AGENDA

NHS North West Ambulance Service NHS Trust

Board of Directors
Wednesday, 25th March 2026
09:45 – 13:30
Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
STAFF STORY				
BOD/2526/141	Staff Story	09:45	Information	Chief Executive
INTRODUCTION				
BOD/2526/142	Apologies for Absence	10:00	Information	Chair
BOD/2526/143	Declarations of Interest	10:00	Decision	Chair
BOD/2526/144	Minutes of the previous meeting held on 28th January 2026	10:00	Decision	Chair
BOD/2526/145	Board Action Log	10:05	Assurance	Chair
BOD/2526/146	Committee Attendance	10:05	Information	Chair
BOD/2526/147	Register of Interest	10:05	Assurance	Chair
STRATEGY				
BOD/2526/148	Chair & Non-Executive Directors' Update	10:10	Information	Chair
BOD/2526/149	Chief Executive's Report	10:20	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2526/150	Risk Appetite Statement 2026-27	10:30	Decision	Director of Corporate Affairs
BOD/2526/151	Proposed Strategic Risks 2026-27	10:40	Decision	Director of Corporate Affairs
BOD/2526/152	Non-Executive Terms of Office; Committee Membership 2026-27 and Non-Executive Champion roles	10:50	Assurance	Director of Corporate Affairs
BOD/2526/153	Board Development Programme 2026-27	11:00	Information	Director of Corporate Affairs
BOD/2526/154	Audit Committee 3A Report from the meeting held on 17th February 2026	11:10	Assurance	Mr N Gower, Non-Executive Director

BOD/2526/155	Charitable Funds Committee 3A Report from the meeting held on 18th February 2026	11:15	Assurance	Mr N Gower, Non-Executive Director
BOD/2526/156	Trust Management Committee 3A report from the meetings held on 18th February 2026 and 18th March 2026	11:20	Assurance	Chief Executive
RESOURCES				
BOD /2526/157	Resources Committee 3A report from the meeting held on 19th March 2026	11:30	Assurance	Mr G Chapman, Non-Executive Director
BOD /2526/158	Estates and Fleet Strategic Plan Roadmap – Annual Review	11:35	Assurance	Director of Finance
BREAK 11:45-11:55				
PEOPLE				
BOD/2526/159	Annual Staff Survey Results	11:55	Assurance	Director of People
BOD/2526/160	Anti-Racism Statement	12:05	Decision	Director of People
QUALITY AND PERFORMANCE				
BOD/2526/161	Integrated Performance Report	12:15	Assurance	Director of Quality & Improvement
BOD/2526/162	Bi-Annual Safeguarding Report	12:30	Assurance	Director of Quality & Improvement
BOD/2526/163	Infection, Prevention and Control (IPC) Report & BAF	12:40	Assurance	Director of Quality & Improvement
BOD/2526/164	Emergency, Preparedness, Resilience and Response (EPRR) Bi Annual Assurance	12:50	Assurance	Director of Operations
BOD/2526/165	Learning from Deaths Q2 2025-26	13:00	Assurance	Medical Director
BOD/2526/166	Quality and Performance Committee 3A report from the meeting held on 23rd February 2026	13:10	Assurance	Ms Clare Todd, Non-Executive Director

STRATEGY AND PLANNING				
BOD/2526/167	Trust Strategy and Strategic Plans	13:15	Decision	Director of Strategy & Partnerships
CLOSING				
BOD/2526/168	Any other business notified prior to the meeting	13:25	Decision	Chair
BOD/2526/169	Risks Identified	13:25	Decision	Chair
DATE AND TIME OF NEXT MEETING				
29th April 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.				

NHS
North West
Ambulance Service
NHS Trust

Minutes
Board of Directors

Details: 9.45 am Wednesday, 28th January 2026
Oak Room, Ladybridge Hall, Trust Headquarters

Ms J Mulligan	Chair
Mr S Desai	Chief Executive
Mr D Ainsworth	Director of Operations
Mr C Butterworth	Non-Executive Director
Dr A Chambers	Non-Executive Director
Mr G Chapman	Non-Executive Director
Ms A Cooper	Non-Executive Director
Prof A Esmail	Non-Executive Director
Mr N Gower	Non-Executive Director
Dr C Grant	Medical Director
Mr M Gibbs	Director of Strategy and Partnerships
Dr E Strachan-Hall	Director of Quality and Improvement
Ms C Todd	Non-Executive Director
Ms A Wetton	Director of Corporate Affairs
Ms C Wood	Director of Finance
Ms L Ward	Director of People

In attendance:

Mrs A Cunliffe	Corporate Governance Manager (Minutes)

Observers:

Ms E Shiner	Deputy Director of Corporate Affairs (in person)
Ms K Pearson	JGP Consultancy (via MS Teams)

Minute Ref:

BOD/2526/122 Patient Story

The Chief Executive introduced a film, which referred to the story of a patient, James, who shared his lived experience of a long-standing seizure condition and the impact of time critical medications not accompanying him to hospital during emergency admissions.

In the video, James talks about complex medical history and the challenges patients face if regular medications are unavailable. He specifically refers to his own experience of becoming unwell while away from home and not having

access to his time critical medications during emergency conveyance or handover.

As a result, on arrival at hospital there have sometimes been delays in treatment while medication details, dosages, and prescribing authorisation are confirmed. These delays have, at times, impacted the management of his other conditions. This issue is not unique to James and affects many patients who rely on regular medication.

James describes the anxiety he experiences when his medications do not accompany him to hospital. He explains his concern about missing doses or not receiving medication at the correct time, and the impact this can have on his health. Without his medication, James is at risk of experiencing seizures or complications related to his other medical conditions. He also reflects on the additional pressure this places on nursing staff, who may need to spend time locating his medications during emergency care.

The film takes a reflective approach, highlighting learning opportunities and identifying ways in which the ambulance service can better support patients to take their medications with them to hospital.

The Board noted that James is a member of the trust's Patient and Public Panel (PPP) now and contributes to the medicine management project currently in development.

Dr A Chambers emphasised the importance of hearing the patient's story as a reminder that people living with chronic illness often understand their own medication needs better than anyone else. She highlighted that missing or delaying essential medications during emergency admissions can have a significant impact on patient safety and the effective management of long-term conditions.

The Board identified several learning points at individual, service, and organisational levels. Members discussed the importance of progressing toward integrated digital systems that enable seamless information flow across sectors, ensuring clinicians have timely access to accurate medication and care information. They also noted the ongoing work to strengthen pathways that support continuity of care for patients as they move through different parts of the system.

The Board:

- Noted the content of the story.

BOD/2526/123 Apologies for Absence

There were no apologies for the meeting.
The Chair welcomed the attendees to the meeting, with a special welcome to the new Non-Executive Directors. A round of introductions was initiated, with the new Non-Executive Directors each briefly providing their professional background.

BOD/2526/124 Declarations of Interest

There were no declarations of interest to note. All standing declarations were recorded in the Register.

BOD/2526/125 Minutes of the Previous Meeting

The Director of Quality and Improvement noted the term 'Interim' should be removed from her attendance record.

With the above amendment, the minutes of the previous meeting, held on 26th November 2025 were agreed as a true and accurate record of the meeting.

The Board:

- Approved the minutes of the meeting held on 26th November 2025.

BOD/2526/126 Board Action Log

The Board Action Log was reviewed. Two items were marked as green, complete and for removal, as per updates provided within the action log.

With regards to action on a dedicated session scoping the use of AI, the Director of Corporate Affairs confirmed, this item was being worked into the Board Development Plan for 2026/27. The action was deemed as closed for removal.

The item was agreed as complete and closed.

BOD/2526/127 Committee Attendance

The Board noted the Committee attendance. Amendments to the attendance at Board meeting in November were recorded to align with the true record as per minutes.

BOD/2526/128 Register of Interest

The Board noted the Register of Interests presented for information, with all entries complete from the new Non-Executive Directors.

BOD/2526/129 Chair & Non-Executives' Update

The Chair reported on several internal and external engagements within the reporting period, including a day with a Community First Responder and regular catch ups with the Chief Executive.

The Chair highlighted her visits to hospitals and thanked the Area Directors for coordinating those as well as very helpful discussions regarding approaches to winter pressure challenges.

The Chair thanked NHSE and the Director of Corporate Affairs for the effective facilitation of the Non-Executive Director recruitment process.

The Board noted that a managed and staged onboarding programme for the newly appointed Non-Executive Directors was in progress, with individual and collective meetings arranged. Committee membership was currently in draft form and would be circulated once finalised.

The Chair confirmed the appointment of Ms C. Butterworth as Senior Independent Director and Ms A. Cooper as Deputy Trust Chair.

The Chair advised that a half-day meeting would be held with the new Non-Executive Directors to gather their initial impressions and reflections, with feedback to be provided to the Chief Executive.

The Board discussed the Mandatory Training requirements for Non-Executive Directors and noted that ESR does not currently hold a discrete profile setting out the required modules.

The Board noted that the Director of People would circulate the definitive list of Mandatory Training modules to all Non-Executive Directors.

The Board:

- Noted the Chair's update.

BOD/2526/130 Chief Executive's Report

The Chief Executive presented a comprehensive report, which covered activity undertaken for the period 22nd November 2025 to 21st January 2026 including detailed information on several areas, such as performance, internal matters, regional issues, national issues and other general information. The Executive Summary of the report headlined highlights relating to corporate affairs, finance, people and culture, operations, medical, strategy quality, organisational and system updates.

The Chief Executive offered his warm welcome to the new Non-Executive Directors and then took the Board through the main points relating to internal updates.

In updates from Finance, the Board noted the Trust has begun the organisational change process within the Digital team, aligning roles and job descriptions with the Government Framework and national standards.

In terms of productivity and efficiency, there was an improvement in the recurrent delivery, and the projected shortfall against target has reduced to £0.516m. The capital programme for 2025/26 has increased by £3.251m to £42.481m due to additional resources of £0.688m from national allocations. There was a significant capital programme (vehicles, estates and digital) planned for 2026/27. Detailed Finance report was included in the Integrated Performance Report.

Moving to updates from People & Culture, the Chief Executive highlighted the launch of the Trust's new Sexual Safety Policy. The importance of taking action

to prevent sexual misconduct in the NHS had been highlighted in a letter received in December from the national Medical Directors and the Director of Nursing. The Board also noted an update on the ongoing dispute with a small cohort of ICC educator workforce.

Referring to handover times, the Chief Executive reported that improvements in handover seen in Q2 and early Q3 had not been sustained into Q4, although performance remained proportionately better than the same period last year. He noted the impact of handover delays on patients and staff. Numerous Acute Trust partners escalated into a prolonged period of OPEL 4, with Critical Incident and Business Continuity incidents also declared. NWAS command and leadership teams supported both system and local response plans, but significant hospital handover delays have caused multiple long waits in the community.

The Board noted updates from Quality & Improvement, with highlights around Improvement Academy and the appointment of Interim Deputy Director of Patient Safety and Regulatory Compliance.

The Chief Executive advised of ongoing Annual Planning work, including the development of the 26/27 annual plan and work on the submission during Q4 to meet NHSE planning timelines for the 5-year plan submission. He added the Director of Strategy in Partnership will work with the Non-Executive Directors regarding design principles for the new five-year Trust Strategy.

In terms of national updates, the Board noted updates on winter viruses, impact statement on the 10 Year Health Plan, Actions to Prevent Sexual Misconduct in the NHS, National Improvement Board, the Mental Health Act 2025, AACE and the Emergency Capabilities Unit event and Future NHS Workforce Solution, which was a separate item later on agenda. The Chief Executive highlighted the Mental Health Act 2025, updates the 1983 Act to strengthen patients' rights, reduce inappropriate detention, and modernise safeguards with most substantive changes coming into force on 18 February 2026, with some administrative provisions already active.

Moving to regional updates, the Chief Executive reported the first wave of Advanced Foundation Trusts authorisation was underway, with early learning being shared to inform wider national rollout. In terms of Medium-Term Plan, the Board noted draft submission was made in December and work was underway towards the final submission in February, with in-depth discussion later on agenda.

The Board noted an update regarding commencement of procurement process for the provision of Non-Emergency Patient Transport Services (NEPTS) across Lancashire, Greater Manchester, Cheshire, Merseyside, Cumbria and part of Derbyshire.

The Chief Executive concluded the presentation with organisational staff announcements, as recorded in the report. He shared that the three colleagues from Sandbach who were injured while responding to the incident on 28

November 2025 were now safely back home. On behalf of the Board, he sent them warm wishes and hopes for their continued recovery and wellbeing.

Ms C Todd enquired whether there was clinical involvement and Quality Impact Assessment process with regards to efficiency programmes. The Chief Executive Officer confirmed both. The Director of Quality and Improvement added there was a policy combing both Quality Impact Assessment and Equality Impact Assessment and a robust process, which was periodically reported through to Quality and Performance Committee.

Ms C Todd noted the update on the Mental Health Act 2025 and was keen to understand its impact on the Trust services. The Chief Executive advised this was being worked through by the mental health team within the Quality Directorate.

Ms A Cooper sought clarification on the update regarding Actions to Prevent Sexual Misconduct in the NHS and the Sexual Safety Policy, specifically in relation to the infrastructure for embedding consequences following investigations.

The Chair asked about partnership arrangements between the Trust and external organisations to support victims.

The Director of People reported that the Trust could demonstrate compliance and examples of a robust approach but acknowledged this remained a journey of learning and improvement. Further work was underway to strengthen comprehensive after-care, and forthcoming national guidance would be welcomed. She confirmed that signposting and in-house wellbeing support were available and offered a full briefing outside the meeting.

The Director of Operations emphasised the importance of cultural development and strong leadership programmes in preventing misconduct. It was noted that a further Culture Day had been scheduled and an invitation would be extended to the Non-Executive Directors.

Mr G Chapman sought clarification on the update regarding Advanced Foundation Trusts, asking whether this was an aspiration or a requirement and what preparations were in place.

The Chief Executive advised that Advanced Foundation Trust status was both a requirement and an aspiration for the future. Learning from the first wave would inform the process, and initial discussions and sharing of learning with other organisations had already commenced. He noted that the Trust's organisational preparedness for Medium-Term Plans and a potential CQC inspection placed it in a strong position for future FT preparation.

The Board noted that the item would be discussed further at a Board Development Session in the upcoming financial year.

The Board:

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

BOD/2526/131 Proposed Q3 Position of the Board Assurance Framework 2025/26

The Director of Corporate Affairs presented the proposed 2025/26 Q23Position of the BAF risks with associated Corporate Risk Register risks scored ≥15, which could be viewed in Appendix 1 and the BAF Heat Maps for 2025/26 year- to-date in Appendix 2.

The Board noted there were two proposed changes to the risk scores, with rationale provided in s2 of the report.

- SR01 has increased in risk score from 10 to 15.
- SR04 has increased in risk score from 10 to 15.

Pointing to s3 of the report, the Director of Affairs advised a rearticulation of SR09 was also proposed due to the volume of planned and unplanned changes to the NED cohort during Q3 and Q4. This risk was expected to close in Q4.

Mr G Chapman would welcome an additional discussion regarding risk appetite at the upcoming Board Development Session (BDS) and referenced a discussion at Resources Committee regarding the digital risk.
The Director of Corporate Affairs confirmed the Risk Appetite 26/27 item was included in the upcoming BDS.

A discussion took place regarding the revised wording for SR09.
Ms C Butterworth suggested that the risk should remain to be monitored into Q1, to allow for a cycle of Committees to take place and the new membership embedded.
The Chair felt the wording of the reiteration was rather strong and added that mitigation was in place with two long standing Non-Executive Directors continuing service until March 2026 and one until March 2028, as well as robust induction underway.

The Chief Executive acknowledged all comments and added the original wording referred to all Board members, as there were previously changes to the Executive membership, which were now settled. He suggested a further discussion in March to monitor the position.

The Board:

- Approved the re-iteration of SR09.
- Approved the Q3 position of the Board Assurance Framework 2025/26.

BOD/2526/132 Freedom to Speak Up Bi-Annual Report

The Medical Director presented the bi-annual report noting that it is usually presented by the Freedom to Speak Up Guardian, who was unavailable on this occasion.

The Medical Director reported within the current financial year 2025/26 the organisation received 67 concerns so far, which was approximately a 15%

reduction from the number of concerns raised at the same point in time for 2024/25. The reduction was partially attributed to the FTSU team's increased effort to proactively signpost people towards more appropriate routes for speaking up. There was an enhanced access to raising concerns online. The primary method used to speak up via the FTSU function was electronically via the online form/app (77.6%) and email (22.4%).

The Board noted there was a continued classification of concerns into ‘open,’ 'confidential,’ and ‘anonymous’. The Medical Director highlighted a new feature has been added to the online form and app to explain what each reporting category means and how concerns will be managed. At the start of the form, colleagues are advised that submitting a concern anonymously may make it harder to resolve the issue and could prevent them from receiving additional support or feedback on the outcome.

The Board noted overall, the number of concerns per service line for the staff numbers was proportional. Most concerns were raised in the PES service line, which accounts for over half of the overall NWAS workforce (53.2%) as of October 2025. Operations EOC (Integrated Contact Centres) was the next area with the highest number of concerns raised. It also accounts for the second-largest cohort of our workforce.

In terms of type of concerns, those related to inappropriate attitudes and behaviours were the most common. Concerns related to patient safety decreased; however, in the context of a reduction in the overall total number of concerns, the number of patient safety concerns remained stable, as the second-highest type of concern raised across the organisation.

The Medical Director highlighted an improvement in timely resolution across all service lines, with an overall mean to closure of 17 days, compared to 28 days last year. The monthly executive assurance meeting continues to meet to discuss key themes or issues which are then shared with the wider Executive team and relevant Board members to consider any risks, further actions and learning for the Trust.

The Board were advised that the well-led review undertaken by the Good Governance Institute (GGI) looked into the FTSU processes and acknowledged that the FTSU function had undergone notable improvements with investment in time, resources, and leadership support. Action was taken following GGI’s feedback to take all future reports through Q&P before Board submission, including this report which was taken to Q&P in December. The recent review of the Freedom to Speak Up Policy (now the Speaking Up Policy) was taken to TMC before Board approval, and this process will be followed for all future policy reviews.

Concluding his presentation, the Medical Director advised the FTSU Team are working with colleagues across Quality and Corporate Affairs directorates on developing triangulation of data to identify themes, trends, and incidents of concern and bring them to wider organisational view.

Dr A Chambers commended the marked improvement in the FTSU process and the quality of reporting during her time with the organisation. She suggested that inviting a Non-Executive Director to the executive review meeting would further strengthen governance and oversight. She also highlighted the importance of addressing the ‘so what?’ question in future reports, encouraging clearer articulation of the impact of concerns raised and the resulting changes.

Ms C Todd agreed that learning arising from concerns should be reflected within the report. She questioned the assumption that a reduction in concerns raised is inherently positive, noting that other organisational mechanisms may be capturing issues instead. She also referred to her previous experience, where benchmarking against protected characteristics was routinely included, and suggested this would be beneficial here.

Mr N Gower supported these observations, noting that with FTSU now well embedded, a decrease in concerns could be interpreted either positively or negatively depending on the wider context.

Mr G Chapman highlighted the increasing influence of social media and suggested that colleagues may be raising concerns through online platforms. He queried whether such activity is monitored or captured.

Ms C Butterworth drew attention to the proportion of anonymous concerns (24%) and recommended including benchmarking data over time, comparing this with other trusts to determine whether the figure is typical. She also requested data demonstrating proportionality by headcount within individual service areas. Finally, she encouraged the inclusion of staff ‘voice’ to reflect their personal experience of the FTSU process.

The Chair summarised the discussion thus far and pointed to significance of further triangulation of data.

The Medical Director acknowledged all comments and would take them away to the FTSU Guardians for consideration. He advised the FTSU Guardians may have more interactions, however, as they redirect them to more appropriate pathways, the number of FTSU concerns itself is reduced. This will be captured in the future reports.

Dr A Chambers reflected on the discussion regarding the reduction in concerns raised. She cited an example from another organisation where both a decrease and a subsequent increase in concerns had been interpreted positively, illustrating the inherent challenge in using volume alone as a measure of FTSU effectiveness. She further noted that FTSU should not function as a catch-all route for all issues and emphasised that many HR-related concerns are more appropriately directed through established organisational processes.

Prof A Esmail reminded the Board of the core purpose of the FTSU process, noting that it was established primarily to address concerns relating to patient safety. He advised that the number of concerns raised should not be viewed as the key indicator of effectiveness. Instead, he emphasised the importance of

understanding staff confidence—both in knowing how and where to raise concerns, and in trusting that the organisation will act on them appropriately.

The Chief Executive outlined the CQC's criteria for assessing effectiveness, noting that inspectors will focus on whether staff understand how to raise a concern and have confidence that it will be addressed. He also referred to the earlier discussion on benchmarking and confirmed that the organisation places less emphasis on fluctuations in the number of concerns raised, focusing instead on the themes identified and the learning derived from them.

The Board:

- Noted the assurance received relating to the ongoing efficacy of speaking up arrangements within the Trust.
- Continued its ongoing commitment to FTSU across the Trust to meet its strategic aims of high quality and inclusive care, together with being a great place to work.

BOD/2526/133 Trust Management Committee 3A Report from the meetings held on 17th December 2025 and 21st January 2026

The Chief Executive presented the Trust Management Committee (TMC) 3A report from the meeting held on 17th December and advised there was one alert and several advisements, approvals and assurance reports, as listed within the report. The alert related the upcoming final submission deadline (12 February 2026) for the medium-term financial plan position.

Referring to the meeting held on 21st January 2026, the Chief Executive reported four alerts and a number of advisements, approvals and assurance reports, as listed within the report. The alerts were related to: MARS Scheme, Early Adopter Programme – Future workforce Solution and 2025 NHS Staff Survey.

Ms C Butterworth enquired about the embargo for the Staff Survey results. The Director of People advised the Trust received the initial high-level results from the 2025 NHS Staff Survey but those were subject to embargo in respect of wider publication until March. The received data would be used for internal planning only until the embargo is lifted.

The Chair referred to the item NWAS Restorative Resilience Supervision training from 21st January TMC with request for more information. Both the Chair and Ms C Todd advised of positive experience it in other organisations where it was found to be helpful with cultural aspects. The Director of People advised the Trust received a proposal from AQUA to train a cohort of resilience supervision trainers. TMC reviewed the offer and concluded the approach was positive and potentially beneficial, however a more detailed proposal was required before a formal approval could be considered. The item would return to TMC when the proposal is firmed up.

The Board:

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

BOD/2526/134 Resources Committee 3A Report from the meeting held on 20th November 2025

Mr G Chapman presented the Resources Committee 3A Report from the meeting held on 22nd January, the first he chaired at NWAS. He noted that the meeting had been well organised and that both the reports and the quality of discussion were of a high standard.

The Board noted there were no alerts and the Committee received a number of reports for approval and assurance, as listed in the 3A report. A number of items would be discussed on today's Board agenda and brought in for final approval at the latter part of the Board.

The Board:

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

BOD/2526/134 Future Workforce Solution – Invitation to be an Early Adopter

The Director of People presented the report on the invitation for the Trust to become an Early Adopter of the Future Workforce Solution, the planned replacement for the Electronic Staff Record (ESR). She outlined that ESR has been in use nationally since 2008 and that, following a procurement exercise by NHSBSA, Infosys has been awarded the contract to deliver the new system. From September 2026, Infosys will assume responsibility for the existing ESR while developing and supporting implementation of its successor.

The Board noted that the new system will be centrally funded, cloud-based, and designed around high levels of self-service, interoperability, and AI-enabled functionality.

The Director of People reported that the Trust had been approached in December to act as an Early Adopter, one of only two ambulance trusts invited. She outlined the associated benefits and risks.

Benefits included opportunities for self-service transformation, streamlined HR processes, improved staff and manager experience, and earlier realisation of cash-releasing savings through the replacement of existing commercial systems. Early Adopters would also receive enhanced technical and project support, not available to later waves. Ambulance-sector involvement was considered important to ensure the system meets sector-specific requirements.

Risks included the inherent risk associated with implementing a system that underpins payroll. As the Trust currently outsources payroll, Early Adopter status would likely require continuation with the current provider throughout implementation and shortly thereafter.

Accordingly, the recommendation was to commit only to the Foundation Readiness phase, running to the end of June, to assess data quality, current system usage, interoperability opportunities, and internal digital and HR readiness. This phase would conclude with a Board-level decision point in June on whether to proceed. If approved, implementation would be targeted for completion by July 2027 under a rapid rollout model.

Mr G Chapman confirmed that the item had been discussed and endorsed by the Resources Committee. He sought clarification on the extent of the Trust's involvement in the development of system functionality and raised concerns regarding the risk of implementation delays and the potential impact on other Trust programmes.

The Director of People advised that the Trust was expected to participate in system testing, although further detail had not yet been provided. She noted that any delay to the roll-out could affect other programmes; however, the contract included strong incentives to support the provider in maintaining the agreed timetable.

Ms C Todd sought assurance regarding the organisation's digital capability to support the roll-out. The Director of People advised that interoperability requirements would be built into the contract.
Mr G Chapman noted that, as the system will be cloud-based, it will not rely on local servers, but adequate network infrastructure will be required to support increased data traffic.

The Chair observed the change of system would have a wide, transformational organisational impact and the learning from such project needs to be captured and harnessed for the future.

The Board:

- Approved the recommendation to commit to participate in the Foundation Readiness phase of the early adopter programme for the Future Workforce Solution.

BOD/2526/135 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 December 2025. She drew out the main points in terms of quality, effectiveness, operational performance, finance and organisational health, as detailed in the executive summary.

In terms of complaints, the Board noted an update from the Director of Corporate Affairs who advised the Q&P Committee receives detailed quarterly reports. There are internal organisational targets for closure of complaints, ahead of the regulatory ones, which depend on complexity of the cases. The Trust receives approximately 2.5 thousand complaints annually.

The current numbers of incidents were being reported as consistent and stable. Closure within SLA for Incidents with Risk Score 4-5 decreased, which was attributable to senior manager's unavailability during winter pressures.

Referring to patient safety incidents, the Director of Quality and Improvement reported a broadly stable position with Care and Treatment being the most common theme and the highest overall reported incident. Additionally, Violence and Aggression also remained the most common theme for non-patient incidents. Overall, there has been a reduction in number of events which was being monitored. There were no new safety alerts affecting the organisation.

With regards to Patient Experience data, the Director of Strategy and Partnership advised of a generally static position, with responses and comments in PES higher in December as compared to November. Satisfaction levels remain similar. The returns for PTS were also higher in December, with satisfaction slightly lower when compared to December 2024. As for NHS 111 return levels remained significantly improved over the last 8 months due to additional opportunities to ask questions via NHS 111 service care text.

The Medical Director reported the Trust was performing above the sector average for most Ambulance Care Quality Indicators (ACQI's), however survival at 30 days post discharge (Utstein) decreased to below to sector average at 18.6%. Analysis by clinical audit indicates no singular cause for this but a deterioration in ROSC performance in C&L.

A discussion took place regarding the categories of calls, the segmentation as well as top-down rigour and the arrangements of senior clinician oversight at ICC, which had been increased over time.

The Director of Operations provided an oversight of the performance over the year, highlighting incident growth and call volume reduction, which was due to responding to calls quicker thus reducing duplicate calls.
He reported on the operational performance data in relation to Paramedic Emergency Services (PES) Activity, PES Call Pick Up and 999 Ambulance Response Performance.

The Board noted the H&T rate was 20.0% and displayed special cause throughout the month, caused by an increase in telephone triage. The decrease in S&T, also displaying special cause at 26.3%, was likely linked to the increase in H&T as both outcomes originate from a similar patient cohort. Nationally, the Trust ranked 4th for H&T, 9th for S&T and 8th for S&C.

In terms of Call pick-up, the Director of Operations reported the volume stabilised towards the end of December however overall pick up was 114,076 in December compared to 105,455 in November. Call handling performance has improved with the average pick-up tome decreased.

Reporting on C1 mean response time, the Director of Operations advised of stable position at 07m:09s unchanged from November. During the first two weeks of December, response times were stable before improving consistently over the remainder of the month.

The Board noted categories C2, C3 and C4 have deteriorated, which was correlated to extended handover times in the system. It was noted however that despite the continued delays, the handover times were 6 minutes better than the previous year at this time and December response to C2 mean was 5 minutes better than last year. The C2 mean standard delivery was critical in terms of UEC.

In terms of long waits, the Director of Operations advised the C1 long-waits incidents increased in December 2025, however remained significantly lower that December 2024. The long waits for C2 and C3 were also lower compared to previous year. The Service Delivery Operational Performance Group continues to monitor and scope opportunities for improvement.

Prof A. Esmail cautioned against the risk of normalising current ambulance response performance and emphasised the need to avoid complacency.

The Director of Operations reported that the constitutional standard for Category 2 average response times, set at 18 minutes in 2018, has not been achieved by any ambulance provider since the Covid-19 pandemic. He confirmed that improvement work remains a priority.
He noted that the current national target set by UEC is under 30 minutes, with NWAS working towards an internal aim of 28 minutes and 46 seconds.

The Chief Executive observed that public expectation remains that an ambulance will attend every 999 call and that it will do so within the historic 18-minute standard. He noted that the operational reality is now different and emphasised the importance of managing public expectations accordingly.

Mr G Chapman noted the significant disparity in ambulance stacking across different hospital sites and asked whether the organisation had the ability to convey patients to a hospital that, while not the nearest, may provide a quicker handover.
The Director of Operations advised this was considered and based on evidence and examples from the system, it was deemed there were more downsides to this approach than benefits, due to complexity of the system and care pathways for the patient.
The Medical Director advised it would never be completely excluded, and the approach was taken occasionally and sparingly. There were some services which were collocated now in hospital which may not be the nearest to a patient.

Prof A. Esmail noted that although NWAS has consistently remained one of the highest-performing ambulance services, its performance appears static while other trusts are showing improvement.
The Director of Operations reported that the levelling up of performance across the sector was a positive development. He advised that NWAS performance is influenced by several external system factors, including Emergency Department handover times. He confirmed that the organisation continues to focus on improving those areas within its direct control while maintaining its position among the leading performers.

Ms A. Cooper sought assurance regarding the level of confidence within the Trust that all reasonable actions are being taken to minimise ambulance clear times.
The Director of Operations advised that the Trust was a top performer in the country for clear time and focus needs to remain on things that are within our control.

The Chair referenced her recent visits to hospital sites, arranged by the Area Directors. She advised that hearing first-hand accounts of current challenges and the actions being taken to improve services had provided valuable insight. She reiterated her intention, noted at previous Board meetings, to invite the Area Directors to share their experiences with all Non-Executive Directors.

The Board received an update on 111 performance and noted that despite increased demand and higher than usual staff sickness the number of answered calls was higher than ever, which was partly attributed cross-skill ICC training activity has led to calls answered within 60 seconds sustaining below average performance during winter.

In reference to Patient Transport Services (PTS), the Board noted activity and performance metrics were stable and operational and workforce improvement plans were in place.

The Director of Finance took the Finance section as read. The Board noted the year-to-date financial position to 31 December 2025 (Month 09 2025/26) was a surplus of £3.562m, compared to a planned surplus of £0.592m. It was noted the Resources Committee received in-depth reports on finance, productivity and efficiency.

The Board noted the main headlines from the Workforce section, including stable and strong position.

The Director of People highlighted information regarding sickness absence. She provided sector context: ambulance services see higher sickness than other NHS parts due to cultural and environmental factors (trauma exposure and manual handling in uncontrolled environments leading to MSK issues). Investment in an Attendance Improvement Team yielded year-on-year sickness improvements and a comparative sector improvement, although this year was more challenging.

The Director of People reported PTS and ICC have faced attendance management challenges, partly due to leadership changes and uncertainty around the PTS tender affecting workforce indicators. There was a significant sickness spike in October/November driven by an earlier flu season and compounded by handover delays leading to burnout. Consequently, there was a risk of missing the annual target of a 0.65% sickness reduction; nevertheless, an overall improvement vs the previous year was expected. The Attendance Improvement Team were focusing on building confidence and capability of new managers in PTS and ICC to manage sickness more effectively. Longer term, the new strategy aims to shift managers into a preventative space

Ms C Todd sought clarification on whether there was any correlation between long-term sickness absence levels and uptake of the Trust's wellbeing offer.
The Director of People reported that this area continues to receive focused attention. She outlined ongoing work to strengthen the comprehensive wellbeing offer, including the recent launch of the online Wellbeing Hub, which has improved staff access and navigation across the various support strands. She also highlighted the Occupational Health provision available to staff. The Director confirmed that efforts remain underway to further enhance awareness, visibility, and accessibility of the wellbeing offer across the Trust.

Ms C Butterworth referenced a discussion at the Resources Committee regarding the current sickness absence position, acknowledging there had been a small incremental change over time. The question of the debate was whether the current performance was the expected baseline. The consensus was there was still improvement possible especially through the organisational culture and strengthening of grip and control. She stated that there remains further scope to the contribution of the Attendance Improvement Team, acknowledging the achievements thus far.

The Board:

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

BOD/2526/137 Quality and Performance Committee 3A Report from the meeting held on 15th December 2025.

Prof A Esmail introduced the report, taken as read, which contained no alerts and several advisements and assurances. He noted that the key issues discussed at the Q&P Committee had been also included and discussed on today's Board agenda.

In relation to the earlier update on the Mental Health Act 2025, he referred to the Mental Health Report outlining the three-year mental health plan and the ongoing Training Needs Analysis presented to the Committee in December. He emphasised the need for continued focus on this area and for further detail to be developed in light of the updated national policy.

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

BOD/2526/138 Communications and Engagement Q3 2025/26 Report

The Director of Strategy and Partnerships took the Board through the key headlines from the report, which were included in the Q3 Dashboard enclosed at Appendix 1.

The Board noted updates Patient Engagement, including nine engagement opportunities with various organisations, for example: Chinese Health Information Centre (CHIC), Sahara in Preston, Manchester Migrant Support group, University of Burnley (Jobs Fair) and Patoss Dyslexia charity.

The Director of Strategy and Partnership further highlighted updates on PTS Health Literacy Project and Patient Surveys.

The Director of Strategy and Partnership pointed to s2.3 of the report including update on NW Ambulance Charity, with highlight of key activities, fundraising and the benefits to NWAS staff and local communities.

The Board noted the comprehensive Dashboard at Appendix 1, with data and details regarding Patient and Public Engagement, Patient and Public Panel, Internal Communication, stakeholder engagement, press and public relations, Freedom of Information requests, digital communications and North West Ambulance Charity.

The Chair thanked the Director of Strategy and Partnership and his team for the comprehensive report and the dashboard and noted the interesting and high-quality social media content for the organisation.

The Board:

- Noted the content of the report and assurance provided.

BOD/2526/139 Any Other Business Notified Prior to the meeting

None advised.

BOD/2526/121 Risks identified

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

Date and time of the next meeting –
25th March 2026 at 09:45 am in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Signed _____

Date _____

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

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
10 - 25/26	28.01.2026	2526/127	Chair & Non-Executives' Update	The Board discussed the Mandatory Training requirements for Non-Executive Directors and noted that ESR does not currently hold a discrete profile setting out the required modules. **The Board noted that the Director of People would circulate the definitive list of Mandatory Training modules to all Non-Executive Directors.**	Director of People	Mar-26	Mar-26	The Director of Corporate Affairs confirmed the definitive list of MT was circulated to the Non-Executive Directors. **Item complete & for removal.**	

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	✔	✔	
Catherine Butterworth	✔	x	✔	x	x	✔	✔	
Dr Alison Chambers	✔	✔	✔	✔	x	✔	✔	
Graeme Chapman							✔	
Anne Cooper							✔	
Salman Desai	✔	✔	✔	✔	✔	✔	✔	
Prof Aneez Esmail	✔	✔	✔	✔	✔	✔	✔	
Michael Gibbs				✔	✔	✔	✔	
Nic Gower							✔	
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	
Dr David Hanley	✔	✔	x	✔	✔	✔		
Julia Mulligan (Chair)				✔	✔	✔	✔	
Dr Elaine Strachan-Hall	✔	✔	✔	✔	✔	✔	✔	
Clare Todd							✔	
Lisa Ward	✔	✔	✔	✔	✔	x	✔	
Angela Wetton	✔	✔		✔	✔	✔	✔	
David Whatley	✔	✔	✔	✔	✔			
Peter White (Chair)	✔	✔	✔					
Carolyn Wood	✔	✔	✔	✔	✔	✔	✔	

Audit Committee							
	25th April	23rd May	18th June	18th July	24th October	16th January	17th February
Nic Gower (Chair)						Meeting Cancelled	✔
Dr Alison Chambers	✔	✔	✔	✔	✔		x
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	✔	✔	✔	x
Michael Gibbs			✔	✔	x	✔
Graeme Chapman **(Chair)**					✔	✔
Nic Gower					✔	✔
Anne Cooper						✔

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

Charitable Funds Committee				
	14th May	23rd July	22nd October	18th February
Daniel Ainsworth	x	x	Meeting Cancelled	x
Catherine Butterworth	✔	✔		✔
Nic Gower (Chair)				✔
Dr David Hanley	x	x		
Lisa Ward	✔	✔		✔
Clare Todd				✔
Angela Wetton	✔	✔		✔
David Whatley (Chair)	✔	✔		
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	✔	✔	No meeting
Dr Alison Chambers	✔	✔	✔	x	✔	✔	✔	
Graeme Chapman							✔	
Anne Cooper							✔	
Prof Aneez Esmail	✔	✔	✔	✔	✔	✔	✔	
Nic Gower							✔	
Dr David Hanley	✔	✔	✔	✔	x	✔		
Clare Todd							✔	
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.
Graeme	Chapman	Non-Executive Director	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		.
Anne	Cooper	Non-Executive Director	Shareholding in Ethical Healthcare Ltd	√					Aug-21	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	03-Mar-26	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.
Nicholas	Gower	Non-Executive Director	Non-Executive Director of Manchester University NHS Foundation Trust				√		Oct-17	Present	Chair and appointment committee aware. No conflict. Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.

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.
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	04-Dec-25	N/A
			Trustee, Independent Domestic Abuse Service (for a period of 2 years)				√	Position of authority	Dec-25		N/A
			Member of Fawcett Society				√		2020	Present	N/A
			Appointed to the Home Secretary's Police Leadership Commission hosted by the College of Policing			√			13-Nov-25	30-Apr-26	There are no risks to be mitigated as time commitment reduced from one role, and then taking on a time-limited, voluntary position that will have learning relevant to NWAS.
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.
Clare	Todd	Associate Non-Executive Director	Non-Executive Director at Pennine Care NHS Foundation Trust				√	Position of Authority	Apr-22	Present	Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
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	
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	
David	Hanley	Non-Executive Director (Left the Trust 30 November 2025)	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 (programme finished December 2025)	Non-Executive Director - Lumen Housing	N/A	N/A	√	N/A	Directorship	Dec-23	Present	

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
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**	☒

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 this report
EXECUTIVE SUMMARY	The purpose of this report is to provide members with the headline information on several areas for the period 22 January – 19 March. **Highlights** **Organisational** <u>Freedom of the Borough</u> I was honoured on behalf of the Trust to accept the Title of Honorary Freeman of the Borough of St Helens in recognition of the outstanding service provided by the Trust and the high esteem in which we are held by both the Council and the local community for our dedication and contribution to the local community. **Finance** <u>Metrics post de-escalation from IAG process</u> The Trust remains within the threshold for all four metrics. <u>Income and Expenditure</u> The financial position to 28 February 2026 is a surplus of £5.657m, against a planned surplus of £0.667m. <u>2026/27 Opening Financial Plans and Budgets</u>

Work on setting the opening financial plans and budgets in line with the approved financial plans are complete and received today for Board approval. Work continues to address the efficiency target shortfall of £2.152m.

People & Culture

Pay Award

The government has accepted the Pay Review Body's recommendation for a 3.3% pay award to be applied to NHS staff on Agenda for Change contracts. The Trust is fully prepared to implement this from 1 April 2026 and welcomes the timely decision, which enables smooth delivery of the award.

Holocaust Remembrance

The Deputy Chief Executive attended a Holocaust Remembrance event hosted by Manchester City Council. As an organisation, we continue to reflect on how we raise awareness of antisemitism and other forms of racism and strengthen our commitment to being actively anti-racist.

Operations

UEC Plan 25/26 update

Deployment of Double-Crewed Ambulance (DCA) hours continue to be above the planned trajectory as set out in the 2025/26 UEC plan.

Medical Assessment Centre – Blackpool Teaching Hospital

The opening of the medical assessment centre is already delivering strong results. Average handover times have fallen by 14 minutes, long delays have reduced significantly, and attendances remain stable. Learning from the early weeks is being captured, and the changes are contributing to improved Cat 2 performance in both the Fylde sector and the wider Cumbria & Lancashire area.

Strategy

2026/27 Annual Plan

The Annual Plan continues to progress through the governance process, defining 19 strategic objectives and 81 deliverables aligned with the emerging Trust Strategy. Achievability assessments have been undertaken to ensure affordability and organisational readiness, strengthening our multi-year planning framework.

Trust Strategy 2026-2031

The Strategy and the four supporting strategic plans are now in their final stages of development, setting out long-term ambitions, delivery priorities, and cross-cutting themes such as health inequalities and EDI. Subject to approval, the focus will shift to launch, engagement, and strengthened assurance through the Planning Group.

Quality

The last classroom teaching session for cohort 2 of the Improvement Academy took place on 19 March. The session focused on adopting the 'habits of an improver' and involved a scale up of ideas.

PREVIOUSLY CONSIDERED BY	Not applicable	
	Date	Click or tap to enter a date.
	Outcome	

1. BACKGROUND

This report provides a summary of the key activities undertaken and the internal, national, regional and system items to note since the last report to the Board of Directors on 28 January 2026.

2. INTERNAL UPDATES

Strategy and Partnerships

Annual Planning

Development of the 2026/27 Annual Plan has progressed throughout Q4 and is now moving through the Trust's governance process. The plan sets out the key delivery priorities for the year ahead and aligns the first year of implementation with the emerging Trust Strategy and Strategic Plans. It brings together 19 strategic objectives and 81 underpinning deliverables, providing a balanced programme that combines ongoing work from the current plan with new priorities identified through strategy development.

As the majority of deliverables are multi-year in nature, the plan supports the Trust's shift toward a more structured multi-year planning approach. A structured achievability assessment has been completed to test each deliverable for affordability, capacity and organisational readiness. Following approval, Planning Group will continue to provide quarterly assurance to TMC and the Resources Committee on delivery progress.

Strategy Development

Development of the Trust Strategy 2026–2031 and the supporting Strategic Plans is now in its final stages, following a comprehensive redevelopment programme undertaken over the past year. The Strategy sets out the Trust's long-term ambition and strategic direction, structured around four strategic aims and underpinned by cross-cutting themes including health inequalities, equality, diversity and inclusion, and continuous improvement.

To translate these aims into actionable delivery priorities, four aligned strategic plans have been produced: the Quality Plan, People and Culture Plan, Clinical Response Plan, and Future Sustainability Plan. Each plan outlines the strategic objectives and delivery roadmap that will guide activity over the next five years and provides the framework for annual planning.

Subject to board approval, focus will shift to launching and embedding the Strategy and plans. This will be supported by a dedicated communications and engagement programme and strengthened delivery assurance arrangements through the Planning Group and associated governance routes.

Finance

Metrics post de-escalation from IAG process

The Trust remains within the threshold for all four metrics.

Income and Expenditure

The financial position to 28 February 2026 is a surplus of £5.657m, against a planned surplus of £0.667m. The month 11 forecast (m11 +1) projects a surplus of £6.483m.
Agency costs in month 11 are nil, year to date costs remain at £0.003m.

Productivity and Efficiency

The 2025/26 target is to deliver £14.878m of recurrent savings, of which £13.634m have been achieved to month 11 which is in line with the month 11 target. The forecast achievement against the plan is £14.905m, which is an overachievement of £0.027m.

The projected recurrent delivery remains at £14.362m, which is an under-delivery of £0.516m, which has been carried forward into the 2026/27 financial plan.

2026/27 Opening Financial Plans and Budgets

Work on setting the opening financial plans and budgets in line with the approved financial plans are complete and received today for Board approval. Work continues to address the efficiency target shortfall of £2.152m.

People & Culture

Holocaust Remembrance

The Deputy Chief Executive attended a Holocaust Remembrance event hosted by Manchester City Council, hearing directly from a survivor who experienced the impact of the regime on him and his family through the war in Hungary. It was a salutary reminder of horrors of the genocide experienced by the Jewish people in the second world war and the importance of speaking out and not remaining silent when we witness poor behaviours around us.

As an organisation we have been reflecting on how we raise the profile of antisemitism and other forms of racism and move towards being actively anti-racist in our approach to patient care and leadership. The Trust published its anti-racism statement in October and drive forward initiatives to bring this to life in the organisation. To strengthen this Board is asked to support the recommendation from Trust Management Committee to adopt the recommended working definition of antisemitism from the International Holocaust Remembrance Alliance. This will then further inform the work of the anti-racism steering group.

Flu

As we come to the end of our Flu vaccination campaign for the winter of 2025/6 we were pleased to receive a letter of congratulations from the NHS England Regional Director in relation to our Flu performance. The Trust has vaccinated in excess of 45% of frontline staff and exceeded the national target of 5% improvement. Vaccination offers an important protection for our staff, their families and for the patients that we treat and is a critical part of our winter preparations. So, whilst we want to continue to drive improvement in levels of uptake we are pleased to have made such good progress this year and to have performed well in comparison with other trusts in the region who don't face the challenges of our geographic spread and peripatetic workforce.

Pay Award

The government announced its acceptance of the Pay Review Body recommendation for a 3.3% pay award to be applied to NHS staff on Agenda for Change contracts. The Trust has the appropriate preparations in place to implement this as planned and is really pleased that this has been agreed in a timely manner to enable full implementation from 1 April 2026.

Staff Networks

Our staff networks continue to provide fantastic support for staff and to bring appropriate challenge to the organisation to help us to improve. The last couple of months has seen the celebration of LGBT+ History month and the launch of CPD resources 'LGBT+ Basics' developed by the network to support staff to build confidence in navigating LGBT+ issues in healthcare. The Women's Network hosted an extremely successful International Women's Day event in Southport attended by around 100 people. Attendees were treated to inspirational personal stories, updates on key pieces of work supported by the network and provided a safe space to surface some of the challenges still faced by women in our workforce. The Armed Forces network has hosted its five year anniversary conference

in March and both the Disability and Race Equality Networks continue to do great work in support of their members.

Operations

Cheshire & Merseyside

Plans to relocate the Paediatric Emergency Department from Ormskirk to Southport over the next three years have now been approved. While the proposal has generated some public concern, the change is expected to deliver significant clinical and operational benefits, particularly through the planned expansion to a full 24/7 service.

Modelling undertaken by the Trust indicates minimal impact on Trust performance, reflecting the very small number of paediatric cases currently conveyed to Ormskirk. The Cheshire & Merseyside ICB has confirmed that funding for this programme will be drawn from the same UEC investment stream that we intend to access for the St Helens rebuild.

Separately, the proposed transfer of Walton Neuro and Clatterbridge Liverpool services to UHLG has been paused. This follows ongoing discussions relating to the configuration of maternity services at Liverpool Women's Hospital. The pause reflects both the operational complexity of the proposals and the levels of public concern.

Cumbria & Lancashire

The opening of the Medical Assessment Centre (MAC) at Blackpool Teaching Hospital has delivered early, positive operational outcomes. In the three weeks following go-live, we have observed:

- Improved average handover – 14 minutes faster than the same period last year (reduced from 38 minutes to 24 minutes)
- Reduced long delays – only one quarter as many handovers exceeded 45 minutes.
- Attendance remained stable – indicating improvements are linked to process rather than demand variation.

Work is ongoing to identify and disseminate learning from this model. The improvement is contributing positively to Cat 2 performance in the Fylde sector and supporting wider performance gains across the Cumbria & Lancashire area.

UEC Plan 25/26 update

Despite the ongoing challenges associated with procurement of private ambulance service providers, deployment of double-crewed ambulance hours continues to be above the planned trajectory as set out in the 2025/26 UEC plan.

Quality

The last classroom teaching session for cohort 2 of the Improvement Academy took place on 19 March. The session focused on adopting the 'habits of an improver' and involved a scale up of ideas.

A celebration and graduation event is due to take place on 24 April, which will mark the end of this cohort.

3. UPDATES

3.1 National Update

NHS Leadership Event

On 27 January, I attended the NHS Leadership Event in London, which brought together ICB and Trust Chief Executives and primary care providers to focus on national priorities, leadership capability and

system-wide collaboration. The programme included sessions on organisational culture, improvement leadership, and the role of senior leaders in supporting recovery and transformation across the NHS. Attendance provided a valuable opportunity to engage with peers, share best practice, and strengthen networks that will support ongoing leadership development and delivery of the trust's strategic objectives.

NHSE Corridor Care Definition Published

NHS England has issued new national requirements to virtually eliminate corridor care, introducing a single definition - patients spending 45 minutes or more in clinically inappropriate areas - and confirming that all trusts must begin submitting data against this from 6 March, with monthly national publication from May 2026. The letter sets out a strengthened national programme including GIRFT-led operational support, clearer expectations for incident reporting and board-level ownership of corridor care as an organisational risk, and reinforcement of existing urgent and emergency care guidance. NHS England has also convened the 30 most challenged trusts to co-produce local improvement actions, emphasising the need for visible executive leadership, improved patient flow, and real-time capture of patient and staff experience.

The NHS Alliance

NHS Confederation and NHS Providers have confirmed that their new merged membership organisation will be called The NHS Alliance. The NHS Alliance will formally launch in April and will represent and support healthcare organisations across England, Wales and Northern Ireland. Its purpose is to provide a strong national voice for health leaders, strengthen collaboration across the system, and enhance advocacy during a period of significant pressure and transformation for the NHS.

NHS Staff Survey 2025

The 2025 NHS Staff Survey, published on 12 March 2026, shows a mixed picture. Nationally, staff report positive relationships with line managers and the lowest-ever levels of discrimination from colleagues, but indicators around workload, burnout and wellbeing have worsened, with almost a third of staff feeling burnt out.

For NWAS, this year saw our highest-ever participation (4,100 responses; 53%), giving us a strong evidence base. Results are largely stable and positive, broadly aligned with Ambulance sector averages, with several areas performing at or above sector level.

The Neighbourhood Health Framework

The Neighbourhood Health Framework, published on 18 March 2026, sets out a national shift toward delivering more integrated, preventative care within local communities rather than relying on hospital-based models. It aims to improve outcomes and reduce inequalities through stronger GP access, more proactive community support and redesigned pathways that reduce avoidable admissions. Integrated Neighbourhood Teams will coordinate care for high-need groups such as frailty, end-of-life, long-term conditions and children and young people, supported by new contracting models and the development of Neighbourhood Health Centres.

3.2 **Sector Update**

Ambulance Leadership Forum Conference

The 2026 Ambulance Leadership Forum (ALF) Conference took place in Windsor on 10–11 March, with NWAS strongly represented throughout the programme. I contributed as part of the CEO panel for the session *'Ensuring sustainable services for our patients and our people'*, where I spoke about sustaining a positive and resilient culture within the ambulance service as a core enabler of safe and effective care that supports our staff.

On day one, Emily Gibbs, Knowledge Vault Manager, presented on behalf of Rebecca Lennox, Emergency Medical Advisor, showcasing Rebecca's research paper *'The ModiBody sustainability product – enhancing staff wellbeing and reducing environmental impact'*. The presentation was well received and demonstrated our continued focus on innovation, staff wellbeing and environmental responsibility.

Area Directors Ian Moses (CAM) and Matt Cooper (CAL) also contributed to the conference programme, taking part in the session *'Becoming Board Ready: the transition from operational to executive leadership'*. They outlined their leadership journeys and reflected on the skills, behaviours and development required for progression into executive roles, highlighting the strength of our internal leadership pipeline.

At the Awards Dinner, NWAS celebrated the success of Angela Jennings, Fleet and Equipment Support Manager, who received the *Exceptional Support Services Member of the Year* award. Angela's leadership ensures frontline teams have the equipment and support required to deliver safe, effective care. She consistently demonstrates professionalism, compassion and a commitment to continuous improvement, exemplifying the critical contribution of support services to our operational effectiveness and overall patient response.

London Ambulance Service – Chief Operating Officer interviews

I supported London Ambulance Service with the recruitment of their new Chief Operating Officer, participating as a member of the interview panel on 20 February. This engagement formed part of our ongoing commitment to sector-wide collaboration, sharing expertise and contributing to strengthened leadership capacity across the wider ambulance community.

3.3 **Regional Update**

NHS England – year end priorities

I joined a call with fellow Chief Executives, Sir Jim Mackey, and NHS England Executive colleagues to discuss year-end delivery priorities for March. The discussion focused on operational performance, financial positions, and the coordinated actions required across the system to ensure successful delivery of national priorities as we approach year end. This engagement supports ongoing alignment across regions and reinforces the collaborative leadership approach needed to maintain stability and performance during the final quarter.

Appointment of NHS England North West Regional Chair

Kathy Cowell has been appointed as the first NHS England North West Regional Chair, bringing extensive NHS leadership and experience. Starting on 1 May 2026, she will provide independent regional leadership, support ICB and provider Chairs, and help drive delivery of the 10-Year Health Plan with a focus on improved outcomes and reduced inequalities.

3.4 **System Update**

Visit to Salford Royal Hospital – Major Trauma Centre

I visited the Major Trauma Centre at Salford Royal Hospital, hosted by Professor Martin Smith, Consultant in Emergency Medicine. The visit included a tour of the new Major Trauma building and provided an opportunity to observe first-hand the high-quality care delivered by the hospital team. It also offered valuable insight into current operational pressures, patient flow and handover processes, and enabled discussion on how we can further strengthen collaborative working between NWAS and the Trust. This engagement supports our commitment to improving system interfaces, enhancing flow, safety and the overall patient experience.

Non-Emergency Patient Transport Service (NEPTS) Update

The NEPTS tender process closed to submissions on 13 March 2026, with the ICB scheduled to confirm the outcome in May 2026.

3.5 **Organisational**

Segmentation and Ranking under NHS Oversight Framework

NWAS has retained its Segment 1 position under the NHS Oversight Framework for Quarter 3 of 2025/26, with no change from Q2. The Trust also continues to rank 1st out of 10 ambulance services nationally. Updated Q3 data will be published in the Model Health System from 18 March 2026, with the public portal update to follow shortly.

External Partners Round Table Events

On 9 February, NWAS hosted two external stakeholder roundtable events to support development of the Trust Strategy 2026–2031. The sessions, led by Dr Susy Cook, CEO of AQuA, brought together system partners from across Lancashire and Cumbria in the morning, and from Greater Manchester, Cheshire and Merseyside in the afternoon. Their purpose was to share the emerging strategic framework, test key assumptions, and explore how partnership working with the ambulance service should evolve over the next five years. These sessions were designed to enable open, constructive discussion rather than formal consultation.

Feedback focused on the four strategic aims - outstanding care, inclusive culture, responsive partnership-based models, and embedding improvement and sustainability. Participants highlighted opportunities, risks, and alignment with system priorities, and identified areas where the Strategy could be clearer or more ambitious. AQuA facilitated structured discussion across both sessions, and the insights gathered are now being synthesised to inform final refinement of the Strategy and supporting strategic plans.

This external engagement represents an important step in ensuring the Strategy is credible, deliverable, and reflective of system needs ahead of submission to the Board of Directors. Further engagement work with AQuA continues.

Ramadan and Eid

Throughout February and March, colleagues across NWAS observed Ramadan, a period of fasting and reflection for our Muslim staff and the communities we serve. This year, NWAS hosted a well-attended Iftar event on 7 March at the Royal Nawaab Pyramid in Stockport, bringing together staff to break the fast. During the month, we provided supportive communication, wellbeing guidance and flexible working considerations for those observing.

Cadet upskill day

I was invited to attend the NWAS Cadet Upskill Day on 24 February at the Bolton Whites Hotel. This year's cohort of level 3 health learners were undertaking observer placements with PTS and PES. The cadet programme continues to grow year on year, with engagement from higher education providers increasing from 8 to 19 since 2023. This year's cohort comprises 43 learners, with strong progression outcomes. Several have already been successful at interview for EMT and ACA roles.

I spoke about my own career pathway, highlighting the transferable skills gained in my early roles and the importance of perseverance. The event provided a valuable opportunity to engage directly with our future workforce and to observe and support the work the education team is doing to inspire, develop and support those aspiring to join NWAS.

One Tonne Challenge

In December 2025, I received a letter from 14-year-old Cheshire schoolboy Thomas Morgan, who challenged NWAS to take part in his One Tonne Challenge - an initiative he created to inspire organisations to reduce their carbon emissions or waste by one tonne through practical, measurable action. I was very impressed by his passion and determination, and the Trust has accepted his challenge. Colleagues from PMO, Improvement, and Sustainability teams are now working together to design our approach, ensuring strong alignment with our Green Plan and wider environmental priorities.

We plan to launch the NWAS One Tonne Challenge in June/July 2026, engaging staff across the organisation and strengthening our partnership with Thomas. This initiative offers an excellent opportunity for NWAS to demonstrate leadership in environmental responsibility, support young people taking action on climate issues, and promote meaningful organisation-wide contributions to sustainability.

National International Women's Day

On Friday 6 March, I attended the morning session of the NWAS Women's Network event held to mark International Women's Day. This year's theme, 'Give to Gain' focused on empowering each other through generosity, collaboration and shared success and brought together over 90 colleagues from across the organisation to celebrate women's achievements, highlight areas where further progression is needed, and strengthen our collective commitment to gender equity and inclusion. The morning opened with a welcome from Rebecca Hargreaves - Women's Network Events Lead, followed by an introduction from Dan Ainsworth – Network Executive Sponsor, setting the tone for a day focused on empowerment, learning and allyship.

The session featured a range of impactful contributions about allyship, sexual safety and breaking down barriers. An update was received from the Maternity Group and a personal reflection from Caroline Duncan, HEMS Senior Paramedic Team Leader, on overcoming barriers and achieving success within the ambulance sector. A workshop delivered by the MAMA's Improvement Academy provided valuable discussion on the new maternity toolkit and its application in practice. The agenda showcased the breadth of issues affecting women across the organisation. Attendance at the event offered an important opportunity to hear directly from staff, and reinforced our commitment to creating a safe, inclusive and supporting working environment for all women across NWAS.

Freedom of the Borough

I was honoured on behalf of the Trust to accept the Title of Honorary Freeman of the Borough of St Helens in recognition of the outstanding service provided by the Trust and the high esteem in which we are held by both the Council and the local community for our dedication and contribution to the local community.

I attended the celebration event and presentation on 14 March, alongside colleagues from the wider Cheshire and Merseyside area. The event included a short parade, bringing together emergency services, cadet forces and community organisations that were also receiving the honour.

Culture Event

I had the pleasure of attending and opening the Leadership Culture Event on 17 March, which brought together leaders from across the Trust to reflect on "ambulance service culture" and the role of leadership in shaping a safe, respectful and inclusive working environment. The event provided protected time for colleagues to step back from day-to-day pressures and engage in meaningful discussion about the cultural challenges facing the ambulance sector, informed by recent national reviews and our own staff survey findings.

The programme encouraged honest conversation about the realities of workplace culture and the responsibilities we hold as leaders to challenge poor behaviour, model positive values and create the conditions in which everyone feels safe, supported and able to thrive. We were joined by guest speakers Carys Ward**,** Tim Roberts, and Guy Disney**,** who offered valuable insight and perspectives to help shape our thinking and strengthen our commitment to improvement. I emphasised in my opening remarks that this event marks an important step in reaffirming our shared expectations of leadership, deepening our understanding of what needs to change, and building collective confidence in our ability to drive a healthier and more inclusive culture across NWAS.

In our thoughts

It is with great sadness that I report the passing of Fiona Roberts (nee Clementson) on 4 February following a short period of illness. Her funeral took place on 24 February, at St Peter's Church, Darwen. Our thoughts continue to be with her husband Paul and her family at this difficult time.

The service was attended by many friends and colleagues from across the organisation, reflecting the deep respect and affection in which Fiona was held. I had the privilege of working alongside Fiona for many years and was honoured to deliver her eulogy.

3.6 **Stakeholder engagement**

Engagement with key stakeholders continues and I held meetings with:

- Clare Duggan – NHS England – 23 February
- Local Government reorganisation in Lancashire – stakeholder briefing – 23 February

4. RISK CONSIDERATION

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

5. EQUALITY/ SUSTAINABILITY IMPACTS

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

6. ACTION REQUIRED

6.1 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, 25 March 2026
SUBJECT	Risk Appetite Statement (RAS) 2026/27
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Risk Appetite Statement for 2026/27.	
EXECUTIVE SUMMARY	The Risk Appetite Statement (RAS) defines the level and types of risk the Trust is willing to accept in delivering its strategic aims. The RAS supports consistent, transparent, and evidence-based decision making across all service lines and strengthens organisational governance. The 2026/27 RAS has been developed using the Good Governance Institute (GGI) framework as a foundation, adapted to reflect the Trust's organisational needs and sector context. The updated appetite categories are more clearly defined and significantly more granular than previous models, enabling richer discussions and deeper understanding. Development of the RAS for 2026/27 included engagement with both Executive Directors and Non-Executive Directors - it can be seen in **Appendix 1**.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee (TMC)	
	Date	Wednesday, 18 March 2026
	Outcome	Supported for Board approval

1. BACKGROUND

The Risk Appetite Statement (RAS) defines the level and type of risk the Trust is willing to accept in pursuit of its strategic aims. A clear and consistent appetite supports effective governance, assists with informed decision-making, and alignment of risk management practices across the Trust.

2. GOVERNANCE AND RESPONSIBILITIES

The Board of Directors retains overall accountability for setting, reviewing and approving the Trust's risk appetite.

Trust Management Committee is where the RAS is reviewed, challenged, and supported for Board approval.

3. ENGAGEMENT AND DEVELOPMENT

The 2026/27 RAS has been developed using the Good Governance Institute (GGI) framework as a foundation, adapted to reflect the Trust's organisational needs and sector context. The updated appetite categories are more clearly defined and significantly more granular than previous models, enabling richer discussions and deeper understanding.

The development included engagement with:

- Non-Executive Directors, to ensure appropriate oversight, balance and assurance.
- Executive Directors, to ensure alignment with operational priorities, workforce impacts, digital ambitions, and financial sustainability.

Feedback from both groups has informed the final version of the RAS. The proposed RAS is included in **Appendix 1**.

4. KEY CHANGES FOR 2026/27

The 2026/27 RAS has been updated to:

- Reflect organisational priorities and the current operating environment.
- Provide refined definitions based on the Government Orange Book – Risk Appetite Guidance Note, 2020.
- Maintain alignment with the Trust's strategic aims.

The RAS sets out appetite levels across key domains including, quality, people, finance, regulatory, digital innovation, and reputation, using the agreed scale from averse to eager/ seek.

a) Within the **Quality** category, the Trust adopts a **cautious risk appetite**, meaning that whilst our preference is for risk avoidance, we may accept decisions carrying a low degree of residual risk where there is potential for improved quality outcomes and appropriate controls in place.

Hear & Treat (H&T) and See & Treat (S&T), and Category 2 segmentation - whilst prioritising the sickest patients, these responses do carry a higher residual clinical risk.

b) In the **People** category, the Trust has an **open risk appetite** meaning that we accept some workforce risk is inherent in both delivery of our service and implementing internal changes, but we are willing to introduce new ways of working and undertake change where clear benefits can be realised.

The Service Delivery Model Review (SDMR), which has now been completed and although this programme brought short-term uncertainty for staff, it offered opportunities such as clearer career development routes and enhances clinical and pastoral support for frontline colleagues.

c) In the **Finance** category, the Trust has an **open risk appetite** which means we are prepared to accept some financial risk where appropriate controls are in place and decisions reflect a holistic view of Value for Money (VfM), with cost not being the sole determining factor. This approach recognises that some investment decisions, with manageable risk, can deliver greater VfM over time.

Financial cost is not the only consideration when awarding contracts.

d) In the **Regulatory** category, the Trust has an **open risk appetite** which means we are prepared to accept some regulatory risk where the benefits outweigh any potential adverse consequences.

This may seem counter-intuitive, however, we accept some residual risk in the quality category (cautious), we accept inherent risk to staff in the people category (open), and we are also willing to accept some financial risk (open), ergo we must be open to accepting some regulatory risk – CQC is not the only regulator of healthcare organisations.

e) In the **Digital Innovation** category, the Trust has an **eager/ seek risk appetite** meaning we actively look for ambitious digital opportunities that could significantly improve patient care, staff experience, or operational efficiency. We are willing to accept a higher degree of digital and technological risk, provided these risks are clearly understood, well-controlled, and managed through strong governance and project processes.

We know that greater reliance on digital systems increased the cyber risk with business interruption and impact on critical emergency infrastructure, but we are scoping projects to create unified systems supporting clinical and operational services and opportunities created through the use of AI.

f) In the **Reputation** category, the Trust has an **open risk appetite** meaning we are prepared to accept some reputational risk, where improved outcomes for stakeholders are achievable. We recognise that some decisions, especially those that drive long term change, may attract external scrutiny, but we are willing to manage that scrutiny where the benefits are clear.

5. RISK CONSIDERATION

The Risk Appetite Statement is a framework for the Board of Directors, senior leaders, managers, and staff on how risk should be assessed, discussed, and managed across the organisation. Overall, the Risk Appetite Statement acts as a practical guide to help the Trust balance opportunity and safety, ensuring that risks are taken transparently and for the right reasons.

The Risk Appetite Statement supports the approach to risk management within the Trust.

6. EQUALITY/ SUSTAINABILITY IMPACTS

The Risk Appetite Statement provides a framework that supports equality, inclusion, and long-term sustainability, but does not itself generate any specific impacts requiring formal assessment.

However, by setting clear expectations for how the Trust considers and manages risk, the RAS indirectly supports:

- Equality, by promoting consistent, transparent and evidence-based decision making across all services, ensuring that risks to staff and patients are managed fairly and without discrimination. Clear appetite levels within domains such as quality and people help ensure decisions considers impacts on different staff groups and communities.

- Sustainability, by encouraging well-balanced decision making that considers long-term value, resource stewardship, and the responsible use of public funds. Appetite levels relating to finance, digital innovation and regulation reinforces sustainable organisational practice by ensuring risks are assessed and managed.

7. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Risk Appetite Statement for 2026/27.

North West Ambulance Service NHS Trust

RISK APPETITE STATEMENT (RAS) 2026/27

The Risk Appetite Statement sets out the level and type of risk North West Ambulance Service (NWAS) NHS Trust is willing to accept in pursuit of its strategic aims. The long-term sustainability of the Trust depends on delivering these aims, working effectively with partners, and maintaining the confidence of our patients, communities, staff and stakeholders.

This statement provides clear guidance to the Board of Directors, senior leaders, and staff on how risk should be assessed, reviewed and managed. It supports good governance, transparency, and consistent, risk-based decision making.

The Trust has adapted definition for risk appetite and risk tolerance from the 'Orange Book – Risk Appetite guidance note', Government Finance Function (October 2020), which are stated below:

- **Risk appetite:** the level of risk with which the Trust **aims** to operate
- **Risk tolerance:** the level of risk with which the Trust is **willing** to operate. It is worth noting that these terms should not be used interchangeably.

The Trust's risk appetite ranges from ***averse*** (no appetite for risk) to ***eager*** (seeking opportunities with higher inherent risk where benefits justify the exposure). Due to the nature of the Trust and its responsibilities, a one-dimensional or heavily quantitative approach to risk appetite would not deliver the right outcomes. To promote consistency and enable staff to take well-judged risks that improve delivery when opportunities arise, whilst also recognising when a more cautious approach is needed to mitigate threats, each risk owner should identify the risk appetite category that best aligns with their risk.

All risks should be analysed with risk appetite in mind. Where target scores remain outside the agreed appetite level, additional mitigations must be proposed, or a decision taken by the Trust Management Committee (TMC) to tolerate a position of operating outside of appetite. In such cases, risks must be escalated to the TMC via inclusion and appropriate escalation through the Corporate Risk Register (CRR).

Each domain includes a graduated set of statements aligned to the following appetite levels:

- **Averse:** no appetite for risk and seeks to avoid all form of exposure
- **Minimal**: strong preference for very safe options carrying a low level of residual risk
- **Cautious:** safe option with a low level of residual risk and limited reward
- **Open:** consider a broad range of delivery options, accepting a balance level of risk
- **Eager/ Seek:** willing to pursue approaches, accepting a greater degree of residual risk.

Review

The Risk Appetite Statement will be reviewed at least annually, or earlier if required due to significant organisational or strategic changes.

	AVERSE NWAS has no appetite for risk and seeks to avoid all forms of exposure	MINIMAL NWAS has a strong preference for very safe options that carry a low level of residual risk and limited potential for reward	CAUTIOUS NWAS prefers safe options with a low level of residual risk and limited reward. Managed and well-understood risks may be accepted where necessary to achieve objectives.	OPEN NWAS is willing to consider a broad range of delivery options, accepting a balanced level of risk in pursuit of opportunities that deliver acceptable benefit.	EAGER / SEEK NWAS is willing to pursue innovative and ambitious approaches that offer higher potential rewards, accepting a greater degree of residual risk where appropriate controls exist.
Score	**1-3**	**4-5**	**6-10**	**12-15**	**≥ 15**
Quality	We have no appetite for decisions that may introduce uncertainty regarding quality outcomes.	We will avoid options that could adversely affect quality unless essential.	Our preference is for risk avoidance. We may accept decisions carrying a low degree of residual risk where there is potential for improved quality outcomes and appropriate controls in place.	We accept the possibility of short-term impacts on quality where longer-term improvements or innovations are anticipated.	We are prepared to pursue innovative approaches with higher residual risk where significant long-term quality gains may be achieved.
People	We have no appetite for decisions that could negatively impact on our workforce.	We will avoid workforce related risks unless unavoidable.	We may accept limited workforce risks arising from the nature of our services or from internal decisions to implement change, provided such changes are well planned, clearly understood, and appropriate controls in place.	We accept that some workforce risk is inherent in both service delivery and implementing internal changes. We are willing to introduce new ways of working and undertake change where clear benefits can be realised.	We are prepared to pursue innovative workforce approaches with higher inherent risk where there is clear potential for long-term benefit, supported by appropriate controls.
Finance	We have no appetite for decisions or actions that may result in financial loss.	We may accept only very limited financial risk.	We may accept limited financial risk, prioritising VFM and statutory break-even responsibilities.	We are prepared to accept some financial risk where appropriate controls are in place and decisions reflect a holistic view of VFM, with cost not being the sole determining factor.	We will invest in opportunities that offer the best possible return and accept the potential for increased financial risk.
Regulatory	We have no appetite for decisions that will compromise regulatory compliance.	We accept very limited residual regulatory risk	We may accept limited residual regulatory risk where robust evidence supports and defends our decisions.	We are prepared to accept some regulatory risk where the benefits outweigh any potential adverse consequences.	We are willing to pursue decisions that may invite regulatory intervention where the benefits outweigh the risks and justification is robust.
Digital Innovation	We have no appetite for decisions that elevate exposure to cyber fraud, data breaches, or related digital risks.	We will not prioritise digital innovation and will only adopt solutions that are established and widely proven to be effective.	We may accept limited digital risk and will consider innovation where there is strong evidence of successful application elsewhere.	We are prepared to accept some digital risks where there is potential to achieve improved outcomes for patients or staff, recognising that innovation may create short-term disruption.	We actively seek digital innovation opportunities that deliver significant benefits, accepting higher inherent risk within a controlled project management environment. Risks will be identified early and managed appropriately and in line with defined risk appetite.
Reputation	We have no appetite for decisions that could increase external scrutiny or public attention.	Our appetite is limited to risks where there is no possibility of significant reputational consequences.	We may accept limited reputational risk where effective controls are in place to mitigate potential adverse impacts.	We are prepared to accept some reputational risk where improved outcomes for stakeholders are achievable.	We are willing to make decisions that invite external scrutiny and will actively promote innovation and new ideas where potential benefits outweigh the associated reputational risks.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	NWAS Strategic Risks 2026/27
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Approve the strategic risks for 2026/27.	
EXECUTIVE SUMMARY	The Board Assurance Framework (BAF) sets out the key strategic risks that could affect delivery of the Trust's strategic aims and provides the primary mechanism through which the Board gains assurances on the effectiveness of controls and mitigations. For 2026/27, the strategic risks have been refreshed to align with the new strategic aims. Engagement with both Executive Directors and Non-Executive Directors has informed the development of the proposed strategic risks, presented in **Appendix 1**. Alongside providing retrospective assurance, the refreshed BAF will adopt a forward looking, strategic foresight approach, ensuring risks are viewed not only in terms of current exposure but also in relation to longer-term organisational resilience.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee (TMC)	
	Date	Wednesday, 18 March 2026
	Outcome	Recommended for approval

1. BACKGROUND

The Board Assurance Framework (BAF) in the NHS is a structured tool used by boards to monitor and manage strategic risks that threaten the achievement of corporate aims/objectives. It provides evidence-based confidence (assurance) that robust controls are in place to manage these risks, linking strategic goals directly to risk mitigation, controls, and assurances.

Key aspects of the BAF include:

- Strategic Focus: It centres on high-level risks rather than daily operational risks, which are handled through risk registers.
- Components: The BAF maps out strategic objectives, the risks to those objectives, the controls in place, and the sources of assurance that the controls are working.
- Risk Management: It identifies gaps in control or assurance, triggering action plans to close those gaps.
- Governance Tool: It is essential for ensuring good governance, helping the Board meet its legal, regulatory, and safety obligations.

The BAF forms the overall approach to risk management within the Trust

2. BOARD RESPONSIBILITIES

The BAF is a live document, owned by the Board with oversight held by its assurance committees. It is the mechanism through which the Board gains assurance that strategic risks are being managed, that controls are effective, and that residual risk is understood and appropriately acted upon.

3. ENGAGEMENT AND DEVELOPMENT

There have been several engagement sessions with Executive Directors and Non-Executive Directors, both individually and as collective groups, throughout the development of these proposed BAF risks which can be seen in full in **Appendix 1**.

4. EQUALITY/ SUSTAINABILITY IMPACTS

Equality Impacts:

- The paper supports the Trust's commitment to embedding equality, diversity and inclusion within strategic risk oversight.
- There are no adverse equality impacts.
- Strengthening assurance around risks related to inclusive care and workforce culture should have a positive impact access and experience for both patients and our workforce.

Sustainability Impacts:

- Approval of the proposed BAF risks maintains appropriate Board-level oversight on environmental sustainability and the Trust's Net Zero obligations.
- There are no negative sustainability impacts.
- Inclusion of environmental sustainability as a strategic risk ensures continued alignment to long-term resilience and NHS sustainability priorities.

5. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the strategic risks for 2026/27.

NWAS Strategic Aims			
Deliver outstanding, inclusive care for everyone we serve	**Build a safe, supportive and inclusive culture together**	**Provide a responsive care model through partnerships**	**Embed continuous improvement and innovation for a sustainable future**
NWAS Strategic Risks			
SR01: There is a risk that if we do not consistently provide inclusive care or effectively address health inequalities, it could result in avoidable harm and poorer outcomes or experiences for our patients. **Director of Quality & Improvement**	**SR02:** There is a risk that if we do not develop an inclusive culture this may limit our ability to attract, retain, and maintain a diverse, thriving workforce and increase negative staff experiences impacting on patient care. **Director of People/ Deputy CEO**	**SR03:** There is a risk that system-wide Urgent & Emergency Care pressures across the region may limit our ability to improve national UEC performance standards, which could impact our financial and workforce plans and the quality of patient care. **Director of Operations**	**SR05:** There is a risk that the Trust is unable to deliver long-term financial sustainability, this may lead to increased regulatory scrutiny, which will impact on our ability to deliver our long-term plans and strategy. **Director of Finance**
		SR04: There is a risk that if we do not engage effectively with strategic regional partners, we will miss opportunities to influence UEC reconfiguration and improvement, which could affect the delivery of our medium- & long-term plans. **Director of Strategy & Partnerships**	**SR06:** There is a risk that if we do not embed a Trust-wide continuous improvement culture, it will impact our ability to harness innovation, learning, and deliver effective sustainable service transformation. **Director of Quality & Improvement**
			SR07: There is a risk that if we do not fully address environmental sustainability within our strategic priorities, we will reduce our positive impact on local communities and limit our contribution to NHS Net Zero targets. **Director of Finance**
			SR08: There is a risk of a cyber incident that could impair operational continuity, compromise sensitive information, and adversely affect our ability to deliver safe and effective services. **Director of Finance**

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Non-Executive Terms of Office; Committee Membership 2026/27 and Non-Executive Champion roles
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to note: • That it remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) and the NHS Code of Governance in respect to Non-Executive Directors Terms of Office. • The Non-Executive Directors Committee membership for 2026/27. • The Non-Executive Director Champion Roles
EXECUTIVE SUMMARY	This report confirms Non-Executive Directors Terms of Office (s2) and provides assurance to the Board of Directors that: 1. The Board can declare compliance with the NHS Code of Governance provision 4.3 with respect to Non-Executive Directors Terms of Office. 2. The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) The Non-Executive Director Committee membership for 2026/27 can be seen in s3. The approach to non-executive director champion roles can be seen in s4.
PREVIOUSLY CONSIDERED BY	Not Applicable
	Date: Not Applicable
	Outcome: Not Applicable

1. BACKGROUND

The purpose of this report is to raise Board awareness of Non-Executive Directors Terms of Office and to provide assurance to the Board of Directors that:

1. The Board can declare compliance with the NHS Code of Governance provision 4.3 with respect to Non-Executive Directors Terms of Office.
2. The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended)

This paper also confirms the Non-Executive Director Committee membership for 26/27.

2. TERMS OF OFFICE

In an NHS Trust, Non-Executive Directors are appointed by NHSE on behalf of the Secretary of State for Health & Social Care for an initial term of office of 2-3 years and at the end of that period, consideration is given to extending their term of office with reappointment for a further 2-3 years.

The NHS Code of Governance provision 4.3 states that Chairs or Non-Executive Directors, to ensure independence, should not serve more than 6 years, however, in exceptional circumstances and following a prescribed process and receipt of approval from NHSE, the term may be extended for up to 12 months.

Terms of Office from 1st April 2026 are shown below:

Non-Executive Directors	
Name	**Term of Office**
Julia Mulligan (Chair)	01/07/25 - 30/06/28
Catherine Butterworth (Senior Independent Director)	Final Term 01/04/26 – 31/03/28 01/04/24 – 31/03/26 01/04/22 – 31/03/24
Graeme Chapman	01/01/26 – 31/12/28
Anne Cooper (Vice Chair)	12/01/26 – 11/01/29
Nic Gower	12/01/26 – 11/01/29
Clare Todd	01/04/26 – 31/03/29

3. COMMITTEE MEMBERSHIP

The Chair has undertaken the annual review of Committee membership, the Non-Executive Director membership for 2026/27 is as follows:

Committee	Membership
Audit Committee	Nic Gower (Chair) Catherine Butterworth Graeme Chapman Clare Todd

Nominations & Remuneration Committee	Chair and all Non-Executive Directors
Quality and Performance Committee	Clare Todd (Chair) Anne Cooper Graeme Chapman
Resources Committee	Graeme Chapman (Chair) Catherine Butterworth Anne Cooper Nic Gower
Charitable Funds Committee	Nic Gower (Chair) Catherine Butterworth Clare Todd

4. ENHANCING BOARD OVERSIGHT: NON-EXECUTIVE DIRECTOR ROLES

Following guidance issued by NHSE in December 2021 regarding a move away from several champion roles, transitioning oversight into the Board Assurance Committees. The roles that must continue to be retained, with the exception of the EPRR champion, can be seen below along with the named Non-Executive:

Role	Type of Role	Legal Basis	Named Non-Executive
Maternity board safety champion	Assurance	Recommended	TBC
Wellbeing Guardian	Assurance	Recommended	Catherine Butterworth
FTSU NED Champion	Functional	Recommended	Clare Todd
Security management NED champion	Assurance	Statutory	Catherine Butterworth
EPRR NED champion	Assurance	n/a	Graeme Chapman

5. LEGAL CONSIDERATION

In accordance with the Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended), the Trust is required to have five voting Non-Executive Directors plus a voting Non-Executive Chair.

