

AGENDA



Board of Directors
Wednesday, 30th September 2026
9.45am – 12:45pm
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
PATIENT STORY				
BOD/2627/065	Patient Story	09:45	Information	Chief Executive
INTRODUCTION				
BOD/2627/066	Apologies for Absence	10:00	Information	Chair
BOD/2627/067	Declarations of Interest	10:00	Decision	Chair
BOD/2627/068	Minutes of the previous meeting held on 29 th July 2026	10:00	Decision	Chair
BOD/2627/069	Board Action Log	10:05	Assurance	Chair
BOD/2627/070	Committee Attendance	10:05	Information	Chair
BOD/2627/071	Register of Interest	10:05	Assurance	Chair
STRATEGY				
BOD/2627/072	Chair & Non-Executive Directors' Update	10:10	Information	Chair
BOD/2627/073	Chief Executive's Report	10:20	Assurance	Chief Executive
GOVERNANCE AND RISK MANAGEMENT				
BOD/2627/074	Mid-Year Confidence Assessment	10:35	Decision	Director of Strategy and Partnerships
BOD/2627/075	Provider Capability Assessment	10:45	Decision	Director of Strategy and Partnerships
BOD/2627/076	Resources Committee 3A report from the meeting held on 24 th September 2026	10:55	Assurance	Mr N Gower, Non-Executive Director
BOD/2627/077	Trust Management Committee 3A reports from the meetings held on 19 th August and 23 rd September 2026	11:00	Assurance	Chief Executive



PEOPLE

BOD/2627/078	Future Workforce Solution	11:10	Decision	Director of People
BOD/2627/079	Disciplinary Policy and Fast Track Disciplinary Procedure Review	11:20	Decision	Director of People
BOD/2627/080	2026/27 Flu Campaign	11:30	Assurance	Director of People

BREAK 11:40 – 11:50

QUALITY AND PERFORMANCE

BOD/2627/081	Integrated Performance Report	11:50	Assurance	Director of Quality and Improvement
BOD/2627/082	2026 Winter Assurance Plan	12:10	Decision	Director of Operations
BOD/2627/083	Emergency, Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance	12:20	Assurance	Director of Operations
BOD/2627/084	Learning from Deaths Q4	12:30	Assurance	Medical Director
BOD/2627/085	Quality and Performance Committee 3A report from the meeting held on 7 th September 2026	12:40	Assurance	Ms C Todd, Non-Executive Director

CLOSING

BOD/2627/086	Any other business notified prior to the meeting	12:45	Decision	Chair
BOD/2627/087	Risks Identified	12:45	Decision	Chair

RISK APPETITE CONSIDERATION (Refer to the Risk Appetite Statement)

Quality: Cautious	People: Open	Finance: Open	Regulatory: Open	Reputation: Open	Digital Innovation: Eager
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DATE AND TIME OF NEXT MEETING

25th November 2026 at 09:45 am in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Exclusion of Press and Public:

In accordance with Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.



Minutes Board of Directors

Details: 9.45 am Wednesday, 29th July 2026
Oak Room, Ladybridge Hall, Trust Headquarters

Ms J Mulligan	Chair
Mr S Desai	Chief Executive
Mr C Butterworth	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:

None

Minute Ref:

BOD/2627/039 Patient Story

The Chief Executive introduced a film, which referred to the patient story featuring Linzi, who shares her family's experience following the emergency care provided to her eight-year-old daughter, Ivy-Mae, after she experienced breathing difficulties.

Linzi reflects on the distressing experience of her daughter Ivy-Mae becoming unwell and being transferred to hospital, describing the fear and uncertainty her family faced during a particularly vulnerable time. While grateful for the care provided by the GP and hospital staff, the family felt that the seriousness of Ivy-Mae's condition and their concerns were not fully recognised by the ambulance crew. The investigation identified important learning opportunities relating to compassionate communication, thorough respiratory assessment, accurate documentation, and adherence to clinical guidelines. By sharing her family's experience, Linzi hopes to help improve care for other children and families,

highlighting the importance of listening to patients and families with empathy, respect and compassion alongside delivering safe and effective clinical care.

The Board noted the learning points from the story:

- Reinforcing the importance of compassionate, respectful and professional communication with patients, families and partner healthcare professionals.
- Ensuring the concerns of patients, relatives and referring clinicians are listened to, acknowledged and responded to appropriately.
- Reinforcing the need to complete and document comprehensive respiratory assessments for patients presenting with breathing difficulties.
- Promoting consistent application of clinical guidelines with care and sensitivity when assessing and managing respiratory conditions, including the appropriate use of oxygen and nebulisers.
- Supporting reflective learning with the clinicians involved to reinforce professional standards, compassionate care and patient-centred practice.
- Providing additional education and training to strengthen respiratory assessment, clinical decision-making and the care of patients experiencing respiratory distress.

The Director of Corporate Affairs linked the patient story to the Complaints Annual Report later on the agenda, noting that professional standards had been identified as a key theme of complaints.

The Director of Quality and Improvement highlighted the incident as a significant near miss and noted the learning arising from it in relation to Jess's Rule and Martha's Rule.

The Board noted that Jess's Rule encourages clinicians in primary care to review and reflect when a patient presents repeatedly with the same issue, while Martha's Rule enables patients, families and carers to request an urgent review if they feel a patient's condition is deteriorating in the hospital setting.

Ms C Todd reflected that the issues raised extended beyond the individual case, noting a theme of staff failing to recognise what is 'the normal' for a patient, which was also evident in complaints. She proposed that a wider review of the systemic issues be undertaken and reported to the Quality and Performance Committee for further scrutiny and discussion.

Ms C Butterworth queried whether there were lessons for primary care colleagues arising from the incident and, if so, whether these had been shared. She observed that weaknesses can sometimes occur at the interfaces between sectors. The Chair sought assurance regarding the wider process for sharing learning with partner organisations.

The Medical Director advised that teams would ordinarily work with external partners and adopt a multidisciplinary approach where learning should be shared, although the immediate priority was to address internal learning. He was

confident that the team would have engaged with primary care colleagues as part of the investigation but agreed to confirm this and report back.

Ms A Cooper referred to the challenges of diagnosing respiratory conditions via telephone consultation and queried whether this represented a wider clinical issue. The Medical Director advised that there had historically been categorisation challenges within the previous triage system; however, these had been addressed through the implementation of the Pathways system. He noted that work continued to strengthen triage arrangements and the management of respiratory symptoms.

The Chief Executive emphasised that, whilst clinical considerations remained important, the principal focus of the patient story was staff conduct, professionalism and compassion.

The Board:

- Noted the content of the story.

BOD/2627/040 Apologies for Absence

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

BOD/2627/041 Declarations of Interest

The Chair advised an amendment to the Board Register regarding the end date of her engagement with the Police Leadership Commission, which should read 7th of July 2026.

All standing declarations were recorded in the Register.

BOD/2627/042 Minutes of the Previous Meeting

The minutes of the previous meetings, held on held on 27th May 2026 were agreed as a true and accurate record of the meeting with one amendment: addition of the Director of Finance to the attendance list.

The Board:

- Approved the minutes of the meeting held on held on 27th May 2026.

BOD/2627/043 Board Action Log

The Director of Quality and Improvement provided an update on action 12-25/26 regarding the planned session with Non-Executive Directors to discuss the Integrated Performance Report (IPR), confirming that the session had been scheduled for August.

The Chair welcomed the update and expressed a wish to attend the session, subject to availability.

BOD/2627/044 Committee Attendance

The Board noted the Committee attendance.

BOD/2627/045 Register of Interest

The Board noted the Register of Interests presented for information.

BOD/2627/046 Chair & Non-Executives' Update

The Chair reported on her attendance at the Greater Manchester Long Service Awards, describing the event as both inspiring and a valuable opportunity to hear about careers that had made a significant difference to patients and communities.

The Chair thanked Board members for their continued engagement in the ongoing Board development programme, including the joint development session and subsequent follow-up sessions.

The Chair formally recorded the Board's thanks to Mr G Chapman, former Non-Executive Director and Chair of the Resources Committee, following his recent departure from the Trust. She advised that a letter of thanks had been sent on behalf of the Board in recognition of his service and contribution to the Trust.

The Board noted that Mr N Gower had agreed to chair the Resources Committee on an interim basis while recruitment to the Non-Executive Director vacancy was underway. The Chair added that the Trust's Non-Executive Director induction arrangements were also being reviewed.

The Chair congratulated the Director of People on being shortlisted for the People Leader of the Year Award at the Healthcare People Management Association (HPMA) Excellence in People Awards 2026.

On behalf of the Chair, Ms A Cooper reported on her attendance at a Chairs' meeting during the Chair's period of leave, noting that care closer to home had been a key topic of discussion.

Ms A Cooper also reported on her attendance at the NHS ConfedExpo in Manchester, which provided valuable opportunities to network with colleagues from partner organisations. She highlighted a session on Advanced Foundation Trust status, noting that a recording was available and recommending it to Board members.

Ms A Cooper further advised of a visit to Cumbria ambulance stations with the Area Director, which provided greater insight into the varying operational contexts across NWAS regions. She noted the strong integration of the Cumbria sector with local communities.

Ms A Cooper also reported on a visit to the Integrated Contact Centre, where she met with staff and discussed current challenges.

Finally, Ms A Cooper advised that work was underway to establish a network for Non-Executive Directors across ambulance trusts.

Ms C Todd reported on her attendance at an R Click meeting, which had provided an opportunity to gain a greater understanding of the system's development journey.

The Board:

- Noted the Chair and Non-Executive Directors 'updates.

BOD/2627/047 Chief Executive's Report

The Chief Executive presented a comprehensive report covering activity from 23 May – 22 July 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 a reminder that the day marked two years since the Southport Incident and noted that the thoughts of the Board members and staff were with the families of the victims, who will never be forgotten.

The Chief Executive took the Board through the internal updates highlighting the following:

- The Trust has successfully submitted Data Security and Protection Toolkit (DSPT). 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.
- 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.
- Launch of a new platform – Thrive – to support Continuing Professional Development.
- 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.
- NWAS was selected as an early adopter of the Future Workforce Solution (FWS) 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.
- 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.
- Susie Rhind of the Quality Directorate received a Royal College of Paramedics Fellowship on 21 July at the Royal College of Paramedics Awards.

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

Moving on to national and regional updates, the Chief Executive highlighted the following information:

- NHS England 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. 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.
- 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 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.
- National maternity 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.
- NHS England is introducing a new NW Performance Accountability Framework (PAF) as the main approach for regional oversight and assurance. There will be four levels of oversight as detailed in the report. Movement between oversight levels will be evidence-based, with clear escalation and de-escalation criteria. Implementation will be phased over the next 12 months.

Moving to the organisational updates, the Chief Executive highlighted the Trust had been selected as one of 16 organisations in tranche 2 to be assessed for Advanced Foundation Trust status, which will give the organisations more freedom to make decisions locally to improve services for our communities. The meeting commencing the preparations would take place the next day and the Director of Strategy and Partnerships as well as the Director of Corporate Affairs will be in attendance.

The Board also noted that NWAS had 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.

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

Mr N Gower sought clarification on the new North West Performance Accountability Framework and how it differed from the national framework. The Chief Executive explained that the framework reflected historical changes in responsibilities, with functions being moved to the region which would enable stronger and consistent alignment across the North West.

Mr Gower queried whether the framework would cease following the integration of NHS England. The Chief Executive advised that the regional teams would continue to undertake this function.

The Chair asked how widely the Level 1 to Level 4 framework was adopted nationally. The Chief Executive advised that he was unable to comment, as the Trust had only recently received its own framework. The Chair noted her experience of similar regimes, observing that while they could be challenging, they provided useful structure and clarity.

The Director of People advised that the Trust had already been working with the North West region which is ahead of others in articulating the new framework. It also broadened oversight beyond workforce issues to include financial impacts and wider workforce and culture matters. Oversight by the region would be quarterly and organisations could be escalated solely on the basis of workforce-related concerns.

Ms C Todd referred to the newly introduced Staff Standards, noting that they would form part of the national operating framework, and asked how performance against them would be reported. The Director of People advised that a detailed report had been presented to the Resources Committee earlier in the month. Performance would be measured primarily through Staff Survey results, with a further report due to the Committee. Reporting would subsequently reduce to an annual basis, reflecting the Staff Survey cycle.

The Director of People also reported that the Trust had been recognised in the Sunday Times Top 100 Apprenticeship Employers list for a second consecutive year.

In relation to the Future Workforce Solution programme, the Director of People advised that confirmation had been received that the programme would progress to the next phase, with significant funding approved and key deadlines extended. A report would be presented to the Board in September, with governance oversight through the Corporate Programme Board.

Ms C Butterworth thanked the Executive Team for the recent briefing provided to Non-Executive Directors on the Advanced Foundation Trust process. She observed that the process appeared highly mechanistic and driven by fixed timelines. She suggested that, depending on the outcome of the Trust's internal diagnostic, flexibility regarding the proposed February assessment date may be beneficial and queried whether concerns regarding the rigidity of the process should be raised.

The Chief Executive advised that he was unable to provide an immediate response, as the programme kick-off meeting was scheduled for the following day and would be attended by the Director of Strategy and Partnerships and the Director of Corporate Affairs. He noted that further clarity regarding the degree of flexibility within the timetable would be available following that meeting.

Ms A Cooper observed that the process could be viewed in two ways: as a mechanism solely to achieve accreditation or as an opportunity to drive organisational improvement and development.

The Director of Strategy and Partnerships advised that, although formal timelines had not yet been confirmed, the Trust's internal diagnostic work was already underway.

The Chair requested an update following the kick-off meeting, including details of the anticipated timetable and the scale of work required.

The Board:

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

BOD/2627/048 Board Assurance Framework Q1 2026/27

The Director of Corporate Affairs presented the Quarter 1 (Q1) 2026/27 review of the Board Assurance Framework (BAF) and associated Corporate Risk Register (CRR) risks scoring 15 or above.

She highlighted the proposed changes to two strategic risks:

- SR03 (Urgent and Emergency Care Performance) increase from a score of 10 to 15
- SR08 (Cyber Security) decrease in risk score from 20 to 15.

The Board noted that a detailed discussion of Strategic Risk 08 (SR08) had taken place at the Resources Committee and that further consideration would be given to the matter during the Part 2 session.

Ms C Todd noted that whilst the Quality and Performance Committee had considered Strategic Risk 03 (SR03), the associated increase in risk score had not been reported at its most recent meeting in June. The Board noted that this was due to the timing of the Committee meeting and the subsequent Board Assurance Framework review.

The Director of Strategy and Partnerships sought clarification on the relationship between the increased SR03 risk score and the potential impact on delivery of the Annual Plan.

The Chief Executive advised that there was currently no identified risk to delivery of the Annual Plan, although the position would require ongoing assessment. The Area Director added that the matter was being actively monitored and that further analysis would be presented to Trust Management Committee in August.

The Chair noted that more detailed strategic analysis of the implications of Urgent and Emergency Care (UEC) performance would be considered by the Quality and Performance Committee and reported back to the Board through the committee Chair's report.

The Board:

- Approved the Q1 position of the Board Assurance Framework 2026/27.

BOD/2627/049 Health, Safety, Security and Fire Annual Report 2025/26

The Director of Corporate Affairs presented the Annual Health, Safety, Security and Fire Report 2025/26.

The Board noted that 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.

The Director of Corporate Affairs reported the performance indicators demonstrated 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.

The Chair thanked the Director of Corporate Affairs for the report and advised that they had discussed the future positioning of the report, with a view to it being considered initially by a Committee, before submission to the Board.

Ms C Todd welcomed the report, describing it as a strong document providing a good level of assurance.

The Director of Corporate Affairs confirmed that the Health, Safety, Security and Fire Group received detailed performance data and that the Board report had been summarised to focus on key themes appropriate for annual Board assurance.

The Director of Strategy and Partnerships noted the improvement in compliance with statutory reporting timescales, with 75% of RIDDOR submissions made

within the required Health and Safety Executive reporting timeframe. He queried why compliance was not closer to 100%.

The Director of Corporate Affairs advised that delays could arise due to staff absence and the time required to gather information from operational colleagues before submissions could be completed.

Ms C Butterworth noted that, in her role as the newly appointed Security Non-Executive Director, she had met with the Director of Corporate Affairs and initiated discussions regarding a framework that would provide Board visibility of the various aspects of health and safety in a single place. She also sought and received confirmation that any significant incidents or escalations would be reported by exception and without delay.

Ms A Cooper observed that she was unclear on the relationship between the MKS related programmes and sickness absence, whilst acknowledging that she did not attend the Resources Committee.

The Director of People advised that the Resources Committee received detailed reports regarding staff sickness absence and confirmed that the Health and Safety and Workforce teams worked closely together to ensure alignment and appropriate oversight.

Mr N Gower welcomed the reported downward trend in violence and aggression incidents. Referring to the Statistical Process Control (SPC) chart included within the report, he queried whether it indicated that there had been no measurable change. The Director of Corporate Affairs confirmed that the reduction was not statistically significant and that there was no evidence of special cause variation. She advised that the impact of the recent awareness campaign was expected to become more evident over the coming year and that violence and aggression would remain a key focus of prevention, training and improvement activity throughout 2026/27.

Mr Gower further sought assurance that the full legislative framework relating to health and safety was being addressed. The Director of Corporate Affairs confirmed that the Health, Safety, Security and Fire Group routinely monitored compliance with all relevant legislative requirements.

The Board reaffirmed that violence and aggression towards staff was unacceptable and noted the ongoing programme of work aimed at preventing such incidents. The Director of Corporate Affairs advised that the Resources Committee received a bi-annual report on health and safety incidents resulting in staff harm or sickness absence, which included a more detailed narrative regarding violence and aggression-related activity and outcomes.

The Board:

- Received the Health, Safety, Security and Fire Annual Report for 2025/26.
- Took assurance that appropriate governance arrangements are in place to manage statutory health, safety, security and fire responsibilities.

- Noted the key achievements and areas for continued focus in 2026/27, particularly manual handling, violence and aggression reduction, and development of VPR data.

BOD/2627/050 Complaints Annual Report 2025/26

The Director of Corporate Affairs presented the Complaints Annual Review 2025/26.

The Board noted 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.

The Director of Corporate Affairs reported 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. She highlighted the key learning could be seen in s9.5 and identified delays, access issues, call handling and communication, particularly.

It was noted that 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 identified 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.

The Director of Corporate Affairs highlighted that complaints and patient safety incidents were triangulated as part of the Trust's assurance processes and advised that common themes were consistently reflected across the various reporting and governance mechanisms.

Ms A Cooper welcomed the report, describing it as clear, focused and comprehensive. She encouraged the continued integration of learning across multiple sources, including complaints and the Patient Safety Incident Response Framework (PSIRF), to support organisational improvement.

Mr N Gower noted that complaints represented a valuable source of intelligence and sought assurance that the Trust benchmarked its complaints data against that of other organisations.

The Director of Corporate Affairs confirmed that benchmarking arrangements were in place and advised that comparative analysis took account of factors such as organisational size and incident volumes to provide appropriate context for the data.

Ms C Todd welcomed the high levels of compliance reported. She noted that, as part of the Advanced Foundation Trust accreditation process, demonstrating how the Trust listens to and acts upon patient feedback would be an important area of focus and evidence.

The Chair referred to the reporting of complex complaints and noted that, in a previous organisation, complaint data had been disaggregated to provide greater visibility of those cases where external processes or investigations impacted timescales and performance. She suggested that a similar approach could provide additional clarity regarding the Trust's performance in managing complex complaints.

The Director of Corporate Affairs advised that all complaints data was drawn from a single system and confirmed that improving the quality and granularity of the data formed part of the DCQI team work plan.

The Chair also highlighted the disparities data presented within the report and encouraged consideration of the findings within a broader organisational context. She emphasised the importance of linking the data to the Trust's Equality, Diversity and Inclusion (EDI) agenda and Integrated Performance Reporting (IPR), rather than viewing it in isolation, to enable a more comprehensive understanding of how disparities manifest across different areas of the organisation.

The Director of People advised that the Diversity and Inclusion Group considered issues relating to system integration. However, access to patient data was not straightforward and would require a technical solution that was currently outside of direct control.

The Chief Executive acknowledged the point and advised that this represented a wider and complex piece of work for which there were no quick solutions. He noted that discussions were taking place through the Trust Management Committee regarding how best to address the issue and confirmed that consideration would be given to strengthening the connections between the various workstreams.

The Director of Quality and Improvement advised that a number of potential approaches were being developed and that these would be shared with the Trust Management Committee once they had been further defined.

The Board:

- Received and noted 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.
- Took 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.
- Noted 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

The Director of Finance presented the Senior Information Risk Owner (SIRO) annual report including a summary of the Trust Information Governance (IG) for the financial year and compliance with regulatory and contractual compliance.

The Board noted the background information. The Director of Finance reminded the members that Data Security and Protection Toolkit (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 increased the rating to 'Approaching standards'. A DSPT Task and Finish group was established for the 25/26 period. A 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.

The Director of Finance further reported an increase in FOI (11.67%) and Subject Access Requests (37.03%). There was a total of 9 requests for BWVC footage relating to incidents categorised as "Violence & Aggression" which was a decrease of 60%.

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.

The Director of Finance further reported a total of 197 data breaches reported via Datix IQ (DCIQ) which was an increase of 40 (25.48%) compared to the previous year. The most frequently reported category remained "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.

The Board noted that Information & Cyber Governance Group reviews all governance and cyber risks each meeting. The Director of Finance added that this report had also been received by TMC and the Audit Committee.

Ms C Todd referred to records management within the Information Governance framework and its linkage to complaints handling and quality improvement.

The Medical Director advised that issues relating to the quality of clinical records had been highlighted within the Learning from Deaths report. He confirmed that the organisation remained focused on improving record quality and that a dedicated work plan was in place to support this improvement.

A discussion took place regarding the most appropriate governance route for receiving reports on records management quality. It was agreed that Ms C Todd would continue discussions with Executive colleagues outside of the meeting to determine the most suitable reporting arrangements.

Ms A Cooper welcomed the report and noted the increasing demand associated with Freedom of Information (FOI) requests and Subject Access Requests

(SARs). She queried how the Trust was responding to this growing demand, particularly in light of emerging performance pressures in meeting response timescales.

The Director of Finance advised that a range of approaches were being explored to improve efficiency, including the potential use of artificial intelligence to support processing and directing requesters to information already available through published sources.

The Board:

- Noted the contents of the report and the assurance it provides.

BOD/2627/052 Audit Committee 3A Report from the meetings held on 24 June 2026 and 24 July 2026

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

Referring to the report from the 24th June 2026, Mr N Gower reported there were no alerts or advisements, however there were several points of assurance as recorded in the report.

The Audit Committee received the Audit Completion Report from the External Auditors, 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 and the Annual Report were recommended to the Board of Directors for approval on 24th June.

In terms of the report from the 24th July 2026, Mr N Gower advised there was one alert and one advisement and several points of assurance. The alert brought to Board attention was in relation to assurance and reassurance and extent of each to ensure a common understanding of those across the organisation.

The Director of Corporate Affairs advised that the assurance vs reassurance topic formed part of the Leaders Development Programme, with the Corporate Affairs Team responsible for delivering the relevant module.

The Chair welcomed this approach and confirmed that the subject would also be incorporated into the Board's ongoing development programme.

The Board:

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

BOD/2627/053 Charitable Funds Committee 3A Report from the meeting held on 23 July 2026

Mr N Gower, Non-Executive Director, presented the report. There was one alert and several advisement and points of assurance as recorded in the report. The alert brought to Board attention requested the Board to schedule appropriate

time during 2026/27 to discuss the future strategy and direction of the NWAS Charity.

Mr N Gower suggested that a formal proposal be developed and presented to the Board, setting out the available options and associated considerations, to support a decision on the preferred way forward, which may require an additional board session.

The Board:

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

BOD/2627/054 Resources Committee 3A Report from the meeting held on 21st May 2026

Mr N Gower, Non-Executive Director, presented the report, on behalf of Mr Graeme Chapman, following his departure from the Trust.

Mr N Gower provided an overview of the Committee's recent meeting, noting there were several approval items which would be discussed at Part 2.

There was one alert and several points of advisement and assurance as recorded in the report. The alert brought to Board attention highlighted a discussion on SR08 and the alignment with the Risk Appetite Statement (RAS).

The Director of Corporate Affairs advised the review of RAS was scheduled in the Board Work Plan and could be brought forward to September meeting.

The Board:

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

BOD/2627/055 Trust Management Committee 3A Report from the meetings held on 17 June 2026 & 22 July 2026

The Chief Executive presented the Trust Management Committee (TMC) 3A report from the meeting held on 17th June and advised there was one alert and several advisements, approvals and assurance reports, as listed within the report. The alert related to challenging May performance across UEC in May.

The Chief Executive provided an overview of the TMC meeting held on the 22nd July 2026. The Board noted two alerts and a number of advisements, approvals and assurance reports, as listed within the report. The alerts related to UEC 26/27 update and concerns regarding data referring to experience of BME and disabled staff with targeted actions and engagement planned to improve these issues.

Following a query from Ms C Todd regarding 'Back to Basics' programme discussed by the TMC in June, the Director of Quality and Improvement advised the topic had been further extended at the July TMC under item: Right First Time

– Service Delivery Standards Improvement Programme. The redesigned process includes embedding learning, and a report will be brought to Quality and Performance Committee following the auditing part of the process.

The Board:

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

BOD/2627/056 EDI Regulatory Reporting including WRES / WDES and Gender Pay Gap

The Director of People introduced 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.

The Director of People presented the key highlights from the report, noting that disability representation had exceeded 10% for the first time, continuing a positive long-term trend. Improvements were also reported in representation at senior clinical grades and recruitment outcomes for disabled applicants. Whilst some indicators relating to the experience of disabled staff remained positive, including reasonable adjustments and presenteeism, concerns remained regarding increased reports of harassment from patients and the public, reduced confidence in fair career progression, and lower levels of staff feeling valued.

The Board noted that BME workforce representation had continued to increase in line with target and ethnicity declaration rates remained high. However, recruitment outcomes for BME applicants had deteriorated, with White applicants continuing to be more likely to be appointed following shortlisting. Although BME staff remained disproportionately represented in formal disciplinary processes, particularly within Integrated Contact Centres, the level of disproportionality was reducing. The Board also noted improvements in staff-reported experiences of discrimination and bullying, with the gap between BME and White staff narrowing or closing.

The Director of People reported that the Gender Pay Gap had reduced to its lowest level since 2020, supported by improved female representation in senior pay quartiles. In contrast, the ethnicity pay gap had widened, reflecting the continued concentration of BME staff in lower-paid roles and reduced representation in senior positions. The disability pay gap remained negligible, with near parity in average earnings.

The Board noted that detailed action plans were set out in the supporting reports and aligned with the Trust's Annual Plans. Priorities for 2026/27 included improving disability disclosure and data quality, strengthening inclusive recruitment practices, addressing workforce disproportionality, delivering the Anti-Racism Workplan, progressing Race Equality Assembly accreditation, and continuing initiatives to reduce the ethnicity pay gap.

Ms C Butterworth thanked the Director of People for the report and acknowledged that it presented a mixed picture. She advised that the Resources Committee had requested a deep dive into the issues identified, which would be

presented at its November meeting, with key outcomes subsequently reported to the Board through the Committee Chair's assurance report.

Ms C Todd enquired whether the organisation provided training on unconscious bias. The Director of People advised that specific unconscious bias training was not currently delivered, as the evidence supporting its effectiveness was limited. However, recruitment training continued to be refreshed regularly, and independent panel members were being introduced to provide objective challenge and strengthen the fairness of recruitment processes.

The Board:

- Reviewed, considered and noted the data contained within the WDES, WRES and Pay Gap reports.
- Received assurance that the Trust has complied with its regulatory and statutory duties to compile, review and submit relevant equality data.
- Approved the reports for publication.

BOD/2627/057 Integrated Performance Report

The Director of Quality and Improvement presented the Integrated Performance Report (IPR) with an overview of integrated performance to the month of June 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:

- 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.
- 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 - 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.

- 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.
- 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.
- 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%)

Ms C Butterworth noted the reduction in patient experience scores and sought assurance regarding the actions being taken to address this.

The Director of Quality and Improvement advised that improving patient experience formed a significant component of the Annual Plan, although the associated work programme had yet to commence.

The Chief Executive observed that the lower patient experience scores coincided with periods of significant operational pressure, including recent heatwaves and increased demand across service lines, and noted that this was consistent with operational performance trends.

Ms A Cooper acknowledged the extensive work undertaken to obtain patient feedback and queried whether the Trust had maximised opportunities to generate meaningful insight and intelligence from the information received.

The Director of Strategy and Partnerships outlined ongoing work to engage with patients through targeted interventions and community-based initiatives. He advised that this work remained ongoing and noted that the Trust's level of patient feedback data was comparable to that of other providers.

The Chief Executive advised that enhancing the approach to patient experience measurement formed part of the Trust's wider improvement programme. He noted that many existing national measures were designed principally for acute settings and were not always reflective of the ambulance sector. Whilst the Trust had achieved some success in adapting these measures, the new Quality Strategy would support the development of broader approaches to capturing patient experience. He further advised that all patients with whom the Trust had contact were offered opportunities to provide feedback through a variety of channels, although obtaining responses remained challenging given that care was often delivered within the unique environment of an ambulance rather than a clinical ward.

The Director of People highlighted that the Diversity and Inclusion Group routinely reviewed patient feedback by demographic group and acknowledged that response rates from BME communities remained lower than would be expected based on population demographics.

Ms C Todd suggested that national patient experience data should be considered alongside local data to provide a broader understanding of performance and patient outcomes.

At the request of the Chief Executive, the Area Director provided additional context regarding recent operational performance. He advised that adverse weather conditions since June had affected Category 2 response performance and trajectory. He outlined the actions being taken to recover performance, including enhanced ambulance provision during July and workforce initiatives aimed at reducing vacancies. He also highlighted the ongoing challenges across the acute sector, including ambulance handover delays, on which the Trust continued to work with NHS England. Despite these pressures, the Trust remained positioned within the middle performing cohort nationally for Category 2 performance and within the leading cohort for Category 1 performance. The Area Director also highlighted ongoing work with Business Intelligence colleagues to improve the use of data to support future planning and service responsiveness.

The Medical Director noted that increased mortality associated with extreme heat events reflected the fact that the UK was not yet fully adapted to changing weather patterns. He advised that this constituted an emerging and ongoing challenge, requiring a longer-term response that incorporated both patient care considerations and measures to support staff wellbeing during periods of extreme heat.

Ms A Cooper sought clarification on NHS England's response to the recent unplanned operational pressures and whether the Trust would be held to account for the decline in Category 2 performance.

The Chief Executive advised that there had been no changes to the national accountability arrangements and that, at present, the Trust should continue to assume that performance would be assessed against the agreed trajectory.

A discussion took place regarding the Trust's Adverse Weather Plan. Members acknowledged that the current plan was primarily focused on severe weather events such as rain and wind and agreed that the approach to heatwaves would require further development. It was noted that this could be achieved either through strengthening the existing heatwave section or by developing a dedicated heatwave plan to reflect the increasing frequency and impact of extreme temperature events.

A further discussion commenced regarding NHS 111 performance. It was agreed that the matter would be considered in detail under Any Other Business during the Part 2 meeting.

The Board:

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

BOD/2627/058 Accountable Officer for Controlled Drugs Annual Report 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 and highlighted the key notes of assurance, achievements and improvements made in 2025/26 as laid out in the executive summary.

The Medical Director confirmed that NWAS currently holds a fully compliant licence but has submitted a renewal application ahead of expiry at the end of September, noting that delays are likely due to national processing constraints.

The Medical Director reported positively that there have been no contraventions in the past year, reflecting robust governance. He also highlighted enhanced monitoring capability, with data now available at individual paramedic level to analyse controlled drug administration patterns, which supports both assurance and identification of variation in practice. Oversight was provided through a multidisciplinary subgroup co-chaired by senior clinical leadership.

Looking forward, the Medical Director outlined key priorities for the coming year, including reviewing the digital solution used to access controlled drugs to ensure it remains fit for purpose, as well as addressing remaining gaps in medicines management quality indicators.

Ms A Cooper advised that she had recently met with the Medical Director and Chief Pharmacist to discuss Controlled Drugs management and expressed confidence in the robustness of the systems and controls in place.

The Director of Strategy and Partnerships sought assurance regarding any residual risk pending implementation of the digital medicines management systems. The Medical Director advised that, while further improvements were within the Trust's control, compliance would not reach 100% due to operational complexities. Controlled Drugs audit results demonstrated generally high levels of compliance, although performance relating to weekly checks remained below target in Q4. This has been identified as an improvement area for 2026/27. Members noted that additional monitoring and reporting arrangements had been introduced to support operational oversight and improve compliance.

The Board:

- Noted the assurance provided and the achievements and improvements made in 2025/26 as well as the challenges and risks for 2026/27.

BOD/2627/059 Safeguarding Annual Report 2025/26

The Director of Quality and Improvement presented the report and took the Board through the headlines as detailed in the executive summary. She advised

the report had been previously received at the Quality & Performance Committee.

The Board noted that the Trust had met its statutory safeguarding responsibilities throughout 2025/26, maintaining effective governance and assurance across its services.

It was highlighted that 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.

In terms of training compliance, members noted it remained above 95% across Safeguarding Levels 1–3, supported by strong professional oversight and ongoing work to align Level 3 training with Intercollegiate guidance.

The Director of Quality and Improvement pointed to areas, which require ongoing oversight, including capacity pressures, partnership engagement, training assurance, and the development of Child Protection–Information Sharing. These are being actively managed through established governance arrangements and do not represent unmanaged risks.

Mr N Gower described the report as helpful and referred to the section 16 outlining safeguarding considerations requiring ongoing oversight. He noted that the report did not include associated actions and suggested that future reports provide greater detail on planned improvements.

Ms C Butterworth welcomed the increase in safeguarding referrals, noting this provided confidence that concerns were being appropriately identified. Drawing on her experience accompanying an ambulance crew, she observed that many attendances reflected gaps in social and primary care provision. She suggested that, in light of anticipated reforms to social care, the ambulance sector should seek opportunities to contribute to the national discussion.

The Chair and Chief Executive welcomed the suggestion and confirmed they would monitor developments to identify any opportunity for the Trust to support wider national conversations on social care reform.

The Board:

- Noted the report, took assurance on statutory safeguarding compliance, and supported the continued focus on prioritised safeguarding activity in 2026/27

BOD/2627/059 Infection Prevention and Control Annual Report 2025/26

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

The IPC BAF was included at Appendix 1 and provided information that appropriate policies, procedures, systems, processes and training were 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 Board noted that the updated BAF contained six amber-rated areas and no red-rated areas. Several elements relevant only to acute trust providers were marked as not applicable to the ambulance service. Gaps in control, mitigating actions and improvement timelines were identified.

It was noted there were four IPC risks on the risk register, including two scored at 12. All risks were 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.

The Director of Quality and Improvement then reported on the IPC commitments for 2026/27, which included statements to maintain high compliance with face fit testing offer across NWAS, to improve compliance with the NHS England National Standards of Cleanliness, to review IPC audit process in line with national guidance and to oversee the staff flu vaccination campaign for 2026/27 and will work alongside key stakeholders from Medicines Management, Human Resources, Communications and Operations.

The Medical Director highlighted the importance of sustained investment in fit testing, noting its role in maintaining preparedness for high-risk infectious disease incidents. He emphasised that retaining this capability avoids the need for rapid scaling of training during emergencies and should be maintained despite wider system pressures.

Mr N Gower referred to the IPC BAF and the partially compliant SafeCheck actions relating to data anomalies, seeking clarification on the associated risks. The Director of Quality and Improvement advised that SafeCheck was originally developed by the Trust for ambulance crew assurance but had expanded over time to incorporate wider quality control and assurance measures. As a result, the system had become cumbersome and required review, creating a risk that complete assurance could not be provided. She confirmed that technical issues had been resolved and that audit parameters were now being developed. The review of SafeCheck forms part of the annual plan.

Mr N Gower also highlighted a partially compliant action relating to respiratory powered hoods, noting that not all units were being serviced in accordance with manufacturer guidance. The Area Director explained that the hoods were used infrequently and there was no evidence of equipment failure. However, regular servicing was required and depended on staff making the units available, with compliance ultimately reliant on individual accountability.

The Chief Executive suggested that the action at section 6.5 of the IPC BAF should be reviewed to confirm whether a partial compliance rating remained appropriate. It was noted that this did not materially affect the overall report.

The Board:

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

BOD/2627/061 Quality and Performance Committee 3A Report from the meeting held on 22 June 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, noting the 3A report provided a retrospective view.

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

BOD/2627/062 Communications and Engagement Q1 2026/27 Report

The Director of Strategy and Partnerships presented the Communications and Engagement Q1 2026/27 Report, including Dashboard at Appendix 1 with a quarterly summary of key outputs and associated highlights of activity.

The Board noted multiple examples of Q1 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 Director of Strategy and Partnerships highlighted that targeted communications delivered the 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.

The Director of Strategy and Partnerships also emphasised the launch of the new staff intranet (Green Room), which 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.

In terms of partnership communications, the Board noted the team worked with the RNLI on hot weather and water safety content, generating more than 513,000 views and 11,600 engagements.

Mr N Gower pointed to the risk section of the report and noted it was very well articulated.

The Board:

- Noted the contents of the report and the impact of activities undertaken by the communications, patient engagement and charity teams.

BOD/2627/063 Any Other Business Notified Prior to the meeting

None advised.

BOD/2627/064 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 –

30th September 2026 at 09:45 am in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Signed _____

Date _____

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

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

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
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	Meeting took place on the 24th August 2026.	
1 - 26/27	29.07.26	2627/039	Patient Story	The Board reflected on Jess's Rule and Martha's Rule in the context of Patient Story and noted the issues raised extended beyond the individual case, noting a theme of staff failing to recognise what is 'the normal' for a patient, which was also evident in complaints. A wider review of the systemic issues was proposed, which would be reported to the Quality and Performance Committee for further scrutiny and discussion. The Director of Quality and Improvement will consider timing for review by the Quality and Performance Committee.	Director of Quality and Improvement	TBC	TBC	Propose transferring this action to the Quality and Performance Committee	
2 - 26/27	29.07.26	2627/039	Patient Story	A query was posed whether there were lessons for primary care colleagues arising from the incident and, if so, whether these had been shared. The Chair sought assurance regarding the wider process for sharing learning with partner organisations. The Medical Director advised that teams would ordinarily work with external partners and adopt a multidisciplinary approach and would provide feedback before the next Board meeting.	Medical Director	Sep-26	Sep-26	Update from Medical Director 03/08/26: confirmed with the investigator that no concerns were raised regarding primary care.	
3 - 26/27	29.07.26	2627/047	Chief Executive's Report	The Board discussed the Advanced Foundation Trust process. The Chair requested an update including details of the anticipated timetable and the scale of work required.	Director of Strategy and Partnerships	Nov-26	Nov-26	A dedicated AFT update session for the Board has been planned for the 25th November 2026.	

4 - 26/27	29.07.26	2627/053	Charitable Funds Committee 3A Report from the meeting held on 23 July 2026	The alert brought to Board attention requested the Board to schedule appropriate time during 2026/27 to discuss the future strategy and direction of the NWAS Charity.	Director of Strategy and Partnerships	Dec-26	Dec-26	A dedicated Charity session for the Board has been planned for the 2nd December 2026.	
5 - 26/27	29.07.26	2627/059	Infection Prevention and Control Annual Report 2025/26	The Board noted partially compliant action relating to respiratory powered hoods, noting that not all units were being serviced in accordance with manufacturer guidance with the suggestion that the action at section 6.5 of the IPC BAF should be reviewed to confirm whether a partial compliance rating remained appropriate.	Director of Quality and Improvement	Sep-26	Sep-26		

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	✓	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)	✓	✓				
Nic Gower (Interim Chair)	✓	✓	✓			
Catherine Butterworth	✓	✓	✓			
Clare Todd			✓			
Daniel Ainsworth	✓	x	✓			
Michael Gibbs	✓	✓	✓			
Lisa Ward	✓	✓	✓			
Carolyn Wood	✓	✓	✓			

Quality and Performance Committee						
	27th April	22nd June	7th September	26th October	14th December	22nd February
Clare Todd (Chair)	✓	✓	✓			
Daniel Ainsworth	✓	✓	✓			
Anne Cooper	✓	✓	x			
Graeme Chapman	✓	✓				
Nic Gower			✓			
Dr Chris Grant	✓	✓	✓			
Dr Elaine Strachan-Hall	✓	✓	✓			
Angela Wetton	✓	x	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	7th July 2026	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.



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 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 July – 22 September 2026. Organisational People & Culture The Trust is strengthening leadership, development and staff standards through the launch of Thrive, a second Developing Leaders programme, and alignment with the new national NHS Leadership and Management Framework. Medical <u>Digital Pharmacy Stock Management Solution</u> The Digital Pharmacy Stock Management System (DPSMS) successfully went live as planned in September 2026, marking a significant milestone in the modernisation of medicines management across NWAS. Quality Tony Okparavero and Aaron Molloy have joined the Quality Directorate from the Communications team to strengthen



	the use of patient insight in support of the trust's improvement work. Their roles will support the annual programme of patient surveys and the national Friends and Family Test, helping ensure patient feedback informs ongoing service improvement.	
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 29 July 2026 and covers the period 23 July – 22 September 2026.

2. INTERNAL UPDATES

Finance

Cyber security incident

The North West Ambulance Charity was notified on Monday 3 August 2026 of a cyber security incident affecting Beacon CRM, a Customer Relationship Management system used by the Charity to monitor engagement with supporters and donors. The incident, which also affected thousands of other UK charities, involved unauthorised access to Beacon CRM systems.

Protecting personal information remains a priority, and the Charity has taken steps to inform those who may be affected as quickly as possible. Further updates will be provided as more information becomes available, including any implications for individuals whose data may have been held within the system.

People & Culture

Leadership and Management

The new national NHS Leadership and Management Code and framework was released in July. The national work aligns closely with our existing Leadership Framework Be Think Do and this enables us to implement the new framework as an evolution of our current leadership development offer. However, the new framework will support us to enhance the focus of our leaders on improvement and inclusion and to reinforce the core accountabilities of our leaders as set out in our strategy. It will also give our leaders a shared language and evidence base for their leadership journey across the wider NHS. Transition plans have been discussed through Board Committees with our focus in 26/27 on socialising the framework and embedding the self-assessment through our appraisal processes. Work will continue into 27/28 to refresh and rebrand our leadership offers to ensure full alignment.

September has also seen the launch of our second Developing Leaders programme which offers a development pathway for our aspiring leadership talent across the Trust. The programme offers a combination of classroom learning with NWAS subject matter experts, mentoring and improvement opportunities. The first programme was highly rated by participants with over 20% having secured leadership positions before the end of the programme. We continue to track the progress of past participants but are exciting to be supporting another 40 talented individuals through the start of their leadership journey.

Staff Standards



Since the Staff Standards launch in July the Trust has been working in partnership with Trade Union colleagues to assess our current position and to prioritise the areas of work we need to do jointly to ensure alignment with the standards. The Trust is able to demonstrate a good level of compliance across all standards but with particularly strong compliance with Championing Sexual Safety, Violence Prevention and Reduction and Health and Wellbeing. However, the standards have also set Trusts some deliberate stretch challenges linking the new line management standard with the new Leadership and Management Framework and setting some increased expectations around Promoting Flexible Working and Tackling Racism. Once the partnership review has been completed, the standards will be launched with staff alongside the ongoing work to improve.

Paramedic Apprenticeships

Our recent cohorts of Paramedic apprentices have recently graduated huge congratulations are due to them for this achievement alongside their role in delivering emergency and urgent care to our patients. Overall, our graduates from the apprenticeship programme are achieving higher classifications than the national average with 38% achieving a First Class Honours compared with only 33% nationally. Overall 78% of our NWAS graduates since the start of the programme have achieved First Class or 2:1 honours.

Thrive launch

The Trust has launched Thrive, its new learning and development platform, providing colleagues with a single, easy-to-access home for personalised learning content to support development at every stage of their career.

Early engagement has been encouraging, with many colleagues already logging in and positive feedback received. The launch represents an important investment in colleague development and will support access to high-quality learning, skills development and career opportunities.

Medical

Digital Pharmacy Stock Management Solution

The Digital Pharmacy Stock Management System (DPSMS) successfully went live as planned in September 2026, marking a significant milestone in the modernisation of medicines management across NWAS. The transition to the new system has been completed successfully, with pharmacy and operational teams working collaboratively to maintain business continuity, fulfil all medicines orders, and ensure frontline ambulances remained fully stocked throughout the first week of operation.

Public Health Webinar – 9 September

The webinar provided an opportunity to hear about the work undertaken across the trust to improve awareness, education and care for people living with sickle cell disease. The session brought together colleagues from Public Health, Clinical Leadership, Pathway Development, Clinical Audit and the Race Equality Network alongside partner organisations and specialist stakeholders.

Topics for discussion included;

- Why this work matters and the learning from the *No One's Listening* report.
- Understanding sickle cell disease and the experiences of people living with the condition.
- How NWS has responded to national learning and health inequalities.
- Development of the new Sickle Cell Clinical Pathway.
- Equality, inclusion and patient experience.
- Audit, evaluation and measuring success.
- Launch of the new NWS Sickle Cell e-learning module.

The webinar marked the introduction of two important resources developed through this programme of work: the **NWS Sickle Cell Clinical Pathway** and a new **e-learning module** designed to support staff in delivering equitable, person-centred care.

Quality

New team members

Two members of the trust's patient experience team have moved across to the Quality Directorate with effect from 1 September – Tony Okaparavero, Senior Patient Experience Analyst and Aaron Molloy, Patient Engagement Analyst Apprentice.

Tony and Aaron have moved across from the Communications Team to support the trust's improvement projects through the provision of patient insight. This will be delivered through the annual programme of patient surveys and the national friends and family test.

Mental Health Urgent Triage Team (MHUT)

The Mental Health Urgent Triage Team has been named as one of three finalists in the Pennine Care People Awards, in the Brilliant Partnership category. The winner will be announced at a ceremony on 26 November 2026.

Introduction to Improvement

The 30-minute Introduction to Improvement module has now launched on ESR, providing colleagues with an accessible introduction to improvement principles and approaches.

Operations

PTS contract announcement

The Greater Manchester PTS contract has now been formally awarded to HATS Group, a private provider. No award was made for Cheshire and Merseyside or Cumbria and Lancashire contracts, and the Trust is awaiting confirmation on the future arrangements for these services beyond April 2027.

Regular meetings have been established with commissioners and HATS Group in relation to Greater Manchester. Discussions remain at an early stage

but are expected to provide greater clarity in the coming weeks on plans for the service and workforce, including the approach to a safe transfer of service.

The Chief Executive and Area Director for Greater Manchester (PTS) are also holding a series of staff forums with PTS colleagues over the coming weeks to provide updates, listen to concerns and support staff through the transition. The Trust will continue to share information with staff as soon as it is available.

3. UPDATES

3.1 National

Thirlwall Inquiry Report

The Thirlwall Inquiry is a significant reminder that patient safety, safeguarding, speaking up and effective Board oversight are everyone's responsibility. NHS England has asked all Boards to review the findings, reflect on whether similar risks could exist within their organisations, and assure themselves that the culture, governance and escalation arrangements needed to identify and act on concerns are firmly in place. A paper will be presented to the Board in November to facilitate a broader discussion and provide assurance on NWS' arrangements in these areas.

Organ Donation

NHS England has issued an urgent call to action following a significant decline in organ donation, with donor numbers, referrals and consent rates all falling while the transplant waiting list reaches record levels. Trusts are being asked to strengthen identification and referral of potential donors, support clinical teams and maintain executive oversight of local performance. Organ Donation Week included a national public awareness campaign.

3.2 Sector

Hear & Treat Reporting

NHS England has agreed that ambulance trusts can align Hear & Treat reporting methodologies backdated to 1 April 2026, addressing national variation that has affected benchmarking and NOF segmentation. NWS is implementing the change and will report the resulting impact on performance measures and NOF once the revised data has been validated.

3.3 Regional

NHS Oversight Framework

NWS has been placed in segment 2 for Q1 2026/27 under the revised NHS Oversight Framework. Changes to the national segmentation methodology may have contributed to movement between segments. The Trust's ambulance sector ranking remains unchanged at 3/10 trusts. The next assessment will be based on Q2 data and is expected in November 202

Local Government Reorganisation (LGR) in Lancashire

Following the Government's recent announcement to pause and review Local Government Reorganisation in Lancashire, discussions are underway to understand the implications and next steps. The review is expected to consider all aspects of the programme, including legal considerations and proposals already submitted, and will apply to all 14 affected areas nationally. While no confirmed timetable has been provided, current indications suggest that, if shadow elections take place in 2028, Vesting Day would likely move to April 2029.

Work on the Lancashire LGR Programme will continue, with councils across Lancashire adapting plans as the review progresses. Existing partnership arrangements and collaborative working across Lancashire will continue, and the Trust will engage accordingly to understand any implications for NWS and support the best possible outcomes for local people.

3.4 **System**

There are no significant system updates to report this period.

