AGENDA

NHS North West Ambulance Service NHS Trust

Board of Directors
Wednesday, 29th July 2026
9.45am – 13.10 pm
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
PATIENT STORY				
BOD/2627/039	Patient Story	09:45	Information	Chief Executive
INTRODUCTION				
BOD/2627/040	Apologies for Absence	10:00	Information	Chair
BOD/2627/041	Declarations of Interest	10:00	Decision	Chair
BOD/2627/042	Minutes of the previous meeting held on 27th May 2026	10:00	Decision	Chair
BOD/2627/043	Board Action Log	10:05	Assurance	Chair
BOD/2627/044	Committee Attendance	10:05	Information	Chair
BOD/2627/045	Register of Interest	10:05	Assurance	Chair
STRATEGY				
BOD/2627/046	Chair & Non-Executive Directors' Update	10:10	Information	Chair
BOD/2627/047	Chief Executive's Report	10:20	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2627/048	Board Assurance Framework Q1 2026/27	10:35	Decision	Director of Corporate Affairs
BOD/2627/049	Health, Safety, Security and Fire Annual Report 2025/26	10:45	Assurance	Director of Corporate Affairs
BOD/2627/050	Complaints Annual Report 2025/26	10:55	Assurance	Director of Corporate Affairs
BOD/2627/051	Senior Information Risk Owner Annual Report 2025/26	11:05	Assurance	Director of Finance

BOD/2627/052	Audit Committee 3A report from the meetings held on 24 June 2026 and 24 July 2026	11:15	Assurance	Mr N Gower, Non-Executive Director
BOD/2627/053	Charitable Funds Committee 3A report from the meeting held on 22 July 2026	11:25	Assurance	Mr N Gower, Non-Executive Director
BOD/2627/054	Resources Committee 3A report from the meeting held on 23 July 2026	11:30	Assurance	Mr N Gower, Non-Executive Director
BOD/2627/055	Trust Management Committee 3A reports from the meetings held on 17 June 2026 & 22 July 2026	11:35	Assurance	Chief Executive
BREAK 11:45 – 11:55				
PEOPLE				
BOD/2627/056	EDI Regulatory Reporting including WRES / WDES and Gender Pay Gap	11:55	Decision	Director of People
QUALITY AND PERFORMANCE				
BOD/2627/057	Integrated Performance Report	12:05	Assurance	Director of Quality and Improvement
BOD/2627/058	Accountable Officer for Controlled Drugs Annual Report 2025/26	12:20	Assurance	Medical Director
BOD/2627/059	Safeguarding Annual Report 2025/26	12:30	Assurance	Director of Quality and Improvement
BOD/2627/060	Infection Prevention and Control Annual Report 2025/26	12:40	Assurance	Director of Quality and Improvement
BOD/2627/061	Quality and Performance Committee 3A report from the meeting held on 22 June 2026	12:50	Assurance	Ms C Todd, Non-Executive Director
STRATEGY AND PLANNING				
BOD/2627/062	Communications and Engagement Q1 2026/27 Report	12:55	Assurance	Director of Strategy and Partnerships
CLOSING				
BOD/2627/063	Any other business notified prior to the meeting	13:05	Decision	Chair
BOD/2627/064	Risks Identified	13:05	Decision	Chair

RISK APPETITE CONSIDERATION (Refer to the Risk Appetite Statement)					
Quality: Cautious	**People:** Open	**Finance:** Open	**Regulatory:** Open	**Reputation:** Open	**Digital Innovation:** Eager

DATE AND TIME OF NEXT MEETING

30th September 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, 27th May 2026
Oak Room, Ladybridge Hall, Trust Headquarters

Ms J Mulligan	Chair
Mr S Desai	Chief Executive
Mr C Butterworth	Non-Executive Director
Dr A Chambers	Non-Executive Director
Mr G Chapman	Non-Executive Director
Ms A Cooper	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 L Ward	Director of People

In attendance:

Mr M Cooper	Area Director
Ms A Cunliffe	Corporate Governance Manager (Minutes)

Observers:

Mr M Green	OKA People, Director

Minute Ref:
BOD/2627/012 Staff Story

The Chief Executive introduced a film, which referred to the staff story featuring Rhys and his work as the Trust's non-fatal overdose pathway practitioner.

Rhys previously worked as a harm-reduction lead in drug services across Cumbria, managing interventions to reduce harm and prevent drug-related deaths by supporting people with addiction and complex needs. He joined NWAS two years ago and, drawing on his experience with high-risk patients, developed the non-fatal overdose referral pathway now available to clinicians across NWAS.

The pathway enables clinicians to refer patients struggling with opiate addiction for tailored, holistic follow-up from specialist drug services, addressing not only

substance use but also wider health, housing, and employment needs. This support reduces future risk and helps keep patients safe.

Patients with drug issues can be challenging for ambulance crews, sometimes becoming aggressive when life-saving medicines reverse the effects of the drugs they have taken. Some may perceive this as clinicians “stopping their trip” and react verbally or physically.

These patients can also become frequent callers, repeatedly contacting 999 with similar concerns. The referral pathway aims to break this cycle.

Rhys notes that many people with addiction avoid seeking help from GPs or health services due to fear of judgement or stigma, sometimes reinforced by clinicians experiencing “compassion fatigue” after difficult encounters. In the video, he emphasises the importance of challenging stigma and maintaining a compassionate approach.

The Board noted the learning points from the story.

- Risk of repeat overdose — Patients who overdose without follow-up support are highly likely to overdose again soon, with each incident increasing the chance of serious harm or death.

- Rhys’ partnership work — Rhys has built strong links with drug services across the North West, creating a referral pathway for clinicians to direct any patient over 18 who has had a non-fatal overdose to adult harm-reduction services.

- Pathway rollout — The pathway, first launched in Cumbria in June 2025, has since expanded across NWAS. The priority now is ensuring staff know it exists and feel confident making referrals to reduce overdose incidents and save lives.

- Successful outcomes — Several positive cases have emerged, including a high-risk homeless patient who, after referral, received urgent medical care, began methadone treatment, engaged in rehabilitation, and ultimately stopped using illicit drugs. This intervention likely prevented their death.

Ms C Butterworth welcomed the story and described it as remarkable. She asked whether the service could manage 5–7 daily referrals and whether there were any indicative figures on longer-term drug use among those who had been through the pathway.

Mr C Todd queried whether referrals were received internally only or also from A&Es.

The Chief Executive reported that Rhys was assessing the capacity of the service, noting it involved multiple services across a wide geography. The work remained in early stages, with ongoing efforts to join up care. Some information was highly sensitive, limiting the ability to obtain feedback on outcomes, though

agencies could confirm whether action had been taken. Individual cases could be reviewed, but many service users had no fixed abode, making follow-up difficult. Referrals were received from frontline clinicians, with police involvement in many cases.

Mrs C Todd highlighted the links between this developing work and partnerships with other organisations, particularly mental health providers, and the potential influence on their service development.

Mr G Chapman asked about case management arrangements for these patients within NWAS. The Chief Executive confirmed that patients were already embedded within existing health and social care pathways for alcohol and drug services, and NWAS would liaise with the relevant multidisciplinary teams.

The Trust Chair noted that referral pathways were already operational but acknowledged the complexity of provision due to the patchwork of services involved. Once more established, best practice could be drawn out. Evaluation would be reflected in reduced demand, though determining whether patients continued using drugs would remain challenging.

Ms A Cooper observed that the service aligned with organisational values and ambitions to support vulnerable people. She noted that even without a clear shift in demand, the work remained essential.

The Chief Executive added that while evaluation was important, the work also formed part of the Trust's strategic approach to inequalities and supporting vulnerable individuals in crisis.

The Board:

- Noted the content of the story.

BOD/2627/013 Apologies for Absence

Apologies were received from: Mr Dan Ainsworth, Director of Operations and Ms Hameeda Khan-Davey, NEXT Programme Director.

The Chair welcomed the attendees to the meeting and asked for a round of introductions for the attendee and observer.

BOD/2627/014 Declarations of Interest

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

BOD/2627/015 Minutes of the Previous Meeting

The minutes of the previous meetings, held on held on 25th March 2026 and 29th April 2026 were agreed as a true and accurate record of the meeting.

The Board:

- Approved the minutes of the meeting held on held on 25th March 2026 and 29th April 2026.

BOD/2627/016 Board Action Log

The Board Action Log was reviewed.

Item 11-25/26 was marked as green, agreed as complete and for removal.

The Director of Quality & Improvement provided an update regarding item 12-25/26 in relation to a planned session with Non-Executive Directors to discuss IPR. The date for the meeting was being sought.

BOD/2627/017 Committee Attendance

The Board noted the Committee attendance.

BOD/2627/018 Register of Interest

The Board noted the Register of Interests presented for information.

BOD/2627/019 Chair & Non-Executives' Update

The Chair thanked the Non-Executive Directors for engaging in the recent objective-setting process.

The Chair reported on her attendance at the Star Awards 2026. This year's event took place on Friday 8 May where more than 300 colleagues celebrated incredible stories of outstanding work, leadership and courage.

The Chair then informed of her introductory meeting with Kathy Cowell CBE, newly appointed Regional Chair for NHS England North West, noting it had been a positive discussion and that Kathy expressed interest in visiting NWAS. Regular meetings will follow.

The Board noted the Chair's visit to the transport and logistics hub, where she was impressed by colleagues' enthusiasm and entrepreneurial initiatives.

Ms A Cooper reported on her day spent with two Area Directors, describing it as a valuable learning experience. She gained insight into local areas and teams, observed positive culture, and provided feedback through Trust processes.

The Board:

- Noted the Chair's update.

BOD/2627/020 Chief Executive's Report

The Chief Executive presented a comprehensive report covering activity from 20 March to 22 May 2026, including updates on performance, internal matters, regional and national issues, and other organisational information. The

Executive Summary highlighted key points relating to organisational affairs, people and culture, strategy and partnerships, and quality and operations.

The Chief Executive opened with the launch of the Trust's new five-year strategy and four supporting strategic plans. Staff briefings, communications and engagement activity had supported awareness, with the focus now on embedding the strategy through the annual plan, directorate objectives and established governance routes to ensure monitored delivery.

The Board noted updates on People & Culture, including recent internal learning celebrations and participation in the National Ambulance Social Partnership Forum Sexual Safety event in Leeds on 27 April.

The Chief Executive reported that the Trust had begun taking delivery of its new driver training vehicles, designed to support high-quality learning and meet forthcoming High Speed Driving Regulations.

Moving to Operational updates, the Chief Executive reported the following:

- For Cumbria and Lancashire, significant handover delays at Royal Lancaster Hospital were reported. Engagement with the acute provider indicated these were primarily driven by patient flow constraints linked to financial improvement measures.

- In Greater Manchester, the ICB had revised its work programme and meeting frequency in November 2025 to prioritise staff support during organisational change. As a result, the UEC Reform Board had not met since February 2026. A dedicated development session was planned for late June 2026 to review UEC strategic objectives and 2026/27 priorities, aligned to the new NHS GM operating model. The GM Area Director remained closely involved.

- For Cheshire and Merseyside, the Board noted the April launch of the ICB's new UEC strategy, with a strong focus on 'left shift' principles. Sustained lobbying for improved community referral access had led to development of a business case for a Merseyside and Cheshire Clinical Assessment Service. The proposed model would broker patients into existing Urgent Community Response teams. NWAS had been actively involved in shaping both the strategy and the service development.

The Chief Executive presented the national updates, and the Board noted the following:

- Anti-Racist Leadership Conference 2026 – Held on 28 April in Leeds. The Chief Executive attended and spoke on the Chief Executive panel alongside system leaders, focusing on tackling racial inequalities, leading with purpose, and promoting anti-racism as an evidence-based, outcomes-driven approach to improving services and workforce experience.

- Change to UK Threat Level – The national terrorism threat level increased from Substantial to Severe on 30 April 2026, indicating an attack is now considered highly likely. Organisations have been asked to

review security, staffing and preparedness, with emphasis on incident response, business continuity and escalation processes.

- NHS Modernisation Bill – The Government introduced the NHS Modernisation Bill (May 2026), representing the most significant structural reform in over a decade. Proposals include abolishing NHS England, transferring its functions to the Department of Health and Social Care, increasing ministerial powers, and providing Integrated Care Boards with greater flexibility as strategic commissioners.

Moving to organisational updates, the Chief Executive appraised the Board on the latest events, highlighting the following:

- Meeting with Mr Asrar Ul-Haq — On 31 March, the Chief Executive met with Mr Asrar Ul-Haq OBE DL in his capacity as newly appointed Deputy Lieutenant of GM, who outlined ambitions to work with St John Ambulance to increase first-aid training for young people and develop a cohort of community members trained to a higher level, supported by associated fundraising that may benefit NWAS.

- Football Charity Event – 2 May — A family-friendly charity football event organised by Zack Kerr took place at Accrington Stanley Sports Hub in support of the North West Air Ambulance Charity. The match between NWAS and Lancashire Police was well attended and generated strong engagement. Over £18,000 had been raised.

- STAR Awards — the Chief Executive attended the STAR Awards on 8 May at the Bolton Whites Hotel. The event, organised by the Communications Team, celebrated the outstanding talent, dedication and selflessness of colleagues across the organisation.

The Chief Executive concluded his presentation with staff announcements as recorded in the report.

Ms A Cooper referred to the Learner Celebration which she had attended and observed it was a great event at which she had an opportunity to speak to many staff recognising their achievements and opportunities ahead of them in the Trust.

The Chair noted that she and two other Non-Executive Directors attended the Staff Awards event, which was a fantastic event celebrating the staff in the Trust.

The Director of Strategy & Partnerships highlighted that NWAS Chief Executive had been recognised in the top 50 chief executives 2026 in HSJ's 12th annual ranking of the pre-eminent leaders of NHS trusts.

The Board:

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

BOD/2627/021 Common Seal Biannual Report

The Director of Corporate Affairs presented the Common Seal Biannual Report. The Board were reminded the Use of the Common Seal is determined by Section 8 of the Trust's Standing Orders and clause 8.4 requires the occasions of use to be reported to the Board on a bi-annual basis.

The Director of Corporate Affairs reported the Trust's Common Seal was applied on one occasion during the period 1st October 2025 to 31st March 2026 and the reason was a Renewal Lease, for Bolton Mountain Rescue.

The Board:

- Noted the occasions of use of the Common Seal as detailed in s2 of the report.
- Took assurance that the action was taken in accordance with Section 8 of the Standing Orders.

BOD/2627/022 Continuity of Services 7 (CoS7): Availability of Resources Declaration

The Director of Corporate Affairs presented the Continuity of Services 7 (CoS7): Availability of Resources Declaration.

The Board were reminded the NHS Provider Licence requires Trusts to make an annual declaration, no later than two months from the end of each financial year.

The Director of Corporate Affairs drew attention to section 3 of the report, which detailed the main factors, which had been taken into consideration in considering the proposed positive declaration, which was included in section 4 of the report.

The Board:

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

BOD/2627/023 Board of Directors – Terms of Reference

The Director of Corporate Affairs advised the terms of reference had been subject to annual review with minor amendments identified as tracked changes within Appendix 1.

Ms C Butterworth noted the demanding turnaround time for the Board minutes and potential pressures on staff. The Board agreed that the short turnaround remained necessary to support accurate recollection, and that timing would continue to be monitored in balance with the governance team's capacity.

The Board noted:

- Approved the Terms of Reference.

BOD/2627/024 Speaking Up Annual Report 2025/26

The Medical Director presented the report on behalf of the Freedom To Speak Up Guardian who was on annual leave.
The Board noted the report had been previously considered at the Quality & Performance Committee.

The Medical Director commenced the presentation by advising that overall, the data suggests that staff continue to speak up through multiple routes, with a shift away from formal FTSU reporting rather than a reduction in staff voice. He added that FTSU represents only one component of a broader staff voice system that also includes DCIQ reporting, HR processes, patient safety systems, trade union engagement and informal leadership dialogue.

The Board noted during 2025–26, 99 concerns were logged as Freedom to Speak Up concerns, which continues to be a sustained reduction in reported concerns over three years. In addition, further concerns were raised with the Guardians but appropriately redirected into other formal routes, which reflects the Guardian's role in listening, safeguarding and signposting.

The Medical Director advised this reduction was interpreted in the context of stable staff survey results and sustained reporting through alternative routes, suggesting a shift in reporting behaviour rather than reduced willingness to speak up.

The Board noted that a significant proportion of concerns continued to be raised confidentially or anonymously, indicating that while staff were willing to speak up, perceived personal or professional risk continues to influence how concerns are raised.

The Medical Director drew attention to feedback from individuals who have raised concerns, indicating that FTSU is widely regarded as a valued and trusted mechanism where confidentiality is protected and communication is clear. He noted however that experience becomes more variable where concerns are managed locally following escalation. Inconsistent communication, limited feedback and lack of visible resolution remained contributors to reduced confidence, even where initial engagement with FTSU was positive. Therefore, the gap between willingness to speak up and confidence in action remains the most significant cultural challenge identified within the data.

Ms C Todd advised that the report had been discussed in depth at the Quality and Performance Committee, with a focus on how concerns are addressed and on strengthening triangulation practice. She confirmed that the Committee would continue to monitor these issues.

As FTSU NED Champion, Ms C Todd had also met with the FTSU Guardians to deepen understanding of the factors behind the data and the inconsistencies observed across the wide geographical area.

The Director of Quality & Improvement linked to the discussion held at the Quality and Performance Committee regarding triangulation of data, patient safety escalation routes, variability in local handling, and learning mechanisms.

Mr N Gower observed that, historically, major issues in NHS organisations have often arisen in situations where staff were aware of concerns but these were not surfaced. He emphasised the need to remain vigilant and continue gathering general intelligence internally wherever possible.

The Director of People reassured the Board that at the monthly Executive–FTSU Guardian meetings, any inconsistencies are reviewed and actions are taken to remove barriers to speaking up.

The Director of People asked about organisational plans to improve diversity data within Speaking Up reporting. While recognising the need to maintain confidentiality, she noted that FTSU Guardians have opportunities to speak directly with staff raising concerns and could encourage voluntary disclosure to strengthen the quality and completeness of the data.

The Medical Director highlighted the distinction between anonymous and confidential reporting and emphasised the importance of building confidence within the team. He noted his understanding that both FTSU Guardians were comfortable holding conversations to collect relevant data and recognised their awareness of its significance. He confirmed he would follow up with the Guardians to explore this further.

Ms C Todd asked about undertaking a temperature check of the data throughout the year.

Ms A Cooper welcomed the Director of Quality & Improvement's earlier comments and was pleased that enhanced triangulation with patient safety data was being actively progressed within the organisation.

The Director of Quality & Improvement highlighted the extensive work underway on the Learning from Experiences Policy, scheduled for completion within six months. The Director of People advised that quarterly data is collected through the Pulse Check and reviewed internally.

The Chief Executive reiterated that FTSU data is considered holistically alongside other intelligence at the monthly Executive–FTSU Guardian meetings. The annual plan of work had been signed off and any additional requests from the digital would need to be considered in terms of the team's capacity.

The Board:

- Noted the assurance provided on the Trust's arrangements for speaking up, listening to, and responding to staff concerns.
- Considered the triangulated intelligence drawn from Freedom to Speak Up, DCIQ, HR and Staff Survey data.
- Supported the continued organisational focus on strengthening follow-up, feedback and visible learning, as the key drivers of staff confidence.

BOD/2627/025 Fit & Proper Persons Requirements Annual Declaration

The Director of People presented the report including the Chairman's Annual Declaration at Appendix 1, confirming that all existing Executive and Non-Executive Directors (both permanent and interim) meet the requirements of the Fit & Proper Persons Test.

The Board noted that during the year 2025/26, the Director of People had overseen the completion of pre-employment checks for new appointments and confirmed that all checks met the FPPT Framework.

The Board noted:

- Confirmed and recorded that the Fit and Proper Persons Test had been conducted for the period 2025/2026 and that all Board members satisfy the FPPT requirements.

BOD/2627/026 Audit Committee 3A Report from the meeting held on held on 24th April 2026 and 22nd May 2026

Mr N Gower, Non-Executive Director, presented the reports.

Referring to the report from the 24th April 2026, Mr N Gower reported there were no alerts and several advisements and points of assurance as recorded in the report. He highlighted the approval of 2026/27 Audit Plans for Internal Audit and Anti-Fraud Services and the receipt of the Head of Internal Audit Opinion for the period 1st April 2025 to 31st March 2026 indicating Substantial Assurance.

In terms of the report from the 22nd May 2026, Mr N Gower advised there were no alerts and two advisements in relation to the draft Annual Governance Statement AGS presented by the Chief Executive and the receipt of the draft unaudited annual accounts 2025/26 and draft Annual Report 2025/26.

The Board:

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

BOD/2627/027 Charitable Funds Committee 3A Report from the meeting held on 20th May 2026

Mr N Gower, Non-Executive Director, presented the report. There were no alerts, but several advisement and points of assurance as recorded in the report.

Mr N Gower highlighted the Committee were presented with the three year NWAS Charity Strategy 2026-2029. Further refinements were requested with a revised version to be circulated to Committee members and finalised within two months.

The Board also noted a robust financial position of the NWAS Charity, contributable among others to generous legacies.

The Board:

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

BOD/2627/028 Resources Committee 3A Report from the meeting held on 21st May 2026

Mr G Chapman, Non-Executive Director, presented the report. There were no alerts and several points of advisement and assurance as recorded in the report.

Mr G Chapman provided an overview of the Committee's recent meeting, noting continued improvement in the Committee's culture. He highlighted the increasingly open and honest dialogue, strengthened communication, and constructive challenge between non-executive and executive members. He further reported that several Committee reports had been enhanced through a clearer focus on risk management and mitigation.

The Board noted that the Committee held an in-depth and positive discussion on the Risk Appetite Statement (RAS). The Committee concluded that each business case presented to the organisation is unique and complex, and that explicit reflection on the organisation's risk appetite provides valuable context when making such decisions.

In reviewing operational areas, Mr G Chapman reported that a stable position had been presented across finance, workforce, digital, and strategy. Several items considered by the Committee were scheduled for further discussion at the Board's Part 1 and Part 2 sessions.

Mr N Gower added that the Committee had received reports from non-member colleagues invited to attend. He noted that their contributions were positive, informative and added a refreshing perspective to the Committee's work.

The Board:

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

BOD/2627/029 Trust Management Committee 3A Report from the meetings held on held on 22nd April 2026 & 20th May 2026

The Chief Executive presented the Trust Management Committee (TMC) 3A report from the meeting held on 22nd April and advised there were three alerts and several advisements, approvals and assurance reports, as listed within the report. The alerts related to further development of the BAF during 2026/27, the increasing volume of business brought to TMC and the importance of effective triangulation between Executive Groups, concerns regarding the pace of progress of the Anti-racism Steering Group. No new risks were identified and the existing risks were discussed as recorded.

The Director of People provided an overview of the TMC meeting held on the 20th May 2026, which she chaired it in the Chief Executive absence. The Board noted reported two alerts and a number of advisements, approvals and

assurance reports, as listed within the report. The alerts related to limitations in the current Quality Assurance Visits (QAV) process and IPC report which noted 6 amber rated areas. The TMC requested an additional report regarding QAVs to be brough back to TMC in September. With regards to the IPC amber areas, the TMC discussed the 'back to basics' approach to close the gaps over the next 12 months with progress to be monitored through existing reporting arrangements.

Ms C Butterworth raised the issue of Quality Assurance Visits and asked whether this should also be reported to the Quality and Performance Committee. She further queried whether QAVs should be included in the audit plan.
The Director of Quality & Improvement advised that the current reporting route for QAVs is through area forums but confirmed she was content to provide update to the Q&P Committee as well. Regarding audit coverage, she noted that inclusion would be beneficial for next year's plan, once the process has been fully established and can be tested.
The Director of People added that the Trust is well sighted on the development of the QAV process and agreed that an audit would be most valuable once the process is embedded.

The Chair referred to the TMC 3A report, noting the identified need for improvement to the Board Assurance Framework (BAF), and sought clarification.
The Chief Executive confirmed that the improvement work had already progressed, as the 3A report pre-dated the April Board meeting.
The Director of Corporate Affairs confirmed that the BAF is monitored regularly and developed quarterly through executive review of the narrative, forward consideration of emerging impacts, and ongoing review at Committees.

The Chair referred to the TMC update on Co-Pilot, noting that work on identifying benefits and potential savings was underway. She questioned whether the organisation was being sufficiently ambitious and whether the approach aligned with the agreed risk appetite.

The Director of Finance explained that, as the organisation is not on a national platform, the focus is on ensuring that the internal use of AI delivers measurable efficiency and productivity gains.

Mr N Gower observed that similar discussions had taken place in other NHS organisations months earlier and encouraged reviewing external examples.

Mr G Chapman raised a broader point regarding the application of risk appetite to digital and transformation programmes, noting that digital capability is often the enabler of wider transformation.

The Chair acknowledged this and proposed continuing the discussion at the forthcoming Board Development Session on digital, including intelligence on how other organisations are implementing AI technology.

The Board:

- Noted the contents of the reports, the assurance provided and actions identified.
- Agreed that Q&P would in the future receive updates on Quality Assurance Visits

BOD/2627/030 Equality, Diversity, and Inclusion Annual Report 2025/26

The Director of People introduced the Trust's 2025/26 Equality, Diversity and Inclusion Annual Report, produced by the Staff Experience Team. The Director of People advised the report provided a comprehensive overview of the work undertaken across the organisation to improve the experiences of both staff and patients, ensuring services and workplace practices are fair, equitable and inclusive.

The Board noted the report had been reviewed by the Diversity & Inclusion Group, the People and Culture Group, the Trust Management Committee and the Resources Committee,

The Board noted the report met the statutory reporting responsibilities in relation to workforce data through publication of representation levels, WRES, WDES and Gender Pay Gap data. However, the Director of People cautioned that the latter data relates to 2024/25 because validated data in relation to the last financial year was not yet available. In light of this, the Trust Management Committee approved a recommendation that from 2026/27 the production of the EDI Annual report would be delayed until September in order to enable the up to date data to be incorporated into the report.

The Director of People also advised the Resources Committee will receive the mid-year deep dive report into the newest data once they are available.

Ms C Todd highlighted the WRES indicator on entry into the formal disciplinary process, noting the continued disparity. She referenced the Just Culture approach used in many NHS organisations and asked whether comparable arrangements existed within the Trust.

The Director of People confirmed the Trust operates an Investigation Review Panel, providing an additional check and balance. She noted that while the formal disciplinary process is robust, issues arise at the informal stage, where managers may lack confidence or feel discomfort in addressing concerns early, leading to quicker escalation into formal procedures. To address this, a Task and Finish Group has been established to undertake detailed analysis of disciplinary data and develop a targeted action plan. This work is being led by the ICC, supported by the HR Business Partnering Team.

Ms C Butterworth welcomed the report and, referring to the section on Staff Networks activity, suggested that future iterations could provide a direct voice from the Staff Networks rather than a descriptive narrative, while noting that Network Leads currently sign off the content.

The Director of People confirmed the report had been reviewed by the D&I Group, whose membership includes all Staff Network Leads.

Mrs A Cooper congratulated the team on the strong presentation of the report. She noted the encouraging increase in staff disclosing disability and long-term conditions and welcomed the organisational work on reasonable adjustments reflected in the data. The Board noted that over 70% of disabled staff reported that reasonable adjustments had been made, representing a significant improvement on the previous year. It was further reported that, following the launch of the Reasonable Adjustments Policy, training has been delivered to managers to support effective handling of adjustment requests.

The Director of People advised that, as seen in other organisations, a disparity remains between Staff Survey results and ESR data regarding disability disclosure, and work is ongoing to address this.

Mrs A Cooper offered to volunteer her support to the Disability Network.

The Board:

- Received assurance that the trust has complied with the Public Sector Equality Duty (specific duty) in producing an EDI Annual Report.
- Approved the report for publication.

BOD/2627/031 Integrated Performance Report

The Director of Quality and Improvement presented the Integrated Performance Report (IPR) with an overview of integrated performance to the month of April 2026. She drew out the main points in terms of quality, effectiveness, operational performance, finance and organisational health, as detailed in the executive summary.

The Board noted the following key points:

- The metrics were stable for complaints and incidents
- No new safety alerts affecting service
- The Trust was performing above the sector average for all of the care bundles with the exception of survival after discharge (8.9% against a sector average of 9.0%)
- H&T and S&T performance continue to show consistency at 18% and 26% respectively, with a combined non-conveyance rate of 44%. The overall improvements in Hear & Treat were 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.
- PES (999): The trust maintains a strong position for ARP
- Call demand and performance were stable and within target
- C1 mean remained unchanged from last month at 06m:50s and stays within target
- C2 mean has improved to 23m:14s but remained outside the ARP target, although it met the new UEC target of 25m. All ICBs have reported an improvement in C2 mean compared to last month.
- Turnaround was signalling improvement post winter pressures, however it remains above the 30-minute target at 35m:33s. Regional variation persists with Cheshire & Mersey ICB the outlier

- 111 - April telephony performance declined due to increased Easter demand, compounded by high Service Advisor sickness absence
- PTS activity and performance metrics were stable
- The financial position to 30 April 2026 (Month 01 2026/27) was a surplus of £0.047m, against a planned deficit of £0.327m. Productivity and efficiency savings were £0.149mn below plan.
- Sickness absence was reducing in line with seasonal patterns in March, but remained above target overall, with persistent pressure in PTS.
- Turnover remained stable and above the national benchmark.

Mr G Chapman referred to the increased demand on the 111 service during the Easter period and queried whether additional resourcing had been put in place to meet this rise in activity.
The Area Director advised that the 111 contract is underfunded relative to current levels of demand. As a result, there is no increase in staffing when demand rises; instead, the service relies on internal flexing of staff to manage periods of heightened activity.

Mr G Chapman asked about the difference between the Ambulance Response Programme (ARP) target for Category 2 (C2) calls, set at 18 minutes, and the Urgent and Emergency Care (UEC) target for C2, set at 25 minutes.
The Area Director confirmed that the ARP C2 mean response target remains 18 minutes, and that there is a planned trajectory to return performance to this constitutional standard over time.

The Chief Executive provided further background, noting that response times had increased during the pandemic. In response, NHSE introduced a multi-year trajectory aimed at gradually reducing C2 response times back to the 18-minute standard. Improvements in Double Crewed Ambulance (DCA) availability, alongside investment in Hear & Treat and alternative pathways, were highlighted as key enablers in reducing C2 waiting times. The Medical Director highlighted that every minute counts for C1 patients and whilst some other patients can wait a little longer, improvements have been made in keeping them safe.

Further discussion followed, with Ms A Cooper seeking clarification on quality monitoring arrangements, and the Chair requesting information on the plans to achieve the 18-minute C2 mean response time in future years. The Chair also queried whether achieving this target was becoming increasingly challenging over time.

The Director of Finance confirmed that the organisation's three-year Medium Term Plan, approved by both the Board and NHSE, includes robust planning assumptions and is subject to rigorous monitoring. Funding allocations are linked to organisational performance during the first half of each financial year.

The Area Director added that C2 performance is influenced by several operational factors, including handover times, resource availability, and the number of vehicles in service. Multiple actions have been taken to increase both Double Crewed Ambulance (DCA) capacity and overall availability.

He further noted that achieving the progressively reducing target is becoming more difficult due to rising demand, which reinforces the need for the three-year plan and associated preparatory work. It is anticipated that NHSE will permit a revision of the plan in year two, enabling updates or changes to delivery approaches if required.

The Chief Executive emphasised the importance of partnership working across the system in order to achieve the reducing response time targets. He highlighted the emerging role of Neighbourhoods, noting that if these models operate effectively, they should contribute to a reduction in demand on ambulance services.

Mr N Gower asked how the organisation plans to manage uncertainty in future demand, specifically how capacity can be understood and planned for when demand patterns continue to shift.

The Area Director advised that this challenge is addressed through modelling undertaken jointly with NHSE, which incorporates a range of variables and scenarios. He noted that this includes consideration of measures such as increasing Hear & Treat capacity, while recognising that the effectiveness of such approaches is dependent on access to community services and the wider system's ability to support alternative pathways.

In response to earlier questions on quality monitoring, the Director of Quality and Improvement advised that the organisation monitors harm through established reporting systems, enabling visibility of the level of harm and any association with delays. She noted that it is not possible to monitor every individual delay, but all cases where harm is reported are reviewed.

The Medical Director added that there is clinical oversight in real time for patients awaiting a response, with the aim of proactively preventing harm.

Ms C Todd enquired about the level of confidence in the organisation's early warning mechanisms, specifically how the system identifies when performance is not on track.

The Chief Executive advised that the leadership team reviews performance data regularly and flags any emerging concerns through established governance routes, including SDAG and TMC, as well as directly to the Director of Operations for review and corrective action. He further noted that performance data is also monitored monthly by NHSE, ensuring that any issues are identified early and the organisation is not caught by surprise.

The Board:

- Noted the contents of the report, the assurance and assurance against the core Single Oversight Framework metrics.

BOD/2627/032 Learning from Deaths Q3 2025-26

The Medical Director presented the report and took the Board through the headlines as detailed in the executive summary. He advised the report had been previously received at the Quality & Performance Committee.

The Board noted the report was divided into two main elements: concerns raised via DCIQ (internal or external), and formal SJRs, where multidisciplinary panels assess care quality. The Q3 dashboard (Appendix A) describes the opportunities to learn from deaths as well as evidence of very good practice. The concerns learning themes as well as areas of good practice were detailed in section 3.3.2 of the report.

The Board noted that of 24 internal concerns reviewed, of which two identified potentially attributable harm, which were managed locally and escalated through appropriate safety and governance processes. External cases reviewed did not identify attributable harm.

The Medical Director referred members to Appendix B, noting that the Incidents Demographics chart demonstrates a gradual increase in data collection, supporting improved understanding of incident trends.

Mr G Chapman reported that, following a request from the Q&P Committee, he had attended one of the Learning from Deaths (LfD) Panels, which he described as very well chaired. He asked how the identified learning themes were implemented in practice.

The Medical Director advised that learning themes are disseminated and embedded through the clinical leadership team, supported by both regional and local Area Learning Forums (ALFs) and through direct engagement with frontline staff. He confirmed that the Q3 Learning from Deaths infographic (Appendix B) will be shared with the clinical leadership team to support this work.

The Director of Quality and Improvement highlighted that work is underway on the Learning from Experience policy, which will consolidate and strengthen the various routes through which learning is identified, shared, and acted upon.

The Director of Corporate Affairs asked whether the national review of Learning from Deaths had progressed. The Medical Director advised that, despite a sector-wide desire for change, the review is unlikely to progress in the near term. If no national developments emerge, the organisation will continue to drive improvement through its own governance channels.
The Board:

- Supported the quarterly dashboard (Appendix A) as the report to be published on the trust public account as evidence of the trust's engagement with the formal process of Learning from Deaths.
- Acknowledged the impact of the SJR process in identifying opportunities for improving care.
- Supported the dissemination process as described in Section 2.

BOD/2627/033 Quality and Performance Committee 3A Report from the meeting held on 27th April 2026

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

The Board noted that the Q&P Committee received the results of the annual effectiveness survey and requested a mid-year review in light of recent changes to Committee membership.

Ms C Todd reported that the Committee continued to receive high-quality papers and benefited from good, challenging and in-depth discussions, supporting effective scrutiny and assurance.

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

BOD/2627/034 Trust Strategy 2025-26 year-end report

The Director of Strategy and Partnerships presented the Trust's Strategy 2025-26 year-end report, reflecting progress during 2025/26 and learning from the full strategy period.

The Director of Strategy and Partnerships reminded colleagues that the strategy set out three strategic aims: to provide high-quality, inclusive care; to be a brilliant place to work for all; and to work together to shape a better future. Annual plans and supporting strategies were used throughout the period to align delivery activity to these aims.

The Board noted that the original strategy did not include agreed strategy-level outcome metrics or trajectories. As a result, this final assurance position has been developed through triangulation of existing evidence, including annual plan assurance reports, committee reporting, the Integrated Performance Report, NHS Staff Survey results, the draft Quality Account and the Equality, Diversity and Inclusion Annual Report.

On that basis, the Director of Strategy and Partnerships reported progress had been made across each of the three strategic aims. He advised there was evidence of improvement in patient safety, quality improvement capability, staff development, leadership, inclusion, 111 call handling and Category 2 response performance. Areas requiring continued focus included sickness absence, PTS performance and the ability to demonstrate a direct line of sight between strategic aims, delivery activity and measurable outcomes. The strength of assurance was limited by the absence of agreed strategy-level outcome measures, baselines and trajectories.

The Director of Strategy and Partnerships emphasised the final year of the strategy has provided significant learning for future strategic delivery. It has highlighted the need for clearer outcome measures, stronger alignment between strategy and annual planning, improved triangulation of performance and delivery evidence. The learning from the previous strategy period has informed

the development of the new strategic framework and will support a more mature approach to strategy delivery, measurement and assurance in future years.

Ms C Todd welcomed the focus in the report on learning (as laid out in section 5 of the report), which would address the previously identified gaps.

Mr G Chapman reported a constructive discussion at the Resources Committee. He noted assurance does not require 100% success; understanding gaps, learning, and mitigation also provide assurance.

The Chair welcomed the report and highlighted the value of learning from the previous strategy iteration. She requested an update on progress of the Strategy Measurement and Assurance Task and Finish Group (TAFG), encouraging future reports to provide full strategic outcome assurance.

The Director of Strategy and Partnerships confirmed this would be addressed through the new framework. The TAFG is a short-term group expected to complete its work in July. As previously requested, an update will be provided to the Board at the end of Q4.

Mr G Chapman asked about measurement methods for the strategy.
The Director of Strategy and Partnerships advised the strategy includes 19 strategic objectives over five years, each with bespoke measures. IPR will support evidence gathering, but strategic measures should remain distinct from operational performance measures.

The Chair commended the openness of the report and confirmed progress will be monitored through existing governance routes: Planning Group, Trust Management Committee, and Resources Committee, with an end-of-year report to the Board.

The Board:

- Noted the progress made during 2025/26 and across the final year of the Trust Strategy 2022–2026;
- Took assurance from the triangulated evidence of progress across the three strategic aims, recognising that the strength of assurance is limited by the absence of agreed strategy-level outcome measures, baselines and trajectories; and
- Noted the learning from the 2022–2026 strategy period, which has informed the Trust's approach to future strategic planning, delivery, measurement and assurance.

BOD/2627/035 Communications and Engagement Q4 2025/26 Report

The Director of Strategy and Partnerships presented the Communications and Engagement Q4 2025/26 Report, including Dashboard at Appendix 1 with a quarterly summary of key outputs and associated highlights of activity.

The Board noted multiple examples of Q4 work from the areas of Patient Engagement, Communications and Charity as reported by the Director of

Strategy and Partnerships. It was noted the dashboard demonstrates how activity aligns with the aims of the organisational strategy, and the positive impact it has on staff, patients, and partners. The report also set out combined team priorities for Q1.

The Director of Strategy and Partnerships also pointed to section 3 of the report on risk considerations, where three risks with mitigations were described.

Ms A Cooper noted that the dashboard indicated an average 54% staff view rate for the organisation's Staff Bulletin. She queried whether it was possible to identify which staff groups were accessing the Bulletin, expressing concern that front-line teams may be less likely to view it.

The Director of Strategy and Partnerships confirmed that this information could be obtained and agreed to provide the breakdown to Ms A Cooper offline.
He also highlighted the positive engagement with the new Connected manager briefing, which had been accessed by 75% of managers, who are expected to cascade key messages to their teams.

The Director of People reported that the forthcoming re-launch of the intranet, the Green Room, would provide an opportunity to improve staff access and engagement. She emphasised that the organisation uses multiple communication channels, and that leaders play a key role in reinforcing messages.

The Chief Executive added that the organisation had invested in iPads for staff to strengthen communication and improve ease of access to corporate information.

The Board:

- Noted the contents of the report.

BOD/2627/036 Biannual Assurance Report – Partnerships & Integration

The Director of Strategy and Partnerships presented the Biannual Assurance Report on Partnerships & Integration on activity undertaken during the second half of 2025/26.

The Board noted that NWAS remained actively engaged across key system forums and transformation programmes during the reporting period and continues to be viewed by partners as a credible and constructive strategic partner across the North West.

The Director of Strategy and Partnerships pointed to section 5 of the report detailing the areas for further improvement and requiring further maturity as the landscape becomes increasingly complex. He emphasised A key area of further development during 2026/27 will be establishing a clearer organisational approach to partnership working including development of a NWAS Partnership Operating Framework. The team will also focus on developing a clearer

organisational position regarding the NWAS role within neighbourhood health and urgent and emergency care pathway development.

The Board noted increased utilisation of the Knowledge Vault with further work during 2026/27 focusing on strengthening how this intelligence is used to support assurance, decision-making and evidence of partnership impact.

The Director of Strategy and Partnerships invited the Non-Executive Directors to spend some dedicated time with Partnerships and Integration team.

The Medical Director referred to the handover delays and NWAS work with the partners and highlighted the distinction between partnership working and performance management in terms of those relationships.

The Area Director highlighted that NWAS maintains strong relationships with its close acute partners. Because of this foundation of trust, difficult conversations can take place constructively, with all parties recognising they are driven by shared goals and patient-centred intent.

The Chair welcomed the report's focus on BAF SR04, noting the increasing complexity of partnership working across an expanding and diverse system footprint. She observed that all Board members have a role in continuing to build and maintain positive, constructive relationships with partners, recognising this as essential to delivering the organisation's strategic aims.

The Board:

- Noted the Partnerships and Integration activity undertaken during the second half of 2025/26 and the actions being taken during 2026/27 to strengthen partnership governance, system influence and organisational oversight.

BOD/2627/037 Any Other Business Notified Prior to the meeting

None advised.

BOD/2627/038 Risks identified

The Chair confirmed there was no additional risks identified for BAF and the application of Risk Appetite Statement was discussed during the meeting.

Date and time of the next meeting –
29th July 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
12 - 25/26	25.03.26	2526/161	Integrated Performance Report	It was agreed that a dedicated session with Non-Executive Directors would be arranged to discuss feedback and suggestions for future development of the IPR.	Director of Quality and Improvement	May-26	Aug-26	**27 May 2026**: The Director of Quality & Improvement advised the date for the meeting was being sought. **Update:** Meeting date has been established for the 24th August 2026.	

NWAS Board and Committee Attendance 2026/27

Board of Directors								
	29th April	27th May	24th June	29th July	30th September	25th November	27th January	31st March
Julia Mulligan **(Chair)**	✔	✔	✔					
Daniel Ainsworth	✔	x	✔					
Catherine Butterworth	✔	✔	x					
Graeme Chapman	✔	✔	✔					
Anne Cooper	✔	✔	✔					
Salman Desai	✔	✔	x					
Michael Gibbs	✔	✔	✔					
Nic Gower	x	✔	✔					
Dr Chris Grant	✔	✔	✔					
Dr David Hanley	✔	✔	✔					
Dr Elaine Strachan-Hall	✔	✔	✔					
Clare Todd	✔	✔	✔					
Lisa Ward	x	✔	✔					
Angela Wetton	✔	✔	x					
Carolyn Wood	✔	✔	✔					

Audit Committee						
	24th April	22nd May	24th June	24th July	23rd October	22nd January
Nic Gower **(Chair)**	✔	✔	✔	✔		
Catherine Butterworth	✔	✔	x	✔		
Graeme Chapman	✔	✔	✔	✔		
Clare Todd	x	✔	✔	✔		

Resources Committee						
	21st May	23rd July	24th September	19th November	21st January	25th March
Graeme Chapman **(Chair)**	✔	✔				
Daniel Ainsworth	✔	x				
Catherine Butterworth	✔	✔				
Lisa Ward	✔	✔				
Carolyn Wood	✔	✔				
Michael Gibbs	✔	✔				
Nic Gower	✔	✔				

Quality and Performance Committee						
	27th April	22nd June	7th September	26th October	14th December	22nd February
Clare Todd **(Chair)**	✔	✔				
Daniel Ainsworth	✔	✔				
Anne Cooper	✔	✔				
Graeme Chapman	✔	✔				
Dr Chris Grant	✔	✔				
Dr Elaine Strachan-Hall	✔	✔				
Angela Wetton	✔	x				

Charitable Funds Committee				
	20th May	22nd July	21st October	17th February
Nic Gower **(Chair)**	✔	✔		
Daniel Ainsworth	✔	x		
Catherine Butterworth	✔	✔		
Michael Gibbs	✔	✔		
Lisa Ward	✔	✔		
Clare Todd	✔	✔		
Angela Wetton	✔	✔		
Carolyn Wood	✔	✔		

Nomination & Remuneration Committee									
	29th April	20th May	27th May	24th June	29th July	30th September	25th November	27th January	31st March
Julia Mulligan **(Chair)**	✔	✔							
Catherine Butterworth	✔	✔							
Graeme Chapman	✔	✔							
Anne Cooper	✔	x							
Nic Gower	x	x							
Clare Todd	✔	✔							

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	
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.
			Non-Executive Director of Leads Community Healthcare NHS Trust				√		May-26	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
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	**7th April 2026**	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	Present	N/A
			Chair of British Eventing				√	Position of authority	23-Apr-26	Present	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	**Terminated in January 2026**	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.
Aneez	Esmail	Non-Executive Director (Left the Trust 31 March 2026)	Board member of Charity Dignity in Dying			√		Board member	May-22	Present	

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	
Alison	Chambers	Non-Executive Director (Left the Trust 31 March 2026)	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.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Chief Executive's Report
PRESENTED BY	Salman Desai
PURPOSE	Assurance

STRATEGIC AIM(S)	All strategic aims							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒
	SR05	☒	**SR06**	☒	**SR07**	☒	**SR08**	☒

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

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 highlights and summary information on several areas for the period 23 May – 22 July 2026. **Organisational** <u>Advanced Foundation Trust (AFT) Status</u> The Trust has been selected as one of 16 NHS organisations nationally to undergo assessment for AFT status. Achieving this status would provide greater local autonomy, including a streamlined annual planning process and increased flexibility to reinvest operational surpluses into capital priorities. <u>HPMA Excellence in People Awards 2026</u> Lisa Ward, Director of People has been shortlisted for the People Leader of the Year Award in the Healthcare People Management Association (HPMA) Excellence in People Awards 2026. **People & Culture** <u>Thrive</u> During July, the Trust launched Thrive, a new Continuing Professional Development platform that significantly enhances staff access to learning, career development and clinical education through a flexible range of events, e-learning, podcasts and tailored content.

	PRIDE month The Trust marked PRIDE month by supporting its LGBT+ network through awareness activities, webinars and attendance at regional PRIDE events, reinforcing its commitment to inclusion, staff wellbeing and addressing health inequalities. Future Workforce Solution We have successfully completed the first readiness phase of the national Future Workforce Solution programme, having been selected as an early adopter for the replacement of the Electronic Staff Record, with further implementation requirements and timelines awaited from the national team. **Quality** Maternity Project The Trust's maternity project has been shortlisted for a prestigious HSJ Patient Safety Award 2026 in the Digital Clinical Safety Initiative of the Year category. **Operations** PTS tender The Trust continues to await formal notification of the outcome of its PTS tender submission. PES Site-specific handover delays continue in parts of Cumbria and Lancashire and Cheshire and Mersey, with recent hot weather adding to operational pressures. Work is underway to strengthen resilience for future prolonged heatwave events. **Strategy and Partnerships** Major project reporting A new reporting approach has been introduced for major projects. Projects valued at more than £1million requiring Board of Directors approval will now be reported through Corporate Programme Board to Resources Committee, strengthening oversight of delivery, financial exposure, key risks and emerging issues.
PREVIOUSLY CONSIDERED BY	
	Date
	Outcome

1. BACKGROUND

This report provides a summary of the key activities undertaken and the internal, regional, system and national items to note since the last report to Board of Directors on 27 May 2026 and covers the period 23 May – 22 July 2026.

2. INTERNAL UPDATES

Finance

Data Security and Protection Toolkit (DSPT) Submission 2026

The Trust has successfully submitted its return. Prior to submission the assessment was independently reviewed by the Mersey Internal Audit Agency (MIAA), providing additional assurance regarding the quality and completeness of the evidence submitted.

The DSPT provides assurance against a range of national data security and information governance standards and includes several elements relating to cyber security. The review identified that, whilst the Trust continues to demonstrate compliance with the DPST requirements, further work is required to strengthen arrangements in a number of key areas, including executive oversight of cyber risk, cyber incident preparedness, and assurance relating to system recovery capabilities following a significant cyber event.

The review also emphasised the importance of continuing to strengthen and regularly test business continuity and recovery plans, particularly in relation to extended disruption scenarios where critical digital systems may be unavailable for prolonged periods. This work will form part of the Trust's ongoing cyber resilience programme to ensure organisational preparedness and maintain the continuity of services in the event of a major cyber incident.

People & Culture

HPMA Excellence in People Awards 2026

I am delighted to report that Lisa Ward, Director of People, has been shortlisted for the People Leader of the Year Award in the Healthcare People Management Association (HPMA) Excellence in People Awards 2026.

The award is for a leader demonstrating excellent leadership and outstanding contribution to the workforce profession over the last 12 months. The nomination recognised Lisa's commitment to creating compassionate and inclusive cultures, contribution to improving workforce delivery and care to patients and her breadth of connections from working directly with front line staff i through to the national work she is involved with.

Lisa and her nominees attended a virtual judging panel on 6 July, and the winners will be announced at the awards ceremony on 12 November.

Thrive

July has seen the launch of a new platform to support Continuing Professional Development. The platform allows staff to manage their own development

journey, providing a range of generic and bespoke content focused on skills development, career support and clinical development. Staff can book onto events, listen to podcasts, undertake e-learning or watch videos. Designed to offer development opportunities to meet busy lifestyles and support the range of staff who work in the organisation, the platform was soft launched at the beginning of July with a full launch following at the end of the month. It represents a significant step forward in comparison with our previous provision both in terms of available content, ease of navigation and the ability for staff to build their own development needs.

PRIDE month

The Trust supported the LGBT+ network in their celebration of PRIDE month, through communications articles, flag raising and the launch of a series of webinars to enhance understanding of a range of LGBT+ employment and health inequality issues. The Trust has also attended the PRIDE events in Blackpool in June and Liverpool in July. We continue to recognise that the LGBT+ community faces a range of health inequalities and that there can be reluctance in parts of the community to access health services. Our LGBT+ staff are also more likely to face violence and aggression than some other groups. In light of this, attendance at PRIDE gives us an opportunity to show support for our staff and to send a positive message to the community that we are an accessible and fair provider of services.

Future Workforce Solution

The Future Workforce Solution (FWS) is the replacement system for the Electronic Staff Record (ESR). This is a national transformation programme which will not only transition all NHS providers to the new system over the next four years, but which also offers the opportunity to rethink and redesign administrative processes. NWAS was selected as an early adopter and has mobilised a project team to take the work forward and the first phase of readiness has now been completed with all the necessary requirements met by the due deadline. We are now waiting to understand the requirements for the next stage and the overall implementation timeline. This will enable the Trust to make a final decision, in conjunction with the national team on whether it proceeds to full implementation as an early adopter.

Quality

AmbulanceQ

The Trust recently hosted AmbulanceQ at Estuary Point, bringing together a network of quality improvement leaders from ambulance services across the UK, supported by the Health Foundation. The event provided an opportunity to showcase the Trust's improvement work, with presentations receiving positive feedback from delegates. The visit also included a tour of the Integrated Call Centre, which was particularly well received and highlighted the Trust's operational and quality improvement initiatives.

Maternity Project

The Trust's maternity project has been shortlisted for a prestigious HSJ Patient Safety Award 2026 in the Digital Clinical Safety Initiative of the Year category. Developed through the Improvement Academy in collaboration

with Trust staff, partner organisations and patients, the project focuses on improving care and outcomes for women during and after pregnancy. This national recognition reflects the impact of the Trust's commitment to innovation, patient safety, and collaborative improvement.

Royal College of Paramedics (RCOP) Fellowship

I am delighted to report that Susie Rhind of the Quality Directorate received a Royal College of Paramedics Fellowship on 21 July at the Royal College of Paramedics Awards. This national honour recognises her significant contribution and leadership in maternity and newborn care and reflects the Trust's influential role in advancing clinical practice and improving patient outcomes at a national level.

Operations

PTS tender

The Trust continues to await formal notification of the outcome of its PTS tender submission.

PES

The Cumbria and Lancashire Area and Cheshire and Mersey areas continue to experience site-specific handover delays, consistent with previous reports, alongside increased operational pressures during the recent period of hot weather. Preparatory work will be undertaken to strengthen resilience and operational response arrangements for future sustained heatwave events.

Strategy and Partnerships

Strategy Partner Feedback Session

Following partner engagement sessions facilitated by AQuA in February, 42 external partners attended a feedback session in July to understand how their views had influenced the final the final Trust Strategy 2026-31.

The session was positively received and has generated further discussions across the North West on shared priorities and opportunities for collaboration. This provides a strong foundation for strengthening partnership working, joining innovation and collaborative delivery as the Trust progresses through the Advanced Foundation Trust programme.

Strategy engagement visits

Executive Directors and Non-Executive Directors have continued to support the launch and implementation of the Strategy 2026-31 through visits to Emergency Departments across all three areas.

The visits have enabled direct engagement with frontline colleagues, strengthened understanding of the Trust's strategic priorities and provided insight into local opportunities and challenges. Feedback has been positive, with further sessions planned for colleagues in the Integrated Contact Centres and Cumbria to maintain momentum and support implementation.

Major project reporting

A new reporting approach has been introduced for major projects. Projects valued at more than £1million requiring Board of Directors approval will now be reported through Corporate Programme Board to Resources Committee, strengthening oversight of delivery, financial exposure, key risks and emerging issues.

3. UPDATES

3.1 National

Online NHS Trust

The Online NHS Trust was established on 1 June 2026 as the first ever national, digital-first NHS Trust. From 2027, the Online NHS Trust will give people in England the option to receive planned care through the NHS App. Virtual services will be developed which will help reduce waiting times, improve access to care across the country and make it easier for people to access NHS services from wherever they are. It will connect people with specialist clinicians across the country, helping them get care sooner without always needing to travel. It is envisaged that services will be offered to patients by the end of 2027.

National Quality Strategy for NHS-Funded Care

NHS England has published a new 10-year Quality Strategy for NHS-funded care in England, providing a national framework to support delivery of high-quality care for all patients and communities. Developed through the National Quality Board, the strategy aligns with the Government's 10 Year Health Plan and reinforces a shared focus on three interdependent domains of quality: safety, effectiveness, and experience.

The strategy does not introduce new priorities but brings together existing commitments and evidence-based approach to improvement. It calls on NHS organisations and system partners to embed the framework within local planning, quality improvement programmes, and performance oversight arrangements, ensuring equal consideration is given to all three quality domains.

The Board is asked to note the publication of the strategy and the expectation that its principles will continue to inform the Trust's approach to quality governance, improvement, and patient outcomes.

NHS Board Development Programme

NHS England is rolling out a new Board Development Programme to strengthen governance and improve board effectiveness across NHS organisations. The programme will provide a tailored 12-months development package for provider and ICB boards.

Interest in the first cohort significantly exceeded available places, and organisations selected for the summer intake have now been notified. Further cohorts, including one starting in October, will be agreed with regions. Overall,

this is intended to become NHS England's primary board development offer for NHS providers and ICBs.

Flu Vaccination Programme 2026/27

NHS England has published the 2026/27 flu vaccination programme letter, setting out national vaccination uptake ambitions and planning expectations for the coming season. Further details on the frontline healthcare worker vaccination programme will follow separately. The letter is primarily for awareness and asks organisations to review the guidance and ensure it is reflected in our local planning and delivery arrangements.

NHS Staff Standards

The NHS Staff Standards, published this month, establish a national baseline of expectations across six areas: line management, health and wellbeing, violence prevention and reduction, sexual safety, tackling racism, and flexible working. Compliance will form part of the National Operating Framework and provider capability assessments, making this a significant area of regulatory focus.

Initial assessment suggests NWAS is well placed, with strong evidence of compliance in several areas and staff survey measures generally performing above the ambulance sector average. A more detailed baseline assessment is underway, including engagement with staff networks and trade union partners, to inform a proportionate action plan for 2026/27. This will be supported by a communications programme to raise awareness of the standards and gather feedback from colleagues.

National Maternity Reviews

The publication of Donna Ockenden's review of maternity services at Nottingham University Hospitals and Baroness Amos' national maternity and neonatal investigation has highlighted significant concerns around patient safety, culture, leadership, workforce pressures and the need to listen more effectively to women and families. Both reviews identified recurring themes of avoidable harm, inconsistent standards of care and a need for stronger accountability and learning across the NHS. In response, NHS England has launched a national improvement programme, including a 10-point action plan and additional investment to support improvements in maternity and neonatal services.

Letter from Sir James Mackey

NHS England has introduced new minimum standards for patients waiting for elective care, aimed at improving communication and patient experience. The standards cover timely confirmation of referrals, regular updates while waiting, accessible communications, advance notice of appointments, prompt rebooking if appointments are cancelled, and clear information when care is complete.

3.2 **Sector**

At their meeting in July the Association of Ambulance Chief Executives considered a number of significant national issues, including a new sector framework to support staff who need to withdraw from scene in situations involving serious abuse or threats to their safety, the ambulance sector's response to proposed extensions of Mental Health Act detention powers, and the recommendations arising from the Lord Mann review into racism and antisemitism in the NHS. Members also received updates on Category 3 performance, leadership development and wider ambulance sector priorities

3.3 **Regional**

North West Performance Accountability Framework (PAF)

NHS England is introducing a new NW Performance Accountability Framework (PAF) as the main approach for regional oversight and assurance. The framework is intended to balance performance management with improvement, partnership working, and organisational autonomy. The approach is based on the principle of earned autonomy with organisations starting from a position of trust and support rather than intervention.

There will be four levels of oversight:

- Level 1 – earned autonomy. Strong performance, stable leadership, and low risk. Light touch oversight and routine monitoring.
- Level 2 – targeted support. Some emerging risks or delivery issues. Additional monitoring and improvement support, but confidence remains in local recovery.
- Level 3 – enhanced oversight. Significant delivery concerns and reduced confidence in progress. Formal oversight, closer performance management, and more frequent regional involvement.
- Level 4 – intensive intervention. Serios or sustained concerns around performance, quality, finance, or governance. Highest level of scrutiny with formal intervention and potential national involvement.

Movement between oversight levels will be evidence-based, with clear escalation and de-escalation criteria. Implementation will be phased over the next 12 months.

North West Greener NHS Update – 3 July 2026

Dr Andrew Furber has forwarded the latest North West Greener NHS update to highlight the positive recognition NWAS is receiving for its sustainability work. The main feature showcases our Net Zero Heroes project at Bury and Rochdale Ambulance Stations, which has delivered significant reductions in energy use, costs and carbon emissions and is now helping to shape similar initiatives across the Trust.

Oversight Arrangements

As the restructures of Integrated Care Boards and NHS England moves through to conclusion, the NW Region has been setting out how it will deliver its performance oversight responsibilities. Our people team had its first oversight meeting with the region in June, focusing on key drivers of workforce performance and culture. It was a positive discussion, balancing the

opportunity to share and disseminate good practice between providers and constructive challenge of areas where improvement is needed. Meetings are anticipated to take place quarterly.

3.4 **System**

NW System Leaders Call – 2 July 2026

The next phase of NHS Reform was the main focus of discussion with three major priorities:

- Neighbourhood health – moving more care closer to home, using population health management, integrated neighbourhood teams, and pro-active support for high-risk patients.
- Outpatient transformation – introducing single points of access, and advice and guidance models to reduce unnecessary hospital activity and shift care into community settings.
- Urgent and emergency care – redesigning services around better care co-ordination, demand management, and alternatives to hospital attendance.

The overall message was that performance has improved across the NHS, but the focus is now shifting from recovery to transformation. Systems were challenged to demonstrate how they are delivering neighbourhood health, outpatient reform, and UEC redesign, while managing financial pressures and organisational change.

L&SC ICB Q1 Financial review and forecast/risk assessment & mitigations

The Lancashire and South Cumbria system is introducing a quarterly financial review process. To support this, the System Finance Group meeting on 24 July will be extended to allow a full review of Q1 financial performance, forecasts, key risks, and mitigation plans. The overall aim is to ensure organisations work together to understand financial risks, align mitigations, and present a coordinated approach to regional oversight discussions. While organisations remain accountable for their own performance, the ICB has stressed the system should continue to work together to identify risks, align mitigations and highlight any areas needing partner or system-level support.

3.5 **Organisational**

Advanced Foundation Trust Status

We have been selected as one of 16 organisations to be assessed for advanced foundation trust status, which will give us more freedom to make decisions locally to improve services for our communities. If we pass the assessment, we will benefit from a streamlined approach to annual planning and more flexibility, allowing us to direct any surplus from day-to-day spending into future capital projects such as equipment or estates work.

We are part of the second wave of NHS Trusts selected for assessment and inclusion in this early stage recognises the hard work of our staff across the organisation, which has enabled us to achieve consistent high performance. We will be working closely with NHS England to demonstrate how we meet the assessment criteria.

The Advanced Foundation Trust Programme is part of the NHS 10 Year Health Plan, which sets out the vision of reinvigorating and reinventing the foundation trust model for modern integrated health system. The ambition is that all NHS providers will achieve advanced foundation trust status by 2035.

Top 100 Apprenticeship Employers for 2026

The organisation has been recognised by the Department of Health & Social Care as one of the Top 100 Apprenticeship Employers for 2026, retaining its ranking of 27th nationally.

This significant achievement reflects the Trust's strong commitment to developing the future NHS workforce through high-quality apprenticeship opportunities. Apprentices play a vital role in supporting workforce sustainability, creating career pathways, and enabling individuals to gain the skills, knowledge and experience required to make a meaningful contribution to healthcare services. By continuing to invest in apprenticeship programmes, the Trust is strengthening its workforce, supporting talent development, and contributing positively to the wider health and care system.

This recognition is testament to the dedication and hard work of colleagues across the organisation, particularly the learning and development team, and reflects the positive culture that has been fostered around learning, professional development, and career progression. The achievement demonstrates the Trust's commitment to investing in its people and ensuring opportunities are available for colleagues to learn, grow and thrive throughout their careers.

One Tonne Plastic Challenge

The Trust has accepted the One Tonne Plastic Challenge, set by 14-year old recycling champion Thomas Morgan, with the aim of recycling one tonne of plastic over a 10-week period. Commencing on 20 July, the challenge will encourage staff to collect and recycle plastic waste through everyday activities, including lunch break recycling initiatives and organised litter picks. Every item collected will contribute towards a shared goal of reducing environmental impact, supporting local communities, and advancing the Trust's journey towards Net Zero. To enable accurate monitoring of progress, designated collection bins will be provided by the Trust's waste management contractor, Suez, at six locations across the Trust, which will be collected as part of the challenge and weighed with regular reporting against the one-tonne target.

NHS ConfedExpo - 10 – 11 June - Manchester

NHS ConfedExpo highlighted a strong national focus on collaboration, transformation and improving outcomes for patients. Key discussions centred on workforce, digital innovation, population health and urgent and emergency care pressures. The event also provided updates on the Advanced Foundation Trust Programme and the 2026/27 NHS Oversight Framework, both of which are relevant to NWAS' improvement and development priorities.

Greater Manchester Long Service Awards

I had the pleasure of attending the Greater Manchester Long Service Awards on 30 June where we celebrated the remarkable dedication and commitment of our colleagues. More than 110 colleagues were recognised for their long service, representing a combined total of 2,685 years of NHS service.

The event provided an opportunity to acknowledge the significant contribution that our colleagues have made over many decades. It is truly inspiring to see so many individuals choose to dedicate such a substantial part of their working lives to serving patients, communities, and the NHS. These achievements are not only a reflection of individual commitment but are often made possible through the support of families and loved ones who help colleagues navigate the demands of shift work, unsocial hours and the challenges associated with frontline healthcare roles.

It was particularly pleasing to meet and speak with family members who had joined the celebrations. They shared with me their pride in the achievements of their relatives and who enjoyed being part of the celebrations.

The awards ceremony was a fitting tribute to the loyalty, professionalism, and dedication of our workforce. I look forward to meeting more colleagues and their families at the two remaining Area Long Service Award ceremonies taking place later this year and extending our appreciation for their outstanding service to the NHS and the communities we serve.

20 years of NWAS

On 1 July 2026, North West Ambulance Service NHS Trust marked the 20th anniversary of its formation, bringing together four regional ambulance services to create a single organisation covering the North West. Over the past two decades, our organisation has continued to grow, evolve and adapt to meet changing patient needs and service demands, while remaining steadfast in its core purpose: helping people when they need us most.

To celebrate this milestone, a programme of activities and events is being delivered throughout the year coordinated by the communications team and running until March 2027. The programme has been designed to enable as many colleagues as possible to participate in and share the celebrations, recognising the dedication, achievements, and contribution of staff past and present to the success of the Trust.

LSC Executive Leadership Day – 3 July

The Chief Executive and Deputy Chief Executive attended the Lancashire and South Cumbria Executive Leadership Day, where over 60 system leaders attended to agree a collective focus on three strategic priorities: reducing poverty and health inequalities, strengthening research and innovation, and accelerating digital and data integration. The event highlighted a strong commitment across partners to work together to improve outcomes for local communities.

Driving Race Equality: Strategies for anti-racist health and care systems – 13 July

The Driving Race Equity Conference, held in July 2026, brought together health and care leaders from across the North West to share learning and practical strategies for advancing anti-racist organisations and improving race equity. The conference reinforced the importance of inclusive leadership, tackling inequalities and embedding equity within organisational culture, workforce practices and service delivery. Resources and learning materials have now been published and will help inform ongoing EDI work across the region.

Senior Managers Briefing – 21 July

On 21 July, we held the second briefing of the 2026/27 financial year, attended by more than 75 senior leaders from across the organisation. The briefing provided updates on key national, regional, system and organisational developments, supporting shared awareness of the evolving healthcare landscape.

The session included a presentation from Dr Andy Knox, Co-Medical Director – Lancashire and South Cumbria ICB on health inequalities, alongside updates on the national context, the Trust's improvement approach, Right Care First Time and the launch of 'Thrive' - the new Continuing Professional Development (CPD) platform. Leaders were also briefed on progress towards Advanced Foundation Trust status. These briefings continue to play an important role in supporting leadership alignment and strengthening organisational understanding and engagement across the organisation.

In our thoughts

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

Former colleague Eddie Varley, who sadly passed away on 26 May after a short illness. Eddie worked in our service from 1980 until 2007 and will be remembered by many of our staff as a Driving Instructor, he continued supporting NWAS until 2017, ten years after formally retiring.

Former colleague Kathy Green, who sadly passed away on 30 May. Kathy had worked in our Accrington and Broughton Control Rooms, giving over 37 years dedicated service.

Former colleague Ronnie May, who sadly passed away on 6 June following an illness. Ronnie joined the service in 1973 and retired as a paramedic after 42 years of dedicated service.

Our colleague Guy Halsall, who sadly and unexpectedly passed away on 19 June. Guy was a paramedic based at Formby Station with 18 years service. He will be remembered as a model professional, dedicated to patient care and as a colleague who truly cared for those around him.

I have written to the families on behalf of the trust to offer our condolences.

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.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Board Assurance Framework: Proposed Q1 Position 2026/27
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

STRATEGIC AIM(S)	All strategic aims							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒
	SR05	☒	**SR06**	☒	**SR07**	☒	**SR08**	☒

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☒	**People:** Open	☒	**Finance:** Open	☒
	Regulatory: Open	☒	**Reputation:** Open	☒	**Digital Innovation:** Eager	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Q1 position of the Board Assurance Framework 2026/27.
EXECUTIVE SUMMARY	This paper presents the Quarter 1 (Q1) 2026/27 review of the Board Assurance Framework (BAF) and associated Corporate Risk Register (CRR) risks scoring 15 or above. The review proposes changes to two strategic risks: • **SR03 (Urgent and Emergency Care Performance)** has increased from a score of 10 to 15 • **SR08 (Cyber Security)** has decreased in risk score from 20 to 15.
PREVIOUSLY CONSIDERED BY	Trust Management Committee and Audit Committee
	Date: 22nd July 2026 and 24th July 2026
	Outcome: TMC Recommended to Board for approval

1. BACKGROUND

The Board Assurance Framework (BAF) is the Trust's principal strategic risk management tool. It sets out the key risks that could impede the achievement of the Trust's strategic aims and provides oversight of the adequacy and effectiveness of the controls and assurances in place to manage those risks.

This report presents the Quarter 1 2026/27 position of the Board Assurance Framework and provides the Board of Directors with an overview of the Trust's strategic risk profile, with the full framework included at Appendix 1. The report summarises proposed amendments to strategic risks and associated controls, assurances and risk scores arising from reviews undertaken through the Board's committee structure during the reporting period.

The Board Assurance Framework maintains clear alignment between strategic risks, the Trust's strategic aims, risk appetite and annual plan objectives. It also identifies links to Corporate Risk Register risks scored at 15 or above, ensuring effective oversight of risks that may have the greatest impact on the delivery of the Trust's strategic objectives.

2. PROPOSED 2026/27 Q1 POSITION

Overall, the Q1 review identifies two strategic risks; one that has deteriorated and one that has improved. The proposed changes reflect current operational and external risk conditions and have been reviewed by the respective Executive Leads.

Following review of each BAF risk, the proposed changes are as follows:

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.				**Exec Lead** D Ainsworth
Opening Score 01.04.2026	**Q1 Risk Score**	**Q2 Risk Score**	**Q3 Risk Score**	**Q4 Risk Score**
10 5x2 CxL	**15** 5x3 CxL			

- **Risk score increased from 10 to 15.**

Following review by the Executive Lead, the risk score has increased to reflect sustained operational pressures across the urgent and emergency care system.

Increased call demand associated with recent periods of extreme weather, coupled with resource production and conveyance performance below planned trajectories, has affected progress against key UEC improvement objectives.

As a consequence, strategic foresight has been revised from **Improving** to **Deteriorating**, reflecting the potential for continued system pressures to adversely impact delivery of national performance standards, workforce sustainability and financial recovery plans if not effectively mitigated.

BAF RISK 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.				Exec Lead C Wood
Opening Score 01.04.2026	**Q1 Risk Score**	**Q2 Risk Score**	**Q3 Risk Score**	**Q4 Risk Score**
20 5x4 CxL	**15** 5x3 CxL			

- Change in risk score for Q1 from 20 to 15

4. RISK CONSIDERATION

The Board Assurance Framework (BAF) and Corporate Risk Register (CRR) provide the principal mechanisms through which the Trust maintains oversight of strategic and key operational risk. They support effective governance by ensuring that key risks, controls and sources of assurance are clearly identified, enabling the Board and its committees to monitor risk exposure and take informed action where further mitigation is required.

5. EQUALITY/ SUSTAINABILITY IMPACTS

5.1 Equality impacts

The Board Assurance Framework supports consideration of equality and inclusion through the identification and oversight of strategic risks incorporating health inequalities, workforce culture, inclusion and equitable access to services. The foresight-based assurance approach strengthens Board oversight by promoting the use of forward-looking indicators and outcome-focused assurance, enabling earlier identification of emerging issues and potential differential impacts on patients, communities and staff.

5.2 Sustainability impacts

The Board Assurance Framework supports organisational and environmental sustainability through the identification and oversight of strategic risks that could affect the Trust's long-term resilience and delivery of its strategic objectives.

Environmental sustainability is recognised as a strategic risk area, and the framework reinforces the need for effective controls, assurance, management of dependencies and monitoring of benefits realisation to support sustainable service delivery.

NHS
North West
Ambulance Service
NHS Trust

Board Assurance Framework 2026/27

Proposed Q1 Position

Board of Directors Part 1– 29th July 2026

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

BOARD ASSURANCE FRAMEWORK DASHBOARD 2026/27								
BAF RISK	**Committee**	**Executive Director Lead**	**01.04.26**	**Q1**	**Q2**	**Q3**	**Q4**	**Risk Appetite**
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.	Quality & Performance	Director of Quality & Improvement	**9** 3x3 CxL	**9** 3x3 CxL				**Cautious 6-10**
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.	Resources	Director of People	**12** 4x3 CxL	**12** 4x3 CxL				**Open 12-15**
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.	Quality & Performance	Director of Operations	**10** 5x2 CxL	**15** 5x3 CxL				**Cautious 6-10**
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.	Resources	Director of Strategy & Partnerships	**12** 4x3 CxL	**12** 4x3 CxL				**Open 12-15**
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.	Resources	Director of Finance	**12** 4x3 CxL	**12** 4x3 CxL				**Open 12-15**
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.	Quality & Performance	Director of Quality & Improvement	**6** 3x2 CxL	**6** 3x2 CxL				**Cautious 6-10**
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.	Resources	Director of Finance	**8** 2x4 CxL	**8** 2x4 CxL				**Open 12-15**
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.	Resources	Director of Finance	**20** 5x4 CxL	**15** 5x3 CxL				**Eager ≥15**

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK 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.

Executive Director Lead:	Director of Quality & Improvement
Strategic Aim:	Deliver
Committee:	Quality & Performance

Strategic Outcomes/ Benefits:	**Strategic Foresight:**	Deteriorating	☐	Static	☒	Improving	☐
▪ Safer & equitable care, better clinical outcomes, stronger patient voice & learning culture.							

2026/27 Annual Plan:	**Strategic Foresight Rationale:**
▪ Reduce avoidable harm by 30% for our PSIRF priorities. ▪ Identify and address improvement needs for patients experiencing sub-optimal care linked to recognised health inequality. ▪ Achieve top-quartile performance in national ambulance quality indicators. ▪ Strengthen patient experience by ensuring patient voice actively shapes clinical services.	This risk reflects a long-term, structural challenge driven by changing population demographics, increasing deprivation, and persistent health inequalities that disproportionately affect vulnerable patient groups. While the Trust has established a clear Quality Strategic Plan and priority programmes aligned to known inequality areas, the control environment remains developmental. Key sources of avoidable harm and the scale of inequality are not yet fully quantified. The work to identify the source of actual harm and scale of avoidable harm has commenced and therefore starting to be quantified.-Early horizon scanning and PSIRF scoping activities act as important early-warning indicators; however, the absence of consistent baselines, and routine organisational reporting on inequalities constrains strategic assurance.

BAF RISK SCORE JOURNEY:

01.04.26	Q1	Assurance Rating	Q2	Assurance Rating	Q3	Assurance Rating	Q4	Assurance Rating	Risk Appetite (RA)
9	9	Static		Choose an item.		Choose an item.		Choose an item.	Quality
3x3	3x3								
CxL	CxL		CxL		CxL		CxL		Cautious 6-10
RA: Within	RA: Within		RA		RA		RA		

RATIONALE FOR RISK SCORE:

The Q1 risk score reflects the high impact of health inequalities on patient safety and outcomes, combined with current uncertainty regarding the scale of inequality, associated harm and achievable improvements. Although improvement activity is underway across priority areas, controls remain at an early stage of maturity and are largely actively focussed rather than outcome based. Assurance is currently limited by gaps in quantification and establishment of consistent organisational reporting, and improvement plans which identify and outline the approaches to address inequalities are at an early stage of development.

CONTROLS	ASSURANCES		EVIDENCE
Scaling mechanism for successful improvement foundations	**Level 1:** Improvement methodology and spread plans embedded within Improvement approach	Adequate	QPC/2627/038
Quality strategic plan	**Level 2:** Oversight of the 5 priority programmes focused on improving safety and reducing inequality	Adequate	QPC/2627/015 QPC/2627/016 QPC/2627/041 QPC/2627/042 QPC/2627/043 BOD/2627/032 PBM/2627/025

PSIRF implementation	**Level 2:** Oversight of PSIRF priorities, commissioned reviews and learning responses to identify sources of avoidable harm	**Adequate**	QPC/2627/033
Targeted improvement initiatives	**Level 2:** Oversight of improvement activity delivery addressing known inequality areas	**Adequate**	QPC/2526/038
Clinical Audit Activity	**Level 2:** Oversight of clinical audit activity of mandated national AQIs and local clinical audit programme.	**Adequate**	QPC/2627/039

Gaps in Control/ Assurance	Required Action	Action Lead	Target Completion	Oversight	Progress
Size and severity of health inequalities and associated avoidable harm are not yet fully quantified	Complete systematic scoping of inequality hotspots and baseline harm by Q1, with validated datasets by Q3	Director of Quality & Improvement	Q3	Quality & Performance Cttee	In Progress
Limited assurance on the effectiveness and scale of improvement interventions in reducing inequalities	Define clear outcomes measures and sustained improvement metrics for each priority programme, including inequality reduction	Director of Quality & Improvement	Q2/Q3	Quality & Performance Cttee	In Progress
Absence of benchmarking against peers or system-level inequality indicators or agreed improvement plans which clarify quantifiable aims.	Introduce benchmarking and comparative analysis to inform prioritisation and assurance	Director of Quality & Improvement	Q2	Quality & Performance Cttee	In Progress
Health inequality reporting is not yet embedded at organisational level	Embed routine organisational reporting on health inequalities and improvement impact from 27/28	Director of Quality & Improvement	To be confirmed	Quality & Performance Cttee	Pending
Duty of Candour Enactment	Duty of Candour review to be undertaken	Director of Quality & Improvement	Q3	Quality & Performance Cttee	In Progress

OPERATIONAL RISKS SCORED 15+ ALIGNED TO BAF RISK: SR01						
Risk ID	Risk Type/ Subtype	Risk Description	Initial Risk Score	Current Risk Score	Trend Analysis	Target Risk Score
There are no operational risks scored 15+ aligned to this risk						

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK SR02:	Executive Director Lead:	Director of People
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.	Strategic Aim:	Build
	Committee:	Resources

Strategic Outcomes/ Benefits:	Strategic Foresight:	Deteriorating	☐	Static	☒	Improving	☐
▪ Inclusive & representative, well-led & supported, health, safe & thriving, skilled & future-ready, connected, empowered & engaged, productive & sustainable.							

2026/27 Annual Plan:	Strategic Foresight Rationale:
▪ Attract & retain a representative workforce through strong onboarding & support. ▪ Develop inclusive, capable leaders who enable staff to thrive. ▪ Provide accessible development and career pathways that support better patient care. ▪ Foster an inclusive, supportive, and safe culture across the employee's lifecycle. ▪ Build a listening culture where staff and learners help drive improvement.	This risk represents a long-term, cumulative people and culture challenge. Externally, evolving national people policy and regulatory oversight are raising expectations of inclusive leadership, staff experience and cultural competence. Labour market pressures and evolving models of delivery may also impact on workforce stability. Internally, sustained focus on performance and finance can limit capacity for cultural investment. While leadership stability provides continuity, limited leadership turnover may slow the pace of embedding new behaviours at scale, and trade union volatility, both nationally and locally remains an ongoing contextual influence. Although current controls provide reasonable assurance at present, sustainable efforts to address gaps in controls will take effect over the longer term through the People and Culture Plan delivery. Key deliverables within the plan reflect current gaps in controls. Workforce intelligence triangulation, leadership competence and consistency of staff experience and workforce engagement mean the risk is assessed as static in the short term, with continuing progress to deliver strategy requirements providing the potential to improve over the medium to long term. Embedding of people metrics within national oversight and clear strategic commitment to prioritise cultural improvement mitigates current risks.

BAF RISK SCORE JOURNEY:

01.04.26	Q1	Assurance Rating	Q2	Assurance Rating	Q3	Assurance Rating	Q4	Assurance Rating	Risk Appetite (RA)
12	12	Static		Choose an item.		Choose an item.		Choose an item.	People
4x3	4x3								
CxL	CxL		CxL		CxL		CxL		Open
RA: Within	RA: Within		RA		RA		RA		12-15

RATIONALE FOR RISK SCORE:

The Q1 risk score reflects the mitigations for this risk which are inherently long-term and cultural, meaning improvements are expected to be incremental and non-linear rather than rapid. Current controls reduce the likelihood of short-term deterioration and provide adequate assurance, however controls need to be embedded and strengthened further to ensure that emerging risks are identified early and that efforts to improve culture keep pace with expectations which may be heightened by national policy expectations. Work is required to ensure consistency of experience and for these reasons, the risk score appropriately remains elevated, recognising both the strategic significance of the risk and the time required for sustained cultural change to translate into measurable outcomes.

CONTROLS	ASSURANCES		EVIDENCE
Equality, Diversity and Inclusion	**Level 2:** Board oversight of equality, diversity and inclusion	Adequate	BOD/2627/030
	Level 2: TMC oversight through regular reporting against EDI activities and strategic priorities	Adequate	TMC/2627/058 RC/2627/019

People & culture strategic plan	**Level 2:** Board oversight through regular reporting of workforce indicators and assurance on delivery of people and culture priorities	**Adequate**	BOD/2526/031 & 034 RC/2627/019
	Level 2: TMC oversight through regular reporting against people and culture strategies and plans	**Adequate**	TMC/2627/059
Leadership capability	**Level 2:** Board oversight through reporting on delivery and impact of the leadership & management development, including appraisals	**Adequate**	RC/2627/019
Workforce offer, reward, and wellbeing	**Level 2:** Board oversight on recruitment, retention, flexible working and wellbeing indicators	**Adequate**	RC/2627/019 RC/2627/022
Absence management	**Level 2:** Board oversight of workforce indicators and attendance improvement	**Adequate**	RC/2627/019 BOD/2627/031
Recruitment and retention	**Level 2:** Board oversight of workforce indicators including vacancy gap	**Adequate**	RC/2627/019 BOD/2627/031
Training, education and career development	**Level 2:** Board oversight of apprenticeship provision, OFSTED recommendations and learner experience	**Substantial**	RC/2627/021

Gaps in Control/ Assurance	Required Action	Action Lead	Target Completion	Oversight	Progress
Workforce intelligence is not consistently triangulated to provide early warning of emerging culture, engagement of inclusion risks	Strengthen workforce intelligence and insight with focus in 2026/27 on improved triangulation of workforce data to inform performance oversight and support earlier identification of emerging risks	Director of People	March 2027	Resources Cttee	Pending
Delivery and impact of people and culture interventions are inconsistent across leadership teams due to geographic challenges and variation in leadership competence, confidence and accountability, limiting assurance that inclusive behaviours are embedded consistently.	Enhance leadership accountability by embedding clearer performance expectations and assurance mechanisms with focus in 2026/27 on aligning leadership and management competence with the NHS leadership and management framework and increasing compliance with leadership induction	Director of People	March 2027	Resources Cttee	Pending
Staff continue to experience negative behaviours with less confidence in reporting than other parts of the NHS, increasing the risk that attendance improvement targets will not be delivered and turnover will rise.	Strengthen understanding of expectations of behaviour and inclusive culture ensuring improved confidence and consistency of experience with focus in 2026/27 on continued reduction in experience of unwanted sexual behaviour, embedding understanding of anti-racism and strengthened framework for wellbeing.	Director of People	March 2027	Resources Cttee	Pending

OPERATIONAL RISKS SCORED 15+ ALIGNED TO BAF RISK: SR02						
SENSITIVE						
Risk ID	Risk Type/ Subtype	Risk Description	Initial Risk Score	Current Risk Score	Trend Analysis	Target Risk Score
821	Financial/People	Sensitive Risk	16 High	16 High	⟷	8 Moderate

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK 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.	**Executive Director Lead:**	Director of Operations
	Strategic Aim:	Provide
	Committee:	Quality & Performance

Strategic Outcomes/ Benefits:	**Strategic Foresight:**	Deteriorating	☒	Static	☐	Improving	☐
▪ More responsive, integrated, efficient, clinically effective and resilient.							

2026/27 Annual Plan:	**Strategic Foresight Rationale:**
▪ Deliver a tech-enabled contact model that improves access, reduced inequality, and boosts efficiency and experience. ▪ Provide a safe, consistent, personalised triage that identifies risk early and gets patients the right care first time. ▪ Deliver a resilient, efficient, patient-centred response model using technology, workforce optimisation and system collaboration.	Externally, sustained financial pressures across providers, significant growth in incidents and 999 call volume has been broadly consistent through Q1, however accentuated through periods of hot weather. Some of the UEC trajectories are below target, specifically, DCA production, conveyance and call pick up. Some of this is offset by improvements to availability and on scene times. Cat 2 mean is broadly on plan but historically by the end of Q1 position, we would be ahead of plan. External factors, specifically variation and limitations in alternatives to conveyance are increasing hospital attendance, alongside variation in clinical assessment service (CAS) commissioning and deteriorating CAS performance. In response to the DCA production issues, a review of both NWAS internal recruitment, operational overtime and private provision has taken place. An improvement plan has commenced to both increase DCA production and return to UEC trajectory by the end of Q2. NWAS Area Directors, supported by the ICC Director are engaged with ICBs and CAS providers to ensure improvements to productivity and hear and treat. We have limited assurance in respect to further commissioning of alternatives to conveyance services and this is a risk to delivery of UEC conveyance trajectories. NWAS are engaged and seeking to be a pilot service for the proposed Cat 3A segmentation which presents opportunities to increase hear and treat and improve Cat 2 response standards. Projecting forward to Q4 26/27 and Year 2/3, a demand and capacity review will be commence in Q2 (due to complete end of Q4) which will provide a strategic plan aimed to optimise operational resources and improve productivity and performance.

BAF RISK SCORE JOURNEY:

01.04.26	Q1	Assurance Rating	Q2	Assurance Rating	Q3	Assurance Rating	Q4	Assurance Rating	Risk Appetite (RA)
10	15	Improving		Choose an item.		Choose an item.		Choose an item.	Quality
5x2	5x3								
CxL	CxL		CxL		CxL		CxL		Cautious 6-10
RA: Within	RA: Exceeded		RA		RA		RA		

RATIONALE FOR RISK SCORE:

The Q1 risk score has increased due to increased demand, production of operational resources and conveyance being below plan. Cat 2 mean is broadly on plan but historically by the end of Q1, the position would be better than plan. Periods of extreme heat have significantly increased call volume and overall demand, this is not anticipated to continue through the remainder of the year. In summary, a number of UEC deliverables are behind plan but recovery is likely to be achieved by the end of Q4.

