AGENDA

NHS North West Ambulance Service NHS Trust

Board of Directors
Wednesday, 26th November 2025
09:45 – 13:00
Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2526/097	Staff Story	09:45	Information	Chief Executive
INTRODUCTION				
BOD/2526/098	Apologies for Absence	10:00	Information	Chair
BOD/2526/099	Declarations of Interest	10:00	Decision	Chair
BOD/2526/100	Minutes of the previous meeting held on 24th September 2025	10:05	Decision	Chair
BOD/2526/101	Board Action Log	10:10	Assurance	Chair
BOD/2526/102	Committee Attendance	10:15	Information	Chair
BOD/2526/103	Register of Interest	10:15	Assurance	Chair
STRATEGY				
BOD/2526/104	Chair & Non-Executive Directors' Update	10:20	Information	Chair
BOD/2526/105	Chief Executive's Report	10:25	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2526/106	Board Assurance Framework Q2 2025/26	10:40	Decision	Director of Corporate Affairs
BOD/2526/107	Bi-Annual Common Seal Report	10:50	Assurance	Director of Corporate Affairs
BOD/2526/108	Corporate Calendar 2026/2027	11:00	Decision	Director of Corporate Affairs
BOD/2526/109	Fit and Proper Person Procedure	11:10	Decision	Director of People
BOD/2526/110	Freedom to Speak Up Policy	11:20	Decision	Medical Director
BOD/2526/111	Ratification of NHSE Board Capability Self-Assessment Statement	11:30	Decision	Director of Strategy & Partnerships

BOD/2526/112	Well-led Developmental Review Action Plan	11:40	Decision	Director of Quality & Improvement
BOD/2526/113	Audit Committee 3A Report from the meeting held on 24th October 2025	11:50	Assurance	Prof A Esmail, Non-Executive Director
BOD/2526/114	Trust Management Committee 3A report from the meetings held on 22nd October 2025 and 19th November 2025	11:55	Assurance	Chief Executive
BREAK 12:00 – 12:10				
RESOURCES				
BOD /2526/115	Resources Committee 3A report from the meeting held on 20th November 2025	12:10	Assurance	Dr D Hanley, Non-Executive Director
QUALITY AND PERFORMANCE				
BOD/2526/116	Integrated Performance Report	12:15	Assurance	Director of Quality & Improvement
BOD/2526/117	Learning from Deaths Q1 2025/26	12:25	Assurance	Medical Director
BOD/2526/118	Quality and Performance Committee 3A report from the meeting held on 27th October 2025	12:35	Assurance	Prof A Esmail, Non-Executive Director
STRATEGY, PARTNERSHIPS AND TRANSFORMATION				
BOD/2526/119	Communications and Engagement Q2 2025/26 Report	12:40	Assurance	Director of Strategy & Partnerships
CLOSING				
BOD/2526/120	Any other business notified prior to the meeting	12:50	Decision	Chair
BOD/2526/121	Risks Identified	13:00	Decision	Chair
DATE AND TIME OF NEXT MEETING				
28th January 2026 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.				

Minutes
Board of Directors

Details: 9.45am Wednesday, 24th September 2025
Oak Room, Ladybridge Hall, Trust Headquarters

Ms J Mulligan	Chair
Mr S Desai	Chief Executive
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 S Wimbury	Area Director
Mr A Makda	NeXT Programme Director
Mrs A Cunliffe	Corporate Governance Manager (Minutes)

Observers:

Ms R Fagbemi	HR Graduate Management Trainee

Minute Ref:
BOD/2526/075 Patient Story

The Chief Executive introduced a film, which originated from a complaint and highlighted the consequences of using outdated manual handling techniques and the impact on patients, showing how such practices could lead to severe complications.

The film featured Mrs Christine Fitzpatrick discussing the experience of her late mother, Mrs Doreen Pilling, who suffered severe complications after outdated manual handling techniques were used by ambulance staff on 3 September 2023.

Mrs Pilling, aged 93, was injured during an attempted lift, resulting in a broken leg and a prolonged hospital stay, ultimately leading to her death from hospital-acquired pneumonia.

An inquest found a direct causal link between the unapproved lifting method and Mrs Pilling's death, with the coroner noting the crew had since received additional training.

No Regulation 28 report or Prevention of Future Deaths report was issued to the Trust. The coroner explained that the NWAS crew had learnt lessons, as was evident from the additional training they had received following this incident.

Mrs Fitzpatrick submitted a complaint to the Trust which resulted in a formal investigation, which took 18 months to complete.

The patient story highlighted unsafe manual handling practice and lack of incident reporting in this instance. It was also found baseline observations and arrival times were not properly recorded in the documentation.

The Board also noted the timeline of events from the incident, through the complaint and Trust meeting with the family.

The presentation advised of the individual, service-level and organisational level outputs and actions undertaken as a result of the learning from the story.

The Board discussed the events, issues involved, delays to the investigation and the learning from the Patient Story. It was noted the Trust was dependant on staff raising incidents, and that messages reinforcing honesty and transparency were being consistently fed back to staff.

Prof A Esmail reported the Quality and Performance Committee were advised staff were instructed not to delay concluding complaints due to ongoing parallel processes, such as disciplinary investigations. It was noted that complainants and families were party to outcomes of disciplinary processes, due to confidentiality.

Dr D Hanley enquired how any continuing outdated practices would be identified and eliminated. The Medical Director advised the internal structure had been remodelled to ensure specialist paramedic supervision is out and about with crews, observing practice. Key messages are introduced to staff from the induction, encouraging them to speak up and challenge any poor practice or behaviours and also to report any incidents in a timely manner.

A discussion took place regarding triangulation of data to uncover whether any incidents went unreported or missed. The Director of Quality and Improvement advised that patterns, red flags and concerns would be scrutinised to identify and reverse any poor practices.

The Board:

- Noted the content of the story.

BOD/2526/076 Apologies for Absence

The Chair welcomed the attendees to the meeting.

Apologies were received from Mrs C Butterworth, Non-Executive Director, Dr A Chambers, Non-Executive Director and Mr D Ainsworth, Director of Operations and Ms M Afsar, NeXT Programme Director.

BOD/2526/077 Declarations of Interest

There were no declarations of interest to note.

BOD/2526/078 Minutes of the Previous Meeting

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

The Board:

- Approved the minutes of the meeting held on 30th July 2025.

BOD/2526/079 Board Action Log

The Board noted all items were complete and approved for removal.

BOD/2526/080 Committee Attendance

The Board noted the Committee attendance.

BOD/2526/081 Register of Interest

The Board noted the Register of Interests presented for information.

BOD/2526/082 Chair & Non-Executives' Update

The Chair reported on several internal and external engagements within the reporting period.

The Chair highlighted that she recently spent a 12 hour shift with a paramedic crew in Preston, where she observed a variety of calls, including a complex case with links to mental health, practices on arrival to patients, as well as challenges in the hospital during handover. The Chair shared she was impressed with how deeply the crew cared for the patients and securing best outcomes for them. The Board also noted the Chair attended a fleet workshop, where she was given insight into ambulance equipment.

The Chair also advised of the ongoing recruitment processes to the Board and congratulated the teams on the successful completion of the Ofsted inspection.

The Board:

- Noted the Chair's update.

BOD/2526/083 Chief Executive's Report

The Chief Executive presented a comprehensive report, which covered activity undertaken for the period 1 August 2025 – 5 September 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 around annual planning delivery and strategy development.

In terms of Finance, the Board noted a strong and stable position with a £934k surplus at Month 5 against a planned deficit of £329k and Q3 assurance submitted to NHS Lancashire and South Cumbria ICB.

Reporting on Integrated Contact Centres, the Chief Executive advised the 'UEC Single Point of Access' went live as a pilot across Mid & North Merseyside on 28 July 2025. Phase 2 was in early delivery, but in the first week of the expanded phase 2, there was encouraging data indicating reduction in conveyance to type 1 ED.

The Board noted the result of the full Ofsted inspection, which took place between 29 August and the 2 September 2025. NWAS retained the 'good' rating overall with one area of outstanding practice.

The Chief Executive reported an Anti-Racism Steering Group had 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 brought together a wide range of stakeholders. Work was underway to launch the Trust's Anti-Racism Statement in late October, alongside a supporting information pack to outline how the commitments apply in practice for staff and managers.

The Chief Executive reported on a letter received from the NHSE North West Regional Director, Louise Shepherd, regarding the increased level of racism linked to the current political situation and reaffirmed the Trust's strong stance against any forms of racism or homophobia.

The Board noted the Trust hosted the sixth Culture Event for leaders, continuing its commitment to strengthening our culture and launched the Developing Leaders Programme with a Welcome Event that brought together 41 mentoring pairs from across the Trust.

The Chief Executive reported that NWAS had run the second of a two-day summer school at Burnley College, designed to provide the young people from diverse areas of our communities with exposure to the opportunities for employment and learning offered by the ambulance service.

In terms of Corporate Affairs, the Board noted updates regarding Well-Led Development Review and Southport Enquiry. Medical updates included NHS North West Exercise Aegis and Single Point of Access.

The Chief Executive took the Board through the national updates, which focused on AACE discussion on the NHS 10-year plan, Provider Capability Assessment and Hospital Handovers.

Due to the required October timescales for the submission of the new Provider Capability Assessment, the Board will receive the document for approval under e-governance, with a formal sign off at the next Board in November.

The Board further received various regional and system updates as per s3.3 and s3.4 of the report.

The Chief Executive concluded the presentation with a focus on organisational updates and staff announcements, as recorded in the report.

The Board:

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

BOD/2526/084 Statement of Responsibilities

The Director of Corporate Affairs presented the refreshed Chair and CEO Statement of Responsibilities.

The Board noted, that in accordance with the Code of Governance for NHS Provider Trusts 2023, the statement outlined 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 highlighted shared accountability, as the Chair and CEO have a shared responsibility in communicating with stakeholders and driving the organisation's effectiveness.

The Board:

- Approved the Statement of Responsibilities for publication on the Trust's website.

BOD/2526/085 Anti-Fraud, Bribery and Corruption Policy

The Director of Finance presented the updated version of the Anti-Fraud, Bribery and Corruption Policy. She advised of a new addition to the policy, under section 5.2, to reflect the new legislation following the introduction of a new corporate offence: Failure to Prevent Fraud, by the Economic Crime & Corporate Transparency Act (ECCTA).

The Chair suggested horizon scanning of new offences being discussed by NPO for awareness of any implications on the health service.

The Board would receive a detailed presentation regarding the new legislation at a separate session later in the day.

The Board:

- Noted the addition to the Anti-Fraud, Bribery and Corruption Policy at section 5.2 and approved the updated version of the policy.

BOD/2526/086 Trust Management Committee 3A Report from the meetings held on 20th August 2025 and 17th September 2025.

The Chief Executive presented the Trust Management Committee (TMC) 3A report from the meeting held on 20th August 2025 and advised there were three alerts and several advisements and assurance reports, as listed within the report. The alerts related to: Staff Survey Action Plans, Staff Survey 2025 – concern was raised about how staff might respond to the socio-economic background questions, and some IPR metrics, which would be discussed at the IPR item.

Prof A Esmail referred to the local Action Plans arising from the Staff Surveys. The Director of People advised those were informed by the results of the Staff Survey 2024. All service lines had been requested to focus on three distinct areas but there was a lot of variability in the development of local plans across the Trust. She advised of significant progress since the discussion at TMC in August.

Referring to the meeting held on 17th September 2025, the Chief Executive reported two alerts and a number of advisements and assurance reports, as listed within the report. The alerts were raised at IPR discussion, and related to the staff sickness percentage being above national average and a review of inter-facility transfers (IFT) and healthcare professional (HCP) incidents. Sickness absence will be picked up during the IPR item later in the agenda.

The Board:

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

BOD/2526/087 Flu Campaign 2025/26 – Board Assurance Checklist

The Director of People presented the report providing the approach to flu campaign for 2025/26. She took the Board through the overview of the last year's campaign, which concluded in March 2025 with the total uptake of 43%, and the areas of learning from it.

The Committee noted the 25/26 Flu Vaccination programme letter issued by NHS England which outlined 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. Specifically, there was a challenging target to achieve 5% increase in uptake, with a focus on early vaccination months October and November, to maximise uptake before winter pressures.

The Director of People advised the approach would be similar to last year, with multifunctional model led by IPC Specialist Lead with support from HR and the Medicines Management teams. Data analysis will be used to drive the comms this year to those areas where uptake was lower, that is BME and younger staff.

Social media, internal bulletins, and local leadership will be used ensure awareness and uptake.

The Director of People shared a concern regarding matching the data between ESR and GP records, which was raised with NHSE. The vaccination data will be reported on two systems and nationally compared to GP records – the match will depend on the name and address being accurate on both systems.

Discussion took place regarding increasing uptake among young people and BME staff. The Director of People advised the Staff Networks will be utilised to encourage the uptake, awareness will be raised also through induction and making vaccinators aware of issues so they can have effective conversations.

The Medical Director observed the risk of flu outbreak in a contact centre would have significant consequences to service delivery, so the role of leaders influencing staff and encouraging staff to take the vaccination will be crucial.

The Chair asked about confidence to achieve the 5% improvement target. The Director of People advised the team was confident to improve, however the target would be very challenging to achieve.

The Board noted the board assurance checklist, which had been previously received and endorsed by the Resources Committee.

The Board:

- Noted the approach to the Flu campaign for 2025/26
- Provided senior commitment to offer all frontline staff a flu vaccination
- Approved the Board checklist.

BOD/2526/088 Resources Committee 3A Report from the meeting held on 18th September 2025

Dr D Hanley presented the Resources Committee 3A Report from the meeting held on 18th September. The Committee received a number of reports for assurance, as listed in the 3A report, and no alerts or risks were raised on this occasion. Dr D Hanley highlighted the stable financial position and good performance on efficiency and productivity albeit with further work needed to meet the target for recurrent savings.

The Board:

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

BOD/2526/089 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 August 2025. She drew out the main points in terms of quality, effectiveness, operational performance, finance and organisational health.

In terms of complaints, the Board noted a stable position for lower acuity complaints with care and treatment being the most common theme for patient incidents and violence and aggression remaining the most common theme for non-patient incidents.

Reporting on effectiveness, the Director of Quality and Improvement highlighted the improved H&T rate which was at 16.8% for August. This was 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.

In terms of Operational Performance, the Board noted the main headlines around PES (999) national ranking, improved Call pick-up time, improved C1 and C2 achieving the UEC target.

The Director of Corporate Affairs presented an overview of complaints and incidents data and noted a stable position and an in-month improvement on closure of lower acuity complaints.

The Director of Quality and Improvement noted there was still a lower number of patient safety events and added language has been identified as a theme.

The Chair queried whether this was concerned with how patients are being spoken to, such as incivility, or if it relates to understanding due to language barriers.

The Director of Quality and Improvement would check that and inform the Chair.

With regards to Patient Experience data, the Director of Strategy and Partnership advised of a generally static position with an increase in total response rates for PES and a decrease in total response rate for PTS when compared to the same point last year.

Prof A Esmail queried whether the numbers of reported patient safety incidents were stable.

The Director of Quality and Improvement advised they were still on a downward trajectory for lower-level incidents, although the numbers were consistent for moderate and high-level incidents. The expectation was for numbers to rise, and staff were continuously encouraged to report any low harm level incidents.

Prof A Esmail referred to the non-patient incidents linked to violence and aggression and enquired about the progress with Body-Worn Cameras (BWC). The Director of Corporate Affairs reported improved use of cameras but also that it is not as high as would be expected. She advised of background work being undertaken by the Violence Prevention Reduction and Security Lead engaging with staff to promote the benefits of the BWC use.

The Director of People explained that the cameras have to be fit for purpose for the sector in an emergency care setting, as otherwise they might obstruct CPR; all these factors are being looked at.

The Medical Director reported the Trust was performing above the sector average for all Ambulance Clinical Quality Indicators (ACQI), except for the Falls bundle. Monitoring of metrics continued as well as EPR system development to drive improvement. The Medical Director informed of several initiatives in the system to improve fall prevention and care.

A discussion took place regarding system navigation and appropriate care settings for dangerous falls vs other falls, with the system working towards integration of falls services into a single access number.

The Area Director reported on the operational performance data in relation to Paramedic Emergency Services (PES) Activity, PES Call Pick Up and 999 Ambulance Response Performance.

In terms of hospital handover, the Area Director reported an improved position but the system was not achieving the target yet with variable results across different hospitals.

In reference to Patient Transport Services (PTS), the Board noted the metrics were stable. Planned and unplanned activity was below 90% contract standard. The procurement exercise would start in October.

The Area Director advised the Trust was in line with required UEC standards.

In terms of Hear & Treat, the Area Director advised the rate had increased but without a significant impact on conveyance yet. Further gains in Hear & Treat were expected from increased use of clinical capacity in the 111 service as part of the Integrated Contact Centre programme.

The Board noted also noted a stable and improved position for Call Pick up. In terms of 111, the position was stable, calls answered were at 83.6%, below the national standard, with continued monitoring post removal of third-party contingency.

Dr D Hanley suggested how data might be analysed, to gain greater insight. He noted the data was presented by area but made no reference to population size, thus making it unclear whether the number was positive or not. In terms of Cat 3 & 4 the data presented the response, and it would be useful to see demand as well.

The Director of Quality and Improvement acknowledged the suggestions for further consideration.

Prof A Esmail enquired about the correlation between increased H&T and conveyance. The Area Director advised that as H&T opportunities increase, conveyance should drop. She added that referrals to services were increasing but they weren't always accepted from the paramedics, there were also very limited pathways for mental health. The Chief Executive added additional resources had been put to ICC to improve the H&T rate.

A discussion took place regarding current C2 targets and whether the standard of 12 minutes would be restored. It was confirmed that there were no indications the current measures represented a permanent change.

The Chair referred to the point made by Dr D Hanley regarding understanding demand in data, and advised she would speak to the Director of Operations and the Medical Director outside of the meeting to understand how it links to health inequalities.

The Medical Director observed the population served by NWAS contains areas of high deprivation and deeply embedded challenges, which the Trust staff encounter and respond to daily.

The Director of Finance presented key data from the Finance section of the Integrated Performance Report and advised the detailed report had been reviewed by the Resources Committee. The Board noted the financial position to 31 August 2025 was a surplus of £0.934m, against a planned deficit of £0.329m due to non-recurrent credits received and the delivery of productivity and efficiency savings slightly above plan.

In terms of efficiencies, the Director of Finance observed that, despite a shortfall in non-recurrent position, the month 5 report compared to last year was significantly better and this year's position continued to improve.

The Director of People took the Board through the key headlines from the Workforce indicators, reporting a stable and improved position. The Board noted turnover had been reducing steadily for the last 12 months, however ICC and PTS remained the most pressured service lines with ongoing action plans in place.

The Director of People reported an improving vacancy gap position. Regarding appraisals, the Board noted compliance on or above target for all service lines except for 111 being slightly under the target.

Mandatory Training compliance shows overall compliance at 88% which was slightly below the revised target of 90%, although data indicated month by month improvement.

The Board noted an update on staff sickness absence, which was overall stable, and significantly down on the two previous years. However, the Director of People pointed to individual service lines, where sickness was higher than the same period last year, especially in EOC and PTS. The Director of People advised of several actions being undertaken and highlighted that the Attendance Improvement Team worked closely with these service lines.

The Area Director explained that both service lines have put in place new to substantive leadership appointments which would add stability to the service. In addition, a workforce improvement plan is in place for PTS.

Dr D Hanley noted the improved lower turnover rates and wondered whether, in the long term, there could be an issue if turnover became too low.

The Director of People advised the trend was positive and it was a national focus for the NHS was to improve retention rates. However, she recognised that over time, continued lower turnover could limit diversity and therefore recruitment should continue to think creatively to mitigate any risk.

A discussion took place regarding external factors that may be impacting lower turnover, such as limited opportunities elsewhere or links to cost of living. However, longevity of change would suggest that the primary reason for higher retention is the work undertaken in the Trust, in creating a great place to work, with opportunities to develop and progress.

The Board:

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

BOD/2526/090 Learning from Deaths (LfD) Q4 2024/25

The Board received the report, with a number of appendices, from the Medical Director for Q4 2024/25. The Appendices included LfD Q4 and annual dashboards, which required publication.

The Medical Director drew attention to section 5 of the report regarding National Guidance Development, which had been an ongoing piece of work. The report outlined some potential key changes. The Board noted the vast majority would not have a significant impact on the Trust as the information was already being gathered, however it would provide clarity to enable trusts to align how LfD is managed.

The Board noted updates on internal and external concerns and arising outcomes. The Medical Director pointed to section 3.3.2 which contained a summary of the identified areas for improvement for the ICC, PES and Trust-wide. Detailed learning themes and Structured Judgement Reviews could be found in the dashboard (Appendix A) and the Infographic (Appendix C). The Medical Director advised work was carried out on the data to review the totality of investigations with a report expected at Quality and Performance Committee in Q4.

Dr D Hanley observed the LfD process was very thorough and pointed to section 4 Outcomes of Learning Themes. He suggested the last piece of the puzzle was to ascertain that learning was bringing change.

The Medical Director advised learning continued to be disseminated and discussed internally as well as added to training. However, he felt that system-change is the principal driver of sustainable change.

Prof A Esmail noted the Quality and Performance Committee receives LfD reports which contained many examples of change from learning. He suggested a record of those examples and changes from LfD should be kept in the Trust.

The Director of People referred to demographics data and enquired whether there was evidence of differential outcomes for those groups. A further discussion took place which led to consensus that outcomes per the demographic data would be analysed.

A further discussion took place regarding links to enacting Duty of Candour and the ways in which it is triggered and measured. The Chair enquired about proxy assurance measures regarding organisational culture of safety to speak up.

The Director of Quality and Improvement informed how the safety incidents were measured and what compliance measures were in place when the legal duty requires to enact the Duty of Candour. The Director of People noted a link to the Staff Survey which includes questions regarding safety to speak up, thus providing proxy measures in terms of culture.

The Board:

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

BOD/2526/091 Emergency Preparedness Resilience Response Annual Assurance 2025

The Board received the report from the Area Director, who advised of an improved position compared to last year. A different approach was taken this year by EPRR Group which received a quarterly assurance report, allowing it to track the updates across the year.

The Board noted the proposed submission against the Ambulance Service Core Standards was 54/58 – 93%, which was substantial compliance against the standard, subject to ICB/NHS England challenge.

The Area Director pointed to the changes, as described in section 2 of the report for Domains 3, 8 and 9. In terms of Domain 9 referring to Data Protection and Security Tool kit, the Board noted the Trust was partially compliant last year and partially compliant this year. The Area Director provided a rationale advising that the standards for the assessment of this metric had changed over the year. 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. The Area Director advised work was underway to deliver against the requirements before the next year.

The Area Director highlighted that some ambulance standards would not reach full compliance in 2025. Pointing to the resources line, she explained that all staff undertaking major incident training would present a significant funding challenge, which had been raised with NHSE.

The Board noted the timeline of the document development and approvals with the final submission to ICB scheduled for the 3rd October.

The Board:

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

BOD/2526/092 Ambulance Winter Plan - Board Assurance Statement

The Area Director presented the report, which had been previously considered by the Board in July and submitted to NHSE. She advised that no follow up queries or clarifications were requested.

The Board noted that NHSE required further assurance from all organisations in the form of a Board Assurance Statement template, which was appended for approval.

The Area Director highlighted the Equality Impact Assessment had been completed for the plan.

The Board:

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

BOD/2526/093 Quality and Performance Committee 3A Report from the meeting held on 1st September 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.

- The Board noted the contents of the report, the assurance provided and actions identified.

BOD/2526/094 Bi-Annual Assurance Report - Partnerships & Integration

The Director of Strategy and Partnerships took the Board through the key headlines from the report.

The Board noted updates concerning the internal and external work of the Partnership and Integration (P&I) team, as set out in section 2. The Director of Strategy and Partnerships reported the recent publication of the NHS 10 Year

Health Plan had resulted in intensive work with the Strategy & Planning team to understand the impacts, implications, risks and arrangements that may need to be put in place.

In terms of the Knowledge Vault (KV) update, the Director of Strategy and Partnerships advised the total combined usage across areas had increased significantly indicating that it is becoming a key source of information, data, and intelligence. The benefits of the KV to NWAS were detailed in section 3.10. The Board noted next steps concerning the further development of this intelligence tool.

The Board was briefed on engagement activities undertaken so far during 2025/26, as per details in section 4, including involvement in PTS improvement programme, Shared External Engagement Calendars and engagement with numerous service reconfigurations across the Trust's areas.

The Director of Strategy and Partnerships reported on the initial results of the recent external engagement maturity survey with partner organisations across the Trust areas, which compared results with 2023. In order to make the survey comparable, the same questions were used and the survey was sent to over 140 external partners. The Board noted the survey had shown an improvement on the 2023 results across most of the metrics, with a dip in two areas: Contributions and Insight & Assurance. The Director of Strategy and Partnerships advised the results would be analysed in-depth then shared with directorates to inform discussions on areas for improvement.

Mr D Whatley enquired about the PTS external engagement. The Director of Strategy and Partnerships advised the existing meetings would be opened up to Executive Directors. The Area Director added the Partnerships and Integration Managers have oversight and are leading on engagement mapping for PTS.

The Medical Director noted the challenges around attending all the meetings, given the Trust's vast geographical area and multiple partnerships.

The Chief Executive reminded the Board that when the Partnerships and Integration Managers were established, they attended all possible meetings, however over time attendance had to be prioritised for practical reasons. It was explained that the managers keep in touch with various groups informally, without meeting attendance. With 250 neighbourhoods and many other localities, NWAS needs to find effective ways to have impact and influence, without always attending meetings. As the strategy development continues, the Trust needs to be clear on the navigation of the system and how to interface with various partners.

The Board:

- Noted the content of the report.
- Supported the ongoing work of the Partnerships and Integration Team.

BOD/2526/095 Any Other Business Notified Prior to the meeting

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

BOD/2526/096 Risks identified

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

Date and time of the next meeting –
26th November 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
6 - 25/26	24.09.2025	2526/089	Integrated Performance Report	The Director of Quality and Improvement noted there was still a lower number of patient safety events and added language has been identified as a theme. The Chair queried whether this was concerned with how patients are being spoken to, such as incivility, or if it relates to understanding due to language barriers. The Director of Quality and Improvement would check that and inform the Chair.	Director of Quality and Improvement	26-Nov-25	26-Nov-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	✔	✔	✔	✔	x			
Dr Alison Chambers	✔	✔	✔	✔	x			
Salman Desai	✔	✔	✔	✔	✔			
Prof Aneez Esmail	✔	✔	✔	✔	✔			
Dr Chris Grant	✔	✔	✔	✔	✔			
Dr David Hanley	✔	✔	x	✔	✔			
Catherine Butterworth	✔	x	✔	x	x			
Lisa Ward	✔	✔	✔	✔	✔			
Angela Wetton	✔	✔		✔	✔			
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	✔	✔	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	Meeting Cancelled	
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	6th October	26th November	28th January	25th March
Catherine Butterworth	✔	x	x	x	x			
Dr Alison Chambers	✔	✔	✔	x	✔			
Prof Aneez Esmail	✔	✔	✔	✔	✔			
Dr David Hanley	✔	✔	✔	✔	x			
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 999 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	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		
Ahmed	Makda	NeXT Programme Director	Non-Executive Director - Lumen Housing	N/A	N/A	√	N/A	Directorship	Dec-23	Present	
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.
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
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	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
David	Whatley	Non Executive Director (Left the Trust 22 October 2025)	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	
Maneer	Afsar	NeXt Programme Director (Left the Trust 13 November 2025)	Public Appointee Independent Member - Parole Board	√				Public Appointee	Sep-19	Present	
			Board of Trustees Nacro Charity		√			Voluntary	Nov-23	Present	

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 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 October – 21 November 2025. **Headline Highlights** **Finance** • £2.038m NHS England capital investment secured for CBRN capability upgrade (modern equipment & vehicles). **People & Culture** • Industrial dispute with ICC educators continues; impact on training mitigated. • Anti-Racism Statement launched; steering group in place. • Sexual Safety Policy introduced; reinforces standards and reporting. • Culture Review: Positive progress noted; ongoing improvement journey. • Wellbeing consultation underway. • HEI partnerships: Induction for new paramedic students; support for programme transitions.

	• TU Partnership: Refreshed agreements and principles approved. **Operations** • ICC support to Yorkshire concluded; national Hear & Treat definition agreed. • Engagement in Neighbourhood Health Programme pilots; challenges include capacity and consistency. • Care coordination advocated at ICS level. • Handover delays escalated; meeting with six most challenged providers. • NEPTS procurement delayed. **Medical & Quality** • Supported contingency planning during resident doctors' strike. • Hosted Royal College of Paramedics visit; focus on education. • CQC engagement meeting held; QA Visits redesign underway. **National & Regional** • NHS England visits and mid-year review focused on performance and winter assurance. **Organisational** • Executive Away Day reviewed strategy and priorities. • Volunteer Celebration Event marked 25th anniversary; recognised 1,200 years of service. • Staff Survey response rate: 44.4% (as of 11 Nov). • Major Incident (Heaton Park Synagogue): praised nationally; HRH King Charles met frontline staff.
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 24 September 2025.

2. INTERNAL UPDATES

Integrated Contact Centres
Call handling support provided to Yorkshire Ambulance Service during their transition to NHS Pathways concluded in the first week of November, which is expected to reduce call volumes and stabilise 999 CPU performance. The national definition for Hear and Treat has been agreed via the National Directors of Operations Group, with an anticipated approved change to Ambulance Quality Indicators reporting from April 2026. Additionally, we have initiated engagement with the NHS England Urgent and Emergency Care National Team to explore participation in the phase 2 pilot for Category 2 segmentation.

Operations
National Neighbourhood Health Implementation Programme (NNHIP)
The National Neighbourhood Health Implementation Programme is progressing in the Greater Manchester Area with wave 1 running until March 2026. Engagement around NNHIP is strong in Greater Manchester, particularly in the Stockport and Rochdale neighbourhood pilot programmes. We are engaged in the programme with our Partnerships and Integrations Manager for the area. NNHIP simulation exercises are taking place week commencing 9 November and early design discussions are underway. This has started to demonstrate the variation in approaches/ tests of change/ proposed structures and expectations of NWAS and other providers.

Discussions to date have started to highlight some potential challenges and points to consider:

- Capacity: multiple neighbourhoods asks could stretch NWAS resources; engagement needs to be proportionate and co-ordinated.
- Consistency: without clear oversight, engagement risks becoming fragmented or inconsistent across localities.
- Data and evaluation: differing neighbourhood priorities will generate varied data requirements; early BI involvement will be essential.
- Understanding and expectation: develop a clear organisational position and guiding principles to ensure consistent messaging, set boundaries, and help staff articulate our role within the wider neighbourhood model amid varying partner expectations.

Care Co-ordination
Engagement continues with system partners relating to care coordination. We are encouraging the delivery of care coordination at ICS level. If delivered at scale NWAS

believe this will deliver greater efficiency and enable wider NWAS resource to support the programmes.

Handover

H45 is experiencing pressure due to rising handover rates. We are working closely with providers, ICS, and NHSE North West to ensure compliance with the national mandate, and a meeting has been scheduled with the six most challenged providers.

PTS

The Invitation to Tender (ITT) for the North West Non-Emergency Patient Transport Services (NEPTS), originally due for release in October, has yet to be issued, potentially resulting in further delays to the procurement process.

Finance

CBRN investment

The trust is to upgrade and enhance its chemical, biological, radiological and nuclear (CBRN) ambulance decontamination capability. We have received £2.038m capital investment – fully funded by NHS England – this will enable us to procure modern, nationally standardised equipment and vehicles, ensuring we are better prepared to respond to high-risk incidents. This is part of a co-ordinated national programme led by the Emergency Capabilities Unit, hosted by London Ambulance Service, with all English ambulance trust's participating.

People

Standing Together - Our Commitment to Anti-racism

The board anti-racism statement was launched at the end of Black History Month. This represents a pledge for us to take action to stand as allies and to address racism in the way we provide care and lead our organisation. The statement is a promise to listen; to learn and to lead change and is a fundamental part of the improvements we are making to our culture. The launch will be followed by a range of communications and training resources to support understanding of anti-racism in the organisation and its intrinsic links to health inequalities and the quality of patient care that we deliver, as well as staff experience. There is a Steering Group in place, with an Area Director as SRO, which will continue to oversee progress of supporting initiatives and delivering on the specific commitments set out in the statement.

Sexual Safety Policy

November also saw the launch of the new Sexual Safety Policy. The organisation first launched its commitment to improve sexual safety in the workplace 18 months ago and has developed a range of resources and communications since that date to support effective change in the workplace. The Policy brings together the national policy framework with the good practice already developed in the trust into a single document. The launch by the CEO and Deputy CEO provides an opportunity to reinforce standards and expectations, to promote reporting routes and provide reassurance to staff that concerns will be taken seriously and managed sensitively. Work continues to oversee sexual safety improvements through a Steering Group chaired by the Deputy CEO.

Ambulance Culture Review

As part of the follow up work arising from the National Ambulance Culture Review, NWAS was visited by the co-chairs of the Guardians Group - Anna Parry, Managing Director of AACE and Tracy Nicholls, Chief Executive, College of Paramedics. They met with the CEO, Chair and Director of People to discuss progress against the Culture Review recommendations. This will then inform national reporting to NHS England along with the opportunity to share and disseminate best practice. It was a useful exercise to reflect on all the positive work that has been undertaken to improve culture but a salutary reminder that this is a long journey to ensure that our staff feel safe, that they belong and that the experience of working for NWAS is consistent across all parts of our organ.

Wellbeing

Being able to support the wellbeing of our workforce remains a central part of our approach. We are currently consulting on some changes to how this is delivered and will be considering feedback from those affected and from trade union colleagues once the consultation closes in early December.

ICC Training dispute

We are still in dispute with a small cohort of our ICC educator workforce who provide training to new call handlers and dispatchers. The dispute relates to the decision not to apply a recruitment and retention premia to new positions following a restructure of the team. Some members of the team continue to take discontinuous industrial action but the impact of this on training of new staff has been largely mitigated.

Working with HEI Partners

This month will see area inductions taking place for all new year 1 paramedic students. The events take place jointly with HEIs and enable us to introduce students to NWAS before they start their first placements. The events are attended by Executive Directors, alongside HEIs and the education team who will be working with them to support them in practice. The inductions were implemented for the first time last year to enhance placement experience and acknowledging that learners may be at more risk of inappropriate behaviours in the workplace. The sessions cover the practicalities of working operationally but also the support available to them to raise concerns and speak up.

The trust has also been working closely with Edge Hill University to support students who are transitioning to new programmes of study following the Nurse Paramedic programme ceasing. NWAS is supporting additional placement activity for those transitioning to the single honours paramedic programme.

Partnership Working

Partnership working with our Trade Union colleagues remains very important to the way we reach effective decisions, engage with our workforce and support the implementation of change. Work was started with the support of ACAS last year in order to refresh our joint commitment to partnership and to discuss frankly and openly what it means to work in partnership effectively. This work has resulted in a clear set of partnership principles setting out how we will work together and the behaviours we expect in our

interactions. We have also refreshed the Recognition Agreement and the working arrangements for consultation and these documents have been approved through the Joint Partnership Council and the Trust Management Committee. Trade Union representatives and management will now be working together on a programme of engagement to relaunch the arrangements.

Medical

Industrial Action – Resident Doctors

We actively contributed to NHS contingency planning arrangements to ensure the continuity of emergency care services during the resident doctors' industrial action, which took place from 14 to 19 November. Our involvement helped maintain patient safety and service resilience throughout the strike period.

Royal College of Paramedics Visit

We hosted a visit from the Royal College of Paramedics senior leadership team, led by Tracy Nicholls, Chief Executive. During the visit, we extended our congratulations on their recent achievement of being granted a Charter of Incorporation by His Majesty King Charles. The day focused on exploring future opportunities for greater collaboration, particularly in the areas of education and training for the paramedic profession.

NWAA Emergency Care conference – 2 October

The North West Air Ambulance (NWAA) held an Emergency Care Conference entitled Improving Cardiac Outcomes on 2 October. The event brought together emergency care professionals from across the North West to share knowledge and innovations in cardiac care. The Trust was represented at the event by the Medical Director, reinforcing our commitment to advancing clinical excellence.

Quality and Improvement

CQC engagement meeting

In October, Middlebrook ICC hosted the CQC engagement meeting with the CQC Engagement Manager and her colleague. In addition to the NWAS update which covered all domains, we presented an overview of the ICC restructure and an update on 45-minute handover. Inspectors were then able to visit contact centre staff and listen to some incoming calls.

Quality Assurance Visits (QAVs)

A workshop to redesign the Quality Assurance Visits process took place on 17 November. The redesign will be based on an accreditation model and will be launched in the new financial year.

3. Updates

3.1 National Update

National Clinical Winter Infection Updates

With effect from Monday 10 November, the Trust has been invited to attend national weekly updates focusing on winter infections. We will be represented on these calls by the Medical Director and Director of Quality and Improvement.

NHS CEO's Briefing – 11 November 2025
Sir James Mackey, Chief Executive Officer, NHS England held a call with ICB and Trust Chief Executives which focused upon the upcoming industrial action and other priority updates.

Attendance at national meetings
I was able to attend the following national meetings during October and November 2025:

- APNA Conference – 16 – 17 October,
- Adult Social Care Race Equality Network – 31 October, where I was able to take part as a key note speaker, sharing my leadership and career progression with others who aspire to develop into leadership roles.
- The King's Fund Annual Conference – 5 – 6 November
- NHS Providers Conference: Recharge, Reconnect and Reflect – 11-12 November
- NHS Impact – National Improvement Board – 20 November

3.2 Regional Update

NHS England visit – 20 October 2025
Together with the executive team, I welcomed Jenny Keane, Director of UEC Delivery, accompanied by her colleagues: Claire Joss (Deputy Director) and Tom Quarterly (Deputy Director of UEC and Regional Operations Centres).

The executive team discussed operational performance, urgent and emergency care, and opportunities for innovation and improvement across the Trust, while also highlighting the growing operational and financial pressures across the system. Accompanied by the Director of Operations and Deputy Director of ICCs, the NHSE team subsequently visited Parkway EOC.

NWAS mid-year review – 27 October 2025
The Chair and I met with James Samson from NHS England to review the Trust's mid-year performance, focusing on operational performance, operational delivery, and financial position. Key discussion areas included Category 2 performance, handover delays, and system winter assurance.

3.3 System Update

Non-Emergency Patient Transport Services (NEPTS) Update
The NEPTS procurement process has been delayed.

3.4 Organisational

Induction welcomes

I have had the pleasure of personally being able to present the executive welcome at the induction programme on 28 October to welcome new PTS starters to the trust as they embark on their new careers with the trust.

Learning and development opportunities

I have been able to attend a number of learning opportunities including:

- The Better Director Event at the University of Bradford
- Preparing for the Corporate Criminal Offence of 'Failure to Prevent Fraud'
- Bravery in the Boardroom – Black History Month webinar

Director of Quality & Improvement

The interviews for a substantive Director of Quality & Improvement took place on 2 October. I am pleased to report that Elaine Strachan-Hall was successful and took up her substantive position from 1 November.

Executive Team Away Day

The Executive Team held an away day on 3 October, key topics discussed were:

- Health and wellbeing check in
- Round up of 2025/26 so far
- Executive visibility and engagement
- Trust Strategic Aims
- Provider Capability Self-Assessment
- Body Worn Video Camera
- Update on Target Operating Model
- CIP – Approach for 2026/27

Stakeholder engagement

Engagement with key stakeholders continues and I held introductory meetings with:

- Matt Killick, BEM, Chief Operating Officer of the St John's Ambulance Service on 14 October. Matt has been in post since May 2025.
- Sir Stephen Watson, QPM, Greater Manchester Police on 20 November.

Senior Managers Briefing

On 15 October 2025, the third Senior Manager Briefing of the financial year was held, bringing together over 80 senior leaders from across the organisation. These sessions provide a valuable opportunity to share updates on key national, regional, system, and organisational developments.

Topics covered during the session included:

- National context and "state of the nation" overview
- The NHS 10-Year Health Plan and Trust Strategy
- Well-led Development Review
- CQC readiness and gap Analysis
- The NWAS 'improvement approach'
- Workforce update including flu, staff survey, leadership and OD updates, introduction of Anti-Racism Statement and TU Partnership Review.

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

Major Incident – 2 October 2025

Following an incident outside the Heaton Park Synagogue in which we declared a major incident. In support I spoke with colleagues involved in the response and offered my praise and support on behalf of the Board. I attended the vigil where I laid flowers at the scene alongside emergency service partners.

Prime Minister Kier Starmer visited to thank the emergency services for our response and met some of our staff to offer his thanks in person.

I also received a heartfelt message from Sir Jim Mackey, Chief Executive of NHS England, who wrote to express his gratitude for the response of our teams, recognising the immediate and compassionate actions taken.

King's Visit – 20 October 2025

Further to the tragic Heaton Park Synagogue incident on 2 October. I, alongside colleagues from other emergency services, had the honour of meeting His Majesty King Charles III. The visit, co-ordinated by Greater Manchester Police and held at their Headquarters, provided an opportunity for the King to meet frontline staff who were directly involved in the response to the incident. Seven of our frontline team members who played a vital role during the incident were privileged to meet and speak to His Majesty in person.

CFR Conference – 25th Anniversary – 7 November

Our 2025 Volunteer Celebration Event was a memorable occasion, bringing together volunteers, staff and leaders from across the organisation to recognise and honour the exceptional contributions of our volunteer community. The event was structured into three parts, - a daytime conference, a development session and an evening gala dinner.

I had the privilege of opening the gala dinner, which featured an emotional address from Bill Morley. Bill shared his personal mission to increase the number of public access defibrillators following the tragic loss of his son to cardiac arrest.

During the evening, we celebrated approximately 1,200 milestone years of combined voluntary service from Community First Responders, volunteer car drivers and Patient and Public Panel members by awarding them certificates. In addition, four individuals were recognised for their outstanding contributions, following peer nominations. The event concluded with a heartfelt thank you from the Chair, reinforcing the Trust's appreciation for the invaluable role volunteers play in supporting our services.

Remembrance Day

Remembrance Sunday saw many of our staff representing the Trust at events across the region, to honour members of the armed forces that have died in the line of duty.

To mark Armistice Day, the Trust held events across our main corporate sites at Broughton, Estuary Point, Lady Bridge Hall and Salkeld Hall, where a two minutes silence was held and colleagues gathered to lay wreathes and pay their respects.

Staff Survey

As of 11 November, the organisation's overall response rate for the Staff Survey stands at 44.4%, with 3474 respondents out of a total of 7,825 staff. The survey remains open until 28 November, and all executives have been encouraged to actively promote completion within their teams.

In our thoughts

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

Mike Earnshaw, sadly passed away on 9 October. Mike joined NWAS on the PTS bank in 1999, where he worked until retirement in 2013.

Dave Cliffe, sadly passed away suddenly and unexpectedly on 11 October. Although retired, Dave was formerly based at Fazakerley and began his career with Mersey Regional Ambulance Service and served with us for 46 years, rising to the role of Senior Paramedic Team Leader.

Alan Fothergill, sadly passed away on 18 October. A former PES colleague, Alan started working with the Trust in 2005 and spent most of his career working on the Wirral until retirement in 2021.

Sarah Russell, sadly passed away suddenly on 22 October. Sarah was a paramedic at Kendal Station joining the service in 2019, having worked in the NHS since 2007.

Geoff Council, sadly passed away, suddenly and unexpectedly aged 72 on 29 October. Geoff dedicated 39 years to the ambulance service as a paramedic before becoming an EMT in the Carlisle area.

I have written to the families of these colleagues and former colleagues on behalf of the trust to offer our condolences.

4. RISK CONSIDERATION

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

5. EQUALITY/ SUSTAINABILITY IMPACTS

There is 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, 26 November 2025
SUBJECT	Proposed Q2 Position of the Board Assurance Framework 2025/26
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Q2 position of the Board Assurance Framework 2025/26.	
EXECUTIVE SUMMARY	The proposed 2025/26 Q2 Position of the BAF risks with associated CRR risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2025/26 year- to- date can be viewed in Appendix 2. There are no proposed changes to the risk scores to highlight to the Board.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee & Audit Committee	
	Date	22nd October 2025 & 24th October 2025
	Outcome	TMC recommended to Board for approval

1. BACKGROUND

This report provides the Board of Directors with an overview of the Q2 position of the Board Assurance Framework (BAF) for 2025/26 which can be seen in full in appendix 1.

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

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

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

2. REVIEW OF THE BAF 2025/26 Q2 POSITION

Following a full review of the strategic risks on the BAF with the executive leads, there are no proposed changes to the risk scores to highlight to the Board.

3. RISK CONSIDERATION

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

4. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Q2 Position of the BAF 2025/26.

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BOARD ASSURANCE FRAMEWORK 2025/26

Proposed Q2 Position 25/26

Board of Directors

26 November 2025

Q2 Position Reporting Timescales:

Trust Management Cttee:	22 October 2025
Audit Cttee:	24 October 2025
Quality & Performance Cttee:	27 October 2025
Resources Cttee:	20 November2025
Board of Directors:	26 November 2025

BOARD ASSURANCE FRAMEWORK KEY

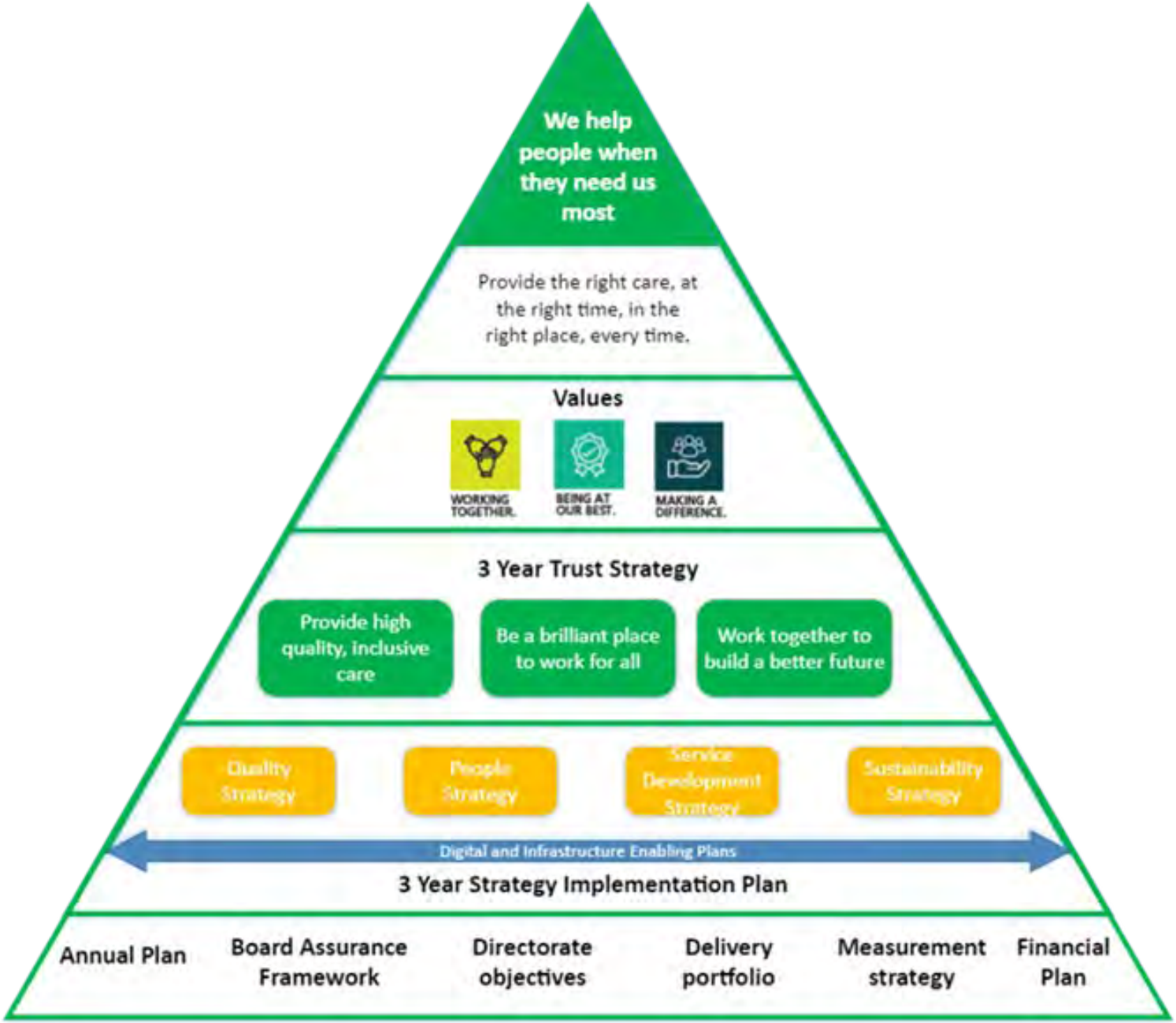
Risk Rating Matrix (Likelihood x Consequence)

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

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

Board Assurance Framework Legend

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


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

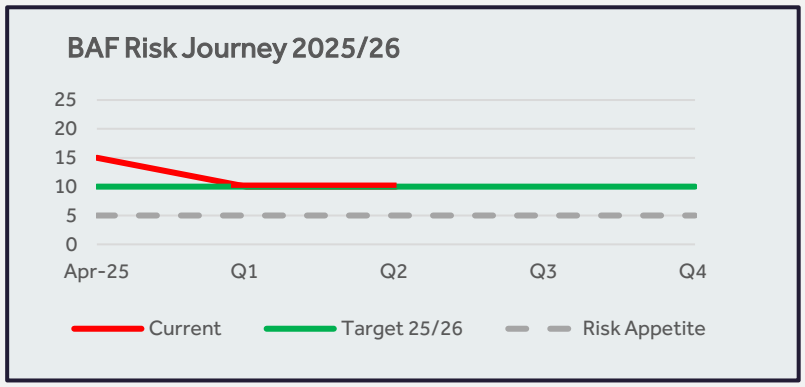
BOARD ASSURANCE FRAMEWORK DASHBOARD 2025/26

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

BOARD ASSURANCE FRAMEWORK 2025/26

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

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



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR RISK SCORE: The risk score at Q2 remains at a risk score of 10. National clinical quality indicators remain strong, in conjunction with strong operational performance and fewer significant clinical complaints and adverse outcomes. Regional variation in hospital handover performance is a significant focus for both operational and clinical teams due to the unacceptable inequalities that arise. Work has been ongoing in relation to previously reported challenges in the management of LFPSE and patient event management with close executive oversight. The LFPSE backlog has largely been eliminated by 170-210 not accepted which require DCIQ or LFPSE intervention to resolve. The number of duty of candour delays has significantly. reduced. With the support of ICC, the number of external-ins waiting to be processed has reduced however there are significant numbers of new external-ins. An escalation framework for delays in patient safety events was agreed at Trust Management Committee in September 2025.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Deteriorating
Q3 sees significant operational and clinical pressure with heightened burden of respiratory presentations and seasonal influenza together with deteriorating hospital handover performance.

CONTROLS →	ASSURANCES →	EVIDENCE
QUALITY		
Focus on delivering national and local priorities in line with PSIRF	**Level 2**: Patient Safety Events Management **Level 2:** Reportable Events Report **Level 2**: Annual Plan Assurance Q1	Reported to Trust Management Cttee TMC/2526/105 Reported to Board of Directors PBM/2526/41 Reported to Resources Cttee RC/2526/044
Local Quality Improvement Plans	**Level 2:** Annual Plan Assurance Q1	Reported to Resources Cttee RC/2526/044
Patient Safety Events Management	**Level 2**: Patient Safety Events Management	Reported to Trust Management Cttee TMC/2526/105
CLINICAL		
Improve the input, analysis and utilisation of data which provides intelligence on population health and health inequalities	**Level 2:** Public Health Oversight Group 3A Report **Level 2:** Annual Plan Assurance Q1	Reported to Clinical and Quality Group CQG/2526/029 Reported to Resources Cttee RC/2526/044
DIGITAL		
Insight and Intelligence	**Level 2**: Integrated Performance Report	Reported to Board of Directors BOD/2526/066 & 089

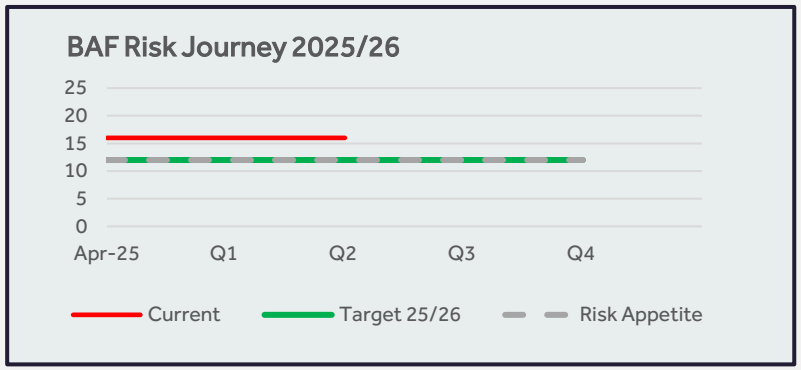
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLINICAL					
Deliver Right Care Programme	Quality Impovement Academy – Cohort 1: Evaluate outcomes to adopt learning across NWAS	Dr C Grant / D Ainsworth	June 2025	TM Cttee	Complete
Improve the input, analysis and utilisation of data which provides intelligence on population health and health inequalities	Develop Phase 2 of population health dashboard.	Dr C Grant / J Wharton	September 2025	TM Cttee	Action Paused
	Use current data to identify improvement initiatives to improve equity of access, experience and outcomes for patients.	Dr C Grant	November 2025	TM Cttee	In Progress
QUALITY					
Focus on delivering national and local priorities in line with PSIRF	Establish improvement plans associated with local and national priorities	Dr E Strachan-Hall	December 2025	Q&P Cttee	In Progress
Delays in responding to patients in mental health crisis	Training needs analysis Mental health	Dr E Strachan-Hall	December 2025	Q&P Cttee	In Progress
	Mental Health Oversight Group to be established	Dr E Strachan-Hall	August 2025	TM Cttee	Complete
	Mental health strategic plan implementation	Dr E Strachan-Hall	December 2025	Q&P Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of EPRR national occupational standards, training, exercising, and subsequent competency assurance, the EOC/ICC leadership team are not adequately prepared to manage large scale, significant or major incidents, which may result in serious avoidable patient harm or death and cause significant reputational damage to the Trust.	15 High	15 High	⇔	5 Low
440	Operational/ Operational Performance	There is a risk that due to NWAS clinicians receiving limited training in managing obstetric emergencies, there is a gap in knowledge and skills for clinicians to manage maternity and newborn care, potentially resulting in patient harm and non-compliance with MNSI safety recommendations.	20 High	15 High	⇩	5 Low
507	Operational/ Emergency Preparedness	Sensitive Risk - FOI Act Section 43 - Commercial Interests	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	Sensitive Risk - FOI Act Section 43 - Commercial Interests	20 High	15 High	⇩	5 Low
580	Quality	There is a risk that safety learning and subsequent improvement may be missed due to incomplete recording of patient events investigation process in DCIQ, which may lead to future patient harm.	16 High	16 High	⇔	4 Low

BOARD ASSURANCE FRAMEWORK 2025/26

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

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



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q2 remains at 16. A balanced financial plan has been agreed, and the full in year efficiency plan has been developed with the risk adjusted forecast for the year exceeding the target value. There remains a recurrent shortfall against the target of £1.1m, and while steady progress is being made in reducing this recurrent gap any shortfall will be carried forward into the new financial year.

Projected Forecast Q3: Deteriorating
Stable
Improving

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

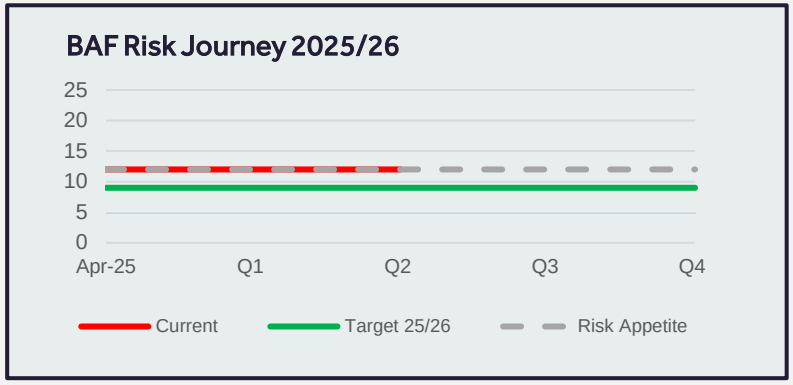
CONTROLS →	ASSURANCES →	EVIDENCE
Financial Performance	**Level 2:** Finance Report M03 **Level 2:** Finance Report M04 **Level 2:** Finance Report M05 **Level 2:** Efficiency and Productivity Update	Reported to Resources Cttee RC/2526/035 Reported to Trust Management Cttee TMC/2526/130 Reported to Resources Cttee RC/2526/060 Reported to Resources Cttee RC/2526/063

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2026/27 Financial Planning	Receipt of 2026/27 planning guidance from NHSE	Ms C Wood	January 2026	Resources Cttee	Not Commenced
	Draft 2026/27 Financial Plan (Revenue & Capital)	Ms C Wood	March 2027	Resources Cttee / BoD	Not Commenced
	Approval of 2026/27 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2027	Resources Cttee / BoD	Not Commenced
PMO support for delivery of efficiency plans – SR02	Change focus of PMO to delivery of efficiency targets	Mr M Gibbs	TBC	TM Cttee	In Progress

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

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR03: There is a risk that if the Trust does not deliver against NHS net zero targets, it will impact on the Trust's ability to contribute towards environmental improvements and delivery of its Green Plan	**Executive Director Lead:**	DoF
	Strategic Aims:	Work together to shape a better future
	Risk Appetite Category:	Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q2 remains at 12. Good progress continues in reducing the emissions associated with the estate.