3.5 **Organisational**

Emergency Services Day

On 6 August, I attended the Emergency Services Day at the Trafford Centre, the North West's largest celebration of the emergency services, where NWS was strongly represented as part of its 20th anniversary celebrations. Around 60 staff and volunteers supported the event, engaging with hundreds of members of the public, sharing health advice, demonstrating life-saving CPR skills and showcasing the breadth and impact of the work undertaken by colleagues across the service.

Blackpool Victoria Hospital – Emergency Department

I was invited to visit the Emergency Department at Blackpool Victoria Hospital on 10 August, accompanied by Matt Cooper, Area Director – Cumbria and Lancashire. The visit provided an opportunity to meet with colleagues, understand the operational pressures being experienced at the front door, and discuss the importance of continued partnership working between the hospital and NWS. It also offered valuable insight into patient flow, ambulance handover arrangements and the shared focus on ensuring patients receive timely, safe and appropriate care.

NHSE North West visit

On 17 August, the Trust welcomed Louise Shepherd CBE, Regional Director, and Scott McLean, Regional Director of Delivery and Transformation, from NHSE North West to Ladybridge Hall for a visit hosted by the Chief Executive and Chair with members of the Executive Team in attendance.

The visit included an overview of NWS and discussion on progress made, areas working well, opportunities for further improvement and current challenges where regional support would add value. The programme also included a visit to Sefton House, Middlebrook, providing an opportunity to tour the NHS 111 call centre and Regional Operational Co-ordination Centre and



speak with call handlers, clinicians, duty managers and senior managers about the breadth and complexity of the services delivered for patients across the North West.

North Cheshire and Mersey NHS Foundation Trust visit – 24 August 2026

The Chair and I welcomed Andy Carter, Chair, and Nik Khashu, Chief Executive of North Cheshire and Mersey NHS Foundation Trust to the organisation recently. The visit provided an opportunity to showcase the breadth and complexity of NWAS services, including 999 emergency response, NHS 111 and patient transport services, as well as the scale of operations across the North West.

Time spent with NHS 111 colleagues highlighted the professionalism, compassion and clinical expertise involved in supporting patients at the first point of contact, while discussions with operational teams reinforced the importance of ambulance capacity, timely hospital handovers, care coordination and strong system pathways to ensure patients receive the right care, in the right place, at the right time. The visit concluded with a shared recognition that healthcare is a team effort and that closer partnership working across organisations is essential to delivering seamless care for patients.

Jewish Representative Council (JRC) Visit

On 26 August, alongside Sian Wimbury, Area Director for Greater Manchester, I welcomed Raphi Bloom and Bernard Yaffe from the Greater Manchester JRC to our trust Headquarters. The meeting provided an opportunity to discuss future opportunities for collaboration between our organisations.

As a follow-up, Sian and I will visit Hatzola headquarters in Salford on 3 December.

Communal Memorial Service

On 31 August, Sian Wimbury represented the organisation at the communal memorial service held at Heaton Park Synagogue to remember and honour Mr Melvin Cravitz and Mr Adrian Daulby, who lost their lives in the Yom Kippur terrorist attack. The service provided an important opportunity to pay tribute to their memory, recognise the impact on survivors and show support for the wider community at a time of reflection and remembrance.

BBC Radio Lancashire Make A Difference Awards 2026

On Saturday 12 September, I had the pleasure of attending the BBC Radio Lancashire Make a Difference Awards 2026 at Lancaster Town Hall. The event celebrated unsung heroes from across the county who have made a significant difference within their communities, providing an important opportunity to recognise the dedication, kindness and contribution of local people whose efforts have a positive impact on others.

Annual General Meeting and Awareness Event

The Trust held a successful Annual General Meeting at Aintree Racecourse on 15 September, attended by approx. 108 colleagues, members and stakeholders. The meeting provided an opportunity to present the Trust's

annual report and accounts, reflect on key achievements and demonstrate accountability to the communities we serve.

The Ambulance Awareness Day event that followed was at full capacity, with 256 registered public attendees in addition to staff, partners and walk-in guests. The event showcased the breadth of NWAS services, careers and volunteering opportunities, strengthened engagement with young people and community groups across Merseyside, and supported a foodbank collection through the Trussell Trust.

The One Tonne Plastic Challenge

I am very pleased to report that the Trust has exceeded its One Tonne Challenge target, inspired by Thomas Morgan, a young environmentalist from Cheshire. The challenge was to collect one tonne of plastic waste from across the Trust over a 10-week period, helping to raise awareness of plastic waste and support more sustainable practices. The challenge ran until 28 September and, at the time of writing, the Trust has achieved its target having collected 1094kg, equivalent to 1.09 tonnes.

In our thoughts

It is with great sadness that I report the death of our colleague Tony Shaw, who passed away following a short illness. Tony was a highly respected member of the driver education team, having previously worked with the trust as an agency driving instructor. He will be remembered as a dedicated professional and supportive colleague who cared for and encouraged his learners.

The Deputy chief Executive has written to Tony's family 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.



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 2026
SUBJECT	Mid-Year Confidence Assessment
PRESENTED BY	Mike Gibbs, Executive Director of Strategy & Partnerships
PURPOSE	Decision

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

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

ACTION REQUIRED	Trust Board of Directors is asked to: - Review and approve the Mid-Year Review Board Self-Assessment at Appendix 1, including the proposed assurance ratings for delivery of the 2026/27 plan, winter preparedness and commencement of planning for 2027/28. - Confirm that the ratings and supporting commentary reflect the Board's collective level of confidence, including any material risks and mitigating actions. - Approve the Board certification and authorise Chair and Chief Executive sign-off and submission to NHS England by 2nd October 2026.
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EXECUTIVE SUMMARY

This paper presents the Trust's Mid-Year Review Board Self-Assessment and Certification for approval ahead of submission to NHS England by 2nd October 2026.

NHS England's North West regional team has requested assurance on three areas: delivery of the 2026/27 plan, preparedness for winter 2026/27 and commencement of planning for 2027/28. The request is set out in its letter dated 18th September 2026, included at Appendix 2.

The assessment draws on existing planning, performance and assurance arrangements, with executive contributions covering operational, financial and workforce matters. Each section requires an assurance rating, supported by commentary on material risks, dependencies and mitigating actions where appropriate.

The proposed ratings are Assured with Managed Risks for delivery of the 2026/27 plan, Partially Assured for winter preparedness and Fully Assured for commencement of planning for 2027/28. The winter rating reflects unresolved system dependencies relating to same-day emergency care provision and hospital handover, which create risks to Category 2 response performance despite the Trust's internal preparations.

The completed assessment is provided at Appendix 1. The Board is asked to review and approve the ratings and supporting commentary, confirm that these reflect its collective confidence, and approve certification and submission following Chair and Chief Executive sign-off.

This regional exercise is separate from the annual Provider Capability Self-Assessment, which is also being presented to the Board and has the same submission deadline.

PREVIOUSLY CONSIDERED BY

Date	
Outcome	

1. BACKGROUND

- 1.1. NHS England's North West regional team wrote to provider Chief Executives on 18th September 2026 requesting completion of a Board Self-Assessment and Certification as part of the 2026/27 Mid-Year Review. The letter is included at Appendix 2
- 1.2. The assessment seeks the Board's view of its confidence in three areas:
 - Delivery of the agreed 2026/27 organisational plan.
 - Preparedness for winter 2026/27.
 - Commencement of planning for 2027/28.
- 1.3. Boards are required to select one of four assurance ratings for each section: Fully Assured; Assured with Managed Risks; Partially Assured; or Not Assured. Supporting commentary should explain material concerns, risks and mitigating actions where assurance is qualified or further action is required.
- 1.4. The exercise is intended to draw on existing performance and assurance arrangements. Although a separate regional winter assurance process is underway, the return requires explicit confirmation that winter preparedness and resilience have been considered.
- 1.5. The submission will inform the regional Mid-Year Review and identify areas requiring further support or intervention. A Partially Assured rating will prompt further executive engagement; a Not Assured rating will result in a formal Board-to-Board discussion.
- 1.6. Completed returns are required by 2nd October 2026. Board consideration on 30 September enables review and approval ahead of certification and submission.

2. NWS POSITION AND EVIDENCE BASE

- 2.1 The assessment draws on existing Board and committee assurance, supported by executive contributions covering annual-plan delivery, operational performance, finance and workforce.
- 2.2 Delivery of the 2026/27 plan: The annual plan comprises 81 deliverables, each with executive sponsorship and an identified Senior Responsible Owner. Progress is reviewed through the relevant executive-led committees and consolidated through quarterly Planning Group reviews. The resulting assurance report progresses through Trust Management Committee to Resources Committee, with the Board receiving the committee's assessment through its 3A report. These arrangements provide oversight of delivery, risks, dependencies and corrective actions.
- 2.3 Winter preparedness: A Strategic Winter Plan is in place. However, the winter Board Assurance Statement identifies gaps in assurance relating to variation in same-day emergency care provision, deteriorating hospital handover performance and delivery of the 45-minute handover standard. These system dependencies create risks to Category 2 response performance and underpin the proposed Partially Assured rating.
- 2.4 Commencement of planning for 2027/28: Planning Group approved the 2027/28 annual planning timeline, framework and prioritisation model in July 2026. An annual-plan

prioritisation session is scheduled for 16th November 2026, with executive and senior leader attendance planned. These arrangements establish the timetable and approach for identifying and prioritising delivery commitments aligned with the Trust's strategy and available resources.

- 2.5 The proposed assurance ratings are summarised below. The completed assessment at Appendix 1 provides the supporting commentary, including material risks and mitigating actions

Assessment area	Proposed assurance rating
Delivery of the 2026/27 plan	Assured with managed risks
Winter preparedness	Partially Assured
Commencement of planning for 2027/28	Fully assured

- 2.6 The Board is asked to consider these ratings alongside the assurance received through its established reporting and committee arrangements, and to confirm whether they accurately reflect its confidence in each area.

3. RISK CONSIDERATION

- 3.1** Assurance risk: The certification must accurately reflect the Board's confidence in delivery, supported by current evidence. Executive review and Board scrutiny should ensure that material risks, dependencies and limitations are reflected in the ratings and commentary.
- 3.2** Delivery risk: Operational, financial, workforce and system pressures may affect delivery of the 2026/27 plan and winter resilience. The assessment should identify where mitigations are sufficient to maintain confidence and where unresolved concerns require further action or regional support.
- 3.3** Submission risk: Board consideration on 30th September leaves a limited period to resolve queries and complete certification before the 2nd October deadline. Any outstanding matters will need prompt resolution with the relevant executive leads and Chair and Chief Executive.

4 EQUALITY / SUSTAINABILITY IMPACTS

- 4.1** No direct adverse equality or sustainability impacts have been identified from completing this self-assessment.
- 4.2** Consideration of plan delivery, winter preparedness and future planning should take account of equitable access to services, patient safety and staff wellbeing, including the impact of pressures and mitigating actions on vulnerable groups.

- 4.3** The assessment considers the Trust's ability to sustain delivery within available operational, financial and workforce resources. Any changes to services or delivery plans arising from the review will remain subject to the Trust's established equality and quality impact assessment arrangements.

ACTION REQUIRED

The Board of Directors is asked to:

- Review and approve the Mid-Year Review Board Self-Assessment at Appendix 1, including the proposed assurance ratings for delivery of the 2026/27 plan, winter preparedness and commencement of planning for 2027/28.
- Confirm that the ratings and supporting commentary reflect the Board's collective level of confidence, including any material risks and mitigating actions.
- Approve the Board certification and authorise Chair and Chief Executive sign-off and submission to NHS England by 2nd October 2026.

Board Self-Assessment and Certification Template

Mid-Year Review 2026/27

Purpose

As part of the Regional Mid-Year Review process, Boards are requested to undertake a self-assessment of their level of assurance against the statements below and provide supporting commentary where appropriate.

The purpose of this assessment is to enable the Regional Team to understand the Board's confidence in:

- Delivery of the 2026/27 plan.
- Preparedness for Winter 2026/27.
- Progress in commencing planning for 2027/28.

Assurance Ratings

Please select one rating for each statement.

Fully Assured

The Board has reviewed the available evidence and is fully confident that:

- Robust plans, governance and oversight arrangements are in place.
- Delivery is on track and within agreed tolerances.
- Risks have been identified and are being effectively managed.
- No material concerns exist that would significantly impact delivery of the stated objective.

Regional Response: No further action required beyond routine monitoring.

Assured with Managed Risks

The Board is assured that delivery remains achievable; however:

- There are known risks, challenges or dependencies requiring active management.
- Appropriate mitigations are in place and are being monitored through established governance arrangements.
- The Board remains confident that the objective will be delivered notwithstanding these risks.
- No immediate regional intervention is required.

Regional Response: Risks and mitigations may be reviewed through routine assurance discussions and monitoring processes.

● Partially Assured

The Board has identified concerns that require further attention and assurance because:

- Significant risks or dependencies remain unresolved.
- Additional mitigating actions are required to secure delivery.
- There is a risk to successful delivery if current issues are not addressed.
- The Board cannot yet provide full confidence that the objective will be achieved.

Regional Response: The Regional Team will seek further clarification through discussions with the Executive Team and review of supporting evidence. Additional actions may be agreed where required.

● Not Assured

The Board does not currently have sufficient confidence that delivery can be achieved because:

- Material risks exist that threaten successful delivery.
- Mitigations are not fully developed, not operating effectively, or are unlikely to be sufficient.
- The Board has significant concerns regarding the organisation's ability to meet the stated objective.

Regional Response: A formal **Board-to-Board discussion** will be initiated to understand the issues, agree support requirements and determine any further actions necessary.

Board Self-Assessment and Certification

Mid-Year Review 2026/27

Organisation: North West Ambulance Service NHS Trust

Section 1: Delivery of the 2026/27 Plan

The Board confirms that it has reviewed progress against the 2026/27 organisational plan and is assured that appropriate governance, performance oversight, risk management and delivery arrangements are in place to support successful delivery of the agreed objectives.

Based on current performance, trajectories, recovery plans and mitigating actions, the Board is confident that the organisation has a credible and deliverable plan and that all reasonable actions are being taken to deliver the commitments set out within the 2026/27 plan.

Self-Assessment Rating

- ☐ Fully Assured
- ☒ Assured with Managed Risks
- ☐ Partially Assured
- ☐ Not Assured

Commentary (including key risks and mitigating actions where applicable)

- year to date financial position is ahead of plan with a surplus of £186k and the organisation remains on track to deliver the breakeven plan
- The annual plan comprises 81 deliverables, with identified executive sponsors and senior responsible owners accountable for delivery.
- Progress is reviewed through the relevant executive-led committees and consolidated quarterly through Planning Group, Trust Management Committee and Resources Committee. The Board receives assurance through the Resources Committee's 3A report.
- UEC delivery is on track for the majority of indicators but not all. Hear and Treat, CPU, elements of the workforce plan are on track. Productivity metrics are ahead of trajectory and current C2 performance is sub 25 minutes.
- However incidents are above plan, handover is behind trajectory and ambulance production is below plan.

- A recovery plan is in place for ambulance production, with the Board and Trust Management Committee sighted on the plan. Improvements in productivity and delivery of other UEC indicators provide mitigation, although above-plan demand and hospital handover delays remain risks to delivery.

Section 2: Winter Preparedness

The Regional Team are aware that a separate winter assurance process is being completed; however this self-certification also seeks explicit assurance that winter planning, preparedness and resilience arrangements have been fully considered and that the organisation remains confident in its ability to deliver its 2026/27 operational, financial and strategic objectives throughout the winter period; therefore is included within this self-certification document.

The Board confirms that it has received assurance regarding the organisation's preparedness for Winter 2026/27.

The Board is satisfied that comprehensive winter planning arrangements are in place, including operational resilience measures, capacity planning, workforce preparations, escalation processes, system coordination arrangements and risk management processes. The Board is assured that identified risks are understood and that appropriate mitigations are being actively managed.

Accordingly, the Board is confident that the organisation is appropriately prepared to respond to anticipated winter pressures.

Self-Assessment Rating

- ☐ Fully Assured
- ☐ Assured with Managed Risks
- ☒ Partially Assured
- ☐ Not Assured

Commentary (including key risks and mitigating actions where applicable)

- A Strategic Winter Plan is in place with detailed risk and assurance as to delivery across winter.
- The Winter BAS does highlight three areas that are currently gaps in assurance. Principally these relate to system level support to NWAS for winter.
- Specifically there are inconsistency of SDEC offer pan region, deterioration of hospital handover and lack of assurance as to handover 45 adherence, resulting in risk to deliver of C2 ARP performance.

Section 3: Commencement of Planning for 2027/28

The Board confirms that planning for 2027/28 has commenced.

The organisation has initiated the development of its strategic and operational planning approach for 2027/28, including consideration of future financial sustainability, service delivery priorities, productivity opportunities, workforce requirements and key strategic risks. Governance arrangements are in place to oversee the planning process and ensure alignment with national, regional and system priorities.

The Board is satisfied that early planning activity is underway and will support the development of a robust and deliverable plan for 2027/28.

Self-Assessment Rating

- ☒ Fully Assured
- ☐ Assured with Managed Risks
- ☐ Partially Assured
- ☐ Not Assured

Commentary (including key risks and mitigating actions where applicable)

- financial planning is underway with plans to present to Resources Committee and Board at the end of November (revenue and capital)
- further work required to review and refresh activity and workforce requirements to align plans
- identification of efficiency schemes for 2027/28 are in early stages of development
- Planning Group approved the 2027/28 annual planning framework, timetable and prioritisation model in July 2026, providing a structured process for translating the Trust Strategy into annual delivery priorities.
- An annual plan prioritisation session is scheduled for 16 November, with executive and senior leader attendance, to consider proposed priorities, delivery capacity and dependencies.
- Further work through the planning cycle will align proposed deliverables with operational, workforce and financial plans and test their affordability and deliverability.

Board Certification

On behalf of the Board, I certify that:

- The Board has reviewed the statements contained within this self-assessment.
- Appropriate evidence and assurance have been considered through the organisation's governance arrangements.
- The ratings provided accurately reflect the Board's current level of confidence and assurance.

The Board acknowledges that:

- A rating of **Assured with Managed Risks** may result in discussion as part of routine regional oversight and assurance processes.
- A rating of **Partially Assured** will prompt further engagement between the Regional Team and the Executive Team to understand outstanding risks, dependencies and mitigating actions.
- A rating of **Not Assured** will result in a formal **Board-to-Board discussion** with the Regional Team to review concerns, identify support requirements and agree next steps.

Organisation: North West Ambulance Service

Board Meeting Date: 30th September 2026

Signed: _____

Name: _____

Role (Chair): _____

Chief Executive: _____

Date of Submission: _____

Regional Review (for completion by NHS England Regional Team)

Assessment Area	Board Rating	Regional Follow-up Required
Delivery of 2026/27 Plan		
Winter Preparedness		
Commencement of 2027/28 Planning		

Overall Regional Assessment:

- ☐ No Further Action
- ☐ Routine Monitoring
- ☐ Further Executive Discussion Required
- ☐ Board-to-Board Discussion Required

Regional Lead: _____

Date: _____

To: Chief Executives - Provider organisations

cc. Chairs
Chief Finance Officers / Directors of Finance
Chief Operating Officers

NHS England
North West Region
3 Piccadilly Place
Manchester
M1 3BN

18 September 2026

Dear Chief Executives

Subject: Mid-Year Review 2026/27: Board Self-Assessment and Certification

As part of the regional Mid-Year Review process for 2026/27, we are asking all Provider Boards to complete the attached Board Self-Assessment and Certification template and return this to the Regional Team by **Friday 2 October 2026**.

The purpose of the self-assessment is to provide a structured and consistent approach through which Boards can formally review and confirm their confidence in the delivery of their 2026/27 plans. It is intended to support open and transparent discussion at Board level regarding organisational performance, delivery risks, mitigations and the actions required to maintain delivery throughout the remainder of the financial year.

The exercise seeks Board assurance across a number of key domains that are critical to successful delivery of annual plans, including operational performance, financial sustainability, workforce, productivity, transformation, governance, risk management and winter preparedness.

Whilst a separate regional winter assurance process is being undertaken, this certification process also seeks explicit Board assurance that winter planning and resilience arrangements have been fully considered and that the organisation remains confident in its ability to deliver its 2026/27 objectives throughout the winter period.

The self-assessment is designed to supplement existing performance and assurance arrangements rather than create an additional monitoring process. We are seeking a Board-level assessment of organisational confidence, supported by evidence and commentary where appropriate, together with an honest reflection of any areas of concern, associated risks and mitigating actions.



The process also provides an opportunity to understand organisational readiness for the next planning cycle and ensure that early preparation for 2027/28 is underway. Boards are asked to assess each assurance statement against the four-point rating scale contained within the template and provide supporting narrative where assurance is not fully achieved or where further action is required.

The outputs from this exercise will:

- Inform the regional Mid-Year Review assessment.
- Support a consistent understanding of delivery confidence across the region.
- Identify common themes, risks and areas requiring further support or intervention.
- Provide assurance to the Regional Executive Team regarding the deliverability of organisational and system plans for 2026/27.
- Indicate organisational readiness for 2027/28 planning.

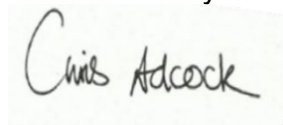
We would be grateful if completed templates could be submitted to the Regional Team by **Friday 2 October 2026** via england.nhs-nwplanning@nhs.net. Following receipt, the Regional Team may engage with organisations where further discussion or clarification is required.

We recognise the significant pressures currently facing organisations and appreciate your support in completing this important assurance exercise. We would encourage the self-assessment to be reviewed and endorsed through appropriate Board governance arrangements prior to submission.

This process is intended not simply as an assurance exercise, but as an opportunity for Boards and the Region to collectively assess confidence in delivery, identify emerging risks early and ensure that the right support is in place to maximise successful delivery of our shared ambitions for 2026/27.

If you have any questions regarding the process, please contact the Regional Team via england.nhs-nwplanning@nhs.net.

Yours faithfully



Chris Adcock
Regional Chief Finance Officer – North West





REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 2026
SUBJECT	Provider Capability Self-Assessment
PRESENTED BY	Mike Gibbs, Executive Director of Strategy & Partnerships
PURPOSE	Decision

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

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

ACTION REQUIRED	Trust Board of Directors is asked to: - Review and approve the 2026 Provider Capability Self-Assessment at Appendix 1, including the proposed rating for each of the six domains. - Confirm that the assessment reflects the Board's collective view of organisational capability, including the supporting evidence, areas requiring development and actions to address them. - Authorise Chair and Chief Executive sign-off and submission to NHS England by 5pm on 2nd October 2026.
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EXECUTIVE SUMMARY

This paper presents NWAS's 2026 Provider Capability Self-Assessment for Board approval ahead of submission to NHS England by 5pm on 2nd October 2026. It builds on the Trust's previous assessment, submitted in October 2025, which resulted in a Green capability rating confirmed in March 2026.

The updated guidance retains six domains and requires a proposed Green, Amber-Green, Amber-Red or Red rating for each. It places greater emphasis on cyber security, digital maturity and Board oversight of staff wellbeing. Boards must demonstrate the effectiveness of their governance arrangements, explain changes since the previous assessment, and identify concerns or development needs alongside the actions being taken.

The previous submission has provided the starting point for the review, with executive colleagues asked to update the narrative and supporting evidence across their portfolios. The assessment draws on existing Board and committee assurance, performance information, audit findings and external reviews.

The proposed assessment is Green across five domains and Amber-Green for Access and delivery of services. The Amber-Green rating reflects positive performance across several UEC indicators alongside ambulance production shortfalls, above-plan demand, increasing hospital handover delays and limited alternative care pathways. Recovery actions are in place, although significant system dependencies remain.

The full assessment is provided at Appendix 1. The Board is asked to review and agree the proposed ratings and supporting narrative, ensuring these reflect its collective assessment of organisational capability, before Chair and Chief Executive sign-off and submission. NHS England will consider the return alongside other evidence to determine the Trust's refreshed capability rating.

PREVIOUSLY CONSIDERED BY

Date	
Outcome	

1. BACKGROUND

- 1.1. NHS England requires provider boards to undertake an annual capability self-assessment across six domains derived from The Insightful Provider Board:
 - Strategy, leadership and planning
 - Quality of care
 - People and culture
 - Access and delivery of services
 - Productivity and value for money
 - Financial performance and oversight.
- 1.2. The assessment considers how effectively the Board leads and governs the organisation, oversees delivery and responds to risks. It draws on existing assurance and evidence of effectiveness, including the Board's track record in identifying and addressing concerns.
- 1.3. The 2026 guidance includes revised expectations relating to cyber security, digital maturity and Board oversight of staff wellbeing. Providers are also required to describe relevant developments and improvements since the 2025 assessment. A four-point rating framework - Green, Amber-Green, Amber-Red and Red, is supported by indicative criteria for each domain.
- 1.4. NHS England regional teams will review the submission alongside their own assessment, third-party information and the Trust's recent track record. The resulting capability rating will undergo national moderation and ratification before being communicated to the Trust and published.
- 1.5. The completed assessment requires Chair and Chief Executive sign-off and submission by 5pm on 2nd October 2026. This is a separate requirement from the regional Mid-Year Review certification of plan delivery, winter preparedness and commencement of planning for 2027/28.

2. NWAS POSITION AND EVIDENCE BASE

- 2.1 The 2025 submission has been used as the baseline for this year's assessment. Executive leads have been asked to review the narrative within their portfolios, update the supporting evidence and identify changes, concerns and development needs against the revised capability statements.
- 2.2 The evidence base draws on established assurance sources, including:
 - Board and committee reports, the Board Assurance Framework and risk registers.
 - Annual Report and Accounts, Quality Account and governance statements.
 - Internal audit findings, independent reviews and external assessments.
 - Workforce, clinical, financial and operational performance information.

- Patient, staff and partner feedback, alongside evidence of improvement

2.3 Relevant developments since the previous submission include approval of the Trust Strategy 2026–31, its alignment with the 10-Year Health Plan, further system engagement and Board development activity. The review also addresses the updated expectations for cyber security, digital maturity and staff wellbeing.

2.4 The proposed domain ratings are summarised below. Appendix 1 provides the supporting narrative, referencing the evidence and assurance arrangements underpinning each assessment. The underlying documents are not reproduced within this paper. The Board is asked to consider the proposed ratings alongside the assurance received through its established reporting and committee arrangements, and to identify any further clarification required before approval.

Domain	Proposed rating
Strategy, leadership and planning	Green
Quality of care	Green
People and culture	Green
Access and delivery of services	Amber-Green
Productivity and value for money	Green
Financial performance and oversight	Green

2.5 The Board is asked to consider whether the evidence supports each rating, whether significant concerns and development needs are adequately reflected, and whether the actions identified are sufficient to address them.

3. RISK CONSIDERATION

3.1 Regulatory risk: Failure to submit an approved assessment by 2nd October 2026 could affect NHS England’s confidence in the Trust’s governance. Board consideration on 30th September provides a limited window for resolving outstanding issues and completing Chair and Chief Executive sign-off.

3.2 Assurance risk: An assessment that overstates capability or omits material concerns could undermine the reliability of the Board’s assurance. Executive review, reference to current evidence and Board scrutiny of the proposed ratings are intended to mitigate this risk.

- 3.3** Reputational risk: Inconsistency between the self-assessment and NHS England's wider evidence could weaken confidence in the Trust's leadership. The return should transparently reflect strengths, development needs and the actions being taken.

4 EQUALITY / SUSTAINABILITY IMPACTS

- 4.1** No direct adverse equality or sustainability impacts have been identified from completing this assessment.
- 4.2** The assessment considers the Board's oversight of inequalities in access, patient experience and outcomes, alongside workforce equality, inclusion and wellbeing. It also considers the Trust's capability to deliver safe, sustainable services through effective planning, partnership working and use of resources.
- 4.3** Any development needs identified will be addressed through the relevant organisational plans and assurance arrangements.

ACTION REQUIRED

The Board of Directors is asked to:

- Review and approve the 2026 Provider Capability Self-Assessment at Appendix 1, including the proposed rating for each of the six domains.
- Confirm that the assessment reflects the Board's collective view of organisational capability, including the supporting evidence, areas requiring development and actions to address them.
- Authorise Chair and Chief Executive sign-off and submission to NHS England by 5pm on 2nd October 2026.

Provider capability self-assessment template 2026

I. Strategy, leadership and planning

Capability statements	Proposed domain rating
	Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	The Board approved the NWS Strategy 2026–31 in March 2026. Developed through engagement with staff, patients, communities and system partners, it reflects the 10-Year Health Plan and sets clear priorities for outstanding inclusive care; a safe, supportive and inclusive culture; a responsive care model through partnerships; and continuous improvement and innovation for a sustainable future. The strategy recognises NWS's contribution to care closer to home, prevention and reducing health inequalities alongside its core ambulance responsibilities. Four supporting strategic plans, the medium-term plan and annual objectives translate this direction into delivery commitments. Operational, workforce, financial and capital planning are brought together through the planning process, with executive accountability for delivery and Board oversight of progress, risks and dependencies. Financial plans are aligned with ICBs. Capital expenditure plans are approved by the Board and reflect capital allocations (CDEL). Monitoring against capital resource limits is managed at a system level. A formal executive succession planning exercise has been reported to the Board and is being refreshed to align with regional talent processes. Development plans are in place for deputies and identified senior talent, with NED succession arrangements being developed as new appointments become embedded. The Board has commenced a development programme to support the establishment of the new Board and strengthen governance, collective effectiveness and the leadership required to deliver the strategy in the context of national reform. Executive responsibilities for quality, access, operational planning and finance are clearly defined and shared across the Board. NWS works across a complex regional footprint, engaging with ICBs, providers, local authorities and wider partners through system and place-based arrangements and ambulance improvement forums. The Trust
2. If in breach of licence: The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	
5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	

	also participates in provider collaboratives, the Northern Ambulance Alliance and AACE. Executive and non-executive engagement supports the Board's understanding of system priorities, pressures and opportunities for joint working. Partner engagement events in February and July 2026 supported the development and implementation of the new strategy, providing opportunities to test priorities, respond to feedback and identify areas for collaboration. This work is informing the Partnership Operating Framework, which is being developed to provide a more consistent and prioritised approach to partnership working. Partner feedback and relationship surveys provide further insight into the effectiveness of engagement and areas requiring attention. System strategies and Joint Forward Plans inform NWS's planning, with shared priorities including urgent and emergency care improvement, reducing inequalities and supporting community-based care. Population-health insight, including nursing-home call activity, supports discussions with partners about demand, variation and opportunities to improve services. The Board recognises that engagement and participation alone do not demonstrate impact: joint delivery remains variable amid operational and financial pressures, and clearer evidence of shared outcomes is needed to strengthen assurance. There is a strategic risk on the BAF in relation to the risk of a cyber incident. This is also supported by further risks on the corporate risk register. The Board approved Future Sustainability Strategic Plan describes digital as an enabler for transformation. There is digital engagement across the ICB footprints and across the ambulance sector.
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II. Quality of care

Capability statements	Proposed domain rating
	Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	NWAS has established governance processes to monitor and continually improve the quality of care. The Clinical and Quality Group, Trust Management Committee, and Quality & Performance Committee provide assurance to the Board through regular reports on patient safety (PSIRF), safeguarding, infection prevention and control, learning from deaths, complaints, CQC updates, and the statutory Quality Account. The Board receives regular reports on patient experience through the Clinical & Quality Group and Quality & Performance Committee, triangulating qualitative and quantitative data.
7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients	Reporting arrangements are in place to monitor and improve the quality of care provided to patients. Recent developments include the introduction of the Right First Time, Every Time improvement programme and the design of a Trust Accreditation Framework, both of which support teams to identify opportunities for improvement, share learning and promote consistent standards of care. Together, these initiatives help to contribute to a culture of continuous improvement and provide a structured approach to quality assurance.
8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Variation in patient experience is assessed through demographic reporting. Quarterly Learning from Deaths infographics provide breakdowns by gender, age, ethnicity, and deprivation to identify potential inequalities. In addition, the new Population Health Dashboard for 999 calls and incidents enables analysis of protected characteristics. This is supported by deliverables in the Annual Plan and EDI plan to embed its use.

	Our Equality Impact Assessment (EIA) process has developed to become the Equality Quality Impact Assessment (EQIA) process, the amalgamation of the two processes enables us to have a more complete view of organisational policy or change impacts, benefits and risks for patients/carers and staff. The Friends and Family Test, complaints reporting, and Freedom to Speak Up data are monitored, with protected characteristics of staff concerns reviewed to identify barriers for particular groups. Serious and recurring complaints are escalated through the Corporate Governance framework to the relevant executive for action and onward reporting to the Board. Patient and public voice is embedded through the Patient and Public Panel (currently 255 members with 37% youth representation and 34% diverse representation), which contributes to Trust projects and improvement work. Insights from service users are fed into governance processes, ensuring they shape improvement. Board members are engaged in learning through development sessions, external reviews such as GGI, and staff-facing initiatives including clinical development days, ensuring they have the skills and insight to oversee patient experience and safety effectively. Non-Executive Directors play an active role in securing assurance, both through the Quality & Performance Committee and via direct engagement with services and patients. NED participation in learning and development sessions provides independent oversight and triangulation of Board-level information. PSIRF priorities are governed through internal and external processes and have been supported by the NWAS Improvement Academy. We have invested in dedicated Patient Safety Improvement leadership to further develop this work. Internal audits (MIAA) have provided substantial assurance in areas such as safeguarding and PSIRF, and learning is shared through regional and national safety groups. We have reviewed our processes established at the launch of PSIRF and we have developed a robust
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	investigation and learning regime that provides assurance that investigations are high quality, timely and learning is embedded into practice. There are clear internal reporting mechanisms and escalation routes to address any difficulties in meeting our statutory responsibilities. Specialist training is available for staff and board to ensure roles, responsibilities and methodologies are clear and applied consistently. We have clear procedures regarding meeting regulatory requirements for Duty of Candour and we are supporting the Care Quality Commission to develop their approach to measuring and monitoring Duty of Candour in the ambulance sector. The Board reviews learning from national reviews (Ockenden, Fuller) and monitors Ambulance Quality Indicators and outcome data, benchmarking against other trusts. A population health dashboard further supports targeted improvement. Our NWAS Improvement Approach documents a strategic plan to develop the organisation into an improvement organisation. This year the focus is on building improvement capability and capacity and transforming our management operating system. This aims to ensure a sustainable improvement approach to operational delivery of quality and performance metrics, with clear management oversight and accountability.
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People and culture

Capability statements	Proposed domain rating
	Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience	The Board regularly reviews workforce diversity data and staff survey results through its reporting cycle to the Resources Committee, Board, and Trust Management Committee. This includes WRES, WDES, gender and ethnicity pay gaps, disability pay gaps, and assurance against the Ambulance Culture Review recommendations.
10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	Diversity and inclusion are monitored through a Board-approved EDI objectives, aligned to strategy, and supporting action plan, overseen by the Diversity & Inclusion Group, which reports to TMC. The plan is data-driven and incorporates high-impact actions. Staff networks (women, disability, race, LGBT+, armed forces) have executive sponsors and feed directly into policy and governance. Staff survey data informs the People & Culture Strategic Plan and annual plans. Local action plans are developed in response to survey results, with progress monitored by the People and Culture Group and reported to TMC. Results have improved year-on-year, with NWAS now in the top three in sector across all themes.
11. Staff can express concerns in an open and constructive environment	The Board engages with staff directly through forums, networks, partnership arrangements with trade unions, and by hearing staff stories at each Board meeting. Learner voice is also actively captured and the Trust has implemented the Safe Learning Environment Charter, with assurance provided to the People and Culture Group. The recent Ofsted rating of “Good” reflected positively on the Trust’s engagement with trainees. These mechanisms ensure that staff feedback consistently informs improvements to culture, workforce experience, and ultimately the quality of care provided. NWAS regularly reviews skills and capabilities across all levels of the organisation. As an employer-provider of apprenticeships, the Trust delivers regulated and in-house training, with provision rated “Good” by Ofsted in 2025. A Paramedic Consultant of Education provides specialist advice to ensure training remains appropriate and current. NWAS also engages with the national education network to share best practice and has undertaken a recent equality impact assessment of its apprenticeship programme content to deliver increased cultural competence in our clinicians and support the health inequalities agenda.

	Mandatory training is compliant with national statutory and Core Skills Training Framework (CSTF) requirements. The Trust is fully aligned with the requirements of the national Statutory and Mandatory Training review. Training priorities are informed by risk analysis and patient safety learning, with requirements agreed through the Oversight Group and TMC. Compliance is monitored by TMC, Resources Committee, and the Board, with deep dives undertaken by the People and Culture Group. Mandatory training compliance remains consistently above target. All Board members and senior leaders have People and Culture-related objectives, which are regularly monitored to strengthen leadership accountability and capability in this area. Performance data and qualitative feedback are used to identify and target areas for improvement, whether thematic (e.g., specific training topics) or geographical/hotspot based, ensuring tailored interventions and continuous learning. Significant investment continues in leadership and improvement capability, including cultural leadership events, senior leadership programmes, and the NWS Improvement Approach. Work has commenced to align the offer to the NHS Leadership & Management framework. Leadership scores for frontline services in the staff survey show significant increases in 2025 results. Clinical practice is further supported by a comprehensive skills and medicines management matrix and advanced paramedic governance framework. The Board has a Health and Wellbeing Guardian who engages actively with the wellbeing agenda at a local and sector level. The Board receives assurance on wellbeing and attendance initiatives a minimum of twice yearly through Resources Committee. NWS has two full-time Freedom to Speak Up (FTSU) Guardians supported by a clear policy, which was described by GGI as “highly commendable” with robust processes for raising and learning from concerns. Mandatory FTSU training compliance is over 90% and has been externally assured by MIAA. The Board receives regular FTSU reports, including lessons learned, and has an identified NED lead. Guardians meet monthly with the CEO, DoO, MD and DoP to escalate issues and ensure executive oversight of complex cases. A streamlined FTSU form and range of reporting methods have been promoted to improve accessibility, with casework overseen through TMC, Resources Committee and the Board. Staff survey results show progress. The proportion of staff who feel safe to speak up (Q25e) increased from 55% in 2021 to 59% in 2025, against a static national average, making NWS one of only two ambulance trusts to show improvement. Confidence that concerns will be addressed (Q25f) has also improved from 41% to 46% over the same period, though it remains below acute trust averages. NWS is one of only three ambulance trusts to record growth in this measure since 2020. The Board monitors reporting culture through staff survey benchmarking, incident reporting data, and safety culture surveys. Reported patient safety events have increased over five years, reflecting improved openness, with feedback loops highlighted as an area for further strengthening.
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	Together, these mechanisms demonstrate a safe reporting culture with clear governance, visible executive oversight, and evidence of action being taken in response to staff concerns, while also identifying where further improvement is required.
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III. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
12. Plans are in place to improve performance against the relevant access and waiting times standards	NWAS is delivering against the majority of internally influenced urgent and emergency care (UEC) metrics, including Hear and Treat, call pick-up, availability, on-scene times, and call-handler and clinician workforce plans. The current Category 2 mean response time is below 25 minutes.
13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients	However, incident volumes are significantly above the UEC plan, ambulance production is below plan, and hospital handover times are increasing and exceeding planned levels. Limited alternatives to conveyance also constrain See and Treat and opportunities to reduce conveyance to emergency departments.
14. Appropriate population health targets have been agreed with the ICB	Delivery of the UEC plan is overseen through the executive-led group, Trust Management Committee, Quality and Performance Committee and the Board. A recovery plan for ambulance production is in place, with the Board and Trust Management Committee sighted on the actions. NWAS has concerns about system leadership, oversight and accountability for UEC delivery following the standing down of ICB-led UEC delivery boards. Plans to expand alternatives to emergency departments remain limited, both for winter and the longer term. The 45-minute hospital handover standard has not been consistently delivered, and delays exceeding 45 minutes continue to increase. NWAS has also observed a significant increase in patients waiting outside emergency departments alongside changes intended to reduce corridor care. These system dependencies constrain delivery despite improvements in performance within the Trust's direct influence. The Trust's health inequalities framework is embedded within the NWAS Strategy 2026–31, with clear delivery commitments included in the 2026/27 Annual Plan. The strategic approach was approved by the Board following consultation with system partners, including ICBs. This year's workplan identifies mental health, maternity and falls as priority areas, translating the strategic commitment into focused programmes of work. Annual plan deliverables have identified executive sponsors and senior responsible owners. Progress is reviewed through the relevant executive-led committees and quarterly Planning Group reviews, with onward assurance through Trust Management Committee, Resources Committee and the Board.

	The Population Health Dashboard enables analysis of 999 activity by age, sex, ethnicity, geography and deprivation, supporting identification of variation in demand and access. Annual Plan and EDI commitments support embedding its use in service planning and improvement. The combined Equality and Quality Impact Assessment process also supports consideration of the effects of organisational policies and service changes on patients, carers and staff. The Board receives information on geographical variation in response times and differences affecting patients with mental health needs. Operational arrangements, including the area-level Clinical Safety Plan, regional coordination of ambulance resources and escalation processes, support action to address variation in response and waiting times. Hospital handover delays and differences in the availability of alternative care pathways remain significant constraints, requiring action with providers, ICBs and NHS England. Population-health insight supports discussions with commissioners and partners about service provision and opportunities to reduce inequalities. Workforce development supports this approach, including health inequalities education and a recent equality impact assessment of apprenticeship programme content to strengthen cultural competence.
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IV. Productivity and value for money

Capability statements	Proposed domain rating
	Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	The Board reviews benchmarking data from the NHS Model Health System and PLICS, with outputs reported through the Resources Committee. This information is used to assess performance against peers, identify unwarranted variation, and target improvement opportunities, particularly within the PES service. NWAS has a strong track record in delivering planned productivity and efficiency programmes. Targets have been achieved in-year for the last three financial years, with improvements in recurrent delivery. Any shortfall is transparently reported through TMC and the Resources Committee and factored into financial planning for the following year

V. Financial performance and oversight

Capability statements	Proposed domain rating
	Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements	NWAS has a comprehensive internal audit plan, agreed by executives and the Audit Committee, which includes annual reviews of data quality to provide assurance on financial systems and the reliability of performance reporting. Clean value for money assessment as part of the 2025/26 annual external audit. There have been no contract disputes in the last 12 months.
17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes	Staffing and financial systems are closely aligned, underpinned by a strong triangulated approach between operational planning, workforce planning and financial management. There is effective joint vacancy control and joint oversight of recruitment and workforce decisions, ensuring resources are deployed safely and efficiently. As a result, the Trust has not been reliant on agency or bank staff. Agency spend reduced to near zero during 2025/26, with only zero costs incurred in-year. The Board stress-tests the impact of financial efficiency plans using the Optima modelling tool, which triangulates activity, performance, and workforce. This approach ensures alignment with the financial envelope while supporting UEC recovery plans and accounting for efficiency and productivity requirements.
18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	Equality and Quality Impact Assessments (EQIAs) are completed for relevant schemes and reported to the Quality Committee, providing safeguards to ensure that efficiency programmes do not compromise quality of care, access, or staff wellbeing. Performance against the financial plan is tracked through the Resources Committee, with variances examined to understand underlying drivers and ensure corrective actions are taken where required. The Board actively contributes to system-wide financial discussions through ICB planning processes and provider collaborative forums. NWAS's financial plan is aligned with partner organisations and Joint Forward Plans across the ICSs in its footprint. The Trust has supported overall system financial performance by delivering a surplus against breakeven plans for the last three financial years, demonstrating its commitment to balancing organisational priorities with system priorities for the benefit of the wider population and the NHS.

Signed on behalf of the Board of Directors

Chair: _____

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: _____

Signature: _____ Date: _____



ESCALATION AND ASSURANCE REPORT

Report from the Resources Committee

Date of meeting	Thursday, 24 September 2026		
Members present	Mr N Gower, Non-Executive Director, Interim Chair Ms C Butterworth, Non-Executive Director Ms C Todd, Non-Executive Director Mr D Ainsworth, Director of Operations 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:

- Workforce: Sickness in July was 7.38% (25/26 7.15%). ICC and PTS now tracking below and PES above 25/26 position. Five-year plan requires an improvement of 1.29% in year and risk of not achieving this is considered high.

ADVISE:

Equality & Human Rights Commission Code of Practice Impact

- The Committee received the report highlighting that the publication of the Equality and Human Rights Commission (EHRC) Statutory Code of Practice, following a UK Supreme Court judgment has significantly changed the legal framework for managing single-sex facilities. Challenges to implementation and the significant estate work required were noted.

NHS Leadership & Management Framework

- The Committee noted the overview of the new NHS Leadership and Management Code and Framework and the implementation plans.

The Committee reviewed the following items and recommended for Board approval:

- Revised 2026/27 Capital Programme
- The Integrated Core System OBC
- Future Workforce Solution - proceeding into Foundational Readiness Phase 2
- Flu Campaign 2026/27 – Board Assurance Checklist
The Committee noted the NHS expectation of 60% plus uptake in Flu vaccination is very challenging when compared to 45% actual last year.
- Disciplinary Policy and Fast Track Disciplinary Procedure. The Committee noted there would be slight changes from version received at the Resources Committee and those would be highlighted in the Board report.



ASSURE:

The Committee received the following reports:

Board Assurance Framework

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

Finance Report Month 05 2026/27

- Financial performance including CIP at or close to plan with actions in hand to deliver full year plan.

Workforce indicators

- The overall vacancy gap is stable at 3.7% with actions in hand to address shortfall in DCA production. Other indicators are generally stable and reported in the IPR.

Other assurance reports received:

- Procurement Report
- Sustainability Update- mainly based on 25/26 full year position.
- Private Ambulance Spend Annual Report
- National Statutory Training Report
- Digital Plan Update

RISKS

Risks discussed:

- As above

New risks identified:

- As above



ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 19 August 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 D Ainsworth, Director of Operations Dr C Grant, Medical Director 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 Mr M Jackson, Chief Consultant Paramedic Mrs J Wharton, Chief Information Officer In attendance Mr S Ali, Deputy Director of Strategy & Partnerships Mrs A Cunliffe, Corporate Governance Manager (minutes)	Quorate	Yes

Key escalation and discussion points from the meeting

ALERT:

- **UEC productivity and workforce** – DCA production remains below plan, with a reported shortfall of 17,664 hours YTD. Workforce availability constraints, particularly within the EMT and UCS workforce continue to impact operational performance.

ADVISE:

The TMC approved the:

- Corporate Risk Register and current corporate risk profile.
- The 2026/27 Flu Vaccination Campaign delivery model and supporting improvement strategies was discussed to maximise uptake.
- Recommendation that the Board of Directors approve progression to Future Workforce Solution Foundational Readiness Phase 2 and delegation of future project decisions to the Corporate Programme Board.

ASSURE:

The TMC received and discussed the following reports for assurance:

- **Finance report month 04** – The Trust reported 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** – Category 2 performance improved significantly during July and retuned within target. Category 1 response times remained outside target. Hear and treat and see and treat performance remained below trajectory. Demand continued to exceed UEC projections and sickness absence pressures continued within ICC and PES.
- **Policy Management Framework** – The Trust continues to demonstrate a positive compliance position. Two policies are overdue review and 16 policies are due for review within the next 3-6 months, with appropriate oversight arrangements in place.
- **NHS Staff Survey 2026 Preparation** – Planning for the survey launch is well advanced, including revised communications, engagement activities and reviewed reporting structures to support participation and meaningful feedback.
- **Flu Vaccination Campaign** – Plans are in place for delivery of the 2026/27 campaign supported by additional NHS England funding. Focus will be placed on improving uptake through leadership, communications, accessibility and staff engagement.
- **Future Workforce Solution Programme** – NWAS successfully completed Phase 1 foundational readiness requirements and has formally passed the first national milestone. Board approval is sought for progression to Phase 2.

The TMC received the following Escalation & Assurance reports:

- **Health, Safety, Security & Fire Group – 14 July 2026**
Concerns were raised regarding the quality of non-clinical incident investigations. Assurance was provided regarding improving safety performance, comparative RIDDOR performance, violence prevention, infection prevention and fleet compliance.

RISKS

Risks discussed:

- The overall risk profile remains stable with no new risks identified and all risks actively managed. The Cyber Security risk reduced from a score of 20 to 15 following successful DSPT submission and positive audit assurance.
- The longstanding risk relating to the national job evaluation review of EMT1 Band 4 post remains open and under monitoring.
- The Patient Transport Services risk is currently under review following the recent procurement decision.

New risks identified: None.