CONTROLS	ASSURANCES		EVIDENCE
Clinical triage and alternative pathway escalation	**Level 2:** Executive oversight of non-conveyance performance and pathway utilisation	Adequate	QPC/2627/009 & 032 BOD/2627/031
Workforce plan aligned to recruitment capacity	**Level 2:** Executive oversight of workforce trajectory and private provider dependency management	Adequate	QPC/2627/009 & 032 TMC/2627/056

			TMC/2627/079
3-year UEC operational and workforce programme	**Level 2:** Board assurance on delivery of Year 1, and readiness for Years 2 and 3	**Adequate**	QPC/2627/009 & 032 BOD/2627/031
UEC performance oversight and assurance	**Level 2:** Enhanced Board & Cttee oversight	**Adequate**	BOD/2627/031

Gaps in Control/ Assurance	Required Action	Action Lead	Target Completion	Oversight	Progress
Reliance on system partners to expand and sustain alternative pathways creates uncertainty in achieving non-conveyance trajectories	Strengthen joint assurance on pathway scalability and resilience with system partners	Director of Operations	March 2027	Quality & Performance Cttee	At Risk
Medium-term recruitment risk beyond 26/27 may impact delivery of planned workforce growth	Scenario-based workforce modelling and contingency planning across the next 3-5 years	Director of Operations	March 2028	Quality & Performance Cttee	In Progress
Dependency on private provider market stability remains a single point of vulnerability	Ongoing market intelligence and development of contingency capacity controls	Director of Operations	March 2029	Quality & Performance Cttee	In Progress
System financial pressures may reduce flow resilience, increasing ambulance queuing risk	Strengthen escalation routes and system-level early warnings	Director of Operations	March 2027	Quality & Performance Cttee	In Progress

OPERATIONAL RISKS SCORED 15+ ALIGNED TO BAF RISK: SR03

SENSITIVE

Risk ID	Risk Type/ Subtype	Risk Description	Initial Risk Score	Current Risk Score	Trend Analysis	Target Risk Score
799	Operational/Emergency Preparedness	Sensitive Risk	20 High	15 High	⬇	5 Low

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK 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.	**Executive Director Lead:** Director of Strategy & Partnerships
	Strategic Aim: Deliver, Build, Provide & Embed
	Committee: Resources

Strategic Outcomes/ Benefits:	**Strategic Foresight:**	Deteriorating	☐	Static	☒	Improving	☐
▪ Drives system-wide improvements, strengthens regional resilience, shared accountability for outcomes, enhances patient experience & safety across the whole care pathway.							

2026/27 Annual Plan:	**Strategic Foresight Rationale:**
▪ Co-design pathways and integrating alternative care models. ▪ Enhanced system navigation & alternative care. ▪ Joint digital development. ▪ Integrated volunteer & third-sector contribution.	The risk continues to be driven by external system change rather than ineffective current engagement. ICB operating models, strategic commissioning arrangements, provider collaboration and neighbourhood health development remain in transition and are not yet fully stabilised. While NWAS has strong and trusted relationships across the system, there is a risk that urgent and emergency care pathway redesign and wider service changes could progress through multiple forums without consistent ambulance service input unless our engagement model evolves in step with system redesign. Further formalisation through a Partnership Operating Framework, supported by a clear Partnership Roadmap and updated influence mapping, will help ensure NWAS can anticipate, prioritise and shape emerging system change rather than respond once decisions are already embedded.

BAF RISK SCORE JOURNEY:

01.04.26	Q1	Assurance Rating	Q2	Assurance Rating	Q3	Assurance Rating	Q4	Assurance Rating	Risk Appetite (RA)
12	12	Static		Choose an item.		Choose an item.		Choose an item.	Reputation
4x3	4x3								
CxL	CxL		CxL		CxL		CxL		Open
RA: Within	RA: Within		RA		RA		RA		12-15

RATIONALE FOR RISK SCORE:

The Q1 risk score reflects the level of external uncertainty affecting strategic partnerships, commissioning arrangements and system decision-making across the North West. Significant change continues through ICB development, neighbourhood health policy, provider collaboration and evolving urgent and emergency care models. Current controls provide reasonable assurance that NWAS is well engaged in existing structures, but they do not yet fully mitigate the future-state risk that decision-making routes become more complex, diffuse or locally variable. This could reduce the consistency of NWAS influence over pathway redesign and service development. Positive partner feedback, established system relationships and regular horizon scanning provide assurance over current position; however, further formalisation of our engagement approach and stronger evidence of where NWAS is influencing system decisions are required to reduce residual risk.

CONTROLS	ASSURANCES		EVIDENCE
System intelligence and horizon scanning	**Level 1:** Regular engagement through system boards, partner meetings, policy scanning and internal intelligence processes	Adequate	BOD/2627/036
Formal system engagement and governance	**Level 2:** Board reporting on partnership engagement and system working, & key external developments supported by internal intelligence and insight	Adequate	BOD/2627/036
Executive & senior led relationship management	**Level 3:** External partner feedback and independent facilitation provide assurance that NWAS is seen as a credible and constructive strategic partner.	Adequate	BOD/2627/036

Gaps in Control/ Assurance	Required Action	Action Lead	Target Completion	Oversight	Progress
Partnership engagement arrangements are not yet formalised into a consistent operating framework that is resilient to changing system structures and decision-making routes	Develop and implement a Partnership Operating Framework setting out engagement principles, internal ownership, escalation routes and decision-making interfaces across regional, ICB and place-based structures	Director of Strategy & Partnerships	September 2026	Resources Cttee	In Progress
Stakeholder and influence mapping does not yet fully reflect emerging ICB arrangements, neighbourhood structures and key forums where future UEC and service redesign decisions may be shaped	Develop a refreshed Partnership Roadmap and influence map aligned to system transition milestones, identifying priority forums, decision-makers and points where NWAS influence is most critical	Director of Strategy & Partnerships	September 2026	Resources Cttee	In Progress
Clarity and shared understanding of NWAS's role within emerging neighbourhood health arrangements and wider UEC models is not yet fully established, limiting assurance that service changes across the system are developed with appropriate consideration of ambulance service impacts	Develop and socialise a clear NWAS position on its role within emerging neighbourhood health arrangements and wider UEC pathway redesign, including key principles, expected areas of contribution and factors that should be considered in local service change discussions.	Director of Strategy & Partnerships	March 2027	Resources Cttee	Pending
Current assurance does not consistently evidence how partnership engagement is influencing system-level decision-making, pathway design, or commissioning discussions	Introduce a simple, consistent approach to capturing and reporting strategic influence, including examples where NWAS engagement has shaped decisions, mitigated risk or secured ambulance service consideration in system redesign	Director of Strategy & Partnerships	March 2027	Resources Cttee	In Progress

OPERATIONAL RISKS SCORED 15+ ALIGNED TO BAF RISK: SR04						
Risk ID	Risk Type/ Subtype	Risk Description	Initial Risk Score	Current Risk Score	Trend Analysis	Target Risk Score
There are no operational risks scored 15+ aligned to this risk						

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK 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.	**Executive Director Lead:** Director of Finance **Strategic Aim:** Embed **Committee:** Resources

Strategic Outcomes/ Benefits:	**Strategic Foresight:**	Deteriorating	☐	Static	☐	Improving	☒
▪ Financially sustainable, efficient & productive, accountable, investment-ready, resilient.							

2026/27 Annual Plan:	**Strategic Foresight Rationale:**
▪ Secure long term financial sustainability through recurrent efficiencies, strong governance, and disciplined, value for money investment in modern services.	This risk reflects the medium to long term challenges rather than an immediate in year financial threat. Horizon scanning indicates sustained national efficiency requirements at 2% recurrent savings per annum for at least the next three years, alongside increasing demand pressures and performance volatility, particularly within urgent and emergency care. From 2026/27, the regulatory environment will shift decisively from system-level oversight to direct NHS England provider scrutiny, Met with NHSE following closure of M2 position with no significant concerns raised. While NWAS currently maintains a strong financial position and has fully identified and embedded recurrent CIP within the 26/27 plan, the strategic risk emerges from the cumulative impact of non-delivery over time. Inability to deliver recurrent efficiencies compounds year on year, progressively eroding financial resilience and increasing the likelihood of regulatory intervention.

BAF RISK SCORE JOURNEY:

01.04.26	Q1	Assurance Rating	Q2	Assurance Rating	Q3	Assurance Rating	Q4	Assurance Rating	Risk Appetite (RA)
12	12	Static		Choose an item.		Choose an item.		Choose an item.	Finance
4x3	4x3								
CxL	CxL		CxL		CxL		CxL		Open 12-15
RA: Within	RA: Within		RA		RA		RA		

RATIONALE FOR RISK SCORE:

The Q1 risk score reflects the strategic significance of long-term financial sustainability, balanced against the Trust's current strong financial grip and delivery confidence. The potential is assessed as less than 1% of annual turnover, but with high strategic importance due to compounding effects over time and the evolving regulatory landscape. Although NWAS is on track for 26/27, at the end of Q1 the risk adjusted forecast for CIP delivery is at 93%. Current assurance arrangements provide confidence in year control but offer more limited forward assurance that future efficiencies will be identified early enough and embedded at operational level.

CONTROLS	ASSURANCES		EVIDENCE
Operational financial capability development	**Level 1:** Education programmes to strengthen financial management capability and CIP delivery ownership at local level	Limited	
Efficiency and productivity oversight	**Level 2:** Enhanced oversight of productivity and efficiency performance, aligning delivery with financial sustainability	Substantial	RC/2627/008
Future sustainability strategic plan	**Level 2:** Oversight of recurrent efficiency expectations, aligned to national requirement & 2% recurrent savings per annum	Substantial	RC/2627/008
Financial governance and reporting framework	**Level 2:** Board oversight of financial performance, recurrent CIP delivery and emerging financial pressures	Substantial	TMC/2627/007 RC/2627/007 RC/2627/008

			TMC/2627/033 RC/2627/070
Capital Programme	**Level 2:** Board oversight of capital allocations and programme for 2026/27	**Substantial**	PBM/2627/11
NHS England regulatory reporting	**Level 3:** Weekly reporting on CIP performance, providing external visibility, scrutiny & early regulatory assurance	**Substantial**	TMC/2627/007 RC/2627/007 RC/2627/070

Gaps in Control/ Assurance	Required Action	Action Lead	Target Completion	Oversight	Progress
CIP identification is currently weighted towards early-year opportunities, with less assurance over identification and delivery of more complex efficiencies required in later years	Strengthen forward CIP pipeline development, including earlier identification of transformational and predictivity-based efficiencies beyond the 'easier wins'	Director of Finance	October 2026	Resources Cttee	In Progress
Variable operational ownership and accountability for financial control and CIP delivery across service lines limits assurance that efficiencies will be sustained as business as usual	Reframe and clarify the accountability framework for financial management, embedding clear ownership for CIP identification and delivery within senior management teams and operational service lines	Director of Finance	To be confirmed	Resources Cttee	Pending
Assurance arrangements currently focus on in-year delivery rather than predictive confidence in future-year sustainability	Enhance assurance to test readiness for future years, including depth of CIP pipelines, leadership behaviours, and organisational maturity for sustained efficiency	Director of Finance	October 2026	Resources Cttee	In Progress

OPERATIONAL RISKS SCORED 15+ ALIGNED TO BAF RISK: SR05						
Risk ID	**Risk Type/ Subtype**	**Risk Description**	**Initial Risk Score**	**Current Risk Score**	**Trend Analysis**	**Target Risk Score**
785	Operational / Health, Safety, Security and Fire	If repairs are not carried out to the roof/atrium at Ladybridge Hall there is potential for the atrium roof to collapse resulting in staff harm and continued failing of the main roof with further water ingress resulting in business interruption.	20 High	15 High	⬇	5 Low
786	Operational / Health, Safety, Security and Fire	If identified failings from fire safety risk assessments, including issues with building compartmentation and fire doors, are not rectified, then in the event of a fire there is an increased risk of fire and products of combustion spreading throughout the premises, resulting in harm to staff and disruption to service delivery.	15 High	15 High	⟷	5 Low
SENSITIVE						
317	Operational/People	**Sensitive Risk**	20 High	15 High	⬇	10 Moderate

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK 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.	**Executive Director Lead:**	Director of Quality & Improvement
	Strategic Aim:	Embed
	Committee:	Quality & Performance

Strategic Outcomes/ Benefits:	**Strategic Foresight:**	Deteriorating	☐	Static	☐	Improving	☒
▪ Systematic, skilled, data-driven, adaptive, learning-orientated, sustainable.							

2026/27 Annual Plan:	**Strategic Foresight Rationale:**
▪ Create a clear, consistent improvement system that aligns strategy, priorities, and operations demonstrates progress against the NHS Impact framework. ▪ Strengthen improvement capability across NWAS by building skills, sharing learning, celebrating success, and enabling effective spread and sustainability.	This risk represents strategic challenge arising from national expectations for demonstrable improvement capability, learning maturity and impact, alongside an accelerating pace of change across the NHS. With improvement now a national priority, peers are investing rapidly in structured improvement infrastructure and external expertise. There is a material risk that NWAS is unable to mature its improvement capability at the pace required to meet future system and regulatory expectations. While the Trust has a clear ambition to be a learning and improvement organisation, understanding and application of 'improvement' is not yet consistent across the organisation, creating risks of fragmented adoption and variable engagement. There is a significant strategic opportunity, the introduction of a Trust-wide Improvement Management System, not yet widely embedded within the ambulance sector, provides NWAS with a strong potential differentiator and foundation for sustainable transformation. Realising this opportunity is conditional on improvement governance, capability, and assurance maturing in parallel however the position has improved due to an increase in the improvement resource and a programme of improvement projects.

BAF RISK SCORE JOURNEY:

01.04.26	Q1	Assurance Rating	Q2	Assurance Rating	Q3	Assurance Rating	Q4	Assurance Rating	Risk Appetite (RA)
6	6	Static		Choose an item.		Choose an item.		Choose an item.	Quality
3x2	3x2								
CxL	CxL		CxL		CxL		CxL		Cautious 6-10
RA: Within	RA: Within		RA		RA		RA		

RATIONALE FOR RISK SCORE:

The Q1 risk score reflects the strategic importance of improvement capability to the Trust's long-term sustainability, balanced against early-stage controls and developing infrastructure. While NWAS has a clear improvement ambition, leadership commitment and emerging systems, improvement maturity, governance and assurance are not yet sufficiently embedded to provide confidence of consistent, organisation-wide impact at pace. Operational pressures, variable understanding of improvement, reliance on a central improvement function and the absence of a defined assurance framework increase the likelihood of slow or uneven progress.

CONTROLS	ASSURANCES		EVIDENCE
Trust-wide improvement management system	**Level 2:** Oversight of improvement activity, aligned to strategic aims, enabling structured delivery and progress tracking	Adequate	QPC/2627/038
Co-production with Service Delivery	**Level 2:** Phased implementation of the improvement management system across areas and sectors to support adoption and learning	Adequate	QPC/2627/038

External engagement	**Level 2:** Oversight of external engagements to maintain currency and external perspective	**Limited**	QPC/2627/038

Gaps in Control/ Assurance	Required Action	Action Lead	Target Completion	Oversight	Progress
Trust-wide assurance framework for improvement activity, capability, culture and impact	Develop and implement a clear improvement assurance framework, including defined metrics, milestones, reporting frequency and escalation routes	Director of Quality & Improvement	December 2026	Trust Management Cttee	In Progress
Improvement reporting focuses on activity and inputs rather than capability, culture or sustained impact	Agree a balanced set of improvement metrics covering delivery, capability, culture and outcomes aligned to the NHS Impact Framework	Director of Quality & Improvement	March 2027	Quality & Performance Cttee	In Progress
Absence of in-year cultural measurement limits early warning of improvement adoption and behavioural change	Introduce in-year cultural sensing mechanisms to compliment the annual NHS Staff Survey and provide timely assurance	Director of Quality & Improvement	September 2026	Trust Management Cttee	In Progress

OPERATIONAL RISKS SCORED 15+ ALIGNED TO BAF RISK: SR06						
Risk ID	Risk Type/ Subtype	Risk Description	Initial Risk Score	Current Risk Score	Trend Analysis	Target Risk Score
There are no operational risks scored 15+ aligned to this risk						

BOARD ASSURANCE FRAMEWORK 2026/27

BAF RISK 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.	**Executive Director Lead:**	Director of Finance
	Strategic Aim:	Embed
	Committee:	Resources

Strategic Outcomes/ Benefits:	**Strategic Foresight:**	Deteriorating	☐	Static	☒	Improving	☐
▪ Greener, resilient, efficient, responsible and future-ready.							

2026/27 Annual Plan:	**Strategic Foresight Rationale:**
▪ Progress towards achieving net zero carbon by 2040 through delivery of our Green Plan.	Horizon scanning indicates no new discrete external threats. The Trust has a clear strategic direction, supported by a Board approved Green Plan and Climate Adaptation Plan, and sustainability initiatives remains financially and operationally constrained. Net zero compliant solutions, including electric doubled crewed ambulances and low carbon estate schemes, currently carry higher capital and whole-life costs than traditional alternatives. In addition, National Grid capacity limitations in part of the North West restrict the pace and scale at which electric charging infrastructure can be deployed, increasing dependency on external factors beyond Trust control. Organisational ownership of sustainability is variable, with progress largely driven by a small group of committed individuals rather than fully embedded across decision-making functions. While environmental sustainability considerations are referenced within impact assessments, there is limited assurance that sustainability and affordability trade-offs are consistently and systematically evaluated.

BAF RISK SCORE JOURNEY:

01.04.26	Q1	Assurance Rating	Q2	Assurance Rating	Q3	Assurance Rating	Q4	Assurance Rating	Risk Appetite (RA)
8	8	Static		Choose an item.		Choose an item.		Choose an item.	Regulatory
2x4	2x4								
CxL	CxL		CxL		CxL		CxL		Open
RA: Below	RA: Below		RA		RA		RA		12-15

RATIONALE FOR RISK SCORE:

The Q1 risk score reflects the high strategic impact associated with our inability to deliver environmental sustainability ambitions, balanced against current mitigating actions and governance arrangements. While the Trust has approved plans, reporting mechanisms and active workstreams in place, the likelihood of delivery slippage remains material due to cost pressures, infrastructure capacity constraints and uneven organisational ownership.

CONTROLS	ASSURANCES		EVIDENCE
Green Plan	**Level 2:** Update against delivery of Green Plan	Adequate	RC/2627/017 TMC/2627/088
Sustainability reporting	**Level 3:** External reporting requirements and transparency to NHS England on sustainability	Substantial	BOD/2627/24

Gaps in Control/ Assurance	Required Action	Action Lead	Target Completion	Oversight	Progress
Dependency on external infrastructure	Introduce forward-looking delivery risk and dependency reporting, including external constraints	Director of Finance	October 2026	Resources Cttee	Pending

Sustainability risks not consistently embedded into decision-making processes	Strengthen governance requirements to explicitly test sustainability, affordability and infrastructure assumptions	Director of Finance	December 2026	Resources Cttee	Pending
Variable organisational ownership and reliance	Embed sustainability accountability across directorates and senior leadership roles	Director of Finance	December 2026	Resources Cttee	Pending

OPERATIONAL RISKS SCORED 15+ ALIGNED TO BAF RISK: SR07						
Risk ID	**Risk Type/ Subtype**	**Risk Description**	**Initial Risk Score**	**Current Risk Score**	**Trend Analysis**	**Target Risk Score**
There are no operational risks scored 15+ aligned to this risk						

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Annual Health, Safety, Security and Fire Report 2025-26
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Assurance

STRATEGIC AIM(S)	Build a safe, supportive and inclusive culture together							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☐	**SR03**	☐	**SR04**	☐
	SR05	☐	**SR06**	☐	**SR07**	☐	**SR08**	☐

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Board of Directors is asked to: • Receive the Health, Safety, Security and Fire Annual Report for 2025/26. • Take assurance that appropriate governance arrangements are in place to manage statutory health, safety, security and fire responsibilities. • Note the key achievements and areas for continued focus in 2026/27, particularly manual handling, violence and aggression reduction, and development of VPR data.
EXECUTIVE SUMMARY	This annual report provides assurance on the effectiveness of the Trust's health, safety, security and fire arrangements during 2025/26 and demonstrates compliance with statutory responsibilities under the Health and Safety at Work Act 1974 and associated legislation. During the year, the Trust continued to strengthen its governance and assurance framework, supported by an established Health, Safety, Security and Fire governance structure, enhanced specialist team capacity, and effective partnership working with staff-side representatives. Improvements have been made across several key areas including incident reporting, workplace inspection programmes, mandatory training compliance, violence prevention and reduction arrangements, infection prevention and control, and statutory compliance monitoring. Performance indicators demonstrate positive progress, including a continued reduction in RIDDOR-reportable incidents, improved timeliness of statutory reporting, high levels of workplace

	compliance identified through health and safety inspections, and a reduction in reported incidents of violence and aggression. The Trust has also made significant progress in implementing its Violence Prevention and Reduction programme, achieving compliance with six of the seven domains of the NHS Violence Prevention and Reduction Standard. Key areas requiring continued focus during 2026/27 include reducing manual handling injuries, addressing violence and aggression towards staff, strengthening data and intelligence capability, and delivering actions arising from workplace inspections, security audits and thematic incident reviews. Overall, the report provides assurance that appropriate governance, monitoring and improvement arrangements are in place and that the Trust continues to make positive progress in maintaining a safe environment for patients, staff, volunteers and others affected by its activities.	
PREVIOUSLY CONSIDERED BY	TMC	
	Date	22/07/26
	Outcome	Supported for onward reporting to Board

1. INTRODUCTION

This report provides TMC with annual assurance regarding the effectiveness of the Trust's health, safety, security and fire management arrangements during 2025/26. It outlines performance against statutory requirements, key risks, governance arrangements, areas of improvement and priorities for 2026/27.

Overall, the Trust has maintained effective health, safety, security and fire management arrangements throughout 2025/26. Governance arrangements remain robust, statutory obligations are being met, key performance indicators show improving performance, and there is evidence of continuous improvement across several areas. Whilst risks remain in relation to manual handling, violence and aggression, and VPR data maturity, appropriate mitigation and improvement plans are in place.

During 2025/26, the Trust's focus has been on strengthening the core foundations of health and safety management to ensure a safe working environment for staff, patients and others affected by our activities. This has included continued development of governance, assurance and risk management arrangements to support compliance with statutory requirements and promote a proactive safety culture. Effective health and safety management not only fulfils the Trust's legal obligations but also contributes to organisational resilience by reducing the human, operational and financial impacts associated with accidents, incidents and avoidable harm.

2. HEALTH & SAFETY GOVERNANCE STRUCTURE

The Health and Safety governance structure for 2025/26 can be seen in the image below.

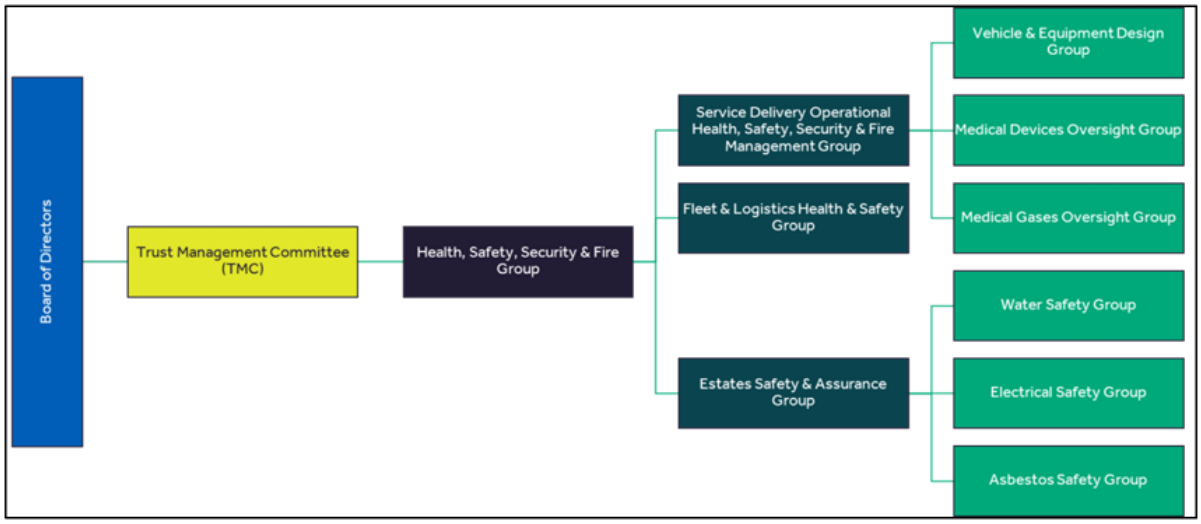


Image 1: Health and Safety Governance Structure

This governance structure and arrangements are central to maintaining core health and safety standards across the trust. The governance framework provides oversight and assurance regarding health, safety, security and fire risks across the organisation.

Our Health and Safety Trade Union Representatives play a fundamental role in the attendance, contribution and participation of our health and safety governance arrangements.

Within our local service lines, Paramedic Emergency Services, Patient Transport Services, and Integrated Contact Centres (ICCs) hold assurance group meetings which seek assurance against core health and safety matters. In addition to these meetings, there are a series of consultative meetings where local senior management teams, in partnership with Trade Union representatives come together and discuss local health, safety, security and fire matters. This arrangement ensures compliance with The Safety Representatives and Safety Committees Regulations 1977.

3. HEALTH, SAFETY, SECURITY & FIRE GROUP

The trust's Health, Safety, Security and Fire Group is chaired by the Director of Corporate Affairs, as Executive Lead. The Group meets bi-monthly and reports into the Trust Management Committee (TMC), with escalation to the Board of Directors.

The Group is tasked with seeking and providing assurance on all health, safety, security and fire matters. The Group is also tasked with monitoring the development, implementation, and delivery of health and safety organisational management throughout the trust.

The Group receives regular assurance regarding:

- Organisational health, safety, security & fire risks.
- Incident trends and RIDDOR reporting.
- Delivery of the annual plan.
- Statutory compliance.
- Violence prevention and reduction.
- Infection prevention and control.
- Mandatory training compliance.

In addition, the Group will receive ad-hoc assurances from internal and external audit reports, accident investigation outcomes and emergency and national risks with a health, safety, security and fire implication.

4. HEALTH, SAFETY, SECURITY & FIRE TEAMS

Following changes to team responsibilities in 2024/25, the Trust has seen improvements in the management of Health and Safety, Security and Fire as separate entities working in collaboration.

The Head of Health and Safety is responsible for the implementation and embedding of health and safety policy and procedures throughout the Trust, while the Head of Violence, Prevention, Reduction and Security undertakes the role of the Local Security Management Specialist (LSMS). Health and Safety and Security sit within the Corporate Affairs Directorate with the Director of Corporate Affairs as the executive lead for both disciplines.

The responsibility for oversight of fire safety remains within the Estate's portfolio, under the Head of Estates and the Director of Finance as the Executive lead for fire safety. A Fire Safety Manager was recruited in 2025/26 to implement improvements to fire safety across the Trust.

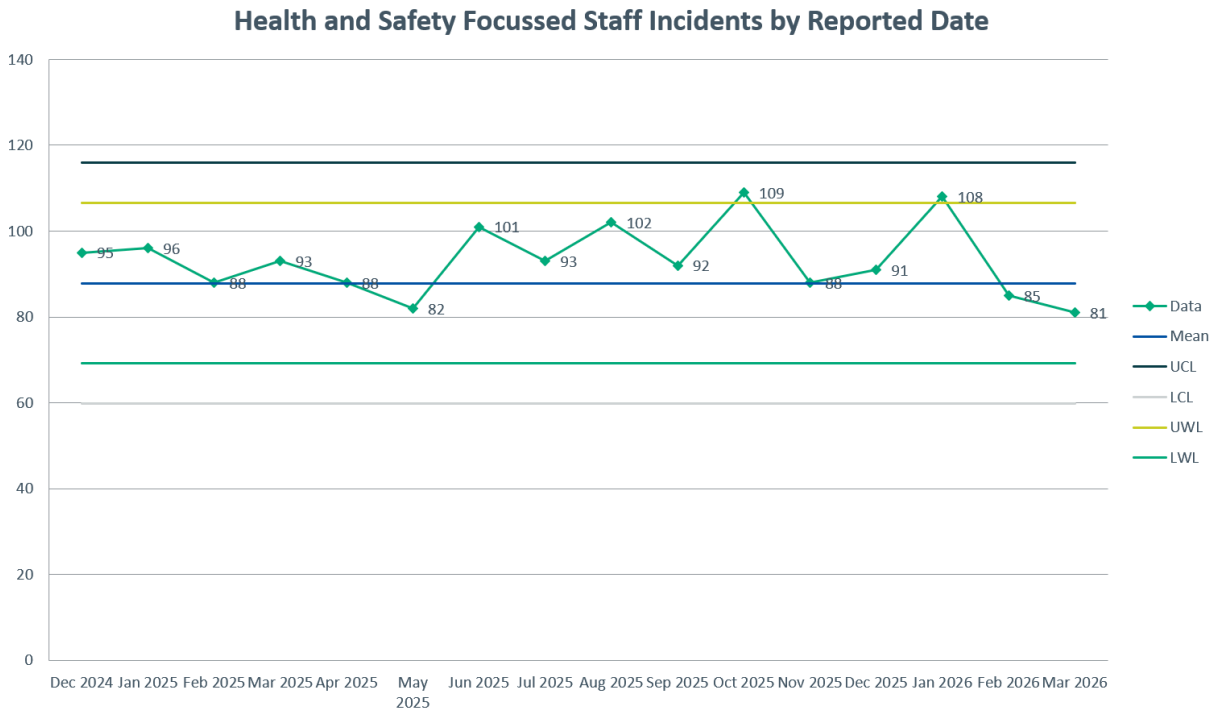
The additional Health and Safety Team structure and related vacancies were filled through numerous recruitment campaigns throughout 2025/26, and the additional resource enabled the achievement of the ambitious annual plan as detailed in section 12 of this report.

5. HEALTH, SAFETY, SECURITY & FIRE INCIDENTS & NEAR-MISSES

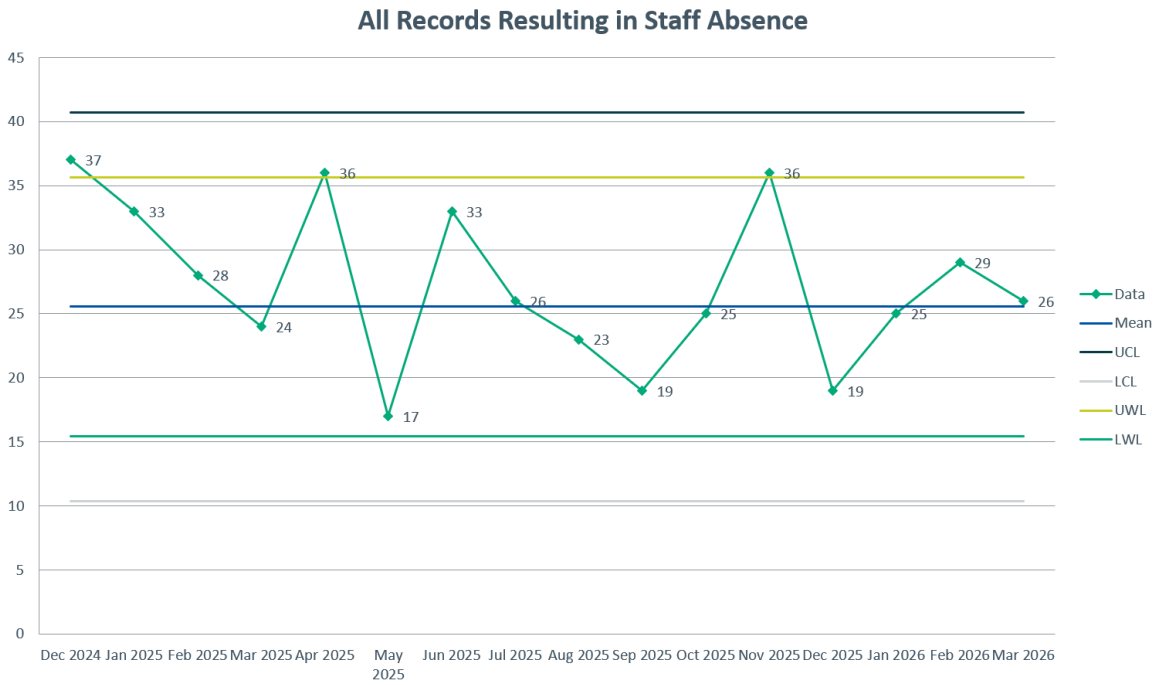
All incidents and near-misses (including health and safety) are reported on the trust's Datix Cloud IQ (DCIQ) system.

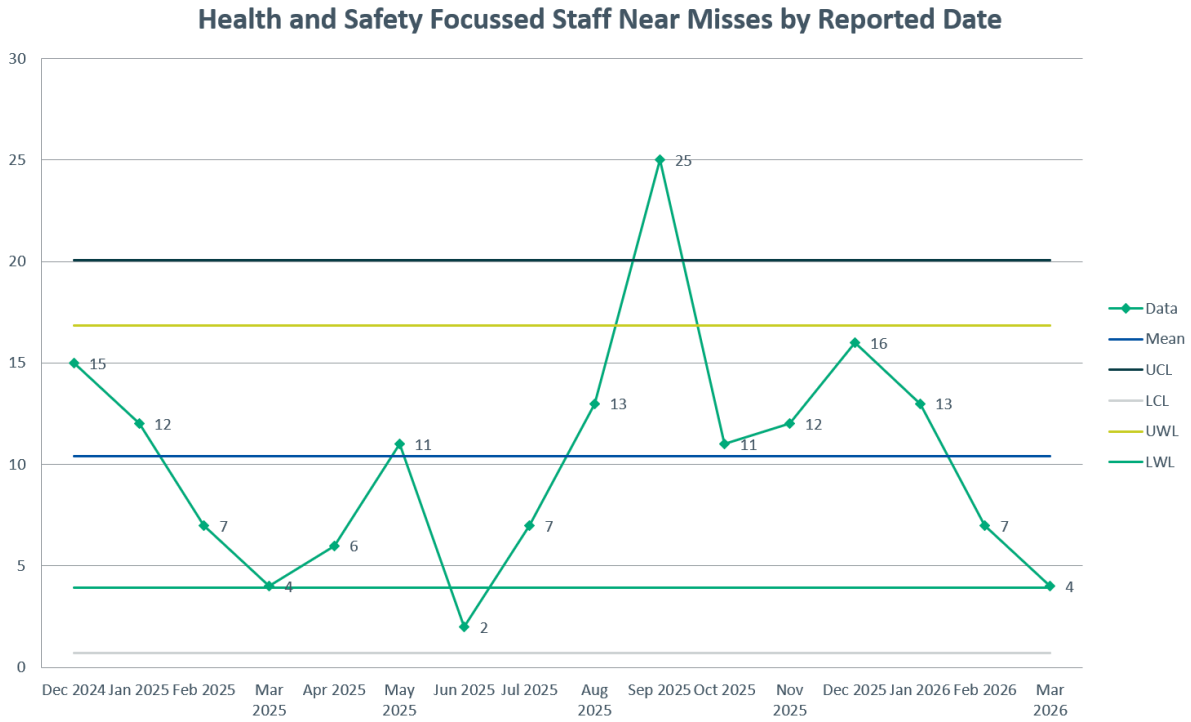
All data is now presented in SPC chart format to monitor performance over time and enable swift identification and investigation of any special cause variation.

Health and Safety Focused Staff Incidents and Near Misses – this data set includes the DCIQ categories of accidents and injuries, equipment, moving and handling, slips trips and falls and welfare.



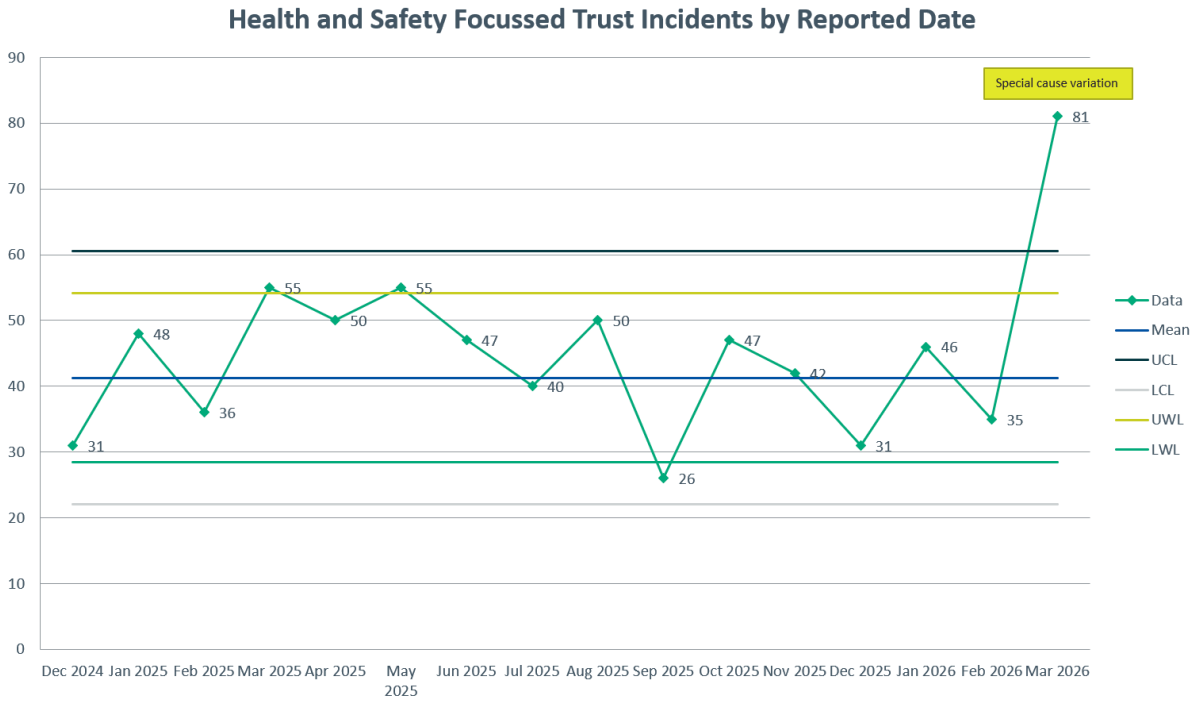
DELIVERING THE RIGHT CARE,
AT THE RIGHT TIME,
IN THE RIGHT PLACE;
EVERY TIME.



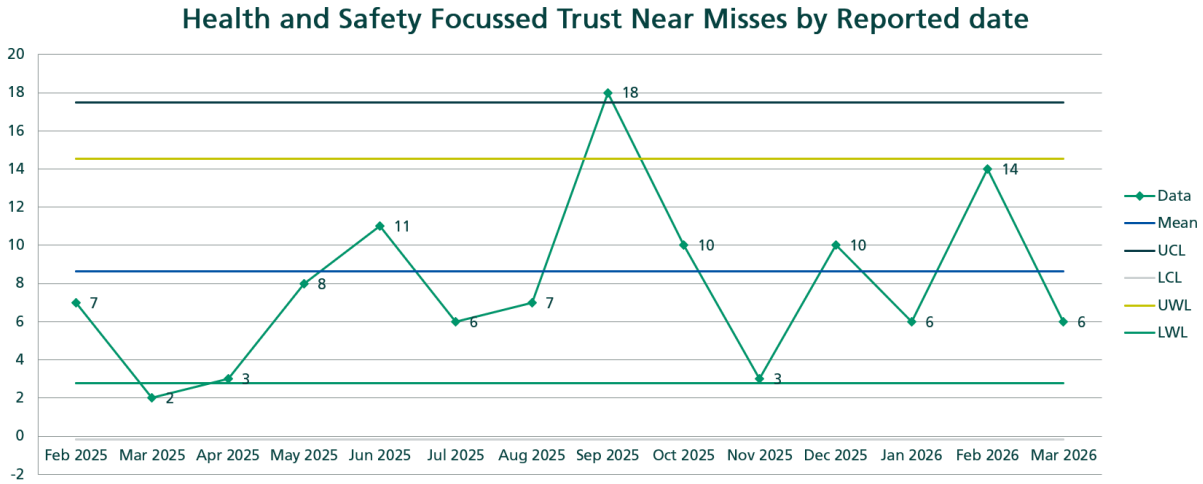


The special cause variation and a peak of near miss reporting in September 2025 was mainly welfare and equipment related reports, rather than injury near misses, which is the general trend.

Trust incidents and near misses

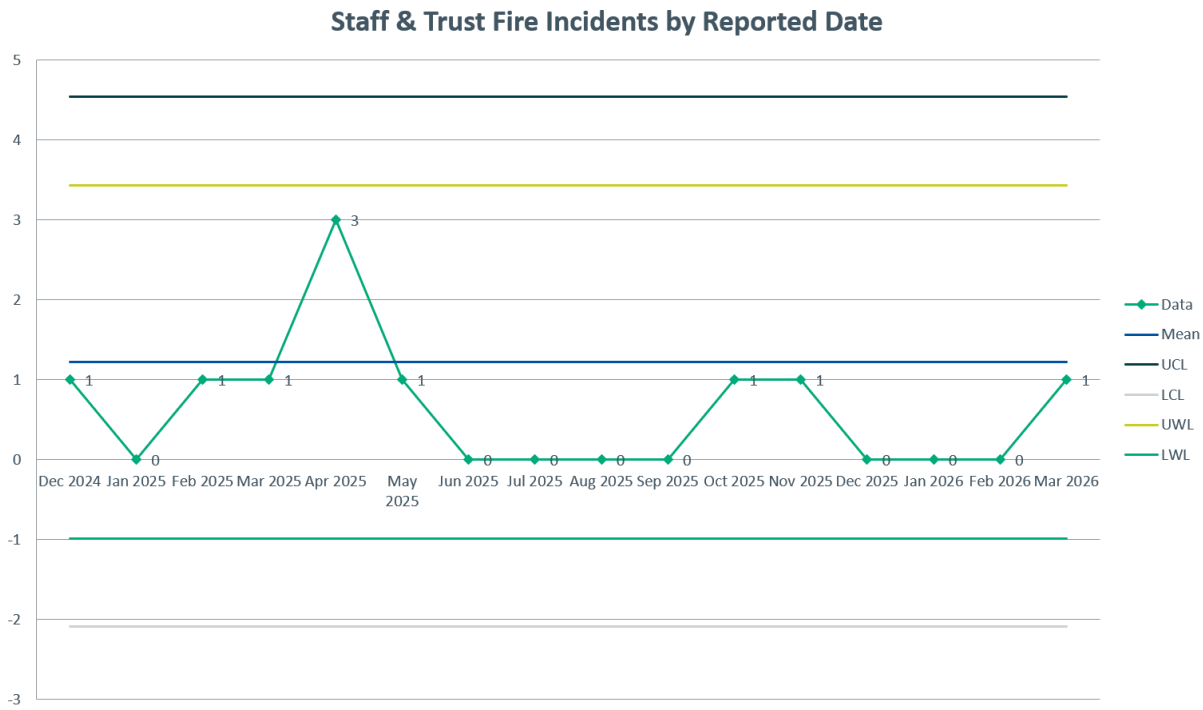


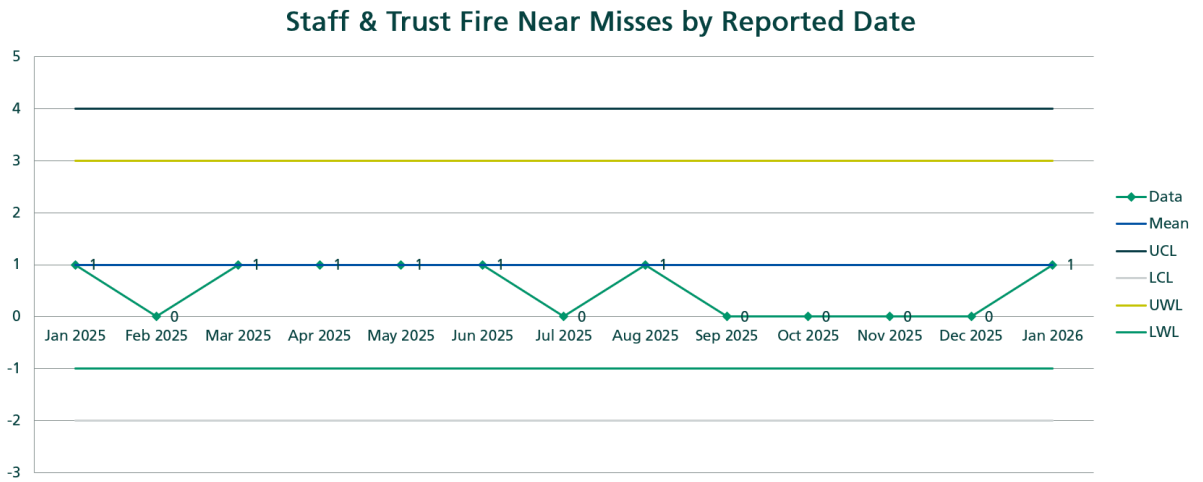
The SPC chart shows special cause variation of 81 H&S focused Trust incidents in March 2026 due to the fleet team raising 40x equipment incidents regarding overdue service of Lifepak defibrillators. 39 incidents have subsequently been approved and closed with the final incident awaiting service line review & local investigator allocation.



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

Fire Incidents and Near Misses





There have been no staff and Trust fire near misses reported since January 2026.

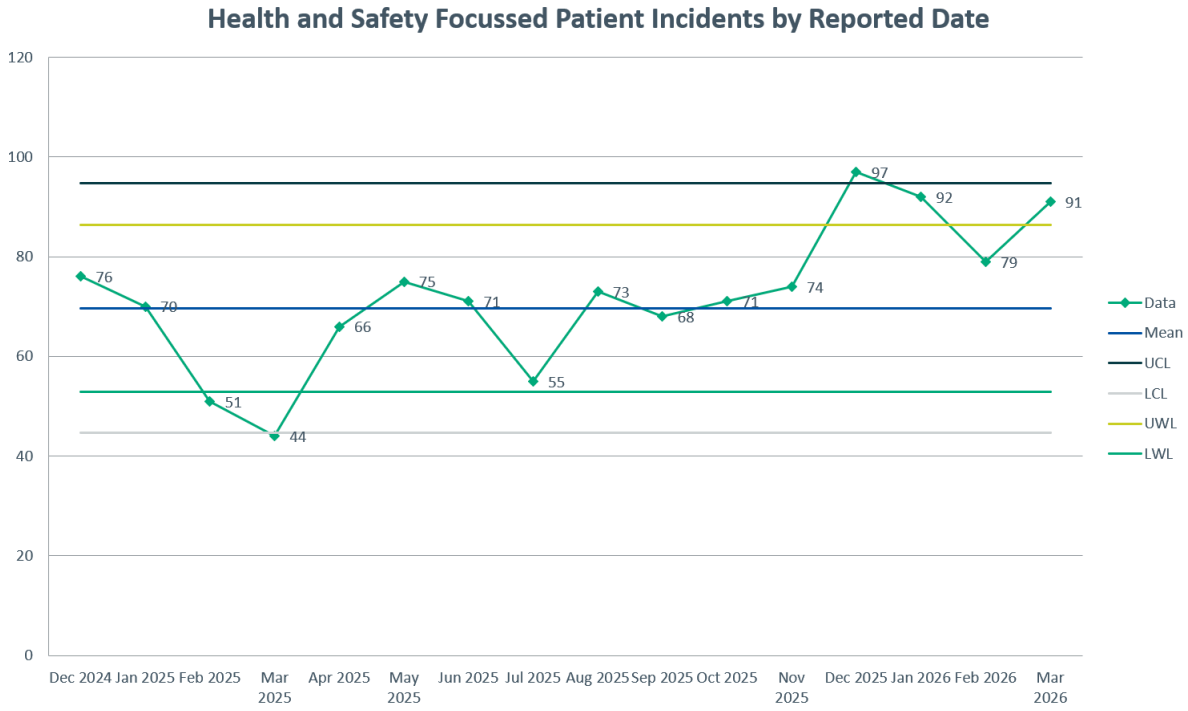
Patient Safety Incidents

Health and Safety focused patient incidents are recorded on the DCIQ system, and are reported to NHS England, via the Learning from Patient Safety Events (LFPSE) system. Patient Safety focused health, safety and security incidents include accident and injuries, equipment, moving and handling, and slips, trips and falls.

All patient safety incidents are managed under the Patient Safety Incident Response Framework (PSIRF). PSIRF focuses on learning from understanding how incidents happen, including the factors which contribute to them. The PSIRF approach is flexible and adapts

as the trust learns and improves, the process determines the level of proportionate response appropriate to learn from all patient safety incidents.

The Health and Safety team review all patient associated health and safety incidents to assess whether they are reportable to the Health and Safety Executive (HSE) under the RIDDOR regulations.



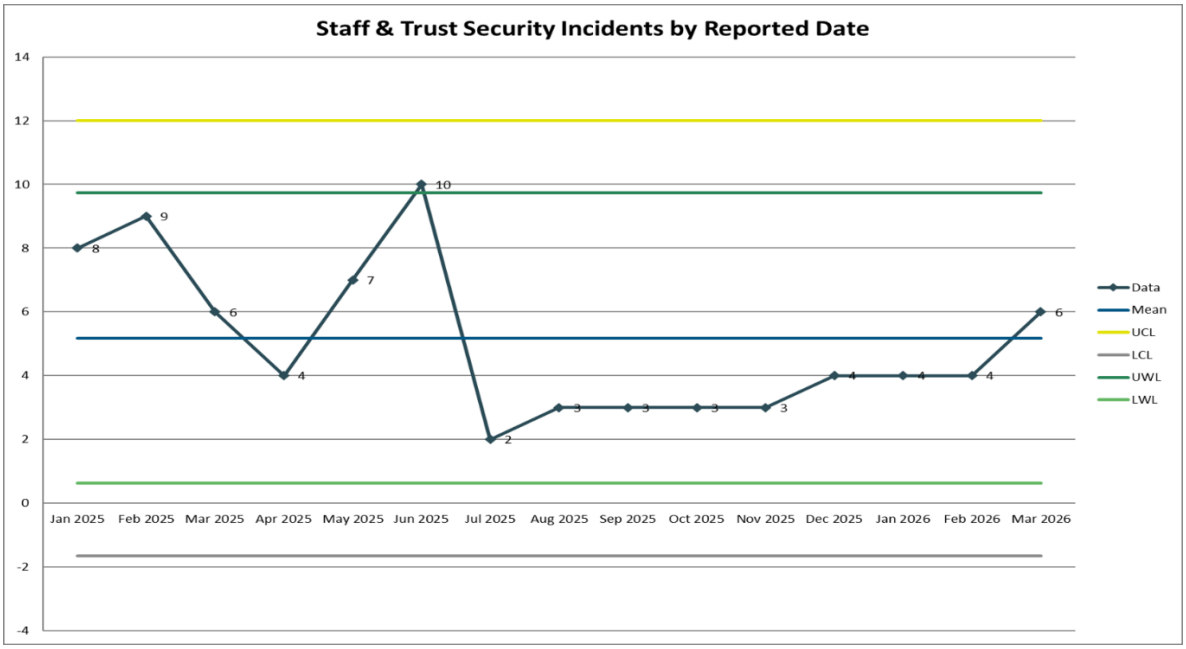
The special cause variation in December 2025 was due to issues with Schiller defibs and ECG electrodes. Schiller Defib related issues are being monitored by a specially established Schiller Defib Working Group.

Security Incidents

Whilst Trust security incident reporting remains low, each incident is assigned a VPR specialist practitioner to review the incident and ensure resolution and any mitigation is put in place in collaboration with the Estates team and partnership agencies.

The highest cause of incidents is attributable to staff leaving equipment or infrastructure unsecured, and work is ongoing with operational staff teams to raise awareness on this and to reduce incidents.

All sites across the trust have undergone a security audit which is being utilised to benchmark any vulnerabilities. The VPR team are working in collaboration with estates to identify short-, medium- and long-term actions that need to be addressed from these audits.



6. RIDDOR INCIDENTS

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 require employers to report specified work-related injuries, occupational diseases, dangerous occurrences and fatalities to the relevant enforcing authority.

During 2025/26, the Trust reported 122 incidents to the Health and Safety Executive (HSE) under the RIDDOR regulations. This represents a continued year-on-year reduction in reportable incidents, compared with 125 in 2024/25 and 150 in 2023/24, despite an increase in overall incident reporting associated with workforce growth.

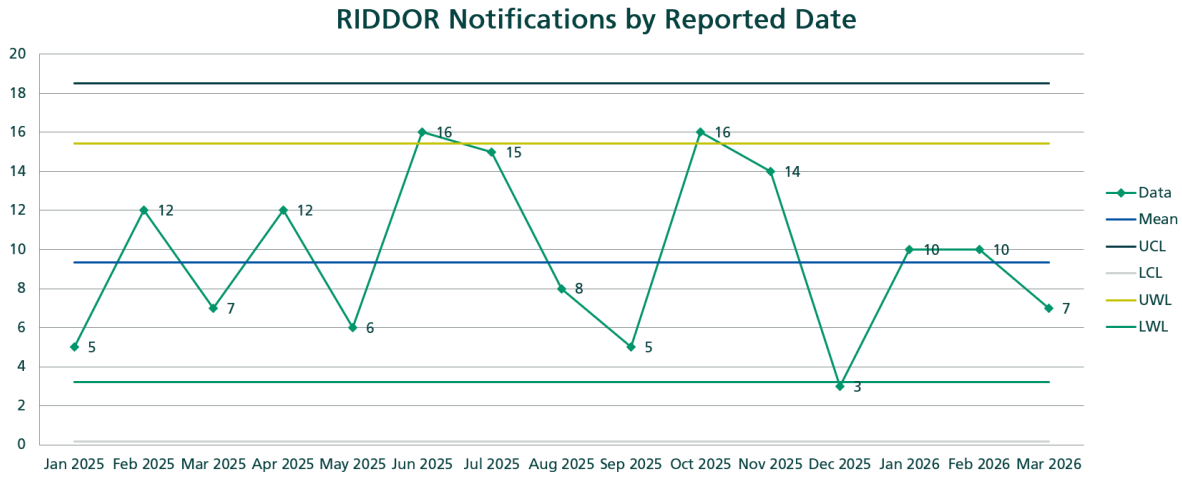
The reduction in the proportion of incidents meeting the RIDDOR reporting threshold suggests a decrease in the severity of harm arising from workplace incidents. December 2025 recorded the lowest monthly level of RIDDOR-reportable incidents seen over the previous 18 months.

Performance has also improved in relation to statutory reporting timescales, with 75% of RIDDOR submissions made within the required HSE reporting timeframe. This reflects improved organisational awareness of reporting requirements and strengthened collaboration between operational services and the Health and Safety Team.

A benchmarking exercise is carried out annually comparing RIDDOR performance across ambulance trusts and NWAS compared favourably with peer organisations - using the standard measure of reportable injuries per 1,000 employees, NWAS achieved a rate of 14.5 per 1,000 staff, placing fourth nationally with the lowest rate being 9.24 and the highest rate being 30.7.

Manual handling remains the most significant cause of RIDDOR-reportable incidents, accounting for 45% of all reports. Slips, trips and falls account for 20%, while violence and

aggression account for 18%. These areas continue to be a focus of targeted prevention, training and improvement activity during 2026/27.



7. HEALTH, SAFETY, SECURITY & FIRE EDUCATION AND TRAINING

Mandatory training compliance for Health, Safety, Security and Fire exceeds the Trust target of 90% (although further improvement is required with the cohort of bank staff), providing assurance that staff have the knowledge and competencies required to undertake their roles safely and in accordance with statutory and organisational requirements.

Compliance data, accurate at 31 March 2026, is presented below and includes fixed-term, permanent and bank staff cohorts.

Competency	Achieved/Assignment Count	Fixed Term & Permanent Employees Compliance %	Achieved/Assignment Count	Bank Staff Compliance %
NHS (CSTF) Fire Safety 2 years	7456/8029	92.86%	292/353	82.72%
NHS (CSTF) Health, Safety and Welfare 3 years	7253/8029	90.34%	295/353	83.57%
NHS (CSTF) Moving and Handing Level 1 2 years	5182/5453	95.03%	271/303	89.44%
NHS (CSTF) Moving and Handing Level 1 3 years	2450/2568	95.40%	40/50	80%
NHS (CSTF) Moving and Handing Level 2 1 year	5155/5453	94.54%	263/303	86.80%
NHS (CSTF) NHS Conflict Resolution (England) 3 years	7705/8029	95.96%	315/353	89.24%
NHS (Mand) Risk Awareness 3 years	7233/8029	90.09%	256/353	72.52%

8. HEALTH & SAFETY WORKPLACE INSPECTIONS

During 2025/26, the Trust implemented a risk-based programme of workplace inspections, prioritising inspection activity according to site risk profile and complexity – for example,

considering the presence of fuel and medical gases as well as the compliance scores from previous inspections.

Inspection frequencies based on a rolling three-year cycle were aligned to risk with all high-risk sites subject to inspection during the year and each subsequent year.

100% of all sites identified received an inspection during the year, in total 91 out of 144 sites, including fleet workshops, PES & PTS stations, Integrated Contact Centres, training centres and corporate premises. Assurance for sites not included within the inspection programme was supplemented through staff-side inspections and subsequent review by the Health and Safety Team.

The inspection programme provided a high level of assurance regarding compliance with health and safety requirements across the estate. The Trust achieved an overall average compliance score of 92%, with consistent performance across Cheshire and Mersey (92.5%), Cumbria and Lancashire (92.5%) and Greater Manchester (92%). First Aid compliance represented the most significant area for improvement, whilst compliance relating to Noise and Personal Protective Equipment achieved the highest scores.

Analysis of inspection findings has identified a number of recurring themes, which have been reported through the Health, Safety, Security and Fire Group. Improvement actions are being progressed with relevant stakeholders to address identified risks and further strengthen compliance across the organisation. Further detail is provided in Section 12.6.

9. VIOLENCE, PREVENTION & REDUCTION (VPR)

The NHS Violence Prevention and Reduction (VPR) Standard provides a risk-based framework to support NHS organisations in preventing, managing and reducing violence and aggression towards staff. Compliance with the Standard is a requirement of the NHS Standard Contract and organisations are required to assess their performance against seven domains covering leadership, governance, collaboration, data, workforce, interventions and evaluation.

The Trust's self-assessment (which has been peer reviewed by another ambulance service) demonstrates compliance with six of the seven domains of the Standard, providing a high level of assurance regarding the effectiveness of current Violence Prevention and Reduction arrangements. The only area not currently fully compliant relates to the **Data** domain, which has been identified as a priority for further development during 2026/27.

Priority areas for improvement include:

Data

- Strengthening reporting, intelligence and analytical capability to improve understanding of trends, risk factors and the differential impact of violence and aggression across the workforce.
- Enhancing the use of data to support targeted interventions, organisational learning and preventative action.

Interventions

- Continuing to implement a risk-based and intelligence-led approach to violence prevention, focused on areas of greatest risk.

- Strengthening partnership working and further developing workforce capability through targeted training and support.

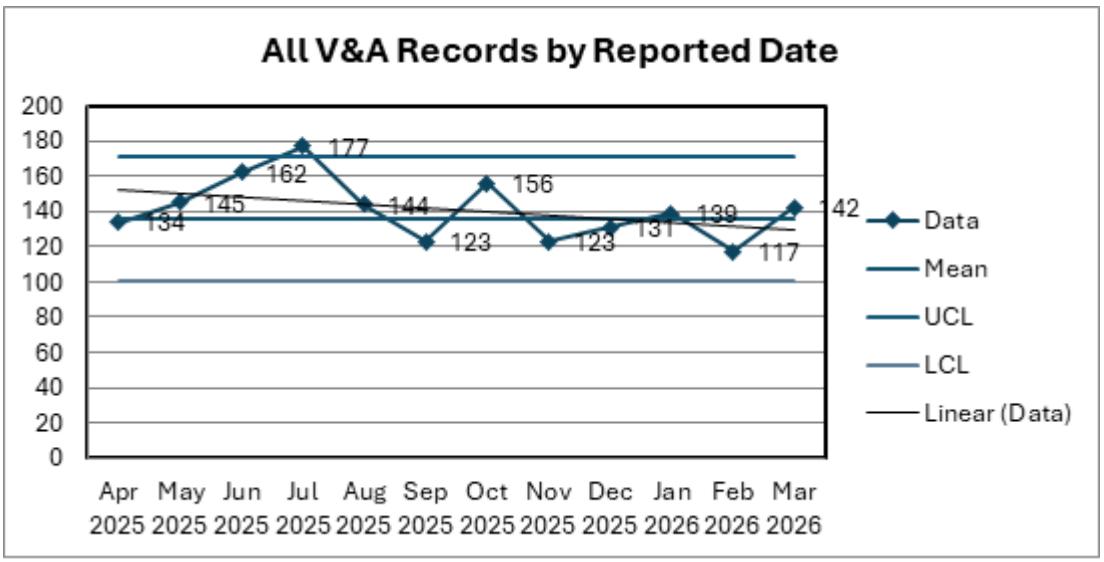
Evaluation

- Commissioning an independent review of the Trust's Violence Prevention and Reduction programme to evaluate effectiveness, identify opportunities for improvement and provide additional assurance regarding impact and outcomes.

The Trust remains committed to providing a safe, inclusive and supportive working environment for all colleagues and to reducing the incidence and impact of violence and aggression across the organisation.

Violence and Aggression Incident Management

All incidents of violence and aggression are reported through the Trust's Datix Cloud IQ (DCIQ) system. During 2025/26, a total of 1,695 incidents were reported, providing valuable intelligence to support targeted prevention, intervention and learning activities across the organisation.



Violence and Aggression Trends and Learning

Whilst overall violence and aggression incidents reduced by 14% compared with 2024/25, indicating the positive impact of targeted interventions and collaborative work with internal and external partners, reports of sexually motivated incidents increased during the year and will remain a priority area of focus during 2026/27.

Analysis of incident reports demonstrates that alcohol-related behaviour, mental health presentations and drug-related presentations continue to be the most common contributory factors associated with violence and aggression incidents. Additional aggravating factors include gender-based abuse, racially motivated incidents, the use of weapons and incidents motivated by sexual behaviour. It should be noted that multiple aggravating factors may be associated with a single incident.

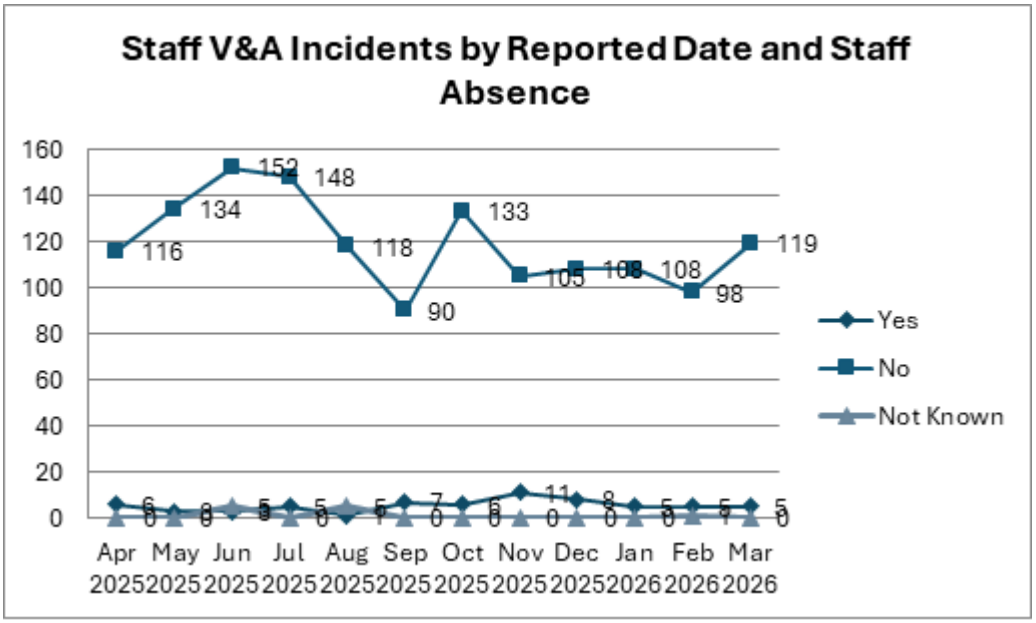
Thematic review of violence and aggression incidents has identified several key learning themes:

- Verbal aggression towards colleagues working within Integrated Contact Centres remains the most frequently reported type of violence and aggression incident, highlighting the need for continued investment in staff support, wellbeing initiatives and targeted training.
- Analysis of geographical trends indicates that Blackpool and Central Manchester continue to experience the highest levels of reported violence and aggression, reflecting both workforce numbers and local risk factors. These locations remain a focus for targeted prevention activity.
- The increase in sexually motivated incidents represents an emerging risk and reinforces the need to strengthen demographic data and analytical capability to better understand underlying causes and inform targeted interventions.

Key Improvements During 2025/26

Significant progress has been made in strengthening the Trust's Violence Prevention and Reduction arrangements during 2025/26, including:

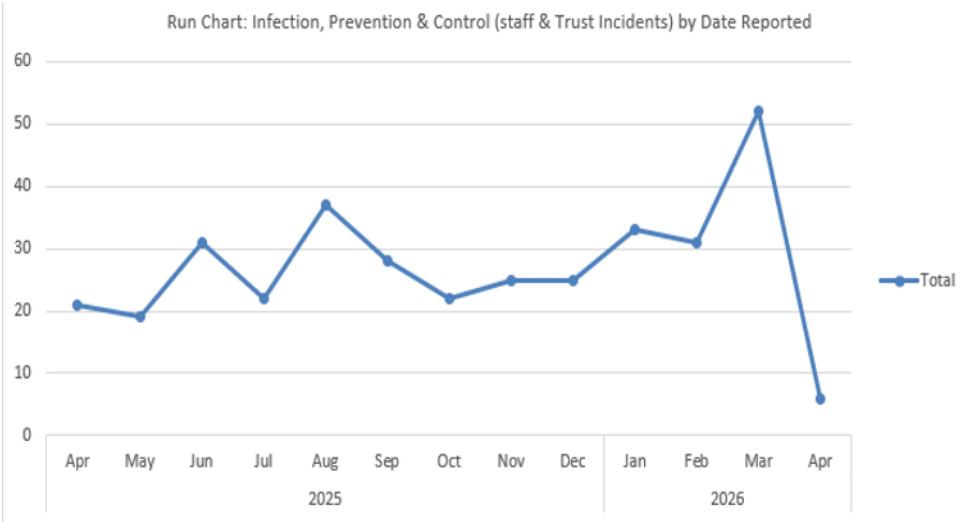
- Enhanced support and training for first-line leaders in responding to and managing violence and aggression incidents.
- Improvements to incident reporting processes, enabling better intelligence gathering, organisational learning and targeted intervention.
- Establishment of a dedicated Violence Prevention and Reduction Team, with specialist practitioners aligned to each geographical area.
- Strengthened governance and review processes for violence and aggression markers.
- Delivery of national and local awareness campaigns to support staff safety and reporting.
- Further development of partnership working and adoption of a public health approach to violence prevention.
- Investment in trauma-informed practice and improvement methodology across the Violence Prevention and Reduction Team to support evidence-based service development.



10. INFECTION, PREVENTION & CONTROL (IPC)

The Infection Prevention and Control (IPC) function sits within the Quality Directorate under the leadership of the Director of Quality and Improvement, who also fulfils the role of Director of Infection Prevention and Control (DIPC). Full details of IPC work can be found in the DIPC Annual Report 2025/26.

IPC incidents are reported through the Trust's Datix Cloud IQ (DCIQ) system and are subject to regular review and thematic analysis. During 2025/26, key themes identified included increased exposure to notifiable infectious diseases, contacts with patients presenting with potential High Consequence Infectious Diseases (HCIDs), and sharps-related incidents.



Key Improvements During 2025/26

During the year, the IPC team delivered a number of improvements aimed at strengthening organisational resilience and compliance, including:

- Updating IPC guidance and resources to ensure alignment with current national requirements and best practice.
- Strengthening arrangements for the management and transfer of patients with possible or probable HCIDs through continued collaboration with the UK Health Security Agency (UKHSA) and the Trust's Resilience Team.
- Supporting implementation of the NHS National Standards of Cleanliness and enhancing assurance relating to cleaning and waste management processes through continued collaboration with Estates, Facilities Management and Fleet.
- Strengthening oversight of respiratory protective equipment and compliance with relevant COSHH requirements (Powered Air Purifying Respirator (PAPR))
- Reviewing IPC audit processes to enhance the quality of assurance and support continuous improvement.
- Updating IPC training, policies and procedures to reflect changes in national guidance and emerging risks.

These improvements have strengthened the Trust's ability to identify, manage and mitigate infection prevention and control risks.

Respiratory Protective Equipment and Face Fit Testing

The Trust maintains a dedicated face fit testing service operating across all geographical areas, supported by trained IPC practitioners, education colleagues and specialist operational staff. This approach provides resilience within the programme and supports continued compliance amongst patient-facing staff.

Face Fit Testing compliance is centrally monitored through MyESR, providing robust organisational oversight and enabling targeted improvement activity where required.

Compliance rates remain high across all geographical areas:

- Cheshire and Merseyside: **94%**
- Cumbria and Lancashire: **92%**
- Greater Manchester: **92%**

Compliance performance is regularly reviewed through the IPC governance structure, providing assurance that appropriate arrangements are in place to protect staff and support safe patient care.

National Alerts and Emerging Risks

Throughout 2025/26, the Trust continued to respond appropriately to national infection prevention and public health alerts issued by UKHSA, NHS England and other relevant bodies. These included guidance and alerts relating to seasonal respiratory infections, meningitis, measles activity, tuberculosis management and product safety notices.

Appropriate review, communication and follow-up arrangements were implemented in response to all relevant alerts, providing assurance that the Trust remains responsive to emerging infectious disease threats and maintains alignment with national IPC requirements.

11. ESTATES, FLEET & LOGISTICS

The occupation and maintenance of Trust property and land is subject to a range of statutory requirements designed to protect the safety of staff, patients, visitors and contractors, and to ensure the effective management of buildings, infrastructure and equipment.

The Trust maintains a Statutory Compliance Audit Framework to provide oversight and assurance against key health, safety, security and fire legislation. The framework identifies responsible leads, measures compliance performance and supports the monitoring of remedial actions where compliance gaps are identified.

Estates

The Estates Statutory Compliance Audit is reviewed monthly and overseen by the Head of Estates.

Overall compliance remained high during 2025/26 at **99%**, providing a high level of assurance regarding statutory compliance across the estate. Two areas did not achieve full compliance:

- Dangerous Substances and Explosive Atmospheres Regulations (DSEAR) 2002: **75%**
- Regulatory Reform (Fire Safety) Order 2005: **82%**

Key improvements during 2025/26 included targeted asbestos remediation works across several sites and the appointment of a Fire Safety Officer to enhance organisational fire safety capacity. In addition, new Fire Safety and Lithium-Ion Battery policies were drafted during the year, strengthening the Trust's governance framework.

Actions to address these areas are well established and will continue to be a priority during 2026/27. Key planned activity includes:

- Completion of Fire Risk Assessments across all sites.
- Development and delivery of a prioritised fire safety improvement programme.
- Completion of DSEAR assessments and implementation of associated actions.

- Investment in fire safety management systems to strengthen oversight and assurance.
- Delivery of priority fire safety improvement works, including fire door replacement and compartmentation programmes.

The Trust has secured NHS England funding to support delivery of required fire safety improvements.

Fleet & Logistics

The Fleet and Logistics Statutory Compliance Audit is reviewed quarterly and is overseen by the Fleet Compliance Officer in partnership with Health and Safety Trade Union Representatives.

Overall compliance remained high at 99%, providing assurance regarding statutory compliance within fleet workshop environments. Areas below full compliance was:

- Fire Code, Alarm and Detection Systems: **88%**
- Control of Substances Hazardous to Health (COSHH) Regulations: **90%**
- Control of Vibration at Work Regulations: **83%**
- Dangerous Substances and Explosive Atmospheres Regulations (DSEAR) 2002: **67%**

Notable improvements during 2025/26 included the completion of the new Cumbria workshop facility, including remote fire alarm monitoring arrangements, and operational changes that have improved working conditions within the Bury workshop environment.

Areas of focus for 2026/27

- In conjunction with the Health & Safety team roll out new COSHH register on the Trust Green room which will supersede the provider held access to data sheets for all Workshop consumables and ancillary products used in the general maintenance of the Trust fleet.
- Review the outcome of the independent Workshop noise assessments & act as appropriate on findings
- Review Workshop DSEAR assessments when completed and act as appropriate on findings

Overall, statutory compliance across both Estates and Fleet remains strong, with compliance levels of 99% achieved in both areas. Where compliance gaps have been identified, improvement plans are in place, supported by dedicated investment and ongoing monitoring through the Trust's governance framework.

12. 2025/26 ANNUAL HEALTH & SAFETY PLAN

The Trust has made substantial progress in delivering the priorities set out within the 2025/26 Annual Health and Safety Plan. Delivery has focused on strengthening organisational capability, improving compliance arrangements, enhancing risk management processes and embedding consistent health and safety practices across the organisation.

12.1 Health & Safety Team

Investment in professional development has continued throughout the year, strengthening specialist capability within the Health and Safety Team. Progress against continuing professional development objectives has supported the development of professional expertise and increased organisational resilience within the health and safety function.

12.2 Accident Investigations

Improvements have been made to accident investigation processes through enhanced governance controls within Datix Cloud IQ and increased support for managers undertaking investigations. Collaborative working with Legal Services and Patient Safety colleagues has strengthened organisational learning, with further training and development resources planned for 2026/27.

12.3 H&S A-Z Toolkit

The Health and Safety A–Z Toolkit is now well established as a central source of guidance and information for staff and managers. Ongoing promotion and engagement activity has supported awareness and accessibility across the organisation.

12.3.1 Procedures

Significant progress has been made in reviewing and updating the Trust's health and safety documentation, with 29 procedures reviewed, updated and republished during the year. Two procedures remain under review due to complex multidisciplinary requirements and system dependencies. Appropriate governance arrangements are in place to support their completion during 2026/27.

The Smoke Free Policy also became due for review during March 2026 and is currently progressing through the review process.

12.3.2 Generic Risk Assessments

A comprehensive suite of 45 generic and service-line-specific risk assessments has been completed and made available through the A–Z Toolkit. Focus has now shifted towards cyclical review arrangements, responding to emerging risks and strengthening managerial capability in local risk assessment development.

12.4 Control of Substances Hazardous to Health (COSHH)

Significant progress has been made in strengthening COSHH compliance arrangements. Despite the scale and complexity of the programme, a comprehensive COSHH register has been established and more than 200 COSHH assessments were completed by the end of March 2026, providing improved oversight and control of hazardous substances across the Trust.

12.5 Risk Assessments

The Health and Safety Team has continued to support operational and specialist teams in the development and review of risk assessments across a range of activities and environments. Work has also commenced to strengthen managerial capability through the

development of targeted learning resources focused on risk assessment, review processes and health and safety responsibilities.

12.6 H&S Workplace Inspections

The 2025/26 workplace inspection programme was delivered in full, with 100% completion of the planned inspection schedule. This included all high-risk sites and provided a high level of assurance regarding compliance across the Trust estate.

Analysis of inspection findings identified several recurring themes, including opportunities to strengthen signage, emergency lighting testing arrangements and consistency of statutory information display. Positive findings included evidence of strong housekeeping standards, improvements in fire evacuation arrangements, secure management of medical gases and increased engagement from operational managers in workplace inspection activity.

The findings have been reported through the Health, Safety, Security and Fire governance framework, with improvement actions identified and monitored to completion.

13. RISK CONSIDERATION

Health and Safety forms an integral part of the Trust's governance, assurance and risk management framework and supports the Board of Directors in discharging its statutory responsibilities. This report provides assurance regarding compliance with relevant health and safety legislation, the effectiveness of associated governance arrangements, and the management of key health and safety risks. Effective oversight and implementation of these arrangements reduce the risk of harm to staff, patients and others affected by Trust activities, whilst mitigating the risk of regulatory intervention, enforcement action, financial loss and reputational damage.

14. EQUALITY/ SUSTAINABILITY IMPACTS

The workstreams and assurance activities outlined within this report support the Trust's commitment to equality, diversity and inclusion by identifying and addressing risks that may disproportionately affect staff with protected characteristics. This includes the continued monitoring and analysis of health, safety, security, fire, and violence and aggression incidents to better understand differential impacts across the workforce.

Targeted improvement initiatives, particularly within the Violence Prevention and Reduction programme, will further strengthen the Trust's ability to identify inequalities, implement appropriate interventions and promote a safe, inclusive and supportive working environment for all staff, in line with its responsibilities as an employer.

APPENDIX 1

2026/27 ANNUAL HEALTH & SAFETY PLAN

The following ten strategic priorities have been identified for 2026/27 and reflect the Trust's commitment to continuously improving health, safety, security and fire management arrangements. The programme is designed to strengthen organisational capability, enhance compliance, reduce avoidable harm and support the delivery of a positive safety culture across the Trust.

Delivery of the 2026/27 Annual Health and Safety Plan will be monitored through the Health, Safety, Security and Fire Group and reported regularly through the Trust's governance framework. Progress will be measured through compliance indicators, incident trends, audit findings, training performance, staff feedback and achievement of agreed programme milestones.

1. Strengthening the Health & Safety Team

- Implement structured personal development plans, supporting qualifications and professional membership.
- Strengthen succession planning arrangements.

Expected outcomes:

- *Improved operational capacity within the Health & Safety team.*
- *Increased technical capacity.*
- *Improved resilience.*

2. Health & Safety Training and Capability

- Develop a comprehensive Trust-wide Health and Safety Training Matrix.
- Identify and address training gaps with new or updated content.
- Collaborate with the Education & Training Team to develop high-quality learning modules.
- Establish a dedicated health and safety area on the CPB hub.
- Promote and embed the work-related stress module for managers to support early intervention and reduce associated absences.

Expected outcomes:

- *Clear visibility of compliance and capability gaps.*
- *Reduced training variation and improved consistency of competencies.*
- *Improved access to training resources.*
- *Earlier identification and interventions for work-related stress & a reduction in work-related stress sickness absence.*
- *Increased health and safety competence amongst line managers, supporting stronger leadership, improved risk management and a positive safety culture.*

3. Strengthening Near Miss Reporting Culture

- Work with DCIQ team to simplify the near miss reporting process.
- Deliver a Trust-wide improvement campaign including communications, training, and roadshows.
- Implement an end-to-end review and learning process for all reported near misses.

Expected outcomes:

- *Increased reporting of near misses, providing evidence of a proactive reporting culture and enhanced workforce engagement in safety improvement.*
- *Improved NHS Staff Survey results in safety-related themes ("we are safe and healthy")*

- *Reduction in staff injuries and associated sickness absence through earlier identification and mitigation of risk.*

4. Reducing Manual Handling Injuries

- Conduct a comprehensive analysis of musculoskeletal (MSK) injury data to identify high-risk activities and locations.
- Run a quality improvement programme aimed at reducing MSK injuries and associated staff absence.
- Implement a structured observation and feedback programme to monitor and improve manual handling techniques.

Expected outcomes:

- *Reduction in manual handling-related injuries, associated sickness absence and RIDDOR-reportable incidents.*
- *Improved compliance with safe systems of work and reduced repeat harm.*

5. Internal Health & Safety Audit Programme

- Develop and deliver a full internal audit of health and safety policies, procedures, and level of organisational compliance.

Expected outcomes:

- *Baseline assessment of organisational compliance.*
- *Identification of systemic gaps and inconsistencies in implementation.*
- *Structured annual audit cycle enabling continuous improvement.*
- *Enhanced Board assurance regarding organisational compliance with health and safety requirements.*

6. Workplace Transport Safety

- Adapt the HSE Workplace Transport Checklist into a digital assessment tool.
- Apply the checklist during all site inspections and analyse the results.

Expected outcomes:

- *A standardised assessment tool used consistently across all sites.*
- *Comprehensive analysis of site-specific transport risks.*
- *Reduction in transport-related incidents.*
- *Improved compliance with HSE requirements.*
- *Increased assurance regarding the effective management of workplace transport risks across the Trust.*

7. Dynamic Risk Assessment Improvement

- Review and update the current dynamic risk assessment training and supporting tools.
- Develop a hazard-prompt checklist for crews.
- Embed the process into EPR to support consistent documentation of dynamic assessments.

Expected outcomes:

- *Updated and simplified DRA guidance embedded across operational teams.*
- *Utilisation of a structured hazard-prompt checklist*
- *Improved documentation, oversight and organisational learning arising from dynamic risk assessments.*
- *More consistent, defensible decision-making in dynamic environments.*

8. Compliance with Regulations (Control of Vibration & Noise at Work)

- Review current Trust controls against HSE guidance (INDG175 and INDG362).

- Undertake noise assessments and monitor trigger times for vibrating equipment.
- Update risk assessments, procedures, and control measures.
- Work with Fleet and Facilities Management (FM) to ensure compliance and complete annual audits.

Expected outcomes:

- *Understanding the Trust's exposure to vibration and noise hazards.*
- *Updated risk assessments and procedures reflecting current HSE standards.*
- *Improved equipment related controls.*
- *Reduced employee exposure to vibration and noise hazards and improved compliance with statutory requirements.*

9. Workplace Inspection Programme

- Review and refine the workplace inspection question set.
- Implement a risk-based schedule:
    - 100% of high-risk sites
    - 50% of medium-risk sites
    - 33% of low-risk sites.

Expected outcomes:

- *Standardised inspection methodology, improving consistency, reliability and comparability of findings.*
- *Enhanced organisational understanding of health and safety risks across the Trust.*
- *Trend analysis and reporting feeding into targeted improvement actions.*

10. Enhancing Learning and Feedback Loops

- Improve review and learning processes following staff safety incidents.
- Strengthen identification of lessons learned to prevent recurrence.
- Provide meaningful feedback to staff who report incidents, reinforcing engagement and trust.

Expected outcomes:

- *Improved quality of investigations and learning following staff safety incidents.*
- *Effective identification of themes, trends, and preventable actions.*
- *Increased staff confidence in reporting processes through timely and meaningful feedback, supported by visible evidence that reported concerns result in learning and improvement.*

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Complaints Annual Review 2025/26
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Assurance

STRATEGIC AIM(S)	Deliver oustanding, inclusive care for everyone we serve							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐
	SR05	☐	**SR06**	☒	**SR07**	☐	**SR08**	☐

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Board of Directors is asked to: • **Receive and note** the contents of the Annual Complaints Report for 2025/26 produced in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. • **Take assurance** from the reduction in complaint volumes, continued improvement in complaint handling performance, and the effectiveness of the Trust's arrangements for managing, investigating and responding to complaints aligned to the PHSO model complaint handling procedure and the expectations of the NHS Complaint Standards. • **Note the key themes and learning** arising from complaints and patient experience feedback, particularly those relating to delays, professional standards, care and treatment, and call handling, and the actions being taken to address these areas.
EXECUTIVE SUMMARY	This report provides an overview of complaints activity, performance, outcomes and learning across the Trust during 2025/26 – see Appendix 1. A total of 2,073 complaints were received during the year, representing a 9% reduction compared to 2024/25. Complaint themes remained consistent with previous years, with delays, professional standards, care and treatment, and call handling accounting for the majority of concerns raised.

	Performance against complaint handling standards continued to improve, with 90% of complaints closed within locally agreed timescales, compared to 86% in 2024/25 and 76% in 2023/24. Key learning can be seen in s9.5 and identifies delays, access issues, call handling and communication, particularly. Professional standards complaints remain significant, reinforcing the importance of supporting staff wellbeing, maintaining compassionate and patient-centred care, and strengthening communication skills. The report also identifies a continuing gap between patient expectations and the service delivery model, demonstrating that clear, timely and consistent communication is critical to improving patient experience, managing expectations, and reducing dissatisfaction.	
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	22 June 2026
	Outcome	Recommended for onward consideration at Trust Board.

1. PURPOSE

The purpose of this annual report is to provide assurance to the Board of Directors regarding the effectiveness of the Trust's complaints management arrangements during the period 1 April 2025 to 31 March 2026. Specifically, the report provides assurance that:

- Robust systems and processes are in place to support compliance with NHS complaints regulations.
- The Trust remains aligned with the Parliamentary and Health Service Ombudsman (PHSO) Complaints Standards and associated guidance on complaint handling.
- Learning arising from complaints is identified, shared and used to support continuous improvement in service quality and patient experience.

This report covers the period from 1 April 2025 to 31 March 2026.

2. BACKGROUND

The Trust has a statutory duty to investigate and respond appropriately to complaints relating to the services it provides, in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and the Health and Social Care Act 2014.

In discharging these responsibilities, the Trust works collaboratively with partner organisations where complaints span multiple providers, ensuring that concerns are investigated comprehensively and that, wherever possible, patients, families and representatives receive a coordinated and timely response. This approach supports effective complaint resolution, organisational learning and the continued improvement of patient experience.

3. ANNUAL REVIEW 2025-26

Complaint activity during 2025/26 has reduced compared with the previous year and remains stable across all service lines. Performance against complaint handling standards has continued to improve, with 90% of complaints closed within agreed local timescales and only one complaint exceeding the six-month statutory threshold.

Complaint themes remain consistent with previous years and are principally associated with delays, professional standards, care and treatment, and call handling and these themes align with findings from patient experience surveys.

Learning from complaints continues to inform service improvement across the organisation, while the low number of PHSO referrals and financial redress cases provides additional assurance regarding the effectiveness of complaint response arrangements.

Overall, the report provides assurance that the Trust maintains an effective complaints management system, is responsive to patient feedback, and continues to

use complaint intelligence to drive improvements in quality, safety and patient experience.

A detailed review of the activity for the period 1 April 2025 to 31 March 2026 is attached as appendix 1.

4. EQUALITY/ SUSTAINABILITY IMPACTS

Equality Impacts

The report demonstrates the Trust's continued commitment to improving its understanding of the experiences of patients and service users from diverse communities. During 2025/26, the PALS and Resolution Team strengthened the collection and analysis of Equality, Diversity and Inclusion (EDI) data within the complaints process, supporting a more informed approach to identifying potential health inequalities and barriers to access.

Analysis of complaints data has highlighted ongoing challenges relating to the completeness of ethnicity and disability information, and work is underway in partnership with the Patient Inclusion Manager, EDI Team and Patient Engagement Team to improve data quality and strengthen organisational insight. The development of a shared patient experience dashboard, incorporating complaints, compliments and patient feedback, supports the identification of trends across protected characteristics and enables targeted improvement activity.

The report also highlights that low levels of complaints from particular communities should not be interpreted as an absence of inequalities. The Trust continues to undertake targeted engagement with underrepresented groups to better understand lived experiences, improve access to services, and ensure that all communities have opportunities to influence service improvement through feedback and engagement

Sustainability Impacts

There are no direct environmental sustainability impacts arising from this report. However, the continued focus on learning from complaints, improving patient experience, enhancing communication, and strengthening service delivery supports the long-term sustainability of Trust services by promoting continuous improvement, maintaining public confidence, and ensuring resources are used effectively to address recurring themes and areas of dissatisfaction.

