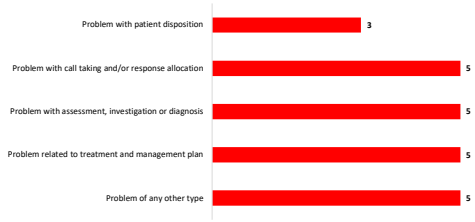


Figure 7

Data last accessed 29/11/2024

NWAS Learning from Deaths Dashboard Q2 24/25

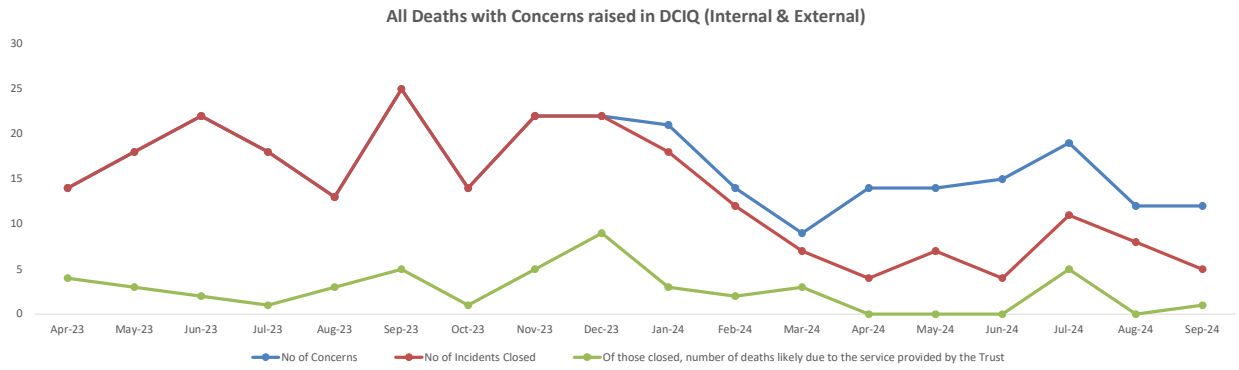


Figure 8

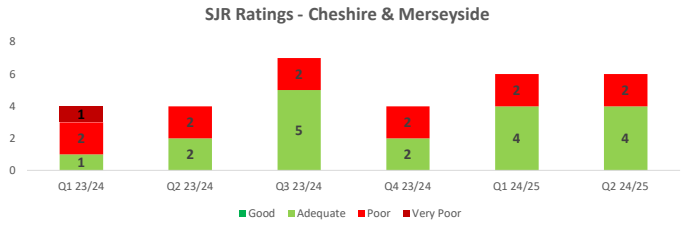


Figure 9

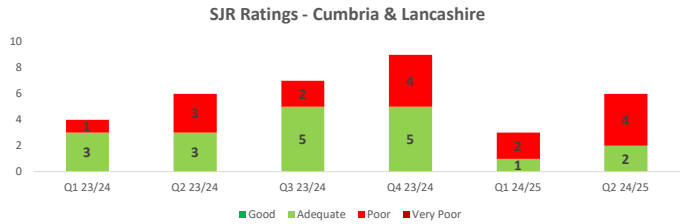


Figure 10

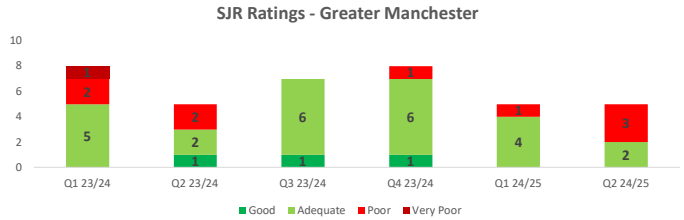


Figure 11

SJR Deaths by Deprivation Index		Quarter					
		Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25
IMD Decile 1= most deprived 10= least deprived	1	**4**	**7**	**6**	**2**	**8**	1
	2	1	0	**4**	1	1	2
	3	**3**	1	3	**3**	0	**5**
	4	1	**2**	1	**3**	0	1
	5	0	**2**	0	**3**	0	0
	6	1	0	1	1	1	2
	7	**3**	0	3	**3**	**3**	**3**
	8	2	0	1	0	0	1
	9	1	**2**	1	0	0	2
	10	0	1	1	1	1	0

Key:

Most occuring

Second most occuring

Table 10

LEARNING FROM DEATHS

NHS North West Ambulance Service

Q2 2024/25 REPORT

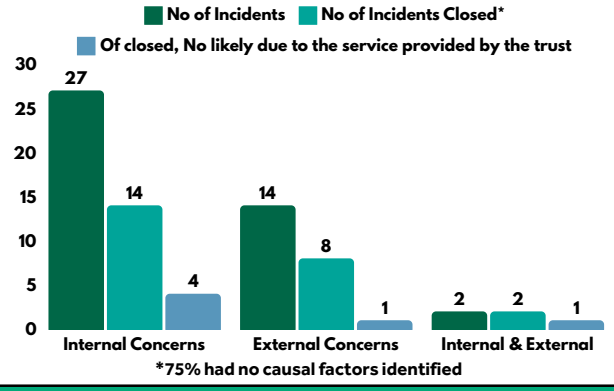
DEATHS WITH CONCERNS RAISED IN DATIX

Internal Concerns 27

External Concerns 14

Internal & External 2

Concerns with casual factors



*75% had no causal factors identified

Top categories from closed internal incidents

Care and Treatment	7
Delays	2
Equipment: Clinical	2
Call Handling	1
Medicines: General	1
Dispatch	1

Learning from Paramedic Emergency Service (PES)

Problem with treatment & management plan:

- Failure to recognise potential seriousness and complexity of condition

Problem with Communication:

- Poor communication with patient/family

Problem with Clinical Monitoring:

- Failure to recognise potential seriousness and complexity of condition

Key learning from ICC

Poor communication with patient (x2)

Key learning from CHUB

Problem with patient disposition: Inappropriate disposition due to failure to recognise potential seriousness and complexity of condition (x2)

Trust themes in Q2

- Delays in allocation due to demand outstripping resources

New themes in Q2

- Problem with patient disposition following Telephone Triage Assessment
- Poor communication from both PES and ICC

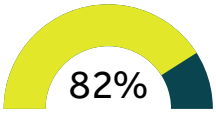
Structured Judgement Reviews (SJRs)

Patient Demographics

47% Female

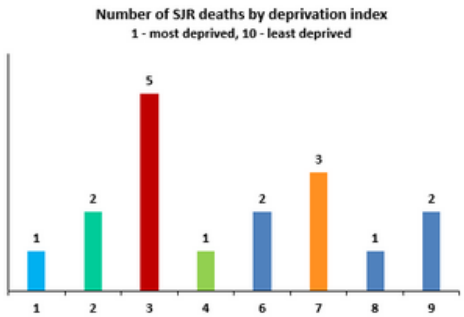
53% Male

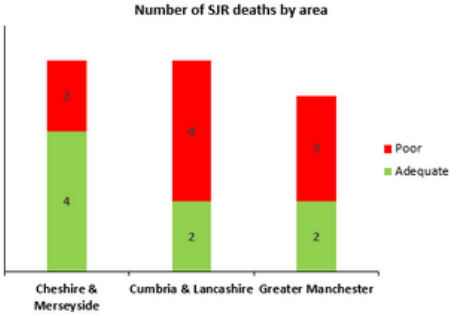
100% of the sample were over 65 years old



More than 3/4 of patients ethnicity recorded as White (British)

Incident Demographics





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

Structured Judgement Reviews (SJRs)

