AGENDA

NHS North West Ambulance Service NHS Trust

Board of Directors
Wednesday, 30th July 2025
09:45 – 12:55
Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2526/050	Staff Story	09:45	Information	Chief Executive
INTRODUCTION				
BOD/2526/051	Apologies for Absence	10:00	Information	Chair
BOD/2526/052	Declarations of Interest	10:00	Decision	Chair
BOD/2526/053	Minutes of the previous meetings held on: • 28th May 2025 • 18th June 2025	10:05	Decision	Chair
BOD/2526/054	Board Action Log	10:10	Assurance	Chair
BOD/2526/055	Committee Attendance	10:15	Information	Chair
BOD/2526/056	Register of Interest	10:15	Assurance	Chair
STRATEGY				
BOD/2526/057	Chair & Non-Executive Directors Update	10:20	Information	Chair
BOD/2526/058	Chief Executive's Report	10:25	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2526/059	Board Assurance Framework Q1 2025/26	10:35	Decision	Director of Corporate Affairs
BOD/2526/060	SIRO Annual Report 2024/25	10:45	Assurance	Director of Finance
BOD/2526/061	Audit Committee 3A report from the meetings held on 18th June 2025 and 18th July 2025	10:55	Assurance	Mr D Whatley, Non-Executive Director
BOD/2526/062	Charitable Funds Committee 3A report from the meeting held on 23rd July 2025	11:05	Assurance	Mr D Whatley, Non-Executive Director

BOD/2526/063	Trust Management Committee 3A reports from the meetings held on 18th June 2025 & 23rd July 2025	11:10	Assurance	Chief Executive
PEOPLE				
BOD/2526/064	Workforce Equalities Data Monitoring Reports	11:20	Decision	Director of People
RESOURCES				
BOD /2526/065	Resources Committee 3A Report from the meeting held on 24th July 2025	11:30	Assurance	Dr D Hanley, Non-Executive Director
BREAK 11:35 – 11:40				
QUALITY AND PERFORMANCE				
BOD/2526/066	Integrated Performance Report	11:40	Assurance	Director of Quality and Improvement
BOD/2526/067	NWAS Strategic Winter Assurance Framework	12:00	Decision	Director of Operations
BOD/2526/068	Accountable Officer for Controlled Drugs Annual Report 2024/25	12:10	Assurance	Medical Director
BOD/2526/069	Safeguarding Annual Report 2024/25	12:20	Assurance	Director of Quality and Improvement
BOD/2526/070	Infection Prevention and Control Annual Report 2024/25	12:30	Assurance	Director of Quality and Improvement
BOD/2526/071	Quality and Performance Committee 3A report from the meeting held on 30th June 2025	12:40	Assurance	Prof A Esmail, Non-Executive Director
STRATEGY, PARTNERSHIPS AND TRANSFORMATION				
BOD/2526/072	Communications and Engagement Q1 2025/26 Report	12:45	Assurance	Interim Deputy Director of Strategy, Partnerships and Transformation
CLOSING				
BOD/2526/073	Any other business notified prior to the meeting	12:55	Decision	Chair
BOD/2526/074	Risks Identified	12:55	Decision	Chair
DATE AND TIME OF NEXT MEETING				

24th September 2025 at 09:45 am in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton
Exclusion of Press and Public: In accordance with Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

NHS
North West
Ambulance Service
NHS Trust

Minutes
Board of Directors

Details: 9.00am Wednesday, 28th May 2025
Oak Room, Ladybridge Hall, Trust Headquarters

Mr P White	Chair
Mr S Desai	Chief Executive
Mr D Ainsworth	Director of Operations
Dr A Chambers	Non-Executive Director
Prof A Esmail	Non-Executive Director
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director
Dr E Strachan-Hall	Director of Quality and Improvement (Interim)
Mrs L Ward	Director of People
Mrs A Wetton	Director of Corporate Affairs
Mr D Whatley	Non-Executive Director
Mrs C Wood	Director of Finance

In attendance:

Ms A Ormerod	Interim Deputy Director of Strategy, Partnerships and Transformation
Ms M Afsar	NeXT Programme Director
Mr A Makda	NeXT Programme Director
Ms F Balon	FTSU Guardian
Mr R Jones	FTSU Guardian
Mrs A Cunliffe	Corporate Governance Manager (Minutes)

Observers:

Mrs E Shiner	Deputy Director of Corporate Affairs
Ms V Davies	Integrated Contact Centres - Assistant Director (Interim)
Mr J Roberts	Senior Consultant, Good Governance Institute

Minute Ref:
BOD/2526/014 Patient Story

The Chief Executive introduced a film, which presented a patient story of Yen Qun, an elderly lady from the Chinese community in Manchester, who needed to call 999 after having difficulty breathing. Her son would usually translate for her, but as he was away, the lady turned to a nurse, Shirley, from the Chinese Health Information Centre (CHIC) in Manchester who helps to translate.

The Board noted that the Chinese community has grown significantly in recent decades, particularly in cities like Manchester, Liverpool and Chester. Engaging with this community has become one of Trust priority areas for patient engagement which would continue during 2025/26.

In the video, Yen Qun explained that her heart condition and needed an ambulance due to experiencing a high fever and difficulty breathing. Shirley immediately called 999 on her behalf but was unable to answer the questions of the call handler due to not being with Yen Qun. Eventually, Shirley called for a neighbour to help take the call from there. Nearly an hour had passed before the ambulance arrived and Yen Qun was taken to hospital due to severe chest discomfort and difficulty breathing. Yen Qun remained in hospital until she requested discharge in the early evening of the next day as she was struggling to communicate with hospital staff due to the language barrier. Through our collaboration with Shirley and the community, Yen Qun now feels more confident reaching out to us directly, without the need for a third party.

The Board acknowledged the Trust has communication aids in place to help our staff communicate with patients who require language translation, and staff are also supported by Language Line and recognised the importance of continuing to highlight the communication tools available within the ambulance service both internally for the awareness of staff, and externally to provide reassurance to other communities.

The Board were advised of a number of initiatives including a community event planned for Saturday 28 June 2025 in Central Manchester for the wider Chinese community to attend. The event would consist of an interactive talk covering our core services, careers, demonstration of the Insight app and CPR demonstrations.

A discussion took place following the presentation of the film.

The Chair observed that anyone who had been abroad and found themselves in an emergency, would understand the stressful situation when you can’t make yourself understood to receive help. He suggested the events could incorporate a teaching opportunity to introduce some useful stock phrases for emergency situations.

The Chief Executive highlighted the importance of working with all of our communities.

Dr A Chambers noted the importance of making all staff aware of the interpreting tools available to them.

The Director of Operations advised of a review of access for non-English speakers to the services to understand if there are any delay or quality of assessment implications.

Ms M Afsar enquired whether British sign language was included in the toolkit and it was confirmed it was.

Mr D Whatley queried whether the access to interpretation communication tools was enabled to volunteers and private providers. The Medical Director advised the toolkit was not available to volunteers, however he would check whether it was enabled for the private provider crews.

Mr A Makda enquired about access to app in areas where there may not be signal available. The Medical Director advised the devices held by crews have a robust, multiple way access to networks, however in an event of no mobile signal, they would utilise the control room on very rare occasions.

The Chair observed the Board held a development session on Population Health & Health Inequalities the previous month, which is a key part of the Trust strategic plan.

The Board:

- Noted the content of the story.

BOD/2526/015 Apologies for Absence

Apologies were received from Mrs C Butterworth, Non-Executive Director.
The Chair welcomed and introduced all observers to the meeting.

The Chair apologised for a slight delay in proceedings due to Trade Union representatives handing in a petition regarding an ongoing dispute. After a respectful and positive conversation with the TU colleagues, it was agreed that a further meeting would be arranged at a different time, due to the significant agenda of the current Board meeting, which required a timely start.

BOD/2526/016 Declarations of Interest

There were no declarations of interest to note.

BOD/2526/017 Minutes of the Previous Meeting

The minutes of the previous meetings, held on 26th March 2025 and 30th April 2025 were agreed as a true and accurate record of the meeting.

The Board:

- Approved the minutes of the meeting held on 26th March 2025 and 30th April 2025.

BOD/2526/018 Board Action Log

The Board noted there was one point of action in relation to Freedom to Speak Up Annual Report, which was included within the meeting's agenda.

BOD/2526/019 Committee Attendance

The Board noted the Committee attendance.

BOD/2526/020 Register of Interest

The Board noted the Register of Interest presented for information.

BOD/2526/021 Chair & Non-Executives' Update

The Chair advised it was his last formal Board meeting prior to retirement and expressed his gratitude for working with the unitary Board.

The Chair referred to the Liverpool parade incident, which happened on 26th May. He observed that the decisions made at Board meetings and the strategic direction from the Board directly impacts on what happens on such day. The complex planning that takes place in preparation for big events demonstrates how important the leadership is.

The Chief Executive provided an in-depth update on the Liverpool parade incident due to a car driven into a crowd of people. As a consequence, 27 patients were conveyed to hospital, two with serious injuries and 20 patients were treated and discharged at the scene. He reassured the Board that NWAS colleagues were physically unharmed and were co-operating with the police in terms of providing dashcam footage and statements. A cyclist paramedic was unfortunately struck by the car but thankfully did not sustain any physical injuries.

The Chief Executive advised of the background to the event and the preparations that took place beforehand. There were multiple events taking place during the bank holiday and so a strategic command was established to make suitable arrangements. As large crowds were expected, NWAS crews had a significant presence at the parade and so were able to reach the injured very quickly. The Trust ambulances, hazardous area response team, MERIT doctors, North West Air Ambulance and senior clinicians offered aid and treatment. St Johns Ambulance also had clinical teams present to support the Trust, and were quick to respond.

The Board noted the Trust had more than 30 resources on scene, with 13 emergency ambulances taking patients to our colleagues at Royal Liverpool, Alder Hey, Arrowe Park and Aintree Hospitals.

The Chief Executive observed that these types of incidents can have a profound effect on all involved; colleagues in call centres had to listen to some terrified callers, and ambulance crews had to manage a complex and panicked scene. All staff involved in the incident continue to receive support.

On behalf of all Board, the Chief Executive expressed gratitude to staff for all they did in such difficult circumstances and relayed the words of thanks received from external agencies.

The Chair reported on a number of meetings and events he attended since the last Board meeting, particularly his attendance at the Annual Staff Awards celebration and Improvement Academy Summit.

The Chair reported on the recruitment process for the new Chair and for the role of Director of Strategy and Partnerships, with both processes now concluded.

The Chair reported he attended regular meetings with NW System Leaders meetings, Trust Chairs meetings and Cheshire and Mersey Trust Chairs which were all focused on finance. He also attended the NWAS Improvement & Assurance Group with PWC, NHSE & ICB where financial planning discussions took place.

The Board noted the Well-led tender process had completed and that The Good Governance Institute had been selected, with the first Board observation taking place today.

The Board:

- Noted the Chair's update.

BOD/2526/022 Chief Executive's Report

The Chief Executive presented a comprehensive report, which covered activity undertaken since the previous Board meeting on 26th March 2025 including information on a number of areas, such as performance, regional issues, national issues and other general information.

The Chief Executive took the Board through the main points relating to performance and highlighted a stable situation in terms of demand and incident volume for the 999 service. He advised C2 performance continued to be below the revised NHSE target of 30 minutes.

Referring to handover across the three areas, the Chief Executive reported it continued to show signs of improvement in 2025. The Board also noted the deployment of Ambulance Liaison Officers (ALOs) across the most challenged sites across the region continues. ALOs support with the flow into departments, the process of cohorting, and assisting crews to clear once they have handed over.

In terms of NHS 111, the Chief Executive reported improved performance in a number of abandoned calls, which was credit to staff.

Referring to Patient Transport Services, the Chief Executive highlighted activity in Cumbria was -20% below baseline, Greater Manchester was 8% above baseline, Lancashire was -25% below baseline and Merseyside was 5% above baseline which was broadly consistent with previous months, and indicative of low unplanned activity in Cumbria and lower planned activity in Lancashire.

The Chief Executive reported on a number of national meetings he attended during April and May, such as NHS Providers Chairs and Chief Executives Network and Transforming Tomorrow through Leadership Today.

The Chief Executive took the Board through highlights of the regional organisational updates and advised of a number of community events as well as Trust the engagement events which took place in April and May.

He also informed of appointment of Michael Gibbs to the role of Director of Strategy and Partnerships.

The Board congratulated the first cohort of community first responders (CFRs) who received the new formal qualification – FAQ level 3 award for First Responders on Scene.

The Chair thanked the Chief Executive for the comprehensive round-up of the latest local, regional and national events. He asked for an update regarding the ambulance commissioning in the future.

The Chief Executive advised the ambulance sector had worked together to produce a paper to inform the future of commissioning in anticipation of the national review of ambulance commissioning expected later this year. The position paper sets out the current challenges of local arrangements and offers a clear perspective on how things could be improved. The document is available online on the website of Association of Ambulance Chief Executives.

Mr D Whatley referred to the challenging financial situation in the NHS and enquired whether the ICBs provided an update on their future operation, with a view to the cost reduction they are required to carry out. The Chief Executive advised there was a draft blueprint under consultation exploring future responsibilities, however latest communications indicated a lot of work was still required around this area.

Noting the information about Mental Health Awareness Week, Mr D Whatley referred to crisis hubs and asked about the implications of those for the Trust. The Chief Executive advised that whilst idea was not completely new, it should contribute to awareness that 999 should be called when there is a physical harm component present.

The Board:

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

BOD/2526/023 Common Seal Bi-annual Report

The Director of Corporate Affairs presented the regular report on the use of the Common Seal as determined by Section 8 of the Trust's Standing Orders.

The Board noted the Trust's Common Seal was applied on five occasions during the period from 1st October 2024 to 31st March 2025, as detailed in s2 of the report.

The Board:

- Noted the occasions of use of the Common Seal as detailed in s2 of the report.

- Noted compliance with s8 of the Standing Orders.

BOD/2526/024 Continuity of Services 7 (CoS7): Availability of Resources Declaration

The Director of Corporate Affairs advised the NHS Provider Licence required Trusts to make an annual declaration, no later than two months from the end of each financial year, as per Section 6 – Continuity of Services of the Provider Licence and CoS7 – Availability of Resources (s2 of the report).

She reported on the considerations in drafting the proposed declaration for the period 1st April 2025 – 31st March 2026, as per s3 of the report, with the proposed positive declaration articulated in s4.

The Certificate, for publication on the Trust's website was appended.

The Board:

- Reviewed and confirmed the declaration of compliance against CoS7 for publication on the Trust's website.

BOD/2526/025 Freedom to Speak Up Annual Report 2024/25

The Medical Director introduced the report and asked the Freedom to Speak Up Guardian (FTSU), Mr R Jones to present the highlights to the Board.

Mr R Jones took the Board through the key messages from the report. He advised of a stable position with a slight drop in the overall number of concerns raised compared to previous year however advised that the Trust completed its Service Delivery Model Review, which raised several concerns during the previous year.

Mr R Jones reported the Trust continued to track the classification of concerns under "open", "confidential" and "anonymous". He noted the previous reports to the Board incorrectly reported both "confidential" and "anonymous" together as "anonymous". In the data contained within this year's report, those were split out to provide greater clarity to the Board on the range of ways people wish their concerns to be handled.

The Board noted the changing trends in the methods people use to speak up with 93% of concerns now being received and dealt with electronically via the online form, or email.

In terms of Reporting by Service Line, Mr R Jones advised PES continued to be the service line where most concerns are raised from, noting it is by far the largest service line by staff numbers. In terms of the nature of concerns, the largest proportion of concerns raised continued to relate to inappropriate attitudes and behaviours, with a stable number of concerns relating to patient safety.

The Board noted staff have many routes to raise concerns, with many formal HR routes for concerns to be handled. Staff can also report concerns via the DCIQ

system to notify their leadership teams of both positive and negative experiences or events.

It was highlighted that there remained no digital method to triangulate concerns across the organisation by service line or geography, and caution was advised when reviewing the FTSU data in isolation.

In terms of resolution times, Mr R Jones reported the longest time for resolution was 152 days with an overall mean time to closure of 30 days as per Figure 4 of the report. He advised all cases were reviewed monthly at an executive assurance meeting. He reported the executive team had agreed a new process for more timely resolution, by escalating through senior leadership teams and advised the FTSU Guardians would continue to monitor the impact of that new process.

Mr R Jones further advised on the follow up processes and actions undertaken in terms of providing feedback and learning to people who speak up, staff training and National Guardians Office Recommendations.

The Board noted the next steps, as laid out in the report, including continuous review of Trust FTSU processes and learning from other trusts through regional and national networks, regulators, and the National Guardians Office.

Dr D Hanley referred to s6 relating to Equality and Sustainability Impacts. He pointed to the gender protected characteristic noting that only 11.7% FTSU concerns had been raised by female staff, whilst 56% of NWAS staff are female. He felt it was a worrying disproportion and encouraged more focus around this area to understand the reasons for it.

The Chair referred to the comment regarding triangulation and observed that the Board received and scrutinised information from various perspectives thus triangulating the data, although recognised it was not a formalised process for FTSU.

Mr R Jones reported he had discussed the triangulation with workforce colleagues, whilst there was no digital system supporting the triangulation, it was possible to draw out main themes. In terms of gender imbalance, he acknowledged the comment and would look into this area.

The Director of People advised that triangulation exercises had been carried out in the past on an ad hoc basis and highlighted two examples from the last 12 months of triangulation and concerted actions as a result of this.

FTSU Guardian, Ms F Balon referred to the gender protected characteristic imbalance and advised it is established through self-identification. She reported the networks discuss the issues as they come up in the concerns raised. She further advised that as a part of concern review, alternative avenues are offered if appropriate.

The Director of Quality and Improvement enquired about the evaluation of resolution to ensure the people who speak up are satisfied with the results. Mr

R Jones advised there was a robust process of addressing concerns raised, although the expectations may not always be met. Even after a case is closed, the dialogue with an individual continued for as long as it is required.

Dr A Chambers, NED Champion for FTSU reported , she informally meets with the FTSU Champions who undertake significant proactive work within the organisation to raise the profile of FTSU. Noting that FTSU is only one of routes to raise concerns in the Trust, she suggested it would be helpful to capture in the future report what happened as a result of the concerns raised and what the priorities for the next year were. Dr A Chambers would pick this up at the upcoming meeting with the FTSU Guardians.

The Chair thanked the FTSU Guardians for the report and discussion and observed the FTSU had progressed tremendously in the last few years, as evidenced by substantial assurance from MIAA audit in 2023.

The Board:

- Noted the content of the report and receive the assurance that the trust has completed the recommendations of the Speaking up, Listening to Workers Report from the NGO.
- Noted the assurance received relating to the ongoing efficacy of speaking up arrangements within the Trust.
- Continued its ongoing commitment to FTSU across NWAS in order to meet its strategic aims of high-quality inclusive care and being a great place to work.

BOD/2526/026 Fit & Proper Persons Requirements Annual Declaration

The Director of People presented the annual report with assurance that all Board Directors meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 including the Annual Chairman's Declaration in Appendix A.

The Board noted the Trust's compliance with the FPPT framework was audited by MIAA in June 2024, with the final report published in July 2024. with an outcome of 'High Assurance'.

The Director of People highlighted the annual assurance process for 2024/25, in line with the revised FPPT Framework, which included a number of checks, as detailed in Appendix 1.

The Board noted, in April this year, NHSE launched a new Board member appraisal framework which applied to all Board members and replaced the Chair appraisal framework. The Director of People advised of the specifics of the new appraisal framework as laid out in s5.1 and 5.2 of the report. She reported any further refinement of the appraisal paperwork to enhance compliance with the new framework would be considered ahead of next year's appraisals, as this year the appraisals had already started when the new guidance was published, and trusts were not expected to redo the process.

The Chair noted the significant of work that is undertaken every year to ensure all Board members remain Fit and Proper.

The Board:

- Recorded that the Fit and Proper Persons Test has been conducted for the period 2024/2025 and that all Board members satisfy the FPPT requirements.
- Noted the new Board appraisal framework.

BOD/2526/027 Annual Health, Safety, Security and Fire Report 2024/25

The Director of Corporate Affairs presented the 2024/25 Annual Health and Safety report providing detail of the Health, Safety, Security & Fire team's operational performance, overview of its achievements and challenges faced during the reporting period, and a look forward to the ambitions for 2025/26.

The Board noted the governance arrangements in place, which provide a comprehensive oversight and support proactive management and continuous improvements in all areas of health and safety, as described in s2 of the report.

The Director of Corporate Affairs presented the details of Incidents and near-miss activity (including health and safety) reported on Datix Cloud IQ (DCIQ), RIDDOR incidents reported to the Health and Safety Executive under the RIDDOR regulations, training compliance, workplace inspections and violence prevention and reduction activity. She advised a thematic review of reported RIDDOR incidents identified the following learning themes: moving and handling; slips, trips and falls; and violence and aggression. The Director of Corporate Affairs brought to attention 6,494 working days were lost as a result of these reportable incidents and required more analysis.

The Board noted during 2024/25, a separate team overseeing violence, prevention and reduction was established within the Quality directorate. The Trust had seen an increase in reporting of violence and aggression incidents during 2024/25, with the largest number of incidents being verbal aggression towards our call handlers within our Integrated Contact Centres (ICCs).

The Director of Corporate Affairs considered whether the report stated the Trust is safe and observed there was no one single indicator that could provide this assurance, however, there is a safety net of reporting, guidance, training and inspections in a difficult environment the Trust operates in.

Dr D Hanley thanked the Director of Corporate Affairs for the report which he found helpful and abundant in data together with being well presented. He referred to chart 15 describing the data for Infection, Prevention & Control (Staff & Trust Incidents) and noted an increased trajectory and queried whether this was a concern. He also pointed to chart 7 containing data on near-misses and noted a drop in reporting of those.

The Director of Corporate Affairs advised it was important to raise awareness regarding reporting of near-misses, which can be sometimes overlooked, due to

staff being used to working in a high-risk environment. The Chair agreed that communication to staff around it could be strengthened, however taking into account the very specific high risk environment staff operate in, such as the recent Liverpool incident which could potentially generate a multitude of near-misses.

Dr A Chambers reported as a NED Champion for security management, she found the report very helpful and noted that an increase in reporting of IPC infection could be indicative of better awareness of those incidents that need to be reported. Referring to staff injuries, she wondered whether a proactive approach could be taken to staff health in terms of health & wellbeing and fitness, in anticipation to difficult working environment, to shift to preventative action.

The Director of People advised the training is being kept up to date, focusing on risky manoeuvres. In addition, the Health & Wellbeing team promote good health and fitness, with resources available on the Green Room. The Director of People noted she would raise the question with HR Directors nationally to scope if anything more could be done.

Prof A Esmail welcomed the comprehensive report and suggested that in future it could be presented in IPR style charts, when more data is acquired. Referring to near-misses, he suggested a concerted effort on that reporting, for example in one month, as this approach could bring higher response level.

The Chair welcomed the report and noted that more in-depth review and benchmarking of the days lost due to incidents would be needed as well as relentless focus on prevention of any violence and aggression against staff.

The Board:

- Noted the 2024/25 Health and Safety Annual Report, the improvements made throughout the reporting period and the focus of the team during 2025/26.

BOD/2526/028 Audit Committee 3A report from the meetings held on 25th April 2025 & 23rd May 2025

Mr D Whatley presented the Audit Committee 3A Reports from the meetings held on the 25th of April and the 23rd of May.

In terms of the Audit Committee meeting held on 25th April 2025, the Board noted there were no alerts and a number of advisements, as listed in the report, including the approval of 2025/26 Audit Plans for Internal Audit and Anti-Fraud Services. Mr D Whatley reported the Audit Committee received the Head of Internal Audit Opinion for the period 1st April 2024 to 31st March 2025, which provided Substantial Assurance.

Reporting from the Audit Committee held on the 23rd of May, Mr D Whatley reported no alerts and advised the draft Annual Governance Statement was presented by the Chief Executive for review by the Committee. The Committee

also received the draft unaudited annual accounts 2024/25 and draft Annual Report 2024/25.

Mr D Whatley congratulated the Finance and Procurement Teams on their recent achievements.

The Board noted the Finance team were named the first ambulance trust team to be rated at Level 3 (the highest) in One NHS Finance Towards Excellence accreditation process, whilst the Procurement team were recently categorised 'Best' with a score of 91% in their Commercial Continuous Improvement Assessment Framework (CCIAF) accreditation – which rates public sector procurement teams on their best practice and processes.

The Board:

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

BOD/2526/029 Charitable Funds Committee 3A Report from the meeting held on 14th May 2025

Mr D Whatley presented the Charitable Funds Committee 3A Report from the meeting held on 14th May 2025. The Committee received a number of reports, and no alerts were raised on this occasion. Mr D Whatley reported the CFC were assured of a successful year 2024-25 and approved the three-year Business Plan for 2025-2028.

The Board:

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

BOD/2526/030 Trust Management Committee 3A Report from the meetings held on 23rd April 2025 and 21st May 2025

The Chief Executive presented the Trust Management Committee (TMC) 3A report from the meeting held on 23rd April 2025 and advised there were three alerts and a number of assurance reports, as listed within the report. The alerts related to UEC growth funding, PTS complex and uncertain operating environment due to delays with the procurement process and an interim update on the Southport Inquiry debrief process. The TMC discussed two risks.

In terms of the report from the meeting held on 21st May 2025, the Chief Executive reported three alerts and a number of assurance reports, as listed within the report. The alerts related to a fallback system 'pathway solo' being withdrawn by NHS Digital, notice of a strike action and a number of large scale events, which required multi-agency co-ordination and mutual aid support due to the size and scale. The TMC also discussed risks, including a new risk identified around UEC Growth Funding, dependant on delivery of Q1 and Q2 targets.

Prof A Esmail referred to the UEC Growth Funding deliverables and enquired whether it was contingent on C2, which was currently on target. The Chief Executive advised C2 was a prominent part of the deliverables in addition to others.. He also noted that the pressure would increase seasonally during winter months as usual, however the Trust continued to work towards improvement ahead of winter.

The Chair requested that the Committees continue to closely monitor the issues raised as per the TMC reports.

The Board:

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

BOD/2526/031 Equality, Diversity, and Inclusion Annual Report 2024/25

The Director of People presented the EDI Annual Report, compiled by the Staff Experience Team. She advised the report fulfils the Trust's statutory obligation under the Public Sector Equality Duty and also serves to demonstrate Trust's commitment to being an inclusive employer and service provider.

The Board noted the report was structured around the progress against the refreshed EDI priorities, agreed by the Board last year. The Director of People reassured the annual report contained previously reported information, and the Annual Report had been received by the Diversity and Inclusion Group as well as the Resources Committee and recommended for Board approval to publish.

The Board noted several highlights from the report, including the publication of the Trust's EDI and Anti-racism Statements, the expansion of the free sanitary products initiative to support staff wellbeing, and the delivery of the ParaMEdic Residential programme aimed at broadening awareness of careers in the ambulance sector. The Director of People also noted the Trust received external recognition for its efforts, achieving awards such as Disability Confident Leader status and the TiDE Gold Award. She added the report included highlights from all five staff networks as well as a summary of the Chaplain's work and, for the first time, the NWAS Charity's contributions to EDI work.

Dr D Hanley reassured the report had been reviewed by the Resources Committee, recognising challenges as well as achievements, together with the great formatting of the report.

The Chair asked the Director of People what she was the most proud of looking back at the last year and key challenges lying ahead. The Director of People advised she was pleased with the development of reasonable adjustments training sessions designed to enhance understanding around effectively supporting staff requiring reasonable adjustments, due to disability or health condition, which caused the positive shift in Staff Survey results as well.
She also referred to the co-delivery of an interactive and engaging ParaMEdic Residential Programme in partnership with the College of Paramedics and Edge Hill University.

In terms of challenges, the Director of People advised there was still improvement required around recruitment and the anti-racism work, to land it effectively and continue the focus to make improvements in this area.

The Chief Executive observed that work around EDI never stopped however the report presented a clear picture of what is being done in the Trust.

Prof A Esmail encouraged to be positive about the achievements, as there have been a lot of improvement in terms of both process and results as compared to a few years ago.

Dr C Grant noted the progress of the last few years by which the focus of EDI shifted from People Department to becoming a part of everyone's portfolio.

The Chair thanked the Director of People for the good report and assurance provided. He observed the achievements so far and further improvements rely on all executive directors supporting the cause.

The Board:

- Reviewed and noted the contents of the EDI Annual Report 2024-25
- Received assurance that the Trust has complied Public Sector Equality Duty (specific duty) in producing an EDI Annual Report
- Approved publication of the report via internal and external communications

BOD/2526/032 Green Plan

The Director of Finance presented the refreshed Green Plan 2025-2028, based on progress to date and taking into account the national targets for the NHS carbon footprint and carbon footprint plus, as well as learning from Trusts which are already aiming to exceed these ambitions.

The Board noted the Trust engaged with internal stakeholders and key partner organisations to inform sustainability priorities and identify areas for productive collaboration.

The Board were advised the Trust continued to work towards to main net zero targets as listed in s3.2 of the report. The Trust action plan is aligned with the latest NHSE Green Plan Guidance as well as the NHSE Carbon Footprint tool for calculating the impacts and is structured around ten key areas of focus, listed in s3.3 of the report.

The Director of Finance highlighted the Green Plan had been reviewed by the TMC and Resources Committee and received positive feedback and was recommended for approval by the Board. She also advised the presented version was subject to change by Communications team to meet readability and accessibility guidance, however the content would not change.

Prof A Esmail was pleased with the content and presentation of the Green Plan. He noted however the challenge regarding expenditure in relation to this and

queried how it fit with the Trust plans. The Director of Finance advised the plan was closely linked to the Trust Sustainability Strategy. The approach to forward planning for the Trust Green Plan would ensure decisions are made with consideration for value for money and the capital programme.

The Chair referred to the risks laid out in s4 and queried how the resources risk and conflicting demand would be met.

The Director of Finance advised the Trust was ahead of the sector regarding the progress of the plan. The biggest risk however was linked to the wider national infrastructure and capacity of electricity across the country, which was a challenge recognised by NHSE.

The Chair acknowledged the Green Plan was a significant priority and the Trust would continue to strive to introduce changes within the areas it can impact on.

The Board:

- Reviewed the content of the Green Plan attached as Appendix A; and
- Approved this 3-year Green Plan for publication, noting that this version is subject to change by Comms to meet readability and accessibility guidance.

BOD/2526/023 Resources Committee 3A Report from the meeting held on 22nd May 2025

Dr D Hanley presented the Resources Committee 3A Report from the meeting held on 22nd May 2025. The Committee received a number of reports for assurance and decision, as listed in the 3A report, and no alerts or risks were raised on this occasion. Dr D Hanley highlighted most of the decision items were included on the Part 2 of the Board agenda, as recommended for approval by the Resources Committee.

The Board:

- Noted the significant workload of the Resources Committee, the contents of the report, the assurance provided and actions identified.

BOD/2526/034 Integrated Performance Report

The Director of Quality and Improvement presented the Integrated Performance Report (IPR) with an overview of integrated performance to the month of April 2025. She provided an overview of the report, with the executive summary drawing out the main points in terms of quality, effectiveness, operational performance, finance and organisational health.

The Board noted, the IPR was presented in an updated format.

Prof A Esmail welcomed the IPR in the new format and observed the refreshed presentation allowed for better visibility of trends and the additional commentary was very helpful as well.

Dr D Hanley echoed the above comment and added the presentation of data was much clearer.

The Director of Corporate Affairs presented an overview of complaints and incidents data and noted a stable position. The Board noted complaints data had been updated to show level 1-2 and 3-5 to match with Patient Advice and Liaison Service (PALS) and Resolution team structures.

In terms of incidents, the Director of Corporate Affairs reported care and treatment remained the most common theme for patient incidents and violence and aggression the most common theme for non-patient incidents. In terms of non-patient incidents, the data presented in IPR listed 15 most common reasons for both patient incidents and non-patient incidents.

The Director of Quality and Improvement added the patient incidents data remained static. She advised the Trust requested to be a part of the national Learning from Patient Safety Events national taxonomy review which aims to improve data collection and reporting.

With regards to Patient Experience data, the Interim Deputy Director of Strategy, Partnerships and Transformation reported static scores and low response rate, noting the patient experience team were piloting an initiative to increase return response rates. Examples of positive and negative comments from patients were included in the pack.

The Chair observed the time of arrival or the time of answering the phone were the biggest indicators for patient satisfaction and it should be kept in mind, notwithstanding how complex it is operationally.

The Medical Director referred to Ambulance Clinical Quality Indicators (ACQI's) and reported The Trust was performing above national average for all ACQI metrics, as detailed in the SPC charts. The Board noted the Falls care bundle performance improved from 20.3% in September to 54.3% in December following the introduction of a falls tile within the electronic patient record (EPR) system.

Prof A Esmail enquired whether stroke data would still be monitored. The Medical Director reassured stroke data was monitored and any escalations would be brought to attention.

The Director of Operations reported on the operational performance data in relation to Paramedic Emergency Services (PES) Activity, PES Call Pick Up and 999 Ambulance Response Performance. He advised that reduction in conveyance remained the area of focus, recognising the correlation between Hear & Treat (H&T). In terms of H&T, the Board noted an increase in the H&T rate to 15.6%, which was indicative of the Phase 3 Integrated Contact Centre (ICC) implementation, whilst nationally, the Trust ranked 5th for H&T, 8th for S&T and 4th for S&C.

The Director of Operations reported a strong position for call pick up and advised all response times continued to improve (including C1 and C2), adding that the

winter pressures would be the real test for the improved handover times and the financial decisions made in the system now, will have an impact on those future scores. Currently, the turnaround was stable, however continued to exceed the 30-minute standard.

In terms of 111, the Director of Operations advised following the withdrawal of national contingency support, the service was operating at full capacity. The call volume and most performance metrics were stable, albeit above national targets. The Board noted the Trust met one performance target (abandoned call rate) and fell short for some other 111 measures.

In reference to Patient Transport Services (PTS), the Board noted no variation from previous months with operational and workforce improvement plans in place.

The Chair observed the strong performance of 111 service, following cessation of national support, was testament to the team. He welcomed the much anticipated improvement in C1 and C2 categories.

Dr D Hanley welcomed the positive performance report. He noted a small error in the chart regarding C1 mean, which would be corrected.

Dr A Chambers noted the significance of the Trust's strong links and cooperation with the system, as well as advancements in call before convey. Prof A Esmail wondered whether call before convey was still in a pilot stage.

The Director of Operations advised there were multiple local variations, some in pilot stage, as work continues to develop 'call before convey' models across all areas of the NW region. The Board noted ICBs work to evolve these models into care co-ordination, which would ensure more consistence around acceptance criteria, access, and hours of delivery. He advised it was a national requirement that all systems have care co-ordination and the Trust works closely with the region on this.

The Director of Finance presented the financial data from the IPR report, highlighting new charts within the IPR. The Board noted the financial position to 30 April 2025 (Month 01) at a surplus of £0.018m, against a planned deficit of £0.448m, with the variance due in part to pay costs and non-pay inflation below the level planned. The Director of Finance advised the agency target for 2025/26 was to reduce agency spending by 30% based on the 2024/25 projected spend (as at month 08). The Chair queried the data in the new CIP chart and the Director of Finance advised this would be checked. The detailed discussion around CIP would take place in Part 2.

The Director of People presented the Organisational Health data from the IPR report, which contained detailed charts and commentary in relation to: staff sickness, turnover, temporary staffing, vacancy gap, appraisals, mandatory training and case management, reporting stable and improving metrics. She pointed to mandatory training data advising the overall compliance was below the revised target of 90% at 83%, which was due to the addition of five extra

modules to the MT, however it was expected the position would recover over coming months.

The Chair was pleased with the positive workforce metrics and advised a strong focus on Mandatory Training and appraisals compliance ahead of the winter pressures. He welcomed the overall good performance in all performance metrics and noted it was a result of the impact of the decisions being made by the Board.

The Board:

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

BOD/2526/035 Learning from Deaths Q3 2024/25

The Medical Director presented the report with Q3 dashboard at Appendix A, advising the main concerns raised internally and externally identified in DatixCloudIQ (DCIQ), were attributed to problems in ICC and PES, specifically around delayed emergency response, and care and treatment. He also highlighted a marked improvement in the quality of patient records.

The Board noted a new process which meant any cases in which harm may have been caused by the Trust would be referred to PSIRF team for a review within the PSIRF priorities.

The Medical Director advised of challenges with availability of panel members due to re-structure process, however with this being now complete, the availability of clinical colleagues was expected to improve. He also advised the core team was now settled, which would further improve consistency.

The Chair thanked the Medical Director for the comprehensive report and welcomed another level of triangulation of the information through the introduction of the PSIRF layer to the process.

Prof A Esmail assured the Quality and Performance Committee received and discussed the report, noting the changing culture of robust triangulation as well as sharing of learning.

Dr D Hanley referred to the trends and noted some are one-off examples and enquired whether there was a way to find out whether those instances happen more regularly. The Medical Director advised these were provided for context but reviews provide constant cross challenge as well as the regional and local area learning forums (ALFs). He further observed the sustainable changes are those to which are hardwired into system design.

The Director of Quality and Improvement added the PSIRF group meets weekly and those issues and themes are picked there through structured reviews.

The Board:

- Supported 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.
- Acknowledged the impact of the SJR process in identifying opportunities for improving care.
- Supported the dissemination process as described in Section 4.

BOD/2526/036 Complaints Annual Report 2024/25

The Director of Corporate Affairs presented the key messages from the report, noting the report develops each year as data collection increases. She reminded the Trust has a statutory obligation to investigate and respond to complaints raised with the organisation in relation to the care which it provides, the Trust works together with other organisations to ensure that the response to complaints or concerns cover all areas of the complaint in one response communicated to the patient, their family or their representative.

The Director of Corporate Affairs highlighted that the complaints management process received substantial assurance following an internal audit during 2024/25.

The Board noted the Trust, in 2024/25 the Trust received 2,277 complaints managed by the Patient Advice and Liaison Service (PALS) and Resolution team. Of the complaints received, 89% were recorded as 'low complexity' complaints and managed by the PALS team who provided appropriate and empathetic apologies within an everyday conversation, as guided by the PHSO's standards. In terms of closure rates, 86% of all complaints were responded to within agreed timeframes.

The Director of Corporate Affairs reported the top three themes were: care and treatment, delays and call handling. Of the 2,242 complaints closed: 28% upheld, 31% partly upheld, 41% not upheld. She pointed to s4 relating to Equality, Diversity and Inclusion (EDI) and advised the EDI data started being collected to capture the protected characteristics of patients who raise complaints, allowing for more meaningful analysis. Further work with Public Health and Patient Inclusion Teams is planned for 2025/26 to better identify, understand and address barriers to access our Complaints' service with the aim of facilitating a deeper understanding of the accessibility and equality of our service.

The Board noted the Trust received 10 notifications from the Parliamentary Health Service Ombudsman advising of complaints submitted for independent review, with 3 cases remaining open into 2025/26.

Ms M Afsar enquired about the methods the Trust would identify and monitor repeat complaints from one individual?

The Director of Quality and Improvement advised data would be held and monitored in local teams, if there were repeat complaints from one member of staff. The Director of People added the responsibility for monitoring of repeat complaints lies with the local team and the local senior management would have

oversight of those. The Director of Operations advised the local score cards would include some of these aspects to see at locality level and identify the outliers.

The Chair referred to sexual health safety aspect of staff welfare based on a hypothetical example of a staff member with a number of low level complaints against them and moving roles across areas. The Director of People advised that through the work sexual safety campaign, the intelligence follows staff members and fact finding goes to independent panel for consistent approach.

The Chair asked the Resources Committee to gain further assurance that the Trust has mechanism to identify an individual amassing low level complaints and escalation would follow from local control team to senior management to review and investigate.

Dr D Hanley suggested it would be helpful if the next year's report included a section describing lessons learned. The Director of Corporate Affairs acknowledged the point for the next year.

The Chair thanked the Director of Corporate Affairs for the comprehensive report.

The Board:

- Noted the assurances provided that Trust's handling of complaints is compliant with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009; the PHSO model complaint handling procedure and the expectations of the NHS Complaint Standards.

BOD/2526/037 Quality and Performance Committee 3A Report from the meeting held on 28th April 2025.

Prof A Esmail introduced the report, which contained no alerts and a number of assurances. He noted that a significant number of updates had been relayed to the Board through the IPR discussion at today's agenda.

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

BOD/2526/038 Trust Strategy 2024-25 Year-end Report

The Interim Deputy Director of Strategy Planning & Transformation introduced the year-end report by providing background to the Trust Strategy development and latest extension to March 2026. She highlighted high-level cumulative progress over the past three years towards the Trust strategic aims advising that detailed delivery assurance reports are routed through the Committees.

The Board noted in 2024-25 numerous metrics of success and cross-reference were developed to measure the progress of the Strategy, noting that most of the data are presented in other reports, such as IPR. The detailed Q4 was received

at the Resources Committee, which noted that those actions, which had not been completed, would be followed up by the Corporate Groups governance assurance route.

The Interim Deputy Director of Strategy Planning & Transformation advised the Trust Strategy would be redeveloped during 2025/26 along with supporting strategies and a measurement working group had been established as part of the project governance structure.

Dr D Hanley confirmed the Resources Committee discussed the detailed strategy report at its last meeting and reviewed the actions which were complete and advised of a clear assurance process for this year. It was discussed that the plan had been very ambitious and a realistic approach had been taken for this year. The Committee also noted that some actions which had not been complete, were outside of NWAS control, noting however a significant progress in delivery of the plan.

Prof A Esmail was pleased with the refreshed presentation of data in the report, including tables and charts. He observed that the delivery of the strategy might also be impacted by the current CIP requirements.

The Chief Executive advised the delivery of Trust Strategy and Annual Plan required a degree of agility and noted there was no single metric to reflect on the progress but a lot of information from various sources needs to be brought together.

The Chair asked the Interim Deputy Director of Strategy Planning and Transformation what the most successful and most challenging issues were with regards to the strategy delivery. The Interim Deputy Director of Strategy, Planning and Transformation advised the strategy now constitutes a part of every meeting and is referenced in all reports as a part of business as usual, which was a positive development. In terms of challenges, there was not one indicator advising of the progress of strategy but a plethora of metrics.

The Chair enquired about the potential risks to non-delivery of the strategy. The Chief Executive advised that whilst the Trust made significant progress with system partners in delivery of our aims, the challenging financial situation and pressures that all organisations are under may slow down this process.

The Chair welcomed the comprehensive report and clear progress made, noting the issue of metrics as well as financial pressures impact on delivery and availability of partnering organisations.

The Board:

- Reviewed and discussed the progress against Our Strategy 2022-2025, and
- Provided feedback on the content and presentation of the paper which may inform the development of strategy assurance updates in the future.

BOD/2526/039 Communications and Engagement Q4 2024/25 Report

The Interim Deputy Director of Strategy Planning and Transformation took the Board through the key headlines from the report and provided an overview of the enclosed dashboard with a quarterly summary of key outputs and highlights including those regarding public engagement, patient experience surveys, internal communication and comms and engagement plans for Q1.

The Board noted there were new expressions of interest to the Patient and Public Panel which now totalled 342 members, with representation from diverse communities at 25%.

In terms of Freedom of Information request, the Interim Deputy Director of Strategy Planning & Transformation highlighted those rose by 44%, the team however managed to achieve 99% compliance with a 20 day response target.

Ms M Afsar queried whether the Trust held information available to repeat FOI requests. The Director of Corporate Affairs confirmed the Trust holds a publication scheme on the Trust website, which covered a wide range of topics.

The Board:

- Noted the content of the report.

BOD/2526/040 Any Other Business Notified Prior to the meeting

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

BOD/2526/041 Risks identified

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

The Chief Executive noted it was the last face to face Board meeting for the Chair, who would leave the Trust at the end of June.

On behalf of the Board, he thanked the Chair for his leadership through 11 years of service and enormous contribution to the Trust development and strong position. He thanked the Chair for constructive challenge, championing equality & diversity and staff matters and relentless focus on patients and quality. Under the Chair's leadership, the Trust navigated the pandemic and went from strength to strength gaining regional and national recognition.

The Chair thanked the Chief Executive for the kind words and expressed it was an honour and privilege to serve the Trust. He observed the ambulance service is the most complex, risk laden part of public sector and to be able to navigate this day by day takes very strong leaders. He asked the Board members to look after each other, especially in challenging times of financial pressures and demand, so that the Board remains unitary and unwavering.

Date and time of the next meeting –

30th July 2025 at 09:45 am in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Signed _____

Date _____

NHS
North West
Ambulance Service
NHS Trust

Part 1 Minutes
Board of Directors

Details: Wednesday, 18th June 2025
10.45 am via Microsoft Teams

Present:

Mr P White	Chair
Mr S Desai	Chief Executive
Mr D Ainsworth	Director of Operations
Mrs C Butterworth	Non-Executive Director
Dr A Chambers	Non-Executive Director
Prof A Esmail	Non-Executive Director
Dr E Strachan-Hall	Interim Director of Quality
Mr D Whatley	Non-Executive Director
Mrs C Wood	Director of Finance
Mrs L Ward	Director of People

In attendance:

Mr A Makda	NeXT Director
Mrs E Shiner	Deputy Director of Corporate Affairs
Mrs P Harder	Head of Corporate Governance (Minutes)

Minute Ref:

BOD/2526/42 **Apologies for Absence**

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

BOD/2526/43 **Declarations of Interest**

There were no declarations of interest to note.

BOD/2526/44 **Audit Completion Report**

The Director of Finance presented the Audit Completion Report which summarised the findings of the external audit of the Trust's financial statements for the financial year ending 31 March 2025.

She noted the intention to issue an unqualified opinion which was a true and fair view of the trust's financial position. She referred to Section 2 which detailed the elements of work still outstanding and would be concluded once the accounts were adopted by the Board of Directors.

Due to a change in accounting standards, the Director of Finance advised the audit certificate could not be issued until the Department of Health and Social Care's accounts had been audited and affected all NHS providers.

She referred to Section 4 relating to significant findings from the audit other key areas of judgment and advised there were no issues to report back to the Audit Committee.

In terms of the summary of disclosure misstatements, the Director of Finance highlighted these were included within Section 5 and related to small changes between the draft and final accounts.

She advised the report was accepted by the Audit Committee and was presented to Board ahead of adopting the accounts.

Mr D Whatley advised the external auditors intended on providing an unqualified opinion, no significant control weaknesses and no significant weaknesses in value for money. He thanked the Director of Finance and team for delivering the accounts ahead of the timescale, particularly the lack of any significant adjustments between managements accounts reported in year and the final accounts.

The Chair echoed these comments and thanked the Director of Finance and team for the word undertaken.

The Board of Directors:

- Noted the content of the audit completion report and assurance provided.

BOD/2526/45 Audited Annual Accounts 2024/25

The Director of Finance presented the audited annual accounts for 2024/25 prepared in line with the Department of Health and Social Care (DHSC) Group Accounting Manual for 2024/25 and had been prepared and submitted in line with the prescribed deadlines.

She reported the Trust met all of its statutory duties, namely:

1. The adjusted financial position is a surplus of £6,288k;
2. The Trust spent in line with its capital resource limit (CRL).

She reported both the draft and audited accounts had been presented to the Audit Committee and recommended to the Board of Directors for approval. She advised the report provided an overview of the primary statements within the accounts and movements from the previous year.

The Board of Directors

- Approved and adopted the audited annual accounts for 2024/25.

BOD/2526/46 **Management Letter of Representation**

The Director of Finance presented the management letter of representation drafted by the external auditors for signature by the Chief Executive on behalf of the Board of Directors.

She advised the contents of the letter attests to the accuracy of the financial statements and was largely driven by matters that the external auditors wish us to confirm to support compliance with accounting and auditing standards. She added the changes from 2023/24 had been included in s1.4.

The Board of Directors:

- Noted the content of the report and confirmed agreement for the letter to be signed on behalf of the Board of Directors.

BOD/2526/47 Annual Report 2024/25

The Deputy Director of Corporate Affairs presented the Annual Report and Accounts and confirmed it met the requirements of the DHSC Group Accounting Manual (GAM).

She added confirmation had been received from the external auditors that no further amendments were required.

In terms of the annual governance statement, she advised the report was presented to the Audit Committee on 23rd May 2025 and provided confirmation in relation to the trust's internal systems of control, with no significant issues identified.

The Deputy Director of Corporate Affairs advised the Annual Report was presented for approval, on recommendation of the Chair of the Audit Committee.

Mr D Whatley commented he had reviewed the draft annual report and had provided feedback. In terms of the annual governance statement, he advised the Chief Executive had attended the Audit Committee in May 2025 to present the draft statement and recommended the Annual Report 2024/25 for formal adoption and approval.

The Board:

- Noted the contents and compliance against the mandatory requirements set out in the DHSC Group Accounting Manual 2024/25; and
- Noted the formal recommendation of the Chair of Audit Committee to the Board of Directors to approve the Annual Report..

- Formally approved the Annual Report 2024/25 and noted the Chief Executive would sign off on behalf of the NWAS Board of Directors.

BOD/2526/48 **Quality Account 2024/25**

The Director of Quality, Innovation and Improvement presented the Quality Account 2024/25 to the Board of Directors for approval.

She reported the Quality Account had been submitted to the Trust Management Committee and circulated to Quality and Performance Committee members and noted their feedback had improved the report and referred to the timescale for review within the executive summary. She advised feedback had been provided in terms of timescales for review and stated this had been extended.

She advised the Quality Account 2024/25 was presented to the Board of Directors for approval. A review of the process undertaken in developing the report had been undertaken to improve the process for next year.

The Chair advised members of the Board, the Quality Account provided an important overview of 2024/25 and was particularly important considering the well-led review currently being undertaken.

Prof A Esmail noted it was a comprehensive document and provided a good overview of the work undertaken, particularly the Improvement Academy and supported the recommendation to the Board of Directors for approval.

The Board:

- Approved the Quality Account 204/25 for publication on 30 June 2025.

BOD/2526/49 Any Other Business Notified Prior to the Meeting

The Chief Executive referred to the amount of work undertaken by the teams of the Director of Finance, Director of Corporate Affairs and Director of Quality. He referred to the current pressures which compounded an already busy schedule and the support of all the Committees to get to this position. The Chair echoed these comments.

Date and time of the next meeting:

9.45 am on Wednesday, 30th July 2025 in the Oak Room at LBH.

Signed……. Dated ……

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	28.5.25	FTSU Annual Report due on Board agenda May 2025. Updated Annual F2SU report will contain agreed actions. 28.05.25 The Board received the FTSU Annual Report at the meeting in May 2025, including references to the agreed actions. This includes protected characteristics whenever possible, excluding truly anonymous reporting.	
1 - 25/26	28.05.25	14	Patient Story	The Medical Director would confirm whether private providers have access to interpretation / communication tools.	Medical Director	30.07.25	30.07.25	Following the meeting, the Medical Director evidenced the private provider access to the Language Line insight app.	
2 - 25/26	28.05.25	36	Complaints Annual Report 2024/25	The Resources Committee would gain further assurance that the Trust has mechanism to identify an individual amassing low level complaints and escalation would follow from local control team to senior management to review and investigate.	Director of Corporate Affairs/Director of People	30.07.25	TBC	Work related to the action is underway with a further meeting in August. As the assurance is to be provided through the Resources Committee, it is suggested that the action is transferred to the RC action log to agree suitable timeline for providing assurance.	

NWAS Board and Committee Attendance 2025/26

Board of Directors								
	30th April	28th May	18th June	30th July	24th September	26th November	28th January	25th March
Daniel Ainsworth	✔	✔	✔					
Dr Alison Chambers	✔	✔	✔					
Salman Desai	✔	✔	✔					
Prof Aneez Esmail	✔	✔	✔					
Dr Chris Grant	✔	✔	✔					
Dr David Hanley	✔	✔	x					
Catherine Butterworth	✔	x	✔					
Lisa Ward	✔	✔	✔					
Angela Wetton	✔	✔	x					
David Whatley	✔	✔	✔					
Peter White (Chair)	✔	✔	✔					
Carolyn Wood	✔	✔	✔					
Dr Elaine Strachan-Hall	✔	✔	✔					

Audit Committee						
	25th April	23rd May	18th June	18th July	24th October	16th January
Dr Alison Chambers	✔	✔	✔	✔		
Dr Aneez Esmail	✔	✔	✔	✔		
David Whatley (Chair)	✔	✔	✔	✔		
Catherine Butterworth	✔	x	✔	✔		

Resources Committee						
	22nd May	24th July	18th September	20th November	22nd January	19th March
Daniel Ainsworth	✔	x				
Catherine Butterworth	x	✔				
Dr David Hanley (Chair)	✔	✔				
Lisa Ward	✔	✔				
David Whatley	✔	✔				
Carolyn Wood	✔	x				

Quality and Performance Committee						
	28th April	30th June	1st September	27th October	15th December	23rd February
Daniel Ainsworth	✔	✔				
Dr Alison Chambers	✔	x				
Prof Aneez Esmail (Chair)	✔	✔				
Dr Chris Grant	✔	x				
Dr David Hanley	✔	✔				
Dr Elaine Strachan-Hall	✔	✔				
Angela Wetton	✔	✔				

Charitable Funds Committee				
	14th May	23rd July	22nd October	18th February
Daniel Ainsworth	x	x		
Catherine Butterworth	✔	✔		
Dr David Hanley	x	x		
Lisa Ward	✔	✔		
Angela Wetton	✔	✔		
David Whatley	✔	✔		
Carolyn Wood	✔	x		

Nomination & Remuneration Committee							
	30th April	28th May	30th July	24th September	26th November	28th January	25th March
Catherine Butterworth	✔	x					
Dr Alison Chambers	✔	✔					
Prof Aneez Esmail	✔	✔					
Dr David Hanley	✔	✔					
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	**Closed**	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	**Closed**	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.
			Interim Board Chair of MioCare which comprises a group of not for profit health and social care companies which are owned by Oldham Metropolitan Borough Council. I have held this position since mid 2024.		√			Position of Authority	Mid-2024	Present	
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	Board member for the Association of Ambulance Chief Executives		√			Position of Authority	Jul-25	Present	Discussion with Chair should any conflicts arise.
			Represent the ambulance sector on the NHS Impact Improvement Board		√			Non Financial Professional Interest.	Jul-25	Present	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.

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	
David	Hanley	Non-Executive Director	Lay Representative Royal College of Physicians			√		Non Financial Professional Interest.	May-24	April 2025	No conflict.
			Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	7th July 2025	No conflict.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
			Chair, Gloucester Safeguarding Adults Board	√					Jun-25		
Julia	Mulligan	Chair	Chair, Gangmasters and Labour Abuse Authority (GLAA)				√	Position of authority	Nov-21	Present	N/A
			Senior Independent Director, Independent Office for Police Conduct				√	Position of authority	May-21	Present	N/A
			Independent Panel Chair, Parole Board of England and Wales				√	Position of authority	Sep-20	Present	N/A
			Chair of Trustees, Independent Domestic Abuse Service				√	Position of authority	Jan-20	Present	N/A
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 financial 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	Feb-25	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	Independent Chair of Audit Committee at Lancashire Combined Authority		√			Non financial professional interest	Jul-25	Present	Withdrawal from the decision making process if the organisations listed within the declarations were involved.
			Trustee Pendle Education Trust		√				Mar-23	Present	
			Governor, Nelson and Colne College Group		√				Mar-23	Present	
			Independent Member of Audit Committee, Pendle Borough Council		√				Mar-23	Jul-25	
			Wife is employed at Manchester Teaching Hospitals NHS FT as a Biochemist				√		Mar-23	Present	
Carolyn	Wood	Director of Finance	Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict.
Elaine	Strachan-Hall	Interim Director of Quality and Improvement	Director of Strachan Hall Associates Ltd	√				Directorships, including non-executive directorships held in private companies or plc (with the exception of dormant companies);	Sep-13	Present	No business to be transacted through consultancy with NWAS whilst employed by NWAS
			Member of the Independent Reconfiguration Panel for the NHS 2003		√			Any other relevant secondary employment	Jul-22	Present	No involvement with any IRP decision making that might impact NWAS whilst employed by NWAS
			Clinical associate with KPMG	√				Any other relevant secondary employment	2013	Present	Notification of any work with KPMG to NWAS during NWAS contract. Withdrawal fro any NWAS contract processes in relation to KPMG. Withdrawal of any KPMG processes in rlatin to NWAS.

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	
Peter	White	Chairman (Left the Trust 30/06/25)	Chair of Lancashire Teaching Hospitals NHS Foundation Trust	√				Second Trust Chair Position in another NHS organisation	Aug-23	Closed 31/12/2024	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
Maxine	Power	Director of Quality, Innovation and Improvement (Left the Trust 31/03/2025)	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.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Chief Executive's Report
PRESENTED BY	Salman Desai
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies											
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒		
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒	**SR11**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	Cyber Security	☐	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 the headline information on several areas for the period 29 May 2025 – 17 July 2025. The highlights are as follows: Strategy & Finance: The 2025/26 Annual Plan is progressing well. Work has begun on the next Trust Strategy. NWAS has been de-escalated from the regional financial oversight process due to confidence in the plans submitted. Infrastructure: New HART base opened in Liverpool. £298k secured for EV charge points across 9 sites. Service Delivery: 999 call handling performance not as strong as previous months; plans in place to recover the position. PTS faces capacity and contract uncertainty. Preparations are underway for the implementation of the 45-minute ambulance handover policy. People & Culture: NWAS ranked 27th in the Top 100 Apprenticeship Employers. Leadership and diversity programmes launched.

	Summer schools are engaging young adults from colleges into ambulance careers. Quality & Safety: Improvement Academy expanded. Learning Loop shortlisted for a national safety award. Recruitment for Executive Director of Quality is ongoing. National & Regional: NHS 10-Year Plan launched, focusing on prevention, digital care, and community services. NWAS is aligning its strategy accordingly. Notable Events: Staff recognised in national honours. Tributes paid to two colleagues who passed away.	
PREVIOUSLY CONSIDERED BY	Not applicable	
	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

This report provides a summary of the key activities undertaken and the internal, national, regional and system items to note since the last report to the Board of Directors on 28 May 2025.

2. INTERNAL UPDATES

Strategy

Annual Plan

The Annual Plan for 25/26 was shared across the Trust in June. The Trusts Planning Group assure TMC and Resources Committee each quarter on progress against the objectives in the annual plan. This ensures the Trust remains focused in delivery of its objectives in the final year of the current strategy. Progress in Q1 has been positive with 21 of 18 objectives and their associated deliverables on track. Planning Group will report to TMC and Resources committee on mitigating actions for those that are off track.

Strategy Development

Work is now underway to develop the next Trust Strategy. During Q1 the Strategy and Planning Team have engaged with staff, patients and senior leads and identified key themes for consideration for strategy development. During Q2 and Q3 Trust Board and TMC will be engaged in designing the new strategy considering where we want to be and looking at the impact of the NHS 10-year plan. The design stage will also include consultation with colleagues, patients and partners. In November 25 we will start to bring everything together for the development of the strategy document to describe how we move from where we are now to where we want to be as a Trust and as a valued employer and strategic partner.

Finance

Improvement and Assurance Group (IAG) Process

Since January 2025, NWAS has participated in the Lancashire and South Cumbria (L&SC) IAG process. On 7 July 2025, the System Turnaround Director confirmed NWAS's de-escalation from the process, recognising the strength of the Trust's financial and waste reduction plans and its contribution to system-wide recovery.

Going forward, NWAS will be monitored monthly against a defined set of metrics. Any significant deviation from these metrics may trigger a review or re-escalation into the IAG process. A breach of two or more metrics will require a formal explanation and corrective action plan.

Re-escalation may also occur if there is a risk to delivery of the FY25/26 financial plan, anticipated breaches of thresholds, or emerging patient safety or quality concerns. The Finance team is currently working with PwC to clarify how these metrics will be measured.

Elm Point

Wates Construction handed the keys over to Head of Special Operations Matt Calderbank for our new, bespoke, dedicated base for Liverpool's Hazardous Area Response Team (HART) situated at Elm Point in Anfield, our HART crews will be moving into their new home on Monday 23 June, the official opening in the community took place last week.

Electric Vehicle Infrastructure Investment

NWAS has been awarded £298,000 through the NHS Chargepoint Accelerator scheme, a joint initiative by the Department for Transport and the Department of Health and Social Care, supported by £8 million from the Office for Zero Emission Vehicles. This funding will enable the installation of electric vehicle charge points at nine NWAS sites across the North West.

NWAS currently operates around 170 charge points supporting over 100 electric vehicles in its frontline and support fleet. This investment supports the Trust's broader electrification strategy, including the installation of a fast charger at Fazakerley Ambulance Station in preparation for the trial of a fully electric ambulance in Liverpool.

Integrated Contact Centres

999 Call Handling Performance

Call pick-up performance for 999 services has experienced recent pressures. Although NWAS remains within national average of 5 seconds, performance has marginally dropped due to several contributing factors. Since April, NWAS has been supporting Yorkshire Ambulance Service (YAS) with call handling during their NHS Pathways implementation. This support has now been scaled back.

In addition, a series of business continuity incidents—primarily related to high temperatures and limited water access in contact centres—have posed operational challenges. These incidents were resolved promptly, with minimal disruption to staff wellbeing or service delivery.

To mitigate ongoing demand pressures, the team is accelerating implementation of the flexible workforce model. This includes redeploying 111 call handlers to assist with 999 calls during periods of high forecasted demand.

Patient Transport Service (PTS)

There continue to be challenges associated with the decommissioning of private PTS capacity by acute trusts to support discharge activity across Lancashire. Work is ongoing

with system partners to expand capacity through both additional resources and productivity improvements to mitigate the impact.

There remains a lack of clarity regarding the procurement approach for the new PTS contract, with the current contract due to expire in March 2026. This uncertainty presents operational and strategic planning challenges, particularly in relation to workforce, fleet, and estate decisions.

PTS data has now successfully transitioned from the Cube to the data warehouse, enabling more robust and sustainable internal and external reporting of quality and performance metrics. This transition has also allowed for the automation of several previously manual reports.

The PTS leadership development programme continues to progress, with Phase 1 receiving positive feedback from all participants.

Paramedic Emergency Services (PES)

Engagement continues with Integrated Care Boards (ICBs) and the NHS England regional team in preparation for the implementation of the 45-minute ambulance handover backstop. Local teams are working closely with acute hospitals to ensure processes are in place to enable ambulance release after 45 minutes of waiting. Internal communications to support this change are being developed jointly by the Service Delivery team and the Medical Directorate. Acute trusts have been asked to implement the necessary processes by 1 August 2025.

In parallel, work is ongoing with system partners to expand alternatives to Emergency Department (ED) conveyance through care coordination and single point of access initiatives. This aligns with the NHS Long Term Plan's aim to shift more care into community settings and reduce reliance on acute hospitals. Reducing ED conveyance also supports improved handover performance and ambulance availability.

Urgent and Emergency Care (UEC)

Delivery against UEC trajectories continues, supported by additional growth funding. Recent efforts have focused on sustaining Double Crewed Ambulance (DCA) output and addressing challenges in hear and treat performance.

While DCA output has fallen below trajectory over the past month, the service remains on track to meet the cumulative target by the end of Q2. Additional ambulance resources have been identified and are expected to be operational by the end of July.

Hear and treat performance remains below trajectory, primarily due to vacancies within the Band 6 clinical workforce in the Integrated Care Centres (ICCs) and reduced productivity as clinicians are diverted to other clinical duties, such as crew advice calls. A targeted action plan is in place to increase clinical capacity in the ICCs and reduce non-core activity.

All other elements of the UEC plan are progressing as scheduled.

People

Top 100 Apprenticeship Employers

NWAS has again been placed in the Sunday Times Top 100 Apprenticeship Employers in 2025, this year ranking at number 27.

The rankings are determined using a range of criteria including apprenticeship intake numbers, achievement rates, diversity and learner feedback and are independently assessed. These prestigious rankings recognise employers' commitment to creating new apprenticeships, the diversity of their apprentices, and the number who successfully complete their apprenticeships.

We have over 700 employees currently on an apprenticeship. These include the EMT1 Associate Ambulance Practitioner apprenticeship, Paramedic apprenticeship, Advanced Clinical Practitioner apprenticeships, a range of corporate and administrative apprenticeships and more.

The top 100 ranking provides national recognition of our ongoing commitment to investing in the professional development of the workforce.

Celebrating Diversity

June and July have provided visible opportunities to demonstrate the trust's ongoing commitment to supporting its staff and celebrating the opportunities that diversity brings to our workforce.

PRIDE month in June was celebrated with the raising of PRIDE flags at our corporate locations, offering the chance to talk to staff about the challenges still faced by our staff and patients from the LGBT+ community. This was further enhanced through communications from the LGBT network.

July allowed us to celebrate Disability PRIDE month, with various communications from the Disability Network and an event held at Estuary Point where our Associate Medical Director, Tim Smith talked about his experience of Disability, Identity and Allyship. It provided a safe space for disabled staff and allies to explore the complex relationship between disability and individual identity and the small steps we can all take to enhance our support for disabled colleagues, along with the importance of making allyship active and visible.

Investing in leadership development

June and July has seen the launch of our Developing Leaders programme. This offers staff from across the organisation the chance to engage with a 12-month development programme supporting them to take their first step into leadership. Combining

mentorship, leadership input, portfolio development and action learning, the programme aims to build leadership skills, as well as a holistic understanding of the contributions made by teams across the Trust to delivering our objectives. Applications for the programme closed recently and interested staff have been through professional discussions to help us to prioritise the first cohort of participants.

An event was also held to celebrate the completion of the second cohort of our reverse mentoring programme. This offers staff from frontline and corporate teams the opportunity to mentor a senior leader in the organisation. It provides senior leaders and directors a powerful opportunity to challenge their thinking and to better understand the experience of staff working in the organisation. Mentors are in the main drawn from staff with a diverse backgrounds who are able to bring very different lived experience to the relationship. The event was opened by the Deputy Chief Executive and closed by the Chief Executive, and it was a real privilege to hear from the positive experience of participants and the rich opportunities for learning and change that have come from the programme.

Manchester College Summer School

NWAS has run the first of a two day summer school at Manchester College. Targeting diverse areas of our community the events are designed to provide the young people attending with exposure to the opportunities for employment and learning offered by the ambulance service young people. The two-day event was opened by the Director of People and was supported by a range of educational and operational staff who could talk directly to students about the career opportunities available in NWAS, as well as providing more general guidance on careers.

A second event is due to run in Burnley in August and aims to encourage young people from diverse communities to consider ambulance careers, supporting our aspirations to improve representation in the workforce.

Quality

Continuous Improvement

A four-phase continuous improvement plan was introduced at the Senior Leaders briefing, with a detailed paper scheduled for discussion at the October Board Development session.

The second cohort of the Improvement Academy has launched, involving six NWAS teams and three external teams from neighbouring trusts (CMFT, East Lancashire, and Blackpool).

Additionally, 23 senior leaders participated in the third Systems Thinking session, delivered by Professor Mohammed Mohammed, which was well received and continues to support leadership development.

Learning Loop

Learning Loop Initiative

The Learning Loop initiative has been shortlisted for the HSJ Patient Safety Awards in September 2025, recognising its impact on improving patient safety. The programme has played a key role in disseminating critical safety learning to frontline staff through multiple channels, contributing to improved patient outcomes, enhanced staff knowledge, and the development of a strong culture of continuous learning and improvement.

Executive Director of Quality and Improvement Recruitment

The recruitment process for the Executive Director of Quality post is now underway. The closing date for applications is 1 September 2025, with stakeholder engagement panels and formal interviews scheduled for the end of September.

Medical

Defining NWAS role in tackling health inequalities workshop

Over 30 colleagues attended a joint workshop led by the Strategy and Planning Team in collaboration with Public Health Leads. The session focused on aligning NWAS' strategic direction with the national 10-year health plan, which emphasises a shift from reactive care to prevention. NWAS will now develop specific plans and objectives in line with the board's strategic direction set during the April board development session.

Public Inquiry – Southport Incident

A public inquiry into the tragic events in Southport last year, where three young girls lost their lives and others were injured, commenced on 8 July 2025 at Liverpool Town Hall. The inquiry will be conducted in two phases: Phase One will examine the circumstances of the attack and preceding events, while Phase Two will explore broader issues around youth involvement in extreme violence. The inquiry is chaired by Sir Adrian Fulford.

In the interest of transparency, NWAS has registered as a core participant and submitted requested information. While the extent of NWAS's involvement remains unclear, the Trust will closely monitor developments.

Support has been offered to staff affected by the incident, with access to wellbeing resources including the Wellbeing Hub and counselling services.

3. Updates

3.1 National Update

Fit for the future: 10-year Health Plan for England

The 10-year Health Plan for England was launched by the UK Government on 3 July 2025. In advance of its publication, I along with other ICB and Trust Chief Executives attended a virtual webinar on 2 July with Rt Hon West Streeting – Secretary of State for Health and

Social Care, Sam Jones – Permanent Secretary – DOH, and Sir James Mackay – NHS Executive, Chief Executive – who briefed us on the content and vision of the plan.

I also attended a webinar launch event on 3 July with NHS England, hearing first hand from Penny Dash - Chair, Claire Fuller - Co-Medical Director, Meghana Pandit - Co-Medical Director, and Duncan Burton, Chief Nurse.

This national Plan sets out a new direction for the NHS and has been shaped by thousands of conversations with NHS staff, patients, partners and members of the public, and it outlines the changes ahead through three main shifts:

- From hospital to community
- From analogue to digital
- From treatment to prevention

The goal being to make care more personalised, empower patients, and make sure the very best of the NHS is available to everyone, wherever they are.

We will review the Plan and take time to understand what it means for NWAS and the wider ambulance service and how it should shape the next phase of our own strategy.

Pay award

The Government announced that all NHS staff on agenda for change will receive an above-inflation pay rise, which will see all trust staff receive a 3.6% rise, backdated to 1 April 2025. Payment of this will be made in the August 2025 pay run.

Attendance at national event

I was able to attend the following national meetings during June and July:

- NHS ConfedExpo 2025 – 11 June
- NHS IMPACT: National Improvement Board – 19 June
- NHS Providers Chairs and Chief Executive Network event – 8 July
- AACE Board – 10 July
- AACE ACEG Strategy meeting – 16 July

3.2 Regional Update

In line with our commitment to collaborative working, engagement has continued with key partner agencies. Most recently, a meeting was held on 14 July 2025 with Chief Fire Officers to discuss Emergency Medical Response and other shared priorities.

NW Systems Leaders

On 3 June 2025, I attended the North West System Leaders meeting. Key topics discussed included the regional financial position, performance against plan, and population

health—highlighting both challenges and achievements. The meeting also covered ongoing work to address cardiovascular disease prevention across the region and featured a presentation on the "Live Well and Neighbourhood" model being implemented in Greater Manchester.

3.3 System Updates

Clinical Reconfiguration Review – Stakeholder Engagement

On 4 June 2025, NWAS welcomed a visit from Dr Hugo Mascie-Taylor, who has been commissioned by NHS Lancashire and South Cumbria ICB to lead a review of the clinical reconfiguration agenda. As part of this work, Dr Mascie-Taylor held one-to-one meetings with members of the Executive Team to gather insights and perspectives. This engagement reflects NWAS's commitment to working collaboratively with system partners on key strategic developments.

3.4 Organisational

Executive Team Away Day

The Executive Team held an away day on 5 June 2025, focused on strategic reflection and leadership development. Dr Suzy Cook from AQuA facilitated a session on building improvement capacity and capability across the organisation.

Key topics discussed included:

- Alignment of annual objectives with organisational culture and executive visibility
- Strengthening accountability and oversight mechanisms
- Addressing emerging workforce challenges
- Financial planning, including delivery of Cost Improvement Plans (CIPs)
- Advancing the continuous improvement agenda

The importance of increasing visibility and engagement across the organisation. In response, a structured programme of executive visits is being developed, with the aim of ensuring that every Trust site is visited by a member of the Executive Team at least once per year. This initiative will support stronger connections with staff, enhance two-way communication, and reinforce leadership presence across all areas of the Trust.

Equality, Diversity and Inclusion (EDI) Annual Report

The Trust has published its Equality, Diversity and Inclusion (EDI) Annual Report, highlighting the significant progress made over the past year in embedding inclusive practices across the organisation. The report reflects our ongoing commitment to promoting equity for staff, patients, and the wider public, and supports the development of a more inclusive and supportive organisation.

Quality Improvement

On 30 June 2025, the latest cohort of the NWAS Improvement Academy was formally launched, with the Executive Team invited to speak at the virtual event. This second cohort brings together multidisciplinary teams from across the Trust, alongside colleagues from neighbouring trusts, to engage in structured improvement work involving learning, coaching, and testing new ideas.

The first cohort demonstrated the significant impact of collaborative improvement efforts, and this next phase builds on that success by continuing to embed a culture of learning and innovation.

Teams in Cohort 2 will focus on the following priority areas:

Cardiac Arrest – Improving outcomes through enhanced ROSC rates, ECG interpretation, and shockable rhythm response.
Maternity – Implementing early warning tools for expectant mothers.
Mental Capacity – Strengthening assessment processes and staff confidence.
Clinical Supervision – Creating psychologically safe spaces for reflection and learning.
Sustainability – Reducing utility usage to support the Trust's net zero ambitions.
Inter-Facility Transfers (IFT) – Aligning clinical need with appropriate response levels.

Senior Manager Briefing – July 2025

On 7 July 2025, the second Senior Manager Briefing of the year was held, bringing together over 80 senior leaders from across the organisation (Agenda for Change Band 8B and above). These sessions provide a valuable opportunity to share updates on key national, regional, system, and organisational developments.

Topics covered during the session included:

- National context and "state of the nation" overview
- The NHS 10-Year Health Plan
- The Trust's current financial position
- Progress on the Urgent and Emergency Care (UEC) Plan
- Quality improvement initiatives
- The recent Supreme Court ruling on the legal definition of "woman"
- The Trust's Well-Led Development Plan

These briefings continue to support leadership alignment and organisational awareness across NWAS.

Wellbeing Roadshow

On 2 July 2025, I visited Salkeld Hall and Carlisle Ambulance Station as part of the trust's ongoing Wellbeing Roadshow. During the visit, I attended the Wellbeing Festival at Carlisle, which featured a range of activities designed to promote staff wellbeing—including a 'rage room' and a short trampolining fitness session.

The Wellbeing Roadshow is currently touring multiple Trust sites, offering staff opportunities to engage in wellbeing-focused activities and access support

Blackburn Community Monitoring Group

I attended the Blackburn with Darwen partnership meeting in July, where discussions focused on the development of the local cohesion and integration strategy. The session also included updates from system partners and a review of the findings from the Casey Review into Child Sexual Exploitation (CSE). These discussions are helping to shape collaborative approaches to safeguarding and community resilience across the locality.

Important Announcements

Paul Smith, King's Birthday Honours List

Duty Officer Paul Smith was awarded a British Empire Medal (BEM) for his services to the community in Merseyside in the 2025 King's Birthday Honours List.

Paul has been formally recognised as the first responder at the Southport incident on 29 July 2024, showing extraordinary courage and professionalism.