Projected Forecast Q3: Deteriorating
Stable
Improving

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

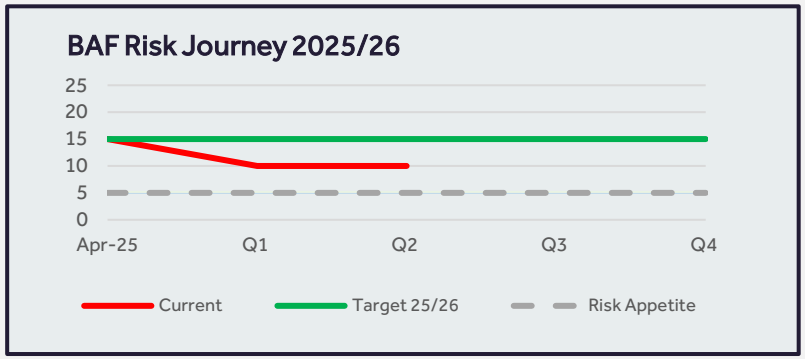
CONTROLS →	ASSURANCES →	EVIDENCE			
Refreshed Green Plan following publication of guidance in February 2025	**Level 2:** Green Plan	Reported to Board of Directors BoD 2526/032			
Progress against the Green Plan	**Level 2:** Sustainability Group 3A Report **Level 2:** Sustainability Progress Report	Reported to Trust Management Cttee TMC/2526/084 Reported to Resources Cttee RC/2526/063			
Heat decarbonisation plan	**Level 2:** Heat Decarbonisation Plan	Reported to Trust Management Cttee TMC/2526/155			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**

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

BOARD ASSURANCE FRAMEWORK 2025/26

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

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



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q2 remains at 10 primarily due to the stability of handover with the ICBs and the continuation of focus in relation to 45 minute release. Achieving C2 gov standard and C1 90th consistently, with 999 call pick-up performing well and good 111 performance. The ICC restructure is now live for Band 7 and majority of Band 5 positions. The Trust understands the ITT will be released on 31st October 2025 for procurement of the PTS contract(s). On track to deliver against the UEC standards at month 6.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Stable
Due to winter pressures, demand will increase which will result in an increase in performance and hospital handovers

CONTROLS →	ASSURANCES →	EVIDENCE
Recruitment Plan Clinical Hub and Operational Staff	**Level 2:** People and Culture Group 3A Group **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2526/119 & 170 Reported to Resources Cttee RC/2526/046 & 068 Reported to Board of Directors BOD/2526/066 & 089
ICC Integration Restructure	**Level 2:** ICC Phase 3 Update **Level 2:** People and Culture Group 3A Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2526/154 Reported to Trust Management Cttee TMC/2526/119 & 170 Reported to Resources Cttee RC/2526/046 & 068 Reported to Board of Directors BOD/2526/066 & 089
Review current care delivery model	**Level 2:** Annual Plan Assurance Q1	Reported to Resources Cttee RC/2526/044
Delivery of UEC Plan 25-26	**Level 2:** NWAS Strategic Winter Assurance Framework **Level 2:** Ambulance Winter Plan – Board Assurance Statement	Reported to Board of Directors: BOD/2526/067 Reported to Board of Directors: BOD/2526/092

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plan Clinical Hub and Operational Staff	*Robust recruitment plan to be delivered to maximise resources to the most efficient level*	*Mr D Ainsworth / Mrs L Ward*	*March 2026*	*Q&P Cttee*	*In Progress*
ICC Integration Restructure	*Delivery of Phase 3 of ICC Restructure*	*Mr D Ainsworth*	*September 2025*	*Q&P Cttee / Resources Cttee*	*Complete*

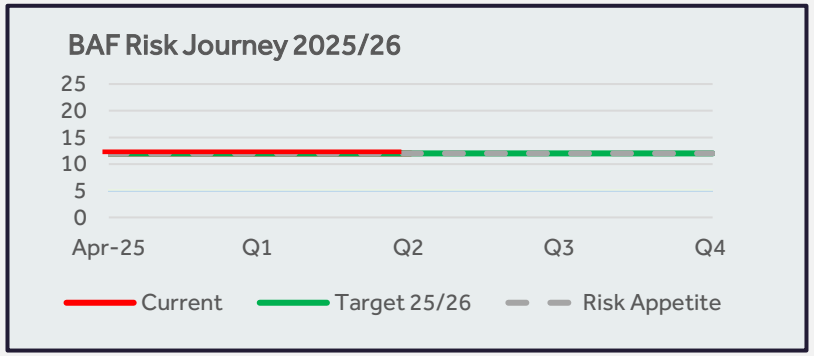
Review current care delivery model	Create a current state map of flow through the organisation from the patient perspective	Mr D Ainsworth	October 2025	*Q&P Cttee / Resources Cttee*	*In Progress*
Improve patient outcomes	Generate ideas for change utilising best practice and national learning/priorities	Mr D Ainsworth	December 2025	*Q&P Cttee / Resources Cttee*	*In Progress*
Develop long term roadmap to deliver initiatives	Highlight short-term initiatives and create a plan	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Right Care Programme of Work	Implement and embed workstreams within the Right Care Programme	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Deliver PTS Improvement Programme	Deliver workforce and operational delivery workstreams	Mr D Ainsworth	March 2026	*Q&P Cttee / Resources Cttee*	*In Progress*
Delivery of UEC Plan 25-26	Delivery of mid year UEC Targets	Mr D Ainsworth	October 2025	TM Cttee	*In Progress*
	Delivery of full year UEC Targets	Mr D Ainsworth	March 2026	TM Cttee	*In Progress*

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of EPRR national occupational standards, training, exercising, and subsequent competency assurance, the EOC/ICC leadership team are not adequately prepared to manage large scale, significant or major incidents, which may result in serious avoidable patient harm or death and cause significant reputational damage to the Trust.	15 High	15 High	⇔	5 Low
440	Operational/ Operational Performance	There is a risk that due to NWAS clinicians receiving limited training in managing obstetric emergencies, there is a gap in knowledge and skills for clinicians to manage maternity and newborn care, potentially resulting in patient harm and non-compliance with MNSI safety recommendations.	20 High	15 High	⇩	5 Low
507	Operational/ Emergency Preparedness	Sensitive Risk - FOI Act Section 43 - Commercial Interests	20 High	15 High	⇩	5 Low
508	Operational/ Emergency Preparedness	Sensitive Risk - FOI Act Section 43 - Commercial Interests	20 High	15 High	⇩	5 Low
717	Reputational/ Emergency Preparedness	Sensitive Risk - FOI Act Section 22 Intended for Future Publication, Section 31 Compliance with Law and Regulation, Section 36 Public Affairs	15 High	15 High	⇔	5 Low
434	Operational/Fleet	There is a risk that due to global delays in parts supply chain for vehicle manufacturing and maintenance, resulting in conversion and maintenance delays, with further vehicle retention and increased VOR vehicle downtime negatively impacting on vehicle availability to service delivery	12 Moderate	16 High	⇧	4 Low

BOARD ASSURANCE FRAMEWORK 2025/26

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

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



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q2 remains at 12. Recruitment and training plans are on track to deliver growth. Retention improvements continue to be positive. There has been good progress against annual plans for cultural and equality and diversity improvement, but such plans will take some time to deliver a step change. Work includes continued progress in leadership development, including developing leaders programme launch, policies in relation to Sexual Safety and professional boundaries approved

Projected Forecast Q3: Deteriorating
Stable
Improving

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

CONTROLS →	ASSURANCES →	EVIDENCE
EDI Priorities	**Level 2:** Diversity and Inclusion 3A Report **Level 2**: EDI Regulatory Reporting (WRES/WDES & Gender Pay Gap)	Reported to Trust Management Cttee TMC/2526/118 Reported to Board of Directors BOD/2526/064
People Promise Exemplar Programme	**Level 2**: People and Culture 3A Report **Level 2:** Health and Wellbeing Annual Report 24/25	Reported to Trust Management Cttee TMC/2526/119 & 170 Reported to Resources Cttee RC/2526/047
Vacancy Position	**Level 2:** People and Culture Group 3A Report **Level 2**: Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2526/119 & 170 Reported to Resources Cttee RC/2526/046 & 068 Reported to Board of Directors BOD/2526/066 & 089
Leadership	**Level 2**: Diversity and Inclusion 3A Report	Reported to Trust Management Cttee TMC/2526/118
Attendance	**Level 2:** People and Culture Group 3A Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Trust Management Cttee TMC/2526/119 Reported to Resources Cttee RC/2526/046 & 068 Reported to Board of Directors BOD/2526/066 & 089
Retention Plans	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee RC/2526/046 & 068
Sexual Safety	**Level 2:** Diversity and Inclusion 3A Report **Level 2:** New People Policies: Approval of Sexual Safety Policy & Professional Boundaries Policy **Level 2:** Annual Plan Assurance Q1	Reported to Trust Management Cttee TMC/2526/118 Reported to Trust Management Cttee TMC/2526/114 Reported to Resources Cttee RC/2526/044
Wellbeing	**Level 2:** Health and Wellbeing Annual Report 24/25	Reported to Resources Cttee RC/2526/047 Reported to Board of Directors BOD/2526/087

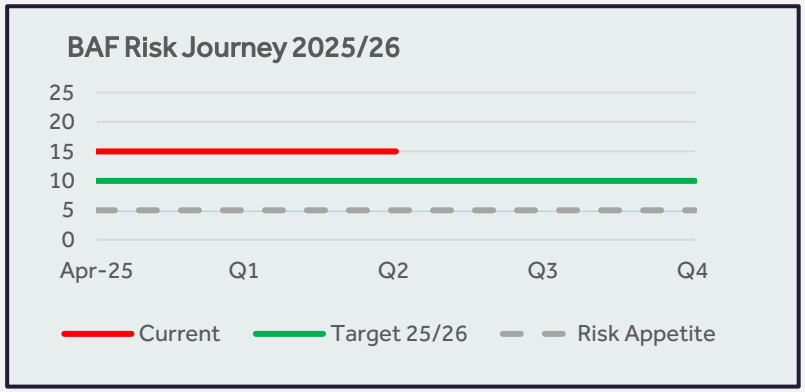
	Level 2: Flu Campaign 2025/26 Board Assurance Checklist				
Learner safety	**Level 2:** Annual Plan Assurance Q1	Reported to Resources Cttee RC/2526/044			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
EDI Priorities	Delivery of agreed 25/26 workforce related actions	Ms L Ward	March 2026	Resources Committee	In Progress
Sexual Safety	Delivery of planned work programme	Ms L Ward	March 2026	Resources Committee	In Progress
Partnership Agreement	*Implementation of revised Partnership Agreement*	*Ms L Ward*	*September 2026*	*TMC Cttee*	*In Progress*
Wellbeing	*Implementation of mental health improvement plans*	*Ms L Ward*	*March 2026*	*Resources Cttee*	*In Progress*
Learner safety	Progress implementation of Safe Learning Environment Charter	Ms L Ward	March 2026	Resources Committee	In Progress
People Promise Exemplar Programme	*Deliver improvements in identified priority areas: flexible working; staff engagement*	*Ms L Ward*	*2025/26*	*Resources Cttee*	*In Progress*
Vacancy position	Delivery 2025/26 recruitment and training plan	Ms L Ward	March 2026	Resources Committee	In Progress
Leadership	Continue to enhance compassionate leadership in support of culture change	Ms L Ward	March 2026	Resources Committee	In Progress
Attendance	Deliver continued improvement in attendance	Ms L Ward	March 2026	Resources Committee	In Progress
Retention Plans	*Delivery of EOC Retention Plans*	*Ms L Ward*	*March 2026*	*Resources Cttee*	In Progress

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

BOARD ASSURANCE FRAMEWORK 2025/26

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

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



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q2 remains at a score of 15. Whilst the recent work undertaken on LFPSE 'not accepted' backlog has reduced, delays remain in the external-in management therefore whilst regulatory risk is reduced, there is still work to do. Quarterly engagement meetings have been established between the Trust and the new CQC relationship manager.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Improving
There is continued work to reduce the external-in backlog to a weekly figure.

CONTROLS →	ASSURANCES →	EVIDENCE
QUALITY IMPROVEMENTS		
Continue to strengthen our delivery against the CQC assessment framework and well-led in readiness for future inspection	**Level 2:** CQC Readiness Report	Reported to Board of Directors PBM/2526/42
Improve the processes associated with medicines management including controlled drugs	**Level 2:** Medicines Management Digital Pharmacy Stock Management System Full Business Case	Reported to Corporate Programme Boad CPB/2526/106
Essential Checks	**Level 2:** IPC Oversight Group 3A Report	Reported to Clinical and Quality Group CQG/2526/049
PEOPLE		
Mandatory Training Compliance 25/26	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** People and Culture Group 3A Report	Reported to Board of Directors BoD/2526/066 & 089 Reported to Resources Cttee RC/2526/046 & 068 Reported to Trust Management Cttee TMC/2526/119
Appraisal Compliance 25/26	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Assurance Report	Reported to Board of Directors BoD/2526/066 & 089 Reported to Resources Cttee RC/2526/046 & 068
DIGITAL		
Digital Clinical Strategy	**Level 2:** Digital Plan Update	Reported to Resources Cttee RC/2526/045 & 067

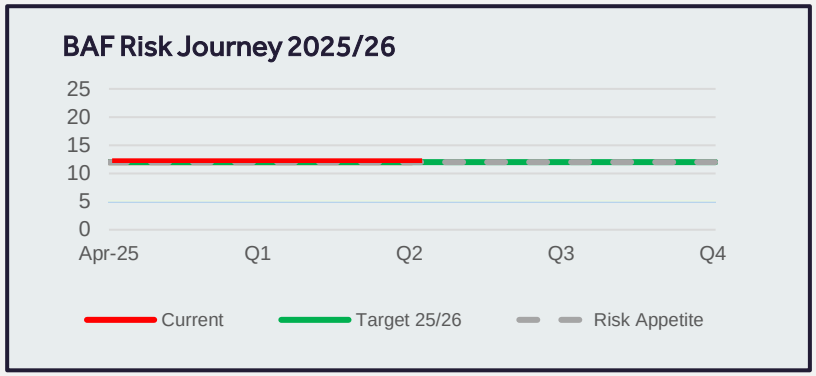
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY IMPROVEMENTS					
Continue to strengthen our delivery against the CQC assessment framework and well-led in readiness for future inspection	Developmental well-led review	Dr E Strachan-Hall	September 2025	TM Cttee	Complete
	Development programme for new board and senior leaders to familiarise with CQC assessment framework	Dr E Strachan-Hall	January 2026	TM Cttee	In Progress
	Desktop exercises for mock CQC inspection for senior leaders & leadership teams	Dr E Strachan-Hall	October 2025	TM Cttee	In Progress
	Review and amend quality assurance visits aligned with new Chief Executive Officer (CEO) accountability reviews	Dr E Strachan-Hall	March 2026	TM Cttee	In Progress
Essential Checks	*Review process and assurance of vehicle and equipment checks and components of actions submitted to CQC*	*Dr E Strachan-Hall*	*December 2025*	*TM Cttee*	*In Progress*
Improve the processes associated with medicines management including controlled drugs	Implement medicines management system	Dr C Grant	March 2026	TM Cttee	Not Commenced
Clinical Audit	Procure clinical audit tool	Dr C Grant	October 2025	Resources Cttee	In Progress
	Implement clinical audit tool	Dr C Grant	March 2026	TM Cttee	Not Commenced
PEOPLE					
Appraisal Compliance 2025/26	Achieve 85% compliance	Ms L Ward	March 2026	Resources Cttee	In Progress
Mandatory Training Compliance 2025/26	Achieve 85% compliance	Ms L Ward	March 2026	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low
580	Quality	There is a risk that safety learning and subsequent improvement may be missed due to incomplete recording of patient events investigation process in DCIQ, which may lead to future patient harm.	16 High	16 High	⇔	4 Low
717	Reputational/ Emergency Preparedness	Sensitive Risk - FOI Act Section 22 Intended for Future Publication, Section 31 Compliance with Law and Regulations, Section 36 Public Affairs	15 High	15 High	⇔	5 Low
755	Operational/ Health, Safety, Security and Fire	There is a risk that due to the lack of 'suitable and sufficient' fire risk assessments, the Trust is not compliant with legislative developments in fire risk assessment management including the Regulatory Reform (fire safety) order 2005, creating a safety risk to staff and premises and enforcement action from the respective fire authorities.	20 High	16 High	⇩	4 Low

BOARD ASSURANCE FRAMEWORK 2025/26

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

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



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q2 remains at 12 due to turbulence in the system partner environment, particularly NHSE and ICBs. Following publication of the 10 year plan, there has been a sector-wide response through AACE and an internal gap analysis against the Trust's current strategic aims and objectives and future direction, which showed minimal variation with the 10 year plan. Engagement and horizon scanning across the system continues to detect early signs of important developments and potential threats and opportunities, shared across internal stakeholders.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Stable
Expected to remain stable; due to the geographical size of the trust, it is challenging to effectively engage with external partners remains.

CONTROLS	ASSURANCES	EVIDENCE
Development of Trust Strategy	**Level 2**: Planning Group 3A Report **Level 2:** Strategy Development **Level 2**: Bi-Annual Assurance Report – Partnerships & Integration	Reported to Trust Management Cttee TMC/2526/120 Reported to Trust Management Cttee TMC/2526/137 Reported to Board of Directors BOD/2526/094
Response to emergent priorities	**Level 2:** Planning Group 3A Report	Reported to Trust Management Cttee TMC/2526/120
Publication of NHS 10 year plan including underpinning policy/guidance documents to provide clarity on the wider national/regional direction of travel.	**Level 2**: Strategy Re-Development Assurance Update	Reported to Resources Cttee RC/2526/066

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Development of Trust Strategy	Communication and engagement work stream established as part of strategy development work programme which will include external stakeholders. Comms plan in development.	Mr M Gibbs	2025/26	TM Cttee	In Progress

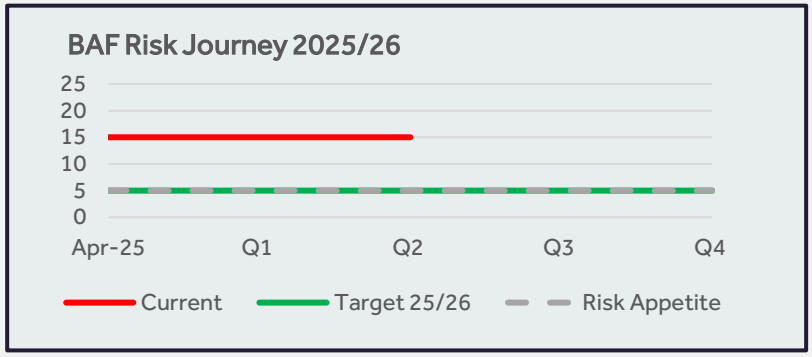
Response to emergent priorities	Planning Group continue to manage risk (Datix ID 729) regarding impact of emergent work arising from external turbulence. The risk is within control. Horizon scanning process in place to communicate with system partners and assess impact to existing plans. Regular item on Planning Group agenda item to discuss specific emergent issues.	Mr M Gibbs	2025/26	TM Cttee	In Progress
Mid year confidence assessment completed to deliver the annual plan is based on current plans	Revisit assessment to identify where there are any pressure relating to financial and other resources.	Mr M Gibbs	Q3	TM Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR07						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2025/26

BAF RISK SR09:
There is a risk that the recent planned changes around the Board over the next 12 months could destabilise the organisation and impact delivery of strategic plans.

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



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score at Q2 remains at 15. The new Chair and Director of Strategy and Partnerships commenced with the Trust during Q2. Recruitment of a substantive Director of Quality is complete. Two non-executive director posts are currently being advertised due to 2 x non-executive directors' terms of office finishing at the end of November 2025. When the final cohort of non-executive directors is in place, the appointment of a new Chair to the Resources Committee, new Vice Chair and new senior independent director will be required plus reconstituting committee members to cover gaps as a result of non-executive director changes.

Projected Forecast Q3: Deteriorating
Stable
Improving

Rationale: Stable
Due to the conclusion of the recruitment process to appoint Non-Executive Directors.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment to vacant Director posts	Appoint Director of Quality and Improvement	Mr S Desai	October 2025	Nom & Rem Cttee	In Progress
Recruitment to two non-executive director posts	NHS England to appoint two NEDs	NHSE	December 2025		In Progress
Development of Board Chemistry	CEO and Chair to consider what's required and when	Mr S Desai	March 2026		Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR09

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

Appendix 2:
2025/26 Board Assurance Framework (BAF) Heat Maps
Q2 Position

NHS North West Ambulance Service NHS Trust

2025/26 Opening BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01 SR04 SR06 SR09	20 SR08	25
4 Major	4	8	12 SR05 SR07 SR10	16 SR02 SR11	20
3 Moderate	3	6	9	12 SR03	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 15 April 2025

Likelihood

Q1 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10 SR01 SR04	15 SR06 SR09	20 SR08	25
4 Major	4	8	12 SR05 SR07 SR11	16 SR02 SR10	20
3 Moderate	3	6	9	12 SR03	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 9 July 2025

Likelihood

Q2 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10 SR01 SR04	15 SR06 SR09	20 SR08	25
4 Major	4	8	12 SR05 SR07	16 SR02 SR10	20
3 Moderate	3	6	9	12 SR03	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4 SR11	5

Populated: 13 October 2025

Likelihood

Q3 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated:

Likelihood

Q4 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated:

Likelihood

2024/25 Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5 SR05 SR08 SR09	10 SR01 SR03	15	20	25
4 Major	4 SR07	8 SR04	12 SR10 SR06 SR02	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 14 April 2024

Likelihood

Risk Appetite Tolerance

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5 SR01 SR03 SR06 SR08	10	15	20	25
4 Major	4	8	12 SR02 SR04 SR05 SR07 SR09	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 11 April 2024

Likelihood

NHS
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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	Use of Common Seal Bi-Annual Report
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Assurance

LINK TO STRATEGY	Not Applicable											
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 occasions of use of the Common Seal as detailed in s2 of the report. • Take assurance that the action was taken in accordance with Section 8 of the Standing Orders	
EXECUTIVE SUMMARY	As required by Clause 8.4 of the Trust's Standing Orders, the affixing of the Common Seal is to be reported to the Board on a biannual basis. During the period 1st April 2025 to 30th September 2025, the Trust's Common Seal was affixed on eleven (11) occasions, the details can be found in s2 of the report.	
PREVIOUSLY CONSIDERED BY	Not Applicable	
	Date	Not Applicable
	Outcome	Not Applicable

1. BACKGROUND

This report advises of occasions that have required the affixing of the Trust's seal during the period 1st April 2025 to 30th September 2025.

2. USE OF COMMON SEAL

In accordance with Section 8 of the Standing Orders, the Trust's Common Seal may be affixed and entered onto the Register of Sealing only after approval by the Chief Executive and the Director of Finance.

Reg No	Date	Reason
185	1st April 2025	Sale of Former Radio Mast – Countess of Cheshire
186	30th April 2025	Planning Agreement: Liverpool City Council & NWAS: Merseyside Ambulance Station, Land at Canterbury Street
187	28th May 2025	Contract – Workington Station
188	2nd July 2025	Deed of Easement – Elm House, Belmont Grove, Liverpool
189	2nd July 2025	JCT Collateral Warranties (27 documents), Elm House, Belmont Grove, Liverpool
190	23rd July 2025	Lease Documents, 12 Stretton Way Huyton
191	23rd July 2025	Sale of former Ramsbottom Ambulance Station
192	23rd July 2025	Sale of former Wesham Ambulance Station
193	30th July 2025	Sale of former Thornton Ambulance Station
194	24th September 2025	Licence for alterations – Widnes Ambulance Station
195	24th September 2025	Licence to Underlet: 1-2 Stretton Way, Huyton, Liverpool

3. ACTION REQUIRED

The Board of Directors is asked to:

- Note the occasion of use of the Common Seal as detailed in s2 of the report.
- Take assurance that the action was taken in accordance with Section 8 of the Standing Orders

NHS
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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	Board and Committee Corporate Calendar 2026/27
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	Not Applicable									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

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 requested to approve the Corporate Calendar 26/27.	
EXECUTIVE SUMMARY	The meeting dates for the Board of Directors and its Committees for 2026/27 can be seen in s2 of the report. In planning the corporate calendar for 2026/27, discussions were held with the Committee Chairs and lead execs to align the dates, as much as is practicable, with schedules for risk, financial and performance reporting and any legal or regulatory reporting schedules.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 19 November 2025
	Outcome	Recommended to Board for approval

1. BACKGROUND

The NWAS Corporate Calendar is compiled annually and provides dates for Board and Board Committee meetings for the coming financial year.

In planning the corporate calendar for 2026/27, discussions were held with the Committee Chairs and lead execs to align the dates, as much as is practicable, with schedules for risk, financial and performance reporting and any legal or regulatory reporting schedules.

The resultant Corporate Calendar for 2026/27 is presented to the Board of Directors for approval.

2. CORPORATE CALENDAR 2026/27

Meeting	Date	Board Membership
Board of Directors 9.45 am – 3.00 pm Bi-monthly in person	29th April (AM only) 27th May 24th June (Year End) 29th July 30th September 25th November 27th January 31st March	All Non-Executive Directors All Executive Directors
Board Development 9.30 am – 4.30 pm Bi-monthly in person	29th April (PM only) 24th June 28th October 9th December 24th February	All Non-Executive Directors All Executive Directors
Charitable Funds Committee 10.00 am – 11.30 am Quarterly	20th May 22nd July 21st October 17th February	Chair: Finance Non-Executive +2 x Non-Executive Directors Director of Finance Director of People/Deputy CEO Director of Corporate Affairs Director of Operations
Nominations & Remuneration Committee 9.00 am – 9.45 am Bi-monthly in person	27th May 29th July 30th September 25th November 27th January 31st March	All Non-Executive Directors
Audit Committee 10.00 am – 12.00 pm Quarterly	24th April 22nd May 24th June 24th July 23rd October 22nd January	Chair: Finance Non-Executive +3 x Non-Executive Directors

Quality and Performance Committee 1.00 pm – 4.00 pm Bi-monthly	27th April 22nd June 7th September 26th October 14th December 22nd February	Chair: Clinical Non-Executive +2 x Non-Executives Director of Quality Medical Director Director of Operations Director of Corporate Affairs
Resources Committee 10.00 am – 1.00 pm Bi-monthly	21st May 23rd July 24th September 19th November 21st January 25th March	Chair: Non-Executive +2 x Non-Executives Director of Finance Director of Operations Director of People/Deputy CEO
Trust Management Committee 1.00 pm – 4.30 pm Monthly in person	22nd April 20th May 17th June 22nd July 19th August 23rd September 21st October 18th November 16th December 20th January 17th February 24th March	All Executive Directors

Membership of Committees will be reported to the Board of Directors in Q4 25/26. Diary invites will be distributed to all Board Members for all meetings based on the current membership and will be updated accordingly in the event of any changes.

3. RISK CONSIDERATION

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

4. EQUALITY/ SUSTAINABILITY IMPACTS

None identified.

5. ACTION REQUIRED

The Board of Directors is asked to approve the Corporate Calendar for 2026/27.

NHS
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NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	FPPT Procedure review
PRESENTED BY	Lisa Ward, Director of People/Deputy Chief Executive
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 are recommended to: - Approve changes to the Procedure on Fit and Proper Persons Requirements
EXECUTIVE SUMMARY	The purpose of the paper is to outline proposed changes to the Procedure on Fit and Proper Persons Requirements following the introduction of the new corporate offence of failure to prevent fraud that came into force on 1st September 2025. The Trust's Fit and Proper Persons Procedure seeks to provide a clear approach to the Trust meeting the requirements of the Regulations. Whilst the procedure was not due to be reviewed until next year, there has been an early review following the introduction of the new corporate offence of failure to prevent fraud. The paper outlines the suggested addition to the procedure that has been proposed by MIAA to reflect the new corporate offence and this is also marked in the attached policy in section 3.7. A general review of the procedure has been undertaken to ensure that references remain relevant and in date. The only other amendments that has been made is to confirm the introduction of the Leadership Competency Framework. At the time of the last

	review this was referenced pending formal release of the document. A full review of the procedure is scheduled for November 2026. The paper also confirms that the Trust continues to meet the FPPT Framework requirements. Whilst the changes are minor, approval of the procedure is reserved to the Board of Directors.	
PREVIOUSLY CONSIDERED BY	xxx	
	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

1.1 The purpose of the paper is to outline proposed changes to the Procedure on Fit and Proper Persons Requirements following the introduction of the new corporate offence of failure to prevent fraud that came into force on 1st September 2025.

1.2 The report outlines the suggested actions by the anti-fraud specialist at Mersey Internal Audit Agency (MIAA) to reflect the changes and these are incorporated in the attached Fit and Proper Persons Procedure which is presented for approval.

2. BACKGROUND

2.1 The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Regulations 5: Fit and Proper Persons Requirement sets out to ensure that those individuals covered by the scope of the procedure are fit and proper to carry out their role as members of the Trust Board.

2.2 In August 2023, NHS England published a Fit and Proper Person Test (FPPT) Framework, effective from 30 September 2023. The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

2.3 The Trust's accompanying Fit and Proper Persons Procedure seeks to provide a clear approach to the Trust meeting the requirements of the Regulations. Whilst the procedure was not due to be reviewed until next year, there has been an early review following the introduction of the new corporate offence of failure to prevent fraud.

The Trust's internal auditors, MIAA, have reviewed a number of Trust policies following introduction of the new corporate fraud offence and have recommended that reference should be made to this within the Fit and Proper Persons Procedure. In the attached procedure this additional reference is made in section 3.7:

2.4 *Alongside the FPPT requirements, all those in scope of this procedure should note that any criminal activity may be investigated by the Trust's Anti- Fraud Specialist. More information is available via the Anti-Fraud, Bribery and Corruption Policy which includes reference to the Bribery Act 2010 and the Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023) and the new corporate fraud offence of 'failure to prevent fraud' which came into force on 1st September 2025.*

2.5 A general review of the procedure has been undertaken to ensure that references remain relevant and in date. The only other amendment that has been made is to confirm the introduction of the Leadership Competency Framework. At the time of the last review this was referenced pending formal release of the document. Compliance with this has already been implemented in practice as part of appraisal processes.

2.6 It is proposed that a full review of the procedure is undertaken in line with the three yearly review cycle, which will be November 2026. At this point the Framework will have been in place for three years and it would be appropriate to review the procedure at this juncture for any required changes.

3. ONGOING ASSURANCE

3.1 In line with the compliance requirements of the FPPT framework, Board members are required to complete an annual self-attestation along with a social media check and a three yearly cycle of DBS checks. All aspects of the checks are also recorded on ESR in line with the criteria set out in the Framework.

3.2 Upon completion of the annual checks a summary of the Board member's FPPT outcomes are recorded on the NHSE FPPT template for onward review by the NHSE Regional Director. Since the introduction of the FPPT framework the Trust has met all the FPPT assurance deadlines for the Regional submission. In addition, the Trust's compliance with the FPPT framework was audited by MIAA in June 2024 with the final report published in July 2024 with an outcome of 'High Assurance'.

3.3 In addition, all newly appointed Board members are subject to pre-employment checks against the FPPT requirements to ensure a robust approach to all Board recruitment in line with the Framework.

4. RISK CONSIDERATION

The Trust has a legal responsibility of adhere to Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

4.1 The Trust has a moderate appetite to risk in relation to its people but a low appetite to risk in relation to compliance and regulation. The procedure is designed to ensure clarity of the Trust's approach to compliance with the requirements of the FPPT framework and approving the procedure will therefore be in line with this risk appetite. The arrangements are also designed to ensure that the leadership of the Trust is fit and proper and this is again in line with the low risk appetite for reputational issues.

5. EQUALITY/ SUSTAINABILITY IMPACTS

5.1 The FPPT criteria is applied equally to all Directors and allowance is made in respect of reasonable adjustments to enable compliance with the regulations by disabled staff.

6. ACTION REQUIRED

The Board of Directors are recommended to:

6.1

- Approve changes to the Procedure on Fit and Proper Persons Requirements.

NHS
North West
Ambulance Service
NHS Trust

Procedure on Fit and Proper Persons Requirements

Recommended by	Board of Directors
Approved by	Board of Directors
Approval date	November 2023
Version number	3.0
Review date	November 2027
Responsible Director	Director of People
Responsible Manager (Sponsor)	Head of HR – Coporate Services
For use by	All Trust employees

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	January 2017	January 2017	V Camfield	Draft Procedure
1.0	February 2017	February 2017	V Camfield	Approved by Board of Directors
1.1	July 2017	July 2017	V Camfield	EMT Approval - Amended following MIAA audit recommendations
1.2	October 2018	October 2018	V Camfield	Amended following Deloittes governance review recommendations.
2.0	October 2021	November 2021	V Camfield	Review in line with approval framework
3.0	November 2023	November 2023	V Camfield	Reviewed following the publications of the FPPT Framework in August 2023.

Policy on Fit and Proper Persons Requirements

Contents

Introduction	Page 5
Scope	Page 5
Fit and Proper Persons Requirements	Page 5
Process for new Executive Directors appointments	Page 6
Non-Executive Appointments	Page 7
Full FPPT Assessment	Page 8
Formal confirmation of appointments	Page 8
On-going fitness	Page 9
Board Member Reference template	Page 10
Electronic Staff Record	Page 11
Information held in ESR	Page 12
Responsibilities	Page 12
Assurance	Page 13
Monitoring of Compliance	Page 13
Appendix 1 - FPPT Checklist	Page 14
Appendix 2 - FPPT – Self Attestation	Page 22
Appendix 3 – Board Member Reference Template	Page 23
Appendix 4 – New starter checklist	Page 37

1. Introduction

1.1 The procedure outlines how the Trust will meet the requirements placed on NHS providers to meet the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulations 5: Fit and Proper Persons Requirement. The regulation sets out to ensure that those individuals covered by the scope of the procedure are fit and proper to carry out their role.

1.2 The purpose of the Fit and Proper Persons Requirements is to ensure that NHS Trusts are not managed or controlled by individuals who present an unacceptable risk either to the organisation or people receiving the service provided by the Trust. The regulation is about ensuring that directors are fit and proper to assume responsibility for the overall quality and safety of care delivered.

1.3 In August 2023, NHS England announced a Fit and Proper Person Test (FPPT) Framework, effective from 30 September 2023. The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

1.4 The framework introduces a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a process to complete references with additional content whenever a director leaves.

2 Scope

2.1

The procedure applies to all Board Members of NHS organisations. Within the national Framework, the term 'board member' is used to refer to:

- Executive directors, irrespective of voting rights
- Non-executive directors (NEDs) and Associate NEDs, irrespective of voting rights
- Interim appointment (all contractual forms) as well as permanent appointments
- Individuals who are called 'directors' within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

For clarity, the procedure has been designed to follow the scope of the NHS England Framework and so does not currently apply to Deputy Directors, Associate Directors, or Area Directors. If any of these roles were required to act up into a Board role for a period of time greater than six weeks, then a temporary appointment may be required and appropriate checks would be made in line with the Framework. Further details are outlined in section 6 of this procedure.

3 Fit and Proper Person Requirements

3.1 Under the regulations, the Trust must ensure that all relevant post holders meet the 'fit and proper persons test' both at the appointment stage as well as assessing ongoing fitness for those individuals covered by the procedure.

3.2 The Trust must satisfy itself that relevant post holders meet the following FPPT requirements:

- The Individual must be of good character
- The individual must have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed
- The individual must be able, by reason of health, after reasonable adjustments, , of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

- The individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying out a regulated activity.
- None of the grounds of unfitness apply.

3.3 The grounds of unfitness specified in Part 1 of Schedule 4 to the Registered Activities Regulations are:

a) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

b) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

c) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

d) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

e) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

f) The person is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated activity, by or under any enactment.

In accordance with part 2 of the Act a person will fail the good character test if they;

(a) Has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.

(b) Has been erased, removed, struck off a register of professionals maintained by a regulator of health care of social work professionals.

3.4 Ensuring high standards of leadership is crucial and requires accountable board members with both outstanding personal conduct and professional capabilities.

3.5 The FPPT assessment is conducted on an individual basis, rather than in relation to the board as a whole. The purpose of the assessment is to ensure that board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives: namely, to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.

3.6 The FPPT requirement places the ultimate responsibility upon the Chair to discharge the requirements place upon the Trust to ensure that all relevant posthodlers meet the fitness test.

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3.7 Alongside the FPPT requirements, all those in scope of this procedure should note that any criminal activity may be investigated by the Trust's Anti- Fraud Specialist. More information is available via the Anti-Fraud, Bribery and Corruption Policy which includes reference to the Bribery Act 2010 and The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023) and the new corporate fraud offence of 'failure to prevent fraud' which came into force on 1st September 2025.

~~3.6~~

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4. Process for new Executive Directors appointments

4.1 Appointments of new Executive Directors are made through a robust and thorough appointment process. The selection process for all Executive appointments will seek to ensure that candidates are

assessed on the specifical skills, qualifications and experience required for the role as set out in the job description and person specification.

4.2 In assessing experience, skills and competence for the role, reference should be made to the NHS Leadership Competency Frameworks (LCF) (expected by March 2024).

4.3 Pre-employment checks for all new appointments are undertaken in line with the NHS Employment Standards. The full list of checks is outlined in Appendix 1:

4.3 At the point of application, all candidates applying for posts that are covered by the Regulations will be required to complete the declaration form in Appendix 2.

4.4 The Chair of the appointments panel will be responsible for ensuring compliance to the regulations and will sign off a checklist confirming the post holder meets the requirements. The checklist (Appendix 4) will be retained on the post holder's personal file. It should be noted that no Executive Director should be appointed and start in post until all FPPT checks have been completed and approved by the Chair

5. **Non-Executive appointments**

5.1 Non-Executive Directors are appointed by NHS England. The recruitment process for Non-Executive Directors is led by the NHS England Appointments team, who will obtain references, conduct the required electronic checks under the FPPT framework, and obtain signed self-attestations.

5.2 The Trust will, however, be responsible for requesting a DBS check and Occupational Health Assessment on each individual prior to appointment. Once the NHSE Selection Panel has approved an appointment, and the Appointments Team have conducted satisfactory FPPT checks, all FPPT documentation together with the letter of appointment issued by NHSE, will be requested by the Trust. All documentation will be retained on the Non-Executive Director's local personal file, along with all local recruitment and appointment information and checks, as described above. All information will be made available to the CQC on request.

5.3. The same process as above will apply to the appointment of the Chair.

5.4 No Non-Executive Director should therefore be appointed and take up their post until all FPPT checks have been completed and approved by the Chair, as appropriate.

5.5 If a Non-Executive is re-appointed NHSE take responsibility for ensuring that nothing has changed for the individual that may impact upon their 'fit and proper' status. Once NHSE have completed the checks, they will share these with the Trust. The Trust is not expected to undertake any further checks, but the individual will be required to undertake the annual self attestation process outlined below.

6. **Full FPPT Assessment**

6.1 A documented, full FPPT assessment will be needed in the following circumstances:

- **New appointments** - Board member roles, whether permanent or temporary, where greater than six weeks, this covers:

  - New appointments that have been promoted within the Trust
  - Temporary appointments (greater than six weeks and including secondments) involving acting up into a board role on a non-permanent basis
  - Existing board members at one NHS organisation who move to the Trust in the capacity of a board member
  - Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.

- **When an individual board member changes role within their current NHS organisation** - for instance, if an existing board member moves into a new board role that requires a different skillset.

- **Annually** – conducted within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

6.2 For new appointments from an individual already within the NHS, the full FPPT will also include a board member reference check. For points Board members moving within their organisation or and when completing the annual self attestation, the Board member reference check will not be needed.

6.3 All checks must be full documented, signed and dated by the Trust's Recruitment Team, Chair of the appointments panel (excluding the annual self attestation) and the Chair.

6.4 Evidence of checks for Executive Directors will also be shared with the CEO. The Chair will review all NED and Associate NED checks. The Senior Independent Director (will review and approve the locally requested checks (DBS and OH) upon recruitment of a new Chair, the annual review of FPPT checks on the Chair, and the Chair's 3-yearly DBS check.

6.7 Appendix 1 outlines the list of checks required for both new appointments and the annual checks.

5. Formal confirmation of appointments

5.1 All appointments (excluding Non-Executive appointments) including interim appointments, will be required to be approved by the Nominations and Remuneration Committee in line with the Trust's scheme of delegation. All decisions on appointments will need to take account of the Trust's obligations under the regulations. The decision must be formally recorded in the minutes taken at the meeting.

5.2 Where the Trust deems that an applicant can be appointed, despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations (Good Character), the reasons will be recorded in the minutes of the relevant meeting such as the Nominations and Remuneration Committee.

5.3 Where the Trust considers that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence(s) to undertake the role within a specified timescale any such discussions or recommendations will be recorded in the minutes of the Nominations and Remuneration Committee. The expected competencies and the timescales for achievement will be agreed by the Committee and communicated to the individual. The Committee will then monitor progress at agreed intervals.

5.4 If the candidate has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to. Any prospective candidate will need to complete the 'Fit and Proper Person' Declaration at Appendix 2. In the event the prospective candidate identifies any physical or mental health concerns (and subject to further information being obtained from the candidate, if necessary) their appointment will be subject to clearance by Occupational Health as part of the pre-appointment process. Any discussion or decision as to whether a candidate is appointable on grounds of health will be recorded in the minutes of the Nominations and Remuneration Committee.

6. On-going fitness

6.1 Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment. The FPPT is carried out on an individual board member basis, and in the annual submission to the NHS England Regional Director, the Chair will provide the overall summary of the FPPT outcome for their board. The annual appraisal process will provide an opportunity to discuss continued 'fitness' to meet the regulations allowing with a discussion oof the adherence to the board competencies set out in the LCF. The appraisal paperwork includes the self attestation form to be signed by the appraiser and appraisee. Any areas of concern will be discussed and progressed by the

appraiser. The Chief Executive will be responsible for appraising the Executive Directors, The CEO will be appraised by the Chair.

6.2 The Chair will be responsible for appraising the Non-Executive Directors. The SID / deputy chair will have responsibility for undertaking the Chair's appraisal and the completion of the annual FPPT review of the chair. On alternate years, arrangements will be made for another NED to be nominated to review the chair's FPPT on a rotational basis.

6.2 However, all individuals covered by the regulations are required to highlight to the Trust as soon as possible any reasons or changes in their circumstances that may mean they no longer meet the regulations. This requirement is also detailed in the contract of employment for the posts covered by the Regulations.

6.3 Where concerns are raised relating to a Board member's fitness to carry out their role, the Chair will address this in the most appropriate, relevant and proportionate way on a case by case basis. If concerns relate to the Chair, the SID shall take responsibility for addressing issues identified. Where it is necessary to investigate or take action the appropriate HR Policies and Procedures will be utilised. For non-executive directors, NHS E will be contacted to manage the process in line with their internal policies and procedures.

6.4 The Chair shall take appropriate and timely action to investigate and rectify the matter, taking expert advice as necessary and ensuring any issues are dealt with in accordance with the Trust's HR People Policies and the NHSE Framework. There may be occasions where the Trust will be required to contact NHS England for advice or to discuss a case directly.

6.5 The Chair, in discussion with NHS England, will put in place interim arrangements, if required, during any period of investigation, suspension or restriction from duties. Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy.

6.6 Where an individual who is registered with a professional regulator (HCPC, GMC etc.) no longer meets the fit and proper person's requirement the Trust must inform the regulator, and also take action to ensure the position is held by a person meeting the requirements. Directors may personally be accused and found guilty by a court of serious misconduct in respect of a range of already prescribed behaviours set out in legislation. Professional regulators may remove an individual from a register for breaches of codes of conduct.

6.7 The Director of People will ensure compliance through an annual audit of files and this will take place during Q4 of each year. The Corporate HR team will undertake the audit and report the findings to the Director of People and the Director of Corporate Affairs for consideration.

6.8 Once the audit has been finalised, the Chair will make an annual statement of compliance on the Fit and Proper Persons Regulations in Q4 to the Board.

7. Board Member Reference template

7.1 A standardised Board Member Reference (BMR) template has been developed by NHSE and is included in Appendix 3.

7.2 When recruiting into a board member role, at least one reference should be obtained on the standardised reference wherever possible.

7.3 For board members:

- An NHS organisation should obtain a minimum of two board member references (using the board member reference template) where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time. These two references should come from different employers, where possible.

7.4 For an individual who moves from one NHS board role to another NHS board role, across NHS organisations:

- Where possible one reference from a separate organisation in addition to the board member reference for the current board role will suffice. This is because their board member reference template should be completed in line with the requirements of the framework so that NHS organisations can maintain accurate references when a board member departs.

7.5 For a person joining from another NHS organisation:

- The new employing/appointing NHS organisation should take reasonable steps to obtain the appropriate references from the person's current employer as well as previous employer(s) within the past six years. These references should establish the primary facts as per the board member reference template

7.6 Where an employee is entering the NHS for the first time or coming from a post which was not at board member level:

- The Trust should make every practical effort to obtain such a reference which fulfils the board member reference requirements and will determine their own reasonable steps to evidence that the individual is suitable for the role. For new appointments from outside of the NHS, the Trust will seek the necessary references to validate a period of six consecutive years of continuous employment (or provide an explanation for any gaps), or training immediately prior to the application being made.

7.7 References should never be used as the sole grounds for assessing an applicant's suitability for a post. Where negative issues are included in a reference, information should be carefully considered and weighed up against the wider range of evidence gathered as part of the recruitment process. The Trust will aim to investigate negative information by sensitively raising it with the individual concerned, giving them the opportunity to explain the situation in more detail and where appropriate, give them a chance to outline any learning from past mistakes or experiences to obtain the necessary assurances about their suitability for a role. If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

7.8 The Trusts will obtain references before the start of the board member's appointment. When requesting the reference the Trust will make it clear that this is being requested in relation to a person being appointed to the role of board member, or for other purposes linked to the board member's current employment.

7.9 References are not required for Non-Executive Director reappointments, i.e. where NHSE have agreed an extension for a further term of office, however NHSE will carry out the required online FPP checks, and obtain a new signed self-attestation form prior to confirming reappointment.

7.10 When a board member leaves the Trust, or a reference request is received for an existing board member, a reference will be produced on the standardised reference form and shared with the individual for full transparency. The reference will be produced irrespective of whether the individual plans to take up further employment within the NHS.

8. Electronic Staff Record (ESR)

8.1 ESR will hold information about each board member in line with the criteria detailed below. NHS England will use its network of regional directors in a direct oversight role to ensure that individual NHS organisations (within the designated regions) are completing their FPPT, via annual submissions to the NHS England regional directors.

8.2 The CQC in its regulatory role may determine that reviews are required over the data integrity and controls that a particular NHS organisation has in relation to the records held in ESR.

8.3 There should be limited access to ESR and it has been determined that the following individuals have access to the FPPT fields in ESR:

- Chair
- Chief executive officer (CEO)
- Senior independent director (SID)
- Director of Corporate Affairs
- Head of Corporate Governance
- Director of People
- Head of HR- Corporate Service
- HR Hub Team Manager (ESR)

8.4 The ESR FPPT data fields need to be maintained to ensure information about the serving board member is current. This will mean that ESR is specifically updated for:

- All board members within the Trust
- New board members who have been appointed
- Whenever there has been a relevant change to one of the fields of FPPT information held in ESR
- Updates for annual completion of the full FPPT
- Annual completion of FPPT confirmed by chairs.

8.5 It is the responsibility of each the Trust to ensure that ESR remains current and is updated for relevant changes in a timely manner. As a minimum it is expected the Trust will undertake an annual review to verify that ESR is appropriately maintained. The Chair will be accountable for ensuring that the information in ESR is up to date.

8.6 A separate guidance document is in place to outline the process for collating the relevant information in an accurate, complete, and timely manner for updating and maintaining ESR. The document also outlines the process for individuals to access and exercise their rights in connection with the information held about them, in accordance with the requirements of data protection law.

8.7 **Information held in ESR**

8.7.1 The information that ESR will hold about board members is detailed below and also summarised in the FPPT checklist. The FPPT assessment on initial appointment of a board member will cover all points mentioned below:

- First name*
- Second name/surname*
- Organisation* (that is, current employer)
- Staff group*
- Job title* (that is, current job description)
- Occupation code*
- Position title*
- Employment history:*
- Training and development
- References*
- Last appraisal and date
- Disciplinary

- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed*
- Date DBS received*
- Disqualified directors register check
- Date of medical clearance* (including confirmation of fitness)
- Date of professional register check
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference*
- Sign-off by chair/CEO.

8.7.2 The annual FPPT requires an NHS organisation to validate all fields above – except for fields marked with an asterisk (*). These do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

8.7.3 While not requiring annual validation, DBS checks will be done on a three-year cycle for all Board members.

7. Responsibilities

7.1 **People Directorate –** It is the responsibility of the HR Hub to undertake all the recruitment checks for Executive Directors, Deputy Directors and Associate Directors, including the pre-employment checks and including the checks under the regulations. These checks are undertaken for all permanent and interim positions as well as acting up arrangements.

Once all checks are complete, the HR Hub will liaise with the recruiting manager from the HR team and send a copy of the following documents to the Corporate Governance team to retain:

- Fit and Proper Persons Self attestation Form
- Fit and Proper Person Test Checklist – New Applicants Check list
- Signed and dates copies of documents to support the checks

The recruiting manager from the HR team will ensure that the Fit and Proper Person Test Checklist – New Applicants Check list is completed. Once the recruitment checks have been completed, the Chair of the appointment panel will be asked to sign the checklist to confirm that they are satisfied that the checks meet the requirements. Following this hard copies of the recruitment documents and the checklist will be set to the Chair to review and with a request to sign off confirming assurance that the checks are complete. All documentation will be handed to the Corporate Governance Team to retain place on the personal file.

Electronic copies of the checks will also be retained on the Trust's electronic personal files. This will ensure that a soft copy of the information is retained in the case of the files held at headquarters being destroyed e.g. through a fire or flood.

The People Directorate are also responsible for adding in the results from the annual self attestation onto ESR.

In addition, the People Directorate will also take responsibility for the annual audit of the Board files to seek assurance that there is clear evidence to support the FPPT process.

7.2 **Corporate Governance Team –** To take responsibility for setting up personal files for all Executive, Non-Executive, Deputy Directors and Associate Directors. The file will contain copies of the recruitment documents as detailed above in section 4. In addition, the Corporate Governance team will also ensure that the files contain the annual Fit and proper Person Regulation declaration form undertaken as part of the appraisal process. The Head of Corporate Governance will work with the People Directorate to ensure that the collating of the FPPT information is accurately inputted onto ESR. In additional, the annual submission of the Trust FPPT self-attestation will be managed by the Head of Corporate Governance.

8. Assurance

8.1 The Chair is the responsible officer for ensuring compliance of Board members to the FPPT requirements.

A summary of compliance to the regulations for both new starters and existing post holders will appear in the Trust's annual report.

9. Monitoring of Compliance

9.1 The Director of People is responsible for monitoring overall compliance with this procedure.

Appendix 1

FPPT checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second name/surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff group	✓	x	✓	x – unless change	✓	✓		
Job title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation code	✓	x	✓	x – unless change	✓	✓		
Position title	✓	x	✓	x – unless change	✓	✓		

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Employment history Including: • job titles • organisations/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Last appraisal and date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Type of DBS disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS received	✓	✓	✓	✓	✓	✓	ESR	
Date of medical clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of professional register check (eg membership of professional bodies)	✓	x	✓	✓	✓	x	Eg NMC, GMC, accountancy bodies.	
Insolvency check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a charity trustee check	✓	✓	✓	✓	✓	✓	Charities Commission	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Employment Tribunal Judgement check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social media check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-attestation form signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other templates to be completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday, whichever latest.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only -
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director -
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	

Appendix 2

NHS
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FPPT self-attestation

Every board member should complete the template upon their commencement in post and thereafter annually.	
I declare that I am a fit and proper person to carry out my role. I: • am of good character • have the qualifications, competence, skills and experience which are necessary for me to carry out my duties • where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals • am capable by reason of health of properly performing tasks which are intrinsic to the position • am not prohibited from holding office (eg directors disqualification order) • within the last five years: – I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more – been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged – nor is on any 'barred' list. • have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity. The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, y must hold such registration and must have the entitlement to use any professional titles associated with this registratic Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker other professional registered with a healthcare or social care regulator, you must inform the regulator in question. Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above) acknowledge that it is my duty to inform the chair.	
Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	

Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix 3

OUR SERVICES
Urgent and Emergency Care
Patient Transport Service
NHS 111

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NHS Trust

Board Member Reference

This reference is to be completed for all Bard members who resign from their position as a member of the Board. This must still be completed by the direct line manager, even if the individual has no plans to take up a Board position in the NHS in the future.

A copy will be retained by the Trusts for future reference and will also be shared with the individual named on the reference for transparency.

Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.	
1. Name of the applicant	
2. National Insurance number or date of birth	
3. Please confirm employment start and termination dates in each previous role	

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*		
Job description attached		
5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	**Starting:**	**Current:**
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:

8. Confirmation of reason for leaving:
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)

Date DBS check was last completed. **Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)** **If an enhanced with barred list check was undertaken, please indicate which barred list this applies to**	**Date:** **Level:** Enhanced Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		

11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print):

Signature: ……

Referee Position Held:

Email address:

Telephone number:

Date:
Data Protection: This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 4

FPPT NEW STARTER CHECKLIST

First Name	
Surname	
Position Applied for	
Start date in post	
Job title Current Job Description	
Organisation (current employer)	
Staff group	

FPPT Area	Received	Comments / Date received	Record in ESR	Local evidence folder	Notes / source of information
Verification of ID as per the right to work checklist NHS employment standards					Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS

FPPT Area	Received	Comments / Date received	Record in ESR	Local evidence folder	Notes / source of information
Confirmation of any restrictions on right to work in UK – *if applicable* Verification of Identification and Right to Work					Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Confirm documents seen and that copies have been taken and Verified Please list documents seen:					
Original certificates seen, copied and verified for mandatory qualifications Please list documents seen:					
Employment history – 6 years and covering at least two roles					Including: • job titles • organisations/ departments • dates and role descriptions gaps in employment

FPPT Area	Received	Comments / Date received	Record in ESR	Local evidence folder	Notes / source of information
Training and development					Relevant training and development from the application and recruitment process; to meet the requirements of the role as set out in the person specification
References Available references from previous employers					
Last appraisal and date					
Disciplinary findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement					Reference request
Grievance against the board member					
Whistleblowing claim(s) against the board member					

FPPT Area	Received	Comments / Date received	Record in ESR	Local evidence folder	Notes / source of information
Behaviour not in accordance with organisational values and behaviours or related local policies					
Type of DBS disclosed		ESR and DBS response.			
Date DBS received		ESR			
Date of medical clearance* (including confirmation of OHA)		OH Fit slip			
Date of professional register check (eg membership of professional bodies)		Eg NMC, GMC, accountancy bodies.			
Insolvency check					Screenshot of check retained as local evidence of check completed. Bankruptcy and Insolvency register Companies House Charities Commission Employment Tribunal Decisions
Disqualified Directors Register check					
Disqualification from being a charity trustee check					
Employment Tribunal Judgement check					
Social media check					
Self-attestation form signed					

Confirmation of checks

Representative from HR Team	
Name	
Signature	
Date	
Chair of appointments panel	
Name	
Signature	
Date	
Chair of the Trust	
Name	
Signature	
Date	

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BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	Speaking Up Policy
PRESENTED BY	Dr Chris Grant – Executive Medical Director
PURPOSE	Decision
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: • Review and approve the Speaking Up Policy
EXECUTIVE SUMMARY	The Speaking Up Policy aims to protect all our people who raise concerns and supports individuals who may wish to speak out, assuring them that they will be valued, listened to, and their concerns will be acted upon. The policy applies to all employees of the Trust, bank staff, agency staff, volunteers, contractors, and students. The policy aims to provide people with information on how to speak up at an early stage and the process in place for the Trust to respond appropriately. The Board is asked to review the Speaking Up Policy following a scheduled review by the Freedom To Speak Up Guardians. This is to ensure it is accessible to all individuals working for NWAS to raise concerns and comply with all legal obligations to take reasonable steps to prevent individuals who speak up from unfair treatment or detriment. The Trust has two full-time equivalent guardians and a Lead Consultant Paramedic. The designated Executive Lead for FTSU is the Medical Director and there is a designated Non-Executive Director lead. The Trust actively participates in external networks, including the northwest regional FTSU network and the national ambulance network, enabling shared

	learning and collaboration. FTSU data is reviewed by the Board twice a year. The FTSU policy was reviewed as part of a recent commissioned leadership review, undertaken by the Good Governance Institute. Their recommendations form part of this update, with the review noting "the Trust's FTSU policy document is well-written and accessible" The policy changes largely reflect updated job titles/roles, changes to governance and assurance nomenclature and references recent NHS guidance. A "track changes" version and "clean" version of the policy are attached.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 22 October 2025
	Outcome	Approved

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Speaking

NHS
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~~Freedom to Speak~~ Up Policy and Procedure

DELIVERING THE RIGHT CARE,
AT THE RIGHT TIME,
IN THE RIGHT PLACE;
EVERY TIME.

Recommended by	Executive Medical Director
Approved by	Board of Directors
Approval Date	November 2022
Version Number	7.3
Review Date	November 2025
Responsible Executive Director	Executive Medical Director
Responsible Manager	Freedom to Speak up Guardian
For use by	All Trust Employees, bank staff, agency staff, all self-employed NHS Professionals, trainees, student placements, volunteers, or contractors

This procedure is available in alternative formats on request. Please contact Human Resources on 01204 498400

This procedure is available in alternative formats on request. Please contact Human Resources on 01204 498400

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
4.0	30th January 2008	30th January 2008	L Slaymaker	Policy approved
4.1	29th November 2011	9th December 2011	E Forsyth	Minor amendment to the Policy
4.2	12th July 2013	12th July 2013	V Camfield	Policy Group
4.3	8th August 2013	8th August 2013	V Camfield	Revisions following EMT approval
5.0	25th September 2013	25th September 2013	V Camfield	Approval by Board of Directors
5.1	7th November 2014	7th November 2014	V Camfield	Amendment following changes to legislation
5.2	28 November 2016		L McConnell	Revisions following Policy Review
6.0	29th March 2017	29th March 2017	V Camfield	Approval by Board of Directors
6.1	July 2017		R Williams	Minor amendment to Policy – Section 4.7
6.2	July 2017	July 20217	V. Camfield	Minor amendment to Policy – section 4.8.3
6.2	26th October 2017	26th October 2017	L. Ward	Amendments following approval by EMT for the section change
6.3	July 2017		K Evans	Amendments following advice to amalgamate the FSU~~F2SU~~ guidance to ensure clarity
6.4	Dec 2019	Dec 2019	K Evans	Approved at Policy Group
7.0	Jan 20	Feb 2020	ELC	Approved at ELC
7.1	Feb 2022		S Bell	Scheduled review. Comprehensive revisions to align with~~to~~ national guidance ~~-~~from the NGO
7.2	Sept 2022	Nov 2022	G Pacey	Comprehensive revisions following the release of the national policy.
7.3	Nov 2022	Jan 2023	M Kumawu	Approved at ELC
7.4	Sep 2025	Nov 2025		Scheduled review. Revisions align with national guidance and the NHS 10-year plan.