Deaths in Scope

Re-contact within 24hrs
13

Category 3/4 Deaths
2

Category 1/2 Delays
4

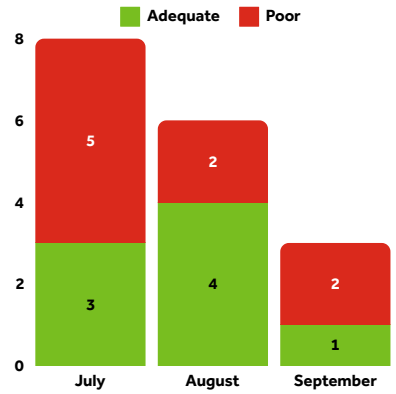
Deaths Reviewed

Total sample
N = 19

Excluded from review
Not moderated = 2

Included for review
n = 17**

SJR Stage 1 Care Assessment



**70.6% had no causal factors identified

Stage 2 = 9 incidents

No causal factors identified
4

Uncertain poor practice led to harm
4

Poor practice led to harm
1

SJR - Themes

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

SJR - PES Findings

Problem related to treatment & management plan:

- MTS not applied correctly
- Lack of clear management plan
- Patient capacity documented but with no detail

Problem with patient assessment:

- Clinical examination poorly documented
- Limited information regarding clinical assessment, examination and diagnosis

Problem with patient disposition:

- Safety netting not documented
- Risk associated with refusing ED not described

SJR - ICCs Findings

Poor call handling elements:

- Lack of probing by EMA
- 'Early exit' used due to 3 not sure answers - enough info in the call to answer the questions
- Call downgraded by EMA - not enough info to downgrade
- EMA should have revisited breathing assessment following more info given at the end of the call

SJR GENERAL LEARNING THEMES

Areas for Improvement

- Patient not referred to primary care when appropriate
- Only one set of observations documented
- Crews using 'Unwell Adult' MTS card when more appropriate cards available
- No detailed worsening advice

Good Practice

- Additional management of patients family following patient passing away
- Good use of 'GP Connect' to support decision making on scene

SJR ACTIONS

- Local learning review completed with crew regarding how we manage HCP admission patients who present with different symptoms with the crew
- Duty of Candour (DOC) to be considered

SJR IMPROVEMENTS

- To continue to highlight and improve the Quality of EPR/clinical documentation
- 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 learning gaps and celebrate good practice

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
SUBJECT	EPRR Annual Assurance (Core Standards)
PRESENTED BY	Director of Operations (AEO)
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the move from non-compliance to substantial compliance for Ambulance Service Provider standards • Note the move from partial compliance to substantial compliance for Interoperability standards • Note the outstanding partially compliant standards with associated actions • Receive assurance for 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	**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 adverse 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** • October 2024 NWAS submitted the following position regarding the Core Standards assessment: - **Ambulance provider: 90% (substantially compliant**), improvement from 41% and non-compliant in 2023 - **Interoperability: 94% (substantially compliant),** improvement from 87% and partially compliant in 2023 - **Deep dive: Cyber resilience (9% - non-compliant).** Assessment included planning, training and testing. Of 11 standards, NWAS submitted 1 fully compliant and 10 partially compliant. This was not assessed last year and is not included in the overall rating. Action plans are in place to improve. **ADVISE** • There are 6 Ambulance Provider standards, and 9 Interoperability standards listed as partially compliant, all have which have actions plans in place. **ASSURE** • NWAS submitted the EPRR Annual Assurance returns to Lancashire and South Cumbria ICB on 25th October 2024 (deadline 31st October 2024). • The ICB met with NHS England for a scrutiny meeting, no changes were advised. • All LHRP meetings have been advised of the outcomes.

	Core standards cover this report include: 6 continuous improvement, 7 risk assessment, 8 risk management, 9 collaborative planning, 10 incident response, 11 Adverse weather, 12 infectious disease, 13 new and emerging pandemics, 15 mass casualty, 18 protected individuals, 21 Trained on-call staff, 22 EPRR training, 23 exercising and testing programme, 26 Staff awareness and training, 27 access to planning arrangements, 33 warning and informing, 35 comms with partners and other stakeholders, 36 media strategy, 44 BC Policy statement, 48 BC testing and exercising, 52 BC Continuous improvement process.	
PREVIOUSLY CONSIDERED BY	Emergency Preparedness Resilience and Response Group	
	Date	Monday, 13 January 2025
	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 adverse 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. PTS and NHS 111 are subsets of the Ambulance Provider standard list, NWAS have agreement from NHS England that they do not have to be submitted separately.

Ambulance Services also report on Interoperable Capabilities. This is assessed and scored but is not included in the overall score for the Service.

The NHS core standards for EPRR cover 10 core domains:

Governance	Response
Duty to risk assess	Warning and informing
Duty to maintain plans	Cooperation
Command and control	Business continuity
Training and exercising	Hazmat and Chemical Biological Radiological Nuclear (CBRN)

The Interoperable Capabilities section contains:

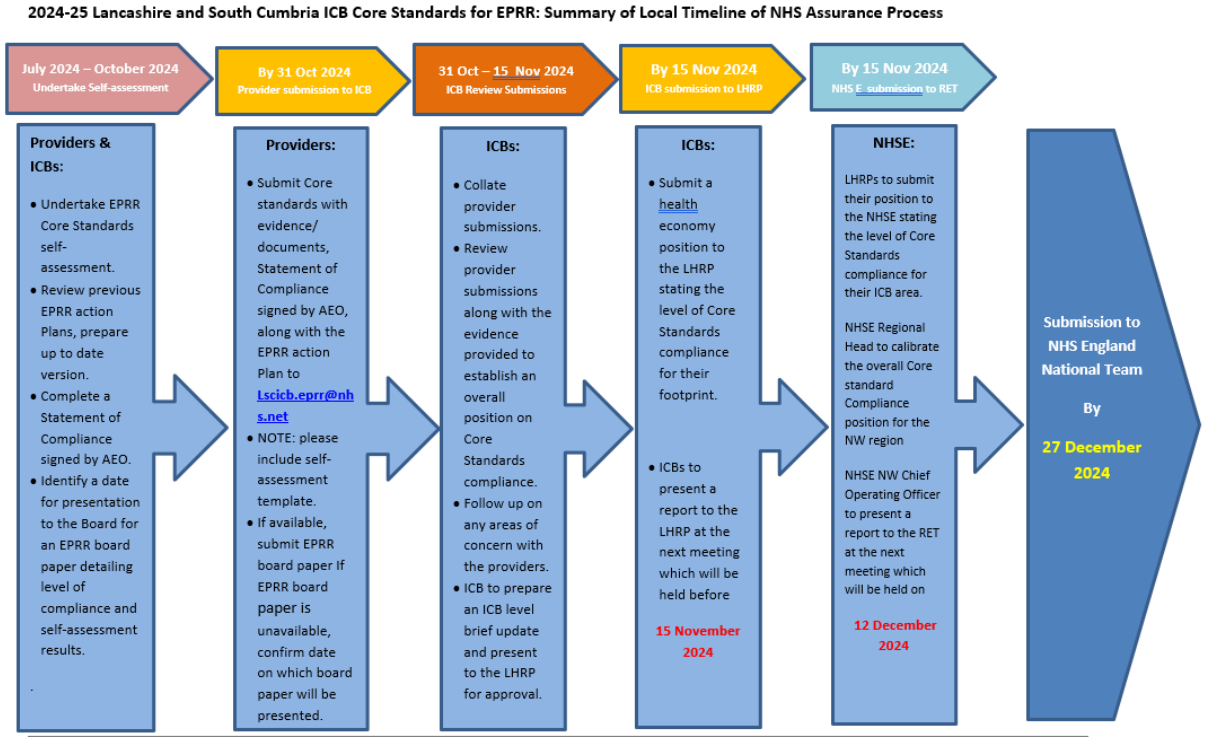
- Hazardous area response teams (HART)
- Special operations response teams (SORT)
- Mass casualty vehicles (MCV)
- Command and control (C2)
- Implementation of the joint emergency services interoperability principles (JESIP)

The 2024/25 EPRR annual deep dive focuses on cyber resilience. This does 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.

The timeline for NWAS is:



Head of Contingency Planning has worked with Lancashire and South Cumbria ICB Head of EPRR to go through all of the standards.

The spreadsheet provided by NHS England and the evidence from NWAS is uploaded on an NWAS Teams channel and was shown to the ICB. An action tracker has been created and will be monitored.

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

It was noted in the LHRP Executive level meetings that large changes in percentage are not always seen in the label it is given. This means Trusts are keen to have the full detail (percentage, change, label) provided in reports to give clarity and context.