Death of colleague – Tim Maddock

It is with great sadness that I inform you of the death of our colleague, Tim Maddock, who sadly passed away suddenly on 31 May. Tim joined the trust in 2002 as an Emergency Medical Technician in Greater Manchester. In 2017, he started working as a Paramedic at Northwich in Cheshire and Merseyside.

Death of colleague – Nadia Wallace

It is with great sadness that I inform you of the death of our colleague, Nadia Wallace, who sadly passed away on 1 June. Nadia joined the trust in September 2021 as an emergency medical advisor based at Broughton.

4. RISK CONSIDERATION

There are no risks directly emerging from the content of this report.

5. EQUALITY/ SUSTAINABILITY IMPACTS

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

6. ACTION REQUIRED

The Board of Directors is asked to:

- Receive and note the contents of this report.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Proposed Q1 Position of the Board Assurance Framework 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**	☒	**SR11**	☒

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

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Q1 position of the Board Assurance Framework 2025/26.	
EXECUTIVE SUMMARY	The proposed 2025/26 Q1 Position of the BAF risks with associated CRR risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2025/26 year- to- date can be viewed in Appendix 2. As part of the Q1 review, the Trust Management Committee (TMC) recommend the following changes for Q1 (see s2): • SR01 has decreased in risk score from 15 to 10 • SR04 has decreased in risk score from 15 to 10	
PREVIOUSLY CONSIDERED BY	Audit Committee & Trust Management Committee	
	Date	18th July 2025 & 23rd July 2025
	Outcome	TMC recommended to Board for approval

1. BACKGROUND

This report provides the Board of Directors with an overview of the Q1 closing position of the Board Assurance Framework (BAF) for 2025/26 which can be seen in full in appendix 1.

It highlights any proposed changes to risk score based on the assurances received by the Board Committees during the reporting period, or any remaining gaps in assurance or control. Any mitigating actions carried over from 2024/25 can be seen in italics.

The framework also links the strategic risk to the corresponding strategic aim and risk appetite category along with any risks currently appearing on the Corporate Risk Register (those scored ≥15).

Changes since the last report seen at Board in April are highlighted in purple for ease.

2. REVIEW OF THE BAF 2025/26 Q1 POSITION

Following a full review of the strategic risks on the BAF, the following changes are proposed:

SR01: There is a risk that if the Trust does not provide the right care, at the right time, in the right place, this may lead to avoidable harm and/or poorer outcomes and experience for patients

- Change in current risk score SR01 for Q1 decreasing from 15 to 10

Opening Score 01.04.2025	Q1 Risk Score	Exec Director Lead
15 5x3 CxL	**10** 5x2 CxL	Dr C Grant Medical Director

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

- Strong national clinical quality indicators
- Strong operational performance
- Fewer significant clinical complaints and adverse outcomes
- Variation in Hospital handover performance which continues to be a significant focus for clinical and operational teams.

SR04: There is a risk that if the Trust does not deliver improved sustained national and local operational performance standards across all services, patients may experience delayed care and/or suffer harm

- Change in current risk score SR04 for Q1 decreasing from 15 to 10

Opening Score 01.04.2025	Q1 Risk Score	Exec Director Lead
15 5x3 CxL	**10** 5x2 CxL	Mr D Ainsworth Director of Operations

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

- Improved management of handover with ICBs
- Recent letter from NHSE to all provider trusts regarding 45-minute release.
- Achieving C2 standard and C1 90th consistently with good performance in relation to 999 call pick-up and 111 performance.

3. RISK CONSIDERATION

The BAF and the CRR forms part of the Trust's risk management arrangements and supports the Board in meeting its statutory duties.

4. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Q1 Position of the BAF 2025/26.

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK 2025/26

Proposed Q1 Position 25/26

Board of Directors – Part 1

30 July 2025

Q1 Position Reporting Timescales:

Audit Cttee:	18 July 2025
Trust Management Cttee:	23 July 2025
Resources Cttee:	24 July 2025
Board of Directors:	30 July 2025
Quality & Performance Cttee:	1 September 2025

BOARD ASSURANCE FRAMEWORK KEY

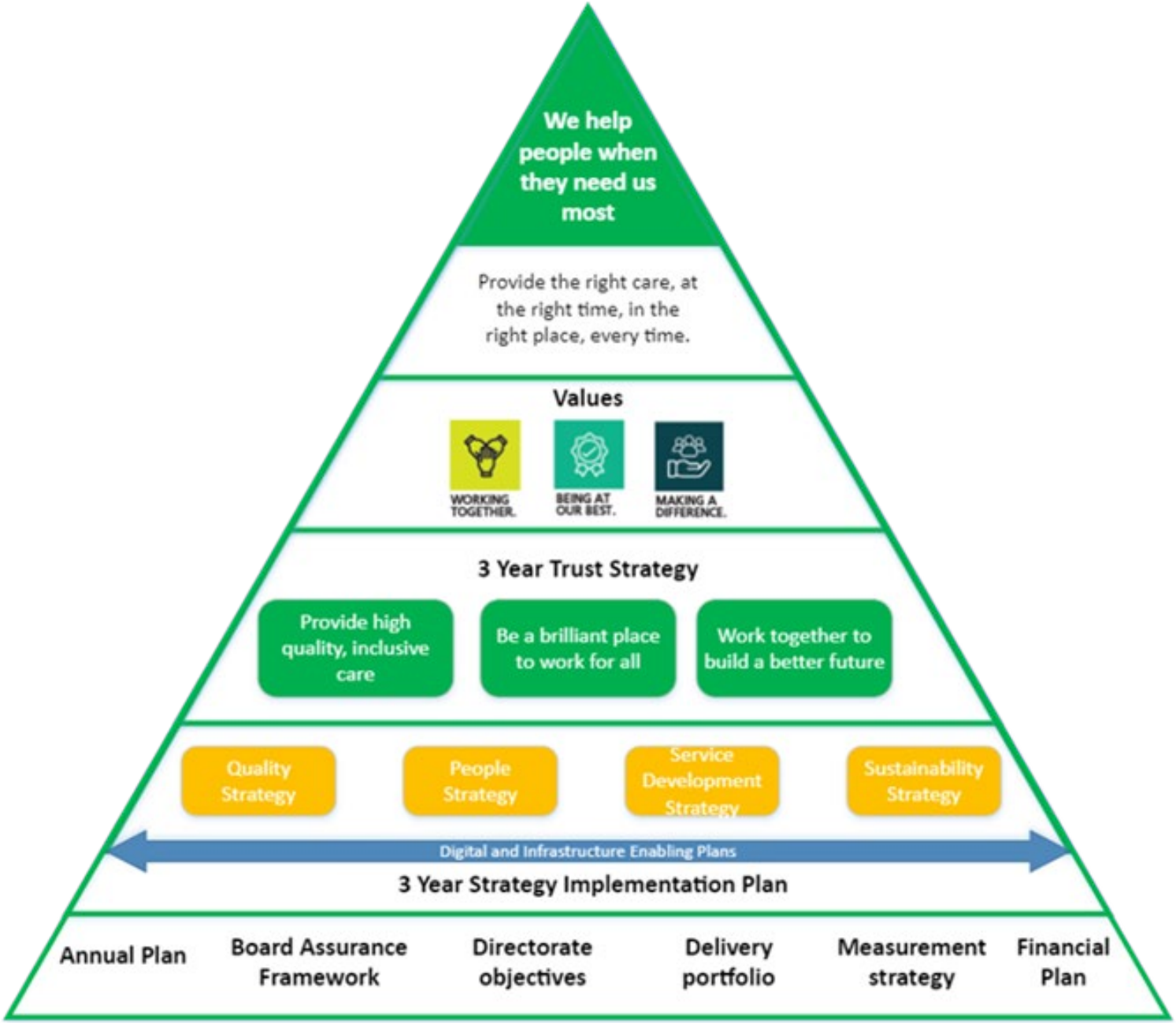
Risk Rating Matrix (Likelihood x Consequence)

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
DoQI	Director of Quality and Improvement
MD	Medical Director
DoF	Director of Finance
DoO	Director of Operations
DoP	Director of People
DoCA	Director of Corporate Affairs
DoSP	Director of Strategy & Partnerships

Board Assurance Framework Legend

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


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

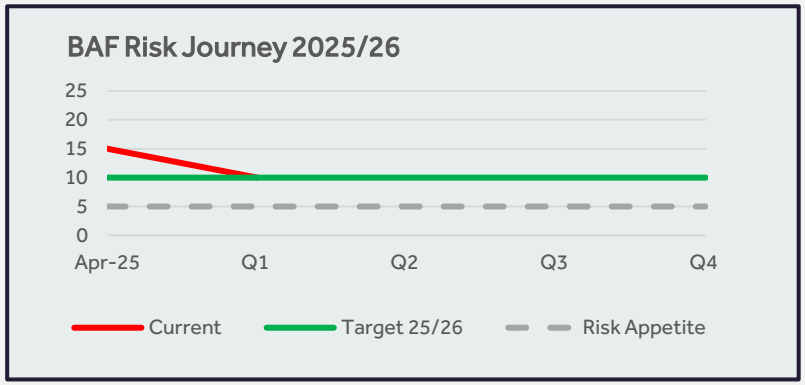
BOARD ASSURANCE FRAMEWORK DASHBOARD 2025/26

BAF Risk	Committee	Exec Lead	01.04.25	Q1	Q2	Q3	Q4	2025/26 Target	Risk Appetite Tolerance
SR01: There is a risk that if the Trust does not provide the right care, at the right time, in the right place, this may lead to avoidable harm and/or poorer outcomes and experience for patients	**Quality & Performance**	**MD**	**15** 5x3 CxL	**10** 5x2 CxL				**10** 5x2 CxL	**1-5**
SR02: There is a risk that if the Trust does not achieve financial sustainability, its ability to deliver high quality (safe and effective) services will be affected	**Resources**	**DoF**	**16** 4x4 CxL	**16** 4x4 CxL				**12** 4x3 CxL	**6-12**
SR03: There is a risk that if the Trust does not deliver against NHS net zero targets, it will impact on the Trust's ability to contribute towards environmental improvements and delivery of its Green Plan	**Resources**	**DoF**	**12** 3x4 CxL	**12** 3x4 CxL				**9** 3x3 CxL	**6-12**
SR04: There is a risk that if the Trust does not deliver improved sustained national and local operational performance standards across all services, patients may experience delayed care and/or suffer harm	**Quality & Performance**	**DoO**	**15** 5x3 CxL	**10** 5x2 CxL				**15** 5x3 CxL	**1-5**
SR05: There is a risk that if the Trust does not create an inclusive environment and look after its people's wellbeing, safety and development, then it will be unable to attract, retain and maximise the potential of its workforce for the benefit of patients.	**Resources**	**DoP**	**12** 4x3 CxL	**12** 4x3 CxL				**12** 4x3 CxL	**6-12**
SR06 There is a risk that a breach of legislative or regulatory standards could result in avoidable harm and/or regulatory action	**Quality & Performance**	**DoQ/DoCA**	**15** 5x3 CxL	**15** 5x3 CxL				**10** 5x2 CxL	**1-5**
SR07: There is a risk that due to the geographical size of the Trust it will be unable to effectively engage with its numerous system partners which may impact on its ability to achieve the medium-long-term plan	**Resources**	**DoSP**	**12** 4x3 CxL	**12** 4x3 CxL				**12** 4x3 CxL	**6-12**
SR08: There is a risk that if the Trust suffers a cyber incident, it could result in an inability to deliver a service and associated harm.	**Resources**	**DoF**	**20** 5x4 CxL	**20** 5x4 CxL				**15** 5x3 CxL	**1-5**
SR09: There is a risk that the recent planned changes around the Board over the next 12 months could destabilise the organisation and impact delivery of strategic plans.	**Board**	**CE/ DoCA**	**15** 5x3 CxL	**15** 5x3 CxL				**5** 5x1 CxL	**1-5**
SR10: Sensitive Risk:	**Resources**	**DoSP**	**12** 4x3 CxL	**16** 4x4 CxL				**12** 4x3 CxL	**6-12**
SR11: Sensitive Risk:	**Resources**	**DoF**	**16** 4x4 CxL	**12** 4x3 CxL				**8** 4x2 CxL	**6-12**

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR01:
There is a risk that if the Trust does not provide the right care, at the right time, in the right place, this may lead to avoidable harm and/or poorer outcomes and experience for patients

Executive Director Lead:	MD
Strategic Aim:	Provide high quality inclusive care
Risk Appetite Category:	Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	15	10				10	1-5
	5x3	5x2				5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Within				Exceeded	

RATIONALE FOR RISK SCORE: The risk score at Q1 has reduced to 10. National clinical quality indicators remain strong, in conjunction with strong operational performance and fewer significant clinical complaints and adverse outcomes. Regional variation in hospital handover performance is a significant focus for both operational and clinical teams due to the unacceptable inequalities that arise. There has been an increase in reporting of patient safety incidents increasing the administrative burden, alongside the complexity of the LFPSE national reporting system, an automated system which has generated additional mandated questions and lack of completion results in a rejection from the national system which has the potential to leave the organisation non-compliant with Reg 16 and 20 (notifiable incidents to CQC).

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Stable
Clinical and operational environment should remain stable.

CONTROLS →	ASSURANCES →	EVIDENCE
QUALITY		
Focus on delivering national and local priorities in line with PSIRF	**Level 2**: Clinical and Quality Group 3A Report **Level 2**: Patient Safety Activity Q4 24/25	Reported to Trust Management Cttee TMC/2526/059 Reported to Quality & Performance Cttee QPC/2526/026
Delays in responding to patients in mental health crisis	**Level 2**: Mental Health Annual Report 24/25	Reported to Trust Management Cttee TMC2526/050

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLINICAL					
Deliver Right Care Programme	Quality Impovement Academy – Cohort 1: Evaluate outcomes to adopt learning across NWAS	Dr C Grant / D Ainsworth	June 2025	TM Cttee	Complete
Improve the input, analysis and utilisation of data which provides intelligence on population health and health inequalities	Develop Phase 2 of population health dashboard.	Dr C Grant / J Wharton	September 2025	TM Cttee	In Progress
	Use current data to identify improvement initiatives to improve equity of access, experience and outcomes for patients.	Dr C Grant	September 2025	TM Cttee	In Progress
	Produce stakeholder engagement map of current public health, population health and anchor groups/networks across the regions	Dr C Grant	September 2025	TM Cttee	In Progress
QUALITY					

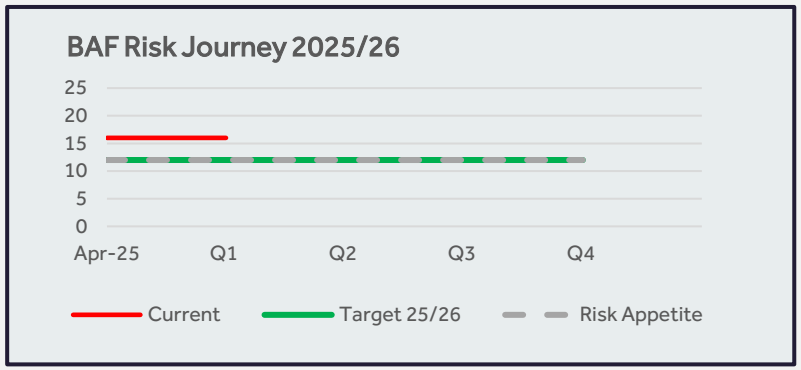
Focus on delivering national and local priorities in line with PSIRF	Establish improvement plans associated with local and national priorities	Dr E Strachan-Hall	December 2025	Q&P Cttee	In Progress
~~Delivery of improvement against local PSIRF priority (mental capacity)~~ – Removed: duplication of above	~~Delivery of improvement against local PSIRF priority (mental capacity)~~	~~Dr E Strachan-Hall~~	~~March 2026~~	~~Q&P Cttee~~	~~In Progress~~
Delays in responding to patients in mental health crisis	Training needs analysis Mental health	Dr E Strachan-Hall	October 2025	Q&P Cttee	In Progress
	Mental Health Oversight Group to be established	Dr E Strachan-Hall	August 2025	TM Cttee	In Progress
	Mental health strategic plan implementation	Dr E Strachan-Hall	October 2025	Q&P Cttee	In Progress
Local Quality Improvement Plans	Service lines to develop local quality improvement plan focussed on safety, effectiveness and experience	Dr E Strachan-Hall / D Ainsworth	June 2025	Q&P Cttee / TM Cttee	Completed
DIGITAL					
Insight and Intelligence	*Integrated quality and performance reporting for service lines and sectors*	*Ms J Wharton*	*July 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
440	Operational/ Operational Performance	There is a risk that due to NWAS clinicians receiving limited training in managing obstetric emergencies, there is a gap in knowledge and skills for clinicians to manage maternity and newborn care, potentially resulting in patient harm and non-compliance with MNSI safety recommendations.	20 High	15 High	⇩	5 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
580	Quality	There is a risk that as a result of local service lines not recording learning and safety improvement actions following a Patient Safety Incident (PSI) safety critical learning will be missed which may result in patient harm	16 High	16 High	⇔	4 Low
655	Operational/ Clinical	There is a risk that due to a lack of clarity around the destruction of waste schedule 2 controlled drugs, the Home Office will not renew the NWAS Controlled Drugs licence, resulting in NWAS not being able to obtain controlled drugs.	10 Moderate	15 High	⇧	5 Low

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR02:
There is a risk that if the Trust does not achieve financial sustainability, its ability to deliver high quality (safe and effective) services will be affected

Executive Director Lead:	DoF
Strategic Aim:	Work together to shape a better future
Risk Appetite Category:	Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	16	16				12	6-12
	4x4	4x4				4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Within	

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q1 remains at 16. Whilst a balanced draft financial plan has been submitted there is still risk within the plan as the full efficiency plans are yet to be fully developed to support delivery of the £14.9m efficiency target. There remains a risk adjusted shortfall against delivery of the full efficiency plan of £0.6m, with a recurrent shortfall of £1.3m. There are mitigations within the year-to-date position that support the small £0.02m surplus.

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Stable
Improvement in the development and delivery of recurrent efficiency plans will support a reduction in the risk score. Monthly forecast reporting to the ICB continues.

CONTROLS	ASSURANCES	EVIDENCE
Financial Performance	**Level 2:** Finance Report M12 (24/25) **Level 2:** Finance Report M01 **Level 2**: Resources Committee 3A Report **Level 2:** Finance Report M02	Reported to Trust Management Cttee TMC/2526/007 Reported to Resources Cttee RC/2526/032 Reported to Board of Directors BoD/2526/033 Reported to Trust Management Cttee TMC/2526/071
Final 2025/26 financial plans	**Level 2**: 2025/26 Financial Plan (Final)	Reported to Board of Directors PBM/2425/79

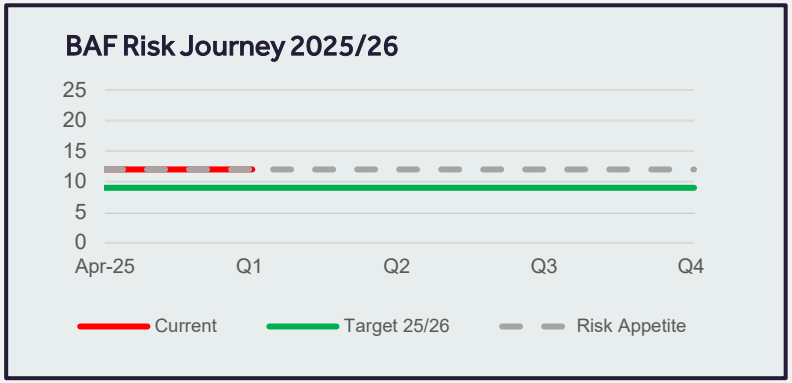
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2026/27 Financial Planning	Receipt of 2026/27 planning guidance from NHSE	Ms C Wood	January 2026	Resources Cttee	Not Commenced
	Draft 2026/27 Financial Plan (Revenue & Capital)	Ms C Wood	March 2027	Resources Cttee / BoD	Not Commenced
	Approval of 2026/27 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2027	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 – FOI Act Section 43 – Commercial Interests						
317	Operational / People	**Sensitive Risk**	20 High	15 High	⇩	10 Moderate

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR03:
There is a risk that if the Trust does not deliver against NHS net zero targets, it will impact on the Trust's ability to contribute towards environmental improvements and delivery of its Green Plan

Executive Director Lead:	DoF
Strategic Aims:	Work together to shape a better future
Risk Appetite Category:	Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	12	12				9	6-12
	3x4	3x4				3x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within	Within				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q1 remains at 12. Good progress continues in reducing the emissions associated with the estate.

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Stable
No significant changes are expected over the course of the second quarter.

CONTROLS	ASSURANCES	EVIDENCE
Refreshed Green Plan following publication of guidance in February 2025	**Level 2:** Green Plan	Reported to Board of Directors BoD 2526/032
Progress against the Green Plan	**Level 2:** Sustainability Group 3A Report	Reported to Trust Management Cttee TMC/2526/084

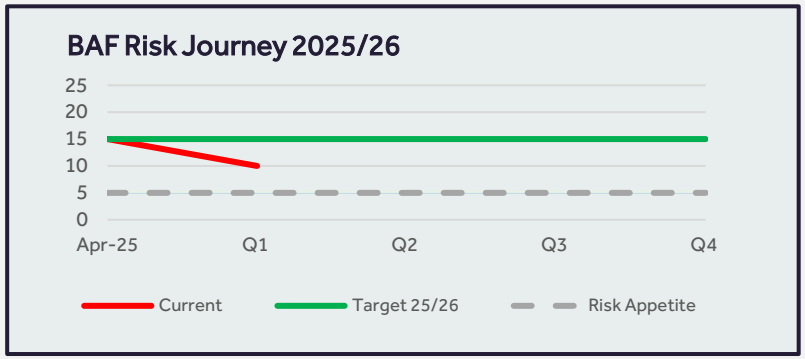
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Heat decarbonisation plan	Board approved heat decarbonisation plan	Ms C Wood	September 2025	BoD	In Progress

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

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR04:
There is a risk that if the Trust does not deliver improved sustained national and local operational performance standards across all services, patients may experience delayed care and/or suffer harm

Executive Director Lead:	DoO
Strategic Aim:	Provide high quality inclusive care
Risk Appetite Category:	Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	15	10				15	1-5
	5x3	5x2				5x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q1 has reduced to 10 primarily due to the improved management of handover with ICBs and the recently issued letter by NHSE to all provider trusts in relation to 45 minute release. Achieving C2 gov standard and C1 90th consistently, with 999 call pick-up performing well and good 111 performance. The ICC restructure is entering its final stages of recruitment to Band 7 and Band 5 positions. The Trust awaits information from ICBs in respect of their intention for procurement of the PTS contract(s).

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Stable
Seasonal variation has seen slight improvements in handover which have helped to improve performance which are expected to be maintained into Q2.

CONTROLS	ASSURANCES	EVIDENCE
Delivery of UEC Plan 25-26	**Level 2**: UEC Growth Funding **Level 2**: UEC Growth Funding Update	Reported to Trust Management Cttee TMC/2526/010 Reported to Trust Management Cttee TMC/2526/047
Recruitment Plan Clinical Hub and Operational Staff	**Level 2:** People and Culture Group 3A Group	Reported to Trust Management Cttee TMC/2526/061

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plan Clinical Hub and Operational Staff	*Robust recruitment plan to be delivered to maximise resources to the most efficient level*	*Mr D Ainsworth / Mrs L Ward*	*March 2026*	*Q&P Cttee*	*In Progress*
ICC Integration Restructure	*Delivery of Phase 3 of ICC Restructure*	*Mr D Ainsworth*	*September 2025*	*Q&P Cttee / Resources Cttee*	*In Progress*
Review current care delivery model	Create a current state map of flow through the organisation from the patient perspective	Mr D Ainsworth	September 2025	*Q&P Cttee / Resources Cttee*	*In Progress*
Improve patient outcomes	Generate ideas for change utilising best practice and national learning/priorities	Mr D Ainsworth	December 2025	*Q&P Cttee / Resources Cttee*	*In Progress*
Develop long term roadmap to deliver initiatives	Highlight short-term initiatives and create a plan	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Right Care Programme of Work	Implement and embed workstreams within the Right Care Programme	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*

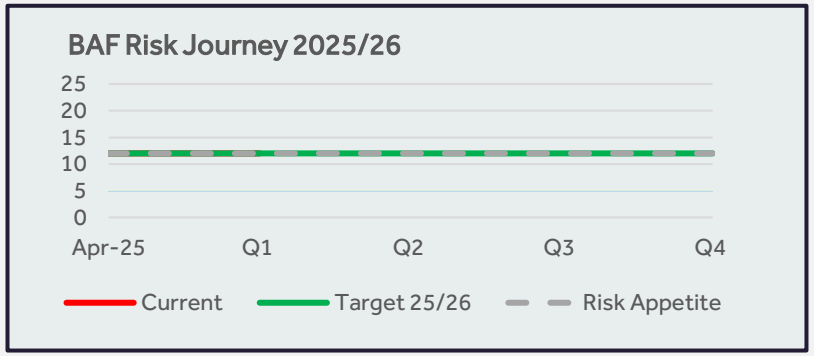
Deliver PTS Improvement Programme	Deliver workforce and operational delivery workstreams	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Delivery of UEC Plan 25-26	Delivery of mid year UEC Targets	Mr D Ainsworth	September 2025	TM Cttee	*In Progress*

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
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
440	Operational/ Operational Performance	There is a risk that due to NWAS clinicians receiving limited training in managing obstetric emergencies, there is a gap in knowledge and skills for clinicians to manage maternity and newborn care, potentially resulting in patient harm and non-compliance with MNSI safety recommendations.	20 High	15 High	⇩	5 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
580	Quality	There is a risk that as a result of local service lines not recording learning and safety improvement actions following a Patient Safety Incident (PSI) safety critical learning will be missed which may result in patient harm	16 High	16 High	⇔	4 Low
655	Operational/ Clinical	There is a risk that due to a lack of clarity around the destruction of waste schedule 2 controlled drugs, the Home Office will not renew the NWAS Controlled Drugs licence, resulting in NWAS not being able to obtain controlled drugs.	10 Moderate	15 High	⇧	5 Low
717	Reputational/ Emergency Preparedness	There is a risk that because the Trust has not followed it's own internal policies and processes following the Southport major incident, the Inquiry may find that NWAS have failed to fully implement and embed any of the learning from the Manchester Arena incident.	15 High	15 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR05:
There is a risk that if the Trust does not create an inclusive environment and look after its people's wellbeing, safety and development, then it will be unable to attract, retain and maximise the potential of its workforce for the benefit of patients.

Executive Director Lead:	DoP
Strategic Aim:	Be a brilliant place to work for all
Risk Appetite Category:	People - Moderate



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	12	12				12	6-12
	4x3	4x3				4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within	Within				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q1 remains at 12. Overall there are challenging requirements for continued growth this year which will require concerted focus on recruitment, development and culture improvement. Recruitment and training plans are on track and retention improvements are positive. There has been good progress against annual plans for cultural and equality and diversity improvement but such plans will take some time to deliver a step change.

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Stable
Expected to remain stable with continuing incremental improvements.

CONTROLS →	ASSURANCES →	EVIDENCE
EDI Priorities	**Level 2:** EDI Annual Report 2024/25 **Level 2:** Diversity and Inclusion 3A Report	Reported to Board of Directors BoD/2526/031 Reported to Trust Management Cttee TMC/2526/060
People Promise Exemplar Programme	**Level 2**: People and Culture 3A Report	Reported to Trust Management Cttee TMC/2526/061
Vacancy Position	**Level 2:** People and Culture Group 3A Report **Level 2**: Workdorce Indicators Assurance Report	Reported to Trust Management Cttee TMC/2526/061 Reported to Resources Cttee RC/2526/022
Leadership	**Level 2**: Leadership Obectives	Reported to Trust Management Cttee TMC/2526/056
Attendance	**Level 2**: AIT Plans **Level 2:** Workforce Indicators Assurance Report	Reported to People and Culture Group PCG/2526/12 Reported to Resources Cttee RC/2526/022
Retention Plans	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee RC/2526/022
Sexual Safety	**Level 2:** Diversity and Inclusion 3A Report **Level 2:** Annual Report on Staff Incidents Resulting in Harm	Reported to Trust Management Cttee TMC/2526/060 Reported to Resources Cttee RC/2526/023

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
EDI Priorities	Delivery of agreed 25/26 workforce related actions	Ms L Ward	March 2026	Resources Committee	In Progress
Sexual Safety	Delivery of planned work programme	Ms L Ward	March 2026	Resources Committee	In Progress

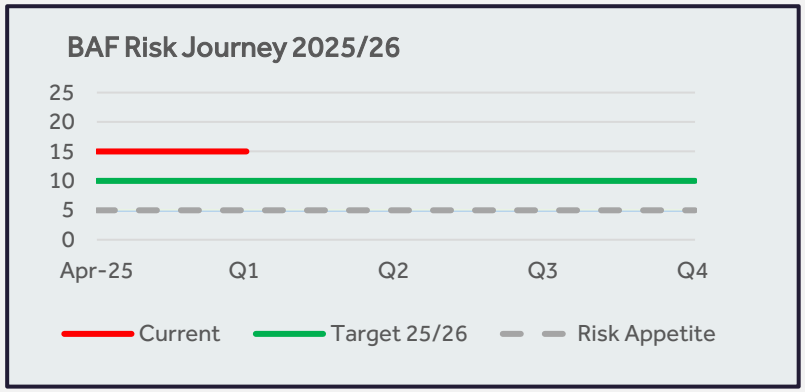
Partnership Agreement	*Implementation of revised Partnership Agreement*	*Ms L Ward*	*September 2026*	*Resources Cttee*	*In Progress*
Wellbeing	*Implementation of mental health improvement plans*	*Ms L Ward*	*March 2026*	*Resources Cttee*	*In Progress*
Learner safety	Progress implementation of Safe Learning Environment Charter	Ms L Ward	March 2026	Resources Committee	Not Commenced
People Promise Exemplar Programme	*Deliver improvements in identified priority areas: flexible working; staff engagement*	*Ms L Ward*	*2025/26*	*Resources Cttee*	*In Progress*
Vacancy position	Delivery 2025/26 recruitment and training plan	Ms L Ward	March 2026	Resources Committee	In Progress
Leadership	Continue to enhance compassionate leadership in support of culture change	Ms L Ward	March 2026	Resources Committee	In Progress
Attendance	Deliver continued improvement in attendance	Ms L Ward	March 2026	Resources Committee	In Progress
Retention Plans	*Delivery of EOC Retention Plans*	*Ms L Ward*	*March 2026*	*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 2025/26

BAF RISK SR06:
There is a risk that a breach of legislative or regulatory standards could result in avoidable harm and/or regulatory action

Executive Director Lead:	DoQ/DoCA
Strategic Aims:	Provide high quality inclusive care Be a brilliant place to work for all Work together to shape a better future
Risk Appetite Category:	Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	15	15				10	1-5
	5x3	5x3				5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded					Low

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q1 remains at 15 due to the changes with the CQC framework, recent whistleblowing query and the external and political regulatory landscape, with potential for the Trust to be subject to additional scrutiny. Regular engagement meetings have been established between the Interim Director of Quality and the CQC relationship manager. *c/f* SR01 - LFPSE.

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Stable
The external and political regulatory landscape changes are likely to lead to additional scrutiny

CONTROLS →	ASSURANCES →	EVIDENCE
QUALITY IMPROVEMENTS		
Continue to strengthen our delivery against the CQC assessment framework and well-led in readiness for future inspection	**Level 2:** CQC Update	Reported to Quality & Performance Cttee QPC/2526/031
PEOPLE		
Appraisal Compliance 24/25	**Level 2:** Integrated Performance Report	Reported to Board of Directors BoD/2526/034
Mandatory Training Compliance 25/26	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Assurance Report	Reported to Board of Directors BoD/2526/034 Reported to Resources Cttee RC/2526/022
Appraisal Compliance 25/26	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Assurance Report	Reported to Board of Directors BoD/2526/034 Reported to Resources Cttee RC/2526/022

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY IMPROVEMENTS					
Continue to strengthen our delivery against the CQC assessment framework and well-led in readiness for future inspection	Developmental well-led review	Dr E Strachan-Hall	September 2025	TM Cttee	In Progress

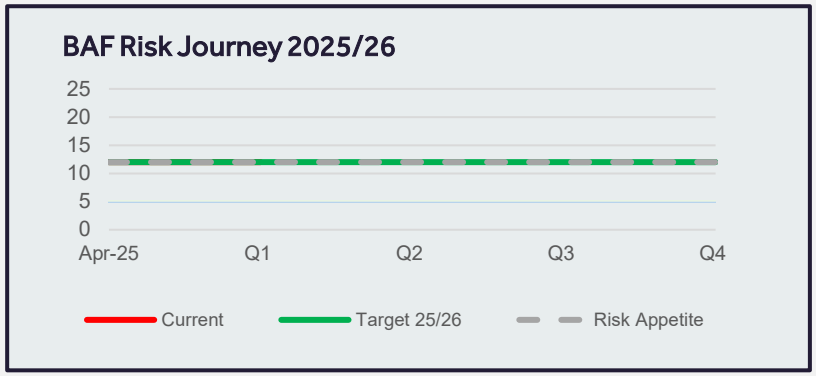
	Development programme for new board and senior leaders to familiarise with CQC assessment framework	Dr E Strachan-Hall	October 2025	TM Cttee	In Progress
	Desktop exercises for mock CQC inspection for senior leaders & leadership teams	Dr E Strachan-Hall	October 2025	TM Cttee	Not commenced
	Review and amend quality assurance visits aligned with new Chief Executive Officer (CEO) accountability reviews	Dr E Strachan-Hall	March 2026	TM Cttee	Not commenced
Essential Checks	*Review process and assurance of vehicle and equipment checks and components of actions submitted to CQC*	*Dr E Strachan-Hall*	*September 2025*	*TM Cttee*	*In Progress*
Improve the processes associated with medicines management including controlled drugs	Procure medicines management system	Dr C Grant	October 2025	Resources Cttee	In Progress
	Implement medicines management system	Dr C Grant	March 2026	TM Cttee	Not Commenced
Clinical Audit	Procure clinical audit tool	Dr C Grant	October 2025	Resources Cttee	In Progress
	Implement clinical audit tool	Dr C Grant	March 2026	TM Cttee	Not Commenced
Digital Clinical Strategy	*Completion of digital clinical safety process on Electronic Patient Record*	*Ms J Wharton*	*September 2025*	*TMC Cttee*	*In Progress*
PEOPLE					
Appraisal Compliance 2025/26	Achieve 85% compliance	Ms L Ward	March 2026	Resources Cttee	In Progress
Mandatory Training Compliance 2025/26	Achieve 85% compliance	Ms L Ward	March 2026	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low
580	Quality	There is a risk that as a result of local service lines not recording learning and safety improvement actions following a Patient Safety Incident (PSI) safety critical learning will be missed which may result in patient harm	16 High	16 High	⇔	4 Low
717	Reputational/ Emergency Preparedness	There is a risk that because the Trust has not followed it's own internal policies and processes following the Southport major incident, the Inquiry may find that NWAS have failed to fully implement and embed any of the learning from the Manchester Arena incident.	15 High	15 High	⇔	5 Low
655	Operational/ Clinical	There is a risk that due to a lack of clarity around the destruction of waste schedule 2 controlled drugs, the Home Office will not renew the NWAS Controlled Drugs licence, resulting in NWAS not being able to obtain controlled drugs.	10 Moderate	15 High	⇧	5 Low

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR07:
There is a risk that due to the geographical size of the Trust it will be unable to effectively engage with its numerous system partners which may impact on its ability to achieve the medium-long-term plan.

Executive Director Lead:	DoSP
Strategic Aims:	Work together to shape a better future
Risk Appetite Category:	Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	12	12				12	6-12
	4x3	4x3				4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within	Within				Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q1 remains at 12 due to turbulence in the system partner environment, particularly NHSE and ICBs. Horizon scanning across the system continues to detect early signs of important developments and potential threats and opportunities, shared across internal stakeholders. Sector-wide engagement with AACE forums ensures we are working collaboratively with other Ambulance trusts and aligned with AACE vision. Publication of the UEC Plan in June 2025 outlined the system priorities for improvement and performance which aligned to previous operational planning guidance and did not pose any significant change within the plans. UEC funding been agreed with NHS England with plans in place. Publication of the NHS 10-year plan is due to be launched in the first week of July.

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Stable
Due to the geographical size of the trust, it is challenging to effectively engage with external partners; the trusts Partnerships and Integration Managers are in place and liaise with operational, clinical and directorate teams to ensure the right representation at strategic and critical meetings across the footprint and also ensuring that this engagement is evidenced and assured. 10 year-plan preparedness plan will be developed to support joined up dissemination of messages and assessment of strengths, weaknesses, opportunities and threats.

CONTROLS	ASSURANCES	EVIDENCE
Development of Trust Strategy	**Level 2:** Planning Group 3A Report	Reported to Trust Management Cttee TMC/2526/058
Horizon scanning process	**Level 2:** Planning Group 3A Report	Reported to Trust Management Cttee TMC/2526/058

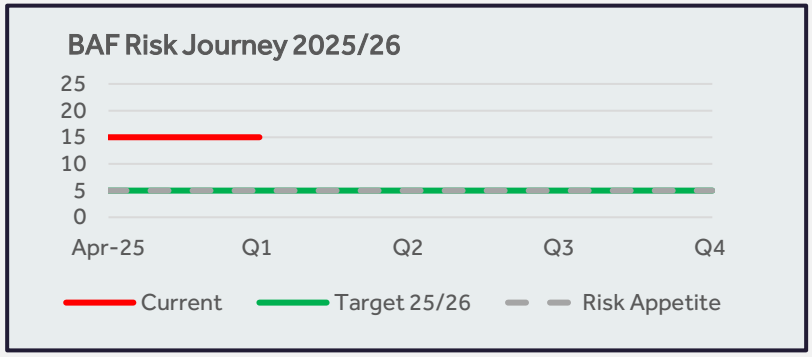
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Development of Trust Strategy	Communication and engagement work stream established as part of strategy development work programme which will include external stakeholders. Comms plan in development.	Mrs A Ormerod	2025/26	TM Cttee	In Progress
Response to emergent priorities	Planning Group continue to manage risk (Datix ID 729) regarding impact of emergent work arising from external turbulence. The risk is within control. Horizon scanning process in place to communicate with system partners and assess impact to existing plans. Regular item on	Mrs A Ormerod	2025/26	TM Cttee	In Progress

	Planning Group agenda item to discuss specific emergent issues.				
Publication of NHS 10 year plan including underpinning policy/guidance documents to provide clarity on the wider national/regional direction of travel.	Process in place to regularly review and update SWOT and PESTLE and review plans to identify opportunities and risks emerging from external context. Weekly 15 minute horizon scanning meetings in place between Partnerships & Integration and Strategy & Planning teams.	Mrs A Ormerod	Q2	TM 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 2025/26

BAF RISK SR09: There is a risk that the recent planned changes around the Board over the next 12 months could destabilise the organisation and impact delivery of strategic plans.	**Executive Director Lead:**	CE / DoCA
	Strategic Aims:	Provide high quality inclusive care Be a brilliant place to work for all Work together to shape a better future
	Risk Appetite Category:	Regulatory - Low



BAF RISK SCORE JOURNEY:

	01.04.25	Q1	Q2	Q3	Q4	25/26 Target	Risk Appetite
	15	15				5	1-5
	5x3	5x3				5x1	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded	Exceeded				Within	

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q1 remains at 15. The recruitment process undertaken by NHS England to appoint a chair concluded successfully and the new Chair will commence on 1st July 2025. Recruitment to appoint the Director of Strategy and Partnerships was also concluded successfully and they will commence in role on 28th July 2025. Recruitment of a substantive Director of Quality will recommence in Q2. The interim Director of Quality will remain in post until a substantive appointment has been made.

Projected Forecast Q2: Deteriorating
Stable
Improving

Rationale: Improving
Due to the conclusion of the recruitment process to appoint the Director of Quality and Improvement.

CONTROLS	ASSURANCES	EVIDENCE
Recruitment to vacant Director posts	Level 2: Appointment of Director of Strategy & Partnerships Level 2: Director of Quality Recruitment Update	Reported to Nominations & Remuneration Cttee NARC/2526/03 Reported to Nominations & Remuneration Cttee NARC/2526/09

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment to vacant Director posts	Appoint Director of Quality and Improvement	Mr S Desai	September 2025	Nom & Rem Cttee	In Progress
Development of Board Chemistry	CEO and Chair to consider what's required and when	Mr S Desai	March 2026		Not Commenced

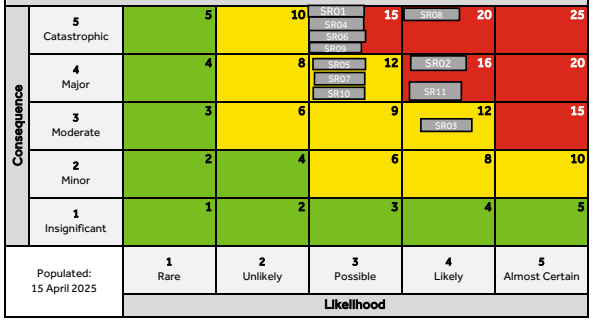
Operational Risks Scored 15+ Aligned to BAF Risk: SR09

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						

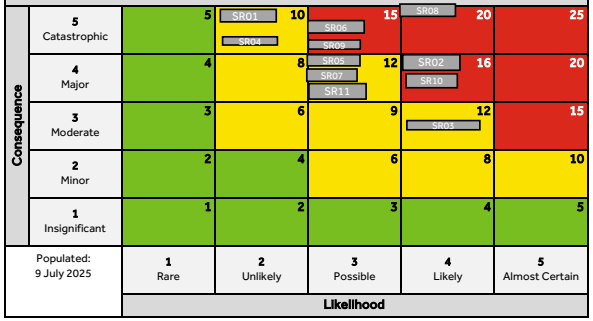
Appendix 2:
2025/26 Board Assurance Framework (BAF) Heat Maps
Q1 Position

NHS North West Ambulance Service NHS Trust

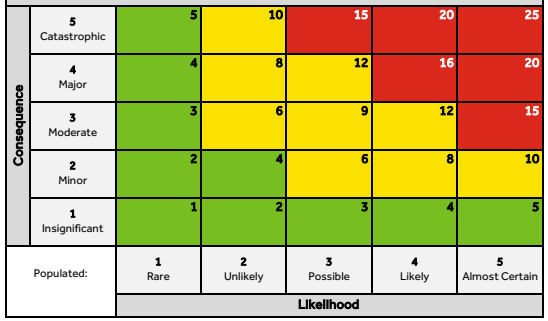
2025/26 Opening BAF Risk Scores



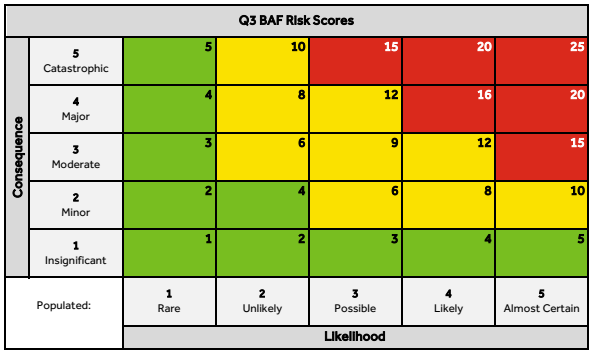
Q1 BAF Risk Scores



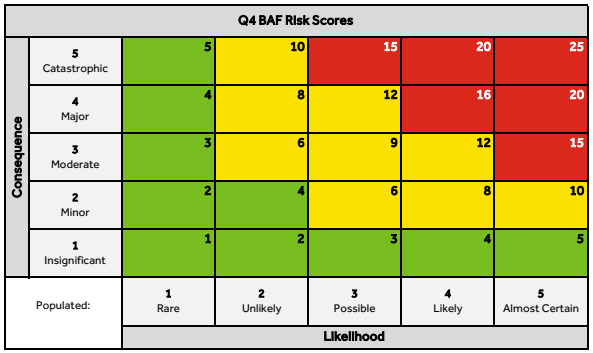
Q2 BAF Risk Scores



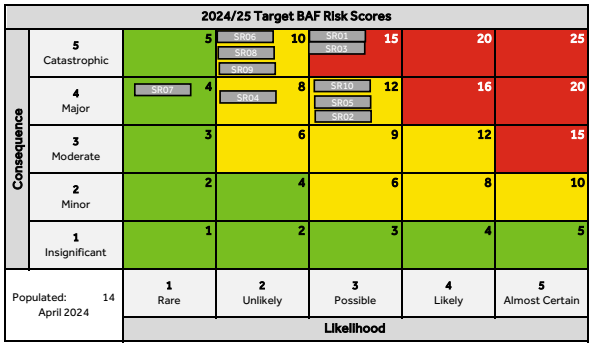
Q3 BAF Risk Scores



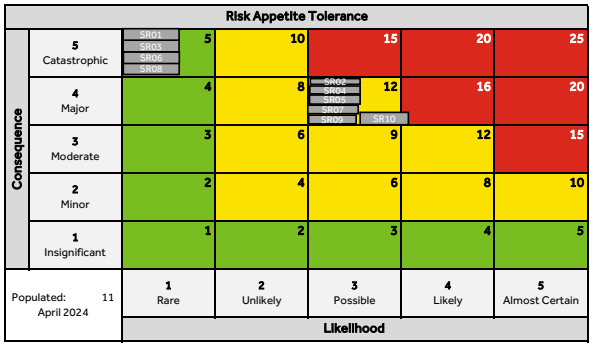
Q4 BAF Risk Scores



2024/25 Target BAF Risk Scores



Risk Appetite Tolerance



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Annual SIRO Report
PRESENTED BY	Carolyn Wood, Director of Finance and SIRO
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies										
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☐	**SR04**	☐	**SR05**	☐	
	SR06	☒	**SR07**	☐	**SR08**	☒	**SR09**	☐	**SR10**	☐	**SR11**	☐

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

ACTION REQUIRED	The Trust Board is asked to note the contents of the report and the assurance it provides.
EXECUTIVE SUMMARY	The Senior Information Risk Owner presents a summary of our information governance (IG) for the financial year and compliance with regulatory and contractual standards. Information Governance (IG) is the framework for handling information in a secure and confidential manner that allows organisations and individuals to manage patient, personal and sensitive information legally, securely, efficiently and effectively to deliver the best possible healthcare and services. There are several legal requirements, standards and best practice that apply to the handling of patient, personal and sensitive information. The key items of legislation and standards covered are • UK Data Protection Act 2018 • UK General Data Protection Regulation 2016 (GDPR) **Data Security and Protection Toolkit (DSPT)** In June 2024 the DSPT for 2023/24, the trust achieved "Approaching Standards" as two requirements were not achieved. The standards not achieved are *Training and awareness activities form part of organisational mandatory training requirements, with a training and awareness needs analysis*

(covering all staff roles) that is formally endorsed and resourced by senior leadership. –The compliance target was not agreed until July 2024.

Multi-factor authentication is enforced on all remote access and privileged user accounts on all systems, with exceptions only as permitted by the national MFA policy. - There were 38 identified applications that required MFA as mandated by the NHSE policy. Of those, 34 are now compliant, leaving 4 outstanding. Work is ongoing, working with suppliers and asset owners to ensure the remaining 4 systems are compliant.

Mersey Internal Audit Agency are required to undertake an internal audit each year, the audit for 2023/24 provided a Substantial Assurance outcome.

The Data Security and Protection Toolkit (DSPT) has now adopted the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF) as its foundation for cyber security and information governance assurance. The submission is due on 30th June 2025, and it is expected the trust will not meet the minimum standards expected which is in line with NHS England expectations for new framework.

Data Breaches
During the reporting period a total of 157 data breaches have been reported via DCIQ, this is an increase of 18 (12.95%) compared to prior year.
There were 5 data breaches that met the threshold to be reported externally via DSPT reporting tool, with 2 requiring no further action and 3 still being reviewed by the ICO.

Freedom of Information Requests
A total of 497 FOI requests have been received during the financial year 24/25 which is an increase of 13.99% (61 more requests) compared to the previous financial year.

Individual Rights Requests (SAR/ A2H)
A total of 3,089 SAR/A2H requests have been received during the financial year 24/25 which is an increase of 16.25% (432 more requests) compared to the previous financial year (increase for SARs is 12.33% (258 more requests); increase for A2Hs is 30.74% (174 more requests).

Data Protection Officer
During the reporting period the Data Protection Officer (DPO) received 12 new complaints. All complaints have been investigated and reviewed. Nine complaints to the DPO have been closed with responses provided to the data subject. Three complaints remain open with an investigation underway

There were 6 Data Protection Impact Assessments (DPIAs) completed during the reporting period.

- Trust ID
- Induction and Onboarding Automation
- TP Health
- Troponin Project
- DCIQ Phase 2
- Aspirer

There were 8 Information Sharing Agreements completed during the reporting period.

Risks

	The Information Governance & Cyber Group go through 2024/25 has been overseeing the risks associated with information governance and cyber. At the end of March there are four active risks	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 18 July 2025
	Outcome	TBC

1. BACKGROUND

1.1 Data is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning and performance management. Information Governance and data protection are concerned with the way NHS organisations handle information about patients/service users and employees, in particular personal and special category information.

1.2 There are several legal requirements, standards and best practice that apply to the handling of patient, personal and sensitive information. The key items of legislation and standards covered are,

- UK Data Protection Act 2018
- UK General Data Protection Regulation 2016 (GDPR)
- Access to Health Records Act
- Computer Misuse Act
- Records Management Code of Practice 2021
- Caldicott Principles
- Network and Information Systems (NIS) regulations 2018

To demonstrate compliance against these key legal requirements and standards and other items the trust reports against key areas through the Information Governance & Cyber Group.

1.3 The Trust Senior Information Risk Officer (SIRO) is accountable for Information Governance within the trust and is supported by the Medical Director, who is the Caldicott Guardian. The Caldicott Guardian is responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. The newly appointed SIRO is the Director of Finance, the SIRO has completed training with the accredited training provider exemplar this training will support her to manage cyber and information risk.

The SIRO will chair the Information Governance & Cyber group, which will provide assurance through to the Trust Management Committee (TMC).

2. DATA SECURITY AND PROTECTION TOOLKIT PERFORMANCE 2023/2024

2.1 The Data Security and Protection Toolkit (DSPT) is designed to provide assurance on the local implementation of the ten data security standards as set out in the National Data Guardian's (NDG) 2016 review and compliance with data protection legislation. The ten security standards are broken down into assertions with mandatory evidence requirements against which the trust is required to submit evidence to demonstrate achievement

2.2 NHS England expects organisations to achieve "standards met" in the DSPT which is defined as compliance with all mandatory evidence requirements. Organisations' statuses are published with the aim of providing assurance to business partners and to patients of the standard of information management within NHS Trusts.

2.3 The submission process for the DSPT is to complete an interim submission in March and then a final submission in June. In the period of this report the final submission was completed in June 2024 which covered 2023/24. For the 2023/24 period there were 35 assertions broken down into 108 mandatory evidence requirements against which evidence was submitted, the trust was able to meet evidence requirements for 106.

2.4 The evidence requirement that was not achieved was,

Training and awareness activities form part of organisational mandatory training requirements, with a training and awareness needs analysis (covering all staff roles) that is formally endorsed and resourced by senior leadership. –The compliance target was not agreed until July 2024.

Multi-factor authentication is enforced on all remote access and privileged user accounts on all systems, with exceptions only as permitted by the national MFA policy. - There are 38 identified applications that require MFA as mandated by the NHSE policy. Of those, 34 have MFA configured, leaving 4 outstanding. Work is ongoing, working with suppliers to ensure the remaining 4 systems are compliant.

2.5 Mersey Internal Audit Agency (MIAA) are required to undertake an internal audit each year on the evidence submitted by the trust on the DSPT across a section of assertions. The audit for the 2023/24 DSPT had an outcome was "Substantial Assurance".

As a result of the assessment of the evidence, an overall assurance across all 10 NDG's standards of "Substantial Assurance" was given. This was calculated by MIAA by using the guidance from the independent assessment guidance.

3 DATA SECURITY AND PROTECTION TOOLKIT PERFORMANCE 2024/25

3.1 The Cyber Assurance Framework (CAF), developed by the National Cyber Security Centre (NCSC), will become the foundation of the Data Security Protection Toolkit (DSPT) from September 2024. This change is a key element of the 2023 health and care cybersecurity strategy, aimed at strengthening cybersecurity and information governance across NWAS and other health organisations.

3.2 DSPT Updated Structure for 2024/25

The updated DSPT is structured around five objectives (A–E), which have 47 outcomes to be measured against. There are three potential levels against each outcome – achieved, partially achieved or not achieved. NHS England have set a minimum standard against which the trust must achieve for 2024/25, not all outcomes are expected to be at achieved.

The objectives and the expectation for the outcomes are profiled below:

DSPT Element	Expected Profile		
Objective	NA	PA	A
Objective A - Managing risk	0	2	5
Objective B - Protecting against cyber-attack and data breaches	3	15	2
Objective C - Detecting cyber security events	3	4	0
Objective D - Minimising the impact of incidents	0	1	4
Objective E - Using and sharing information appropriately	0	1	7

3.3 DSPT Performance 2024/25

As in line with previous years an interim submission was completed in December 2024 and the final submission was completed at end of June 2025.

The position of the DSPT submission will be that the trust has not met all outcomes to the minimum level required, which we expect to be defined as expectations not met. The gaps in the achievement are described as below, as at end of June2025.

A set of the outcomes were audited by Mersey Internal Audit Agency (MIAA) as part of the required process by NHS England and provided us with an assessment that the trust is High Risk with High Confidence. High Risk means that between 2 and 4 outcomes assessed are rated as not meeting the minimum achievement levels. High Confidence means that the internal assessment is in line with the external assessment.

This is a change in the way that MIAA provide an outcome on their audit and not in line with other audits undertaken.

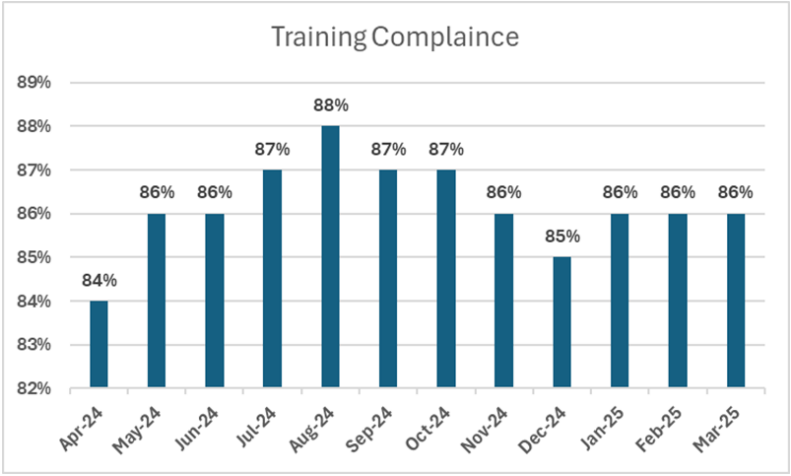
Objective	Title	Outcome position
A	Managing Risk	Achieving minimum standard on 5 of 7 outcomes
B	Protecting against cyber-attack and data breaches	Achieving minimum standard on 13 of 20 outcomes
C	Detecting cyber security events	Achieving minimum standard on 7 of 7 outcomes
D	Minimising the impact of incidents	Achieving minimum standard on 4 of 5 outcomes
E	Using and sharing information appropriately	Achieving minimum standard on 8 of 8 outcomes

DSPT 2024/25 Submission and Improvement Plan

The full outcome of the submission and the audit report will be reported through to Information & Cyber Group in August 2025 and beyond to the relevant governance groups. This will include the improvement plan details which will be set out how the trust will achieve the minimum standards expected for 2024/25.

4. DATA SECURITY AWARENESS COMPLIANCE

4.1 During the reporting period, the Information Governance (IG) Mandatory Training compliance rate stands at 85.46 % (averaged compliance over April 24 to March 25). To meet compliance standards, the trust requires that IG and Data Security training levels be maintained at 85% or above.



5. INFORMATION ASSETS

5.1 An information asset is a body of information, defined and managed as a single unit so it can be understood, shared, protected and exploited effectively. Information assets have recognisable and manageable value, risk, content and life cycles. The trust is responsible for creating and maintaining an Information Asset Register (IAR).

The IAR is a database which holds details of all the Information Assets (IA) within the trust. This includes physical assets such as paper files and computer systems (hardware) as well as software. Through the year the Information Governance team have worked with colleagues across the trust to identify information assets which are now recorded on the IAR.

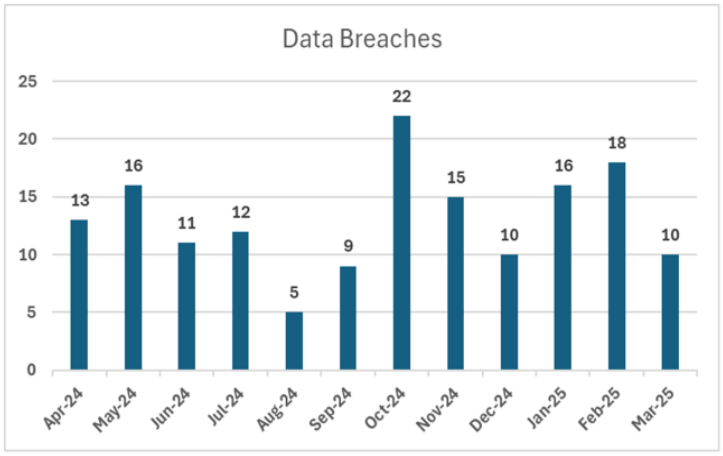
5.2 As part of the IAR there is a requirement to ensure that each asset has the following

- An approved Data Protection Impact Assessment (DPIA) if applicable
- System Level Security Policies (SLSP)
- Backup Process Documentation
- Data Flow Documentation

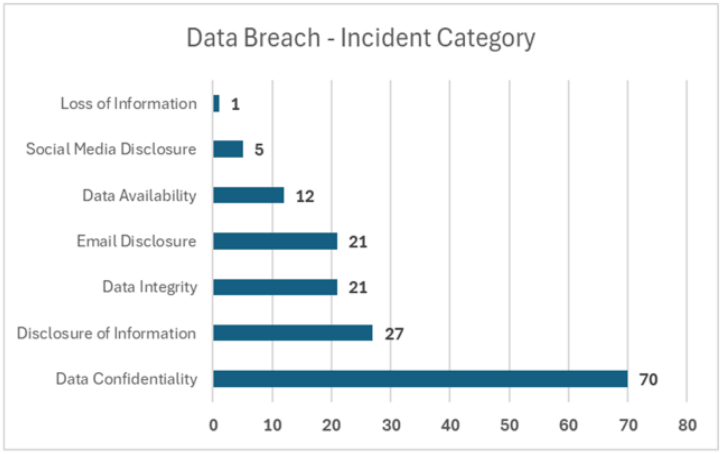
A task and finish group has been set up to work on outstanding actions/gaps in the asset register. The identified IAOs in the digital team have completed SLSPs for their assets. Work is ongoing with IAOs to review draft DPIAs for systems that have been in use pre–UK GDPR.

6. DATA BREACHES

6.1 The trust effectively uses the RLDatix System, DCIQ, to capture data breaches by all levels of staff via the incidents module. During the 2024/25 financial year there were 157 breaches reported.



The categories of the breaches were split as below with Data Confidentiality the highest.



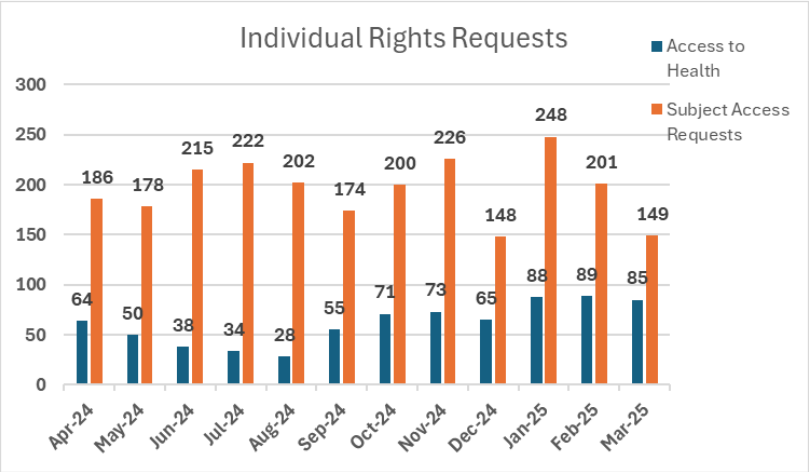
There were five data breaches that met the threshold to be reported externally via DSPT to the ICO during the reporting period. Two have been assessed with no further actions required and three are awaiting ICO review.

6.2 The Key Performance Indicator (KPI) for data breaches is to report any externally reportable data breaches within a 72-hour timescale.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Data Breaches	To report any externally reportable data breaches within the 72-hour timescale.	100% (0)	100% (1)	100% (1)	0% (3)	75%

7. INDIVIDUAL RIGHTS REQUESTS

7.1 A total of 3,089 Subject Access Requests (SAR) and Access to Health (A2H) requests have been received during the financial year 2024/25. This is an increase of 16.25% (432 more requests) compared to the previous financial year (increase for SARs is 12.33% (258 more requests); increase for A2Hs is 30.74% (174 more requests)).



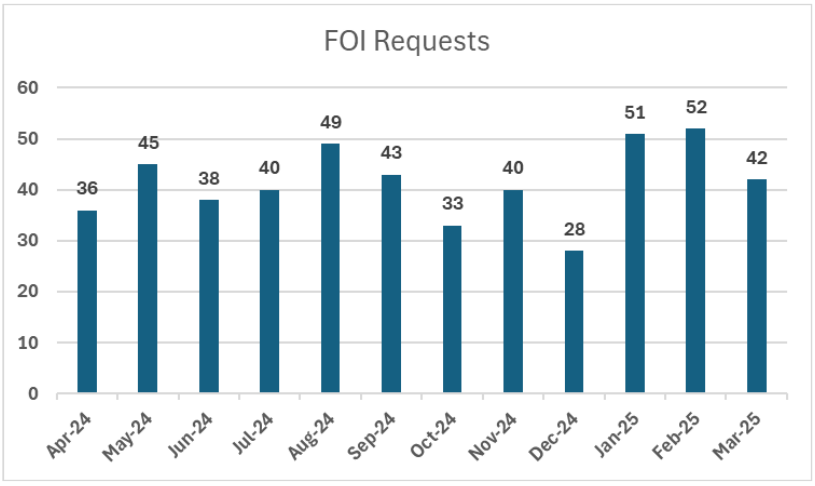
The KPI for SARs has been achieved for the period 2024/25.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Subject Access Requests (SARs)	To respond to 85% of requests without undue delay and at the latest, within one month.	100%	100%	99.74%	99.88%	99.9%

During the reporting period three Individual Rights requests exceeded the legally mandated timeframe due to awaiting information from 3rd party providers (Northwest Air Ambulance and Community Ambulance) or internal teams (Safeguarding and Legal), ensuring full compliance with the legal requirements set out in data protection regulations.

8. FREEDOM OF INFORMATION REQUESTS (FOI)

8.1



Under the Freedom of Information Act 2000 individuals can make a request to the trust to seek information that it holds. The trust is required to respond to these promptly and a target of responding within 20 days for 90% of requests has been set. For 2024/25 this has been achieved for the year and in each quarter.

The number of requests received in the year was 497.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Freedom of Information Request (FOI)	To respond to 90% of requests within 20 working days.	99.16%	100%	100% %	99.31%	99.6%

9. BODY WORN VIDEO CAMERA (BWVC) DATA PROTECTION REQUESTS

9.1 A total of 25 data protection requests from the Police for BWVC footage relating to incidents categorised as "Violence & Aggression" have been received within the reporting period, which is an increase of **108% (13 more requests)** compared to the previous financial year.

The highest month for Violence and Aggression requests was August 2024 (30).

Month	Police Requests	Violence and Aggression	CMI
Apr-24	3	28	3
May-24	5	29	9
Jun-24	2	18	2
Jul-24	1	13	6
Aug-24	2	30	1
Sep-24	0	25	4
Oct-24	2	28	2
Nov-24	2	24	4
Dec-24	0	12	3
Jan-25	3	19	2
Feb-25	2	11	10
Mar-25	3	17	3

10. DATA PROTECTION OFFICER

The DPOs assists the Trust to monitor internal compliance, and advise on data protection obligations, also provide advice regarding Data Protection Impact Assessments (DPIAs) and acts as a contact point for data subjects and the Information Commissioner's Office (ICO).
The DPO is independent, an expert in data protection, adequately resourced, and reports to the highest management level. The Trust procure the DPO service from Mersey Internal Audit Agency MIAA).

The DPO has received 12 complaints which have all been addressed and closed.

KPI	Target	Q1	Q2	Q3	Q4	Overall
Data Protection Requests	To respond to 85% of requests within 40 working days	100%	100%	100%	100%	100%

11. DATA PROTECTION IMPACT ASSESSMENTS

11.1 Over the past year the IG team's focus has been on ensuring that new information assets, changes to existing assets and changes in procedures involving personal identifiable data, are risk assessed in compliance with the UK GDPR, article 35 'Data Protection Impact Assessment'. The Trust has introduced a comprehensive assessment which is facilitated by the IG team and involves internal and external stakeholders with knowledge of the information asset and purposes of information processing.

There were 6 Data Protection Impact Assessments (DPIAs) completed during the reporting period.

- Trust ID
- Induction and Onboarding Automation
- TP Health/ Optima
- Troponin Project
- DCIQ Phase 2
- Aspirer

12. INFORMATION SHARING REQUESTS

12.1 There were 8 Information Sharing Agreements completed during the reporting period.

- North West Air Ambulance regarding main review of HEMSbase
- Stockport NHS Foundation Trust Serum Troponin project (Data sharing to support the implementation and impact of pre-hospital point of care cardiac troponin testing)
- Tameside & Glossop NHS Foundation Trust Serum Troponin project (Cardiac Acute Transfer System-CATS)
- Medical Examiners System Access Agreement
- Lancashire Resilience Forum Preparing for Emergencies update
- NWAS/Wirral University Health Trust (WUTH) review patients conveyed to WUTH who are discharged without treatment
- Tameside Adults Safeguarding Partnership Board & Tameside Safeguarding Children Partnership between Partner Agencies à Tameside Safeguarding Children Partnership, NHS Greater Manchester and Greater Manchester Police
- MFT Troponin (Data sharing to support the implementation and impact of pre-hospital point of care cardiac troponin testing)

13. DATA QUALITY

The Data Quality Team have continued to grow and enhance it's offering to the Trust. The team have established a core set of workstreams which have been developed which include

- Data Quality Monitoring reporting, this has been used predominantly to support key national submissions such as the Ambulance Data Set and PLICs. This area of work is also going to be used

and scoped out to support data quality reporting within Patient Transport Services over the next financial year.

- Data Quality Analysis, this has a wide variety of use cases which have been applied. After the CrowdStrike cyber incident, the team completed analysis to understand if our 111 service had suffered any significant data loss and to identify any changes in which GP surgeries were referring into the service. The team are also supporting the Trusts initiative to improve and understand unavailability reporting by scoping how data is presented and structured through different environments to understand if it is accurate, consistency, validity and completeness to be able to successfully report upon.
- Data Quality Audits, the team have worked to deep dive the way in which incident reporting flows from DATIX into the Data Warehouse. This involved conversations with key stakeholders to understand how they entered data, what limitations they experienced and their thoughts on how improved data entry would help them in their roles. The team validated data moving from system into the data warehouse and provided reasonable recommendations to the Trust on areas for improvement.

14. RISK CONSIDERATION

The Information and Cyber group reviews all information governance and cyber risks each meeting, there continue to be several key risks within the committee's remit. The work programme is set to provide assurance on the controls and the gaps in controls for those risks

At the end of March 2025 the following relevant risks were in place and being monitored through the Information & Cyber Group meeting.

Risk ID	Risk Description	Current risk score
330	There is a risk that due to gaps in controls end user education/awareness, the trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	20
331	There is a risk due to digital/expansion/interoperability increasing the trust's surface which in turn increases the overall risk to the trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	16
117	There is a risk that key components of the core ICT infrastructure might fail due to due to unforeseen circumstances which could result in multiple systems becoming inoperable.	12
578	There is a risk due to no clearly defined process, templates or guidance that the trust may implement digital products without following the requirements of DCB0129 and DCB0160. These standards demonstrate that the implementation of digital products have considered any potential clinical safety hazards and have the appropriate controls in place to implement products safely. This could lead to failure to comply with the required legislation and could lead to patient safety issue.	12
581	There is a risk that due to the Trust not having active robust privacy monitoring procedures in place that staff can access patient and staff identifiable and sensitive information from all the Trusts systems without being detected which could lead to a breach in confidentiality.	12

119	There is a risk of infrastructure and systems becoming unsupported by vendors due to a lack of vendor management which may result in additional financial consequences, cyber vulnerability or loss of systems	9
685	There is a risk due to lack of appropriate resources and processes that changes will be enacted on critical systems which may result in partial or full system failure	9
384	There is a risk that due to the lack of clear governance, centralised oversight, and retention schedules in place for clinical and corporate records, the Trust is not meeting the regulatory compliance required for the management of all records held within the Trusts digital and paper systems, which may result in incorrect use of personal information, reputational damage, or litigation.	8
151	There is a risk that an individual could obtain sensitive/confidential data and use it fraudulently resulting in the data being used for personal gain leading to reputation damage and a financial loss to the Trust.	6
141	There is a risk that due to the lack of capacity and capability within the IT on call team, we will not be able to support key business services out of normal 9-5 working hours which could result in system disruption or loss of critical services.	6
245	There is a risk that due to the legacy completion of paper PRFS and the current business continuity process of EPR that reverting back to paper PRFS could result in the inability to retrieve paper clinical records for coroners, claims and complaints, subject access requests, internal investigations and Police requests leading to breaches in law, reputational damage and financial penalty.	6
145	There is a risk that due to scheduled maintenance and replacement tasks not being progressed in a timely manner, critical network communications may be lost resulting in failure of communication systems negatively impacting on service delivery.	5
518	There is a risk that due to NWAS having no formal processes in place for the accessing and release of CCTV from Trust sites, the rights and freedoms of the data subject may be compromised, which could lead to a breach in Data Protection Legislation and a complaint to the Information Commissioner's Office, resulting in reputational damage to the Trust.	4

15. ACTION REQUIRED

Trust Board are asked to:

- Review the report and take assurance from the information provided that there are appropriate controls in place to maintain the security of information.

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ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Wednesday, 18 June 2025		
Members present	Mr D Whatley, Non-Executive Director (Chair) Dr A Chambers, Non-Executive Director Mrs C Butterworth, Non-Executive Director Prof A Esmail, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- No items

ADVISE:

- No items.

ASSURE:

- External Auditors presented the Audit Completion Report for the year ended 31 March 2025. The report set out the intention to issue an unqualified opinion on the trust's financial statements.
- External auditors presented the draft Annual Audit Report. The report summarised the work undertaken for the year ended 31 March 2025.
- The audited financial statements were recommended to the Board of Directors for approval on 18th June. It was noted the Trust met all of its statutory duties.
- The management letter of representation was noted for presentation to the Board of Directors for signing.
- The Annual Report 2024/25 was recommended to the Board of Directors for approval on 18h June 2025.No items.

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Friday, 18 July 2025		
Members present	Mr D Whatley, Non-Executive Director (Chair) Dr A Chambers, Non-Executive Director Mrs C Butterworth, Non-Executive Director Prof A Esmail, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- No items

ADVISE:

- External auditors presented the audit follow up letter confirming conclusion of the matters marked as outstanding within the Audit Completion Report presented to the Committee on 18th June 2025.
- Losses and Compensation for Q1 2025/26 totalled £81k.

ASSURE:

- Internal Audit reported one reviews was completed during Q1 2025/26.
  - E-Timesheets – Moderate Assurance

  Management representatives will attend the next meeting to provide further assurance in relation to the agreed recommendations.
- The Anti-Fraud Progress report detailed activities undertaken against the agreed anti-fraud work plan. The Counter Fraud Functional Standard Return annual assessment received an overall rating of green and across all components.
- The SIRO Annual Report 2024/25 provided assurance that appropriate controls are in place to maintain security of information.
- The Q1 Position of the Board Assurance Framework 2025/26 was presented, prior to approval by the Board of Directors on 30th July 2025. Committee members considered the report within the context of their role as Audit Committee.
- Three waivers were approved during Q1 2025/26.
- MIAA presented the outcome of the Committee Effectiveness Review which was carried out line with the HFMA Audit committee Handbook.

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Charitable Funds Committee

Date of meeting	Wednesday, 23 July 2025		
Members present	Mr D Whatley, Non-Executive Director (Chair) Mrs C Butterworth, Non-Executive Director Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None identified.

ADVISE:

- The Q1 financial position of the NWAS Charity was overall funds of £640k: general funds £303k and restricted funds £337k.

ASSURE:

- The NWAS Charity risk register was presented following quarterly review. Committee noted the closure of some risks, rearticulation of a risk associated with capacity of the Charity team and retention of a risk associated with skills/commitment of Trustees given the forthcoming changes in board/non-executive composition.
- Summary of the operational, strategic and charitable activity undertaken during Q1 2025/26 and noted the use of restricted and unrestricted funds and updates in relation to the NHS Charities Together grants. Additional resource to support the Charity team has been identified.
- A summary of the fundraising activities undertaken during Q1 2025/26 was provided, together with fundraising plans scheduled for Q2 2025/26.

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 June 2025		
Members present	Mr S Desai, Chief Executive (Chair) Dr C Grant, Medical Director Mrs E Orton, Assistant Director of Nursing & Quality Ms E Strachan-Hall, Interim Director of Quality Mrs L Ward, Director of People Ms S Rose, Director of Integrated Contact Centres Mrs A Ormerod, Interim Deputy Director of Strategy, Partnerships & Transformation Mrs J Wharton, Chief Information Officer Mrs C Wood, Director of Finance Ms S Wimbury, Area Director (GM) In attendance Mrs E Shiner, Deputy Director of Corporate Affairs Mrs J Turk, Executive Business Support Manager	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Productivity & Efficiency:** Two substantive schemes were to be finalised before they could be moved into development/implementation plans. The job cycle time scheme was to be reviewed further and if identified as non-cash releasing, a further scheme would need to be identified to substitute it. Work was ongoing.

- **Data Security Protection Toolkit Submission (DSPT) June 2025:** Significant changes have been made to the approach and remit of the DSPT with a greater focus on cyber assurance around data and assets. The trust must achieve against five main objectives to be compliant, currently the trust is compliant against two of the objectives. The trust's submission for DSPT on 30 June will be non-compliant. A task and finish group has been set up to work through the areas for improvement.

- **EPRR mandatory training:** The trust was not meeting the 90% JESIP training compliance, but a clear action plan was in place to recover.

