AGENDA

NHS North West Ambulance Service NHS Trust

Board of Directors
Wednesday, 24 September 2025
09:45 – 12:40
Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2526/075	Patient Story	09:45	Information	Chief Executive
INTRODUCTION				
BOD/2526/076	Apologies for Absence	10:00	Information	Chair
BOD/2526/077	Declarations of Interest	10:00	Decision	Chair
BOD/2526/078	Minutes of the previous meeting held on 30th July 2025	10:05	Decision	Chair
BOD/2526/079	Board Action Log	10:10	Assurance	Chair
BOD/2526/080	Committee Attendance	10:15	Information	Chair
BOD/2526/081	Register of Interest	10:15	Assurance	Chair
STRATEGY				
BOD/2526/082	Chair & Non-Executive Directors' Update	10:20	Information	Chair
BOD/2526/083	Chief Executive's Report	10:25	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2526/084	Statement of Responsibilities	10:40	Decision	Director of Corporate Affairs
BOD/2526/085	Anti-Fraud, Bribery and Corruption Policy	10:50	Decision	Director of Finance
BOD/2526/086	Trust Management Committee 3A report from the meetings held on 20th August 2025 & 17th September 2025	11:00	Assurance	Chief Executive
PEOPLE				
BOD /2526/087	Flu Campaign 2025/26 – Board Assurance Checklist	11:10	Assurance	Director of People
RESOURCES				

BOD /2526/088	Resources Committee 3A report from the meeting held on 18th September 2025	11:20	Assurance	Dr D Hanley, Non-Executive Director
BREAK 11:25 – 11:35				
QUALITY AND PERFORMANCE				
BOD/2526/089	Integrated Performance Report	11:35	Assurance	Director of Quality
BOD/2526/090	Learning from Deaths Q4 2024/25	11:55	Assurance	Medical Director
BOD/2526/091	Emergency Preparedness Resilience Response Annual Assurance 2025	12:05	Assurance	Director of Operations
BOD/2526/092	Ambulance Winter Plan - Board Assurance Statement	12:15	Decision	Director of Operations
BOD/2526/093	Quality and Performance Committee 3A report from the meeting held on 1st September 2025	12:25	Assurance	Prof A Esmail, Non-Executive Director
STRATEGY, PARTNERSHIPS AND TRANSFORMATION				
BOD/2526/094	Bi-Annual Assurance Report - Partnerships & Integration	12:30	Assurance	Director of Strategy & Partnerships
CLOSING				
BOD/2526/095	Any other business notified prior to the meeting	12:40	Decision	Chair
BOD/2526/096	Risks Identified	12:40	Decision	Chair
DATE AND TIME OF NEXT MEETING				
26th November 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: 9.45am Wednesday, 30th July 2025
Oak Room, Ladybridge Hall, Trust Headquarters

Ms J Mulligan	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
Mr M Gibbs	Director of Strategy and Partnerships
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
Mrs A Cunliffe	Corporate Governance Manager (Minutes)

Observers:

Mr J Roberts	Senior Consultant, Good Governance Institute

Minute Ref:
BOD/2526/050 Staff Story

The Chief Executive introduced a film, which presented the work of the Research and Development team, who work with a range of partners, such as the National Institute for Health and Care Research (NIHR), other NHS organisations and academic institutions to support research that contributes to improving the health of patients on a local and national level.

This film focuses on an example of two clinical trials that the Research and Development team have worked on, and it shows how reliant that team is on

recruiting and having the backing from NWAS staff to engage and collaborate with them.

The clinical trials described in the video refer to:

- ‘Paramedic 3’, which concluded last year and involved the collection of data on two different ways drugs were administered to patients by ambulance clinicians in cardiac arrest to find out if that made an impact on the patient’s quality of recovery.
- ‘Speedy’ currently ongoing at the gathering data stage, which looks at an early intervention pathway in which ambulance crews convey suspected stroke patients directly to the specialist unit at Preston Hospital, rather than the nearest emergency department, to see if this improves cognitive outcomes.

In terms of learning points from the story, the Board noted the speed of clinical decisions could be the difference between a patient returning to full health unimpeded or living with life changing outcomes, making research vital to make improvements so patients receive the highest and most informed quality of care. Engagement with staff who need to be aware of new clinical practices was crucial.

Additionally, the film highlighted the challenges of engaging and recruiting ambulance crews to take part in research trials, especially with constant time pressures that frontline staff face. However, staff have embraced research projects by recognising how they themselves can be a part of future clinical practice and policy changes.

Mr D Whatley described the story as very positive with an outlook to the future and mentioned the ‘Speedy’ trial had been picked up by the media as well. He wondered how the research was funded.

The Medical Director observed the ambulance sector had started recognising the crucial role it could play in research rather than having research done to the Trust by external organisations. The research was centrally funded in terms of infrastructure. Referring to ‘Speedy’ trial, the Medical Director added the trial was looking to widen access to highly specialised units and the Trust linked to work with national and regional medical directors on how to improve this offer.

Dr A Chambers was pleased to see the developments of the Research and Development function in the Trust and the continuous embedding as a learning organisation. She enquired about the numbers of Research Paramedics in the Trust.

The Medical Director advised there were two Senior Research Fellows, two Research Paramedics and one Research Officer. The funding mechanism process was on annual basis. The staff were offered hybrid opportunities to retain their clinical practice. There were also plans to develop partnerships with higher education.

Prof A Esmail advised the Quality and Performance Committee received the Research and Development annual report and it noted the development of the function as well as the ambition of further embedding the research in the Trust. He queried whether there were plans to build further capacity and strengthening academic partnerships with Higher Education.

The Medical Director advised the academic aspect in NHS Pathways was at this time minimal and there was a role of ambulance sector to support the development of the academic side in the system, with early conversations taking place in the system. The Trust will continue to work on building those links and connections to bring the potential future research projects.

The Director of Strategy and Partnerships added that due consideration will be given to R&D to be built into the Trust strategy.

The Chair was pleased to hear of progress achieved over time and looked forward to conversations on embedding R&D as well as its growth, into the Trust future strategy.

The Board:

- Noted the content of the story.

BOD/2526/051 Apologies for Absence

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

BOD/2526/052 Declarations of Interest

There were no declarations of interest to note.

BOD/2526/053 Minutes of the Previous Meeting

The minutes of the previous meetings, held on 28th May 2025 and 18th June 2025 were agreed as a true and accurate record of the meeting.

The Board:

- Approved the minutes of the meeting held on 28th May 2025 and 18th June 2025.

BOD/2526/054 Board Action Log

The Board noted two items (121 – 24/25 and 1 – 25/26) were complete and approved for removal.

With regards to item 2 – 25/26, in reference to additional assurance required following from the Annual Complaints Report, the Board noted work related to the action was underway with a further meeting in August. As the assurance is to be provided through the Resources Committee, the Board agreed the action should be transferred to the RC action log to agree suitable timeline for

providing assurance.

BOD/2526/055 Committee Attendance

The Board noted the Committee attendance.

BOD/2526/056 Register of Interest

The Board noted the Register of Interest presented for information.
The Chair reported an additional declaration to be added to the register with regards to her membership of the Fawcett Society.

BOD/2526/057 Chair & Non-Executives' Update

The Chair reported on the first two weeks of activity in the new role and a series of internal and external meetings held during that time.

She thanked the previous Chair for a series of comprehensive handover meetings and also expressed gratitude to the Non-Executive Directors for their time and advice during their individual meetings.

The Chair advised the introductory meetings with Executive Directors were underway and she had also met with external partners from Northern Alliance and ACCE.

The Board also noted the Chair had carried out a number of observations of the Trust Committees and took part in the Well-led interview.

The Chair made positive observations with regards to the financial management and the governance structure of the Trust.

The Board:

- Noted the Chair's update.

BOD/2526/058 Chief Executive's Report

The Chief Executive presented a comprehensive report, which covered activity undertaken for the period 29 May 2025 – 17 July 2025 including detailed information on a number of areas, such as performance, internal matters, regional issues, national issues and other general information.

The Chief Executive took the Board through the main points relating to internal updates, highlighting positive progress in Q1 against the Annual Plan objectives and engagement work being underway to develop the next Trust Strategy.

In terms of Finance, the Board noted NWAS's de-escalation from the Improvement and Assurance Group (IAG) process, recognising the Trust's stable financial position.

Reporting on performance, the Chief Executive advised of recent pressures for 999 call pick-up. Although stable, performance dropped slightly partially due to supporting Yorkshire Ambulance Service (YAS) with call handling during their NHS Pathways implementation. This support has now been scaled back.

In terms of Patient Transport Service (PTS), the Chief Executive reported challenges associated with the decommissioning of private PTS capacity by acute trusts to support discharge activity across Lancashire. There was ongoing work with system partners to expand capacity and improve productivity to mitigate the impact. Additionally, uncertainty around the procurement approach for the new PTS contract presented ongoing challenges.

With reference to Paramedic Emergency Services (PES), the Board noted continued engagement with Integrated Care Boards (ICBs) and the NHS England regional team in preparation for the implementation of the 45-minute ambulance handover backstop. The Chief Executive also highlighted ongoing work with system partners to expand alternatives to Emergency Department (ED) conveyance through care coordination and single point of access initiatives.

Reporting on Urgent and Emergency Care (UEC), the Chief Executive advised delivery against UEC trajectories continued, with the Double Crewed Ambulance (DCA) service remaining on track to meet the cumulative target by the end of Q2. Hear and treat (H&T) performance remained below trajectory however there was a targeted action plan is in place to increase clinical capacity in the ICCs and reduce non-core activity.

The Board noted that NWAS had again been placed in the Sunday Times Top 100 Apprenticeship Employers in 2025, this year ranking at number 27. The Trust has over 700 employees currently on an apprenticeship.

The Chief Executive reported the Trust continued to celebrate diversity, through various events linked to PRIDE month in June and Disability PRIDE month in July.

In terms of Quality, the Board noted several initiatives including a four-phase continuous improvement plan introduced at the Senior Leaders briefing, launch of the second cohort of the Improvement Academy and a Systems Thinking session, delivered by Professor Mohammed Mohammed, which had been well received.

The Chief Executive reported national updates. He highlighted the 10-year Health Plan for England had been launched by the UK Government on 3 July 2025. The plan would be reviewed to understand what it means for NWAS and the wider ambulance service and how it should shape the next phase of our own strategy.

The Chief Executive outlined the national meetings he attended during June and July as detailed in the report. In terms of systems update, the Board noted NWAS welcomed a visit from Dr Hugo Mascie-Taylor, who had 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.

The Board also noted updates from Executive Away Day, Senior Managers Briefing and Wellbeing Roadshow.

The Chief Executive made staff announcements as recorded in the report.

Prof A Esmail thanked the Chief Executive for the comprehensive report and enquired whether the 45 minute handover target could have negative consequences on the Trust, expressing a concern it could become a new standard, when in several areas, the Trust's performance exceeds this

The Chief Executive advised negative consequences of handover 45 had not yet been experienced and confirmed the underpinning handover standard has always been, and remains, at 15 minutes.

The Director of Operations said communication with workforce was crucial and announcements were made in operational bulletin to staff on the 29th July regarding information on Handover 45 (HO45), including detailed guidance and FAQs.

Dr A Chambers asked for more detail about the Clinical Reconfiguration Review. The Chief Executive advised this concerned the organisation of services. During his visit, Dr Hugo Mascie-Taylor, discussed the potential impact which may not be linked to savings, and advised that it was advantageous for an organisation to involve him very early in the review so he can support the change.

Mr D Whatley referred to the information regarding the Executive Away Day, and the importance of increasing visibility and engagement across the organisation. Noting a structured programme of executive visits was being developed, he suggested that Non-Executive Directors should be sighted on this so they could attend the visits when possible.

The Chief Executive welcomed the suggestion and said mapping BoD member visibility was underway to ensure full geographical cover and avoid duplication, and that aa new template is being developed to capture feedback.

The Chair referred to the information regarding strategy development and requested that the Trust strategy development timetable is finalised and circulated to the Board.

The Board:

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

BOD/2526/059 Board Assurance Framework Q1 2025/26

The Director of Corporate Affairs presented the proposed Q1 Position of the Board Assurance Framework 2025/26. She highlighted the Committees

reviewed the relevant sections of the BAF and advised the updates were marked in purple font in Appendix 1.

The Board noted two proposed changes, with rationale detailed in s2 of the report: SR01 for Q1 decreasing from 15 to 10 and SR04 for Q1 decreasing from 15 to 10.

The Trust Chair thanked the Director of Corporate Affairs for the report and noted the Committees had reviewed and supported the recommended changes to the scores.

Prof A Esmail was pleased to see the decrease in score of SR01 and the reassuring rationale underpinning the suggested new score.

The Board:

- Approved the Q1 position of the Board Assurance Framework 2025/26.

BOD/2526/060 SIRO Annual Report 2024/25

The Director of Finance, the Senior Information Risk Owner (SIRO), presented a summary of the Trust's information governance (IG) for the financial year and compliance with regulatory and contractual standards. She advised the report had been previously received by the Audit Committee.

The Board noted the Trust achieved "Approaching Standards" for Data Security and Protection Toolkit (DSPT) for 2023/24, as two requirements were not achieved. However, the audit for 2023/24 carried out by Mersey Internal Audit Agency (MIAA) provided a Substantial Assurance outcome.

The SIRO pointed to s3.2 of the report on DSPT Updated Structure for 2024/25. She advised that the Data Security and Protection Toolkit (DSPT) had adopted the National Cyber Security Centre's (NCSC) Cyber Assessment Framework (CAF) as its foundation for cyber security and information governance assurance.

Referring to s3.3 of the report on DSPT Performance 2024/25, the SIRO advised an interim submission was completed in December 2024 and the final submission at end of June 2025. The Trust will not have met all the standards of the new framework, as expected by NHS England.

The Board received detailed information regarding: Data Breaches (157 data breaches during the reporting period), Freedom of Information Requests (497 FOI requests), Individual Rights Requests (3,089) and activity of the Data Protection Officer.

The SIRO highlighted the Information Governance & Cyber Group oversees the risks associated with information governance and cyber. At the end of March there were several risks as detailed in s14 of the report.

Dr A Chambers referred to the increase of 13.99% in Freedom of Information (FOI) requests and queried whether this had an impact on the capacity of resources to respond to those.
The SIRO advised this had not caused a significant impact on capacity thus far. The Chief Executive Officer advised the Trust Management Committee would assess any impact. The Director of People added the digital team worked hard to streamline access to data and for now it felt manageable however it remained under review.

The Director of Quality and Improvement referred to the data breaches and enquired about any commonalities. The SIRO advised investigations of individual breaches would identify themes and process, and training would be improved to close the loop. The Board noted the Trust effectively uses the RLDatix System, DCIQ, to capture data breaches, which also include categories of breaches.

The Chair referred to the increase in FOIs and Individual Rights Requests (SAR) and enquired about the reason for this trend.
The Director of People advised some of the SARs increase was caused by more requests from individuals undergoing complex disciplinary processes.
The Chief Executive added that a quarterly review of FOIs was in place.
The Director of Strategy and Partnerships advised FOIs had increased across a number of providers in the region.

The Board:

- Noted the contents of the report and assurance provided.

BOD/2526/061 Audit Committee 3A report from the meetings held on 18th June 2025 & 18th July 2025

Mr D Whatley presented the Audit Committee 3A Reports from the meetings held on the 18th June and 18th July.

In terms of the Audit Committee meeting held on 18th June 2025, the Board noted there were no alerts and no advisements. The Committee received the year end reports from the External Auditors and recommended the Annual Report 2024/25 for Board approval. All year end reporting timescales were met.

Referring to the Audit Committee held on the 18th July, Mr D Whatley reported no alerts and two advisements in relation to Audit Completion Report and Losses and Compensation for Q1. Mr D Whatley highlighted the Committee received the outcomes of the annual effectiveness review, which had been carried out by MIAA in line with the HFMA Audit Committee Handbook, which brough positive results.

The Board:

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

BOD/2526/062 Charitable Funds Committee (CFC) 3A Report from the meeting held on 23rd July 2025

Mr D Whatley presented the Charitable Funds Committee 3A Report from the meeting held on 23rd July 2025. The Committee received a number of reports, and no alerts were raised on this occasion.
The Board noted the Q1 financial position for NWAS Charity.

Mr D Whatley highlighted the CFC received the NWAS Charity risk register and 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.

Mr D Whatley shared he would be participating in one of the upcoming charity events: Cross Bay Walk – Sunday 31 August 2025 and encouraged other Board members to consider the upcoming events.

The Board:

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

BOD/2526/063 Trust Management Committee 3A Report from the meetings held on 18th June 2025 and 23rd July 2025.

The Chief Executive presented the Trust Management Committee (TMC) 3A report from the meeting held on 18th June 2025 and advised there were three alerts and a number of advisements and assurance reports, as listed within the report. The alerts related to productivity & efficiency, Data Security Protection Toolkit Submission (DSPT) June 2025 and EPRR mandatory training.

Prof A Esmail asked for more information regarding the productivity and efficiency alert. The Chief Executive advised work was underway on two substantive schemes, which needed to be finalised before they could be moved into implementation plans. If any measures were identified as non-cash releasing, replacements would be identified.

Prof A Esmail queried whether the underlying issues with JESIP training compliance were systematic or rotation issues.
The Director of Operations advised it linked to a data issue, and technical challenges with login. He added the number of individuals required to undertake training was increased. He highlighted that the latest information received by EPRR Group reflected an improving position. Having moved from spreadsheet to ESR, the oversight had significantly improved, as had commander training compliance which was 100%.
The Director of People added that whilst overall compliance was reported to the Board, the deep dives into specific modules were considered and addressed at the People and Culture Group. Prof A Esmail thanked for the additional information and would look forward to receiving the filtered data.

Referring to the meeting held on 23rd July 2025, the Chief Executive reported three alerts and a number of advisements and assurance reports, as listed within

the report. The alerts related to industrial action, productivity and efficiency and patient safety events data backlog.

Dr D Hanley queried the rationale for the proposed amalgamation of the Equality and Quality Impact assessment process with the draft QIA policy .
The Director of Quality and Improvement advised the new national guidance provides a template which combines those two processes,
The Chief Executive advised this was at an explorative stage and the two processes have not been brought together yet as opportunities and risks were being assessed.

Prof A Esmail queried the productivity and efficiency alert about a forecast shortfall. The Director of Finance advised a detailed report had been taken to the Resources Committee. Despite the shortfall forecast, the position was much better than in previous years, as well as much improved governance around CIP monitoring and delivery.

The Chair referred to the patient safety events management and requested more information on this subject.

The Chief Executive advised the TMC had received a detailed report the patient safety events management backlog and mitigating actions and a briefing note to the Non-Executive Board members would be issued to provide more information.

The Board:

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

BOD/2526/064 Workforce Equalities Data Monitoring Reports

The Director of People presented the key messages from the report, which contained four appendices:

- Workforce Disability Equality Standard (WDES)Data Report Covering the period of1st April 2024 – 31st March 2025
- Workforce Race Equality Standard (WRES) Data Report Covering the period of 1 April 2024 – 31 March 2025
- Pay Gap Data Report (Gender, Ethnicity & Disability) Covering the period of 1st April 2024 – 31st March 2025
- Update following a review of 2023/24 formal disciplinary process cases involving BME staff – relating to WRES Indicator 3.

The Board received an overview of the above documents and key findings from the data, noting full reports for the detailed context.

In terms of WDES, the Board noted overall levels of representation across all levels of the organisations were improving, which was also reflected in the pay gap report, which was in a good position in terms of disability. There was a positive and improved position on shortlisting to appointment and close to no

difference between disabled and non-disabled staff in terms of recruitment process.

Referring to WRES, the Director of People reported continued improvements in overall representation and a positive improving position in relation to staff experience with an improved position across the board in terms of the staff survey responses as well as increase in confidence in in fair career progression among BME staff.

The Director of People highlighted the main areas of concern, advising BME applicants were nearly 2.5 times less likely to be appointed after being shortlisted than white applicants, and BME staff were nearly 2.7 times more likely to enter formal disciplinary processes than white colleagues.

The Board also noted the staff survey showed gaps in experience for staff who were disabled in comparison with other protected groups despite significant improvements around reasonable adjustments reported by disabled staff. The Director of People reported disabled staff were nearly 4.5 times more likely than non-disabled staff to enter the formal capability process, cautioning the numbers overall in those processes were small, which could lead to significant shifts in statistics.

In terms of Pay Gap report, the Director of People advised of slightly widened gaps for gender and ethnicity linked to improvements in entry level recruitment, with continued focus on progression required.

The Board noted the appended data reports outlined a range 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, overseen by the Resources Committee. The Director of People highlighted focused work was in place on leadership with close monitoring of leadership recruitment.

The Board noted three substantial areas of focus: WRES Indicator 2, WRES Indicator 3 and WDES Metric 3 and actions to address them. A number of reviews into the data would take place to aid understanding, to be completed by October, with a view to take the report to the Diversity and Inclusion Group for initial scrutiny and then to the Resources Committee in November with further actions identified as a result of deeper understanding of data.

Dr D Hanley confirmed the reports had been discussed at the Resources Committee and a further report would be brought back in November with an in-depth analysis of data and actions. He acknowledged and welcomed the progress made in certain areas as reported.
In terms of areas of concern, he referred to the satisfaction levels of the disabled staff and queried why 70% reported dissatisfaction with how their work is valued, whilst 71.3% of disabled staff reported that reasonable adjustments were made. The Director of People offered to share the detailed questions of the survey outside of the meeting. She advised the issue was addressed through raising awareness with leadership teams and managers around how best to support disabled staff, providing reasonable adjustments and having positive and constructive conversations.

The Director of People pointed out the number of people who report themselves as being disabled through the staff surveys was at around 30% last year in comparison to much lower reporting through ESR, so staff need confidence to disclose disability for managers to be able to make reasonable adjustments for them.

The Chair referred to the issue of disabled staff potentially feeling less valued, and observed this could be an acute issue triggered by an inappropriate use of language, of which managers need to be cognisant.

Prof A Esmail noted the high quality of the reports and good detail provided therein. He noted there had been significant effort and work put into advertising, which brought results in increased BME application numbers, however the BME applicants were nearly 2.5 times less likely to be appointed than white applicants in 2024/25. As this referred to entry level roles, he observed there was the least oversight of recruitment lower down in the organisation. More work was required to explain this situation.

Prof A Esmail referred to Appendix 4 containing an update following a review of formal disciplinary process cases involving BME staff. He acknowledged a further review would be carried out internally, however advised that there was a plethora of research available on this subject, providing insight into reasons, challenges and ways to prevent it.
The Director of People acknowledged the comment, and advised external research would support the findings, she added however that the internal review was needed to be able to present to the managers the specific impact of their decisions.
The Chief Executive agreed with the point made by Prof Esmail and observed that the deep dive brought some answers and generated more questions about the complexity of potential conscious and unconscious bias. Targeted work was underway to address the issue and create the right and fair environment for staff. He acknowledged the achievements thus far, notwithstanding the work that remains to be done.

Mr A Makda noted the importance of diverse recruitment panels.
Ms M Afsar observed some managers might prefer to enter formalised disciplinary processes instead of having challenging conversations to protect themselves from being accused of sexism or racism and work was needed on enabling them to feel comfortable to have those difficult informal conversations.

The Chair thanked the Director of People for the reports and observed the organisation needs to challenge itself on the issues discussed.

The Board:

- Reviewed, considered and noted the data in the WDES, WRES and Pay Gap reports.
- Received assurance the Trust has complied with its regulatory and statutory duties to compile and submit the data.
- Approved the publication of the data as set out in the Appendices.

BOD/2526/065 Resources Committee 3A Report from the meeting held on 24th July 2025

Dr D Hanley presented the Resources Committee 3A Report from the meeting held on 24th July 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 and the other advisory notes had also been covered during discussions at today's Board.

The Board:

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

BOD/2526/066 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 June 2025. She drew out the main points in terms of quality, effectiveness, operational performance, finance and organisational health.

The Director of Corporate Affairs presented an overview of complaints and incidents data and noted a stable position. The Board noted Patient Advice and Liaison Service (PALS) complaints indicated improvement, consistent with a period of reduced operational pressures.

In terms of incidents, the Director of Corporate Affairs reported stable metrics, with care and treatment being the most common theme for patient incidents and the highest overall reported incident, whilst violence and aggression was the most common theme for the non-patient incidents. In terms of violence and aggression the most common occurrence was verbal aggression.
The Chair asked about potential offences being progressed.
The Chief Executive advised the Trust worked with magistrates and police forces on individual cases and raising awareness, there was also targeted work in the Trust regarding sexual safety concerns.

With regards to Patient Experience data, the Interim Deputy Director of Strategy, Partnerships and Transformation presented the data which included examples of positive and negative comments from patients. She highlighted a positive increase in returns in 111. Work was underway to increase return repose rates, piloting sending broadcast invites to surveys outside of normal send window.

The Medical Director reported the Trust was performing above national average for all Ambulance Clinical Quality Indicators (ACQI), as detailed in the Statistical Process Control charts. The Board noted that the Falls care bundle performance had improved following the introduction of a Falls tile within the Electronic Patient Record system.

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 the call pick up increased to 4 second mean and 27 second 95th percentile owing to many factors including an agreement to take calls for Yorkshire Ambulance Service as they migrate to NHS Pathways. Some of the support had been since stood down and dual handling (111 & 999) was increased to meet the demand.

The Board noted the H&T rate has steadied in Q1 and there was a clear action plan in place to support an improvement in the target by the end of Q2.

In terms of hospital handover, the Director of Operations reported turnaround was stable however it continued to exceed the 30-minute standard with ongoing regional variations. NHSE were leading a new rapid release system where crews would be required to initiate a rapid handover of any patient waiting over 45 minutes outside Emergency Department.

The Director of Operations reported stable C2 performance times consistent with patterns observed it the last two years. The Board noted the Trust remained third in the national rankings for C1 performance and improved to third for C2 performance.

In terms of 111, the Director of Operations advised of stable call volume and call answering metrics displaying improvement.

In reference to Patient Transport Services (PTS), the Board noted stable metrics, with planned and unplanned at the 90% contract standard. The Director of Operations advised of work with system partners on PTS delivery.

Prof A Esmail referred to C2 times and queried whether the UEC target could be achieved and sustained through the pressures of winter.
The Director of Operations advised the Trust was ahead of the trajectory and preparing for the winter in terms of continuing to internally increase operational capacity notwithstanding external constraints and regional variations.

Dr A Chambers enquired whether long waits, C3 and C4 impacted patient harm, and if some became critical due to waiting time.
The Director of Operations advised the Trust had improved clinical oversight over C3 and C4 patients and strived for balance against C2; even during periods of high demand, the resource is there.
The Director of Quality and Improvement advised long waits and delays were being monitored in incidents, as they came under the Care and Treatment category.

The Medical Director observed ongoing reviews of the response model supported further improvements. He said inter-facility transfers and healthcare professional incidents are being reviewed, in which the Trust was a national outlier. As the hospitals reconfigure their services, resource is needed to move

patients between centres which inevitably causes delays. The Trust was working with partners to improve efficiency and access to care pathways.

The Director of Finance presented the financial data from the IPR report. The Board noted the financial position to 30 June 2025 (Month 03) was at 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 the plan.

The Board noted the metric for agency use had been removed as it had reduced to zero.

The Director of People presented the Organisational Health data from the IPR report, which contained detailed charts and commentary in relation to the following: staff sickness, turnover, temporary staffing, vacancy gap, appraisals, mandatory training and case management, reporting stable and improving metrics. The Board noted sickness absence was broadly consistent with the position at the same time last year, however there had been two months of rising sickness absence in PTS. The Director of People advised the revised sickness policy with supporting resources had been launched on the 1st July. In terms of mandatory training, NWAS compliance was at 88%, against a revised target of 90%, expected to recover in year.

Dr D Hanley referred to the rise in sickness absence in PTS, noting however that turnover in PTS dropped. The Director of People acknowledged there were differences in indicators, which reflected targeted work underway in PTS with the aim to stabilise in year.

The Board:

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

BOD/2526/067 NWAS Strategic Winter Assurance Framework

The Director of Operations presented the report advising that NHS England requires all Trust Boards to have approved their strategic winter plan by the end of August 2025.

The Board noted that in 2024/25, the plan format was revised to a strategic framework document that forms the basis of a further supporting tactical plan for Service Delivery. The Director of Operations reported the tactical plan was under construction and would be approved by the Service Delivery SMT in September. The Board noted the revisions to the plan for 2025 as laid out in s3.1 of the report, which included the specific expectations upon NWAS connected with additional UEC investment in 2025/26.

Mr D Whatley referred to the financial considerations and interdependencies with social care. He pointed to the statement in the Winter Plan concerning the links between access to Social Care and the impact on Acute Providers struggling to discharge patients, thus affecting ambulance handover at Emergency

Departments. Mr D Whatley queried whether the Trust had any impact on the situation.
The Director of Operations observed the social care gaps had an impact on wider NHS. The Strategic Planning Group engage with partners to demonstrate the impact on the Trust, should certain services be removed. However, the Trust can only influence those decisions to a certain extent and so the focus remains on internal preparedness.

The Board:

- Noted and approved the content of document for submission to NHS England NW.

BOD/2526/068 Accountable Officer for Controlled Drugs (CDs) Annual Report 2024/25

The Medical Director presented the report noting achievements and improvements made in 2024/25, including: roll out of digital paramedic possession CD keys, high level of CD reporting, CD policy up to date, medicines management quality indicator for vehicles compliant, ambulance stations targets met and Designated Body self-assessment complete.

The Board also noted the challenges encountered in 2024/25, including the ongoing risk regarding the Home Office CD licence renewal.

Dr A Chambers asked if a contingency plan was in place, should the licence not be issued in time. The Medical Director reassured mitigation was in place with a previous supplier.

Ms M Afsar queried the increase in CD incidents, as compared to the previous year. The Medical Director advised the increase was considered positive due to an improved reporting culture and ease of reporting incidents. Most CD incidents were low or no harm.

The Chair thanked the Medical Director for the report and requested that the Director discusses further assurance regarding the contingency plans in mitigation of the CD licence risk with the Chair of the Quality and Performance Committee.

The Board:

- Noted the assurance provided and the achievements and improvements made in 2024/25 as well as the challenges and risks.

BOD/2526/069 Safeguarding Annual Report 2024/25

The Director of Quality and Improvement presented the report providing an overview of safeguarding activity within the Trust during 2024/25, which had been previously reviewed by the Quality and Performance Committee.

The Board noted a total of 39,561 safeguarding and early help referrals were made during 2024/25, which was an increase of 19% compared to 2023/24. This

was attributed to enhancements in Safeguarding training, as a result of a full Training Needs Analysis that aligned Safeguarding Children and Young People roles. In addition, bespoke training had been provided to staff in Integrated Contact Centres (ICC) during 2024.

The Director of Quality & Improvement highlighted the small and decreased rejection rate for 2024/25, thus providing continued assurance that the safeguarding information shared by NWAS was high quality.

The Board also noted MIAA carried out a comprehensive safeguarding audit in Q3 2024/25, the outcome of which was “Substantial Assurance”.

Dr D Hanley welcomed the report noting the good progress made, as well as ambitions for 2025/26. He suggested next year’s report should provide additional analysis describing measures taken to ensure no one was missed.
The Director of Quality & Improvement acknowledged the suggestion.

The Board:

- Received the assurance that NWAS safeguarding activity during 2024-25 continued to meet the statutory requirements.

BOD/2526/070 Infection Prevention and Control (IPC) Annual Report 2024/25

The Director of Quality and Improvement presented the IPC Annual Report with an addendum to the IPC BAF. This highlighted the Trust’s continued progress in delivering against its key priorities. The Director of Quality and Improvement highlighted the team’s focus on ensuring compliance with CQC regulations, as well as monitoring compliance with IPC policies, procedures and training via station and vehicle audits.

The Board noted the IPC governance arrangements including the structure of the team, reporting processes and risk management.

The Director of Quality and Improvement reported the IPC BAF had 6 amber rated areas (partially compliant) and no red rated areas. Actions against the areas were detailed in the IPC BAF. The Director of Quality and Improvement advised there were five IPC risks on the risk register, all scoring less than 12 and advised the report had been previously discussed at the Quality and Performance Committee meeting.

The Board:

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

BOD/2526/071 Quality and Performance Committee 3A Report from the meeting held on 30th June 2025.

Prof A Esmail introduced the report, which contained no alerts and several advisements and assurances. He noted that all the key issues discussed at the Q&P Committee had been relayed to the Board today through the discussion around IPR, as well as through other reports on the agenda, which had previously been reviewed at the Q&P Committee.

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

BOD/2526/072 Communications and Engagement Q1 2025/26 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 public engagement, patient experience surveys, internal communication and comms and engagement plans for Q1.

The Board welcomed highlights from the NWAS charity such as income, events and the impact of charity funding for our staff, volunteers and communities.

The Interim Deputy Director of Strategy Planning & Transformation took the Board through the Dashboard Report as per s2 of the enclosed paper, highlighting that 6 Patient and Public Panel members successfully enrolled onto cohort 2 of the Quality Improvement Academy. She also advised of panel member involvement sessions and other events and engagement opportunities including targeted focus groups with underrepresented groups.

Referring to Communications, s2.2 of the report, the Interim Deputy Director of Strategy Planning & Transformation provided an outline of a significant number of communications activities including their impact on the staff and Trust strategic objectives.

The Chair asked if communication challenges and language barriers had any impact on service delivery.
The Chief Executive advised that focus group feedback would be included when service impact was discussed and provided an example.
The Medical Director also offered an example of feedback influencing guidance concerning the transportation of assistance dogs to prevent separation from patients.

The Chief Executive thanked the Interim Deputy Director of Strategy Planning and Transformation for stepping in to reporting to the Board and welcomed the newly appointed Strategy and Partnership Director who would present the reports to the Board going forward.
The Board:

- Noted the content of the report.

BOD/2526/073 Any Other Business Notified Prior to the meeting

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

BOD/2526/074 Risks identified

The Chair confirmed there was no additional risk identified for BAF.

Date and time of the next meeting –
24th September 2025 at 09:45 am in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Signed _____

Date _____

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

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

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
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 was suggested that the action is transferred to the RC action log to agree suitable timeline for providing assurance. 30 July 2025: the Board agreed the action should be transferred to the RC action log to agree suitable timeline for providing assurance. **The action was transferred to the Resources Committee.**	
3 - 25/26	30.07.25	58	Chief Executive's Report	The finalised Trust strategy development timetable would be circulated to the Board.	Director of Strategy and Partnerships	24.09.25	24.09.25	Finalised Trust Strategy Development Timeline was circulated on the 19th Septmeber 2025.	
4 - 25/26	30.07.25	63	Trust Management Committee 3A report	A briefing on patient safety events management and mitigating actions would be circulated to the Non-Executive Board members. The Executive Directors received the detailed report at TMC in July.	Director of Quality and Improvement	24.09.25	24.09.25	The briefing was cirulated to Non-Executive Directors on the 11th August 2025.	
5 - 25/26	30.07.25	68	Controlled Drugs Annual Report 2024/25	The Medical Director will discuss further assurance regarding the contingency plans in mitigation of the CD licence risk with the Chair of the Quality and Performance Committee	Medical Director	24.09.25	24.09.25	Update 02/09/25 from the Medical Director: Meeting occurred 26/08/25 and update provided at Quality & Performance Committe 01/09/25	

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	✔	x				
Lisa Ward	✔	✔	✔	✔				
Angela Wetton	✔	✔	x	✔				
David Whatley	✔	✔	✔	✔				
Peter White (Chair)	✔	✔	✔					
Carolyn Wood	✔	✔	✔	✔				
Dr Elaine Strachan-Hall	✔	✔	✔	✔				
Julia Mulligan (Chair)				✔				
Michael Gibbs				✔				

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	x			
Catherine Butterworth	x	✔	x			
Dr David Hanley (Chair)	✔	✔	✔			
Lisa Ward	✔	✔	✔			
David Whatley	✔	✔	✔			
Carolyn Wood	✔	x	✔			
Michael Gibbs			✔			

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	✔	✔	x			

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	x				
Dr Alison Chambers	✔	✔	✔				
Prof Aneez Esmail	✔	✔	✔				
Dr David Hanley	✔	✔	✔				
David Whatley	✔	✔	✔				
Peter White (Chair)	✔	✔					
Julia Mulligan (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	
Michael	Gibbs	Director of Strategy & Partnerships	Ex-wife employee within NWAS 000 service		√			Non-Financial Professional Interest	Jul-25	Present	Declare an interest and withdraw from discussions as and when required.

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	
Chris	Grant	Medical Director	NHS Consultant in Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			A member of Festival Medical Services, a 'not for profit' registered charity staffed by volunteers, delivering professional medical services at events throughout the country. NWAS does not sub-contract events nor does FMS operate any significant activity in the North West.		√			Non Financial Professional Interest.	Jul-22	Present	If FMS run events in the North West, these would be undertaken via usual NWAS command functions and EPRR planning and I would remove myself from any interactions and engage with the NWAS Deputy Director should involvement be required from the Medical Directorate.
David	Hanley	Non-Executive Director	Lay Representative Royal College of Physicians			√		Non Financial Professional Interest.	May-24	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
			Member of Fawcett Society				√		2020	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, East Lancashire Learning Group (formerly known as 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.

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	
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.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 September 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 1 August 2025 – 5 September 2025. The highlights are as follows: Strategy: The Trust Strategy is moving into the development phase and a revised timeline has been produced to reflect the interdependencies with the new NHSE framework and the 5-year plan submission. This stage will continue to engage Trust Board, TMC, colleagues, patients, and system partners. Finance: Quarter 3 financial assurance: NWAS reports a strong position and confirms progress against strategic plans. Integrated Contact Centres: The 'UEC Single Point of Access' went live as a pilot across Mid & North Merseyside on 28 July 202 which saw an 87% increase in referrals across North Merseyside, and a 47% increase in St Helens.

	Phase 2 is in early delivery, but in the first week of the expanded phase 2, conveyance to type 1 ED reduced from a year-to-date position of 53.0% to 50.04% last week. Formal evaluation will be undertaken at the end of week 4 (mid-October). People & Culture: On 25 August 2025 the trust received notification of a full OFSTED inspection. The inspection commenced on Tuesday 29 August and concluded on the 2 September 2025. The trust retained its 'good' rating overall with one area of outstanding practice. One notable area to improve was the engagement of operations in the learner reviews on which we are monitored by the Department for Education. A working group will be arranged to progress this work. Corporate Affairs: The Director of Operations in his role as Accountable Emergency Officer (EAO) will be attending the Southport Inquiry to give evidence on 24 September 2025 and cover arrangements are in place in the trust for the short period that he will be unavailable prior to this date. Notable Events: VJ 80th anniversary commemoration. Tributes paid to three colleagues who have passed away. Retirement of Dave Kitchin, Head of Operations – Cheshire & Merseyside Area.	
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 30 July 2025.

2. INTERNAL UPDATES

Strategy

Annual Planning

The 2025/26 Annual Plan, launched in June, continues to provide focus during the final year of the current Trust Strategy. The Planning Group provides quarterly assurance to TMC and the Resources Committee on delivery progress. Q1 monitoring indicates positive progress overall, with most objectives and associated deliverables on track. Mitigating actions are being overseen for those that are off track, ensuring delivery remains on course.

In August, NHS England released the new 5-Year Integrated Planning Framework. The Trust has reviewed the requirements and confirmed submission is expected in Q3. As a result, the planning timeline has been adjusted: the 2026/27 annual planning round, which would normally commence in September, will now begin in Q4 to allow sufficient time to focus on the 5-year submission.

Strategy Development

Development of the next Trust Strategy is progressing at pace. The diagnose and design phases are now complete, having engaged staff, patients, and senior leaders to identify key themes. The programme is now moving into the development phase, which will focus on consensus building around the emerging themes. A revised timeline has been produced to reflect the interdependencies with the new NHSE framework and the 5-year plan submission. The development stage will continue to engage Trust Board, TMC, colleagues, patients, and system partners.

Finance

Improvement and Assurance Group (IAG) Process

As previously reported, the Lancashire & South Cumbria (L&SC) System Turnaround Director confirmed NWAS' de-escalation from the Improvement and Assurance Group (IAG) process. Monthly monitoring has since commenced, with specific metrics and thresholds established to trigger formal review if breached.

As of the latest reporting period, NWAS remains within all four monitored thresholds.

Q3 Financial Assurance – L&SC ICB

NWAS has provided Q3 financial assurance to NHS Lancashire and South Cumbria ICB, confirming a strong position with a £934k surplus at Month 5 against a planned deficit of

£329k. All financial and activity contracts have been signed with commissioners, and savings delivery is ahead of plan, forecasting £14.911m against a target of £14.878m. Progress on the NHS England-approved Urgent and Emergency Care plan remains on track, with regular oversight from national teams.

Integrated Contact Centres

The 'UEC Single Point of Access' went live as a pilot across Mid & North Merseyside on 28 July 2025. The plan for this was to bring Urgent Community Response, Primary Care, and SDEC referrals into one single number making it as easy for people to refer patients as possible. The pilot was evaluated at the end of week 4 by the provider collaborative and we saw an 87% increase in referrals across North Merseyside, and a 47% increase in St Helens.

This led to the expansion of the pilot to be pan area going live on 8 September. There have been associated communications and engagement from leaders across the area to promote the single telephony, but also to push other elements such as own or taxi transport and clinical learning points from the initial pilot being covered in staff communication.

Phase 2 is in early delivery, but in the first week of the expanded phase 2, conveyance to type 1 ED reduced from a year-to-date position of 53.0% to 50.04% last week. While there are not enough data points to be able to confirm a statistically significant change, this is being monitored through system calls and referral activity and will be formally evaluated at the end of week 4 which will be mid-October.'

People

<u>OFSTED Inspection 2025</u>
On 25 August 2025 NWAS received notification of a full OFSTED inspection. The inspection commenced on Tuesday 29 August and concluded on the 2 September 2025. Following moderation, the final inspection report was issued. NWAS retained their 'good' rating overall with one area of outstanding practice. One notable area to improve was the engagement of operations in the learner reviews on which we are monitored by the Department for Education. A working group will be arranged to progress this work. The inspectors would like to thank all those who participated in the inspection. As a 'good' provider, the maximum time before the next inspection is 5 years, but they can inspect anytime between now and then.

Further education and skills inspection report

Ofsted
raising standards
improving lives

Inspection of North West Ambulance Service NHS Trust

Inspection dates: 29 July to 1 August 2025

Overall effectiveness	**Good**
The quality of education	**Good**
Behaviour and attitudes	**Outstanding**
Personal development	**Good**
Leadership and management	**Good**
Apprenticeships	**Good**
Overall effectiveness at previous inspection	Good

Celebrating Diversity

Following Board approval of the Trust's Anti-Racism Statement earlier this year - affirming a strong organisational commitment to building an anti-racist culture - an Anti-Racism Steering Group has been established to provide leadership and coordination in addressing racism across the Trust. The Group held its first formal meeting at the beginning of September and brings together a wide range of stakeholders, including representatives from operations, workforce, EDI, communications, and staff networks. The Group is chaired by Sian Wimbury, Area Director for Greater Manchester.

At its initial meetings, the Group has highlighted the importance of adopting an unapologetic and proactive approach to anti-racism, the need for a robust communications plan to support the launch of the Anti-Racism Statement, and the requirement for additional resources to help staff and managers put the Statement into practice. The Group also recognised the complexity of implementing a zero-tolerance approach and agreed that sub-groups will be needed to drive forward specific workstreams.

Work is now underway to launch the Statement in late October, to coincide with Black History Month. Alongside the Statement, a supporting information pack is being developed to outline how the commitments apply in practice for staff and managers.

Investing in leadership development

In August, we hosted our sixth Culture Event for leaders, continuing our commitment to strengthening our culture. This session focused on three important themes—sexual safety, allyship, and generational differences—while providing leaders with practical tools to spark meaningful conversations within their teams and set clear expectations for how we can all perform at our best.

On 4 September, we launched the Developing Leaders Programme with a Welcome Event that brought together 41 mentoring pairs from across the Trust, with 70% of mentees coming from operational services. This represents a breakthrough in leadership development, as we know frontline staff often find it challenging to access opportunities beyond mandatory training. Over the coming months, mentees will take part in a series of facilitated learning sessions covering project management and quality improvement,

finance, governance, risk, and leadership development. These sessions will also build skills in emotional intelligence, leading across generations, and promoting civility and respect.

Alongside this, we have been refreshing our leadership recruitment processes, working closely with networks and key stakeholders to ensure we identify and nurture talent effectively, securing the right leadership for the future. The new approach will launch in October.

We have also completed our refresh of the Civility and Respect learning session and trained this out to educators for use in induction and this will also feature as part of the newly launched Leadership induction.

Burnley College Summer School

NWAS has run the second of a two-day summer school at Burnley 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.
Further reviews will now take place to continue this model with further operational involvement.

Executive Director of Quality and Improvement Recruitment

The recruitment process for the Executive Director of Quality post is now underway. The stakeholder engagement panels are scheduled for 29 September and formal interviews scheduled for the 2 October.

Corporate Affairs

Well-Led Development Review

The commissioned well-led developmental review has now been completed by Good Governance Institute (GGI) and the draft report has been checked for factually accuracy. A session with Board members is scheduled for 24 September to receive the findings. The full report, along with the Trust's response, will be presented to the Board at the next meeting.

Southport Inquiry

Following receipt of formal notification, the Director of Operations in his role as Accountable Emergency Officer (EAO) will be attending the Southport Inquiry to give evidence on 24 September 2025 and cover arrangements are in place in the trust for the short period that he will be unavailable.

As always, our thoughts remain with all those affected by this tragedy, particularly with the families of Alice, Bebe and Elsie.

Medical

NHS North West Exercise Aegis

As part of NHS England's winter assurance process for 2025/26, an exercise took place in Warrington on 8 September. Senior NWAS operational and clinical leaders joined over 230 delegates from across North West systems. The aim was to test NHS winter plans, identify risks and issues, and explore potential mitigations – ensuring plans are robust and connected to help manage winter pressures.

Single Point of Access

From Monday, 8 September, Cheshire and Merseyside will adopt a single point of access (SPoA) telephone number for all referrals, including Urgent Community Response (UCR), Same Day Emergency Care (SDEC), and GP out-of-hours services, available 24/7. This initiative supports the safe reduction of conveyances to emergency departments and contributes to delivering our See and Treat ambitions.

3. Updates

3.1 National Update

AACE NHS 10-year plan

On 11 August I travelled to London to join other Ambulance Service Chief Executives at the national AACE discussion on the NHS 10-year plan. It was an opportunity to share ideas and explore how the ambulance sector might operate in the future.

Provider Capability Assessment

NHS England has introduced a new provider capability assessment as part of the NHS Oversight Framework (NOF). Alongside NOF segmentation, this rating will inform decisions on improvement support and Foundation Trust status. The assessment includes an annual Board self-assessment, triangulated with performance data and third-party input, and will be updated throughout the year.

The Executive Team will complete the self-assessment template by the end of September, after which it will be shared with Non-Executive Directors for feedback and approval prior to

Hospital handovers

From 1 August, all ambulance handovers in the North West should be completed within a maximum of 45 minutes. This new standard, supported by NHS England, integrated care boards (ICBs) and acute trusts, aims to improve patient care and reduce the time our crews spend waiting at hospitals. The 45 minute handover target is part of this year's NHS Operational Planning Guidance and the national Urgent and Emergency Care Plan for 2025/26. From August, every hospital in our region with a Type 1 emergency department must have a local escalation protocol in place to support this.

This is a vital step in reducing risk, improving patient outcomes, and helping us to provide the best possible care.

NHS England Update – Strategic Focus for H2 2025/26

Sir Jim Mackey, NHSE CEO, has outlined key priorities for the second half of the financial year, focusing on:

- **Financial discipline** and credible recovery plans.
- **Performance improvement** in elective care, urgent/emergency services, and primary care access.
- **Winter preparedness**, including reduced bed occupancy and enhanced vaccination/discharge strategies.
- **Leadership visibility** and staff support during high-pressure periods.
- **Forward planning** for 2026/27, with emphasis on digital transformation and workforce development.

Additionally, DHSC and NHS England have announced appointments to a joint executive team as part of their organisational integration.

3.2 **Regional Update**

Segmentation and ranking under NHS Oversight Framework

Following the publication of the NHS Oversight Framework in June, the Quarter 1 segmentation and league table position for 2025/26 has now been validated. North West Ambulance Service NHS Trust has been placed in Segment 1, with a ranking of 1st out of 10 in the national ambulance league table.

North Manchester General Hospital – improvement

I visited North Manchester General Hospital with Elaine Strachan-Hall, Interim Director of Quality and Chedia Hoolickin, Head of Improvement on 7 August. The hospital team there has achieved and sustained one of the best handover times in the country and what began as a small test of change has grown into a culture of continuous improvement which has benefitted both patients and staff.

Initiatives such as Doc @ the Door – where a senior clinician is involved in early decision making as patients arrive, and Power Hour, which brings together senior leaders to act quickly when pressures build were particularly powerful and impressive examples of teamwork, leadership and shared responsibility.

Cumbria Constabulary

I held an introductory meeting with Chief Constable Darren Martland of Cumbria Constabulary on 18 August 2025. It was a useful opportunity to discuss partnership working and how we will continue to strengthen arrangements between our services.

North West Air Ambulance

As part of my continued meetings with stakeholders on 19 August I was able to visit the Barton Airbase and meet with Heather Arrowsmith, Chief Executive of the NWAA. We discussed openly about a range of topics including quality, governance, estates and culture. I was also fortunate to receive a tour of the site and air assets which showcased

the amazing work of the team there. We will continue to build upon our collaborative working arrangements for the benefit of patients across the NW.

3.3 **System Update**

Non-Emergency Patient Transport Services (NEPTS) Update
The NEPTS procurement process in the North West is being relaunched. Revised service specifications aim to improve patient experience. The process is being led by lead ICB with support from NHS Shared Business Services. A market engagement event has already taken place, with further updates expected.

Announcement of Mark Fisher's Retirement
Mark Fisher CBE will retire as Chief Executive of NHS Greater Manchester Integrated Care Board at the end of March 2026. He has led the ICB since its formation in July 2022.

On behalf of the Board, we extend our thanks to Mark for his service and wish him every happiness in his retirement.

3.4 **Organisational**

Induction welcomes
I have had the pleasure of personally being able to present the executive welcome at two induction programmes in August to welcome new starters to the trust – Health Advisors and Paramedics as they embark on their new careers with the trust.

Point of care troponin pilot
On 12 August I spent some time with Phil Jones to see our troponin trial in action, almost one year since I last responded with him. The initiative is improving care for chest pain patients by giving paramedics access to a point of care test. I learned from Phil about how the trial is progressing and the plans moving forward.

Site visits

During August, I undertook several site visits across the region. On 5 August, I visited Middlebrook 111, followed by Sharston Station where I reviewed the single standards and Whitefield Area Office to speak to corporate teams on 7 August. On 12 August, I spent time at Parkway 3 and 4, speak with colleagues across call taking, dispatch, ROCC, digital, and informatics teams.

VJ Day 80th Anniversary
On Friday 15 August some of our colleagues took part in local VJ 80th anniversary commemorations, joining communities across the country in honouring the sacrifices of the Second World War generation.