NHS England require presentation and discussion of the outcomes at a public Board meeting prior to submission and publication in the annual report within the organisation's own reporting requirements. They accept that the submission dates are not always in line with Board meetings but request the date that it will occur to be noted in the submission paperwork.

3. EPRR COMPLIANCE AGAINST THE CORE STANDARDS – 2024/2025

Lancashire and South Cumbria ICB completed a peer-type assessment between September and October 2024. The Self-Assessment was **submitted on 25th October 2024** (deadline 31st October 2024).

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.

NWAS submitted the following to the assessing ICB:

Focus	2023			2024		
Ambulance provider	**41%**	Non-compliant		**90%**	Substantially compliant	↑
Interoperability	**87%**	Partially compliant		**94%**	Substantially compliant	↑
Deep dive	**80%**	Training		**9%**	Cyber preparedness	N/A

There are 4 standards where the ICB felt more evidence was needed but NWAS were comfortable with the processes as they stand while recognising improvement could be made.

15 Mass casualty planning – NHS England regional and national are reviewing Mass Casualty plans and ICBs have been instructed to support Acutes in testing their ability to make capacity. NWAS will join the testing in Q4. Small exercises to train/refresh staff on the use of the Regional Mass Casualty Plan took place in commander training.

49 Data Protection and Security Toolkit – The Trust are currently not compliant with the toolkit assessment (sits with Information Governance), but an action tracker is live, and collaboration is in place between Resilience and Information Governance.

50 BC monitoring and evaluation – The ICB want to see more evidence being presented to the Board in terms of evaluation reporting. NWAS are comfortable the information is provided at the correct level, and the AEO (Executive Director) is presented with the reports. NWAS agreed to review what is presented to the Board.

52 BC continuous improvement – The lessons and actions identified from BC plan reviews and exercises are recorded on Continuity 2 and have started to be reported into EPRR Group. ICB suggested this is combined with the wider lessons identified process and reported to Board. NWAS are working on improving the lesson and learning cycle and will look to include BC lessons in the RCLIG workstreams.

Ambulance Provider Core Standards (90% - substantial)

In the Ambulance provider category (58 standards)

- 32 standards moved **up** from partial to full compliant
- 4 moved **down** from fully compliant to partial (see below for actions)
- 2 remained partially compliant (see below for actions)
- 20 remained fully compliant

There are no standards rated as 'non-compliant'.

It should be noted there are **6 standards** in the Ambulance Provider section currently rated as **partially** compliant:

Standard	2024 rating	Status and actions to be taken
5 – EPRR Resources	↔	Funding requested linked to Manchester Arena recommendation 20. CEO to maintain contact with ICB for funding. **Likely to remain partially compliant due to reliance on partners for completion.**

6 – Continuous improvements	↓	Formalised reporting or lessons into LHRPs and the Board required. Discussions are taking place with the ICB leads to establish a more formal, documented route for sharing of lessons/debriefs in the LHRP Annual paper to the Board will include an overview of the lessons identified and how they have been managed.
10 – Incident response	↓	The Incident Response Plan is presented to EPRR Group January 2025 for noting. It will also go to TMC and Board for comment/noting
37 – LHRP engagement	↓	Attendance at meetings need to be at AD level. This has been noted and will be monitored quarterly, updates provided to EPRR Group.
38 – LRF engagement	↓	Attendance at meetings need to be at AD level. This has been noted and will be monitored quarterly, updates provided to EPRR Group.
51 – BC Audit	↔	**Recommendation: Audit committee to consider provision of external BC audit**

An action tracker is in place and will be provided with future updates.

Interoperability Core Standards outstanding (94% substantial)

In the Interoperability category (135 standards)

- 1 standard moved **up** from partial to full compliant
- 4 standards moved **down** from fully compliant to partial (see below for actions)
- 5 remained partially compliant (see below for actions)
- 125 remained fully compliant

There are no standards rated as 'non-compliant'.

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

Standard	**2024 rating**	**Status and actions to be taken**
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 to change in the next 18 months due to reliance on partners.**
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. **Likely to remain partially compliant due to reliance on partners for completion.**
H32 – capital estate provision	↔	Elm Point is being built, Ashburton Point plans for renovation are being reviewed due to costing changes; this standard will remain open until they are completed.
S25 – HAZMAT/CBRN plan	↓	This plan is under review and out for consultation.
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.
C32 – availability of medical advisors	↓	A rota is in place for Strategic medical advisors, and it is covered by internal staff. The Tactical/operation medical advisors are external staff and not always available to cover rota places. Plans in place to recruit doctors to complete the rota (target is 40).

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. Reminders are flagged on ESR 3 months prior to the expiry date. Staff need to be proactive is signing up to the courses due to session availability. ASMs are now meeting with the Resilience team to confirm provision of courses and identify commanders who need to participate. This will be monitored through EPRR Group and area assurance meetings.
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. ASMs are now meeting with the Resilience team to confirm provision of exercise opportunities and identify commanders who need to participate. This will be monitored through EPRR Group and area assurance meetings.
J13 – 90% staff JESIP aware	↔	Figures remain around 80% compliance for ESR completion which can be seen 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 took place on 2nd October 2024.

Of the 11 deep dive questions, 1 is fully compliant, 10 partially compliant (**9% - non-compliant**) and actions have been put in place.

Standards include:

- 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.

Actions include:

- Inclusion of ICT/Digital team in the EPRR Group
- Defining roles and responsibilities, provision of reviews and updates
- Gaining governance signoff
- Use of common language
- Updating of Digital BC Plan
- Creation of an exercise programme
- Implementation of debriefing process
- Cyber security training (mandated) and response sessions

These are expected to be completed by Q3 2025.

Future methodology
A national review process is under way to establish what stakeholders feel the Core Standards should look like going forward. It is expected this will take a year so the submission process July-October 2025 will mirror this year. NWAS will prepare for the next submission on an on-going basis including completion of the spreadsheet with updates, storing evidence, and updating the action tracker. This should reduce the workload during the assessment and support continuous improvement.

Other health Trusts
There is currently no platform to show how the other ambulance services performed but locally NWAS have access to the LHRP reports including other health partners. This has shown a level of improvement across most services.

A thematic analysis has been completed by the ICBs to show the highest level of partial/non-compliance, indicating where broader work needs to take place to identify cause and solution. Although NWAS are only partially compliant with one of the areas listed, the Trust will participate in this work to continue improvement and collaborative working with partners.

Maintain plans
13 – new and emerging pandemics
14 - countermeasures
16 – Evacuation and shelter

Training and exercising
22 – EPRR training
24 – Responder training
25 – staff awareness and training

BC
47 – BC plans
48 – BC testing
51 – BC audit (noted by NWAS)
52 – BC continuous improvement process

CBRN
63 – CBRN training resource (Not applicable to ambulance services)
64 – staff training (recognition and decontamination) (Not applicable to ambulance services)

4. Annual summary with associated core standards

Core standard 3 requires the Board to be appraised of:

- Training and exercises completed
- Incidents
- Lessons identified

This is to advise on the state of readiness for the Trust to respond and recover from incidents while maintaining business as usual in the community.

Training and exercises

Staff training

The Command and Resilience Education (CARE) team lead on training for commanders within NWAS, the team also input into the mandatory training with recommendations on content based on lessons identified and national direction. There are time constraints on provision due to other topics from other departments requiring time. For this coming year, Resilience has been allocated 2 hours. This will include persons in crisis and triage. JESIP will be incorporated into other sessions.

Stand J13 mandates 90% of Trust staff who may respond to an incident, including in control rooms, should have an annual JESIP awareness. NWAS host an awareness session on ESR, the reporting shows 78% completion. JESIP is also covered on SORT sessions, face to face JESIP courses and exercises, external and internal commander training, and induction training. but the completion data is not available to deconflict and give a true total. Work is ongoing between Area Support Managers and Resilience to increase ESR awareness completion. Face to Face mandatory training is on track to reach the Trust target of 80%.