ADVISE:

- Agency costs in month 03 are nil, YTD costs remain at £0.003m.
- A further return was to be submitted to ICB and PwC with work undertaken to review how the £1.120m shortfall can be reduced further.
- The TMC approved the extension of the Troponin pilot until December 2025. Working in collaboration with Health Innovation Manchester and Manchester Foundation Trust.
- The TMC approved the purchase of 39 PTS vehicles in September 2025.
- The TMC approved the Quarter 1 changes to the trust annual plan as outlined in the change control register.
- The TMC approved the review of desk top evaluated posts in line with the SDMR structure review in Quarter 4. A further paper detailing the approach would follow.
- Planning Group was assured that all of the annual plan uncontrolled risks now had mitigations in place. The annual plan was deemed achievable with governance in place to monitor throughout the year.
- **EPRR annual assurance:** The trust was likely to submit 'substantially compliant' and expected to deliver 92% for Ambulance Service Standards and 95% for Interoperability.

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - 2526/071 Finance Report month 02
  - 2526/080 Work-Related Stress – action plan

- Received the following Escalation & Assurance reports:
  - 2526/081 Health, Safety, Security & Fire Group – 13 May 2025
  - 2526/082 Planning Group – 10 June 2025
  - 2526/083 EPRR Group – 19 May 2025
  - 2526/084 Sustainability Group – 2 June 2025

RISKS

Risks discussed:

- The 7 commercially sensitive risks were reviewed and agreed as correctly tagged in DCIQ risk module.
- Risk ID717 was agreed for inclusion on the corporate risk register.
- Risks ID580 and 655 were agreed for escalation to the corporate risk register, subject to ID655 being re-articulated.
- The TMC did not support the closure of risk ID318 at this time.

New risks identified:

- None.

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 23 July 2025		
Members present	Mr S Desai, Chief Executive (Chair) Dr C Grant, Medical Director Mrs E Orton, Assistant Director of Nursing & Quality Mrs L Ward, Director of People/DCEO Ms S Rose, Director of Integrated Contact Centres Mrs A Ormerod, Interim Deputy Director of Strategy, Partnerships & Transformation Mrs J Wharton, Chief Information Officer Ms S Wimbury, Area Director, Greater Manchester Mrs A Wetton, Director of Corporate Affairs Mr M Cooper, Area Director, Cumbria & Lancashire Mr I Moses, Area Director, Cheshire & Mersey Mr M Jackson, Chief Consultant Paramedic In attendance Ms K Butler, Executive Business Support Manager Ms J Watson, Good Governance Institute M Brooks, Deputy Director of Finance	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Industrial action**: Action involving resident doctors is due to take place 25th July to 30th July 2025. Comms are planned for staff and the public.
- **Productivity and efficiency:** Savings of £4.145m have been achieved to month 3, which is £0.338m above the month 03 target of £3.807m. The forecast achievement against the £14.878m target for 2025/26 is £14.259m, which is a shortfall of £0.619m.
- **Patient Safety:** The TMC supported the recovery plan to deal with the backlogs across patient safety, however requested a deeper review and a more robust proposal to be brought back to this committee.

ADVISE:

- The TMC has approved the decision to remove NWAS from Schedule 4 of the Investigatory Powers Act
- The TMC approved and recommended the Q1 position of the Board Assurance Framework 2025/26 to the Board of Directors.
- The TMC supported the Policy Update as a standing agenda item for this committee.
- The TMC supported the bringing together Equality and Quality Impact assessment with a working draft of a new policy to be developed.
- The TMC approved the NWAS Strategic winter plan.
- The TMC approved the Sexual Safety Policy
- The TMC approved the Professional Boundaries Policy

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - 2526/094 Finance Report month 03
  - 2526/103 Policy Management Framework: Policy Update
  - 2526/104 Annual SIRO Report
  - 2526/105 Patient Safety Events Management
  - 2526/108 NWAS Strategic Winter Plan
  - 2526/109 Leadership Review Closure report
  - 2526/111 Annual Plan Assurance Q1 2025/26
  - 2526/112 EDI Regulatory Reporting including WRES / WDES and Gender Pay Gap
  - 2526/113 HR Case Management Risks

- Received the following Escalation & Assurance reports:
  - 2526/115 Information and Cyber Governance Group 10 June 20
  - 2526/116 Clinical and Quality Group 1 July 2025
  - 2526/117 Service Delivery Assurance Group (SDAG) 1 July 2025
  - 2526/118 Diversity and Inclusion Group 11 July 2025
  - 2526/119 People and Culture Group 16 July 2025
  - 2526/120 Planning Group – 3 July 2025

RISKS

Risks discussed:

- TMC approved and recommended the Q1 position of the Board Assurance Framework 2025/26 to the Board of Directors.
- Reviewed and discussed the risks identified on the corporate risk register
- Commercially sensitive risks were reviewed and agreed
- Risk ID317 was overdue a review on the corporate risk register.

- Risks ID434 was agreed for escalation to the corporate risk register.

New risks identified:

- None.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Workforce Equalities Data Monitoring Reports
PRESENTED BY	Lisa Ward, Director of People
PURPOSE	Decision

LINK TO STRATEGY	All Strategies										
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☒	**SR05**	☒	
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐	**SR11** ☐

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

ACTION REQUIRED	The Board of Directors is asked to: • Review, consider and note the data in the WDES, WRES and Pay Gap reports. • Receive assurance the Trust has complied with its regulatory and statutory duties to compile and submit the data. • Approve the publication of the data as set out in the Appendices
EXECUTIVE SUMMARY	This paper presents an overview of the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Pay Gap data reports, with individual reports provided in the appendix. It highlights key findings from the data, but the full reports should be consulted for the detailed context. **Workforce Disability Equality Standard** • Disability declaration among staff rose to 9.4% in March 2025, up from 7.8% in 2024 • Representation of disabled staff has improved across Bands 1–8b, with nearly 1 in 5 leadership and management staff identifying as disabled or having a long-term condition. • Recruitment data shows increased appointments of disabled applicants and a relative likelihood ratio of 1.17 for appointment – closer to the target of 1.0 than in previous years.

- Disabled staff are nearly 4.5 times more likely than non-disabled staff to enter the formal capability process.
- Perceptions of fairness around career progression and feeling valued have declined among disabled staff, with over half viewing progression as unfair and 70% reporting dissatisfaction with how their work is valued.
- The proportion of disabled staff reporting that reasonable adjustments were made increased from 65.2% in 2023 to 71.3% in 2024.

Workforce Race Equality Standard

- The number of BME staff has continued to rise year-on-year, nearly doubling since 2019.
- BME applicants were nearly 2.5 times less likely to be appointed than White applicants in 2024/25.
- BME staff were nearly 2.7 times more likely to enter formal disciplinary processes than White colleagues - a small increase on the previous year and representing the highest disparity since reporting began.
- Experiences of negative behaviours from colleagues have decreased for both groups – by 5.5% for White staff and 4.4% for BME staff. However, nearly 1 in 5 BME staff still report experiencing abuse.
- Confidence in fair career progression among BME staff rose by 5.6% in 2024 and the perception gap between BME and White staff narrowed from 12% to 6%.

Pay Gaps

- Gender: Female representation in the organisation increased to 56.19%, with growth in most pay quartiles, particularly the lower quartile (+2.26%). The mean hourly gender pay gap widened slightly to -7.63%, while the median gap reached a high of 12.68%.

- Ethnicity: BME staff are most represented in the lower pay quartile and least in the upper. The mean and median ethnicity pay gaps are -4.38% (£0.86) and -6.28% (£1.14) respectively, both widening by approximately 1.7% compared to last year despite improved representation.

- Disability: Representation of disabled staff increased across all quartiles in 2025. The mean and median pay gaps are -0.71% and -1.29%, the smallest among all protected characteristics, but still reflect lower average pay for disabled staff.

Actions

The appended data reports outline actions for 2025/26 aimed at addressing disparities and improving staff experience. These actions align with and complement existing priorities in the EDI Annual Plan, which is overseen by this committee.

	There are however, four substantial areas of focus which require special attention: 1. To address disparities in BME recruitment (WRES Indicator 2), we will undertake a deep dive to identify barriers to appointment, strengthen targeted 1:1 application support through the Positive Action Team, increase BME participation in pre-employment programmes for entry-level roles, and deliver focused training to managers to improve inclusive and equitable interview practices. 2. To address disparities in entry to the formal disciplinary process (WRES Indicator 3), we will review disciplinary cases involving BME staff to identify patterns and inform a targeted action plan that promotes fair and consistent application of the disciplinary policy. Continue to receive assurance on progress of ICC project to address disciplinary disparity, especially in relation to low level matters. 3. To address disparities in entry to formal capability process (WDES Metric 3), we will carry out a detailed review of the disproportionate involvement of disabled staff in the capability processes, working with HR, Disability Network, and teams with higher prevalence of cases to identify root causes and inform targeted improvements. The reviews referenced in the three actions above will aim to be concluded by October, with reports on outcomes and next steps presented to the Diversity & Inclusion Group and Resources Committee in November 2025. To address the gender pay gap, there are continuing pieces of work in this 2025/26 plan, including seeking to improve the representation of women in middle and senior leadership, through opportunities such as the Developing Leaders programme. We are also keeping leadership recruitment processes under review to ensure they are not disadvantaging women, and the People Promise flexible working workstream will contribute to improving access to flexible working opportunities within leadership. Additionally, further work will be undertaken to breakdown the GPG data to enable a better understanding of challenges and issues at a directorate/service line level.

PREVIOUSLY CONSIDERED BY	**People & Culture Group**	
	Date	Wednesday, 16 July 2025
	Outcome	Report was noted and recommended to TMC/RC for onward approval.
PREVIOUSLY CONSIDERED BY	**Diversity & Inclusion Group**	
	Date	Friday, 11 July 2025

	Outcome	Report was noted, extensive discussion relating to the data took place, particularly on WRES 2 and GPG. Recommended to TMC/RC for onward approval.
PREVIOUSLY CONSIDERED BY	**Trust Management Committee**	
	Date	Wednesday, 23 July 2025
	Outcome	Report was noted and recommended to Resources Committee for onward approval. Monitoring of actions and ongoing assurance to be provided through Diversity and Inclusion Group to TMC.
PREVIOUSLY CONSIDERED BY	**Resources Committee**	
	Date	Thursday, 24 July 2025
	Outcome	Publication recommended to Board for onward approval. Further assurance on key areas of action requested for November meeting

1. BACKGROUND

1.1 This paper provides an overview of the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and Pay Gap data reports for the period 1 April 2024 – 31 March 2025.

1.2 Individual reports for each data set are included in the appendix to this cover paper. A summary of key findings is presented below; however, readers are encouraged to refer to the full reports for detailed analysis and context.

1.3 With regards pay gap data, this is the first year that the Trust is publishing data on ethnicity and disability pay gaps, in addition to the gender pay gap – which has been reported for several years.

1.4 The WDES and WRES data was submitted to NHS England in May 2025 in line with the reporting time frame. Gender Pay Gap data will be entered on the Government portal later this year, while submission requirements for ethnicity and disability pay gaps are yet to be announced.

2. WDES

2.1 During the reporting period (April 2024 to March 2025), there has been a continued increase in staff disclosing a disability (Metric 1). As of March 2025, 9.4% of the workforce had declared a disability, up from 7.8% in 2024 and nearly double the 2022 figure of 5.0%. In the 2024 NHS Staff Survey, approximately 32% of NWAS respondents (from a sample of over 3,500) identified as disabled.

2.2 There has also been an improvement in the representation of disabled staff across Bands 1–8b in both clinical and non-clinical roles. Notably, nearly 20% of staff in leadership and management positions now identify as disabled or as having a long-term condition - reflecting year-on-year progress.

2.3 There are around 400 staff members who have not declared their disability status on ESR. While still a sizeable figure, this is 50% less than the undeclared figure in 2021.

2.4 In terms of recruitment (Metric 2), 716 disabled applicants were shortlisted and 113 appointed between April 2024 and March 2025. These figures reflect a modest increase from the previous year. The relative likelihood of non-disabled staff compared to disabled staff being appointed stands at 1.17 this year, and is the closest to the target figure (1.0) when compared to the last five years – indicating that disabled staff are more likely to be appointed now than five years ago.

2.5 There are however some areas of concern that have re-emerged. For example, in Metric 3 which looks at the relative likelihood of entering the formal capability process, shows a marked deterioration. Disabled staff are now almost 4.5 times more likely than non-disabled staff to be subject to formal performance procedures. Overall numbers remain very low which can affect the scale of change, but the disproportionality is significant and will be examined in detail in collaboration with the HR Business Partnering Team.

2.6 Figures continue to show that around 1 in 5 disabled staff experience abuse from colleagues – a higher proportion than that of non-disabled staff (Metric 4.3). Notably, the gap between the two groups has slightly widened this year, following three consecutive years of reduction.

2.7 Staff feedback on perceptions of fairness in career progression and development (Metric 5, Staff Survey data) has also declined among disabled colleagues for the first time since 2021, while responses from non-disabled staff have remained stable. Over 50% of disabled staff continue to report a lack of confidence in the fairness of progression or promotion processes.

2.8 One in three disabled staff reported feeling pressured to come to work when not well enough (Metric 6), compared to just over one in four non-disabled staff. Positively, the figures for disabled staff show a downward trend since 2021, but the proportion of non-disabled staff experiencing this pressure has increased compared to the previous year.

2.9 Around 70% of disabled staff indicated dissatisfaction with how their work is valued by the organisation (Metric 7, Staff Survey data), compared to approximately 65% of non-disabled staff. Although overall satisfaction levels remain broadly consistent with the previous year, the gap between disabled and non-disabled staff has widened following a narrowing trend seen in 2023.

2.10 A positive development during the reporting period is the increase in the proportion of disabled staff who reported that reasonable adjustments had been made to support them at work (Metric 8, Staff Survey data). This figure rose from 65.2% in 2023 to 71.3% in 2024 – an increase of 6%. This improvement may be attributed to the implementation of the reasonable adjustments policy and the targeted training provided to managers to ensure its effective application.

3. WRES

3.1 There has been a continued year-on-year increase in the number of BME staff across the organisation (Indicator 1), with numbers nearly doubling since 2019. As of 31 March 2025, there were 77 more BME staff compared to the previous year. The Trust exceeded its target of a 0.5% annual increase in BME representation, rising from 6.0% in 2024 to 6.7% in 2025. The ethnicity declaration rate remains high, at over 99%.

3.2 Recruitment data (Indicator 2) shows a deterioration in the relative likelihood of appointment for BME applicants. White applicants were nearly 2.5 times more likely to be appointed than their BME counterparts in 2024/25, compared to the previous year's figures. Despite an increase in both the number and proportion of BME applicants (46%) and shortlisted candidates (27%), only 10% of new starters were from BME backgrounds.

3.3 The increase in BME applicants and shortlisted candidates may be attributed to a range of factors, including expanded staff capacity in the Positive Action Team, inclusive communications using diverse imagery, and ongoing improvements in the language used in job adverts. Approximately 20 successful BME applicants this year benefited from personalised 1:1 coaching and support provided by the Positive Action Team.

3.4 Despite sustained efforts over several years to improve recruitment processes, a significant challenge remains in converting the increasing number of BME applications into successful appointments. The recent decline in this indicator is a serious concern. To better understand the underlying causes and identify actionable solutions, a detailed deep dive will be undertaken. This work will concentrate on key recruitment stages, such as shortlisting and interviews/assessments, while also requiring managers to critically reflect on potential bias and ensure fairness in their decision-making. Findings from the deep dive will inform targeted interventions, with progress monitored through this committee.

3.5 In addition, the Positive Action Team will work to enhance the effectiveness of coaching and support available for developing high-quality personal statements and preparing for interviews

and assessments. This work aims to offer a range of accessible support options to help candidates strengthen their applications, improve assessment/interview readiness, and ultimately increase their chances of being shortlisted and successfully appointed.

3.6 Figures in Indicator 3 show that the disparity in entering the formal disciplinary process between BME and White staff also remains a significant challenge. BME staff continue to be over 2.5 times more likely to enter a formal disciplinary process than White colleagues, marking the widest gap since reporting began.

3.7 In total, the Trust recorded around 180 formal disciplinary cases in 2024/25, a sharp rise from 92 in the previous year. Of these, 29 involved BME staff (up from 15 in 2023/24), accounting for 16% of cases – more than double the BME representation in the overall workforce (~7%).

3.8 There were around 180 formal disciplinary cases in the Trust this year – a substantial increase on the 92 cases reported in the previous year. 29 cases this year related to BME staff, compared to 15 last year. This means that 16% of those in the formal disciplinary process were BME staff – a proportion significantly higher than the ~7% representation in the workforce.

3.9 A targeted review was undertaken earlier this year, based on the 2023/24 data for this Indicator, and highlighting a concentration of cases in Integrated Contact Centres. A joint deep dive by the HR and ICC Management teams sought to explore, identify and address the underlying causes. Further details are provided in Appendix 4 and the D&I group is receiving assurance on the progress of the ICC work already underway to reduce disparities.

3.10 The percentage of staff experiencing negative behaviours from colleagues (Indicator 6, Staff Survey data) has continued to fall consistently, year on year. In the last year, the figures show a reduction of 5.5% among White staff and 4.4% among BME staff compared to 2023. However, almost 1 in 5 BME staff continue to experience abuse from colleagues.

3.11 Following a decline in 2023, BME staff reported a 5.6% increase in confidence regarding the fairness of career progression in 2024 (Indicator 7, Staff Survey data). The gap in perceptions between BME and White staff has halved – from 12% to 6%. While this improvement is encouraging, more than half of BME staff still feel that career progression within the Trust is unfair. It is anticipated that initiatives such as the Developing Leaders programme and work to create clearer progression pathways from ICCs and the Patient Transport Service into Emergency Medical Technician roles will contribute to further improvements in this area.

4.1 PAY GAPS

4.1 **Gender Pay Gap:** Female representation within NWAS has increased to 56.19%, up from 53.13% in the previous year. This year has seen growth in the proportion of female staff across the lower, lower-middle, and upper pay quartiles. However, there was a slight decline in the upper-middle quartile compared to the previous year. The most notable increase was in the lower pay quartile, where female representation rose to 59.89% - an increase of 2.26% year-on-year.

The mean (average) hourly pay gap currently stands at -7.63%, a slight increase from -7.27% in 2024. Although still a notable gap, this represents the second-lowest mean figure since reporting began in 2020. In contrast, the median hourly pay gap has continued to widen, reaching 12.68% this year – the highest level recorded since reporting commenced.

4.2 **Ethnicity Pay Gap:** The largest proportion of BME staff in NWAS (141) are in the lower pay quartile, with the smallest proportion (99) in the upper quartile. By comparison, there are approximately 1750 White staff in each pay quartile.

The hourly mean pay gap between BME and White staff stands at -4.38% (£0.86), while the median pay gap is -6.28% (£1.14). Despite increased BME representation in the upper pay quartiles this year, both the average and median pay gaps have widened by approximately 1.7% compared to the previous year.

4.3 **Disability Pay Gap:** The representation of disabled staff is relatively evenly distributed across the four pay quartiles, with approximately 165 – 185 disabled staff in each quartile. In contrast, there are over 1,700 non-disabled staff in the lower quartile, nearly 1,600 in the upper quartile, and more than 1,500 in both the lower middle and upper middle quartiles. There has been a significant increase in the representation of disabled staff across all pay quartiles in 2025, compared to the 2024 figures

The mean and median hourly pay gap between disabled and non-disabled staff is -0.71% and -1.29% respectively - indicating that non-disabled staff earn between £0.13 and £0.25 more per hour than their disabled colleagues. While this gap warrants attention, it is notably the smallest when compared to the pay gaps observed across ethnicity and gender.

5 ACTIONS

Each of the data reports appended to this paper list the actions which will be taken in 2025/26 to address disparities and make improvements to shift the dial in respect metric, but also for enhanced staff experiences. The tasks set out in the reports overlap with work already identified and set out in the EDI Annual Plan, monitored by this committee.

There are however, four substantial areas of focus which require special attention:

5.1 WRES Indicator 2 – Recruitment

- We will carry out a comprehensive analysis to identify and understand the barriers preventing higher rates of BME appointments, using data and insights to inform meaningful change. This review will aim to conclude by October, with a report to be presented to the Diversity & Inclusion Group in November 2025.
- Bespoke 1:1 coaching for prospective applicants at the application and interview stages provided by the Positive Action Team will be reviewed and strengthened. Support will be targeted through applicant tracking, outreach, and referrals.
- We will proactively work to boost engagement of BME individuals in pre-employment programmes, with a focus on improving access to and readiness for entry-level roles.
- We will design and deliver concise, practical training for recruiting managers to enhance interview capability - specifically strengthening awareness and application of equality, diversity, and inclusion principles in the assessment process.

5.2 WRES Indicator 3 – Formal disciplinary process

- We will continue to review disciplinary cases involving BME staff (particularly within ICCs) to gain deeper insight into patterns and root causes. This analysis will inform the development of a targeted action plan aimed at ensuring the disciplinary policy is applied consistently, fairly, and without bias across all areas of the organisation. The D&I group will continue to receive assurance on progress of ICC project to address disciplinary disparity, especially in relation to low level matters.

5.3 WDES Metric 3 – Formal capability process

- We will conduct an in-depth review to understand the underlying causes of the disproportionate involvement of disabled staff in the Trust's formal capability processes. This work will be led in collaboration with the HR Business Partnering Team, the Disability Network, and representatives from teams with a higher incidence of capability cases, ensuring a comprehensive and informed approach to identifying systemic issues and driving meaningful change. This review will aim to conclude by October, with a report to be presented to the Diversity & Inclusion Group in November 2025.

5.4

Gender Pay Gap

- Work is continuing to improve the representation of women in middle and senior leadership roles, for example by empowering and preparing females through the Developing Leaders programme. Additionally, we are keeping leadership recruitment processes under review to ensure they are not disadvantaging women.
- The People Promise flexible working workstream will contribute to improving access to flexible working opportunities – recognising that a lack of flexibility has previously been noted as a barrier to women progressing into senior roles.
- We will also seek to breakdown the GPG data to enable a better understanding of challenges and issues at a directorate/service line level.

5.5 TMC have requested additional assurance via the Diversity and Inclusion Group and a commitment has been given to provide an update and assurance on progress to Resources Committee in November.

6. RISKS

The report seeks approval to publish the data which impacts on the following elements of the risk appetite statement:

People	The Trust has a moderate risk appetite in relation to its people. The reports show a balance of improvement and challenge which could have a negative impact on morale when published but the overall intention of being transparent over the data is to drive improvement.
Compliance & regulatory	The Trust has a low risk appetite for regulatory compliance. Publication of gender pay gap data is a statutory requirement and failure to publish may result in enforcement action. The requirement to publish WRES and WDES is set out in the standard contract and failure to publish could have negative regulatory outcomes.
Quality	The Trust has a low risk appetite for issues which impact adversely on quality. There is a direct link between staff experience and quality of care but the overall intention of being transparent with the data is to drive improvement.
Reputation	We have a moderate risk appetite for damage to reputation. The publication does pose a risk to reputation but this is equally matched by the reputational risks from non-publication and any consequent adverse publicity in relation to enforcement action.

6.1

The overall outcome of the reports identify a range of potential risks in relation to the attractiveness of the organisation as employer and the adverse issues which may arise from poor staff or patient experiences.

7. EQUALITY/ SUSTAINABILITY IMPACTS

7.1 The collation and assessment of WDES, WRES and Pay Gap data is essential to help improve the experiences of all staff. The data informs the delivery of the EDI Annual Plan.

8. ACTION REQUIRED

The Board of Directors is asked to:

8.1

- Review, consider and note the data in the WDES, WRES and Pay Gap reports.
- Receive assurance the Trust has complied with its regulatory and statutory duties to compile and submit the data.
- Approve the publication of the data as set out in the Appendices 1-3

North West Ambulance Service
NHS Trust

Workforce Disability Equality Standard (WDES) Data Report

Covering the period of
1st April 2024 – 31st March 2025

Introduction

This report sets out the 2024/25 annual workforce data in relation to disability which the trust is required by NHS England to publish. Working to address inequalities identified by workforce data demonstrates our compliance with the Equality Act 2010 and the Public Sector Equality Duty. Monitoring workforce equalities data is also central to ensuring that we are delivering on our equality, diversity and inclusion priorities:

1. We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels.
2. We will educate and empower our workforce and leaders to promote a positive psychologically safe culture, to support a reduction in the experience of bullying, harassment, discrimination and an improvement in retention.

Workforce Disability Equality Standard (WDES)

The WDES is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. We use the metrics data to develop and publish an action plan, building on high impact actions as set out in the EDI improvement plan. Year on year comparison enables us to demonstrate progress against the indicators of disability equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers.

The data in this report relates to the period of 1 April 2024 – 31 March 2025 and comprises information taken from the Electronic Staff Record (MyESR), HR Business Partnering, Learning & Development, and the 2024 NHS Staff Survey.

In line with the nationally mandated timeframe, the data was submitted to NHS England in May 2025.

Metric 1: Percentage of staff in Agenda for Change (AfC) pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

The following two tables provide a breakdown of representation of disabled staff within NWAS non-clinical and clinical workforces.

Non-clinical Staff

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
Cluster 1: Bands 1 - 4	6.7%	10.7%	10.4%	13.3%	**14.8%**
Cluster 2: Bands 5-7	5.8%	6.2%	8%	10.5%	**13.1%**
Cluster 3: Bands 8a-8b	0.0%	4.7%	3.6%	4.8%	**10.1%**
Cluster 4: Bands 8c-9 and VSM	5.1%	5.0%	14%	10.2%	**9.7%**

Clinical Staff

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
Cluster 1: Bands 1-4	4.5%	4.5%	6.1%	7.4%	**9.1%**
Cluster 2: Bands 5-7	4.5%	5.0%	6.4%	7.5%	**8.7%**
Cluster 3: Bands 8a-8b	5.2%	6.9%	14.3%	16.7%	**17.9%**
Cluster 4: Bands 8c-9 and VSM	13.3%	11.1%	0%	0%	**0%**

The data shows an increase in the representation of disabled staff in Bands 1 – 8b across both clinical and non-clinical staff groups. Almost 1 in 5 members of staff in clinical and non-clinical leadership and management roles identify as disabled, or having a long-term condition – which is a notable improvement from the previous year.

We have continued to see more staff declaring their disability status, with figures from the end of March 2025 showing that 9.4% of all staff had declared they had a disability. This is an increase from 7.8% in 2024 and almost double the declaration rate in 2022 (5.0%).

The sustained increase in declaration rates may be attributed to the ongoing promotion of internal communications campaigns aimed at encouraging staff to update their disability status on the Electronic Staff Record (MyESR). Additionally, the Disability Network have continued to undertake initiatives to engage staff around disability declaration. The introduction and awareness-raising of the reasonable adjustments and neurodiversity support policies also appear to have had a positive impact on encouraging staff to declare or update their disability status.

The Trust continues to be a member of the Hidden Disabilities Sunflower scheme, which aims to raise awareness of and assist individuals with hidden disabilities. In addition to promoting the Sunflower lanyard and wristbands, staff can also access an e-learning package to increase their understanding of hidden disabilities and the scheme.

There are around 400 staff members who have not declared their status on the electronic staff record. While still a sizeable figure, this is 50% less than the undeclared figure in 2021. We will continue to encourage all colleagues to keep their disability status up to date, and aim for engagement with the following staff groups in particular:

Staff group		Disability status unknown as of 31/3/25	Disability status unknown on 31/3/24
Clinical	Band 3	3.9% - 68 people	5.4%, 88 people
	Band 5	5.1% - 41 people	5.9%, 47 people
	Band 6	9% - 183 people	10.4% - 198 people
Non-clinical	Band 8d	7.1%	15.4%
	VSM	22.2%	31.3%

Metric 2: Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.

The target outcome is a figure of 1.0 – meaning that disabled candidates are no less likely to be appointed from shortlisting than candidates who have not declared a disability. A figure of 1.0 reflects well on the fairness of current recruitment processes.

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
Likelihood	1.39	1.56	1.26	1.29	**1.17**

The likelihood score this year has improved compared to the 2023/24 figures. In fact, the current score is the closest to the target figure when compared to the last five years – indicating that disabled staff are more likely to be appointed now than five years ago.

Between April 2024 and March 2025, 716 disabled applicants were shortlisted for Trust roles (703 in 2023/24), and 113 disabled staff were appointed during this period (compared to 108 in 2023/24).

While there is still work to do to improve the metric score, the continued increase in the number of disabled applicants applying for and being appointed to Trust roles is a positive development. These improved figures may reflect the use of inclusive language and imagery in recruitment adverts, the promotion of the Trust as a Disability Confident Leader, the external highlighting of the Disability Network's work, and the development of compassionate and inclusive leadership through diversity and inclusion training modules – including those focused on reasonable adjustments and neurodiversity. The work of the Positive Action and Widening Access Teams, who actively engage with communities, has also contributed to increasing the representation of disabled people at NWAS.

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure

A figure of 1.0 or below is desired, as this would indicate disabled staff are no more or less likely to enter into the formal capability process than non-disabled staff. This metric is based on data from a two-year rolling average of the current year and the previous year and looks at capability on the grounds of performance only, rather than ill health.

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
Likelihood	2.71	0.00	1.47	1.63	**4.46**

The likelihood score this year shows that disabled staff are almost four-and-a-half times more likely to enter the performance process compared to non-disabled staff – a significant deterioration from last year's figure.

While the number of non-disabled staff entering the formal performance process has also increased this year, the overall number of staff involved in this process remains small relative to the total workforce. Nevertheless, it is important to understand the factors contributing to the disproportionate representation of disabled staff in the formal capability procedure. This issue will be further investigated in partnership with the HR Business Partnering Team.

The data in the following Metrics (4 - 9) is based on responses in the NHS Staff Survey.

In 2024, we achieved our highest level of participation in the NHS Staff Survey, with more than 3,500 responses (compared to 3,400 in 2023), equating to nearly 50% of the workforce. Around 32% of all respondents (30% in 2023) indicated that they had a disability or long-term condition. This is substantially higher than the disability declaration rate recorded on ESR. However, NWAS is not unique in this regard, as NHS organisations across the country consistently report higher rates of disability declaration in the Staff Survey compared to the ESR.

While the reasons for this discrepancy are not fully understood, several factors may contribute. These include differences in how the question about disability is phrased in the Staff Survey compared to ESR, concerns that declaring a disability on ESR could lead to negative assumptions from managers or colleagues, and fears about confidentiality.

Metric 4: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

- **4.1: Patients/Service users, their relatives or other members of the public**

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	42.1%	37.8%	34.1%	26.8%	**34.9%**
Disabled	47.0%	45.9%	47.2%	45.1%	**41.8%**
Difference	4.9%	8.1%	13.1%	18.3%	**6.9%**

The proportion of disabled staff experiencing these negative behaviours has decreased compared to the previous year. However, 4 in 10 disabled staff still report experiencing such behaviours, and the proportion of non-disabled staff experiencing abuse from the public has increased for the first time since 2020.

Over the past year, the Trust has invested significantly in developing a Violence Prevention Reduction Team, which has been working to empower staff to report their experiences and to engage with the police on prosecutions. It is anticipated that the team's efforts will help reduce the prevalence of these behaviours, and staff experiences will continue to be monitored through the Staff Survey results.

- **4.2: Managers**

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	14.5%	11.3%	10.1%	10.1%	**9.0%**
Disabled	22.1%	18.6%	16.8%	16.1%	**15.0%**
Difference	7.6%	7.3%	6.7%	6%	**6%**

Responses to this question from both disabled and non-disabled staff have remained relatively unchanged compared to the previous year. However, a positive downward trend has been observed since 2020, and the gap in experiences between the two staff groups has been consistently narrowing over the past five years.

- **4.3: Other colleagues**

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	15.5%	14.1%	14.0%	13.4%	**13.3%**
Disabled	23.0%	23.6%	21.8%	19%	**20.2%**
Difference	7.5%	9.5%	7.8%	5.6%	**6.9%**

Figures continue to show that around 1 in 5 disabled staff experience abuse from colleagues – a higher proportion than that of non-disabled staff. Notably, the gap between the two groups has slightly widened this year, following three consecutive years of reduction.

Reaffirming our commitment to fostering a safe and inclusive workplace, the Trust has delivered thematic learning sessions on sexual safety and hate crime over the past year. In addition, a series of Leadership and Culture events brought together leaders from across NWAS to reflect on their role in shaping a positive organisational culture. The impact of these initiatives will continue to be monitored through future Staff Survey results, with the aim of further improving staff experiences across all groups.

- **4.4: Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	43.4%	43.8%	45.1%	46%	**52.4%**
Disabled	49.3%	46.3%	44.7%	48.7%	**49.9%**
Difference	5.9%	2.5%	-0.4%	2.7%	**-2.5%**

Around half of both disabled and non-disabled staff indicated that they reported their most recent negative experience, with a notable increase in reporting among non-disabled staff compared to the previous year.

These encouraging figures may be attributed to the Trust's continued promotion of violence prevention and reduction work, alongside the expansion of the Freedom to Speak Up function over the past year. However, there remains significant work to be done to ensure that more staff feel empowered to report their experiences and are aware of the range of accessible avenues available for doing so.

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	52.0%	49.7%	51.9%	52.2%	**52.5%**
Disabled	44.9%	39.4%	45.1%	48.7%	**47.8%**
Difference	-7.1%	-10.3%	-6.8%	-3.5%	**-4.7%**

Responses from disabled staff dipped slightly for the first time since 2021, while figures for non-disabled staff remained largely unchanged compared to the previous year. The data continues to highlight a persistent concern, with over half of disabled staff indicating that they do not believe the organisation acts fairly regarding career progression.

The Trust remains committed to improving the retention of talent and supporting equitable career development opportunities. The launch of the Developing Leaders programme, alongside work to enhance career pathways from the Integrated Contact Centres (ICCs) and Patient Transport Service into Emergency Medical Technician roles, is expected to positively influence perceptions and outcomes.

Additionally, the Inclusive Recruitment Working Group will be re-launched in 2025/26, with membership from both operational and corporate teams. This group will provide a collaborative forum to drive continued improvements in recruitment and selection practices. Insights and themes emerging from exit interviews and new starter surveys will be analysed and used to inform ongoing improvements, supporting a more inclusive experience for both current employees and prospective applicants.

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	29.5%	28.6%	27.2%	24.8%	**27.2%**
Disabled	38.9%	40.6%	38.3%	35%	**33.3%**
Difference	9.4%	12.0%	11.1%	10.2%	**6.1%**

One in three disabled staff reported feeling pressured to come to work when not well enough, compared to just over one in four non-disabled staff. While the figures for disabled staff show a downward trend since 2021, the proportion of non-disabled staff experiencing this pressure has increased compared to the previous year.

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	35.2%	32.9%	33.6%	35.7%	**36.2%**
Disabled	29.1%	27.5%	23.9%	31.1%	**30.4%**
Difference	6.1%	5.4%	9.7%	4.6%	**5.8%**

Around 70% of disabled staff indicated they did not feel satisfied with how the organisation values their work, compared to approximately 65% of non-disabled staff feeling the same. While the overall proportion of staff expressing satisfaction has remained similar to the previous year for both groups, the gap between disabled and non-disabled staff has widened again after narrowing in 2023.

Metric 8: Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.

Staff Survey Year	2020	2021	2022	2023	**2024**
Disabled	71.0%	57.8%	63.0%	65.2%	**71.3%**

Positive responses to this question have steadily increased since 2021, with over 70% of disabled staff in 2024 indicating that reasonable adjustments had been made for them.

Following the launch of the reasonable adjustments policy in December 2023, training has been delivered to managers on facilitating reasonable adjustment requests. The bite-size training module has been well received by participants and may be a key factor in the significant increase in positive responses to this question in the Staff Survey. The reasonable adjustments and neurodiversity policies are continually promoted to new and existing staff through internal communications and the staff induction process.

The Trust continues to provide equipment and support to staff to ensure they have what they need to work from home when operationally suitable, while also maintaining safe and inclusive work environments on Trust sites.

Metric 9: Staff engagement score for calculated from nine specific questions in the NHS Staff Survey

Staff Survey Year	2020	2021	2022	2023	**2024**
Non-disabled	6.4	6.2	6.2	6.3	**6.3**
Disabled	6.0	5.6	5.6	5.9	**5.9**
Difference	0.4	0.6	0.6	0.4	**0.4**

The 2024 staff engagement score shows that the gap between disabled and non-disabled staff has remained the same at 0.4, with the scores remaining the same as last year for both staff groups.

This metric also asks **whether the organisation has taken action to facilitate the voices of staff with disabilities to be heard**, to which we answered 'Yes', and added the following note:

"The Disability Network is open to all staff with disabilities and long-term health conditions, staff who care for someone with a disability and colleagues who want to learn more about disability. During Disability History Month 2024, the network collaborated with the Communications team to film various colleagues, such as a Director, HR managers, Sector managers, and an Emergency Medical Advisor. This highlighted the significance of reasonable adjustments to enhance workforce diversity at all levels. The initiative was unveiled at the network's third anniversary celebration event themed 'Disability Livelihood and Employment'. The event included a 'reasonable adjustments display' where network members showcased specialised equipment used in their roles."

Metric 10: Representation of disabled people among Board members

Percentage difference between the organisation's board voting membership and overall workforce, disaggregated by:

- *voting and non-voting membership of the board*
- *executive and non-exec membership of the board.*

Disability declarations

NWAS Disabled staff 31/03/2025	9.4%	**Disabled Board Members 31/03/2025**	7.7%
Voting Board Members	9.09%	**Non-Voting Board Members**	0%
Executive Board Members	14.3%	**Non-Executive Board Members**	0%

The proportion of total board members declaring a disability has reduced to 8% (14%, 2024), but disability declarations in the workforce overall have increased year on year to 9.4% (7.8%, 2024).

The table below shows the percentage difference when comparing the total Board number to the overall workforce.

Year	2023/24	**2025**
Disabled	7%	-2%
Non-disabled	-29%	-24%
Disability unknown	22%	26%

Trust-wide actions

The WDES data along with the Workforce Race Equality Standard (WRES), and Gender Pay Gap data (set out in separate reports) reflects the ongoing work to support all our staff groups and address inequalities in the workplace. While there have been some improvements across a number of key areas, we recognise that there remains a significant difference in the experiences of disabled and non-disabled staff. We will continue to explore the reasons for this and put in place actions to help improve the employee experience of our colleagues with disabilities.

Metric 2 – Recruitment

- Positive Action and Widening Access teams will continue to work to enable increases in increases in applications from underrepresented groups. This will be delivered though targeted community outreach, online and offline engagement, and bespoke 1:1 support and coaching.
- We will develop and deliver bitesize training for managers, designed to improve interview skills, with a particular emphasis on assessing understanding around equality and inclusion focus on diversity and inclusion in the interview process.

Metric 3 – Formal capability process

- Undertake a review to explore the reasons for the disproportional involvement of disabled staff in the Trust's formal capability process.

Metric 4 – Negative experiences

- Through collaborative working between operations management and the Violence Prevention Reduction Team, we will Implement a clear procedure to support staff dealing with disability prejudice, racist abuse and unwanted sexual behaviour.

Metric 5 – Fair career progression opportunities

- We will deliver the first cohort of the *Developing Leaders* programme with a diverse group of participants. The programme is anticipated to commence in September 2025, following an application process earlier in the summer.
- We will develop and promote visible career pathways readily accessible to all new and existing staff to support progression and development.

Metric 7 – Feeling satisfied by organisational recognition

- We will continue the rollout of the *Leading with Diversity & Inclusion* module, ensuring all designated managers have completed it by the end of 2025/26.
- We will continue to equip managers with the knowledge and awareness to support their staff who require reasonable adjustments or neurodiversity support.

A full set of actions are set out in our EDI Annual Plan.

North West Ambulance Service
NHS Trust

Workforce Race Equality Standard (WRES) Data Report

Covering the period of
1 April 2024 – 31 March 2025

Introduction

This report sets out the 2024/25 annual workforce data in relation to race, which the trust is required by NHS England to publish.

Working to address inequalities identified by workforce data demonstrates our compliance with the Equality Act 2010 and the Public Sector Equality Duty. Monitoring workforce equalities data is also central to ensuring that we are delivering on our equality, diversity and inclusion priorities:

1. We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels.
2. We will educate and empower our workforce and leaders to promote a positive psychologically safe culture, to support a reduction in the experience of bullying, harassment, discrimination and an improvement in retention.

Workforce Race Equality Standard (WRES)

The WRES is a set of nine specific measures (indicators) which enables NHS organisations to compare the workplace and career experiences of Black and Minority Ethnic (BME) staff. We use the data to inform the development of projects and initiatives to improve NWAS for BME staff. Year on year comparison enables us to demonstrate progress against the indicators of race equality to create the cultures of belonging and trust that will improve retention, recruit from the widest possible talent pool and provide sustainable careers.

The data in this report relates to the period of 1 April 2024 – 31 March 2025 and comprises information taken from the Electronic Staff Record (MyESR), HR Business Partnering, Learning & Development, and the 2024 NHS Staff Survey.

In line with the nationally mandated timeframe, the data was submitted to NHS England in May 2025.

Indicator 1: Workforce information

Percentage of BME staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of BME staff in the overall workforce

Overall	31/03/ 2019	31/03/ 2020	31/03/ 2021	31/03/ 2022	31/03/ 2023	31/03/ 2024	**31/03/ 2025**
Total workforce	6356	6598	6807	6815	7073	7421	**7775**
BME staff	286	304	342	325	365	444	**521**
% BME staff in total workforce	4.5%	4.6%	5.0%	4.8%	5.2%	6.0%	**6.7%**

- **Representation of BME staff in non-clinical and clinical roles**

Agenda for Change bandings	2024/25 Non-clinical Staff	2024/25 Clinical Staff
Cluster 1: Bands 1 - 4	10.6%	8.1%
Cluster 2: Bands 5-7	10.3%	4.6%
Cluster 3: Bands 8a-8b	7.0%	2.6%
Cluster 4: Bands 8c-9 and VSM	12.9%	0%

Figures show a year-on-year increase in the number of BME staff in the organisation (almost double since 2019). There were 77 more BME staff in the organisation on 31 March 2025, compared to the same date in March 2024.

While there has been a slight decrease from the previous year in the percentage of BME staff in non-clinical cluster 2 and clinical cluster 3 (around 0.5%), there has, however, been a significant increase in the non-clinical cluster 4 – going from 6.8% in 2024 to 12.9% in 2025. In addition, the trust has surpassed its target of 0.5% annual increase in the representation of BME staff representation, rising from 6.0% in 2024 to 6.7% in March 2025.

The declaration rate for ethnicity in the trust is more than 99%, with only around 70 staff members not having declared. Colleagues are regularly reminded to update their details on the Electronic Staff Record and work continues to reduce the number of non-declarations, including through collaboration with the Race Equality Network.

Indicator 2: Recruitment

Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants

The target outcome is a figure of 1.0 – meaning that BME candidates are no less likely to be appointed from shortlisting than candidates who are White. A figure of 1.0 reflects well on the fairness of recruitment processes.

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
Likelihood	1.51	1.98	1.26	1.61	**2.39**

The figures show that White staff are nearly two-and-a-half times more likely to be appointed, compared to BME applicants – a deterioration of the previous year's position. This is despite more people from BME backgrounds applying and being shortlisted for trust roles in 2024/25 compared to the previous year, and more applicants being shortlisted.

In 2024/25 the Trust received more than 17500 applications for roles advertised across the organisation, with ~8000 applications from BME backgrounds – double the number of BME applicants in 2023/24. This year, 1485 BME applicants were shortlisted, an increase of over 400 from the year before.

Historic BME shortlisting and appointment data

Year	2021/22	2022/23	2023/24
BME Shortlisted	349	602	1046
BME New starters	48	102	134

This year overall, White applicants represented 52% of all applicants, rising to 70% at the shortlisting stage and 84% of those appointed. In comparison, BME applicants made up 46% of applications but were underrepresented in later stages – accounting for 27% of shortlisted candidates and just 10% of new starters (65 out of 620+ total).

Despite sustained efforts over several years to improve recruitment processes, a significant challenge remains in converting the increasing number of BME applications into successful appointments. The recent decline in this indicator is a serious concern. To better understand the underlying causes and identify actionable solutions, a detailed deep dive will be undertaken. This work will concentrate on key recruitment stages, such as shortlisting and interviews/assessments, while also requiring managers to critically reflect on potential bias and ensure fairness in their decision-making.

The increase in the number of BME applicants and shortlisted candidates however, may be attributed to a range of factors including increases in capacity and staff resource of the Positive Action Team, use of diverse and inclusive imagery in communications campaigns for trust roles, and continuing review of inclusive language in job adverts. Around 20 successful BME applicants this year had benefitted from bespoke and in-depth 1:1 support and coaching from the Positive Action Team.

Additionally, the management leadership training modules (Beyond Bias and Leadership for Inclusion & Diversity) have helped enable greater awareness around managing cultural bias which influences recruitment and other areas.

More information on our inclusive recruitment work can be seen in the Equality, Diversity and Inclusion Annual Report 2024-25.

A point on data - *It should be noted that on our recruitment portal (Trac), a campaign is considered completed when all appointees from a campaign have commenced in post. This means that for example, if there is a vacancy that opens on 1 March 2025, but the successful individual(s) does not commence in post until 15 April 2025, this recruitment will not be counted in the data. This issue with the data is a particular challenge for us, as the trust manages several mass recruitment campaigns each year, and at times, these may cross over from one financial year to the other. The portal only closes a vacancy once every individual with an offer starts in the position.*

In the case of mass recruitment campaigns this could lead to distorted data, as often there can be up to twelve months between a campaign opening and the last individual commencing on a training course. As a result, the data that is presented for the WRES submission, while correct at the time, may not accurately reflect our actual position.

Indicator 3: Formal Disciplinary Process

Relative likelihood of BME staff entering the formal disciplinary process compared to White staff

A figure of 1.0 or below is desired, as this would indicate BME staff are no more or less likely to enter the formal disciplinary process than White staff.

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
Likelihood	1.70	2.23	1.86	2.59	**2.67**

The data in this Indicator continues to show that BME staff are more than two-and-a-half times more likely to enter the formal disciplinary performance compared to their White colleagues. This marks the most significant disparity between the two staff groups since reporting began.

In 2024/25, there were around 180 formal disciplinary cases in the trust – which was a substantial increase on the 92 cases reported in the previous year. 29 cases this year related to BME staff, compared to 15 last year. This means that 16% of those in the formal disciplinary process were BME staff – a proportion significantly higher than the ~7% representation in the workforce.

A high-level review of cases involving BME staff showed that 12 cases in 2024/25 related to allegations of gross misconduct (compared to three GM cases in 2023/24).

The majority of BME staff in NWAS work within the Integrated Contact Centres (ICC), and three-quarters of cases involved BME staff working in the ICC. This is a similar picture to data from 2023/24,

which led to a deep dive undertaken by HR and ICC Management Team to explore, identify, and resolve the potential reasons for the disparity.

A dedicated Task and Finish Group has been established to undertake a detailed examination of the disciplinary data, with preliminary findings indicating that this issue is not unique to NWAS, but is also evident across other ambulance and wider NHS Trusts. As part of the ongoing review, case studies have been analysed to extract key learnings and inform the development of an action plan.

Indicator 4: Non-mandatory training and CPD

Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff

The target outcome is a figure of 1.0 – meaning that BME staff are no less likely to be able to access non-mandatory training and CPD that White staff.

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
Likelihood	1.34	1.01	1.01	1.11	**0.95**

Since 2021/22, data has shown that BME and White staff groups have accessed non-mandatory training and CPD at comparable rates. This year's figures indicate that, proportionally, more BME staff accessed these training opportunities than their White colleagues — although the overall numbers for both groups were lower than in the previous year:

- 2024/25 BME – 293; White – 3,838
- 2023/24 BME – 313; White – 5,406

The data in the following indicators (5 – 8) is based on responses from the NHS Staff Survey .

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

Staff Survey Year	2020	2021	2022	2023	**2024**
White staff	43.5%	40.0%	38.1%	39.5%	**37.3%**
BME staff	38.2%	37.1%	34.4%	33.3%	**34.4%**
Difference	5.3%	2.9%	3.7%	6.2%	**2.9%**

Figures this year show that the gap in experiences between BME and White staff narrowed significantly to less than 3%, due to a reduction in the percentage of White colleagues experiencing these negative behaviours. For both staff groups however, around one third continue to experience experiencing bullying, harassment or abuse from the public.

In the last year, the Trust has invested significantly in developing a Violence Prevention and Reduction Team who have been working to empower staff to report their experiences, and engaging with the

police on prosecutions. It is anticipated that the work of the team will help reduce the prevalence of these negative behaviours, and staff experiences will continue to be monitored through the Staff Survey results.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Staff Survey Year	2020	2021	2022	2023	**2024**
White staff	25.7%	23.6%	22.2%	20.9%	**15.5%**
BME staff	24.2%	29.5%	23.7%	22.4%	**18.0%**
Difference	1.5%	-5.9%	-1.5%	-1.5%	**-2.5%**

The percentage of staff experiencing negative behaviours from colleagues has continued to fall consistently, which is extremely positive. In the last year, the figures show a reduction of 5.5% among White staff and 4.4% among BME staff compared to the previous year. However, almost 1 in 5 BME staff continue to experience abuse from colleagues.

The positive decreases in this Indicator may reflect the impact of thematic learning sessions on sexual safety and hate crime delivered this year, with the Sexual Safety Steering Group reviewing incident data, identifying trends, and implementing targeted interventions and educational initiatives to improve sexual safety in the Trust. In addition, a series of Leadership and Culture events were delivered between October 2024 – March 2025, successfully bringing together leaders from across the Trust to engage in conversations about the culture review of the ambulance sector, which was published in February 2024.

Indicator 7: Percentage of staff believing that their trust provides equal opportunities for career progression or promotion

Staff Survey Year	2020	2021	2022	2023	**2024**
White staff	51.3%	47.8%	50.4%	52.0%	**51.6%**
BME staff	39.1%	33.6%	44.1%	40.0%	**45.6%**
Difference	12.2%	9.0%	6.3%	12.0%	**6.0%**

Following a decline in positive responses from BME staff on this question in 2023, the 2024 results showed a noteworthy increase of 5.6%. The gap between BME and White staff has halved, decreasing from 12% to 6%.

While this increase is encouraging, the figures still indicate that more than half of BME staff feel that career progression within the organisation is not fair. It is anticipated that the introduction of the *Developing Leaders* programme, along with work to improve career pathways from the Integrated Contact Centres (ICCs) and Patient Transport Service to Emergency Medical Technician roles, will help shift the dial further and improve perceptions.

Additionally, the Inclusive Recruitment Working Group will be re-launched in 2025/26, with membership from both operational and corporate teams. This group will provide a collaborative forum to drive continued improvements in recruitment and selection practices. Insights and themes emerging from exit interviews and new starter surveys will be analysed and used to inform ongoing improvements, supporting a more inclusive experience for both current employees and prospective applicants.

Indicator 8: Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleagues

Staff Survey Year	2020	2021	2022	2023	**2024**
White staff	10.1%	10.0%	11.1%	10.8%	**10.1%**
BME staff	8.6%	22.4%	14.0%	13.0%	**12.4%**
Difference	1.5%	-12.4%	-2.9%	-2.2%	**-2.3%**

Responses to this question in the Staff Survey from both BME and White staff this year have not shown any significant change compared to 2023.

The experiences of White staff have remained largely consistent over the past five years. However, responses from BME staff have fluctuated during the same period, with around 4% more BME respondents in 2024 reporting that they had experienced discrimination compared to 2020.

We remain committed to becoming an anti-racist organisation and to nurturing positive environments for all staff. Through this work, we aim to reduce incidents of discrimination and feelings of exclusion. Over the past year, NWAS managers have undertaken training on diversity, inclusion, and bias. Feedback from participants has highlighted improved awareness of the experiences of underrepresented groups and increased confidence in addressing EDI-related challenges. Staff have particularly valued the interactive discussions, lived experiences shared, and practical tools provided to help challenge bias.

Indicator 9: Representation of BME people among board members

Percentage difference between the organisation's board voting membership and overall workforce, disaggregated by:

- *Voting membership of the Board*
- *Executive membership of the Board.*

NWAS BME staff 31/03/2025	6.7%	**BME Board Members 31/03/2025**	15.4%
Voting Board Members	18.2%	**Non-Voting Board Members**	0%
Executive Board Members	14.3%	**Non-Executive Board Members**	16.7%

BME representation on the Board has increased to 15.4% in 2024/25, up from 14.2% in 2023/24. The proportion of BME individuals on the Board is now more than double that of the overall workforce.

All members of the Board have declared their ethnicity.

The table below shows the percentage difference when comparing the total Board number to the overall workforce.

Year	2020/21	2021/22	2022/23	2023/24	**2024/25**
White staff	-5.5%	-17.1%	-15.2%	-14%	**-7.8%**
BME staff	0.9%	10.6%	9.1%	8.3%	**8.7%**
Ethnicity unknown	4.6%	6.4%	6.1%	6.1%	**-0.9%**

Trust-wide actions

The WRES data, along with the Workforce Disability Equality Standard (WDES) and Gender Pay Gap data (set out in separate reports), reflects the ongoing work to support all our staff groups and address inequalities in the workplace. While there have been some improvements across a number of key areas, we recognise that significant differences remain in the experiences of BME and White staff. We will continue to explore the reasons for this and implement actions to improve the employee experience of our BME colleagues.

Indicator 1 – Workforce representation

- We aim to establish and deliver specific targets for service lines around BME recruitment to help improve representation in our operational teams. These targets will contribute to the overall Trust target of a 0.5% year-on-year increase in BME workforce representation.

- We will deliver the first cohort of the *Developing Leaders* programme with a diverse group of participants. The programme is anticipated to commence in September 2025, following an application process earlier in the summer.

Indicator 2 – Recruitment

- We will carry out a comprehensive analysis to identify and understand the barriers preventing higher rates of BME appointments, using data and insights to inform meaningful change.

- Positive Action and Widening Access teams will continue to work to effect increases in applications from underrepresented groups. This will be delivered though targeted community outreach, focusing on areas in the North West with significant BME populations. We will build on our previous work to reach communities by partnering with key stakeholders in local areas which support people into employment.

- Large-scale recruitment campaigns for entry and support level roles will be promoted via our network of external organisations. We will deliver online and offline engagement activities with the support of community groups, to enable prospective applicants to better understand the organisation, roles, and recruitment process.

- We will enhance the bespoke 1:1 support and coaching at application and interview stages for prospective applicants, provided by the PA and WA teams – helping increase the number of quality applications. Applicants requiring support will be identified through the 'Applicant Tracking & Monitoring', as well as via direct outreach engagement and referrals. Applicant Tracking - offering support to previously unsuccessful applicants from underrepresented groups, has been undertaken for selected roles, and this will be expanded to include all patient-facing roles.

- We will work to increase the participation of BME people in Pre-employment Programmes for entry level roles.

- We will develop and deliver bitesize training for managers, designed to improve interview skills, with a particular emphasis on assessing understanding around equality and inclusion focus on diversity and inclusion in the interview process.

Indicator 3 – Formal disciplinary process

- We will continue to review disciplinary cases relating to BME staff (particularly in ICCs) to better understand the data and develop an action plan to improve the application of disciplinary policy, ensuring it is used appropriately and fairly.

Indicator 5 – Experiences of harassment, bullying and abuse from the public

- Through collaborative working between ICC management and the Violence Prevention Reduction Team, we will Implement a clear procedure to support ICC staff dealing with racist abuse and unwanted sexual behaviour.

Indicator 8 – Discrimination

- We will progress our work to become an anti-racist organisation, publishing our Anti-racism Statement, establishing a steering group and working towards bronze level recognition of NW BAME Assemble Anti-racism Framework.

- We will continue the rollout of the *Leading with Diversity & Inclusion* module, ensuring all designated managers have completed it by the end of 2025/26.

A full set of actions are set out in our EDI Annual Plan.

North West Ambulance Service NHS Trust

Pay Gap Data Report (Gender, Ethnicity & Disability)

Covering the period of 1st April 2024 – 31st March 2025

Published: **June 2025**

Introduction

Pay gap reporting helps demonstrate transparency around how employers reward their workforce, foster a fair and more inclusive workplace, and identifying and addressing disparities. For North West Ambulance Service, this is not just about compliance; it is also about utilising talent to enhance public service, strengthen our workforce, and improve patient care.

This report presents an overview of our gender, ethnicity, and disability pay gaps as of 31 March 2025 (snapshot date), based on data from the Electronic Staff Record (ESR). On this date, there were 7,810 NWAS members of staff in post.

The reporting period covers 1 April 2024 to 31 March 2025, with hourly pay calculated in accordance with government guidelines as per Schedule 2 of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

Our reporting follows the government's guidance as published by the Women and Equalities Unit, measuring the average hourly pay difference between:

- Men and women (Gender Pay Gap)
- White and Black and minority ethnic (BME) staff (Ethnicity Pay Gap)
- Non-disabled and Disabled staff (Disability Pay Gap)

The purpose of examining pay gaps is to explore the differences between the hourly wage of different staff groups. The figures are affected by how many female, BME or disabled staff are at a given grade/band and their position on the pay scale. Pay gap data shows the difference in the average and median pay between the comparable staff groups.

In the case of the gender pay gap, it is worth noting that this is different from equal pay. Equal pay looks at the difference in pay of men and women doing the same or similar job, or a job of equal value.

Monitoring of workforce equalities data from a race (WRES), disability (WDES) and pay gap perspective is central to ensuring that we are delivering on our equality, diversity and inclusion priorities:

1. We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels.
2. We will educate and empower our workforce and leaders to promote a positive psychologically safe culture, to support a reduction in the experience of bullying, harassment, discrimination and an improvement in retention.

Note: *Pay gap data for gender, ethnicity and disability relies on self-declaration. Due to limitations in ESR, not all colleagues are able to or choose to self-declare or identify their protected characteristics, including ethnicity, gender identity etc. As such, the data used for pay gap reporting may not fully reflect the diversity of the workforce, but efforts to improve data capture are ongoing.*

Gender Pay Gap Data

Table A: 2025 Gender Split by Quartile

Quartile	Female	Male
Lower pay quartile (LQ)	**59.89%** (57.63%, 2024)	**40.11%** (42.37%, 2024)
Lower middle quartile (LMQ)	**61.89%** (60.29%, 2024)	**38.11%** (39.71%, 2024)
Upper middle quartile (UMQ)	**50.03%** (50.54%, 2024)	**49.97%** (49.46%, 2024)
Upper quartile (UQ)	**45.66%** (44.06%, 2024)	**54.34%** (55.94%, 2024)

Female representation in the NWAS workforce has consistently increased over a number of years, and as of 31 March 2025, 56.19% of staff in NWAS were female (53.13% in 2024).

Table A indicates an increase in female representation this year across the lower, lower-middle, and upper pay quartiles. However, there has been a slight decline in the upper-middle quartile compared to the previous year, as shown in Table B. The most significant growth occurred in the lower pay quartile, where female representation has risen to 59.89% - an increase of 2.26% from the previous year. Additionally, there continue to be more women than men in the two lower quartiles, and a majority of staff (albeit by a smaller margin) in the upper middle quartile are female.

Table B: Historic gender split by quartile for comparison

Quartile	2020 F	2020 M	2021 F	2021 M	2022 F	2022 M	2023 F	2023 M
LQ	55.26%	44.74%	60.95%	39.05%	55.1%	44.9%	58.78%	41.22%
LMQ	53.65%	46.35%	56.04%	43.96%	58.5%	41.5%	60.63%	39.37%
UMQ	46.81%	53.19%	47.43%	52.57%	49.4%	50.6%	50.11%	49.89%
UQ	36.74%	63.26%	37.23%	62.77%	37.8%	62.2%	39.05%	60.95%

Table C: 2025 Hourly Pay Gap

	Average Hourly Rate	Median Hourly Rate
Male	£20.37	£19.30
Female	£18.82	£16.86
Difference	£1.56	£2.45
Pay Gap %	**-7.63%**	**-12.68%**

Table C shows that the mean (average) hourly pay gap currently stands at -7.63%, a slight increase from -7.27% in 2024 (Table D). Although still a notable gap, this represents the second-lowest mean figure since reporting began in 2020.

In contrast, the median hourly pay gap has continued to widen, reaching 12.68% this year – the highest level recorded since reporting commenced.

Further analysis is required to fully understand the factors driving this disparity. However, one likely contributor is the distribution of employees across pay quartiles. A larger proportion of female staff (2,289) are concentrated in the lower and lower-middle pay quartiles, positioning the median female salary within the lower-middle quartile. Conversely, fewer than 50% of male staff (1,470) fall into these lower quartiles.

The gender distribution in the upper-middle quartile is nearly equal (940 females and 939 males), while the upper quartile reflects a higher number of male employees (1,021) compared to female employees (858). As a result, the median male salary lies within the upper-middle quartile.

Another potential factor influencing the pay gap is length of service. On average, male employees have longer tenure, increasing their likelihood of being positioned at the higher end of their pay bands.

Table D: Historic hourly pay gap for comparison

	2020	2021	2022	2023	2024
Average hourly pay gap	-8.79%	-10.89%	-9.80%	-10.77%	-7.27%
Median hourly pay gap	-7.2%	-9.26%	-8.66%	-10.54%	-11.17%

Ethnicity Pay Gap Data

This is the first time that Ethnicity Pay Gap data has been published by NWAS, and the second year that the data has been reviewed.

As of 31 March 2025, 6.7% of our workforce identified as BME, 92.3% as White, and 1% chose not to declare their ethnicity. According to the 2021 Census, 85.6% of the population in the North West of England identified as White, with 14.4% representing diverse ethnic backgrounds.

Table E: 2025 Ethnicity split by quartile

Quartile	White	BME	Unknown
Lower pay quartile	**91.70%**	**7.50%**	**0.80%**
Lower middle quartile	**92.39%**	**6.71%**	**0.90%**
Upper middle quartile	**93.08%**	**5.96%**	**0.96%**
Upper quartile	**92.76%**	**5.27%**	**1.97%**

Table E shows the representation of BME and White staff in each pay quartiles. 141 BME staff are accounted in the lowest quartile with the upper quartile including 99 BME staff. By comparison, there are approximately 1750 White staff in each pay quartile. Additionally, nearly 40 individuals who have not declared their ethnicity are represented in the upper quartile. Notably, the proportion of BME staff has increased in three of the four pay quartiles in 2025, compared to the 2024 figures shown in Table F.

Table F: Historic Ethnicity split by quartile for comparison

Quartile	2024 White	2024 BME	2024 Unknown
LQ	92.76%	6.37%	0.87%
LMQ	92.59%	6.48%	0.93%
UMQ	92.81%	6.26%	0.93%
UQ	93.57%	4.63%	1.80%

The hourly mean pay gap between BME and White staff stands at -4.38% (£0.86), while the median pay gap is -6.28% (£1.14). Despite increased BME representation in the upper pay quartiles, both the average and median pay gaps have widened by approximately 1.7% compared to the previous year, as shown in Table H.

Table G: 2025 Hourly Pay Gap

Ethnicity	Average Hourly Rate	Median Hourly Rate
White	£19.55	£18.12
BME	£18.69	£16.98
Difference	-£0.86	-£1.14
BME Pay Gap %	**-4.38%**	**-6.28%**

Table H: Historic hourly pay gaps for comparison

	2024
BME Average hourly pay gap	-2.67%
BME Median hourly pay gap	-4.53%

With only two years of data available, it is challenging to draw definitive conclusions about the widening of pay gaps. However, one likely contributing factor is the distribution of staff across pay quartiles. White staff are represented in significantly higher numbers across all quartiles throughout the organisation. In contrast, BME staff are disproportionately concentrated in the lower pay quartile, with 141 individuals compared to just 99 in the upper quartile—representing over 40% more staff in the lowest pay band.

Another influencing factor may be length of service. On average, White staff may have longer tenure than their BME colleagues, increasing the likelihood of being positioned at the top of their respective pay bands.

Disability Pay Gap Data

This is the first time that Disability Pay Gap data has been published by NWAS, and the second year that the data has been reviewed.

As of 31 March 2025, 9.3% identified as disabled, and 85% declared as non-disabled. The remainder (5.7%) chose not to declare their disability status.

Table I: 2025 Disability split by quartile

Quartile	Non-disabled	Disabled	Not declared	Prefer not to answer	Unspecified
Lower pay quartile	85.66%	10.19%	2.27%	0.28%	1.61%
Lower middle quartile	88.21%	9.07%	1.33%	0.41%	0.97%
Upper middle quartile	81.33%	9.10%	4.52%	0.64%	4.41%
Upper quartile	84.79%	8.83%	3.19%	0.53%	2.66%

The representation of disabled staff is relatively evenly distributed across the four pay quartiles, with 184 in the lower quartile, 177 in the lower middle quartile, 171 in the upper middle quartile, and 166 in the upper quartile, which accounts for the smallest group. In contrast, there are over 1,700 non-disabled staff in the LQ, nearly 1,600 in the UQ, and more than 1,500 in both the LMQ and UMQ. The highest number of staff who have not declared their disability status is found in the UMQ, followed by the UQ.

There has been a significant increase in the representation of disabled staff across all pay quartiles in 2025, compared to the 2024 figures, as shown in Table J.

Table J: Historic Disability split by quartile for comparison

Quartile	2024 Non-disabled	2024 Disabled
LQ	92.10%	7.90%
LMQ	92.76%	7.24%
UMQ	92.65%	7.35%
UQ	92.48%	7.52%

This year, the average hourly pay rate for non-disabled staff was £0.13 more per hour than for disabled colleagues. While this gap warrants attention, it is notably the smallest when compared to the pay gaps observed across ethnicity and gender. Conversely, the median hourly pay rate for disabled staff was £0.25 more than non-disabled staff.

Table K: 2025 Hourly Pay Gap

Disability status	Average Hourly Rate	Median Hourly Rate
Non-disabled	£19.43	£19.51
Disabled	£19.30	£19.76
Difference	-£0.13	£0.25
Disability Pay Gap %	**-0.71%**	**1.29%**

Comparatively, in 2024, the average hourly rate for disabled staff was actually £0.15 higher than non-disabled staff, although the median rate was £0.18 lower. The 2025 figures, therefore, reflect a slight deterioration in average pay equity for disabled staff compared to the previous year.

Table L: Historic hourly pay gaps for comparison

	2024
Disability Average hourly pay gap	0.79%
Disability Median hourly pay gap	-1.06%

As with the Ethnicity Pay Gap, it is challenging to definitively identify the factors influencing the Disability Pay Gap. Although the gap between workforce groups is considerably narrower, it remains important to understand the underlying causes. Addressing this disparity in a positive and collaborative manner – through engagement with a range of stakeholders, including the Disability Network, will be key to driving meaningful progress.

Bonus Pay – Gender / Ethnicity / Disability

In 2025, based on the following criteria, no bonus payments were made this year. Bonus pay includes any rewards related to:

- profit sharing
- commission
- performance
- incentive
- productivity
- long service awards with a monetary value (cash, vouchers or securities)

Trust-wide actions

At NWAS, we apply the national NHS terms, conditions of service, and use the national job evaluation system to determine job bandings. These systems have been equality impact assessed and are jointly reviewed by trade unions and managers in partnership at a national level. We believe these systems provide a non-discriminatory set of conditions which meet the requirements of equal pay for work of equal value. We remain committed to working to closing pay gaps through improvements in representation in the upper quartiles of pay.

Our approach to narrowing pay gaps will address systemic barriers and factors common to all, while also targeting inequalities faced by specific groups based on their protected characteristics such as gender, ethnicity and disability.

We are committed to building a better place to work which is why we have already taken several important steps to address our pay gaps:

- Launched a new Leadership for Diversity and Inclusion (LfD&I) training programme, equipping managers with knowledge and awareness to address bias and promote inclusion.
- Strengthened our inclusive recruitment practices, and invested in our Positive Action and Widening Access Teams.
- Reviewed and updated our Career Break Guidance, Maternity Procedure, New Parent Support Leave Procedure and Strategic Mental Health Plan policies.
- Encouraged staff to declare the equality monitoring information to help better understand the diversity of our workforce.

Over the next year, we will continue to work towards nurturing a positive culture for all, by:

- Further strengthening recruitment practices, including standardising criteria, reducing bias, and diversifying interview panels to improve representation in senior roles.
- Developing strategies for equitable access to training, development, and leadership opportunities, especially for underrepresented groups.
- Encouraging diverse participation on the Developing Leaders programme.
- Providing targeted mentorship to support underrepresented groups to progress into senior roles.
- Ensuring a fair and inclusive workplace where all colleagues can succeed requires a clear focus on pay gaps and the barriers that contribute to them.

Appendix 4

Update following a review of 2023/24 formal disciplinary process cases involving BME staff – relating to WRES Indicator 3

Background

NWAS WRES data for the 2023/24 year indicated that our BME employees were 2.59 times more likely to enter the formal disciplinary performance, compared to White staff.

During 2023/24 a total of 94 disciplinary cases were investigated - 15 of these related to BME employees, which equated to 16% of the total cases. Out of the 15 cases during this period, 11 of those cases (73%) were undertaken within our integrated contact centre. The other 4 cases related to PTS workforce (2) and PES workforce (2) service areas.

In order to understand what the cause may be the following actions were taken in order to explore possible reasons for over representation of BME staff:

- In October 2024 the HR team undertook a deep dive to audit the decisions taken to progress via the disciplinary policy in all 15 cases.
- A listening event took place in February 2025 with members of ICC management team in order to review and understand any potential challenges, for ICC leadership team faced when dealing with employee mis conduct matters and if there are any cultural issues at play in behaviours.
- A number of Communities of Learning events have been run across the wider trust relating to the management of employee misconduct hosted by HRBP team.
- A commitment was made to perform ½ yearly reviews of disciplinary case work data to identify any variation in experiences across service areas to enable us an opportunity to consider steps that can be taken. The first ½ yearly review will take place in October 2025.

The actions taken above highlighted that:

- No adverse outcomes were found through the HR review of cases.
- All those which received formal sanctions were escalated appropriately through the Disciplinary policy.
- Where there was a formal sanction, each individual had received a structured conversation in the first instance.
- All cases were reviewed by the Investigation Review Panel.
- The majority of cases for BME staff were for allegations of ‘failure to follow reasonable instruction’ and ‘lateness’.
- All but one of the employees were under the age of 26.
- For the large majority of staff working within 111/EOC their role with NWAS is a part time casual role. ICC management feel this results in less importance being placed on following Trust behaviours/conduct

Further work is being undertaken by the ICC management team and a dedicated Task and Finish Group has been established for this purpose.

Preliminary findings indicate that this issue is not unique to NWAS, but is also evident across other NHS Trusts, including ambulance services. As part of the ongoing review, case studies have been analysed to extract key learnings and inform the development of an action plan.

A key theme emerging from the data is punctuality. To investigate this further, lateness records were reviewed to determine whether staff are being treated equitably. Additionally, a survey was distributed to ICC management teams to evaluate current approaches to managing lateness and to assess the consistency of their application. The findings revealed inconsistencies in how lateness is interpreted and addressed, highlighting a lack of clarity and variation in the implementation of disciplinary policies.

Feedback from a listening event held in January 2025 with ICC management colleagues revealed a level of apprehension among managers when addressing misconduct involving BME staff. Many expressed a perception that strict adherence to policy and procedure was essential to mitigate the risk of potential allegations of bias or discrimination.

Initial Insights into 2024/25 WRES Data

Initial high level analysis of 2024/25 data highlights.

Sector	BME Case Numbers	% of total BME cases	% of total disciplinary cases for sector
111	19	66%	59%
EOC	3	10%	15%
PES	5	17%	5%
PTS	2	7%	8%
	29	100%	

12 of the 29 cases are recorded under the gross misconduct route which suggest that case related to much more serious conduct allegations than in 2023/24 when only 3 cases were the recorded for gross misconduct.

A further deep dive into the data is currently being undertaken, with findings and any resulting action to be reported back to relevant committees from October 2025.

Actions

Building on insights gathered over the past year and looking at the WRES data which has emerged from 2024/25, a structured work plan has been developed around four key themes within ICC: Data Transparency, Policy Awareness, Leadership Development, and Cultural Engagement.

Key actions include conducting quarterly data reviews, enhancing communication and guidance on policy implementation, delivering targeted training on bias and inclusive decision-making, and deepening engagement with both colleagues and leadership teams.

In addition, all ICC leaders will hold one-on-one sessions with their teams to reinforce expectations regarding the disciplinary process and to emphasise the importance of seeking guidance to ensure consistency. A follow-up review is planned in six months to assess progress, measure impact, and guide further improvements.

North West Ambulance Service NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Thursday, 24 July 2025		
Members present	Dr D Hanley, Chair Mr D Whatley, Non-Executive Director Ms C Butterworth, Non-Executive Director Mrs L Ward, Director of People Mr S Desai, Chief Executive Officer	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None raised.

ADVISE:

Finance Report Month 03 2025/26

- Received assurance in relation to the financial performance indicators.

2025/26 Efficiency and Productivity Update

- Received assurance on progress and noted further work needed to meet the target for recurrent savings.

Workforce Indicators Report

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

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

- EDI Regulatory Reporting including WRES / WDES and Gender Pay Gap and agreed a further report to be submitted to the Committee in November on progress with priorities.
- PES DCA Vehicle Replacement Programme 26/27
- Taxi Contract Renewal Recommendation
- Microsoft Enterprise Services Agreement (ESA) Contract Renewal
- Contract Award for Paramedic Apprenticeships

Discussed the Health and Wellbeing Annual Report 2024/25 and approved for publication.

ASSURE:

Received the following reports for assurance:

- Board Assurance Framework
- PLICS submission
- Estates, Fleet and Facilities Management Assurance Report
- Agency Performance against ceiling
- Annual Plan Assurance Q1 25/26

- Digital Plan Update

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Integrated Performance Report
PRESENTED BY	Elaine Strachan-Hall, Interim Director of Quality
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	**Background** This report provides a summary of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of **June 2025**. Further narrative is embedded within the accompanying data pack. Data are presented over time using statistical process control charts (SPCs), aligned to the NHS England's Making Data Count initiative, which aims to support informed decision making by identifying genuine trends, variations and patterns in the data. The report shows historical and current performance on Quality, Effectiveness, Operational performance, Finance, and Organisational Health to address three important assurance questions: 1. How are we performing over time as a continuously improving trust? 2. How are we performing with respect to strategic goals? 3. How are we performing compared to our peers and the national comparators?

Quality

- **Complaints**: Patient Advice and Liaison Service (PALS) complaints are indicating improvement, consistent with a period of reduced operational pressures. Other metrics are stable.
- **Incidents:** Care and treatment remains the most common theme for patient incidents and Violence and aggression the most common theme for non-patient incidents.
- **Safety Alerts:** One new safety alert has been received (NatPSA/2025/002/UKHSA) regarding potential contamination of non-sterile wipes.

Effectiveness

- The patient experience team are piloting an initiative to increase return response rates.
- The Trust is performing above the sector average for all Ambulance Care Quality Indicators (ACQI's).
- The H&T rate is 15.0% and has steadied in Q1; the target for the UEC improvement plan is for 17%. There is a clear action plan in place to support an improvement in the target by the end of Q2. Recruitment challenges in Integrated Contact Centres are a causal factor.
- Nationally, the trust decreased in H&T rankings, now 7th. Additionally, we placed 8th for S&T and 9th for S&C.