Speaking

~~Freedom to Speak~~ Up Policy and Procedure

Contents

~~1. Introduction ..... 5~~

1. Introduction 5

2. Scope 5

3. What can I speak up about? 5

4. Public Interest Disclosure Act 6

5. Responsibilities 6

6. Feeling safe to speak up 7

7. Who should I raise my concerns with? 8

8. Process for raising or escalating a concern 9

9. How will your concern be handled by a freedom to speak up guardian? 10

10. Review and monitoring 11

11. How will we learn from your concerns? 11

1. INTRODUCTION

1.1 We welcome speaking up and ~~we~~ will listen. By speaking up at work, you will be playing a vital role in helping us to keep improving the services for all our patients and the working environment for our people.

1.2 This Speaking~~Freedom to Speak~~ Up Policy aims to protect all our people who raise concerns~~a concern~~. The policy also aims to support people who~~that~~ may wish to speak out about a concern and provides an assurance that they will be valued, listened to, and their concern acted upon.

1.3 NWAS is committed to an open and just culture ~~in order~~ to maintain the highest standards of staff and patient safety ~~and care~~ in keeping with the Trust values, and to ensure the organisation acts with honesty and integrity to act as a responsible employer.

1.4 This policy has been introduced to provide~~enable~~ you with information on how to speak up about concerns at an early stage, and a process in place for the Trust to respond~~.~~

2.0 SCOPE

2.1 This policy applies to **ALL** employees of the Trust, bank staff, agency staff, volunteers, contractors, and students working for NWAS (herein known as NWAS 'people'). However, volunteers are not afforded protection under the Public Interest Disclosure Act (PIDA).

3.0 WHAT CAN I SPEAK UP ABOUT?

~~3.1~~ You can speak up about anything that impacts~~gets in the way of~~ patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others are~~is~~ affecting your wellbeing or that of your colleagues or patients. Indicative examples may include:

3.1

- action we are taking that may be causing unsafe patient care
- unsafe working conditions
- unethical behaviour that may bring their profession into disrepute
- procurement concerns
- recruitment malpractice
- a bullying culture

This is not an exhaustive list, and you are encouraged to raise concerns or seek advice for any matter that~~you are worried~~ is causing you concern~~concerns~~ at work.

3.2 Speaking up captures a wide range of issues, some of which may be appropriate for other existing processes and policies, for example, formal HR Processes or patient safety processes. As~~, that's fine as~~ an organisation, we will work with you to identify the most appropriate way of responding to the issue you raise.

3.3 We know some groups in our workforce face additional barriers in speaking up~~feel they are seldom heard~~ or are reluctant to do so.~~speak up.~~ You could be an agency worker, bank worker, volunteer, contractor, or student.

Date of Approval:	November 2022	Status:	Final
Date of Issue:	January 2023	Date of Review:	November 2025

We also know people with legally protected characteristics do not always feel able to speak up. ~~This policy is for all our people, and we want to hear all our people's concerns.~~

4.0 PUBLIC INTEREST DISCLOSURE ACT (PIDA)

4.1 Protected Disclosures

A protected disclosure is defined in the Public Disclosure Act 1998. This legislation allows certain categories of workers to lodge a claim for compensation with an employment tribunal if they suffer as a result of 'speaking up'.

To

4.2 ~~In order to~~ qualify for protection under the Public Interest Disclosure Act 1998, you must make a protected disclosure. This has three main elements to it:

- You must provide information of a concern that you "reasonably believe" shows a category of wrongdoing set out in the law.
- You must reasonably believe that the concern is in the public interest.
- You must raise your concern in accordance with the law – either internally to your employer or externally to an outside body.

To help you consider whether you might meet these criteria, the trust suggests you ~~should~~ seek independent advice from Protect or a legal representative.

5.0 RESPONSIBILITIES

5.1 The Board of Directors will: -

- Be responsible for approving and reviewing the Speaking~~Freedom to Speak~~ Up policy against best practice guidelines.
- Ensure the policy is accessible to all staff and training is absorbed into mandatory training.
- Ensure there is a range of support options for~~to~~ staff who raise concerns~~a concern~~
- Ensure compliance with all legal obligations to take reasonable steps to prevent individuals who speak up from unfair treatment or detriment.
- Ensure data is evaluated and learn lessons from concerns raised and action taken, making necessary improvements where appropriate

5.2 Leaders are responsible for: -

- Being familiar with the policy, understanding, and adhering~~understand and adhere~~ to the relevant processes and procedures.
- To encourage our people to raise any concerns with line managers within the first instance, where deemed appropriate.
- Respecting the person's~~persons~~ concern and actively listen to facilitate resolution
- To be confidential and supportive to the person providing feedback as and when required
- To provide consistent support for all parties concerned when a concern has been raised and manage expectations appropriately.

Date of Approval:	November 2022	Status:	Final
Date of Issue:	January 2023	Date of Review:	November 2025

- Keeping up to date with changes surrounding freedom to speak up by engaging with the freedom to speak up process and education offered.

5.3 NWAS People are responsible for: -

- Reading the policy and becoming familiar with the associated procedure and processes.
- Engaging with the training and engagement~~education~~ offered
- Raising concerns at the earliest opportunity in person or in writing, giving as much detail as possible.
- Raise the concern with their line manager initially, unless there is a good reason for not doing so.
- Adhering to a duty of confidentiality in respect of their professional NHS responsibilities and codes of conduct, particularly regarding patient data.

6.0 FEELING SAFE TO SPEAK UP

6.1 Your Safety and Security – The Trust Board is committed to an open, transparent and Just Culture. If you raise ~~a~~ genuine concern, you will not be at risk of losing your job or suffering any form of detriment~~retribution~~ as a result.

6.2 Your Confidence – The Trust Board will ensure you will not be at risk of losing your job or suffering any form of detriment~~reprisal~~ from any source as far as practicably possible. The Trust will not tolerate the harassment or victimisation of anyone raising a concern, nor~~and the Trust~~ will it~~not~~ tolerate any attempt to prevent an individual from raising a concern. Such behaviour is a breach of our values and may result in disciplinary action.

6.3 We hope you will feel confident~~comfortable~~ raising your concern openly, but we also appreciate that you may want to raise it confidentially. If you ask us to protect your identity by keeping your confidence, we will not disclose it without your consent. If~~If the situation arises where~~ we are not able to resolve the concern without revealing your identity, we will discuss with you whether and how we can proceed.

6.4 Anonymous Complaints - You have the choice to speak up anonymously if you do not want to reveal your identity to anyone. We are unable~~This can make it difficult for others~~ to gather~~ask you for~~ further information about the matter when concerns are raised anonymously, which makes~~and may make~~ it more challenging~~complicated~~ to ~~act and~~ resolve the issue and provide feedback. It also means you may not be able to access any extra support you need or any feedback on the outcome. The Trust will consider what action may be justified in response to~~by~~ an anonymous report, based on the available information~~ available~~.

6.5 Personal Support – we recognise that speaking up~~this~~ can be a stressful experience for all concerned. The Trust will take reasonable steps to assist all parties affected by~~through~~ any stress or difficulty arising from the raising of concerns~~a concern~~, including access to a free, confidential counselling service. You can also access peer support within the Trust to act as a listening ear, such as staff networks~~.~~

7.0 ~~7.0~~ WHO SHOULD I RAISE MY CONCERNS WITH?

Speaking

7.1 ~~7.1~~ ~~Most speaking~~ up can happen~~happens~~ through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice, and we encourage you to explore this option – it may well be the easiest and simplest way of resolving any issues.~~matters.~~

7.2 However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you and your concern; -

7.3 ~~7.2~~ **Patient Safety Team –** The Patient Safety Team can be contacted when you have concerns surrounding patient safety or wider quality issues.

7.4 ~~7.3~~ **HR Business Partnering Team –** Your local HR team will be able to discuss your options on the appropriate course of action or process to follow ~~in order~~ for your concern to be raised and heard effectively.

7.5 ~~7.4~~ **Local Counter Fraud Team** – If~~if~~ you are concerned about fraud, the Area~~local~~ NHS Counter Fraud Specialist (AFS), Andrew Wade, can be contacted via phone on 07824 104209 or by email at Andrew.Wade@miaa.nhs.uk. The AFS will investigate any~~.~~ allegations of Fraud, bribery and corruption using legislation that includes the Bribery Act 2010 and The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023), which includes the corporate fraud offence of 'failure to prevent fraud'. For further details refer to the Trust's Policy on Anti-Fraud, Bribery and Corruption and Response plan.

7.6 ~~7.5~~ **Trade Unions –** Your Trade Union will also be able to discuss your options and provide support regarding the appropriate process.

~~7.6~~ **Freedom to Speak Up Guardian(s)** – The Trust has appointed Freedom to Speak up Guardian(s). The role of the~~a~~ Freedom to Speak Up Guardians~~Guardian~~ is to be an independent and impartial source of advice regarding the application and procedure associated with raising concerns~~a concern~~ at work. They will also:

- Act as the point of contact for all people within the Trust who require support, guidance or advice when they wish to discuss or formally raise a concern.
- Discuss and signpost other options that may be more appropriate in the first instance
- Advise if the Speaking~~Freedom to Speak~~ Up Policy~~policy~~ is ~~being~~ applied appropriately.
- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.
- Signpost individuals to support mechanisms available across the organisation, externally or internally, as required, to support individuals, managers and others involved in the freedom to speak up process
- Ensure that individuals receive appropriate feedback on how issues that they speak up about are handled~~investigated~~, and the conclusion of any review~~such investigation~~.
- The Freedom to Speak up Guardian(s) can be contacted via email:

fr eedom2.speakup@nwas.nhs.uk

7.7 ~~**Freedom to Speak Up**~~ **Champions** – the~~The~~ role of champions raising awareness, signposting and promoting ~~the~~ freedom to speak up forms part of~~champion is to provide confidential independent support and information to people who want to raise~~ a combined role developed in collaboration with

7.7Wellbeing, ED&I and People Promise colleaguesconcern.

If you remain concerned after this, you can contact:

7.8 **Our Executive Medical Director, with responsibility for Freedom to Speak Up,** ~~– who~~ provides senior oversight to the speaking up process.

7.9 **Our Non-Executive Director with responsibility for Freedom to Speak Up –** provides independent support for people who speak up: they also provide a fresh pair of eyes to ensure that processes~~investigations~~ are conducted with rigour~~rigor~~ and, when needed, can assist in escalating issues.

In the ~~rare~~ case where you may need to contact the above, their contact details can be requested from the corporate affairs team.

7.10 In a situation where~~rare cases~~ you ~~still~~ may not feel able to speak up to someone within the organisation. You can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services.
- Following publication of the Patient Safety Landscape Review, the functions of the~~The~~ National Guardian's~~Guardians~~ Office will be transferred to NHS England. Until such time, the National Guardian's Office will remain as the primary function to~~can~~ independently review how people have been treated, having raised concerns.
- NHS England – NHS England may decide to investigate your concern themselves, ask the organisation or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of~~to~~ the relevant organisation. The precise action they take will depend on~~in~~ the nature of your concern and how it relates to their various roles. NHS England will assume responsibility for leading work on Freedom To Speak Up national guidance and support from 2026/27 onwards.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters.

If you would like to speak up externally about the conduct of a registered professional~~clinician~~, you can do this by contacting the relevant professional body, including:.

- The General Medical Council
- Health and Care Professionals Council
- Nursing and Midwifery Council
- General Pharmaceutical Council

8.0 PROCESS FOR RAISING AND ESCALATING A CONCERN

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c) Head of Human Resources.

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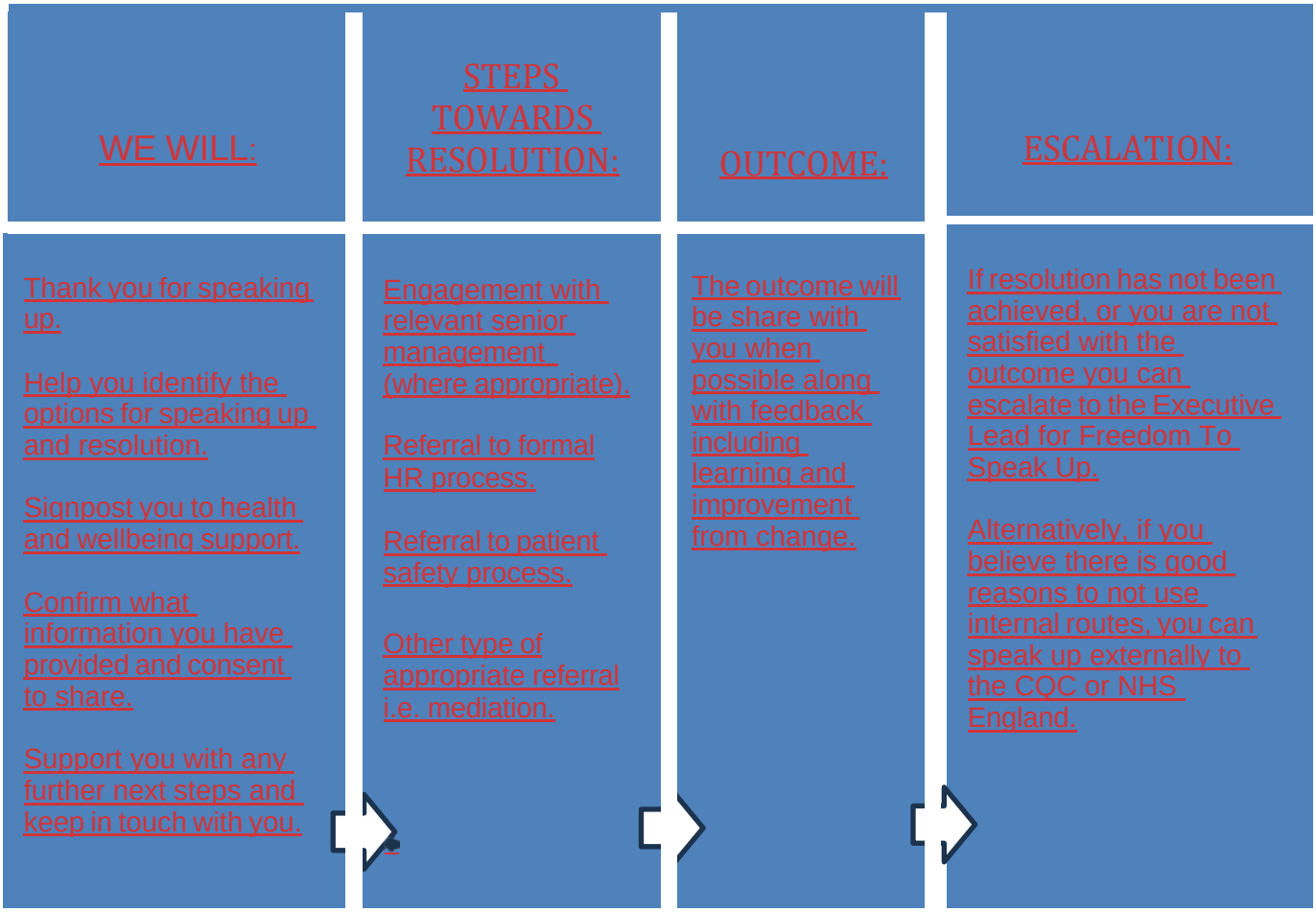
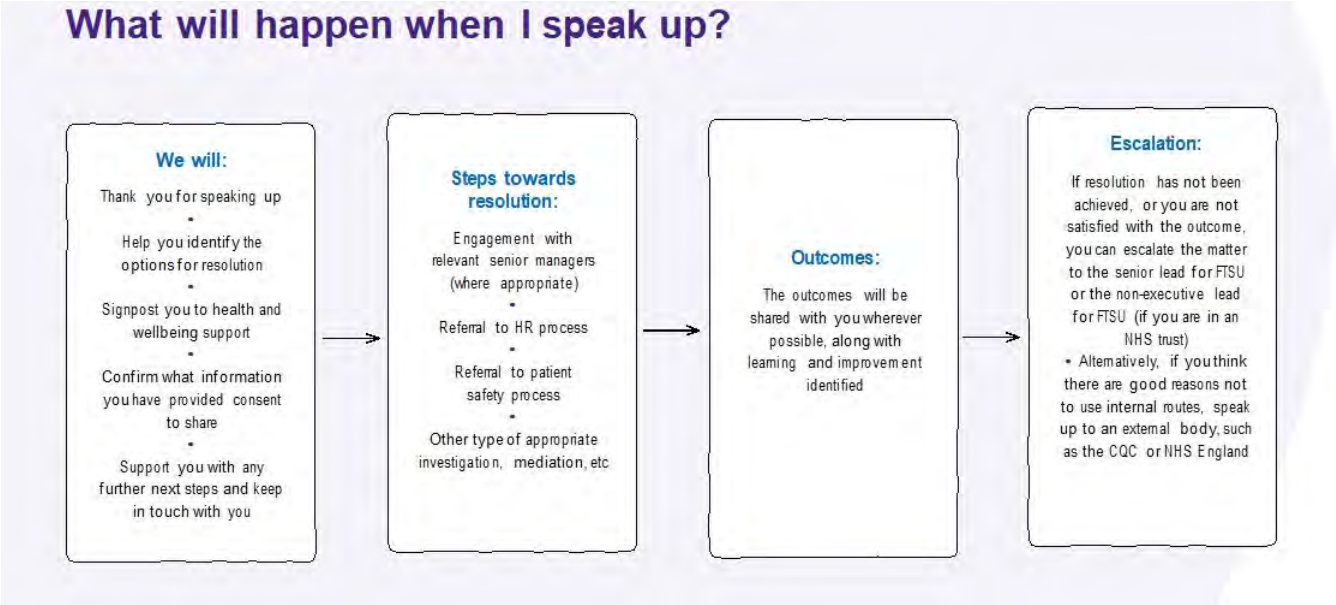
9.1 The Freedom to Speak Up Guardians will handle your concern in line with the NHS England national policy guidance seen in Figure~~fig~~ 1.

Fig 1: Whatwill happenwhen I speak up?





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10.4 The Policy will be available to all our people on the Greenroom and will also be retained in the HR Department.

11.0 HOW WILL WE LEARN FROM YOUR CONCERNS?

11.1 The focus of all speaking upinvestigation outcomes will be on improving the service we provide for patients. Where it identifies improvements that can be made, we will track them to ensure necessary changes are made and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Speaking Up Policy and Procedure

Recommended by	Executive Medical Director
Approved by	Board of Directors
Approval Date	November 2022
Version Number	7.3
Review Date	November 2028
Responsible Executive Director	Executive Medical Director
Responsible Manager	Freedom to Speak up Guardian
For use by	All Trust Employees, bank staff, agency staff, all self-employed NHS Professionals, trainees, student placements, volunteers, or contractors

This procedure is available in alternative formats on request.
Please contact Human Resources on
01204 498400

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
4.0	30th January 2008	30th January 2008	L Slaymaker	Policy approved
4.1	29th November 2011	9th December 2011	E Forsyth	Minor amendment to the Policy
4.2	12th July 2013	12th July 2013	V Camfield	Policy Group
4.3	8th August 2013	8th August 2013	V Camfield	Revisions following EMT approval
5.0	25th September 2013	25th September 2013	V Camfield	Approval by Board of Directors
5.1	7th November 2014	7th November 2014	V Camfield	Amendment following changes to legislation
5.2	28 November 2016		L McConnell	Revisions following Policy Review
6.0	29th March 2017	29th March 2017	V Camfield	Approval by Board of Directors
6.1	July 2017		R Williams	Minor amendment to Policy – Section 4.7
6.2	July 2017	July 20217	V. Camfield	Minor amendment to Policy – section 4.8.3
6.2	26th October 2017	26th October 2017	L. Ward	Amendments following approval by EMT for the section change
6.3	July 2017		K Evans	Amendments following advice to amalgamate the FSU guidance to ensure clarity
6.4	Dec 2019	Dec 2019	K Evans	Approved at Policy Group
7.0	Jan 20	Feb 2020	ELC	Approved at ELC
7.1	Feb 2022		S Bell	Scheduled review. Comprehensive revisions to align with national guidance from the NGO
7.2	Sept 2022	Nov 2022	G Pacey	Comprehensive revisions following the release of the national policy.
7.3	Nov 2022	Jan 2023	M Kumawu	Approved at ELC
7.4	Sep 2025	Nov 2025	F Ballon	Scheduled review. Revisions align with national guidance and the NHS 10-year plan.

Speaking Up Policy and Procedure

Contents

1. Introduction 5
2. Scope 5
3. What can I speak up about? 5
4. Public Interest Disclosure Act 6
5. Responsibilities 6
6. Feeling safe to speak up 7
7. Who should I raise my concerns with? 8
8. Process for raising or escalating a concern 9
9. How will your concern be handled by a freedom to speak up guardian? 10
10. Review and monitoring 11
11. How will we learn from your concerns? 11

1. INTRODUCTION

1.1 We welcome speaking up and will listen. By speaking up at work, you will be playing a vital role in helping us to keep improving the services for all our patients and the working environment for our people.

1.2 This Speaking Up Policy aims to protect all our people who raise concerns. The policy also aims to support people who may wish to speak out about a concern and provides an assurance that they will be valued, listened to, and their concern acted upon.

1.3 NWAS is committed to an open and just culture to maintain the highest standards of staff and patient safety in keeping with the Trust values, and to ensure the organisation acts with honesty and integrity to act as a responsible employer.

1.4 This policy has been introduced to provide you with information on how to speak up about concerns at an early stage, and a process in place for the Trust to respond.

2.0 SCOPE

2.1 This policy applies to **ALL** employees of the Trust, bank staff, agency staff, volunteers, contractors, and students working for NWAS (herein known as NWAS 'people'). However, volunteers are not afforded protection under the Public Interest Disclosure Act (PIDA).

3.0 WHAT CAN I SPEAK UP ABOUT?

3.1 You can speak up about anything that impacts patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others are affecting your wellbeing or that of your colleagues or patients. Indicative examples may include:

- action we are taking that may be causing unsafe patient care
- unsafe working conditions
- unethical behaviour that may bring their profession into disrepute
- procurement concerns
- recruitment malpractice
- a bullying culture

This is not an exhaustive list, and you are encouraged to raise concerns or seek advice on any matter that is causing you concern at work.

3.2 Speaking up captures a wide range of issues, some of which may be appropriate for other existing processes and policies, for example, formal HR processes or patient safety processes. As an organisation, we will work with you to identify the most appropriate way of responding to the issue you raise.

3.3 We know some groups in our workforce face additional barriers in speaking up or are reluctant to do so. You could be an agency worker, bank worker, volunteer, contractor, or student.

We also know people with legally protected characteristics do not always feel able to speak up.

4.0 PUBLIC INTEREST (PIDA)

4.1 Disclosures

A protected disclosure is defined in the Public Disclosure Act 1998. This legislation allows certain categories of workers to lodge a claim for compensation with an employment tribunal if they suffer as a result of 'speaking up.'

4.2 To qualify for protection under the make a protected disclosure. This has three main elements to it:

- You must provide information of a concern that you "reasonably believe" shows a category of wrongdoing set out in the law.
- You must reasonably believe that the concern is in the public interest.
- You your employer or externally to an outside body.

To help you consider whether you might meet these criteria, the trust suggests you seek independent advice from Protect or a legal representative.

5.0 RESPONSIBILITIES

5.0 The Board of Directors will: -

- Be responsible for approving and reviewing the Speaking Up policy against best practice guidelines.
- Ensure the policy is accessible to all staff and training is absorbed into mandatory training.
- Ensure there is a range of support options for staff who raise concerns
- Ensure compliance with all legal obligations to take reasonable to prevent individuals who speak up from unfair treatment or detriment.
- Ensure data is evaluated and learn lessons from concerns raised and action taken, making necessary improvements where appropriate

5.1 Leaders are responsible for: -

- Being familiar with the policy, understanding, and adhering to the relevant processes and procedures.
- To encourage our people to raise any concerns with line managers within the first instance, where deemed appropriate.
- Respecting the person's concern and actively listen to facilitate resolution
- To be confidential and support when required
- To provide consistent support for all parties concerned when a concern has been raised and manage expectations appropriately.

- Keeping up to date with changes surrounding freedom to speak up by engaging with the freedom to speak up process and education offered.

5.1 NWAS People are responsible for: -

- Reading the policy and becoming familiar with the associated procedure and processes.
- Engaging with the training and engagement offered
- Raising concerns at the earliest opportunity in person or in writing, giving as much detail as possible.
- Raise the concern with their line manager initially, unless there is a good reason for not doing so.
- Adhering to a duty of confidentiality in respect of their professional NHS responsibilities and codes of conduct, particularly regarding patient data.

6.0 FEELING SAFE TO SPEAK UP

6.1 Your Safety and Security – The Trust Board is committed to an open, transparent and Just Culture. If you raise genuine concern, you will not be at risk of losing your job or suffering any form of detriment as a result.

6.2 Your Confidence – The Trust Board will ensure you will not be at risk of losing your job or suffering any form of detriment from any source as far as practicably possible. The Trust will not tolerate the harassment or victimisation of anyone raising a concern, nor will it tolerate any attempt to prevent an individual from raising a concern. Such behaviour is a breach of our values and may result in disciplinary action.

6.3 We hope you will feel confident raising your concern openly, but we also appreciate that you may want to raise it confidentially. If you ask us to protect your identity by keeping your confidence, we will not disclose it without your consent. If we are not able to resolve the concern without revealing your identity, we will discuss with you whether and how we can proceed.

6.4 Anonymous Complaints - You have the choice to speak up anonymously if you do not want to reveal your identity to anyone. We are unable to gather further information about the matter when concerns are raised anonymously, which makes it more challenging to resolve the issue and provide feedback. It also means you may not be able to access any extra support you need or any feedback on the outcome. The Trust will consider what action may be justified in response to an anonymous report, based on the available information.

6.5 Personal Support – we recognise that speaking up can be a stressful experience for all concerned. The Trust will take reasonable steps to assist all parties affected by any stress or difficulty arising from the raising of concerns, including access to a free, confidential counselling service. You can also access peer support within the Trust to act as a listening ear, such as staff networks.

7.0 WHO SHOULD I RAISE MY CONCERNS WITH?

7.1 Speaking up can happen through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice, and we encourage you toe– it may well be the easiest and simplest way of resolving any issues.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you and your concern; -

7.2 **Patient Safety Team –** The Patient Safety Team can be contacted when you have concerns surrounding patient safety or wider quality issues.

7.3 **HR Business Partnering Team –** Your local HR team will be able to discuss your options on the appropriate course of action or process to follow for your concern to be raised and heard effectively.

7.4 **Local Counter Fraud Team** – If you are concerned about fraud, the Area NHS Counter Fraud Specialist (AFS), Andrew Wade, can be contacted via phone on 07824 104209 or by email at Andrew.Wade@miaa.nhs.uk. The AFS will investigate any allegations of Fraud, bribery and corruption using legislation that includes the Bribery Act 2010 and The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023), which includes the corporate fraud offence of 'failure to prevent fraud'. For further details refer to the Trust's Policy on Anti-Fraud, Bribery and Corruption and Response plan.

7.5 **Trade Unions –** Your Trade Union will also be able to discuss your options and provide support regarding the appropriate process.

7.6 **Freedom** to Speak up Guardian(s). The role of the Freedom to Speak Up Guardians is to be an independent and impartial source of advice regarding the application and procedures associated with raising concerns at work. They will also:

- Act as the point of contact for all people within the Trust who require support, guidance or advice when they wish to discuss or formally raise a concern.
- Discuss and signpost other options that may be more appropriate in the first instance
- Advise if the Speaking Up Policy is applied appropriately.
- Take immediate appropriate action when matters that people are speaking up about indicate that safety and quality may be compromised.
- Signpost individuals to support mechanisms available across the organisation, externally or internally, as required, to support individuals, managers and others involved in the freedom to speak up process
- Ensure that individuals receive appropriate feedback on how issues that they speak up about are handled, and the conclusion of any review.
- The Freedom to Speak up Guardian(s) can be contacted via email: freedom2.speakup@nwas.nhs.uk

7.7 **Champions –** the role of champions is raising awareness, signposting and promoting freedom to speak up and forms part of a combined role developed in collaboration with Wellbeing, ED&I and People Promise colleagues. If you remain concerned after this, you can contact:

7.8 **Our Executive Medical Director, with responsibility for Freedom to Speak Up**, provides senior oversight to the speaking up process.

7.9 **Our Non-Executive Director with responsibility for Freedom to Speak Up –** provides independent support for people who speak up: they also provide a fresh pair of eyes to ensure that processes are conducted with rigour and, when needed, can assist in escalating issues.

In the case where you may need to contact the above, their contact details can be requested from the corporate affairs team.

7.10 In a situation where you may not feel able to speak up to someone within the organisation. You can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services.
- Following publication of the Patient Safety Landscape Review, the functions of the National Guardian's Office will be transferred to NHS England. Until such time, the National Guardian's Office will remain as the primary function to independently review how people have been treated, having raised concerns.
- NHS England – NHS England may decide to investigate your concern themselves, ask the organisation or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles. NHS England will assume responsibility for leading work on Freedom To Speak Up national guidance and support from 2026/27 onwards.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters.

If you would like to speak up externally about the conduct of a registered professional, you can do this by contacting the relevant professional body, including:

- The General Medical Council
- Health and Care Professionals Council
- Nursing and Midwifery Council
- General Pharmaceutical Council

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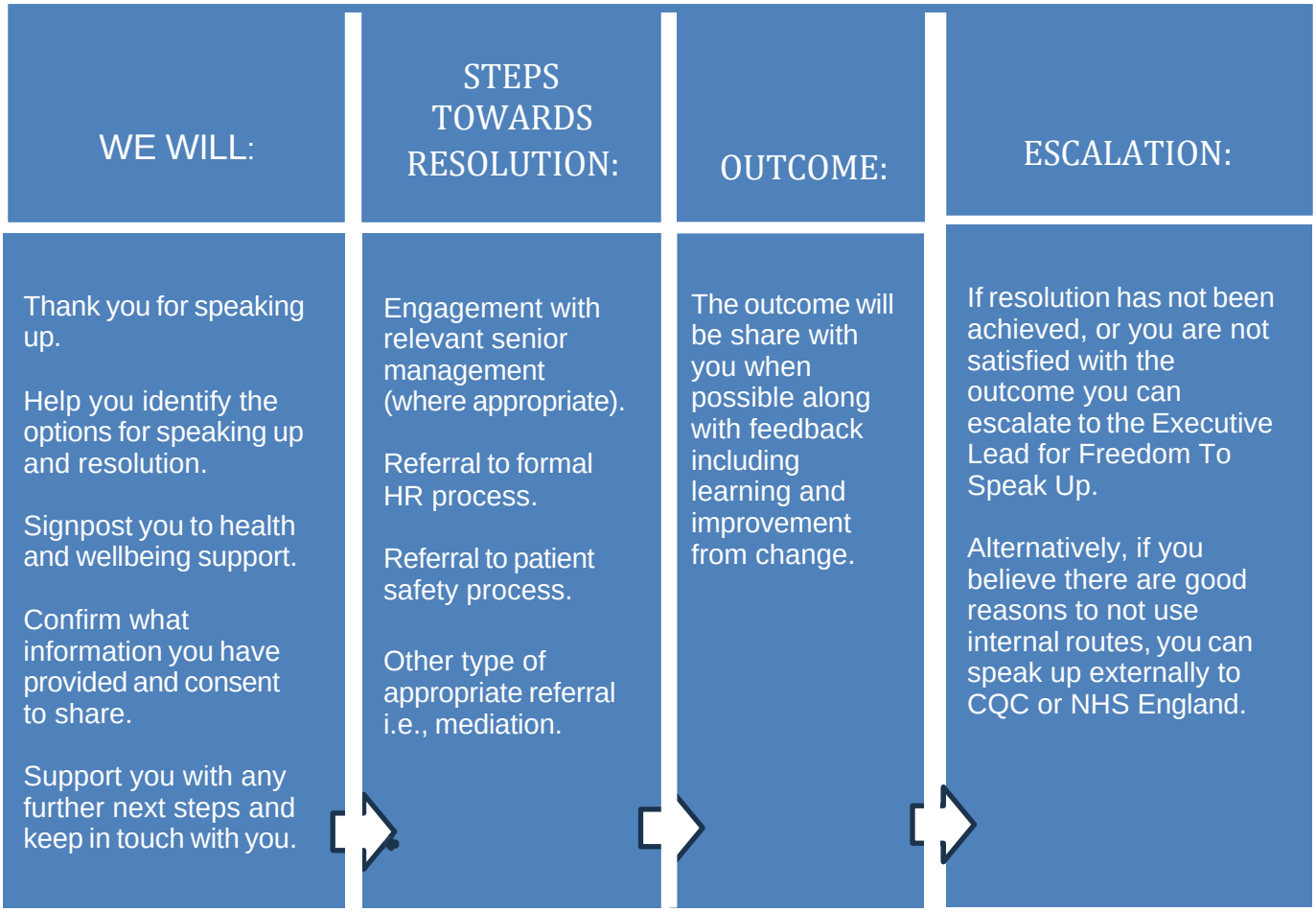

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NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	NHS England Board Capability Self-Assessment
PRESENTED BY	Mike Gibbs, Director of Strategy and Partnerships
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: • Receive and ratify the Provider Capability Self-Assessment submitted to NHS England on 22 October 2025. • Confirm that the submission reflects the Board's collective view of organisational capability. • Note that the assessment document is included at Appendix 1 for assurance and audit purposes
EXECUTIVE SUMMARY	NWAS has completed and submitted its Provider Capability Self-Assessment to the NHS England North West System Coordination Team (22 October 2025). All Board members reviewed and agreed the submission in advance of the deadline through established governance routes. The self-assessment forms part of the national Insightful Board approach and is designed to provide assurance on how well organisations are led and governed. It reflects a snapshot of the Board's collective view, supported by existing evidence, demonstrating that NWAS is effectively and capably led. The full assessment is provided at Appendix 1 for formal ratification. Evidence used within the submission is drawn entirely from established assurance sources including statutory documents, governance statements, internal audit reports, Ofsted inspection findings, and the Good Governance Institute Well-Led review.
	xxx

PREVIOUSLY CONSIDERED BY	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

NHS England requires all providers to complete an annual Provider Capability Self-Assessment as part of the Insightful Board framework. The assessment focuses on five domains:

1. Strategy, Leadership & Planning
2. Quality of Care
3. People & Culture
4. Access & Delivery
5. Productivity & Value for Money

The process draws primarily on existing evidence such as Board reports, governance statements, performance data, and Well-Led reviews. Providers are asked to rate their position against each domain as confirmed, partially confirmed, or not met, alongside a supporting evidence narrative.

Importantly, the assessment is not designed to test operational delivery or grip. It is focused on leadership capability, governance, and organisational maturity. Where gaps are identified, the issue is not their existence, but whether the organisation recognises them and has credible plans to address them. The intention is to foster constructive reflection rather than to penalise providers.

The outcome will inform ongoing provider oversight and will, in future, form part of Foundation Trust assessments.

NWAS submitted the completed assessment to NHS England on 22 October 2025, following confirmation from all Board members that the return accurately represented the organisation's position.

2. NWAS POSITION AND EVIDENCE BASE

The NWAS return reflects a triangulated review across executive and non-executive functions. Evidence was drawn from:

- Statutory documents (Annual Report and Accounts, Quality Account)
- Independent reviews (Ofsted apprenticeship inspection, GGI Well-Led review)
- Committee and sub-committee assurance reports
- Workforce, clinical, financial, and operational performance information
- Improvement and cultural development programmes

The assessment summarises areas of strength, areas requiring continued focus, and the improvement work already underway across the Trust.

The full assessment is included at Appendix 1 for Board assurance and formal ratification.

3. RISK CONSIDERATION

Regulatory risk: Non-compliance could impact NHS England oversight assessments. Submission was completed in full and on time, mitigating this risk.

Assurance risk: The assessment draws on established assurance sources, ensuring alignment with the Board's existing assurance and oversight arrangements.

Reputational risk: A robust, evidence-based submission supports confidence from regulators and partners in the Trust's governance and leadership capability.

4. EQUALITY/ SUSTAINABILITY IMPACTS

No negative equality or sustainability impacts have been identified.

Where relevant, the assessment draws on the Trust's established work on health inequalities, workforce EDI, population health, and sustainable care models. These remain embedded in existing governance and performance structures.

5. ACTION REQUIRED

The Board is asked to:

- Receive and ratify the Provider Capability Self-Assessment submitted on 22 October 2025.
- Confirm that the submission reflects the Board's collective assessment of provider capability.
- Note the inclusion of the full assessment at Appendix 1.

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*Financial planning is fully reconciled with ICB templates and the Planning Finance Return (PFR). Capital expenditure plans are approved by the Board and reflect system-level capital allocations (CDEL), with submissions reconciled and agreed through the planning process. All Board positions are currently filled. Recruitment is underway for 2 x NED roles as the current incumbents reach end of their term this calendar year to bring new NED competencies to help us meet future goals, challenges and ensure continuity of leadership.* *A formal succession planning exercise has been completed for executive directors and reported to the Board, supported by engagement with NHSE regional processes through the Scope for Growth methodology. Further plans will be developed for NEDs once recruitment has been completed. Development plans are in place for deputies and identified senior talent.*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*NWAS has established governance processes to monitor and continually improve the quality of care. The Clinical and Quality Group, Trust Management Committee, and Quality & Performance Committee provide assurance to the Board through regular reports on patient safety (PSIRF), safeguarding, infection prevention and control, learning from deaths, complaints, CQC updates, and the statutory Quality Account. The Board receives regular reports on patient experience through the Clinical & Quality Group and Quality & Performance Committee, triangulating qualitative and quantitative data, including comparative benchmarks such as Ambulance Quality Indicators (AQIs).* *Variation in patient experience is assessed through demographic reporting. Quarterly Learning from Deaths infographics provide breakdowns by gender, age, ethnicity, and*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*The Board regularly reviews workforce diversity data and staff survey results through its reporting cycle to the Resources Committee, Board, and Trust Management Committee. This includes WRES, WDES, gender and ethnicity pay gaps, disability pay gaps, and assurance against the Ambulance Culture Review recommendations.* *Diversity and inclusion are monitored through a Board-approved EDI strategy and supporting action plan, overseen by the Diversity & Inclusion Group, which reports to TMC. The*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	*NWAS are delivering against the UEC standards.* *Delivery of C2 mean target.* *Delivering the majority of wider UEC indicators.* *Achieving call pick up standards.* *Monitored via internal UEC Group / TMC / Q and P / Board – monthly via IPR and quarterly via UEC paper to TMC.* *External oversight via NHSE NW UEC Programme Board.* *We have completed Board Assurance for winter – high degree of confidence in delivery.* *Supported by NWAS Strategic Winter plan – tactical plans in development.* *Operational performance improvement group established – focus on H&T / C1 / C2 response.* *Engaged widely on Call Before Convey NHSE Regional Group.* *Supporting Handover 45.* *Launched revised Clinical Safety Plan – and area level response.* *In 2024/25 NWAS invested Public Health and Business Intelligence resources to deliver Phase 1 of a Population Health Dashboard, aligned with NHS England's duty under section 13SA of the NHS Act 2006. This tool enables analysis of 999 service data by protected characteristics (age, sex, ethnicity) as well as population health factors such as location and deprivation.* *The dashboard provides the first Trust-wide capability to track variation in access and outcomes. Embedding its use to minimise unwarranted variation is a priority within the 2025/26 Annual Plan and EDI deliverables. This includes dissemination across the organisation and integration into Equality Impact Assessments, Board reports, and operational decision-making.* *The dashboard is hosted on the NWAS Green Room platform and will support more consistent monitoring, reporting, and targeted action to address inequalities in access and waiting times.* *The Board receives information about response times in different areas.* *The variation in mental health provision across ICB population has been reported to the Board and the Board receives information about response times for patient with mental health issues compared with times for patients with physical need indicating equality for CAT 1 and 2 responses but divergence in response times in for category 3 and 4 patients.* *The equality of provision for emergency responses is tracked in real time by area, and resources (ambulances and response vehicles) are deployed across areas and sectors to address variation in response time.* *Core aspect is our management of response to patients. NWAS have several mechanisms in place to ensure equity of response.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*The Board reviews benchmarking data from the NHS Model Health System and PLICS, with outputs reported through the Resources Committee. This information is used to assess performance against peers, identify unwarranted variation, and target improvement opportunities, particularly within the PES service.* *NWAS has a strong track record in delivering planned productivity and efficiency programmes. Targets have been achieved in-year for the last three financial years, with improvements in recurrent delivery. Any shortfall is transparently reported through TMC and the Resources Committee and factored into financial planning for the following year.*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*NWAS were part of the investigation and intervention process undertaken in L&SC by an NHSE nominated lead for financial recovery who assessed the organisation as green.* *NWAS were not part of the detailed intervention work (phase 2) and did not receive an individual organisational report from the NHSE financial recovery lead.* *Clean value for money assessment as part of the 2024/25 annual external audit.* *There have been no contract disputes in the last 12 months.* *Staffing and financial systems are closely aligned, underpinned by a strong triangulated approach between operational planning, workforce planning and financial management.* *There is effective joint vacancy control and joint oversight of recruitment and workforce decisions, ensuring resources are deployed safely and efficiently. As a result, the Trust has not been reliant on agency or bank staff. Agency spend has reduced to near zero, with only minimal costs (£3k) incurred in-year.* *The Board stress-tests the impact of financial efficiency plans using the Optima modelling tool, which triangulates activity, performance, and workforce. This approach ensures alignment with the financial envelope while supporting UEC recovery plans and accounting for efficiency and productivity requirements.* *Quality Impact Assessments (QIAs) are completed for relevant schemes and reported to the Quality Committee, providing safeguards to ensure that efficiency programmes do not compromise quality of care, access, or staff wellbeing.* *Performance against the financial plan is tracked through the Resources Committee, with variances examined to understand underlying drivers and ensure corrective actions are taken where required.* *The Board actively contributes to system-wide financial discussions through ICB planning processes and provider collaborative forums. NWAS's financial plan is aligned with partner organisations and Joint Forward Plans across the ICSs in its footprint.* *The Trust has supported overall system financial performance by delivering a surplus against breakeven plans for the last three financial years, demonstrating its commitment to balancing organisational priorities with system priorities for the benefit of the wider population and the NHS.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors

Signature	
Name	Mike Gibbs
Date	21st October 2025

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	Good Governance Institute (GGI) Well-Led Review
PRESENTED BY	Elaine Strachan-Hall
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: • Accept the final report • Note the recommendations • Agree the action plan and note intention to report progress through Quality and Performance committee	
EXECUTIVE SUMMARY	• The Good Governance Institute was appointed to undertake a developmental well-led review. • This review focused on the CQC's well-led quality statements and was conducted through interviews with key individuals and stakeholders, review of relevant documentation, meeting observations and focus groups, triangulated with established principles of governance best practice drawn from GGI's extensive knowledge and cross-sector experience. • The findings from the review are presented in a final report attached as Appendix A • An action plan has been developed to address agreed recommendations and is attached as Appendix B	
PREVIOUSLY CONSIDERED BY	Board Development session	
	Date	Wednesday, 29 October 2025
	Outcome	Discussion of recommendations

1. BACKGROUND

The Trust commissioned a developmental review of the Well-led domain of the CQC Single Assessment Framework.
This was awarded through competitive tender to Good Governance Institute. This review focused on the CQC's well-led quality statements referred to below:

1. Shared direction and culture
2. Capable, compassionate, and inclusive leaders
3. Freedom to Speak Up
4. Workforce equality, diversity and inclusion
5. Governance, management and sustainability
6. Partnerships and communities
7. Learning, improvement and innovation
8. Environmental sustainability

2. METHODOLOGY

Methodology comprises a series of interviews with key individuals and stakeholders, review of relevant documentation, meeting observations and focus groups, triangulated with established principles of governance best practice drawn from GGI's knowledge and cross-sector experience.

In addition, this review assessed the effectiveness of the trust's governance developments and any gaps, (including a review of assurance groups below committee-level), integration with the wider system governance, the use of the BAF and 3As report, and the effectiveness of the 4-year strategy.

3. FINAL REPORT

Initial findings were presented, and an initial report presented for factual accuracy. The final report was amended and circulated to Board members followed by a full presentation to a Board Development session. The report is reproduced as Appendix A and makes twenty-two recommendations.
These recommendations have now been formulated into an action plan detailing the activity to be completed with the responsible executive identified and the timescale for delivery noted. This is reproduced in Appendix B.

4. RISK CONSIDERATION

This developmental review was undertaken in order to identify risks of non-compliance to the standards required by the Care Quality Commission.

5. EQUALITY/ SUSTAINABILITY IMPACTS

This report includes reference to well-led elements of Equality and Sustainability activities and encourages further work to continue progress in these areas.

6. ACTION REQUIRED

The Board of Directors is asked to:

- Accept the final report
- Note the recommendations
- Agree the action plan and note intention to report progress through Quality and Performance committee

Strategy
Leadership
Governance

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North West Ambulance Service NHS Trust

Developmental well-led review

A report from GGI

Creating lasting value for society

September 2025

www.good-governance.org.uk

GGI exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat – in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

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North West Ambulance Service NHS Trust

Developmental well-led review report

Date:	September 2025
Authors:	Joanna Watson, Principal Consultant
	Joe Roberts, Senior Consultant
	Sophia Adesoye, Consultant
	Rianna Lewis, Junior Consultant
Reviewed by:	Simon Hall, Principal Consultant
	Penny Venables, Associate Consultant
Edited by:	Martin Thomas, GGI Communications Manager

This report has been prepared by GGI Development and Research LLP (T/A GGI) for the board of North West Ambulance Service NHS Trust. The report highlights the conclusions drawn from the developmental well-led review commissioned by the board and an outline of future suggested actions and improvements to address the identified shortcomings and strengthen the organisation's governance.

The matters raised in this report are limited to those that came to our attention during this assignment and are not necessarily a comprehensive statement of all the opportunities or weaknesses that may exist, nor of all the improvements that may be required. GGI Development and Research LLP has taken every care to ensure that the information provided in this report is as accurate as possible, based on the information provided and documentation reviewed. However, no complete guarantee or warranty can be given regarding the advice and information contained herein. This work does not provide absolute assurance that material errors, loss or fraud do not exist.

This report is prepared solely for use by North West Ambulance Service NHS Trust. Details may be made available to specified external agencies, including regulators and external auditors, but otherwise the report should not be quoted or referred to in whole or in part without prior consent. No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

GGI has carried out client work with around 1,000 organisations over the last decade-and-a-half. We are part-owned by the Good Governance Institute, the EU-based independent governance reference centre focusing on the public and third sectors. We have specific expertise in governance reviews of complex public purpose organisations. Our high-quality and ethical governance consultancy is carried out by our specialist staff team, supported by subject matter expert associates and partners.

contact@good-governance.org.uk

www.good-governance.org.uk

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Table of contents

INTRODUCTION 5

APPROACH AND ASSESSMENT FRAMEWORK 6

HEADLINE FINDINGS 8

DETAILED FINDINGS, ANALYSIS AND RECOMMENDATIONS 10

Shared direction and culture 10

Capable, compassionate and inclusive leadership 12

Freedom to speak up 14

Workforce equality, diversity and inclusion 17

Governance, management and sustainability 19

Partnership and communities 23

Learning, improvement and innovation 25

Environmental sustainability 29

APPENDIX 32

Introduction

Context

GGI was appointed by North West Ambulance Service NHS Trust (NWAS) to undertake a governance review in advance of the trust's next Care Quality Commission well-led inspection. This review has been designed to support the trust in assessing its current leadership, governance and management maturity, and to identify the actions required to move towards outstanding.

Fieldwork was carried out between May and August 2025. Our approach has been developmental rather than diagnostic. We have used the eight quality statements from the CQC's well-led framework as the basis for our assessment, triangulating evidence from interviews, meeting observations, focus groups and document review. The aim has been to provide a rounded view of NWAS governance and leadership, with a focus on learning, improvement and impact.

This report sets out our findings and recommendations. It is intended to support NWAS in strengthening its governance arrangements and identifying areas for development ahead of a CQC well-led inspection.

Acknowledgements

The GGI review team would like to thank everyone who made themselves available for interviews and those who provided project support and documentation for review, in particular Emma Orton and Debra Collins.

Limitations

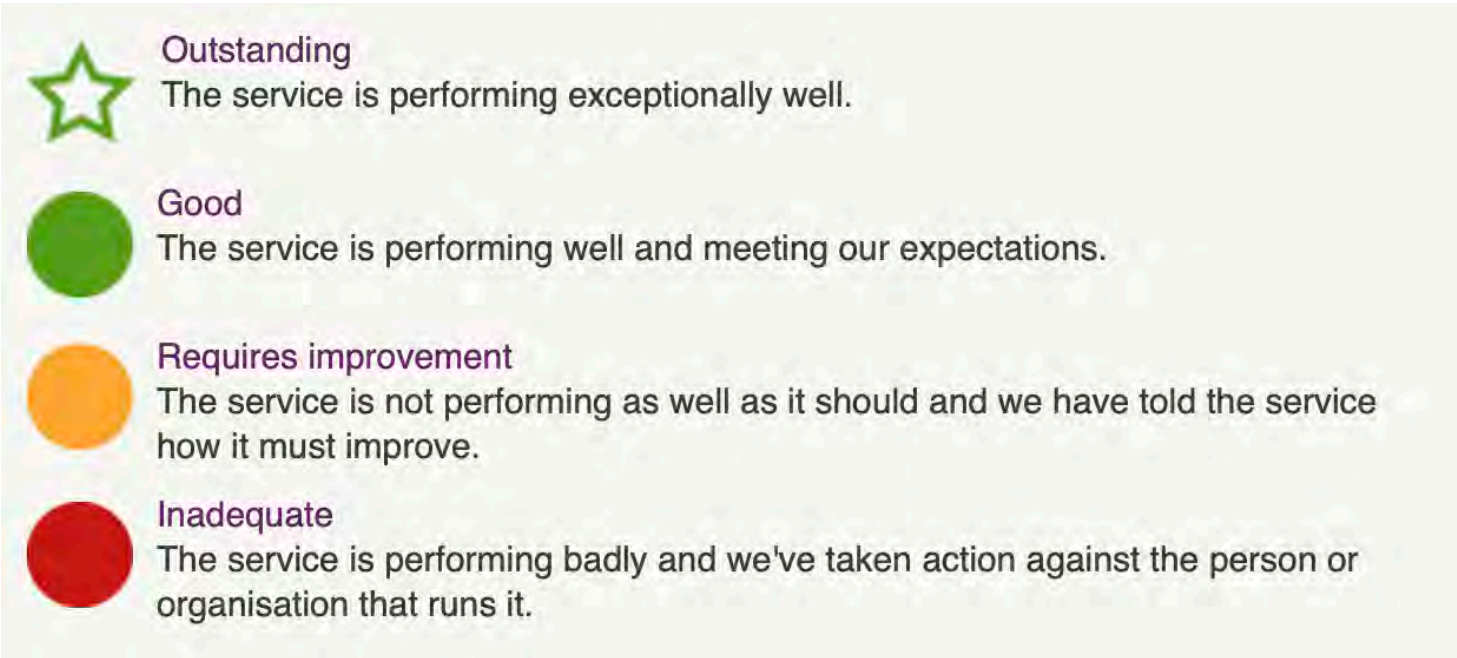
The review is limited to the documentation that was provided to GGI during the period described, and to the information provided by those we interviewed as part of this process or observed at those meetings we were able to attend. This, together with the other limitations, provides a caveat to the report's findings.

Approach and assessment framework

The CQC inspects NHS and other care services and ask five key questions of them as set out below.

Are they safe?	Safe: you are protected from abuse and avoidable harm.
Are they effective?	Effective: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
Are they caring?	Caring: staff involve and treat you with compassion, kindness, dignity and respect.
Are they responsive to people's needs?	Responsive: services are organised so that they meet your needs.
Are they well-led?	Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

The ratings are set out below:



The CQC will carry out a well-led review as a specific inspection, in addition to considering leadership when reviewing individual services. A review will generate a rating and actions for improvement.

This review has been carried out using the CQC well-led quality statements as a basis for our assessment. These are as follows:

Shared direction and culture

We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement and understanding challenges and the needs of people and our communities in order to meet these.

Capable, compassionate and inclusive leadership

We have inclusive leaders at all levels and understand the context in which we deliver care, treatment and support and embody the culture and values of the workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

Freedom to speak up

We foster a positive culture where people feel they can speak up and their voices will be heard.

Workforce equality, diversity and inclusion

We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

Governance, management and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes and we share this securely with others when appropriate.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, improvement and innovation

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Environmental sustainability – sustainable development

We understand any negative impact of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same. I've put this in.a box just for now - Sophia, could you ask Helen to turn this into an image as we'll be using it a lot!

Headline findings

Shared direction and culture

- The trust has a clear vision and strategy in place, which is currently being refreshed.
- The wide geography and number of staff make it difficult to foster a unified organisational culture.
- Changes in the culture of the organisation have been positively received, while recognising there is work to do.
- Staff in focus groups described a sense of pride in their work and a strong sense of community.

Capable, compassionate and inclusive leadership

- The trust has a capable and effective board, with collaborative and inclusive leadership.
- Visibility is challenging given the trust's geography and number of services.
- The trust is committed to leadership development and training.
- Given the changes at board, this would be a good time for a board development programme.

Freedom to speak up

- FTSU is well-resourced with two full-time FTSU guardians and strong executive supports.
- Staff show high awareness and confidence in the service and are regularly encouraged to speak up about concerns.
- There is work to be done for staff to feel more comfortable raising concerns via informal routes rather than the formal FTSU guardian service.
- There is also room to improve triangulation of data through strengthening interactions between FTSU and trade unions.

Equality, diversity and inclusion

- Workforce data shows that the trust has some way to go in developing a workforce that is more representative of the communities it serves, for example in terms of ethnic diversity.
- It also shows room for improvement in opportunities for career progression and staff experience more generally.
- There is a strong commitment from management to promote equality, diversity and inclusion that is well-resourced and backed up by practical action.

Governance, management and sustainability

- Board and committee meetings function well, although we have made some suggestions for how they could be improved further.
- The trust has redesigned its governance structure below board level, in line with good governance principles, and this is now becoming more embedded.

- The trust has a well-designed and well-established process for risk management, encompassing both strategic and operational risks.
- The board would benefit from a more structured approach to providing assurance regarding compliance with regulations such as the CQC fundamental standards.

Partnership and communities

- The trust is well regarded by healthcare partner organisations across the region for its good track record in finance, quality and performance.
- Partners are keen that the trust's new strategy should match the NHS 10 year plan's emphasis on community-based services.
- Patient and public involvement represents a challenge for a trust with such a large catchment area, but the trust is making a real effort to engage with people who use services and the wider community.
- The relationship between management and trade unions is strained and needs to be reset in the interests of the organisation as a whole.

Learning, improvement and innovation

- NWAS has a strategic focus on learning improvement and innovation, supported by the senior leadership, with numerous initiatives and mechanisms in place to support shared learning.
- Research and development is a notable area for the trust, compared to other ambulance trusts in our experience.
- There are good governance arrangements in place to support learning, improvement and innovation, and efforts from the trust to involve staff and patients in these processes.
- However, there is still work to be done to fully embed a culture of a learning organisation in NWAS.

Environmental sustainability

- There is a strong commitment from the leadership of the trust towards environmental sustainability.
- The recently refreshed 2025-2028 green plan is a comprehensive and well-structured document, outlining measurable targets, and aligns well with NHS guidance.
- Sustainability is well-governed, with a dedicated budget, steering group and board-level reporting.
- Staff engagement is growing, though infrastructure limitations and mobile workforce pose challenges.

Detailed findings, analysis and recommendations

Shared direction and culture

> *"We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these"*

Trust strategy and vision

The current strategy was set for the period 2022-25 but has been extended by a further year because of the change of chair and chief executive. The current chief executive's background in the trust includes having been director of strategy, so he is very much seen as having led the development of the existing strategy.

The clear aim has been to set a strategy that resonates at all levels of the organisation, supported by a range of enabling strategies. The strategy is short, clearly articulated, and sets out what it means for patients, people and partners. The intention is that it can be reframed depending on the reader, so that it is equally of value to frontline staff and corporate staff, at all levels. The strategy was tested within the organisation through a range of consultation events such as workshops and roadshows, and externally through stakeholder consultation and the patient public panel.

As is the case for all ambulance services working across large geographies, it is a significant challenge to make sure that the trust's specific strategy aligns to the strategy of each integrated care board (ICB), and looking forward NWAS will need to establish its role in the context of the NHS 10 year health plan, with its focus on neighbourhood health. The trust leadership is fully aware of these issues, and the significant opportunities that these provide for the future. The trust is currently undergoing a strategy refresh, with staff actively engaged through consultation events.

While there was much that was positive about the strategy, concerns were raised by board members about how effectively the trust communicates its strategic direction to mobile staff – such as paramedics and those working in patient transport services – who may feel disconnected from the broader organisational goals.

The vision – "right care, right time, right place" – is well understood, but perhaps inevitably it is easier for paramedics and clinicians to relate to. There is recognition that not all services are clinical, and that there is a need to be more inclusive to reflect the whole organisation, because everyone's role matters.

Values and behaviours

Recent changes in leadership have led to a cultural shift within the organisation, presenting both challenges and opportunities. The trust demonstrates a strong commitment to patient and staff safety and experience. It was clear through all our work that being diverse, treating everyone with dignity and respect, and acting on poor behaviour are all very important to the organisation. The chief

executive has a high profile in promoting diversity, alongside which we observed strong buy-in at senior management level. Diversity is recognised as not just being about the policies and processes, but also messaging, role-modelling and more.

Culture

A challenge for NWAS is to balance being an NHS trust with being an emergency service, as these can lead to very different cultures. Emergency services tend to be 'command and control', because at times they need to be. There is strong awareness among leaders of the need to balance that with being an NHS trust, where matters such as learning and being able to speak up are valued and well understood. There is a risk that the command-and-control culture dominates in a range of ways, including a tendency to focus more on process than on quality, which we expand on further below. NWAS operates across approximately 109 sites and employs around 7,000 staff across five counties, making it difficult to foster a unified organisational culture. To quote one interviewee: "Working in Rochdale is very different from working in central Manchester, working in 111 is different from the emergency contact centres". We heard leaders talk about their recognition of this issue, and the desire to have an organisation where the values are universally recognised and people are treated with dignity and respect – and that where behaviour does not meet those values, this is addressed. In interviews, leaders frequently talked about equality, diversity and inclusion (EDI) at the same time as talking about culture, recognising the linkages between the two. Changing the culture of an organisation such as an ambulance service, with a significant number of long-serving staff, takes time but it was recognised that there has been change over the past two or three years, in particular in tackling poor behaviours, including some which would previously have been seen as acceptable and become normalised. There is also recognition that there is still much to do. We heard a range of descriptions of the culture in our interviews, including:

Staff in focus groups described a sense of pride in their work and a strong sense of community.