ESCALATION AND ASSURANCE REPORT

Report from the Trust Management Committee

Date of meeting	Wednesday, 23 September 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 D Ainsworth, Director of Operations Dr C Grant, Medical Director Mr M Gibbs, Director of Strategy and Partnerships Ms S Rose, Integrated Contact Centres Director Ms J Wood, Integrated Contact Centres Director Ms S Wimbury, Area Director – Greater Manchester Mr M Cooper, Area Director – Cumbria & Lancashire Mr I Moses, Area Director – Cheshire & Merseyside Mr M Jackson, Chief Consultant Paramedic Mrs J Wharton, Chief Information Officer In attendance Mrs J Turk, Executive Business Support Manager (minutes)	Quorate	Yes

Key escalation and discussion points from the meeting

ALERT:

- **Procurement of 10 additional electric ambulances (BEV DCA)** – The TMC did not approve the procurement of 10 additional electric ambulance vehicles. Members agreed that the existing vehicles already in place should be used for robust testing and evaluation before any further commitment to purchasing additional electric ambulances is made.
- **UEC productivity and workforce** – UEC performance remains under pressure, with DCA production cumulatively behind plan, demand continues above plan and PES sickness above seasonal forecast. Improvement plan in place and being progressed.
- **Winter assurance and handover** – The TMC noted the outcomes of the regional winter exercise held on 18 September. While the exercise worked through a very specific scenario, there were aspects of handover arrangements that could not be fully tested or assured through the exercise, particularly given the differing operational pressures and performance variations across the region.

ADVISE:

- **Capital programme** – The TMC recommended the revised 2026/27 capital plan to Resources Committee for approval.

- **Hear and Treat** - The TMC noted the proposed changes to Hear and Treat reporting and NOF segmentation, including the intention to backdate reporting to 1 April 2026 and align trust reporting with national requirements.
- **Disciplinary Policy and Fast Track Disciplinary Procedure** – The TMC recommended approval of the revised policy and procedures to Resources Committee and Board, subject to the inclusion of reference to wording about permitting staff access to information for work purposes only.
- **PTS Demobilisation** – The TMC noted progress with the demobilisation plan and approved the revised approach to the PTS digital roll out programme.

ASSURE:

The TMC received and discussed the following reports for assurance:

- **Finance report month 05** – The TMC noted a £0.186m surplus against a planned deficit of £1.074m and a month 05 forecast breakeven position in line with financial plans. Savings of £5.317m had been achieved to month 05, with a risk adjusted in year shortfall of £0.564m.
- **Integrated Performance Report** – The TMC noted improvements in Cat 2 performance and NHS 111 performance despite higher demand, whilst recognising ongoing pressures relating to handover, PES, sickness, hear and treat, see and treat and clinical outcome measures.
- **Policy Management Framework** – The Trust continues to demonstrate a high policy compliance at 96% with four overdue policies and 16 due for review within 3-6 months. Oversight arrangements remain in place to monitor policy review and renewal activity.
- **UEC Performance and Improvement Plan** – Progress was being made to support UEC recovery, including workforce recovery actions and work with PAS providers, while recognising that further clarity is required on delivery trajectories and DCA hour recovery.
- **Winter Assurance Submission** - The TMC approved the winter assurance template return for submission to NHS England and approved the stage 1 EQIA subject to the amendments discussed.
- **Leadership and Management Framework** – The NHS Leadership and Management Code and Framework was approved and the TMC supported a phased approach to self-assessment, with TMC members agreeing to champion the process and monitor completion through directorate leadership teams.

The TMC received the following Escalation & Assurance reports:

- Information & Cyber Governance Group – 11 August
- Operational & Performance Group – 25 August
- Diversity & Inclusion Group – 3 September
- Sustainability Group – 7 September
- Clinical & Quality Group – 8 September
- People & Culture Group – 16 September

RISKS

The overall corporate risk profile remained stable. The adequacy of controls, assurances and mitigating actions were reviewed.

New risks identified: Risk ID 867 was approved for addition to the Corporate Risk Register, relating to the arboriculture survey and risks associated with trees across the Trust estate. The initial score of 15 was discussed with ownership to be assigned to the Director of Finance.



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 2026
SUBJECT	Future Workforce Solution – project approval to proceed to Foundational Readiness Phase 2
PRESENTED BY	Lisa Ward, Director of People/Deputy Chief Executive
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 <i>(Decision Papers Only)</i>	Quality: Cautious	☐	People: Open	☒	Finance: Open	☒
	Regulatory: Open	☐	Reputation: Open	☐	Digital Innovation: Eager	☒

ACTION REQUIRED	The Board of Directors is asked to: - Approve the Trust proceeding into Foundational Readiness Phase 2 - Support the delegation of future project decisions to the Corporate Programme Board
EXECUTIVE SUMMARY	The Department for Health and Social Care (DHSC) has commissioned the NHS Business Services Authority (NHSBSA) to identify and deliver the Future NHS Workforce Solution. NWAS was offered the opportunity to become an early adopter in January 2026 and approval was given by the Board to proceed to complete the Phase 1 foundational readiness assessment with the opportunity to approve proceeding into implementation at the end of phase 1. The Trust has mobilised a project oversight structure reporting into the Corporate Programme Board. This incorporates a Project Board chaired by the SRO; a Steering Group; and Technical and Business Transformation task and finish groups. Additional project groups including communications and training have been scoped and will be mobilised at a suitable point in the project. The project is supported through the PMO. NWAS completed the required submissions in the Part 1 foundational readiness stage by the due deadline of 30th June 2026. This phase included:

- Project governance structure developed
- Technical and Business process transformation groups initiated
- Lead identified for each of the solution Domains
- Systems landscape (workforce applications) template completed
- Interface list template completed
- Data cleansing and mapping commencement
- Shared services providers notified of early adopter status
- Benefits workshop completed – benefits logic model drafted, with 3 prioritised benefits identified
- Key stakeholders attended 'Domain deep dive' webinars

Following submission of the Phase 1 scoping document NWS has received formal confirmation that it has successfully passed the first official programme milestone and have been formally approved to move into the next phase of the project. This is subject to formal Board approval to proceed with the project which needs to be in place by 30th September 2026. In light of this the Trust is currently proceeding at risk to commence work on phase 2 foundational readiness pending this confirmation from Resources Committee on behalf of Board.

It should be noted that the overall timeframes for the project have been extended nationally with an additional readiness phase from July to November 2026. This will be followed by a design and testing phase until Q4 2027/2028 followed by Go Live. There will be key decision milestones and safeguards built into the programme to enable the trust to review involvement if required.

A full Project Initiation Document will now be developed by November 2026 in line with the end of the second foundational readiness phase.

PREVIOUSLY CONSIDERED BY

Resources Committee

Date	24 th September 2026
Outcome	Recommended approval of the Trust's continuation as an early adopter and for the project to be remitted to the Corporate Programme Board for continuing oversight.

Trust Management Committee

Date	19 August 2026
Outcome	Approved the trust's continuing involvement in project and recommend the responsibility for future project decisions transferring to Corporate Programme Board.

1. BACKGROUND

- 1.1 The Electronic Staff Record (ESR) has been in use across the NHS since 2008. Digital technology and the needs and expectations of the NHS have now advanced significantly meaning that ESR is no longer fit for purpose.
- 1.2 The Department for Health and Social Care (DHSC) has commissioned the NHS Business Services Authority (NHSBSA) to identify and deliver the Future NHS Workforce Solution. The NHSBSA had led a procurement exercise to identify the supplier for the future solution and Infosys have been awarded the contract to deliver a new enhanced workforce management solution. Infosys will take over running of the existing ESR contract from September 2026, as well as developing and implementing the new solution.
- 1.3 As a current user of ESR, NWAS will have to transition to the new system at some point during the planned implementation roll out between 2027 and 2030. However, NWAS was offered the opportunity to become an early adopter in January 2026 and approval was given by the Board to proceed to complete the Phase 1 foundational readiness assessment with the opportunity to approve proceeding into the readiness phase 2 and subsequently, implementation at the end of phase 1.
- 1.4 The implementation of the Future Workforce Solution (now to be called the People Portal) is not just a replacement of an existing software platform, it is intended to provide an opportunity to review and transform HR and payroll processes and to provide a single transferable record for each NHS employee. Implementation therefore offers a real opportunity for improvement.
- 1.5 The People and Culture Strategic Plan includes a key deliverable, under the Leadership and Management objective, associated with the transformation of processes and the release of management time. This recognised that the Future Workforce Solution would be implemented within the timeframe of the strategy, so early adoption supports strategy delivery and opens opportunities for further integration and improvement in systems.

2. CURRENT POSITION

- 2.1 The Trust has mobilised a project oversight structure reporting into the Corporate Programme Board (CPB). This incorporates a Project Board chaired by the SRO; a Steering Group and Technical and Business Transformation project groups. Additional project groups, including communications and training, have been scoped and will be mobilised at a suitable point in the project. The project is supported through the PMO.
- 2.2 NWAS completed the required submissions in the Part 1 foundational readiness stage by the due deadline of 30th June 2026. This phase included:
 - Project governance structure developed
 - Technical and Business process transformation groups initiated
 - Lead identified for each of the solution Domains
 - Systems landscape (workforce applications) template completed
 - Interface list template completed
 - Data cleansing and mapping commencement
 - Shared services providers notified of early adopter status

- Benefits workshop completed – benefits logic model drafted, with 3 prioritised benefits identified
- Key stakeholders attended 'Domain deep dive' webinars

2.3 Following submission of the Phase 1 scoping document NWS has received formal confirmation that it has successfully passed the first official programme milestone and have been formally approved to move into the next phase of the project. This is subject to formal Board approval to proceed with the project which needs to be in place by 30th September 2026. In light of this the Trust is currently proceeding at risk to commence work on phase 2 foundational readiness pending this confirmation from Board.

2.4 Successfully completing the first phase of the project means the Trust is now eligible to draw down NHSBA funding to support project delivery across the next 18 months. This funding is only available to early adopters. The funding will be used to fund change management capacity to support engagement with the organisation on the implementation and process transformation, and to support PMO and testing/technical capacity.

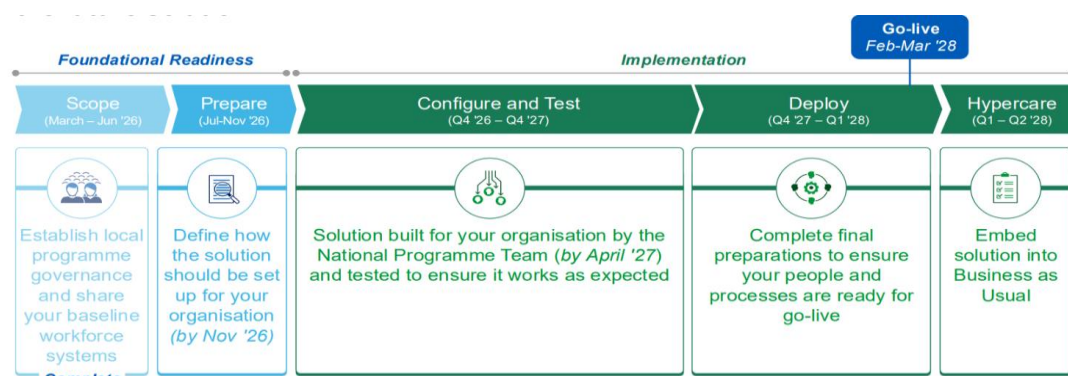
3. NEXT PHASES OF THE PROJECT

3.1 Board will note that the original intention had been to outline the anticipated resources, project timeline and capacity commitment by the end of the first phase through the production of a full Project Initiation Document. This has not proved possible because the project is still evolving nationally and indeed a second readiness phase has been added to the programme instead of moving into design and testing phases. As a result, this paper provides an overview of the known commitments in the next phase and the overall revised timeline for the project.

3.2 A full Project Initiation Document (PID) will now be developed. This will be required as part of the Foundational Readiness 2 phase by the end of November 2026 but we aim to take the PID to CPB in early November for approval. However, in line with the requirements of the national project, approval to proceed into this second phase is required from Board before a full PID is in place.

3.3 Overview of new timeline

Below is the new national project timeline and it should be noted this includes an extension of the overall project timeline into 2028/9 from the previous target implementation date of July 2027.



NB. Dates shown as calendar year Jan-Dec

3.4 Overview of each phase

Prepare (July to November 2026)

This is a new phase of readiness and preparation added to the programme since we commenced the project and will include:

- Sign data sharing and processing agreements
- Support first data upload
- Provide inputs to set up the solution
- Confirm functional domain selection
- Sign Scoping document part 2
- Complete change impact assessment

3.5 **Configure and test** (Q4 26/27 to Q4 27/28)

This will encompass the main development of the system and the testing process at an individual Trust level. It will involve:

- Work with third-party suppliers to ensure they can integrate with the programme's APIs
- Provide System Integration Testing inputs
- Train testers and execute first User Acceptance Testing cycle
- Execute parallel payroll run
- Develop and start to implement business process readiness plan

3.6 **Deploy** (Q4 27/28 to Q1 28/29)

Early adopter Trusts will then go live with the new system in a phased approach across two quarters, depending on the outcomes of the configuration and testing processes. It will involve:

- Execute second UAT cycle
- Go live
- Deliver professional user training
- Develop cutover plan

3.7 There will then follow a period of Hypercare (Q1-Q2 2028) during which solution performance will be monitored, any immediate issues will be managed and we will complete end user testing.

3.8 There will continue to be gateways built into the programme, where either party can review their involvement. This means that commitment to proceed at this stage is not binding to the whole programme. Gateways are scheduled at:

Stage gate 1 – June 2026 (completed)

Stage gate 2 – November 2026 - Submission of scoping document Part 2

Stage gate 3 – October – December 2027 - Pre-Go live readiness assessment

Stage gate 4 – January – March 2028 - Go live readiness assessment

Stage gate 5 – April – June 2028 - Exit readiness assessment

3.9 Informal checkpoints (implementation readiness) will be scheduled throughout 2027 between stage gates 2 and 3.

3.10 Entry to the programme was required by the national team to be a Board decision and a commitment was given that movement into the next phase would also be

remitted to Board for final decision. However, the project structure is now in place to ensure full oversight of the project through the Corporate Programme Board. As a result it is proposed that following this approval to proceed, ongoing oversight of the project and further gateway decisions will be remitted to the Corporate Programme Board in line with all other large-scale projects in the organisation. With this project being reported alongside normal project reporting through Resources Committee.

4. RISK CONSIDERATION

- 4.1 An overarching project risk has been articulated for the project and is currently scored at 12. A project risk register has been established with no risks scoring higher than 9 currently.
- 4.2 The Trust will have to implement this programme of work at some point in the next four years, so the risks articulated below will, in the main, be faced at some point by the organisation. There are some risks which relate to being an early adopter such as the fact that we are supporting the development of a new system which has not yet been tested and which is therefore a higher risk in relation to pay. However, these risks are mitigated to a degree by the level of personalised support offered through the programme, the additional funding to support to project and the involvement in development and testing of the product itself to a greater degree than will be possible at later stages. The existence of decision gateways prior to go live should ensure that transition to the new system only takes place when risk have been mitigated.
- 4.3 The following considers the Trust's risk appetite in the context of the decision to proceed into the next stage of the programme.

Risk category & appetite	Considerations
People - Open	The main risk affecting our people is that this is the system which manages their pay, career history and development records. However, the project oversight and support provide effective mitigations to these risks. The gateways are designed to provide a go/no go decision at key points in the programme and particularly in relation to payroll accuracy. This will ensure that implementation takes place only where risks have been sufficiently mitigated. The implementation of the system should also offer significant benefits for staff providing much greater visibility of their records, increasing transferability and providing AI generated support to improve accessibility to Trust policies and procedures. On balance therefore the decision to proceed is consistent with our risk appetite in relation to people.
Finance - open	There are no financial risks associated with proceeding at this stage. Being an early adopter offers pump prime funding of £270k for an 18-month period which will not be available to later cohorts. If there is a decision not to proceed later in the programme, then the Trust will only have to repay the remaining amount and not the total.

	One of the key benefits identified is the possibility of cash releasing benefits arising from the release of current HR related software contracts which it is hoped will be incorporated in the new system. A decision not to proceed now could therefore pose a greater financial risk than the decision to proceed, as it would not deliver additional supporting income which could cause future cost pressures and will delay the release of potential cash releasing efficiencies.
Digital innovation Eager	- The project is a digital innovation which is expected to support transformational change within the organisation. The decision to proceed is therefore consistent with our risk appetite.

5. EQUALITY/ SUSTAINABILITY IMPACTS

A national equality impact assessment of the product will be undertaken with input from the early adopters. A quality/equality impact assessment approach will also be embedded in the project, particularly in relation to changes to processes which may arise from implementation. At this stage there are no identified equality considerations other than system access.



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 2026
SUBJECT	Disciplinary Policy and Fast Track Disciplinary Procedure Review
PRESENTED BY	Lisa Ward, Director of People/Deputy Chief Executive
PURPOSE	Decision

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

Risk Appetite Statement <i>(Decision Papers Only)</i>	Quality: Cautious	☐	People: Open	☒	Finance: Open	☐
	Regulatory: Open	☒	Reputation: Open	☐	Digital Innovation: Eager	☐

ACTION REQUIRED	The Board of Directors is asked to: Approve the revised Disciplinary Policy and Fast Track Disciplinary Procedure.
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EXECUTIVE SUMMARY	The Disciplinary Policy & Procedure and the associated Fast Track Disciplinary Procedure have been reviewed and updated in line with the agreed 3-year review cycle. Approval of the policy is currently reserved to Board. Minor changes have been made to both documents following a major re-write of the Disciplinary Policy and the introduction of the FastTrack Procedure in 2022/23 - with a shift in focus to adopt an approach that emphasises the HPMa Avoiding Harm principles, and reinforces early resolution, proportionality, consistency of application and employee wellbeing. Both documents were agreed at the Trust's Policy Group in July 2026.
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PREVIOUSLY CONSIDERED BY	Resources Committee	
	Date	24 th September 2026
	Outcome	Recommending approval.
	Trust Management Committee	
	Date	19 August 2026
	Outcome	Recommending approval. Sought additional monitoring of fast track access by demographics. Minor changes agreed to Code of Conduct.



1. Background

- 1.1 The current Disciplinary Policy came into effect in 2023 following a comprehensive revision supported by legal advice, and which included the introduction of the Fast Track Disciplinary procedure. In line with the agreed 3-year review cycle, the Disciplinary Policy & Procedure and the associated Fast Track Disciplinary Procedure have been reviewed and updated. The approval of the Disciplinary Policy is reserved to Board.
- 1.2 Having a Disciplinary Policy in place is a statutory and contractual requirement. Ensuring that the policy is fair and consistently applied is critical to mitigating quality and safety risks and mitigating unfair dismissal or other conduct related claims. It also contributes to creating a fair and supportive environment in which standards and expectations are clear and actions taken are viewed to be proportionate and fair.
- 1.3 This review aimed to identify opportunities for improvement, in particular the aspiration was to reduce case numbers and duration; and strengthen consistency of application, staff confidence and wellbeing. The review has also taken into account learning from the Avoiding of Harm research and resources produced through the Healthcare People Management Association. This work aims to prevent the unintentional psychological emotional damage caused by poorly managed Hr and disciplinary processes in the workplace.
- 1.4 The People Directorate engaged Marie Knox-Davis, a Chartered Fellow of the CIPD and HR Practitioner with over 30 years' experience working in the public sector to conduct an independent assessment of NWAS's investigation and disciplinary processes.
- 1.5 Prior to submission of the reviewed documents at Policy Group in June and July 2026, extensive stakeholder engagement was undertaken with a varied sample of investigating officers and case mangers; HR managers and advisers supporting cases; Trade union colleagues and FTSU champions, and staff who have been the subject of investigation, including some who had been suspended from work under the disciplinary process.
- 1.6 It was generally considered that the policy was working, but more work was needed to ensure proportionate and consistent application across the Trust.

2. Improvements identified through stakeholder engagement

- 2.1 A number of key areas emerged, indicating opportunities for further improvement through enhanced focus and targeted action:
 - Timeliness and time taken to conclude cases
 - Inconsistencies in practice
 - Communication throughout the process
 - Competence and confidence of investigating officers and case managers
 - Clear understanding of roles and responsibilities
 - Managing sickness absence through the process
- 2.2 While the review did not identify a need for any fundamental changes to the agreed policy and procedures themselves, it concluded that greater focus should be placed

on strengthening their implementation. In particular, improvements were recommended in the consistent application of the policy and Fast Track procedure through training, guidance, and development to support those responsible for conducting the processes.

3. Summary of the key changes to the policy

3.1 The following amendments were made to the policy reflecting the outcomes of the review process and identified areas for improvement:

- Widened the scope of the policy to include learners and students and to explicitly state who is not covered by the policy i.e. agency workers, contractors, volunteers, students not employed by the Trust etc...
- Included the required wording from MIAA regarding the reference to Failure to Prevent Fraud Act.
- Strengthened the role of the Independent Review Panel and their role in moderating and ensuring consistency of approach.
- Expanded the guidance on suspension, outlining the consideration of alternative duties, and improving frequency of communication and support for staff. Providing guidance on sickness during suspension.
- Clarified the wording under Criminal investigations and offences committed outside work.
- Included reference to DBS under referrals to professional bodies.
- Clarified some of the wording of Disciplinary rules and listed sexual misconduct as a separate rule from offensive or abusive behaviour.
- Included reference to email and social media in regard of sexual safety in both general and gross misconduct.
- Added stalking or harassment; plagiarism and academic misconduct; and the misuse of patient records through accessing, viewing, searching for, retrieving or sharing of, under gross misconduct rules.

3.2 The review has not resulted in any substantive changes to the purpose or overall operation of the Fast Track Procedure. The principal amendments focus on improving clarity, simplifying language, strengthening employee wellbeing provisions, broadening the ability for relevant stakeholders to suggest the Fast Track route, and providing greater clarity regarding procedural outcomes.

3.3 The changes are expected to have a positive impact on employee experience by making the Fast Track Disciplinary Procedure easier to understand, more accessible, and less adversarial in nature. The revised wording places greater emphasis on early resolution, employee wellbeing, and informed choice, while providing clearer information about the process and its outcomes. Trust Management Committee and Resources Committee supported the Fast Track Procedure but have asked for some additional monitoring both of demographics of those accessing and also effectiveness.

3.4 The Policy and Procedure were consulted with the Trade Unions through Policy Group which concluded in July. However, since then one further amendment has been made to the Code of Conduct in order to strengthen the wording in relation to inappropriate access to records. Unison have raised a concern about this change and have requested that it revert back to the original wording in relation to breaches of confidentiality. Having considered this objection Trust Management Committee took the view that the change to the wording was helpful in bringing greater clarity to what constitutes inappropriate access to records and as a result are

recommending approval despite this objection. However, they did ask for some minor changes to ensure better alignment with the wording in employment contracts – these changes have been tracked. This position was discussed and supported at Resources Committee.

4. Supporting documents and planned training

4.1 To support the Policy and procedure there is ongoing work to develop a suite of supporting documents anticipated to be concluded by the end of Q4, which will include the following guidance material:

- Toolkits for Investigating Officers / Case Managers / HR Advisors / Welfare Officers
- Support Guide for staff who are the subject of investigations
- Suspension Guidance
- Separate guidance on Some Other Substantial Reason dismissals
- Guidance process for managing the loss of Driving Licences to enhance consistency
- Bitesize training videos for managers
- Series of training and development sessions to build awareness and understanding in how to turn the Policy into practice (Master classes)
- Communities of Learning to share good practice and look for continuous improvement
- The introduction of an Authority and Decision-Making Framework to broaden the pool of managers authorised to undertake disciplinary investigations and chair disciplinary hearings.

5. Risk considerations

5.1 The revisions to the policy are designed to make improvements to the process and particularly in terms of timeliness, communication and consistency of approach. The risk with a policy of this nature is in the consistency of application and whether the intended aims of the policy are achieved in practice. There are safeguards in the policy application through the strong involvement of the HR team in the management of serious cases through the policy and in the use of the Independent Review Panel at key stages to moderate and support consistency of approach. The additional guidance and training identified as part of implementation should help to mitigate this risk. The trust has an OPEN appetite to risk involving its People and approval of the policy is in line with that risk appetite.

5.2 There are regulatory and reputational risks associated with the disciplinary policy. The Policy being proposed is compliant with ACAS guidance and its approval will ensure regulatory obligations to have a policy are met. As outlined above fair a consistent application of the policy is critical to minimise regulatory and reputational risks arising from tribunals. Again our risk appetite in relation to both these areas is OPEN.

6. Equality / Sustainability Impacts

6.1 The EQIA risk assessment did not identify any specific risks or negative impact on staff, patients or carers arising from the policy itself. We are obviously aware of the higher propensity for BME to staff to enter the formal disciplinary process and there is already work ongoing which is seeking to improve this position. This is an



issue of application rather than the policy itself and there is an opportunity to further address some of these issues through the planned training.

- 6.2 The revised Disciplinary Policy and Procedure is expected to have an overall positive impact on equality, diversity and inclusion by promoting fair, transparent and consistent management of conduct issues.
- 6.3 The policy contains check points to ensure reasonable adjustments and individual circumstances are considered throughout the process. Disciplinary outcomes and processes should be monitored routinely to identify and address any potential disproportionality.



**North West
Ambulance Service**
NHS Trust

Disciplinary Policy & Procedure

Version 1.0, August 2026

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1. Introduction

North West Ambulance Service is committed to creating a safe, respectful, and supportive environment where everyone can work, learn, and thrive. The purpose of this Disciplinary Policy is to provide a clear, fair, and consistent framework for addressing conduct or behaviour that falls below the standards we expect.

The Trust expects all colleagues to meet high standards of conduct and behaviour, which support our values to deliver the right care, at the right time, in the right place whilst treating the public with dignity and protecting them from harm. This document sets out the Trust's policy and procedure for responding to situations where an employee's conduct breaches Trust values, policies, or rules, or otherwise falls short of the standards expected.

The Trust aims to develop an open and fair culture which encourages self-reflection and improvement and where relevant, lessons learnt are openly discussed and embedded across the service. Guided by these values, this policy seeks to ensure that any action taken minimises foreseeable harm and treats all individuals with dignity.

It is recognised that many employees are members of professional bodies which have professional standards of capability, conduct and competence. The Trust requires employees in those professions to abide by those standards. Consideration should be given (and advice sought) as to whether any misconduct matter also needs to be referred to the relevant professional body.

2. Scope

This policy applies to all staff employed within the North West Ambulance Service NHS Trust, including apprentices, learners and students who are employed directly by NWAS.

This policy excludes agency workers, contractors, volunteers, governors, students not directly employed by the Trust, and individuals engaged through third-party organisations. Any concerns relating to these individuals will ordinarily be managed in accordance with the procedures of the relevant education provider, employer, contracting organisation, or governing body. However, they may be required to participate in investigations where relevant.

3. Key Principles

It is the Trust's intention to ensure that every disciplinary matter is dealt with fairly, and that adequate steps are taken in the early stages to establish the facts before initiating formal action.

- **Fairness and consistency:** The Trust is fully committed to treating all staff fairly, equally, with dignity and without discrimination, in line with the principles outlined in the Equality, Diversity and Inclusion Policy. All employees will be treated consistently, with decisions based on objective evidence rather than assumptions or bias. Similar cases will be handled in similar ways.
- **Impartiality and Objectivity:** Those involved in investigations or decision making must remain unbiased and have no conflict of interest.
- **Transparency and Clarity:** Employees understand the processes that will be followed, and their rights at each stage.

- **Aiming to resolve the matter informally:** Where possible, and where appropriate, cases of misconduct will be dealt with informally in the first instance, between the employee and their line manager.
- **Proportionality:** Responses to concerns are appropriate to the seriousness of the issue. Wherever possible, informal or early-resolution options should be considered before formal action.
- **Health and Well-being:** The health and welfare of employees involved in these procedures, either directly or indirectly, will be foremost to the Trust. Employees will be offered appropriate support both during and following the process. Processes are designed to minimise unnecessary stress, escalation, or reputational impact, and should focus on learning and improvement wherever possible.
- **Right to be heard:** Employees will have the opportunity to fully explain their perspective before any decisions are made. While efforts will be made to facilitate attendance at all stages, informal meetings will not normally be delayed if a Trade Union representative or colleague is unavailable. Employees have the right to be accompanied at all stages of the formal process.
- **Confidentiality:** Information is shared only with those who have a legitimate need to know. It is the responsibility of all parties involved in the process to maintain confidentiality and objectivity.
- **Timeliness:** Matters are addressed promptly to ensure fairness, reduce stress, and allow issues to be resolved before they escalate.
- **Right to appeal:** Employees can challenge decisions through a fair and transparent appeal process overseen by individuals not previously involved.

4. Underlying Principles

- This policy is fully legally compliant and meets and exceeds the requirements of the ACAS Code of Practice.
- Any fraud, bribery and corruption allegations will be investigated by the Trust's Anti-Fraud Specialist under fraud, bribery, and corruption legislation, which includes the Bribery Act 2010, and The Fraud Act 2006 - which includes The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023), and the new corporate fraud offence of 'failure to prevent fraud'.
- No formal action will be taken without first seeking the advice or involvement of the HR Department.
- As soon as the Trust becomes aware of any allegations against an accredited representative of a recognised Trade Union, the circumstances will be discussed with a TU lead of the organisation concerned before any action is taken.
- If a grievance arises during an ongoing disciplinary case and relates to the matter, the Trust will consider pausing proceedings or manage both issues together, assessing each situation individually and, if needed, appointing an alternative manager to ensure fairness.

5. Responsibilities

Roles and responsibilities within the disciplinary process ensure a fair, ordered, and consistent approach, with all individuals treated with dignity and respect within an inclusive and engaging culture.

The Trust Board

- The Board provides strategic leadership to promote an open, fair, and consistent culture across the Trust and seeks assurance that disciplinary matters are managed appropriately. It holds overall accountability for monitoring the implementation and outcomes of this policy.
- The Trust is responsible for ensuring that all employees are aware of and understand the standards of conduct required of them in their roles.

Human Resources Business Partnering Team (HR Team)

- The HR Team is responsible for ensuring that this policy complies with current employment legislation and is implemented consistently and in line with best practice. The HR team will also provide advice and support to managers on the application of the policy and associated procedures and will keep appropriate records of matters.

Managers

- Managers are responsible for ensuring that misconduct matters are treated sensitively and confidentially, and that any actions taken are reasonable and fair, and importantly that the employees' health and wellbeing is considered and the correct support put in place. Managers should speak with HR before taking any action and decide if informal resolution can be undertaken in the first instance.

All employees

- It is the responsibility of all employees to be aware of the standards of conduct required of them in their roles and to carry out their duties in accordance with their contract of employment and the Trust's values.

6. Procedure

Concerns about conduct can be sensitive and may have a significant impact on those involved. For this reason, the Trust aims to approach all disciplinary matters with care, proportionality, and a focus on early intervention wherever possible. The aim is to resolve issues informally when appropriate, supporting individuals to understand expectations, reflect on their behavior, and make positive changes.

When formal processes are required, they will be handled transparently, impartially, and with full consideration of the rights and needs of everyone affected. The Trust seeks to minimise distress, avoid unnecessary escalation, and ensure that no individual is subjected to foreseeable harm during the disciplinary process.

By following these principles, we strive to maintain a fair and inclusive culture where concerns are addressed responsibly, relationships are preserved whenever possible, and all members of staff feel valued, respected, and safe.

The disciplinary procedure consists of a number of stages. The stage at which the procedure will be instigated will depend upon the seriousness of the alleged misconduct.

7. Handling Minor Conduct Issues via Early Resolution and Informal Structured Conversations

Normally, where there are minor breaches of rules, this will be dealt with by the immediate manager on a one-to-one basis.

The manager should arrange to speak to the employee in private as soon as possible, normally within a few days. This will be a collaborative discussion, aimed at talking through areas of concern and encouraging improvement.

In all cases, the manager will evaluate whether the matter can be dealt with satisfactorily through reflection alone, or whether a structured conversation is required.

Structured conversations do not form part of the formal disciplinary process and employees should be reminded of this. It should not be necessary for employees to be accompanied at these meetings, as this is an informal means of resolution.

Even though the process is informal ACAS recommends keeping a confidential written record of the conversation. This should be captured on the pro-forma (appendix 2) and stored on the employee's personal file. The record will be 'live' for a 6-month period. The pro-forma should only be referred to during this 'live' period and should be disregarded for the purpose of disciplinary proceedings after this stage. If, however, there are repeated / patterns of behaviour identified, the manager should meet with the employee to discuss their concerns and may extend the 'live' period to allow further time for any improvements to be made.

8. Handling More Serious Allegations of Misconduct and Assessing the Facts

When more serious allegations, or repeated cases of misconduct arise (see Appendix 1 Disciplinary rules) an initial assessment should be made by the line manager, to decide if it is appropriate for the matter to be managed informally or whether further investigation is needed before that decision can be reached.

The line manager should carry out an initial fact-finding assessment using the Preliminary Fact-Finding Checklist (Appendix 3). During this process, it may be necessary to meet with other relevant individuals to get an understanding about what has happened. This is **not a full investigation**, and the aim is to establish the facts in order to determine whether a full investigation process may be required.

Where it is determined via the Fact-Finding Checklist that further, more formal investigation may be appropriate, this should be recommended on the form and submitted to the Independent Review Panel (IRP).

If IRP agrees with the recommendation made the Case Manager will be responsible for allocating an appropriately trained Investigating Officer and for clearly defining what is to be investigated. The Case Manager must ensure that the appointed Investigating Officer has the capacity to complete the investigation and can prioritise its' completion.

The scope of the investigation will be defined using a Terms of Reference document which will include the allegations, the scope of the investigation, the timeframes for completion and will include any pertinent document(s) which may assist with the completion of the investigation.

There may be occasions where concerns are managed via an alternative investigation framework (e.g., clinical complaints/ serious incidents) which then require review under the Disciplinary Policy due to the circumstances of the case. In this eventuality, the completed investigation report will be used where possible to avoid unnecessary delays. Employees will be given the opportunity to share any additional information with the assigned investigating officer before the case proceeds to a Hearing, if they feel this is relevant to the disciplinary case.

9. Protecting Health and Wellbeing

Managers are responsible for ensuring that any staff involved within a disciplinary process are appropriately supported at all stages of the process and the nature of the support that is required will be discussed and agreed with the employee. This will normally be the employee's line manager, however, if they are also the assigned Investigating Officer, the Case Manager will assign an alternative manager to provide welfare support (the Welfare Officer).

At the outset of any disciplinary process the employee will be reminded of the support services available to them through the Trust's Occupational Health and counselling service. The employee should be advised that a self-referral to those services can be made or alternatively a management referral will be made on their behalf with permission. In some circumstances the Case Manager may refer an employee to support services dependent on the nature of the allegations or the employee's circumstances. The employee will also be issued a Support Guide to help them understand the process and the support options available to them.

Where an employee who is subject to this process has concerns regarding their health and wellbeing, they should raise this in the first instance with the Case Manager, who will ensure they are appropriately supported.

10. Representation

Any employee subject to formal disciplinary processes will have the right to be accompanied at an investigatory meeting or Hearing by any one of the following persons:

- A trade union representative
- An official employed by a trade union
- A workplace colleague.

All companions have an important part to play in providing advice and support to employees and working constructively with the Trust, HR and managers to achieve resolutions.

This companion will be allowed to address the Hearing to present / sum up the employee's case. This companion may also confer with the employee during the Hearing, including asking witnesses questions, but may not answer questions on the employee's behalf.

In exceptional circumstances such as where concerns have been raised by Occupational Health about the employee's health and wellbeing at any formal Hearing, with permission from the Head of HR, employees may be accompanied by a non-workplace companion in a supportive capacity. In these circumstances, this companion will not be allowed to address the Hearing, sum up the employee's case, ask questions of others, or respond on the employee's behalf during the Hearing.

In some circumstances it may not be appropriate for some individuals to be accepted as a companion. It is not reasonable for an employee to be accompanied by a colleague whose presence would prejudice the Hearing or who might have a conflict of interest. An example of this being if they are a witness in the case being investigated.

It is ultimately the employee's responsibility to arrange appropriate representation - to contact their companion and ensure that they are willing to act in that capacity and to arrange their attendance at any meeting/hearing. But all parties will seek to co-operate on meeting arrangements.

11. Suspension

Suspension from work will always be a last resort and usually the employee will be able to continue doing their normal job while issues are investigated. Suspension is a neutral action with no assumption of guilt and is not a formal sanction.

Alternatives to suspension should always be considered and discussed where appropriate; this may include the employee temporarily:

- Being moved to a different area of the workplace
- Changing their working hours e.g., moving from nights to days where there is more supervision, or working with a different shift / team pending conclusion of the investigation / disciplinary process.
- Being placed on restricted duties including having reduced access to Trust systems where appropriate
- Being transferred to a different role within the workforce

Suspension will only be considered if there is a serious allegation which, on the face of it, could amount to gross misconduct and/or:

- Working relationships have severely broken down
- There is a risk of the employee interfering with evidence or witnesses or the investigation.
- There is a risk to other employees, property or patients.
- The employee is the subject of criminal allegations which may affect whether they are fit to undertake their role.

When considering suspension/ action short of suspension line managers must assess the risk of the employee remaining at work and seek HR advice. Where a line manager feels it necessary to suspend an employee, they must complete the Suspension/ Action Short Record (Appendix 6) to demonstrate that all alternatives have been considered before seeking approval from a more senior manager (usually Head of Service, or manager with delegated authority). Suspension should always be seen as a last resort.

Where suspension is under consideration outside of core hours (applicable only where staff work during unsocial hours) the local manager should contact the senior on call manager for direction and if applicable, for authority to temporarily remove the employee from duty.

The Director of the Service Area and the relevant HR Manager must be notified following the decision to suspend the employee and a copy of the Suspension/ Action Short of Suspension Decision Record (Appendix 6) sent on for their record.

It is best practice to complete both the Preliminary Fact-Finding Checklist (Appendix 3) and the Suspension/ Action Short Record (Appendix 6) prior to a suspension taking place, however, it is acknowledged that in some circumstances, immediate action is needed to prevent risk. In this circumstance, immediately following the suspension, priority should be given to gathering as much relevant information as possible by completing the Preliminary Fact-Finding pro-forma (Appendix 3). Should it be determined that suspension is no longer necessary, this must be discussed and authorised in conjunction with the HR Manager and lifted without delay.

In the event of suspension all parties must ensure that priority is given to concluding investigations and arranging the necessary disciplinary proceedings, in a timely manner.

Suspensions ongoing for more than one month, must be subject to review to determine if the suspension remains necessary. This should take place on a fortnightly basis as a minimum, or if the circumstances of the case materially change. The employee must be advised of any delays in the investigation process and the reasons for this on at least a fortnightly basis by the Case Manager.

Where an external issue, such as a criminal investigation, means that the Trust has limited control over the investigation and timescales, the employee will be advised that the suspension (or alternative duties) will continue until an agreed date, which will be kept under review, and will be communicated in writing to the employee.

Employees should accept, where possible, alternative duties reasonably offered to them as an alternative to suspension.

In the case of suspension of accredited representatives, the Trust will notify the Staff side Branch Secretary/TU lead at the earliest opportunity.

During any period of suspension, employees remain on full pay as though they were at work i.e. pay will include contractual payments e.g. enhanced/unsociable hours.

Employees who are suspended or placed on restricted duties must inform their line manager if they hold a second job either within the Trust or external to the Trust, and if they wish to continue with this second job during suspension. The manager must consider if the reason for suspension would impact secondary employment and this will need to be discussed with HR support before a decision is reached

Sickness during suspension

An employee who is suspended from duty remains subject to the Trust's sickness absence reporting procedures. If an employee becomes unwell during a period of suspension, they must notify their Line Manager and follow the Trust's usual sickness reporting procedures.

Sickness absence does not automatically bring suspension to an end, and the conditions of suspension will still apply in regard of being available to attend meetings (on the advice from Occupational Health where appropriate) and not contacting potential witnesses.

While consideration will be given to the employee's health and wellbeing, sickness absence does not automatically prevent the Trust from continuing investigatory or disciplinary processes, and matters will not be delayed unreasonably. Each case will be managed on its individual merits, balancing fairness to the employee with the Trust's duty to manage risk and reach a timely outcome.

12. Formal Investigation

The purpose of an investigation is to objectively establish the facts, in a fair, unbiased and comprehensive way to enable conclusions to be drawn from the allegations. Investigations should be carried out by an appropriately trained / experienced Investigating Officer.

Investigations should be carried out without unreasonable delay. It is expected that the majority of investigations should be completed within a 6-week period. However, in the case of complex investigations approvals for an extension to the investigation timeframe should be discussed and agreed with the Case Manager. All case timescales will be reported on a monthly basis to the Executive Board for oversight.

The Case Manager is responsible for keeping the employee informed of the progress of the investigation and any delays. The Investigating Officer will be responsible for ascertaining the full facts of the case and for providing a report to the Case Manager.

Trust employees are required to co-operate with internal investigations to ensure that the Trust is able to gather all relevant facts. An employee who has been identified as a witness in an investigation may not unreasonably refuse to provide a statement or attend a meeting. Reasonable time off from duties should be afforded to the witness based on discussion with their line manager. Witnesses do not ordinarily have the right to be accompanied at investigation meetings and / or disciplinary Hearings but the Trust will allow witnesses to have appropriate support in place at any such meetings if they wish to do so.

Should the Investigating Officer consider that the scope of the investigation should be widened as the investigation proceeds, this must be approved by the Case Manager and confirmed to the employee in writing.

When the Investigating Officer has completed their investigation, they will write a report detailing the facts, the evidence they have established and their conclusions. The report will include all documentation, statements and interview notes which have contributed to the investigation. This will be submitted to the Case Manager. The Case Manager will then review and provide timely feedback and support to the Investigating Officer on the basis of the evidence available and their recommendations as to whether there is a case to answer.

On completion of the investigation, the Case Manager submits their recommendations to the next IRP meeting for confirmation of any onward action. Following the IRP meeting the Case Manager advises the employee accordingly, in writing.

If it is determined that there is no case to answer the Case Manager will arrange to meet with the employee to discuss the outcome. At this meeting, any outstanding areas for concern or need for future improvements will be discussed along with arrangements for a return to duties in the event the employee has been redeployed or suspended.

13. Disciplinary Hearing

If, after a thorough investigation, it is determined that there is a disciplinary case to answer the employee will be invited in writing to attend a disciplinary Hearing. The invitation will set out the specific allegation(s) to be considered, the possible outcomes, and the arrangements for the Hearing.

The detailed order of proceedings for a disciplinary Hearing is set out in Appendix 4. Appendix 4 should be read alongside the procedural requirements in this section and is intended to provide practical guidance on the format and conduct of the Hearing.

On notification of the disciplinary hearing the employee will be provided with a copy of the Investigation Report, including any written evidence which forms part of the case against them including any witness statements (where applicable). The employee will normally receive at least 14 calendar days' notice of a disciplinary hearing. Where the allegation is one of potential gross misconduct, the employee will normally receive at least 21 calendar days' notice. Any variation to these timescales must be reasonable in the circumstances and agreed with HR and the employee.

If the employee wishes to rely on written evidence or a written statement of case, this will normally be submitted to the HR representative supporting the Hearing Chair no later than seven calendar days before the Hearing, unless mutually agreed otherwise. (Where agreed, the employee may sometimes choose to present their case orally.) The HR representative will share the

management pack and any information submitted by the employee or their representative with the Hearing Chair or panel. Any supporting evidence submitted by the employee will also be shared with the Investigating Officer.

If the employee's representative is not available on the proposed Hearing date, the Hearing may be postponed by up to ten calendar days. The employee or representative should provide alternative availability within that period. Where an employee or their representative is unable or unwilling to attend after reasonable attempts to rearrange, the Hearing may proceed in the employee's absence, and a decision may be made based on the evidence available.

In exceptional circumstances such as where an employee is unfit to attend a Hearing in person, consideration can be given to both parties providing written submissions in respect of the Hearing. This must be agreed between the employee / their representative and the Trust in advance.

Disciplinary Hearings will be chaired by an appropriately trained/experienced manager who will be supported by a member of the HR team. (refer to Appendix 4 for the Disciplinary Hearing Format).

The Investigating Officer will normally attend the Hearing to present the investigation report, the evidence gathered and the conclusions reached. The employee or their representative will have the opportunity to respond to the case, ask relevant questions and present their own case in line with the Hearing format set out in Appendix 4.

Anyone providing a witness statement should be advised that they may be required to attend a subsequent hearing. However, in most cases, particularly where a statement is not in dispute, witnesses will not be required to attend a disciplinary Hearing in person and their statement will suffice. The Hearing Chair will assess the relevance and reasonableness of a request made by the Investigating Officer or the employee or their representative for a witness to attend a Hearing in person and reserves the right to refuse the presence of a witness if it is deemed unnecessary or not appropriate.

Should witnesses be required to attend the disciplinary Hearing, it will be the responsibility of the Investigating Officer and/or the employee and their representatives to make the necessary arrangements directly with their respective witnesses. Witnesses will need to request the release from duties from their line manager who should make every effort to facilitate attendance where required.

If a decision is not provided on the day of the Hearing, the employee will be informed of the decision and any outcome in writing within seven calendar days; this written confirmation will provide details of any right of appeal.

Those who have been involved in the investigation process will not form part of Disciplinary Hearing Panel.

14. Disciplinary Sanctions

When determining what, if any, disciplinary sanction is appropriate the Chair of the Hearing must act reasonably in all the circumstances. Factors relevant in determining which disciplinary sanction to apply include:

- The extent to which standards have been breached and / or the seriousness of the misconduct.
- Consistency of treatment.
- Current 'live' warnings.

- Other special circumstances which might mitigate or otherwise affect the appropriate severity of the penalty.
- Impact of the actions on others and the Trust (including reputation).
- Whether the intended disciplinary action is reasonable in all circumstances.
- The employee's general record.

All disciplinary sanctions must be confirmed in writing. This will normally be within seven calendar days of a Hearing.

The following disciplinary sanctions may be applied. This process is not sequential. A sanction can be applied at any level (i.e. a Final Written Warning without a Written Warning being applied first):

Levels of Disciplinary Sanctions

Disciplinary Sanction	Examples of Circumstances	'Live' Period
First Written Warning	Instances where a structured conversation has taken place to address low level misconduct, but this behavior has then been repeated. A first written warning may also be issued without prior application of the procedure for first episodes of misconduct if the circumstances of the case justify this level of action.	12 months
Final Written Warning	Instances of misconduct or negligence when a first written warning is still in effect i.e. "live" at the time the misconduct occurred, or: Where serious misconduct is found as a first offence.	12 months - This may be extended to 24 months if issued as an alternative to dismissal.
Downgrading	Where it is deemed that as a result of misconduct, it is no longer suitable/ appropriate for the employee to remain in their substantive position.	A Final Written Warning will be issued in addition to the act of downgrading.
Dismissal with notice	Dismissal may be the appropriate sanction if, following the issue of a final written warning, there is still no improvement in conduct or if a further offence is committed.	
Dismissal without notice (summary dismissal)	Summary dismissal will be applied in cases of gross misconduct. In such cases, dismissal is without notice.	

The sanctions will normally be effective from the date of the disciplinary Hearing. If there have been exceptional unjustified delays, then the Chair of the disciplinary Hearing will consider backdating the effective date the disciplinary sanction runs from.

Warnings will be disregarded for the purpose of considering cumulative disciplinary sanctions after the expiration of their “live period” but the facts / circumstances may be deemed relevant to future cases so details will remain on the employee’s personal files.

Staff who are employed on Agenda for Change Terms and Conditions should refer to ‘Annex 23: Pay Progression’ of the Agenda for Change handbook if issued with a disciplinary sanction.

Downgrading as an alternative to dismissal

If the outcome of the Hearing determines that the employee’s actions amount to gross misconduct, or in the case where a live final written warning has been breached, the Chair of the Hearing can consider downgrading the employee as an alternative to dismissal.

The Chair of the Hearing, in conjunction with HR, will need to consider if suitable opportunities exist within the organisation which would be reasonable/ appropriate to offer to the employee.

Providing reasonable/ appropriate posts are available, the employee may be offered the option of a lower banded post and will have seven calendar days to make their decision. If a lower banded post is accepted by the employee, the employee will be issued with a final written warning/ extension of a final written warning, effective from the date of the disciplinary Hearing. If the employee declines the offer of a lower banded post, they will be summarily dismissed from employment.

An act of downgrading will retain the employee’s continuity of service. The exact pay point within the lower band to which they will be appointed and remunerated will be discussed and agreed by the Chair of the Disciplinary Hearing and HR, taking account of length of service previously served at the same/ higher grade. In instances of downgrading pay protection will not apply.

The individuals’ increment date will become the date of transfer to the new post.

If the employee is offered a post on a different base site to their previous post, protection of travel will not be paid.

Once the associated disciplinary sanction has been spent the downgraded employee can apply for vacant posts at their previous grade.

15. Appeals

Employees have the right to appeal against any formal disciplinary outcome or sanction.

The purpose of an appeal is to review the decision reached at the disciplinary hearing, rather than to rehear the case in full. The appeal will focus on whether:

- the correct procedure was followed
- the findings were reasonable based on the evidence available at the time
- the sanction applied was proportionate in the circumstances
- any new, relevant evidence has emerged that was not previously available

To submit an appeal, the employee must:

- set out their full grounds for appeal in writing, using the appropriate pro forma (Appendix 7)
- ensure the appeal is submitted within 14 calendar days of receiving the outcome letter.

Appeals submitted without clearly defined grounds will not normally be considered.

An employee has the right to be accompanied at the appeal hearing by a trade union representative or workplace colleague.