Operational Performance

PES (999)

Measure	ARP Standard (hh:mm:ss)	June 25 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:07:14	3rd
C1 90th	00:15:00	00:12:19	3rd
C2 mean*	00:18:00	00:25:36	3th
C2 90th	00:40:00	00:49:34	3th
C3 mean	01:00:00	01:42:03	5th
C3 90th	02:00:00	03:34:59	5th
C4 90th	03:00:00	04:21:27	4th

*UEC C2 Standard = 29mins (achieved)

- Call pick up increased to 4 second mean and 27 second 95th percentile owing to many (expected transient) factors including an agreement to take calls for Yorkshire Ambulance Service, performance spikes during weather events, sickness/absence, and business continuity events at call handling sites.
- Hospital turnaround continues to exceed the 30-minute standard at 37m:04s. During June, 11% of patient handovers were over 45

minutes equating to approximately 180 a day and in line with the previous month.

111

- Call volume (n=164,526) is stable.
- Call answering metrics are displaying sustained improvement, albeit above national targets.
- The trust only met one performance target (abandoned call rate) with some (in **bold** below) far short.

111 Measure	Standard	June 25	National Ranking
Answered within 60s	95%	83.6%	18th/28
Average time to answer	<20s	35s	17th/28
Abandoned calls	<5%	2.4%	18th/28
Call-back within 20m	**90%**	**30.4%**	--
Average call back	--	52min	--
Warm transfer to nurse	**75%**	**6.7%**	--

Patient Transport Services (PTS)

- PTS activity metrics are stable. Operational and workforce improvement plans are in place.

Finance

- The year-to-date financial position to 30 June 2025 (Month 03 2025/26) is a surplus of £0.022m, compared to a planned deficit due to lower than anticipated pay costs, and the delivery of productivity and efficiency savings slightly above plan.

Organisational Health

- Overall sickness absence is at 6.82%, consistent with the same period last year.
- Turnover is at 7.98%, the lowest in 3 years and improving across all service lines.
- The vacancy position for the Trust is at –2.96% for June 2025 remains stable. PES and 111 vacancy gap is positive (i.e. fully established). UEC growth funding will go into establishments from autumn.
- Appraisal compliance is 84.1%, slightly behind the target of 85%.
- The introduction of 5 new mandatory training modules for 2025/26 has seen compliance drop below the revised target of 90% (n=88%) but this is expected to increase in year.
- Two staff were dismissed during June: one absence long term sickness and one performance related.

Risk Consideration
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.

Equality/Sustainability Impacts
The Diversity and Inclusion sub-committee are reviewing the trust's protected characteristics data to understand and improve patient experience. Updates are reported into the Diversity and Inclusion sub-committee.

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.

PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 23 July 2025
	Outcome	

North West Ambulance Service NHS Trust

Integrated Performance Report

Board of Directors - July 2025

nwas.nhs.uk

SPC format: Making Data Count

NHSE Making Data Count is an NHS England initiative aimed at improving data literacy across healthcare organisations. It focuses on enabling NHS staff to make better-informed decisions by understanding and using data effectively. The key aspects of this initiative include:

- **Encouraging Data-Driven Decision-Making**: Helping NHS teams move away from reactive decision-making based on single data points or short-term trends.
- **Statistical Process Control (SPC)**: Teaching NHS staff how to use SPC charts to identify genuine trends, variations, and patterns in data.
- **Avoiding Misinterpretation**: Emphasising the importance of avoiding common pitfalls, such as reacting to random fluctuations rather than meaningful trends.
- **Training and Resources**: Providing tools, workshops, and e-learning resources to improve data literacy at all levels of the NHS.
- **Supporting Continuous Improvement**: Enabling NHS teams to use data to drive service improvements and enhance patient outcomes.

Interpreting the variation.

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

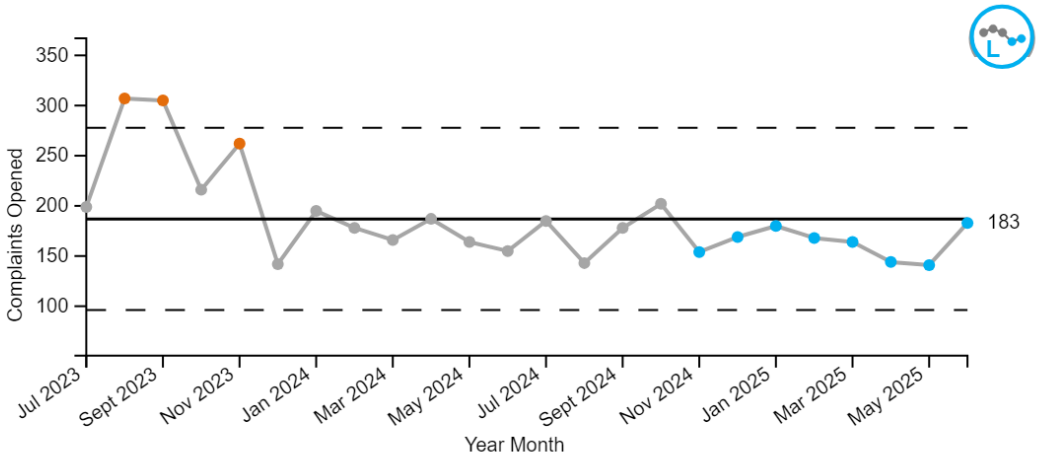
N.B. purple indicates non performance related indicator with arrow indicating direction of travel 

Quality & Effectiveness

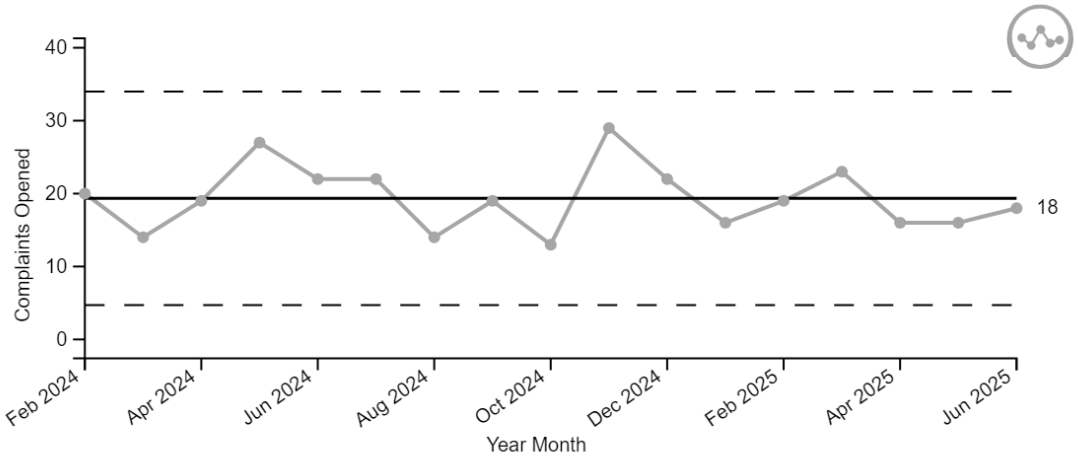
Q1 Complaints
Q2 Incidents
Q3 Safety Alerts
E1 Patient Experience
E2 Ambulance Clinical Quality Indicators (ACQI)
E3 Activities and Outcomes

Q1 Complaints

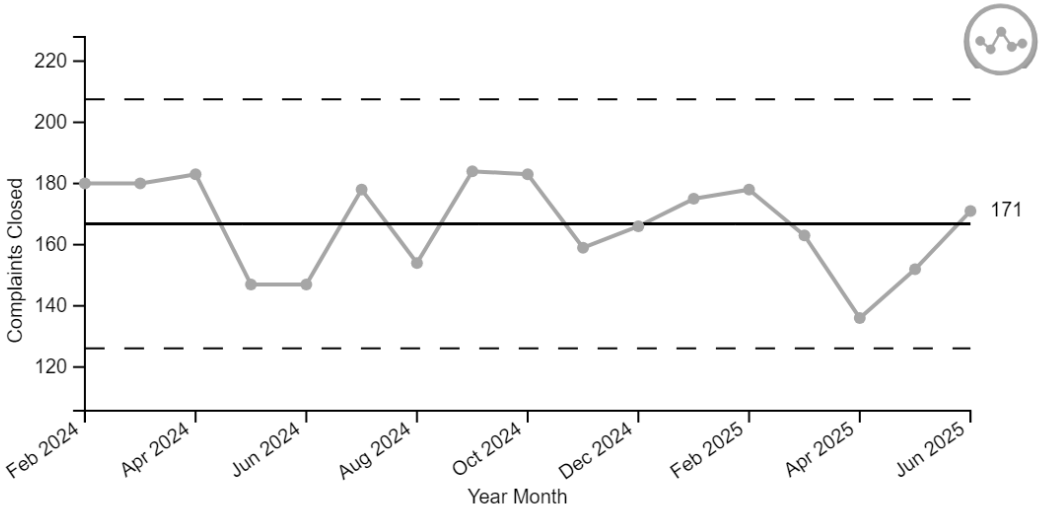
Complaints Opened with Risk Score 1-2



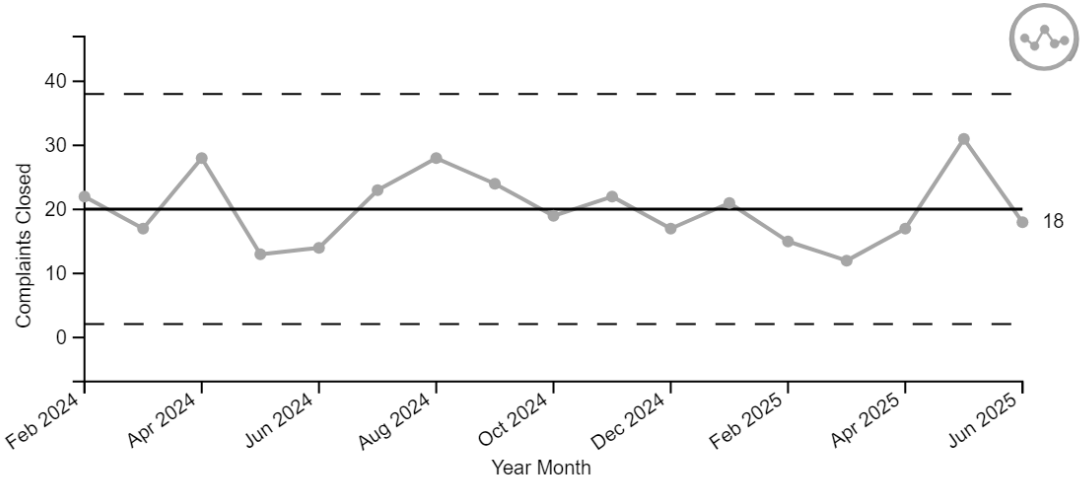
Complaints Opened with Risk Score 3-5

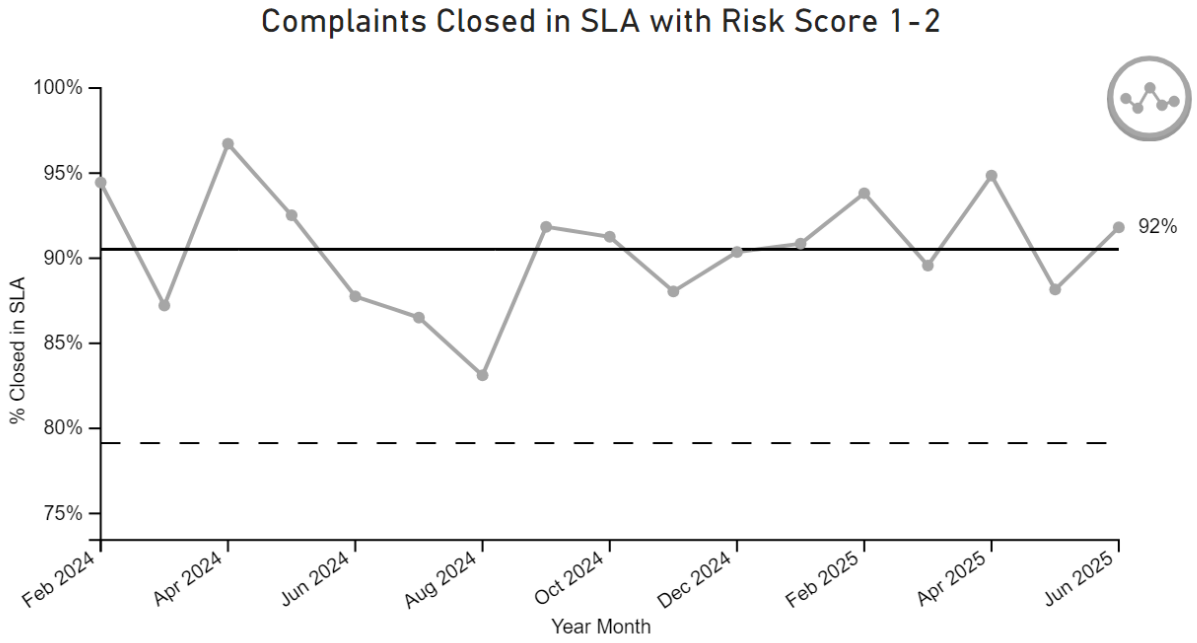


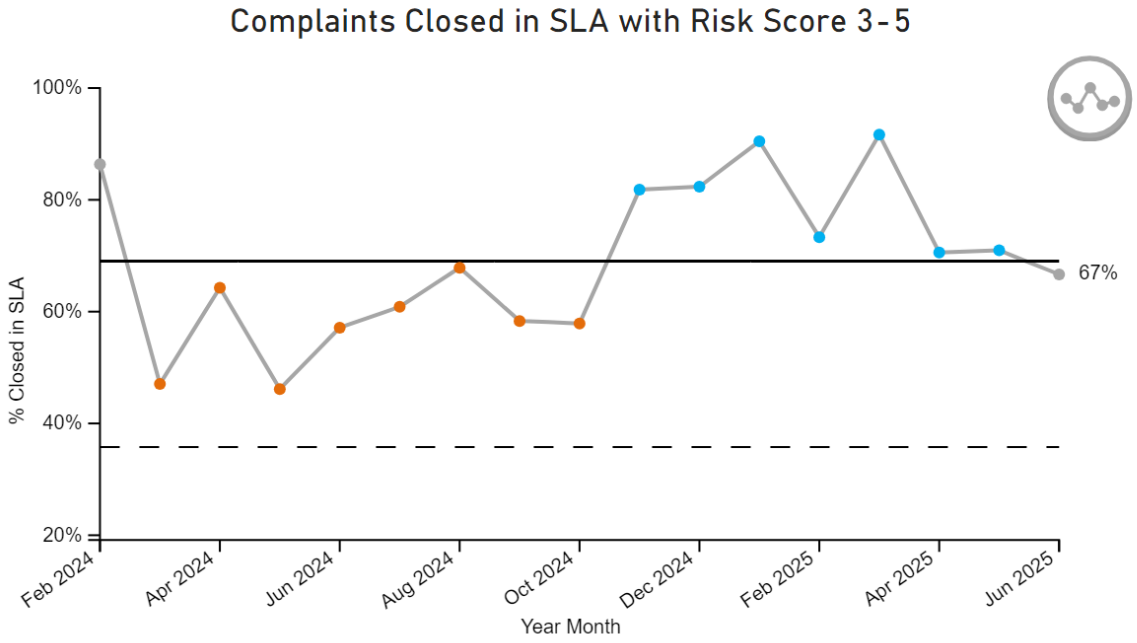
Complaints Closed with Risk Score 1-2



Complaints Closed with Risk Score 3-5





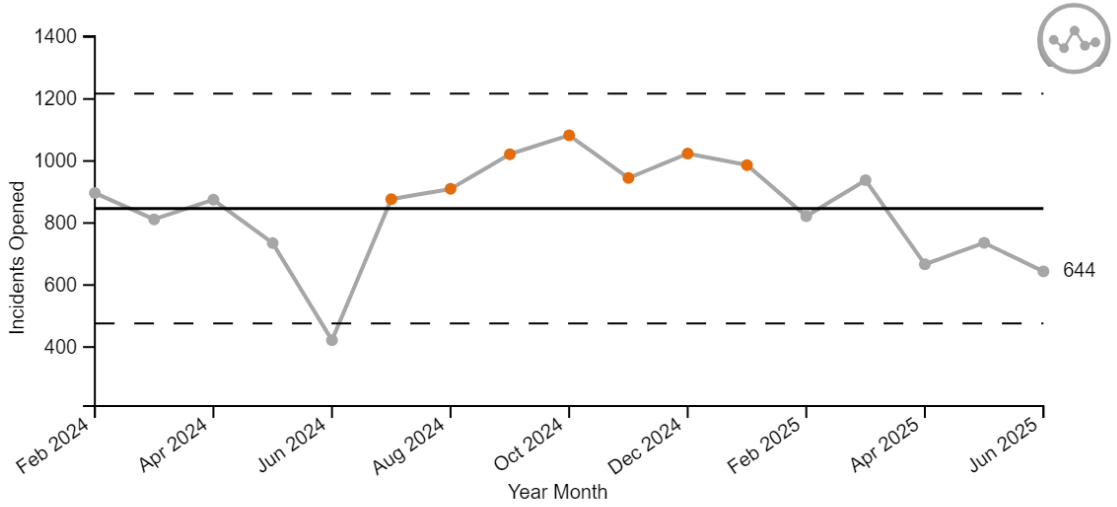


Summary: Patient Advice and Liaison Service (PALS) complaints (risk score 1-2) received into the trust is showing improvement, likely linked to the current period of stable and improved performance. Of note, 50% of PALS received are from PTS, often owing to missed or late appointment activity. All other metrics are stable.

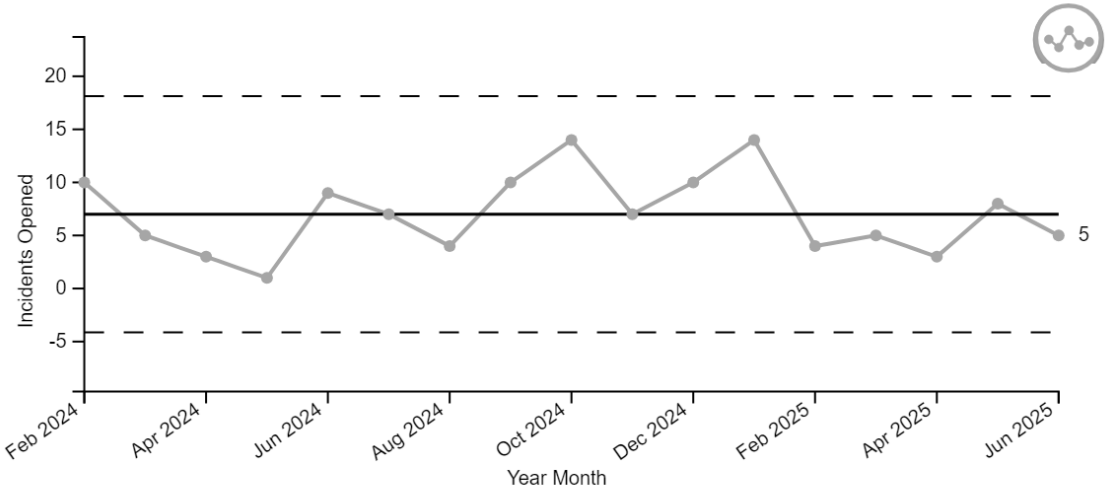
Actions: Nil required

Q2 Incidents

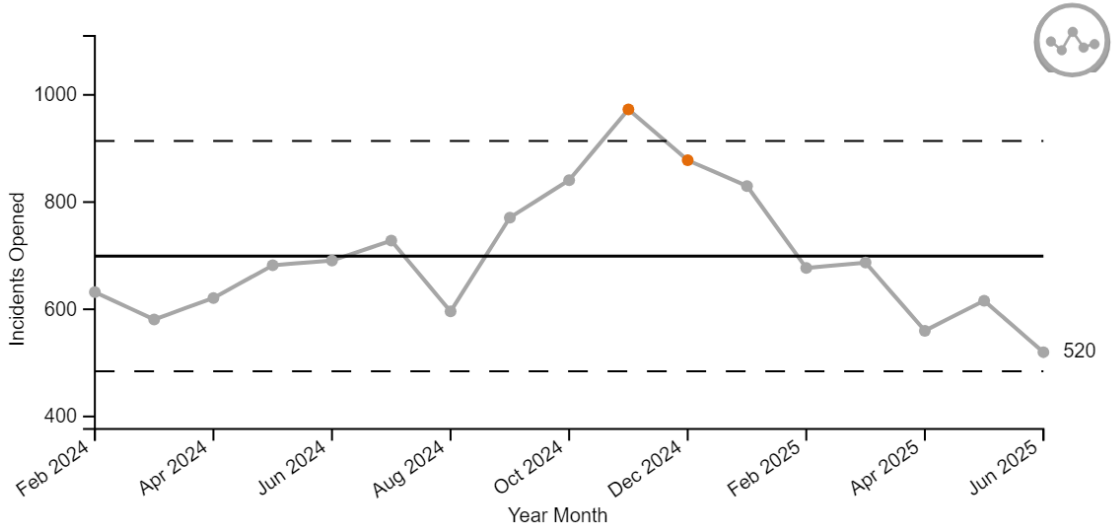
Incidents Opened with Risk Score 1-3



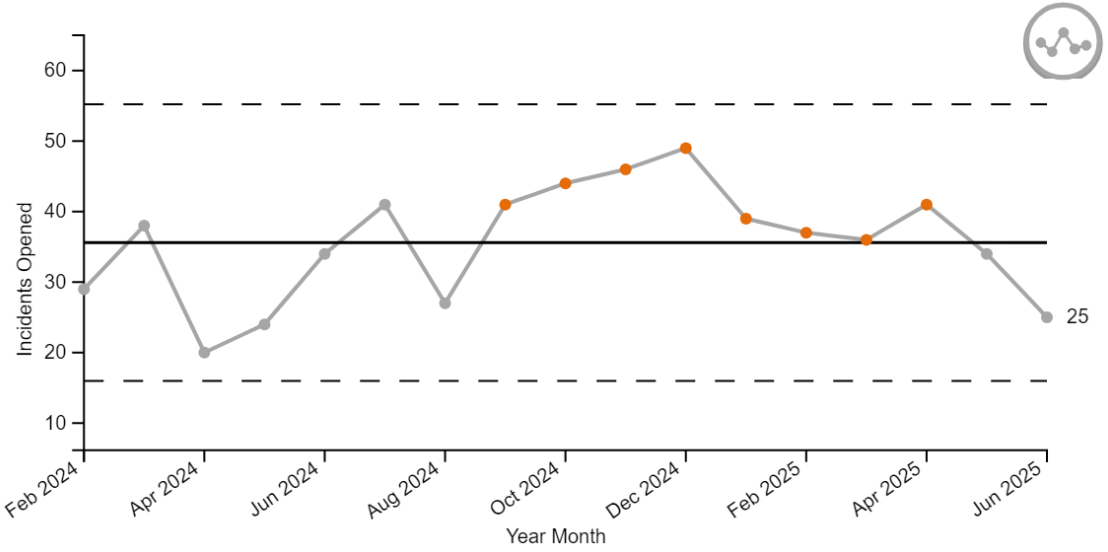
Incidents Opened with Risk Score 4-5



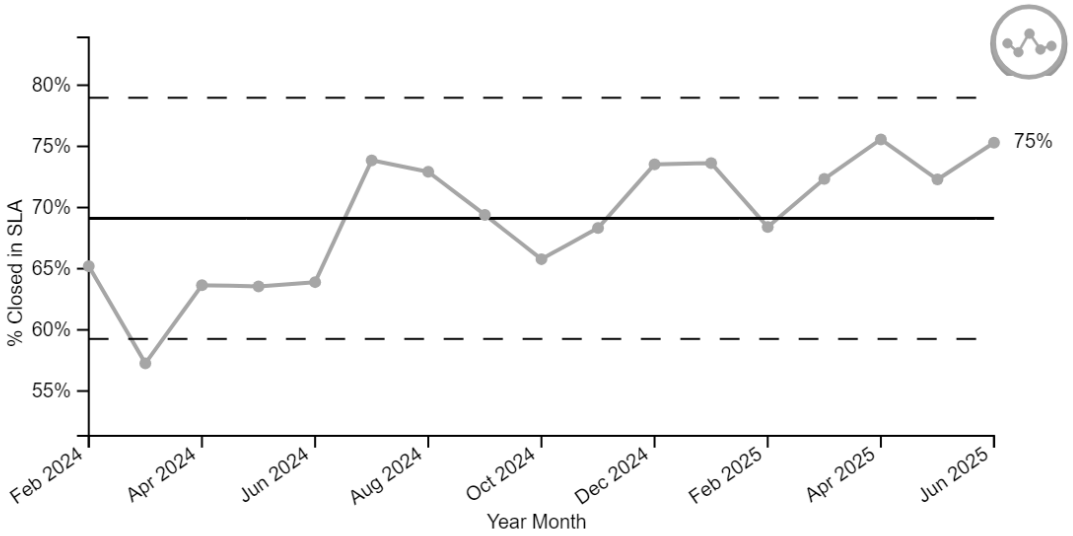
Incidents Opened - Patient



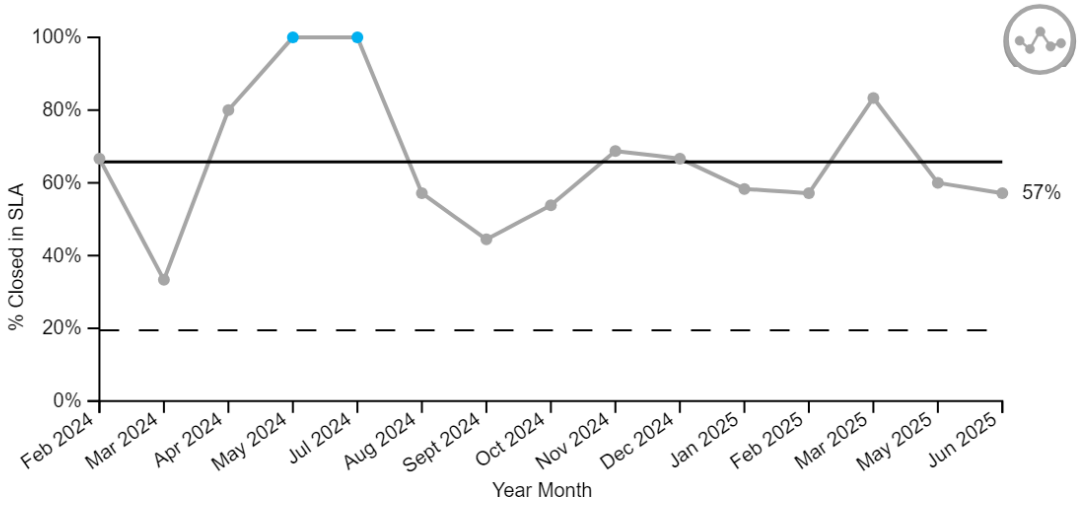
PSIRF Reported Level of Harm (Severe & Fatal)

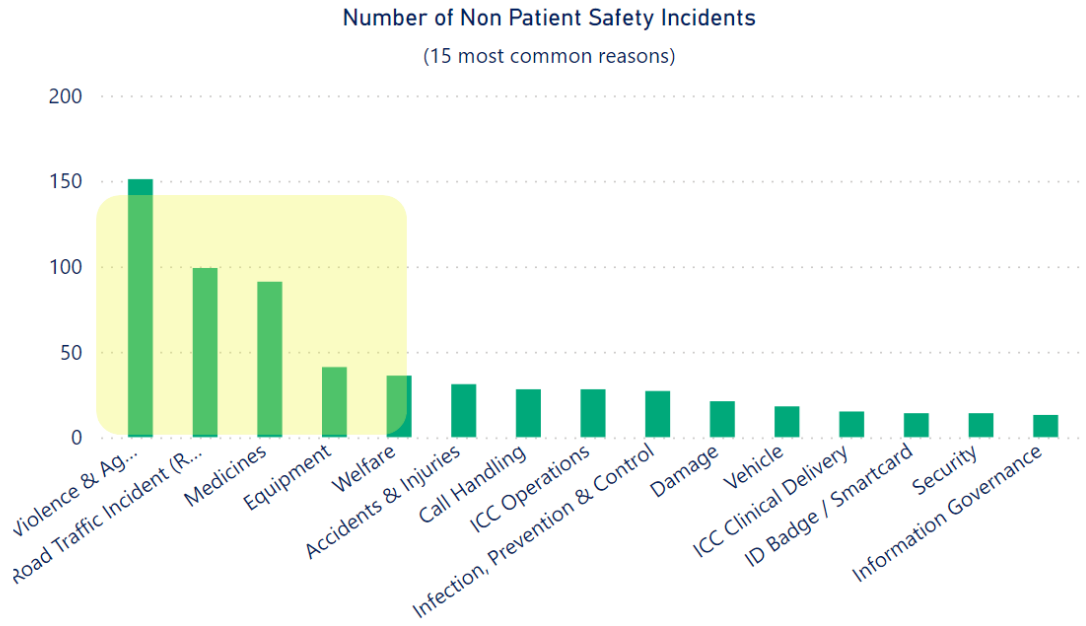


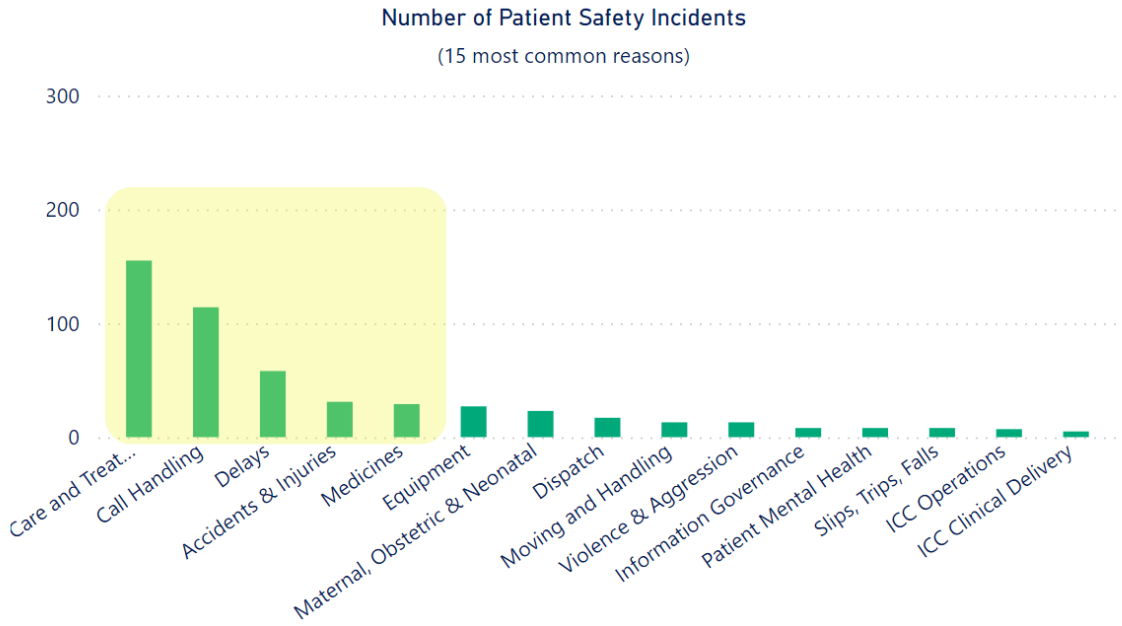
Incidents with Risk Score 1-3 % Complete within SLA

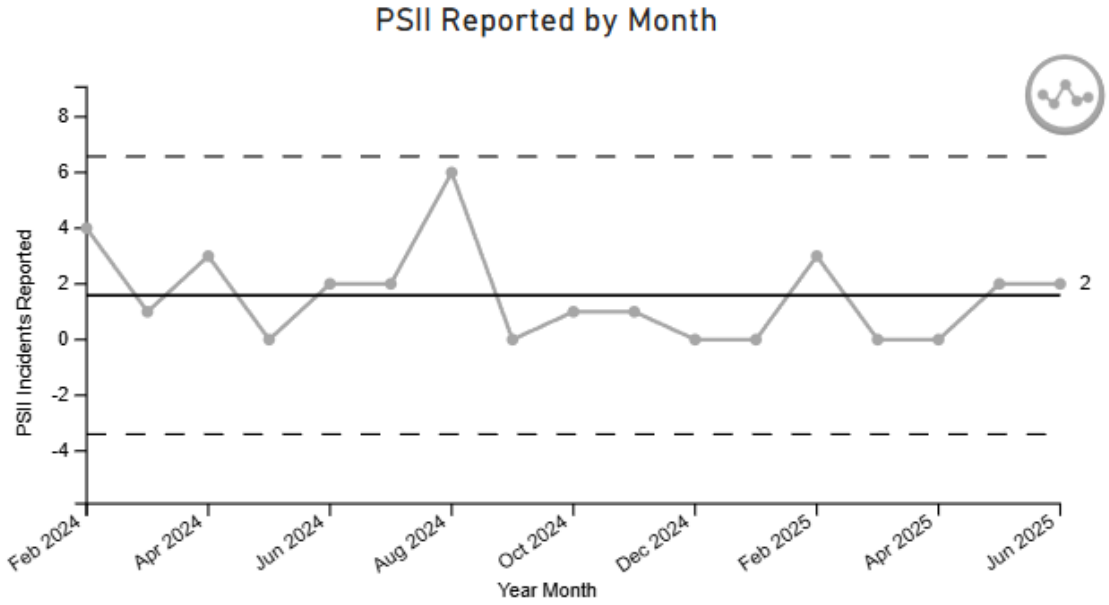


Incidents with Risk Score 4-5 % Complete within SLA









Summary: All incident metrics are stable.

Care and treatment is the most common theme for patient incidents and the highest overall reported incident. Violence and aggression (V&A) is the most common theme for non-patient incidents.

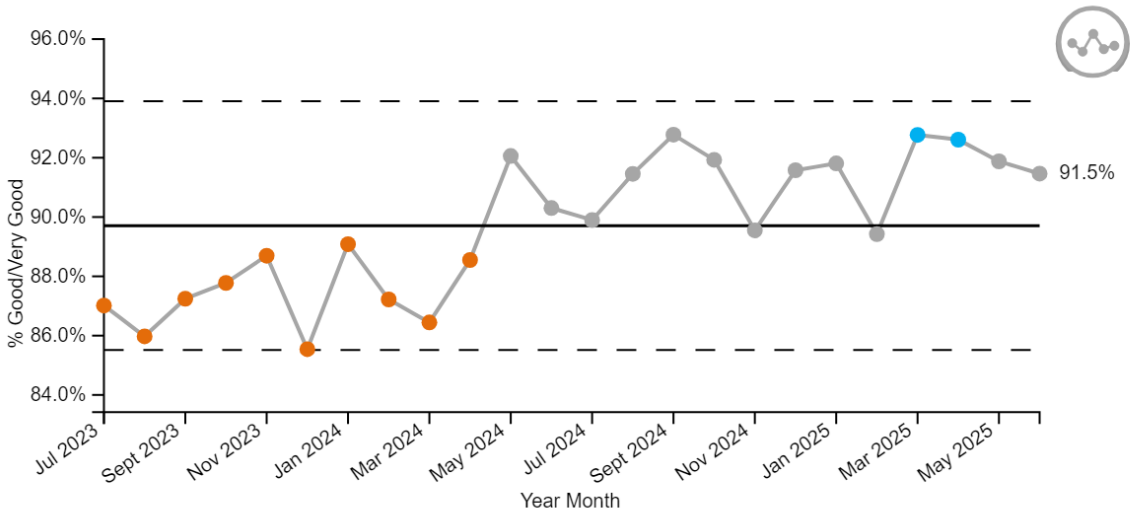
Action: There are improvement plans being developed for maternity care, informed consent and cardiac arrest through the patient safety team/ PSIRF processes . Elements of which are being supported by the improvement academy. There is continued work by the V&A team to encourage a healthy reporting culture, with specialist practitioners assigned to each incident to provide support, identify areas of prevention through public health and trauma informed approaches and provide feedback to reporters.

Q3 Safety Alerts

Safety Alerts	Alerts Received (July 24 – June 25)	Alerts Applicable (July 24 – June 25)	Alerts Open	Notes
CAS Helpdesk Team	0	0	0	
Patient Safety Alert: UKHSA	1	1	1	NatPSA/2025/002/UKHSA: Potential Contamination on non sterile alcohol free wipes with Burkholderia. Measures being taken to reduce patient risk. Issued 26/6/25
National Patient Safety Alert: NHS England	0	0	0	
National Patient Safety Alert: DHSC	6	0	0	
National Patient Safety Alert: OHID	0	0	0	
CMO Messaging	2	0	0	
National Patient Safety Alert: MHRA	0	0	0	
Medicine Alerts: MHRA	71	0	0	
IPC	0	0	0	
National Patient Safety Alert: NHS England Patient Safety	1	0	0	

E1 Patient Experience

PES Friends & Family Test (See & Treat) %



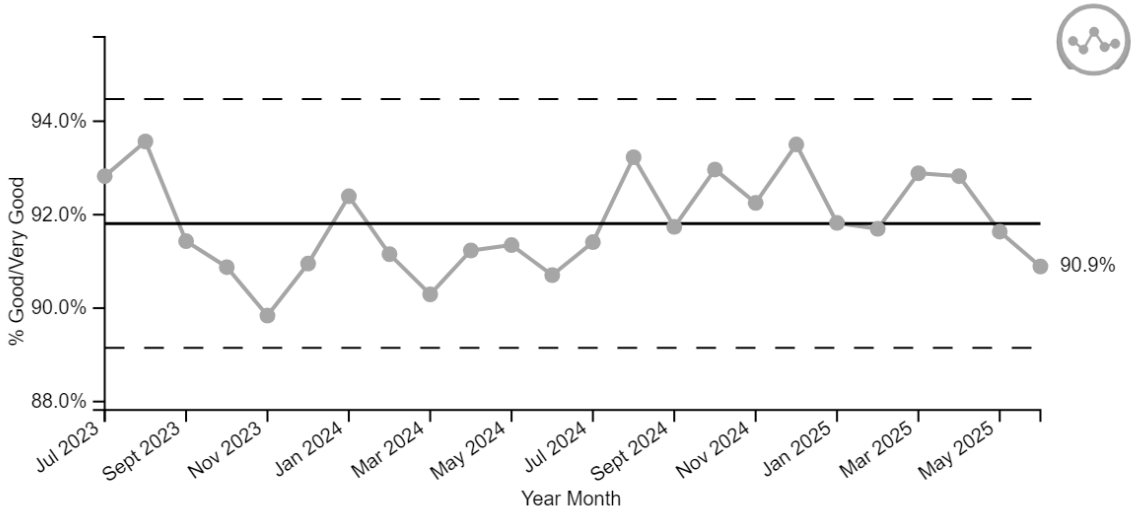
PES positive:

- *"It was my first experience to come across a service user who had a fall and I was traumatised and I could not even speak well on the phone but the person who answered the phone handled me with patience, professionalism and care, even the paramedics when they arrived they were spot on. I felt relieved."*
- *"They were very fast, efficient, knew what they were talking about and they got my son in hospital after I was refused. He had a clot in his leg which travelled to his brain, they knew what to do which was to get him into hospital which they did promptly. Thank you paramedics."*
- *"First responder came very quickly followed by ambulance in due course. First class care and service."*

PES negative:

- *"My 91-year-old mum had to wait 30 hours plus."*
- *"Paramedics were unhelpful and told us there was nothing they or a hospital could do - they told us to see our GP who told us to go to hospital immediately - we then spent the next three days in hospital."*
- *"The decisions made by the ambulance crew during both visits. The appropriateness of refusing transport given his visible pain. The lack of physical assistance, compassion, and follow-up at hospital. The overall professionalism and conduct of the crew involved."*

PTS Friends & Family Test %

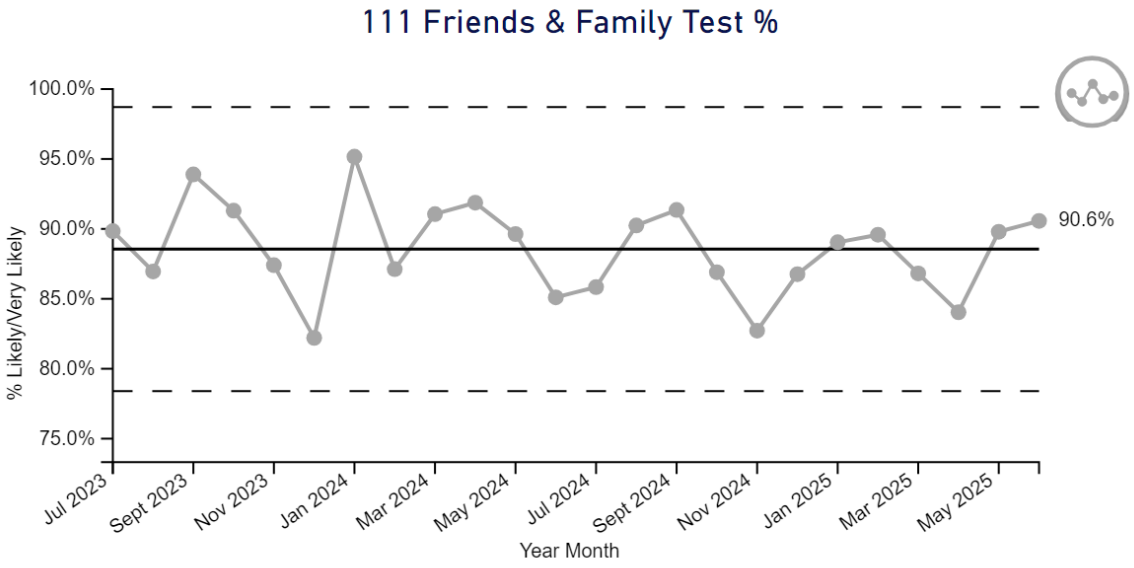


PTS positive:

- *"The driver, was professional, had empathy and kindness, also something you cannot teach, common sense. He was excellent."*
- *"I found people picking you up and caring for you on your trip to and from hospital was 2nd to none. First class. Very friendly and professional."*
- *"From start to finish, everything was good. Although my pick-up was delayed a little (due to vehicle probs.), I needn't have worried because everything had been fully explained to the consultant and her team, for when I arrived! I didn't have to wait long for my return journey and all the drivers, as they always are, were friendly, polite and helpful*

PTS negative:

- *"Very late pick up, appt at hospital cancelled due to lateness. Waited 4 to 5 hrs for pick up from hospital when suffering Spinal Stenosis leading to extreme lower back pain."*
- *"Because I broke my femur and they sent me a black cab that parked a good way from my door so I had to walk with my Zimmer frame to the taxi I was in tears and he was half an hour late for my appointment."*
- *"4 hour wait to get picked up to go home. A taxi came. He said he only just got the message to pick me up 10 minutes ago."*



NHS 111 positive:

- *"I was completely satisfied with everything. I received information and an appointment to see a doctor. I received 5 phone calls - excellent service. Very impressed."*
- *"Felt reassured. Especially when the text came through to verify my location. I knew if something went wrong an ambulance could be sent to me."*
- *"As my call was early evening the service was extremely busy. I was kept in the picture with a 2nd phone call explaining was told a nurse would call ASAP. Within 1/2 hour I was contacted and advised what to do next."*

NHS 111 negative:

- *"My concern was not addressed and I was assessed for an irrelevant issue. I understand some questions in the questionnaire appear to be irrelevant, but in my case they actually were as I clarified right from the start what my concern was."*
- *"I waited between 9-12 hours with COPD, not being able to breathe to wait for a five-minute phone consultation at 1:30 in the morning."*
- *"Didn't receive a care advice text. Didn't receive a return phone call until 24 hours later after assessment."*

Summary: PES: The 656 responses for June are 8.1% lower when compared to May's of 714, with comments also lower, at 7.9% (509 for June compared to 553 from May). The overall experience score for June of 91.5% is 0.4% lower than the 91.9% reported in May.

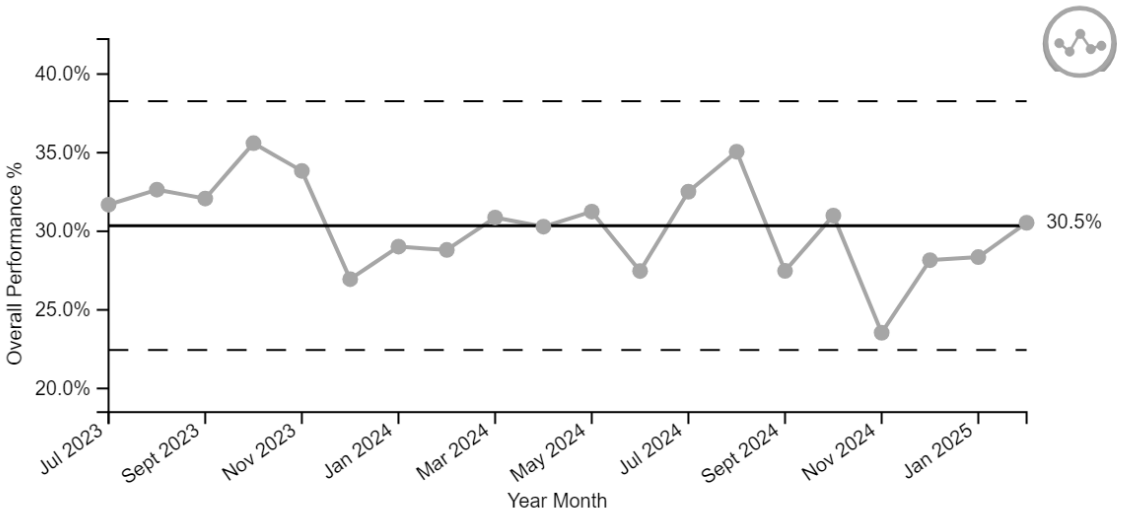
PTS: the 1,010 responses from June are 9.2% lower than for May 1,112, with supporting comments also lower, by 8.8%, (829 for June compared to 909 from May). The overall experience score for June of 90.9% is 0.7% lower than the 91.6% reported for May.

111: We have 562 returns so far for June, compared to the 647 returns updated for May. These increased returns are due to the inclusion of feedback responses from 111 survey completion following the receipt of 'care advice' via SMS after the 111 calls. So far from returns for June, we see an 90.6% likelihood of the 111 service being recommended, a current difference of 0.8% compared to the updated 89.8% reported for May.

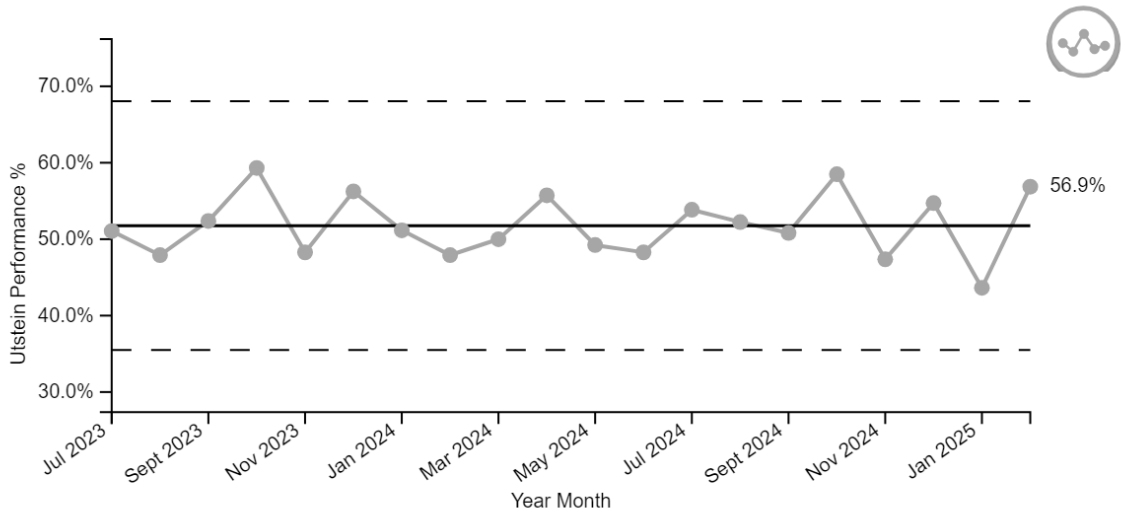
Actions: To increase return response rates, particularly in 111, we are piloting sending broadcast invites for our digital localised NWAS NHS 111 PE surveys between 1800 - 2000, outside the normal send window of 0900 – 1800, Mon - Fri. Random selection, which will be doubled just for this pilot period, will be taken from users of the service within the last 24 - 48 Hrs. The success response rates will be monitored.

E2 Ambulance Clinical Quality Indicators (ACQI)

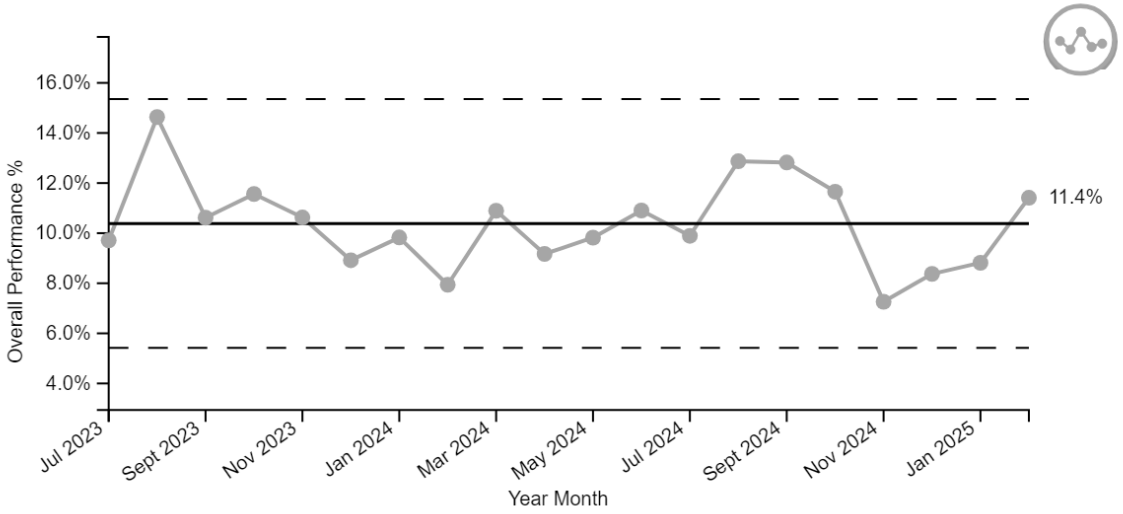
ROSC - Overall Performance



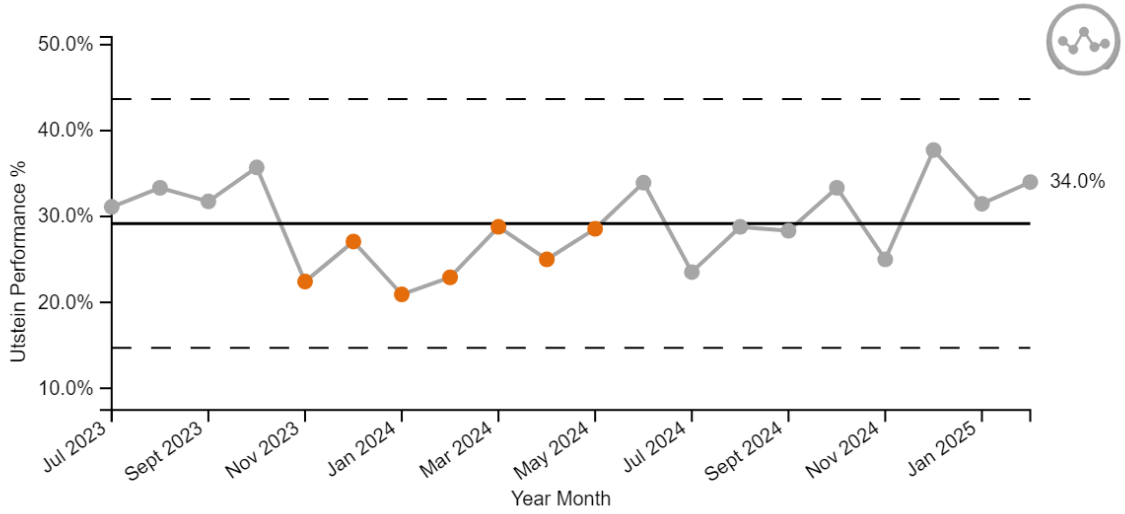
ROSC - Utstein Performance



Survival at 30 Days Post Discharge - Overall Performance

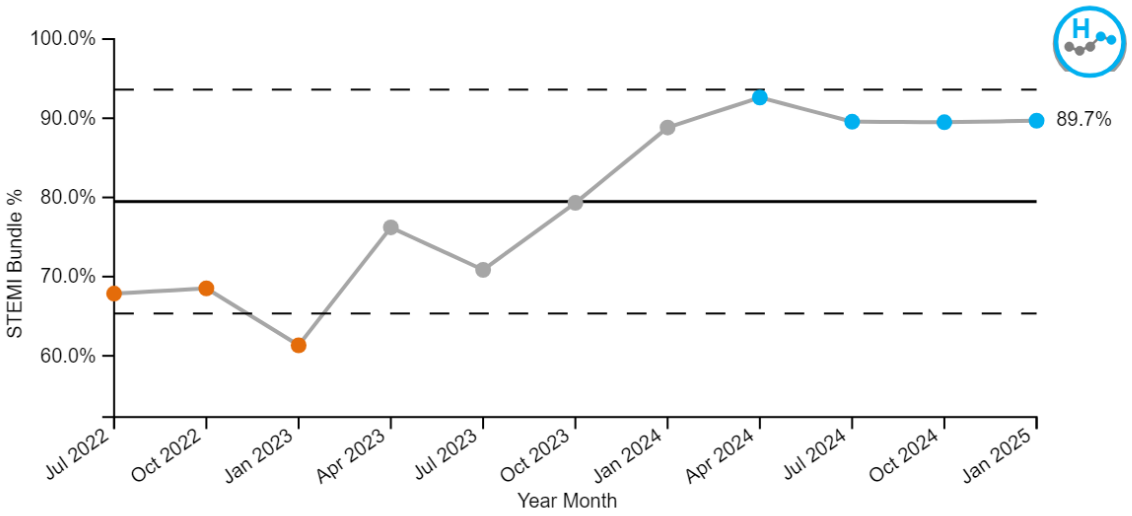


Survival at 30 Days Post Discharge - Utstein Performance

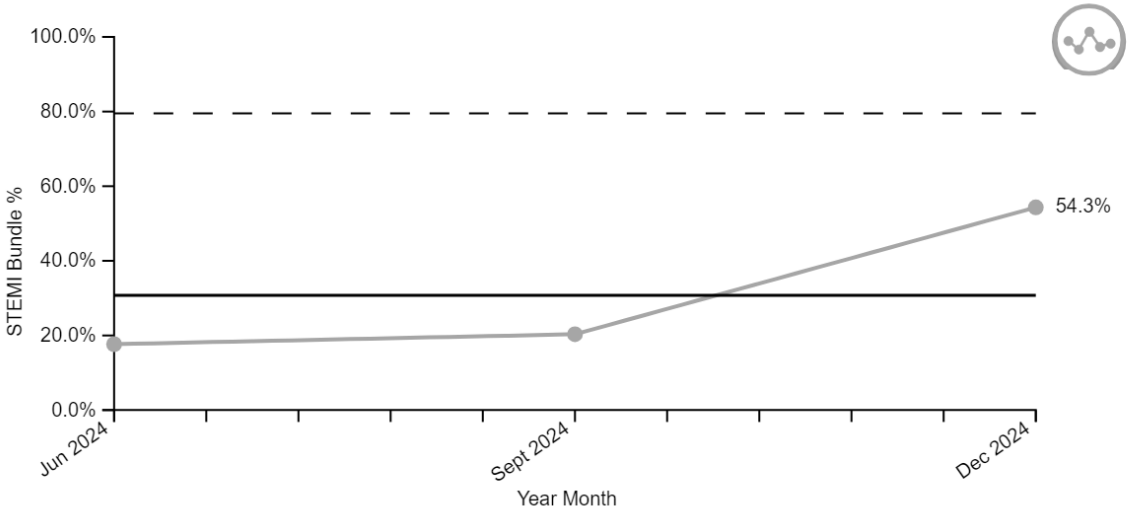


E2 Ambulance Clinical Quality Indicators (ACQI)

STEMI Care Bundle



Falls Care Bundle



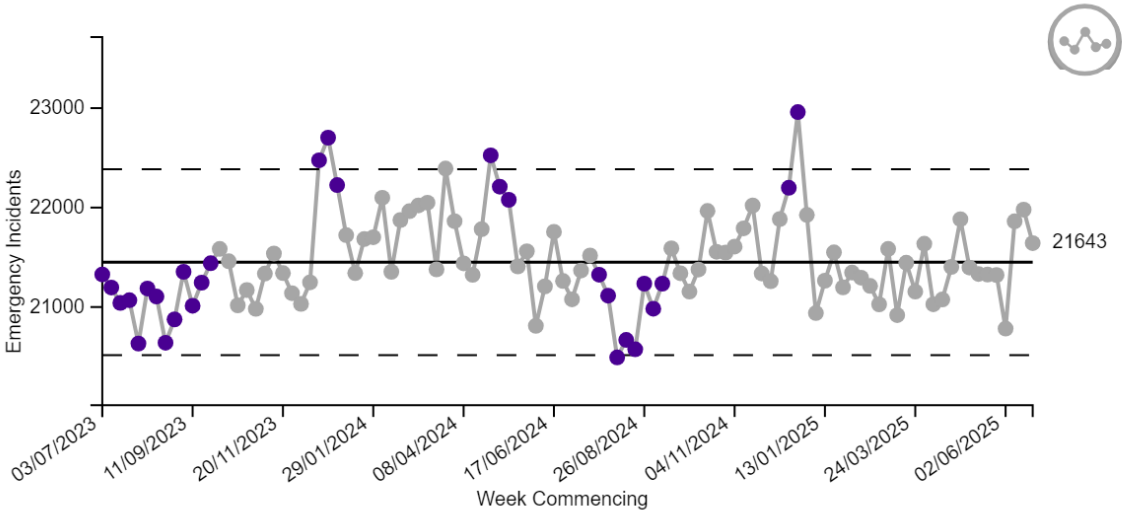
Summary: The Trust is currently performing above national average for all ACQI metrics. Falls care bundle performance has improved from 20.3% in September to 54.3% in December following the introduction of a Falls tile within the electronic patient record (EPR) system.

- Return of Spontaneous Circulation (ROSC) overall performance - last reported in February 25 (30.5%), **above** the national average of 27.4%.
- ROSC Utstein performance - last reported in February 25 (56.9%), **above** the national average of 55.3%.
- Survival at 30 days after discharge overall performance - last reported in February 25 (11.4%), **above** the national average of 9.6%.
- Survival at 30 days after discharge Utstein performance - last reported in February 25 (34.0%), **above** the national average of 31.7%.
- STEMI bundle - last reported in January 25 (89.7%), **above** the national average of 82.4%.
- Falls bundle – last reported in December 24 (54.3%), **above** the national average of 47.1%.

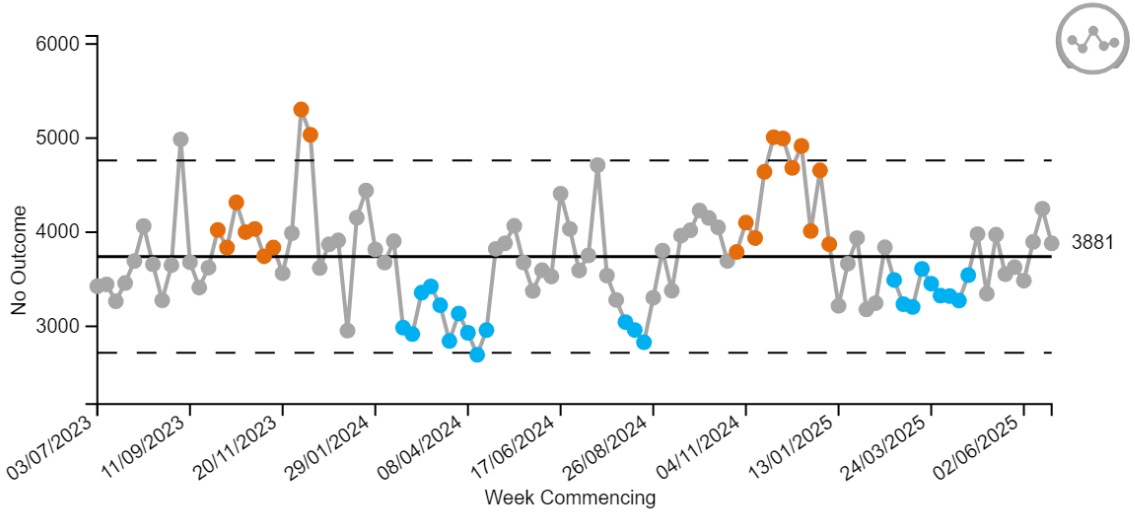
Actions: Continued monitoring of metrics and EPR system development to drive improvement.

E3 Activity & Outcomes

Emergency Incidents

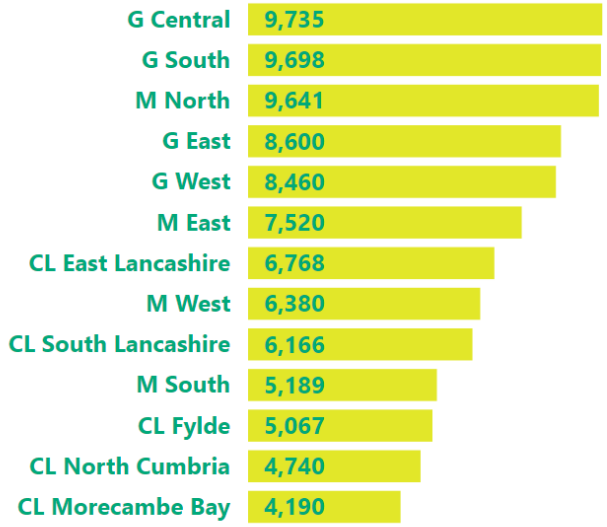


No Outcome Contacts

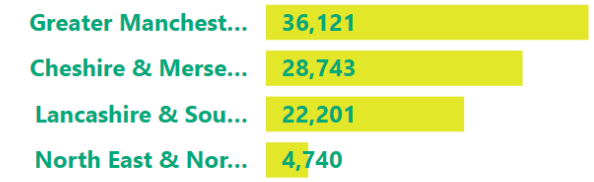


Emergency Incidents

Emergency Incidents by Operational Sector

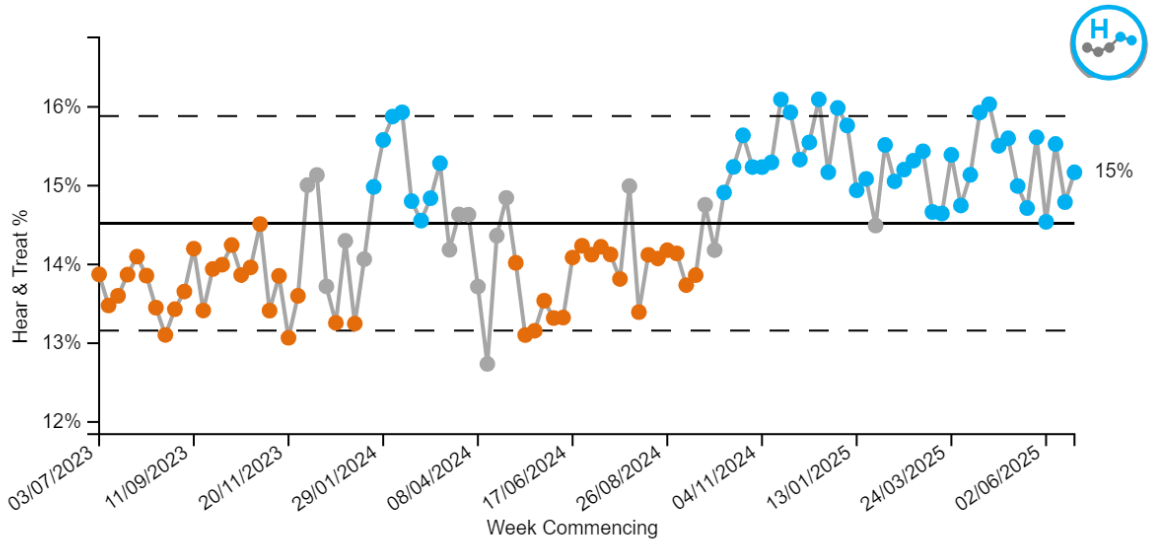


Emergency Incidents by ICB

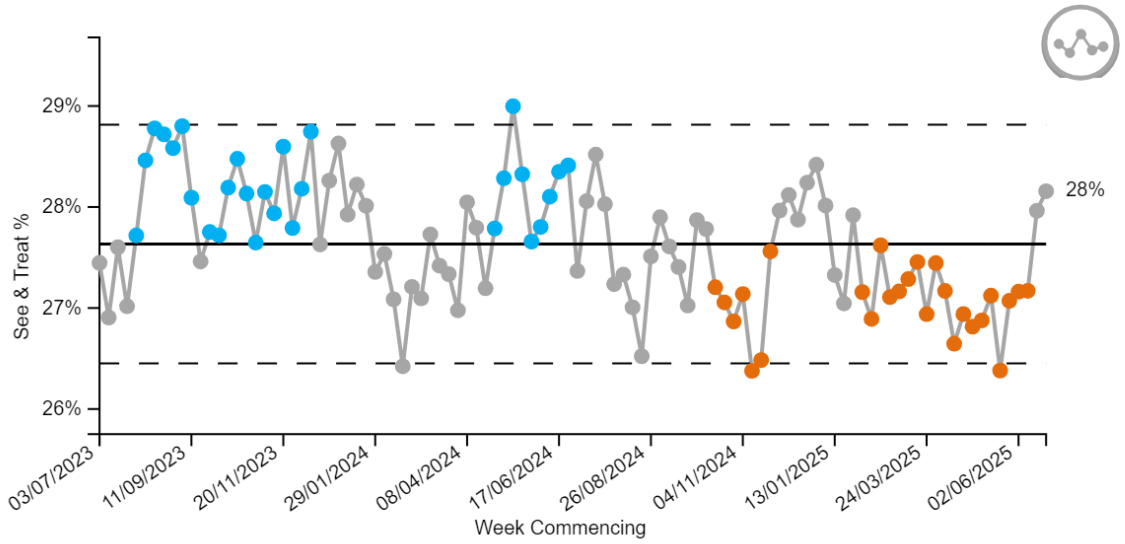


Calendar Year	Month	Calls	% Change from previous year	Incidents	% Change from previous year
2022	Jun	131,065		90,923	
2023	Jun	118,947	-9.25 %	91,932	1.11 %
2024	Jun	118,615	-0.28 %	91,317	-0.67 %
2025	Jun	119,972	1.14 %	92,471	1.26 %

Hear & Treat (AQI)



See & Treat (AQI)



Months Hear & Treat by Sector

G Central	17.3%
CL Fylde	16.0%
G East	15.9%
CL South Lancashire	15.9%
CL East Lancashire	14.9%
G South	14.8%
M South	14.7%
G West	14.1%
M West	13.9%
M North	13.5%
CL North Cumbria	13.4%
M East	13.1%
CL Morecambe Bay	12.9%

Months Hear & Treat by ICB

Greater Man...	15.6%
Lancashire ...	15.1%
Cheshire & ...	13.7%
North East ...	13.4%

Months See & Treat by Sector

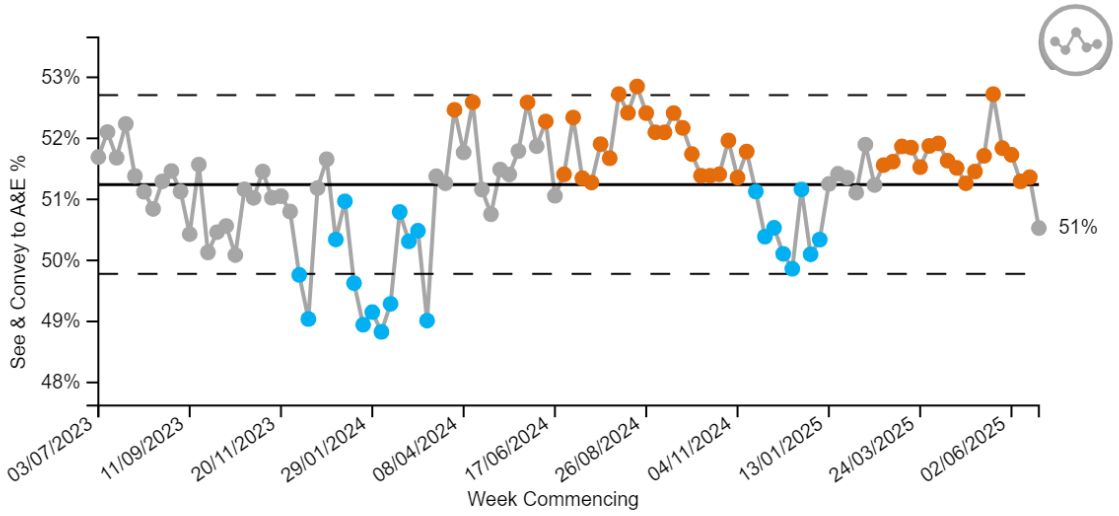
CL Morecambe Bay	30.8%
CL North Cumbria	29.6%
M West	29.4%
M South	29.4%
CL Fylde	29.1%
CL East Lancashire	28.8%
G West	28.0%
G Central	27.5%
CL South Lancashire	27.0%
G East	26.7%
G South	26.5%
M North	26.4%
M East	25.1%

Months See & Treat by ICB

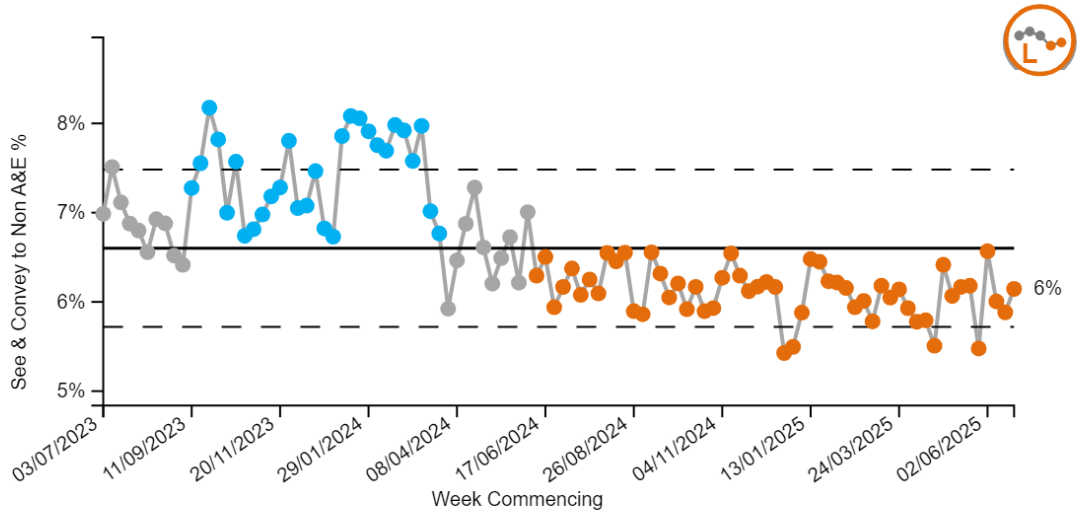
North East ...	29.6%
Lancashire ...	28.7%
Cheshire & ...	27.3%
Greater Man...	27.1%

BAF ID SR01

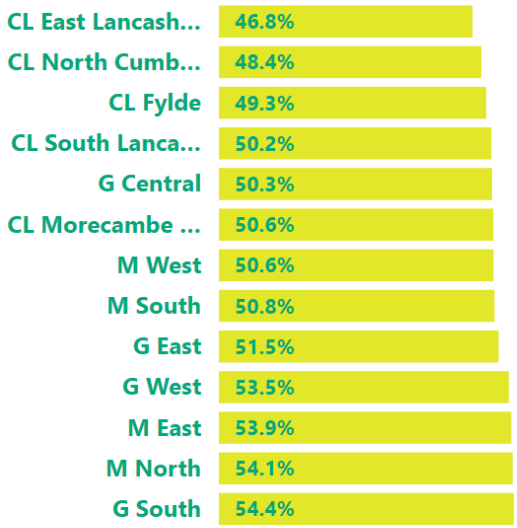
See & Convey to A&E (AQI)



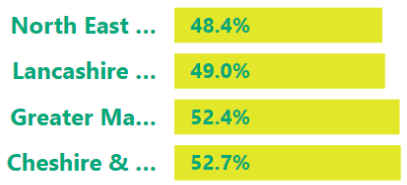
See & Convey to Non A&E (AQI)



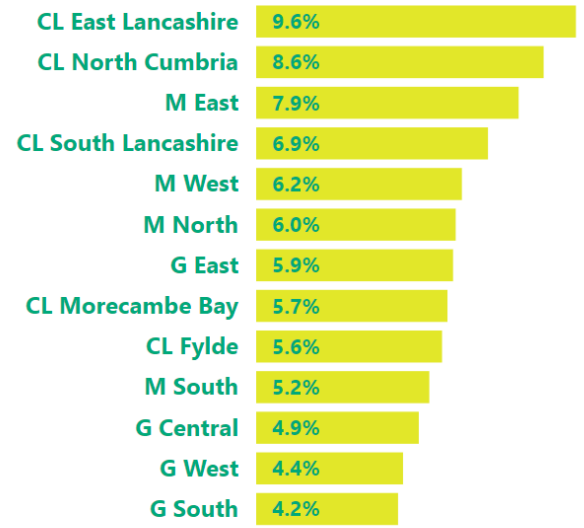
Months See & Convey (AE) by Sector



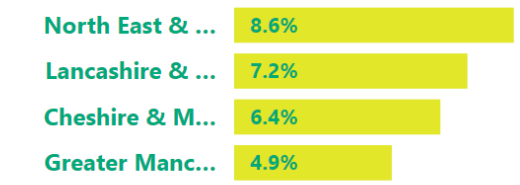
Months See & Convey (AE) by ICB

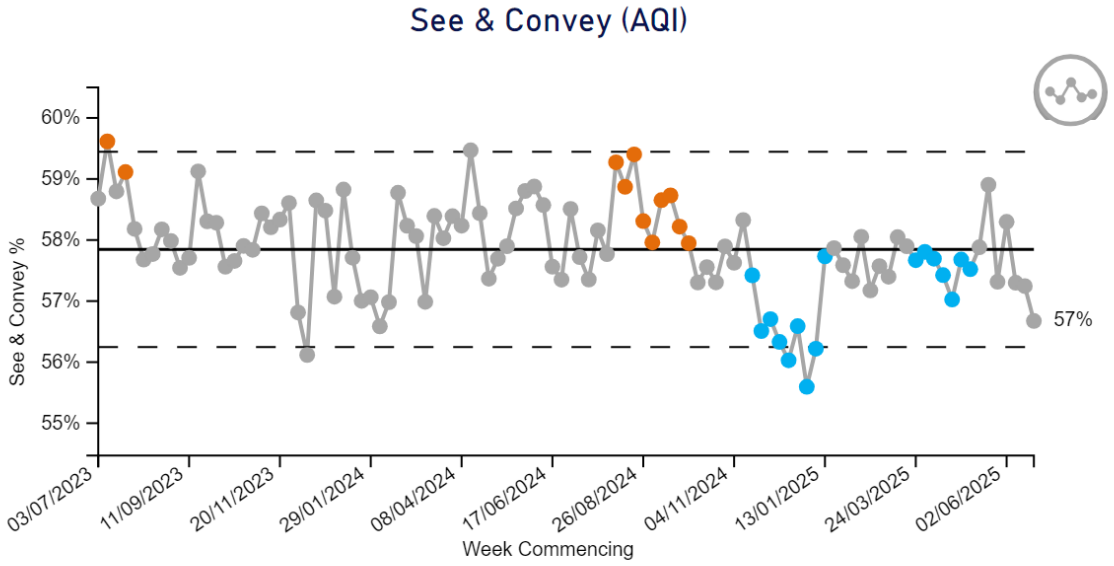


Months See & Convey (Non AE) by Sector



Months See & Convey (Non AE) by ICB





Months See & Convey by Sector

CL Fylde	54.8%
G Central	55.2%
M South	56.0%
CL Morecambe Bay	56.3%
CL East Lancashire	56.3%
M West	56.8%
CL North Cumbria	57.0%
CL South Lancashire	57.2%
G East	57.4%
G West	57.8%
G South	58.6%
M North	60.1%
M East	61.8%

Months See & Convey by ICB

Lancashire & ...	56.2%
North East & ...	57.0%
Greater Manc...	57.3%
Cheshire & M...	59.0%

Activity & Outcomes

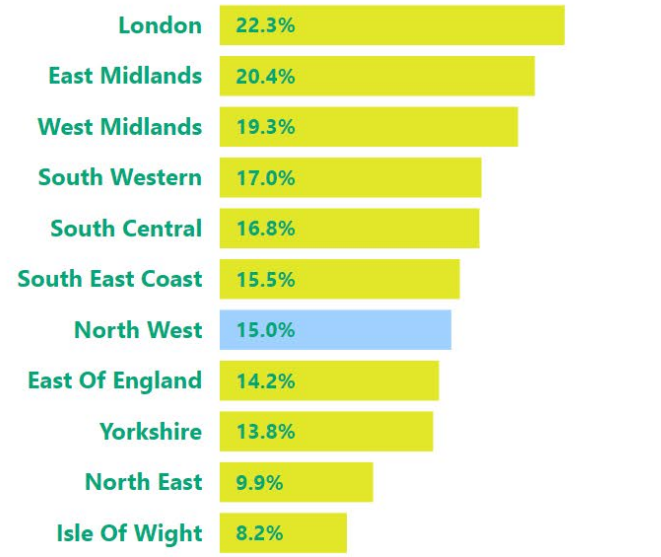
Summary: Of the n=119,972 emergency calls received by the trust, 77.1% (n=92,471) became incidents. In comparison there were 1.14% more calls, and incidents increased by 1.26%, indicating stable relative performance to this period last year (a similar change in calls and incidents).