Zack Kerr – fundraiser
I had the pleasure of meeting with Zack Kerr at LBH on 20 August. Zack has quadriplegic cerebral palsy and wrote to me recently with ideas how to improve our service

specifically around the provision of defibrillators, personal wheelchairs on emergency vehicles, ambulance wait times for older people, Makaton and mental health services. It was beneficial to hear his views.

Zack is a member of the trust's Patient and Public Panel and an avid supporter of the ambulance service. He is currently working closely with our Charities Team to raise funds to enable the purchase of more community defibrillators. A charity football match and fun day has been arranged for 2 May 2026 where the ambulance service will compete against police colleagues.

Dave Kitchin, Head of Operations - CAM

On 29 August, after 44 years of NHS service, 38 of which were within the Ambulance Service we said goodbye to Dave Kitchin, Head of Operations for the Cheshire and Merseyside Area. Family, friends and colleagues from over the years joined us at his retirement presentation which covered his role as a commander, his love of football and other key career events. On behalf of the Board of Directors I attended to wish Dave a very happy and healthy retirement.

Director of Quality

The recruitment process for the substantive Director of Quality position is progressing well. Longlisting took place on 3 September and shortlisting on the 18 September with the stakeholder sessions and interviews scheduled for early October 2025.

Cyber security scam

The trust experienced a cyber breach recently and has taken advice from the local and national cyber teams. Whilst investigations are ongoing, precautionary steps have been taken to protect the trust from any further breaches.

In our thoughts

It is with great sadness that we learned of the death of three of our colleagues since my last report:

Charlene Richards, sadly passed away on 22 July. She was one of our 111 Health Advisors based at Sefton House, where she was a highly respected and well-loved member of the team.

Andrew Levett, who sadly passed away on 3 September. Andrew started his career with NWAS in 2009 as a dispatcher and then moved to PES as an EMT1 based in Lancashire.

Suffia Alam, who sadly passed away on 11 September. Suffia started working for the trust on the ICT service desk with GMAS before moving to ICT Infrastructure Administrator. She had been with the trust for over 20 years.

Dave Cooksey, who sadly passed away on the 16 September. Dave served over 20 years in the ambulance service, starting in 2001 with GMAS. He held various roles across the trust, most recently as Service Delivery Manager in the Integrated Contact Centre's Call Handling team.

I have written to the family of these colleagues on behalf of the trust and Board of Directors to offer our condolence.

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, 24 September 2025
SUBJECT	Chair and CEO Statement of Responsibilities
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 Statement of Responsibilities for publication on the Trust's website.	
EXECUTIVE SUMMARY	The Code of Governance for NHS Provider Trusts 2023 (NHS Code) requires the division of responsibilities for the Chair, Chief Executive, Senior Independent Director, the Board and its committees to be clear and set out in writing, agreed by the Board of Directors and made publicly available. The attached statement outlines a clear division of roles which supports a balance of power by preventing any one individual from holding excessive, or "unfettered," power, however, it also highlights shared accountability, as the Chair and CEO have a shared responsibility in communicating with stakeholders and driving the organisation's effectiveness.	
PREVIOUSLY CONSIDERED BY	Not applicable	
	Date	Not Applicable
	Outcome	Not Applicable

STATEMENT OF RESONSIBILITIES

The Code of Governance for NHS Provider Trusts 2022 (NHS Code) requires the division of responsibilities for the Chair, Chief Executive, Senior Independent Director, the Board and its committees to be set out in writing, agreed by the Board of Directors and made publicly available.

The NHS Code also states that 'responsibilities should be clearly divided between the leadership of the board' and that 'no individual should have unfettered powers of decision'. As the Trust seeks to adhere to the NHS Code, these responsibilities have been set out in this statement.

Responsibilities of the Board of Directors and its Committees

The Board of Directors are responsible for setting the overall strategic direction of the trust. The business of the trust is managed by the Board of Directors, with all powers exercised by the Board of Directors on its behalf. The matters reserved for the Board of Directors and those delegated to individual directors or committees, are clearly documented within the Scheme of Delegation.

The Board operates in accordance with the Standing Orders and Reservations of Power and the organisation operates in accordance with the financial rules set out in the Standing Financial Instructions, agreed by the Board.

The Board has established committees to have oversight and seek assurance in specified areas. All committees have clear terms of reference that set out the scope of the committee's responsibilities and any delegated powers from the Board. These committees report back to the Board after each meeting, providing assurance or escalating risks as appropriate.

Role of the Chair of the Trust

The Chair is responsible for:

Board of Directors

- Chairing meetings of the Board of Directors and the Nominations & Remuneration Committee.
- Managing the Board and ensuring its effectiveness in all aspects of its role, including regularity and frequency of meetings.
- Setting the Board agenda and ensuring this is forward-looking, with a focus on strategic matters and important issues facing the Trust.
- Ensuring appropriate delegation of authority from the Board to the Executive Team and effective implementation of Board decisions.
- Ensuring that the Board receives accurate, timely and clear information, including on the Trust's performance, to enable the Board to make sound decisions, monitor and scrutinise effectively and provide advice to promote the success and sustainability of the Trust.
- Allowing sufficient time for discussion of complex or contentious issues. The Chair should ensure that directors (particularly non-executive directors) have sufficient time to consider critical issues and obtain answers to any questions or concerns they may have and are not faced with unrealistic deadlines for decision making.
- Ensuring the Board plays a full part in the development and determination of the Trust's strategy and overall objectives.

- Building an effective, complementary unitary Board.

Directors

- Facilitating effective contribution of directors and encouraging active engagement from all members of the Board.
- Promoting effective relationships and open communication between executive and non-executive directors, both inside and outside the boardroom, ensuring an appropriate balance of skills and experience.
- Holding meetings with non-executive directors without the executive directors being present.
- Establishing a close relationship of trust with the Chief Executive providing support and advice whilst respecting executive responsibility.
- Overseeing the application of the Board of Directors' Code of Conduct and if in the Chair's opinion an individual director has failed to observe any part of the code, take the necessary action until the matter is investigated or resolved.
- Accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of the organisation is maintained to support an effective FPPT regime.

Induction, development and performance evaluation

- Ensuring that all new non-executive directors participate in a full, formal and tailored induction programme.
- Ensuring that the development needs of directors (in particular non-executive directors) are identified and met.
- Regularly evaluate the performance of the Chief Executive.
- Identifying the development needs of the Board as a whole to enhance its overall effectiveness.
- Ensuring the performance of the Board, its committees and individual directors (in particular the Chief Executive and the non-executive directors) are evaluated at least once a year; acting on the result of such evaluation by recognising the strengths and addressing the weaknesses of the Board.
- Reporting on the outcome of the appraisal of the non-executive directors to NHSE.

Governance

- Upholding the highest standards of integrity and probity
- Setting the agenda style and tone of the Board of Directors to promote effective decision making and constructive debate.
- Ensuring a clear structure and the effective running of Board and its committees.
- With the assistance of the Company Secretary, promote the highest standards of corporate governance, seeking full compliance with the Code of Governance.
- Ensuring compliance with the Board of Directors corporate governance framework.
- The Chair's direct reports are the Chief Executive and the non-executive directors. Other than the Chief Executive no executive director will report directly to the Chair. The Chair reports to the Board of Directors and the Secretary of State via NHSE.

Role of the Chief Executive

Within the authority limits delegated by the Board, and not to the exclusion of any duty detailed in the Accounting Officer Memorandum, the Chief Executive is responsible for:

Business Strategy and Management

- Developing the Trust's objectives and strategy having regard to its responsibilities to service users, carers, staff, partners and other stakeholders.
- The successful achievement of organisational objectives and execution of strategy following presentation to and approval by the Board of Directors.
- Recommending to the Board an annual budget and forward plan and ensuring their achievement following Board approval.
- Optimising as far as is reasonably possible the use of the Trust's resources.

Investment and Financing

- Examining all proposed major capital expenditure and the recommendation to the Board of Directors of those which are material either by nature or cost.
- Identifying and executing acquisitions and disposals, ensuring all major proposals or bids receive appropriate approval in line with the Standing Financial Instructions.
- Identifying and executing new business opportunities.

Risk Management and Controls

- Managing the Trust's risk profile in line with the Board approved Risk Appetite Statement.
- Ensuring appropriate internal controls are in place.

Board Committees

- Making recommendations to the Nominations & Remuneration Committee on remuneration policy, executive remuneration and terms of employment of the executive directors.
- Making recommendations to the Nominations & Remuneration Committee on the role and capabilities required in respect of the appointment of executive directors.

Communication

- Providing a means for timely and accurate disclosure of information, including an escalation route

Human Resources

- Setting Trust HR policies, including management development and succession planning for the Executive Team and approving the appointment and termination of employment of members of that team in conjunction with the Nominations & Remuneration Committee. The duties which derive from these responsibilities include:
    - Leading the executive directors in the day-to-day running of the Trust's business, including chairing the Trust Committee meetings and communicating decisions / recommendations to the Board.
    - Ensuring effective implementation of Board decisions.

- Regularly reviewing operational performance and the strategic direction of the Trust's business.
- Regularly reviewing the Trust's organisational structure and recommending changes as appropriate.
- Formalising the roles and responsibilities of the Executive Team, including clear delegation of authority.
- Ensuring that all policies and procedures are followed and conform to the highest standards.
- Providing coherent leadership of the Trust, including representing the Trust and ensuring there is effective communication in place with service users, carers, staff, regulators, partners, stakeholders, commissioners, community and the public.
- Keeping the Chair of the Trust informed on all important, complex, contentious or sensitive matters.
- Ensuring that the Executive Team provides accurate, timely and clear information to the Board of Directors.
- Ensuring the development needs of the executive directors are identified and met, including a properly constructed induction programme and appraisal process.
- Promoting and conducting the affairs of the Trust with the highest standards of integrity, probity and corporate governance.
- The Chief Executive's direct reports are the executive directors and the Company Secretary if the role exists separately.
- The Chief Executive reports to the Chair of the Trust and the Board of Directors directly

Responsibilities of the Senior Independent Director

The Board of Directors appoint one of the independent Non-Executive Directors to be the Senior Independent Director. The role of the Senior Independent Director is to:

- Act as a sounding board for the Chair and serve as an intermediary for other directors as necessary.
- Undertake the performance evaluation of the Chair, within the chairs appraisal framework guidance provided by NHSE.
- Lead meetings of the non-executive directors without the Chair present at least annually to appraise the Chair's performance or as deemed appropriate.
- Be available to discuss any concerns that contact through the normal channels of Chair, Chief Executive, or Company Secretary has failed to resolve or where such contact is inappropriate.

This statement was approved by the Board of Directors at its meeting on 24 September 2025

JULIA MULLIGAN

Chair

For and on behalf of the Board of Directors

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 September 2025
SUBJECT	Policy on Anti-Fraud, Bribery and Corruption
PRESENTED BY	Executive Director of Finance
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 the addition to the Anti-Fraud, Bribery and Corruption Policy at section 5.2 and approve the updated version of the policy.	
EXECUTIVE SUMMARY	On the 1 September 2025, the Economic Crime & Corporate Transparency Act (ECCTA) introduced a new corporate offence: Failure to Prevent Fraud. This landmark change places direct accountability on organisations to prevent fraud committed by employees, contractors, or associates that benefits the organisation. The Anti-Fraud, Bribery and Corruption policy has been reviewed by the Anti-Fraud Specialist and section 5.2 has been added to reflect the new legislation.	
PREVIOUSLY CONSIDERED BY		
	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

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

The policy was last reviewed and approved by the Board of Directors in July 2024 as part of the biannual review of the policy by the MIAA Anti-Fraud Specialist and the Deputy Director of Finance and Fraud Champion for the Trust.

On the 1 September 2025, the Economic Crime & Corporate Transparency Act (ECCTA) introduced a new corporate offence: Failure to Prevent Fraud. This landmark change places direct accountability on organisations to prevent fraud committed by employees, contractors, or associates that benefits the organisation.

The Anti-Fraud, Bribery and Corruption policy has been reviewed by the Anti-Fraud Specialist and section 5.2 has been added to reflect the new legislation.

2. RISK CONSIDERATION

Compliance/ regulatory	NWAS will take all the necessary steps to counter fraud, bribery and corruption in accordance with this Policy and with regard to the policies, directions, instructions and guidance as issued by the NHS Counter Fraud Authority (NHS CFA), as well as in accordance with relevant UK legislation. This risk is mitigated by the Trust contracting for specialist Anti-Fraud support and management, currently provided from Mersey Internal Audit Agency. They are accredited by the NHS CFA and accountable to them professionally for the completion of a range of preventative anti-fraud, bribery and corruption work, as well as for undertaking any necessary investigations. Locally accountable to the Director of Finance and reports to the Audit Committee.
People	It is key that all staff within the Trust understand their responsibilities within this Policy. Most people who work in the NHS conduct themselves in an honest and professional manner and support anti-fraud activities and believe it is wholly unacceptable. Staff are in the best position to recognise any specific fraud risks within their areas, and the risk is that staff do not report it. Within the Policy it is clear they have a duty to ensure that those risks are identified, reported and eliminated as much as possible. There is a risk around staff not complying with the Trust's SFIs, policies and procedures which may increase the Trust's exposure to fraud. This Policy, along with adequate training and support, reduces this risk and makes staff aware of their own responsibilities

Financial/ value for money	The risk of financial loss across the NHS from fraud remains high. In line with the Policy, the Trust will adopt a zero-tolerance approach to fraud, bribery or corruption through the maintenance of an anti-fraud culture, investigating all reported instances and following disciplinary and criminal proceedings.
Reputation	One of the basic principles of public sector organisations is the proper use of public funds. NWAS is committed to reducing the level of fraud, bribery and corruption and aims to eliminate all such activity as far as possible, as ultimately it leads to the reduction in the resources available for patient care and has a negative reputational impact.

3. EQUALITY/ SUSTAINABILITY IMPACTS

The equality impact assessment has been reviewed and there are no issues to highlight to the Board in relation to this policy update.

4. ACTION REQUIRED

The Board of Directors is asked to note the addition to the Anti-Fraud, Bribery and Corruption Policy at section 5.2 and approve the updated version of the policy.

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

Policy on Anti-Fraud, Bribery and Corruption		Page:	Page 1 of 14
Author:	Anti-Fraud Specialist	Version:	3.2
Date of Approval:		Status:	Final
Date of Issue:		Date of Review	

Document Control	
Policy Title	Anti-Fraud, Bribery and Corruption and Response Plan
Policy Reference Number	BOD-05
Version number	3.2
Approval date	
Approved by	Board of Directors
Date for Review:	
Executive Sponsor	Director of Finance
Policy Lead	Deputy Director of Finance
For use by	All Trust employees (permanent and temporary) including volunteers, executives and nonexecutives.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
2.8	December 2020	January 2021	Andy Wade (AFS)	Reflect changes and the newly appointed AFS
2.9	April 2021	July 2021	Andy Wade (AFS)	Introduce the new Government standards to the document
3.0	October 2023	October 2023	Andy Wade (AFS)	Reflect change to NHS Counter Fraud Authority who has updated its strategy for 2023-2026.
3.1	July 2024	July 2024	Andy Wade (AFS) / Michelle Brooks	Review of existing policy
3.2	September 2025	September 2025	Andy Wade (AFS)	Inclusion of the new Failure to Prevent Fraud Act to the policy.

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

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1. Introduction

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

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

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

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

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

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

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

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

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

2. Purpose and Scope

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

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

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

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

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

3. Definitions

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

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

Government Functional Standard GovS 013: Counter Fraud (NHS Requirements). A requirement in the NHS standard contract is that providers and commissioners of NHS services must take the necessary action to comply with the NHSCFA's counter fraud standards. Other's should have due regard to the standards. The contract places a requirement on providers / commissioners to have policies, procedures and processes in place to combat fraud, corruption and bribery to ensure compliance with the standards. The NHSCFA carries out regular assessments of health organisations in line with the counter fraud standards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Duties

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

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

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

The Chief Executive must ensure adequate policies and procedures are in place to protect the organisation and the public funds it receives. However, responsibility for the operation and

maintenance of controls falls directly to line managers and requires the involvement of all Trust employees. The Trust therefore has a duty to ensure employees who are involved in or who are managing internal control systems receive adequate training and support to carry out their responsibilities. Therefore, the Chief Executive and Director of Finance will monitor and ensure compliance with this policy.

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

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

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

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

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

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

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

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

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

Human resources (HR) play a role in relation to employees in suspected cases of fraud, bribery, and corruption, including liaison with the AFS and the conduct of any investigation, and instigating the necessary disciplinary action against those who fail to comply with the policies, procedures, and processes. HR work with the AFS to ensure the appropriate parallel sanctions are applied (in

accordance with the NHSCFA Anti-Fraud Manual) where fraud, bribery or corruption is proven against employees. Appropriate joint working protocols exist to detail this relationship.

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

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

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

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

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

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

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

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

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

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

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

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

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

responsibilities in accordance with the organisation's standards of behaviour and in protecting the organisation from these crimes.

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

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

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

5. Policy information section – The Response Plan

5.1 Bribery and Corruption

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

The organisation also has a policy and procedure in place in relation to the completion of declarations of interest, declarations of secondary employment and the hospitality/gifts register. The relevant policy and procedures are accessible via https://greenroom.nwas.nhs.uk/library/standards-of-business-conduct-policy-on-managing-conflicts-of-interest-gifts-hospitality-and-sponsorship/ and staff are required to comply with these arrangements. Instances of non-compliance may be referred to the AFS for further investigation.

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

5.2 The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023)

The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023) includes a new corporate fraud offence of 'failure to prevent fraud' which came into force on 1st September 2025.

This fraud is where someone connected with the organisation (what the Act calls an 'associated person') commits a fraud offence that intentionally benefits the Trust, rather than just the individual, and where the Trust should have had procedures in place to prevent it happening.

If this offence occurs, the health body can be prosecuted.

The offence applies to large organisations (which includes NHS organisations), and all those 'associated persons' conducting work on their behalf. 'Associated persons' includes employees of all levels and volunteers, but can also include contractors, associates, subsidiaries, agents and other partner organisations.

Successful prosecutions under the 'failure to prevent fraud' section of the ECCTA 2023 may result in an unlimited fine to the organisation. In addition to this there may be associated reputational damage to the Trust as well as operational disruption and other sanctions against those who committed the fraud or allowed it to happen through their actions or inactions.

The 'benefit' to the Trust has not been defined, but is not limited to a purely financial benefit, and the benefit does not have to materialise; the intention is sufficient. An example of this kind of fraud may be where a Trust manager liaises with an established recruitment agency to ensure that additional staff are available to meet demands; standard recruitment controls are intentionally ignored to ensure sufficient resources can be provided.

All organisations can prevent prosecution if they have 'reasonable procedures' in place, which are intended to make people aware of their responsibilities and mitigate the risk of someone committing the offence on behalf of the organisation. These procedures are supported by the work of the Local Counter Fraud Specialist, who can provide further information.

5.3 Reporting Fraud, Bribery or Corruption

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

All genuine suspicions of fraud, bribery and corruption must be reported directly to the AFS – Andy Wade.
Email – andrew.wade@miaa.nhs.uk
Tel – 07824 104209

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

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

Details of a suspected fraud, bribery and corruption may also be reported through the **NHS Fraud and Corruption Reporting Line** on **Freephone 0800 028 40 60**, (powered by 'Crimestoppers 24/7') or online at **https://cfa.nhs.uk/reportfraud** in addition to the AFS or the organisation's Director of Finance.
The AFS and/or NHSCFA will undertake an investigation and seek to apply criminal and civil sanctions, where appropriate. Any investigation would follow our set investigative procedures.

Investigations may also include police involvement, where appropriate.

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

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

5.4 Disciplinary Action

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

5.5 Sanctions and Redress

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

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

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

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

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

Disciplinary – Disciplinary procedures will be initiated where an employee is suspected of being involved in a fraudulent or illegal act, as per Section 5.4 of this policy.

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

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

5.6 Monitoring and auditing of policy effectiveness

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

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

5.7 Dissemination of the policy

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

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

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

6. References

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

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

NHS Audit Committee handbook 2024 nhs-audit-committee-handbook-7077.pdf

https://www.gov.uk/government/publications/bribery-act-2010-guidance

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

Speaking up to NHS England https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/public-and-partners/if-you-whistleblow-to-nhs-england/

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 20 August 2025		
Members present	Mr S Desai, Chief Executive (Chair) Mr D Ainsworth, Director of Operations Dr C Grant, Medical Director Mrs E Orton, Assistant Director of Nursing & Quality Mrs E Strachan-Hall, Interim Director of Quality Mrs A Wetton, Director of Corporate Affairs Ms S Rose, Director of Integrated Contact Centres Mr M Gibbs, Director of Strategy & Partnerships Mrs J Wharton, Chief Information Officer Mr M Jackson, Chief Consultant Paramedic Mrs C Wood, Director of Finance Ms S Wimbury, Area Director - Greater Manchester Mrs L Ward, Director of People/DCEO In attendance Mrs J Turk, Senior Executive Business Support Manager	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

Staff Survey Plans Update:

- The Director of People advised that only 9 local people plans had been submitted from across the trust. Positive changes arising from staff survey feedback were to be shared with the engagement team for use in staff communications.

- The 2025 staff survey was to include questions relating to socio-economic background and concern was raised about how staff might respond to these new questions. It was agreed that direct communications should be shared with teams to explain the purpose.

IPR:

- Call pick up maintained a 4 second mean, which was still below target.
- H&T was being monitored through the UEC Group with actions in place.
- C2 mean was above the mean target.

ADVISE:

The TMC:

- Approved funding should either or both ICB digital funding bids not be successful. The costs would be sought from the capital monies allocated to digital in 2025/26.
- Approved the capital investment to replace the current Rhapsody Integration Engine and the annual revenue costs.
- Reviewed and provided update on progress against trust policies that were out of date or due a review within 6 months.
- Supported the move from a 3 to 5 year trust strategy.
- Supported the transition to the 'develop' phase of strategy development and the associated engagement activities.
- Approved the incentives scheme for the 2025 national staff survey.
- Noted the overall effectiveness grade of 'good' and the grades for the four judgements arising from the Ofsted visit.

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - 2526/130 Finance report M04
  - 2526/134 Policy update
  - 2526/137 Strategy development
  - 2526/140 Outcome of the Ofsted visit

- Received the following Escalation & Assurance reports:
  - HSSF Group – 8 July 2025
  - EPRR Group – 14 July 2025
  - Information & Cyber Group – 5 August 2025

RISKS

Risks discussed:

- Risk IDs 330, 331, 474, 655 and 717 were to be imminently reviewed by the executive leads.
- The 7 commercially sensitive risks were reviewed and agreed
- Did not approve the escalation of risk ID741 onto the corporate risk register.

New risks identified:

- None.

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee			
Date of meeting	Wednesday, 17 September 2025		
Members present	Mr S Desai, Chief Executive (Chair) Dr C Grant, Medical Director Mrs E Orton, Assistant Director of Nursing & Quality Mrs E Strachan-Hall, Interim Director of Quality Mrs A Wetton, Director of Corporate Affairs Ms S Rose, Director of Integrated Contact Centres Mr M Gibbs, Director of Strategy & Partnerships Mrs J Wharton, Chief Information Officer Mrs C Wood, Director of Finance Ms S Wimbury, Area Director - Greater Manchester Mr I Moses, Area Director – Cheshire and Merseyside Mr M Cooper, Area Director – Cumbria and Lancashire In attendance Ms K Butler Executive Business Support Manager Mrs L McConnell, Deputy Director of People Ms C Hoolickin, Head of Improvement	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

IPR

- Staff sickness remains above National Average at 7.08%
- A review of inter-facility transfers (IFT) and healthcare professional (HCP) incidents is to take place, in which the trust is a national outlier.

ADVISE:

The TMC:

- Received and noted the 2025/26 reported financial position to 31 September 2025.

- Approved the Heat Decarbonisation Plan
- Noted the policies due for renewal within 3-6 months
- Approved the NWAS Improvement Approach to enable work to progress against Year 1 objectives
- Approved submission to Board of the Winter Assurance Statement
- Approved commencement of consultation under organisational change process for a proposed team restructure.

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - 2526/153 Finance report M05
  - 2526/158 Policy Management Framework Update
  - 2526/159 The NWAS Improvement Approach
  - 2526/160 CQC Gap Analysis
  - 2526/161 Patient Safety Events Management Update
  - 2526/163 EPRR Annual Assurance Report
  - 2526/164 Ambulance Winter Plan - Board Assurance Statement
  - 2526/166 Job Evaluation Metrics

- Received the following Escalation & Assurance reports:
  - Service Delivery Assurance Group – 26th August
  - Sustainability Group Assurance Report - 1st September
  - Clinical and Quality Group - 2nd September
  - People and Culture Group - 10th September

RISKS

Risks discussed:

- The 7 commercially sensitive risks were reviewed and agreed
- Approved the reduction in score from 15 to 10 of risk ID474 relating to lithium-ion batteries.

New risks identified:

- None.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 September 2025
SUBJECT	2025/26 Flu Campaign
PRESENTED BY	Lisa Ward, Director of People
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 are asked to: • Note the approach to the Flu campaign for 2025/26 • Provide senior commitment to offer all frontline staff a flu vaccination • Approve the Board checklist.
EXECUTIVE SUMMARY	The flu vaccination campaign for 2024/25 officially commenced in October 2024 and ended on 31 March 2025. It should be noted that the campaign was extended from the end of February to the end of March in line with NHSE guidelines published part way through this year's campaign. The 25/26 Flu Vaccination programme letter issued by NHS England outlines the expectation for providers to deliver a 100% offer to eligible healthcare workers with a focus on groups where uptake has been lower in previous years. **Overview of last year's campaign** The campaign commenced in October 2024 and concluded on 31 March 2025.The Trust vaccinated 3,450 staff (out of 8,105 eligible) which was 43%. This was an increase from last year and also exceeded the national average uptake of 43%. Based on uptake, the Trust was ranked 7th out of 37 North West Trusts, which is a notable

	achievement considering the challenges of vaccinating a dispersed workforce. Out of 146 staff trained to vaccinate during the campaign, 102 staff administered vaccines. As with previous years the challenges with the campaign included staff non-responsiveness to the vaccine offer, some variation in vaccinator productivity and a sharp reduced uptake of the offer after October when the campaign commenced. All vaccinations were recorded on Flumis, the system procured by the Trust to record vaccinations as well as the national vaccination database which changed from NIVS to RAVS during the campaign. Within Appendix A of the report there is a detailed overview of staff uptake of the vaccine by work area and protected characteristics. This data will help to identify where to focus engagement during the campaign. **Key Plans for 2025/26** The national flu letter outlines that the start of the adult programme for 2025 to 2026 will be from the beginning of October with the majority of the vaccinations to be completed by the end of November.In preparation for this year's campaign the Trust has procured 3,700 Seqirus vaccines. The Trust will operate with a Written Instruction as in previous years. As with previous campaigns, the vaccination model will be peer led throughout the Trust's footprint. The focus will be on early uptake of the vaccine ahead of the start of winter pressures. The campaign will be led by IPC Specialist Lead with support from the HR and Medicines Management teams. The paper outlines this year's budget, which largely replicates previous years and is managed by the People Directorate. The communication and engagement strategy will focus on early uptake, targeting groups who have previously had a lower uptake as well seeking management engagement and visible executive support. Social media, internal bulletins, and local leadership will be used ensure awareness and uptake. Appendix B details the HCW Flu Vaccination Best Practice Management Checklist, and this demonstrates that the Trust's programme has these core components in place for the 2025/26 programme.
PREVIOUSLY CONSIDERED BY	Resources Committee
	Date: Thursday, 18 September 2025
	Outcome:

1.	**BACKGROUND**
1.1	Influenza (flu) vaccines are offered free to all NWAS staff as part of the national flu vaccination programme. NWAS has historically participated in the national vaccination programme which is led by the HR department. The flu vaccination campaign for 2024/25 officially commenced in October 2024 and ended on 31 March 2025. It should be noted that the campaign was extended from the end of February to the end of March in line with NHSE guidelines published part way through this year's campaign.
1.2	The 24/25 Flu Vaccination programme letter issued by NHS England outlines the expectation for providers to deliver a 100% offer to eligible healthcare workers. In addition, the letter advises that providers should '*ensure they make firm plans to equal or improve uptake rates in 2025 to 2026, particularly in those cohorts where uptake has been lower. Providers should also ensure they have robust plans in place to identify and address health inequalities for all underserved groups, and it is expected progress will be made on reducing unwarranted variation and improving uptake'.*
1.3	In line with the national letter, the Trust's campaign for 2025/26 seeks to ensure all eligible staff have the offer of a vaccine and that appropriate strategies for offering to underrepresented groups are developed.
2.	**OVERVIEW OF LAST YEAR'S CAMPAIGN**
2.1	Last year's campaign was based upon learning from previous Flu campaigns. The campaign is overseen by the People Directorate who also take responsibility for the inward and outward reporting requirement. As with the 2023/24 campaign, the Infection Prevention & Control Specialist Lead In the Quality Directorate to an overall role in leading the campaign.
2.2	A Flu Project Team was established in July 2024 with representatives from HR, PES Area Leads, PTS, Communications, Medicines, IPC and 111. The Flu Lead chaired the group and discussions included designation of area leads, processes for cold chain management of vaccines, training for vaccinators as well as key messages to capture for communication releases.
2.3	Area based flu leads were asked to identify small cohorts of vaccinators by early September 2024.
2.4	A total of 190 clinical staff were put forward to undertake vaccinator training by the area leads with 146 of these staff` completing all training modules compared to 121 the previous year. A total of 102 of the 146 trained vaccinators went on to administer vaccines with a training to vaccinator rate of 70% compared to last year's rate of 77%. As with previous years, the campaign saw some variation in vaccinator productivity, with 40 vaccinators administered less than 10 vaccines each totalling 134 vaccines combined (4.6% of total vaccines given). Five vaccinators administered over 100 vaccines each accounting for 31% of all vaccines administered. Of these 2 vaccinators were from the IPC team supporting non-PES departments to have access to vaccines and they administered 458 vaccines (16% of total administered) between them. At the end of the campaign the average vaccines given per vaccinator was 29 vaccines.
2.5	The Trust used the external Flumis software to record vaccinations against a central staff list. The list was reviewed at the end of the campaign to take out any leavers and include new starters. In addition, all vaccinations were recorded on the National Immunisation and Vaccination System (NIVS) and part way through this year's campaign this was replaced by the NHS Record a Vaccination Service (RAVS).

2.6	As with the 2023/24 campaign, the Trust adopted the use of the National Written Instruction. A Written Instruction allows medicines to be provided by occupational health vaccinators under exemption in Schedule 17 of the Human Medicines Regulations 2012. The use of a Written Instruction is not subject to the same legislated framework required for PGDs. It is an arrangement between the named registered vaccinator and the authorising doctor (Medical Director in NWAS). The Written Instruction commenced on 1 October 2024 expired on 31 March 2025.
3.	**2024/25 FLU CAMPAIGN DATA**
3.1	A total of 3450 staff were vaccinated either within or external to NWAS. This is an increase in last year's campaign where 3172 staff were vaccinated. The total overall figure available to vaccinate was 8105 staff, which does not include volunteers and students eligible under the inclusion criteria of the Written Instruction.
3.2	Vaccinators used the 'referred' option on Flumis for staff who they were unsure to be eligible for the vaccine and the deferred option for staff that wanted the vaccine but not at that exact moment and also to identify that a person had been asked to avoid repeatedly contacting them. There was an understanding that all those that deferred their vaccination should be contacted again at the end of the campaign and either vaccinated or marked as a declined.
3.3	Table 1: NWAS staff vaccine uptake 2023/24

	Received at NWAS	Received elsewhere	Declined	Referred	Deferred
No. of staff	2865	585	4506	96	53
% of staff	35.3%	7.2%	55.6%	1.2%	0.65%

3.4	Across the North West region a reduced uptake of the flu vaccine by healthcare workers was reported, nationally the uptake of the vaccine declined from 42.8% in 2023/24 to 37.9% of frontline healthcare staff in 2024/25. NWAS uptake exceeded the national average by 5.1% and was ranked 7th overall out of 37 NW Trusts for vaccine uptake. The highest uptake of all Trusts in the NW achieved a 50.1% uptake and only 3 trusts saw an increase on last years uptake.
3.5	The NWAS campaign commenced on the 1st October 2024 with 2213 vaccinations were administered, 539 were administered in November, 100 in December, 53 in January 2025, 11 in February and 2 in March.
3.6	One of the challenges that continues every year to be an issue for the flu team is that staff do not respond to the offer of a flu vaccination and this creates difficulties in assuring that 100% of staff have had the offer of a vaccine. This year, early in the campaign, staff were contacted, either by email or individually face to face, to see if they wanted the vaccine. Staff who declined were recorded on Flumis (the flu recording system), staff that did not respond were sent a further two emails and if they did not respond to those they were declined on the system. Lists of staff that had not responded were also sent to line managers to ensure staff were aware that the flu vaccines were available.
3.7	Within Appendix A of the report, there is an overview of the vaccinations undertaken and uptake. Table 1 outlines the number of vaccinations undertaken in terms of NWAS staff, the numbers who left the Trust during the vaccination cycle and the numbers of those who are not NWAS staff who have been vaccinated, such as volunteers and students.

3.8	Within table 2 in Appendix A there is an overview of NWAS staff uptake by age group. This indicates that the younger age band of staff had the lowest uptake, with the highest uptakes being amongst staff between the ages of 51 – 70. As such learning for next year's campaign will focus on how to target those age groups who have the lowest uptakes, with consideration on how best to reach these staff in terms of communication strategies and information about the benefits of the vaccine.
3.9	A detailed summary of vaccinations by work area and protected characteristics is outlined in table 3. This shows that 111 ICC staff had the lowest uptake, which is concerning given that staff within the call centre environment should have a greater opportunity to take up the offer of a vaccine. Equally, the data also indicates a lower uptake amongst BME staff, which is a pattern that has been noted in previous years. This also correlates with national concerns about uptake amongst BME staff. In line with the national letter for the 2025/26 campaign, there will be consideration on how best to engage BME staff and understand the reasons for declining the offer of the vaccine.
4.	**2025/26 FLU CAMPAIGN**
4.1	The national flu letter outlines that the start of the adult programme for 2025 to 2026 will be from the beginning of October with the majority of the vaccinations to be completed by the end of November. The letter explains that the later start date is based on the advice from JCVI concerning the waning of flu vaccine's effectiveness in adults. This suggests that it is preferable to vaccinate individuals closer to the time when the flu virus is likely to circulate (which typically peaks in December or January), as this will provide optimal protection during the highest risk period.
4.2	To commence this year's campaign, the Trust has procured 3700 Seqirus vaccines, which is a 7.5% reduction in the previously order of 4000 vaccines. Last year 900 vaccines were not used and should the Trust require more vaccine during the campaign, there is an option to purchase more with a high confidence around the availability of stock. This is a single vaccine and is suitable for all ages and is egg free. It is however recommended that staff over the age of 65 receive a vaccine via their GP or pharmacy. A request has been made for a delivery date of week commencing 15th September to enable the distribution of vaccines ahead of commencing the campaign in October 2025. As with previous campaigns, the Trust will adopt the National Written Instruction and this will be authorised by the Trust's Medical Director. The Written Instruction is effective form the date that the national campaign commences. As such there is not the opportunity for the Trust to commence vaccination prior to the start of the national campaign.
4.3	To support the preparation for the campaign, Medicines Management are ensuring that the calibration of fridges is completed as early as possible along with collating completed flu fridge checklists to ensure that all areas are ready for the distribution of vaccines in September.
4.4	The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model. This involved the area flu leads identifying a group of vaccinators who then travel to offer and administer the vaccine to all staff in scope within their area. The flu leads take responsibility for reviewing the data around uptake and identifying key sites or staff groups where further targeting of the vaccination is required. The model is best described as a 'roaming model' and relies on vaccinators travelling to deliver vaccinations to staff.
4.5	For staff who are in site-based roles such as in our contact centres, corporate sites, the existing approach of advertising flu clinics will remain in place. In the past we have also put specific clinics into place for PTS staff and in particular those in GM who are not necessarily on the same sites as PES staff. It is proposed that a similar approach for PTS is taken for this year's campaign.

4.6	The Quality Directorate will take a lead role in the campaign and this will be led by the Infection, Prevention and Control Specialist lead who will work closely with the Medical Management Team, along with the Chief Pharmacist support the overall leadership and governance of the project. The Corporate HR team also take responsibility on fulfilment of national reporting requirements.
4.7	Support will also be provided by the Communication Team to ensure that staff are fully aware of the campaign and the benefits of the vaccine.
4.8	Following discussions with this year's flu team, there is a recognition that the offering of the vaccine to staff needs to occur early on in the campaign for two main reasons. Firstly, as last year's data shows, uptake of the vaccine is at its highest within the first two month's of the campaign. Secondly, there is a significant impact on frontline resources through the delivery of a per led campaign As a result, ensuring the majority of vaccines are administered ahead of the start of winter pressure will minimise the impact on front line resources.
5.	**GOVERNANCE AND RECORDING OF VACCINATIONS**
5.1	As with last year, there is a national directive to ensure that all vaccinations were also recorded As with last year, it is proposed that the vaccinators will input onto both Flumis and RAVS at the point of care (POC). There is a requirement to ensure that all information is inputted onto RAVS within 7 days. As such it is prudent to ensure that the accuracy and timeliness of input is maintained by training vaccinators to input onto both systems.
5.2	As frontline staff all have access to iPads this will support this approach. In case of a loss of IT access, paper forms will be available for use, but will require vaccinators to input onto both Flumis and RAVS at the earliest opportunity.
5.3	Training and access to both Flumis and RAVS will be provided to designated vaccinators ahead of the start of the campaign.
6.	**COMMUNICATION AND ENGAGEMENT**
6.1	The communications plan will be developed over the coming weeks and will be developed in line with previous years. The plan will largely reflect last year's plan with social media and visual messages. It is proposed that as with previous years, the Trust Board are able to show visible support of the campaign in the form of social media and bulletin features.
6.2	Based on learning from previous years and from other Trusts, the best approach to engage staff to have a vaccination comes from their management teams. It is therefore proposed that there is clear engagement from management teams to support the flu leads and directly encourage staff to have the flu vaccine.
6.3	As outlined in the national flu letter, the engagement plan will seek to ensure a targeted approach to both staff groups along with improving uptake within under represented groups. Prior to the start of the campaign, then there will be engagement with the Staff networks to see how to address uptake across underrepresented groups.
7.	**THE HCW FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST**
7.1	In July 2024, the Health Care Workers (HWC) vaccination letter was published and this has a clear focus on encouraging staff to access both the flu and COVID 19 vaccinations on offer.

7.2	The Flu Vaccination Best Practice Management Checklist is included at appendix B and demonstrates that the Trust's programme has these core components in place for the 2024/25 programme.
7.3	The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. This is supported by a comprehensive communications plan. Whilst, like all ambulance services, the vaccination delivery model for our dispersed workforce presents challenges, the flu team have worked hard to ensure appropriate flexibilities and options are in place to maximise vaccination rates
8.	**RISK CONSIDERATION**
8.1	There is a risk that the Trust will not equal or improve uptake rates during the forthcoming flu campaign. The campaign will be carefully managed to ensure that all staff are offered a vaccine and that this is completed at an early stage in the campaign.
9.	**EQUALITY/ SUSTAINABILITY IMPACTS**
9.1	The vaccine procured by the Trust is egg free and should therefore address potential concerns arising from religious, ethical or life style choices. The campaign will consider any specific advice and guidance linked with pregnancy, age or underlying health conditions.
10.	**ACTION REQUIRED**
10.1	The Board of Directors are asked to: • Note the approach to the Flu campaign for 2025/26 • Provide senior commitment to offer all frontline staff a flu vaccination • Approve the Board checklist.

Appendix A

2024/25 staff flu vaccination uptake

Table 1 – number of vaccinations undertaken by NWAS

Vaccinated by NWAS (Excludes Elsewhere, Previous Employer)	Headcount
Employees @ 31st Mar 25	3450
Employees who left NWAS during the cycle	48
Not employees (Agency, Volunteer, Student, Contractor etc.)	53
Total	**3551**

Table 2 – overview of vaccination by age bands

% Vaccinated By Age Band (Includes Elsewhere, Previous Employer)	<=20 Years	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>=71 Years	Total
Yes	18.80%	37.64%	36.26%	36.72%	40.15%	43.89%	46.20%	49.74%	48.76%	54.53%	54.84%	44.12%	42.57%
No	81.20%	62.36%	63.74%	63.28%	59.85%	56.11%	53.80%	50.26%	51.24%	45.47%	45.16%	55.88%	57.43%

Table 3 – Vaccination by work area and protected characteristics

Vaccinated by Work Area (Includes Elsewhere, Previous Employer)	Total %age Vaccinated	% Sex Male Vaccinated	% Sex Female Vaccinated	% BME Vaccinated	% Disability Declared Yes Vaccinated	% LGB(T) Declared Vaccinated
Operations PES	44.22%	45.34%	43.14%	28.87%	49.38%	51.94%
Operations PTS	39.03%	42.80%	35.45%	36.17%	36.49%	36.67%
Operations Resilience	46.77%	46.32%	48.28%	50.00%	80.00%	100.00%
Operations EOC	39.97%	46.67%	37.15%	27.59%	52.05%	48.91%
Operations 111	36.84%	33.15%	38.08%	22.28%	41.75%	46.67%
Corporate	46.09%	40.24%	51.96%	31.33%	55.43%	62.79%
NWAS Total	**42.57%**	**43.97%**	**41.44%**	**27.44%**	**48.73%**	**50.51%**

Appendix B

Healthcare Worker Flu Vaccination Best Practice Management Checklist

A	Committed Leadership	Trust Self Assessment
A1	Board records their commitment to achieving the ambition of vaccinating all frontline healthcare workers	Commitment recorded through September public board meeting.
A2	Link with Medical Directors and Directors of Nursing to promote key messages and get strategic buy-in	Full engagement with the Chief Nurse and Medical Director around communication messages to staff to encourage take up of the vaccine.
A3	Trust order and provide suitable vaccine for all healthcare workers	The Trust has ordered 3700 vaccines which can be delivered to the majority of our staff taking into account age and religious belief.
A4	Board receive an evaluation of the previous year's flu programme including data, success, challenges and lessons learnt	Both Resources Committee and the Board of Directors have received an evaluation of learning from the 2024/25 flu programme and plans for the 2025/26 programme. Presented to September meetings.
A5	Agree a board champion for flu	The Director of People will be the champion for the Flu campaign.
A6	Publicise board members receiving their flu vaccine	Plans will be put in place once the campaign commences to ensure the opportunity for take up by Board and this forms a clear part of the communications campaign.

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

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

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

North West Ambulance Service NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Thursday, 18 September 2025		
Members present	Dr D Hanley, Chair Mr D Whatley, Non-Executive Director Mrs L Ward, Director of People Mrs C Wood, Director of Finance Mr M Gibbs, Director of Strategy and Partnerships	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None raised.

ADVISE:

Finance Report Month 05 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.

Digital Plan Update

- The Committee received assurance with regards to the cyber issues and the Ambulance Radio Programme and response made.

ASSURE:

Received the following reports for assurance:

- Board Assurance Framework
- Grip and Control Update
- Sustainability Update
- Private Ambulance Expenditure Annual Report (PES)
- Procurement Assurance Report
- Strategy Re-development Assurance Update
- Workforce Indicators Report
- Staff Survey Follow Up Report

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 September 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**	☒	**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 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 **August 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 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.
- **Patient Experience:** The friends and family test scores remain generally static
- **Safety Alerts:** No new safety alerts have been received during this period.

Effectiveness

- The patient experience team have seen monthly increases in the number of 111 survey responses since May 2025, following a pilot initiative.
- The Trust is performing above the sector average for all Ambulance Care Quality Indicators (ACQI's), except for the Falls bundle.
- The H&T rate is indicating improvement and was 16.8% for August. This is due to a range of factors including improved management of frequent callers, better use of CAS providers and new reporting views which have improved oversight.
- Nationally, the trust increased in H&T rankings, to 4th. Additionally, we placed 9th for S&T and 9th for S&C.

Operational Performance

PES (999)

Measure	ARP Standard (hh:mm:ss)	August 25 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:06:58	3rd
C1 90th	00:15:00	00:11:57	3rd
C2 mean*	00:18:00	00:23:03	3rd
C2 90th	00:40:00	00:43:58	3rd
C3 mean	01:00:00	01:27:39	5th
C3 90th	02:00:00	03:04:49	4th
C4 90th	03:00:00	03:44:36	2nd

- Call pick-up improved to a 1 second mean and 0 second 95th percentile, due in part to reduction in support provided to Yorkshire Ambulance Service.

- C1 mean continues to indicate improvement, with the Trust exceeding the ARP standard, achieving 06m:58s against a target of 7 minutes.
- C2 mean was 23m:03s for August, achieving the UEC target.
- The new 'rapid release' handover system led by NHSE was implemented across the North West during August. Whilst still too early to draw conclusions from the project, early indications are that there have been notable reductions in long handover waits, particularly across Cheshire and Mersey.
- Hospital turnaround overall is continuing to indicate improvement, at 31m:26s in August but still exceeding the 30-minute standard.

111

- Call volume (n=164,781) 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	August 25	National Ranking
Answered within 60s	95%	83.7%	17th/28
Average time to answer	<20s	36s	18th/28
Abandoned calls	<5%	2.3%	16th/28
Call-back within 20m	90%	33.9%	--
Average call back	--	49min	--
Warm transfer to nurse	75%	1.6%	--

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 31 August 2025 (Month 05 2025/26) is a surplus of £0.934m, compared to a planned deficit of £0.329m due to non-recurrent credits received and the delivery of productivity and efficiency savings slightly above plan.

Organisational Health

- Overall sickness absence is at 6.79%, lower than the same period this time last year.
- Turnover is at 7.62%, with continued improvements across all service lines.

- The vacancy position for the Trust is at –4.39% for August 2025 which reflects additional growth added to the establishment since June 2025.
- Appraisal compliance is 86.75%, ahead of target of 85%.
- Overall mandatory training compliance is 88%, slightly behind the revised 90% target.
- Five staff were dismissed during August, two for capability (health) and three for conduct.

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, 17 September 2025
	Outcome	

North West Ambulance Service
NHS Trust

Integrated Performance Report

Board of Directors – September 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.