COMPLAINTS ANNUAL REVIEW

2025/26

NHS
North West Ambulance Service
NHS Trust

Table of Contents

1	Introduction	3
2	Summary of Complaint Activity 2025/26	3
3	Complaint Activity	4
4	PALS and Resolution Performance	8
5	Complaint Outcomes	10
6	Financial Redress	12
7	Re-opened Complaints	12
8	Parliamentary and Health Service Ombudsman	12
9	Learning from Complaints	12
10	Equality, Diversity and Inclusion	14

1. INTRODUCTION

1.1 The North West Ambulance Service (NWAS) is committed to providing high standards of care which is centred on its patients and service users. NWAS welcomes all forms of patient and service user feedback, including complaints, as an important source of assurance regarding service quality, patient experience, and opportunities for improvement.

1.2 Complaints that are raised by service users are managed by the Patient Advice and Liaison Service (PALS) and Resolution Team. The PALS function is responsible for managing new enquiries and lower-level complaints whilst the Resolution function deals with more complex complaints, categorised as either medium or high in complexity.

1.3 Complaints are handled in accordance with the requirements of the Local Authority Social Services and National Health Service Complaint Regulations 2009 (the 2009 Regulations), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations) and the Good Complaint Handling Principles from the Parliamentary Health Service Ombudsman (PHSO).

1.4 The PALS and Resolution team ensure that all investigations are conducted in an open and honest manner, in line with relevant legislation and the Model Complaint Handling Procedure issued by the PHSO. The aim is to achieve a timely and satisfactory resolution for complainants while maintaining compliance with best practice standards.

2. SUMMARY OF COMPLAINT ACTIVITY 2025/26

2.1 During 2025/26, NWAS received **2,073** complaints, representing a 9% reduction from 2,277 in 2024/25. The sustained reduction in complaint volumes, alongside improved timeliness of resolution, provides assurance that complaint activity remains stable and proportionate to service demand. A significant proportion (**89%**) of the complaints we received were low complexity and were effectively managed by the PALS team through early resolution, supported by timely acknowledgment, empathetic communication, and a focus on “good conversation” in line with PHSO Good Complaint Handling guidance.

2.2 The principal themes arising from complaints were delays, professional standards, care and treatment, and call handling. These themes were consistent across service lines and broadly mirror the challenges identified through other patient experience and performance intelligence.

2.3 Performance against complaint handling standards has continued to improve, with 90% of complaints closed within agreed timescales. This represents sustained year-on-year improvement from 86% in 2024/25 and 76% in 2023/24, with one complaint exceeding the six-month closure threshold, and demonstrates a more responsive and effective complaints management process.

2.4 Financial redress was issued in 7 cases where a quantifiable financial loss was identified.

2.5 11 complaints were re-opened during the year, reflecting continued focus on ensuring completeness and accuracy of responses.

2.6 Learning from complaints remains a key priority, with focused insights providing the

opportunity to improve clinical practice, patient safety, staff behaviour, communication, and operational processes. This learning is shared across service lines and embedded within wider quality improvement activity.

2.7 The PALS & Resolution Team also continued to strengthen accessibility, engagement, and service improvement activities throughout the year, alongside ongoing development of staff capability and consistency in complaint handling.

3. COMPLAINT ACTIVITY: A CLOSER LOOK

3.1 Complaint activity has remained stable and well controlled, averaging around 500 complaints per quarter with no sustained upwards trend. A recurring seasonal increase in Q3 (October-December) is evident each year, aligning with known winter system pressures, but this is predictable and not indicative of deteriorating performance.

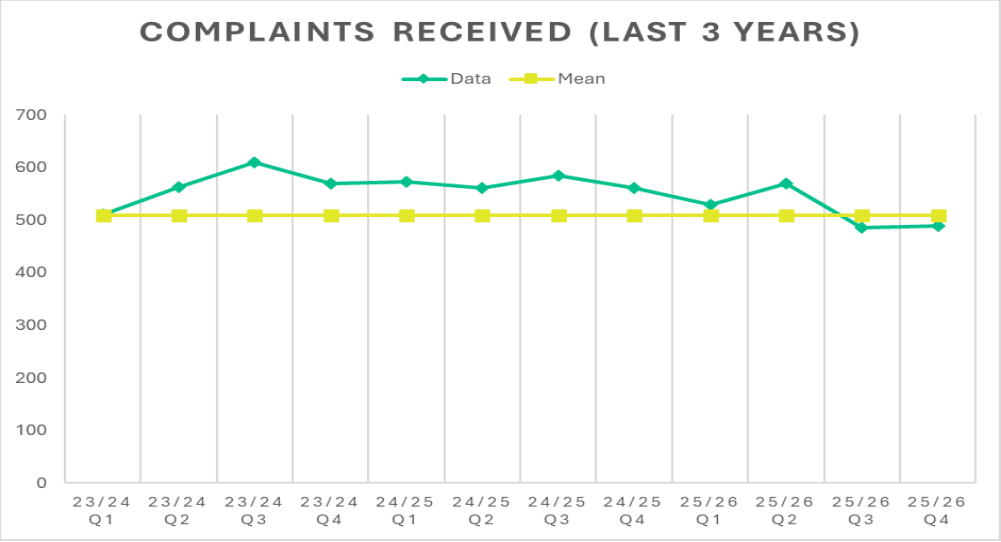


Figure 1: Comparative data of total complaints received.

3.2 Throughout 2025/26, complaint activity has been driven predominantly by low complexity concerns, which form the clear majority (135-190 per month). The volume of medium complexity cases remains modest and stable, while high complexity complaints are consistently low with no evidence of escalation. Notably, periods of increased demand do not correspond with a rise in higher-complexity complaints, indicating that increases in demand have not been associated with a corresponding increase in higher-complexity complaints or concerns relating to patient safety.

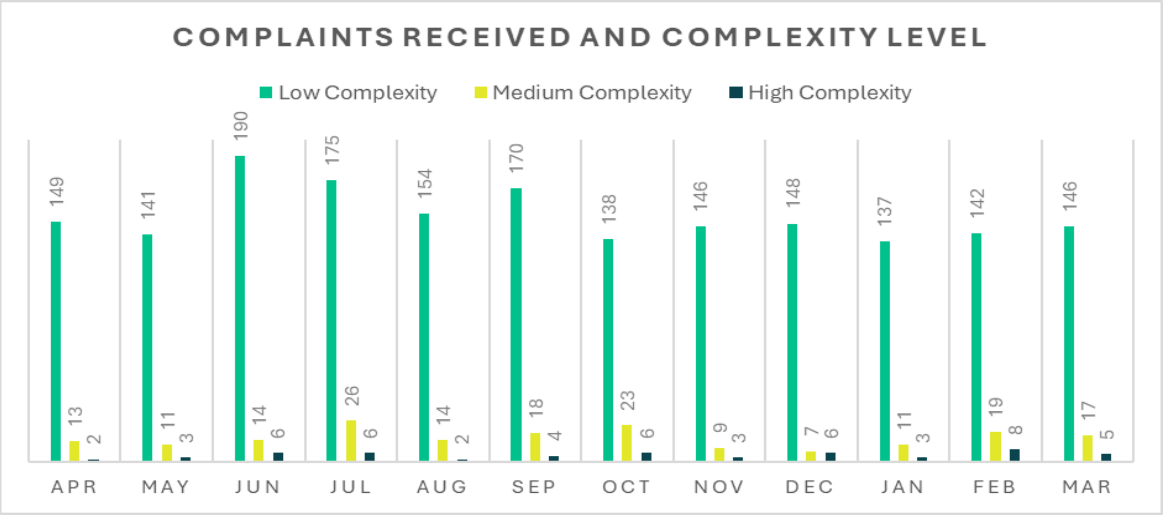


Figure 2: Total complaints received in 2025/26, by month

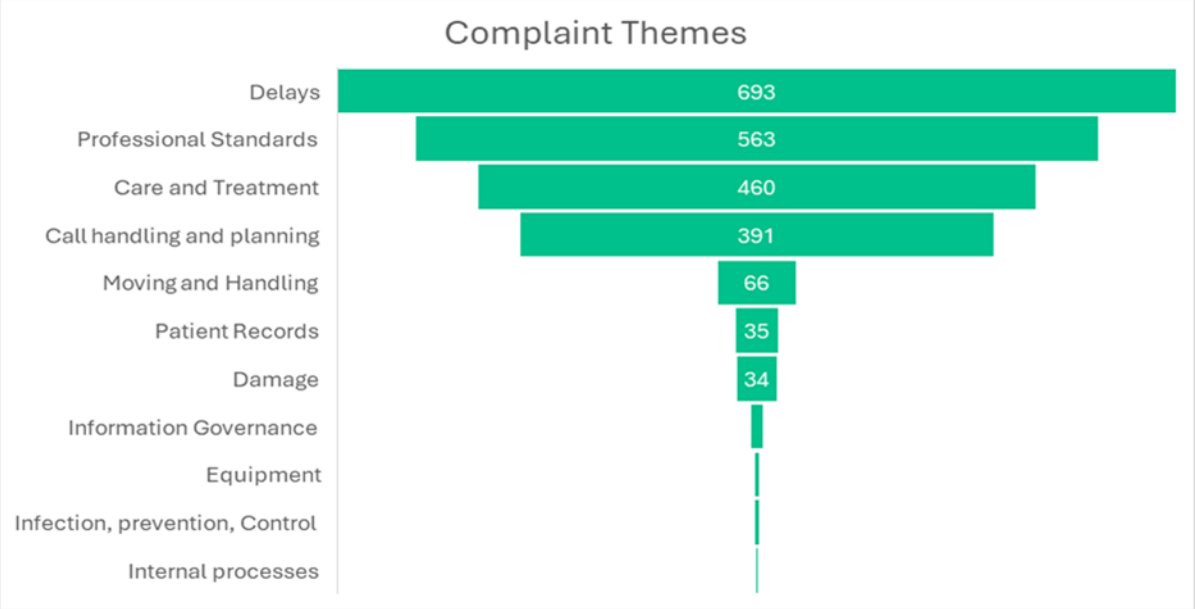


Figure 3: Complaint themes in 2025/26

	PES Operations	PTS Operations	Integrated Contact Centre (111 / PTS / PES)	Total
Delays	13	124	556	**693**
Professional Standards	257	201	105	**563**
Care and Treatment	335	26	97	**460**
Call handling and planning	2	9	379	**391**
Moving and Handling	24	36	6	**66**
Patient Records	28	1	6	**35**
Damage	20	7	7	**34**
Information Governance	6	1	3	**10**
Equipment	1	2	2	**5**
Infection, prevention, Control	0	5	0	**5**
Internal processes	2	0	0	**2**
Total	686	412	1161	**2262**

Figure 4: Complaint themes, per service line. Nb: many complaints include more than one service line so the figure shown here is greater than the total number of complaints.

3.3 Thematic analysis shows complaints are concentrated within a small number of drivers: delays (693) are the largest contributor, followed by professional standards (563), care and treatment (458), and call handling and planning (390), with all other themes comparatively low.

3.4 Overall, complaint volumes and themes remain broadly stable, with the majority linked to service delivery pressures and patient experience factors rather than concerns indicating significant or emerging patient safety issues.

COMPLAINT THEMES: ALIGNMENT WITH PATIENT EXPERIENCE SURVEYS

3.5 Throughout 2025/26, the Resolution & PALS team have been collaborating with the Patient Engagement Team to try to bring together the insights from the complaints that we receive and the feedback provided by way of patient experience surveys. A joint dashboard report is now regularly shared with Senior Leaders in Service Delivery.

3.6 The themes arising from complaints align with the areas of dissatisfaction identified through the Friends and Family Tests and Patient Experience surveys carried out by the Patient Engagement Team. Dissatisfaction surrounding delays emerged as a consistent issue across Patient Emergency Service (PES) and Patient Transport Service (PTS). Similarly the concerns about professional standards in complaints are reflected in patient feedback where poor ratings of the service were due to poor communication, lack of empathy and not feeling listened to. Also, care and treatment complaints align with patient feedback relating to incorrect diagnosis and/or advice, perceived lack of knowledge from call handlers and unmet expectations of care.

3.7 The following information has been contributed to the report by the Patient Experience Team in order to provide a more holistic view of the patient feedback that the trust receives. Work is ongoing to further evolve the joint dashboard and report

Patient Experience Surveys

3.8 Figure 5 below provides a summary matrix of response across the four core patient experience surveys of: PTS, PES, Urgent Care and NHS 111.

2025 - 2026 Patient Engagement Surveys

SMS Text Delivery/Postal/On-line

April 2025 - March 2026 *

Service Line	Cared for appropriately with Dignity, Compassion and Respect (Strongly Agree/Agree)					Overall Satisfaction Received (Very Satisfied/Fairly Satisfied - Yes)					Overall Experience of Service / Recommend Ambulance Service to Friends and Family (Very Good/Good - Extremely likely/Likely)				
	Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD	Q1	Q2	Q3	Q4	YTD
Patient Transport Service	93.5%	92.8%	92.4%	92.0%	92.7%	n/a	n/a	n/a	n/a	n/a	90.6%	89.6%	92.1%	90.0%	90.6%
Paramedic Emergency Service	94.4%	94.0%	91.6%	91.2%	93.5%	n/a	n/a	n/a	n/a	n/a	94.4%	93.2%	93.9%	91.2%	93.1%
Urgent Care Service	94.4%	91.7%	96.2%	93.1%	94.0%	n/a	n/a	n/a	n/a	n/a	87.5%	82.1%	91.8%	84.7%	84.4%
NHS 111 Service	95.5%	95.0%	91.3%	84.8%	92.1%	86.1%	86.4%	86.8%	82.3%	85.8%	85.9%	87.1%	91.6%	89.8%	88.8%

PTS

3.8 Cumulatively, the overall experience scores were:

- 90.56% rated as 'very good/good'
- 5.16% rated as 'poor/very poor'.

The key themes PTS users liked about their experience were the friendliness and helpfulness of professional staff, both when booking, as well as when on transport journeys; the efficient service which was reflected in the timeliness of pick-ups and drop offs.

Where PTS users indicated they disliked their experience, the themes were long wait times, especially for return journeys home from appointments, which caused a great deal of frustration and stress; communication issues, not being updated on transport delays or changes to booking.

PES

3.9 Cumulatively, the overall experience scores were:

- 93.1% rated as 'very good/good'
- 4.69% rated as 'poor/very poor'.

Where experience was positive, the themes of the feedback centered around professionalism, caring and reassurance shown by very knowledgeable paramedics; excellent service in the treatment and support provided by the crews, during stressful times.

The themes around feedback for poor experience were centered around frustrations with long wait times and poor communication; a lack of empathy, feeling dismissed by emergency services staff.

NHS 111 SERVICE

3.10 Cumulatively, the recommend scores were:

- 88.78% rated as 'extremely likely/likely'

- 4.20% rated as ‘unlikely/extremely unlikely’.

Where a positive experience was had and they would recommend the service, the themes were around polite, helpful and caring call handlers, who were reassuring and calming; fast response in arranging next steps in the process; appreciation of being able to access medical advice very quickly.

In the areas where NHS 111 callers were unhappy about their experience, the themes were around the long wait time for call backs from clinicians; the triage process that is very prescriptive and rigid in the nature of the script.

4 PALS AND RESOLUTION PERFORMANCE

4.1 The PALS team promotes early resolution and high standards of customer service through proactive engagement and effective communication. Wherever possible, complaints are addressed through an initial “good conversation,” enabling concerns to be resolved promptly and informally.

4.2 The PALS and Resolution Team appreciate that raising a concern with a large organisation such as NWAS can feel daunting for complainants and may sometimes be perceived negatively. The Team is committed to ensuring this is not the case, and to making sure individuals feel listened to and supported, with concerns addressed effectively at first resolution wherever possible, avoiding the need for complaints to be reopened.

4.3 Where a complaint is resolved within one working day, the case is recorded on the DCIQ system and closed verbally with feedback shared with the relevant service line to support learning and improvement. **424 cases were closed within 1 working day, which is 20% of total complaints closed for 2025/26.**

4.4 Where further review is required, cases can be managed as an early resolution case with a target resolution timeframe of 10 working days. **794 cases were closed within 10 working days, which is 38% of total complaints closed for 2025/26**.

4.4 Alternatively, cases can be managed as a low-level complaint to be closed within 20 working days in accordance with the Complaints Policy and Service Level Agreement (SLA). PALS performance reporting is measured against the proportion of cases closed within the 20-working day target. **1,831 low level complaints were closed and 1,660 (91%) were closed within SLA.**

4.5 Resolution performance reporting is also measured by the timely closure of cases, which is within 40 working days for medium complexity and 60 working days for high complexity matters. Whilst excellent communication with the enquirers is still expected, there is more planning, review and analysis of an incident that is completed and incorporated into a report and response for medium and high complexity complaints. **193 medium complexity complaints were closed and 166 (86%) were closed in SLA. 52 high complexity cases were closed, with 25 (48%) being closed within SLA.**

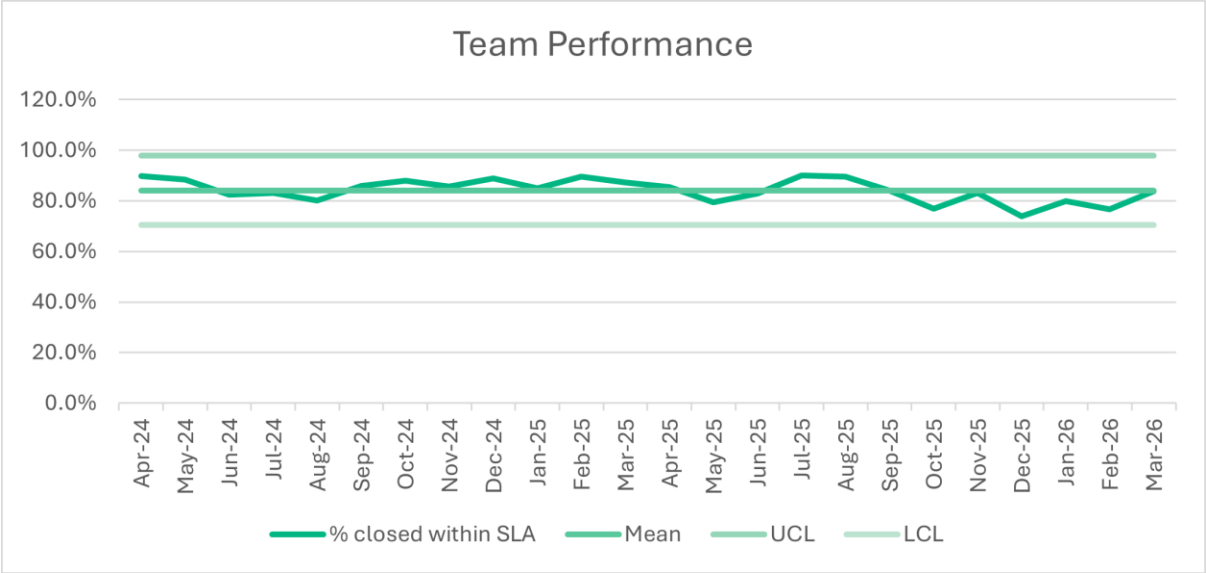


Figure 6: Team Performance

4.6 There are also often factors outside the control of the case handler that influence high complexity complaints, such as external factors or parallel process which can delay the findings being approved and sent to the enquirer.

4.7 All complaints should be acknowledged within 3 days and closed within 6 months, in line with the NHS Complaints Standards legislation. We have a robust administrative process and are confident in the effective management of incoming complaints received via telephone, email, or online form.

4.8 Only 1 complaint was managed outside of the 6 months during 2025/26. This was a complaint where internal HR processes were progressing parallel to the complaint and conclusions were delayed due to the complexities of internal matters. The complaint was closed 11 days outside of the 6-month timeframe.

4.9 The PALS & Resolution team overall performance for **closure of complaints within SLA was 90%**, which is a year on year improvement from 76% in 2023/24 and 86% in 2024/25.

5 COMPLAINTS OUTCOMES

5.1 2,066 complaints were closed in 2025/2026**.** The PALS and Resolution Team uses DCIQ data to track outcomes, identify themes, and highlight risks to support learning and improvement.

5.2 Complaints are upheld where care or service falls below expected standards, including delays linked to call handling, resourcing pressures, or missed ARP/PTS targets which have resulted in missed NHS appointments. Many are partly upheld, recognising patient experience and perception even where no misconduct is found, with a focus on feedback and learning. Not upheld complaints confirm appropriate care or reflect factors outside the Trust's control.

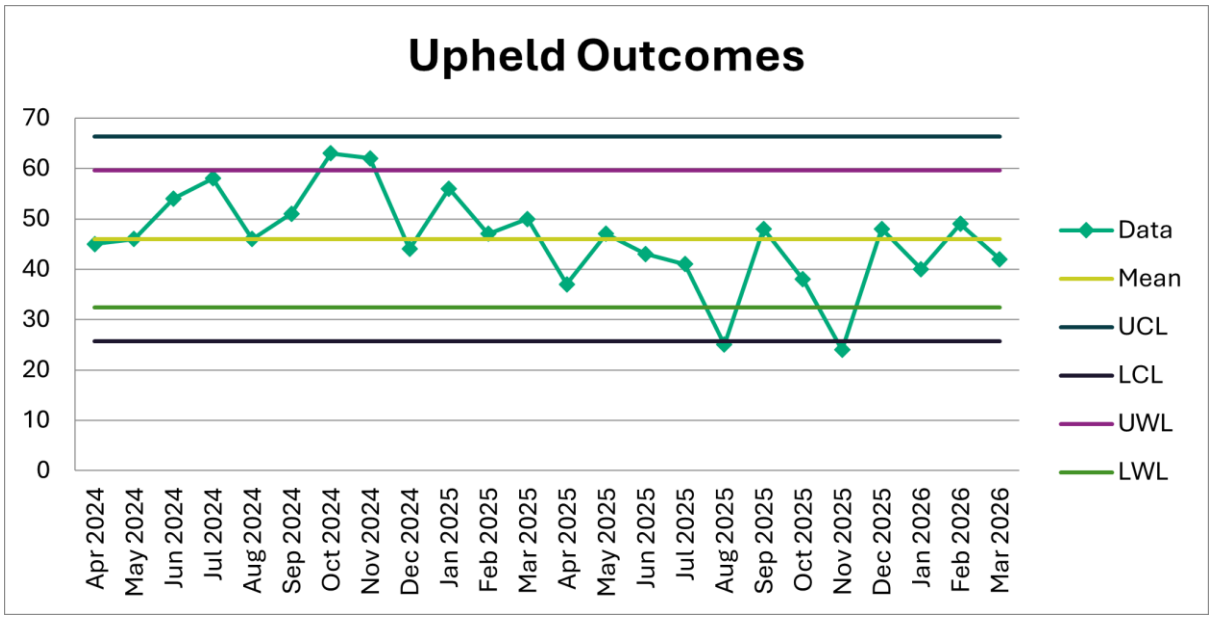


Figure 7: Upheld outcomes

Complaint Outcome	Complaint Level		Total
Upheld	High	23	481
	Medium	56	
	Low	402	
Not Upheld	High	13	834
	Medium	80	
	Low	741	
Partly Upheld	High	14	751
	Medium	56	
	Low	681	

Figure 8: All complaint outcomes

The distribution of complaint outcomes remains broadly consistent with previous years. Partially upheld complaints continue to reflect the complexity of many cases, where aspects of the patient experience may not meet expectations despite no identified failings.

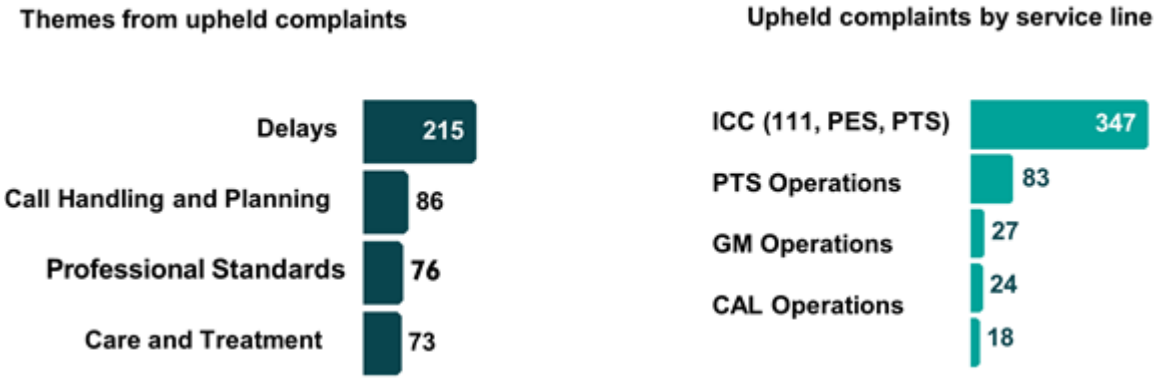


Figure 9: Themes from upheld complaints and upheld complaints by service line

6 FINANCIAL REDRESS

6.1 Financial redress is considered in line with Parliamentary and Health Service Ombudsman (PHSO) guidance, with the aim of restoring complainants, as far as possible, to the position they would have been in had the service been delivered appropriately. Where complaints are upheld in full or in part and a quantifiable financial loss is identified as a direct result of Trust

actions or omissions, consideration is given to appropriate financial remedy. **In 2025/26, 7 cases resulted in an outcome of financial redress.**

Service Line	Reason	Amount
ICC	Forced Entry	Referred to legal as amount exceeds Redress Policy (£500)
ICC	Forced Entry	£474
ICC	Forced Entry	£230
PTS Ops	Damage to wheelchair	£10
PTS Ops	Damage to property by driver of ambulance	£90.84
PES Ops	Damage to flags on driveway	£480
PES Ops	Carpet stains	£300.98

Figure 10: Financial redress payments

7 RE-OPENED COMPLAINTS

7.1 The team continues to embed a “one response, once” approach, following improvements made to response letters during the previous financial year. This is done by clearly agreeing issues at the outset, maintaining regular communication and sharing findings for discussion before issuing final responses. Where enquirers later request clarification or raise additional points, cases are reopened to ensure that these are fully explored and addressed through a supplementary response. **During 2025/26, 11 cases were re-opened for a further response.**

8 PARLIMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO)

8.1 Where complainants remain dissatisfied at the completion of the Trust’s complaints process, they may choose to refer their concerns to the Parliamentary and Health Service Ombudsman (PHSO) for an independent review.

8.2 In 2025/26, NWAS received notification that the PHSO had received 9 referrals, of which 6 remain under investigation. PHSO closed 6 cases during the reporting period of which 4 were closed at initial assessment with no failings identified, and 2 were not upheld following completion of PHSO’s full review. The limited number of referrals to the PHSO, together with the absence of upheld findings in completed reviews during the reporting period, provides external assurance regarding the quality and robustness of the Trust's complaint handling processes.

9 LEARNING FROM COMPLAINTS

9.1 Complaints, concerns, and patient feedback provide valuable opportunities for the Trust to identify learning, improve patient experience, and strengthen service delivery. Information recorded within the DCIQ system enables themes, trends, and recurring issues to be analysed and monitored across the organisation.

9.2 Learning identified through complaints is shared with local service lines and management groups to support reflective practice, service improvement, and operational oversight. Where wider organisational themes are identified, this learning also informs Trust-wide actions, including the implementation of new processes, guidance, and quality improvement initiatives aimed at improving patient care and experience.

9.3 At the commencement of 2025/26, modifications were made to the complaint's DCIQ module in order to capture and identify the learning outcomes from upheld complaints for example, where individual learning/action was required.

9.4 Learning identified through complaints aligns with some areas of dissatisfaction identified by the Friends and Family Tests for PES, which rated the service as poor due to issues with incorrect diagnosis and poor attitude, and PTS, which rated the service as poor due to issues with taxis/third-party service providers, along with comfort and safety concerns.

9.5 Through Q3 and Q4, a strategic foresight approach has been adopted to identify key areas of learning and enable focused actions. The key learnings identified are as follows:

Access, delays and caller experience remain the primary drivers of dissatisfaction. With continuing volumes of delays and call handling & planning complaints, particularly within ICC, improvements in relation to telephony access, queue experience, and proactive communication remains crucial.

End-to-end patient journey issues are increasing. The continued high volumes of multi-service complaints highlights the need to focus on whole-system pathways rather than isolated service improvements.

PTS operational pressures continue to impact experience. Delays and professional standards complaints within PTS indicate ongoing challenges in scheduling, resource allocation and communication. Steps to strengthen booking, dispatch and expectation-setting remains a key area for focus.

Compassion fatigue leading to poor professional conduct. Professional standards complaints remain a significant contributor to overall complaint volumes, highlighting the importance of supporting staff wellbeing, strengthening communication skills and maintaining a compassionate patient-centred culture.

Persisting gap between patient expectations and service delivery. Many complaints reflect perceived experience rather than clinical failure, reinforcing the importance of clear, consistent communication.

10 EQUALITY DIVERSITY AND INCLUSION

10.1 During 2025/26, the PALS and Resolution team has strengthened its approach to identifying and addressing health inequalities through improved data collection, analysis and partnership working. From April 2025, the team began systematically capturing Equality, Diversity and Inclusion (EDI) date across complaints including gender, ethnicity and disability as mandatory within the DCIQ system.

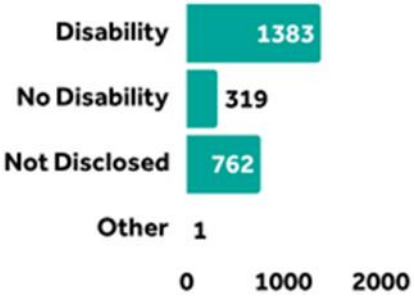
10.2 Where gender was known, 56% of complainants were female and 44% were male.

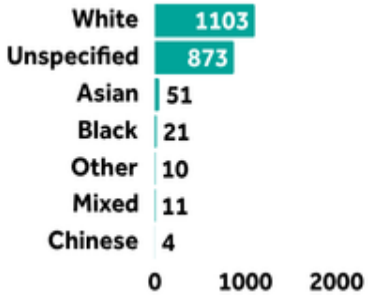
10.3 Disability data shows that 31% of disability records were not disclosed, limiting insight. It is important to note that the Trust's Patient Transport Service predominantly supports patients with mobility needs, long-term conditions and other vulnerabilities; therefore, a higher proportion of service users, and consequently complainants, are people with disabilities.

Interestingly, the Patient Engagement team reported that mobility impairment was the most commonly reported disability, especially within PTS Patient Experience surveys (67.3%) and PTS Friends and Family Tests (44.8%).

10.4 It should also be noted that some patients have multiple disabilities that are populated within one complaint. Therefore, the total number of complaints by disability, is not often the same total of complaints.

10.5 While ethnicity data completeness remains a challenge (42% recorded as unspecified/not stated), action is underway to improve data quality and strengthen the Trust's understanding of the experiences of different communities.





10.6 The above ethnicity data does align with that obtained by the Patient Engagement team where most respondents reported White ethnicity, ranging from 87.2% to 94.0% across the surveys, while representation from other ethnic groups remained low.

10.7 The team have worked collaboratively with the Patient Inclusion Manager, EDI Advisor and Patient Engagement Team to improve data quality and staff understanding of EDI data collection. This intelligence has been used to guide action. A shared patient experience dashboard has been developed, triangulating complaints, compliments and feedback to identify trends by protected characteristics and support targeted improvements. Community engagement activity, including work with underrepresented groups, is ongoing to address disparities in service use and voice.

10.8 The Trust recognises that low complaint volumes from specific communities do not necessarily indicate equitable experience or access. Ongoing work therefore focuses on improving community engagement, understanding barriers to access, and ensuring that all communities can influence service improvement through feedback and lived experience.

A YEAR IN PALS & RESOLUTION

APRIL 2025

A one-day Plain English course improved the clarity, consistency, and accessibility of response letters, supporting transparent, empathetic communication and enhancing customer experience.

MAY 2025

Since May 2025, the Resolution Manager and PALS Team Leader have met with the Patient Engagement Team aligning insights from engagement surveys, patient feedback and complaints and reporting via the Service Delivery Assurance Group.

JUNE 2025

From June 2025, Resolution Team representatives have supported the Patient Inclusion Group, improving engagement with underrepresented communities and inclusivity.

JULY 2025

Resolution Team members completed Human Factors training, facilitated by the PSIRF team, strengthening investigative practice and improving complaint handling and learning.

SEPTEMBER 2025

The team assumed responsibility for NHS 111 complaints from the 111 service, supporting integration through training and system changes to deliver a consistent, streamlined approach.

JANUARY 2026

The Resolution Manager enabled team members to lead parts of meetings, building confidence, leadership skills, and professional development.

FEBRUARY 2026

The team shifted in their reporting style to a proactive and foresight approach rather than a retrospective approach which is informing service lines of future challenges and opportunities rather than simply reporting on past performance.

MARCH 2026

PHSO representatives attended a team meeting to outline the escalation process and host a Q&A session. The team developed an SOP to manage AI-generated complaints, supporting clear, consistent responses in line with Trust values and NHS standards.

THROUGHOUT 2025/26

The team invested in their own development and improvement, strengthening patient experience and organisational learning. The team also delivered ICC engagement sessions and complaints training to support consistency, collaboration, and investigative practice.

Thank You

If you have any questions or require further assistance, please don't hesitate to contact us.

Michelle Wainwright, Resolution Manager

michelle.wainwright@nwas.nhs.uk

Lois Peterson, Head of Legal & Resolution

lois.peterson@nwas.nhs.uk

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Annual SIRO Report - 2025/26
PRESENTED BY	Executive Director of Finance (SIRO)
PURPOSE	Assurance

STRATEGIC AIM(S)	All strategic aims							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☐	**SR03**	☐	**SR04**	☐
	SR05	☐	**SR06**	☒	**SR07**	☐	**SR08**	☒

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Trust Board is asked to note the contents of the report and the assurance it provides.
EXECUTIVE SUMMARY	The Senior Information Risk Owner (SIRO) annual report presents a summary of our Information Governance (IG) for the financial year and compliance with regulatory and contractual compliance. **Data Security and Protection Toolkit** The Data Security and Protection Toolkit (DSPT) is an online self-assessment that allows organisations to measure their performance against the National Data Guardian's data security standards. The DSPT for 2024/25 was submitted in June 2025. The trust submitted for 'Standards not met' and provided an improvement plan in July 2025 which improved the rating to '**Approaching standards'.** A DSPT Task and Finish group was established for the 25/26 period. An MIAA audit was completed on 10th March 26. The second phase of this audit took place on 27th May 26. The deadline for submission of the DSPT is 30th June. **Information Asset Register** An information asset register (IAR) is a comprehensive catalogue of every information asset (IA) held by NWAS. An information asset is a body of information that is defined and managed as a single unit so it

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

can be understood effectively. The trust is responsible for creating an Information Asset Register.

Work has been underway to improve the Information Asset Register including the creation of an essential function list and engagement with stakeholders responsible for these systems (IAOs and IAAs). A new system called IT Health has also been procured to hold the IAR in a more modern and usable format.

Freedom of Information Requests
A total of **555 FOI requests** have been received during the financial year 25/26 which is an increase of **11.67% (58 more requests)** compared to the previous reporting period.

Individual Rights
A total of **4,233 Subject Access Requests (SAR)/Access to Health (A2H) requests** have been received for the financial year 25/26. This is an **increase of 37.03% (1,144 more requests).**

During this period 27 SARs breaches the legal timeframe of responding to the data subject within one calendar month.

Body Worn Video Camera (BMVC) Requests
A total of **9** requests for BWVC footage relating to incidents categorised as "Violence & Aggression" have been received within the reporting period. This is a decrease of 60%.

Complaints
During the reporting period, the Data Protection Officer (DPO) received 24 complaints. This is a 100% increase from the previous year (12 complaints). 2 remain open and are being actively investigated. The rest have been closed.

Data Protection Impact Assessments
There were 3 Data Protection Impact Assessments (DPIAs) completed during the reporting period

There were 9 Information Sharing Agreements completed during the reporting period.

Data Breaches
During the reporting period, a total of 197 data breaches have been reported via Datix IQ (DCIQ). This is an increase of **40 (25.48%)** compared to the previous year.

The most frequently reported category remains "Data Confidentiality" which accounted for **81 (41.15%)** of the 197 incidents. Data confidentiality incidents cover a broad variety of incidents such as incorrect paper being included within a meeting pack or improper storage of paper records.

Externally reportable breaches

	There were 6 externally reportable data breaches that met the threshold to be reported externally via the DSPT reporting tool. **Risks** The Information & Cyber Governance Group reviews all governance and cyber risks each meeting. At the end of April 2025, 1 risk remains open on the Information Governance Risk Register and will be reviewed for closure in July 2026. **Records Management** Records Management has now returned to the remit of Information Governance in the restructure of the digital directorate. Records Management mandatory training is currently at **88.49%**. The trust has achieved a **91.54% (optimal)** rating in December 2025 on the National Archives S46 Code Self-Assessment Tool for Public organisations.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 24 July 2026
	Outcome	Noted

1. Background

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

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

- UK Data Protection Act 2018 (DPA)
- UK General Data Protection Regulation (GDPR)
- Access to Health Records Act
- Computer Misuse Act
- Records Management Code of Practice 2021
- Caldicott Principles
- Network and information Systems (NIA) regulations 2018
- Data Use and Access Act (DUAA)2025

To demonstrate compliance against these key legal requirements and standards, the trust reports key updates to the Information and Cyber Governance Group.

The trust Senior Information Risk Officer (SIRO) is accountable for Information Governance within the trust and is supported by the Medical Director, who is the Caldicott Guardian. The Caldicott Guardian is responsible for protecting confidentiality of people's health and care information and making sure it is used properly. The current SIRO is the Director of Finance.

2. Data Security and Protection Toolkit (DSPT)

The Data Security and Protection Toolkit (DSPT) adopted the National Cyber Security Centre's (NCSC) Cyber Assurance Framework (CAF) as the foundation for cyber security and information governance assurance. The reporting period is the second year of the DSPT's aligning with the Cyber and Assurance Framework.

DSPT 2024/25

The DSPT for 2024/25 was submitted in June 2025. The trust submitted for 'Standards not met'. This outcome was reaffirmed by audits completed by MIAA in 2025. The trust submitted an improvement plan in July 2025 which improved the rating to **'Approaching standards'.**

The requirements of the DSPT that the trust was not compliant in included:

- A3.a **Asset Management**
- B2.a **Identify verification, authentication, and authorisation**
- B2.c **Privileged user management**
- B2.d **Identity and risk management (IdAM)**
- B4.a **Secure by design**
- B4.b **Secure configuration**

- B4.d **Vulnerability management**
- B5.a **Resilience preparation**
- B5.b **Design for resilience**
- D1.b **Response and recovery capability**

The improvement plan sought to address the above non-compliant criteria in order to achieve 'Standards Met' for 2025/26.

DSPT 2025/26

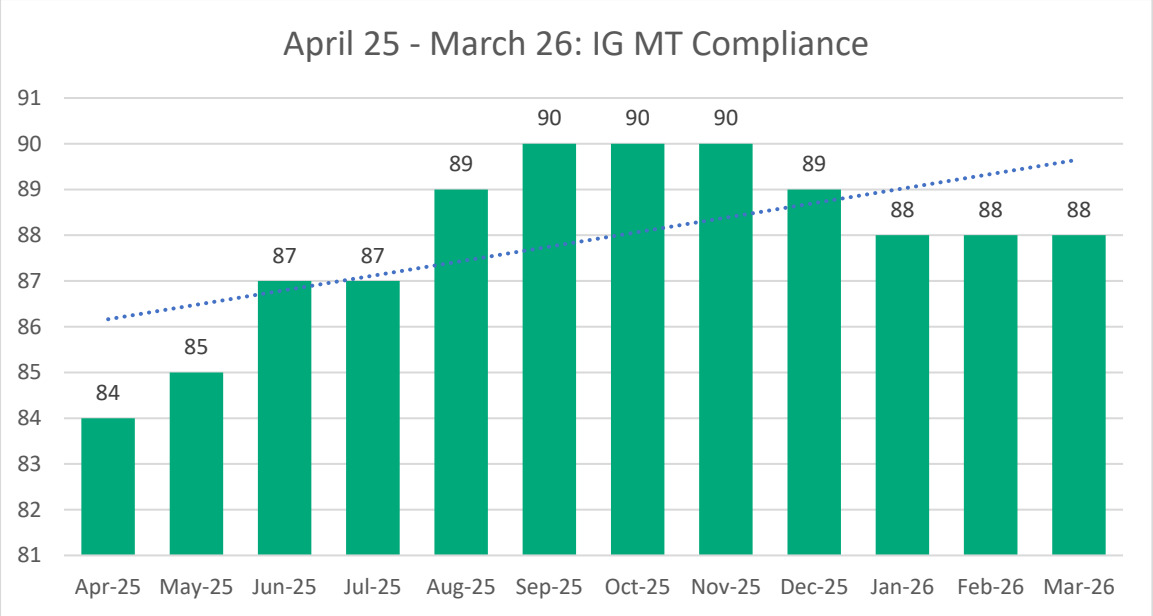
The DSPT requirements for 2025/26 reporting builds on these changes by including:

- Stronger evidence requirements
- Greater leadership accountability
- Enhanced focus on risk, assets, and suppliers
- Focus on measurable resilience

A task-and-finish DSPT Group including key staff members such as the Cyber lead and IG manager, have met every Monday to scope and source evidence for the DSPT objectives. An audit undertaken by the Mersey Internal Audit Agency (MIAA) was completed on 10th March 2026. The results from the first phase of this audit were received on 20th April 2026, highlighting gaps in the evidence submitted thus far. Work was undertaken around additional evidence in preparation of the second audit. The second phase of the audit was undertaken on 27th May 2026. The deadline for final submission of the DSPT is 30th June 2026. Positive feedback was received on the day of phase 2 audit from the auditor, with a deadline given to produce remaining evidence by 10th June. An interim report will be submitted by the auditor to be signed off by the trust SIRO, this will highlight achievements and give assurance to the Board. The final MIAA report will be uploaded on the DSPT as one of the contributing outcomes.

IG Mandatory Training

During the reporting period, the Information Governance (IG) mandatory training compliance stands at 86.71% (averaged compliance between April 2025 to March 2026). To meet compliance standards, NWAS requires that IG and Data Security Training be maintained at 90% or above.



2. Information Assets

An Information Asset Register (IAR) is a centralized catalogue of the information our organization holds. It is a master map of the organisation's data—where it lives, who is responsible for it, and how it is protected. Information assets have recognisable and manageable value, risk, content, and life cycles. The trust is responsible for creating and maintaining an Information Asset Register.

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

- An approved Data Protection Impact Assessment (DPIA) if applicable
- System Level Security Policies (SLSP) if required
- Backup process documentation
- Data flow documentation

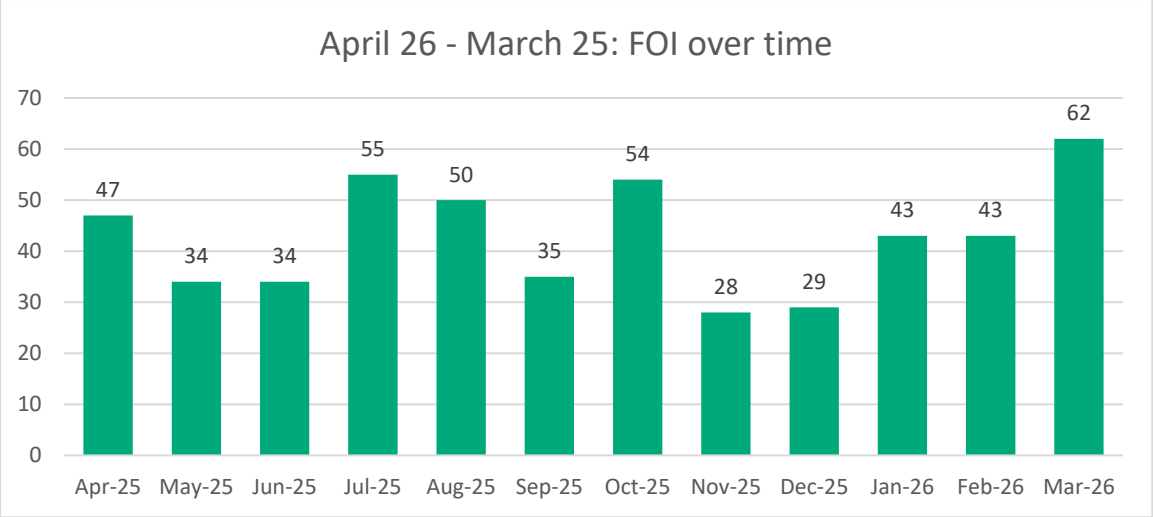
As part of the digital restructure and changes to Information Asset Owners, the IAR will be re-reviewed for the period 2026/27.

Work has been underway to improve the Information Asset Register including the creation of an essential function list and engagement with stakeholders responsible for these systems. A new system called IT Health has also been procured to hold the IAR in a more modern and usable format.

3. Freedom of Information (FOI) Requests

During this reporting period, **20** Freedom of Information (FOI) requests were responded to outside the 20-working day timeframe due to awaiting a response from an internal department, maintaining full compliance with the relevant statuary deadline. This demonstrates a consistent commitment to timely responses, enduring that public accountability and transparency requirements are met.

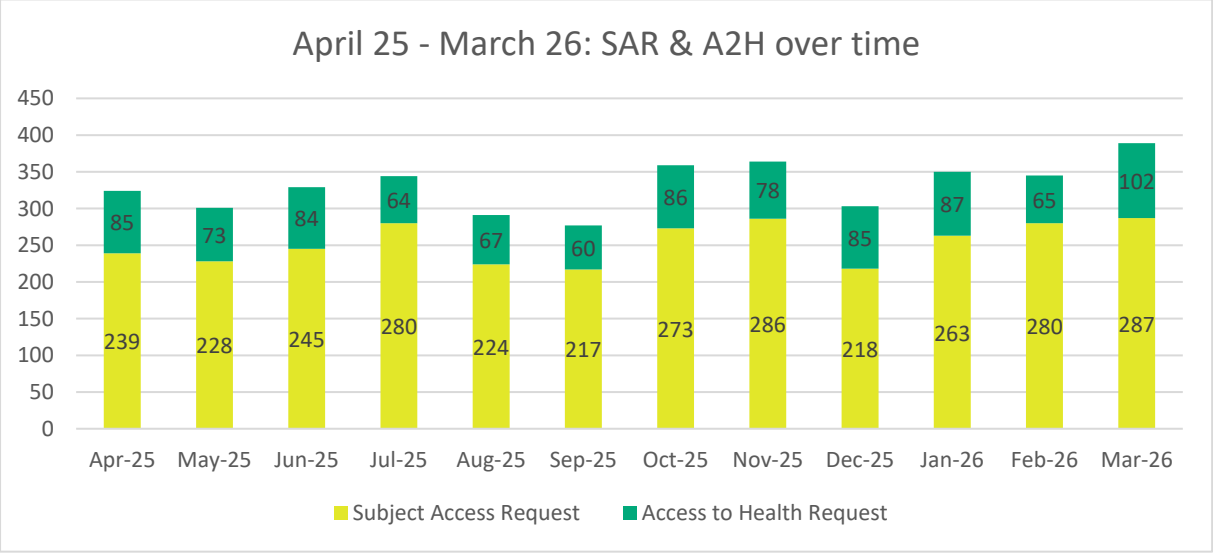
A total of **555** FOI requires have been received during the financial year 25/26 which is an increase of **11.67% (58 more requests)** compared to the previous financial year.



4. Individual Rights Requests (Subject Access Requests (SAR) / Access to Health Requests (A2H))

During the reporting period, **27** Individual Rights requests exceeded the legally mandated timeframe due to the increasing number of requests and increase of HR and complex requests.

A total of **4,233 SAR/A2H requests** have been received during the financial year 25/26 which is an increase of increase of **37.03% (1,144 more requests).** Assuming a minimum time take to complete a SAR/A2H is 30 minutes and maximum for a complex SAR/A2H being 2 hours **– this equates to a minimum increase of 76.25 7.5 hour working days or a maximum increase of 305.06 7.5 hour working days in terms of increased workload for the Individual Rights Team.**

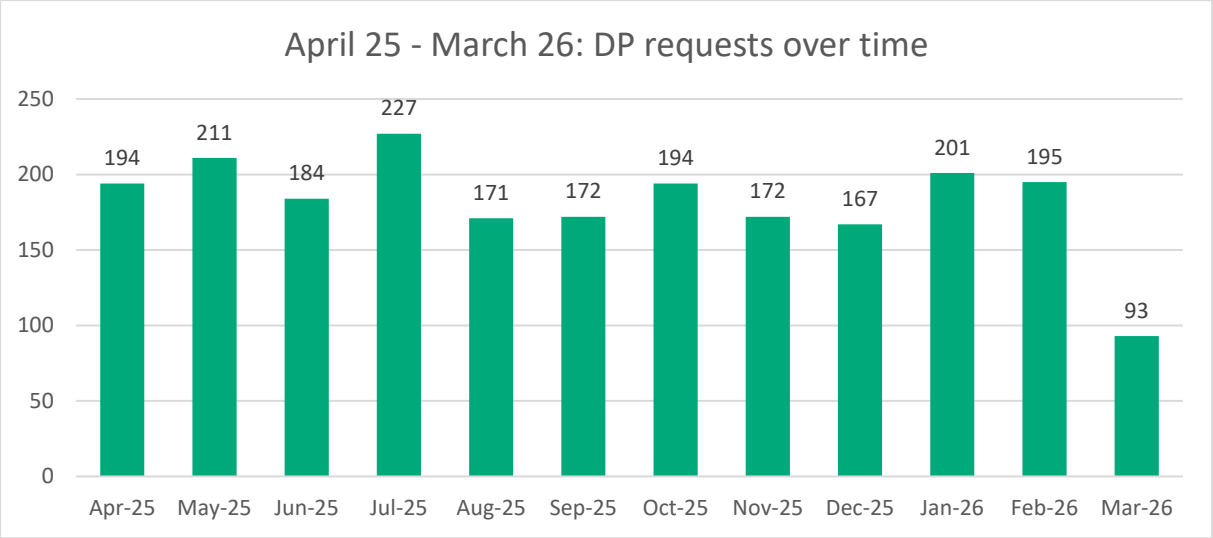


The increasing number of SARs/A2H continue to create pressure for the team and has resulted in higher-than-normal number of data breaches, complaints, and chase emails causing congestion in the IR inbox. Two new members of staff are currently being trained to support the team to process SARs and Access to Health requests. Other methods of streamlining the process such as use of AI Agents and recruiting light duty staff is being explored. Once team is back to full capacity and control of ongoing SARs/A2Hs has been regained, a lessons-learned exercise will be undertaken to explore the root cause of why this increase occurred, as well as a full review of the SAR/A2H process.

5. Data Protection (DP) Requests

During the reporting period, no DP requests exceeded the legal timeframe, ensuring full compliance with statuary obligations.

During the reporting period, a total of **2181** DP requests have been received. This is a decrease of **234 request (10% decrease)** compared to the previous reporting period.



5. Body Worn Video Camera (BWVC) DP Requests

A total of 9 requests for BWVC footage relating to incidents categorised as "Violence & Aggression" have been received within the reporting period, which is a decrease of 6 (6 less requests) compared to the previous reporting period.

These figures only include incidents where BWVC footage was provided to the police. In addition, the IG Team continue to receive requests for incidents for which no BWVC footage is available, and searches are required on the system to ensure that the tagging has not been missed. A review of this process will be undertaken in June/July 2026.

Month	Volume
April 2025	3
May 2025	2
June 2025	0
July 2025	0
August 2025	0
September 2025	0
October 2025	0
November 2025	1
December 2025	0
January 2026	0
February 2026	2
March 2026	1

6. Complaints

The Data protection Officer (DPO) assists the trust to monitor internal compliance and advise on data protection obligations. The DPO is an independent expert in data protection and reports to the highest management level. The trust procures the DPO service from the Mersey Internal Audit Agency (MIAA). The DPO has monthly meetings with the SIRO and Chief Information Officer (CIO).

During the reporting period, the DPO received **24** new complaints. This is a **100%** increase in the number of complaints compared to the previous reporting period. All complaints have been investigated. 2 remain open, while the remaining 22 have been closed.

The increase of complaints has largely been a result of the increasing pressures of SARs/A2H on the IG Team. **17** of the 24 complaints related to delays in responding to a SAR/A2H.

7. Data Protection Impact Assessments

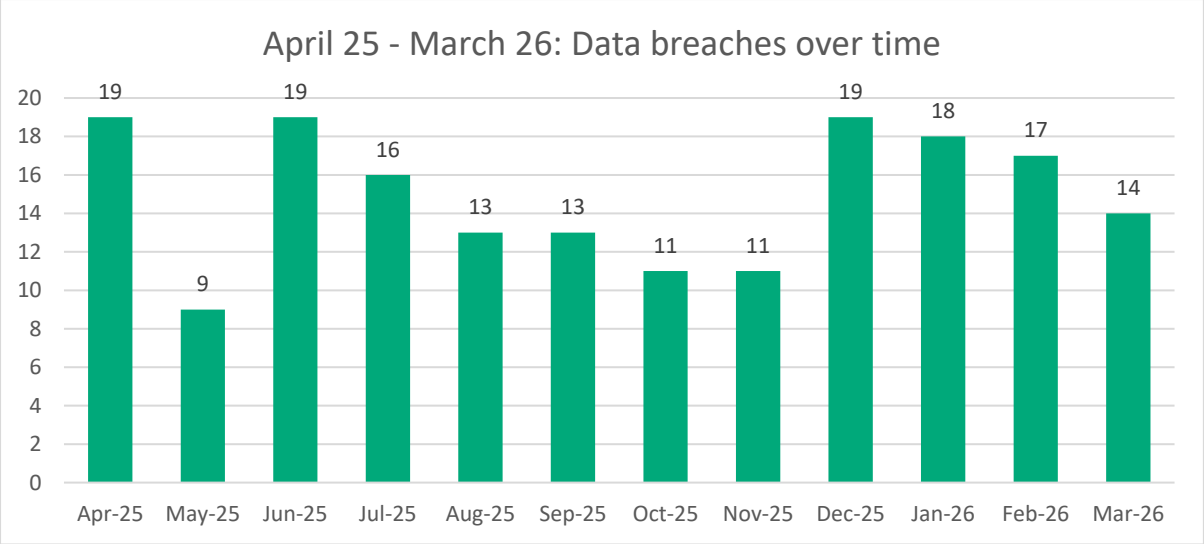
Over the past year, the IG Team has focused on ensuring that new information assets, changes to existing assets and changes to procedures involving personal identifiable data are risk assessed in compliance with UK GDPR, article 35 "Data protection impact assessment." The trust has introduced a comprehensive assessment which is facilitated by the IG Team and involves internal and external stakeholders with knowledge of the information asset and purposes of information processing.

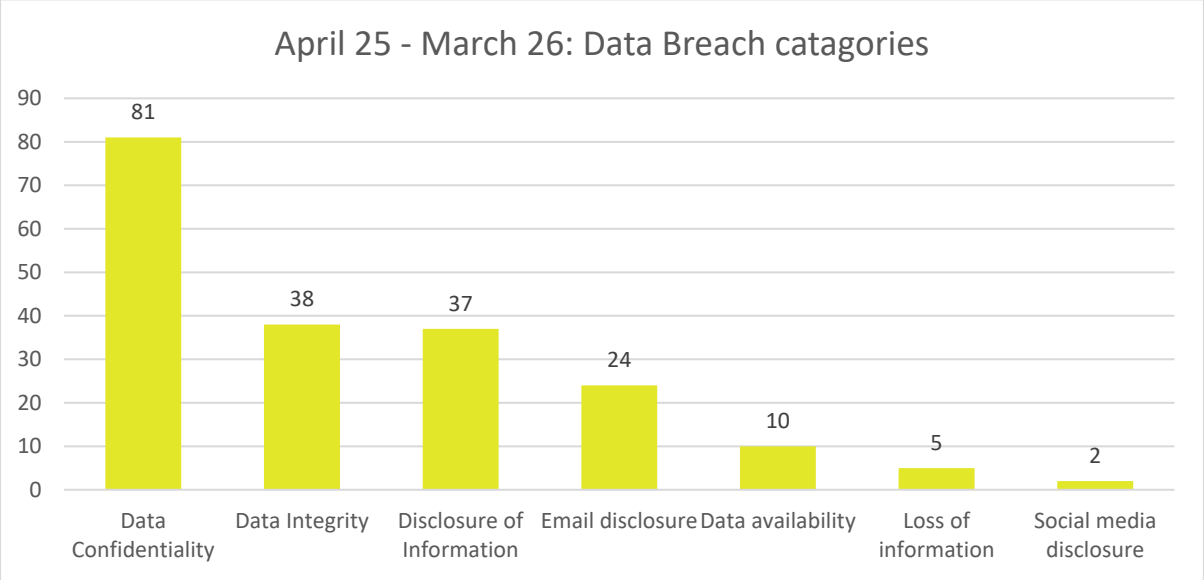
There were 3 Data protection impact assessments (DPIAs) signed off by the Trust DPO during the reporting period.

8. Data breaches

During the reporting period, a total of 197 data breaches have been reported via Datix IQ (DCIQ). This is an increase of 40 (25.48%) compared to the previous year.

The most frequently reported category remains "Data Confidentiality" which accounted for 81 (41.15%) of the 197 incidents. Data confidentiality incidents cover a broad variety of incidents such as incorrect paper being included within a meeting pack or improper storage of paper records.





9. Externally reportable data breaches

There were 6 data breaches which met the threshold to be reported externally via DSPT to the ICO during the reporting period April 2025 to March 2026.

Date	DCIQ ID	Description	ICO Actions
04/04/25	37320	Incorrect information provided by the police, that led to an employee	No action against NWAS – advisory best practice documentation
06/06/25	40394	Address of an employee subject to bullying was included in the pack sent to the staff under investigation	Initial request by the ICO for additional information - No action against NWAS
22/08/25	44241	Sensitive health information included in error in a	No action against NWAS – advisory

		disciplinary meeting pack	best practice documentation
23/01/26	52383	Sensitive employee health data was made viewable via the trust system GRS	No action against NWAS – advisory best practice documentation
25/02/26	Complaint 18549 DCIQ incident report 54469	Confidential patient information disclosed by mistake because of markers of other patient attached to a health record. This incident has been linked to other DCIQ reports of similar nature, however only 54469 has been reported externally	The data breach was reported to the ICO – further investigation ongoing regarding markers on patient's health records is ongoing – the IG Manager has progressed the data breach outside the DCIQ report.
17/03/26	55272	Personal details of 3 witnesses were included in error by HR, to Management Statement of case circulated to the panel and to the staff dismissed	No action against NWAS – advisory best practice documentation

10. Risk Consideration

The Information and Cyber Governance Group review risks each meeting. There continues to be several key risks within the committee's remit. The work programme is set to provide assurance on the controls and gaps in controls for those risks.

As of April 2026, only one risk remains on the Information Governance risk register. This risk is being reviewed in July 2026 with a view for closure.

Eight additional risks remain on other risk registers relating to Digital and are being regularly reviewed and updated.

Risk ID	Date Opened	Risk description	Current risk score
766	25/11/2025	If there is a cyber-attack the Trust will may experience a significant digital disruption and/or data breach, resulting in the exposure of personal and sensitive data, leading to legal consequences, severe reputational damage and significant disruption of essential functions and services.	20
767	25/11/2025	There is a risk that due to failure to maintain and manage core digital solutions the trust could experience a digital disruption, negatively impacting on the trust continuing to provide essential functions and services.	12
581	06/02/2024	There is a risk that due to the Trust not having active robust privacy monitoring procedures in place that staff	12

		can access patient and staff identifiable and sensitive information from all the Trusts systems without being detected which could lead to a breach in confidentiality.	
117	06/10/2017	There is a risk that key components of the core ICT infrastructure might fail due to due to unforeseen circumstances which could result in multiple systems becoming inoperable.	12
119	19/12/2017	There is a risk of infrastructure and systems becoming unsupported by vendors due to a lack of vendor management which may result in additional financial consequences, cyber vulnerability or loss of systems	9
384	25/01/2023	There is a risk that due to the lack of clear governance, centralised oversight and retention schedules in place for clinical and corporate records, the trust is not meeting the regulatory compliance required for the management of all records held within the Trusts digital and paper systems, which may result in incorrect use of personal information, reputational damage, or litigation.	8
151	23/09/2022	There is a risk that an individual could obtain sensitive/confidential data and use it fraudulently resulting in the data being used for personal gain leading to reputation damage and a financial loss to the Trust	6
685	21/11/2024	There is a risk due to lack of appropriate resources and processes that changes will be enacted on critical systems which may result in partial or full system failure	6
146	21/04/2021	There is a risk that due to scheduled maintenance and replacement tasks not being progressed in a timely manner, critical network communications may be lost resulting in failure of communication systems negatively impacting on service delivery.	5

11. Records Management

Records Management has now returned to the remit of Information Governance in the restructure of the digital directorate. Records Management mandatory training is currently at 88.49%. The trust has achieved a 91.54% (optimal) rating in December 2025 on the National Archives S46 Code Self-Assessment Tool for Public organisations.

Clinical and Corporate Records will be unified into a single function under IG. The IG Team has inherited the Records Improvement project and will look to bring the clinical and corporate records policies into a single document when the policies are up for renewal.

12. ACTION REQUIRED

The Information and Cyber Governance Group is asked to note the contents of the report and the assurance it provides.

NHS
North West
Ambulance Service
NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Wednesday, 24 June 2026		
Members present	Mr N Gower, Non-Executive Director Mr G Chapman, Non-Executive Director Mrs C Todd, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- No items.

ADVISE:

- No items.

ASSURE:

- External Auditors presented the Audit Completion Report which summarised the audit findings and conclusions for the year ended 31 March 2026. The report set out the intention to issue an unqualified opinion on the trust's financial statements.
- The audited financial statements were recommended to the Board of Directors for approval on 24th June. It was noted the Trust met all of its statutory duties.
- The management letter of representation was noted for presentation to the Board of Directors for signing.
- The Annual Report 2025/26 was recommended to the Board of Directors for approval on 24th June 2026. In relation to outstanding work of the Audit Committee, it was agreed to amend page 118 relating to significant risks relating to the valuation of property plant and equipment.

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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

NHS
North West
Ambulance Service
NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Audit Committee

Date of meeting	Friday, 24 July 2026		
Members present	Mr N Gower, Audit Committee Chair Mr G Chapman, Non-Executive Director Mrs C Butterworth, Non-Executive Director Mrs C Todd, Non-Executive Director	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- The organisational understanding of assurance and reassurance and extent of each requires the Board's attention.

ADVISE:

- Losses and Compensation for Q1 26/27 totalled £77k.

ASSURE:

- Internal Audit reported two reviews were completed during Q1 2026/27.
  - Computer Aided Dispatch (CAD) System (C3) – Moderate Assurance
  - Cyber Assessment Framework aligned Data Security and Protection Toolkit – Low Risk
- The Anti-Fraud Progress Report detailed the activities undertaken during Q1 2026/27.
- The Q1 2026/27 Board Assurance Framework was presented, prior to approval by the Board of Directors on 29th July 2026. Committee members considered the report within the context of their role as Audit Committee.
- The bi-annual NHS Provider Licence self-certification for 2025/26 confirmed compliance with all applicable licence conditions and identified no breaches or areas of material non-compliance.
- The SIRO Annual Report 2025/26 provided assurance in relation to activity undertaken during year maintained security of information.
- During Q1 2026/27, one waiver was raised and approved in line with the Scheme of Delegation.

RISKS

Risks discussed:

- None identified.

New risks identified:

- None identified.

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

NHS
North West
Ambulance Service
NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Charitable Funds Committee

Date of meeting	Wednesday, 22 July 2026		
Members present	Mr N Gower, Non-Executive Director Mrs C Butterworth, Non-Executive Director Mr M Gibbs, Director of Strategy and Partnerships Mrs C Todd, Non-Executive Director Mrs L Ward, Deputy Chief Executive/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:

- The Committee requests the Board to schedule appropriate time during 2026/27 to discuss the future strategy and direction of the NWAS Charity.

ADVISE:

- The Q1 2026/27 financial position of the NWAS Charity was overall funds of £799k; general funds £552k and restricted funds £247k. The Annual Plan for 2026/27 was noted.
- Approval of expenditure of £105k was provided for 150 public access defibrillators for a project with Cumberland Council.

ASSURE:

- A summary of the operational, strategic and charitable activity undertaken during Q1 2026/27 was noted, together with the use of restricted and unrestricted funds and updates in relation to the NHS Charities Together grants.
- A summary of the fundraising activities undertaken during Q1 2026/27 was provided.

RISKS

Risks discussed: None identified

New risks identified: None identified

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

North West Ambulance Service NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Thursday, 23 July 2026		
Members present	Mr G Chapman, Non-Executive Director, Chair Ms C Butterworth, Non-Executive Director Mr N Gower, Non-Executive Director Ms C Wood, Director of Finance Ms L Ward, Director of People Mr M Gibbs, Director of Strategy and Partnerships	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- Discussion on SR08 and the alignment with the risk appetite statement.

ADVISE:

Efficiency and Productivity Update

- The Committee received a report of efficiency achieved to month 03, representing a marginal adverse variance of £0.022m against plan.

Workforce Indicators Report

- The Committee received assurance on strong and stable workforce indicators, noted however in terms of sickness absence the position was stable in line with last year but was not showing an improvement. Sickness has followed seasonal trends into the start of 2026/27.

Staff Standards & Management & Leadership Framework

- The Committee noted the introduction of the NHS Staff Standards and the NHS Management & Leadership Framework. The NHS Staff Standards meet a government commitment set out in the 10 year plan to establish a consistent minimum baseline of expectations in relation to employment in the NHS.

Lord Mann Review

- The Committee noted the findings and recommendations of the Lord Mann review into antisemitism and other forms of racism in the NHS, and the actions NHS England has asked all trusts to take in response, together with the Trust's current position against each. A further update, including the mapping exercise will be brought to the Committee in November. The Committee Endorsed the adoption the UK government's definition of anti-Muslim hostility.

Annual Plan 2026/27 Quarter 1

- The Committee considered the Quarter 1 Annual Plan assurance report. Members noted that delivering was evidenced or sufficiently progressed in a number of areas, while further evidence or governance clarification remained necessary in a small number of areas.

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

A member challenged whether the evidence presented was sufficient to provide assurance. Quarter 2 actions are planned to strengthen delivery reporting, evidence quality, governance routes and benefits and measures mapping

Health Assurance Report Projects over £1m

- The Committee received the inaugural Heath Assurance Report Projects >£1m.

Recommended for Board approval

EDI Regulatory Reporting including WRES / WDES and Gender Pay Gap

- The Committee received the Regulatory Reporting including WRES / WDES and Gender Pay Gap EDI Annual Report, received assurance that the Trust is meeting its statutory equality reporting duties and is taking evidence-based action to address identified disparities and recommended the report for onward approval by Board for publication.

ASSURE:

The Committee received the following reports for assurance:

Board Assurance Framework

- The Committee reviewed the risks aligned to its remit for the proposed 2026/27 Q1 Position of the Board Assurance Framework (BAF).

Finance Report Month 03 2026/27

- The Committee received assurance in relation to the financial performance indicators, noting a stable position and surplus at Month 03.

Other assurance report received:

Sexual Safety Report
Wellbeing and Attendance Improvement Report
Staff Incidents Resulting in Harm
Patient Level Costing Post-Submission Assurance Report
Estates, Fleet and Facilities Management Assurance Report
Digital Plan Update

RISKS

Risks discussed:

- Workforce Indicators - Sickness Levels.

New risks identified:

- None identified.

NHS
North West
Ambulance Service
NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 17 June 2026		
Members present	Mr S Desai, Chief Executive (chair) Dr C Grant, Medical Director Mrs A Wetton, Director of Corporate Affairs Mr M Gibbs, Director of Strategy and Partnerships Dr E Strachan-Hall, Director of Quality & Improvement Mr D Ainsworth, Director of Operations Mr I Moses, Area Director – Cheshire and Merseyside Ms S Rose, Integrated Contact Centres Director Ms S Wimbury, Area Director – Greater Manchester Mrs J Wharton, Chief Information Officer Mr M Jackson, Chief Consultant Paramedic In attendance Mrs L McConnell, Deputy Director of People Mrs M Brooks, Deputy Director of Finance Mrs J Turk, Executive Business Support Manager (minute taker)	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **UEC Performance** – May performance across UEC was challenging with rising demand, reduced CAS capacity, increased conveyance and ongoing hospital flow pressures compounded by workforce and capacity constraints. While recovery remains possible, significant risks persist around demand growth, workforce imbalances, and limited contractual levers, with a need to focus on sustainable, controllable improvements.

ADVISE:

The TMC approved:

- The submission of the Data Security Protection Toolkit.
- The revised Debrief Policy (v1.8) and endorsed the supporting SOP framework including the establishment of RLOG.

ASSURE:

The TMC received and discussed the following reports for assurance:

- **Finance report** –month 02 forecast shows a breakeven position in line with submitted financial plans.
- **Integrated Performance Report**

- **Policy Management Framework** – members agreed to approve a six-month extension for the Time Off and Facilities for Staff Representatives Policy to allow further consultation and updates.
- **Southport Inquiry recommendations** – the TMC were assured of the Trust's response to the Inquiry recommendation 9 and noted the summary of phase 1 of the inquiry.
- **Training Needs Analysis –** the TMC noted the EPRR command training needs analysis and supported the recovery plan for Operational Commander compliance.
- **The Quality Accounts 2025/26 draft**
- **Back to Basics** - The TMC received a proposal for a 'back to basics' programme, including the pilot of an accreditation style visit model to replace the current QAV approach, with a focus on more effective use of resources and staff engagement. The TMC did not approve the proposal as presented and highlighted the need for clarity on delivery, ownership and communication with an agreement to further refine the proposal while continuing existing QAV activity and actions in the interim.
- Received an update on the **Future Workforce Solution** which outlined progress to date. Phase 1 focused on foundation readiness, and Phase 2 will require the trust's commitment to develop a detailed project plan ahead of validation testing. The programme remains on track with submission planned by end of June 2026, full system roll out will continue to develop over time with the full national implementation anticipated by 2030.

The TMC received the following Escalation & Assurance reports:

- Health, Safety Security and Fire Group – 12 May
- Sustainability Group – 1 June

RISKS

Risks discussed:

- Approved the inclusion of two high level risks IDs 799 and 821 onto the corporate risk register.
- Reviewed and confirmed the 10 sensitive risks as correctly tagged as sensitive.
- Noted the one longstanding risk ID 317.

New risks identified:

- None.

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

NHS
North West
Ambulance Service
NHS Trust

ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 22 July 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 Gibbs, Director of Strategy and Partnerships Dr E Strachan-Hall, Director of Quality & Improvement Ms S Rose, Integrated Contact Centres Director Ms S Wimbury, Area Director – Greater Manchester Mr M Cooper, Area Director – Cumbria & Lancashire Mrs J Wharton, Chief Information Officer In attendance Dr T Smith, Associate Medical Director Mr M Dunn, Consultant Paramedic – Cumbria & Lancashire Mr L Marriner, Deputy Director, Integrated Contact Centres (part) Mrs J Turk, Executive Business Support Manager (minute taker)	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- **UEC 26/27 update** – Cumulative DCA production is behind the planned position – approx. 1000 hours per week. A recovery plan to increase additional PAS (Private Ambulance Service) output has been put in place with confidence expressed against delivery of PAS capacity.
- **EDI Regulatory Reporting including WRES/WDES and Gender Pay Gap** – Positive progress was noted in improving the experience of BME staff; however, concerns remain regarding bullying and harassment experienced by BME and disabled staff, disparities in career progression and workforce processes, and the challenges associated with implementing reasonable adjustments. Further targeted actions and engagement were planned to improve these issues.

ADVISE:

The TMC approved:

- Facilities management space utilisation proposal
- Preston phase 3 early works
- Board Assurance Framework proposed Q1 position 2026/27

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

- Corporate Risk Register
- Clinical Safety Plan v3.1

ASSURE:

The TMC received and discussed the following reports for assurance:

- **Finance report** –month 03 forecast shows a breakeven position in line with 2026/27 financial plans. The trust has identified 93% of efficiency schemes and further action was being taken to progress schemes through the development stages into delivery.
- **Integrated Performance Report**
- **Policy Management Framework** - 3 policies were overdue a review – NW Divert and Deflection Policy (owned by NHSE NW), Smoke Free Policy, and Management of Allegations Against Staff Policy. 14 policies were due for review within 3-6 months.
- **HSS&F Annual Report 2025-26** – the Trust is compliant with 6 out of 7 domains. There has been an increase in sexually motivated incidents, and this will be a priority focus for the Trust in 2026/27. Manual handling account for 45% of RIDDOR reportable incidents, an improvement initiative entitled 'we've got your back' will be a strategic priority for this year.
- **Annual SIRO KPI Assurance Report**
- **UEC 26/27 update and assurance** – Cumulative DCA production is behind the planned position – approx. 1000 hours per week and cat 2 performance has been impacted. A recovery plan to increase PAS output has been put in place. The project lead was confident against recovery and delivery of PAS capacity.
- **Right First Time – Service Delivery Standards Improvement Programme** – the TMC endorsed the 12-week improvement programme which would focus on reliability of core standards, back to basics and visible operational leadership. A progress update, emerging themes and outcomes would be received following completion of the 12-week programme.
- **Duty of Candour** – a review covering the period 01 October 2025 – 31 March 2026 had been undertaken. The review highlighted that DoC conversations were predominately conducted by telephone, with further work required to understand the reasons for this, and to ensure face to face options are offered where appropriate. Focus groups and discussions with the CQC to inform future policy and practice were to take place.
- **EDI Regulatory Reporting including WRES/WDES and Gender Pay Gap**
- **Job Evaluation** - activity and national audit outcomes reviewed, along with compliance against emerging national requirements. The Trust remains in a strong position following completion of nursing and midwifery reviews and in terms of established JE practice. Data cleanse activity will be required and it is anticipated further work will be required in partnership to meet national expectations.
- **HR case management risks** – the TMC noted increasing levels of complex casework, particularly within PTS, alongside a rise in high-risk cases which reflects improved oversight and control. Ongoing concerns include sexual safety and substance misuse cases, variations in call avoidance cases by ethnicity, rising Employment Tribunal claims in line with national trends, work continues to strengthen learning and consistency across the service.
- **Job evaluation update**

- **Staff standards & management & leadership framework**
- **Annual plan assurance Q1 2026/27** – evidence had been received for 62 of the 81 deliverables, with further assurance being sought for 6 deliverables. 25 approved changes to the plan have been reviewed through the planning governance process with no significant impact identified on overall delivery. Some quality-related changes and a patient safety programme remain subject to further scoping and review.

The TMC received the following Escalation & Assurance reports:

- Information & Cyber Governance Group – 9 June
- Operations & Performance Group – 23 June
- Clinical & Quality Group – 7 July
- Planning Group – 8 July
- EPRR Group – 13 July
- Diversity & Inclusion Group – 14 July
- People & Culture Group – 15 July

RISKS

Risks discussed:
The overall risk profile remained stable with no new risks identified, no changes in current risk scores, no risks overdue a review and no risks closed during the reporting period.

1 longstanding risk (ID 317) has remained open for more than 24 months. This reflects ongoing national job evaluation processes outside of the Trust's direct control. Mitigating actions continue to be progressed and monitored.

The proposed Q1 BAF position was reviewed and confirmed. Members discussed SRO3 and SR08 and agreed the increase in risk score of SR03 from 10 to 15 and decrease in risk score of SR08 from 20 to 15.

New risks identified: None.

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Workforce Equalities Monitoring Data (WDES, WRES, Pay Gaps)
PRESENTED BY	Lisa Ward, Director of People / DCEO
PURPOSE	Decision

STRATEGIC AIM(S)	Build a safe, supportive and inclusive culture together							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☐	**SR04**	☐
	SR05	☐	**SR06**	☐	**SR07**	☐	**SR08**	☐

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Board of Directors is asked to: • Review, consider and note the data contained within the WDES, WRES and Pay Gap reports. • Receive assurance that the Trust has complied with its regulatory and statutory duties to compile, review and submit relevant equality data. • Approve the reports for publication
EXECUTIVE SUMMARY	This cover report presents a summary of the Trust's annual workforce equalities position for 2025/26, covering the Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), and gender, ethnicity and disability pay gaps. Readers are encouraged to refer to the full reports in the appendix for analysis, supporting data and contextual information. **Key highlights from the data** a. Disability representation has passed 10% for the first time, continuing a positive multi-year trend, with improved representation at senior clinical grades and better recruitment outcomes for disabled applicants moving closer to parity. b. Disabled staff experience however, shows a mixed picture. Harassment from patients and the public has worsened, confidence in fair career progression has declined, and feelings of being valued have fallen, even as presenteeism and reasonable adjustments remain broadly positive.

c. BME representation has grown in line with target and ethnicity declaration rates remain high, but BME recruitment outcomes have deteriorated, with white applicants still significantly more likely to be appointed following shortlisting.
d. BME staff remain disproportionately represented in formal disciplinary processes (18% of cases vs. ~7% of the workforce), concentrated within Integrated Contact Centres, though this disproportionality is narrowing.
e. Staff-reported discrimination and bullying from colleagues have both improved for BME staff, with the gap to White staff narrowing or closing.
f. The gender pay gap has narrowed to its lowest level since 2020, supported by improved female representation in senior pay quartiles.
g. The ethnicity pay gap has widened, reflecting continued concentration of BME staff in lower-paid roles and reduced senior representation.
h. The disability pay gap remains negligible, with near parity in average earnings.

Actions

Detailed action plans are set out in the appended reports and align with existing Annual Plans.

Priorities for 2026/27 include: improving disability disclosure and data quality; strengthening inclusive recruitment practices, panel diversity and outreach for both disabled and BME candidates; addressing disproportionality in disciplinary processes, particularly within Integrated Contact Centres; delivering the Anti-Racism Workplan and progressing towards Northwest Race Equality Assembly accreditation; and continuing work to close the ethnicity pay gap through targeted progression and recruitment initiatives.

Assurance

These reports demonstrate that the Trust is meeting its statutory equality reporting duties and is taking evidence-based action to address identified disparities. The Board is asked to note the findings and support continued delivery of the associated action plans.

PREVIOUSLY CONSIDERED BY	D&I Group & TMC	
	Date	14/07/26 & 27/07/26
	Outcome	D&I Group – reviewed and noted areas for improvement align with plans already subject to oversight through the group Supported publication. TMC – reviewed and noted areas of improvement. Recommended for publication.
	Resources Committee	
	Date	23rd July 2026

		Discussed report and agreed further assurance of progress against plans and benchmarking for November Committee. Recommended for publication.

1. BACKGROUND

1.1 This paper provides an overview of the workforce equalities reporting, particularly:

- Workforce Disability Equality Standard (WDES)
- Workforce Race Equality Standard (WRES)
- Disability, Ethnicity and Gender Pay Gap

1.2 The production and publication of the WRES and the WDES are required within the NHS contract. Submissions to the national team have been made by the due date and publication of results and actions will follow Board approval. Publication also supports the Trust in meeting its Public Sector Equality Duty in relation to publication of workforce data and progress against actions.

1.3 Gender Pay Gap reporting and publication is statutory. The Trust has implementing pay gap reporting for race and disability over the last two years to provide a better understanding of the position within the trust and to pre-empt anticipated legislation.

1.4 The newly published staff standards include a specific Standard relating to Tackling Racism and the staff survey responses currently included in the WRES will also feed into the staff standard score in the national operating framework. The standard relating to Promoting Flexible Working is also likely to have an indirect impact on the gender pay gap as a lack of flexible working in more senior roles can act as a barrier to progression which is the main determining factor in the pay gap.

1.5 Individual reports for each data set covering the period 1 April 2025 – 31 March 2026 are included in the appendix to this cover paper. A summary of some of the key findings is presented below; however, readers are encouraged to refer to the full reports for analysis, supporting data and contextual information.

2. WORKFORCE DISABILITY EQUALITY STANDARD

2.1 **Metric 1 – Workforce Representation:** As at 31 March 2026, 833 staff (10.4% of the workforce) had declared a disability or long-term health condition, exceeding 10% for the first time and continuing the positive year-on-year upward trend (9.4% in 2024/25). This reflects sustained efforts to encourage disclosure through communications, the Disability Staff Network and increased awareness of reasonable adjustments and neurodiversity support.

In the 2025 Staff Survey, 33% of 4100 respondents indicated they had a disability or long-term condition, which is significantly higher than the 10% declaration rate recorded on ESR. This difference is consistent with the national picture, where staff surveys typically report higher levels of disability disclosure.

Disability representation remains strongest within Clusters 1, 2 and Clinical Cluster 3, with improved representation also seen at senior clinical grades for the first time since 2021/22. The proportion of staff with an unknown disability status has reduced to 4.5%, although non-declaration remains higher within some clinical groups.

2.2 **Metric 2 – Recruitment:** Recruitment outcomes for disabled applicants continued to improve during 2025/26, with increases in both shortlisted and appointed candidates. The relative likelihood of appointment following shortlisting improved from 1.17 to 1.07, moving closer to parity with non-disabled applicants (target 1.0).
This demonstrates continued progress towards more equitable recruitment outcomes and reflects the impact of ongoing improvements to inclusive recruitment practices.

2.3 **Metric 3 – Entry to capability process:** Although the number of disabled staff entering the capability process increased, the relative likelihood of entering capability reduced significantly from 4.46 to 2.59. This largely reflects an increase in ill health-related capability cases, which are excluded from the WDES calculation.
Given the small number of cases, annual variation should be interpreted with caution. Work will continue with HR Business Partners to monitor themes, ensure reasonable adjustments are considered appropriately, and reduce any disproportionate impact on disabled staff.

A deep dive into the data behind this metric earlier this year has informed a set of recommendations now being progressed collaboratively by HR, L&D and operational teams. These include earlier EDI/HR intervention in performance cases to prevent escalation, equipping managers to address barriers for disabled staff (initially focused on ICC educators), and reviewing training and assessment processes to ensure appropriate support and reasonable adjustments are in place.

2.4 **Metric 4.1 – Harassment, bullying and abuse:** The experience of disabled staff deteriorated in 2025, with over 45% reporting harassment, bullying or abuse from patients, service users, relatives or the public (compared to 42% in 2024/25). While experiences amongst non-disabled staff remained broadly stable at around 35%, the gap between the two groups widened.

The Trust will continue to monitor this indicator through Staff Survey results, alongside internal reporting data and the work of the Violence Prevention and Reduction Team.

2.5 **Metric 5 – Career progression:** Disabled staff reported a further decline in confidence that the Trust provides fair opportunities for career progression and promotion (48% 2024/25, 46% 2025/26) , while perceptions amongst non-disabled staff remained stable (53%). Consequently, the disparity between the two groups has widened.

Improving equitable access to career development and progression opportunities remains an area of focus.

2.6 **Metric 6 – Presenteeism:** The proportion of staff reporting pressure from managers to attend work when unwell has fallen to its lowest level since 2021 for both disabled and non-disabled staff, with the gap between the two groups continuing to narrow.

While this represents encouraging progress, a significant proportion of staff continue to experience presenteeism, indicating further work is required to support staff wellbeing and foster a healthy workplace culture.

2.7 **Metric 7 – Feeling valued:** Disabled staff reported lower levels of satisfaction that the organisation values their work compared with the previous year, while satisfaction amongst non-disabled staff increased. This has resulted in a widening gap between the two groups.

In response, the Trust has strengthened its approach to recognition through improvements to the compliments process and will introduce a Trust-wide Recognition Framework during 2026/27. Further work will also be undertaken with the Disability Staff Network to ensure disabled colleagues feel valued and recognised.

2.8 **Metric 8 – Reasonable Adjustments:** Over two-thirds of disabled staff reported receiving the reasonable adjustments they require. Although this represents a small reduction from the previous year, performance remains above pre-2024 levels.

The Trust will continue to strengthen its approach through policy development, manager guidance and ongoing training, building on positive feedback from the reasonable adjustments programme delivered during 2025/26.

3. WORKFORCE RACE EQUALITY STANDARD

3.1 **Indicator 1 – Workforce representation:** BME representation within the workforce increased to 7.2%, achieving the Trust's year-on-year 0.5% improvement target. Ethnicity declaration rates remain above 99%, providing a high level of confidence in the data.

While representation continues to be strongest within entry-level non-clinical roles and in Cluster 4, increasing representation across middle management and clinical roles remains an ongoing priority.

3.2 **Indicator 2 – Recruitment:** The recruitment indicator has deteriorated, with White applicants remaining significantly more likely to be appointed following shortlisting than BME applicants (2.53 2025/26, 2.34 2024/25). Although applications from BME candidates remain strong, this is not translating into appointments, with a reduction in both the number and proportion of BME candidates progressing through the recruitment process.

Addressing this disparity remains a key priority. A range of actions are underway, including a dedicated BME Recruitment Action Group, strengthened positive action activity, more inclusive recruitment processes, enhanced interviewer training, and revised leadership recruitment arrangements designed to improve fairness and representation.

3.3 **Indicator 3 – Formal disciplinary process:** BME staff continue to be disproportionately overrepresented within the formal disciplinary process, with the relative likelihood remaining broadly unchanged from the previous year despite a reduction in overall disciplinary cases.

In 2025/26, there were around 160 formal disciplinary cases, a reduction from 187 in the previous year. Of these, 29 involved BME staff, compared with 30 last year. BME staff therefore accounted for 18% of formal disciplinary cases, while representing approximately 7% of the workforce.

3.4 Two thirds of BME disciplinary cases involved staff working within the Integrated Contact Centres, where a significant proportion of BME staff are employed. However, the proportion of BME disciplinary cases within ICC reduced from 43% last year to 35% this year, an improvement of 8%.

3.5 ICC is leading a Task and Finish Group to take action on the disproportionality within the disciplinary process. Planned actions include strengthening managers' confidence to resolve issues informally where appropriate, embedding equality, diversity and inclusion considerations into fact-finding processes, and improving diversity within leadership teams to support fair and consistent decision-making.

3.6 **Indicator 5 – Harassment, bullying or abuse from patients, relatives or the public:** Reports of harassment, bullying and abuse from patients, relatives and the public increased for both BME and White staff during 2025. While the gap between the two groups has narrowed considerably, the overall prevalence remains high.

In contrast to 2024 and preceding years, when BME staff reported lower incidence than White staff, this is the first year in which both groups have reported equal levels, at around 38%. This represents an 8% increase for BME staff since 2023, and a 3.5% increase since 2024. The rise in reported incidence among BME staff over recent years may reflect the influence of wider national and geopolitical social narratives and discourse.

The Trust continues to strengthen its approach through violence prevention initiatives, improved reporting and support arrangements, alongside targeted work to address racism and sexual safety.

3.7 **Indicator 6 – Harassment, bullying or abuse from staff:** Staff survey results demonstrate continued improvement, with fewer staff reporting harassment, bullying or abuse from colleagues across both groups. Since 2021, experiences reported by BME staff have improved significantly and, for the first time, are marginally more positive than those reported by White staff.

Despite this positive trend, around one in five staff continue to report experiencing inappropriate behaviours from colleagues, highlighting the need for continued cultural improvement.