The Initial Operational Response (managing a hazardous material incident) ESR session shows 95.77% of staff have completed it. This supports a Joint Organisational Learning (JOL) action note was published in 2023 stating the updated guidance should be provided to staff. IOR is also included on induction sessions.

Commander and command support training

A training needs analysis has been created for commanders and command support staff. 2 training cycles run during the year to provided command-specific training based on lessons identified and plan awareness.

Nationally the Command and Control Guidance shows a role for a Safety Officer but there is no training specified. NWAS are leading nationally on the design of such training, working collaboratively with other Trusts. The NHS Resilience Special Capabilities Unit (formerly NARU) have asked NWAS to work with them on the project.

Commanders have to attend a face to face multiagency JESIP course every 3 years, current compliance is 86%, a drop of 2% from August 2024. This is thought to be because commanders are leaving it too late to book and courses have not been available. Notification of compliance expiration has been amended from 3 to 6 months to allow more time to book on.

Exercises

NWAS have been involved in a large number of exercises including COMAH site exercises, both live and tabletop, and marauding terrorist attacks. Internally, Exercise Mimas looked at a Cyber incident with a number of NWAS departments, identifying planning needs and improving understanding of interdependencies.

Exercise Pegasus, a nationally agreed emerging pandemic exercise, takes place in September to November with NWAS involvement in each Local Resilience Forum area. There will be exercises prior to this to test readiness at a smaller scale.

Hospitals are currently completing exercises to test their ability to increase capacity in the event of a mass casualty incident in line with the NHS England Mass Casualty Concept of Operations. NWAS have requested questions include how they will release the vehicles at the door. NWAS will take a more active part in the subsequent exercises to ensure multiagency coordination, communication, and situational awareness. This will ultimately feed into the NHS England review of health readiness and planning for this type of incident.
(standard 6 – continuous improvement, 21 – trained on call staff, 22 – EPRR Training, 23 EPRR exercising and testing programme, 24 – responder training, 25 – staff awareness training, J13)

Incidents

Large scale incidents attended by NWAS include:

- Showcase cinema shooting (major incident declared)
- Trafford Park COMAH chemical leak (major incident declared)
- Southport stabbing and subsequent disorder (major incident declared)
- RTC in Barrow (major incident declared)
- Building fire affecting motorway (Major incident declared by police, supported by NWAS)
- BAE Submarines fire (Major incident declared)
- Preston building fire (Major incident declared by police, supported by NWAS)
- Kirby Lonsdale Fire (major incident declared)
- Whitehaven explosion (major incident declared)
- Flooding (Major incident declared in Greater Manchester)

Business continuity incidents include:

- Estuary Point Evacuation (Airconditioning issues, denial of access to estates)
- National IT outage affecting NHS patient record systems
- 111 disruption (server failure due to damaged fibre cable)

(standard 10 – incident response, 11 – adverse weather, 15- mass casualty, 20 - on call mechanism, 21 – trained on call staff, 28 – management of business continuity incidents, 29 – decision logging, 30 – situation reports, 33-36 – warning and informing, 40 – arrangements for multi area response, 43 – information sharing, 47 – Business impact analysis and plans)

Lessons identified

The lessons identified process has been resigned as a wholesale review of continuous learning with the aim of providing more exploration of learning opportunities and evidence of improvement. To standardise the approach to debriefing and identifying lessons, after action reviews are being included to examine what happened in comparison with what was expected to happen, from the position of the participants in incidents and exercises. This is in line with Patient Safety Incident Response Framework (PSIRF).

The Trust take lessons from national platforms such as Joint Organisational Learning, directives through JESIP Action notes, internal and external debriefs.

JESIP action notes from the last 12 months are

- Update of the JESIP Doctrine and Initial Operational Response documents
- Person in crisis
- Submerged persons

NWAS have complied with these action notes by adding the detail into training, putting out bulletins, and updating plans.

The Thematic analysis of the lessons identified from April 2024 falls into the following areas:

- Realistic and Frequent training – based on real life events
- Proactive communication and early information sharing
- Inter-agency collaboration and command arrangements
- Operational readiness and tactical decision making
- Casualty management and rescue operations

- Specialist skills and equipment

These lessons result in actions including training sessions and videos, plan reviews, or the new Learning Loop which is run through the Regional Clinical Learning and Improvement Group (RCLIG).

(standard 6 – continuous improvement, 10 – incident response, 11 – adverse weather, 15- mass casualty, 20 - on call mechanism, 21 – trained on call staff, 28 – management of business continuity incidents, 29 – decision logging, 30 – situation reports, 33-36 – warning and informing, 40 – arrangements for multi area response, 43 – information sharing, 47 – Business impact analysis and plans)

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 of Directors is asked to:

- Note to move from non-compliance to substantial compliance for Ambulance Service Provider standards
- Note to move from partial to substantial compliance for Interoperability standards
- Note the outstanding partially compliant standards with associated actions
- Receive assurance for 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 – Outcomes

Core standards table

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	4	2	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	10	1	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	7	0	0
Total	58	52	6	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	35	1	0
JESIP	13	10	3	0
Total	135	127	8	0

Deep dive – cyber

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	1	10	0
Total	11	1	10	0

	Ambulance Service Provider requirements	Submit 2023	Submit 2024
1	Senior Leadership		
2	EPRR Policy Statement		
3	EPRR board reports		
4	EPRR work programme		
5	EPRR Resource		
6	Continuous improvement		
7	Risk assessment		
8	Risk Management		
9	Collaborative planning		
10	Incident Response		
11	Adverse Weather		
12	Infectious disease		
13	New and emerging pandemics		
14	Countermeasures		
15	Mass Casualty		
16	Evacuation and shelter		
17	Lockdown		
18	Protected individuals		
19	Excess fatalities		
20	On-call mechanism		
21	Trained on-call staff		
22	EPRR Training		
23	EPRR exercising and testing programme		
24	Responder training		
25	Staff Awareness & Training		
26	Incident Coordination Centre (ICC)		
27	Access to planning arrangements		
28	Management of BC incidents		
29	Decision Logging		
30	Situation Reports		

		Submit 2023	Submit 2024
33	Warning and informing		
34	Incident Communication Plan		
35	Communication with partners and stakeholders		
36	Media strategy		
37	LHRP Engagement		
38	LRF / BRF Engagement		
39	Mutual aid arrangements		
40	Arrangements for multi area response		
43	Information sharing		
44	BC policy statement		
45	Business Continuity Management Systems (BCMS) scope and objectives		
46	Business Impact Analysis/Assessment (BIA)		
47	Business Continuity Plans (BCP)		
48	Testing and Exercising		
49	Data Protection and Security Toolkit		
50	BCMS monitoring and evaluation		
51	BC audit		
52	BCMS continuous improvement process		
53	Assurance of commissioned providers / suppliers BCPs		
54	Computer Aided Dispatch		
55	Hazmat Governance		
67	ATS Capability		
68	ATS Capability Review		
69	ATS Capability Review Frequency		
70	ATS Capability Review report		
71	ATS Train the trainer		
72	ATS Aligned training		
73	ATS Training sessions		

	HART	Submit 2023	Submit 2024				Submit 2023	Submit 2024
H1	HART tactical capabilities				H17	Local risk assessments		
H2	National Capability Matrices for HART				H18	Lessons identified reporting		
H3	Compliance with National Standard Operating Procedures				H19	Safety reporting		
H4	Staff competence				H20	Receipt and confirmation of safety notifications		
H5	Protected training hours				H21	Change Request Process		
H6	Training records				H22	Initial deployment requirement		
H7	Registration as Paramedics				H23	Additional deployment requirement		
H8	Six operational HART staff on duty				H24	Attendance at strategic sites of interest		
H9	Completion of Physical Competency Assessment				H25	HART Mutual aid		
H10	Mandatory six month completion of Physical Competency Assessment				H26	Capital depreciation and revenue replacement schemes		
H11	Returned to duty Physical Competency Assessment				H27	Interoperable equipment		
H12	Effective deployment policy				H28	Equipment procurement via national buying frameworks		
H13	Identification appropriate incidents / patients				H29	Fleet compliance with national specification		
H14	Notification of changes to capability delivery				H30	Equipment maintenance		
H15	Recording resource levels				H31	Equipment asset register		
H16	Record of compliance with response time standards				H32	Capital estate provision		