6. ACTION REQUIRED

The Board of Directors is asked to note:

- That it remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended), and the NHS Code of Governance in respect to Non-Executive Directors Terms of Office.
- The Non-Executive Directors Committee membership for 2026/27.
- The Non-Executive Director Champion Roles.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Board Development Programme 2026/27
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	For Noting

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the Board Development Programme for 2026/27	
EXECUTIVE SUMMARY	Section 2 of the report details the sessions prioritised and agreed by the Chair and CEO for 2026-27. There is space within the programme for emerging matters to be included and the programme will be reviewed by the Chair and CEO on a regular basis to ensure it continues to meet the Board's needs for the coming year. To complement this programme, and in consideration of the early stage of this Board in its current composition, there are also three additional sessions held in diaries across the year for a separate focused piece of work across two main themes: 1) team effectiveness and 2) board effectiveness.	
PREVIOUSLY CONSIDERED BY	N/A	
	Date	N/A
	Outcome	N/A

1. BACKGROUND

All NHS Trusts are expected to have a programme of board development – this is the widely used, accepted terminology of sessions designed to support the Board, by providing a programme of development and learning throughout the year. This list is not exhaustive but is a compilation of topics prioritised and agreed with both the Chair and the CEO, which is subject to continuous review throughout the year to ensure that it remains fit for purpose. There is space within the programme for additional items that may emerge throughout the year and I have linked the sessions to the four key strategic aims - Deliver outstanding, inclusive care for everyone we serve; Build a safe, supportive and inclusive culture together; Provide a responsive care model through partnerships and Embed continuous improvement and innovation for a sustainable future, and there is also a link to the strategic risks for 26-27 where appropriate.

2. BOARD DEVELOPMENT PROGRAMME 2026-27

DATE	SESSION	LINK TO STRATEGIC AIM	STRATEGIC RISK 26-27
29th April (pm only)	Engagement session with CQC	All aims with particular consideration of - Deliver outstanding, inclusive care for everyone we serve	SR01
	Staff Survey	Build a safe, supportive and inclusive culture together	SR02
24th June	Partnerships Across the Region	Provide a responsive care model through partnerships	SR04
	NHS Impact - Improvement	Embed continuous improvement and innovation for a sustainable future	SR06
	Advanced Foundation Trust Status	All aims	n/a
28th October	AI - education around the word AI, also a wider understanding required on how the roles of NED and Executives will change with the implementation and use of AI tools (half-day)	Embed continuous improvement and innovation for a sustainable future	SR08
	EPRR	Deliver outstanding, inclusive care for everyone we serve Provide a responsive care model through partnerships	SR01 SR03 SR08

9th December	**Keep Free for Emerging Matters**		
24th February 27	Strategy Yr1 Review	All aims	All
	Draft Risk Appetite Statement & BAF 27/28	All aims	All
	Staff Survey - Emerging Themes	Build a safe, supportive and inclusive culture together	SR02

There are also three additional sessions held in diaries across the year for a separate focused piece of work across two main themes: 1) team effectiveness and 2) board effectiveness.

3. ACTION REQUIRED

The Board of Directors is asked to note the Board Development Programme for 2026-27.

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ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Tuesday, 17 February 2026		
Members present	Mr N Gower, Chair Prof A Esmail, Non-Executive Director Mrs C Butterworth, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- No items

ADVISE:

- External auditors reported the National Audit Office had confirmed the closure of the 24/25 DHSC audit and reported on progress in relation to the 25/26 audit.
- Losses and Compensation for Q3 2025/26 totalled £199k.

ASSURE:

- Internal Audit reported three reviews were completed during Q3 2025/26.
  - Compliance with Lease Car Policy – Substantial Assurance
  - Recruitment and Retention – Substantial Assurance
  - Risk Management Core Controls – High Assurance
- The Committee received the latest position from Internal Audit in relation to the Follow-Up to recommendations from reviews undertaken.
- The Anti-Fraud Progress report detailed activities undertaken against the agreed anti-fraud work plan and noted the recommendations from the NHSCFA procurement exercise.
- The approved Q3 Position of the Board Assurance Framework 2025/26 was received. Committee members considered the report within the context of their role as Audit Committee.
- The Committee received the outcome of a benchmarking exercise against the Good Governance Institute: Board Assurance Prompt.
- The Committee noted two waivers were approved during Q3 2025/26.
- 3A reports from the following Committee meetings were presented for assurance:
  - Quality and Performance Committee – 27th October 2025
  - Resources Committee – 18th September 2025

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Charitable Funds Committee

Date of meeting	Wednesday, 18 February 2026		
Members present	Mr N Gower, Non-Executive Director (Chair) Mrs C Butterworth, Non-Executive Director Mrs C Todd, Associate Non-Executive Director Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Mrs C Wood, Director of Finance	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- None identified.

ADVISE:

- A summary of the operational, strategic and charitable activity undertaken during Q3 2025/26 was noted, together with the use of restricted and unrestricted funds and updates in relation to the NHS Charities Together grants. The requirement for additional resource within the Charity team was highlighted. The Committee will review the proposal at the next meeting.

ASSURE:

- The Q3 financial position of the NWAS Charity was overall funds of £745k: general funds £412k and restricted funds £333k.
- The NWAS Charity risk register was presented following quarterly review.
- A summary of the fundraising activities undertaken during Q3 2025/26 was provided.

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 18 February 2026		
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 Mr M Cooper, Area Director – Cumbria and Lancashire Mr I Moses, Area Director – Cheshire and Merseyside Ms S Rose, Director of Integrated Contact Centres Mr M Jackson, Chief Consultant Paramedic Dr C Grant, Medical Director In attendance Mrs M McLeavy, Deputy Director of Patient Safety and Compliance Mr I Stringer, Assistant Director of Compliance (part – ms teams) Mrs S Latham, Head of Strategy, Partnerships and Transformation (part) Mrs J Turk, Executive Business Support Manager	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- A national audit of job evaluation was anticipated, with a requirement for regular reporting to Board Committee.
- The TMC were assured that the Trust is responding positively to the expectations set out by NHSE in relation to action on antisemitism and endorsed the adoption of the IHRA definition of antisemitism as requested by NHSE.

ADVISE:

The TMC:

- Approved the spend on operational activity planned to deliver against the UEC growth funding trajectories, noting further work was required before deciding how the remaining UEC funding should be allocated.
- Approved the new policy on Artificial Intelligence (AI).

- Agreed in principle the definition of 'night worker' for NWAS as per s2.3.
- Approved in principle the recommended option 3 to offer pre-employment and annual night worker questionnaires to all PES 'night workers'.

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - Finance report month 10.
  - Update on the 2025/26 and Medium-Term Planning (MTP) productivity and efficiency.
  - Policy Management Framework – noting 3 overdue policies; NW Divert and Deflection, PTS Relief Staff and Individual and Collective Grievance, noting the latter had been extended to March 2026.
  - 2025/26 End of Year Statutory Reporting Timelines.
  - Integrated Performance Report – call pick up performance discussed amongst other areas.
  - Job Evaluation Oversight.
  - Trust Strategy Update.
  - Annual Plan 2026-27 – draft priorities.

- Received the following Escalation & Assurance reports:
  - EPRR Group – 19 January
  - Health, Safety & Security Group – 20 January
  - Clinical and Quality Group – 20 January
  - Diversity and Inclusion Group – 23 January

RISKS

Risks discussed:

- Reviewed the 10 corporate risks on the corporate risk register (CRR).
- One longstanding risk ID318, had decreased in score and was supported for closure.
- The 8 commercially sensitive risks were reviewed and agreed.
- Agreed to action a full risk review of the 6 longstanding risks.

New risks identified:

- A general job evaluation risk would be articulated.

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ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 18 March 2026		
Members present	Mr S Desai, Chief Executive (Chair) Mrs L Ward, Director of People Mrs A Wetton, Director of Corporate Affairs Dr C Grant, Medical Director Mr D Ainsworth, Director of Operations 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 Mrs S Rose, Director of Integrated Contact Centres Mrs J Wharton, Chief Information Officer Mr M Jackson, Chief Consultant Paramedic Mr J Collins, Chief Clinical Information Officer (via ms teams – part only item 2526/332) In attendance Mrs M Brooks, Deputy Director of Finance Mrs J Turk, Executive Business Support Manager	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Staff Survey** – the 2025 survey represents the strongest level of participation ever achieved with 4,100 responses, a 53% response rate. A largely stable and positive overall position has been seen in the results, with significant change in two People Promise themes – always learning and flexible working. Local People Plans will be developed, and SMART group will coordinate a Trust-wide action plan to ensure alignment between local insights and organisational priorities.
- **Friends and Family Test (FFT)** – Work to align themes from FFT with incidents and complaints would be taken forward to strengthen how feedback informs quality improvements. Moving into 2026/27, there is a need to clearly articulate how patient feedback, including FFT comments and complaint themes will be narrated and used to driver the high-level deliverables set out in the quality plan.

ADVISE:

The TMC:

- Recommended the opening of 2026/27 budgets to Board for approval.

- Noted the Medium-Term Plan will be resubmitted on 18 March with the latest CIP position including risk adjusted position.
- Approved the updated Estates and Fleet Roadmap.
- Approved the National Care Record System/National Record locator as the strategic direction for Shared Care Records Access and agreed a hybrid onboarding approach for NWAS clinicians.
- Endorsed the Trust Strategy and Strategic Plans for consideration and approval by Board.
- Approved the Annual Plan for 2026-27 for onward recommendation to Resources Committee and Board.

ASSURE:

- The TMC received and discussed the following reports for assurance:
  - Finance report month 11
  - Update on the 2025/26 and Medium-Term Planning (MTP) productivity and efficiency
  - Policy Management Framework update – the Framework was in a good position with just two policies due for review by end of March – Learning from Experiences and Smoke Free
  - Integrated Performance Report
  - Annual Staff Survey Results

- Received the following Escalation & Assurance reports:
  - Information & Cyber Group – 10 February
  - Sustainability Group – 2 March
  - Clinical and Quality Group – 2 March
  - Health, Safety & Security Group – 5 March
  - People & Culture Group – 11 March

RISKS

Risks discussed:

- Reviewed the 9 corporate risks on the corporate risk register (CRR).
- Reviewed and agreed the 8 commercially sensitive risks.
- Three risks (IDs 376, 513 and 515 were agreed as to be tolerated on DCIQ.
- The 5 longstanding risks received were to receive a full risk review.
- Work to review the overall Trust risk register position was to be undertaken.

The proposed Strategic Risks for 2026-27 were recommended to Board for approval.

The Risk Appetite Statement for 2026-27 was to be recommended to Board for approval.

New risks identified:

- None.

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ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Thursday, 19 March 2026		
Members present	Mr G Chapman, Non-Executive Director, Chair Ms C Butterworth, Non-Executive Director Ms A Cooper, Non-Executive Director Mr N Gower, Non-Executive Director Ms L Ward, Director of People 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 11 2025/26

- The Committee received assurance in relation to the financial performance indicators, noting a stable position and surplus at month 11.

Efficiency and Productivity Update

- The Committee received assurance the actual efficiency delivered in Month 11 was in line with the year-to date plan.

Workforce Indicators Report

- The Committee received assurance on strong and stable workforce indicators, noted however that the sickness absence target would likely not be achieved by the end of Q4.

Staff Survey

- The Committee received a deep dive on the annual Staff Survey results, noted the improved outcomes, as well as focus areas, and would continue the discussion at the upcoming Board Development Session.

Culture Review – End of Year Update

- The Committee received the final report on recommendations from Culture Review and commended the significant amount of work ongoing in the Trust. The Committee noted that going forward, reports on individual workstreams have been planned into the Committee work plan throughout the year.

Board Assurance Framework

- The Committee reviewed the risks aligned to its remit and recommended rephrasing of the digital BAF.

Trust Strategy and Strategic Plans 2026 – 2031

- The Committee received the Trust Strategy 2026-2031 with the enabling plans, were assured of the robust methods and process by which the strategy was co-produces by multiple internal stakeholders and supported the recommendation that the Trust Strategy is approved at Board.

Trust Annual Plan 2026-27

- The Committee received the Trust Annual Plan 2026/27, noting that work was ongoing to finalise the document before a summarised report progresses to the Board.

The Committee discussed the following items and recommended them to the Board of Directors for approval:

- 2026-2027 Opening Financial Plans and Budgets
- Provision of Bulk Fuel and Ancillary Products
- Adopting the Antisemitism Statement
- Received the effectiveness review results and recommended ToR for approval subject to final amendments (Board in April)

ASSURE:

Received the following reports for assurance:

- Estates, Fleet and Facilities Management Assurance Report
- Estates and Fleet Strategic Roadmap – 2025/26 Progress and Update
- Sustainability Update
- Digital Plan Update
- Early Indicator Process for Identifying Staff of Concern

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Estates and Fleet Strategic Roadmap – 2025/26 Progress and Update
PRESENTED BY	Executive Director of Finance
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the report; and • Review the content of the updated Estates and Fleet Roadmap attached as Appendix A.
EXECUTIVE SUMMARY	In March 2025, the Board of Directors approved the Estates and Fleet Strategic Plan Roadmap, which was the final element of the Estates and Fleet Strategic Plan 2024-30. The roadmap captures the larger programmes of work which will support delivery of the strategic plan. This paper provides an overview of the annual refresh of the Estates and Fleet Strategic Roadmap including an update on the progress made during 2025/26. During the year good progress has been made with key milestones achieved in major infrastructure redevelopment, fleet decarbonisation, and strategic workshop planning. Estates projects have advanced through planning, option appraisal and design stages across multiple sites including Preston, St Helens, Greater Manchester workshop, and Integrated Contact Centre locations. Fleet progress includes the delivery of low-carbon vehicle strategies, EV charging infrastructure expansion and forward-planned replacement programmes of battery electric vehicles (BEV).

	The Facilities Management Roadmap has evolved to include a further high-level objective to establish a facilities management hub within the Green Room. This will streamline processes that support colleagues and effectively optimise resources. During the year, progress has focussed on developing and producing the Trust single standards matrix, due for publication this month. Space Utilisation appraisals have also been completed for the corporate sites focussing on use of space with recommendation on how to optimise the Trust estate. Overall, the refreshed roadmaps demonstrate continued alignment to organisational strategy and continued advancement of key enabling functions and are attached at Appendix A.	
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	Thursday, 19 March 2026
	Outcome	

1. BACKGROUND

1.1 In June 2022, the Board of Directors approved Our Strategy 2022-2025 and in July 2023 the four supporting strategies, including the Sustainability Strategy were approved.

1.2 In March 2024, the Board of Directors approved the Estates and Fleet Strategic Plan 2024-30 which set out the principles which guide our approach to decisions around estates and fleet. The strategic plan was developed with engagement from our Service Delivery directorate to ensure that the principles reflect the needs of our services.

1.3 The Estates and Fleet Strategic Plan 2024-30 sets out three principles which set the direction for our estates, fleet and facilities management functions. These principles are as follows:

- Our estates and fleet support the delivery of high-quality patient care and a positive patient experience;
- Our estates and fleet will offer modern work environments that everyone can be proud of; and
- Our estates and fleet will be economically efficient and have a positive impact on the environment and our local communities.

1.4 The final element of the approved strategic plan was the commitment to develop the roadmap during 2024/25, using the principles in the strategic plan, to set out how we will deliver our estates, fleet and facilities management portfolios over the next six years. The roadmap captures the large, transformative programmes of work which will support delivery of the strategic plan. Business as usual maintenance and smaller scale works are not included in the roadmap but will continue throughout the life of the strategic plan.

1.5 The roadmaps were developed for Facilities Management, Fleet and Estates and collectively are the Estates and Fleet Roadmap and form the final part of the Estates and Fleet Strategic Plan.

1.6 The initial roadmap was approved by the Board of Directors in March 2025, and it was agreed that the roadmap would be reviewed at least annually to ensure that they remain current and that we maintain a forward view of our estates and fleet. The refreshed roadmap is attached in Appendix A.

2. 2025/26 PROGRESS AGAINST THE FACILITIES MANAGEMENT ROADMAP

2.1 The Facilities Management Roadmap primarily addresses the second principle in the strategic plan, '*Our estates and fleet will offer modern work environments that everyone can be proud of*' and was developed by the Facilities Management team who identified the initiatives which would be delivered through the roadmap. These were single standards and space utilisation.

2.2 During the course of the year the single standards matrix has been development and produced and is in final stages of review prior to publication in March 2026. This will support

the procurement and tendering process for relevant Trust project and further embed the brand standards now seen across the estate.

2.3 The appointment of a deputy head of facilities management has been successful. This post was fundamental and crucial to delivery of the second initiative, Trust wide space utilisation.

2.4 In addition, a further objective to establish a facilities management hub within the Green Room will streamline processes that support colleagues and effectively optimise resources.
The format of the facilities management roadmap has also been refreshed to align with the estates and fleet roadmaps.

3. 2025/26 PROGRESS AGAINST THE FLEET ROADMAP

3.1 The Fleet Roadmap is largely driven by external drivers, primarily the NHS net zero travel and transport roadmap, which aims for the full fleet, including ambulances, to be decarbonised by 2040.

3.2 There are several key steps that will mark the transition to full fleet decarbonisation by 2040. These are as follows and have been incorporated into the roadmap.

- From 2027, all new vehicles (excluding ambulances) will be zero-emission vehicles
- From 2030, all new ambulances will be zero-emission vehicles
- Development and roll out of sustainable travel strategies
- Transition our leased and owned cars to zero emission so that by 2035 all vehicles (excluding ambulances) will be zero emissions.

3.3 Alongside the transition to a decarbonised fleet, our Fleet Roadmap also illustrates the annual fleet replacement scheme which ensures that we maintain a modern fleet which is reliable and fit for purpose using the latest engineering technologies supporting move to net zero.

3.4 The roadmap also includes a review of the workshops estate which supports our fleet. This infrastructure is critical to ensuring that vehicles are well maintained and that we maximise the availability of the fleet for service delivery.

3.5 During the course of the year the following progress has been made:

- The Trust Lease Car Policy has been reviewed and published with the requirement that all future lease cars will be either all electric or hybrid with emissions below 50g/kg, in line with NHS Net Zero Transport & Travel Strategy;
- All vehicle replacement fleet programmes are complete for 2025/26 with vehicles and conversion slots (79 DCAs) booked and confirmed for 2026/27;
- The Trust has supported partners with bids to NHS England for the installation of BEV DCA EV charge points outside acute emergency departments. Funding has been secured for charge points at three acute hospital sites, Royal Liverpool, Aintree and Blackpool Victoria hospitals. Discussions have now also commenced with the Northern Care Alliance to support them in securing national funding for this initiative.

3.6 The review of workshop infrastructure is ongoing with options being considered for Greater Manchester, which could include Oldham stations (PES and PTS). National funding

for make ready has provided the opportunity to combine the redevelopment / replacement of St Helens station with a new workshop in Merseyside. Work continues to support delivery of outline business cases.

3.7 There have been no changes to the Fleet Roadmap.

4. 2025/26 PROGRESS AGAINST THE ESTATES ROADMAP

4.1 The Estates Roadmap was the most complex to develop. The Estates team worked closely with the Strategy, Planning and Transformation team and Area Directors to identify the high-priority sites for development over the next six years.

4.2 The roadmap itself was developed by the Estates team to set out the expected timelines for commencing work on each of the identified priorities and included projects which had already been approved by the board of directors and the pipeline work which is under development.

4.3 Since approval in March 2025, the following projects have been completed and the roadmap updated to reflect this:

- Altrincham station remodelling
- New Cumbria workshop facility
- Reprovision of station at Grange-over-Sands
- New HART facility for Liverpool
- Remodelling of Sharston station
- Reprovision of station in Huyton

4.4 Live (board approved) projects now included in the roadmap are:

- The refurbishment and remodelling of Distington station; and
- Remodelling of Morecambe station, funded from national capital.

4.5 The timelines for pipeline schemes have been reviewed and the roadmap updated accordingly.

5. RISK CONSIDERATION

Risk appetite category	Implications
Compliance / regulatory	The facet survey conducted as part of the development of the Estates Roadmap considered the compliance of our buildings. All our estates are found to be compliant with regulations. Business as usual maintenance and the implementation of single standards will ensure that we continue to be compliant
Quality outcome	Our approach to identifying the priorities for our Estates Roadmap included consideration of the impact of our sites on the quality of outcomes. This was gained via the area directors and through engagement in local area meetings.
People	Our single standards which will be rolled out across our estates will ensure that we promote staff wellbeing and

	ensure that our estates meet the needs of our diverse workforce.
Financial / value for money	The integrated approach to forward planning in our Estates Roadmap will ensure that decisions are made proactively and with consideration for value for money and will support a well-planned capital programme.
Reputation	Our single standards will ensure that our estates have a consistent professional feel which will enhance our reputation. Our fleet replacement programme and move to a zero-emission fleet will provide us with a high-quality, modern work environment for our staff on the road and for our patients.
Innovation	The delivery of our future building projects which are identified in the roadmap will give us the opportunity to innovate to reduce energy costs and increase the energy efficiency of our estates. We will also be at the forefront of testing new electric ambulances as we move towards a zero-emission fleet.

6. EQUALITY/ SUSTAINABILITY IMPACTS

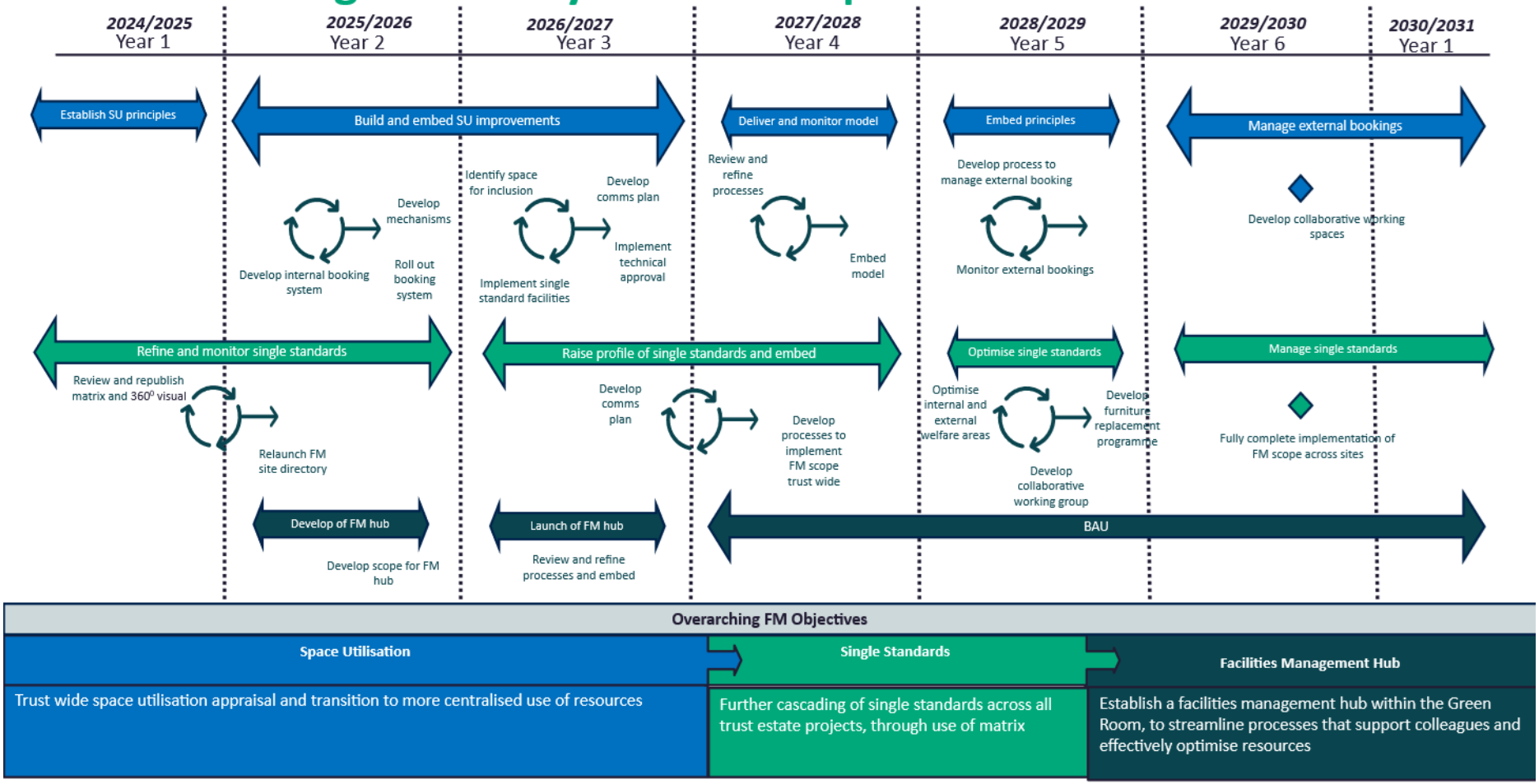
6.1 The Estates and Fleet Roadmap has been designed to have a positive impact on equality and sustainability, with specific workstreams which aim to improve in both areas. Individual workstreams in the roadmap will have their own impact assessments, where they are required, to ensure that the full impacts on equality and sustainability are understood.

6. ACTION REQUIRED

The Board of Directors is asked to:

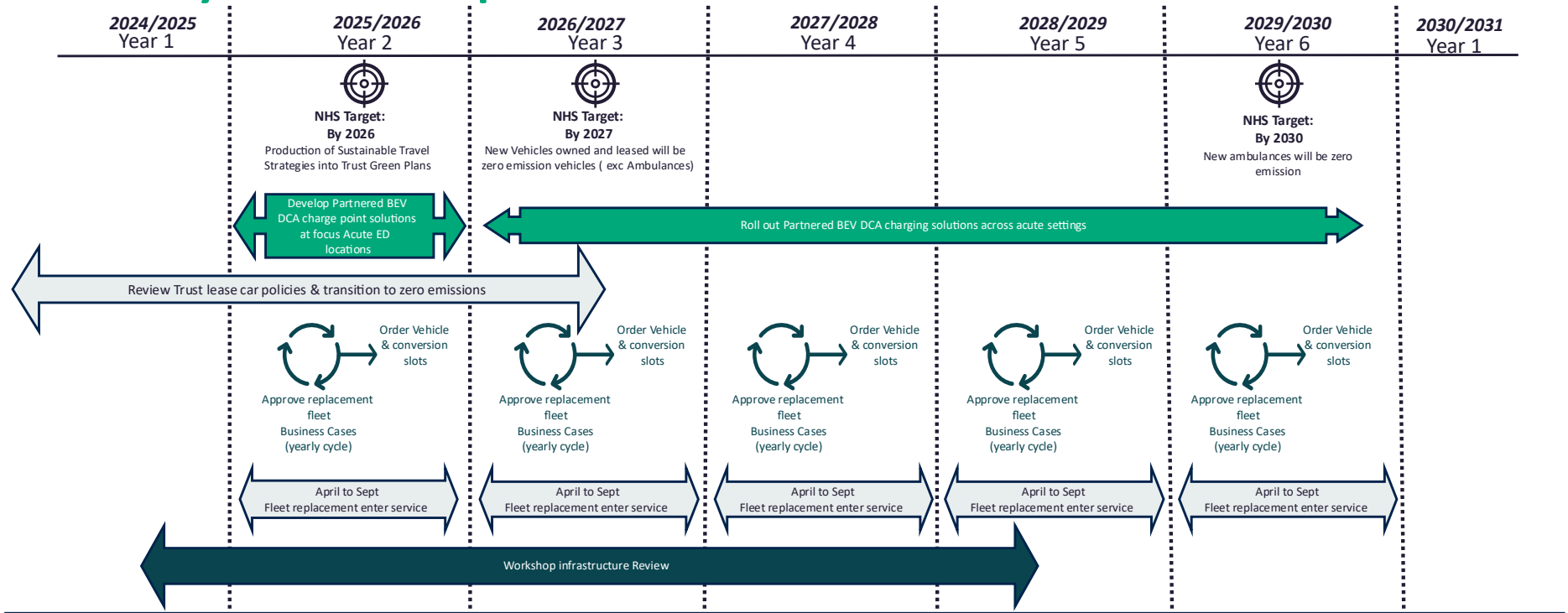
- Note the report; and
- Review the content of the updated Estates and Fleet Roadmap attached as Appendix A.

Facilities Management: 6-year Roadmap



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

Fleet: 6-year Roadmap



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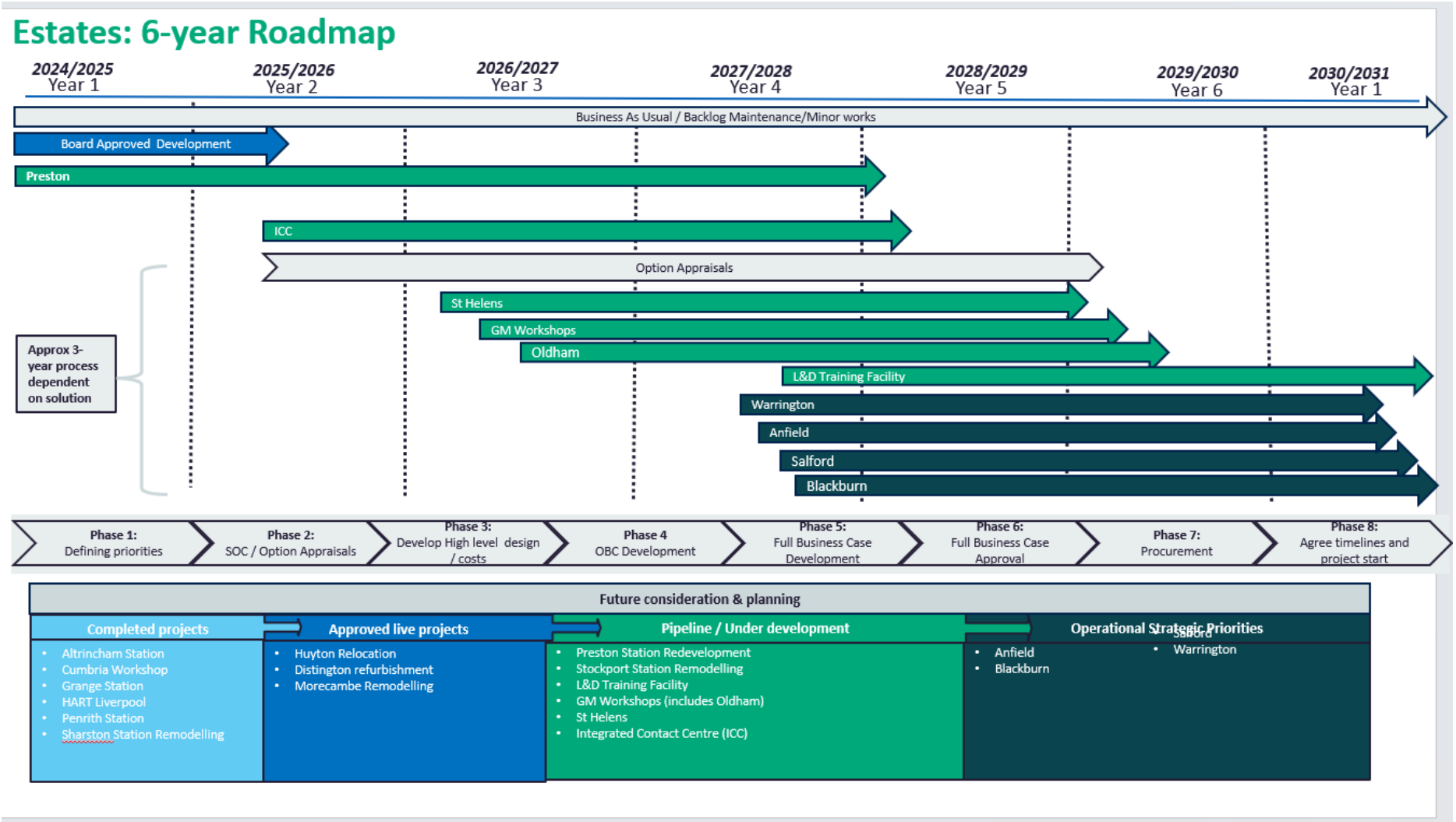

**DELIVERING THE RIGHT CARE,
AT THE RIGHT TIME,
IN THE RIGHT PLACE;
EVERY TIME.**

NHS
North West
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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	NHS Staff Survey 2025: People Promise and Benchmarking
PRESENTED BY	Lisa Ward KAM – Director of People / Deputy Chief Executive
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Receive assurance from the NHS Staff Survey 2025 results.
EXECUTIVE SUMMARY	The NHS Staff Survey remains a key national tool for understanding staff experience, culture and engagement across the NHS. For NWAS, the 2025 survey represents the strongest level of staff participation ever achieved – with 4,100 responses, equating to a 53% response rate. The Trust's results show a largely stable and positive overall position, even with a significant increase in responses from frontline teams, and performance continues in the main to outperform Ambulance sector averages. Several areas match or exceed sector averages, but there are still areas of improvement required. This year's results highlight statistically significant change in two People Promise themes – We are always learning and We work flexibly. The Trust has taken purposeful steps to expand access to learning opportunities and strengthen flexible-working practices, including the introduction of new digital processes, and development of the CPD Hub. These actions may have contributed to influencing staff experiences positively and are helping to build a more supportive and responsive working environment.

Analysis of directorate level data

Operational areas show encouraging signs of progress, with both PES and PTS reporting steady improvements across multiple aspects of staff experience, narrowing the gap between frontline services and Trust-wide averages. Resilience continues to perform strongly and is now one of the highest-scoring groups across the organisation.

Corporate directorates also maintain a largely positive profile, with several areas building on already strong foundations. The People, Strategy & Planning, Quality, Finance and Clinical directorates all demonstrate continued positive scores – in most cases which exceed the trust averages.

Actions taken to improve staff experience

During 2025 the Trust has delivered a focused programme to enhance staff experience, including:

- Wellbeing: Increased visibility and accessibility of wellbeing support, enhanced wellbeing conversations, and continued promotion of the Wellbeing Hub.
- Sexual Safety & Culture: Delivery of the charter commitments; strengthened expectations for dignity, respect and safe behaviours; enhanced manager resources and reporting processes.
- Violence & Aggression: Expanded body-worn video use, improved follow-up support, stronger incident reviews and partnership work.
- Inclusion: Progress on EDI and anti-racism priorities, enhanced reporting, and greater involvement of staff networks.
- Flexible Working: Participation in the NHS People Promise Exemplar programme to embed improved, more responsive approach to flexible working.

Key indicators of culture

The report includes some oversight of the questions relating to some of the key indicators of culture and linked with the interventions outlined.

- Recommendation as a place to work has improved and NWAS is placed second amongst ambulance trusts in terms of this response
- Immediate line managers scores have shown small improvements overall but a deep dive into PES and PTS scores shows some significant improvements
- Negative experiences show small improvements with an overall drop of 1.2% in experience of unwanted sexual behaviour
- Scores related to professional development have improved but the fairness of career progression remains stable at 50%

	• Responses in relation to confidence in speaking up are also stable **Next steps** To support targeted improvement, management teams have already received detailed data packs to inform updates to their Local People Plans, while the SMART group will coordinate a Trust-wide action plan to ensure alignment between local insights and organisational priorities. Further analysis will deepen understanding of staff experience, including focused work on EDI-related themes and generational patterns, alongside a comprehensive review of free-text comments in line with NHS Medium Term Plan requirements, supported by forthcoming thematic analysis from Picker. Progress will continue to be monitored through regular reporting to TMC, the Resources Committee and the Board, ensuring robust governance and sustained organisational focus on delivering measurable improvements.	
PREVIOUSLY CONSIDERED BY	TMC	
	Date	21/1/26 & 18/03/26
	Outcome	Assurance received and commitment given to utilisation of the data to drive improvement
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	19/3/26
	Outcome	Assurance received from deep dive

1. BACKGROUND

1.1 The NHS Staff Survey (NSS) is an annual national survey led by NHS England that gathers feedback from staff about their working experiences and organisational culture. It provides a consistent and nationally comparable evidence base that supports both Trust-level and system-wide improvement. For the 2025 cycle, survey fieldwork was undertaken between 22 September and 28 November 2025, exceeding the minimum eight-week period to maximise participation across all staff groups.

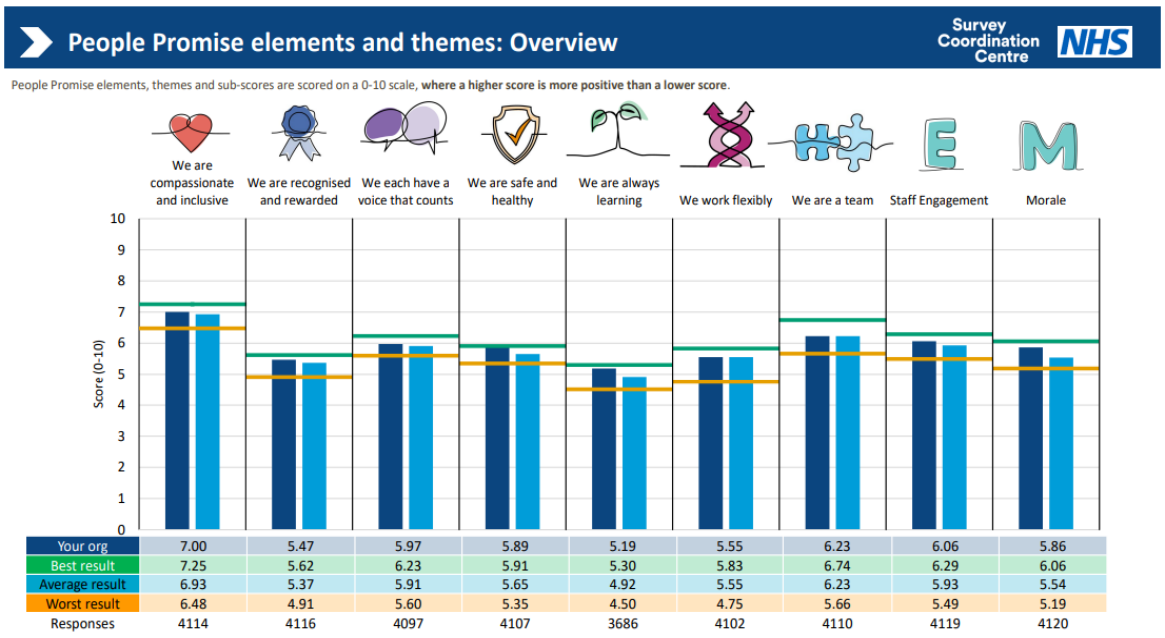
1.2 The Trust achieved its highest-ever response rate in 2025, with 4120 responses from 7741 eligible staff, equating to 53%. This was a notable improvement on the 48% response rate in 2024 and broadly aligned with the Ambulance sector benchmark median of 55%. The majority of the growth in responses came from frontline staff, providing a better representative sample of responses.

2. OVERALL PERFORMANCE: PEOPLE PROMISE

2.1 The NSS is aligned to the NHS People Promise framework, enabling the Trust to assess staff experience and sentiment across each of the seven People Promise themes (plus two additional themes – staff engagement and morale). This structure provides a consistent and meaningful way to understand how well the organisation, and the NHS in general, is delivering on the conditions and culture that staff say matter most.

2.2 In 2025, the Trust's results present a largely stable and positive overall picture, even with a significant increase in the number of frontline staff responding to the survey. NWAS performed broadly in line or above sector averages, with several themes exceeding the benchmarking group average and some approaching the best-performing organisations.

2.3 The People Promise scores below (out of 10) reflect staff perceptions across the specific set of questions that map to each theme, offering a clear and comparable measure of progress year on year.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.00	5.47	5.97	5.89	5.19	5.55	6.23	6.06	5.86
Best result	7.25	5.62	6.23	5.91	5.30	5.83	6.74	6.29	6.06
Average result	6.93	5.37	5.91	5.65	4.92	5.55	6.23	5.93	5.54
Worst result	6.48	4.91	5.60	5.35	4.50	4.75	5.66	5.49	5.19
Responses	4114	4116	4097	4107	3686	4102	4110	4119	4120

2.4 When compared with the 2024 results, two areas show a statistically significant positive shift - We are always learning and We work flexibly.

2.5 Over the past year, the Trust has taken targeted steps to expand access to learning and development, including the further development of the CPD Hub, increased promotion of accredited distance-learning opportunities and pre-apprenticeship support. There has been a focus on supporting aspiring leadership through standardised local portfolio development for Senior Paramedic roles and launch of the Developing Leaders programme. These initiatives have widened participation and strengthened the visibility of professional development across the organisation.

2.6 Similarly, focused work has been undertaken to enhance flexible working. This includes the development of a new digital request form, the rollout of flexible-working e-learning, and producing updated guidance and resources for managers and staff. This has been visibly operationally led which has supported traction across operational teams.

2.7 Taken together, these improvements reflect a sustained organisational commitment to improving the employee experience and are likely to have contributed directly to the uplift in People Promise scores for these two themes.

Appendix B: Significance testing – 2024 vs 2025

Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2024 and 2025*. For more details, please see the Technical Guide.

People Promise elements	2024 score	2024 respondents	2025 score	2025 respondents	Statistically significant change?
We are compassionate and inclusive	6.97	3551	7.00	4114	Not significant
We are recognised and rewarded	5.48	3552	5.47	4116	Not significant
We each have a voice that counts	6.01	3539	5.97	4097	Not significant
We are safe and healthy	5.87	3542	5.89	4107	Not significant
We are always learning	5.07	3274	5.19	3686	Significantly higher
We work flexibly	5.44	3532	5.55	4102	Significantly higher
We are a team	6.19	3548	6.23	4110	Not significant
Themes					
Staff Engagement	6.12	3554	6.06	4119	Not significant
Morale	5.84	3553	5.86	4120	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

3. STAFF EXPERIENCES: OPERATIONS

3.1 Within Operations, PES results show a broadly positive trajectory across all People Promise themes, with a continued narrowing of the gap between Operations scores and Trust-wide averages. In 2025, the c*ompassionate and inclusive* score increased from 6.54 to 6.77, while s*afe and healthy* rose from 5.34 to 5.55. *Always learning* improved from 4.69 to 5.06 and w*ork flexibly* increased from 4.82 to 5.08. Additionally, t*eamworking* rose from 5.80 to 6.00 and m*orale* from 5.58 to 5.79.

3.2 For PTS, survey outcomes also show year-on-year improvement across every People Promise element. The c*ompassionate and inclusive score* increased from 6.35 to 6.85, and *having a voice that counts* rose from 5.63 to 5.88. *Always learning* increased from 4.29 to 4.73, *work*

flexibly went from 5.10 to 5.21, and *we are a team* from 5.42 to 5.81. *Morale* improved from 5.45 to 5.72, and *reward and recognition* increased from 4.82 to 4.96. Notably, score in two areas exceeded NWAS averages in 2025 - s*afe and healthy* and *staff engagement* – 5.84 to 6.11 (safe and healthy), 5.81 to 6.26 (staff engagement).

3.3 Although PES and PTS scores in the main continue to sit below the overall NWAS average, the trajectory is moving in a positive direction. The implementation of the PES restructure following SDMR, together with sustained culture-improvement efforts within PTS, is beginning to generate visible improvements in staff experience. While further work is required to ensure consistently improved experiences across both teams, these scores demonstrate positive impacts of initiatives.

3.4 Responses from Resilience staff continue to reflect some of the highest levels of satisfaction within the Operations directorate. The c*ompassionate and inclusive* score increased from 7.03 to 7.60, *Recognition and reward* rose from 6.07 to 6.62, and w*ork flexibly* saw a significant uplift from 5.95 to 6.85. *Teamworking* also improved markedly, rising from 6.72 to 7.45, while s*afe and healthy* increased from 6.67 to 6.99. *Staff engagement* and *morale* showed more modest gains, moving from 6.54 to 6.78 and 6.57 to 6.78 respectively. Overall, these results position Resilience well above the Trust average across most People Promise elements.

3.5 For ICC, a direct year-on-year comparison is not possible because the 2024 breakdown reported 111 and EOC separately, whereas the 2025 results present a combined ICC grouping. For context, the 2025 ICC scores include 5.38 for *recognition and reward*, 5.57 for *staff engagement*, and 5.47 for m*orale*. In 2024, 111 reported significantly higher scores – 6.42 for recognition, 6.64 for engagement, and 6.58 for morale. Comparatively, EOC results score were lower at 5.45, 5.86, and 5.73 respectively. Historically, 111 colleagues have consistently reported more positive experiences than those in EOC. However, the new consolidated ICC grouping, which also incorporates the PTS contact centre, will provide a refreshed and more representative baseline for monitoring and improving staff experience across all contact-centre-based roles. It should be noted that the staff survey fieldwork period coincided directly with the transition period to the revised leadership structure and it is likely that this period of change and uncertainty has impacted on results.

4. STAFF EXPERIENCES: CORPORATE TEAMS

4.1 Across corporate teams, the year-on-year pattern presents a generally positive picture, with most directorates continuing to outperform the Trust average while still showing areas where targeted improvement would add value. For example, the People Directorate demonstrates particularly strong progress, with increases across every People Promise element. Notable improvements include a rise in *work flexibly* from 6.86 to 7.31, *reward and recognition* from 6.39 to 6.70, and *always learning* from 5.73 to 6.07, alongside higher *staff engagement* (7.00 to 7.24) and *morale* (6.15 to 6.54).

4.2 The Quality Directorate also shows improvement across several key areas. Scores increased for *compassionate and inclusive* (7.52 to 7.79), *reward and recognition* (6.41 to 6.69) and *always learning* (5.58 to 5.90). Although results for s*afe and healthy* (6.69 to 6.43) and w*ork flexibly* (7.35 to 7.04) declined, both remain significantly higher than Trust-wide averages and continue to reflect a strong staff experience overall.

4.3 The Strategy & Planning Directorate continues to report some of the most positive staff experience scores in the organisation. Indicators of culture, safety and engagement have improved further, with increases in *compassionate & inclusive* (7.79 to 7.90), *safe & healthy*

(7.08 to 7.22) and *staff engagement* (7.49 to 7.57). Modest reductions in *reward and recognition* (7.15 to 7.06) and *we are a team* (7.55 to 7.36) were seen, though both remain high relative to Trust averages.

4.4 Results for the Clinical Directorate in 2025 show consistently strong levels of staff experience, outperforming the 2024 results previously reported for the Medical Directorate. Staff in Clinical report exceptionally positive views across culture, recognition, flexibility, learning and engagement, including *compassionate and inclusive* at 7.81, *reward and recognition* at 6.96, and *work flexibly* at 7.22, all higher than the equivalent Medical directorate scores from the previous year.

4.5 The Finance Directorate also shows a broadly positive shift between 2024 and 2025, maintaining a strong and stable profile across most themes. Improvements are seen in *compassionate and inclusive* (7.48 vs 7.32), *reward and recognition* (6.21 vs 6.17), *having a voice that counts* (6.70 vs 6.66) and safe and healthy (6.94 vs 6.86). While *staff engagement* remains steady and *morale* shows only a marginal decrease (6.38 vs 6.43).

5. KEY ACTIONS TAKEN TO IMPROVE STAFF EXPERIENCE IN 2025/26

5.1 During 2025, NWAS delivered a focused programme of work to strengthen staff experience across a number of priority areas.

5.2 In relation to wellbeing, activity centred on maintaining and promoting the Trust's wellbeing support systems, including the Wellbeing Hub, wellbeing-focused events, and leadership input designed to enhance the quality of wellbeing conversations between managers and staff. Overall, this work aimed to make support more visible, easier to access, and better integrated into daily management practices.

5.3 On sexual safety and wider workplace culture, NWAS progressed practical delivery through its charter commitments and related engagement activity, while also reinforcing expectations around dignity, respect and appropriate behaviour at work. This included continuing sexual safety engagement activity, equipping managers with supporting resources, and reinforcing expectations around reporting, responding to concerns, and maintaining a respectful working environment and continued promotion of the Dignity at Work campaign and action to support a safer and more respectful working environment.

5.4 Work to address violence and aggression also continued during 2025 through the Trust's prevention and reduction approach. Delivery included specialist follow-up support for affected staff, closer review of incident patterns and repeat abuse, wider operational use of body worn video, and partnership work to improve both prevention and the response to incidents. This reflected an ongoing effort to improve staff safety, particularly in frontline and contact centre settings.

5.5 Inclusion remained a visible area of delivery during 2025. NWAS progressed its equality, diversity and inclusion commitments through implementation of its EDI and anti-racism priorities, publication of its annual EDI reporting, and continued involvement of staff networks in shaping improvement activity. This work supported the wider aim of improving belonging, representation and the day-to-day experience of staff across the Trust.

5.6 Flexible working was also advanced during 2025 through NWAS's participation in the NHS People Promise Exemplar programme. This provided a structured route for developing improvement work linked to flexibility, staff voice and recognition, with the intention of

creating more responsive working arrangements and a more positive employment experience.

6. KEY UNDERPINNING THEMATIC ANALYSIS

6.1 Whilst the people promise themes give a good high level overview of progress for Board to consider, but the staff survey results can also be a key measure of the impact of improvement activity. In light of the brief summary of interventions outlined above, the following are examples of some of the key areas of thematic analysis which enable us to consider the impact of work carried out and some key barometers of culture.

6.2 **Immediate line managers:** Responses to questions relating to relationships with immediate managers remained largely positive and stable between 2024 and 2025, with the Trust continuing to score above average across all nine measures.

6.3 Analysis by operational services highlighted significant variation in staff experience. Resilience reported markedly higher scores across all measures of managerial support, with positive responses typically exceeding 80%, suggesting a highly supportive and engaged management environment. ICC scores broadly aligned with the Trust average, where nearly two-thirds of staff responded positively.

6.4 Responses from PES and PTS staff were below the Trust average across all nine questions, particularly in relation to being asked for their opinions, receiving clear feedback, and feeling supported in addressing challenges. However, in both cases both PES and PTS responses show a significant improvement in comparison with 2024. PES results across these questions have risen between 3.5% and 6% and PTS scores have risen between 4.7% and 11.4%. This correlates with the restructure of PES roles, the changes to leadership recruitment and the investment in development for these groups.

6.5 **Negative experiences:** Results relating to bullying, harassment and discrimination from managers and colleagues showed small improvements from 2024 to 2025. Experiences of unwanted sexual behaviour from colleagues reduced from 8.36% in 2024 to 7.19% in 2025. The experience of women in relation to unwanted sexual behaviour from colleagues has improved by 1.4% over the last two years but remains just above 8%. Whilst these improvements are encouraging, this still equates to nearly 300 staff, reinforcing the need for continued focus on prevention, reporting and support.

6.6 The proportion of staff who reported their most recent experience of physical violence or harassment, bullying or abuse declined slightly in 2025. Around three-quarters reported physical violence, compared with around half reporting harassment or bullying. Although reductions were modest (2–3%), they highlight the ongoing importance of strengthening confidence in reporting processes and ensuring staff feel safe and supported to raise concerns.

6.7 **Professional development:** The proportion of staff who felt there are opportunities to develop their career in NWAS increased from 54% to 59%, while those who felt supported to develop their potential rose from 48% to 50%. However, the position in relation to perceived fairness of career progression remains at 50%. Whilst there have been a number of changes to improve development, progression and recruitment into operational leadership positions, this will take time to embed and for confidence to build.

6.8 88% of respondents confirmed they had received an appraisal in the previous 12 months, up from 87% in 2024. However, the proportion of staff who felt that their appraisal helped them improve how they do their job remains very low at 18%, suggesting that while appraisals are taking place in high numbers, the perceived quality and developmental impact remain areas for further attention.

6.9 **Speaking up:** Fewer staff (68%) reported feeling secure raising concerns about unsafe clinical practice (69% in 2024), and confidence that the organisation would address such concerns has remained stable at 52%.

6.10 The number of staff who felt safe to speak up about any concerns remained stable at 59%, while confidence that the organisation would act on concerns rose slightly from 45% to 46%

6.11 None of the changes in relation to speaking up are consider statistically significant but taken together, these results highlight the need for continued focus on strengthening psychological safety and ensuring staff have confidence that speaking up leads to meaningful action.

6.12 **Recommend as a place to work:** this measure saw a stable position from 2024 to 2025 at 55%. This is the second highest score in the ambulance sector where the range in response to this question was 37% to 58%.

7. NEXT STEPS

7.1 To support local improvement planning, management teams have already received detailed data packs to inform the development/refresh of their Local People Plans. The SMART (survey coordination group) will be overseeing the development of a Trust-wide action plan, ensuring that local insights and organisational priorities are aligned and progressed consistently.

7.2 Further in-depth analysis will be undertaken to strengthen understanding of staff experience, including a detailed review of EDI-related data to identify priority themes, and an exploration of age-related patterns to understand potential generational differences.

7.3 In line with national requirements in the NHS Medium Term Plan, comprehensive analysis of free-text comments to identify the areas of greatest dissatisfaction and agree targeted actions will take place. Thematic analysis from Picker (survey provider), aligned to the People Promise, is expected shortly.

7.4 Ongoing reporting will ensure robust governance and visibility of progress. Findings, analysis and subsequent actions will continue to be shared regularly with TMC, the Resources Committee and the Board to provide assurance and maintain organisational focus on delivering measurable improvement.

8. EQUALITY/ SUSTAINABILITY IMPACTS

8.1 The NSS includes equality monitoring questions, providing insight into the experiences of colleagues with different protected characteristics. This understanding will be further enriched this year by local-level EDI data, which will be analysed and shared through the Diversity & Inclusion Group and Staff Networks.

8.2 Several NSS questions also contribute to the metrics used in the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES). Reports relating to NSS WDES and WRES are still pending and once received will also be shared with the D&I Group and Staff Networks to inform targeted action and improvement. This data will be shared in more detail with Board when the full WRES and WDES data is published.

9. ACTION REQUIRED

9.1 The Board of Directors is asked to:

- Receive assurance from the People Promise themes from the NHS Staff Survey 2025.

NHS
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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Action on Antisemitism
PRESENTED BY	Lisa Ward, Director of People
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Receive assurance that the Trust is responding positively to the expectations set out by NHSE in relation to action on antisemitism. • Endorse the adoption of the IHRA definition on antisemitism as requested by NHSE.
EXECUTIVE SUMMARY	The purpose of this paper is to update the Board of Directors on progress relating to NHS England's expectations regarding action on antisemitism. In a letter from NHS England's CEO in October 2025, following the terrorist attack at Heaton Park Synagogue, NHS organisations were asked to take three actions: • adopt the International Holocaust Remembrance Alliance (IHRA) non-statutory definition of antisemitism, • ensure staff refresh national EDI training, • prepare for updated national guidance on uniforms and workwear. The Diversity & Inclusion Group has reviewed the position. It has been noted that local, regional and national NHS organisations are increasingly adopting the antisemitism definition, including Yorkshire Ambulance Service and Greater Manchester Integrated Care Board.

	However, a consistent approach across the ambulance sector has not yet emerged. From an NWAS perspective, the Trust has already committed to becoming an anti-racist organisation. Adopting the definition of antisemitism would further strengthen this commitment and reinforce the Trust's clear stance on challenging and addressing all forms of racism. The definition is accompanied by a set of illustrative examples developed by the IHRA. While the definition itself has been widely adopted, the examples have been subject to ongoing academic, legal and political debate, particularly in relation to concerns about freedom of expression, and are not universally endorsed. Trust Management Committee has considered the position and recommended adoption to Resources Committee. The proposal is to adopt the core definition without examples at this stage. The steering group in relation to anti-racism will review the position on the examples in due course through continued engagement with Jewish communities and stakeholders across the North West. The update to the EDI and Human Rights mandatory training module with inclusion of antisemitism, Islamophobia and discrimination learning content is yet to be rolled out. Once it has been released, the Trust will ensure timely completion by all staff through a technical solution to advance module compliance. This has been incorporated into the 2026/27 mandatory training programme. National guidance on uniforms and workwear is under review, with a focus on balancing religious expression and professional standards. Though the refreshed guidance is still to be published, the Trust's existing Uniform Policy already provides clarity on the wearing of badges. Staff will be reminded of current requirements via internal communications and management briefing. Overall, these actions provide assurance that the Trust is positively engaging to take action on antisemitism, and is committed to ensuring safe, inclusive environments for staff and patients across the North West.	
PREVIOUSLY CONSIDERED BY	D&I Group	
	Date	14/11/25 & 23/01/26
	Outcome	D&I Group reviewed and supported the adoption of the IHRA definition on antisemitism but not the illustrative examples. Recommended to TMC for endorsement.
PREVIOUSLY CONSIDERED BY	TMC	
	Date	18/02/26

	Outcome	TMC endorsed the recommendation of the D&I Group.
PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	19/03/26
	Outcome	Verbal update to be given at Board

1. BACKGROUND

1.1 In October 2025, NHS England Chief Executive, Sir James Mackey, wrote out to all NHS Trusts setting out NHS England's expectations in relation to strengthening efforts to tackle antisemitism (appendix A). The letter followed the terrorist attack at Heaton Park Synagogue and requested NHS organisations to:

1. Adopt the International Holocaust Remembrance Alliance (IHRA) non-statutory definition of antisemitism
2. Ensure staff refresh their competence on the EDI mandatory training module without waiting for the three year refresher
3. Prepare for updated national NHS guidance on uniforms and workwear

1.2 Following discussions at the Diversity & Inclusion Group meetings in November last year and January 2026, this paper sets out the steps the Trust intends to take in response to the letter.

2. ANTISEMITISM DEFINITION

2.1 Over the last few months, engagement has been undertaken to understand how other NHS organisations, particularly within the ambulance sector and regionally, have responded to the request to adopt the IHRA definition of antisemitism.

2.2 It has been noted that:

- Yorkshire Ambulance Service has formally adopted the IHRA definition.
- Greater Manchester Integrated Care Board has also adopted the definition.
- A small number of other NHS organisations nationally have also published their commitment to adopting the definition (i.e. NHS Resolutions, Shropshire Telford Wrekin ICS, NHS Race & Health Observatory).
- However, a consistent approach across all ambulance trusts has not yet emerged.

2.3 NWAS has made a clear commitment to becoming an anti-racist organisation. Adoption of the IHRA definition would further strengthen this position and reinforce the Trust's resolve to challenging and addressing all forms of racism.

2.4 Therefore, the TMC is recommending the adoption of the following IHRA non-legally binding working definition of antisemitism:

"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

2.5 The IHRA definition is accompanied by a set of illustrative examples to support interpretation and application. These examples have however, been the subject of academic, legal and political debate, particularly in relation to concerns about potential implications for freedom of expression. As a result, organisational approaches to adoption have varied. While many public bodies have adopted the definition, not all have formally endorsed the accompanying examples. In 2016, the Home Affairs Select Committee recommended adoption of the definition with certain clarifications intended to safeguard freedom of speech.

2.6 Given that the examples are not universally endorsed and remain an area of ongoing debate, it is recommended that the Trust adopts the IHRA definition at this stage without the accompanying examples. This approach would align the Trust with the core definition, while allowing further consideration of the examples in due course. Through continued engagement with Jewish communities and representative groups across the North West, the Trust can review its position on the examples at a later stage to ensure any future decision is informed, proportionate and reflective of stakeholder views. This work will be undertaken as part of the anti-racism programme of work.

2.7 The socialisation and communication of the definition will also be developed through the work of the anti-racism programme.

2.8 In addition, the Government confirmed in October 2025 that recommendations from the independent working group on Islamophobia, including a proposed definition of anti-Muslim hatred, are under review. It is anticipated that once agreed, NHS organisations will be asked to adopt a definition of Islamophobia too, and the Trust will consider this accordingly.

3. EDI MANDATORY TRAINING

3.1 The letter from NHSE also notified of forthcoming updates to the NHS Core Skills Training Framework, specifically the Equality, Diversity and Human Rights component. The revised national training will include explicit content on antisemitism, Islamophobia and wider forms of discrimination.

3.2 NHSE asked organisations not to wait for the usual three-year refresher cycle and instead ensure that all staff complete the updated training as soon as it becomes available, which is likely be from April 2026.

3.3 Once released, the Workforce Development Team has confirmed that the Trust will use a technical solution to advance module completion for all staff to ensure timely compliance and organisational assurance. This approach has been endorsed by TMC who have committed to its inclusion in the 2026/27 mandatory training programme.

4. UNIFORM AND WORKWEAR GUIDANCE

4.1 NHSE is currently reviewing national guidance on uniforms and workwear, last updated in 2020. The refresh aims to balance freedom of religious expression with the need for patients to feel safe, respected and confident in the professionalism of the care environment.

4.2 The updated guidance is understood to have been prompted by concerns about the increasing use of pin badges or other items not forming part of the approved uniform, which may negatively impact colleagues or patients.

4.3 While the refreshed guidance from NHSE is awaited, the Trust's existing Uniform Policy already provides clarity regarding the wearing of badges and staff will be reminded of current requirements via internal communications and management briefing.

5. RISK CONSIDERATION

5.1 Failure to take action on all types of racism, including antisemitism, may present both regulatory and reputational risks for the Trust, and could also negatively impact patient outcomes and employee experience.

5.2 In recognition of this, the Board confirmed in March 2025 its commitment to NWAS becoming an anti-racist organisation. To support delivery of this ambition, the Board approved an Anti-Racism Statement and an Anti-Racism Steering Group has been established to provide oversight and drive this work forward across the Trust.

5.3 The Trust has a low risk appetite approach to regulatory and reputational concerns and in relation to quality of patient care. Adoption of a clear statement on antisemitism, combined with a refresh of the training in the next 12 months will be a step towards mitigating these risks as the Trust will be able to demonstrate steps to address the risks of racism occurring. It also enables us to demonstrate due consideration of the request set out by NHSE and compliance with the requirements of our public sector equality duty. We have some evidence of patients being adversely affected by the wearing of badges which may be interpreted as antisemitic, and a close management of this issue will again support in managing this risk.

5.4 The Trust has a moderate approach to risk in relation to its people but the steps set out in this paper have the potential to have a positive impact on the working environment by reinforcing the commitment to anti-racism and raising awareness of the impact of antisemitism.

6. EQUALITY/ SUSTAINABILITY IMPACTS

6.1 It is important to demonstrate equal rigour in tackling all forms of hatred and racism. During the race riots of 2024, NHS organisations played a key role in supporting staff to take an active stance against racism, particularly in response to Islamophobia at that time. The current climate in some communities reinforces the need to redouble efforts to create workplaces where both staff and patients feel safe and welcome.

6.2 Adoption of the antisemitism definition will provide reassurance to Jewish colleagues and patients across the North West, demonstrating the Trust's commitment to being an inclusive employer and service provider.

7. ACTION REQUIRED

7.1 The Board of Directors is asked to:

- Receive assurance that the Trust is responding positively to the expectations set out by NHSE in relation to action on antisemitism.
- Endorse the adoption of the IHRA definition on antisemitism as requested by NHSE.

To: ICB, NHS Trust and Foundation Trust:
- Chairs
- Chief Executives
- Chief People Officers

cc. NHS England regional directors
Commissioning support units

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 October 2025

Dear colleagues,

Request for action on racism including antisemitism

We write to ask for your assistance in implementing important initiatives that support our shared commitment to fostering an inclusive, respectful, and professional environment – for colleagues, patients and visitors – across the NHS and assuring our communities of our commitment to tackling hatred in all its forms.

We want to reiterate our zero tolerance stance to all forms of hatred, antisemitism, Islamophobia, racism and to any form of discriminatory behaviour. We reiterate our commitment to creating workplaces and services where everyone feels safe, valued and supported, regardless of their background, faith or identity.

In line with this, NHS England is formally and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism.

Th UK Government adopted the definition in 2016 and the Secretary of State has today reaffirmed the Department of Health and Social Care's commitment to it. The Secretary of State has asked that other DHSC Executive Agencies and Arms-Length Bodies adopt this.

The definition includes illustrative examples of how antisemitism may manifest in contemporary settings, including but not limited to denial of the Holocaust, accusations of Jewish conspiracy, and the targeting of Israel as a proxy for Jewish people. Criticism of Israel similar to that levelled against any other country, however, cannot be regarded as anti-Semitic.

We strongly encourage all NHS organisations to adopt this definition and to note the associated commitments to free speech in order to reinforce our collective stance against antisemitism – whether experienced by our colleagues, our patients, our communities or partners.

We need to demonstrate equal rigour in tackling all other forms of hatred and racism. During the race riots of 2024, local NHS organisations acted as beacons of hope in their local communities – supporting staff in taking an active stance against racism, in particular at that time against Islamophobia.

The current climate in some of our communities means we need to redouble our efforts to create workplaces where our staff and patients alike feel safe and welcome.

The government is also reviewing the recommendations of the independent working group on Islamophobia.

Uniform and workwear guidance update

Ensuring everybody feels safe to present for care and treatment when they need it and in working environments for our colleagues is a patient safety matter.

Working with stakeholder groups, we will update our existing uniform and workwear guidance, drawing on the policies developed in Manchester, UCLH and other good practice. The guidance will continue to uphold the principles that underpinned its creation including freedom of religious expression, ensuring patients feel safe and respected at all times, and that staff political views do not impact on patients' care or comfort.

Antiracism including antisemitism training

We are also updating the existing NHS Core Skills Framework module on Equality, Diversity and Human Rights, extending the section on discrimination and content on antisemitism and Islamophobia, and including new questions on this in the assessment. We are working to ensure all NHS organisations are aligned to the Framework to ensure that all 1.5m NHS staff are required to complete this training as part of their mandatory training.

Working with Lord Mann, we will update the content developed with EDI, racism, antisemitism and Islamophobia subject matter experts and aligned to the core skills training framework.

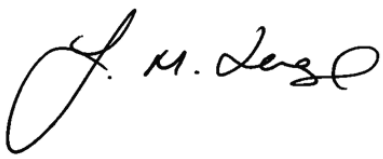
The existing training is completed by staff every three years, but we are asking for your help and support to ensure that all staff in your organisation refresh their EDI training as soon as this content is available rather than waiting for the prompt in the current three-year cycle.

Separately, work is underway to draft a new Statutory and Mandatory Training competency framework which will replace the Core Skills Training Framework (CSTF) – setting out all nationally recommended subjects to be mandated and is due to go live by April 2026.

We appreciate your leadership in implementing these changes and we ask you to support all staff in feeling safe and valued at work and also to support our communities accessing NHS services. We also recognise the importance of supporting NHS organisations in implementing these important initiatives and look forward to working with you to do this.

Yours sincerely,

Sir James Mackey
Chief Executive
NHS England



Jo Lenaghan
Chief Workforce Officer
NHS England

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Integrated Performance Report
PRESENTED BY	Elaine Strachan-Hall, Director of Quality and Improvement
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 **February 2026.** 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. **Quality** Complaints and incidents metrics are stable and there are no new safety alerts affecting NWAS. In terms of effectiveness the Trust is performing just below the sector average for ROSC performance, and just above the sector average for the 30-day survival after discharge measures. Hear and Treat (H&T) performance continued to show special cause variation, reaching 18% in February. The corresponding decrease in See and Treat (S&T), which also displays special cause at 26.3%, is likely linked to this as both measures relate to the same underlying patient cohort. Nationally, the trust ranked 6th for H&T and 10th for S&T.

Operational Performance

PES (999)

Nationally the trust maintains a strong position for ARP.

Measure	ARP Standard (hh:mm:ss)	February 26 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:06:54	3rd
C1 90th	00:15:00	00:11:48	3rd
C2 mean*	00:18:00	00:27:08	6th
C2 90th	00:40:00	00:53:32	3rd
C3 mean	01:00:00	01:37:34	6th
C3 90th	02:00:00	03:20:15	4th
C4 90th	03:00:00	04:18:40	2nd

*UEC C2 Standard = 28mins (achieved)

- Call pick-up volume was stable and call pick up time has reduced during February.
- Hospital turnaround continues to exceed the 30-minute standard at 40m:52s. Turnaround times in Lancashire and South Cumbria ICB have displayed a special cause variation above the mean for the last two months.

111

- Call demand for 111 decreased over the last two months and calls answered within 60 seconds is stable although the percentage of calls which were abandoned rose in February beyond the 5% standard.

111 Measure	Standard	Feb 26	National Ranking
Answered within 60s	95.0%	64.62%	25th/28
Average time to answer	<20s	1m25s	23rd/28
Abandoned calls	<5%	5.1%	23rd/28

Patient Transport Services (PTS)

- PTS activity and performance metrics are stable.

	Finance • The financial position at Month 11 2025/26 is a surplus of £5.657m, against a planned surplus of £0.667m. Vacancies are contributing to the underspend. **Organisational Health** • Overall sickness absence is at 8.95%, consistent with seasonal trends. • Turnover continues to improve across all service lines. • The overall vacancy gap was -2.92% in February 26 and in line with plans. • Overall appraisal compliance is 87.30% (above the target of 85%). • The overall mandatory training compliance is just under 93%, above the 90% target. **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, 18 February 2026
	Outcome	

North West Ambulance Service
NHS Trust

Integrated Performance Report

Board of Directors - March 2026

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.

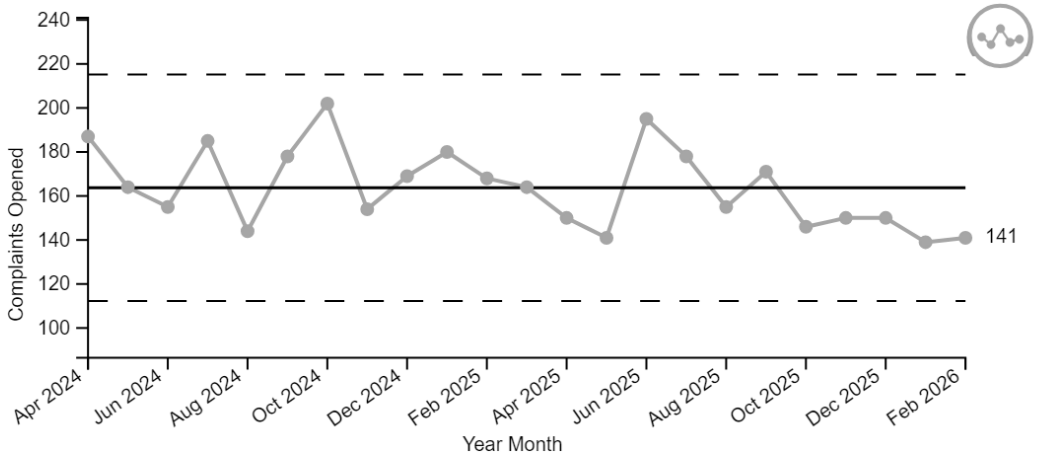
N.B. purple indicates non performance related indicator with arrow indicating direction of travel 

Quality & Effectiveness

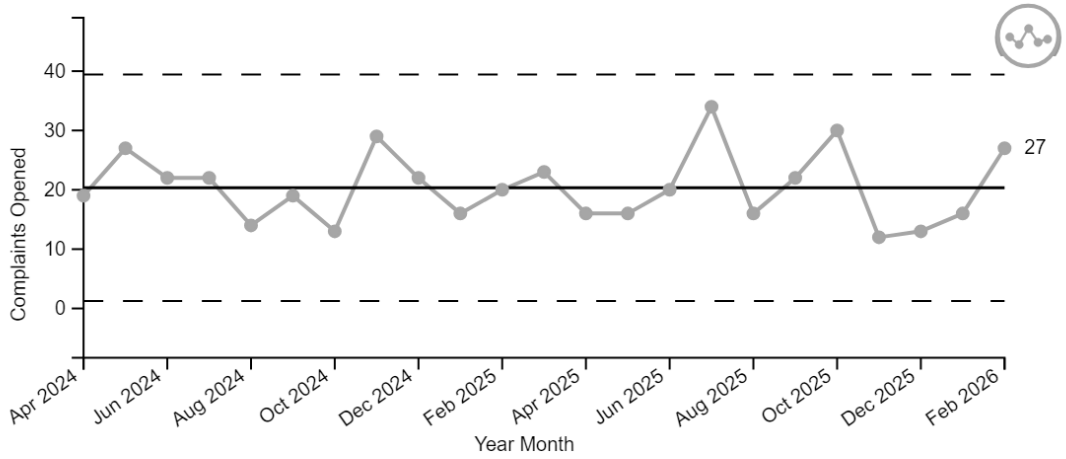
Q1 Complaints
Q2 Incidents
Q3 Safety Alerts
E1 Patient Experience
E2 Ambulance Clinical Quality Indicators (ACQI)
E3 Activities and Outcomes

Q1 Complaints

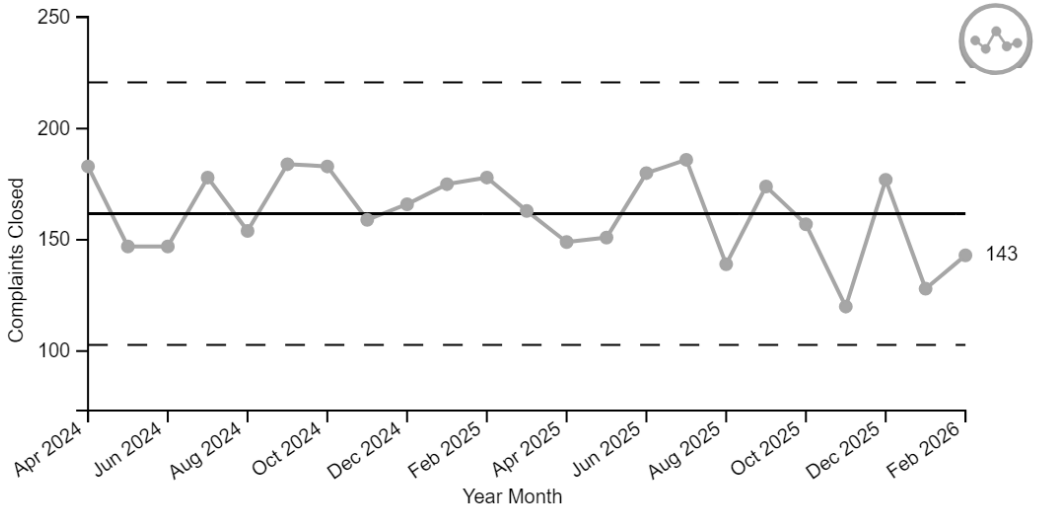
Complaints Opened with Risk Score 1-2



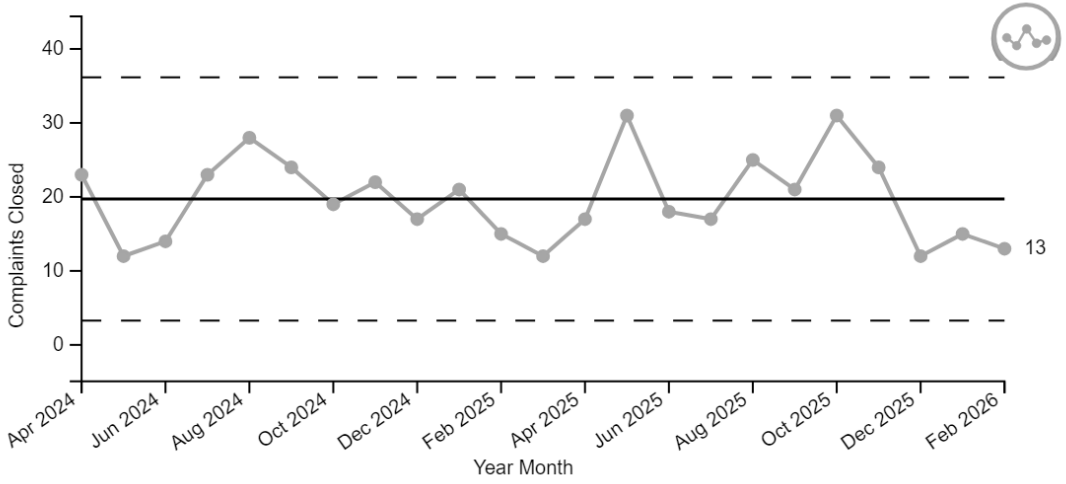
Complaints Opened with Risk Score 3-5

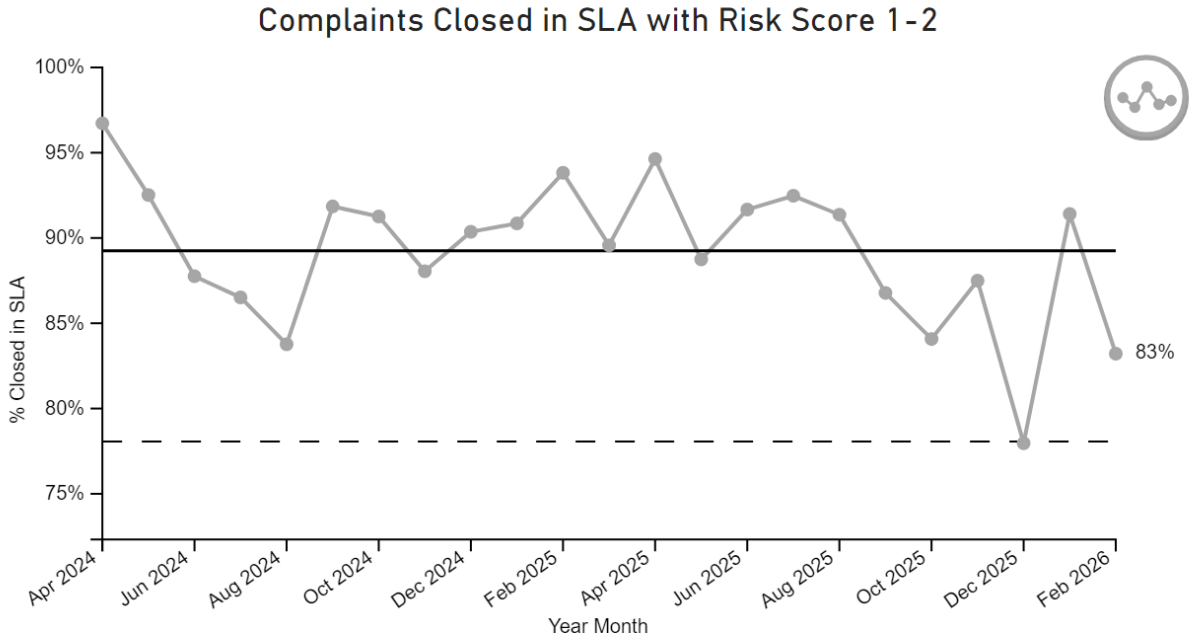


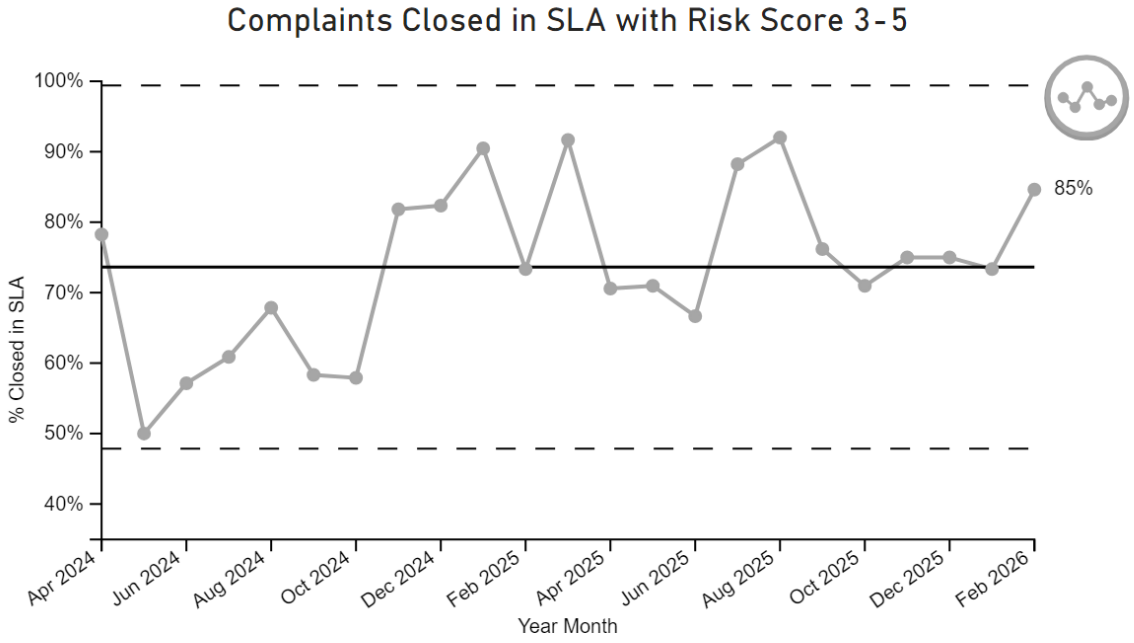
Complaints Closed with Risk Score 1-2



Complaints Closed with Risk Score 3-5





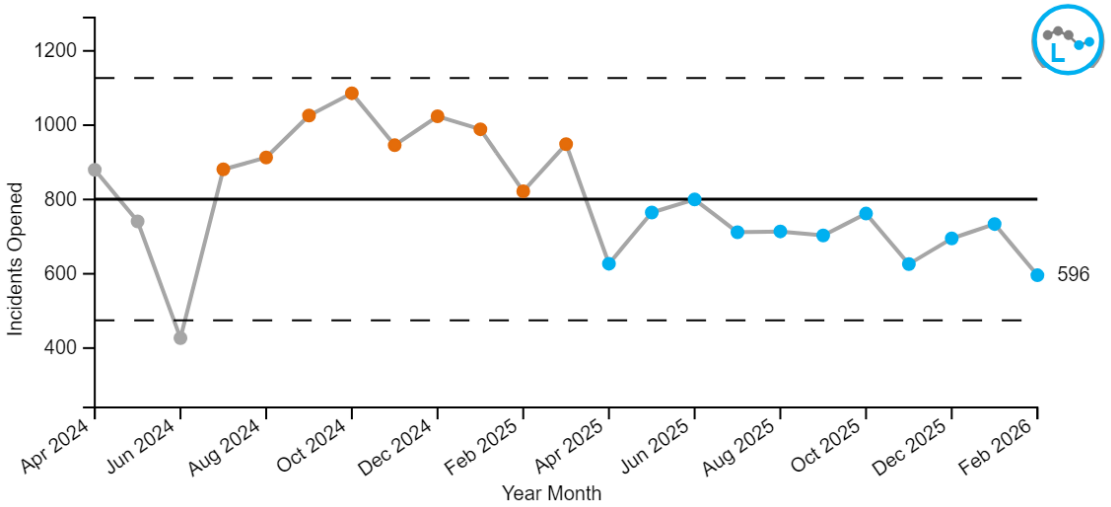


Summary: Patient Advice and Liaison Service (PALS) complaints (risk score 1&2), remain stable. Cases closed in SLA remains stable.
The number of complaints closed with a risk score of 1-2 dropped in December due to staff absences within the team, This was recovered in January and team resilience is being managed