3.8 **Indicator 7 – Career progression fairness:** Perceptions of equal opportunities for career progression remained broadly unchanged for White and BME groups during 2025/26. However, around half of all staff continue to believe that opportunities for progression are not equitable, demonstrating that this remains a significant organisational challenge.

The Trust will continue to focus on inclusive leadership development, fair recruitment practices and targeted career development programmes to improve confidence in progression opportunities.

3.9 **Indicator 8 – Discrimination:** The proportion of staff reporting discrimination continued to decline, with notable improvement for BME staff and the gap between BME and White staff effectively eliminated. Around 9% of both groups reported experiencing discrimination.

This positive trend reflects sustained work to strengthen inclusion through leadership development, equality, diversity and inclusion training, and improved processes for raising concerns and addressing unacceptable behaviour.

4. PAY GAPS

4.1 **Gender Pay Gap:** Female representation within the Trust continues to increase, reaching 56.6% of the workforce as at 31 March 2026 (56.2% in 2024/25). Representation has improved across the upper, upper-middle and lower-middle pay quartiles, with female representation in the upper quartile increasing from 45.7% to 47.7%, demonstrating continued progress towards a more balanced workforce at senior pay levels.

4.2 The Trust's gender pay gap has narrowed, with the mean hourly pay gap improving from -7.63% to -6.34% and the median hourly pay gap improving from -12.68% to -10.34%. Both measures represent the lowest pay gap reported since 2020.

4.3 The gender pay gap continues to be influenced by workforce distribution across pay quartiles, with a higher proportion of women in the lower and lower-middle quartiles and a higher proportion of men in the upper quartile. Length of service is also likely to be a contributing factor, as male staff have, on average, longer tenure and are therefore more likely to be positioned at higher incremental pay points within bands.

4.4 **Ethnicity Pay Gap:** The Trust's ethnicity pay gap widened during 2025/26. The mean hourly pay gap increased from -4.38% to -5.65%, while the median hourly pay gap increased from -6.28% to -11.23%, indicating a widening disparity in earnings between White and BME staff.

4.5 White staff earned an average hourly rate of £20.62, compared with £19.46 for BME staff, representing a mean difference of £1.17 per hour. At the median, White staff earned £19.30 per hour compared with £17.13 for BME staff, a difference of £2.17 per hour.

4.6 The widening pay gap has occurred despite some improvements in BME representation across the workforce and reflects the continued concentration of BME staff within lower-paid roles and lower representation in senior pay quartiles. Further analysis will be undertaken to better understand the impact of workforce distribution, recruitment, progression and length of service, with targeted action continuing to improve representation and progression into higher-paid roles.

4.7 **Disability Pay Gap:** The Trust's disability pay gap remains minimal, indicating near parity in earnings between disabled and non-disabled staff. During 2025/26, disabled staff earned an average hourly rate of £20.62, compared with £20.57 for non-disabled staff, resulting in a mean pay gap of +0.24% in favour of disabled staff.

4.8 At the median, disabled staff earned £19.18 per hour compared with £19.19 for non-disabled staff, representing a median pay gap of -0.05%, demonstrating almost complete pay parity.

4.9 This represents an improvement on 2024/25, when the mean pay gap was -0.71% and the median pay gap was -1.29%. While the overall position remains positive, continued monitoring will ensure the Trust maintains equitable outcomes and supports disabled colleagues to thrive within the organisation.

5. ACTIONS

5.1 Each of the data reports appended to this paper sets out actions for 2025/26 and beyond to address identified disparities, improve workforce experience and support progress against the Trust's equality, diversity and inclusion priorities. These actions align with work already identified in the Annual Plans.

5.2 **WDES:** For 2026/27, the Trust will continue to focus on improving workforce data quality and representation by encouraging staff to update their disability status. In partnership with the Disability Staff Network, targeted engagement activity will be delivered in areas where declaration rates are lowest to improve completeness and accuracy of workforce information.

5.3 In relation to recruitment, the Widening Access Team will continue to deliver targeted outreach and careers support, including community events, online engagement and partnerships with local organisations, with an increased focus on improving engagement with disabled people. This will be complemented by the development of inclusive recruitment training for hiring managers, aimed at reducing bias and strengthening fair and consistent selection practices.

5.4 Further work will be undertaken to review themes within capability data, ensure reasonable adjustments are consistently applied, and provide targeted support to managers to reduce disproportionality in outcomes for disabled staff. In addition, the Trust will work closely with the Disability Staff Network to identify further opportunities to strengthen recognition and ensure disabled colleagues feel valued, respected and supported within the organisation.

5.5 **WRES:** For 2026/27, the Trust will deliver the BME Recruitment and Retention Action Plans to improve representation of BME staff across the organisation. This will be supported by a range of targeted actions within recruitment, including ongoing review of job descriptions and person specifications to ensure they remain inclusive and accessible, the introduction of Independent Panel Members, and increased BME representation on recruitment and assessment panels. In addition, the Trust will strengthen monitoring and tracking of applicants from underrepresented groups to improve engagement with unsuccessful candidates, alongside the rollout of inclusive recruitment and selection training for panel members from Q2 2026/27, with evaluation planned at year end.

5.6 Further work will focus on improving fairness and consistency within people processes. This includes strengthening managers' confidence to address workplace issues through timely informal resolution where appropriate, reducing unnecessary escalation to formal disciplinary processes, and introducing a refreshed fact-finding pro forma that embeds equality, diversity and inclusion considerations throughout the investigation process.

5.7 The Trust will also implement a clear procedure to support staff within Integrated Contact Centres who experience racist abuse or sexual harassment from members of the public, ensuring a consistent approach across 111 and 999 services and appropriate managerial support and escalation. In addition, the Anti-Racism Workplan will be developed and delivered, with the Trust progressing towards Northwest Race Equality Assembly accreditation status by the end of 2026/27.

6. RISK CONSIDERATIONS

6.1 Inequity in the workplace carries organisational health risks through increased turnover, inability to attract diverse staff and increased sickness absence. It also carries risks of litigation for discrimination or harassment on grounds of a protected characteristic. We are currently seeing some of these risks materialise with high turnover amongst BME compared with white staff and a number of number of employment tribunal claims which have an element of discrimination linked to the claim. However, it should be noted that the inclusion of discrimination elements is not unusual given that these can increase the value of any subsequent award. Overall the picture is mixed for both disability and race with elements of our position which mitigate these risks and elements which, if not addressed, could heighten the risk.

6.2 There are also regulatory risks from both CQC oversight as equality features heavily in the KLOEs and also through the national oversight framework, the staff standards and NHSE oversight frameworks at a regional level. Again this is a mixed picture of risk. The staff survey indicators feeding into the NOF are positive and in a strong position but it is expected that our position on likelihood of appointment from shortlisting for BME staff and entry to formal processes for disabled and BME staff could both generate regulatory scrutiny. Action plans to address all of these are included in this years annual plan ad are being monitored through TMC.

7. EQUALITY/ SUSTAINABILITY IMPACTS

7.1 The collation and assessment of WDES, WRES and Pay Gap data is essential to understanding workforce inequalities and improving staff experience. The data supports development of a more inclusive workplace culture and enables the Trust to identify areas of progress, areas requiring further attention and targeted actions to address disparity through the delivery of the EDI annual priorities.

7.2 The reports also support assurance that NWAS is meeting its statutory and regulatory equality reporting duties and is taking evidence-based action to improve representation, inclusion and fairness across the workforce.

North West Ambulance Service NHS Trust

Workforce Disability Equality Standard (WDES) Data Report

Covering the period of 1st April 2025 – 31st March 2026

Introduction

This report sets out the 2025/26 annual workforce data in relation to disability which the trust is required by NHS England to publish. Working to address inequalities identified by workforce data demonstrates our compliance with the Equality Act 2010 and the Public Sector Equality Duty. Monitoring workforce equalities data is also central to ensuring that we are delivering on our equality, diversity and inclusion priorities:

- Priority 1: We will embed fair and inclusive recruitment and progression processes to improve the diversity of the workforce at all levels.

- Priority 2: We will educate and empower our workforce and leaders to promote a positive psychologically safe culture, to support a reduction in the experience of bullying, harassment, discrimination and an improvement in retention.

Workforce Disability Equality Standard (WDES)

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

The data in this report relates to the period of 1st April 2025 – 31st March 2026 and comprises information taken from the Electronic Staff Record (MyESR), HR Business Partnering, Learning & Development, and the 2025 NHS Staff Survey.

In line with the nationally mandated timeframe, the data was submitted to NHS England in May 2026.

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

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

Non-clinical Staff

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
Cluster 1: Bands 1 - 4	10.7%	10.4%	13.3%	14.8%	**13.9%**
Cluster 2: Bands 5-7	6.2%	8%	10.5%	13.1%	**13.5%**
Cluster 3: Bands 8a-8b	4.7%	3.6%	4.8%	10.1%	**11.6%**
Cluster 4: Bands 8c-9 and VSM	5.0%	14%	10.2%	9.7%	**12.7%**

Clinical Staff

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
Cluster 1: Bands 1-4	4.5%	6.1%	7.4%	9.1%	**9.5%**
Cluster 2: Bands 5-7	5.0%	6.4%	7.5%	8.7%	**9.3%**
Cluster 3: Bands 8a-8b	6.9%	14.3%	16.7%	17.9%	**18.2%**
Cluster 4: Bands 8c-9 and VSM	11.1%	0%	0%	0%	**8.3%**

As of 31 March 2026, 833 staff (10.4% of the workforce) had declared a disability or long-term health condition, marking the first time that the proportion has exceeded 10%.This is an increase from 9.4% in 2024/25 and continues the increasing year-on-year trend. This improvement reflects ongoing work to encourage declaration, including internal communications, support from the Disability Network, and increased awareness of reasonable adjustments and neurodiversity support.

In 2025/26, the representation of disabled staff remained highest within non-clinical Clusters 1 and 2 and Clinical Cluster 3, which together accounted for over 45% of disabled staff across the organisation. Nearly one in five staff in clinical Bands 8a–8b identified as disabled or as having a long-term health condition. Encouragingly, for the first time since 2021/22, disabled staff were also represented within senior clinical roles at Bands 8c to Very Senior Manager level, indicating progress in representation at the highest levels of the organisation.

There are 363 staff (4.5% of the workforce) whose disability status is recorded as unknown, a reduction from 400 in 2024/25. Non-declaration remains most evident in Clinical Band 6 roles, with smaller pockets in some senior grades.

Work will continue to encourage staff to update their disability status and to target engagement in areas where declaration rates remain lowest.

Table: Disability status unknown

Staff group		Disability status unknown as of 31/3/25	Disability status unknown on 31/3/24	Disability status unknown as of 31/3/26
Clinical	Band 3	3.9% - 68 people	5.4% - 88 people	3.6% - 44 people
	Band 5	5.1% - 41 people	5.9% - 47 people	4.3% - 28 people
	Band 6	9% - 183 people	10.4% - 198 people	7.7% - 156 people
Non-clinical	Band 8d	7.1%	15.4%	6.7%
	VSM	22.2%	31.3%	9.1%

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

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

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
Likelihood	1.56	1.26	1.29	1.17	**1.07**

Between 1 April 2025 and 31 March 2026, 792 disabled applicants were shortlisted for roles (up from 716 in 2024/25), with 138 appointed (up from 113). This compares with 3,889 shortlisted and 726 appointed non-disabled applicants over the same period.

The relative likelihood for 2025/26 is 1.07, improving from 1.17 in 2024/25 and moving closer to the target position of 1.0. This indicates that disabled applicants are almost as likely as non-disabled applicants to be appointed following shortlisting.

This continued improvement suggests that actions to strengthen inclusive recruitment practices are supporting more equitable outcomes for disabled applicants.

Work will continue to focus on reviewing recruitment processes, ensuring inclusive advert wording, strengthening panel capability, and facilitating reasonable adjustments to further improve equity across the recruitment pathway.

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

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

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
Likelihood	0.00	1.47	1.63	4.46	**2.59**

The number of disabled staff entering the capability process increased during 2025/26. However, their relative likelihood of entering the process decreased significantly from 4.46 in 2024/25 to 2.59 in 2025/26. This reflects the fact that the majority of capability cases involving disabled staff related to ill health this year – and therefore are not counted for his metric. In 2025/26, 24.5 of the 36.5 cases capability cases related to ill health, compared with higher proportion of 14 of 28.5 cases in 2024/25.

Given the relatively small number of capability cases overall, the relative likelihood measure has fluctuated considerably between reporting years.

A deep dive into the data underpinning this metric was undertaken earlier this year, informing a series of recommendations that are now being progressed through collaborative working between HR BP, HR Corporate, Learning & Development, and operational teams.

These recommendations include earlier intervention by EDI and HR specialists in performance cases to help prevent escalation to Stage 3, and equipping managers to proactively identify and address barriers faced by disabled staff - with initial focus on ICC educators. Work is also underway to review training and assessment processes, exploring alternative delivery methods and additional support for disabled staff, alongside consideration of extended timelines or reasonable adjustments for mandatory assessments.

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

In 2025, we achieved our highest ever level of participation in the NHS Staff Survey, with over 4,100 responses, equating to a 53% response rate, compared with 3,500 in 2024.

33% of respondents reported having a disability or long-term condition, which is significantly higher than the 10% declaration rate recorded on ESR. This difference is consistent with the national picture, where staff surveys typically report higher levels of disability disclosure.

This gap highlights the importance of continuing to build trust and confidence in staff declarations. Feedback from staff engagement suggests that some colleagues remain concerned about how this information may be used. Work is ongoing with Communications and the Disability Network to address misconceptions, promote the benefits of declaration, and encourage staff to keep their records up to date. Improving declaration rates remains a priority to ensure staff can access appropriate support and reasonable adjustments.

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

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

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	37.8%	34.1%	34.7%	34.9%	**34.3%**
Disabled	45.9%	47.2%	42.7%	41.8%	**45.5%**
Difference	8.1%	13.1%	8.0%	6.9%	**11.2%**

While the experiences of non-disabled staff have remained largely stable in recent years, responses from disabled colleagues showed a favourable downward trend from 2023 before deteriorating again in 2025. More than four in ten disabled staff (compared with 34.3% of non-disabled staff) reported experiencing harassment, bullying or abuse from patients, service users, relatives or members of the public. This has widened the gap between the two groups, from 6.9% in 2024 to 11.2% in 2025.

The Trust will continue to monitor this indicator through Staff Survey results, alongside internal reporting data and the work of the Violence Prevention and Reduction Team. This includes ongoing efforts to encourage reporting, strengthen support for staff, and work with police partners to increase prosecutions.

- **4.2: Managers**

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	11.3%	10.1%	9.1%	9.0%	**7.7%**
Disabled	18.6%	16.8%	14.8%	15.0%	**14.9%**
Difference	7.3%	6.7%	5.7%	6%	**7.2%**

The proportion of disabled staff experiencing negative behaviours from managers has remained stable since 2023, while the proportion of non-disabled staff has decreased compared with the previous year. Figures from the 2025 staff survey show that disabled colleagues are approximately twice as likely to experience bullying and harassment from managers compared with non-disabled staff.

This indicator highlights the need for continued focus on inclusive management practice and compassionate leadership, ensuring all staff are supported to work in a safe and respectful environment.

- **4.3: Other colleagues**

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	14.1%	14.0%	12.7%	13.3%	**11.4%**
Disabled	23.6%	21.8%	18.2%	20.2%	**18.5%**
Difference	9.5%	7.8%	5.5%	6.9%	**7.1%**

Disabled staff remain significantly more likely to experience negative behaviour from their peers, with almost one in five affected compared with just over one in ten non-disabled staff.

We continue to reinforce expectations of inclusive and respectful behaviour through leadership, culture, and learning and development initiatives, and will monitor whether this gap in colleague-to-colleague experiences narrows in future Staff Survey results.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	43.8%	45.1%	46.2%	52.4%	**50.2%**
Disabled	46.3%	44.7%	47.8%	49.9%	**49.5%**
Difference	2.5%	-0.4%	1.6%	-2.5%	**-0.7%**

Around half of both disabled and non-disabled staff reported their most recent incident of harassment, bullying or abuse, broadly in line with the previous year's results, though non-disabled staff saw a slight decrease of 2%.

While reporting levels are broadly consistent across the two groups, this indicates that a significant proportion of incidents continue to go unreported. Further work is required to ensure all staff feel safe and supported to report concerns through the full range of available routes, including line management, Freedom to Speak Up and other formal mechanisms.

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

In line with the 2025 NHS Staff Survey Technical Guide, some caution is advised when interpreting trends in Metric 5, as the wording of this question changed in 2025, meaning previous years may not be directly comparable.

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	49.7%	51.9%	52.2%	52.5%	**52.9%**
Disabled	39.4%	45.1%	48.7%	47.8%	**45.5%**
Difference	-10.3%	-6.8%	-3.5%	-4.7%	**-7.4%**

In 2025, fewer disabled staff compared to the previous year felt that the Trust acts fairly with regard to career progression or promotion - a decrease of 2.3% from 2024. This compares with 52.9% of non-disabled staff, an increase of 0.4%. The gap between the two groups has widened to 7.4%.

This indicates a continuing disparity in experience, with over half of disabled staff feeling that opportunities for progression are unfair. The downward trend since 2023, when this figure was 48.7%, highlights the need for continued focus on addressing barriers to progression.

To support fair recruitment practices, Recruitment and Selection training has been mandated for all new leaders, ensuring managers are equipped to undertake objective, inclusive and values-based decision-making.

The Trust also continues to invest in apprenticeships as a key route for workforce development and progression. For example, in 2025/26, over 175 new starters joined the EMT Apprenticeship programme, with 18% identifying as disabled, supporting broader efforts to improve access to career opportunities across the organisation.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	28.6%	27.2%	24.8%	27.2%	**23.8%**
Disabled	40.6%	38.3%	35%	33.3%	**29.0%**
Difference	12.0%	11.1%	10.2%	6.1%	**5.2%**

The proportion of both disabled and non-disabled colleagues feeling pressured by their manager to attend work despite not feeling well enough has fallen to its lowest level since 2021, with the gap between the two groups narrowing to 5.2%, continuing the trend of gradual improvement.

Despite this progress, a significant proportion of staff continue to report feeling pressure to attend work when unwell, with nearly 3 in 10 disabled staff and almost a quarter of non-disabled staff affected. This indicates that, while improvements have been made, further work is required to support a culture where staff feel able to prioritise their health and wellbeing.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	32.9%	33.6%	35.7%	36.2%	**37.2%**
Disabled	27.5%	23.9%	31.1%	30.4%	**24.6%**
Difference	5.4%	9.7%	4.6%	5.8%	**12.6%**

Around a quarter of disabled staff reported being satisfied with the extent to which the organisation values their work, a decrease of approximately 6% from 2024. This compares with 37.2% of non-disabled staff, an increase of 1%. The gap between the two groups has widened to 12.6% - significantly higher than the previous year's difference.

As part of the People Promise Exemplar programme, the Trust has reviewed and refreshed its compliments process to ensure that positive feedback is captured more consistently, shared more promptly, and reflects the contributions of all staff. Building on this work, a Trust-wide Recognition Framework will be launched in 2026/27 to provide a fair, consistent and inclusive approach to recognising exceptional contributions across all teams and service areas.

The Trust will also work in partnership with the Disability Staff Network to explore further opportunities to ensure disabled colleagues feel valued, recognised and respected within the organisation.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
Disabled	57.8%	63.0%	65.2%	71.3%	**69.0%**

In 2025, over two-thirds of disabled said that they had received reasonable adjustments. While this metric saw a slight decline compared to the previous year, the figure remains higher than levels from 2021 – 23.

We will continue to build on existing work to strengthen reasonable adjustments, including policy development, manager guidance and neurodiversity support. Training on reasonable adjustments, delivered since October 2024, has been attended by 390 leaders, managers and staff over 50 sessions, with significant numbers rating the training as good or very good. Feedback highlights the value of the training in supporting both individual needs and wider team awareness.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
Non-disabled	6.2	6.2	6.3	6.3	**6.3**
Disabled	5.6	5.6	5.9	5.9	**5.6**
Difference	0.6	0.6	0.4	0.4	**0.7**

The 2025 Staff Survey results show that the gap for this metric between disabled and non-disabled staff has widened to 0.7, compared with 0.4 in both 2024 and 2023.

While engagement scores for non-disabled staff have remained stable, scores for disabled staff have declined to levels last seen in 2021/22.

This position highlights the need for continued focus on improving engagement and overall staff experience for disabled colleagues, ensuring that all staff feel supported, valued, included and able to contribute fully within the organisation.

Metric 10: Representation of disabled people among Board members

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

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

Disability declarations

NWAS Disabled staff 31/03/2026	10.4%	**Disabled Board Members 31/03/2025**	18.75%
Voting Board Members	16.67%	**Non-Voting Board Members**	25%
Executive Board Members	25%	**Non-Executive Board Members**	12.5%

The proportion of total board members declaring a disability has increased to 18.75% (8% in 2025).

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

Year	2023/24	2024/25	**2025/26**
Disabled	7%	-2%	**8.37%**
Non-disabled	-29%	-24%	**-16.34%**
Disability unknown	22%	26%	**7.98%**

Trust-wide actions

The WDES data along with the Workforce Race Equality Standard (WRES), and Pay Gap data (set out in separate reports) reflects the ongoing work to support all our staff groups and address inequalities in the workplace.

While there have been some improvements across a number of key areas, we recognise that there remains a significant difference in the experiences of disabled and non-disabled staff. We will continue to explore the reasons for this and put in place actions to help improve the employee experience of our colleagues with disabilities.

Listed below are some of our areas of focus for 2026/27:

Indicator 1 – Workforce representation
We will continue to encourage staff to update their disability status and with the support of the Disability Network, deliver targeted engagement activities in areas where disability declaration rates remain lowest, to improve the accuracy and completeness of workforce data.

Metric 2 – Recruitment

- We will continue to deliver targeted careers support through the Widening Access Team, including community careers events, online engagement sessions, partnerships with local organisations and one-to-one coaching, with an increased focus on improving engagement with and representation of disabled people.
- We will develop and deliver training for recruiting managers on inclusive interview skills, with a particular focus on reducing bias and promoting diversity and inclusion throughout the recruitment process.

Metric 3 - entering the formal capability process on the grounds of performance
Review emerging themes within capability data, ensure reasonable adjustments are consistently considered, and provide targeted support to managers to reduce disproportionality and improve outcomes for disabled staff.

Metric 7 – Satisfaction with the extent to which organisation values work.
Work in partnership with the Disability Staff Network to explore further opportunities to ensure disabled colleagues feel valued, recognised and respected within the organisation.

North West Ambulance Service
NHS Trust

Workforce Race Equality Standard (WRES) Data Report

Covering the period of
1 April 2025 – 31 March 2026

Introduction

This report sets out the 2025/26 annual workforce data in relation to race, which the Trust is required by NHS England to publish.

Monitoring workforce equalities data supports compliance with the Equality Act 2010 and the Public Sector Equality Duty. It is also central to delivering our Equality, Diversity and Inclusion (EDI) priorities:

- Embedding fair and inclusive recruitment and progression processes
- Promoting a psychologically safe working environment
- Reducing experiences of bullying, harassment and discrimination
- Improving retention and career progression for underrepresented groups

Workforce Race Equality Standard (WRES)

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

The data in this report relates to the period of 1 April 2025 – 31 March 2026 and comprises information taken from the Electronic Staff Record (MyESR), HR Business Partnering, Learning & Development, and the December 2025 annual NHS Staff Survey.

In line with the nationally mandated timeframe, the data was submitted to NHS England in May 2026.

Indicator 1: Workforce information

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

Overall 2025/26	31/03/2026
Total workforce	**8023**
BME staff	**575**
% BME staff in total workforce	**7.2%**

These figures show an increase of 0.5% in BME representation from 6.7% in 2024/25, meeting the Trust's year-on-year improvement target. The declaration rate for ethnicity in the trust has remained at more than 99%, with only around 75 staff members not having declared as at 31 March 2025. Colleagues are regularly reminded to update their details on the Electronic Staff Record and work continues to reduce the number of non-declarations.

Historic Overall	31/03/ 2022	31/03/ 2023	31/03/ 2024	31/03/2025
Total workforce	6815	7073	7421	7775
BME staff	325	365	444	521
% BME staff in total workforce	4.8%	5.2%	6.0%	6.7%

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

Agenda for Change bandings	Non-clinical Staff		Clinical Staff	
	2025/26	2024/25	**2025/26**	2024/25
Cluster 1: Bands 1 - 4	**21.0%***	10.6%	**5.7%**	8.1%
Cluster 2: Bands 5-7	**7.7%**	10.3%	**4.6%**	4.6%
Cluster 3: Bands 8a-8b	**7.5%**	7.0%	**2.6%**	2.6%
Cluster 4: Bands 8c-9 and VSM	**10.9%**	12.9%	**0%**	0%

*When collating data for this year's return it was identified that the occupation codes G2D and G2E should be counted as 'non clinical' and had been counted on previous returns as clinical. This accounts for the variation in numbers for non-clinical overall by 1,000 and a reduction of clinical by 800 in comparison to previous year's figures.

There has been a further increase in the proportion of BME staff within the overall workforce, compared with the previous year, with representation exceeding 7% for the first time. The data indicates that approximately one in five employees in entry-level non-clinical roles are from BME backgrounds. Representation across other non-clinical staff groups is broadly aligned with overall NWAS BME workforce representation, and BME staff continue to be overrepresented in Cluster 4, despite a slight decline from the previous year.

In contrast, BME representation across clinical cohorts remains limited. Proportionally, fewer BME staff are employed in clinical roles compared to non-clinical, and their presence diminishes further at management and leadership levels.

Indicator 2: Recruitment

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

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

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
Likelihood	1.98	1.26	1.61	2.39	**2.53**

Data for Indicator 2 shows that White applicants were around two-and-half times more likely to be appointed from shortlisting compared to BME applicants – which is a deterioration compared to the previous year. Although numbers of applications from people of BME backgrounds remain strong, converting these applications into appointments continues to be a significant challenge.

BME shortlisting and appointment data

Year	2021/22	2022/23	2023/24	2024/25	2025/26
BME Shortlisted	349	602	1046	1568	1059
BME Appointments	48	102	134	144	90

In 2025/26, the Trust received approximately 18,200 applications, of which around 8,300 (45%) were from Black and Minority Ethnic (BME) applicants. White applicants accounted for 53% of all applications, a 1% increase compared with the previous

year. While BME applicants represented a substantial proportion of the applicant pool, their representation reduced markedly through the recruitment process, accounting for 22% of shortlisted candidates (approximately 500 fewer than the previous year) and 11% of appointments. White applicants, by comparison, comprised 76% of shortlisted candidates and 85% of appointments. Although the proportion of BME appointments increased slightly from 10% in the previous year to 11%, the overall number of BME appointments fell significantly, representing the first year-on-year decline in BME appointments.

The proportion of applicants who chose not to disclose their ethnicity remained low, increasing from 2% at application stage to 4% at appointment.

Several initiatives are underway to help address the disparity in outcomes for BME applicants:

- BME Recruitment Action Group has been established, bringing together key stakeholders to review recruitment practices across attraction, shortlisting, assessment and interviews. The group is focused on identifying practical actions to improve BME representation in NWAS.
- Job descriptions and person specifications have been reviewed, particularly for entry-level and high-volume roles such as ICC Call Handlers and EMT Apprenticeship, to ensure they are relevant, accessible and inclusive.
- Improving the diversity of interview and assessment panels through the proposed introduction of Independent Panel Members, and more BME staff completing interview training.
- Positive Action Team continues to engage with underrepresented communities to encourage and support applicants from those backgrounds. The team also tracks and monitors the progression of BME applicants throughout the recruitment process, to understand clearly where applicants may be disproportionately exiting the process, so that improvements can be made.
- Recruitment and Selection training has been mandated for all new leaders, ensuring recruiting managers are equipped to undertake fair, objective, values-based decision-making.
- Introduction of a refreshed approach to leadership recruitment for all direct line-manager and Band 8+ roles. The revised process embeds fairness and inclusion, supporting the Trust's ambition to improve workforce diversity while placing greater emphasis on candidates' overall capability and potential, rather than observed behaviours alone.

A point on data - *It should be noted that on our recruitment portal (Trac), a campaign is considered completed when all appointees from a campaign have*

commenced in post. This means that for example, if there is a vacancy that opens on 1 March 2026, but the successful individual(s) does not commence in post until 15 April 2026, this recruitment will not be counted in the data. This issue with the data is a particular challenge for us, as the trust manages several mass recruitment campaigns each year, and at times, these may cross over from one financial year to the other. The portal only closes a vacancy once every individual with an offer starts in the position.

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

More information on our inclusive recruitment work can be seen in the Equality, Diversity and Inclusion Annual Report 2025-26.

Indicator 3: Formal Disciplinary Process

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

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

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
Likelihood	2.23	1.86	2.59	2.67	**2.64**

The indicator measuring entry into the formal disciplinary process continues to show a significant disparity. BME staff were over two-and-a-half times more likely than White staff to enter the formal disciplinary process, broadly in line with the previous year.

In 2025/26, there were around 160 formal disciplinary cases, a reduction from 187 in the previous year. Of these, 29 involved BME staff, compared with 30 last year. BME staff therefore accounted for 18% of formal disciplinary cases, while representing approximately 7% of the workforce.

Two thirds of BME disciplinary cases involved staff working within the Integrated Contact Centres (ICC), where a significant proportion of BME staff are employed. However, the proportion of BME disciplinary cases within ICC reduced from 43% last year to 35% this year, an improvement of 8%.

To support positive action in relation to this Indicator, a dedicated Task and Finish Group led by ICC management, with support from the HR Business Partnering Team has been established to focus on identifying practical actions to reduce disproportionality and support fair, consistent and inclusive application of the disciplinary process across NWAS. Planned actions include increasing managers' confidence and capability to address workplace issues through early, informal discussions where appropriate, reducing unnecessary escalation to formal processes. Additionally, the introduction of a refreshed fact-finding pro forma that incorporates equality, diversity and inclusion considerations, alongside initiatives to support greater diversity within leadership teams have been identified as areas of focus.

Indicator 4: Non-mandatory training and CPD

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

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

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
Likelihood	1.01	1.01	1.11	0.95	**1.12**

Access to CPD is a key enabler for career progression, skills development and retention, and remains a priority for the Trust. Ensuring fair and consistent access across all staff groups is essential to improving workforce diversity and outcomes across WRES indicators.

The indicator measuring access to non-mandatory training and CPD shows a slight decline for BME staff compared with the previous year; however, it continues to demonstrate broadly equitable access between White and BME staff groups. The change is partly attributable to an improved methodology for collating CPD participation data this year, which provides a more accurate reflection of staff access by eliminating the double-counting of individuals that occurred in previous years.

In 2025/26, 183 BME staff accessed non-mandatory training and CPD, compared with 293 in the previous year. In contrast, 2,619 White staff accessed CPD, down from 3,838 the year before.

The data in the following indicators (5 – 8) is based on responses from the NHS Staff Survey 2025.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
White staff	40.0%	38.1%	37.3%	37.3%	**38.2%**
BME staff	37.1%	34.4%	30.8%	34.4%	**38.0%**
Difference	2.9%	3.7%	6.5%	2.9%	**0.2%**

Figures for 2025/26 show that nearly four in ten of both BME and White staff experienced harassment, bullying or abuse from patients, relatives or the public during the year. This represents a year-on-year increase, and for BME staff, a significant jump from 2023 figures. The figures also show a narrowing in the experience gap between BME and White staff to 0.2%, the lowest level recorded.

Over the past year, the Violence Prevention and Reduction team, has been working to strengthen reporting processes, increase prosecutions and enhance support for affected staff. Work is also continuing to address sexual safety challenges and racism faced by our staff, through the Sexual Safety and Anti-racing Steering Groups.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
White staff	23.6%	22.2%	19.5%	21.1%	**19.4%**
BME staff	29.5%	23.7%	20.0%	21.5%	**18.5%**
Difference	-5.9%	-1.5%	0.5%	0.4%	**-0.9%**

The most recent Staff Survey results show a continued reduction in the proportion of staff experiencing harassment, bullying or abuse from colleagues, with a decrease of 1.7% for White staff and 3% for BME staff compared with the previous year. Since 2021, responses from BME staff have improved by 11%, reflecting sustained progress in the Trust's work to improve organisational culture and staff experience. For the first time, a lower proportion of BME staff than White staff reported experiencing these negative behaviours. Despite this positive trend, the findings indicate that around one in five staff still experience harassment, bullying or abuse from colleagues.

The results suggest that, whilst progress has been made, further work is required to ensure a consistently positive and inclusive working environment for all staff. The improvements seen reflect a range of initiatives implemented across the Trust, including a strengthened focus on leadership, culture and behaviours, delivery of training on inclusion, civility and psychological safety, and improved processes for raising and addressing concerns, including Freedom to Speak Up.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
White staff	47.8%	50.4%	52.0%	51.6%	**50.8%**
BME staff	33.6%	44.1%	40.0%	45.6%	**45.5%**
Difference	9.0%	6.3%	12.0%	6.0%	**5.3%**

On career progression, the Staff Survey results show a largely stable position when compared to the previous year, for both BME and White staff.

However, the challenge remains that a significant proportion of staff overall continue to perceive career progression opportunities as not being fair. Around 55% of BME staff and 49% of White staff, do not feel that there are equal opportunities for progression or promotion.

The positive movement in this indicator is likely to come from leadership and development programmes to support progression from underrepresented groups, improvements to inclusive recruitment and selection practices, and a greater focus on career pathways and internal development opportunities. Improving staff confidence in equal opportunities for career progression is essential in supporting retention, engagement and representation at all levels of the organisation.

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

Staff Survey Year	2021	2022	2023	2024	**2025**
White staff	10.0%	11.1%	10.8%	10.1%	**9.2%**
BME staff	22.4%	14.0%	13.0%	12.4%	**9.3%**
Difference	-12.4%	-2.9%	-2.2%	-2.3%	**-0.1%**

The proportion of staff experiencing discrimination has fallen consistently in the last few years, with the current figure at around 9% for both BME and White staff.

There has been a notable improvement for BME staff, with numbers reducing from 12.4% in 2024 to 9.3% in 2025. The improving position reflects ongoing work across the Trust such as delivery of training on equality, diversity and inclusion, an increased focus on leadership behaviours and inclusive culture, and strengthened processes to support staff to raise concerns and report incidents.

The Trust remains committed to creating an environment where all staff feel valued, respected and able to be themselves at work. Reducing experiences of discrimination will continue to be at the heart of our agenda to become a more inclusive organisation.

Indicator 9: Representation of BME people among board members

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

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

NWAS BME staff 31/03/2025	7.2%	**BME Board Members 31/03/2025**	12.5%
Voting Board Members	16.7%	**Non-Voting Board Members**	0%
Executive Board Members	12.5%	**Non-Executive Board Members**	12.5%

BME representation on the Board has reduced to 12.5%, compared with 15.4% in 2024/25 and 14.2% in 2023/24. Despite this decrease, representation at Board level remains higher than across the overall workforce, with a difference of 5.3%.

All Board members have declared their ethnicity, ensuring completeness of reporting for this indicator.

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

Year	2021/22	2022/23	2023/24	2024/25	**2025/26**
White staff	-17.1%	-15.2%	-14%	-7.8%	**-4.4%**
BME staff	10.6%	9.1%	8.3%	8.7%	**5.3%**
Ethnicity unknown	6.4%	6.1%	6.1%	-0.9%	**-0.9%**

Actions for improvement

The Workforce Race Equality Standard (WRES) data, alongside the Workforce Disability Equality Standard (WDES) and Pay Gap reports (presented separately), reflects the Trust's ongoing commitment to supporting all staff groups and addressing inequalities in the workplace.

While there have been improvements across a number of WRES Indicators, we recognise that significant disparities persist in the experiences of BME and White staff. We will continue to take action to explore the underlying causes of these differences and implement targeted actions to improve the experience and outcomes of our BME colleagues.

Indicator 1 – Workforce representation
We will deliver the BME Recruitment and Retention Action Plans to improve the representation of BME staff across the organisation.

Indicator 2 – Recruitment

- We will continue to review job descriptions and person specifications to ensure they are relevant, accessible, and inclusive.
- We will introduce Independent Panel Members and increase BME representation on recruitment and assessment panels.
- We will strengthen monitoring and tracking of applicants from underrepresented groups to improve timeliness and effectiveness of engagement with unsuccessful candidates.
- We will develop and deliver training for panel members on inclusive recruitment and selection, with rollout planned from Q2 2026/27 and evaluation at year end.

Indicator 3 – Formal disciplinary process

- We will strengthen managers' confidence and capability to address workplace issues through timely, informal conversations where appropriate, reducing unnecessary escalation to formal disciplinary processes.
- We will introduce a refreshed fact-finding pro forma that embeds EDI considerations throughout the investigation process.

Indicator 5 – Experiences of harassment, bullying and abuse from the public
We will implement a clear procedure to support ICC staff who experience racist abuse or sexual harassment from the public. A standard operating procedure (SOP) is currently under review within ICC to ensure alignment between 111 and 999 services, enabling consistent managerial support and appropriate escalation where required.

Indicator 8 – Discrimination

We will develop and deliver the Anti-Racism Workplan and progress towards achieving Northwest Race Equality Assembly accreditation status by late 2026/27.

North West Ambulance Service NHS Trust

Pay Gap Data Report (Gender, Ethnicity & Disability)

Covering the period of 1st April 2025 – 31st March 2026

Published: **July 2026**

Introduction

Pay gap reporting provides an opportunity to understand how different groups of staff are represented and rewarded across the organisation, helping to identify where inequalities exist and where action is needed. For North West Ambulance Service, it is an important part of our commitment to creating a fair, inclusive and supportive workplace where everyone has the opportunity to thrive. By addressing disparities, we aim to strengthen our workforce, maximise talent, and ultimately improve the care we provide to our patients and communities.

This report provides an overview of NWAS's gender, ethnicity and disability pay gaps as at 31 March 2026, using pay gap reporting data drawn from the Electronic Staff Record (ESR). On this date, the pay gap reporting cohort comprised 8,008 staff. This may differ slightly from workforce totals reported through WRES and WDES due to reporting methodology and inclusion criteria.

The reporting period covers 1 April 2025 to 31 March 2026. Hourly pay has been calculated in line with government guidance, in accordance with Schedule 2 of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017.

Reporting follows guidance issued by the Government Equalities Office and measures the difference in average hourly pay between the following groups:

- Men and women (Gender Pay Gap)
- White staff and Black and Minority Ethnic (BME) staff (Ethnicity Pay Gap)
- Non-disabled staff and disabled staff (Disability Pay Gap)

While the Trust has published gender pay gap information for many years, 2025/26 represents the second year that ethnicity and disability pay gap data has been published and the third year that the data has been analysed to better understand workforce inequalities and inform targeted action.

Pay gap analysis considers differences in average and median hourly pay between staff groups. These differences are influenced by workforce distribution across pay bands and positions within those bands.

It is important to note that pay gap reporting is distinct from equal pay. Equal pay relates to differences in pay between individuals performing the same or similar roles, or work of equal value, whereas pay gap reporting reflects the overall distribution of different groups across the organisation.

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

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

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

Gender Pay Gap Data

Table A: 2025/26 Gender Split by Quartile

Quartile	Female	Male
Lower pay quartile (LQ)	**57.72%**	**42.28%**
Lower middle quartile (LMQ)	**62.49%**	**37.51%**
Upper middle quartile (UMQ)	**51.45%**	**48.55%**
Upper quartile (UQ)	**47.67%**	**52.33%**

Female representation within the NWAS workforce has continued to increase over recent years. As at 31 March 2026, 56.58% of staff were female, compared with 56.19% in 2025 and 53.13% in 2024.

Table A demonstrates a varied position across the pay quartiles. Female representation has increased in the lower-middle, upper-middle and upper quartiles when compared with the previous reporting year. Representation in the upper quartile saw a notable increase to 47.67% (from 45.66% in 2025), while the upper-middle quartile rose slightly to 51.45% (from 50.03%). The lower-middle quartile also experienced a modest increase to 62.49% (from 61.89%).

In contrast, female representation in the lower pay quartile has decreased to 57.72%, compared with 59.89% in 2025.

Overall, women continue to comprise the majority of staff within the lower and lower-middle quartiles and remain marginally overrepresented in the upper-middle quartile. Although men continue to represent a higher proportion of staff in the upper quartile, the gap has narrowed from 7.7% in 2024/25 to 4.7 this year.

Table B: Historic gender split by quartile for comparison

Quartile	2020/21 F	2020/21 M	2021/22 F	2021/22 M	2022/23 F	2022/23 M	2023/24 F	2023/24 M	2024/25 F	2024/25 M
LQ	60.95%	39.05%	55.1%	44.9%	58.78%	41.22%	57.63%	42.37%	59.89%	40.11%
LMQ	56.04%	43.96%	58.5%	41.5%	60.63%	39.37%	60.29%	39.71%	61.89%	38.11%
UMQ	47.43%	52.57%	49.4%	50.6%	50.11%	49.89%	50.54%	49.46%	50.03%	49.97%
UQ	37.23%	62.77%	37.8%	62.2%	39.05%	60.95%	44.06%	55.94%	45.66%	54.34%

Table C: 2025/26 Hourly Pay Gap

	Average Hourly Rate	Median Hourly Rate
Male	£21.31	£20.26
Female	£19.96	£18.17
Difference	-£1.35	-£2.10
Pay Gap %	**-6.34%**	**-10.34%**

Table C shows that the mean (average) hourly gender pay gap is -6.34%. This represents an improvement compared to -7.63% in 2025 (see Table D) and is the lowest mean pay gap reported in the last seven years.

The median hourly pay gap is -10.34%, which also reflects an improvement from -12.68% in 2025. While the gap remains notable, this indicates a positive shift in the distribution of earnings between male and female employees.

Differences in pay continue to be influenced by workforce distribution across pay quartiles. A higher proportion of female staff remain concentrated within the lower and lower-middle pay quartiles, which lowers the overall average and median hourly pay for women. In contrast, male staff are more highly represented in the upper pay quartile, contributing to a higher average and median hourly rate.

The upper-middle quartile shows a near-equal gender distribution, with a slightly higher proportion of female staff. The upper quartile continues to have a higher proportion of male employees, although the difference has decreased yet again year on year. This distributional imbalance remains a key factor influencing both the mean and median pay gaps.

Length of service is also likely to be a contributing factor. On average, male employees have longer tenure, increasing the likelihood of being positioned at higher incremental pay points within bands.

Table D: Historic hourly pay gap for comparison

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Average hourly pay gap	-8.79%	-10.89%	-9.80%	-10.77%	-7.27%	-7.63%
Median hourly pay gap	-7.2%	-9.26%	-8.66%	-10.54%	-11.17%	-12.68%

Ethnicity Pay Gap Data

BME representation in the Trust increased to 7.2% in 2025/26, up from 6.7% in 2024/25. However, the WRES Indicator 1 data shows representation remains uneven across the workforce, with BME staff more highly represented in lower band roles and less represented in senior clinical leadership and management roles. This distribution is likely to remain a key factor influencing the ethnicity pay gap.

91.9% of NWAS staff identify as White, and 0.9% did not declare their ethnicity. By comparison, data from the 2021 Census indicates that 85.6% of the North West population identified as White, with 14.4% representing ethnic minority groups.

Table E: 2025/26 Ethnicity split by quartile

Quartile	White	BME	Unknown
Lower pay quartile	**89.84%**	**9.33%**	**0.83%**
Lower middle quartile	**92.28%**	**6.89%**	**0.83%**
Upper middle quartile	**93.94%**	**5.13%**	**0.93%**
Upper quartile	**92.07%**	**6.01%**	**1.92%**

BME representation remains lowest in the upper-middle quartile (5.13%) and highest in the lower pay quartile (9.33%). In numerical terms, there are 180 BME staff within the lower quartile compared to 116 in the upper quartile. In contrast, White staff are consistently represented in significantly higher numbers across all quartiles, with approximately 1,750 individuals in each.

There are also a small number of staff who have not declared their ethnicity across each quartile, with the highest proportion (1.92%, 37 staff) recorded in the upper quartile.

Comparison with the previous year (Table F) shows a mixed but generally positive trend, with BME representation increasing in three of the four pay quartiles, most notably in the lower quartile and upper middle quartile.

Table F: Historic Ethnicity split by quartile for comparison

Quartile	2023/24 White	2023/24 BME	2023/24 Unknown	2024/25 White	2024/25 BME	2024/25 Unknown
LQ	92.76%	6.37%	0.87%	91.70%	7.50%	0.80%
LMQ	92.59%	6.48%	0.93%	92.39%	6.71%	0.90%
UMQ	92.81%	6.26%	0.93%	93.08%	5.96%	0.96%
UQ	93.57%	4.63%	1.80%	92.76%	5.27%	1.97%

The mean hourly pay gap between White and BME staff has increased to -5.65% (-£1.17) , while the median pay gap has almost doubled to -11.23% (-£2.17), as shown in Table G.

Table G: 2025/26 Hourly Pay Gap

Ethnicity	Average Hourly Rate	Median Hourly Rate
White	£20.62	£19.30
BME	£19.46	£17.13
Difference	-£1.17	-£2.17
BME Pay Gap %	**-5.65%**	**-11.23%**

Both the mean and median ethnicity pay gaps have widened compared with the previous year. The mean hourly pay gap increased from -4.38% in 2024/25 to -5.65% in 2025/26, while the median gap increased from -6.28% to -11.23%.

This widening has occurred despite improvements in BME representation in some pay quartiles and highlights the need for further analysis of workforce distribution, length of service, role type and progression patterns.

Table H: Historic hourly pay gaps for comparison

	2023/24	2024/25
BME Average hourly pay gap	-2.67%	-4.38%
BME Median hourly pay gap	-4.53%	-6.28%

Given the limited data available over three years, caution should be exercised in drawing definitive conclusions. However, workforce distribution continues to be a key influencing factor. BME staff remain proportionately more concentrated within the lower pay quartile and less represented in the upper quartiles, which continues to impact both average and median earnings.

Length of service may also be a contributory factor. White staff, on average, have longer tenure, increasing the likelihood of progression to higher pay points within bands.

Ongoing monitoring and further analysis will be required to better understand the drivers behind these trends and to inform targeted actions to address identified disparities.

Disability Pay Gap Data

As at 31 March 2026, 10.1% of staff in the organisation identified as disabled – and increase from 9.3% in the previous year. The proportion of non-disabled staff remained at 85%, and 4.9% (down from 5.7% previous year) of staff did not disclose their disability status.

Table I: 2025/26 Disability split by quartile

Quartile	Non-disabled	Disabled	Not declared	Prefer not to answer	Unspecified
Lower pay quartile	85.54%	10.67%	1.81%	0.36%	1.61%
Lower middle quartile	88.50%	9.43%	1.04%	0.21%	0.83%
Upper middle quartile	82.18%	9.22%	3.73%	0.62%	4.25%
Upper quartile	83.89%	10.88%	2.69%	0.52%	2.02%

The distribution of disabled staff across the four pay quartiles remains relatively even. Representation ranges from 9.22% in the upper middle quartile to 10.88% in the upper quartile. The proportion is slightly higher in the lower (10.67%) and upper (10.88%) quartiles compared to the middle quartiles.

The upper middle quartile also contains the highest proportion of staff who have not declared their disability status (including “not declared,” “prefer not to answer,” and “unspecified”), indicating a higher level of non-disclosure than other quartiles.

Table J: Historic Disability split by quartile for comparison

Quartile	2023/24 Non-disabled	2023/24 Disabled	2024/25 Non-disabled	2024/25 Disabled
LQ	92.10%	7.90%	85.66%	10.19%
LMQ	92.76%	7.24%	88.21%	9.07%
UMQ	92.65%	7.35%	81.33%	9.10%
UQ	92.48%	7.52%	84.79%	8.83%

Comparison with previous years shows there has been a clear increase in the representation of disabled staff across all pay quartiles. In 2024, disabled representation ranged from 7.24% to 7.90%, and in 2025 it increased to between 8.83% and 10.19% across the quartiles.

This upward shift reflects improved representation and also indicates increased confidence among staff in disclosing their disability status, supported by internal communication campaigns and continuing work by the Disability Network.

Table K: 2025/26 Hourly Pay Gap

Disability status	Average Hourly Rate	Median Hourly Rate
Non-disabled	£20.57	£19.19
Disabled	£20.62	£19.18
Difference	£0.05	-£0.01
Disability Pay Gap %	**+0.24%**	**-0.05%**

In 2025/26, the average hourly pay rate for disabled staff was slightly higher than that of non-disabled staff. Disabled staff earned an average of £20.62 per hour, compared to £20.57 for non-disabled staff, resulting in a small positive pay gap of +0.24% in favour of disabled staff.

At the median level, disabled staff earned £19.18 per hour, compared to £19.19 for non-disabled staff. This represents a very small negative gap of -0.05%, indicating near parity between the two groups.

Overall, the differences in both average and median hourly pay are minimal, suggesting a broadly equitable pay position between disabled and non-disabled staff.

Table L: Historic hourly pay gaps for comparison

	2023/24	2024/25
Disability Average hourly pay gap	-0.79%	-0.71%
Disability Median hourly pay gap	-1.06%	-1.29%

As with the Ethnicity Pay Gap, it is difficult to attribute the Disability Pay Gap to any single factor. While the overall gaps are small and indicate a broadly equitable position, continued monitoring is important.

Understanding the underlying drivers of these differences will require ongoing engagement with key stakeholders, including the Disability Network. A collaborative and evidence-based approach will support NWAS in maintaining progress and ensuring equitable outcomes for all staff.

Bonus Pay – Gender / Ethnicity / Disability

Bonus pay includes payments related to profit sharing, performance, productivity, commission, incentives, or long service awards with a monetary value.

In 2025/26, no bonus payments were made under the reporting criteria.

Trust-wide actions

The Trust applies national NHS terms and conditions of service, alongside the national job evaluation system, to determine job banding. These frameworks have been equality impact assessed and are subject to joint national review by trade unions and management. Collectively, they provide a robust, non-discriminatory foundation that supports equal pay for work of equal value. NWAS remains committed to reducing pay gaps by improving representation within the upper pay quartiles.

Our approach focuses on addressing systemic barriers that affect all staff, while also taking targeted action to address inequalities experienced by specific groups, including those defined by gender, ethnicity, and disability.

We are committed to creating an inclusive workplace and we aim to build on the range of actions underway to address identified pay gaps:

- Job descriptions and person specifications have been reviewed, particularly for entry-level and high-volume recruitment roles such as ICC Call Handlers and EMT Apprenticeships, to ensure requirements are relevant, accessible and inclusive

- Work is underway to improve the diversity of interview and assessment panels

- A review and refresh of the leadership recruitment process has been undertaken in 2025/26, which aims to reduce the risk of unconscious bias and promotes greater fairness and consistency in decision-making in the recruitment of leaders

- Positive Action Team has improved processes to track and monitor the progress of BME applicants throughout the recruitment journey. This will support a clearer understanding of where applicants may be disproportionately exiting the process and inform further targeted interventions

- We have reviewed and updated our Flexible Working Policy, Menopause Policy, Sexual Safety Policy, Career Break Policy and Dignity at Work Policy

- Continued to encourage staff to declare the equality monitoring information to help better understand the diversity of our workforce and increase declaration rates.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Integrated Board Report
PRESENTED BY	Elaine Strachan-Hall, Director of Quality and Improvement
PURPOSE	Assurance

STRATEGIC AIM(S)	All strategic aims							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒
	SR05	☒	**SR06**	☒	**SR07**	☒	**SR08**	☒

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

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 **June 2026.** Further narrative is contained within the accompanying data pack. The report shows historical and current performance on Quality, Effectiveness, Operational performance, Finance, and Organisational Health. **Quality** Quality indicators remain broadly stable. Complaints and incident reporting remain within expected levels of variation and there are no significant emerging themes or concerns requiring escalation. Violence and aggression remains a key focus area, with ongoing work to strengthen reporting and support arrangements across operational services Actions continue around violence and aggression, with ongoing work in the Integrated Contact Centre ahead of changes leading to increased reporting from the 111 service in line with the new standard operating procedure. **Effectiveness**

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

Patient experience scores reduced across PES, PTS and NHS 111 during June, although overall feedback remains positive. Ambulance Care Quality Indicators continue to perform strongly, with all metrics performing above the national average with the exception of ROSC Utstein, which is below the national average.

Hear and Treat performance improved slightly to 18.2% in June (17.9% in May), while See and Treat remained stable at 25.8%. Ongoing improvement work is focused on increasing clinical intervention rates, improving conversion performance and reducing avoidable conveyance.

Operational Performance

Operational performance deteriorated during June following a period of sustained hot weather and increased demand. High activity levels contributed to deterioration in response performance across Categories 1–4 and increased long waits. Category 1 response performance moved marginally outside target, and C2 mean fell outside of the UEC target. Despite this deterioration, the Trust continues to perform strongly compared to peers and remains ranked second nationally for Category 1 performance.

Turnaround: Hospital handover performance remains above the 30-minute standard, although lost unit hours reduced during June.

NHS 111: performance declined during June due to periods of high demand and workforce pressures, with call answering metrics remaining below national standards. However, clinical call-back performance continues to improve and wider ICC improvement activity remains underway.

PTS: activity remains stable, although some performance metrics remain below contractual standards.

Finance

The Trust reported a Month 03 surplus of **£0.163m** against a planned deficit of **£0.788m**. Productivity and efficiency delivery is broadly on plan.

Organisational Health

- Sickness absence remains stable compared to last year but is not yet showing improvement against medium-term plan targets.
- Turnover remains broadly stable overall.
- The vacancy gap risk remains within PES, where recruitment and training plans are operating at maximum capacity.
- Appraisal compliance remains in line with target
- Mandatory training compliance continues to improve (88.7%)

PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	22/07/2026
	Outcome	Noted – UEC performance discussed in depth

North West Ambulance Service NHS Trust

Integrated Performance Report

Board of Directors – July 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.

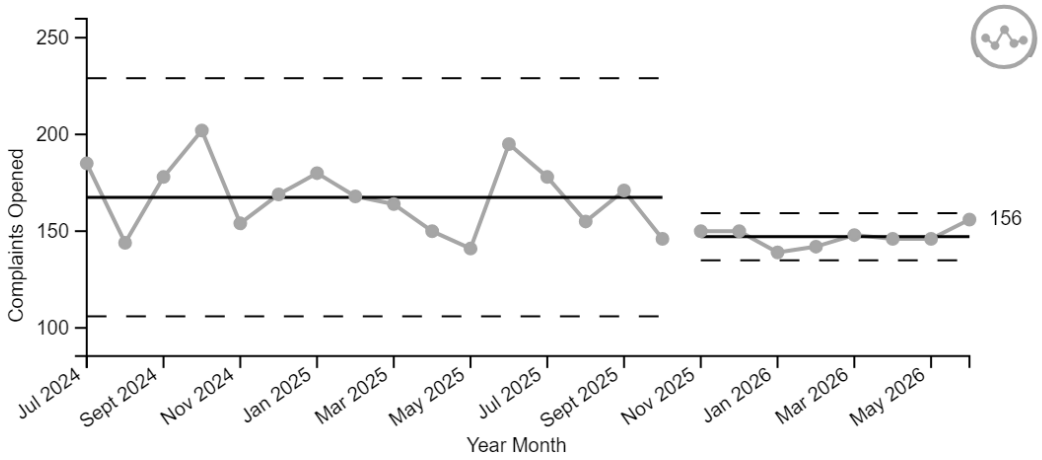
N.B. purple indicates non performance related indicator with arrow indicating direction of travel

Quality & Effectiveness

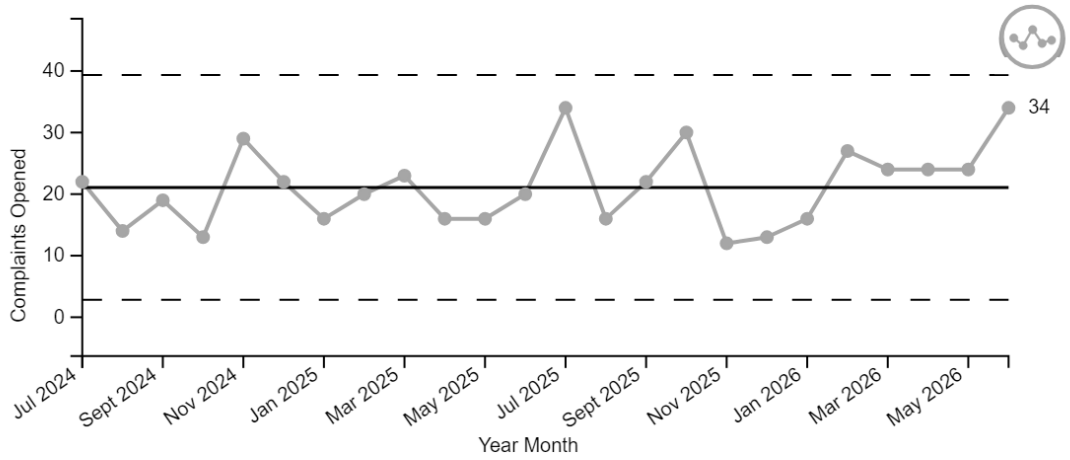
Q1 Complaints
Q2 Incidents
Q3 Safety Alerts
E1 Patient Experience
E2 Ambulance Clinical Quality Indicators (ACQI)
E3 Activities and Outcomes

Q1 Complaints

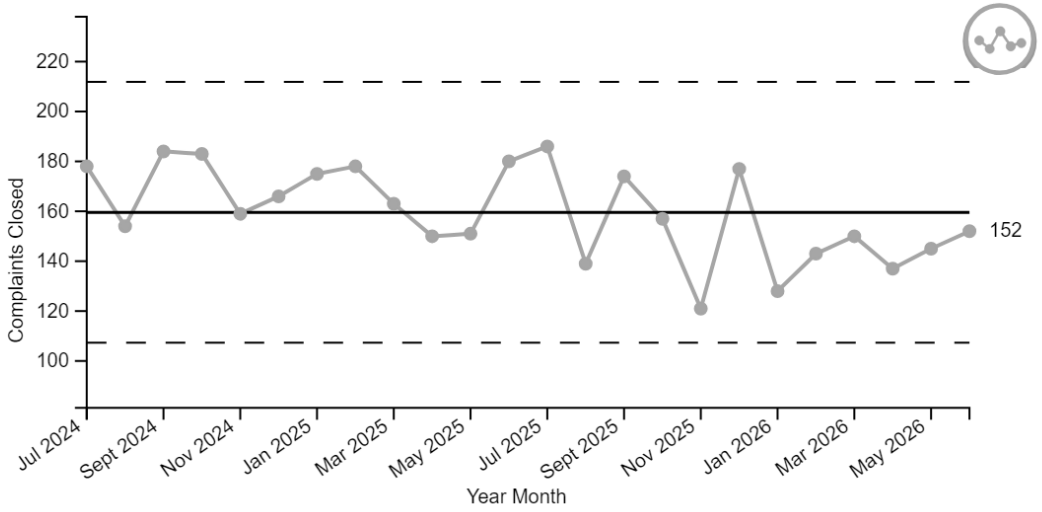
Complaints Opened with Risk Score 1-2



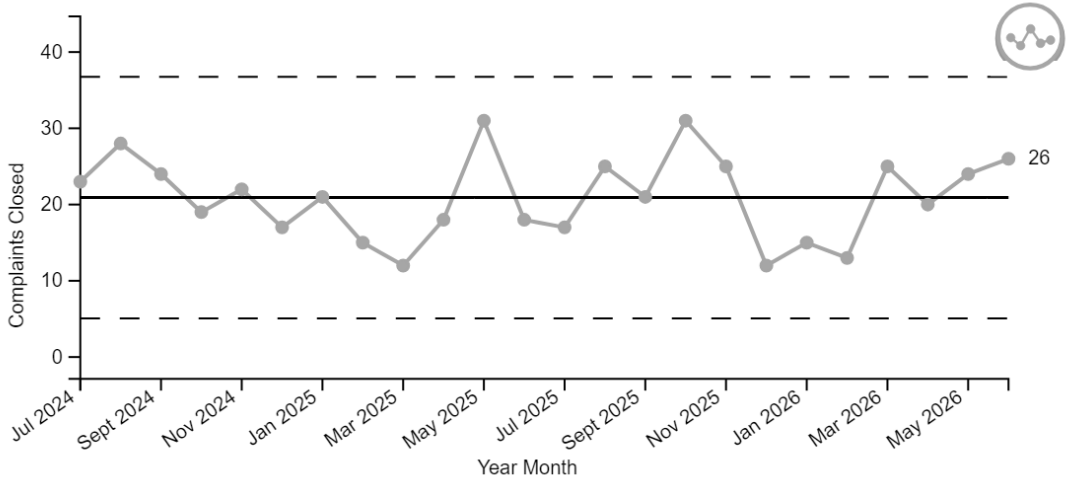
Complaints Opened with Risk Score 3-5

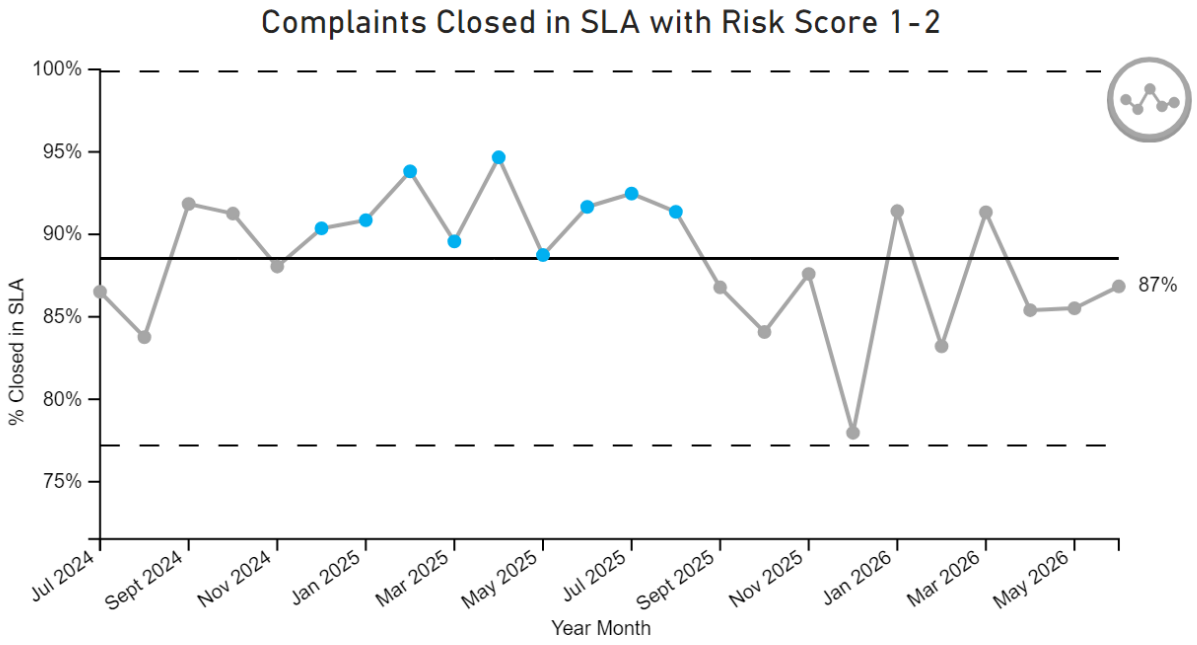


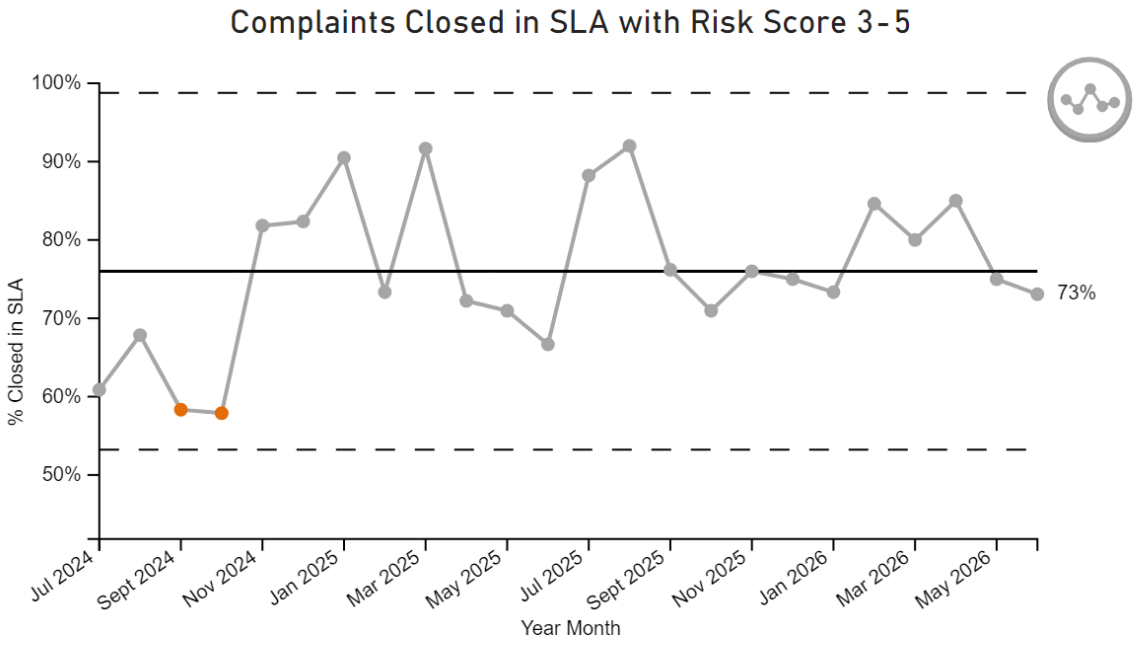
Complaints Closed with Risk Score 1-2



Complaints Closed with Risk Score 3-5





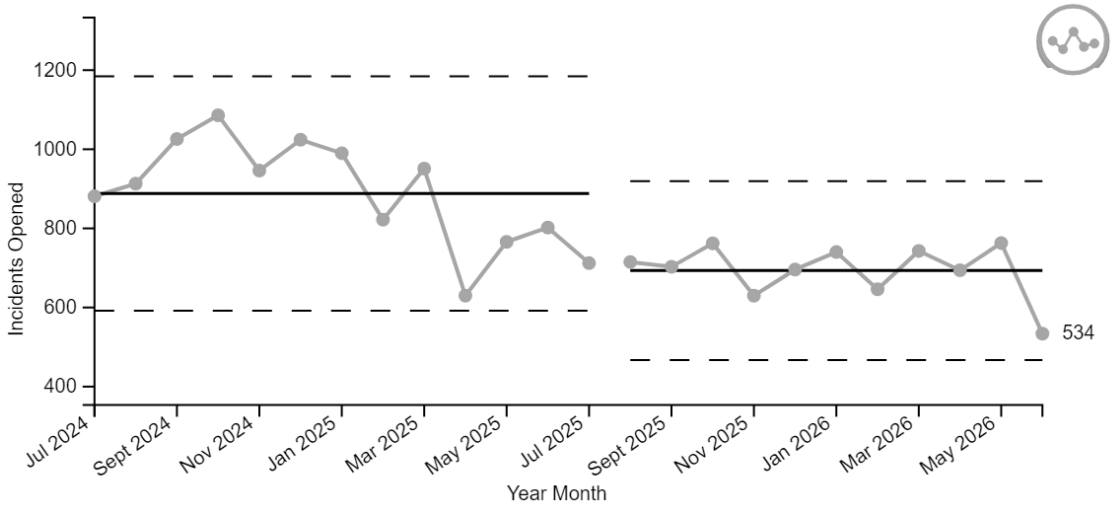


Summary: Patient Advice and Liaison Service (PALS) complaints performance remains stable overall.
Risk 1–2 complaints opened have reduced in variation and the average number of complaints has decreased since Nov 25. Complaints closed remain stable but have been below the average line since Jan 26.
Risk 3–5 complaints opened and closed increased above the average in the last month but remain within expected variation (below the UCL). No specific complaint themes have been identified, although service performance may have contributed to the increase. SLA performance has reduced slightly over the past two months but continues to be monitored.
Overall, there are no significant concerns, and performance remains stable despite increased higher-risk complaint activity

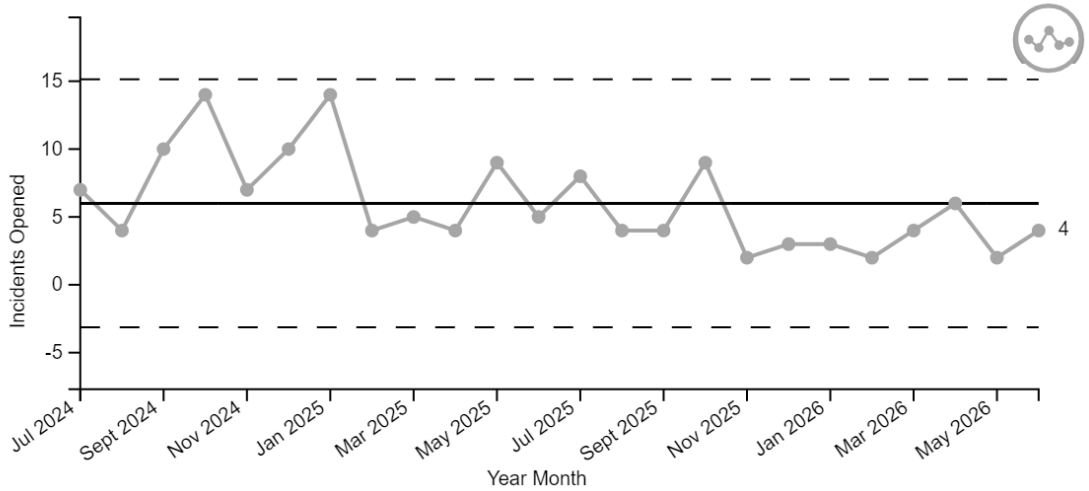
Actions: Nil required

Q2 Incidents

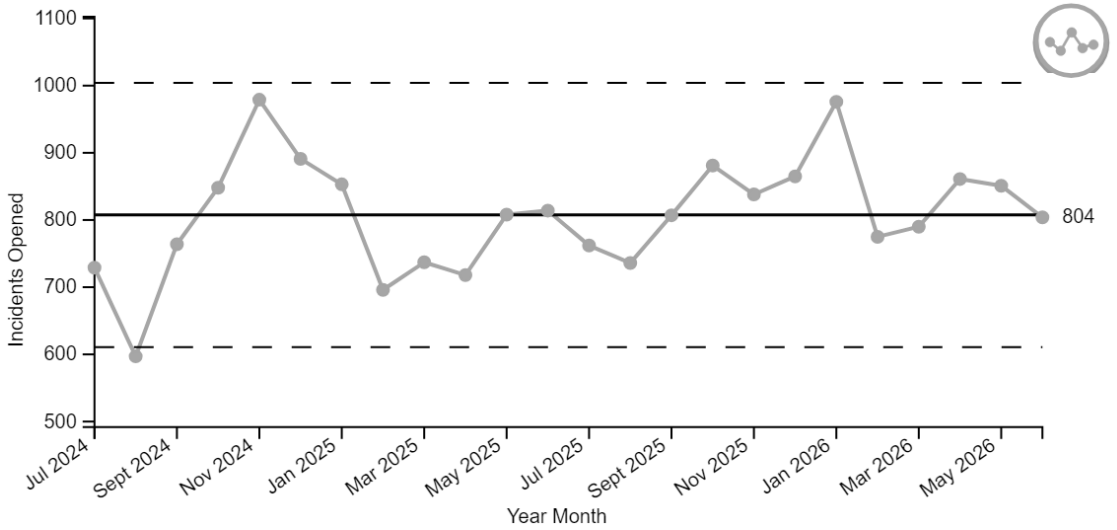
Incidents Opened with Risk Score 1-3



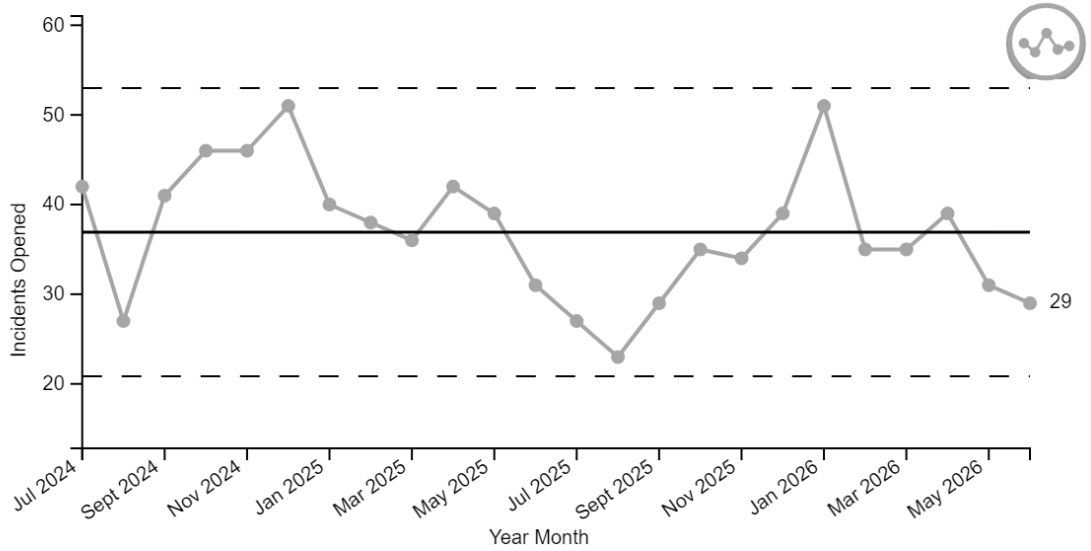
Incidents Opened with Risk Score 4-5

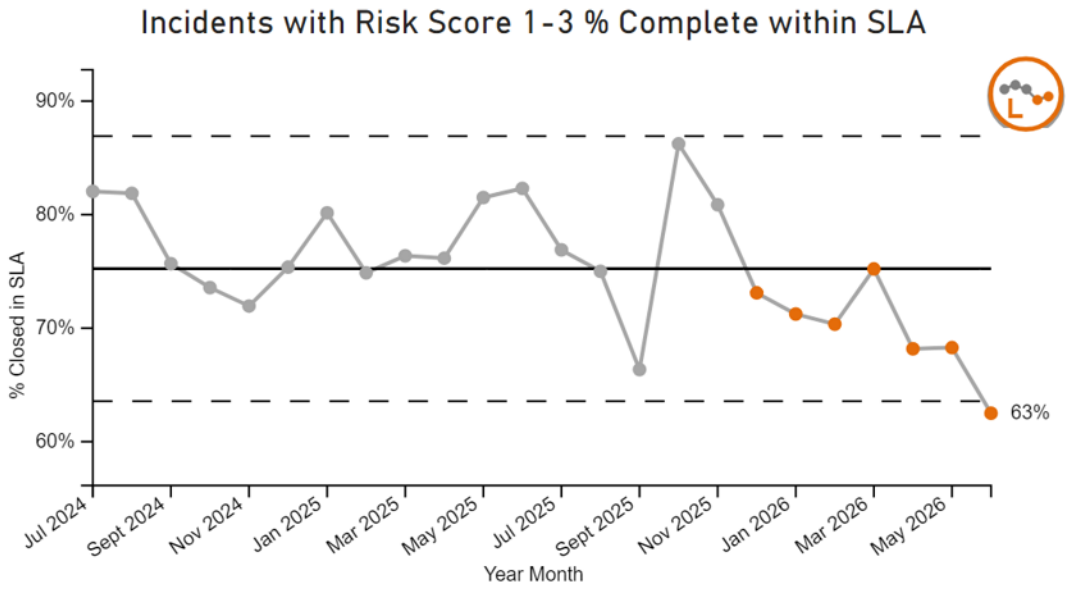


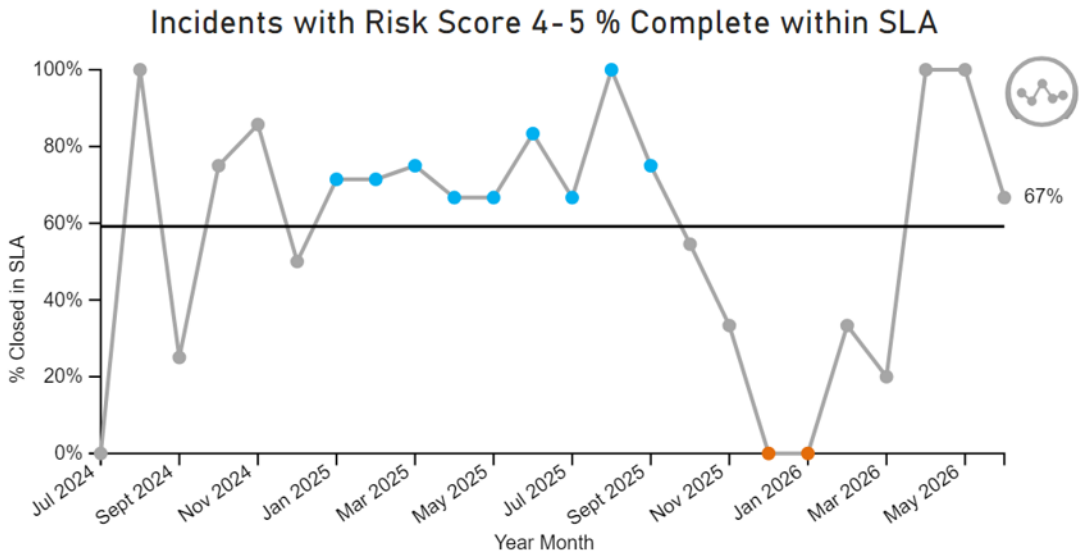
Incidents Opened - Patient



PSIRF Reported Level of Harm (Severe & Fatal)



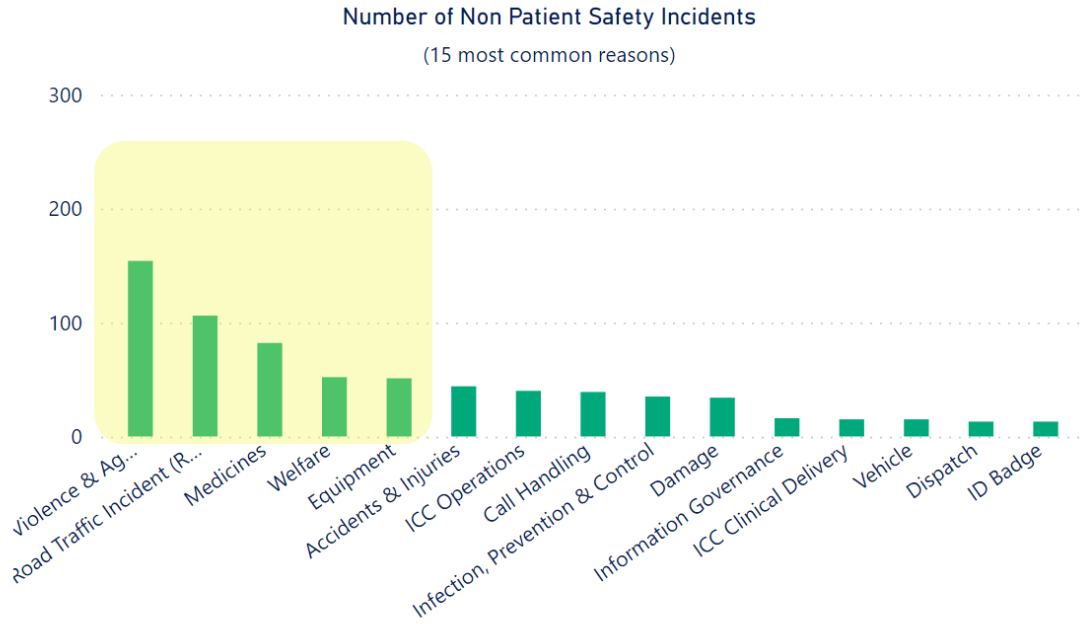


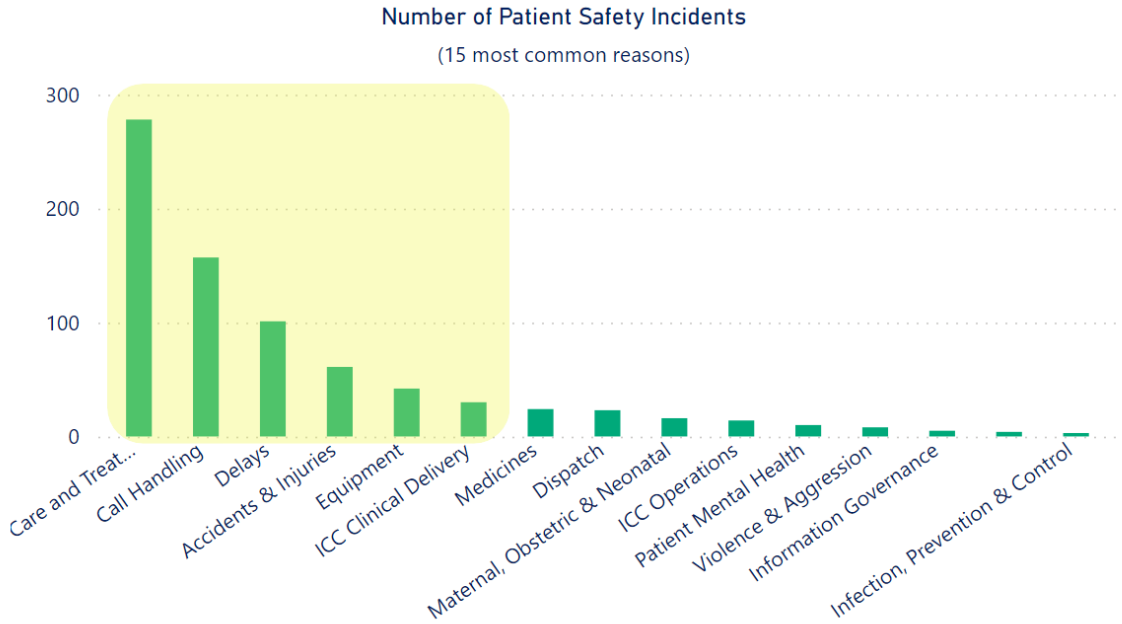


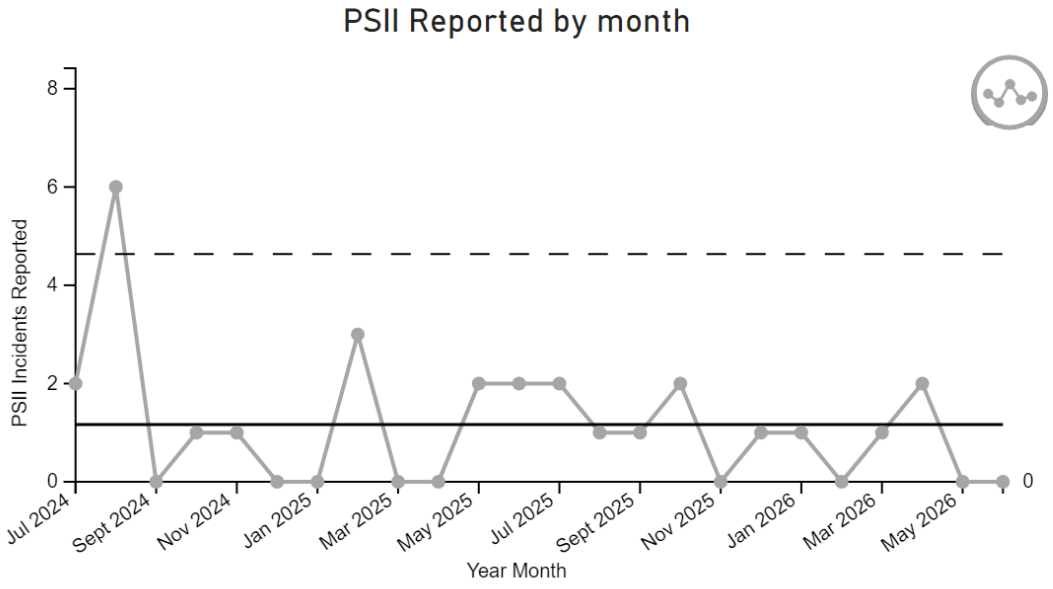
Summary: Incidents opened with a risk score of 1-3 have been rebased suggesting a sustained reduction in the number of incidents. There were 6 incidents closed with a risk score of 4-5 last month and 4 were completed within the 30-day SLA.

Record ID	Incident Type	Category	Subcategory	Days to Close
31749	Staff Event (Inc. Volunteers)	WELFAR	Work Related Stress	383
56919	Trust Event	IPC	Disposal: Contaminated Waste	37
59452	Staff Event (Inc. Volunteers)	IG	Data Confidentiality	19
60121	Staff Event (Inc. Volunteers)	WELFAR	Sexual Safety (Staff to Staff)	0
59360	Staff Event (Inc. Volunteers)	STFMH	Suicide Attempt	0
60196	Staff Event (Inc. Volunteers)	WELFAR	Sexual Safety (Staff to Staff)	0

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.
V&A reporting remains stable for June, with staff incidents reported below the median line.

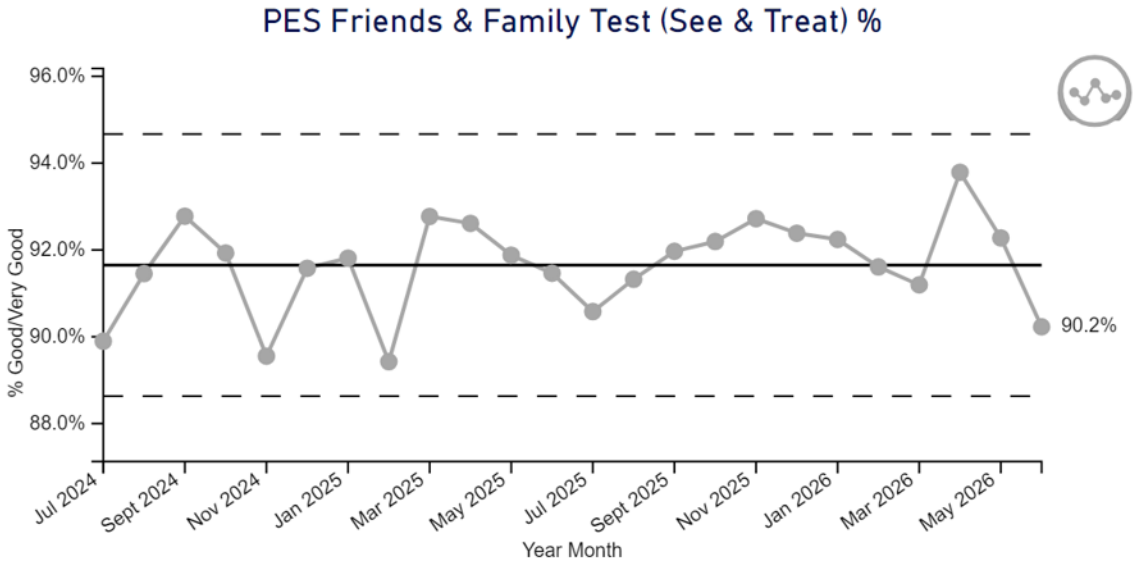
Actions:
V&A had a decrease in sexual assaults and physical assaults compared to May the highest reported category for V&A for this month was verbal abuse and threatening behaviour. Work is ongoing in the ICC in preparation for a change in their SOP for V&A which is aimed at providing more support and timely reporting of incidents. With the preparatory work ongoing the V&A team are seeing reporting increasing from the 111 service in line with the new SOP.