Recommendations

1. As the strategy is refreshed, ensure there are robust communication and engagement plans in place to make the most of a new opportunity to build a consistent culture across the trust

Capable, compassionate and inclusive leadership

> *"We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty"*

Leadership skills and experience

Following a period of stability, the board has seen significant change over the past few months, in particular with the substantive appointment of the chief executive and the appointment of a new chair.

We have found that the trust has a capable and effective board with clear dedication from the senior leadership team. The board is operating effectively as a unitary board. Board relationships are described as settled and open. Non-executive directors (NEDs) provide constructive challenge at both board and committee levels. Executive directors share information with each other. One commented: "If there's a problem, I know about it before a meeting".

Leadership is widely described as collaborative, helpful, approachable and inclusive, although it is recognised that in emergency situations this will change to being command-and-control. There have been culture changes in trust leadership, with investment in leadership development in softer skills of management, and in areas such as sexual safety and racial discrimination. Historically, there has been a strong emphasis on performance and numbers. The trust is now working to rebalance its priorities, ensuring that safety and wellbeing are consistently placed at the heart of decision-making.

Below the board, the recent leadership review was recognised as being challenging. The area director role is relatively new and is seen as a positive step. We saw very positive involvement and engagement of area directors at the meetings we observed of the trust management committee and service delivery assurance group. Some concerns remain about hierarchical dynamics within directorates—for example, perceptions linked to epaulette colour.

Leadership visibility

The executive team have made deliberate efforts to be visible and accessible across the organisation. These efforts were recognised by staff in focus groups, in particular the chief executive's regular communications. Several comments were made regarding how approachable executives are, that they are willing to make time and will reply to emails.

However, the widespread geography and different working patterns make all aspects of visibility challenging. Some staff are unable to easily access emails to read bulletins, while others commented that their workloads are such that they have little time to read bulletins and that there is less face-to-face communication, which makes communication less effective.

Non-executive directors have committed time to attend large gatherings such as award ceremonies, quality summits and community meetings, and to visit different parts of the service. It is recognised as

being important that board members are visible by staff, and that this brings specific insights back into the board meetings. One executive director expressed the view that it would be more valuable to NEDs to spend more time 'walking the floor'.

Overall, it was recognised that while board members do commit to being visible, this is challenging given the geography of the trust. With a new chair, it is timely for board members to agree what the expectation is for both executives and non-executives, and being realistic and explicit about what is achievable.

Leadership development

Board

There is a clear formal induction process for NEDs, utilising NHS Providers' induction course, one-to-one meetings with the executives, and observational shifts on ambulances.

Given the changes that have recently taken place, and new appointments that will soon be taking place, this is a time when the board needs to stabilise. Spending time together to get to know each other and build professional relationships is valuable and will encourage trust, candour and respect in board meetings. With the strategy refresh in progress, now is an ideal time to implement a board development programme.

Senior leaders

There is a range of opportunities for senior leaders, including the NHS Providers' development programmes such as aspiring directors. The leadership programme for middle managers is run in-house, and the aim is to ensure that a range of individuals across different backgrounds attend, to increase the diversity of leaders.

Staff in the corporate focus group talked very positively about training, including aspiring leaders, availability of mentors, and that the leadership development offer at NWAS is better than at other trusts. The service delivery group was less positive about the available offer, including that people are promoted before they receive relevant training.

There has recently been a succession planning exercise, relating to all direct reports to board, with development plans put in place. Plans are being developed to take this down to the next level.

Recommendations

2. Agree the expectations of board members – in particular NEDs – spending time visiting different parts of the service and across the geography of the trust
3. With the appointment of a new chair, now is an ideal time to implement the planned strategy development sessions as part of the board development programme
4. Review the range of ways in which the board communicates with staff, to establish whether there are further options that could be explored

Freedom to speak up

"We foster a positive culture where people feel that they can speak up and that their voice will be heard"

Freedom to speak up (FTSU) service

The freedom to speak up service in the trust has undergone notable improvements, including the recent appointment of an additional FTSU guardian. The trust now has two full-time equivalent guardians, one of whom also chairs the disability staff network. There is a designated executive lead for FTSU, and a non-executive lead, with plans in place to appoint a replacement following the current NED's departure. The service is well-resourced, with a dedicated budget and oversight within the executive medical director's portfolio. The relationship between FTSU and the executive medical director is open and supportive, with monthly assurance meetings providing regular engagement.

The trust actively participates in external networks, including the northwest regional FTSU network and the national ambulance network, enabling shared learning and collaboration.

FTSU data is reviewed at board level twice a year, with both annual and biannual reports presented and discussed. However, the most recent FTSU annual report was presented directly to the board without prior review at the resources committee, quality and performance subcommittee or trust management committee, which is not good practice.

The trust's FTSU policy document is well-written and accessible. It uses inclusive and personal language, reflecting the trust's commitment to "*hear all our people's concerns*". The policy outlines multiple routes for raising concerns including HR and patient safety processes, and relevant national bodies where appropriate. It also includes a clear process for raising concerns and concludes with a paragraph explaining how the trust will learn from concerns.

Staff feedback from focus groups indicates strong awareness of and confidence in the FTSU service. The service is widely promoted across, including via trust-wide roadshows, staff engagement events, and staff forums. Guardians are visible and approachable, contributing to a culture of openness.

In 2024/25, the trust achieved over 90% compliance with FTSU training for all staff – a commendable achievement that reflects the trust's emphasis on the importance of speaking up. The FTSU annual report in its equality impact assessment highlights the proportion of concerns raised by staff with protected characteristics. However, the data shows lower reporting rates on the bases of disability, ethnicity and sexual orientation compared to female staff.

Characteristic	NWAS workforce (%)	FTSU concerns (%)
Disability	9%	3.3%
Ethnicity	7%	1.6%
Gender (Female)	56%	11.7%
Sexual Orientation	6%	1.7%

An internal audit by MIAA in 2023/24 identified areas of good practice in the trust including high FTSU training compliance and an FTSU policy compliant with national guidance. One recommendation from the review was for the trust to establish a network of FTSU champions. In response, the trust made the decision to combine the role of FTSU champion with the health and wellbeing function, creating a network of cultural ambassadors to support staff. However, the current FTSU policy still references FTSU champions, which should be updated during the next policy review in November 2025.

Overall, the FTSU guardian service is highly commendable. The trust's investment in time, resource, and leadership support demonstrates a strong commitment to enabling staff to raise concerns safely and effectively.

One area requiring attention is the triangulation of FTSU data with other sources, particularly trade union feedback. Currently, there is no formal link between the FTSU service and the trade unions, which may limit opportunities for shared learning and coordinated improvement. An example of good practice seen in other ambulance trusts involves establishing a learning review group with representation from management, FTSU guardians, patient safety, patient engagement and experience, staff networks, HR, and trade unions. This enables robust multi-perspective discussions of concerns and complaints.

Speaking up culture

The trust offers several mechanisms for staff to raise concerns as mentioned above, including speaking directly to supervisors and line managers. Senior leaders are actively involved in promoting openness. The staff networks, discussed under the workforce equality, diversity and inclusion section of this report, also provide a safe space for staff to share their experiences and raise any concerns. However, our review has found that some staff do not always feel comfortable raising concerns, particularly outside of the formal FTSU process.

The 2024 NHS staff survey results show that 59.17% of staff at NWAS agreed with statement 'I feel safe to speak up about anything that concerns me in this organisation', which is above the national average of 53.56%. The full results for the four key speaking up statements are shown below:

Statement	2022	2023	2024
I would feel secure raising concerns about unsafe clinical practice	66.23%	67.15%	68.75%
I am confident my organisation would address my concerns	48.57%	52.16%	51.49%
I feel safe to speak up about anything that concerns me in this organisation	55.68%	56.69%	59.17%
If I spoke up about something that concerned me, I am confident my organisation would address my concern	40.48%	45.74%	44.65%

While the trust performs above the national average in all areas, there is still room for improvement – particularly in staff confidence that their concerns will be addressed, with fewer than half of

respondents expressing confidence in this area. Some interviews highlighted concerns among staff about the potential negative impact on their careers if they speak up. While this was not the majority view, it was mentioned more than once and warrants further attention. We recommend the trust looks into this in more depth, triangulating it with the staff survey data to better understand the barriers to speaking up, and strengthen the culture of openness.

Most concerns raised related to inappropriate attitudes and behaviours rather than clinical or operational issues, which is not unusual in the NHS. However, the trust's EDI annual report indicates a 40% increase in concerns relating to bullying and harassment, including sexual harassment. This notable rise warrants further investigation to identify any emerging themes or organisational hotspots. The trust should consider developing a targeted action plan to address these issues and strengthen protection for staff.

Recommendations

5. Establish formal links between the FTSU service and trade unions to support data triangulation, shared learning, and a more cohesive approach to staff voice and organisational improvement
6. Promote a culture where staff feel confident raising concerns openly through line managers and other channels, not solely via confidential FTSU routes.
7. Review staff culture, concerns and psychological safety, triangulating with staff survey data to identify barriers to speaking up
8. Continue efforts to improve staff confidence that concerns will be addressed

Workforce equality, diversity and inclusion

"We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us"

Workforce demographics

Our overall impression is that this is an area where there is a lot to do, but also that the leadership of the trust is genuinely committed to make improvements – and there are signs of progress. An organisation's approach to promoting equality, diversity and inclusion is a key part of its culture, and cultural change is a gradual process.

The trust's data for the Workforce Racial Equality Standard in 2023/24 showed that it is less ethnically diverse than the population it serves, with 6.1% identifying as from minority ethnic backgrounds (although this percentage had gradually increased over the previous five years) and these are concentrated in the lower Agenda for Change bands 1-7. It also showed that the relative likelihood of white applicants being appointed from shortlisting is 60% higher than for minority ethnic applicants. There was also a very large disparity in the likelihood of staff from minority ethnic backgrounds entering formal disciplinary proceedings compared to their white counterparts. In response to this statistic, the trust undertook to complete a review of disciplinary cases involving minority ethnic staff to better understand the data, and consider improvements to the application of disciplinary policy.

Ambulance services have traditionally been seen as having a male-dominated culture. Over recent years, the proportion of the workforce that is female has grown steadily and reached 53% in 2024, including most staff in the operations directorate and half of the staff in corporate services. Representation of women in higher-banded roles has grown, although they remain under-represented. The hourly average gender pay difference was 7.3% in favour of men, although this was at the lowest (best) level since it became mandatory to report gender pay gaps.

Planning for change

The trust has an annual plan for equality, diversity and inclusion based on three main objectives. These objectives, which were refreshed in 2024/25 and are in place until 2027, cover the following topics:

- improving the diversity of the workforce at all levels, through fair and inclusive recruitment and progression processes
- promoting a positive culture of psychological safety, by tackling bullying, harassment, and discrimination where they exist
- reducing health inequalities for patients.

The trust's work around recruitment and career progression is styled 'positive action'. This has been developed within the framework of the Equality Act and supports the trust in fulfilling its responsibilities under the Act. Positive action does not represent positive discrimination, and this has been made clear when publicising and explaining this workstream.

The development and implementation of the annual plan is overseen by a diversity and inclusion group. This is a bi-monthly meeting chaired by the director of people and deputy chief executive, and reports directly into the trust management committee. It brings together representatives from across the trust's directorates, and the network chairs.

Resources to support equality, diversity and inclusion

There are five such networks for staff with different characteristics (armed forces veterans, racial equality, women's, disability, and LGBT+). These groups each have a small budget and their chairs are given two days per month of protected time, which can be shared with other members of the network. Each network has an executive director as sponsor. The resourcing of these networks is an example of good practice. The networks are consulted about policy and strategy developments that are likely to impact on the people they represent. They also organise events for their members such as meetings with speakers and participate in external events such as Pride.

The trust has an EDI lead who is a senior manager within the human resources function, heading a team which has a wider remit encompassing culture and staff experience and welfare. The level of resource allocated to promoting equalities compares favourably with numerous other NHS organisations.

The strength of leaders' intention to promote equality, diversity and inclusion as part of a wider cultural change was made clear in individual interviews. The trust is working towards accreditation as an anti-racist organisation. There is a positive tone from the top and a determination to challenge behaviours that are inconsistent with these objectives. People coming into new managerial roles as part of recent organisational changes are expected to participate in 'cultural leadership events'. There are strong links to individual appraisals, career progression and recruitment.

We also heard about a wide range of worthwhile initiatives, which were mentioned to us by different people around the organisation. These include wellbeing hubs, mobile apps, cultural festivals and flexible working arrangements. The trust is making changes to ensure training is more accessible to neurodiverse staff. It has also developed a new policy on sexual safety at work. We also heard an example of good practice whereby a workshop was held with support from the trust's risk management function, to assess the risks around failing to support a diverse workforce and how these risks should be managed.

Recommendations

9. Identify any service areas or staff groups that have been less receptive to the equality, diversity and inclusion agenda and prioritise further work with them

Governance, management and sustainability

"We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate"

Board and committee business

As part of our fieldwork for this review, we observed two meetings of the board of directors, including one private session, and one meeting of each of the board's assurance committees. We formed a positive view of these meetings. Board members were well-prepared, and their questions were constructive, directed to seeking assurance, and were mostly succinct. Constructive challenge was received and responded to well by executives. A focus on the needs of patients was evident even when the subject matter was less clinical in nature. Some agendas – although not all – include time at the end to reflect on the business of the meeting.

Board and committee packs are busy and heavy, as is very common in NHS organisations, although not excessively so. Information is presented in a variety of formats, including dashboards with graphics, and not solely in narrative reports. We understand that training in report writing has been provided to authors of papers which go to the board or its committees. The integrated performance report is a useful tool to enable accountability. It follows standard practice in the NHS, following the 'Making Data Count' principles and using statistical process charts that helpfully distinguish changes in performance that are statistically significant from those which represent normal variation in process operations. It would benefit from including more explanatory narrative about the reasons for changes in performance and what corrective actions are being taken.

Managers below board level who have written papers for the board or committees are often able to present their own work and respond to questions from board members. This is positive because it gives these managers exposure to the work of the board, thus helping them to understand better the board's information needs and supporting their own professional development. It also allows the board to hear different perspectives rather than having all information filtered through executive directors. We did however observe some papers being presented at greater length than was necessary given that committee members would already have read them.

The board's agenda is broken down into sections for strategy, performance and quality, people (workforce) and resources. This helps to ensure a balance between looking forward at future plans and backwards at recent performance, and between looking inward at the organisation and outward at the work it is doing with partners. As well as its formal meetings, the board also holds seminars as part of its agreed development programme. These allow it to be briefed about topical issues affecting the NHS, to explore strategic issues in greater depth, and to strengthen the 'soft skills' of working together as a unitary board.

Committees have annual work plans setting out what reports they will receive during the year. They are developed in a systematic way through discussions involving the chair and lead executive for each committee. They are comprehensive, although we note that some committees, such as QPC, receive several annual reports at the same time, limiting the attention that can be given to each; it may be

helpful to spread these reports over several months. The committees review their own terms of reference annually and self-assess the extent to which they have fulfilled them. In the case of the audit committee, the annual assessment process is facilitated by the internal auditors.

The board's structure of subcommittees is conventional for an NHS trust although it does not have a workforce committee (or equivalent). Such committees are increasingly common in an NHS context. The trust did previously have a workforce committee, but this was disbanded some years ago and oversight of workforce issues transferred to another subcommittee of the board, namely the resources committee. NWAS has made clear its determination to promote cultural change, including a greater focus on diversity and inclusion. Based on the experience of other trusts, a workforce committee could be a powerful voice helping to drive this agenda forward.

Operational governance

Below the board, in 2023/24 the trust redesigned its system of operational governance, through which plans are developed, policies approved and performance managed. As GGI would recommend, this is separate from the board governance structure, reflecting the distinction between day-to-day management of the trust, and the board's responsibility for oversight and strategic direction. At the top of this structure sits the trust management committee (TMC), comprising the executive team, the area directors and selected senior people below board level such as the director of infection prevention and control and the chief consultant paramedic.

We observed the TMC as a group that is working as it should. Despite its full agenda, the discussions were robust and conversation was constructive and collegiate in tone. It provides a helpful forum where operational and corporate functions are brought together. Nine committees, styled as 'groups' to distinguish them from board assurance committees, report into the TMC. They report via 3A reports, the 3As being 'alert' (issues of concern that are being escalated to TMC for decision or action), 'assure' (positive assurances where standards and goals are being achieved) and 'advise' (new or future developments whose impact is uncertain).

The trust's corporate affairs function facilitated a post-implementation review six months after the new structure was implemented, and a further review after 12 months. This is good practice when changing the governance structure. Corporate affairs also co-ordinate these groups' annual self-assessments of effectiveness. Some changes have been made in the light of experience, for example by establishing the service delivery assurance group (SDAG). The meeting we observed had good engagement from all those attending and was a good opportunity for area directors and corporate leads (finance, quality risk, HR) to meet, receive assurance from groups reporting into SDAG, and focus on solutions to operational challenges.

We commented above that there is a risk that the command-and-control culture dominates in a range of ways, including a tendency to focus relatively more on process rather than on quality. Our observation of management meetings and review of the related papers indicate that this is an area worth exploring further. For example, the discussion on quality at the Trust Management Committee and Service Delivery Assurance Group meetings we observed tended to focus on the processes, such as addressing the backlog in patient safety activity, rather than learning and prevention, and the

narrative in the integrated performance report focuses on changes in numbers rather than the impact on patients.

Risk management and compliance systems

The trust's risk management process is robust, incorporating many elements of good practice. There is a risk management strategy, and all staff receive mandatory training in managing risk, which is tailored to their level of seniority. There is a central team for risk and incident management which can provide guidance and support to colleagues in applying the process, including through a risk helpline. The incident and risk database has been upgraded, improving useability for staff. The risk management process was audited by the trust's internal auditors, MIAA, and graded 'high assurance'. When we reviewed risk registers ourselves, we were pleased to note that risks were clearly articulated in terms of cause and effect, had been recently updated, and listed actions which were mostly SMART.

The board has collectively determined its risk appetite and periodically revisits this assessment. The appetite for risk is balanced and realistic – there is a low tolerance for risks to clinical quality, regulatory compliance and cyber-security, a moderate appetite for financial and workforce risks, and more appetite for risks associated with innovation. The board assurance framework, which covers the strategic risks facing the organisation, is a well-presented document that achieves the difficult balance between detail and digestibility.

The trust's annual submission for the Data Security Protection Toolkit recorded that it was fully achieving only two of the five objectives, meaning that it self-assessed the trust as not compliant. There is an action plan to close the gaps, which includes updating information asset registers, extending multi-factor authentication and testing business continuity plans. Internal audit has validated the trust's self-assessment.

In terms of managing incidents, the trust has put considerable effort into applying the national Patient Safety Incident Response Framework, which takes a more qualitative and less process-driven approach to learning from incidents. There has been good progress, including through work with lay people who support the trust as patient safety partners, and the patient safety priorities have been reviewed and updated to reflect the latest safety data. The quality and performance committee has received regular updates, including a post-implementation review.

The trust is strongly committed to quality improvement and has put resources behind QI work, which is described further in the 'learning, improvement and innovation' section of this report. It is rightly proud of its achievements. We did hear, however, that work on quality assurance and compliance had a lower profile. In particular, NWAS was last inspected by the Care Quality Commission more than five years ago, and an inspection could take place at any time. It is important that the trust should collate evidence to support the quality statements centrally and that the board and / or QPC should receive assurance about compliance with the CQC's fundamental standards. This appears to be a gap at present, which we understand is being addressed.

Recommendations

10. Consider how the board can best obtain assurance about workforce issues, whether through re-establishment of a workforce committee, or revisiting the terms of reference and work plan of the resources committee
11. Further refine the work plans of the board and committees to reduce the risk of overload at particular meetings or times of the year
12. Further refine the management information that is provided to the board and committees, with an emphasis on writing for assurance and reporting by exception
13. Review papers to ensure that outcomes and learning have equal priority with process and performance
14. Ensure that evidence of compliance with regulatory standards is collated centrally and reported to the board and / or the quality and performance committee

Partnership and communities

"We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement"

Health and social care partners

During our fieldwork, we met with a number of senior people from other health and social care organisations in the region and obtained their views about this trust. It was evident from these interviews that NWAS is well regarded and has long had positive, productive working relationships with its partners, under both the current and previous leadership. System partners see NWAS as a team player and spoke favourably about individual trust leaders, including the chief executive. They also highlighted tangible benefits in their localities that had accrued from joint working with the ambulance service. The trust is respected for its strong operational performance and financial management, although there was a sense that it could sometimes be taken for granted during difficult times when commissioners' attention is consumed by the red lights flashing on the dashboard.

The lead commissioner for the ambulance service in the North West region is Lancashire and South Cumbria (LSC) Integrated Care Board, although there are another two ICBs wholly within NWAS' catchment area and two more partly within it. The trust is active within the LSC system, particularly through the provider collaborative board, and joint working with the Greater Manchester system takes place through several different channels, both executive and operational. However, there may be scope to increase its presence and further develop working relationships in the Cheshire and Merseyside system.

As NWAS commences work on a new corporate strategy, we asked external partners what they were looking for in a new strategy. The most common answer was that it should take account of the emphasis on community-based, out-of-hospital care in the government's recently published 10-year plan for the NHS.

Patient and public involvement

Patient and public involvement is a challenge for ambulance services, which serve large and geographically dispersed populations for whom time being attended to by NWAS is just one part of their journey through the healthcare system. The trust has made a real effort to work with patients and the public and to gain richer, deeper feedback than surveys such as the Friends and Family Test can provide. It has a very active patient and public panel established in 2019 and now has over 300 members, including a healthy proportion of young people. Panel members participate in activities such as the weekly patient safety committee meeting, health inequalities workshop and consultations about redesigning services. There are different ways for members to get involved depending on their interests and how much time they have available. The trust aims to *'meet people on their terms'* by holding public engagement events in local communities across the region, as well as joining in well-attended events such as county fairs, Pride celebrations and university freshers' weeks.

Staff side

Employees are of course major stakeholders in any organisation, and in NHS trusts there are formal partnership arrangements with Staff Side, which brings together the various trade unions present among their workforces. The relationship between Staff Side and management at NWAS is clearly strained; at the time of our review local industrial action was underway involving a group of staff from the training department. Several senior leaders expressed a common view that the trade unions are outdated and inflexible in their approach; meanwhile, trade unions feel that they are not kept informed about plans and significant developments and that the formal consultation mechanisms are ineffective. They do, however, report having good working relationships with some individual managers. There is a perception on both sides that the relationship between management and Staff Side has deteriorated in recent years.

It was beyond the scope of our work to investigate how this situation has come about, but we are clear that management and Staff Side need to work together to build mutual trust in the interests of organisational effectiveness. We have been informed that proposals to improve communication and consultation mechanisms are to be discussed with unions at a forthcoming meeting of the Joint Partnership Committee.

Recommendations

15. Explore opportunities to build closer relationships at executive and operational level with integrated care boards other than the lead commissioner
16. Engage integrated care boards and provider trusts in its strategy development process
17. Progress the planned work to review mechanisms for consultation and partnerships with trade unions and seek to develop better working relationships

Learning, improvement and innovation

"We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research"

NWAS demonstrates a clear commitment to continuous improvement, with strong leadership support. The chief executive has identified improvement as one of his four strategic priorities, which is also a key area in the trust's 2022-2025 strategy as necessary to achieving the trust's strategic objectives. This focus was consistently highlighted during our review as an area of strength.

Improvement sits within the portfolio of the executive director of quality and improvement. The trust has recently appointed a head of improvement who is actively working with senior leaders to embed a culture of learning and improvement across the trust. The trust has established an improvement group to oversee change programmes and align improvement efforts across directorates, and a quality improvement network which meets monthly to showcase projects and share learning.

A learning organisation

NWAS's approach to learning is structured around three areas:

- when things go wrong
- when we find variation
- from feedback.

The trust has implemented several initiatives to support shared learning, including:

- learning loops (recently shortlisted for an HSJ award)
- 'must-do' conversations and bulletin boards to share key messages
- after action reviews following incidents
- regional clinical learning and improvement groups, quality business groups, and learning forums.

Staff in focus groups described regular team meetings to review risks, improved communication with patients and families, and active learning forums in contact centres. The 'Closing the Loop' initiative ensures patient safety learning reaches frontline staff through multiple channels, improving awareness and embedding learning into practice. To assess the effectiveness of learning loops, the trust asked staff whether they could recall recent topic. Feedback showed that staff awareness of the topics increased significantly from 4% at the start of 2024 to 50% by the end of the year. However, as noted elsewhere, communication remains a challenge due to the mobile nature of the workforce, particularly among paramedics and Patient Transport Service staff, which can impact the dissemination of learning.

Complaints and patient safety

Complaints in the trust are managed by the Patient Advice and Liaison Service (PALS) and resolution team and are reviewed quarterly by the quality performance committee. In 2024/25, most complaints related to care and treatment, and delayed attendances. The trust's complaints handling process involves triaging each complaint, with response timescales determined by the level of complexity of the complaint. The trust has been successful in resolving complaints within six months of being raised, which is compliant with NHS complaint legislation. Additionally, 86% of complaints were closed within local complaint handling timescales.

Learning from complaints is shared through a multi-disciplinary complaint review group. The resolution team works closely with sector clinical leads to ensure learning is identified and disseminated effectively.

The trust has fully implemented the patient safety incident response framework (PSIRF), with 18 patient safety incident investigations (PSIIs) commissioned in 2024/25. In engaging with patients and public under PSIRF, the trust developed the role of patient safety partners, lay people with experiences of using health services. The trust has also recently completed a 12-month post-implementation review. Improvements made following this review include:

- earlier multidisciplinary case conferences within seven days of the PSII commission
- improvements to call handling and dispatch, mental health and medicines management are some of the improvements that have been made as a result
- enhanced patient and family engagement in investigations.

In response to this review, the trust has made amendments to the PSIRF plan to progress in its trajectory of improvement and learning. The patient safety specialist also works closely with the head of improvement to support learning dissemination through learning loops and frontline communications.

Feedback and engagement

NWAS gathers regular feedback from staff, patients and the public through surveys, the Friends and Family Test, and the patient engagement and experience team. Feedback is reviewed annually by service teams and the patient public panel (see further comments regarding the panel in the 'partnership and communities' section of this report), with reports presented to the quality and performance committee. Patient stories are also shared at board and committee meetings. Overall, feedback from patients and the public is highly positive, with 92.8% of survey respondents reporting they were treated with dignity, compassion and respect.

Overall, the trust has many initiatives in place, however, there remains a question around whether NWAS has fully embedded a culture of learning and improvement. As Peter Senge describes, a learning organisation is one where "*people continually expand their capacity to create the results they truly desire… and where people are continually learning to see the whole together.*" NWAS is clearly on this journey, but there is recognition that further progress is needed.

Improvement and innovation

The trust is currently developing an improvement plan aligned with its strategic priorities. Staff and executive input have shaped this process, and continuous quality improvement is reflected in the 2024/25 quality account, which includes:

- use of the NHS IMPACT baseline self-assessment across the trust
- local quality improvement plans across teams
- launch of the NWAS improvement academy
- rolling out digital innovations via the smart stations scale up
- a full review of integrated performance reporting.

The quality strategy 2023–26 outlines NWAS's improvement approach, drawing on the IHI Model for Improvement, supported by 'Plan Do Study Act' cycles, systems thinking, and the NHS IMPACT framework. Staff are actively involved in improvement work through the improvement academy, coaching programmes, and the monthly improvement network. The improvement academy, launched in 2024, provides nine months of training for teams working on real-time projects aligned with strategic priorities. Projects include:

- reducing ED conveyance
- improving hand hygiene
- enhancing payroll accuracy
- reducing staff assaults
- improving advanced care planning.

Staff are supported in improvement and development through 'Kickstart' coaching, leading improvement courses, ESR-based QI e-learning, and monthly improvement network meetings. The quality and safety committee also received reports on improvement, allowing the senior leadership to monitor key performance indicators (KPIs) for example, the percentage of staff participating in training. Eight members of the patient public panel are set to join the next academy cohort, reflecting strong patient involvement. NWAS also collaborates with other providers, inviting external partners to take part in its improvement programmes.

Research and development

NWAS is engaged in research and development via partnerships with various organisations. The trust's research and development (R&D) team works collaboratively with the national institute for health and care research (NIHR), health and care providers and higher education institutions such as the University of Liverpool. The trust also creates opportunities for patients, staff and the public to take part in the NIHR research delivery network (RDN), which saw a 53% recruitment increase between 2020/21 and 2024/25.

Research and development is overseen by the executive medical director and reports to the quality and performance committee annually. The trust currently has nine research paramedics and a senior research fellow, working with the organisation in contribution to the trust's research and development objectives. Research and development is typically less established within ambulance services, making NWAS's progress in this area particularly noteworthy and commendable.

Staff reported that they are offered opportunities to further their education and progress in their career – for example, several members of staff have been supported by the trust in obtaining their master's degree. However, as with all NHS organisations, staff are under significant operational demands, which can make it difficult to free up time for staff to attend training and development opportunities, as we heard anecdotally in focus groups with staff.

Recommendations

18. Strengthen the reach of learning loops and other learning mechanisms, particularly for mobile staff
19. Consider protected time for staff training and development, which should be supported through line managers and prioritised in appraisals
20. Keep an eye on outcomes and processes, and consider ways to embed a culture of learning and improvement in the trust

Environmental sustainability

"We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same"

Ambulance services play a critical role in the NHS sustainability agenda, particularly due to their reliance on a large, mobile fleet of emergency vehicles. NWAS has made commendable progress towards its net-zero goals, with a clear focus on maintaining service quality while reducing environmental impact.

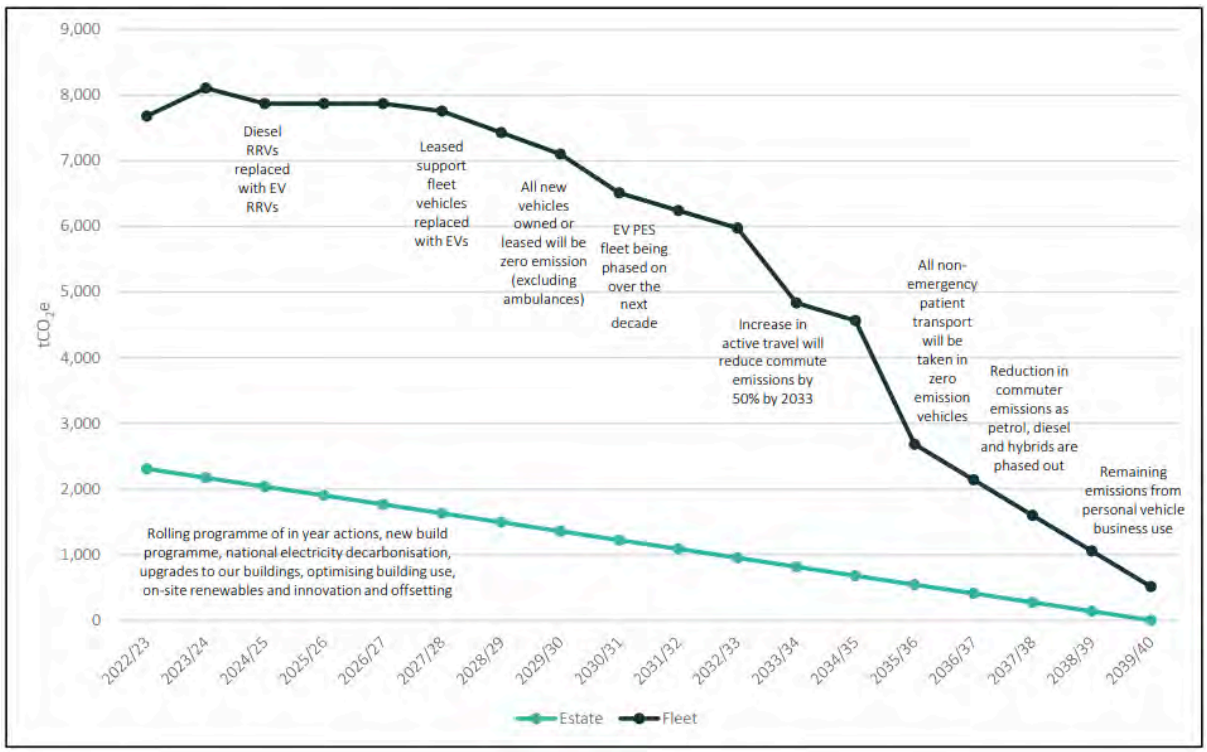
Key initiatives include the ongoing transition to electric and hybrid fleet vehicles, the installation of low-energy lighting across trust sites, and the development of a solar farm on the roof of Estuary Point. Campaigns such as 'No Idling' and efforts to deliver care while minimising unnecessary patient transport are helping to reduce day-to-day fleet emissions. Notably, the trust has achieved a 63.4% reduction in carbon emissions from electricity and gas between 2013/14 and 2023/24. Since 2015 NWAS has sent no waste to landfill and currently recycles 35% of its waste.

Sustainability is overseen by the director of finance and is managed by the estates energy and sustainability manager. The trust has a sustainability steering group, chaired by the director of finance, which meets quarterly and includes representation from fleet, operations, and occasionally public health and ICB representatives. Sustainability updates are presented biannually to the resources committee and to the board via the annual report. The trust benefits from a dedicated sustainability budget and has successfully secured external funding, such as grants for solar energy installation at the trust's sites. There is strong executive-level commitment to sustainability, and the estates energy and sustainability manager is well supported in delivering this agenda.

NWAS also collaborates with other ambulance trusts, through the Green Ambulance network, which meets monthly or quarterly. The trust also engages in joint sustainability initiatives with police and fire rescue services and contributes to ICB-level discussions.

Green plan

The trust has recently published its refreshed green plan for 2025-2028 which has been developed over the past two years. The plan outlines NWAS's ambition to be the best ambulance service in the UK and demonstrates how sustainability is integral to achieving this goal. It includes clear communication strategies for staff and external stakeholders and features a visual roadmap to net-zero by 2039/40:



The plan sets out measurable annual targets across key areas including gas and water usage, recycling, procurement, and transport emissions. It aligns with the latest NHS Green Plan Guidance and the NHS Futures Carbon Footprint tool. Governance arrangements are clearly defined with regular reporting to assurance groups and supporting documentation such as policies and procedures.

Importantly, the action plan includes a section titled 'Our People' which outlines how the trust intends to engage staff, patients, and the public in its sustainability efforts. It concludes with a risk assessment related to the delivery of the green plan. Overall, this is a comprehensive and well-structured document, and the trust is to be commended for its thoughtful and ambitious approach.

Staff awareness and engagement

Staff and public awareness of sustainability initiatives is one of the key areas of focus for the green plan. The trust communicates its efforts through sustainability training, awareness sessions, regular staff bulletins and a dedicated green room on the intranet. In focus groups staff shared numerous examples of sustainability initiatives in the trust including those mentioned above, reflecting strong engagement.

However, some concerns were raised about the condition of the trust's estate infrastructure, particularly regarding the suitability of certain sites for installing electric vehicle chargers. As noted elsewhere, communication with staff is inherently challenging for ambulance trusts due to wide geographical spread and the mobile nature of the workforce. This presents barriers to engaging frontline staff in sustainability initiatives.

The trust is in the process of establishing green champions which should help staff with communicating the green message across the trust and would enable a bottom-up approach to sustainability, empowering staff to lead and innovate in sustainability efforts.

21. Develop a plan for communicating the refreshed green plan to staff, taking into consideration the best approach for reaching mobile staff
22. Build on the establishment of green champions and the communication of the green plan, to encourage a bottom-up approach to sustainability, encouraging staff to take the initiative

Appendix

Internal Interviewees

Name	Role
Dan Ainsworth	Director of Operations
Catherine Butterworth	Non-Executive Director
Jon Byrne	Lead for Environmental Sustainability
Professor Alison Chambers	Vice-Chair and Senior Independent Director
Salman Desai	Chief Executive
Dr Aneez Esmail	Non-Executive Director and Chair of the Quality and Performance Committee
Dr Chris Grant	Medical Director
Dr David Hanley	Non-Executive Director and Chair of the Resources Committee
Chedia Hoolickin	Head of Improvement
Roger Jones	Freedom to Speak Up Guardian
Carly Manning	Head of Patient Safety
Julia Mulligan	Incoming Chair
Usman Nawaz	Head of Culture and Staff Experience
Emma Orton	Assistant Director of Quality and Nursing
Dr Elaine Strachan-Hall	Interim Director of Quality, Innovation and Improvement
Jonathan Taylor	Head of Integrated Governance, Risk and Assurance
Julie Treherne	Head of Patient Experience and Engagement
Lisa Ward	Director of People and Deputy Chief Executive
Angela Wetton	Director of Corporate Affairs
David Whatley	Non-Executive Director and Chair of the Audit Committee
Peter White	Outgoing Chair
Carolyn Wood	Director of Finance

External Interviewees

Name	Role
Gary Baines	Regional Assurance Director, MIAA
Aaron Cummins	Chief Executive, University Hospitals of Morecambe Bay NHS Foundation Trust and Lead CEO of the LSC Provider Collaborative
Raj Jain	Chair, Cheshire and Merseyside Integrated Care Board
Colin Scales	Deputy Chief Executive, Greater Manchester Integrated Care Board
Sam Proffitt	Acting Chief Executive, Lancashire and South Cumbria Integrated Care Board
Emma Woollett	Chair, Lancashire and South Cumbria Integrated Care Board

Focus Groups

Staff group	Date
Service Delivery staff	29 July 2025
Corporate Services staff	1 August 2025
Staff Side representatives	5 August 2025
Staff Network Chairs	6 August 2025

Meeting observations

Meeting	Date
Quality and Performance Committee	30 June 2025
Clinical Quality Group	1 July 2025
Audit Committee	18 July 2025
Trust Management Committee	23 July 2025
Resources Committee	24 July 2025
Board of Directors	28 May 2025 and 30 July 2025
Service Delivery Assurance Group	26 August 2025

Documents reviewed (not an exhaustive list)

Annual Reports

- Annual reports and accounts
- Internal audit reports

Governance Structures

- Board and committee terms of reference
- Board meetings packs, including agendas, papers and minutes from previous three meetings
- Committee meeting packs, including agendas, papers and minutes.
- Cycle of business/workplans for the board and board committees

Management Structures

- Scheme of delegation
- Board development plan
- Corporate meeting structure and organograms for the trust

Risk Management

- Risk management policy
- Risk register

Strategies and Plans

- Strategy and supporting strategies
- Trust's green plan
- Equality, diversity and inclusion plan


Strategy
Leadership
Governance

WELL-LED KLOE	RECOMMENDATION	EXEC LEAD	RESPONSE	SPECIFIC ACTIONS	BY WHEN
Shared direction and culture	1. As the strategy is refreshed, ensure there are robust communication, and engagement plans in place to make the most of a new opportunity to build a consistent culture across the trust	**Director of Strategy & Partnerships**	Accepted Already a comms plan in place, we will strengthen it based on feedback. Use of strategy tour bus visiting sites as previous. Also 'convo cafe' approach to help with the comms (and visibility) of the refreshed strategy.	• A twenty-eight-point plan has been put together by the Comms and Engagement team which will be used to ensure this action is met	Action Plan finalised 30/11/2025 Delivery 2026 - onwards
Capable, compassionate and inclusive leadership	2. Agree the expectations of board members – in particular NEDs – spending time visiting different parts of the service and across the geography of the trust	**CEO** **Chair**	Accepted The Execs have agreed and committed to a plan at their away-day 3 October. Expectation agreement and plan needed from Chair and NEDs		Complete
	3. With the appointment of a new chair, now is an ideal time to implement the planned strategy development sessions as part of the board	**Director of Corporate Affairs**	Accepted These are now scheduled into October, December and February Board Development days.	• Evidence: Board Development Programme 25/26	Complete

	development programme				
	4. Review the range of ways in which the board communicates with staff, to establish whether there are further options that could be explored	**Director of Strategy & Partnerships**	**Accepted** This is underway and will form part of the annual comms workplan which will then become business as usual	• Fourteen point plan of how this will be achieved with a RAG rating speed of delivery	31/12/2025
Freedom to speak up	5. Establish formal links between the FTSU service and trade unions to support data triangulation, shared learning, and a more cohesive approach to staff voice and organisational improvement	**Medical Director**	**Accepted** Bi-annual meeting with TU colleagues in place to continue the work towards shared learning and cohesion. FTSU Policy and the workplans have been updated to include / highlight this work.	• The updated FTSU Policy will be presented at the Board 26/11/25	Complete
	6. Promote a culture where staff feel confident raising concerns openly through line managers and other channels, not solely via confidential FTSU routes.			• Other channels mentioned within updated FTSU Policy for approval at Board 26/11/25	26/11/2025
	7. Review staff culture, concerns and				31/07/2026

	psychological safety, triangulating with staff survey data to identify barriers to speaking up			• Develop cultural dashboard for annual triangulation of information. This will be used to inform the work of the People and Culture Group	
	8. Continue efforts to improve staff confidence that concerns will be addressed				
Workforce equality, diversity and inclusion	9. Identify any service areas or staff groups that have been less receptive to the equality, diversity and inclusion agenda and prioritise further work with them	**Director People/Deputy CEO**	**Partially Accepted** There is further work to be undertaken to ensure that EDI is seen as part of BAU by management teams. This is ongoing work supported this year by the Culture Events, local people plans, service line recruitment objectives and individual culture objectives with a focus as we move forward on continuing education, evidencing action and holding to account.	• Approach networks to identify if any areas or staff groups have been less receptive. • Seek an assurance report at the end of the financial year from Operations on contribution to EDI priorities. • Build EDI metrics into the cultural dashboard to identify where less receptive groups might exist	31/03/2026 31/05/2026 31/05/2026
Governance, management and sustainability	10. Consider how the board can best obtain assurance about workforce issues, whether through re-establishment of a	**Director People/Deputy CEO & Director of Corporate Affairs**	**Under Consideration** The Trust's assurance purview does not identify any gaps in assurance on workforce issues that are currently overseen by the Resources Committee and reported up to Board via that	• Map current governance arrangements and present to Resources Committee	31/12/2025 31/12/2025

	workforce committee, or revisiting the terms of reference and work plan of the resources committee		route and in some cases also reported directly at Board too. The IPR seen at Board covers all key workforce metrics aligned to the NHS Single Oversight Framework along with some further metrics such as case management as recommended by the Baroness Harding review. This work will be encompassed into the annual committee effectiveness reviews during the latter part of the year.	• Undertake a best practice review of other trust arrangements • Review governance arrangements and best practice review with consideration of annual committee effectiveness review	20/04/2026
	11. Further refine the work plans of the board and committees to reduce the risk of overload at particular meetings or times of the year	**Director of Corporate Affairs**	**Accepted** This is a standard exercise at the end of every year when committee effectiveness reviews are carried out	• The effectiveness questionnaires and review of committee workplans will take place throughout February 2026. • The output reports and any improvement actions will be presented to the committees during March 2026.	31/03/2026
	12. Further refine the management information that is provided to the board and committees, with an emphasis on writing for assurance	**All Execs**	**Accepted** All execs have a responsibility to ensure the papers they sign-off before submission to meeting address the recommendations. This will continue to be an area of focus.	• Annual review of committee performance to include specific reference to the quality of the papers with regard to management information and assurance	31/05/2026

	and reporting by exception		The Head of Integrated GRA will be recrafting the sessions we deliver to senior leaders across the Trust on how to write a good assurance paper, to focus on these recommendations.		
	13. Review papers to ensure that outcomes and learning have equal priority with process and performance			• Review of committee performance to include specific reference to the respective priority of outcomes and learning	
	14. Ensure that evidence of compliance with regulatory standards is collated centrally and reported to the board and / or the quality and performance committee	**Director of Quality**	**Accepted** This central collation is already in place and will be factored into the Q&P business cycle.	Continue collation and review of evidence and report evidence review and self- assessment to Q&P.	30/04/2026
Partnership and communities	15. Explore opportunities to build closer relationships at executive and operational level with integrated care boards other than the lead commissioner	**Director of Strategy & Partnerships**	**Accepted** Further work to be done to scope this.	• Use insights from the Sept 2025 External Engagement Survey for improvements. • Reinforce messages with managers to ensure consistency in external mtgs.	30/11/2025

				• Define and regularly review area engagement plans with ADs Directors. • Assign a dedicated lead for all key strategic meetings within ICB/Place/NbH, with oversight from AD / PIM. • Strengthen evidence and assurance of external engagement through the Knowledge Vault. • Explore formal membership opportunities with provider collaboratives.	
	16. Engage integrated care boards and provider trusts in its strategy development process		**Accepted** This is already planned in and happening	• Survey ICB colleagues to understand input and engagement in strategy and NHS planning. • Use stakeholder analysis to map influence vs interest and design targeted engagement activities for the comms plan. • Align ICB plans with our strategy to identify shared priorities. • Cross-check plans against national direction (e.g., 10-year plan, etc).	31/03/2026

				• Review stakeholder survey to identify individuals for targeted engagement. • Work with Digital team to explore engagement opportunities with digital partners, e.g. record sharing.	
	17. Progress the planned work to review mechanisms for consultation and partnerships with trade unions and seek to develop better working relationships	**Director People/Deputy CEO**	**Accepted** This work continues to progress with the principles accepted at the Joint Partnership meeting in September 2025.	• Approval of partnership principles and revised Recognition Agreement • Joint communications activity to embed expected ways of working • Evaluation at end of Q2	Complete 31/03/2026 30/09/2026
Learning, improvement and innovation	18. Strengthen the reach of learning loops and other learning mechanisms, particularly for mobile staff	**Director of Quality**	**Accepted** NWAS' learning framework currently under review.	• All learning activity mapped and presented to Clinical and Quality committee for consideration. • Mechanisms for communicating with mobile staff documented and reviewed for effectiveness	31/03/2026 30/06/2026
	19. Consider protected time for staff training and development, which	**Director of People/Deputy CEO / Director of Operations**	**Not Accepted** The Trust already has the following in place:		

	should be supported through line managers and prioritised in appraisals		• mandatory training which is focused not only on statutory subjects but also risk based clinical refreshers • release for a whole range of qualifications for example masters/enhanced practice for APPs • support for range of development interventions SP away days; developing leaders programme etc. To provide protected time for all staff or even just registered staff would come at a significant financial cost and would add to cost pressures. It might be an aspiration but not something we can probably afford to deliver at this point. Costs for one day release runs into million.		
	20. Keep an eye on outcomes and processes, and consider ways to embed a culture of learning and improvement in the trust	**Director of Quality**	Accepted Improvement work already happens with the dosing strategy and academy. Improvement will be woven into the strategic plans for 26/27. Further work to be done alongside the review of the learning framework,	• Refreshed Trust Strategy include reference to improvement aims and methodologies • Strategic enabling plan for improvement produced as part of suite of strategic plans.	31/03/2026 30/04/2026 30/04/2026

				• Current learning framework reviewed	
Environmental sustainability	21. Develop a plan for communicating the refreshed green plan to staff, taking into consideration the best approach for reaching mobile staff	**Director of Finance**	**Accepted** This is already built into the work of the exec-led Sustainability Group where there is representation from all directorates, including comms. There are monthly initiatives, but take-up can be limited. The members should feed back to their respective directorates and feed into the group local initiatives.	• Comms plan to be developed and shared with sustainability group	31/03/2026 31/03/2026
	22. Build on the establishment of green champions and the communication of the green plan, to encourage a bottom-up approach to sustainability, encouraging staff to take the initiative			• Specific ask to the green champions with initiatives brought back and shared with the green champions network and sustainability group	

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ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Friday, 24 October 2025		
Members present	Prof A Esmail, Non-Executive Director Dr A Chambers, Non-Executive Director	**Quorate**	No

Key escalation and discussion points from the meeting

ALERT:

- No items

ADVISE:

- A report was received from external audit regarding the 24/25 audit and planning for the 25/26 audit.
- Losses and Compensation for Q2 2025/26 totalled £126k.

ASSURE:

- Management representatives reported on the steps taken to implement recommendations from the E-Timesheets review conducted by MIAA.
- Internal Audit reported three reviews were completed during Q2 2025/26.
  - Absence Management – Substantial Assurance
  - Conflicts of Interest – Substantial Assurance
  - Data Security & Protection Toolkit – High Risk
- The Anti-Fraud Progress report detailed activities undertaken against the agreed anti-fraud work plan and an update on the actions related to the Failure to Prevent Fraud Offence.
- The Q2 Position of the Board Assurance Framework 2025/26 was reviewed, prior to approval by the Board of Directors on 26th November 2025. Committee members considered the report within the context of their role as Audit Committee.
- The bi-annual assessment of compliance with the NHS Provider Licence confirmed the Trust's compliance with all applicable licence conditions.
- The Trust's response to the latest MIAA checklist in relation to AI Governance was presented for assurance.
- Six waivers were approved during Q2 2025/26.
- 3A reports from the following Committee meetings were presented for assurance:
  - Quality and Performance Committee - 30th June 2025 and 1st September 2025
  - Resources Committee - 24th July 2025 and 18th September 2025

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee			
Date of meeting	Wednesday, 22 October 2025		
Members present	Mr S Desai, Chief Executive (Chair) Mrs L Ward, Director of People Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs Dr C Grant, Medical Director Mr M Gibbs, Director of Strategy & Partnerships Mr M Cooper, Area Director – Cumbria and Lancashire Mr I Moses, Area Director – Cheshire and Merseyside Ms S Rose, Director of Integrated Contact Centres Mrs E Orton, Assistant Director of Nursing & Quality Mrs J Wharton, Chief Information Officer In attendance Ms J Turk, Executive Business Support Manager	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Policy Management Framework Update** - further assurance sought for policies with lengthy extensions.
- **The AI Policy** - was discussed but not approved, TMC noted that this was a fast-evolving area with increased activity and interest. It was agreed that clear guidance and strategic direction would be beneficial to support safe and ethical implementation.
- **Handover times** - Significant improvements have been seen since the introduction of the 45 minutes handover time. Comparing September 24 to September 25 data.
- **Learning Disability & Autism mandatory training** - Significant training and financial pressures were envisaged in relation to the statutory requirement to roll out tier 2 training to frontline staff. Further work to plan how best to roll out the training was underway.

ADVISE:

The TMC:

- Approved the FTSU Policy.
- Approved the AI Policy.
- Approved the Security Policy and Acceptable Use Standard Policy.
- Approved the Professional Boundaries Policy Update.
- Noted the policies due for renewal within 3-6 months.
- Approved the proposed closure of SR11 on the Board Assurance Framework (BAF).
- Agreed and recommended the BAF Q2 position to the Board of Directors.
- Provided evidence for inclusion in the 10 Year Workforce Plan call for evidence which would be submitted by 31 October 2025.

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - The 2025/26 reported financial position to 30 September 2025
  - Policy Management Framework update
  - North West Air Ambulance Bi- Annual Assurance Report
  - Progress against the Fuller Inquiry recommendations
  - UEC Growth Funding update
  - HR Casework update – Quarter 2
  - Recognition Agreement

- Received the following Escalation & Assurance reports:
  - HSSF Group – 9 September
  - Diversity & Inclusion Group – 12 September
  - Information & Cyber Group – 7 October

RISKS

Risks discussed:

- The 12 corporate risks on the corporate risk register were reviewed.
- Approved the escalation of risk ID755 to the corporate risk register.
- Noted the closure of risk ID655.
- The 8 commercially sensitive risks were reviewed and agreed.

New risks identified:

- None.

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 19 November 2025		
Members present	Mr S Desai, Chief Executive (Chair) Mrs L Ward, Director of People Mrs C Wood, Director of Finance Mrs A Wetton, Director of Corporate Affairs Dr C Grant, Medical Director Mr D Ainsworth, Director of Operations Mr M Gibbs, Director of Strategy & Partnerships Dr E Strachan-Hall, Director of Quality & Improvement Mr M Cooper, Area Director – Cumbria and Lancashire Mr I Moses, Area Director – Cheshire and Merseyside Ms S Wimbury, Area Director – Greater Manchester Ms S Rose, Director of Integrated Contact Centres Mrs E Orton, Assistant Director of Nursing & Quality Mrs J Wharton, Chief Information Officer Mr M Jackson, Chief Consultant Paramedic In attendance Mrs J Turk, Executive Business Support Manager	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Learning Disability & Autism mandatory training** – The training would be incorporated into the PES and PTS mandatory training classroom days for 26/27. Further work would be undertaken to confirm if the proposed training model for ICC staff is the most feasible.
- **Mandatory training** – It was recognised that there would be limited capacity in the 26/27 mandatory training programme for additional training topic requests unless they could be incorporated into scenario training. This is due to the core training requirements and additional requests already incorporated.

ADVISE:

- A new process for the Quality Assurance Visits was being developed, which was largely an accreditation-led model.

The TMC:

- Approved the Capital Programme update recommendations.
- Approved the Financial Planning report recommendations for 2026/27.
- Approved the potential investment for the expansion of CoPilot Premium pilot over a 12 month period based on the submission of successful bids.
- Reviewed the 11 risks identified on the Corporate Risk Register and confirmed the 8 sensitive risks as correctly tagged as commercially sensitive.
- Noted the Corporate Calendar for 2026/27 for approval by the Board of Directors.
- Approved the Duty of Candour Policy and supporting Procedures.
- Supported the extension of the Pay Protection Policy until September 2026.
- Approved the incorporation of Learning Disability & Autism learning programme into PES and PTS mandatory training classroom days.

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - Finance report – month 07 - Metrics post de-escalation from IAG process – to date the Trust remains within the threshold for all four metrics.
  - Policy Management Framework update
  - Q2 Annual Plan update
  - Water Street Incident debrief

- Received the following Escalation & Assurance reports:
  - EPRR Group – 13 October
  - SDAG – 28 October
  - Clinical and Quality Group – 4 November
  - Planning Group – 5 November
  - People and Culture Group – 12 November

RISKS

Risks discussed:

- The 11 corporate risks on the corporate risk register (CRR) were reviewed.
- Approved the escalation of risk ID680 to the CRR.
- Approved the de-escalation in score of risk IDs 434 and 580 with removal from the CRR.
- The 8 commercially sensitive risks were reviewed and agreed.

New risks identified:

- None.

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ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Thursday, 20 November 2025		
Members present	Dr D Hanley, Non-Executive Director, Chair Ms C Butterworth, Non-Executive Director Mrs L Ward, Director of People Mrs C Wood, Director of Finance Mr D Ainsworth, Director of Operations 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 07 2025/26

- Received assurance in relation to the financial performance indicators.

Capital Programme Update

- Received assurance on capital spend to date and approved the proposed capital programme updates including recommendations of rephasing of expenditure into next financial year and bringing forward capital expenditure for the board approved vehicle and defibrillator replacement programmes.

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

- Financial Planning report approved but accepted that the position was moving at pace as national guidance was being received. Board to receive updated briefing in November.
- Preston Phase 3 outline business case (OBC)

National Assessment of Job Evaluation and practices

- The Committee noted the assurance on Trust plans to meet the requirements of the national job evaluation review and supported the work to ensure compliance with the NHS Job Evaluation Scheme. The Committee agreed to take a bi-annual report to monitor progress of this programme.

EDI Follow Up Report

- The Committee received the report and noted the outcomes for BME candidates remain inequitable. The Committee supported the workplan.

ASSURE:

Received the following reports for assurance:

- Board Assurance Framework
- Efficiency and Productivity Update

- Estates, Fleet and Facilities Management Assurance Report
- Annual Plan Q2 Assurance
- Digital Plan Update
- Workforce Indicators Report
- Bi-Annual Report on Staff Incidents Resulting in Harm

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	Integrated Performance Report
PRESENTED BY	Elaine Strachan-Hall, Director of Quality
PURPOSE	Assurance

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

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	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 **October 2025**. Further narrative is embedded within the accompanying data pack. Data is presented over time using statistical process control charts (SPCs), aligned to NHS England's Making Data Count, 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:** Metrics are stable. **Incidents:** Reported Level 1-3 incidents are showing improvement (fewer incidents). Improved ARP and handover in the same period is a likely causal factor.

Safety Alerts: One new safety alert (DMRC – 37371169) has been received regarding incorrect labelling of medicine, although it does not pose a risk to patients. Sector Clinical Leads are carrying out an audit.

Effectiveness

- The Trust is performing above the sector average for all Ambulance Care Quality Indicators (ACQI's).
- The H&T rate is 18.6% and has displayed special cause throughout the month, linked to an increase in telephone triage.
- The decrease in S&T, also displaying special cause at 25%, is likely causally linked to the increase in H&T as both outcomes originate from a similar patient cohort.
- Nationally, the trust ranked 5th for H&T, 10th for S&T and 8th for S&C.

Operational Performance

PES (999)

Nationally the trust maintains a strong position for ARP.

Measure	ARP Standard (hh:mm:ss)	October 25 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:07:04	3rd
C1 90th	00:15:00	00:12:03	2nd
C2 mean*	00:18:00	00:27:36	2nd
C2 90th	00:40:00	00:54:47	2nd
C3 mean	01:00:00	01:42:01	5th
C3 90th	02:00:00	03:36:52	3rd
C4 90th	03:00:00	04:43:06	2nd

*UEC C2 Standard = 28mins (achieved)

- Call pick up was stable despite increased demand in the latter weeks of October.
- Hospital turnaround continues to exceed the 30-minute standard at 35m:49s. Cheshire and Merseyside ICB had the top 3 hospitals for Lost Unit Hours for delayed handovers in October.

111

- Increased demand, higher than usual staff sickness and cross-skill ICC training activity has led to calls answered within 60 seconds (%) decreasing from 80% to 57% between September and October.
- None of the national standards were met.

111 Measure	Standard	October 25	National Ranking
Answered within 60s	95.0%	57.4%	28th/28
Average time to answer	<20s	114s	26th/28
Abandoned calls	<5%	6.7%	27th/28

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 October 2025 (Month 07 2025/26) is a surplus of £2.232m, compared to a planned surplus of £0.311m. This is due to vacancies in various Directorates, non-recurrent credits received and the delivery of productivity and efficiency savings above plan.

Organisational Health

- Data is now presented at a combined level to align to the Integrated Contact Centre (ICC) model of delivery which incorporates EOC, 111 and PTS call handling.
- Overall sickness absence is at 6.28%, consistent with the same period last year.
- Turnover continues to improve across all service lines.
- The overall vacancy gap has reduced to -2.83% in Oct 25. This is due to a combination of an overall reduction in establishment WTE in line with the ICC new structure and additional new starter WTE.
- Overall appraisal compliance is 87.18%, above the target of 85%.
- The overall mandatory training compliance is at 90%.
- Three staff were dismissed during October: two long term sickness and one conduct case.