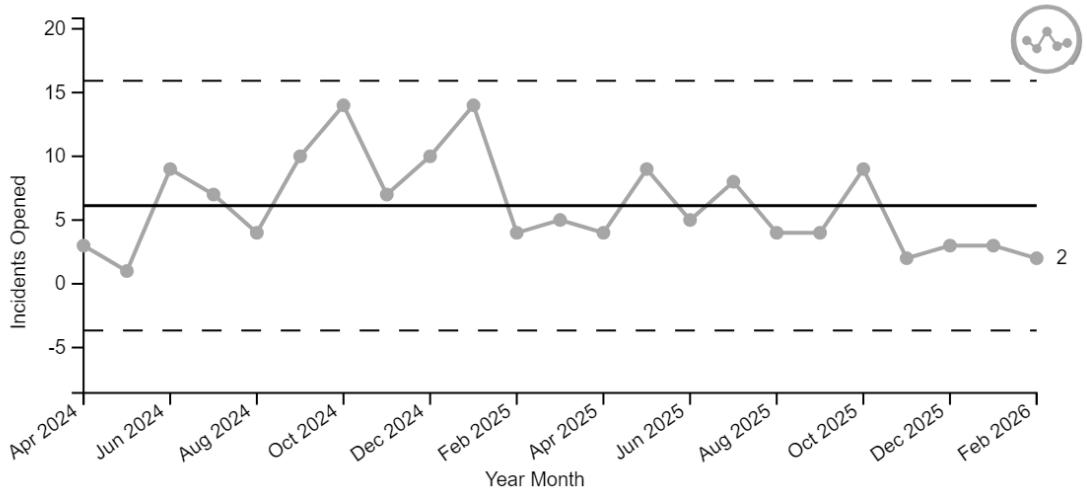
Actions: Nil required

Q2 Incidents

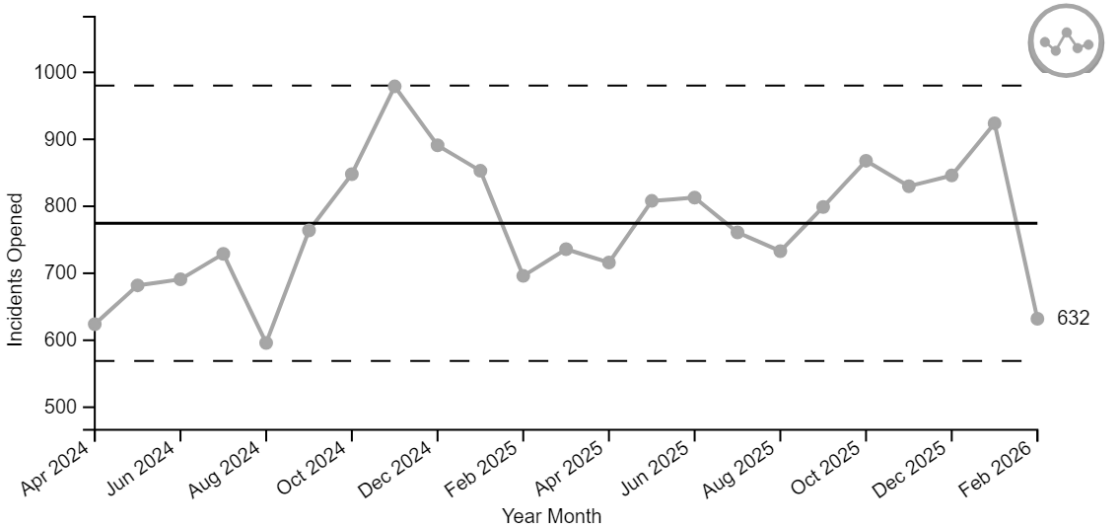
Incidents Opened with Risk Score 1-3



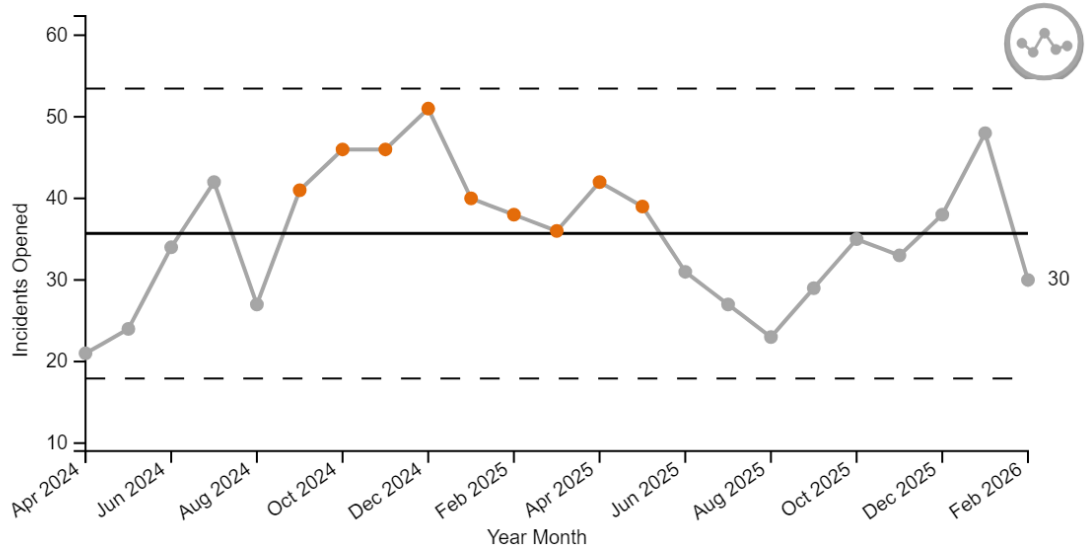
Incidents Opened with Risk Score 4-5

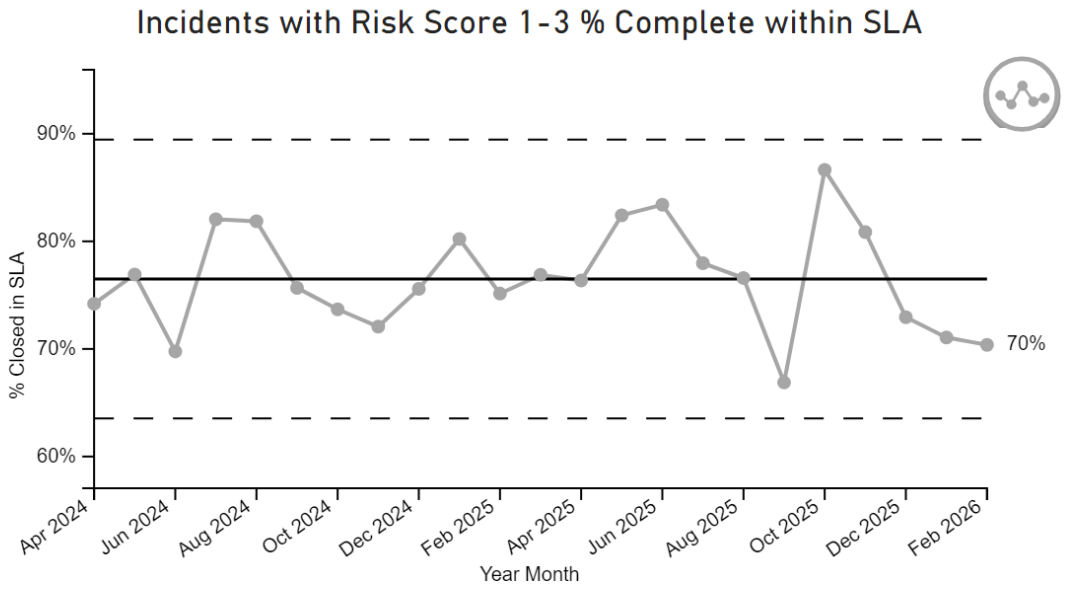


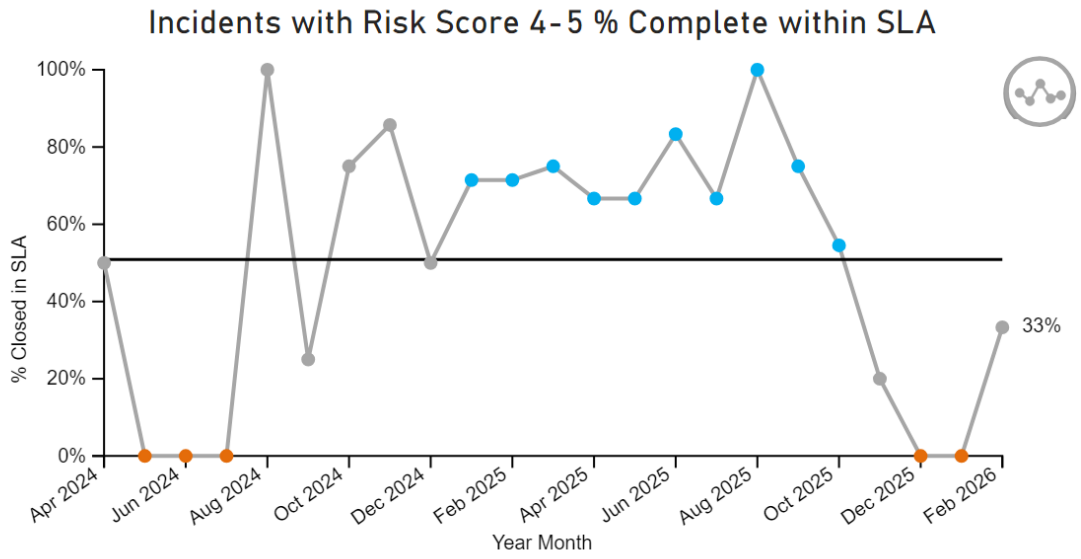
Incidents Opened - Patient



PSIRF Reported Level of Harm (Severe & Fatal)

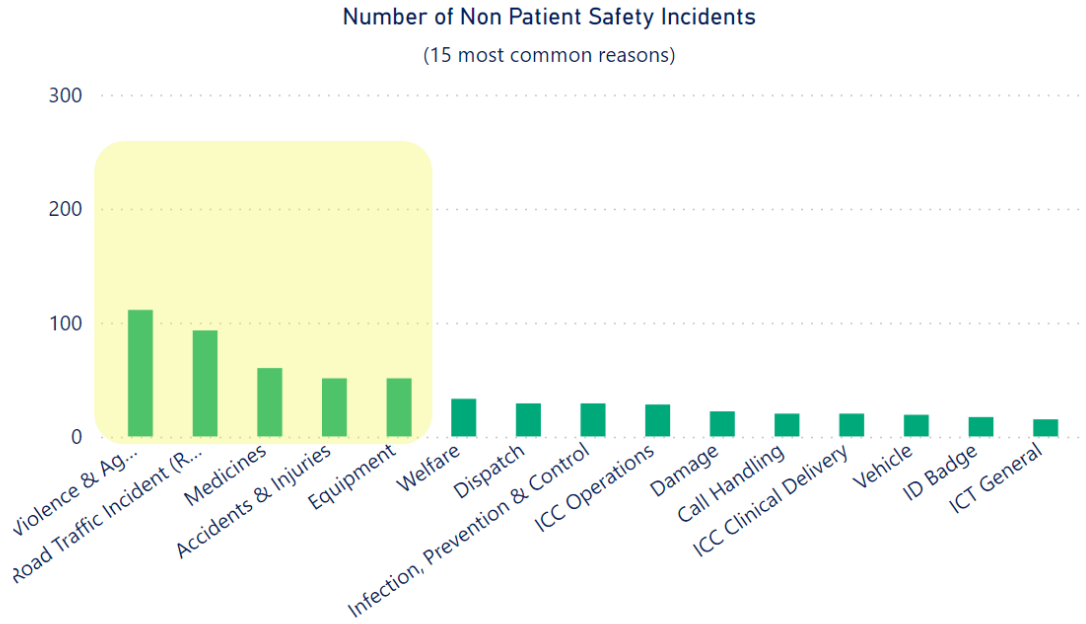


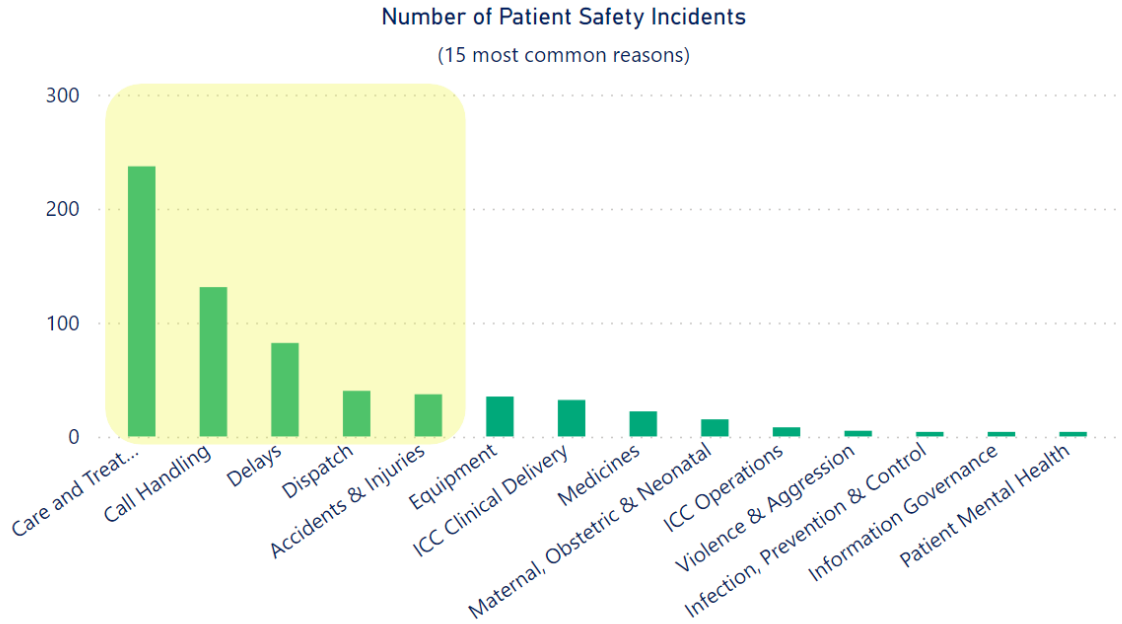


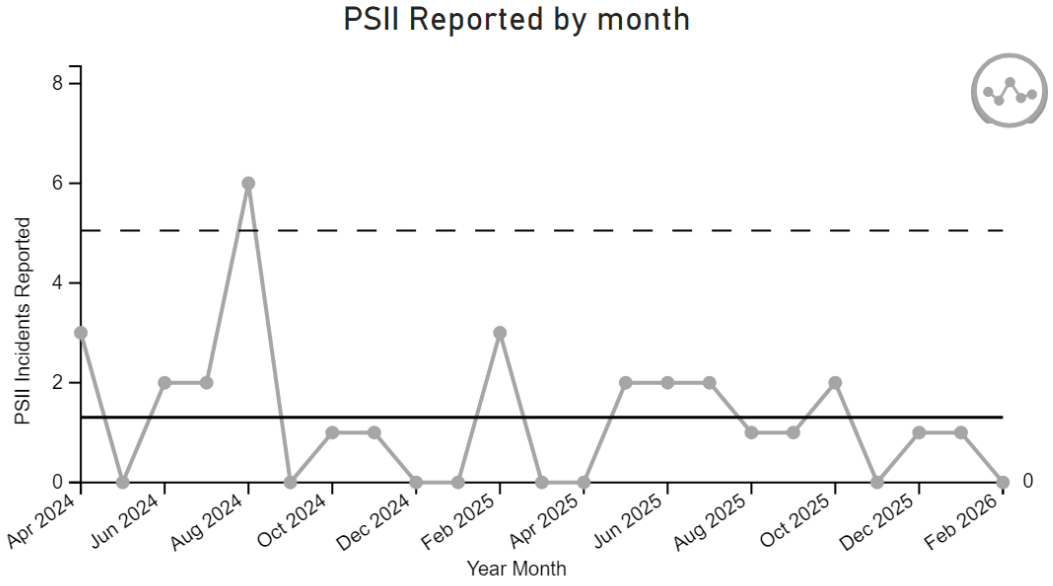


Summary: Incidents opened with a risk score of 1-3 remain below the mean for the 11th consecutive month. Incidents with a risk score of 4-5 within SLA was at 33% for February. There was a significant drop in patient incidents reported in February…..

Actions: Nil required







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.

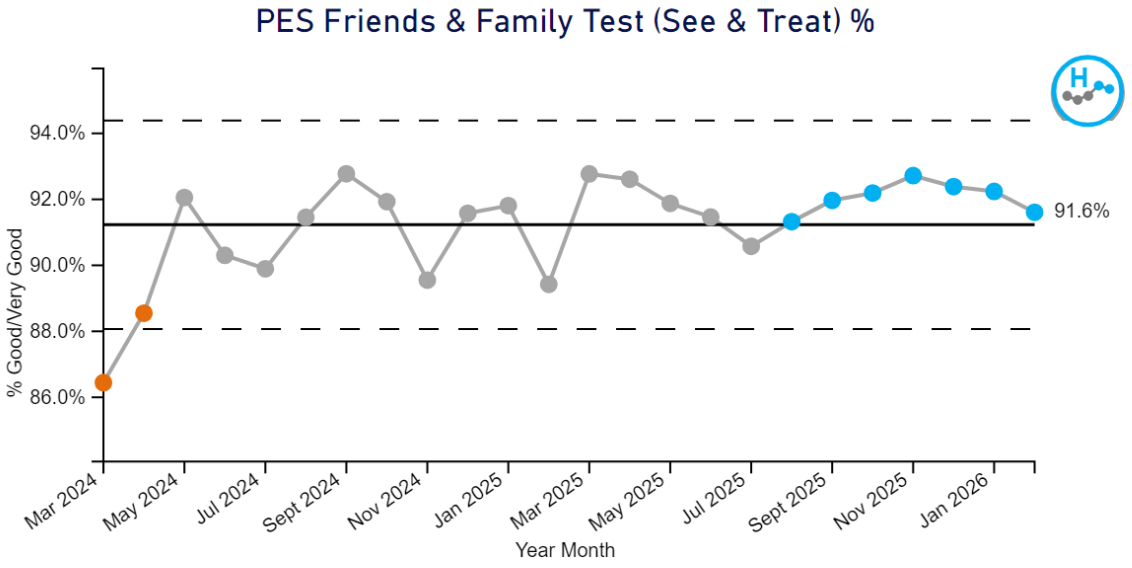
Actions:
The V&A team will be focussing on sexual assaults in Q4 and have awareness and education days planned in.

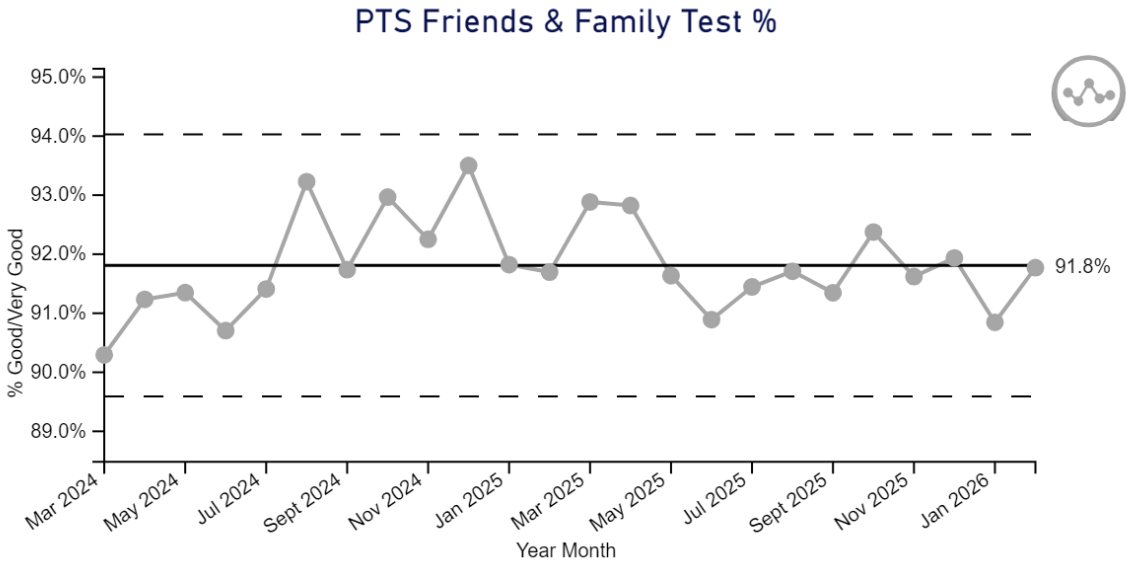
Q3 Safety Alerts

Safety Alerts	Alerts Received (March 2025 - February 2026)	Alerts Applicable (March 2025 - February 2026)	Alerts Open	Notes
CAS Helpdesk Team	**1**	**1**	**0**	Description : Update from the CAS Helpdesk: National Supply Disruption Response (NSDR) now accredited to issue National Patient Safety Alerts. Issue Date: 07 July 2026. Deadline: -. Actions: No Response Required
National Patient Safety Alert - UKHSA	**1**	**1**	**0**	Description : Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia spp: measures to reduce patient risk. Issue Date: 26 June 2025. Deadline: 29 August 2025. Actions: The majority of skin preparation wipes used in the Trust are sterile, but as non-sterile wipes are also used throughout the Trust, a clinical bulletin will be cascaded to all clinicians.
National Patient Safety Alert- NHS England Patient Safety	**3**	**1**	**0**	Description : Harm from incorrect recording of a penicillin allergy as a penicillamine allergy. Issue Date: 20 November 2025. Deadline: 20 November 2026. Actions: Highlighted to Chief Pharmacist and Clinical Informatics Leads for wider discussion required to determine how allergies are currently recorded in the EPR System. These discussions will shape further discussions. On 3 Dec 2025 at Medicines Optimisation Group agreed no further action needed in response to alert for NWAS. Alert will be shared with EPR Development group for information on allergy recording. Discussed. Alert considered low risk for NWAS. A new record is started in NWAS EPR system for each patients seen. In 2026 GP Connect will be pulling data on allergies over from GP systems so if the information is updated in GP side of system the correct information should pull across to NWAS. Current EPR system also does not list drugs A-Z to pick from for allergy recording, but data is entered as free text. MOG agreed no need to do a free text search of NWAS EPR records for penicillamine. Action : ** EPR Development group to be informed of the alert and the doc to be sent for awareness
National Patient Safety Alerts - NHS England & NHS Improvement	**0**	**0**	**0**	

National Patient Safety Alert - DHSC	**5**	**0**	**0**	
National Patient Safety Alerts - OHID	**0**	**0**	**0**	
CMO Messaging	**2**	**2**	**0**	Description Influenza season 2025/26: early season activity and implications for clinical practice. Issue Date: 05 November 2025. Deadline: -. Actions: Response not Required Description Influenza season 2024/25: ending the prescribing and supply of antiviral medicines in primary care. Issue Date: 15 May 2025. Deadline: -.
National Patient Safety Alerts MHRA	**1**	**0**	**0**	
MHRA - Medicine Alerts	**57**	**1**	**0**	Description Class 3 Medicines Recall: Accord Healthcare Ltd, Ipratropium Bromide 500 microgram / 2ml Nebuliser Solution, EL(25)A/45. Issue Date: 23/10/25, Deadline : Not Included. Actions: Discussed at MOG 3/12/25 - there are 2 pouches still to be checked from 110 that have been identified. This is being escalated to CPs - No risk to patients - product correct. Of all the others checked none with Korean writing on found.
Infection Prevention & Control	**0**	**0**	**0**	

E1 Patient Experience





PES positive

- *"They were very quick in arriving and they did everything possible for my son. Kept us well updated while fighting for his life."*
- *"On ringing the operator was lovey, clear spoken and was very reassuring. Ambulance crew were extremely professional and my mum was seen to with dignity."*
- *"A first responder paramedic (volunteer) was first to arrive. Did some checks, reassured me and told me what would happen next. Two paramedics from the Ambulance team arrived. We were briefed by the first chap. Had a chat with me and did an ECG. They were lovely. Reassuring, professional and friendly. What was a very anxious situation for a 62 woman home alone was quickly and calmly resolved."*

PES negative

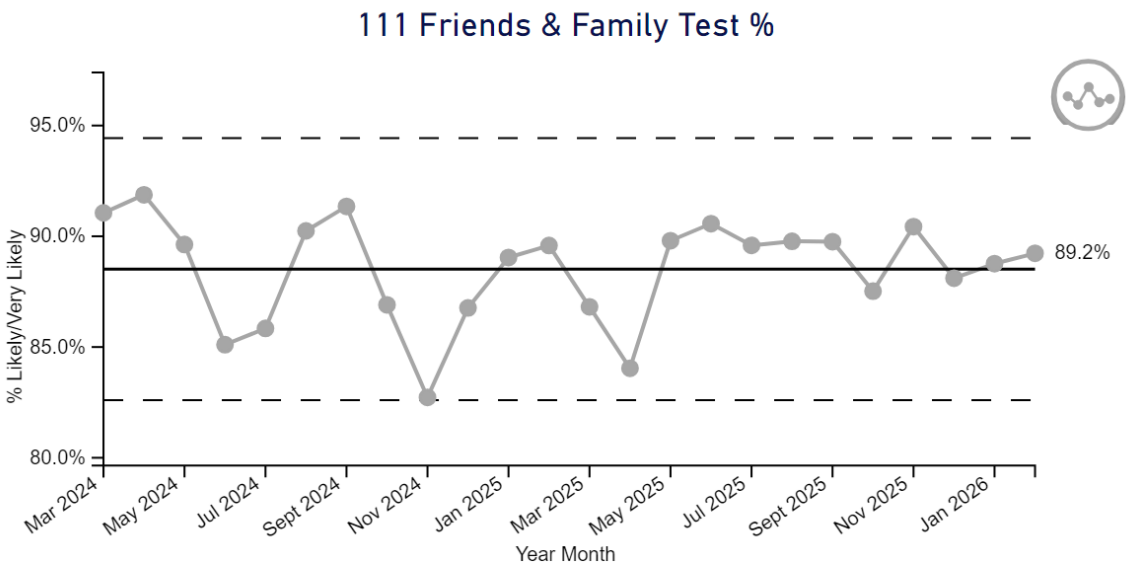
- *"The paramedics were rude, bossy, had poor communication skills, kept interrupting and talking over me, poor listening skills, aggressive and confrontational manner, utterly traumatising experience."*
- *"They were 4 hours late. My son was in crisis and out of control. The time they arrived, he was sleeping."*

PTS positive

- *"Polite, helpful, patient with my mother, treated her with respect and dignity."*
- *"I've used this service a few times, drives have always been polite and very helpful, I get very anxious and nervous stressing out over my illness but somehow they make you feel human and not just a job if that makes sense."*
- *"Easy booking, listened to my needs and the driver was fantastic."*

PTS negative

- *"The taxi service has let me down three times."*
- *"They arrived after the time of the appointment, and so she was still at the hospital after the department had closed, and she was panicking as she's virtually immobile. Booking Patient Transport is now really difficult, as you keep getting a message to ring back as they're too busy. It used to be much better until the start of this year."*
- *"Vehicle used was not suitable for someone who had knees surgery."*



NHS 111 positive

- *"Being on the spectrum, it's sometimes challenging to remember automated instructions. But overall, she was able to put me at ease, and the instructions were clear and precise."*
- *"No problems with 111, I told them my problem wasn't urgent but they still assisted me and got me to speak to a clinician which was very helpful and put my mind at rest."*
- *"The representative for NHS 111 was excellent. The lady got me a dentist and they have taken me on. It has taken five years to get a dentist. Happy days."*
- *"Call was answered promptly. Call handler listened carefully and gave clear, concise advice as to what would happen next. I felt very reassured."*

NHS 111 negative

- *"I think that it is an extraordinary length of time to go through a computer-generated questionnaire to basically end up where you actually needed to be which was to discuss the patient's problem with a medical practitioner."*
- *"Listen to my problem better. The future is terrifying for us oldies."*
- *"Because I got passed to pillar to post. Just no help at all."*
- *Dissatisfied with no message left that described what would happen next. Had to call back in the morning."*

PES FFT

The 715 responses for February 2026 are 4.5 % higher than January, with comments also higher, at 12.8% (599 for February compared to 531 from January). February 2026's overall experience score is 91.6%, down 0.6% from January but up 2.1% compared with February 2025.

PTS FFT

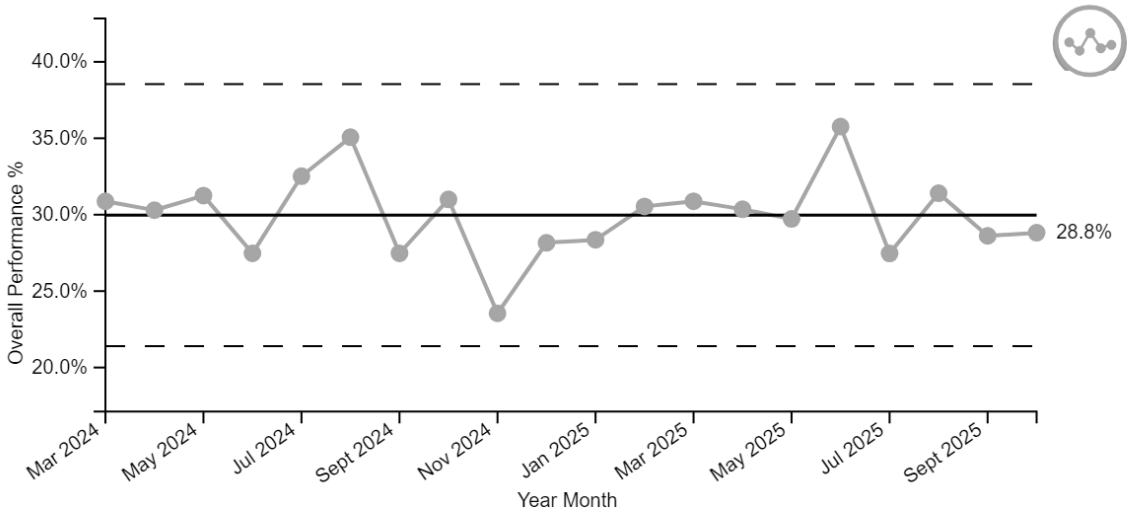
The 1,118 responses received in February 2026 is 2.6% less than January (1,147). Supporting comments also fell by 6.7% (896 vs. 956). The overall February experience score was 91.8%, up 1.0% from January, and marginally higher (0.1%) than February 2025.

NHS 111

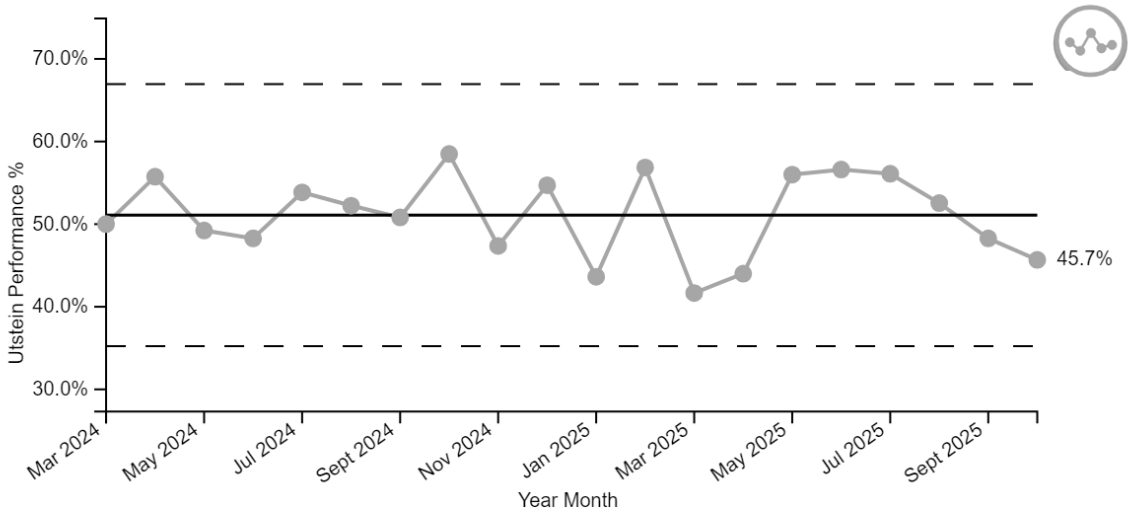
For February 2025 we have 520 returns, compared to 623 returns in January. From the February returns, we see an 89.2% likelihood of the 111 service being recommended, an increase of 0.4 % compared to January and a decrease of 0.4% compared to February 2025.

E2 Ambulance Clinical Quality Indicators (ACQI)

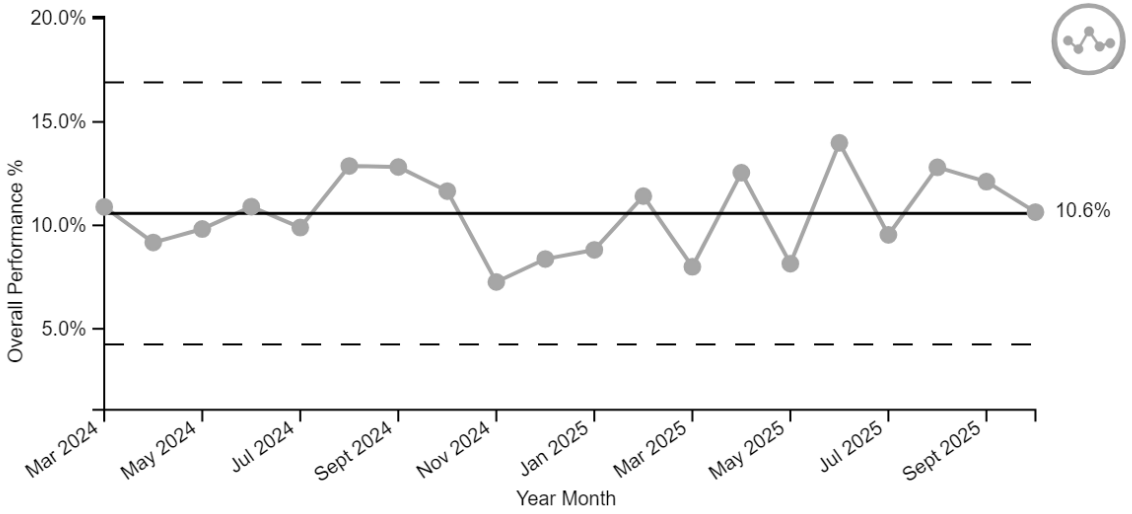
ROSC - Overall Performance



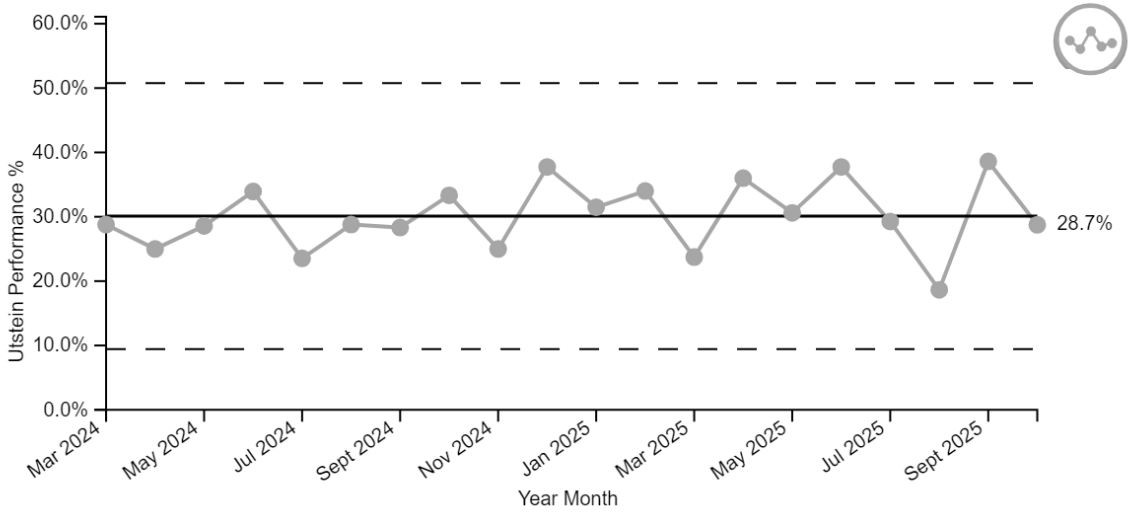
ROSC - Utstein Performance



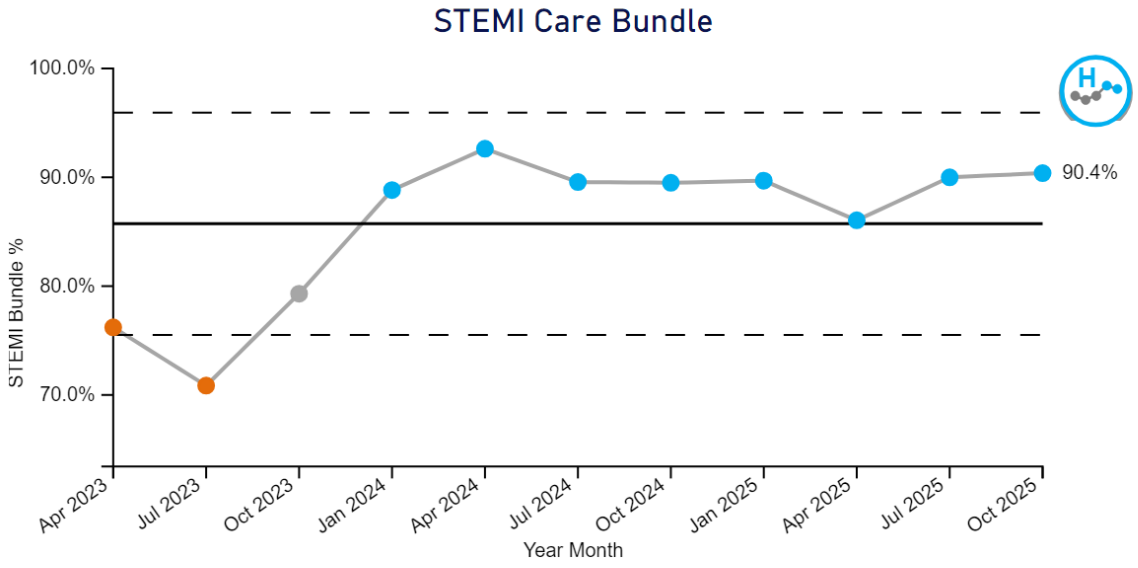
Survival at 30 Days Post Discharge - Overall Performance

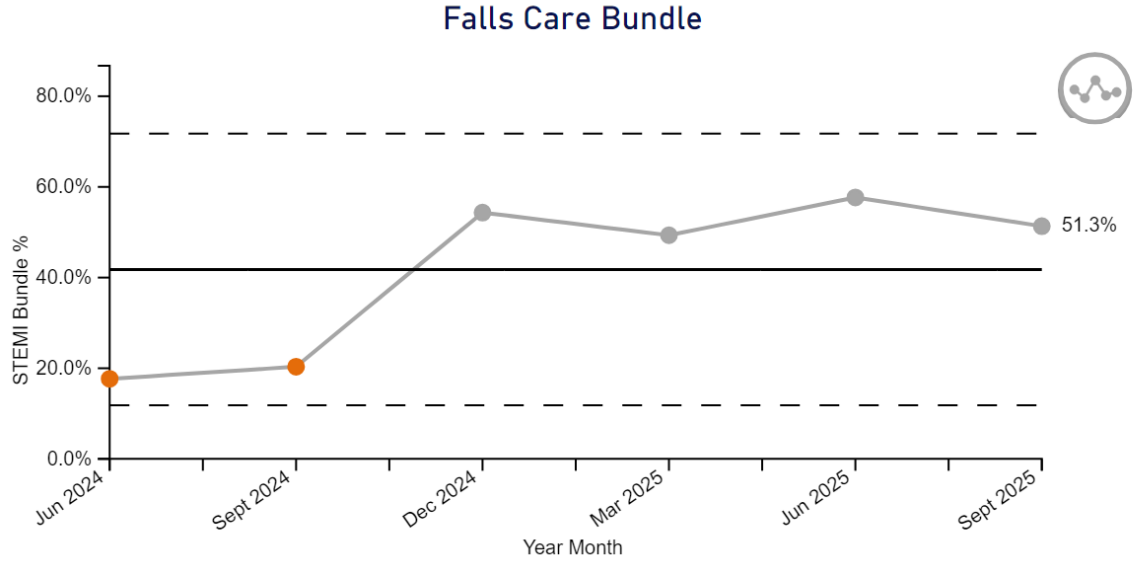


Survival at 30 Days Post Discharge - Utstein Performance



E2 Ambulance Clinical Quality Indicators (ACQI)



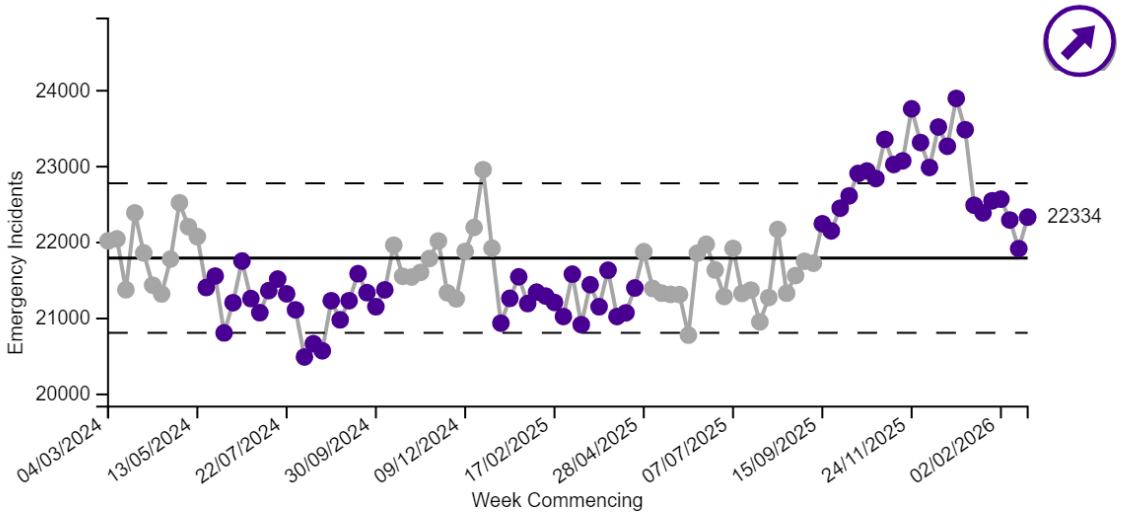


Summary:

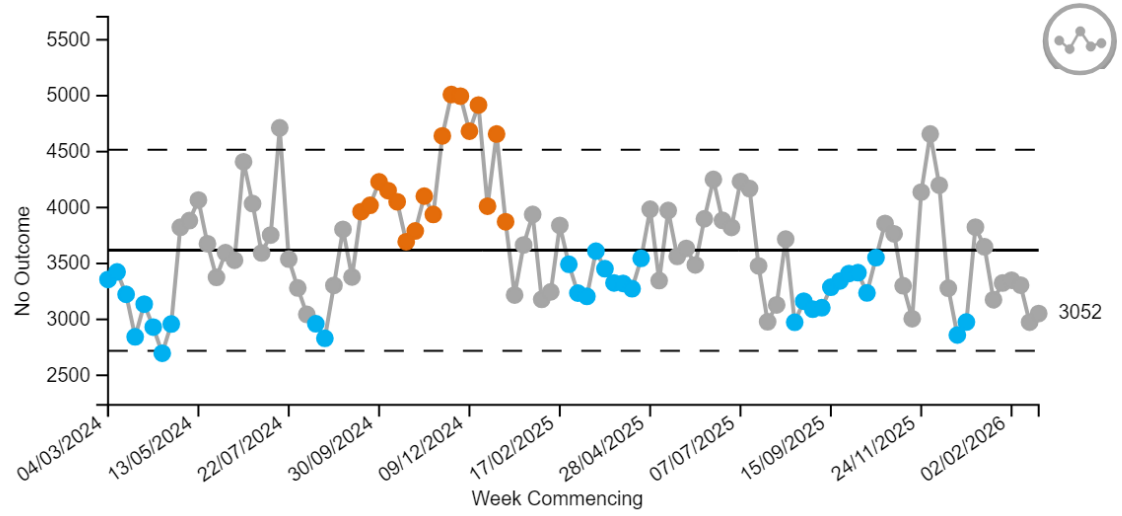
- ROSC overall performance - last reported in Oct 25 (28.8%), **below** the national average of 28.9%.
- ROSC Utstein performance - last reported in Oct 25 (45.7%), **below** the national average of 51.3%.
- Survival at 30 days after discharge overall performance – last reported in Oct 25 (10.6%), **above** the national average of 10.1%.
- Survival at 30 days after discharge Utstein performance – last reported in Oct 25 (28.7%), **above** the national average of 27.9%.
- STEMI bundle - last reported in Oct 25 (90.4%), **above** the national average of 82.6%.
- Falls bundle – last reported in Sep 25 (51.3%), **below** the national average of 53.4%.

E3 Activity & Outcomes

Emergency Incidents

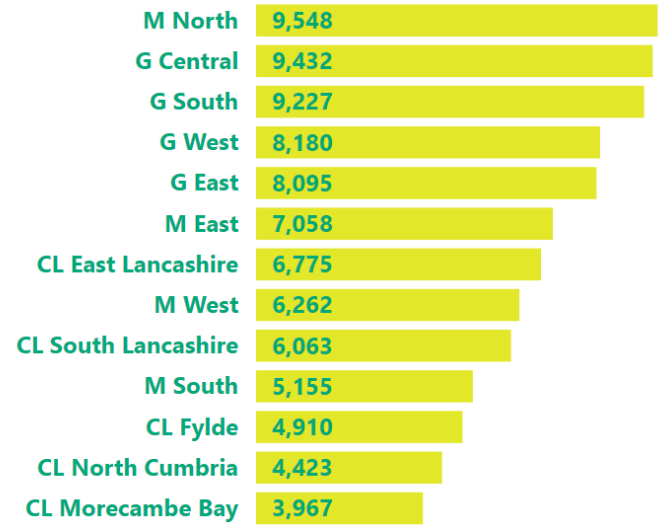


No Outcome Contacts

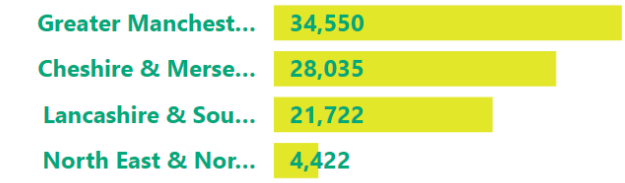


Emergency Incidents

Emergency Incidents by Operational Sector

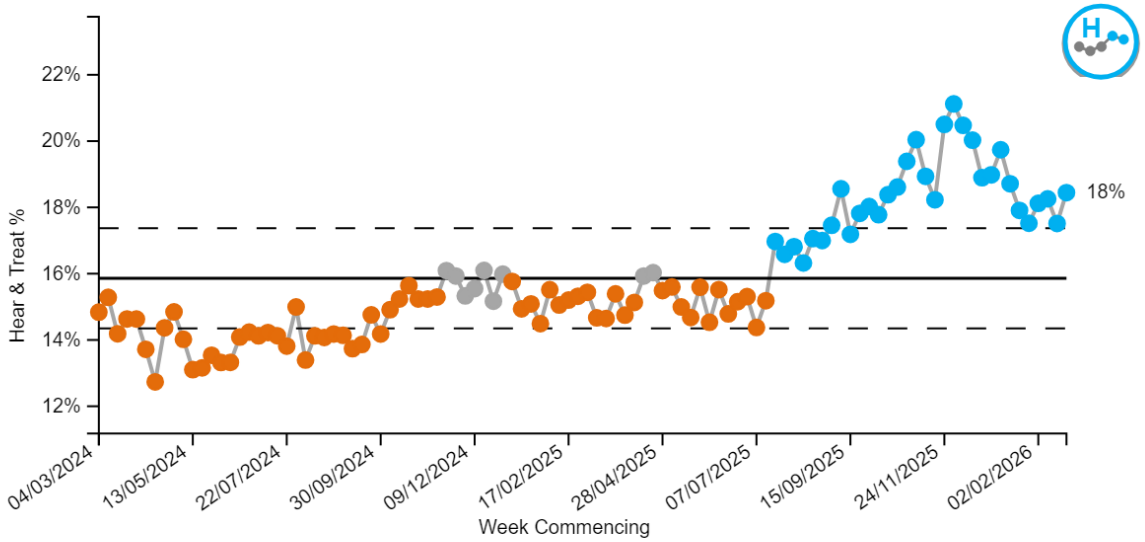


Emergency Incidents by ICB

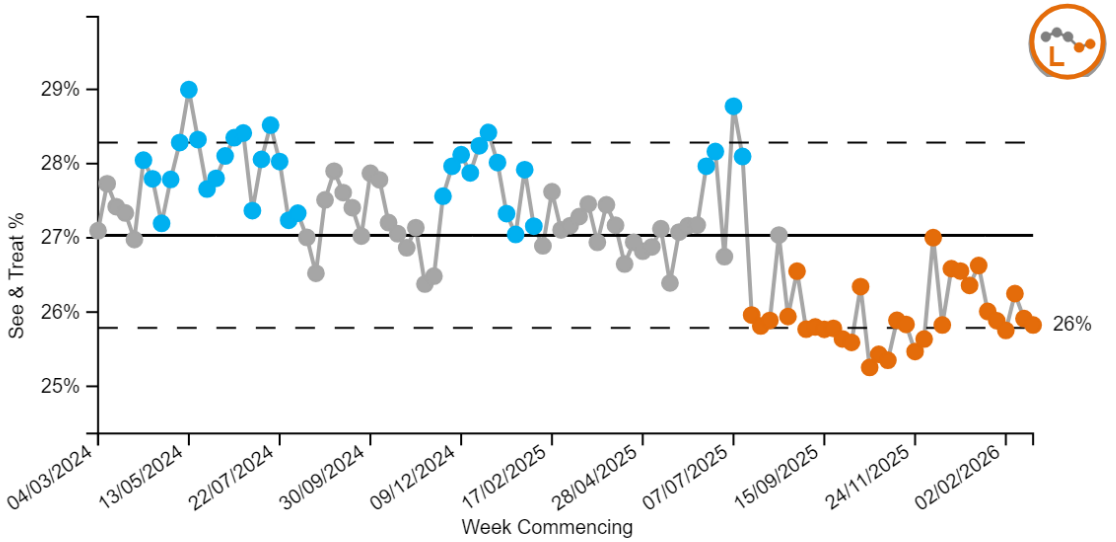


Calendar Year	Month	Calls	% Change from previous year	Incidents	% Change from previous year
2023	Feb	97,181	-12.24 %	79,935	-5.57 %
2024	Feb	116,879	20.27 %	90,442	13.14 %
2025	Feb	106,619	-8.78 %	85,031	-5.98 %
2026	Feb	107,630	0.95 %	89,172	4.87 %

Hear & Treat (AQI)



See & Treat (AQI)



Months Hear & Treat by Sector

G Central	21.5%
CL South Lancashire	20.5%
G West	18.6%
CL East Lancashire	18.5%
CL Fylde	18.4%
G East	17.8%
M West	17.6%
M East	17.5%
M South	17.1%
M North	17.0%
G South	16.4%
CL Morecambe Bay	15.3%
CL North Cumbria	14.0%

Months Hear & Treat by ICB

Greater Man...	18.6%
Lancashire ...	18.4%
Cheshire & ...	17.3%
North East ...	14.0%

Months See & Treat by Sector

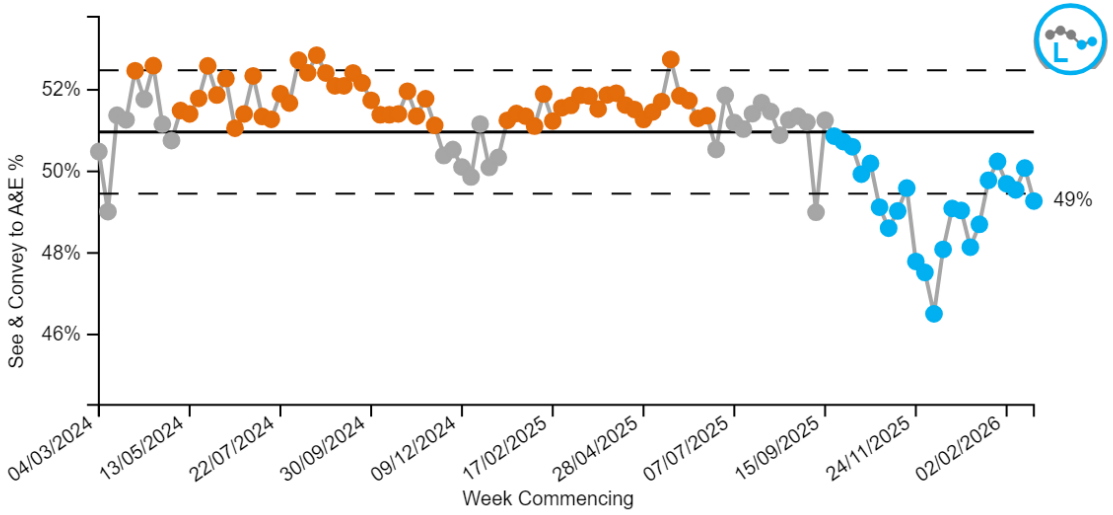
CL Morecambe Bay	30.5%
CL North Cumbria	29.9%
CL Fylde	28.3%
CL East Lancashire	28.0%
M South	27.0%
M West	26.8%
G East	26.0%
G West	25.2%
G Central	25.1%
G South	25.1%
M North	24.9%
CL South Lancashire	23.9%
M East	22.9%

Months See & Treat by ICB

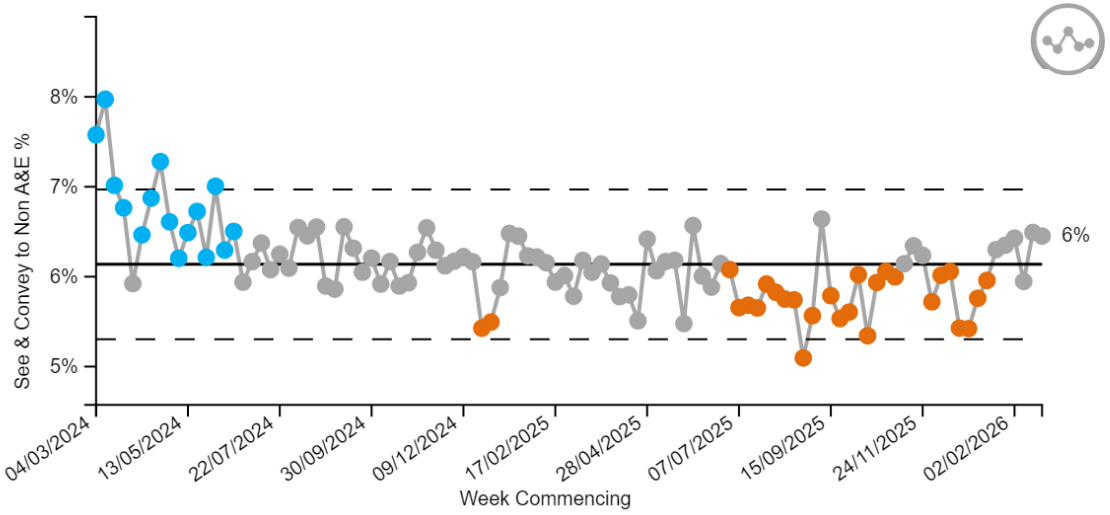
North East ...	29.9%
Lancashire ...	27.4%
Greater Man...	25.3%
Cheshire & ...	25.2%

BAF ID SR01

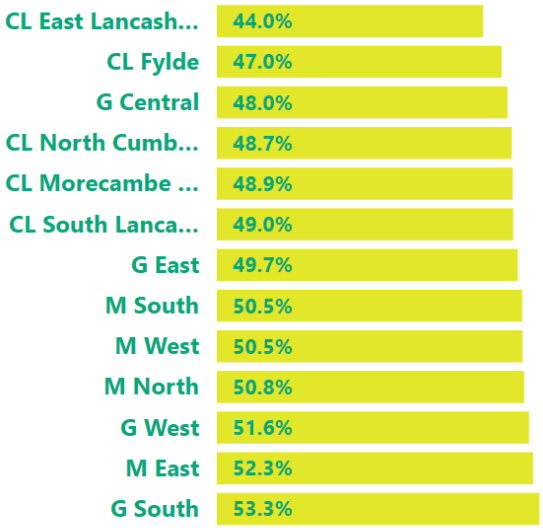
See & Convey to A&E (AQI)



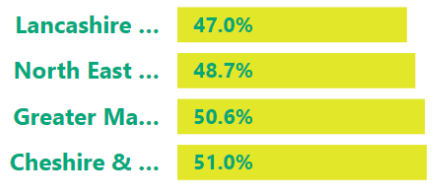
See & Convey to Non A&E (AQI)



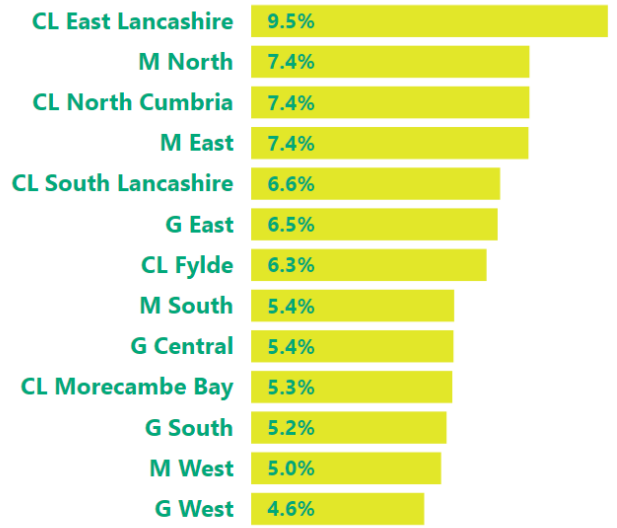
Months See & Convey (AE) by Sector



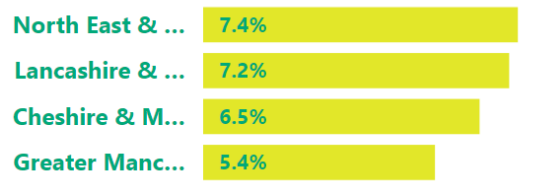
Months See & Convey (AE) by ICB



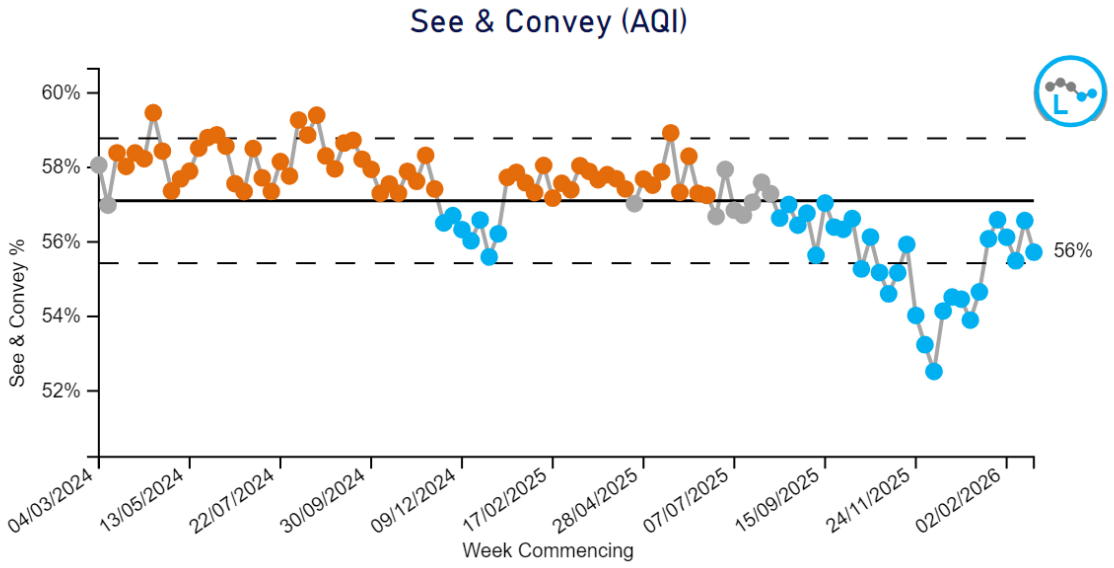
Months See & Convey (Non AE) by Sector



Months See & Convey (Non AE) by ICB



BAF ID SR01



Months See & Convey by Sector

CL Fylde	53.3%
G Central	53.4%
CL East Lancashire	53.5%
CL Morecambe Bay	54.2%
M West	55.6%
CL South Lancashire	55.6%
M South	55.8%
CL North Cumbria	56.1%
G West	56.2%
G East	56.3%
M North	58.2%
G South	58.5%
M East	59.6%

Months See & Convey by ICB

Lancashire & ...	54.2%
North East & ...	56.1%
Greater Manc...	56.1%
Cheshire & M...	57.5%

Activity & Outcomes

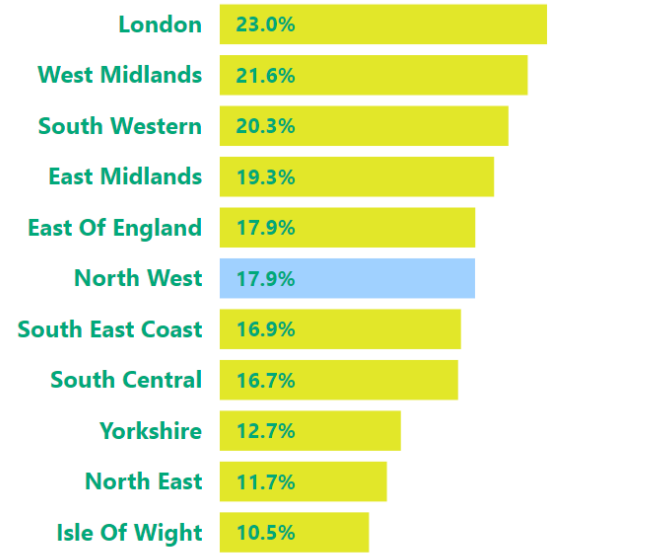
Summary: Of the 107,630 emergency calls received by the trust, 82.3% (89,172) became incidents. Emergency Incidents had continued to rise since September 25 until mid January 26.

The overall improvements in Hear & Treat are due to several factors, including better management of frequent callers, improved navigation processes, better use of external CAS providers and improved oversight and changes to reporting.

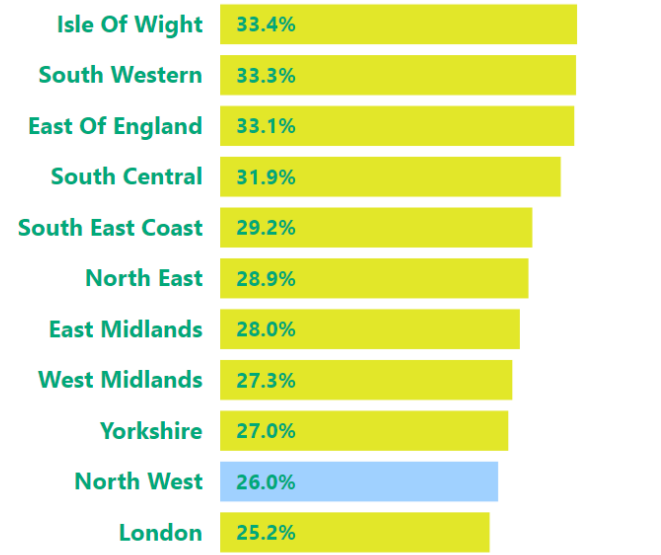
The H&T rate for February was 18% and S&T was 26%, equating to a non-conveyance rate of 44%. The Trust is currently ranked 6th for H&T (5th in Jan 26) and 10th for S&T.

Action:
Additional H&T productivity metrics are being monitored within the Trust's clinical delivery dashboard.

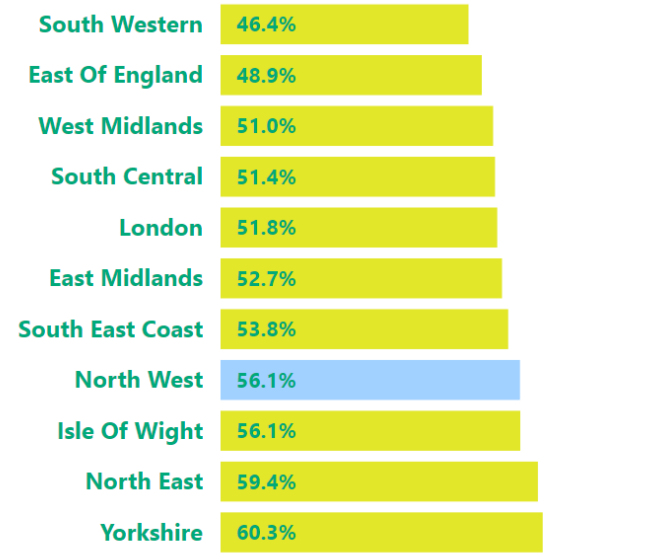
Hear & Treat % by Trust



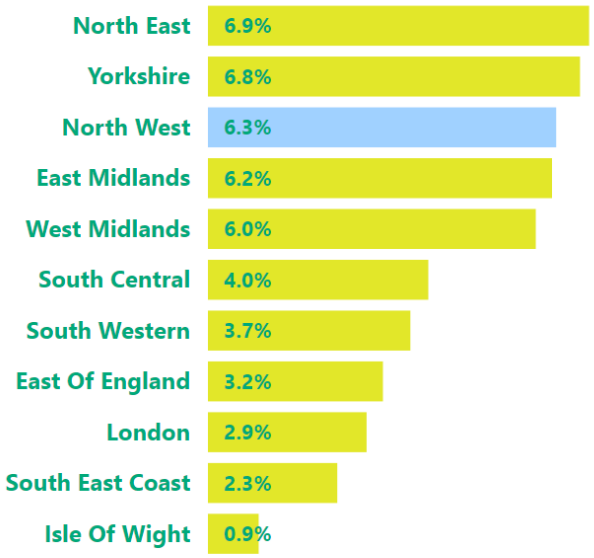
See & Treat % by Trust



See & Convey % by Trust



See & Convey non A&E % by Trust



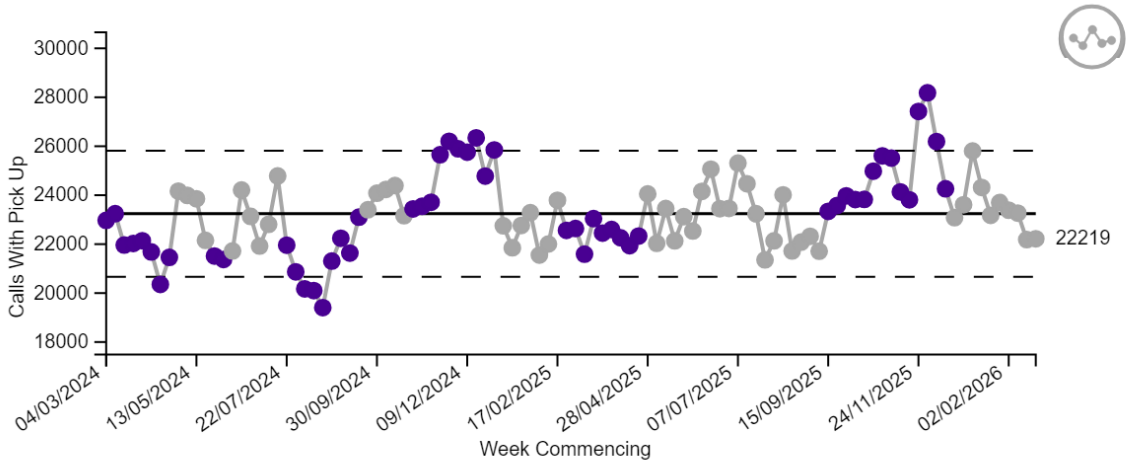
BAF ID SR01

Operational

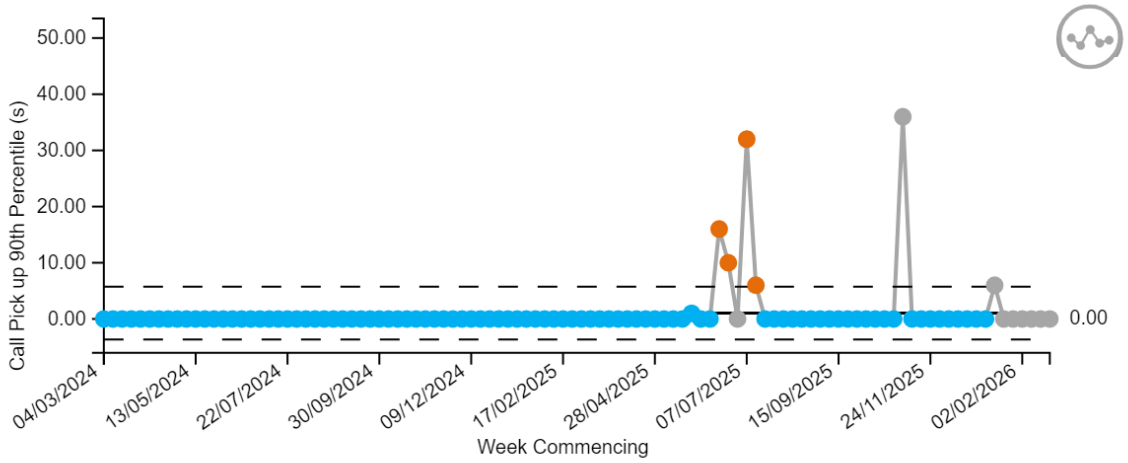
O1 Call Pick up
O3 ARP Response Times
O3 ARP Provider Comparison
O3 A&E Turnaround
O3 A&E Turnaround ICB
O4 111 Activity & Performance
O5 PTS Activity

O1 Call Pick Up

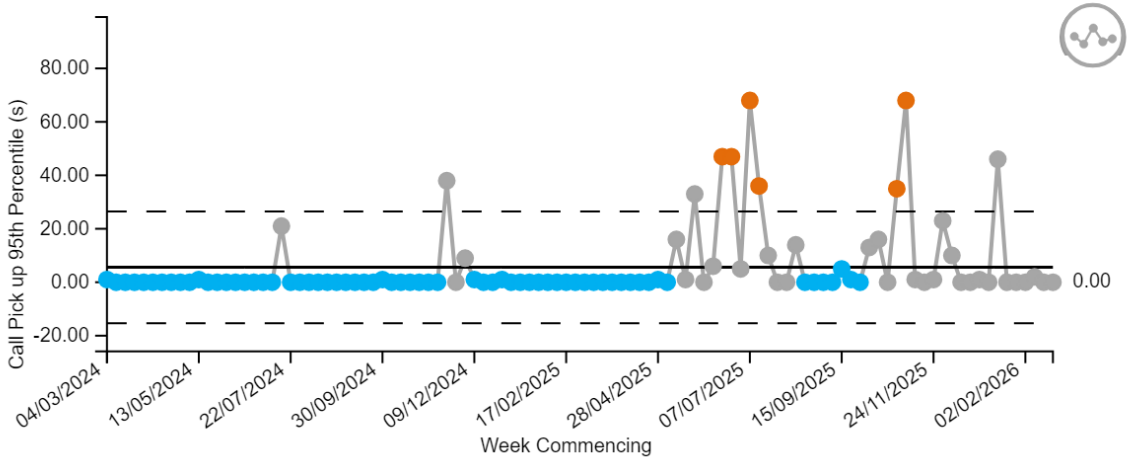
Calls With Pick up



Call Pick up 90th Percentile



Call Pick up 95th Percentile



Call Pick Up Mean	
Month	1
YTD	2
Ranking	4

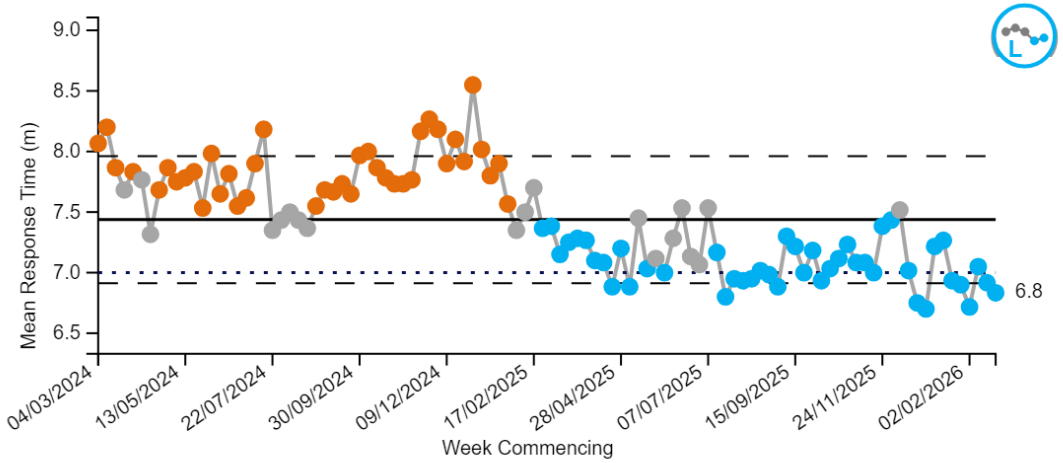
Call Pick up 90th Percentile	
Month	0
YTD	0
Ranking	3

Call Pick up 95th Percentile	
Month	0
YTD	5
Ranking	2

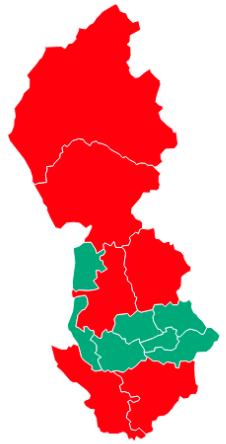
Call pick-up volume is stable and call handling performance has improved. The average pick-up time decreased from 2 seconds to 1 seconds, and the 95th percentile improved from 5 seconds to 0 seconds.