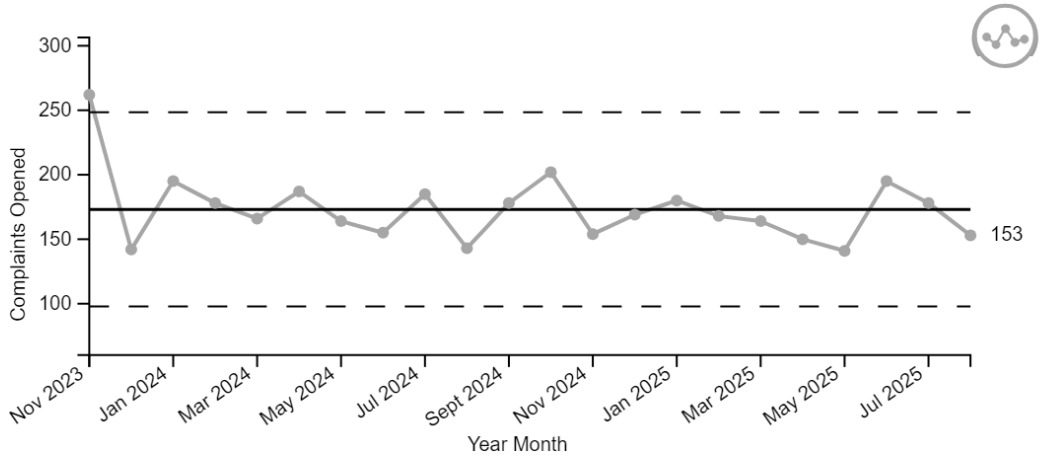
N.B. purple indicates non performance related indicator with arrow indicating direction of travel 

Quality & Effectiveness

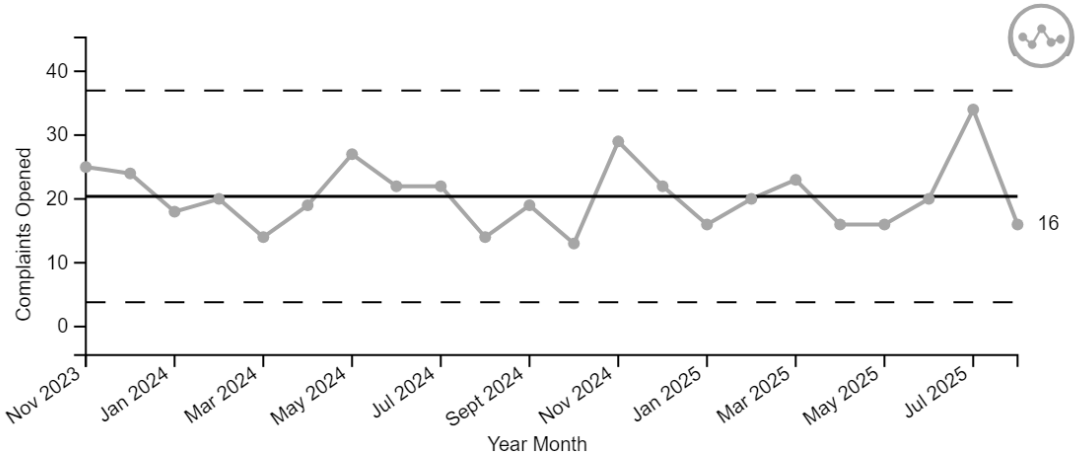
Q1 Complaints
Q2 Incidents
Q3 Safety Alerts
E1 Patient Experience
E2 Ambulance Clinical Quality Indicators (ACQI)
E3 Activities and Outcomes

Q1 Complaints

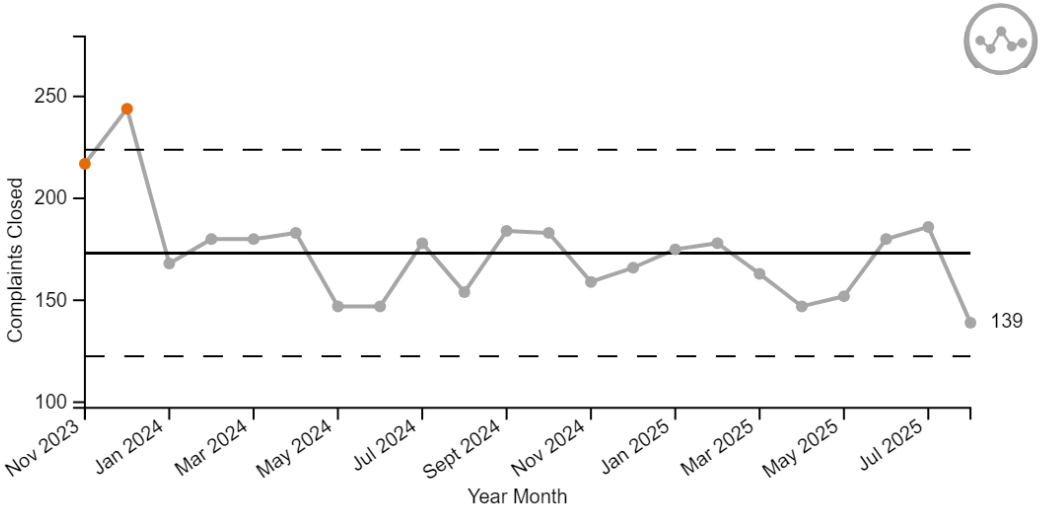
Complaints Opened with Risk Score 1-2



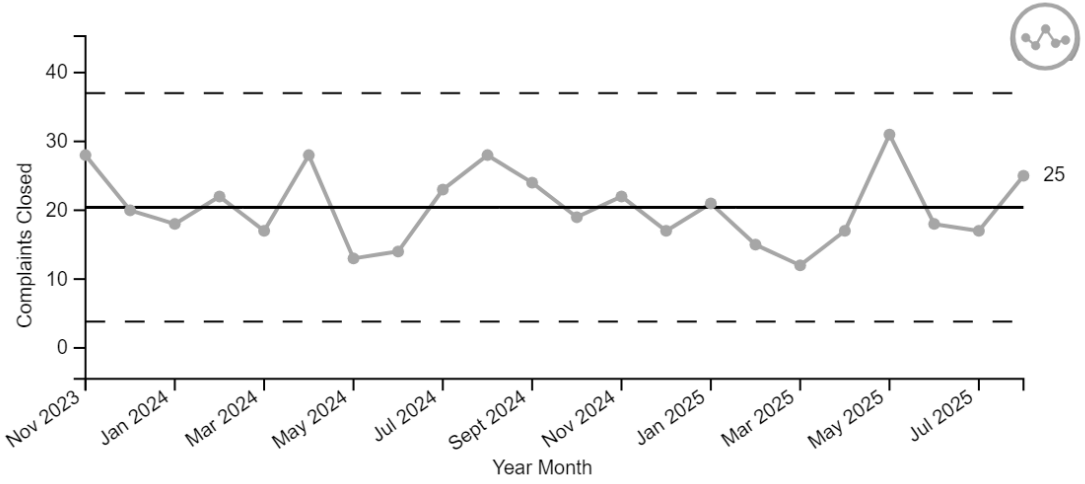
Complaints Opened with Risk Score 3-5

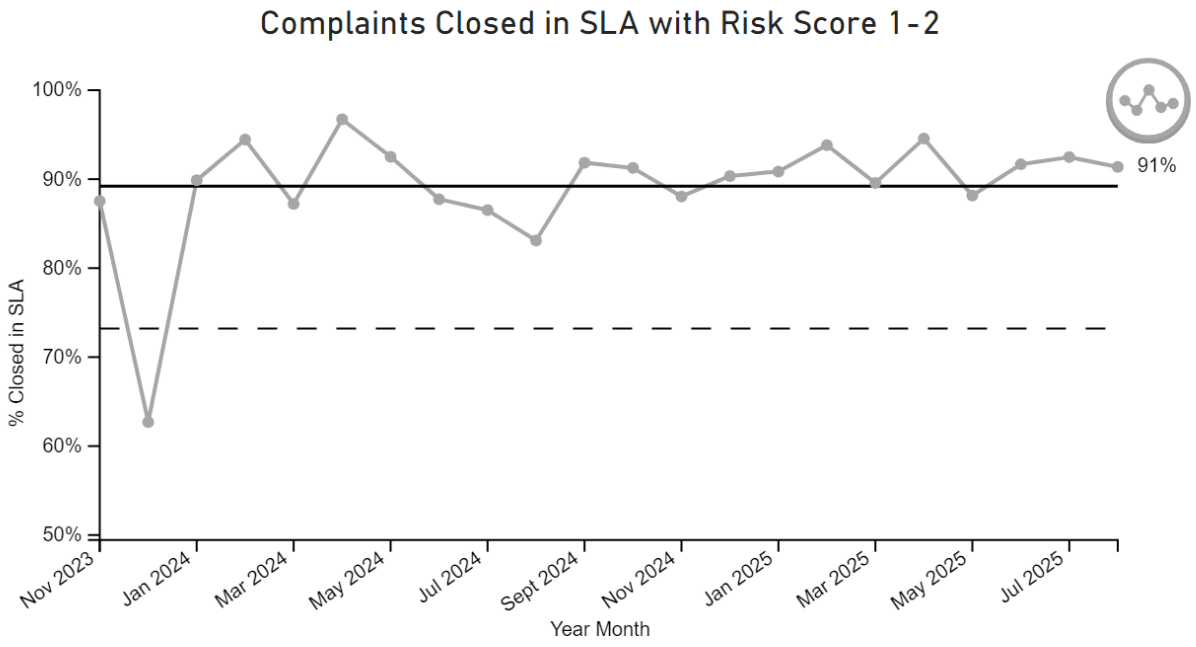


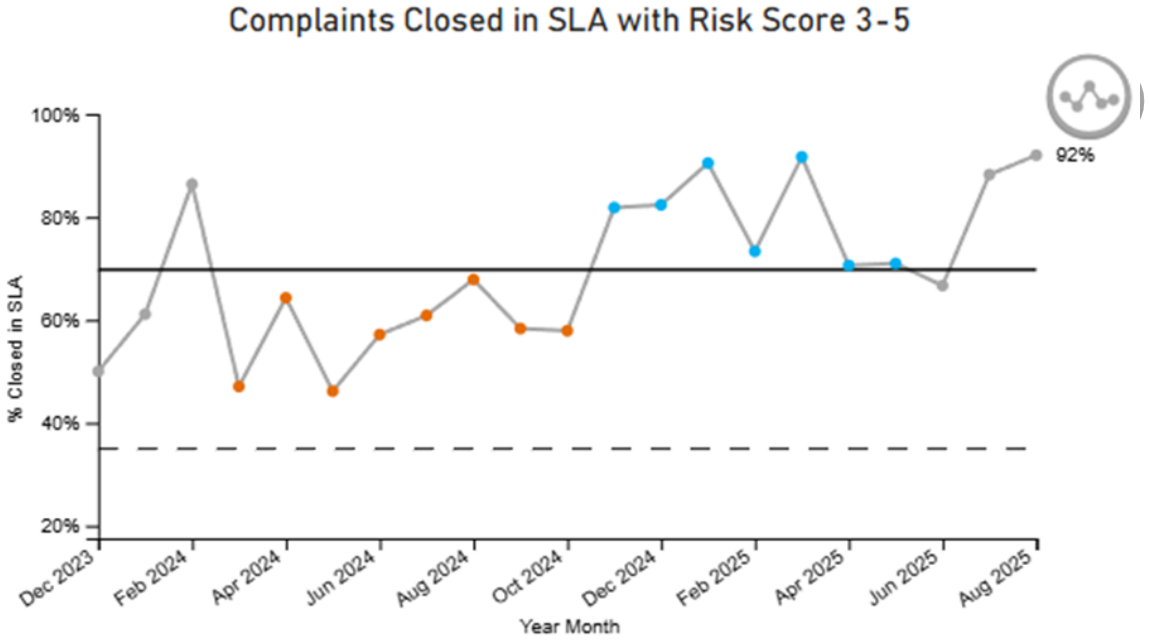
Complaints Closed with Risk Score 1-2



Complaints Closed with Risk Score 3-5





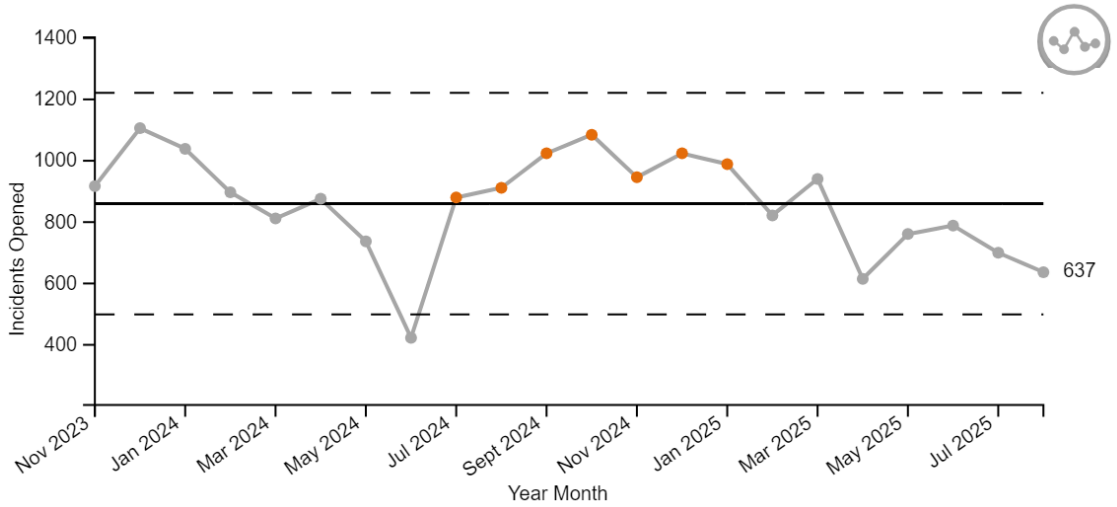


Summary: Patient Advice and Liaison Service (PALS) complaints (risk score 1&2), along with all other metrics, remain stable. Of note, 50% of PALS received are from PTS, often owing to missed or late appointment activity.

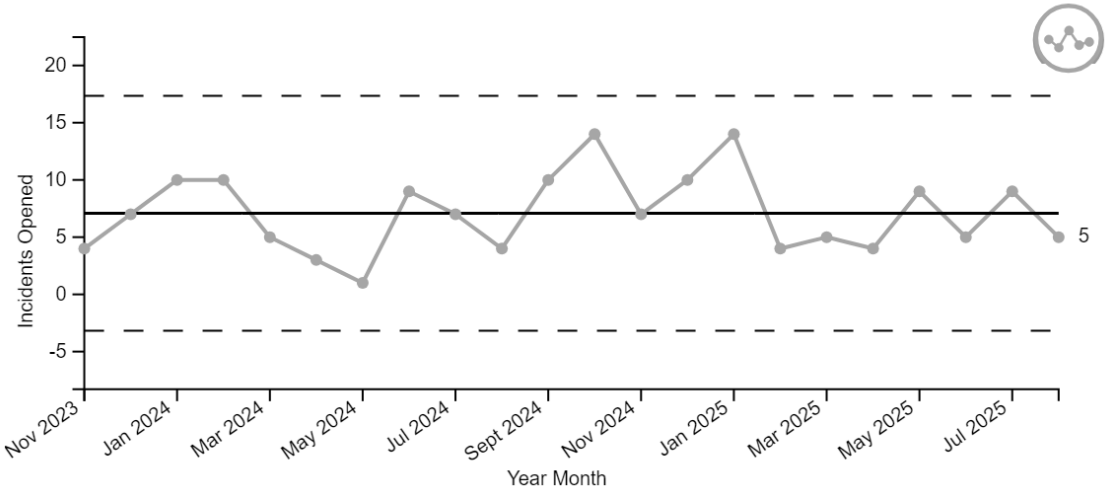
Actions: Nil required

Q2 Incidents

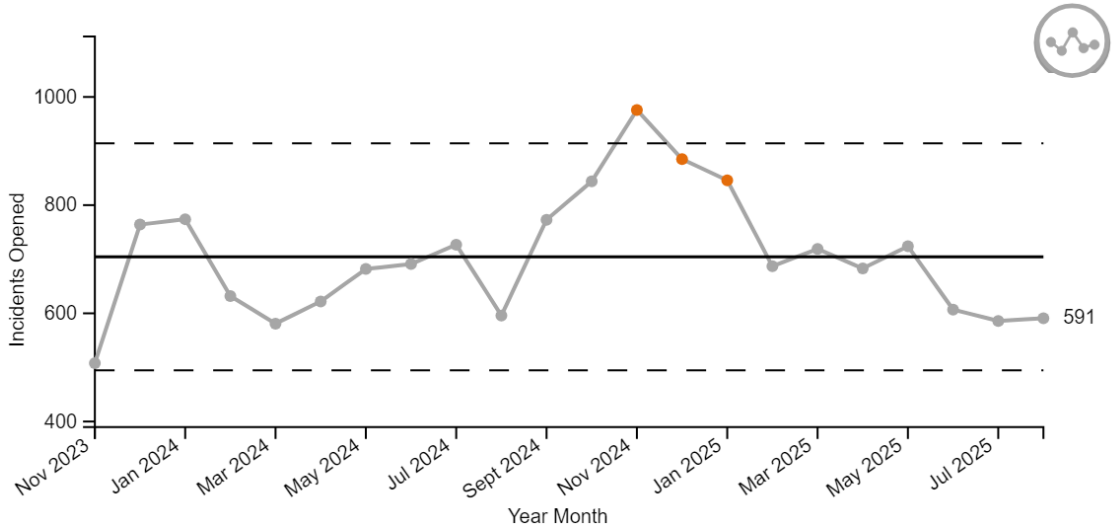
Incidents Opened with Risk Score 1-3



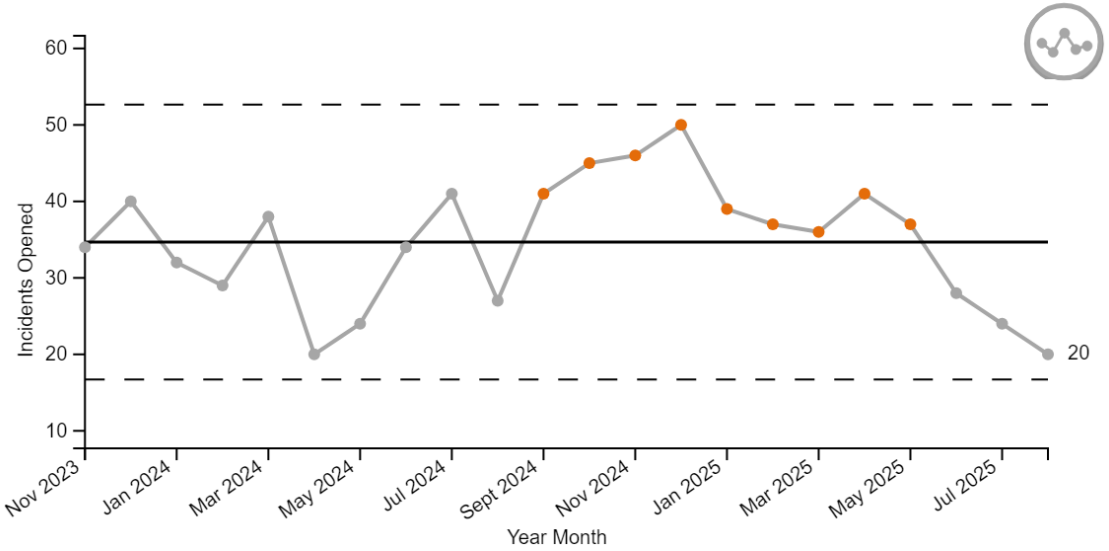
Incidents Opened with Risk Score 4-5



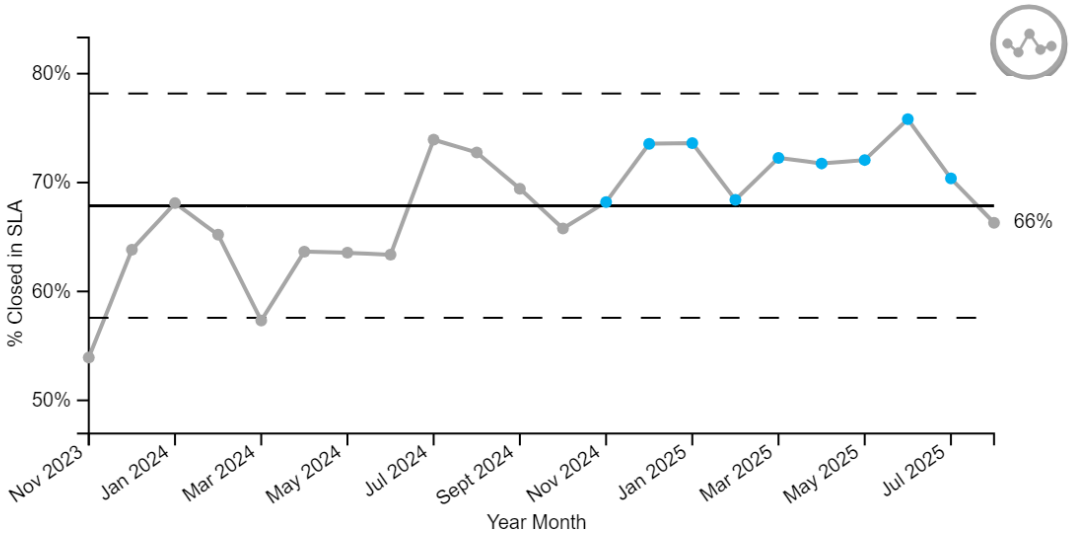
Incidents Opened - Patient



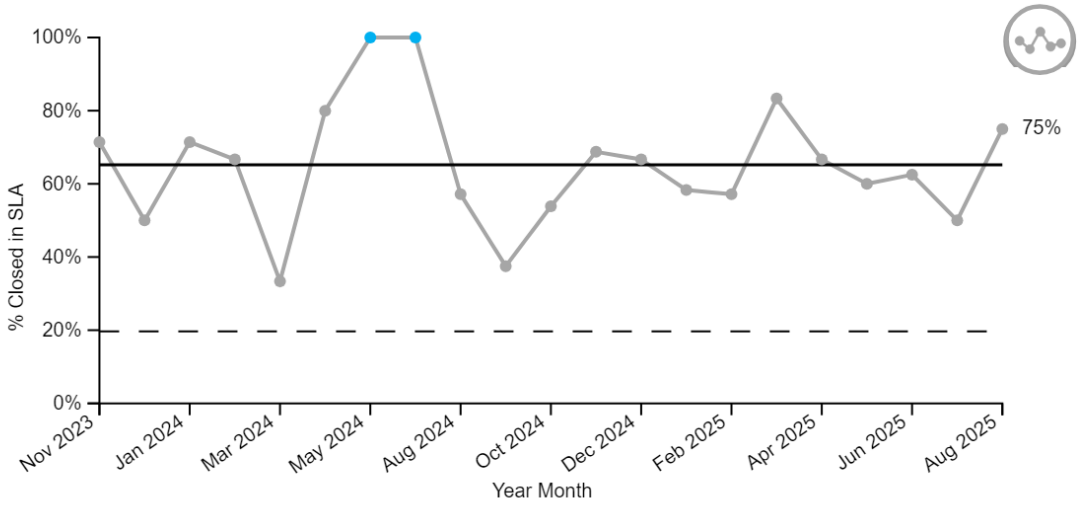
PSIRF Reported Level of Harm (Severe & Fatal)

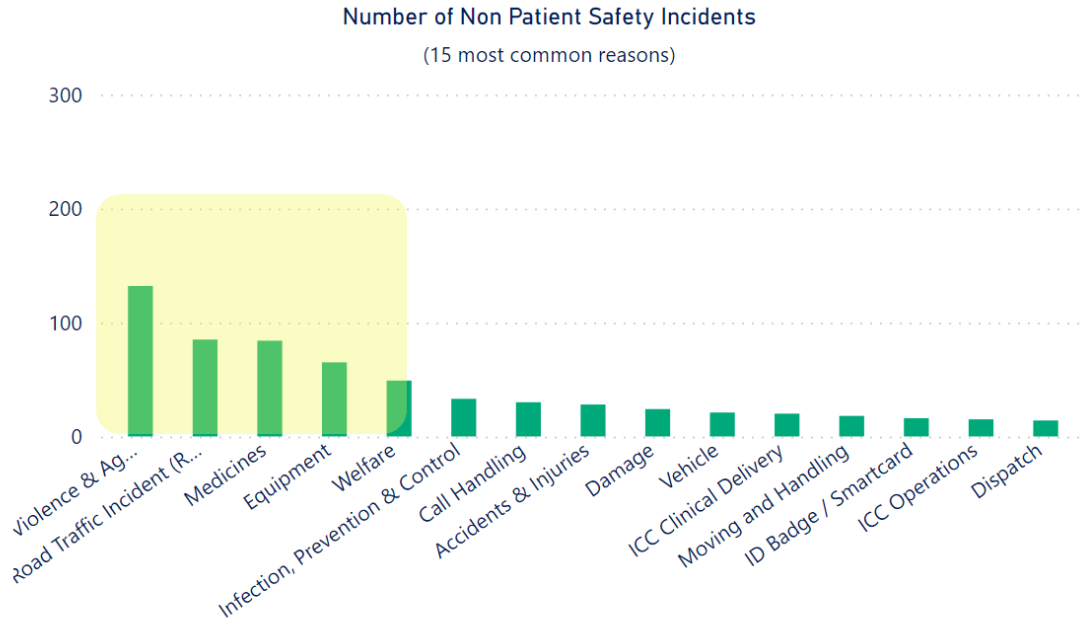


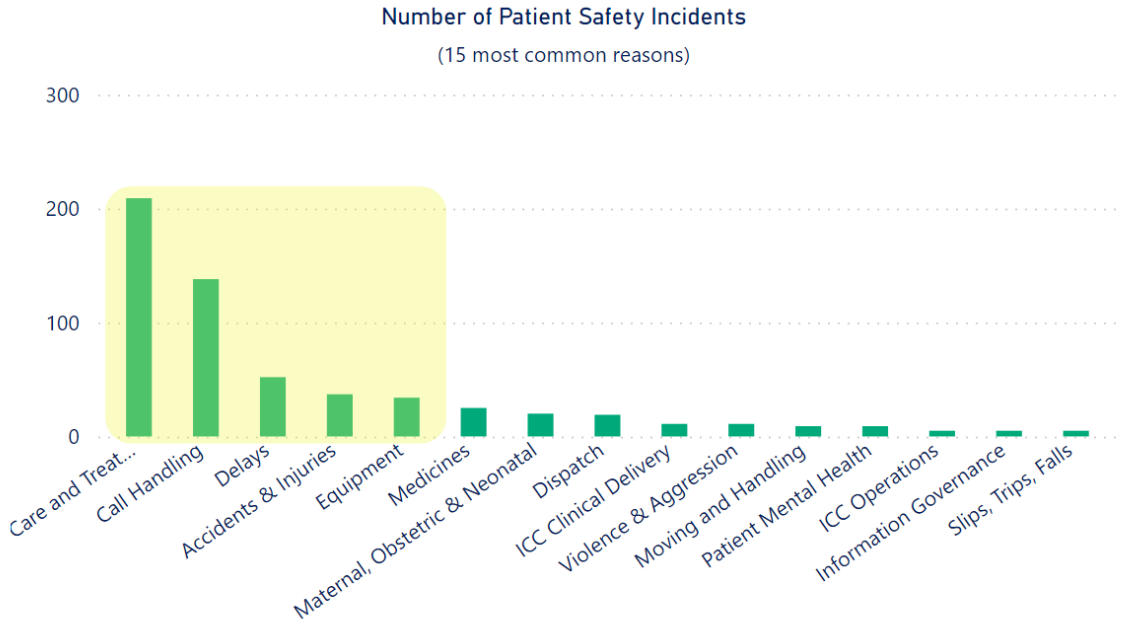
Incidents with Risk Score 1-3 % Complete within SLA

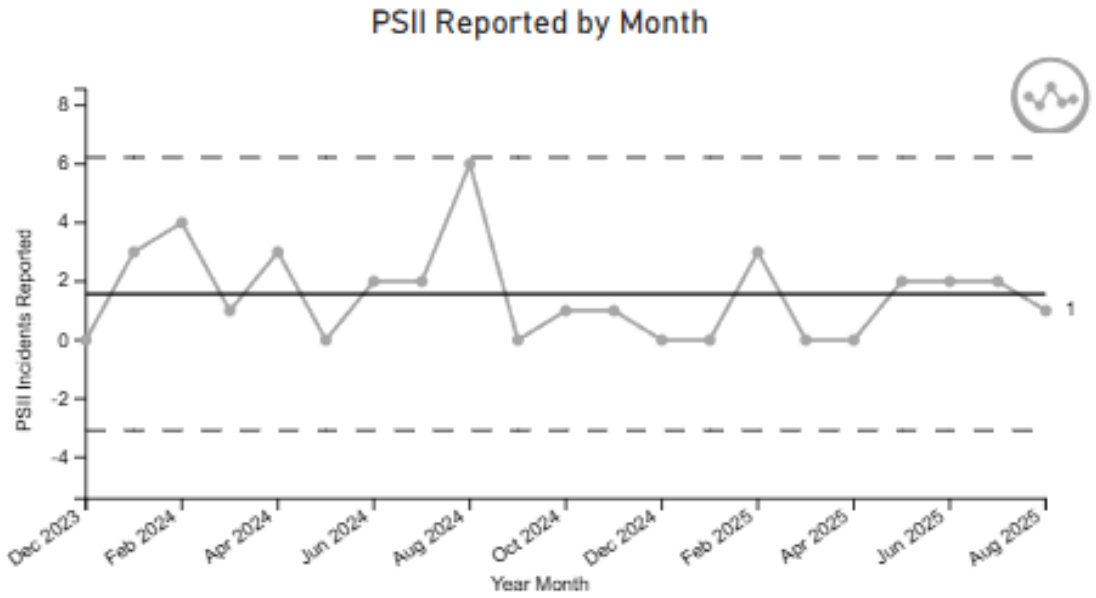


Incidents with Risk Score 4-5 % Complete within SLA









Summary:
All incident metrics are stable. Care and treatment remains the most common theme for patient incidents and the highest overall reported incident. Additionally, Violence and aggression(V&A) also remains the most common theme for non-patient incidents.

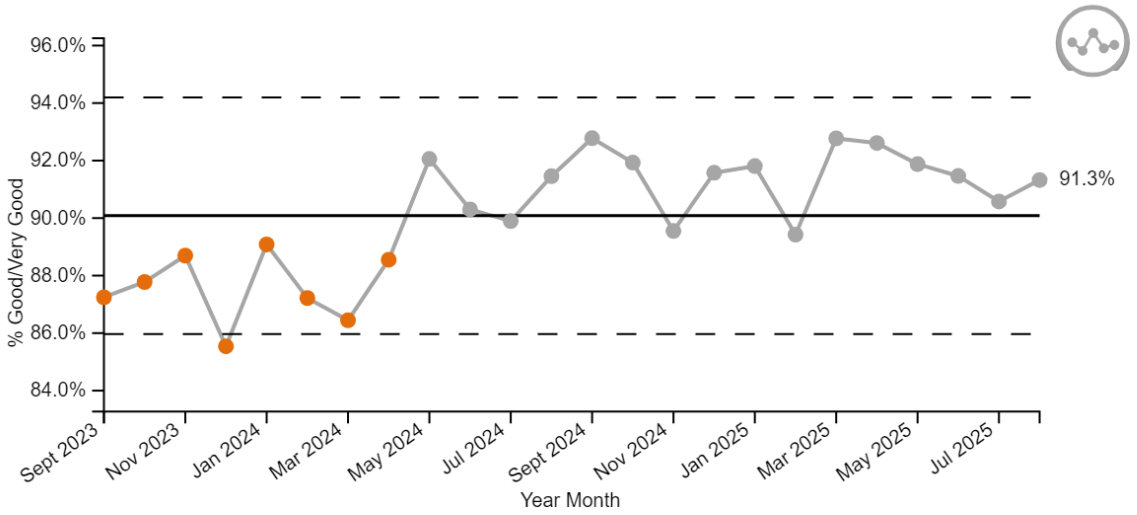
Action: There have been 2 new Violence Prevention and Reduction specialists recruited into post and work is ongoing across the ICC to tackle verbal aggression which is the highest reported incident type. This includes conflict resolution training and a review of standard operating procedures to ensure support with difficult calls. Our violence prevention work continues to tackle physical assaults against frontline staff with further engagement sessions planned for the winter months.

Q3 Safety Alerts

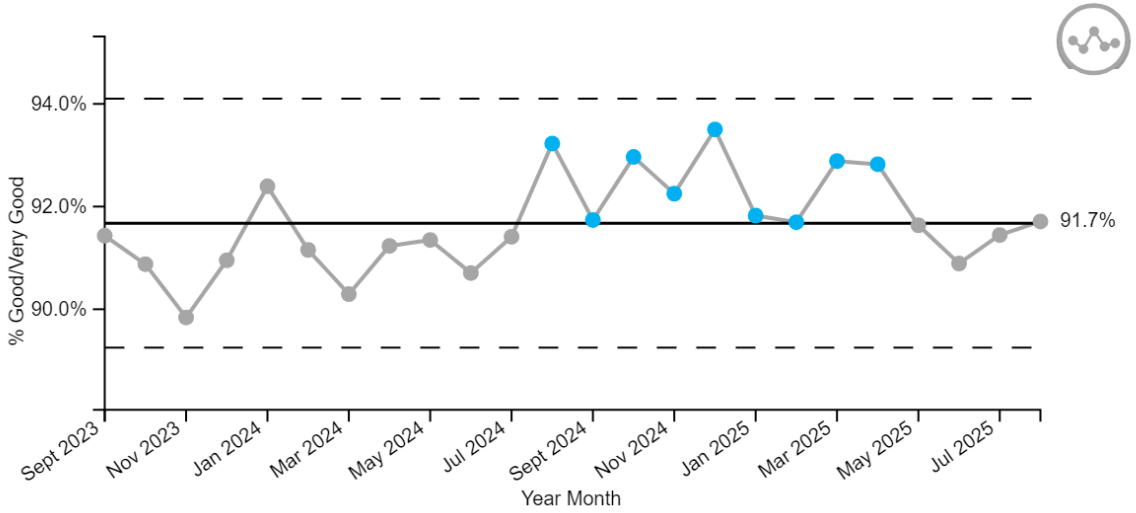
Safety Alerts	Alerts Received (September 24 – August 25)	Alerts Applicable (September 24 – August 25)	Alerts Open	Notes
CAS Helpdesk Team	1	0	0	
Patient Safety Alert: UKHSA	1	1	0	NatPSA/2025/002/UKHSA: Potential Contamination on non sterile alcohol free wipes with Burkholderia. Measures being taken to 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	66	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) %



PTS Friends & Family Test %



PES POSITIVE

- "The call takers for both calls were professional and empathetic and relayed information and advice well. The crew that attended were reassuring and helpful and spoke to the patient (who has cognitive impairment) in a way he could understand and were thoroughly professional throughout."
- "Triage questions were detailed and I understood their necessity. Although it was a non-life-threatening situation, the paramedics arrived within an hour and made the person safe and on the road to full recovery. They were skilled and empathic, reassuring my distressed relative. By their timely intervention, a downward medical spiral was reversed, and much greater distress (and cost to the NHS) was averted. Thank you."

PES NEGATIVE

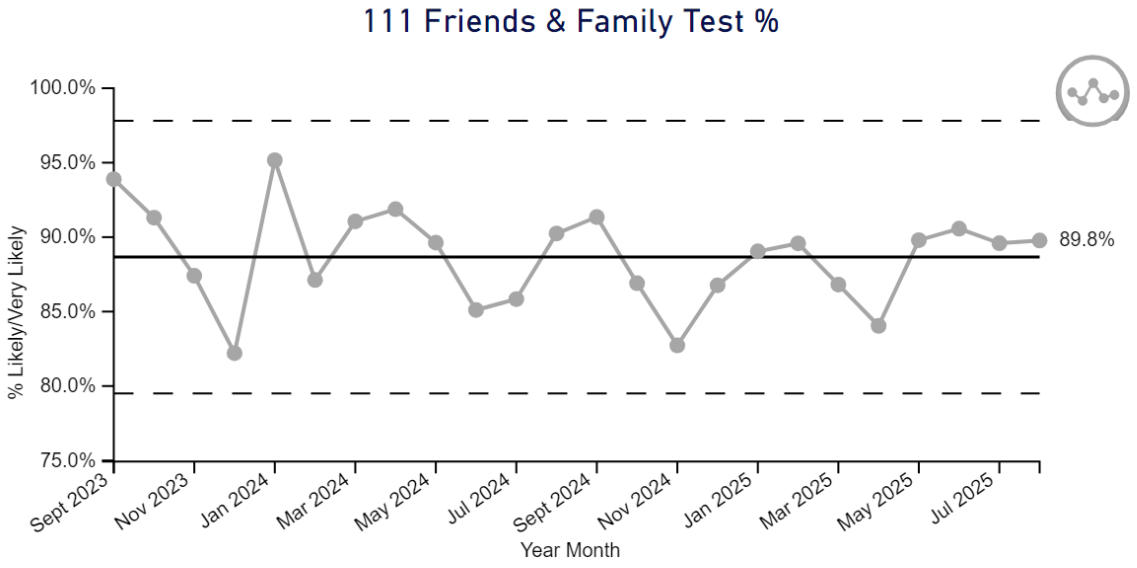
- "Operator threatened to ring police if I didn't answer my door despite saying I would struggle to get down my stairs to the front door. Ambulance then came 5 hours later at 1am whilst I was obviously asleep."
- "Police rang the ambulance for my son who had acute psychotic symptoms. In spite of what I told the medics they didn't even check him up. They asked a few questions then told him to talk to GP. My son is still having psychotic symptoms, and I am stuck in my house with a mad person."

PTS POSITIVE

- "Because they went out of their way to ensure you were comfortable in all that traffic and gave us a small container of water to drink and one of the crew gave the 3 of us one of his bananas. Opened windows and sky light to let some fresh air in. We were stuck in traffic both ways to Cumberland Infirmary due to an overturned lorry covering both lanes. They were a credit to the Ambulance Service."
- "My stepson is epileptic and partially sighted and he needs transport to get him to and from hospital appointment's. The driver and staff are always friendly and helpful."
- "Booking was easy, advisor polite. Taxi on time, ride pleasant."

PTS NEGATIVE

- "I had to wait 3 hours, sat there not even a glass of water. Is it because I am over 80?"
- "Waiting to come back with a patient with dementia is hard enough. Waiting for two hours is too long."
- "Rude drivers, asking inappropriate questions about my health, always extremely late and unreliable."



NHS 111 POSITIVE

- "The advice from the call taker was excellent. He was calm, compassionate and didn't make me feel I was wasting his time. He gave me clear advice and even another option. I cannot commend the service enough and just wish I thought to call earlier."
- "For someone who has a season ticket to doctors and specialists, today was a breath of fresh air. Everyone was trying to reassure me and genuinely just listened."
- "The advisor was compassionate, caring and felt that my child's symptoms needed assessment at out of hours."

NHS 111 NEGATIVE

- "Was not dealt with in a timely manner. Would have been easier and quicker actually going to A&E."
- "I have not received a follow up call which I was advised would happen. Each time I answered the call diverted immediately to recorded message. This happened on 4 separate occasions."
- "Too robotic, no compassion and call handler booked to 'see a medic within 2 hours' for the following night. No patient choice and there is no treating the patient, just a clinical triage which we had already had at the UTC."

Summary:

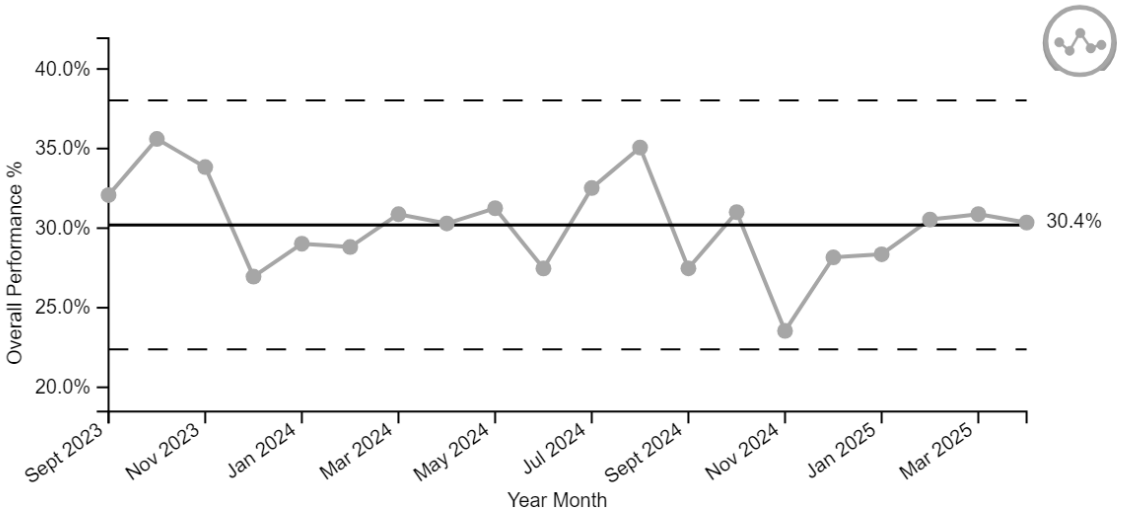
PES: There were 657 responses in Aug 25, consistent with recent response rates. The proportion of responses as Good/Very Good are 0.7% higher in Aug 25 (91.3%), than the previous month (Jul 90.6%) and similar to the same period last year (91.3% for Aug 25, 91.5% for Aug 24) . There is an increased total response rate of approx.100 respondents when compared to the same point last year.

PTS: There were 953 responses in Aug 25, with responses continuing to drop since May 25. The proportion of responses as Good/Very Good are 0.3% higher in Aug 25 (91.7%), than the previous month (Jul 91.4%) . When compared to position in previous year, the proportion of Good/Very Good responses are 1.5% less (91.7% for Aug 25, 93.2% for Aug 24). There is a decrease in total response rate of approx.400 respondents when compared to the same point last year.

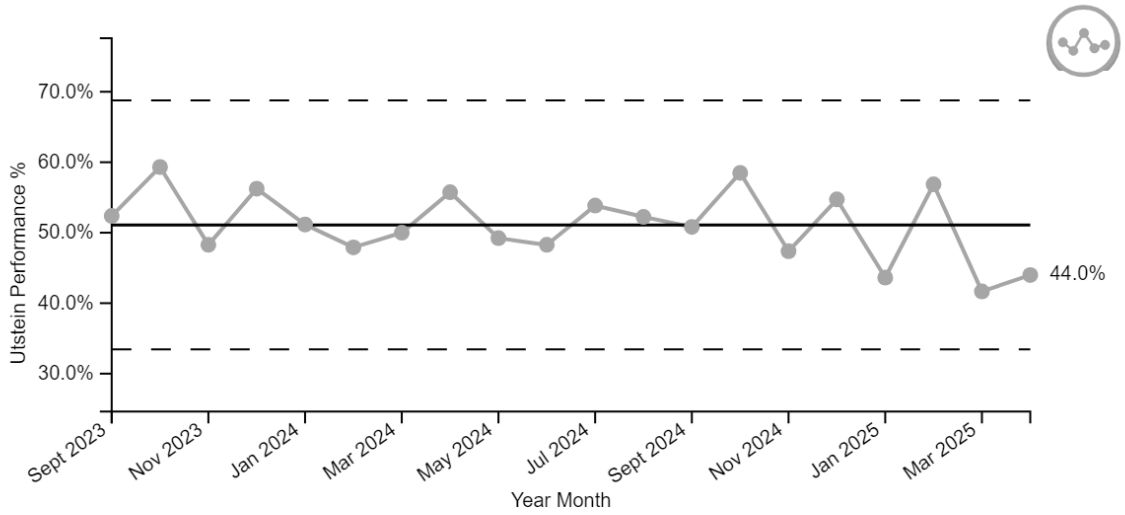
NHS 111: There were 528 responses in Aug 25, with responses increasing since May 25 (n=490). These increased returns are due to the inclusion of responses following the receipt of 'care advice' via SMS after the 111 calls. The % of Likely/Very Likely are 0.2% higher in Aug (89.8%) when compared with previous month (89.6%), and similar to te the same time last year (0.4% difference).

E2 Ambulance Clinical Quality Indicators (ACQI)

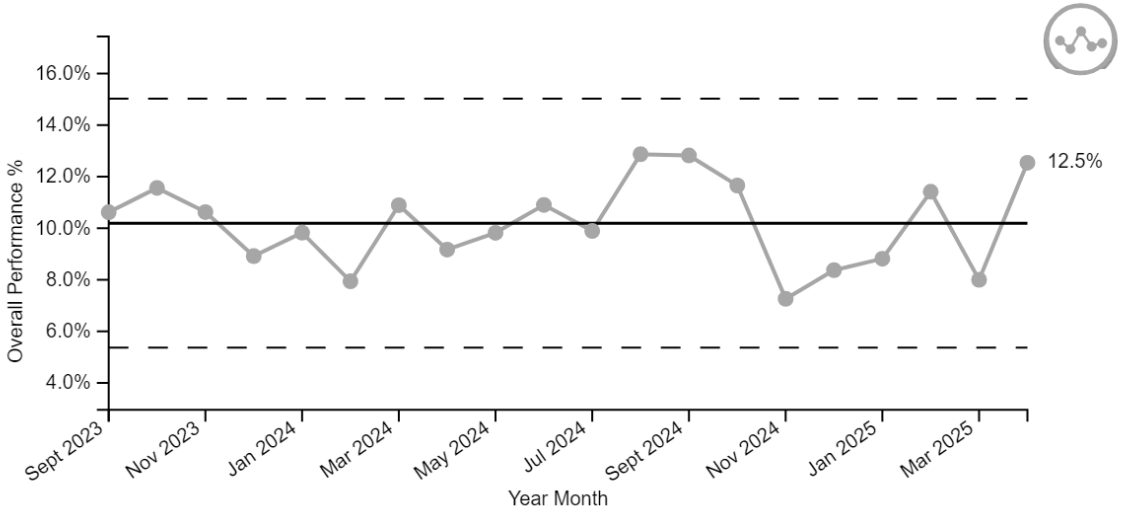
ROSC - Overall Performance



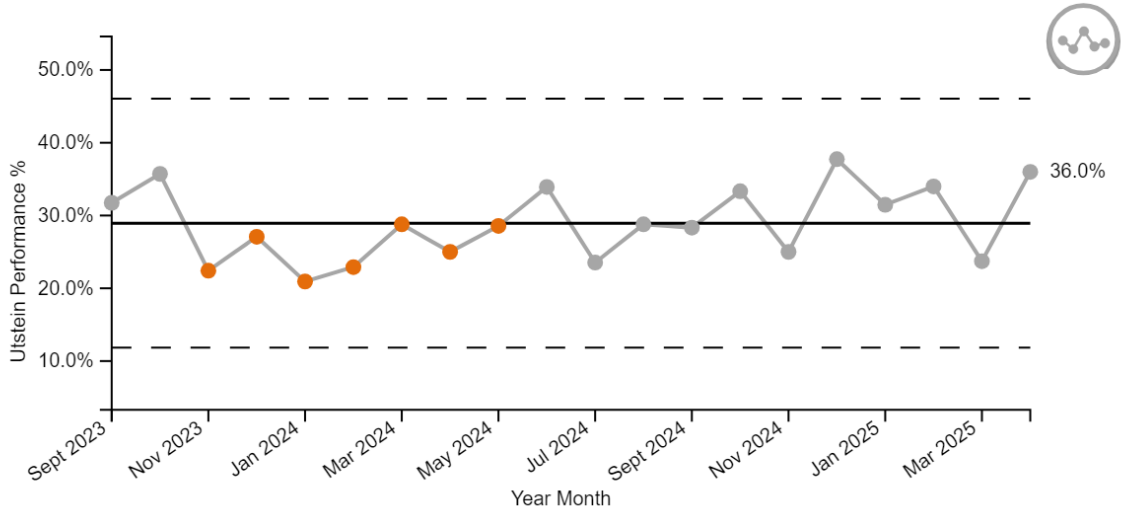
ROSC - Utstein Performance



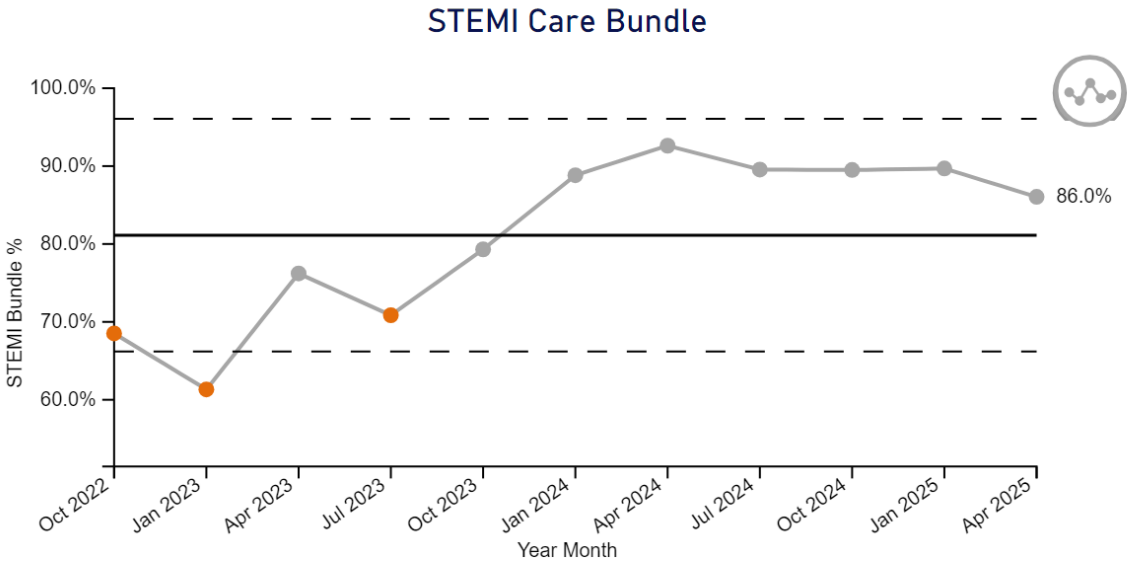
Survival at 30 Days Post Discharge - Overall Performance

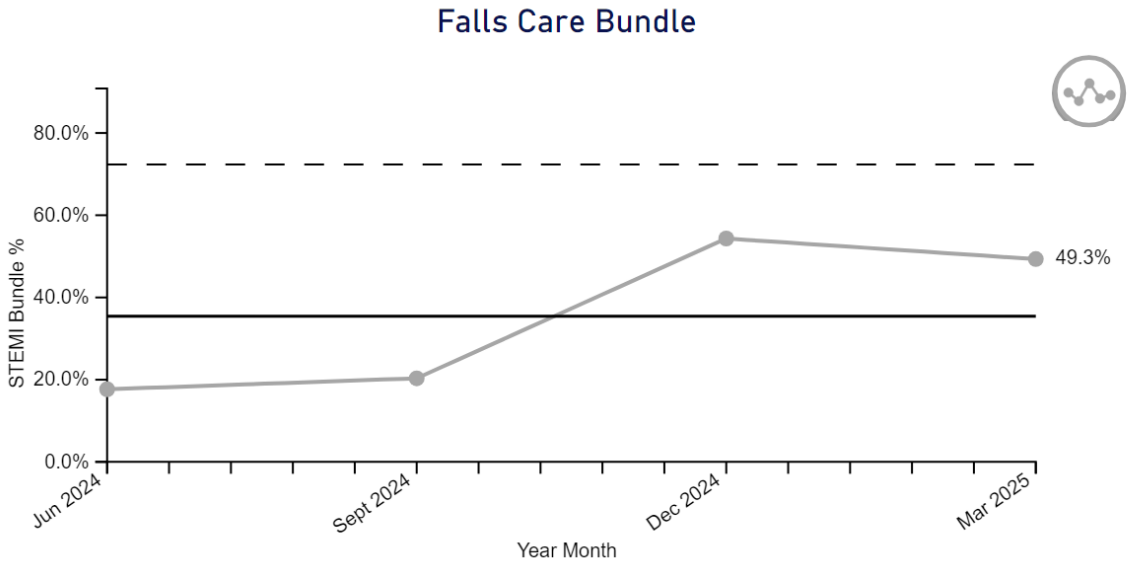


Survival at 30 Days Post Discharge - Utstein Performance



E2 Ambulance Clinical Quality Indicators (ACQI)





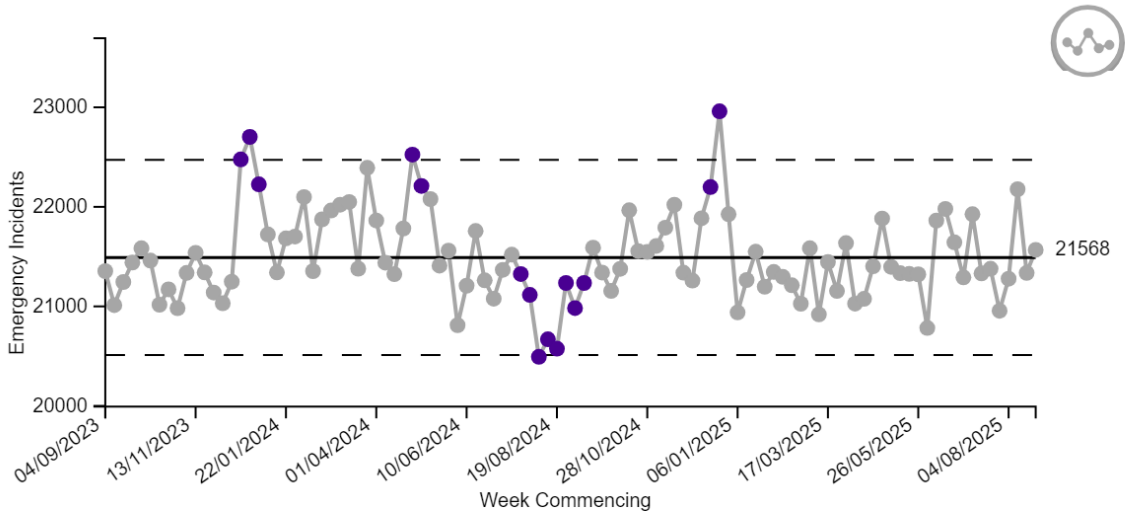
Summary: The Trust is currently performing above national average for all ACQI indicators with the exception of the Falls bundle.

- ROSC overall performance - last reported in Apr 25 (30.4%), **above** the national average of 26.2%.
- ROSC Utstein performance - last reported in Apr 25 (44.0%), **above** the national average of 42.1%.
- Survival at 30 days after discharge overall performance - last reported in. Apr 25 (12.5%), **above** the national average of 10%.
- Survival at 30 days after discharge Utstein performance - last reported in Apr 25 (36.0%), **above** the national average of 27.1%.
- STEMI bundle - last reported in Apr 25 (86.0%), **above** the national average of 80.0%.
- Falls bundle – last reported in March 25 (49.3%), **below** the national average of 50.2%.

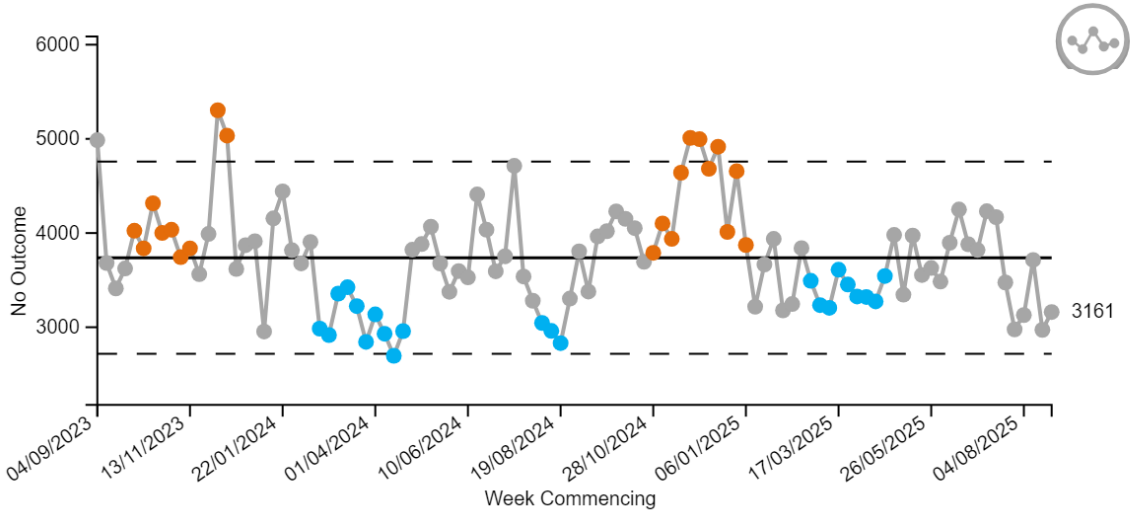
Actions: Continued monitoring of metrics and EPR system development to drive improvement.