	SORT	Submit 2023	Submit 2024				Submit 2023	Submit 2024
S1	Maintenance of national specified MTFA capability				S22	Lessons identified reporting		
S2	Compliance with safe system of work				S23	Safety reporting		
S3	Interoperability				S24	Receipt and confirmation of safety notifications		
S4	Access to specialist scientific advice				S25	HAZMAT / CBRN plan		
S5	SORT establishment				S26	SORT Audit and inspections		
S6	Completion of a Physical Competency Assessment				S27	SORT capability funding		
S7	Staff competency				S28	SORT Readiness to deploy		
S8	Training records				S29	SORT response time		
S9	Provision of clinical training				S30	SORT Mutual Aid		
S10	Staff training requirements				S31	PPE availability		
S11	Arrangements to manage staff exposure and contamination				S32	Equipment procurement via national buying frameworks		
S12	CBRN Lead trainer				S33	Equipment maintenance		
S13	FFP3 access				S34	SORT asset register		
S14	IOR training for operational staff				S35	PRPS - minimum number of suits		
S15	Effective deployment policy				S36	Individual / role responsible for SORT assets		
S16	Identification appropriate incidents / patients				S37	CBRN countermeasures		
S17	Change Management Process				S38	Water supply for clinical decontamination		
S18	Record of compliance with response time standards				S39	Equipment Vehicles		
S19	Notification of changes to capability delivery				S40	Equipment vehicle readiness		
S20	Recording resource levels				S41	Vehicle Tracking		
S21	Local risk assessments							

	Mass casualty arrangements	Submit 2023	Submit 2024
M1	Mass casualty response arrangements		
M2	Arrangements to work with NACC		
M3	EOC arrangements		
M4	Casualty management arrangements		
M5	Casualty Clearing Station arrangements		
M6	Management of non-NHS resource		
M7	Mass Cas Audits and Inspections		
M8	MCV accommodation		
M9	Maintenance and insurance		
M10	Mobilisation arrangements		
M11	Mass oxygen delivery system		
M12	Drug and pharmaceutical stock management		
M13	Fleet compliance with national specification		
M14	Compliance with safe system of work		

	JESIP	Submit 2023	Submit 2024
J1	Incorporation of JESIP doctrine		
J2	Operations procedures commensurate with Doctrine		
J3	Review process		
J4	Access to JESIP products, tools and guidance		
J5	Awareness of JESIP - Responders		
J6	Awareness of JESIP - control room staff		
J7	Training records - staff requiring training		
J8	Command function - interoperability command course		
J9	Training records - annual refresh		
J10	Commanders - interoperability command course		
J11	Participation in multiagency exercise		
J12	Induction training		
J13	Training records - 90% operational and control room staff are familiar with JESIP		

	Command and control	Submit 2023	Submit 2024				Submit 2023	Submit 2024
C1	Consistency with NHS England EPRR Framework				C19	Strategic commander competence - nationally recognised course		
C2	Consistency with Standards for NHS Ambulance Service Command and Control.				C20	Tactical commander competence - National Occupational Standards		
C3	NARU notification process				C21	Tactical commander competence - nationally recognised course		
C4	AEO governance and responsibility				C22	Operational commander competence - National Occupational Standards		
C5	Command role availability				C23	Operational commander competence - nationally recognised course		
C6	Support role availability				C24	Commanders - maintenance of CPD		
C7	Recruitment and selection criteria				C25	Commanders - exercise attendance		
C8	Contractual responsibilities of command functions				C26	Training and CPD - suspension of non-compliant commanders		
C9	Access to PPE				C27	Assessment of commander competence and CPD evidence		
C10	Suitable communication systems				C28	NILO / Tactical Advisor - training		
C11	Risk management				C29	NILO / Tactical Advisor - CPD		
C12	Use of JESIP JDM				C30	Loggist - training		
C13	Command decisions				C31	Loggist - CPD		
C14	Retaining records				C32	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor		
C15	Decision logging				C33	Medical Advisor of Forward Doctor - exercise attendance		
C16	Access to loggist				C34	Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures		
C17	Lessons identified				C35	Control room familiarisation with capabilities		
C18	Strategic commander competence - National Occupational Standards				C36	Responders awareness of NARU major incident action cards		

Wider health results

Organisation	Compliance level 2023 / 24	Compliance level 2024 / 25	
L&SC ICB	Non-compliant	Non-compliant	↔
BTH	Non-compliant	Partially compliant	↑
ELHT	Non-compliant	Partially compliant	↑
LSCFT	Non-compliant	Non-compliant	↔
LTH	Non-compliant	Substantially Compliant	↑
UHMB	Non-compliant	Substantially Compliant	↑
NWAS	Non-compliant	Substantially Compliant	↑
C&M ICB	Non-compliant	Partially compliant	↑
Alder Hey	Non-compliant	Non-compliant	↔
Countess of Chester	Non-compliant	Partially compliant	↑
East Cheshire	Non-compliant	Partially compliant	↑
Liverpool University	Non-compliant	Substantially Compliant	↑
Mersey & West Lancashire	Non-compliant	Partially compliant	↑
Mid Cheshire	Non-compliant	Non-compliant	↔
Warrington and Halton	Non-compliant	Non-compliant	↔
Wirral University Hospitals	Non-compliant	Partially compliant	↑
GM	Non-compliant	Non-compliant	↔
Bolton NHS Foundation Trust	Substantially Compliant	Substantially Compliant	↔
Manchester University NHS Foundation Trust	Partially compliant	Substantially Compliant	↑
Northern Care Alliance NHS Foundation Trust	Substantially Compliant	Partially compliant	↕
Stockport NHS Foundation Trust	Non-compliant	Partially compliant	↑
Tameside and Glossop Integrated Care NHS Foundation Trust	Partially compliant	Partially compliant	↔
Wrightington, Wigan and Leigh NHS Foundation Trust	Partially compliant	Substantially Compliant	↑
Greater Manchester Mental Health NHS Foundation Trust	Non-compliant	Non-compliant	↔
Pennine Care NHS Foundation Trust	Partially compliant	Partially compliant	↔
The Christie NHS Foundation Trust	Non-compliant	Non-compliant	↔

Some of the Trusts have significantly improved their percentage of fully compliant standards, some have individual standards that have moved from non-compliant to partially compliant, but the way the data is recorded does not show this therefore should not be taken as in isolation.

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ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Friday, 24 January 2025		
Members present	Dr D Hanley, Chair Ms C Butterworth, Non-Executive Director Mr D Whatley, Non-Executive Director 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:

Finance Report Month 09 2024/25

- Received assurance in relation to the financial performance indicators.
- Noted that the final CIP recurrent savings are yet to be agreed.

ADVISE:

Workforce Indicators Report

- Received assurance and alerts relating to Workforce Indicators
- Noted the overall position remains stable.

Draft Financial Plan for 2025/26

- Received assurance on the current draft financial plan.

Update of the 2024/25 Capital Plan and the Five-Year Rolling Capital Programme

- Received assurance that full expenditure of the capital plan would be achieved.
- Noted that 2025-26 programme is being developed.

Discussed the following items and recommended to the Board of Directors approval:

- iPad Procurement Contract Award
- ICC Estates Outline Business Case
- Medicines Management Outline Business Case

ASSURE:

Received the following reports for assurance:

- Board Assurance Framework
- NHSE Recovery Lead Review of I&I Process
- Digital Strategy Update
- Cyber Exercise (Exercise MIMAS 02/10/2024)

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 January 2025
SUBJECT	Communications and Engagement Dashboard
PRESENTED BY	Alison Ormerod, Interim Deputy Director of Strategy, Partnerships and Transformation
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to note the contents of this report and discuss the impact of its content.
EXECUTIVE SUMMARY	The Communications and Engagement Team provides a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. The dashboard demonstrates how activity aligns with the aims and objectives of the trust strategy, and the positive impact it has on staff, patients, and partners.
PREVIOUSLY CONSIDERED BY	Not applicable
	Date: Click or tap to enter a date.
	Outcome:

1. BACKGROUND

This report provides the Board of Directors with a summary of key outputs, impact and associated highlights on the work of the combined Communications and Engagement Team for quarter three of the financial year 2024/25 (October-December 2024).