O3 ARP Response Times

ARP C1 Mean



C1 Mean (Red =>7min)



C1 Mean by Sector

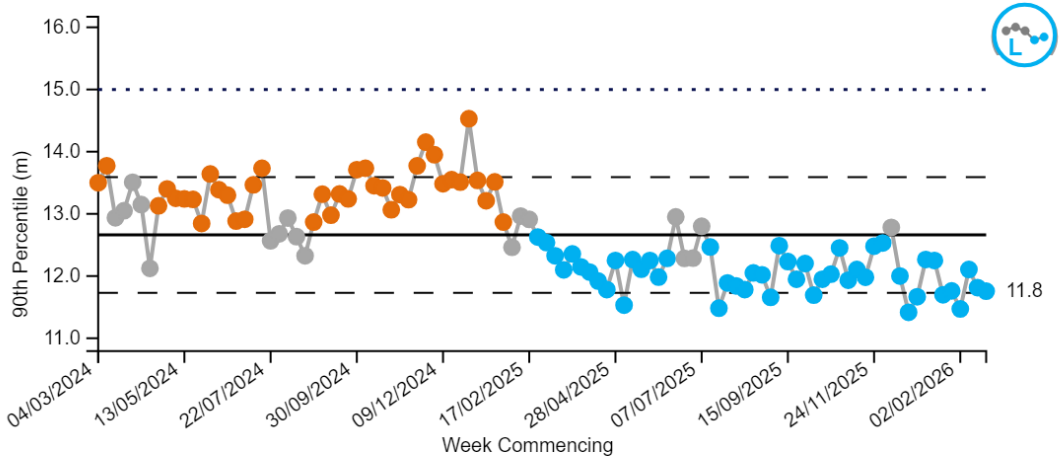
CL North Cumbria	00:08:45
CL Morecambe Bay	00:08:13
M South	00:08:13
M West	00:07:27
CL South Lancashire	00:07:18
CL East Lancashire	00:07:01
M East	00:06:53
G West	00:06:40
G East	00:06:38
CL Fylde	00:06:31
G Central	00:06:26
G South	00:06:19
M North	00:06:09

C1 Mean by ICB

North East & Nort...	00:08:45
Lancashire & Sout...	00:07:10
Cheshire & Mersey...	00:06:56
Greater Manchester	00:06:28

C1 Mean	
Target	00:07:00
Month	00:06:54
YTD	00:07:06
Ranking	3

ARP C1 90th



C1 90th (Red =>15min)

C1 90th by Sector

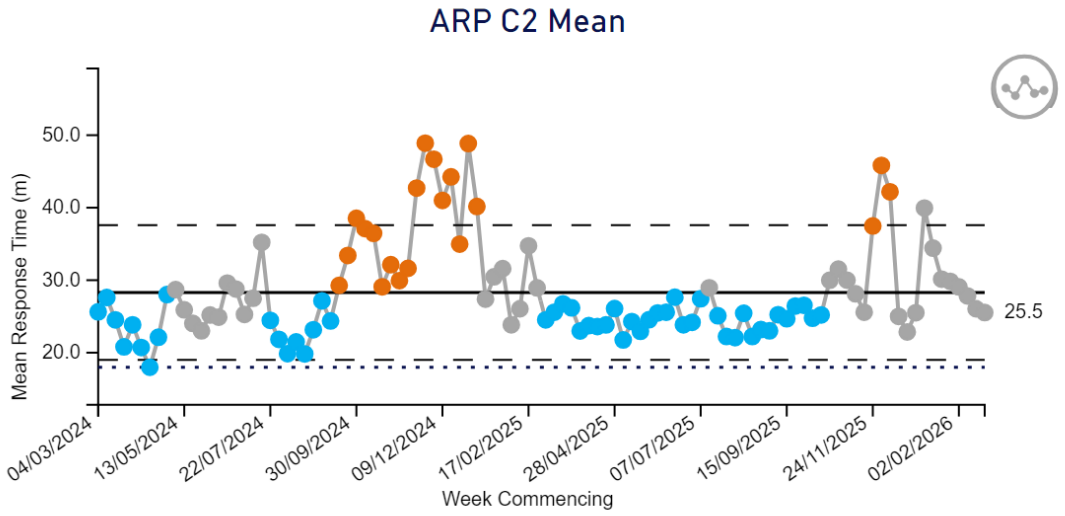
CL North Cumbria	00:16:36
CL Morecambe Bay	00:15:43
M South	00:14:08
M West	00:13:17
CL South Lancashire	00:12:56
CL East Lancashire	00:12:28
M East	00:11:45
CL Fylde	00:11:39
G East	00:10:48
G Central	00:10:44
G West	00:10:31
G South	00:10:20
M North	00:10:06

C1 90th by ICB

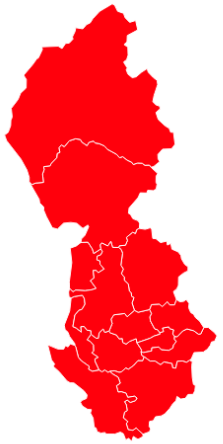
North East & N...	00:16:37
Lancashire & So...	00:12:53
Cheshire & Mer...	00:12:03
Greater Manche...	00:10:31

C1 90th	
Target	00:15:00
Month	00:11:48
YTD	00:12:05
Ranking	3

O3 ARP Response Times



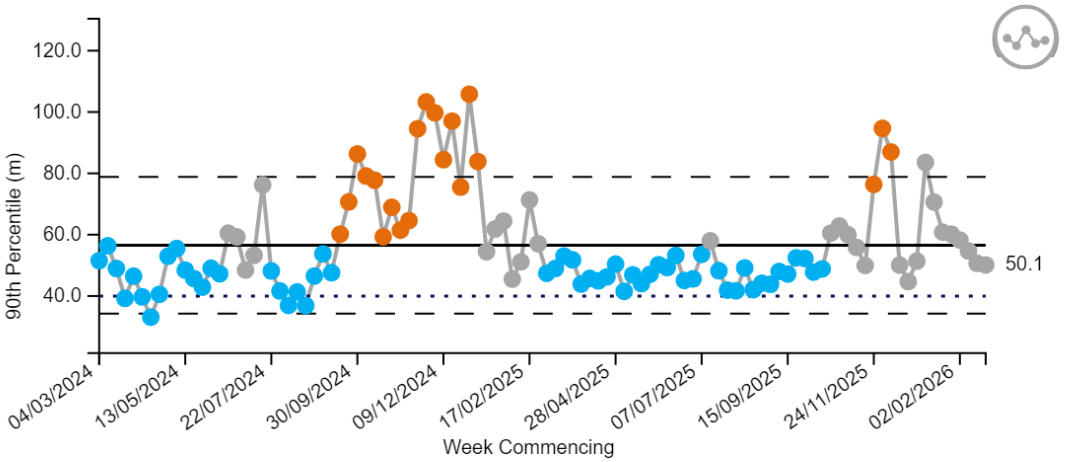
C2 Mean (Red => 18min)



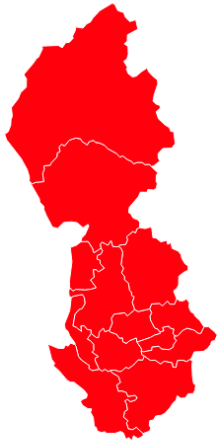
C2 Mean by Sector	
M West	00:33:44
CL Morecambe Bay	00:32:31
M North	00:31:40
M East	00:31:13
M South	00:30:05
CL North Cumbria	00:29:34
CL Fylde	00:27:51
CL South Lancashire	00:27:10
G West	00:25:43
G East	00:24:56
G Central	00:22:19
CL East Lancashire	00:22:04
G South	00:21:28

C2 Mean by ICB	
Cheshire & Mersey...	00:31:42
North East & Nort...	00:29:34
Lancashire & Sout...	00:26:43
Greater Manchester	00:23:26

C2 Mean	
Target (ARP)	00:18:00
Target (UEC)	00:28:00
Month	00:27:08
YTD	00:27:12
Ranking	6



C2 90th (Red => 40min)

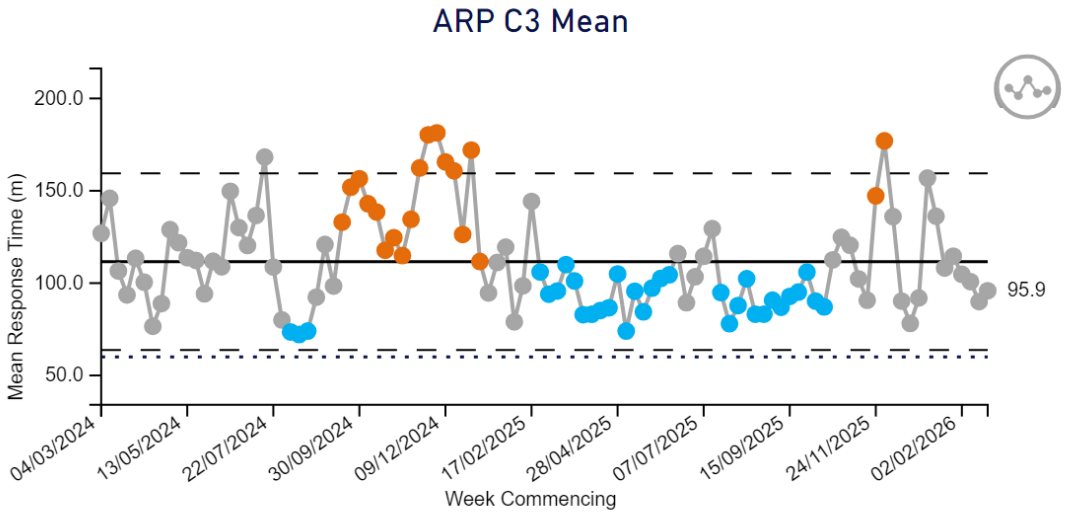


C2 90th by Sector	
CL Morecambe Bay	01:11:01
M West	01:06:50
M North	01:03:20
M East	01:00:54
CL Fylde	00:59:06
CL North Cumbria	00:59:04
M South	00:57:21
CL South Lancashire	00:51:30
G West	00:50:01
G East	00:47:43
G Central	00:44:17
CL East Lancashire	00:42:47
G South	00:42:02

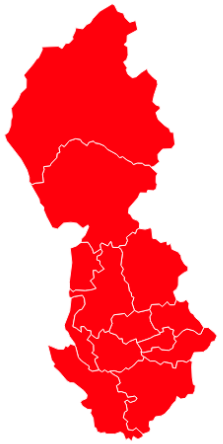
C2 90th by ICB	
Cheshire & Mersey...	01:02:28
North East & Nort...	00:59:04
Lancashire & Sout...	00:53:10
Greater Manchester	00:45:45

C2 90th	
Target	00:40:00
Month	00:53:32
YTD	00:54:04
Ranking	3

O3 ARP Response Times



C3 Mean (Red => 60min)



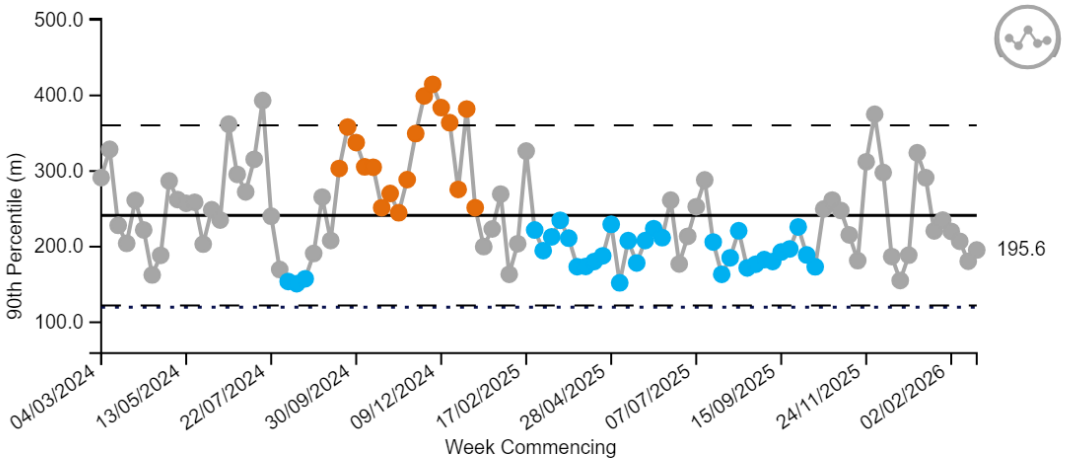
C3 Mean by Sector

M North	01:50:38
M East	01:48:41
G West	01:47:01
G East	01:46:38
M West	01:44:26
G Central	01:39:06
CL Fylde	01:34:19
CL South Lancashire	01:32:41
G South	01:31:14
M South	01:26:32
CL Morecambe Bay	01:26:07
CL East Lancashire	01:22:00
CL North Cumbria	01:18:09

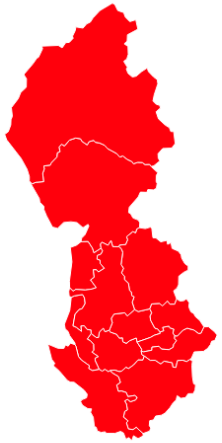
C3 Mean by ICB

Cheshire & Mersey...	01:43:44
Greater Manchester	01:40:55
Lancashire & Sout...	01:28:25
North East & Nort...	01:17:52

C3 Mean	
Target	00:60:00
Month	01:37:34
YTD	01:41:17
Ranking	6



C3 90th (Red => 2h)



C3 90th by Sector

M East	03:48:46
M North	03:47:26
M West	03:31:34
G West	03:26:46
G East	03:24:44
CL Fylde	03:24:08
CL Morecambe Bay	03:11:54
CL South Lancashire	03:11:37
G Central	03:11:12
M South	03:07:15
G South	03:02:30
CL East Lancashire	02:54:32
CL North Cumbria	02:30:53

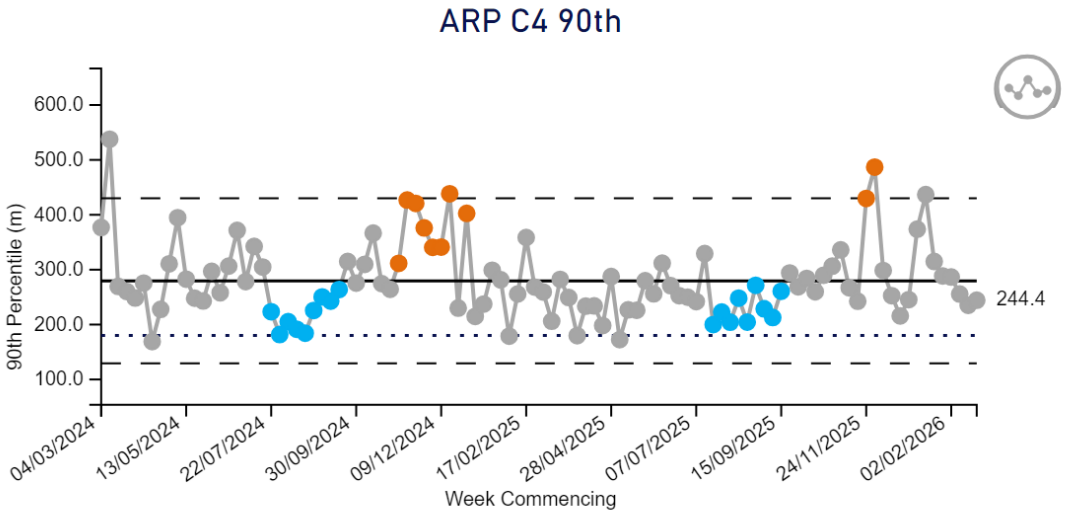
C3 90th by ICB

Cheshire & Mersey...	03:35:00
Greater Manchester	03:17:26
Lancashire & Sout...	03:08:46
North East & Nort...	02:30:00

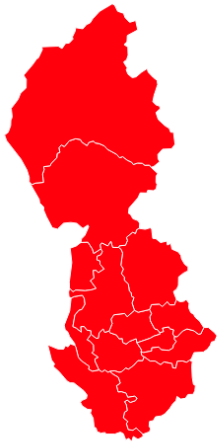
C3 90th	
Target	01:30:00
Month	03:20:15
YTD	03:34:27
Ranking	4

BAF ID SR03

O3 ARP Response Times



C4 90th (Red => 3h)



C4 90th by Sector

CL Fylde	04:53:51
G East	04:42:34
G West	04:42:25
M West	04:41:33
G South	04:39:26
G Central	04:31:11
CL South Lancashire	03:59:29
CL Morecambe Bay	03:53:18
M North	03:16:55
CL North Cumbria	03:16:36
M East	03:14:08
M South	03:08:55
CL East Lancashire	03:05:40

C4 90th by ICB

Greater Manchester	04:34:51
Lancashire & Sout...	03:57:28
Cheshire & Mersey...	03:39:38
North East & Nort...	03:16:36

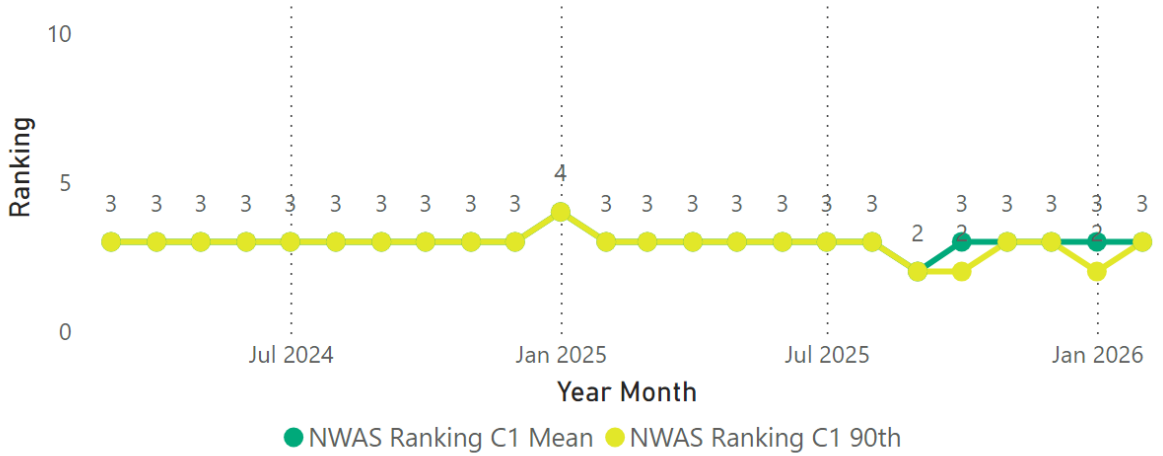
C4 90th	
Target	03:00:00
Month	04:10:44
YTD	04:18:40
Ranking	2

C1 mean response time remained strong this month, improving by 8 seconds to 06m:54s bringing performance within target for the first time since August 2025. The C1 90th percentile also improved, falling by 10 seconds to 11m:48s, 03m:12s below the ARP target. C1 activity levels were the lowest recorded since September 2025

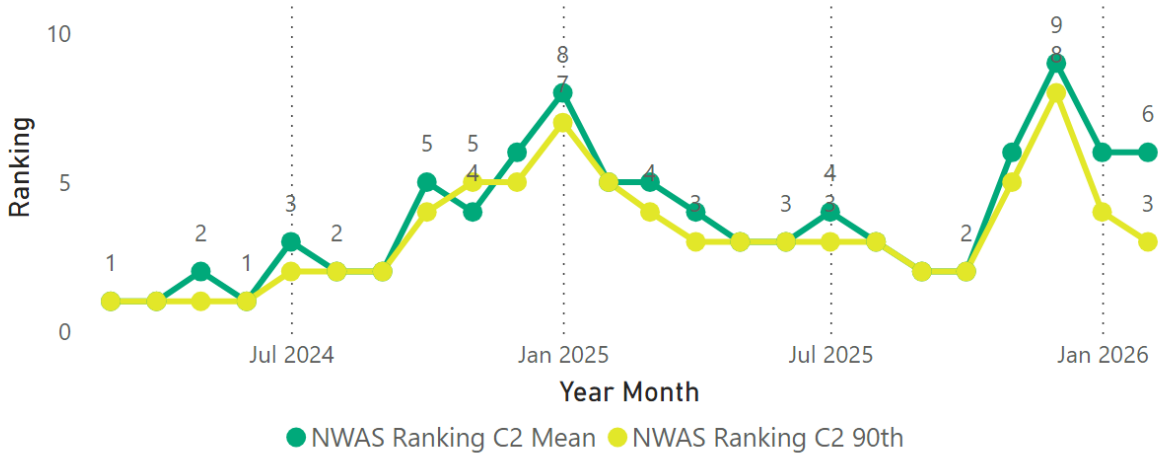
C2 mean response time improved week-on-week throughout February, resulting in an overall mean of 00h:27m:08s. Overall performance is now below the UEC target, although it continues to remain outside the ARP target. Both Cheshire and Merseyside and North East and North Cumbria ICB recorded improvements, with Cheshire and Merseyside showing a reduction of 10m:35s in its C2 mean response time. The C2 90th percentile also improved to 53m:32s, though it continues to exceed the 40-minute target.

O3 ARP Provider Comparison

C1 Mean & 90th Percentile ranking over time



C2 Mean & 90th Percentile ranking over time



C1 Mean by Trust

North East	00:06:13
London	00:06:49
North West	00:06:54
Yorkshire	00:07:48
West Midlands	00:07:53
South Central	00:08:10
South East Coast	00:08:19
East Of England	00:08:45
Isle Of Wight	00:08:54
East Midlands	00:08:55
South Western	00:08:59

C1 90th by Trust

North East	00:10:43
London	00:11:44
North West	00:11:48
Yorkshire	00:13:39
West Midlands	00:14:09
South Central	00:14:49
South East Coast	00:15:26
East Midlands	00:15:41
East Of England	00:16:26
South Western	00:16:36
Isle Of Wight	00:17:23

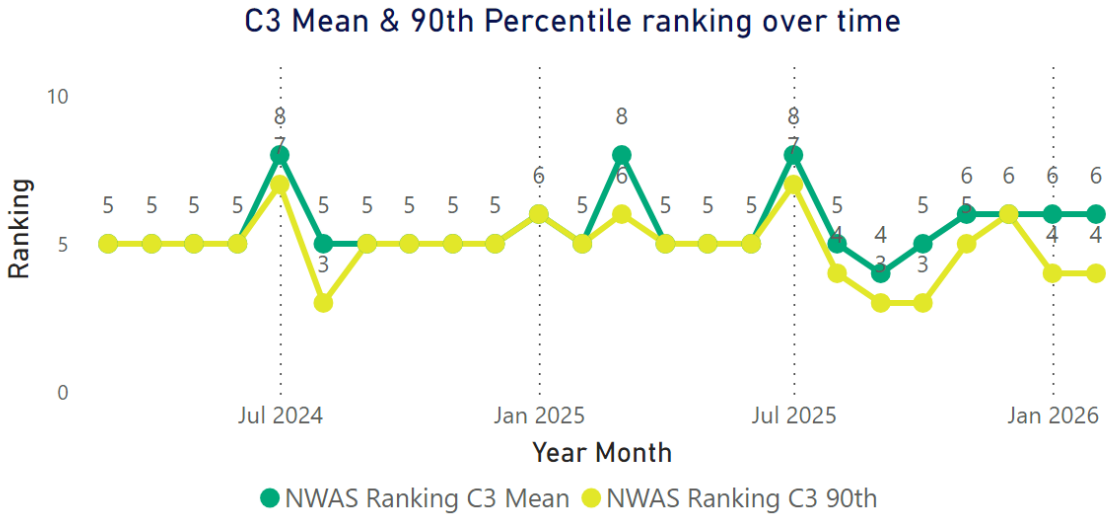
C2 Mean by Trust

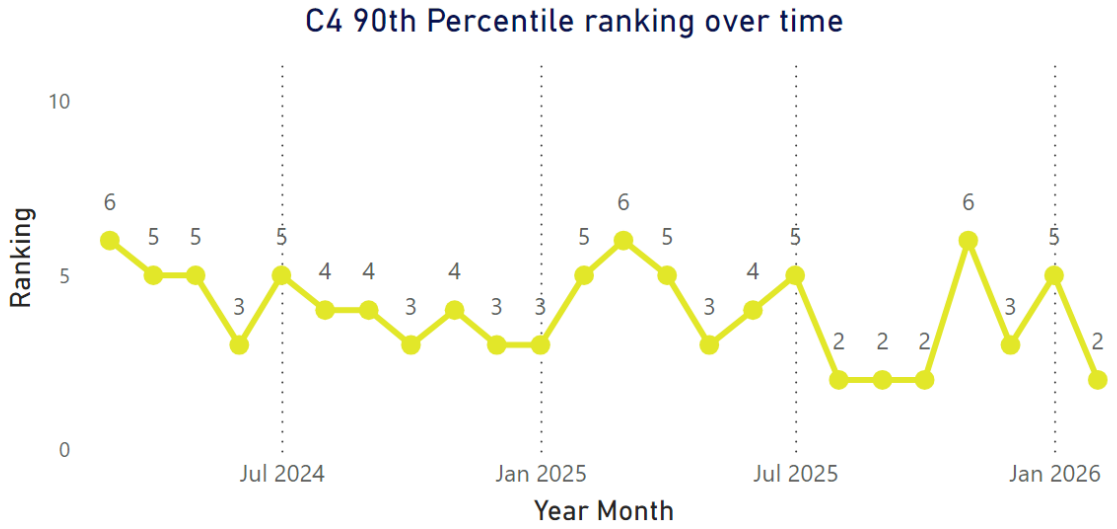
North East	00:20:41
West Midlands	00:20:42
Yorkshire	00:25:55
South East Coast	00:26:44
London	00:26:50
North West	00:27:09
South Central	00:29:05
Isle Of Wight	00:31:21
South Western	00:34:11
East Of England	00:37:11
East Midlands	00:37:23

C2 90th by Trust

North East	00:40:43
West Midlands	00:41:29
North West	00:53:32
Yorkshire	00:53:46
South East Coast	00:53:59
London	00:55:31
South Central	00:56:48
Isle Of Wight	01:09:28
South Western	01:10:15
East Of England	01:19:20
East Midlands	01:19:45

BAF ID SR03





C3 Mean by Trust

North East	00:51:58
London	01:18:43
Yorkshire	01:20:13
West Midlands	01:34:00
Isle Of Wight	01:35:56
North West	01:37:23
South Western	01:46:25
East Of England	01:59:19
South East Coast	02:00:16
South Central	02:26:28
East Midlands	02:28:07

C3 90th by Trust

North East	02:02:44
London	03:05:52
Yorkshire	03:05:54
North West	03:19:41
Isle Of Wight	03:35:18
West Midlands	03:56:12
South Western	03:59:06
South East Coast	04:29:46
East Of England	04:43:15
South Central	05:01:43
East Midlands	05:37:56

C4 90th by Trust

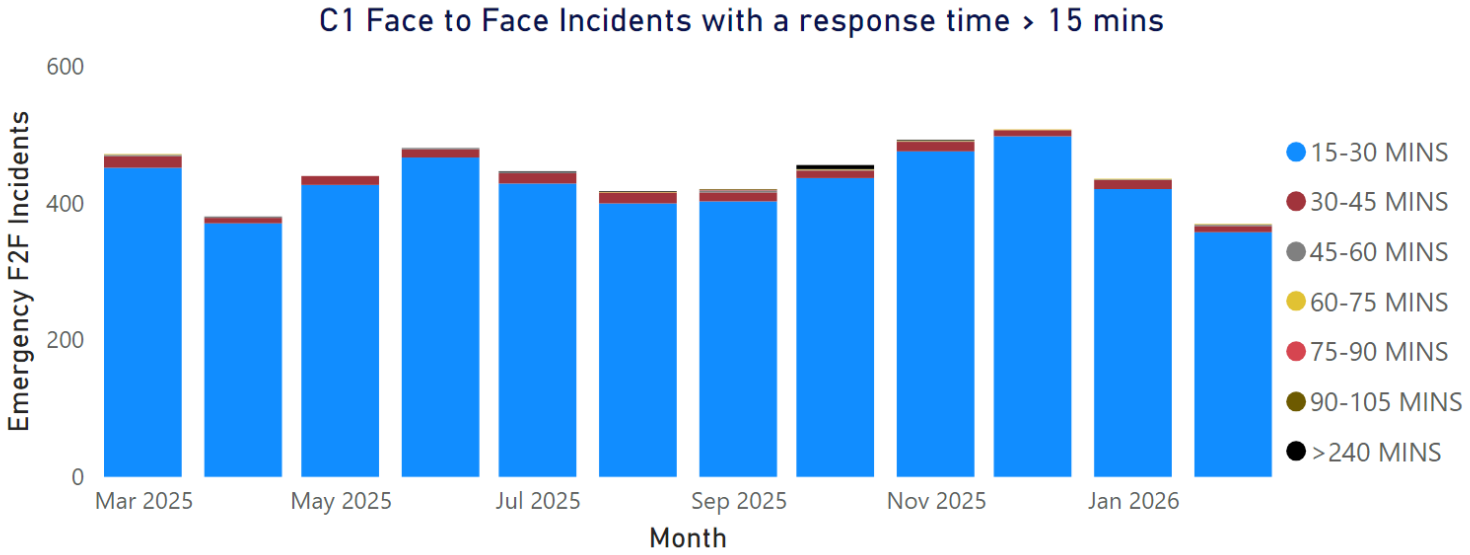
North East	02:57:48
North West	04:08:26
Yorkshire	04:15:40
London	04:34:13
West Midlands	05:23:11
East Of England	05:25:14
South East Coast	05:44:45
South Western	06:27:47
South Central	06:39:16
Isle Of Wight	07:48:27
East Midlands	11:08:13

Summary:
The Trust has maintained strong national performance for C1 mean and C1 90th percentile holding its position at third nationally.

C2 performance nationally has improved in February. The Trust is now ranked 6th for C2 Mean and 3rd for C2 90th, representing an improvement in national ranking compared to previous months.

For lower acuity categories, C3 mean remaining 6th nationally while the 90th percentile position has improved to 4th. C4 90th percentile performance is now ranked 2nd nationally.

O3 Long Waits C1



Month Year	Total No. of C1 Long Waits
Mar 2025	471
Apr 2025	380
May 2025	439
Jun 2025	480
Jul 2025	446
Aug 2025	417
Sep 2025	420
Oct 2025	455
Nov 2025	492
Dec 2025	507
Jan 2026	435
Feb 2026	369

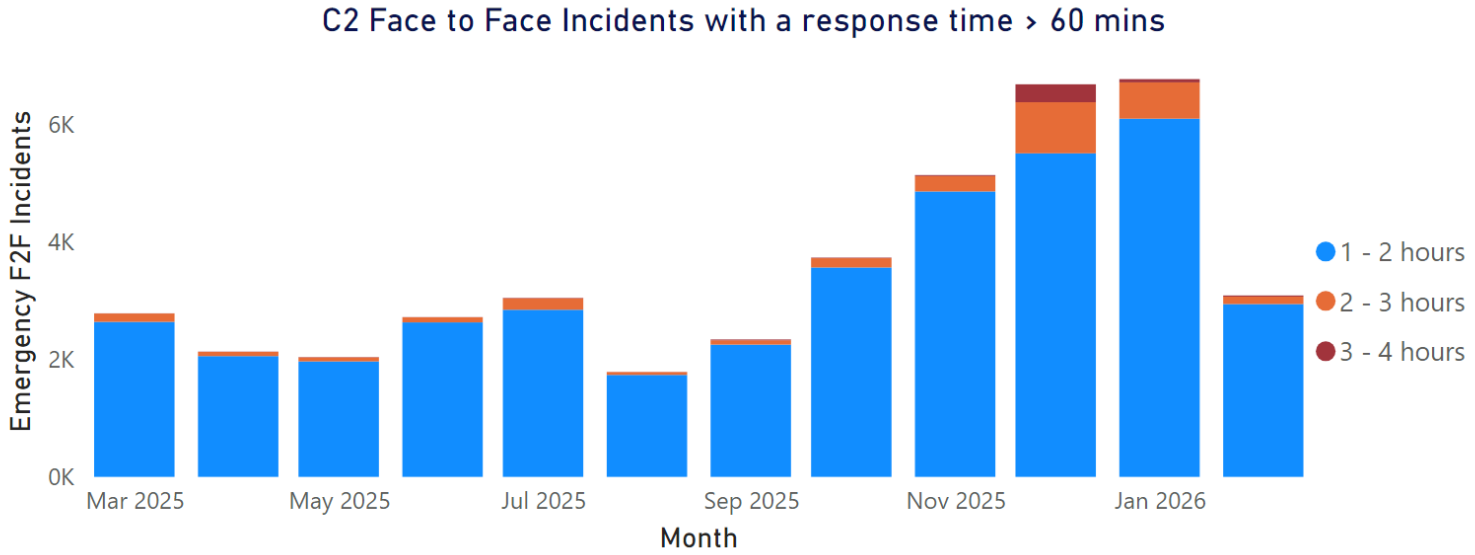
Summary:

In February 2026, the number of C1 long-wait incidents decreased to 369. C1 long waits are lower than February 2025, which reported 465, representing a 21% decrease for the same period last year.

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
Mar 2025	2,784
Apr 2025	2,132
May 2025	2,040
Jun 2025	2,719
Jul 2025	3,047
Aug 2025	1,787
Sep 2025	2,339
Oct 2025	3,732
Nov 2025	5,138
Dec 2025	6,683
Jan 2026	6,771
Feb 2026	3,088

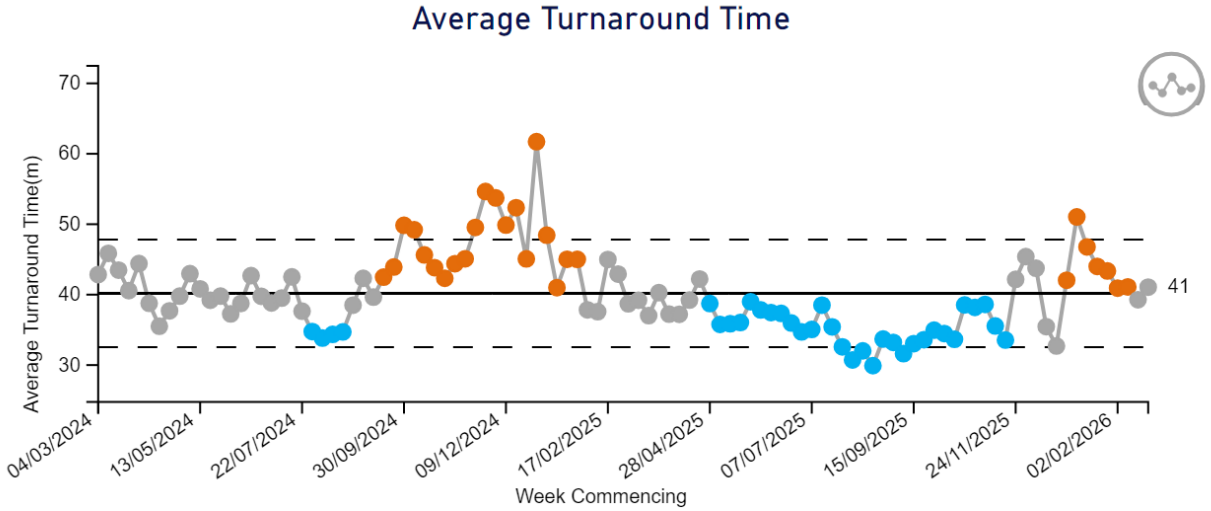
Summary:

In February 2026, the total number of C2 long-wait incidents was 3,088, representing a decrease of 3,683 compared to the previous month. February 2026 represents a substantial improvement compared with the November to January period, bringing levels back close to mid-2025 performance.

Action:

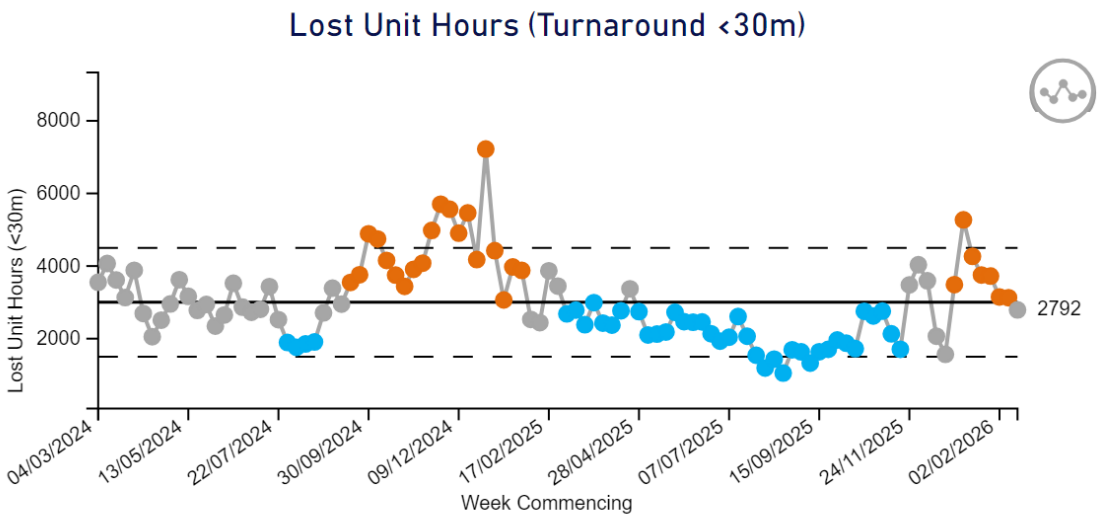
Continued monitoring by the Service Delivery Operational Performance Group.

O3 A&E Turnaround



Month	Hospital Attendances	Average Turnaround Time(hh:mm:ss)	Average Arrival to Handover Time (hh:mm:ss)	Average Handover to Clear Time(hh:mm:ss)
Feb 2025	44,053	00:41:13	00:32:07	00:09:05
Mar 2025	48,911	00:38:36	00:29:39	00:09:07
Apr 2025	47,340	00:39:13	00:30:13	00:09:09
May 2025	49,476	00:36:25	00:27:13	00:09:17
Jun 2025	47,627	00:37:04	00:27:49	00:09:25
Jul 2025	48,826	00:35:33	00:26:14	00:09:24
Aug 2025	49,030	00:30:59	00:21:47	00:09:15
Sep 2025	47,965	00:32:55	00:23:43	00:09:17
Oct 2025	50,740	00:35:41	00:26:22	00:09:22
Nov 2025	48,975	00:37:19	00:27:57	00:09:27
Dec 2025	49,755	00:39:38	00:30:21	00:09:18
Jan 2026	50,184	00:46:41	00:37:37	00:09:02
Feb 2026	44,653	00:40:52	00:31:43	00:09:10

O3 A&E Turnaround



Month	No of patients wating outside ED for handover
Feb 2025	1199
Mar 2025	1417
Apr 2025	1686
May 2025	1042
Jun 2025	1054
Jul 2025	1150
Aug 2025	687
Sep 2025	992
Oct 2025	1442
Nov 2025	1691
Dec 2025	2221
Jan 2026	3592
Feb 2026	2303

Summary:
Hospital attendances fell in February to 44,653, the lowest level since August 2025 on a days-adjusted basis.

Compared with last month, average turnaround time decreased by 05m:49s to 40m:52s, and arrival-to-handover reduced by 05m:54s to 31m:43s. In contrast, handover-to-clear increased slightly by 8 seconds to 09m:10s. Lancashire and South Cumbria ICB's turnaround time continues to display special cause variation.

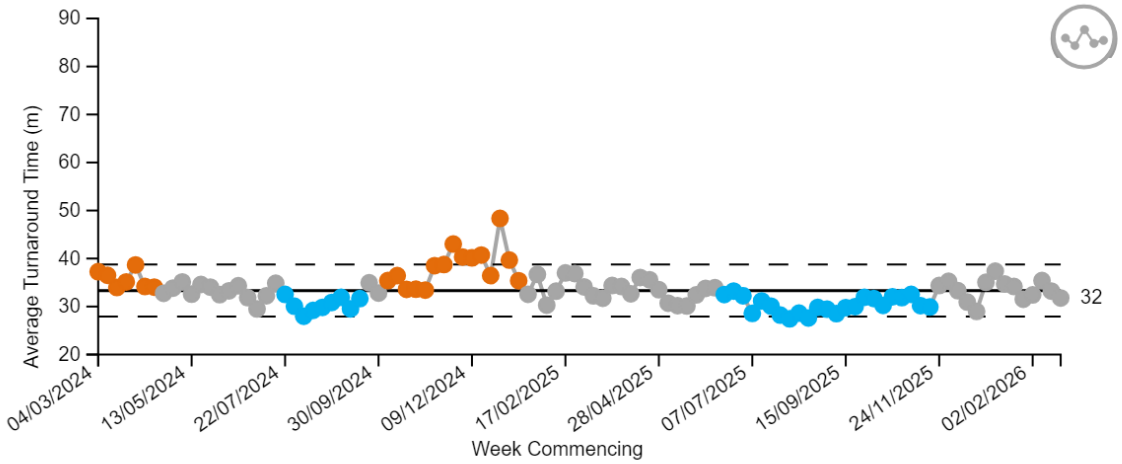
Whiston recorded a substantial improvement in lost unit hours, reducing from 2,381 last month to 1,224, despite only a marginal decrease in hospital attendances from 2,299.

Top 5 Trusts with most lost unit hours

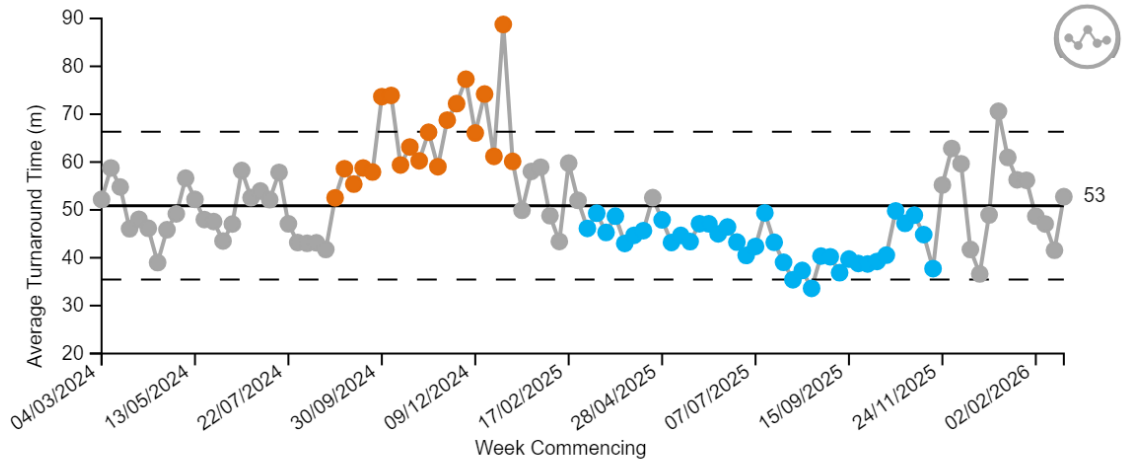
Destination Short Name	Hospital Attendances to AE	Lost Time Turnaround >30m (h)	Mean at Hospital to Clear Time(hh:mm:ss)	Mean at Hospital to Handover Time(hh:mm:ss)	Mean Handover to Clear Time(hh:mm:ss)
Royal Liverpool University	2,138	1316.07	01:02:48	00:53:24	00:09:57
Whiston	2,103	1224.37	00:59:38	00:49:46	00:10:11
Blackpool Victoria	2,292	1122.02	00:52:24	00:43:06	00:09:25
Royal Oldham	1,670	801.85	00:53:18	00:44:15	00:08:57
Royal Lancaster Infirmary	1,327	788.38	01:00:36	00:51:44	00:08:57

O3 A&E Turnaround by ICB

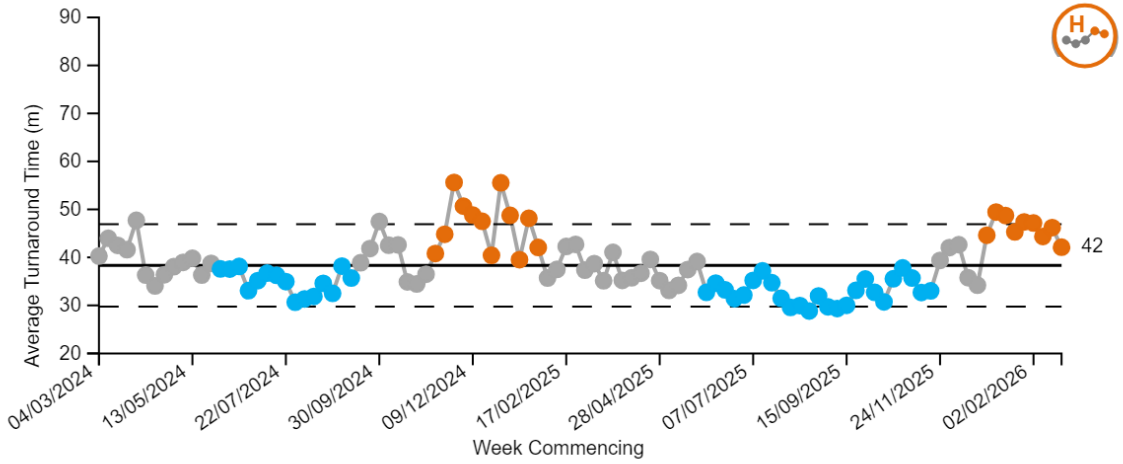
Average Turnaround Time - Greater Manchester ICB



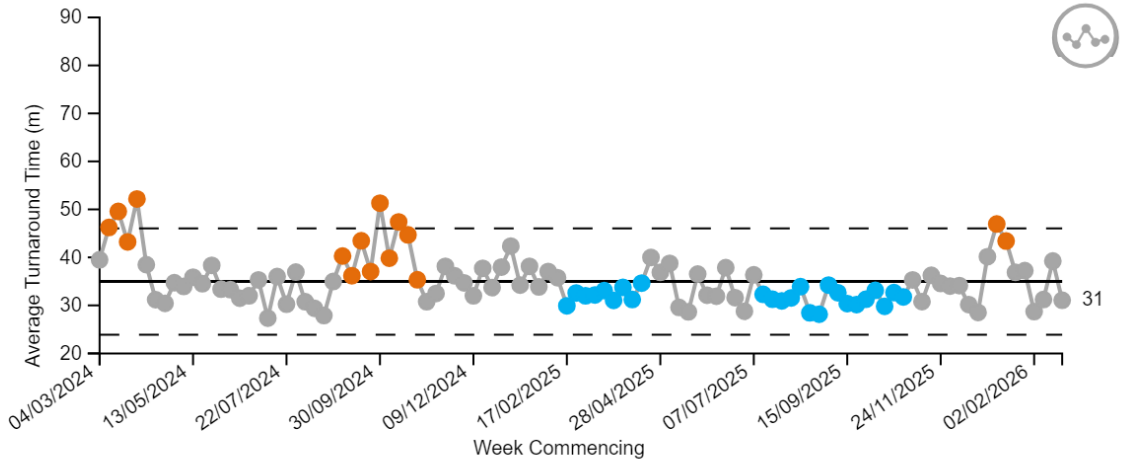
Average Turnaround Time - Cheshire & Mersey ICB



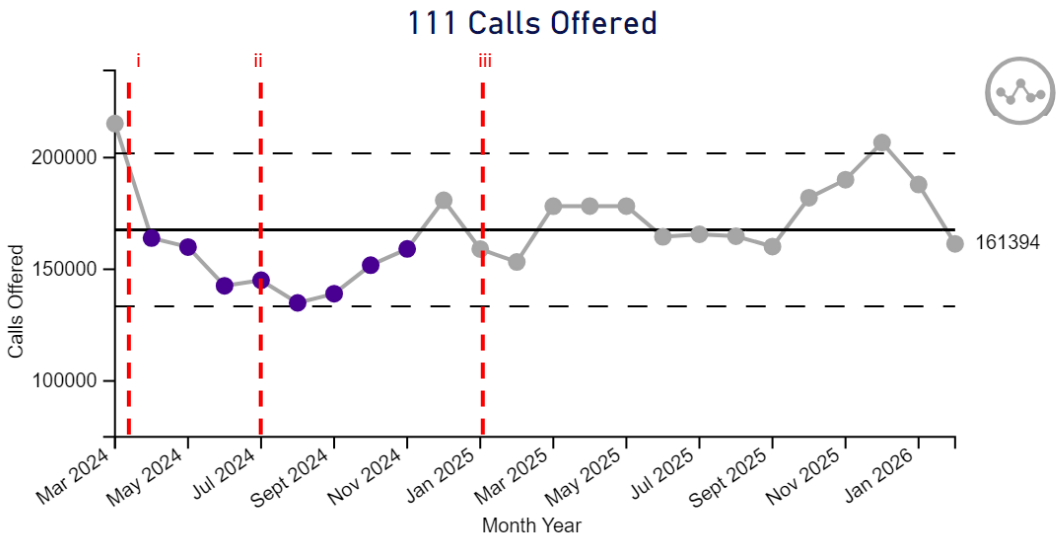
Average Turnaround Time - Lancashire & South Cumbria ICB

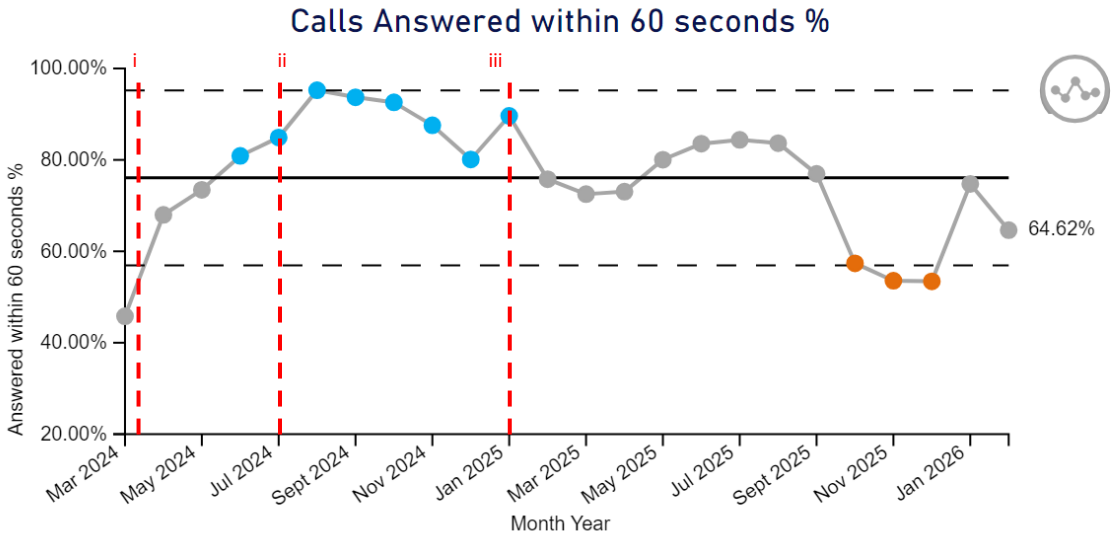


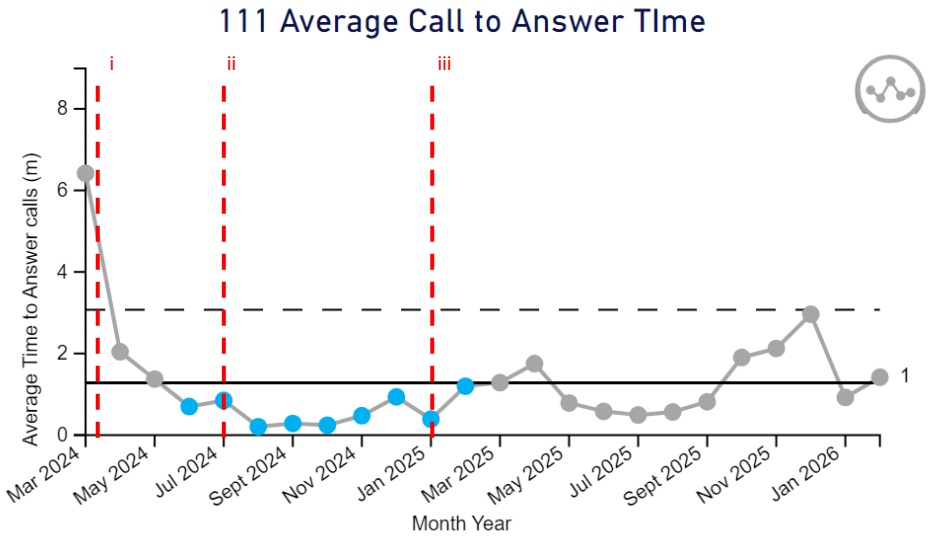
Average Turnaround Time - North East & North Cumbria ICB



04 111 Activity & Performance







Calls Offered	
Month	161.39K
YTD	1,939,958

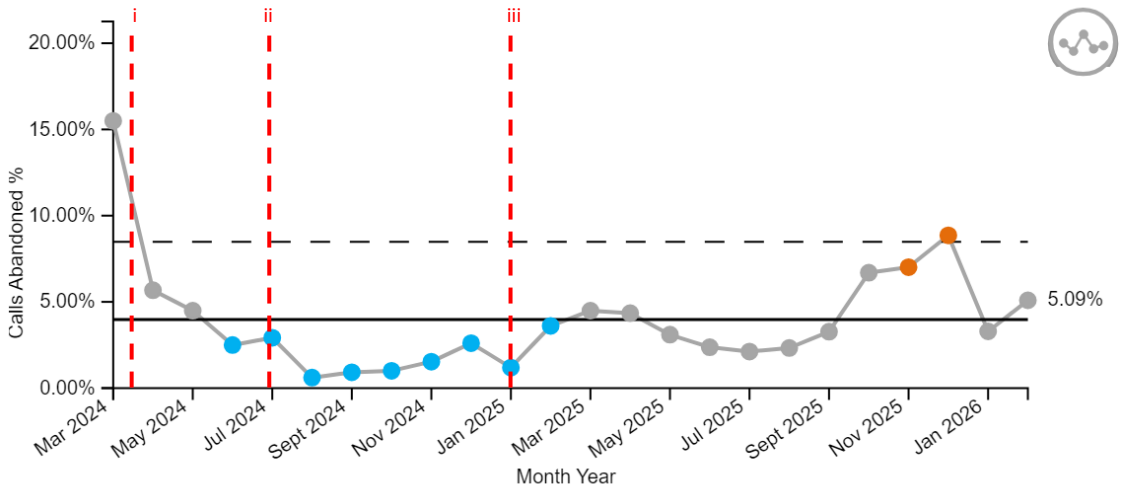
Calls Answered within 60 Seconds %	
Target	95%
Month	64.62%
YTD	71.0%
National	80.1%
Ranking	25

Average Call to Answer Time (s)	
Target	<20
Month	85
YTD	80
National	66
Ranking	23

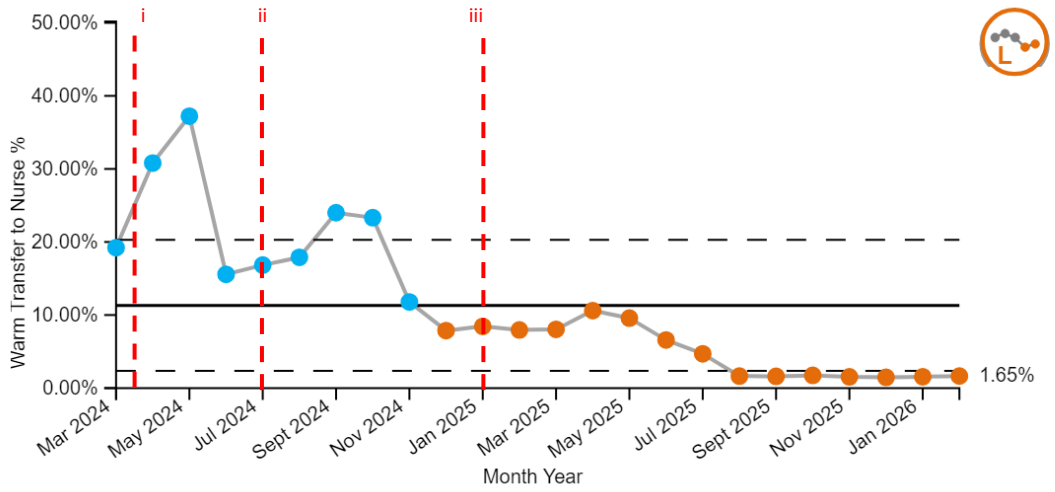
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency
Iv 14th July Clinicians stopped taking front end calls

BAF ID SR03

111 Calls Abandoned %



Warm Transfer to Nurse When Required %

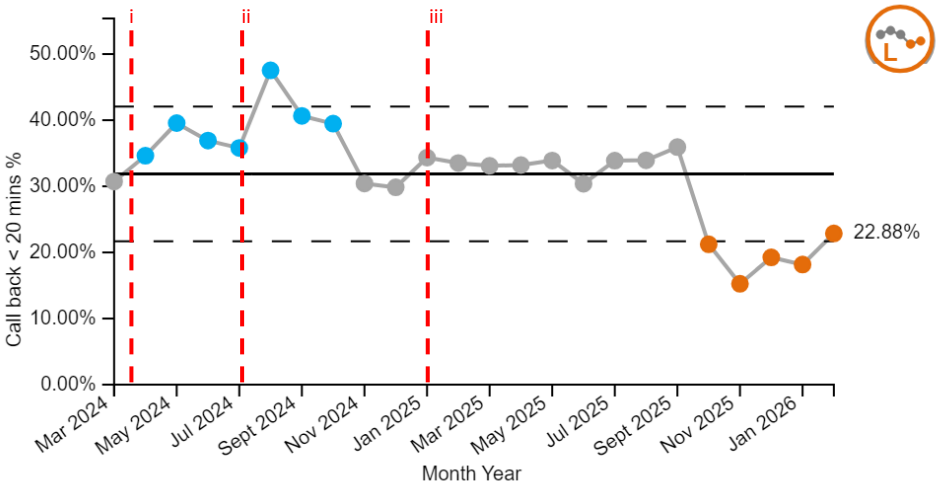


Calls Abandoned %	
Target	<5%
Month	5.09%
YTD	4.53%
National	3.8%
Ranking	23

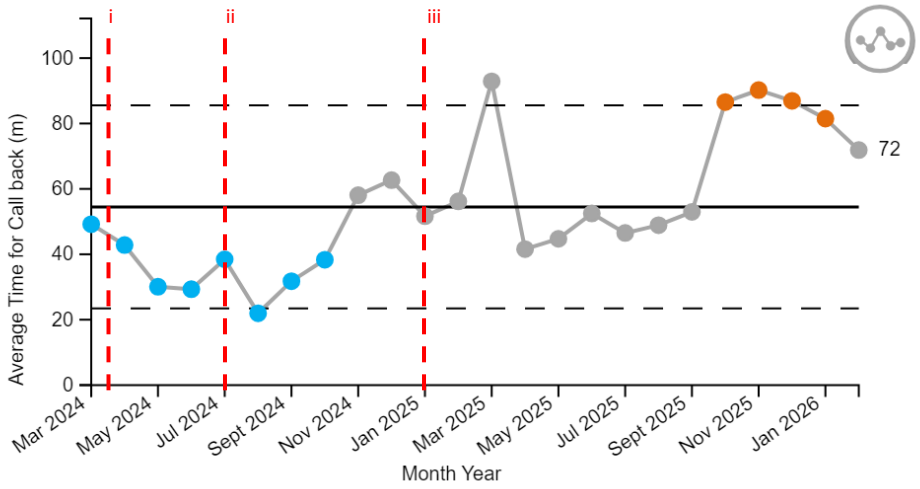
Warm Transfer %	
Target	75%
Month	1.65%
YTD	4.03%

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

111 Call back <20 Minutes %



111 Average Time for Call Back



Call Back <20 (m)	
Target	90%
Month	22.88%
YTD	27.44%

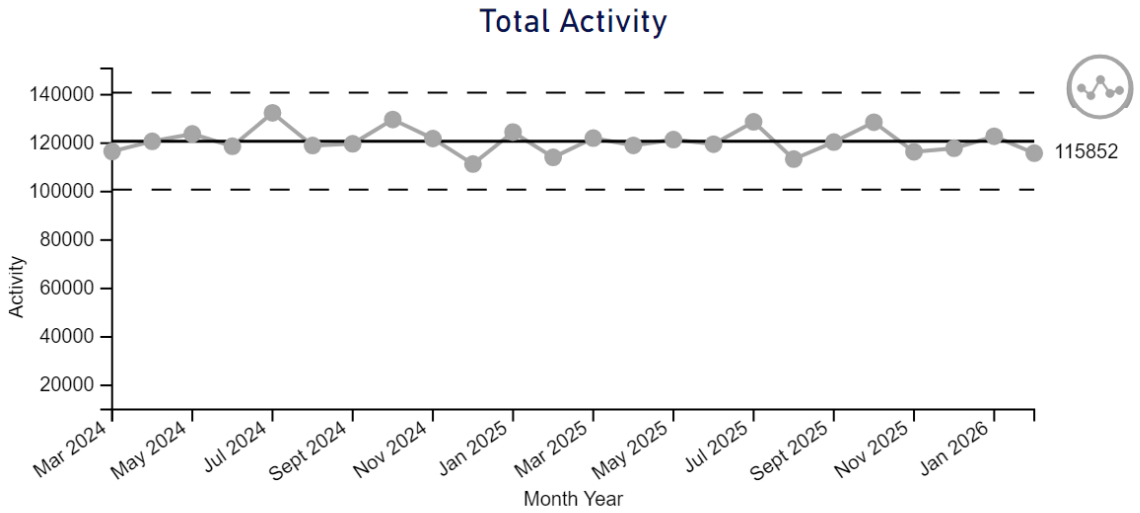
Demand for 111 has decreased for the second consecutive month to 161,394 calls. This will partly be driven by the lower number of days in February .

Call answering performance within 60 seconds slightly decreased to 64.62% but still stable, with a corresponding abandonment rate of 5.09%.

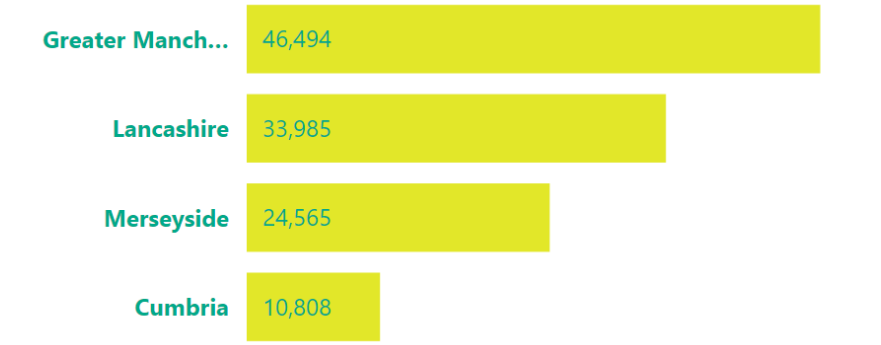
Call back in 20 has increased to 22.88% and average call back remained stable 72 seconds.

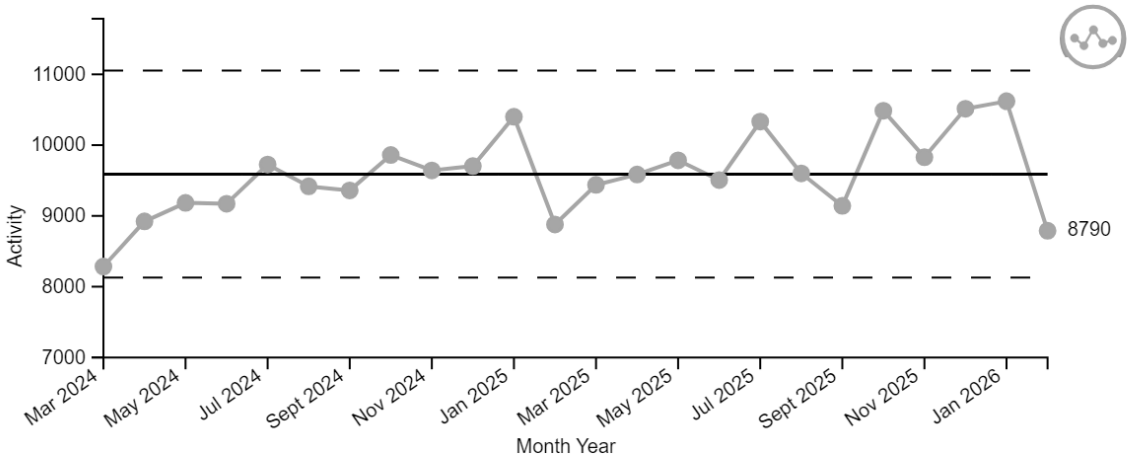
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency
Iv 14th July Clinicians stopped taking front end calls

05 PTS Activity

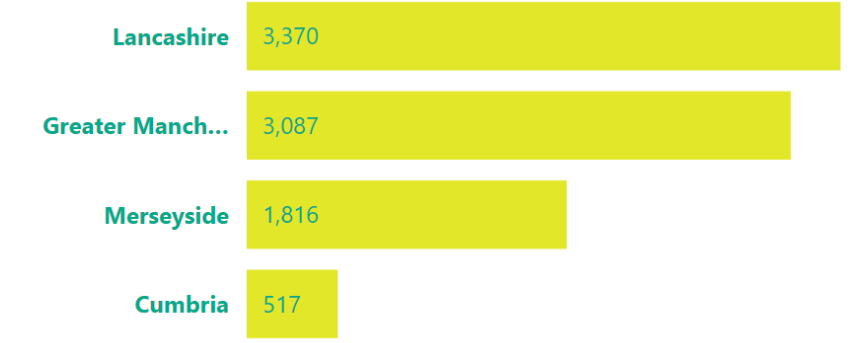


Total Activity by Contract

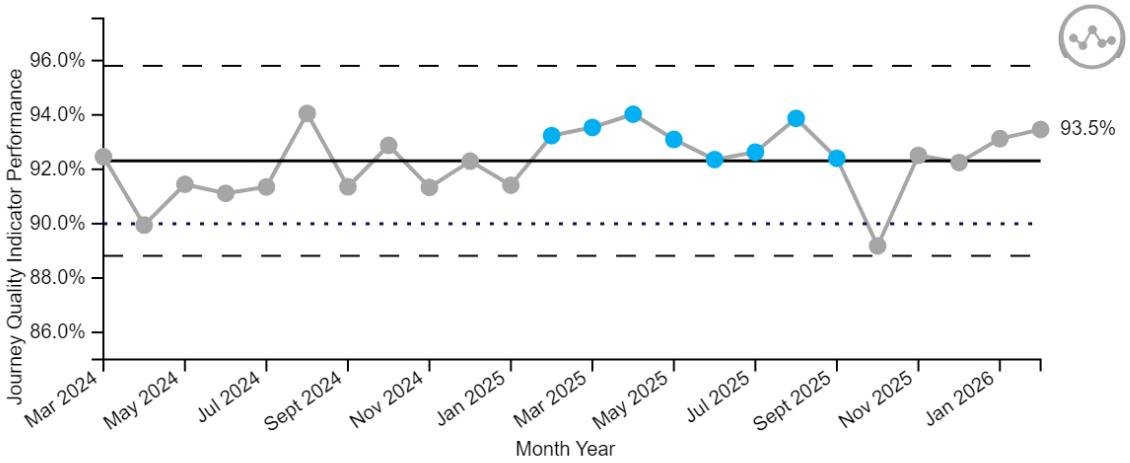




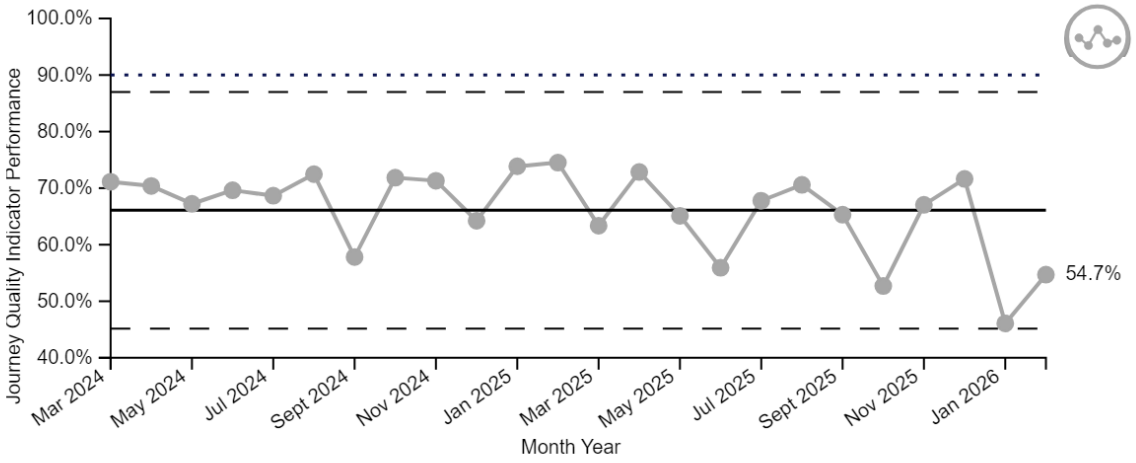
Unplanned Activity by Contract



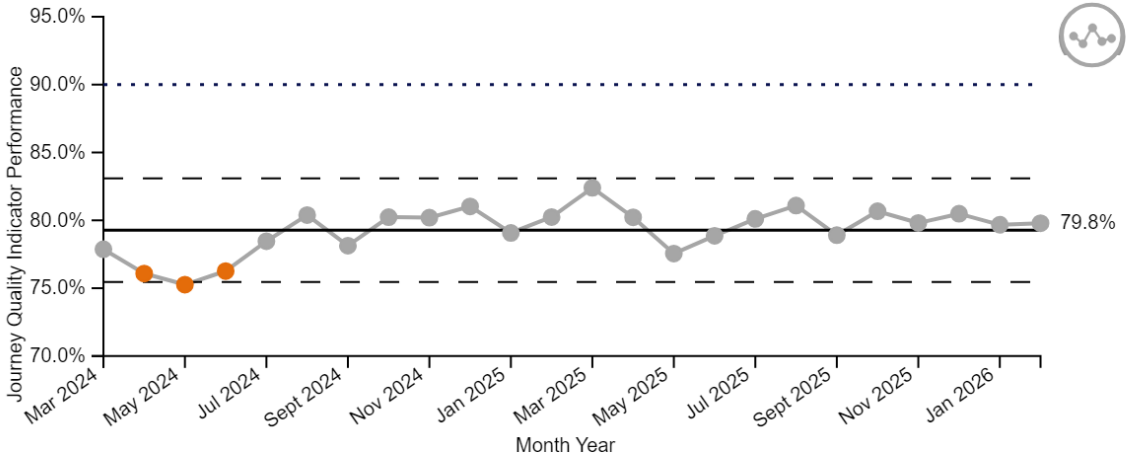
Collection after treatment (EPS) within 90 min



Collection after treatment (Unplanned) within 90 min



Collection after treatment (Planned) within 90 min



Summary:

PTS activity metrics are stable. Planned and unplanned activity is currently below the 90% contract standard.

Only EPS achieved the collection after treatment target of 90%

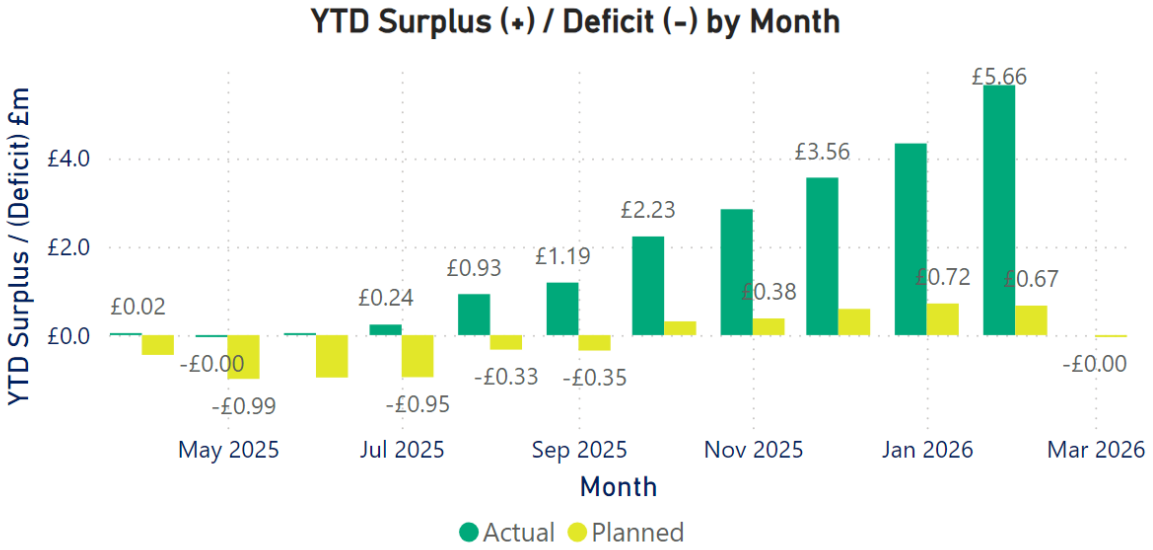
Actions:

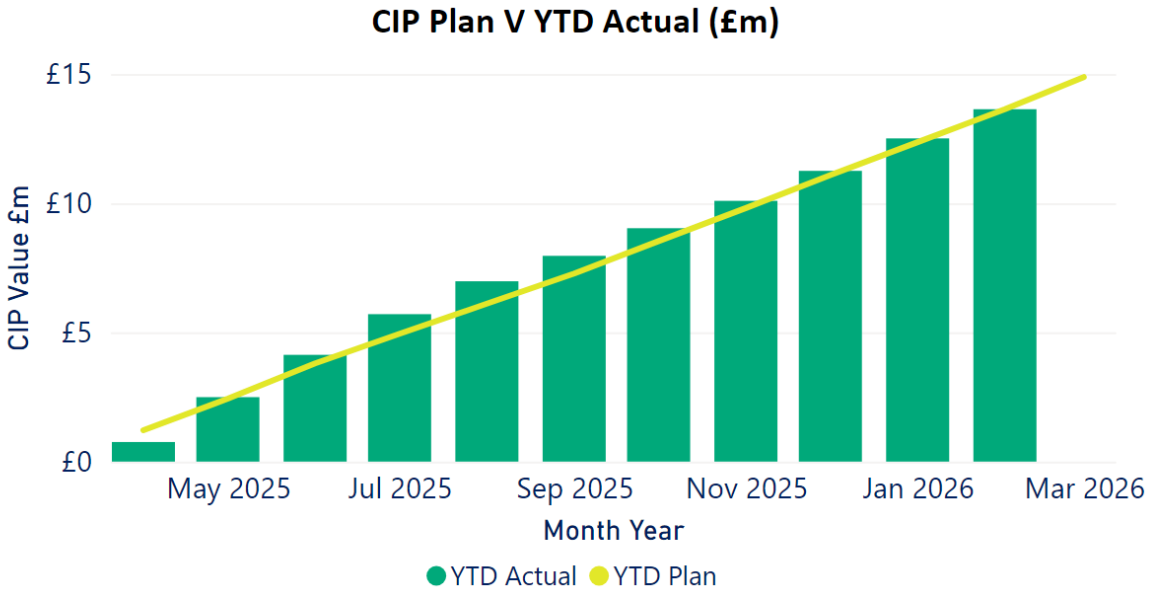
Operational and workforce improvement plans are in place

Finance

F1 Financial Score

F1 Financial Score



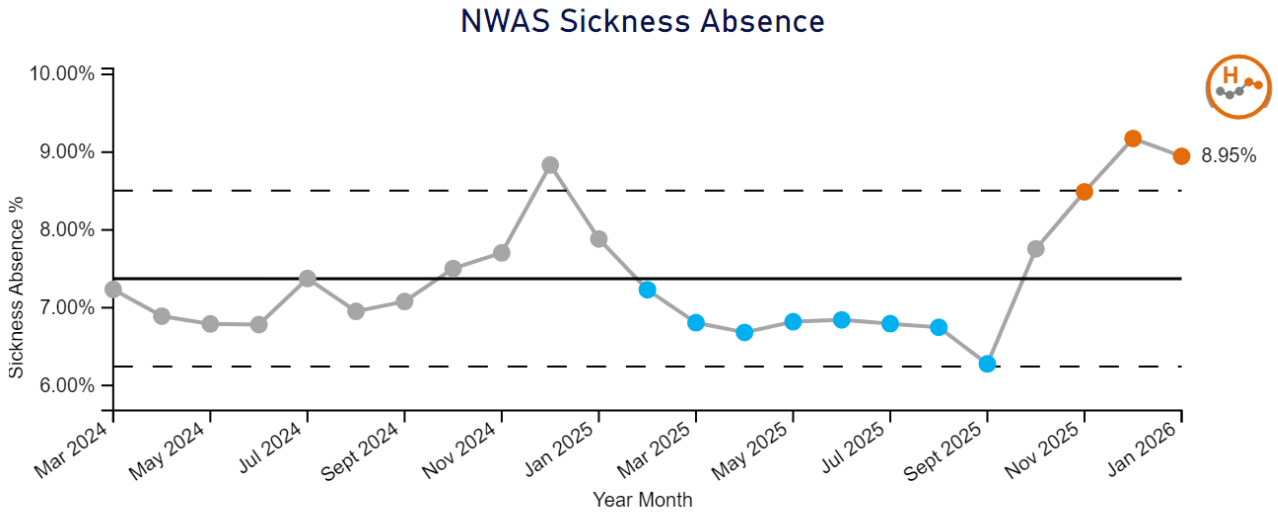


Summary:
The financial position to 28 February 2026 (Month 11 2025/26) is a surplus of £5.657m, against a planned surplus of £0.667m. Vacancies are contributing to the underspend.

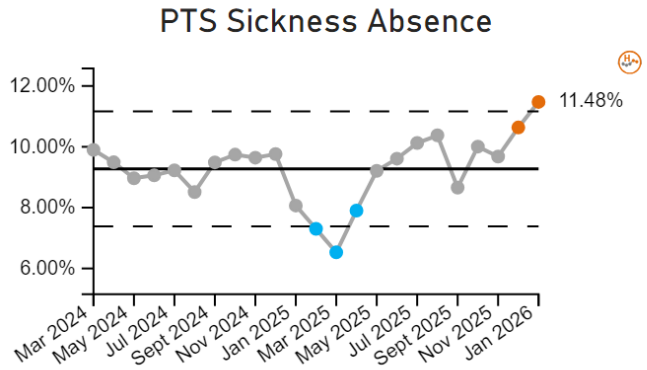
Organisational Health

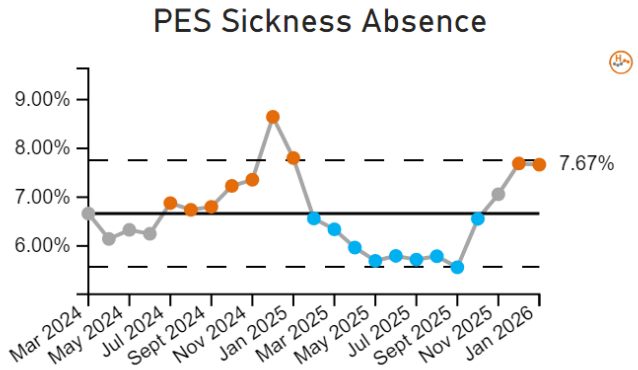
OH1 Staff Sickness
OH2 Staff Turnover
OH5 Vacancy Gap
OH6 Appraisals
OH7 Mandatory Training
OH8 Case Management

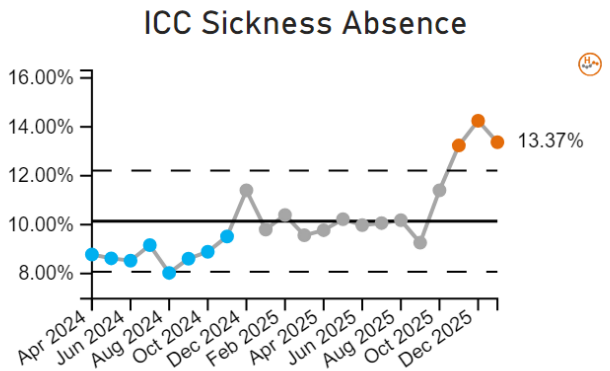
OH1 Staff Sickness



Month	NWAS	Amb. National Average
Mar 2025	6.81%	6.50%
Apr 2025	6.68%	6.26%
May 2025	6.82%	6.23%
Jun 2025	6.84%	6.38%
Jul 2025	6.79%	6.68%
Aug 2025	6.75%	6.75%
Sep 2025	6.28%	6.74%
Oct 2025	7.76%	7.17%
Nov 2025	8.49%	7.39%
Dec 2025	9.18%	8.26%
Jan 2026	8.95%	





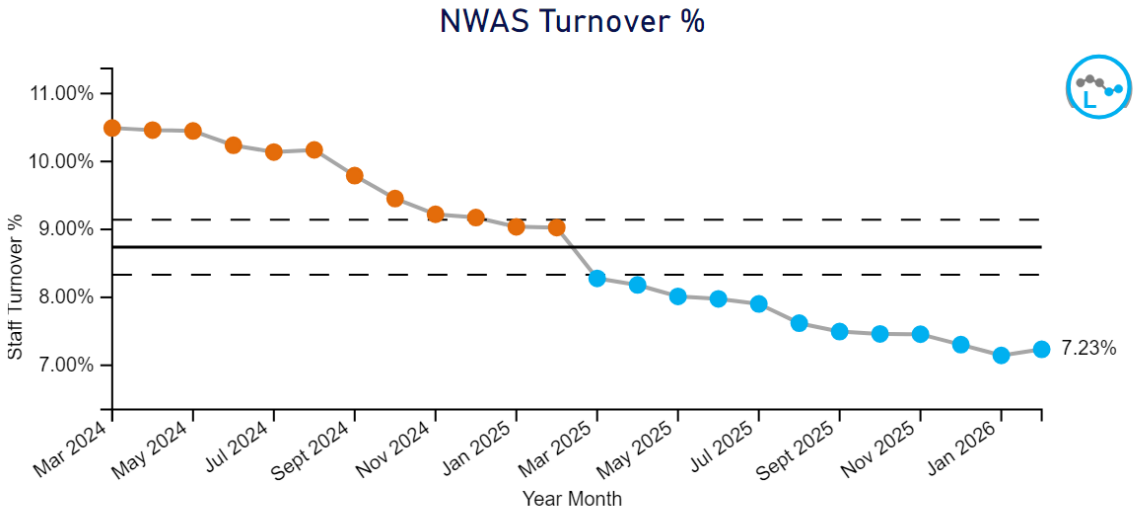


Overall sickness has dropped slightly to 8.95% in Jan 26 from 9.18% in December 25. This follows the seasonal trend we would expect to see but remains above upper control limits. PTS sickness has risen to 11.48% in Jan 26 from 10.63% in December 25. All other service lines have dropped slightly. The rolling 12 month average February 25 – January 26 is 7.38% absence which is consistent with 2024/25.

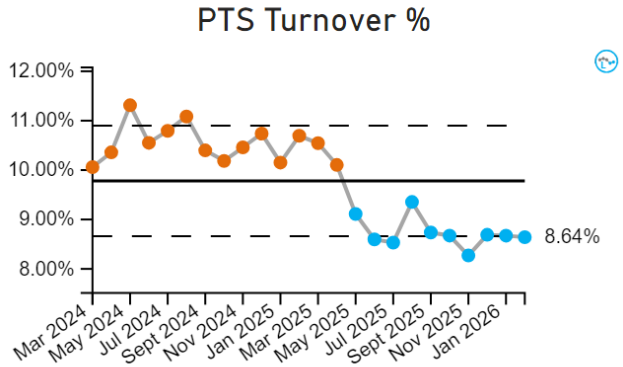
The Attendance Improvement Team continues to focus on interventions to support.

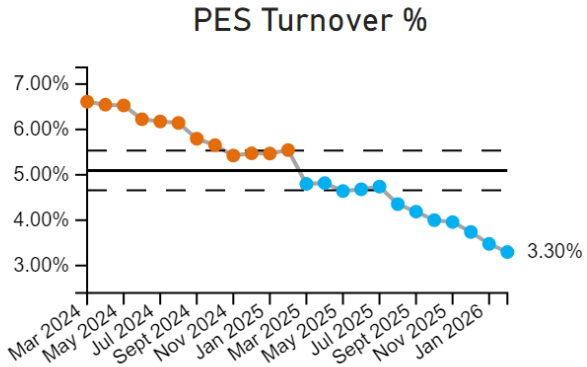
BAF ID SR04

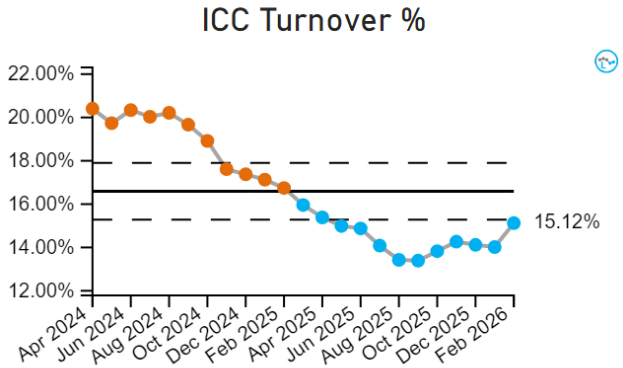
OH2 Staff Turnover



Month	NWAS	Amb. National Average
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%	9.35%
Sep 2025	7.50%	9.35%
Oct 2025	7.46%	9.18%
Nov 2025	7.46%	9.15%
Dec 2025	7.30%	8.99%
Jan 2026	7.14%	
Feb 2026	7.23%	







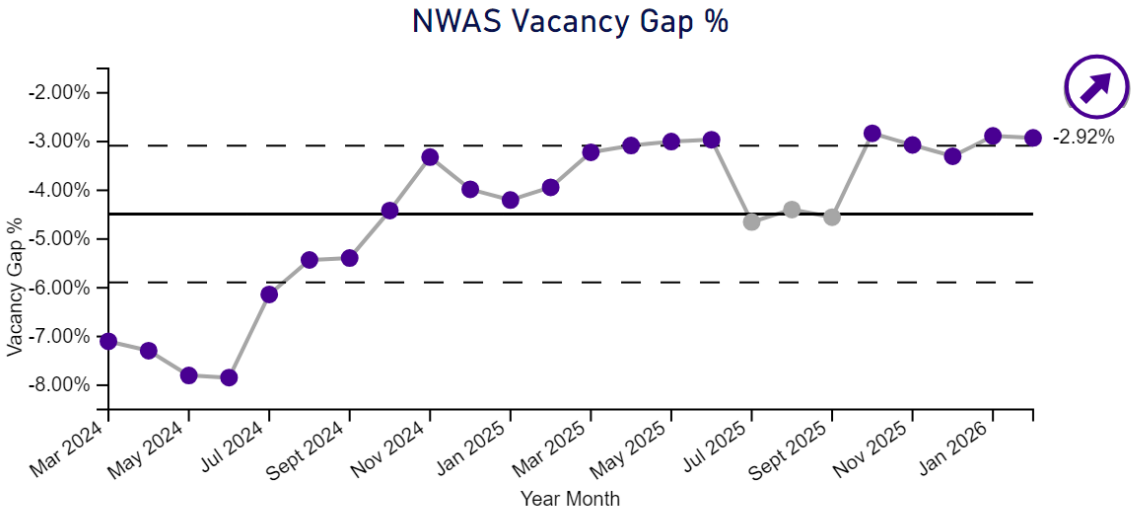
Overall turnover remains stable at 7.23% in February 26 from 7.14% in Jan 26 and still remains below the Ambulance Sector National Average.