E3 Activity & Outcomes

Emergency Incidents

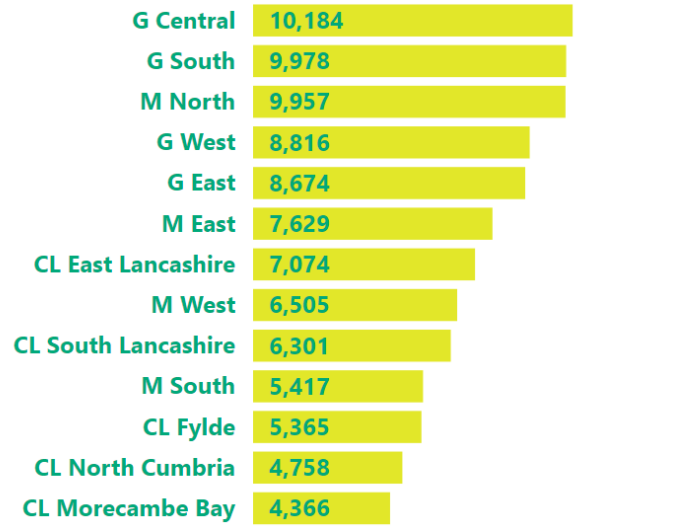


No Outcome Contacts

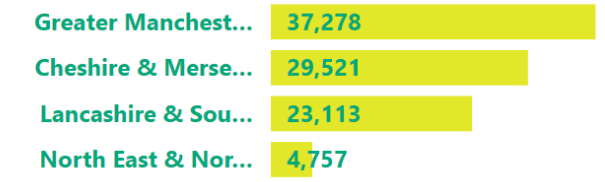


Emergency Incidents

Emergency Incidents by Operational Sector



Emergency Incidents by ICB

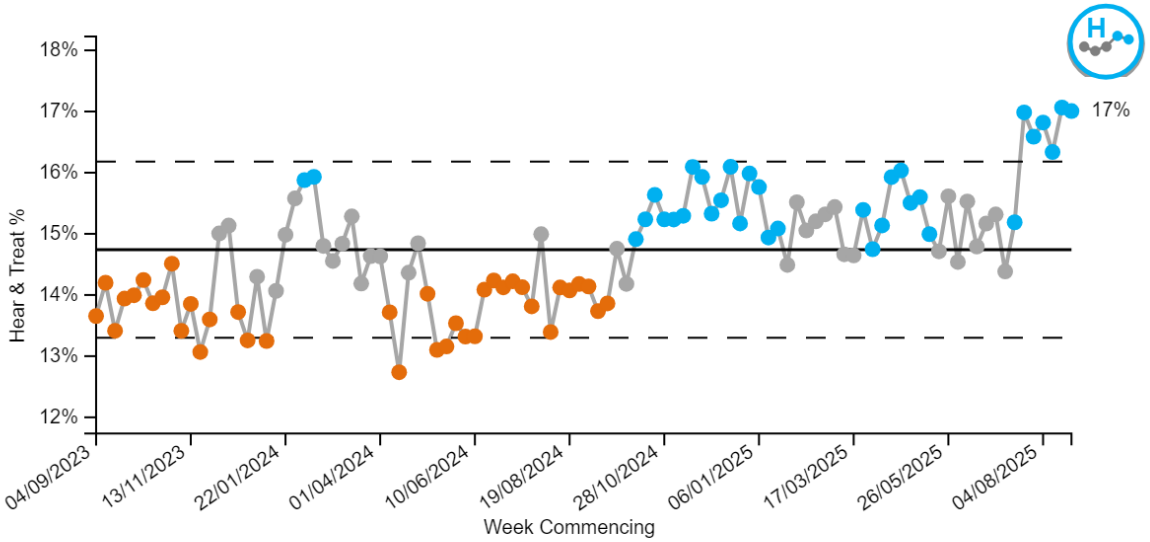


Calendar Year	Month	Calls	% Change from previous year	Incidents	% Change from previous year
2022	Aug	127,821	-9.73 %	89,655	-3.98 %
2023	Aug	118,713	-7.13 %	92,315	2.97 %
2024	Aug	110,438	-6.97 %	92,000	-0.34 %
2025	Aug	116,948	5.89 %	95,218	3.50 %

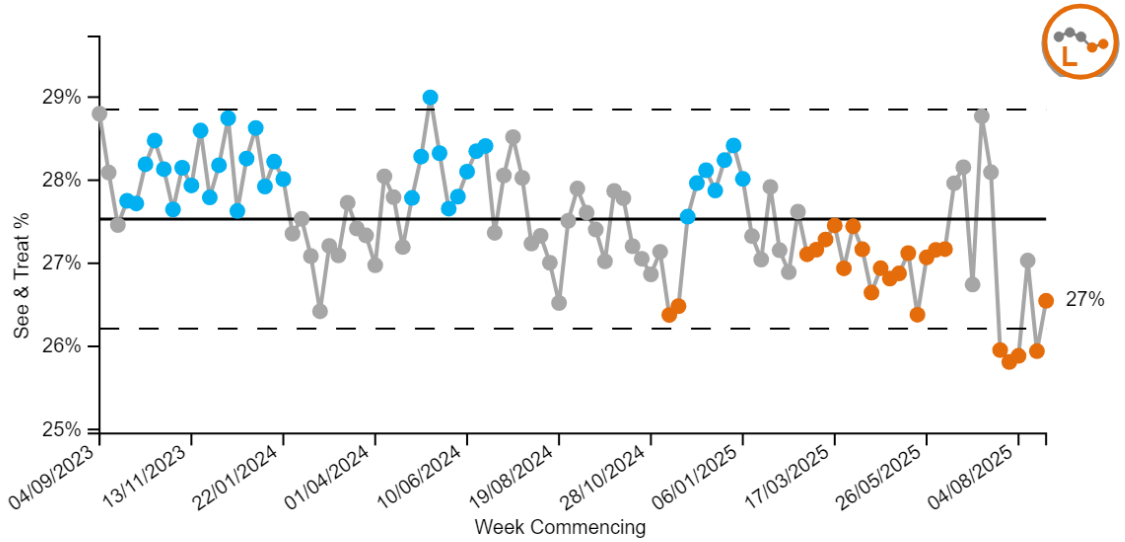
E3 Activity & Outcomes

BAF ID SR01

Hear & Treat (AQI)



See & Treat (AQI)



Months Hear & Treat by Sector

G Central	23.2%
CL South Lancashire	17.8%
G East	17.7%
G West	17.5%
CL Fylde	17.0%
CL East Lancashire	16.0%
G South	15.8%
CL North Cumbria	15.3%
M East	15.2%
M South	15.0%
CL Morecambe Bay	14.4%
M North	14.4%
M West	14.1%

Months Hear & Treat by ICB

Greater Man...	18.7%
Lancashire ...	16.4%
North East ...	15.3%
Cheshire & ...	14.6%

Months See & Treat by Sector

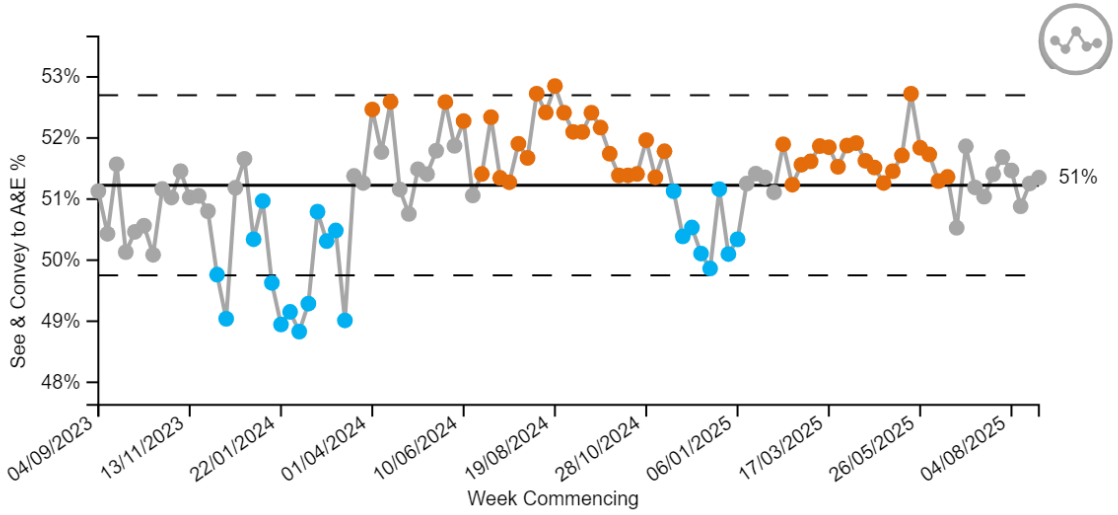
CL North Cumbria	30.4%
CL Morecambe Bay	29.6%
M South	29.1%
CL East Lancashire	27.7%
M West	27.3%
CL Fylde	26.9%
G West	26.4%
CL South Lancashire	25.8%
G East	25.7%
M North	25.4%
G South	25.4%
G Central	24.6%
M East	24.4%

Months See & Treat by ICB

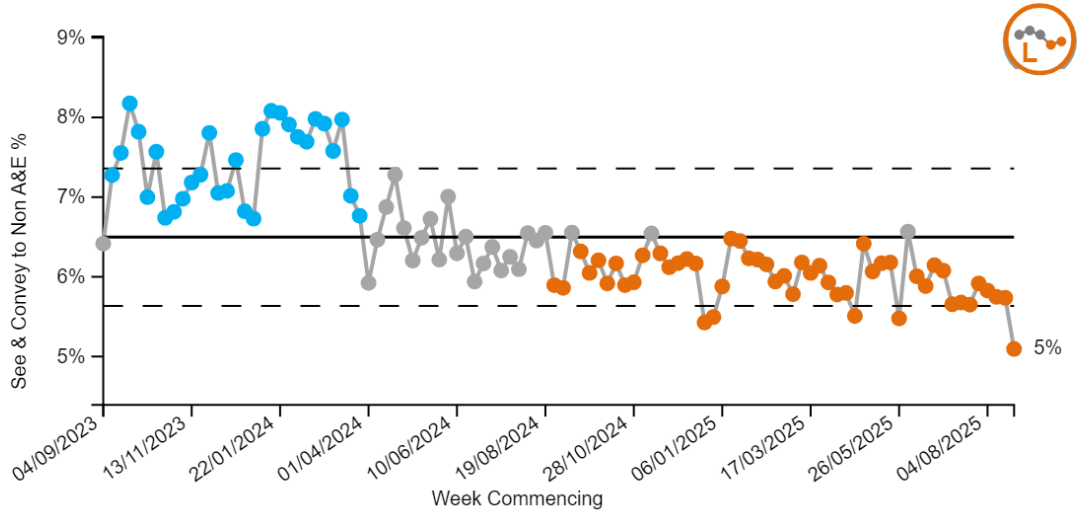
North East ...	30.4%
Lancashire ...	27.3%
Cheshire & ...	26.2%
Greater Man...	25.5%

BAF ID SR01

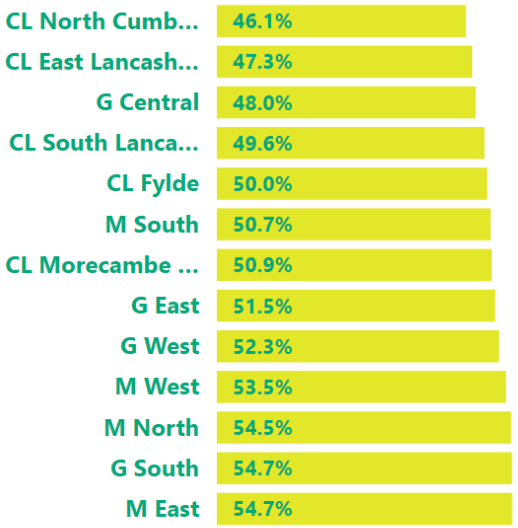
See & Convey to A&E (AQI)



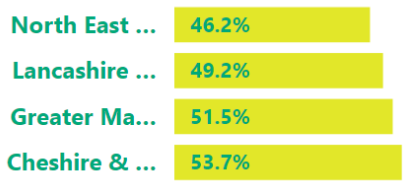
See & Convey to Non A&E (AQI)



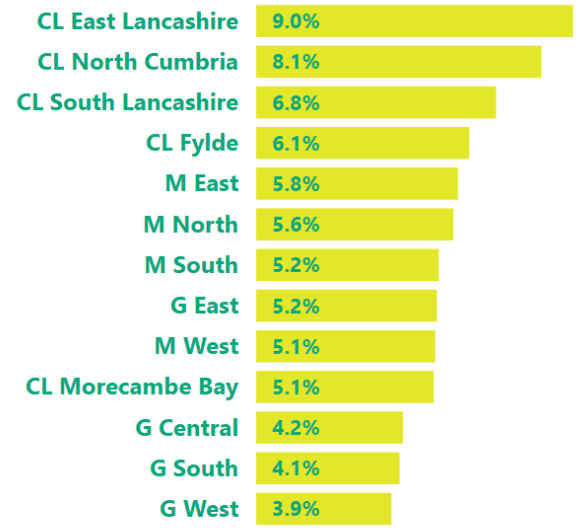
Months See & Convey (AE) by Sector



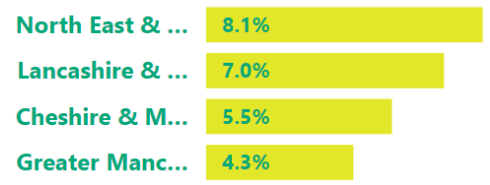
Months See & Convey (AE) by ICB

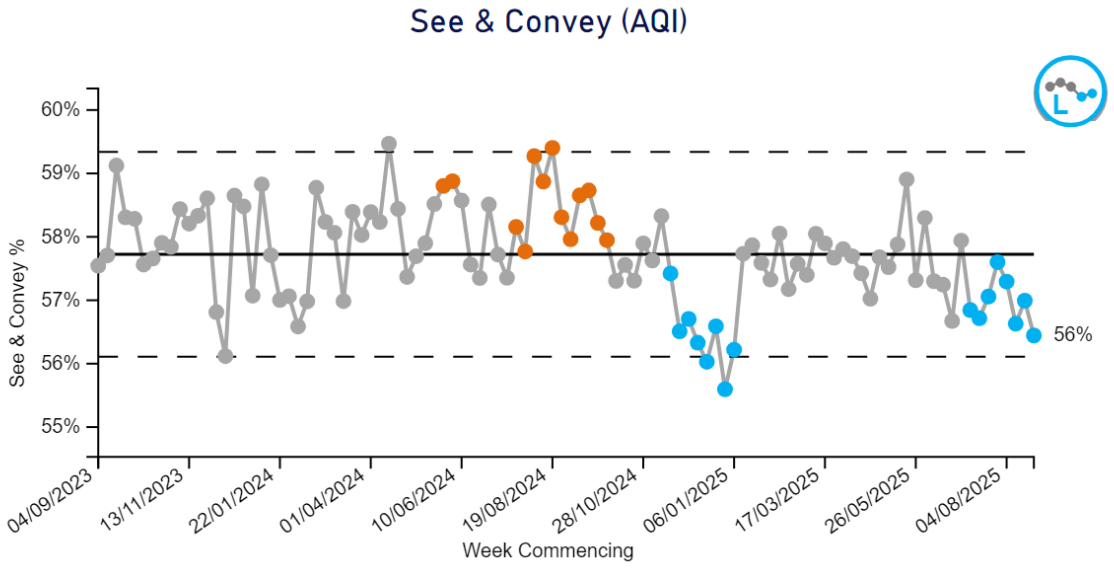


Months See & Convey (Non AE) by Sector



Months See & Convey (Non AE) by ICB





Months See & Convey by Sector

G Central	52.1%
CL North Cumbria	54.3%
M South	55.9%
CL Morecambe Bay	56.0%
CL Fylde	56.1%
G West	56.1%
CL East Lancashire	56.3%
CL South Lancashire	56.4%
G East	56.7%
M West	58.6%
G South	58.7%
M North	60.1%
M East	60.5%

Months See & Convey by ICB

North East & ...	54.3%
Greater Manc...	55.9%
Lancashire & ...	56.2%
Cheshire & M...	59.1%

Activity & Outcomes

Summary: Of the n=116,948 emergency calls received by the trust, 81.4% (n=95,218) became incidents. In comparison to previous month there were 6,452 fewer calls, but increased proportion of incidents, up 4.6% from 76.8% in Jul 25 (453 more incidents).

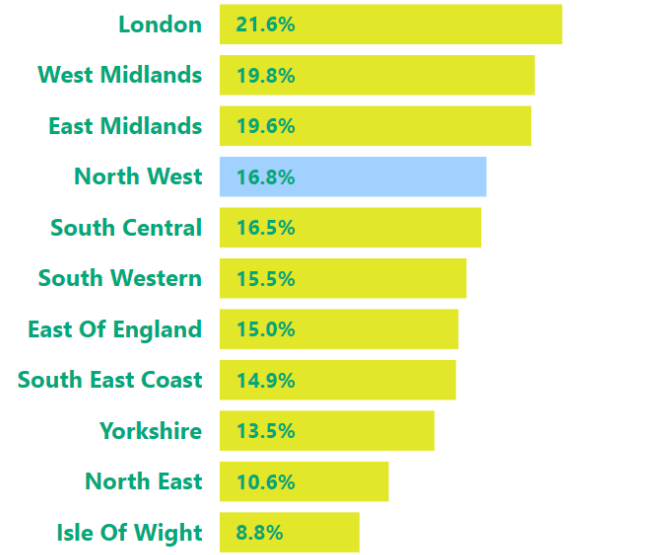
The H&T rate for August was 16.8% and S&T was 26.4%, equating to a non conveyance rate of 43.2% the highest it has been since December 24 (43.7%)

Improvements in Hear & Treat are due to a number of factors, including better management of frequent callers, better use of external CAS providers and improved oversight and changes to reporting.

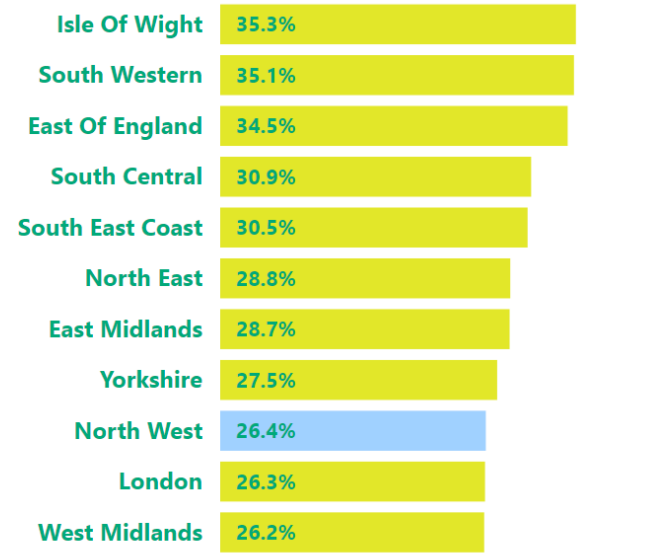
Nationally, the Trust rose in ranking for H&T to 4th whilst achieving 9th for S&T and S&C.

Action: Further gains in Hear & Treat are expected from increased use of clinical capacity in the 111 service as part of the Integrated Contact Centre programme.

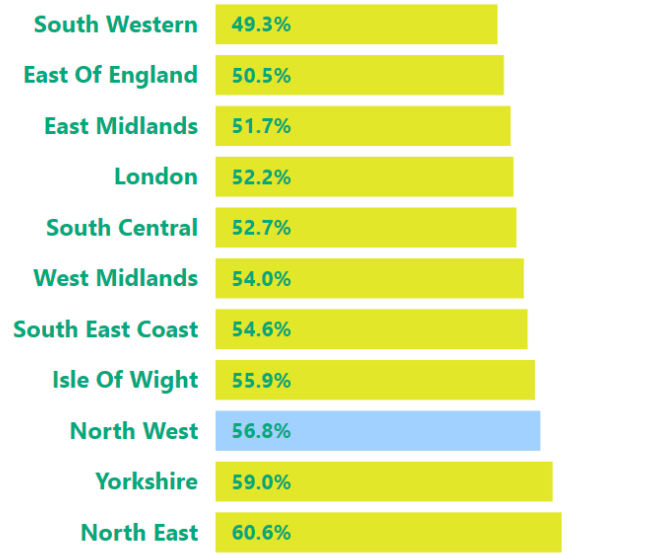
Hear & Treat % by Trust



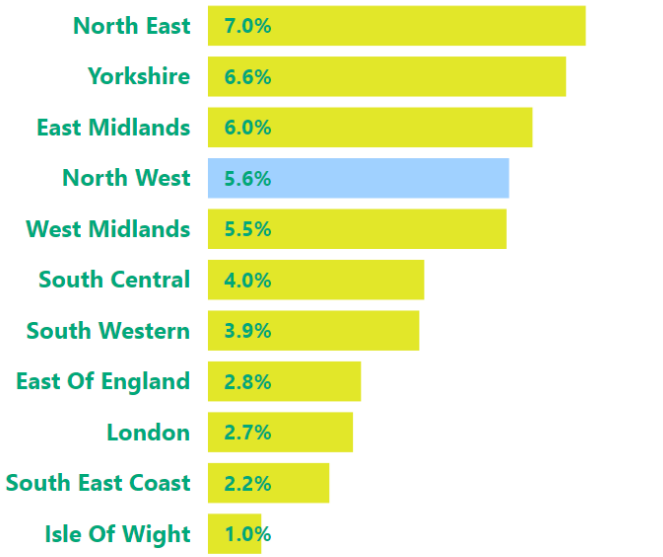
See & Treat % by Trust



See & Convey % by Trust



See & Convey non A&E % by Trust



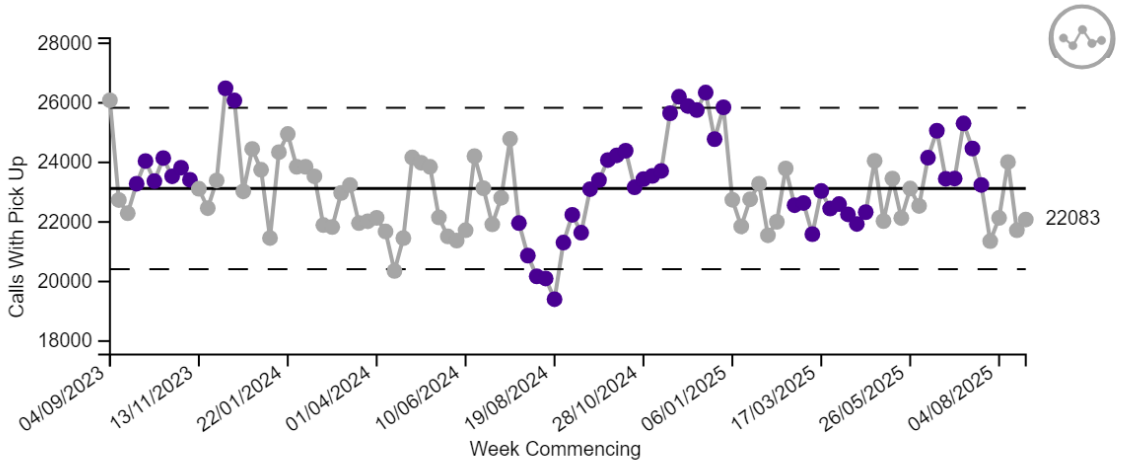
BAF ID SR01

Operational

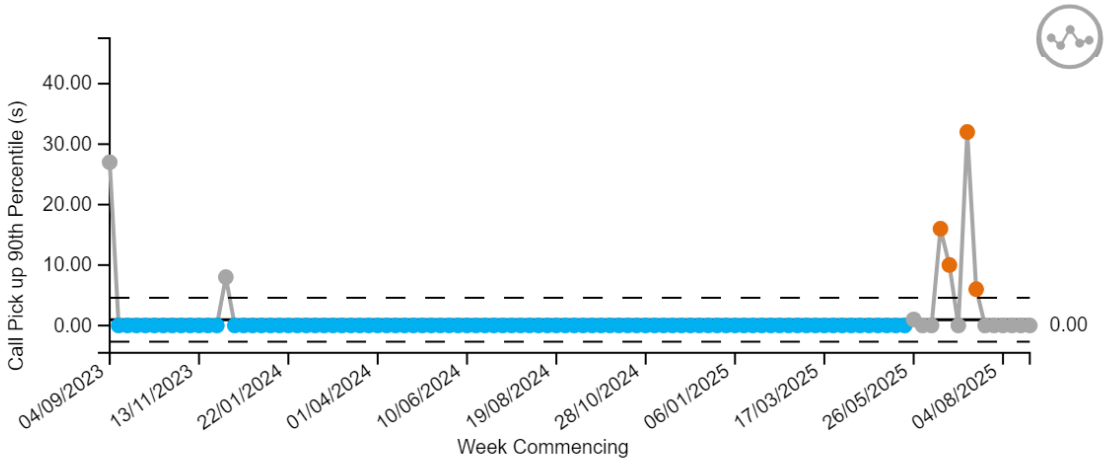
O1 Call Pick up
O3 ARP Response Times
O3 ARP Provider Comparison
O3 A&E Turnaround
O3 A&E Turnaround ICB
O4 111 Activity & Performance
O5 PTS Activity

O1 Call Pick Up

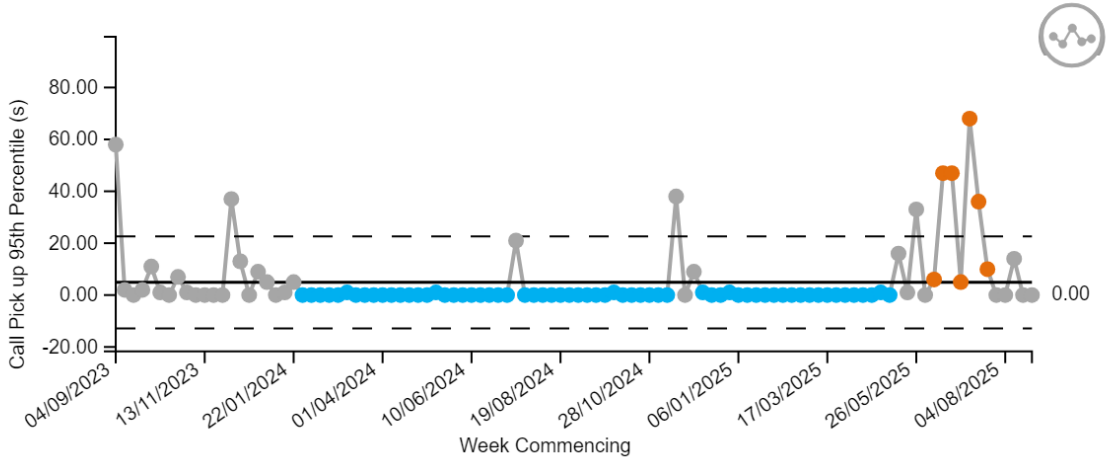
Calls With Pick up



Call Pick up 90th Percentile



Call Pick up 95th Percentile



Call Pick Up Mean	
Month	1
YTD	3
Ranking	2

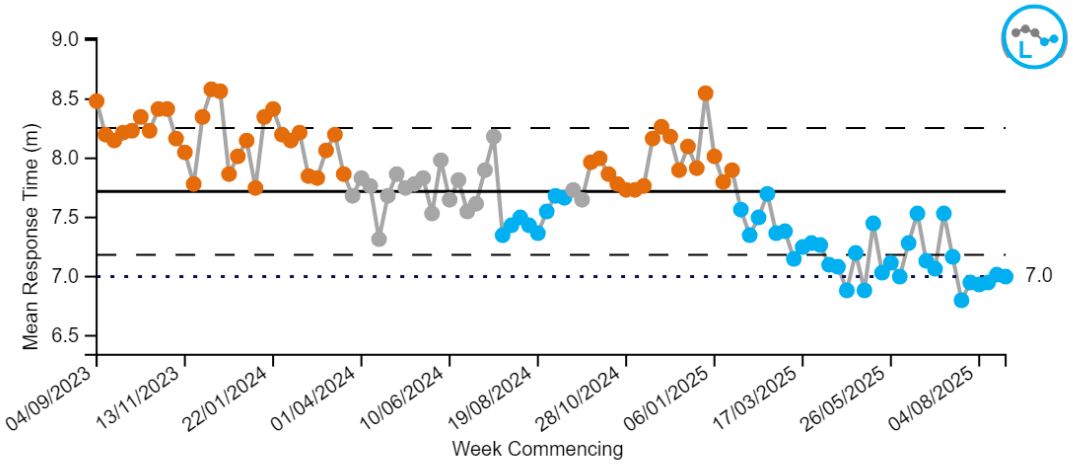
Call Pick up 90th Percentile	
Month	0
YTD	0
Ranking	Joint 1st

Call Pick up 95th Percentile	
Month	0
YTD	9
Ranking	Joint 1st

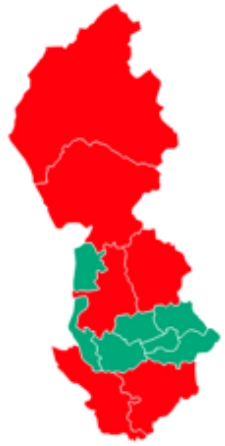
Summary: Call pick up has improved in August, achieving a 1 second mean (within 5 second target) and 0 second 95th percentile. Part of the improvement is due to the reduction in support provided to the Yorkshire Ambulance Service (YAS) from Friday to Saturday as they transition to NHS Pathways.

O3 ARP Response Times

ARP C1 Mean



C1 Mean (Red =>7min)



C1 Mean by Sector

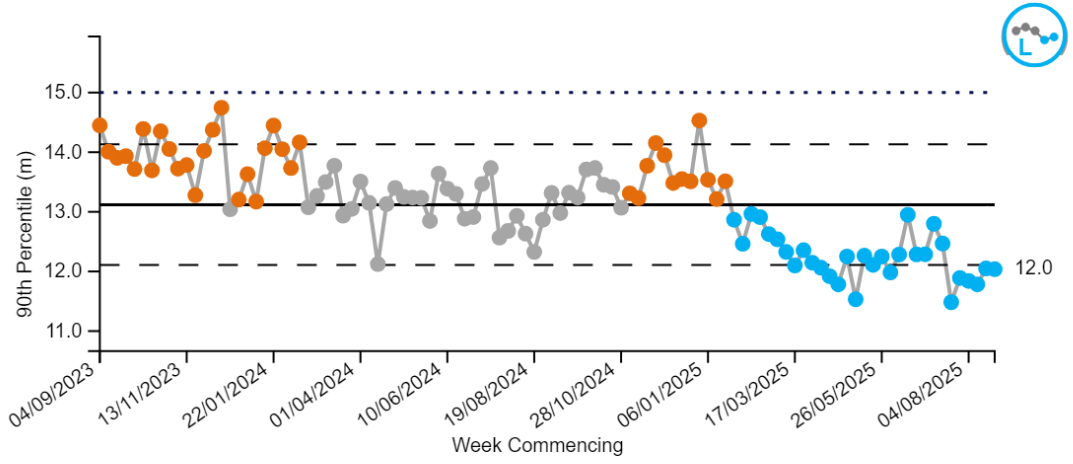
CL Morecambe Bay	00:08:56
CL North Cumbria	00:08:51
M South	00:07:55
CL South Lancashire	00:07:25
M West	00:07:25
CL East Lancashire	00:07:12
G West	00:06:57
M East	00:06:49
G East	00:06:39
CL Fylde	00:06:30
G South	00:06:30
G Central	00:06:29
M North	00:06:08

C1 Mean by ICB

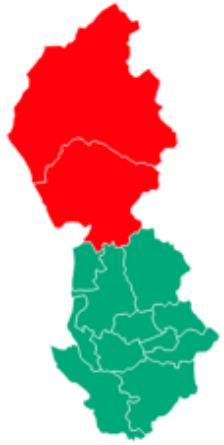
North East & Nort...	00:08:51
Lancashire & Sout...	00:07:21
Cheshire & Mersey...	00:06:52
Greater Manchester	00:06:36

C1 Mean	
Target	00:07:00
Month	00:06:58
YTD	00:07:07
Ranking	3

ARP C1 90th



C1 90th (Red =>15min)



C1 90th by Sector

CL Morecambe Bay	00:18:50
CL North Cumbria	00:16:06
M South	00:13:54
CL South Lancashire	00:13:13
M West	00:12:53
CL East Lancashire	00:12:35
CL Fylde	00:11:48
M East	00:11:21
G West	00:11:11
G South	00:10:55
G East	00:10:53
G Central	00:10:30
M North	00:10:16

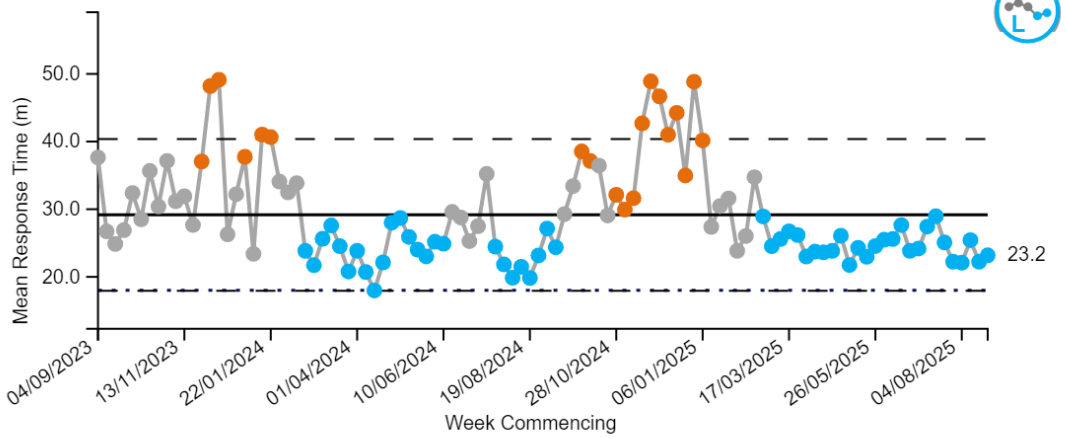
C1 90th by ICB

North East & N...	00:16:06
Lancashire & So...	00:13:06
Cheshire & Mer...	00:11:47
Greater Manche...	00:10:46

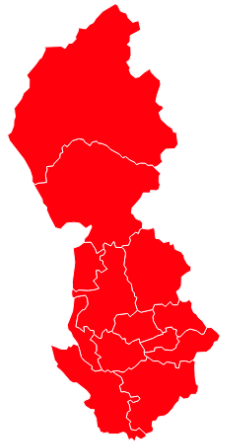
C1 90th	
Target	00:15:00
Month	00:11:57
YTD	00:12:07
Ranking	3

O3 ARP Response Times

ARP C2 Mean



C2 Mean (Red => 18min)



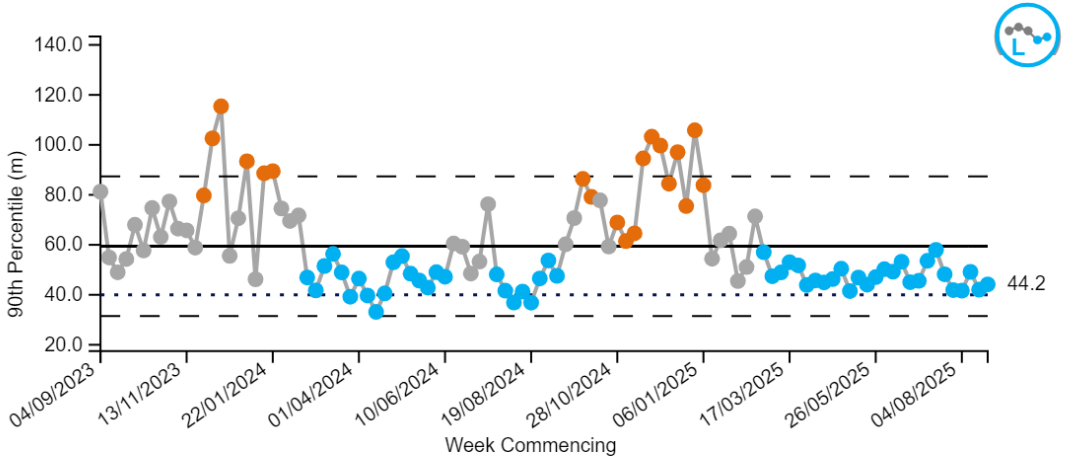
C2 Mean by Sector	
M West	00:28:43
M South	00:27:25
M East	00:26:58
M North	00:25:58
CL Morecambe Bay	00:25:31
CL North Cumbria	00:24:23
G West	00:23:10
CL South Lancashire	00:22:04
G East	00:21:05
CL Fylde	00:20:09
CL East Lancashire	00:19:51
G Central	00:19:12
G South	00:19:02

C2 Mean by ICB	
Cheshire & Mersey...	00:27:05
North East & Nort...	00:24:21
Lancashire & Sout...	00:21:36
Greater Manchester	00:20:28

C2 Mean	
Target (ARP)	00:18:00
Target (UEC)	00:28:00
Month	00:23:03
YTD	00:24:26
Ranking	3

O3 ARP Response Times

ARP C2 90th



C2 90th (Red => 40min)

C2 90th by Sector	
M West	00:57:12
M North	00:52:20
M South	00:51:27
M East	00:51:13
CL Morecambe Bay	00:51:09
CL North Cumbria	00:47:00
G West	00:43:51
CL South Lancashire	00:40:28
G East	00:38:42
CL Fylde	00:38:42
CL East Lancashire	00:36:00
G South	00:35:39
G Central	00:35:00

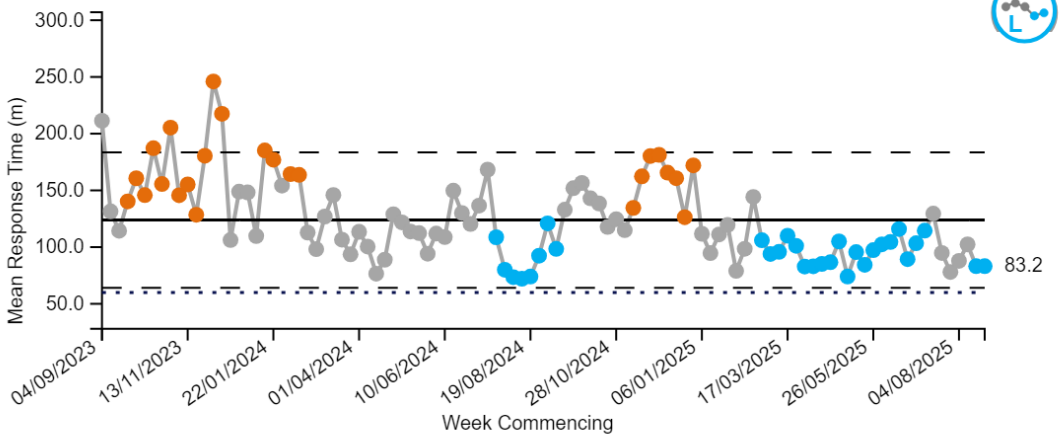
C2 90th by ICB	
Cheshire & Mersey...	00:52:59
North East & Nort...	00:46:56
Lancashire & Sout...	00:40:47
Greater Manchester	00:38:11

C2 90th	
Target	00:40:00
Month	00:43:58
YTD	00:47:06
Ranking	3

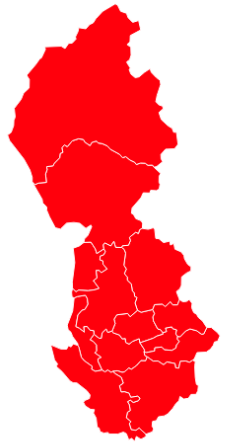
BAF ID SR03

O3 ARP Response Times

ARP C3 Mean



C3 Mean (Red => 60min)



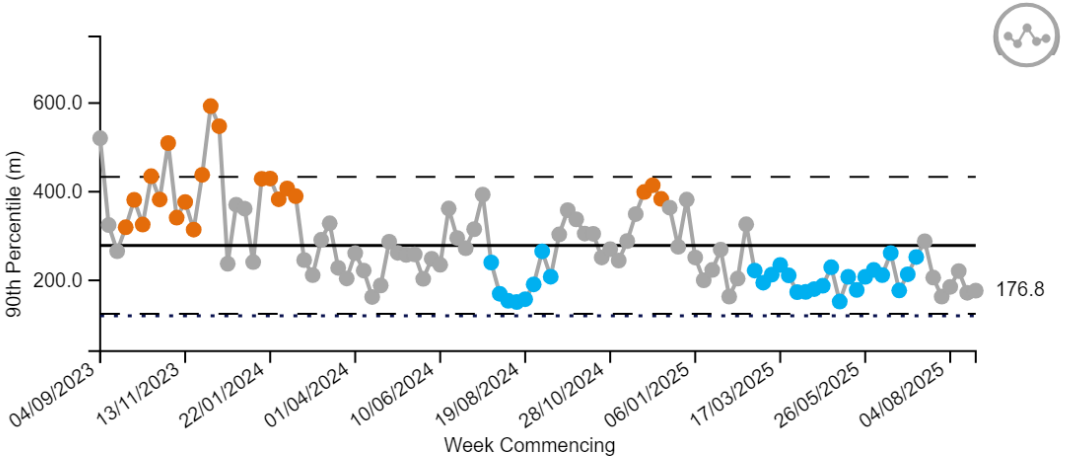
C3 Mean by Sector	
M West	01:41:59
M North	01:39:21
M East	01:37:15
G West	01:35:37
G East	01:30:00
G Central	01:28:50
M South	01:28:25
CL North Cumbria	01:19:48
G South	01:18:10
CL Morecambe Bay	01:17:45
CL South Lancashire	01:16:55
CL East Lancashire	01:15:41
CL Fylde	01:11:04

C3 Mean by ICB	
Cheshire & Mersey...	01:37:03
Greater Manchester	01:28:06
North East & Nort...	01:19:48
Lancashire & Sout...	01:15:24

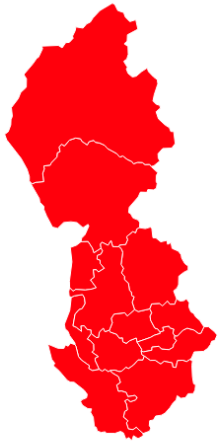
C3 Mean	
Target	00:60:00
Month	01:27:39
YTD	01:34:21
Ranking	5

O3 ARP Response Times

ARP C3 90th



C3 90th (Red => 2h)



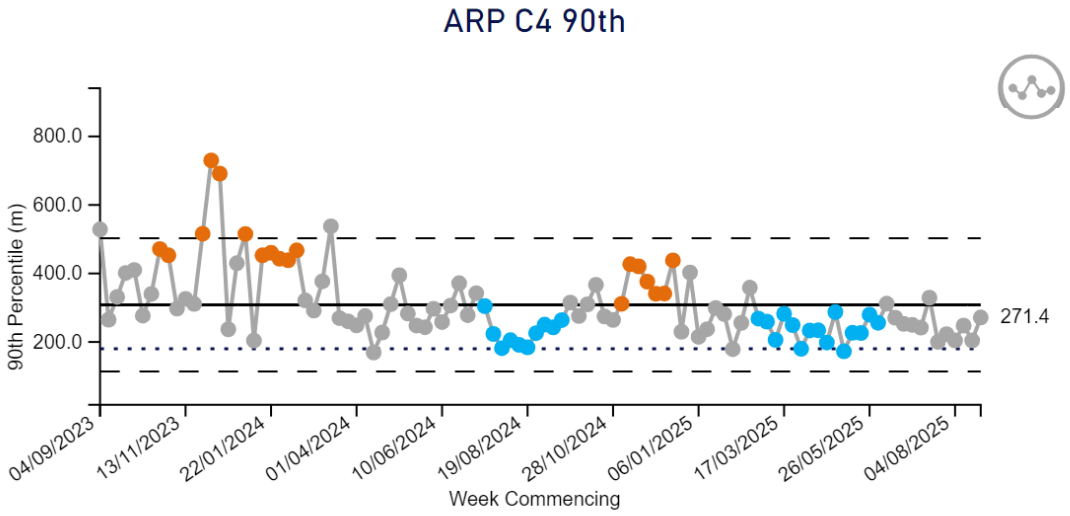
C3 90th by Sector	
M West	03:44:52
M East	03:42:38
M North	03:42:14
G West	03:20:17
M South	03:00:35
CL Morecambe Bay	02:58:24
G Central	02:57:52
G East	02:57:50
CL North Cumbria	02:51:16
CL East Lancashire	02:41:42
G South	02:38:48
CL South Lancashire	02:33:42
CL Fylde	02:32:25

C3 90th by ICB	
Cheshire & Mersey...	03:35:18
Greater Manchester	02:59:19
North East & Nort...	02:51:16
Lancashire & Sout...	02:39:28

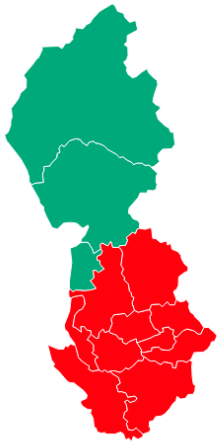
C3 90th	
Target	01:30:00
Month	03:04:49
YTD	03:21:43
Ranking	4

BAF ID SR03

O3 ARP Response Times



C4 90th (Red => 3h)



C4 90th by Sector

M North	05:23:44
G Central	04:56:42
M West	04:38:30
CL South Lancashire	04:33:23
M East	04:21:11
CL East Lancashire	03:57:16
G South	03:57:10
G West	03:55:47
M South	03:41:38
G East	03:33:58
CL Morecambe Bay	02:46:21
CL Fylde	02:34:26
CL North Cumbria	02:21:38

C4 90th by ICB

Cheshire & Mersey...	03:58:34
Greater Manchester	03:57:36
Lancashire & Sout...	03:20:20
North East & Nort...	02:21:38

C4 90th	
Target	03:00:00
Month	03:44:36
YTD	03:57:33
Ranking	2

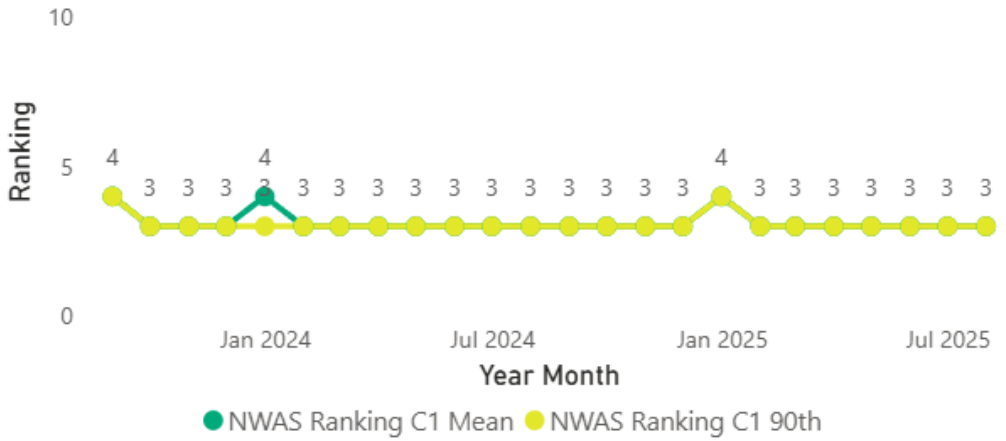
O3 ARP Response Times

Summary:
C1 mean continues to indicate improvement and the Trust has exceeded the C1 mean ARP standard, achieving 06m:58s against a target of 7 minutes. C2-C4 response times have improved since July with C2 mean achieving the UEC target. Cheshire and Merseyside ICB (CAM) continue to record the slowest C2-C4 responses. For C2 it takes an average of 04m:02s longer in CAM (27m:19s) compared to the rest of the trust (23m:03s). Hospital handover continues to be a causal factor.

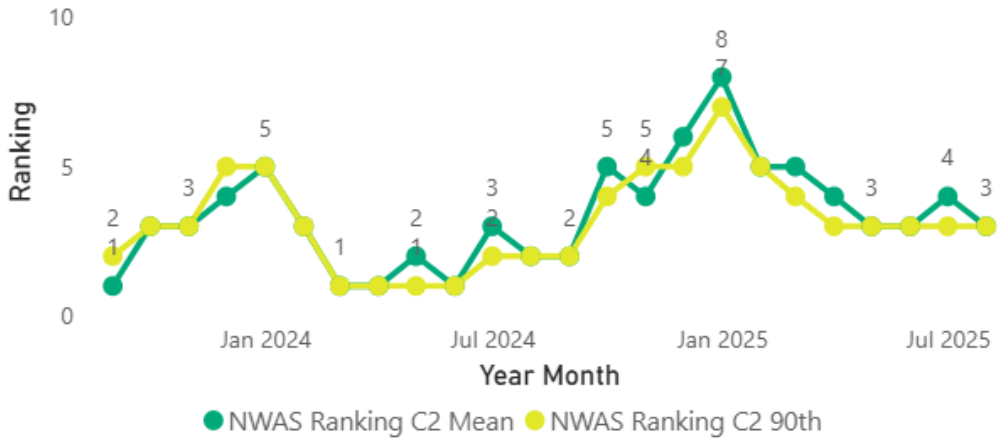
Action:
Ongoing reviews of the response model are supporting further improvements. This includes a review of inter-facility transfers (IFT) and healthcare professional (HCP) incidents, in which the trust is a national outlier, as well as a refreshed pre-alert process.