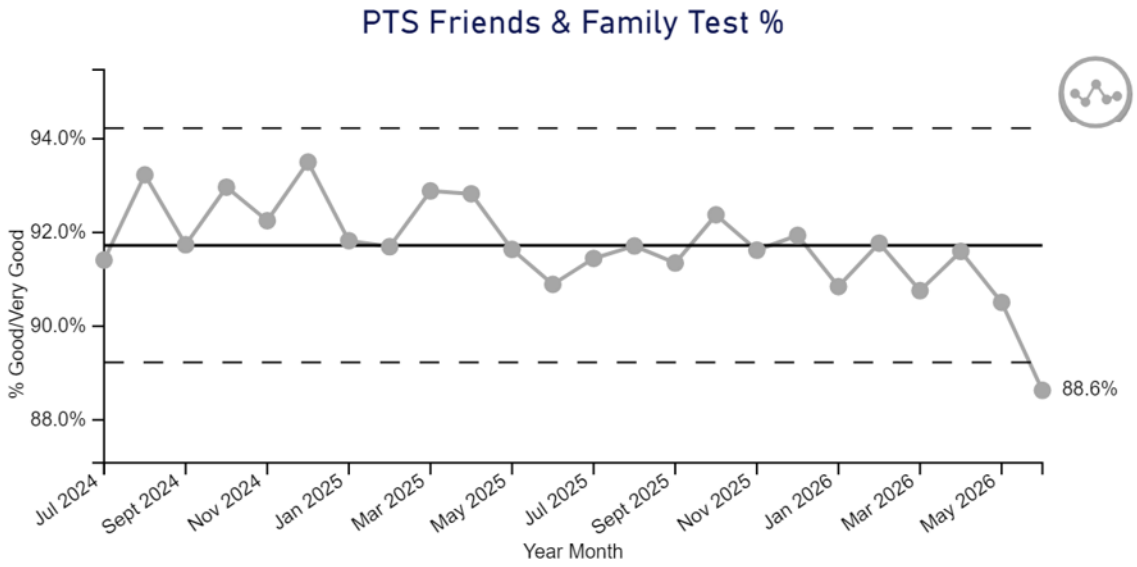
Q3 Safety Alerts

Safety Alerts	Alerts Received (July 2025 - June 2026)	Alerts Applicable (July 2025 - June 2026)	Alerts Open	Notes
CAS Helpdesk Team	**2**	**2**	**0**	Description: CHT/2025/001. Update from the CAS Helpdesk: National Supply Disruption Response (NSDR) now accredited to issue National Patient Safety Alerts. Issue Date: 7 July 2025 Deadline: Response Not Required. Actions: Description: CHT/2026/001. Changes to the CAS website login process. Issue Date:13 May 2026 Deadline: Response Not Required. Actions:
National Patient Safety Alert - UKHSA	**0**	**0**	**0**	
National Patient Safety Alert- NHS England Patient Safety	**3**	**1**	**0**	Description NatPSA/2025/006/NHSPS. Harm from incorrect recording of a penicillin allergy as a penicillamine allergy Issue Date: 20 Nov 2025. Deadline: 20 Nov 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.
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	**1**	**1**	**1**	Description: CEM/CMO/2025/002. Influenza season 2025/26: early season activity and implications for clinical practice Issue Date: 05 Nov 2025. Deadline: Response Not Required Actions:
National Patient Safety Alerts MHRA	**1**	**0**	**0**	
MHRA - Medicine Alerts	**55**	**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: All checked now and none found at NWAS
Infection Prevention & Control	**0**	**0**	**0**	

E1 Patient Experience





PES positive:

- *"2 gentlemen attended my 92-year-old mum and gave exemplary care. Kind considerate thorough and explained everything in detail. As an NHS worker myself I feel proud and would love them to receive our thanks. We didn't need to take mum to a very overstretched A and E."*
- *"Fast response caring towards my son who has severe learning difficulties and explained everything to us x."*
- *"Paramedics were friendly but professional and had great interpersonal skills. They listened to the patient and took into consideration their wishes."*

PES negative

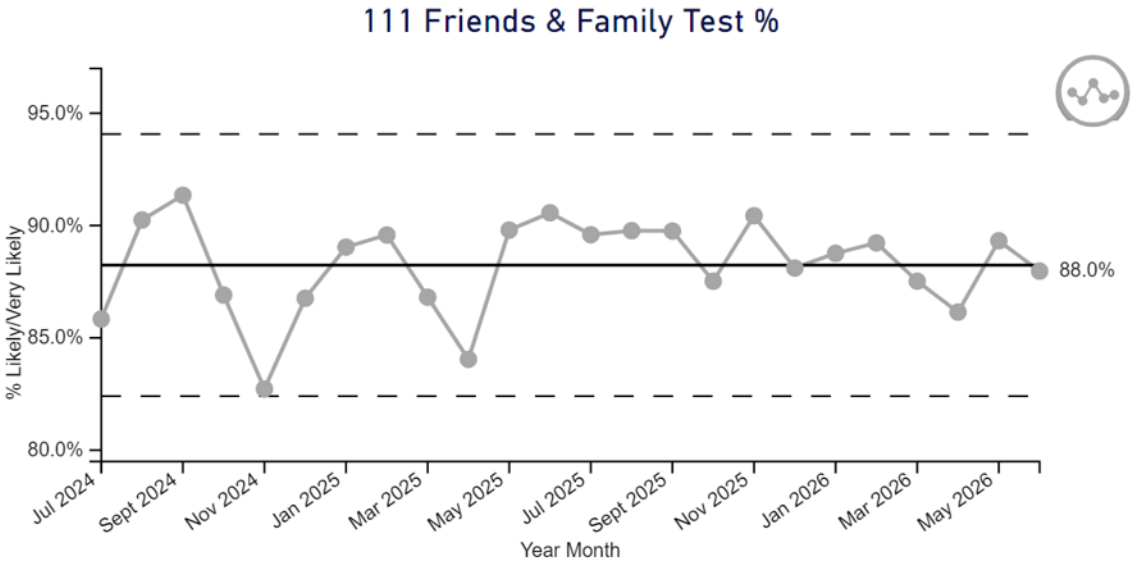
- *"I called on behalf of my friend that attempted multiple suicide attempts and they said 'why don't you just let her take the tablets' and whilst sat outside her flat they saw her try and jump out of the window and I had to tackle her onto the floor and tried to signal to them and they shrugged at me and drove off. The level of neglect I saw was horrendous. They left knowing she was going to do it again and she lives alone. I have never experienced anything like it before."*
- *"Get them to listen to people, not talk over people and improve their attitude."*

PTS positive:

- *"The driver was polite and friendly. Cared about my safety getting in and out of the ambulance. A safe driver. The ambulance was spotless. The driver arrived to pick me up on time, so I didn't have to worry about bring late. Booking the ambulance was straight forward also. Very pleasant telephonist."*
- *"Very polite and helpful especially as I was on my own just made me relaxed and safe."*

PTS negative:

- *"You need to sort out information that we need for the transport i.e. taking the hoist sling off from under the patient because they're not allowed to travel on it. I am his wife and I didn't know how I would get him off the chair and back onto the bed at home without the sling as he can't stand up he's totally bedbound and hoisted. Also, I've just bought him an electric wheelchair, and I was told that he couldn't use that in the transport, these should be things we're told when booking transport."*
- *"Was really late but no text or call saying that ..rang them but phone was not answered just a busy message over and over. Late for my appointment."*



NHS 111 positive:

- *"You were perfect. My GP practice let me down badly today not caring that I had a UTI with infection. Your team were amazing, responding very quickly. I am so impressed with your service THANK YOU."*
- *"I wasn't aware 111 could support with prescription medication and instantly support with my pharmacist, this was invaluable and very necessary for the severity of the case. Thank you."*
- *"Call back in 2 minutes when told it may take an hour plus. Thank you NHS."*

NHS 111 negative:

- *"Was told I needed to speak to someone in next 6 hours, got zero advice and then didn't get a call back from out of hours. Wasn't told of anywhere I could go if I needed to be seen before I got the call or any back up options."*
- *"The person on the phone was patronising and when you have a baby with a 39 almost 40 temperature and recently medicated you want answers and not to be talked down. Disappointed to say the least!"*
- *"I rang about a wound following a hospital procedure and several times I stated that it was not bleeding. The advice I was given was for how to stop it bleeding which is not the advice I was ringing about."*

Summary

PES FFT

In June, 614 responses were received, down 18.2% from May's 751. Comment volumes also decreased by 19.1% (462 in June versus 571 in May). June's overall experience score was 90.2%, which is 2.1 percentage points below May's 92.3%, and 1.3 percentage points lower than June 2025.

PTS FFT:

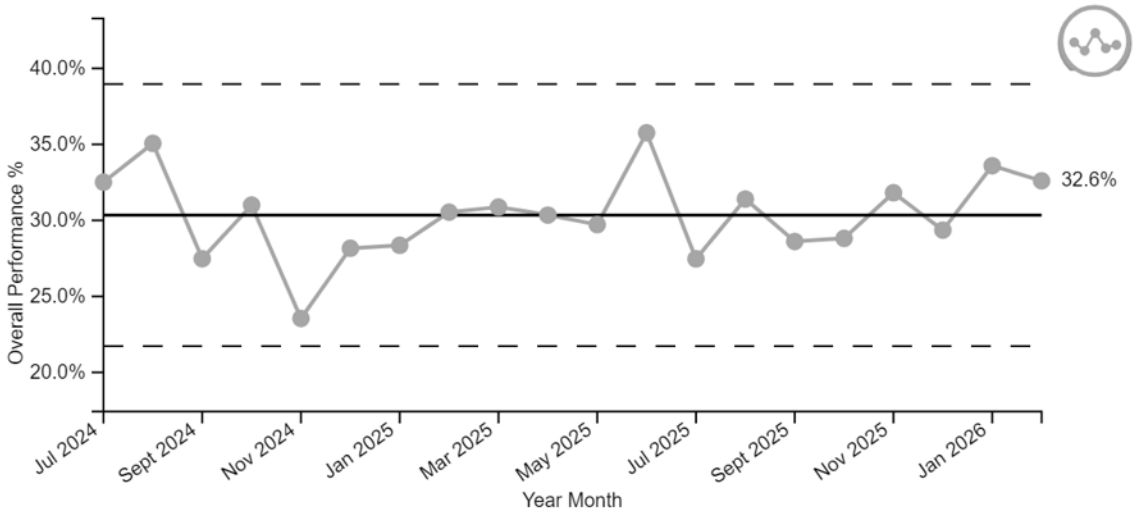
The 1,205 responses from June are 2.1% higher than May's 1,180, with supporting comments higher, by 1.9%, (965 for June compared to 947 from May). The overall experience score for June of 88.6% is 1.9 percentage points lower than the 90.5% reported for May and 2.3 percentage points lower than June 2025.

NHS 111 FFT:

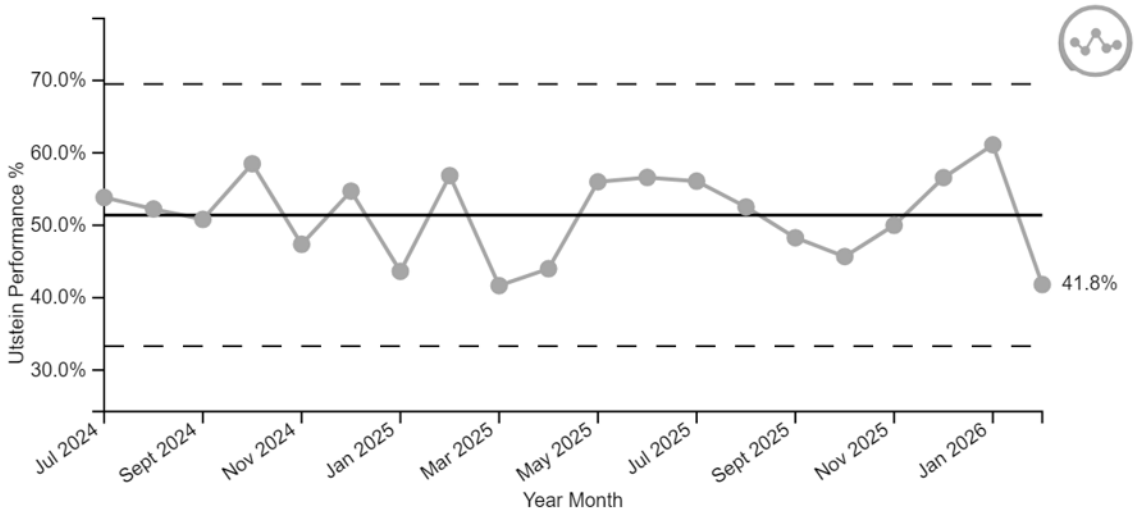
For June we have 507 returns, compared to the 590 returns reported for May. From the June returns, we see an 87.9% likelihood of the 111 service being recommended, a difference of 1.4% compared to the 89.3% reported for May. This was 90.6% in June 2025, a difference of 2.7%.

E2 Ambulance Clinical Quality Indicators (ACQI)

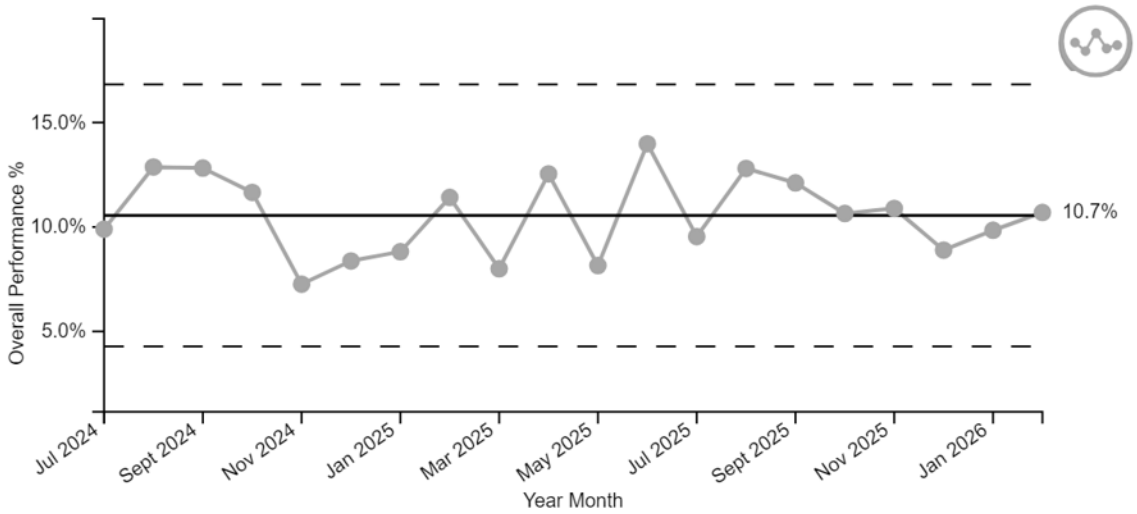
ROSC - Overall Performance



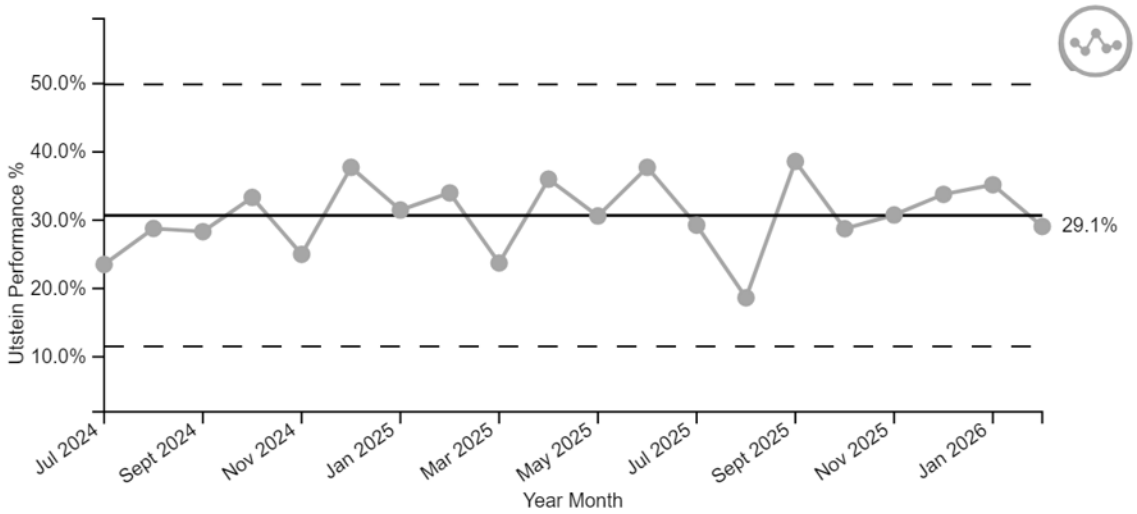
ROSC - Utstein Performance



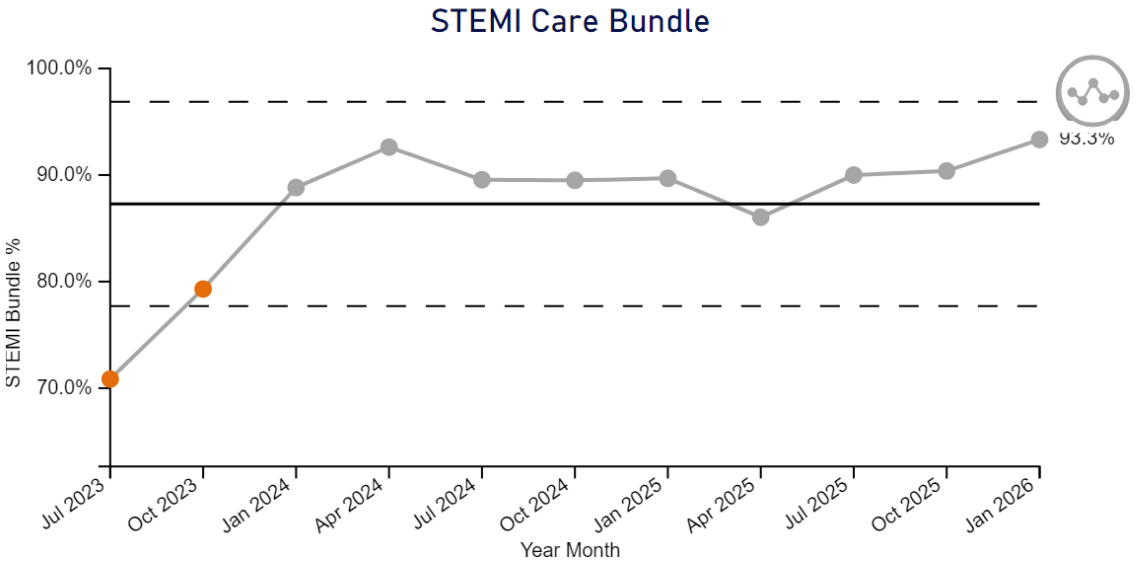
Survival at 30 Days Post Discharge - Overall Performance

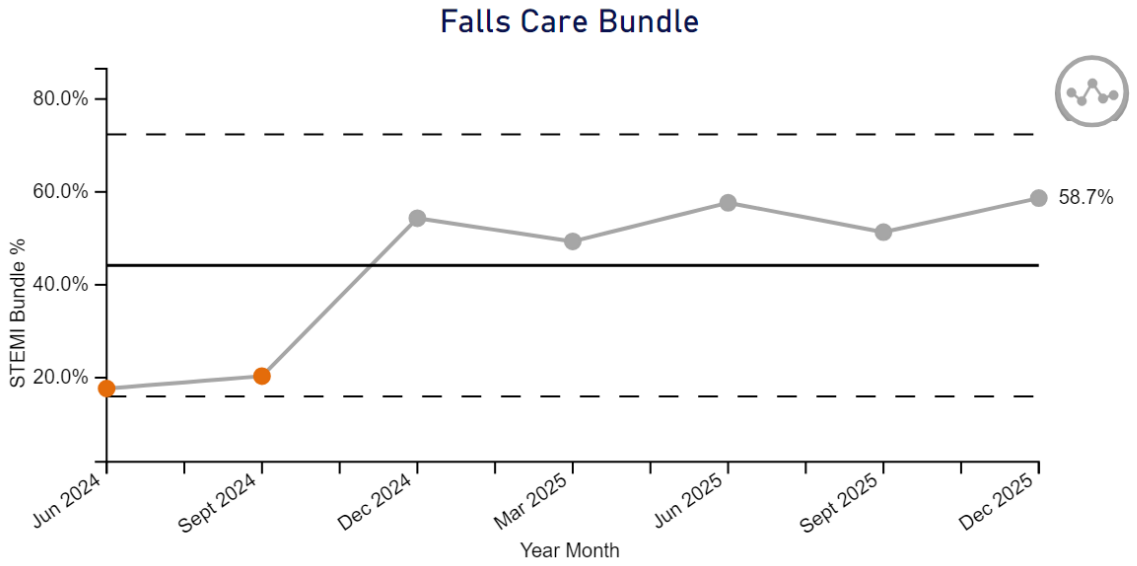


Survival at 30 Days Post Discharge - Utstein Performance



E2 Ambulance Clinical Quality Indicators (ACQI)





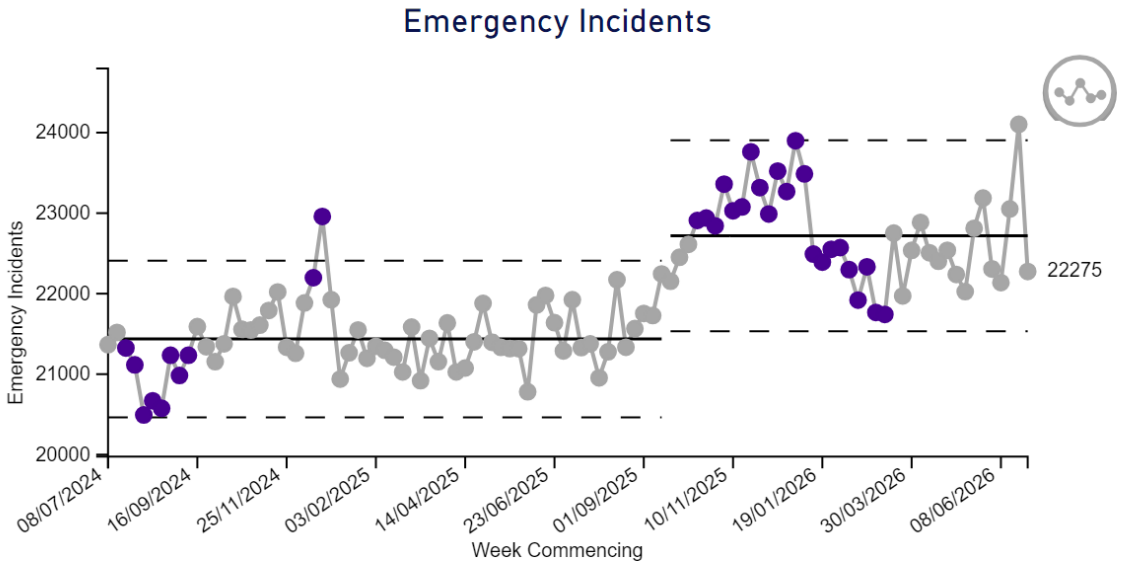
Summary:

All ACQI metrics are performing above the national average with the exception of ROSC Utstein.

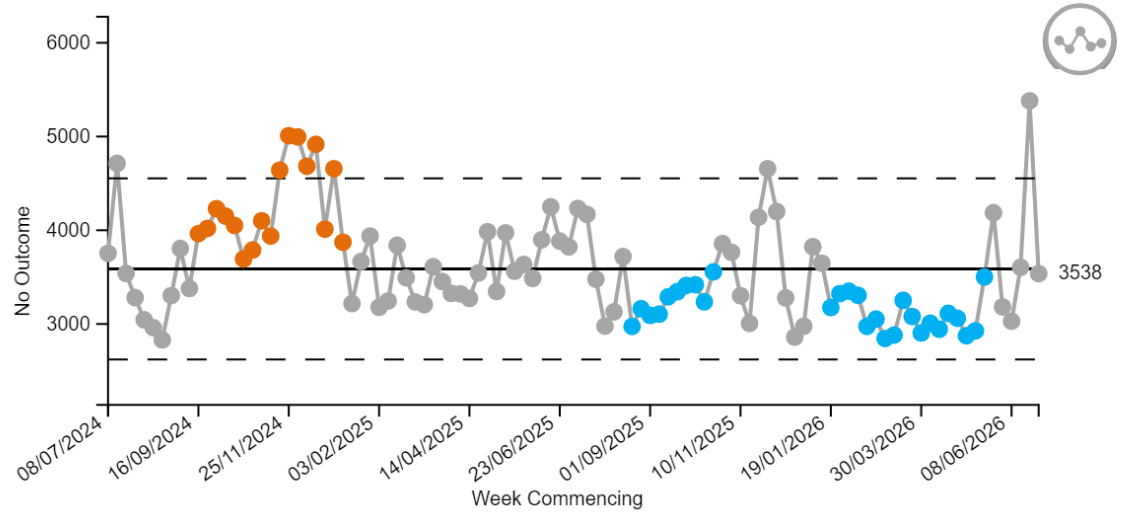
- ROSC overall performance - last reported in Feb 26 (32.6%), **above** the national average of 28.2%.
- ROSC Utstein performance - last reported in Feb 26 (41.8%), **below** the national average of 45.9%.
- Survival at 30 days after discharge overall performance – last reported in Feb 26 (10.7%), **above** the national average of 9.1%.
- Survival at 30 days after discharge Utstein performance – last reported in Feb 26 (29.1%), **above** the national average of 27.4%.
- STEMI bundle - last reported in Jan 26 (93.3%), **above** the national average of 85.3%.
- Falls bundle – last reported in Dec 25 (58.7%), **above** the national average of 56.3%.

E3 Activity & Outcomes

Emergency Incidents

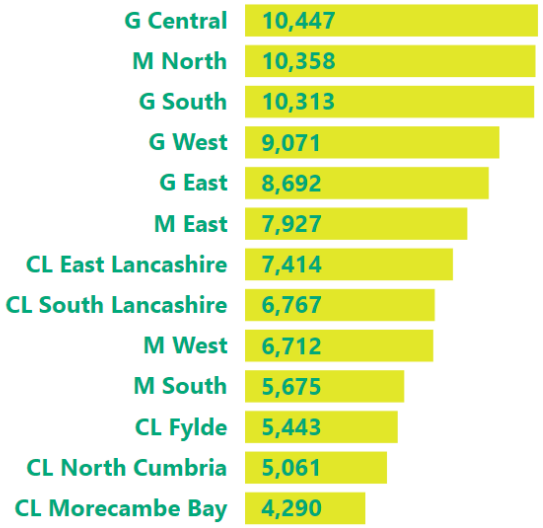


No Outcome Contacts

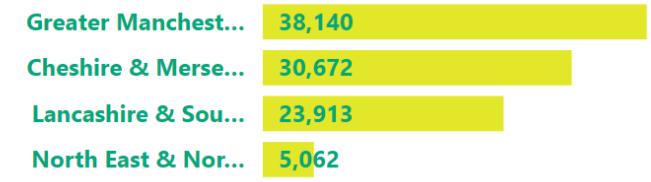


Emergency Incidents

Emergency Incidents by Operational Sector

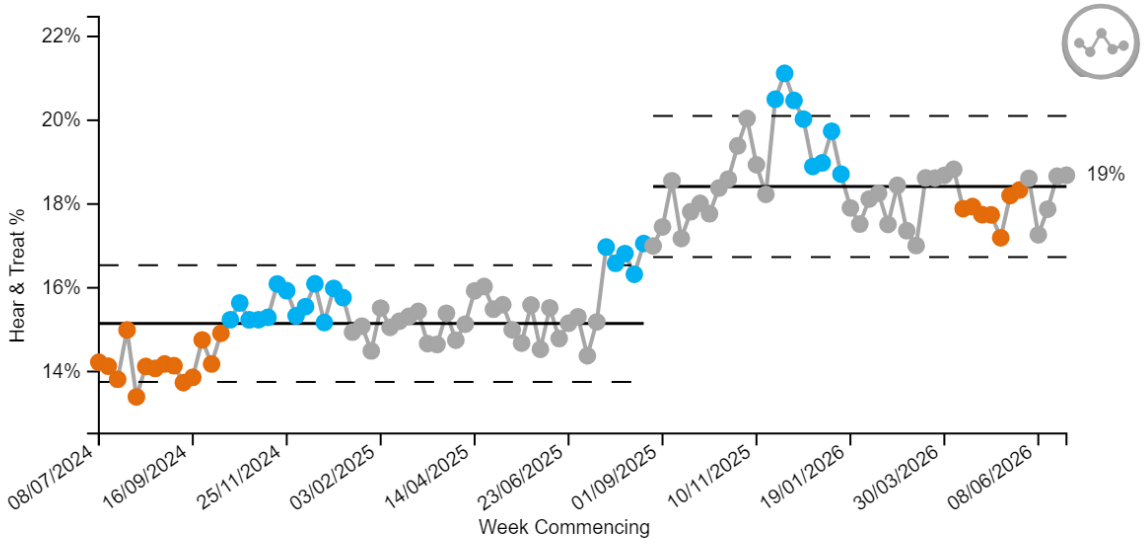


Emergency Incidents by ICB

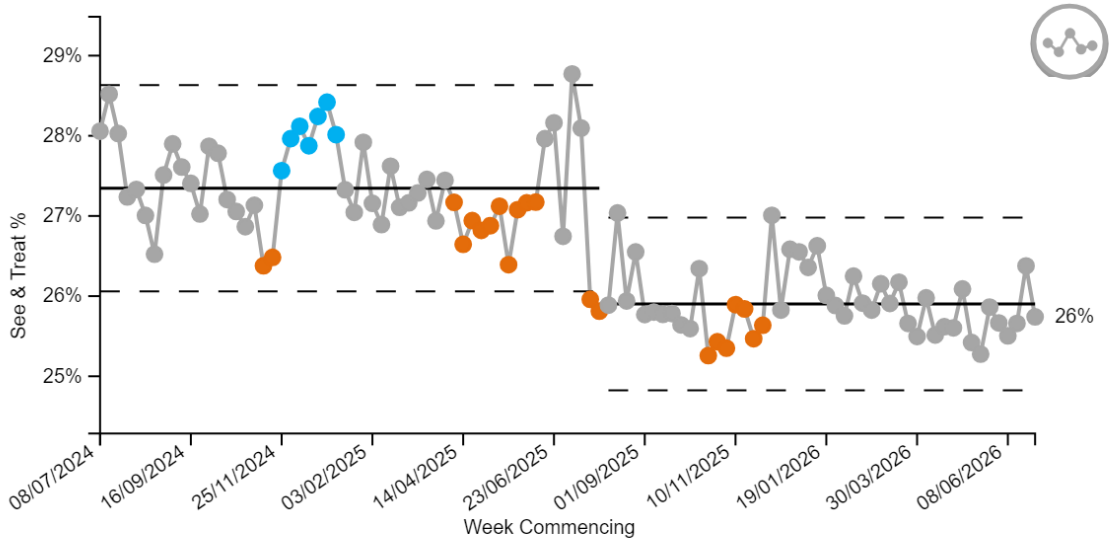


Calendar Year	Month	Calls	% Change from previous year	Incidents	% Change from previous year
2023	Jun	118,947	-9.25 %	91,932	1.11 %
2024	Jun	118,615	-0.28 %	91,317	-0.67 %
2025	Jun	119,972	1.14 %	92,462	1.25 %
2026	Jun	125,466	4.58 %	98,277	6.29 %

Hear & Treat (AQI)



See & Treat (AQI)



Months Hear & Treat by Sector

CL South Lancashire	21.1%
G Central	20.7%
CL Fylde	19.6%
CL East Lancashire	19.0%
G East	18.3%
M North	18.1%
G West	18.1%
M South	17.3%
M West	17.2%
M East	17.0%
G South	16.7%
CL Morecambe Bay	16.1%
CL North Cumbria	15.0%

Months Hear & Treat by ICB

Lancashire ...	19.2%
Greater Man...	18.5%
Cheshire & ...	17.5%
North East ...	15.0%

Months See & Treat by Sector

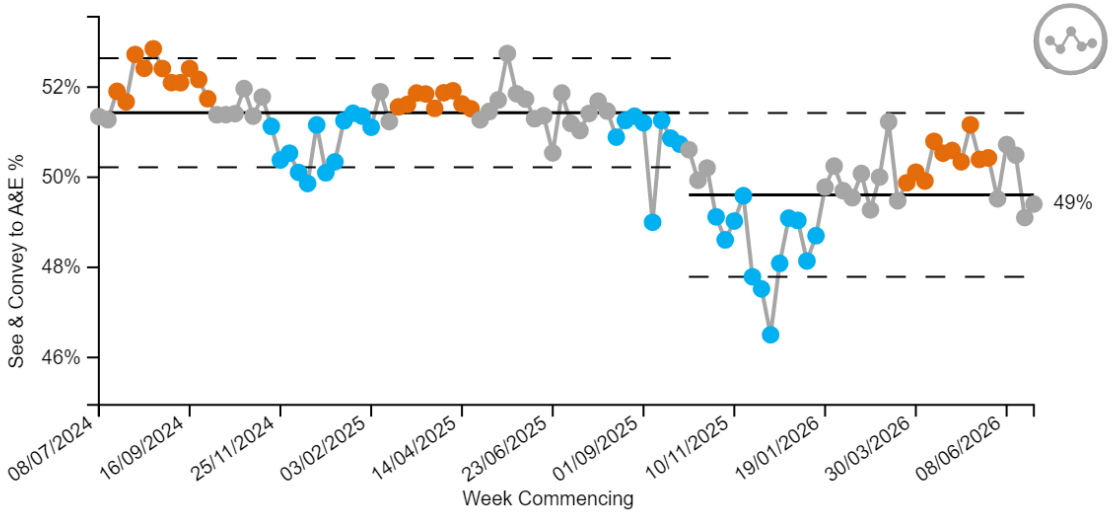
CL Morecambe Bay	29.9%
CL North Cumbria	29.7%
M South	26.9%
M West	26.4%
G East	26.2%
CL East Lancashire	26.0%
CL Fylde	26.0%
G Central	26.0%
G South	25.2%
M North	24.6%
G West	24.4%
M East	24.2%
CL South Lancashire	23.9%

Months See & Treat by ICB

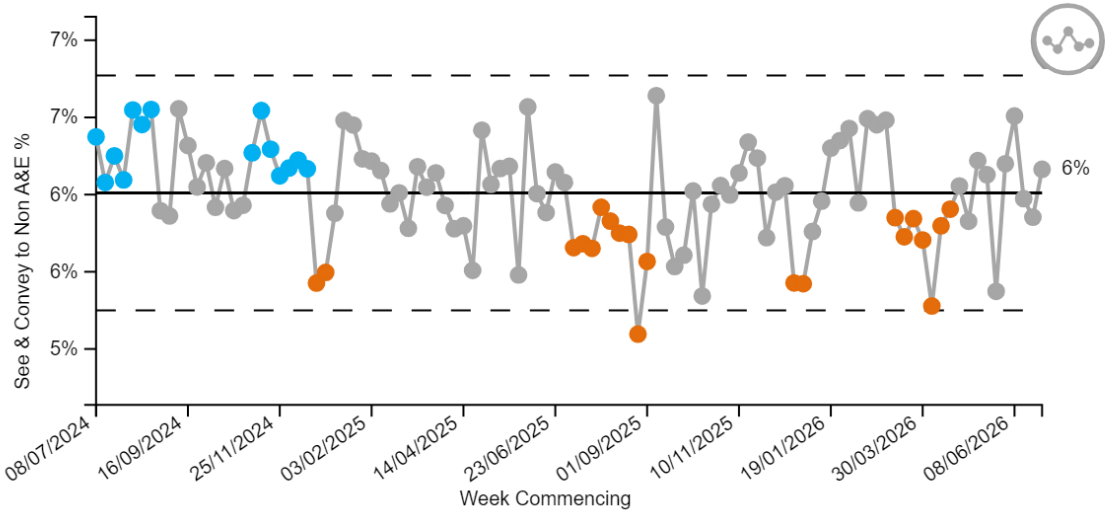
North East ...	29.7%
Lancashire ...	26.1%
Greater Man...	25.4%
Cheshire & ...	25.3%

BAF ID SR01

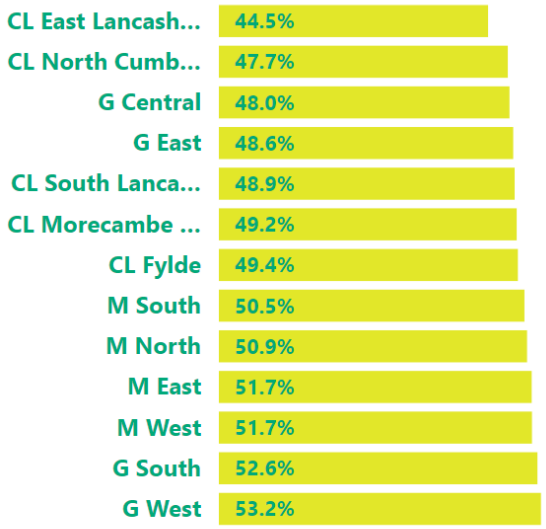
See & Convey to A&E (AQI)



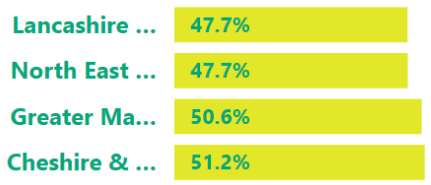
See & Convey to Non A&E (AQI)



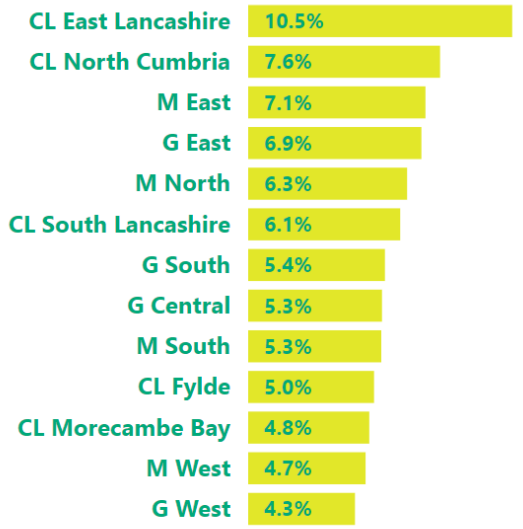
Months See & Convey (AE) by Sector



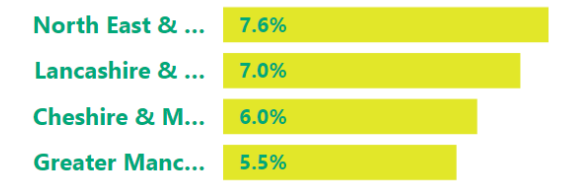
Months See & Convey (AE) by ICB



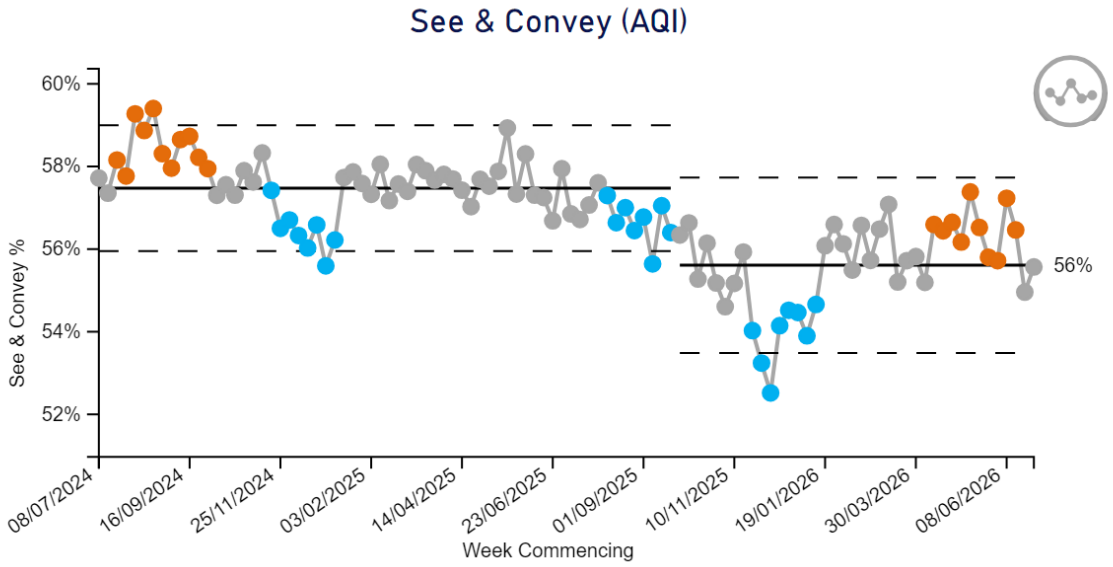
Months See & Convey (Non AE) by Sector



Months See & Convey (Non AE) by ICB



BAF ID SR01



Months See & Convey by Sector

G Central	53.3%
CL Morecambe Bay	54.0%
CL Fylde	54.4%
CL South Lancashire	54.9%
CL East Lancashire	55.0%
CL North Cumbria	55.4%
G East	55.5%
M South	55.8%
M West	56.4%
M North	57.3%
G West	57.5%
G South	58.1%
M East	58.7%

Months See & Convey by ICB

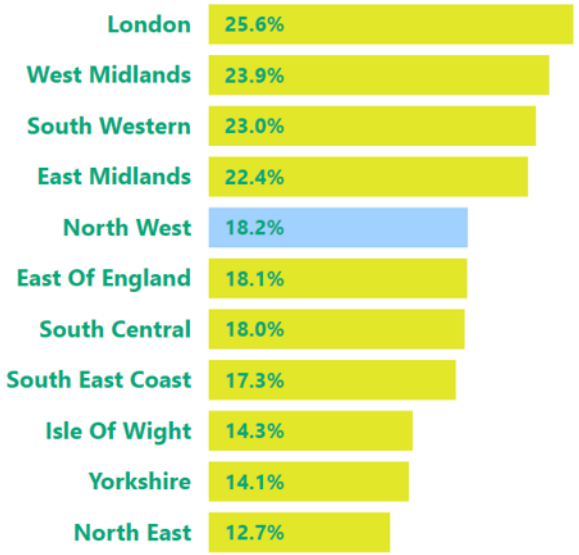
Lancashire & ...	54.7%
North East & ...	55.4%
Greater Manc...	56.1%
Cheshire & M...	57.2%

Summary: Of the 125,466 emergency calls received by the trust, 78.3% (98,277) became incidents.

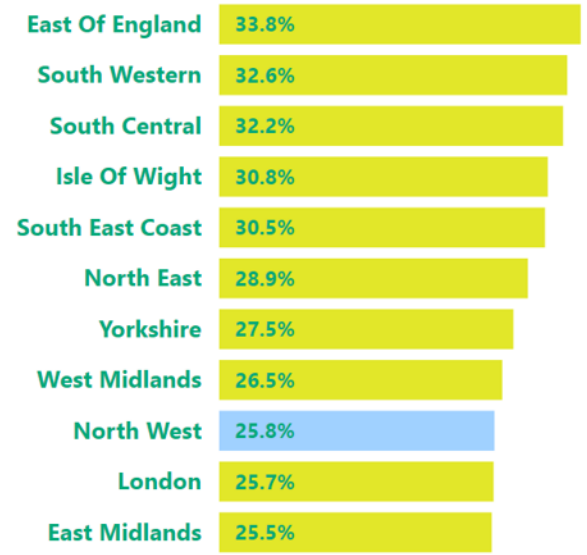
H&T performance in June was 18.2%, 0.3% higher than May (17.9%) but below the current planned UEC trajectory. S&T performance remained at 25.8%.

Action:
Key operational actions are focused on increasing clinical capacity and improving conversion performance through AI-supported transcription, strengthening the navigator/CAS model, and tighter scrutiny of Category 2 ambulance dispatch and CAS pass backs. These interventions are being introduced through phased trials, supported by enhanced performance monitoring and accountability arrangements.

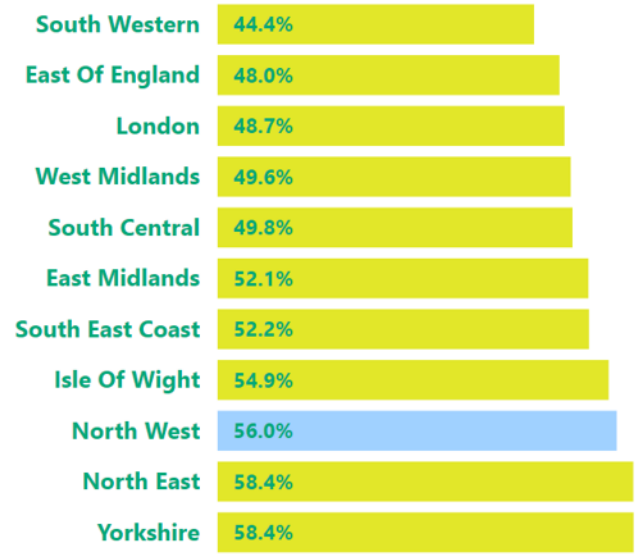
Hear & Treat % by Trust



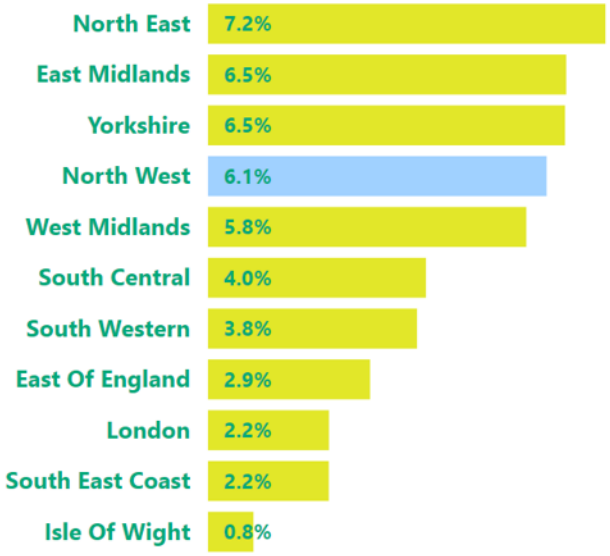
See & Treat % by Trust



See & Convey % by Trust



See & Convey non A&E % by Trust



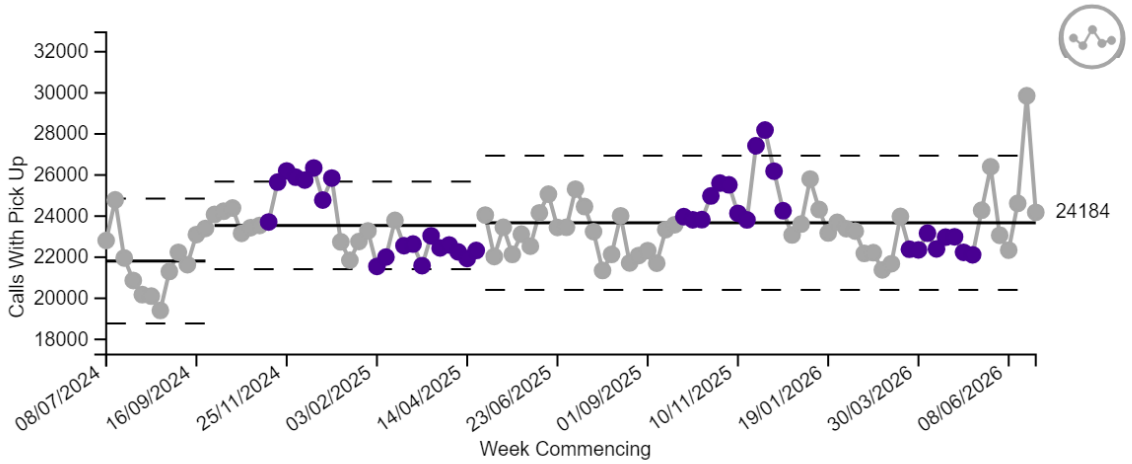
BAF ID SR01

Operational

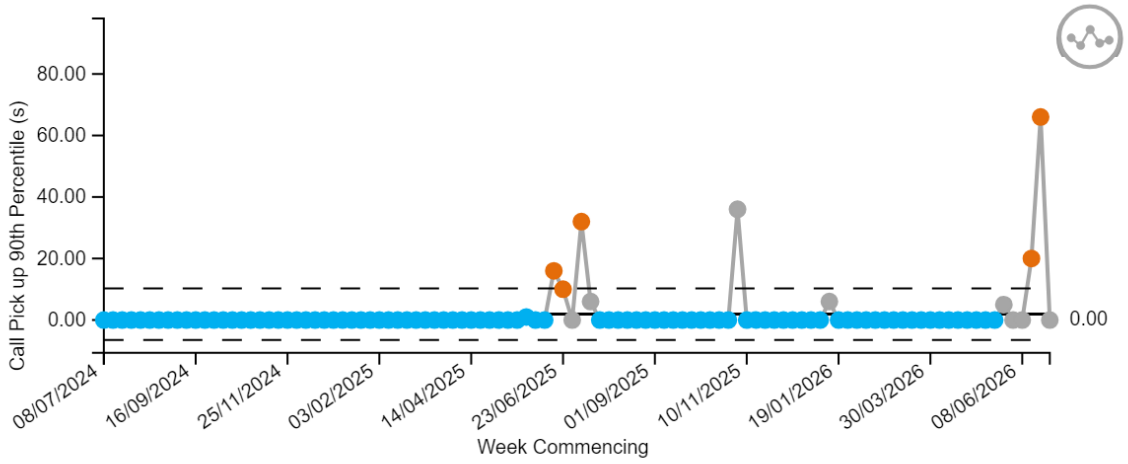
O1 Call Pick up
O3 ARP Response Times
O3 ARP Provider Comparison
O3 A&E Turnaround
O3 A&E Turnaround ICB
O4 111 Activity & Performance
O5 PTS Activity

O1 Call Pick Up

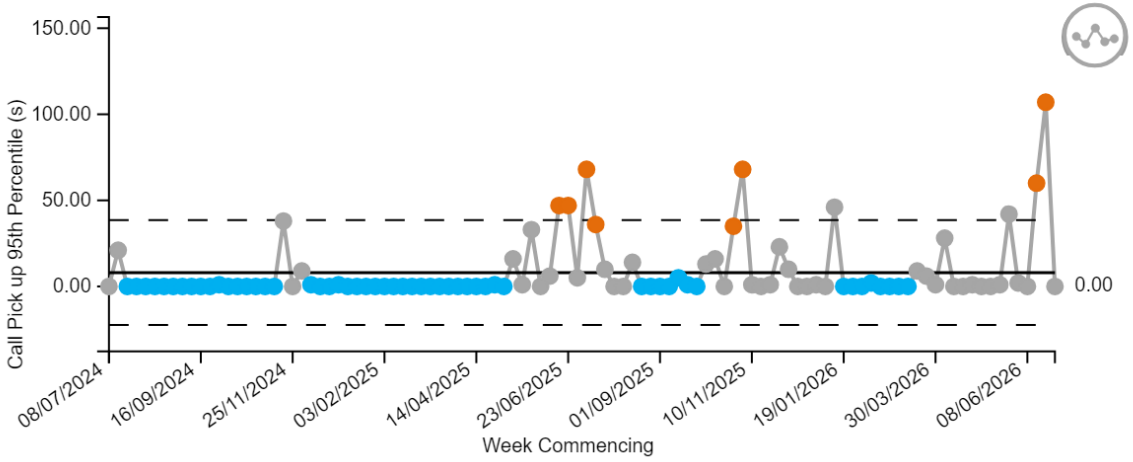
Calls With Pick up



Call Pick up 90th Percentile



Call Pick up 95th Percentile



Call Pick Up Mean	
Month	7
YTD	4
Ranking	6

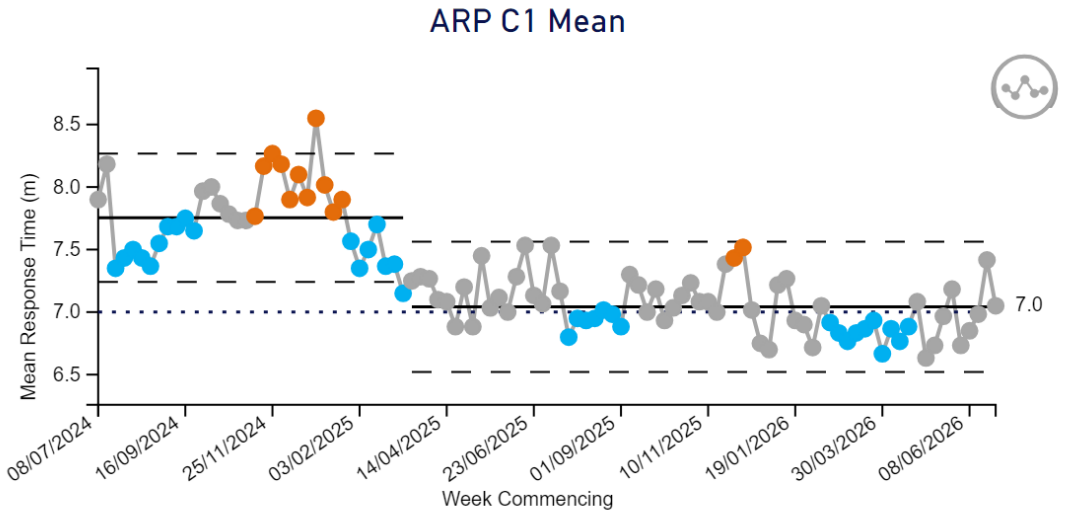
Call Pick up 90th Percentile	
Month	11
YTD	0
Ranking	7

Call Pick up 95th Percentile	
Month	55
YTD	21
Ranking	8

Summary: Call pick-up volume increased from 105,149 to 107,507, with demand rising sharply during late June hot weather. Average pick-up remained low at 7 seconds, although the 90th and 95th percentiles increased to 11 and 55 seconds respectively, with SPC charts indicating special cause variation.

Action: Hot weather events will be managed as part of severe weather planning.

O3 ARP Response Times



C1 Mean (Red =>7min)

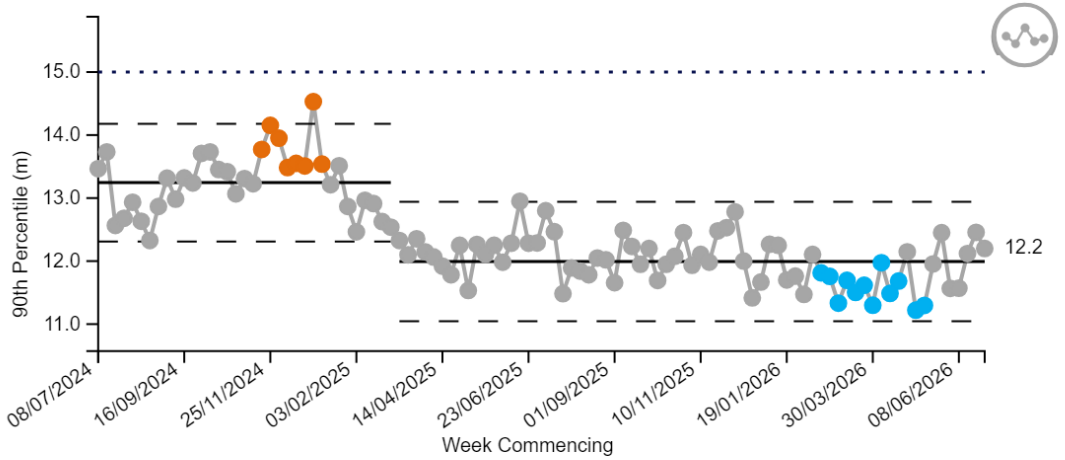
C1 Mean by Sector

CL Morecambe Bay	00:09:20
CL North Cumbria	00:09:10
M South	00:08:20
CL South Lancashire	00:07:52
M West	00:07:23
CL East Lancashire	00:07:09
M East	00:07:05
G East	00:06:48
G West	00:06:46
CL Fylde	00:06:23
G Central	00:06:21
M North	00:06:20
G South	00:06:15

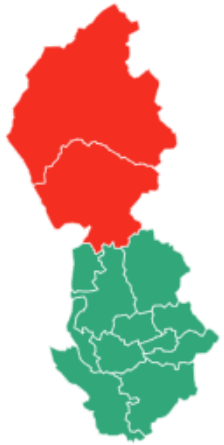
C1 Mean by ICB

North East & Nort...	00:09:10
Lancashire & Sout...	00:07:31
Cheshire & Mersey...	00:07:06
Greater Manchester	00:06:29

C1 Mean	
Target	00:07:00
Month	00:07:03
YTD	00:06:56
Ranking	2



C1 90th (Red =>15min)



C1 90th by Sector

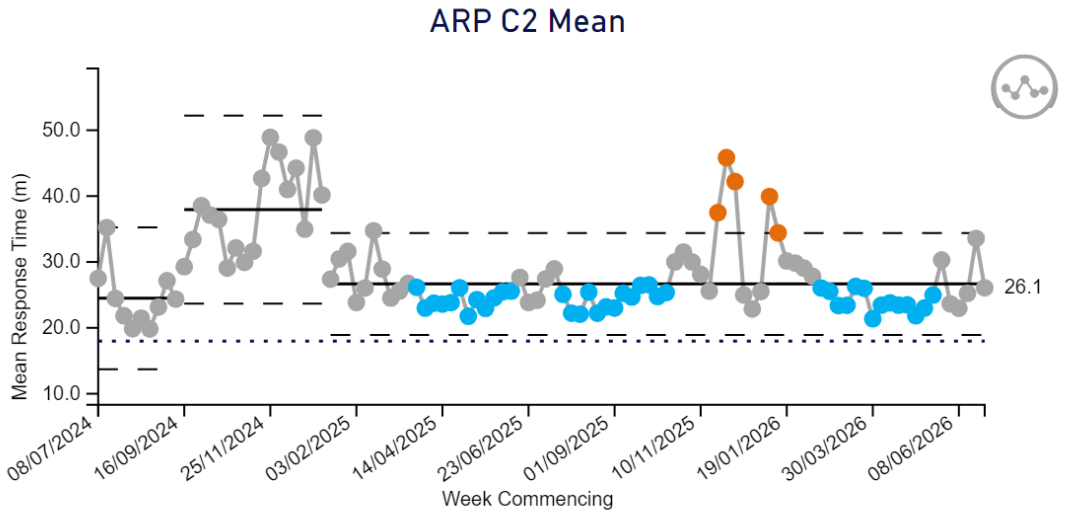
CL Morecambe Bay	00:18:09
CL North Cumbria	00:17:26
M South	00:14:39
CL South Lancashire	00:14:14
M West	00:12:49
CL East Lancashire	00:12:24
CL Fylde	00:11:43
M East	00:11:30
G East	00:11:02
M North	00:10:50
G West	00:10:45
G Central	00:10:28
G South	00:10:28

C1 90th by ICB

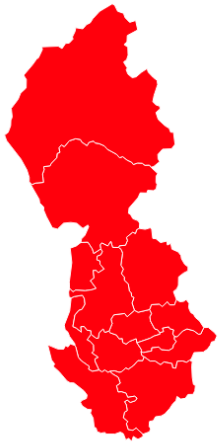
North East & N...	00:17:26
Lancashire & So...	00:13:35
Cheshire & Mer...	00:12:14
Greater Manche...	00:10:37

C1 90th	
Target	00:15:00
Month	00:12:02
YTD	00:11:51
Ranking	2

O3 ARP Response Times



C2 Mean (Red => 18min)



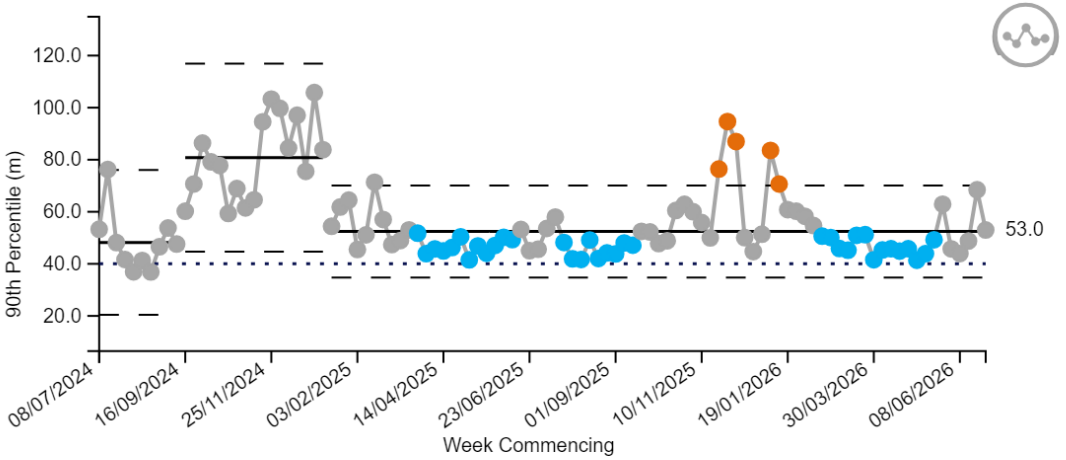
C2 Mean by Sector

M East	00:33:54
M South	00:32:45
CL Morecambe Bay	00:32:36
M West	00:32:17
M North	00:31:02
CL North Cumbria	00:28:25
CL South Lancashire	00:26:18
G East	00:25:12
G West	00:24:52
CL Fylde	00:24:07
G South	00:22:41
G Central	00:22:24
CL East Lancashire	00:22:02

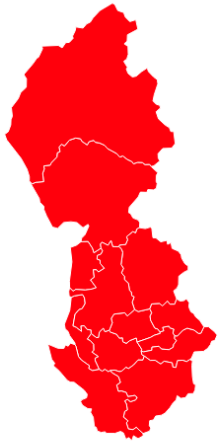
C2 Mean by ICB

Cheshire & Mersey...	00:32:23
North East & Nort...	00:28:26
Lancashire & Sout...	00:25:39
Greater Manchester	00:23:40

C2 Mean	
Target (ARP)	00:18:00
Target (UEC)	00:25:00
Month	00:27:07
YTD	00:25:05
Ranking	5



C2 90th (Red => 40min)



C2 90th by Sector

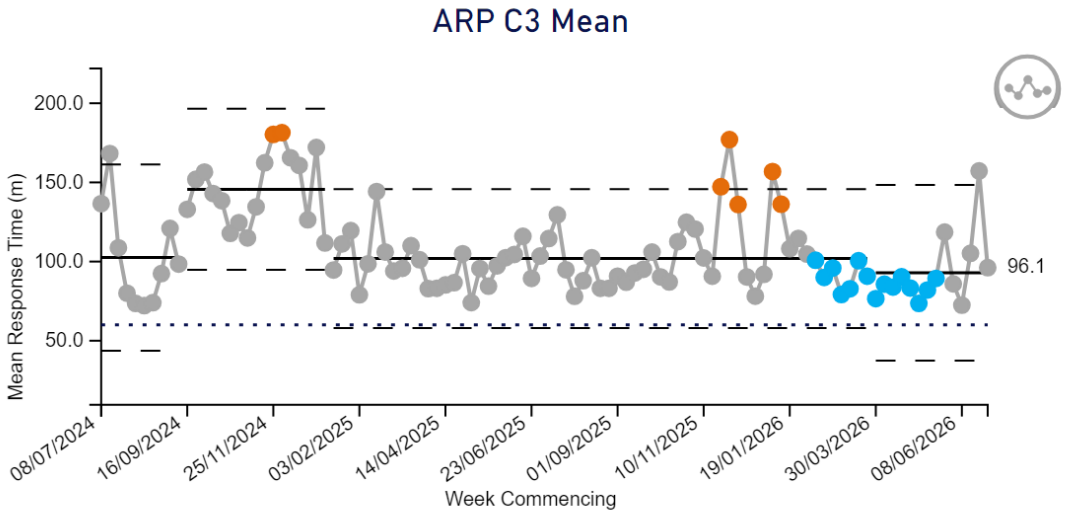
CL Morecambe Bay	01:07:52
M East	01:06:22
M South	01:05:05
M West	01:04:29
M North	01:03:04
CL North Cumbria	00:57:37
CL South Lancashire	00:50:46
G East	00:48:12
G West	00:47:52
CL Fylde	00:47:00
G South	00:44:56
G Central	00:43:42
CL East Lancashire	00:43:25

C2 90th by ICB

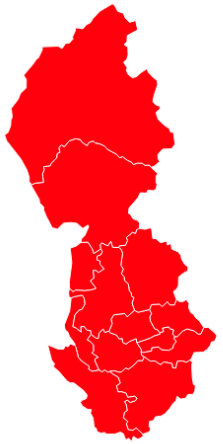
Cheshire & Mersey...	01:04:43
North East & Nort...	00:57:42
Lancashire & Sout...	00:51:19
Greater Manchester	00:46:08

C2 90th	
Target	00:40:00
Month	00:54:15
YTD	00:49:09
Ranking	4

O3 ARP Response Times



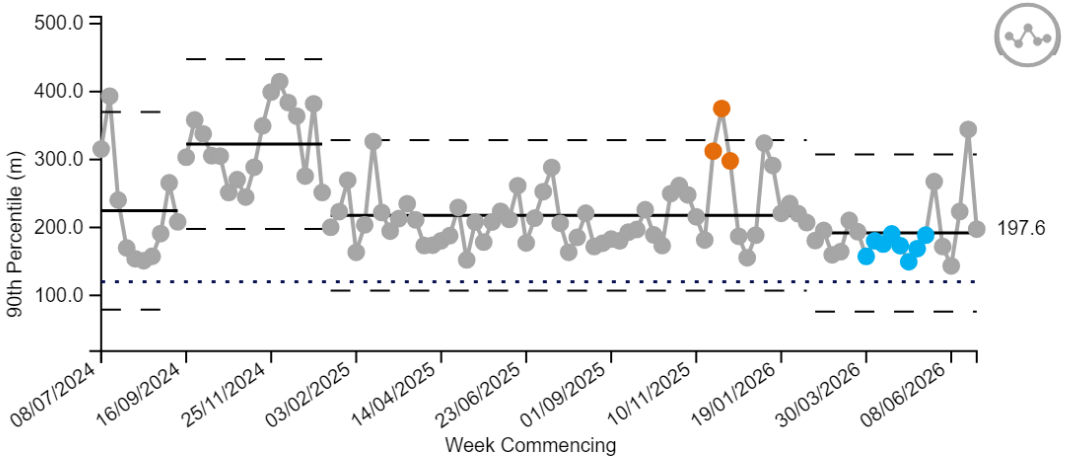
C3 Mean (Red => 60min)



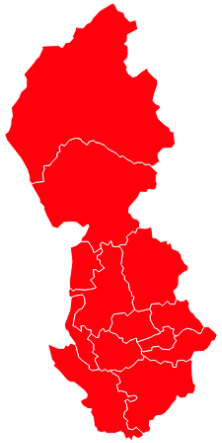
C3 Mean by Sector	
M East	02:10:19
M North	02:08:50
M West	01:47:57
G East	01:47:10
G Central	01:45:52
CL South Lancashire	01:45:47
G West	01:44:09
M South	01:43:31
G South	01:41:09
CL Fylde	01:35:16
CL Morecambe Bay	01:34:41
CL North Cumbria	01:33:22
CL East Lancashire	01:22:48

C3 Mean by ICB	
Cheshire & Mersey...	01:58:59
Greater Manchester	01:44:31
Lancashire & Sout...	01:34:32
North East & Nort...	01:33:22

C3 Mean	
Target	00:60:00
Month	01:46:27
YTD	01:33:27
Ranking	5



C3 90th (Red => 2h)



C3 90th by Sector	
M North	04:53:54
M East	04:42:51
M West	04:00:53
CL South Lancashire	03:58:16
M South	03:57:58
G East	03:34:39
G West	03:34:32
CL Fylde	03:34:03
CL Morecambe Bay	03:31:19
G South	03:29:55
G Central	03:26:52
CL North Cumbria	03:23:38
CL East Lancashire	02:57:02

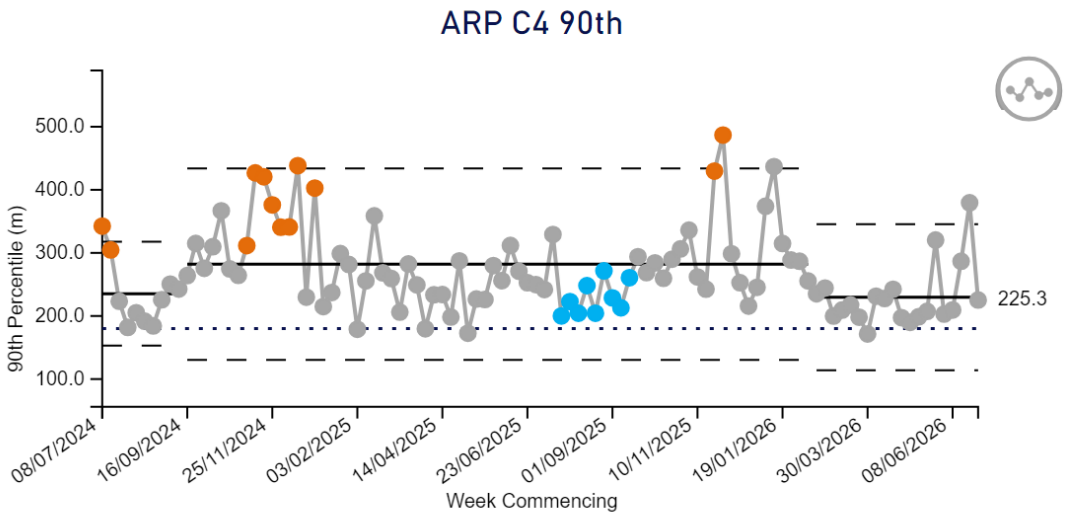
C3 90th by ICB	
Cheshire & Mersey...	04:22:23
Greater Manchester	03:32:17
Lancashire & Sout...	03:31:19
North East & Nort...	03:23:38

C3 90th	
Target	01:30:00
Month	03:48:48
YTD	03:16:44
Ranking	4

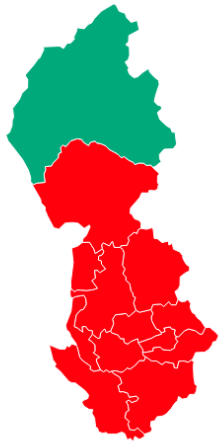
O3 ARP Response Times

BAF ID SR03

O3 ARP Response Times



C4 90th (Red => 3h)



C4 90th by Sector	
CL Fylde	05:27:46
M East	05:18:53
CL East Lancashire	05:16:23
M North	04:55:59
G Central	04:43:13
G West	04:36:32
G South	04:35:48
M West	04:19:15
G East	04:10:20
M South	03:53:21
CL South Lancashire	03:28:28
CL Morecambe Bay	03:18:08
CL North Cumbria	02:53:53

C4 90th by ICB	
Cheshire & Mersey...	04:22:51
Greater Manchester	04:19:04
Lancashire & Sout...	04:17:40
North East & Nort...	02:53:53

C4 90th	
Target	03:00:00
Month	04:20:52
YTD	03:49:44
Ranking	4

O3 ARP Response Times

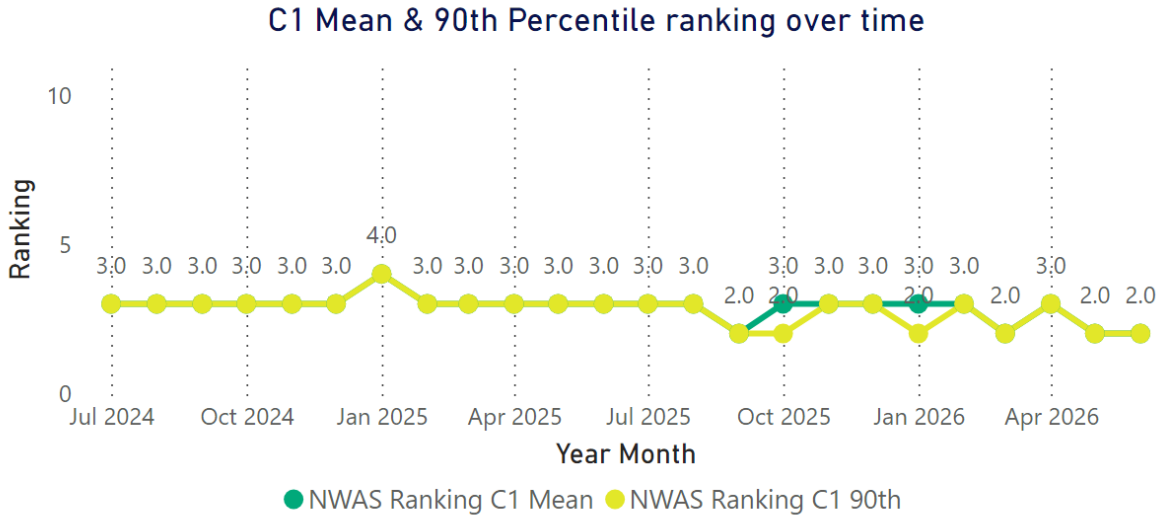
Summary:
C1 mean response time increased from 6m54s to 7m03s, moving outside target. June saw the highest C1 demand of the year, with performance deteriorating during the week commencing 22/06/2026 due to the hot weather. Greater Manchester ICB was the only area to remain within target. The C1 90th percentile remained within target at 12m02s.

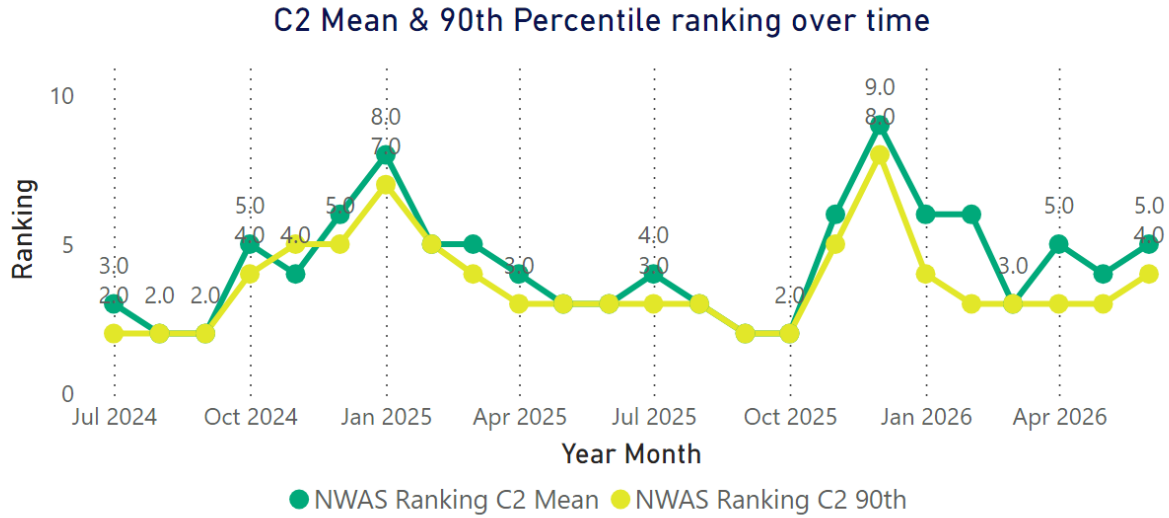
C2 mean response time increased from 24m51s to 27m07s during the second-highest activity month of the year. Five sectors exceeded 30 minutes, and Greater Manchester ICB was the only ICB to achieve target. The C2 90th percentile rose to 54m15s and remained outside target across all sectors and ICBs.

C3 mean response time increased from 1h 29m45s to 1h 46m27s, with all sectors remaining outside target. The C3 90th percentile increased to 3h48m48s and remained outside target across all sectors. The C4 90th percentile increased to 4h20m52s, although North East and North Cumbria ICB achieved target this month.

Action: Additional PAS (private ambulance service) resourcing comes online in August to support improvements in C2 performance. Enhanced operational monitoring, severe weather actions and system escalation arrangements were implemented to manage demand, resource pressures and hospital flow.

O3 ARP Provider Comparison





C1 Mean by Trust

North East	00:06:07
North West	00:07:03
London	00:07:05
Yorkshire	00:07:51
Isle Of Wight	00:08:15
South East Coast	00:08:18
West Midlands	00:08:19
South Central	00:08:44
East Of England	00:08:51
East Midlands	00:08:59
South Western	00:09:41

C1 90th by Trust

North East	00:10:30
North West	00:12:02
London	00:12:07
Yorkshire	00:13:37
West Midlands	00:14:50
Isle Of Wight	00:15:04
South East Coast	00:15:19
South Central	00:15:44
East Midlands	00:16:02
East Of England	00:16:48
South Western	00:17:57

C2 Mean by Trust

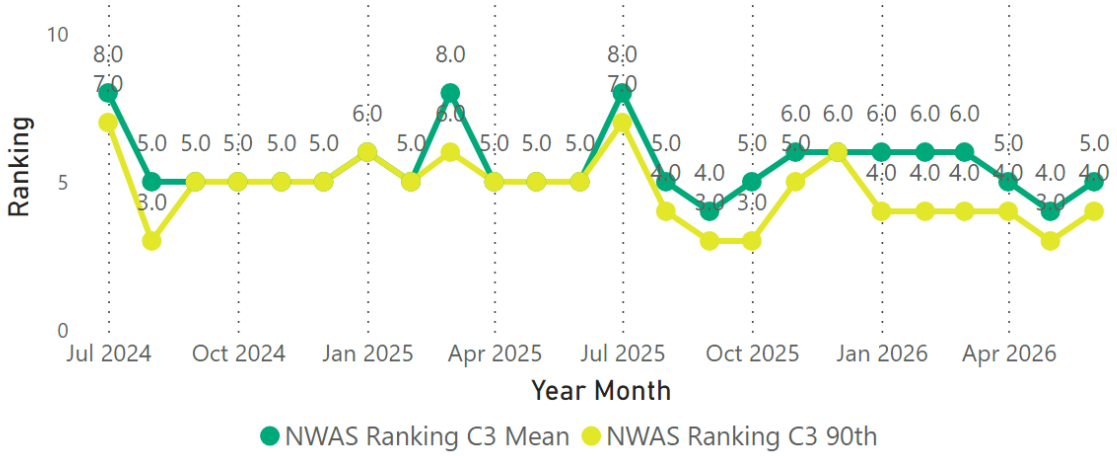
North East	00:19:35
West Midlands	00:25:22
Yorkshire	00:25:30
Isle Of Wight	00:26:30
North West	00:27:08
South East Coast	00:28:30
London	00:33:00
East Of England	00:37:33
East Midlands	00:38:12
South Central	00:40:51
South Western	00:44:59

C2 90th by Trust

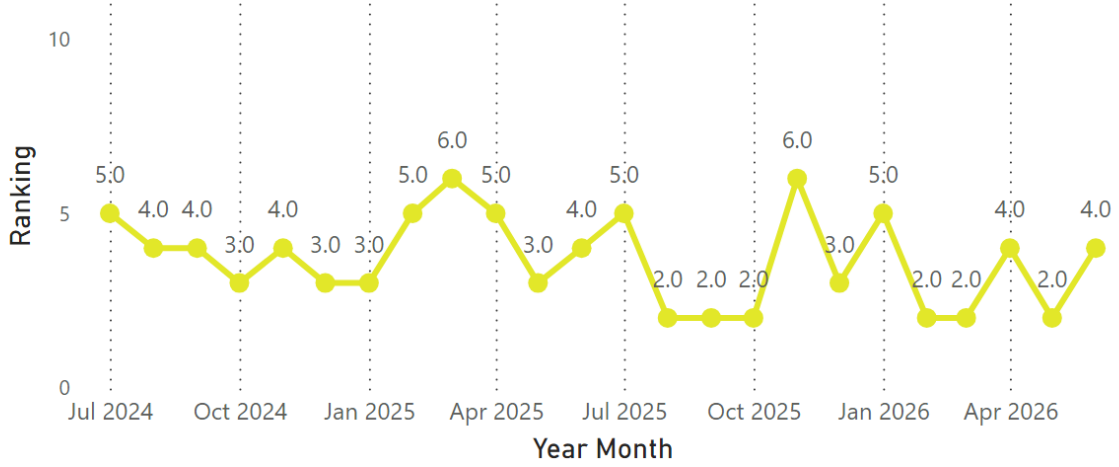
North East	00:39:10
West Midlands	00:51:16
Yorkshire	00:52:22
North West	00:54:15
Isle Of Wight	00:56:08
South East Coast	00:57:26
London	01:11:13
East Midlands	01:16:04
East Of England	01:20:17
South Central	01:20:22
South Western	01:33:53

BAF ID SR03

C3 Mean & 90th Percentile ranking over time



C4 90th Percentile ranking over time



C3 Mean by Trust

North East	00:53:05
Isle Of Wight	01:17:16
Yorkshire	01:23:14
London	01:38:33
North West	01:46:26
East Of England	02:03:40
West Midlands	02:08:50
South East Coast	02:15:15
East Midlands	02:34:26
South Western	02:43:29
South Central	03:01:54

C3 90th by Trust

North East	01:56:17
Isle Of Wight	02:38:41
Yorkshire	03:12:34
North West	03:48:38
London	04:08:40
East Of England	04:58:14
South East Coast	05:09:52
West Midlands	05:19:39
East Midlands	05:46:02
South Western	06:34:57
South Central	06:54:13

C4 90th by Trust

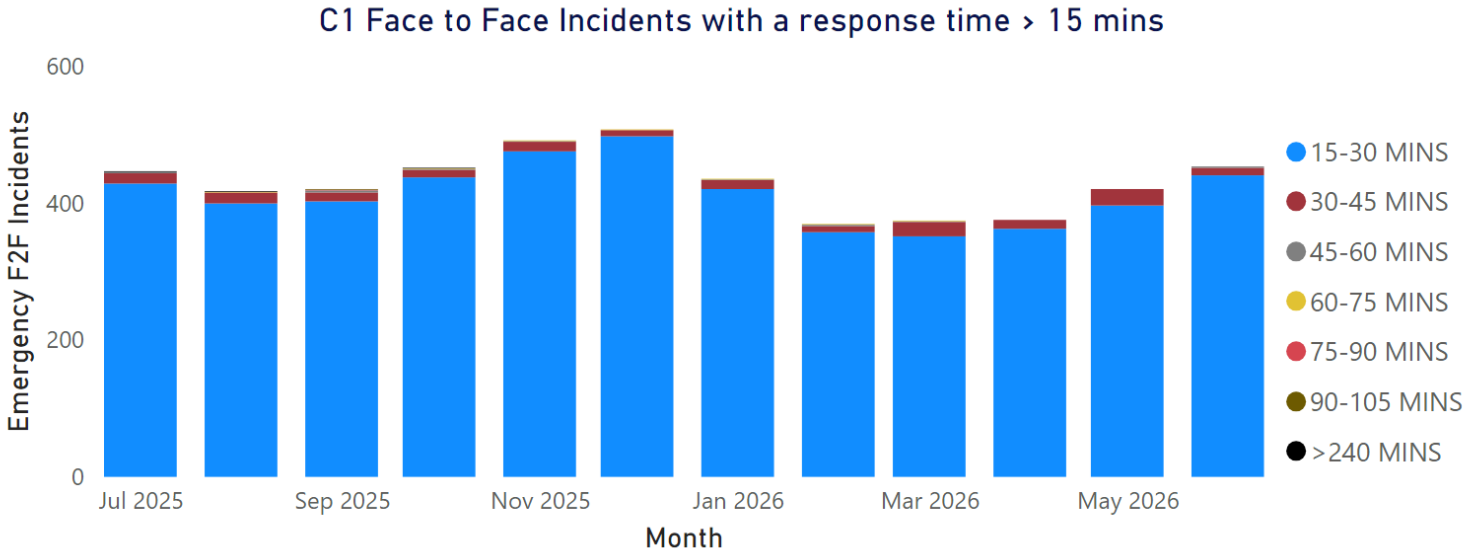
North East	02:30:28
Yorkshire	04:05:42
Isle Of Wight	04:20:35
North West	04:20:39
South East Coast	05:21:06
East Of England	05:52:18
London	06:20:07
West Midlands	07:05:54
South Central	07:12:05
South Western	09:45:57
East Midlands	13:45:45

Summary:
The Trusts national performance for C1 mean and C1 90th percentile has remained 2nd nationally.

Performance rankings indicate a slight deterioration in Category 2 metrics, with the C2 mean falling from 4th to 5th place, C2 90th percentile moving from 3rd to 4th.

Similar reductions have been observed within lower acuity categories, where category 3 mean performance has dropped from 4th to 5th, and category 4 90th from 2nd to 4th.