ICC turnover has risen by just over 1% to 15.12%.

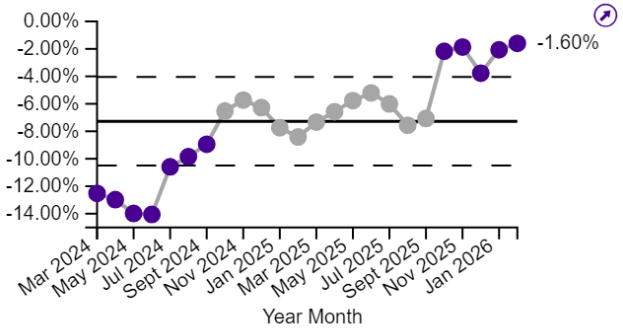
PES turnover continues a downward trend.

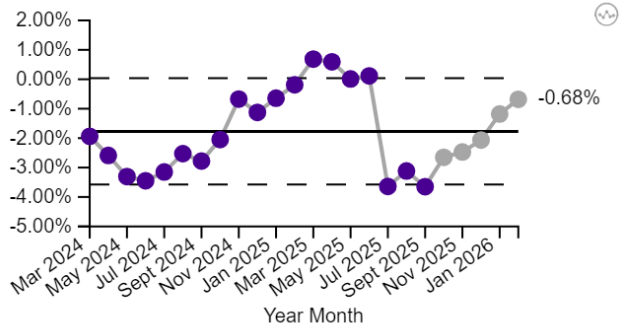
BAF ID SR05

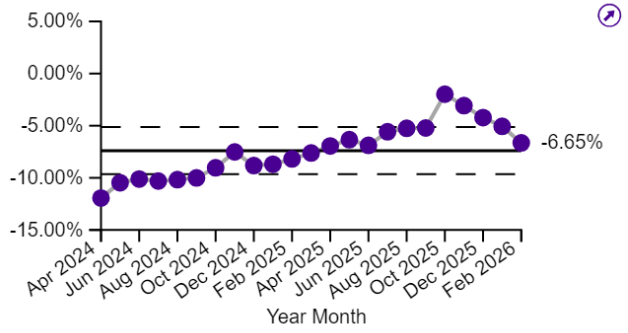
OH5 Vacancy Gap



Month	NWAS Total % Vacancy Gap
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%
Nov 2025	-3.07%
Dec 2025	-3.30%
Jan 2026	-2.88%
Feb 2026	-2.92%



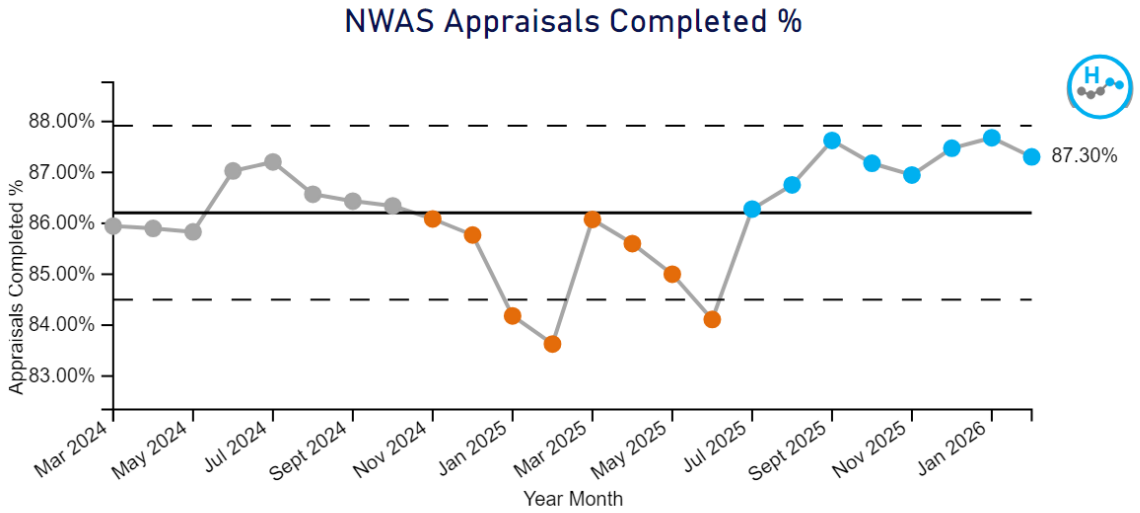




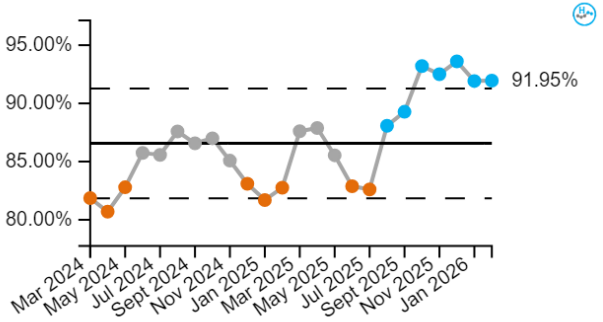
Overall vacancy gap has increased very slightly to -2.92% in February 26 from -2.88% in January 26 in line with plans.

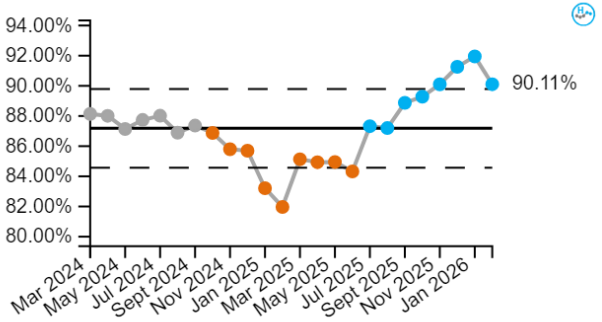
PTS and PES vacancy gaps have reduced. ICC has increased slightly.

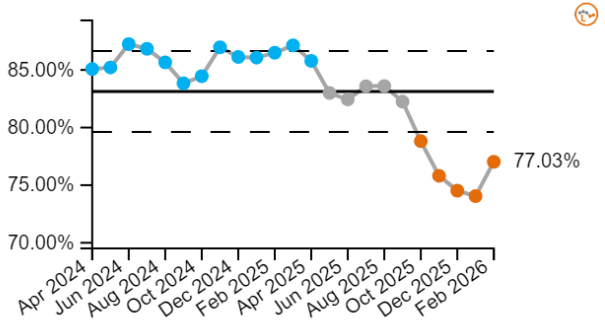
OH6 Appraisals



Month	NWAS Total % Complete Appraisals
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%
Nov 2025	86.95%
Dec 2025	87.47%
Jan 2026	87.68%
Feb 2026	87.30%







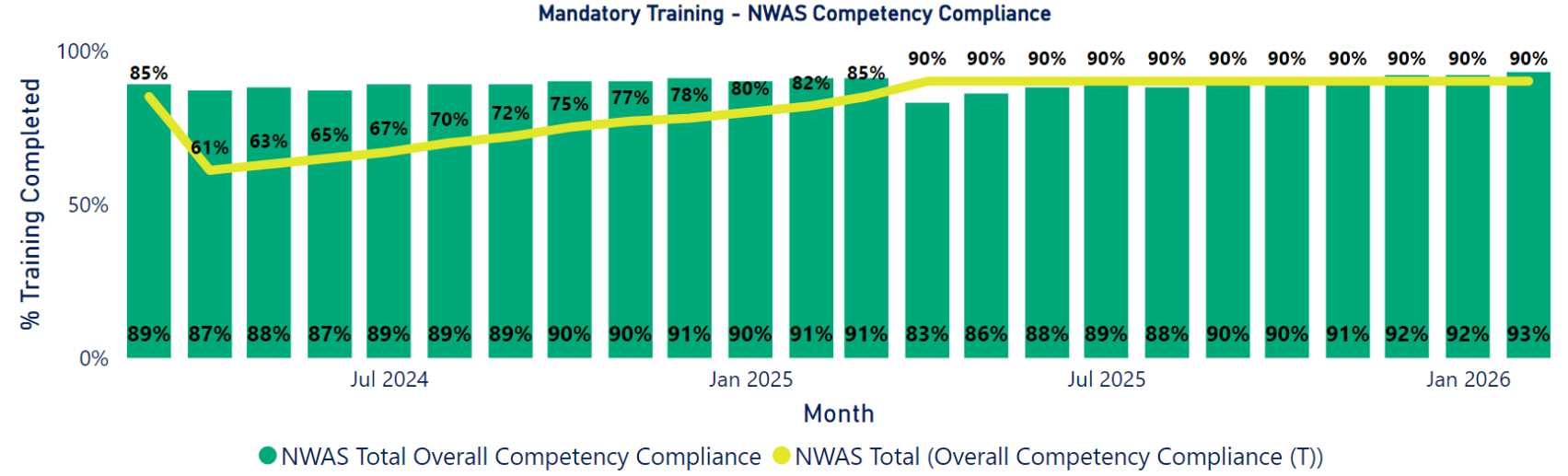
Overall Appraisal compliance rate remains steady at just over 87% which is above target.

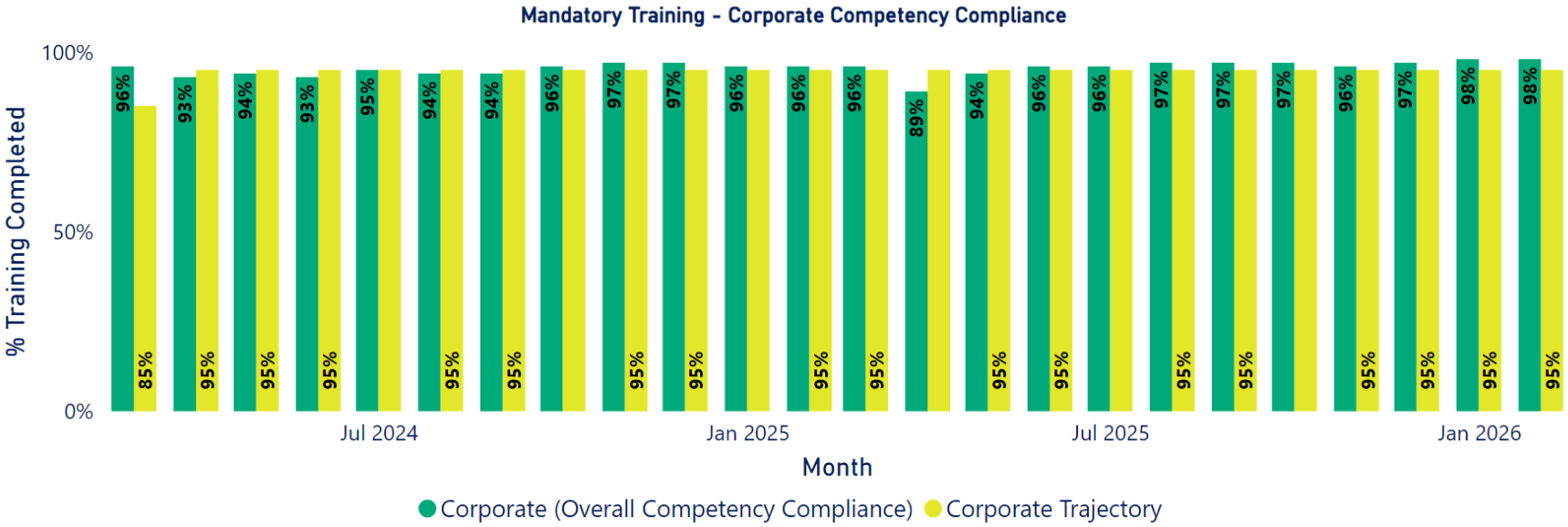
ICC compliance has increased to just over 77% in February 26 from 74% in January 26.

Corporate compliance remains at just under 91%.

BAF ID SR05

OH7 Mandatory Training



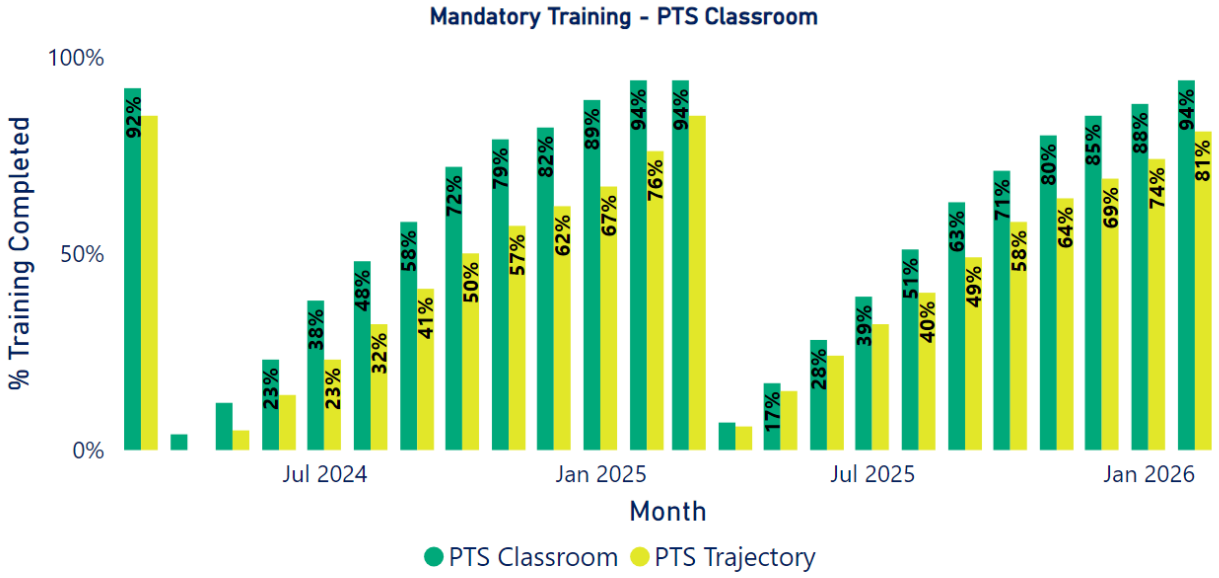


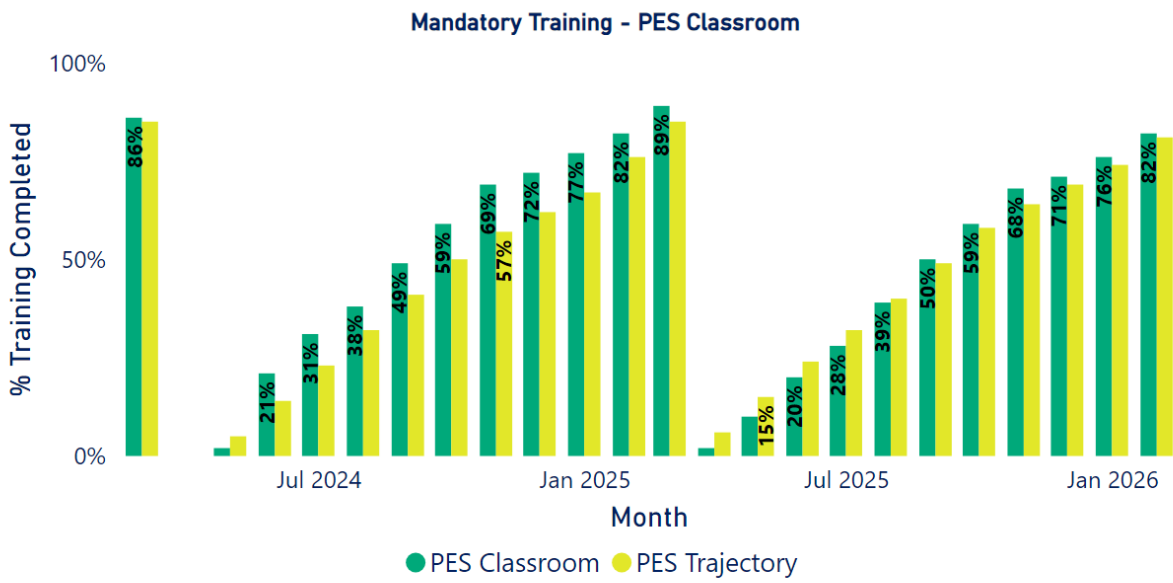
Overall Mandatory Training compliance has risen to just under 93%, above the 90% target.

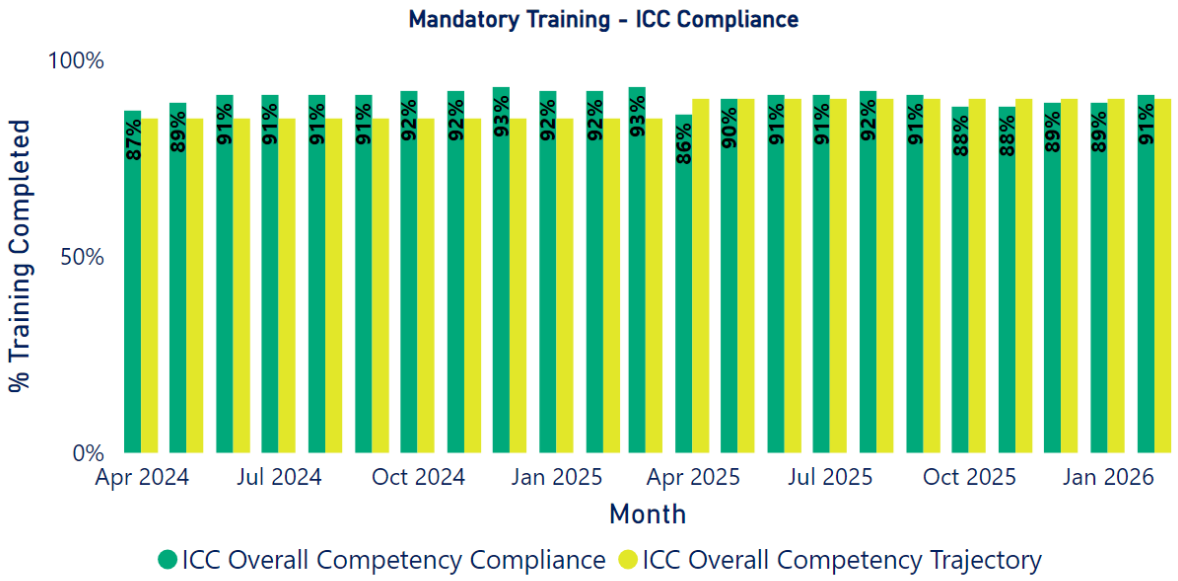
Corporate remain above their 95% target.

BAF ID SR05 Risk Rating NA Strategy Goal NA

OH7 Mandatory Training







Rolling 12 months classroom compliance remains steady for both PTS and PES at over 95%.

25/26 cycle classroom attendance is on trajectory for both PES and PTS with 82% and 94% compliance respectively against the target of 81% for end of February 26.

ICC are now above their 90% target overall, but in the detail the ICC Senior Leadership group are showing as only 73% compliant, and ICC Clinical Delivery group at 85% compliant.

BAF ID SR05 Risk Rating NA Strategy Goal NA

OH8 Case Management

NWAS Summary

Service Line	Live cases	Prevalence live cases (per 100 staff)	Cases closed in 12 months	Prevalance closed cases in 12 months (per 100 staff)	Avg weeks to close in 12 months (top 4 case type)
Operations – PES	**72**	**1.75**	**302**	**7.33**	**11.6**
PES CAL	25	1.98	119	9.40	9.7
PES CAM	31	2.26	98	7.15	11.6
PES GM	16	1.11	84	5.85	13.8
PES Other	0	0.00	1	1.94	17.3
Operations – ICC	**44**	**2.60**	**187**	**11.06**	**8.1**
Operations – PTS	**15**	**2.13**	**72**	**10.21**	**10.3**
Operations – Resilience	**0**	**0.00**	**5**	**3.71**	**10.0**
Corporate	**14**	**1.77**	**57**	**7.20**	**10.8**
Other	**1**	**0.00**	**12**	**0.00**	**12.2**
Total	**146**	**1.96**	**635**	**8.53**	**10.3**

Notes
Other - count of incidents with several staff members, making it not possible to attribute incident to a specific service line.

Number of cases applies to 7 case types: Dignity at Work, Disciplinary, Fact Finding, Grievance, Organisational Change, Performance and Litigation.

Average time to close applies to Dignity at Work, Disciplinary, Fact Finding and Grievance case types.

Date period for closed cases is Mar 2025 to Feb 2026

Case Type Summary

Case Type	Live Cases	Cases closed in 12 months	Avg weeks to close in 12 months (top 4 case type)
Dignity at Work	15	55	10.9
Disciplinary	70	165	20.1
Fact Finding	14	190	4.8
Grievance	22	146	7.5
Litigation	9	25	
Organisational Change	4	6	
Performance	12	48	
Total	**146**	**635**	**10.3**

Case Dismissals in last month

Case Type	Case Sub Type	Department	Outcome Date
Disciplinary	Gross misconduct	CAM - North	10 February 2026
Performance	Stage 3 truncated	ICC Call Handling	09 February 2026
Performance	Stage 3 truncated	ICC Call Handling	10 February 2026
ABS STS	Stage 4	ICC Clinical Delivery	05 February 2026

Live cases length of time open

Case Type	Under 3 Months	3 to 6 Months	6 to 12 Months	Greater than 12 Months	Total
Dignity at Work	10	2	3		**15**
Disciplinary	28	26	15	1	**70**
Fact Finding	11	3			**14**
Grievance	18	4			**22**
Litigation	2	2	2	3	**9**
Organisational Change	1	2		1	**4**
Performance	3	4	3	2	**12**
Total	**73**	**43**	**23**	**7**	**146**

New Litigation cases in last month

Case Type	Case Sub Type	Department	Received Date
Litigation	Unfair dismissal	Merseyside	27 February 2026

Most common opening reasons for Displinary cases in 12 months

Opening reason	Count
Inappropriate / Unprofessional Behaviour	35
Dereliction of duty	17
Sexual misconduct	12
Poor patient care	9
Incapacity through alcohol/substance misuse	8

Disciplinaries: Suspensions or alternative duties (live)

Status	Count
Alternative duties	0
Restricted practice (alt to suspension)	2
Suspension	18
Total	**20**

Live case numbers had seen a steady drop in recent months, however, this month's report shows an increase in numbers to 146 live cases.

This now includes litigation, performance and organisational change case figures too.

There were 4 dismissals in February 26:
1 sickness capability
1 conduct
2 performance management.

There are currently 18 individuals suspended with 2 on restricted practice.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Bi-Annual Safeguarding Report
PRESENTED BY	Dr Elaine Strachan-Hall
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the activity that contributes to assurance that NWAS safeguarding activity during Q1 and Q2 2025-26 continues to meet our statutory requirements.
EXECUTIVE SUMMARY	**Safeguarding Activity:** Activity levels have increased. Comparing Q2 of 2024/25 -9513 referrals and Q2 2025/26 – 11,719. NWAS made increase of 2,206 Safeguarding and Early Help referrals (this is an increase of 23 % in comparison to the same period year on year, slightly down on the comparative figures in Q1 of 27 % increase year on year), with the referral rejection rate reduced to below 2%. **Audits:** Two rolling audit programmes continue to provide assurance: • Children's High-Intensity Presentations. • Complex Safeguarding/Early Help **Training:** Compliance data is at 95.6% overall **Allegations Against Professionals**: 17 referrals received **The Safeguarding Dashboard** is now operational, providing enhanced visibility of safeguarding concerns and improved reporting and analysis. Development of the DCIQ Safeguarding Module is progressing well, with go-live expected in Q4.

	Pending Referrals Risk: An issue identified in Q2 has been logged on the risk register (#757). Investigation and IT solution development are underway.	
PREVIOUSLY CONSIDERED BY	Clinical & Quality Group	
	Date	Tuesday, 20 January 2026
	Outcome	Approved
	Quality & Performance Committee	
	Date	Monday 23 February 2026
	Outcome	Approved

1. BACKGROUND

This Safeguarding Bi-Annual Report provides an overview of safeguarding activity within the Trust during Q1 and Q2 2025/26.

The Trust has a statutory responsibility to safeguard children and adults who are at risk of harm from abuse. This commitment is underpinned by specific legislation, namely the Children's Act (1989 and 2004) and the Care Act (2014). The Trust works in partnership with other organisations to ensure that the response to individuals who are at risk of harm from abuse or neglect, is communicated in an effective manner which results in an appropriate response. Safeguarding child and adult standards are determined nationally for NHS Provider Organisations and are monitored by the Care Quality Commission (CQC) and via submission of the Safeguarding Assurance Framework to the Integrated Care Board (ICB) and the Provider Safeguarding Assurance Toolkit (P-SCAT) to NHS England. In addition to safeguarding practice and processes, standards relate to policies and procedures, recruitment processes, and leadership.

The specific standards are contained within:

- Safeguarding Assurance Framework (SAF) which is presented to the lead Commissioners (Lancashire and South Cumbria ICB) on an annual basis.
- Mersey Internal Audit Agency (MIAA) who conduct safeguarding audits on behalf of the Trust Audit Committee.
- The Care Quality Commission (CQC).

2. Safeguarding Team

The team currently comprises of the Head of Safeguarding, who reports directly to the Assistant Director of Quality and Nursing, four Safeguarding Practitioners (3.6 whole time equivalent) who cover specific areas across the NWAS geographical footprint, as well as providing safeguarding support to our Integrated Contact Centres (ICC). A secondment post to cover maternity leave of one of the Practitioners was in place for Q1&2 but has now ended. The team has two Administration Support Officers (1.8 whole time equivalent). In addition, some safeguarding work has been taken up by the LD&A Practitioner. Safeguarding referrals by NWAS staff continue to be made via the Support Centre in Carlisle and are sent electronically to the appropriate local authority using the Cleric referral system.

The Head of Safeguarding left the trust in Q1, and recruitment has been completed with the new post holder due to take up post January 2026. From 1st June 2025 for six months a post of 8a Named Professional for Safeguarding has been in place to cover the Trust statutory obligations and ensure a seamless transition for the incoming Head of Safeguarding.

3. Safeguarding Activity

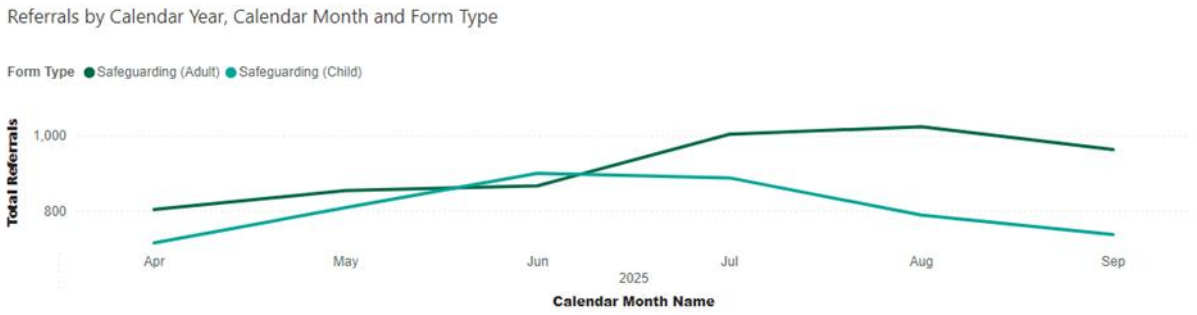
NWAS makes safeguarding referrals to 27 local authorities within the geographical footprint. Referrals are made electronically via our Support Centre in Carlisle to the appropriate local authority as linked to the postcode. During Q1 and Q2 2025/26, NWAS made 23,144 Safeguarding and Early Help referrals. This is an increase of 4,585 compared to Q1&2 in 2024/25, likely to be attributable to several different factors including ever increasing 999 demands from the public, a review of the safeguarding training needs analysis (TNA) which resulted in more staff aligned to level 3, thus potentially improving safeguarding knowledge and confidence. There is also a greater understanding of mental health pathways and this, along with the use of the non-fatal opiate

pathways and social prescribing pathways, provides alternative routes to access the most appropriate support for our patients.

The number of referrals rejected by local authorities is less than 2% indicating the safeguarding information we share is reaching the right localities for onward assessment for our patients. In addition, the child concerns continue to be shared down the Child Heath Pathway which provides an added layer of information sharing to partners such as health visiting or school nursing staff, ensuring children are supported by those teams who have oversight of their care in community settings.

Referral Activity

The tables below detail referral activity for Q1 and Q2 2025/26. 53.2% of the safeguarding referral are for adults. Comprising of GM 41%, CM 30%, CL 26%, Other 3%.



Calendar Year, Calendar Month Name	Safeguarding (Adult)	Safeguarding (Child)
2025, Apr	803	714
2025, May	853	808
2025, Jun	866	899
2025, Jul	1,003	887
2025, Aug	1,023	788
2025, Sep	962	736

Safeguarding Dashboard Report – Summary

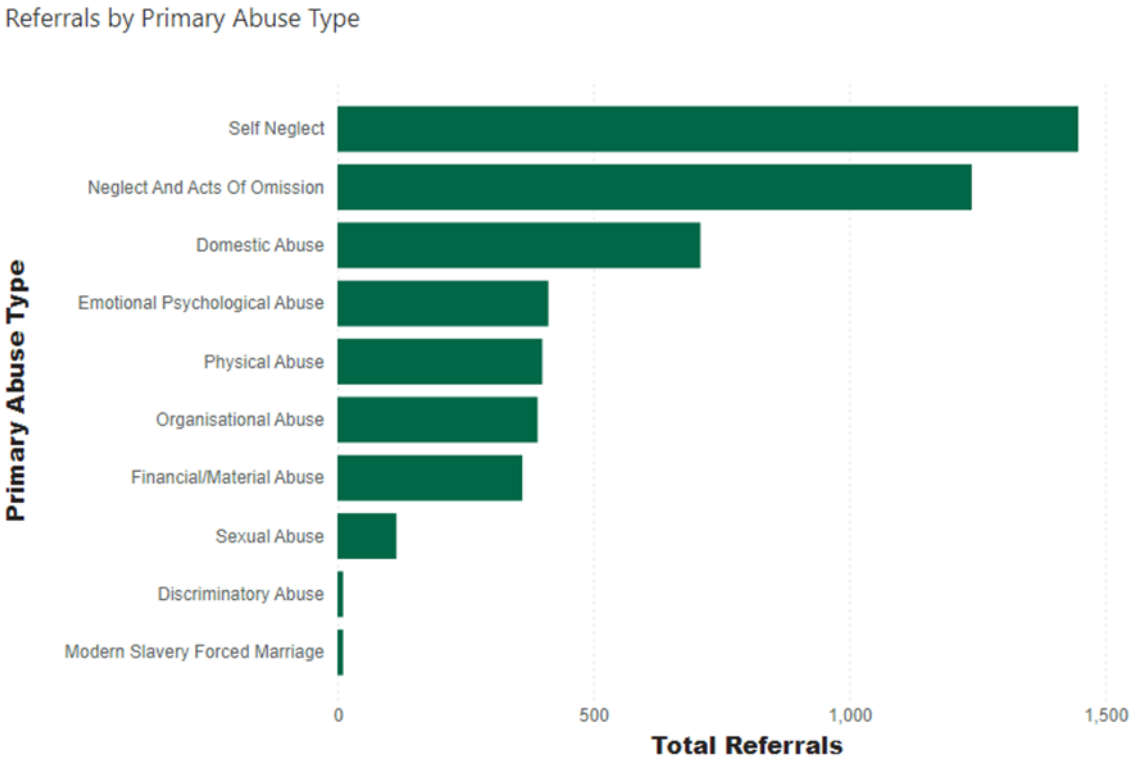
As this is the first report containing safeguarding dashboard data, it is challenging to provide a detailed narrative or identify trends at this stage.

Data Reporting Approach:

- The dashboard primarily reports on the primary abuse category as indicated by the referrer.
- The Cleric Safeguarding Form enables staff to record primary, secondary, and tertiary abuse types, allowing for comprehensive information sharing.
- For example, a safeguarding concern may be primarily classified as domestic abuse but also include elements of physical abuse or other combinations.

Key Observations - Adult Safeguarding:

- During this reporting period, self-neglect was the most frequently recorded abuse type for adults.
- Other significant categories include neglect and domestic abuse. Please see the table below.

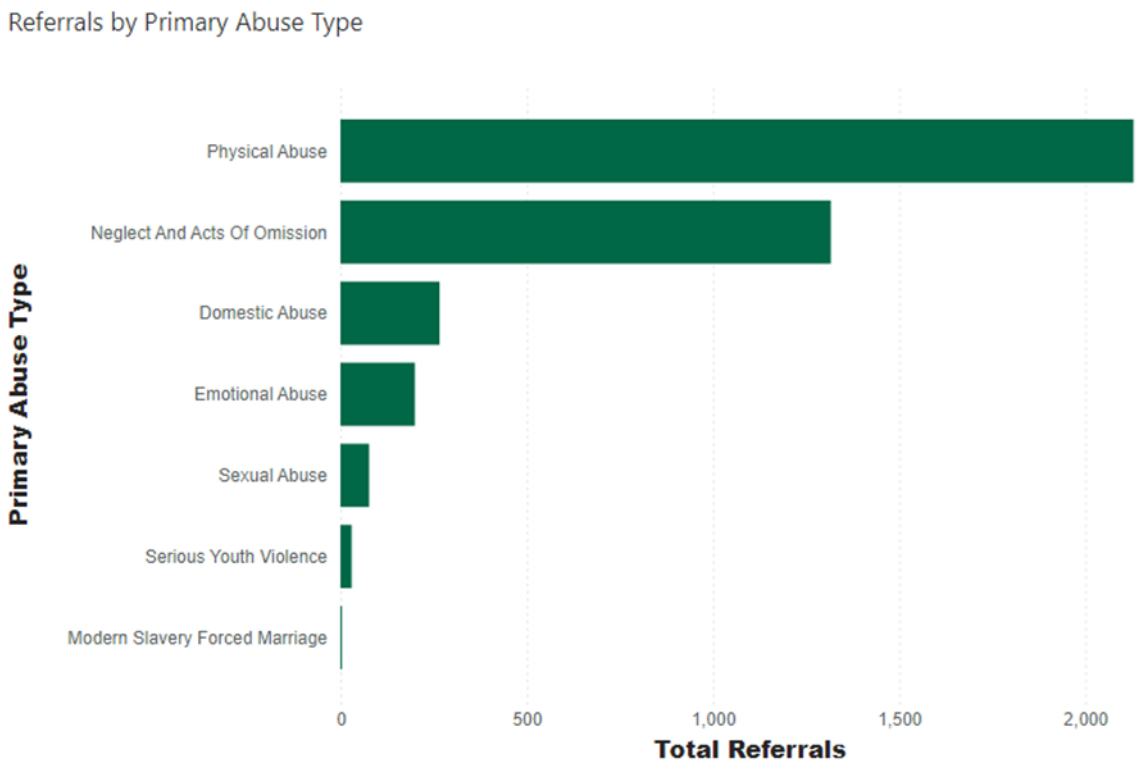


Referrals by Primary Abuse Type

Primary Abuse Type	Total Referrals	% of Total Referrals
Discriminatory Abuse	11	0.22%
Domestic Abuse	709	13.91%
Emotional Psychological Abuse	412	8.08%
Financial/Material Abuse	361	7.08%
Modern Slavery Forced Marriage	11	0.22%
Neglect And Acts Of Omission	1,239	24.31%
Organisational Abuse	391	7.67%
Physical Abuse	400	7.85%
Self Neglect	1,447	28.39%
Sexual Abuse	115	2.26%

Key Observations - Child Safeguarding:

• The physical abuse category includes cases where children exhibit self-injurious behaviours. This classification reflects the category most selected by the referrer.

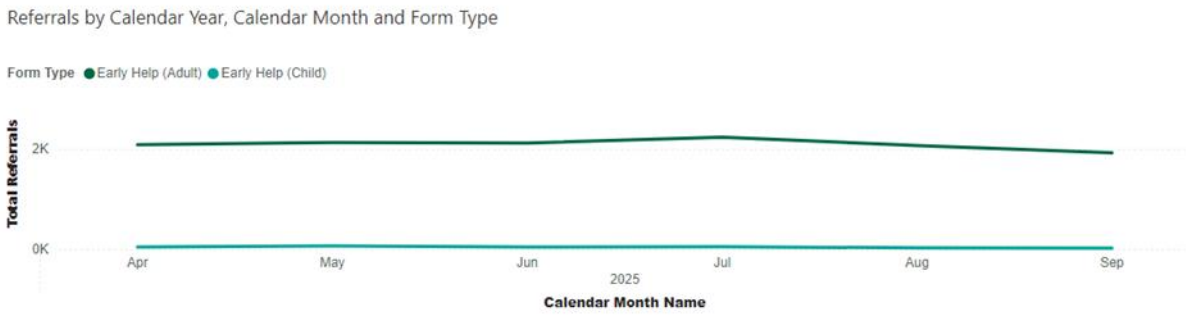


Referrals by Primary Abuse Type

Primary Abuse Type	Total Referrals	% of Total Referrals
Domestic Abuse	266	6.61%
Emotional Abuse	200	4.97%
Modern Slavery Forced Marriage	3	0.07%
Neglect And Acts Of Omission	1,317	32.74%
Physical Abuse	2,130	52.95%
Serious Youth Violence	30	0.75%
Sexual Abuse	77	1.91%

Early Help.

• 98% referrals for adults. Comprising of GM 40%, CM 30%, CL 29%, Other 1%. This shows to be quite consistent throughout the reporting period. Please see the table below.



Calendar Year, Calendar Month Name	Early Help (Adult)	Early Help (Child)
2025, Apr	2,082	47
2025, May	2,127	66
2025, Jun	2,116	44
2025, Jul	2,232	52
2025, Aug	2,068	27
2025, Sep	1,920	21

The below table reports the referral data by service line:

	Safeguarding	Early help	Combined.
111	1385	1380	2765
999	6455	9781	16236
CFR	3	3	6
ICC-CHUB	927	739	1666
ICC-EOC	1181	240	1421
Private Provider	318	598	916
PTS	69	60	129
None specified	4	1	5

The number of safeguarding concerns raised by the PTS service line is notably low. This is particularly significant given that PTS staff frequently interact with adults who have care and support needs during routine journeys. This will be a priority area for the incoming Head of Safeguarding, who will undertake further exploration to understand potential barriers and identify opportunities for improvement.

SAFEGUARDING REFERRAL QULITY ASSURANCE

Assurance regarding the quality of NWAS safeguarding referrals is monitored through two key processes: Referral Rejections via Cleric System

- We track referrals rejected by local authorities through the Cleric system.
- The current rejection rate is approximately 1.76% of all referrals made in Q1 and Q2.
- Most rejections are due to postcode discrepancies within Cleric, which result in referrals being sent to the wrong local authority.
- These cases are reviewed daily by Administration Support staff, who correct the postcode and manually redirect the referral to the appropriate authority.

AUDIT AND STRENGTHENED QUALITY ASSURANCE PROCESSES

Following an audit of referrals rejected by the Support Centre, we have enhanced our quality assurance procedures. Support Centre staff record all referrals on a Cleric form. Referrals that do not meet the safeguarding threshold are discussed during the daily huddle, allowing for detailed review of complex cases. This process has helped identify recurring themes and areas within the organisation that require targeted safeguarding support. It also provides Safeguarding Practitioners with an opportunity to deliver meaningful feedback to the workforce.

Safeguarding Referral System Assurance.

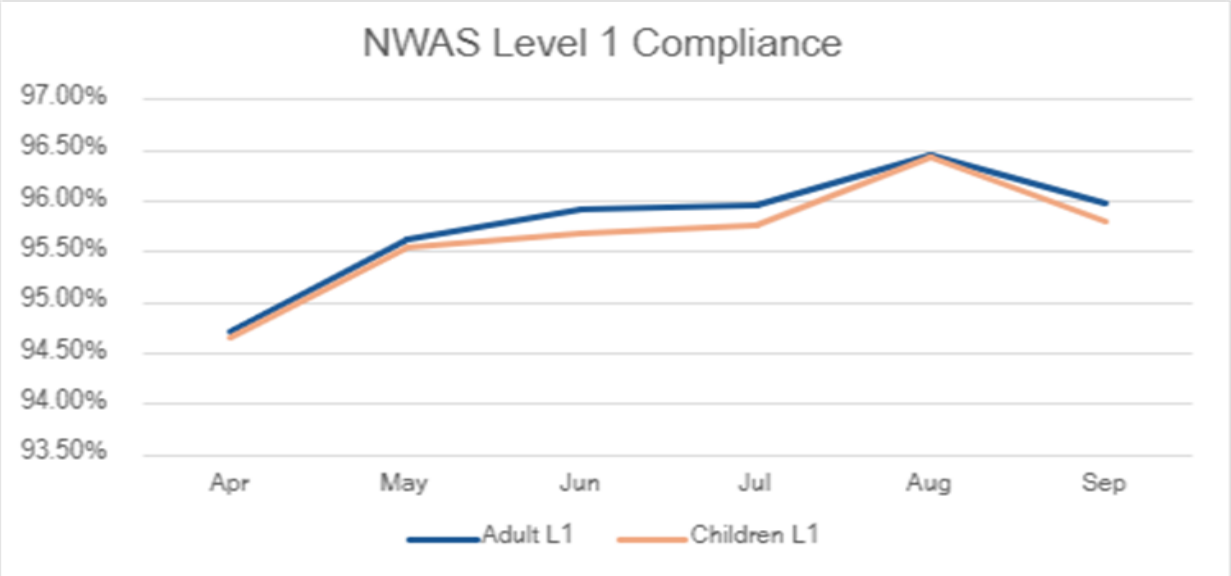
In Q2 2025, the Named Professional for Safeguarding identified an issue within the Cleric safeguarding referral system, where a small number of referrals had become 'stuck' and were not accessed by local authorities as intended. A comprehensive audit was conducted to locate and resolve these referrals, ensuring that the appropriate local authorities received the necessary

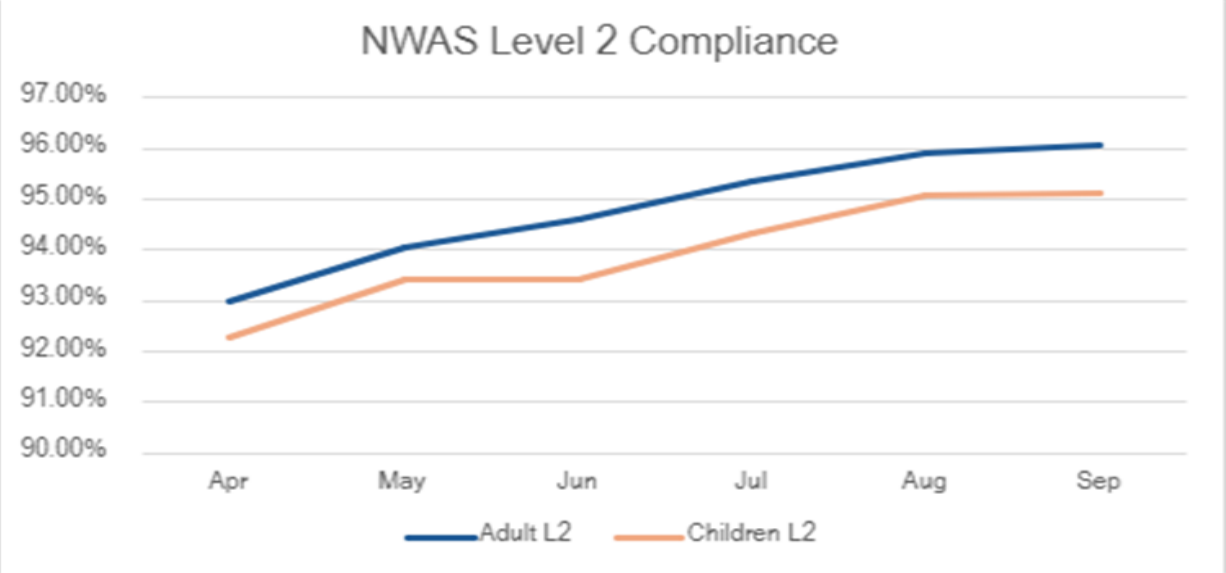
information. To prevent recurrence, safeguarding team administrators have introduced an enhanced daily check to ensure no referrals remain in a pending state within Cleric. NWAS IT colleagues are collaborating with Cleric to design and implement a permanent solution to eliminate the pending status. This work is currently in progress and is recorded on the risk register (#757).

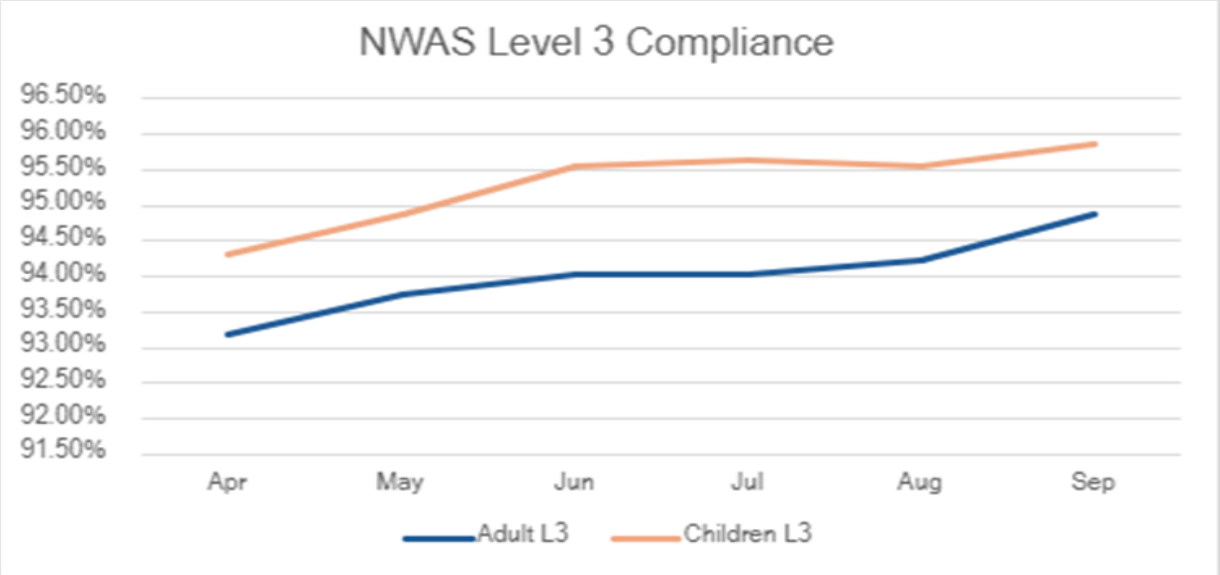
Update: As of the end of October, Cleric has provided costings to address the pending referral issue, alongside improvements to dashboards and the child health pathway. The Assistant Director of Quality has approved funding for these enhancements. NWAS, IT has confirmed that Cleric plans to commence the work in mid-December 2025, with completion anticipated by the end of January 2026.

TRAINING

The L&D Team provides safeguarding training data. Compliance is monitored by the Safeguarding Team on an ongoing basis. At 30/9/25, the Learning and Development Team report overall safeguarding training compliance for levels 1-3 as below: Level 1 & Level 2 safeguarding is delivered through e-learning packages which are accessed via My ESR.







Level 4 training: Limited senior roles are profiled to level 4 including The Head of Safeguarding, Assistant Director of Nursing and Quality as well as the Safeguarding Practitioners who are all compliant with level 4 training.

Safeguarding Training Needs Analysis

A review of the training needs analysis (TNA) was completed in 2024 to ensure that roles are aligned with the Safeguarding Children and Young People: Roles and Competences for Health Care Staff and Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Documents. Since completion of the Service Delivery review in ICC, this now requires a further assessment, although there are some challenges with the profiling of new roles within ICC. Further engagement from the teams within ICC and Learning & Development (L&D) team is required to complete this process.

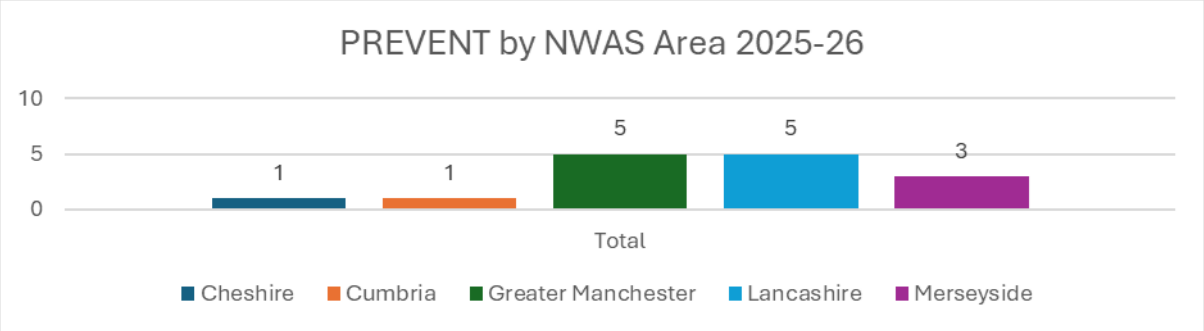
A sustainable solution is needed, potentially through automation (e.g., AI) to match job profiles to intercollegiate standards at role creation. Ongoing monitoring of the extensive TNA is resource intensive and unmanageable within current safeguarding staffing levels.

Level 3 Safeguarding training for profiled corporate staff and ICC staff was historically supported face-to-face by the Safeguarding Team. However, as the service (and subsequently the workforce) has increased, this is no longer possible both in terms of releasing staff for face-to-face sessions and due to limited capacity within the Safeguarding Team to train enough. In agreement with the Learning and Development Team and ICC operational leads, additional Level 3 E-Learning for Health (eLfH) safeguarding modules are now accessible to ICC staff via ESR, which provides 50% of overall compliance. However, there is a requirement in the intercollegiate documents for face-to face delivery, ideally by a subject matter expert, however, this is no longer feasible due to workforce growth and limited capacity. A further review of the TNA will be required once the new Head of Safeguarding is in post and the ICC service redesign is complete.

The Head of Safeguarding will work with Corporate and ICC senior leaders and the L&D team to establish a robust model for meeting Level 3 training requirements and ensuring sustainable profiling processes for new roles.

PREVENT ACTIVITY SUMMARY

At the end of September 2025, The Learning and Development Team report overall safeguarding training compliance with Prevent Basic Awareness 3 years as 91.03%, this is a rise of 1.1% on last year's data. During Q1 and Q2 2024/25, the safeguarding team processed 15 PREVENT referrals to counter terrorism partners using the national referral system, compared to 10 referrals in the same period last year. Feedback on these referrals is generally limited to confirmation of receipt. An increase in referrals is anticipated due to heightened national awareness following high-profile events. Additionally, NWAS has experienced a rise in information-gathering requests from Counter Terrorism Police regarding service contacts, which the safeguarding team continues to monitor. Prevent referrals sent by area: Q1&2 -33% GM, 33% Lancs, 20% Mersey, 7% Cheshire, 7% Cumbria.



SAFEGUARDING AUDITS

The Safeguarding Team conducts two rolling audit programmes annually:

Children's High-Intensity Presentations

- Provides assurance of collaborative working between NWAS and Children's Social Care.
- Repeat child presentations (five or more contacts in a calendar month) are flagged monthly by the High Intensity Users Team.
- Safeguarding Practitioners triangulate data from ePRs, SOEs, Cleric, and 111 calls, and liaise with social care teams or social workers to ensure effective information sharing and prevent silo working.

Complex Safeguarding/Early Help

- Focuses on improving referral quality and clarity, ensuring NWAS submissions support social care intervention.
- Enhances understanding of abuse categories and care/support needs, providing feedback to both Support Centre staff and operational colleagues.
- Addresses a gap consistently identified by staff regarding safeguarding feedback on QAVs.

Future Audit Activity

The team will explore opportunities to conduct a dip sample audit of ePR over a fixed time period to highlight any potential safeguarding referral opportunities

ADDITIONAL ASSURANCE ACTIVITY

- The Safeguarding Dashboard went live in January 2025. Data from the previous calendar year will be analysed to inform future training themes, in addition to statutory training requirements and learning from local and national safeguarding reviews.
- The safeguarding dashboard informs training themes and locality data, shared with relevant teams.

- Practitioners audit DCIQ records three times weekly, reviewing approximately 36 reported incidents per week and providing safeguarding oversight. The Safeguarding Team will provide appropriate advice when required

Safeguarding Policies and Procedures:
All safeguarding policies and procedures are accessible to staff via the Safeguarding Resource section on the Green Room. These pages are regularly updated with emerging themes and include learning resources such as concise guides (e.g., 7-minute reads) based on recommendations and actions from case reviews.

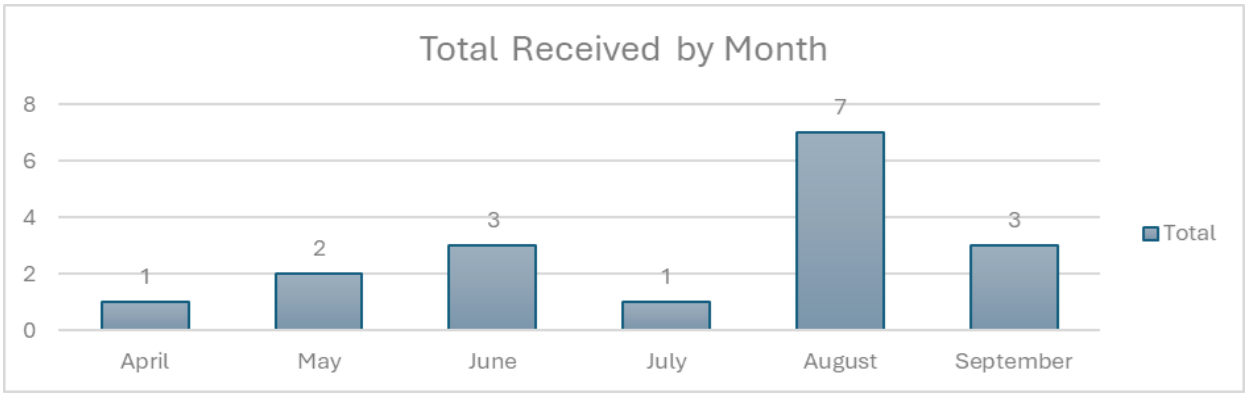
RECENT UPDATES Q2

- SUDC Procedure: Reviewed and updated following a child death; minor wording changes made regarding resuscitation after JRCALC discussion in CCRG/PSEC.
- PREVENT Guidance: Reviewed and updated.

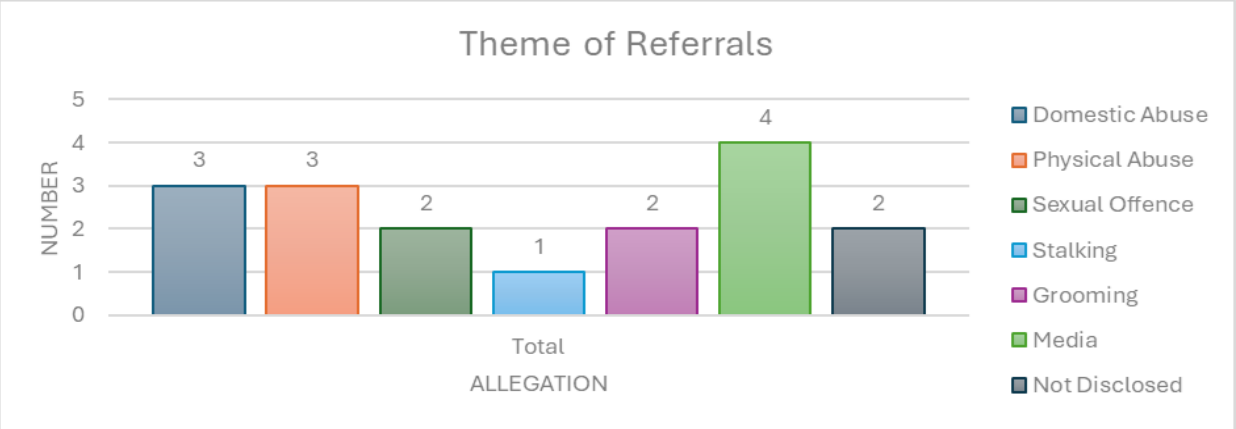
ALLIGATIONS AGAINST PROFESSIONALS

- A dedicated email inbox is functioning effectively for reporting.
- Safeguarding Practitioners, supported by the Named Professional, work closely with local authority PIPOT/LADO teams to meet statutory duties.
- Collaboration with HR, Operational Leads, and the Freedom to Speak Up Guardian ensures appropriate intelligence sharing and robust, case-by-case risk assessments.

Allegations against staff.
In Q1 and Q2 2025/26, 17 allegations matters have been received by the NWAS Safeguarding Team of which 12 have been closed in agreement with the Local Authority Designated Officer (LADO) or Person in a Position of Trust (PiPOT), due to no further safeguarding action required and/or in favour of HR processes. 5 cases remain open.



August shows a significant rise, however in September the number reduces back to 3 which more consistent with the rest of the reporting period. The table below details the themes identified. The inappropriate use of 'media' is the highest this reporting period.



INTERFACE WITH KEY WORKSTREAMS AND DEVELOPMENTS

Safeguarding Interface with Key NWAS Workstreams. Safeguarding is now fully integrated into patient safety processes through collaboration with the Patient Safety Incident Response Team (PSIRF). The Safeguarding Team has access to all patient safety events and participates in every stage—from initial reporting to Complex Case Review Group (CCRG) and Patient Safety Event Committee (PSEC) meetings. This ensures safeguarding considerations are embedded within investigations, reduces duplication, and enables identification of workforce areas requiring targeted support.

Key Developments:
• Microsoft 365 Migration: Completed successfully in Q2.

DCIQ Integration: A bespoke safeguarding module within DCIQ is in development, with implementation planned for Q4. This will provide secure, auditable record management, link safeguarding with patient safety events, and embed safeguarding learning into wider Trust processes.

ONGOING ENGAGEMENT

The Safeguarding Team actively contributes across the Trust, including RCLIG, Area Learning Forums, and daily huddles with Support Centre Managers. Practitioners provide real-time guidance during complex incidents and maintain regular engagement with Sector Clinical Leads, Group Managers, PTS Managers, IG, HIU, ICC investigators, HR, and Legal teams.

PARTNERSHIP WORKING

Partnership working:
The Mersey Internal Audit Agency report, completed prior to this period, provided "substantial overall assurance", which was shared with external safeguarding board partners in Q1 and Q2. This positive outcome has strengthened dialogue and reinforced the Trust's standing with safeguarding boards.

Statutory Reviews:

- NWAS participated in 99 statutory reviews during Q1 and Q2 (an increase of 10 from the same period last year), including:
  - Safeguarding Adult Reviews (SARs)
  - Local Child Safeguarding Practice Reviews (LCSPRs)
  - Domestic Abuse Related Death Reviews (DARDRs)

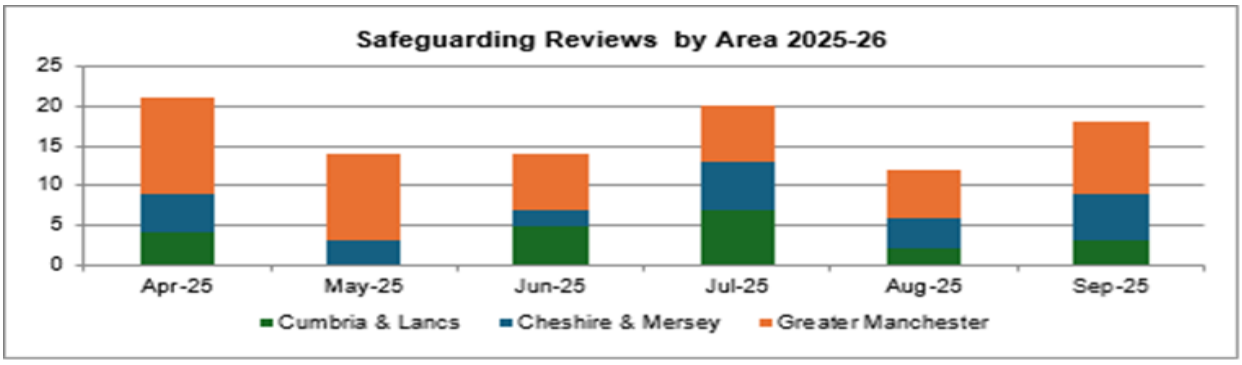
- No significant NWAS-specific learning emerged; however, reviews generated system wide learning to improve quality.
- Safeguarding practitioners represented NWAS on review panels, ensuring pre-hospital perspectives informed final reports.

Key Training Themes Identified:
- Recognition of domestic abuse and children as victims
- Impact of previous trauma on wellbeing
- Trauma-informed practice during crisis response
- "Think Family" approach
- Professional curiosity and confidence in safeguarding decisions

Themes identified have been a focus of safeguarding mandatory training in 2024/25 and there has been a focus on strengthening confidence and professional curiosity which has now been embedded into scenario based training.

REGIONAL ACTIVITY

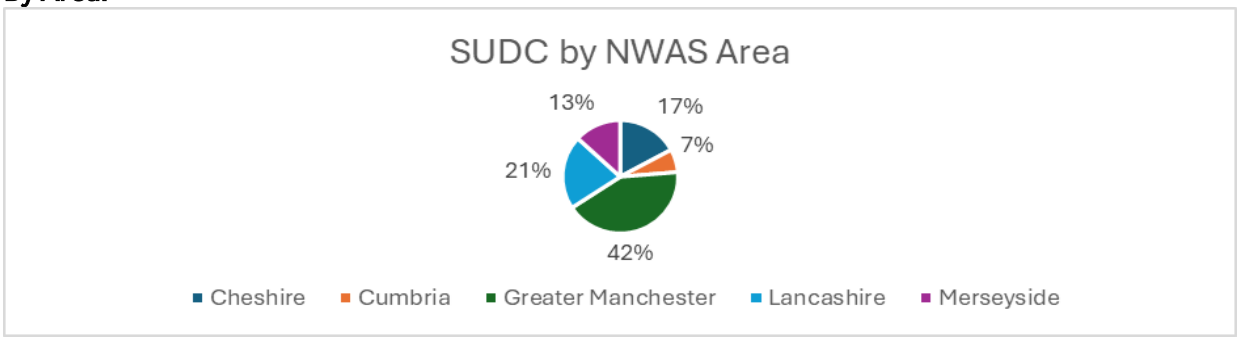
Greater Manchester accounted for the highest Serious Case Review activity (SAR's/DARD/Local Child SPR's): GM 52%, CM 26%, CL 22%.



SUDC (Sudden Unexpected Death in Children)

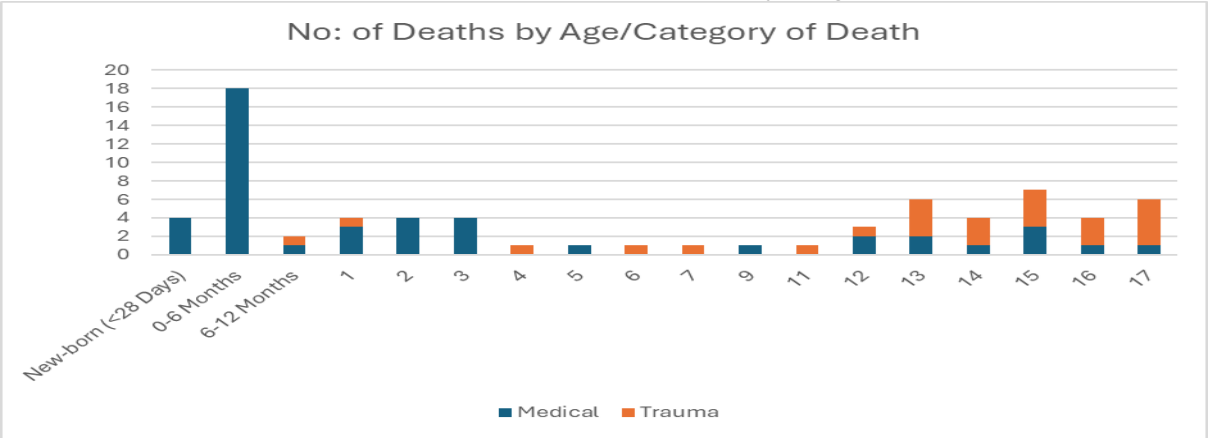
SUDC refers to the unexpected death of a child or young person aged 1 to 18 that remains unexplained after a complete investigation. Where suicide is identified as a cause of death this is not identified as SUDC. In Q1&2 there were sadly 76 child deaths.

By Area:



The chart below presents the number of deaths across age groups, categorized by presumed cause: Medical and Trauma (actual cause of death is determined following Child Death Review process and not known at point of reporting). The highest number of deaths occurred in the 0–6 months age group, with 18 medical-related cases, highlighting a critical vulnerability in early infancy.

Medical deaths are more prevalent in younger age groups, while trauma-related deaths become more prominent in older children and adolescents, particularly at ages 13, 15, and 17.



EXTERNAL ENGAGEMENT

In Q2 each Safeguarding Board/Partnership Board was formally written to by the Named Professional to share the Trust Annual Safeguarding Report and inform them of our commitment to engage with the Safeguarding Boards, and to continue good working relationships in each locality area.

NWAS engagement with system-wide, proactive safeguarding activity remains a challenge due to the large geographical area we cover. To make the most effective and equitable use of the resource within the Safeguarding Team, we are keen to work closely with our Integrated Care Boards to develop leaner ways of working and to ensure that our contributions are meaningful and proportionate.

The Safeguarding Team participates with the following panels and sub-groups:

- Child Death Overview Panel
- Rapid Response meetings
- Acute Life-Threatening Event meetings (ALTE)
- Brief Learning Reviews
- Serious Case Review groups
- Safeguarding Adults Review groups
- Domestic Homicide Reviews
- Front line visits with local board members
- Wider stakeholder meetings
- Joint Agency Review (JAR) meetings following death of a child (U18).
- Section 42 enquiry meetings.
- High Risk Patients review meetings.

Demand is dependent on activity and varies from week to week. On average it is estimated that the team participates in 20 to 30 forums weekly. As part of ongoing service evaluation, the team will audit activity during Q1 2026/27 to ascertain service demand across the whole NWAS footprint.

NATIONAL AMBULANCE SAFGUARDING GROUP

For the reporting period, the Named Professional for Safeguarding attends the National Ambulance Safeguarding Groups (NASaG). Engagement with NASaG ensures the Trust are informed of any changes to the national safeguarding policy, safeguarding standards, or regulatory framework. They liaise and work with other ambulance trusts to share and learn information. The JRCALC Child

Safeguarding module was recently updated by this group and is now live on the JRCALC app, with an adult safeguarding resource for JRCALC currently under development by the group.

SAFEGUARDING FLAG ALERTS

Safeguarding flags maybe placed by safeguarding practitioners on addresses where it has been identified that an individual who is at high risk of harm or abuse resides. Need for the flag is assessed on a case-by-case basis. Flags are placed for short periods and are reviewed regularly to ensure they are current and relevant.

Maternity alerts (more accurately described as child protection alerts) are also placed onto the Cleric system. Maternity alerts are placed upon the request of external maternity professionals, these alerts are usually placed when the unborn child is at immediate risk following birth, or if the child is to be removed at birth, and/or the mother is avoiding maternity services.

WORKPLAN FOR Q3 & Q4 2025 -2026

- The Safeguarding Team members will welcome and support the new Head of Safeguarding into their role in NWAS.
- Go live with the new Safeguarding DCIQ module.
- Continue to seek and implement IT/Cleric resolution of the 'pending' referrals.
- Continued engagement with Integrated Care Boards to streamline assurance requirements and to provide a conduit to safeguarding boards/partnership boards.
- Continue to develop easily accessible safeguarding resources for our workforce – available to all on the Green Room.
- Engage with IT, ePR and support centre to enable data to be pulled through to Cleric safeguarding and early help referrals, thus speeding up the process of data input which is an ongoing Cleric/ePR development project.
- Continue to meet the statutory demands and timed deadlines from Safeguarding Boards for case review engagement, and for section 42 (Care Act) and section 47 (Children's Act) safeguarding investigations.
- Development of safeguarding team linking with investigations staff within our Integrated Contact Centres to enable the safeguarding team to access timely and relevant information to inform statutory processes and case reviews, including detailed chronology requests.

4. RISK CONSIDERATION

- Cleric Safeguarding Referral System – Safeguarding Referrals made by NWAS being held as 'Pending' by the Cleric system and not shared with Local Authority in a timely manner - risk register (#757). Business continuity plans in place to manage this including manual oversight of referral system.

5. EQUALITY/ SUSTAINABILITY IMPACTS

The Safeguarding Power BI Dashboard provides visibility of ethnicity data recorded when NWAS staff submit safeguarding or early help referrals. Current data indicates that the largest recorded category is White British (65.3% for safeguarding referrals and 87.69% for early help referrals).

The dashboard enables regional analysis, which shows that the Greater Manchester (GM) area has a lower proportion of referrals for White British patients compared to Cheshire & Merseyside (C&M) and Cumbria & Lancashire (C&L). Further detailed analysis could offer valuable insights; however, this is currently constrained by the existing safeguarding team structure and capacity.

6. ACTION REQUIRED

- The Board is asked to consider the safeguarding activity and oversight described in this report, which contributes to assurance of NWAS's compliance with statutory safeguarding requirements.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Infection Prevention & Control Assurance Report
PRESENTED BY	Elaine Strachan-Hall – Director of Quality & Improvement
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Note the content of the report. • Note the assurances it provides. • Note the arrangements for ongoing monitoring via the IPC BAF. • Note the key risks and mitigations.
EXECUTIVE SUMMARY	This report provides a summary of activity undertaken by the Infection Prevention and Control (IPC) service for the period 1 April 2025 to 30 November 2025. Assurance regarding the delivery of IPC within the Trust is monitored through the IPC Board Assurance Framework (BAF). The BAF has been updated and has been presented to the Clinical and Quality Group in January 2026 ant the Quality & Performance Committee in February 2026. The updated framework is included with this report. The report brings together relevant assurance information and highlights the key IPC-related risks to the organisation identified during the reporting period.
PREVIOUSLY CONSIDERED BY	Clinical & Quality Group
	Date: Tuesday, 20 January 2026
	Outcome: Approved

	Quality & performance Committee	
	Date	Monday 23rd February 2026
	Outcome	Approved

1.	BACKGROUND
	The IPC report summarises activity undertaken by the Trust's Infection Prevention and Control (IPC) service during the period 1 April to 30 November 2025. This includes delivery of the Trust's Fit Testing programme, completion of IPC audits, and progress against the annual staff influenza vaccination programme. The report also provides detail on IPC incidents and near misses. Throughout the reporting period, the IPC team has remained committed to promoting best practice by adhering to national guidance and updating Trust policies and procedures in line with revised national directives. During this period, the IPC team has worked collaboratively across all healthcare services to deliver the Trust's annual organisational IPC work plan, which is reviewed on a monthly basis. Infection prevention and control is the responsibility of all staff across the Trust. The IPC team supports this through strong engagement with staff, adopting a collaborative approach and maintaining visibility across the organisation. This assurance report demonstrates current performance, highlights areas of good practice, and identifies opportunities for innovation and continuous improvement. Effective systems for the management of Infection Prevention and Control are essential across all NHS providers. The Trust has a statutory duty to comply with the Health and Social Care Act 2008, specifically the Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. The Trust's IPC approach is informed by guidance issued by the UK Health Security Agency (UKHSA) and NHS England, which remain the established national authorities for translating research evidence into NHS practice. The National Infection Prevention and Control Manual, implemented by NHS England more than two years ago, continues to be updated on a regular basis. The manual is accessible to all Trust staff and includes references to local policies where national guidance is not specific to ambulance services. The IPC team ensures that all education and training packages are updated to reflect changes to this guidance and issues regular communications, including bulletins, to support staff awareness of IPC measures and personal safety requirements. Compliance with IPC policies, procedures, and mandatory training is monitored through an ongoing programme of audits undertaken by the IPC team. Audit findings are recorded in line with national IPC guidance on Safecheck and displayed via a Power BI dashboard. These include, the availability of PPE, adherence to bare below the elbow, and the cleaning of equipment. There remains an identified risk on the risk register concerning the accuracy of IPC audits recorded within Safecheck. The risk is currently rated at 12 and is subject to monthly review. Some areas are unable to generate a fully reliable report, due to inaccuracies in the reporting of certain themes on the PowerBI dashboard, resulting in limited assurance. This risk has been discussed at the IPC Assurance Group, and the IPC team are in regular dialogue with the digital BI team on timescales for further work and fixes to the Safecheck system. The IPCT have since met with Trish Reilly (Associate Chief Information Officer) to discuss continuing issues with audit recording and accurate data from Safecheck – there is an alternative method of recording data and will develop a programme for this data to be inputted. No timeframe discussed but not anticipated to take more than a few weeks once all required audit information is made available. This risk has been escalated appropriately through to Clinical, Quality Group. Data from these audits form part of area-based reports presented to the IPC Oversight Group. Actions arising from station audits are recorded on the Trust's Integrated Action Tracker (IAT), enabling managers to monitor progress and maintain oversight of required actions.

	In addition, IPC practice is reviewed through analysis of incidents reported via the Trust's incident management system, Datix Cloud IQ (DCIQ). Incident themes, alongside audit findings, are used to inform intelligence on areas requiring system improvement, targeted training, or the strengthening of risk management controls. In the period for the report 140 IPC incidents were report, 52 relating to exposure of notifiable diseases, 72 relating to sharps injuries/incorrect disposal of sharps, 2 relating to waste disposal, 2 relating to PPE availability and 12 relating to vehicle or premises cleanliness.
2.	**IPC BAF**
	The IPC Board Assurance Framework (BAF) has been revised in line with the Code of Practice on the prevention and control of infections issued under the Health and Social Care Act 2008 (H&SCA 2008). The Act establishes the overall framework for the regulation of health and adult social care activities by the Care Quality Commission (CQC). The Code was reviewed and republished in December 2022 to reflect learning from the pandemic and the transition away from the IPC specific 'COVID' BAFs that were in place during that period. Part 2 of the Code sets out the ten criteria against which the CQC assesses how registered providers comply with infection prevention and control requirements, including cleanliness. These criteria are reflected within the IPC BAF. To ensure that consistently high standards of IPC are developed and sustained, providers are required to consider the Code in its entirety and apply it appropriately to their sector, rather than focusing on selected elements only. A number of criteria have been identified as 'Not Applicable' for ambulance services, specifically those relating to antimicrobial stewardship, inpatient isolation facilities, and access to pathology services. Assurance is provided through the submission of evidence against each applicable criterion, together with clearly defined mitigating actions where criteria are not yet fully met. The IPC BAF has been updated during the current reporting period and will be presented to the Clinical and Quality Group alongside this assurance report. At the time of reporting, the Trust has no red rated areas and six amber rated areas. Identified gaps in control are clearly articulated within the framework, together with agreed actions and timescales for improvement. The IPC BAF will be formally reviewed on a six-monthly basis, through the IPC Oversight Group, or more frequently where required in response to changes in national guidance or local circumstances. The IPC BAF was last reviewed in June 2025.
3.	**RISK CONSIDERATION**
	Infection Prevention and Control (IPC) is a statutory requirement placed on NHS Trusts. This assurance report supports good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance. During 2025, IPC risks have been aligned, managed and monitored through the IPC Board Assurance Framework (BAF) and discussed at the IPC Working Group. The BAF enables monitoring of Trust performance against key healthcare criteria and provides structured evidence and assurance regarding the management of identified risks. Risks are continually reviewed, re assessed and, where appropriate, escalated to the organisational risk register. The Trust Management Committee (TMC) provides oversight of organisational management of the BAF. Since the previous report, two risks have been closed, and one new risk has been opened.

	There are currently four risks recorded on Datix Cloud IQ (DCIQ) which align to IPC: **Risk 697 (Score: 10)** There is a risk that, due to staff not undertaking inspections of personal issue Sundström hoods or required servicing not being completed, the Trust will not be compliant with Control of Substances Hazardous to Health (COSHH) legislation. **Risk 698 (Score: 6)** There is a risk that, due to staff not carrying out visual inspections of their personal issue Sundström hoods, or where servicing has not been undertaken, essential respiratory protective equipment will not be available or provide effective protection, resulting in staff exposure to hazardous environments. In line with COSHH legislation, staff are required to undertake monthly inspections of their Sundström hood. At present, there has been limited assurance that these checks are being completed consistently. Staff seemed to be unaware that monthly inspections should be completed and so a training package has been developed by the IPC Team to support staff in completing and recording checks correctly. This package is currently being adapted for upload onto ESR, subject to approval at the Mandatory Training Oversight Group. A question has also been added to Safecheck for staff to complete to record the monthly inspection. **Risk 713 (Score: 9)** Update March 2026 – this risk has now been closed There is a risk that, due to emerging infectious diseases and changes to national guidance, staff may not be aware of the appropriate Personal Protective Equipment (PPE) required to protect themselves and patients and to prevent onward transmission of infection. The IPC Team continues to work closely with Communications and Operational Leads to ensure frontline staff are informed on the correct selection, donning and doffing of PPE. Training packages are reviewed and updated regularly and are incorporated into mandatory training programmes. However, despite these interventions, this risk remains at a 9 but is reviewed regularly. **Risk 756 (Score: 12)** There is a risk that, due to inaccuracies within the Safecheck audit tool, the IPC Team is unable to gain adequate assurance on compliance with IPC policies and procedures, potentially resulting in unsafe environments for patients and staff. It is unlikely that the issue is to be resolved in the near future so the team will be working with the appropriate stakeholders to propose an interim way forward. Following a recent system update, a number of data anomalies have been identified within Power BI outputs, which has impacted the ability to provide assurance through the IPC Oversight Group. This issue has been formally escalated to the Clinical and Quality Group.
4.	**POLICIES AND PROCEDURES**
	The Infection Prevention and Control Specialist Lead attends the National Ambulance Service Infection Prevention and Control Leads Group (NASIPCG) and contributes to AACE guidance prior to formal approval. The Specialist Lead also attends the NHS England North West Regional IPC meeting, alongside IPC leads from other healthcare organisations. AACE position statements support local implementation of IPC guidance. During the reporting period, AACE published a position statement relating to IPC precautions during hospital handover delays.