O3 ARP Provider Comparison

C1 Mean & 90th Percentile ranking over time



C2 Mean & 90th Percentile ranking over time



C1 Mean by Trust

North East	00:06:19
London	00:06:41
North West	00:06:59
Yorkshire	00:07:44
West Midlands	00:07:47
South East Coast	00:08:14
South Central	00:08:18
East Of England	00:08:32
East Midlands	00:08:54
South Western	00:09:03
Isle Of Wight	00:09:29

C1 90th by Trust

North East	00:10:46
London	00:11:25
North West	00:11:57
Yorkshire	00:13:22
West Midlands	00:13:46
South East Coast	00:15:21
South Central	00:15:29
East Midlands	00:15:48
East Of England	00:15:59
Isle Of Wight	00:17:14
South Western	00:17:14

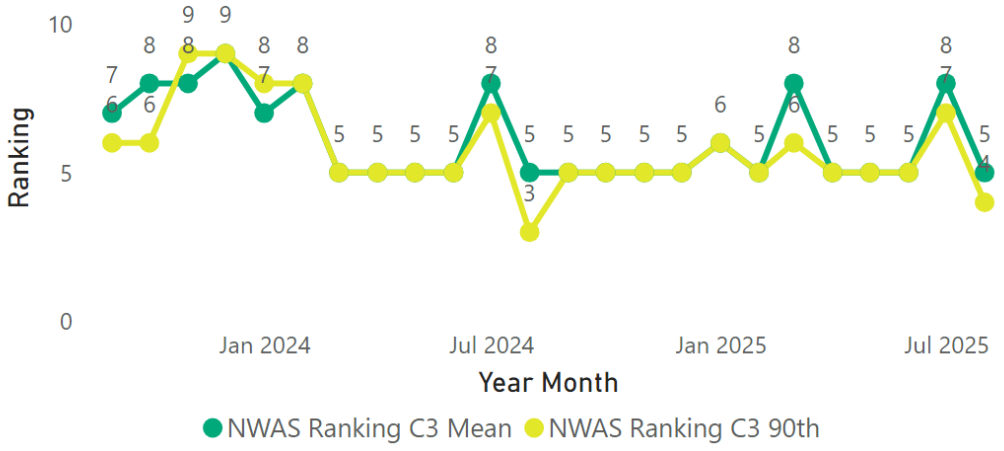
C2 Mean by Trust

West Midlands	00:19:21
North East	00:20:42
North West	00:23:04
Yorkshire	00:24:12
London	00:25:53
Isle Of Wight	00:26:08
South Central	00:27:12
South East Coast	00:28:32
East Of England	00:30:54
South Western	00:32:06
East Midlands	00:37:35

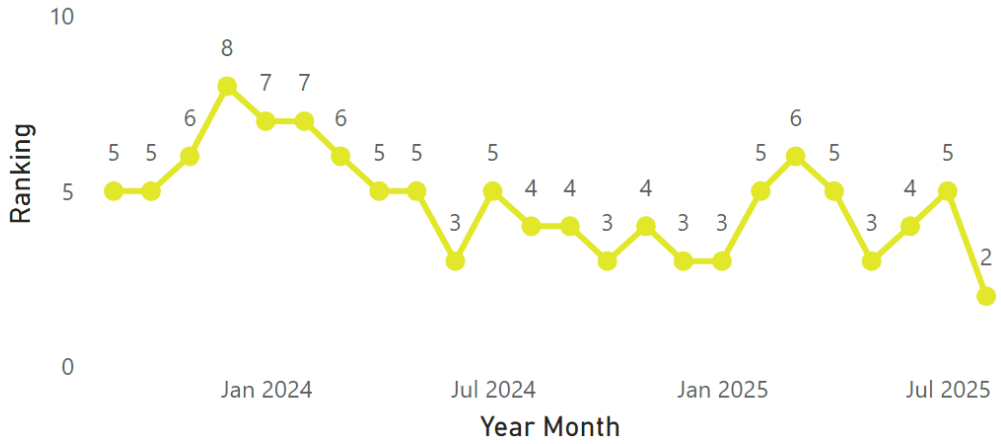
C2 90th by Trust

West Midlands	00:39:05
North East	00:40:35
North West	00:43:58
Isle Of Wight	00:50:21
Yorkshire	00:50:53
South Central	00:51:58
London	00:53:40
South East Coast	00:57:34
East Of England	01:03:49
South Western	01:05:43
East Midlands	01:16:39

C3 Mean & 90th Percentile ranking over time



C4 90th Percentile ranking over time



C3 Mean by Trust

North East	00:51:14
London	01:09:38
Yorkshire	01:11:22
Isle Of Wight	01:16:11
North West	01:27:38
West Midlands	01:31:35
East Of England	01:32:49
South Western	01:33:42
South East Coast	01:59:27
East Midlands	02:04:17
South Central	02:15:25

C3 90th by Trust

North East	01:58:01
London	02:41:26
Yorkshire	02:42:57
North West	03:04:49
Isle Of Wight	03:12:41
South Western	03:32:11
East Of England	03:34:17
West Midlands	03:44:20
South East Coast	04:29:08
East Midlands	04:49:54
South Central	04:52:04

C4 90th by Trust

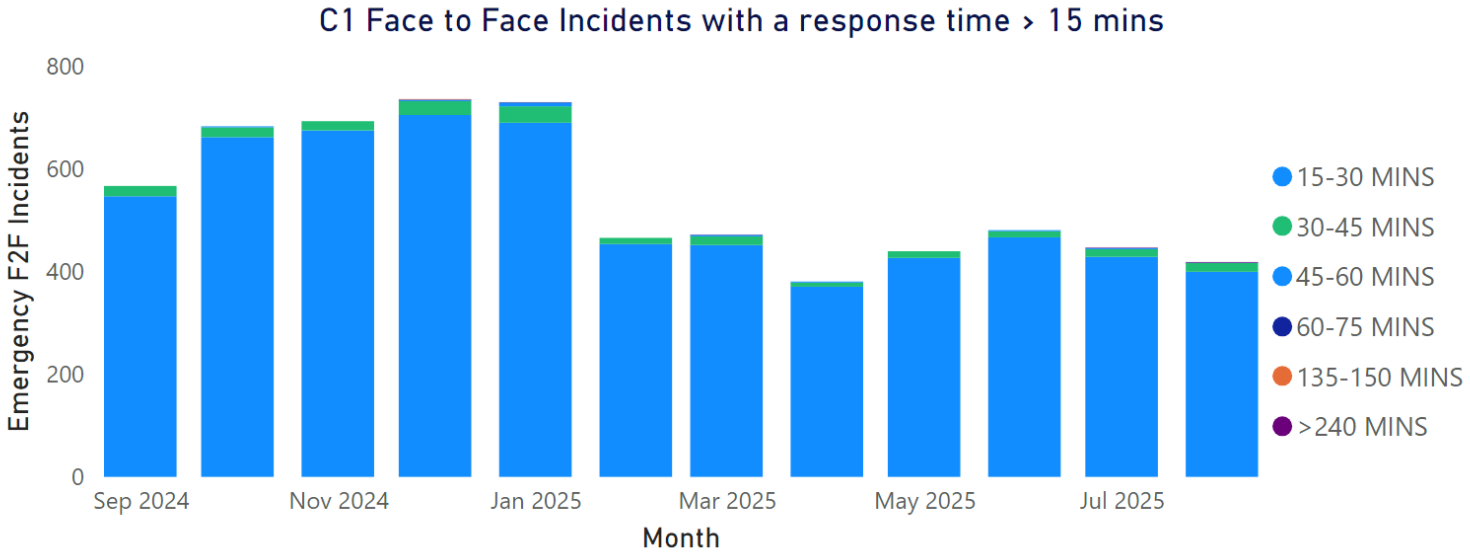
North East	02:22:33
North West	03:44:26
Yorkshire	04:08:28
London	04:34:15
South Western	04:44:28
South East Coast	04:57:02
South Central	05:11:47
East Midlands	05:35:07
East Of England	05:36:26
West Midlands	05:43:30
Isle Of Wight	05:52:42

Summary:

The Trust remained third in the national rankings for C1 and C2 performance.

For lower acuity incidents, the Trust remained 5th for C3 performance and 2nd for C4 90th.

O3 Long Waits C1



Month Year	Total No. of C1 Long Waits
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
Jul 2025	446
Aug 2025	418

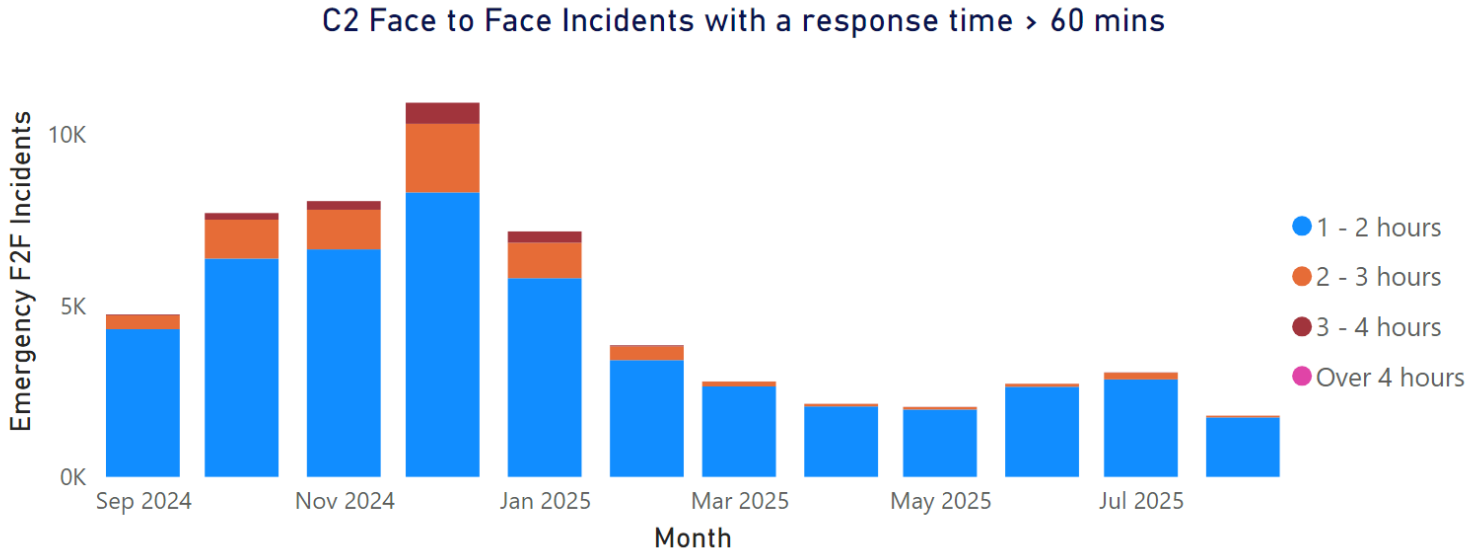
Summary:

In August 2025, the number of C1 long-wait incidents was 418. This is the second lowest number of incidents reported in the entire period shown and is 43% lower than the peak in December 2024.

Action:

Opportunities for improvement continue to be explored via the C1 improvement workstream which reports into the Service Delivery Operational Performance Group.

O3 Long Waits C2



Month Year	Total No. of C2 Long Waits
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
Jul 2025	3,048
Aug 2025	1,787

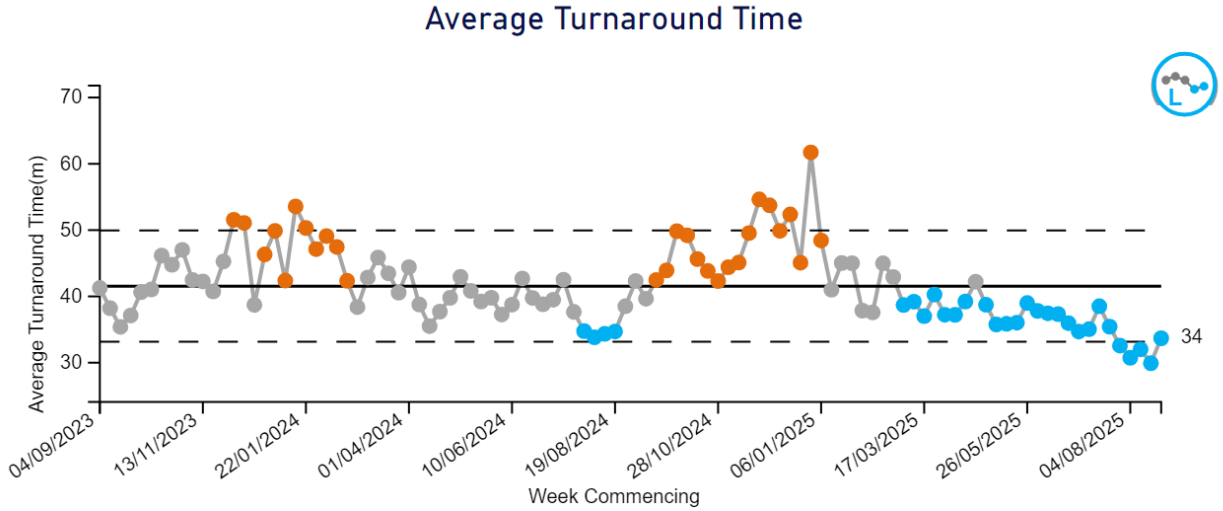
Summary:

In August 2025, the total number of C2 long-wait incidents was 1,787. This marks the lowest number of incidents reported during the entire period.

Action:

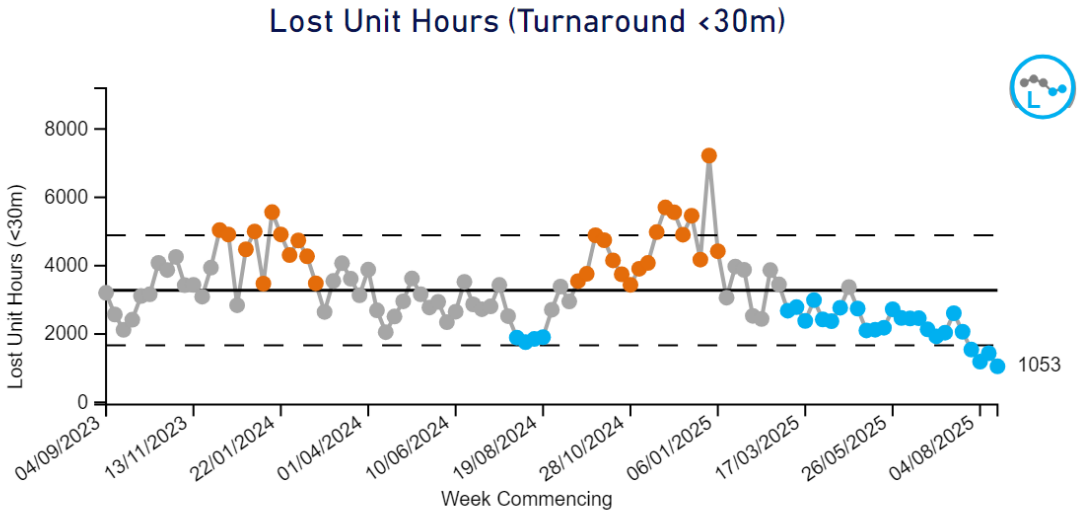
Continued monitoring by the Service Delivery Operational Performance Group.

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)
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	47,627	00:37:14	00:28:18	00:09:10
Jul 2025	48,826	00:35:38	00:26:42	00:09:07
Aug 2025	49,030	00:31:26	00:22:34	00:08:59

O3 A&E Turnaround



Month	No. of patients waiting outside A&E for handover
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
Jul-25	1114
Aug-25	645

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)
Whiston	2,415	663.99	00:43:19	00:32:45	00:10:48
Aintree University	2,366	620.21	00:41:29	00:30:41	00:11:17
Blackpool Victoria	2,644	307.99	00:32:00	00:22:52	00:09:21
Royal Oldham	1,936	306.45	00:34:18	00:25:55	00:08:23
Royal Liverpool University	2,362	283.39	00:34:27	00:23:19	00:11:18

Summary:

Hospital attendances have increased in August (49,030) compared with July (48,826).Turnaround has improved (31m:26s) however, continues to exceed the 30-minute standard.

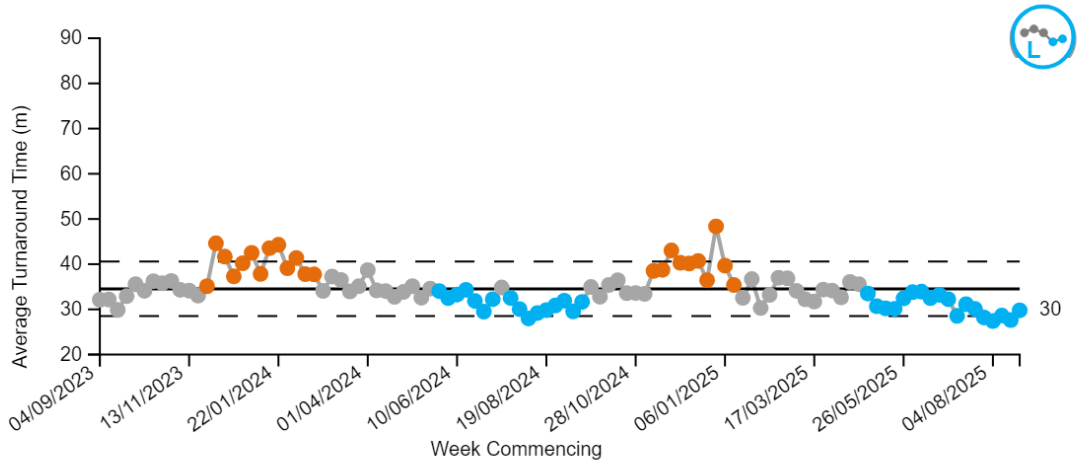
Action:

The new rapid release system (led by NHSE with ICB support) where crews initiate a rapid handover of any patient waiting over 45 minutes outside ED went live for NWAS on 1st August. It is still too early to draw conclusions from the project, particularly at this time of year where handover performance is better than average, however early indications are that there have been notable reductions in long handover waits, particularly in Cheshire and Merseyside.

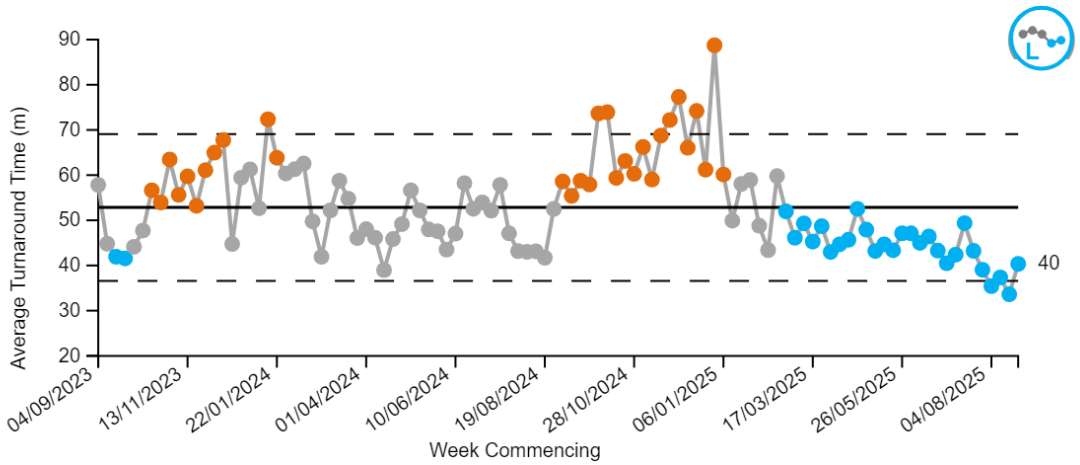
For context, the trust encountered 2,819 handovers over 45 minutes, compared to a 3-year August average of 3,553 handovers over 45 minutes.

O3 A&E Turnaround by ICB

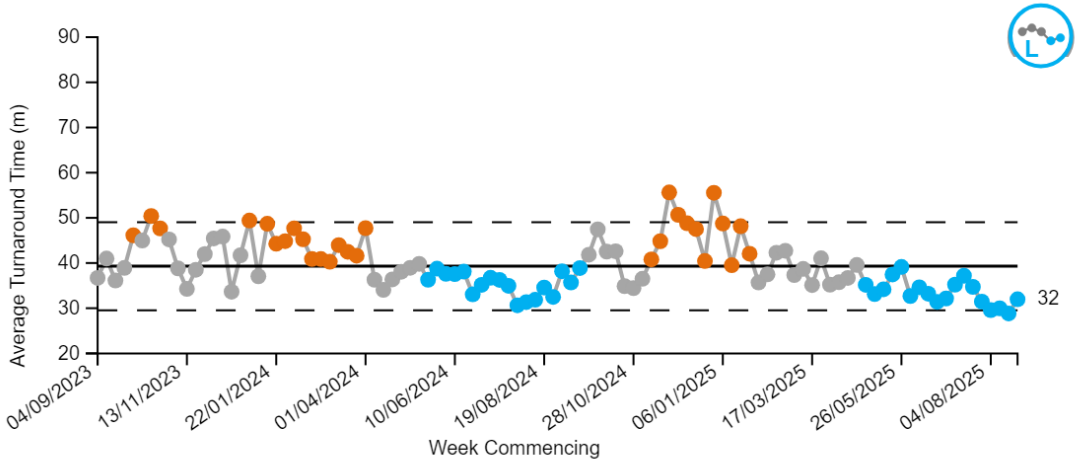
Average Turnaround Time - Greater Manchester ICB



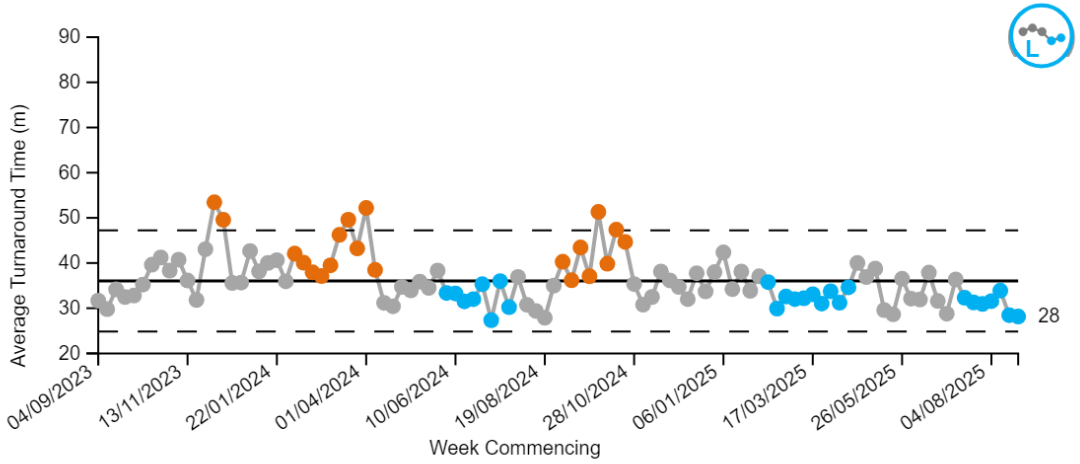
Average Turnaround Time - Cheshire & Mersey ICB



Average Turnaround Time - Lancashire & South Cumbria ICB

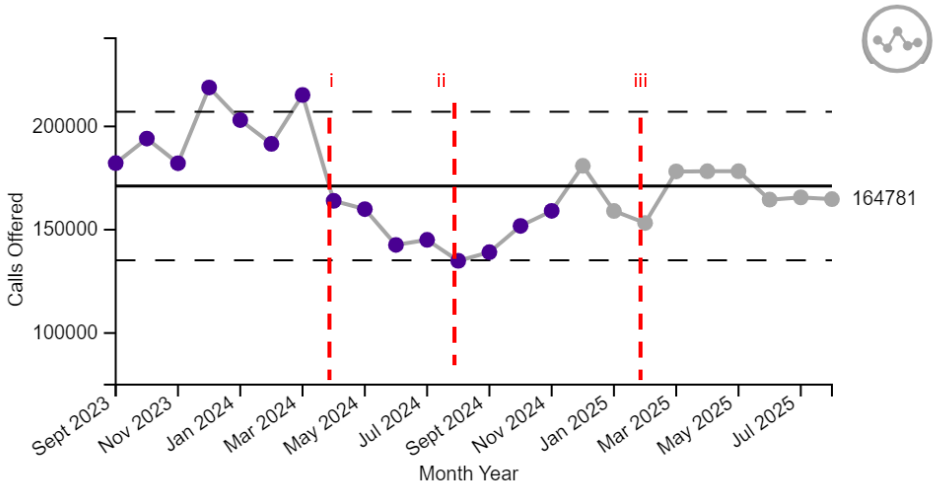


Average Turnaround Time - North East & North Cumbria ICB

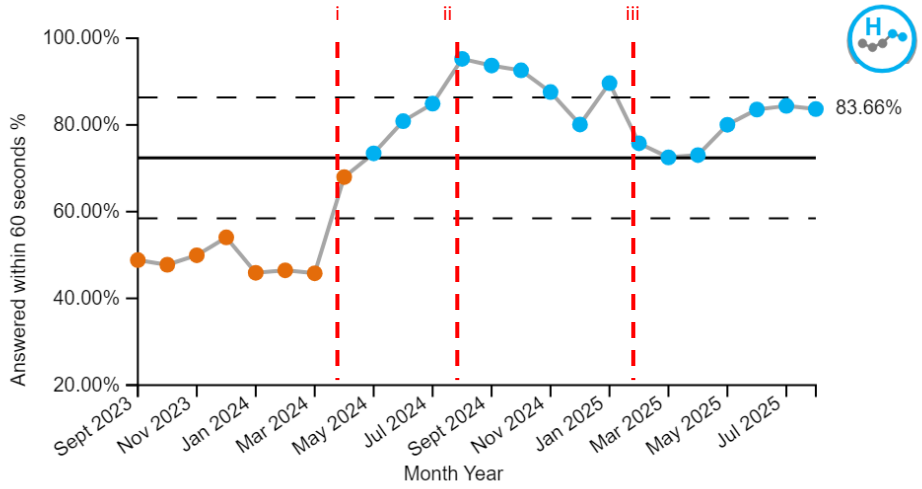


04 111 Activity & Performance

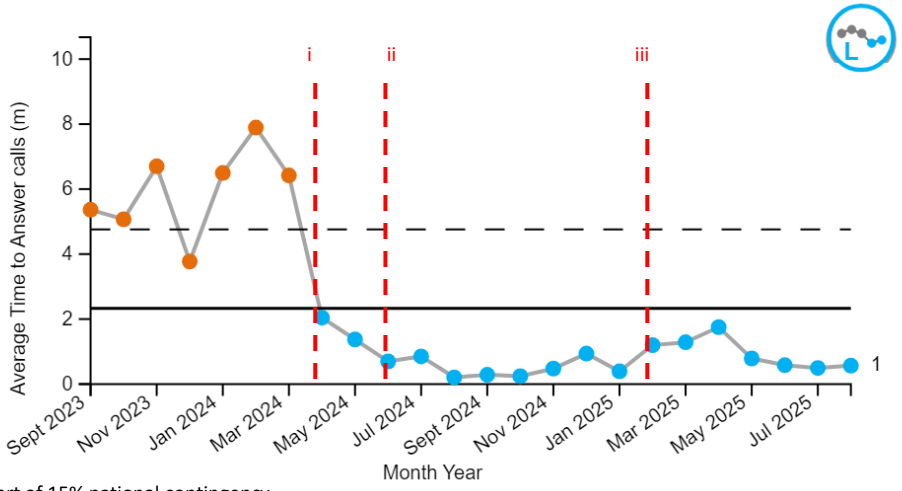
111 Calls Offered



Calls Answered within 60 seconds %



111 Average Call to Answer TIme



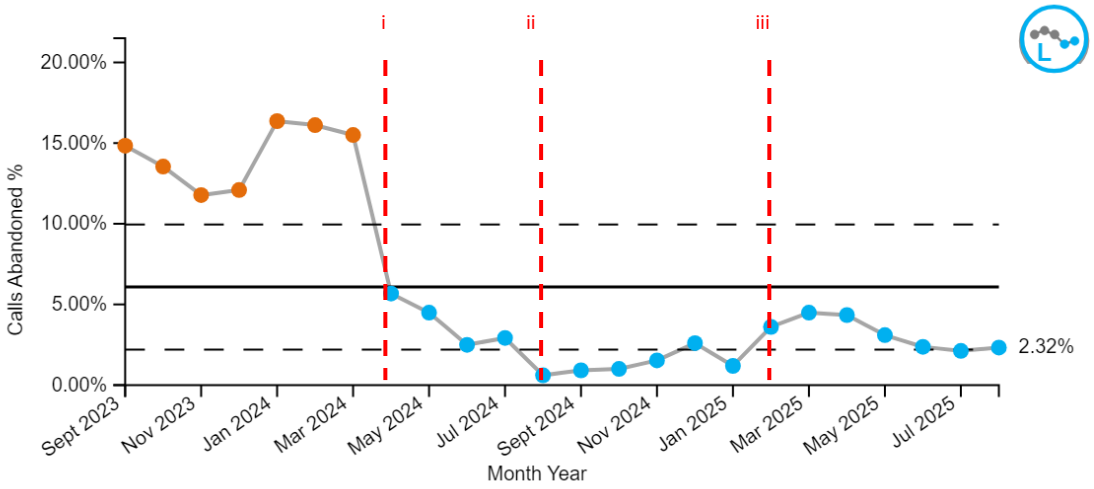
Calls Offered	
Month	164.78K
YTD	851,552

Calls Answered within 60 Seconds %	
Target	95%
Month	83.66%
YTD	80.8%
National	86.2%
Ranking	17th

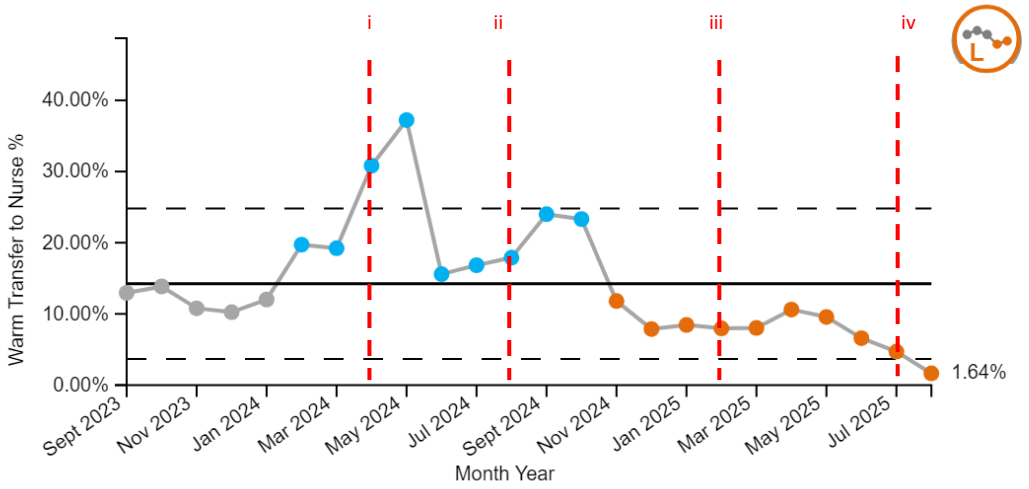
Average Call to Answer Time (s)	
Target	<20
Month	34
YTD	51
National	36
Ranking	18th

i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency

111 Calls Abandoned %



Warm Transfer to Nurse When Required %

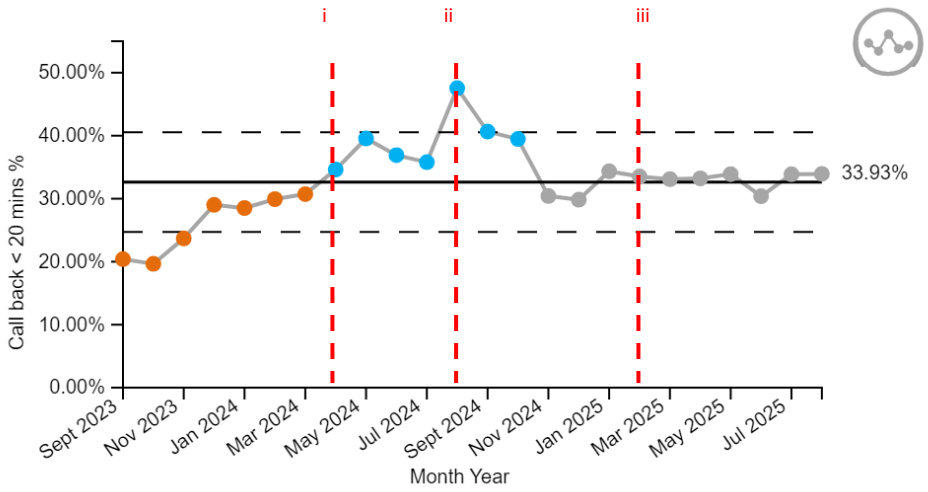


Calls Abandoned %	
Target	<5%
Month	2.32%
YTD	2.88%
National	2.4%
Ranking	16th

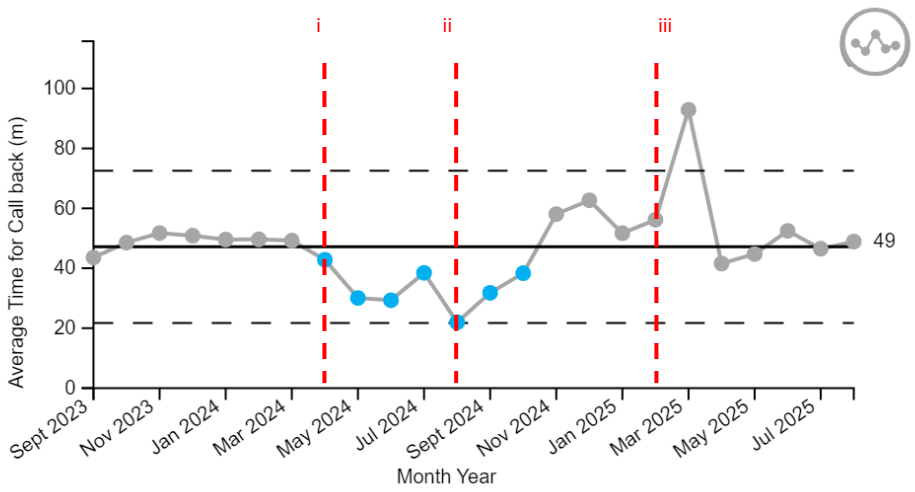
Warm Transfer %	
Target	75%
Month	1.64%
YTD	6.68%

i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency
Iv 14th July Clinicians stopped taking front end calls

111 Call back <20 Minutes %



111 Average Time for Call Back



Call Back <20 (m)	
Target	90%
Month	33.93%
YTD	33.08%

Summary: Third party support (referred to as national contingency) ceased on 14 February 2025.

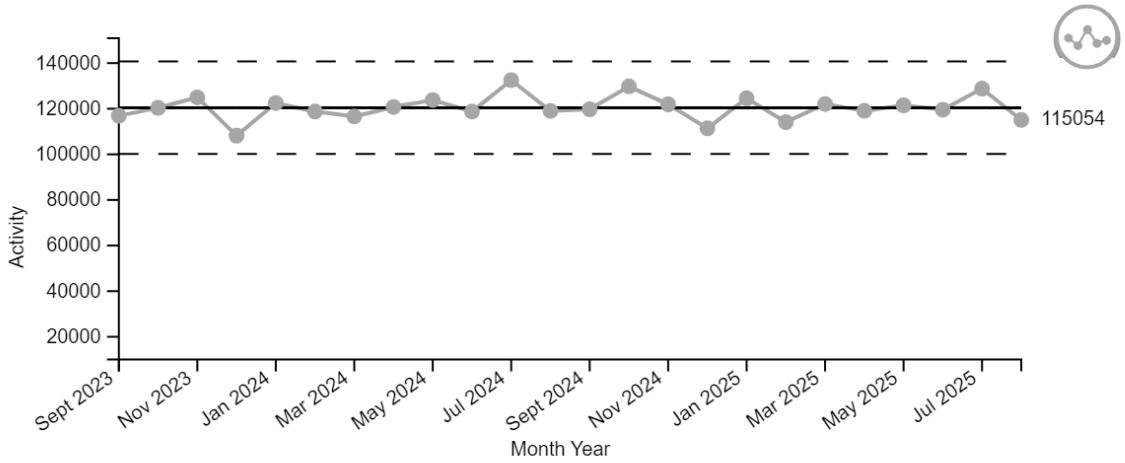
Calls answered are at 83.6%, below the national standard of 95%. Warm transfer to nurse continues its downward trend at 1.64% in August and is now below the control limit. This reduction in performance is attributed to the clinical front-ending process change.

Actions: Continued monitoring post contingency changes.

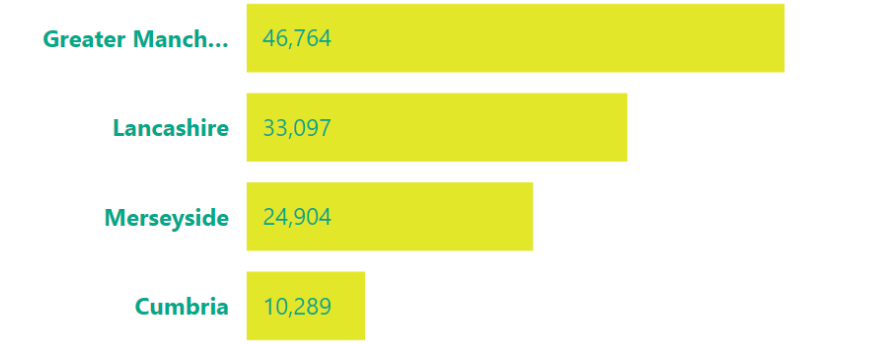
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency

05 PTS Activity

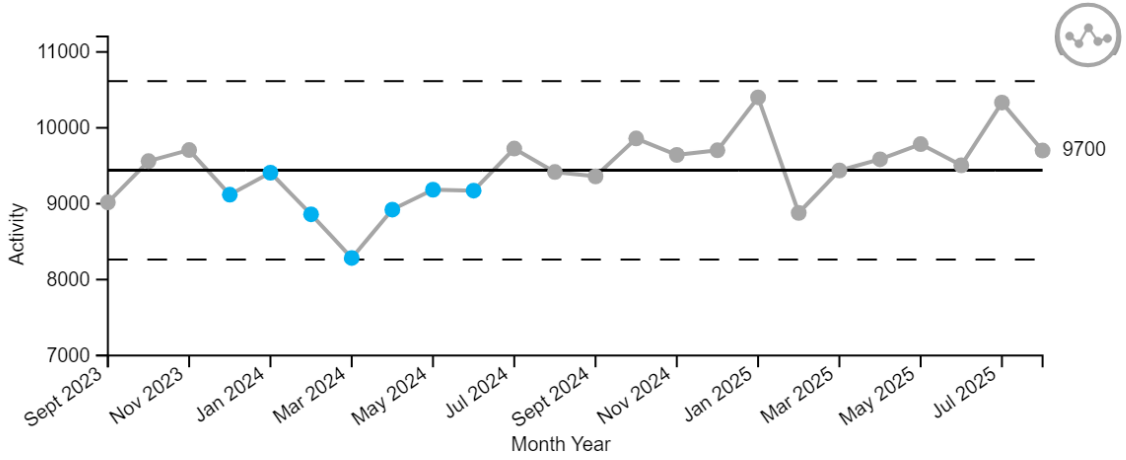
Total Activity



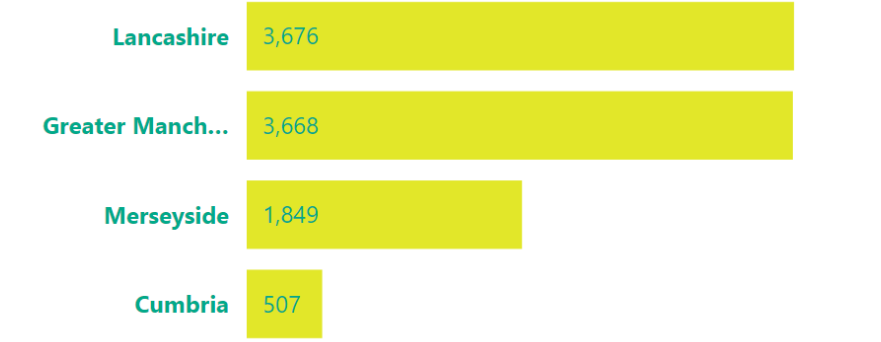
Total Activity by Contract



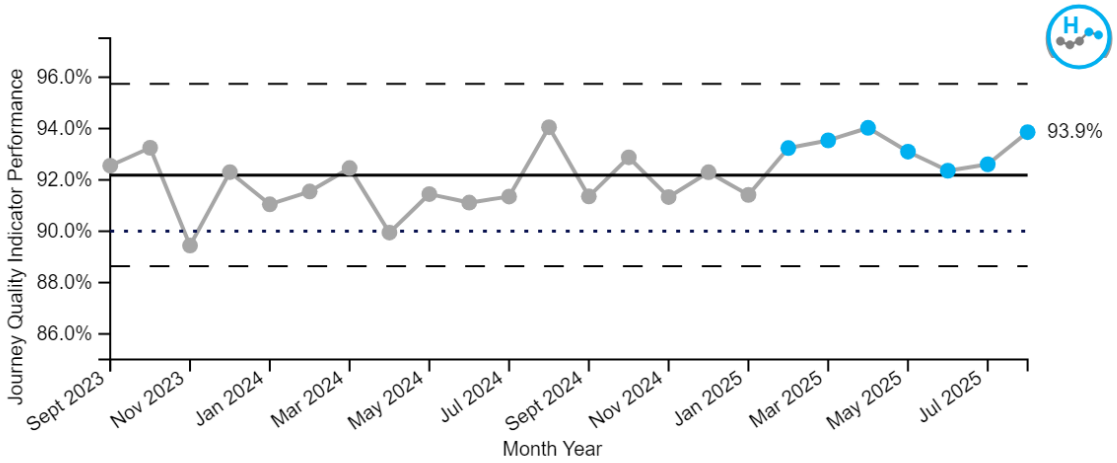
Unplanned Activity



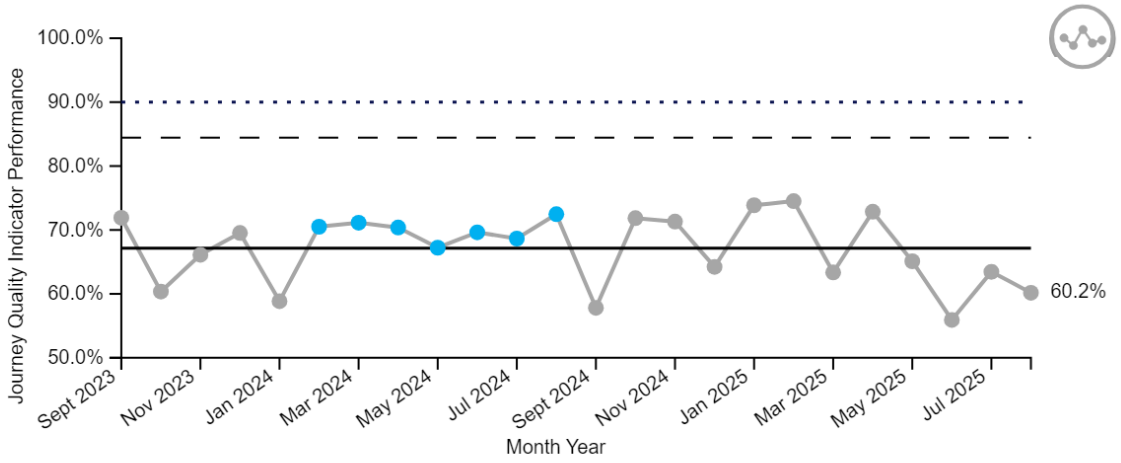
Unplanned Activity by Contract



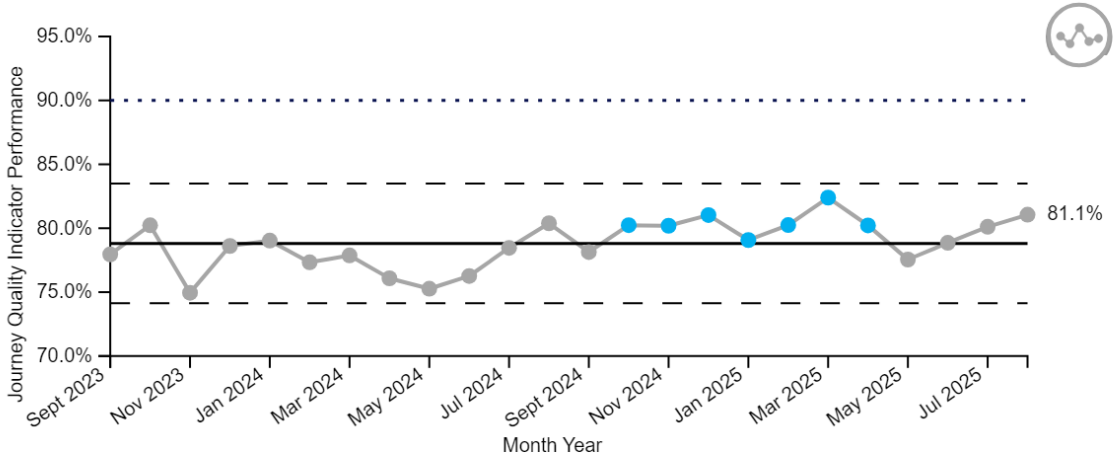
Collection after treatment (EPS) within 90 min



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.

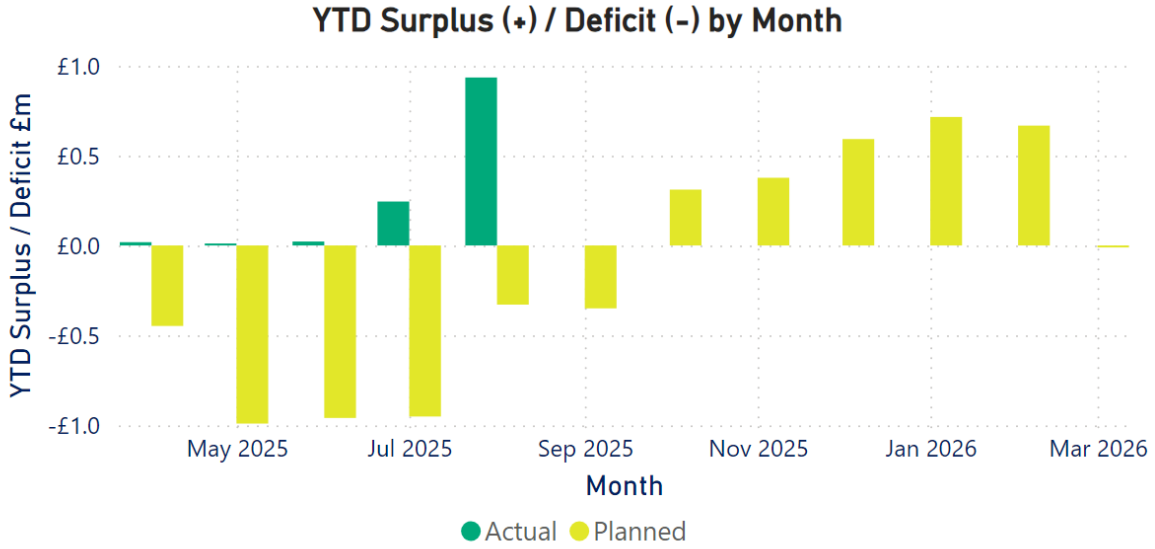
Only EPS achieved the collection after treatment target of 90%

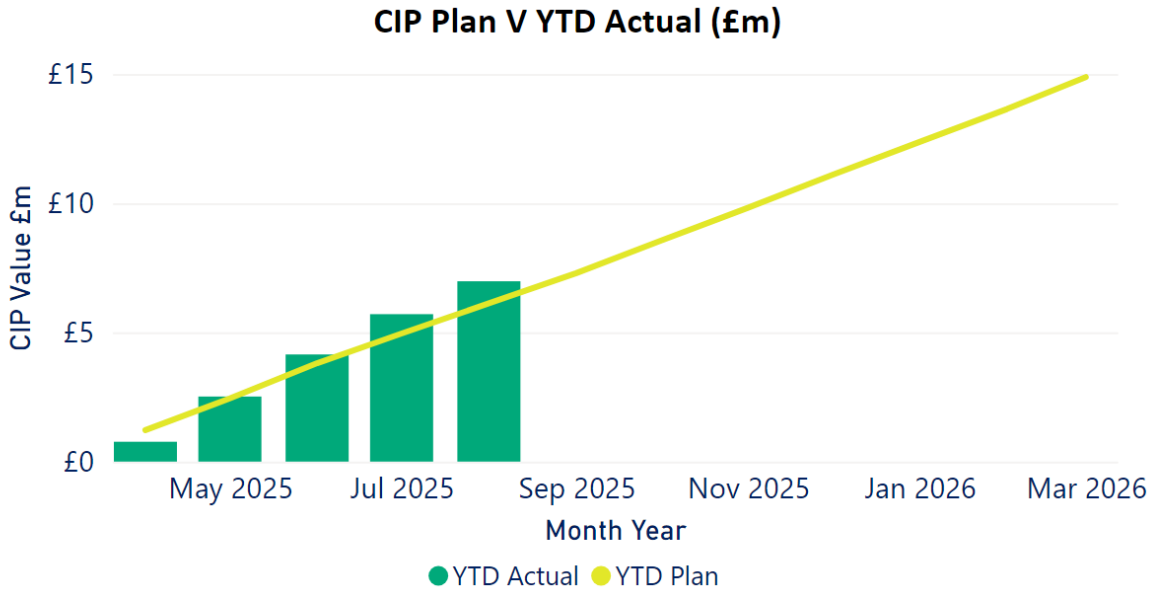
Actions: Operational and workforce improvement plans are in place

Finance

F1 Financial Score

F1 Financial Score



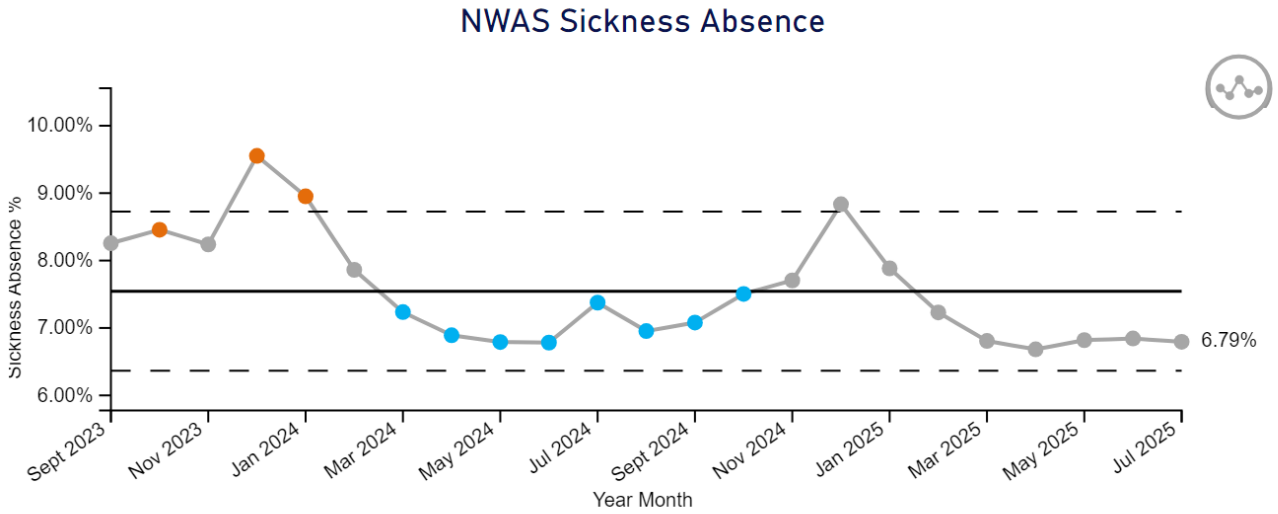


The year-to-date financial position to 31 August 2025 (Month 05 2025/26) is a surplus of £0.934m, compared to a planned deficit of £0.329m due to non-recurrent credits received and the delivery of productivity and efficiency savings slightly above plan.