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.

PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	Wednesday, 19 November 2025

	Outcome	

North West Ambulance Service NHS Trust

Integrated Performance Report

Board of Directors - November 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.

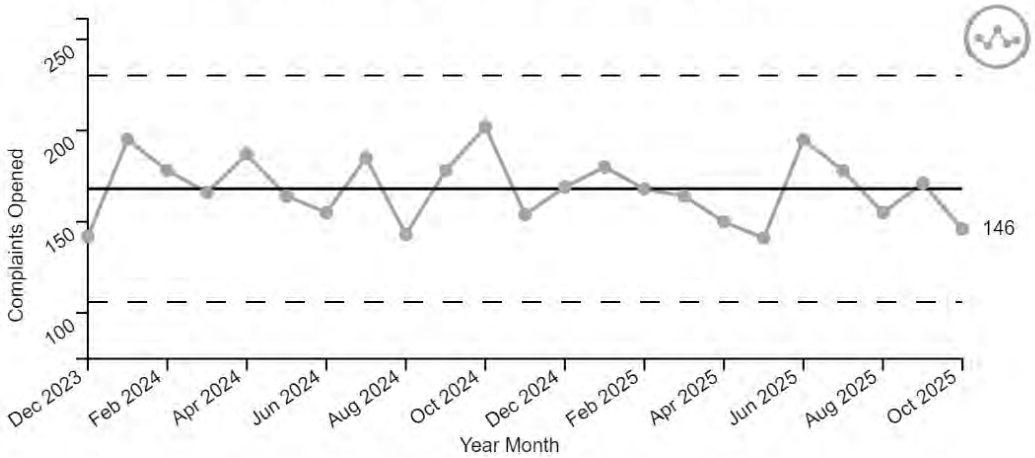
N.B. purple indicates non performance related indicator with arrow indicating direction of travel 

Quality & Effectiveness

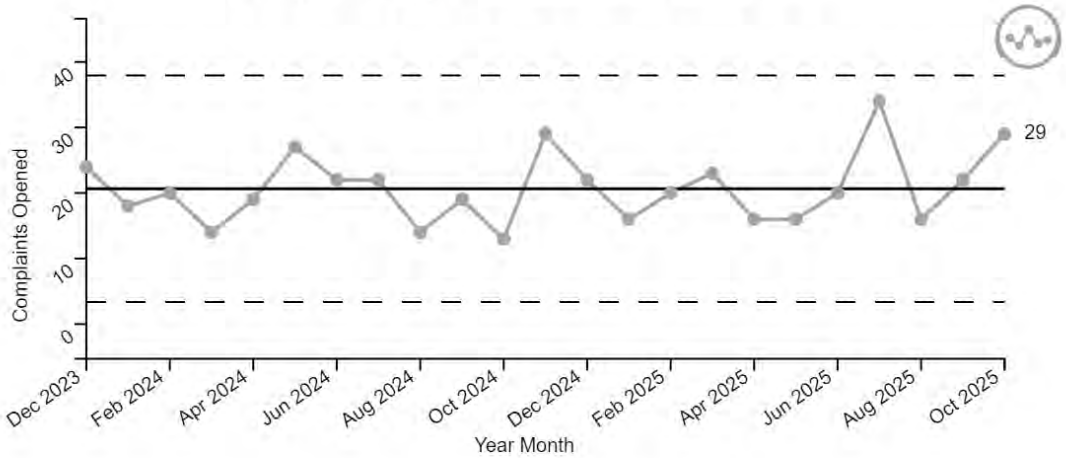
Q1 Complaints
Q2 Incidents
Q3 Safety Alerts
E1 Patient Experience
E2 Ambulance Clinical Quality Indicators (ACQI)
E3 Activities and Outcomes

Q1 Complaints

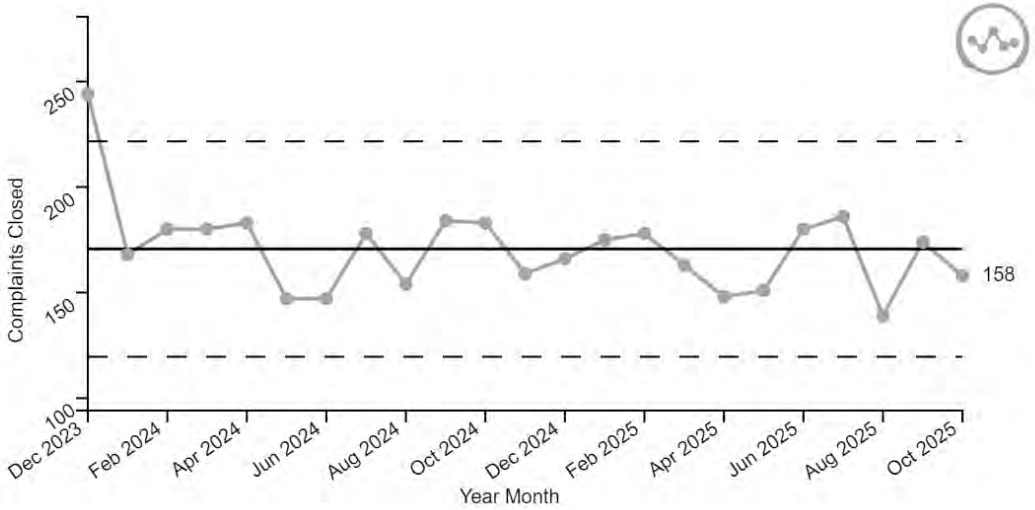
Complaints Opened with Risk Score 1-2



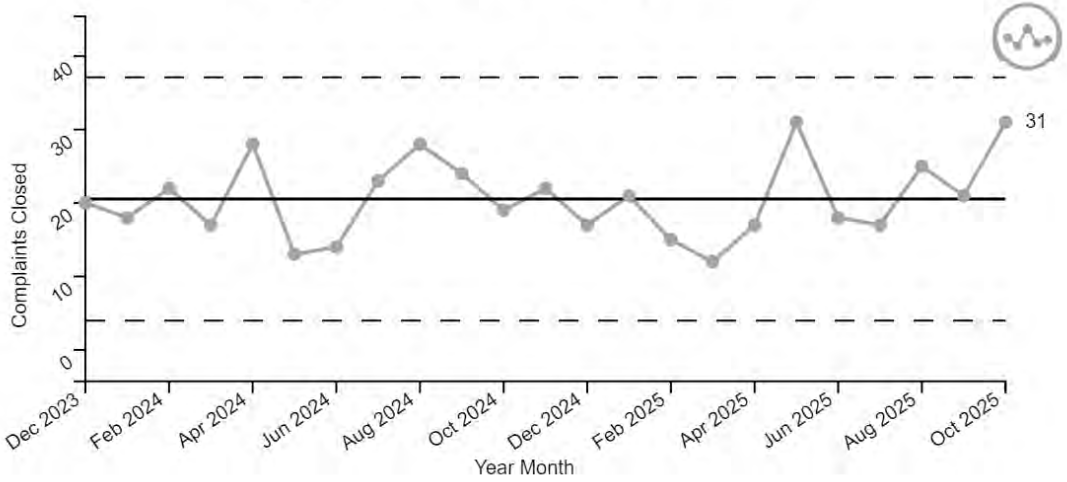
Complaints Opened with Risk Score 3-5

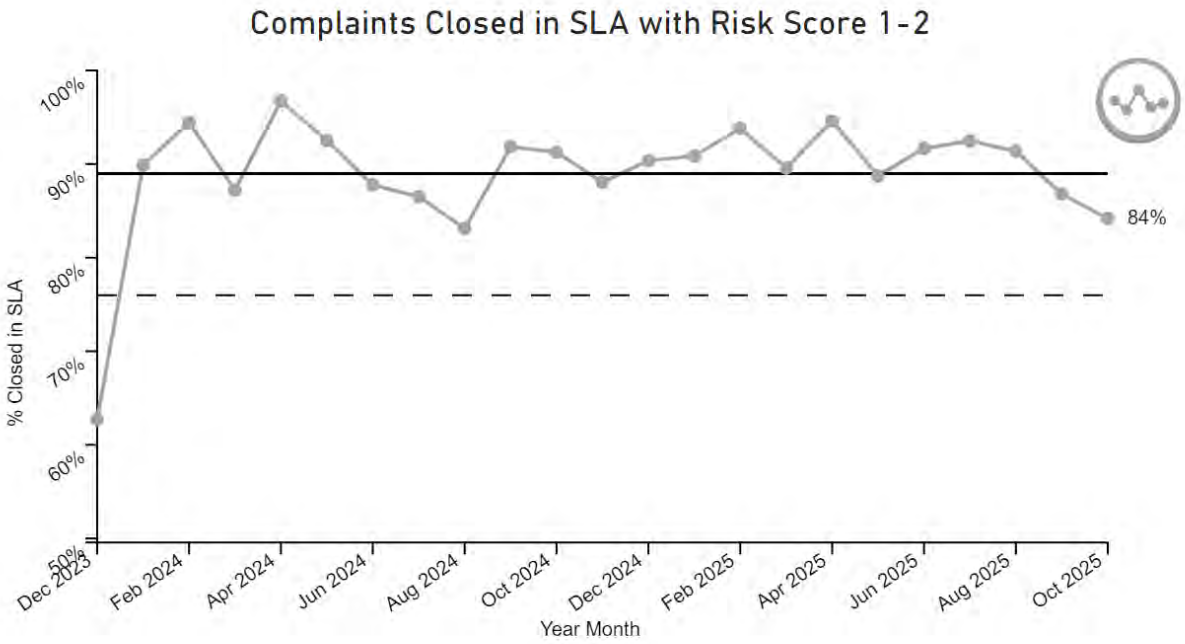


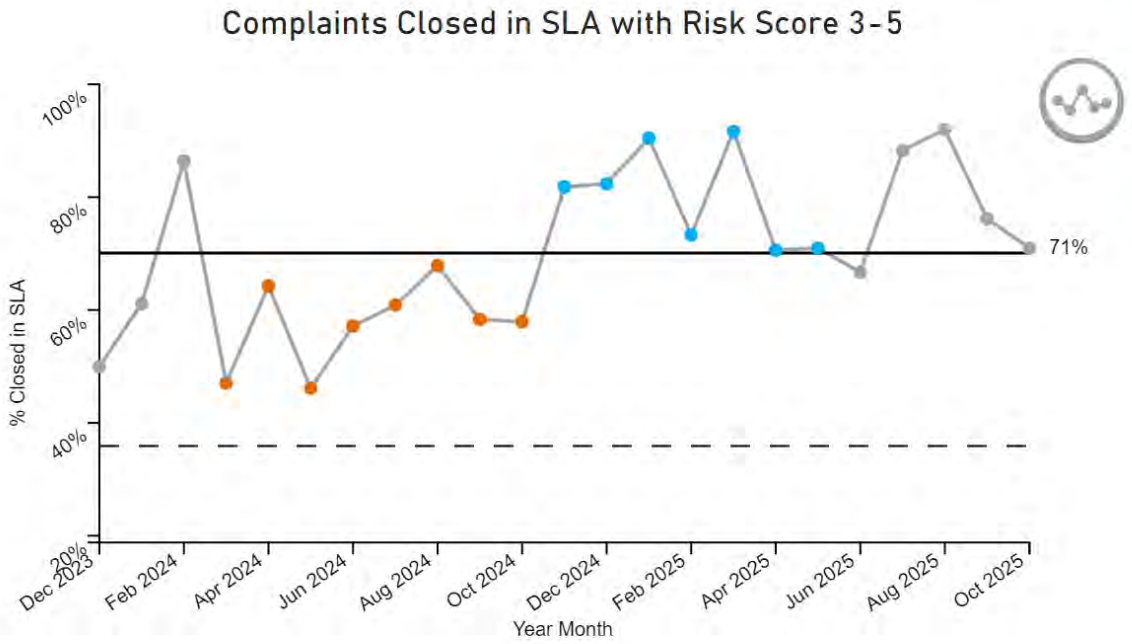
Complaints Closed with Risk Score 1-2



Complaints Closed with Risk Score 3-5







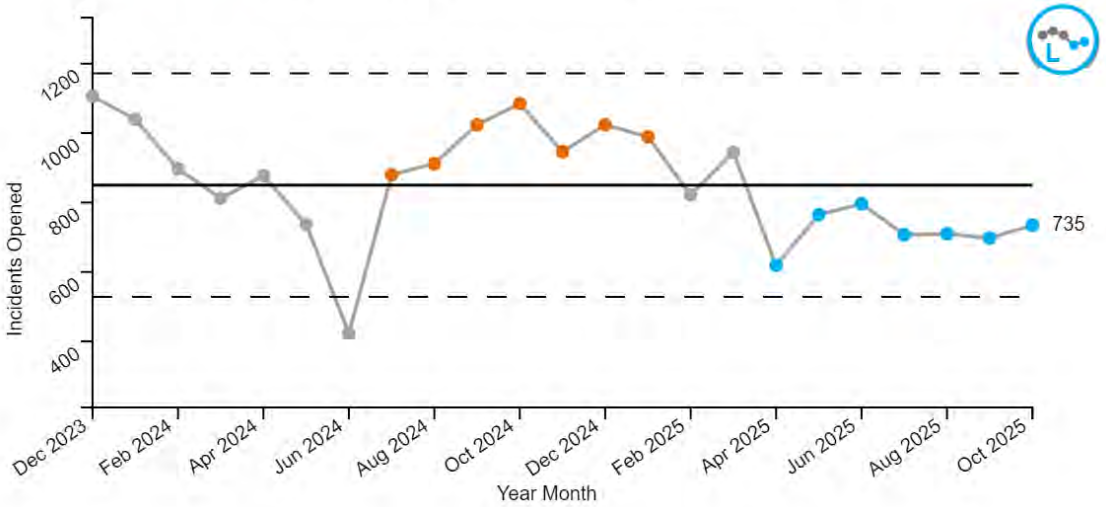
Summary: Patient Advice and Liaison Service (PALS) complaints (risk score 1&2), along with all other metrics, remain stable.

Actions: Nil required

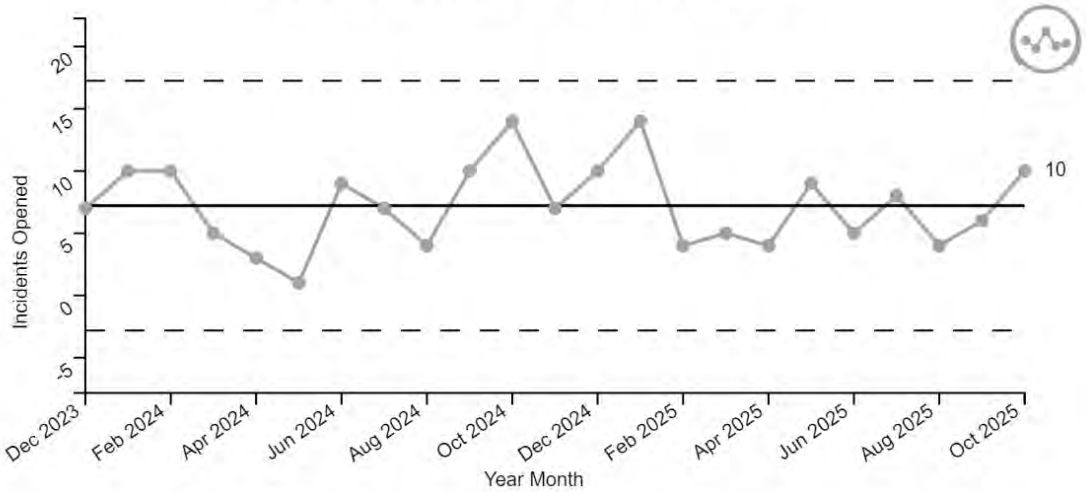
BAF ID SR01

Q2 Incidents

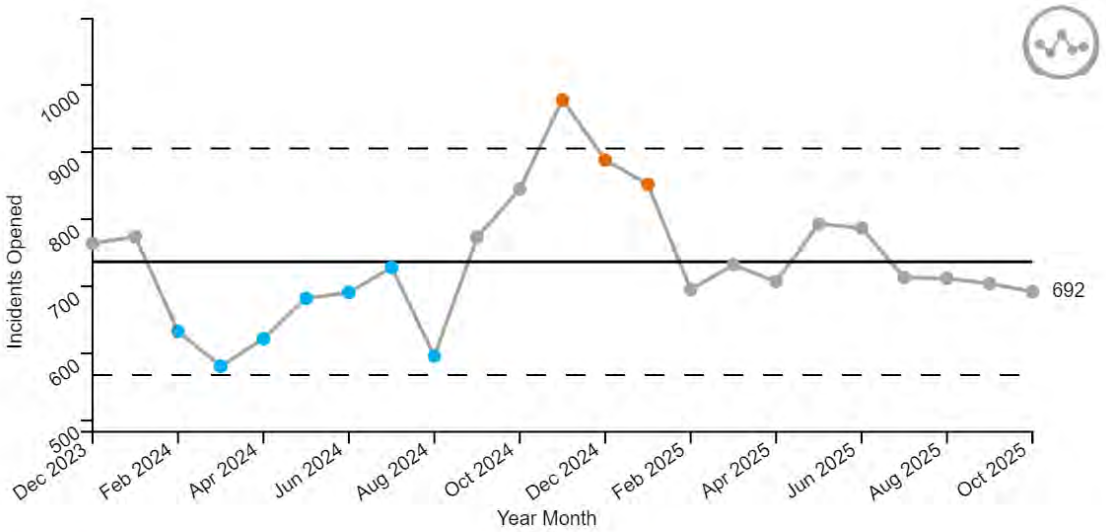
Incidents Opened with Risk Score 1-3



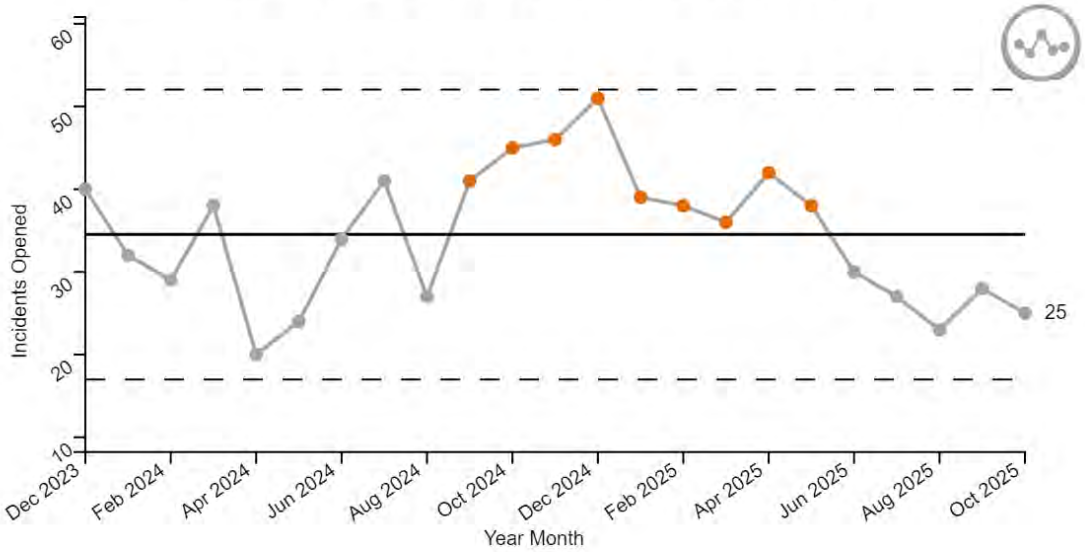
Incidents Opened with Risk Score 4-5



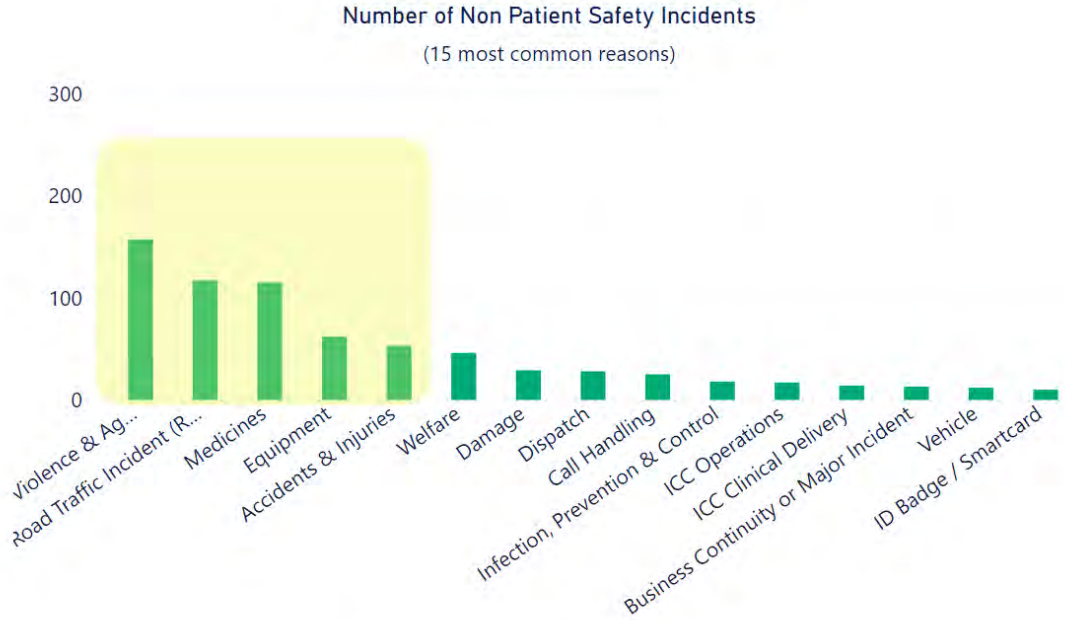
Incidents Opened - Patient

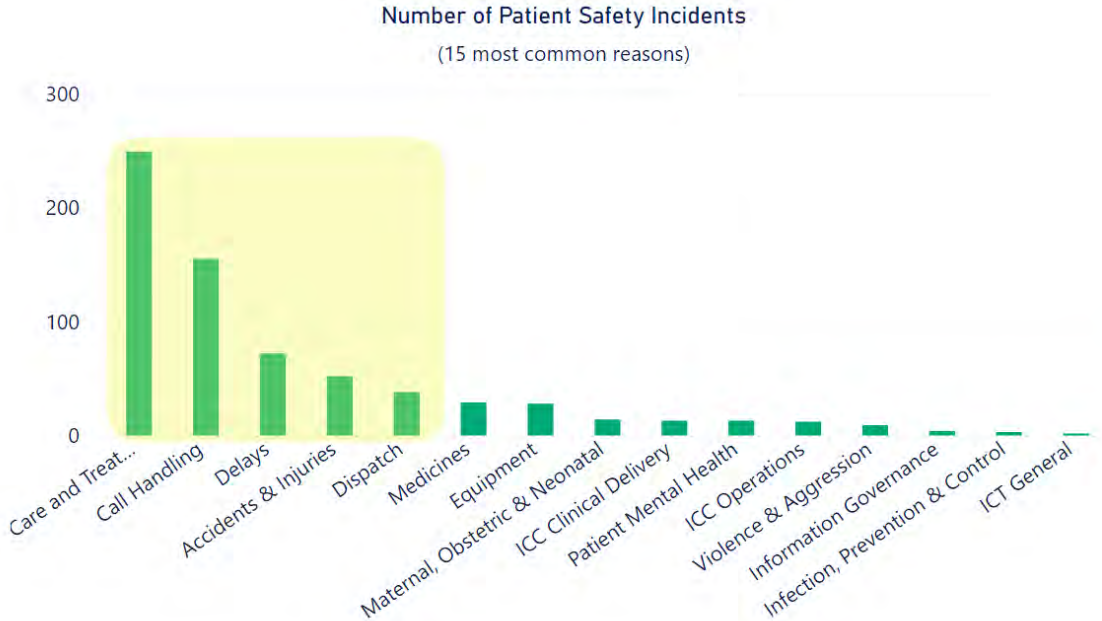


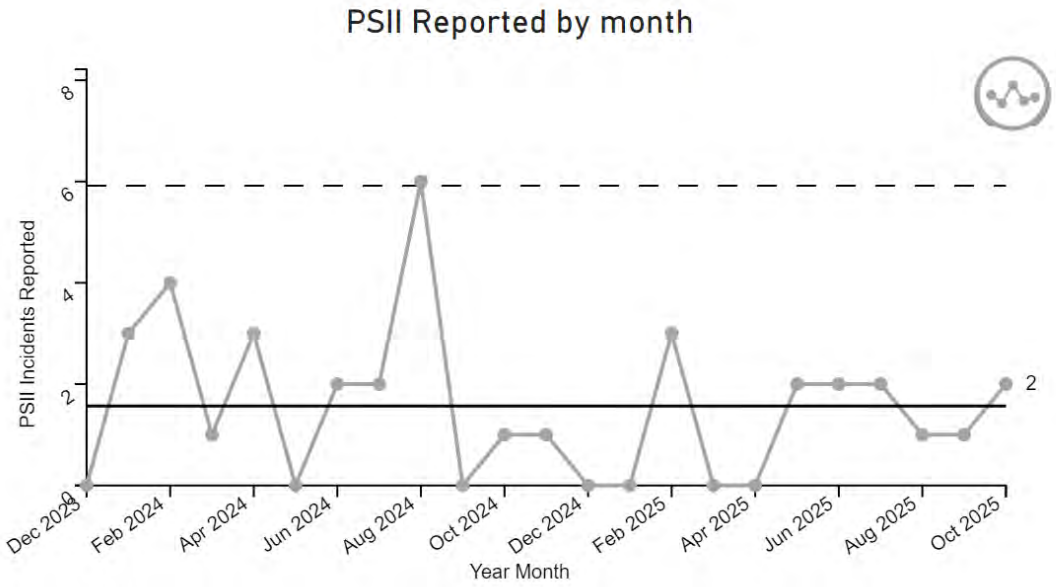
PSIRF Reported Level of Harm (Severe & Fatal)



BAF ID SR01







Summary:
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.

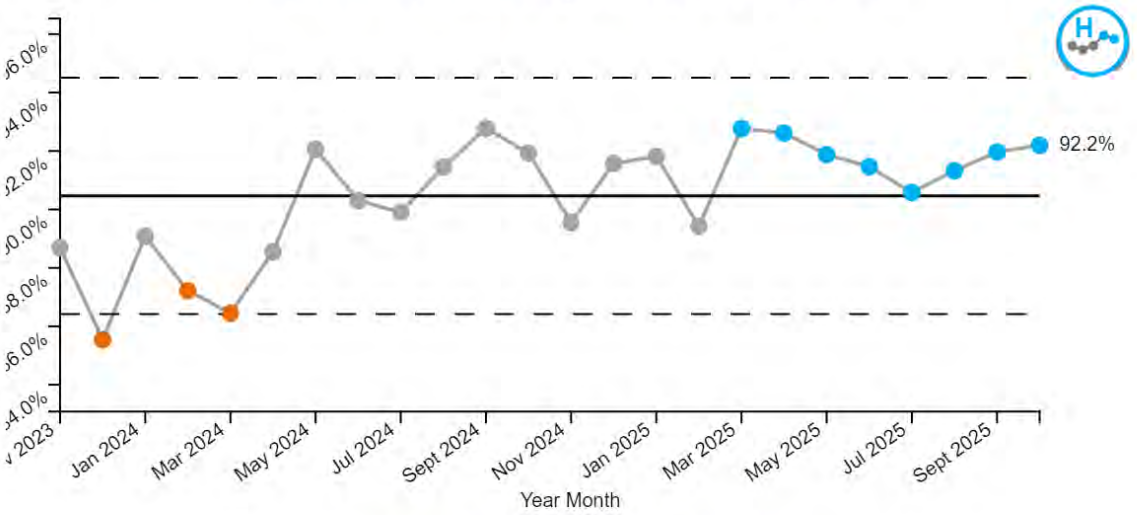
Actions:
There has been a 29% increase in V&A reported incidents from Sept-Oct. Notable in this is a 50% increase in physical assaults towards our staff. The V&A team are working closely with the reporters on a separate programme of work specifically looking at repeat offenders and locations, working with partner agencies to reduce repeat offending. The rise in incidents is primarily linked to periods of elevated demand and which have resulted in a marked increase in violent occurrences. Overall, there has been a 14% decrease in V&A incidents compared to the same time last year.

Q3 Safety Alerts

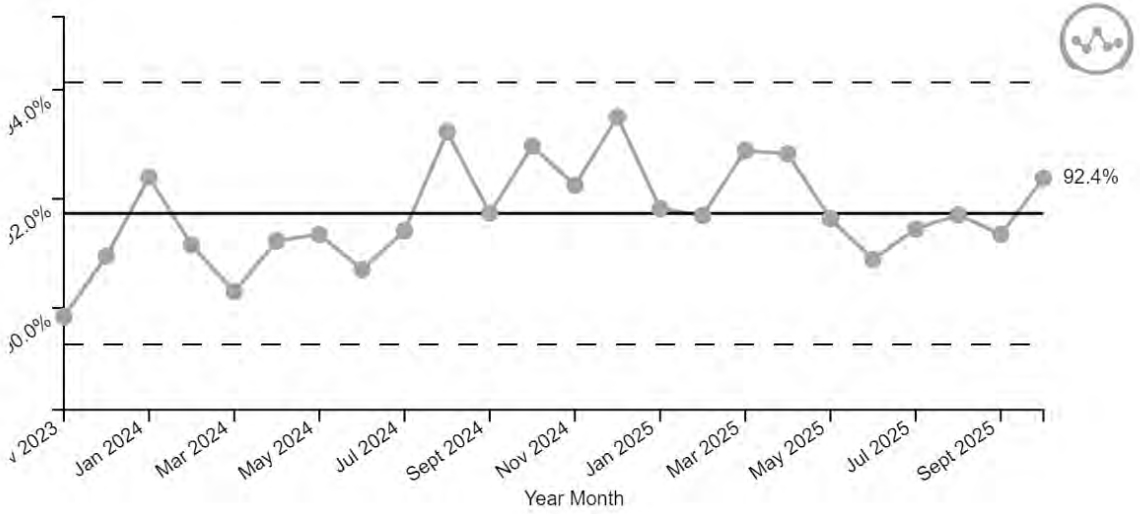
Safety Alerts	Alerts Received (November 24 – October 25)	Alerts Applicable (November 24 – October 25)	Alerts Open	Notes
CAS Helpdesk Team	1	0	0	
Patient Safety Alert: UKHSA	1	0	0	
National Patient Safety Alert: NHS England	0	0	0	Description: Harm from delayed administration of Rasburicase for tumour lysis syndrome Deadline: 09/03/2026 Actions: Nill affecting
National Patient Safety Alert: DHSC	4	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	58	1	1	Description : Class 3 Medicines Recall: Accord Healthcare Ltd, Ipratropium Bromide 500 microgram / 2ml Nebuliser Solution, EL(25)A/45Issue Date : 23-Oct-25 Deadline : Action within 5 days Actions: Separate action plan held by medicines hub but in summary NWAS received 140 boxes of the batch named on the recall - Not all these will be affected but all needed checking. The batches were identified to which pouch they had gone out to and which station. With the help of SCL staff these are all in the process of being checked, so far only one has been identified as being written in Korean. This is being returned to the medicines hub so that it can be returned to the manufacturer. There is no patient risk with this recall the medicine contained within the plastic neb is the correct item.
IPC	0	0	0	
National Patient Safety Alert: NHS England & NHS Improvement	0	0	0	

E1 Patient Experience

PES Friends & Family Test (See & Treat) %



PTS Friends & Family Test %



PES positive

- *"My dad didn't need to go into the hospital, but all the paramedics were really respectful and made sure to involve him and me (his son/carer) in the discussion regarding plans and his health."*
- *"Call handler was excellent, carefully attentive clear in what they said. Very reassuring. Paramedics who attended, were professional, caring, supportive, knowledgeable. Made me feel cared for."*
- *"My husband and I are both elderly and it was a frightening experience. The ambulance staff reassured us both that the episode wasn't life threatening."*

PES negative

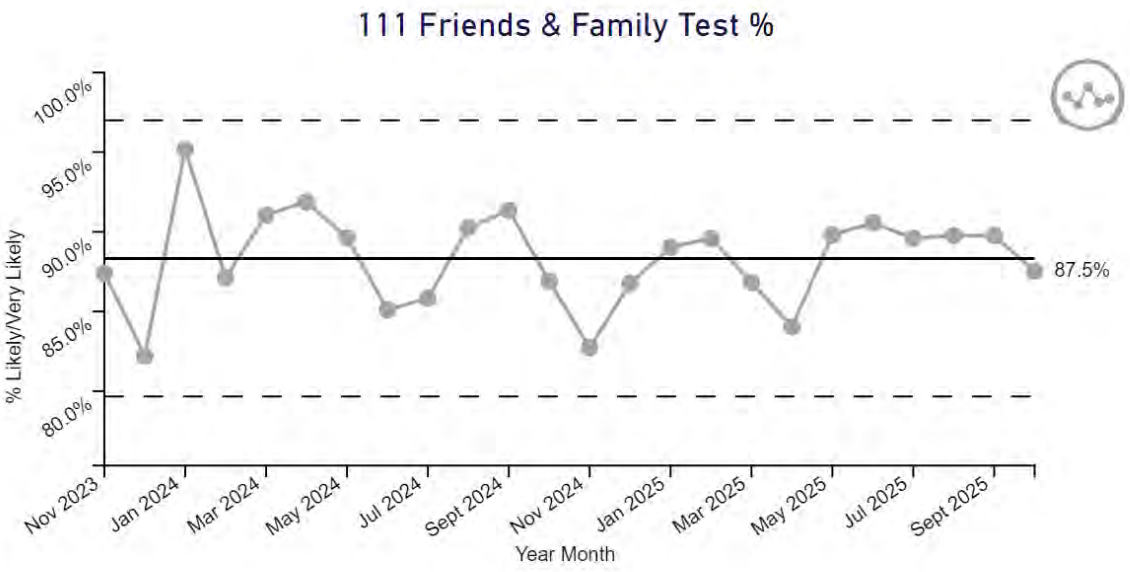
- *"Because I didn't think they took me seriously. All the male said was I should have phoned my doctor. I felt so ill and very short of breath."*
- *"I didn't like the way the 2 ambulance ladies dealt with my mum. I am disabled myself. I was worried that mum had thought her hip had gone. It's the one she was going in for a new hip. They decided it was muscular before they have even seen her."*
- *"Didn't listen to the patient."*

PTS positive

- *"My Mum has used your AMAZING service approximately 20 times in the past year and each time, your crews have been patient, supportive, friendly, courteous, professional. Absolutely nothing is too much trouble for them despite the fact that we reside in the extreme far side of the Aintree Hospital catchment area (so the road journey is long) and my Mum lives on the first floor of a block of flats. First and foremost, on your crews' minds are my Mum's safety and comfort. Their consistent high standards of care and can-do attitude is so reassuring for her and my family. God bless you all."*
- *"He rang to give us a time when he would pick us up. He was very professional and helpful and was easy to talk to also rang when he was close to pick us back up to take us home."*

PTS negative

- *"My booked transport was an hour late with no contact to update me. I was 40mins on a call to you to query this. The person I eventually spoke to refused to contact the therapies dept to inform them and on arrival I couldn't be seen and was marked 'non- attendance' - I was told the PTS were supposed to let them know."*
- *"Driver was speeding and using phone on the journey to the hospital."*



NHS 111 positive

- *"Call handler was very clear with their information regarding what would happen, who would contact me and approx. when. Also, what to do if I hadn't been contacted within the time quoted. They were also very patient, and they confirmed I understood what had to be agreed."*
- *"Health advisor was clear and efficient was clear and efficient. Which gave me confidence in her help. Phone call was not overly long. I am encouraged to continue calling NHS 111 when needing telephone assistance."*
- *"Nonjudgemental patient care excellent."*

NHS 111 negative

- *"The person on the phone made it sound like I was given an appointment time for 10am and told me to go to urgent care. When I arrived, they said this is incorrect and sent me through to A&E to be triaged. Waiting hrs."*
- *"The reason for my call was ignored. Was taken down an irrelevant route which wasted my time as wasn't the reason for my call."*
- *"It took a long time to speak to someone on the phone and by the time the nurse rang it had been around 7-8 hours so by then it was pointless. Considering this was regarding a 6-month-old baby I was very disappointed and had to seek help elsewhere. The information provided by the health advisor was completely irrelevant to the situation and therefore unhelpful."*

Summary:

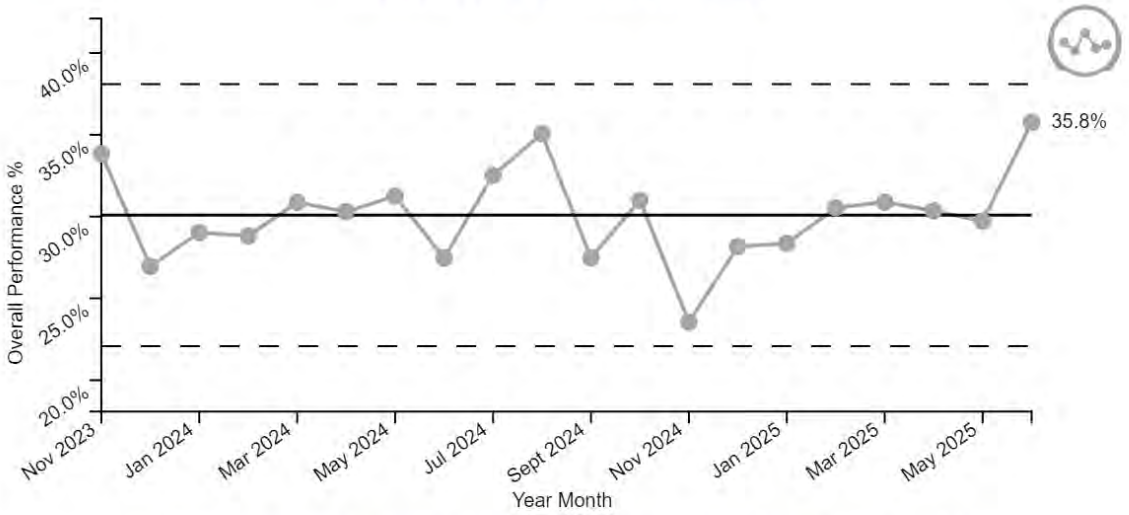
PES: There were 666 responses in Oct 25, consistent with recent response rates. The proportion of responses as Good/Very Good similar to pe previous month at 92% and similar to the same period last year (92% for Oct 25, 92.8% for Oct 24) . There are similar number of respondents when compared to the same point last year.

PTS: There were 1128 responses in Oct 25, with responses returning to similar previous numbers. The proportion of responses as Good/Very Good are 1.1% higher in Oct 25 (92.4%), than the previous month (Sep 91.3%) . When compared to position in previous year, the proportion of Good/Very Good responses are similar. Response rates have increased since last month and are now similar to the time position last year.

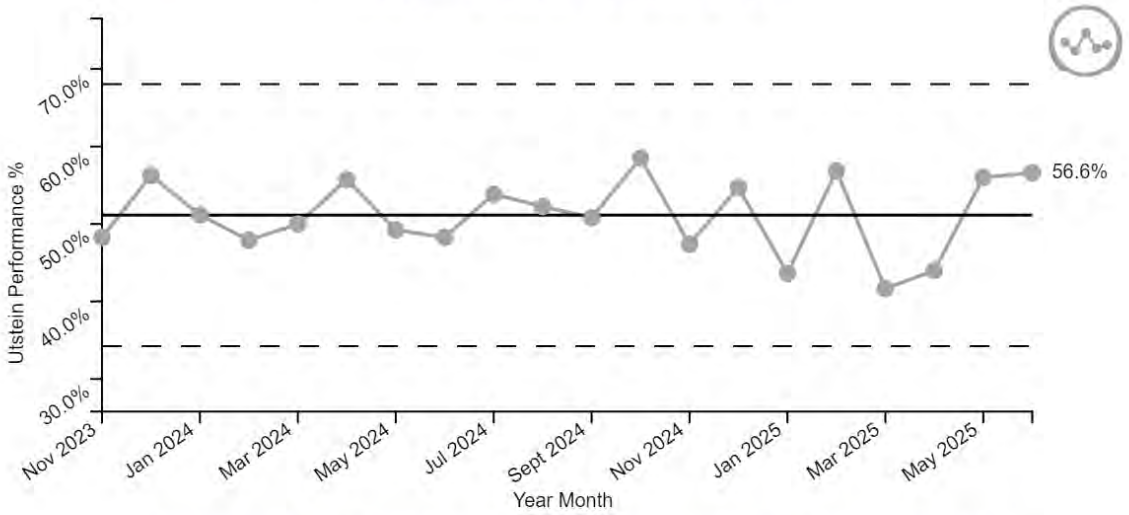
NHS 111: There were 569 responses in Oct 25, with responses increasing since May 25 (n=490). These increased returns are due to the inclusion of responses following the receipt of 'care advice' via SMS after the 111 calls. The % of Likely/Very Likely similar to the same time last year (0.6% difference).

E2 Ambulance Clinical Quality Indicators (ACQI)

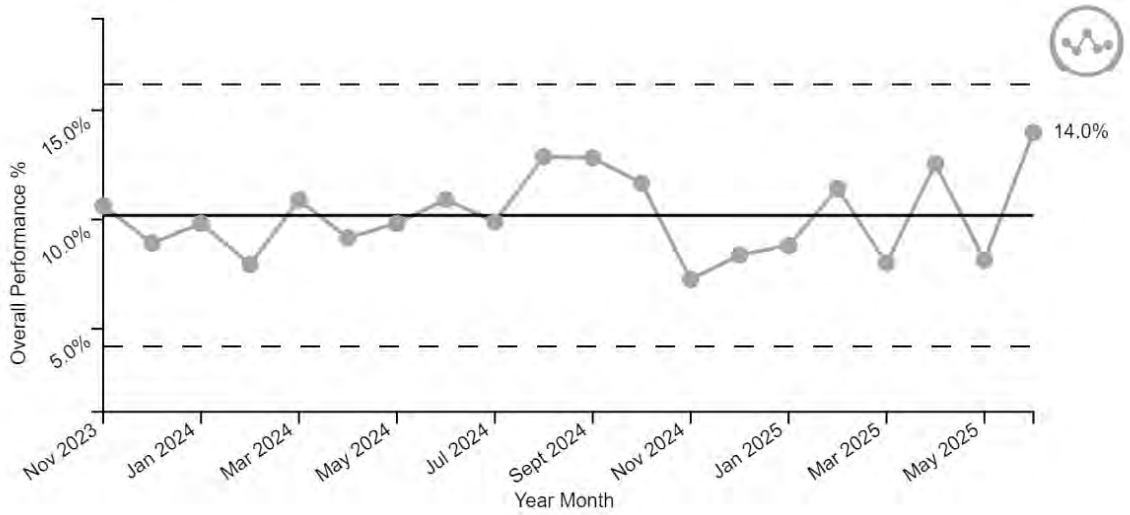
ROSC - Overall Performance



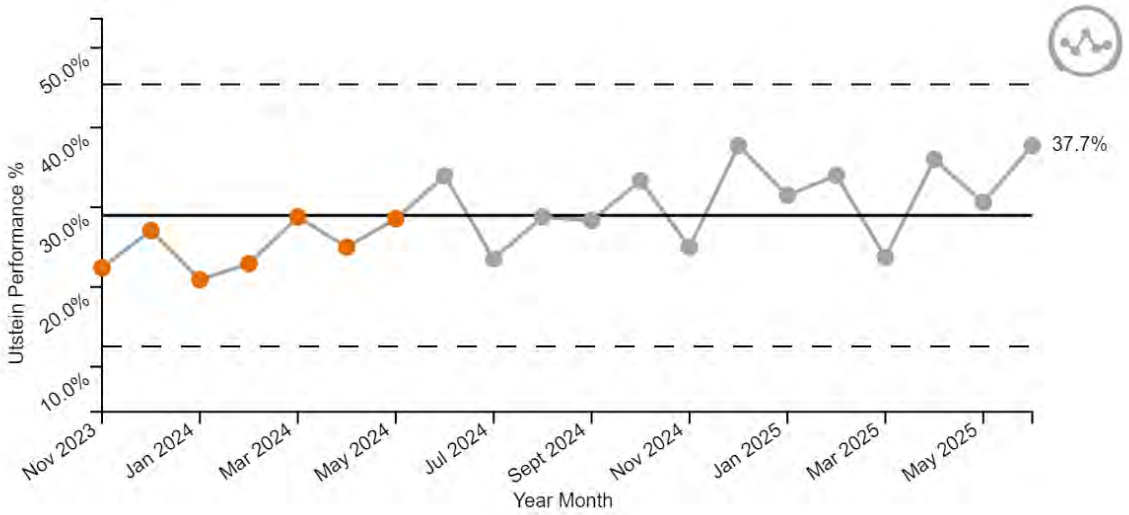
ROSC - Utstein Performance



Survival at 30 Days Post Discharge - Overall Performance

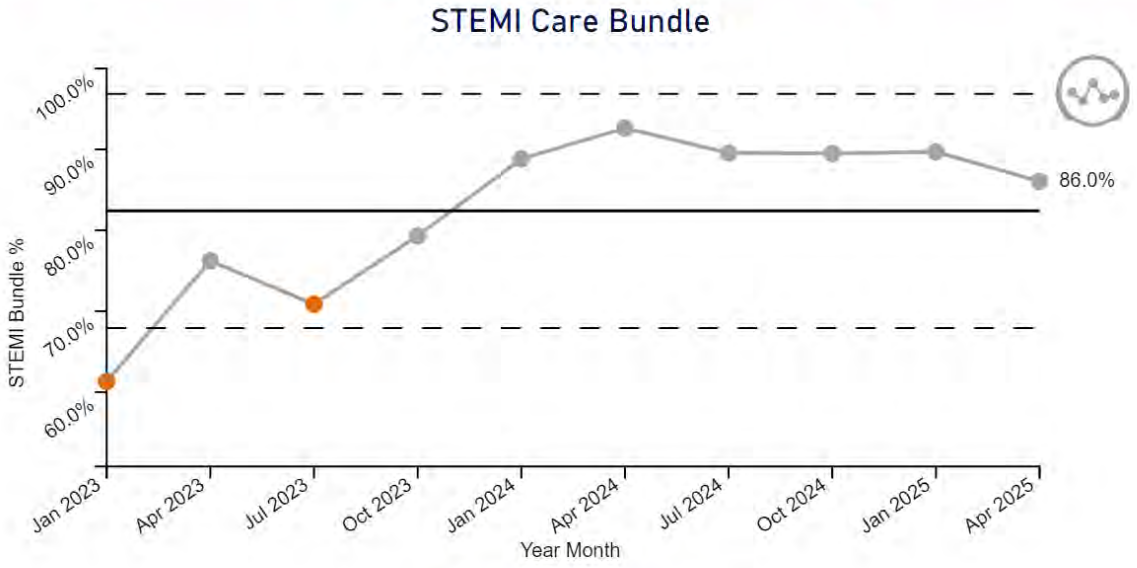


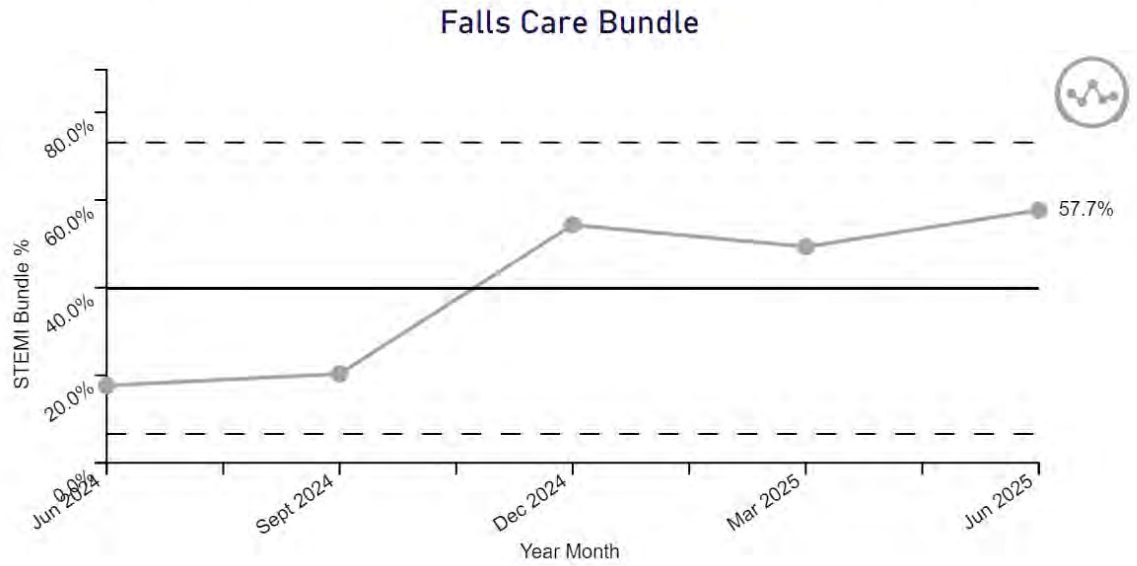
Survival at 30 Days Post Discharge - Utstein Performance



BAF ID SR01

E2 Ambulance Clinical Quality Indicators (ACQI)





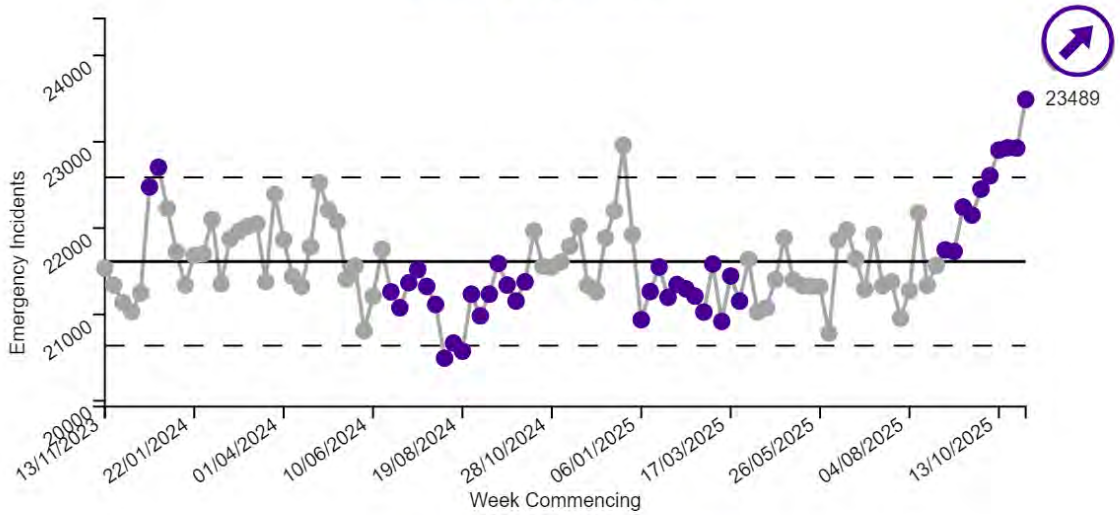
Summary:

- ROSC overall performance - last reported in Jun 25 (35.8%), **above** the national average of 22.2%.
- ROSC Utstein performance - last reported in Jun 25 (56.6%), **above** the national average of 55.1%.
- Survival at 30 days after discharge overall performance - last reported in. Jun 25 (14.0%), **above** the national average of 10.4%.
- Survival at 30 days after discharge Utstein performance - last reported in Jun 25 (37.7%), **above** the national average of 32.9%.
- STEMI bundle - last reported in Apr 25 (86.0%), **above** the national average of 80.0%.
- Falls bundle – last reported in Jun 25 (57.7%), **above** the national average of 51.7%.

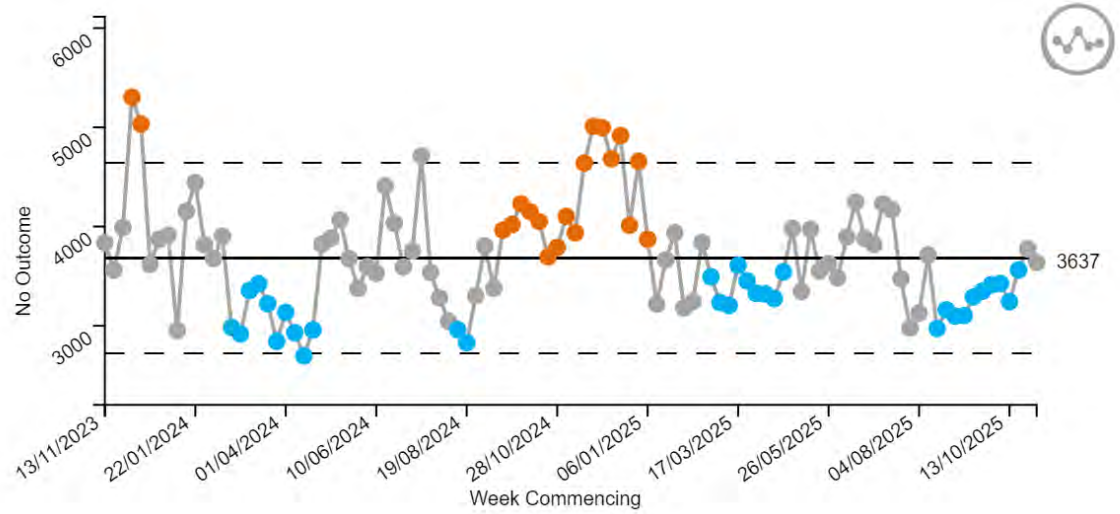
Actions: Continued monitoring of metrics and EPR system development to drive improvement.