The Hear and Treat (H&T) rate for was 15.0%, whilst the S&T rate was 27.6%, equating to a total non-conveyance rate of 42.6%, the same as the previous report.

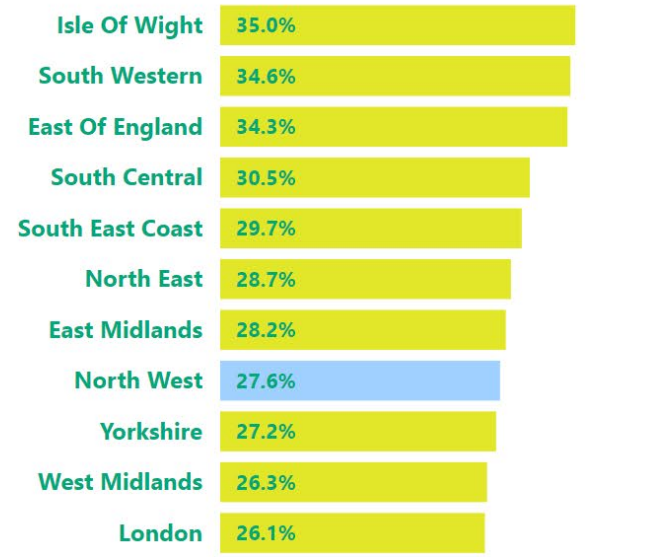
Nationally, the trust position fell in ranking for H&T to 7th while posting 8th for S&T and 9th for S&C.

Action: The phase of the Integrated Contact Centre (ICC) programme has not currently realised further increases in H&T; further imminent investigation is required to understand the stabilisation.

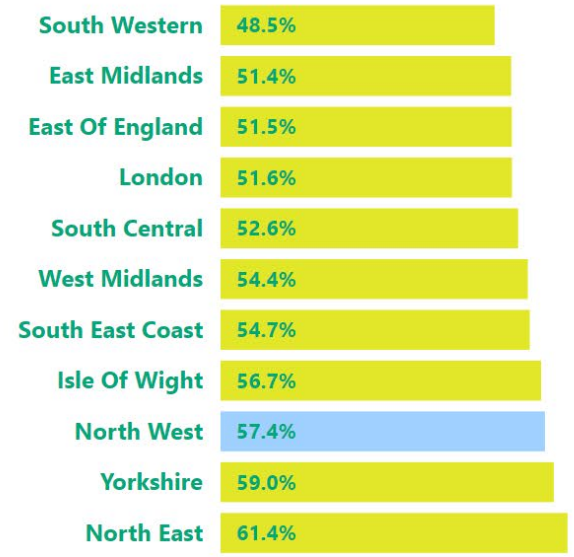
Hear & Treat % by Trust



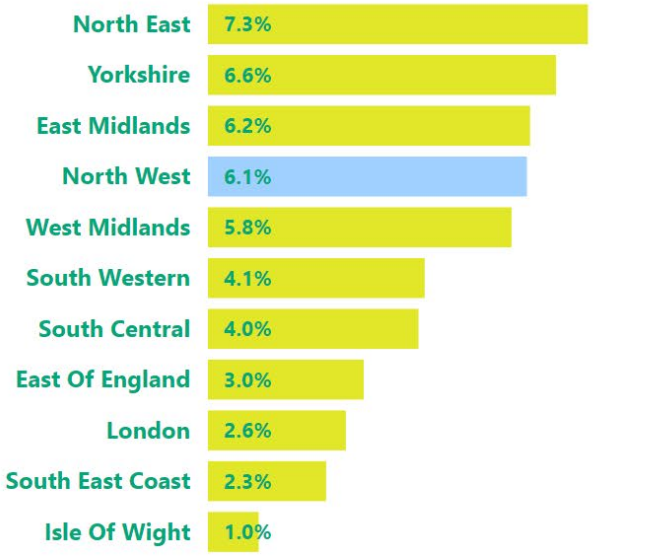
See & Treat % by Trust



See & Convey % by Trust



See & Convey non A&E % by Trust

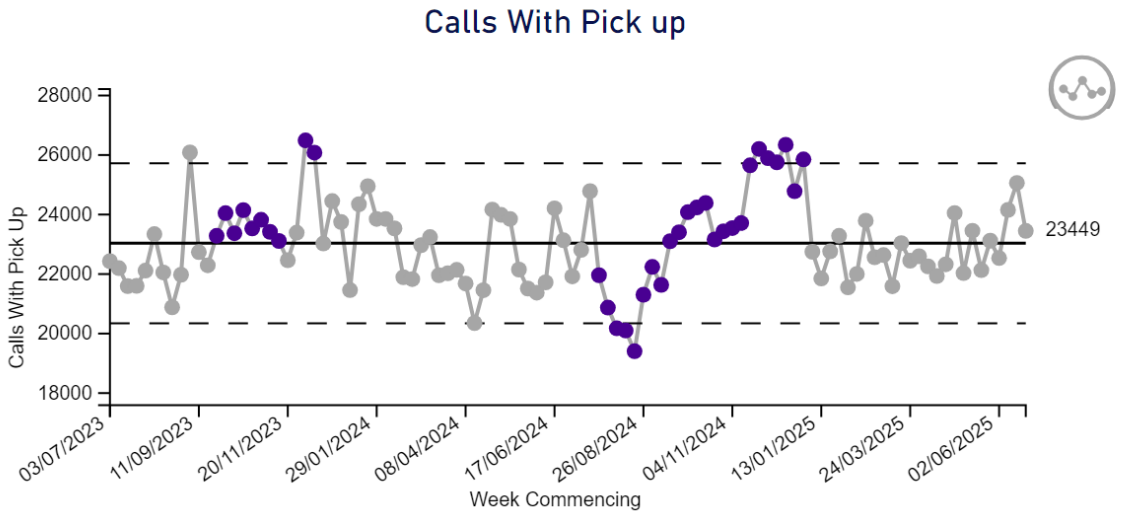


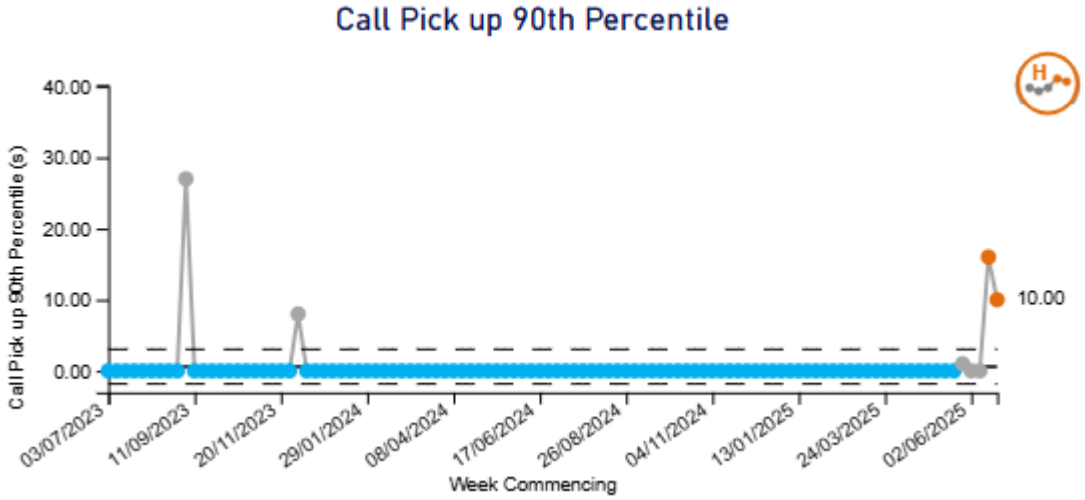
BAF ID SR01

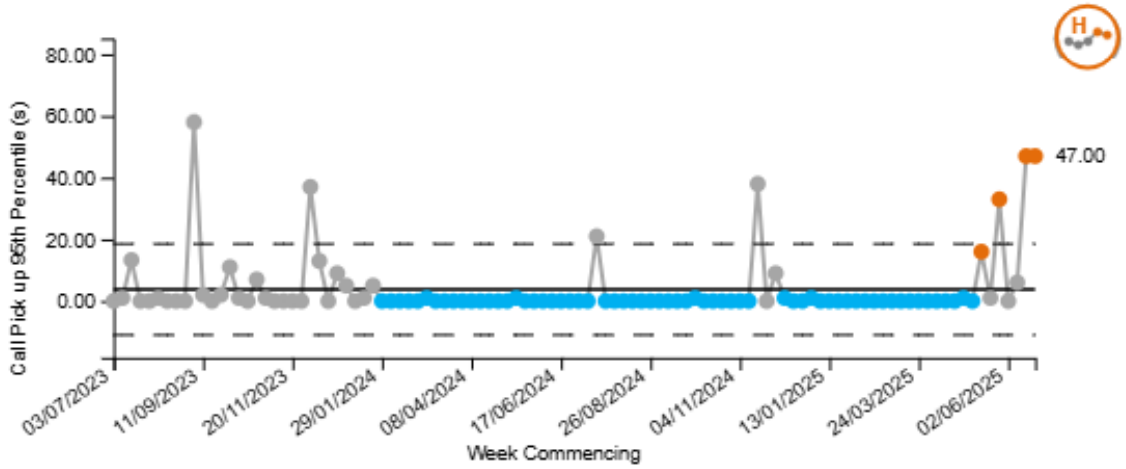
Operational

O1 Call Pick up
O3 ARP Response Times
O3 ARP Provider Comparison
O3 A&E Turnaround
O3 A&E Turnaround ICB
O4 111 Activity & Performance
O5 PTS Activity

O1 Call Pick Up







Call Pick Up Mean	
Month	4
YTD	2
Ranking	6

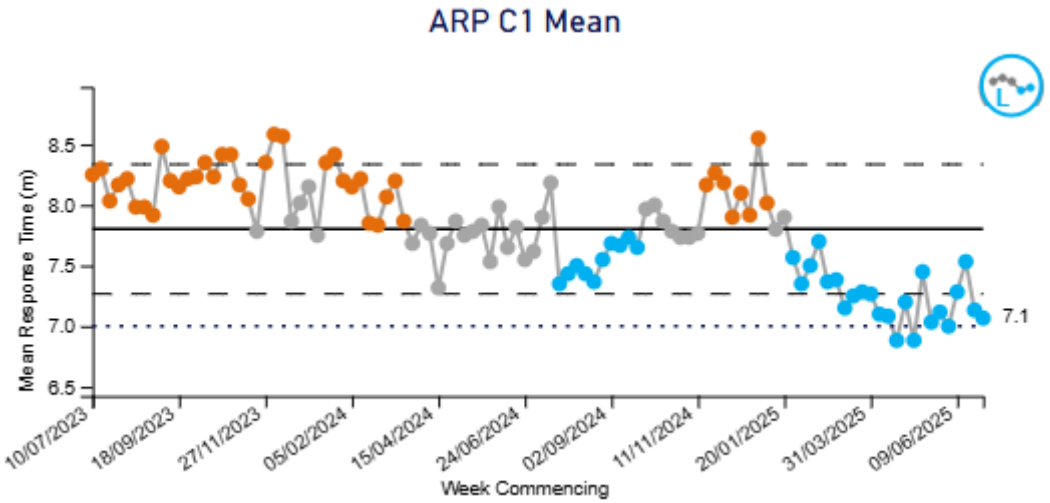
Call Pick up 90th Percentile	
Month	0
YTD	0
Ranking	1

Call Pick up 95th Percentile	
Month	27
YTD	6
Ranking	8

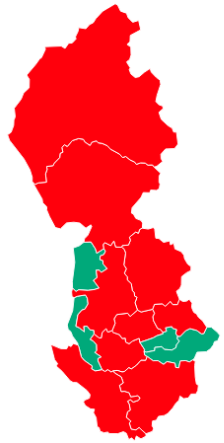
Summary: Call pick up has deteriorated in June, posting a 4 second mean (within 5 second target) and 27 second 95th percentile. Part of this deterioration is linked to the support being provided to Yorkshire Ambulance Service (YAS) as they migrate to NHS Pathways.

Actions: ICC are working with YAS to vary the support offered to minimise the impact on call pick up.

O3 ARP Response Times



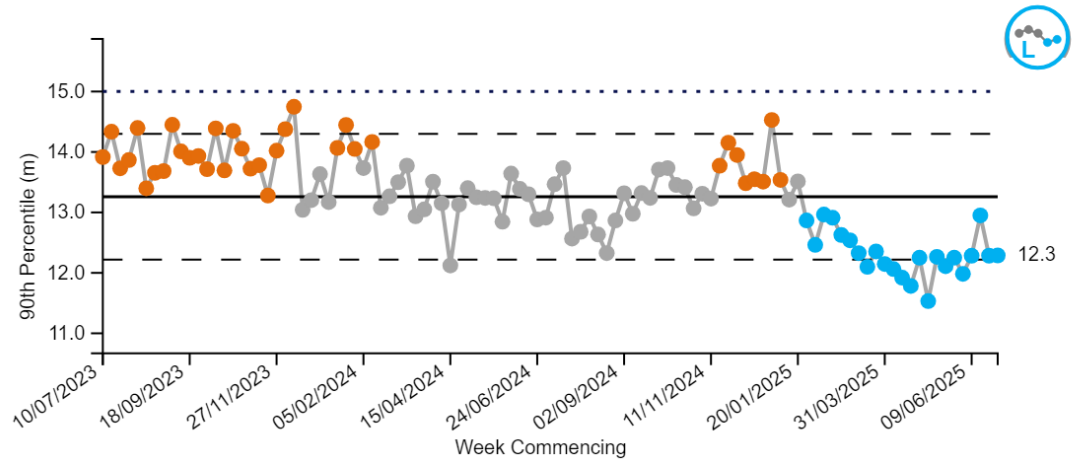
C1 Mean (Red =>7min)



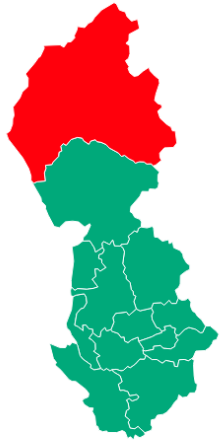
C1 Mean by Sector	
CL North Cumbria	00:09:05
M West	00:08:15
M South	00:08:04
CL Morecambe Bay	00:07:50
CL South Lancashire	00:07:36
CL East Lancashire	00:07:29
G West	00:07:19
M East	00:07:14
G East	00:07:08
G Central	00:06:39
CL Fylde	00:06:34
G South	00:06:33
M North	00:06:30

C1 Mean by ICB	
North East & Nort...	00:09:05
Lancashire & Sout...	00:07:21
Cheshire & Mersey...	00:07:20
Greater Manchester	00:06:52

C1 Mean	
Target	00:07:00
Month	00:07:14
YTD	00:07:09
Ranking	3



C1 90th (Red =>15min)



C1 90th by Sector	
CL North Cumbria	00:16:31
CL Morecambe Bay	00:14:31
M South	00:14:29
M West	00:14:05
CL South Lancashire	00:13:42
CL East Lancashire	00:13:34
CL Fylde	00:12:22
G East	00:12:16
G West	00:11:48
M East	00:11:35
G Central	00:10:56
G South	00:10:48
M North	00:10:48

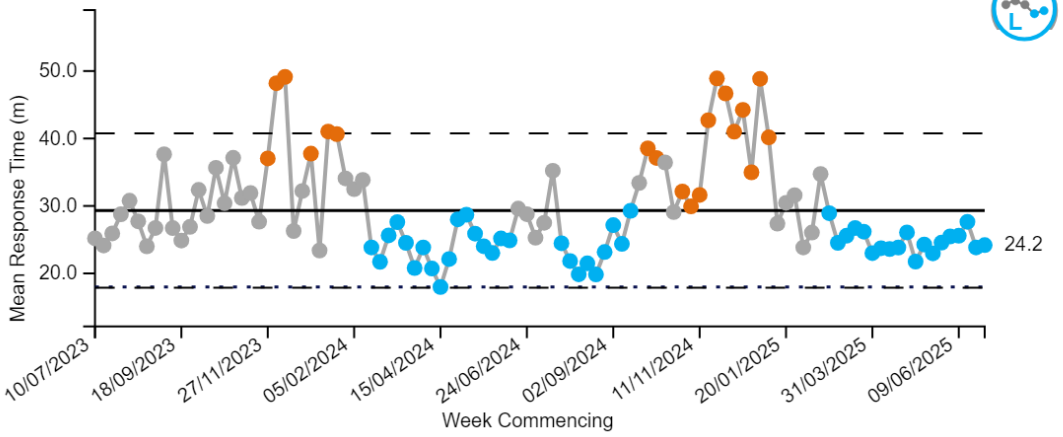
C1 90th by ICB	
North East & N...	00:16:31
Lancashire & So...	00:13:18
Cheshire & Mer...	00:12:21
Greater Manche...	00:11:19

C1 90th	
Target	00:15:00
Month	00:12:19
YTD	00:12:09
Ranking	3

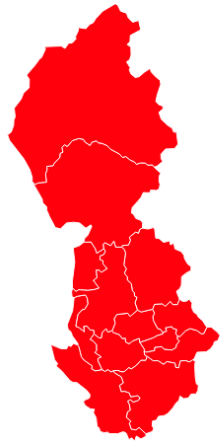
BAF ID SR03

O3 ARP Response Times

ARP C2 Mean



C2 Mean (Red => 18min)



C2 Mean by Sector

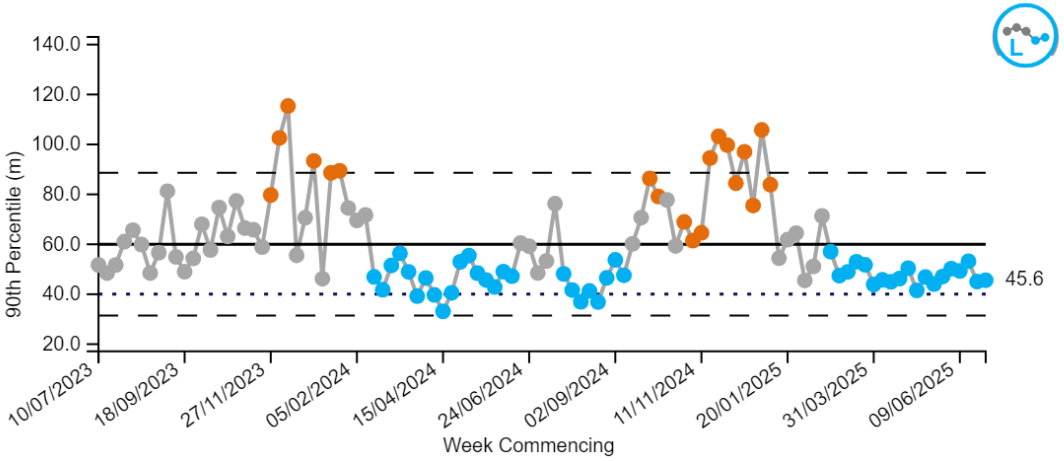
M West	00:31:18
M East	00:30:21
M South	00:30:20
M North	00:29:54
CL South Lancashire	00:26:02
CL North Cumbria	00:26:00
CL Morecambe Bay	00:25:39
G West	00:24:38
G East	00:24:22
CL Fylde	00:23:37
CL East Lancashire	00:21:49
G Central	00:21:23
G South	00:21:02

C2 Mean by ICB

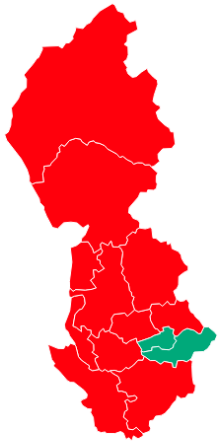
Cheshire & Mersey...	00:30:24
North East & Nort...	00:26:03
Lancashire & Sout...	00:24:07
Greater Manchester	00:22:42

C2 Mean	
Target (ARP)	00:18:00
Target (UEC)	00:28:00
Month	00:25:38
YTD	00:24:21
Ranking	3

ARP C2 90th



C2 90th (Red => 40min)



C2 90th by Sector

M West	01:01:40
M North	01:00:08
M South	00:59:55
M East	00:59:07
CL Morecambe Bay	00:52:09
CL North Cumbria	00:49:24
CL South Lancashire	00:48:23
G West	00:45:57
G East	00:45:30
CL Fylde	00:45:25
CL East Lancashire	00:40:23
G South	00:39:43
G Central	00:39:09

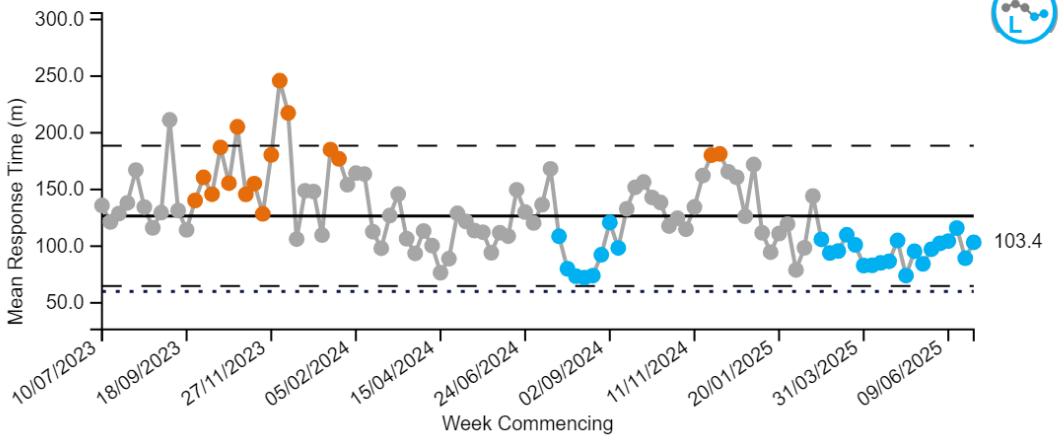
C2 90th by ICB

Cheshire & Mersey...	01:00:16
North East & Nort...	00:49:33
Lancashire & Sout...	00:46:16
Greater Manchester	00:42:31

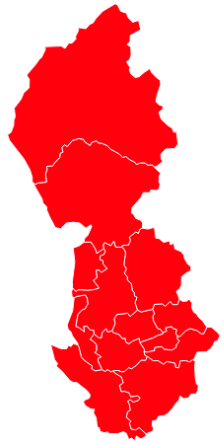
C2 90th	
Target	00:40:00
Month	00:49:39
YTD	00:46:56
Ranking	3

O3 ARP Response Times

ARP C3 Mean



C3 Mean (Red => 60min)



C3 Mean by Sector

M North	01:54:51
M East	01:53:13
G East	01:53:01
G Central	01:50:20
G West	01:50:02
M South	01:44:09
G South	01:41:32
M West	01:40:31
CL South Lancashire	01:35:39
CL Fylde	01:32:16
CL East Lancashire	01:26:02
CL Morecambe Bay	01:24:10
CL North Cumbria	01:24:03

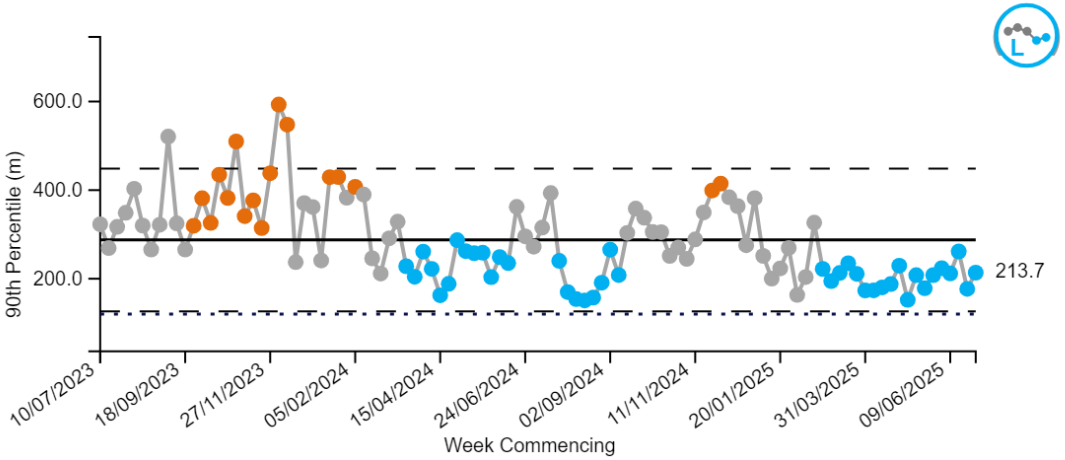
C3 Mean by ICB

Cheshire & Mersey...	01:48:51
Greater Manchester	01:48:43
Lancashire & Sout...	01:29:42
North East & Nort...	01:23:46

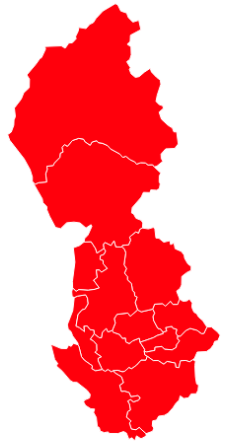
C3 Mean	
Target	00:60:00
Month	01:42:55
YTD	01:32:50
Ranking	5

O3 ARP Response Times

ARP C3 90th



C3 90th (Red => 2h)



C3 90th by Sector

M East	04:11:00
M North	03:58:42
G East	03:48:09
G West	03:47:52
G Central	03:41:38
M South	03:39:16
M West	03:31:31
G South	03:30:57
CL Fylde	03:28:50
CL South Lancashire	03:18:09
CL Morecambe Bay	03:07:05
CL East Lancashire	03:00:40
CL North Cumbria	02:59:34

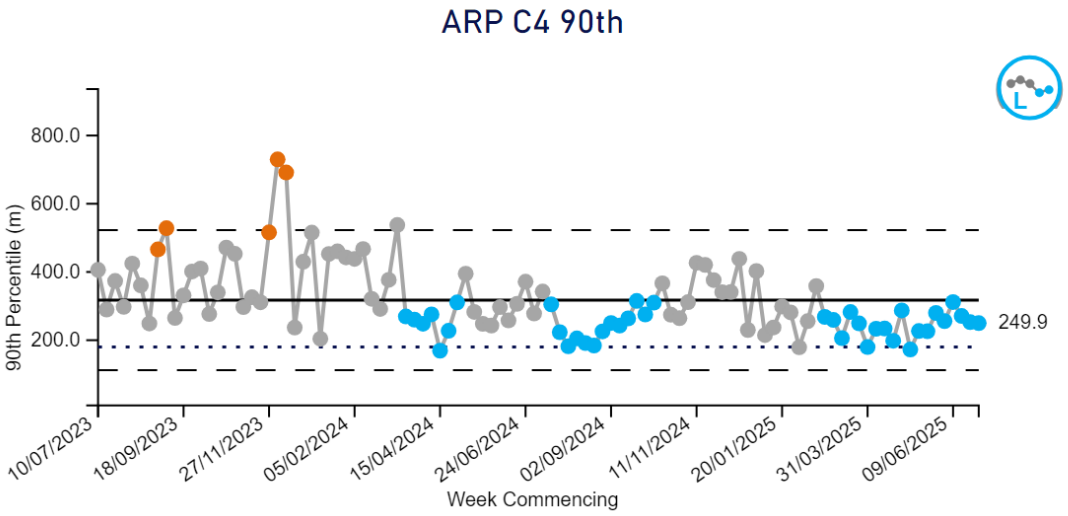
C3 90th by ICB

Cheshire & Mersey...	03:51:43
Greater Manchester	03:42:28
Lancashire & Sout...	03:13:28
North East & Nort...	02:59:20

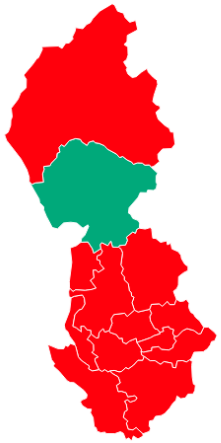
C3 90th	
Target	01:30:00
Month	03:37:39
YTD	03:17:59
Ranking	5

BAF ID SR03

O3 ARP Response Times



C4 90th (Red => 3h)



C4 90th by Sector

M North	05:55:27
CL South Lancashire	05:31:02
G Central	05:24:23
G West	05:06:11
CL Fylde	04:40:31
M East	04:35:02
M South	04:17:12
G South	04:10:47
G East	04:07:18
M West	03:37:02
CL East Lancashire	03:22:41
CL North Cumbria	03:21:00
CL Morecambe Bay	02:45:07

C4 90th by ICB

Greater Manchester	04:37:58
Cheshire & Mersey...	04:20:32
Lancashire & Sout...	04:10:45
North East & Nort...	03:21:00

C4 90th	
Target	03:00:00
Month	04:20:28
YTD	03:56:58
Ranking	4

Summary:

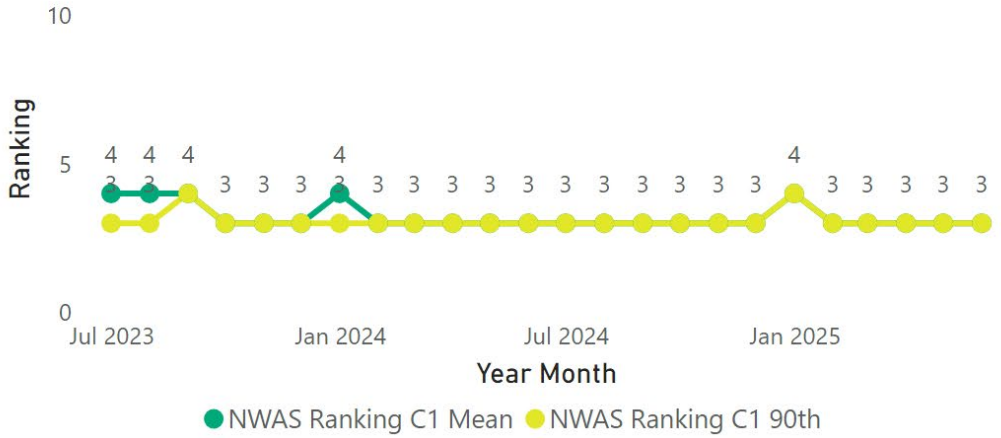
C1 90th is the only ARP standard that was achieved however all ARP metrics are in a sustained period of improvement. Cheshire and Merseyside ICB (CAM) have the slowest response times for C2-C4. For C2 it takes an average of 06m:51s longer for a C2 response in CAM (30m:19s) compared to the rest of the trust (23m:28s); hospital handover is a causal factor.

Action:

Ongoing reviews of the response model are supporting further improvements. This includes a review of inter-facility transfers (IFT) and healthcare professional (HCP) incidents, in which the trust is a national outlier, as well as a refreshed pre-alert process.

O3 ARP Provider Comparison

C1 Mean & 90th Percentile ranking over time



C2 Mean & 90th Percentile ranking over time

C1 Mean by Trust

North East	00:06:20
London	00:07:07
North West	00:07:15
Yorkshire	00:07:46
West Midlands	00:08:01
South East Coast	00:08:19
East Of England	00:08:28
South Central	00:08:36
Isle Of Wight	00:08:41
East Midlands	00:08:42
South Western	00:09:03

C1 90th by Trust

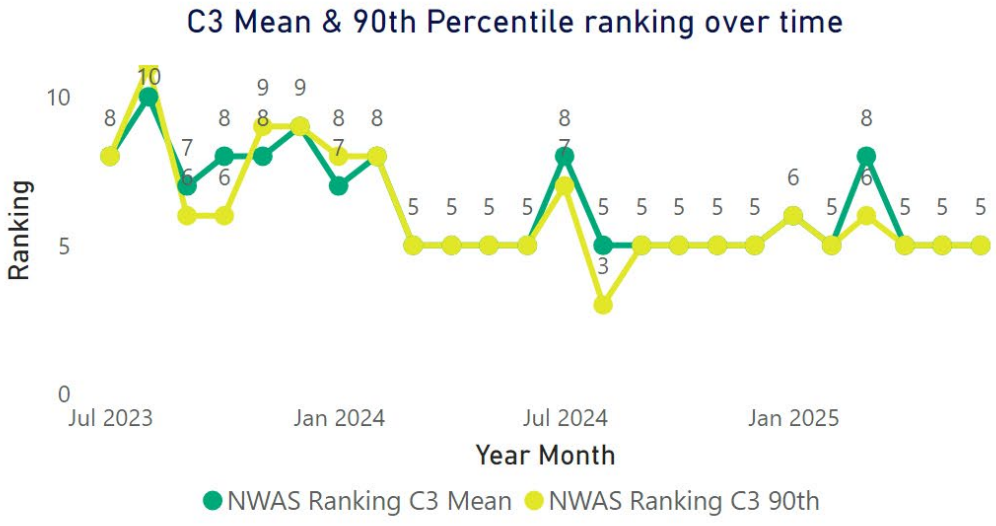
North East	00:10:55
London	00:12:14
North West	00:12:19
Yorkshire	00:13:25
West Midlands	00:14:15
East Midlands	00:15:20
South East Coast	00:15:23
South Central	00:15:31
East Of England	00:15:42
Isle Of Wight	00:16:35
South Western	00:17:04

C2 Mean by Trust

North East	00:21:27
West Midlands	00:22:42
North West	00:25:39
Yorkshire	00:26:33
Isle Of Wight	00:26:58
South Central	00:29:38
South East Coast	00:30:42
London	00:32:34
East Of England	00:32:51
East Midlands	00:35:02
South Western	00:35:31

C2 90th by Trust

North East	00:43:01
West Midlands	00:46:37
North West	00:49:39
Isle Of Wight	00:52:11
Yorkshire	00:56:11
South Central	00:56:57
South East Coast	01:01:02
London	01:07:55
East Of England	01:08:12
East Midlands	01:10:52
South Western	01:13:00



C3 Mean by Trust

North East	00:51:09
Isle Of Wight	01:18:30
Yorkshire	01:19:06
London	01:24:07
North West	01:42:46
East Of England	01:43:23
West Midlands	01:44:26
South Western	01:50:26
East Midlands	02:03:51
South East Coast	02:06:38
South Central	02:47:06

C3 90th by Trust

North East	01:55:46
Yorkshire	03:05:01
Isle Of Wight	03:13:09
London	03:16:36
North West	03:37:12
East Of England	04:03:31
West Midlands	04:10:42
South Western	04:13:32
South East Coast	04:49:25
East Midlands	04:52:42
South Central	05:46:01

C4 90th by Trust

North East	02:28:27
Yorkshire	02:57:46
Isle Of Wight	03:57:32
North West	04:15:41
South East Coast	04:55:58
East Midlands	05:11:17
London	05:28:49
West Midlands	06:36:55
South Western	06:47:09
East Of England	06:51:11
South Central	06:57:05

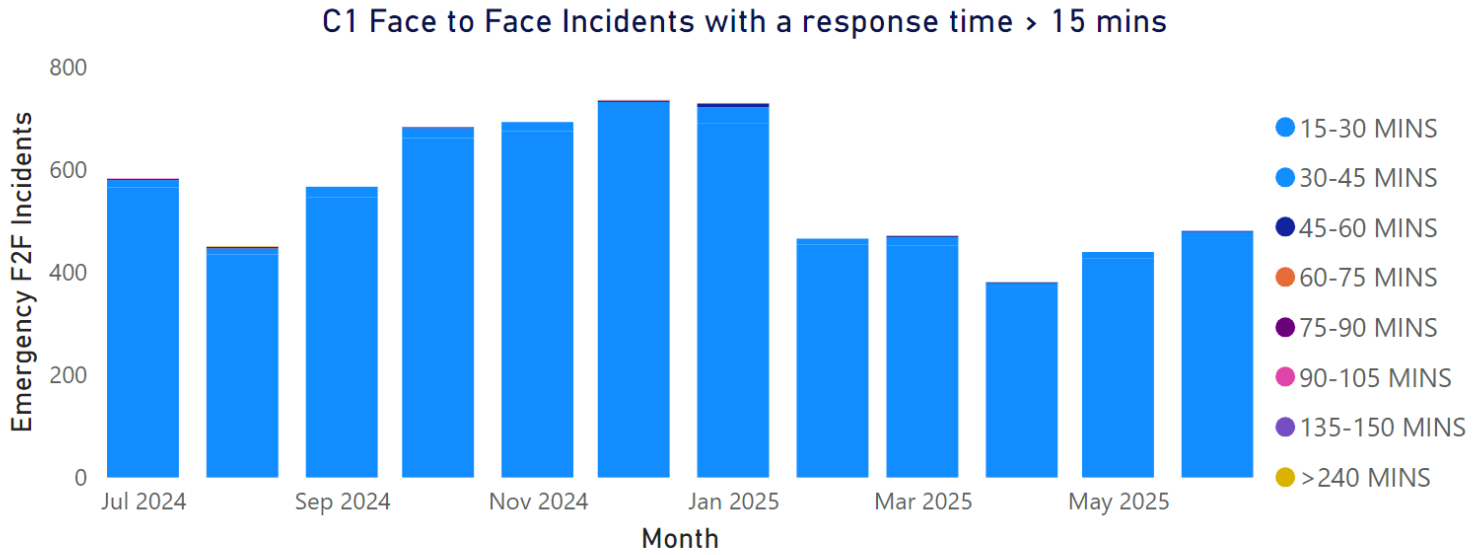
Summary:

The Trust remained third in the national rankings for C1 performance and improved to third for C2 performance

For lower acuity incidents, C3 performance remained 5th for Q1 and 4th .

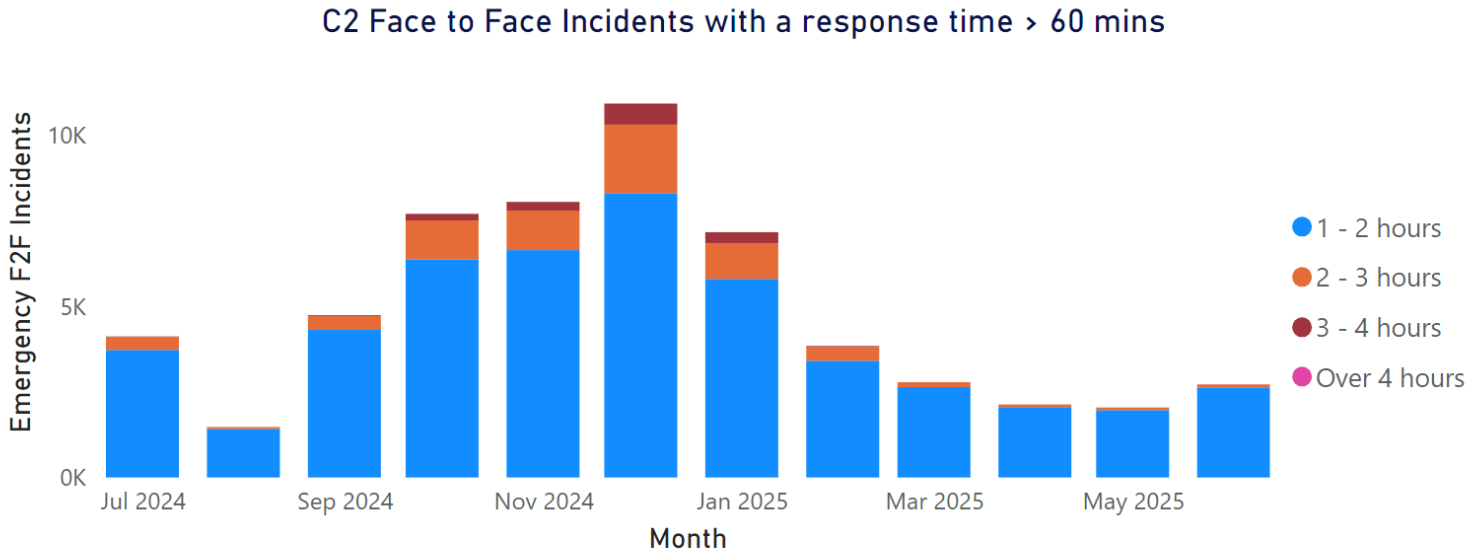
BAF ID SR03

O3 Long Waits C1



Month Year	Total No. of C1 Long Waits
Jul 2024	582
Aug 2024	450
Sep 2024	566
Oct 2024	682
Nov 2024	692
Dec 2024	735
Jan 2025	729
Feb 2025	465
Mar 2025	471
Apr 2025	380
May 2025	439
Jun 2025	480

O3 Long Waits C2



Month Year	Total No. of C2 Long Waits
Jul 2024	4,117
Aug 2024	1,473
Sep 2024	4,738
Oct 2024	7,699
Nov 2024	8,048
Dec 2024	10,920
Jan 2025	7,163
Feb 2025	3,840
Mar 2025	2,784
Apr 2025	2,132
May 2025	2,041
Jun 2025	2,719

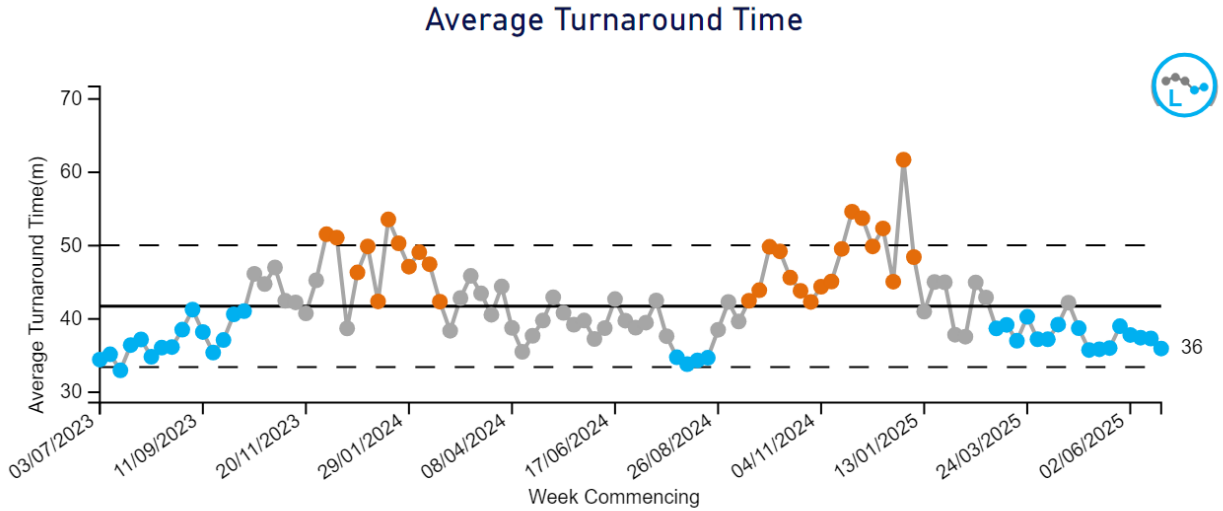
Summary:

Long waits were consistent with the pattern observed in the last two years. C2 long waits increased compared to May 25 and both data points are historically low.

Action:

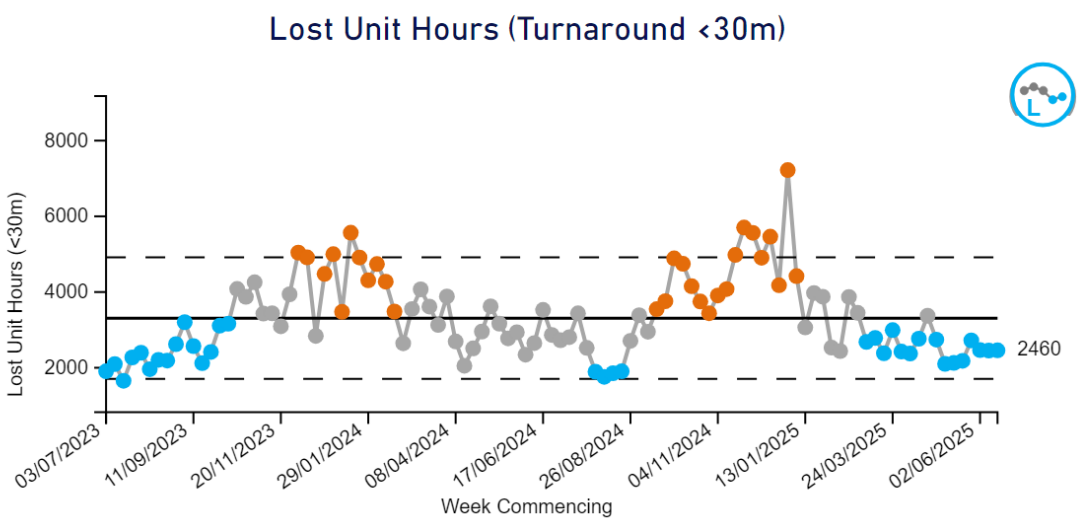
Continued monitoring by the Service Delivery Operational Performance Group.

O3 A&E Turnaround



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)
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	47,566	00:42:12	00:33:22	00:09:04
Oct 2024	49,175	00:46:46	00:38:06	00:08:56
Nov 2024	47,828	00:47:10	00:38:36	00:08:55
Dec 2024	49,454	00:51:07	00:42:22	00:08:59
Jan 2025	48,251	00:47:49	00:39:23	00:08:39
Feb 2025	44,053	00:41:08	00:32:24	00:08:51
Mar 2025	48,911	00:38:33	00:29:56	00:08:52
Apr 2025	47,340	00:39:14	00:30:35	00:08:56
May 2025	49,476	00:36:35	00:27:45	00:09:01
Jun 2025	45,915	00:37:11	00:28:14	00:09:11

O3 A&E Turnaround



Month	No. of patients waiting outside A&E for handover
Jun-24	1594
Jul-24	1851
Aug-24	989
Sep-24	1877
Oct-24	2681
Nov-24	2432
Dec-24	2392
Jan-25	1600
Feb-25	1179
Mar-25	1385
Apr-25	1638
May-25	1019
Jun-25	1008

Top 5 Trusts with most lost unit hours

Destination Short 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)
Royal Oldham	1,920	1222.31	01:01:29	00:54:10	00:08:52
Arrowe Park	1,945	650.39	00:45:28	00:35:56	00:09:53
Warrington	1,641	591.44	00:45:42	00:34:06	00:11:50
Royal Liverpool University	2,347	924.33	00:50:32	00:39:10	00:11:51
Aintree University	2,161	1224.80	00:58:03	00:46:29	00:12:00

Summary:

Turnaround (37m:11s) is stable, however continues to exceed the 30-minute standard.

Regional variation persists; during June turnaround in Cheshire and Mersey ICB (49m:33s) took 16m:29s minutes longer on average than the rest of the trust (33m:04s).

Action:

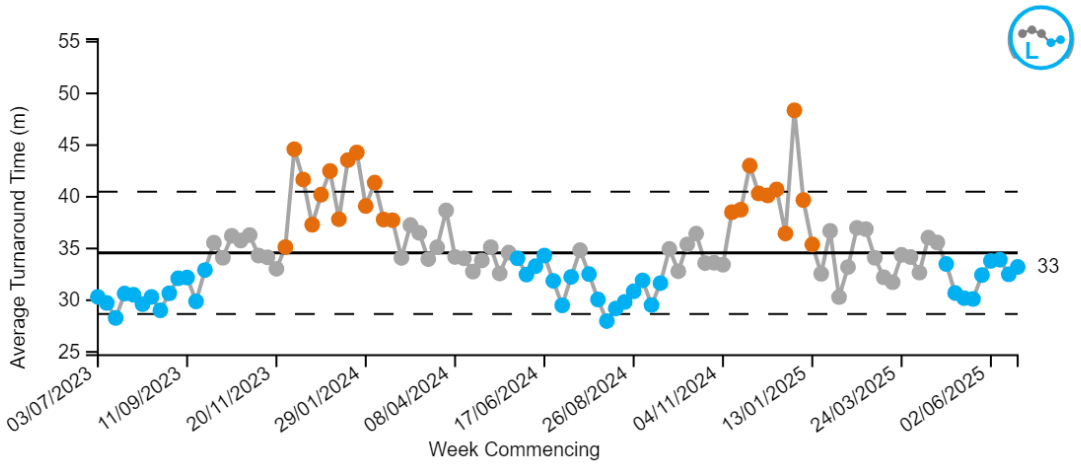
NHSE are leading (with ICB support) a new rapid release system where crews will be required to initiate a rapid handover of any patient waiting over 45 minutes outside ED.

Area Directors are supporting NHSE and the ICBs with coordination in their areas and sectors are engaged with local acute trusts.

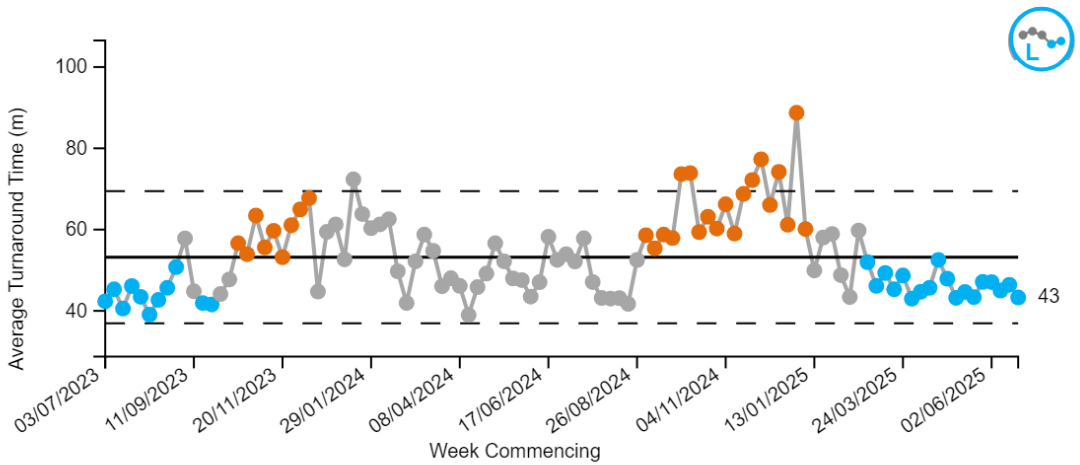
For context, the trust encountered 5,346 handovers over 45mins (11% of the total), this ratio has been maintained throughout Q1.

O3 A&E Turnaround by ICB

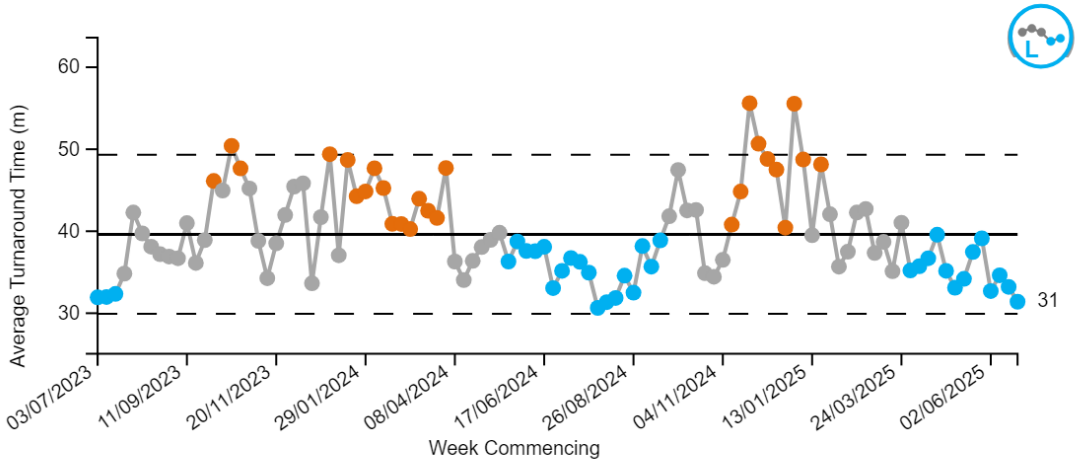
Average Turnaround Time - Greater Manchester ICB



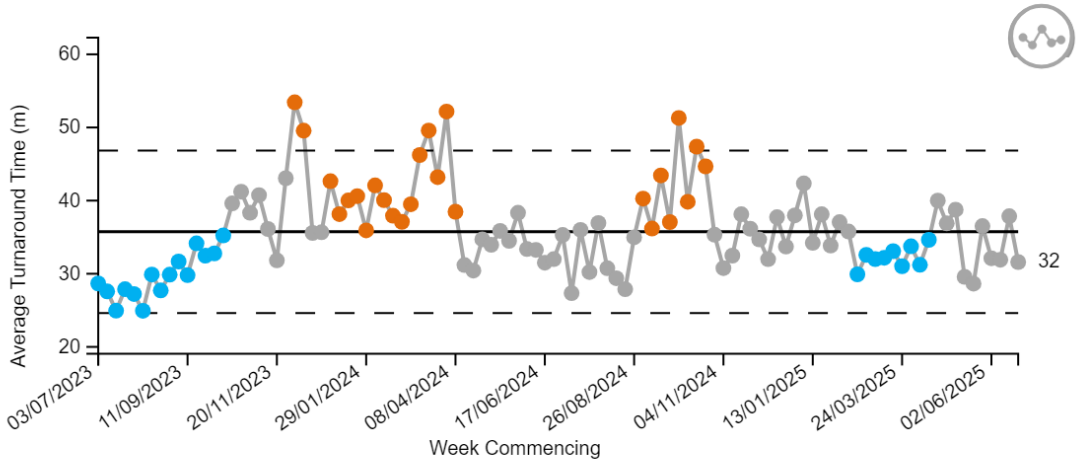
Average Turnaround Time - Cheshire & Mersey ICB



Average Turnaround Time - Lancashire & South Cumbria ICB

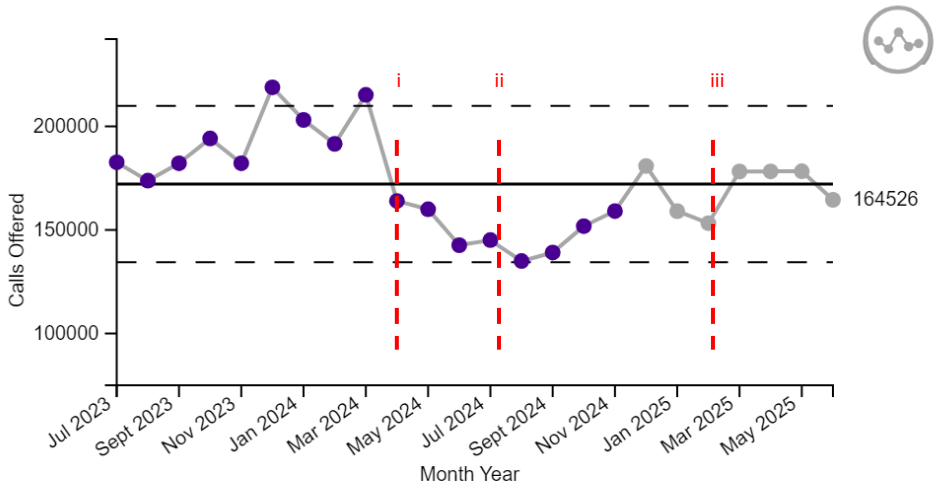


Average Turnaround Time - North East & North Cumbria ICB

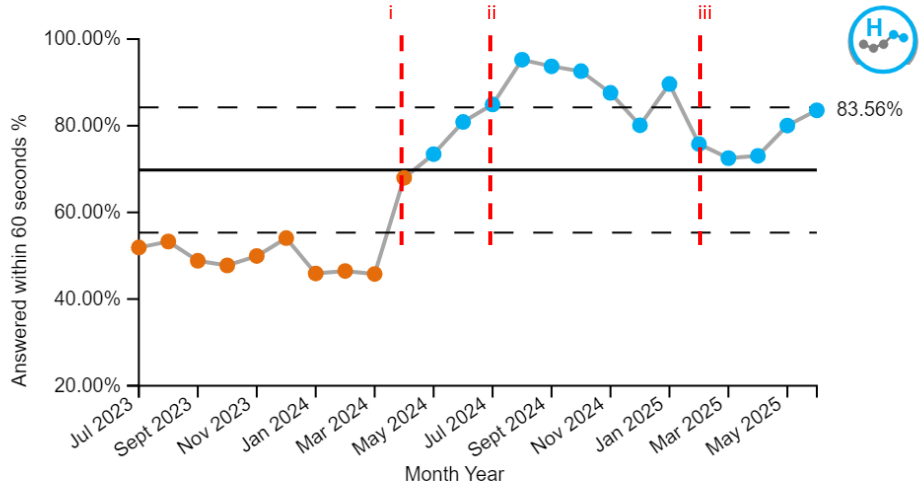


04 111 Activity & Performance

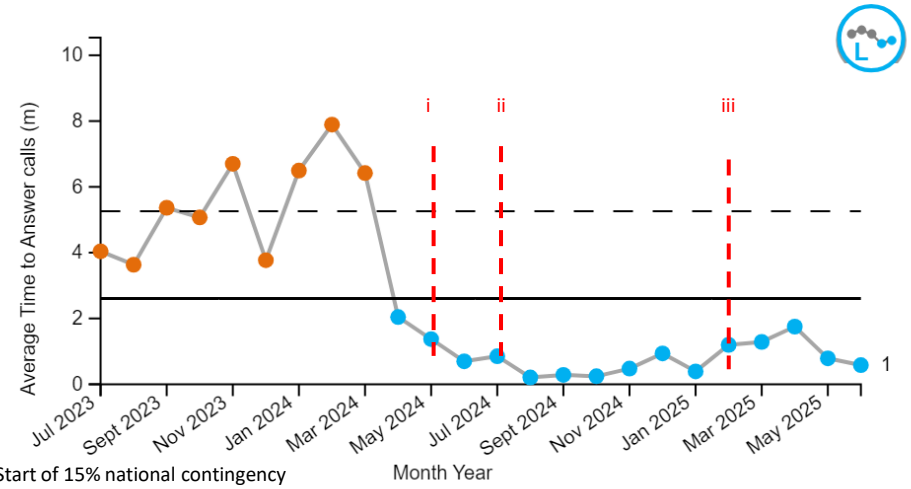
111 Calls Offered



Calls Answered within 60 seconds %



111 Average Call to Answer TIme



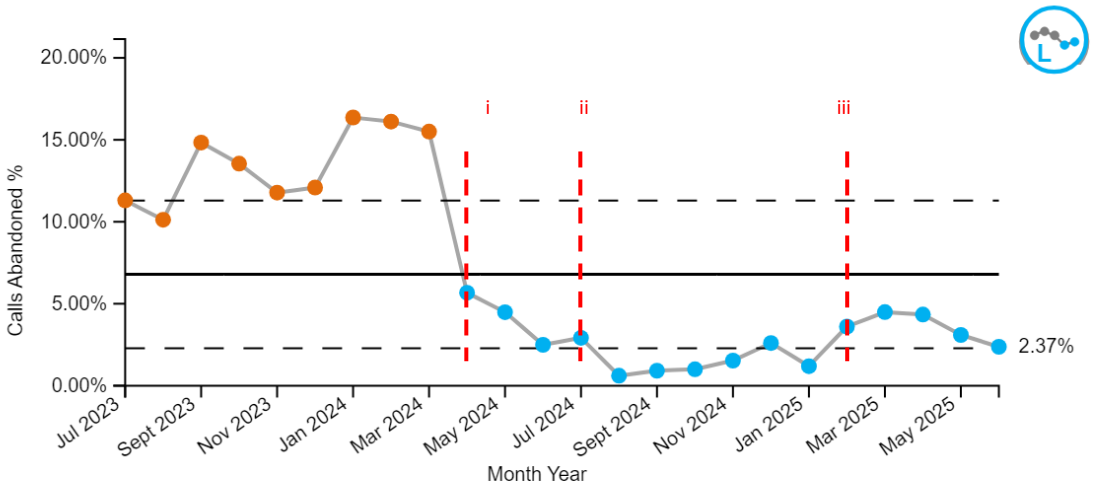
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency

Calls Offered	
Month	164.53K
YTD	521,104

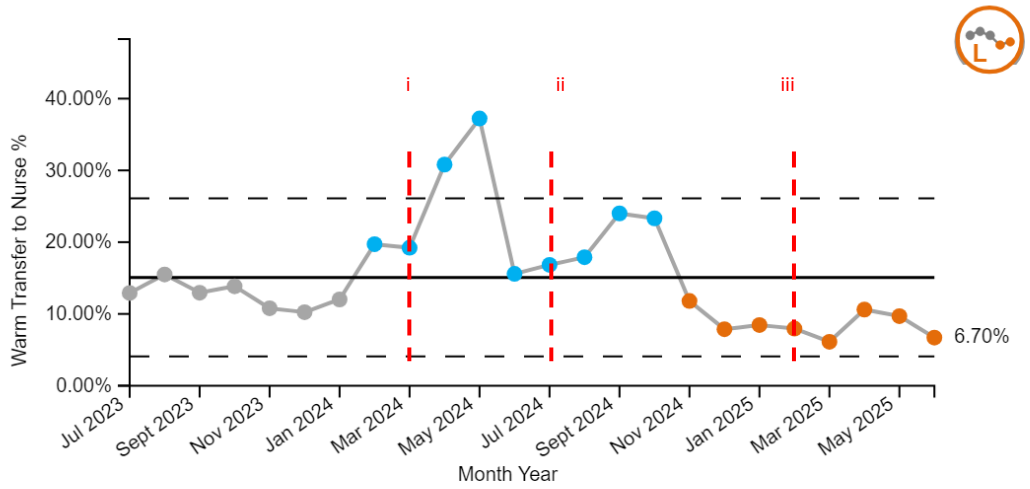
Calls Answered within 60 Seconds %	
Target	95%
Month	83.56%
YTD	78.8%
National	86.6%
Ranking	18

Average Call to Answer Time (s)	
Target	<20
Month	35
YTD	63
National	40
Ranking	17

111 Calls Abandoned %



Warm Transfer to Nurse When Required %



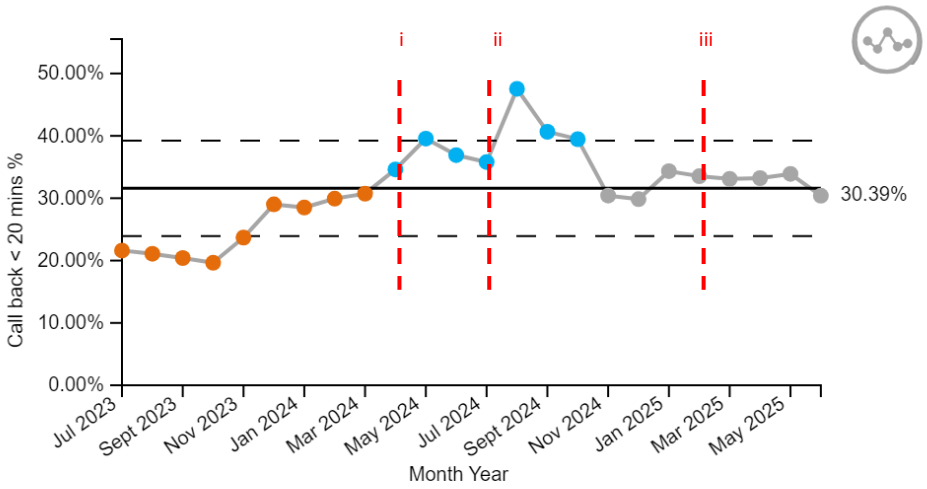
Calls Abandoned %	
Target	<5%
Month	2.37%
YTD	3.29%
National	2.6%
Ranking	18

Warm Transfer %	
Target	75%
Month	6.70%
YTD	9.05%

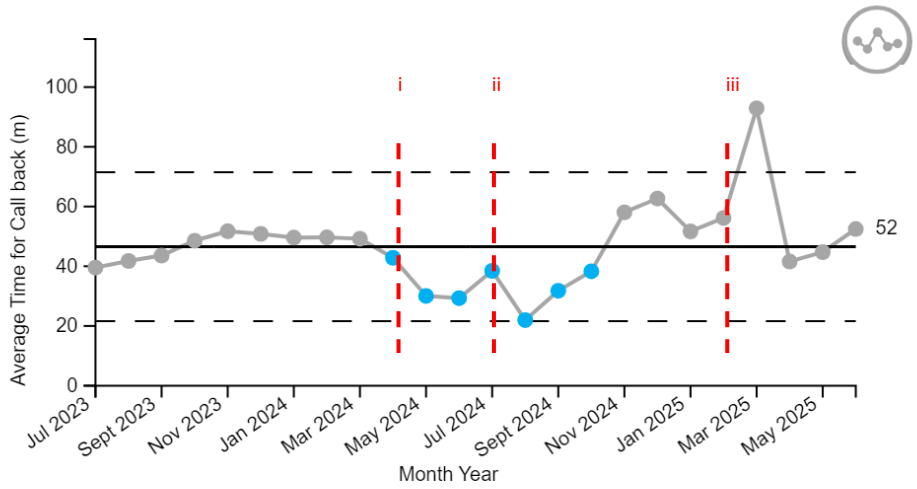
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency

BAF ID SR03

111 Call back <20 Minutes %



111 Average Time for Call Back



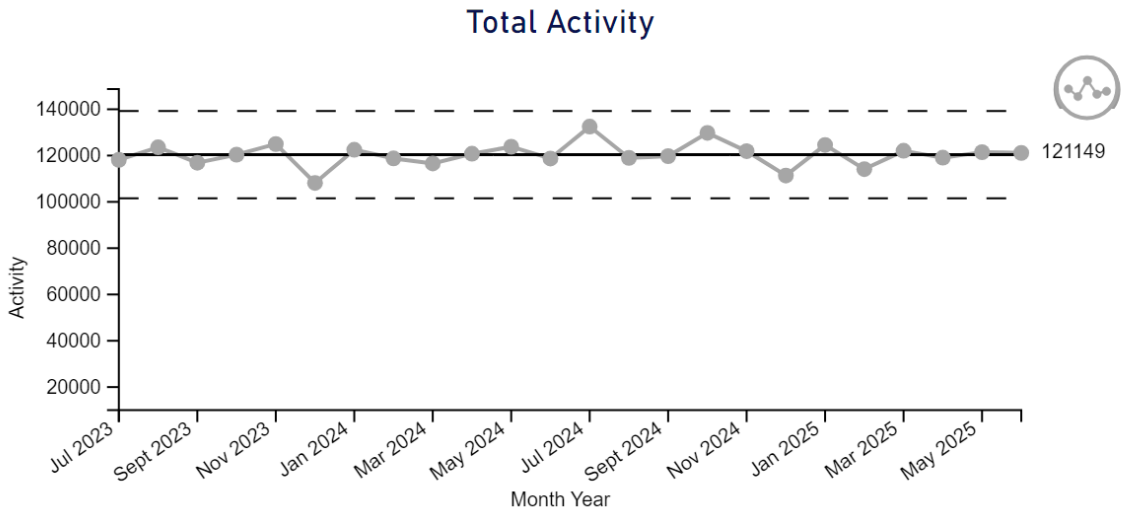
Call Back <20 (m)	
Target	90%
Month	30.39%
YTD	32.54%

Summary: Third party support (referred to as national contingency) ceased on 14 February 2025. Early indications show that calls levels are stable (within control limits), and call pick up performance is also stable, albeit below the national standard.

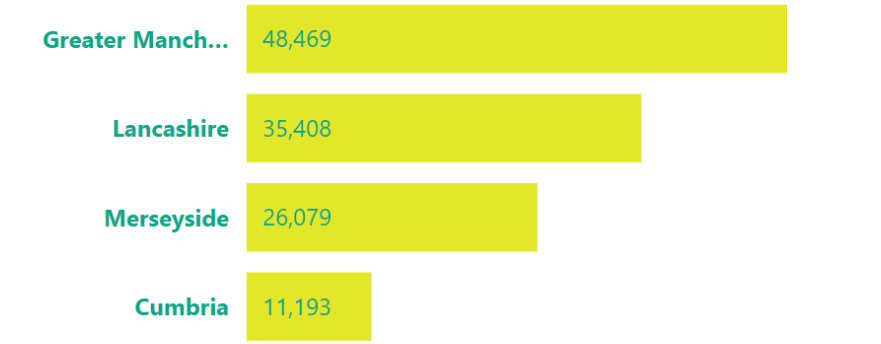
Actions: Continued monitoring post contingency changes.

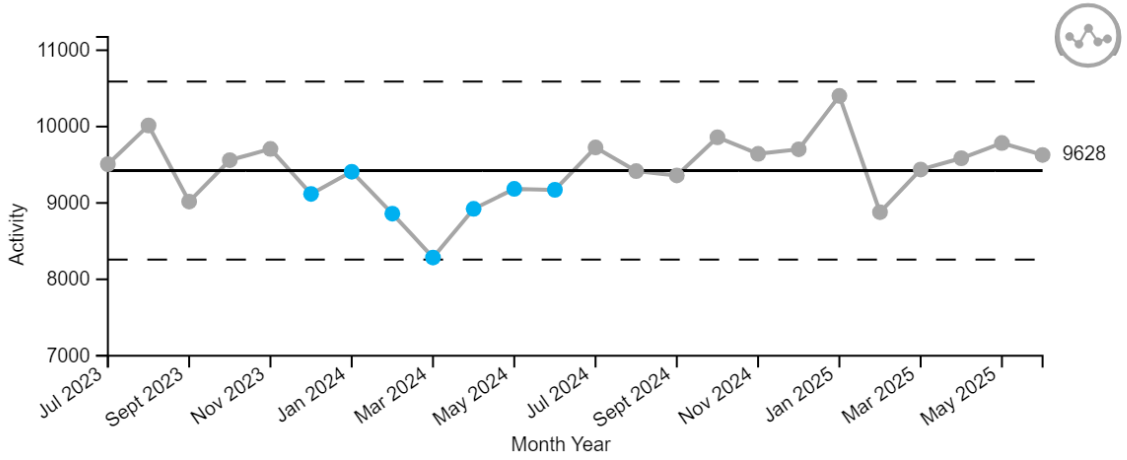
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency

05 PTS Activity

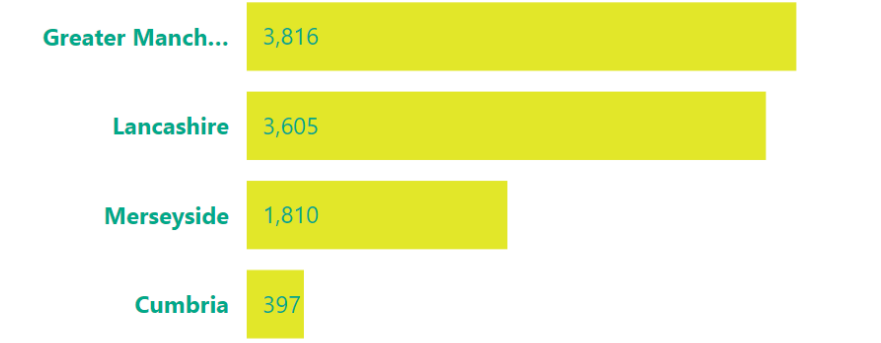


Total Activity by Contract

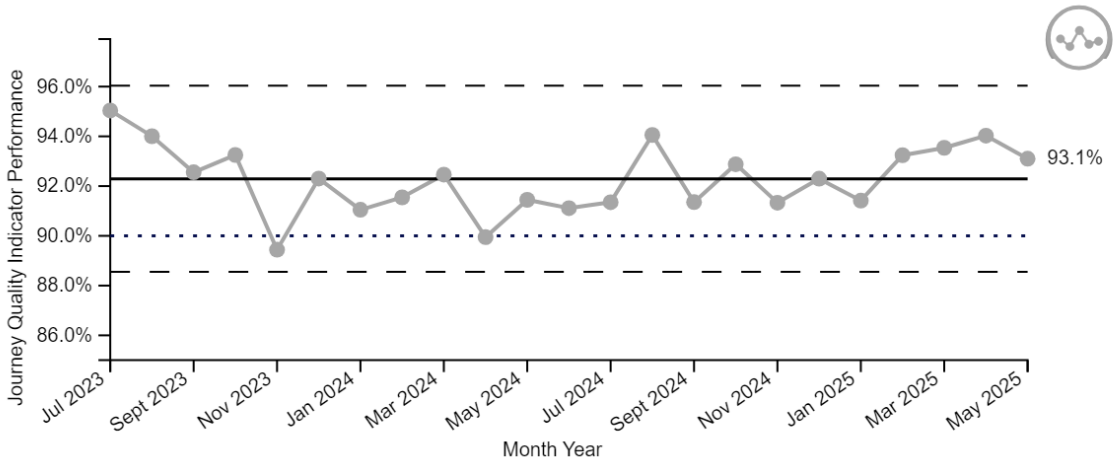




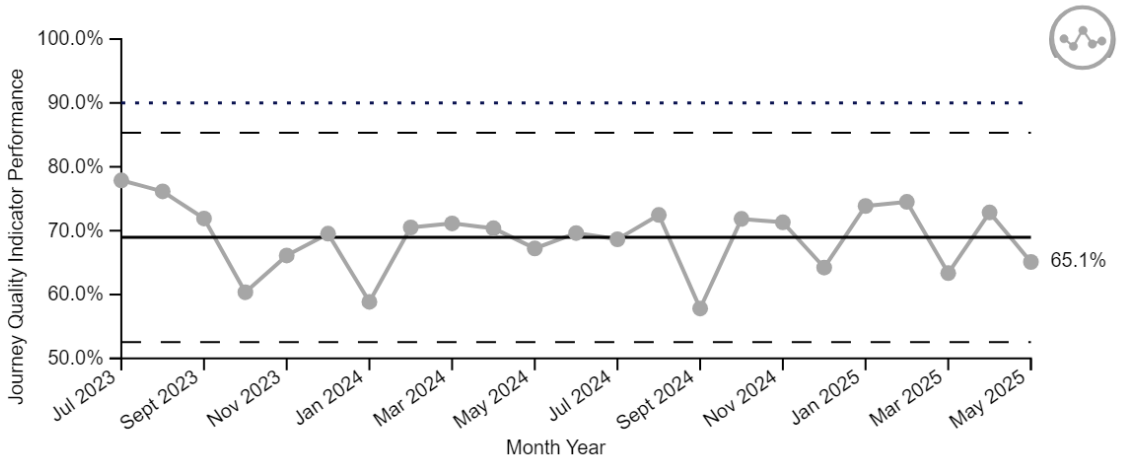
Unplanned Activity by Contract



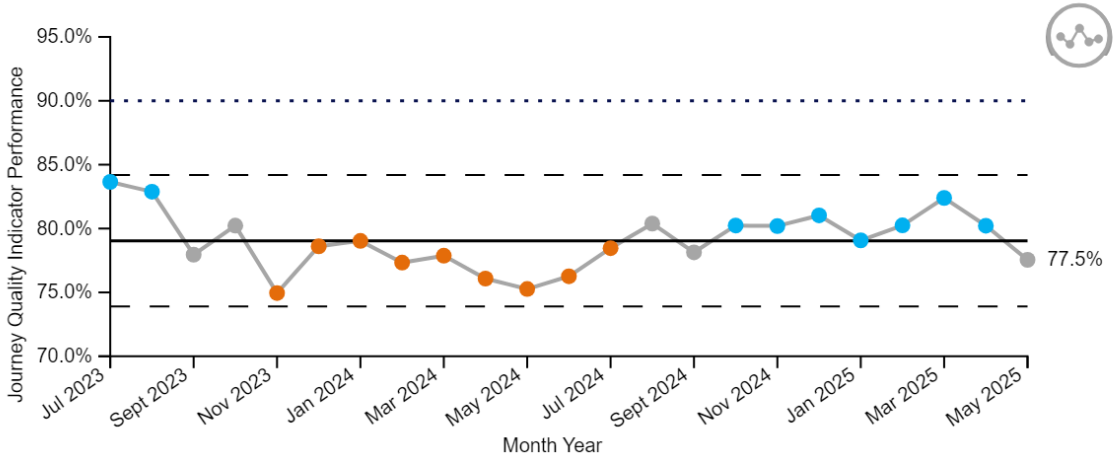
Collection after treatment (EPS) within 90 min



Collection after treatment (Unplanned) within 90 min



Collection after treatment (Planned) within 90 min



Summary: PTS activity metrics are stable. Planned and unplanned activity is currently below the 90% contract standard.