It demonstrates how the activity of the team contributes to the strategic aims and objectives of the trust strategy.

2. REPORT

The dashboard demonstrates how activity aligns with the aims and objectives of the trust strategy, and the positive impact it has on staff, patients, and partners.

Key points to note are:

Aim – Provide high quality, inclusive care
Objective – Identify opportunities to improve clinical practice and patient experience.

Statistical content and narrative is provided to outline patient engagement activity that meets this aim and objective.

For Q3, this includes:

- 10 community engagement opportunities arranged or attended by the patient engagement team. These include going along to events, or arranging meetings with specific community groups, for example: Warrington Deaf Centre, Liverpool Chinese Students and Scholars Association, and Healthwatch Wirral.
- The third of our five NWAS 'ambulance awareness events' was held in Cumbria and was attended by more than 60 members of the public.
- The Patient and Public Panel (PPP) membership was maintained above the 300 member target (with 345 members). Youth representation remains at 32% in Q3 and representation from diverse communities is at 25%. We are not actively recruiting to the panel, but continue to engage with ethnic minority groups to promote opportunities to get involved.

Examples of the impact of this work are included in the report:

- Engagement with the Chinese Health Information Centre led to some suggested changes to some of the health information on our website and available in leaflets, to ensure Chinese people understand how to access our services.
- The PPP supported an NHS England-led project, where members visiting urgent and emergency care services at Blackpool Hospital to identify areas for improvement. They gave feedback on several areas, including the relatives' room/spaces.
- The Patient Engagement Team was involved in a National Ambulance Service Patient Experience Group (NASPEG) initiative to survey patients who had a hospital handover delay longer than 30 minutes. Our surveys were conducted at Blackpool, Bolton and Aintree hospitals. All feedback was submitted for national analysis. The feedback we gathered suggested: an understanding of the challenges faced during winter pressures, as well being happy with the care they received while waiting to be handed over at ED.

Aim – Be a brilliant place to work for all
Objective – Improve the health, wellbeing and safety of our people

Statistical content and narrative is provided to outline communications activity that meet this aim and objective.

The focus of this section is internal communications which helps to ensure staff are engaged, informed and equipped to do their job.

In Q2-Q3, work was underway to improve how we measure the effectiveness of some of our email communication via a platform called e-shot. Therefore, for the Q3 dashboard, we have presented our internal communications information in an improved way. We will be able to make comparisons between the data in the Q4 dashboard.

Data reported in the Q3 dashboard includes:

- The percentage of 'engaged' staff – a colleague is considered 'engaged' when they have opened, viewed or clicked a link in an email within the last 30 days.
- Display rates of three of our email communication bulletins – the Weekly Bulletin, CEO Message and Better Health Better You. The display rate reflects the number of times an email has been displayed, but is only counted when an email is opened and the 'images are downloaded' (something which staff have to click to allow). Therefore, display rates show the minimum amount of times an email has been opened, it's likely the true rate is higher that the display rate reflects. Display rates for our email bulletins range from 60% - 35%. Our platform provider e-shot advises that an average display rate across its public sector clients is 44.5%.

Examples of the impact of this work are included in the report.

- The e-shot data is allowing us to test improvements to increase our engagement rates. It tells us that staff are most interested in news that has a direct impact on them. Therefore, we are working on testing different subject lines and reordering content to make it more relevant to certain staff groups.

The report also covers some highlights from other internal communications campaign and project support, such as

- The staff survey – following communications including bulletin pieces, a video with Dan Ainsworth, reminders on the staff Facebook group and targeted messages for managers, NWAS achieved its highest ever return rate for the staff survey.
- End of Shift procedure trial – we supported the launch of the new procedure with the usual information bulletin but also a short video summarising the main changes, to make it easier for staff to digest. This video was viewed 700 times in the first 24 hours.

Aim – Work together to shape a better future
Objectives – Improve sustainability, productivity and efficiency; Design a sustainable operational model and implement in line with the UEC recovery priorities.

Statistical content and narrative is provided to outline communications activity that meet this aim and objective.

For Q3, this includes:

- 16 positive broadcast media opportunities arranged and 33 proactive stories issued. These covered topics such as winter preparedness and action against violence and aggression.
- 14 media statements drafted. Some of these were part of significant support for staff-related incidents that attracted press interest, which involved media management, formal response and support to the individuals affected.
- Data and activity highlights from the first few months of our winter campaign. October focused on public education about managing common illnesses – the reach and engagement of our content was huge, reaching thousands of people. This was reflected in a 25% reduction in 111 calls for sore throats, earaches and rashes.

The report also captures other areas of communications and engagement activity which cut across the three aims:

- Stakeholder communication – which included 5 MP letters, 5 reports to overview and scrutiny committees (OSCs) and 24 other letters to partner organisations in Q3.

- FOIs - 101 received and 80 completed in Q3. We are at 99% compliance against the 20 working day response time, exceeding our target of 95% compliance.

- Social media – our audience grew by 2% in Q3.

  Compared to Q2, our number of posts was high and our engagement was down. These figures are skewed due to the Southport major incident in July which meant in Q2, we posted fewer times but got unusually high engagement. Our engagement rates in Q3 were still very good – much higher than the average social media engagement rates.

  We have also continued our focus in Q3 on developing short-form video content (Reels), to ensure we keep up with trends and changing algorithms. This focused effort meant we hit over a million views on our video content, 28.2% higher than last quarter. Our violence and aggression Reels, which featured real staff and their experiences of abuse at work, attracted significant attention from the public, with over half a million views across Facebook and Instagram.

- Green Room and website – more than 650,000 pages of the Green Room were viewed in Q3. This included a significant increase in visits to the 'Bulletins' section, which is likely to be caused by interest in subjects such as Christmas annual leave, the pay increase and end of shift protection.

  Website views are down slightly. This is another statistic likely to be affected by the Southport incident in Q2, in which traffic to the news section of our website increased. There were also no call handler vacancies advertised in Q3, and these usually direct many people to the careers section of the site.

3. EQUALITY/ SUSTAINABILITY IMPACTS

All of the trust's communications and engagement activities seek to promote equality and diversity and ensure information is accessible to all.

4. ACTION REQUIRED

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.

Communications and Engagement Dashboard Q3 2024/25 (October, November, December)

All communications and engagement activity is planned and undertaken to support the aims of the trust strategy, and the accompanying strategic objectives. Our dashboard details examples of how we've achieved this in Q3 2024/25, before summarising other highlights from our activity.

MAKING A DIFFERENCE.

The 'making a difference' value icon is used to highlight how our activity has a positive impact on staff, patients or partner organisations.

NHS North West Ambulance Service NHS Trust

Provide high quality, inclusive care

Objective: Identify opportunities to improve clinical practice and patient experience

Patient experience surveys

15,910 surveys sent

1266 surveys returned ▲ 1%

86% were likely to recommend the service to friends and family ▼ 4%

87% were very or fairly satisfied with the overall service they received ▼ 1%

93% agreed they were cared for with dignity, compassion and respect ▲ 1%

10 community engagement opportunities

with groups including the Warrington Deaf Centre, Liverpool Chinese Students and Scholars association, Lancashire Teaching hospital Carers forum, Chinese Wellbeing group, Signing Solutions, Healthwatch Wirral BRIDGE forum and the Chinese Health Information centre.

1 NWAS community event held

- The third of our five scheduled 'Ambulance Awareness Events' was held in Kendal, Cumbria.
- More than 60 members of the public attended, including students from local schools and colleges.
- The event included short talks about our services, interactive activities, CPR demos, and careers guidance and advice.
- Following feedback, this event was tailored to young people.
- Two further events will be held in Q4.