O3 Long Waits C1



Month Year	Total No. of C1 Long Waits
Jul 2025	446
Aug 2025	417
Sep 2025	420
Oct 2025	451
Nov 2025	491
Dec 2025	507
Jan 2026	435
Feb 2026	369
Mar 2026	374
Apr 2026	375
May 2026	420
Jun 2026	453

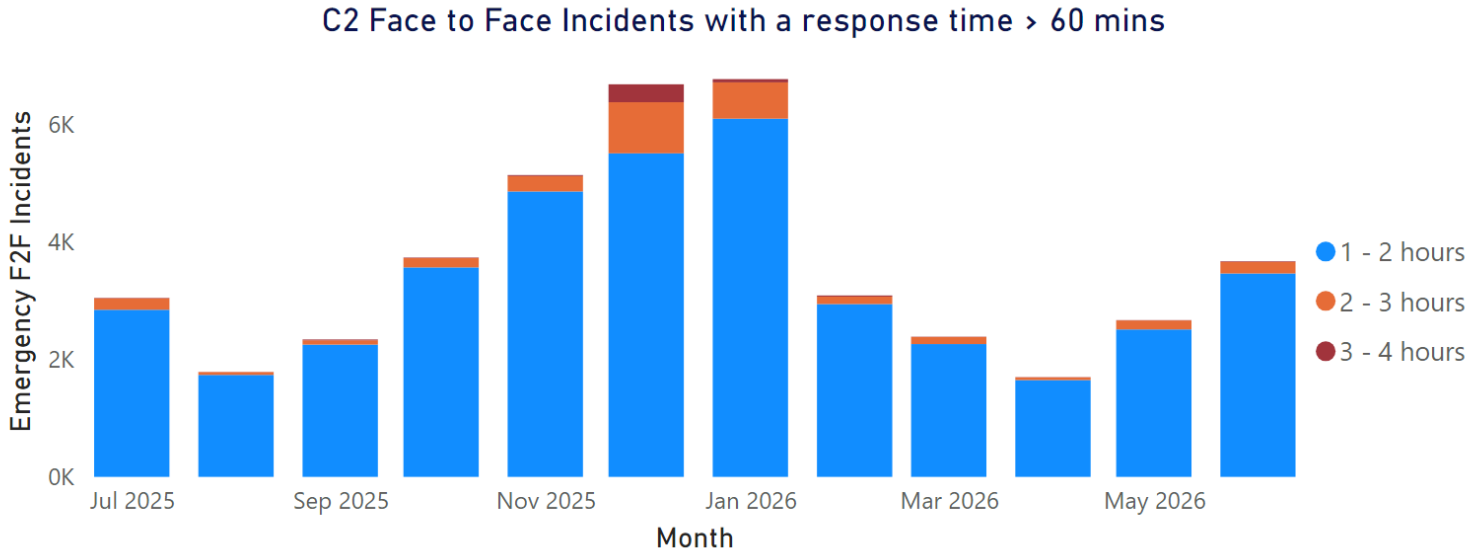
Summary:

C1 long waits increased from 420 last month to 453 with approximately 4% of all C1 activity resulting in a long wait. Approximately 97% of long waits fell within the 15–30 minute band, compared with 94% last month. However, two C1 incidents (Morecambe Bay and North Cumbria) experienced waits of 45–60 minutes. Long waits peaked during the week commencing 22/06/2026 accounting for 32% of all C1 long waits recorded during June.

C&L contributed 52% of all C1 long waits, with Morecambe Bay being the most significant contributor. During June, 16.5% of C1 incidents in Morecambe Bay resulted in a long wait, increasing further to 18.3% in the week commencing 22/06/2026. North Cumbria also experienced notable pressure, with 14.5% of C1 incidents resulting in a long wait across the month, rising to 19.3% during the week commencing 22/06/2026, the highest proportion recorded across all sectors during that period.

Action: Staff have been transferred to Morecambe Bay to resolve some of the vacancy challenges and improve cover levels. Additional PAS resources are being commissioned for Cumbria which come online in August.

O3 Long Waits C2



Month Year	Total No. of C2 Long Waits
Jul 2025	3,047
Aug 2025	1,787
Sep 2025	2,339
Oct 2025	3,733
Nov 2025	5,138
Dec 2025	6,683
Jan 2026	6,771
Feb 2026	3,088
Mar 2026	2,386
Apr 2026	1,698
May 2026	2,668
Jun 2026	3,671

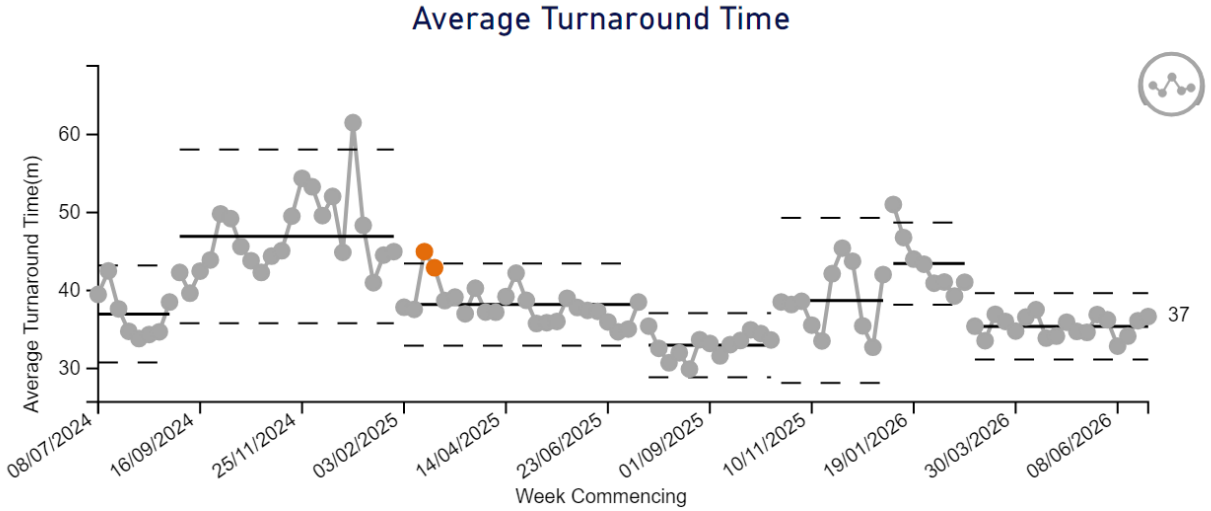
Summary:

C2 long waits increased by 37.5% compared with last month, with approximately 8% of all C2 activity resulting in a long wait. More long waits were in the 1–2 hour band, which accounted for a greater proportion of all C2 long waits than in the previous month. However, there was also a slight increase in the proportion of long waits within the 3–4 hour band, and June recorded two incidents with waits exceeding 240 minutes.

C&M accounted for approximately 50% of all C2 long waits across the operational area. Similar to the pattern observed for C1 incidents, the week commencing 22/06/2026 was a particular area of concern, accounting for 46% of all C2 long waits recorded during June.

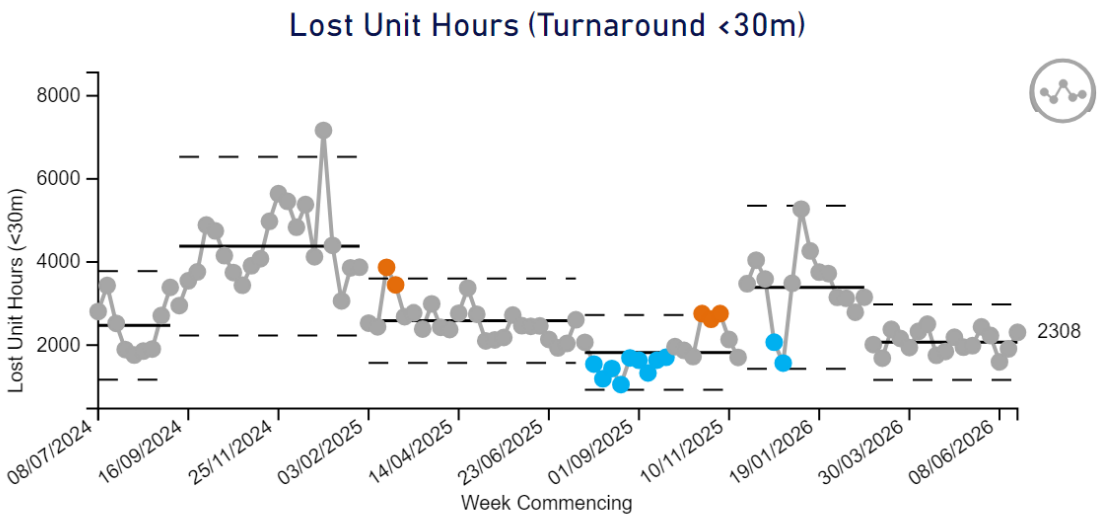
Action: Hot weather events will be managed as part of severe weather planning.

O3 A&E Turnaround



Month	Hospital Attendances	Average Turnaround Time(hh:mm:ss)	Average Arrival to Handover Time (hh:mm:ss)	Average Handover to Clear Time(hh:mm:ss)
Jun 2025	47,631	00:37:03	00:27:49	00:09:25
Jul 2025	48,832	00:35:33	00:26:14	00:09:24
Aug 2025	49,030	00:30:59	00:21:47	00:09:15
Sep 2025	47,966	00:32:55	00:23:42	00:09:17
Oct 2025	50,758	00:35:41	00:26:21	00:09:22
Nov 2025	48,975	00:37:19	00:27:55	00:09:26
Dec 2025	49,754	00:39:39	00:30:20	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
Mar 2026	49,398	00:35:28	00:26:14	00:09:14
Apr 2026	48,997	00:35:33	00:26:25	00:09:10
May 2026	50,817	00:35:06	00:26:00	00:09:06
Jun 2026	49,361	00:35:20	00:26:19	00:09:04

O3 A&E Turnaround



Month	No of patients wating outside ED for handover
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
Mar 2026	1676
Apr 2026	1840
May 2026	2004
Jun 2026	1816

Top 5 Trusts with most lost unit hours

Destination Short Name	Hospital Attendances to AE	Lost Time Turnaround >30m (h)	Mean at Hospital to Clear Time(hh:mm:ss)	Mean at Hospital to Handover Time(hh:mm:ss)	Mean Handover to Clear Time(hh:mm:ss)
Whiston	2,355	1012.12	00:51:32	00:41:31	00:10:34
Royal Liverpool University	2,311	997.99	00:52:47	00:43:12	00:09:57
Warrington	1,700	855.51	00:54:29	00:43:41	00:11:13
Blackpool Victoria	2,670	716.20	00:41:22	00:32:00	00:09:33
Royal Preston	2,235	635.72	00:40:11	00:32:51	00:07:48

Summary:
Hospital attendances decreased in June to 50,817, a fall of 1,456 (2.9%) compared to May. The decrease is most likely attributable to weather-related signposting activity. Despite the decrease in attendances, average turnaround time worsened by 14 seconds to 35m:20s, while arrival to handover worsened by 19 seconds to 26m:19s.

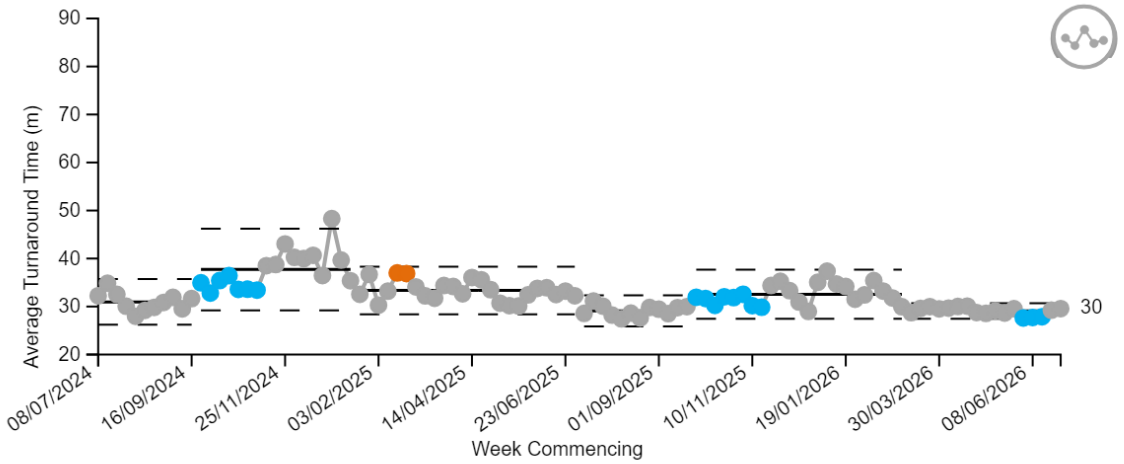
Overall weekly turnaround performance has remained stable throughout June. Greater Manchester continues to record the lowest average turnaround time at 30 minutes, while Cheshire & Merseyside remains the highest at 46 minutes. North East and North Cumbria average turnaround reached the upper control limit in the second to last week of June.

Lost unit hours decreased from 2,004 in May to 1,816 in June. Blackpool fell into the top 5 in June. Whiston continues to record the highest lost unit hours, followed by Royal Liverpool University.
The slight deterioration in turnaround performance during June is likely attributable to the period of extreme hot weather, which placed additional pressure on both ambulance services and acute hospitals.

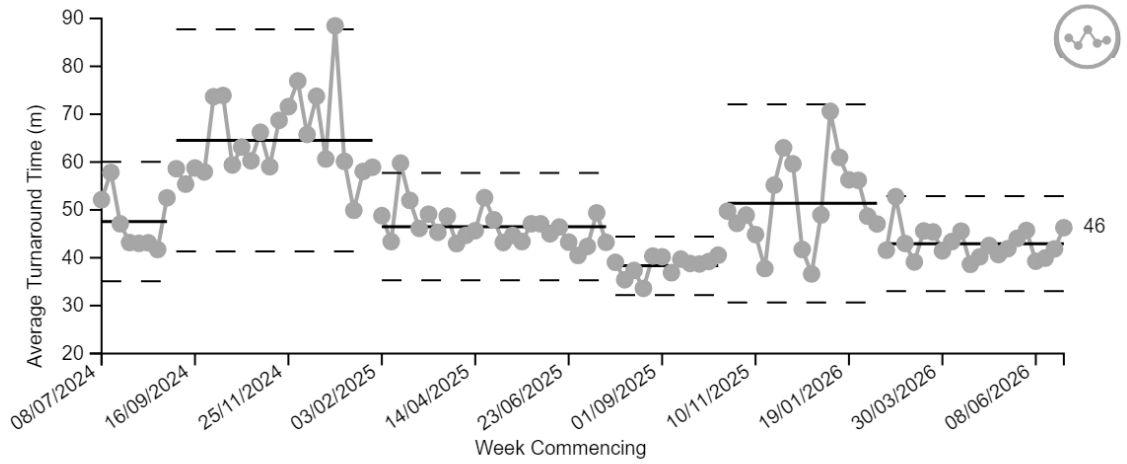
Actions: Engagement continues with acute trusts who have a high volume of lost hours, with static and roaming HALOs (hospital ambulance liaison officers) being focused on these sites.

O3 A&E Turnaround by ICB

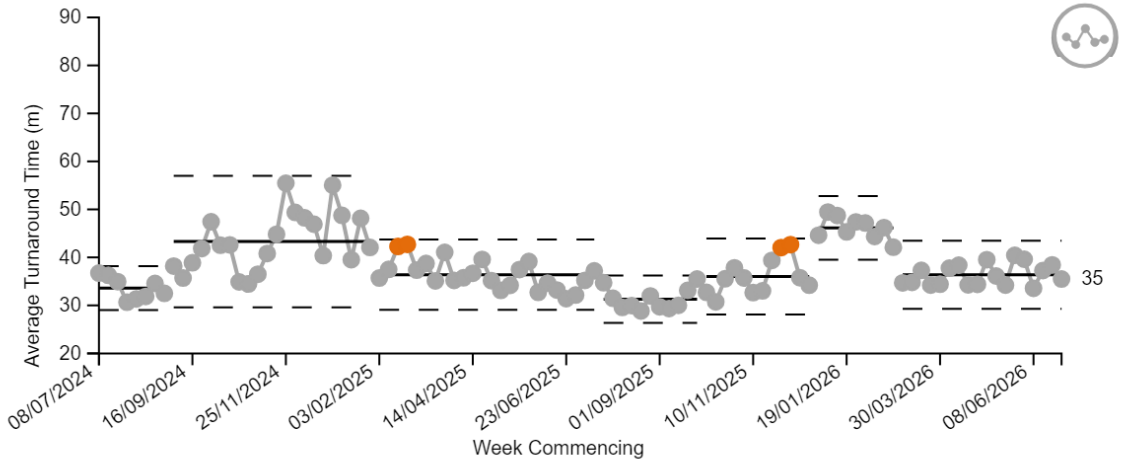
Average Turnaround Time - Greater Manchester ICB



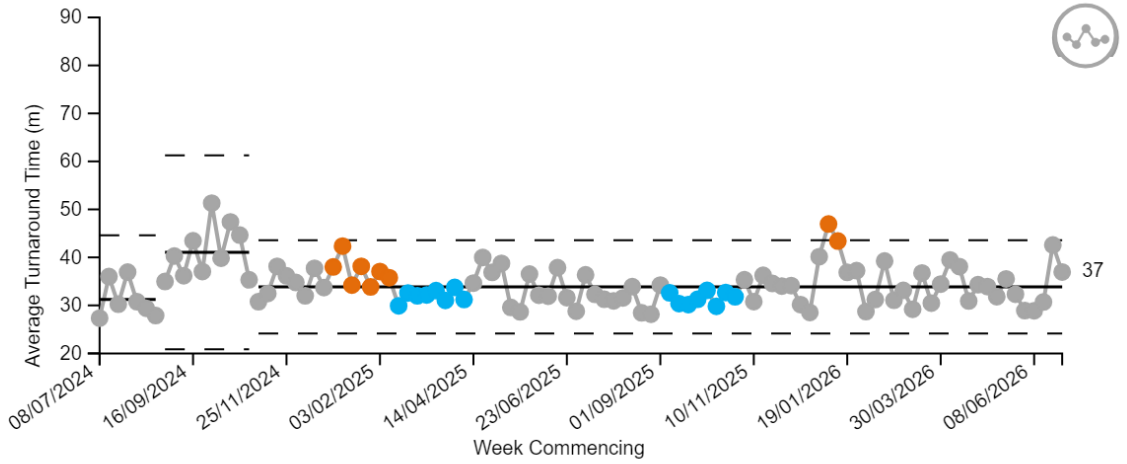
Average Turnaround Time - Cheshire & Mersey ICB



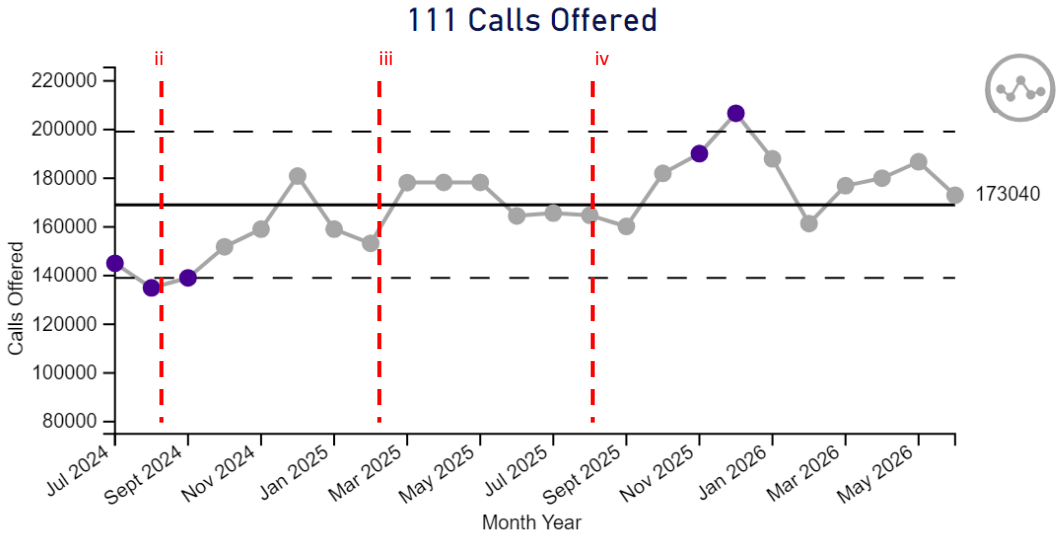
Average Turnaround Time - Lancashire & South Cumbria ICB

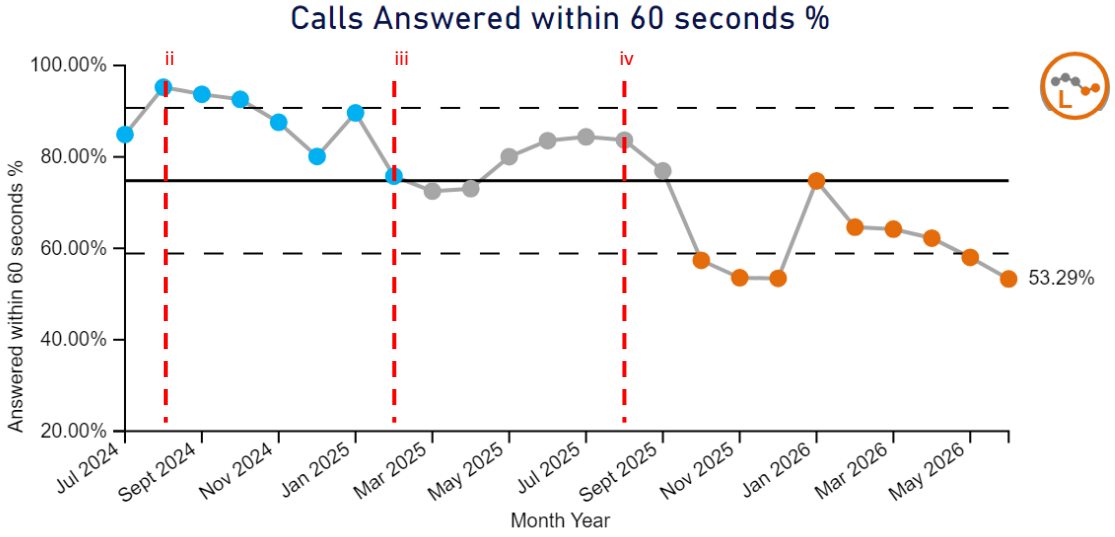


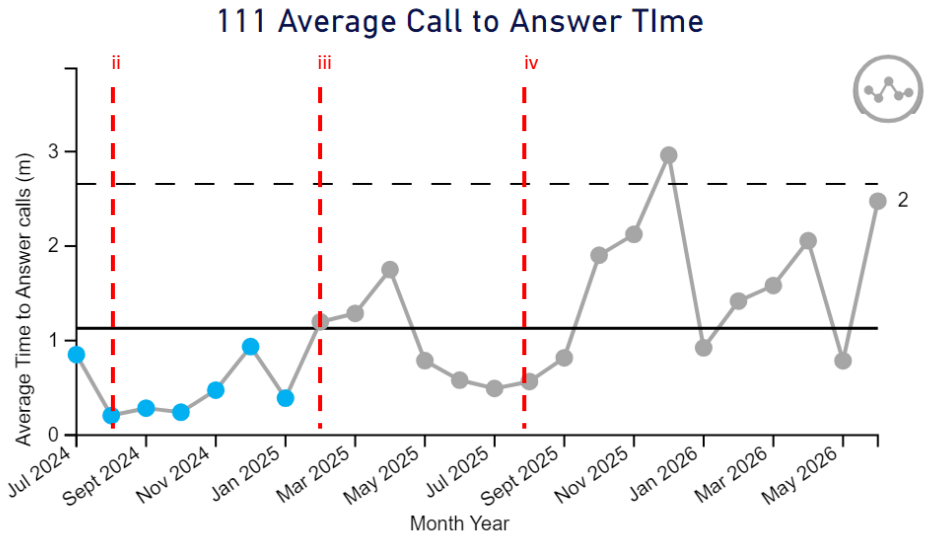
Average Turnaround Time - North East & North Cumbria ICB



04 111 Activity & Performance







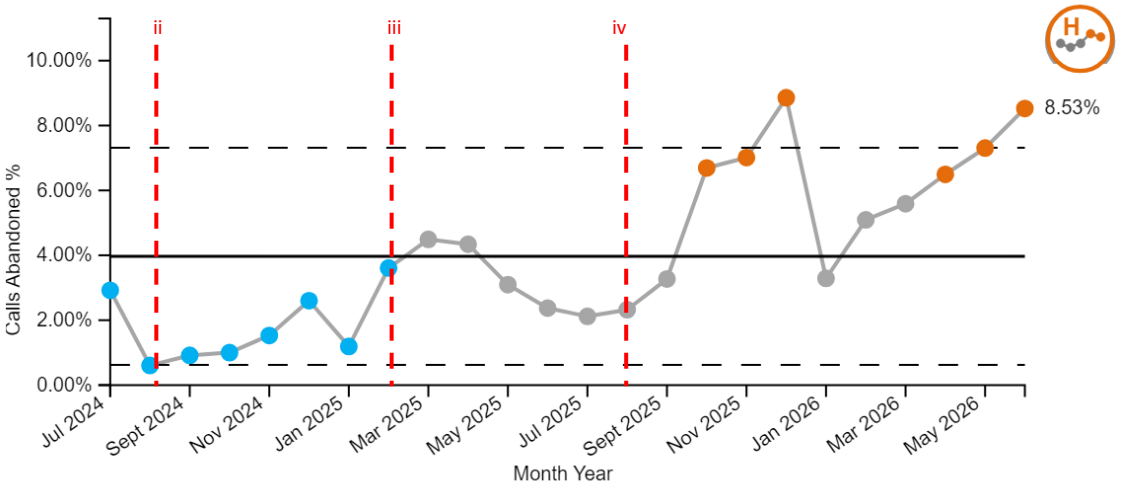
Calls Offered	
Month	173.04K
YTD	539,871

Calls Answered within 60 Seconds %	
Target	95%
Month	53.29%
YTD	57.9%
National	75.1%
Ranking	28th

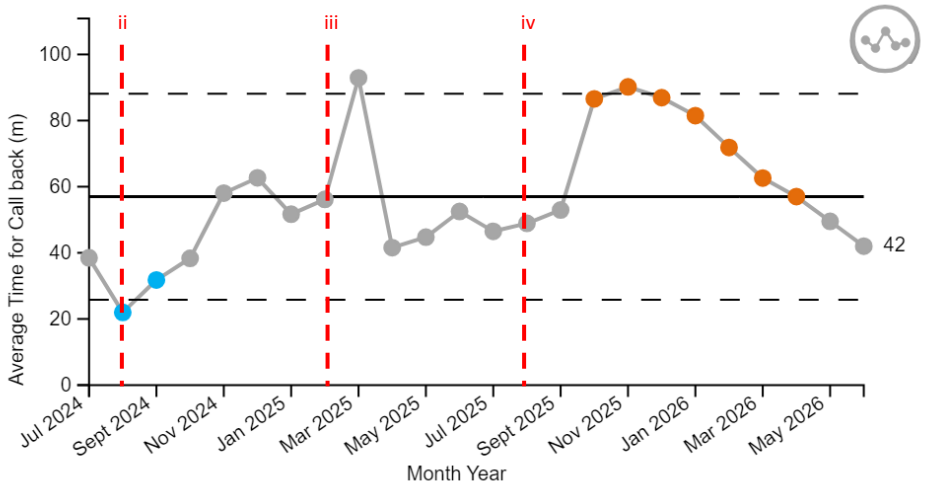
Average Call to Answer Time (s)	
Target	<20
Month	149
YTD	105
National	81
Ranking	28th

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

111 Calls Abandoned %



111 Average Time for Call Back



Calls Abandoned %	
Target	<5%
Month	8.53%
YTD	7.43%
National	4.5%
Ranking	27th

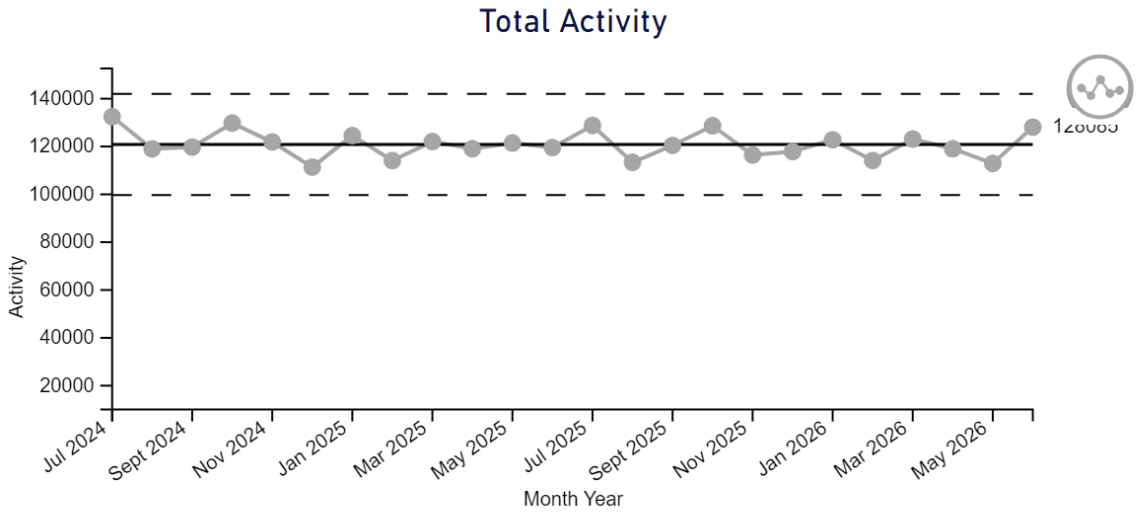
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency
Iv 14th July Clinicians stopped taking front end calls

Summary:
Telephony performance for 111 declined in June, primarily due to a sharp increase in demand during the hot weather period. High levels of sickness absence further reduced available capacity during this period.
Call answering within 60 seconds deteriorated for the fifth consecutive month to 53.29%, with abandonment at 8.53%. Prior to the hot weather period, answered in 60 performance had been averaging around 60%.

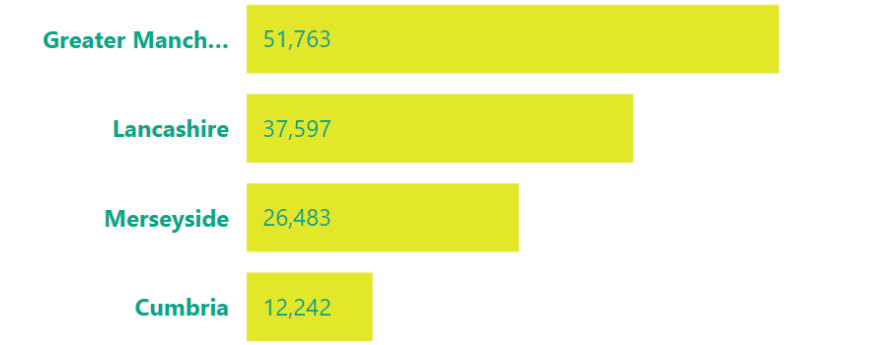
Overall calls offered decreased from 186,788 in May to 173,040 in June; however, the hot weather period created concentrated peaks in demand that adversely affected service performance.
Average time for clinical call back improved for the sixth consecutive month, to 42 minutes.

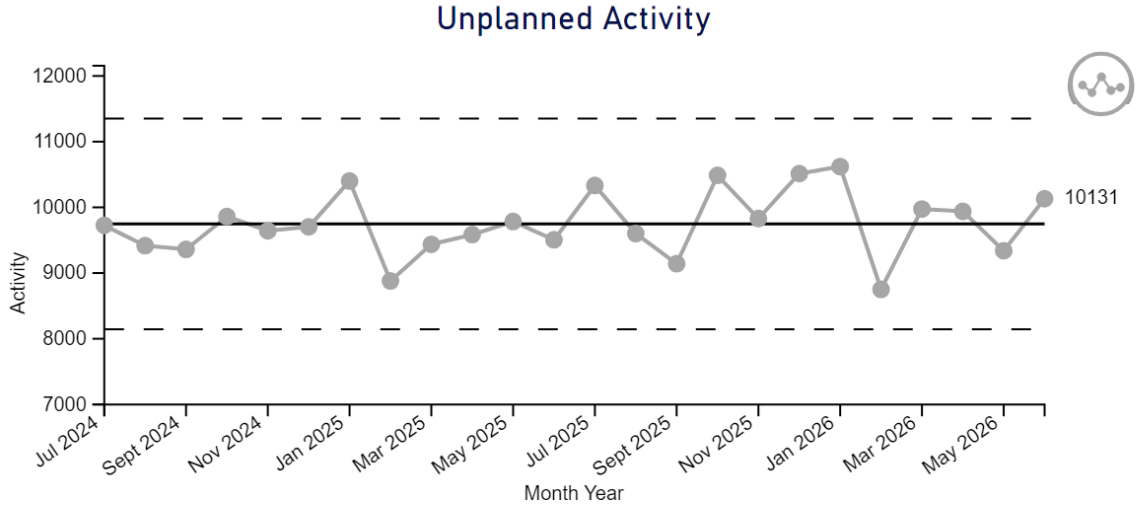
Action: Hot weather events will be managed as part of severe weather planning and ongoing ICC improvements.

05 PTS Activity

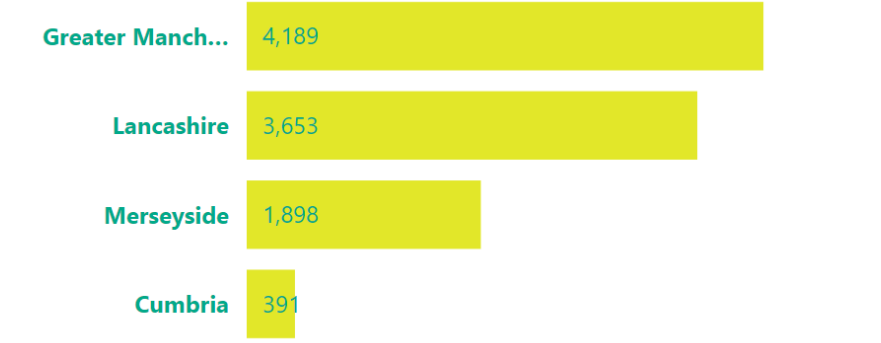


Total Activity by Contract

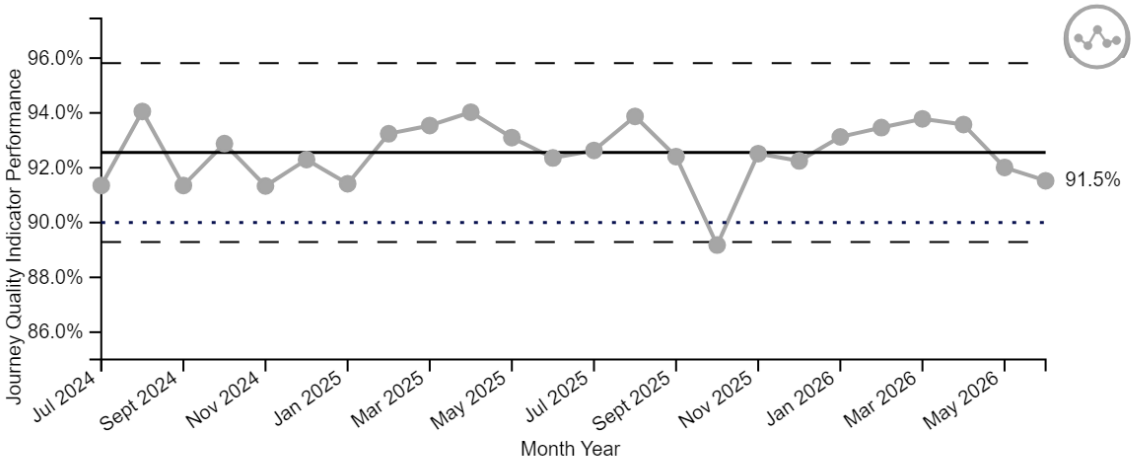




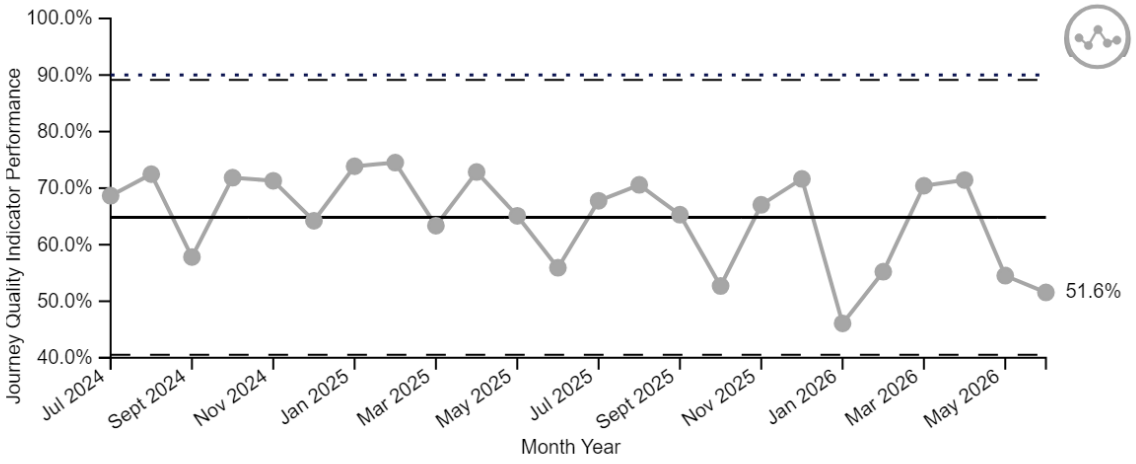
Unplanned Activity by Contract



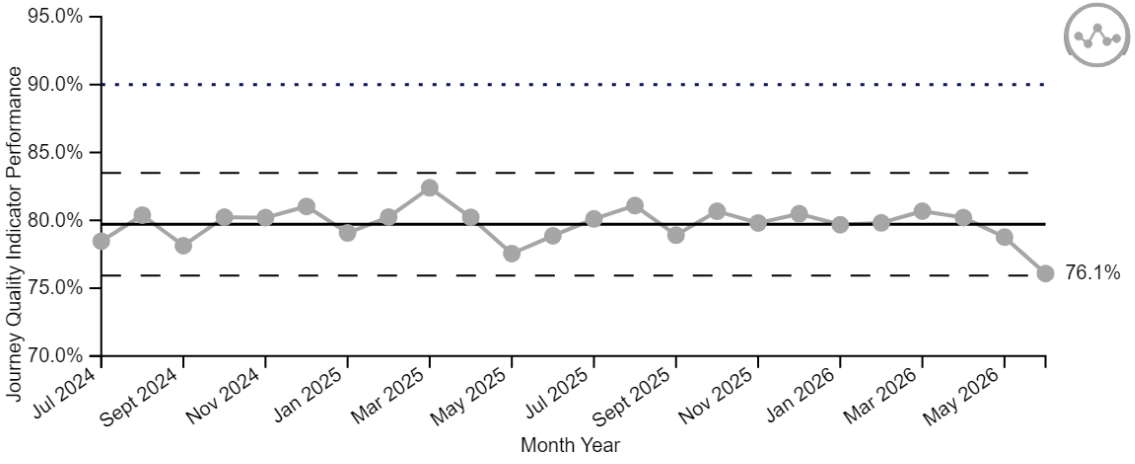
Collection after treatment (EPS) within 90 min



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%

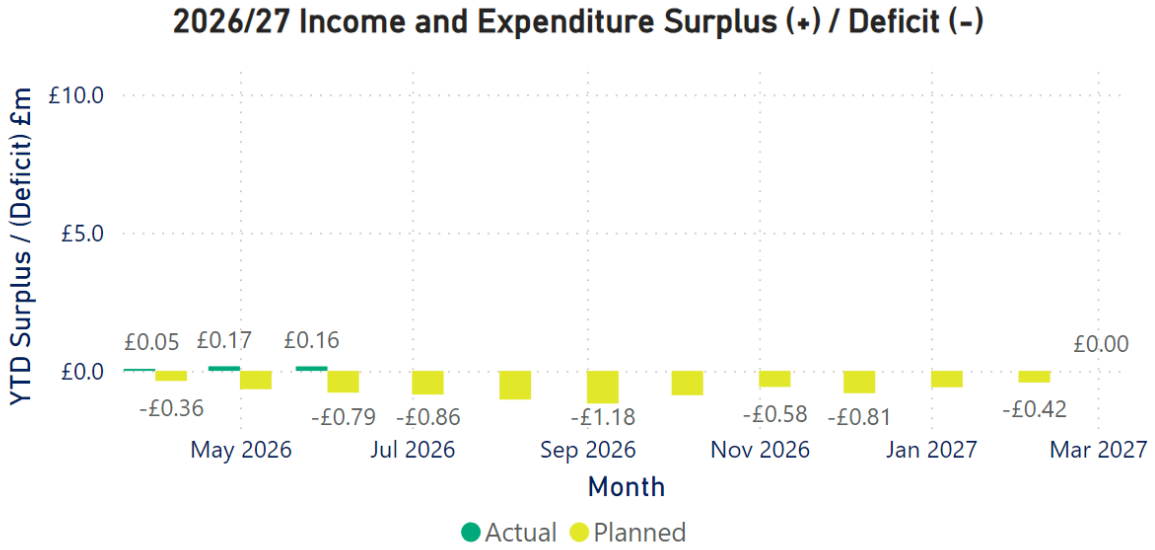
Actions:

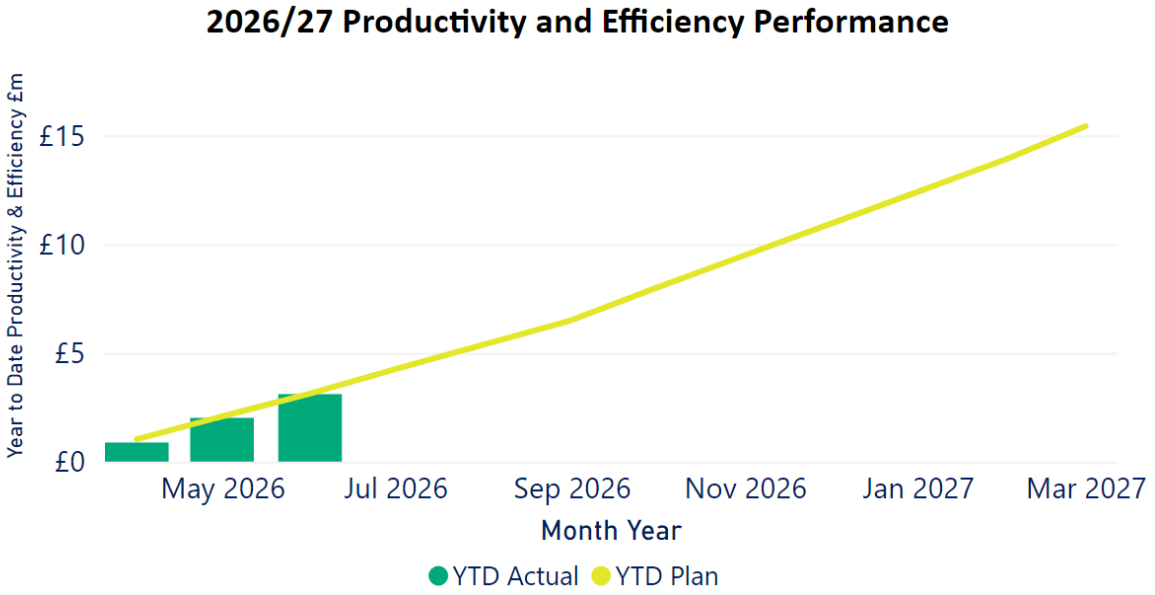
Operational and workforce improvement plans are in place

Finance

F1 Financial Score

F1 Financial Score





Summary:
The financial position to 30 June 2026 (Month 03) is a surplus of £0.163m, against a planned deficit of £0.788m. Workforce numbers are expected to increase throughout the year, which will increase expenditure and ensure that the trust delivers a break-even financial position at year-end.

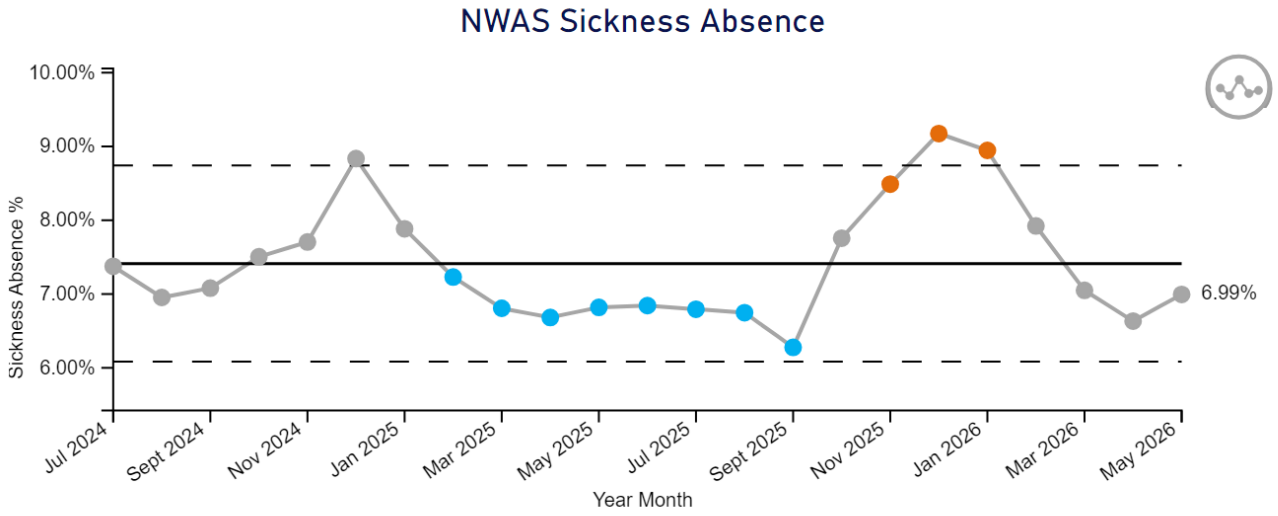
Productivity and efficiency savings at Month 03 are slightly behind plan at £3.101m, against the year to date plan of £3.123m.

Actions:
Service leads are continuing to develop efficiency plans which will increase the delivery of savings in year.

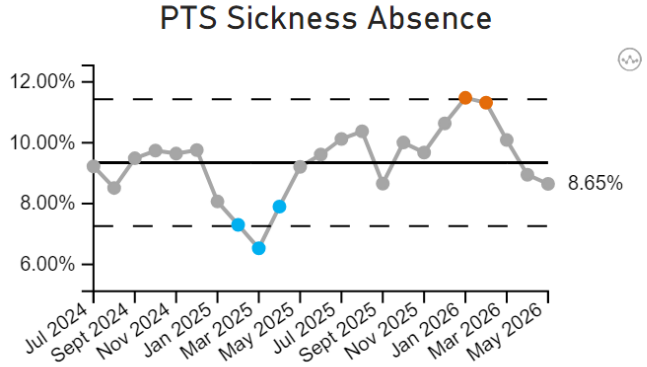
Organisational Health

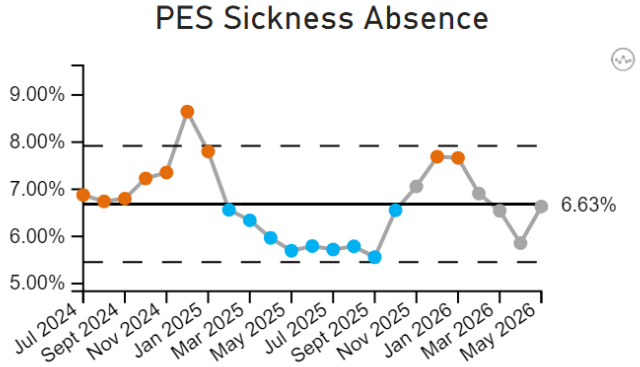
OH1 Staff Sickness
OH2 Staff Turnover
OH5 Vacancy Gap
OH6 Appraisals
OH7 Mandatory Training
OH8 Case Management

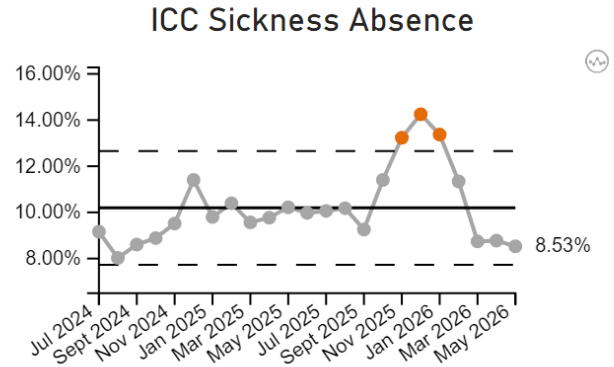
OH1 Staff Sickness



Month	NWAS	Amb. National Average
Jul 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%	7.88%
Feb 2026	7.92%	7.19%
Mar 2026	7.05%	6.79%
Apr 2026	6.63%	6.57%
May 2026	6.99%	





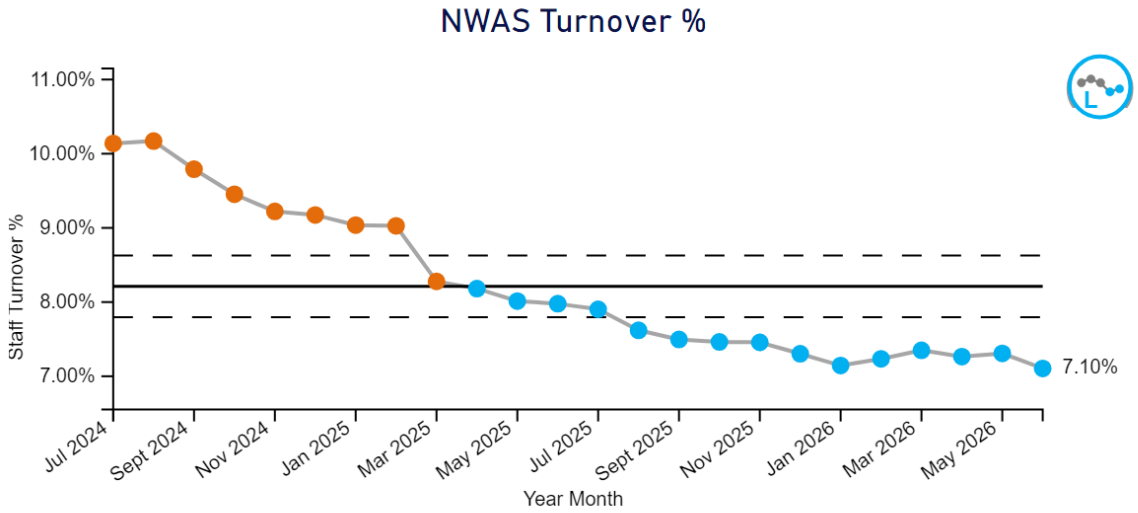


Overall sickness shows a stable position in relation to last year but is not showing overall improvement against medium term plan targets.

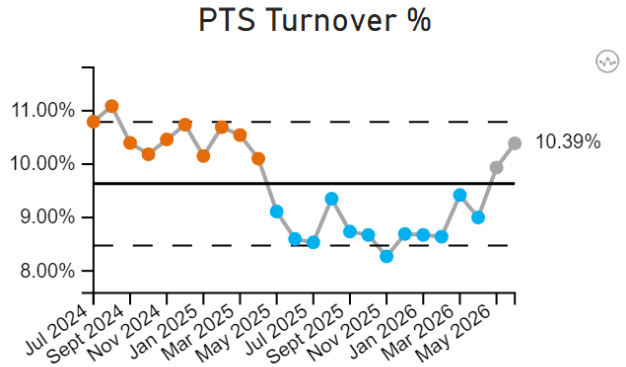
The Attendance Improvement Team are focusing actions on supporting recovery, particularly in ICC and PTS services lines, through training, coaching and deep dive analysis of individual and collective drivers of absence. There are a number of workstreams in the annual plan aimed at supporting improvements including H&S focused work on MSK and stress related absence; violence and aggression prevention and wellbeing improvements. Attendance is a key improvement metric for teams with the aim of delivering reductions in comparison with 25/26.

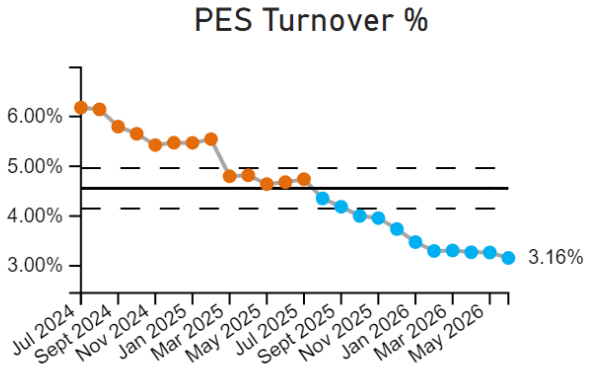
BAF ID SR04

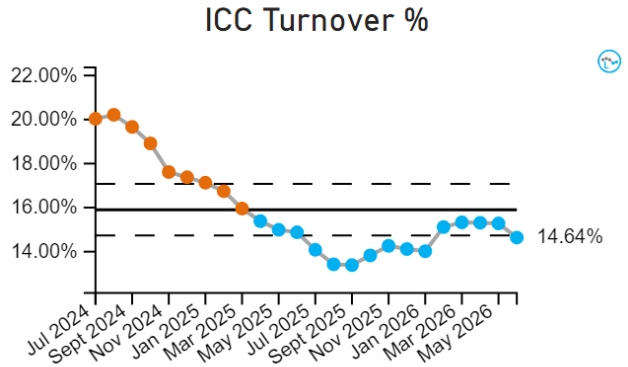
OH2 Staff Turnover



Month	NWAS	Amb. National Average
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%	9.07%
Feb 2026	7.23%	9.10%
Mar 2026	7.35%	9.01%
Apr 2026	7.26%	
May 2026	7.31%	
Jun 2026	7.10%	





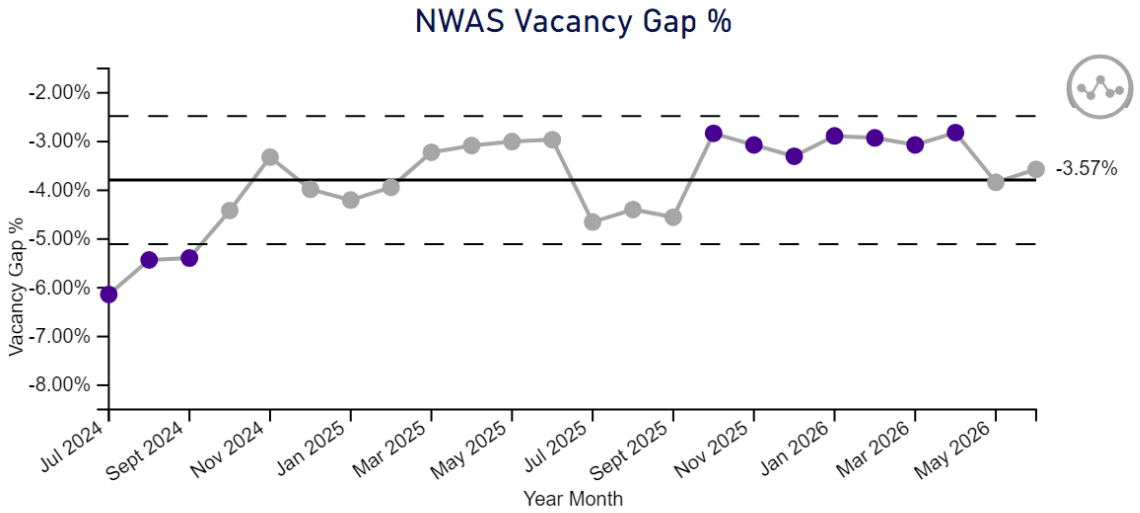


Overall turnover remains stable/reducing. Key areas of risk are increasing PTS turnover which is impacted by external factors such as the tender uncertainty and cultural improvements which are progressing. In addition, PES lower than anticipated turnover is a risk as workforce plans were based on higher attrition assumptions causing skill mix difficulties and potential financial risks from paramedic oversupply.

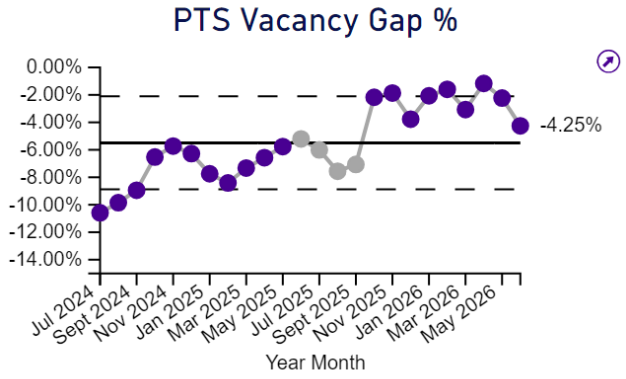
Actions are underway with Operations and Finance colleagues to review workforce modelling and recruitment projections in response to lower than anticipated turnover rates, mitigating the risk of workforce oversupply while ensuring sufficient staffing levels are maintained to meet service demand. This is being considered over the UEC recovery plan period to ensured sustained plans that mitigate the risks.

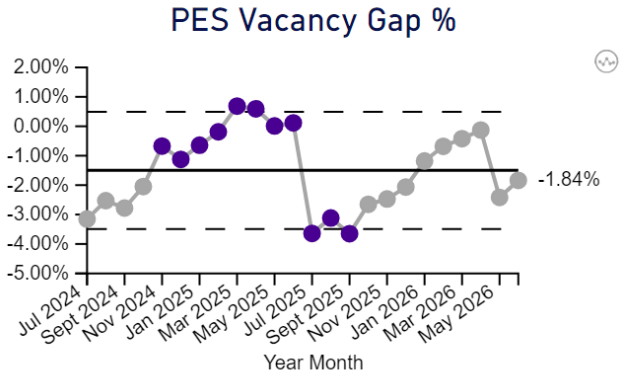
BAF ID SR05

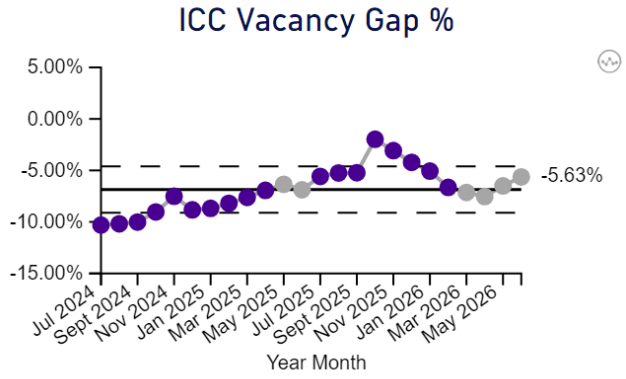
OH5 Vacancy Gap



Month	NWAS Total % Vacancy Gap
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%
Mar 2026	-3.07%
Apr 2026	-2.82%
May 2026	-3.84%
Jun 2026	-3.57%



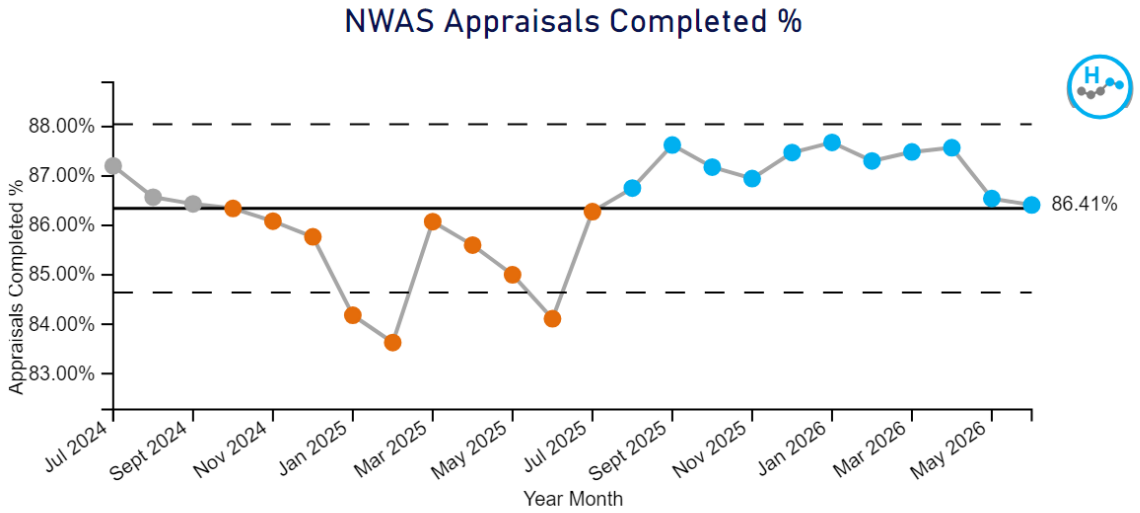




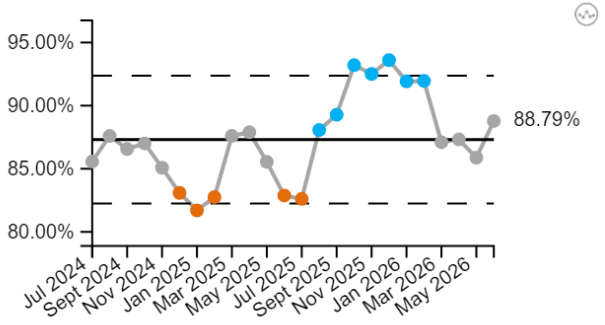
In the main overall and service line vacancy gaps are not a cause for concern. There are some emerging risks within PES, even thought the overall position looks strong.
Actions are in place to manage workforce plans closely and mitigate the impact of the continued movement of PTS staff into EMT1 roles. Robust recruitment and training plans are established across all frontline service lines and are subject to regular joint monitoring.
The principal area of risk remains PES, where recruitment and training plans are operating at maximum capacity, leaving limited flexibility to respond to unexpected changes in workforce demand, turnover, or service requirements. Delivery of these plans has been adversely impacted by external C1 testing delays and reductions in EMT1 course fill. A range of mitigations are being actively explored at pace to mitigate UEC delivery risks.

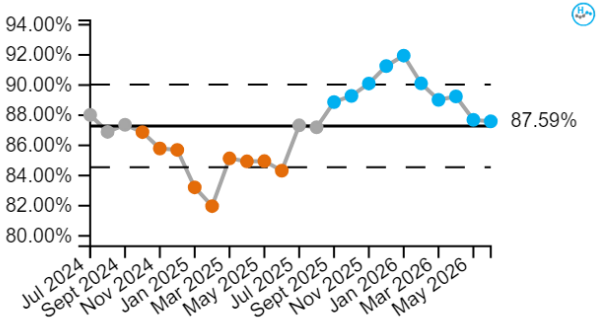
BAF ID SR04

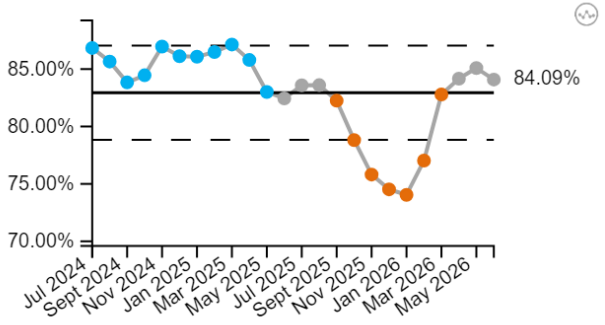
OH6 Appraisals



Month	NWAS Total % Complete Appraisals
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%
Mar 2026	87.49%
Apr 2026	87.57%
May 2026	86.54%
Jun 2026	86.41%





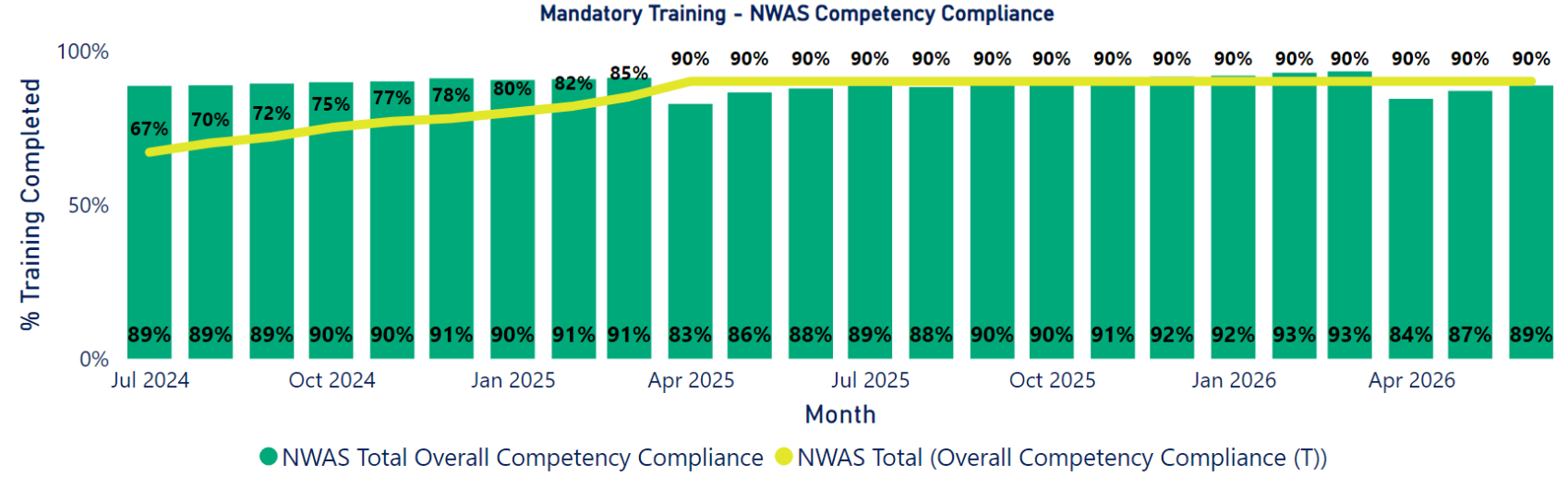


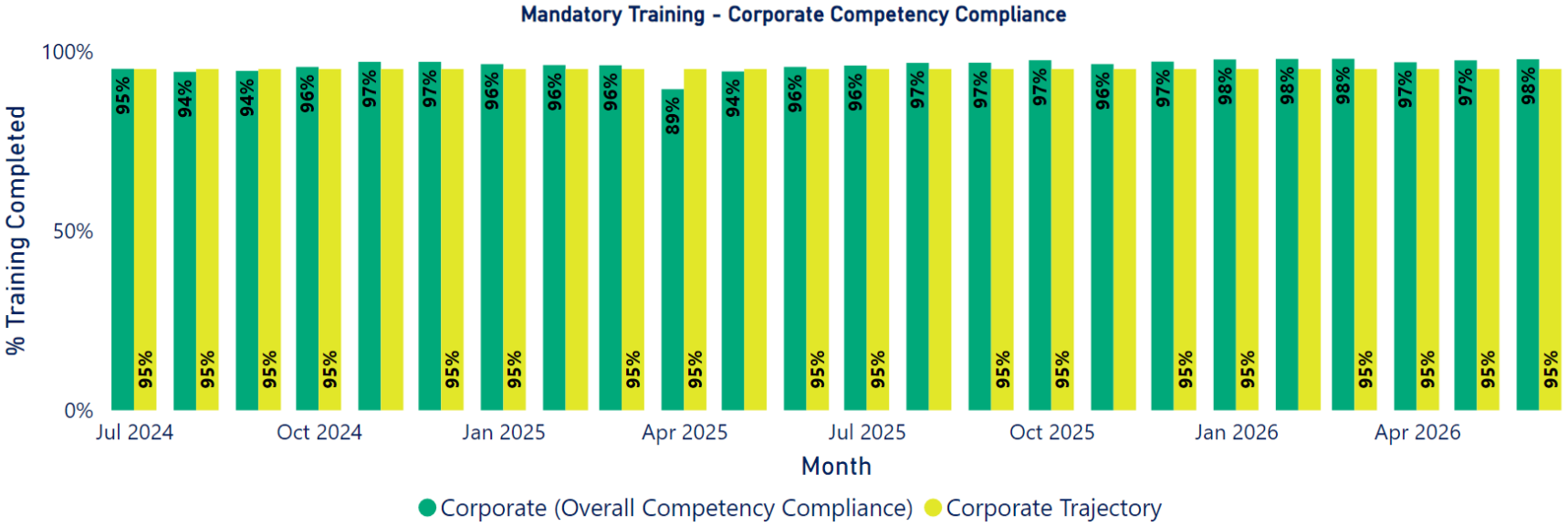
Overall compliance is in line with target with ICC and corporate recovery actions in place.

Whilst compliance is strong, improvement work has commenced which seeks to understand and address the gap between compliance and quality which emerges through the staff survey results. This work will make recommendations later in the year but is unlikely to influence the 2026 staff survey results.

BAF ID SR05

OH7 Mandatory Training



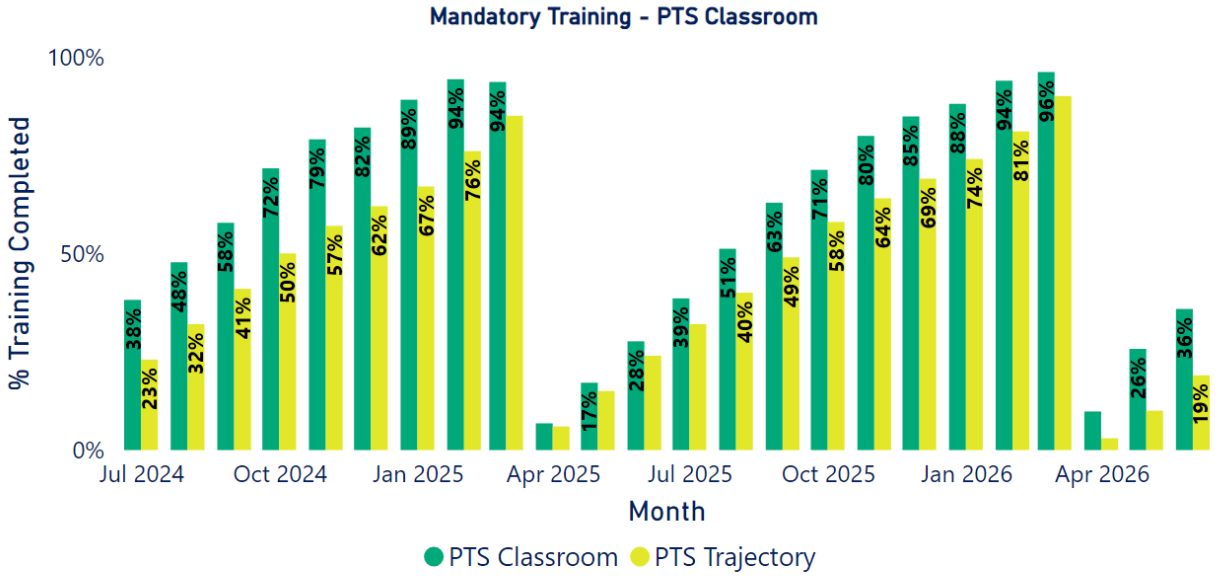


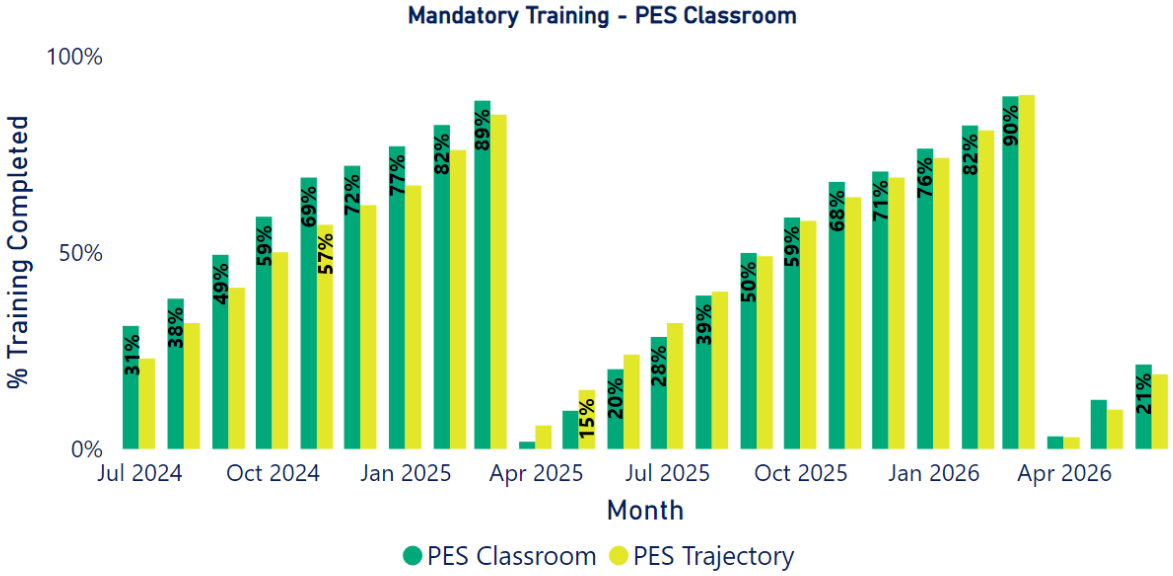
Overall compliance is continuing to rise after new competencies were added in April and is now at 88.7%.

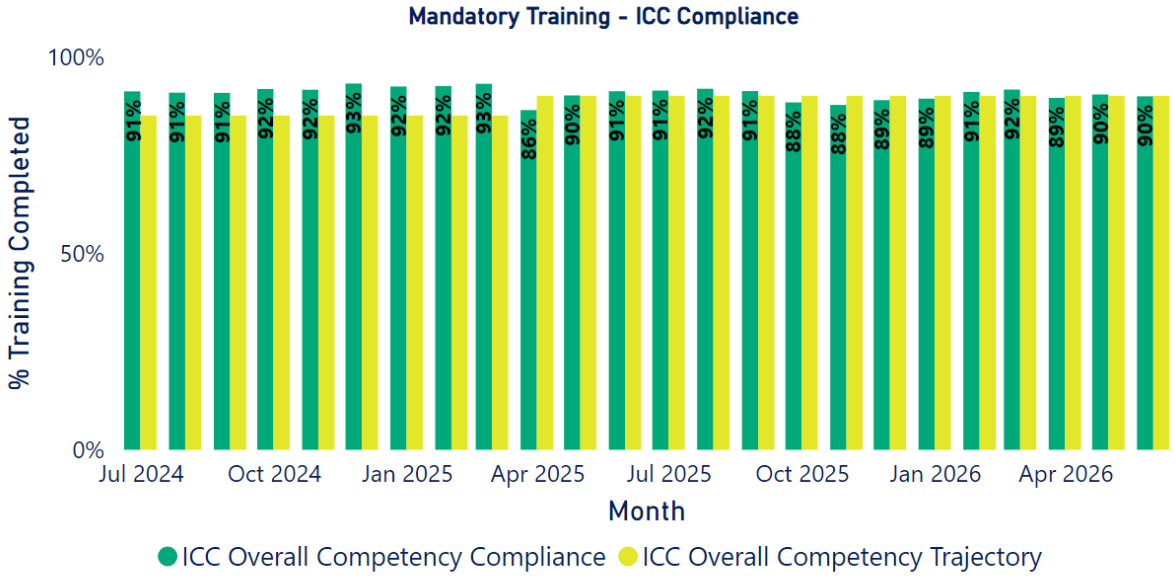
Progress of recovery to the 90% target can be seen and there are no concerns.

BAF ID SR05 Risk Rating NA Strategy Goal NA

OH7 Mandatory Training







2026-27 cycle Classroom attendance is above the 19% June target for both PES and PTS.

BAF ID SR05 Risk Rating NA Strategy Goal NA

OH8 Case Management

BRE relating to Employee Relations - Jul 2026

NHS North West Ambulance Service NHS Trust

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	**78**	**1.88**	**285**	**6.87**	**13.55**
PES CAL	21	1.65	106	8.33	11.05
PES CAM	31	2.26	103	7.52	16.07
PES GM	24	1.65	76	5.22	13.78
PES Other	2	3.88			
Operations ~ ICC	**48**	**2.83**	**178**	**10.50**	**10.90**
Operations ~ PTS	**30**	**4.26**	**66**	**9.38**	**11.94**
Operations ~ Resilience	**0**	**0.00**	**1**	**0.76**	**19.86**
Corporate	**16**	**2.00**	**55**	**6.89**	**11.17**
Other	**3**	**0.00**	**10**	**0.00**	**14.44**
Total	**175**	**2.34**	**595**	**7.96**	**12.40**

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 Jul 2025 to Jun 2026.

NWAS Summary

Case_Type	Live cases	Cases closed in 12 months	Avg weeks to close in 12 months (top 4 case type)
Dignity at Work	11	54	15.20
Disciplinary	66	153	23.88
Fact Finding	28	176	4.80
Grievance	31	146	8.44
Litigation	22	17	
Organisational Change	3	4	
Performance	14	45	
Total	**175**	**595**	**12.40**

Case Dismissals in last month

Case Type	Case Sub Type	Department	Outcome Date
ABS LTS	Non work related	ICC Clinical Delivery	02/06/2026
ABS LTS	Non work related	Lancashire	22/06/2026
ABS LTS	Non work related	Manchester	24/06/2026
Disciplinary	Gross misconduct	CAL - Morecambe	19/06/2026
Disciplinary	Gross misconduct	CAL - Morecambe	24/06/2026
Disciplinary	Gross misconduct	ICC Call Handling	10/06/2026
Performance	Stage 3 truncated	Finance ~ Fleet & Estates	04/06/2026
Performance	Stage 3 truncated	ICC Call Handling	03/06/2026
Performance	Stage 3 truncated	ICC Call Handling	04/06/2026

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	8	3			**11**
Disciplinary	27	25	13	1	**66**
Fact Finding	25	2	1		**28**
Grievance	24	5	2		**31**
Litigation	8	5	4	5	**22**
Organisational Change		1	1	1	**3**
Performance	8	5		1	**14**
Total	**100**	**46**	**21**	**8**	**175**

New Litigation cases in last month

Case Type	Case Sub Type	Department	Received Date
Litigation		People	19/06/2026
Litigation	Constructive dismissal	GM - West	01/06/2026
Litigation	Unfair dismissal	Chief Executive - Strategy & Planning	15/06/2026
Litigation	Unfair dismissal	ICC Call Handling	05/06/2026
Litigation	Unfair dismissal	People	05/06/2026
Litigation	Unfair dismissal	People	16/06/2026

Most common opening reasons for Displinary cases in 12 months

Opening reason	Count
Inappropriate / Unprofessional Behaviour	30
Dereliction of duty	23
Sexual misconduct	16
Poor patient care	9
Failure to follow reasonable management instructions/procedures	8
Negligent Behaviour	8

Disciplinaries: Suspensions or alternative duties (live or in last month)

Status	Count
Alternative duties	0
Restricted practice (alt to suspension)	4
Suspension	14
Total	**18**

Delivering the right care, at the right time, in the right place, every time.

Key areas of risk remain the level and complexity of casework which is placing pressure on capacity in people and operational teams. There is an increasing number of litigation cases which reflects a growing trend across the NHS which poses financial risks.

There remains a continued focus on concluding extended cases as quickly as possible but with a parallel focus on new cases being managed to tighter timeframes. Challenges still remain with timeliness being affected by police involvement, long term sickness of staff involved in the process and some issues around availability but there is strong oversight through directorates of case timeliness and through TMC.

Average case times remains at 12.4 weeks due to both volume and complexity of cases and we aim to keep that stable.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Controlled Drugs Annual Report 2025/26
PRESENTED BY	Rachael Fallon – Chief Pharmacist
PURPOSE	Assurance

STRATEGIC AIM(S)	Choose an item.							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐
	SR05	☐	**SR06**	☐	**SR07**	☐	**SR08**	☐

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Board is asked to: • Note the assurance provided and the achievements and improvements made in 2025/26 as well as the challenges and risks for 2026/27.
XECUTIVE SUMMARY	The report details the following key notes of assurance and the achievements and improvements made in 2025/26: • A Home Office Controlled Drug (CD) licence has been received with no stipulated changes to our service provision. • Assurance reporting into NHSE. • High level of CD reporting, with the significant majority “no” or “low” harm, demonstrating a good reporting culture. • Scrutiny of CDs administered to patients and follow up of any concerns. • The CD policy and all CD procedures are in date. • Medicines Management Quality Indicators (MMQI) for vehicles shows full compliance with all areas except with the weekly checks.

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

	• MMQI for ambulance stations (daily and weekly checks) have been met for the first time since introduction. • The Designated Body Self Assessment against the assurance and improvement framework has been submitted. The report notes the main challenges in 2025/26: • Resourcing issues for the digital paramedic personal possession CD keys. The related assurance against delivery of strategic plan sits with: Quality Objective 1: High Level Deliverable 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.	
PREVIOUSLY CONSIDERED BY	Quality & Performance Committee	
	Date	Monday 22 June 2026
	Outcome	Approved

1. BACKGROUND

This annual report is intended to update the Trust and provide assurance around controlled drug (CD) management for the financial year 2025/26.

It is a national requirement for Trusts to employ a CD Accountable Officer (CDAO), who must produce an annual report for the Board of Directors or its delegated committee. The CDAO at NWAS is Executive Medical Director, Dr Chris Grant, and the NWAS Chief Pharmacist, Rachael Fallon, deputises as CDAO in his absence.

The management of medicines, including CDs, forms part of the Care Quality Commission inspection.

This report covers:

2.1 Control Drugs Arrangements
2.2 Reactive Assurance
2.3 Proactive Assurance

This report complements the Medicines Management Annual Report and provides more detail on CD management.

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

2.1 CONTROLLED DRUGS ARRANGEMENTS:

2.1.1 Controlled Drugs Used:

Controlled drugs (CDs) used at NWAS are as listed in Figure 1. The only change in 2025/26, was to swap morphine tablets to oral liquid.

Figure 1: Controlled Drugs Used

Controlled Drug	Schedule	Profession	Restrictions
Diazepam 10mg/2ml injection	4 (part 1)	Doctor & Paramedic	N/A
Diazepam rectal 5mg tubes	4 (part 1)	Doctor & Paramedic	N/A
Fentanyl 500micrograms/10 ml pre-filled syringe	2	Doctor	NWAA Doctor only
Fentanyl 500micrograms in 10ml ampoule	2	Doctor	NWAA Doctor only
Ketamine 200mg/20ml	2	Doctor & Paramedic	NWAA Doctor, Consultant Paramedic (CP), Clinical Support Manager, Sector Clinical Lead, Advanced Paramedic Practitioner, HEMS Critical Care Paramedic (CCP) whilst working within the NWAA (this includes Senior HEMS Paramedic Team Leaders), HART Specialist Paramedic and Special Operations Clinical Lead.
Ketamine 200mg/20ml pre-filled syringe	2	Doctor	NWAA Doctor only
Ketamine 500mg/10ml vial	2	Doctor	NWAA Doctor only
Midazolam 5mg/5ml injection	3	Doctor & Paramedic	NWAA Doctor, Consultant Paramedic (CP), Clinical Support Manager, Sector Clinical Lead, Advanced Paramedic Practitioner, HEMS Critical Care Paramedic (CCP) whilst working within the NWAA (this includes Senior HEMS Paramedic Team Leaders).
Morphine 10mg in 1ml Injection	2	Doctor & Paramedic	N/A
Morphine oral liquid 10mg in 5ml	2	Doctor & Paramedic	N/A

2.1.2 Controlled Drug Supplies:

The receipt of CDs has not changed over the last year, after consolidation the previous year. A national change to the way medicines are procured for the Emergency Capabilities Unit (ECU) mass casualty vehicles occurred in 2025 where responsibility for the ordering of medicines was passed to the Ambulance Trust. Therefore, all CDs for use in NWAS are not only receipted by the Medicines Supply Hub but also procured. This includes CDs for the NW Air Ambulance.

The lack of a Pharmacy Stock Management System to track the different supplies in an auditable digital system is a risk and is on the risk register. The Trust has approved the full business case and contracts with the supplier have been signed. The digital system is currently part way through project implementation, due for completion in Sept 2026. In addition, an electronic digital CD register would support enhanced governance of CDs once issued from the Medicines Supply Hub. The outline business case has been approved, and a specification is being developed.

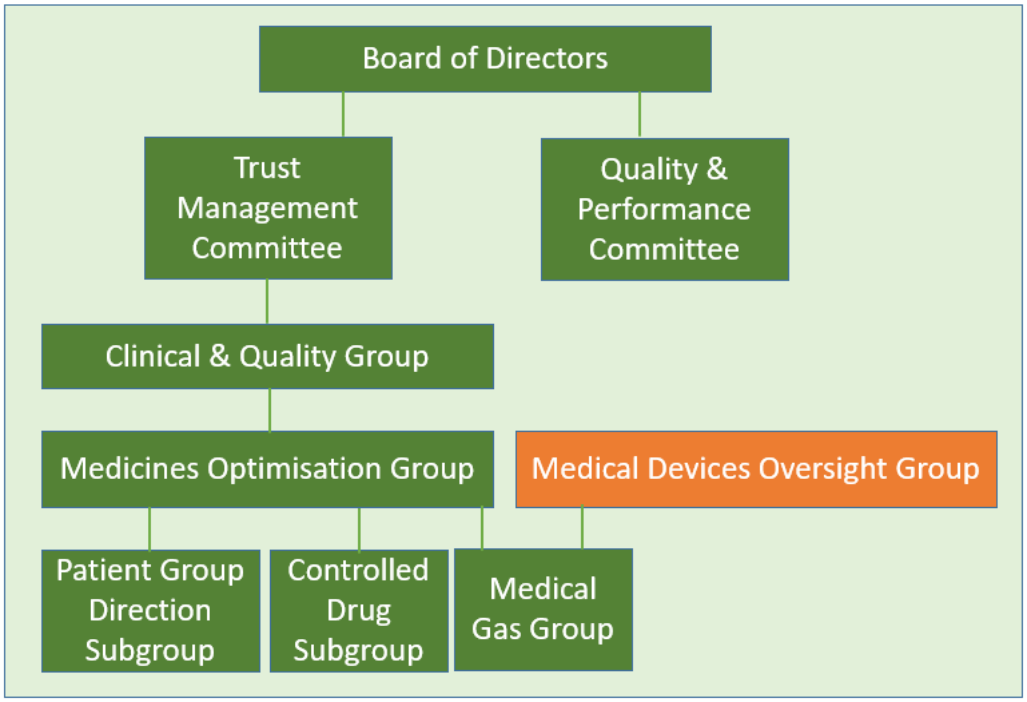
2.1.3 Controlled Drug Financial Costs and volumes:

The Trust spend on CDs has increased by £22,610 in the last year to a total of £53,290. This is primarily due to the introduction of morphine oral liquid to replace the morphine orodispersible tablets. Full details can be found in the Medicines Management Annual Report.

2.1.4 Controlled Drug Governance Arrangements:

Since 2022, there has been a dedicated Group overseeing the CD governance arrangements in NWAS, the CD SubGroup. This group reports to the Medicines Optimisation Group (MOG) via a Chair's Assurance Report. Figure 2 shows how the governance arrangements fit in with the NWAS structure.

Figure 2: Organogram of medicines governance arrangements



2.1.5 Controlled Drugs Destroyed by Authorised Witnesses:

During 2025/26 there were approximately 300 medicines in varying quantities from 1 to 100 destroyed and 140 visits to our CD sites around the North West by Authorised Witnesses. This was a significant workload and largely due to the need to remove morphine sulphate tablets from stocks. This is not expected again as we have moved to using morphine oral liquid instead which should turn over quicker due to a single patient administration in each bottle. These destructions are coordinated and monitored by the Medicines Team.