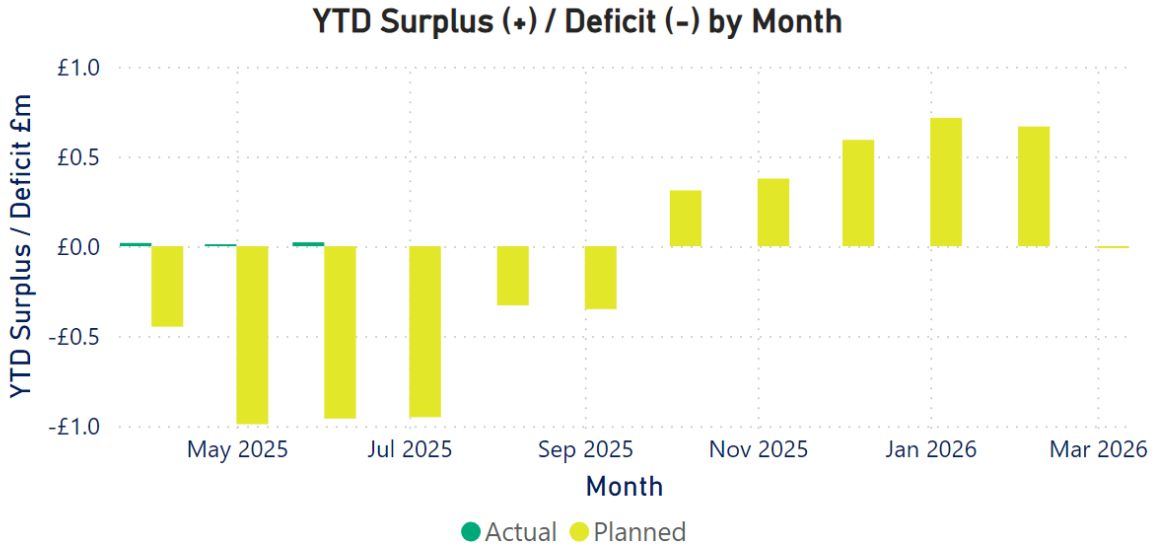
Only EPS achieved the collection after treatment target of 90%

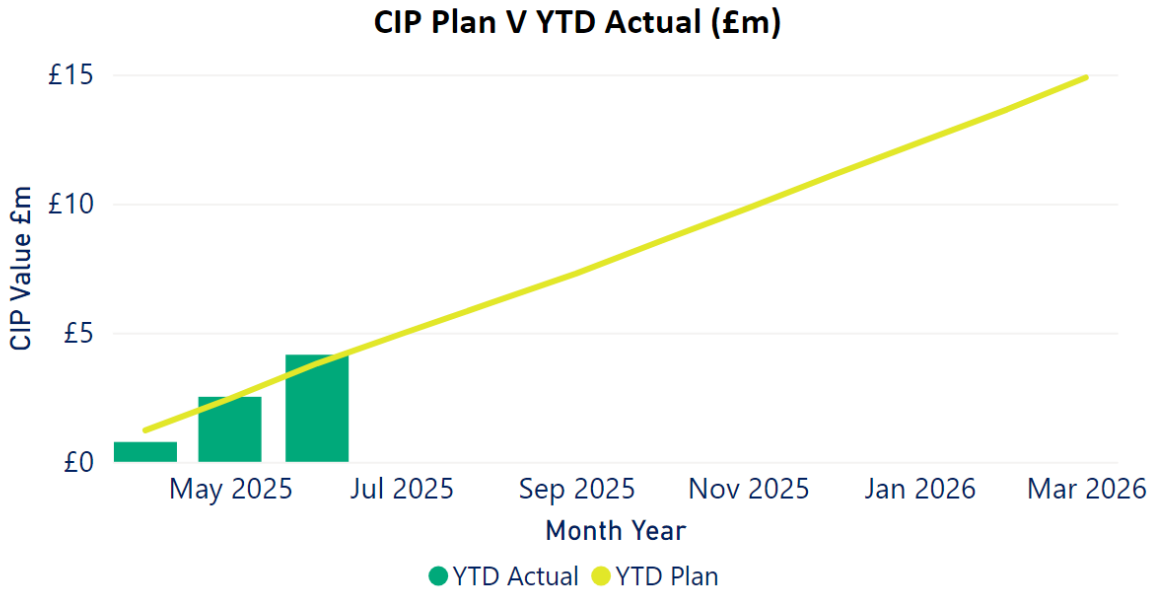
Actions: Operational and workforce improvement plans are in place.

Finance

F1 Financial Score

F1 Financial Score



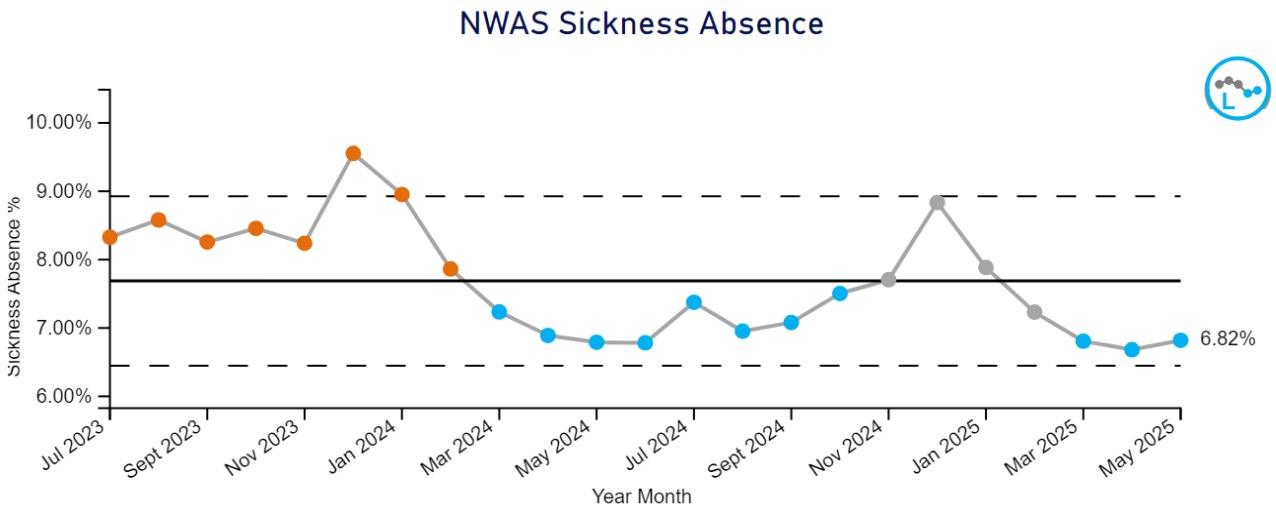


The year-to-date financial position to 30 June 2025 (Month 03 2025/26) is a surplus of £0.022m, compared to a planned deficit due to lower than anticipated pay costs, and the delivery of productivity and efficiency savings slightly above plan.

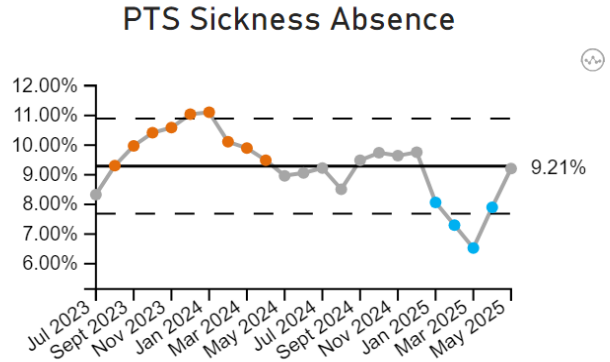
Organisational Health

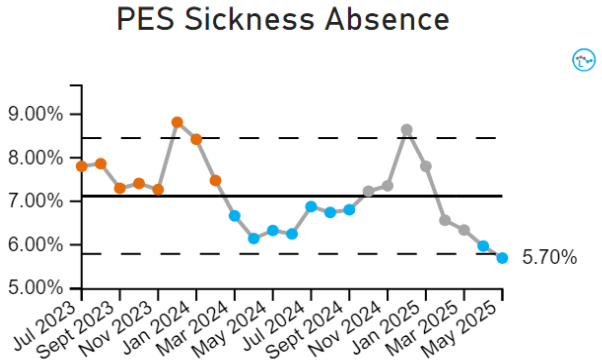
OH1 Staff Sickness
OH2 Staff Turnover
OH5 Vacancy Gap
OH6 Appraisals
OH7 Mandatory Training
OH8 Case Management

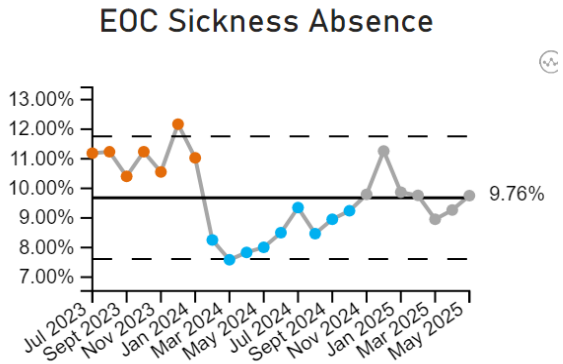
OH1 Staff Sickness

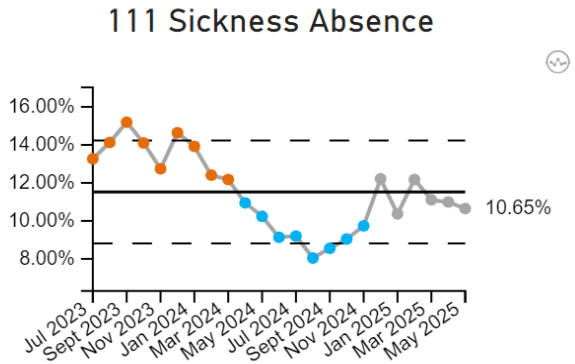


Month	NWAS	Amb. National Average
Jul 2024	7.38%	6.80%
Aug 2024	6.95%	6.40%
Sep 2024	7.08%	6.50%
Oct 2024	7.50%	6.80%
Nov 2024	7.71%	7.20%
Dec 2024	8.83%	8.30%
Jan 2025	7.88%	7.70%
Feb 2025	7.23%	6.90%
Mar 2025	6.81%	
Apr 2025	6.68%	
May 2025	6.82%	







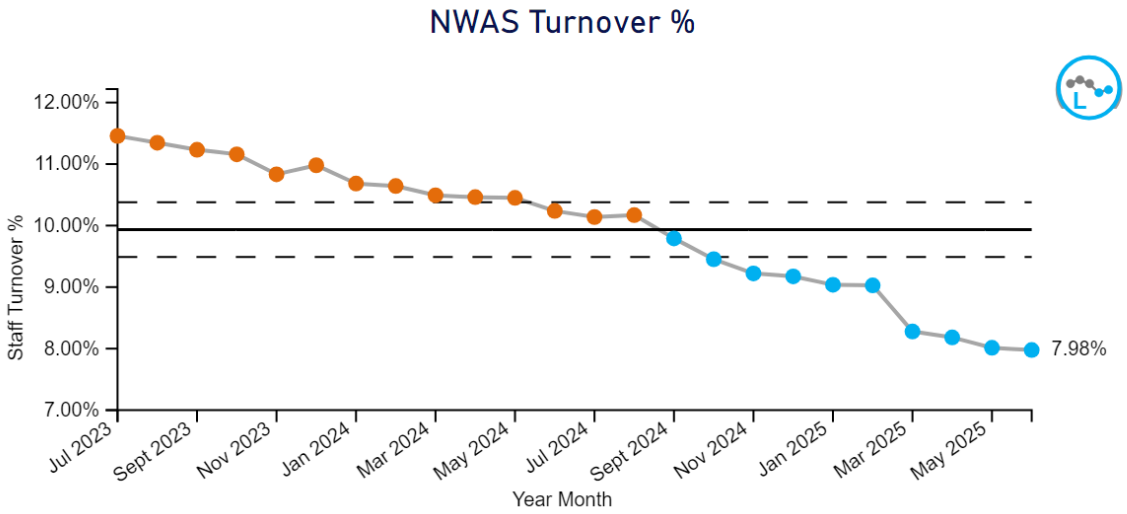


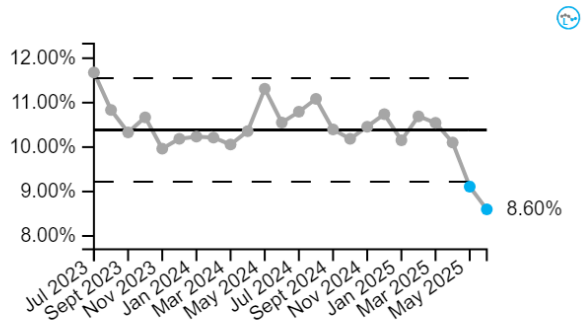
April (6.68%) and May (6.82%) sickness absence is broadly consistent with the position at the same time last year in 24/25. PTS has seen 2 consecutive months rising to 9.21% in May. There is a supply issue with the national data but the gap to sector average is narrowing and as a Trust we continue to move closer to the average.

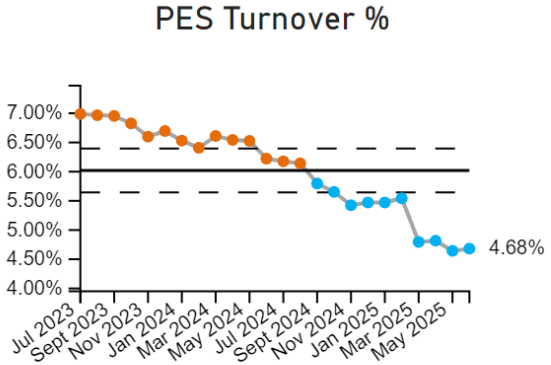
The 25/26 improvement target set in the operating plan is to deliver a reduction of cumulative absence of 0.65%. Additional assurance on AIT plans is being sought. Revised sickness policy with supporting resources launched 1st July.

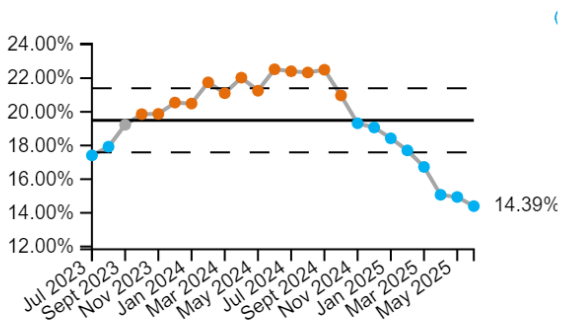
OH2 Staff Turnover

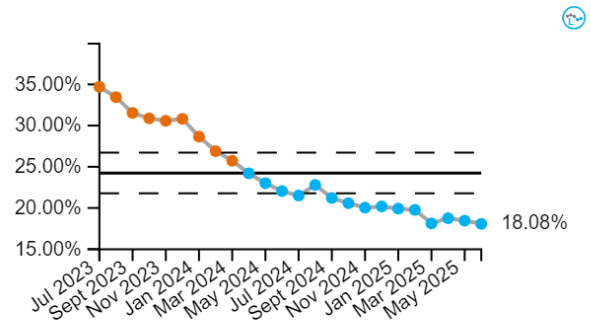
Month	NWAS	Amb. National Average
Jul 2024	10.14%	9.13%
Aug 2024	10.17%	9.13%
Sep 2024	9.79%	8.92%
Oct 2024	9.45%	9.03%
Nov 2024	9.22%	9.03%
Dec 2024	9.17%	8.84%
Jan 2025	9.04%	9.05%
Feb 2025	9.03%	9.15%
Mar 2025	8.28%	9.08%
Apr 2025	8.18%	
May 2025	8.01%	
Jun 2025	7.98%	





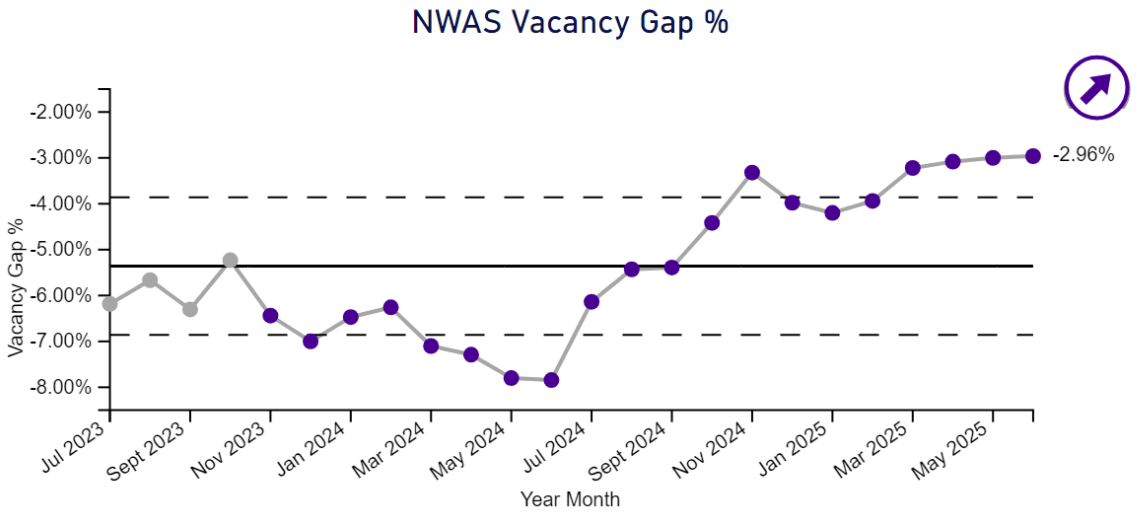




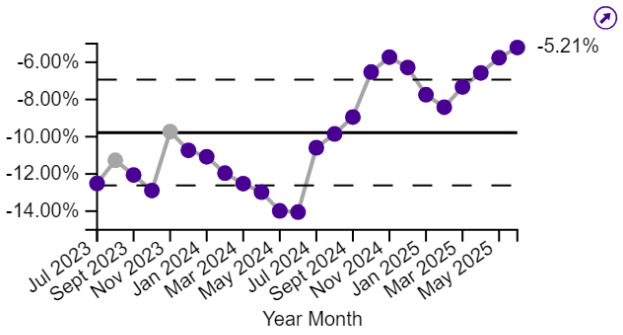


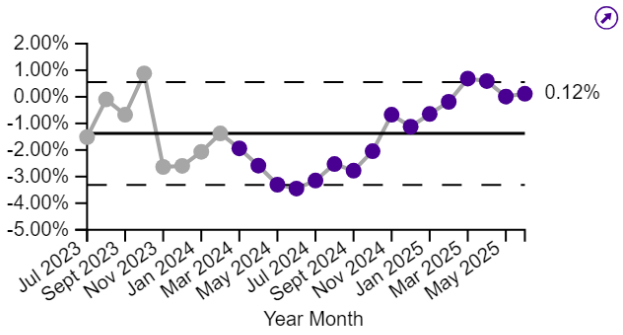
Overall turnover is reducing and below sector average. The position in June 25 was 7.98%. EOC turnover was 14.39% for June 25 and is now showing consistent improvement since 22.25% in September. Improvements plans in ICC remain in place. It remains the case that ICC and PTS are the service lines under most pressure and are those with the lowest graded positions i.e. call handling and care assistants. PES turnover has been steadily reducing since August and is currently at 4.68%. Overall turnover for PES remains lower than other service lines.

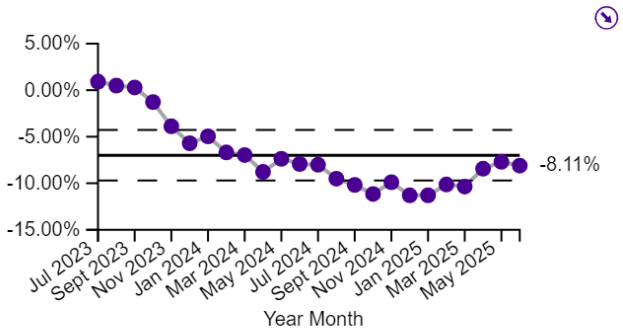
OH5 Vacancy Gap

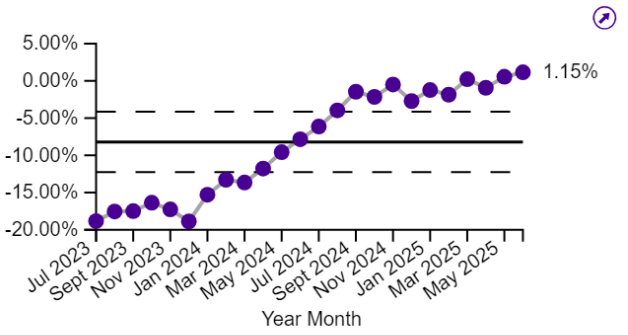


Month	NWAS Total % Vacancy Gap
Jul 2024	-6.14%
Aug 2024	-5.43%
Sep 2024	-5.39%
Oct 2024	-4.42%
Nov 2024	-3.32%
Dec 2024	-3.98%
Jan 2025	-4.20%
Feb 2025	-3.94%
Mar 2025	-3.22%
Apr 2025	-3.08%
May 2025	-3.00%
Jun 2025	-2.96%



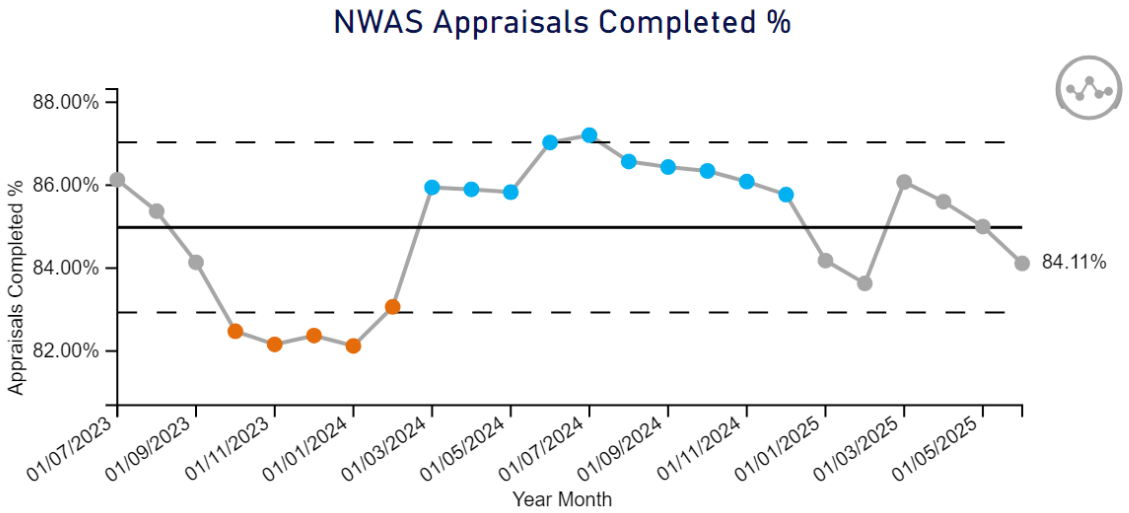




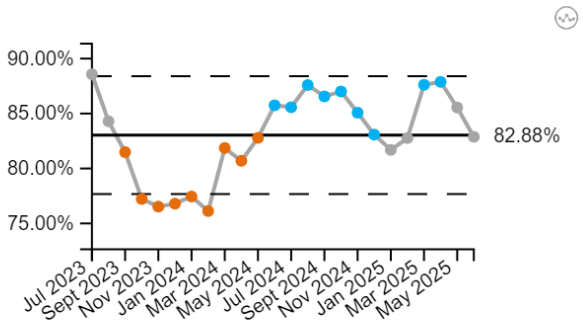


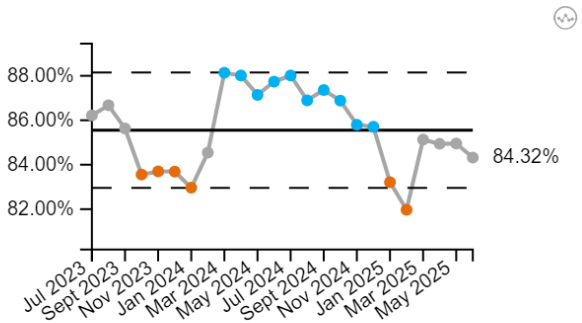
The vacancy position for the Trust is at –2.96% for June 2025 remains stable. The EOC position indicates an under-establishment of –8.11% and an improvement from the December 2024 position of -11.31% but remains overstated pending revision of establishments within ICC for 25/26. The vacancy position in 111 is 1.15% over-established and reflects the general positive trend over the last 12 months and a significant improvement on position in April 2024 of – 7.84%. PES show a slight over-establishment of 0.12%. There is an under establishment within EMT 1s and this is balanced off by an over establishment of Paramedics. UEC growth will go into establishments from autumn. Recruitment plans on track.

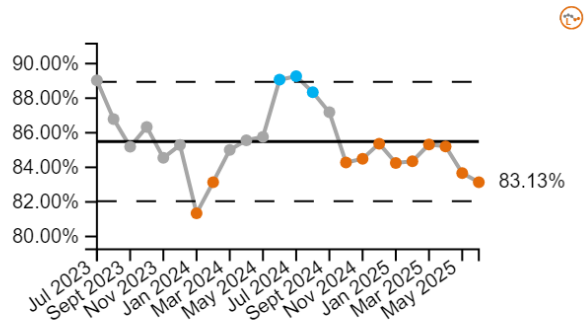
OH6 Appraisals

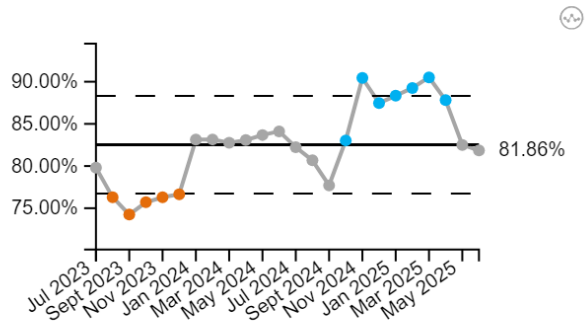


Month	NWAS Total % Complete Appraisals
Jul 2024	87.21%
Aug 2024	86.57%
Sep 2024	86.44%
Oct 2024	86.34%
Nov 2024	86.09%
Dec 2024	85.77%
Jan 2025	84.18%
Feb 2025	83.63%
Mar 2025	86.08%
Apr 2025	85.60%
May 2025	85.00%
Jun 2025	84.11%





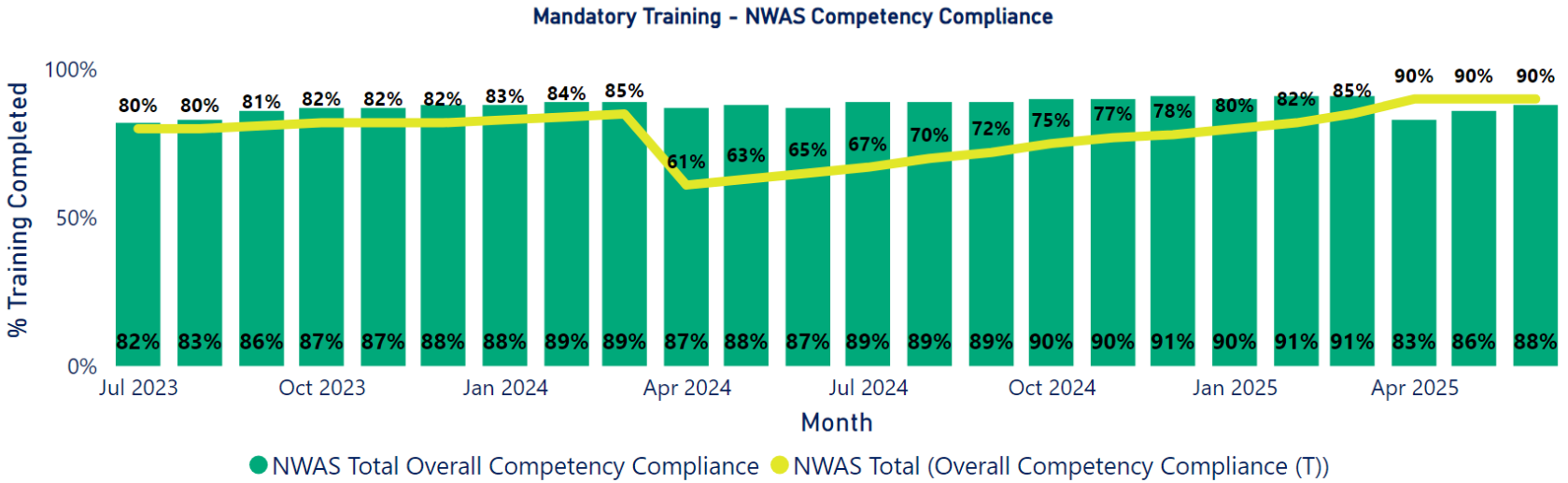


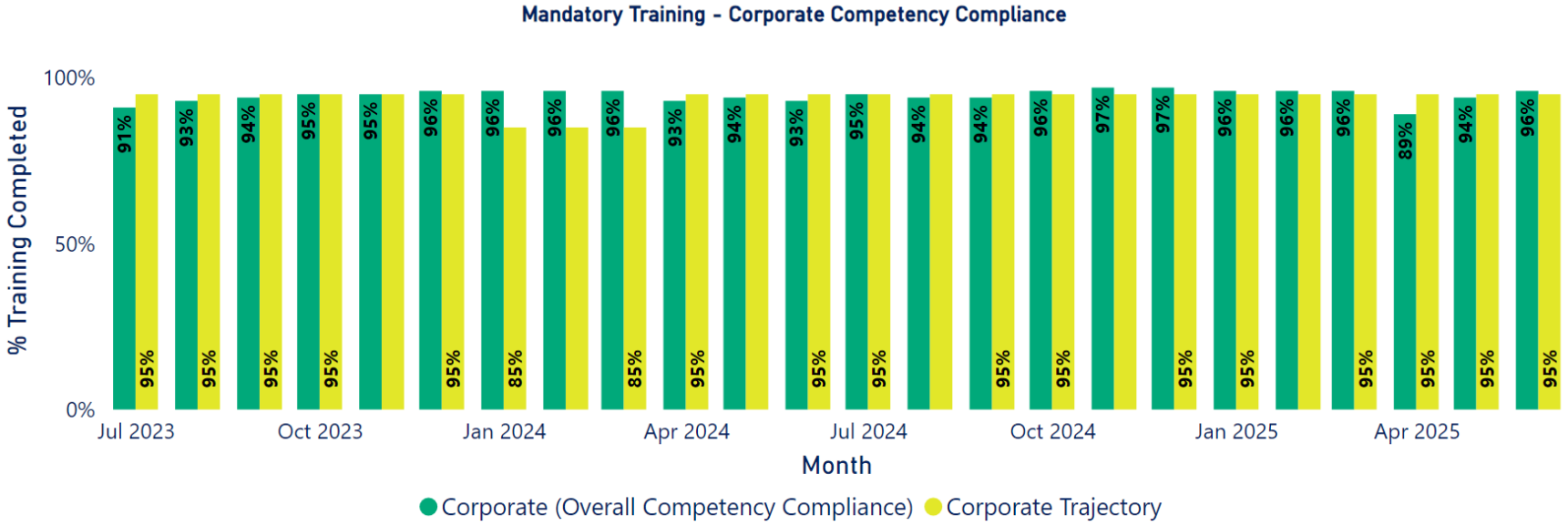


Appraisal completion rates are at 84% for June 2025, which is slightly behind target for the Trust. Targets for 2025/26 are 85% overall with expectations that leadership and corporate compliance should be at 90%. There is variation across service lines but overall there has been a slight drop in performance, with all service lines slightly below target. Corporate appraisal compliance is at 88%, slightly below target of 90%. A new digital tool for capturing appraisals is being rolled out across the Trust with an audit underway to ensure reporting accuracy between this system and ESR.

BAF ID SR05

OH7 Mandatory Training



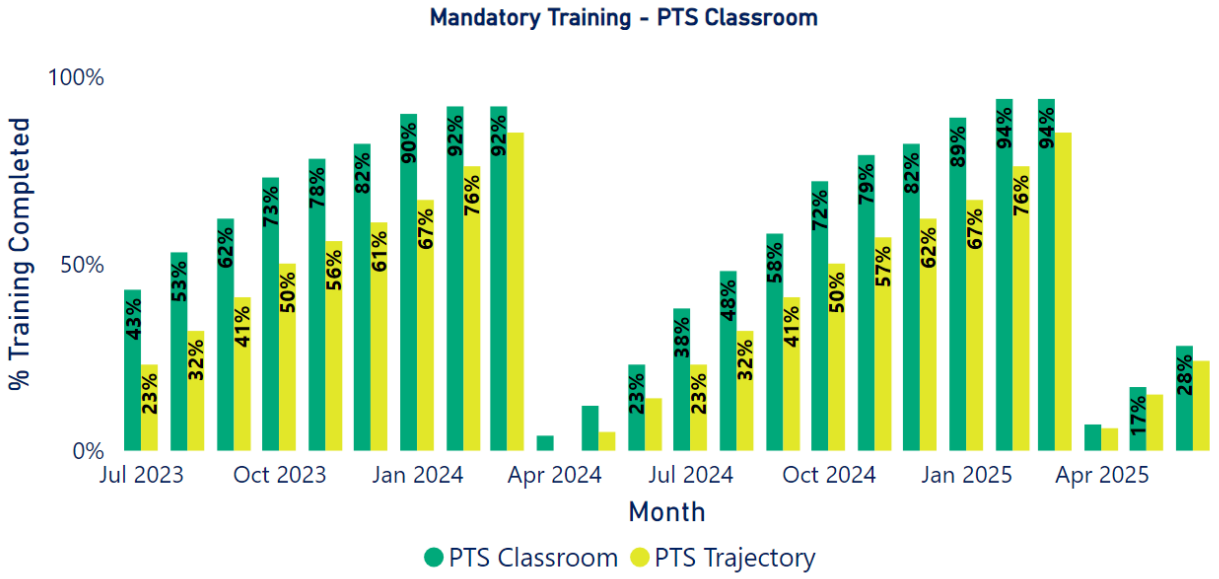


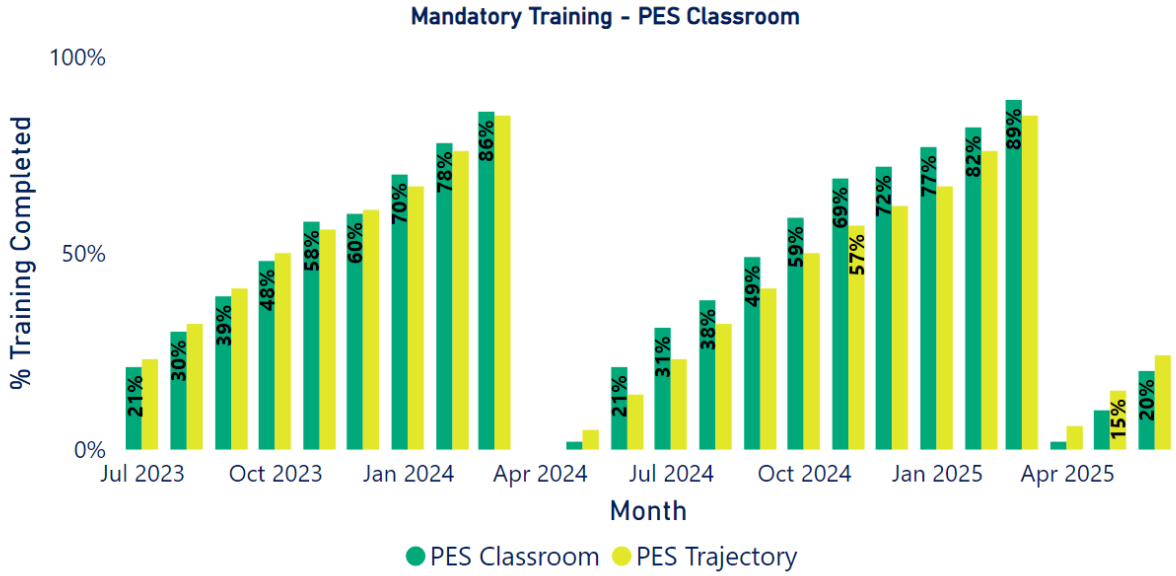
NWAS overall compliance is 88% which is slightly behind the revised 90% target. This represents a combination of face to face and online completions.

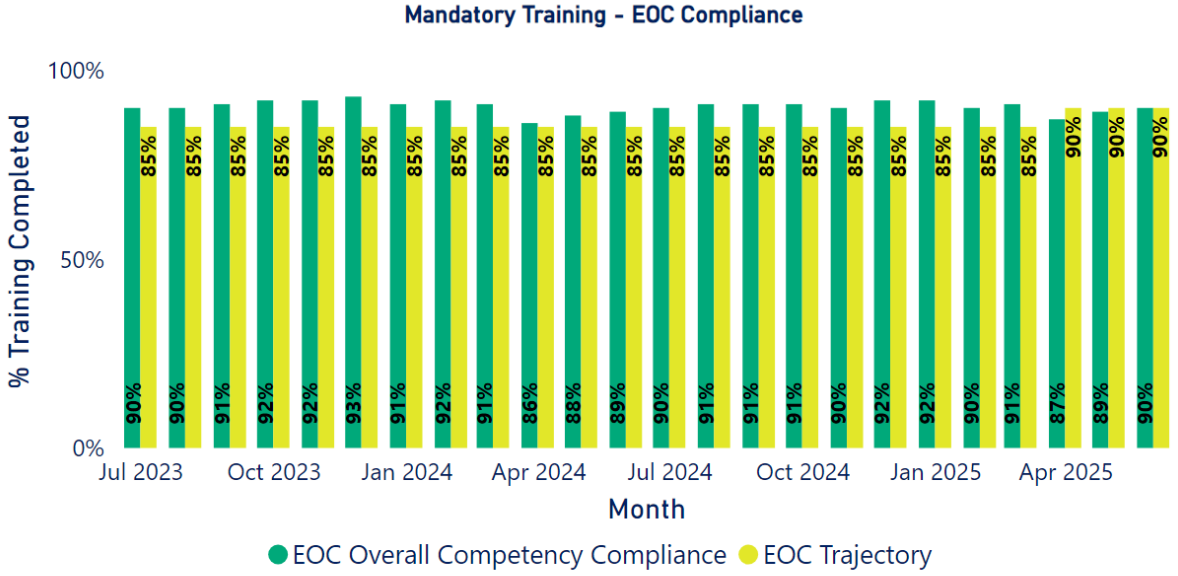
Additional modules have been added to ESR which has impacted on compliance in Q1, however the position is expected to recover in year. PTS classroom training is ahead of trajectory. PES are slightly behind trajectory. Corporate teams are now ahead of trajectory at 96%.

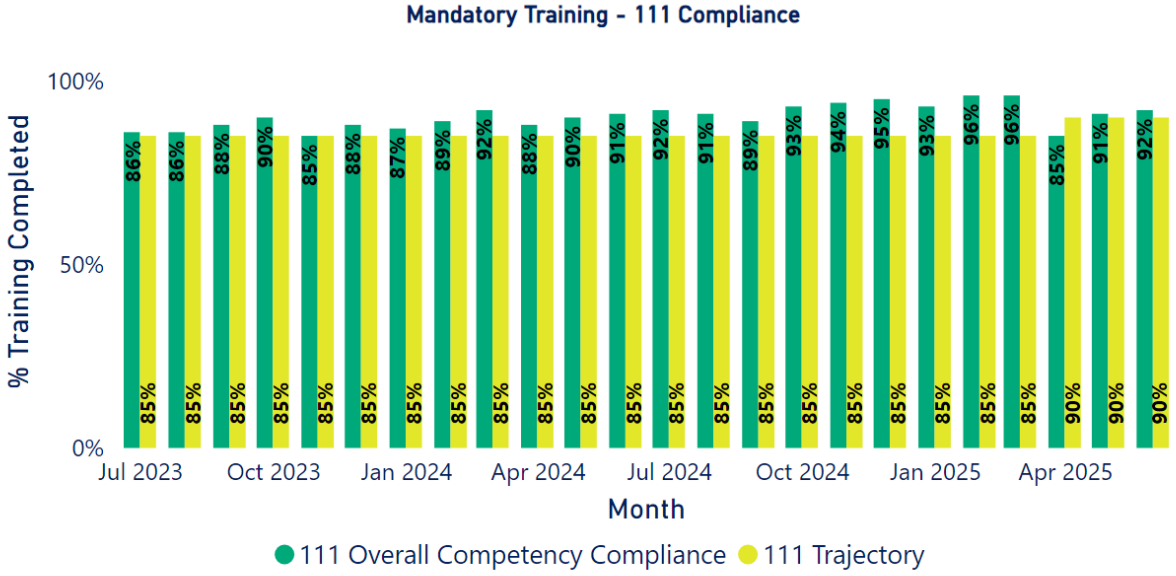
BAF ID SR05 Risk Rating NA Strategy Goal NA

OH7 Mandatory Training









BAF ID SR05 Risk Rating NA Strategy Goal NA

OH8 Case Management

Board Reportable Events relating to Employee Relations July 2025

Data correct to 7th July 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	65.00	1.6	274.00	6.7	13.94
CAM PES	25.00	1.8	92.00	6.6	12.52
CAL PES	17.00	1.3	98.00	7.7	13.15
GM PES	23.00	1.6	77.00	5.4	15.62
Operations ~ EOC	14.00	1.2	75.00	6.6	9.37
Operations ~ 111	15.00	2.2	85.00	12.2	6.83
Operations ~ PTS	22.00	2.5	77.00	8.7	9.51
Operations ~ Resilience	1.00	0.7	4.00	2.8	9.50
Corporate	12.00	2.1	22.00	3.8	13.96
Other	0.00		0.00		
NWAS Summary	129.00	1.7	537.00	7.1	11.51

Other * - This included a number of incidents with several staff members involved, making it impossible to attribute them to a certain sector.

Case Type Summary

Case Type	Number of Live cases	Number of cases closed in last 12 months	Average length of time (weeks) taken to close ER cases in last 12 months
Dignity at Work	15	58	12.47
Disciplinary	62	181	20.69
Fast Track	3	52	10.8
Fact Finding	31	185	5.04
Grievance	21	113	6.88
Case Summary	129	537	11.51

Case Dismissals in June 2025

Service Line	Case Type	Case Sub Type
PTS - Merseyside	ABS LTS	Non work related
PES GM	Performance	Stage 3 truncated

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	6	8	1	0
Disciplinary	21	20	20	1
Fact Finding	24	4	3	0
Grievance	12	6	3	0
Case Total	63	38	27	1

New Litigation cases in June 2025

Service Line	Case Type	Case Sub Type	Information Category	Received Date
Corporate	Litigation	Unfair dismissal	Unfair dismissal	03/06/2025
PES CAL	Litigation	Constructive dismissal	Constructive dismissa	04/06/2025
PES CAM	Litigation	Unfair dismissal	Unfair dismissal	18/06/2025
PES GM	Litigation	Constructive dismissal	Constructive dismissa	23/06/2025
PES CAM	Litigation	Discrimination	Religious belief or pol	25/06/2025

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

Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	41
Lateness	16
Sexual misconduct	11
Failure to follow reasonable management instructions/procedures	11
Incapacity through alcohol/substance misuse	9
NWAS Summary	88

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

Suspended	Alternate Duties
17	6

Live case numbers have seen a slight drop since the last report from 150 to current 129 cases. Case numbers are at a slightly higher level to those reported at the same time last year (122 live cases). The average length of time taken to close cases remains around 11 weeks.

PES continue to have the highest case levels which is expected based upon headcount figures. 111 continue to show higher than average prevalence of closed cases across the year, although many of their cases tend to be lower level.

There are currently 17 staff on suspension with a further 6 on amended duties as an alternative to suspension.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	NWAS Strategic Winter Assurance Framework
PRESENTED BY	Mr D Ainsworth, Executive Director of Operations
PURPOSE	Decision

LINK TO STRATEGY	All Strategies										
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☐	**SR04**	☒	**SR05**	☐	
	SR06	☐	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐	**SR11**	☒

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

ACTION REQUIRED	The Board of Directors is asked to: • Note and approve the content of document • Approve submission to NHS England NW	
EXECUTIVE SUMMARY	NWAS develops annual winter strategy plans to set out our overall approach to sustained operational delivery of services in what is generally the most pressurised period for NWAS and the wider Urgent and Emergency Care system. NHS England requires all Trust Boards to have approved their strategic winter plan by the end of August 2025. The strategic plan then forms the framework for development of a tactical delivery plan, which will contain the detail of operational deployment, staff welfare and escalation planning.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 23 July 2025
	Outcome	Approved

1.	**BACKGROUND**
1.1	NWAS is required, as part of annual escalation and contingency planning, to develop a Strategic Winter Plan.
1.2	In 2024/25 the Plan format was revised to take the form of a strategic framework document that forms the basis of a further supporting tactical plan for Service Delivery / Operations.
1.3	The tactical plan is under construction and will be approved by the Service Delivery SMT in September.
2.	**NHS ENGLAND ASSURANCE**
2.1	National Scrutiny of Urgent and Emergency Care (UEC) performance and contingency planning is heightened this year, and there is a specific ask of all Trusts to review their winter strategic plan at Board by the end of August 2025.
3.	**REVISIONS FOR 2025**
3.1	This document is based upon the revised format document that was approved in 2024, however it has been reviewed and updated to include the following areas of strategic importance / risk this year: • The prevailing NWAS and wider NHS system financial constraints, and their effect upon community and acute trust resourcing decisions. • The specific expectations upon NWAS connected with additional UEC investment in 2025/26. • Organisational change in NHS England and Integrated Care Boards, with loss of staff posts and organisational knowledge. • Addition of specific high 999 demand planning for the festive period.
4.	**RISK CONSIDERATION**
4.1	There is no direct risk associated with the paper, other than the failure to meet NHSE expected Board approval timelines if it cannot be approved.
4.2	This strategic framework and underpinning tactical plan will link to our mitigation of BAF Risks SR01, SR02, SR04 and SR11.
5.	**EQUALITY/ SUSTAINABILITY IMPACTS**
5.1	There are no direct Equality or Sustainability impacts.
5.2	The underpinning tactical plan will deal with escalation planning that will affect our provision of welfare resources to our operational staff, and how we maintain equity of service to all users during times of extreme pressure. This surge planning will be supported by the revised NWAS clinical Safety Plan, due for adoption during September 2025
6.	**ACTION REQUIRED**
	The Board of Directors is asked to:

	• Note and approve the content of document • Approve submission to NHS England NW

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NWAS

Winter Assurance

2025-2026

NWAS Winter Assurance 2025-2026		Page:	1
Author:	Business Continuity Manager	Version:	1.3
Date of Approval:		Status:	Draft
Date of Issue:	14.7.2025	Date of Review	13.7.2026

Recommended by:	Assistant Director of EPRR Steve Hynes
Approved by:	Ian Moses – Area Director – Cheshire & Merseyside
Approval date:	
Version number:	1.3
Review date:	
Responsible Director:	Dan Ainsworth – Executive Director of Operations
Responsible Manager (Sponsor):	Joanne Hodson Head of Contingency Planning
Responsible Manager (Author):	Andy Jackson Business Continuity Manager
For use by:	All departments

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

Change record form.

Version	Date of change	Date of release	Changed by	Reason for change
0.1	21/08/2023		A Jackson	Document creation
0.2	25/09/2024		C. O'Neill	Commissioner Comments/Review following discussion with NWAS colleagues on 24/09/2024
0.3	29/09/2024		J Hodson	Amendment of wording in line with the aim of provision of assurance.
0.4	07/10/2024		A Jackson	Amended to reflect above reviews.
1.0	12/12/2024	12/12/2024	A Jackson	Approved at TMC on the 27 November
1.1	01/07/2025		A Jackson	Review of document
1.2	10/07/2025		A Jackson	Following review by Winter Lead AD I Moses, additional information around specific risks for this year added. Also added forecasting data to the appendices following update from HoRP GL.
1.3	11/07/2025		A Jackson	Changes made following update from NHSE around section 4 and winter escalation. Other changes made to sentence structure on a number of points following a further review by Winter Lead AD I Moses
2.0	23.7.2025		I Moses	Approved at TMC

Contents

1. Introduction

1.1. The North West Ambulance Service (NWAS) NHS Trust remains one of the busiest UK Ambulance Services, spanning a large geographical area, and covering over seven million people. As such, there is a responsibility on the Trust to ensure it has robust business continuity arrangements in place to respond to immediate or emerging disruptions and comply with legislation (Cabinet Office, 2004) and guidance (NHS England, 2022) which sets out our responsibilities. There is also an expectation that as a Category 1 Responder under the CCA (Cabinet Office, 2004), NWAS will monitor, review and react to any changes in risk profiles within the National Risk Register (HM Government, 2025).

1.2. The recently publish Urgent and Emergency Care Plan 2025/2026 (NHS England, 2025) will provide much of the focus and drivers for this year's NHS winter planning arrangements. The document sets out expectations of how systems are required to work together to address seven key priorities. Generally, NHS England will send a specific 'Winter Letter' which is received by all NHS organisations during late summer/early autumn. It is anticipated, as in previous years, that the priorities focused on in that letter will mirror those identified in the UEC.

1.3. NWAS will continue to apply specific focus in the following areas, in line with the seven priorities detailed within the UEC Plan (NHS England, 2025):

1.3.1. **Admission / Attendance Avoidance** –

- Expansion of the Connected Care Records for ambulance services, giving paramedics access to the patient summary (including recent treatment history) from different NHS services, enabling better patient care and avoiding unnecessary admissions
- Operate a call before convey principle and enable "see and treat", supported by additional clinicians in emergency operating centres and single point of access across our ICB systems.
- Ambulance services will do everything they can to avoid conveyance, and no 111 emergency ambulance response dispositions should occur without going through validation, even if that means holding risk out-of-hours and overnight.

1.3.2. **UEC Performance** –

- Reduce the variation in rates of "hear and treat" and "see and treat".
- Patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes.
- Expand overnight support for 999 call handlers and clinicians to provide urgent in-home care for clinically assessed patients, with follow-up services available the next day.

1.3.3. **Handover Times** –

- Eradicating last winter's lengthy ambulance handover delays to a maximum handover time of 45 minutes

1.3.4. **Working with Partners**

- Ambulance trusts are rapidly adapting best practice to maximise improvement opportunities this winter and nominating an executive director to work with every ICB to develop the system winter plan.

- System winter plans should clearly set out how local partners – NHS acute trusts and primary care – are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for them. They should also detail how they plan to expand access to SDEC and enable direct ambulance off-loading at specialty facilities, such as SDECs.

1.3.5. Financial Considerations and Interdependencies

This year sees significant impacts in terms of fiscal stability within the commissioning structure of the NHS (NHS England, 2025), in summary:

- **Structure Review** – there are a number of changes within ICB and NHS England structures, including consolidation of functions and the merging of departments. There is a risk this may lead to a loss of capacity and organisational memory and knowledge.

- **Finance Control –** although ICBs have been given more local control of their funding arrangements, this must be considered in the context of an ambitious series of efficiency and balanced budget targets – which may affect UEC staffing capacity during the potential high pressure, high demand period.

- **Social Care** – with the NHS announcing a focus on a number of key areas, such as waiting times, A&E Performance and ambulance response, there is a high reliance upon access to Social Care, with an impact on Acute Providers struggling to discharge patients from the acute setting, affecting ambulance handover at Emergency Departments.

1.3.6 2025/25 Investment and specific UEC Planning

In response to these national objectives and known local interdependencies, NWAS has received specific UEC funding support this year, intended to enable increases in front line response capacity, and in supporting infrastructure to improve operational resilience and safe delivery of patient care. NWAS delivery against these objectives is subject to national and local oversight and review.

2. Purpose

2.1. The purpose of this NWAS Winter Assurance document is to provide ICBs and system partners with assurance that the Trust has well established planning arrangements and mitigations to meet the expected increases in demand and the challenges that arise during the winter months. This document outlines, at a high level, the measures being taken by the Trust to maintain operational resilience, patient safety, and quality of care under expected additional pressures arising from (for example) seasonal increases in patient acuity, adverse weather conditions, and increased hospital admissions.

2.2. The sections outlined in the document include an overview of the high level risks for the Trust across the winter period, how NWAS will engage with the regional reporting and escalation processes in place across the system and the forecasting of expected additional demand over winter. The document also sets out the Trust's response to mitigating additional demand through its response to resource allocation, workforce planning, and collaboration with partners (including hospitals, Integrated Care Boards (ICBs) and other system healthcare providers).

2.3. The winter plans developed by the Trust, on which this assurance document is based, focuses on delivering services over the winter period against a background of expected and predictable surges in emergency and NHS 111 calls and actions that can be taken by the Trust to reduce, where possible, ambulance handover delays at hospitals, supported by the Rapid Release 45 initiative (NHS England, 2024). The winter plan aims to maintain increased staff availability to mitigate the effects of potential disruptions arising from increased staff sickness levels, attrition or inability of staff to attend work due to severe weather conditions.

2.4. The Trust is committed to the principles of accountability and transparency, of working with system partners and providing assurance to NHS England, ICBs, the General Public and other stakeholders that the ambulance service is being proactive in its winter preparedness and aware of national policies and guidance that protect patients and staff over winter through efficient and effective operational delivery.

3. Risks

3.1. During the winter period, NWAS faces a range of heightened risks that can affect its ability to deliver timely and effective care. These risks are primarily driven by increased demand, environmental factors, and operational challenges. Key risks include:

3.1.1. Increased Demand for Services: Winter typically brings increases in urgent and emergency calls due to seasonal illnesses such as influenza, respiratory infections, and complications from chronic conditions like asthma or heart disease. Additionally, cold weather can lead to an increase in slips, trips and falls, and other accidents, further straining resources.

3.1.2. Adverse Weather Conditions: Snow, ice, and heavy rain can slow ambulance response times across much of the region, both urban and rural road networks; in particular access to more remote or rural areas. Additionally, heavy snow affects staff ability to physically attend work, affecting ambulance and emergency operations centre availability.

3.1.3. Staffing Shortages and Fatigue: Winter illnesses can affect all staff, leading to shortages and reduced availability. Coupled with increased demand, this can lead to staff fatigue and burnout, reducing overall service efficiency and safety.

3.1.4. Hospital Delays and Capacity Issues: As hospitals experience higher patient admissions during winter, ambulance crews may face delays when transferring patients. These handover delays can result in longer waiting times for ambulances to become available for emergency calls awaiting a conveying resource or face to face clinician within the community.

3.1.5. Supply Chain Disruptions: Adverse weather conditions may also affect the supply of critical medical equipment, medications, and vehicle maintenance services. This can limit the availability of necessary tools for ambulance crews to provide effective care in emergencies.

3.1.6. Vulnerable Patient Populations: Elderly patients, those with chronic illnesses, and individuals with respiratory conditions are particularly vulnerable during winter. A failure to reach these patients quickly can result in severe health consequences, placing additional pressure on services.

3.2. Based on previous experience and from identifying and preparing for these risks, NWAS is able to implement strategies to mitigate disruptions and ensure that patients continue to receive timely and effective care through winter.

3.3. As part of its normal business, internal NWAS departments have business continuity plans to mitigate staff shortages and supply chain disruptions. The Trust has an Adverse Weather Plan (NWAS, 2025) which is aligned to Estates and Fleet plans, Clinical Safety Plan (NWAS, 2025), Divert and Deflection, Escalation, and REAP (NWAS, 2021) to support management of demand surges.

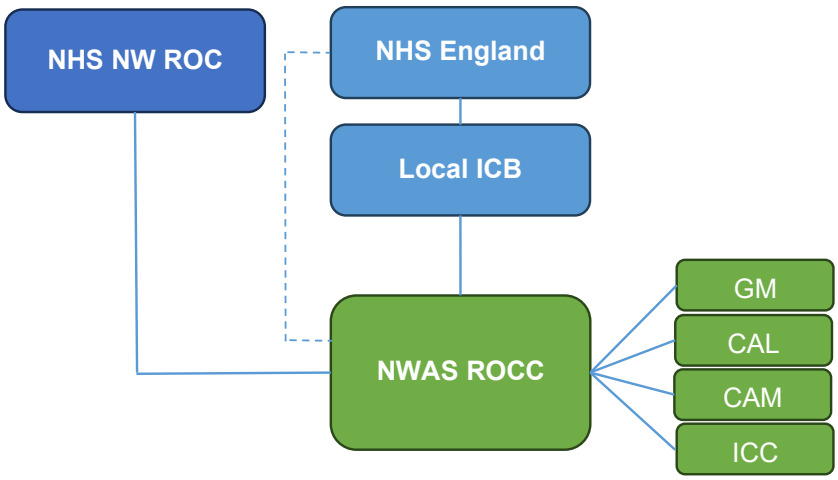
4. Reporting & Escalation

4.1. Winter Reporting structure:

4.1.1. Through the summer period, NWAS and other providers have had the option to escalate UEC pressures through to the North West Regional Operations Centre (NWROC) – which operates seven days a week from 0800-1800hrs.

4.1.2. NHSE have confirmed that their NWROC will continue seven days a week operating 0800-1800hrs as part of their winter operating model. The NWROC will meet twice daily (virtually) with NWAS (via NWAS ROCC) and NW ICB SCCs.

4.1.3. Additional meetings may be required outside of operating hours, and they will be facilitated by NHSE on call, in agreement with NWAS and SCCs based on dynamic risk assessment of the position.



4.2. Expectation of Support from ICBs

4.2.1. During the winter period, NWAS expect on-going collaborative support from Integrated Care Boards (ICBs) to manage the seasonal surge in demand and ensure coordination across the healthcare system. Key expectations, supported by the principles set out in the UEC Plan (NHS England, 2025) include:

a. **Effective System-Wide Coordination**: ICBs are expected to engage with and support collaboration between NWAS, hospitals, social care, and community health services to ensure efficient patient flow and reduce hospital handover delays.

b. **Capacity Management**: ICBs should help manage capacity by ensuring alternative care pathways are available, directing non-urgent cases away from emergency services, and coordinating with primary care and community services to alleviate pressure on ambulance

crews. Through the provision of alternatives to hospital admissions this will focus on people who are better served with a community response including complex needs, frailty, mental health.

c. **Data Sharing and Communication**: ICBs will provide real-time data sharing platforms that help monitor demand, track resource availability, and support decision-making during high-pressure periods. This includes clear communication of capacity updates.

d. **Proactive identification of patients:** ICBs should proactively identify and manage people with complex needs and long-term conditions so care is optimised through primary and community services working with patients to avoid hospital admissions.

f. **Support to NHS Trusts to meet their requirements**: This includes review and testing of core and escalation bed capacity plans, escalation notification to a senior level and engagement with stakeholders including NWAS to address issues from a system perspective, availability of senior clinical decision makers in live time to manage flow (risk-based decision making to ensure ED crowding is minimised and ambulances released in a timely way), and plan in place to maximise patient flow 7 days a week.

4.2.2. By receiving this support from ICBs, NWAS can maintain focus on providing operational resilience and deliver high-quality patient care during the winter period.

5. Service Resilience

5.1. The NWAS strategy for the winter period will be supported by area and department tactical plans that address specific operational areas. These tactical plans ensure that the service is well-prepared to manage increased demand, adverse conditions, and staffing challenges. Each tactical plan contributes to the broader goal of maintaining service resilience and patient safety. The main plan areas are:

5.1.1. Demand and Surge Management

Tactics based on predicting and managing the expected increase in demand for NWAS during winter include mechanisms for surge capacity, such as increasing the number of available vehicles and staff, deploying temporary resources, and using dynamic dispatch models to prioritise and focus on higher acuity incidents. The plans also outline coordination with other healthcare providers to ensure that patients with non-urgent needs are directed to appropriate care settings, reducing pressure on NWAS services.

This approach is supported by specific risk mitigation plans to ensure a robust process is followed:

- Resource Escalation Action Plan (REAP) (NWAS, 2021)
- Clinical Safety Plan (CSP) (NWAS, 2025)

Emergency Call demand modelling is undertaking by the NWAS Regional Planning Team (Appendix 1), who use numerous datasets to evaluate the likely demand across the winter and festive period. The methodology used includes the following:

- Modelling of the last nine years of data – excluding the two COVID years.
- The methodology considers;
    - day of the week and likelihood of contacting NWAS

- human factors around behaviour during Bank Holiday periods.

The Regional Planning Team also undertake a full review of their predictions against actual demand following the winter period. Enabling a degree of confidence to be applied to any publish information.

5.1.2. Logistics and Resource

This ensures that ambulances and medical equipment are properly maintained and available throughout the winter. It covers vehicle maintenance schedules to prevent breakdowns during adverse weather, as well as supply chain planning to ensure that essential medical supplies, such as oxygen, medications, and PPE (Personal Protective Equipment) are readily accessible. Provisions for adverse weather conditions include access to 'all weather' tyres as standard fitment on all vehicles.

5.1.3. Collaboration with Hospitals and Health Systems

Coordination with hospitals and other healthcare facilities is critical during winter requiring methods for reducing ambulance handover delays at emergency departments, improving patient flow, and ensuring that emergency care pathways are well-aligned with hospital capacity. Collaboration with community health services and primary care networks helps divert non-emergency patients away from ambulance services, easing system pressures.

5.1.4. Workforce and Staffing

During the winter period, NWAS implements a number of staff well-being initiatives to support its workforce, recognising the increased demand and pressures of the season. These initiatives focus on reducing stress, preventing burnout, and promoting both physical and mental health. Key measures include flexible shift patterns to manage workload, access to counselling services and mental health support.

Additionally, to support people to stay well, physical health programs such as flu vaccinations and initiatives to promote good nutrition and hydration are made available to protect staff from illness and maximise vaccination uptake in patient-facing staff. Leadership teams also prioritise open communication, offering check-ins and support channels to ensure staff feel valued and heard. These efforts help maintain staff morale, resilience, and the overall effectiveness of NWAS throughout the challenging winter period.

5.1.5. Communications and Public Awareness

Effective communication with the public and healthcare professionals is essential for managing demand during winter. The tactical plans cover public messaging campaigns to educate the community on when to call 999 and 111, how to stay safe during winter, and alternative care options. This is to promote the 'Supporting People to Stay Well' initiative where NWAS will work with NHS England and ICBs to deliver community and staff messaging. Internally, it ensures that ambulance staff and other healthcare providers are informed about operational changes, weather alerts, and capacity updates to facilitate coordinated responses.

5.2. By integrating these tactical plans into the overall winter assurance strategy, NWAS can mitigate the seasonal pressures it faces, maintaining safe patient care and operational effectiveness.

6. Review

6.1. The strategy will be reviewed following the winter period, to ensure it is still fit for purpose but is likely to remain unchanged as it is in line with the requirements set out by NHS England.

6.2. The Tactical plans will be reviewed to ensure that the tactics being applied to meet the strategy are effective.

6.3. Normal BAU methodology will apply on an ongoing basis and should be reviewed to ensure standardised practices are fit for purpose. Should a business continuity or critical incident occur which is associated with surge or other capacity planning, a hot debrief will be performed to identify if any urgent safety issues have been identified. This change will be affected with stakeholder engagement.

6.4. NWAS will participate in exercises run by NHS England and/or ICBs to re-confirm capacity plans.

6.5. When the defined winter period finishes, NWAS will complete an internal structured debrief and engage with stakeholders in external debriefs to share wider learning.

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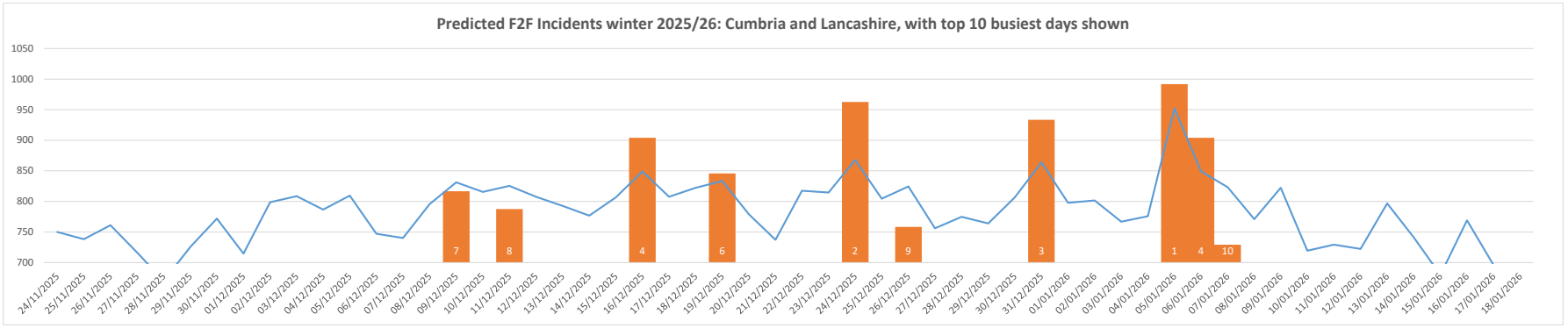
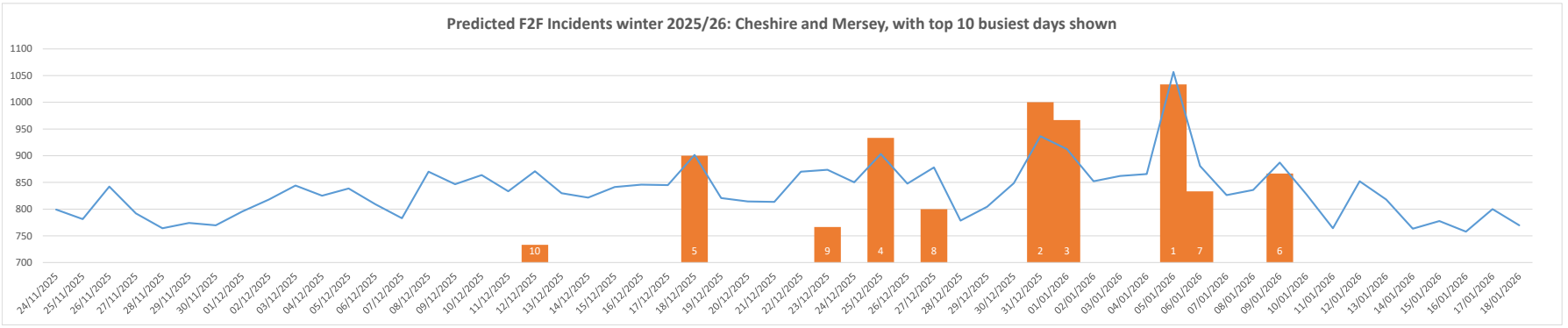
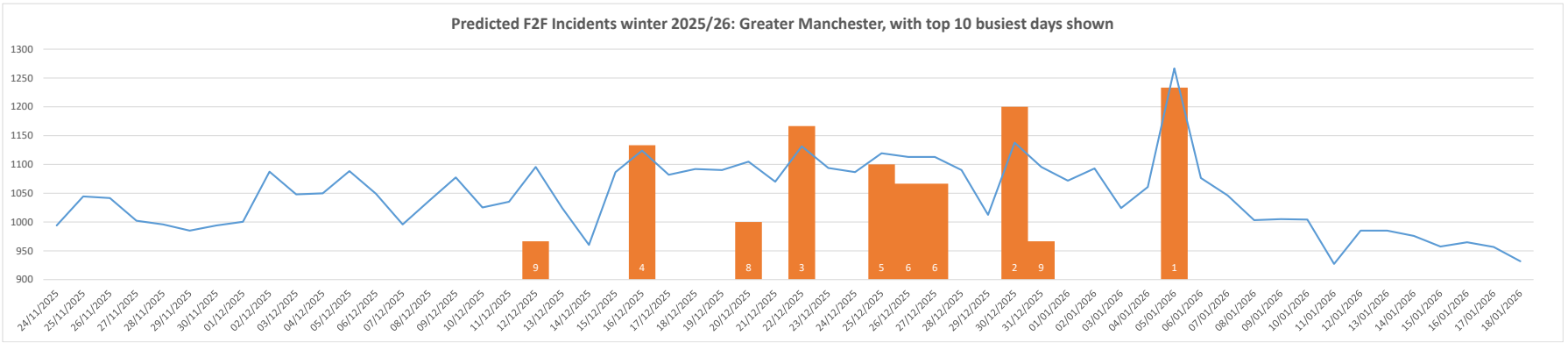
Appendix 1 – Winter Forecast 2025-2026







NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Controlled Drugs Annual Report 2024/2025
PRESENTED BY	Dr Chris Grant, Executive Medical Director
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the assurance provided and the achievements and improvements made in 2024/25 as well as the challenges and risks.
EXECUTIVE SUMMARY	The report details the following key notes of assurance and the achievements and improvements made in 2024/25: • Roll out of digital paramedic possession CD keys. • Reporting into NHSE. • High level of CD reporting, largely no or low harm, demonstrating a good reporting culture. • Scrutiny of CDs administered to patients and follow up of any concerns. • The CD policy and all CD procedures are up to date. • Medicines management quality indicator (MMQI) for vehicles show compliance with all areas except with the weekly checks which is consistently around 70%.

	• MMQI ambulance stations for the first time all targets have been met including the daily and weekly checks. • The Designated Body self assessment against the assurance and improvement framework has been to Board for scrutiny and challenge. The report notes the challenges in 2024/25: • Lack of digital pharmacy stock management system – full business case being developed. • Lack of electronic CD register – specification being developed. • Site security and CDs – CCTV for 15 remaining sites is the current priority. • Lack of CD licence renewal with the Home Office – CD destruction a concern that the Home Office are reviewing.	
PREVIOUSLY CONSIDERED BY	Quality & Performance Committee	
	Date	Wednesday, 21 May 2025
	Outcome	Approved

1. BACKGROUND

This annual report is intended to update the Trust and provide assurance around controlled drug (CD) management for the financial year 2024/25.

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

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

This report covers:

2.1 Control Drugs Arrangements
2.2 Reactive Assurance
2.3 Proactive Assurance

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

2.1 CONTROL DRUGS ARRANGEMENTS:

2.1.1 Controlled Drugs Used:

Controlled drugs used at NWAS are as listed in Figure 1. There were no changes made in 2024/25, except for the roles using them updated to reflect changes

Figure 1: Controlled Drugs Used

Controlled Drug	Schedule	Profession	Restrictions
Diazepam 10mg/2ml injection	4 (part 1)	Doctor & Paramedic	N/A
Diazepam rectal 5mg tubes	4 (part 1)	Doctor & Paramedic	N/A
Fentanyl 500micrograms/10 ml pre-filled syringe	2	Doctor	NWAA Doctor only
Fentanyl 500micrograms in 10ml ampoule	2	Doctor	NWAA Doctor only
Ketamine 200mg/20ml	2	Doctor & Paramedic	NWAA Doctor, Consultant Paramedic (CP), Clinical Support Manager, Sector Clinical Lead, Advanced Paramedic Practitioner, HEMS Critical Care Paramedic (CCP) whilst working within the NWAA (this includes Senior HEMS Paramedic Team Leaders), HART Specialist Paramedic and Special Operations Clinical Lead.
Ketamine 200mg/20ml pre-filled syringe	2	Doctor	NWAA Doctor only
Ketamine 500mg/10ml vial	2	Doctor	NWAA Doctor only
Midazolam 5mg/5ml injection	3	Doctor & Paramedic	NWAA Doctor, Consultant Paramedic (CP), Clinical Support Manager, Sector Clinical Lead, Advanced Paramedic Practitioner, HEMS Critical Care Paramedic (CCP) whilst working within the NWAA (this includes Senior HEMS Paramedic Team Leaders).
Morphine 10mg in 1ml Injection	2	Doctor & Paramedic	N/A
Morphine 1mg and 5mg orodispersible tablets	2	Doctor & Paramedic	N/A

In 2025/26 work will continue to review medicines to treat seizures, particularly the benzodiazepine of choice. There is some concern that diazepam rectal tubes may be discontinued in the future due to a commercial viability, as they are a less favoured option. There is also a review of morphine orodispersible tablets to potentially switch to morphine sulphate oral liquid 10mg in 5ml.