Patient and Public Panel (PPP)

10 new expressions of interest

3 new panel members

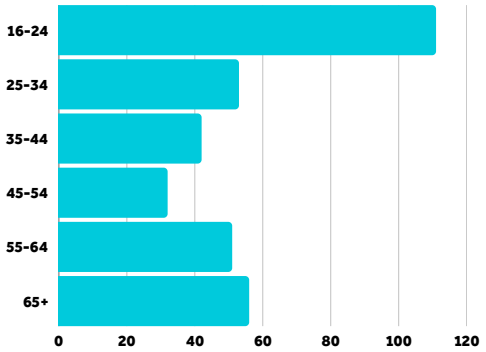
345 total panel members ▼ 1
against a target of 300 members

4 new requests for panel Involvement

11 involvement opportunities delivered

We are not actively recruiting to the panel, meaning the membership number remained steady throughout Q3.

Youth representation is at 32%.



Representation from diverse communities is at 25% and it is our aim to maintain or exceed this figure. We are not actively recruiting panel members, but continue to engage with ethnic groups to ensure opportunities to join the panel are promoted.

Our top three ethnic groups currently are:

1) White
2) Asian / Asian British
3) Black African / Caribbean

We also have members from the Chinese, Indian, Polish and Jewish communities.

Making a difference

Engagement with the Chinese Health Information Centre revealed a lack of awareness about access to 999. We met with the group again to discuss updating a leaflet which contains information about how to access the ambulance service, and translating it to Cantonese and Mandarin. We will also be updating our website with some information to help the Chinese community about what to say to our call handlers if you do not speak English. A further meeting with the group is scheduled for February to discuss the changes we have made and our translation service with Language Line.

The PPP supported an NHS England-led project, involving peer reviews of urgent and emergency care (UEC) services. A team visited Blackpool Hospital to identify strengths and areas for improvement.

The PPP posed insightful questions and gave feedback on several areas, including the relatives room. They spoke to patients and explored patient pathways, identifying effective practices and opportunities to improve the Urgent Treatment Centre and Emergency Department Mental Health pathways.

We supported a National Ambulance Service Patient Experience Group (NASPEG) initiative to survey patients who had a hospital handover delay longer than 30 minutes. Our surveys were conducted at Blackpool, Bolton and Aintree hospitals. All feedback was submitted for national analysis. The feedback we gathered suggested: an understanding of the challenges faced during winter pressures, as well being happy with the care they received while waiting to be handed over at ED

Be a brilliant place to work for all

Objective: Improve the health, wellbeing and safety of our people

Internal (staff) communication

Emails for all staff, such as The Bulletin and CEO message, are sent through a system (e-shot) which provides analytics.

We have improved the quality of the data held in e-shot to allow more accurate reporting and quarter-to-quarter comparisons, which will be in this dashboard going forward.

Important definitions:

- Displays - the number of times an email has been displayed. This is only counted when an email is opened and the images are downloaded - something which staff have to click to allow. Therefore this is the minimum number of times an email has been displayed - it's fair to assume that more staff read the emails than the 'display' figures suggest. Our platform provider e-shot advises that an average display rate across its public sector clients is 44%.
- Clicks - the number of times a user has clicked to access more information such as a link to the Green Room or to open an attached bulletin.

Engaged staff

When a user has opened an email, viewed online or clicked a link in the past 30 days, they are an 'engaged contact'. The percentage of engaged staff is as follows:

- Corporate and support - **89%**
- Emergency - **87%**
- EOC and Clinical Hub - **71%**
- NHS 111 - **72%**
- PTS - **61%**

The Bulletin

In Q3,the weekly bulletin had **1,045 link clicks** on average, per edition.

The display rates for The Bulletin were:

Highest: 55% **Average: 50%** **Lowest: 40%**

meaning that, on average, at least half of all staff opened the bulletin email.

Bulletins with a higher-than-average display rate covered topics including:

- Protecting emergency workers
- Starbucks cups
- Pay uplift

CEO Message

In Q3, the display rates for the CEO message were:

Highest: 60% **Average: 45%** **Lowest: 35%**

Based on display rates, the most popular topics were:

- 'Goodbye from me' - Daren Mochrie (60% displays)
- Changes to the Board of Directors
- Good news for the long service awards
- HCPC standards review and social media
- NHS in critical condition
- Top of the charts for 111

The least popular topics were:

- Community open day
- Looking after our mental health
- Showcasing our work to NHS England

The results suggest that staff are interested in the CEO's views on strategic issues that have an impact on the frontline.

Better Health Better You

Subjects covered in the quarter:

- Cervical screening
- Organ donation
- Prostate cancer

The display rates for Better Health Better You were:

Highest: 46% **Average: 43%** **Lowest: 37%**

Making a difference

The topics which gain the best display rates for the weekly bulletin and the CEO message reinforce that staff are most interested in news that has a direct impact on them.

We are working to improve engagement by testing out different subject lines and ordering stories by relevance to service line groups. We are also exploring how best to use e-shot for vital information bulletins such as clinical messages, where we have the functionality to send automated reminders to anyone that hasn't opened the message within a specified time period.

Campaigns and project support

Staff survey:
The staff survey comms campaign came to an end in Q3. We shared bulletin pieces encouraging staff to complete the survey, worked with the Staff Experience Team to send targeted messaging to managers, created a video with Dan Ainsworth highlighting the importance of the survey, and shared reminders on our staff Facebook group.

Star Awards:
Continued preparation for the awards, which will be held in Q4. This included the shortlisting of nominees and further event logistics.

End of Shift protection trial go-live:
Supported the launch of the new procedure with:

- A video summary of the main changes - this was viewed more than **700 in the first 24 hours.**
- A bulletin to staff and a Green Room page with FAQs

Integrated Contact Centres - phase 3 restructure:
Continued to advise re the ICC phase 3 job role review. Activity included 2 editions of an ICC newsletter and an update for managers, drafted on behalf of the senior leadership team

Paramedic Emergency Service Leadership Review:
Promoted new roles in the structure - 1 video and bulletin piece per week to introduce new roles and direct to Green Room.

Changes to Board, inc new CEO appointment

- Staff and stakeholder communication in relation to the departure of Daren Mochrie and appointment of Salman Desai
- Announced Lisa Ward's award in the New Year's Honours list

Team Talk Live
A live staff briefing with Chris Grant and Dan Ainsworth was viewed live by more than 180 staff, and has since been viewed a further 240 times. Chris and Dan gave updates on winter preparedness and answered staff questions.

Other topics covered in Q3 included: NHS Change - have your say to shape 10-year health plan; National announcement that long service medals will include EOC staff; Disability History Month alongside the Disability Network; poppy-wrapped remembrance vehicles to support the Armed Forces Network; flu vaccine campaign; 2025 community calendar with images and quotes from staff across the trust, and highlight awareness days and holidays.

Making a difference

This year we received our highest ever number of staff survey responses - over 3,560 people filled out the survey.

We launched the end of shift procedure with a video summary to help people digest the information in a quick and easy format. This was very popular and viewed more than 700 times in the first 24 hours.

Work together to shape a better future

Objectives: Improve sustainability, productivity and efficiency; design a sustainable operational model and implement in line with the UEC recovery priorities.

Press and public relations

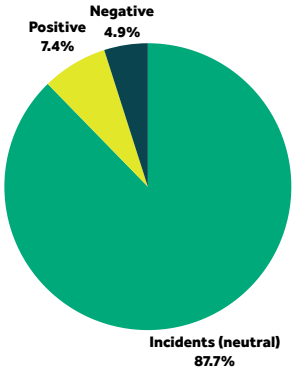
Press office activity / output

179	incident checks handled	▲ 20%
14	statements prepared in response to media enquiries	▲ 6%
16	positive broadcast media opportunities secured	▲ 12%
33	proactive stories issued, against our target of **16**	

Q3 was a busy quarter for the press office. We supported several proactive media opportunities, such as: two patient reunion stories and interviews about winter preparedness and our violence and aggression reduction campaign.

We also provided significant support for staff-related incidents that attracted press interest. This involved media management, formal responses and providing support and advice to the individuals involved.

Towards the end of Q3, there was growing media coverage of winter demand and enquiries about activity and delays.