2.1.6 Controlled Drug Home Office Licence:

The Trust holds a Home Office CD licence which permits supply and possession of specific schedule 2 to 5 CDs. To hold such a licence, there is a requirement to meet a range of standards covering procurement, receipt, storage, security, supply and destruction of CDs.

No change in contraventions 2025/26. NWAS has two low contraventions (8351905 and 8238548) from 14/12/22 and one medium contravention (re 8440428) from 15/12/23 on file.

Following an application for a renewed licence in June 2023 this was received in Sept 2025, following escalation as being 'clinically urgent', in May 2025. The concern the Home Office had regarding CD destruction was accepted with no change to our processes. The changes required to licensed sites were made. A review has been undertaken with the Estates Team of all leased sites to mitigate risks around being served notice and then not being able to store CDs. In 2026 licence renewal will be made in May prior to expiry in September.

2.2 REACTIVE ASSURANCE:

2.2.1 Incident Management:

Medicines related incidents should be reported on the Trust incident reporting tool, Datix. These incidents are viewed by the Medicines Team regularly to provide support to the operational team for any investigation or follow up. A quarterly report is provided to the Medicines Optimisation Group and the CD Subgroup. All Level 3 incidents and above have additional narrative information provided. If there is a serious patient safety event it would be reviewed to see if a Patient Safety Incident Investigation (PSII) is required. In 2025/26 no PSIIs were required for CDs.

The Medicines Team has a dedicated email address, where any concerns around the use of CDs within NWAS or in the wider health economy, can be escalated.

If an incident is reported by NWAS that has occurred outside of the organisation, these are followed up by the Medicines Team, primarily through NHS England who can reach out the external organisation's CD Accountable Officer (if they are a designated body) or to the Community Pharmacy Contract Leads (for community pharmacies). If the organisation is registered with the NHS England Learning from Patient Safety Events (LFPSE) system the NWAS External Liaison function will coordinate communication and liaise with the external organisation to support review and any necessary actions.

2.2.2 Incident reporting to NHS England:

NHS England require declaration of any CD related incident that falls into specific categories as an individual report. NWAS has made 8 individual reports during 2025/26. They are listed in figure 3 along with the previous year's reports for comparison.

Figure 3: NHS England Individual Report Submissions

NHSE Category	2023/24	2024/25	2025/26
Real or perceived staff diversion of controlled drugs	1	1 Member of staff no longer works at NWAS and has an interim suspension with the HCPC.	0
Real or perceived staff substance misuse of controlled drugs	3 One of these led to a NHSE alert being issued	0	5 4 of these persons are no longer employed by NWAS
Patient or Member of the Public of concern that might require an NHSE alert to be issued to health and care settings	5	7	3
Patient involved	1	2 - A NWAS patient, level 5 patient safety event - harm caused. -NWAS reported a third party dispensing error of morphine instead of metformin.	0

The Medicines Team work closely with the various NWAS teams including Human Resources Team, Service Delivery Team, Security Team and High Intensity Users Team. Externally the Medicines Team work with the Regional CD Team (part of NHSE) and the CD Liaison Officers.

2.2.3 Controlled Drug Incidents:

CD incidents reported are similar (782) compared to the previous year (733) this is a rate of 8 reports per 10,000 face to face patients attended. When incident reporting there are three types of events that can be recorded: 'Patient Event', 'Trust Event' or 'Staff Event (including volunteers)'. From April 2025 the patient event type reports no longer receive a severity grading but instead a harm level.

The majority of CD incidents (reported as trust or staff event) are low or no harm. There have been no incidents that are classed as an NHS 'never event'. There has been one level 4 incident and no level 5 incidents.

The level 4 incident occurred in quarter one. A member of the public saw a NWAS medicines pouch fall off the roof of a NWAS QX vehicle (used by advanced practice paramedics). They picked it up and handed to an ambulance that they then flagged down. The medicines pouch had CDs inside it but was unopened and the seal intact. All CDs were subsequently reconciled back to the vehicle and matched with the CD register. It is not appropriate nor procedure for these CDs to be in a medicines pouch so that practice (which was an isolated issue) was stopped.

Figure 4 shows a breakdown by type of incident and Figure 5 shows a comparison between the types of incidents for this year compared to last. The highest reported error is 'CD documentation'. The rate of CD documentation errors has increased in recent years we believe partly due to the introduction of morphine tablets then the subsequent change from morphine tablets to liquid, which requires more frequent safe access and handling. As the safe is opened more often, staff are more likely to overlook completing all documentation pages fully, including recording the new tag number consistently. With the morphine tablets present there were three different pages to document the new tag number on, with oral liquid it's now two. These omissions are then reported as documentation errors. There is also a greater awareness of the need to report even minor documentation errors such as wrongly written numbers for CD safe tags.

The number of missing CDs reported has reduced from the previous year. Although there were 12 reports, upon investigation there were 8 incidents truly unaccounted for (see Figure 6), they were all very small amounts. A CD is considered missing when the CD record book in the vehicle or ambulance station does not reflect the balance of the CD safe. This is usually due to a documentation error and the record book is updated retrospectively when the item is accounted for. All of the unaccounted-for CDs were reported to the police and NHS England. None raised any concerns of diversion.

Figure 4: CD incident types reported per area 2025/26

Controlled Drug Incident Breakdown by Area 2025/26							
Datix Subcategory / MMQI coding	**CL**	**CM**	**GM**	**HART**	**NWAA**	**EOC/111**	**TOTALS**
CD Administration Error	4	2	3	0	1	0	10
CD Adverse Reaction	2	2	6	0	0	0	10
Any Other CD problems	7	9	9	0	1	0	26
CD Damaged	34	66	71	0	4	0	175
CD Missing	4	3	5	0	0	0	12
CD Safe Access Problem	12	20	12	0	0	0	44
CD Stock Problem	36	52	51	0	0	0	139
CD Documentation Error	81	146	113	0	2	0	342
Suspected Misuse	7	10	7	0	0	0	24
Total	**187**	**310**	**277**	**0**	**8**	**0**	**782**

Figure 5: Comparison of CD incidents reported over time

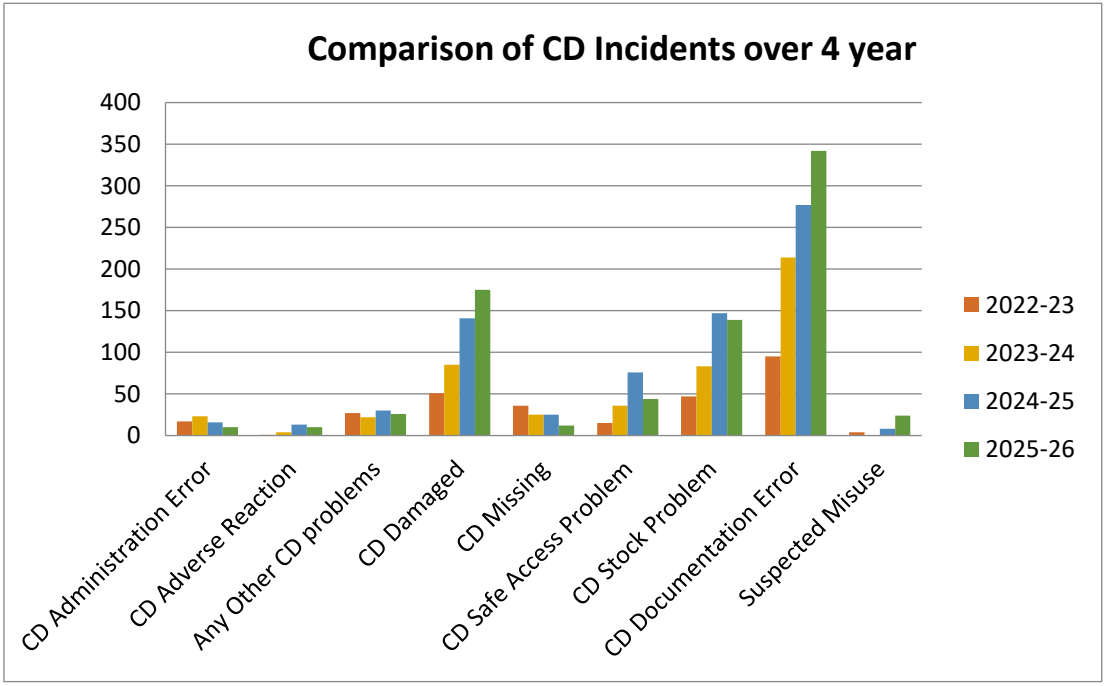


Figure 6: Unaccounted for CDs 2025/26

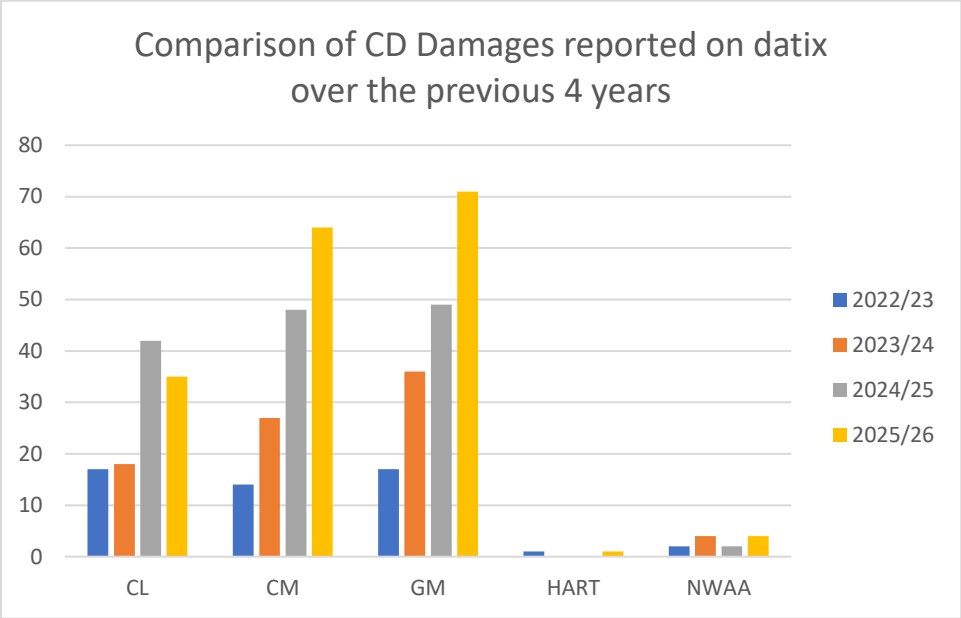
Controlled drug	Area
Diazepam 5mg rectal tube x 4 tubes	C&M – One occasion 5mg GM – One occasion 5mg C&L – Two occasion (5mg x 1,10mg x1)
Diazepam IV solution x 2 vials	GM – One occasion 10mg C&L – One occasion 10mg
Morphine 10mg ampoule x 1	C&L – One occasion 10mg
Morphine diluted part syringe x 1	C&M – One occasion 5mg

Breakages of CDs are to be reported as incidents and these are monitored by the Medicines Team. Overall, 175 items have been broken. See Figure 7 for the summary data. This is an increase from the previous year (141) and the previous year to that (85), Figure 8 shows a comparison of the data over time. This is likely due to an increased awareness of the requirement to report any CDs found damaged or damaged during handling following the training in addition to this now being actively looked at when auditing CD record books. Reported damages are rising across all areas evenly with no patterns seen in reports which suggests there no reason to suggest diversion. Of the 175 damages/ breakages, 101 were morphine 10mg injection, 12 orodispersible morphine tablets,15 morphine oral solution, 36 diazepam 10mg injection, 9 diazepam 5mg rectal tubes, 1 ketamine 200mg vial and 1 midazolam 5mg injection. This data is provided quarterly to the CD SubGroup.

Figure 7: CD breakages reported 2025/26

	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
GM	3	4	10	5	4	10	6	4	12	2	5	6	**71**
CM	3	6	4	5	5	7	7	7	6	7	3	4	**64**
CL	1	1	1	5	7	4	3	4	0	3	3	3	**35**
NWAA	1	1	0	0	1	1	0	0	0	0	0	0	**4**
HART	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Total	8	12	15	15	17	22	16	15	18	12	12	13	**175**

Figure 8: Comparison of CD breakages reported via Datix over time



The Medicines Team triangulate incidents, unaccounted for losses, damages and usage to see if there are connections or patterns and act where needed.

2.3 PROACTIVE ASSURANCE:

2.3.1 Controlled Drug Use Monitoring:

As a CD designated body, it is a requirement that we monitor the use of CDs to ensure safe and appropriate use. A CD dashboard linked to the electronic patient records allows use to be monitored. Reports on CD usage are provided to the CD Subgroup, covering:

- Total doses of CDs used by areas – total doses for morphine and diazepam have been consistent with more variation (as expected) for use of ketamine and midazolam.
- Number of patients receiving CDs – these have been consistent.
- Average doses used – these have been consistent and within expected ranges.
- Top 5 indications per CD used – indications have been consistent and as expected.

Flags provide alerts to doses administered that fall outside of normal ranges for further scrutiny. This process has been streamlined in 2025/26 and cases are resolved in a

timelier manner. 196 doses flagged out of 38,938 patients who received a CD. Of the 196, 119 following a review did not need escalating. Of the 77 escalated, 64 have been closed so far. In 99.5% of cases, we can say that patients are receiving doses in line with our expectations and that the remaining 0.5% have all been reviewed and either there has been a plausible explanation, or it has been escalated to a senior paramedic (consultant or sector clinical lead) for review and response. It should be noted that "outside of normal range" includes low doses as well as high. In many cases it involves feedback to the clinician about accurate documentation rather than any concerns with clinical practice. If a concern is raised, it is logged via the incident reporting system. This information is monitored by the CD SubGroup. As the Sector Clinical Leads are involved in the process, this helps with any themes being identified.

Further developments in 2025/26 involved governance of CDs used in advanced practice (midazolam and ketamine). The Medicines Team hold a central register of which clinicians are approved to administer the medicines and whether that is autonomous or supervised use (all paramedics undergo supervision at first). There are currently 92 paramedics approved to use midazolam (62 by autonomous administration and 30 by supervised administration) and 104 paramedics approved to use ketamine in NWAS (64 by autonomous administration and 40 by supervised administration). A review of anonymised individual clinician use, be that paramedic or doctor, is carried out to look at doses being used and frequency of use to ensure competence. The information is provided to the relevant Consultant Paramedic as well as the CD SubGroup.

The addition of HART Specialist Paramedics being able to use ketamine for analgesia was approved in 2022 and stocks/new processes set up in 2023. This cohort consists of 12 staff and they have administered ketamine to 9 patients from August 2023 to 31st March 2026.

2.3.2 Controlled Drug Vehicle Audit

NWAS carries out a CD audit of vehicles. This was conducted each quarter with a high level of compliance with the numbers of vehicles being audited. Full details are provided in the Medicines Management Annual Report. Figure 9 shows the results over time and an excellent level of compliance with most of the standards except for the weekly CD checks of the CD safe and the seizure pouch where it has been consistently around 70% with a decrease in Q4. This is an area identified for improvement in 2026/27 and the

Medicines Team are working with Service Delivery to improve this. A Sharepoint site for sector managers to have a weekly overview of what percentage of vehicles have had a weekly stock check in the previous 7 days has been set up. In addition, weekly emails from the Medicines Team showing compliance are sent. Having this data available to support Service Delivery has been challenging but it is hoped this is now able to be provided accurately and consistently going forward and improvements should then follow.

Figure 9: Critical MMQIs CD Vehicles 2025/26

Qu	Critical criteria	Q1	Q2	Q3	Q4
Q1	Are all CD stocks within their expiry date with any expired CDs segregated and labelled for destruction?	100	100	99	100
Q2	Are all CDs stored in the correctly designated place for the storage of CDs?	100	100	100	100
Q3	Confirm the vehicle is either locked or attended at the time of audit?	99	100	99	100
Q4	For paramedic staffed vehicles - does the paramedic have their CD key on their person and it is activated for the duration of the current shift? For unstaffed/non-paramedic crewed vehicles, is there a CD key attached to the ignition keys?	99	99	99	99
Q5	Is the CD safe(s) visibly in good working order with no damage?	99	99	99	99
Q6	Is the current stock balance correct and correctly documented in words & figures for each CD listed in the CDRB?	99	99	100	99
Q7	Over the last 30 days has the stock balance of morphine injection fallen below 7 amps (DCA) / 3 amps (Car) without a corresponding order being raised prior to this date that was awaiting delivery - check the pink order section.	99	98	99	99
Q8	There has been a documented weekly check of CDs held in the **CD safe** for the last 4 'available' weeks . 'Available' meaning the vehicle was not in workshops for the duration of at least 7 consecutive days and was available for operational duties.	75	70	72	62
Q9	There has been a documented weekly check of CDs held in the **seizure pouch** for the last 4 'available' weeks . 'Available' meaning the vehicle was not in workshops for the duration of at least 7 consecutive days and was available for operational duties	74	69	71	59

2.3.3 Controlled Drugs Ambulance Station Audit

The Medicines Team carry out a CD audit of ambulance stations, all ambulance stations with CDs (32) were audited. This was introduced in Q3 2020/21 and due to the consistent achievement of all indicators bar two from April 2024, it was agreed that the audit would be carried out annually rather than 6 monthly. This has allowed the Medicines Team to provided increased support for the two standards not being met, i.e. the daily and weekly checks, where compliance is reported quarterly. The results for 2025/26 are shown in Figure 10. They show that 9/10 critical MMQIs have been met by the end of the year. This is the first time that the two MMQIs for daily and weekly checks have been met. Last year two new questions (Q9 and Q10 in Figure 10) were added into the audit so that ongoing

monitoring of CCTV being in place or not was available. It is reported that on audit, 5 sites do not have CCTV in place. Two are currently under refurbishment and were known about (Carlisle and Stockport). The other three sites should have CCTV and this is now being addressed with Estates Team support, they are: Central Manchester (a new medicines room is being planned with CCTV), HART Ashburton (the medicines room location is under review) and Chester. It has been recommended that the CCTV policy should be updated to include an incident form to be completed should CCTV not be operating for any reason. The same approach of quarterly monitoring for two questions and annual for the others, will continue in 2026/27.

Figure 10: Critical MMQIs CD Ambulance Stations 2025/26

Qu	Critical criteria Result →	Q1	Q2	Q3	Q4
Q1	Are the CD keys held securely in an electronic key safe or the safe has an electronic lock?	93			
Q2	Are all CDs stored in a CD safe?	100			
Q3	Is the balance correct for each CD listed in the CDRB/stored in the CD safe?	100			
Q4	Has a daily stock check taken place and documented in the CDRB?	88	72	92	92
Q5	Were any discrepancies on the daily CD check acted upon and documented?	100			
Q6	Has a weekly stock check taken place and documented in the CDRB including tag changes?	100	94	98	100
Q7	Are all receipts of CD stocks received by a paramedic and witnessed by the courier in the CD record book?	97			
Q8	Have all deliveries recorded by the MSH been received into the CDRB?	100			
Q9	There is CCTV in place at the ambulance station?	94			
Q10	There is CCTV on the CD safe?	84			

2.3.4 Designated Body Assurance and Improvement Framework

The Regional CD Team have introduced an Assurance and Improvement Framework. The CDAO of each Designated Body is requested to complete a survey detailing their confidence in CD related systems and processes. The survey was completed and submitted in March 2026, following scrutiny by Quality and Performance Committee in April 2026.

2.3.5 Changes in legislation and policy

There were no changes in legislation in relation to CDs for paramedics in 2025/26. There are some proposed changes which will involve expanding the list of medicines

paramedics can administer under exemption and is likely to include some CD items. This has not yet been written into legislation.

2.3.6 CQC CD Annual Report

The CQC CD Annual Report is reviewed by the CD SubGroup and any points noted and any actions followed up. The report referenced key issues occurring nationally that NWAS is also managing, these remain the same as the previous year, i.e.: CD diversion, Home Office CD licensing and CD destruction.

Of note the report supported NWAS position on CD destruction. It stated:

"Our understanding of the law is that the CDAO can do this. Preventing services from doing this would lead to an accumulation of stocks of controlled drugs awaiting destruction and the associated risks. We have heard specific examples of this issue leading to increased risks of patient harm and diversion in the last year. Any person authorised to witness destruction should have appropriate training and follow appropriate governance arrangements."

All NWAS authorised witnesses receive training and are asked to be 'curious', they have a procedure to follow, and we hold a full detailed record.

The report discusses the use of random drug testing of staff to provide a deterrent and also stresses the need for designated bodies to ensure that their CD Accountable Officer is adequately resourced.

2.3.7 Local Intelligence Network Activity

During 2025/26, a member of the NWAS Medicines Team has attended all six local intelligence network (LIN) meetings as well as one national CD learning event. A summary of each meeting is presented at the CD subgroup meeting where any learning or points relevant to NWAS can be discussed. Themes of discussion have included:

- Concerns around the Home Office licensing process.
- Supporting staff who are using substances.

- Awareness of new illicit substances and general sales items such as DAB pens (THC devices that look like a writing pen).
- Awareness of extensive organised crime using counterfeit medicines.
- Learning from investigations including not jumping to conclusions based on appearance, collaborate with other organisations and a simple curiosity about a situation can lead to a large and complex investigation.
- Awareness of people breaking the law unintentionally, e.g.: supplying CDs on prescription from a prescriber that is not authorised to prescribe CDs, and to ensure you understand the law.
- Stolen identity of healthcare professionals and in particular paramedics to obtain CDs for alleged private use.

2.3.8 Policy and procedures

The NWAS CD Policy is in date. No updates were made 2025/26.

All CD standard operating procedures are in date. Minor updates have been made during 2025/26 mainly to reflect changes to formulary where morphine orodispersible tablets were changed to morphine oral liquid as well as minor stock level changes on vehicles.

2.3.9 Training

Training on CDs was provided by the Medicines Team on five occasions (either face to face or via Teams):

- Drug seeking behaviour presentation to Sector Clinical Leads
- EMT to Paramedic apprentices (on 3 occasions) – Medicines training which included CD governance, reporting obligation, documentation and how to report suspicions.
- Senior Paramedic Induction in Cheshire and Mersey – CD governance, reporting, how to investigate concerns and who to contact.

In addition, e-learning covered:

- CD update and calculations (as part of the Medicines Management Update) for all clinicians
- Morphine oral liquid PGD for all paramedics as this was a new medicine.

2.3.10 Risk Register

In 2025/26, two risks were closed on the risk register related to CDs:

- Home Office CD licence lack of renewal due to CD destruction process (risk 655)
- CDs and Site Security (risk 318)

and one continues to be actively managed:

- Electronic CD register (risk 481).

2.3.11 Projects

Paramedic personal possession digital CD keys are an issue in terms of resource and budget. It has been agreed for a project team to be set up to oversee this and resolve the issues.

3. RISK CONSIDERATION

This report demonstrates a robust approach to governance and development of systems to monitor how medicines are managed.

Controlled drugs (CDs) are regulated by a number of legislative instruments, including but not limited to:

- the Misuse of Drugs Act 1971,
- the Misuse of Drugs Regulations 2001 and
- the Controlled Drugs Regulations 2013.

4. EQUALITY/ SUSTAINABILITY IMPACTS

Nil

5. ACTION REQUIRED

The Board is asked to:

- Note the assurance provided and the achievements and improvements made in 2025/26 as well as the challenges and risks.
- Recommend the onward presentation of the report to the Board of Directors

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Safeguarding Annual Report 2025/26
PRESENTED BY	Director of Quality and Improvement - Elaine Strachan-Hall
PURPOSE	Assurance

STRATEGIC AIM(S)	All strategic aims							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☒
	SR05	☐	**SR06**	☒	**SR07**	☐	**SR08**	☐

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Board is asked to: • Note the report, take assurance on statutory safeguarding compliance, and support the continued focus on prioritised safeguarding activity in 2026/27
EXECUTIVE SUMMARY	North West Ambulance Service NHS Trust (NWAS) has met its statutory safeguarding responsibilities throughout 2025/26, maintaining effective governance and assurance across its services. Safeguarding referrals increased by 22% during the year, reflecting appropriate escalation of identified risks, while low and improving rejection rates indicate consistent application of safeguarding thresholds. The Trust continued to engage effectively with statutory reviews, safeguarding partnerships, Prevent and Channel processes, and domestic abuse and child death reviews. Training compliance remained above 95% across Safeguarding Levels 1–3, supported by strong professional oversight and ongoing work to align Level 3 training with Intercollegiate guidance. A small number of areas require ongoing oversight, including capacity pressures, partnership engagement, training assurance, and the development of Child Protection–Information Sharing (CP-IS). These are being actively managed through established governance arrangements and do not represent unmanaged risks.

PREVIOUSLY CONSIDERED BY	Clinical & Quality Group	
	Date	07/06/26
	Outcome	Approved
	Quality and Performance Committee	
	Date	22/06/26
	Outcome	Approved

1 Introduction

North West Ambulance Service NHS Trust (NWAS) has a statutory responsibility to safeguard and promote the welfare of children and adults who may be at risk of abuse or neglect. As a provider of urgent, emergency and unscheduled care, NWAS staff frequently enter private environments, often at times of acute crisis. This places the Trust in a unique position to identify safeguarding concerns that may otherwise remain hidden and to act as an early point of intervention.

Safeguarding is a fundamental component of clinical care, patient safety and quality governance within NWAS. Effective safeguarding arrangements ensure that risks of harm are identified promptly, appropriate action is taken, and opportunities for early help and prevention are maximised.

Statutory and Regulatory Context

The Trust's safeguarding responsibilities are underpinned by key legislation and statutory guidance, including the Children Act 1989 and 2004, the Care Act 2014, *Working Together to Safeguard Children* and the *Care and Support Statutory Guidance*. These frameworks place clear duties on organisations to safeguard children and adults at risk and to work effectively with partner agencies.

NWAS is required to demonstrate safeguarding assurance through nationally mandated frameworks and regulatory oversight, including the annual Safeguarding Assurance Framework (SAF) submission to its commissioning ICB, completion of the Provider Safeguarding Assurance Toolkit (PSAT/PSCAT) for NHS England, Care Quality Commission (CQC) oversight, and independent internal assurance processes. Together, these mechanisms provide assurance that safeguarding arrangements are effective, risks are identified and managed, and learning is embedded.

Overview of NWAS

NWAS is one of the largest ambulance trusts in England, delivering services across a large and diverse geographical footprint including Cumbria and Lancashire, Cheshire and Merseyside, and Greater Manchester. Services include pre-hospital emergency care, NHS 111 clinical assessment and patient transport services, delivered by a workforce of over 7,000 staff and more than 1,000 volunteers.

During 2025/26, the Trust managed very high volumes of emergency, urgent and planned care activity across multiple service lines. Combined with increasing patient complexity and vulnerability, safeguarding considerations are routinely encountered across all NWAS services. Operating across 27 local authorities and multiple Integrated Care Systems requires the Trust to maintain consistent safeguarding standards while responding to local arrangements and thresholds, making robust governance and assurance essential.

Purpose of this Report

This annual safeguarding report provides assurance on the effectiveness of NWAS safeguarding arrangements during 2025/26. It demonstrates how the Trust meets its statutory responsibilities, complies with national safeguarding standards, and uses data, audit and learning to drive continuous improvement.

The report aligns with SAF and PSAT requirements and supports the Board in understanding where safeguarding arrangements provide assurance, how risks are being managed, and what actions are planned to further strengthen safeguarding practice. Once approved, the report will be shared with safeguarding partners and key stakeholders as evidence of safeguarding assurance and performance.

2 Safeguarding Team Overview

The NWAS Safeguarding Team is a specialist function providing expert advice, professional oversight and assurance across all aspects of safeguarding children and adults at risk. The team sits within the Quality Directorate, with the Head of Safeguarding reporting directly to the Assistant Director of Quality and Nursing, ensuring safeguarding is embedded within core quality, patient safety and governance arrangements. The team works closely with frontline clinicians, operational services and corporate teams to support the consistent identification, escalation and management of safeguarding concerns as part of routine clinical practice.

The Safeguarding Team is currently fully staffed within agreed funding and comprises:

- 1.0 WTE Head of Safeguarding (Named Nurse for Safeguarding – All Age, Prevent Lead)
- 3.6 WTE Safeguarding Practitioners (4 staff)
- 0.5 WTE Specialist Safeguarding Practitioner support
- 1.8 WTE Safeguarding Business Support Administration (including Term Time Working arrangements)

This establishment provides the capacity required to discharge statutory safeguarding functions, maintain organisational assurance and support safeguarding activity across the Trust's large and complex operational footprint at current levels of service demand.

The Safeguarding Team's core functions include:

- Providing expert safeguarding advice and professional decision-making support to staff
- Supporting high-quality and timely information sharing with partner agencies
- Participation in statutory multi-agency processes, including safeguarding reviews, domestic abuse-related death reviews and child death processes
- Oversight of allegations against staff and people in positions of trust

- Oversight of PREVENT referrals and information sharing within the national PREVENT and Channel frameworks
- Oversight and quality assurance of safeguarding and early help referrals to local authority partners
- Supporting the design of safeguarding and PREVENT training in collaboration with the Trust Learning and Development Team
- Share learning from local and national reviews relevant to NWAS and wider collaborative working
- Providing assurance reporting to Trust committees, the Board, commissioners and regulators

Through these functions, the team plays a critical role in reducing the risk of harm, supporting early intervention and strengthening organisational and system-wide safeguarding arrangements.

Capacity and Workforce

During 2025/26, the Safeguarding Team operated within a context of sustained growth in safeguarding demand across the Trust, including a 22% increase in combined safeguarding referrals (48,280), engagement in 186 statutory reviews and external requests, and response to 163 Channel information requests alongside increased Prevent referral activity (Sections 3, 4 and 6). The team prioritised statutory responsibilities and safeguarding assurance, ensuring all legislative and regulatory duties continued to be met throughout the reporting period.

During the reporting period, the Safeguarding Team experienced leadership and workforce transitions, including the retirement of the previous Head of Safeguarding and a period of maternity leave within the practitioner team. To ensure continuity of statutory safeguarding oversight, an experienced safeguarding practitioner was appointed as Interim Head of Safeguarding and Named Professional for Adults and Children. Despite increased demand and temporary capacity constraints, safeguarding governance, oversight and assurance were maintained throughout. A new Head of Safeguarding commenced in January 2026, restoring full leadership capacity, with additional business support introduced in March 2026 to support planned maternity leave and ongoing workload.

3 Safeguarding and Early Help Activity 2025/25

Key Messages

- Safeguarding referrals increased significantly during 2025/26, reflecting rising operational demand, patient complexity and strengthened safeguarding assurance.

- Referral thresholds remain appropriate, with high referral quality and reduced rejection rates despite increased volume.
- Early Help activity remained stable, supporting proportionate use of safeguarding escalation.
- Increased activity has capacity implications which are actively managed through risk-based prioritisation of statutory safeguarding activity and close multi-agency working with system partners.

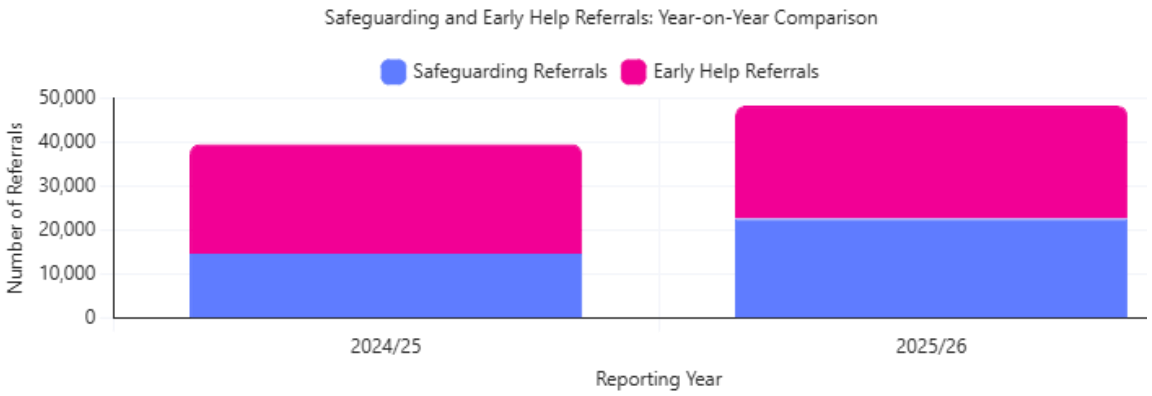
Overview of Safeguarding and Early Help Activity

During 2025/26, NWAS made a total of 48,280 safeguarding related referrals, comprising:

- 22,632 safeguarding referrals
    - 12,920 adult referrals (57%)
    - 9,712 children's referrals (43%)
- 25,648 Early Help referrals
    - 25,280 adult referrals (99%)
    - 368 children's referrals (1%)

Between 2024/25 and 2025/26, safeguarding referrals increased by 54.6%, while Early Help activity increased by 2.9%. When considered together, total safeguarding related activity increased by 22.0% year on year (Figure 3.1).

Figure 3.1: Safeguarding and Early Help Referrals – Year-on-Year Comparison



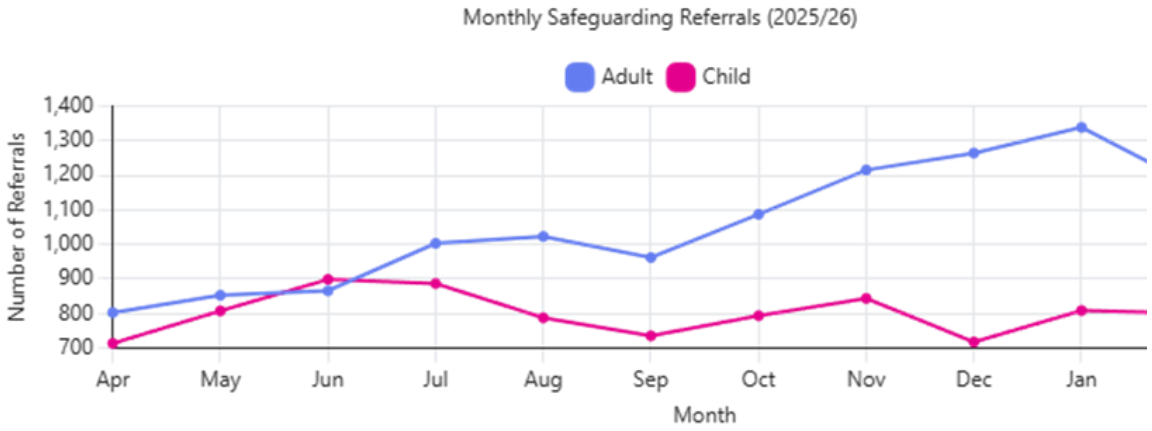
This increase reflects rising service demand, indicators of increasing patient complexity (including age, frailty, self-neglect and cumulative risk) and improved safeguarding recognition, rather than inappropriate escalation.

While this growth has placed additional pressure on safeguarding capacity across NWAS and partner agencies, statutory safeguarding oversight and assurance have been maintained throughout the reporting period.

Safeguarding Activity Trends

Adult safeguarding referrals increased progressively across the year, peaking during winter months in line with known seasonal pressures and operational demand (Figure 3.2). As with wider ambulance service activity, winter periods are associated with increased call volumes, acuity and system pressure, which in turn increases the likelihood of safeguarding concerns being identified during patient contact. Children's safeguarding activity remained broadly stable, with predictable seasonal variation. Overall, this pattern indicates safeguarding activity that is responsive to service demand and seasonal pressure rather than erratic or disproportionate escalation.

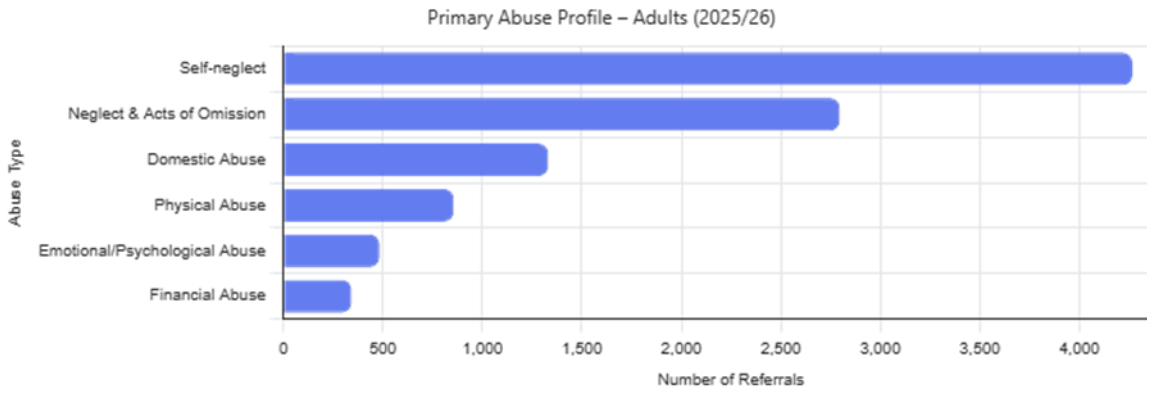
Figure 3.2: Monthly Safeguarding Referrals (Adults and Children)



Nature of Safeguarding Concerns

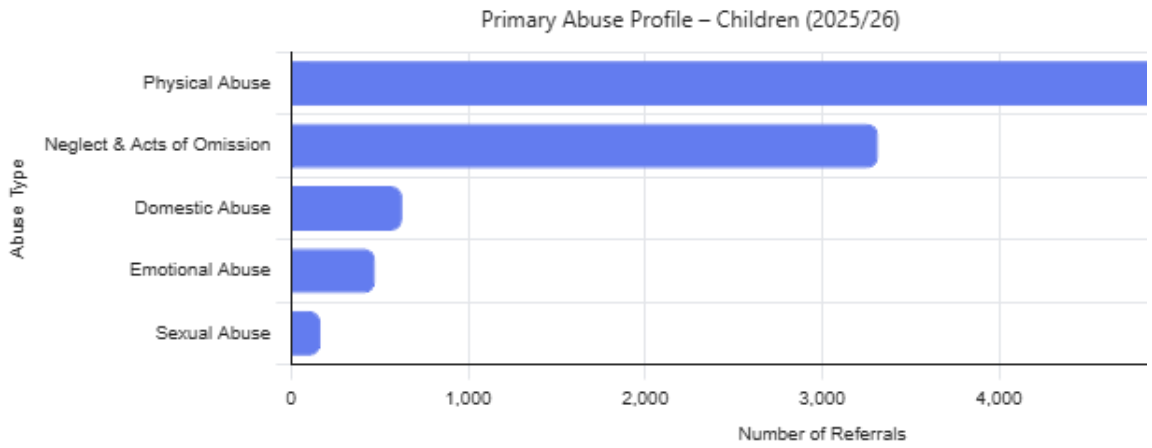
Adult safeguarding referrals during 2025/26 were dominated by self-neglect and neglect or acts of omission, reflecting increasing frailty, unmet care needs and complexity within the adult population (Figure 3.3). Self-neglect refers to circumstances in which individuals are unable or unwilling to care for their own basic needs, including personal hygiene, health, nutrition or living conditions, where this places them at risk of harm. Domestic abuse and physical abuse remain significant features, reinforcing the ambulance service's role in identifying risk in acute and crisis situations.

Figure 3.3: Adult Safeguarding – Primary Abuse Profiles (2025/26)



Children's safeguarding referrals were primarily associated with physical abuse and neglect, with domestic abuse and emotional abuse remaining significant contributing factors (Figure 3.4). The physical abuse category also includes presentations such as overdose, self-harm and intoxication (including alcohol-related harm), as the current coding framework does not enable these to be recorded separately. Many of these presentations reflect clinical complexity and vulnerability rather than safeguarding threshold being met in every case, and therefore do not always result in onward safeguarding action. This profile is consistent with previous years and national trends and reinforces the importance of professional judgement in distinguishing safeguarding risk from clinical need.

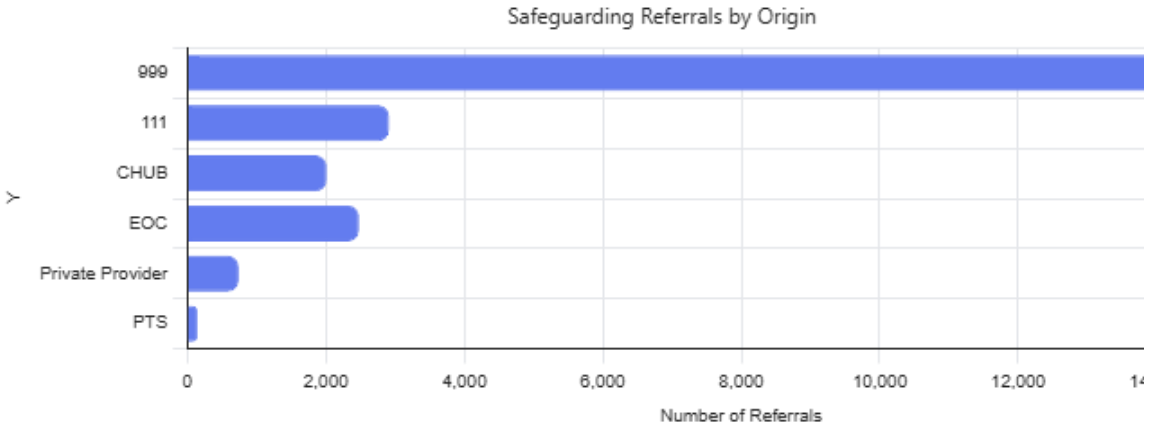
Figure 3.4: Children's Safeguarding – Primary Abuse Profiles (2025/26)



Referral Origin and Patient Transport Services (PTS)

Most safeguarding and Early Help referrals originated from PES, NHS 111 and clinical hub activity, demonstrating that safeguarding is embedded across both face-to-face and telephone-based clinical assessment (Figure 3.5).

Figure 3.5: Safeguarding and Early Help Referrals by Origin



Referrals from Patient Transport Services (PTS) remain disproportionately low relative to service activity. Given the vulnerability of the PTS patient cohort, this has been identified as an area requiring further focus. Work is underway with PTS leads to understand referral patterns and remove barriers to escalation, including improved access to electronic referral systems. This work aims to support appropriate safeguarding recognition rather than indiscriminate increases in referral volume.

Age Profile and Vulnerability

Safeguarding referrals increase significantly from age 65 and peak between 80–85 years, strongly aligning with self-neglect and neglect-related concerns (Figure 3.6). This reflects increasing complexity in later-life safeguarding, where risk is often cumulative and closely linked to frailty, capacity and care arrangements. This profile highlights the importance of continued focus on older adult safeguarding guidance and professional development.

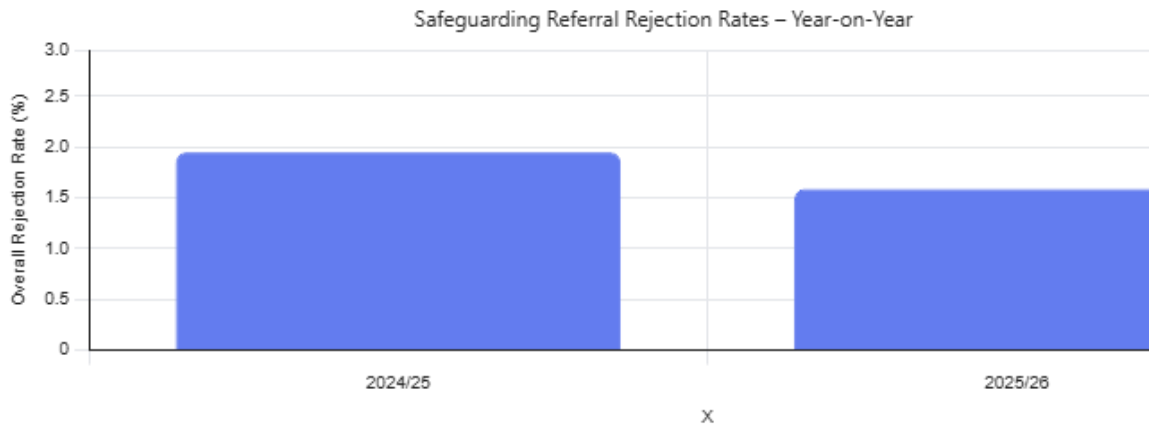
Figure 3.6: Safeguarding Referrals – Older Adult Age Bands

Referral Quality Assurance and Planned Audit Activity

Referral rejection rates provide an indication of administrative accuracy in the referral process rather than a measure of safeguarding quality, professional judgement, or

threshold application. In 2025/26, the combined rejection rate remained low at 1.59% despite a 54.6% increase in referral volume, suggesting most submissions contained sufficient information to be processed by partner systems. Variations between adult (0.87%) and children's (2.57%) referrals reflect differences in local authority system requirements and data validation processes. The majority of rejections were due to incomplete mandatory fields or incorrect demographic information (e.g. postcodes) or routing issues. Targeted work is underway with identified areas to improve data completeness and reduce avoidable administrative rejections, while assurance of safeguarding quality continues through separate qualitative measures including planned audit activity.

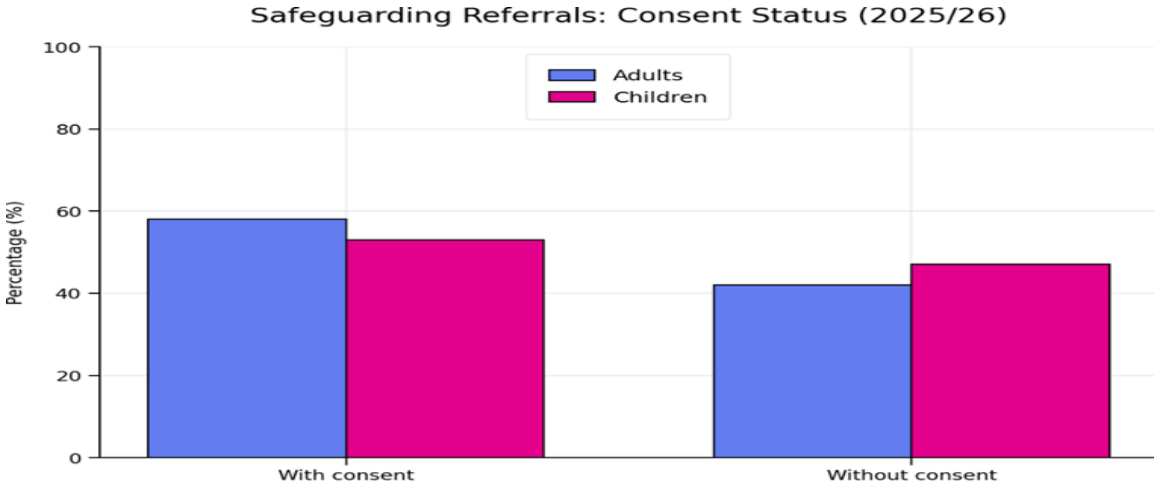
Figure 3.7: Safeguarding Referral Rejection Rates – Year-on-Year



Consent and Safeguarding / Early Help Referrals

During 2025/26, 42% of adult safeguarding referrals and 47% of children's safeguarding referrals were made without consent (Figure 3.8). In these cases, referrals were appropriately justified by assessed risk of significant harm or lack of capacity, with action taken in individuals' best interests.

Figure 3.8: Safeguarding Referrals – Consent (2025/26)



This pattern aligns with statutory guidance and national learning, which consistently identifies over-reliance on consent as a barrier to effective safeguarding intervention.

Consent is required for all Early Help referrals. A proportion of Early Help referrals were recorded without consent being obtained, potentially reflecting a training and process issue rather than safeguarding risk. Targeted training reinforcement and exploration of digital solutions to strengthen consent recording are underway.

Overall safeguarding and Early Help activity during 2025/26 provides assurance that NWAS is appropriately identifying safeguarding concerns, applying thresholds consistently and maintaining assurance indicators despite significant increases in demand. Capacity pressures are recognised and actively managed through risk-based prioritisation of statutory activity, close working with system partners to reduce duplication and delay, and planned improvement actions to strengthen processes and information flow.

4 Statutory Reviews and External Requests

Overview

Statutory reviews and external safeguarding requests are a core component of the Trust's safeguarding responsibilities and provide an important mechanism for multi-agency scrutiny, learning and system improvement. NWAS is routinely required to contribute to reviews led by safeguarding partners and other statutory bodies and has engaged consistently throughout 2025/26.

Volume and Types of Reviews

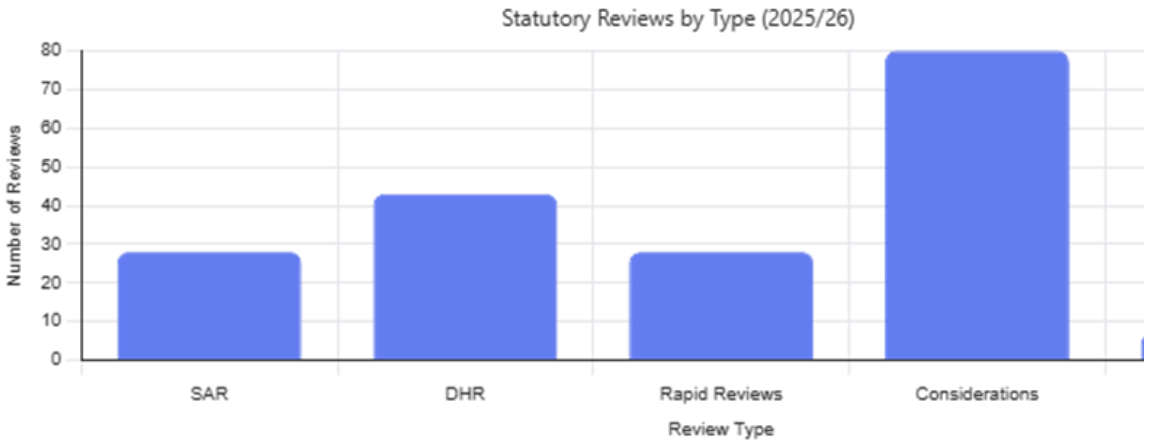
During 2025/26, NWAS received 186 statutory review and external request notifications, compared with 171 in 2024/25, representing an 8.8% year-on-year increase.

These figures reflect new requests received during the reporting period only and do not include open statutory reviews from previous years which continued to require input and oversight during 2025/26. As a result, the cumulative workload associated with statutory reviews is higher than indicated by annual request volumes alone and represents a sustained demand on safeguarding capacity.

Review activity during the year comprised:

- Safeguarding Adult Reviews (SARs): 28
- Domestic Abuse-Related Death Reviews (DARDRs): 43
- Joint SAR/DARDRs: 2
- Children's Rapid Reviews: 28
- Brief and Learning Reviews: 5
- Consideration Requests: 80

Figure 4.1: Statutory Reviews by Type (2025/26)



Review activity was sustained across the year with a consistent monthly profile, indicating ongoing system demand rather than isolated peaks. Consideration requests represent a significant component of workload, reflecting NWAS's routine involvement at early stages of statutory decision-making.

Domestic Abuse-Related Reviews

Domestic abuse-related reviews continue to represent a substantial proportion of statutory review activity. During 2025/26, NWAS contributed to 43 DARDRs and 2 joint SAR/DARDRs, broadly consistent with 2024/25.

Learning from these reviews consistently reflects national themes, including early identification of domestic abuse, recognition of cumulative risk and effective information sharing. These themes align with safeguarding referral patterns and domestic abuse indicators reported elsewhere in this report.

Children's Reviews and Child Death Processes

While no Local Child Safeguarding Practice Reviews (LCSPRs) were commissioned during 2025/26, NWAS contributed to 28 Rapid Reviews, reflecting routine involvement in early statutory scrutiny following serious incidents involving children.

NWAS also continued to support statutory child death review processes, including Sudden Unexpected Death in Childhood (SUDIC) reviews. During 2025/26, the Trust responded to 153 SUDIC-related requests, completing 135 Form B submissions (A Form B is a statutory information-sharing form used by health services to provide relevant clinical information to child death review panels). Although overall SUDIC volume reduced year-on-year, the proportion of cases requiring detailed information increased, reflecting the complexity of cases requiring ambulance service input.

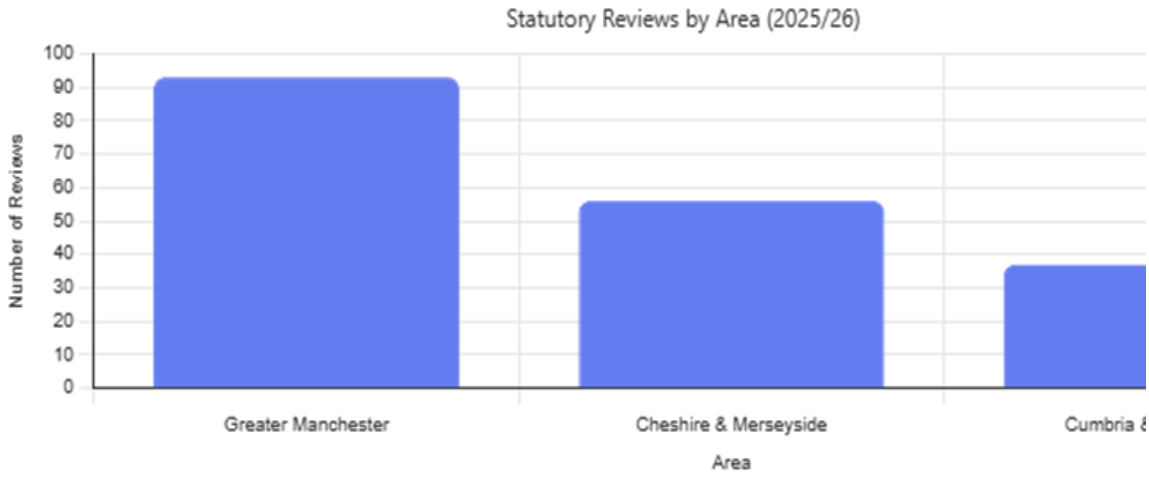
Geographical Distribution

Statutory review activity remained proportionately distributed across the Trust's footprint and consistent with previous years:

- Greater Manchester: 93 reviews
- Cheshire & Merseyside: 56 reviews
- Cumbria & Lancashire: 37 reviews

This distribution aligns with population size, deprivation levels and service demand and does not indicate variation in safeguarding engagement or practice.

Figure 4.2: Statutory Reviews by Area (2025/26)



Learning and Capacity Impact

Learning from statutory reviews and consideration requests mirrors national safeguarding themes, including information sharing, recognition of cumulative risk, professional curiosity and timely escalation of concern. Learning is reviewed alongside internal safeguarding data and training needs analysis to inform organisational learning and assurance activity. Practitioner experience during the reporting period also suggests an increasing number of Domestic Abuse-Related Death Reviews involving young adults, including deaths by suicide where domestic abuse has been identified as a contributing factor, reinforcing the importance of recognising less visible patterns of harm and vulnerability.

The volume and breadth of statutory review activity represent a sustained demand on safeguarding capacity. While all statutory obligations were met during 2025/26, the cumulative impact reinforces the importance of prioritisation, proportionate engagement and effective system working.

NWAS has met its statutory responsibilities in relation to safeguarding reviews and external requests during 2025/26. The Trust has engaged consistently with safeguarding partners, contributed to system-wide learning and maintained effective safeguarding oversight despite increasing demand.

5 Safeguarding Training

Safeguarding training across NWAS is delivered in line with the NHS Core Skills Training Framework (CSTF), with training requirements linked to staff roles and responsibilities. Training is delivered by the Trust's Learning and Development (L&D) team, with professional oversight provided by the Safeguarding Team.

Safeguarding training compliance remains high across the Trust, with overall completion rates consistently above 95% for Safeguarding Levels 1, 2 and 3. This provides assurance that the majority of the workforce has accessed the required safeguarding training in line with role-based requirements and statutory expectations.

Training Compliance Overview

At a Trust-wide level during 2025/26:

- Safeguarding Level 1 compliance: approximately **96%**
- Safeguarding Level 2 compliance: approximately **97%**
- Safeguarding Level 3 compliance: approximately **97–98%**

Compliance levels are broadly consistent across operational, patient-facing and corporate services. Where small pockets of lower compliance exist, these are primarily related to workforce turnover, role-specific requirements or the timing of refresher training and are managed through routine training governance and line management oversight.

Safeguarding Level 3 Training – Assurance and Review

Safeguarding Level 3 training is required for staff with enhanced safeguarding responsibilities and clinical decision-making roles. While completion rates for Level 3 training remain high, attendance alone does not provide assurance regarding the consistency, depth or quality of training content and learning across services.

Intercollegiate guidance emphasises that Level 3 training should be interactive, support discussion and reflection, and be delivered by appropriately experienced safeguarding professionals, with opportunities for face-to-face learning where possible to support complex case discussion and professional judgement.

Currently, Safeguarding Level 3 training is delivered through a range of locally developed models, reflecting differences in roles, service delivery and historical training approaches. As the professional lead for safeguarding, the Head of Safeguarding is responsible for providing assurance that training content and learning outcomes are aligned with the Intercollegiate Guidance on Safeguarding Children and Adults.

Further work is required to strengthen assurance regarding the consistency and quality of Level 3 training across the Trust. To address this, a refreshed safeguarding training needs analysis will be undertaken in partnership with Learning and Development. This will review alignment with Intercollegiate guidance, workforce changes and increasing

safeguarding complexity, and will inform future training priorities and delivery models that are proportionate, sustainable and operationally realistic.

Overall safeguarding training arrangements provide assurance that safeguarding training requirements are being met at scale across the Trust, with high levels of staff completion in line with role-based statutory expectations. Professional oversight and planned review of Safeguarding Level 3 training will further strengthen assurance regarding the consistency and quality of training delivery across services.

6 PREVENT and Channel

NWAS continues to meet its statutory responsibilities under the Prevent duty, supporting the identification of individuals who may be vulnerable to radicalisation and ensuring concerns are appropriately escalated through Prevent referrals and responses to Channel information requests.

Channel Information Requests

During 2025/26, the Trust responded to 163 Channel information requests, compared to 8 recorded requests in 2024/25, representing a substantial increase in activity and demand on safeguarding capacity (approximately a nineteen-fold increase). Requests were predominantly received from Lancashire (140), with additional requests from Cumbria (22) and Greater Manchester (1).

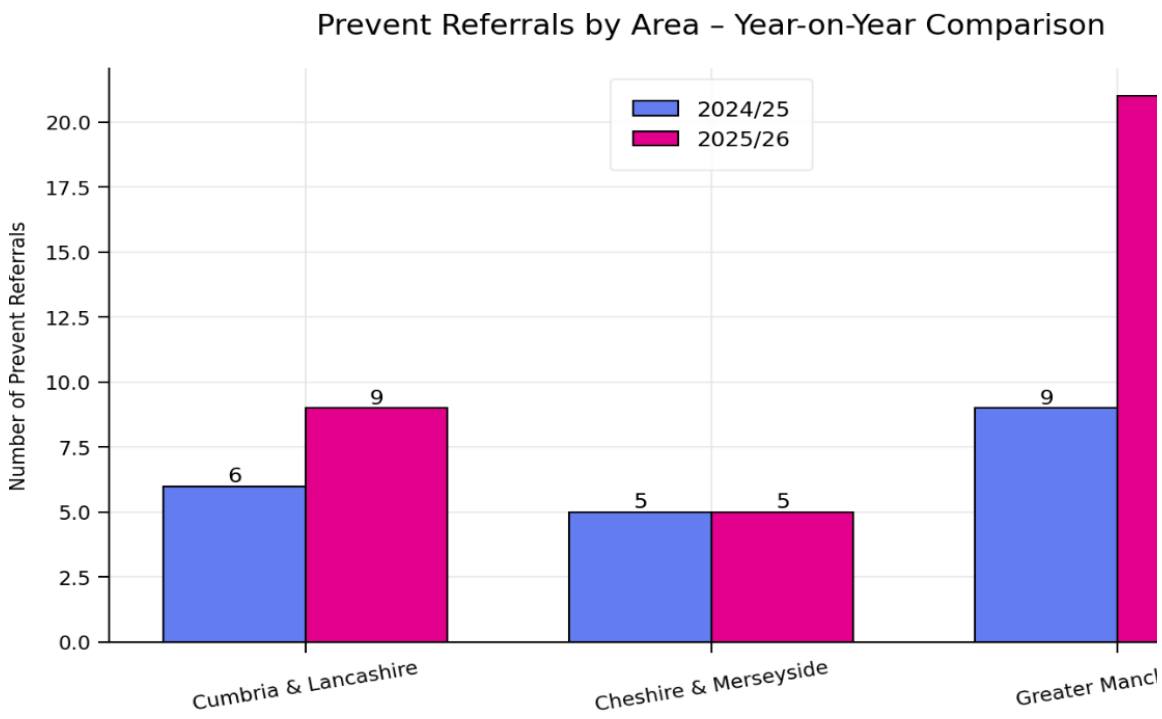
The Safeguarding Team has engaged with the Lancashire Channel Panel to confirm whether any changes in local processes or thresholds may have contributed to this increase and is awaiting a response. It is noted that this increase followed the Southport attacks in July 2024, which may have contributed to heightened system vigilance.

Channel information requests require timely review of clinical records and professional safeguarding input to support multi-agency risk assessment and decision-making. The volume of requests reflects NWAS's role as a key information holder within Channel processes, and all statutory requests were responded to within required timescales.

Prevent Referrals

Prevent referral activity increased during 2025/26, particularly within Greater Manchester, while remaining proportionate to population size and operational demand (Figure 6.1).

Figure 6.1: Prevent Referrals by Area – Year-on-Year Comparison



2025/26 Prevent referrals:

- Cumbria & Lancashire: 9
- Cheshire & Merseyside: 5
- Greater Manchester: 21

This increase provides assurance that staff are recognising Prevent-related concerns and escalating risk appropriately in line with statutory expectations.

Capacity Impact and Assurance

Prevent and Channel activity during 2025/26 demonstrates effective identification of vulnerability and appropriate escalation through statutory processes. However, the significant increase in Channel information requests, alongside rising safeguarding referrals and statutory review activity, has contributed to cumulative demand pressures on safeguarding capacity.

Despite this, NWAS has met all Prevent and Channel statutory requirements during the reporting period. Activity levels will continue to be monitored to ensure arrangements remain proportionate, effective and sustainable.

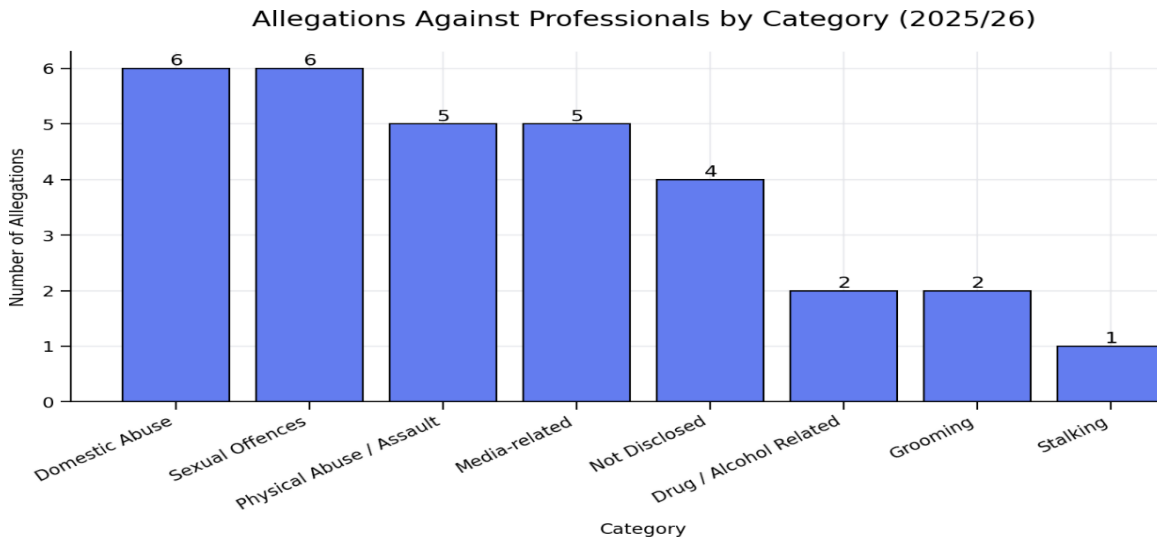
7 Allegations Against Professionals/Staff

During 2025/26, a total of 31 allegations against professionals were opened. At year-end, 4 cases remained open, with the remaining cases progressed to conclusion in line with safeguarding, employment and local safeguarding partnership procedures.

Allegations are managed in accordance with statutory guidance and multi-agency arrangements, ensuring safeguarding risks are addressed promptly, proportionately and with appropriate oversight. The Safeguarding Team works closely with internal leads and external partners to align safeguarding processes with employment governance.

The number and nature of allegations during the reporting period are proportionate to the size and operational scale of the Trust. The low number of cases remaining open provides assurance that concerns are appropriately triaged, investigated and progressed in a timely manner alongside Local Authority Designated Officer (LADO) or Person in a Position of Trust (PiPOT) processes.

Figure 7.1: Allegations Against Professionals by Category (2025/26)



8 Datix Cloud IQ (DCIQ)

During Q4 2025/26, a dedicated Safeguarding Module was launched within Datix Cloud IQ (DCIQ). This module is now the primary mechanism for recording safeguarding activity and supports improved auditability, reporting and oversight.

The introduction of the module strengthens safeguarding information governance by providing a single, secure recording system and supports closer alignment between safeguarding and patient safety learning.

Implementation has been managed in a controlled and proportionate way, with a defined transition period during which existing systems continue to operate in parallel to mitigate risk and ensure continuity of safeguarding oversight.

9 Audit Activity and Policy Update

Increased safeguarding demand and temporary workforce constraints during 2025/26 required the Safeguarding Team to prioritise statutory functions. As a result, capacity for routine audit activity was limited during the reporting period.

Despite this, safeguarding assurance has been maintained through ongoing oversight, data monitoring and partnership engagement focused on areas of highest risk. Planned audit activity will be reprioritised in line with service capacity and emerging safeguarding risks during 2026/27.

Policy review activity commenced during Q4, including review of the Managing Allegations Against Professionals/Staff Policy and the Domestic Abuse Policy. These reviews are being undertaken in collaboration with Human Resources and operational colleagues and are expected to be completed by Q1 2026/27.

A scheduled review of the NWAS Safeguarding Policy will follow in Q2 2026/27 to ensure alignment with updated national guidance.

10 Partnership Working

NWAS engages with over 50 safeguarding partnerships, including Safeguarding Adults Boards, Children's Safeguarding Partnerships and Child Death Overview Panels, reflecting the scale and complexity of the Trust's operational footprint.

During 2025/26, requests for additional safeguarding input increased, including attendance at partnership meetings and contributions to local assurance activity. While this reflects the Trust's valued role within safeguarding systems, it has occurred alongside sustained operational demand and finite safeguarding capacity.

In response, partnership engagement is prioritised based on statutory requirements, safeguarding risk, relevance to NWAS services and team capacity. The Safeguarding Annual Report continues to be used as a key mechanism for providing system-wide assurance and maintaining transparency with safeguarding partners.

11 National Ambulance Safeguarding Group (NASaG)

The Head of Safeguarding represents NWAS at the National Ambulance Safeguarding Group (NASaG). Engagement supports awareness of national policy developments, safeguarding standards and regulatory expectations, and enables shared learning and collaboration with other ambulance trusts.

12 Child Protection Information Sharing (CP-IS)

Child Protection – Information Sharing (CP-IS) is a national NHS digital system that supports the timely sharing of information for children who are subject to Child Protection Plans, Looked After Children arrangements, or other statutory safeguarding measures. The system enables authorised health professionals to be alerted when a child with a protection plan presents to health services, supporting early safeguarding awareness and appropriate escalation.

At present, NWAS has access to CP-IS within the NHS 111 service only. This allows safeguarding status to be identified during telephone-based clinical assessment and supports appropriate decision-making, information sharing and onward safeguarding action where required.

NWAS does not currently have CP-IS functionality embedded within 999 ICC systems or frontline PES workflows. As a result, safeguarding information relating to child protection status is not consistently available across all service access points.

In line with emerging expectations within Working Together to Safeguard Children (2026) and wider national guidance, the Safeguarding Team will review CP-IS requirements and work with ICC colleagues to explore feasibility and readiness for Phase 2 rollout, supporting wider access to CP-IS alerts where appropriate. This work will include consideration of operational impact, information governance, workforce training and system integration.

In parallel, the Safeguarding Team will explore how relevant and proportionate safeguarding information can be shared to support other NWAS services beyond NHS 111 or direct ambulance attendance, including consideration of system development and the use of enhanced digital technology to support timely, lawful and appropriate information sharing.

The phased and proportionate approach to CP-IS reflects the Trust's commitment to strengthening safeguarding assurance and early identification of risk, while ensuring any expansion of access is safe, sustainable and aligned with operational realities.

13 Safeguarding Maternity Alerts

Safeguarding maternity alerts are applied within 999 systems at the request of maternity services where an unborn child is assessed as being at immediate risk following birth. Alerts are postcode-based, time-limited and applied proportionately in accordance with GDPR and Caldicott principles. All requests are reviewed by a Safeguarding Practitioner before action and automatically removed from the system at an agreed time.

During 2025/26, 65 safeguarding maternity alerts were recorded. These alerts support early information sharing and effective multi-agency safeguarding responses, reinforcing the critical role of ambulance services in protecting vulnerable newborns.

Learning from a recent Child Safeguarding Practice Review Panel report following the death of Baby Victoria Martin reinforces the critical role ambulance services play in identifying safeguarding risk and protecting vulnerable newborns. The use of maternity alerts reflects this learning and supports early recognition, escalation and multi-agency coordination where risk is identified.

14 Safeguarding Achievements 2025/26

During 2025/26, NWAS has continued to demonstrate strong safeguarding governance, resilience and statutory compliance within a context of sustained operational pressure and increasing safeguarding demand. Key safeguarding achievements during the reporting period include:

- Statutory safeguarding responsibilities met in full throughout 2025/26 despite sustained increases in service demand and safeguarding activity.
- Safeguarding referrals increased by 54.6% year-on-year, with referral quality maintained and overall rejection rates reduced.
- High-volume engagement in statutory and multi-agency review activity, including SARs, Domestic Abuse-Related Death Reviews, Rapid Reviews and child death processes.
- Dedicated Safeguarding Module implemented within Datix Cloud IQ (DCIQ), strengthening information governance, auditability and safeguarding assurance.
- Safeguarding training compliance maintained above 95% across Levels 1, 2 and 3, with clear professional oversight of training governance and future alignment with Intercollegiate guidance.
- Appropriate and proportionate use of Prevent and Channel arrangements, with increased referrals and information sharing reflecting effective recognition and escalation of risk.
- Timely and proportionate management of allegations against professionals, with the majority of cases concluded within the reporting period.
- Sustained partnership working across over 50 safeguarding partnerships, with clear prioritisation to ensure statutory engagement remains effective and sustainable.

15 Planned Actions for NWAS Safeguarding team 2026/27

As part of the Quality Directorate, the Safeguarding Team contributes to the Trust's wider Quality Plan. Safeguarding activity underpins several key objectives within the plan, including a specific objective aligned to reducing avoidable harm by 30% in relation to notifiable incidents within PSIRF priorities. This includes an ambition to design and implement a digital safeguarding referral system, in collaboration with the ICC digital systems team, to streamline reporting, improve data quality and timeliness, strengthen multi-agency information sharing and enhance organisational assurance.

In addition, the Safeguarding Team's planned actions for 2026/27 include:

- Maintain full statutory safeguarding compliance while responding to continued growth in safeguarding demand and system pressure.
- Embed and optimise use of the Datix Cloud IQ (DCIQ) Safeguarding Module to strengthen audit, reporting, learning and information governance.
- Complete a refreshed safeguarding training needs analysis, with particular focus on Safeguarding Level 3 alignment to Intercollegiate guidance.
- Re-establish and prioritise risk-based safeguarding audit activity to strengthen assurance and inform service improvement.
- Progress scheduled policy reviews, including the Safeguarding Policy, Managing Allegations Against Professionals/Staff Policy and Domestic Abuse Policy, ensuring alignment with updated national guidance.
- Strengthen safeguarding oversight within Patient Transport Services, improving identification and appropriate escalation of safeguarding concerns.
- Review CP-IS requirements and readiness to enable strategic, proportionate expansion of safeguarding information sharing across NWAS services.
- Continue to monitor and respond to Prevent and Channel demand, ensuring arrangements remain proportionate, effective and sustainable.
- Maintain effective oversight of allegations against professionals, ensuring timely management, learning and alignment with employment governance.
- Sustain partnership engagement across SABs and CSPs through prioritised, risk-based involvement, supported by clear assurance reporting.
- Use learning from statutory reviews, audits and national guidance to inform safeguarding practice, training priorities and system learning.

16 Safeguarding Considerations Requiring Ongoing Oversight

The following considerations have been identified from the 2025/26 safeguarding activity and assurance processes. These reflect areas requiring ongoing oversight and prioritisation in the context of increased demand and system complexity, rather than unmanaged or unmitigated risk.

Safeguarding Considerations Requiring Ongoing Oversight – 2025/26

Area of Focus	Description	Evidence from Report	Current Approach / Mitigation	Oversight Position

Safeguarding Demand and Capacity	Sustained increases in safeguarding activity require continued prioritisation to ensure assurance arrangements remain effective and sustainable.	54.6% increase in safeguarding referrals; increased statutory review and Channel activity.	Statutory prioritisation; risk-based engagement; daily threshold reviews with Support Centre.	Under active management
Safeguarding Level 3 Training Consistency	Variation in locally delivered Level 3 training models requires further assurance against Intercollegiate guidance.	Multiple delivery models across service areas.	Professional oversight; planned safeguarding training needs analysis with L&D.	Planned improvement activity
Audit Coverage and Proactive Assurance	Limited capacity for routine audit activity during periods of high demand reduces proactive assurance outside statutory activity.	No annual audit activity undertaken in 2025/26 due to prioritisation of statutory functions.	Live oversight; data monitoring; risk-based audit programme planned for 2026/27.	Time-limited, acceptable position
Safeguarding Visibility within PTS	Lower referral volumes from PTS highlight the need for continued	Disproportionately low referrals relative to PTS activity levels.	Engagement with PTS leads; access to technology;	Emerging focus area

	focus on recognition and escalation in this area.		ongoing monitoring.	
Prevent and Channel Workload	Growth in Prevent referrals and Channel requests continues to place additional demands on safeguarding capacity.	163 Channel information requests; increased referrals in Greater Manchester.	Proportionate referral practice; statutory timescales met; demand monitoring.	Capacity-sensitive
Safeguarding Information Sharing (CP-IS)	Current CP-IS access is limited to NHS 111, requiring review in light of emerging national expectations.	CP-IS not embedded across all services.	Review of Working Together (2026); phased exploration of CP-IS expansion and digital options.	Strategic development area
Partnership Engagement Sustainability	Scale and volume of partnership engagement requires prioritisation to maintain impact and sustainability.	Engagement with 50+ safeguarding partnerships; increased requests for attendance and assurance input.	Risk-based prioritisation; clear communication with partners; annual report used as assurance mechanism.	

17 Equality/Sustainability Impacts

Safeguarding activity supports equity by protecting individuals and groups at increased risk of harm, including those with protected characteristics. No adverse equality impacts have been identified arising from the content of this report. The report has no direct sustainability implications as it relates to assurance and governance rather than changes to service delivery.

18 Action Required

The Board of Directors are asked to note the report, take assurance on statutory safeguarding compliance, and support the continued focus on prioritised safeguarding activity in 2026/27.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Infection Prevention & Control Annual Report and Board Assurance Framework
PRESENTED BY	Elaine Strachan-Hall – Director of Quality and Improvement
PURPOSE	Assurance

STRATEGIC AIM(S)	All strategic aims							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐
	SR05	☐	**SR06**	☒	**SR07**	☐	**SR08**	☐

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Board of Directors is asked to: • Note the content of the report. • Note the assurances it provides. • Note the arrangements for ongoing monitoring via the IPC BAF. • Note the key risks and mitigations.
EXECUTIVE SUMMARY	This paper provides the Board of Directors with the Infection Prevention and Control (IPC) Annual Report and updated IPC Board Assurance Framework (BAF). The IPC BAF provides assurance that appropriate policies, procedures, systems, processes and training are in place to minimise infection risks to patients, service users and staff, while identifying any gaps, risks and mitigations. The Framework is structured around 10 key lines of enquiry. The updated BAF contains six amber-rated areas and no red-rated areas. Several elements relevant only to acute trust providers are marked as not applicable to the ambulance service. Gaps in control, mitigating actions and improvement timelines are clearly identified. There are currently four IPC risks on the risk register, including two scored at 12. All risks are subject to regular review and management, with ongoing actions in place. The updated IPC BAF will continue to be monitored through the IPC Oversight Group.
	Clinical & Quality Group

PREVIOUSLY CONSIDERED BY	Date	Tuesday 5th May 2026
	Outcome	Approved
	TMC	
	Date	Wednesday 20th May
	Outcome	Approved
	Quality & Performance Committee	
	Date	Monday 22nd June
	Outcome	Approved

Section header	Page
Statement by Director of Infection Prevention and Control	7
Purpose and Background	7
Compliance with Regulators CQC ▪ Quality Assurance Visits (QAV) ▪ Estates and Facilities Management	8
IPC Governance Arrangements ▪ Progress Against BAF Key Lines of Enquiry ▪ Provide and Maintain a Clean Environment ▪ Provide Suitable Information on Infections for Staff and Patients	9
Assurance ▪ IPC Audits ▪ IPC Risk Management ▪ Mitigated Risks During 2022/23 ▪ Private Provider Group ▪ Churchill Contract Meetings (Deep Clean) ▪ Clinical Waste Tender	12
Policies and Procedures	17
Governance ▪ Outbreak Management ▪ Outbreak Reporting ▪ Community Outbreak Management	17
PPE ▪ Personal Protective Equipment (PPE) ▪ PPE stock ordering and distribution ▪ PPE Recalls and Safety Alerts ▪ Respiratory Protective Equipment ▪ Respiratory Hoods ▪ Compliance auditing of RPE preparedness	19
Vaccination ▪ Flu Vaccination Program	23
Facilities Management ▪ Review of cleaning regimes across all sites ▪ Decontamination ▪ Premises cleaning and increase to cleaning provision. ▪ Clinical waste ▪ Vehicle Cleaning ▪ Deep Clean Tender Contract	24
Training	25
Communications and Engagement ▪ IPC Team ▪ IPC Communications	27
Unplanned Activates ▪ Tuberculosis (TB) Staff Case ▪ Meningitis Outbreak ▪ Exercise Solaris	28
Innovation ▪ Exercise Solaris ▪ Environmental Innovation and Continuous Sanitisation Light Trial	28
IPC Commitments 2026/27	30

STATEMENT BY THE DIRECTOR OF INFECTION PREVENTION AND CONTROL

This report highlights the Trust's continued progress in delivering against its key priorities for Infection Prevention and Control (IPC). Our ongoing commitment to promoting best practice and upholding high clinical standards remains central to all our efforts.

The IPC team plays a vital part in the development, implementation, and monitoring of infection prevention measures across the Trust. Working closely with both internal colleagues and external partners, the team provides expert advice, support, and training to ensure compliance with the Health and Social Care Act 2008. Their work is instrumental in safeguarding the health and wellbeing of both patients and staff by reducing the risk of healthcare-associated infections (HCAI) and supporting the delivery of safe, high-quality care.

National guidance and initiatives continue to shape elements of our annual IPC work programme, which remains dynamic and responsive as we look ahead to 2026/27. Infection Prevention and Control is a shared responsibility, and our collective success depends on collaboration at every level. This annual report outlines our current performance, celebrates areas of achievement, and identifies opportunities for innovation and continuous improvement.

PURPOSE AND BACKGROUND

Purpose

The purpose of this report is to present both the achievements and challenges met by the IPC team for the North west Ambulance Service (NWAS). This report will focus on all aspects of IPC activity throughout the year, the ongoing response to emerging infectious diseases, incidents reported and the cascading of new national guidance to ensure the safety of both staff and patients. The reporting period is 1st April 2025 until 31st March 2026

Background

Effective systems for the management of IPC are essential for all NHS providers. NWAS has a legal duty to comply with the Health and Social Care Act 2008, specifically the Code of Practice for the NHS on the prevention and control of HCAIs and related guidance. Our IPC approach is taken from the guidance published by United Kingdom Health and Security Agency (UKHSA) and NHS England (NHSE), the NHS's trusted authorities for translating research evidence into practice.

The IPC team monitor compliance to IPC policies, procedures and training via IPC station and vehicle audits. The IPC Practitioners and the Respiratory Protective Equipment (RPE) Fit Testers complete audits in addition to the audits completed by the operational staff. All completed IPC audits are reported through a Power BI dashboard which allows all service lines to review audit data and monitor their progress in real time. The dashboard also forms assurance reports that are presented by area representatives at the IPC Oversight Group. For a number of months, since an update in the system there have been

issues identified with accurate data being presented on the dashboard, however, audits are still being completed and recorded and any non-compliance issues are reported at the time of audit to the responsible manager. The IPCT have worked closely with the BI team to advise of the inaccuracies, to date some issues have been resolved but there remains gaps in assurance as completed audits are not always displayed in the correct section. The IPC Oversight group reports directly to the Clinical and Quality Group.

The team actively monitors IPC incidents and infection-related concerns through the Trust's incident management system, Datix Cloud IQ (DCIQ), which features an IPC dashboard summarising all reported incident. This approach ensures that key themes identified from incidents in each area are combined with audit data to enhance our understanding of where system improvements are needed, where further training should be provided or incorporated into existing programmes, and where risk management measures need to be implemented.

Quality Assurance Visits (QAV's)

North West Ambulance Service carries out annual Quality Assurance Visits (QAV) across all service lines to provide assurance on the quality and safety of operational premises, vehicles, and services at sector level. Keeping pace with evolving regulatory requirements remains a key priority for NWAS. As part of this process, the Infection Prevention (IPC) and Control team plays an active role in current QAVs, offering specialist oversight – the team have attended nearly 100% of QAV's completed during the reporting period. Any instances of non-compliance with IPC policies or procedures identified during QAVs are recorded in the Trust's internal management systems, enabling relevant teams to address the issues - often with support from the IPC team. All non-compliance is subsequently followed up by the IPC team to confirm that the concerns have been fully resolved.

Estates and Facilities Management

The Estates and Facilities Management team conduct compliance audits on all NWAS owned properties to ensure the sites remain safe, clean, well maintained and all associated equipment is in a safe and operational condition. The team ensures that appropriate maintenance and inspection records are held centrally and comply with statutory legislation.

The Head of Estates has several safety groups in operation to provide assurance in relation to the Health and Safety Executive (HSE) legislation. These groups include, but are not limited to, the management of; asbestos, water safety, gas and electrical safety, portable appliance testing, air conditioning and air monitoring safety with planned preventative maintenance undertaken in line within current contract specifications. Compliance reports are provided to the Health Systems Support Framework (HSSF) group and other Trust Committees.

Air Quality monitoring for carbon dioxide levels takes place in all the Integrated Contact Centres (ICC) quarterly in line with the Health and Safety Executive guidance– zones within the ICC are monitored by the Estates officers. Over the past 12 months there have

been zones in 4 of the ICC's that have been higher than the recommended level (indicates poor ventilation) – these have been investigated by Estates and any repairs or adjustments to the air condition units were completed by the relevant contractor. In some cases, the air conditioning units had been switched off hence the levels being recorded as higher than normal.

The IPC Specialist Lead is a member of the Water Safety Group that commenced this year in line with the requirement in the Health and Social Care Act 2008. A Trust Water Safety plan has been developed and approved by the group. Results of regular monitoring of water samples are reported to the Water Safety group. Monthly monitoring of water outlets in the Trust is completed by a private provider and reports are submitted to the Estates Department. Any anomalies are recorded on a central database which is monitored by the Estates department and action is taken accordingly to address any issues. This year the only issues reported have been in relation to low water temperatures and action has been taken to rectify these problems. All legionella risk assessments have been completed apart from the stations that are in the process of being refurbished.

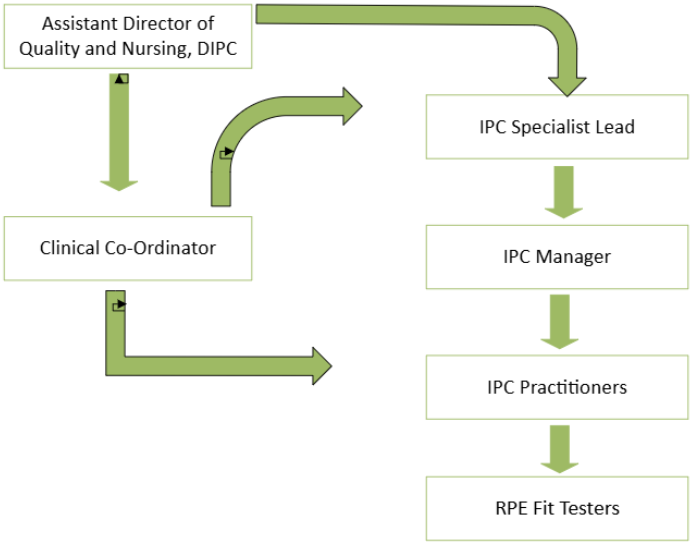
The IPC team participate in the planning stages of all refurbishments and new builds across the organisation. This year the team have been involved in the planning for the new workshops at Distington, the new stations at Stockport, Preston and the new HART base at Elm Point. The team ensure that these plans are compliant with national guidance on the safe disposal of waste and sharps, storing clean linen and have adequate storage for sterile and single use items. The team advise on material for work surfaces, walls and flooring to facilitate effective cleaning.

IPC GOVERNANCE ARRANGEMENTS

In NWAS the corporate responsibility for IPC sat with the Assistant Director of Quality and Nursing, who was also the Director of IPC (DIPC) until the end of March 2026. The DIPC is responsible for the management of the IPC team and provides assurance to the Board and the wider Executive team through assurance reports, the annual workplan and the IPC Board Assurance Framework (BAF).

The IPC team currently consists of an IPC Specialist Lead, an IPC Manager (currently on a 2-year career break), three IPC Practitioners (one for each area) and a Clinical Quality Coordinator who provides administrative support to the DIPC and the IPC team. The IPC team is also responsible for fit testing within the Trust - there are three RPE Fit Testers, one for each area, who directly report to the IPC Practitioners. The IPC team sits within the Quality and Improvement Directorate.

(Chart 1 below demonstrates the structure of the IPC team)



Progress Against BAF Key Lines of Enquiry

This year we have reviewed and updated the following IPC policies and procedures

- Communicable Diseases Policy
- A-Z Communicable Diseases Guidance
- Linen Policy
- IPC Policy
- Cannulation procedure
- Vehicle decontamination Standard Operating Procedures

Provide and Maintain a Clean Environment

In February 2025, NHS England issued updated *National Standards of Cleanliness*, which, for the first time, included specific requirements for ambulance services. Following this update, the Infection Prevention and Control (IPC) team, in partnership with the Facilities Management team, commenced a detailed review of current Trust practices to identify areas of non-compliance against the revised standards. Findings from this gap analysis will inform the development of a comprehensive action plan aimed at ensuring full compliance and sustaining high standards of cleanliness across all relevant services.