2.1.2 Controlled Drug Supplies:

The receipt of CDs has not changed over the last year, after consolidation the previous year, arrangements are:

NWAS stocks are procured by the Medicines Supply Hub and received into the Medicines Supply Hub. This includes stocks for the NW Air Ambulance.
NARU Mass Casualty Vehicle stocks are ordered at a national level and delivered via Movianto only to the Medicines Supply Hub.

The lack of a Pharmacy Stock Management System to track all of these different supplies in an auditable digital system is a risk and is on the risk register. NWAS has approved the outline business case and a tender specification has been written, a full business case will be completed in 2025/26. In addition, an electronic digital CD register would support enhanced governance of CDs once issued from the Medicines Supply Hub. The outline business case has been approved and a developing a specification is the next step.

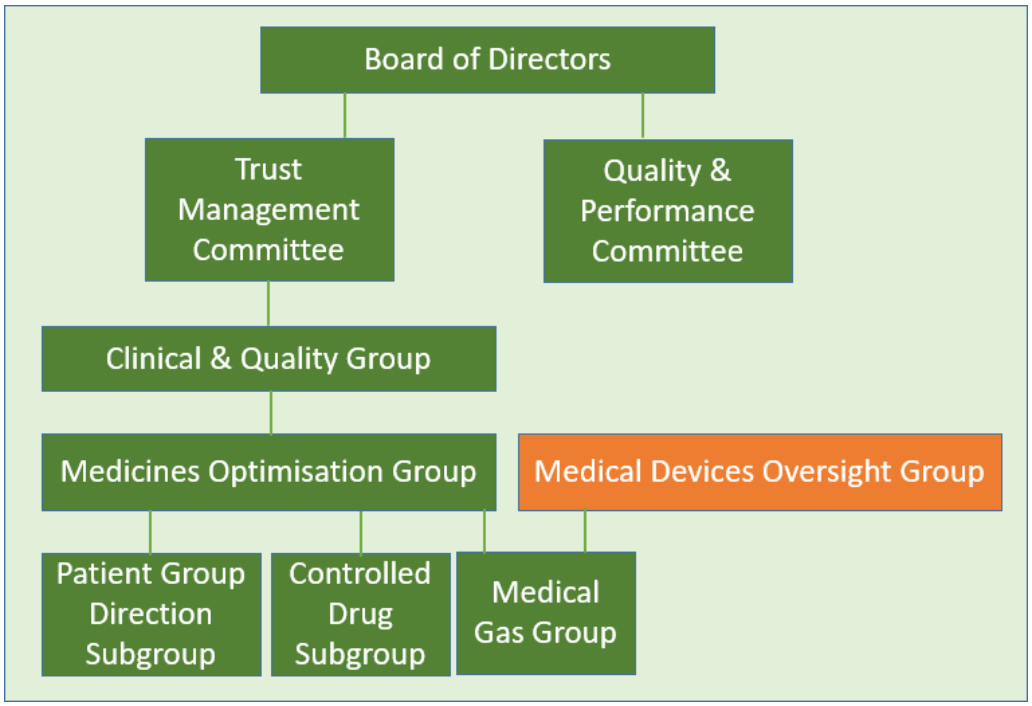
2.1.3 Controlled Drug Financial Costs and volumes:

NWAS spend on CDs has decreased by £9,179 in the last year to a total of £30,680. This is primarily due to the introduction of morphine orodispersible tablets in 2023/24 which required bulk stock procurement for launch stock.
Full details can be found in the Medicines Management Annual Report.

2.1.4 Controlled Drug Governance Arrangements:

Since 2022, there has been a dedicated Group overseeing the CD governance arrangements in NWAS, the CD SubGroup. This group reports to the Medicines Optimisation Group (MOG) via a Chair's Assurance Report. Figure 2 shows how the governance arrangements fit in with the NWAS structure.

Figure 2: Organogram of medicines governance arrangements



2.1.5 Controlled Drug Home Office Licence:

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

No change in contraventions 2024/25. NWAS has two low contraventions (8351905 and 8238548) from 14/12/22 and one medium contravention (re 8440428) from 15/12/23 on file.

NWAS applied to renew its licence in June 2023. There were two inspections in January and February 2024. The outstanding concern for around CD destruction is on-going with some correspondence with the Home Office during 2024/25. The Home Office Policy Group is looking into the issue. In the meantime, at year end the need for an up to date licence is becoming more pressing and a clinically urgent application has be made to the Home Office.

Recently one air ambulance did not renew its Home Office CD licence and this led to them operating without a licence and unable to hold CDs and making the national

press. The North West Air Ambulance service is covered by the NWAS HO licence so would not be an occurrence for us.

2.2 REACTIVE ASSURANCE:

2.2.1 Incident Management:

Medicines related incidents should be reported on the Trust incident reporting tool, Datix. These incidents are viewed by the Medicines Team regularly to provide support to the operational team for any investigation or follow up. A quarterly report is provided to the Medicines Optimisation Group and the Controlled Drug Subgroup. All Level 3 incidents and above have additional narrative information provided. If there is a serious patient safety event it would be reviewed to see if a Patient Safety Incident Investigation (PSII) is required. In 2024/25 no PSIIs were required for CDs.

The Medicines Team has a dedicated email address, where any concerns around the use of CDs within NWAS or in the wider health economy, can be escalated.

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

2.2.2 Incidents reporting to NHSE:

NHS England require declaration of any CD related incident that falls into specific categories. NWAS has made ten reports. They are listed in figure 3 along with last year's reports for comparison.

Figure 3: NHS England Submissions

NHSE Category	2023/24	2024/25
Real or perceived staff diversion of controlled drugs	1	1 Member of staff no longer works at NWAS and has an interim suspension with the HCPC.
Real or perceived staff substance misuse of controlled drugs	3 One of these led to a NHSE alert being issued	0
Patient or Member of the Public of concern that might require an NHSE alert to be issued to health and care settings	5	7
Patient involved	1	2 • A NWAS patient, level 5 patient safety event - harm caused. • NWAS reported a third party dispensing error of morphine instead of metformin.

The Medicines Team work closely with the various NWAS teams including Human Resources Team, Service Delivery Team, Security Team and High Intensity Users Team. Externally the Medicines Team work with the Regional CD Team (part of NHSE) and the CD Liaison Officers.

2.2.3 Controlled Drug Incidents:

CD incidents reported are considerably higher compared to the previous year (733 compared to 492) this is a rate of 8 reports per 10,000 face to face patients attended. The continued increase is still thought to be due to the change in the ease of reporting incidents. In addition, there was a lot of reports about the digital CD key system as this was being introduced staff were asked to report any concerns/issues. Staff reported each time the keys would not open locks, this was often due to user error, not an error in the system, but it meant that information to help minimise user issues could be communicated.

The majority of CD incidents are low or no harm. There have been no never events, no level 4 incidents and one level 5 incidents relating to CDs.

The level 5 incident occurred in quarter two. The crew were called to a patient who was receiving palliative care treatment and was recently discharged from the hospital and now in pain. The crew used the patient's own documentation about their medicines to formulate a plan for them to take their medicines to help with the pain. Unfortunately, the plan was incorrect and so in following it, the patient received too much opiate medications from the family member which resulted in the patient becoming lethargic and suffering from falls, being readmitted to hospital and later passing away. It is unclear if the medicines hastened the death but did lead to the lethargy and falls resulting in another NWAS crew being called who realised the patient may have taken too much opiates. Learning from the incident took place with the crew and also in collaboration with the discharging hospital as patient, whilst at home, was unclear after discharge what they should have been taking and when.

Figure 4 shows a breakdown by type of incident and Figure 5 shows a comparison between the types of incidents for this year compared to last. The amount of missing CDs reported has stayed exactly the same from the previous year. Although there were 25 reports, upon investigation there were 18 incidents truly unaccounted for (see Figure 5), they were all very small amounts except for one involving the loss of a seizure pouch. A CD is considered missing when the CD record book in the vehicle or ambulance station does not reflect the balance of the CD safe. This is usually due to a documentation error and the record book is updated retrospectively when the item is accounted for. All of the unaccounted-for CDs were reported to the police and NHS England. The missing seizure pouch was fully investigated by the Sector Manager, however, three months later the pouch has turned up and all contents accounted for.

Figure 4: CD incident types reported per area 2024/25

Controlled Drug Incident Breakdown by Area 2024/25							
Datix Subcategory / MMQI coding	**CL**	**CM**	**GM**	**HART**	**NWAA**	**EOC/ 111**	**TOTALS**
CD Administration Error	9	4	3	0	0	0	16
CD Adverse Reaction	8	2	3	0	0	0	13
Any Other CD problems	5	14	10	0	1	0	30
CD Damaged	42	48	49	0	2	0	141
CD Missing	4	15	6	0	0	0	25
CD Safe Access Problem	19	32	25	0	0	0	76
CD Stock Problem	40	52	49	0	6	0	147
CD Documentation Error	60	105	111	1	0	0	277
Suspected Misuse	4	2	2	0	0	0	8
Total	**191**	**274**	**258**	**1**	**9**	**0**	**733**

Figure 5: Comparison of CD incidents reported over time

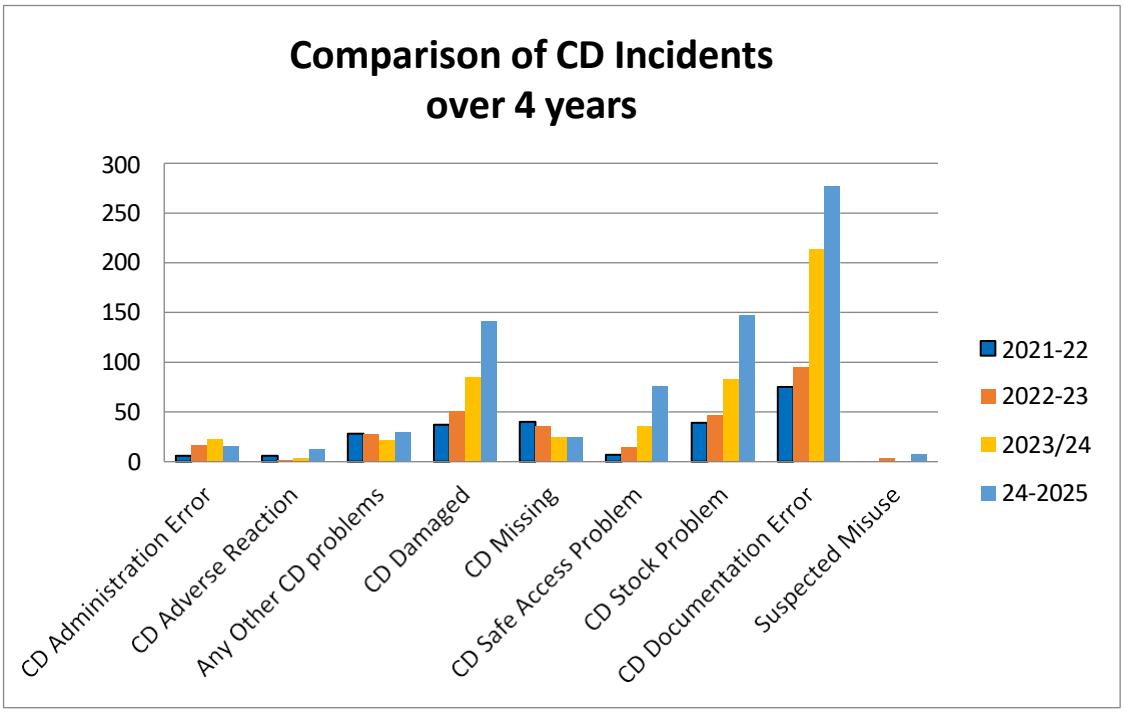


Figure 6: Unaccounted for CDs 2024/25

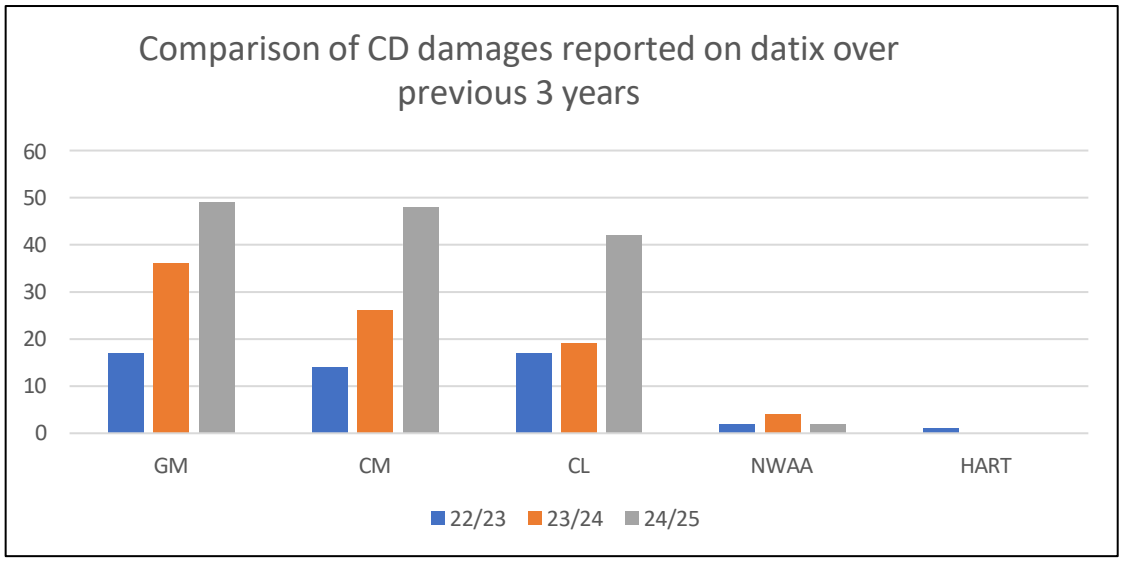
Controlled drug	Area
Diazepam 5mg rectal tube x 1	C&M – three separate occasions GM – one occasion C&L – two occasions
Diazepam IV solution x 2 vials	C&M
Morphine 10mg ampoule x 1	C&L
Morphine diluted part syringe	C&L – one occasion 5mg C&M – one occasion 5mg GM – one occasion 7.5mg
Morphine orodispersible 1mg tablets	GM – one occasion (two tablets)
Morphine orodispersible 5mg tablets	C&M – (four separate occasions from different areas) 3 occasions were one tablet and one occasion was a loss of two tablets C&L – one tablet
Missing seizure pouch	GM – one occasion containing 18 diazepam amps and 3 rectal tubes. *Update June 2025 – all accounted for.*

Breakages of CDs are to be reported as incidents and these are monitored by the Medicines Team. Overall, 141 items have been broken. See Figure 7 for the summary data. This is an increase from the previous year (85) and the previous year to that (51). This is likely due to an increased awareness of the requirement to report any CDs found damaged or damaged during handling following the training in addition to this now being actively looked at when auditing CD record books. Of the 141 damages/ breakages, 82 were morphine 10mg injection, 7 orodispersible morphine tablets, 45 diazepam 10mg injection, 3 diazepam 5mg rectal tubes, 1 fentanyl 500mcg amp and 3 midazolam 10mg injection. This data is provided quarterly to the CD SubGroup. Figure 8 shows a comparison of the data over time.

Figure 7: CD breakages reported 2024/25

Area	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Totals
GM	6	5	5	4	4	3	1	4	5	2	4	6	49
CM	2	4	5	4	3	2	6	4	4	10	4	0	48
CL	3	5	4	7	3	3	1	5	5	1	2	3	42
NWAA	0	0	0	0	0	0	1	0	0	0	1	0	2
HART	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	11	14	14	15	10	8	9	13	14	13	11	9	141

Figure 8: Comparison of CD breakages reported via Datix over time



2.3 PROACTIVE ASSURANCE:

2.3.1 Controlled Drug Use Monitoring:

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

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

Flags provides alerts to data that falls outside of normal ranges for further scrutiny. Where this does not provide a plausible explanation for the deviation, it is escalated to the relevant Consultant Paramedic who provides a review and response. This information is monitored by the CD SubGroup. Some examples of the types of deviations seen include:

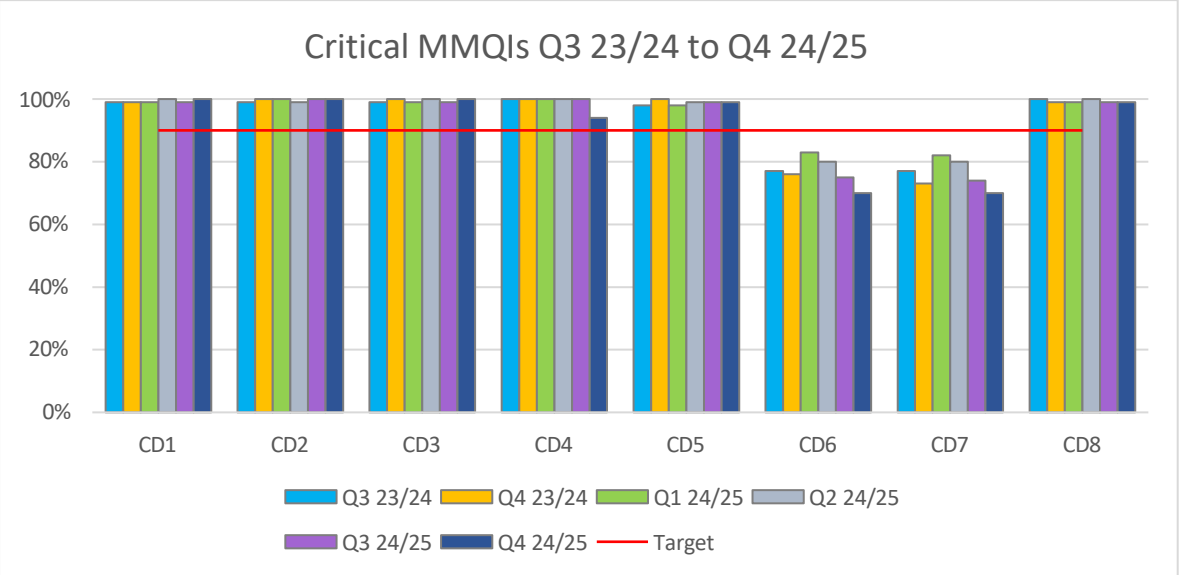
- Diazepam IV administration over JRCALC maximum doses.
- Documentation confusion of mls versus mgs.
- End of life medicines confusion.

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

2.3.2 Controlled Drug Vehicle Audit

CD audit of vehicles was conducted each quarter with a high level of compliance with the numbers of vehicles being audited. Full details are provided in the Medicines Management Annual Report. Figure 9 shows the results over time. This shows excellent compliance with the majority of the standards with the exception of the weekly CD checks of the CD safe and the seizure pouch where it has been consistently around 70%.

Figure 9: MMQIs CD Vehicles over time

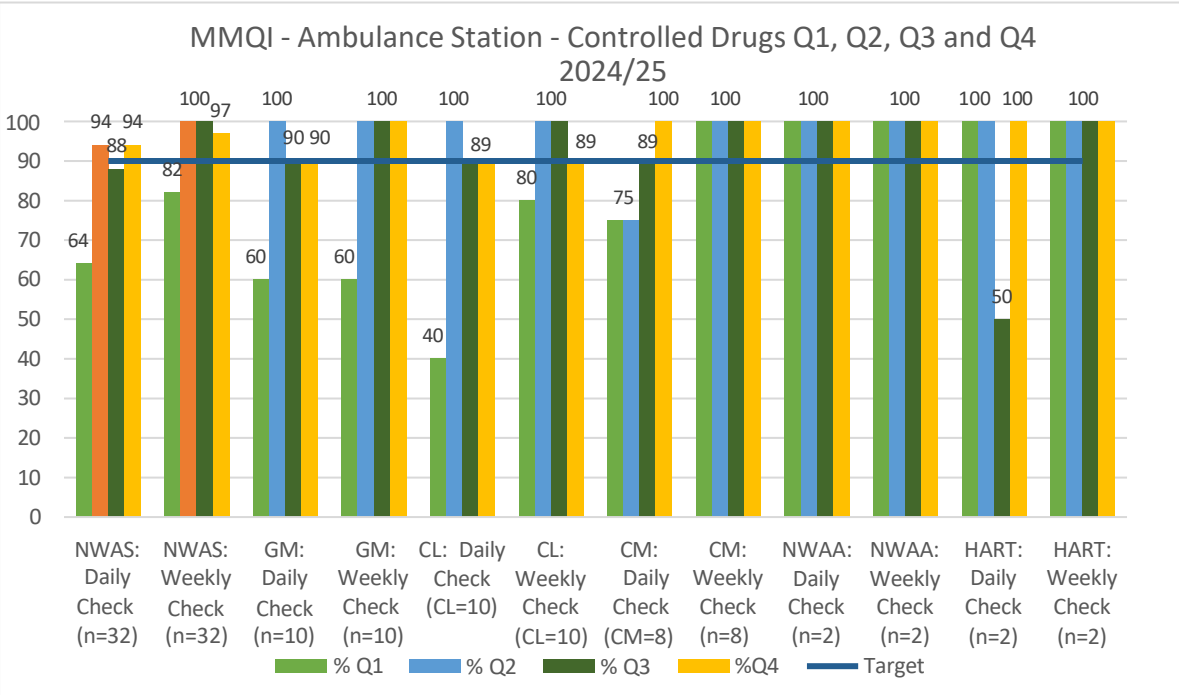


2.3.3 Controlled Drugs Ambulance Station Audit

The MMQIs for ambulance stations were introduced in Q3 2020/21. Due to the consistent achievement of all indicators bar two from April 2024 rather than the Medicines Team doing a full audit of ambulance stations 6 monthly it is conducted annually and increased scrutiny was placed on the two failing indicators, daily and weekly checks.

In Q4 the overall NWAS daily checks were at 94% and weekly checks at 97%, both above the target 90% for the first time. See figure 10. This approach will continue in 2025/26.

Figure 10: MMQIs CD Ambulance Stations 2024/25 for the daily and weekly checks



For the remaining indicators (20 questions) all the ambulance stations (33) were audited by a member of the Medicines Team in 2024/25. Each site passed every question with the exception of seven sites not passing the question "Q17: CD deliveries are transferred to vehicles within 72hrs?". The seven that failed was largely due to geographical reasons where stations that receive the deliveries are sometimes far away from where the vehicle is based. Systems are in place at most stations to alert crews to collect CD orders as quickly as possible but it isn't always possible within the 72 hours. For the 2025/26 audit this question has been slightly reworded to allow some tolerance 'The majority of CD deliveries (>80% in the last 30 days) are transferred to vehicles within 72hrs?'. This will accurately reflect that efforts are made to get CD deliveries back to ambulance safes as soon as possible.

In 2025/26 there are some slight changes to the audit questions, approved by the Medicines Optimisation Group. These mainly reflect the security standards required to hold CDs on station such as CCTV and dedicated medicines rooms.

2.3.4 Designated Body Assurance and Improvement Framework

The Regional CD Team have introduced an Assurance and Improvement Framework. The CDAO of each Designated Body is requested to complete a survey detailing their confidence in CD related systems and processes. The survey was completed and submitted in March 2025, following scrutiny by NWAS Board on 26th March. Actions that were put in place, after this was last completed in March 2024, have been completed. This includes:

- Updated CD policy to reflect our duty to share information.
- Collaboration/links with HR Business Managers, including a joint meeting held with NWAS HR and Chief Pharmacist along with two experienced colleagues from the NW CD Team – a pharmacist and CD Liaison Officer (Police).
- Introduction of digital personal possession CD keys for paramedics.
- Collaboration with new Security Advisor with CDAO and Medicines Team.

2.3.5 Changes in legislation and policy

Changes to legislation in 2024/25 included:

- Paramedics legally able to prescribe (note – NWAS currently does not have any non-medical prescribers)

- Widened access to naloxone allowing specific services and roles to supply take home naloxone without a prescription.

2.3.6 CQC CD Annual Report

The CQC CD Annual Report is reviewed by the CD SubGroup and any points noted and any actions followed up. The report referenced key issues occurring nationally that NWAS is managing too, for example around CD diversion, Home Office CD licensing and CD destruction. The concern for patients regarding synthetic opiates entering the supply chain was highlighted, this will feature in an e-learning module on Toxic Ingestion that all NWAS clinicians to complete in 2025 as part of mandatory training. The report asks CD Accountable Officers to ensure staff can speak up and make CD safety everyone's business. The Medicines Team continue to provide training and discussions with senior paramedics to help understanding of responsibilities and to support curiosity around CDs handling. Following staff changes in roles (due to conclusion of the service delivery model review) these sessions have been important and also well received. Once again medicines management mandatory training in 2025 will provide a focus on CDs and the requirement for escalation of concerns by all. The CQC had conducted some focus groups to gain learning from organisations that have deployed electronic CD registers. The findings of this have been shared with the Project Team overseeing the development of a business case for an electronic CD register at NWAS. Due to changes within CQC there have not been any CQC CD National SubGroup meetings whilst this is reviewed, however the Chief Pharmacist meets ad hoc with the CQC National Lead for CDs to collaborate and escalate key issues.

2.3.7 Local Intelligence Network Activity

During 2024/25, a member of the NWAS Medicines Team has attended all five local intelligence network (LIN) meetings as well as one national CD learning event. A summary of each meeting is presented at the CD subgroup meeting where any learning or points relevant to NWAS can be discussed. Themes of discussion have included:

- Verification of professional registration and identity of the employee.
- Counterfeit medicines.
- Need for heightened awareness and tight security measures where CDs are stored.
- In-house large-scale diversion of CDs.

- Paramedics obtaining CDs via private requisitions for personal use.
- Importance of daily CD stock checks.

The CDAO attended a training session on 'Board Accountabilities for CD Safe Use'.

2.3.8 Policy and procedures

The NWAS CD policy is in date. A minor update was made in February around record keeping requirements (following the MIAA CD Audit recommendations) and the need for information sharing.

All CD standard operating procedures are in date. Updates have been made during 2024/25 mainly to reflect changes to use of CD keys and following the role out of the digital CD keys.

2.3.9 Training

Training on CDs was provided by the Medicines Team on three occasions branded as 'Smart Drop In' sessions about the new electronic CD key system, as well as a separate session provided to GM managers reminding them of their obligations with CDs and safety and security.

A training and discussion session was held with the Chief Pharmacist and the Human Resources Business Managers, a CD Liaison Officer and NHS England CD pharmacist about the requirement of NWAS, as a designated body, to report and share concerns around staff and any potential concerns around use of drugs of abuse.

2.3.10 Risk Register

In 2024/25, one new risk was added to the risk register related to CDs, none were removed and two continue to be actively managed.

- Home Office CD licence lack of renewal due to CD destruction process (risk 655) – this is new for 2024/25 with a risk score 10. *Note in June 2025 the risk score was increased to 15.*
- Electronic CD register (risk 481) – an outline business case has been approved, a detailed specification will now be developed.
- CDs and Site Security (risk 318) – the priority is to have CCTV installed on all sites that store CDs. At year end there are 15 sites outstanding.

There is concern about the CD storage on the new mass casualty vehicles that have been delivered from the National Ambulance Resilience Unit and NWAS is currently awaiting assurance of the Home Office approval for CD storage on the vehicles. In the meantime, mitigation has been put in place.

2.3.11 Projects

SMART key cabinets and paramedic personal possession digital CD keys project has been completed and is now business as usual. This has created a lot of a continual administrative workload for the Medicines Team who programme the keys for all paramedics, the request for a 0.5WTE band 4 has not been funded and is creating a capacity issue for the team.

3. RISK CONSIDERATION

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

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

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

Risks around CDs are on the risk register. Lack of consistency of approach by the Home Office raises concerns with ambulance services being advised differently. As we enter 2025/26, some new pressures have become apparent with not having the licence updated.

4. EQUALITY/ SUSTAINABILITY IMPACTS

Nil

5. ACTION REQUIRED

The Board of Directors are asked to note the assurance provided and the achievements and improvements made in 2024/25 as well as the challenges and risks.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Safeguarding Annual Report 2024/25
PRESENTED BY	Elaine Strachan-Hall – Interim Director of Quality & Improvement
PURPOSE	Assurance

LINK TO STRATEGY	Choose an item.										
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐	
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐	**SR11**	☐

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

ACTION REQUIRED	The Board of Directors is asked to: • Receive the assurance that NWAS safeguarding activity during 2024-25 continues to meet our statutory requirements. • Approve the onward progression of this report for consideration at the Board.
EXECUTIVE SUMMARY	This Safeguarding Annual Report provides an overview of safeguarding activity within the Trust during 2024/25. Safeguarding Activity continues to provide a high level of assurance throughout this financial year. A total of 39561 safeguarding and early help referrals were made during 2024/25 (a 19% increase on 2023/4). Assurance in relation to the quality of NWAS referrals is monitored in two ways: • Reporting on referrals rejected by our Local authorities via the Cleric system which remains less than 2% of all referrals made. • Additional oversight of Safeguarding and referrals deemed not to meet the safeguarding threshold by the Support Centre.

	Safeguarding Audits are carried out for repeat safeguarding children's concerns and domestic abuse. At the request of the NWAS Board, Mersey Internal Audit Agency (MIAA) carried out a comprehensive safeguarding audit in Q3 2024/25, with an outcome of "Substantial Assurance". Safeguarding Training – A full review of the Safeguarding Training Needs Analysis has aligned requirements for all roles with the Safeguarding Children and Young People: Roles and Competences for Health Care Staff and Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Documents. At the end of March 2025 overall safeguarding training compliance is reported as >90% for all levels of training. In addition, bespoke participative training has been provided to our Integrated Contact Centres (ICC) during October and November 2024. Preliminary feedback from ICC colleagues was positive. Prevent Training – Overall safeguarding training compliance with Prevent Basic Awareness is 90% at year-end and Level 3 Prevent training is lower at 81%, requiring additional focus during Q1 2025/26. Safeguarding Case Reviews – The Safeguarding Team continue to meet our statutory duties in terms of required reviews. Allegations Against Professionals – A dedicated email inbox is in place to receive all referrals which enables us to share intelligence appropriately and to complete joined up risk assessments on a case-by-case basis. Project Emerald - The Safeguarding Team continue to monitor the Cleric referral system and engage with social care partners. Phase two of the project is now complete, and a safeguarding dashboard created. This has enhanced our reporting ability and allows for identification of themes by service line and by geographical location. Private Providers – The Safeguarding Assurance Framework (SAF/Section 11) document is issued to all private ambulance providers on an annual basis. Communication – Safeguarding Resources on the Green Room have been expanded and updated and will transfer to the dedicated SharePoint site upon completion of the trust-wide data migration to Microsoft 365. Safeguarding Interface with Key NWAS Workstreams – Safeguarding oversight has been embedded within patient safety processes. The Safeguarding Team have access to all patient safety events and are involved in each aspect of the process.
	Quality & Performance Committee

PREVIOUSLY CONSIDERED BY	Date	Monday, 30 June 2025
	Outcome	Approved

1. INTRODUCTION

The Trust has a statutory responsibility to safeguard children and adults who are at risk of harm from abuse. This commitment is underpinned by specific legislation, namely the Children's Act (1989 and 2004) and the Care Act (2014). The Trust works in partnership with other organisations to ensure that the response to individuals who are at risk of harm from abuse or neglect, is communicated in an effective manner which results in an appropriate response. and further through internal audits.

Safeguarding child and adult standards are determined nationally for NHS Provider Organisations and are monitored by the Care Quality Commission (CQC) and via submission of the Safeguarding Assurance Framework to the Integrated Care Board (ICB) and the Provider Safeguarding Assurance Toolkit (P-SCAT) to NHS England. In addition to safeguarding practice and processes, standards relate to policies and procedures, recruitment processes and leadership. The specific standards are contained within:

- Safeguarding Assurance Framework (SAF) which is presented to the lead Commissioners (Lancashire and South Cumbria ICB) on an annual basis.
- Mersey Internal Audit Agency (MIAA) who conduct safeguarding audits on behalf of the Trust Audit Committee.
- The Care Quality Commission (CQC).

Safeguarding assurance is reported via bi-annual reports to the Trust Management Committee.

2. THE SAFEGUARDING TEAM

During 2024/25, there have been some changes to the structure of the Safeguarding Team, due to the Head of Safeguarding being seconded to the combined role of Strategic Head of Safeguarding and Mental Health. The team comprises four Safeguarding Practitioners who cover specific geographical areas across the NWAS footprint, one Safeguarding and Learning Disability Practitioner, one Governance and Training Practitioner and two Administration Support Officers (1.8 whole time equivalent). Safeguarding referrals by NWAS staff continue to be made via the Support Centre in Carlisle and are sent electronically to the appropriate local authority using the Cleric referral system.

3. SAFEGUARDING ACTIVITY

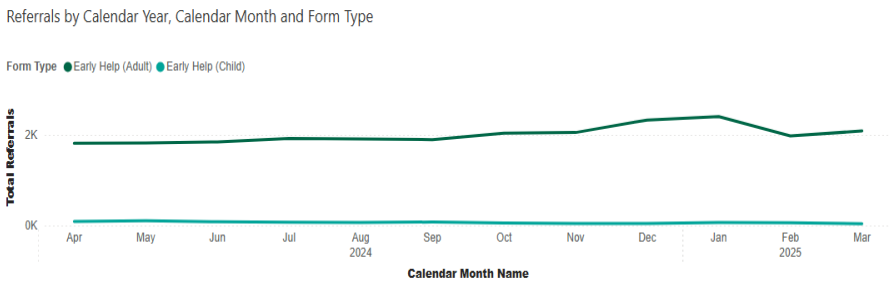
NWAS makes safeguarding referrals to 27 local authorities within the geographical footprint. Referrals are made electronically via our Support Centre in Carlisle to the appropriate local authority. During 2024/25, we have seen a 19% increase in safeguarding and early help referrals made by NWAS staff. This is likely attributable to the TNA review which resulted in more staff now aligned to level 3 training and a subsequent increase in staff knowledge and confidence.

We continue to closely monitor the rate of referral rejections by the local authorities. The rejection rate for 2024/25 is 1.95%, down from 2.73% in 2023/24, thus providing continued assurance that the safeguarding information shared by NWAS is of a high quality.

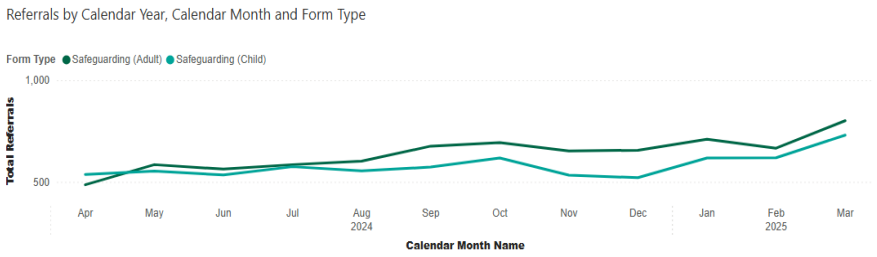
The tables below (Figures 1 and 2) demonstrate referral activity for 2024/25.

Early Help

Figure 1



Safeguarding Diagram



Implementation of the NWAS safeguarding dashboard has allowed us to further examine referral activity data by service line (figures 3 and 4), by geographical location (figure 5) and by local authority (figures 6 and 7).

As expected, the highest number of NWAS referrals have been generated by Paramedic Emergency Service (PES) staff: 78% of Early Help referrals and 64% of Safeguarding referrals.

Diagram 3 -Early Help Activity by Service Line

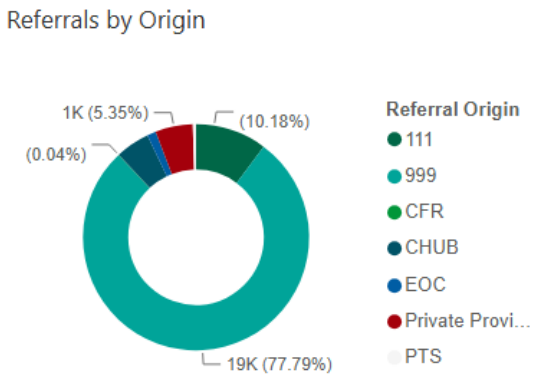


Figure 4 - Safeguarding Activity by Service Line

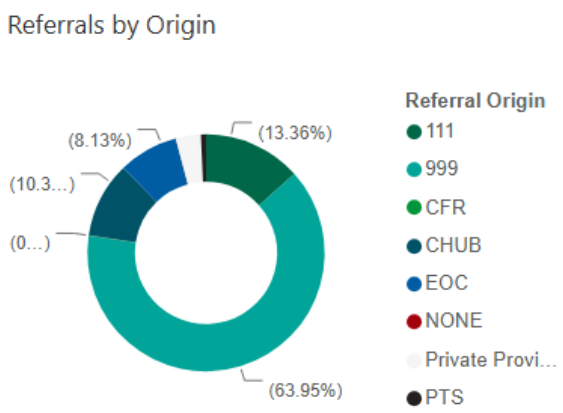


Figure 5 - Referrals by Region

	Early Help Referrals	Safeguarding Referrals
Cumbria and Lancashire	7534	4236
Cheshire and Mersey	6949	4129
Greater Manchester	10235	6045
Other (private providers and out of area referrals)	230	203
Total	**24929**	**14640**

Greater Manchester, our largest region, accounts for 41% of all referrals. Geographically, NWAS make approximately 42% more Early Help referrals than Safeguarding Referrals indicating that our staff are proactive in recognising when an early intervention can reduce the risk of neglect or abuse leading to significant harm.

Referrals by Local Authority

Chart 6 - Early Help Referrals

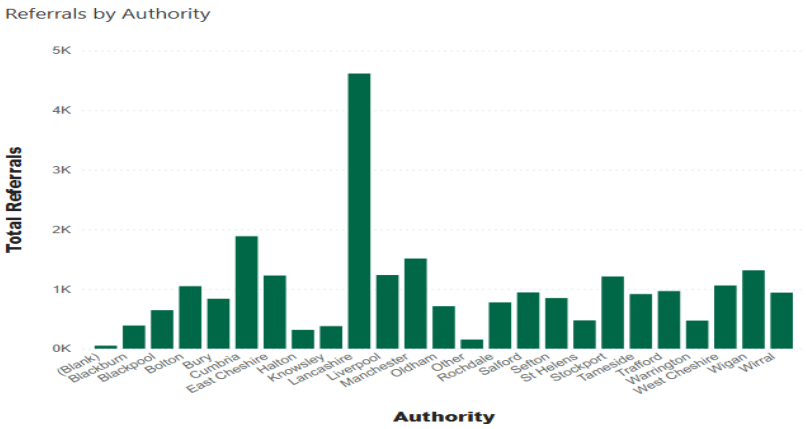
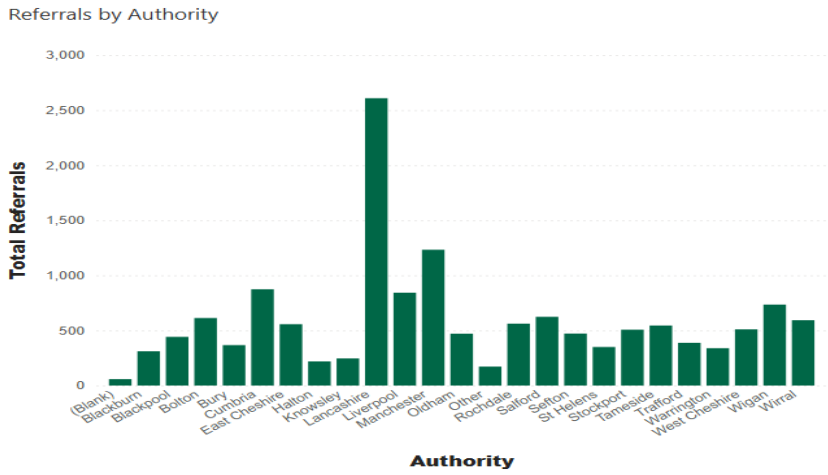


Chart 7 - Safeguarding Referrals



Referral activity by each local authority is proportionate to population size and relative depravation as would be expected. Of note, Lancashire County Council covers 11 of the 13 council districts within Lancashire which accounts for the significantly higher number of referrals to this local authority.

Safeguarding referrals continue to be made our Support Centre Team who take telephone referrals from our crews and send them electronically to the relevant local authority using the Cleric referral system. Assurance in relation to the quality of NWAS referrals is monitored closely by the Safeguarding Team.

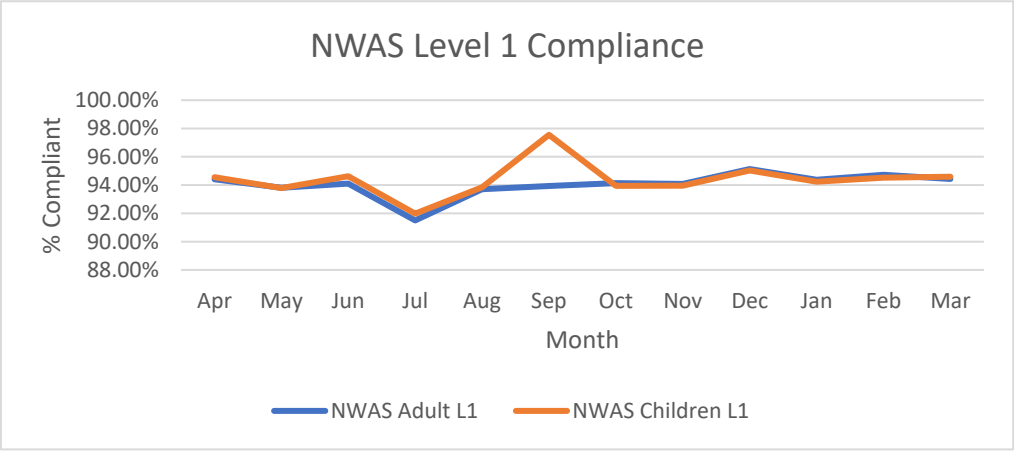
We report on referrals rejected by our Local authorities via the Cleric system. The referral rejection rate for 24/25 was 1.95% of total referrals made with 49% of these rejections being due to patients not being eligible for social care upon further review by the relevant local authority, thus indicating that our referrals are of a good quality.

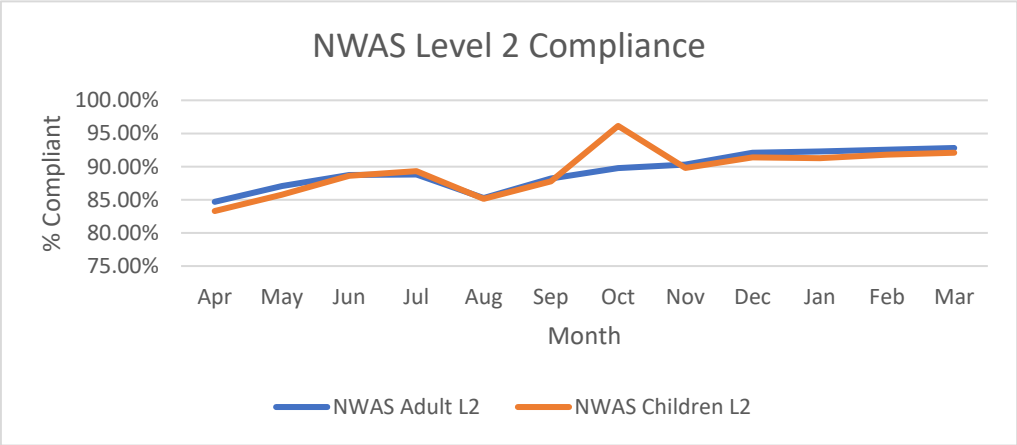
Our low rate of rejections is likely in part due to increased knowledge and confidence within our workforce and also due to internal quality assurance processes. Approximately 10% of all referrals deemed not to meet the safeguarding threshold by the Support Centre are subsequently put on 'hold' and forwarded electronically to the Safeguarding Team for additional oversight, thus ensuring that the potential for missed safeguarding opportunities is minimised. Diagram 8 (below) indicates that in 69% of 'hold' cases, the Safeguarding Team agree that the referral does not meet the safeguarding threshold. In 31% of cases, a safeguarding referral is required. This process has enabled the identification of themes requiring targeted safeguarding support and meaningful feedback. It has additionally formed the basis for monthly support sessions for Support Centre staff, to assist with the training and continued development of our referral advisors.

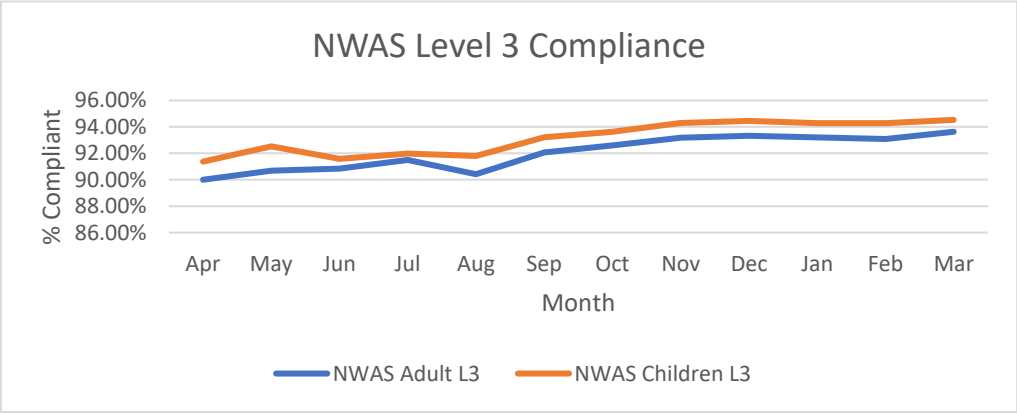
4. TRAINING

Safeguarding training compliance is monitored closely. At 31.3.25 the Learning and Development Team report overall safeguarding training compliance (levels 1-3) to be above 90%.

Figure 9 - Safeguarding Training Compliance 2024/25







Level 1 & Level 2 safeguarding is delivered through e-learning packages which are accessed via the Electronic Staff Record (ESR).

Level 3 safeguarding training is delivered across multiple platforms. Frontline staff who have been identified as requiring level 3 safeguarding training receive this face to face via the mandatory training programme.

Level 4 training: The Head of Safeguarding, Assistant Director of Nursing and Quality and the Safeguarding Practitioners are all compliant with level 4 training this year.

Safeguarding training for ICC staff was historically supported face-to-face by the Safeguarding Team. However, as the service (and subsequently the workforce) has increased, this has become more challenging both in terms of releasing staff for face-to-face sessions and also due to limited capacity within the Safeguarding Team to train sufficient numbers of ICC staff.

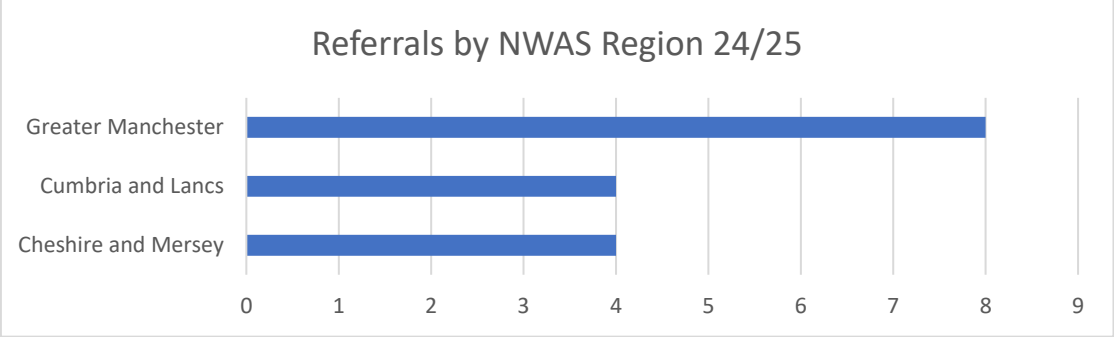
In agreement with the Learning and Development Team and ICC operational leads, additional E-Learning for Health (ELfH) safeguarding modules are now accessible to ICC staff via ESR. During Q3, the Safeguarding Team piloted the delivery of face-to face 'Lightening Learning' sessions with our ICC colleagues which led to an increase in successful referrals being raised during Q4. These sessions will recommence upon completion of the ICC restructure which is underway at the time of this report.

4.1 PREVENT TRAINING

On 31st March 2025, the Learning and Development Team report overall training compliance with Prevent Basic Awareness as 90%. Compliance with Level 3 Prevent training is reported as 81%, requiring additional focus during Q1 2025/26.

During 2024-2025 the Trust has made 16 PREVENT referrals to the National Referral Programme, an increase of 33% from 2023/24. This is possibly due to the major incident in Southport, in July 2024 and the associated impact on emergency services staff.

Figure 10



5. PROJECT EMERALD

The Safeguarding Team continue to monitor the Cleric referral system and to ensure continued, positive engagement with Social Care partners. Phase two of the project is now complete and from Q4, our data reporting ability has improved with the implementation of a safeguarding dashboard. This allows for scrutiny of themes and trends in terms of referral activity and types of abuse, by service line, geographical area and by local authority, subsequently informing bespoke, targeted training delivery.

6. SAFEGUARDING AUDITS

At the request of the NWAS Board, Mersey Internal Audit Agency (MIAA) carried out a comprehensive safeguarding audit in Q3 2024/25, the outcome of which was "Substantial Assurance".

The Safeguarding Team currently carry out two audit cycles a year, focussing on repeat children's safeguarding concerns and domestic abuse. These audits are carried out on a weekly basis by the team to explore any cases where we have multiple concerns raised regarding the same child/ren to ensure that all the necessary services are provided.

The children's audit provides oversight and assurance of collaborative working between children's social care and NWAS. Repeat child concerns are raised when there are three or more concerns raised within a year for a child under the age of 18. When a child is identified as a having had repeat safeguarding concerns raised for them, the Safeguarding Practitioners contact the relevant social care team or the child's social worker and discusses the NWAS contacts and the safeguarding concerns that are raised. This discussion allows planning processes to be agreed between the Trust and the responsible social care organisation. These cases are raised with Children's Social Care to ensure that they are known to services and are being supported appropriately. If they are known in the system, this is highlighted so that we can be assured that the child is being supported, and a 'flag' can be removed.

The domestic abuse audit is carried out to ensure that there have been no missed opportunities to raise concerns for the person at risk. It is to provide assurance that staff are reporting appropriately through onward communication with Social Care or the Police and that when domestic violence is witnessed or disclosed then a safeguarding concern has been raised. It also provides the team with the opportunity to review more in-depth cases and to educate staff where needed. These audits also provide assurance that where cases of domestic violence are raised, safeguarding concerns for any children in the family are also raised jointly.

Both audits require the analysis of data and the contacting of the relevant multi agency partners, which for these specific audits would usually be Social Care and the Police.

7. SAFEGUARDING POLICIES

Safeguarding policies have been reviewed and are available for staff to access on the Safeguarding Resource section of the Green Room.

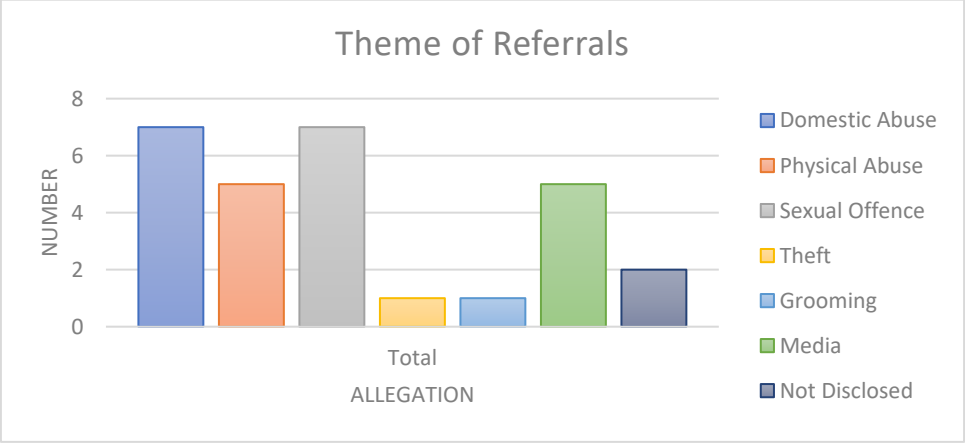
8. ALLEGATIONS AGAINST STAFF

A dedicated E-mail inbox is in place for the Safeguarding Team to receive notification of allegations against NWAS staff. Ongoing collaboration with Human Resources and Operational Leads allows us to share intelligence appropriately and to complete joined up risk assessments on a case-by-case basis. All actions are guided by supporting policies and are proportionate to the level of risk to patients and to NWAS staff.

The Safeguarding Team produce a monthly analysis report enabling scrutiny of the data to collate themes and trends by geographical area and by service line. During 2024/25, 28 notifications have been received, of which 15 have been closed in agreement with the Local Authority Designated Officer (LADO) or Person in a Position of Trust (PiPOT), due to no further safeguarding action required and/or in favour of HR processes. 13 cases currently remain open.

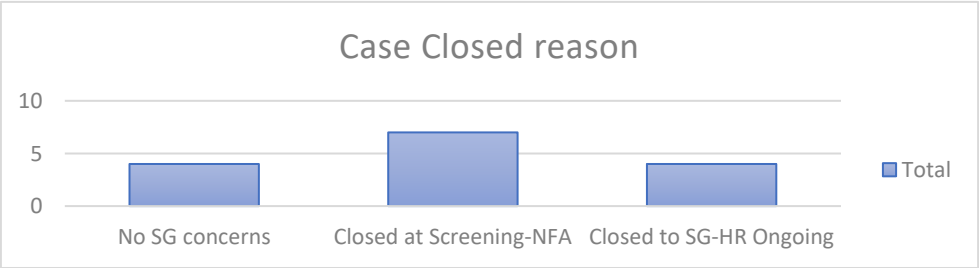
Chart 11 (below) demonstrates themes in relation to allegations and indicates that domestic abuse and offences of a sexual nature account for 50% of all allegations against our staff. The Safeguarding Team are represented at the NWAS Sexual Safety Steering Group which has ensured that the Allegations Against Professionals Policy is appropriately considered within the process to manage sexual safety concerns.

Figure 11



Of the 15 cases closed, following initial screening by the Safeguarding Team, 6 were closed following discussion with the relevant LADO/PiPOT due to no further action required and 4 were closed to safeguarding in favour of Human Resources processes (Figure 12 below).

Figure 12

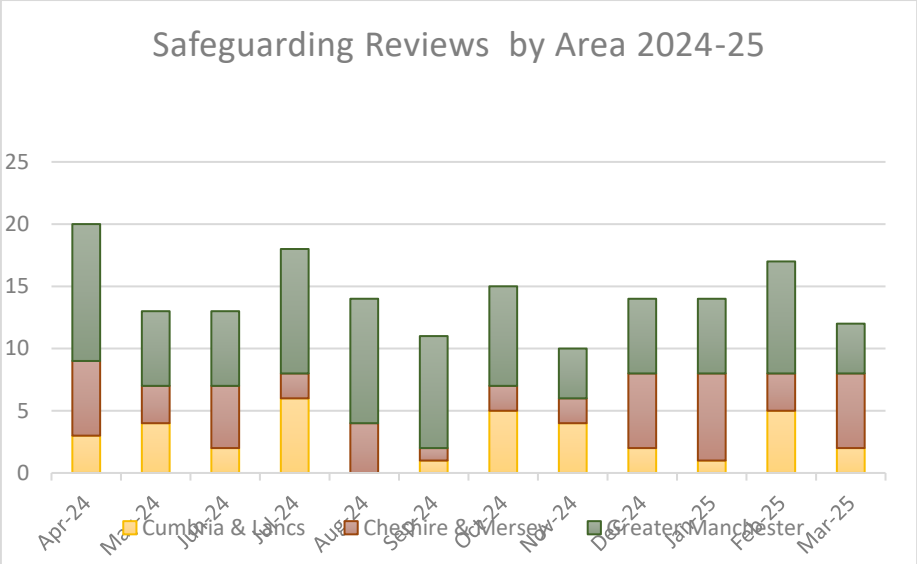


9. PARTNERSHIP WORKING

During 2024/25, the Trust has engaged in 171 statutory reviews consisting of: 94 Safeguarding Adult Reviews (SAR's), 42 Domestic Abuse-Related Death Reviews (DARDR's) and 35 Local Child Safeguarding Practice Reviews LCSPR's). Greater Manchester, our largest area, continues to generate the most safeguarding activity as demonstrated in Figure 13 (below). Thematic learning from reviews is shared via the Green Room and via Safeguarding Practitioners attending their area Learning Forums. NWAS-specific learning is delivered directly to Sector Leads for immediate communication with the relevant staff/service lines. The Trust Management Committee are

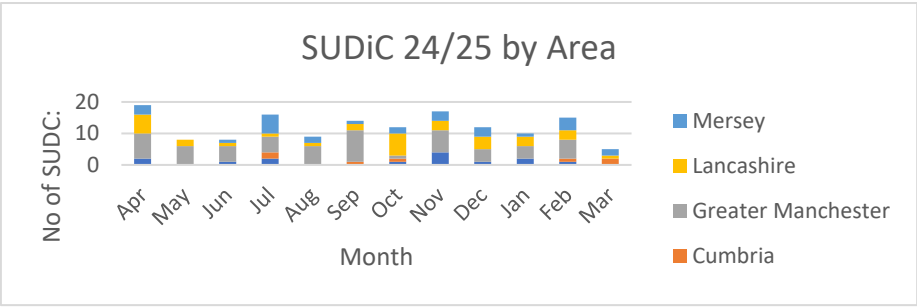
apprised of the outcomes of all statutory reviews and any action plans subsequently formulated via the bi-monthly Reportable Events paper. Risks identified during participation in a review are escalated as per Trust policy. There are currently no risks in relation to safeguarding on the Trust Risk Register.

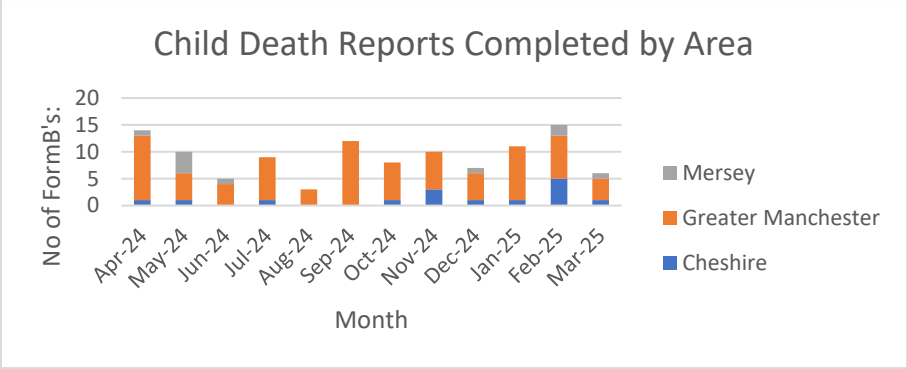
Figure 13



In addition to our statutory commitments, NWAS has, in conjunction with our Patient Safety Team and Consultant Midwife, participated in 145 Sudden Unexpected Death of an Infant or Child (SUDiC) reviews. This involves attendance at Joint Agency Response (JAR) meetings along with the provision of additional information, as required, via completion of Child Death Reports in support of the Child Death Overview Panel (CDOP) process. Figure 14 (below) details SUDiC activity by area.

Figure 14





NWAS engagement with system-wide safeguarding activity remains a challenge due to the large geographical area we cover. In order to make the most effective and equitable use of the resource within the Safeguarding Team, we are working closely with our ICB's to develop leaner ways of working and to ensure that our contributions are meaningful and proportionate.

Each Safeguarding Board/Partnership Board is formally written to on an annual basis by the Head of Safeguarding to inform them of our commitment to engage with the Safeguarding Boards, and to establish good working relationships in each area. A copy of the Trust annual safeguarding report is also shared.

The Safeguarding Team participates with the following panels and sub-groups:

- Child Death Overview Panel
- Rapid Response meetings
- Alternative Life-Threatening Event meetings
- Brief Learning Reviews
- Serious Case Review groups
- Safeguarding Adults Review groups
- Domestic Abuse-Related Death Reviews
- Frontline visits with local board members
- Wider stakeholder meetings
- Multi-agency review meetings following the Sudden Unexplained Death of a Child (SUDiC)
- Section 42 and Section 47 enquiry meetings.
- High risk patients review meetings.

10. SAFEGUARDING INTERFACE WITH KEY NWAS WORKSTREAMS

Collaborative working with the NWAS Patient Safety Incident Response Team (PSIRF) has seen safeguarding oversight increasingly embedded within patient safety processes. The Safeguarding Team have access to all patient safety events and are thus involved in all aspects of the process from initial event reporting, through to attendance at the Complex Case Review Group (CCRG) and Patient Safety Event Committee (PSEC). This affords us the opportunity to consider patient safety events through the safeguarding lens and to identify any missed opportunities to safeguard children and adults at risk. Moving forwards, we are anticipating the introduction of a safeguarding module within the incident reporting (DatixCloudIQ) System by

Q2 2025/26. This will improve our ability to identify themes and areas of our workforce requiring bespoke, safeguarding support, reduce the risk of duplication in investigative processes and will ensure that safeguarding learning is fully embedded within our Patient Safety Incident Response Framework (PSIRF) system-based approach to learning and quality improvement.

11. PRIVATE PROVIDERS

The Safeguarding Assurance Framework (SAF/Section 11) document is issued to all private ambulance providers annually and the requirement to complete this and to submit the appropriate evidence is reflected in private provider contracts. The Governance and Learning Safeguarding Practitioner works collaboratively with the Service Delivery and Governance Team to coordinate this piece of work, collate compliance data and to support private providers in completing any actions identified to achieve full compliance.

12. NATIONAL AMBULANCE SAFEGUARDING GROUP

The Head of Safeguarding attends the National Ambulance Safeguarding Group (NASaG). Engagement with NASaG ensures the Trust are informed of any changes to national safeguarding policies, safeguarding standards, and regulatory framework. The group also facilitates collaboration with other ambulance trusts to share best practice and to work together in addressing challenges. The workplan for 2025/26 includes development of a safeguarding training suite that is bespoke to ambulance services following acknowledgement that examples within existing training packages do not adequately reflect pre-hospital care.

13. SAFEGUARDING FLAGS

Safeguarding flags are placed on addresses (by postcode) where it has been identified that an individual who is at high risk of harm or abuse resides. Flags are placed for short periods and are reviewed to ensure they are current and relevant. Maternity alerts are also placed onto the Cleric system, at the request of maternity professionals, when an unborn child is at immediate risk following birth.

14. SAFEGUARDING ACHIEVEMENTS 2023/24

- Delivery of bespoke, participative safeguarding training for Integrated Contact Centre and Support Centre staff has improved knowledge and confidence within this staff group, who by nature of their role, are safeguarding 'at a distance' over the telephone as opposed to face-to face with our patients.
- Restructure within the Safeguarding Team has enhanced cross working and sharing of expertise between safeguarding and mental health staff.
- We have seen the benefits of the Safeguarding training needs analysis review, in that referral numbers have increased, and the referral rejection rate has decreased, following the alignment of additional staff to level 3 safeguarding training.
- Completion of phase 2 of the Safeguarding Cleric system, including development of the Summit viewer to enable access to historical safeguarding information held on the now decommissioned ERRIS system.

- Development and implementation of the safeguarding dashboard which has enhanced our reporting and assurance processes.
- Continued engagement with Integrated Care Boards to streamline assurance requirements and to provide a conduit to safeguarding boards/partnership boards.
- Continued development of easily accessible safeguarding resources for our workforce.

15. AMBITIONS 2025/26

- Embed Safeguarding Supervision within the Trust appraisal process, anticipated by Q3 2025/26.
- Implementation of a safeguarding module within the DatixCloudIQ System in order that safeguarding learning is embedded within our response to patient safety events, anticipated by Q2 2025/26.
- Development of safeguarding champions/link staff within our Integrated Contact Centres, anticipated by Q4 2025/26/

Ongoing delivery, from Q2 2025/26, of bespoke, face-to-face, lightening learning sessions to our Integrated Contact and Support Centre Staff.

16. RISK CONSIDERATION

The Trust appetite for risk in relation to quality outcomes is low and the action taken to improve quality assurance processes between the Safeguarding Tean and the Support Centre, enhances assurance in relation to NWAS safeguarding activity.

17. EQUALITY/ SUSTAINABILITY IMPACTS

N/A

18. ACTION REQUIRED

The Board of Directors is asked to:

Receive the assurance that NWAS safeguarding activity during 2024-25 continues to meet our statutory requirements.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Infection Prevention and Control Annual Report 2024/25
PRESENTED BY	Elaine Strachan-Hall – Director of Quality and Improvement
PURPOSE	Assurance

LINK TO STRATEGY	Quality Strategy										
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐	
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐	**SR11**	☐

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the content of the report. • Note the assurances it provides. • Note the arrangements for ongoing monitoring via the IPC BAF. • Note the key risks and mitigations.
EXECUTIVE SUMMARY	This paper provides the Board of Directors with the IPC Annual Report updated IPC BAF. The IPC BAF provides assurance that policies, procedures, systems, processes, and training are in place to minimise the risk of transmission infection to service users, patients and staff. It also identifies gaps in assurance, IPC risks and mitigations. The Framework is organised under 10 Key lines of enquiry, each with a series of questions which need to be addressed. The IPC BAF has 9 amber rated areas and no red rated areas. There are several areas that are aimed at acute trust providers and are clearly marked as Not Applicable for the ambulance service in this document. Gaps in Control and mitigating actions are clearly articulated and a timeline to improve declared throughout the BAF.

	There are currently five IPC risks on the risk register all scoring less than 12. Risks are regularly reviewed and managed, and action undertaken. The updated IPC BAF will be monitored by the IPC Oversight Group.	
PREVIOUSLY CONSIDERED BY	Clinical & Quality Group	
	Date	Tuesday, 06 May 2025
	Outcome	Approved
	Trust Management Committee	
	Date	Wednesday 21st May 2025
	Outcome	Approved
	Quality & Performance Committee	
	Date	Monday 30th June 2025
	Outcome	Approved

INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2024/2025

1. STATEMENT BY THE DIRECTOR OF INFECTION PREVENTION AND CONTROL

This report highlights the Trust's continued progress in delivering against its key priorities for Infection Prevention and Control (IPC). Our ongoing commitment to promoting best practice and upholding high clinical standards remains central to all our efforts.

The IPC team plays a vital part in the development, implementation, and monitoring of infection prevention measures across the Trust. Working closely with both internal colleagues and external partners, the team provides expert advice, support, and training to ensure compliance with the Health and Social Care Act 2008. Their work is instrumental in safeguarding the health and wellbeing of both patients and staff by reducing the risk of healthcare-associated infections (HCAI) and supporting the delivery of safe, high-quality care.

National guidance and initiatives continue to shape elements of our annual IPC work programme, which remains dynamic and responsive as we look ahead to 2025/26. Infection Prevention and Control is a shared responsibility, and our collective success depends on collaboration at every level. This annual report outlines our current performance, celebrates areas of achievement, and identifies opportunities for innovation and continuous improvement.

2. PURPOSE AND BACKGROUND

Purpose

The purpose of this report is to present the achievements and challenges of the IPC team for Northwest Ambulance Service (NWAS). This report will focus on the different aspects of IPC activity and our ongoing response to emerging infectious diseases, incidents reported and the cascading of new national guidance. The reporting period is 1st April 2024 until 31st March 2025.

Background

Effective systems for the management of IPC are essential for all NHS providers. NWAS has a legal duty to comply with the Health and Social Care Act 2008, specifically the Code of Practice for the NHS on the prevention and control of HCAIs and related guidance. Our approach to IPC is taken from the guidance published by United Kingdom Health and Security Agency (UKHSA) who remain the trusted NHS authority on the implementation of research evidence into NHS practice.

The IPC team monitor compliance to IPC policies, procedures and training via station and vehicle audits. The IPC Practitioners and the Respiratory Protective Equipment (RPE) Fit Testers complete audits in addition to the audits completed by the operational staff. All completed IPC audits are reported through a Power BI dashboard which allows all service lines to review audit data and monitor their progress in real time. The dashboard also

forms assurance reports that are presented by area representatives at the IPC Oversight Group. This group reports directly to the Clinical and Quality Group.

The team actively monitors IPC incidents and infection-related concerns through the Trust's incident management system, Datix Cloud IQ (DCIQ), which features an IPC dashboard summarising all reported incident. This approach ensures that key themes identified from incidents in each area are combined with audit data to enhance our understanding of where system improvements are needed, where further training should be provided or incorporated into existing programmes, and where risk management measures need to be implemented.

3. COMPLIANCE WITH CARE QUALITY COMMISSION (CQC) REGULATIONS

In 2023, CQC redesigned its assessment process and introduced a new system called the Single Assessment Framework (SAF). The CQC began to implement the SAF in the third quarter of 2023. However, full deployment was delayed following restructuring within the CQC and feedback from stakeholders. During this period CQC's interaction with NWAS during 2024/25 included routine engagement meetings and specific enquiries.

On an annual basis, NWAS conducts Quality Assurance Visits (QAV) across all service lines. The purpose of these visits is to provide assurance regarding the quality and safety of operational premises, vehicles, and services at sector level. Remaining up to date with changes to regulatory requirements has continued to be a focus for NWAS. The IPC team actively participates in QAVs to provide specialised oversight on these visits. Instances of non-compliance with IPC policies and procedures on station audits are identified and documented in the Trust's internal management systems allowing respective parties to address the issues, often with support from the IPC team. Any non-compliance is followed up with an IPC audit to ensure all concerns have been resolved.

NWAS has adapted and improved its internal processes in response to changes made by the CQC. This includes working with subject matter experts to add tailored questions to the QAV framework, ensuring alignment with the CQC's evidence categories and Quality Statements. Ongoing adjustments are being made so that NWAS's assurance processes continue to evolve alongside the CQC's updated approach.

Estates and Facilities Management

The Estates and Facilities Management team conduct compliance audits on all NWAS owned properties to ensure the sites remain safe, clean, well maintained and all associated equipment is in a safe and operational condition. The team ensures that appropriate maintenance and inspection records are held centrally and comply with statutory legislation.

The Head of Estates has several safety groups in operation to provide assurance in relation to the Health and Safety Executive (HSE) legislation. These groups include, but are not limited to, the management of; asbestos, water safety, gas and electrical safety, portable appliance testing, air conditioning and air monitoring safety with planned

preventative maintenance undertaken in line within current contract specifications. Compliance reports are provided to the Health Systems Support Framework (HSSF) group and other Trust Committees.

The IPC Specialist Lead is a member of the Water Safety Group that commenced this year in line with the requirement in the Health and Social Care Act 2008. A Trust Water Safety plan has been developed and approved by the group. Results of regular monitoring of water samples are reported to the group. Any anomalies are recorded on a central database which is monitored by the Estates department and action is taken accordingly to address any issues.

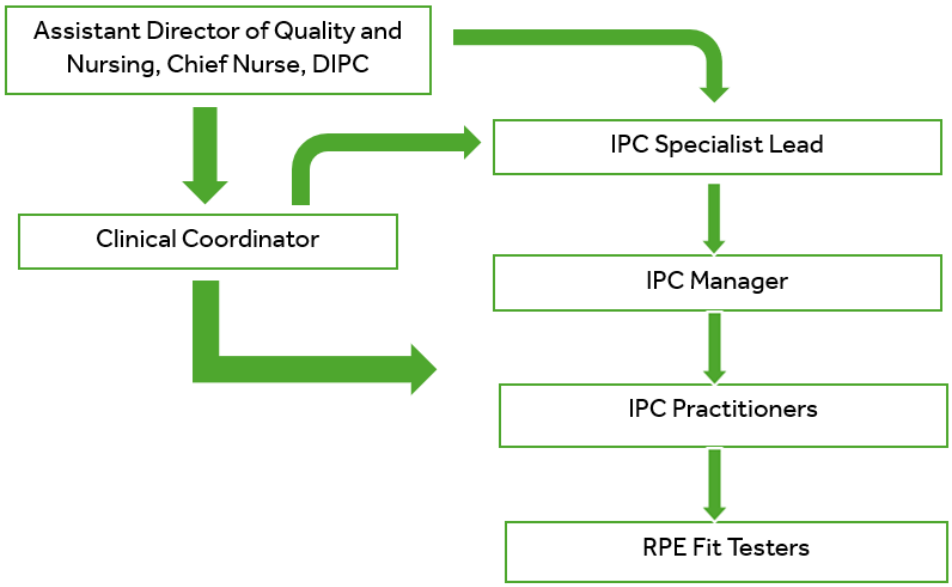
The IPC team participate in the planning stage of refurbishment and new builds across the organisation. The team ensure that these plans are compliant with national guidance on the safe disposal of waste and sharps, storing clean linen and have adequate storage for sterile and single use items. The team advise on material for work surfaces, walls and flooring to facilitate effective cleaning.

4. IPC GOVERNANCE ARRANGEMENTS

In NWAS the corporate responsibility for IPC sits with the Assistant Director of Quality and Nursing, who is also the Director of IPC (DIPC). The DIPC is responsible for the IPC team and provides assurance to the Board and the wider Executive team through assurance reports, the annual workplan and the IPC Board Assurance Framework (BAF).

The IPC team consists of an IPC Specialist Lead, an IPC Manager (currently on a 2-year career break), three IPC Practitioners (one for each area) and a Clinical Coordinator who provides support to the DIPC and the IPC team. The IPC team is also responsible for fit testing within the Trust so therefore there are three RPE Fit Testers, one for each area, who directly report to the IPC Practitioners. The IPC team sits within the Quality, Improvement and Innovation Directorate and is overseen by the Assistant Director of Quality and Nursing and DIPC.

(Chart 1 below demonstrates the structure of the IPC team)



Progress Against BAF Key Lines of Enquiry

The IPC BAF has been revised in line with the code of practice on the prevention and control of infections under the Health and Social Care Act 2008. This act sets out the overall framework for the regulation of the Health and Social Care Act activities by the CQC.

The IPC BAF provides assurance that policies, procedures, systems, processes, and training are in place to minimise the risk of transmission infection to service users, patients, and staff. It also identifies gaps in assurance, IPC risks and mitigations. The Framework is organised under 10 key lines of enquiry, each with a series of questions which need to be addressed. To ensure that consistently high levels of IPC (including cleanliness), are developed and maintained, it is essential that all providers consider the document in its entirety, and its application in the appropriate sector. Several sections have been highlighted as 'not applicable' for ambulance services as they relate to Antimicrobial Stewardship, Inpatient isolation facilities and access to pathology services. Assurance is provided by demonstrating evidence against each criterion and mitigating actions where the criteria are not fully met.

The BAF was reviewed in November 2024 and presented to both the Quality and Performance Committee and Trust Board for assurance. NWAS is rated green for 28 criteria with no red rated criteria and 7 amber rated key lines of enquiry. Eighteen of the criteria are not applicable for the ambulance service as they refer to the isolation facilities, access to a pathology laboratory and surveillance of infections. Any gaps in control and mitigating actions are clearly circulated. The amber rated criteria are included in the document and incorporate fit testing and standards of cleanliness.