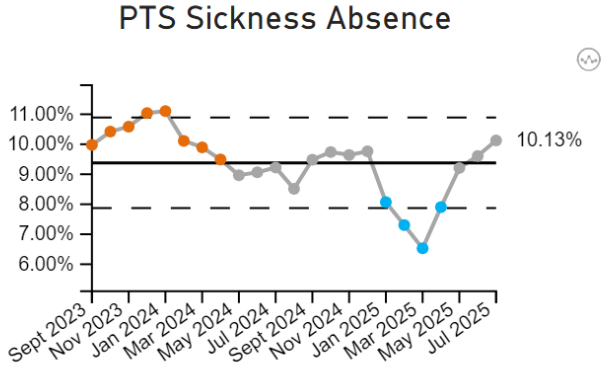
Organisational Health

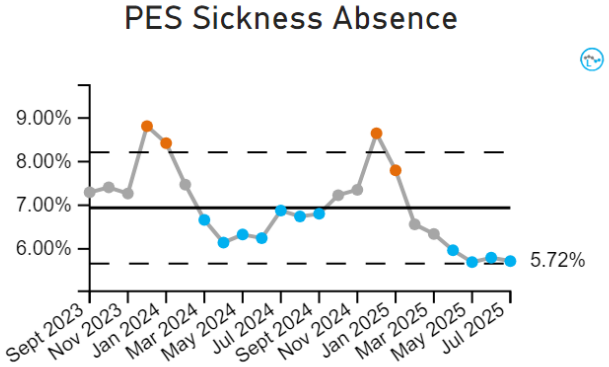
OH1 Staff Sickness
OH2 Staff Turnover
OH5 Vacancy Gap
OH6 Appraisals
OH7 Mandatory Training
OH8 Case Management

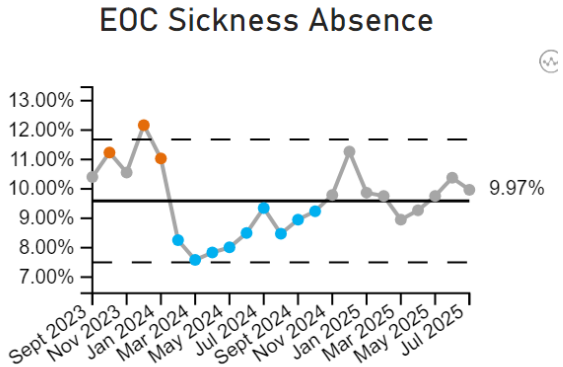
OH1 Staff Sickness

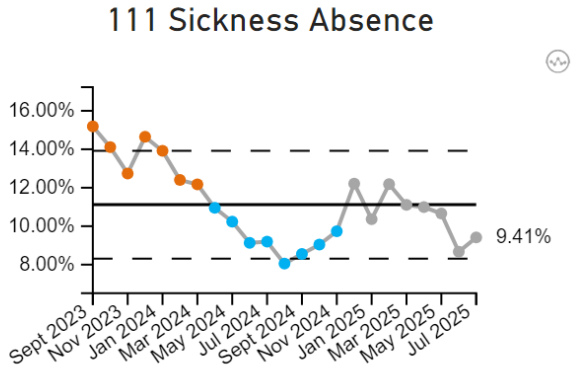


Month	NWAS	Amb. National Average
Sep 2024	7.08%	6.50%
Oct 2024	7.50%	6.80%
Nov 2024	7.71%	7.20%
Dec 2024	8.83%	8.30%
Jan 2025	7.88%	7.70%
Feb 2025	7.23%	6.90%
Mar 2025	6.81%	
Apr 2025	6.68%	
May 2025	6.82%	
Jun 2025	6.84%	
Jul 2025	6.79%	



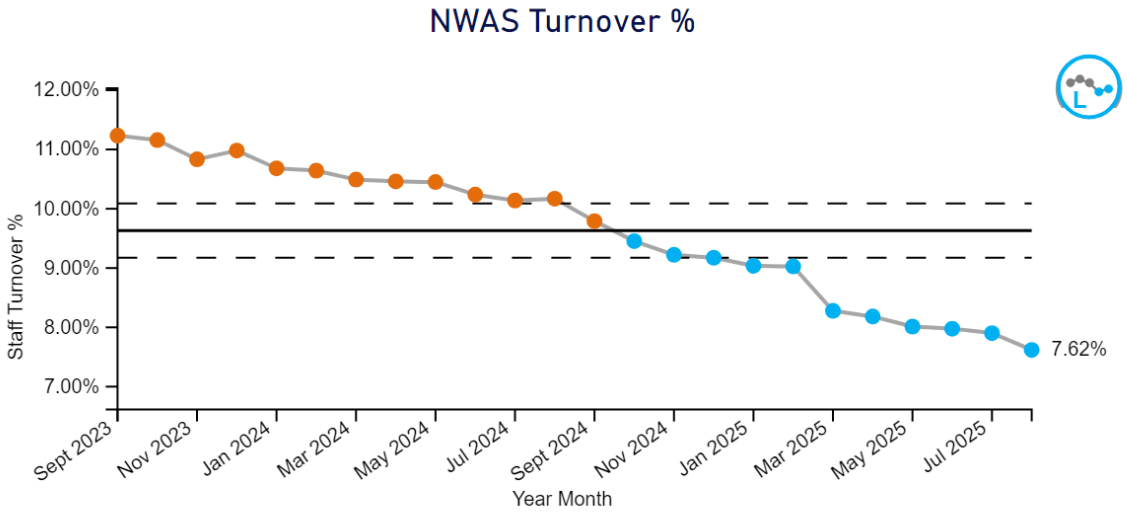




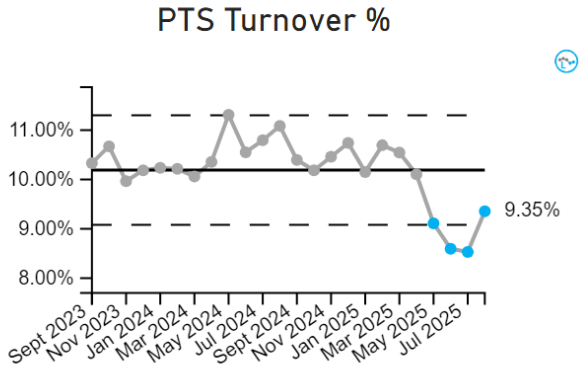


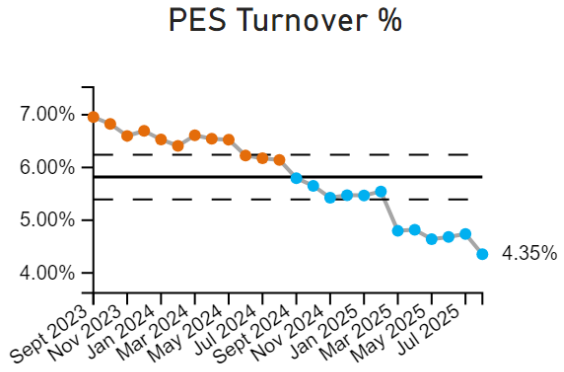
Summary: The static but stable position we saw in April and May continued into June (6.84%) and July (6.79%). July however was down quite significantly on the previous 2 years (July 2024/25: 7.38% July 2023/24: 8.33%).
Action: The 25/26 improvement target set in the operating plan is to deliver a reduction of cumulative absence of 0.65%, bringing us closer to pre-pandemic levels and we continue to closely monitor this. There is a supply issue with national data but the gap to sector average is narrowing and as trust we continue to move closer to the average.

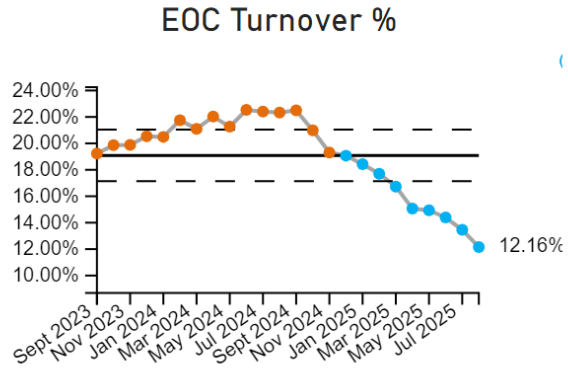
OH2 Staff Turnover

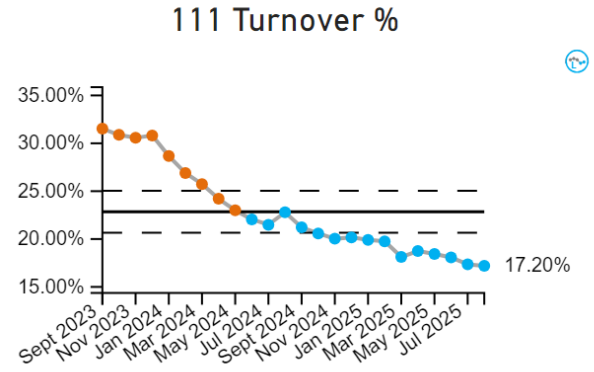


Month	NWAS	Amb. National Average
Sep 2024	9.79%	8.92%
Oct 2024	9.45%	9.03%
Nov 2024	9.22%	9.03%
Dec 2024	9.17%	8.84%
Jan 2025	9.04%	9.05%
Feb 2025	9.03%	9.15%
Mar 2025	8.28%	9.08%
Apr 2025	8.18%	9.76%
May 2025	8.01%	9.64%
Jun 2025	7.98%	
Jul 2025	7.90%	
Aug 2025	7.62%	





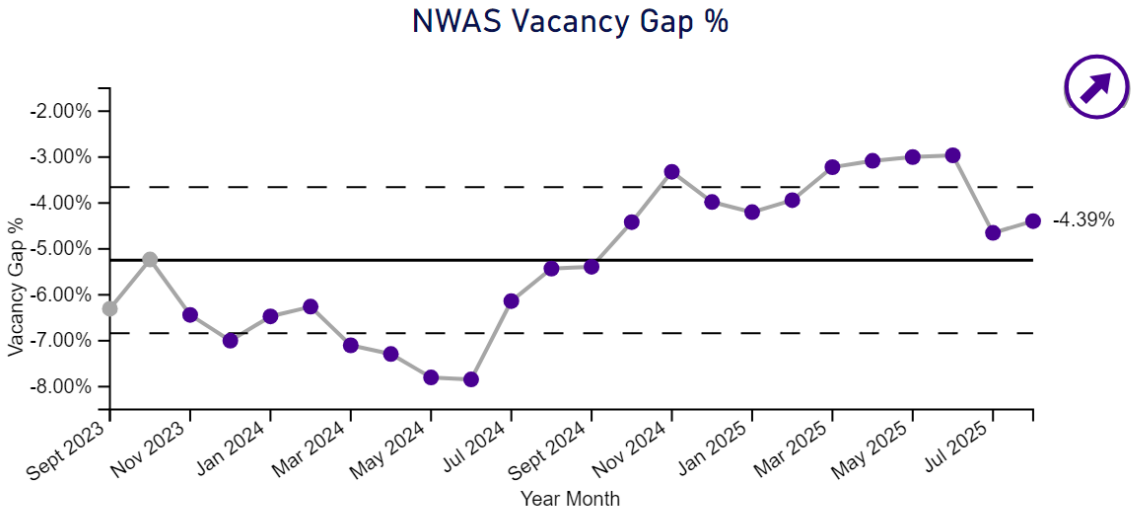




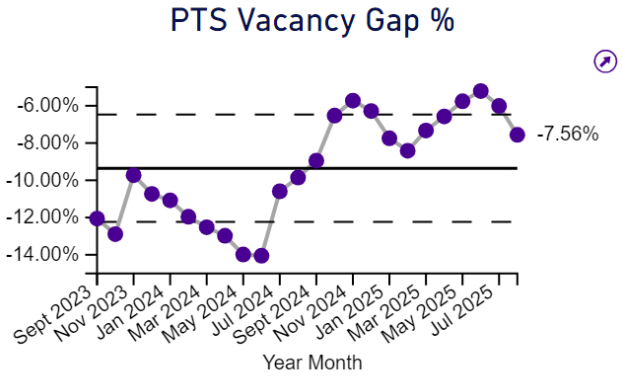
Summary: Staff turnover for August 2025 was 7.62%. This is calculated on a rolling year average. Overall, turnover has now been reducing steadily over the last 12 months. This is a 2.55% improvement over the last 12 months. It remains the case that ICC and PTS are the service lines under most pressure and are those with the lowest graded positions i.e. call handling and care assistants.

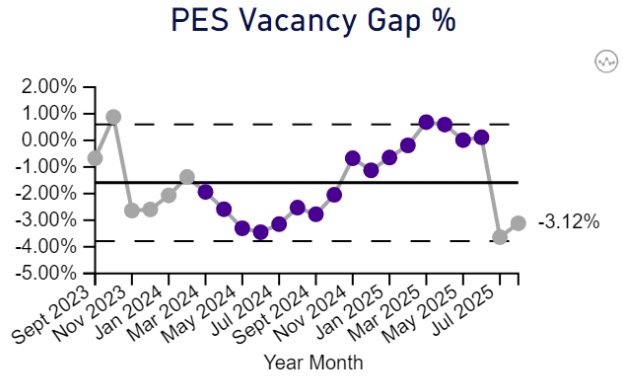
Action: Ongoing plans and actions are in place to seek to address areas with higher turnover and to improve overall retention, with a focus on flexible working along with the development of a reward and recognition framework.

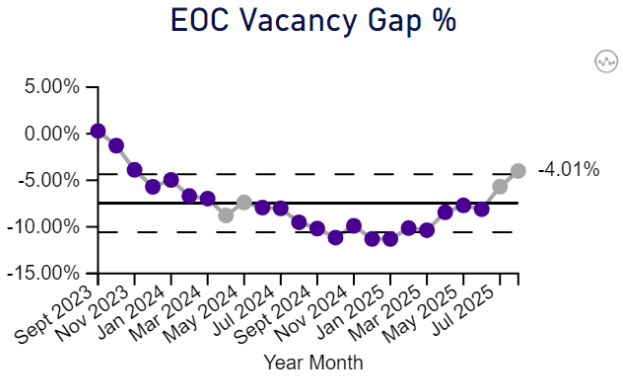
OH5 Vacancy Gap

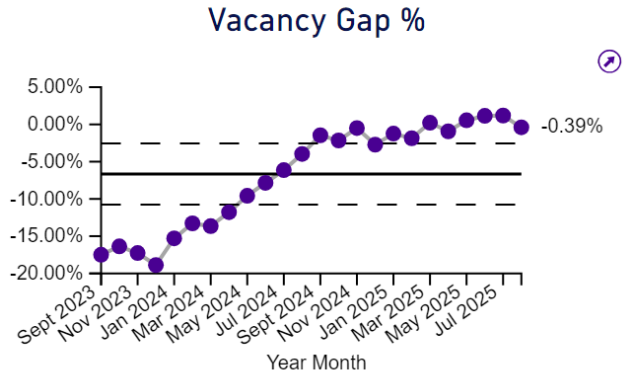


Month	NWAS Total % Vacancy Gap
Sep 2024	-5.39%
Oct 2024	-4.42%
Nov 2024	-3.32%
Dec 2024	-3.98%
Jan 2025	-4.20%
Feb 2025	-3.94%
Mar 2025	-3.22%
Apr 2025	-3.08%
May 2025	-3.00%
Jun 2025	-2.96%
Jul 2025	-4.65%
Aug 2025	-4.39%





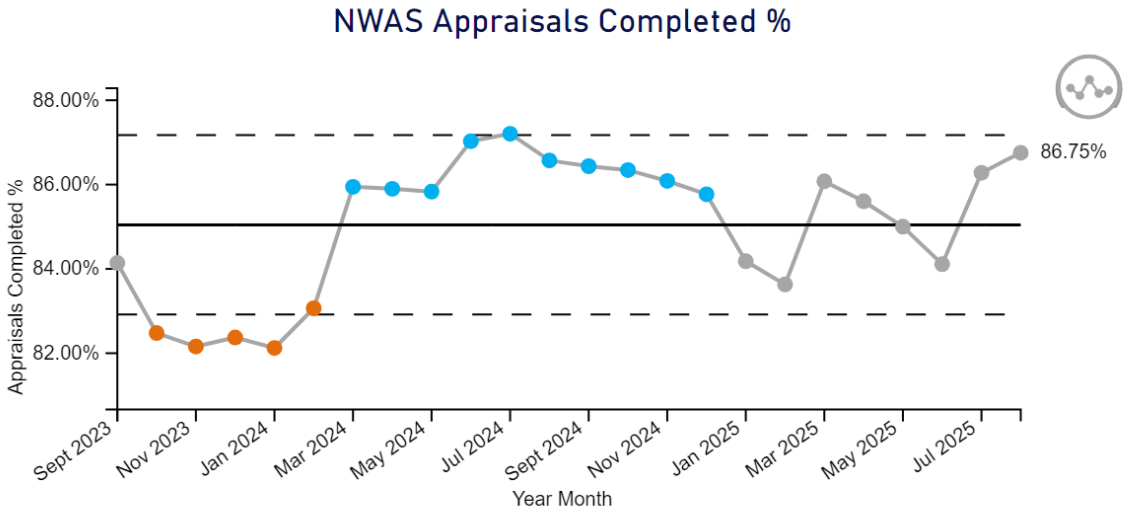




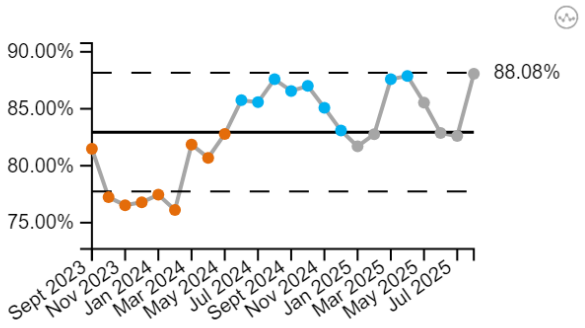
Summary: The vacancy position for the Trust is at -4.39% for August 2025 which reflects the additional growth in 149 WTE added to the establishment since June 2025, the majority of the additional UEC funding growth going into PES.
Action: Recruitment plans are in place for PES to recruit to the additional growth positions. The EOC position indicates an under-establishment of –4.00% and shows an improvement from the June position of -8.11%, reflecting recruitment to support the ongoing restructure. PES show a slight under establishment of -3.12% which reflects additional growth that has been added to the establishment in July 2025. There is an under establishment within EMT1's balanced by an over establishment of Paramedics. The PTS vacancy position shows a vacancy gap to –7.56% which is a significant decrease from -9.85% in August 2024. Whilst the position is an improvement, work continues to ensure the gap is reduced. This position is mitigated by robust bank arrangements.

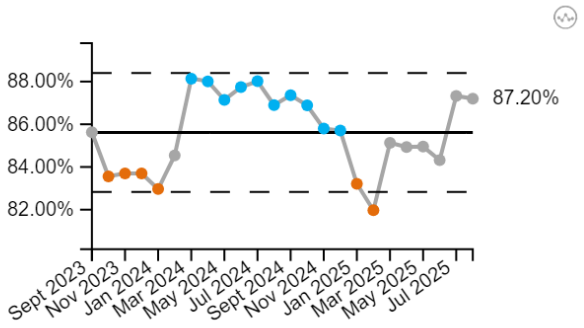
BAF ID SR04

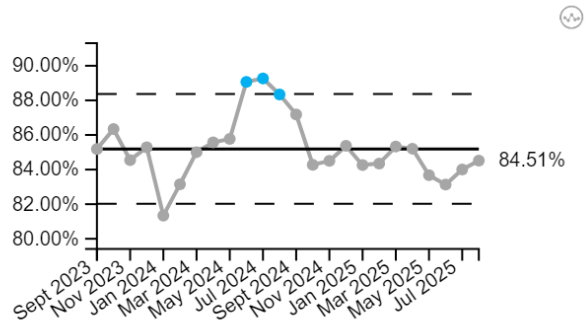
OH6 Appraisals

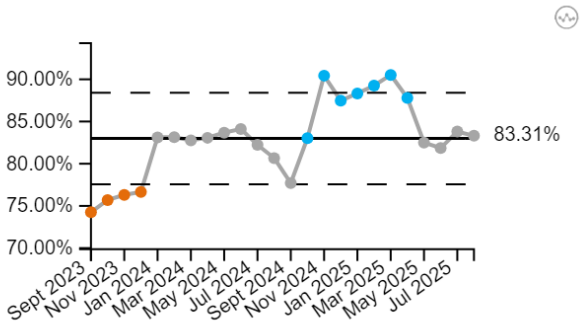


Month	NWAS Total % Complete Appraisals
Sep 2024	86.44%
Oct 2024	86.34%
Nov 2024	86.09%
Dec 2024	85.77%
Jan 2025	84.18%
Feb 2025	83.63%
Mar 2025	86.08%
Apr 2025	85.60%
May 2025	85.00%
Jun 2025	84.11%
Jul 2025	86.28%
Aug 2025	86.75%





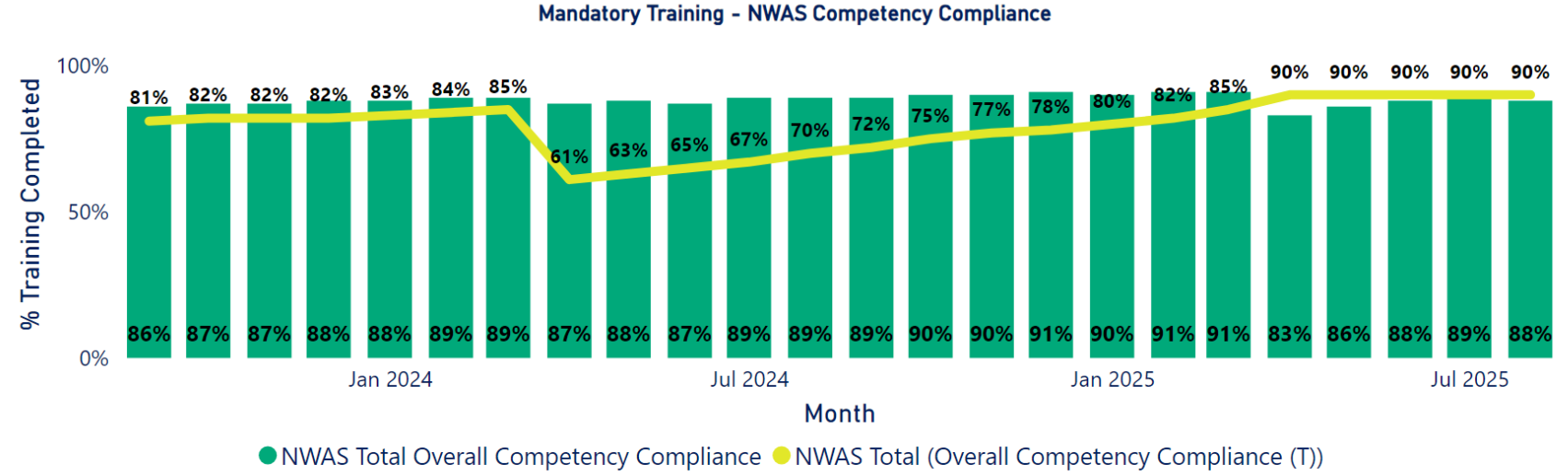


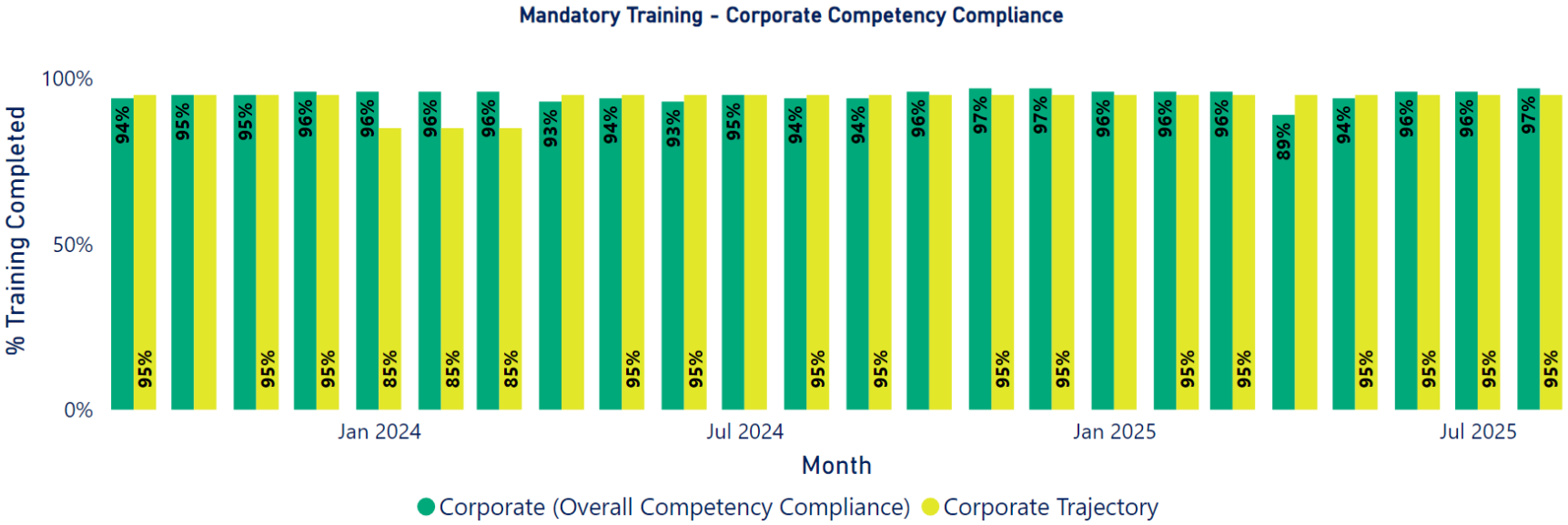


Summary: Appraisal compliance is above the 85% target at 87%. All service lines are currently at or above target apart from 111 who are at 83%.

Action: Continued focus on compliance and online platform for recording appraisals being rolled out across the Trust. Additional support put in place for new leaders following leadership review.

OH7 Mandatory Training





Summary:
NWAS overall compliance is 88% which is slightly behind the revised 90% target but data is showing month by month improvement. This represents a combination of face to face and online completions.

Additional modules have been added to ESR which has impacted on compliance in Q2 however the position is expected to recover in year.

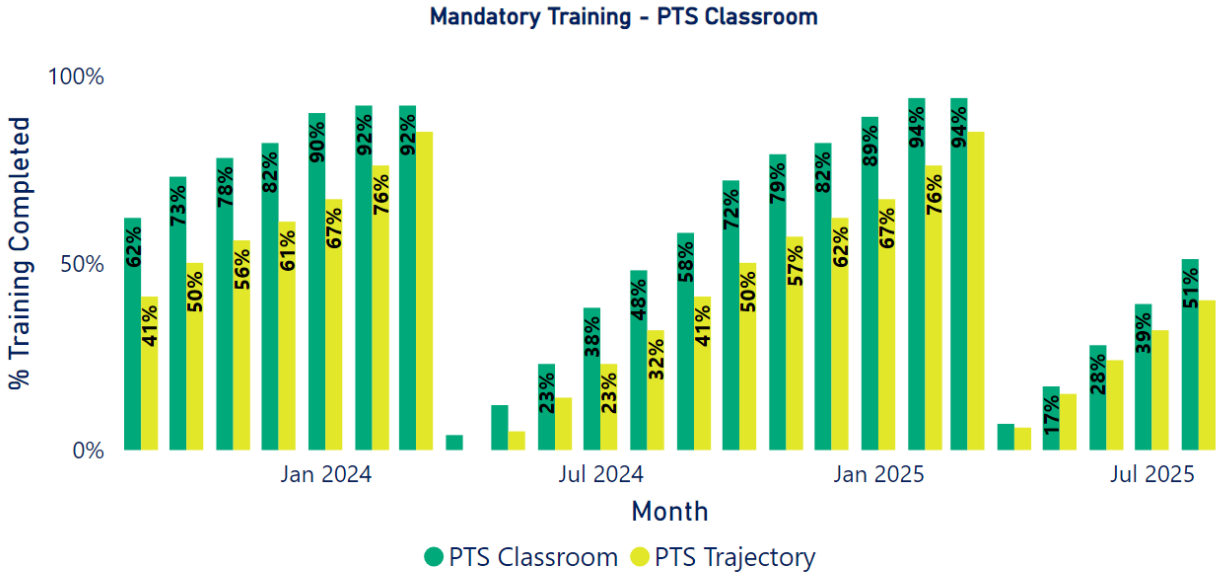
PTS classroom training is ahead of trajectory. PES are on target.

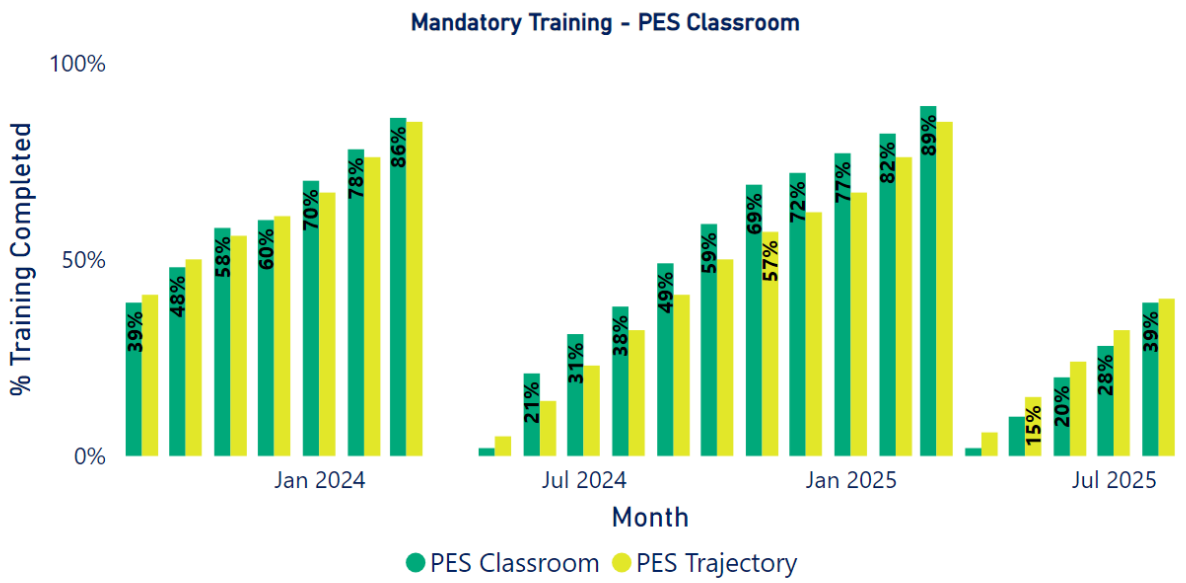
Corporate teams are now ahead of trajectory at 96%.

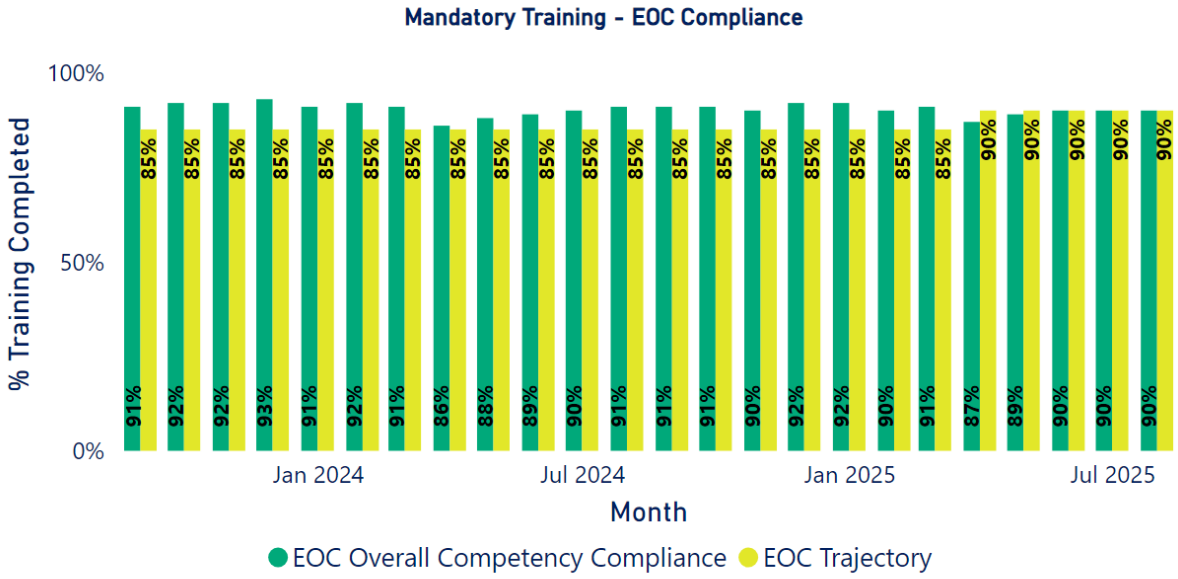
Action:
Service lines to continue profiling of classroom training to maintain the position and completion of new mandated modules.

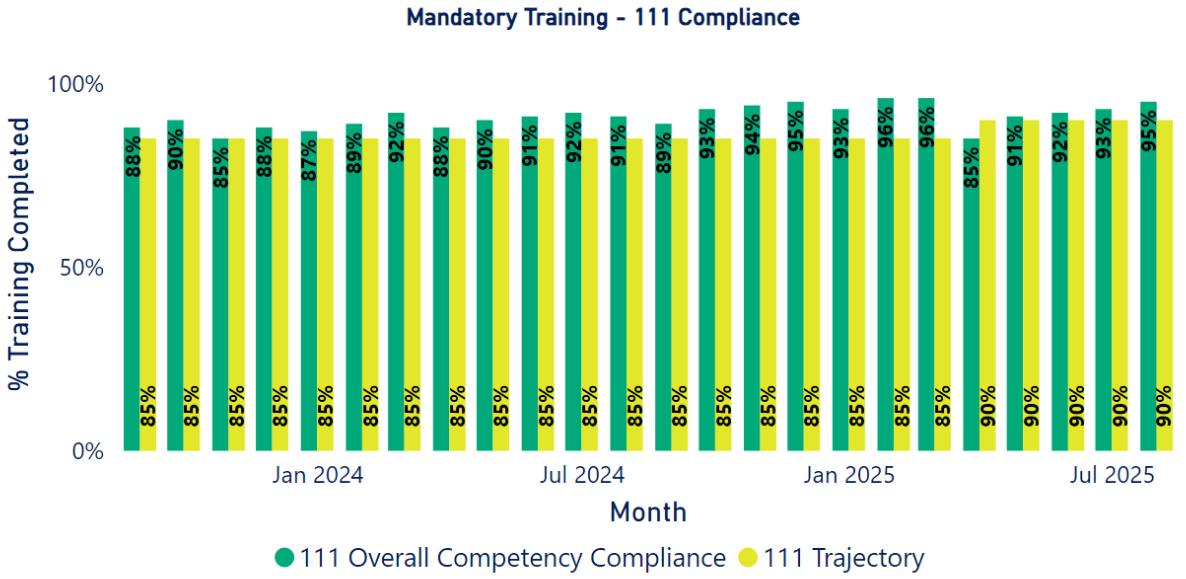
BAF ID SR05 Risk Rating NA Strategy Goal NA

OH7 Mandatory Training









BAF ID SR05 Risk Rating NA Strategy Goal NA

OH8 Case Management

Board Reportable Events relating to Employee Relations September 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	66.00	1.6	274.00	6.7	13.94
CAM PES	30.00	2.1	90.00	6.4	12.58
CAL PES	19.00	1.5	98.00	7.7	13.15
GM PES	17.00	1.2	79.00	5.6	15.50
Operations ~ EOC	15.00	1.3	75.00	6.6	9.37
Operations ~ 111	11.00	1.6	84.00	12.1	6.77
Operations ~ PTS	14.00	1.9	76.00	8.6	8.98
Operations ~ Resilienc	1.00	0.7	4.00	2.8	9.50
Corporate	3.00	0.4	15.00	1.9	11.53
Other	0.00		0.00		
NWAS Summary	114.00	1.5	547.00	7.0	11.15

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	14	59	12.54
Disciplinary	57	176	20.46
Fast Track	2	52	10.8
Fact Finding	24	183	4.99
Grievance	19	129	6.57
Case Summary	114	547	11.15

Case Dismissals in August 2025

Service Line	Case Type	Case Sub Type	Case Closed Date
PTS	ABS LTS	Non work related	02/07/25
PES GM	ABS LTS	Non work related	09/07/25
111	Disciplinary	Gross misconduct	28/07/25
111	Disciplinary	Gross misconduct	15/07/25
EOC	Disciplinary	Gross misconduct	25/07/25

Length of current live cases by case type

Case Type	less than 3 months	more than 3 months	more than 6 months	more than 12 months
Dignity at Work	7	4	2	0
Disciplinary	23	22	9	3
Fact Finding	18	2	1	0
Grievance	11	5	3	0
Case Total	59	33	15	3

New Litigation cases in August 2025

Service Line	Case Type	Case Sub Type	Information Category	Received Date

No New litigation cases in August

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
7	3

Summary:
Current levels of suspensions (7) reflects the overall reduction in live cases which have seen a drop to 114 live cases from a high of 150. Five staff dismissed in August: two capability (heath) and three for conduct.

Action:
Continued focus on maintaining timeliness of casework. Investment in additional resources focussed on quality improvement across the process for 25/26. Continued focus on sexual safety which should be noted may mean continuing high caseload across the year.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 September 2025
SUBJECT	Learning from Deaths summary report and dashboard Q4 2024/25
PRESENTED BY	Dr Chris Grant – Medical Director
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: • Support the quarterly dashboard (Appendix A) as the report to be published on the trust public account as evidence of the trust's full engagement with learning from deaths. • Acknowledge the impact of the Structured Judgement Review (SJR) process in identifying opportunities for improving care. • Support the dissemination process as described in Section 4
EXECUTIVE SUMMARY	The trust is required to publish on its public accounts a quarterly and then an annual summary of learning from deaths. The Q4 dashboard (Appendix A) describes the opportunities to learn from deaths. The main concerns raised internally and externally identified in DatixCloudIQ (DCIQ), were attributed to problems in Integrated Contact Centre and our Paramedic Emergency Service, specifically around delayed emergency response and care and treatment delivered. Of the concerns closed, there was one (SJR) incident where causal factors were identified by the investigator. The annual dashboard for 24/25 requires publication (Appendix B). The peer review process now encompasses ICCs and as a result the trust is fully compliant with the national framework. The key areas for

	improvement reflect similar themes from the previous quarter. This includes ensuring a correct patient disposition, including more detail in a patient assessment and ensuring calls are triaged correctly using NHS Pathways. The quality of patient records has dropped this quarter, with 23% receiving a "poor" or "very poor" rating, compared to 8% in the previous quarter. This figure shows a slight decline from the previous quarter but is still an improvement throughout the rest of the year. There were three patient records that received a "good" rating for quality, which is a slight decrease from seven in the previous quarter. The panel continues to welcome observers to help raise awareness of the project and embed learning from the peer reviews. The learning from deaths programme has faced some challenges over this quarter which have affected the number of cases reviewed, and therefore reduced the number reported on in this paper. The introduction of PSIRF to the trust along with changes made to the way incidents are raised in DCIQ has potentially resulted in fewer DCIQ concerns falling under the Learning from Deaths framework. This is under review to further investigate and resolve. There have also been challenges seen with the availability of panel members due to the organisational re-structure process. Now that the PES element of this process is complete, availability of clinical colleagues will improve. The panel members from ICC teams have been and continue to be affected by the ICC element of the re-structure process, and this has resulted in fewer cases being able to be presented at the panels. This will also be resolved post implementation of restructure.	
PREVIOUSLY CONSIDERED BY	Quality & Performance Committee	
	Date	Monday, 01 September 2025
	Outcome	

1. PURPOSE

1.1 The purpose of this report is to meet the requirements of the 'National guidance for ambulance trusts on Learning from Deaths: A framework for NHS ambulance trusts in England on identifying, reporting, reviewing and learning from deaths in care' as referenced in the trust Learning from Deaths policy.

Appendix A is a summary dashboard of the Q4 2024/25 learning from deaths review, and it is proposed this document is published on the trust's public accounts by 30 September 2025 in accordance with the national framework and trust policy. The dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q4. Learning from the panels is discussed later in this paper.

Appendix B is the annual dashboard which also requires publication.

2. BACKGROUND

2.1 Learning from deaths is an integral part of informing and developing the safest possible systems for the delivery of care to our patients. NWAS must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the clinical audit team at Learning.FromDeaths@nwas.nhs.uk.

3. LEARNING FROM DEATHS COHORT SUMMARY

3.1 The number of patients whose deaths were identified as in scope for review was 84 (55 concerns raised in Datix and 29 sampled for SJR).

3.2 Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 02/04/2025. Please note that due to the complexity, the granular updates for the previous quarters will be received within other patient safety reports and the thematic analysis will be captured within the annual learning from deaths report.

The breakdown of concerns raised:

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

3.2.1 Internal Concerns

Of the 35 internal concerns, 15 were reviewed and closed. There was one cases in which the investigation concluded the trust had contributed in some way to that patient death.

3.2.2 External Concerns

Of the 18 external concerns, 9 are still in the early stages of review and so it is unknown at the time of writing if the care given was in line with best practice. 9 concerns have been closed with no causal factors identified.

3.2.3 Concerns raised internally and externally

Of the 2 concerns raised internally and externally, both are still being investigated, and therefore it is unknown whether the trust had contributed towards the death.

3.2.4 Outcomes from concerns raised

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

3.3 SJR Stage 1 Outcomes

26 patient deaths were presented by reviewers and following the moderation panels the outcomes of the reviews were determined as described in the dashboard (Appendix A). There were 3 cases not presented at panel in this quarter due to the clinical lead being unable to attend the panel.

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

3.3.1 SJR Stage 2 Outcomes

Nine cases were identified as needing second stage review following stage 1. The second stage review concluded that two deaths were not avoidable, and five cases were uncertain whether poor practice had led to harm. Two cases concluded that poor practice led to harm. The care experienced by these patients in terms of patient assessment and management plan were below expected levels.

The Learning from Deaths team have recently implemented a new process within the stage 2 reviews. It has been agreed with the PSIRF team that any cases in which harm may have been caused by the trust, the case will be referred to them for a review within the PSIRF priorities. This process was implemented in early February 2025, and we are still working through this process to ensure we are sufficiently following up on any themes that may be suitable for the PSIRF process.

Within Q4, we have also ensured that any information that would be beneficial to the crew that attended the incident is fed back. This looks at both areas for improvement, and examples of good practice. This feedback is given via the Sector Clinical Leads, to ensure that they can see what is happening within incidents in their Sector.

We are continuing to ensure that Duty of Candour is considered in all cases that the panel deem appropriate, particularly with any cases that have a stage 2 outcome. We ensure that we link in any operational staff that are required for these reviews, as well as the Patient Safety Learning Team for their oversight.

3.3.2 SJR & Concerns Learning Themes

Detailed learning themes for concerns and SJRs can be found in the dashboard (Appendix A) and the Infographic (Appendix C). A summary of the themes which identified areas for improvement includes:

ICC:

- Insufficient probing around patients breathing and level of consciousness
- Calls where the line goes silent not being handled correctly
- Incorrect coding of call

PES:

- Limited information regarding clinical assessment/examination
- No referral to AVS/GP when appropriate to do so
- No specific worsening advice documented
- MTS not used/not applied correctly
- Equipment failures reported
- Quality of EPR

Trust:

- Delays in allocation on Category 2 and Category 3 calls which exceeded expected dispatch times. It was noted this is due to demand exceeding resources available.

In this quarter there were also areas of good practice identified within the SJR review process. These include:

PES:

- Extensive patient assessment
- Involvement of patient and family in holistic conversations and decisions made in the best interest of the patient
- Patient centred decisions around frailty, co-morbidities and past medical history

3.3.3 General Areas for Improvement

Additional learning themes were also identified within the reviews that received an 'Adequate' rating. Whilst these were not necessarily 'Poor' or 'Good' themes, they were recurrently seen in reviews throughout Q4 and demonstrate where additional learning can be found, as well as highlighting more good practice. These include:

Areas for improvement:

- 12 lead ECG not completed during assessment – may have supported on scene decision making
- Frailty and pain scores not recorded within observations
- Detailed worsening advice not documented

Good practice:

- Additional management of patient's family following patient passing away
- Effective use of Clinical Hub/Critical Incident Hub for escalation and joint decision making
- Use of ultrasound during cardiac arrest to aid decision making in the best interest of the patient

4. OUTCOME OF LEARNING THEMES

A commitment to disseminating and promoting good practice has been made by the clinical leadership team through the regional and local area learning forums (ALFs) and individual frontline staff. The Q4 Learning from Deaths infographic (Appendix C) will be shared with the clinical leadership team.

The opportunities for improvement identified as general themes from the Datix review and more specifically from the SJR review will be taken to ALFs.

We continue to welcome observers to our panels from all departments of the trust. We have recently had observers from ICCs, corporate teams and operational staff, and feedback from observers has continued to be positive.

Observers have noted that the SJR reviewers showed knowledge and professionalism whilst trying to recognise good practice and provide constructive criticism. They also noted the importance of writing a clear and detailed EPR and stated that they would take that into their own practice going forward. It was also noted that there were rich discussions where everyone is welcome to state their opinion to ensure we had covered all aspects of the case.

5 NATIONAL GUIDANCE DEVELOPMENT

A review of the 2019 national Learning from Deaths (LfD) guidance has been carried out by the National Ambulance Service Learning from Deaths Task and Finish Group, on behalf of NASLfD group. This review aimed to address variation in processes identified in the national benchmarking paper. NWAS has actively contributed to these national discussions.

A proposal and technical specification have been circulated to NASLfD members for consultation, with final approval required from QIARD (Quality Improvement and Risk Directors) and NASMed (National Ambulance Service Medical Directors Group).

Key proposed changes:

- Exclusions:
  - Patients in cardiac arrest at time of the 999 call
  - Cases with obvious death descriptors during the call
  - Deaths under investigation
- All category 1 and category 2 responses (**change**)
- System delays do not contribute to the low scores

- Deaths after handover – clarification needed on definition, as some trusts include discharges on scene in the handover phase (**slight change** – this is captured within the on-scene phase)
- End of life care deaths (**change**)
- The overall care score should take all aspects into consideration and should be based on the 'whole picture' of care. It is not an 'average' of all the care scores, and it is not necessarily dependent on either one or more phases reaching a 'Very Poor' rating (**change**)
- The second stage reviewer is a more senior clinician than the first stage reviewer (Chair of the moderation panels is senior to sector clinical leads).

6. RISK CONSIDERATION

There are no legal implications associated with content of this report and the data gathered to produce the dashboard has been managed in accordance with the Data Protection Act 2018.

7. EQUALITY/ SUSTAINABILITY IMPACTS

No equality or sustainability implications have been raised as a concern from this report.

8. ACTION REQUIRED

The Board of Directors is asked to:

- Support the quarterly dashboard (Appendix A) as the report to be published on the trust public account as evidence of the trust's full engagement with learning from deaths.
- Acknowledge the impact of the Structured Judgement Review (SJR) process in identifying opportunities for improving care.
- Support the dissemination process as described in Section 4

NWAS Learning from Deaths Dashboard Q4 24/25

Overall Dashboard Description: This is a systematic dashboard that is a combination of those outlined in the guidance as 'must review' and those in the specified sample. These are described in more detail in the data-splits below.