	Policies are reviewed and updated in response to changes in national guidance and local governance arrangements. During this period, the A-Z of Communicable Diseases guidance has been updated and made available to staff via the Green Room. This includes the High Consequence Infectious Diseases (HCID) pathway for the North West, developed collaboratively with the Trust's Resilience Team and external partners including UKHSA and regional Infectious Diseases Units. Compliance with policies, procedures and training is monitored through audits undertaken locally by operational managers and IPC specialist practitioners. Audit assurance is presented by each area to the IPC Oversight Group. The IPC Team also contributes to Quality Assurance Visits (QAVs), where monitoring of IPC compliance forms a key element of the review.
5.	**IPC OVERSIGHT GROUP**
	The IPC Oversight Group is chaired by the Director of Infection Prevention and Control (DIPC) and meets on a quarterly basis to ensure ongoing regulatory compliance. Updated Terms of Reference have been developed and approved. At each meeting, IPC risks are reviewed alongside newly published guidance and corresponding actions required to maintain compliance. The group is attended by representatives from UK Health Security Agency (UKHSA) and Occupational Health, who provide updates on community infection prevalence. Staff-side representatives are also invited to attend. Members are consulted on new policies and BAF updates prior to formal approval at Committee. Each area submits an assurance report to the Oversight Group to support oversight and challenge.
6.	**NATIONAL STANDARDS OF HEALTHCARE CLEANLINESS**
	An updated version of the National Standards of Healthcare Cleanliness was published in February 2025, marking the first inclusion of ambulance service trusts. The Trust's Head of Facilities Management and Facilities Management Regional Officer contributed to the development of these standards as members of the national working group. Trusts have been given 12 months by NHS England to implement the standards. Facilities Management has implemented the standards across premises cleaning. The National Ambulance Service IPC Group raised concerns with NHS England regarding a lack of clarity on the frequency of vehicle audits and subsequently developed a national position statement. The IPC Specialist Lead is working closely with the Fleet Logistics Manager, who oversees the vehicle deep-cleaning contract, to ensure the standards are implemented appropriately. Despite the standards not yet being in place for 12 months, they are already subject to further review. NHS England has established working groups to ensure the standards are fit for purpose. The IPC Specialist Lead for NWAS has been invited to contribute to both the research working group and the ambulance-specific working group. The IPCT and the facilities team continue to monitor cleanliness standards by completing premises and vehicle audits. The IPC Specialist Lead attends the monthly contract meetings with the third-party provider for the vehicle deep cleans.
7.	**IPC AUDITS**
	The IPC Team continues to work with Digital Services, including Safecheck and Power BI, to improve IPC audit systems and dashboards. These developments enable service areas to record

	audit activity and monitor progress in real time. The Integrated Contact Centres are now also able to record audits via Safecheck. However, following a recent Safecheck system update, data anomalies have been identified within Power BI outputs. These issues have been reported but remain unresolved, preventing reliable Trust-wide assurance reporting to the IPC Oversight Group. Audits continue locally to address non-compliance, but consolidated Trust-level reporting is currently unavailable. Work to resolve these issues is ongoing. **Outbreak Management** Arrangements remain in place to support staff safety across all NWAS workplaces. Safety stations, including surgical masks, wipes and alcohol gel, are available at entrances to all sites. Staff are reminded of the importance of regular hand hygiene and workstation cleaning. Compliance is monitored through routine IPC audits. The IPC Team works closely with UKHSA and local councils to manage outbreaks in external care settings, including residential and nursing homes. Notifications are received via the IPC inbox and shared with the Address Base Team and PTS managers, who apply address alerts for crews attending affected locations. Alerts are reviewed regularly and removed once outbreaks are closed. In April 2025, one confirmed norovirus outbreak occurred within the organisation, affecting four staff members. This was managed through timely advice, operational liaison and proportionate control measures. During December, there was a significant increase in respiratory infections, particularly influenza, resulting in increased hospital admissions and ward-based outbreaks. In response, some acute trusts introduced mandatory mask-wearing in emergency and assessment areas. Where implemented, this information was cascaded to crews attending those locations.
8.	**FACE FIT TESTING (Current Fit Testing Compliance is 91% for Operational staff – March 2026)**
	The Trust maintains a dedicated Respiratory Protective Equipment (RPE) fit testing team, operating across Cumbria & Lancashire, Cheshire & Merseyside, and Greater Manchester. The team supports compliance by delivering fit testing, providing advice on appropriate RPE selection, and advising on retesting requirements. Fit testing compliance is centrally recorded on MyESR, providing Trust-wide oversight of staff compliance and mask type compatibility. Frontline staff are required to undertake fit testing every two years, or sooner where significant facial changes occur. Compliance data is reviewed at the IPC Working Group, chaired by the Assistant Director of Nursing and Quality / DIPC. The RPE team works closely with Operations to target areas with lower compliance and prioritise staff. As of 15 December 2025, Trust-wide fit testing compliance stands at 89.9%, representing the highest level achieved since the programme commenced. To support timely re-testing, staff are contacted when tests are due to expire. IPC Practitioners and the Clinical Education Practitioner (CEP) team are also trained as fit testers and support new starters, transferees and PTS staff during induction.

Cumbria & Lancashire 93.5% compliance

Work Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon	% Complete		
Operations PES	Cumbria & Lancashire	1364	1111	138	1249	87	1336	93.5%	83.2%		
Operations PES	CAL - East Lancs	316	274	31	305	8	313	97.4%	87.5%		
Operations PES	CAL - Fylde	207	168	27	195	10	205	95.1%	82.0%		
Operations PES	CAL - Morecambe	263	215	22	237	22	259	91.5%	83.0%		
Operations PES	CAL - North Cumbria	264	198	21	219	32	251	87.3%	78.9%		
Operations PES	CAL - South Lancs	285	238	33	271	10	281	96.4%	84.7%		
Operations PES	CAL - Service Delivery	29	18	4	22	5	27	81.5%	66.7%		

Greater Manchester 89.1% compliance

Work Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon	% Complete		
Operations PES	Greater Manchester	1492	1220	93	1313	160	1473	89.1%	82.8%		
Operations PES	GM - Central	367	320	12	332	31	363	91.5%	88.2%		
Operations PES	GM - East	325	247	37	284	39	323	87.9%	76.5%		
Operations PES	GM - South	432	361	21	382	47	429	89.0%	84.1%		
Operations PES	GM - West	337	275	21	296	36	332	89.2%	82.8%		
Operations PES	GM - Service Delivery	31	17	2	19	7	26	73.1%	65.4%		

Cheshire & Merseyside 94.9% compliance

Cheshire & Merseyside 94.9% compliance Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon	% Complete		
Operations PES	Cheshire & Mersey	1448	1218	138	1356	73	1429	94.9%	85.2%		
Operations PES	CAM - East	343	284	48	332	7	339	97.9%	83.8%		
Operations PES	CAM - North	508	448	31	479	25	504	95.0%	88.9%		
Operations PES	CAM - South	278	218	41	259	17	276	93.8%	79.0%		
Operations PES	CAM - West	288	249	15	264	19	283	93.3%	88.0%		
Operations PES	CAM - Service Delivery	31	19	3	22	5	27	81.5%	70.4%		

9. RESPIRATORY HOODS

The Trust continues to issue powered respiratory hoods as personal issue RPE to all operational patient-facing staff. The equipment used is the Sundström SR520 Hood with SR700 Fan Unit.

Operational compliance audits are undertaken three times per year by Senior Paramedics during clinical contact shifts. Audits confirm whether staff are fit-tested or carrying their hood where required.

Although fit testing is not required for powered hoods, staff receive training on safe use and maintenance. The IPC Team continues to work to ensure servicing compliance and adherence to COSHH legislation.

10. STAFF FLU CAMPAIGN

The IPC Team led the annual flu vaccination campaign for 2025/26. Planning commenced in April following evaluation of the previous campaign. Low-uptake cohorts were identified in partnership with HR, particularly BAME staff and younger staff, and targeted engagement plans were implemented.

The staff flu vaccinating commenced on the 1 October 2025 and flu vaccines are to be offered until the 31 March 2026. NHS England set all healthcare organisations a target of a 5% increase in flu vaccination uptake amongst frontline healthcare staff which is a significant challenge. Trusts are also being asked to try to complete their flu campaign by the end of November so that staff are protected for the Christmas period.

Over 120 vaccinators were trained ahead of vaccine delivery. Flu vaccination commenced on 1 October 2025 and will continue until 31 March 2026. By 30 November, 3,313 vaccinations had been administered. 2,806 staff declined the vaccination. Uptake stands at 40% of all staff and 43% of frontline staff.

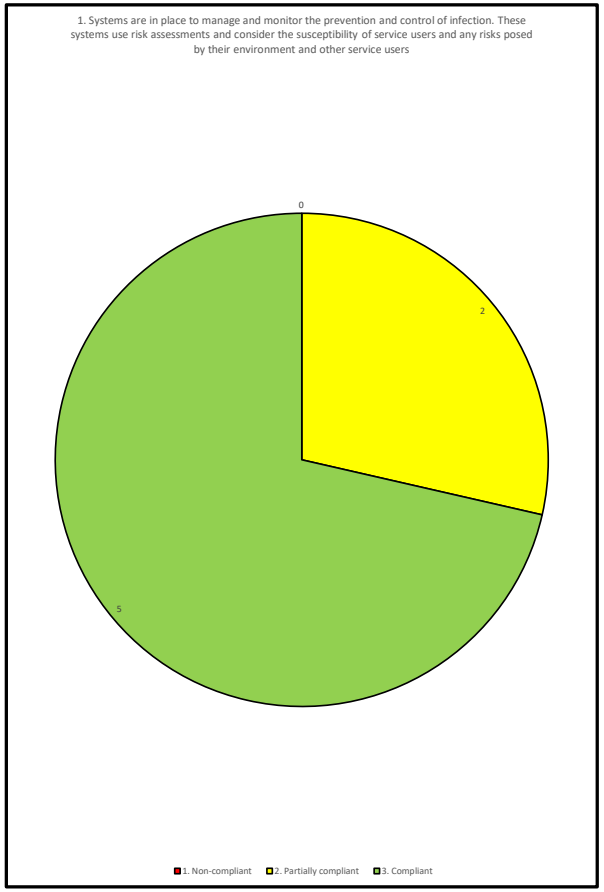
An evaluation session has been planned for March 2026 to identify any areas for improvement for the forthcoming campaign.

11.	**NEW BUILDS AND REFURBISHMENT**
	The IPC team work closely with facilities management and estates to ensure that any new build or refurbishments are compliant with IPC standards. The Head of Estates and the Head of Facilities Management are both key members of the IPC Oversight Group to ensure there is assurance provided around premises cleanliness and building work at the meeting.
12.	**COMMUNICATIONS**
	The IPCT continue to work closely with the communications team to try and ensure effective messaging for staff should any updated guidance be published and to improve access for staff to IPC resources on the Green Room. The team are also working with the Safecheck team to get up to date IPC information on the Hubara boards available on all stations.
13.	**TRAINING**
	The IPC Team continues to work closely with the Mandatory Training Team to ensure all clinical staff complete the required IPC training. Learning themes identified through DCIQ incidents are fed back into training content to strengthen staff awareness and promote safer practice. IPC also delivers an IPC presentation as part of the corporate induction programme for all new starters. This training is aligned to the UK Core Skills Training Framework (CSTF) at Level 1 and Level 2, ensuring consistency with national standards from the outset. Over the last six months, training and communications have focused on reducing preventable risks, including sharps injuries, exposure to high-consequence infectious diseases, and the correct selection and use of PPE in different clinical scenarios. There has also been targeted IPC input to support changes in clinical waste management, with guidance provided on safe bag handling and securing waste correctly to maintain compliance and reduce audit failures.
14.	**IPC GUARDIANS**
	The IPC Guardians network continues to provide a vital link between the IPC Team and staff across the organisation. Guardians act as local IPC champions, supporting good practice, reinforcing key messages and raising concerns within their teams. The network includes both frontline operational staff and colleagues within corporate and support services, helping to identify issues early and promote consistent IPC standards across all areas. Guardians are supported through a monthly IPC Guardians bulletin, which shares updates on current risks, learning from incidents and outbreaks, and reminders of key IPC priorities. Guardians also have access to a dedicated IPC report form, allowing them to raise concerns, request support and highlight issues requiring review by the IPC Team
15.	**EQUALITY/ SUSTAINABILITY IMPACTS**
	There are no equality or sustainability impacts.
16.	**ACTION REQUIRED**

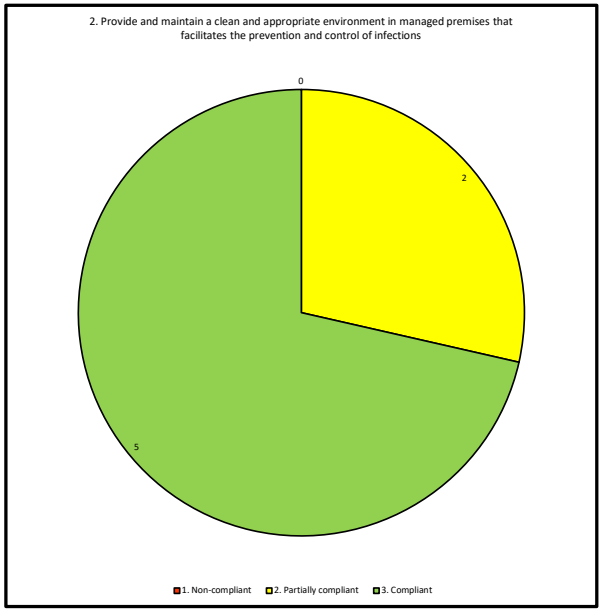
	The Board of Directors is asked to: • Note the content of the report. • Note the assurances it provides. • Note the arrangements for ongoing monitoring via the IPC BAF. • Note the key risks and mitigations.

Infection Prevention and Control board assurance framework v4.0

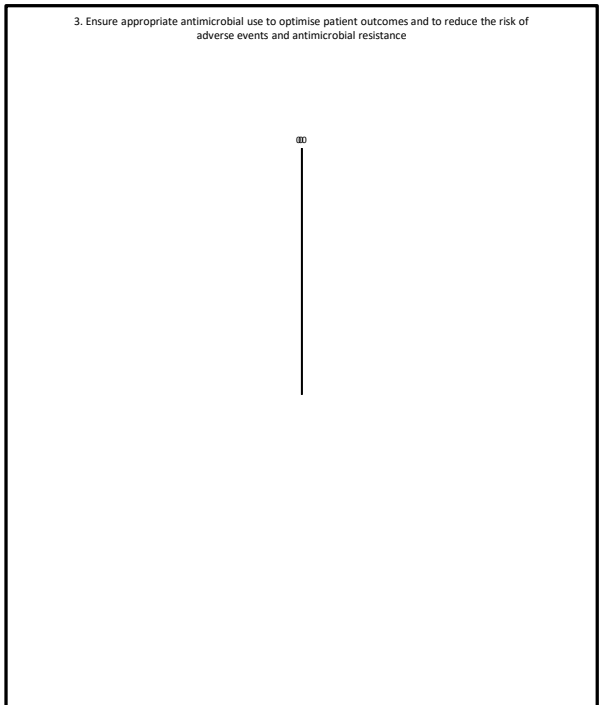
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	DIPC (Assistant Director of Quality and Nursing), bi-monthly IP Oversight Group reporting to Clinical & Quality Group, IPC Specialist Lead in post,IPC practitioners, IPC policy reviewed and updated in line with national guidance, functioning IPCT. Annual IPC report presented to and approved by Board. IPC task & finish groups developed from gaps in assurance report to IPC Oversight Group.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Staff infections reported through OH. Outbreaks reported to IPCT (various sources - Carlisle Support centre/direct from Managers/HR reports). IPCT responsible for managing outbreaks and reporting, as required, to NHSE. Safety stations remain in place at entrance to all buildings. Work with partners if any patient infections as part of a PIR. OH & UKHSA providing reports to bi-monthly IPC Oversight Group.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Incident reporting widely promoted at NWAS. IPC incidents form part of area assurance reports that are presented at IPC Oversight Group. Key themes analysed by IPCT and any necessary mitigating actions are put in place. . FTSU guardian widely promoted in the Trust. IPC present at Area learning forums. Lessons learned from incidents incorporated into IPC training and comms bulletins. Some joint audits being completed now with H+S. Developing links with patient safety with respect to IPC & PSIRF. IPC have regular slot to present key themes at RCLIG meeting.				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	IPC station completed 12 monthly by practitioners to capture adherence to NIPCM. Target of 10 vehicle audits per month per area. Ops managers carry out monthly audits. HH and clinical practice monitored on contact shifts. Deep Clean Audits completed with private provider. IPCT attend Quality Assurance Visits. All audits inputted onto safecheck & presented on dashboard. Link to NWAS policies & procedures are included in IPC manual.	Unable to provide complete assurance due to data anomalies within the Safecheck/Power BI systems. Scoring as a 12 on the risk register. Update on progress on fixing the issue due at end of January 2026	Audits continue to take place and any issues directly escated to Ops staff		2. Partially compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.					0. Not applicable
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	IPC station completed 12 monthly by practitioners to capture adherence to NIPCM. Target of 10 vehicle audits per month per area. Ops managers carry out monthly audits. HH and clinical practice monitored on contact shifts. All audits inputted onto safecheck & presented on dashboard. Link to NWAS policies & procedures are included in IPC manual. Face Fit Testers ensure compliance with health & safety executive for face fit testing. Assurance presented by areas at the IPC Oversight Group.	Unable to provide complete assurance due to data anomalies within the Safecheck/Power BI systems. Scoring as a 12 on the risk register. Update on progress on fixing the issue due at end of January 2026	Audits continue to take place and any issues directly escated to Ops staff		2. Partially compliant



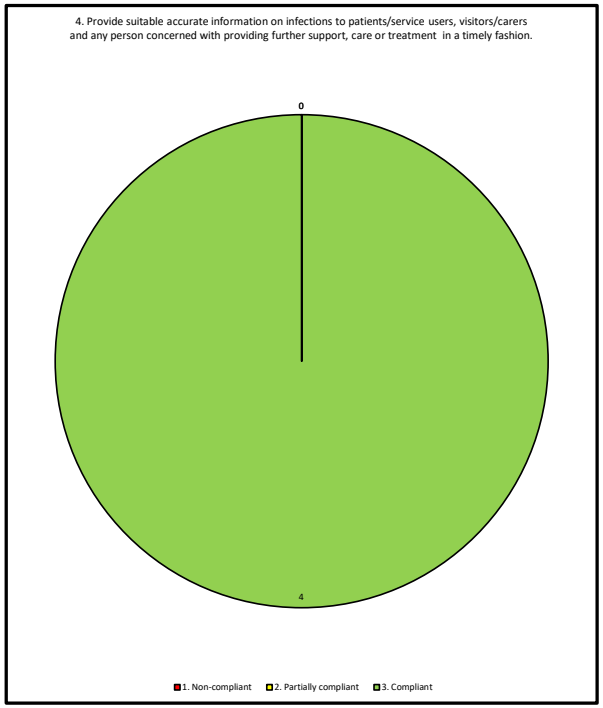
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All Trust staff, including those employed via temporary staffing and contractors receive IPC induction. All clinical staff require annual IPC training, non-clinical staff have bi-annual training. IPCT are also available to provide ad-hoc training as required. All training packages are updated annually or as required with changes in guidance to reflect best practice. The IPCT has its own Trust intranet/public facing webpage where staff can access information, policies, leaflets, hand decontamination posters, and other helpful resources.				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Staff can contact IPC during office hours via email, teams or mobile numbers. Outside of these hours staff can contact their managers/ operational managers for IPC support. ONcall tactical advisors are also available to provide necessary IPC guidance. ICC have access to A-Z of communicable diseases which has recently been updated in line with national guidance. Advacnced paramedics are contactable out of hours for advice. Policies, procedures and guidance are on the Green Room page which all trust staff have access to.				3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	National Standards of cleanliness published in Feb 25..Section specific to ambulance service. Cleanliness is monitored and audited with locally agreed protocols and via IPC audits. NWAS have a cleaning contractor who is monitored by the facilities manager. Audits are carried out by the contractor, NWAS staff and IPC team for assurance of standards on stations. IPC are involved in any contract tenders related to station/vehicle cleaning.	Trust compliant with most of the standards for premises- need to display a 'Commitment to Cleanliness' charter in all Trust premises - due for completion Feb 2026. IPC Specialist Lead working with Fleet Logistics Manager to ensure vehicle cleaning is also in line with the standards.	Charter in process of being printed and placed at all premises- will be completed by 31.1.26		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.					0. Not applicable
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Policies and procedures are in place to inform staff of responsibilities in relation to cleaning and decontamination. National and being applied to NWAS.Reusable equipment is cleaned after patient use Vehicle audits provide evidence of cleaning - these are reported though the IPC SC. IPC do unannounced audits on the 6 weeekly deep clean of vehicles completed by a private provider.	Difficulty completing required number of audits after deep clean due to operational demands. In process of working with private provider to complete joint audits post deep clean.	Fit Testers trained to complete audits - have more opportunity to complete audits as based on stations daily		2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Water Safety Group meets every 6 months and provides assurance to the health,safety and security sub committee via the Estates, Fleet + Facilities management health, safety and security committee. Ventialtion testing is carried ut in line with national guidance. The Water Safety Group receives reports of anomolies of any water testing carried out at NWAS sites completed by the contractor. Policies and procedures are in place in relation to water safety and ventilation systems.				3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	IPCT are involved from the planning stage of new builds and refurbishments. IPCT are invited to meetings and site walkabouts throughout the refurbishment period and IPC have to sign off works prior to staff working from the premises.				3. Compliant



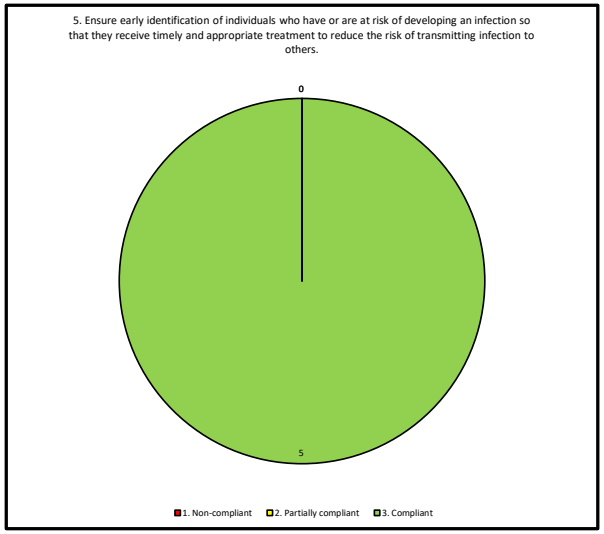
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Minimal linen is stored on vehicles, used linen is disposed of at hospital sites when conveying a patient. Linen which is on the vehicle at the time of service/ scheduled deep clean is removed, bagged and put into carts to be disposed of by local agreement at a local trust. Linen policy has been reviewed.				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Policies and procedures are in place in line with national guidance. Waste management overseen by facilities. IPC monitor compliance through audit. Correct waste disposal is included in all teaching sesssions and resources are also available on the Green Room.Waste collection carried out by a private contractor. Waste contract recentlly been up for tender (October 2025) - IPC involved in tender process.				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	All reusable equipment is decontaminated between use. Any surgical instruments are single use. Decontamination certificates are used when equipment sent for servicing/repair.				3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.					0. Not applicable
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	No antibiotics are prescribed - administered under PGD and in line with JRCALC. Only 2 antibiotics are used within the Trust. They are for emergency use and are a one off dose. Paramedics follow PGD for antibiotic use. AMS lead is in the DIPC role supported by the Chief Pharmacist	N/A	N/A	N/A	0. Not applicable
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	PGD compliance monitoring as part of audit plan - reported into Medicines Optimisation Group which feeds into Clinical Effecftiveness Sub Committee. Audit includes frequency of administration, if compliant with guidance & any related incidents.	N/A	N/A	N/A	0. Not applicable
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	Director of quality, innovation and improvement - delegates responsibility to the DIPC	NA	NA	NA	0. Not applicable
3.4	To optimise patient outcomes and minimise inappropriate prescribing: • Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' • Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. • Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.					0. Not applicable

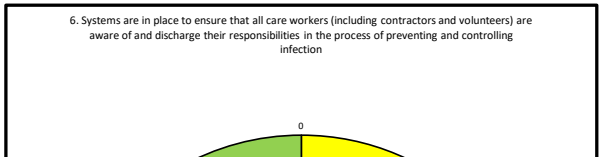


3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.					0. Not applicable
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)					0. Not applicable
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Service user input for the trust is obtained from the engagement team. All information which is in the public domain on the Trust website/ available to the public is checked by comms. Staff have access to language line to promote communication with patients. Information about minimising risk of infection for patients (PPE etc) is available on vehicles. Engaged with religious partners via EDI team with respect to PPE/RPE. Representative from UKHSA attends IPC Oversight Group to present local demographic reports for infectious diseases. Patient representative working with IPCT on Improvement academy project				3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Service user input for the trust is obtained from the engagement team. All information which is in the public domain on the Trust website/ available to the public will be checked by comms. Staff have access to language line to promote communication with patients. Information about minimising risk of infection. Posters displayed if outbreak on any site to inform visitors for patients (PPE etc) is available on vehicles. Safety stations remain in place at all Trust premises where staff have access to hand gel and face masks as required.				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	All information which is on Trust website is reviewed regularly and updated in line with local and national guidelines. Information is available digitally.				3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Patients and escorts will be asked to wear a mask if it has been risk assessed it is appropriate to do so by the crew or if local/national guidance states so. Outbreak management is undertaken by the IPC team in liaison with ops managers, risk assessments to be carried out to identify necessary actions and implement mitigations - information to be communicated to relevant staff within NWAS. vaccination programme is co ordianted by occupational health. Flu Vaccinations offered to staff - other necessary vaccinations provided by OH. Hand hygiene wipes available on vehicles. New national guidance on emerging infectious diseases cascaded to staff via different communications channels. Patients utilising PTS will be risk assessed for any infection on booking transport				3. Compliant

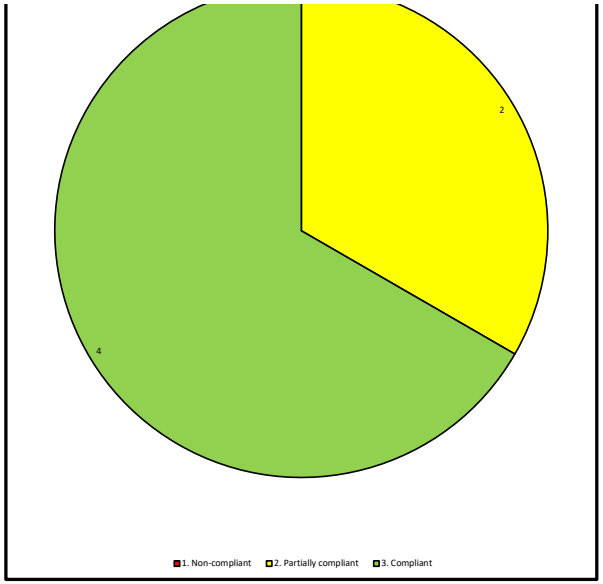


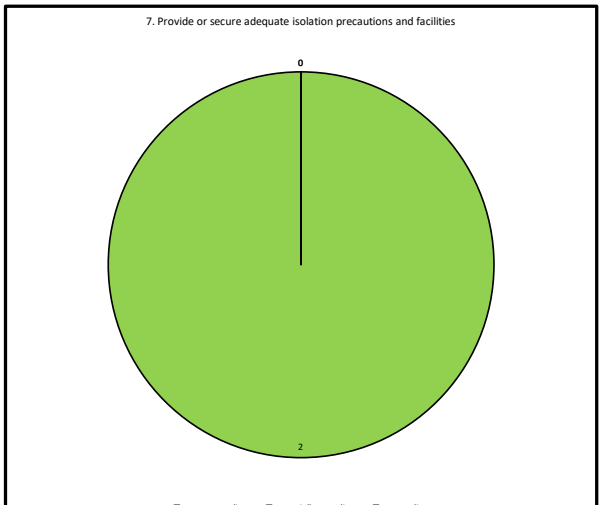
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	NWAS rely on information from patient/person reporting incident and also accurate handover for transfers from hospital staff when conveying a patient in terms of infection status. PTS have booking system available which will assess risk of infection status and also identify those patients at risk of infection. Infectious status (if known) would be recorded on PRF.	Invasive device passports not always used/ used in all trusts. Infectious status of the patient not always communicated	Staff are aware of implementation of SICPS and how to risk assess for appropriate PPE and decontamination. This is also on mandatory training and e learning packages		0. Not applicable
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	NWAS do not have any inpatient areas. Staff are aware of IPC measures to put in place to reduce the risk of picking up an infection from a patient. Crews will alert receiving ED/ID unit to ensure patient is placed in an approriate facility to minimise risk of onward transmission.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.	Crews will identify if patient potentially has infection and will pass this information on to receiving care facility to ensure patient is cared for in an environment that minimisies risk of onward transmission of infection. Vehicles are cleaned after use as per policy.				3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Crews will inform receiving department if infectious status known & will be documented on PRF.				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	NWAS do not have any settings where patients are in-situ. Safety stations (masks, wipes & alcohol hand gel) remain in place at the entrance to all buidings.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	NWAS outbreak policy identifes 2 or more staff will trigger an outbreak - these are reported externally to NHSE. Outbreaks are investigated by the IPCT and managers, extra IPC measures are implemented in the setting. Outbreaks are reported monthly to TMC and also to IPC Oversight group. Safety stations remain in place at entrance to all NWAS premises. managers are aware to inform IPCT of any suspected outbreaks amongst staff.				3. Compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	All training reviewed annually and updated and is in line with the National IPCM. Staff responsibilities documented in the IPC policy. Any new national guidance in incorporated into training packages.				3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Training needs analysis completed by the Education Department to ensure staff receive appropriate training for their role. Staff responsibilities documented in the IPC policy.				3. Compliant



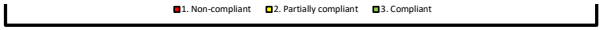


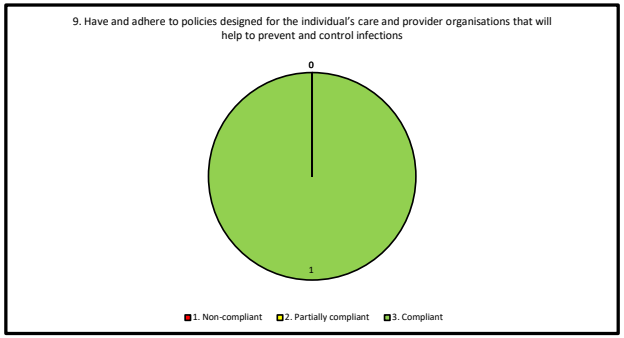
6.3	Monitoring compliance and update IPC training programs as required.	IPC training programmes are reviewed regularly and are updated with any changes in national guidance. Compliance with Mandatory Training is monitored closely by the Education Department. IPC monitor MT compliance as part of assurance reports presented at IPC Oversight group.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	All covered in mandatory training. Resources also available on the Green Room - this includes flow charts and videos showing staff how to correctly don + Doff PPE. Training videos on use of RPE and all new starters on their induction are shown how to use the equipment correctly.				3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff are fit tested to 2 masks as per requirements. Quantitative fit testing method being used within NWAS in line with health & safety executive guidance. All staff are also provided with a respiratory powered hood on commencing with NWAS. Training is delivered on how to use the hood correctly. Fit testing recorded centrally on ESR. Fit testers have now been in post since September 2023 & overall fit testing compliance is at 90.5% for operational staff in the Trust	Not all power units are being serviced as per manufactureres guidance.	IPCT liaising with fleet to ensure that powered motor units are being serviced as per manufacturers recommendations service intervals have been amended and list of serviced motor units is available from oxylitre. Reliant on staff to make motor units available for servicing to take place		2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	NWAS staff are trained in aseptic technique and medical device insertion whilst in training at University. Staff are monitored for clinical competencies during contact shifts. Policies in place to support aseptice technique.	No further aseptic technique competency checking completed.	Included in IPC annual workplan to roll out ANTT training. Resources have been developed and to discuss with ops staff as to how this can be delivered effectively.		2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking which will determine how they are transported. PPE available for both staff and patients on vehicles.				3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID				0. Not applicable
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Staff are trained in line with the national IPC manual and will wear appropriate PPE/put in place IPC measures. PTS also risk assess patients when booking . Signage N/A.				3. Compliant



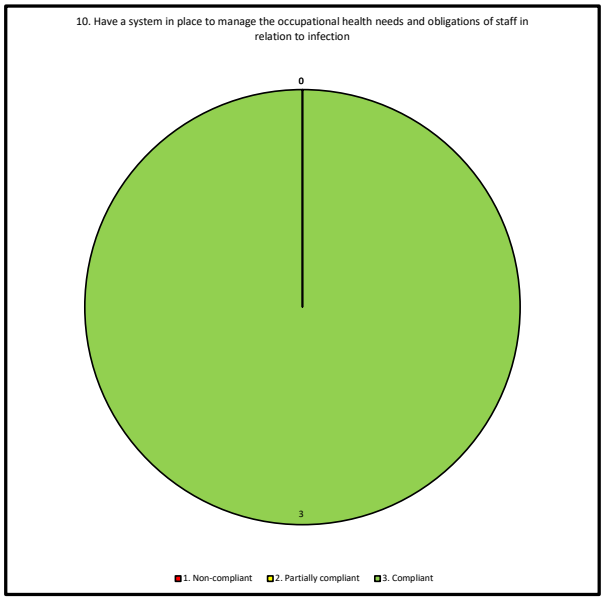


7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have a transmissable infection to ensure that patients are able to be suitably placed. This will also be documented on the PRF. PTS carry out risk assesments on patients when booking transport and will transport patienst on their own if necessary. HART have access to epishuttle for transfer of patients with HCID				0. Not applicable
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	N/A NWAS do have access to a microbiologist if required via OH. OH also able to advise for staff with infections. IPCT work closely wwith UKHSA & health protection teams as necessary for contact tracing and any necessary prophylactic treatment of staff	N/A	N/A	N/A	0. Not applicable
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	N/A	N/A	N/A	N/A	0. Not applicable
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	N/A	N/A	N/A	N/A	0. Not applicable
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	N/A	N/A	N/A	N/A	0. Not applicable
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	N/A	N/A	N/A	N/A	0. Not applicable
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	N/A	N/A	N/A	N/A	0. Not applicable
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	N/A	N/A	N/A	N/A	0. Not applicable
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this process.	Training provided to all staff in line with the national IPC manual. IPC resources are available on the Trust intranet site. Staff can readily contact IPC for advice via phone, email or microsoft teams. Policies are in place and accessible on the intranet site. Safety stations remain in place at all sites, signage and the implementation of IPC measures available in event of an outbreak. Spcific outbreak policy in place. Outbreak reporting to NHSE is in place as required and all outbreaks are internally monitored by the IPCT and reported to the IPC Oversight group. Communcations sent out via bulletins to inform staff of any local outbreaks.				3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						





10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Staff are referred to OH and are also risk assessed by their line mananger to ensure are not put at risk in the workplace. Risk assessment in place for staff who are pregnant. Managers responsibility to complete risk assessments. Alternative duties available for staff at risk				3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Staff are referred to OH and are also risk assessed by their line mananger to ensure are not put at risk in the workplace. Risk assessment in place for staff who are pregnant. Managers responsibility to complete risk assessments. Alternative duties available for staff at risk				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	This is completed by OH pre employment and as necessary dependant on risk assessment. GP's also provide some vaccinations. Vaccinations are recorded on RAVS. IPC liaised closely with new OH provider to ensure have an up to date record of vaccinations. Discussions held over whooping cough and measles vaccine in light of national outbreak & agreement made in terms of priority group for NWAS staff.				3. Compliant



NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	EPRR Annual Assurance and Actions
PRESENTED BY	Dan Ainsworth, Director of Operations
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board of Directors is asked to: • Be assured that the submission to the ICB and NHS England was on time, accepted, and shown as substantially compliant with the Core Standards. • Be advised that the process for assurance for 2026 is underway. • Review how information regarding EPRR is provided to the Board (Core Standard 3). • Review options for BC audit (Core Standard 51).
EXECUTIVE SUMMARY	The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from adverse weather conditions, an infectious disease outbreak, a major transport accident, a cyber-security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. The NHS England Annual Assurance Core Standard 3 states that '*The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually.* *The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements'*

	This report sets out the background to the self-assessment process, previous and current positions with rationale and actions, and a description of the plans NHS England have to refresh the process going forward. **ASSURE** NWAS submitted substantially compliant in both the Core and Interoperability Standards. This was accepted by the ICB and NHS England. This is consistent with the other trusts in the Northern Ambulance Alliance. **ADVISE** Plans are in place to address most of the standards currently at 'partial' and keep the remaining standards in 'full' compliance with improvement in quality. These are being done in conjunction with the DSPT and MIAA outstanding actions to ensure a holistic approach.	
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	Monday, 23 February 2026
	Outcome	Noted

1. BACKGROUND

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

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

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

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

The NHS Core Standards cover 10 core domains applicable to all NHS services. PTS and NHS 111 are subsets of the Ambulance Provider standard list, NWAS have agreement from NHS England that they do not have to be submitted separately.

The NHS Core Standards for EPRR cover 10 core domains:

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

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

The Interoperable Capabilities section contains:

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

As part of the self-assessment NHS England define an area for a *'Deep Dive'* to be performed. The *deep dive* does not contribute to the overall organisational EPRR assurance rating. There was no requirement to undertake a *deep dive* in the 2025 submission. The 2024 EPRR annual deep dive focused on cyber resilience.

The submission process with the providers, ICB and NHS England is shown in appendix 1. Definitions for compliance levels are in appendix 2. Submission details are shown in appendix 3.

The Trust position is reported quarterly into EPRR Group, annually to the Board as per Core Standard 3.

This table (1) shows the position in 2024 and 2025.

Table 1 - NWAS core standards submission 2024 and 2025

Focus	2024			2025	
Ambulance provider	**90%**	Substantially compliant		**93%**	Substantially compliant
Interoperability	**94%**	Substantially compliant		**90%**	Substantially compliant

The outcomes have been presented to all ICBs, submission to the commissioning area LHRP was presented by our Executive Director of Operations. Lancashire and South Cumbria ICB have presented to NHS England and received no challenges for NWAS.

The EPRR teams in the Northern Ambulance Alliance meet approximately quarterly to discuss elements of the Core Standards. The ICBs are invited to the final meeting so they can gain support from each other in terms of how to assess ambulance services. Yorkshire Ambulance Service (YAS) and North East Ambulance Service (NEAS) both submitted 93% and were accepted by the ICBs. The amount of check and challenge varied across the areas.

2. CORE STANDARDS PROCESS 2026

The EPRR Core Standards will be supplied in July 2026 are expected to be the same as the previous 3 years. They are currently under national review but have not been provided for consultation or initial assessment.

NWAS Head of Contingency Planning and ICB Head of EPRR (commissioners) have met to discuss how to move forward with manageable assessment on an ongoing basis. They will meet once a quarter to review some of the standards and agree them in batches. This will give time for amendments or reconsideration of process.

3. EPRR CORE STANDARDS – POINTS OF NOTE

EPRR Core standard 3 requires the AEO to discharge their responsibility to provide EPRR reports to the Board no less than annually. This was noted by the ICB as having room for improvement in the 2025 submission. Through public Board minutes, the organisation should publicly state its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements.

As a minimum they should include an overview on:

- training and exercises undertaken by the organisation
- summary of incidents (BC, critical, major) experienced by the organisation
- lessons identified and learning undertaken from incidents and exercises
- compliance in relation to the annual assurance process

It is requested the EPRR Group and Q&P Committee consider how best to provide this information to the Board.

Standard 6 (continuous improvement) has been raised with all the ICB heads of EPRR for consideration in the LHRPs. There is a lack of consistency in how organisations are sharing the lessons which makes a regional challenge to provide evidence showing 'participation within a regional process for sharing lessons with partner organisations. The Trust also need to consider how learning is shared internally and who the audience is.

Standard 37 and 38 (LHRP and LRF) – The strategic/executive level meetings are all well attended. There is currently no process in the trust to collate what is being discussed at each LRF and LHRP to ensure that attendees and the AEO are clear and up to date.

Resilience Team now sit on the DSPT (standard 49) working group and are looking at how Digital impacts business continuity and vice versa.

Plans need to be made to audit the Trust BC process (standard 51). Head of Contingency spoke to NHS England and MIAA regarding this. MIAA said, if used, they would audit the Trust against the BC policy which should satisfy the requirement for 'an independent business continuity management audit report' but it would not be measured against ISO 22301 or NHS England BC Toolkit audit. NHS England said it is up to the Trust if it feels comfortable that this is in enough depth to provide assurance.

Standard 53 (assurance regarding suppliers BC plans) continues to be challenging as the suppliers provide plans but there is currently no process in place to assure/test them. Procurement are working to address this.

ICC have recently formed an EPRR Oversight group to manage their approach and align actions with the requirements of the Core Standards, CQC and other audit tools. It is in its infancy, the TOR has been agreed, there is representation from across ICC and the Resilience Team.

They are looking at options for tracking testing in one place with the potential to run a dashboard for assurance. A testing SOP is in draft to set out the process. It is possible that this could be utilised for wider tracking of testing and outcomes across the Trust to show when plans have been used in a response to an incident and create feedback as part of the PDSA cycle.

It was noted in the Oversight group that a process for exercises is needed. This will include how ICC commit to exercises and are involved in the planning, how and where it is carried out and the facilitation process. This will run alongside the exercise SOP held by Resilience, and they will work in tandem.

4. INTEROPERABILITY CORE STANDARDS – POINTS OF NOTE

Standard C24 requires commanders to complete CPD in line with technical information sheets (TIS). There currently isn't a TIS for Strategic, NHS ECU are reviewing this as part of their updated strategy. The process for monitoring the quality of commander portfolios is under review by CARE (standard C27).

Standard J5 requires *all* frontline responders to attain and maintain a basic knowledge and understanding of JESIP. Standard J13 requires the maintenance of training records which show 90% of operational and control room staff are familiar with JESIP and can construct a METHANE report. In line with the MIAA audit actions, the Resilience Team are looking at the sources of data available to show how many of the staff have access to this knowledge through training and exercises. It is unlikely that every member of staff will have covered JESIP (note the rationale for

accepted levels of mandatory training attendance) but it is expected be more than those completing the awareness module on ESR.

5. RISK CONSIDERATION

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

NWAS Resilience is also a key component of the NHS Ambulance Standard Contract and is governed by the NHS England & Improvement Emergency Preparedness, Resilience and Response (EPRR) Core Standards which are revised annually. Non-compliance with the minimum core standards could lead to a reduction in confidence from NHS England, NWAS Board, stakeholders and the public. It could also mean that the Trust are not working in a way conducive to effective planning and response.

6. EQUALITY/ SUSTAINABILITY IMPACTS

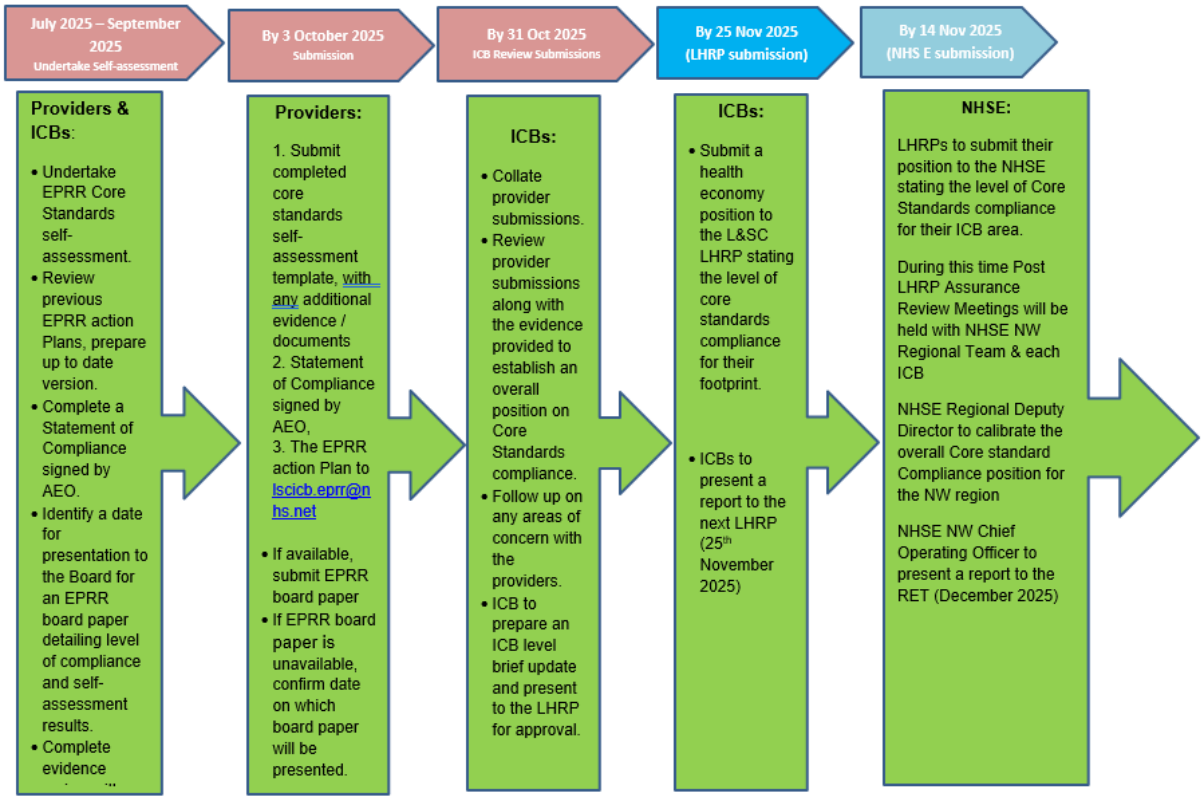
None.

7. ACTION REQUIRED

The Board of Directors is asked to:

- Be assured that the submission to the ICB and NHS England was on time, accepted, and shown as substantially compliant with the Core Standards.
- Be advised that the process for assurance for 2026 is underway.
- Review how information regarding EPRR is provided to the Board (Core Standard 3).
- Review options for BC audit (Core Standard 51).

Appendix 1


July 2025 – September 2025
Undertake Self-assessment
By 3 October 2025
Submission
By 31 Oct 2025
ICB Review Submissions
By 25 Nov 2025
(LHRP submission)
By 14 Nov 2025
(NHS E submission)
Providers & ICBs:
• Undertake EPRR Core Standards self-assessment.
• Review previous EPRR action Plans, prepare up to date version.
• Complete a Statement of Compliance signed by AEO.
• Identify a date for presentation to the Board for an EPRR board paper detailing level of compliance and self-assessment results.
• Complete evidence
Providers:
1. Submit completed core standards self-assessment template, with any additional evidence / documents
2. Statement of Compliance signed by AEO,
3. The EPRR action Plan to lscicb.eprr@nhs.net
• If available, submit EPRR board paper
• If EPRR board paper is unavailable, confirm date on which board paper will be presented.
ICBs:
• Collate provider submissions.
• Review provider submissions along with the evidence provided to establish an overall position on Core Standards compliance.
• Follow up on any areas of concern with the providers.
• ICB to prepare an ICB level brief update and present to the LHRP for approval.
ICBs:
• Submit a health economy position to the L&SC LHRP stating the level of core standards compliance for their footprint.
• ICBs to present a report to the next LHRP (25th November 2025)
NHSE:
LHRPs to submit their position to the NHSE stating the level of Core Standards compliance for their ICB area.
During this time Post LHRP Assurance Review Meetings will be held with NHSE NW Regional Team & each ICB
NHSE Regional Deputy Director to calibrate the overall Core standard Compliance position for the NW region
NHSE NW Chief Operating Officer to present a report to the RET (December 2025)

Appendix 2

Compliance for each standard is defined as:

Compliance level	Definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

Full and partial compliance of a standard does not have a sliding scale, for example if a plan is in place but has not been tested, or if it was in draft at time of submission, this would be partial compliance.

Organisational rating is defined as follows:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

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

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

Appendix 3 ICB reporting of NWAS figures 2025

EPRR Core Standards 2025-26 (10 Domains, 58 standards)

North West Ambulance Service self-assessment

NHS Lancashire and South Cumbria Integrated Care Board

D1 (x6)	D2 (x2)	D3 (x11)	D4 (x2)	D5 (x4)	D6 (x5)	D7 (x4)	D8 (x5)	D9 (x11)	D10 (x8)
1	7	9	20	22	26	33	37	44	55
2	8	10	21	23	27	34	38	45	67
3		11		24	28	35	39	46	68
4		12		25	29	36	40	47	69
5		13			30		41	48	70
6		14			31		42	49	71
		15			32		43	50	72
		16	**Key:**	Fully compliant	NWAS **x 54**			51	73
		17		Partially compliant	NWAS **x 4**			52	
		18		Non-compliant	NWAS **x 0**			53	
		19		Not NWAS standard	NWAS self-assessed as 'Substantially compliant', overall compliance of 93%			54	

Domains

D1: Governance | **D2**: Duty to assess risk | **D3**: Duty to maintain plans | **D4**: Command & control | **D5**: Training & exercising
D6: Response| **D7**: Warning & informing | **D8**: Cooperation | **D9**: Business continuity | **D10**: CBRN

EPRR Core Standards 2025-26 (Interoperable Capabilities)

HART	HART	SORT	SORT	SORT	MassCas	C2	C2	C2	JESIP
1	17	1	17	33	1	1	17	33	1
2	18	2	18	34	2	2	18	34	2
3	19	3	19	35	3	3	19	35	3
4	20	4	20	36	4	4	20	36	4
5	21	5	21		5	5	21		5
6	22	6	22		6	6	22		6
7	23	7	23		7	7	23		7
8	24	8	24		8	8	24		8
9	25	9	25		9	9	25		9
10	26	10	26		10	10	26		10
11	27	11	27		11	11	27		11
12	28	12	28		12	12	28		12
13	28	13	29		13	13	29		13
14	30	14	30		14	14	30		
15	31	15	31			15	31		
16	32	16	32			16	32		

EPRR Core Standards 2025-26

North West Ambulance Service Overall compliance

NHS
Lancashire and South Cumbria
Integrated Care Board

Overall Ratings for 2023/24, 2024/25 & 2025/26

	23/24	24/25	25/26
Overall compliance:	N	S	S
Percentage compliance:	41%	90%	93%
Standards 'Fully compliant':	24	52	54
Standards 'Partially compliant':	34	6	4
Standards 'Non-compliant':	0	0	0

Overall Compliance Ratings

F: FULL	100%
S: SUBSTANTIAL	89-99%
P: PARTIAL	77-88%
N: NON-COMPLIANT	76% or less

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

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 25 March 2026
SUBJECT	Learning from Deaths - Summary Report and Dashboard Q2 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**	☐

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 engagement with the 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 2
EXECUTIVE SUMMARY	The Trust is required to publish on its public accounts a quarterly and then an annual summary of learning. The Q2 dashboard (Appendix A) describes the opportunities to learn from deaths. The main concerns raised internally and externally identified in DatixCloudIQ (DCIQ), were attributed to problems in Integrated Contact Centres (ICC) and Paramedic Emergency Services (PES), specifically with call handling and dispatch errors, equipment malfunction, and care and treatment. Of the concerns closed, there were no incidents where causal factors were identified by the investigator. The peer review process now encompasses ICCs and the trust is fully compliant with the national framework. The key areas for improvement in this quarter were focused on call taking – both within ICC and clinical delivery. Individual errors in call taking were

	seen, but in small numbers so no significant themes were found. The quality of patient records has dropped this quarter, with 44% receiving a "poor" or "very poor" rating, compared to 33% in the previous quarter. Only one case received a "good" rating for documentation. This element of the SJR review process continues to be highlighted in all reports and with senior clinical colleagues as an area for improvement. The panel continues to welcome observers to help raise awareness of the process and embed learning from the peer reviews. In Q2, the panel welcomed 14 observers from all areas of the trust. Under-reported figures, due to changes in module search criteria occurred in this reporting period. A solution has been implemented, ensuring that deaths in care are now reliably flagged to the Learning from Deaths team. Early Q3 data appears accurate, and a contingency extraction method is available to identify any miscoded cases. Continued monitoring of this change will continue into Q4 before full assurance is expected. 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, 23 February 2026
	Outcome	Accepted

1. BACKGROUND

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

Appendix A is a summary dashboard of the Q2 2025/26 Learning from Deaths review, and it is proposed this document is published on the trust's public accounts by 1 April 2026 in accordance with the national framework and trust policy. The dashboard includes output from moderation panels held following the structured judgement reviews (SJRs) for Q2. Learning from the panels is discussed later in this paper.

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

2. LEARNING FROM DEATHS COHORT SUMMARY

The number of patients whose deaths were identified as in scope for review was 34 (25 concerns raised in Datix and 9 sampled for SJR).

Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 02/10/2025. 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:

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

One concern raised both internally and externally

Internal Concerns

Of the 13 internal concerns, 5 were reviewed and closed. In no case did the investigation find that the trust had contributed to the patient's death.

External Concerns

Of the 11 external concerns that have been reported, 7 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. 4 concerns have been closed with no causal factors identified.

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 below.

DCIQ Updates

During Q2, issues were identified in the extraction of data relating to deaths from the DCIQ system. These issues resulted in the reported figures appearing lower than in previous Q2 reporting periods. The discrepancy was linked to recent changes within the DCIQ modules, which altered the search criteria used to identify relevant cases and affected both the completeness and reliability of the extraction.

A solution has now been developed collaboratively with the DCIQ team, and the module leads for both Complaints and Incidents. This solution is designed to ensure that any known deaths in care are appropriately and reliably flagged to the Learning from Deaths team. Early indications suggest that the Q3 data appears accurate. In the event that numbers drop unexpectedly, the DCIQ team is able to run an alternative listing report to identify and "mop up" any cases that may have been miscoded, thereby ensuring continued accuracy and completeness of reporting.

To help prevent similar issues in the future, a formal change request process has been introduced. This will improve communication and raise awareness of upcoming developments within specific modules, allowing for better preparation and impact assessment across affected teams.

SJR Stage 1 Outcomes

Nine 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).

Seven 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.'

Two cases were identified as needing second stage review. The second stage review concluded that both deaths were not avoidable. The care experienced by these patients in terms of patient assessment and management plan were below expected levels. As in previous quarters, 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.

Duty of Candour is considered in all cases that the panel deem appropriate, particularly with any cases that have a Stage 2 outcome. The relevant clinical and ICC leads are notified along with the Patient Safety Learning Team for oversight.

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:

- Call not re-triaged when new symptoms were described
- Incorrect coding of call
- Missed allocation of an appropriate vehicle

PES:

- Limited information regarding clinical assessment/examination
- Equipment failures reported
- Quality of EPR
- Poor communication with patients and families

Trust:

- Delays in allocation on category 2 calls which exceeded expected dispatch times. It is noted that this is at a similar level to the previous quarter

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

PES:

- Good recognition and escalation of a critically unwell patient
- Patient-centred decisions around frailty, comorbidities, and history

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 Q2 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
- Incomplete observations
- Issues within cardiac arrest documentation (e.g. % oxygen documented, LUCAS utilisation)

Good practice:

- Clear and detailed worsening advice documented
- Good detail regarding risks associated with patient refusing ED admission
- Clinicians using holistic decision making and advocating for patients' best interests

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 Q2 Learning from Deaths infographic (Appendix B) will be shared with the clinical leadership team.

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

Observers will be invited to SJR 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 we had covered all aspects of the case.

3. RISK CONSIDERATION

There are no risk 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.

4. EQUALITY/ SUSTAINABILITY IMPACTS

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

5. 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 engagement with the 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 2

NWAS Learning from Deaths Dashboard Q2 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.

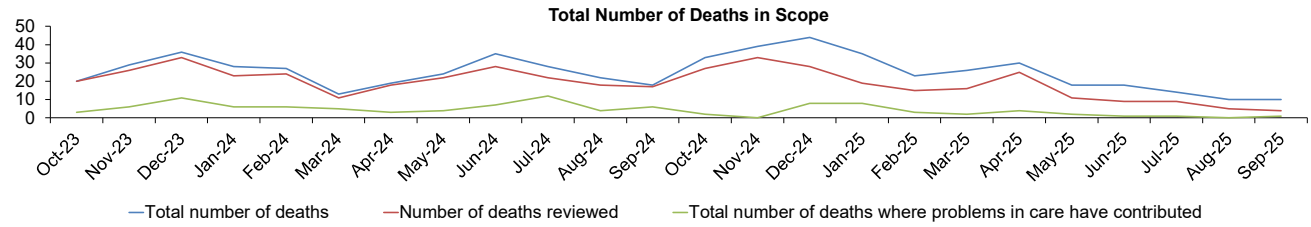


Figure 1

Concerns Raised in DCIQ

Internal Concerns

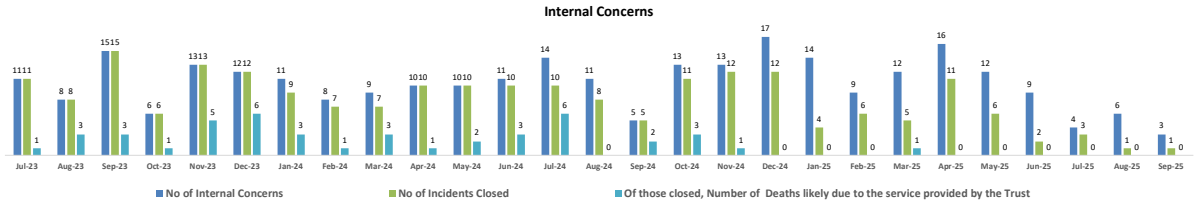


Figure 2

Figure 3

Learning Identified from all Internal Concerns raised in DCIQ

PES:

Equipment
- Schiller issue - reading rhythm despite pads not being attached
- Lifepak - issue with being unable to get capnography readings during ALS (x3)

Care & Treatment
- Potential incorrect grade of staff dispatched
- Patient airway temporarily blocked by dislodged teeth during ALS
- Delay in attending correct destination due to difficulties in communication between vehicles

ICC:
- Delay in allocating available resources - vehicle with long ETA allocated, closer vehicles became available but were not allocated
- Call not triaged correctly for a patient with shortness of breath, call therefore was coded incorrectly
- Call not triaged correctly - EMA should have re-triaged when new symptoms were described at the end of the call

Trust
- Category 2 delays: 40mins - 1hr 20 (x5)

Table 1

External Concerns

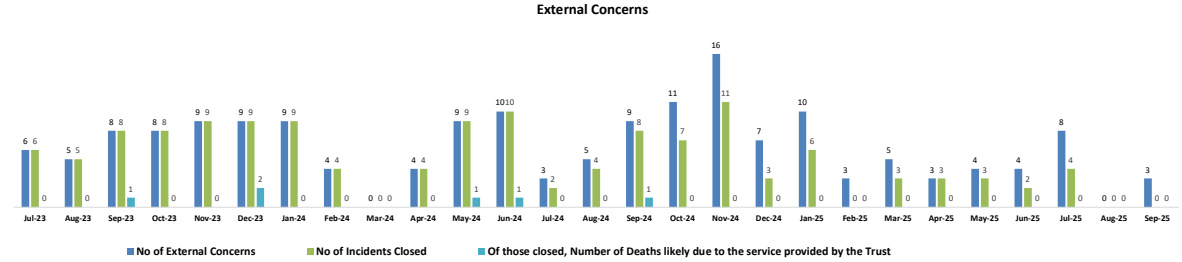


Figure 4

Learning Identified: PES

Problem with communication:
- Poor communication (x3)
- Poor communication during handover (x3)

Problem with patient assessment:
- Failure to recognise potential seriousness of condition (x2)

Table 2

Learning Identified: PES/ICC

Problem with call taking/response allocation:
- Poor communication with patient/family

Problem with patient disposition:
- Correct pathway not followed

Table 3

Internal and External Concerns

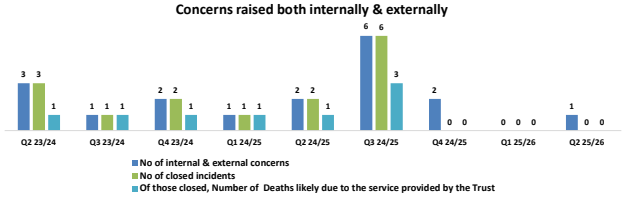


Figure 5

Data last exported: 02/10/2025; Data last cleansed: 22/12/2025

NWAS Learning from Deaths Dashboard Q2 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	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
	Q2	9	9	2
	Total	**182**	**158**	**54**

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

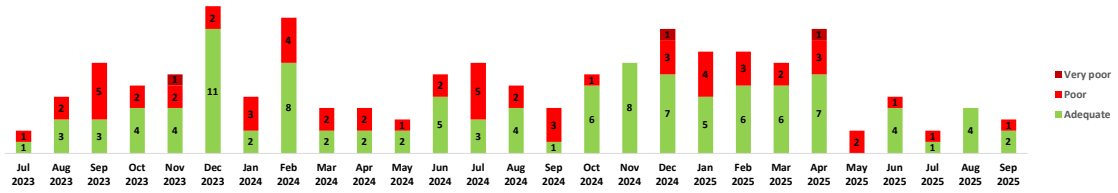


Figure 6

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	1	7	1
Right Care	Patient Assessment Rating	0	8	1
	Management Plan/Procedure Rating	0	8	1
Right Place	Patient Disposition Rating	0	9	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	1	2	0
Right Care	Patient Assessment Rating	0	3	0
	Management Plan/Procedure Rating	0	3	0
Right Place	Patient Disposition Rating	0	3	0

Table 6

SJR Learning Themes

Evidence of Poor/Very Poor Practice

Findings identified from 'Poor' ratings

Problem with call taking and/or response allocation:

- Not enough probing by EMA around the patients level of consciousness, EMA didn't ask to speak to the patient directly
- EMA didn't call the patient back with wait times and specific worsening advice when the line cleared at the end of the call

Problem with assessment, investigation or diagnosis - Clinical Delivery:

- Clinician missed the opportunity to upgrade the call to a category 1 during triage

Poor Quality of EPR (x4)

Table 7

Evidence of Poor/Very Poor Practice

Figure 7

Evidence of Good/Very Good Practice

Evidence of Good/Very Good Practice

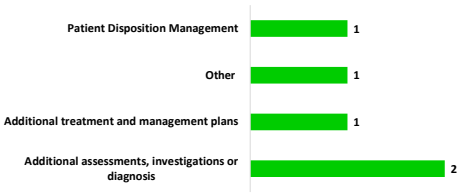


Figure 8

Findings identified from 'Good' ratings

Additional assessments, investigations & diagnosis:

- Involvement of those important to the patient, with holistic conversations noted
- Patient centred decisions around frailty, comorbidities and history

Additional treatment & management plan:

- Good recognition and escalation of a critically unwell patient

ICC disposition management:

- Good recognition and escalation of a critically unwell patient by EMA

Good Quality of EPR (x1)

Table 8

NWAS Learning from Deaths Dashboard Q2 25/26

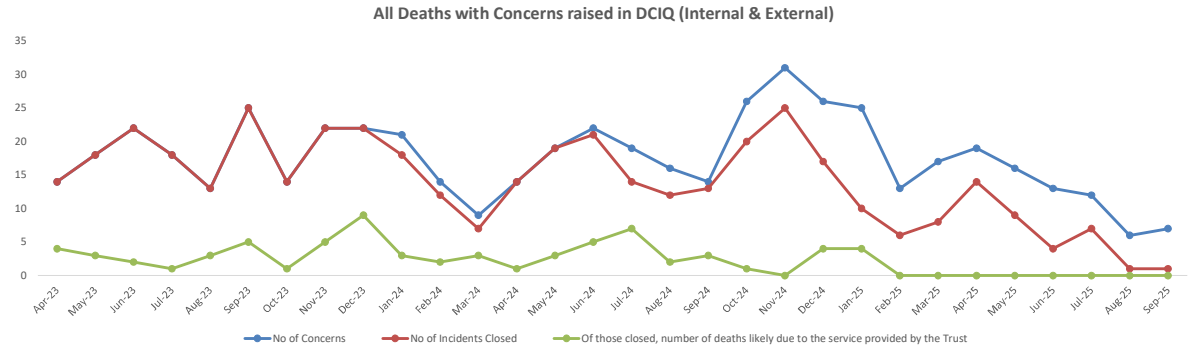


Figure 9

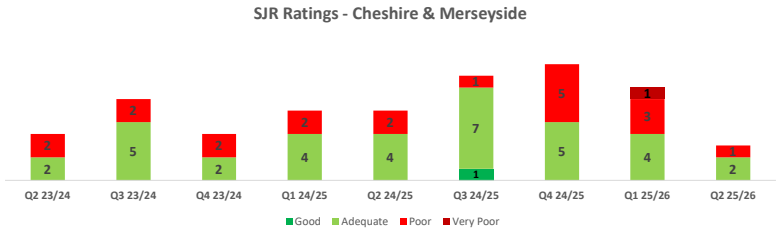


Figure 10

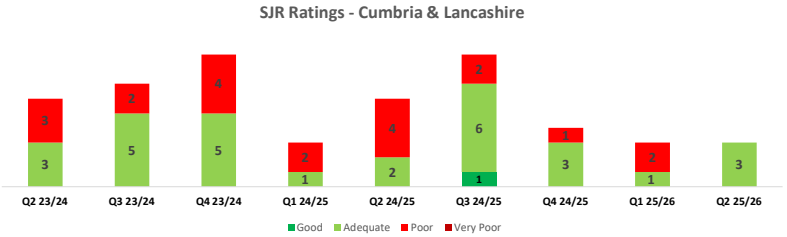


Figure 11

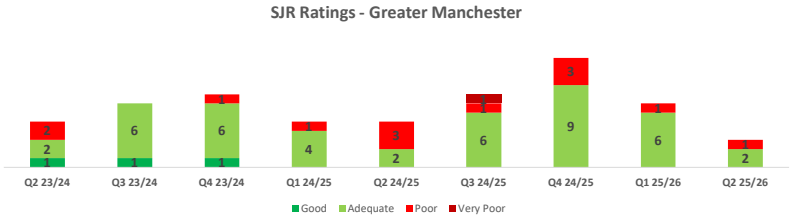


Figure 12

SJR Deaths by Deprivation Index		Quarter							
		Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Q1 25/26	Q2 25/26
IMD Decile 1= most deprived 10= least deprived	1	**6**	**2**	**8**	1	**6**	3	**3**	**1**
	2	**4**	1	1	2	**6**	3	2	**1**
	3	3	**3**	0	**5**	2	2	1	**1**
	4	1	**3**	0	1	**3**	2	1	**1**
	5	0	**3**	0	0	1	**4**	**4**	**0**
	6	1	1	1	2	1	**5**	0	**2**
	7	3	**3**	**3**	**3**	2	1	1	**1**
	8	1	0	0	1	**3**	**4**	1	**2**
	9	1	0	0	2	1	2	**4**	**0**
	10	1	1	1	0	1	0	1	**0**

Key:

Most occuring

Second most occuring

Table 9

LEARNING FROM DEATHS

NHS North West Ambulance Service

Q2 2025/26 REPORT

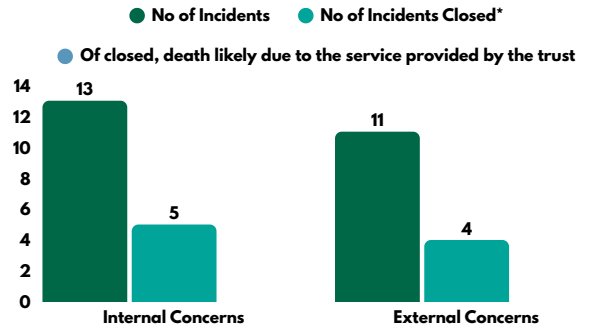
DEATHS WITH CONCERNS RAISED IN DATIX

Internal Concerns 13

External Concerns 11

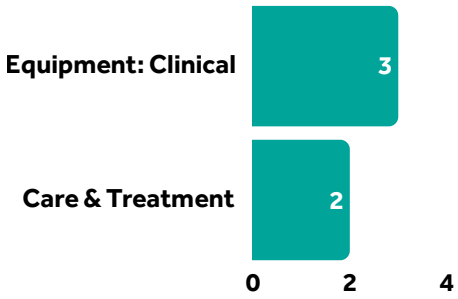
Internal & External 1

Concerns with casual factors



*None of the closed incidents had causal factors identified

Categories from closed internal incidents



Learning from Paramedic Emergency Service (PES)

Problem with treatment & management plan:

- Potential incorrect grade of staff dispatched
- Patient airway temporarily blocked by dislodged teeth during ALS
- Delay in attending correct destination due to difficulties in communication between vehicles

Equipment:

- Schiller issue - reading rhythm despite pads not being attached
- Lifepak - issue with being unable to get capnography readings during ALS (x3)

Other Learning Opportunities

Learning from ICC:

- Delay in allocating available resources - vehicle with long ETA sent and closer resources not re-allocated
- Call not triaged correctly for a patient with shortness of breath
- Call not triaged correctly - should have re-triaged when new symptoms were presented at the end of the call

Learning over time

- The number of category 2 delays has increased slightly since Q1 - 5 delays reported compared to 2 in the previous quarter
- There continues to be reports of equipment issues
- The overall number of datix incidents fitting the LfD criteria has dropped in this quarter

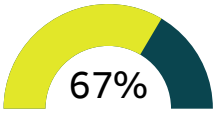
Structured Judgement Reviews (SJRs)

Patient Demographics

67% Female

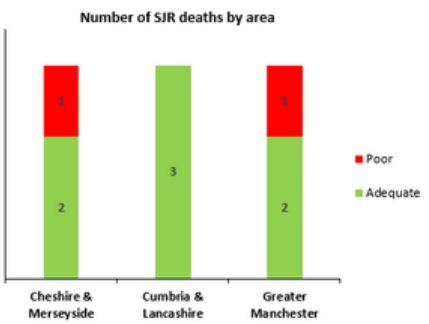
33% Male

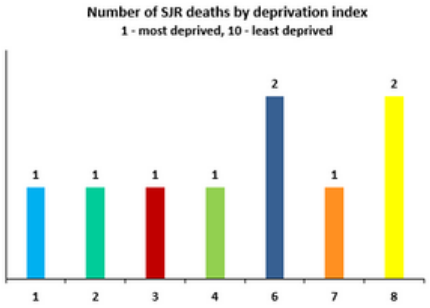
89% of the sample were over 65 years old



Majority of patients ethnicity recorded as White (British)
33% Not Documented

Incident Demographics





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

Structured Judgement Reviews (SJRs)

Deaths in Scope

Re-contact within 24hrs
3

Category 3/4 Deaths
0

Category 1/2 Delays
6

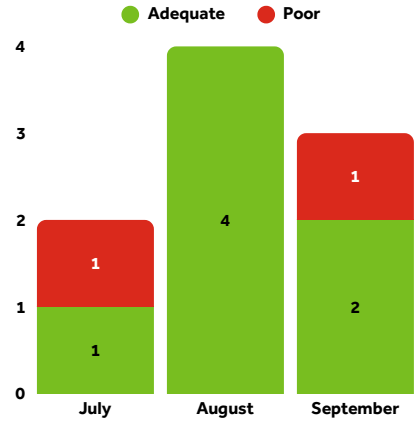
Deaths Reviewed

Total sample
N = 9

Excluded from review
Not moderated = 0

Included for review
n = 9**

SJR Stage 1 Care Assessment



**77.8% had no causal factors identified

Stage 2 = 2 incidents

No causal factors identified
1

Uncertain poor practice led to harm
1

Poor practice led to harm
0

SJR - Themes

Problem with call taking and/or response allocation

Problem with patient assessment

Problem of any other category (Quality of EPR)

Stage 2 - Findings

Problem with call taking and/or response allocation:

- Not enough probing by EMA around the patients level of consciousness, EMA didn't ask to speak to the patient directly
- EMA didn't call the patient back with wait times and specific worsening advice when the line cleared at the end of the call

Stage 2 - Findings

Problem with assessment, investigation or diagnosis - Clinical Delivery:

- Clinician missed the opportunity to upgrade the call to a category 1 during triage

Poor Quality of EPR (x4)

SJR GENERAL LEARNING THEMES

Areas for Improvement

- Incomplete observations
- EPR tiles not completed when appropriate
- Frailty and pain scores missing from observations
- Issues with cardiac arrest: no LUCAS available on scene, no APP available to attend scene, no oxygen documented during ALS

Good Practice

- Good detail regarding risks associated with patient refusing ED admission
- Clear and detailed worsening advice documented
- Crew advocating for patients best interests and using holistic decision making

SJR ACTIONS

- Positive feedback to be given to crew
- Learning feedback to be given to crew
- Dispatch decisions to be reviewed
- Clinical delivery triage call to be audited and fed back
- 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 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 - in Q2 14 colleagues attended and participated in discussions

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ESCALATION AND ASSURANCE REPORT

Report from the Quality & Performance Committee

Date of meeting	Monday, 23 February 2026			
Members present	• Prof A Esmail (Chair) • Dr A Chambers • Ms A Cooper • Ms C Todd • Ms A Wetton • Mr D Ainsworth • Dr C Grant	Non-Executive Director Non-Executive Director Non-Executive Director Non-Executive Director Director of Corporate Affairs Director of Operations Medical Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- The Committee were advised of ongoing technical issues with the SafeCheck system, affecting the Infection Prevention and Control and Medicines Management reporting, limiting the ability to provide assurance in those areas.

ADVISE:

- The Q&P Dashboard highlighted:
    - Care and treatment remained the most common theme for patient incidents and the highest overall reported incident
    - The Hear and Treat (H&T) rate for January was 18% and See and Treat (S&T) was 26%, equating to a non-conveyance rate of 44%. The Trust was ranked 5th for H&T and 10th for S&T.
    - Category 1 long-waits have decreased by approximately 40% compared to January 2025
    - Category 2 long-wait incidents have decreased by 7.6% compared to January 2025
- The Committee received the EPRR Annual Assurance report, noting that the Trust submission was on time, accepted, and shown as substantially compliant with the Core Standards.
- The Committee received the comprehensive reports for the following items and noted their progression for consideration to the Board:
    - Bi-Annual Safeguarding Report
    - Infection Prevention and Control Report and BAF
    - Learning from Deaths Q2 2025/26

ASSURE:

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

- Board Assurance Framework Q3
- Complaints Assurance Report Q3 2025/26
- CQC Update
- Improvement Quarterly Report
- Medicines Management Q3 2025/26
- Clinical Audit Plan Q3 2025/26

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, 25 March 2026
SUBJECT	Our Strategy and Strategic Plans 2026 - 2031
PRESENTED BY	Mike Gibbs, Director of Strategy & Planning
PURPOSE	Decision

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

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

ACTION REQUIRED	The Board of Directors are asked to: • Approve the Trust Strategy 2026–2031 and its strategic direction. • Approve the four supporting Strategic Plans as the framework for delivery over the next five years.

EXECUTIVE SUMMARY	This paper presents the Trust Strategy 2026–2031 and four supporting Strategic Plans for Board approval. The strategy establishes the Trust's long-term direction, priorities and ambition, supported by aligned plans which set out how each strategic aim will be delivered. The strategy and plans have been developed through a structured programme of work since January 2025, incorporating engagement with staff, patients, Board members and system partners. The key shift from previous approaches is the introduction of a coherent multi-year planning framework, with clear alignment between strategy, strategic plans and the annual planning process. This provides a stronger line of sight from long-term ambition through to deliverable priorities and assurance. The supporting Strategic Plans translate each strategic aim into defined objectives, deliverables and a rolling three-year roadmap. The Annual Plan 2026–27 represents the first year of delivery. Elements of the delivery architecture, including the detailed measurement framework and enabling plans, will continue to be refined through established governance processes. The Board of Directors is asked to approve the Trust Strategy 2026–2031 and the four supporting Strategic Plans.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee, Resources Committee	
	Date	18/03/2026 and 19/03/2026
	Outcome	Recommended for approval at Board

1. BACKGROUND

1.1 The strategy redevelopment programme commenced in January 2025 to refresh the Trust's strategic direction and supporting plans. The outcome is a five-year Trust Strategy and four aligned Strategic Plans, supported by a structured delivery and assurance framework.

1.2 The scope of the programme included the review of the existing strategy, development of revised strategic aims and objectives, and the establishment of a multi-year planning approach linking strategy to delivery.

1.3 Development has been informed by targeted engagement with staff, patients, Board members and system partners, alongside analysis of organisational performance, system context and future challenges

1.4 Appendix A summarises the structured approach undertaken (diagnose, design, develop and embed).

2. OUR STRATEGY 2026 -2031

2.1 The Trust Strategy 2026–2031 (Appendix B) sets the long-term direction, ambition and priorities for the organisation.

2.2 The strategy provides a clear framework for decision-making and resource prioritisation over the next five years, aligned to national policy direction and system priorities It is structured around four key components:

- Understanding our context - organisational position, system environment, and strategic challenges
- Our strategic direction - purpose, values, vision and four strategic aims, including measures of success
- Core themes - health inequalities, equality, diversity and inclusion, and improvement, embedded across all aims
- Delivery framework - how the strategy will be implemented, monitored and assured

Collectively, these components provide a clear line of sight from strategic ambition through to delivery and assurance.

3. STRATEGIC PLANS

3.1 The four Strategic Plans (Appendices C–F) translate the Trust Strategy into deliverable priorities and define how each strategic aim will be achieved.

3.2 Each plan aligns directly to one of the four strategic aims:

- Quality Plan
- People & Culture Plan
- Clinical Response Plan
- Future Sustainability Plan

Collectively, these components provide a clear line of sight from strategic ambition through to delivery and assurance.

3.3 Each plan sets out strategic objectives, key deliverables and a rolling three-year roadmap to support sequencing, prioritisation and multi-year planning. The Annual Plan 2026–27 represents year one delivery and is directly derived from the priorities set within the Strategic Plans

3.4 Four enabling plans (Digital; Estates, Fleet and Facilities; Improvement; Environmental Sustainability) underpin delivery and will be finalised through committee governance processes.

4. LAUNCH AND EMBED ACTIVITIES

4.1 Following Board approval, a structured programme of communication and engagement will support the launch and embedding of the strategy and plans.

4.2 Initial activity will focus on leadership alignment and ensuring clear translation of the strategy into directorate, team and individual objectives.

4.3 Engagement will be undertaken with staff and system partners to reinforce strategic priorities and expectations.

4.4 A pulse survey will be conducted following the initial embed phase to assess staff awareness and understanding.

4.5 All activity will be delivered in line with governance requirements, including pre-election restrictions.

5. DELIVERY ASSURANCE

5.1 A structured delivery and assurance framework will support implementation of the strategy.

5.2 Planning Group will provide oversight of progress against the strategic aims, with updated terms of reference aligned to the new framework. Quarterly assurance reporting will be provided to Trust Management Committee and Resources Committee, with escalation of risks and exceptions through the Board Assurance Framework and Board reporting.

Executive SRO accountability will be aligned to each strategic aim.

5.3 A time-limited Measurement and Assurance Task and Finish Group is developing the overarching framework for measuring progress and impact. Outputs from this work will inform future reporting and assurance processes.

6. RISK CONSIDERATION

6.1 Delivery of the strategy carries a number of inherent risks, including organisational capacity and prioritisation, financial sustainability, workforce availability, and dependency on system partners.

These risks are reflected within the Board Assurance Framework and will be monitored through the strategic delivery and assurance processes.

No new or immediate risks are identified for escalation at this time.

7. EQUALITY/ SUSTAINABILITY IMPACTS

7.1 A combined Equality and Quality Impact Assessment (EQIA) process has been undertaken for the strategy and supporting plans.

7.2 Stage 1 assessments have been completed and reviewed through a multi-disciplinary panel, with Stage 2 assessments undertaken where required.

7.3 This process has provided assurance that equality, quality and health inequalities considerations are embedded within the strategy and plans.

8. ACTION REQUIRED

8.1 The Board of Directors are asked to:

- Approve the Trust Strategy 2026–2031, including its strategic direction, aims and content.

- Approve the four supporting Strategic Plans as the framework for delivery over the next five years.

Appendix A – Strategy redevelopment process

Phase	Question	Activities	Outputs
Diagnose Oct 2024 – June 2025	• Where are we now? • People • Context • Measurement	• Engagement with staff, patients and senior leads • SWOT • PESTLE • Data analysis	• Confirmed current state • Agreed scope • Draft design principles
Design June – Dec 2025	• Where do we want to be?	• Consolidation information from diagnose phase • Design and initiate consensus building approach • Stakeholder analysis • Engagement with strategic plan leads	• Confirmed design principles • Consensus building plan • Communications and engagement plan • Initiation of Equality impact assessment process • Measurement approach defined
Develop Nov 2025 – Feb 2026	• How do we get from where we are now to where we want to be?	• Board and TMC engagement • Develop documentation • Annual planning	• Trust Strategy • Strategic plans • Completed impact assessments
Embed and evaluate April 2026 onwards	• What have we learnt? • Through the strategy development process • About the impact of delivery of the strategy via strategy assurance	• Launch and embed activities as per communications plan • Strategy development process evaluation • Initiation of strategy assurance process	• Continued learning and intelligence

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Our Strategy 2026 - 2031

Delivering the right care,
at the right time,
in the right place;
everytime.

Contents

Foreword from our Chair and Chief Executive

Every day, thousands of people across the North West rely on us at some of the most critical moments of their lives. It is a responsibility we hold with respect for the trust placed in us. Our new North West Ambulance Service strategy for 2026–2031 has been shaped by the insight, experience and ambition of our people, patients, volunteers and partners, and reflects what matters most to those we serve.

Despite significant pressure across the urgent and emergency care system, we have delivered meaningful progress. We have strengthened the quality and safety of our care, improved access to our services, and invested significantly in our workforce. The integration of our 999 and NHS 111 contact centres, the expansion of clinical pathways and the growth of our digital capability have created stronger foundations for the future. These achievements belong to our 7,500 colleagues and more than 1,200 volunteers whose dedication to helping people when they need us most never wavers.

As we look ahead, we do so with realism and optimism. Demand for urgent and emergency care continues to rise, inequalities across our region remain stark, and national policy is shifting towards more community-based, connected and digital, data and technology enabled models of care. As the only regional provider working across five integrated care systems, we have a unique leadership role in shaping how urgent and emergency care evolves over the next five years.