In exceptional circumstances, such as where concerns have been raised by Occupational Health about the employee's health and wellbeing at any formal hearing and with permission from the Head of HR, an employee may be accompanied by a non-workplace companion in a supportive capacity. In these circumstances, this companion will not be allowed to address the Hearing, sum up the employee's case, ask questions nor respond to questions on the employee's behalf during the Hearing.

Appeal hearings will be conducted by an appropriate senior manager who has had no prior involvement in the case, supported by an HR representative. In cases of dismissal, appeals will be heard by two senior managers, with support from an HR representative.

All Appeal Hearing decisions and outcomes will be confirmed in writing. This will normally be within seven calendar days of a hearing concluding. There will be no further right to appeal after this stage.

Further detail on the appeal process and hearing format is provided in Appendix 5.

16. Fast Track Disciplinary Process

In some circumstances, where the allegations are not contested, the Trust may offer the use of, or the employee may request their case be dealt with via the fast-track process as set out in the Trust's Fast Track Disciplinary Procedure.

It is intended that, by accessing this policy, disciplinary matters may be dealt with more quickly and alleviate some of the stress associated with a difficult or prolonged disciplinary investigation. The employee retains the right to be accompanied at a fast-track disciplinary hearing. There is no right to appeal any sanctions issued under the Fast Track Disciplinary Procedure.

17. Resignation During the Disciplinary Process

Where an employee resigns and leaves the employment of the Trust prior to the conclusion of a disciplinary hearing, the Case Manager will consider whether the process should continue to conclusion.

If it is decided that it will proceed, the former employee will be advised that the investigation will continue to reach a conclusion, and they will be offered the opportunity to participate in any remaining process.

If, when the employee resigns, a safeguarding allegation remains under investigation, it may be the duty of the Trust to conduct the investigation and, where appropriate, proceed to a formal hearing to reach a conclusion. The former employee will be advised of this and will be provided with the right to respond/ opportunity to attend the hearing.

Where the employee is professionally registered, the relevant professional lead will be informed

and will consider whether a referral to the employee's professional body is required.

Any future employment reference will indicate that the employee was under investigation when they left the Trust.

18. Procedure

Employees should inform their line manager at the earliest opportunity if they are arrested or are the subject of a police criminal investigation or interview, or if they are under investigation in any secondary employment or volunteering role.

This enables the Trust to consider whether any action is required to safeguard patients, colleagues, and the employee concerned. Any information disclosed will be handled sensitively and in accordance with confidentiality and data protection requirements.

Where allegations concerning an employee's conduct outside of work are brought to the attention of the Trust by staff, members of the public, other agencies, or professional bodies and where such allegations have the potential to affect the employee's suitability to undertake their role, continue working for the Trust, or to damage the Trust's reputation, the Trust may investigate the matter so far as reasonably practicable and/or take such other action as considered appropriate. This may include dismissal in appropriate cases.

Where the alleged offence or police involvement relates to mistreatment of a child or an "at risk" adult, the appropriate senior manager (to be determined based on the seniority of the person under investigation) should inform the Safeguarding Team who will consider whether it is necessary to make a report to the Local Authority Designated Officer (LADO).

Where appropriate, investigations by the counter fraud team, other agencies such as police or social services, may be carried out separately from investigations under this procedure. In these circumstances the Trust will only delay carrying out internal investigations and following the disciplinary procedure where absolutely necessary and when advised to do so by the professional body and/or other agency.

19. Referrals to Professional Bodies

Where an employee (or individual not directly employed by the Trust) who is subject to a disciplinary process is a healthcare professional and is registered with a regulatory body, they may be referred by the Trust or may be advised to self-refer, based on the regulator's code of practice.

The regulator will be notified of any suspensions, long term restrictions to practice (determined as part of a disciplinary sanction) or dismissals from employment.

The decision to refer in any other circumstances will be determined by the Trust's Head of Profession who will be sent, in a redacted format, the details of any cases which are subject to a formal disciplinary process. Individuals will be informed of the decision made by the Head of Profession in writing.

The Trust will make a referral to the Disclosure and Barring Service (DBS) where both following conditions are met:

- The employee (or individual not directly employed by the Trust) has been removed from regulated activity. This can include dismissal, redeployment, retirement, redundancy, or resignation.

- The organisation thinks the individual has engaged in relevant conduct or satisfies the harm test.

Appendix 1

NORTH WEST AMBULANCE SERVICE DISCIPLINARY RULES

1. Introduction

The examples below outline conduct that the organisation considers unacceptable and which may result in formal disciplinary action. They are intended to provide guidance rather than an exhaustive list.

Misconduct generally refers to action that breaches organisational standards or policies, or behaviour that falls below the standards expected by the organisation.

Gross misconduct involves more serious acts that could result in more significant disciplinary outcomes up to summary dismissal.

Each case will be considered carefully on its own facts, taking into account all relevant circumstances. The Trust aims to deal with conduct matters fairly and proportionately, with a focus on learning and improvement wherever appropriate.

2. Misconduct

The following examples reflect behaviours that do not meet the organisation's expected standards of conduct or performance and may lead to disciplinary action.

If recurrent, these offences could eventually lead to dismissal.

1. Failure to comply with reasonable instructions or a reasonable management request
2. Unacceptable behaviour or use of inappropriate, offensive or discriminatory language towards colleagues, patients or general members of the public, even if not directed at a specific person, when it can be overheard by others
3. Inappropriate or unprofessional communication (including email or social media use)
4. Failure to uphold Sexual Safety Standards (refer to the Trust's Sexual Safety Policy)
5. Misuse of authority or position
6. Failure to adhere to agreed Trust policies and procedures, including own department protocols.
7. Failure to maintain appropriate standards of confidentiality
8. Failure to conform to defined working practices or processes
9. Unauthorised use or misuse of the Trust's property, systems, or resources

10. Unauthorised absence which can include:
- a. persistent lateness / poor timekeeping
 - b. failure to comply with the Trust's notification/ certification requirements for sickness absence
 - c. absence from the workplace without permission
 - d. abuse of urgent domestic leave
11. Any matter listed under Gross Misconduct which is assessed as falling below the threshold for gross misconduct.

3. Gross Misconduct

A breach of contractual terms of employment, which may warrant summary dismissal:

1. Theft or attempted theft associated with employment, of the Trust's property or from a third party.
2. Dishonesty or deliberate misuse, misappropriation, or attempted misappropriation of the Trust's, other staff, or patients' funds or resources.
3. Fraudulent manipulation or falsification of official documentation (including time sheets/attendance logs, signing in/out for other employees, patient records, claims for expenses and any information used in support of an application for any post).
4. Any offences under the Fraud Act 2006 and related legislation
5. Serious or repeated breaches of Trust policies and/or procedures
6. Acceptance of gifts and hospitality in contravention of NHS guidelines on Standards of Business Conduct as outlined in the Trust's Standards of Business Conduct.
7. Serious breach of confidentiality
8. Working whilst contravening an enactment, or breach of rules laid down by statutory bodies, for example removal, suspension, or expiry of a statutory or regulatory registration or licence required to perform the role.
9. Criminal offences that may impact an individual's suitability for their role, or a failure to disclose criminal charges, convictions, or ongoing proceedings.
10. Malicious or willful damage to the Trust's property.
11. Serious breach of health and safety rules (by act or omission)
12. Any act or omission constituting gross negligence or dereliction of duty including causing a serious delay to an emergency response
13. Refusal to comply with lawful instruction which could result in immediate serious consequences.

14. Inappropriate use of email or internet including retaining received and forwarding to colleagues, emails containing offensive or obscene material (the Trust's social media Policy contains a non-exhaustive list of what may be considered offensive or obscene)
15. Incapability at work through alcohol/drugs or being under the influence of alcohol, non-medically prescribed drugs and or illegal drugs in the workplace (refer to the Trust's Drug, Alcohol and Substance Misuse policy)
16. Violence or exceptionally offensive or abusive behaviour
17. Serious sexual safety breaches (refer to the Trust's Sexual Safety Policy)
18. Stalking or harassment of a member of staff, or a patient; including in-person, digital, or through a third party, whether occurring within or outside the workplace.
19. Inappropriate, offensive or abusive language which may cause patients/ service users/ fellow staff members to feel threatened, degraded or offended
20. Discrimination or victimisation of a patient, member of staff or member of the public on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation (refer to Trust's Bullying and Harassment policy)
21. Bullying or Harassment (refer to the Trust's Dignity & Respect at Work Policy)
22. A serious breach of trust and confidence (excluding any protected disclosure under the Trust's Freedom to Speak Up Policy) or any actions bringing the Trust into disrepute.
23. Failure to report an incident or disclose information which would or has seriously compromised patient safety, clinical care or the Trust's reputation or obligations (e.g. failing to disclose situations where staff have committed an act of gross misconduct).
24. Plagiarism and academic misconduct – dishonestly presenting the work, ideas, data, or qualifications of another person as one's own, or falsifying academic or professional records.
25. Unauthorised recording and misuse of personal data - any deliberate or unauthorised recording, filming, or capture of audio, images, or video of staff, patients, or others during the course of employment, without appropriate consent or lawful basis, including the misuse of personal data obtained through such activity.
26. Accessing, viewing, searching for, retrieving, sharing, or using [information of a confidential nature relating to the work of the Trust or to matters relating to staff or patients](#)~~patient records~~ without a legitimate work-related reason, or beyond what is necessary for the performance of your role. This includes accessing the records of family members, friends, colleagues, public figures, [staff](#) or any other individual when there is no authorised business need to do so.

Section 2 and Section 3 above outline the main disciplinary rules applying to employees. However, they do not limit the Trust's ability to appropriately classify potential misconduct cases on an individual basis. It is possible that other circumstances could lead to disciplinary action, including dismissal, being taken

Where appropriate, the Trust reserves the right to report an employee to the appropriate external body, such as the police, MIAA or the HCPC as outlined in the Policy.

Appendix 2

Structured Conversation Record

Employee Name:		
Role:		
Date of Structured Conversation:		
Matters Discussed:		
Action Plan		
Required improvement/s	Support required to facilitate improvement	
Name of Manager		
Position		
Employee's Comments		
I confirm that the above is a record of our meeting and that I have received a copy of this record.		

Appendix 3

Preliminary Fact-Finding Checklist

The purpose of fact-finding is to gather information about the alleged incident and determine what action, if any, should be taken next.

You are not being asked to undertake a full investigation at this stage.

SECTION 1

1. Is there a protocol, procedure or policy that sets out the expected standard of behavior or conduct?	Yes	No
2. Have you reviewed the members of staff skills and competency and determined whether they were aware of the rules or expected performance standard?	Yes	No
3. Would you expect another member of staff in a similar role, with similar experience, to act in a similar manner?	Yes	No
4. Did the individual knowingly breach established rules, safe operating procedures and/or Trust values and behaviors?	Yes	No
5. Have there previously been informal discussions with the individual about this issue or similar issues?	Yes	No
6. Can this incident be resolved informally? Tick as appropriate.	Yes ☐ feedback/reflective practice ☐ incident learning ☐ training/coaching	No
If no, what is the rationale?		
7. Can this incident be resolved through a structured conversation?	Yes	No
If no, what is the rationale?		

Before proceeding to Section 2, please reflect on the following:		
Have similar cases been handled in a consistent way across your team/service area?	Yes	No
Could bias, assumptions or stereotypes be influencing your decision?	Yes	No
Have you considered any relevant protected characteristics?	Yes	No

Personal details			
Employee Initials:		Employee Role:	
Service Line:		Area:	
Line Manager Name:		Name of Person Conducting Fact-Finding:	
Incident:			
Date incident occurred:			
Brief outline of allegations/incident:			

Decision Making Checklist

Answer the following questions before deciding on the next steps:

SECTION 2

1. Which disciplinary rule(s) do you consider may have been breached? (Refer to Appendix 1 of the Disciplinary Policy.)		
2. Has this incident resulted in suspension, alternative duties or restricted practice?	Yes	No
3. What is the individual's response to the alleged incident? <i>(The individual should always be given the opportunity to respond unless this is not advised for safeguarding or data protection reasons)</i>		
4. Please summarise any key facts/findings relating to the incident. This may include witness information where relevant.		
5. Briefly explain why you consider formal investigation to be the necessary course of action.		
Before submitting this form to IRP, please reflect on the following:		
Have similar cases been handled consistently across your team/service area?	Yes	No
Could bias, assumptions or stereotypes be influencing your decision?	Yes	No
Have you considered any relevant protected characteristics?	Yes	No
Recommendations following fact-finding assessment (please tick):		
☐	Fast track (only applicable to incidents of general misconduct)	
☐	Formal Investigation	
☐	No case to answer	

Nominated case manager:	
HR advice provided by:	
Date submitted to IRP:	

IRP OUTCOME

Date of IRP:	
Outcome of IRP:	Agreed with recommendations
	If no, revised recommendation:

Appendix 4

Format of the Disciplinary Hearing

This appendix sets out the standard format for a disciplinary Hearing. It should be read alongside Section 13 of this policy, which sets out the procedural requirements, notice provisions, employee rights, panel arrangements, witness principles and outcome requirements.

1. Purpose of the Hearing

The purpose of the disciplinary hearing is to allow the Hearing Chair or panel to consider the investigation report, the evidence available, the management case, and the employee's response before deciding whether the allegation(s) are upheld and, if so, what outcome is appropriate.

The Hearing must be conducted fairly, consistently and without unnecessary formality, while ensuring that all parties have a reasonable opportunity to present their case, ask relevant questions and respond to the evidence.

2. Before the Hearing

The HR representative should ensure that the following arrangements have been considered before the Hearing takes place:

- the employee has been invited to the Hearing in line with Section 13;
- the disciplinary pack has been issued to the employee and, where appropriate, their representative;
- the employee has been advised of their right to be accompanied;
- the employee has been advised of the deadline for submitting any written evidence or statement of case;
- the Hearing Chair or panel has received the full case materials;
- any witnesses required to attend have been identified and notified;
- witnesses have only been provided with documents relevant to their evidence;
- reasonable arrangements have been made to support attendance, including any adjustments or welfare considerations where appropriate;
- arrangements have been made for a note taker; and
- all parties understand the format of the Hearing.

3. Attendance at the Hearing

The following people will normally attend the disciplinary Hearing:

- the Hearing Chair;
- any panel members, where applicable;
- the HR representative supporting the Hearing Chair or panel;
- the employee;
- the employee's representative or workplace companion, where applicable;
- the Investigating Officer;
- the HR representative supporting the Investigating Officer, where applicable;
- any witnesses required to attend; and
- a note taker

Witnesses should only attend for the part of the Hearing relevant to their evidence, unless otherwise agreed by the Hearing Chair.

4. Conduct During the Hearing

The Hearing Chair is responsible for managing the Hearing and ensuring that it is conducted fairly and respectfully.

During the Hearing:

- all parties must follow the directions of the Hearing Chair;
- neither side should interrupt while another party is presenting their case;
- questions should be relevant to the allegations, evidence or outcome under consideration;
- the Hearing Chair may intervene if questioning is repetitive, inappropriate or not relevant;
- either party may request a short adjournment where reasonably required;
- official notes will be taken; and
- recording of the Hearing will not be permitted unless expressly agreed in advance as a reasonable adjustment.

5. Order of Proceedings

The usual order of proceedings will be as follows:

5.1 Introduction by the Hearing Chair

The Hearing Chair will:

- introduce everyone present and confirm their role;
- confirm the purpose of the Hearing;
- confirm the allegation(s) to be considered;
- confirm the potential outcomes;
- confirm that the employee understands their right to be accompanied;
- confirm that all parties have received the relevant documentation;
- confirm whether any witnesses are to be called;
- explain the format of the Hearing; and
- remind all parties of confidentiality and expected standards of conduct.

5.2 Management Case

The Investigating Officer will present the management case, including:

- a summary of the investigation undertaken;
- the evidence gathered;
- the findings and conclusions reached;
- any relevant policies, standards or expected behaviours;
- the basis on which it is considered there is a case to answer; and
- any witnesses required to give evidence.

The employee or their representative will be given the opportunity to ask questions of the Investigating Officer and any management witnesses.

The Hearing Chair, panel members and HR representative may also ask questions to clarify the evidence.

5.3 Employee Case

The employee or their representative will then be invited to present the employee's case, including:

- their response to the allegation(s);
- any explanation, mitigation or contextual information;

- any evidence submitted in support of their case;
- any relevant challenge to the management case; and
- any witnesses required to give evidence.

The Investigating Officer or management side will be given the opportunity to ask questions of the employee and any employee witnesses.

The Hearing Chair, panel members and HR representative may also ask questions to clarify the employee's case.

5.4 Summing Up

Both parties will be given the opportunity to summarise their case.

The Investigating Officer or management side will normally summarise first, followed by the employee or their representative.

No new evidence should be introduced during the summing-up stage unless agreed by the Hearing Chair. If new evidence is accepted, the Hearing Chair should consider whether an adjournment is required to allow all parties to review and respond to it.

6. Adjournment and Decision-Making

The Hearing Chair will adjourn the Hearing to consider the evidence and reach a decision. Where there is a panel, the decision will be made by the panel with advice from HR.

In reaching a decision, the Hearing Chair or panel should consider:

- whether a fair and reasonable process has been followed;
- whether the allegation(s) are upheld on the evidence available;
- the seriousness of any misconduct found;
- any mitigation presented;
- consistency with previous comparable cases, where known;
- the employee's disciplinary record, including any live warnings;
- the employee's length of service and general employment record;
- any relevant equality, health, wellbeing or welfare considerations;
- whether the outcome is reasonable and proportionate in all circumstances; and
- any relevant Trust policy, professional standards or regulatory obligations.

HR may provide advice on policy, process, consistency and employment law considerations, but the decision remains the responsibility of the Hearing Chair or panel.

7. Communicating the Outcome

Where possible, the Hearing Chair may reconvene the Hearing and provide the outcome verbally on the day. Where this is not possible, the outcome will be confirmed in writing in line with Section 13.

The written outcome should include:

- the allegation(s) considered;
- whether each allegation is upheld, partially upheld or not upheld;
- a summary of the evidence relied upon;
- the key reasons for the decision;
- any mitigation considered;
- the outcome or sanction, if applicable;
- the effective date of any sanction;
- the duration of any warning, where applicable;

- any required improvement, remedial action or expectations going forward;
- the consequences of further misconduct, where relevant;
- any support or follow-up arrangements;
- confirmation of how long any warning will remain live, where applicable; and
- the employee's right of appeal and how to exercise it.

8. Witnesses

Where witnesses are required to attend, they should only be present for the relevant part of the Hearing unless the Hearing Chair determines otherwise.

The usual approach will be:

- the witness is invited into the Hearing;
- the party calling the witness asks relevant questions first;
- the other party is given the opportunity to ask relevant questions;
- the Hearing Chair, panel members or HR representative may ask clarification questions;
- the witness is then released from the Hearing unless the Chair considers there is a need for them to remain available.

Witnesses should not be asked to comment on matters outside their direct knowledge or evidence.

9. Adjournments

The Hearing Chair may adjourn the Hearing at any point where this is necessary to ensure fairness. This may include adjournments to:

- consider new information;
- allow a party to review evidence;
- seek clarification;
- take advice;
- allow a welfare break;
- consider whether further investigation is required; or
- deliberate on the outcome.

Where an adjournment means the Hearing cannot conclude on the same day, the Hearing Chair should confirm the next steps and anticipated timescales to the parties.

10. Notes of the Hearing

A written note of the Hearing will be taken. The notes are not intended to be a verbatim transcript but should provide an accurate summary of the key points discussed, questions asked, responses given, adjournments, decisions and outcomes.

The notes should be retained in accordance with Trust record keeping requirements.

Appendix 5

Appeals Procedure

1. Right to Appeal

All employees have the right to appeal against any formal disciplinary action taken.

2. Purpose of the Appeal

An appeal is a review of the original decision, not a rehearing of the disciplinary case. The panel will consider the specific grounds of appeal and determine whether the original outcome remains appropriate.

3. Grounds for Appeal

Appeals must be based on one or more of the following:

- a failure to follow the Trust's disciplinary procedure
- new evidence has come to light that could not reasonably have been presented at the original hearing
- the level of sanction imposed was disproportionate to the findings

4. Submitting an Appeal

Appeals must:

- be submitted in writing to the Head of HR Business Partnering (or nominated officer)
- clearly set out the grounds for appeal
- be received within 14 calendar days of the disciplinary hearing outcome letter

5. Arranging the Hearing

- The appeal hearing will normally take place as soon as reasonably practicable, typically within four weeks of receipt
- The employee will receive at least 14 calendar days' notice of the hearing
- Both parties must submit all documentation in advance; this will usually be shared no later than 5 calendar days before the hearing, unless otherwise agreed

6. Conduct of the Hearing

- The hearing will focus on the stated grounds of appeal
- The employee (or representative) will present their case and respond to questions
- The management representative will then present the management case and respond to questions
- Both sides will have the opportunity to sum up their case. Neither party may introduce any new matters for consideration in the final summary
- The panel may adjourn to consider any complex information
- No additional evidence will normally be accepted on the day of the Hearing unless agreed by the Chair. Where new evidence is accepted, both parties will be given the opportunity to consider it.
- The Appeal panel will deliberate in private only recalling both parties to clarify points of uncertainty on evidence already given.

7. Outcome

The decision of the Appeal panel will normally be communicated at the end of the meeting. The panel may:

- uphold the original decision
- revoke the decision
- substitute or reduce the sanction

The decision will normally be confirmed in writing within 7 calendar days.

8. Finality

The outcome of the appeal is final and marks the end of the Trust's internal process.

A copy of the appeal hearing notes will be retained on file and can be provided upon request.

Appendix 6

Suspension/Action short of Suspension

Employee Details			
Employee Initials:		Employee Role:	
Service Line:		Area:	
Head of Operations/ Equivalent Senior Manager:		HR Advisor:	

	Consideration	Response	Evidence
1	Has a preliminary investigation/ fact finding exercise been undertaken to understand the situation?	Yes / No	<i>Please see and complete Appendix 3</i>
2	Do the concerns amount to allegations of serious misconduct and / or is there concern that: - Working relationships have severely broken down - The employee could tamper with evidence or influence witnesses - There is a risk to other employees, property or patients - Further incidents may occur - The individual needs safeguarding from further allegations? - The employee is the subject of criminal proceedings which may affect whether they can continue to undertake their role.	Yes / No	(SUSPENSION SHOULD ALWAYS BE A LAST RESORT)
3	If yes to any of the above, is it possible to: - Temporarily move the individual to another area until the outcome of the investigation? - Limit/restrict/supervise the employee's duties or practice whilst the investigation is carried out?	Yes / No	
4	If no to Q3, have you contacted the Business HR team to discuss the possibility of suspension?	Yes / No	
5	Before carrying out the suspension, have you consulted with the respective Head of Operations (or Equivalent) for your area?	Yes / No	

Consideration		Response	Evidence	
Do you need to contact the Trust Safeguarding Team?		Yes / No		
Does the individual work on the Bank? Do you need to liaise with GRS to prevent the worker from working bank shifts for the Trust during the period of suspension?		Yes / No		
Final Decision:	Suspension	Yes / No	Action short of suspension	Yes / No
			Detail of ASOS	
Case Manager			Date	
HR Representative			Date	

NB: Copy of this form must be sent to the Head of Business HR and relevant Area Director

Appendix 7

Employee Registration of Appeal Pro-Forma

In order to submit an appeal, please complete this form, providing as much information as possible.

To register your appeal, this should be sent via email to the Head of HR Business Partnering

Section 1 – Details

Personal Details (to be completed by the person submitting an appeal)			
Name of employee:			
Job Title		Employee Number	
Division/Area			
Date of Disciplinary Hearing:		Sanction you are appealing against:	(Delete as appropriate) ☐ First Written Warning ☐ Final Written Warning ☐ Dismissal ☐ Alternative to Dismissal (i.e. Downgrading)

Section 2 – Grounds of Appeal

Please detail the grounds of appeal. Please note, the purpose of an appeal is to consider the decision made by the chair of the disciplinary hearing. An appeal hearing is not a re-hearing of the original case

Further Explanation – Grounds of Appeal

Please provide further explanation of your grounds of appeal. This should contain specific Issues/ examples which support your grounds of appeal detailed in Section 2.

Please use additional sheets of paper/ provide supporting documentation if required but ensure that all pages are numbered and clearly referenced.

☐	I wish to be accompanied by a Trade Union representative/Workplace colleague at any appeal meeting	Name (please provide where possible)	
		Contact Details:	
☐	I do not wish to be accompanied		

Appendix 8

Independent Review Panel (IRP)

Guiding Principles

In line with NHS Improvement recommendations NWAS has established an Independent Review Panel (IRP) as a means of ensuring senior level oversight of all disciplinary cases.

The IRP meets weekly, acting as a consistency check for conduct matters across the Trust and provides advice and guidance to line managers, investigating officers and/or case managers regarding consistency of outcomes at informal levels, and ensuring uniformity of recommendations to progress cases to formal disciplinary hearings.

The IRP is not a decision-making panel. Its primary purpose is to support recommendations made by the appropriate managers to ensure fairness, proportionality and consistency of practice in matters of conduct and behaviour. The ultimate decision regarding informal case outcomes and any onward action lies with relevant managers detailed above.

Fact Finding Checklists

On receiving an allegation of misconduct, an initial fact-finding assessment should be undertaken, in line with section 8 of the Disciplinary Policy in order to establish what action/ if any is required. If the recommendation is for an investigation, the completed pro-forma must be submitted to the local HRBP Team who will arrange for the case to be submitted to the next IRP meeting.

IRP will consider the pro-forma and support the recommendation or advise otherwise.

Investigation Reports

Once an investigation report is complete, which must include the Case Manager's recommendations, it should be forwarded to the local HRBP team who will arrange for it to be considered at the next IRP meeting.

Disciplinary hearings should not be arranged prior to oversight and feedback from IRP.

Timescales

The IRP meets weekly. All documentation should be submitted at least 36 hours before the meeting to enable the panel to review the documents. Feedback from the panel will usually be provided 36 hours after the panel has met.

Outcome

In the unusual circumstance that the IRP does not support the recommendation made, a conversation between a member of HR and the relevant manager will take place, and the final decision will be recorded.

EQUALITY & QUALITY IMPACT AND RISK ASSESSMENT (EQIA) SCREENING TOOL - STAGE 1

Directorate:

People Directorate

Name of programme/project/policy:

Disciplinary Policy

Date of completion:

03.07.2026

Team:

Human Resources Business Partner Team

Lead/author:

Marie Knox-Davis

Date of planned next/future review:

Jul-29

Brief overview of the proposals (project/programme/policy) being assessed

Review the Disciplinary Policy to strengthen consistent application, reduce the number of disciplinary cases, and improve staff confidence and wellbeing by incorporating "Avoiding Harm" guidance.

GENERAL GUIDANCE

Please use the rationale box to provide an explanation of your 'Y' / 'N' indicative responses. Following a review by EDI and Quality teams, a recommendation will be provided on whether a Stage 2 EQIA is required.

QUESTION No.	ABOUT THE PROPOSAL	Enter Y or N	Rationale <i>if you have indicated 'yes' or 'no' for any questions, please briefly explain</i>
1	Is the proposal about introducing a new service or activity?	N	No - it's a review, with minor amendments to the existing Disciplinary Policy which should have a positive impact.
2	Does the proposal plan to withdraw a service, activity or presence?	N	No planned withdrawal of any service, activity or presence.
3	Does the proposal relate to introducing, reviewing or changing a policy, strategy or procedure?	Y	3-year review in line with the Trust's policy management practices, following a re-write of the policy in 2022/23. The review makes minor positive impacts.
4	Does the proposal affect staff, or levels of training for those who will be delivering the service?	Y	<i>Detail which staff groups are affected</i> Affects staff positively in that additional training will be available to support team leaders and managers, and aspiring managers, who will be applying the policy to improve the management of disciplinary matters.
5	Does the proposal affect service users?	N	No, the revised policy will not directly affect service users, but they may indirectly receive a slightly more positive, consistently applied service.
6	Does the proposal plan to reduce the service, activity or presence?	N	No reduction to service, activity or presence.
7	Does the proposal primarily relate to limiting access to, or delivery of a service?	N	No limited access to, or delivery of a service
8	Does the proposals plan to change to a commissioned service?	N	No changes to commissioned service

9	As a result of the proposal, will patients or the public see a change in the service they currently receive?	N	Highly unlikely that patients or the public will see a change in the service they currently receive.
10	Does the proposal change the ways of working of the current or future workforce?	N	No change in the ways of working of the current or future workforce.
EQUALITY IMPACT		Enter Y or N	Rationale <i>if you have indicated 'yes' or 'no' for any questions, please briefly explain</i>
11	Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?	N	<i>More information about these groups is on the 'Guidance' tab</i> No foreseen negative impacts on any Protected Characteristics groups or inclusion health groups as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.1	Age	N	No foreseen negative impacts towards age as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.2	Disability	N	No foreseen negative impacts towards disability groups as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.3	Gender reassignment	N	No foreseen negative impacts towards gender reassignment as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.4	Marriage and civil partnership	N	No foreseen negative impacts towards marriage and civil partnerships as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.

11.5	Pregnancy and maternity	N	No foreseen negative impacts towards pregnancy and maternity as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.6	Race	N	No foreseen negative impacts towards race as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.7	Religion or belief	N	No foreseen negative impacts towards religion as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.8	Sex	N	No foreseen negative impacts towards sex as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.9	Sexual orientation	N	No foreseen negative impacts towards sexual orientation as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.
11.10	Inclusion health groups - E.g. People who: - Are socially excluded, - Typically experience multiple overlapping risk factors for poor health (i.e. poverty / violence / complex trauma). - Experience homelessness, drug and alcohol dependence, vulnerable migrants, - From Gypsy, Roma and Traveler communities, - Sex workers, - Are in contact with the justice system - Are victims of modern slavery.	N	No negative impacts can be foreseen towards any inclusion health groups as a result of this review of the Disciplinary policy. Should any be found in the application of the policy going forward, these will be mitigated in line with Trust practices.

QUALITY IMPACT		Enter Y or N	Rationale <i>if you have indicated 'yes' or 'no' for any questions, please briefly explain</i>
12	Does the proposal have a negative impact on the quality of patient care?	N	
13	Does the proposal have a negative impact on the safety of patient care provision?	N	
14	Does the proposal present a risk of harm to patients?	N	
15	Does the proposal present a risk of harm to carers, contractors or the public?	N	
16	Are there any foreseeable negative impacts on the individual patient experience?	N	
17	Is there a potential that patient satisfaction will be decreased as a result of the proposal?	N	
RISK ASSESSMENT		Enter Y or N	Explanation <i>if you have indicated 'yes' or 'no' for any questions, please briefly explain</i>
18	Have you collated and reviewed any data relating to the impact of the proposal on patients/staff? Please list any relevant data/documents.	Y	NWAS Data Quality ER cases dashboards, NWAS Workforce Race Equality Standard (WRES), HPMa Guidance on Avoiding Harm, NHS England guidance on Conducting Investigations, CIPD and ACAS guidance documents.
19	Have you taken specialist advice? (Legal, ED&I / Quality Teams, etc).	Y	Reviewed in line with current legislation to ensure accuracy, and specific legal guidance from Weightman's taken in regard of sickness absence and suspension.
20	Are there any risks affecting the quality of patient care provision?	N	No expected effect to the quality of patient care provision, but if any, it should be slightly positive

21	Are there any risks affecting the safety of patient care provision?	N	No expected effect to the safety of patient care provision, but if any, it should be slightly positive
22	Are there any risks affecting the quality of patient experience?	N	No expected effect to the quality of the patient experience but if any, it should be slightly positive
23	Does the proposal support the aims of the Public Sector Equality Duty?	Y	The revised Disciplinary Policy supports the aims of the Public Sector Equality Duty by promoting fair, transparent, and consistent treatment of all employees. The policy provides clear procedures to help ensure disciplinary matters are managed objectively and without unlawful discrimination.
24	Have you identified stakeholders (patient/carers/staff) to engage with on the proposals?	Y	Staff groups, staff networks, individual staff members subject to disciplinary processes, Trade union colleagues, line managers, HR colleagues.
25	Have you already undertaken engagement with stakeholders, or are planning to do so? Please explain	Y	extensive engagement with a number of stakeholders including a varied sample of investigating officers and case managers (Q2 2025); HR managers and advisers supporting cases (Q2 2025); Trade union colleagues and FTSU champions (Q3 2025), 2 x Trust wide Policy Group meetings (Q1 2026), and sessions with staff who have been the subject of investigation (Q4 2025) to listen to and understand their lived experiences.
26	How will you mitigate or minimise any potential negative impacts on Protected Characteristics groups? (Patients and staff).	Y	At the time of the policy review there were no foreseen negative impacts in relation to any of the Protected Characteristics groups, but the application of the policy will be kept under continual review with feedback regularly sought from ED & I, Managers, HR, TU and Policy Group. Should there be any potential or negative impact these will be mitigated in line with Trust procedures and policies and specialist advice where relevant.

HUMAN RIGHTS IMPACT		Rationale
27	Does the proposal potentially adversely impact the human rights of patients, carers or staff? If so, please provide an explanation	No adverse impacts have been identified.
Human Rights: A2 Right to Life A3 Prohibition of torture, inhuman or degrading treatment A4 Prohibition of slavery and forced labour A5 Right to liberty and security A6 Right to a fair trial A7 No punishment without law A8 Right to respect for private and family life A9 Freedom of thought, conscience and religion A10 Freedom of expression A11 Freedom of assembly and association A14 Prohibition of discrimination P1A2 Right to education		The revised policy primarily supports the principles of the following Human Rights Articles: A6 - Right to a fair trial, A8 Right to Respect for Private and Family Life, A9 Freedom of Thought, Conscience and Religion, A10 Freedom of Expression, A11 Freedom of Assembly and Association, A14 Prohibition of Discrimination.,

Please send this completed Screening Tool to EQIA@nwas.nhs.uk for review and feedback

FOR REVIEWERS

Is a Stage 2 EQIA likely to be required?

EDI - NO
Quality - NO

Comments from the ED&I Team

22/07/2026 - WM - v1.0 - 1st Review: feedback/comments added (Review > Show Comments) once adjustments made in this link provided document, then email EQIA@nwas.nhs.uk to request a 2nd Review

04/08/2026 - WM - v1.0 - 2nd Review: recommend to Quality Directors to remain at stage 1 at their stage 1 oversight check/approval

Reviewed by:

WM - v1.0 - 1st Review
WM - v1.0 - 2nd Review

Date

22/07/2026 - v1.0 - WM
04/08/2026 - v1.0 - WM

Comments from the Quality Team

04/08/2026 - MMc - v1.0 - 1st Review: No comments to add, once WM comments addressed happy to sign off at stage 1

Reviewed by:

MMc - v1.0 - 1st Review

Date

04/08/2026 - v1.0 - MMc

Oversight by Quality Directors

Status: Approved to remain at stage 1

Comments from Quality Directors

06/08/2026 - CG - v1.0 - 1st Review: Approved

06/08/2026 - ESH - v1.0 - 1st Review: Policy and EQIA reviewed and Approved - standard review process

Reviewed by:

ESH - v1.0 - 1st Review

Date

06/08/2026 - v1.0 - ESH

Reviewed by:

CG - v1.0 - 1st Review

Date

06/08/2026 - v1.0 - CG

Document Control

Document Control					
Policy Title	Disciplinary Policy and procedure	Policy Reference Number	P-007	Version Number	5
Approval Date		Approved By	Director of People	Date for Review	
Executive Sponsor	Director of People	Policy Lead	HR Project Manager	For Use By	All Staff

Change Record Form

Version	Replaces	Date of Change	Date of Release	Changed By	Reason for Change
	v4.5			HR Project Manager	Normal policy review cycle.



NHS

**North West
Ambulance Service**
NHS Trust

Fast Track Disciplinary Procedure

Version 1.0, August 2026

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Introduction

1. Introduction

- 1.1 The Trust expects all colleagues to maintain high standards of behavior which reflect its values and support the delivery of the right care, at the right time, in the right place. Employees must treat the public with dignity and respect and help protect them from harm. This procedure provides an alternative process for dealing with misconduct where an employee's behaviour falls below the standards expected by the Trust, or breaches Trust values, policies or rules.
- 1.2 The Trust aims to develop an open and fair culture that encourages learning, self-reflection and improvement. Where appropriate, lessons learned will be shared and embedded across the service into everyday practice.
- 1.3 This procedure is only applicable where:
 - The allegations are not considered to be potential gross misconduct;
 - The employee fully accepts the allegations
 - The employee wishes to resolve the matter and avoid a full disciplinary to support their wellbeing.
- 1.4 This procedure applies to all employees of the North West Ambulance Service NHS Trust and should be read alongside the Trust's Disciplinary Policy & Procedure.

Purpose

2. General Principles

- 2.1 The Trust is committed to dealing with all disciplinary matters fairly. Before formal action is taken, reasonable steps must be taken in the early stages to establish the relevant facts.
- 2.2 The Fast Track Procedure may be requested by the employee, their representative or the Case Manager. It may also be suggested by the line manager, TU representative or HR representative. For this procedure to be used it is essential that sufficient facts have been established to understand that a formal disciplinary process would be likely to result in a sanction of no more than a Final Written Warning.
- 2.3 This procedure cannot be used where:
 - the employee already has a live formal warning on file, or
 - there is a connected disciplinary process involving another employee.
- 2.4 This procedure must not be used without the involvement of a member of the HR team.

- 2.5 Where the Fast Track Procedure is accepted by the assigned Case Manager, a full disciplinary investigation will not be required. However, sufficient and reasonable fact finding must have taken place to ensure that during the Fast Track Hearing (FTH) the facts can be fully considered and an informed decision can be made. Any information gathered as part of the initial fact find will be shared with the employee in advance of the hearing.
- 2.6 If, whilst the Fast Track Procedure is on-going,
- the employee disputes the allegations previously accepted or,
 - if further information becomes apparent which means the use of this procedure is no longer appropriate (e.g. allegations arising which may amount to gross misconduct),
- 2.7 The Fast Track Procedure will be stopped, and the process will resume or commence under the Trust's Disciplinary Policy. This Case Manager will decide whether an investigation is required and where appropriate, appoint or direct an Investigation Officer.
- 2.8 An employee can request resolution via the Fast Track Procedure at any time prior to a formal disciplinary hearing date.
- 2.9 By agreeing to the use of a Fast Track Procedure, an employee accepts that they will not have the right to appeal any formal disciplinary sanction issued at the Fast Track Hearing. This is because both parties have agreed to use this process and accepted the range of potential outcomes before the hearing takes place.
- 2.10 Everyone involved in this process must maintain confidentiality and act objectively throughout.

3. Supporting Health and Wellbeing

- 3.1 The Trust recognises that being involved in a disciplinary process can be stressful for employees who are the subject of investigations, as well as other staff who may become involved. Managers are responsible for ensuring that any staff involved within a disciplinary process are appropriately supported at all stages of the process.
- 3.2 At the start of any disciplinary case the employee will be reminded of the support services available to them through the Trust's Occupational Health and counselling service. Employees may refer to these services or, with their agreement, be referred by their manager. In some circumstances the Case Manager may make a referral without a request from the employee dependent on the nature of the allegations or the employee's circumstances.
- 3.3 Employees who have concerns regarding their health or wellbeing, should raise in the first instance with their line manager, or the Case Manager, who will ensure they are appropriately supported.

4. Applying the Fast Track Procedure

- 4.1 When concerns of misconduct arise, which are too serious to be handled via informal

resolution, and where a Preliminary Fact-Finding Checklist (see Disciplinary Policy appendix 3) indicates that a more formal investigation may be appropriate, the use of the Fast Track Procedure may be applied with the support by the Case Manager.

- 4.2 In such cases, and if the employee has admitted the allegation(s) put to them in full, via the fact-finding process, they may request their case is progressed via the Fast Track Process (FTP). Equally the Case Manager, the line manager, TU rep or HR may suggest the use of the Fast Track Process as a voluntary option.
- 4.3 In order to proceed using the Fast Track process, the following must apply:
- The allegations, if proven, could not result in summary dismissal,
 - The employee has no live disciplinary warning
 - The employee fully accepts the allegations (but may have mitigation to put forward)
 - The employee does not wish to proceed with a full disciplinary investigation and hearing in line with the Trusts' Disciplinary Policy,
 - The employee completes a Fast Track Request Form
- 4.4 Employees are encouraged to seek advice from their trade union representative, workplace colleague or member of the HR team before deciding whether to use the Fast Track route. The employee and/or their representative should then complete and sign the Fast Track Application form and submit it to the fact-finding manager for completion. The Case Manager will, as soon as is practicably possible, discuss the matter with HR to agree if the matter is suitable for a Fast Track Hearing.
- 4.5 In the unlikely situation that an agreement to follow the FTP cannot be reached, then a full investigation will be instigated in line with the Trust's Disciplinary Policy. The employee will be informed in writing.
- 4.6 If the Fast Track Application is accepted, a formal investigation report will not normally be required, although enough fact-finding must have taken place to allow the Fast Track Hearing Chair to reach a fair and informed decision.
- 4.7 Once it has been agreed to proceed via FTP it is anticipated that the process will be concluded within 28 days, unless exceptional circumstances arise. Any unreasonable delays should be escalated to HR.

5. Fast Track Hearing Process

- 5.1 The formal disciplinary hearing will be replaced with a Fast Track Hearing (FTH). Under the fast-track process the hearing will be chaired by an appropriately trained/ experienced Trust representative, who will be assigned in line with the Trust's Scheme of Delegation. Also, members of the HR team will attend to provide support and advice. The employee has the right to be accompanied by a trade union representative or a workplace colleague at the Fast Track Hearing.
- 5.2 The employee will receive written notice of the Fast-Track hearing of at least 3 days' notice. This letter will set out the allegations that the employee has admitted and will confirm that any sanction issued will not exceed a 12-month final written warning. At this stage the employee has a final opportunity to withdraw from the fast-track process and request a full disciplinary hearing. Choosing to do so will not disadvantage them in any way.
- 5.3 At a Fast-Track hearing, an employee or their representative has the opportunity to present

any mitigating circumstances. The Chair will consider this together with the information detailed on the Fast Track application. No witnesses will be called, no formal statements of case will be exchanged, and only brief notes of the hearing will be kept by the panel.

- 5.4 The Hearing may be adjourned briefly for the Chair to consider their decision. In exceptional circumstances, where more information is needed before a decision can be taken, the hearing may be adjourned to allow further enquiries to take place. The Chair will decide what further information is required and how long the adjournment will last.
- 5.5 Normally the outcome will be given verbally on the day of the hearing and confirmed in writing within seven calendar days. Where this is not possible, the Chair will aim to meet with the employee and their representative to inform them of the decision. In circumstances where it is not possible to meet, the decision will be provided in writing.

6. Disciplinary Sanctions

- 6.1 When determining what, if any, disciplinary sanction is appropriate the Chair must act reasonably and consider all relevant circumstances, including:
- The extent to which standards have been breached and / or the seriousness of the misconduct.
 - Consistency with similar cases.
 - Other special circumstances which might mitigate or otherwise affect the appropriate severity of the penalty.
 - Impact of the misconduct on patients, colleagues, the public and the Trust (including reputation).
 - Whether the proposed sanction is reasonable and proportionate.
 - The employee's employment record.
- 6.2 Any sanction will be issued will be in accordance with the Trust's Disciplinary Policy and will not exceed a final written warning. Any final written warnings issued under this procedure will not exceed 12 months.
- 6.3 Disciplinary sanctions are not applied sequentially. Where appropriate, any level of sanction available under this procedure may be applied.
- 6.4 Any sanction will normally be effective from the date of the fast-track hearing.
- 6.5 Once the "live period" of a warning has expired, it will no longer be used for the purpose of considering cumulative disciplinary sanctions, but the facts / circumstances may be deemed relevant to future cases, and so details will remain on the employee's personal file.

There is no right of appeal and this is the end of the process.

Appendix 1

Fast Track Procedure Application

Full Name:		Role:	
Service Line:		Area:	
Line Manager:		HR rep:	
Do you have any Live Disciplinary Warnings	Yes/No		
2. Case Details (Completed by Fact Finding Manager)			
Date allegation initially raised:		Name of Manager who undertook Fact Finding	
Nature of Allegation (to be completed by manager who conducted Fact Find)			
Date meeting to discuss allegations took place		Names of those present:	
Main Points of Fact-Finding Discussion			

3. Employee Submission Case Details

Do you dispute any of the allegations/facts above?	Yes/No If yes, please note your Fast Track application cannot proceed
Please provide a full explanation of the incident(s) that led to these allegations of misconduct (you can detail this on a separate attached sheet if you wish)	
Please provide details of any mitigation you would wish to be considered.	
Please detail the lessons you have learnt from this situation and your intentions for the future.	
I confirm my acceptance of the allegation(s) of misconduct against me and am making this request for my case to be considered under the Fast Track Disciplinary Process.	
Employee Name	
Employee Signature	
Date	

Document Control

Document Control					
Policy Title	Disciplinary Policy and procedure	Policy Reference Number	P-007	Version Number	5
Approval Date		Approved By	Director of People	Date for Review	
Executive Sponsor	Director of People	Policy Lead	HR Project Manager	For Use By	All Staff

Change Record Form

Version	Replaces	Date of Change	Date of Release	Changed By	Reason for Change
0.1	v4.5	November 2022	December	J Massey	Document creation
1.0		March 2023	March 2023	M Kumawu	Approval by Executive Leadership Committee
1.1		May 2024	May 2024	HR Manager	Agreed extension to August 2024.
1.2		June 2024	July 2024	HR Manager	12-month review at Policy Group, agreed extension for a further 12 months to May 2025.
1.3		May 2025	May 2025	HR Manager	Agreed extension to September 2025



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 2026
SUBJECT	2026/27 Flu Campaign
PRESENTED BY	Lisa Ward, Director of People/Deputy Chief Executive
PURPOSE	Assurance

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

Risk Appetite Statement <i>(Decision Papers Only)</i>	Quality: Cautious	☐	People: Open	☒	Finance: Open	☒
	Regulatory: Open	☐	Reputation: Open	☐	Digital Innovation: Eager	☒

ACTION REQUIRED	The Board of Directors is asked to: - Receive assurance that there are plans in place to deliver the 2026/27 flu campaign - Note that reporting of progress will be made through workforce indicators reports to future Resources Committee meetings
EXECUTIVE SUMMARY	The 2025/26 flu campaign showed improvement, with 44% overall staff uptake and 45% uptake amongst frontline healthcare workers, achieving the NHS England expectation of a 5% increase in uptake. Whilst comparative performance was good in the North West, performance remained below the ambulance sector average. The main groups with lower uptake were: - Younger staff. - ICC staff. - Staff from BME backgrounds. NHS England has set an ambitious target for 2026/27 of vaccination of 60-65% healthcare staff. This is a significant challenge. Reporting will form part of the NOF and therefore links directly with Trust oversight. Staff vaccination also forms a core part of winter planning. Learning has been taken from the 2025/26 campaign to enhance the 2026/27 approach which will: - Continue with a peer-led vaccination model.

- Target younger staff, ICC colleagues and BME staff through tailored engagement and communications.
- Focus vaccination activity in the first two months when uptake is highest.
- Use an additional £30,000 of funding to increase vaccinator capacity and outreach activity.
- Prioritise frontline PES and PTS staff during the early stages of the campaign.
- Introduce the Staff Anywhere model in Lancashire & South Cumbria, allowing staff to access vaccinations across participating NHS organisations.
- Increase vaccination opportunities in Emergency Departments and around shift handovers.
- Strengthen manager accountability for promoting vaccination uptake.
- Improve reporting processes and focus performance reporting on uptake rather than offer rates.
- Focus communications on professional and clinical responsibility i.e. A focus on the risk to patients as well as the risk to staff

The campaign builds on the lessons from 2025/26 and introduces targeted measures aimed at increasing uptake and reducing inequalities across staff groups. The main risk remains achieving the significantly increased national ambition, but a comprehensive delivery plan is in place to support improvement.

**PREVIOUSLY
CONSIDERED BY**

Resources Committee

Date	24 th September 2026
Outcome	Plan noted. Noted that the revised targets represent a stretch challenge.

Trust Management Committee

Date	19 August 2026
Outcome	Plan approved.

1. BACKGROUND

- 1.1 The 2026/27 Flu Vaccination programme letter issued by NHS England outlines the expectation for providers to deliver a 100% offer to eligible healthcare workers. In addition, the letter advises that providers should *'ensure they make firm plans to enable delivery of more vaccinations in the 2026 to 2027 season than they did in the 2025 to 2026 season. Providers should also ensure they have robust plans in place to identify and address health inequalities for all underserved groups, and we would like to see progress on reducing unwarranted variation and improving uptake'*.
- 1.2 A further letter was issued in July 2026 which set out an increased level of ambition for 2026/27. NHS England has identified frontline healthcare worker flu vaccination uptake a key priority to support this year's winter plans and outlined a revised target to increase uptake to between 60-65% for the frontline workforce.
- 1.3 The Healthcare worker vaccination rate forms part of the National Oversight Framework metrics and therefore has a direct link to Trust performance and oversight.
- 1.4 Flu vaccination also forms part of the NWS winter plan. The national definition of healthcare worker is based only on those staff with direct patient contact and the 60% target therefore relates to our PES and PTS cohorts of staff. However, uptake of flu vaccination is considered more broadly in NWS winter plans, particularly in the context of the resilience risk that a flu outbreak in our contact centres would pose. Our flu campaign offer and monitoring is therefore broader than the national measurement.
- 1.5 As a result, the Trust's campaign for 2026/27 seeks to ensure all staff have the offer of a vaccine and that appropriate strategies for offering to underrepresented groups are developed.