Throughout the reporting period, the IPC team continued to provide clear guidance on vehicle cleanliness. The team recommends that all vehicle equipment is cleaned daily and between each patient contact to maintain safe operational environments. Enhanced cleaning procedures have been maintained for all suspected or confirmed infection cases, as well as following Aerosol Generating Procedures (AGPs).

All Trust Emergency and Planned Care vehicles have a 6 weekly deep clean at allocated sites within the Trust footprint. The IPC Specialist Lead attends the monthly Churchill contract Meetings chaired by the Fleet Logistics Manager who oversees the deep clean contract for vehicles. The purpose of the meeting is to monitor the compliance with the 6-weekly frequency – can be affected by operational pressures and if a vehicle is off the road – and the standard of cleaning. The IPC team complete deep clean audits and any issues are raised directly with the Churchill operatives and discussed at the contract meetings.

See table/graph below for compliance with 6 weekly deep cleans which show the amount of vehicles due to be cleaned per month and the number that were cleaned giving a completed percentage of vehicles cleaned. Compliance percentage are cleans completed +/- 7days against what is due that month

Month 25/26	Due in Month	Completed in Month	Completed %	Compliance %
Mar-26	725	681	94%	85%
Feb-26	530	510	96%	77%
Jan-26	673	624	93%	68%
Dec-25	716	632	88%	73%
Nov-25	596	570	96%	81%
Oct-25	697	661	95%	79%
Sep-25	660	628	95%	86%
Aug-25	609	571	94%	83%
Jul-25	702	657	94%	81%
Jun-25	628	594	95%	88%
May-25	653	609	93%	81%
Apr-25	653	611	94%	86%
Average over year			**94%**	**81%**

Provide Suitable Information on Infections for Staff and Patients

Updated national guidance and changes to local operating procedures were disseminated regularly to staff throughout the reporting period. This was achieved through a range of communication channels, including staff bulletins, social media platforms, the internal intranet, and reports to the IPC Oversight Group. All training materials for staff and volunteers were reviewed and updated during the year to ensure alignment with the most recent national IPC guidance.

Local risk assessments, guidance, and procedures remain in place to ensure that patients are appropriately triaged and assessed for infection risk prior to transportation. Ongoing collaboration with other healthcare providers supports the safe transfer of patients with known or suspected transmissible infections, helping to minimise the potential for

onward transmission and ensuring patients are placed in the most appropriate care setting.

The IPC team continues to maintain strong working relationships with IPC colleagues across all partner healthcare organisations. This collaborative approach ensures early awareness of any increases in infection rates within the community. Relevant information is shared promptly with operational staff in affected areas to support situational awareness and ensure appropriate precautions are implemented.

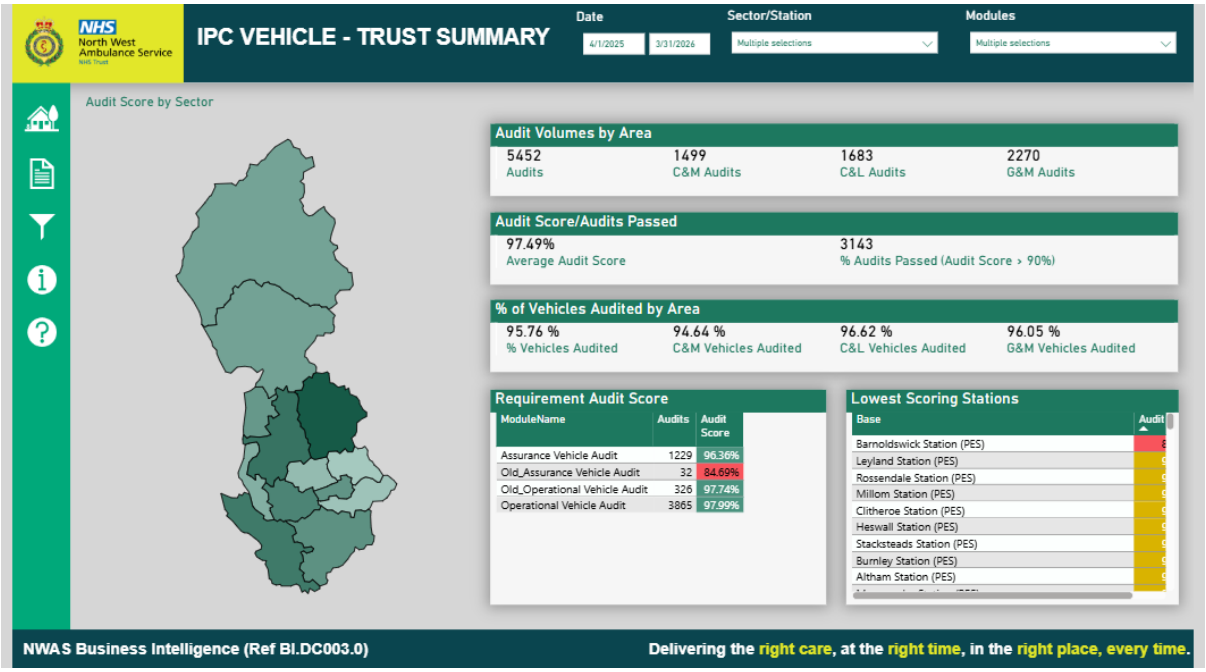
Occupational Health (OH) and the United Kingdom Health Security Agency (UKHSA) are both represented on the IPC Oversight Group, providing valuable specialist input into the Trust's governance structure. Their attendance ensures that the group receives up-to-date information on emerging infections and any increases in incidence across the Trust's footprint. This proactive sharing of intelligence supports timely decision-making, strengthens situational awareness, and enables appropriate IPC measures to be implemented across operational services.

ASSURANCE

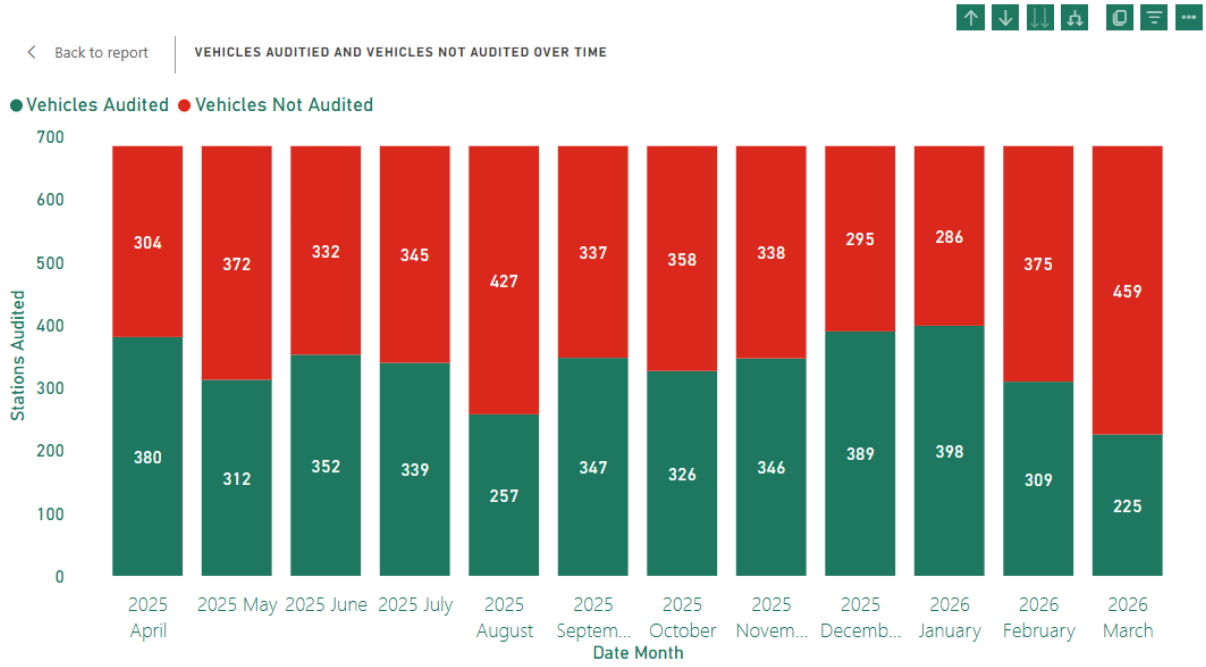
IPC Audits

IPC audits are completed on vehicles and on stations to provide assurance that IPC policies and procedures are being followed. There are 2 types of audits completed – operational audits that are completed by the operational staff and assurance audits that are completed by the IPC team. Some elements of IPC are also explored on clinical contact shifts. All IPC audits are completed on Safecheck which then feed through to a power BI dashboard. There have been some difficulties this year with data flowing through to the dashboard following an upgrade to safecheck which has meant that some operational audits have been recorded as assurance audits. These audits are presented by the areas at the quarterly IPC Oversight Group.

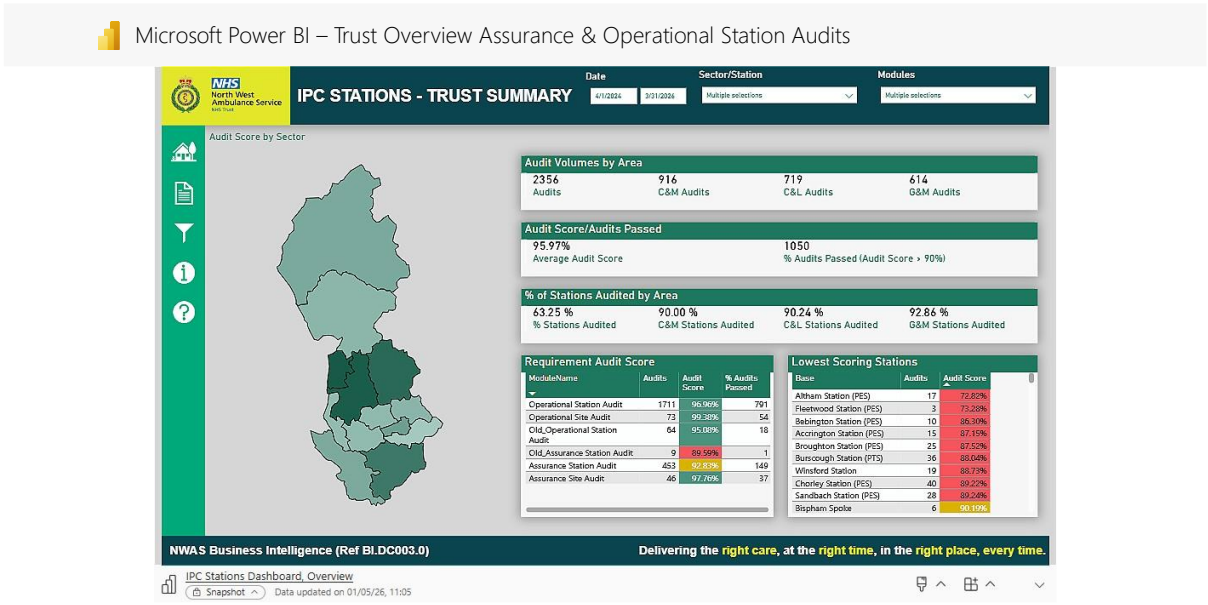
In total for the year 5452 vehicle audits were conducted – please see below – with an average audit score of 97.5%. These are broken down into areas and also gives the percentage of vehicles audited per area. All vehicles should be audited 3 monthly by operational staff.



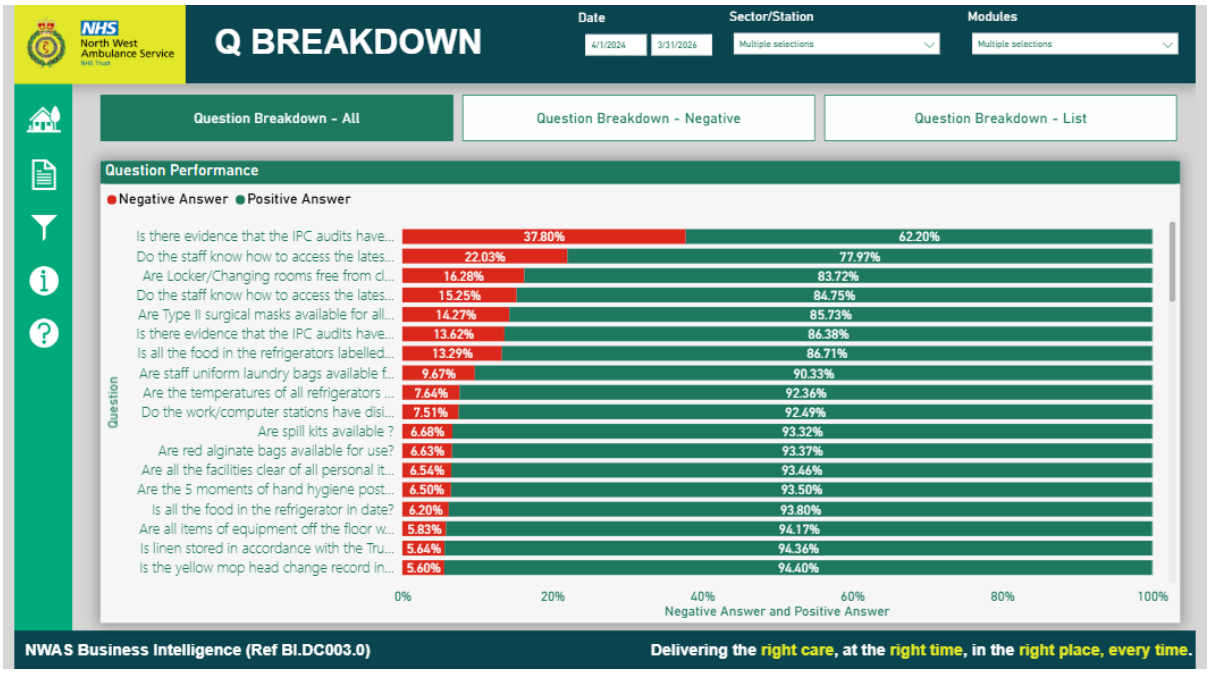
The chart below gives an indication of the number of vehicles audited/not audited per month – this can obviously be impacted by operational pressures and if vehicles are off the road.



For station audits 2356 have been completed during the reporting period, stations are audited monthly by operational staff and 6 monthly by the IPCT;



With the table below showing a breakdown of the results of the questions on station audits for the last 12 months



Key themes identified through audits and incident reporting are integrated into teaching and learning sessions. These themes are also reviewed at the IPC Oversight Group to promote the sharing of good practice across all areas.

IPC Risk Management

During 2025/26 risks in relation to IPC have been aligned, managed, and monitored as part of the IPC BAF, in addition to the organisational BAF and the Corporate Risk Register.

All risks are reported on the DCIQ system and there are currently five risks aligned to IPC, three risks that are scoring less than a 12 and one risks scoring a 12.

- Risk number 697 - There is a risk that due to staff not carrying out inspections on personal issue Sundstrom Hoods or regular services being undertaken, the Trust will not comply with Control of Substances to Hazardous Health (COSHH) legislation. Risk Score 10. Actions being taken to mitigate the risk include fit testing staff demonstrating the checks when completing fit testing, a question has been added to safecheck to capture the monthly visual inspection and a email informing staff who have failed a fit test of the importance of having an available hood and instructions of how to use it.

- Risk number 698 - There is a risk that due to staff not carrying out a visual inspection of their personal issue Sundstrom Hood or if the service has not been undertaken, essential respiratory equipment will not be available or provide effective protection, resulting in staff being exposed to hazardous environments. Risk Score 6. Actions being taken to mitigate the risk include fit testing staff demonstrating the checks when completing fit testing, a question has been added to safecheck to capture the monthly visual inspection and a email informing staff who have failed a fit test of the importance of having an available hood and instructions of how to use it.

- Risk number 756 - There is a risk that due to inaccuracies within the SafeCheck Audit tool the Infection Prevention & Control Team are unable to gain adequate assurance on compliance with Infection Prevention & Control policies and procedures, leading to an unsafe environment for patients and staff. Risk Score 12. Actions being taken to mitigate the risk include ongoing meetings with SafeCheck and power BI teams to attempt to resolve reported issues and the continuation of IPC audits and local reporting of any identified issues.

- Risk number 787 - There is a risk that due to an invasive outbreak of Meningococcal B Meningitis in Kent, and the potential for transmission across the rest of the UK, staff in the North West who are not immunised or wearing appropriate PPE may be exposed and contract the illness, resulting in further transmission to colleagues and the wider community and leading to increased staff harm and absence causing business disruption. Risk Score 10. Actions being taken to mitigate the risk include ongoing monitoring and liaison with NHSE and UKHSA and distributing updated guidance to clinicians.

- Risk number 792 - There is a risk that due to Respiratory Protective Equipment (RPE) Motor Units not being presented for annual servicing, out of 1509 units only 363 24% have been serviced within the recommended time frame, meaning that in case of IPC, Chemical incidents staff may not be adequately protected. Risk Score 12. Actions being taken to mitigate the risk include escalation to the Medical Devices Oversight Group, information to be cascaded to clinical staff to ensure that motor units are presented to

be serviced and fit testers to check motor units when fit testing.

These five risks have been reviewed monthly and updated as further actions and mitigations have been put in place, this is reported via the IPC Oversight Group for assurance. All five risks identified are in relation to areas highlighted in the report, including areas of improvement and additional assurances.

Mitigated Risks (Closed) During 2025/26

The three risks below were closed in the reporting period, and a new risk was opened to encompass PPE wearing - risk number 713. This was also closed during the reporting period.

- Risk number 605 - There is a risk that due to increased prevalence of Measles in the community, staff who are not immunised or wearing the correct PPE will be exposed and at risk of contracting Measles resulting in further transmission in both the community and colleagues leading to absence from work. This risk was closed April 2025 as target rating had been reached and rates of measles in the community had decreased.

- Risk number 668 - There is a risk that due to the increased prevalence of Mpox Clade 1- a HCID (and the associated declaration from the World Health Organisation (WHO) that it is a public health emergency of international concern) that staff may not sure what Personal Protective Equipment (PPE) to don /how to safely transfer a suspected High Consequence Infectious Disease patient. This risk was closed April 2025 as a new generic risk was opened to cover the lack of PPE wearing for all infectious diseases rather than being specific to Mpox

- Risk number 678 - There is a risk that due to the large number of staff fit tested two years ago by NHS England funded external fit testing services, these staff will not be fit tested in the Health Safety and Environment (HSE) required two year fit test cycle and must use their personal issue Sundstrom hoods which they may not have with them, forgot how to use them or they don't like to use. This risk was closed in August 2025 as fit testing compliance rates were consistently above 90% for last few months and manageable numbers of staff requiring fit testing in the forthcoming months.

- Risk number 713 There is a risk that due to the increased prevalence of emerging infectious diseases and changing guidance that staff will not be aware of what Personal Protective Equipment (PPE) to wear to protect themselves and patients to prevent onward transmission of infection. Risk closed February 2026 as target score met – all guidance for staff readily available on the green room and is incorporated into mandatory training. The A-Z of common diseases also revised and has a comprehensive list of PPE to be worn/actions to be taken for suspected/confirmed infectious diseases

Private Provider Group

This year, the Infection Prevention and Control (IPC) team has continued to provide specialist IPC support to the private provider group responsible for commissioning and managing Private Provider Paramedic Emergency Services (PES) and Patient Transport Services (PTS). Support has included undertaking vehicle spot-check audits at emergency departments, delivering foundational IPC education to staff, providing specialist IPC advice, and completing site visits for commissioning and audit purposes. Collectively, these activities have strengthened assurance processes, improved provider compliance, and enhanced overall infection prevention and control standards across the service.

Deep Clean Monitoring

The IPC Specialist Lead attends regular vehicle deep clean monitoring meetings with Fleet colleagues. All vehicles receive a scheduled six-weekly deep clean at allocated sites across the Trust footprint. The purpose of the meetings is to monitor compliance with the six-weekly frequency, which can be affected by operational pressures or vehicles being off the road, and to review the standard of cleaning. The IPC team complete deep clean audits, and any issues identified are raised with the relevant teams for review and action.

Clinical Waste Tender

The clinical waste contract was up for renewal January 2026 – the IPC Specialist Lead attended the tender evaluations and the supplier presentations with the Fleet Logistics Manager who oversees the contract, representatives from procurement and the Estates Energy and Environment Manager. The main focus of the tender was to ensure that the Trust is compliant with the NHS England guidance 'Safe and sustainable management of healthcare waste' which sets targets around waste segregation, sustainability and innovation in waste management. The incumbent provider was successful in retaining the contract.

As a Trust we are falling short of the legislation stipulated clinical waste segregation split of 60% (Tiger Bag), 20% (Orange Bag) & 20% (Yellow Bag (Including Sharps)) introduced on the 1 Jan 2026. Current percentages provided by the waste provider are 25% Tiger Bag, 8% Orange Bag and 67% Yellow Bag. This is due to staff not using the correct coloured bags and or not tagging the handles of bins. Numerous bulletins and resources have been distributed out to staff to inform them of the importance of using the correct coloured bags and tagging the handles of bins.

POLICIES AND PROCEDURES

The IPC Specialist Lead attends the monthly National Ambulance Service IPC Group (NASIPCG) and with the other IPC leads contributes to Association of Ambulance Chief Executives (AACE) guidance prior to approval. Once the AACE guidance is approved, the IPC team work closely with the Communications team in NWAS to ensure an updated bulletin is distributed to inform staff of any changes.

The Trust's IPC policies and procedures are regularly reviewed and updated to ensure they are aligned to national guidance. The IPC team also work closely with the

Communications team to ensure that new policies and procedures are available on the Trust intranet. The team then liaise directly with the Heads of Service and inform them when new or updated policies are available, to improve Trust compliance.

This year we have reviewed and updated the Cannulation procedure, the Communicable Diseases policy and the A-Z Common Diseases Guidance. The team have also worked closely with the resilience team, local Infectious Diseases Consultants and UKHSA to develop a flowchart for the transfer of High Consequence Infectious Diseases (HCID) patients.

GOVERNANCE

The Trust's IPC Oversight Group meet quarterly to ensure ongoing regulatory compliance, to approve updated policies and procedures and to oversee infection prevention initiatives. The Group is chaired by the DIPC and has representatives from procurement, Consultant paramedics, facilities, fleet and staff side and external representation from OH and UKHSA. The Oversight group should receive assurance reports from each area and also from OH, although no report has been received from OH for nearly 12 months. This has been escalated to the Trust Human Resources Department who oversee the OH contract.

The IPC Oversight Group addresses a wide spectrum of IPC challenges with a focus on the following key areas:

- **Hand Hygiene improvement initiatives**: Supporting the Trust's quality improvement projects and monitoring compliance, including reviewing hand hygiene audits, and implementing strategies for continuous improvement
- **Environmental decontamination and vehicle hygiene**: Reviewing cleaning audits and identifying areas for enhancement, ensuring that all areas, including vehicles, meet infection prevention and control standards.
- **Outbreak management and emerging infection risks:** Coordinating response planning for seasonal and novel infections, ensuring preparedness and timely interventions, including monitoring and reporting staff flu vaccination status.
- **Staff IPC compliance**: Enhancing education, engagement and assurance processes through compliance reviews to ensure staff are well informed and adhere to IPC practices.
- **RPE fit testing compliance**: Reviewing and reporting fit testing figures managed by the IPC team to ensure that staff members are equipped with appropriate respiratory protection.

Additionally, the IPC Oversight Group engages in regular updates and reviews from various sectors including:

IPC guidance and regulations:

Ensuring alignment with updated national and local IPC standards and AACE position statements.

- **Vehicle and station audits and risk assessments**: Incorporating vehicle and station audits as part of the broader risk management strategy for infection prevention.
- **Items for escalation to the Quality and Performance Committee**: Raising critical issues for high level review to ensure alignment with overall Trust performance standards. **Outbreak Management**

Outbreaks are identified and declared by the IPC team when two or more cases of a communicable disease are linked by time or location. Within the ambulance service, this may involve cases connected to specific stations, offices, fleet services, call centres or among crew members.

The IPC team oversees outbreak management, ensuring a timely, coordinated and effective response from initial detection through to closure. Any lessons learned are shared through the IPC Oversight Group. A standardised approach is used across NWAS, with managers provided with consistent advice on enhanced IPC measures to minimise the risk of onward transmission.

As part of this process, the IPC team coordinates infection control measures in relation to buildings, ensuring appropriate decontamination and any necessary restrictions are implemented. The team also provides guidance on the correct use of PPE and works with Occupational Health to support risk assessments for affected staff.

During the period covered in this report, the IPC team managed two outbreaks of diarrhoea and vomiting (D&V) within the Trust.

Sharston Station (24/04/2025 – 06/05/2025): Four staff members were affected, all associated by time and location, presenting with D&V symptoms.

Salford Station (02/03/2026 – 06/03/2026): Six staff members were affected, all associated by time and location, presenting with D&V symptoms.

In both outbreaks, enhanced cleaning was implemented, and staff were reminded of the importance of effective hand hygiene and cleaning of shared surfaces and touch points to reduce the risk of further spread.

Meningitis Outbreak

In March UKHSA confirmed an ongoing outbreak of invasive meningococcal disease (IMD) in Kent, with 29 probable cases, 21 confirmed cases and 2 deaths linked to the University of Kent and Club Chemistry (5–7 March exposure window). Investigations confirmed that cases are group B meningococcal disease. Cases include young adults and teenagers, with widespread antibiotic prophylaxis being issued to close contacts.

The outbreak had significant press coverage and as a result the ICC's saw a significant increase in calls with suspected meningitis. Information was sent out via a clinical bulletin to inform staff of signs and symptoms of meningitis, the correct PPE to wear and advise on cleaning equipment following the transportation of a suspected or confirmed case. The team liaised with OH to ensure that support was available to staff who may have been exposed and Medicines Management monitored stock levels of Benzylpenicillin to ensure that there was sufficient supplies available as increased amounts had been administered in the month of March.

At the time of writing the report there have been no reported cases of Meningitis in the North West linked to the Kent outbreak.

Community Outbreak Management

The IPC team is notified of outbreaks occurring within the community via UKHSA and local authorities. These may include infectious illnesses and infestations such as norovirus, influenza, scabies and fleas.

On receipt of this information, the IPC team works alongside the Address Base team to share relevant details. Address warnings are then applied to specific locations, providing operational crews with up-to-date information prior to attendance.

This ensures that PES and PTS staff are aware of potential risks and are able to don the appropriate PPE and take the necessary precautions when attending patients, helping to reduce the risk of exposure and onward transmission.

PPE

PPE is readily available to all patient-facing staff, who are trained in its correct use, including donning and doffing. National PPE guidance has been updated, replacing the previous 'PPE levels' with Transmission-Based Precautions (TBP). Staff choose the appropriate PPE based on what transmission route was needed i.e. contact, droplet or airborne. These changes have been incorporated into all training materials and are reflected in the reviewed 'A-Z of Common Diseases & High Consequence Infectious Diseases (HCID) guide' which provides specific PPE recommendations for each infectious disease.

PPE Stock Ordering and Distribution

The NWAS Procurement Team is responsible for the sourcing and acquisition of Personal Protective Equipment (PPE) for the organisation. The Infection Prevention and Control (IPC) Team is responsible for assessing and approving the clinical suitability of PPE items prior to their use.

Following the cessation of the national PPE push-stock supply model by NHS England in April 2024, all trusts are required to manage and order their own PPE supplies. Within NWAS, PPE orders are placed through NHS Supplies by local operational leadership teams. These teams are accountable for ensuring that adequate and appropriate PPE stock levels are maintained within their respective sectors for staff to use.

PPE Recalls and Safety Alerts

The Medicines and Healthcare Regulatory Agency (MHRA) issues safety alerts from the Central Alerting System (CAS). The Working Area Specialist (WAS) Board of Directors are identified via the Integrated Performance Report (IPR) of safety alerts received.

The IPC team were alerted via a National Patient Safety Alert regarding the recall of a specific non-sterile, alcohol-free wipe product due to an increased risk of patients contracting Burkholderia stabilis infections. In response, the product recall was promptly logged on the Datix DCIQ system, and Trust-wide communications were issued instructing all services to identify and dispose of the affected wipes without delay. This ensured rapid removal of the product from clinical use and reduced the potential risk to patient safety. The IPC team continues to monitor the situation and provide guidance to clinical areas as needed.

RPE

The FFP3 respirator mask covers the mouth and nose to protect against particulate hazards, such as airborne infectious viruses, and is an essential part of PPE for staff who carry out Aerosol Generating Procedures (AGP). An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract. The only AGP likely to be completed by NWAS staff is the suctioning of a tracheostomy on a patient. There are infectious diseases where the requirement for respiratory protection is essential.

- Middle Eastern Respiratory Virus (MERS)
- Mpox
- Chicken pox
- Other High Consequence Infectious Diseases (HCID)

RPE must also be worn if there is a risk of exposure to asbestos or glass particles for example at road traffic collision and fire servicing are cutting glass.

FFP3 masks are available to order by operational teams at a sector level ensuring they have their own supplies for staff working in their sector. A selection of five masks is available that staff can be fit tested with, which provide an option for various face shapes and sizes. These masks are all available on the NHS supply chain website and are widely available. Anyone who fails on all five masks must use the Sundstrom powered respiratory hoods that are supplied as personal issue when commencing in the trust. All fit test fails and any staff whose fit test result has expired, receive an email reminding them that they need to have their Sundstrom hood with them when on duty and access to a Sundstrom fan unit on their vehicle.

Under COSHH legislation, FFP3 masks must be fit tested to ensure they fit the individual wearer. Since October 2023, NWAS has a fit test team of three, with one fit tester to cover each area. The fit testing team undertake the fit testing of operational staff who require a new fit test every two years. For new staff to NWAS, the Clinical Education Practitioners

fit test them during their training/induction course. To support fit testing, the three IPC Practitioners are trained fit testers and fit test as required in areas of low compliance or due to large staff numbers who require fit testing.

Operational pressures contribute to the challenge of ensuring staff are fit tested– both the member of staff and the vehicle, are taken off the road whilst the fit test is completed. Despite this, the Trust fit test compliance is the highest on record – please see tables below. Please note that 'expiring soon' refers to staff whose fit test runs out in the next 3 months.

Fit testing Compliance March 2026

Work Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon
Operations PES	**Operations PES**	**4500**	**3760**	**272**	**4032**	**331**	**4363**	**92.4%**

Work Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon
Operations PES	**Clinical Leads**	**70**	**59**	**5**	**64**	**6**	**70**	**91.4%**
Operations PES	**CAL - Clinical Leads**	27	22	2	24	3	27	88.9%
Operations PES	**CAM - Clinical Leads**	20	17	1	18	2	20	90.0%
Operations PES	**GM - Clinical Leads**	23	20	2	22	1	23	95.7%

Work Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon
Operations PES	**Greater Manchester**	**1534**	**1303**	**83**	**1386**	**128**	**1514**	**91.5%**
Operations PES	**GM - Central**	373	320	24	344	25	369	93.2%
Operations PES	**GM - East**	334	295	12	307	24	331	92.7%
Operations PES	**GM - South**	450	370	40	410	36	446	91.9%
Operations PES	**GM - West**	346	296	6	302	39	341	88.6%
Operations PES	**GM - Service Delivery**	31	22	1	23	4	27	85.2%

Work Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon
Operations PES	**Cheshire & Mersey**	**1459**	**1248**	**89**	**1337**	**100**	**1437**	**93.0%**
Operations PES	**CAM - East**	347	299	19	318	25	343	92.7%
Operations PES	**CAM - North**	508	439	41	480	23	503	95.4%
Operations PES	**CAM - South**	277	248	4	252	21	273	92.3%
Operations PES	**CAM - West**	297	243	22	265	27	292	90.8%
Operations PES	**CAM - Service Delivery**	30	19	3	22	4	26	84.6%

Work Area	Area/Sector	Total Headcount	Match	Expiring Soon	Match & Expiring Soon Total	Required	Grand Total	% Complete with Expiring Soon
Operations PES	**Cumbria & Lancashire**	**1368**	**1150**	**95**	**1245**	**96**	**1341**	**92.8%**
Operations PES	**CAL - East Lancs**	317	288	11	299	15	314	95.2%
Operations PES	**CAL - Fylde**	206	167	20	187	17	204	91.7%
Operations PES	**CAL - Morecambe**	265	219	15	234	27	261	89.7%
Operations PES	**CAL - North Cumbria**	260	202	25	227	20	247	91.9%
Operations PES	**CAL - South Lancs**	292	252	22	274	14	288	95.1%
Operations PES	**CAL - Service Delivery**	28	22	2	24	3	27	88.9%

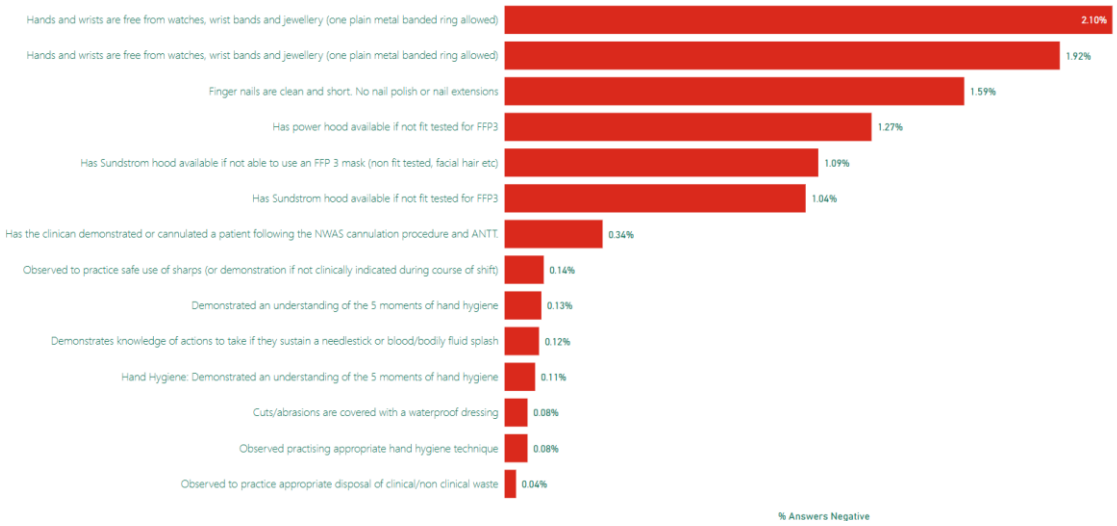
Respiratory Hoods

NWAS continue to issue powered respiratory hoods as RPE as personal issue to all emergency service patient facing staff. The powered respiratory hood, which the Trust uses, is the Sundstrom SR 520 Hood with the SR700 Fan unit. This enables staff who fail a fit test, those with beards, stubble or facial disfigurement to wear respiratory protective equipment. There is no need for fit testing however the user does need to be trained in how to test and wear the equipment.

There is a requirement for the Sundstrom Hood filtering units to be serviced on an annual basis to ensure compliance with the COSHH regulations. The filter units are serviced by Sundstrom trained Oxylitre service engineers. These records are held by Fleet who oversee the servicing contracts however only around 25% of these units have been serviced in 2025/26.

Compliance Auditing of RPE Preparedness

The IPC team has an audit tool for monitoring operational compliance of our staff regarding preparedness to attend an incident requiring PPE. This audit is carried out by a Senior Paramedic (SP) team during their clinical contact shifts with frontline operational staff. This should happen on three occasions a year. This audit measures whether the staff member is in date for their FFP3 fit test and, if not, if they have their Sundstrom hood with them. The audit is recorded on the Safecheck system and can be viewed on the power BI dashboard. The results of the audit show that nearly 99% of staff had access to their own personal issue Sundstrom hood if they had failed or were out of date for fit testing. See below for power BI audit results.



VACCINATIONS

Flu Vaccination Programme

The Trust delivered its 2025/26 staff flu vaccination programme following a similar model of peer vaccinating as in previous years. NHS England mandated all Trusts to increase uptake amongst frontline staff by 5% and to complete the vaccination programme by the end of November so that staff would be protected for the December/January period. Flu leads were identified and planning meetings commenced in July to ensure an effective campaign – the meetings were attended by key stakeholders to the campaign including Operational leads, representatives from Human Resources, medicines management and the Communications team. Medicines management were pivotal in ensuring that the vaccine fridges were switched on in advance and monitored fridge temperatures throughout the campaign. Over 100 vaccinators were trained and peer vaccinated their colleagues. The campaign commenced on the 1st October and vaccines were offered until the end of March 2026. The IPC Specialist Lead coordinated vaccinations for corporate staff, with trained IPC team members running clinics across the Trust. The IPCT also vaccinated PTS staff, who lacked an internal vaccinator, and visited educational settings to vaccinate new starters. In total, the IPC team administered 651 vaccinations, accounting for 21% of the total staff vaccinated by the Trust.

National recording of uptake this year was different – the national vaccine database was linked in with ESR to determine the %uptake. This meant that there would be a margin of error if staff did not have up to date information on their NHS record and it wouldn't be matched up to their ESR record. When receiving the vaccine staff were encouraged to ensure that their GP records were accurate and updated to minimise the reporting discrepancy. The 5% target increase for vaccinating frontline staff was achieved on the 12th December – this was a significant achievement and we were the 5th Trust in the GM area to achieve this.

Vaccinations are offered until the end of March resulted in the final figures for the flu campaign at the end of March is that 3037 staff were vaccinated - which equates to 43.5%, 45% of frontline staff were vaccinated and 53.3% of staff declined the vaccine.

FACILITIES MANAGEMENT

Review of Cleaning Regimes Across All Sites

Since publication of the National Standards of Healthcare Cleanliness in February 2025, the Head of Facilities Management and Facilities Management Regional Officer have been working to implement the outstanding mandatory aspects of the standards. The Commitment to Cleanliness Charter rollout was the final aspect to meet compliance and this was completed by the end of February 2026 with charters now on display at all NWAS sites.

Facilities Management in collaboration with IPC undertook a Trust wide review of cleaning provisions in 2024, which specifically included the provision of the sluice and storage facilities provided in premises, that enable effective cleaning at stations and premises. In total 106 audits were completed. As a result of the audits and identification of substandard facilities a business case was put forward for funding to ensure standardised sluice and storage facilities across the Trust. This piece of work has been completed in this financial year and all identified cleaning provisions are now up to standard. Some sites required large capital investment and improvements to provisions at these sites are being made as capital projects are planned.

The collaborative work with IPC will continue with a view to conducting joint audits for premises cleaning and IPC, with the cleaning provider as part of our continuous improvement aims.

Decontamination

Through 2025, there was no requirement to use this service in respect of the cleaning of premises. However, the decontamination service for workstations and premises remains available to call on as and when necessary, through the contractor.

Premises Cleaning and Increase to Cleaning Provision

We will continue to review service schedules in line with any changes to the Trust's operational delivery plans or as the estate portfolio is increased or reduced.

Clinical Waste

The clinical waste stream in the Trust is managed and monitored by the Fleet Logistics Team with the collection and disposal of clinical waste provided by Stericycle following the award of a 3-year contract commencing on 1st April 2026. The Trust has robust systems in place for disposing safely and effectively of clinical waste. In line with legislation introduced on the 1st January 2026, the Trust has implemented the clinical waste segregation across all locations to achieve the required 60-20-20 split and disposal of all clinical waste. The segregation introduced the replacement of the

previously used Yellow Bag - Incineration (HI) with the Tiger Bag - Non-Hazardous (HL) - Yellow Bag with Black Stripes within the bins of each vehicle. In the vast majority of cases, the Tiger Bag waste stream will be the required disposal route. In the event a specific case requires the clinical waste disposal for either Alternative Treatment (Orange Bag) or incineration (Yellow Bag), additional bags for these waste streams continue to be provided along with the required additional bins and signage at each station. There has been no change to the disposal of sharps bins. To assist members of staff with the transition, the required supporting information has been distributed accordingly alongside the introduction of mandatory training.

The service delivery provided by Stericycle in the provision of clinical waste disposal is managed and reviewed monthly during contact management meetings, which is managed by the Fleet Logistic Manager in collaboration with IPC and the Procurement team.

Deep Clean Tender Contract

The vehicle deep clean contract, including the make ready service provided by Churchill Ltd entered into a 1-year extension concluding on the 31st December 2026. The delivery of the service is managed by Fleet with support from the Trust's IPC team to ensure the service provider follows the national guidance on IPC and that their products used are suitable for cleaning both the equipment and the vehicles.

TRAINING

IPC Training

IPC is a key element of the mandatory training programme for all staff. The training consists of an initial IPC module completed upon recruitment, provided by the IPC team. This is then followed by regular updates including a Level 1 ESR mandatory training course every three years and a Level 2 course annually.

The IPC team have developed a structed presentation tailored for new frontline staff ensuring that IPC principles are effectively communicated. This presentation aligns with the latest National IPC Manual, WHO guidance and UKHSA protocols. It also meets the UK Core Skills Training Framework and mandatory training standards. The presentation aims to equip staff with a solid understanding of IPC practices and protocols. The key topics covered include:

- Systems and procedures related to IPC
- Relevant legislation and policies
- Definitions of HCAIs and strategies to reduce them
- The importance of personal hygiene in IPC in line with WHO hand hygiene
- Roles and responsibilities in IPC
- Cleaning and decontaminating vehicles and equipment

- Safe management of sharps and linen
- Hand hygiene techniques
- The role of risk assessments in IPC

IPC Induction Training Summary (New starters)

Between 1 April 2025 and 31 March 2026, the IPC team delivered IPC induction training to all identified new starters within the staff groups below, achieving 100% compliance against recruitment intake figures provided for this period. A total of 513 staff received IPC induction training.

Staff Group	Number Trained
Patient Transport Service (PTS)	144
Paramedics/PI	148
Associate Ambulance Practitioners (AAP)	182
Urgent & Emergency Care Assistant Practitioners (UECAP)	9
Advanced Paramedic Practitioners (APP)	5
Logistics Assistants	25
Total	513

The IPC induction remains aligned to CSTF Level 1 and 2 requirements, covering the key principles of infection prevention and how these apply in practice within the ambulance setting. This includes standard and transmission-based precautions, hand hygiene, PPE and RPE, dynamic risk assessment, cleaning, waste management, and sharps safety. Staff are also provided with guidance relating to HCIDs, notifiable diseases, and how to access IPC support and advice within NWAS.

Training Feedback Summary

Category	Average Score (out of 5)	Summary
Clarity and understanding	4.93	The majority rated clarity as excellent.
Communication & Delivery	4.92	Presenters were described as engaging, knowledgeable, and clear.

Impact on practices	4.92	Attendees reported improved understanding and positive influence on practice.

Feedback received from 100 participants

Qualitative feedback themes:

Feedback continues to show the sessions are well received, with staff describing them as clear, informative, and relevant to their role. The interactive elements, particularly the Kahoot quiz and hand hygiene activities, were mentioned a lot and clearly make a difference in keeping people engaged.

Several staff members said the training helped improve their understanding of IPC and gave them more confidence in applying it in practice. There was also positive feedback about the presenters, who were described as approachable, knowledgeable and able to explain things in a way that made sense.

Continuous Improvement

Feedback has been used to make improvements to the sessions, with the main themes this year focusing on adding more interactive elements and increasing hands on learning, particularly around PPE. A small number of comments also highlighted that some slides were a little word heavy, along with requests to update some of the PPE videos. The focus going forward will be on introducing additional interactive elements throughout the session, including more quizzes and practical opportunities to apply learning, as well as updating PPE videos.

COMMUNICATION AND ENGAGEMENT

IPC Team

The IPC team continue to work hard to maintain a strong and visible presence across the Trust. Attendance at locality meetings and forums is routine, ensuring regular opportunities to share IPC information and updates. The IPC Practitioners provide specialist guidance and play an integral role in supporting QAV processes throughout the Trust.

Beyond internal engagement, the IPC team have established robust networks with IPC teams in other healthcare organisations, including UKHSA and NHSE. They have also built effective relationships with company representatives to support the development of ambulance-specific products and promote improvements within the ambulance environment.

In addition, the RPE Fit Tester delivers fit testing across the Trust and provides valuable support to the IPC team, fulfilling a vital function within the service.

IPC Communications

The IPC team designed an IPC-specific public-facing webpage to help members of the public understand the measures the Trust takes to keep patients and staff safe. The page was developed with input and support from a Patient Public Panel member to ensure accessibility and clear communication.

The IPC team also publish regular staff bulletins through the Trust Communications team. These are distributed via email and displayed at station sites on Hubara screens also shared via SharePoint supporting the Trust's sustainability agenda by reducing reliance on printed materials. Information is further shared through Operational Leadership Team meetings, ensuring key messages are cascaded directly to frontline staff.

In addition, the IPC team utilise social media platforms—such as Facebook and Twitter—via the Trust Communications team to expand the reach of IPC updates and promote engagement across the organisation.

UNPLANNED ACTIVITY

Tuberculosis (TB) case staff member

In February the IPC team were informed that a staff member had been diagnosed with pulmonary TB. The staff member had been working with one of the Integrated Contact Centres (ICC) and had been symptomatic in work for over 6 weeks. The IPC team liaised with OH who initially asked the team manager to identify close contacts in the workplace should they need to be contact traced. UKHSA was also involved and were the conduit between the IPC team and the community TB team who were in contact with the staff member to identify and test household contacts. To date no contact tracing has taken place within the ICC's. The IPC Team worked with Communications in the Trust & UKHSA to share information amongst the ICC to reassure staff.

Exercise Solaris

In April/May 2025 the IPC Team were invited by the resilience team to join area wide meetings for Exercise Solaris. The meetings were organised by UKHSA to exercise multi-agency pandemic response arrangements and plans at a local and regional level in preparation for Exercise Pegasus (a Tier 1 national pandemic exercise to be held throughout September to November 2025).

The team worked alongside other emergency services and representatives from public health, local authority and the Integrated Care Boards (ICB's) to draw on their experience from the Covid pandemic to identify areas which could be included in the design of Exercise Pegasus to plan for any future pandemics. The team also attended some of the Exercise Pegasus held across the Local Resilience Forums (LRF'S).

INNOVATION

Several years ago to streamline the IPC audit process and improve data visibility, the IPC team implemented audit functionality within the SafeCheck platform, with data visualisation delivered through Power BI. Since deployment, however, the audit data has

shown signs of unreliability due to several factors, including system behaviour, data transfer issues, and limitations in the current configuration.

Despite collaborative efforts and multiple meetings with system developers of SafeCheck and Power BI to address these concerns significant data instability and reporting inconsistencies persist. Although some progress has been made, several questions remain unanswered and the irregularities continue to impact the accuracy of IPC reporting. Following recent discussions with SafeCheck's development team, both parties have agreed that a more fundamental review is necessary. This will prevent more reactive work being undertaken and allow for a full review which will support a more robust configuration for long term data stability.

In collaboration with NHS Supply Chain representatives, the North West region is working to develop a standardised equipment list. The primary aim of this initiative is to reduce unwarranted variation, enable group purchasing opportunities, and ensure greater consistency in the clinical devices used across organisations. One of the IPC Practitioners attends these meetings to ensure the ambulance service has representation.

Establishing an agreed regional device catalogue has the potential to deliver significant cost savings through economies of scale, minimise unnecessary changes in patient equipment, and enhance continuity of care. Furthermore, this collaborative approach will facilitate shared learning, reduce duplication of procurement activity, and strengthen alignment with regional clinical and operational priorities.

The IPC Practitioners strive in developing new ways of working to provide a safer working environment for NWAS staff and safe places to be treated for our patients. In 2026/27, the IPC Practitioners will be working on the following:

- Reviewing and developing safe storage for PPE for staff.
- Ensuring compliance with the National Standards of Healthcare Cleanliness
- Developing ambulance and specialist vehicle specific IPC audits.
- Reviewing the process and compliance of audits for IPC.
- Developing an IPC area on the staff Hubara boards.
- Making IPC easily available to staff.

Environmental Innovation and Continuous Sanitisation Lighting Trial

The IPC Team has been working with an external company, NWAS Fleet and NWAS Estates colleagues to progress an innovative continuous sanitisation lighting trial. The technology uses a specific wavelength of visible light and is designed to help reduce background levels of bacteria, viruses and mould in occupied spaces.

As part of the trial, bespoke lighting has been developed for installation within:

- The ICC at Middlebrook
- An ambulance vehicle

This will help us understand whether this type of technology could have practical benefits within ambulance service environments, where shared spaces, high-touch

surfaces and continual use can make environmental cleanliness more challenging. Results of the trial will be fed back through the IPC Operational Group and a further business case will be developed should the group feel that the lighting should be utilised in more of the Trust premises. This work reflects the team's commitment to looking at new and practical ways to support infection prevention, alongside the cleaning and decontamination measures already in place.

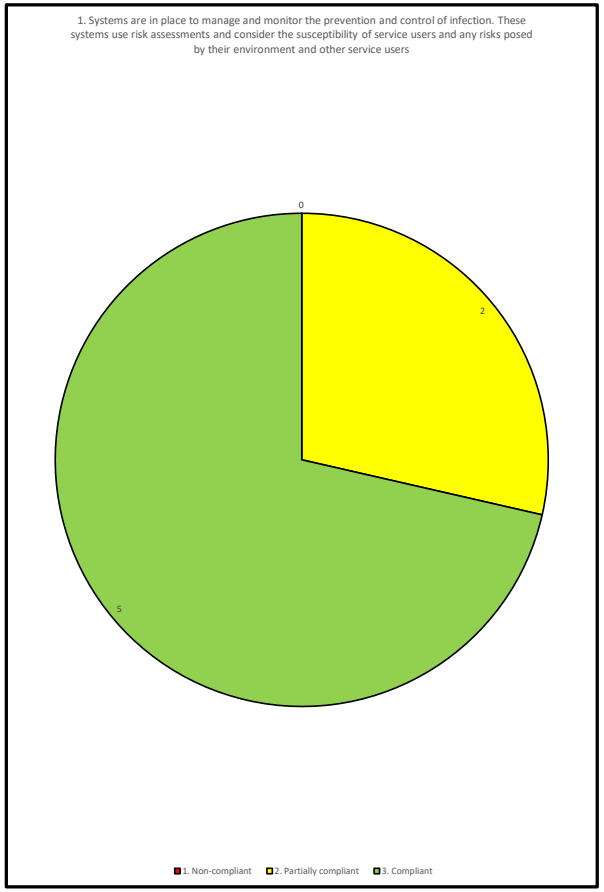
IPC Commitments 2026/27

The Trust will continue to maintain its regulatory compliance for IPC in line with the Health and Social Care Act in the forthcoming year, in addition to this the IPC team will align closely to the IPC annual workplan which includes the following ambitions.

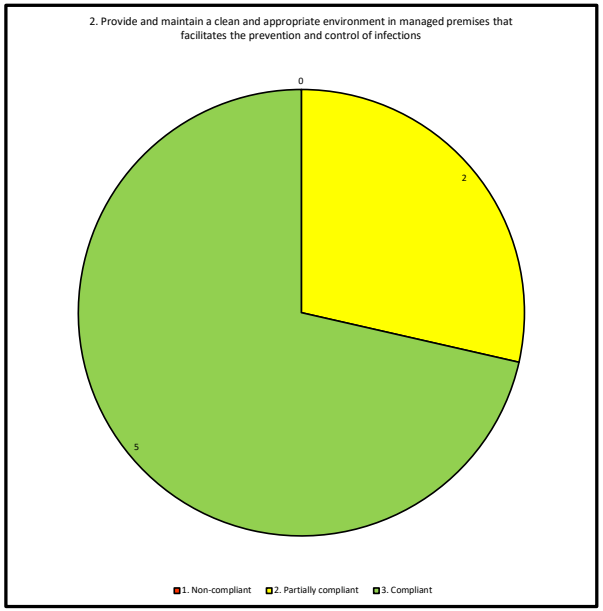
- Maintain high compliance (above 85%) with face fit testing offer across NWAS.
- In line with the Quality Plan view and improve compliance with the NHS England National Standards of Cleanliness and establish improved cleaning performance by applying functional risk categories to vehicles and Trust premises.
- Gain assurance that staff are completing required checks on their Powered Air Purifying Respirator (PAPR) equipment in line with COSHH and to ensure the equipment functions correctly when required.
- The IPC Specialist Lead will oversee the staff flu vaccination campaign for 2026/27 and will work alongside key stakeholders from Medicines Management, Human Resources, Communications and Operations staff to plan and deliver an effective vaccination campaign to maintain staff and patient safety.
- Collaborative working will continue with the Contracts Manager, Facilities Management, Fleet and cleaning contractors to ensure robust processes are in place to be compliant with the NHSE standards of cleanliness. To ensure IPC involved in contract tenders in relation to cleaning and waste disposal.
- Continue to build on strengthening relationships with partners outside of NWAS including UKHSA, Occupational Health, and IPC teams in other health care Trusts.
- Review IPC audit process in line with national guidance to ensure assurance is available that staff are compliant with IPC practice.
- Review and update training packages, resources, policies and procedures to reflect any changes in national IPC guidance.
- To provide development opportunities for all members of the IPC team to ensure they all are delivering best practice in a professional manner within their roles.

Infection Prevention and Control board assurance framework v4.0

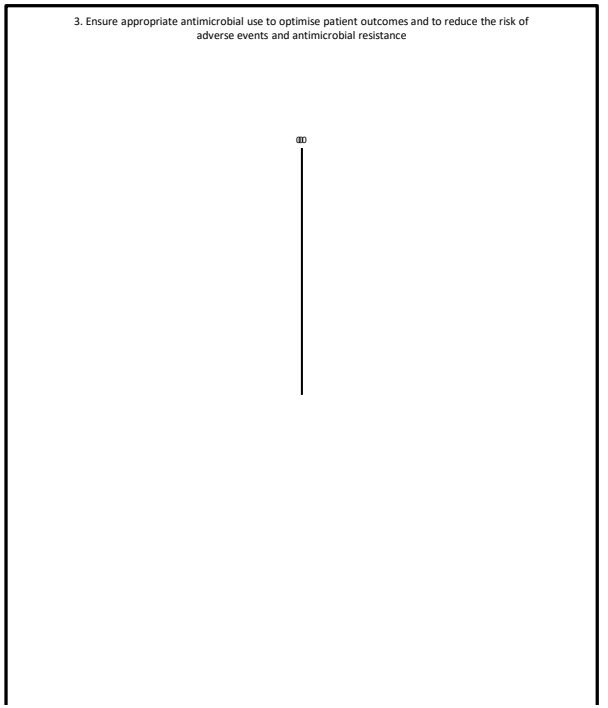
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may 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 Quarterly 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 6 monthly by IPCT 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. Techincal issues on safecheck addressed - just awaiting parameters for audits to be completed	Audits continue to take place and any issues directly escalated 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. Techincal issues on safecheck addressed - just awaiting parameters for audits to be completed	Audits continue to take place and any issues directly escalated to Ops staff		2. Partially compliant



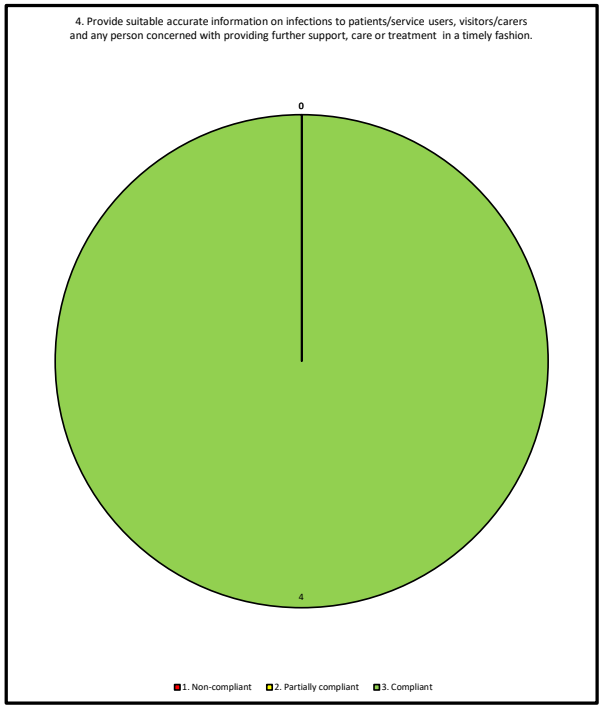
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All Trust staff, including those employed via temporary staffing and contractors receive IPC induction. All clinical staff require annual IPC training, non-clinical staff have bi-annual 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 common 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 all standards for premises. IPC Specialist Lead working with Fleet Logistics Manager to develop paper to be presented at IPC Oversight Group to get approval for derogation in line with AACE position statement on the NSoC for ambulance service..			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 now trained to complete audits - have more opportunity to complete audits as based on stations daily. To start in May 2026		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



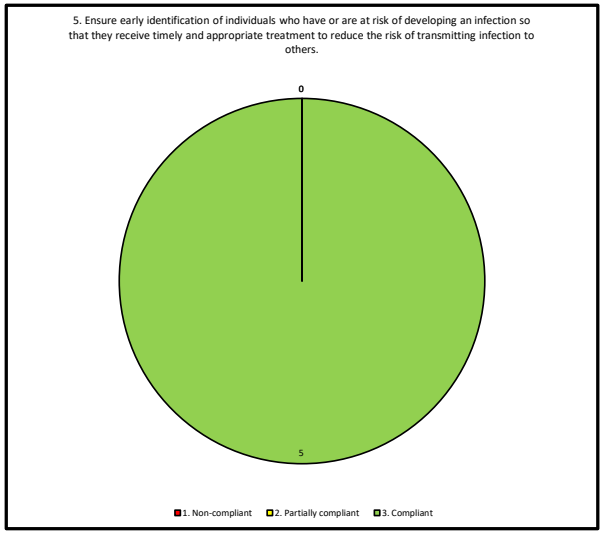
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Minimal linen is stored on vehicles, used linen is disposed of at hospital sites when conveying a patient. Linen 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.				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

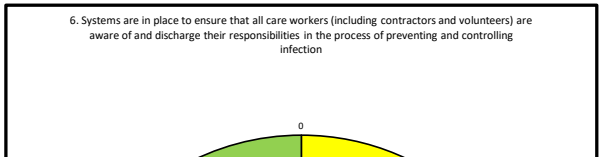


3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • 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.				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

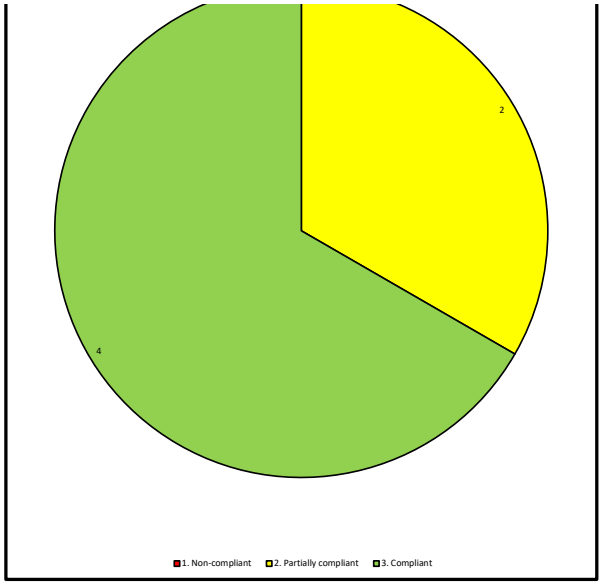


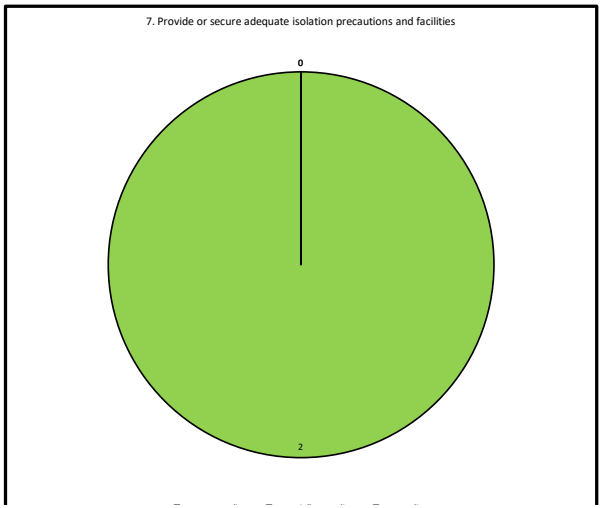
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	NWAS rely on information from patient/person reporting incident and also accurate handover for 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



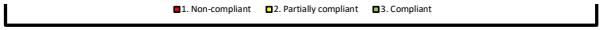


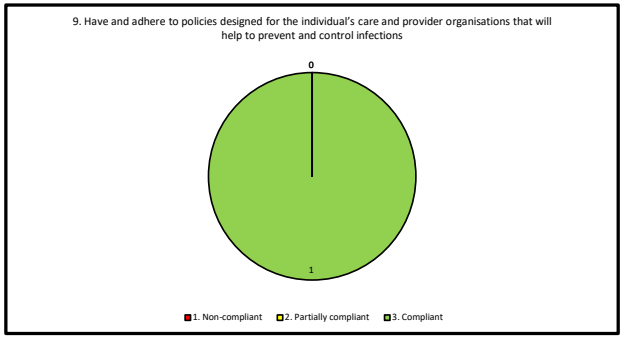
6.3	Monitoring compliance and update IPC training programs as required.	IPC training programmes are reviewed regularly and are updated with any changes in national guidance. Compliance with Mandatory Training is monitored closely by the Education Department. IPC monitor MT compliance as part of assurance 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 92% 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



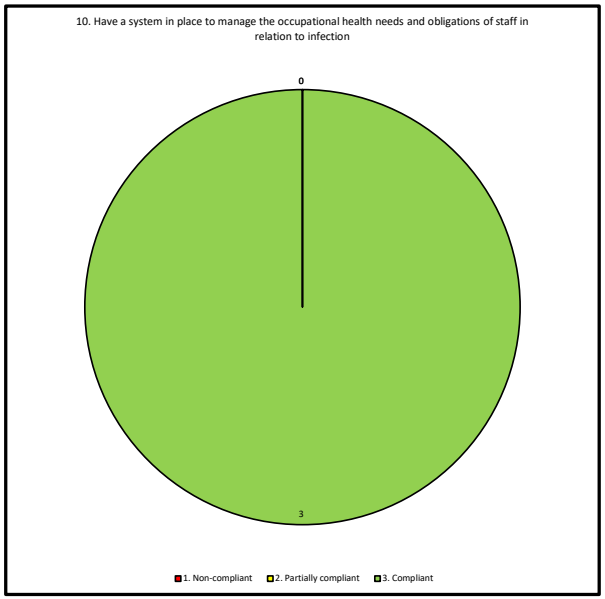


7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	N/A - NWAS do have processes in place to ensure admitting units are pre -alerted to patients who are suspected/known to have 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

ESCALATION AND ASSURANCE REPORT

Report from the Quality & Performance Committee				
Date of meeting	Monday, 22 June 2026			
Members present	Ms C Todd Ms A Cooper Mr G Chapman Mr D Ainsworth Dr C Grant Dr E Strachan-Hall	Non-Executive Director (Chair) Non-Executive Director Non-Executive Director Director of Operations Medical Director Director of Quality and Improvement	**Quorate**	Yes

Key escalation and discussion points from the meeting

ALERT:

- No alerts.

ADVISE:

- The Q&P Dashboard highlighted:
  - Complaints and incident reporting were broadly static whilst patient experience FFT improved for 111 in May but fell for PES and PTS.
  - January data showed a small improvement in Utstein, ROSC, STEMI and Falls bundle compliance.
  - PES response - May saw a deterioration in all categories although still within UEC standard of 25 mins for Cat2, which was attributed to higher volume and hot weather in later weeks of May.
  - Hear and Treat and See and Treat Percentages were broadly stable in May at 17.9% and 25.8% respectively
  - Metrics in the 111 were static in May.
  - In PTS unplanned activity fell in May although collection within 90 mins also fell.

- The Committee noted that NWAS was operating slightly below planned UEC trajectory in several areas. It was confirmed that mitigating actions were in place and a more detailed update would be provided at the next Q&P Committee meeting regarding resolutions and a look forward.

- The Committee received and recommended the onward presentation of the report to the Board of Directors the following annual reports:

  - Annual Complaints Report 2025/26

  - Quality Account 2025/26

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

- Controlled Drug Infection, Prevention and Control (IPC) Annual Report 2025/26 & IPC BAFs Annual Report 2025/26
- Safeguarding Annual Report 2025/26

ASSURE:

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

- Board Assurance Framework approved 2026/27 Opening Position
- Patient Safety Activity Bi-Annual report
- CQC Update
- EQIA Process Assurance Report
- Improvement Quarterly Report
- Clinical Audit Plan Q4
- Mental Health Annual Report 2025/26
- Debrief Policy

Extended discussions took place for each agenda item, with in-depth considerations including strategic continuous Trust-wide improvement, significance of demonstrable impact of organisational learning, aligning learning from audits, Learning from Deaths, complaints and patient experience as well as system-wide links and collaboration especially in terms of Mental Health report.

RISKS

Risks discussed:

- SR01

New risks identified:

- No new risks identified.

NHS
North West Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 29 July 2026
SUBJECT	Dashboard report: Communications, Engagement and Charity
PRESENTED BY	Mike Gibbs, Director of Strategy and Partnerships
PURPOSE	Assurance

STRATEGIC AIM(S)	All strategic aims							
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☐	**SR04**	☐
	SR05	☐	**SR06**	☐	**SR07**	☐	**SR08**	☐

Risk Appetite Statement *(Decision Papers Only)*	**Quality:** Cautious	☐	**People:** Open	☐	**Finance:** Open	☐
	Regulatory: Open	☐	**Reputation:** Open	☐	**Digital Innovation:** Eager	☐

ACTION REQUIRED	The Board of Directors is asked to note the contents of this report and discuss the impact of activities undertaken by the communications, patient engagement and charity teams.
EXECUTIVE SUMMARY	The communications, patient engagement and charity teams provide a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. The dashboard demonstrates how activity aligns with the aims of the our organisational strategy, and the positive impact it has on staff, patients, and partners. Comprehensive activity reports are provided to the Diversity and Inclusion Subgroup in relation to patient engagement work and the charity team provides regular updates to the Charitable Funds Committee, so this dashboard report gives just a visual snapshot of some key activities and the impact they have.
PREVIOUSLY CONSIDERED BY	

Date	
Outcome	

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

1. BACKGROUND

This report provides the Board of Directors with a summary of key outputs, impact and associated highlights on the work of the combined communications, engagement and charity teams for quarter one of the financial year 2026/27 (April to June 2026).

It demonstrates how the activity of the teams contributes to the strategic aims of our strategy.

2. DASHBOARD REPORT

The visual report groups the work delivered by each team eg Patient Engagement, Communications, and Charity.

Below we have provided a high-level summary of key work delivered across the teams under the headings of our strategic aims.

2.1 Aim: Provide outstanding, inclusive care for everyone we serve

The team strengthened patient voice, improved access to health information and helped turn community feedback into action.

Patient experience improved across all three reported measures. A total of 91.34% of respondents would recommend the service, 89.71% rated their overall experience positively and 93.23% agreed that they were treated with dignity, compassion and respect.

Nine community engagement events were attended, a 12.5% increase on the previous quarter. Activity focused particularly on communities that may experience barriers to accessing services, including migrant, deaf, transgender, Black, Asian and Chinese communities.

More than 210 people were reached through CPR engagement within Chinese communities, supported by the launch of Cantonese and Mandarin CPR resources. Feedback from the Sahara community has also led to a targeted cardiovascular health session addressing inequalities experienced by Black and minority ethnic communities.

Patient and community feedback is informing further work on British Sign Language support and public understanding of Patient Transport Service eligibility.

Charitable funding is strengthening cardiac arrest response and community resilience. A new 12-month project will fund two defibrillator officers and a cardiac arrest project lead to help bring offline defibrillators back into use.

The charity is also jointly funding seven defibrillators for organisations in areas with limited coverage. Fundraising in Cumbria has already enabled five community-

access defibrillators to be installed, with remaining funds supporting 12 Community First Responder kit bags and associated equipment.

Strategic areas of focus supported: patient experience, health inequalities, safety and effectiveness.

2.2

Aim: Build a safe, supportive and inclusive culture together

Targeted communications delivered the our most successful call-handler recruitment campaign to date.

Social media activity generated 1,391 applications across all sites, compared with a usual average of approximately 135. More than 1,000 people registered for the first candidate support session and a further 900 registered for the second, compared with the usual attendance of 50 to 100 people.

Internal activity also supported recognition, inclusion and organisational culture. Around 340 people attended the Star Awards, while our 20th-anniversary campaign has so far generated more than 50 nominations recognising colleagues who make a positive difference. Staff sent 597 digital thank-you cards (Express Mail), almost double the amount from the previous period due to a new prominent location on the Green Room.

Career profiles, staff network campaigns and content supporting Pride Month, Armed Forces Week, Learning Disability Week and the Potential Not Problems campaign increased the visibility of different experiences, careers and contributions across the service.

The charity provided £15,000 towards recognition events for staff and volunteers.

Strategic areas of focus supported: attraction and welcome, wellbeing, culture and inclusion, developing for the future, and leadership and management.

2.3

Aim: Deliver a responsive care model through partnerships

Partnership communications helped communities understand how to access the right support in an emergency and promoted public safety.

The team worked with the RNLI on hot weather and water safety content, generating more than 513,000 views and 11,600 engagements.

The Ambulance Awareness Day and wider community events provided practical education on CPR, NHS 111, when to call 999, mental health, knife crime, road safety and water safety.

Engagement with Healthwatch West Cumberland and Furness has initiated joint work with Patient Transport Service colleagues in response to recommendations about public awareness of PTS eligibility.

Partnership activity with community first responders, educational organisations, local community groups, Healthwatch and public health colleagues extended the reach of health information and supported more tailored communication with different communities.

The frailty and alternative pathways podcast also helped staff understand options for supporting patients safely within the community.

A partnership started in 2025 with Blues and Two Credit Union to donate seven defibrillators to organisations without coverage is being delivered for the second year. The charity will 50% match fund the contribution from Blues and Twos. Following an application process, the seven devices will be allocated to organisations in 'hot spot' areas.

Strategic areas of focus supported: contact, assessment, response and partnership working.

Aim: Embed continuous improvement and innovation for a sustainable future

2.4

The launch of the new staff intranet (Green Room) delivered a significant digital shift in how staff find information and access workplace tools.

Since its April launch, the Green Room has recorded more than 1.92 million visits from 7,870 unique viewers. Its task-based navigation allows staff to find information without needing to understand the trust's organisational structure. The most used areas include tools and systems, the HR portal and professional boundaries information.

The team also delivered a communications campaign supporting the launch and embedding of the new organisational strategy, including accessible documents, films, animations, briefings, digital assets and frequently asked questions.

Twenty five CQC briefings were produced to increase staff understanding of services and responsibilities across the organisation.

Film production increased from six completed films in the previous quarter to 24 this quarter.

A new communications protocol has strengthened governance by clarifying which channels should be used, when specialist support is needed and how teams can reach audiences effectively without creating unnecessary or duplicative channels.

The charity generated £184,000 in restricted and unrestricted income during the quarter, providing additional funding for patient, community and staff benefits beyond core NHS provision.

Community-led fundraising included more than £18,000 from Zack Kerr's charity football match, alongside income from challenge events, raffles and staff-led campaigns.

Strategic areas of focus supported: digitally enabled, improvement focused and value for money.

2.5 **Open, transparent and accountable**

Alongside activities that align to our strategic aims, the team delivered a substantial workload that is either statutory or supports transparency and accountability.

The team managed 92 media statements and briefings, supported 11 broadcast interviews and delivered 29 proactive stories against a quarterly target of 16. This included preparation for the Southport Inquiry report and management of several complex and sensitive reputational issues.

A total of 120 Freedom of Information requests and 16 MP letters were managed, alongside briefings, overview and scrutiny committee activity and correspondence with political and public sector stakeholders.

Strategic areas of focus supported: safety, health inequalities, wellbeing and culture, partnership working, and value for money.

3. RISK CONSIDERATION

There is a risk that feedback from patients, communities and panel members is not consistently used to inform service improvement, resulting in patients and communities feeling their involvement does not lead to change, thus reducing trust and future participation.

To mitigate this, our annual objectives strengthen links between engagement activity and service teams, improve access to feedback and identify barriers to turning insight into action.

There is a risk that high volumes of organisational change, operational pressure and competing messages may lead to communication overload, resulting in disengagement from key messages. To mitigate this, internal channels are constantly reviewed against analytics, and stronger channel governance will be introduced in 2026/2027, along with the communications protocol published in this reporting period to clarify we share key messages.

There is a risk that awareness of the charity's role and impact may remain limited among staff, supporters and local communities, which could reduce engagement and income. To mitigate this risk, the charity is strengthening its communications through regular newsletters, social media planning, supporter stories and closer alignment with trust-wide campaigns and events.

4. EQUALITY/ SUSTAINABILITY IMPACTS

All of our communications, engagement and charitable activities seek to promote diversity and ensure information is accessible to all.

Quarter one activity included targeted work with communities where language, confidence, health inequalities or understanding of ambulance services may affect access to care – see the patient engagement section for details.

Communications, Engagement and Charity Quarterly Report

Q1 2026/27 (April, May and June 2026)

NHS North West Ambulance Service NHS Trust

This report summarises the work of the Communications, Patient Engagement, and Charity teams, which play a vital enabling role by working in partnership with services and departments to support the achievement of our shared strategic goals and objectives. Through clear and consistent communication, meaningful engagement with patients and the public, and the development of charitable initiatives that enhance care and experience in our communities, our work helps to amplify, inform, and connect efforts of colleagues across the organisation to meet the strategic aims.

Provide outstanding, inclusive care for everyone we serve

Listening to our communities

Attended 9 events, including: Manchester Migrant Support group, Preston and Burnley Health Melas, Preston Caribbean Festival, Eid Extravaganza event, National Transgender Charity 'Sparkle' weekend and Hopwood Hall College community fun day.

Engagement focused on communities which may face barriers to accessing health information. It improved awareness of ambulance services, increased access to lifesaving skills and helped identify opportunities to make services more inclusive.

Our fourth Ambulance Awareness Day, held at The Lowry in Manchester, brought together operational teams, volunteers, students and local residents. Attendees learned CPR, when to call 999, how to use NHS 111 and how to stay safe in relation to knife crime, mental health, water and roads.

Listening activity also led to practical follow-up, for example:

- Concerns raised by the Silent Voices group informed work to improve BSL support for patients conveyed to hospital.
- Feedback from the Sahara BME community resulted in a bespoke cardiovascular health session being arranged for August.

More than **210** people were reached through engagement linked to the CPR Card initiative, with resources in Cantonese and Mandarin to improve access to life-saving information. This will be expanded into additional under-represented communities to address challenges relating to language barriers.

Patient and staff stories

A filmed staff story was shared with the Board. Non-Fatal Overdose Pathway Practitioner Rhys Ash describes the non-fatal overdose pathway and why it's important to refer patients who have overdosed to their local drug service. This helps a cohort of patients that are often overlooked get the care and support they need.

Patient feedback surveys

Surveys are sent to 1% of patients. Our Q1 return rate was 6.5%.

In Q1, **91.34%** of respondents would recommend the service.

89.71% rated the overall service received as 'very good/good'. Broken down by service:

PTS - 91.19% - "Same crew on the return journey; cheerful, efficient, comforting, and highly professional. Couldn't praise more highly."

PES - 91.24% - "The paramedics were lovely and very professional. They reassured us that they would be around should we need them."

111 - 86.98% - "My call was answered quickly, dealt with sympathetically and help offered immediately."

Patient and Public Panel membership

252 total members - 2 new members this quarter

35% Youth representation (target 30%)

37% Ethnic diversity representation (target 40%)

6 New requests for involvement

12 Structured/task-based sessions delivered

Involvement opportunities including the Right Care Steering Group, AI-assisted call triage project, and contirbutions to the Quality Improvement programme.

Charity impact

Charitable funding is strengthening cardiac arrest response and community resilience.

A new 12-month project will fund two defibrillator officers and a cardiac arrest project lead to help bring offline defibrillators back into use.

Cardiac arrest response in Cumbria was strengthened using **£17,000** raised by one family. Five community public access defibrillators have been installed, with a further **£8,000** funding **12** Community First Responder kit bags and essential consumables.

Build a safe, supportive and inclusive culture together

Recruitment drive

Targeted communications delivered our most successful call-handler recruitment campaign to date.

Creative and strategic social media content generated **1,319** job applications across all sites, compared with a usual average of approximately 135.

More than **1,900** people registered for two online candidate support sessions, compared to the usual attendance of 50-100 people.

Celebrating staff

Star Awards

- Delivered the 2026 Star Awards for **340** attendees
- Presented eight peer-nominated awards and a Stand Out Moment award recognising the response to an RTC involving NWAS colleagues.
- In-house production of **9 films** and a suite of graphics created a consistent, engaging experience while reducing external costs.

Showcased career development

- Published career journey profiles demonstrating the breadth of roles and progression opportunities available across NWAS.

Celebrating 20 years

- Built engagement around NWAS's 20th anniversary
- Generated more than **100** staff photo submissions and over **50** nominations for the '20 for 20' recognition campaign, with three colleagues celebrated so far.
- Produced a 'looking back' film

Express Mail - staff recognition cards

597 digital thank you cards were sent -almost double from the previous quarter, thanks to a new prominent location on the Green Room.

Inclusivity and wellbeing

- Produced staff stories and social media content, and supported events relating to: Pride Month, Armed Forces Week, Learning Disability Week and the Disability Network's 'Potential, Not Problems' campaign.
- One example of this - a video with Dan Smith about Allyship - reached **2200** people on the staff Facebook page, gaining **87** likes.
- Developed an identity for Beacon - the new health and wellbeing hub.

Charity impact

The charity invested **£15,000** in staff and volunteer recognition, helping celebrate the contribution and achievements of colleagues.

Strategy launch

Delivered an accessible, multi-channel package, including an full strategy brochure, poster, pop up banner, QR code postcards, desktop background, press release, CEO message, **6 films** including a director introduction and summary animations of the strategy and strategic plans, supporting social media posts for internal and external audiences.

Collaborated with strategy team on FAQs and briefing pack and liaised with external suppliers on design, printing and an accessible website version.

In the first month,

- The Green Room page was viewed **933** times
- The website (public) was viewed **1,050** times
- The animation was viewed **386** times
- The director intro was viewed **212** times
- Facebook post (public) had **23,800** views

Day-to-day staff comms

Email bulletin engagement

When a colleague has opened an email or clicked a link in the past 30 days, they are an 'engaged contact'. At the end of Q1, the percentages of engaged staff were:

- Corporate and support – 88% (was 91%)
- Emergency – 92% (was 95%)
- Integrated Contact Centres - 75% (was 84%)
- PTS – 72% (was 79%)

Engagement has dropped this quarter. We believe this is due to changes to how we add and remove contacts to auto-sync with Active Directory. We have also introduced the new Green Room where updates appear first, before being issued on email.

Email bulletin views

Views (or 'displays') are counted when an email is opened and images are downloaded, which requires staff to click to allow. It's fair to assume that more staff read the emails than the display figures suggest.

Benchmark: Our platform provider e-shot advises that an average display rate across its public sector clients is 44%

The Bulletin display rates:

Highest: 60% Average: 52% Lowest: 43%

Bulletins with a higher-than-average display rate covered topics including:

- EMT and paramedic apprenticeships
- Star awards winners

CEO Message display rates:

Highest: 57% Average: 56% Lowest: 56%

Connected display rates:

Our managers update is one of our best read email bulletins with a **72%** display rate.

Better Health, Better You display rates:

Highest: 49% Average: 47% Lowest: 46%

Deliver a responsive care model through partnerships

Promotion through partnerships

Partnership communications helped communities understand how to access the right support in an emergency and promoted public safety.

We worked with the RNLI on hot weather and important water safety content, generating more than **513,000** views and **11,600** engagements across our social media channels.

Engaging together

Our Ambulance Awareness Day and attendance alongside partners at the 9 wider community events provided practical education on CPR, NHS 111, when to call 999, mental health, knife crime, road safety and water safety to hundreds of members of the public.

Engagement with partners has led to positive change. For example: Healthwatch West Cumberland and Furness has initiated joint work with Patient Transport Service colleagues to raise public awareness of PTS eligibility.

Charity impact

We have expanded access to lifesaving equipment in areas of greatest need through a second-year partnership with Blues and Twos Credit Union.

Seven defibrillators will be allocated to organisations in identified hotspot areas, with the charity match-funding 50% of the contribution.

Operational communications

Our day-to-day communications supports a responsive care model by promoting partnership working and public health and helping to provide operational staff with the information they need to do their job.

For example, a podcast recorded with the Urgent and Emergency Care Team about frailty and alternative pathways helps to explain options for supporting patients in the community.

Partner communications

Correspondence with partners, including MPs and other health trusts, this quarter has included:

- 16 MP letters on topics including taxi use for 999 calls, ambulance delays, PTS eligibility, hospital conveyance, estates and recruitment.
- Letters to congratulate KAM recipients
- A letter to GM deputy mayor about a dog attack on a paramedic and a police investigation
- A letter to Women's Rights Network stating NWAS position re: Pride parades.
- The Quality Account was shared with Overview and Scrutiny Committees (OSCs) for feedback. Attendance was arranged and a presentation prepared for Cumberland OSC.

Embed continuous improvement and innovation for a sustainable future

Digital comms improvements

A new Green Room

Following feedback from staff and months of development, our new SharePoint intranet launched in April. Since then, it has had:

- **1.92 million** visits
- from **7,870** users

Its task-based navigation allows staff to find information without needing to understand the trust's organisational structure.

Other highlights include an enhanced search function, take a tour feature to learn about the homepage, new on call and on duty section, a locations section complete with station photos, a people and teams directory and a personalised dashboard which displays content a user can 'save for later'.

Anecdotally, we have received excellent feedback from staff using the new site with content and information much more visible than the previous version of the site. This has encouraged more engagement from teams and departments requesting space to share resources, updates and team responsibilities.

Next steps include expanding the patient care section to appeal to emergency service staff, digitising manual forms, and ensuring a seamless experience on iPads used by frontline staff.

More short-form video

Our 2025 internal comms audit told us staff would like to see more short-form video content on topics that matter most to them.

Film production increased this quarter from six to **24**, covering topics from strategy to Star Award nominees.

Improvement stories

Stories of continuous improvement featured in our communications this quarter. For example:

- News of the MAMAs improvement project being shortlisted for an award
- **25** CQC 5-minute briefings - including one dedicated to the NWAS improvement approach - were issued over the quarter to build awareness of services, functions and responsibilities across the trust.

Charity impact

£184,000 of income was generated during the quarter, providing additional funding for patient, community and staff benefits beyond core NHS provision. Community-led fundraising included more than **£18,000** from Patient and Public Panel member Zack Kerr's charity football match, alongside income from challenge events, raffles and staff-led campaigns.

Making a difference everyday

Alongside activities that align to individual strategic aims, the team delivers a substantial and significant workload that:

- promotes transparency and accountability
- supports the day-to-day operations of the organisation, by promoting public health and awareness of where to go for heath care support and advice
- ensures readiness for warning and informing in the event of a major incident

Freedom of Information (FOI)

We have a statutory duty to reply to 90% of FOIs within 20 working days and an internal stretch target of 95%.

120 FOIs were received in Q1 (-4%)

97% compliance year-to-date against 20 day target

Topics included: IT systems, policies and workforce info

Publications

A bumper edition of Your Call was issued with:

- 12 staff and volunteer stories including a special 20 years as NWAS piece and a write up of our Star Awards 2026.
- 3 Your Call stories have been shared on social media gaining over **401k** views and **43k** engagements.
- The magazine has been read online more than **900** times.

Press and public relations

92 incident checks handled

18 statements prepared in response to enquiries

11 positive broadcast media opportunities secured

29 proactive stories issued, against our target of 16

Press office activity in Q1 included preparation for the publication of the Southport Inquiry report. We handled enquiries relating to the death of a patient in Wigan and a connected Patient Safety investigation. There was national reporting about a former paramedic facing serious criminal allegations.

We secured positive coverage on the trust's 20th anniversary, and arranged media interviews about the recent heat, with an emphasis on health messages.

Social media stats

Having a large and engaged social media audience allows us to reach more people with important health messaging, and warning and informing in the event of a major incident.

109,700 Facebook followers
67,800 X (Twitter) followers
23,500 Instagram followers
14,000 LinkedIn followers

Audience growth +2.1%

Engagement

345 posts published on all channels (+78%)

13 million post views (+170%)

605,096 engagements (comments, likes, retweets, shares etc) (+175%)

4.6% engagement rate (+2.1%)

1.1 million reel/video views (+56%)

Significant increases compared to last quarter were driven by successful campaigns including World Cup health messaging, promotion of Your Call stories, and, in particular, the call handler recruitment campaign.

NOTE

'Post views' the number of times our content may have been seen by a member of the public

'Engagements' include all interactions with a post such as comments and shares.

'Engagement rate' shows us the number of interactions our content receives per follower

Charity social media stats

860 Facebook followers
439,000 post views (+220%)
1,300 engagements (+42%)

712 Instagram followers
23,300 post views (-3%)
381 engagements (-52%)

455 LinkedIn followers
11,700 post views (+17%)
300 engagements (+20%)

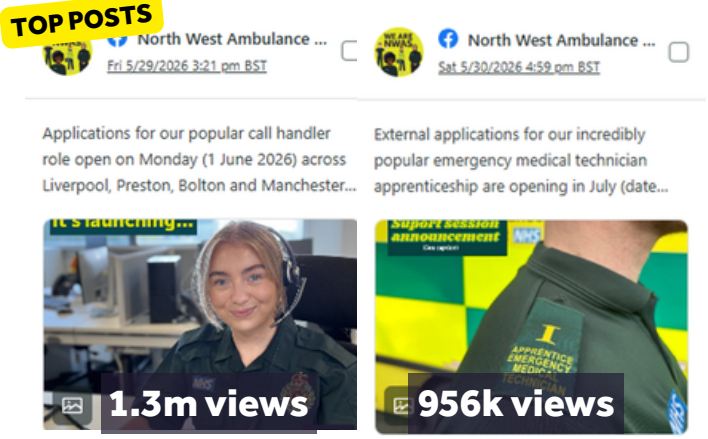
3 newsletters with fundraising news and supporter stories were issued this quarter to our internal and external mailing lists.

Our external (public and stakeholder) mailing list has **646** subscribers with an average open rate of **48%** which is higher than the charity industry average at 28%.

Internal email open rate is **49%**

Social media and newsletter content this quarter included Zack's charity football match, which raised £18,000. This generated the increase in Facebook reach and engagement.

TOP POSTS



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.