E3 Activity & Outcomes

Emergency Incidents

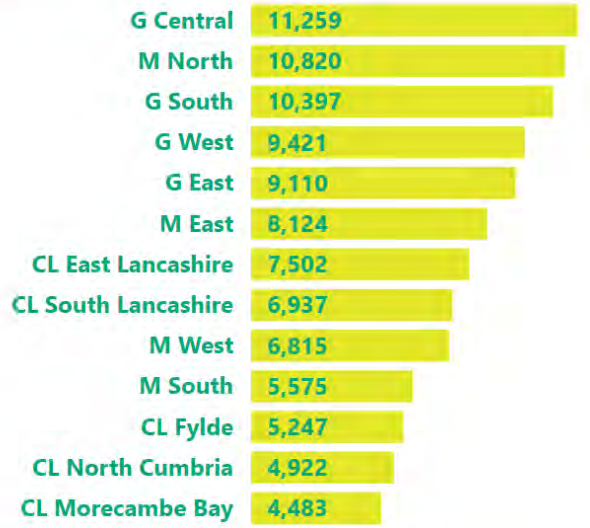


No Outcome Contacts



Emergency Incidents

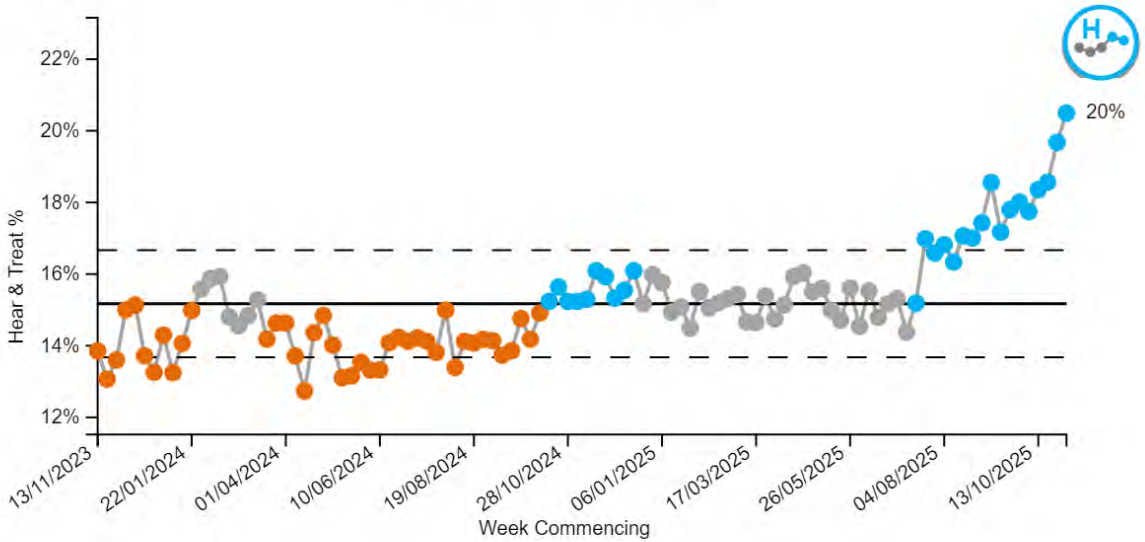
Emergency Incidents by Operational Sector



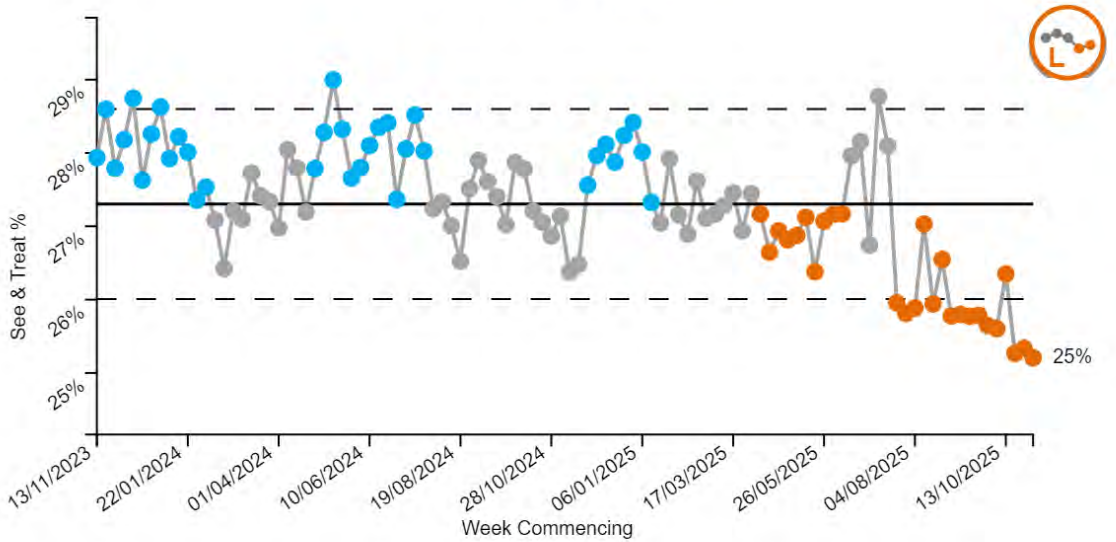
Emergency Incidents by ICB

Calendar Year	Month	Calls	% Change from previous year	Incidents	% Change from previous year
2023	Oct	127,219	-9.45 %	94,304	3.16 %
2022	Oct	140,501	-7.97 %	91,417	-1.60 %
2024	Oct	125,675	-1.21 %	95,047	0.79 %
2025	Oct	126,646	0.77 %	100,952	6.21 %

Hear & Treat (AQI)



See & Treat (AQI)



Months Hear & Treat by Sector

G Central	25.4%
CL South Lancashire	19.9%
G East	19.0%
CL Fylde	18.7%
M North	18.0%
G West	17.9%
CL East Lancashire	17.6%
M South	17.1%
M East	17.0%
G South	16.8%
M West	16.2%
CL Morecambe Bay	14.8%
CL North Cumbria	14.5%

Months Hear & Treat by ICB

Greater Man...	20.0%
Lancashire ...	18.0%
Cheshire & ...	17.2%
North East ...	14.5%

Months See & Treat by Sector

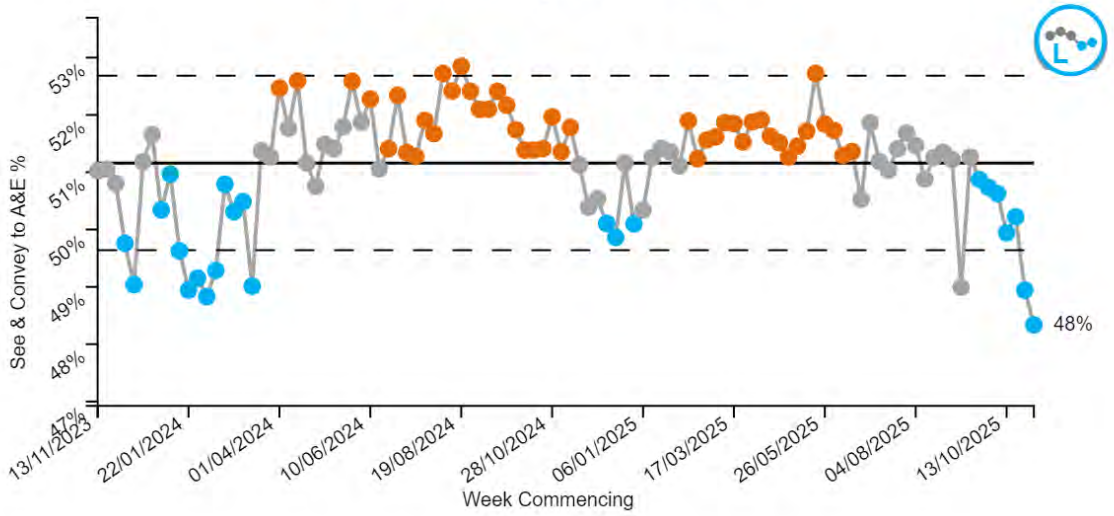
CL Morecambe Bay	31.4%
CL North Cumbria	29.6%
CL East Lancashire	27.2%
M South	26.2%
M West	25.9%
G East	25.7%
CL Fylde	25.4%
G South	25.2%
G West	24.9%
CL South Lancashire	24.7%
G Central	24.2%
M North	24.2%
M East	23.9%

Months See & Treat by ICB

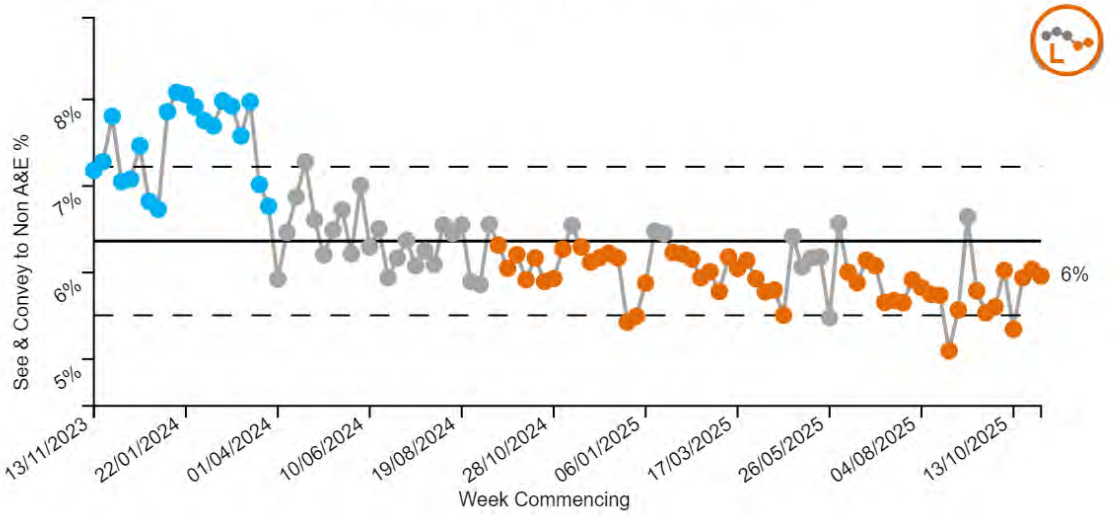
North East ...	29.6%
Lancashire ...	26.9%
Greater Man...	24.9%
Cheshire & ...	24.8%

BAF ID SR01

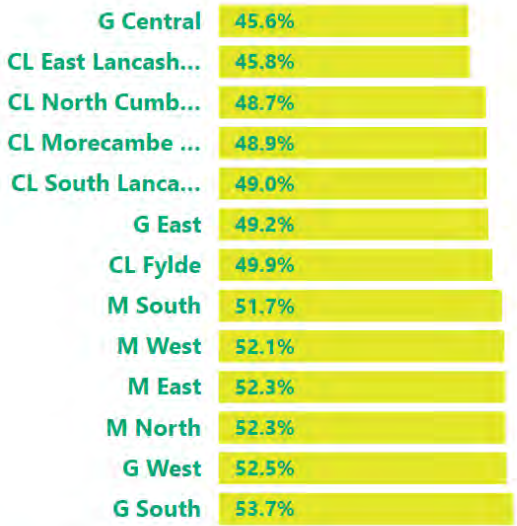
See & Convey to A&E (AQI)



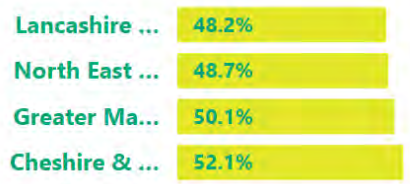
See & Convey to Non A&E (AQI)



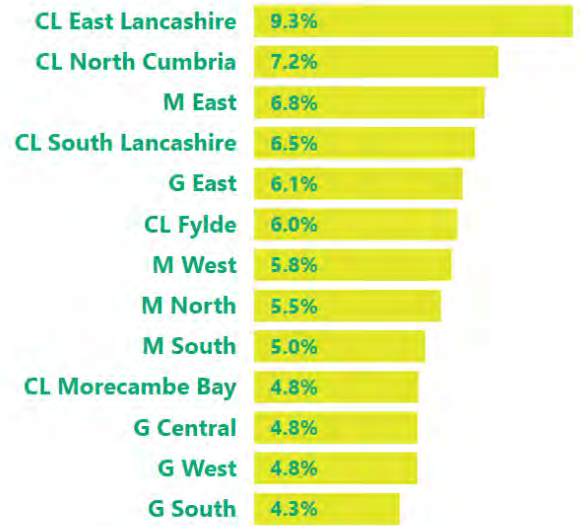
Months See & Convey (AE) by Sector



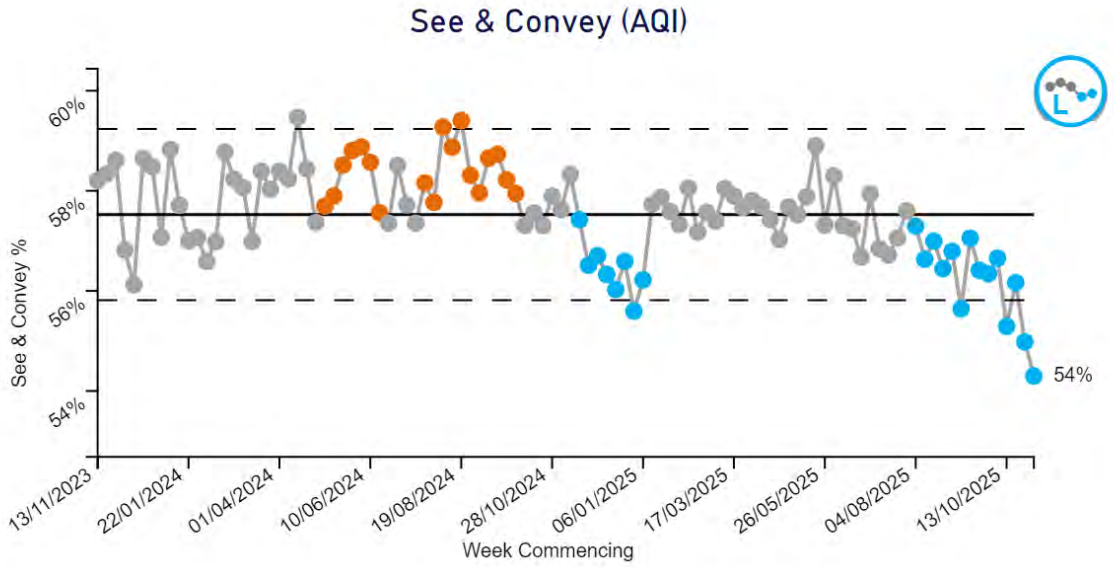
Months See & Convey (AE) by ICB



Months See & Convey (Non AE) by Sector



Months See & Convey (Non AE) by ICB



Months See & Convey by Sector

G Central	50.4%
CL Morecambe Bay	53.8%
CL East Lancashire	55.2%
G East	55.3%
CL South Lancashire	55.4%
CL North Cumbria	55.9%
CL Fylde	55.9%
M South	56.7%
G West	57.3%
M North	57.8%
M West	57.9%
G South	58.0%
M East	59.0%

Months See & Convey by ICB

Greater Manc...	55.1%
Lancashire & ...	55.1%
North East & ...	55.9%
Cheshire & M...	57.9%

Activity & Outcomes

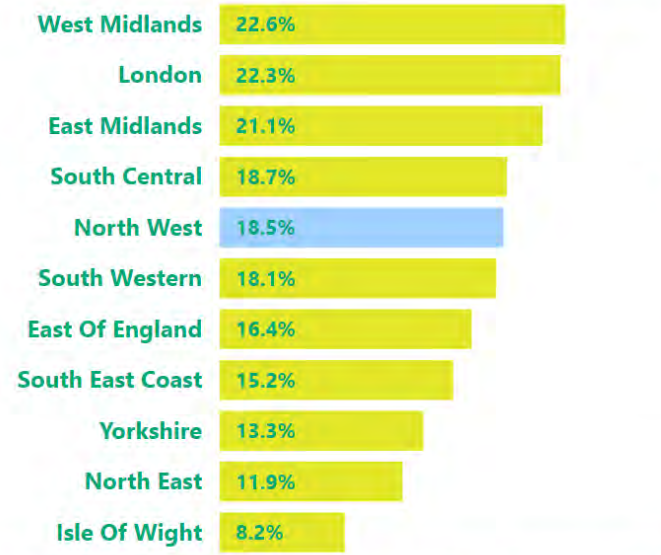
Summary: Of the n=126,646 emergency calls received by the trust, 79.7% (n=100,952) became incidents. In comparison to previous month there around 10,000 more calls, but a decrease in proportion of incidents, down 1.5% from 81.2% in Sep 25.

Two stop codes previously coded as 'No Outcome', WINFO and MENH, are now coded as outcome 'Hear & Treat', approx. 1000 contacts. This is likely a contributing factor in recent increase in Hear & Treat numbers and decrease in See & Treat. Ongoing 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.

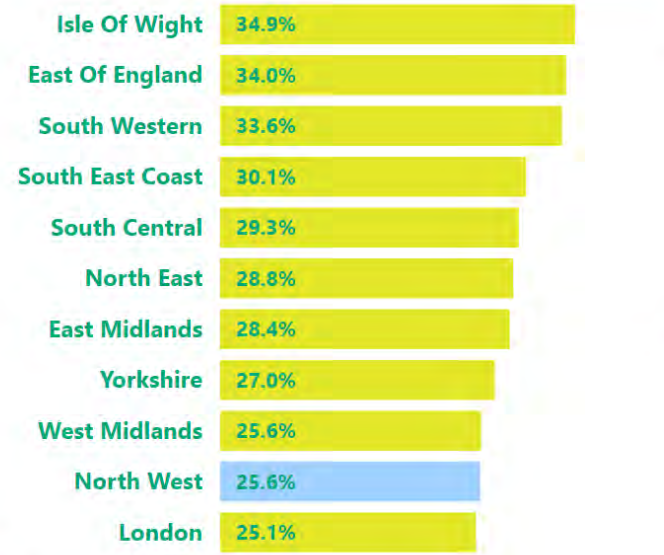
The H&T rate for October was 20% and S&T was 25%, equating to a non-conveyance rate of 45%

Action:
Further gains are expected through the introduction of CAS providers in the Cheshire and Merseyside areas.

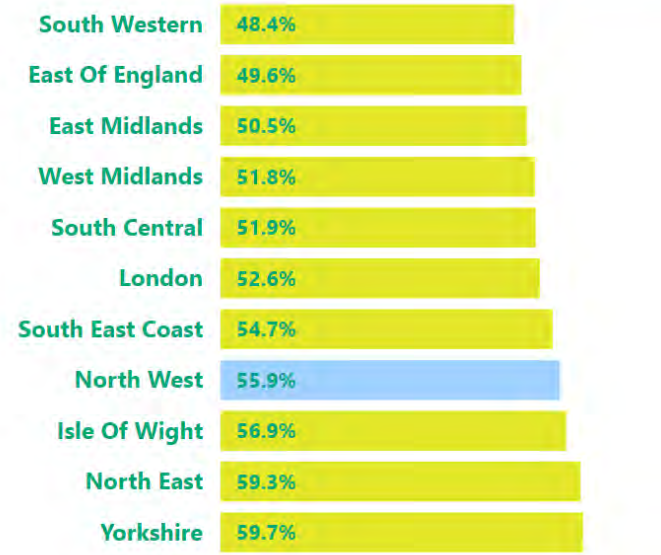
Hear & Treat % by Trust



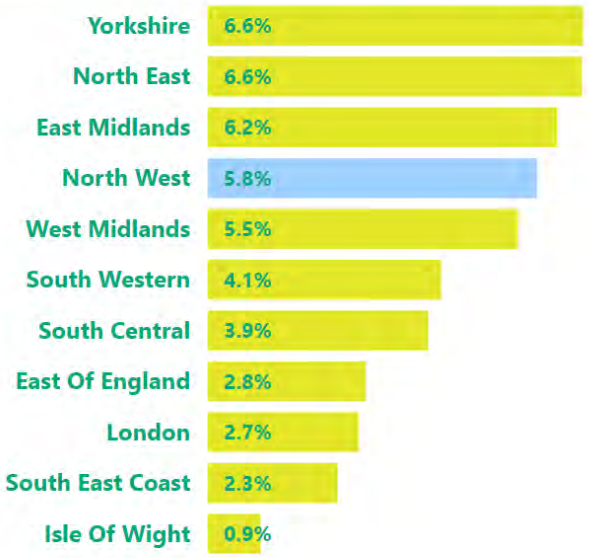
See & Treat % by Trust



See & Convey % by Trust



See & Convey non A&E % by Trust

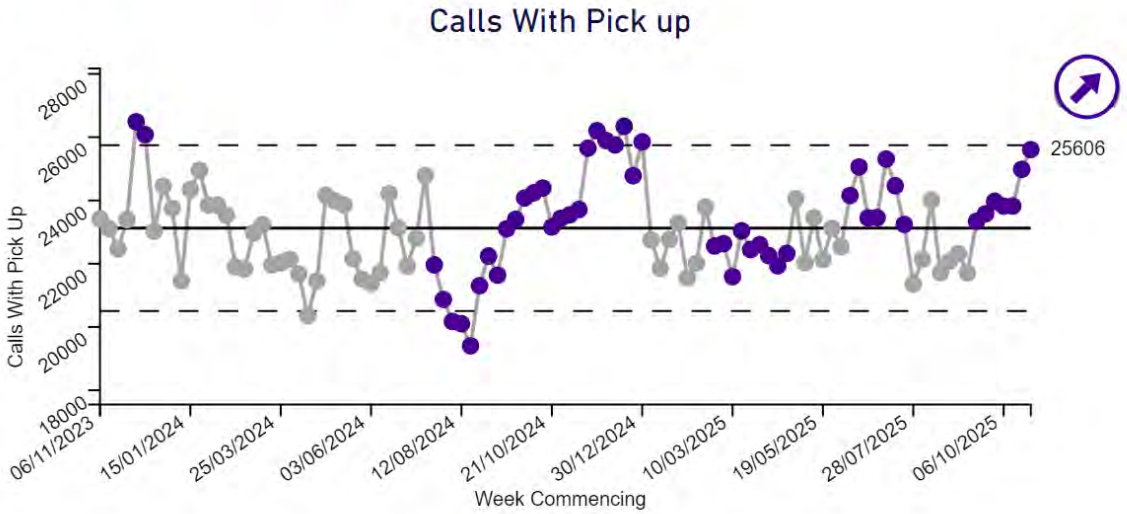


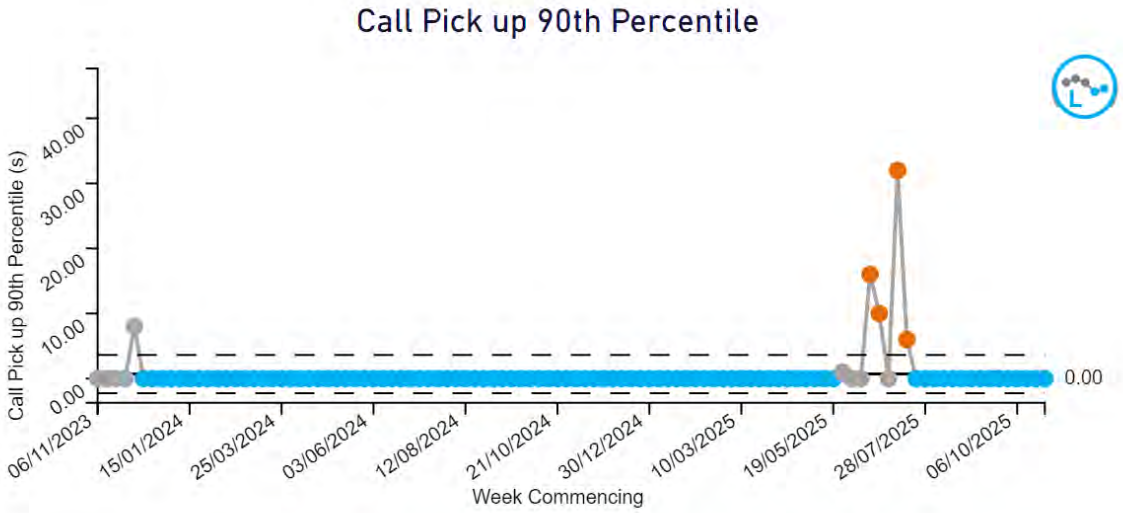
BAF ID SR01

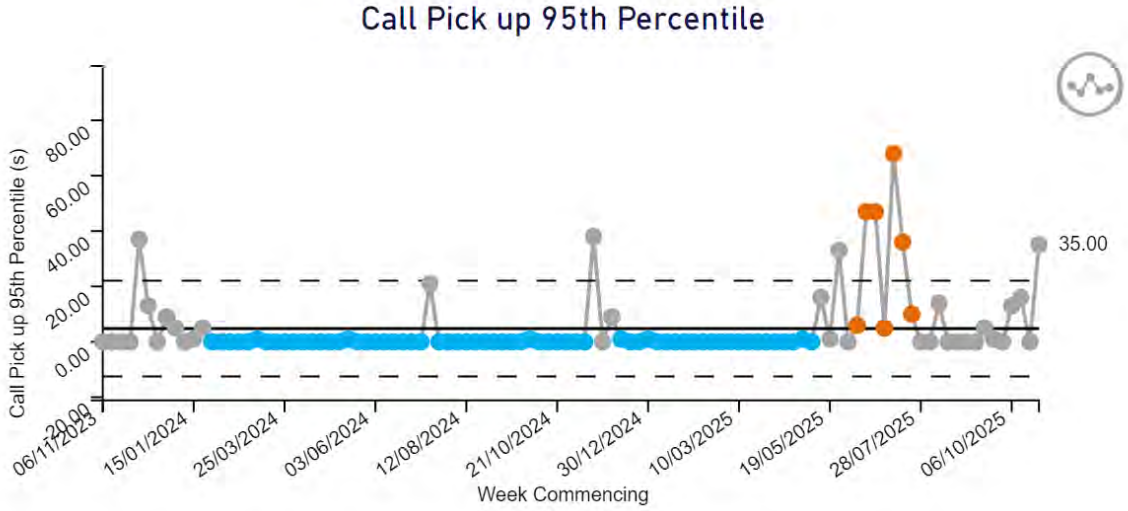
Operational

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

O1 Call Pick Up







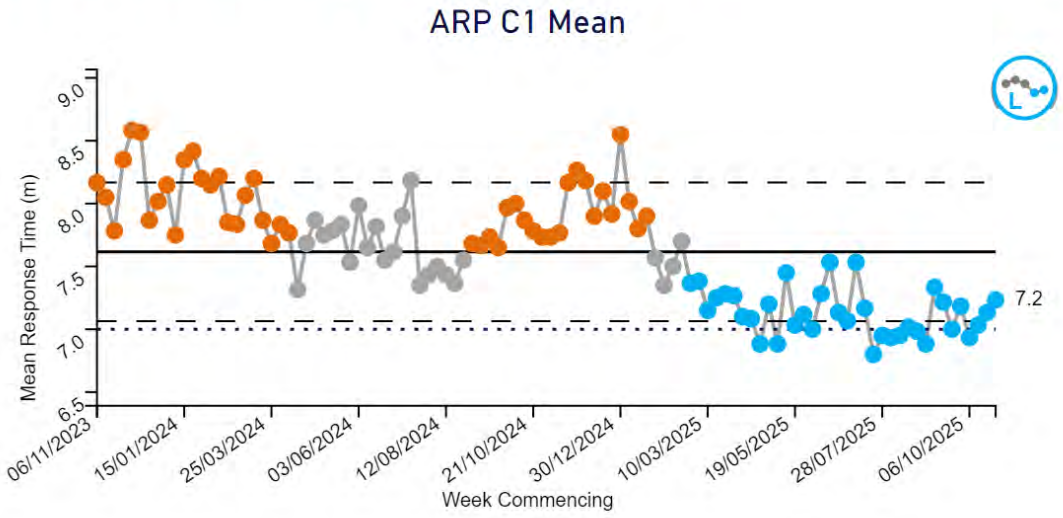
Call Pick Up Mean	
Month	2
YTD	2
Ranking	4

Call Pick up 90th Percentile	
Month	0
YTD	0
Ranking	2

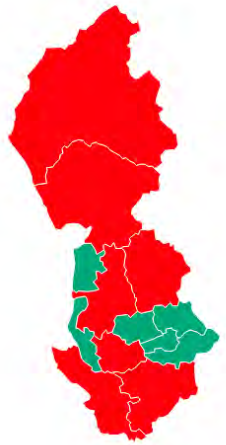
Call Pick up 95th Percentile	
Month	1
YTD	4
Ranking	1

In October, call volume increased by 10%, significantly increasing in the last 2 weeks. Despite this increased demand, the performance metrics for handling calls remained strong, achieving a 2 second mean and 1 second 95th percentile. The service continued to support the Yorkshire Ambulance Service throughout October, committing to 20% of (YAS) total call volume throughout the month.

O3 ARP Response Times



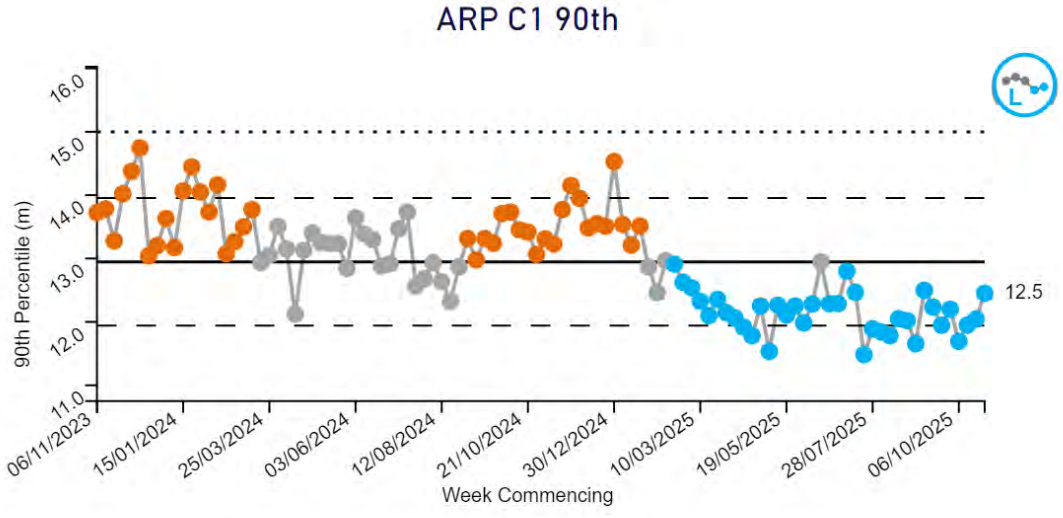
C1 Mean (Red =>7min)



C1 Mean by Sector	
CL North Cumbria	00:08:50
CL Morecambe Bay	00:08:21
M South	00:07:49
CL South Lancashire	00:07:39
M West	00:07:39
CL East Lancashire	00:07:12
M East	00:07:10
G East	00:06:58
G West	00:06:54
G South	00:06:34
CL Fylde	00:06:32
G Central	00:06:30
M North	00:06:20

C1 Mean by ICB	
North East & Nort...	00:08:50
Lancashire & Sout...	00:07:22
Cheshire & Mersey...	00:07:04
Greater Manchester	00:06:42

C1 Mean	
Target	00:07:00
Month	00:07:04
YTD	00:07:07
Ranking	3



C1 90th (Red =>15min)

C1 90th by Sector	
CL North Cumbria	00:16:17
CL Morecambe Bay	00:15:10
M South	00:13:38
M West	00:13:16
CL South Lancashire	00:13:14
CL East Lancashire	00:12:31
CL Fylde	00:12:08
M East	00:11:44
G West	00:11:10
G Central	00:11:10
G East	00:11:08
G South	00:10:46
M North	00:10:43

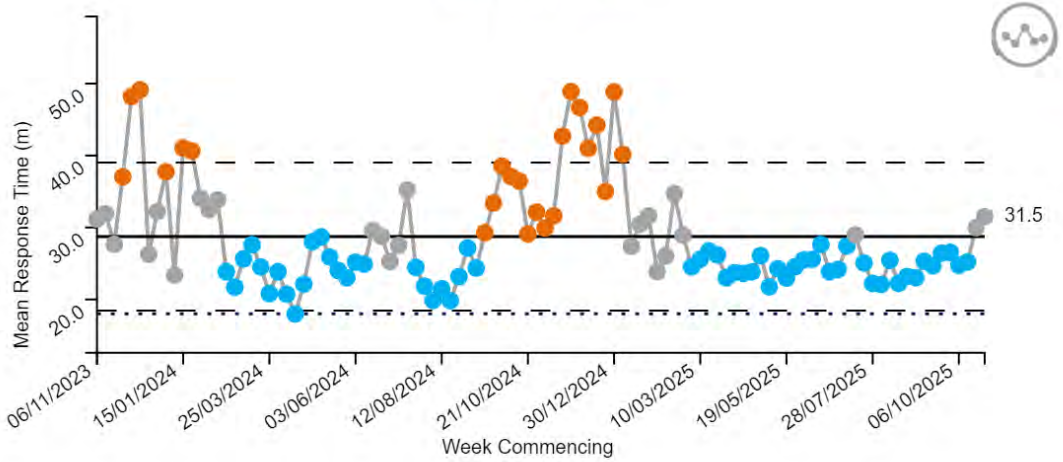
C1 90th by ICB	
North East & N...	00:16:17
Lancashire & So...	00:13:10
Cheshire & Mer...	00:12:01
Greater Manche...	00:10:59

C1 90th	
Target	00:15:00
Month	00:12:03
YTD	00:12:06
Ranking	2

O3 ARP Response Times

O3 ARP Response Times

ARP C2 Mean



C2 Mean (Red => 18min)

C2 Mean by Sector

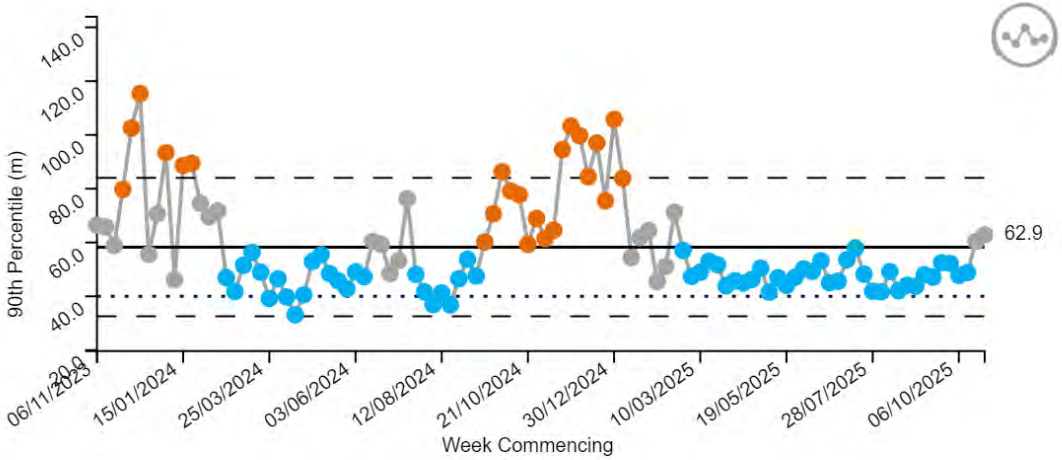
M South	00:34:05
M East	00:33:17
M West	00:32:51
M North	00:32:31
CL Morecambe Bay	00:29:55
CL North Cumbria	00:28:05
CL South Lancashire	00:27:16
G West	00:27:05
G East	00:25:52
CL Fylde	00:23:18
G Central	00:23:07
CL East Lancashire	00:22:43
G South	00:22:32

C2 Mean by ICB

Cheshire & Mersey...	00:33:04
North East & Nort...	00:28:05
Lancashire & Sout...	00:25:29
Greater Manchester	00:24:29

C2 Mean	
Target (ARP)	00:18:00
Target (UEC)	00:28:00
Month	00:27:36
YTD	00:24:59
Ranking	2

ARP C2 90th



C2 90th (Red => 40min)

C2 90th by Sector

M West	01:06:53
M South	01:05:48
M North	01:05:36
M East	01:04:36
CL Morecambe Bay	01:01:37
CL North Cumbria	00:55:44
G West	00:53:21
CL South Lancashire	00:53:14
G East	00:49:49
CL Fylde	00:45:24
G Central	00:44:57
G South	00:44:03
CL East Lancashire	00:42:06

C2 90th by ICB

Cheshire & Mersey...	01:05:38
North East & Nort...	00:55:44
Lancashire & Sout...	00:49:45
Greater Manchester	00:47:57

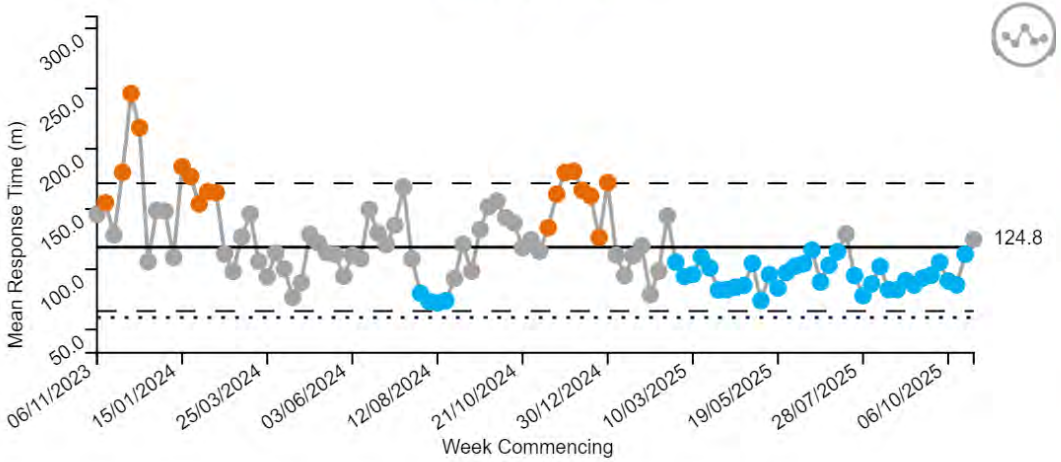
C2 90th	
Target	00:40:00
Month	00:54:47
YTD	00:48:29
Ranking	2

O3 ARP Response Times

BAF ID SR03

O3 ARP Response Times

ARP C3 Mean



C3 Mean (Red => 60min)

C3 Mean by Sector

M East	01:58:28
G West	01:57:21
M North	01:56:23
G Central	01:52:08
G East	01:48:36
M West	01:43:17
G South	01:34:10
M South	01:31:28
CL South Lancashire	01:29:47
CL North Cumbria	01:28:08
CL Morecambe Bay	01:26:35
CL Fylde	01:25:46
CL East Lancashire	01:23:05

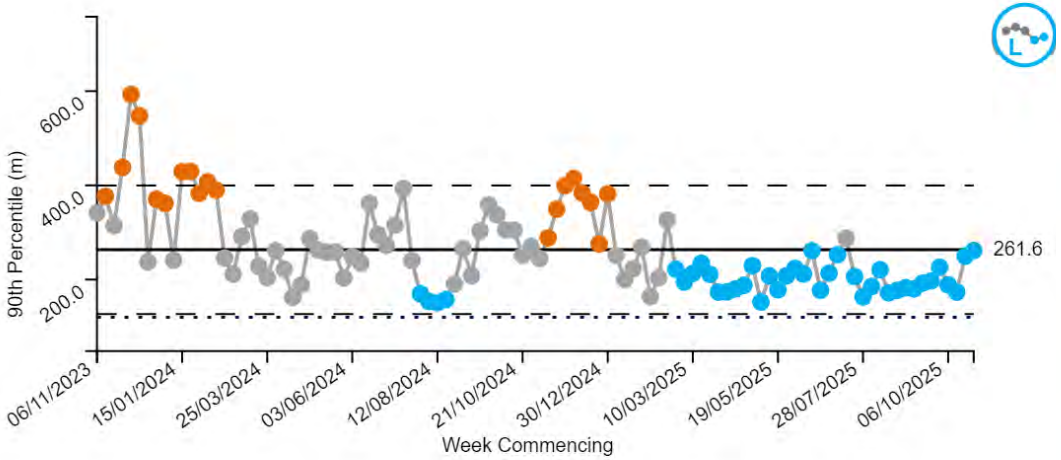
C3 Mean by ICB

Cheshire & Mersey...	01:49:03
Greater Manchester	01:48:17
North East & Nort...	01:28:10
Lancashire & Sout...	01:26:15

C3 Mean	
Target	00:60:00
Month	01:42:01
YTD	01:35:23
Ranking	5

O3 ARP Response Times

ARP C3 90th



C3 90th (Red => 2h)

C3 90th by Sector

M East	04:12:58
M North	04:11:32
G West	04:03:38
G Central	03:47:22
M West	03:39:01
G East	03:33:45
CL Fylde	03:22:31
CL Morecambe Bay	03:18:35
G South	03:13:36
M South	03:12:20
CL South Lancashire	03:10:05
CL North Cumbria	03:04:44
CL East Lancashire	03:00:13

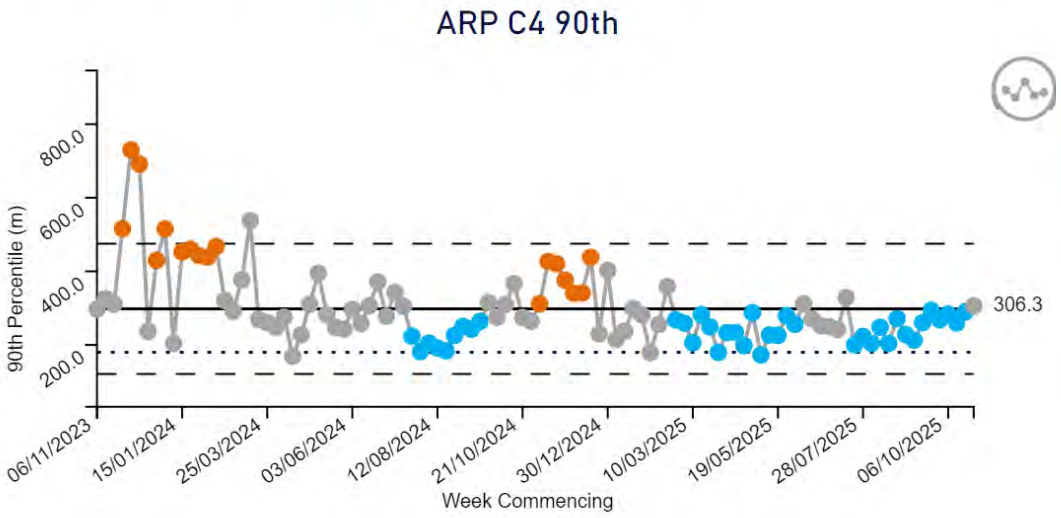
C3 90th by ICB

Cheshire & Mersey...	03:55:30
Greater Manchester	03:42:20
Lancashire & Sout...	03:10:31
North East & Nort...	03:04:47

C3 90th	
Target	01:30:00
Month	03:36:52
YTD	03:23:18
Ranking	3

BAF ID SR03

O3 ARP Response Times



C4 90th (Red => 3h)

C4 90th by Sector

G West	06:14:05
CL South Lancashire	05:40:20
G East	05:29:02
G Central	05:24:38
G South	05:16:44
M East	05:07:52
M North	04:41:56
CL North Cumbria	04:22:09
M West	03:58:14
M South	03:27:53
CL Fylde	03:09:58
CL East Lancashire	02:52:01
CL Morecambe Bay	02:38:15

C4 90th by ICB

Greater Manchester	05:31:48
North East & Nort...	04:22:09
Cheshire & Mersey...	04:20:17
Lancashire & Sout...	03:27:10

C4 90th	
Target	03:00:00
Month	04:43:06
YTD	04:05:16
Ranking	2

O3 ARP Response Times

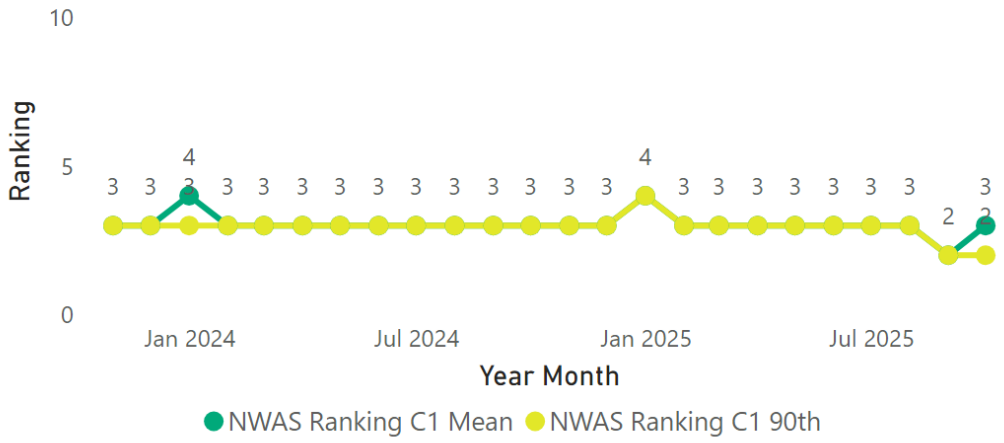
C1 mean response time remains strong and has improved in October by 3 seconds to 07m:04s. C1 90th also improved by 2 seconds against the previous month (00:12:05) and remains below the ARP target by 02m:57s.

C2 mean response times have increased this month to 27m:36s from 25m:00s in September, though performance remains within the UEC target overall. Greater Manchester and Lancashire & South Cumbria ICBs continue to meet the UEC target of 28 minutes, however no ICB or sector achieved the national standard target of 18 minutes. C2 90th percentile performance has also declined, rising to 54m:47s from 48m:11s in September. No ICB or sector met the 40-minute 90th centile target, with Cheshire and Merseyside ICB recording the highest response times.

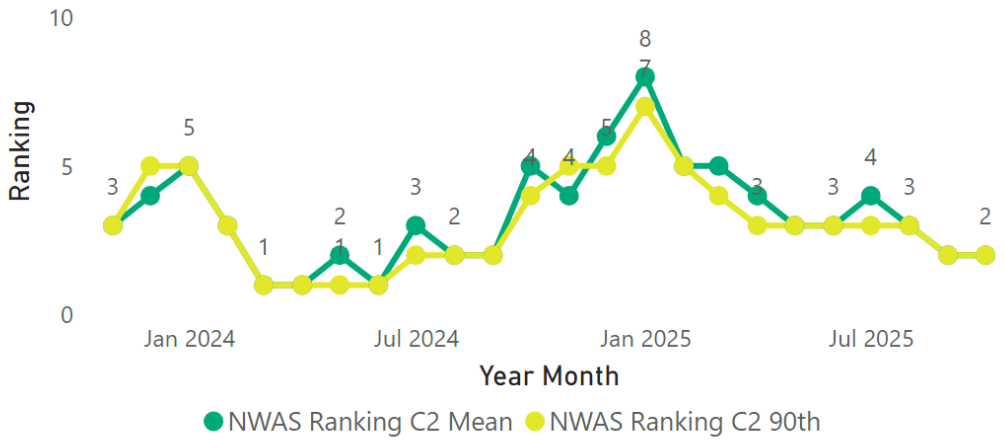
C3 mean response times have continued to deteriorate since last month, rising from 01h:33m:37s to 01h:42m:01s, which remains above the national target. All sectors have seen an increase in mean response times, with none currently meeting the target. C4 90th percentile is stable. Greater Manchester ICB has recorded the largest rise in mean response time (05:31:48), representing a 40% increase from last month.

O3 ARP Provider Comparison

C1 Mean & 90th Percentile ranking over time



C2 Mean & 90th Percentile ranking over time



C1 Mean by Trust

North East	00:06:15
London	00:07:02
North West	00:07:05
Yorkshire	00:08:00
West Midlands	00:08:06
South East Coast	00:08:24
South Central	00:08:32
South Western	00:08:59
East Of England	00:09:03
East Midlands	00:09:10
Isle Of Wight	00:09:18

C1 90th by Trust

North East	00:11:01
North West	00:12:03
London	00:12:04
Yorkshire	00:13:54
West Midlands	00:14:29
South Central	00:15:27
South East Coast	00:15:41
East Midlands	00:16:15
East Of England	00:16:48
South Western	00:16:53
Isle Of Wight	00:17:16

C2 Mean by Trust

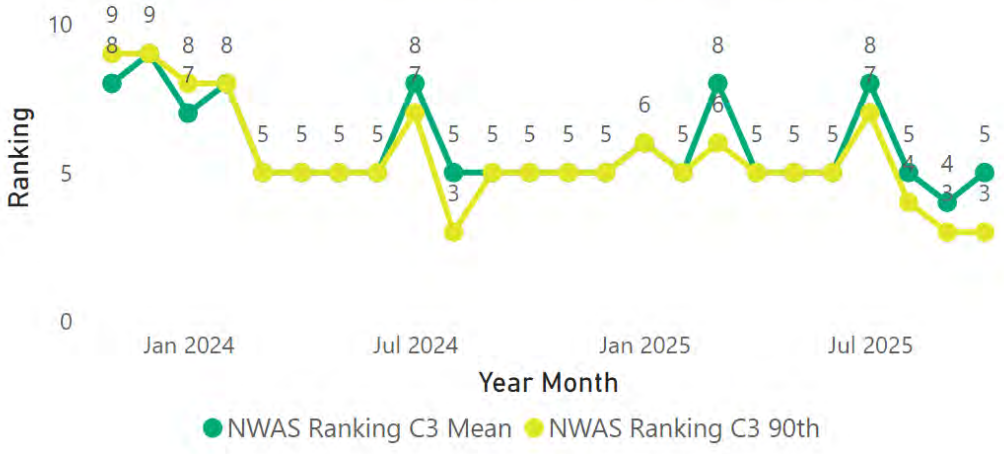
North East	00:21:14
North West	00:27:37
Yorkshire	00:28:02
South East Coast	00:28:11
London	00:30:33
West Midlands	00:31:40
South Central	00:31:54
Isle Of Wight	00:33:16
South Western	00:34:27
East Of England	00:40:41
East Midlands	00:46:55

C2 90th by Trust

North East	00:41:29
North West	00:54:47
South East Coast	00:57:05
Yorkshire	00:58:13
South Central	01:01:41
London	01:04:00
West Midlands	01:07:58
South Western	01:10:29
Isle Of Wight	01:11:49
East Of England	01:23:54
East Midlands	01:40:35

BAF ID SR03

C3 Mean & 90th Percentile ranking over time



C4 90th Percentile ranking over time

C3 Mean by Trust

North East	00:58:39
Yorkshire	01:27:49
Isle Of Wight	01:32:38
London	01:33:51
North West	01:41:15
South Western	01:47:29
South East Coast	02:07:06
East Of England	02:29:23
West Midlands	02:49:08
South Central	03:10:48
East Midlands	03:23:39

C3 90th by Trust

North East	02:15:22
Yorkshire	03:23:44
North West	03:35:10
Isle Of Wight	03:40:04
London	03:52:58
South Western	04:05:47
South East Coast	04:48:00
East Of England	05:59:23
South Central	06:49:22
West Midlands	07:13:17
East Midlands	08:58:07

C4 90th by Trust

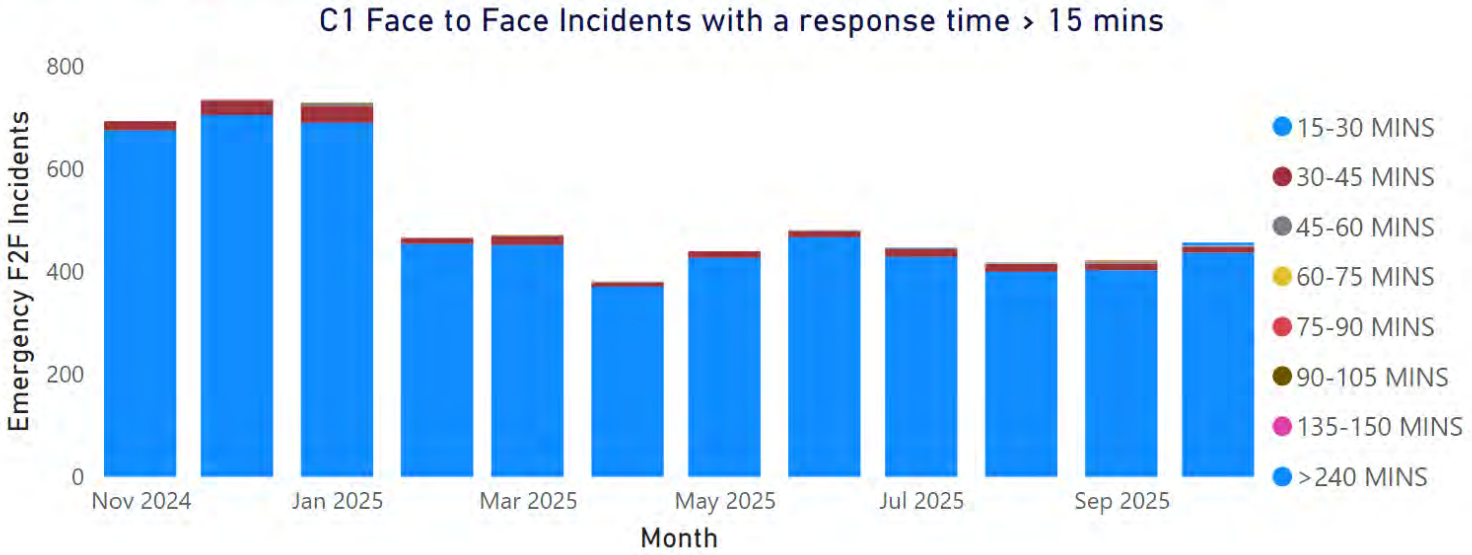
North East	03:02:06
North West	04:41:57
Yorkshire	04:47:25
South East Coast	05:05:20
London	05:42:11
Isle Of Wight	05:45:35
South Western	06:27:30
South Central	07:19:25
East Of England	07:32:38
East Midlands	11:37:33
West Midlands	11:49:59

Summary:

The Trust has maintained strong national performance for C1 and C2, with the C1 90th percentile holding its position at second nationally. The C1 Mean has dropped slightly to third place, while both the C2 Mean and 90th percentile have remained in second place.

For lower acuity categories, C3 performance have dipped, with the mean falling to fifth nationally while the 90th percentile position remains unchanged at third. C4 90th percentile performance continues in second place.

O3 Long Waits C1



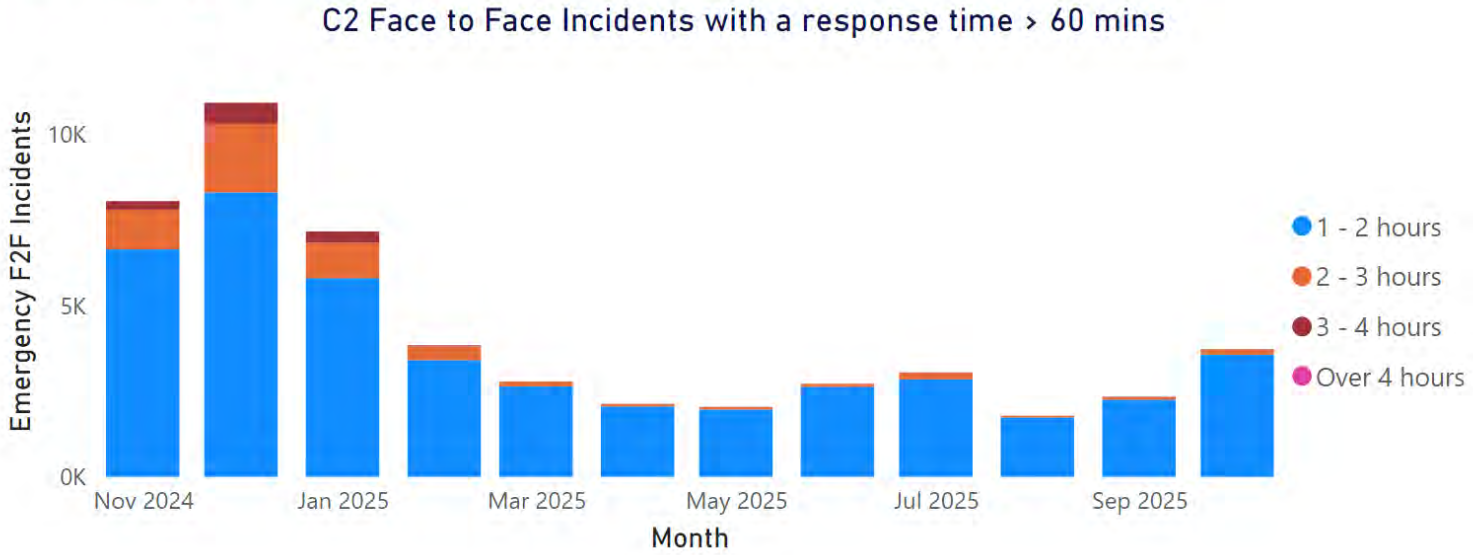
Month Year	Total No. of C1 Long Waits
Nov 2024	692
Dec 2024	735
Jan 2025	729
Feb 2025	465
Mar 2025	471
Apr 2025	380
May 2025	439
Jun 2025	480
Jul 2025	446
Aug 2025	417
Sep 2025	421
Oct 2025	456

Summary:

In October 2025, the number of Category 1 long-wait incidents rose to 456, marking an 8.3% increase compared to September (421). Notably, 6 of these incidents involved wait times exceeding 240 minutes. However, Category 1 long-waits have decreased by 33% compared to October 2024 (682).

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

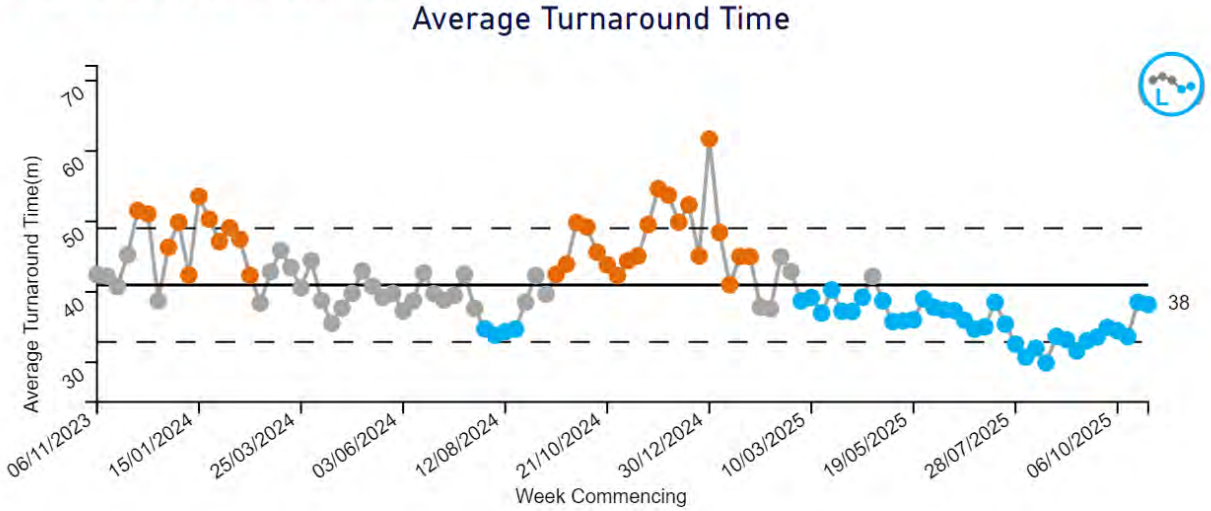


Month Year	Total No. of C2 Long Waits
Nov 2024	8,048
Dec 2024	10,920
Jan 2025	7,163
Feb 2025	3,840
Mar 2025	2,784
Apr 2025	2,132
May 2025	2,041
Jun 2025	2,719
Jul 2025	3,048
Aug 2025	1,787
Sep 2025	2,339
Oct 2025	3,732

Summary:

In October 2025, Category 2 long-wait incidents increased significantly to 3,732, representing a 59.6% rise from September (2,339). However, Category 2 long-wait incidents for this month have decreased by 51.5% compared to October 2024 (7,699).