2. OVERVIEW OF LAST YEAR'S CAMPAIGN

- 2.1 The campaign was delivered through a multi-disciplinary Flu Project Team, established in July 2025, comprising representatives from HR, PTS, PES, Communications, Medicines Management, IPC and ICC.
- 2.2 The campaign was led operationally by the Infection Prevention and Control Specialist Lead within the Quality Directorate, with oversight provided by the People Directorate, which also retained responsibility for national reporting requirements.
- 2.3 The campaign saw an increase vaccinator utilisation, with an 80% conversion rate from trained vaccinator to active vaccinator compared with 70% in the previous year.
- 2.4 A total of 3,616 staff received a flu vaccination either through NWS or an external provider. This represents an increase from the 2024/25 campaign. Against an eligible workforce of 8,271 staff, this equates to an overall uptake rate of 44%.
- 2.5 Table 1: NWS staff vaccine uptake 2025/26

Outcome	Staff	%
Vaccinated by NWS	3,072	37.1%
Vaccinated elsewhere	544	6.6%
Declined/no response	4,551	55.0%
Deferred/referred	104	1.3%

- 2.6 Nationally, frontline healthcare workers uptake improved from 37.9% in 2024/25 to 45% in 2025/26, representing an increase of 7.%. The Trust achieved the nationally defined 5% improvement target for staff flu vaccination uptake and was the fifth Trust in the Greater Manchester Area to do so. NWAS uptake by frontline healthcare workers was 45%, this met the national average. Ambulance trusts averaged 49% uptake, NWAS was 4% below this. At a regional level, the North West averaged 41.6%, NWAS exceeded this by 3.4%.

3. KEY LEARNING FROM 2025/26 CAMPAIGN

- 3.1 Overall uptake of vaccination is lower in the North West than other areas of the UK. We are still seeing the impact of COVID on flu vaccination uptake, with the frequency of vaccination combined with the threat of enforcement for healthcare workers having an ongoing detrimental impact on uptake. Local Trade Unions are supportive in principle but remain very focused on individual right to choose.
- 3.2 Analysis of the 2025/26 campaign identified lower uptake among:
- Younger staff age groups;
 - ICC staff;
 - Staff from BME backgrounds.

These groups will form the focus of targeted interventions during the 2026/27 campaign.

- 3.3 The detailed analysis by work area and protected characteristic demonstrates that uptake amongst ICC staff remains the lowest within the organisation and mirrors patterns seen in previous years. Early discussions have already taken place with ICC leadership to identify actions to improve uptake. Similarly, uptake amongst BME staff remained lower than the Trust average. This reflects a pattern seen both locally and nationally and will be addressed through targeted engagement, including collaboration with staff networks to better understand barriers to vaccination.
- 3.4 Historically there has also been a focus in some areas on achieving the offer target with less emphasis on the uptake. This has in some areas led to a position where contact with staff to offer the vaccine has proceeded at pace to be able to show good progress against the target of offering the vaccine to all staff but with less focus on the time and effort to persuade staff to reconsider the refusal of vaccination.
- 3.5 Analysis of local data versus the nationally reported data has also highlighted discrepancies. NHS England measure performance through the Reporting and Vaccination System (RAVS). For the last campaign this showed a negative discrepancy of 4.8% in records. This discrepancy is most likely to reflect challenges in capturing and recording vaccinations received by staff outside of NWAS where their local GPS records have not appropriately aligned with their employment as a frontline healthcare worker.
- 3.6 The key learning from the 2025/26 campaign is that early engagement, targeted approaches for lower-uptake groups, effective deployment of vaccinators and strong management support are the factors most likely to improve vaccination uptake in line with national expectations during the 2026/27 campaign.

4. 2026/27 FLU CAMPAIGN

- 4.1 The national flu vaccination programme for adults will commence on 1 October 2026. The later start date reflects Joint Committee on Vaccination and Immunisation (JCVI) advice regarding the waning effectiveness of flu vaccines and the need to maximise protection during peak influenza circulation.

- 
- 4.2 The Trust has procured 3,500 vaccines for the 2026/27 campaign, reflecting demand during the previous campaign. Additional stock can be obtained if required. Vaccines are expected to be available from September to support distribution ahead of the national programme launch on 1 October 2026
- 4.3 The delivery model will largely replicate the strategy of previous years which has operated via a 'peer led' model. This involved the area flu leads identifying a group of vaccinators who then travel to offer and administer the vaccine to all staff in scope within their area. The flu leads take responsibility for reviewing the data around uptake and identifying key sites or staff groups where further targeting of the vaccination is required. The model is best described as a 'roaming model' and relies on vaccinators travelling to deliver vaccinations to staff.
- 4.4 For staff who are in site-based roles such as in our contact centres, corporate sites, the existing approach of advertising flu clinics will remain in place. In the past we have also put specific clinics into place for PTS staff, and particularly those in GM who are not necessarily on the same sites as PES staff. It is proposed that a similar approach for PTS is taken for this year's campaign.
- 4.5 The Quality Directorate will lead the campaign through the Infection Prevention and Control Specialist Lead, who will work closely with the Medicines Management Team and Chief Pharmacist to provide overall leadership and governance of the programme. The Corporate HR Team will continue to be responsible for fulfilling national reporting requirements. Support will also be provided by the Communication Team to ensure that staff are fully aware of the campaign and the benefits of the vaccine.
- 4.6 Following discussions with the Flu Project Team, there is clear recognition that vaccination activity should be concentrated within the early stages of the campaign. Historical data demonstrates that uptake is highest during the first two months, while early delivery also minimises the impact on frontline resources during periods of increased winter demand.
- 4.7 The campaign will place particular emphasis on delivering vaccinations during the first two months of the programme, reflecting historical evidence that uptake is highest during this period and minimising operational impact during peak winter pressures.
- 4.8 In addition to our standard approach there are several changes being made to the campaign in order to try to maximise progress towards the ambitious target set.
- 4.9 The Trust receives recurrent annual funding of £10,000 through its NHS England contract allocation. In addition, the Trust has secured £30,000 of non-recurrent funding to support delivery of the national ambition to achieve 60% frontline healthcare worker flu vaccination uptake. The additional funding will be used to enhance vaccination capacity, improve accessibility, and support targeted vaccination activity across the Trust, with particular plans to:
- Provide additional vaccination capacity during peak campaign periods
 - Release staff to deliver peer vaccination activity
 - Enhance outreach to areas such as PTS and ICCs
 - Increase capacity for Fluathon events and mobile vaccination programmes
- 4.10 Whilst the campaign always seeks to maximise uptake in the first two months of the campaign, it has been agreed that vaccinator capacity will be focused more heavily on frontline healthcare worker uptake within the first month. This does not preclude clinics running in ICC or for corporate teams but focus will be weighted toward and PES and PTS

uptake in the October period. There will also be an increased focus in providing vaccination opportunities within Emergency Departments and aligning clinics with shift handovers to maximise accessibility.

- 4.11 A key component of the 2026/27 programme will be implementing the Staff Anywhere Model which is available across the Lancashire and South Cumbria footprint. This will allow staff from any identified NHS Trust to receive their flu vaccination at any participating vaccination clinical, Fluathon event, mobile vaccination unit across Lancashire and South Cumbria regardless of their employing organisation. For NWS staff who routinely travel across provider footprints, this model offers significant opportunities to improve access and flexibility. Work is ongoing to explore the opportunities for similar schemes across the other ICB footprints.
- 4.12 The campaign is always supported by an extensive communications campaign but this year will be particularly focused on the wider impact of flu on our vulnerable patients. This enables a professional conversation with clinical staff about their responsibilities to protect their patients through vaccination. This is anticipated to support higher uptake amongst the younger age group who anecdotally do not see the need for vaccination for themselves but may consider this differently in the context of their exposure to vulnerable patient groups.
- 4.13 Continued work will also be undertaken with the Race Equality Network to target messaging to BME staff, particularly in the contact centres.
- 4.14 In terms of reporting discrepancies, communications will emphasise to staff the importance of making external vaccination providers aware of their employment status as a healthcare worker and we will monitor and seek to address discrepancies between national and local reporting. We are also changing our local reporting back to teams to ensure that the focus sits more heavily on uptake rather than offer.
- 4.15 Evidence from previous campaigns demonstrates that local management engagement has the greatest influence on staff participation. Managers will therefore be expected to actively support delivery of the campaign and encourage uptake within their teams. There is a balance to be struck between Flu leads driving the overall campaign messaging but with immediate line managers supporting more effective conversations about reluctance to vaccinate.
- 4.16 Consideration was given to the use of incentives to increase vaccine uptake. While incentives may support engagement, evidence suggests sustained improvements are more strongly associated with leadership support, targeted communications, local accountability and easy access to vaccination. Following discussion at TMC, it was agreed that incentives would not form part of the 2026/27 campaign and that focus should remain on these evidence-based approaches.

5. THE HCW FLU VACCINATION BEST PRACTICE MANAGEMENT CHECKLIST

- 5.1 The Flu Vaccination Best Practice Management Checklist is included at appendix A and demonstrates that the Trust's programme has these core components in place for the 2026/27 programme.
- 5.2 The checklist demonstrates that the Trust has clear senior commitment in place and robust campaign management arrangements through the cross functional flu team. This is supported by a comprehensive communications plan. Whilst, like all ambulance services, the vaccination delivery model for our dispersed workforce presents challenges, the flu

team have worked hard to ensure appropriate flexibilities and options are in place to maximise vaccination rates

6. RISK CONSIDERATION

- 6.1 There remains a risk that the Trust may not achieve the improvements in vaccination uptake and reduction in variation across staff groups expected by NHSE, which could impact workforce resilience during winter periods. This risk will be mitigated through early mobilisation, targeted interventions, strengthened management accountability, regular performance monitoring and enhanced communications.
- 6.2 Vaccination uptake for frontline healthcare workers will also operate as a key metric in the NOF and there is a risk that a failure to reach the nationally set target or continue below average performance in comparison with the sector could impact on overall performance levels.
- 6.3 There are also risks associated with the discrepancies between national and local reporting identified in 2025. Actions are planned to try to mitigate this but it does rely on the actions of individual staff to notify of their status when they receive their vaccination elsewhere. It is anticipated that discrepancies are likely to continue but the mitigations should reduce this below the 4.8% level seen in 2025/26.

7. EQUALITY/ SUSTAINABILITY IMPACTS

- 7.1 The vaccine procured by the Trust is egg-free and should therefore address potential concerns arising from religious beliefs, ethical considerations or dietary choices. The campaign will also seek to address identified health inequalities through targeted engagement with staff groups that have historically demonstrated lower uptake rates, including younger staff and BME colleagues and particularly those in ICC.

Appendix A

Healthcare Worker Flu Vaccination Best Practice Management Checklist

A	Committed Leadership	Trust Self-Assessment
A1	Board records their commitment to achieving the ambition of vaccinating all frontline healthcare workers	Commitment recorded through September public board meeting.
A2	Link with Medical Directors and Directors of Nursing to promote key messages and get strategic buy-in	Full engagement with the Chief Nurse and Medical Director around communication messages to staff to encourage take up of the vaccine.
A3	Trust order and provide suitable vaccine for all healthcare workers	The Trust has ordered 3700 vaccines which can be delivered to the majority of our staff taking into account age and religious belief.
A4	Board receive an evaluation of the previous year's flu programme including data, success, challenges and lessons learnt	Both Resources Committee and the Board of Directors have received an evaluation of learning from the 2025/26 flu programme and plans for the 2026/27 programme. Presented to September meetings.
A5	Agree a board champion for flu	The Director of People will be the champion for the Flu campaign.
A6	Publicise board members receiving their flu vaccine	Plans will be put in place once the campaign commences to ensure the opportunity for take up by Board and this forms a clear part of the communications campaign.
A7	Flu team formed with representatives from all directorates and staff groups to advocate and lead by example	Cross functional flu team has been established. Strengthened this year by a clinical lead. Trade Unions briefed at JPC September and involved in campaign.
A8	Flu team meet regularly from September to March	Regular meetings already commenced.

A9	Monitor uptake across all areas and seek to understand the reasons for low uptake in departments and offer support to increase uptake	Weekly flu reports will be sent out once the campaign commences. The flu team will review take up and reasons for low uptake to target areas for promotion.
A10	In low uptake areas a list of staff is made available, and these are targeted with public health messages and information. Managers to support unvaccinated staff in getting the vaccine and arrange flu clinics for these areas	Lists are sent to flu leads who will then take a strategic approach to low uptake with communication messages and targeted flu clinics.
B	Communications Plan	
B1	Order and use/share national staff-facing materials/resources	Materials have been ordered.
B2	Rationale for flu vaccination programme and facts to be published	The rationale and facts around the flu campaign will form part of the Trusts wide communications plan.
B3	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Range of communications methods included in the plan.
B4	Content showing board and staff members having their vaccine	The communications plan includes the promotion of the vaccine with picture of the Board and other staff, including the Staff Networks, receiving their vaccination.
B5	Flu vaccination programme and access to vaccination on induction and large meetings/events	Dates for induction programmes and mandatory training sessions to form part of the vaccination plan.
B6	Vaccination programme to be publicised on screensavers, posters and social media	The vaccination programme will be promoted via the bulletin and station-based wall boards. Promotion in the ICC's is also undertaken via their SharePoint sites.
B7	Weekly feedback of percentage uptake for directorates, teams and professional groups. Consider 'Fluathon'	Weekly reports published weekly with percentage uptake split by Sectors and Service lines.
C	Flexible Accessibility	

C1	Concentrating on high-risk areas first	All staff are encouraged to access the vaccine as part of the campaign. Specific focus is made on front line staff, including the ICCs.
C2	Peer vaccinators in clinical areas to be identified, trained, released to vaccinate and empowered to encourage others	The Trust uses a peer led vaccination model.
C3	Schedule for easy access drop-in clinics agreed or online booking systems	Local clinics are advertised, and flu vaccinators take a flexible approach to vaccinating based on local requirements.
C4	Schedule for 24-hour mobile vaccination clinics to be agreed with vaccinations available across all shift patterns, days, evening, nights and weekends	Flu vaccinators are paramedics who work a range of shifts.
C5	Link with ward managers/matrons to ascertain the best times to visit in order not to disturb the normal working shift	Not applicable – but this engagement takes place on sites with high density such as ICCs
C6	Hub and spoke models in larger Trusts	Not applicable
C7	Pop-ups and roving models in community providers in recognition of multiple sites across a large geography	Roaming model forms core of delivery model
D	Incentives	
D1	Board to agree on incentives and how to publicise this	Agreement that incentives do not form part of the campaign.
D2	Success to be celebrated weekly	Vaccination uptake is published and celebrated weekly during the campaign.



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 2026
SUBJECT	Integrated Board Report
PRESENTED BY	Elaine Strachan-Hall, Director of Quality
PURPOSE	Assurance

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

Risk Appetite Statement <i>(Decision Papers Only)</i>	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 August 2026. Further narrative is contained within the accompanying data pack. Data is presented over time using statistical process control charts (SPCs), aligned to NHS England's Making Data Count, which aims to support informed decision making by identifying genuine trends, variations and patterns in the data. The report shows historical and current performance on Quality, Effectiveness, Operational performance, Finance, and Organisational Health to address three important assurance questions: - How are we performing over time as a continuously improving trust? - How are we performing with respect to strategic goals? - How are we performing compared to our peers and the national comparators?

Quality

Quality indicators remain broadly stable. Further analysis is planned to better understand incident themes within the care and treatment category and identify improvement opportunities. Violence and aggression reporting remains elevated, largely reflecting increased visibility following changes to 111 reporting processes.

Effectiveness

Patient experience scores remain stable, with area-level feedback to be reviewed through Area Learning Forums to identify improvement opportunities.

Ambulance Clinical Quality Indicators (ACQIs) show Falls and STEMI bundle compliance remaining above the national average, with STEMI performance at 98.3%. Recent changes to cardiac arrest guidance and forthcoming updates to national reporting specifications for cardiac arrest, falls and STEMI measures may influence future reporting.

Hear and Treat performance improved to 19.5%, representing the strongest performance seen in recent months, while See and Treat reduced slightly to 25.1%. Current priorities include improving Hear and Treat conversion rates, maximising clinical productivity and external CAS contribution, and working with system partners to increase community pathway capacity.

Operational Performance

Operational performance improved during August as activity reduced across all response categories. Response times improved across Categories 1 to 4, with Category 1 performance remaining strong and Category 2 performance returning to achievement of the UEC standard. While Category 2 and lower-acuity response times are not meeting ARP standards, the Trust continues to perform comparatively well against national peers.

PES ARP Standards:

Measure	ARP Standard (hh:mm:ss)	August '26 (hh:mm:ss)	YTD April to August '26 (hh:mm:ss)	National ranking
C1 mean	00:07:00	00:06:57	00:06:57	2 nd
C1 90 th	00:15:00	00:11:42	00:11:52	2 nd
C2 mean*	00:18:00	00:23:03	00:24:22	3 rd
C2 90 th	00:40:00	00:44:58	00:47:38	3 rd
C3 mean	01:00:00	01:25:42	01:30:33	3 rd
C3 90 th	02:00:00	02:58:36	03:09:31	2 nd
C4 90 th	03:00:00	03:05:33	03:42:24	2 nd

*UEC C2 Standard = 25mins (achieved)

Turnaround: Vehicle turnaround time remains broadly stable but increased from 33.57 minutes in July to 34.49 minutes in August.

NHS 111: demand increased during August, with performance improving across all key measures despite higher call volumes. However, performance remains below national standards and continues to be a key focus, supported by ongoing workforce planning and monitoring.

111 Measure	Standard	Aug 26	National Ranking
Answered within 60s	95.0%	54.8%	22 nd /28
Average time to answer	<20s	152s	28 th /28
Abandoned calls	<5%	8.3%	23 rd /28

PTS: activity remains stable, although some performance metrics remain below contractual standards. Operational and workforce improvement plans remain in place.

Finance

The Trust reported a Month 05 surplus of £0.186m against a planned deficit of £1.074m. Productivity and efficiency delivery is currently under plan, with further efficiency opportunities being developed to support achievement of the year-end financial position.

Organisational Health

Organisational Health indicators remain broadly stable. Workforce resilience within PES remains a key risk, with increasing sickness levels, and recruitment and training plans operating at maximum capacity. Turnover pressures also continue to present workforce planning challenges across PES and PTS.

Targeted attendance improvement, workforce planning and recruitment actions continue, while increasing employment case complexity and litigation activity remain under close review.

Risk Consideration

Failure to ensure on-going compliance with national targets and registration standards could render the trust open to the loss of its registration, prosecution, and other penalties.

Equality/Sustainability Impacts

The Diversity and Inclusion sub-committee are reviewing the trust's protected characteristics data to understand and improve patient experience. Updates are reported into the Diversity and Inclusion sub-committee.

PREVIOUSLY CONSIDERED BY

Date

Outcome



North West
Ambulance Service
NHS Trust



Integrated Performance Report

Board of Directors September 2026

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

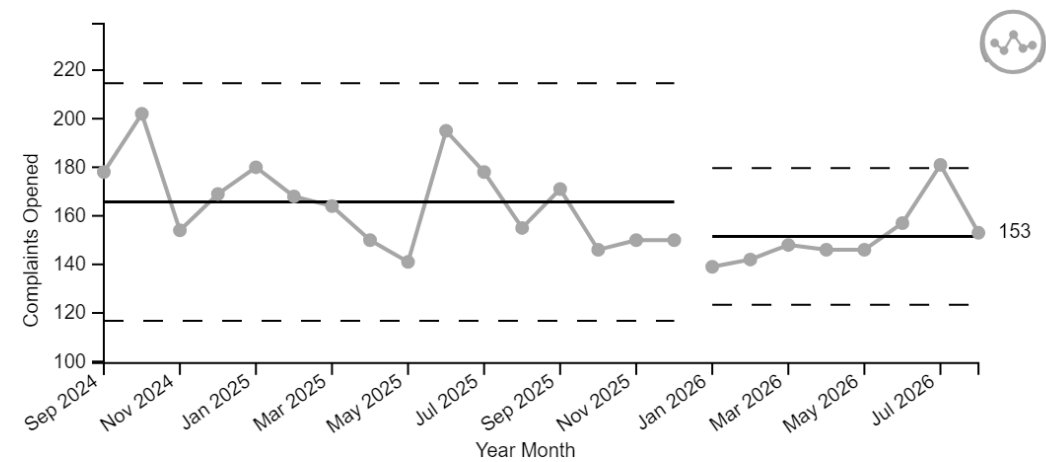
E1 Patient Experience

E2 Ambulance Clinical Quality Indicators (ACQI)

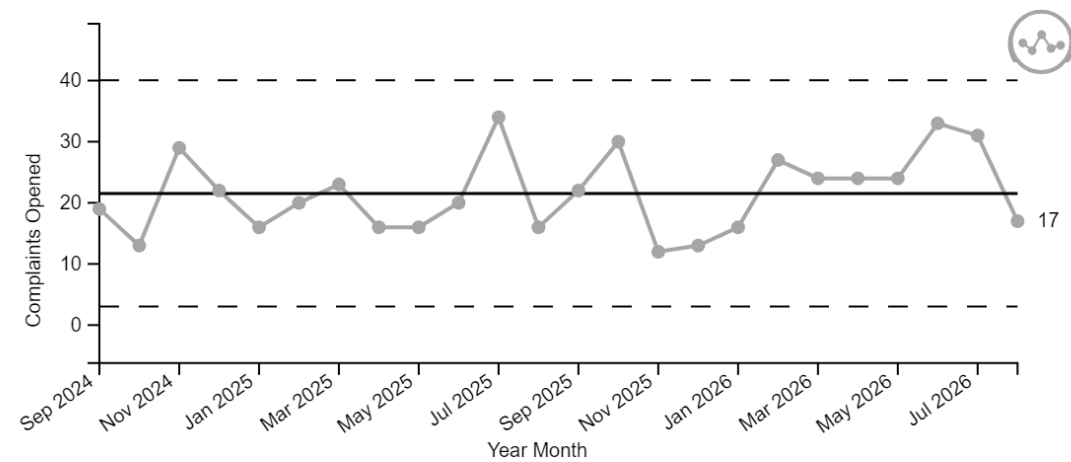
E3 Activities and Outcomes

Q1 Complaints

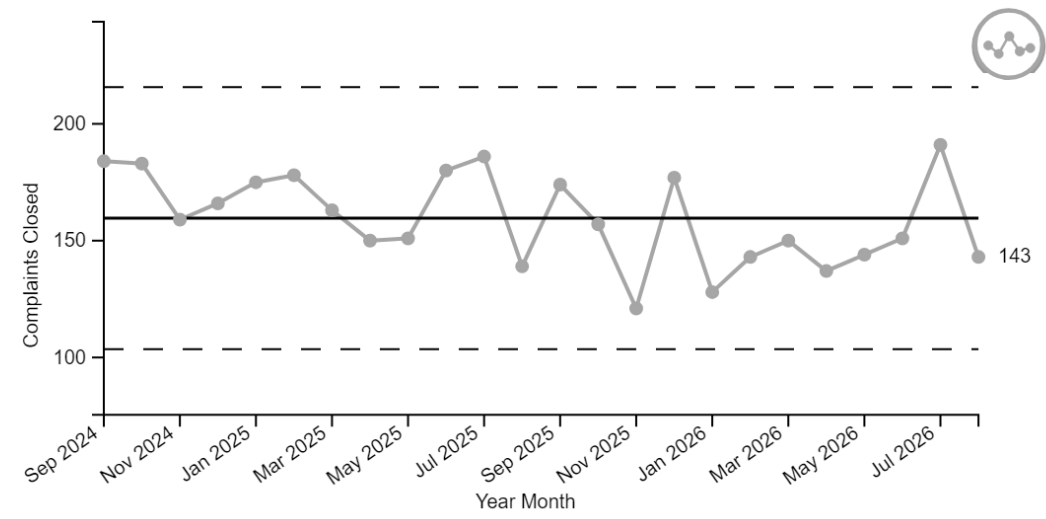
Complaints Opened with Risk Score 1-2



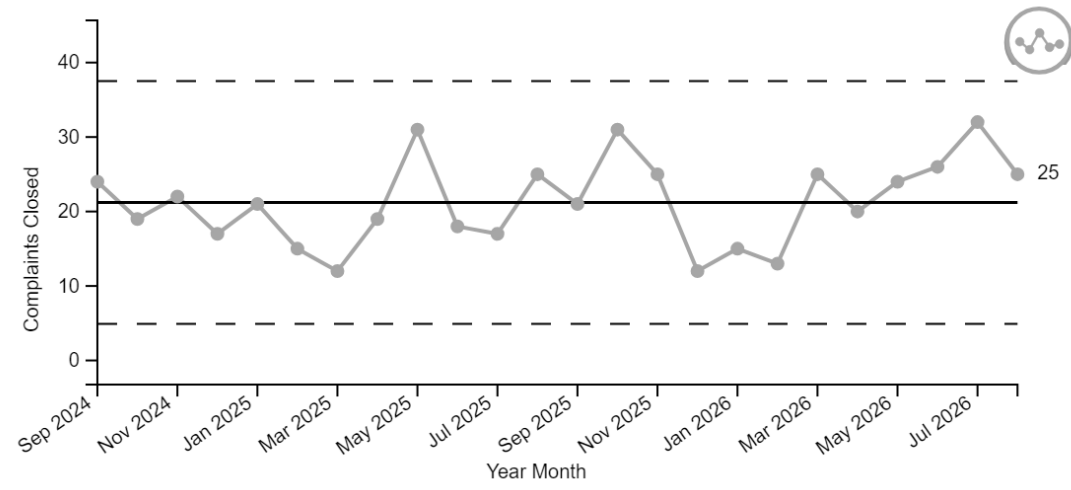
Complaints Opened with Risk Score 3-5



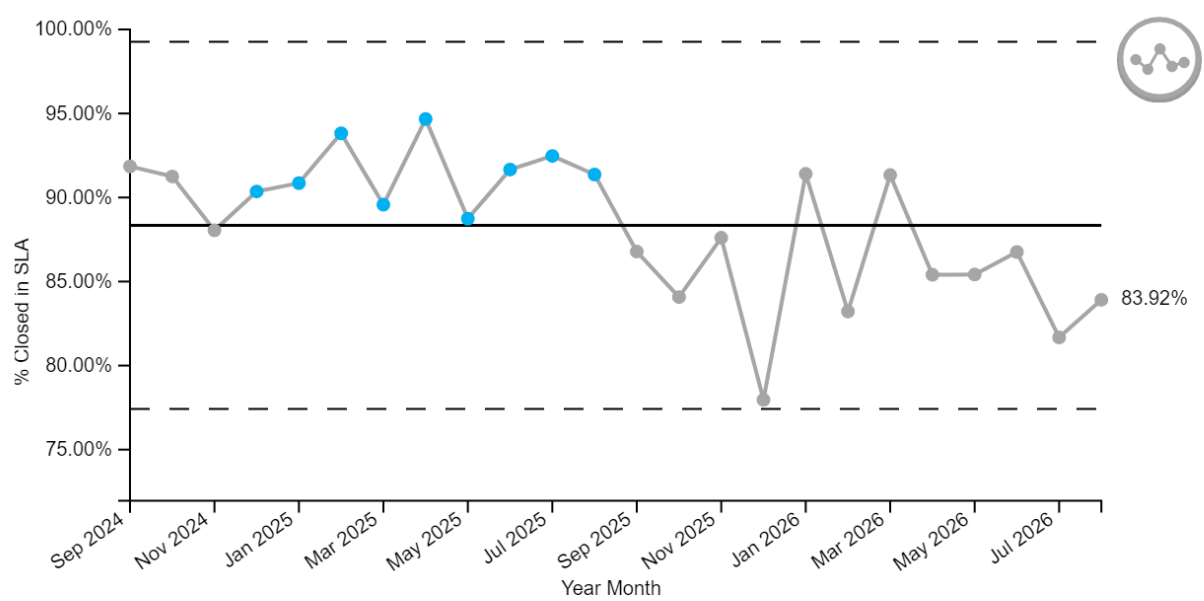
Complaints Closed with Risk Score 1-2



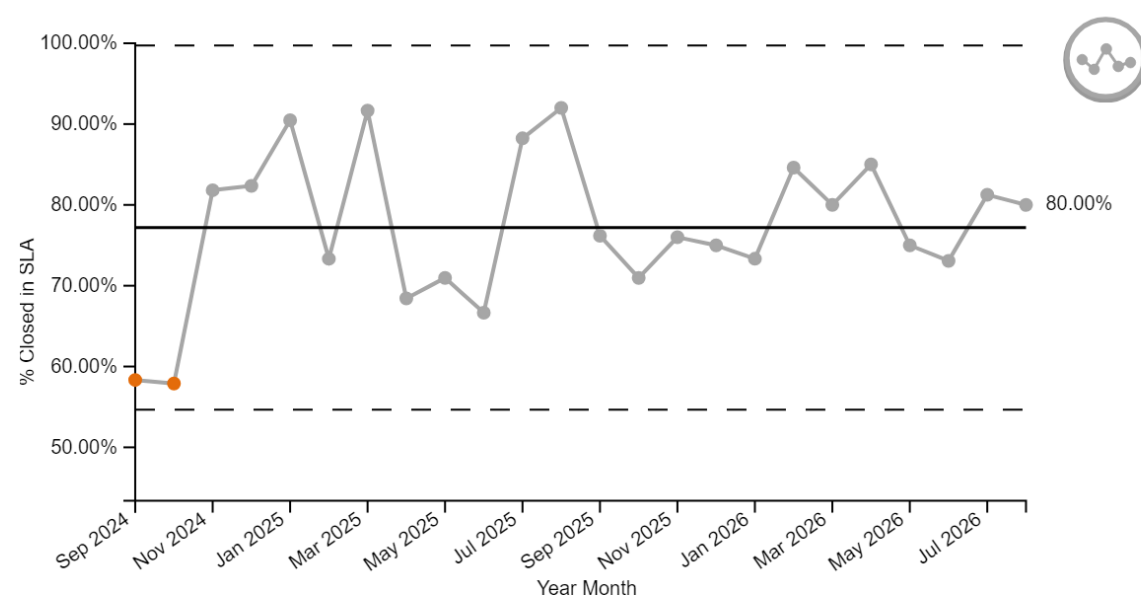
Complaints Closed with Risk Score 3-5



Complaints Closed in SLA with Risk Score 1-2



Complaints Closed in SLA with Risk Score 3-5

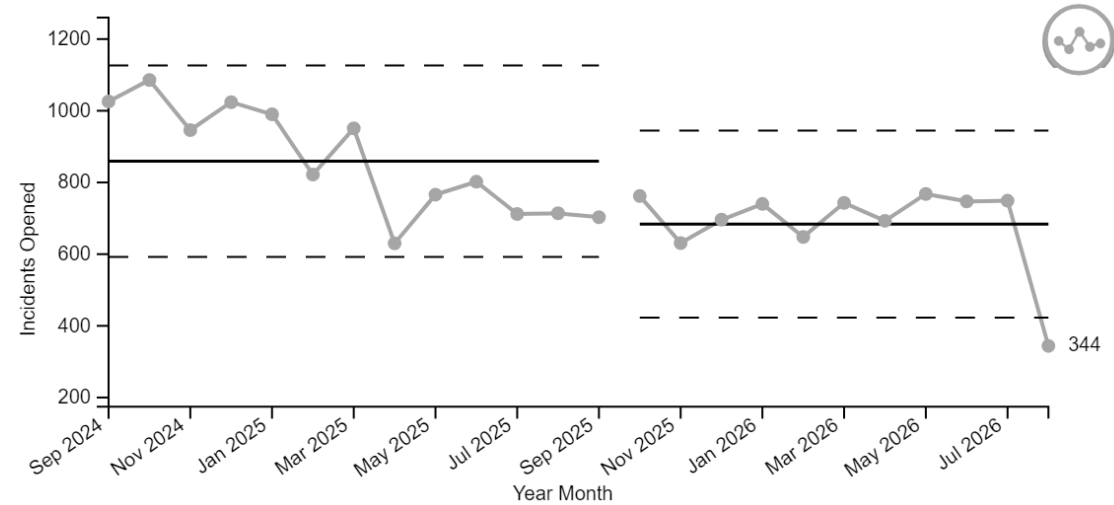


Summary: Increased capacity and greater focus on early assessment and proactive engagement is beginning to support more effective complaint management and timely resolution. Given the relatively short reporting period, the focus will remain on sustaining this improvement and ensuring that reductions in activity translate into continued SLA performance and effective resolution.

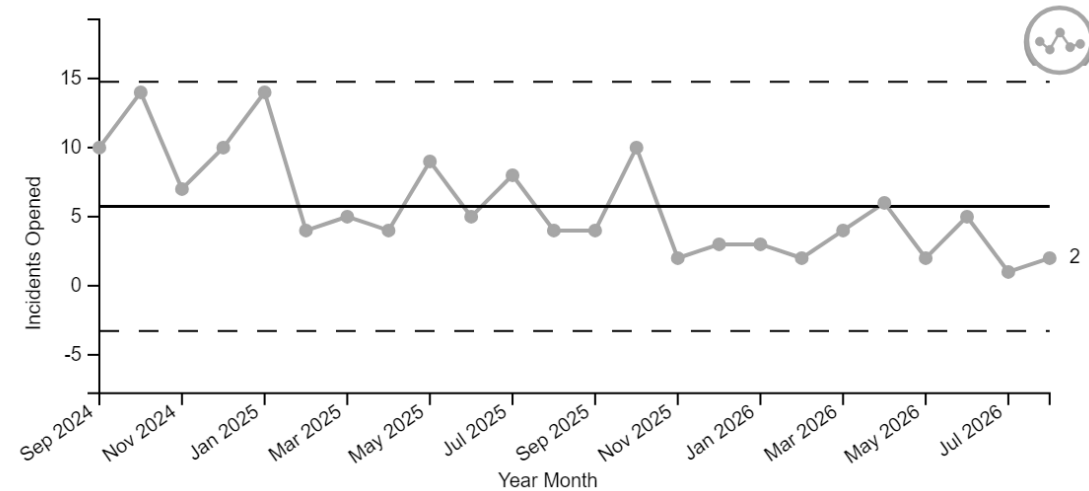
Actions: Continue to embed the increased focus on early complaint assessment, proactive contact and timely resolution, with performance monitored through monthly review of volumes and SLA compliance. Closer weekly scrutiny on case load management and performance with team leaders and case handlers should help ensure all necessary actions and focus are captured.

Q2 Incidents

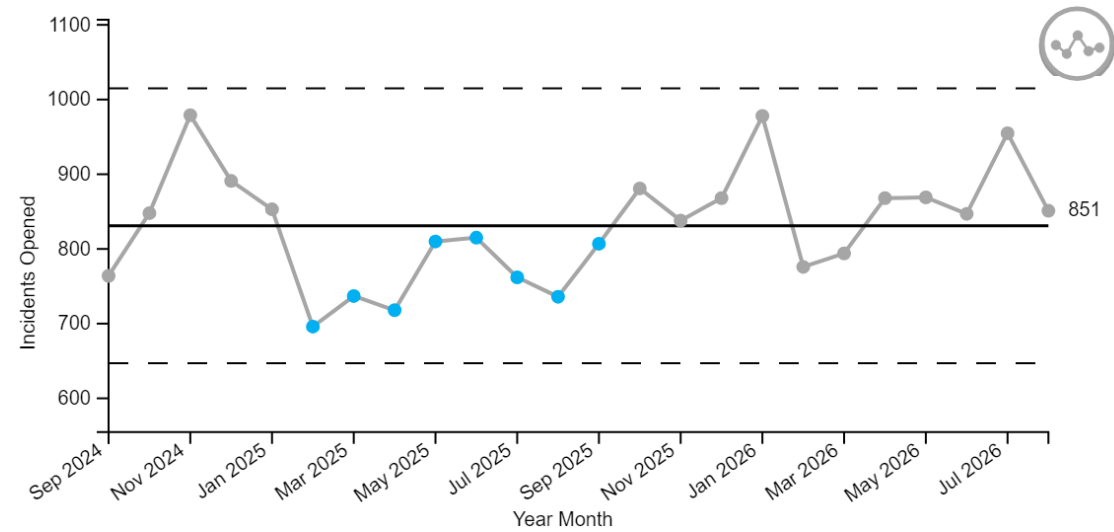
Incidents Opened with Risk Score 1-3



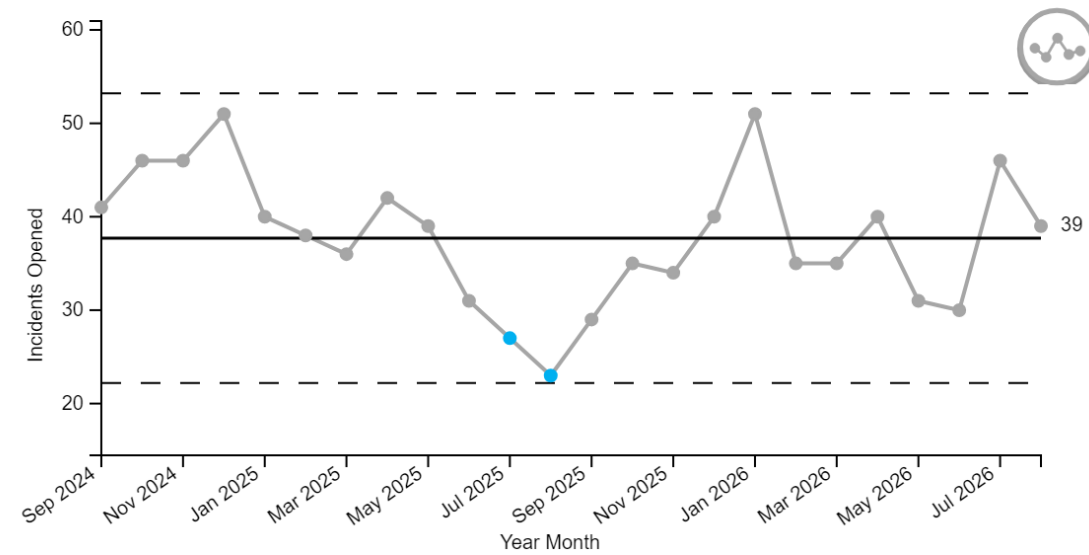
Incidents Opened with Risk Score 4-5



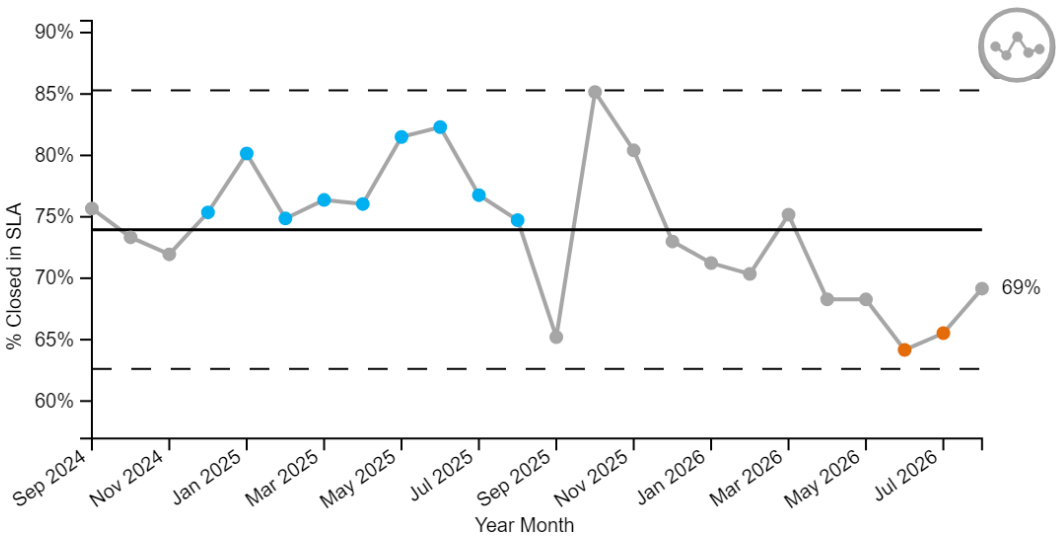
Incidents Opened - Patient



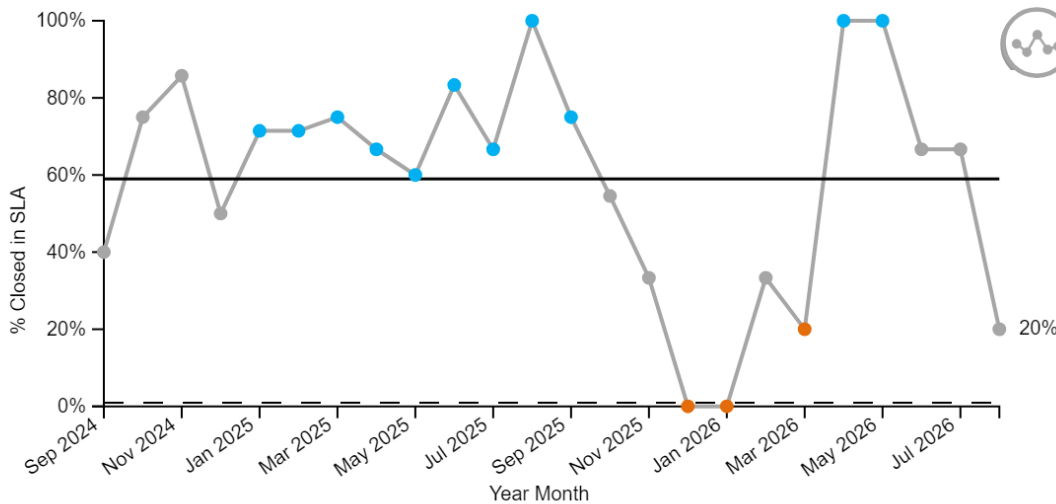
PSIRF Reported Level of Harm (Severe & Fatal)



Incidents with Risk Score 1-3 % Complete within SLA



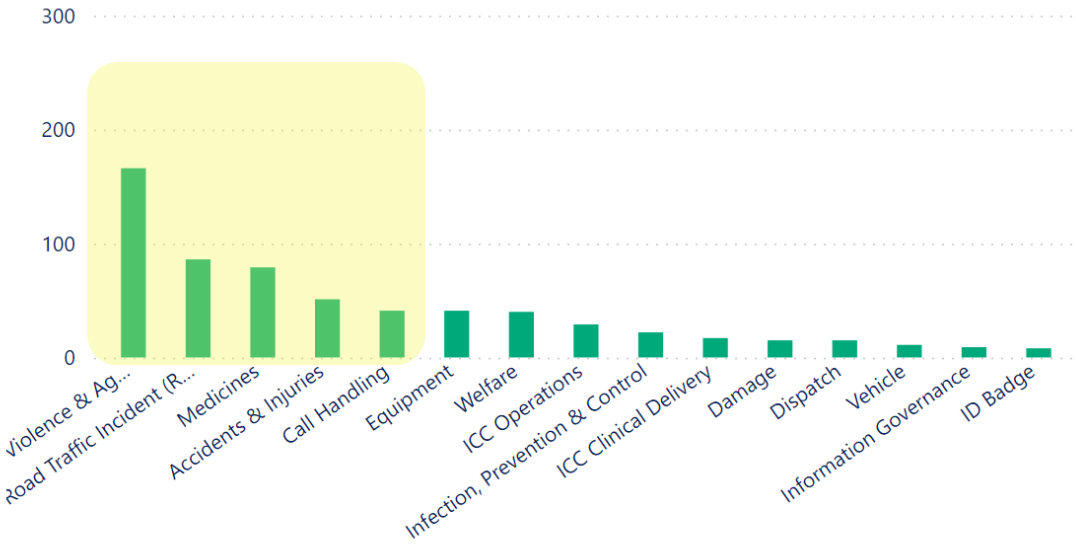
Incidents with Risk Score 4-5 % Complete within SLA



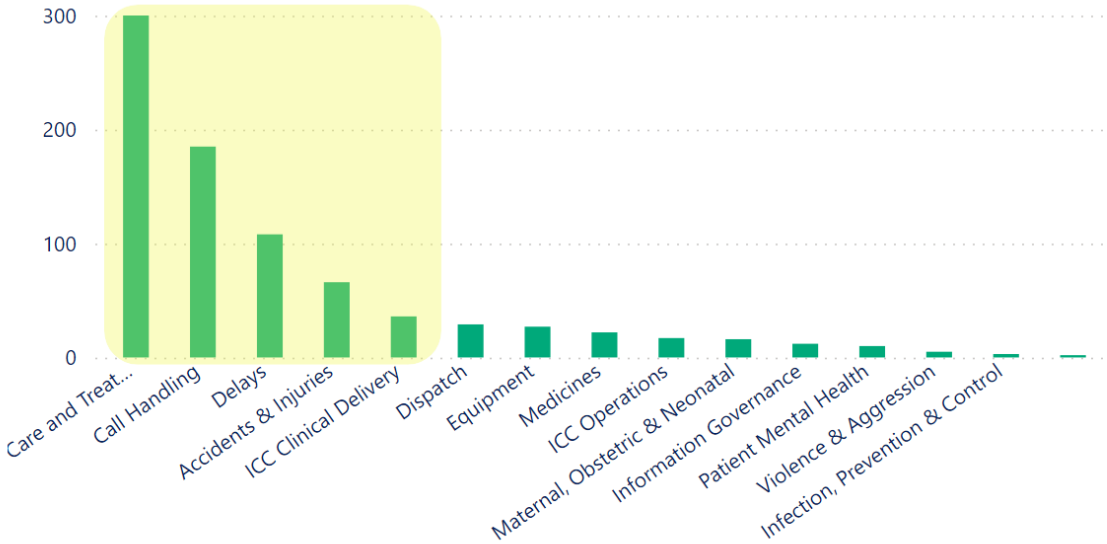
Summary: Incidents opened with a risk score of 1-3 have been rebased suggesting a sustained reduction in the number of incidents. There were 5 incidents closed with a risk score of 4-5 last month and 1 was completed within the 30-day SLA.

Actions: A potential data quality issue affecting incident reporting remains under investigation, with work ongoing to identify the cause.