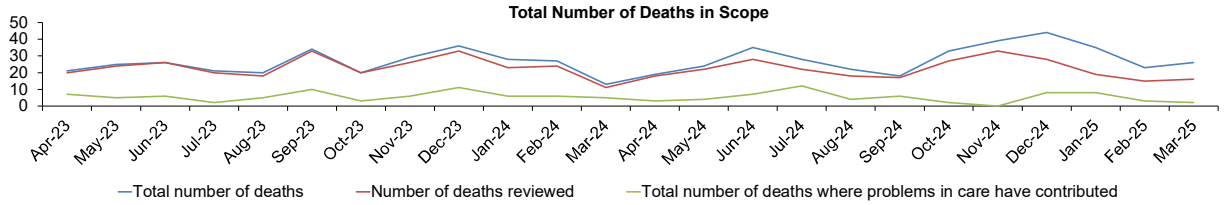


Figure 1

Concerns Raised in DCIQ

Internal Concerns

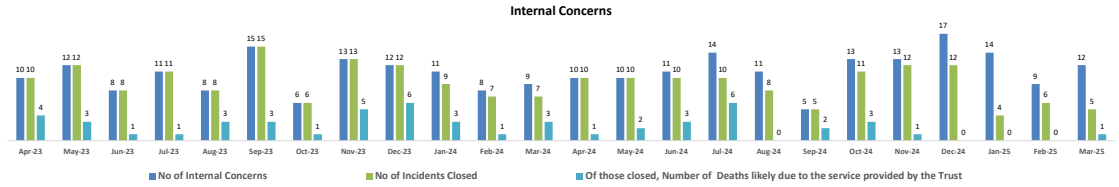


Figure 2

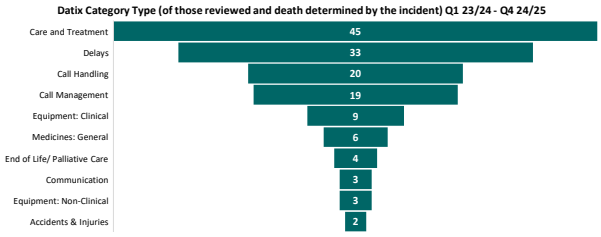


Figure 3

Trends Identified from Internal Concerns raised in DCIQ

PES:

Care & Treatment
- Procedure not followed for UCS crew leaving a patient at home
- Good practice - crew administered subcutaneous Morphine to an EOL patient to ease the patients symptoms

Equipment
- Schiller defib in AED mode advised a shock but cancelled before delivering it
- Lifepak defib switched off during transport of a post ROSC patient
- Defib pads had intermittent connectivity and a rhythm could not be read

Medicines
- One dose of Adrenaline administered to patient during ALS was out of date
- Incorrect dose of Amiodarone administered during ALS

ICC:

Call Handling
- Insufficient probing around patients breathing and level of consciousness
- Inappropriate downgrade to category 2 with a first party caller line going silent
- Call incorrectly marked as abandoned despite being able to hear the patient gasping for breath
- Incorrect coding of call as a Cat2 rather than Cat1

Dispatch
- Forced entry guidance not followed by dispatcher

Trust:

Delays
- Cat2 delays - 20min - 1hr delay (x6)
- Cat2 delays - 2hr 15 - 3hr delay (x2)
- Cat3 delays - 1hr - 6hr delay (x3)

Table 1

External Concerns

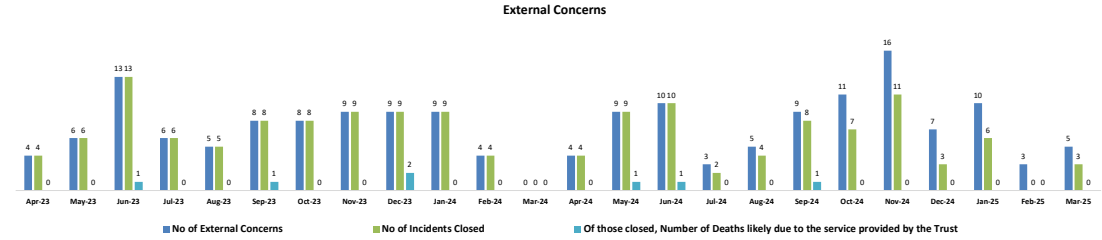


Figure 4

Learning themes: PES

Problem with treatment & management plan:
- Crew should have explored other methods of administering pain relief when IV access was not achieved

Problem with patient disposition:
- MTS outcome not fully documented on EPR - would have supported decision made to leave patient at home

Problem with communication:
- Poor communication with patients' family (x4)

Table 2

Other Learning Opportunities

Key learning from CHUB

Problem with assessment, investigation or diagnosis:
- Failure to recognise potential seriousness and complexity of condition - not enough probing during Telephone Triage Assessment

Table 3

Learning themes: ICC

Call Handling
- EMA should have seeked advice from the Non-Clinical Advice Hunt (NCAH) for breathlessness mentioned at the end of the call
- Caller not able to be next to patient - EMA should have used 'early exit - remote observer' procedure which could have elicited a higher response

Dispatch
- VAS/PAS crew incorrectly allocated to incident

Table 4

Internal and External Concerns

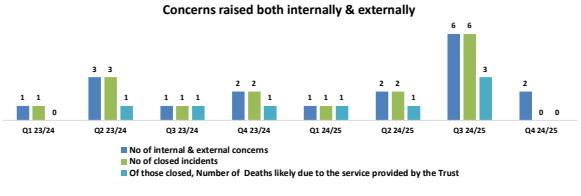


Figure 5

Learning themes: PES

Problem with treatment and management plan:
- ECG recognition - patient had an ECG rhythm which required further intervention which wasn't recognised by clinicians
- Potential incorrect MTS card used by crew - may have elicited a specific outcome of attending ED if a more appropriate card was used

Table 5

Data last exported: 02/04/2025; Data last cleansed: 21/05/2025

NWAS Learning from Deaths Dashboard Q4 24/25

Structured Judgement Review (SJR) Sample

Reporting Year	Incidents used for the sample criteria		Number of Deaths Reviewed	Total number of deaths where care is deemed to be less than adequate
23/24	Q1	18	16	9
	Q2	19	15	8
	Q3	27	26	7
	Q4	24	21	9
24/25	Q1	23	14	5
	Q2	19	18	10
	Q3	33	26	5
	Q4	29	26	9
	Total	192	162	62

Table 6

SJR Scoring Key:

Adequate: Care that is appropriate and meets expected standards;

Poor/Very Poor: Care that is lacking and/or does not meet expected standards;

Good/Very Good: Care that shows practice above and/or beyond expected standards

SJR Stage 1 Overall Care Assessment for Year

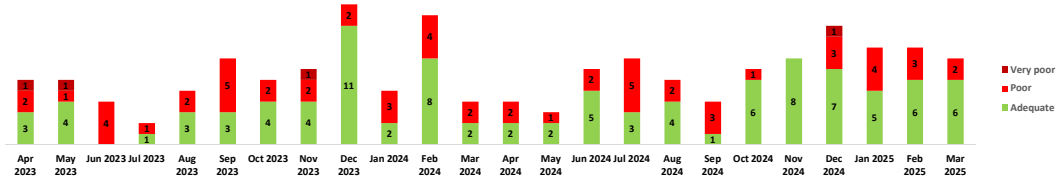


Figure 6

Initial Contact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good
Right Time	Call Handling/Resource Allocation	0	26	0
Right Care	Patient Assessment Rating	6	18	2
	Management Plan/Procedure Rating	5	20	1
Right Place	Patient Disposition Rating	7	18	1

Table 7

Recontact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good
Right Time	Call Handling/Resource Allocation	0	19	0
Right Care	Patient Assessment Rating	0	19	0
	Management Plan/Procedure Rating	1	18	0
Right Place	Patient Disposition Rating	0	19	0

Table 8

SJR Learning Themes

Evidence of Poor/Very Poor Practice

Findings identified from 'Poor' ratings

Problem with patient assessment:
- Limited information regarding clinical assessment, examination and outcome (x4)
- Clinical examination poorly documented (x1)
- Breathing assessment lacks detail (x1)

Problem with patient disposition:
- No referral to AVS/GP when appropriate to do so (x4)
- No specific worsening advice documented (x4)

Poor Quality of EPR (x6)

Problem related to treatment and management plan:
- MTS not used/not applied correctly (x5)
- Risks associated with not attending ED not described (x2)
- Capacity to consent assessed but no details provided (x1)

Problem with medication:
- NWAS medicines not given in line with JRCALC guidelines (x1)

Problem with resuscitation:
- Ineffective BLS performed before PES arrival (x1)

Table 9

Evidence of Poor/Very Poor Practice

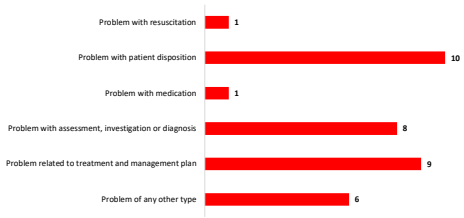


Figure 7

Evidence of Good/Very Good Practice

Evidence of Good/Very Good Practice

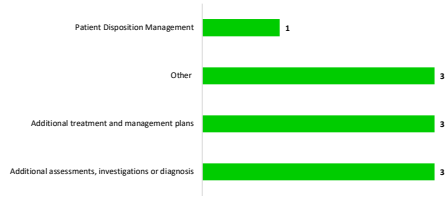


Figure 8

Findings identified from 'Good' ratings

Additional assessments, investigations & diagnosis:
- Good understanding of patient condition to ensure the patient is managed safely and quickly (x2)
- Extensive patient assessment

Additional treatment & management plan:
- Documentation states involvement of those important to the patient
- Full capacity assessment documented
- Multiple sets of observations and discussed patients' condition with GP and family

Patient Disposition Management:
- Patient centred decisions around frailty, co-morbidities and history

Good Quality of EPR (x3)

Table 10

Data last accessed 21/05/2025

NWAS Learning from Deaths Dashboard Q4 24/25

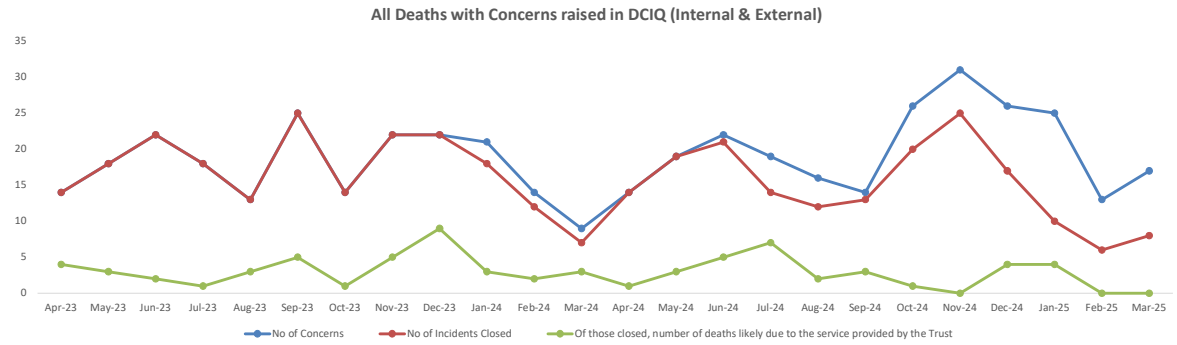


Figure 9

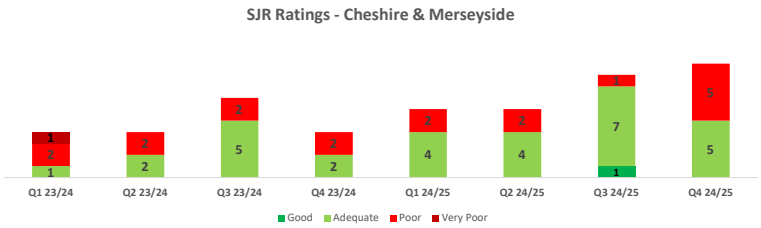


Figure 10

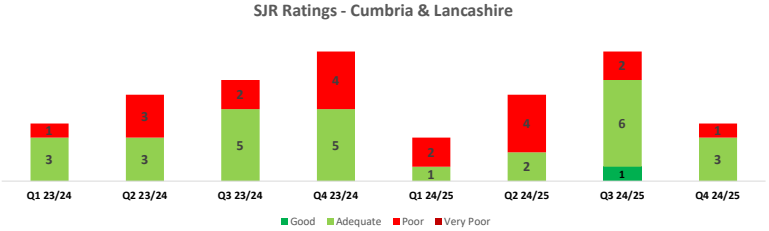


Figure 11

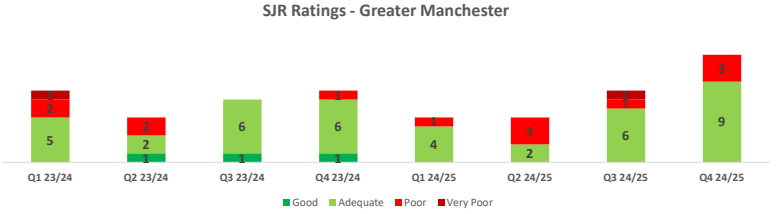


Figure 12

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

Key:

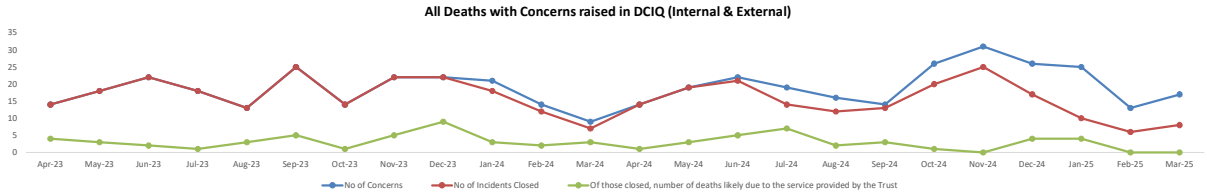
Most occuring

Second most occuring

Table 11

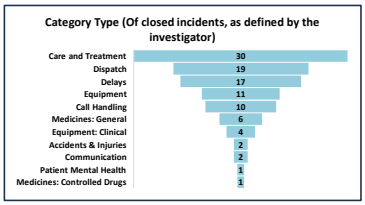
NWAS Learning from Deaths Annual Dashboard 2024-25

Deaths with concerns raised in DCIQ



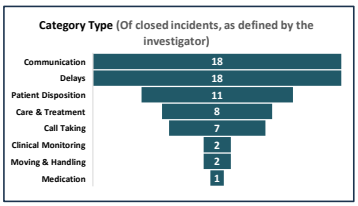
Internal Concerns

	Number of Incidents	Number of Incidents Closed	Of those closed, number of deaths likely caused by service by the trust	% death likely caused by the trust
Q1	31	30	6	20.0%
Q2	30	23	8	34.8%
Q3	43	35	4	11.4%
Q4	35	15	1	6.7%
24/25	**139**	**103**	**19**	**18.4%**



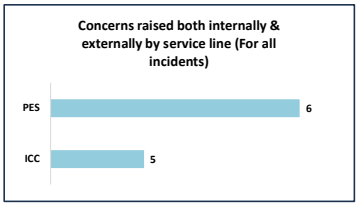
External Concerns

	Number of Incidents	Number of Incidents Closed	Of those closed, number of deaths likely caused by service by the trust	% death likely caused by the trust
Q1	23	23	2	8.7%
Q2	17	14	1	7.1%
Q3	34	21	0	0.0%
Q4	18	9	0	0.0%
24/25	**92**	**67**	**3**	**4.5%**



Concerns raised both Internally & Externally

	Number of Incidents	Number of Incidents Closed	Of those closed, number of deaths likely caused by service by the trust	% death likely caused by the trust
Q1	1	1	1	100.0%
Q2	2	2	1	50.0%
Q3	6	6	3	50.0%
Q4	2	0	0	0.0%
24/25	**11**	**9**	**5**	**55.6%**



Themes from Closed Internal Incidents

ICC:	**10**
Call Handling/Dispatch	
Missed opportunity to allocate	5
Patient not re-contacted when line disconnects or goes silent	3
Not enough probing during call	2
PES:	**49**
Care & Treatment	
Issues with resuscitation - missed opportunity to start BLS, ineffective CPR performed, missed opportunity to shock patient, TOR/DOA outside of policy	5
Potential missed diagnosis/ incorrect treatment of symptoms	4
Incorrect patient disposition	3
Capacity assessment lacked detail and did not support decision making	2
No causal factors found	15
Equipment	
Issues and/or malfunction with defibrillators (Lifepak & Schiller) - failures to deliver shock, connectivity issues, device freezing or turning off whilst in use	10
Equipment malfunctioning on scene	3
Medicine	
Incorrect dosage of medicines given during ALS	7

Themes from Closed External Incidents

ICC:	**13**
Call Handling/Dispatch	
Poor communication with patient/colleagues	6
Incorrect coding of call	4
Missed opportunity to upgrade call	2
Correct pathway not followed	1
PES:	**36**
Care & Treatment	
Failure to recognise potential seriousness and complexity of condition	6
Incorrect treatment plan	2
Communication	
Poor communication with patients/family	9
Crew did not act appropriately	3
Patient Disposition	
Missed opportunity to convey patient to ED	7
Correct pathway not followed	4
Problem with clinical monitoring	2
Problem with moving & handling	2
Problem with medication	1

Themes from Closed Concerns Raised Internally & Externally

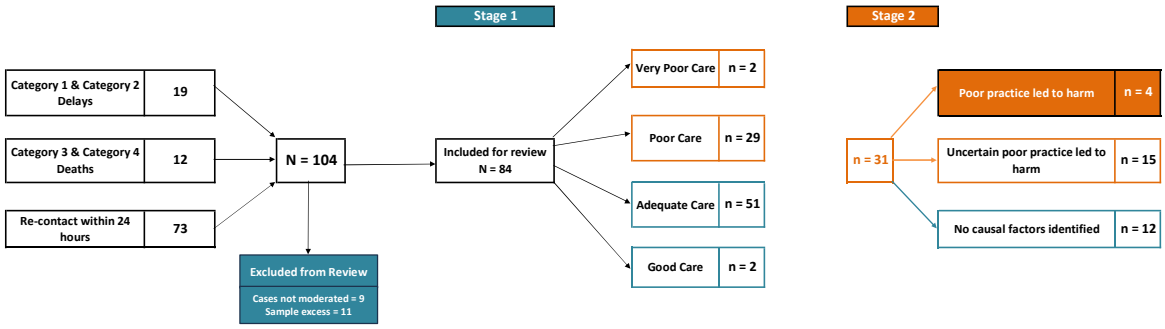
PES:	**4**
Care & Treatment	
Policy not followed regarding when to drive on blue lights	1
Failure to recognise Abdominal Aortic Aneurysm	1
Correct pathway not followed	1
Poor communication with patient/family	1
ICC:	**2**
Call Handling	
Incorrect coding of call	2
CHUB:	**1**
Care & Treatment	
Incorrect disposition	1

Trustwide Themes Across All Concerns

Category 2: 40min - 2hr delays	21
Category 3: 1hr - 6hr delays	8
System pressures - delays caused by:	18
Hospital handover delays	
Acute hospital pressures	
Operational deficiencies	
Staffing pressures:	4
Mealbreak management issues in ICC	
Operational deficiencies	

NWAS Learning from Deaths Annual Dashboard 2024-25

Structured Judgement Reviews (SJRs)



SJR Themes and Findings - 'Poor & Very Poor' Ratings

PES:	
Problem with assessment	
Limited information recorded regarding clinical assessment and examination	12
Capacity to consent assessed but no details provided	2
Breathing assessment lacks detail	2
12 lead ECG not performed when appropriate to do so	2
No medical model used	1
Problem related to treatment & management plan	
MTS not used or not applied correctly	9
Lack of clear management plan and diagnosis	2
Failure to recognise EOL care patient	1
No repeated observations documented	1

PES:	
Problem with patient disposition	
No referral to AVS/GP when appropriate to do so	6
Specific worsening advice not documented	4
Risks associated with not attending ED not described	3
Safety netting not documented	2
Diagnosis of Death form not completed	1
Problem with medication	
NWAS medicines not given in line with JRCALC guidelines	3
Problem with resuscitation	
Ineffective BLS performed before PES arrival	1
Poor quality of Electronic Patient Record (EPR)	15

ICC:	
Problem with call taking/response allocation	8
Call not triaged correctly	
Missed Cat1 at pre-alert due to entering patient was breathing	1
Incorrect address inputted into C3	1
EMA asked questions that are not part of the triage	1
Not enough information gained to downgrade call	1
Questions should have been re-visited when new information was mentioned at the end of the call	1
EMA did not follow opening call scripts	1
EMA should have asked caller for a mobile number or switched to remote observer procedure	1
Early exit procedure not used correctly - could have reached a higher disposition	1

Learning is currently taking place through discrete, standalone points with no evident overarching themes.

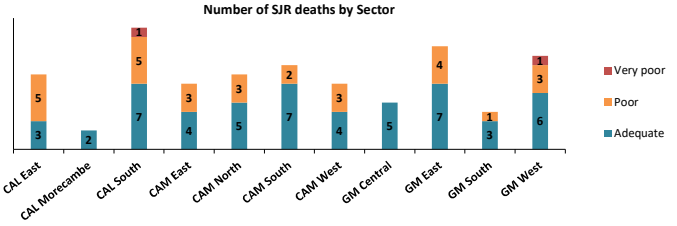
SJR Themes and Findings - 'Good & Very Good' Ratings

PES:	
Additional assessments	
Extensive patient assessment	3
Excellent recognition of a patient dying	2
Good understanding of patient condition to ensure the patient is managed safely and quickly	2
Additional treatment & management plans	
Documentation states involvement of those important to the patient, with holistic conversation noted	2
Full capacity assessment	1
Handover to OOHGP noted with reference to organising a package of care	1
Patient centred decisions around frailty, co-morbidities and history	1

PES:	
Patient disposition management	
Recognition of EOL and empowerment of clinicians to not resuscitate patient with advanced or reversible conditions	1
Patient centred decisions around frailty, co-morbidities and history	1
Good quality of Electronic Patient Record (EPR)	12
CHUB	
Additional assessments & treatment plans	1
Extensive patient assessment	
Good understanding of patient condition to ensure the patient is managed safely and quickly	1
Good management of patient expectations and concerns	1

SJR Demographics

Number of SJR deaths by Sector



Sample Split

41 43

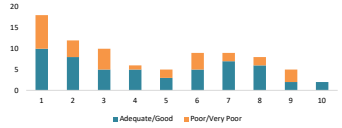
88% of the sample were 65 years and older

86% of patient ethnicity recorded as White (British)

14% cases were had no ethnicity recorded

13
Good practice letters sent!

IMD Decile by SJR Rating



Top Call Reasons by Category

Category 1 & Category 2 Delays
- Vomiting 35%
- Breathing problems 18%

Category 3 & Category 4 Deaths
- Falls 50%
- Vomiting 30%

Re-contact within 24 hours
- Breathless/DIB 35%
- Diarrhea & Vomiting 16%
- Falls 11%

SJR Rated Adequate or Above by Area

Cumbria & Lancashire 57%

Cheshire & Merseyside 65%

Greater Manchester 70%

Overall cases which recieved adequate or good care in 24/25
63%

Outcomes from SJRs

Following the learning generated through Structured Judgement Reviews (SJRs), the Regional Clinical Improvement Group (RCLIG), and the Patient Safety Team, several key themes and priority areas for improvement have been identified. These include the use of learning loops to raise awareness around the SJR process and panel functions, as well as the identification and management of paced rhythms. This approach supports continuous learning and the dissemination of best practices across clinical teams. Additionally, there is a growing emphasis on triangulating learning from multiple sources to gain a deeper, system-level understanding of clinical practice. For example, clinical documentation audits have been embedded into the 2025/26 Clinical Audit Plan to support this integrated approach and drive continuous quality improvement.

LEARNING FROM DEATHS

NHS North West Ambulance Service

Q4 2024/25 REPORT

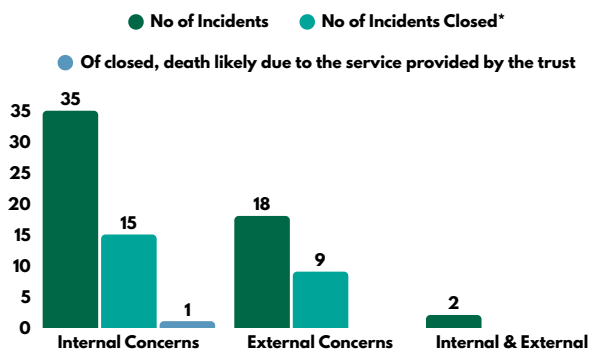
DEATHS WITH CONCERNS RAISED IN DATIX

Internal Concerns 35

External Concerns 18

Internal & External 2

Concerns with casual factors



*98% had no causal factors identified

Top categories from closed internal incidents

Care & Treatment	4
Delays	3
Equipment: Clinical	2
Dispatch	2
Medicines: General	2
Call Handling	2

Learning from Paramedic Emergency Service (PES)

Problem with treatment & management plan:

- Crew should have explored other methods of administering pain relief when IV access was not achieved

Problem with Patient Disposition:

- MTS outcome not fully documented on EPR - would have supported decision made to leave patient at home

Problem with communication:

- Poor communication with patients family (x4)

Key learning from ICC

Call Handling:

- EMA should have seeked advice from the Non-Clinical Advice Hunt (NCAH) for breathlessness mentioned at the end of the call
- Caller not able to be next to patient - EMA should have used 'early exit - remote observer' procedure which could have elicited a higher response

Key Learning from ICC

Dispatch:

- VAS/PAS crew incorrectly allocated to incident

Key learning from CHUB

Problem with assessment:

- Failure to recognise potential seriousness and complexity of condition - not enough probing during Telephone Triage Assessment

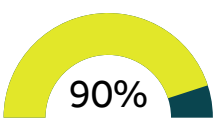
Structured Judgement Reviews (SJRs)

Patient Demographics

58% Female

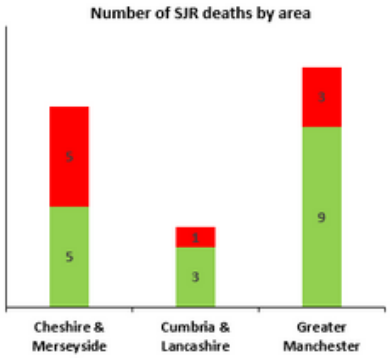
42% Male

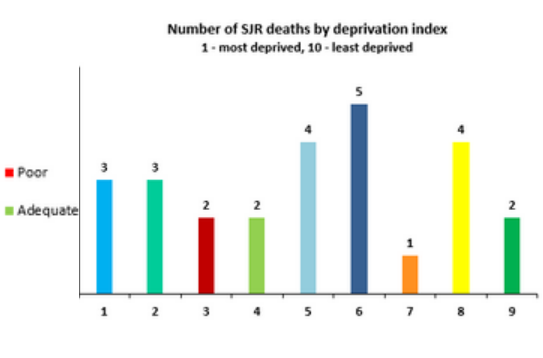
85% of the sample were over 65 years old



Majority of patients ethnicity recorded as White (British)
10% Not Documented

Incident Demographics





For more information contact: Learning.FromDeaths@nwas.nhs.uk

Structured Judgement Reviews (SJRs)

Deaths in Scope

Re-contact within 24hrs
20

Category 3/4 Deaths
2

Category 1/2 Delays
7

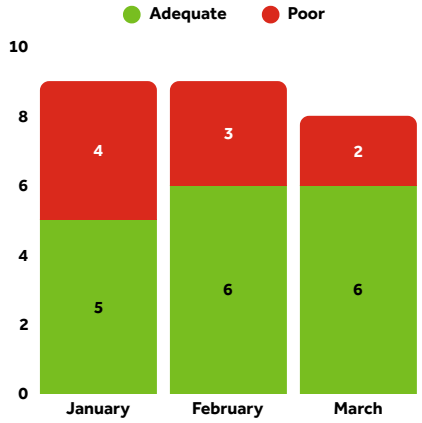
Deaths Reviewed

Total sample
N = 29

Excluded from review
Not moderated = 3

Included for review
n = 26**

SJR Stage 1 Care Assessment



**65.4% had no causal factors identified

Stage 2 = 9 incidents

No causal factors identified
2

Uncertain poor practice led to harm
5

Poor practice led to harm
2

SJR - Themes

- **Problem with treatment & management plan**
- **Problem with patient assessment**
- **Problem with patient disposition**
- **Problem of any other category (Quality of EPR)**

Stage 2 - PES Findings

Problem with patient assessment:

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

Problem with patient disposition:

- No referral to AVS/GP when appropriate to do so
- No specific worsening advice documented

Poor Quality of EPR (x6)

Stage 2 - PES Findings

Problem related to treatment and management plan:

- MTS not used/not applied correctly (x5)
- Risks associated with not attending ED not described (x2)
- Capacity to consent assessed but no detail provided (x1)

Problem with medication:

- NWAS medicines not given in line with JRCALC guidelines (x1)

SJR GENERAL LEARNING THEMES

Areas for Improvement

- 12 lead ECG not completed during assessment - may have supported decision making
- Frailty and pain scores not recorded within observations
- Detailed worsening advice not documented
- Asystole ECG strip not uploaded to media for DOA/TOR

Good Practice

- Good reassurance by EMA during CPR
- Additional management of patients family following patient passing away
- Good use of Clinical Hub/CIH for escalation & joint decision making
- Good involvement of patients' family in patients care
- Use of Ultrasound during cardiac arrest to aid decision making

SJR ACTIONS

- EMA call audit requested
- Duty of Candour (DoC) to be considered
- Positive feedback to be given to crew
- Learning feedback to be given to crew
- Themes sent to PSIRF team for collaborative reviews to take place

SJR IMPROVEMENTS

- To continue to highlight and improve the Quality of EPR/clinical documentation
- To continue to circulate learning points from Learning from Deaths to all staff networks and learning forums
- To continue to perform thematic analysis of the LfD dataset
- To continue to work with the PSIRF team to triangulate learning themes and identify areas for improvement

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 September 2025
SUBJECT	Emergency Preparedness Resilience Response Annual Assurance 2025
PRESENTED BY	Executive Director of Operations
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board is asked to: • Be assured on the EPRR AA self-assessment submission for 2025 is to be reported as Substantially Compliant for the EPRR Core Standards. • Note the progress made following last year's (2024) Emergency Preparedness Resilience & Response (EPRR) Annual Assurance (AA) self-assessment. • Note the timeline on providing EPRR AA 2025 self-assessment and submission.

EXECUTIVE SUMMARY	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from adverse weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. **ALERT** The letter from NHS England regarding Core Standards 2025 has been received by the Trust. There is no deep dive as part of the process this year. The Trust will submit 'Substantially Compliant' in the EPRR Annual Assurance self-assessment. The Data Protection Security Toolkit process changed in 2024 to have more of a cyber resilience focus. Prior to this, NWAS had an action plan to achieve compliance but the requirements of the DPST have meant this needed to be amended. Compliance is expected 2026. This will move NWAS to partially compliant from full compliance in this standard. **ASSURE** Resilience Team are working with other parts of the Trust and partner agencies to maintain the growth achieved last year and improve and embed EPRR processes. **ADVISE** The attendance at the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) meetings are broadly at the standard set by NWAS in response to the national standards and NHS England advice. Observations from attendees is that not all attendees from partner agencies at the meetings are at a comparable level.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 17 September 2025
	Outcome	Noted

1. BACKGROUND

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from adverse weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022.

The NHS England Annual Assurance Core Standard 3 states that: *'The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.*

The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements'.

The NHS Core Standards for EPRR (the 'Core Standards') are the basis for the assurance process and are the minimum requirements commissioners and providers of NHS-funded services must meet. They are based on robust delivery of duties under the Civil Contingencies Act (2004).

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

The letter from NHS England for the 2025 assessment was received 4th July 2025. The Summary of the Assurance Process for Lancashire and South Cumbria can be found in Appendix 1 of this report.

The EPRR Annual Assurance led by the Resilience team will be submitted for assurance as follows:

- Quality & Performance Committee – 1st September 2025
- Service Delivery SMT – 2nd September 2025
- TMC – 17th September 2025
- Board (Public) – 25th September 2025
- **FINAL** Submission to ICB – 3rd October 2025
- EPRR G – 13th October 2025
- Service Delivery Assurance Group (SDAG) – 28th October 2025

2. AMBULANCE SERVICE CORE STANDARDS

EPRR AA 2025 submission is 54/58 – **93% substantial (subject to ICB/NHS England challenge).**

Changes to note:

- Domain 3 – compliant as Incident Response Plan went live 1st June. As the structure within ICC changes, the IRP will need to be reviewed to make sure it remains up to date. The

updated version will take into account any other feedback received, and the same communication method used to provide updates to staff.

- Domain 8 – 2 LHRP areas are compliant, 2 have the potential to be depending on attendance at the next meeting. 3 LRF areas are compliant, 2 have the potential to be. Lancashire have changed their meeting dates and they now conflict with the diary for the AD in that area, they were previously ringfenced for attendance. This conflict caused by date changes could affect submission.

- Domain 9 – Data Protection and Security Tool kit was not compliant last year but had a small set of actions. In September 2024 the DSPT changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and information governance assurance.

  NHS England view is that expectations for cyber security and IG controls should remain at a reasonably comparable level to the current DSPT, tightening only in areas where NHSE and DHSC believe the higher standard to be a necessary obligation.

  NWAS Digital and IG is currently working with MIAA to answer the questions provided in the tool kit. The expectation is that the Trust won't be compliant until 2026. This was presented at the Board development day in June 2025.

For awareness:
https://www.dsptoolkit.nhs.uk/News/Attachment/826
https://digital.nhs.uk/services/data-security-and-protection-toolkit

The following table (1) shows a summary against the Ambulance Service Core Standard Domains for EPRR AA self-assessment and compared with last year's submission.

Ambulance Service Standards

Domain	Submission 2024	Submission 2025	Movement
Governance	4/6	4/6	↔
Risk	2/2	2/2	↔
Plans	10/11	11/11	↑
Command and control	2/2	2/2	↔
Training and exercising	4/4	4/4	↔
Response	5/5	5/5	↔
Warning and informing	4/4	4/4	↔
Cooperation	3/5	5/5	↑
Business continuity	10/11	9/11	↓
Hazmat/CBRN	1/1	1/1	↔
CBNR support to Acutes	7/7	7/7	↔
Total	52/58	54/58	↑
	90% substantial	93% substantial	↑

Table 1: Ambulance Service Standards

3. INTEROPERABILITY CORE STANDARDS

EPRR AA 2025 submission is 125/135 – **93% substantial (subject to ICB/NHS England challenge).**

Changes to note:

- S25 Hazmat/CBRN plan has been through validation but requires some amendments.
- S14 IOR awareness training needs to be 100% of staff. It is covered as a module on ESR but is no longer mandatory. It is included in induction training, and there is a plan in place to include use it in a scenario for face-to-face mandatory training in future. This is the same principle as the marauding terrorist scenarios. It is also included in the Commander training Summer 2025. This standard will move to partial.
- J10 Commander reflection on the use of JESIP – Command and Resilience Education (CARE) team are looking into the reporting function on ParaFolio to see if this can be measured and what the statistics are if it can.

The submission scoring has been calculated on worst case, assuming the Hazmat plan standard (S25), IOR (S14) not compliant, and JESIP reflection (J10) are not compliant.

The following table (2) shows a summary against the Interoperability Standards, specific for Ambulance Trusts, for EPRR AA self-assessment compared with last year's submission.

Interoperability Core Standards

Domain	Submission 2024	Submission 2025	Movement
HART	29/32	29/32	↔
SORT	39/40	37/40	↔
Mass Casualty	14/14	14/14	↔
Command and control	35/36	36/36	↑
JESIP	10/13	9/13	↔
Total	126/135	125/135	↓
	93% substantial	93% substantial	↔

Table 2: Interoperability Standards

4. ROLLING STANDARD COMPLIANCE

An individual standard is either fully, partially, or non-compliant. It can only be partially compliant if it can be addressed in 12 months, if it can't then it would be non-compliant. The guidance for the assessment is that anything that is not fully compliant needs to have an action plan for completion in the next 12 months.

The overall assessment scoring and aligned banding (full, substantial, partial, non-compliant) only measures full compliance. This means if something drops from partial to non-compliant it won't affect the overall score but will be shown in the table as red rather than amber.

Some standards that were shown as partial in 2024 will not be fully compliant in 2025.

Ambulance standards that will not reach full compliance in 2025 and/or were partially compliant in 2024:

- 5 resources – dependant on funding
- 6 continuous improvement – reliant on partner agency processes
- 49 DSPT – NHSE have changed the format of the assessment
- 51 BC audit – requires authorisation from Audit Committee

Interoperability standards that will not reach full compliance in 2025 and/or were partially compliant in 2024:

- S29 – response times for SORT
- J8 – JESIP course attendance
- J11 – multiagency exercises attendance
- J13 – requirement for 90% of staff completing JESIP awareness

5. RISK CONSIDERATION

The Trust's contingency planning arrangements and capabilities assist in providing evidence of compliance with our duties under the CCA (2004), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework together with other legislation such as the Corporate Manslaughter and Corporate Homicide Act 2007 and the Human Rights Act 1998.

NWAS Resilience is also a key component of the NHS Ambulance Standard Contract and is governed by the NHS England & Improvement Emergency Preparedness, Resilience and Response (EPRR) Core Standards which are revised annually.

6. EQUALITY/ SUSTAINABILITY IMPACTS

None.

7. ACTION REQUIRED

The Board is asked to:

- Be assured on the EPRR AA self-assessment submission for 2025 is to be reported as Substantially Compliant for the EPRR Core Standards.
- Note the progress made following last year's (2024) Emergency Preparedness Resilience & Response (EPRR) Annual Assurance (AA) self-assessment.
- Note the timeline on providing EPRR AA 2025 self-assessment and submission.

Ref	Domain	Standard name	Standard Detail
Domain 1 - Governance			
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Domain 2 - Duty to risk assess			
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain Plans			
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control			
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising			
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
Domain 6 - Response			
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
Domain 7 - Warning and informing			
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.

Ref	Domain	Standard name	Standard Detail
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation			
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.
Domain 9 - Business Continuity			
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon
Domain 10 - CBRN			
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented
67	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.
69	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).
70	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.
71	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.
72	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.
73	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.

Ref	Domain	Standard	Detail
HART			
Domain: Capability			
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials (HazMat) • Chemical, Biological Radiological, Nuclear, Explosives (CBRN) • High Consequence Infectious Disease (HCID) • Marauding Terrorist Attack • Water Operations • Safe Working at Height • Confined Space • Unstable Terrain • All-Terrain Vehicle Operations • Support to Security Operations These represent both local and national capabilities that mitigate risks within the National Risk Register. They must be maintained even through periods of significant local or regional demand pressure.
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain the HART capabilities in compliance with the scope and interoperable specification defined within the National HART Capability Matrices.
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments. It is the personal responsibility for each member of HART staff to access and know the content of the National Standard Operating Procedures (SOPs)
Domain: Human Resources			
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies.
H5	**HART**	**Protected training hours**	I Training Information Sheets for HART. Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies. 1 – 4 H5 H5 Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). If HART staff are given additional local skills and training requirements outside of the scope defined within the National HART Matrices, that local training must be provided in addition to the 37.5 hours protected for core HART training.
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for each member of HART in their establishment. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets. It must also include any restrictions in practice and corresponding action plans. Individual training records must directly cross reference the National Training Information Sheets.
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered pre-hospital clinician. This will normally be an NHS paramedic, but this standard does not preclude the use of other NHS clinical professionals providing the Trust ensures the individuals have an appropriate level of pre-hospital experience and training. To ensure the appropriate clinical standard of care is maintained in accordance with the original DHSC mandate, the expectation is that the clinical level will be equivalent to or exceeding that of an NHS Paramedic.
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must be recruited in accordance with the minimum requirements set out in the national HART recruitment and selection manual. Local recruitment provisions can be added to this mandatory minimum as required by NHS Ambulance Trusts.
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing Physical Competency Assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard. The Trust must then implement appropriate support for individuals on a restriction of practice.
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any HART staff returning to work after a period of absence which exceeds 7 weeks must be subject to a formal review to ensure they receive sufficient catch up training and to ensure they are sufficiently fit (evidenced through the successful completion of a Physical Competency Assessment) and competent to continue with HART operational activity. It is the responsibility of the employing Trust to manage this process.
Domain: Administration			
H12	**HART**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.
H13	**HART**	**Identification appropriate incidents / patients**	Organisations must maintain an effective process to identify incidents or individual patients, at the point of receiving a 999 call, that may benefit from the deployment of HART capabilities. Organisations must also have systems in place to ensure unreasonable delays in HART deployments are avoided.
H14	**HART**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the HART capabilities safely or if consideration is being given to locally reconfigure HART to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the HART capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.

H15	**HART**	**Recording resource levels**	Organisations must record HART resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily at shift change over even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where HART staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.
H16	**HART**	**Record of compliance with response time standards**	Organisations must monitor and maintain accurate local records of their level of compliance with all HART core standards defined in this document. That must include accurate records of compliance with staffing levels and responses time standards for every HART deployment. Organisations must comply and fully engage with any audits or inspections of the HART capabilities that are commissioned by NHS England. Compliance records must be made available for annual audits or inspections conducted by NHS England or NARU and must be made available to NHS commissioners or regulators on their request.
H17	**HART**	**Local risk assessments**	Organisations must maintain a set of local specific HART risk assessments which supplement the national HART risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation must also ensure there is a local process to determine how HART staff should conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.
H18	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.
H19	**HART**	**Safety reporting**	Organisations must have a robust and timely written process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 24 hours of the risk being identified.
H20	**HART**	**Receipt and confirmation of safety notifications**	Organisations must have a written process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU or other relevant national body within 2 days of the notification being issued.
H21	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.
Domain: Response time standards			
H22	**HART**	**Initial deployment requirement**	Four HART personnel must be available or released and mobilised to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations. The standard will not apply if the nearest HART unit is already deployed dealing with a higher priority incident requiring HART capabilities. If the HART team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.
H23	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. Confirmation of this requirement would usually come from; the HART Team Leader based on information from the call, one of the four HART Operatives already mobilised or from other emergency service personnel (including Ambulance personnel) in attendance at the scene. Delays in the deployment of all six HART staff could create a direct risk to the application of a safe system of work at the scene.
H24	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on scene at strategic sites of interest within 45 minutes. These sites were initially determined through the Model Response Doctrine which led to the strategic placement of HART units. The 45 minute standard is therefore primarily associated with key transport infrastructure and densely populated areas. Where a Trust through their LRF have identified additional strategic sites of interest which may be beyond a 45 minute HART response, the Trust must have local multi-agency plans to act as a contingency for a potentially delayed HART response. A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region. If the HART Team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.
H25	**HART**	**HART Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30-minute notice to move to anywhere in the United Kingdom following a mutual aid request endorsed by NHS England or NARU. Trusts can also maintain the 30-minute notice to move by way of a recall to duty or on-call process (i.e. where members of the on-duty team are unable to deploy due to child care or personal commitments at the time of the notification). A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region
Domain: Logistics			
H26	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment. This must include maintaining capital provisions of at least £1.9 million depreciated over 5 years to maintain the HART fleet and incident ground equipment. Internal HART budgets and expenditure must be in accordance with the reference costs set nationally for HART units. Given that the HART capabilities are national as well as local, HART funding provision must not be reallocated internally away from HART within the express permission of NHS England (the National EPRR team).

H27	**HART**	**Interoperable equipment**	Organisations must procure and maintain minimum levels of interoperable equipment specified in National Equipment Data Sheets. To maintain minimum levels of interoperability, national interoperable equipment that has not be specified within National Equipment Data Sheets should not be utilised as part of the HART capabilities.
H28	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks (where applicable) coordinated by NARU unless they can provide assurance that the local procurement is interoperable and meets the requirements of the National Equipment Data Sheets. Any locally procured equipment that does not have a National Equipment Data Sheet which has been procured locally to support the delivery of training, sits outside of the national safe system of work. Trusts must ensure that they have local risk assessments and governance provisions in place to manage the use of such equipment. Any such equipment must not be deployed at incidents in support of HART capabilities.
H29	**HART**	**Fleet compliance with national specification**	Organisations must ensure that the HART fleet and associated incident ground technology remain compliant with the national specification. Nationally specified vehicles must conform to the national loading lists for each vehicle and the vehicles state of readiness must be updated on the national monitor systems. This will include national location tracking.
H30	**HART**	**Equipment maintenance**	Organisations must ensure that all HART equipment is maintained according to applicable standards and in line with manufacturers recommendations. This will include standards specified in the National Equipment Data Sheets and relevant associated BS or EN related standards (or equivalent).
H31	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).
H32	**HART**	**Capital estate provision**	Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.
SORT			
Domain: Capability			
S1	**SORT**	**Maintenance of national specified MTFA capability**	NHS Ambulance Trusts must maintain a combined MTA (Marauding Terrorist Attack) and CBRN (Chemical Biological Radiological Nuclear) capability in accordance with national specifications. These capabilities operate in support of Hazardous Area Response Team deployments when required.
S2	**SORT**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain compliant with the national safe system of work specified by the National Ambulance Resilience Unit (NARU).
S3	**SORT**	**Interoperability**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain nationally interoperable and confirm the scope of operational practice defined within national capability matrices published by NARU.
S4	**SORT**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. All Commanders and NILOs / Tactical Advisors must be able to access this advice at all times (24/7).
Domain: Human Resources			
S5	**SORT**	**SORT establishment**	NHS Ambulance Trusts must maintain a minimum establishment of 290 SORT trained staff. For compliance purposes this must be for at least 90% of the calendar year. Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily (365 days per year). Recall to duty programmes must be in addition to this on duty requirement. For compliance monitoring and reporting the following provisions apply: • Trusts will not be penalised or deemed to be non-compliant if the number of SORT staff fluctuates between 30 and 35 during any given shift. • Less than 35 but more than 25 on up to 3 occasions per month = compliant. • Less than 30 and more than 25 on more than 3 occasions in any given month = non-compliant. • Less than 25 at any time = non compliant.
S6	**SORT**	**Completion of a Physical Competency Assessment**	All active SORT staff within each NHS Ambulance Trust must successfully complete a physical competence assessment every 12 months (annually). The physical competence assessment must be conducted to the nationally specified standard (as specified by the National Ambulance Resilience Unit). 'Active' staff means staff that are undertaking operational shifts where their numbers are being included within SORT staffing level data for the Trust. SORT staff that have not successfully completed a physical competency assessment within a 12 month period must be placed on a restriction of practice. They must not respond to an incident as a SORT operative whilst on such a restriction of practice and the Trust must have robust processes in place to ensure compliance with this provision. Staff on a restriction of practice for SORT must not be counted as part of the SORT on-duty staffing levels.
S7	**SORT**	**Staff competency**	NHS Ambulance Trusts must ensure that each individual SORT member of staff remains compliant with the competency standards defined within national Training Information Sheets (TIS's) published by NARU for SORT staff and CBRN training is aligned to Skills for Health occupational standard EC25 – Decontaminate individuals affected by chemical, biological, radiological or nuclear incident. This training requirement includes providing a minimum of 7 days training (minimum of 52.5 hours) every 12 months. This training must be split into at least two separate sessions per operative per annum (it cannot be delivered in a single consecutive training session or period).

S8	**SORT**	**Training records**	NHS Ambulance Trusts must ensure that comprehensive training records are maintained for all SORT personnel in their establishment. These records must include; a record of mandated training completed aligned to the national Training Information Sheets (TISs), when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the SORT skill sets. It must also include any restrictions in practice and corresponding action plans.
S9	**SORT**	**Provision of clinical training**	NHS Ambulance Trusts are required to provide supportive training to statutory Fire and Rescue Services within their Trust geography that have a declared MTA capability. That supportive training must cover the clinical elements of the response and working jointly with Ambulance HART and SORT deployments for MTA incidents.
S10	**SORT**	**Staff training requirements**	NHS Ambulance Trusts must ensure that all frontline operational staff have received familiarisation training or briefing on how non-specialist / non-protected Ambulance responders should deal with an MTA incident. This should be included as part of annual mandatory training requirements. It is recognised that Ambulance Trusts have various staff in training or on alternate duties at any point in time. Therefore, for compliance purposes, the Trust will be deemed to be compliant with this requirement providing it can evidence that over 80% of frontline staff have received the required familiarisation training when audited or inspected.
S11	**SORT**	**Arrangements to manage staff exposure and contamination**	NHS Ambulance Trusts must ensure they have robust procedures in place to document all staff who may have become exposed or contaminated during incidents involving CBRN or hazardous materials. These procedures must include attendance at scene monitoring, exposure monitoring and post exposure management.
S12	**SORT**	**CBRN Lead trainer**	NHS Ambulance Trusts must have sufficient capacity of dedicated training or instructional staff for SORT to enable the Trusts to deliver and maintain the nationally specified training requirements each year.
S13	**SORT**	**FFP3 access**	NHS Ambulance Trusts must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent such as a Powered Respirator Protective Hood PRPH) and that they have been appropriately fit tested (where applicable). The specification and standards for this protection (including the Air Particulate Filtration) must comply with the provisions set out in the relevant national Equipment Data Sheet (EDS).
S14	**SORT**	**IOR training for operational staff**	NHS Ambulance Trusts must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR) principles of Remove Remove Remove. Organisations must maintain records to demonstrate how many staff are trained (and when the training occurred).
Domain: Administration			
S15	**SORT**	**Effective deployment policy**	NHS Ambulance Trusts must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the SORT capability. These procedures must be aligned to the MTA Joint Operating Principles (produced by JESIP).
S16	**SORT**	**Identification appropriate incidents / patients**	NHS Ambulance Trusts must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of SORT personnel to an incident requiring the MTA or CBRN capability. This must include specific mechanisms to identify on-duty SORT staff and make them available to response to the incident as quickly as possible. These procedures must be aligned to relevant Joint Operating Principles (JOPs, produced by JESIP).
S17	**SORT**	**Change Management Process**	NHS Ambulance Trusts must use the national Change Management Process coordinated by NARU before reconfiguring (or changing) any SORT procedures, equipment or training that has been specified as nationally interoperable.
S18	**SORT**	**Record of compliance with response time standards**	NHS Ambulance Trusts must monitor their compliance with the SORT core standards set out in this document. The Accountable Emergency Officer in each Trust is responsible to their Board for the levels of compliance against these standards. Each NHS Ambulance Trust must maintain accurate records of their compliance with the core standards set out in this document and make those records available during annual audits or inspections commissioned by NHS England. These records should also be made available to NHS commissioners and regulators on request.
S19	**SORT**	**Notification of changes to capability delivery**	SORT is both a national and regional capability. It provides critical mitigation to risks articulated in the risk register for the United Kingdom. NHS Ambulance Trusts must not take the SORT capability offline or reconfigure it locally without first obtaining permission from the National Ambulance Resilience Unit or NHS England's national EPRR team. In the first instance, the discussion needs to be with the NARU On-Call Duty Officer. In any event that the organisation is unable to maintain the SORT capability safely or if consideration is being given to locally reconfigure SORT to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the SORT capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.
S20	**SORT**	**Recording resource levels**	NHS Ambulance Trusts must record SORT resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where SORT staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.
S21	**SORT**	**Local risk assessments**	NHS Ambulance Trusts must maintain a set of local specific SORT risk assessments which supplement the national SORT risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation may determine what locations are considered high-risk (often in conjunction with the LRF), but the assessment must be for/or include MTA and CBRN specific risks. The organisation must also ensure there is a local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.
S22	**SORT**	**Lessons identified reporting**	NHS Ambulance Trusts must have a robust and timely process to report any lessons identified following a SORT deployment or training activity that may affect the interoperable service to NARU within 12 weeks using the nationally approved lessons database. Note: the 12 weeks starts from resolution of the incident.
S23	**SORT**	**Safety reporting**	NHS Ambulance Trusts have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the SORT service as soon as is practicable and no later than 24 hours of the risk being identified. Reports must be made using the national safety alert system managed by NARU.