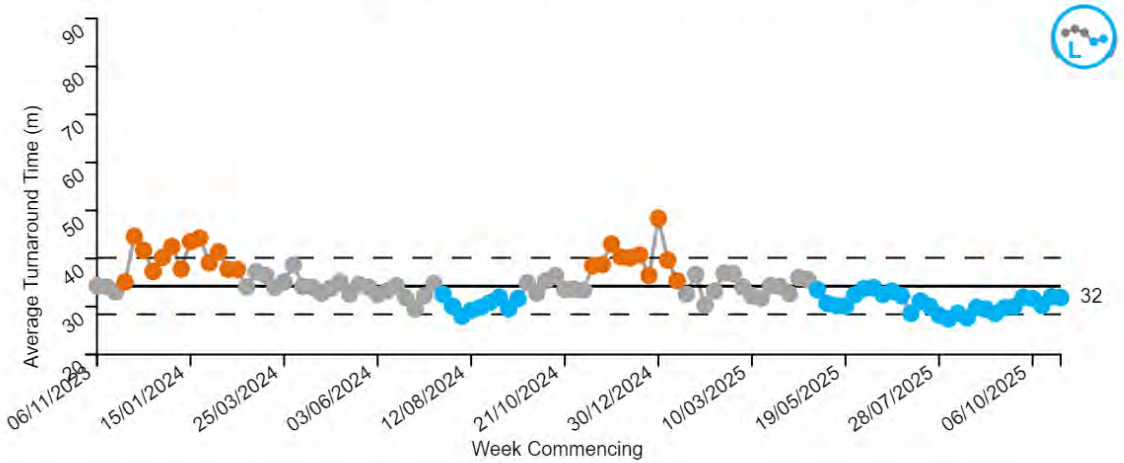
O3 A&E Turnaround



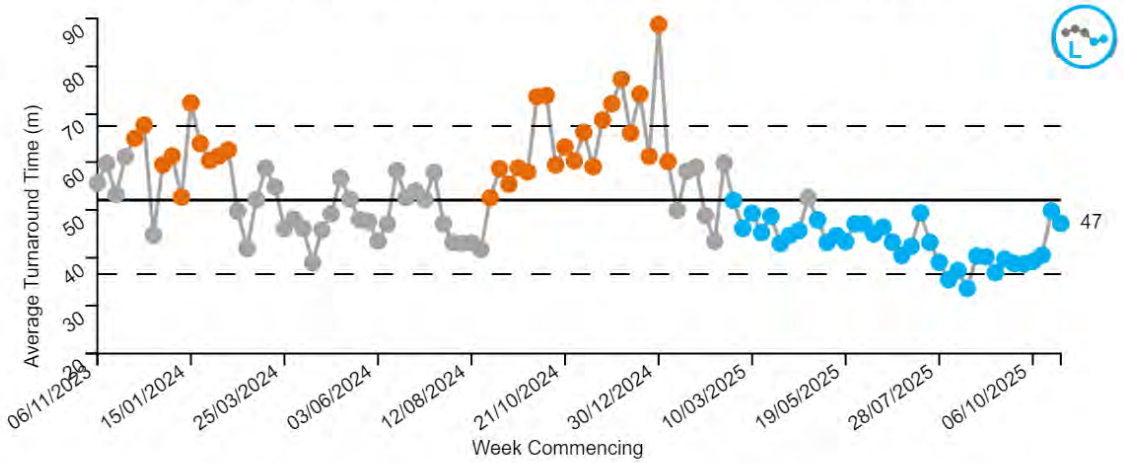
Month	Hospital Attendances	Average Turnaround Time(hh:mm:ss)	Average Arrival to Handover Time (hh:mm:ss)	Average Handover to Clear Time(hh:mm:ss)
Oct 2024	49,175	00:46:46	00:38:06	00:08:56
Nov 2024	47,828	00:47:10	00:38:36	00:08:55
Dec 2024	49,454	00:51:07	00:42:22	00:08:59
Jan 2025	48,251	00:47:49	00:39:23	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
Sep 2025	47,965	00:33:16	00:24:23	00:08:58
Oct 2025	50,740	00:35:49	00:26:54	00:09:03

O3 A&E Turnaround by ICB

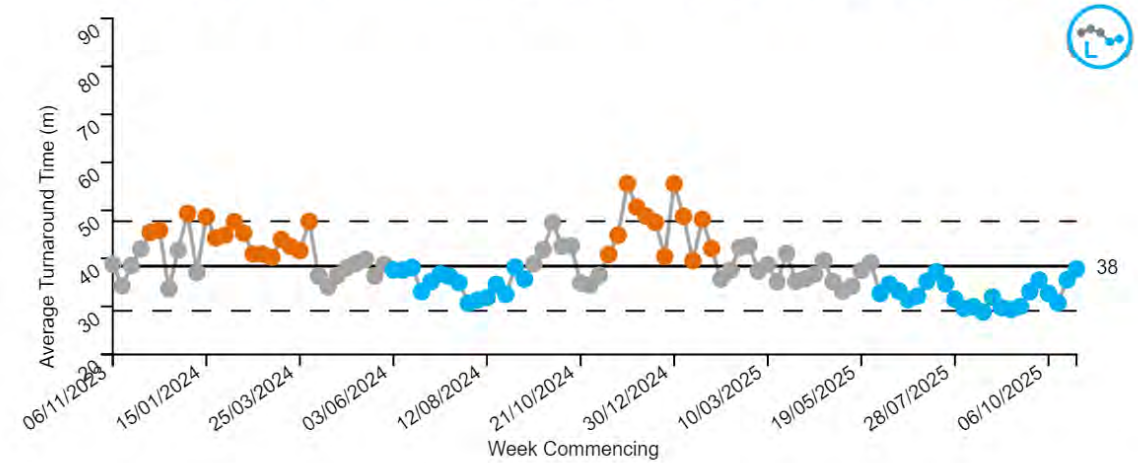
Average Turnaround Time - Greater Manchester ICB



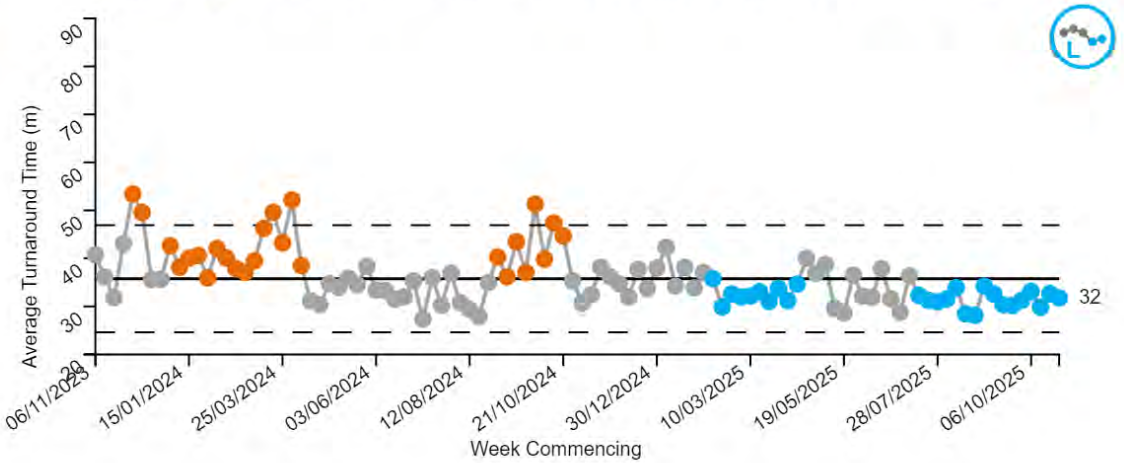
Average Turnaround Time - Cheshire & Mersey ICB



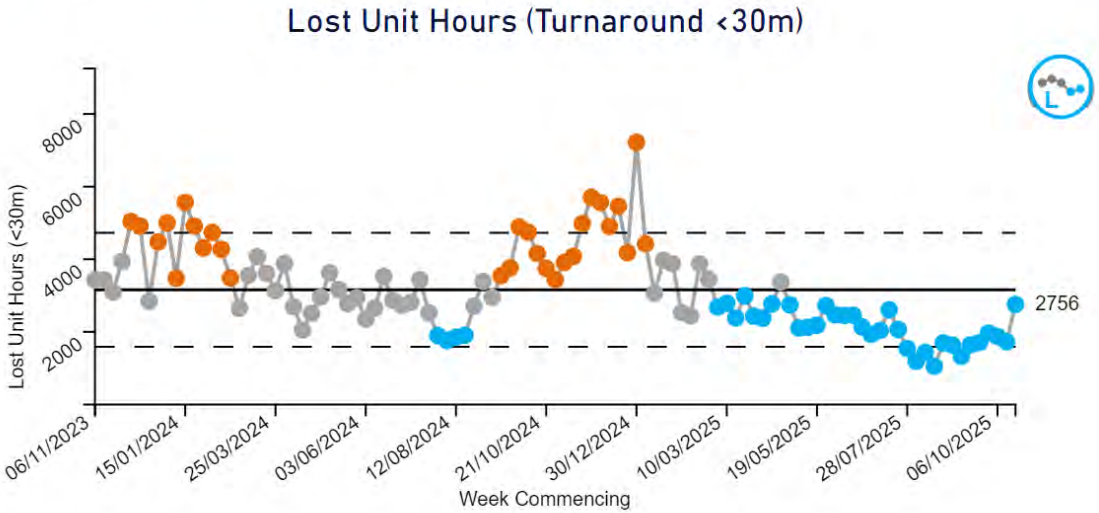
Average Turnaround Time - Lancashire & South Cumbria ICB



Average Turnaround Time - North East & North Cumbria ICB



O3 A&E Turnaround



Month	No. of patients waiting outside A&E for handover
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
Sep-25	923
Oct-25	1392

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)
Aintree University	2,320	1526.67	01:03:35	00:53:17	00:11:04
Whiston	2,438	927.96	00:49:08	00:38:23	00:10:50
Royal Liverpool University	2,557	772.67	00:45:19	00:34:44	00:10:47
Royal Oldham	1,922	569.64	00:42:33	00:33:43	00:08:46
Blackpool Victoria	2,562	604.02	00:39:05	00:29:54	00:09:28

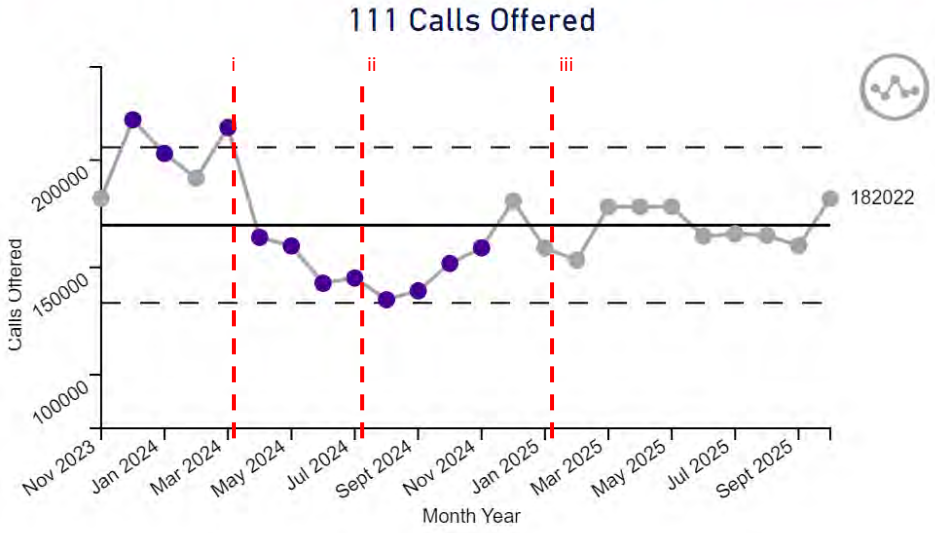
Summary:

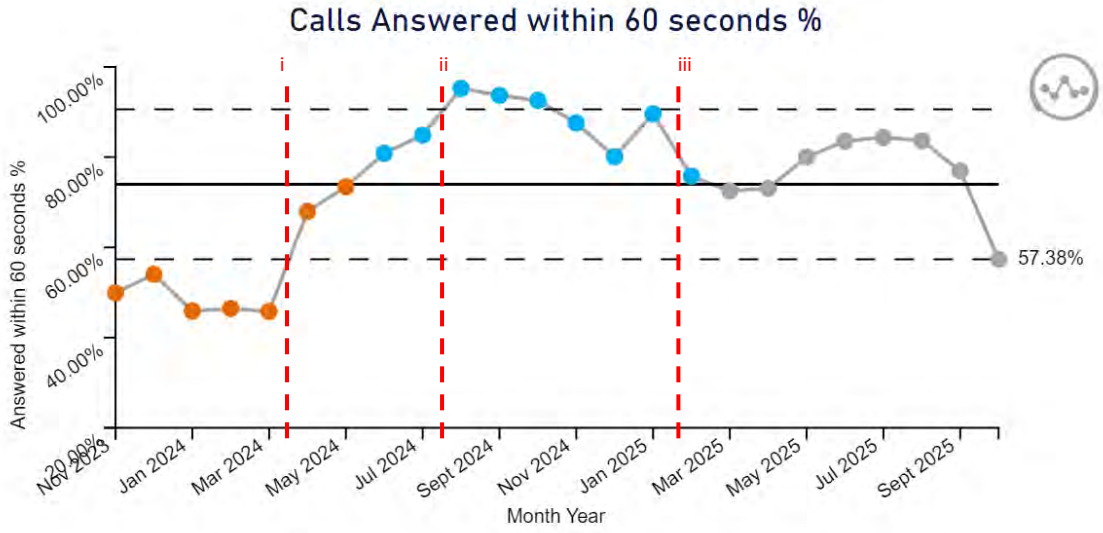
The average turnaround time for October 2025 was 35m:49s, increasing by 2 minutes and 33 seconds from 33m:16s in September. Lost Unit Hours are within normal levels but have seen an increase in October. Aintree University Hospital has the largest single volume of lost hours at 1,526 hours.

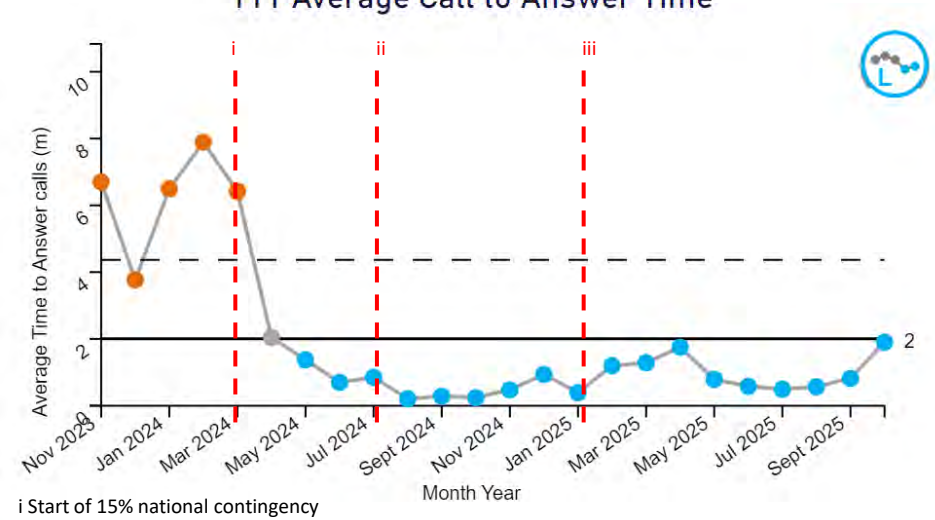
Action:

The Handover in 45 minutes (HO45) rapid release system, which allows crews to initiate a rapid handover for any patient waiting over 45 minutes outside the Emergency Department (ED), started on August 1st. Although handover improvements are observable, this is in line with previous years and monitoring into the winter pressure period is required to understand whether the intervention is a causal factor.

04 111 Activity & Performance







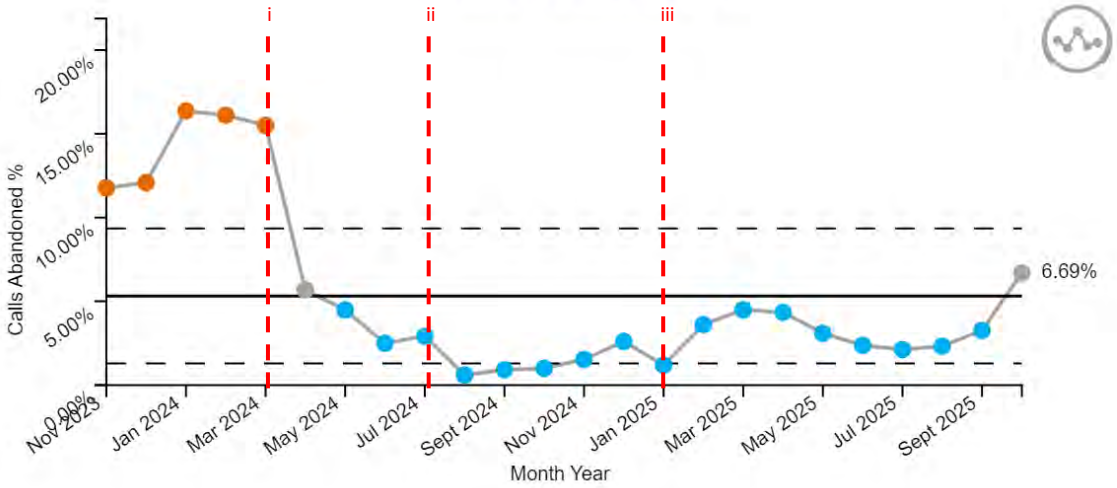
Calls Offered	
Month	182.02K
YTD	1,193,769

Calls Answered within 60 Seconds %	
Target	95%
Month	57.38%
YTD	76.9%
National	81.2%
Ranking	28

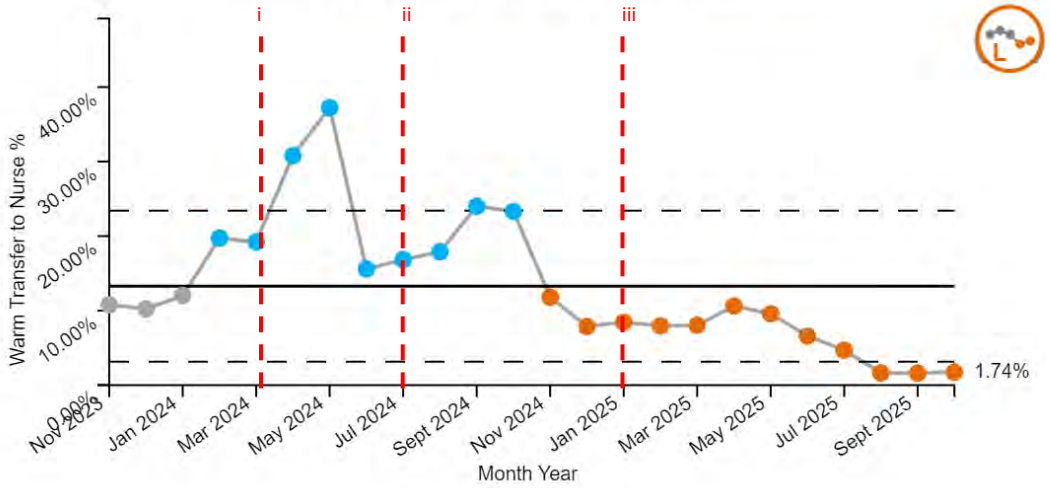
Average Call to Answer Time (s)	
Target	<20
Month	114
YTD	60
National	47
Ranking	26

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 Calls Abandoned %



Warm Transfer to Nurse When Required %

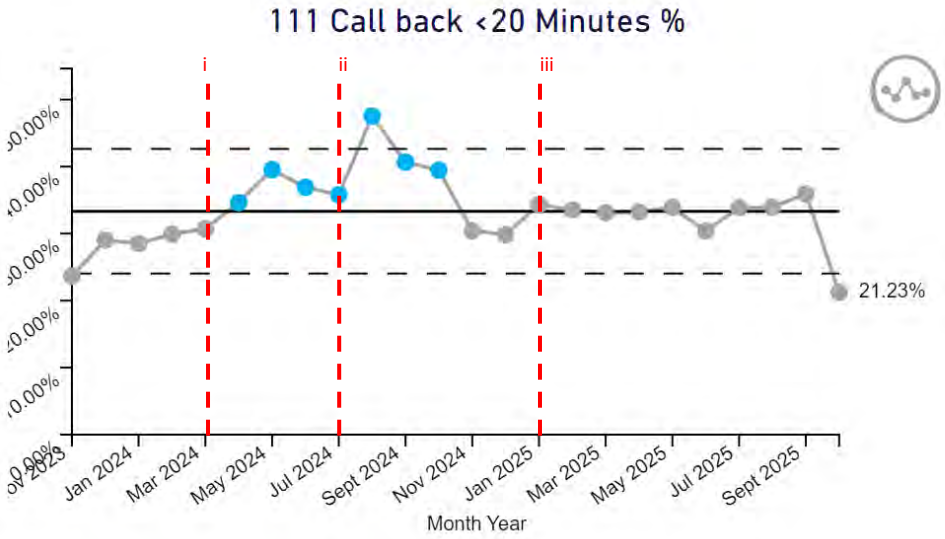


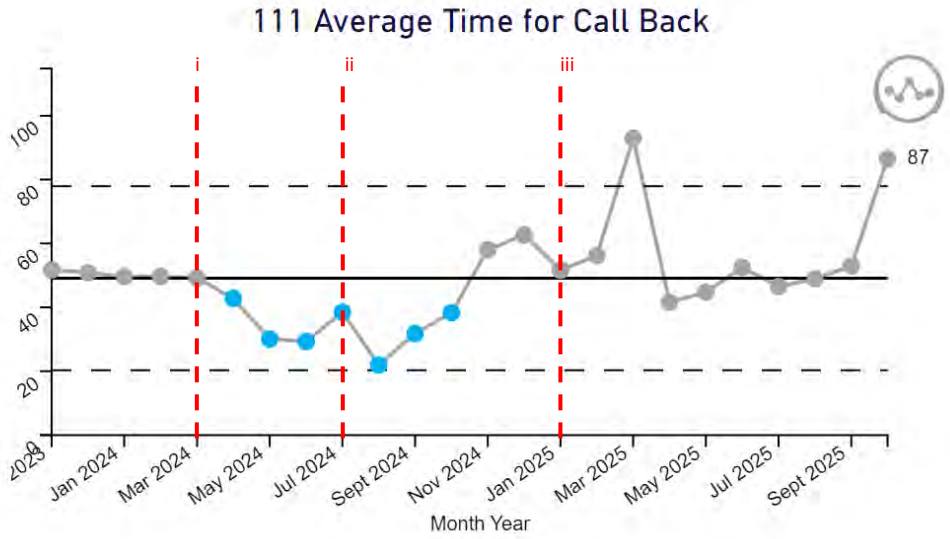
Calls Abandoned %	
Target	<5%
Month	6.69%
YTD	3.51%
National	3.1%
Ranking	27

Warm Transfer %	
Target	75%
Month	1.74%
YTD	5.31%

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

BAF ID SR03





Call Back <20 (m)	
Target	90%
Month	21.23%
YTD	31.87%

There was a 13.6% increase in 111 demand during October, with calls offered rising to 182,022. Call answering performance within 60 seconds fell significantly to 57.3%, with a corresponding abandonment rate of 7%. Nationally, the Trust is performing near the bottom of the league tables, ranking lowest for answer in 60 seconds and second-lowest for call abandonment.

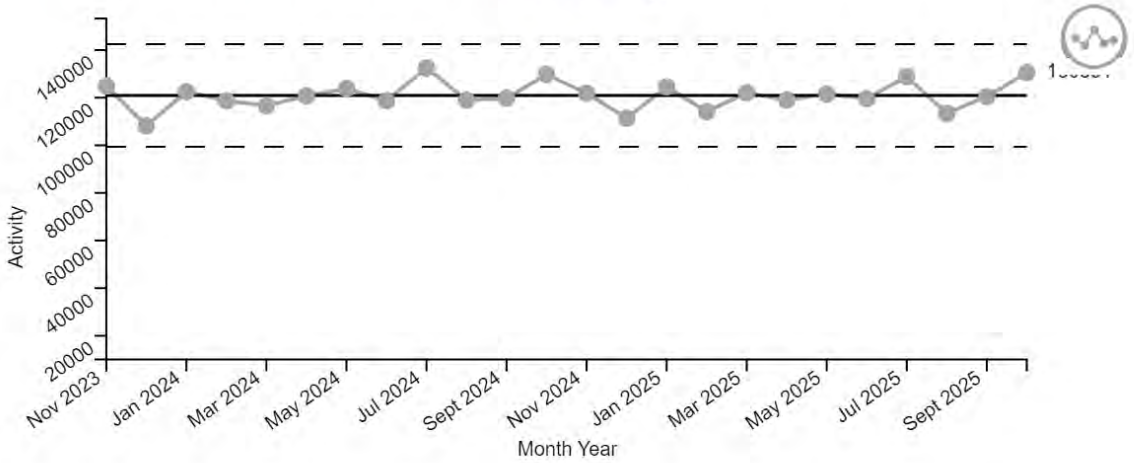
Call back in 20 has fallen to 21.23% and average call back increased to 87 seconds.

Contributing factors included increased demand, higher than usual staff sickness in late October and cross-skill training activity linked to ICC.

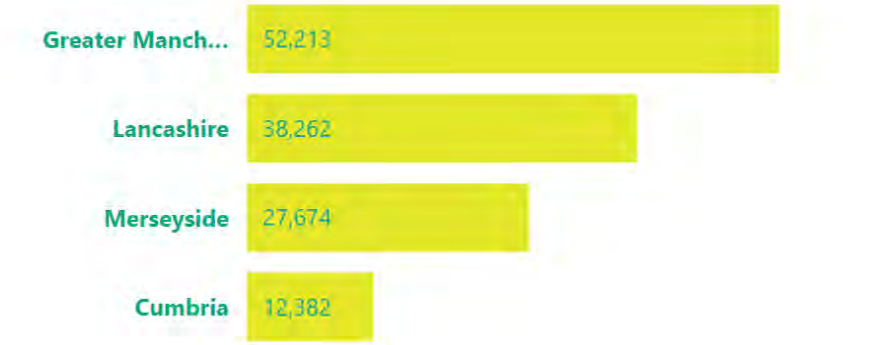
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency
Iv 14th July Clinicians stopped taking front end calls

05 PTS Activity

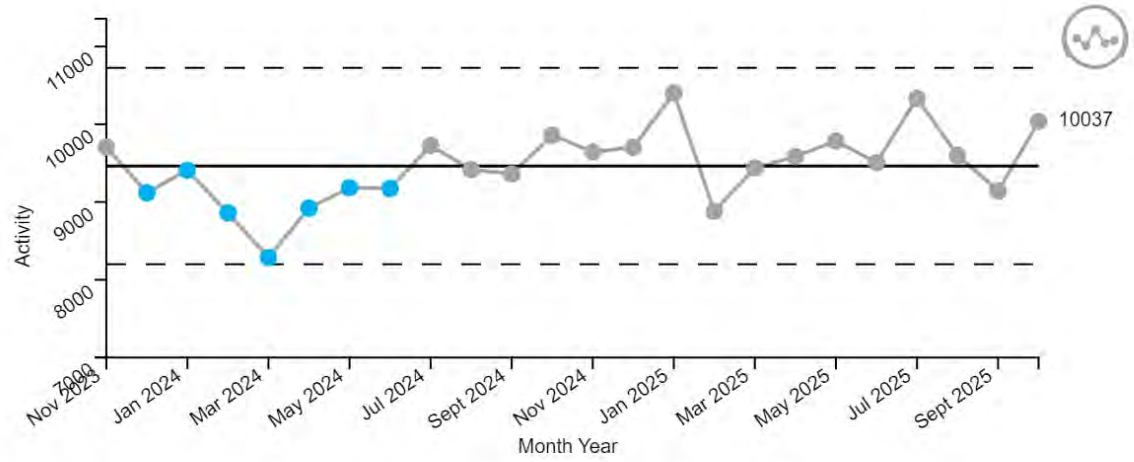
Total Activity



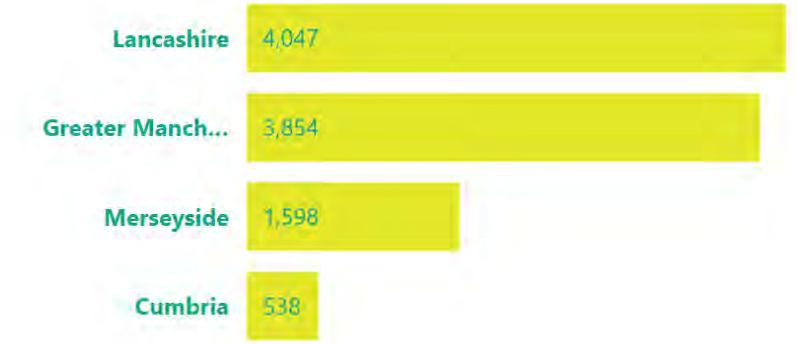
Total Activity by Contract



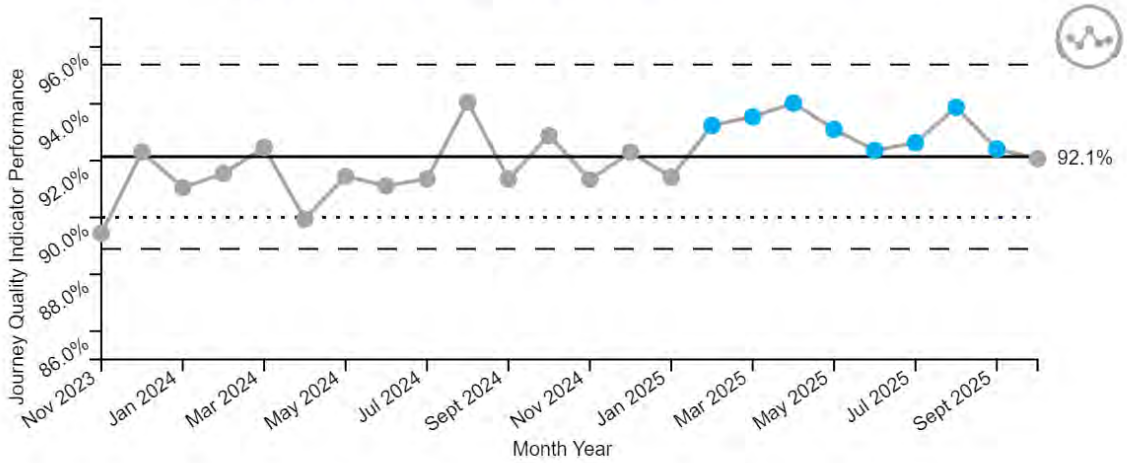
Unplanned Activity



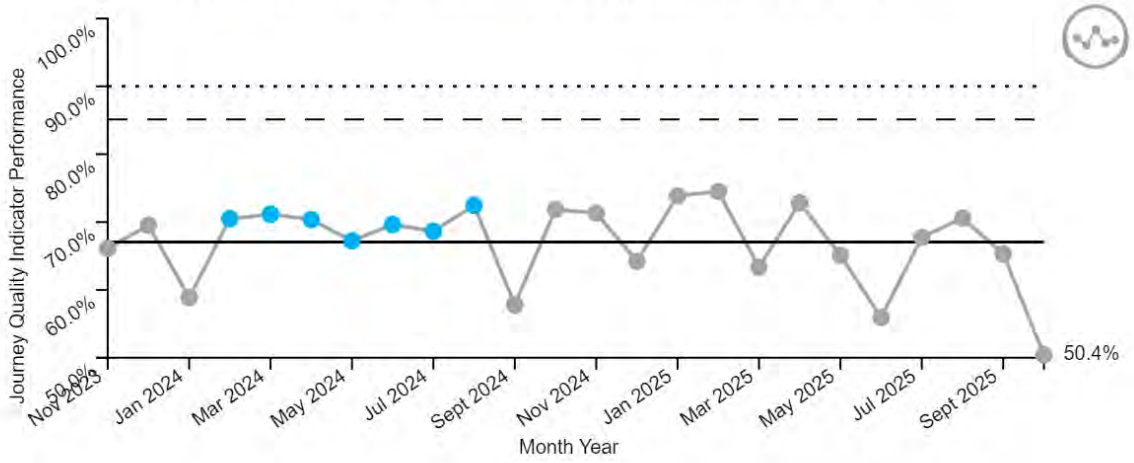
Unplanned Activity by Contract



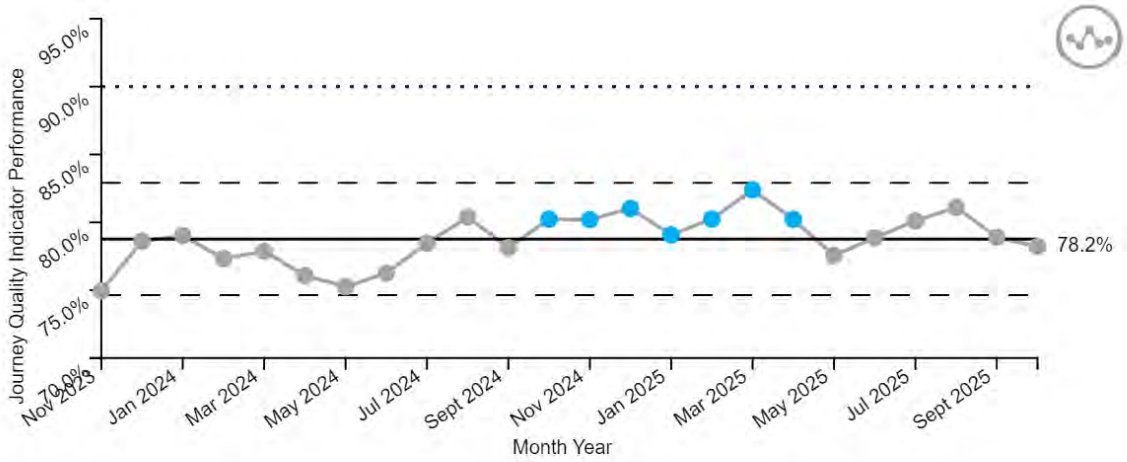
Collection after treatment (EPS) within 90 min



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, with collection after unplanned treatment within 90mins falling significantly to 50%

Only EPS achieved the collection after treatment target of 90%

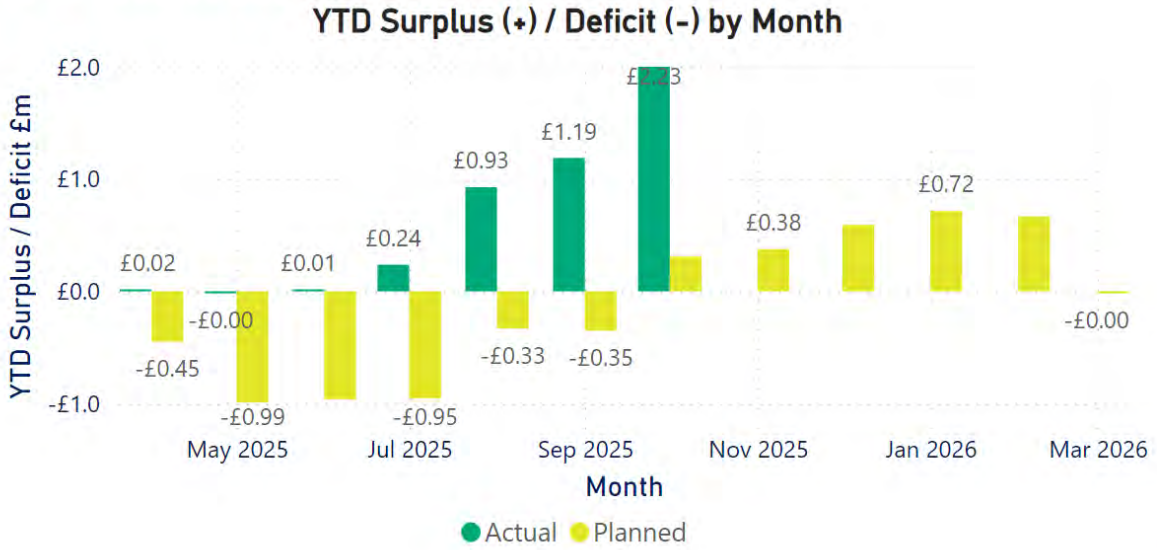
Actions:

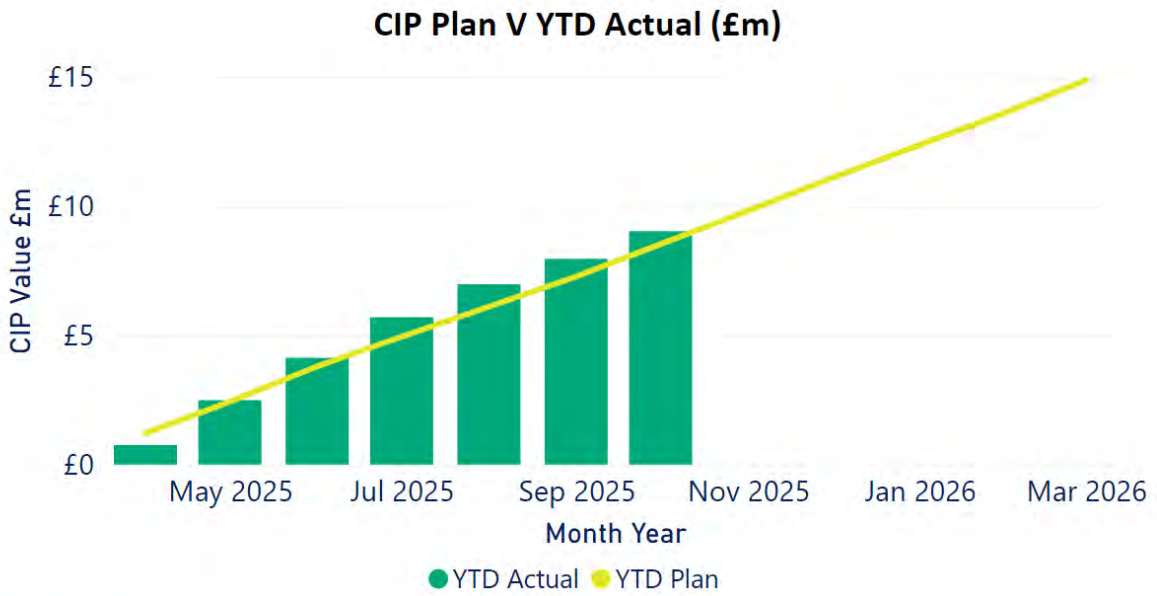
Operational and workforce improvement plans are in place

Finance

F1 Financial Score

F1 Financial Score



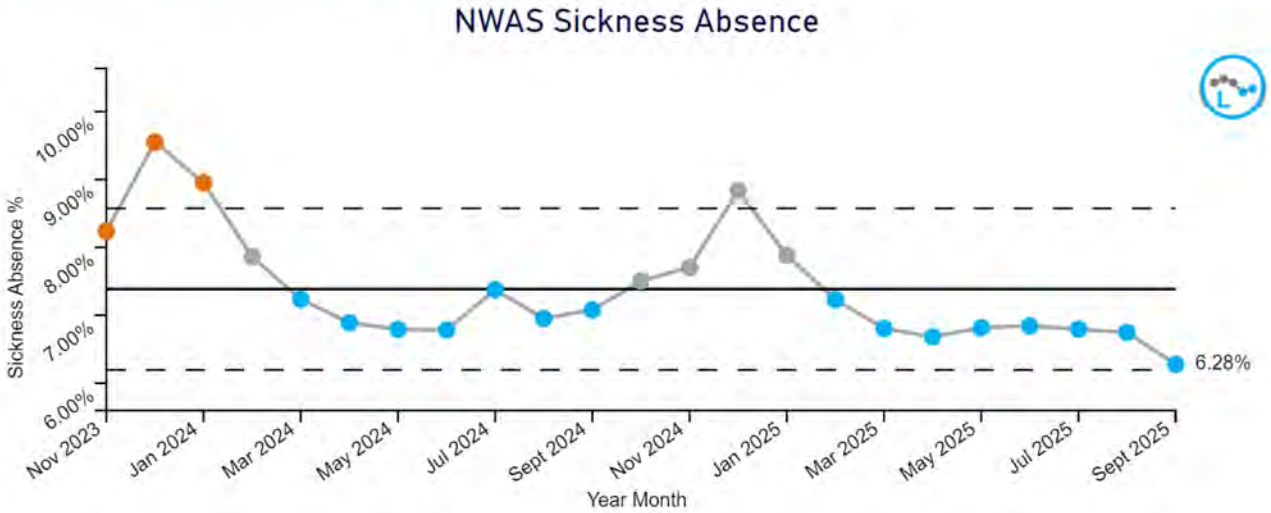


The year-to-date financial position to 31 October 2025 (Month 07 2025/26) is a surplus of £2.232m, compared to a planned surplus of £0.311m. This is due to vacancies in various Directorates, non-recurrent credits received and the delivery of productivity and efficiency savings above plan.

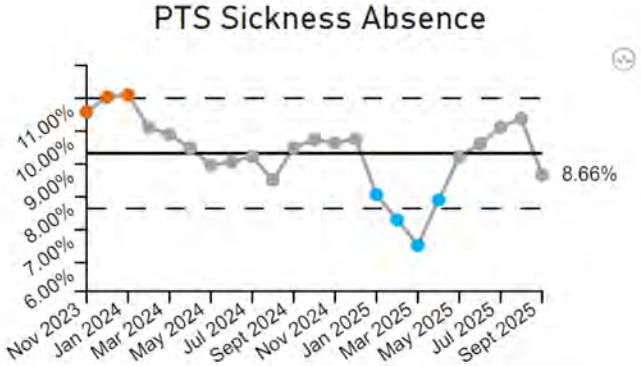
Organisational Health

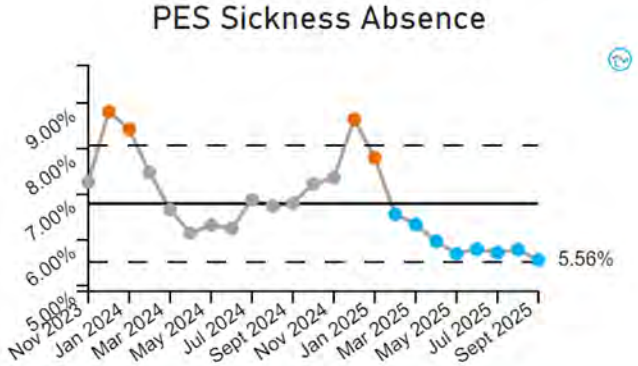
OH1 Staff Sickness
OH2 Staff Turnover
OH5 Vacancy Gap
OH6 Appraisals
OH7 Mandatory Training
OH8 Case Management

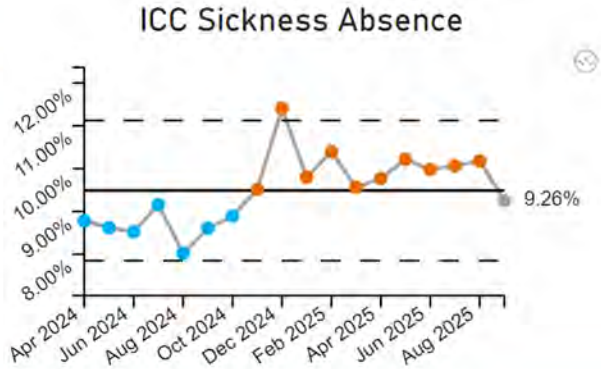
OH1 Staff Sickness



Month	NWAS	Amb. National Average
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%	6.50%
Apr 2025	6.68%	6.30%
May 2025	6.82%	6.20%
Jun 2025	6.84%	6.40%
Jul 2025	6.79%	6.70%
Aug 2025	6.75%	6.80%
Sep 2025	6.28%	







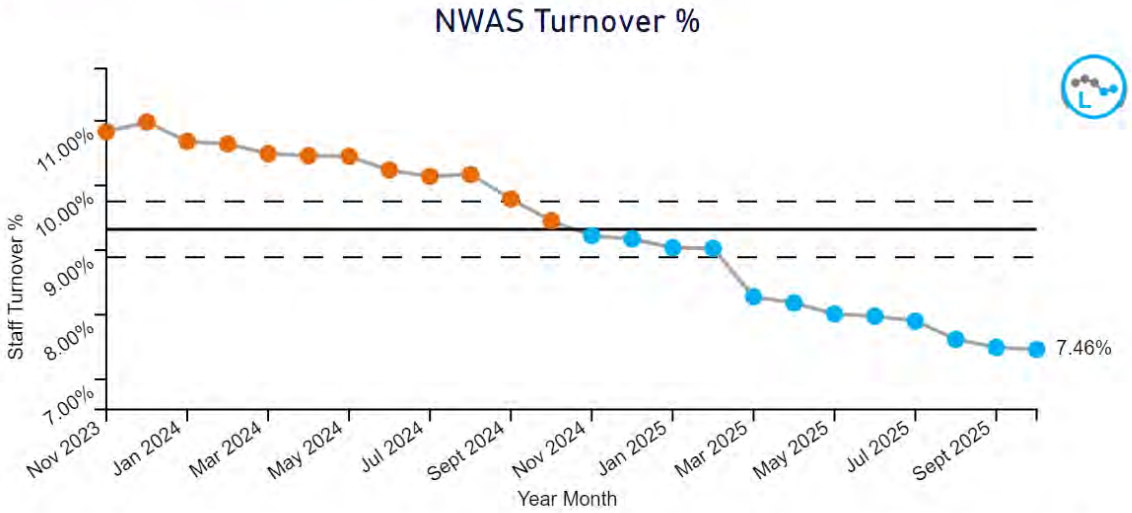
New ICC reporting
The new Phase 3 ESR structure for ICC reporting is active from 1st Oct 25. EOC, 111 and PTS Bureau now fall under the ICC umbrella and cannot be reported on separately going forwards. We have calculated some indicative historic data for ICC from Apr 24 to Sep 25 in order to be able to show any general trends in the charts. This data is a combination of EOC, 111 and PTS Bureau but should not be taken as exact. From Oct 25 onwards the data for ICC should be exact. From Oct 25 onwards PTS Bureau will be removed from the PTS data (but not historically).

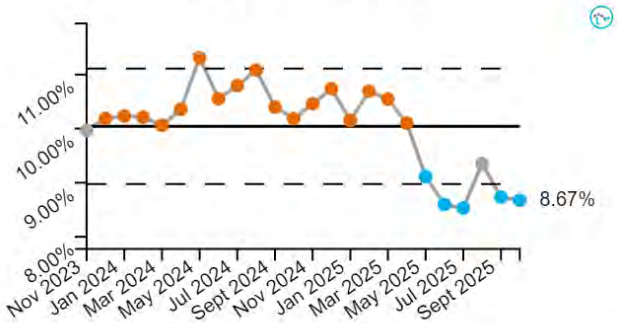
Sickness
Sickness overall has reduced slightly from 6.75% in August 25 to 6.28% in Sep 25. Only Corporate area has seen a rise but this is still below 3%. NWAS dropped below national average for the first time in August.
For clarity PTS sickness includes PTS Bureau for Sept 25. PTS Bureau will be removed from the PTS sickness figures in the next round of reporting. This is because we are always a month behind with sickness reporting due to the ETAD system.

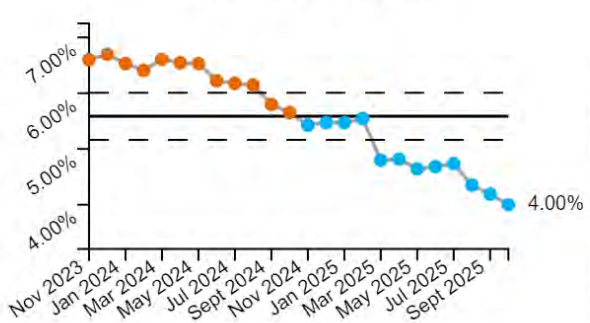
BAF ID SR04

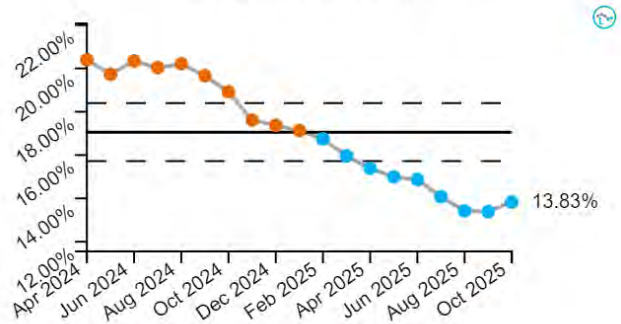
OH2 Staff Turnover

Month	NWAS	Amb. National Average
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%	9.09%
Jul 2025	7.90%	9.40%
Aug 2025	7.62%	
Sep 2025	7.50%	
Oct 2025	7.46%	





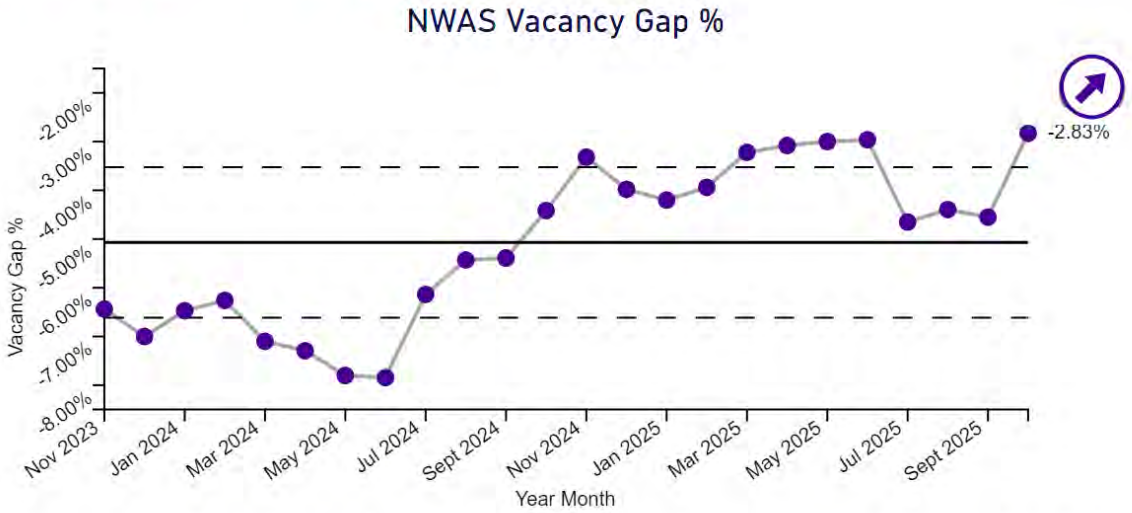




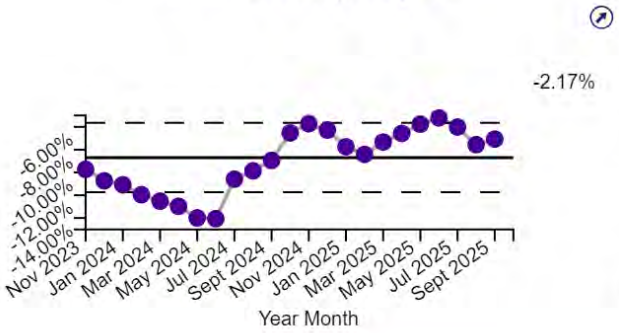
Turnover remains stable/reducing overall with PES reducing to 4%.

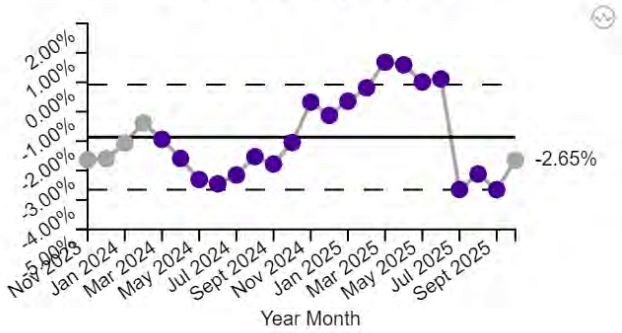
BAF ID SR05

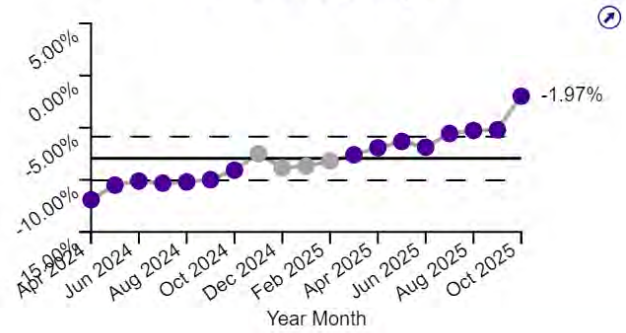
OH5 Vacancy Gap



Month	NWAS Total % Vacancy Gap
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%
Sep 2025	-4.55%
Oct 2025	-2.83%



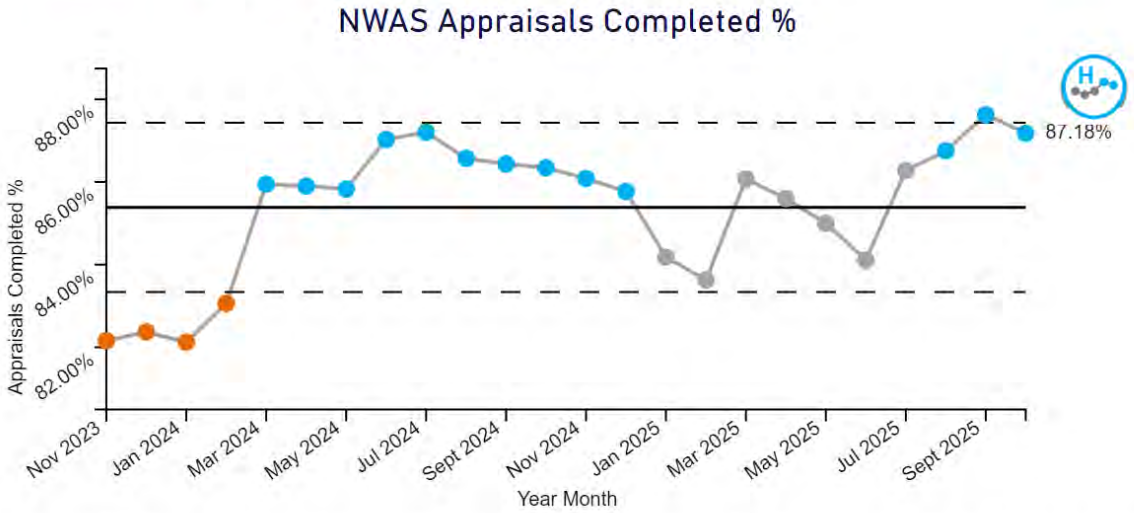




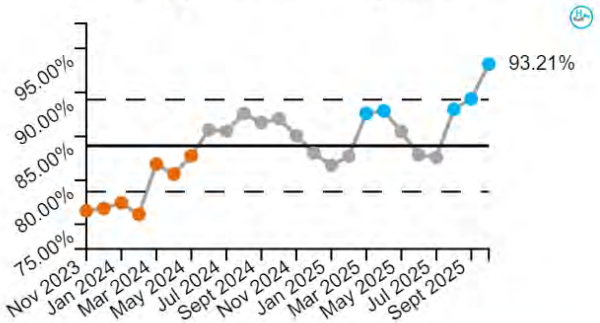
The overall vacancy gap has reduced from -4.55% in Sep 25 to -2.83% in Oct 25 and has reduced significantly for ICC. This is due to a combination of an overall reduction in establishment WTE in line with the ICC new structure and additional new starter WTE.

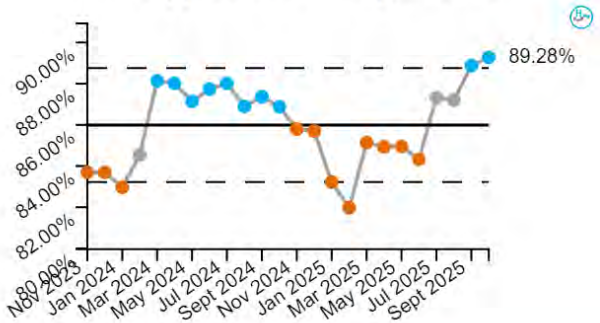
BAF ID SR04

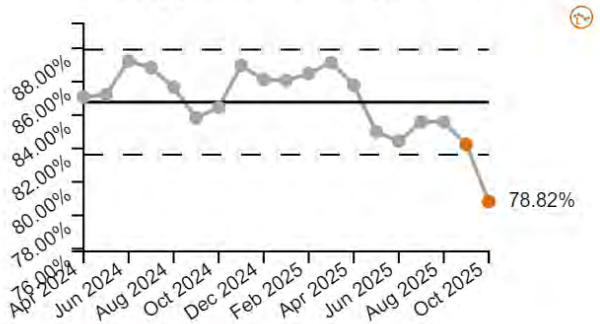
OH6 Appraisals



Month	NWAS Total % Complete Appraisals
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%
Sep 2025	87.63%
Oct 2025	87.18%





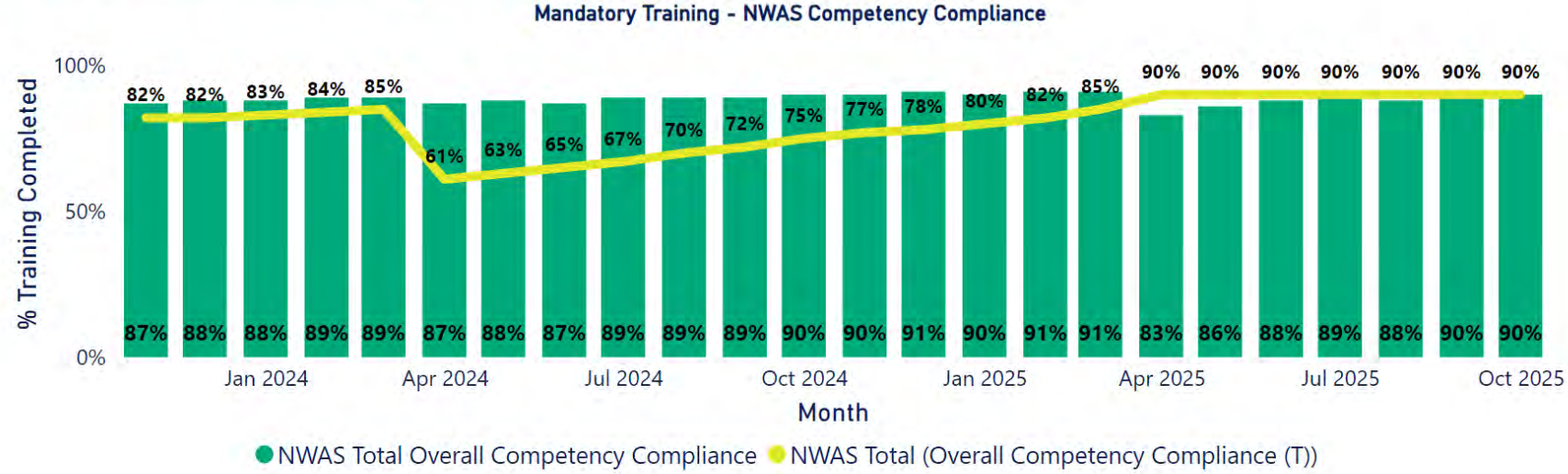


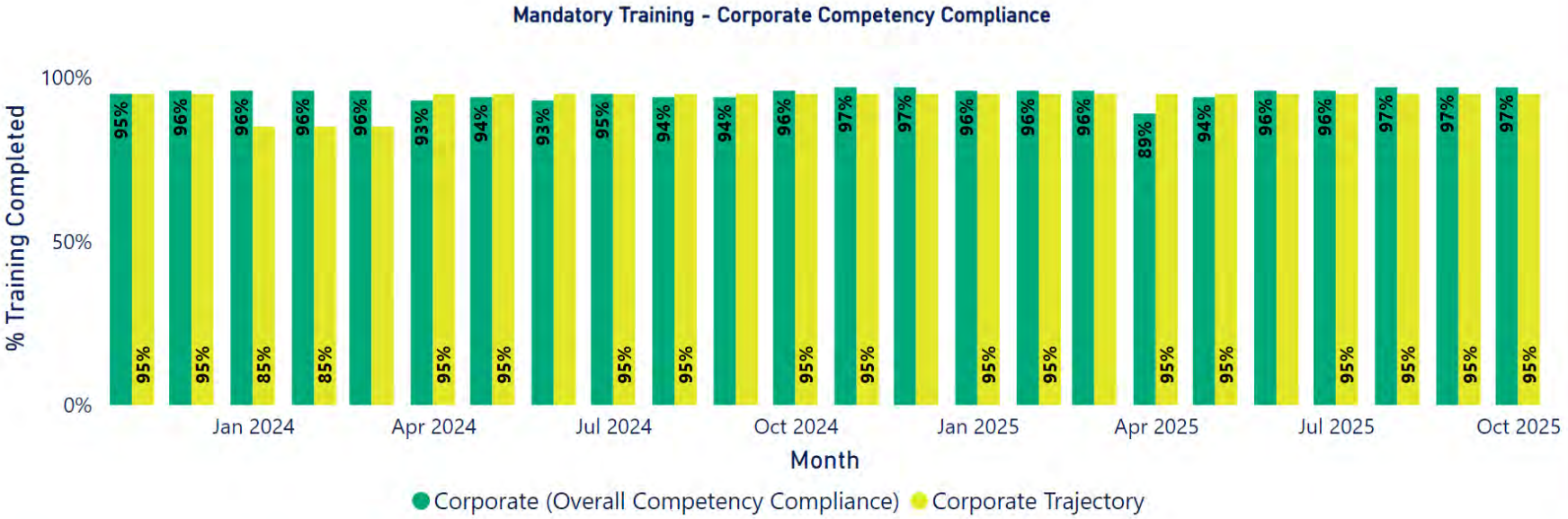
Overall appraisal compliance remains at above the 85% target. PTS have shown a significant improvement, this is due to PTS Bureau being removed from their figures.