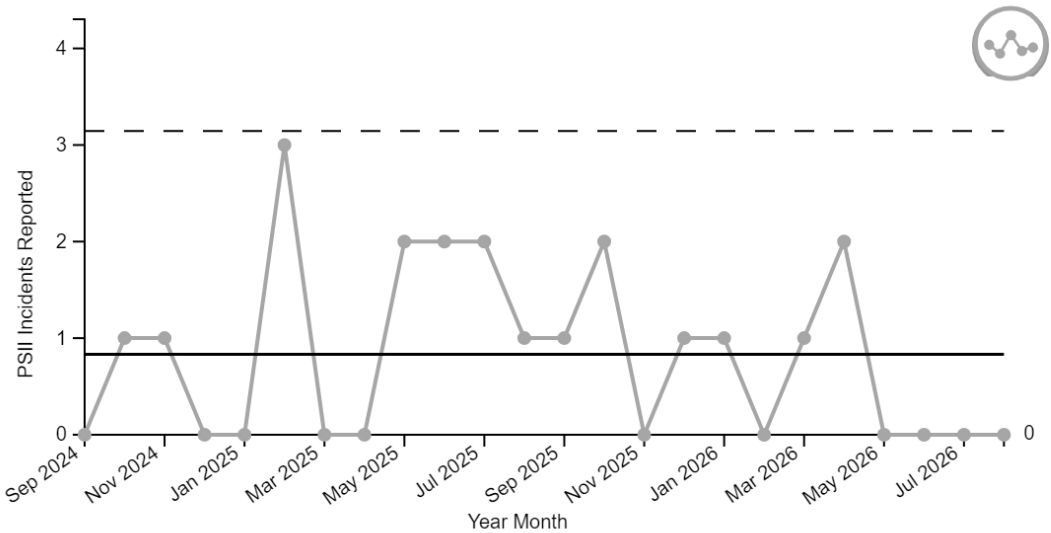
Number of Non Patient Safety Incidents
(15 most common reasons)



Number of Patient Safety Incidents
(15 most common reasons)



PSII Reported by month



Summary:

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

Actions:

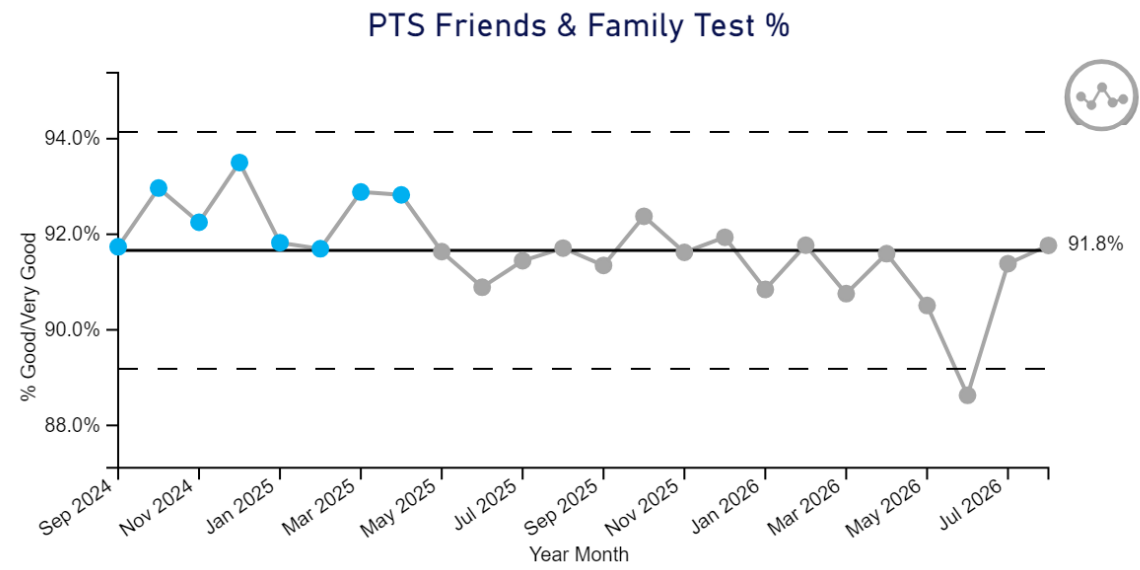
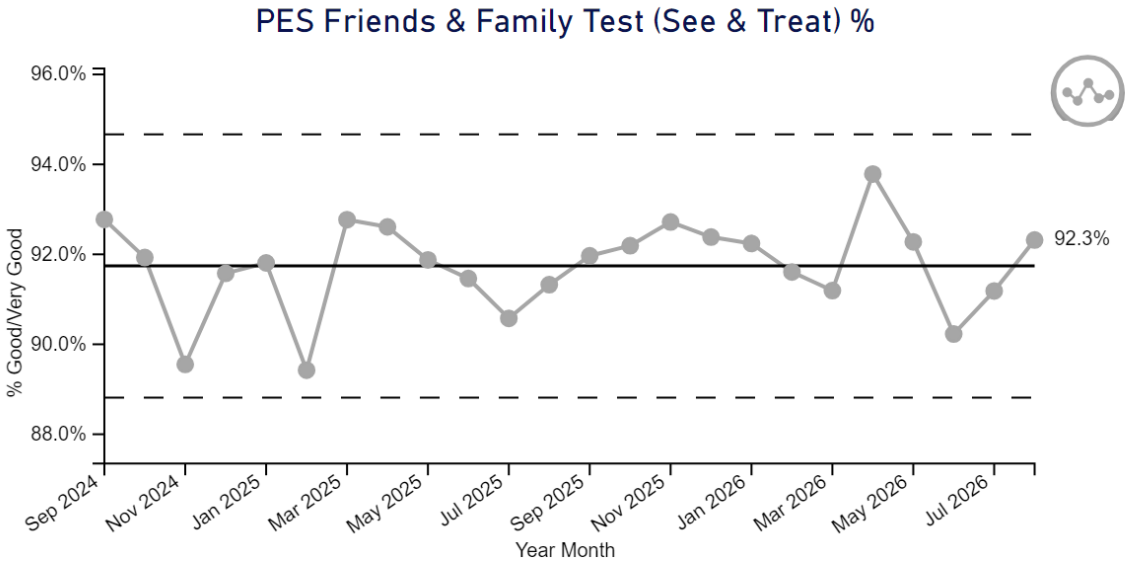
Further work is planned to better understand the themes and opportunities for improvement within the care and treatment category. Reported violence and aggression incidents have remained higher than earlier in the year, with verbal abuse continuing to be the most commonly reported category. The introduction of the revised 111 service SOP, which requires calls terminated due to abusive behaviour to be reported through the DCIQ system with management oversight, has led to a sustained increase in reporting. Reporting from the 111 service remains around 50% higher than before the change, providing greater visibility of these incidents.

Q3 Safety Alerts

Safety Alerts	Alerts Received (Sep 2025 - Aug 2026)	Alerts Applicable (Sep 2025 - Aug 2026)	Alerts Open	Notes
CAS Helpdesk Team	4	0	0	
National Patient Safety Alert - UKHSA	0	0	0	
National Patient Safety Alert- NHS England Patient Safety	2	1	0	Description - NatPSA/2025/006/NHSPS -Harm from incorrect recording of a penicillin allergy as a penicillamine allergy. Issue Date 20/11/2025. Deadline 20/11/2026 Actions: Discussed. Alert considered low risk for NWAS. A new record is started in NWAS EPR system for each patients seen. In 2026 GP Connect will be pulling data on allergies over from GP systems so if the information is updated in GP side of system the correct information should pull across to NWAS. Current EPR system also does not list drugs A-Z to pick from for allergy recording, but data is entered as free text. MOG agreed no need to do a free text search of NWAS EPR records for penicillamine. Action : EPR Development group to be informed of the alert and the doc to be sent for awareness.
National Patient Safety Alerts - NHS England & NHS Improvement	0	0	0	

National Patient Safety Alert - DHSC	3	0	0	
National Patient Safety Alerts - OHID	0	0	0	
CMO Messaging	1	1	1	Description - CEM/CM0/2025/002 - Influenza Season 2025/26: Early Season Activity And Implications For Clinical Practice. UKHSA surveillance data indicates that influenza is circulating in the community earlier than usual this season with a drifted strain of Influenza A(H3N2) predominating. Clinicians should continue to promote and deliver influenza vaccination for eligible patients and for healthcare workers. Issue Date 05/11/2026. Actions: No Response required
National Patient Safety Alerts MHRA	0	0	0	
MHRA - Medicine Alerts	49	1	0	Description : Class 3 Medicines Recall: Accord Healthcare Ltd, Ipratropium Bromide 500 microgram / 2ml Nebuliser Solution, EL(25)A/45. Issue Date: 23/10/25. Deadline : Not Included Actions: Discussed at MOG 3/12/25 - All pouches checkednone with Korean writing on found.
Infection Prevention & Control	0	0	0	

E1 Patient Experience



PES FFT

Positive:

- “Honestly you could have not done anything any better. My mum is end of life care, and I have contacted paramedics on a few occasions, the support has been wonderful and has enabled her to remain at home in our final days together. They treat my mum with dignity respect and kindness, and that also applies to me. Although these are very difficult times, this has made such a massive difference, and I want to thank everyone involved, including call handlers. You all have made such a difference, and I won't ever forget that.”

Negative:

- “Your algorithm is not tailored to meet the needs of injured people. Your operators should be allowed to use common sense. 45 mins response time for somebody with a head injury and profuse bleeding is not acceptable. I felt your operator was slightly irate with me as I had given my address and the patient was next door. I would not give a location were the injured person could not be found. Finally, I tried to cancel the ambulance as I took the person in my car. This
- does not seem possible as your operator started asking all the same questions again and would not listen to me. I believe the ambulance did arrive. This was a waste of an emergency vehicle again due to your computer algorithm.”

PTS FFT

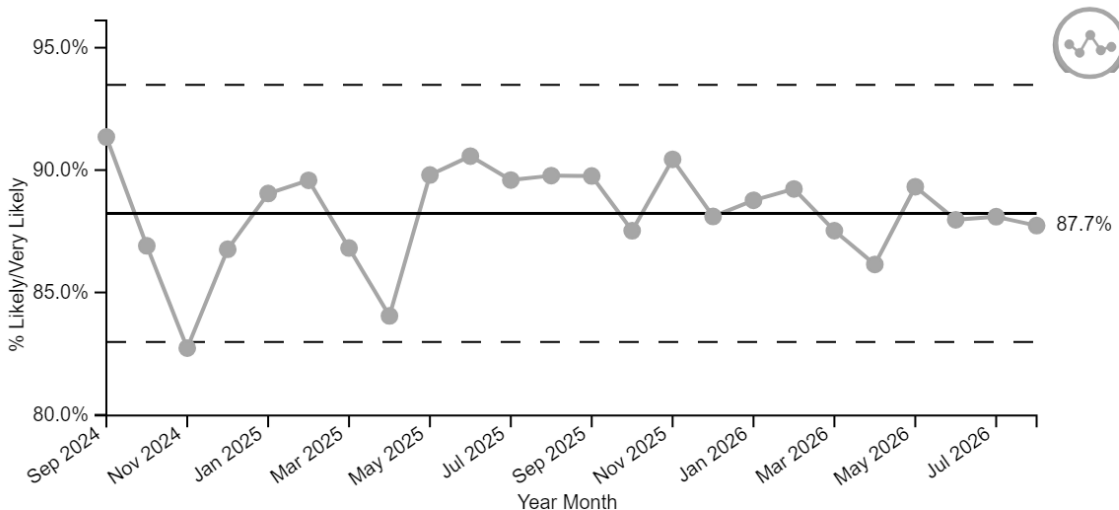
Positive:

- “Had a very good experience. Arrived for appointment in plenty of time, did not have to wait too long for return journey. Staff excellent, very respectful and helpful. Could not have been better. First time used service. We are elderly and my husband, the patient, unable to use public transport and we have no car. Thank you.”
- “Every time I have to book an ambulance, I can say your staff are so caring and polite and I am so grateful for the help. I unable say what you could do to improve as you got it right.”

Negative:

- “The one to the hospital had the wrong time and left me waiting outside my house for 30 minutes. The one from the hospital never turned up. After 45 minutes I had to 'phone you to send one out.”
- “I need a 2-man crew because of my disabilities. I was provided a Taxi. I had no help getting in or out of the taxi and making my way to my appointment so I'm not happy customer.”

111 Friends & Family Test %



NHS 111

Positive:

- “Original call operator was brilliant speaking to me and providing me with information of her next actions. Was patient and very understanding. The paramedic who called me afterwards following my call was AMAZING and was brilliant with his advice.”
- “The adviser was extremely helpful and remained calm and reassuring throughout the call which was very comforting. I was put at ease and felt that my baby's issues were comprehensively reviewed and explored. Thank you.”

Negative:

- “Attitude of the advisor was poor. My partner was supporting me during the call and I handed the phone over to undertake a task where I felt dizzy (the reason for the call) her response to my partner was abrupt and unprofessional in the manner it was held. He was providing support and relaying the responses as I was in crutches and couldn't hold the phone and crutches at the same time. This really put us off using this service.”
- “The operator demanded an interpreter when one wasn't needed. This led to a misdiagnosis and an extended call.”

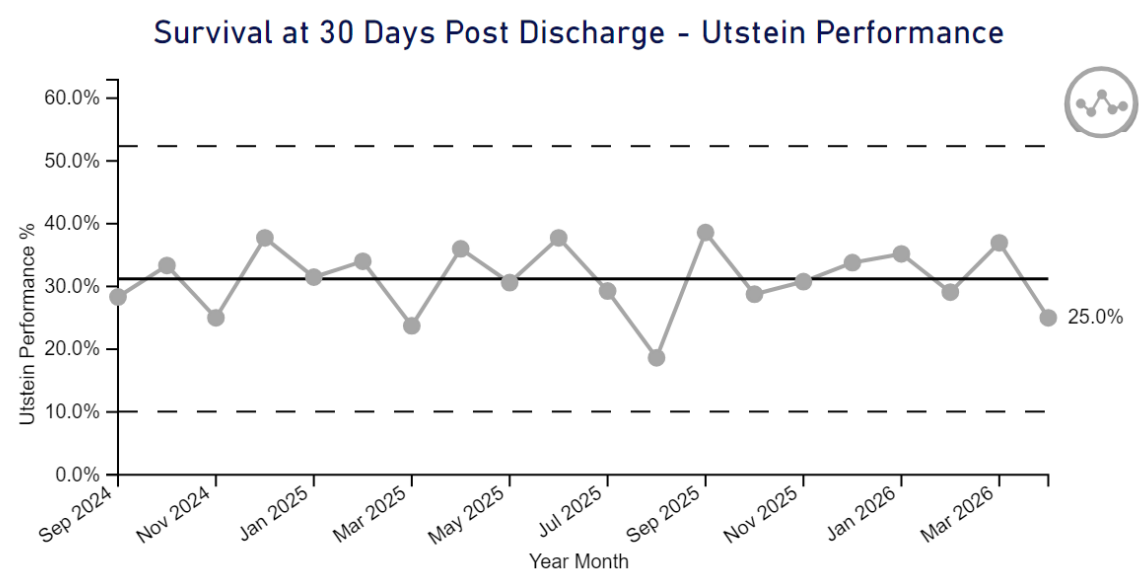
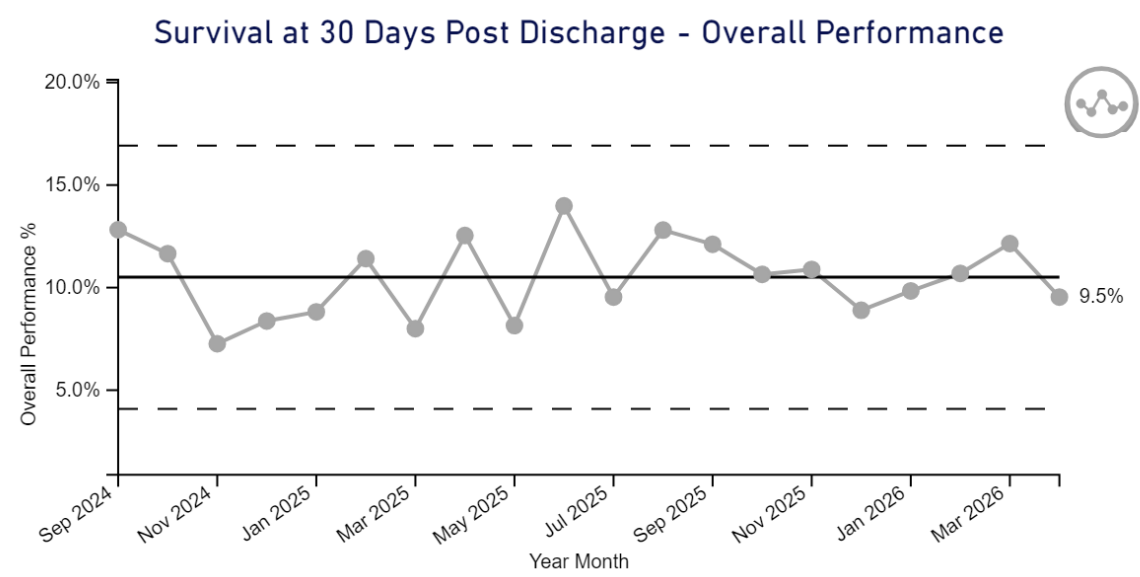
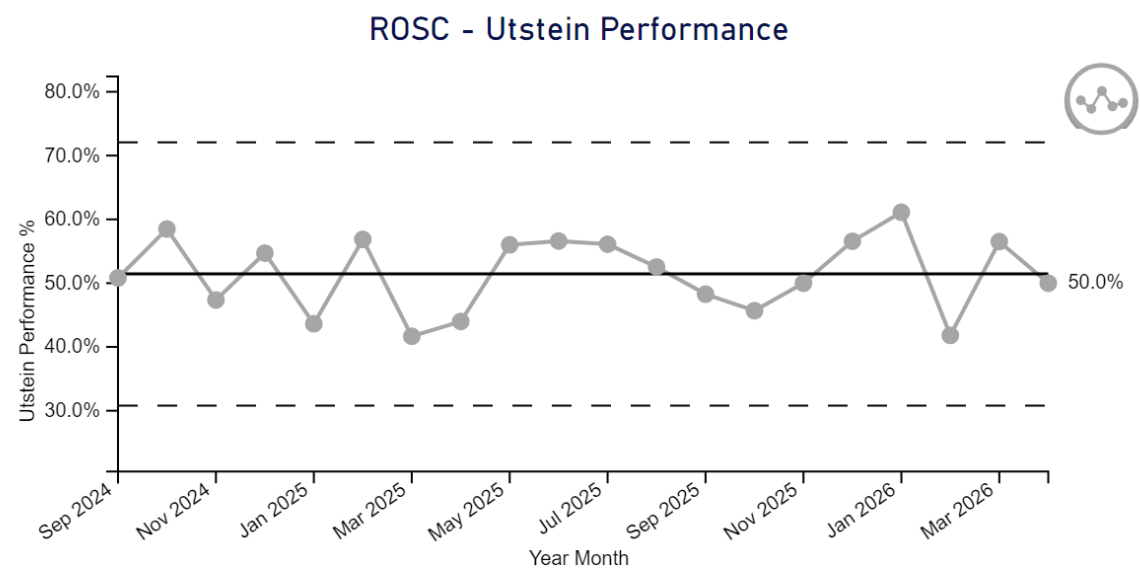
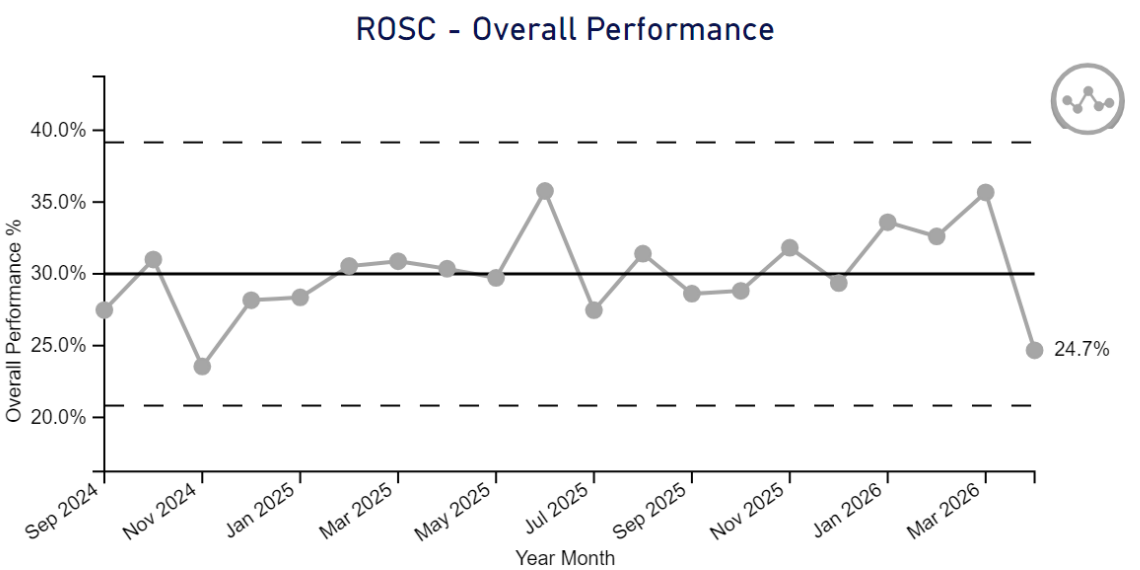
PES FFT: The 716 responses for August are **8.8%** higher when compared to July's of 658, with comments **7.8%** higher, (534 for August and 495 in July). The overall experience score for August of 92.3% is **1.1%** higher than the 91.2% % reported in July, but it was **91.3% in August 2025**, a difference of **1.0%**.

PTS FFT: The 1,166 responses from August are **1.5%** lower than July's 1,184, with supporting comments lower, by **1.7 %**, (909 for August compared to 925 from July). The overall experience score for August of 91.8% is **0.4%** higher than the 91.4% reported for July, but was **91.7% in August 2025**, a difference of **0.1%**.

NHS 111: For August we have 489 returns, compared to the 420 returns reported for July. The more than average drop in returns is attributed to suspended postal surveying for the national 111 survey due to Cleric address linkage issue which is still undergoing testing following an upgrade/fix. From the reduced August returns, we see an 87.7% likelihood of the 111 service being recommended, a difference of **0.4%** compared to the 88.1% reported for July. This was **89.8% in August 2025**, a difference of **2.1%**.

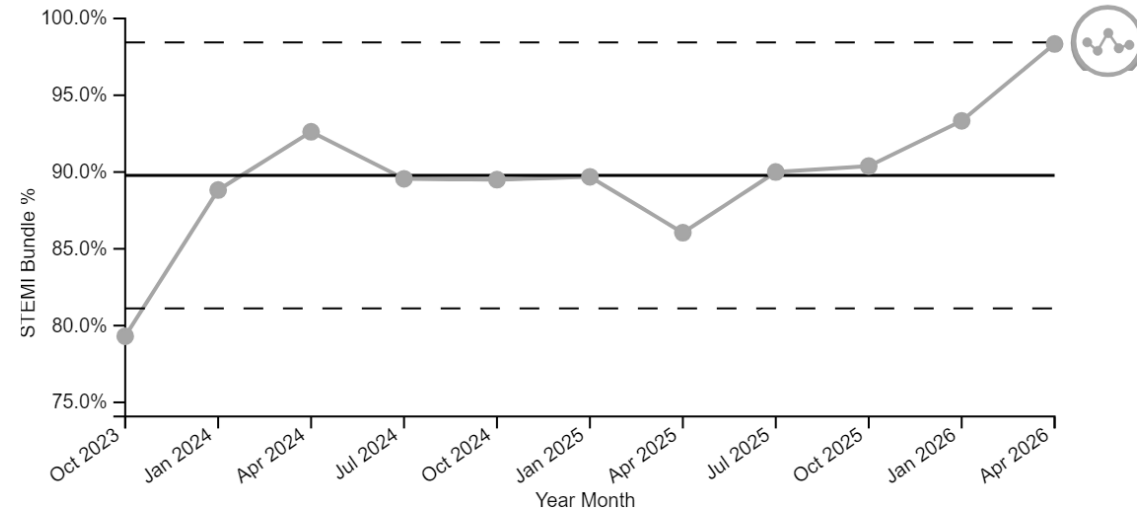
Action: Area-level data will be reviewed through Area Learning Forums to identify opportunities for improvement and shared learning.

E2 Ambulance Clinical Quality Indicators (ACQI)

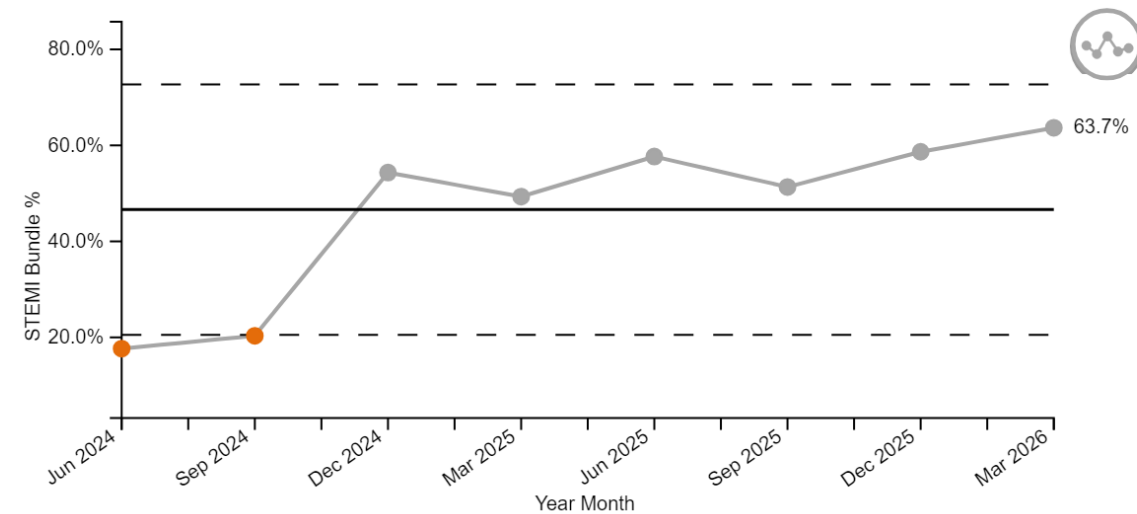


E2 Ambulance Clinical Quality Indicators (ACQI)

STEMI Care Bundle



Falls Care Bundle

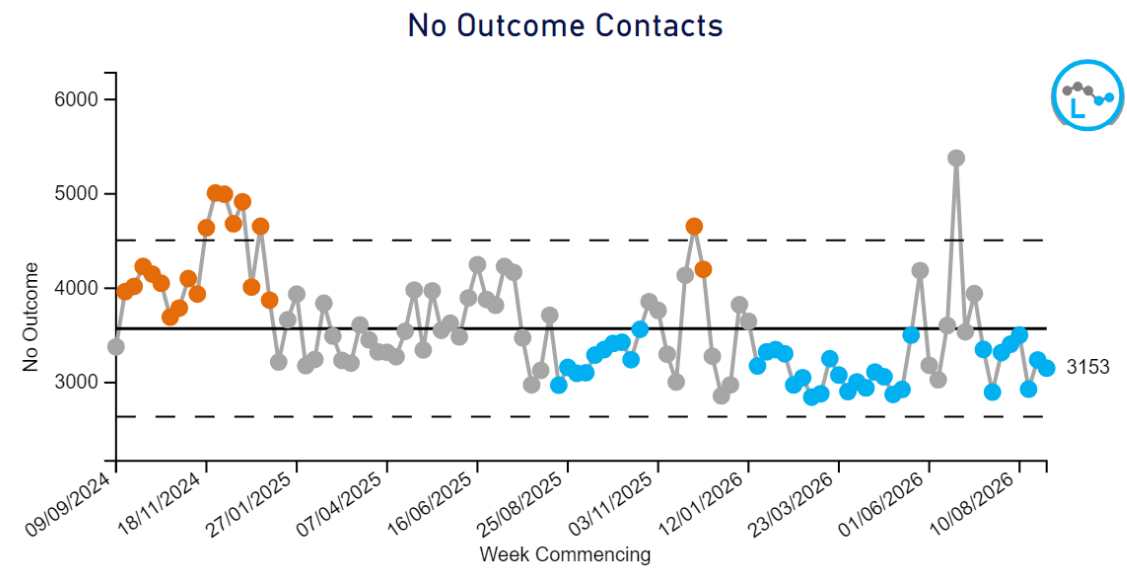
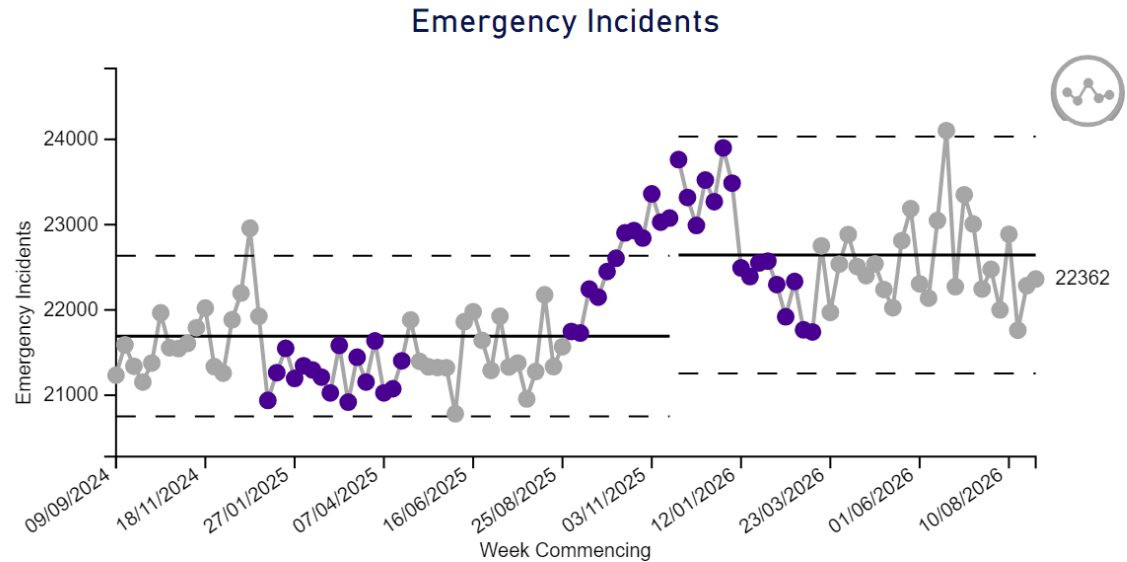


Summary:

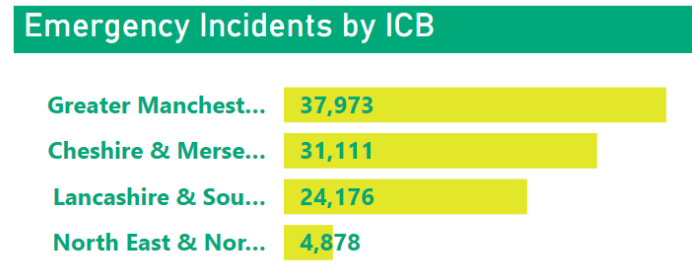
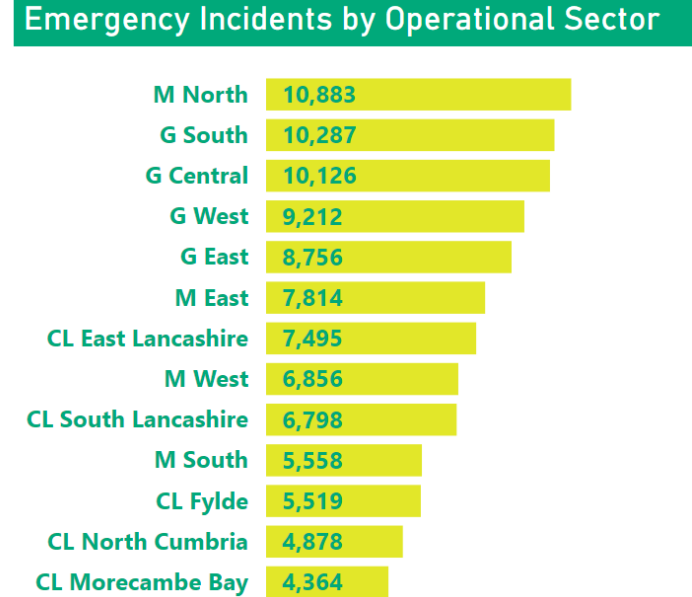
- ROSC overall performance - last reported in April 26 (24.7%), **below** the national average of 28.2%.
- ROSC Utstein performance - last reported in April 26 (50.0%), **below** the national average of 53.4%.
- Survival at 30 days after discharge overall performance – last reported in April 26 (9.5%), **below** the national average of 10.2%.
- Survival at 30 days after discharge Utstein performance – last reported in April 26 (25.0%), **below** the national average of 31.6%.
- STEMI bundle - last reported in April 26 (98.3%), **above** the national average of 83.6%.
- Falls bundle – last reported in Mar 26 (63.7%), **above** the national average of 57.9%.

Recent changes to cardiac arrest guidance, together with forthcoming updates to national reporting specifications for falls and STEMI, may influence future performance data.

E3 Activity & Outcomes

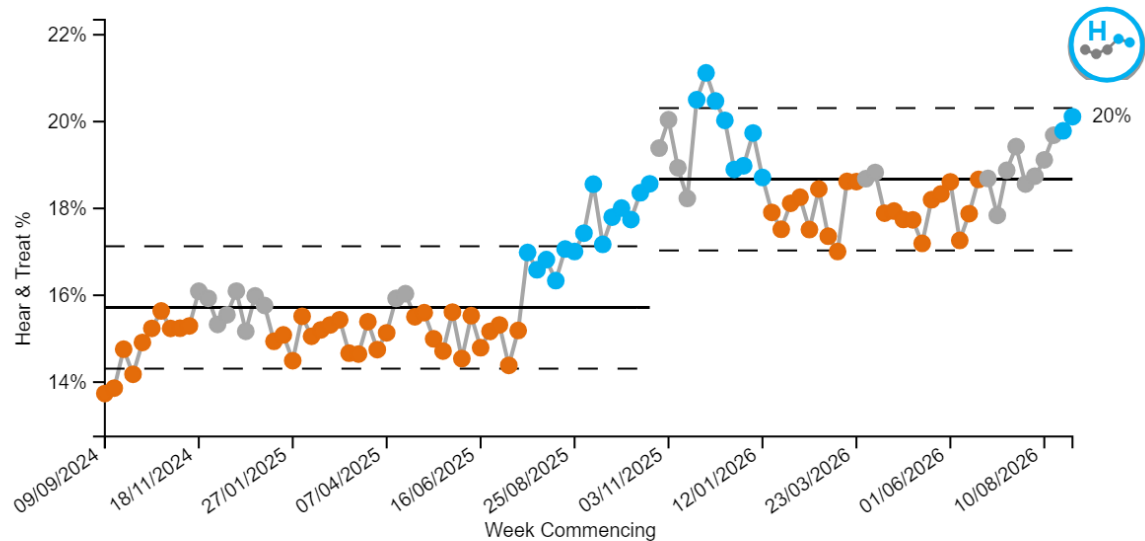


Emergency Incidents

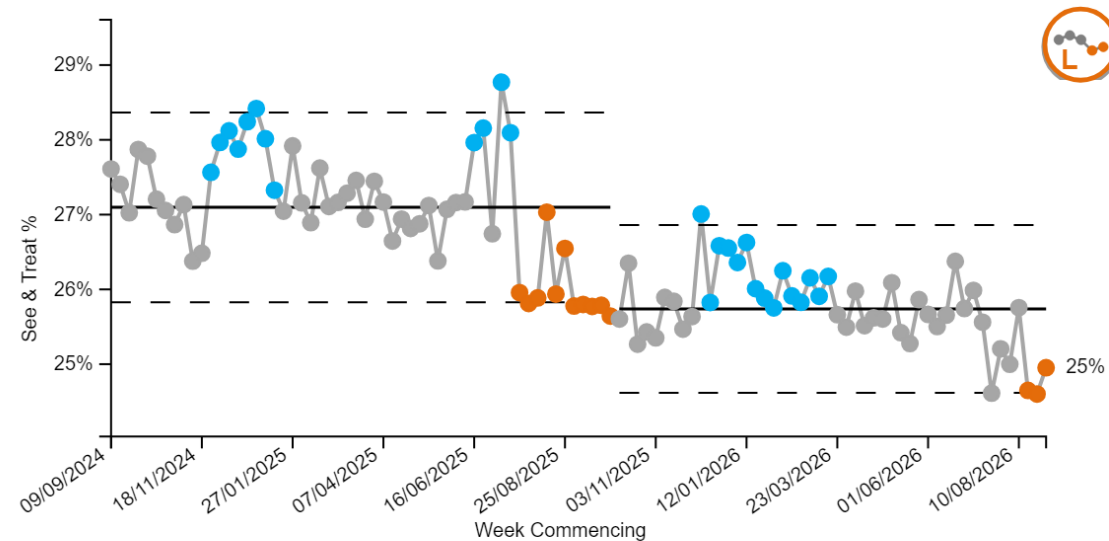


Calendar Year	Month	Calls	% Change from previous year	Incidents	% Change from previous year
2023	Aug	118,713	-7.13 %	92,315	2.97 %
2024	Aug	110,438	-6.97 %	92,000	-0.34 %
2025	Aug	116,948	5.89 %	95,218	3.50 %
2026	Aug	120,507	3.04 %	98,646	3.60 %

Hear & Treat (AQI)



See & Treat (AQI)



Months Hear & Treat by Sector

G Central	23.0%
CL South Lancashire	21.4%
CL Fylde	21.1%
M West	20.7%
CL East Lancashire	20.2%
G East	19.1%
G West	19.0%
M South	18.8%
M North	18.6%
M East	18.3%
CL Morecambe Bay	17.8%
G South	17.7%
CL North Cumbria	16.2%

Months Hear & Treat by ICB

Lancashire ...	20.3%
Greater Man...	19.8%
Cheshire & ...	19.0%
North East ...	16.2%

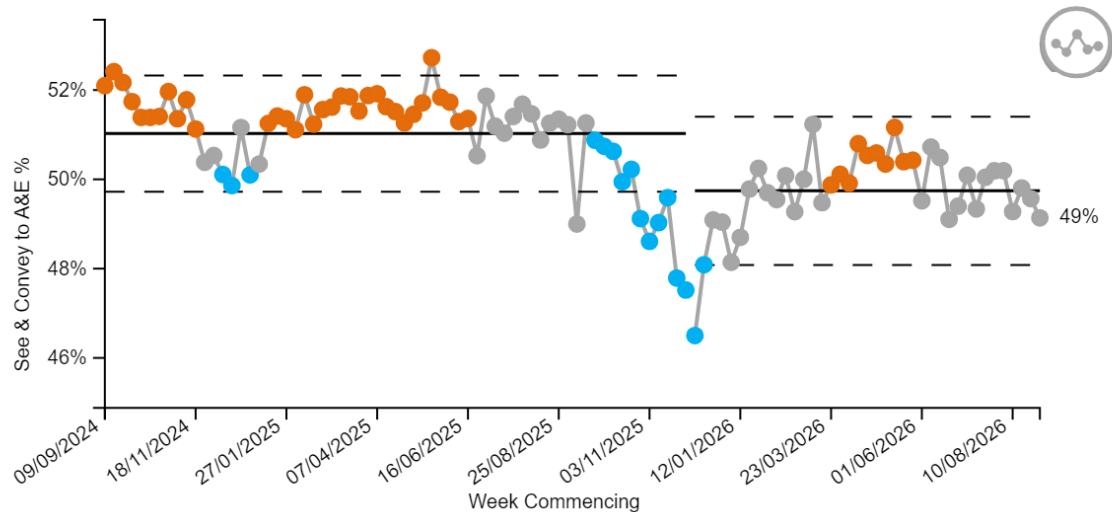
Months See & Treat by Sector

CL North Cumbria	28.7%
CL Morecambe Bay	28.6%
M South	26.3%
G East	26.1%
CL East Lancashire	25.2%
G South	25.1%
M West	25.0%
CL South Lancashire	24.6%
M North	24.5%
CL Fylde	24.5%
G Central	24.0%
G West	23.8%
M East	23.3%

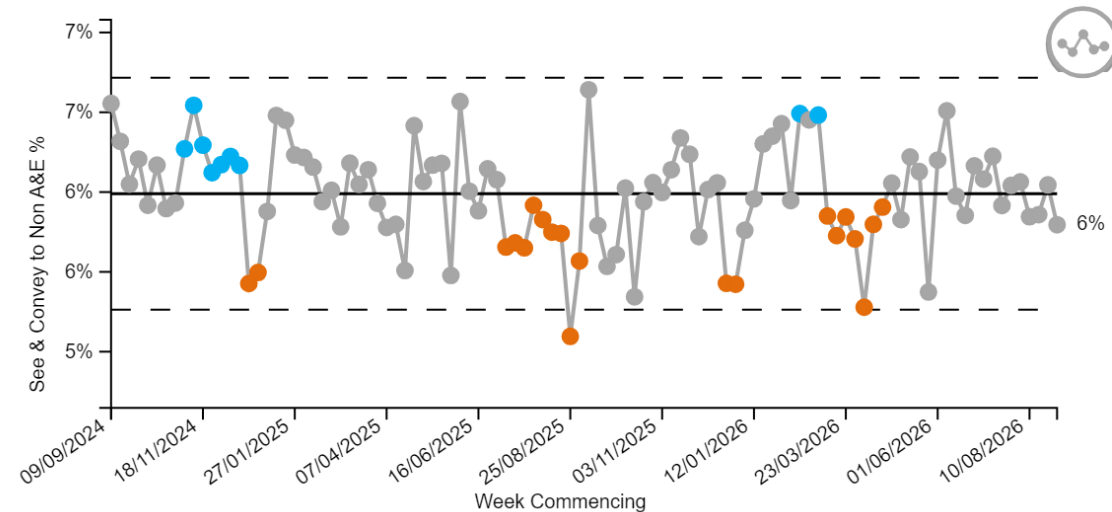
Months See & Treat by ICB

North East ...	28.7%
Lancashire ...	25.5%
Greater Man...	24.7%
Cheshire & ...	24.6%

See & Convey to A&E (AQI)



See & Convey to Non A&E (AQI)



Months See & Convey (AE) by Sector

CL East Lancash...	43.5%
CL South Lanca...	47.1%
CL North Cumb...	47.8%
G Central	48.0%
G East	48.7%
CL Morecambe ...	49.2%
CL Fylde	49.2%
M South	49.5%
M West	49.9%
M North	51.2%
G South	52.2%
M East	52.5%
G West	53.3%

Months See & Convey (AE) by ICB

Lancashire ...	46.8%
North East ...	47.8%
Greater Ma...	50.5%
Cheshire & ...	50.9%

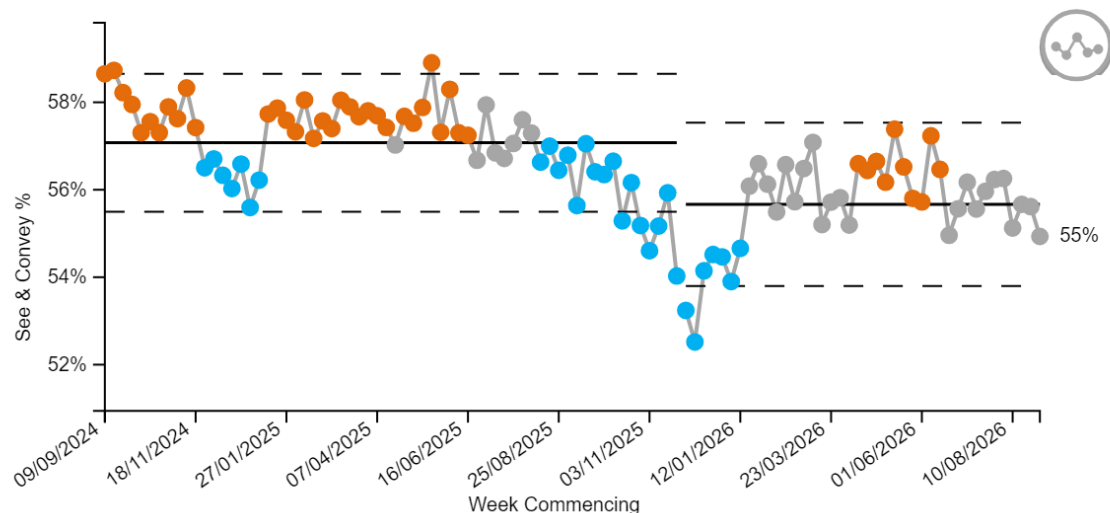
Months See & Convey (Non AE) by Sector

CL East Lancashire	11.1%
CL North Cumbria	7.3%
CL South Lancashire	6.8%
G East	6.2%
M East	5.9%
M North	5.7%
M South	5.5%
CL Fylde	5.2%
G Central	5.0%
G South	5.0%
M West	4.4%
CL Morecambe Bay	4.4%
G West	3.9%

Months See & Convey (Non AE) by ICB

Lancashire & ...	7.3%
North East & ...	7.3%
Cheshire & M...	5.4%
Greater Manc...	5.0%

See & Convey (AQI)



Summary:

Of the 120,507 emergency calls received by the trust, 81.9% (98,646) became incidents. Hear & Treat performance in August was 19.5%, 1% higher than July (18.5%) but below the current planned UEC trajectory. See & Treat performance in August was 25.1%, 0.3% lower than July (25.4%).

There has been no change this month in NWS's ranking compared with other ambulance trusts, apart from See and Convey, where we have improved from 9th to 8th place.

Recent H&T improvements have primarily been driven by increased clinical productivity, stronger telephone triage deflection rates, higher available clinical hours, and better workforce availability, with August delivering the strongest performance seen in recent months.

S&T Performance is reliant on access to appropriate pathways in the community, and capacity in these pathways, to manage patients without the need for them to be transported to ED.

Action:

Additional focus is being given to further improve conversion rates for individual clinicians and strategies for engagement with external CAS providers to further improve their production and impact on H&T. For S&T, work is underway with system partners to increase capacity in pathways, as part of the care coordination agenda.