Our refreshed strategy sets out four clear aims:

- Provide outstanding, inclusive care for everyone we serve.
- Build a safe, supportive and inclusive culture.
- Deliver a responsive care model through strong partnerships.
- Embed continuous improvement and innovation for a sustainable future.

These aims reflect what our patients and staff told us they value: safe and compassionate care, a positive culture, coordinated services, and a commitment to learning, sustainability and innovation.

Tackling health inequalities is central to this strategy. The diversity and complexity of the North West means that where people live, work and grow up still shapes their health outcomes. Our new Health Inequalities Framework will guide how we target our efforts and work with partners to ensure access, experience and outcomes improve for those who need us most.

We also recognise that our people are at the heart of achieving our ambition. This strategy reinforces our commitment to their wellbeing, development and representation, ensuring everyone feels valued, supported and able to thrive.

By 2031, our ambition is clear: to be a trusted, high-performing and forward-thinking ambulance service that delivers safe, inclusive and person-centred care, works seamlessly with partners, and remains sustainable for the long term. We want to thank everyone who contributed to shaping this strategy. Your insight has informed a shared vision for the future - one we are proud to lead.

Together, we will continue to help people when they need us most.

Julia Mulligan, Chair

Salman Desai KAM, Chief Executive

Understanding our context

CLINICAL

Clinical Safety
Research and Development
Public Health and Prevention
Freedom to Speak Up
Medicines Governance and Optimisation
Clinical Audit
Clinical Learning and Improvement

SERVICE DELIVERY

Paramedic Emergency Service
Integrated Contact Centres
Resilience
Volunteers

QUALITY AND IMPROVEMENT

Mental Health
High-Intensity Users
Safeguarding
Infection Prevention and Control
Quality Improvement
Regulatory Compliance

CORPORATE AFFAIRS

Legal Services
Corporate Governance
Incidents and Risk Management
PALS and Resolutions
Health and Safety
Violence Prevention and Reduction

STRATEGY AND PARTNERSHIPS

Communications
Patient Engagement
Charity
Strategy and Planning
Programme Management Office
Partnerships and Integration
Urgent and Emergency Care
Improvement

PEOPLE

Education and Training
Learning and Organisational
Development
Human Resources
Staff Experience

FINANCE

Finance
Procurement
Estates, Fleet and Facilities Management
Support Services Sustainability
Clinical and Digital Information
Data Insights and Intelligence
Information Governance

We are a team of more than 7,500 people working in 300 different roles.

Most of us work directly with patients; supporting people when they call 999 or 111, responding to emergencies, and helping them get safely to and from hospital appointments.

Others work behind the scenes, providing expertise and vital services to make sure all parts of the organisation are well-run and have the right support.

Our teams:

- **Service Delivery** – Paramedic Emergency Service, Community First Responders, Patient Transport Service, Resilience and Integrated Contact Centres
- **Quality, Innovation and Improvement** – Metal Health, High-Intensity Users, Safeguarding, Infection Prevention and Control, Improvement and Regulatory Compliance.
- **Clinical** – Clinical Safety, Research and Development, Public Health and Prevention, Freedom to Speak Up, Medicines Governance and Optimisation, Clinical Audit, and Clinical Learning and Improvement.
- **Finance** – Finance, Procurement, Estates, Fleet and Facilities Management, Clinical and Digital Information, Data Insights and Intelligence, and Information Governance.
- **People** – Education and Training, Learning and Organisational Development, Human Resources, and Staff Experience and Culture.
- **Corporate Affairs** – Legal Services, Corporate Governance, Incidents and Risk Management, PALS and Resolutions, Health and Safety, and Violence Prevention and Reduction.
- **Strategy and Partnerships** – Communications, Patient Engagement, Charity, Strategy and Planning, Programme Management Office, Partnership and Integration, and Urgent and Emergency Care Improvement.

We operate from over 100 sites across the North West with over 1000 vehicles.

We have more than 1,200 volunteers, including some who respond to emergencies in their communities and others who help vulnerable people get to and from important hospital and clinic appointments.

The service we provide

Contact

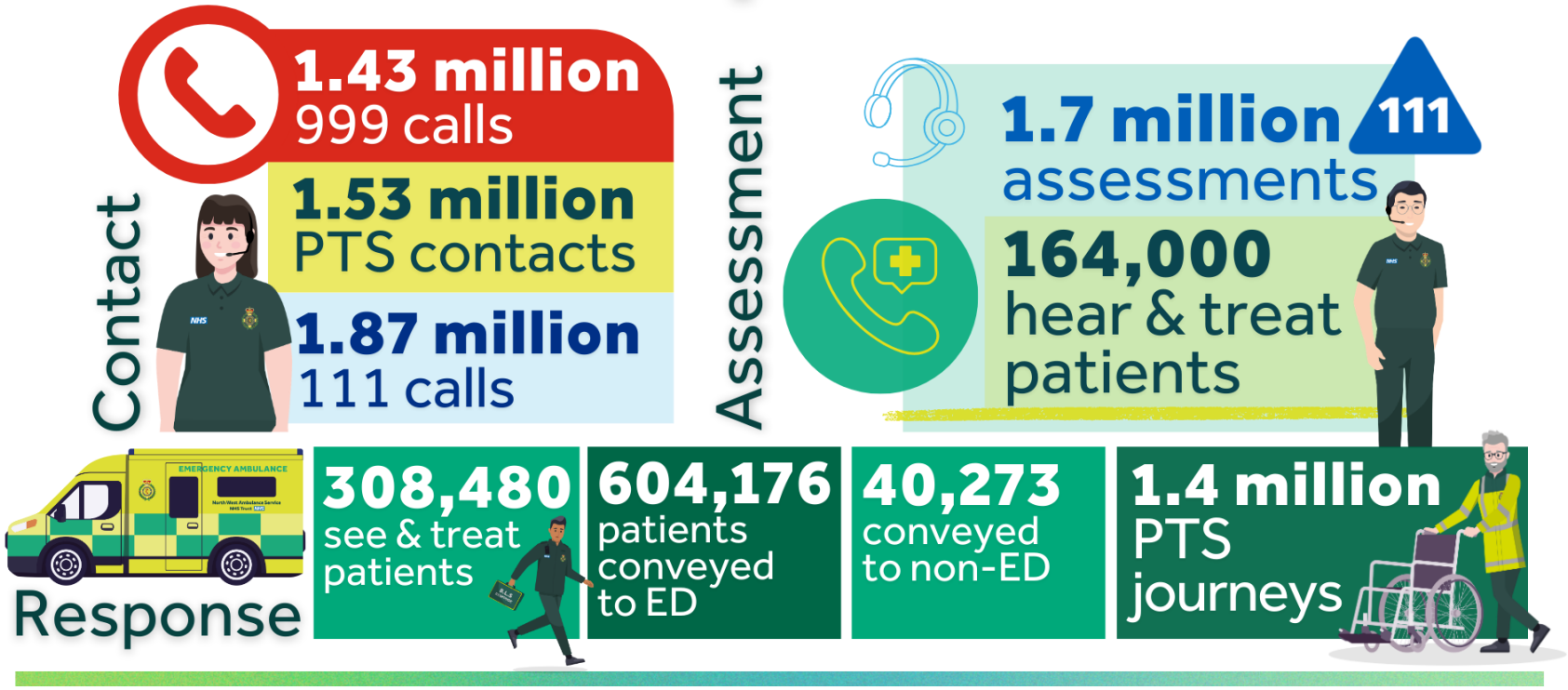
- 1.87 million 111 calls
- 1.43 million 999 calls
- 1.53 million PTS contacts

Assessment

- 1.7 million 111 assessments
- 164,000 patients care resolved over the phone (hear and treat)

Response

- 308,480 patients discharged at scene (see and treat)
- 604,176 patients conveyed to ED
- 40,273 conveyed to non-ED
- 1.4 million PTS journeys



Where we are today

Our population and geography

We serve a population of over 7.5 million people across 5,400 square miles in the communities of Cumbria, Lancashire, Cheshire, Merseyside, Greater Manchester and Glossop (Derbyshire). We cover a mix of major cities, towns, coastal and rural communities.

The factors that might impact on health and social care needs are different in each area we cover.

Cumbria and Lancashire

North Cumbria
510,680 population
2 placed based partnerships
1 trust
9 primary care networks

Lancashire and South Cumbria
1,443,153 population
4 place based partnerships
5 trusts
42 primary care networks

Cheshire and Merseyside

2,615,425 population
9 placed based partnerships
17 trusts
50 primary care networks

Greater Manchester

3,082,709 population
10 placed based partnerships
9 trusts
65 primary care networks

Health inequalities in the North West*

The diversity in our region makes the North West a unique place to live but also presents some challenges. We know from our data that the overall health of our region's population has a huge effect on demand for our services.

- In the North West, 32% of people live in the most deprived communities in England which impacts health outcomes, healthcare experiences and life expectancy than the general population.
- Life expectancy is significantly lower than the national average in areas such as Blackpool and Knowsley. People in these communities are more likely to suffer from long-term illnesses or have higher need for emergency care services.
- The North West has a higher prevalence of chronic conditions, and a larger percentage of its population with Long Term Conditions (30%) compared to all other regions.

Demographic changes*

- 19% of the North West population are aged 65+ (nearly 1.4m people).
- By 2040, the 65+ population in the North West is likely to increase by 36% to 1.8m people.
- People aged 90+ will have increased by 93%

What this means

These inequalities and demographic changes put extra pressure on health services, including ambulance services, as demand is often greater in deprived areas.

We are seeing rising urgent care demand, increasing clinical complexity and greater variation across communities.

By actively addressing health inequalities, we can help improve patient outcomes, reduce pressure on emergency services, and support a more sustainable healthcare system.

**Sources: North West Analysis (2024), State of Health Ageing in the North West (2022).*

Progress against our 2022-2025 strategy

What have we achieved?

For our patients

Over the last three years, we have delivered meaningful improvements to the experience and outcomes of the people we serve. Key highlights include:

- Integrated 111 and 999 triage systems
- Improved call handling and response performance
- Expanded community referral pathways
- Above national average performance in Ambulance Clinical Quality Indicators
- Increased opportunities for patients and public engagement

For our people

We have continued to invest in and support our people, ensuring colleagues have the skills, confidence and leadership they need to deliver excellent care. Key highlights include:

- New leadership structures and Area Directors introduced
- CPD and Learning Hub launched
- Violence Prevention Team established
- OFSTED rated our education provision as Good
- Launch of sexual safety campaign and anti-racism statement

For our organisation and system partners

We have continued to develop into a more collaborative and future-focused organisation. Key highlights include:

- Stronger partnerships across five Integrated Care Systems
- Mobile data and vehicle solutions implemented
- Smart programme pilots and digital innovation initiatives
- Nationally recognised performance through the NHS Oversight Framework

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These achievements provide a strong platform, but the health and care environment is changing rapidly and new challenges are emerging.

Forces shaping our strategy

We operate in a rapidly changing health and care environment. A combination of population need, system pressures and national reform is reshaping how urgent and emergency care must be delivered across the North West. These forces will shape our role over the coming years.

Population health and inequalities

The North West experiences some of the highest levels of deprivation and poorest health outcomes in England. Higher prevalence of long-term conditions and lower life expectancy increase demand for urgent and emergency services.

Growing and ageing population

The number of people aged 65 and over is expected to increase by 36% by 2040. Older populations are more likely to live with multiple long-term conditions, increasing the complexity of care.

Urgent and emergency care system pressure

Demand for urgent and emergency care continues to rise while capacity across hospitals, community services and primary care remains constrained.

National reform and changing care models

The NHS 10 Year Health Plan sets out three major shifts:

Hospital → Community

Analogue → Digital

Treatment → Prevention

Digital and data opportunity

Advances in digital technology and analytics enable:

- Improved clinical decision support
- Better demand insight
- More coordinated care pathways.

Workforce Sustainability

Like the wider NHS, ambulance services face recruitment, retention and wellbeing challenges, requiring a skilled, flexible and resilient workforce.

Together, these forces are reshaping the role ambulance services play in urgent and emergency care. We must continue to evolve - strengthening partnerships, improving how patients access care and developing new ways of working to meet the needs of the population we serve

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The strategic challenge

The forces shaping urgent and emergency care create a set of strategic challenges for us. To meet the needs of the population we serve, we must evolve how we deliver care, work with partners and use our resources.

Demand is increasing faster than system capacity

Demand for urgent and emergency care continues to grow while capacity across hospitals, primary care and community services remains constrained. This places sustained pressure on ambulance response and patient flow.

The role of ambulance services is expanding

Ambulance services are increasingly expected to act as system co-ordinators, helping patients access the most appropriate care rather than defaulting to hospital conveyance.

Digital and data capability will become critical

Better use of digital, data and technology tools and clinical decision support will be essential to anticipate demand, support clinicians and improve patient outcomes.

Greater collaboration is required across systems

Working across multiple systems within a complex and evolving health and care landscape. Partnership working will be essential to improve pathways, reduce variation and support integrated urgent and emergency care.

Workforce sustainability

Changing models of care require a flexible and skilled workforce able to adapt to change and supported by a culture which enables them to deliver the highest quality of care.

Delivering sustainable services

We must continue improving quality, productivity and innovation to ensure services remain sustainable in a financially constrained NHS.

In response to these challenges, this strategy sets out our purpose, our vision for the future and the strategic aims that will guide how we evolve over the coming years.

Our strategic direction

Our strategy 2026 - 2031

Our purpose

We have kept our purpose statement and values unchanged in the updated strategy because they continue to provide a clear anchor for everything we do, reminding us why our organisation exists and what unites us across all roles and services.

Whatever our role, we all share a common purpose:

To help people when they need us most.

We aim to achieve the best possible physical and mental health outcome for each person who needs us.

We will provide high-quality emergency care to save lives and make a difference to people with life-threatening illnesses or injuries.

For those with less serious conditions, we will tailor our response to each person's needs. This may include urgent clinical assessment, advice over the phone, referring them elsewhere or alternative transport for scheduled appointments.

Our values

- **Working together**
  We work together to understand and value every role in achieving our shared purpose. We live and breathe inclusivity; everyone matters.

- **Being at our best**
  We challenge ourselves to be the best we can be. We are curious and push boundaries to improve everything we do.

- **Making a difference**
  We make a difference through doing the right thing by our staff, patients, partners and communities. We act with compassion and kindness.

Our values are the behaviours that underpin all that we do. They describe how we should approach our work. They can be found in our systems and processes, from appraisal paperwork to planning tools for large-scale projects for change.

Putting our values into practice supports us to provide compassionate care and improve outcomes and experiences for our people, patients and communities.

Our vision

In 2022 we set out our vision to deliver the right care, at the right time, in the right place; every time. We include a vision statement because it provides a clear picture of the future we are working towards, helping to align our priorities, guide long-term decision-making and ensure that our collective ambition remains the driving force behind our actions.

Through our engagement on this strategy refresh, our staff and patients told us that they felt this vision statement remained relevant and therefore we have kept it the same but broken down each element to demonstrate what our ambition is between now and 2031.

Delivering the right care, at the right time, in the right place; every time.

Right care

Patients receive care that is safe, effective and personal. Our teams have the skills, tools and information needed to make the best clinical decisions.

Right time

Patients receive a rapid and reliable response when they need urgent help. We will meet or exceed national standards for emergency response and NHS 111.

Right place

More patients receive care in the most appropriate setting. We will work with partners to reduce unnecessary emergency department attendance.

Every time

Our services are reliable, consistent and sustainable. Continuous improvement and innovation will help us deliver high-quality care across the region.

Where we want to be in 2031

By 2031, we will be a trusted provider and partner in urgent and emergency care, working closely with others to design services that are responsive and focused on patients. We will keep learning and improving every step of the way.

Our strategic aims

To achieve our vision, we will focus on four strategic aims that will guide our priorities and decisions over the next five years.

Provide outstanding, inclusive care for everyone we serve.

Build a safe, supportive and inclusive culture together.

Deliver a responsive care model through partnerships.

Embed continuous improvement and innovation for a sustainable future.

Together, these aims will help us create a service that is trusted, inclusive, and ready for the future. By improving patient care, supporting our workforce, strengthening partnerships, and embedding innovation, we will deliver better outcomes for the communities we serve and ensure our services remain sustainable for years to come.

Aims

Provide outstanding, inclusive care for everyone we serve

What is our ambition for 2031

We will provide consistently high-quality, safe and compassionate care for our communities, reducing unwarranted variation and tackling health inequalities. Our population will experience timely access to care, strong clinical outcomes and a service that listens and improves using their feedback.

What are our areas of focus

- **Safety**
  Deliver our Patient Safety Incident Response Framework (PSIRF) priorities and reduce avoidable harm.
- **Effectiveness**
  Improve clinical outcomes and raise performance to the top quartile of ambulance quality indicators.
- **Health inequalities**
  Identify and address areas where patients experience sub-optimal care due to recognised health inequalities and take targeted, measurable remedial action.
- **Patient experience**
  Drive year-on-year improvement in experience alongside ongoing engagement with communities and volunteers to help co-design services.

How will we measure progress

- **Safety**
  30% reduction in avoidable harm (notifiable incidents) across PSIRF priorities; learning actions completed and sustained.
- **Effectiveness**
  Performance in Ambulance Clinical Quality Indicators (ACQIs) and other clinical indicators in the top quartile; fewer unwarranted variations across geographies and clinical groups.
- **Health inequalities**
  Reduction in identified outcome and access gaps for priority population and clinical groups; evidence of targeted interventions and impact reviews, improve against AACE maturity assessment tool.
- **Patient experience**

≥5% improvement in FFT/complaints compliments ratio and thematic improvements from patient feedback; response and resolution times.

Build a safe, supportive and inclusive culture together

What is our ambition for 2031

Our leaders create a compassionate, inclusive and supportive workplace culture, where everyone has a voice, can be at their best and is supported to improve and develop.

What are our areas of focus

- **Attraction and welcome**
  Attract and retain a representative workforce with effective onboarding and sustained support.
- **Leadership and management**
  Develop confident and inclusive leaders with the skills and tools to lead through complexity; use digital tools to release time.
- **Developing for the future**
  Develop high quality, accessible opportunities for career development and progression, supported by high-quality education and CPD, embrace future roles and changing care delivery models.
- **Wellbeing, culture and inclusion**
  Develop an inclusive, supportive and safe culture across the employee lifecycle.
- **Listening and involvement**
  Staff and learners are active partners in improving how we work and the care we provide.

How will we measure progress

- **Attraction and welcome**
  Increase in ethnic minority representation to 10% workforce, reduce Workforce Race Equality Standard (WRES) shortlisting to appointment indicator to below 1.25, streamlined recruitment processes and improved retention in first year of appointment.
- **Leadership and management**
  Increased levels of representation of women and ethnic minorities in leadership positions, staff survey leadership scores in top 3 in sector, 90% compliance with leadership induction, increased uptake of coaching and mentoring.
- **Developing for the future**
  Ofsted exceptional rating for 3 out of 5 standards, staff survey ‘We are always learning theme’ in top 3 in sector, learning evaluation measures, traffic to learning hub increased.

- **Wellbeing, culture and inclusion**
  NHS Staff Survey ‘We are Safe and Healthy’ theme and experience of negative behaviours in top 3 in sector; absence reduced to 5%, improving staff safety culture and narrowing of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) staff experience indicators to below 5%.
- **Listening and involvement**
  NHS Staff Survey ‘Engagement’ and ‘Morale’ themes in top 3 in sector, continuous improvement in learner feedback.

Deliver a responsive care model through partnerships

What is our ambition for 2031

We will optimise our delivery model and work closely with partners so that care is coordinated, equitable and responsive to population needs.

What are our areas of focus

- **Contact**
  Deliver an integrated, technology-enabled contact model that improves accessibility, reduces inequality, and enhances efficiency and patient experience.
- **Assessment**
  Deliver safe, consistent, and personalised triage and assessment that identifies risk early, reduces variation, and ensures patients receive the right care first time.
- **Response**
  Deliver a resilient, efficient, and patient-centred response model that uses technology, workforce optimisation, and system collaboration to provide the right care, in the right place, at the right time.

How will we measure progress

- **Core standards**
  Meet and sustain all national performance standards for urgent and emergency response, patient transport and Emergency Preparedness, Resilience and Response (EPRR).
- **Flexible care delivery model**
  Capacity sustainably meets changing demand, reduced waiting times, improved accessibility to our services, increased productivity and resilience within our operational model, sustained resource optimisation.
- **Clinical assessment**
  Optimised clinical decision making and risk stratification, increased agility of clinical workforce.
- **Hospital to community**
  Increase in access to and use of alternative care pathways, technology-enabled direct booking, information sharing, increase in telephone/virtual triage and treatment and sustained reduction in unnecessary conveyance to emergency departments (EDs).

Embed continuous improvement and innovation for a sustainable future

What is our ambition for 2031

We will embed a culture of learning and improvement that drives productivity and delivers clinical, operational, workforce, financial and environmental sustainability.

What are our areas of focus

- **Improvement focused**
  Embed a consistent improvement management system that connects strategy, priorities and operations; build improvement capability from Board to frontline.
- **Value for money**
  Secure long-term financial sustainability and deliver high-value, cost-effective services through strong financial governance and disciplined investment.
- **Digital, data and Technology enabled**
  Create a sustained digital shift by using trusted digital tools, strong data, and innovation to improve services.
- **Environmentally sustainable**
  Progress towards achieving net zero carbon by 2040 through delivery of our Green Plan.

How will we measure progress

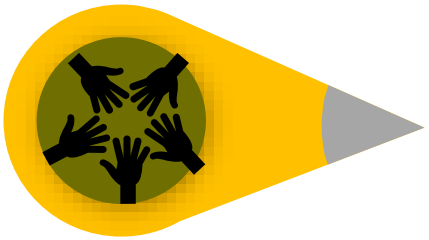
- **Improvement focused**
  Improved NHS IMPACT self-assessment, increased uptake of improvement training, increase in adoption of improvement tools and methods.
- **Value for money**
  Delivery of recurrent financial savings included in the medium-term financial plans, reduce non-recurrent measures in CIP programmes.
- **Digital, data and Technology enabled**
  Improved digital literacy, increased access to and use of data insights, more resilient and reliable digital foundations including management of digital disruption and cyber risks, digital tools supporting safer care, clinical decisions and improved patient outcomes.
- **Environmentally sustainable**
  Year-on-year improvement against Green Plan indicators.

Core themes

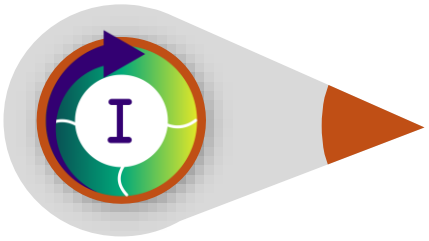
Introducing our core themes

Our strategic aims are underpinned by three core themes that guide our decision making and shape our services. The themes are health inequalities, equality, diversity and inclusion, and continuous improvement. They are not standalone priorities but are integral to every strategic aim and objective: shaping how we design our services, utilise our resources and measure our success. Each strategic plan will consider and address these core themes.

Tackling health inequalities is a national priority and each strategic plan will address how we can reduce gaps in access, experience and outcomes, ensuring all the communities we serve can benefit from improved health and wellbeing. Our new Health Inequalities Framework will inform this work and provides direction for each of the strategic plans.

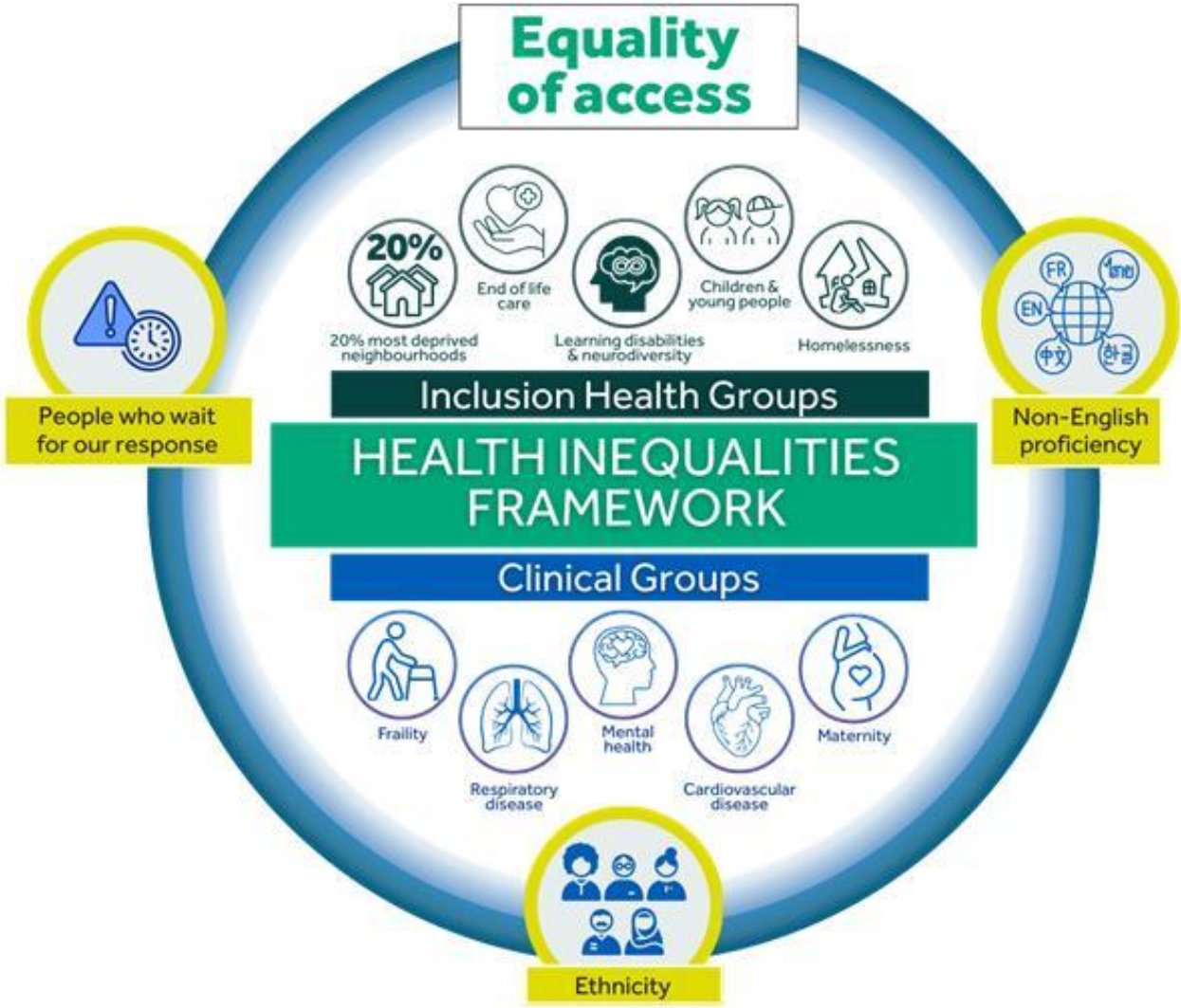


We are committed to an **active approach to equality, diversity and inclusion** where it informs our service design and the equity of the care we provide. Taking visible and meaningful steps to eliminate discrimination; to improve the diversity of our thinking through better representation in our workforce and to create an inclusive environment which enables our people to be at their best.



We strive to become an **improvement organisation**, meaning that we will empower our people to apply improvement methods to continuously learn, adapt and enhance the quality of our care and services. This improvement approach will become the method or ‘the how’ through which we deliver our strategic aims and the detail of ‘the what’ we will improve should be embedded into every strategic plan.

Theme 1: Health inequalities



Reducing health inequalities

Our Health Inequalities Framework explains where we think we can make the biggest difference. It's based on evidence, data and conversations with the people we serve and work with.

The framework follows the CORE20PLUS5 principles, and presents the vulnerable groups for targeted and coordinated action:

- **Equality of access**

  The ambulance service is the access point for urgent, emergency and planned care, and we need to ensure that our population feels safe to access our care and there are no barriers (such as communication difficulties) which might affect the quality of service we provide.

- **Clinical groups**

  Aligned to CORE20PLUS5, ICB priorities across our region, and our top-demand reasons – frailty, respiratory disease, mental health, cardiovascular disease and maternity. These are the clinical areas where we feel we can have the most impact on health inequality over the period of this strategy.

- **Inclusion health groups**

  Identifying unwarranted variation and working with our system partners on initiatives which support patients living in areas of highest deprivation, calling us with end-of-life care needs, patients with learning disabilities and neurodiversity, children and young people, and patients facing homelessness.

- **Culturally aware care and patient experience**

  We need to ensure that our people are confident and competent to deal sensitively with the individual needs of their patients. We will also actively engage with our patients to listen and learn from their experiences.

Importantly, we need to continue to work in collaboration with our system partners to achieve these.

Theme 2: Equality, diversity and inclusion

Creating a truly inclusive culture for our workforce is critical to delivering high quality inclusive care and improving health inequalities. This core theme identifies two underpinning priorities for improvement: **improving representation and inclusive culture.**

Core to delivery of improvement in these areas is the effective capture and analysis of diverse data and the use of impact assessment tools to identify and eliminate inequality. These principles and tools will underpin our approach across all our strategic plans.

Improving representation

To deliver high quality inclusive care we need a workforce which reflects the diversity of our population at all levels. This enhances the diversity and creativity of our thinking, helps us to deliver social value and improves the life opportunities for our communities.

Our data tells us that our workforce does not represent our community profile, especially in relation to race, and that staff with different backgrounds and genders are not fairly represented in leadership positions. Our recruitment processes are not always valuing diversity, and our people do not feel that career progression is fair.

Our priorities in this area are therefore:

- **Representative recruitment**

  Improving the attraction of diverse groups; eliminating discrimination in our recruitment processes and taking positive action to improve representation.

- **Fair career progression**

  Improving development opportunities for all; ensuring our processes for career progression are fair and equitable; removing barriers to progression; increasing flexibility in leadership roles.

- **Community engagement**

  Actively promoting careers within our communities; creating employment opportunities for under-represented groups.

Building an inclusive culture

Our aim is to develop an environment where diversity is truly valued. We recognise that discrimination exists in society, in our workplaces and in healthcare. Our commitment is to take proactive steps to address inequalities. The creation of an inclusive culture where everyone can thrive, is a responsibility shared by everyone at NWAS.

Our data currently tells us that the experiences of our staff with different protected characteristics (such as age, gender, disability and sexual orientation) is different. Exposure to negative experiences such as bullying, harassment, discrimination or sexual misconduct remains too high. Turnover in some groups is higher than the average. Entry into management processes such as discipline and performance management is higher for people from ethnic minority backgrounds and disabled staff. This leaves some of our people feeling under-valued and unfairly treated. They cannot give their best to patients unless the culture and environment support them and value them.

Our priorities in this area are therefore:

- **Inclusive leadership and allyship**

Our leaders should be visible role models for inclusion and act as positive allies. Inclusion needs to be at the heart of our leadership development, building confidence and competence to support their diverse teams. We also need to hold our leaders to account for the environments they create.

- **Reducing negative behaviours**

  We will continue to build confidence in speaking up; taking positive action to address negative behaviours such as bullying and harassment; sexual safety and discrimination.

- **Reducing discrimination in processes**

  We will actively measure the differing impacts of our processes and take steps to address inequalities which are identified.

- **Anti-racist**

  We aim to bring our anti-racism statement to life. To confront racism in any form. To actively identify, challenge and change policies, systems, attitudes and beliefs that perpetuate racist ideas and actions.

- **Diverse staff voices**

  We will engage our staff in change and the decisions that affect them; ensuring that the voices of all groups are actively sought out and that our staff networks are vibrant and supported.

Theme 3: Improvement

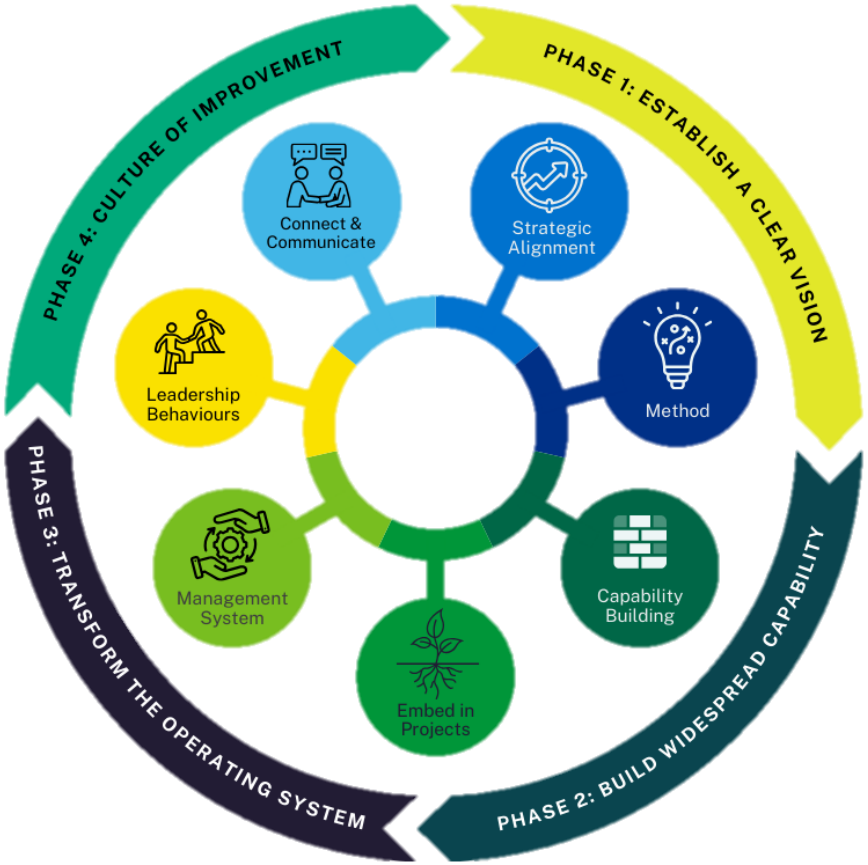
Embedding an improvement culture

Improvement should be a core theme across all our strategic aims because it helps us create an organisation where everyone feels able to make a positive difference in their everyday role. When improvement is part of how we work, not an isolated project or specialist activity, we build a culture where ideas are encouraged, problems are solved early, and better ways of working spread naturally across teams and services.

Making improvement a core theme also means we can develop capability from the Board to frontline colleagues, giving everyone the skills, confidence and tools to make changes that benefit patients, our people and the wider system. When leaders model and support this approach, and teams feel empowered to test ideas and learn from experience, improvement becomes something we all share and contribute to.

Embedding improvement across all our aims also helps us work more consistently. A single, shared way of approaching change, supported by good data, clear priorities and simple methods, makes it easier to align efforts, build on what works and ensure progress is sustained. This strengthens collaboration across services and helps us use our resources more effectively.

Above all, having improvement as a core theme supports a culture of continuous learning and curiosity. It enables us to keep adapting, keep getting better, and keep focusing on what matters most for our patients, our people and the communities we serve.



Over the next five years, we will make continuous improvement part of how we work at NWAS, so we can deliver our ambitions and provide the best possible care for patients.

Our improvement journey will move through four stages:

1. Set a clear vision for improvement, with visible leadership commitment.
2. Build the skills, tools and support our people need to improve services and deliver meaningful change.
3. Make changes to how we operate based on improvement expertise.
4. Embed improvement into everyday practice, so it becomes part of our culture and the way we work.

How we will deliver our strategy

Implementation and delivery

Our five-year **strategy** outlines where we are now, where we want to be and the areas we want to focus on to achieve our vision. We all share responsibility for the aims and must work together to achieve success.

We have four **strategic plans** which each align to one aim and provide detail on specific delivery objectives and key measures of success. These plans also include a roadmap which shows the sequencing of objectives and outcomes over the next three to five years.

We also have **enabling plans** which crosscut several or all our aims. These plans focus on digital, estates and fleet, improvement and environment. They outline more specific pieces of work which will be undertaken to help support delivery of our plans.

The **NHS England medium term plan** is a mandated external submission which is refreshed annually. It uses key information from our strategic plans plus updated modelling assumptions to provide triangulated view of delivery and assurance that we will achieve key performance targets.

Each year, we will develop an **annual plan** which shows what the projects, milestones and measures will be for the coming year. This plan will also assess whether we have the right capacity, expertise and resource to deliver our objectives. The annual plan should also be used to shape directorate, team and individuals' objectives and ensure we're all working towards a shared set of priorities.

We must have a way of providing **assurance** back through our Board of Directors that we are making year-on-year progress towards achieving our strategy.

Delivery of the strategy will be overseen through our governance framework. Progress against strategic objectives will be monitored through the Board Assurance Framework, performance reporting and regular strategy delivery reviews. The Board of Directors and its committees will receive routine updates on progress, risks and delivery milestones to ensure the strategy remains on track.

Appendices

Appendix 1: How we developed our strategy

Working with our stakeholders

It's essential that our strategy reflects the diverse perspectives of our stakeholders, including staff, patients, and system partners. To achieve this, we collaborated with key leads to identify the most effective ways to engage these groups and ensure the strategy is truly representative.

To support the development of the strategy, we undertook targeted engagement with key stakeholders. This included a combination of structured workshops, focused discussions, and one-to-one sessions designed to build on themes identified during the diagnostic phase.

Workshops were held to discuss the following themes: people, digital, staff safety, patient safety, and health inequalities.

Further targeted engagement - Additional discussions with subject matter experts explored emerging priorities such as environmental sustainability, our future care delivery model, value for money, quality, and infrastructure requirements.

Leadership engagement - Strategic input was also gathered through focused discussions with our senior leadership group, executives and non-executive directors.

External engagement - We have shared our draft strategic ambition with partners from across our geographical footprint to ensure that we are aligned and clear on how trusted partnerships will support delivery of our strategy.

In total, the sessions engaged a broad range of stakeholders, including over 270 colleagues from across key areas and system partners, ensuring diverse perspectives were represented throughout the process.

Using insights from our stakeholders we have developed a refreshed set of strategic aims which reflect the major themes identified through consensus building. These aims have been re-tested with stakeholders to ensure they resonate with the organisation's purpose, vision, and values and that they provide a clear framework for our underpinning strategic plans.

Appendix 2: Glossary of terms

Our strategy

Term	Definition	Example
Purpose statement	A purpose statement is a clear, concise sentence that explains why something exists or is being done.	To help people when they need us most.
Values	Our values underpin everything that we do and guide our people, decisions, actions and behaviours.	Working together, being at our best, and making a difference.
Vision	A vision is a clear statement of what an organisation or person strives to achieve in the future.	To deliver the right care in the right place at the right time; every time.
Strategic aim	Our strategic aims are long-term, yet high-level goals which will translate vision into tangible reality.	Deliver outstanding, inclusive care for everyone we serve.

Strategic plans

Term	Definition	Example
Strategic objective	Each plan outlines a set of specific, measurable objectives that supports the delivery of the organisation's strategic aims.	Attract and recruit a representative workforce, providing effective onboarding and support to retain them.
Deliverables	Activities which will ultimately deliver an objective.	Deliver a talent management framework to enable us to grow our talent.
Measures of success	Sets out how we will measure achievement of our strategic objectives.	Improvement against workforce race equality workforce indicators.

Annual plan

Term	Definition	Example
Annual priorities	Summarises the organisations delivery priorities for each financial year and aligns with workforce, financial and operational planning assumptions.	Embed new operational leadership structures and ensure leaders have the skills to deliver their roles effectively.

Other key terms

Term	Definition	Example
ICB	Integrated Care Boards are statutory NHS organisations responsible for planning, funding and coordinating health services within a defined local area.	Our service covers five ICBs - Cheshire and Merseyside, Greater Manchester, Lancashire and South Cumbria, North Cumbria and Derby and Derbyshire (Glossop).
Place based partnerships	These are collaborative groups involving a range of health and care providers within a local area who collectively influence population health and wellbeing.	Partners include NHS organisations, local authorities, voluntary and community organisations, social care providers and other public sector partners.
Primary care networks (PCNs)	PCNs bring together general practices (GPs) with other health services to improve access and provide more integrated care for local populations.	There are 166 PCNs across the North West footprint.
Core20PLUS5	Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level.	Core20: identify the most deprived 20%in the population. PLUS: Locally identified groups who experience poorer access or outcomes. 5: five key priority clinical areas identified for accelerated improvement.

Delivering the right care for **20 years**

Delivering the right care, at the right time, in the right place; everytime.

North West Ambulance Service NHS Trust

Quality

Strategic Plan 2026 – 2031

Foreword

This strategic quality plan describes our ambition to continuously improve the quality of the services that patients and those close to them experience. Building on the positives of the previous three-year quality strategy, this plan aims to embed quality improvement and learning as the way we, NWAS, do what we do. At its core this means focussing on getting the basic of our care right every time: our response, the timeliness and the patient experience. This is not to acknowledge that in challenging circumstances and in complex situations we may not always get things right first time but we have a commitment to hold up the mirror to ourselves and to drive improvement through learning and an unstinting focus on doing what is right for the patients we serve across the North West.

In order to ensure that any changes we are making are good changes- in the interests of those we serve, this plan details our themed programmes of work over the next five years and aligns our ambitions against the Trust strategic aim of delivering outstanding, inclusive care for everyone we serve. In order for our care to be judged as outstanding we commit to systematically addressing areas of avoidable harm in our patient care and improve the clinical outcomes and patient experience to be amongst the best nationally. We want our care to be inclusive to all and this means a focus on reducing health inequalities where these are within our control which is also detailed within this plan. We recognise the constraints on a publicly funded service and this quality plan is underpinned by principles of clinical effectiveness and operational efficiency.

It is no mistake that content overlaps with other strategic plans as a quality focus is core to all that we will do, similarly our ambition to be a learning and improvement organisation guides how we will deliver this plan and is also underpinned by elements of the people plan. This strategic plan therefore supports the clinical response plan and uses a quality lens to describe what we are committed to delivering over future years.

Elaine Strachan-Hall
Director of Quality, Innovation and Improvement

Executive summary

This summary provides a consolidated overview of the Quality Strategic Plan for 2026–2031, bringing together NWAS's commitments to improving patient safety, clinical effectiveness, patient experience and reducing health inequalities. It outlines how NWAS will strengthen its safety culture, reduce avoidable harm, improve outcomes across major clinical pathways, and embed patient voice and continuous improvement into everyday practice. By aligning these programmes of work to the organisation's strategic aim of providing outstanding, inclusive care for everyone we serve, this plan sets out a clear, systematic roadmap for achieving consistently high-quality care across all services.

The plan also describes how NWAS will use data, learning and improvement methodologies to drive change, how cross-cutting themes such as health inequalities and EDI will shape delivery, and how quality will act as the lens that underpins all strategic and operational decision-making. Over the next five years, this plan will guide the Trust's priorities, interventions and measures of success to ensure care is safer, more effective and more inclusive for all communities.

The plan is structured around 4 strategic objectives:

- **Objective 1:** Reduce avoidable harm by 30% for PSIRF priorities
- **Objective 2:** Improve the effectiveness of care by prioritising improvement activity for patients who experience sub-optimal care because of recognised health inequalities.
- **Objective 3:** We will improve the clinical outcomes for our patients to be in the top quartile of ambulance quality indicators
- **Objective 4:** We will drive continuous enhancements in patient experience by ensuring the patient voice is central to shaping and improving clinical services, achieving a 5% uplift in experience and embedding meaningful patient involvement across improvement activity.

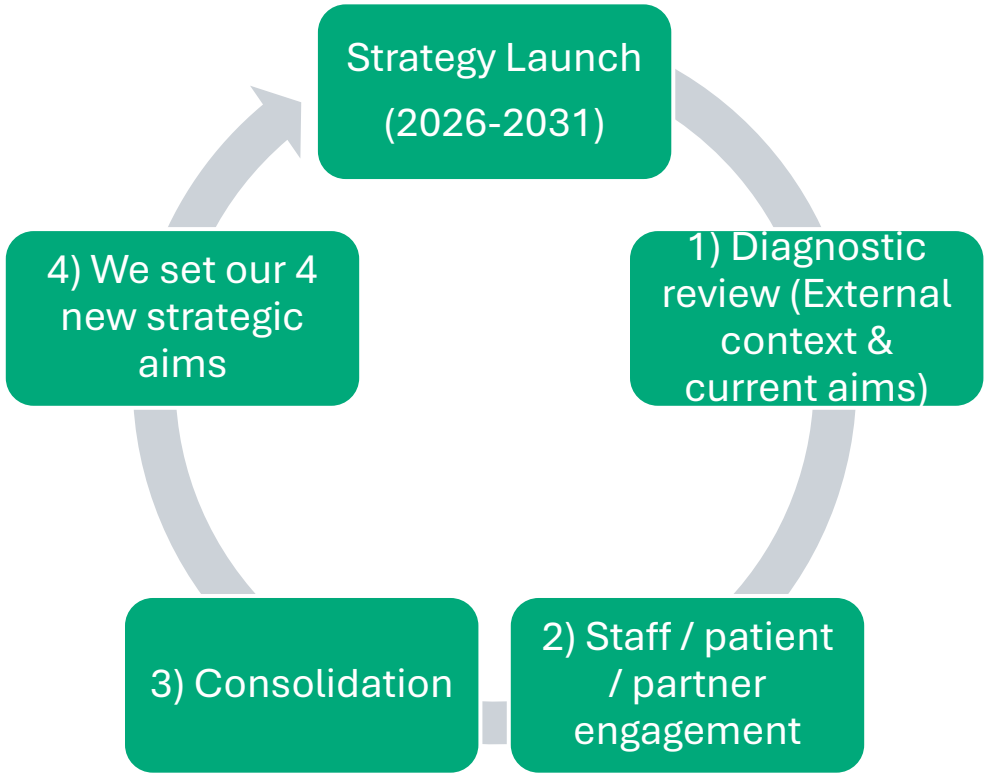
Contents

Our strategy development process

Our 2026-2031 strategy was shaped through wide range engagement with our staff, volunteers, patients, and partners, alongside a diagnostic review of our current position. Using this as a guide, we designed our strategic aims.

At its heart, the strategy defines our shared purpose: helping people when they need us most. Guided by this, our vision is simple and remains the same - providing the right care, at the right time, in the right place, every time.

This year, we will continue working with stakeholders to keep our strategy relevant and up to date against the current context.


Strategy Launch (2026-2031)
1) Diagnostic review (External context & current aims)
2) Staff / patient / partner engagement
3) Consolidation
4) We set our 4 new strategic aims

Strategic framework

- Our five-year **trust strategy** outlines where we are now, where we want to be and the areas we want to focus on to achieve our vision. We all share responsibility for the aims and must work together to achieve success.
- We have four **strategic plans** which each align to one aim and provide detail on specific delivery objectives and key measures of success. These plans also include a roadmap which shows the sequencing of objectives and outcomes over the next three to five years.
- We also have **enabling plans** which cross-cut several or all our aims. These plans focus on digital, estates and fleet, improvement and environment and outline more specific pieces of work which will be undertaken to help support delivery of our plans.
- The **NHS England medium term plan** is a mandated external submission which is refreshed annually. It uses key information from our strategic plans plus updated modelling assumptions to provide triangulated view of delivery and assurance that we will achieve key performance targets.
- Each year, we will develop an **annual plan** which shows what the projects, milestones and measures will be for the coming year. This plan will also assess whether we have the right capacity, expertise and resource to deliver our objectives. The annual plan should also be used to shape directorate, team and individuals' objectives and ensure we're all working towards a shared set of priorities.
- We must have a way of providing **assurance** back through our Board of Directors that we are making year-on-year progress towards achieving our strategy.

Our strategic aims

Our trust strategy has been designed around four clear aims that will guide everything we do over the next five years. Each aim sets out what we want to achieve, the priorities we will focus on, and the measures we will use to track success. Together, these aims will help us create a service that is trusted, inclusive, and ready for the future. This **Quality Plan** aligns primarily to our first aim: 'provide outstanding, inclusive care for everyone we serve' and provides detail on the specific delivery objectives and key measures of success which we'll focus on over the next five years.

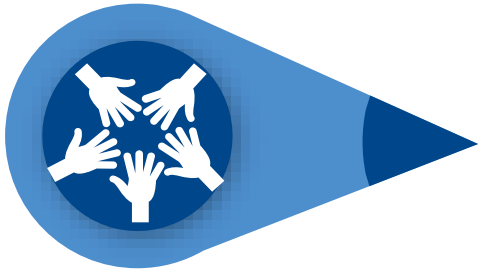
Strategic aims	PROVIDE	BUILD	DELIVER	EMBED
	Provide outstanding, inclusive care for everyone we serve	**Build a safe, supportive and inclusive culture together**	**Deliver a responsive care model through partnerships**	**Embed continuous improvement and innovation for a sustainable future**
Ambition for 2031	We will provide high-quality, safe and compassionate care for all our communities, continuously improving to reduce unwarranted variation and health inequality.	Our leaders create a compassionate, inclusive and supportive workplace culture, where everyone has a voice, can be at their best and is supported to improve and develop.	We will strengthen and develop our operating model and work closely with partners to ensure care is coordinated, equitable and responsive to population needs.	We will embed a culture of learning and improvement that drives productivity and delivers clinical, operational, workforce, financial and environmental sustainability.
Headline description	**Outstanding care** – what we provide to patients and communities.	**Inclusive culture** – how we create the environment for success.	**Care model** – how we organise and collaborate to meet need.	**Continuous improvement** – how we evolve and secure the future.
Strategic outcomes / benefits	• Safer care • More effective care • Better patient experience • Reduced health inequalities	• Improved culture • Better place to work • More representative workforce • Workforce fit for future	• Delivery of core standards • Contribution to 3 shifts (10YP) • Flexible and adaptive model • Trusted partner	• Improvement-focused • Reduced waste • Digitally enabled • Environmentally sustainable

Cross cutting themes – health inequalities, equality, diversity & inclusion & improvement

Our strategic plans are supported by cross-cutting themes that guide our decision making and shape our services. The themes are health inequalities, equality, diversity and inclusion, and continuous improvement. They are not standalone priorities but are integral to every strategic objective, shaping how we design our services, utilise our resources and measure our success. Each strategic plan will outline how they will consider and address these key themes.

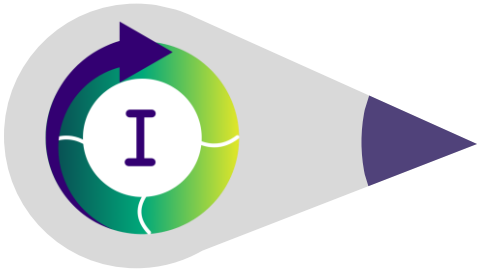
Tackling health inequalities is a national priority and our plan will address how we can reduce gaps in access, experience and outcomes, ensuring all the communities we serve can benefit.

Through this plan we will focus on the inclusive groups outlined within the health inequalities framework to guide future work on clinical effectiveness. This will ensure future improvement focuses on reducing unwarranted variation in access, experience and outcomes. By targeting priority population group and improving our understanding of inequalities, the plan will strengthen to inclusivity and effectiveness of care.



We are committed to an **active approach to equality, diversity and inclusion and** it is a fundamental underpinning focus of this plan.

EDI principles shape how services are designed, how patient voice is heard and how staff are supported. The plan strengthens equitable communication, ensures learning from diverse patient groups and staff informs improvement, and reinforces inclusive leadership behaviours that contribute to safer, more compassionate care. Our approach to delivering the plan will consider opportunities to be actively anti-racist and will seek to identify and eliminate discrimination in our processes.



We strive to become an **improvement organisation**.

Continuous improvement is the method through which this plan is delivered. The plan embeds PSIRF learning cycles, clinical supervision, use of real-time data, and systematic feedback loops so that teams can identify variation, learn from incidents and make changes that lead to safer, more effective and more consistent care.

Quality Strategic Plan

Background and progress so far

Previous strategic focus & intent

The previous Quality Strategy (2023–2026) was designed to support the Trust's overarching vision of delivering the right care, at the right time, in the right place, every time. Its intent was to embed a culture of continuous improvement and ensure care was consistently safe, effective, and patient-centred.

The strategy focused on three core pillars:

- **Safety First**: Building the safest possible system for 999, 111, and PTS patients by reducing avoidable harm, strengthening safety culture, and implementing the Patient Safety Incident Response Framework (PSIRF).
- **Highly Effective Care**: Improving clinical outcomes through evidence-based practice, reducing unwarranted variation, and achieving stretch targets for Ambulance Clinical Quality Indicators (ACQIs), particularly for cardiac arrest and stroke.
- **Patient-Centred Partnerships**: Ensuring patients were active partners in care design, expanding engagement through the Patient and Public Panel, and embedding shared decision-making into clinical practice.

The strategy also committed to digital enablement, SMART innovations, and quality management systems to underpin improvement, alongside a strong emphasis on equality, diversity, and inclusion.

Since the Quality Strategy was developed, the NHS has laid out its 10-year plan and explicitly identified three shifts (hospital to communities, analogue to digital and from sickness to prevention) each of which underpin the development of this local quality strategy (plan). The NHS 10 year plan also makes reference to the development of a national Quality Strategy by the National Quality Board which is likely to refer to a providing a safe, effective and positive experience for patients, with the expectation that quality of care is inextricably linked to access and value. This plan aligns with these expectations and gives an overview of how NWAS will go about making these a reality for the people we serve.

Delivery and progress achieved to date

Over the past few years, the Trust has delivered significant progress aligned to its ambition of providing safe, effective, and patient-centred care:

- **Safety Culture & Insight:** Embedded safety culture surveys across all services, introduced real-time safety dashboards, and strengthened partnerships for shared learning.
- **Implemented the Patient Safety Incident Response Framework** and appointed Patient Partners into our governance structures.
- **Highly Effective Care:** Improved compliance with Ambulance Clinical Quality Indicators (ACQIs), particularly for cardiac arrest and stroke care. Reduced unwarranted variation in treatment and outcomes, and advanced care for maternity, mental health, and frailty.
- **Digital & SMART Innovations**: Rolled out SMART notice boards and undertaken test of concept for elements of a SMART station and SMART vehicles programme, driving efficiency and safety. Enhanced digital systems for EPR, enabling real-time measurement of safety and effectiveness.
- **Patient-Centred Partnerships:** Expanded Patient & Public Panel to nearly 300 members, embedded patient stories into governance, and strengthened co-design approaches. Increased engagement through FFT, complaints, and social media feedback.
- **Learning & Improvement:** Established the Improvement academy, built Power BI dashboards for performance monitoring, and started the journey to deliver improvement capability across teams.

What remains to be addressed

This Quality strategic plan builds on the previous quality strategy and encapsulates the aims and ambitions to safeguard and systematically improve the quality of the services we offer over the next 5 years.

While significant progress has been made, there are opportunities to use a sustained focus to achieve our ambition of delivering outstanding, inclusive care. Moving forward, we need to strengthen consistency in care delivery, embed a mature safety culture, and tackle health inequalities. Patient voice must become a standard part of service design, and we must build improvement capability at scale to ensure continuous learning and innovation across all teams.

Key Areas:

- Embedding safety improvement culture: Identifying and addressing key areas that could lead to patient harm. Building our safety culture, moving from measurement to full cultural maturity, ensuring psychological safety and proactive risk management
- Consistency in safe and effective care delivery: Reduce unwarranted variation across pathways, especially for people with mental health needs, frailty, maternity, and complex respiratory and cardiovascular needs.
- Health inequalities: Address gaps in access and outcomes for vulnerable groups through targeted improvement programmes.
- Patient voice at scale: Ensure that patient feedback influences care delivery and that we co-design the expansion of feedback mechanisms to ensure diverse representation and real-time influence on service design and delivery.
- Improvement capability: Build critical mass of staff skilled in improvement science and sustain collaboratives at scale.

This plan draws from other strategic plans, particularly the clinical response plan and the people plan and addresses the thematic elements of quality showing clear alignment to overarching objectives and priorities. Annual dependency and resource mapping will enable the scheduling of key workstreams.

Strategic context

National direction

The national Quality Strategy is likely to focus on ensuring patients have a safe, effective and good experience of care with the following explanation

Safe – care that is delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.

Effective –care that is informed by consistent and up-to-date high-quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit.

Positive experience – care that is responsive, personalised and caring – shaped by what matters to people, their preferences and strengths; care that empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable; and care that is delivered with compassion, dignity and mutual respect.

Beyond these must do expectations however, quality is of care is inextricably linked with access and value and the National Quality Strategy is likely to set out an approach to improving quality with as much rigour as access, performance, finance and use of resources, and also consider them together 'in the round' identifying where the strategy needs to feed into wider strategic work. This approach recognises that quality care is better value for money, and that financial and operational decisions must be informed by a clear focus and clarity on quality risks and inequalities impact, including any adverse impacts. The National Quality strategy will take into consideration:

a. **Access:** as a pre-requisite for quality. Access impacts on all 3 dimensions of quality – effectiveness, safety, experience. Maintaining a relentless focus on improving access is therefore central to meeting our quality duty. The quality strategy will consider where issues in access are impact quality and ensure this is fed into the 10 Year Health Plan approach, particularly the vision working group considering how to deliver the statement "I can access the high quality and effective care I need, when and where I need it".

b. **Value:** quality of care at every level can increase value including through technical efficiency (eg at a clinical level by reducing errors or readmissions for example) and allocative efficiencies (eg at a population level by maximising health gain). There is a role for integrated care boards (ICBs) as strategic

commissioners to support quality through a shift of care upstream and commissioning for quality and maximising value in terms of health gain. The quality strategy should ensure it considers and aligns with the operating model to achieve this.

The national and regional ask of ambulance services is to deliver the constitutional expectations of timeliness of services for CAT 1-4 whilst maintaining or improving the ambulance quality indicators

Category 1: Mean response time under 7 minutes and 90% of calls reached within 15 minutes.

Category 2: Mean response time under 18 minutes and 90% within 40 minutes.

Category 3: 90% of calls responded to within 120 minutes.

Category 4: 90% of calls responded to within 180 minutes.

ACQIs include both:

- AmbSYS (system indicators): response times, call answer performance, handover delays, and other operational standards.
- AmbCO (clinical outcomes): measures such as ROSC, STEMI and stroke pathway performance, trauma outcomes, and sepsis indicators.

Together, the constitutional standards and ACQIs define the national expectations for safe, timely, effective ambulance care and form the basis for our commitment to achieving top-quartile patient outcomes.

This national direction underpins the mission of NWAS to provide the right care at the right time in the right place.

Internal direction

NWAS has been recognised as one of the top performing ambulance trusts via the NHS Oversight Framework. NWAS strategic plan outlines the ambition to be the best or amongst the best provider of ambulance services so that the patients we serve can be confident of consistent help when they need it most.

Introducing the plan

There is a clear need for a dedicated Quality Strategic Plan to ensure that quality is an underpinning principal at the heart of everything we do. This plan sets out our ambition to improve patient safety, clinical effectiveness, outcomes, patient experience whilst systematically addressing key areas of health inequality. The healthcare landscape is evolving rapidly, with increasing complexity in patient needs, regulatory requirements, and system integration. Recent learning from incidents, variation in outcomes, and national priorities such as the Patient Safety Incident Response Framework (PSIRF) highlight the urgency of a coordinated approach. This plan provides a structured overview of how we will reduce avoidable harm, reduce unwarranted variation, and embed continuous improvement and strengthen safety culture across all services, ensuring we deliver outstanding, inclusive care for every patient.
This plan has been developed through a number of workshops, both organisation wide and within the Quality directorate where we have considered our ambition and our commitments to specific programmes of work which address the four strategic aims whilst focusing on the delivery of outstanding, inclusive care for everyone we serve.

Alignment with the Trust strategy and planning framework

The Quality Strategic Plan is fully aligned with the Trust's overarching purpose of delivering the right care, at the right time, in the right place, every time. It directly supports the four strategic aims whilst focusing on the delivery of outstanding, inclusive care for everyone we serve.

- Provide – Quality initiatives focus on reducing unwarranted variation, improving clinical outcomes, and embedding patient-centred care, ensuring outstanding care for everyone we serve.
- Build – By fostering a strong safety culture and inclusive approach, the plan contributes to creating a safe, supportive environment for staff and patients.
- Deliver – Through partnerships and collaborative improvement programmes, the plan strengthens care models and ensures equitable, coordinated services.
- Embed – Continuous improvement is at the heart of the Quality Plan, driving innovation in safety, effectiveness, and patient experience to secure sustainable progress.

The plan sits within the Trust's strategic framework, aligning with the annual business plan and supporting enablers such as EDI, Digital and Health Inequalities. It complements other strategic plans by providing the quality lens that underpins all service delivery

Strategic objective & high-level deliverables

Objective: 1

We will reduce avoidable harm by 30% for our PSIRF priorities.

The ambulance service exists to help people when they need it most which includes responding to a very broad scope of incidents and situations and an increasingly complex set of individual patient conditions requiring excellent assessment and communication skills and the proportionate and effective delivery of first contact care. Although many of our pathways are established in nationally verified guidance we know that there are situations where we do not get it right and harm may occur. To deliver outstanding care for everyone we must identify what contributes to avoidable harm and take steps to address these systematically. This objective sets an ambitious target to reduce avoidable harm by a significant proportion in order to deliver outstanding care for everyone.

High-level deliverables

1. We will identify the main contributors to avoidable harm by strengthening our safety data and triangulating a range of insights across the trust including a focus on near misses and low harm events.
2. We will progress the improvement priorities of the PSIRF Framework to focus early year attention on the priority areas of cardiac arrest, harm related to non-conveyance and pre-hospital maternity and newborn care.
3. We will review and improve compliance with the NHS England National Standards of Cleanliness and establish improved cleaning performance by applying functional risk categories to vehicles and Trust premises. We will carry out robust audits to monitor this to ensure a 5% improvement on average audit scores.
4. We will review the approach to quality data for the organisation, building data science capability.
5. Design and implement a digital safeguarding referral system that streamlines reporting, improves data quality and timeliness, strengthens multi-agency information sharing and enhances organisational assurance. This will include robust quality oversight and staff support to ensure safeguarding concerns are identified, escalated and monitored consistently and effectively across the organisation.
6. Develop our programme of Senior Leadership walkarounds to align with annual plans.

7. We will progress the development of the ‘Early Warning System’ to look for patterns across data sets that could indicate a risk to patient safety and quality and take early remedial action to address risk.

8. We will improve tracking and monitoring of medicines using digital solutions to reduce risks in current systems and processes including digital stock pharmacy management system and electronic controlled drugs register.

Objective: 2

Improve the effectiveness of care by prioritising improvement activity for patients who experience sub-optimal care as a result of recognised health inequalities.

Outstanding care is effective care and the effectiveness of care can be impacted by inequalities in the way the care is delivered or unwarranted variation which may not cause harm but is less effective than it could be. As an ambulance service we have the privilege of attending people in their own homes and therefore, we have opportunities to make every contact count and to improve the inclusivity of our care by addressing inequalities in practice or access using improvement methodologies to run successive PDSA's or tests of change. By exploring key areas of our activity in relation for patients who experience sub-optimal care as a result of recognised health inequalities we can use this insight into any areas of deficit to prioritise remedial action in a targeted and measurable manner.

High-level deliverables

1. Review inequalities and outcomes for people with Mental Health needs, identifying key opportunities for making every contact count and identify process measures of impact. Following scoping we will identify an appropriate percentage improvement expected from the delivery of the remedial activity and demonstrate improved outcomes for our patients.

2. Review inequalities and outcomes for people with Frailty, identifying key opportunities for making every contact count and identify process measures of impact. Identify key interventions to test and skill staff in key every contact count interventions. Following scoping we will identify an appropriate percentage improvement expected from the delivery of the remedial activity to enable us to monitor the effectiveness of our activity and demonstrate improved outcomes for our patients.

3. Review inequalities and outcomes for pregnant mothers, identifying key opportunities for making every contact count and identify process measures of impact. Identify key interventions to test and where indicated skill staff in key interventions. Following scoping we will identify an appropriate percentage improvement expected from the delivery of our remedial activity to enable us to monitor the effectiveness of our activity and demonstrate improved outcomes for our patients.

4. Review inequalities and outcomes for people with Respiratory needs, identifying key opportunities for making every contact count and identify process measures of impact and identify key interventions to test. Following scoping we will identify an appropriate percentage improvement expected from the delivery of the remedial activity and demonstrate improved outcomes for our patients.

5. We will review inequalities and outcomes for people with cardiovascular disease, identifying key opportunities for making every contact count and identify process measures of impact. Identify key interventions to test. Following scoping we will identify an appropriate percentage improvement expected from the delivery of the remedial activity and demonstrate improved outcomes for our patients.

6. We will review inequalities and outcomes for people with LD&A, identifying key opportunities for making every contact count and identify process measures of impact. Identify key interventions to test. Following scoping we will identify an appropriate percentage improvement expected from the delivery of the remedial activity and demonstrate improved outcomes for our patients.

7. We will improve our ethnicity capture as per requirements of NHSE ethnicity recording improvement plan. Following scoping we will identify an appropriate percentage improvement expected from the delivery of the remedial activity and demonstrate improved outcomes for our patients.

Objective: 3

We will improve the clinical outcomes for our patients to be in the top quartile of ambulance quality indicators

In ambulance service the effectiveness of care can be measured by the outcome of interventions such as resuscitation and the application of standardised pathways or care bundles. However, there is not a comprehensive set of outcomes by which to measure outstanding care and therefore the first requirement will be to scope the measures by which the outcomes of contact, assess and respond elements can be measured. Subject matter experts will contribute to driving forward improvements in services towards outstanding inclusive care. This strategic objective also includes plans to review our quality control and quality assurance mechanisms firstly to improve our governance and oversight and secondly to reduce the audit burden where appropriate.

High-level deliverables

1. Adopt and integrate the A-EQUIP (Advocating and Educating for Quality Improvement) model for the clinical work force ensuring all clinicians have regular access to supportive, developmental and restorative supervision.
2. Scope the opportunity for improvement in each of the AQI
3. Progress the 'what good looks like' dashboard
4. Explore technology options to better support High Intensity Users
5. Evaluate and redesign the quality assurance and quality control mechanisms to better support improvement
6. Procure and embed a replacement clinical audit tool that enables us to use learning and insight to enhance clinical effectiveness and improve performance against ACQIs
7. Complete the roll out of Defibrillator Replacement Project (Phase 3) to ensure that patients receive effective and reliable care.

Objective: 4

We will drive continuous enhancements in patient experience by ensuring the patient voice is central to shaping and improving clinical services, achieving a 5% uplift in experience and embedding meaningful patient involvement across improvement activity.

Outstanding care is characterised by an excellent patient experience and we know from patient feedback that their experience of our services is impacted by the timeliness of our response but also by the effective and compassionate communication with our staff. In order to deliver an outstanding experience for everyone we will seek to increase the feedback particularly from hard to reach groups and identify specific improvements that will improve how patients experience our care

High-level deliverables

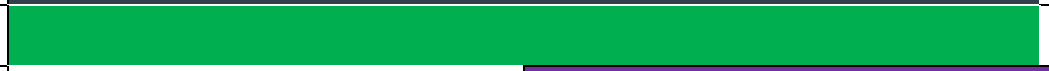
1. Share learning from patient experience, particularly from underrepresented groups, working with other teams to inform greater insights and target our improvement opportunities at opportunities to improve how people experience our care.
2. Review the current use of patient feedback by area and service line together with any potential barriers or misperceptions and strengthen the patient voice and focus in our improvement activity to identify specific areas of patient and public feedback.
3. Expand our patient and public involvement
4. Design and implement a measurement system to assess the level of patient experience involvement and the timeliness of the involvement.

What does success look like?

Alignment to strategic aims	Embed continuous improvement and innovation for a sustainable future
Measures	1. 30% decrease in NWAS attributed to avoidable harm 2. 5%-6% increase in patient experience 3. Improvements in Frailty assessment, by X 4. Reduction in health inequalities for patients with mental health care needs 5. Improvements in compliance with cardiovascular care and respiratory pathways 6. Reduction of harm in pre-hospital maternity and newborn care
What will look different?	Patients, families and staff will have increased confidence that care is consistently safe, with fewer incidents of avoidable harm and stronger learning embedded across services. Patients will feel listened to, respected and involved in decisions about their care, with more consistent, compassionate interactions throughout their contact with NWAS. Improvement activity will be shaped by the patient voice. Older and frail patients will receive earlier, more accurate identification of frailty, leading to more personalised care, better decision-making and improved outcomes. Patients with suspected cardiovascular conditions will experience more timely, evidence-based assessment and treatment, improving outcomes and reducing unwarranted variation in care. Mothers, babies and families will experience safer, more reliable care, with staff feeling confident and supported to deliver high-quality maternity and newborn interventions in pre-hospital settings.

Sequencing

Objective 1: We will reduce avoidable harm by 30% for our PSIRF priorities.	**2026**	**2027**	**2028**
We will identify the main contributors to avoidable harm and progress improvement programmes to deliver a sustainable reduction in harm events.			
We will progress the thematic reviews and improvement priorities of the PSRIF Framework to focus early year attention on the priority areas of cardiac arrest, harm related to non-conveyance and pre-hospital maternity and newborn care.			
We will review and improve the organisational approach to IPC including establishing and auditing new cleaning standards			
Explore technology options to better support High Intensity users			
Strengthen safeguarding arrangements for those we serve by interagency communication and collaboration and improving recognition and onward referral for those in need			
Implement senior leadership walkarounds			

Progress the early warning system			
Improve tracking and monitoring of medicines using digital solutions to reduce risks in current systems and processes (YR1 = digital stock pharmacy mgmt system and electronic controlled drugs register FBC)			
Objective 2: We will improve the effectiveness of care by prioritising improvement activity for patients who experience sub-optimal care as a result of recognised health inequalities.	**2026**	**2027**	**2028**
Mental Health			
Frailty			
Pregnant mothers			
Respiratory			
Cardiovascular			
LD&A			
Improve our ethnicity capture			
Objective 3: We will improve the clinical outcomes for our patients to be in the top quartile of ambulance quality indicators	**2026**	**2027**	**2028**

Adopt and integrate the A-EQIP (Advocating and Educating for Quality Improvement) model for the clinical work force to ensuring all clinicians have regular access to supportive, developmental and restorative supervision.			
Scope the opportunity for improvement in each of the AQI			
Progress the 'what good looks like' dashboard			
Explore technology options to better support High Intensity users			
Redesign the quality assurance and quality control mechanisms to better support improvement			
Produce and embed a replacement clinical audit tool that enables us to use learning and insight to enhance clinical effectiveness and improve performance against ACQIs			
Complete the roll out of Defibrillator Replacement Project (Phase 3) to ensure that patients receive effective and reliable care.			
Objective 4: We will drive continuous enhancements in patient experience by ensuring the patient voice is central to shaping and improving clinical services, achieving a 5% uplift	**2026**	**2027**	**2028**

in experience and embedding meaningful patient involvement across improvement activity.			
Share learning from patient experience, particularly from underrepresented groups, working with other teams to inform greater insights.			
Review the current use of patient feedback by area and service line together with any potential barriers or misperceptions.			
Design and implement a measurement system to assess the level of patient experience involvement and the timeliness of the involvement.			

Glossary of terms

Term	Definition	Example
Trust strategy		
Purpose statement	A **purpose statement** is a clear, concise sentence that explains why something exists or is being done.	To help people when they need us most
Vision	A **vision** is a clear statement of what an organisation or person strives to achieve in the future.	To deliver the right care in the right place at the right time; every time
Values	Our values underpin everything that we do and guide our people, decisions, actions and behaviours.	Working together, being at our best, and making a difference
Strategic aim	Our strategic aims set the direction of travel for the organisation and translate the vision into action.	Deliver outstanding, inclusive care for everyone we serve
Strategic plans		
Strategic objective	Each plan outlines a set of specific, measurable objectives that supports the delivery of the organisation's strategic aims.	Attract and recruit a representative workforce, providing effective onboarding and support to retain them

Deliverables	Activities which will ultimately deliver an objective.	Deliver a talent management framework to enable us to grow our talent
Measures of success	Sets out how we will measure achievement of our strategic objectives.	Improvement against WRES workforce indicators
Annual plan		
Annual priorities	Summarises the organisations delivery priorities for each financial year and aligns with workforce, financial and operational planning assumptions.	Embed new operational leadership structures and ensure leaders have the skills to deliver their roles effectively.

North West Ambulance Service NHS Trust

People & Culture

Strategic Plan 2026 – 2031

Foreword

The People and Culture Strategic Plan outlines how we will achieve the Trust's strategic aim of "Build a safe, supportive and inclusive culture together". Through the delivery of this plan, we will ensure our patients experience outstanding care from colleagues who reflect the diverse communities we serve, have a voice that is heard, are able to reach their full potential and are part of a compassionate, inclusive and supportive workplace.

We have listened to our people who have told us where we need to do more and the plan describes our focus on five key areas - Attraction & Welcome; Leadership & Management; Developing for the future; Wellbeing, Culture & Inclusion and Listening to staff. We will deliver change and innovation across the board from using the latest technology to build our administrative infrastructure to implementing clearly defined career and leadership development opportunities that start on day one and continue throughout people's employment journey with us.

All of this work sits within a rapidly changing regional and national environment. Our plan will need to align with the outputs from the Ten-Year Plan and the national Workforce Plan whilst upholding our commitment to the People Promise work we have already begun.

Our people are at the centre of this plan. Their voices have been heard and are reflected in our priorities. Through supporting their development and recognising their commitment, we will continue to deliver outstanding patient care across the North west.

Lisa Ward
Director of People & Culture

Executive summary

The People & Culture Strategic Plan (2026–2031) sets out how NWAS will achieve the strategic aim to **"Build a safe, supportive and inclusive culture together."** Rooted in engagement with our people, the plan outlines how we will create an environment where colleagues feel valued, supported, and empowered to deliver exceptional care.

The plan focuses on five priority areas: **Attraction & Welcome; Leadership & Management; Developing for the Future; Wellbeing, Culture & Inclusion; and Listening to Staff**. Each is designed to enhance the employee experience across the entire lifecycle. It builds on strong progress made through the previous strategy, including strengthened leadership development, improved retention, enhanced wellbeing support, and more inclusive cultural foundations.

Across the next five years, our work will ensure we attract and retain a representative workforce, build confident and inclusive leaders, provide high-quality learning and career pathways, embed a culture that prioritises wellbeing and psychological safety, and strengthen how we listen and respond to staff feedback.

The plan is structured around five strategic objectives:

- **Objective 1:** Attraction and Welcome – Attract and recruit a representative workforce, providing effective onboarding and support to retain them
- **Objective 2:** Leadership and Management – Develop confident and inclusive leaders who respond effectively to complexity and support staff to thrive
- **Objective 3:** Developing for the Future – Provide high-quality, accessible development and career progression opportunities
- **Objective 4:** Wellbeing, Culture and Inclusion – Build an inclusive, supportive and safe culture across the employee lifecycle
- **Objective 5:** Listening to Staff – Build a listening culture where staff and learners are active partners in improvement

This plan will provide further detail on what our strategic objectives and delivery priorities will be over the next five years, as well as the underpinning measures of success.

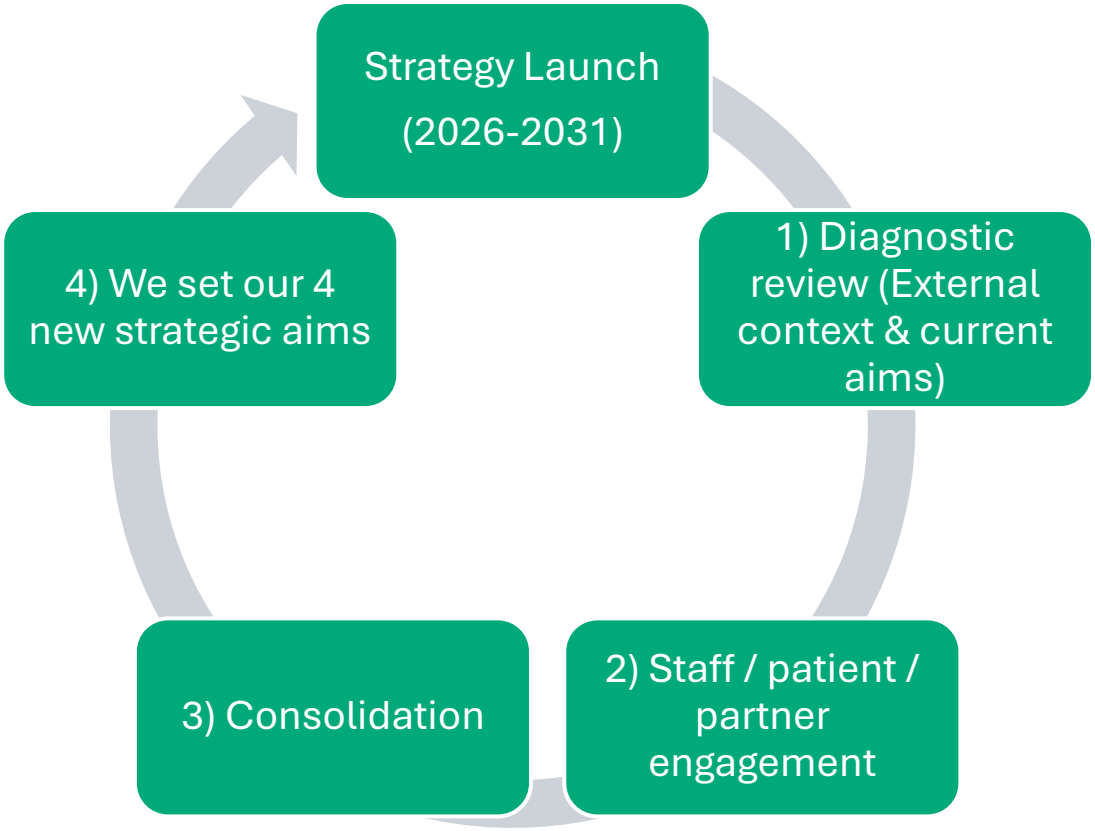
Contents

Our strategy development process

Our 2026-2031 strategy was shaped through wide range engagement with our staff, volunteers, patients, and partners, alongside a diagnostic review of our current position. Using this as a guide, we designed our strategic aims.

At its heart, the strategy defines our shared purpose: helping people when they need us most. Guided by this, our vision is simple and remains the same - providing the right care, at the right time, in the right place, every time.

This year, we will continue working with stakeholders to keep our strategy relevant and up to date against the current context.


Strategy Launch (2026-2031)
1) Diagnostic review (External context & current aims)
2) Staff / patient / partner engagement
3) Consolidation
4) We set our 4 new strategic aims

Strategic framework

- Our five-year **trust strategy** outlines where we are now, where we want to be and the areas we want to focus on to achieve our vision. We all share responsibility for the aims and must work together to achieve success.
- We have four **strategic plans** which each align to one aim and provide detail on specific delivery objectives and key measures of success. These plans also include a roadmap which shows the sequencing of objectives and outcomes over the next three to five years.
- We also have **enabling plans** which cross-cut several or all our aims. These plans focus on digital, estates and fleet, improvement and environment and outline more specific pieces of work which will be undertaken to help support delivery of our plans.
- The **NHS England medium term plan** is a mandated external submission which is refreshed annually. It uses key information from our strategic plans plus updated modelling assumptions to provide triangulated view of delivery and assurance that we will achieve key performance targets.
- Each year, we will develop an **annual plan** which shows what the projects, milestones and measures will be for the coming year. This plan will also assess whether we have the right capacity, expertise and resource to deliver our objectives. The annual plan should also be used to shape directorate, team and individuals' objectives and ensure we're all working towards a shared set of priorities.
- We must have a way of providing **assurance** back through our Board of Directors that we are making year-on-year progress towards achieving our strategy.

Our strategic aims

Our trust strategy has been designed around four clear aims that will guide everything we do over the next five years. Each aim sets out what we want to achieve, the priorities we will focus on, and the measures we will use to track success. Together, these aims will help us create a service that is trusted, inclusive, and ready for the future. This **People and Culture Plan** aligns primarily to our second aim: 'build a safe, supportive and inclusive culture together' and provides detail on the specific delivery objectives and key measures of success which we'll focus on over the next five years.