ICC has dropped below 80% to 78.8% and a recovery plan is required to improve this position.

BAF ID SR05

OH7 Mandatory Training



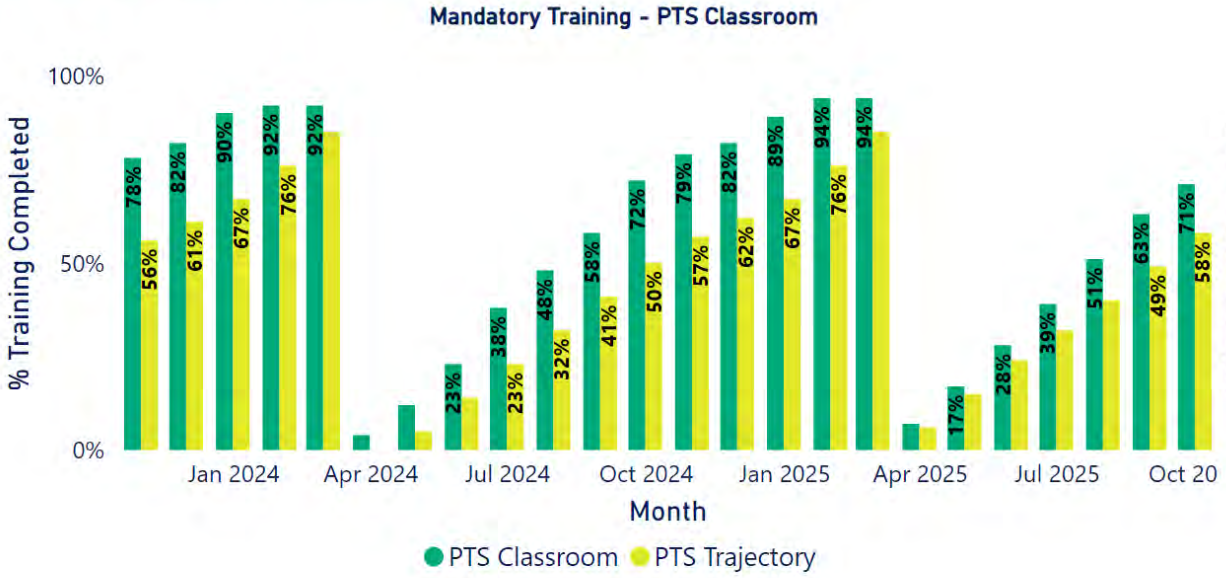


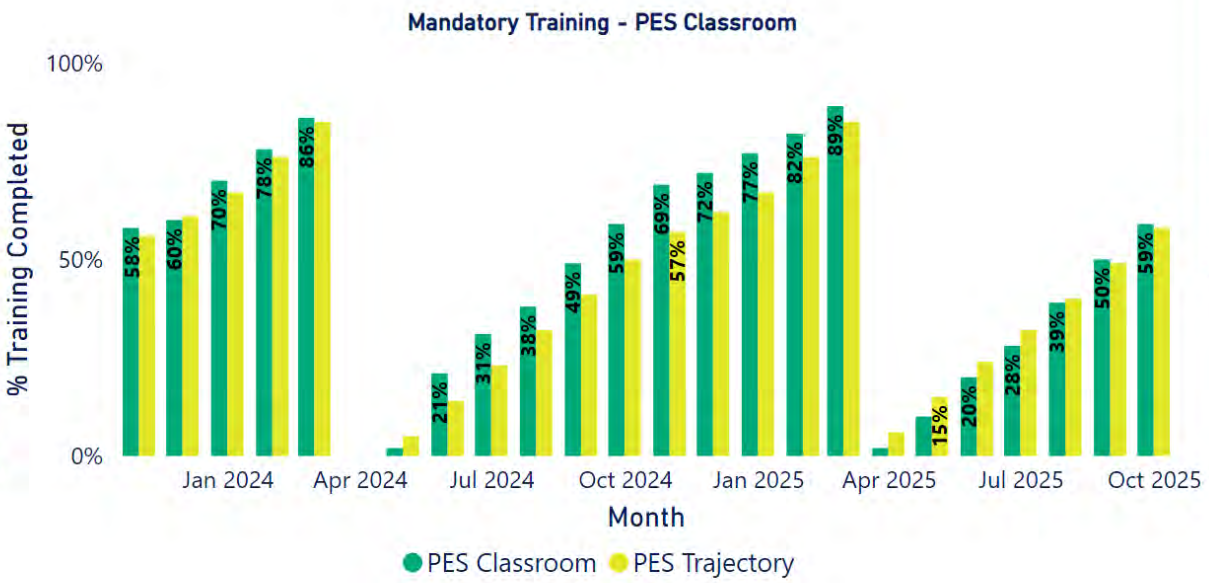
NWAS Overall Competency compliance remains at 90%.

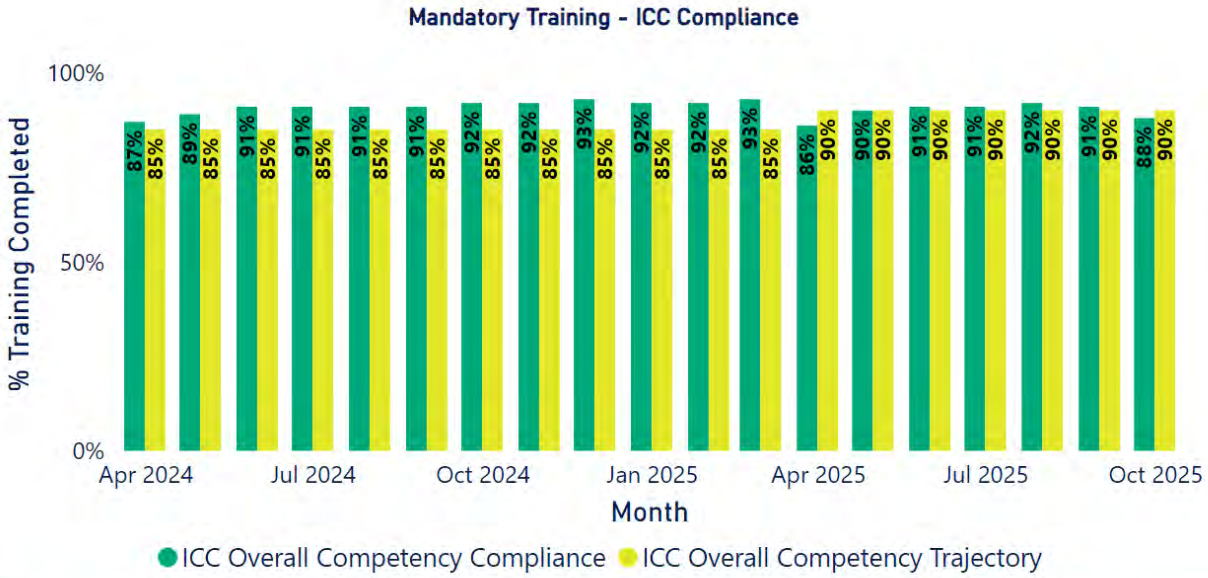
Corporate compliance is above the 95% target.

BAF ID SR05 Risk Rating NA Strategy Goal NA

OH7 Mandatory Training







Classroom attendance for both PES and PTS is above the 58% target.

ICC overall competency compliance has dropped to 88% however, there are still adjustments to be made to some positions and their mandatory training requirements following the restructure. We expect this work to be completed, with the cooperation of ICC, before the next round of reporting in December.

BAF ID SR05 Risk Rating NA Strategy Goal NA

OH8 Case Management

Board Reportable Events relating to Employee Relations November 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	70.00	1.7	262.00	6.3	14.37
CAM PES	32.00	2.3	83.00	5.9	14.39
CAL PES	24.00	1.8	98.00	7.5	12.17
GM PES	14.00	1.0	77.00	5.3	16.88
Operations ~ ICC	29.00	1.47	160.00	7.68	8.17
Operations ~ PTS	9.00	1.2	95.00	12.1	9.65
Operations ~ Resilienc	0.00	0.0	4.00	2.8	11.07
Corporate	1.00	0.1	20.00	2.4	15.59
Other	0.00		0.00		
NWAS Summary	109.00	10.7	541.00	6.9	9.31

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	13	51	10.00
Disciplinary	52	166	18.31
Fast Track	1	52	10.8
Fact Finding	20	189	3.73
Grievance	24	135	5.82
Case Summary	109	541	9.31

Case Dismissals in October 2025

Service Line	Case Type	Case Sub Type	Case Closed Date
PTS	ABS LTS	Non work related	01/10/25
PTS	ABS LTS	Non work related	01/10/25
PES CAL	Disciplinary	Gross misconduct	22/10/25

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	5	4	3	1
Disciplinary	18	25	7	2
Fact Finding	19	1	0	0
Grievance	19	4	1	0
Case Total	61	34	11	3

New Litigation cases in October 2025

Service Line	Case Type	Case Sub Type	Information Category	Received Date
Corporate	Litigation	Unfair dismissal	N/A	06/10/2025

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

Opening reason	Number of cases in 12 months
Inappropriate / Unprofessional Behaviour	37
Lateness	13
Failure to follow reasonable management instructions/procedures	11
Incapacity through alcohol/substance misuse	9
Sexual misconduct	9
NWAS Summary	79

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

Suspended	Alternate Duties
8	4

Live cases at 109, a drop from 150.

Average cases times reduced from 11 weeks to 9.3 weeks.

3 dismissals in October, 2 long term sickness (capability) and 1 conduct case.

BAF ID SR05 Risk Rating NA Strategy Goal NA

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 26 November 2025
SUBJECT	Learning from Deaths - Summary Report and Dashboard Q1 2025/26
PRESENTED BY	Dr Chris Grant – Executive Medical Director
PURPOSE	Assurance

LINK TO STRATEGY	Quality Strategy										
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐	**SR05**	☐	
	SR06	☐	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐	**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 ongoing engagement with the formal process of 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 annual summary of learning. The Q1 dashboard (Appendix A) describes the opportunities to learn from deaths. The main concerns raised internally and externally identified in DatixCloudIQ (DCIQ), were attributed to problems in Integrated Contact Centre (ICC) and Paramedic Emergency Service (PES). This was specifically call handling and dispatch errors, equipment malfunction, care, and treatment. 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 triage tools are used and applied correctly. The quality of patient records has dropped this quarter, with 33% receiving a "poor" or "very poor" rating, compared to 23% in the previous quarter. There were three patient records that received a "good" rating for quality, which is the same as in the previous quarter. The panel continues to welcome observers to help raise awareness of the project and embed learning from the peer reviews. During this quarter, there have been challenges in extracting data on deaths with concerns raised within the DCIQ system. As a result, the reported figures may appear lower compared to previous Q1 reports. Recent changes to the DCIQ modules have affected the search criteria used to identify these cases. While a permanent resolution has not yet been implemented, work is ongoing in collaboration with the DCIQ team and module leads to address and resolve the issue. While work on the restructuring of the ICC remains ongoing, panel member availability has been notably strong this quarter. Close liaison with clinical panel members has continued, ensuring panels remain quorate and appropriately composed to facilitate comprehensive case review and moderation. All cases within scope for this quarter have been successfully reviewed and moderated.
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	Monday, 27 October 2025
	Outcome	Supported

1. PURPOSE

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

Appendix A is a summary dashboard of the Q1 2025/26 Learning from Deaths review, and it is proposed this document is published on the trust's public accounts in accordance with the national framework and trust policy. The dashboard includes output from moderation panels held following the structured judgement reviews for Q1. 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 safe systems for the delivery of care to our patients. The trust must identify suboptimal care and support the identification of areas for improvement. The methodology is available on request from the clinical audit team at Learning.FromDeaths@nwas.nhs.uk.

3. LEARNING FROM DEATHS COHORT SUMMARY

3.1 The number of patients whose deaths were identified as in scope for review was 66 (48 concerns raised in Datix and 18 sampled for SJR).

3.2 Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 22/07/2025. 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:

- 37 internal concerns were raised through the Incidents Module (Events).
- 11 external concerns were raised through the Patient Experience Module (Feedback).
- Zero concerns raised both internally and externally

3.2.1 Internal Concerns

Of the 37 internal concerns, 19 were reviewed and closed. There were zero cases in which the investigation concluded the trust had contributed in some way to that patient death.

3.2.2 External Concerns

Of the 11 external concerns that have been reported, three 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. Eight concerns have been closed with no causal factors identified.

3.2.3 Outcomes from concerns raised

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

3.2.4 DCIQ Updates

During Q1, the ability to extract cases where concerns were raised has been impacted by recent updates to the DCIQ system. Although a permanent resolution is not yet in place, the DCIQ team is working collaboratively with module leads to develop alternative methods for identifying cases that meet the Learning from Deaths criteria.

As a result, the reported numbers for this quarter may appear lower compared to previous years. It is anticipated that, once a suitable solution is implemented, the data can be re-run to provide a more accurate reflection of cases in scope.

To help prevent similar issues in the future, a formal change request process will be introduced. This will improve communication and raise awareness of upcoming developments within specific modules, allowing for better preparation and impact assessment across affected teams.

3.3 SJR Stage 1 Outcomes

18 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).

11 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

Seven cases were identified as needing Stage 2 review. These reviews concluded that two deaths were not avoidable, and five cases were uncertain whether poor practice had led to harm. The care experienced by these patients in terms of patient assessment and management plan were below expected levels.

In February 2025, the Learning from Deaths team engaged in consultation with the PSIRF team and wider patient safety colleagues across the Trust to consider enhancements to the Stage 2 review process. As a result of these discussions, a revised approach has been agreed.

Under the new process, any case where there is an indication that harm may have been caused by the Trust will be referred to the PSIRF team for consideration under their established priority framework. This referral process is conducted in collaboration with the Sector Clinical Leads and their respective clinical teams and aims to strengthen oversight and alignment with the Trust's broader patient safety priorities.

This approach remains under active development and refinement as we continue to embed it into existing review structures.

As in Q4, we have continued to ensure that any information that would be beneficial to the crew that attended the incident is fed back. This includes both areas for improvement and examples of good practice identified during case reviews. Feedback is delivered through the Sector Clinical Leads to ensure they maintain visibility of incident-related learning within their respective sectors. This approach supports continuous learning, promotes reflective practice, and reinforces positive clinical behaviours across the workforce.

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 B). A summary of the themes which identified areas for improvement includes:

ICC:

- Incorrect pathway used by EMA
- Incorrect coding of call
- Missed allocation of an appropriate vehicle

PES:

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

Trust:

- Delays in allocation on category 2 and category 3 calls which exceeded expected dispatch times. It is noted that this has significantly decreased from the previous quarter

In this quarter there were also some 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

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:

- EPR tiles not completed when appropriate
- Frailty and pain scores not recorded within observations
- No detail regarding how the patient was lifted from the floor
- Detailed worsening advice not documented

Good practice:

- Good reassurance by EMA during CPR
- Good amount of probing by EMA
- Additional management of patient's family following patient passing away
- Clinicians using holistic decision making where appropriate

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

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

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 was welcome to state their opinion to ensure all aspects of the case were covered.

5. NATIONAL GUIDANCE DEVELOPMENT

The development of ambulance-specific guidance and related proposals has been temporarily paused, pending the release of the revised national Learning from Deaths Framework, expected in Q4. This decision has been made to ensure alignment with forthcoming national standards and expectations.

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 recommended to:

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

NWAS Learning from Deaths Dashboard Q1 25/26

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.

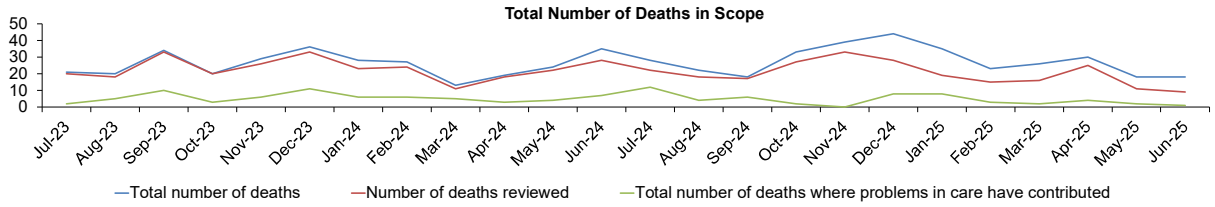


Figure 1

Concerns Raised in DCIQ

Internal Concerns

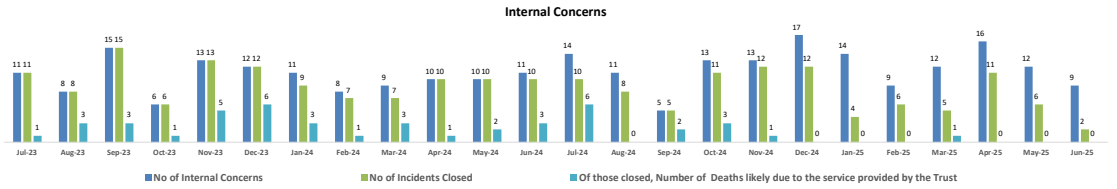


Figure 2

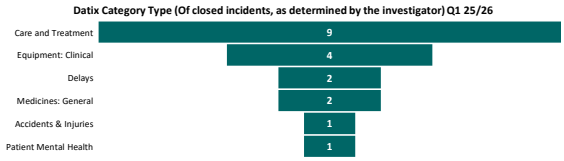


Figure 3

Learning Identified from all Internal Concerns raised in DCIQ

PES:

Care & Treatment
- Death within 12 hours of contact with NWAS - patient was left at home on initial contact (x9)
- Medicine error - missed first dose of Amiodarone during ALS
- Delay in attaching AED pads resulting in delay in first shock being administered

Equipment
- Schiller issues - failed to deliver shock when advised, incorrect pads attached, malfunctioned due to being in heavy rain
- Suction unit failed during ALS
- EZIO gun failed during use
- BVM unable to be used due to adult & child mouthpieces being stuck together

Medicines
- Student giving IV meds - out of scope of practice
- Incorrect dose of post-rosc Adrenaline given
- Out of date medicines given - Furosemide & Adrenaline

ICC:

Call Handling
- Incorrect pathway used by EMA
- Missed opportunity to gain Cat 1 response
- Call incorrectly downgraded by EMA
- Staff attitude/demeanour

Dispatch
- Delay in mobilisation on Cat 2 call
- Missed allocation on Cat 3 call - caused 3 hr delay
- RRV incorrectly stood down from cardiac arrest
- Missed allocation of closest vehicle - caused slight delay in arrival at scene

Trust:

Delays
- Cat 2 delays - 20min - 40 min delay (x2)
- Cat 3 delays - 2hr delay (x1)

- No SPTL available to attend paediatric arrest
- Vehicle issue - no oil in vehicle missed during vehicle

Table 1

External Concerns

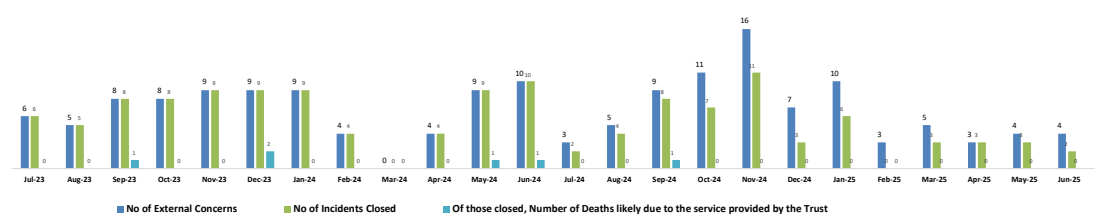


Figure 4

Learning Identified: PES

Problem with treatment & management plan:
- Incorrect techniques used to lift patient from the floor following a fall
- Incorrect MTS application

Problem with patient disposition:
- Potential missed opportunity to take patient to ED (x4)
- Potential incorrect hospital destination (x2)
- Incorrect procedure for contacting police after a patient passed away

Table 2

Other Learning Opportunities

Learning from CHUB
- Incorrect procedure for contacting police for remote verification of death after a patient passed away

Learning from PTS
- Problem with communication with patient and family during a discharge home from hospital

Table 3

Internal and External Concerns

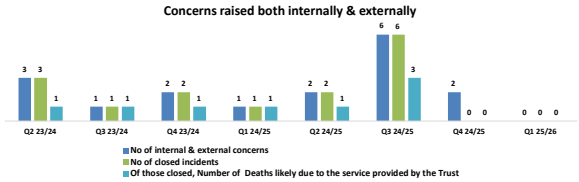


Figure 5

Data last exported: 22/07/2025; Data last cleansed: 14/08/2025

NWAS Learning from Deaths Dashboard Q1 25/26

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	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
25/26	Q1	18	18	7
	Total	**192**	**164**	**60**

Table 4

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

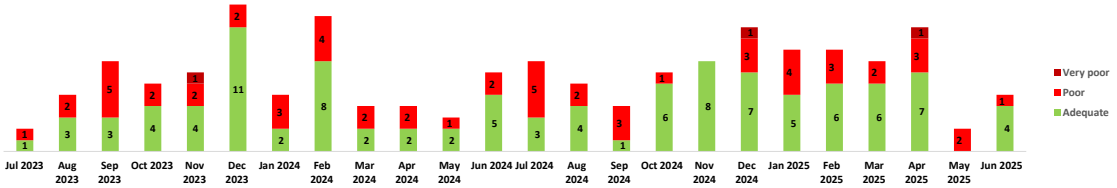


Figure 6

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	18	0
Right Care	Patient Assessment Rating	5	12	1
	Management Plan/Procedure Rating	3	14	1
Right Place	Patient Disposition Rating	1	17	0

Table 5

Recontact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good
Right Time	Call Handling/Resource Allocation	0	15	0
Right Care	Patient Assessment Rating	0	15	0
	Management Plan/Procedure Rating	1	14	0
Right Place	Patient Disposition Rating	0	15	0

Table 6

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 (x5)
- No medical model used (x1)
- Clinical examination poorly documented (x1)
- 12 lead ECG not performed when appropriate to do so (x1)
- Breathing assessment lacks detail (x1)

Poor Quality of EPR (x6)

Problem with patient disposition:
- No documentation of worsening advice or SOS advice (x1)
- No referral to AVS/GP services when appropriate to do so (x1)

Problem related to treatment & management plan:
- MTS not applied correctly (x3)
- Lack of clear management plan (x1)
- Capacity to consent not assessed correctly (x1)
- No senior clinical advice sought (x1)
- Risks associated with not attending ED not described (x1)

Table 7

Evidence of Poor/Very Poor Practice

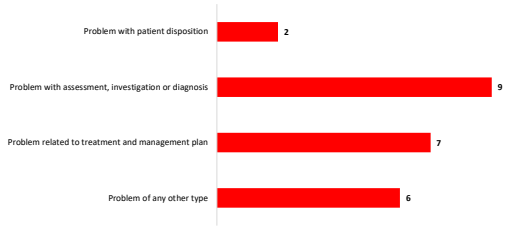
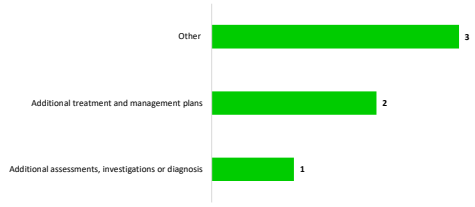


Figure 7

Evidence of Good/Very Good Practice

Evidence of Good/Very Good Practice



Data last accessed 19/08/2025

Figure 8

Findings identified from 'Good' ratings

Additional assessments, investigations & diagnosis:
- Extensive patient assessment documented (x1)

Additional treatment & management plan:
- Involvement of those important to the patient, with detailed holistic conversations noted (x1)
- Multiple sets of observations documented, and patients condition and plan discussed with the patients family and with GP services (x1)

Good Quality of EPR (x3)

Table 8

NWAS Learning from Deaths Dashboard Q1 25/26

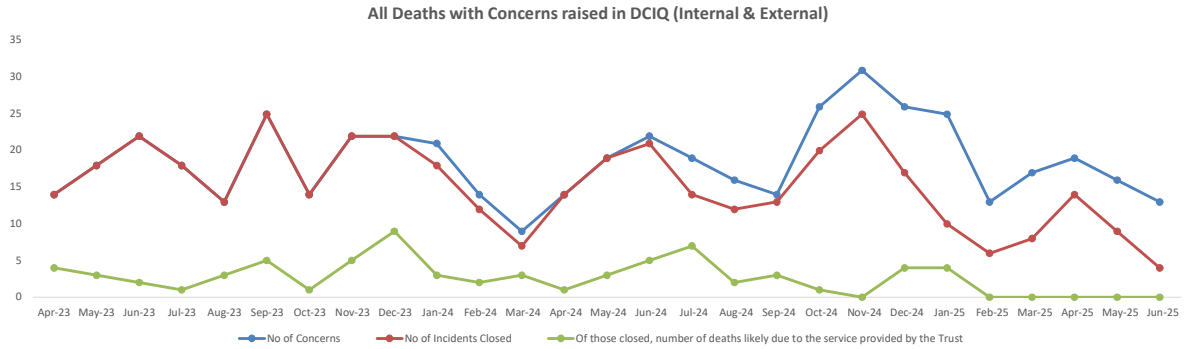


Figure 9

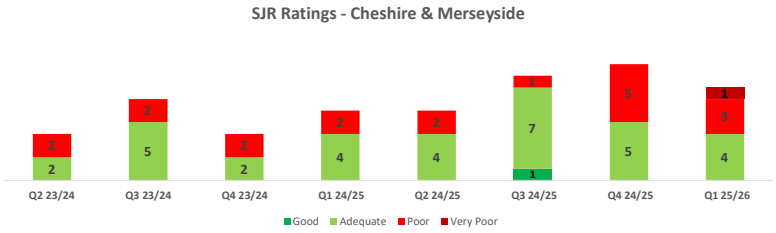


Figure 10

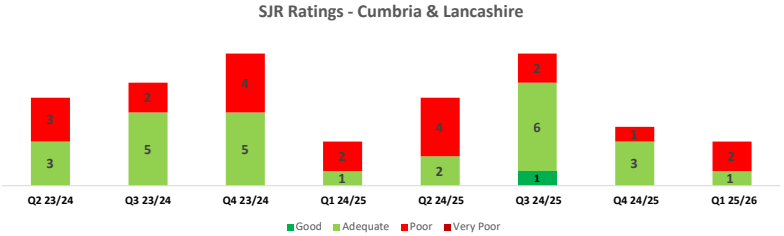


Figure 11

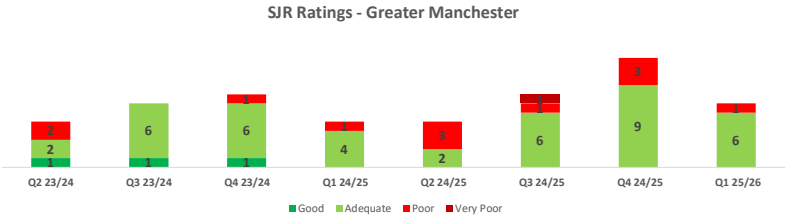


Figure 12

SJR Deaths by Deprivation Index		Quarter							
		Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26
IMD Decile 1= most deprived 10= least deprived	1	**7**	**6**	**2**	**8**	1	**6**	3	**3**
	2	0	**4**	1	1	2	**6**	3	2
	3	1	3	**3**	0	**5**	2	2	1
	4	**2**	1	**3**	0	1	**3**	2	1
	5	**2**	0	**3**	0	0	1	**4**	**4**
	6	0	1	1	1	2	1	**5**	0
	7	0	3	**3**	**3**	**3**	2	1	1
	8	0	1	0	0	1	**3**	**4**	1
	9	**2**	1	0	0	2	1	2	**4**
	10	1	1	1	1	0	1	0	1

Key:

Most occuring

Second most occuring

Table 9

LEARNING FROM DEATHS

NHS North West Ambulance Service

Q1 2025/26 REPORT

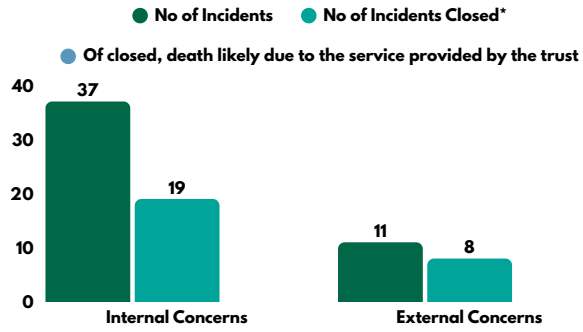
DEATHS WITH CONCERNS RAISED IN DATIX

Internal Concerns 37

External Concerns 11

Internal & External 0

Concerns with casual factors



*None of the closed incidents had causal factors identified

Categories from closed internal incidents

Care & Treatment	9
Equipment: Clinical	4
Delays	2
Medicines: General	2
Accidents & Injuries	1
Patient Mental Health	1

Learning from Paramedic Emergency Service (PES)

Problem with treatment & management plan:

- Incorrect techniques used to lift patient from the floor following a fall
- Incorrect MTS application

Problem with Patient Disposition:

- Potential missed opportunity to take patient to ED (x4)
- Potential incorrect hospital destination (x2)
- Incorrect procedure for contacting police after a patient passed away

Other Learning Opportunities

Learning from CHUB

- Incorrect procedure for contacting police for remote verification of death after a patient passed away

Learning from PTS

- Problem with communication with patient and family during a discharge home from hospital

Learning over time

- There has been less delays reported within DCIQ in Q1 - only two Cat 2 delays compared to eight in the previous quarter
- There continues to be reports of equipment issues - mainly regarding Schiller defibrillators
- There continues to be small numbers of medicine errors reported, particularly with Adrenaline and Amiodarone during ALS

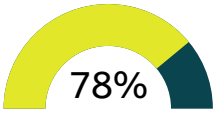
Structured Judgement Reviews (SJRs)

Patient Demographics

61% Female

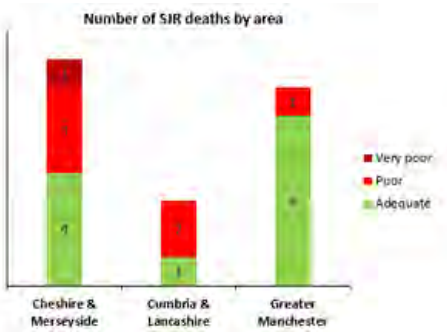
39% Male

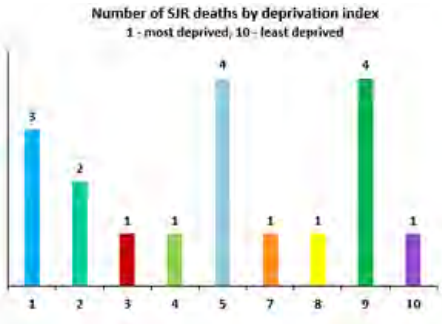
All of the sample were over 65 years old



Majority of patients ethnicity recorded as White (British)
22% Not Documented

Incident Demographics





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

Structured Judgement Reviews (SJRs)

Deaths in Scope

Re-contact within 24hrs

15

Category 3/4 Deaths

3

Category 1/2 Delays

0

Deaths Reviewed

Total sample

N = 18

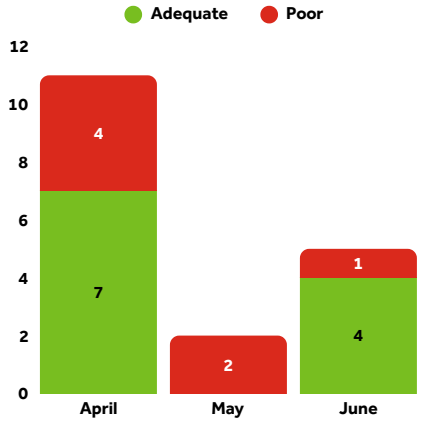
Excluded from review

Not moderated = 0

Included for review

n = 18**

SJR Stage 1 Care Assessment



**61.1% had no causal factors identified

Stage 2 = 7 incidents

No causal factors identified

2

Uncertain poor practice led to harm

5

Poor practice led to harm

0

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 (x5)
- No medical model used (x1)
- Clinical examination poorly documented (x1)
- Breathing assessment lacks detail (x1)
- 12 lead ECG not performed when appropriate to do so (x1)

Poor Quality of EPR (x6)

Stage 2 - PES Findings

Problem related to treatment and management plan:

- MTS not applied correctly (x3)
- Risks associated with not attending ED not described (x1)
- Capacity to consent not assessed correctly (x1)
- No senior clinical advice sought (x1)
- Lack of clear management plan (x1)

Problem with patient disposition:

- No referral to AVS/GP when appropriate to do so (x1)
- No specific worsening advice documented (x1)

SJR GENERAL LEARNING THEMES

Areas for Improvement

- EPR tiles not completed when appropriate
- Frailty and pain scores not recorded within observations
- No detail regarding how the patient was lifted from the floor
- Detailed worsening advice not documented

Good Practice

- Good reassurance by EMA during CPR
- Good amount of probing by EMA
- Additional management of patients family following patient passing away
- Clinicians using holistic decision making where appropriate

SJR ACTIONS

- Duty of Candour (DoC) to be considered
- Positive feedback to be given to crew
- Learning feedback to be given to crew
- EMA call audit requested and outcome fed back to staff member

SJR IMPROVEMENTS

- 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
- To continue to welcome observers from all areas of the trust to the monthly panels

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ESCALATION AND ASSURANCE REPORT

Report from the Quality & Performance Committee

Date of meeting	Monday, 27 October 2025			
Members present	• Prof A Esmail (Chair) • Dr D Hanley • Dr A Chambers • Ms A Wetton • Dr E Strachan-Hall • Mr D Ainsworth • Dr C Grant	Non-Executive Director Non-Executive Director Non-Executive Director Director of Corporate Affairs 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:
  - Complaints and patient safety incidents were broadly stable with a reduction in Violence and Aggression Incidents.
  - Patient experience remained broadly stable with a marginal improvement in the FFT over the previous month for PES and a marginal decline for PTS.
  - C1 mean response time remained strong, although had increased in September to 07m:07s, taking us just over the target of 7 minutes.
  - C2 mean response times had risen (25m:00s) but remained within the UEC target overall.
  - C3 mean response times had increased (01h:33m:37s) and continued to remain outside the national target
  - C4 mean response time had increased to 4 hours (outside the national target)

- The Committee received the proposed Board Assurance Framework 2025/26 for Q2 and discussed the risks and mitigations within the remit of Quality & Performance Committee.

- The Committee received assurances from the Disability and Autism Learning Annual Report and acknowledged the challenges of data extraction and case matching committing to further exploring ways to measure the outcomes to identify any potential inequalities.

- The Committee received the first Improvement Quarterly Report with assurances provided against the Improvement Annual Plan objective and noted some challenges as

well as progress made to date to implement NHS IMPACT and CQC requirements in building an organisational approach to improvement.

ASSURE:

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

- Clinical Audit Plan 01 2025/26
- Learning from Deaths Q1 2025/26.
- CQC Inspection Preparedness Update.

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, 26 November 2025
SUBJECT	Dashboard report: Communications, Engagement and Charity Teams
PRESENTED BY	Mike Gibb, Director of Strategy and 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 report and discuss the impact of activities undertaken by the communications, patient engagement and charity teams.	
EXECUTIVE SUMMARY	The communications, patient engagement and charity teams provide a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. The dashboard demonstrates how activity aligns with the aims of the trust strategy, and the positive impact it has on staff, patients, and partners. Comprehensive activity reports are provided to the Diversity and Inclusion Subgroup in relation to patient engagement work and the charity team provides regular updates to the Charitable Funds Committee, so this dashboard report gives just a visual snapshot of some key activities and the impact they have.	
PREVIOUSLY CONSIDERED BY	Not applicable	
	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

This report provides the Board of Directors with a summary of key outputs, impact and associated highlights on the work of the combined Communications, Engagement and Charity Teams for quarter two of the financial year 2025/26 (July-September 2025).

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

2. DASHBOARD REPORT

2.1 PATIENT ENGAGEMENT

Aim – Provide high quality, inclusive care

Annual patient engagement mapping informs targeted engagement with our community, patient and public priority groups, our focus for community awareness days and priority areas for development. This quarter saw a continued focus on better understanding the experiences of underrepresented communities. Targeted sessions were held with Chinese, Jewish, Eastern European and asylum/refugee communities in Manchester and Liverpool.

What we heard:

- communication and cultural challenges,
- reliance on others to communicate on their behalf,
- limited understanding on when and where to seek urgent help and
- a desire for information and basic lifesaving skills.

Actions taken include:

- delivery of CPR sessions
- translated information now available in multiple languages
- creation of a patient inclusion task and finish group to share findings and work collaboratively with other teams.
- further sessions with community partners to reassure and build confidence in accessing ambulance services.

Whilst our primary approach is to proactively engage with target audiences, where possible we respond positively to invitations to attend meetings of specialist patient and community groups, attend high footfall events across the North West and hold our own community events. Other engagement work has included:

- Attendance at many events, including Healthwatch Salford Health Fair 2025, Warrington Disability Partnership 'Disability Awareness Day', MSV Housing Community summer event, Emergency Services day in Manchester, Preston City Mela, LivesWyth-out Knives Youth Connect 2025, Southport African Caribbean Heritage Association's 'Community and Cohesion Fair', Healthwatch Oldham Women's Health Forum.
- Delivery of the trust's AGM and Open Day 2025 in Lancashire, which attracted 190 attendees. We achieved strong youth engagement, with over half of attendees aged under 24. The event received highly positive feedback: 95% enjoyed the event and 83% felt more confident using NWAS services. Feedback will inform the 2025–26 engagement programme, with continued focus on youth engagement and practical interactivity.
- PTS Health Literacy Project:
    - A pre and post improvement action survey has been developed, and work is now taking place to work with patients and the PPP to co-produce improved information. This may also include improvements to the trust's website, the PTS booking script that patients hear when calling to book transport and the SMS text they can choose to receive about their booking.
    - Work is also underway to see if PTS signposting information can be added to hospital letters sent to patients in relation to their appointments.
    - Additionally, a new PTS patient booking app is being developed and information on how to cancel unneeded appointments is also being reviewed.

New approaches to patient feedback

- A new combined patient survey, complaints and compliments report has been produced in conjunction with the Patient Resolutions Team to triangulate feedback and identify themes. This is being reported to Service Delivery Assurance Group.
- A sustained increase in NHS 111 service feedback has been achieved through use of the care text sent following a patient accessing NHS 111.
- Demographic reporting is now possible for NHS 111 patients. Although sample numbers are small, there is currently little difference shown for patient experience in relation to sex, race or disability.

Impacts:

- **Chinese community** – building relationships and working with community partners to inform, reassure and identify obstacles to access. Face to face CPR training and emergency care information is being made available in different languages (a CPR card with access to the info via a QR code) to assist our engagement with underrepresented groups and better meet their needs.

- **Community CPR Training – Targeted Outreach:** Responded to recurring feedback regarding low CPR awareness by delivering a dedicated training session for the Manchester Migrant Support Group. This activity built confidence and preparedness within a group expressing clear demand for lifesaving skills.
- **British Islamic Medical Association Collaboration:** In September, NWAS trained 95 members of Muslim communities in Greater Manchester, addressing identified gaps in CPR awareness. Participants demonstrated strong engagement, citing increased confidence in responding to cardiac emergencies.
- **BSL Insight App – Awareness Content:** Completed filming with a volunteer from Deaf Village to demonstrate practical use of the Insight App in supporting communication with deaf patients. The forthcoming internal video will help colleagues better understand accessibility tools and strengthen inclusive practice at the frontline.

2.2 COMMUNICATIONS

Aim – Be a brilliant place to work for all

Statistical content and narrative are provided to outline communications activity, including:

- Peer recognition cards – 558 sent compared to 381 cards sent during Q1, most popular cards are "Just to say a big thank you" and "you're a star". The cards were rebranded under the header 'Express Mail'.
- Open rate for key publications:
- The Bulletin - highest – 56% Average – 53% Lowest – 48%
- BHBY - Highest – 51% Average – 49% Lowest – 48%
- CEO – Highest – 54% Average – 49% Lowest – 45%

Impacts:

- **Star Awards 2026:** The nomination campaign launched with strong early engagement, demonstrating high levels of staff participation and continued momentum in building a culture of recognition ahead of the event in May 2026.
- **Sexual Safety Policy:** Developed and executed a comprehensive communications plan, including video content, to support the launch of the new policy. This has strengthened organisational understanding of expectations, reporting routes and the trust's commitment to a safe working environment.
- **The Handover (Patient Safety Feature):** Designed and launched a new monthly patient-safety learning product in collaboration with the Patient Safety Learning Team. Early feedback indicates improved visibility of learning themes and increased staff engagement with safety improvements.

Aim – Work together to shape a better future

- MP letters = 20 on Concerns about access to properties, PTS delays, siren noise, closure of ambulance stations, PTS eligibility, 999 triage/categorisation.
- Statements and briefings in response to media enquiries = 16
- Broadcast interviews = 5
- Proactive stories, against our internal target of 16 = 22

Impacts:

- **BBC Verify – Deep Fake Report:** Provided comprehensive support to a national BBC Verify investigation following manipulation of an NWAS video for Russian propaganda in Poland. Enabled accurate reporting by facilitating an interview with the featured call handler, ensuring NWAS's position and the risks of deep fakes were clearly represented across BBC online and national radio.
- **Dale Cregan Documentary:** Supported production of a documentary examining the 2012 killing of two GMP officers. Arranged and prepared an interview with ROCC Commander Derek Poland, whose first-hand account added significant operational insight while ensuring sensitive handling of organisational involvement.
- **Major Incident – Salford Bus Crash:** Coordinated timely media communications during the major incident response in July, issuing casualty updates and ensuring consistent, accurate information was shared publicly to support public reassurance and operational partners.
- **NHS League Tables Coverage:** Provided strategic comment and briefing in response to national coverage of the NHS league tables, highlighting NWAS's top ranking among English ambulance trusts and ensuring balanced, factual reporting.

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

- 8 films created in-house; our AGM film, CPR Instruction film, Safety Spotlight on MARSI, "Could it be measles?", Armed Forces Insight: Careers with NWAS, 'Being accountable' – a patient story, Becoming an Urgent and Emergency Care Clinician and the NHS Staff Survey launch film.

- FOI requests have increased again by 23% to 140. We are consistently responding above the national target of 90% within 20 working days.

- Website views have dipped which is likely due to no significant external incidents driving traffic. Work has begun on the 'Green Room Future' project to replace the intranet with a SharePoint solution. To date, work has focused on auditing the existing site, and examining analytics to identify popular pages and pinpoint those that are no longer required.

2.3 CHARITY

The charity team provide comprehensive reports to the Charitable Funds Committee. Our dashboard report gives a highlight of key activities, fundraising and the benefits to NWAS staff and local communities.

Impacts:

- Charitable funding this quarter has delivered meaningful impact across the organisation and our communities. Investments in station enhancements, including new relaxation areas and murals, have supported colleague wellbeing, while continued NHS Charities Together Ambulance Grant funding has sustained three Community Resuscitation Engagement Officers through to March 2026. We have strengthened community safety by contributing to the installation of new CPADs in previously uncovered areas and bringing orphaned units back into use. In addition, wellbeing festivals and roadshows have provided staff across the North West with accessible health and wellbeing support, and small but significant gestures - such as flowers for bereaved colleagues and new parents - have helped reinforce a compassionate and caring organisational culture.

4. EQUALITY/ SUSTAINABILITY IMPACTS

All the trust's communications, engagement and charitable activities seek to promote equality and diversity and ensure information is accessible to all.

5. ACTION REQUIRED

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.

Dashboard: Communications, Engagement and Charity Teams

Q2 2025/26 (July, August and September)

NHS North West Ambulance Service NHS Trust

This report summarises the work of the Communications, Patient Engagement, and Charity teams, all of which play a vital enabling role across the organisation by working in partnership with services and departments to support the achievement of our shared strategic goals and objectives. Through clear and consistent communication, meaningful engagement with patients and the public, and the development of charitable initiatives that enhance care and experience in our communities, our work helps to amplify, inform, and connect the efforts of colleagues in the various directorates across the organisation - contributing to better outcomes and experiences for our staff, volunteers, patients, and communities.

Where there is an explicit link to delivery of the must-do objectives in the Annual Plan 2025-26, the target icon is used to highlight this.

Aim: Provide high quality, inclusive care

Patient and Public Engagement

Listening to under-represented groups
Communities reached: Chinese • Jewish • Eastern European • Asylum/Refugee (Manchester & Liverpool)

What we heard:

- Language and cultural barriers exist
- Reliance on others to speak on their behalf
- Unsure when/where to seek urgent help
- Strong desire for information & lifesaving skills

What we did:

- CPR training delivered
- Info translated into multiple languages
- Internal patient inclusion task & finish group set up to share findings and work with other teams to improve our service.
- Confidence-building sessions with community partners

Other engagement activity:
Healthwatch Salford Fair • Disability Awareness Day • MSV Housing Summer Event • Emergency Services Day • Preston Mela • LivesWyth-out Knives Youth Connect • Southport AC Heritage Fair • Women's Health Forum Oldham • Manchester Migrant Group • British Islamic Association

Improvements for the deaf community
We filmed a new BSL Insight App demonstration with the Deaf Village. It will be shared internally to support staff awareness and improve patient experience.

AGM & Open Day 2025
190 attendees (50%+ aged under 24)
95% enjoyed the event
83% feel more confident using NWAS
Insights will inform our youth engagement programme for the year ahead.

PTS health literacy improvement project
Co-produced with Patient & Public Panel + PTS users:
Revamping the PTS web pages
Updating booking call script & SMS messages
Exploring PTS signposting in hospital appointment letters
Developing a new PTS booking app
Improving cancellation pathways

Patient feedback surveys

- A new combined patient survey, complaints and compliments report has been produced in conjunction with the Patient Resolutions Team to triangulate feedback and identify themes. This is being reported to Service Delivery Assurance Group.
- A sustained increase in NHS 111 service feedback has been achieved through use of the care text sent following a patient accessing NHS 111.
- Demographic reporting is now possible for NHS 111 patients. Although sample numbers are small, there is currently little difference shown for patient experience in relation to sex, race or disability.

Patient story

Shared at the Board of Directors meeting:
The patient story shared with the Board highlights the serious consequences of outdated manual handling techniques and the impact on patient safety.

This example will be used to reinforce the importance of maintaining up-to-date clinical practice. Mandatory training will be reviewed and refreshed to incorporate this learning. Clinicians will be reminded to challenge outdated practices through supervision and ongoing professional development.

Patient and Public Panel

Membership overview

225	Total members (a further reduction due to membership cleanse)
8	New members joined
6	New expressions of interest
33%	Youth representation (Target 30%)
34%	Ethnic diversity representation (Target 40%)
9	New requests for involvement
16	Structured/task-based sessions delivered

Example: Supported a health inequalities workshop and proof of concept using AI.

Notable achievements: For the first time, we were given the opportunity to invite a PPP member to get involved in the assessment centre for the Head of Operations recruitment.

Aim: Be a brilliant place to work for all

Internal (staff) communication

Emails for all staff, such as The Bulletin and CEO message, are sent through a system (e-shot) which provides analytics.

NOTE
Displays are only counted when an email is opened and images are downloaded, which requires staff to click to allow. It's fair to assume that more staff read the emails than the 'display' figures suggest. Our platform provider e-shot advises that an average display rate across its public sector clients is 44%.

Engaged staff

When a user has opened an email, viewed online or clicked a link in the past 30 days, they are an 'engaged contact'. The percentage of engaged staff is as follows:

- Corporate and support - 90% (-)
- Emergency - 94% (+1%)
- EOC and Clinical Hub - 82% (+1%)
- NHS 111 - 80% (+2%)
- PTS - 75% (+1%)

The Bulletin

Display rates for The Bulletin :

Highest: 56% **Average: 53%** **Lowest: 48%**

Bulletins with a higher-than-average display rate covered topics including:

- Sickness absence policy
- PTS contract update
- Total rewards

CEO Message

Display rates for the CEO message:

Highest: 54% **Average: 49%** **Lowest: 45%**

Better Health Better You

Display rates for Better Health Better You:

Highest: 51% **Average: 49%** **Lowest: 48%**

Viewing figures from the Green Room:

The Handover - patient safety feature
October - 408 views
September - 347 views

Bulletins & Briefings section - 11,785

Express Mail - staff recognition cards

Colleagues can send an e-card to any of their peers via the Green Room. Physical cards are also available in our contact centres but numbers issued are not tracked.

558 cards sent

The most popular cards remained the same: "Just to say a big thank you" and "You're a star".
The cards were relaunched under the header 'Express Mail - Thoughtful messages delivered instantly'.

Campaigns and project support

Star Awards – venue confirmed and nomination campaign live with strong early engagement. The event is due to take place in May 2026.
Wellbeing – delivered themed newsletters aligned to key national campaigns.
Flu – produced bulletin content and myth-busting messages; developed endorsement comms to target low-uptake groups.
NHS Staff Survey – created leadership video messages emphasising improvements and encouraging completion.
TASC Memorial Service - coordinated NWAS representation and purchased ceremonial standards.
Co-pilot Launch - supported safe-AI rollout with clear guidance and promotional comms.
Staff App – completed content review. New sign on procedure now with ICT/IG for approval.
Sexual Safety Policy - developed a communications plan and coordinated video content for the policy launch.
Staff Networks – delivered comms plan for Anti-Racism statement.
People Promise – updated staff benefits content and supporting materials.
Falls Awareness Week – produced staff promotion, printed materials and external social content.
World Overdose Awareness Day – delivered article, quiz and social video content.
Schiller defib rollout – filmed an explanatory video to support upcoming device deployment.
Southport Inquiry – provided ongoing internal updates on organisational involvement.
Sickle Cell Awareness Month – produced and promoted content with Public Health.
Disability Pride Month – delivered profile feature to support inclusivity messaging.
The Handover – designed, edited and launched new monthly patient safety learning feature with Patient Safety Learning team.
Reward Partners - We launched a new sponsorship opportunity for suppliers and external companies to support the reward and recognition of our people.

Film & photography

8 completed Vs 8 in the previous time period

6 in progress

Film topics:

- AGM film
- CPR Instruction film
- Safety Spotlight on MARSI
- "Could it be measles?"
- Armed Forces Insight: Careers with NWAS
- Being accountable – a patient story
- Becoming an Urgent and Emergency Care Clinician
- NHS Staff Survey launch film

Patient and staff stories are available for staff to view on the Green Room following their debut at the trust board meeting. The patient story titled 'Being accountable' received over 350 views in its first week, making it the most viewed story among all patient and staff stories.

Within the next quarter work begins on a series of career films that many may not think of when considering a role in the ambulance service such as within our fleet and finance teams.

Aim: Work together to shape a better future

Stakeholder engagement

21 MP letters (+50%)

Topics: Concerns about access to properties, PTS delays, siren noise, closure of ambulance stations, PTS eligibility, 999 triage/categorisation.

0 MP visits

10 x MP meetings planned to take place between October and February with Chair Julia Mulligan.

Stakeholder communication:
1x General Stakeholder brief (August)
1x Notice of the Southport Inquiry opening
1x Industrial Action brief

CEO, stakeholder & public affairs support:

- OSC report produced and co-ordinated Area Director attendance for Blackpool.
- x3 staff condolence letters, thank you letter to Cheshire West and Chester Council, x2 condolence letters to Derbyshire Fire & Rescue, letters issued to all North West MPs on behalf of new Chair Julia Mulligan, CFR/blue light driving letter to Cheshire and Merseyside ICB. Invite letters also issued to Merseyside/Liverpool Lord Lieutenant, Mayor and High Sheriff for the Elm Point event.

Estuary Point
The team delivered a launch event at our new specialist base in Liverpool. Elm Point opened on 25 September and is home to one of the two Hazardous Area Response Teams (HART) in the North West. The new £14.5 million base is on the site of Elm House, the former HQ of Merseyside Regional Ambulance Service.

Press and public relations

120	incident checks handled	**-38%**
16	statements prepared in response to media enquiries	**+6%**
5	positive broadcast media opportunities secured	**-**
22	proactive stories issued, against our target of 16	

BBC Verify - We supported a report on social media deepfakes after one of our videos was manipulated to promote Russian propaganda in Poland. The call handler who appeared in the original video was interviewed for the piece, which was covered online and on national radio.

Dale Creegan documentary - We also contributed to a documentary looking at the killing of two GMP officers in 2012. They interviewed ROCC Commander Derek Poland, who was the first on scene at the time of the incident.

Other notable media interest – The team supported a major incident response to a bus crash in Salford, providing casualty updates to the media (July).
We provided comments on the coverage of the new NHS league tables after NWAS appeared at the top of the rankings of English ambulance trusts (September).

Freedom of Information (FOI)

140 received (+23%)

97% compliance year-to-date against 20 day target

Topics included:

- Incidents/999 calls
- Contracts
- Agency spend

NOTE
We have a statutory duty to reply to 90% of FOIs within 20 working days and an internal stretch target of 95%.

Social media - Facebook, X, Instagram and Linkedin

NOTE
'Impressions' is the number of times our content may have been seen by a member of the public

'Engagements' is when someone engages with our content eg clicks a link, reacts to it by clicking 'like', or shares or retweets it

'Engagement rate' shows us the number of interactions our content receives per follower

97,038	Facebook followers
68,940	X (Twitter) followers
22,202	Instagram followers
12,627	LinkedIn followers

Audience growth
+ 1%

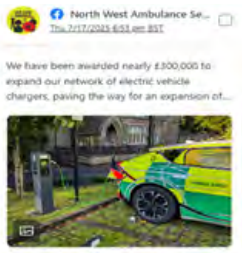
Engagement

310	posts published on all channels (-18%)
6,297,255	impressions (-19%)
263,635	engagements (comments, likes, retweets, shares etc) (-30%)
5%	engagement rate (-1%)
318,051	reel/video views (-50%)

Social media performance dipped this quarter with key metrics all down compared to the previous period. However, our engagement rate remains strong at 5.2%, significantly above healthcare benchmarks (0.25% on Facebook, 1.5% on Instagram, 2.6% on LinkedIn), indicating that our content still resonates despite reduced reach. Compared to the performance of channels from other ambulance trusts, our engagement advantage persists, suggesting that our quality-over-quantity focus remains a strength.

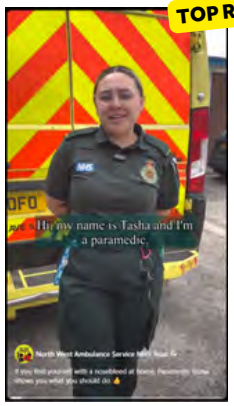
TOP POSTS

Views 159k



Views 111k

TOP REELS



Views 201k

Views 179k

Digital communications

Website

262,226 users **380,940** page views

Most viewed
Vacancies – 113,631
PTS – 55,220
Locations – 20,906

Devices used to visit our site
Mobile 55%
Desktop 42%
Tablet 3%

A reduction in views can be attributed to an unusual previous quarter, during which we experienced the Liverpool City Centre major incident, and we also launched an EMT recruitment drive, which resulted in 14,500 and 18,500 website visits, respectively.

Green Room

19,275 users **615.047** page views

Most viewed
Managers on duty – 113,440
HR Portal – 27,063
Bulletins - 23,847

Devices used to visit the Green Room
Desktop 70%
Mobile 16%
Tablet 14%

Work has begun on the 'Green Room Future' project to replace the intranet with a SharePoint solution. To date, work has focused on auditing the existing site, and examining analytics to identify popular pages and pinpoint those that are no longer required.

NOTE A 'user' is a person who has an engaged session. An 'engaged session' is when a user is engaged for longer than 10 seconds, performs an action, or views at least 2 pages. This discounts visits where users immediately move onto another site.

Upcoming developments include:

- Continuation of the Green Room Future project – with a focus on finalisation of new site map and navigation and working with departments to develop and finalise content for the new site.
- Website - Improvements to inform data collection for thank-yous from the public and complaints.

North West Ambulance Charity

Making a difference

The Charity has used funds to fulfil various charitable objectives totalling approximately. £157k.

Including:

- Enhancements to NWAS sites to support relaxation and wellbeing, including relaxation areas and murals on stations - £7k
- Continued funding under the Ambulance Grant from NHS Charities Together, which includes the salaries of 3 x community resuscitation engagement officers until end March 2026 - £50k.
- Contributions towards community-led projects to install CPADs in areas previously without coverage, plus funding for various ancillaries to bring orphaned units back online - £43k.

Health and wellbeing support:

- Provision of Wellbeing Festivals and Road Shows across the North West - £18k.
- Flowers for bereaved colleagues/new parents - £1k
- Charity collateral, including branded pens, t-shirts, coffee cups - £2k

Fundraising

Key events:

- Born Survivor – 13 participants – raised £2,489
- Yorkshire Three Peaks – 10 participants – raised £2,436
- Great North Run – 7 participants – raised £2,793
- Cross Bay Walk was cancelled, but 100 places were sold. A small profit was still made. Due to the uncertainty of the weather affecting this event, we have decided not to run with it in 2026 but to instead introduce a new event in its place.

Community fundraising support:

- Marc North completed a 24-hour run up Snowdon as a way of thanking emergency frontline workers for saving the life of his dad after he had suffered a heart attack in the street. Marc's raised £2205.
- NWAS colleague Laura completed the Grasmere Three Peaks in September and raised £180.

Community first responder fundraising:

- Wirral CFRs: Completed 16k walking challenge from Arrowe Park to Parkgate and back whilst carrying NWAS Kit Bags. Raised £3208
- Alston CFRs: Completed a sponsored skydive and raised a total of £790.

Social media

The charity uses Instagram and Facebook to share supporter stories and encourage donations.
Combined views: 67,582 +119%
Interactions (comments/shares/saves): 547

TOP POST

Support spotlight – Daisy Price who took part in the Great North Run
Views – 9,681
51 link clicks to fundraiser page

Combined team priorities for Q3

- Community engagement event - Cheshire.
- NWAS volunteers celebration event – led by Community Resuscitation, supported by us (7 Nov).
- Create a series of films showcasing the various roles across NWAS, which will be featured on our website and support recruitment efforts.
- Implementing changes from the Internal Communications Audit – specifically a managers' briefing and WhatsApp for clinical team communication - that took place earlier in the year.
- Agree a site map for the new intranet.
- New charity Digital Communications Officer (13 Oct).
- Winter comms plan to be implemented to support appropriate use of services.