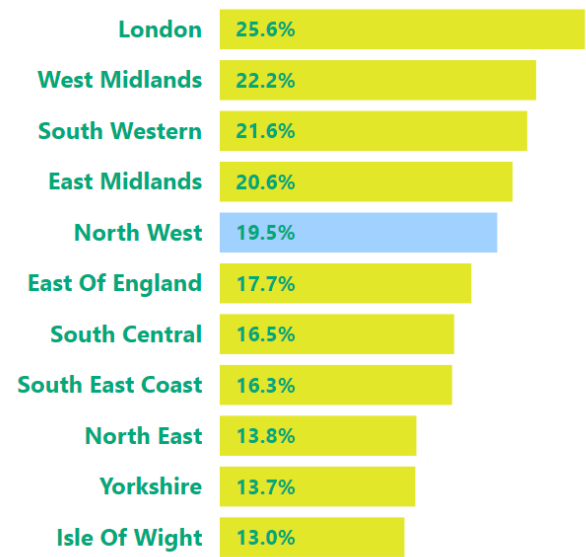
Months See & Convey by Sector

G Central	53.0%
CL Morecambe Bay	53.6%
CL South Lancashire	54.0%
M West	54.3%
CL Fylde	54.4%
CL East Lancashire	54.6%
G East	54.9%
M South	54.9%
CL North Cumbria	55.1%
M North	56.9%
G South	57.2%
G West	57.3%
M East	58.4%

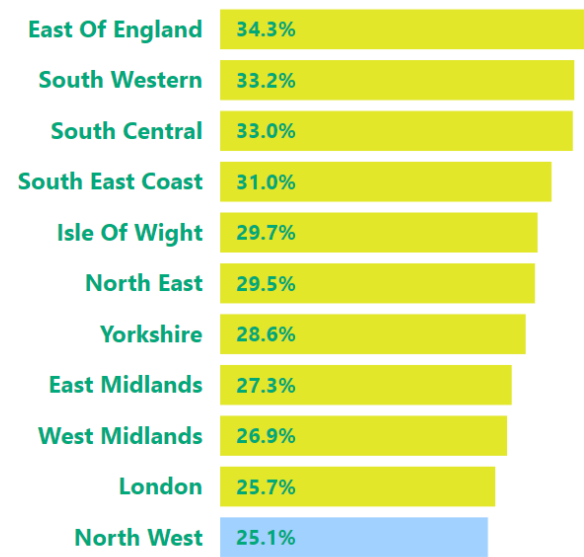
Months See & Convey by ICB

Lancashire & ...	54.2%
North East & ...	55.1%
Greater Manc...	55.5%
Cheshire & M...	56.4%

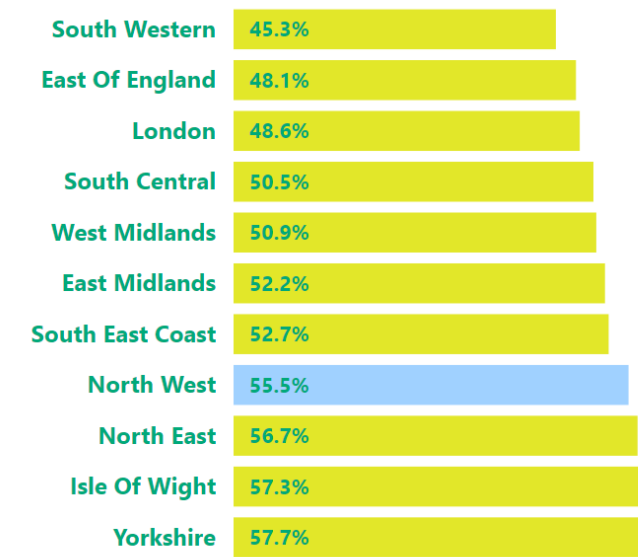
Hear & Treat % by Trust



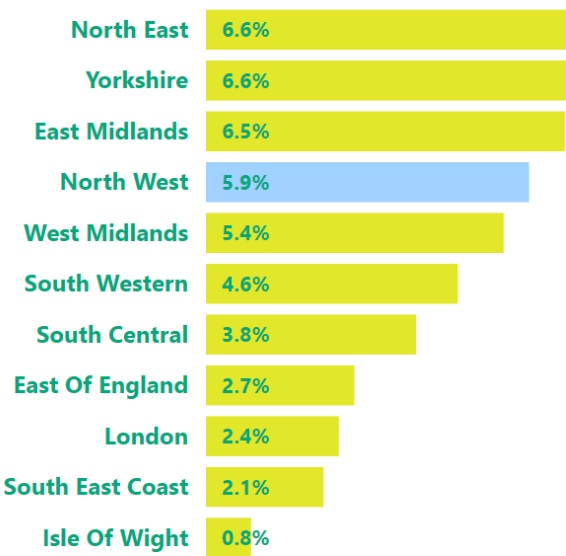
See & Treat % by Trust



See & Convey % by Trust



See & Convey non A&E % by Trust



Operational

O1 Call Pick up

O3 ARP Response Times

O3 ARP Provider Comparison

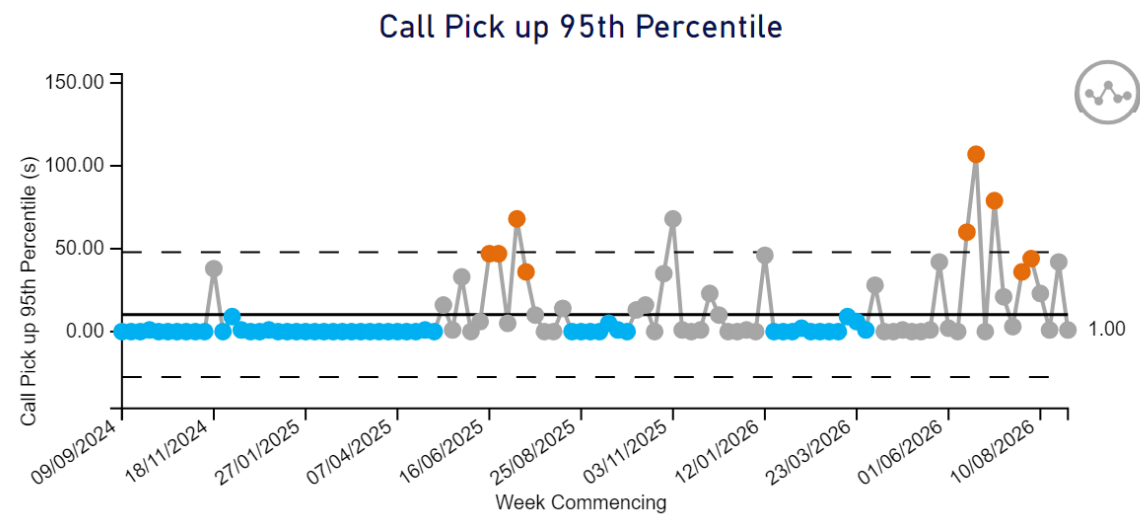
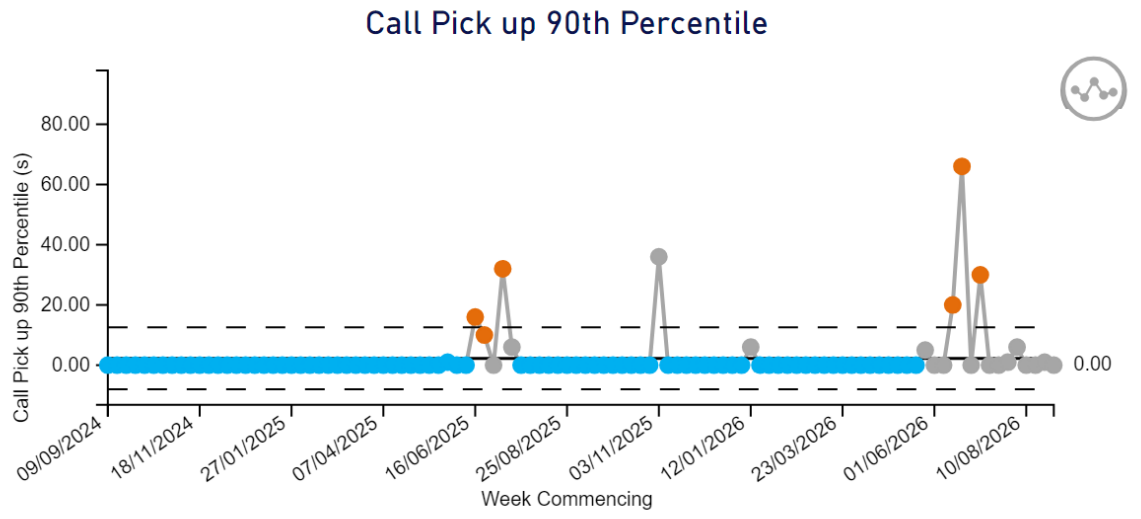
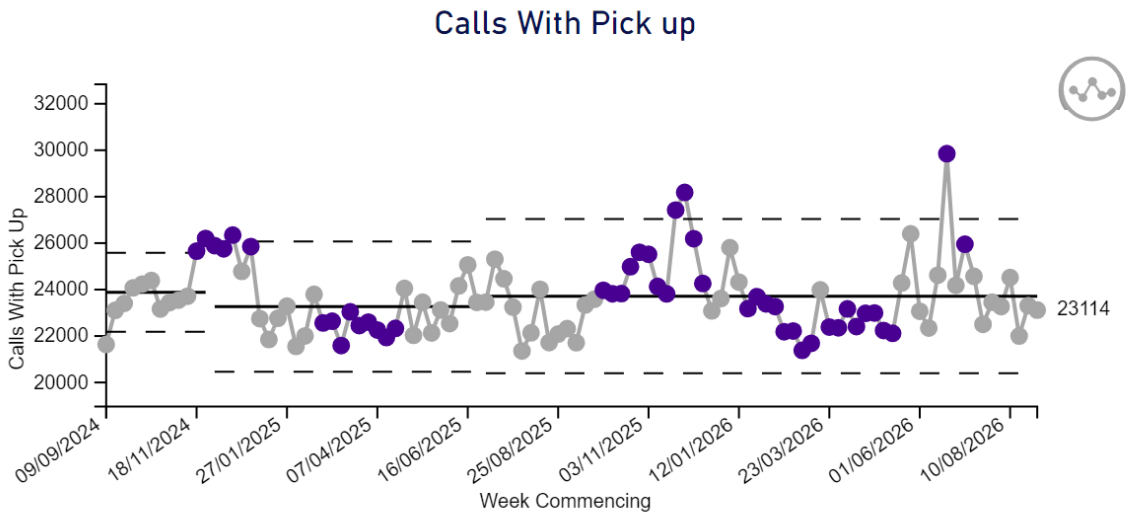
O3 A&E Turnaround

O3 A&E Turnaround ICB

O4 111 Activity & Performance

O5 PTS Activity

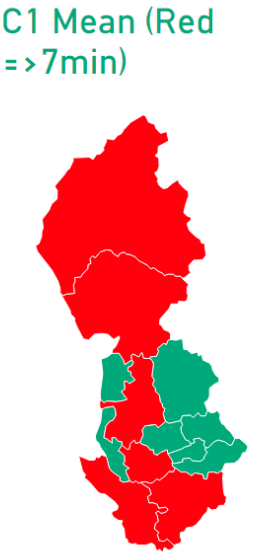
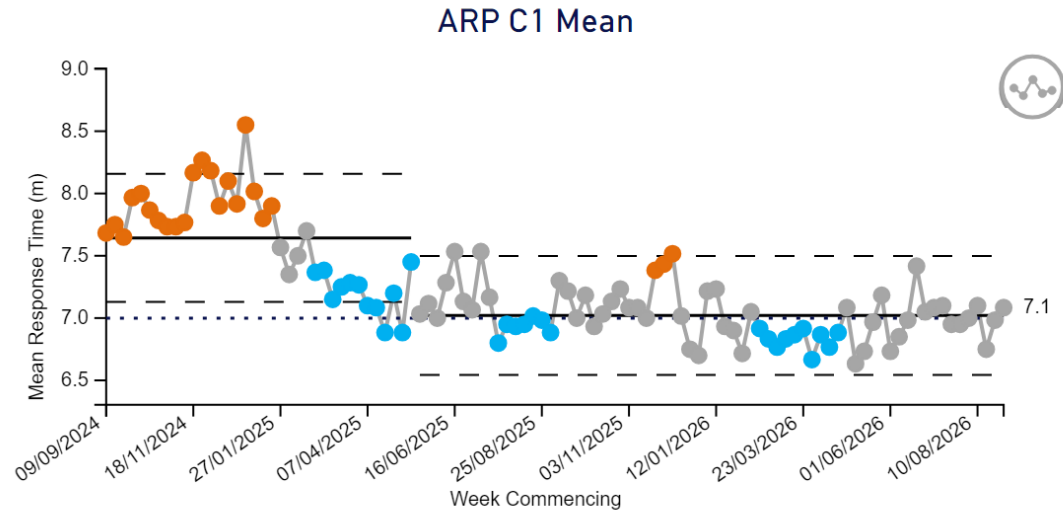
O1 Call Pick Up



Call Pick Up Mean		Call Pick up 90th Percentile		Call Pick up 95th Percentile	
Month	4	Month	0	Month	32
YTD	4	YTD	0	YTD	25
Ranking	7	Ranking	1	Ranking	7

Summary: Calls reduced by 2.7% from 106,152 in July to 103,301 in August, consistent with seasonal demand trends. Average pick-up remained at 4 seconds and the 90th percentile at 0 seconds. The 95th percentile increased from 30 to 32 seconds, indicating delays were limited to a small proportion of calls. Weekly performance remained largely stable, with some deterioration linked to workforce pressures. **Action:** Continue workforce planning and performance monitoring to address scheduling challenges and improve resilience during periods of operational pressure.

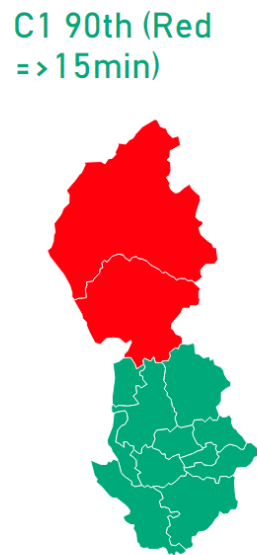
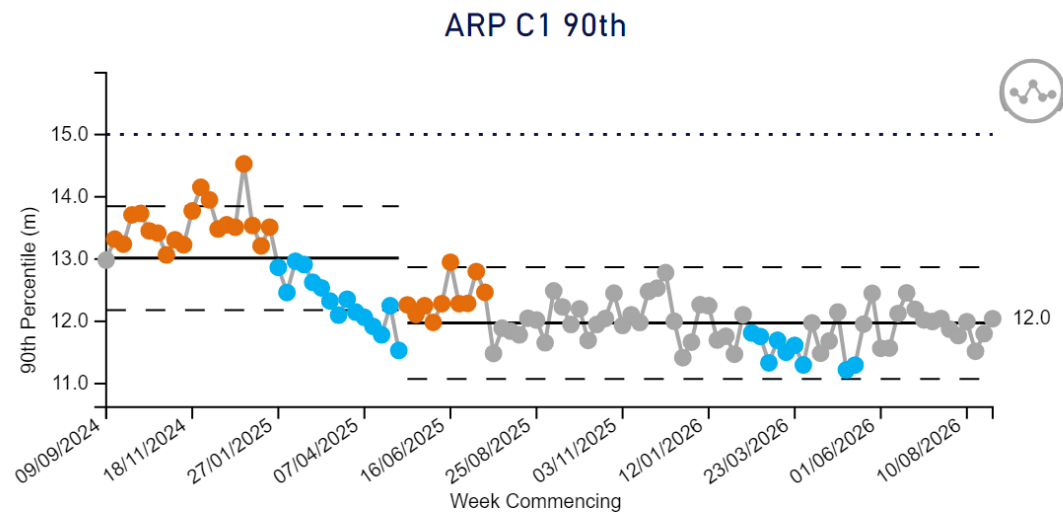
O3 ARP Response Times



C1 Mean by Sector	
CL North Cumbria	00:09:09
CL Morecambe Bay	00:08:28
CL South Lancashire	00:07:43
M South	00:07:31
M West	00:07:24
M East	00:07:07
CL East Lancashire	00:06:50
G East	00:06:44
G West	00:06:42
M North	00:06:29
CL Fylde	00:06:27
G Central	00:06:25
G South	00:06:11

C1 Mean by ICB	
North East & North...	00:09:09
Lancashire & Sout...	00:07:13
Cheshire & Mersey...	00:07:00
Greater Manchester	00:06:28

C1 Mean	
Target	00:07:00
Month	00:06:57
YTD	00:06:57
Ranking	2

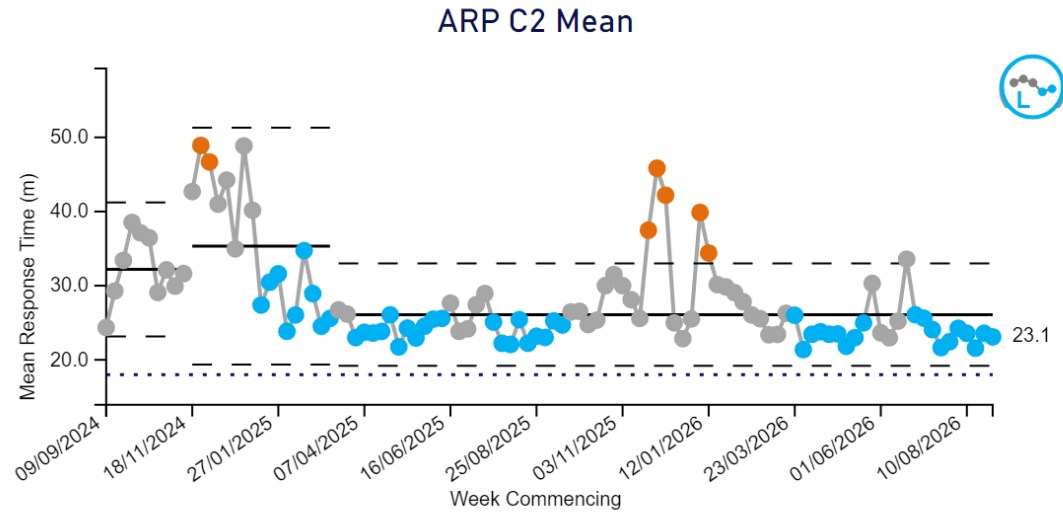


C1 90th by Sector	
CL North Cumbria	00:17:33
CL Morecambe Bay	00:16:07
CL South Lancashire	00:13:30
M South	00:13:04
M West	00:12:30
CL Fylde	00:11:55
CL East Lancashire	00:11:28
M East	00:11:28
G West	00:11:03
M North	00:10:52
G East	00:10:45
G Central	00:10:33
G South	00:10:22

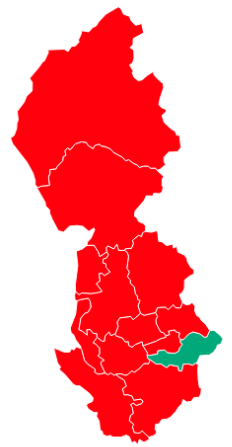
C1 90th by ICB	
North East & N...	00:17:33
Lancashire & So...	00:12:51
Cheshire & Mer...	00:11:39
Greater Manche...	00:10:34

C1 90th	
Target	00:15:00
Month	00:11:42
YTD	00:11:52
Ranking	2

O3 ARP Response Times



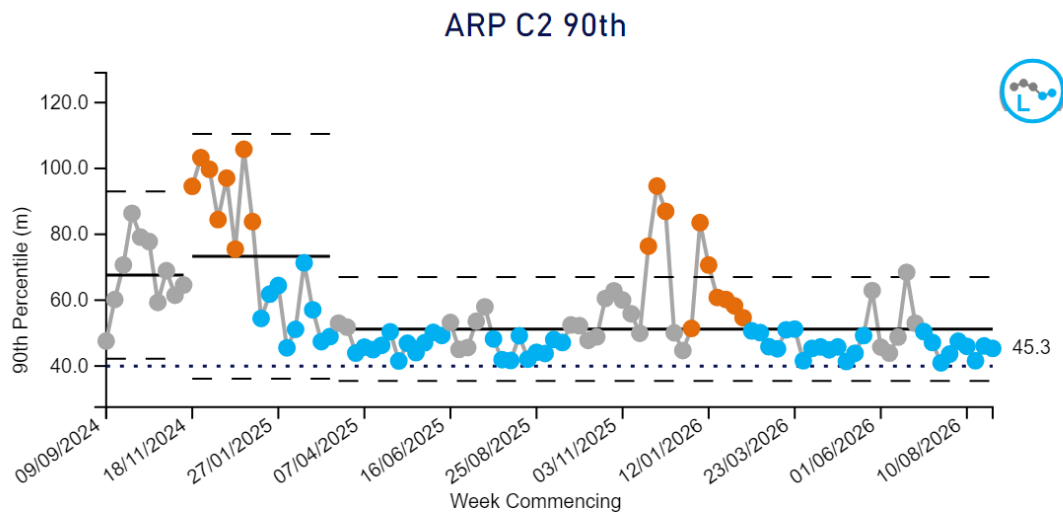
C2 Mean (Red => 18min)



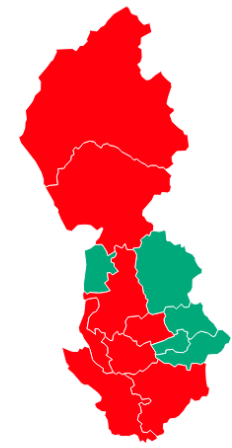
C2 Mean by Sector	
M North	00:29:12
M West	00:28:43
M East	00:28:23
CL North Cumbria	00:26:13
CL Morecambe Bay	00:25:33
M South	00:24:33
CL South Lancashire	00:23:19
G West	00:21:37
CL Fylde	00:20:30
CL East Lancashire	00:19:47
G East	00:19:31
G Central	00:18:09
G South	00:17:38

C2 Mean by ICB	
Cheshire & Mersey...	00:28:05
North East & Nort...	00:26:13
Lancashire & Sout...	00:21:59
Greater Manchester	00:19:08

C2 Mean	
Target (ARP)	00:18:00
Target (UEC)	00:25:00
Month	00:23:03
YTD	00:24:22
Ranking	3



C2 90th (Red => 40min)

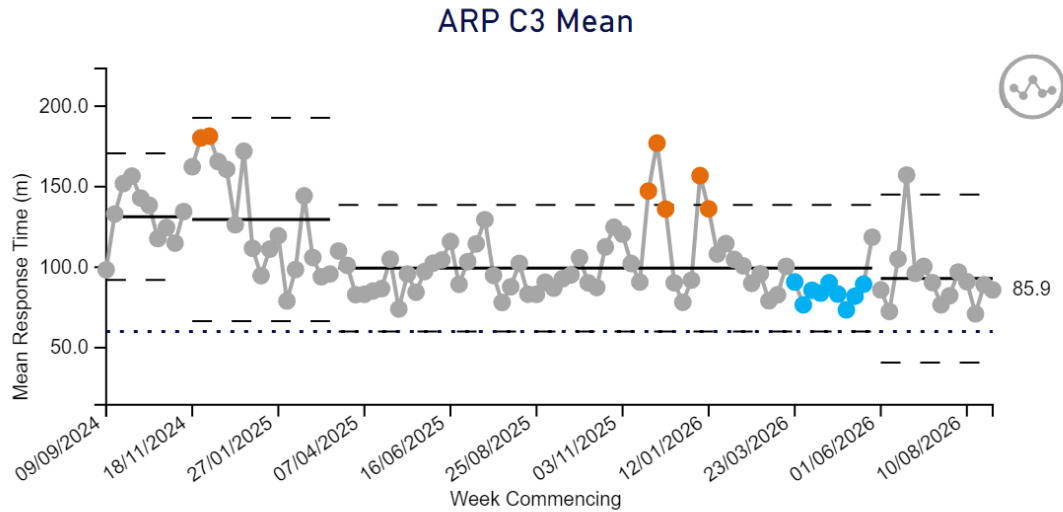


C2 90th by Sector	
M North	00:58:40
M West	00:57:01
M East	00:55:34
CL North Cumbria	00:52:44
CL Morecambe Bay	00:52:26
M South	00:46:15
CL South Lancashire	00:43:37
G West	00:40:41
CL Fylde	00:39:08
CL East Lancashire	00:37:33
G East	00:36:39
G Central	00:34:19
G South	00:33:44

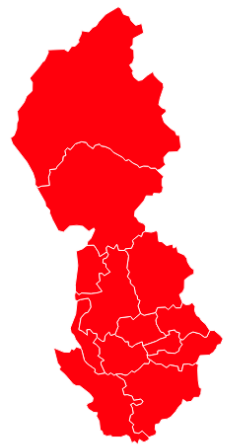
C2 90th by ICB	
Cheshire & Mersey...	00:55:05
North East & Nort...	00:52:44
Lancashire & Sout...	00:41:54
Greater Manchester	00:36:22

C2 90th	
Target	00:40:00
Month	00:44:58
YTD	00:47:38
Ranking	3

O3 ARP Response Times



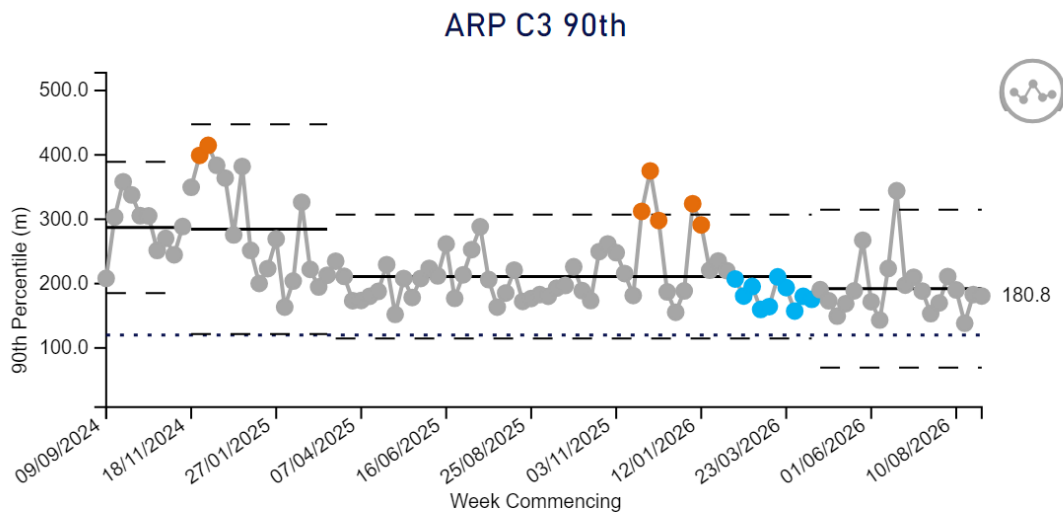
C3 Mean (Red => 60min)



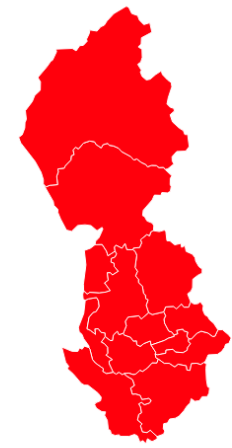
C3 Mean by Sector	
M North	02:01:34
M East	01:58:29
M West	01:40:39
G West	01:24:56
CL South Lancashire	01:20:48
G East	01:19:32
G Central	01:18:34
CL North Cumbria	01:13:07
CL Fylde	01:13:04
M South	01:10:53
CL Morecambe Bay	01:10:12
G South	01:07:26
CL East Lancashire	01:06:46

C3 Mean by ICB	
Cheshire & Mersey...	01:45:47
Greater Manchester	01:17:24
North East & Nort...	01:13:07
Lancashire & Sout...	01:12:57

C3 Mean	
Target	00:60:00
Month	01:25:42
YTD	01:30:33
Ranking	3



C3 90th (Red => 2h)

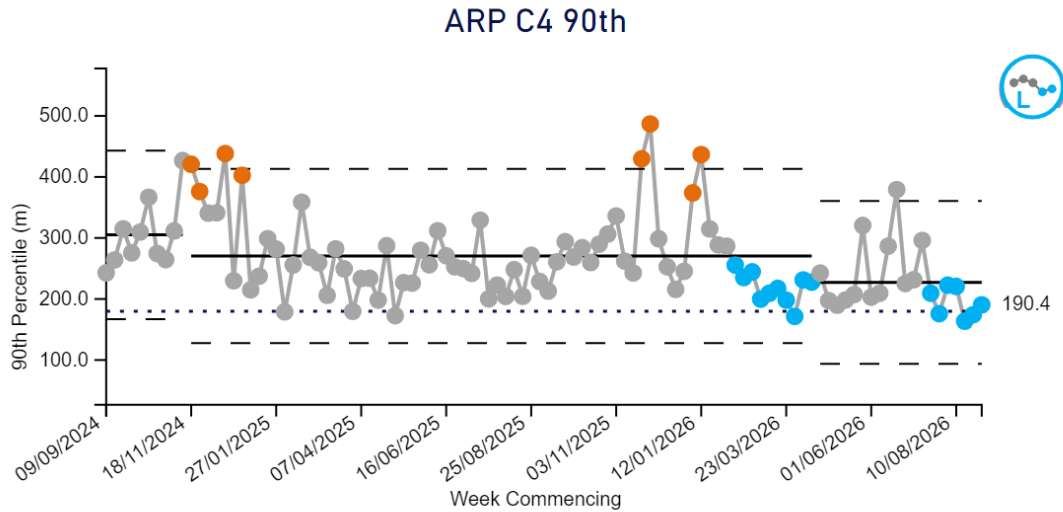


C3 90th by Sector	
M East	04:29:08
M North	04:28:38
M West	03:36:38
CL South Lancashire	02:50:38
G West	02:48:25
G Central	02:34:12
CL Morecambe Bay	02:33:08
CL Fylde	02:29:02
G East	02:26:33
CL North Cumbria	02:26:04
CL East Lancashire	02:25:57
M South	02:19:47
G South	02:07:52

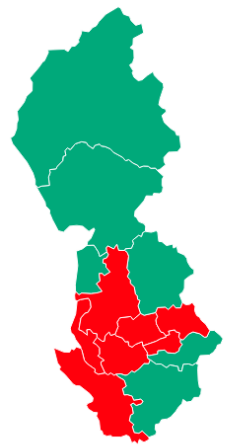
C3 90th by ICB	
Cheshire & Mersey...	03:55:00
Lancashire & Sout...	02:34:46
Greater Manchester	02:29:35
North East & Nort...	02:26:04

C3 90th	
Target	02:00:00
Month	02:58:36
YTD	03:09:31
Ranking	2

O3 ARP Response Times



C4 90th (Red => 3h)



C4 90th by Sector	
M East	07:43:34
G West	04:53:32
CL South Lancashire	04:02:04
M North	03:36:05
G East	03:22:15
G Central	03:03:08
M West	03:00:45
CL North Cumbria	02:50:47
CL East Lancashire	02:48:30
CL Morecambe Bay	02:45:02
CL Fylde	02:25:44
G South	02:23:45
M South	02:08:38

C4 90th by ICB	
Cheshire & Mersey...	03:33:29
Greater Manchester	03:08:40
North East & Nort...	02:50:47
Lancashire & Sout...	02:46:50

C4 90th	
Target	03:00:00
Month	03:05:33
YTD	03:42:24
Ranking	2

Summary:

C1: Activity decreased by 3.5%, with mean response improving from 7m:02s to 6m:57s. C1 performance in M South and M West contributed heavily to the increased overall mean response time in C&M by 5s, with the C&M ICB now at the ARP target threshold. The 90th percentile improved from 12m:03s to 11m:42s.

C2: Activity decreased by 2.5% and is at its lowest level this financial year. Mean response improved from 23m:30s to 23m:03s, remaining within the UEC target but outside ARP. One additional sector (M South) met the UEC target, while G South was the only sector to meet the ARP target. The 90th percentile improved from 45m:43s to 44m:58.

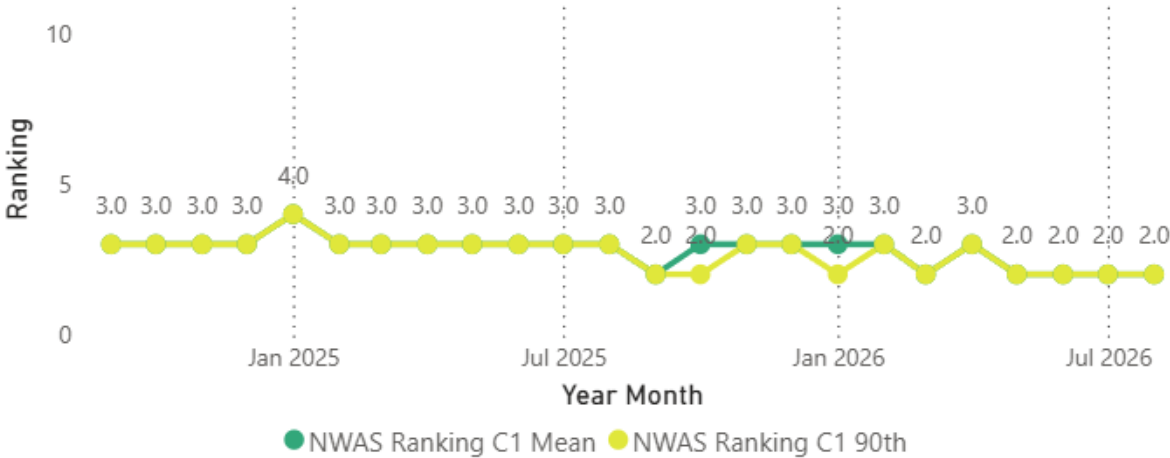
C3: Activity decreased by 2%. Mean response improved from 1h:26m:55s to 1h:25m:42s, the 90th percentile was largely unchanged (+18s). All sectors and ICBs remain outside target.

C4: The 90th percentile improved from 3h:51m:57s to 3h:05m:33s. The number of sectors meeting target increased from 2 to 6, and ICBs meeting target increased from 0 to 2. M East experienced a notable deterioration, worsening from 4h:11m:44s to 7h:43m:34s.

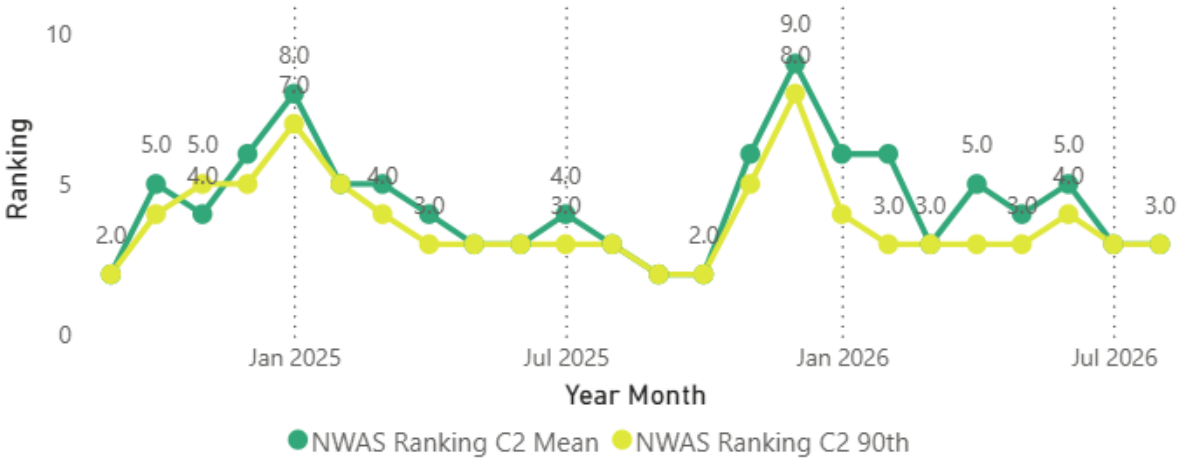
Action: Additional PAS (Private Ambulance Service) resourcing continues to be utilised to support service improvement and enhance C2 performance.

O3 ARP Provider Comparison

C1 Mean & 90th Percentile ranking over time



C2 Mean & 90th Percentile ranking over time



C1 Mean by Trust

North East	00:06:14
North West	00:06:58
London	00:07:07
South East Coast	00:07:25
Yorkshire	00:07:54
West Midlands	00:08:00
South Central	00:08:43
East Of England	00:08:46
East Midlands	00:08:50
Isle Of Wight	00:08:56
South Western	00:09:35

C1 90th by Trust

North East	00:10:42
North West	00:11:42
London	00:12:05
Yorkshire	00:13:40
West Midlands	00:14:22
South East Coast	00:14:42
East Midlands	00:15:41
South Central	00:16:12
East Of England	00:16:18
Isle Of Wight	00:17:30
South Western	00:17:42

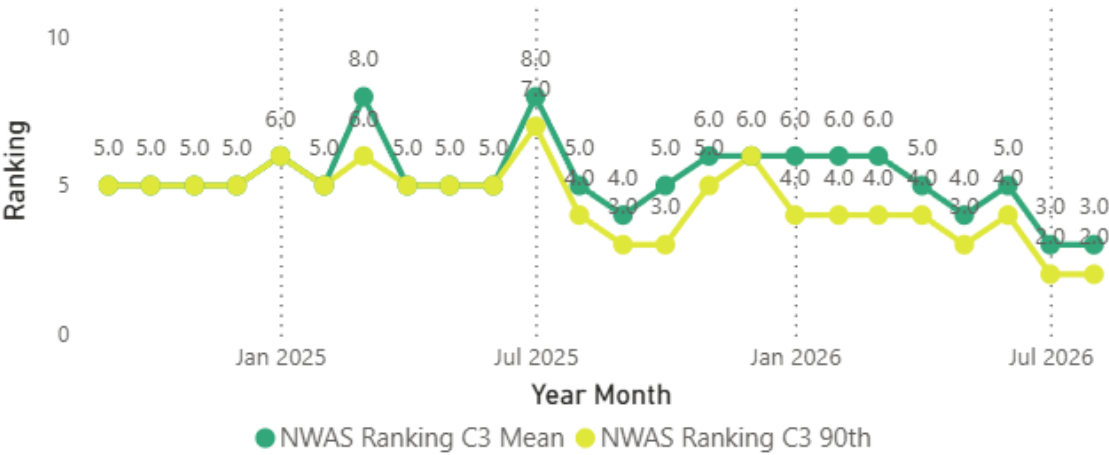
C2 Mean by Trust

North East	00:19:48
West Midlands	00:20:56
North West	00:23:03
Yorkshire	00:24:27
South Central	00:28:44
Isle Of Wight	00:28:45
South East Coast	00:29:22
East Midlands	00:31:47
London	00:32:23
East Of England	00:34:17
South Western	00:37:41

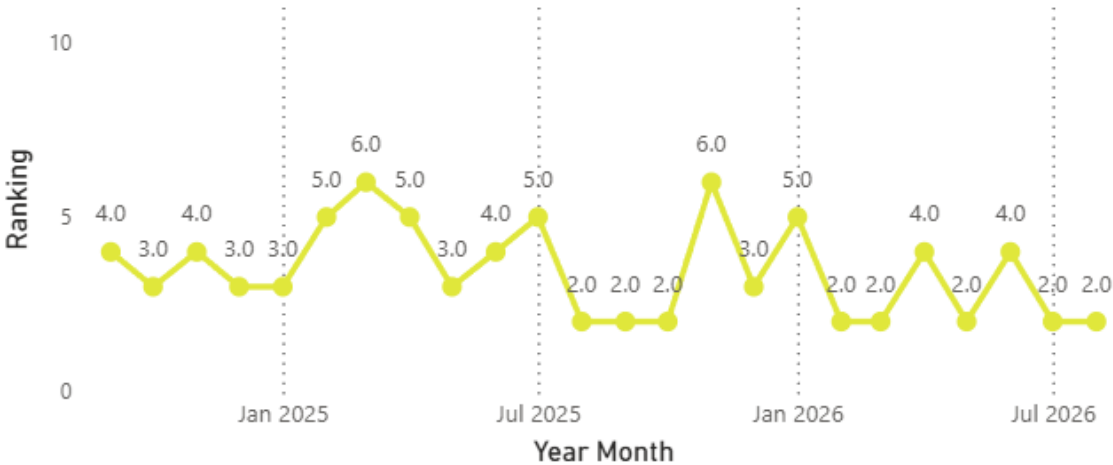
C2 90th by Trust

North East	00:39:59
West Midlands	00:41:52
North West	00:44:58
Yorkshire	00:49:37
South Central	00:55:15
South East Coast	00:58:38
Isle Of Wight	01:01:44
East Midlands	01:02:56
London	01:08:25
East Of England	01:11:41
South Western	01:17:19

C3 Mean & 90th Percentile ranking over time



C4 90th Percentile ranking over time



C3 Mean by Trust

North East	00:57:14
Yorkshire	01:19:35
North West	01:25:43
Isle Of Wight	01:26:09
London	01:41:39
West Midlands	01:50:08
East Of England	01:55:55
South Central	02:03:53
South Western	02:04:33
East Midlands	02:15:43
South East Coast	02:21:13

C3 90th by Trust

North East	02:13:02
North West	02:58:36
Yorkshire	03:01:08
Isle Of Wight	03:22:11
London	04:13:39
South Central	04:24:50
East Of England	04:32:46
West Midlands	04:36:00
South Western	04:49:05
East Midlands	05:04:01
South East Coast	05:35:28

C4 90th by Trust

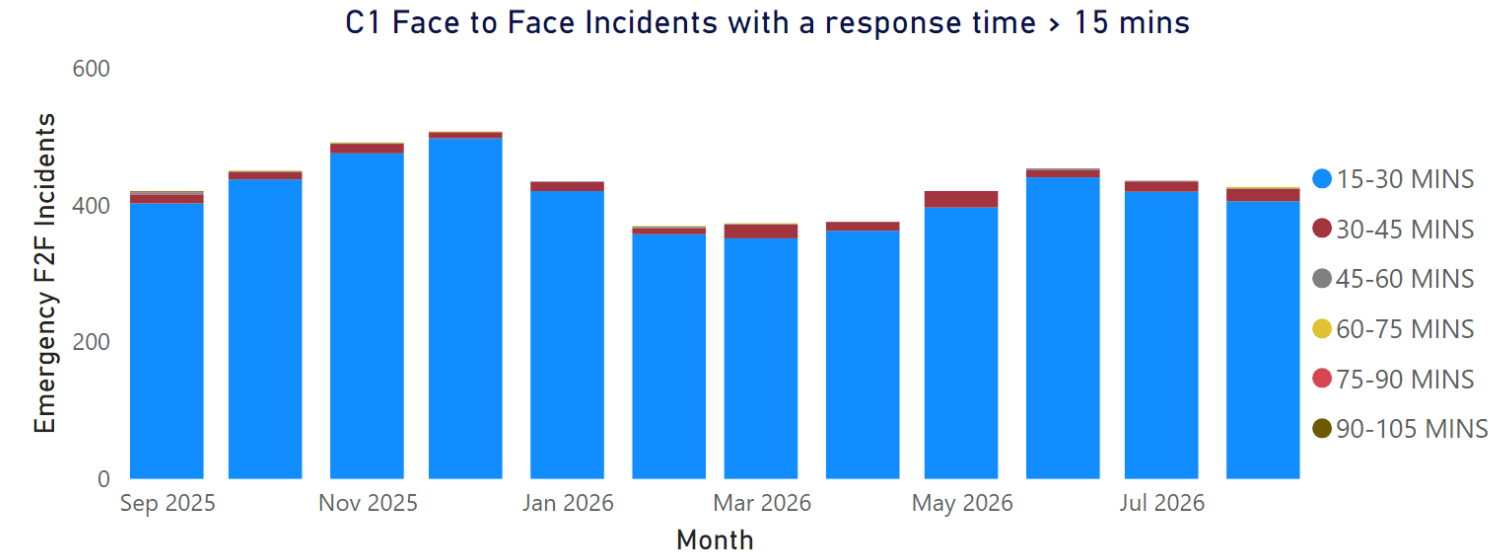
North East	02:56:19
North West	03:05:21
Yorkshire	03:37:40
South Central	04:43:02
East Of England	04:48:59
Isle Of Wight	05:23:36
West Midlands	05:25:19
South East Coast	06:11:12
South Western	06:16:54
London	06:44:53
East Midlands	07:19:19

Summary:

The Trust's national rankings remain unchanged this month. C1 mean and 90th percentile continue to rank 2nd, while both C2 measures remain 3rd nationally.

Lower-acuity performance is similarly stable; C3 mean remains 3rd, with C3 and C4 90th percentile measures both holding 2nd place. Overall, the Trust ranks within the national top three across every reported metric.

O3 Long Waits C1

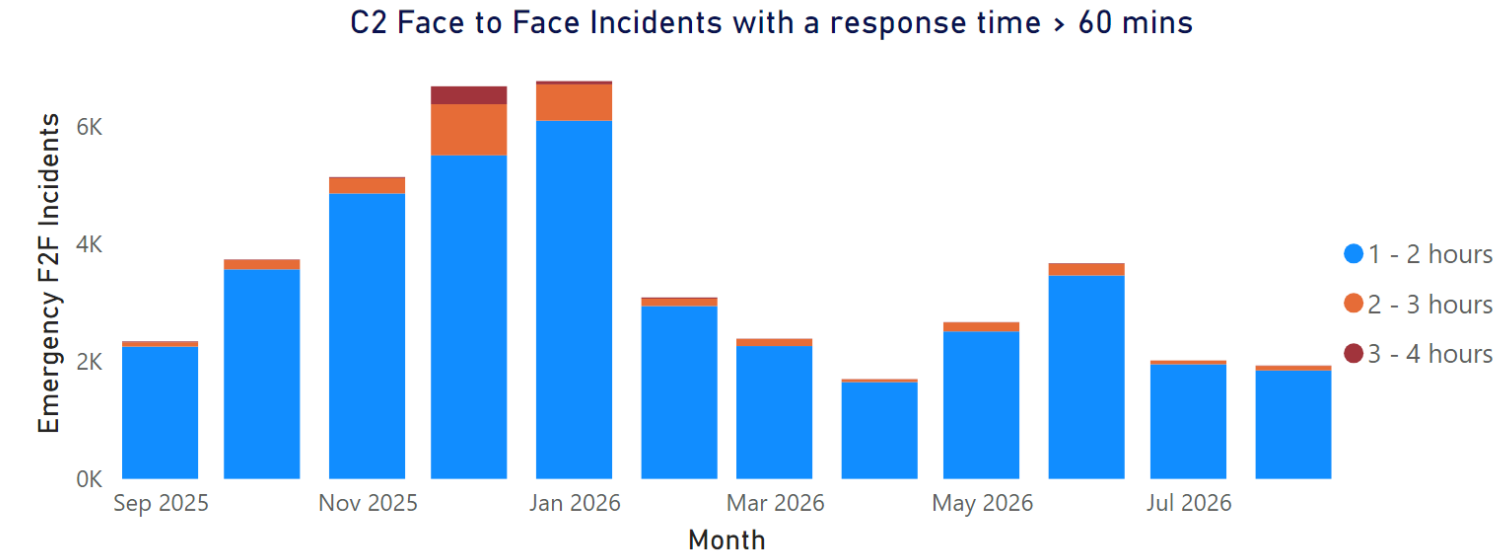


Month Year	Total No. of C1 Long Waits
Sep 2025	420
Oct 2025	450
Nov 2025	491
Dec 2025	507
Jan 2026	434
Feb 2026	369
Mar 2026	373
Apr 2026	375
May 2026	420
Jun 2026	453
Jul 2026	435
Aug 2026	426

Summary: C1 long waits fell to 426, with the share occurring within 15–30 minutes down 1 percentage point. C&L remained the largest contributor (48%, down from 54%), while Morecambe Bay and North Cumbria recorded the highest activity-adjusted rates (12% and 15%). These sectors drove 55% of C&L’s 30–45-minute waits and 58% of all waits in this band year to date. Two incidents occurred in the 60–75-minute band across C&L and C&M, an increase on last month. GM retained the lowest overall volume, despite a 43% rise from 65 to 93, mostly within 15–30 minutes; GM South and GM West increased by 71% and 81%, respectively.

Action: Additional resource is being deployed within Cumbria as part of a sustained recruitment initiative aimed at strengthening operational capacity through the remainder of the year.

O3 Long Waits C2



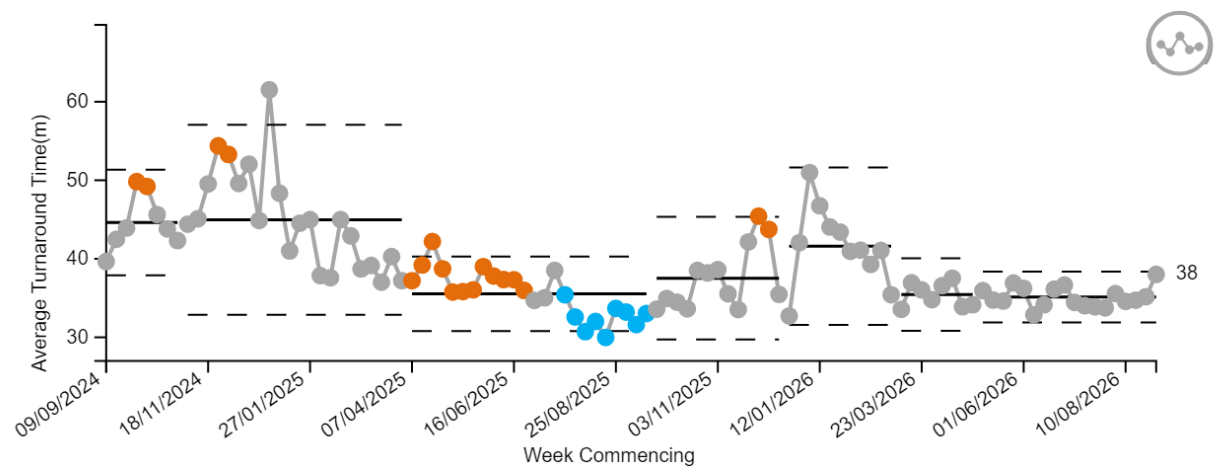
Month Year	Total No. of C2 Long Waits
Sep 2025	2,340
Oct 2025	3,734
Nov 2025	5,138
Dec 2025	6,683
Jan 2026	6,771
Feb 2026	3,088
Mar 2026	2,386
Apr 2026	1,698
May 2026	2,668
Jun 2026	3,671
Jul 2026	2,016
Aug 2026	1,929

Summary:
C2 long waits reduced by approximately 4% compared with last month, from 2,016 to 1,929 incidents. Overall, 4.1% of all C2 incidents experienced a long wait, broadly in line with last month (4.2%) but higher than August 2025 (3.7%). Around 57% of all C2 long waits occurred within the 60 to 75 minute time band. C&M accounted for 60% of all C2 long waits (1,160 incidents). Approximately 8% of all C2 activity within C&M resulted in a long wait, the highest rate across all areas. M North recorded the largest share of C2 long waits within C&M, accounting for 42% (495 incidents). Relative to activity levels, 9.4% of all C2 incidents in M North resulted in a long wait. C&L recorded the lowest C2 long wait rate, with approximately 4% of C2 activity resulting in a long wait. Morecambe Bay and North Cumbria recorded the highest rates within the region (6.7% each), although both remain substantially lower than the corresponding C1 long wait rates.

Action: From September 2026, operational modelling across Cheshire & Merseyside will enable increased DCA capacity to support Category 2 performance and protect Category 1 performance.