NHS England (NHSE) published the national standards of cleanliness in late February 2025, and the IPC team is working closely with the Facilities Management team to ensure the Trust's alignment with these standards. Notably, for the first time, the standards include a dedicated

section for the ambulance sector. IPC risks are reviewed monthly, and the IPC BAF is reviewed bi-annually by the IPC Oversight Group, or earlier if required by national guidance.

Provide and Maintain a Clean Environment

The IPC team recommend that vehicle equipment should be cleaned daily and in between patients. Enhanced cleaning continued to be undertaken for suspected or confirmed infection cases and where Aerosol Generating Procedures (AGP) had been undertaken within the vehicle. All Trust vehicles undergo a 6 weekly deep clean and deep clean audit data is presented at the IPC Oversight Group for assurance.

Provide Suitable Information on Infections for Staff and Patients

Any updated national guidance and local operating processes are disseminated regularly to staff via bulletins, social media, internal intranet, and the IPC Oversight Group. All training materials for staff and volunteers were reviewed throughout the reporting period and amended to reflect changes in national guidance.

Local risk assessments, guidance and procedures remain in place to ensure that patients are appropriately triaged and assessed for level of risk prior to transportation collaboration with other healthcare providers regarding patients with transmissible infections helps minimise the risk of further transmission by ensuring patients are placed in the most appropriate care setting. The IPC team maintains close working relationships with IPC teams across all healthcare organisations, allowing collaboration between the teams to stay informed about any rise in infection rates within the community. This information is then shared with staff working in affected areas to raise awareness and support appropriate precautions

The IPC team also collaborates closely with the United Kingdom Health and Security Agency (UKHSA) to identify care facilities reported to be experiencing an outbreak. UKHSA shares this information via email to the IPC inbox, where it is reviewed by the team. They then liaise with the NWAS Gazetteer team to place a note on the relevant address on the IT system, alerting attending crews to the outbreak. These markers are removed once the outbreak is officially declared over. The IPC team is currently working with the Risk team to explore integrating this process into DCIQ and is trialling the method to assess its effectiveness.

5. ASSURANCE

IPC Risk Management

During 2024/25 risks in relation to IPC have been aligned, managed, and monitored as part of the IPC BAF, in addition to the organisational BAF and the Corporate Risk Register.

All risks are reported on the DCIQ system and there are currently five risks aligned to IPC that are all scoring less than a 12.

- Risk number 605 - There is a risk that due to increased prevalence of Measles in the

community, staff who are not immunised or wearing the correct PPE will be exposed and at risk of contracting Measles resulting in further transmission in both the community and colleagues leading to absence from work.

- Risk number 668 - There is a risk that due to the increased prevalence of Mpox Clade 1- a HCID (and the associated declaration from the World Health Organisation (WHO) that it is a public health emergency of international concern) that staff may not sure what Personal Protective Equipment (PPE) to don /how to safely transfer a suspected High Consequence Infectious Disease patient.
- Risk number 678 - There is a risk that due to the large number of staff fit tested two years ago by NHS England funded external fit testing services, these staff will not be fit tested in the Health Safety and Environment (HSE) required two year fit test cycle and must use their personal issue Sundstrom hoods which they may not have with them, forgot how to use them or they don't like to use.
- Risk number 697 - There is a risk that due to staff not carrying out inspections on personal issue Sundstrom Hoods or regular services being undertaken, the Trust will not comply with Control of Substances to Hazardous Health (COSHH) legislation.
- Risk number 698 - There is a risk that due to staff not carrying out a visual inspection of their personal issue Sundstrom Hood or if the service has not been undertaken, essential respiratory equipment will not be available or provide effective protection, resulting in staff being exposed to hazardous environments.

These five risks have been reviewed monthly and updated as further actions and mitigations have been put in place, this is reported via the IPC Oversight Group for assurance. All five risks identified are in relation to areas highlighted in the report, including areas of improvement and additional assurances.

Mitigated Risks (Closed) During 2024/25

The two risks below were closed in the reporting period.

- Risk number 236 - There is a risk that due to not all staff being FFP3 face fit tested and Sundstrom hoods not suitable for all scenarios, staff are unable to respond safely to AGPs leading to risk to personal safety of staff.
- Risk number 255 - There is a risk that due to lack of awareness or capacity 20% of sharps boxes found in sharps bins aren't correctly labelled and / or with temporary safety lock correctly activated resulting in no auditable trail and discarded sharps bins leading to harm or injury to both NWAS staff and external clinical waste collection staff.

Private Provider Group

Over the past 12 months, the IPC team have been involved and supported the private provider group who have ownership of commissioning and managing the private providers for Paramedic Emergency Services (PES) and Patient Transport Services (PTS). The support has ranged from the IPC Practitioners undertaking spot check audits on vehicles at emergency departments, providing basic IPC education, offering specialist advice, and visiting sites for commissioning and audit purposes.

6. POLICIES AND PROCEDURES

The IPC Specialist Lead attends the monthly National Ambulance Service IPC Group (NASIPCG) and contributes to Association of Ambulance Chief Executives (AACE) guidance prior to approval. Once the AACE guidance is approved, the IPC team work closely with the Communications team in NWAS to ensure an updated bulletin is distributed to inform staff of any changes. The IPC team also support the Heads of Service in implementing the necessary changes.

The Trust's IPC policies and procedures are regularly reviewed and updated to ensure they are aligned to national guidance. The IPC team also work closely with the Communications team to ensure that new policies and procedures are available on the Trust intranet. The team then liaise directly with the Heads of Service and inform them when new or updated policies are available, to improve Trust compliance.

This year we have reviewed and updated the following IPC policies and procedures

- Communicable Diseases Policy
- A-Z Communicable Diseases Guidance
- Linen Policy
- IPC Policy

7. GOVERNANCE

The Trust's IPC Sub Committee met bi-monthly to ensure ongoing regulatory compliance and to oversee infection prevention initiatives. While its initial focus was on COVID-19-related risks, such as the use of Respiratory Powered Equipment (RPE), its scope expanded over time to include wider IPC priorities like hand hygiene compliance and environmental decontamination. Despite changes to government COVID-19 guidelines in April 2023, the IPC Sub Committee continued to operate as a structured forum for reviewing emerging infection risks and maintaining alignment with national IPC standards. Following its final meeting on 12th March 2024, the committee was succeeded by the IPC Oversight Group, which now meets quarterly and provides a more structured approach to infection prevention governance.

The IPC Oversight Group addresses a wide spectrum of IPC challenges with a focus on the following key areas:

- **Hand Hygiene improvement initiatives**: Supporting the Trust's quality improvement projects and monitoring compliance, including reviewing hand hygiene audits, and implementing strategies for continuous improvement.

- **Environmental decontamination and vehicle hygiene**: Reviewing cleaning audits and identifying areas for enhancement, ensuring that all areas, including vehicles, meet infection control standards.

- **Outbreak management and emerging infection risks:** Coordinating response planning for seasonal and novel infections, ensuring preparedness and timely interventions, including monitoring and reporting staff flu vaccination status.

- **Staff IPC compliance**: Enhancing education, engagement and assurance processes through compliance reviews to ensure staff are well informed and adhere to IPC practices.

- **RPE fit testing compliance**: Presenting and reviewing fit testing figures managed by the IPC team to ensure that staff members are equipped with appropriate respiratory protection.

Additionally, the IPC Oversight Group engages in regular updates and reviews from various sectors including:

- **IPC guidance and regulations**: Ensuring alignment with updated national and local IPC standards.

- **Vehicle and station audits and risk assessments**: Incorporating vehicle and station audits as part of the broader risk management strategy for infection prevention.

- **Items for escalation to the Quality and Performance Committee**: Raising critical issues for high level review to ensure alignment with overall Trust performance standards. The transition to the IPC Oversight Group and its quarterly meeting schedule provides a more structured and sustainable approach to infection prevention governance, ensuring that all priorities are addressed systematically and effectively.

Outbreak Management

Outbreaks are identified and declared by the IPC team when two or more cases of a communicable disease are linked by time or location. Within the ambulance service, this may involve cases connected to specific stations, offices, fleet services, call centres or among crew members.

The IPC team is responsible for overseeing outbreak management, and ensuring a timely, coordinated, and effective response. This process spans from initial detection, ongoing monitoring of further cases through to formal closure. Any lessons learned are discussed at the IPC Oversight Group. A standardised approach is maintained across NWAS with managers given consistent advice on what enhanced IPC measures should be implemented to minimise the risk of further onward transmission of infection.

As part of this process, the IPC team coordinates infection control measures in relation to buildings, ensuring appropriate decontamination and restriction protocols are followed.

The team also provide guidance on the correct use of PPE and liaise with Occupational Health to conduct risk assessments for impacted staff.

During the period covered in this report, the IPC team managed one outbreak of diarrhoea and vomiting (suspected Norovirus) within the Trust. This outbreak was at Bury station and four members of staff were affected – all had been in contact with each other at work. Enhanced cleaning at the station was implemented and staff were advised to ensure that they washed their hands regularly and clean down surfaces at the station after use.

8. PPE

PPE is widely available to all patient facing staff and they are trained in its use, including 'donning and doffing.' The national PPE guidance has changed - the previous PPE requirements known as 'PPE levels' were replaced with Transmission Based Precautions (TBP). Staff choose the appropriate PPE based on what transmission route was needed i.e. contact, droplet or airborne. These updates have been reflected in all training packages and in the document 'A-Z of Communicable Diseases' which now gives specific advice on suitable PPE for infectious disease.

PPE Stock Ordering and Distribution

The NWAS Procurement team have responsibility for sourcing PPE in NWAS. The IPC team determines the suitability of PPE. Since April 2024, NHSE have removed the push stock supply model for PPE and individual trusts now order their own PPE as required. In NWAS, the ordering is completed via NHS Supplies by local operational leadership teams to ensure they have the correct stock levels for use in their sector.

PPE Recalls and Safety Alerts

The Medicines and Healthcare Regulatory Agency (MHRA) issues safety alerts from the Central Alerting System (CAS). The Working Area Specialist (WAS) Board of Directors are identified via the Integrated Performance Report (IPR) of safety alerts received. During 2024/25 NWAS received one IPC related safety alert from the Health and Safety Executive regarding Sundstrom hoods that are issued personally to PES staff. The hoods contain latex, although the latex is covered by fabric, so it does not encounter the skin unless there is wear and tear to the fabric covering. Measures have been put in place to mitigate this risk to staff who have a known latex allergy.

RPE

The FFP3 respirator mask covers the mouth and nose to protect against particulate hazards, such as airborne infectious viruses, and is an essential part of PPE for staff who carry out AGPs. An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract. The only AGP likely to be completed by NWAS staff is the suctioning of a tracheostomy on a patient. There are infectious diseases where the requirement for respiratory protection is essential;

- Middle Eastern Respiratory Virus (MERS)

- Avian Flu
- Mpox
- Other HCIDs

RPE must also be worn if there is a risk of exposure to asbestos or glass particles for example at road traffic collision and fire servicing are cutting glass.

During 2023/24 FFP3 masks were available free of charge to all NHS Trusts via the Central Governments push stock. This was removed during 2024 as existing national stocks were used up. NWAS were able to choose from a list of approved FPP3 masks of which the supply was guaranteed. A selection of four masks is available that staff can be fit tested with, which provide an option for various face shapes and sizes. Anyone who fails on all four masks must use the Sundstrom powered respiratory hoods that are supplied as personal issue when commencing in the trust.

Under COSHH legislation, FFP3 masks must be fit tested to ensure they fit the individual wearer. Since October 2023, NWAS has a fit test team of three, with one fit tester to cover each area. The fit testing team undertake the fit testing of operational staff who require a new fit test every two years. For new staff to NWAS, the Clinical Education Practitioners fit test them during their training/induction course. To support fit testing, the three IPC Practitioners are trained fit testers and fit test as required in areas of low compliance or due to large staff numbers who require fit testing. Compliance at 27th March 2025 is detailed in the tables below;

Cumbria & Lancs (CAL)	Match	Non-Requirement Competence	Not Required	Required	Grand Total	Percentage
CAL-Clinical Leads	17			2	19	89%
CAL-East Lancs	287	1		18	310	94%
CAL-Fylde	182			15	199	92%
CAL-Morecambe	224		2	25	261	90%
CAL-North Cumbria	228		10	27	270	90%
CAL-Service Delivery	18		3	3	24	88%

CAL-South Lancs	246		1	17	268	94%
Total	1202	1	16	107	1351	92%

Cheshire & Mersey (CAM)	Match	Non-Requirement Competence	Not Required	Required	Grand Total	Percentage
CAM-Clinical Leads	12			5	20	75%
CAM-East	311		3	24	341	93%
CAM-North	413		3	64	488	87%
CAM-Service Delivery	17		4	2	23	91%
CAM-South	242		2	29	276	89%
CAM-West	246	1	4	32	289	89%
Total	1241	1	16	56	1437	89%

Greater Manchester (GM)	Match	Non-Requirement Competence	Not Required	Required	Grand Total	Percentage
GM-Central	280	2	2	60	358	83%
GM-Clinical Leads	13			4	18	78%
GM-East	290		3	33	336	90%
GM-Service Delivery	13		4	7	25	72%
GM-South	347	1	4	66	434	85%
GM-West	217		2	89	321	72%
Total	1160	3	15	259	1492	83%

Operational pressures contribute to the challenge of ensuring staff are fit tested– both the member of staff and the vehicle, are taken off the road whilst the fit test is completed. Any PES staff who have not been fit tested or have failed a fit test are told to use their individual issue powered respiratory hood.

Respiratory Hoods

NWAS continue to issue powered respiratory hoods as RPE as personal issue to all emergency service patient facing staff. The powered respiratory hood, which the Trust uses, is the Sundstrom SR 520 Hood with the SR700 Fan unit. This enables staff with beards, stubble, spectacles, and facial disfigurement to wear the equipment. There is no need for fit testing however the user does need to be trained in how to test and wear the equipment.

There is a requirement for the Sundstrom Hood filtering units to be serviced on an annual basis to ensure compliance with the COSHH regulations. The filter units are serviced by Sundstrom trained Oxylitre service engineers. These records are held by Fleet who oversee the servicing contracts.

Compliance Auditing of RPE Preparedness

The IPC team has developed an audit tool for monitoring operational compliance of our staff regarding preparedness to attend an incident requiring PPE. This audit is carried out by a Senior Paramedic (SP) team during their clinical contact shifts with frontline operational staff. This should happen on three occasions a year. This audit measures whether the staff member is in date for their FFP3 fit test and, if not, if they have their Sundstrom hood with them. The audit is recorded on the Safecheck system and can be viewed on the power BI dashboard.

9. VACCINATION

Flu Vaccination Programme

The Trust delivered its 2024/25 flu vaccination programme following a similar model to the previous year. The IPC Specialist Lead coordinated vaccinations for corporate staff, with trained IPC team members running clinics across the Trust. They also vaccinated PTS staff, who lacked an internal vaccinator, and visited educational settings to vaccinate new starters. In total, the IPC team administered 462 vaccinations, accounting for 14% of the overall total.

The campaign, extended to March 2025 per NHSE guidance, resulted in 2880 staff vaccinated at NWAS and 578 elsewhere—an overall uptake of 43.08%, a 5.55% drop from the previous year. Despite this decline, NWAS performed better compared to previous years and national averages, as uptake across the NHS also decreased.

A lessons-learned session was held to review the campaign and explore ways to improve future uptake, including engaging with staff who declined the vaccine. The IPC team will continue to support the 2025/26 campaign through mobile flu clinics across the Trust.

10. FACILITIES MANAGEMENT

Review of Cleaning Regimes Across All Sites

The updated version of the National Standards of Healthcare Cleanliness was published in February 2025, and for the first time included requirements for ambulance service trusts. The Head of Facilities Management and Facilities Management Regional Officer at the trust contributed to these standards as part of a working group. The principles of the new standards were applied during the re-tender of the premises cleaning contract in September 2024, the IPC Specialist Lead was a member of the panel and provided input into the specification. Work in ongoing to meet the mandatory aspects of the standards.

Facilities Management in collaboration with IPC undertook a Trust wide review of cleaning provisions in 2024, which specifically included the provision of the sluice and storage facilities provided in premises, that enable effective cleaning at stations and premises. In total 106 audits were completed. Work is in progress to ensure that all cleaning provisions are brought up to standard, minor improvements that are required will be completed by the end of August. Some sites require large capital investment and facilities are in the process of looking at how these can be funded.

This collaborative work will continue with a view to conducting joint audits for premises cleaning and IPC, with the cleaning provider as part of our continuous improvement aims.

Decontamination

Through 2024, there was no requirement to use this facility in respect of the cleaning of premises. However, the decontamination service for workstations and premises remains available to call on as and when necessary, through the contractor.

Premises Cleaning and Increase to Cleaning Provision

We will continue to review service schedules in line with any changes to the Trust's operational delivery plans or as the estate portfolio is increased or reduced.

Clinical Waste

The clinical waste stream in the Trust is managed and monitored by the Fleet Logistics Team and the contract at present sits with Stericycle which has entered a 1-year extension until 31st March 2026. The Trust has robust systems in place for disposing safely and effectively of clinical waste.

The frequency of collections driven by the monitoring of each individual bin weight is continually monitored to ensure the Trust achieves value for money whilst providing the appropriate provision at each station. Consequently, the following year on year annual savings have been accomplished:

- FY 2021/22 £9K
- FY 2022/23 £15K
- FY 2023/24 £9K
- FY 2024/25 £1K

Following the successful pilot of the Alternative Treatment (Orange Bag) waste disposal at Blackpool and CAL South, this approach is being rolled out to other sectors. All remaining sectors will be introduced throughout 2025 in readiness to meet the legislation implementation date of 1st January 2026.

The service delivery provided by Stericycle in the provision of clinical waste disposal is managed and reviewed monthly during contact management meetings, which is managed by the Fleet Logistic Manager in collaboration with the Trust's Energy and Sustainability Manager and Procurement team.

Vehicle Cleaning

All ambulance interiors and equipment are cleaned and disinfected after every patient contact with clear guidance provided within the IPC procedures in line with national guidance. All ambulance vehicle exteriors are cleaned regularly and when required.

In addition, every vehicle receives a 'deep clean' every 6 weeks delivered through a combination of fixed and mobile sites across the Trust footprint. This is further underpinned by additional unannounced audits carried out by the IPC team. The deep clean audit results are presented at the IPC Oversight Group for assurance.

Deep Clean Tender Contract

The vehicle deep clean contract, including the make ready service, awarded to Churchill Ltd on 1st January 2024 has entered the second year. The delivery of the service is managed by Fleet with support from the Trust's IPC team to ensure the service provider follows the national guidance on IPC and that their products used are suitable for cleaning both the equipment and the vehicles.

11. TRAINING

IPC Training

IPC is a key element of the mandatory training programme for all staff. The training consists of an initial IPC module completed upon recruitment, provided by the IPC team. This is then followed by regular updates including a Level 1 ESR mandatory training course every three years and a Level 2 course annually.

The IPC team have developed a structed presentation tailored for new frontline staff ensuring that IPC principles are effectively communicated. This presentation aligns with the latest National IPC Manual, WHO guidance and UKHSA protocols. It also meets the UK Core Skills Training Framework and mandatory training standards. The presentation aims to equip staff with a solid understanding of IPC practices and protocols. The key topics covered include:

- Systems and procedures related to IPC
- Relevant legislation and policies
- Definitions of HCAIs and strategies to reduce them

- The importance of personal hygiene in IPC in line with WHO hand hygiene
- Roles and responsibilities in IPC
- Cleaning and decontaminating vehicles and equipment
- Safe management of sharps and linen
- Hand hygiene techniques
- The role of risk assessments in IPC

IPC Induction Training Summary (New starters)

Period: 1st April 2024 – 31st March 2025

Staff Group	Number Trained
Patient Transport Service (PTS)	189
Paramedics	298
Associate Ambulance Practitioners (AAP)	332
Urgent Care Services (UCS) Staff	51
Total	870

Training Feedback Summary

Feedback received from 100 participants

Category	Average Score (out of 5)	Summary
Presentation clarity and understanding	4.9	The majority rated clarity as excellent.
Effectiveness of communication	4.9	Presenters were described as engaging, knowledgeable, and clear.
Impact on IPC practices	4.8	Attendees reported improved understanding and positive influence on practice.

Qualitative feedback themes:

Strengths

- The session was widely praised for being engaging, clear and easy to follow.
- Presenters were commended for making the topic interesting despite its complexity.
- The use of quizzes, real-world examples and videos helped maintain engagement.
- Staff highlighted that the presenters were knowledgeable, approachable, and able to answer questions effectively.
- Real-word scenarios from frontline paramedics made the session relatable and applicable.
- Some attendees reported feeling more confident in applying IPC principles in their roles.

Areas for improvement

- More Kahoot quizzes including one at the end to reinforce learning.
- More hands-on activities such as handling sharps bins and PPE donning/doffing exercises.
- Some noted that the videos did not always work reducing the effectiveness of certain segments.
- Requests were made for clearer, more engaging donning/doffing PPE videos.

Conclusion

The feedback highlights the effectiveness of the IPC presentation in delivering key IPC messages to new staff. These findings support the continued implementation and refinement of the IPC training programme to maintain high IPC standards across the organisation. The IPC team is also committed to improving local training by responding to station and vehicle audit findings as well as incidents reported on DCIQ. This ensures ongoing assessment of current practices and identification of areas for improvement.

12. COMMUNICATION AND ENGAGEMENT

IPC Team

The IPC team continue to work hard to maintain their visibility across the Trust. Attendance at locality meetings and forums to share information on IPC is a regular occurrence and the IPC Practitioners offer specialist guidance and act as integral support to the QAV processes across the Trust.

In addition to the internal engagement, the IPC team have formed strong infrastructures with IPC teams at other healthcare providers, including UKHSA and NHSE. The IPC team have also developed good relationships with company representatives to develop ambulance specific products such as hand wipes and bespoke sharps containers. The recruitment of three Fit Testers has increased the exposure of the wider IPC team, who continue to strengthen visibility and support across the organisation.

IPC Communications

The IPC team, 12 months ago, designed an IPC specific informative page for members of the public to learn what measures the Trust takes to keep patients and staff safe. The page was developed with the support of the patient public panel member to ensure accessibility.

The IPC team publish regular staff bulletins through the Trust Communications team, and these are disseminated via email and displayed at station sites via the Hubara screens, which supports the Trust's sustainability agenda. Information is also communicated through operational leadership team meetings who disseminate directly to frontline staff. The IPC team also utilise social media platforms such as Facebook and Twitter, through the Trust Communications team.

Improvement Academy Project

The IPC team applied and were successful in gaining a place at the first improvement academy. The aim of the improvement academy was to get 100% of NWAS staff sanitising their hands on entry to Blackpool Emergency Department (ED). The IPC team worked on the project with one of the IPC Nurses from the Blackpool Hospital Trust, a Senior Patient Safety Manager and a Senior Data Insight Analyst, to form an improvement team. The team were supported through the project by a Quality Improvement Manager and the course involved attendance for three 3-day teaching sessions run by improvement experts, and the team held weekly meetings to monitor progress against the aim.

Improvement methodology was utilised to improve hand sanitisation uptake amongst staff and several Plan, Do, Study, Act (PDSA) cycles were used with outcomes recorded. Audit results were recorded on a Teams questionnaire and support from the Data Analyst meant that the team could present data in several ways. Initially, there was some difficulty engaging with the Senior Clinical staff from Blackpool station, however later into the project, the new Sector Clinical Lead supported the project and audit results started to improve. The team produced a poster and a presentation that is to be delivered at a graduate on ceremony in April.

13. UNPLANNED ACTIVITY

Increase in Pertussis (Whooping Cough) Cases

Pertussis case numbers in England continued to rise across all regions in 2024. Importantly, incidence is highest in infants under the age of 3 months, with a significant number of laboratory-confirmed cases identified and several deaths reported.

Pertussis is a highly contagious infectious disease that can spread rapidly from person to person through contact with infectious respiratory particles. Pertussis cases are considered infectious from the onset of coughing until 48 hours after commencement of appropriate antibiotic treatment, or 21 days from onset of their cough if not receiving treatment.

Recommendations were published for health care workers in terms of priority for vaccination. The IPC team met with our Occupational Health provider and Human Resources (HR) representation following enhanced advice from UKHSA. It was agreed with the medical director and Occupational Health that at that point frontline Trust staff did not meet the criteria for immediate vaccination. This would be reviewed in line with any changes in national guidance.

Pertussis Vaccine

In response to an increase in pertussis cases reported in the UK, UKHSA produced new guidance in June on the management of cases of pertussis. As part of the new guidance, recommendations for the prioritisation of the vaccination of categories of health care workers were published. After discussions with the Medical Director of our Occupational Health provider and guidance from UKHSA it was agreed that our patient facing staff did not meet the criteria for the top priority group for vaccination. The guidance emphasised the importance of ensuring that Occupational Health has an accurate record of all the Trust staff's vaccination status.

Mpox

In the summer, WHO declared the Mpox outbreak in parts of Africa as a public health emergency of international concern. The highly contagious disease killed at least 450 people during an initial outbreak in the Democratic Republic of Congo and then spread across parts of Central and East Africa. Scientists were concerned about how fast the new variant was spreading and its high fatality rate.

The UKHSA issued a bulletin to raise awareness for clinicians which was sent via a clinical bulletin to staff across the Trust. Clade I (MPXV) is a HCID which may be more severe and transmissible than the clade II Mpox, which has been present in the UK since 2022. Guidance was given to clinicians in relation to assessment on suspicion of Mpox, correct PPE to be worn and the transfer of the patient.

Although the number of reported cases outside of Africa was relatively low, the risk of transmission is high, and so regular messages were distributed to ensure staff remained vigilant to symptoms and mitigating actions to minimise the risk of onward transmission.

Measles

The UKHSA declared the Measles outbreak in England a national incident and guidance on Measles for health care workers was updated on 2nd January 2024. Despite no large outbreaks being reported in the Northwest area, a regular number of cases continue to be reported throughout the year within the trust footprint.

One of the key elements of the guidance was to increase the uptake of the MMR vaccine to reduce the spread of measles. . The IPC team worked with the Occupational Health providers to ensure vaccination records were available for frontline staff. In addition, the IPC team actively promoted the Measles, Mumps and Rubella (MMR) vaccine, in areas of the trust which presented with a higher risk of outbreaks i.e. at Integrated Contact Centres (ICC).

Clinical bulletins have been issued and distributed widely in the Trust to advise staff of the signs and symptoms of Measles, and what PPE should be worn if in contact with a known or suspected case. Some staff have been identified as contacts of known Measles cases and have been referred on to Occupational Health for advice. Occupational Health would then follow national guidance after checking the staff members vaccination status.

Increase in Respiratory Infections

During December, data from NHSE showed that Flu continued to put a significant pressure on the NHS. In one week in December, there was an average of 5408 patients a day in hospital with Flu A, including 256 of these individuals requiring critical care, with this figure being3.5 times higher than the same week in the previous year.

Other communicable diseases including Covid, RSV and Norovirus cases also remained high which led to several trusts declaring critical incidents citing exceptional demand caused by the colder weather and respiratory viruses.

As a result, several hospitals have introduced mandatory face mask wearing in emergency departments, assessment areas and inpatient areas for all staff, patients and visitors. To maintain staff and patient safety, the Trust strongly recommend mask wearing for staff whilst on duty in these areas. Staff were also reminded of the importance of good hand hygiene.

Tuberculosis (TB) Case in an Ambulance Worker

A male staff member who worked for a private provider contracted by NWAS for PTS work was diagnosed with TB in January 2024. The individual had significant lung disease and had active symptoms whilst working with other staff and patients over a 6-month period. A Strategic Oversight Group, which included 3 of our ICB regions was set up following an incident management meeting led by UKHSA.

NWAS were asked to join the group and provide patient contacts for the period – in total 484 patients had contact with the index case. The index case also had 40 colleague contacts also. It was anticipated that there may have been some media interest so joint communications was prepared by UKHSA/NHS England/NWAS should a briefing be required.

In line with British Thoracic guidance, staff contacts were offered screening and patients thought to be at risk were informed via a 'warn and inform' letter to seek medical advice should they have symptoms. These letters were sent out by the Integrated Care Board (ICB) after agreement at the oversight group.

14. INNOVATION

The IPC team are currently working on having all the IPC audit data captured on Safecheck, which has now been ongoing for several years. The move to Safecheck meant that all the Trust's audits are housed onto one system, designed to encourage staff to complete audits in a format which is familiar to them and is easy to pull reports from. The improvement project has developed a Power BI dashboard which will ensure the Trust can improve its analysis of IPC data and compliance and provide broader comparative data from all audits. This data is then presented at the IPC Oversight Group which allows the user to see an overarching view of the Trust's compliance with IPC policies and procedures from audit results. The dashboard also enables users to drill down to each station's compliance and overarching compliance to each question in the audit. The data can be formatted to be displayed in several ways – it can be exported in excel tables or can be viewed in various chart forms. The IPC Practitioners are currently working with PTS colleagues to support and develop PTS specific audits which will be used on the Safecheck platform. This is still ongoing from 2024.

During 2024/25 the IPC team worked with VDEG and Operational teams to trial a disposable head block. After capturing the data from the IPC vehicle assurance audits, it was highlighted that our current head blocks could be a potential source of infection by cross contamination. Several head blocks were trialled, and an alternative product has been identified to move forward with which is now available to order.

The IPC Practitioners strive in developing new ways of working to provide a safer working environment for NWAS staff and safe places to be treated for our patients. In 2025/26, the IPC Practitioners will be working on the following:

- Reviewing and developing safe storage for PPE for staff.
- Developing ambulance and specialist vehicle specific IPC audits.
- Reviewing the process and compliance of audits for IPC.
- Developing an IPC area on the Green Room.

IPC Commitments 2025/26

NWAS will continue to maintain its regulatory compliance for IPC in line with the Health and Social Care Act, in addition to this the IPC team will align closely to the IPC annual workplan which includes the following ambitions.

- Maintain high compliance with face fit testing across NWAS.
- Gain assurance that staff are completing required checks on their Powered Air Purifying Respirator (PAPR) equipment in line with COSHH and to ensure the equipment functions correctly when required.

- The IPC Specialist Lead will oversee the staff flu vaccination campaign for 2025/26 and will work alongside key stakeholders from Medicines Management, Human Resources, Communications and Operations staff to plan and deliver an effective campaign to maintain staff safety.

- Collaborative working will continue with the Contracts Manager, Facilities Management, and cleaning contractors to ensure robust processes are in place to be compliant with the NHSE standards of cleanliness.

- Continue to build on strengthening relationships with partners outside of NWAS including UKHSA, Occupational Health, and IPC teams in other health care Trusts.

- Review audit process and scoring system to ensure its reflective of best practice and consistent.

- Review the membership of the IPC Oversight group to ensure that key stakeholders are represented, and attendees can facilitate actions raised.

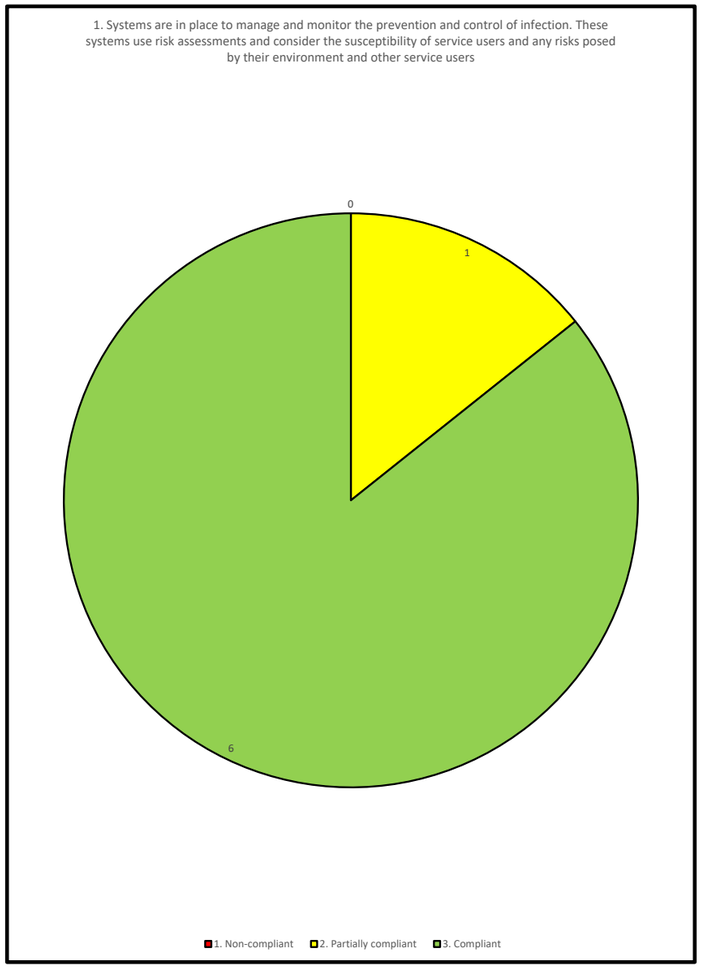
15. RECOMMENDATIONS

The Board of Directors is asked to:

- Note the content of the report.
- Note the assurances it provides.
- Note the arrangements for ongoing monitoring via the IPC BAF.
- Note the key risks and mitigations.
- Support the report for onward approval by Board for publication on the Trust website.

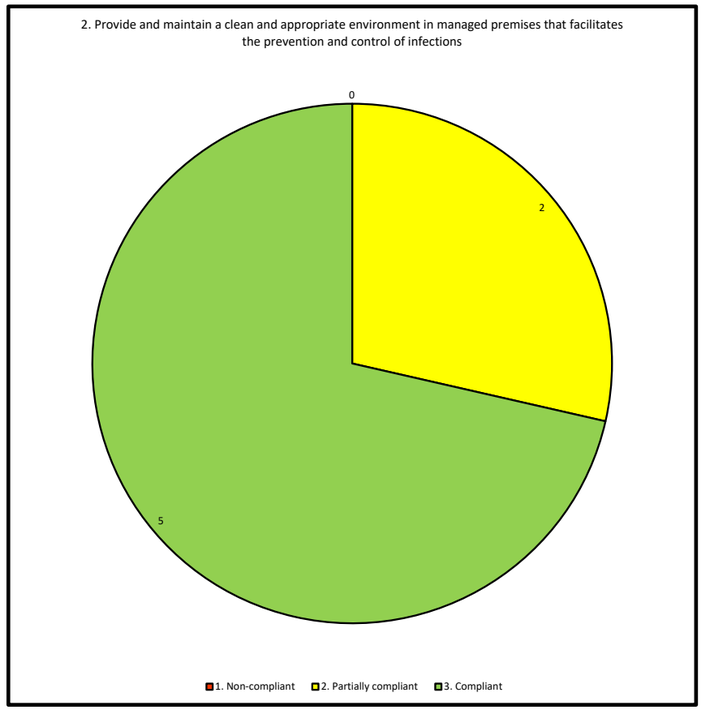
Infection Prevention and Control board assurance framework v4.0

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

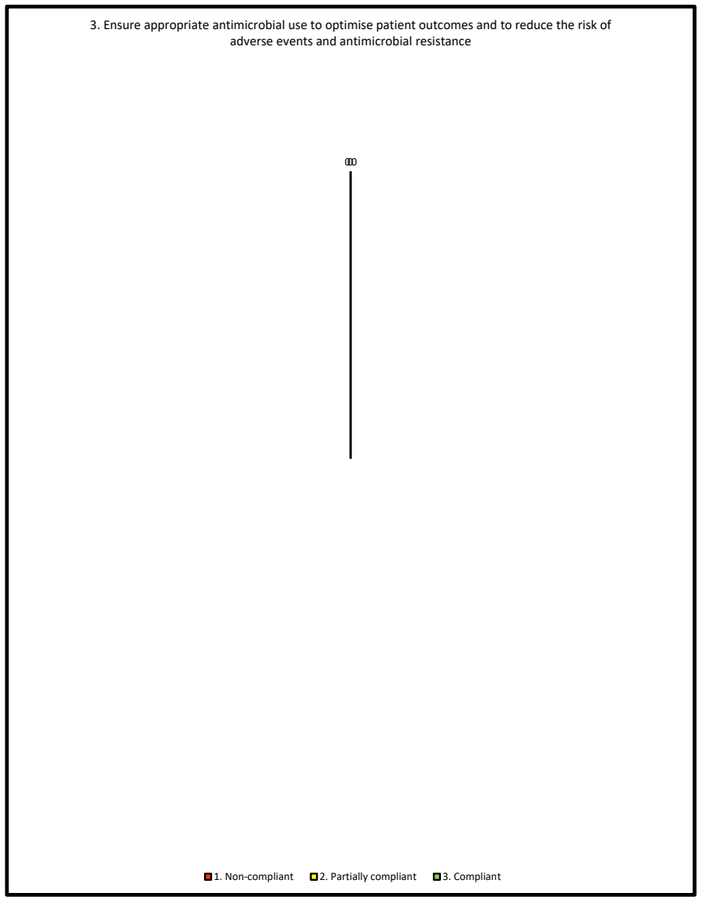


1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	staff can contact IPC during office hours via email, teams or mobile numbers. Outside of these hours staff can contact their managers/ operational managers for IPC support. ONcall tactical advisors are also available to provide necessary IPC guidance. ICC have access to A-Z of communicable diseases which has recently been updated in line with national guidance. Advacnced paramedics are contactable out of hours for advice. Policies, procedures and guidance are on the Green Room page which all trust staff have access to.				3. Compliant

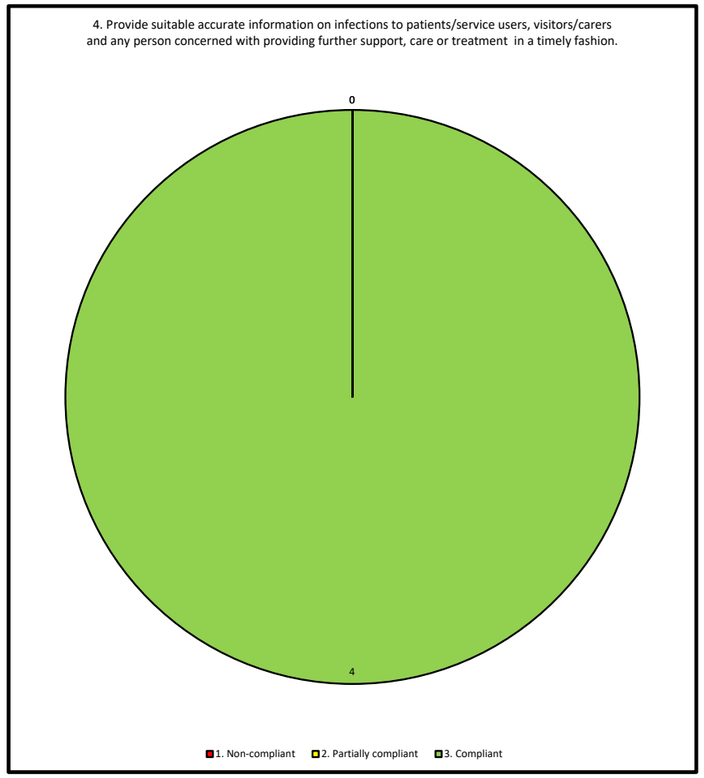
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	National Standards of cleanliness published in Feb 25..Section specific to ambulance service. Cleanliness is monitored and audited with locally agreed protocols and via IPC audits. NWAS have a cleaning contractor who is monitored by the facilities manager. Audits are carried out by the contractor, NWAS staff and IPC team for assurance of standards on stations. IPC are involved in any contract tenders related to station/vehicle cleaning	Trust compliant with most of standards - just need to display a 'Commitment to Cleanliness' charter in all Trust premises	Charter in process of being printed and placed at all premises		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.					0. Not applicable
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Policies and procedures are in place to inform staff of responsibilities in relation to cleaning and decontamination. National and being applied to NWAS.Reusable equipment is cleaned after patient use Vehicle audits provide evidence of cleaning - these are reported though the IPC SC. IPC do unannounced audits on the 6 weeekly deep clean of vehicles completed by a private provider.	Difficulty completing required number of audits after deep clean due to operational demands. In process of working with private provider to complete joint audits post deep clean			2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Water Safety Group meets every 6 months and provides assurance to the health,safety and security sub committee via the Estates, Fleet + Facilities management health, safety and security committee. Ventialtion testing is carried ut in line with national guidance. The Water Safety Group receives reports of anomolies of any water testing carried out at NWAS sites completed by the contractor. Policies and procedures are in place in relation to water safety and ventilation systems.				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	IPCT are involved from the planning stage of new builds and refurbishments. IPCT are invited to meetings and site walkabouts throughout the refurbishment period and IPC have to sign off works prior to staff working from the premises.				3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Minimal linen is stored on vehicles, used linen is disposed of at hospital sites when conveying a patient. Linen which is on the vehicle at the time of service/ scheduled deep clean is removed, bagged and put into carts to be disposed of by local agreement at a local trust. Linen policy has been reviewed				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Policies and procedures are in place in line with national guidance. Waste management overseen by facilities. IPC monitor compliance through audit. Correct waste disposal is included in all teaching sesssions and resources are also available on the Green Room.Waste collection carried out by a private contractor. Waste contract up for tender - IPC involved in tender process				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	All reusable equipment is decontaminated between use. Any surgical instruments are single use. Decontamination certificates are used when equipment sent for servicing/repair.				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.					0. Not applicable



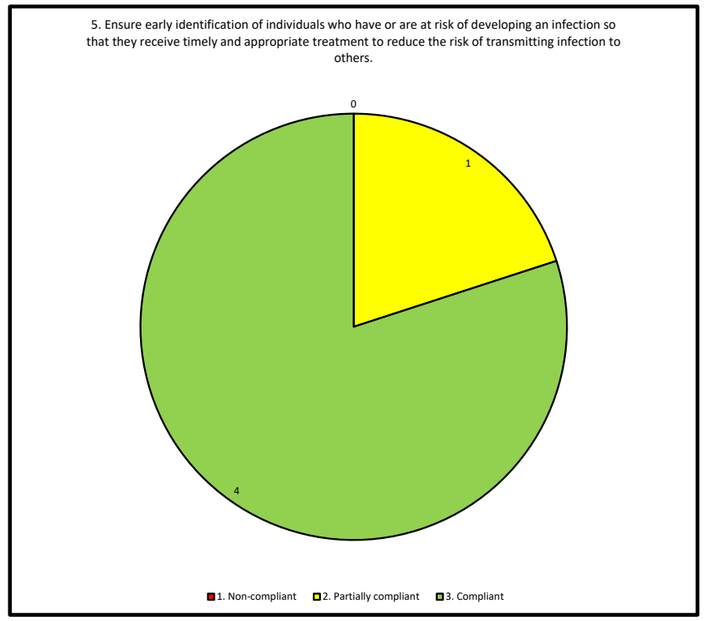
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	No antibiotics are prescribed - administered under PGD and in line with JRCALC. Only 2 antibiotics are used within the Trust. They are for emergency use and are a one off dose. Paramedics follow PGD for antibiotic use. AMS lead is in the DIPC role supported by the Chief Pharmacist	N/A	N/A	N/A	0. Not applicable
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	PGD compliance monitoring as part of audit plan - reported into Medicines Optimisation Group which feeds into Clinical Effecftiveness Sub Committee. Audit includes frequency of administration, if compliant with guidance & any related incidents.	N/A	N/A	N/A	0. Not applicable
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	Director of quality, innovation and improvement - delegates responsibility to the DIPC	NA	NA	NA	0. Not applicable
3.4	To optimise patient outcomes and minimise inappropriate prescribing: • Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' • Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. • Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.					0. Not applicable
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.					0. Not applicable
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)					0. Not applicable



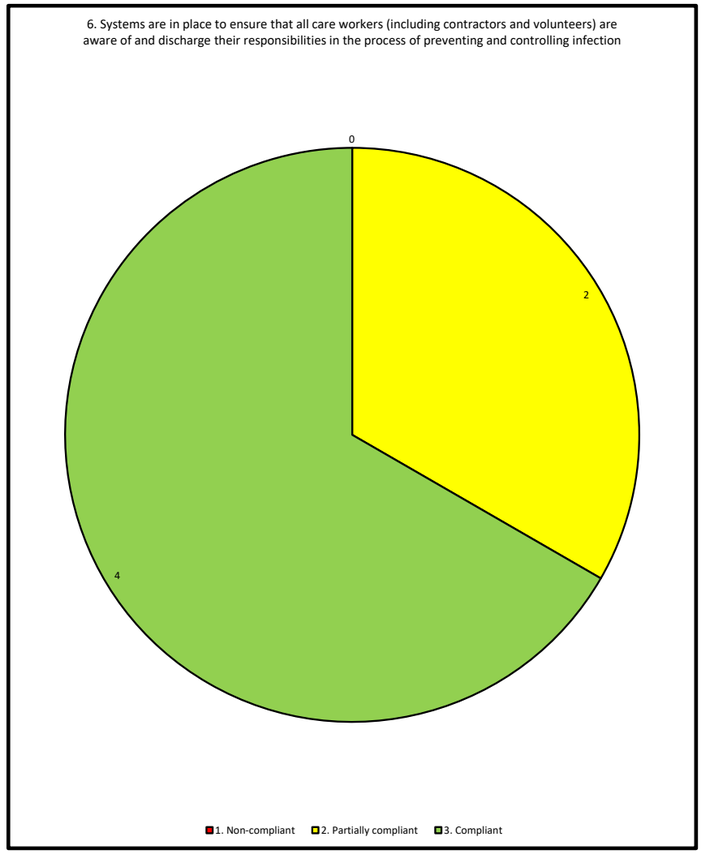
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed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



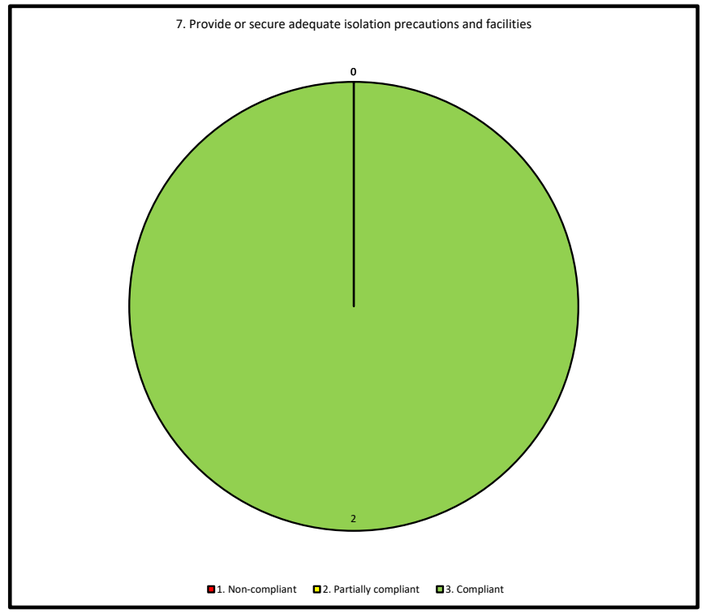
5.	**Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.**					
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	NWAS do not have any inpatient areas. Staff are aware of IPC measures to put in place to reduce the risk of picking up an infection from a patient. Crews will alert receiving ED/ID unit to ensure patient is placed in an approriate facility to minimise risk of onward transmission.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.	Crews will identify if patient potentially has infection and will pass this information on to receiving care facility to ensure patient is cared for in an environment that minimisies risk of onward transmission of infection.				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Crews will inform receiving department if infectious status known & will be documented on PRF.				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	NWAS do not have any settings where patients are in-situ. Safety stations (masks, wipes & alcohol hand gel) remain in place at the entrance to all buidings.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	NWAS outbreak policy identifes 2 or more staff will trigger an outbreak - these are reported externally to NHSE. Outbreaks are investigated by the IPCT and managers, extra IPC measures are implemented in the setting. Outbreaks are reported monthly to TMC and also to IPC working group. Safety stations remain in place at entrance to all NWAS premises.	Reliant on managers informing IPCT that they have staff off sick. No longer asymptomatic testing in place so uncertain if cases of illness are caused by same pathogen.	Regular visists to all settings from IPCT to raise awareness. IPC have implemented weekly audits to be completed by Ops managers within ICC's and have started to attend their regular Quality Business Group meetings to update on new guidance/rates of community prevalence of infection. IPC Specialist lead working with ICC managers to ensure facilities available for staff who feel vulnerable - assurance to be fed back via IPC Oversight group		2. Partially compliant



6.5	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	All training reviewed annually and updated and is in line with the National IPCM. Staff responsibilities documented in the IPC policy. Any new national guidance in incorporated into training packages.				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Training needs analysis completed by the Education Department to ensure staff receive appropriate training for their role. Staff responsibilities documented in the IPC policy.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	IPC training programmes are reviewed regularly and are updated with any changes in national guidance. Compliance with Mandatory Training is monitored closely by the Education Department. IPC monitor MT compliance as part of assurance reports presented at IPC Oversight group.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	All covered in mandatory training. Resources also available on the Green Room - this includes flow charts and videos showing staff how to correctly don + Doff PPE. Training videos on use of RPE and all new starters on their induction are shown how to use the equipment correctly.				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff are fit tested to 2 masks as per requirements. Quantitative fit testing method being used within NWAS in line with health & safety executive guidance. All staff are also provided with a respiratory powered hood on commencing with NWAS. Training is delivered on how to use the hood correctly. Fit testing recorded centrally on ESR. Fit testers have now been in post since September 2023 & overall fit testing compliance is at 86% for the Trust	Not all power units are being serviced as per manufactureres guidance.	IPCT liaising with fleet to ensure that powered motor units are being serviced as per manufacturers recommendations service intervals have been amended and list of serviced motor units is available from oxylitre. Proposal being developed by IPCT to ensure more effective use of motor units within the service		2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	NWAS staff are trained in aseptic technique and medical device insertion whilst in training at University. Staff are monitored for clinical competencies during contact shifts. Policies in place to support aseptice technique.	No further aseptic technique competency checking completed.	Included in IPC annual workplan to roll out ANTT training. Resources have been developed and to discuss with ops staff as to how this can be delivered effectively.		2. Partially compliant

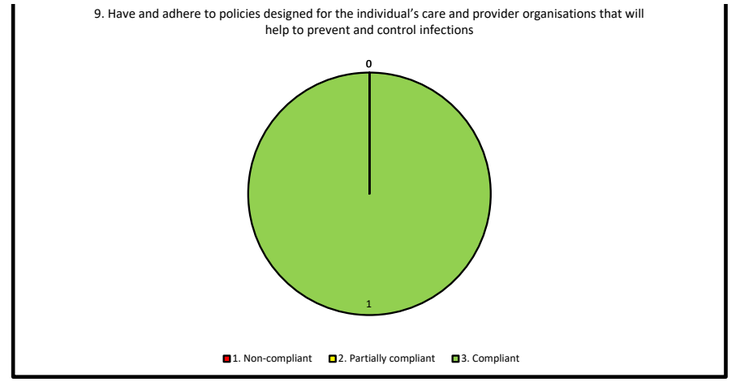


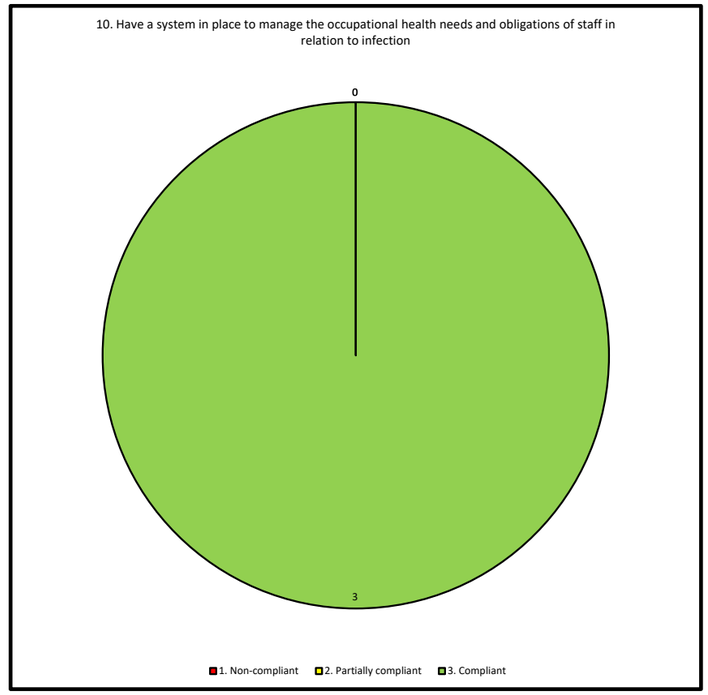
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking which will determine how they are transported. PPE available for both staff and patients on vehicles.				3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •Single rooms are in short supply and if there are two or more patients with the same confirmed infection. •There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID				0. Not applicable
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking . Signage N/A.				3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID				0. Not applicable



8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	N/A NWAS do have access to a microbiologist if required via OH. OH also able to advise for staff with infections. IPCT work closely wwith UKHSA & health protection teams as necessary for contact tracing and any necessary prophylactic treatment of staff	N/A	N/A	N/A	0. Not applicable
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	N/A	N/A	N/A	N/A	0. Not applicable
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	N/A	N/A	N/A	N/A	0. Not applicable
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	N/A	N/A	N/A	N/A	0. Not applicable
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	N/A	N/A	N/A	N/A	0. Not applicable
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	N/A	N/A	N/A	N/A	0. Not applicable
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	N/A	N/A	N/A	N/A	0. Not applicable

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





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ESCALATION AND ASSURANCE REPORT

Report from the Quality & Performance Committee

Date of meeting	Monday, 30 June 2025		
Members present	• Prof A Esmail (Chair), Non-Executive Director • Dr David Hanley, Non-Executive Director • Ms A Wetton, Director of Corporate Affairs • Mrs E Strachan-Hall, Director of Quality and Improvement • Mr D Ainsworth, Director of Operations	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None

ADVISE:

- The Q&P Dashboard highlighted:
  - Cat 1 mean performance in May was just outside the ARP target
  - Cat 2 in month mean performance was better than the UEC 30 minute target but was outside the ARP target of 18 minutes
  - Cat 3 performance remains longer than the mean ARP target and is negatively impacted by A&E turnaround times with regional variation in this performance.
  - 111 call volume and performance metrics were stable
  - PTS activity metrics were stable
  - Overall ROSC was stable and above national average
  - Fewer complaints had been opened than previous 7 months

- The Committee received the Trust Adverse Weather Plan and noted it was in alignment with national guidance and had been exercised through a tabletop.

- The Committee received the proposed Q1 position of the Board Assurance Framework.

- The Committee received the Clinical Audit Progress Report for Q4, which advised of monthly AQI submissions for STEMI, and Older Adult Falls delivered as per schedule and detailed progress report on the local clinical audit programme. The Committee also received the 2025/26 clinical audit plan, which reflected the national mandated workstreams and priorities set by NHS England and local priorities required by the Trust.

- In reference to reporting of patient safety incidents, the Committee noted increased activity and challenges around the LFPSE national reporting system, resulting in processes taking longer and a backlog in some of the patient safety reporting processes.

- The Committee received assurance from the Controlled Drugs Annual Report 2024/25 and noted the ongoing challenge regarding renewal of CD licence with the Home Office with solution being imminent.

- The Committee received assurance from the Mental Health Annual Report 2024/25 and noted the challenges in the system as well as disparity of pathways across the Trust geography.

- The Committee received the Safeguarding Annual Report 2024/25 for assurance and recommended for progression to Board.

ASSURE:

The Q&P Committee received the following reports for assurance:

- Patient Safety Activity Q4
- QIA Process Assurance Report
- Quality Account
- CQC Update
- Resolution/Complaints Assurance Report Q4 and Annual Review 2024/25
- Controlled Drugs Annual Report 2024/25
- IPC Annual Report 2024/25
- Maternity Annual Assurance Report 2024/25

RISKS

Risks discussed:

- Strategic Risks aligned to the Committee SR01, SR03, SR06.

New risks identified:

- None identified.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 July 2025
SUBJECT	Dashboard report: Communications, Engagement and Charity Teams
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**	☒	**SR11**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	Cyber Security	☐	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, Engagement and Charity Teams provide 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 of the trust strategy, and the positive impact it has on staff, patients, and partners. The charity team moved over from the Corporate Affairs directorate on 1 May 2025 so, for the first time, the report includes highlights from the charity such as income, events and the impact of charity funding for our staff, volunteers and communities.	
PREVIOUSLY CONSIDERED BY	Not applicable	
	Date	Click or tap to enter a date.
	Outcome	

DELIVERING THE RIGHT CARE, AT THE RIGHT TIME, IN THE RIGHT PLACE; EVERY TIME.

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, Engagement and Charity Teams for quarter one of the financial year 2025/26 (April-June 2025).

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

2. DASHBOARD REPORT

2.1 PATIENT ENGAGEMENT

Aim – Provide high quality, inclusive care

Statistical content and narrative are provided to outline patient engagement activity, including:

- 6 Patient and Public Panel members have successfully enrolled onto cohort 2 of the Quality Improvement Academy. They will be working with various project teams using Quality Improvement tools to help achieve their project aim.
- 20 panel member involvement sessions were delivered, including a Liverpool John Moores University research study on the impact of Lifesaving Interventions (iLife) - supporting patients and families following the patient surviving a cardiac arrest.
- We have had a total of 23 events/engagement opportunities, 9 of these were targeted focus groups with underrepresented groups including Chinese, Romanian and Ukranian members.

Impact:

- A consistent theme across all focus group engagement with underrepresented groups was the challenge of communication. Many participants shared that language barriers made it difficult or impossible to access services or understand information. This extended beyond healthcare to include other essential services such as applying for financial support or registering children at school. When language support was lacking, individuals often relied on family, friends, or neighbours to communicate on their behalf, particularly in urgent health situations. In some cases, individuals only contacted ambulance services as a last resort, often feeling overwhelmed and unsure where else to turn. This feedback and themes will be fed into strategy development work during the design phase of the next trust strategy.
- Feedback also revealed a limited understanding of ambulance services beyond emergency scenarios. Many participants expressed uncertainty about when to contact 999, 111, or their GP, which sometimes led to inappropriate use of emergency services or hesitation to seek help when it was genuinely needed.

This confusion was especially prevalent among those new to the UK or unfamiliar with how the NHS works.

- Our team has delivered CPR awareness sessions and shared information in multiple languages during engagement events.
- Patient survey returns improved after we altered the broadcast time of the SMS.
- A new survey is being worked on that captures feedback from patients are attended by a community first responder.

2.2 COMMUNICATIONS

Aim – Be a brilliant place to work for all

Statistical content and narrative are provided to outline communications activity, including:

- Peer recognition cards - 381 cards sent during Q1, most popular cards are "Just to say a big thank you" and "you're a star"
- Open rate for key publications:
- The Bulletin - highest – 57% Average – 53% Lowest – 48% (11 in total)
- BHBY - Highest – 49.4% Average – 48.9 Lowest – 48.4% (3 in total)
- CEO – Highest – 54% Average – 50.6% Lowest – 47% (7 in total)

Impact:

- Star Awards - Feedback survey and post-event learning report complete. New categories have been launched and are now open for year-round nominations.
- Health literacy project for PTS – Some members of the team have undertaken health literacy training and to improve the quality and accessibility of information for patients using PTS (part of a pilot project with the Office of Health for Health Improvement and Disparities).
- ICC Phase 3 job role review - Ongoing support to the Integrated Contact Centres Phase 3 project team, including regular formal communication via ICC bulletins and updates on local SharePoint sites.
- The findings from our Internal Communications Audit were reviewed by the team and by external experts. The audit offered a valuable pulse check on how well we are informing, engaging, and listening to our staff. A comprehensive findings report has been produced separately, and a summary of themes found included in the dashboard:
- Relevance - staff say they don't have time to process all the communication, and they only want what's relevant.
- Inequality in communication exists - disparities are evident by role and department, suggesting a need for tools and training.
- Strategy and processes - too reactive. There is a need to develop a strategic, proactive approach to internal comms.

Aim – Work together to shape a better future

- MP letters = 14 on ICC dispute, PTS eligibility, private ambulance service redundancies, siren use, frequent callers, delays.
- Statements and briefings in response to media enquiries = 15 (- 48%)
- Broadcast interviews = 5 (+150%)
- Proactive stories, against our internal target of 16 = 29
- Pieces of media coverage = 253 (+ 35%)
- Our social media followers have grown by 13%.

Impact:

- We were able to get positive media coverage about performance with interviews with both the HSJ (talking about recovery since the COVID pandemic) and BBC North West (highlight improved hospital handover performance in GM). BBC Morning Live also gave to the opportunity to promote CPR training and talk about the positive outcome for one of patient following a cardiac arrest.

- The last quarter has also seen coverage of industrial action by ICC trainers. In June the comms team also supported the comms response a major incident following the Liverpool FC parade which included a multi-agency press conference.

- The dashboard shows our top performing social media reels. This quarter we have picked the top performing posts by reach as it provides an accurate picture of how many people who see our content. Whilst follower numbers are good to know, and we have a strong presence on all our platforms, the algorithms don't show our posts to all of our followers, and so non-followers may see our content based on searches, shares, and hashtags and content recommendation engines. This number will be a mixture of followers and non-followers.

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

- 8 films created in-house have focused on what it's like to be a dual-trained 999/111 ICC call handler, how we are reaching out to communities who don't speak English, and how a pilot scheme in Lancashire is helping to support colleagues who may be going through a difficult time.

- FOI requests have increased by 20% to 116. We are consistently responding in excess of the national target.

- Website and Green Room page visits remain consistent. A feedback form was added on all PTS pages, which are frequently in the top visited, to gain insight into what people are looking for on PTS pages and whether they can find the info they need as part of the health literacy project. The top news story was the Liverpool City Centre incident, with 14,436 views.

2.3 CHARITY

- £87k total income.
- 29 fundraising pages set up
- Events:

- Abseil: 13 took part, raised a collective total of £5,521.
- NHS Big Tea: 11 expressions of interest and 4 sites. Total raised so far approx. £300 but money still coming in.
- Cross Bay Walk: 54 sign-ups.
- Yorkshire Three Peaks: 6 sign-ups.
- Born Survivor (April/September) 20 sign-ups – sold out.
- Great North Run: 7 sign ups'

Impact:

- Continue to fund and support 3 community resuscitation officer roles until March 2026.
- 19 new public access defibs and cabinets placed in communities across the North West.
- Megan Stephenson – who undertakes a community resuscitation officer role that is funded by the charity – won a Pride of Cumbria award.

4. 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.

5. 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.

Dashboard: Communications, Engagement and Charity Teams

Q1 2025/26 (April, May and June)

NHS North West Ambulance Service NHS Trust

This report summarises the work of the Communications, Patient Engagement, and Charity teams, all of which play a vital enabling role across the organisation by working in partnership with services and departments to support the achievement of our shared strategic goals and objectives. Through clear and consistent communication, meaningful engagement with patients and the public, and the development of charitable initiatives that enhance care and experience in our communities, our work helps to amplify, inform, and connect the efforts of colleagues in the various directorates across the organisation - contributing to better outcomes and experiences for our staff, volunteers, patients, and communities.

Where there is an explicit link to delivery of the must-do objectives in the Annual Plan 2025-26, the target icon is used to highlight this.

Aim: Provide high quality, inclusive care

Patient and Public Engagement

23 events and engagement sessions
130% increase on last quarter

Comprising 9 focus groups with underrepresented communities including Chinese, Romanian, and Ukrainian participants.

Events included:
British Islamic Medical Association life savers & AACE collaboration 2025
Preston Caribbean festival
Burnley Health Mela
Preston Windrush
Sparkle weekend (hosted by The National Transgender Charity)

What we heard:
Language barriers make it difficult or impossible to access services or understand information.

People rely on family, friends, or neighbours to communicate on their behalf, particularly in urgent health situations.
Ambulance services are a last resort for individuals who often feel overwhelmed and unsure where else to turn.
Ambulance services are often misunderstood, particularly among those new to the UK.
People want education to help them understand what services exist and how to access them appropriately.

What we did:

- Ran CPR and AED awareness sessions with communities that reported language barriers to us. We shared information about how to access our services in different languages. We also demonstrated our communication aids such as the pictorial communications handbook and insight app.
- Hosted our first dedicated Chinese community event – reached 78 attendees
- Translated NWAS leaflets into Cantonese and Mandarin (now being distributed via community groups)
- Insight App film completed – shows paramedics supporting patients with a language barrier

Patient feedback surveys

17,338 surveys sent

1,191 surveys returned

86%	were likely to recommend the service to friends and family	**-2%**
90%	were very or fairly satisfied with the overall service they received	**+1%**
94%	agreed they were cared for with dignity, compassion and respect	**-**

Positively, more surveys were returned after a change in the broadcast time of the SMS. In partnership with the Resolution Team, the first combined patient survey, compliments and complaints report was produced and a working group established to look at improvements.

Patient story

Shared at the Board of Directors meeting:
A patient from the Chinese community shared challenges in accessing our services due to language barriers.

Patient and Public Panel

Membership overview

342	Total members (a reduction due to membership cleanse)
9	New members joined
8	New expressions of interest
32%	Youth representation (Target 30%)
25%	Ethnic diversity representation (Target 40%)
7	New requests for involvement
20	Structured/task-based sessions delivered

Example: Supported a Liverpool John Moores University research study on the impact of Lifesaving Interventions (iLife), helping families of cardiac arrest survivors.

Notable achievements: 6 PPP members successfully enrolled in Cohort 2 of the Quality Improvement Academy. They are now supporting project teams across the Trust using QI tools to drive service improvements.

Aim: Be a brilliant place to work for all

Internal (staff) communication

Emails for all staff, such as The Bulletin and CEO message, are sent through a system (e-shot) which provides analytics.

NOTE
Displays are only counted when an email is opened and images are downloaded, which requires staff to click to allow. 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%.

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 - 90% (-)
- Emergency - 93% (+1%)
- EOC and Clinical Hub - 81% (+6%)
- NHS 111 - 78% (-6%)
- PTS - 74% (-7%)

The Bulletin

Display rates for The Bulletin :

Highest: 57% Average: 53% Lowest: 48%

Bulletins with a higher-than-average display rate covered topics including:
- Call before convey FAQs
- 2025/26 annual plan
- Paramedic apprenticeship

CEO Message

Display rates for the CEO message:

Highest: 54% Average: 51% Lowest: 47%

Better Health Better You

Display rates for Better Health Better You:

Highest: 49% Average: 49% Lowest: 48%

Observations and analytics of note:
- Introducing the annual plan - a guide for managers, achieved an open rate of 73%. This was sent to approximately 1,000 contacts.
- A HR bulletin issued to all staff on the Supreme Court ruling on the definition of a "woman" achieved an open rate of 67%.

Staff recognition cards

Colleagues can send a card to any of their peers via the Green Room. Physical cards are also available in our contact centres but numbers issued are not tracked.

381 cards sent

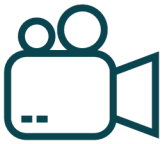
The most popular cards were: "Just to say a big thank you" and "you're a star".

Campaigns and project support

Internal Communications Audit
Offered a valuable pulse check on how well we are informing, engaging, and listening to our staff.
Summary of themes found:
Relevance - staff say they don't have time to process all the communication, and they only want what's relevant.
Inequality in communication exists - disparities are evident by role and department, suggesting a need for tools and training.
Our approach - too reactive. There is a need to develop a strategic and proactive approach to internal comms.

Star Awards
Feedback survey and post-event learning report complete. New categories launched for year-round nominations.
Health literacy project for PTS
Undergone health literacy training to improve the quality and accessibility of information for patients using PTS as part of a pilot project with the OHID.
ICC Phase 3 job role review
Ongoing support to the Phase 3 project team, including regular formal communications (bulletins) and updates on the ICC SharePoint.
Learning at Work week (May)
Worked with Learning and Development to deliver 'comms takeover' mix of video, staff profile, and signposting content on the value of learning and opportunities available.
CQC Five Minute Briefings
Started to review and update documents with the Compliance team to prepare for the expected inspection.
Staff networks and Pride month
Produced content around VE Day/Armed Forces Day for Armed Forces Network, and staff articles on Pride Month.
Right Care Programme
Created content including a Green Room page and various bulletins on care coordination schemes. The next phase of communications includes podcasts for frontline staff.

Film & photography



8 completed Vs 36 in the previous time period

5 in progress

Film topics:

- Supporting our colleagues – staff Board story
- Meet a senior paramedic
- What it's like to be an ICC call handler
- Update to the incident response plan
- Communicating in Chinese – patient Board story
- Improvement Academy celebration
- CEO Induction film for new recruits
- Improving outcomes through research – staff Board story

There was a reduction in the number of films produced compared to the previous period, bringing us back to normal range after the Star Awards peak.
Recently produced films have focused on highlighting what it's like to be a dual-trained 999/111 ICC call handler, how we are reaching out to communities who don't speak English, and how a pilot scheme in Lancashire is helping to support colleagues who may be going through a difficult time.

Aim: Work together to shape a better future

Stakeholder engagement

14 MP letters (+7.6%)

Including: ICC dispute, PTS eligibility, private ambulance service redundancies, siren use, frequent callers, delays

2 MP visits

Michael Wheeler MP did an observational shift in Salford and Phil Brickell MP visited LBH to meet Area Director Sian Wimbury and then toured our NHS 111 site at Middlebrook.

Stakeholder communication:
1x General Stakeholder brief (June)
2x Industrial Action Briefs
1x Liverpool Major Incident Brief
1x Chair appointment – 5 in total

Other stakeholder relations of note:

- Issued the Quality Account to all Council health committees
- Organised attendance at Cheshire West and Cheshire OSC
- Provided performance figures for West Craven council
- Organised x 5 NWAS representatives to attend a ministerial briefing in Blackpool
- Organised x 4 staff to attend a reception with the Prime Minister
- Issued letters of thanks to all staff, private ambulance services, NWAA and volunteer services who assisted with the Liverpool Parade major incident x 50 letters in total
- Assisted Director of People Lisa Ward and NHSE with a written response to Metro Mayor Andy Burnham re. ICC dispute.

Press and public relations

120	incident checks handled	+24%
15	statements prepared in response to media enquiries	+48%
5	positive broadcast media opportunities secured	+150%
29	proactive stories issued, against our target of 16	

We were able to get positive media coverage about performance with interviews with both the HSJ (talking about recovery since the COVID pandemic) and BBC North West (highlight improved hospital handover performance in GM). BBC Morning Live also gave to the opportunity to promote CPR training and talk about the positive outcome for one of patient following a cardiac arrest. The last quarter has also seen coverage of industrial action by ICC trainers.

In June the team also supported the response to a major incident following the Liverpool FC parade, which included a multi-agency press conference.

Freedom of Information (FOI)

116 received (+20%)

99% compliance year-to-date against 20 day target

Topics included:

- Agency spend
- Fleet list
- Private ambulance use

NOTE
We have a statutory duty to reply to 90% of FOIs within 20 working days and an internal stretch target of 95%.

Social media - Facebook, X, Instagram and Linkedin

NOTE
'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

95,573	Facebook followers
69,096	X (Twitter) followers
21,998	Instagram followers
11,997	LinkedIn followers

Audience growth
+ 13%

Engagement

447	posts published on all channels (-4%)
6,297,255	impressions (+13%)
379,948	engagements (comments, likes, retweets, shares etc) (+5%)
6%	engagement rate (-0.5%)
643,852	reel/video views (+31%)

Our content has performed strongly across all measures except for a minor drop in engagement rate. A brief competitor analysis (of other ambulance trusts) reveals our engagement average for the quarter is 43,422, compared to theirs at 17,932. Our engagement per post averages 457, while theirs averages 123. On average, we post 95 times, whereas competitors post 145 times, indicating that we achieve better engagement with carefully curated content and fewer posts.

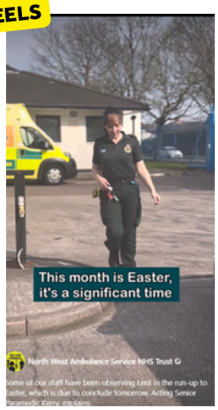
TOP POSTS

Views 242k

View 154k

TOP REELS

Views 166k



Views 189k

Digital communications

Website

300,190 users **437,175** page views

Most viewed
Vacancies – 126,809
PTS – 54,461
Locations – 22,585

Devices used to visit our site
Mobile - 58%
Desktop - 39%
Tablet - 3%

As part of the health literacy project, a feedback form was added on all PTS pages to gain insight into what people are looking for and whether they can find it. The top news story was the Liverpool City Centre incident, with 14,436 views.

Green Room

19,321 users **623,940** page views

Most viewed
Managers on duty – 120,041
Bulletins – 32.025
HR Portal – 27,356

Devices used to visit the Green Room
Mobile - 72%
Desktop - 16%
Tablet - 12%

We now have access to the WordPress search metrics, which show what people are searching for. This lets us improve the search results for highly searched terms and where we can focus future development.

NOTE 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.

Upcoming developments include:

- Intranet - New A-Z and directory templates will be introduced, an accessibility toolkit, new filters to be introduced on the homepage search results.
- We're also exploring options for a new intranet to launch in 2026.
- Website – Ambulance Academy blog posts, Using PTS feedback to develop content.

North West Ambulance Charity

Income, fundraising and grants

- Total income: £87,000
- 29 fundraising pages created (incl. events, memorials, and individual supporters)
- 2 legacies in probate – £10,000 received in June
- Community Resilience Grant submitted for £142,000 (outcome due July)

Funding directed to:

- Staff health & wellbeing
- Saving lives and community CPR access

Event highlights

- Abseil: 13 participants raised £5,521
- NHS Big Tea: 4 sites participated (£300+ raised so far)
- Cross Bay Walk: 54 sign-ups
- Yorkshire Three Peaks: 6 sign-ups
- Born Survivor: 20 sign-ups (sold out)
- Great North Run: 7 sign-ups

Social media reach

Approx. 35,870 views/impressions across Facebook, Instagram, X and LinkedIn

Making a difference

- 19 new public access defibrillators & cabinets installed across the North West
- Community Resuscitation Engagement Officers (3 roles) funded until March 2026
- Ongoing enhancement requests submitted for indoor/outdoor staff spaces

Pride of Cumbria
Megan Stephenson was awarded a Pride of Cumbria award for her community resuscitation work. Megan's role, and two additional community resuscitation officers, is funded by the charity thanks to a grant from NHS Charities Together.

Emotional reunion
A family from Eccleston in Lancashire has raised over £1,600 for the North West Ambulance Charity in memory of a loved one. Jill Banks' husband, David, passed away in March 2022 despite the best efforts of Jill and medical crews. In his memory, every year Jill organises a memorial walk around her village.

Combined team priorities for Q2

- Scope out our five community engagement events
- Identify community engagement priority groups
- Implement a feedback survey specific to patients who had a response from a community first responder
- Implement priority changes based on findings from our internal communications audit
- Charity to support the Wellbeing Team with a roadshow to boost staff morale
- Southport Public Inquiry support
- Winter communications plan research and first draft - to include more staff-facing content this year
- AGM and open day event
- Additional stock photos to be taken
- Establish 'reward partners' scheme for staff and volunteer reward and recognition