S24	**SORT**	**Receipt and confirmation of safety notifications**	NHS Ambulance Trusts have a process to acknowledge and respond appropriately to any national safety notifications issued for SORT by NARU within 2 days.
S25	**CBRN**	**HAZMAT / CBRN plan**	NHS Ambulance Trusts must ensure that their major or complex incident plans include specific provisions to manage a MTA or CBRN incident. These provisions must align to the national SORT matrices and operating procedures published by NARU. All SORT staff must have access to both the Trust plans and the national safe system of work provisions (including procedures, generic risk assessments etc) published by NARU and should be familiar with their contents. These plans must also be aligned to the relevant JESIP / JOP provisions.
S26	**SORT**	**SORT Audit and inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the SORT capability that are commissioned by NHS England.
S27	**SORT**	**SORT capability funding**	NHS Ambulance Trusts must ensure that the national funding provided to support the SORT capability within Trusts is used to support the maintenance of that capability. The Trust must not redirect these funds and use them for other internal purposes within the express permission of NHS England or NARU.
Domain: Response time standards			
S28	**SORT**	**SORT Readiness to deploy**	NHS Ambulance Trusts must ensure their SORT capability remains at a high state of readiness to deploy to MTA or CBRN related incidents between the hours of 0600 and 0200 daily. On receipt of an emergency call or notification by a partner agency of a potential incident involving CBRN or a marauding terrorist attack, NHS Ambulance Trusts must immediately identify all SORT staff on duty within their system and prepare to deploy those that are not committed or that can be made available from lower priority calls.
S29	**SORT**	**SORT response time**	Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. Any SORT staff available to respond in less than 60 minutes, must be responded as quicky as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders must be assigned to the incident. The NHS Ambulance Trust can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident must be approved by a Tactical or Strategic Commander and must be clearly documented. The decision will be subject to external review post incident.
S30	**SORT**	**SORT Mutual Aid**	NHS Ambulance Trusts must maintain their SORT capability at a state of readiness which is able to support a national deployment under mutual aid with reference to the national mutual aid policy. As an interoperable capability, it is nationally expected that Trusts provide SORT mutual aid when requested by NHS England, NARU or the National Ambulance Coordination Centre.
Domain: Logistics			
S31	**SORT**	**PPE availability**	NHS Ambulance Trusts must ensure that the nationally specified personal protective equipment is available for all operational SORT personnel and that the equipment remains compliant with the relevant national Equipment Data Sheets (EDSs).
S32	**SORT**	**Equipment procurement via national buying frameworks**	NHS Ambulance Trusts must procure SORT (MTA and CBRN) equipment specified in the SORT (MTA and CBRN) related Equipment Data Sheets and where applicable through the buying frameworks maintained by NARU. NHS Ambulance Trusts must also ensure sufficient financial provisions are in place to replace SORT equipment as specified by the relevant national Equipment Data Sheets. For MTA equipment, this should include an annual programme of rolling replacement.
S33	**SORT**	**Equipment maintenance**	All SORT equipment must be maintained in accordance with the manufacturer's recommendations and applicable national industry standards. This must include a programme of regular inspections and preventative maintenance as specified in relevant national Equipment Data Sheets.
S34	**SORT**	**SORT asset register**	NHS Ambulance Trusts must maintain an asset register of all SORT (MTA and CBRN) assets specified in the relevant national capability matrices and associated national Equipment Data Sheets. The register must include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).
S35	**SORT**	**PRPS - minimum number of suits**	NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. Trusts must also ensure they have a financial / revenue replacement plan in place to ensure the minimum number of suits is maintained and replaced as required by the national Equipment Data Sheets.
S36	**SORT**	**Individual / role responsible for SORT assets**	NHS Ambulance Trusts must have a named individual or role that is responsible for ensuring SORT assets are managed appropriately.
S37	**SORT**	**CBRN countermeasures**	NHS Ambulance Trusts must ensure that they make CBRN countermeasures available for use by frontline Ambulance staff. This must include distribution of countermeasures across frontline assets in accordance with the specification and requirements defined within the relevant national matrix and Equipment Data Sheets (EDSs).
S38	**SORT**	**Water supply for clinical decontamintion**	NHS Ambulance Trusts must ensure they have local or regional agreements and procedures in place to facilitate access to water supplies to carry out clinical decontamination. This may be achieved in conjunction with Fire and Rescue Services.
S39	**SORT**	**Equipment Vehicles**	Organisations must maintain a minimum of four vehicles to provide the MTA pooled equipment These vehicles should be replaced at a maximum of every 7 years. A minimum of 160 sets of pooled ballistic PPE and associated medical consumables must be available split over the organisations geographical area based on a local Trust assessment of risk.
S40	**SORT**	**Equipment vehicle readiness**	In conjunction with standards S29 and S30, MTA pooled equipment vehicles must be maintained at a high state of readiness to deploy. At least one asset must be mobilised within 15 minutes of a SORT response being confirmed as being required for an incident. Failure to rapidly mobilise the equipment on these vehicles will delay the deployment of responders at the scene.
S41	**SORT**	**Vehicle Tracking**	NHS Ambulance Trusts must ensure that vehicles used to deploy interoperable capabilities can be tracked nationally by NARU via nationally approved systems. This includes the vehicles associated with the SORT capability that are used to transport either pooled MTA equipment or CBRN resources to the scene of an incident.
Mass Casualty Capability			

Domain: Capability Alignment Standards			
M1	**MassCas**	**Mass casualty response arrangements**	NHS Ambulance Trusts must ensure they have plans and procedures in place that specifically cater for a mass casualty incident and that those provisions are aligned to the national framework or concept of operations for managing mass casualty incidents published by NHS England.
M2	**MassCas**	**Arrangements to work with NACC**	NHS Ambulance Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) in the event that national coordination is required or activated.
M3	**MassCas**	**EOC arrangements**	NHS Ambulance Trusts must have effective and tested arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving medical facilities (including designated Acute Trusts) within the first hour of mass casualty or major incident being declared.
M4	**MassCas**	**Casualty management arrangements**	NHS Ambulance Trusts must have a Casualty Management Plan (CMP) (including patient distribution model) which has been produced in conjunction with Regional Trauma Networks and / or individual receiving facilities. These plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise.
M5	**MassCas**	**Casualty Clearing Station arrangements**	NHS Ambulance Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station or multiple Casualty Collection Points at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation / evacuation.
M6	**MassCas**	**Management of non-NHS resource**	NHS Ambulance Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources, as part of the patient distribution model: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers
M7	**MassCas**	**Mass Cas Audits and Inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the mass casualties capability that are commissioned by NHS England.
Domain: Mass Casualty Equipment			
M8	**MassCas**	**MCV accommodation**	NHS Ambulance Trusts must maintain the number of mass casualty vehicles assigned to them by the National Ambulance Resilience Unit. These vehicles must be maintained in compliance with the national specification and any guidance produced by NARU to ensure effective interoperability.
M9	**MassCas**	**Maintenance and insurance**	NHS Ambulance Trusts must insure, mechanically maintain and regularly run the mass casualty vehicles. Each nationally specified mass casualty vehicle must be securely accommodated undercover (garaged) when not deployed and must be maintained with an appropriate shoreline / electrical feed. The vehicle must be parked in a way that would facilitate rapid mobilisation and a high state of readiness. In the event of a mass casualty vehicle being unavailable, within 2 hours the national electronic dashboard must be updated and the NARU On Call Duty Officer informed.
M10	**MassCas**	**Mobilisation arrangements**	NHS Ambulance Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents or events which may benefit from the deployment of the asset(s). Trusts must ensure that their mass casualty vehicle (MCV) assets maintain a 30-minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the MCV is already deployed at a local incident or is non operational.
M11	**MassCas**	**Mass oxygen delivery system**	NHS Ambulance Trusts must maintain the mass oxygen delivery system on the vehicles, in accordance with the manufacturers guidance (including regular servicing and maintenance).
M12	**MassCas**	**Drug and pharmaceutical stock management**	In accordance with agreements and instructions from NHS England and local Pharmacy Leads, the drugs and pharmaceuticals which form part of the minimum nationally specified stock for each MCV must be appropriately and effectively maintained by the NHS Ambulance Trust.
M13	**MassCas**	**Fleet compliance with national specification**	NHS Ambulance Trusts must ensure that the minimum contents for each MCV (specified through the national load list) are maintained on the vehicle and remain fit for operational deployment / utilisation.
M14	**MassCas**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that each MCV is managed in accordance with national procedures and other associated national safe system of work provisions.
Command and control (C2)			
Domain: Generic Standards			
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements. Each NHS Ambulance Trust must comply and fully engage with any audits or inspections of the command and control capability that are commissioned by NHS England.
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the National Command and Control Guidance published by NARU.
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure (strategic commander down to functional roles) and utilisation of the Trusts interoperable capability assets to manage an incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS ambulance strategic commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Trust is responsible for ensuring compliance with these core standards and the provisions set out within the National Command and Control Guidance published by NARU. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.
Domain: Resource			
C5	**C2**	**Command role availability**	NHS Ambulance Trusts must ensure that the command roles defined within the National Command and Control Guidance published by NARU are maintained and available at all times within their service area.
C6	**C2**	**Support role availability**	NHS Ambulance Trusts must ensure that there is sufficient resource in place to provide each command level (strategic, tactical and operational) with the dedicated support roles set out in the National Command and Control Guidance published by NARU standards at all times.

C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Trusts must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions. Those skills and the mandatory levels of competence are defined within the National Training Information Sheets for Command and the National Occupational Standards for Command. This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.
C8	**C2**	**Contractual responsibilities of command functions**	Staff expected to discharge strategic, tactical, and operational command functions must have those responsibilities explicitly defined within their individual contracts of employment.
C9	**C2**	**Access to PPE**	The NHS Ambulance Trust must ensure that each commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function. To ensure interoperability at a national incident, this must include access to tabards that are compliant with the specification defined within the National Command and Control Guidance published by NARU.
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Trust must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.
Domain: Decision making			
C11	**C2**	**Risk management**	NHS ambulance commanders must manage risk in accordance with the method prescribed in the National Command and Control Guidance published by NARU and the JESIP principles.
C12	**C2**	**Use of JESIP JDM**	NHS ambulance commanders at all levels must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.
C13	**C2**	**Command decisions**	NHS ambulance command decisions at all three levels must be made within the context of the legal and professional obligations set out in the National Command and Control Guidance published by NARU. Tactical and operational commanders must utilise the national Standard Operating Procedures (SOPs) for command and associated safe system of work provisions.
Domain: Record keeping			
C14	**C2**	**Retaining records**	All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.
C15	**C2**	**Decision logging**	Commanders at all three levels (strategic, tactical and operational) must have access to an appropriate system of logging their decisions which conforms to national best practice. Ambulance Trusts are under a legal, professional and contractual obligation to ensure their commanders maintain appropriate decision logs.
C16	**C2**	**Access to loggist**	Each level of command (strategic, tactical and operational) must be supported by a trained and competent loggist. A minimum of three loggists must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one operational commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for additional logs to be kept by non trained loggists should the need arise.
Domain: Learning Lessons			
C17	**C2**	**Lessons identified**	NHS Ambulance Trusts must ensure they maintain an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards and that such learning is shared on the national systems produced by NARU and/or JESIP.
Domain: Competence			
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the strategic commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Strategic commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Strategic commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions.
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the strategic commander function must have successfully completed a nationally recognised strategic commander course (nationally recognised by NHS England / NARU). Individuals must not be placed on an active command rota or fulfil strategic commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the tactical commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Tactical commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Tactical commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service tactical commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to a tactical commander understanding the capabilities under their command.
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the tactical commander function must have successfully completed a nationally recognised tactical commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil tactical commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.

C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the operational commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Operational commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Operational commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service operational commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to an operational commander understanding the capabilities under their command.
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the operational commander function must have successfully completed a nationally recognised operational commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil operational commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.
C24	**C2**	**Commanders - maintenance of CPD**	All strategic, tactical and operational commanders must maintain appropriate Continued Professional Development (CPD). This CPD must be aligned to the relevant National Training Information Sheet for Command and the NHS England Minimum Occupational Standards for EPRR. The core competency requirements defined within the relevant Training Information Sheet must be specifically referenced within the CPD portfolio maintained by the individual commander. Individual CPD portfolios must demonstrate sufficient maintenance of skill and competence against the minimum requirements for the role.
C25	**C2**	**Commanders - exercise attendance**	All strategic, tactical and operational commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger multiagency exercises, including table top exercises. The requirement to attend an exercise in any 18 month period can be negated by discharging the individuals specific command role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties in their command role as part of the incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. Failure to demonstrate and document these command functions at an exercise or live incident within an 18 month period must result in the individual being immediately suspended from their command duties until such time as they are able to fulfil this mandatory competency requirement.
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any ambulance service strategic, tactical or operational commander that has not maintained the competency requirements specified in the National Training Information Sheet applicable to their role, or that has not maintained the relevant continued professional development (CPD) obligations, must be immediately suspended from their command duties. They must be removed from any active command rota and must not discharge their command functions at an incident until such time as the minimum level of mandated competence can be fully demonstrated.
C27	**C2**	**Assessment of commander competence and CDP evidence**	Each NHS Ambulance Trust must have a process in place to check and verify that strategic, tactical and operational commanders are maintaining appropriate levels of CPD evidence and that they are maintaining the minimum levels of competence defined within the National Training Information Sheets. As a minimum, this must include obtaining an annual signed declaration from all active commanders that they understand the obligations defined within these core standards and that they have maintained the minimum levels of competence and CPD defined within the relevant National Training Information Sheet. Further to these annual declarations, each Ambulance Trust must undertake 'dip sampling' of multiple CPD portfolios from the strategic, tactical and operational command levels to verify the declarations being made. This assessment of randomly selected CPD portfolios should be undertaken by a suitably competent person, such as an Emergency Preparedness professional. The Accountable Emergency Officer in each Ambulance Trust is responsible for ensuring that any commander at any level who has not been able to maintain the minimum competency requirements is immediately suspended from discharging command functions at an incident.
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge a NILO or Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO or tactical advisor function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to date competence in the NILO or tactical advisor discipline.
C30	**C2**	**Loggist - training**	Personnel that discharge the loggist function must have completed a loggist training course which covers the elements and requirements defined by the National Ambulance Service Command and Control Guidance published by NARU.
C31	**C2**	**Loggist - CPD**	Personnel that discharge the loggist function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The medical director of each NHS ambulance service is responsible for ensuring that the strategic medical advisor, medical advisor and forward doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the National Ambulance Service Command and Control Guidance published by NARU).

C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the medical advisor or forward doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise involving ambulance service interoperable capabilities every 18 months. Attendance at these exercises will form part of mandatory continued professional development and evidence must be included in the form of documented reflective practice for each exercise
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (strategic, tactical and operational) and the NILO and tactical advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in compliance with these principles
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors (or equivalent) must be aware of the ambulance service's operational capabilities, including the interoperable capabilities, and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the National Command and Control Guidance published by NARU to enable the initial steps to be taken (e.g. notifying the Trust command structure, wider alerting mechanisms, following action cards etc.)
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line ambulance responders will often be, by default, the interim first commander at scene. So, all frontline operational ambulance staff must be aware of basic major incident principles, including their Trust's major incident plan and the need to follow major incident action cards. They must all have access to such cards. All frontline operational ambulance staff must be sufficiently competent to provide accurate information back to the control room and take the initial steps detailed on relevant major incident action cards safely and effectively.
JESIP Specific Core Standards			
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine must be incorporated into all organisational policies, plans and procedures relevant to a multi-agency emergency response within NHS Ambulance Trusts.
J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.
J3	**JESIP**	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine
J4	**JESIP**	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that commanders and command support staff have access to the latest JESIP products, tools and guidance.
J5	**JESIP**	**Awareness of JESIP - Responders**	All relevant front-line NHS ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene.
J6	**JESIP**	**Awareness of JESIP - control room staff**	NHS ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets.
J7	**JESIP**	**Training records - staff requiring training**	NHS ambulance service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.
J8	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.
J9	**JESIP**	**Training records - annual refresh**	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.
J10	**JESIP**	**Commanders - interoperability command course**	All active commanders (strategic, tactical and operational) are required to ensure that JESIP forms part of their ongoing continued professional development portfolios and evidence. This must include reflective practice that includes specific JESIP principles from an exercise or live incident every 18 months.
J11	**JESIP**	**Participation in multiagency exercise**	At least every three years, all NHS ambulance commanders (at strategic, tactical and operational levels) must participate as a player in a joint exercise with at least Police and Fire Service command players where JESIP principles are applied.
J12	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.
J13	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a M/ETHANE message.

Lancashire and South Cumbria Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

STATEMENT OF COMPLIANCE

North West Ambulance Service has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, North West Ambulance Service will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____

Date signed

01/09/2025 26/11/2025 _____

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Lancashire and South Cumbria Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2025-2026

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Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

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Signed by the organisation's Accountable Emergency Officer

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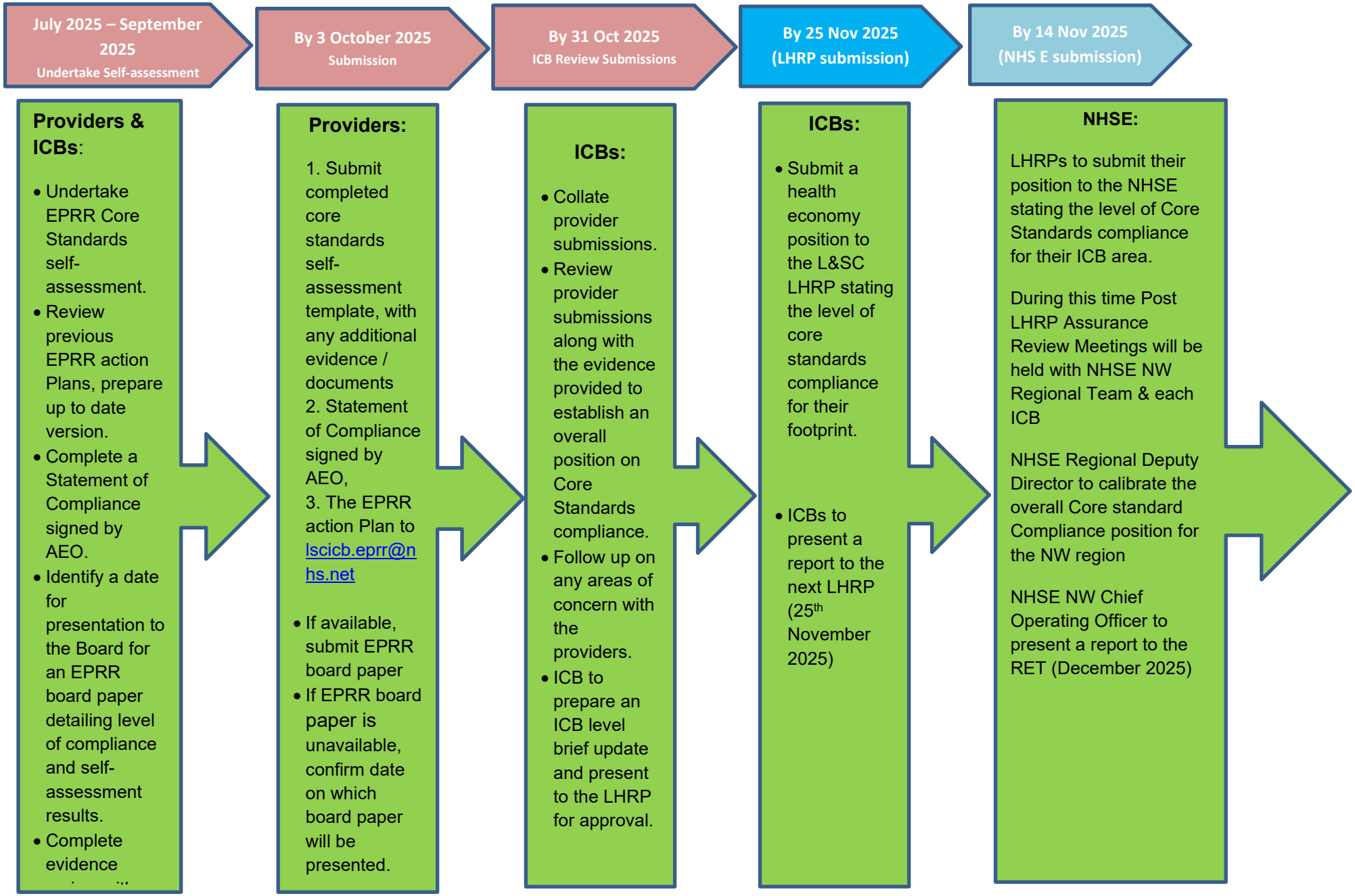
Date signed

01/09/2025 26/11/2025 _____

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

2025-26 NHS England North West Core Standards for EPRR:
Summary of the Assurance Process for Lancashire and South Cumbria
(Version 0.1, 17th July 2025)



NHS
North West Ambulance Service
NHS Trust

REPORT TO THE TRUST BOARD OF DIRECTORS

DATE	Wednesday, 24 September 2025
SUBJECT	NWAS Winter Board Assurance Statement
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 has already requested sight of the NWAS Strategic Winter Plan and supporting winter planning template. These were submitted to NHSE on 30 July 2025, with no follow up queries or clarifications requested. The strategic plan has now the framework for development of a tactical delivery plan, which will contain the detail of operational deployment, staff welfare and escalation planning. Tactical Planning is underway led by the Area Director for C&M. NHSE requires further assurance from all organisations in the form of a short Board Assurance Statement template, appended for approval.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 17 September 2025
	Outcome	Approved with amendment

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. There are no sustainability impacts, and that the EQIA has not identified any equality impacts.

6.	ACTION REQUIRED
	The Board of Directors is asked to: • Note and approve the content of document • Approve submission to NHS England NW

Winter Planning 25/26

Board Assurance Statement (BAS)

Ambulance Trusts

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the National Ambulance Team via england.ambulance@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	The Board approved the NWAS Strategic Plan in July 2025. This Strategic Plan, alongside other escalation plans, now forms the framework from regional and local tactical and operational plans.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The NWAS plan for 2025/26 builds upon plans developed over years of system engagement. The plan has been shared with our lead commissioners and system partners.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Exercise Aegis was attended by NWAS on 8 September 2025.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Mr Dan Ainsworth, Executive Director of Operations.
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its Category 2 ambulance response time trajectory and is assured the Winter	Yes	NWAS response trajectory is reviewed regularly

Provider:	Double click on the template header to add details

Plan will mitigate any risks to ensure delivery against the trajectory already signed off and returned to NHS England in Q1 2025/26.		alongside NHSE colleagues, in accordance with tracking progress associated with UEC specific investment this year.

Provider CEO name	Date	Provider Chair name	Date
Salman Desai		Julia Mulligan	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5-percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	YES	NWAS has taken improvement learning from 2024/25, and has a well developed plan ready for deployment on 1 October. The plan is supported by a new staff communications campaign to promote vaccine uptake.
Demand Management – Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	YES	Demand in 999 and NHS 111 services is known to be different on different days. These days though are predictable, enabling staffing to be flexed as far as possible to meet demand surges, within an ultimately finite staffing profile. Additional external resources are procured to augment mainstream NWAS resources throughout the winter period. This additional cover has already been increased by 30% in preparation for the Autumn.
3. Rotas have been reviewed and updated to ensure there is maximum decision-making capacity at times of peak pressure, including weekends and bank holidays.	YES	Additional senior paramedic posts have been introduced into operations this year, alongside additional EOC clinicians and a

		new team of 60 operational Duty Officers to support our operational clinicians and to address issues as they arise. Additional advanced paramedic practitioners are being recruited to support real time remote crew advice calls. These new posts will be active during Q3.
4. Rotas have been reviewed and updated to ensure optimisation of call handler and clinical capacity within EOCs, including overnight, to manage forecasted call demand and deliver the level of clinical assessment required.	YES	NWAS has procured new workforce management systems this year for 999 and 111 call handling to plan staff numbers, and to track real time activity, performance and productivity.
5. Rotas have been reviewed and updated to ensure optimisation of front-line staffing capacity to respond to forecasted demand profiles.	YES	In year recruitment will deliver additional staff into operations by the end of the calendar year. NWAS has strong demand and performance prediction experience to plan rosters. The operational fleet has been increased to enable the production of additional physical resources as well as staffing.
6. Annual leave schedules have been reviewed and updated ahead of winter and procedures are in place to rapidly adjust arrangements in response to surge pressures, including cancelling annual	YES	NWAS has worked with Trade Unions to extend the annual leave reduction / embargo period from 2 weeks to 3 weeks over the festive

leave and standing up overtime arrangements if required.		period, to include the known high pressure period after New Year.
7. Opportunities to maximise resource utilisation have been considered, including increased utilisation of non-DCA resources to respond to incidents including use of PTS, CFRs, RRVs etc.	YES	The NWAS Clinical Safety Plan has been fully revised, reissued on 8th September 2025.
Demand Management – Operations		
8. Plans include actions to maximise clinical navigation and validation and increase ‘’hear and treat’’ rates, referring into alternative services where appropriate. Clinical models have been reviewed and can be flexibly deployed in response to operational demand to ensure delivery of performance improvements.	YES	Well established hear and treat processes in place, which will be augmented this year by further re-assessment of inbound HCP demand.
9. Call Before Convey pathways are in place in line with locally agreed protocols to support “see and treat” activity and reduce avoidable conveyance. Ambulance crews should have access to additional support from EOC clinicians and SPOAs.	YES	All localities have local non conveyance arrangements, though SPOA’s are not present in every area. NWAS has invested in 18 additional Advanced Paramedics this year with a focus on providing real time crew clinical advice. This cadre will be active during December 2025.
10. Processes are in place to provide overnight support for call handlers and clinicians to provide urgent in-home care for non-emergency, clinically assessed patients, with follow-up services available the next day.	YES	NWAS has well established arrangements with local OOH services to immediately accept low acuity calls. They are not held on the NWAS waiting queue.
11. Plans and SOPs are in place to support ambulance crews to complete hospital	YES	HO 45 is established everywhere except North Cumbria. NWAS has inveted in ambulance

handovers within 15 minutes, with none exceeding the 45-minute maximum.		liaison officers at the highest attendance sites. All ICB areas have Ambulance Improvement Groups in place to regularly review handover performance. There is a regional steering group in place led by NHSE to oversee the HO45 workstream.
12. CSP and DMP frameworks have been reviewed and updated and will be utilised as appropriate.	YES	CSP has been fully reviewed and implemented in September 2025.
13. Plans are in place to support staff welfare through periods of high demand.	YES	In addition to statice ALOs at key sites, we have further mobile ALO resources. NWAS has invested in 60 Duty Officers this year who are available 24/7 to support staff. All ED's have facilities for snacks and hot drinks, provided by NWAS.
Infection Prevention and Control (IPC)		
14. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	YES	IPC colleagues are part of the tactical winter planning team Practical measures in respect of PPE are part of that group's focus.
15. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	YES	Fit Testing compliance is good in all operational areas. This is reported monthly through operational assurance monitoring.
Leadership		

16. On-call arrangements are in place and have been tested.	YES	Augmented this year by the 60 operational Duty Officers.
17. Business Continuity Plans have been reviewed and include processes and mitigating actions to maintain service delivery over winter.	YES	The NWAS IRP has been reviewed and updated this year.
18. Learning from previous winters has been reviewed and has been factored into planning.	YES	Particular additional focus this year on staff wellbeing.
19. Discussions have taken place with NHSE regional teams, ICBs and local systems to support enhanced ability to refer patients into alternative services, reduce avoidable conveyance and ensure hospital handover compliance.	YES	All areas have implemented local models of Call before Convey / Single Points of Access. Work already well underway to implement digital referral models.
20. Engagement has been undertaken with system partners, including primary care, to ensure appropriateness of HCP and IFT requests, supported by sufficient clinical senior decision making within EOCs.	YES	NWAS Clinicians are now re-assessing low acuity HCP demand to direct patients to most appropriate ‘front doors’ and to avoid ambulance conveyance wherever possible. All IFT request are clinically validated to confirm clinical priority and best response vehicle type.

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ESCALATION AND ASSURANCE REPORT

Report from the Quality & Performance Committee

Date of meeting	Monday, 01 September 2025			
Members present	• Prof A Esmail (Chair) • Dr D Hanley • Dr A Chambers • Dr E Strachan-Hall • Mr D Ainsworth • Dr C Grant	Non-Executive Director Non-Executive Director Non-Executive Director Director of Quality Director of Operations Medical Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None

ADVISE:

- The Q&P Dashboard highlighted:
  - Cat 1 mean performance in July was within the 90% percentile
  - Cat 2 sustained level of performance and was achieving the UEC standards
  - Cat 3 performance remained longer than the mean ARP target. This was negatively impacted by A&E turnaround times which exceed the 30-minute maximum standard although have fallen since May. There was significant regional variation in this performance.
  - PTS - stable metrics and an increase in unplanned activity following the withdrawal of funding from local provision
  - Overall ROSC (return of circulation performance) was stable and above national average)
  - Increase in higher risk score complaints
  - Decrease in patient safety events
  - The patient Friends and Family test average rose slightly in PTS but fell slightly in PES and 111

- The Committee received the approved Q1 position of the Board Assurance Framework.

- The Committee received an update on the patient safety and noted significant progress in addressing the backlog.

- The Committee received the draft Emergency, Planning, Resilience, Response (EPRR) Annual Assurance 2025 and noted the anticipated submission against the Ambulance Service Core Standards was 93%, which was substantial.

- The Committee received assurance from the Medicines Management Q1 2025/26 including update regarding Home Office licence risk and mitigation.

ASSURE:

The Q&P Committee received the following reports for assurance:

- QIA Follow up report
- Complaints Assurance Report Q1 25/26
- Learning from Deaths Q4 24/25 including annual dashboard.

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, 24 September 2025
SUBJECT	Bi-Annual Assurance Report – Partnerships & Integration
PRESENTED BY	Mike Gibbs, Director of Strategy & Partnerships
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 paper • Support the ongoing work of the Partnerships and Integration Team

EXECUTIVE SUMMARY	This report highlights the progress made by the P&I team from April 2025. It provides a summary of:
	• **Internal / External work** (page 3-4)
	• **Evidence and Assurance via Knowledge Vault, including developments and next steps** (page 4)
	• **Engagement Activities 2025/26** (page 7) specifically:
	  ○ Communities of Learning – Leadership for external engagement
	  ○ PTS external engagement
	  ○ Stakeholder engagement mapping
	  ○ Shared external engagement calendars
	  ○ Potential re-introducing of exec-led information sharing meetings
	  ○ Service reconfigurations
	• **External Engagement maturity survey with partner organisations across the trust areas** (page 11)
	  ○ Initial results of the 2025 survey

	○ Areas for improvement and next steps	
PREVIOUSLY CONSIDERED BY	N/A	
	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

This report provides an update on the work of the Partnerships and Integration (P&I) team from April 2025 to date, along with a summary of progress across our key areas of focus. The P&I team are made up of a Partnerships and Integration Manager (PIM) for each of the three trust areas.

The NHS England Guidance on Good Governance and Collaboration sets clear expectations of all NHS organisations and system partners to work together around:

- Shared planning and decision-making.
- Collective responsibility for service delivery across system and place.
- Delivery of agreed system improvements

This is re-enforced by the NHS Provider licence; The Health and Care Act 2022 and the NHS Constitution. The P&I team are crucial in our working together and partnership working with external partners. The main remit of the team is to:

- Strengthen partnership working both internally and externally
- Manage and maintain relationships / External engagement
- Improve the flow and exchange of information

The team has continued to work at pace throughout 2025/26, recognising that strong internal and external partnerships will be crucial in any future CQC or external inspection of the Trust. With that in mind, the focus has been on building and strengthening these relationships.

2. HIGHLIGHTS FROM APRIL 2025

2.1 Internal work has included:

- Building capability, confidence and competence through a Communities of Learning session around Leadership for External Engagement for managers with external engagement responsibilities
- Supporting directorates in progressing "Release to Rescue 45" work
- Mapping engagement with PTS and supporting the Operational Delivery Group
- Developing and embedding the "Call Before Convey" approach
- Contributing to strategy development
- Sharing the implications, opportunities, risks and impacts of the 10-Year Health Plan
- Helping directorates ensure the right people are attending the right meetings, sharing the right messages
- Continuing to evidence and assure the Trust's external engagement through the Knowledge Vault
- Developing the KV further through user feedback

2.2 Externally the focus has been on:

- Building, maintaining, and developing relationships with key partners by attending meetings and working together on system-level challenges
- Regularly updating stakeholder engagement map across the Trust to keep track of all external meetings and ensure we're engaged in the right conversations, at the right level
- Horizon scanning of local, regional and national documents to ensure the trust is sighted and has a view going forward

- Refreshing an external engagement maturity survey with over 140 external partners to see their view on the value of our external engagements and any feedback or improvements we can make

2.3 The P&I team are focussed on working both internally and externally and the main priorities for Q1-Q2 2025/26 have been around the three areas listed in s1.2 and the priorities formed on the back of the annual plan for 2025/26.

2.4 The recent publication of the NHS 10 Year Health Plan has meant a lot of intensive work with the Strategy & Planning team to work through the impacts, implications, risks and working together arrangements that may need to be put in place.

3. EVIDENCE & ASSURANCE OF EXTERNAL ENGAGEMENT – THE KNOWLEDGE VAULT (KV)

3.1 The KV is an in-house build which allows the assurance, evidence and information of external engagement.

3.2 This aims to meet the CQC recommendation that trusts should have effective governance and assurance systems in place to manage external partnerships and engagement, through transparency and accessibility.

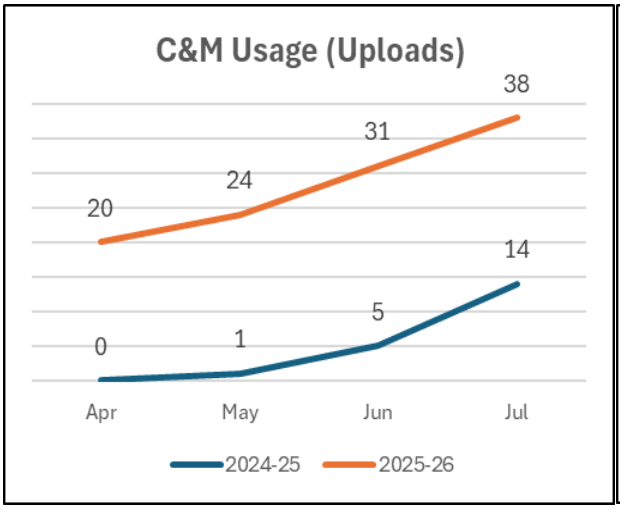
3.3 Increased use over the past 18 months has provided improved assurance around engagement and promoted consistency in messaging due to teams having access to notes and insights from meetings taking place in their area and therefore being more prepared for future meetings, by ensuring actions are followed up.

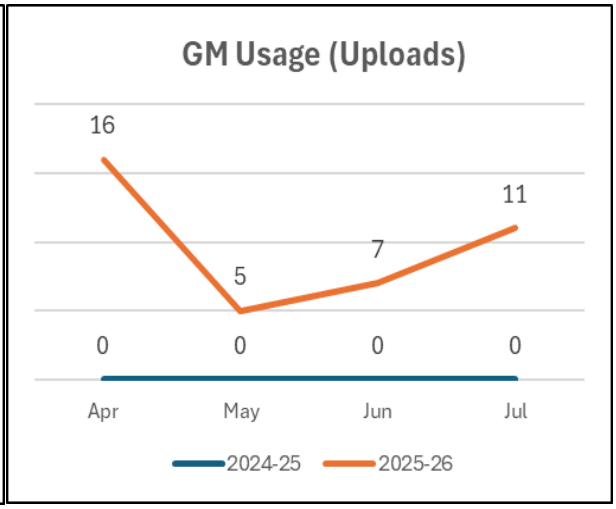
3.4 It is important to note that the KV is only as good as the input, and the PIMs are regularly working with all directorates to ensure any managers with external engagement responsibilities utilises the KV through input and access to information.

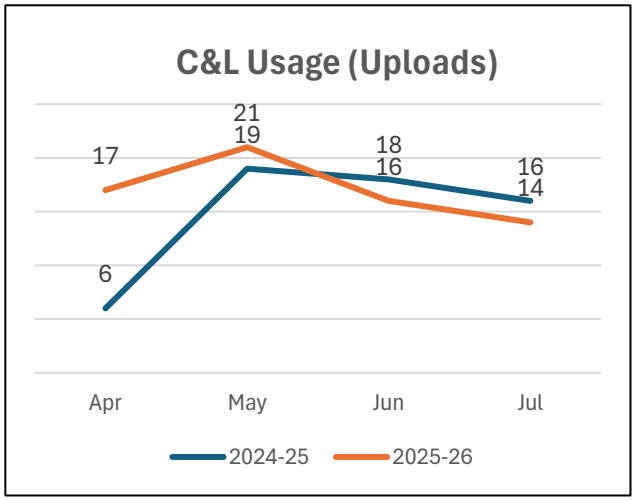
3.5 The P&I team have worked closely with service delivery teams in each area to promote the value of using the KV and will continue to promote the platform. This is evident in the recent significant increase in those accessing the information stored within Knowledge Vault.

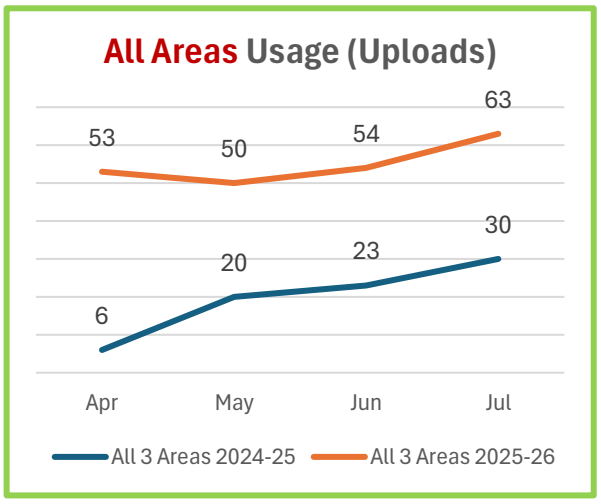
3.6 Line graph 1 below shows the number of uploads (meeting notes; action trackers; agendas etc) per area for the period April to July 2024 vs April to July 2025:

- Cheshire & Merseyside has seen a significant increase from last year
- Greater Manchester has seen an improving position from a nil start last year
- Cumbria & Lancashire has maintained consistent utilisation







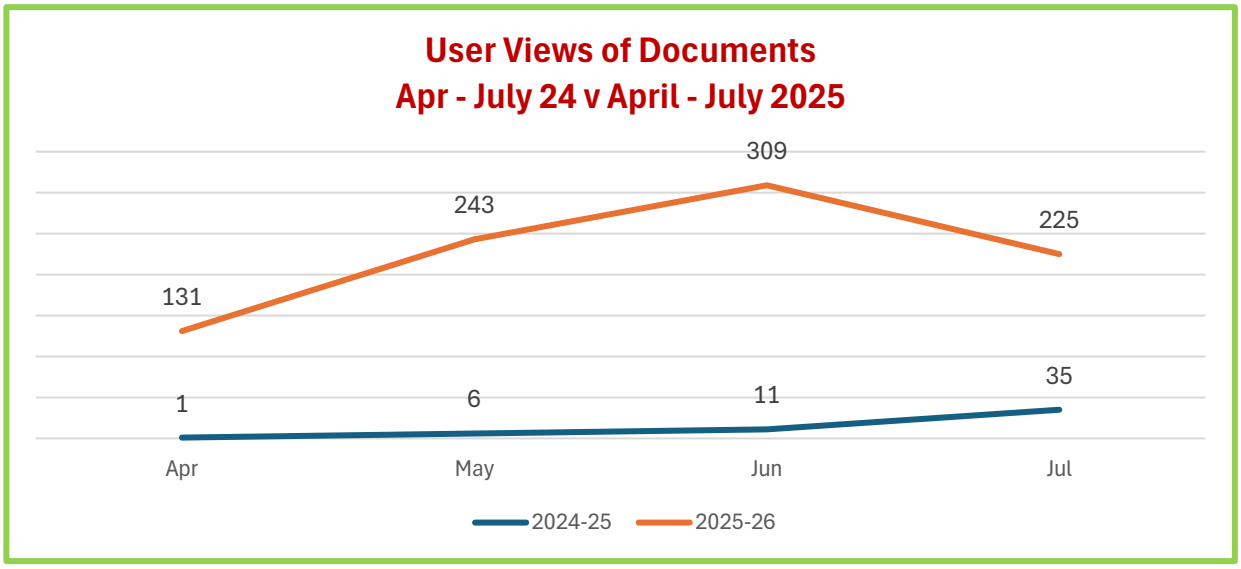


Line Graph 1 - KV Usage April – Jul 2024 v April to Jul 2025

- The usage across the three service delivery areas combined for April to July 2025/26 vis-à-vis the same period last year shows significant improvements.
- The PIMs have been tasked with ensuring this improvement continues

3.7 It is important, from a reference and accountability perspective, that managers actively view uploaded documents and meeting notes.

Line graph 2 below illustrates the number of views for meetings / documents across the Trust during the same period. This indicates that the KV is becoming a key source of information, data, and intelligence which is increasingly being utilised.



Line Graph 2 – User Views of Documents: April – Jul 2024 v April to Jul 2025

3.8 KV Developments from user feedback and new improvements - We've made several improvements to the KV based on user feedback to make it easier and quicker to use, these include:

Development	Benefit
Quick Access on Login	Showing the most recent meetings / documents
Tagging Users	Tagging colleagues into actions
Usage Tracking	Allowing user activity to be monitored
Folder Permissions	Security in place for folders
Popular Content Table	Details on the most viewed documents

3.9 Going forward, the migration to NWAS hosting ensures that the KV has the potential to be developed further, e.g. converting the website into a desktop & alerts via a phone app. Considerable development work has enabled the KV platform to be more secure and has greater potential for future developments.

3.10 Benefits of the KV to NWAS - The KV allows:

- Evidence and assurance that external engagement at differing levels within the trust is taking place
- Information and intelligence to be available internally to inform dialogue, discussion, debate and decision making
- Provision of effective governance and assurance system for any external inspection
- The monitoring of actions to ensure they are completed
- Allows managers with external engagement responsibilities to be fully prepared for meetings

3.11 KV Way Forward - We are on a journey to ensure that all external engagement is consistently recorded and assured. While progress has been made, we have not yet reached our goal. Work is still needed to achieve full commitment and adoption, across all Trust directorates.

3.12 Next Steps:

- Continue to promote KV, raise awareness, and hold open sessions for managers with external engagement responsibilities
- Ongoing development and enhancement of KV
- Continue sharing utilisation data with Exec Directors and Area Directors to help identify where targeted support and focus on managers is required
- Feedback on quality of submissions

4. ENGAGEMENT ACTIVITIES

4.1 Communities of Learning (CoL) - Leadership for External Engagement - In May, the team ran a CoL session across each of the three Trust areas. The session focused on learning through reflection and helped support managers to be more confident and competent in external engagement and the support they may need.

4.2 PIMs helped guide, facilitate and lead the session by sharing their own experiences, and managers had the chance to talk about their work with external partners and to explore differing methods of engagement.

4.3 The P&I team will continue to support leadership teams in building a more consistent approach to external engagement when required.

4.4 PTS External Engagement - Within the wider PTS Improvement Programme, it was recognised that NWAS's external relationships for PTS had diminished post-COVID, with reduced participation in local forums and unclear escalation routes.

4.5 To address this, a targeted PTS-specific relationship survey has been developed to assess:

- Current engagement levels
- Communication
- System visibility
- Issue resolution across the footprint

4.6 Co-designed by the P&I team with input from the PTS Operational Delivery Group, the survey is due to be issued in September 2025. The results will inform local improvement actions and guide future engagement approaches, with a summary of findings due by October 2025.

4.7 This is a necessary first step to take stock of where are with our current engagement and what needs to be put in place.

4.8 Stakeholder Engagement Mapping – this is refreshed regularly across all three areas and all directorates across the Trust to ensure that it is up to date. It maps all our external meetings with partners across the areas as well as regionally. This is a necessary first step in ensuring that we know where we need to focus our relationship management and work with partners.

4.9 It is also important in ensuring that we have the right representation, at the right level, attending the right meeting, with the right messages. The updated mapping across the areas is shared with Area Directors and senior managers to ensure they are aware of any changes taking place across their areas.

4.10 A key benefit of the mapping allows the identification any new structures externally and of any gaps in representation.

4.11 It is also timely at the point as it allows our strategy and planning team to progress their strategy development work with partners, as well as allowing the trust to engage around the 10 YHP.

4.12 Shared External Engagement Calendars - Shared external engagement calendars allow each PIM to see who is meeting with whom, ensure consistent and appropriate representation, and track information flow back into the organisation via KV uploads, it enables a coordinated and consistent approach to our PES engagement and to allow greater transparency over external engagement.

4.13 Cheshire and Merseyside piloted a shared calendar system earlier in 2025 to coordinate this work, creating a more structured and intentional approach to external engagement.

4.14 Following its success, the system has been rolled out across Cumbria and Lancashire, replacing ad-hoc arrangements with strategic oversight of external partnerships. Work is ongoing with Greater Manchester area to get it into a position to follow.

4.15 This greater visibility of what is going on, on a daily/weekly basis allows the PIMs/Area Directors and area management teams to have a more proactive working together approach to external engagement.

4.16 Potential reintroduction and of exec-led information sharing meetings - It is important to get our senior internal engagement right, as a result work is underway to explore reinstating the executive-led information sharing meetings.

4.17 These meetings previously brought together the executive director responsible for each area, along with the Area Director, Head of Service, Consultant Paramedic, PIM, and the Head of Partnerships and Integration.

4.18 The focus was on sharing data, intelligence, and insights that would benefit area management teams.

4.19 The meetings were discontinued due to inconsistencies in format and approach between areas. Current efforts will aim to relaunch them with a clearer purpose, defined expectations, and a consistent structure to improve the quality and flow of information shared. However, it is important to balance this with diary commitments. Where possible the intention will be to add the engagement elements into existing meetings with the required attendees.

4.20 Service Reconfigurations - The P&I team are involved in numerous service changes across the three areas. This generally involves detailed work with Service Delivery, People, Finance, and Clinical teams at specific stages of the changes. The table shows the main ones in the areas:

Area	Active Reconfigurations
Cheshire and Merseyside	**Shaping Care Together** • Covering Southport, Ormskirk, and Whiston hospitals. • Aims to improve care quality and make services sustainable. • Services in scope: urgent & emergency care, maternity, sexual health, gynaecology, elderly care, paediatrics, and planned care. • Two possible future setups for A&E (adult & children): 1. All based at Southport – ready by **June 2029**. 2. All based at Ormskirk – ready by **June 2031**. **Liverpool Hospitals Merger – University Hospitals of Liverpool Group (UHLG)** • In Nov 2024, Liverpool University Hospitals NHS FT and Liverpool Women's NHS FT merged into UHLG covering Aintree, Broadgreen, Liverpool Clinical Labs, Liverpool Women's, Royal Liverpool, Clatterbridge Cancer Centre, The Walton Centre. • The goal is closer collaboration & less duplication, especially in gynaecology, anaesthetics, surgery, cardiology, thrombectomy, and thrombosis. • No specific service changes yet – discussions ongoing. **Women's Hospital Services in Liverpool** • Reviewing maternity & gynaecology services at Liverpool Women's (currently separate from ICU/critical care). • Options due Sept 2025; business case in Q3. • Modelling will take place once plans are clearer. • High media/public interest – leaders told not to comment publicly.

Greater Manchester	**Major Trauma Network Reconfiguration** • The current setup doesn't meet national standards. • Major trauma patients now go to Manchester FT (MFT) or Salford Royal depending on location. • Three options being considered, including centralising all care at either MFT or Salford Royal. • NWAS involved in design, modelling, and cost analysis. • A revised "NWAS-only" pathway was rejected as it wouldn't meet standards. • It is likely that after modelling that extra resources will be needed whichever model is chosen. **Point-of-Care Troponin Testing (T-MACS Pilot)** • Led by Manchester FT. Tests for heart attacks in the ambulance using a handheld device & app. • NWAS involved in app testing and small-scale trials in Greater Manchester. • Still a pilot – no rollout date yet.
Cumbria & Lancashire	**Vascular Network Reconfiguration** • **Current system:** two vascular centres (Royal Blackburn & Royal Preston) covering Lancashire, South Cumbria, and Wigan. • National guidance says each network should have one hub for complex surgery serving 800k+ people. • **Proposal:** one specialist arterial centre at Royal Preston Hospital. • Strategic business case nearly finished. • Modelling has been completed based on projected activity.

5. EXTERNAL ENGAGEMENT SURVEY WITH PARTNERS ORGANISATIONS ACROSS THE TRUST AREAS

5.1 To assess the maturity of our external relationships, the P&I team surveyed external stakeholders in 2023. The responses were reviewed to inform focused improvement work with area teams, particularly with regard to inconsistent or no NWAS representation.

5.2 This exercise was recently repeated, expanding the range of stakeholders, including traditional blue light partners, NHS providers, voluntary sector and local government.

5.3 External engagement maturity surveys 2023 v 2025 - Are we adding value: The aim of the survey was simple:

- to understand if we are adding value
- see how our engagement with partners is progressing
- identify where we can do better

5.4 The latest survey reached partners across all three areas of the Trust and was sent to over 140 external partners – much like in 2023. To make sure the results could be directly comparable, the same questions as in 2023, were used.

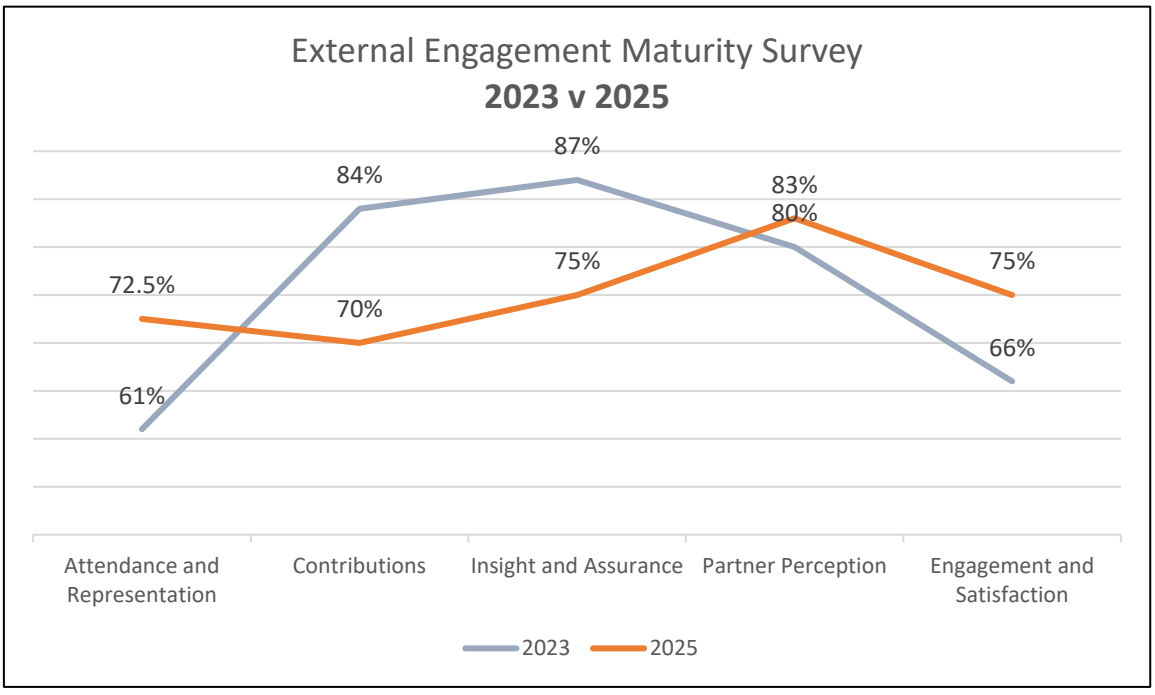
The survey has shown an improvement on the 2023 results across most of the metrics.

Below is a summary of the 2025 responses under 5 broad headings.

No	Area	Narrative	2023 %	2025 %
1	Attendance and Representation	NWAS always attends meetings, with consistent leads	61	72.5
2	Contributions	NWAS representatives always provide useful input to discussions and decisions	84	70
3	Insight & Assurance	NWAS attendees always provide suitable insight into the organisation and felt NWAS offers adequate levels of assurance	87	75
4	Partner Perception	Agree that NWAS are good partners	80	83
5	Engagement Satisfaction	felt appropriately engaged, with many appreciating NWAS' understanding of system pressures and willingness to collaborate	66	75

5.5 This is shown in line graph 3 below, some of the comments from the 2025 survey stated NWAS are:

- forward-thinking, keen to engage, and effective in partnership working
- fantastic partnership working approach
- excellent partners



Line Graph 3 – External Engagement Maturity Survey August 2025

5.6 Areas for Improvement and Next Steps - As this survey was only finalised in early September 2025, more in-depth analysis is required. Although the initial analysis shows an improving position, it's also clear there are areas where we can improve and where attention is required, these areas being:

- Contributions – showed a drop from 84% in 2023 to 70% in 2025
- Insight and Assurance – showed a drop from 87% in 2023 to 75% in 2025

5.7 A full analysis and summary will be shared with directorates, split by area / trust. The survey outcomes will inform discussions with directorates to address areas where we need to focus improvement.

6. RISK CONSIDERATION

Currently there is SR07 reported through the internal assurance processes, however this is being managed well, and has been mitigated through the previous year. Any other risks identified will be managed proactively and reported through the internal process.

7. EQUALITY/ SUSTAINABILITY IMPACTS

We will ensure that Equality, Diversity and Inclusion is considered throughout the work and any equality impact assessments produced where necessary. The team is committed to an engagement approach which is inclusive to all.

Sustainability will be a theme within the engagement work. The aim is to have sustainable, lasting relationships and working together arrangements both internally and externally.

8. ACTION REQUIRED

The Board of Directors are asked to:

- Note the contents of this paper
- Support the ongoing work of the P&I team