Resulting media coverage

To give us a picture of NWAS in the media, we log all news coverage available online. This will not include every mention in local press or broadcast media, but allows us to see the overall sentiment of reporting.

- The majority is about incidents, including a mention of NWAS with details provided by our press office, which is factual and neutral in tone.
- Negative coverage overall reflects NWAS negatively, but usually includes a statement from us in response.
- Positive coverage is usually a result of proactive press activity carried out by our press office.

Winter campaign

The campaign launched with self-help month in October, focusing on public education about managing common illnesses. The aim was to reduce 111 calls for non-urgent issues such as sore throats, earaches, and rashes, which were consistently among the top five reasons for 111 calls in previous winters. Data showed most calls from ethnic minorities came from Asian/Asian British Pakistani and Asian/Asian British Bangladeshi communities in Greater Manchester, so we tailored our activity to reach these people. Activity included:

- Self–help reels featuring staff that reached over **238,000** views on social media.
- An ad for Muslim radio station Heritage Radio that reached on average over **1.4 million** listeners.
- A Winter Watch stakeholder newsletter which had a 41.5% read rate and 41% click rate – a 23% increase in readership and a 123% surge in clicks compared to September's stakeholder update.
- A digital self-help leaflet shared with **400** GP practices across Greater Manchester as well as **1,250** physical copies.
- Self-help leaflets shared with schools in Greater Manchester - **20** schools passed the information to parents/guardians.

In November, the campaign focused on falls prevention, targeting the 70+ age group in Preston. Data revealed a high rate of falls-related calls in this area during the previous winter, relative to its population size. Messaging emphasised falls prevention strategies, including the role of medication management. Throughout November, we:

- Held an event with the Alzheimer's Society. 50 attendees heard our falls prevention talk and many received 121 advice from our falls lead.
- Created and printed **2,000** copies of a falls prevention and medication postcard, with Lancashire Fire and Rescue Service helping to distribute when out doing their falls home inspections.
- Produced a suite of falls social media posts that reached over **58,000** impressions.
- Created two falls newspaper adverts for the Lancashire Post - with a readership of **44,000.**

Additionally:

- Media interviews included the Director of Operations Dan Ainsworth and Medical Director Dr Chris Grant featuring on BBC local radio and BBC North West Tonight.
- A 3-week radio advertising campaign reached more than **1 million** people in the North West.

In December, the campaign focused on repeat prescription messages, a violence and aggression theme, and festive well-wishes to staff from the Chairman, from the public and from family and friends. More detail about December activity and the results of it will be shared in the next dashboard.

Making a difference

During October we saw a 25% reduction in 111 calls related to sore throats, earaches and rashes, with 2,300 fewer calls compared to the previous October. A full evaluation to include Nov and Dec data will be produced and results shared in Q4 dashboard.

Stakeholder communications

5 letters to MPs on topics including taxi standards for PTS journeys, medical markers, resources in Southport, crew decision making.

5 reports or briefings prepared for overview and scrutiny committee (OSC) meetings and meetings with MPs

24 other letters, including condolences, retirements, congratulations, responses to staff re: equality and diversity and VIP visits, the new AACE chair, New Year Honours and a letter to the Secretary of State about a complaint.

Freedom of Information (FOI)

101 received ▼ 24%

80 completed

99% compliance year-to-date against 20 day target ▲ 1%

Topics included:

- Assaults on staff
- Temporary staff
- NWAS fleet

NOTES
We have a statutory duty to reply to FOIs within 20 working days.
The national target is 90% for this and we set an internal stretch target of 95%.

Social media - Facebook, X (Twitter) and Instagram

Audience

		Audience growth
91,202	Facebook followers	▲ 2%
68,896	X (Twitter) followers	
21,226	Instagram followers	
10,382	LinkedIn followers	

Engagement

606 posts published on all channels ▲ 45%

7,258,885 impressions ▲ 2%

354,735 engagements (comments, likes, retweets, shares etc) ▼ 27%

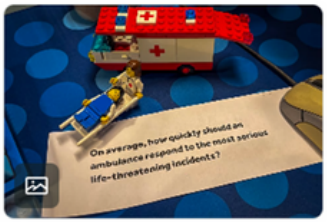
4.9% engagement rate ▼ 29%

1,053,490 video views ▲ 28%

TOP POSTS

North West Ambulance ...
Sun 12/15/2024 6:53 am GMT

NWAS quiz time:❓ Do you know, on average how quickly an ambulance should respond to the most life-...



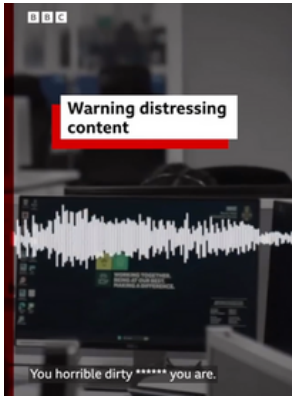
31.4% engagement rate

North West Ambulance ...
Tue 10/15/2024 6:01 pm BST

A new fleet of vehicles for the Hazardous Area Response Team (HART) have just been deployed in Greater...

27.8% engagement rate

TOP REELS



A clip of verbal abuse directed at a call handler - 276,000 views

A clip of staff giving Halloween safety advice - 298,000 views

'Impressions' is the number of times our content may have been seen by a member of the public

'Engagements' is when someone engages with our content eg clicks a link, reacts to it by clicking 'like', or shares or retweets it

'Engagement rate' shows us the number of interactions our content receives per follower

'Reels' are short, entertaining videos with audio tracks

Making a difference

Engagement rate is down in Q3, while number of posts is up, compared to Q2. These figures are skewed due to the Southport major incident in Q2 which meant we cancelled most social media posts for at least a week (reducing our planned number of posts) but the updates we did post relating to the incident got very high engagement. According to industry experts, the average engagement rate is less than 0.5% for Facebook, 2.5% for X and 1.5% for Instagram, meaning our engagement rate for Q3 was still high.

Most of our posts with high engagement come from Facebook. The next best performing post for engagement was on LinkedIn, where we've been continuing to improve our content and grow our audience.

To keep up with changing social media platform algorithms, we continued to test displaying our content in a mixture of static images and short form vertical video (Reels). Whilst engagement rates appear lower in this Q, our video views have collectively hit over a million, 28.2% higher than last Q, and **513%** higher than this period last year. We produced 27 Reels this Q, an increase of 29% on the previous quarter. Our violence and aggression staff campaign really made an impression on the public, with the Reels achieving over half a million views across Facebook and Instagram.

Green Room

20,982 users ▲ 1%

654,185 page views ▲ 4%

Most viewed

Managers on duty (88,651 views)
Bulletins (19,787 views)
HR Portal (18,178 views)

NOTES

A 'user' is a person who has an engaged session. An 'engaged session' is when a user is engaged for longer than 10 seconds, performs an action, or views at least 2 pages. This discounts visits where users immediately move onto another site.

Website

279,873 users ▼ 18%

394,047 page views ▼ 18%

Most viewed

Vacancies (101,151 views)
Apprenticeships (24,412 views)
Our locations (20,931 views)

How did visitors find our website?

Direct (searched/typed NWAS web address) - 152,132 users – 49%
Organic (searched on Google or other) - 134,365 users – 44%
Social media – 21,430 users – 7%

Making a difference

Green Room users and page views have remained fairly steady from Q2, increasing slightly. There has been a significant increase in bulletin views, likely due to the interest in subject matter (christmas annual leave, pay increase, hospital pre-alerts, end of shift protection). New staff recognition cards were added to the Green Room at the end of the quarter so we hope to see an impact from this next quarter.

Communications and engagement plans for Q4

- Continue to support new starters to settle into the team: Shafqat Rahim Chaudhry, Patient Inclusion Manager, who is working to improve demographic reporting, and Aaron Molloy who is working on analytics of patient engagement data.
- An internal communications audit, with feedback from staff, to identify areas for improvement .
- Further testing of e-shot emails to improve engagement.
- The submission of an options paper for future of the Green Room (intranet).
- A full evaluation of the winter campaign.
- Delivery of the Star Awards.
- Hosting of the final two NWAS community open days for 2024/25.