Strategic aims	PROVIDE	BUILD	DELIVER	EMBED
	Provide outstanding, inclusive care for everyone we serve	**Build a safe, supportive and inclusive culture together**	**Deliver a responsive care model through partnerships**	**Embed continuous improvement and innovation for a sustainable future**
Ambition for 2031	We will provide high-quality, safe and compassionate care for all our communities, continuously improving to reduce unwarranted variation and health inequality.	Our leaders create a compassionate, inclusive and supportive workplace culture, where everyone has a voice, can be at their best and is supported to improve and develop.	We will strengthen and develop our operating model and work closely with partners to ensure care is coordinated, equitable and responsive to population needs.	We will embed a culture of learning and improvement that drives productivity and delivers clinical, operational, workforce, financial and environmental sustainability.
Headline description	**Outstanding care** – what we provide to patients and communities.	**Inclusive culture** – how we create the environment for success.	**Care model** – how we organise and collaborate to meet need.	**Continuous improvement** – how we evolve and secure the future.
Strategic outcomes / benefits	• Safer care • More effective care • Better patient experience • Reduced health inequalities	• Improved culture • Better place to work • More representative workforce • Workforce fit for future	• Delivery of core standards • Contribution to 3 shifts (10YP) • Flexible and adaptive model • Trusted partner	• Improvement-focused • Reduced waste • Digitally enabled • Environmentally sustainable

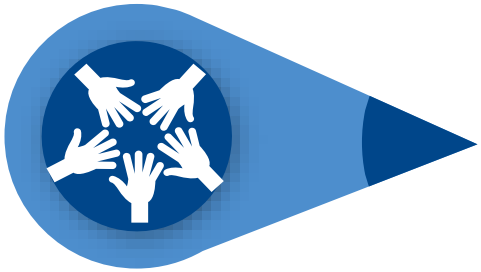
Cross cutting themes – health inequalities, equality, diversity & inclusion & improvement

Our strategic plans are supported by cross-cutting themes that guide our decision making and shape our services. The themes are health inequalities, equality, diversity and inclusion, and continuous improvement. They are not standalone priorities but are integral to every strategic objective, shaping how we design our services, utilise our resources and measure our success. Each strategic plan will outline how they will consider and address these key themes.

Tackling health inequalities is a national priority and our plan will address how we can reduce gaps in access, experience and outcomes, ensuring all the communities we serve can benefit.

We will deliver:

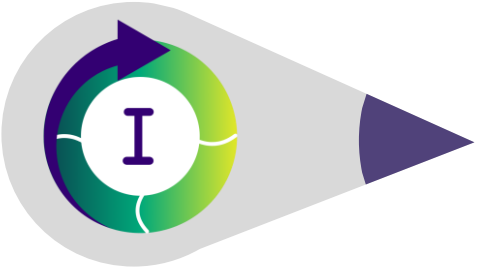
- Attraction activities that are embedded in our work with communities
- Increases in cultural competence in the delivery of care
- A preventative approach to wellbeing & attendance



We are committed to an **active approach to equality, diversity and inclusion and** it is a fundamental underpinning focus of our plan.

Through this plan, we will deliver:

- Increases in diverse representation at all levels through fair attraction, career progression and community engagement
- Increases in cultural competence of staff and leaders
- A culture which is more inclusive – reducing negative experiences, narrowing experience gaps, reducing discrimination
- Progress towards the organisation being actively anti-racist
- Continued support for diverse voices to be heard



We strive to become an **improvement organisation** – meaning that we will empower our people to apply improvement methods to continuously learn, adapt and enhance the quality of our care and services.

We will:

- Make improvement behaviours a core expectation for all leaders
- Build improvement capability and an improvement professional road map to support all levels of the organisation
- Use improvement methodology to support the delivery of effective and sustainable change in delivery of this plan

People & Culture Strategic Plan

Background and progress so far

The Trust's People Strategy (2023–2026) set out our ambition to 'Be a brilliant place to work for all'.

Over the lifespan of this strategy, we made significant progress. To support our aim to develop compassionate leadership, we have seen our foundation leadership development offer refreshed and mandated. Large scale organisational change for PES and ICC has been supported through revised leadership recruitment approaches and leadership induction delivered to over 400 new leaders. A talent management programme for aspiring leaders has successfully launched, alongside formalising of development routes into operational leadership.

Our commitment to improving culture was demonstrated through our Stop, Speak, Support sexual safety campaign and more latterly the launch of our anti-racism statement. These have been supported through leadership events and additional learning for all our people, and this remains a focus for this strategic plan. We have revised approaches to investigations, improved timeliness and enabled improvements to flexible working, reasonable adjustments and maternity.

We have continued to enable our people to reach their potential. Our onboarding and induction approaches have also been refreshed. Apprenticeship numbers continue to grow, and OFSTED have rated our provision as Good. We have enhanced the way we listen to and keep our learners safe. The support offered by our Widening Access and Positive Action teams to internal staff and local communities has continued to grow. The CPD and Learning Hub is now firmly established and is an actively used resource for learning and development.

Our Staff Networks are flourishing, helping us to improve our levels of representation across the workforce and influencing policy and practice. We have invested in support to tackle violence prevention, launched new Occupational Health support and seen significant improvements in attendance.

We have exceeded our targets for appraisals and mandatory training, significantly improved retention and seen positive improvements in staff survey results.

All of this work represents significant achievement and is a reflection of the hard work of our teams across the trust. We will build on these solid foundations, embedding good practice and continuing to innovate.

Strategic context

National and regional direction

The 10-year plan and its supporting workforce plan, offers a vision for the transformation of NHS services. We have to remain agile and flexible to respond to the opportunities it offers, enabling our workforce to develop new skills, transition to new roles and work collaboratively with partners to deliver change.

National programmes of work are anticipated to impact on People Plans. They provide the opportunity to enhance consistency of experience and benefit from best practice. Examples include the NHS Leadership and Management Framework, national People Policies, review of statutory and mandatory training, employment standards and reform of terms and conditions.

The Culture Review of Ambulance Services report and recommendations also remains a guide for our work towards a more inclusive and safer cultural environment. This plan will build on the foundations we have already established, and it will align and reflect national and regional strategies and drivers. The plan will drive the transformation of how we access and deliver people services and support the organisation's ability to listen, learn and improve.

Digital commitments for staff set out in the 10-year plan will also influence NWAS plans. In particular, the period of the strategy will see the implementation of the new workforce solution, national job evaluation system and the staff app.

The way in which people services are delivered is also evolving through national work around the Target Operating Model, harnessing digital technology and shared service arrangements to maximise ease of access, self service and efficiency.

Internal strategic direction

Whilst significant steps forward were made with the previous people strategy, there is more work for us to do. Through the staff survey, staff networks and workforce metrics, our people have told us where we need to focus our efforts:

- Negative experiences at work remain too high and confidence in speaking up still needs to grow
- Our processes do not always feel fair to staff, particularly their experience of career progression
- Our equality data shows differential experiences and potential discriminatory practice
- Staff are keen to develop and progress but want greater transparency and access to development opportunities

- Staff want to be involved, be listened to and want to be able to influence the work they do and how they do it
- When things go wrong our staff want to be supported
- We have five different generations in the workforce with different aims, aspirations and ways of working
- We are often reactive to deterioration in wellbeing, rather than focusing on prevention

The NHS People Promise sets out ambitions for what people working in the NHS should expect to experience in work. These ambitions, alongside our own values of Making a Difference, Being at our Best and Working Together, underpin the People and Culture Plan.

Introducing the plan

The People and Culture Strategic Plan will contribute to the delivery of the all the trust strategy aims, as it will support our people to enable them to deliver what is needed by our patients and communities as we move through the changes expected in the NHS.

However, the plan will have a particular focus on the delivery of the strategic aim:

Build a safe, supportive and inclusive culture together.

We will achieve this through a focus on:

- Attraction and welcome
- Leadership and management
- Developing for the future
- Wellbeing, culture and inclusion
- Listening to staff

Equality, Diversity and Inclusion

Equality, Diversity and Inclusion is a central theme that cuts across our Trust Strategy and all our Strategic Plans. It is a fundamental underpinning focus of the People and Culture Plan. It does not stand alone as a priority area as it is essential that it is considered as part of the implementation of the whole strategic plan. However, there are key areas in which this plan is expected to deliver EDI improvements over the course of its implementation:

- Increases in diverse representation at all levels through fair attraction, career progression and community engagement
- Increases in cultural competence of staff and leaders
- A culture which is more inclusive – reducing negative experiences, narrowing experience gaps, reducing discrimination
- Progress towards the organisation being actively anti-racist

- Continued support for diverse voices to be heard

Strategic objective and high-level deliverables

Objective: 1

Attraction and welcome - attract and recruit a representative workforce, providing effective onboarding and support to retain them

We want to attract the best talent, give them a sense of belonging and connection with the organisation from their first day and inspire them with an exciting future with NWAS which means that they stay. We want the experience of recruitment and onboarding to be positive, streamlined and easy to navigate. We want to eliminate the discrimination in our processes and embed our recruitment in the communities that we serve.

High-level deliverables

1. Increased BME representation across our workforce
2. Deliver a comprehensive onboarding and induction programme
3. Attraction activities embedded in our work with communities
4. Effective support for the first 12 months of joining the trust
5. Improving recruitment processes and applicant experience

Objective: 2

Leadership and management - develop confident and inclusive leaders who have the skills and tools to respond to complexity and enable our staff to reach their potential

We want our leaders to understand and embrace their responsibilities to our people. We want them to be confident, skilled and visible in creating an inclusive culture, where staff feel safe and reach their potential. We commit to developing our leaders to operate in a complex and evolving environment. Through national digital tools we aim to transform people processes to increase self-service and to release administrative time.

High-level deliverables

1. Fit for purpose leadership and management development aligned with national expectations
2. Make improvement a core expectation for all leaders through embedding improvement behaviours into leadership development, appraisal, recruitment and job descriptions
3. Comprehensive and effective coaching and mentoring offer
4. What Good Looks Like Framework for holding leaders to account
5. Increased diversity of leaders and leaders equipped to create inclusive environments
6. Reduce administration burden for staff and managers through digital development and process improvement

Objective: 3

Developing for the future - develop high quality, accessible opportunities for ongoing development and career progression which meet the aspirations of individuals and support improved patient care

We want all our staff to be able to see their future and how to get there, whether that's career opportunities or being the best that they can be in their current role. We want this to be a learning and improvement organisation where people take responsibility for their learning and we enable them to access the resources and support to succeed. We want our education and learning delivery to be first class. We want to equip our staff with the knowledge and skills to embrace future roles and changing demands.

High-level deliverables

1. Visible career pathways and signposted support
2. A talent management framework to enable us to grow our talent
3. Development of skills and roles fit for the future
4. Continuing professional development for all
5. Developing cultural competence
6. Building improvement capability

Objective: 4

Wellbeing, culture and inclusion - continue to develop a culture that is inclusive, supportive, safe and responsive to the needs of staff across the employee lifecycle

We want to provide the building blocks to support staff through their employee lifecycle. To provide access to high quality wellbeing resources and support; to be flexible when life presents challenges; to provide options to balance work and home life; to make a difference to the working lives of staff. We want to continue to create an environment which is inclusive, actively anti-racist and which feels safe. We want to reduce experiences of violence and aggression and make sure that the right support is in place where staff experience this. In return we expect staff to engage with the options available, take steps to support their own wellbeing and recognise the balance needed to deliver services to patients.

High-level Deliverables

1. Developing the confidence and practice to be actively anti-racist
2. Creating an environment which is psychologically & sexually safe
3. Relevant & accessible mental health and wellbeing offer
4. Preventative approach to wellbeing & attendance
5. Improve outcome and safety measures regarding physical and verbal abuse
6. Strengthen staff safety culture and reporting
7. Fair and consistent experiences at work
8. Improved work-life balance
9. Operational working practices which balance the needs of patients and staff

Objective: 5

Listening to staff - build a listening culture where staff and learners are active partners in improving how we work and provide care

We want staff to feel involved and able to influence the way in which they work. We want staff to have regular and meaningful conversations with their leaders. We want staff to feel confident to speak up, to make suggestions, to be listened to and to receive timely feedback. We want to work proactively with trade union partners and directly with staff to improve what we do and how we work.

High-level deliverables

1. Effective appraisal and staff conversations
2. Increased opportunities for staff engagement and partnership working to shape and influence what we do and how we work
3. Implementation of recognition framework
4. Improved learning and feedback loops
5. Increased opportunities for learner voice to be heard and for it to influence the way education and learning is delivered
6. Developing the effectiveness of teams

What does success look like?

Strategic Objective	Attraction & Welcome	Leadership & Management	Developing for the Future	Well-being, Culture & Inclusion	Listening to Staff
Measures	To increase: • BME representation to 10% of the workforce To improve • Application to shortlisting & Shortlisting to appointment metrics • Retention in first year • Candidate & recruiting management feedback To reduce: • WRES shortlisting to appointment indicator to below 1.25% • Time to recruit	To improve: • Levels of representation of women and BME staff in leadership positions • Staff survey leadership scores to top 3 in sector • Evaluation feedback on leadership development To increase: • Uptake in coaching and mentoring • Compliance with leadership induction to 90%	To improve: • OFSTED rating to exceptional for 3 out of 5 standards • Staff survey 'we are always learning theme' to top 3 in sector • Staff survey improvement question above average • Learning evaluation measures To increase: • Uptake of learning offers • Traffic to Learning Hub	To improve: • Staff survey 'we are safe and healthy theme' and experience of negative behaviours to top 3 in sector • Retention in PTS/ ICCs/ Corporate teams To reduce: • Absence rates to 5% • Violence & aggression • Pay gaps • WRES/WDES gaps in experience indicators to below 5%	To improve: • Staff survey 'engagement & morale themes' to top 3 in sector • Learner feedback about their experiences • Staff survey - Speaking up measures
Descriptors of what feel different	• Co-ordinated/impactful positive actions to	• Visibly diverse role models and leaders • Coaching and mentoring is	• All staff know the career pathways open to them and	• Staff are confident that concerns will be	• Staff have regular and meaningful conversations

	attract and recruit BME staff. • Faster recruitment with great communication. • New starters have a sense of belonging from day 1. • New starters have access to all the resources, information and support needed to support them to thrive. • Reduced/no disparity in the appointment of White and BME applicants	accessible to all leaders • All new leaders complete a leadership induction • Leaders can demonstrate the contribution they make to a positive and inclusive culture. • Leaders are confident to have difficult conversations and challenge poor behaviours • Services are responsive and accessible, designed to reduce time spent processing. • Improvement is fundamental to the way we lead.	how to access support to achieve their goals. • Staff feel confident that career development and progression is fair • Staff are confident to deliver care in an inclusive and culturally competent way • There is a shared ownership for development • Educational venues are fit for purpose • Staff are confident to apply improvement methodologies to their work.	listened to and acted upon. • Staff are able to recognise the factors impacting on their own wellbeing and take steps to address or seek support. • Leaders feel confident to have honest conversations about wellbeing • Flexible working is a normal part of working life • Staff feel safe in work • The organisation is actively anti-racist and challenges discrimination	with their line manager. • Leaders take the opportunity to recognise the contribution of staff • Staff are involved in the decisions affecting them and feel able to contribute to improvements • Learners' experience is positive and safe • Staff see how their voice makes a difference • A recognition framework which helps staff to feel valued by managers

Sequencing

Objective 1	2026	2027	2028
Attraction & Welcome	Increasing BME representation		
	Improving processes & applicant experience		
	Comprehensive onboarding & induction		
		Attraction activities are embedded in our work with communities	
		Support in first 12 months	
Objective 2	**2026**	**2027**	**2028**
Leadership & Management	Leadership & management development		
		Coaching & mentoring	
		Holding to account & performance management	
	Increased diversity of leaders equipped to create inclusive environments		
	Reduce administration burden for staff and managers		
	Make improvement a core expectation for all leaders		
Objective 3	**2026**	**2027**	**2028**
Developing for the future	Visible career pathways		
		Growing our talent	
	Developing cultural competence		
		Continuing professional development for all	
			Skills & roles fit for the future

	Building improvement capability		
Objective 4	**2026**	**2027**	**2028**
Wellbeing, Culture & Inclusion	Anti racism		
	Psychologically & sexually safety		
	Relevant & accessible mental health and wellbeing offer		
		Preventative approach to wellbeing & attendance	
	Improve measures regarding physical and verbal abuse		
		Strengthen staff safety culture and reporting	
		Fair and consistent experiences at work	
	Work-life balance		
		Operational working practices	
Objective 5	**2026**	**2027**	**2028**
Listening to Staff		Effective appraisal & staff conversations	
	Staff engagement & partnership working		
	Recognition framework		
	Improved learning and feedback loops		
	Learner voice		
		Developing teams	

Glossary of terms

Term	Definition	Example
Trust strategy		
Purpose statement	A **purpose statement** is a clear, concise sentence that explains why something exists or is being done.	To help people when they need us most
Vision	A **vision** is a clear statement of what an organisation or person strives to achieve in the future.	To deliver the right care in the right place at the right time; every time
Values	Our values underpin everything that we do and guide our people, decisions, actions and behaviours.	Working together, being at our best, and making a difference
Strategic aim	Our strategic aims set the direction of travel for the organisation and translate the vision into action.	Deliver outstanding, inclusive care for everyone we serve
Strategic plans		
Strategic objective	Each plan outlines a set of specific, measurable objectives that supports the delivery of the organisation's strategic aims.	Attract and recruit a representative workforce, providing effective onboarding and support to retain them
Deliverables	Activities which will ultimately deliver an objective.	Deliver a talent management framework to enable us to grow our talent
Measures of success	Sets out how we will measure achievement of our strategic objectives.	Improvement against WRES workforce indicators

Annual plan		
Annual priorities	Summarises the organisations delivery priorities for each financial year and aligns with workforce, financial and operational planning assumptions.	Embed new operational leadership structures and ensure leaders have the skills to deliver their roles effectively.

NHS
North West
Ambulance Service
NHS Trust

Clinical Response Plan

Strategic Plan
2026 – 2031

Foreword

As we look ahead to the next five years, this Clinical Response Strategic Plan sets out how we will continue to improve the care we provide to patients across the North West. Our service has come a long way in recent years, with stronger clinical models, closer integration across 111, 999 and PTS, and better support for our clinicians to make safe, prompt decisions. This progress provides a solid foundation for the future, but we know there is more to do.

Demand for ambulance services is rising, patients' needs are becoming more complex, and expectations of what ambulance trusts can deliver are changing. We are increasingly required not only to respond, but to coordinate and guide care across the whole system. To meet this challenge, we need a clear and shared direction for how we deliver contact, assessment and response in a way that is safe, consistent, and equitable for every community we serve.

This plan brings our clinical and operational ambitions together into one coherent framework. It describes how we will strengthen early clinical decision making, expand alternatives to hospital care, build a resilient and skilled workforce, and use digital tools and data to improve outcomes. Most importantly, it sets out how we will ensure patients receive the right care, in the right place, at the right time, every time.

We are grateful to colleagues across clinical, operational and support services who have shaped this work, and to our partners who will continue to play a vital role in delivering it. This plan marks the next stage in our journey to provide outstanding, inclusive care and to support the health and wellbeing of the communities we serve.

Dan Ainsworth
Director of Operations

Chris Grant
Executive Medical Director

Executive Summary

The Clinical Response Strategic Plan sets out how NWAS will evolve the delivery of urgent and emergency care over the next five years. It provides a clear strategic framework for strengthening our contact, assessment and response model so that patients consistently receive the right care, in the right place, at the right time.

With our previous strategy, NWAS has made significant progress in improving the way patients access and receive care. The integration of NHS 111, 999 and Patient Transport Services, alongside stronger clinical leadership and improved triage processes, has enhanced the organisation's ability to respond to demand and deliver safe, timely care. These developments have enabled more patients to be assessed, treated or referred without conveyance to hospital and have strengthened NWAS's role within the wider urgent and emergency care system.

However, demand for ambulance services continues to grow and patient needs are becoming more complex. Pressures across the wider health and care system continue to affect patient flow and access to appropriate pathways. While national policy also increasingly expects ambulance services to act not only as responders but as coordinators and navigators of care across the system.

This plan sets a clear direction for how NWAS will strengthen clinical decision-making, improve consistency in patient pathways, and expand alternatives to hospital care. It focuses on developing a clinically led, digitally enabled model that supports early assessment, effective care coordination and responsive operational delivery.

Ultimately, this plan establishes the foundations for a more integrated, resilient and patient-centred care delivery model, aligning clinical and operational priorities deliver safe, equitable and sustainable urgent and emergency care across the North West.

The plan is structured around three strategic objectives:

- **Objective 1 (Contact):** Deliver an integrated, technology-enabled contact model that improves accessibility, reduces inequality, and enhances efficiency and patient experience
- **Objective 2 (Assessment):** Deliver safe, consistent, and personalised triage and assessment that identifies risk early, reduces variation, and ensures patients receive the right care first time.
- **Objective 3 (Response):** Deliver a resilient, efficient, and patient-centred response model that uses technology, workforce optimisation, and system collaboration to provide the right care, in the right place, at the right time.

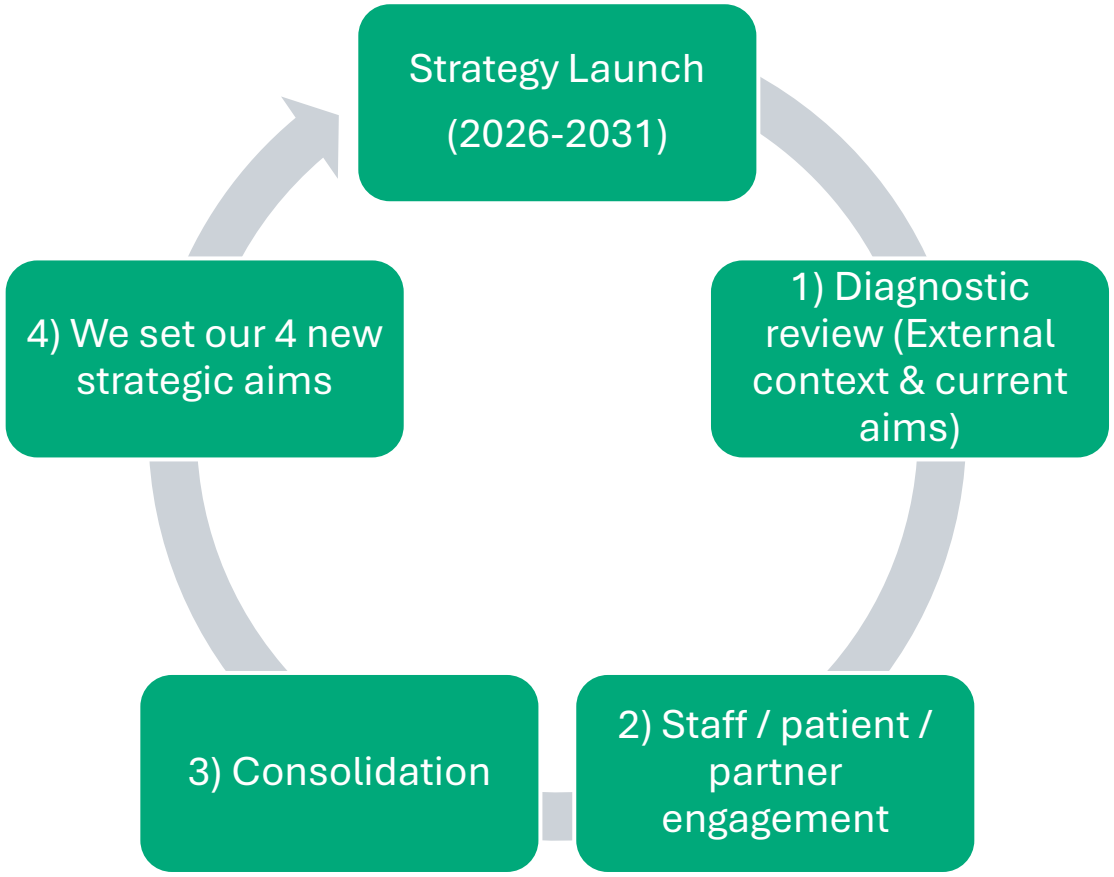
Contents

Our strategy development process

Our 2026-2031 strategy was shaped through wide range engagement with our staff, volunteers, patients, and partners, alongside a diagnostic review of our current position. Using this as a guide, we designed our strategic aims.

At its heart, the strategy defines our shared purpose: helping people when they need us most. Guided by this, our vision is simple and remains the same - providing the right care, at the right time, in the right place, every time.

This year, we will continue working with stakeholders to keep our strategy relevant and up to date against the current context.



Strategic framework

- Our five-year **trust strategy** outlines where we are now, where we want to be and the areas we want to focus on to achieve our vision. We all share responsibility for the aims and must work together to achieve success.
- We have four **strategic plans** which each align to one aim and provide detail on specific delivery objectives and key measures of success. These plans also include a roadmap which shows the sequencing of objectives and outcomes over the next three to five years.
- We also have **enabling plans** which cross-cut several or all our aims. These plans focus on digital, estates and fleet, improvement and environment and outline more specific pieces of work which will be undertaken to help support delivery of our plans.
- The **NHS England medium term plan** is a mandated external submission which is refreshed annually. It uses key information from our strategic plans plus updated modelling assumptions to provide triangulated view of delivery and assurance that we will achieve key performance targets.
- Each year, we will develop an **annual plan** which shows what the projects, milestones and measures will be for the coming year. This plan will also assess whether we have the right capacity, expertise and resource to deliver our objectives. The annual plan should also be used to shape directorate, team and individuals' objectives and ensure we're all working towards a shared set of priorities.
- We must have a way of providing **assurance** back through our Board of Directors that we are making year-on-year progress towards achieving our strategy.

Our strategic aims

Our trust strategy has been designed around four clear aims that will guide everything we do over the next five years. Each aim sets out what we want to achieve, the priorities we will focus on, and the measures we will use to track success. Together, these aims will help us create a service that is trusted, inclusive, and ready for the future. This **Clinical Response Plan** aligns primarily to our third aim: 'deliver a responsive care model through partnerships' and provides detail on the specific delivery objectives and key measures of success which we'll focus on over the next five years.

Strategic aims	PROVIDE	BUILD	DELIVER	EMBED
	Provide outstanding, inclusive care for everyone we serve	**Build a safe, supportive and inclusive culture together**	**Deliver a responsive care model through partnerships**	**Embed continuous improvement and innovation for a sustainable future**
Ambition for 2031	We will provide high-quality, safe and compassionate care for all our communities, continuously improving to reduce unwarranted variation and health inequality.	Our leaders create a compassionate, inclusive and supportive workplace culture, where everyone has a voice, can be at their best and is supported to improve and develop.	We will strengthen and develop our operating model and work closely with partners to ensure care is coordinated, equitable and responsive to population needs.	We will embed a culture of learning and improvement that drives productivity and delivers clinical, operational, workforce, financial and environmental sustainability.
Headline description	**Outstanding care** – what we provide to patients and communities.	**Inclusive culture** – how we create the environment for success.	**Care model** – how we organise and collaborate to meet need.	**Continuous improvement** – how we evolve and secure the future.
Strategic outcomes / benefits	• Safer care • More effective care • Better patient experience • Reduced health inequalities	• Improved culture • Better place to work • More representative workforce • Workforce fit for future	• Delivery of core standards • Contribution to 3 shifts (10YP) • Flexible and adaptive model • Trusted partner	• Improvement-focused • Reduced waste • Digitally enabled • Environmentally sustainable

Cross cutting themes – health inequalities, equality, diversity & inclusion & improvement

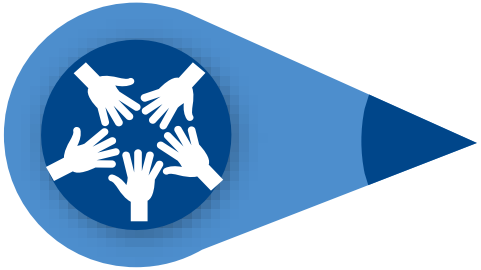
Our strategic plans are supported by cross-cutting themes that guide our decision making and shape our services. The themes are health inequalities, equality, diversity and inclusion, and continuous improvement. They are not standalone priorities but are integral to every strategic objective, shaping how we design our services, utilise our resources and measure our success. Each strategic plan will outline how they will consider and address these key themes.

Reducing health inequalities is a national priority. Therefore, our contact, assessment and response processes must be more consistent, accessible, and fair for all communities.

Our focus is on removing barriers to care, reducing unwarranted variation, and improving outcomes for groups who face greater risks or poorer access. We will use data, partnership working and inclusive practice to ensure our model supports those who need us most.

Our commitment includes:

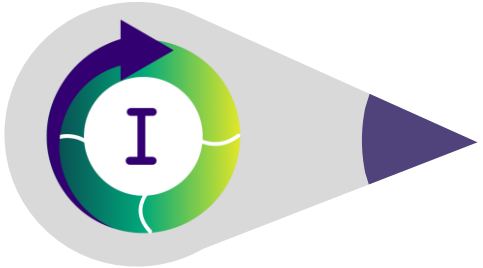
- Improving accessible communication and reducing language barriers.
- Ensuring consistent pathways across all localities.
- Using data to identify and address inequity.
- Supporting staff to deliver culturally competent, inclusive care



We are committed to an active approach to equality, diversity and inclusion where it informs our service design, supports our delivery, and improves the equity of the care we provide.

Our commitment includes:

- Seeking opportunities in delivery of the plan to be actively anti-racist.
- Seeking to identify and reduce discrimination in our contact, assessment, and response processes.
- Engaging with diverse patient, staff and community groups to inform our models of care and improve our delivery and representation.
- Working to improve representation, so those delivering our care mode are reflective of the communities they serve
- Ensuring our leaders visibly and proactively consider equality, diversity and inclusion in the development and delivery of the plan.



Our focus is on practical, evidence-based changes that support frontline decision-making, reduce variation and enhance flow. By making improvement a routine part of clinical and operational practice, we can respond faster, work more efficiently, and deliver better outcomes.

Our commitment includes:

- Using real-time data and insight to target variation.
- Equipping teams with simple, effective improvement tools.
- Testing and scaling changes that improve safety and flow.
- Working with partners to streamline pathways and reduce friction in the system.

Clinical Reponse Stategic Plan

Background and progress so far

Previous strategic focus and intent

The Trust's Service Development Strategy (2023–2026) built on the foundations established by the Urgent and Emergency Care Strategy (2019). Together, these strategies set out a clear intent to bring NWAS operational service lines closer together, including NHS 111, 999, Emergency Operations Centres, Paramedic Emergency Services, Patient Transport Services, and volunteer responder models. The focus was on improving how patients access care, strengthening clinical assessment and decision-making, and integrating systems, leadership, and management arrangements so that patients receive the right care in the right place, regardless of how they contact the service.

Delivery and Progress achieved to date

Over the lifespan of the previous strategy, NWAS has delivered significant progress. NHS 111, 999 and Patient Transport Services have been integrated into a single, more efficient contact centre model, supported by new clinical assessment and leadership structures. This has delivered measurable improvements in call handling performance, including increased calls answered within 60 seconds, reduced call abandonment and improved 999 call pick-up times. Clinical models have also evolved, with increasing use of triage and treatment over the phone, strengthened clinical supervision, and expanded referral pathways into community and specialist services. As a result, more patients are now safely managed without conveyance to hospital, supported by access to virtual wards, urgent community response and condition-specific pathways.

What remains to be addressed

While strong progress has been made, not all ambitions of the previous strategy are fully realised. Variation remains in access to alternative pathways, system integration, and flow across the NWAS footprint, and hospital handover delays continue to impact operational delivery in some areas.

The previous strategy also did not set out a single, explicit articulation of the future care delivery model across contact, assessment, and response. As expectations of ambulance services continue to evolve, there is a need to consolidate learning to date and provide a clearer, Trust-wide strategic framework for patient care.

This Clinical Response Strategic Plan builds on the foundations and learning from previous strategies. It provides a single, coherent framework to describe how care will be delivered across NWAS, bringing together clinical and operational objectives and creating shared ownership of future direction.

The plan establishes the basis for further development by clinical and operational leaders and will be refined through ongoing engagement with system partners to ensure alignment and deliverability

Strategic context

Internal direction

Strong foundations and improving performance

NWAS enters this planning period as a high-performing ambulance trust, with strong foundations across contact, assessment, and response. Significant progress has been made through the integration of NHS 111, 999 and PTS, delivering improved access, resilience, and patient experience.

Performance in call handling and urgent response places NWAS as the leading ambulance trust nationally.

Clinical models continued to evolve, with increasing use of Hear & Treat and See & Treat approaches, improved clinical validation, and expanded access to community and specialist pathways. These developments have enabled more patients to receive safe, effective care without conveyance to the hospital and have strengthened NWAS's role within the wider urgent and emergency care.

Rising demand, system pressure and changing expectations

Demand for ambulance services continues to rise in both volume and acuity, driven by population ageing, increasing multi-morbidity, health inequalities and constrained capacity across community, primary and acute services. Persistent system pressures, including hospital handover delays and variable access to alternative pathways, continue to impact patient flow and operational performance.

At the same time, national policy is redefining the role of ambulance services. NWAS is increasingly expected to act as a system coordinator and navigator, supporting care closer to home, protecting emergency capacity and improving system flow. While current models have delivered improvement, they are not sufficient on their own to meet future expectations at scale without a clear, strategic approach to care delivery.

National and regional direction

The national and regional ask of ambulance services

National policy and commissioning direction is clear that ambulance services must play a pivotal role in stabilising and transforming urgent and emergency care systems. The NHS 10 Year Health Plan, Medium Term Planning Framework and ambulance service specification set expectations that ambulance services will move beyond a predominantly transport-based model to act as system coordinators, navigators, and senior clinician decision-makers.

Key national priorities include improving response for the sickest patients, with an explicit ambition to achieve a Category 2 mean response time of 18 minutes, alongside a sustained reduction in avoidable emergency department attendance. Ambulance services are expected to significantly increase the proportion of patients safely managed through remote clinical models, on-scene decision-making, and referral into community-based care.

Regionally, the focus is on consistency, collaboration, and neighbourhood health delivery. Ambulance trusts are expected to reduce unwarranted variation, support system flow, and work as anchor partners within Integrated Care Systems to improve access, equity, and outcomes.

What it means for NWAS over the next few years

For NWAS, this direction requires a deliberate evolution of our care delivery model. We must continue to protect and improve emergency response for life-threatening incidents, while expanding our capability to assess, treat and resolve a greater proportion of urgent care safely outside of the hospital.

This will require further growth in Hear & Treat and See & Treat models, consistent access to alternative pathways across the footprint, and strengthened senior clinical decision-making supported by digital tools and shared records. It also demands closer alignment with community, primary care, and mental health partners to ensure pathways are available, trusted, and responsive.

Over the next few years, NWAS must balance short-term performance delivery with longer-term transformation, building the workforce capability, digital infrastructure and systems relationships required to deliver sustainable, equitable care at scale while supporting ambitions and the Trust's strategic aims.

Introducing the plan

Why this Plan? Why Now?

A clear need for a dedicated Clinical Response Plan

This Clinical Response Strategic Plan has been developed to respond to the changing role of ambulance services and the increasing complexity of the urgent and emergency care system. While previous strategies have delivered strong operational integration and performance improvement, further progress requires a more explicit, Trust-wide articulation of how care will be delivered, coordinated, and sustained over the next five years.

Without a clear strategic direction, there is a risk that future improvement becomes fragmented, reactive, and constrained by system variation, limiting the Trust's ability to sustain performance, reduce unwarranted variation and deliver equitable outcomes for all communities in our footprint.

Alignment with the Trust strategy and planning framework

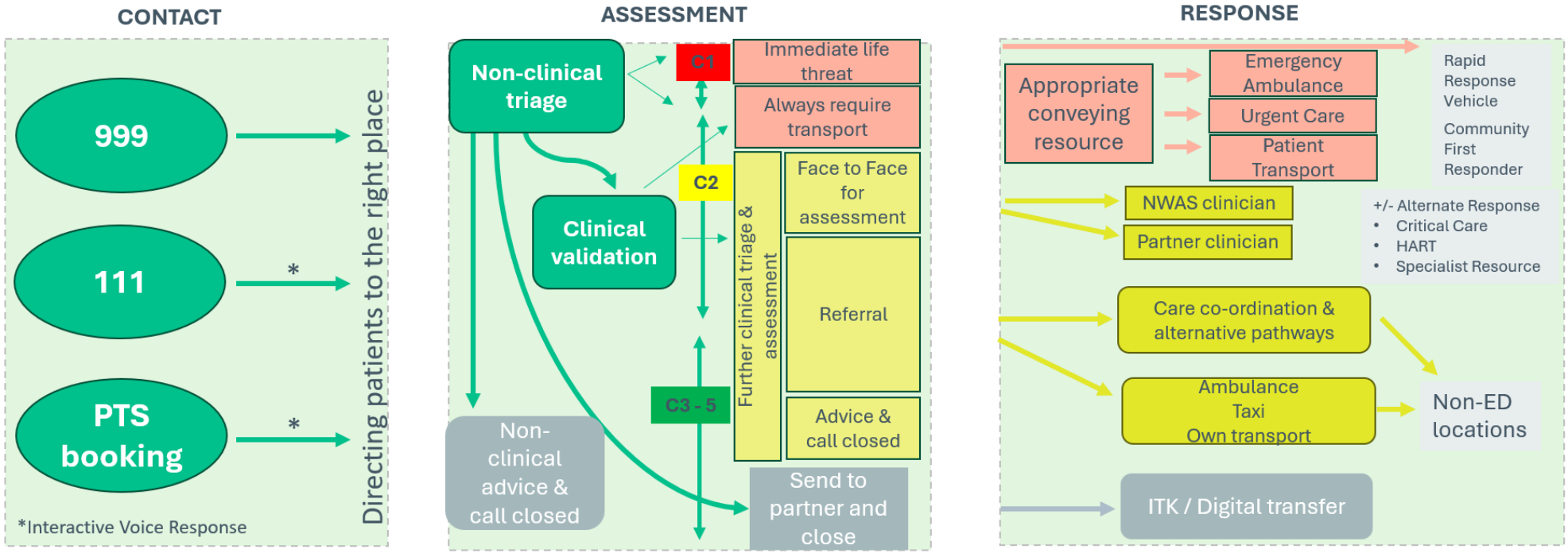
This plan is one of four integrated Trust strategic plans and forms a core component of the Trust's planning framework. It provides the lens through which the Trust's quality, people and culture, finance, digital, sustainability, improvement and estates strategies are aligned and operationalised in support of the Trust's four strategic aims: Deliver, Build, Provide and Embed.

The plan sets strategic direction rather than detailed solutions. It stabilises the principles, priorities and sequencing required to evolve care delivery models in a clinically led, operationally credible and system-aligned way, ensuring NWAS continues to deliver the right care, in the right place, at the right time – every time.

Responsive care model

Our strategic aim is to provide a responsive care model through partnerships

Our 25/26 Annual Plan contains a key service delivery strategic objective: "*Understand our current care delivery model through the eyes of the patient, highlighting opportunities to shape our future care delivery model and establishing a plan for implementing those changes in the next 3-5 years*." Working to achieve this objective, our draft care delivery model has been developed in partnership with operational and clinical teams and shared with wider teams at our Strategy Development Away Day in October 2024. The model will be further developed and tested during Year 1 of this strategic plan.
The model is informed by the following guiding principles:



Our future delivery model will be: Clinically led and digitally enabled; integrated and collaborative; equitable and inclusive; efficient and sustainable; patient-centred and outcome-focused.

Strategic Objective and High-level Deliverables

Objective: Contact

Deliver an integrated, technology-enabled contact model that improves accessibility, reduces inequality, and enhances efficiency and patient experience.

In 3–5 years, contacting our service will be more accessible and integrated. Patients will have multiple ways to reach us—phone, digital channels, and accessible tools—without language or literacy being a barrier. Our contact centres will operate as one integrated system, supported by connected digital platforms and AI technology, ensuring faster responses and better resource management. Staff will work within an integrated structure with the right infrastructure, information and support. This means patients get the right help quickly, safely, and without unnecessary delays, improving experience and outcomes for all.

High-level Deliverables

1. Integrate contact centre infrastructure to optimise estate and enable seamless operations.
2. Connect core digital systems to improve data flow, operational efficiency, and strategic insight, this includes working with system partners to improve interoperability and enhance patient care.
3. Complete AI options appraisal (covering data modelling, resource optimisation, natural language processing) and implement findings to enhance service efficiency.
4. Reduce inequality by removing language barriers through technology solutions, including digital translation tools, to improve safety, experience, and outcomes – this will be achieved by working with ambulance sector partners to deliver a telephony platform that is fit for the future.
5. Expand accessibility by introducing additional digital access channels beyond telephone which will reduce inequities in access to our services.
6. Embed new structures and workforce management tools to sustain integrated ways of working and culture.
7. Optimise Patient Transport Services (PTS) contact model in line with new contract requirements (TBC).

Objective: Assessment

Deliver safe, consistent, and personalised triage and assessment that identifies risk early, reduces variation, and ensures patients receive the right care first time.

In 3–5 years, our assessment process will be smarter, faster, and more personalised. AI and advanced decision support will help us identify the sickest patients immediately, while robust protocols and shared systems will reduce variation and risk. Clinicians will work flexibly—remotely and on-scene—supported by advanced practitioners for complex cases. Patients will experience seamless care transfers through integrated pathways and digital solutions, and our approach will actively reduce health inequalities by focusing on prevention, not just treatment. This means safer decisions, fewer unnecessary referrals, and better outcomes for every patient.

High-level Deliverables

1. Optimise our model to ensure high-risk patients are identified quickly through improved clinical risk stratification, AI and advanced decision support.
2. Optimise secondary triage and assessment through an agile, remote clinical workforce and advanced practitioners for complex cases.
3. Enhance clinical frameworks (incl. IFT/HCP) to ensure responses are proportionate to patient need, not call origin.
4. Expand and integrate alternative pathways (SPOAs, UCRs, CAS) with partners, supported by digital solutions for seamless care transfer.
5. Co-design integrated urgent and emergency care pathways with system partners, including trusted assessor models and shared accountability.
6. Enhance clinical assessment through remote consultations, integrated shared care records, and streamlined direct booking to improve patient experience and care coordination.
7. Target health inequalities by optimising assessment and proactive interventions for priority groups, shifting from reactive to preventative care.

Objective: Response

Deliver a resilient, efficient, and patient-centred response model that uses technology, workforce optimisation, and system collaboration to provide the right care, in the right place, at the right time.

In 3–5 years, our response model will be more agile, resilient, and connected. Automated dispatch and advanced rostering will ensure resources are deployed efficiently, while a future-focused workforce model and integrated volunteer roles will maximise capacity. We will act as a true system connector, working with partners to keep patients closer to home and reduce unnecessary hospital admissions. Our model will consistently meet national standards, adapt to demand throughout the year, and remain robust in the face of major incidents. This means patients receive timely, appropriate care wherever they are, supported by a system that works seamlessly together.

High-level Deliverables

1. Automate dispatch processes to improve productivity and optimise face-to-face response.
2. Conduct a comprehensive demand and capacity review (111, 999, PTS) to align resources with demand across the lifecycle of the strategy.
3. Embed advanced rostering technology to maximise workforce utilisation and responsiveness.
4. Review and optimise workforce model to ensure the right roles and resources for patient needs.
5. Enhance volunteer model to integrate more effectively with the care delivery model.
6. Strengthen our role as a system navigator by collaborating with partners to optimise alternatives to emergency departments where conveyance is necessary.
7. Consistently meet ARP Category 2 standards by 2028/29, leveraging pre-dispatch opportunities.
8. Ensure resilience through EPRR planning, embedding robust processes for emergency preparedness and response. This will include working with partners to exercise and learn.

What does success look like?

Strategic Objective	Contact	Assessment	Response
What will look different in future?	Patients will be able to contact us when they need us, via a channel that meets their needs, and without any barriers. Our call handling across 111, 999, and transport services, will be fully embedded and will be able to flex to the changes in levels of demand. Our contact centre staff will work in an environment that supports delivery of the contact and assessment elements of our operational model.	At the point of call, we will be able to identify those patients that are the sickest and need the most urgent response. Where patients don't have a life-threatening emergency, we will assess their needs, with technology, with non-clinical triage, and with a range of clinicians to find the right solution for their need. Where patients may be better served by alternatives to an ambulance response, we will have integrated alternative pathways, including digital referral, into care provided by our partners.	We will have the right resources, in the right place, at the right time to meet the patient demand across the North West. Where someone is having a life-threatening emergency, we will dispatch the closest available resource with the skills required to save a life as quickly as possible. Where someone is having a life-threatening emergency, we will also dispatch any specialist resources required to manage their care. Where the needs of the patient are less acute, we will find the right response, which may be sending a clinician for face-to-face assessment, providing support over the telephone, or referring them into another health or social care service. When a significant incident occurs in the North West, we will have the right staff trained to respond: to provide care to patients, to manage the scene of the incident, and to work closely with our partners in the NHS and the other emergency services. Volunteers will be at the heart of our model of response to patients who are in need, especially those with a life-threatening emergency.

Sequencing

Objective: Contact	2026/27	2027/28	2028/29
Deliver an integrated, technology-enabled contact model that improves accessibility, reduces inequality, and enhances efficiency and patient experience.	Integrate contact centre infrastructure to optimise estate and enable seamless operations.		
	Connect core digital systems to improve data flow, operational efficiency, and strategic insight, this includes working with system partners to improve interoperability and enhance patient care.		
	Complete AI options appraisal (covering data modelling, resource optimisation, natural language processing) and implement findings to enhance service efficiency.		
		Reduce inequality by removing language barriers through technology solutions, including digital translation tools, to improve safety, experience, and outcomes – this will be achieved by working with ambulance sector partners to deliver a telephony platform that is fit for the future	
		Expand accessibility by introducing additional digital access channels beyond telephone which will reduce inequities in access to our services	
	Embed new structures and workforce management tools to sustain integrated ways of working and culture		
	Optimise Patient Transport Services (PTS) contact model in		

	line with new contract requirements (TBC)		
Objective: Assessment	**2026/27**	**2027/28**	**2028/29**
Deliver safe, consistent, and personalised triage and assessment that identifies risk early, reduces variation, and ensures patients receive the right care first time.		Optimise our model to ensure high-risk patients are identified quickly through improved clinical risk stratification, AI and advanced decision support.	
	Optimise secondary triage and assessment through an agile, remote clinical workforce and advanced practitioners for complex cases		
	Enhance clinical frameworks (incl. IFT/HCP) to ensure responses are proportionate to patient need, not call origin.		
	Expand and integrate alternative pathways (SPOAs, UCRs, CAS) with partners, supported by digital solutions for seamless care transfer.		
	Co-design integrated urgent and emergency care pathways with system partners, including trusted assessor models and shared accountability		
		Enhance clinical assessment through remote consultations, integrated shared care records, and streamlined direct booking to improve patient experience and care coordination.	
		Target health inequalities by optimising assessment and proactive interventions for priority groups, shifting from reactive to preventative care.	
Objective: Response	**2026/27**	**2027/28**	**2028/29**
Deliver a resilient, efficient, and patient-centred response model that uses technology, workforce optimisation, and system collaboration		Automate dispatch processes to improve productivity and optimise face-to-face response.	
	Conduct a comprehensive demand and capacity review (111, 999, PTS) to align resources with demand across the lifecycle of the strategy.		

to provide the right care, in the right place, at the right time.		Embed advanced rostering technology to maximise workforce utilisation and responsiveness.	
			Review and optimise workforce model to ensure the right roles and resources for patient needs.
	Enhance volunteer model to integrate more effectively with the care delivery model. Year 1-2		
	Strengthen our role as a system navigator by collaborating with partners to optimise alternatives to emergency departments where conveyance is necessary		
	Consistently meet ARP Category 2 standards by 2028/29, leveraging pre-dispatch opportunities		
	Ensure resilience through EPRR planning, embedding robust processes for emergency preparedness and response. This will include working with partners to exercise and learn.		

Glossary of terms

Term	Definition	Example
Trust strategy		
Purpose statement	A **purpose statement** is a clear, concise sentence that explains why something exists or is being done.	To help people when they need us most
Vision	A **vision** is a clear statement of what an organisation or person strives to achieve in the future.	To deliver the right care in the right place at the right time; every time
Values	Our values underpin everything that we do and guide our people, decisions, actions and behaviours.	Working together, being at our best, and making a difference
Strategic aim	Our strategic aims set the direction of travel for the organisation and translate the vision into action.	Deliver outstanding, inclusive care for everyone we serve
Strategic plans		
Strategic objective	Each plan outlines a set of specific, measurable objectives that supports the delivery of the organisation's strategic aims.	Attract and recruit a representative workforce, providing effective onboarding and support to retain them

Deliverables	Activities which will ultimately deliver an objective.	Deliver a talent management framework to enable us to grow our talent
Measures of success	Sets out how we will measure achievement of our strategic objectives.	Improvement against WRES workforce indicators
Category 1 (Cat 1) **Life Threatening**	Immediately life-threatening illnesses or injuries requiring an instant response, often involving resuscitation.	Examples: cardiac arrest, ineffective breathing, airway obstruction.
Category 2 (Cat 2) **Emergency**	Serious conditions that are not immediately life-threatening but need rapid assessment and/or urgent transport.	Examples: stroke, heart attack, major trauma, diabetic emergencies.
Category 3 (Cat 3) **Urgent**	Urgent but not immediately life-threatening conditions. Patients often require treatment to relieve suffering, either at home or via appropriate referral.	Examples: abdominal pain, uncomplicated diabetic issues.
Category 4 (Cat 4) **Less Urgent**	Non-urgent problems requiring clinical assessment (telephone or face-to-face) and sometimes transport within a safe timeframe.	Examples: minor injuries, diarrhoea/vomiting, uncomplicated falls, unexpected deaths.

Category 5 (Cat 5) **Routine / Non-urgent**	Category 5 appears in NHS Data Dictionary coding but is not part of the national 999 ambulance response categories. Used for very low-acuity, routine, or non-urgent cases, often in healthcare professional requests or internal processes rather than public 999 calls.	Examples: routine transfers, non-urgent healthcare professional requests, or “other” calls not requiring a time-critical response.
Annual plan		
Annual priorities	Summarises the organisations delivery priorities for each financial year and aligns with workforce, financial and operational planning assumptions.	Embed new operational leadership structures and ensure leaders have the skills to deliver their roles effectively.

NHS
North West
Ambulance Service
NHS Trust

Future Sustainability

Strategic Plan
2026 – 2031

Foreword

As an organisation with a clear purpose—helping people when they need us most—we must ensure we are equipped to deliver safe, high-quality and sustainable care both now and in the future. This Future Sustainability Strategic Plan brings together four essential components of our long-term resilience: environmental sustainability, digital transformation, improvement, and financial sustainability. For the first time, these areas are aligned within a single plan, strengthening how we make decisions, invest resources and deliver value for the communities we serve.

Over recent years we have built strong foundations. We have strengthened our digital infrastructure, developed a maturing improvement culture, invested in modern and energy-efficient estates, and continued to deliver financial stability in a challenging national environment. These achievements reflect the commitment and professionalism of colleagues across NWAS and provide a solid base for the next stage of our journey.

However, the scale and pace of change across healthcare demands that we think and work differently. Sustainability is no longer an isolated theme; it is a core requirement of how we operate. This plan sets out a clear and coordinated approach to embedding improvement, reducing unwarranted variation, modernising our digital capabilities, delivering on our pathway to net zero, and ensuring we remain a financially resilient organisation able to invest in the future.

Central to this is our commitment to value for money and responsible stewardship of public resources. By improving productivity, using data and insight more effectively, and making targeted investments in the right infrastructure, we can protect frontline services and support a model of care that is flexible, responsive, and sustainable. Our financial decisions will continue to be rooted in strong governance, transparency, and long-term planning, ensuring we deliver high-quality care in the most efficient way possible.

I am proud of the progress we have made and confident in our collective ability to deliver this plan. By working together, we can create a more resilient, modern, and sustainable organisation—one that delivers the right care, in the right place, at the right time, every time.

Carolyn Wood
Director of Finance

Executive summary

The Future Sustainability Strategic Plan for 2026–2031, brings together our commitments across improvement, digital, finance and environmental sustainability. It outlines how NWAS will strengthen organisational capability, modernise digital foundations, secure long-term financial resilience and deliver progress towards net zero. By aligning these elements to our strategic aims, the plan provides a clear roadmap for delivering a resilient, future-ready organisation.

Building on strong foundations developed in recent years, the plan focuses on embedding an improvement culture, improving productivity, modernising our digital and physical infrastructure, and accelerating progress toward net zero. By aligning these enablers into a single strategic plan, we aim to become a more innovative, digitally enabled and sustainable organisation that continues to deliver high-quality care for the communities we serve.

The plan is structured around five strategic objectives:

- **Improvement Objective 1:** Strengthen improvement capability
- **Improvement Objective 2:** Create consistent improvement management system
- **Finance Objective 3:** Secure long-term financial sustainability
- **Digital Objective 4:** Create a sustained digital shift
- **Environmental Sustainability Objective 5:** Deliver Green Plan and progress towards net zero

This plan will provide further detail on what our strategic objectives and delivery priorities will be over the next five years, as well as the underpinning measures of success.

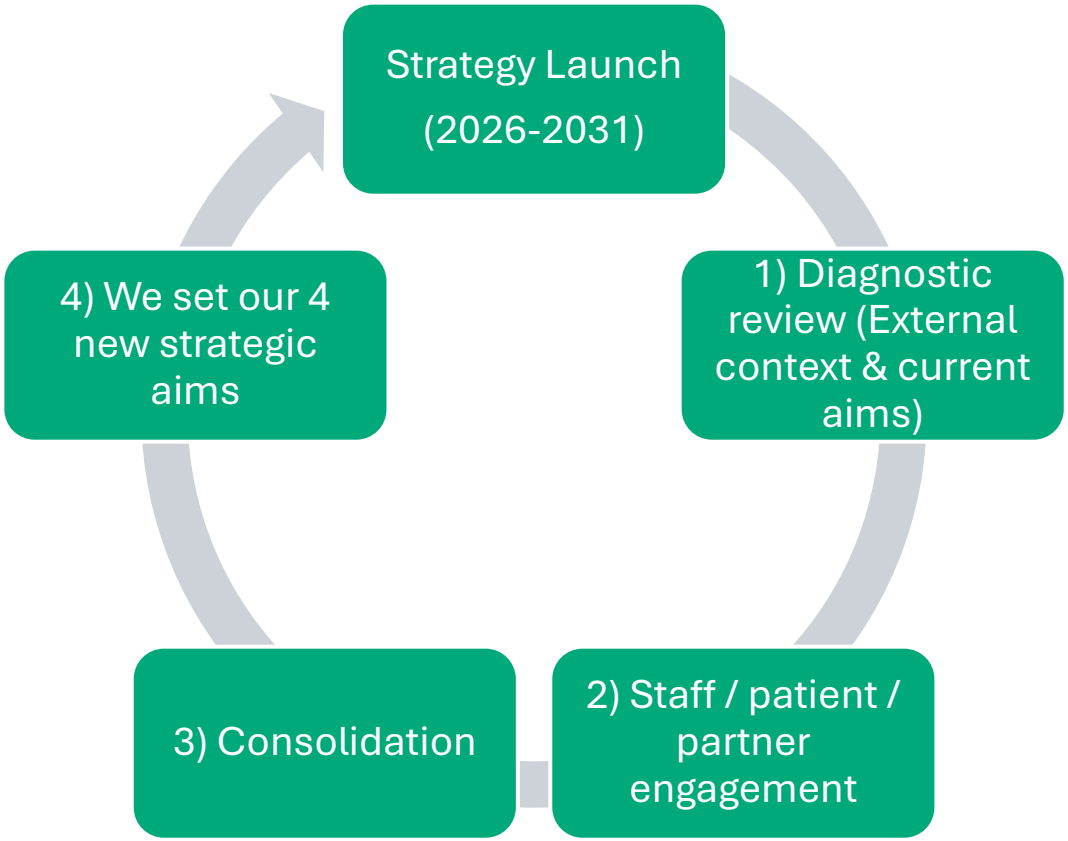
Contents

Our strategy development process

Our 2026-2031 strategy was shaped through wide range engagement with our staff, volunteers, patients, and partners, alongside a diagnostic review of our current position. Using this as a guide, we designed our strategic aims.

At its heart, the strategy defines our shared purpose: helping people when they need us most. Guided by this, our vision is simple and remains the same - providing the right care, at the right time, in the right place, every time.

This year, we will continue working with stakeholders to keep our strategy relevant and up to date against the current context.



Strategic framework

- Our five-year **trust strategy** outlines where we are now, where we want to be and the areas we want to focus on to achieve our vision. We all share responsibility for the aims and must work together to achieve success.
- We have four **strategic plans** which each align to one aim and provide detail on specific delivery objectives and key measures of success. These plans also include a roadmap which shows the sequencing of objectives and outcomes over the next three to five years.
- We also have **enabling plans** which cross-cut several or all our aims. These plans focus on digital, estates and fleet, improvement and environment and outline more specific pieces of work which will be undertaken to help support delivery of our plans.
- The **NHS England medium term plan** is a mandated external submission which is refreshed annually. It uses key information from our strategic plans plus updated modelling assumptions to provide triangulated view of delivery and assurance that we will achieve key performance targets.
- Each year, we will develop an **annual plan** which shows what the projects, milestones and measures will be for the coming year. This plan will also assess whether we have the right capacity, expertise and resource to deliver our objectives. The annual plan should also be used to shape directorate, team and individuals' objectives and ensure we're all working towards a shared set of priorities.
- We must have a way of providing **assurance** back through our Board of Directors that we are making year-on-year progress towards achieving our strategy.

Our strategic aims

Our trust strategy has been designed around four clear aims that will guide everything we do over the next five years. Each aim sets out what we want to achieve, the priorities we will focus on, and the measures we will use to track success. Together, these aims will help us create a service that is trusted, inclusive, and ready for the future. This **Future Sustainability Plan** aligns primarily to our fourth aim: 'embed continuous improvement and innovation for a sustainable future' and provides detail on the specific delivery objectives and key measures of success which we'll focus on over the next five years.

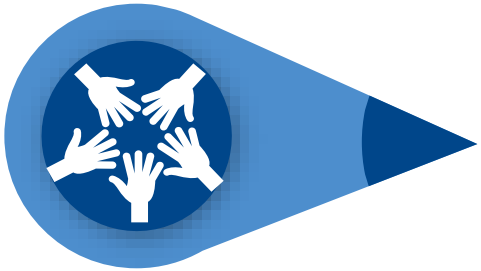
Strategic aims	PROVIDE	BUILD	DELIVER	EMBED
	Provide outstanding, inclusive care for everyone we serve	**Build a safe, supportive and inclusive culture together**	**Deliver a responsive care model through partnerships**	**Embed continuous improvement and innovation for a sustainable future**
Ambition for 2031	We will provide high-quality, safe and compassionate care for all our communities, continuously improving to reduce unwarranted variation and health inequality.	Our leaders create a compassionate, inclusive and supportive workplace culture, where everyone has a voice, can be at their best and is supported to improve and develop.	We will strengthen and develop our operating model and work closely with partners to ensure care is coordinated, equitable and responsive to population needs.	We will embed a culture of learning and improvement that drives productivity and delivers clinical, operational, workforce, financial and environmental sustainability.
Headline description	**Outstanding care** – what we provide to patients and communities.	**Inclusive culture** – how we create the environment for success.	**Care model** – how we organise and collaborate to meet need.	**Continuous improvement** – how we evolve and secure the future.
Strategic outcomes / benefits	• Safer care • More effective care • Better patient experience • Reduced health inequalities	• Improved culture • Better place to work • More representative workforce • Workforce fit for future	• Delivery of core standards • Contribution to 3 shifts (10YP) • Flexible and adaptive model • Trusted partner	• Improvement-focused • Reduced waste • Digitally enabled • Environmentally sustainable

Cross cutting themes – Health Inequalities, Equality, Diversity, Inclusion & Improvement

Our strategic plans are supported by cross-cutting themes that guide our decision making and shape our services. The themes are health inequalities, equality, diversity and inclusion, and continuous improvement. They are not standalone priorities but are integral to every strategic objective, shaping how we design our services, utilise our resources and measure our success. Each strategic plan will outline how they will consider and address these key themes.

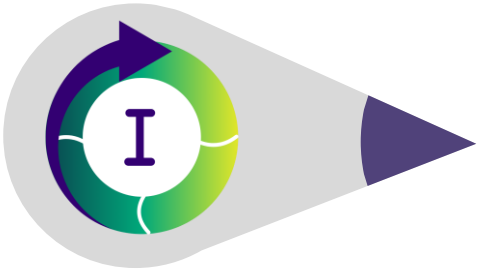
Tackling health inequalities is a national priority and our plan will address how we can reduce gaps in access, experience and outcomes, ensuring all the communities we serve can benefit. Through this plan we will:

- Improve the collection and utilisation of data to better understand variation
- Embed an improvement culture which helps to identify and reduce variation in care
- Continue to ensure we deliver social value through our future infrastructure investments and work on environmental sustainability



We are committed to an **active approach to equality, diversity and inclusion and** it is a fundamental underpinning focus of our plan. Through this plan, we will:

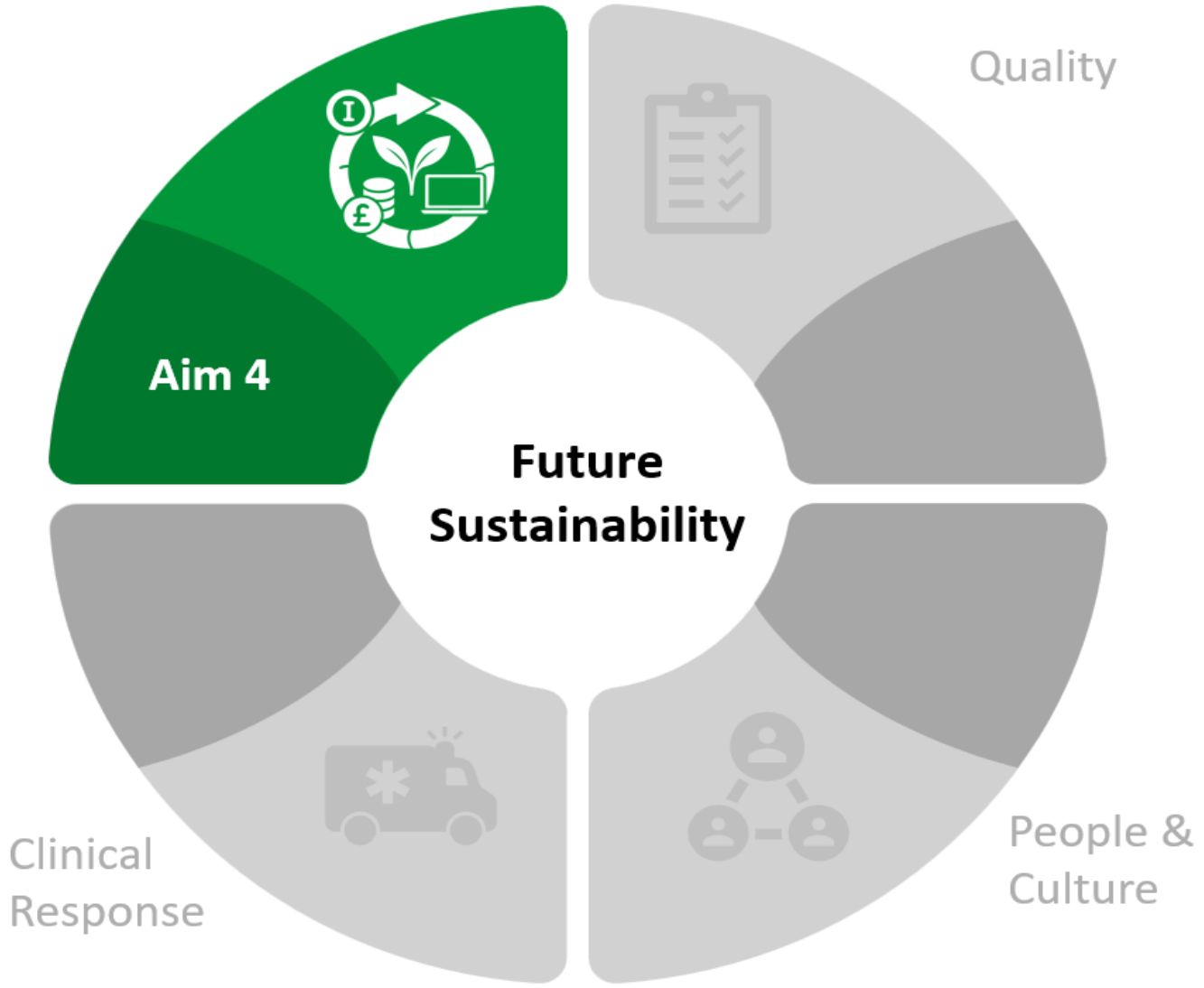
- Reduce digital exclusion
- Ensure diverse voices help shape our improvement activities
- Improve data quality and insight to better understand inequalities
- Consider accessibility, fairness and equality in the design and delivery of improvement initiatives, digital innovation and future investment decisions
- Ensuring our leaders visibly and proactively consider equality, diversity and inclusion in the delivery of the plan



We strive to become an **improvement organisation**. Through this plan we will:

- Embed a consistent improvement management system which embeds improvement culture from strategy to operational delivery
- Build organisational capability in using improvement tools methods
- Embed ownership for improvement across all levels of the organisation, empowering people to translate ideas into meaningful change

Future Sustainability Strategic Plan



Background and progress so far

Over the past three years, we have had a Sustainability Strategy in place which provided strategic direction around improving environmental performance, our infrastructure and our wider contribution to public health. As we set our strategic ambitions for 2026-2031 it is important we reflect on what we have achieved so far.

Environmental Sustainability

Over the past three years, our sustainability strategy has strengthened our approach to environmental responsibility and enabled targeted investment in modern, energy-efficient and resilient infrastructure. This progress has been guided by our Board-approved Green Plan, which sets out our pathway to achieving net zero by 2040 for the emissions we directly control. The plan has helped embed sustainability into decision-making, improve carbon management, and support the delivery of greener operations across our estate, fleet and services.

Digital foundations

Since 2019, our digital strategy has helped us establish stronger digital foundations and significantly expand digital innovation. We have strengthened core infrastructure, modernised frontline devices, enhanced cyber security and improved connectivity across our estate. We advanced the Electronic Patient Record, built a single digital portfolio, improved referral and directory systems and introduced new technology to support more integrated working across 999 and 111.

Since 2023, we have focused on improving digital governance and engagement. Colleagues from across the organisation now help shape and prioritise digital developments, ensuring they reflect operational and clinical needs. The creation of a clinical informatics function means digital solutions better support clinical safety, improve staff experience and enhance the quality of care.

Looking ahead, we want to become a digitally enabled organisation where technology and data reduce administrative burden, support better decisions and improve the experience of patients and staff.

Our improvement journey

One of the most significant developments in recent years has been the growth of continuous improvement across the organisation. Through our Improvement Academy, we have supported teams across our front line and corporate functions to build improvement skills and lead meaningful change. We invested in a

central team to grow expertise, trained large numbers of colleagues in improvement science and delivered large-scale improvement programmes, including successful work to improve hospital handover times.

This has strengthened our culture, supported innovation and been recognised nationally through patient safety and quality awards. We know building an improvement culture is a long-term journey. The next stage of this strategy will focus on embedding consistency, using data and evidence more effectively and ensuring improvement becomes an everyday part of how we work.

Financial sustainability

We remain in a strong financial position, even while operating within a wider system that is experiencing significant financial pressure. Our track record of robust financial governance, stringent controls, and the consistent delivery of Cost Improvement Plans (CIPs) has ensured we maintain stability and use resources responsibly. Strong budget management, clear accountability, and disciplined financial decision-making have enabled us to maintain frontline services, invest in our estate and digital capabilities, and maintain organisational resilience. These foundations will remain critical as we progress a strategic plan that emphasises sustainability, efficiency and long-term value.

Strategic context

National and regional direction

National policy continues to set a strong and increasingly detailed direction for sustainability, improvement and digital transformation across the NHS. Updated NHS Green Plan guidance reinforces the statutory requirement for every trust to develop and refresh a Board-approved Green Plan, ensuring each organisation contributes to the NHS's legally binding commitment to reach net zero for directly controlled emissions by 2040 and for wider emissions by 2045. This national mandate places clear expectations on ambulance services to reduce emissions from fleet, buildings and operations, strengthen environmental resilience, and improve the sustainability of service delivery.

Digital modernisation is also central to the NHS's long-term direction. Recent updates to the NHS Long Term Plan emphasise the shift toward a technology-enabled, data-driven and integrated health and care system, underpinned by investment in shared care records, improved digital architecture and a federated data platform to support safer, more consistent care. For ambulance services, this means strengthening real-time data use, improving interoperability across emergency and urgent care pathways, and supporting operational efficiency through better digital tools.

Continuous improvement is also now a core national expectation, reinforced through NHS IMPACT, which encourages organisations to apply a consistent, organisation-wide approach to making things better. To do this well, improvement needs to be linked to good data, strong digital systems, and clear priorities around sustainability and value.

We are also operating in a challenging financial environment, and the need for long-term financial sustainability is a key national priority. Bringing these areas together helps us make better decisions about where we invest, how we use our resources and how we create long-term value for our communities.

By consolidating these elements into a single sustainability strategic plan, we can make sure our work is aligned, easier to understand and more effective. It ensures our environmental ambitions, digital developments, improvement activity and financial decisions all support each other—creating a clearer path toward a more resilient, modern and sustainable organisation.

Strategic objective & high-level deliverables (Improvement)

Objective 1

Strengthen improvement capability across NWAS by developing skills, sharing ideas, celebrating success, and developing clearer routes for spread and sustainability

Sustainable improvement depends on equipping people at every level with the skills, confidence, and permission to make change happen. At NWAS, we will continue to invest and build upon the good progress in developing improvement capability across the organisation, providing training in core improvement methods and change leadership. Building capability also means creating opportunities for colleagues to apply their skills in real life, supported by coaching, peer networks, and access to data.

Feedback also highlights the need to strengthen how improvement activity is connected across NWAS, ensuring ideas, learning, and successes are visible and improvement work is sustained. To support this, we will develop clearer and more systematic ways to gather colleagues' improvement ideas and develop clearer pathways for the spread and sustainability of improvement ideas. Recognising and celebrating achievements will remain an essential part of our approach, reinforcing that colleagues' contributions matter and helping to sustain momentum for improvement.

High-level deliverables

1. Deliver an evidence-based improvement capability framework. Provide accessible improvement learning for all colleagues embedding in a multi approach programme of learning, and development of new products (e.g. Improvement fellowship model)
2. Establish a clear and practical model for how the geographically dispersed and diverse workforce can participate in improvement activity at all levels
3. Scope opportunities to externally accredit NWAS training (e.g. with a higher education partner) and expand opportunities for publishing, links to research and formal recognition of improvement work
4. Create a structured, organisation-wide programme that sets out the principles, tools and pathways for spreading improvement across NWAS
5. Design and test a consistent organisation-wide process to capture improvement ideas

Objective 2

Create a clear, consistent improvement management system that aligns strategy, priorities, and operations, demonstrating continued progress against the NHS IMPACT framework

In 25/26 NWAS developed the NWAS Improvement enabling plan articulating our vision and approach to improvement. Through this work we aim to create a clear, consistent management system with improvement at its core which provides the structure, tools, and processes needed to deliver organisational objectives and embed learning at scale. By embedding improvement into strategic plannings, decision-making, and day-to-day operations, NWAS are creating a consistent message: improvement is not a one-off project but a sustained, organisation-wide commitment to delivering better care and outcomes for the patients we serve.

High-level deliverables

1. Scope, test and develop elements of the improvement management system, establish a faculty to oversee the work and across the 3 years of this strategy develop the foundations of an improvement management system across NWAS.
2. Develop a framework for large-scale programmes to adopt improvement principles and review organisational practice to strengthen consistent use of improvement methodology across documents and governance processes.
3. Organisational wide reassessment of NHS IMPACT (or equivalent) framework to determine NWAS level of improvement maturity and adapt the NWAS Improvement Approach based on results. Process incorporated as part of a Board development programme

Strategic objective & high-level deliverables (Finance)

Objective 3

Secure long-term financial sustainability through recurrent efficiencies, strong financial governance, and disciplined investment that delivers value for money and cost-effective modern services.

This strategic objective is to secure long-term financial sustainability by embedding strong financial governance and maintaining a sustained focus on productivity. We will do this by developing and delivering a continuous programme of productivity and efficiency initiatives that generate recurrent savings and ensure our resources are utilised in a value-driven, cost-effective manner. This will be underpinned by improving financial capability at all levels of the organisation and ensuring investment decisions are aligned to strategic priorities, supported by robust evidence-based business case processes.

High-level deliverables

1. A recurrent sustainable financial position, achieved through annual delivery of a continuous programme of productivity and efficiency initiatives that generate recurrent savings and reduce reliance on non-recurrent measures.
2. Strengthened financial governance and oversight, including improved forecasting, enhanced financial controls, with greater accountability across all management levels.
3. Continue the development and delivery of a comprehensive financial training programme ensuring all budget holders can deliver cost-effective services.
4. Prioritised investment planning that supports effective organisational modernisation (digital, workforce, fleet, estates).
5. Enhance data-driven decision-making through improved costing, analytics, benchmarking and digital finance tools.

Strategic objective & high-level deliverables (Digital)

Objective 4

Create a sustained digital shift by using trusted digital tools, strong data, and innovation to improve services.

This objective focuses on creating a sustained digital shift across the organisation by embedding trusted, insight-driven and digitally-enabled ways of working. By strengthening our digital foundations, improving how we use data to inform decisions, and accelerating innovation, we will modernise service delivery and enable long-term, meaningful transformation

High-level deliverables

1. Maintain and strengthen our core digital foundations to secure stable, resilient and reliable digital services.
2. Improve the utilisation of data to make informed decisions.
3. Deliver a digital shift by accelerating transformation and innovation that modernises services and supports long term system change.

Strategic objective & high-level deliverables (Environmental Sustainability)

Objective 5

Progress towards achieving net zero carbon by 2040 through delivery of our Green Plan.

Climate change poses a major risk to health and wellbeing, as well as a significant service delivery and financial threat to the NHS, impacting both infrastructure and services for patients. To support the co-ordination of carbon reduction efforts across the NHS and the translation of this national strategy to the local level NWAS has set out several key actions to deliver emissions reductions and support resilience to climate impacts over the next three years. This timeframe is considered a minimum and should allow the plan to strike an appropriate balance between immediate emissions reductions in some areas, alongside strategic development of capability in others.

High-level deliverables

1. Deliver specific actions outlined within the Green Plan which will drive improvements in environmental sustainability year on year.

What does success look like?

Improvement

Alignment to strategic aims	Embed continuous improvement and innovation for a sustainable future
Measures	1. Year on year improvement against NHS IMPACT self-assessment (or equivalent) 2. Year on year increase in number of colleagues who have undertaken improvement training 3. Year on Year increase in strategic programmes utilising framework/ improvement approach 4. Develop a measurement system, linked to NHS Staff survey to assess the NWAS improvement culture 5. Develop a measurement system, as part of the management system scoping work
What will look different?	Improvement evolves from a series of one of projects to the way the organisation manages it priorities and operates. Leaders will be equipped to champion improvement and decision-making will be more inclusive and data driven. Our people will feel empowered, skilled, and equipped to drive meaningful improvements within their own areas, strengthening our overall capacity to deliver sustainable, high-impact change. The voice of our patients and colleagues will be central to shaping improvement, ensuring that changes reflect 'what matters most' to those closest to our services. The cultural shift will strengthen NWAS's ability to adapt quickly, maintain high standards, and deliver sustainable improvements for patients and communities. This plan accelerates the progress already underway moving from strong foundations to a maturing organisation-wide improvement culture that enhances learning and engagement, and where improvement is 'everyone's business'

Finance

Alignment to strategic aims	Embed continuous improvement and innovation for a sustainable future
Measures	1. Delivery of the recurrent financial savings included in the medium-term financial plans to achieve long term financial sustainability. 2. Reduce the proportion of non-recurrent measures delivered in the CIP programmes. 3. All directorates meet agreed financial accountability standards, measured through performance reviews and financial performance meetings 4. Completion rates of mandatory financial training for budget holders. 5. Development of high quality, robust capital and revenue business cases using public sector best practice Five Case business case model, ensuring they are strategically aligned, economically viable, commercially feasible, affordable and manageable to achieve best value and planned objectives. 6. Investments deliver planned financial benefits (productivity and cost reduction) within the agreed timeframes. 7. Increased utilisation of benchmarking and PLICS insights in decision making. 8. Annual improvements against model ambulance benchmarks, including costs per incident, fleet utilisation, corporate benchmarking and workforce efficiency.
What will look different?	• Budget Holders more accountable for their service costs, both in year and forecast positions, proactively managing resources, strengthened by clear performance expectations. • Identification of productivity and efficiency schemes will no longer be seen as part of the development of the annual plan. • Recurrent efficiency improvements to become the norm, reducing reliance on non-recurrent measures to balance the CIP plans. • All investment decisions and business cases will be produced consistently, in line with best practice.

Digital

Alignment to strategic aims	Embed continuous improvement and innovation for a sustainable future
Measures	9. Improved staff digital literacy survey results (10%) Improved skill base of staff in new technology 10. Stable capacity to support improvement and innovation 11. Resilience and management of digital disruption and cyber risks
What will look different?	• Digital tools support safer care, better clinical decisions and improved patient outcomes. • Staff are better supported by usable systems, high-quality data and improved clinical assurance. • Digital processes remove duplication and unnecessary manual activity, building capacity. • Staff feel confident and capable using digital systems to improve their work. • Staff have digital confidence to innovate without compromising BAU delivery. • Strong cyber resilience minimises disruption and protects patient care.

Environmental Sustainability

Alignment to strategic aims	Embed continuous improvement and innovation for a sustainable future
Measures	1. Year on year improvement against NWAS Green Plan and NHSE Net Zero by 2040 plan 2. Year on year improvements in technology for Fleet and the Estate that will drive scope 1 & 2 emissions reductions 3. Year on year increase in the number of staff trained in Carbon Literacy and behavioural change 4. Update performance through annual reporting, Greener NHSE returns and ERIC data
What will look different?	The organisation will visible and tangible signs of environmental and sustainability improvements which can be traced back to the baseline year of 2013. For a long time, the changes have been 'behind the scenes', such as improving electricity supplies to sites, purchasing green energy from electricity tariffs and software to enable detailed examination of energy, water and carbon. However, soon it will be more visible: solar panels now cover around 25% of our sites, all of our RRVs are electric, 10%+ of the estates has moved away from gas to heat buildings and new smart LED lighting has been installed in all major capital projects and retrospectively in over 20 sites.

Sequencing

Improvement

Objective 1	2026/27	2027/28	2028/29
Strengthen improvement capability across NWAS by developing skills, sharing ideas, celebrating success, and developing clearer routes for spread and sustainability	Deliver an evidence based improvement capability framework. Provide accessible improvement learning for all colleagues embedding in a multi approach programme of learning, and development of new products (e.g. Improvement fellowship model)		
	Establish a clear and practical model for how the geographically dispersed and diverse workforce can participate in improvement activity at all levels		
	Scope opportunities to externally accredit NWAS training (e.g. with a higher education partner) & expand opportunities for publishing, links to research and formal recognition of improvement work		
	Create a structured, organisation-wide programme that sets out the principles, tools and pathways for spreading improvement across NWAS		
	Design and test a consistent organisation-wide process to capture improvement ideas		
Objective 2	**2026/27**	**2027/28**	**2028/29**
Create a clear, consistent improvement management system that aligns strategy, priorities, and operations, demonstrating continued progress against the NHS IMPACT framework	Scope, test and develop elements of the improvement management system, establish a faculty to oversee the work and across the 3 years of this strategy develop the foundations of an improvement management system across NWAS		
	Develop a framework for large-scale programmes to adopt improvement principles and review organisational practice to strengthen consistent use of improvement methodology across documents and governance processes		
	Organisational wide reassessment of NHS IMPACT (or equivalent) framework to determine NWAS level of improvement maturity and adapt the Improvement Approach based on results. Process incorporated as part of a Board development programme		

Environmental Sustainability

Objective 1	2026/27	2027/28	2028/29
FS1 - Progress towards achieving net zero carbon by 2040 through delivery of our Green Plan.	Deliver specific actions outlined within the Green Plan which will drive improvements in environmental sustainability year on year.		

Glossary of terms

Term	Definition	Example
Trust strategy		
Purpose statement	A **purpose statement** is a clear, concise sentence that explains why something exists or is being done.	To help people when they need us most
Vision	A **vision** is a clear statement of what an organisation or person strives to achieve in the future.	To deliver the right care in the right place at the right time; every time
Values	Our values underpin everything that we do and guide our people, decisions, actions and behaviours.	Working together, being at our best, and making a difference
Strategic aim	Our strategic aims set the direction of travel for the organisation and translate the vision into action.	Deliver outstanding, inclusive care for everyone we serve
Strategic plans		
Strategic objective	Each plan outlines a set of specific, measurable objectives that supports the delivery of the organisation's strategic aims.	Attract and recruit a representative workforce, providing effective onboarding and support to retain them

Deliverables	Activities which will ultimately deliver an objective.	Deliver a talent management framework to enable us to grow our talent
Measures of success	Sets out how we will measure achievement of our strategic objectives.	Improvement against WRES workforce indicators
Annual plan		
Annual priorities	Summarises the organisations delivery priorities for each financial year and aligns with workforce, financial and operational planning assumptions.	Embed new operational leadership structures and ensure leaders have the skills to deliver their roles effectively.