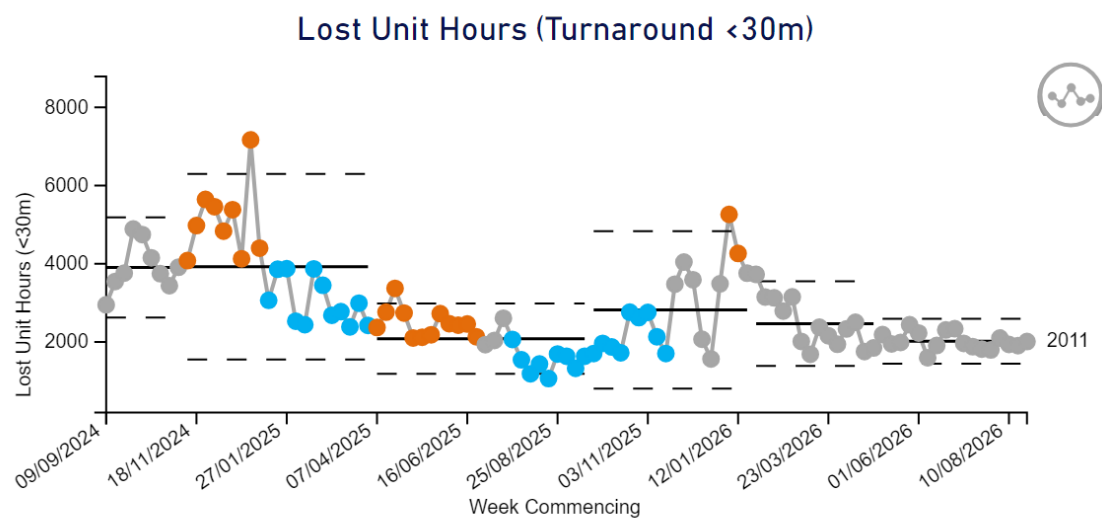
O3 A&E Turnaround

Average Turnaround Time



Month	Hospital Attendances	Average Turnaround Time(hh:mm:ss)	Average Arrival to Handover Time (hh:mm:ss)	Average Handover to Clear Time(hh:mm:ss)
Aug 2025	49,027	00:31:00	00:21:46	00:09:15
Sep 2025	47,964	00:32:55	00:23:41	00:09:17
Oct 2025	50,753	00:35:40	00:26:20	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	50,187	00:46:41	00:37:35	00:09:02
Feb 2026	44,653	00:40:53	00:31:43	00:09:10
Mar 2026	49,398	00:35:28	00:26:14	00:09:14
Apr 2026	49,002	00:35:33	00:26:25	00:09:10
May 2026	50,818	00:35:06	00:26:00	00:09:06
Jun 2026	49,361	00:35:20	00:26:19	00:09:04
Jul 2026	50,305	00:33:57	00:24:55	00:09:06
Aug 2026	49,278	00:34:49	00:25:47	00:09:05

O3 A&E Turnaround



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	2,354	1119.20	00:54:04	00:43:38	00:10:33
Royal Liverpool University	2,506	1082.70	00:53:05	00:43:41	00:09:59
Aintree University	2,296	571.02	00:40:28	00:30:40	00:10:08
Royal Preston	2,114	524.21	00:38:07	00:30:07	00:08:18
Blackpool Victoria	2,700	522.35	00:36:58	00:27:55	00:09:20

Month	No of patients waiting outside ED for handover
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
Jul 2026	1641
Aug 2026	2124

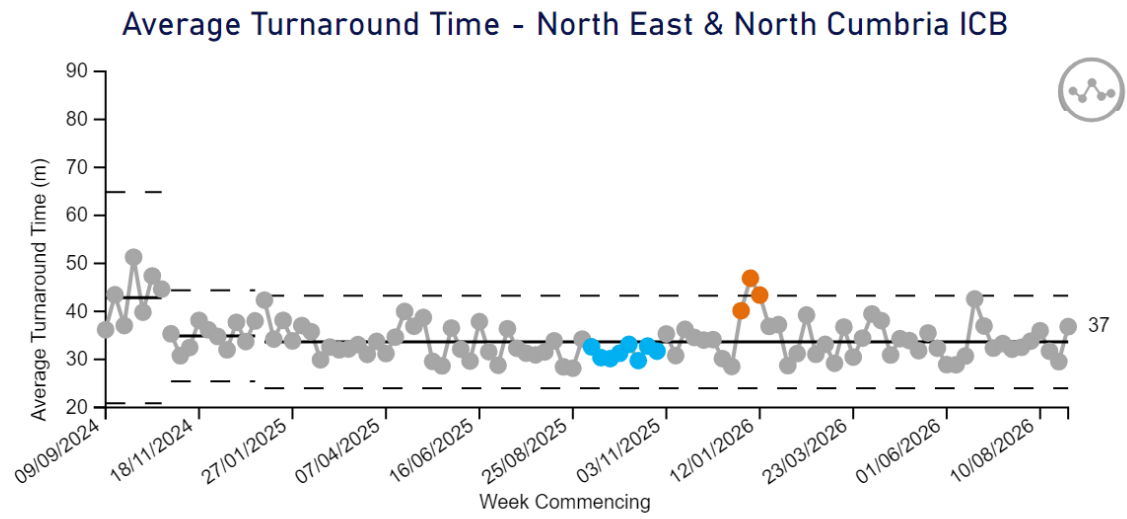
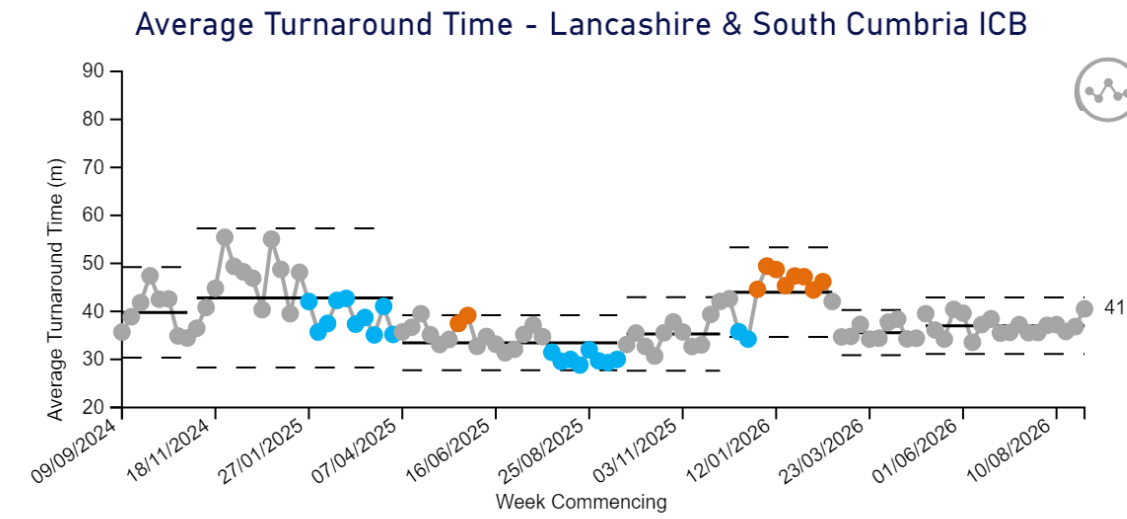
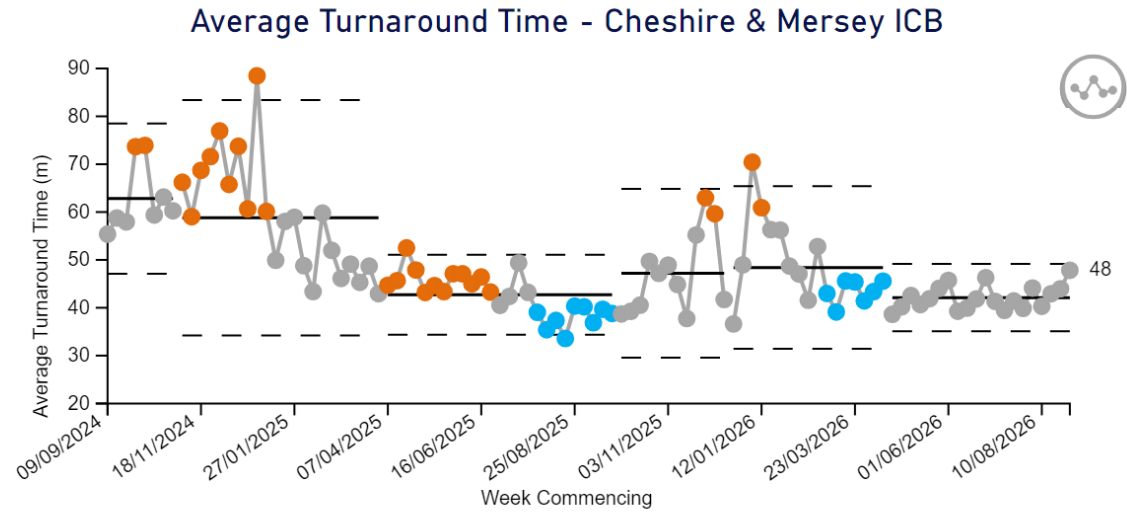
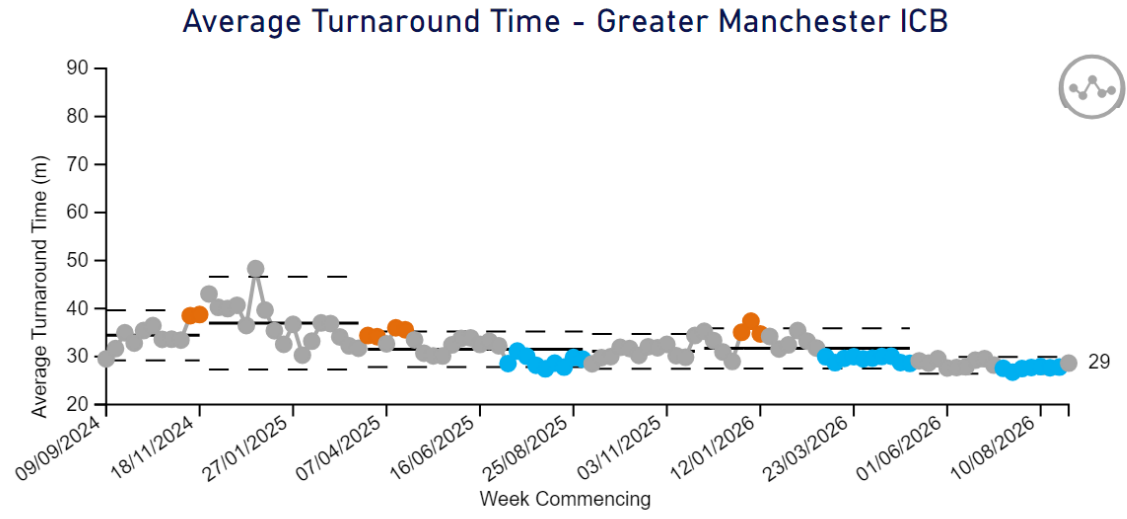
Summary:

Despite attendances reducing from 50,305 to 49,278, overall ambulance turnaround performance worsened compared to the previous month, with increases observed in average turnaround time, arrival to handover time, and handover to clear time.

Patients waiting outside ED for handover increased by 29% compared to the previous month (1,641 to 2,124). The trusts recording the highest levels of lost unit hours remained largely unchanged, with Whiston, Royal Liverpool, Preston and Aintree all continuing to rank among the five worst-performing sites.

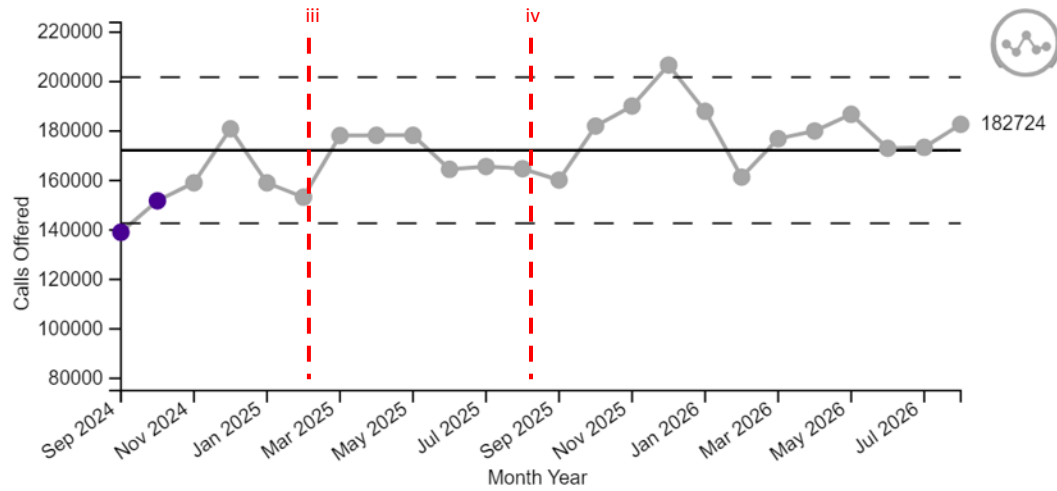
For the five trusts with the most lost hours, the most significant improvement was observed at Whiston Hospital, where lost unit hours reduced by approximately 26% (1518.68 to 1119.20) and average hospital-to-clear times fell by more than 7 minutes. Royal Preston also recorded modest improvements. These gains were offset by substantial deterioration at Royal Liverpool University Hospital, where lost unit hours increased by approximately 60% (677.94 - 1082.70) despite stable activity levels, driven primarily by longer handover delays.

O3 A&E Turnaround by ICB

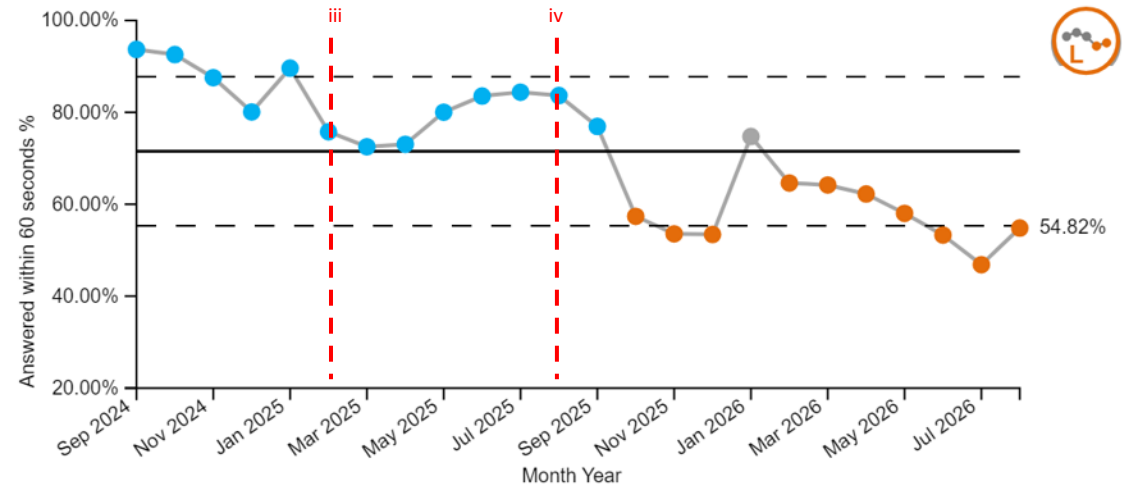


04 111 Activity & Performance

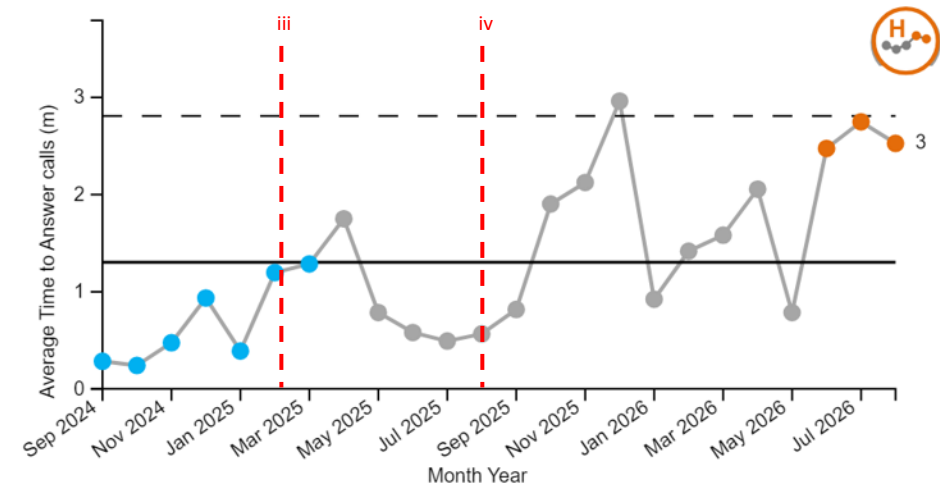
111 Calls Offered



Calls Answered within 60 seconds %



111 Average Call to Answer Time

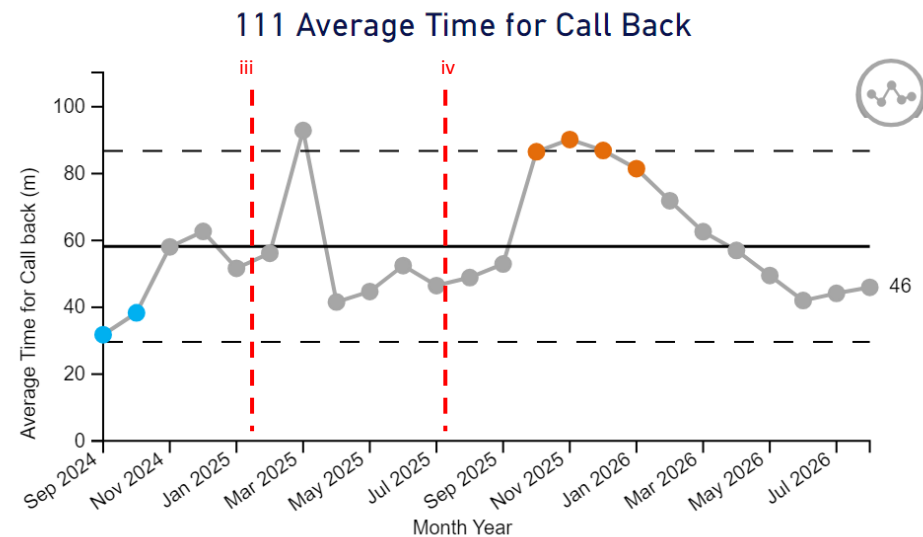
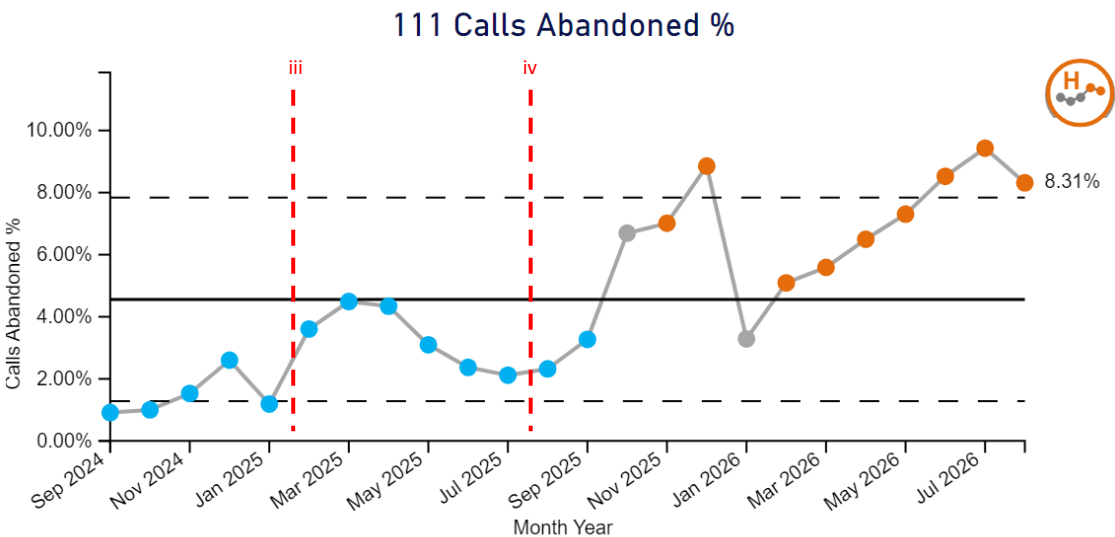


Calls Offered	
Month	182,724
YTD	896,008

Calls Answered within 60 Seconds %	
Target	95%
Month	54.82%
YTD	55.2%
National	69.6%
Ranking	22

Average Call to Answer Time (s)	
Target	<20
Month	152
YTD	126
National	105
Ranking	28

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



Calls Abandoned %	
Target	< 5%
Month	8.31%
YTD	8.00%
National	5.30%
Ranking	23

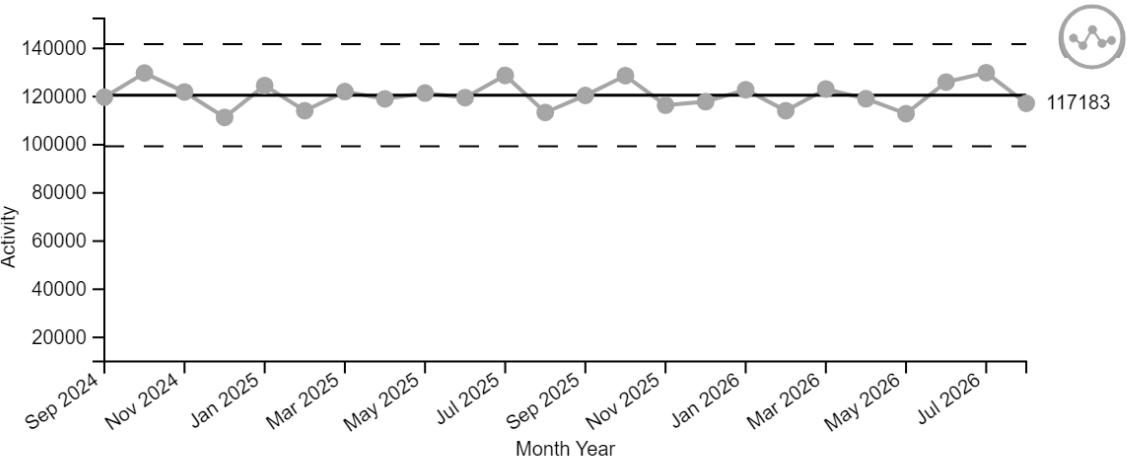
Summary: 111 calls offered increased by 5.4%, from 173,413 in July to 182,724 in August. Despite higher demand, performance improved across all key measures. Calls answered within 60 seconds increased from 46.8% to 54.8%, average answer time reduced from 165 to 152 seconds, and call abandonment fell from 9.4% to 8.3%. Average call back time remained below one hour, at 46 minutes. While performance improved across all measures, it remains below the national standards.

Action: Continue workforce planning and performance monitoring to improve service levels.

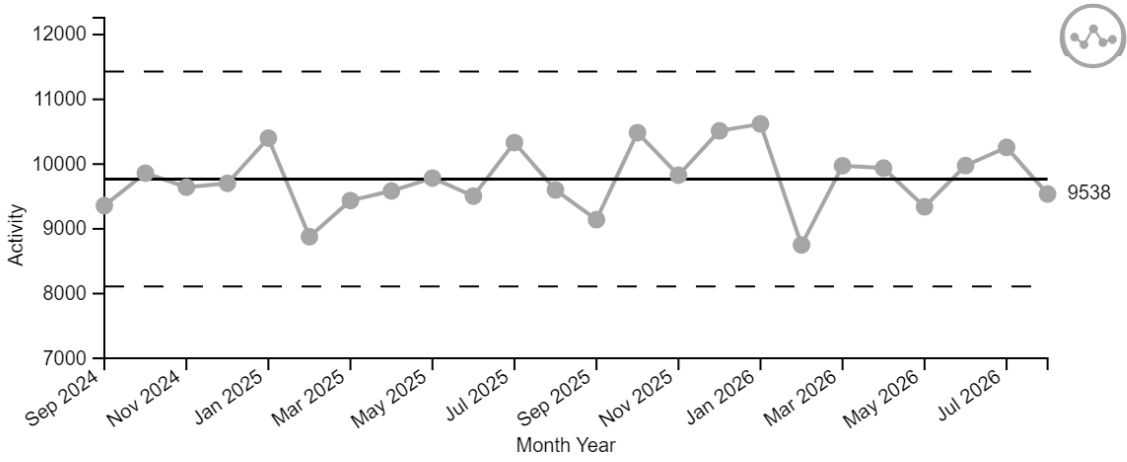
i Start of 15% national contingency
ii Reduction to 10% National contingency
iii Removal of contingency
Iv 14th July Clinicians stopped taking front end calls

05 PTS Activity

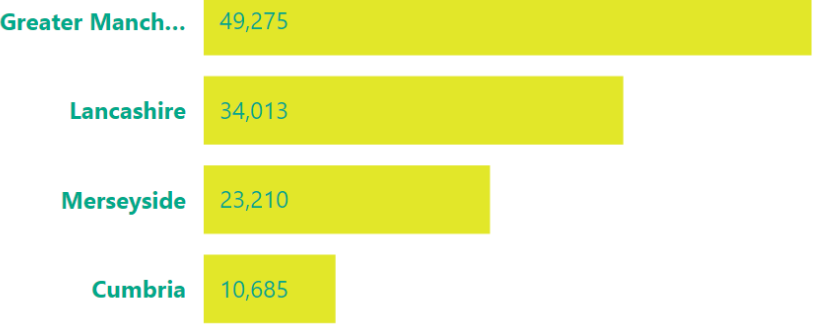
Total Activity



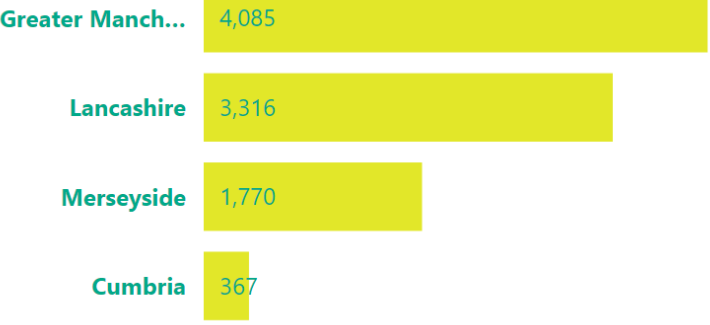
Unplanned Activity

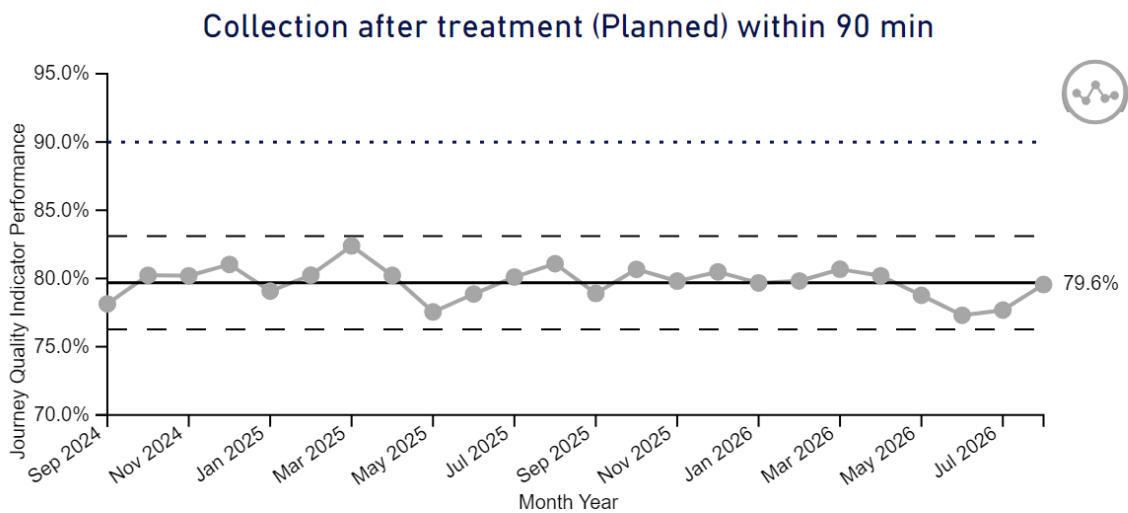
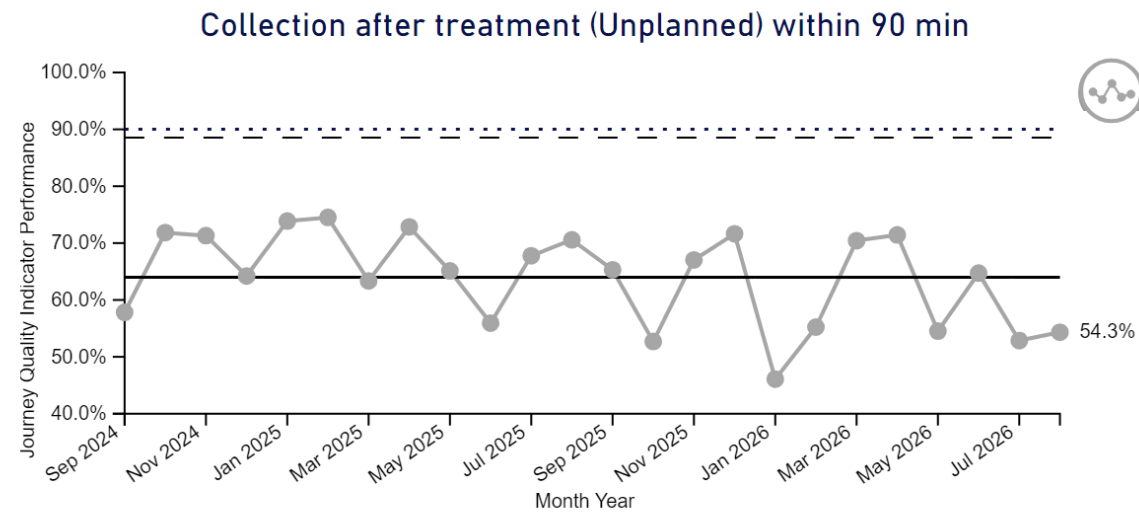
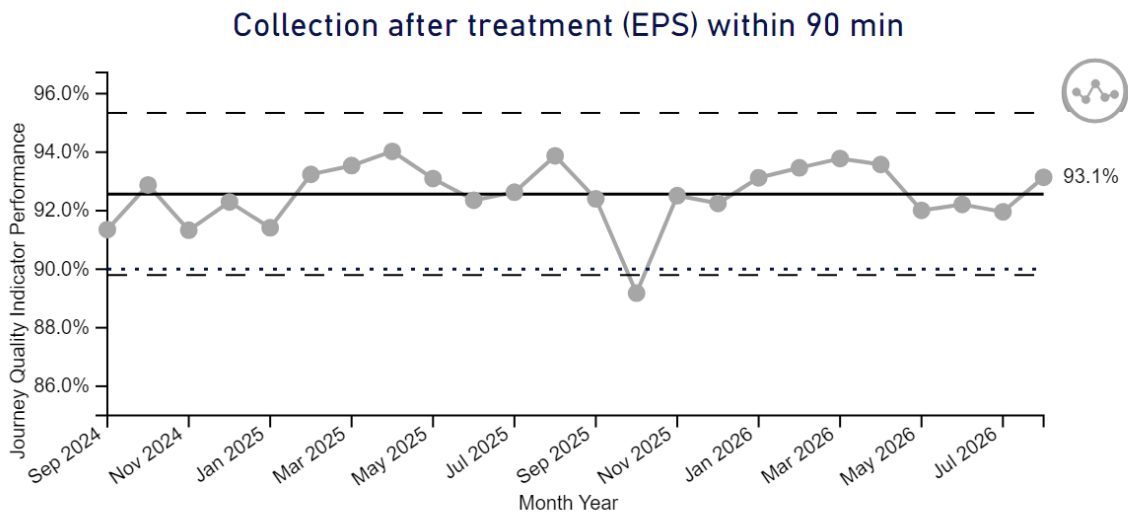


Total Activity by Contract



Unplanned Activity by Contract





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:

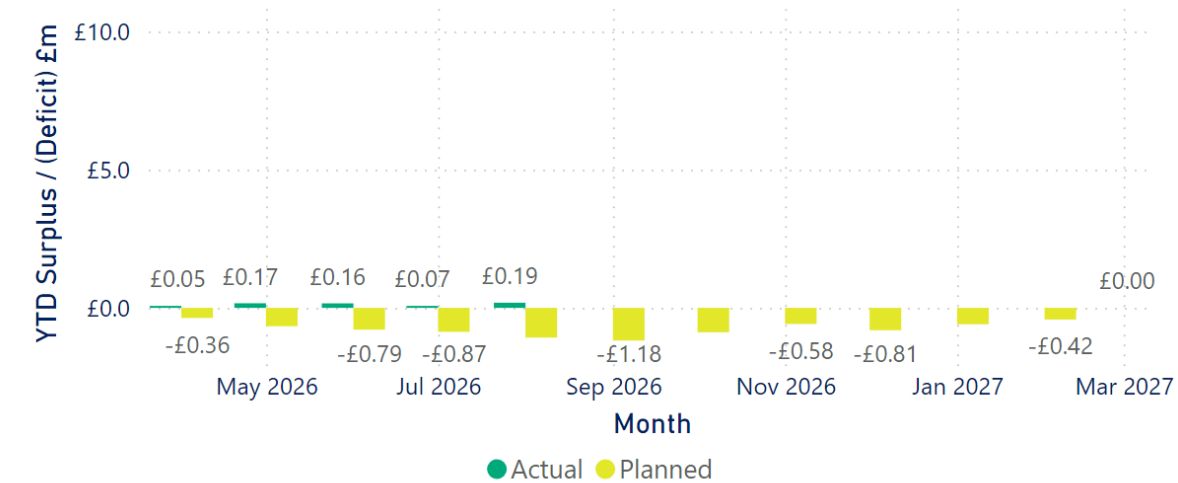
Operational and workforce improvement plans are in place.

Finance

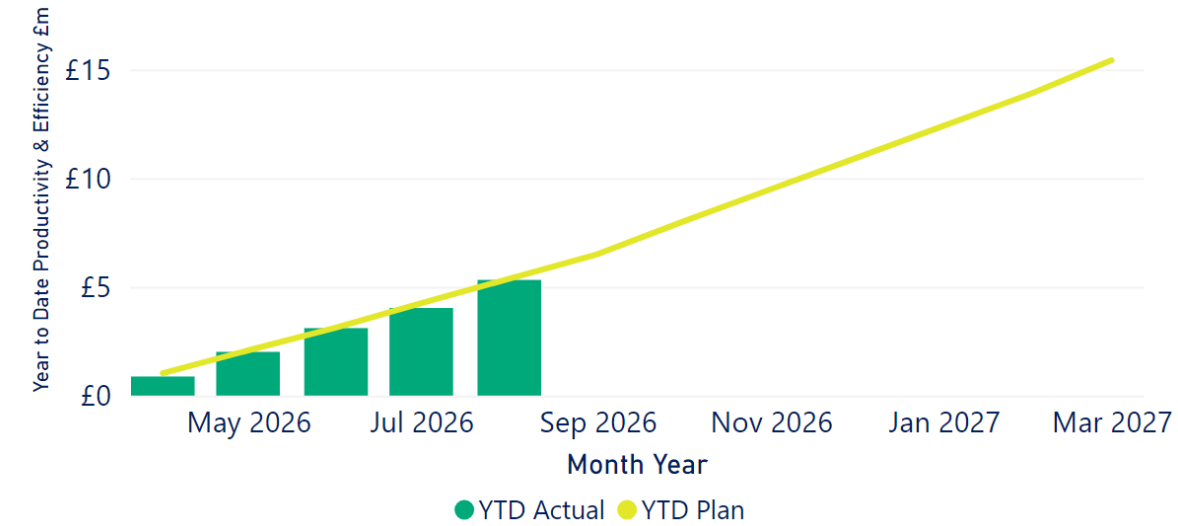
F1 Financial Score

F1 Financial Score

2026/27 Income and Expenditure Surplus (+) / Deficit (-)



2026/27 Productivity and Efficiency Performance



Summary:

The financial position to 31 Aug 2026 (Month 05) is a surplus of £0.186m, against a planned deficit of £1.074m. 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 05 are behind plan at £5.317m, against the year-to-date plan of £5.372m.

Actions:

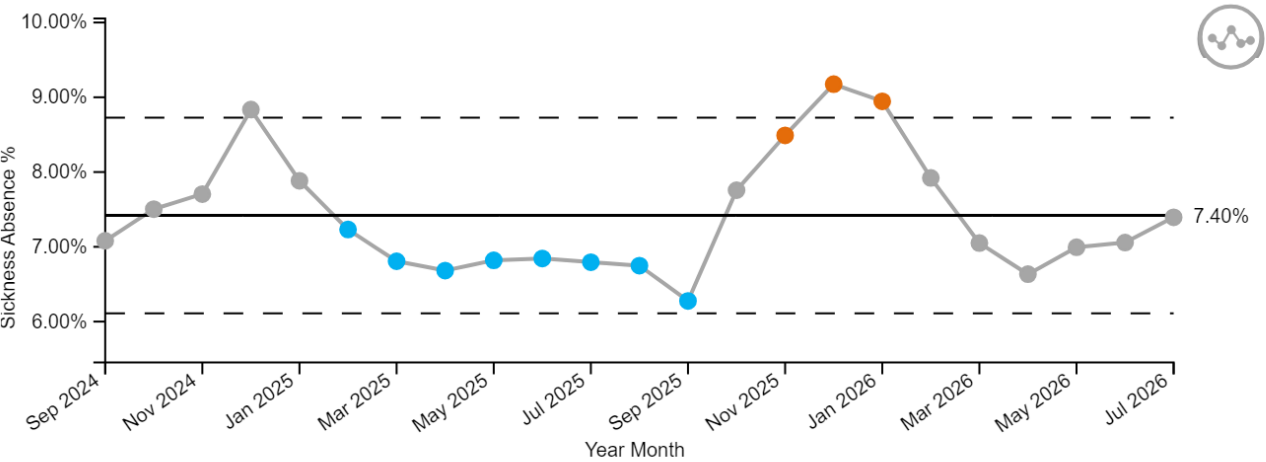
Service leads are continuing to develop efficiency plans which will increase the delivery of savings in year.

Organisational Health

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

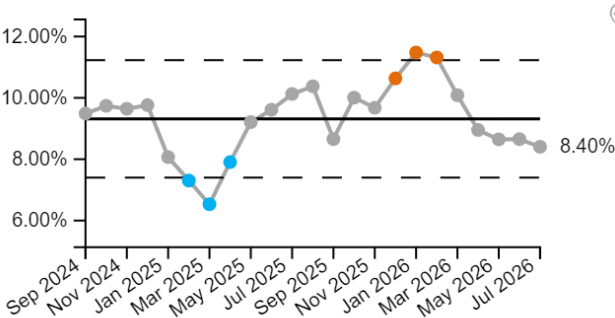
OH1 Staff Sickness

NWAS Sickness Absence

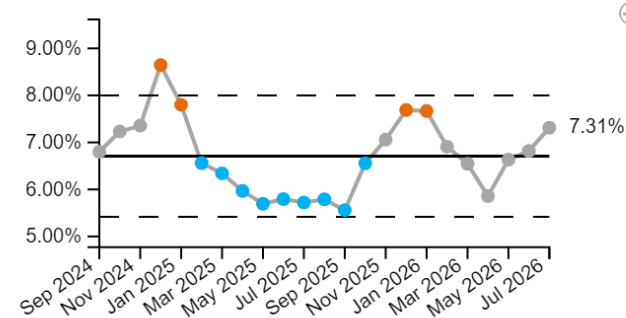


Month	NWAS	Amb. National Average
Sep 2025	6.28%	6.74%
Oct 2025	7.76%	7.17%
Nov 2025	8.49%	7.39%
Dec 2025	9.18%	8.26%
Jan 2026	8.95%	7.88%
Feb 2026	7.92%	7.19%
Mar 2026	7.05%	6.79%
Apr 2026	6.63%	6.57%
May 2026	6.99%	
Jun 2026	7.06%	
Jul 2026	7.40%	

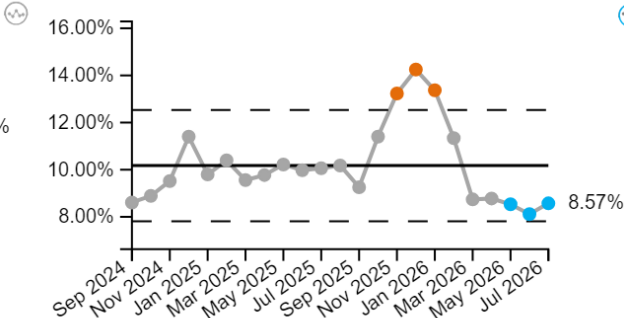
PTS Sickness Absence



PES Sickness Absence



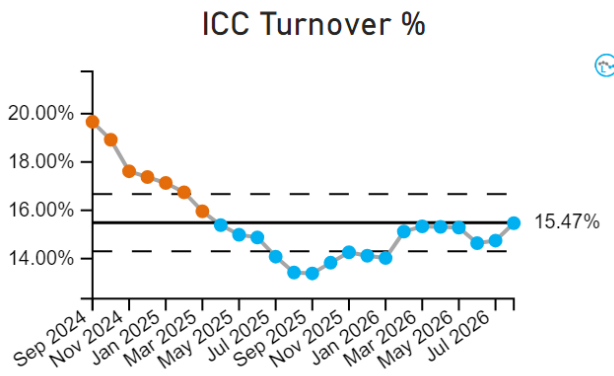
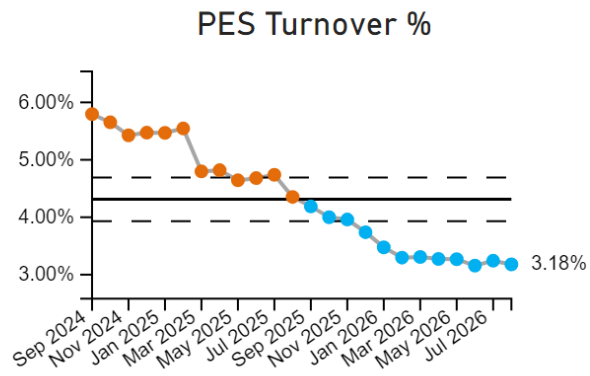
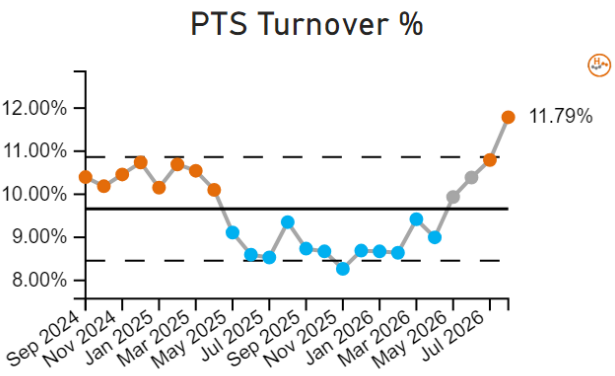
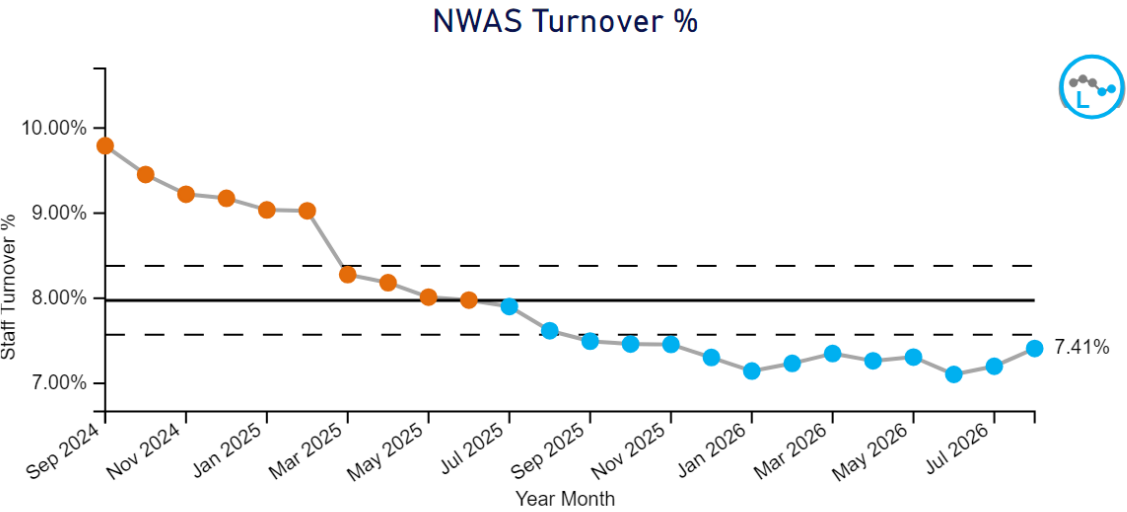
ICC Sickness Absence



Summary: Overall sickness shows a stable position in relation to last year but is not showing overall improvement against medium term plan targets. PES data is starting to indicate risk as it is increasing against the seasonal trend and is running higher than the same time last year.

Actions: 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.

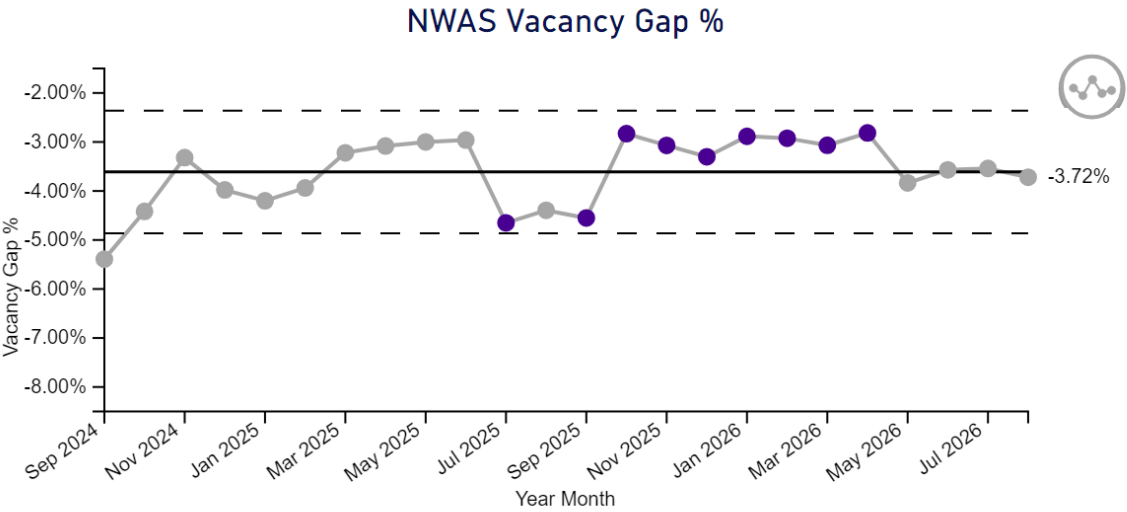
OH2 Staff Turnover



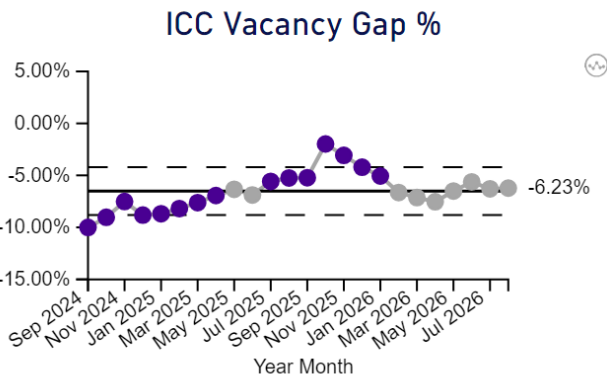
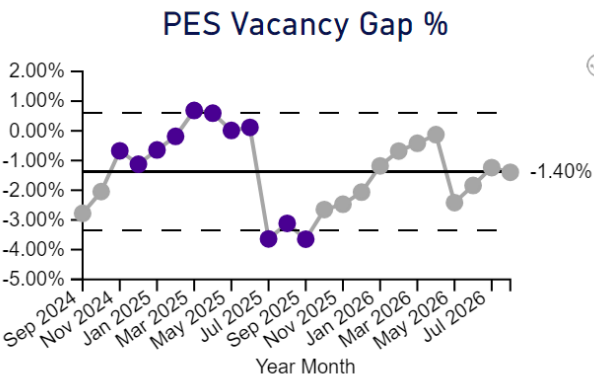
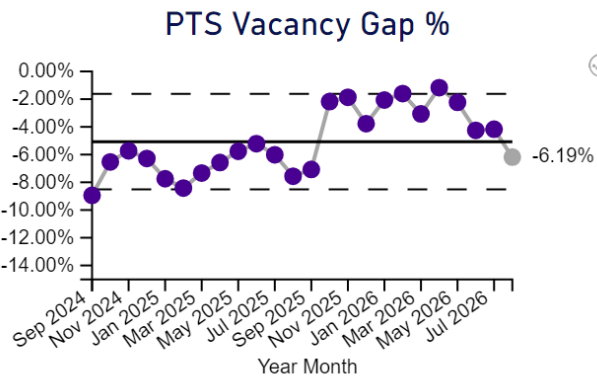
Summary: Overall remains stable/reducing. Key areas of risk are increasing PTS turnover which is impacted by external factors such as the tender uncertainty and cultural improvements which are progressing. In addition, PES lower than anticipated turnover is a risk as workforce plans were based on higher attrition assumptions causing skill mix difficulties and potential financial risks from paramedic oversupply.

Actions: Operations and Finance colleagues are undertaking a review of 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.

OH5 Vacancy Gap



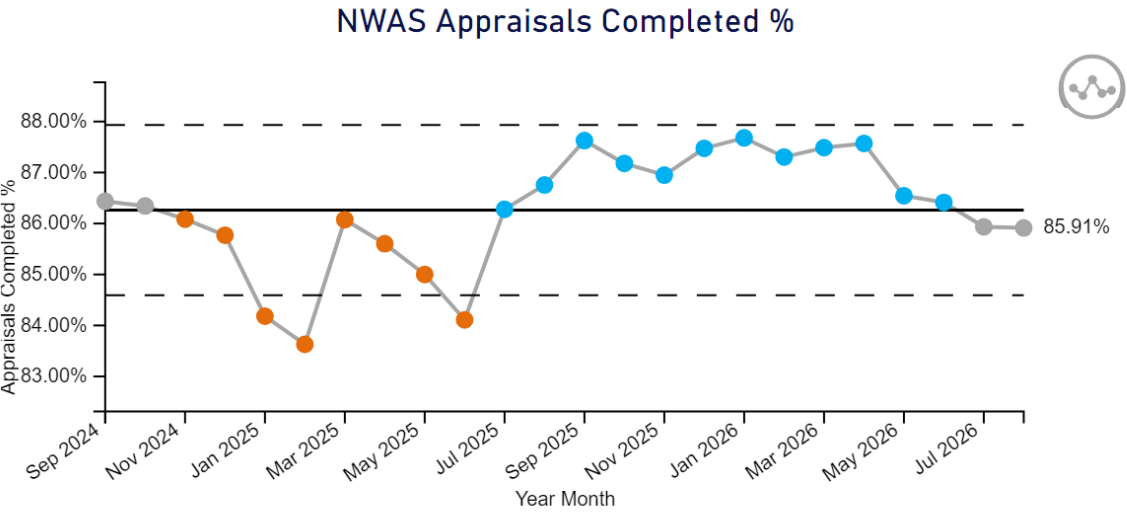
Month	NWAS Total % Vacancy Gap
Sep 2025	-4.55%
Oct 2025	-2.83%
Nov 2025	-3.07%
Dec 2025	-3.30%
Jan 2026	-2.88%
Feb 2026	-2.92%
Mar 2026	-3.07%
Apr 2026	-2.82%
May 2026	-3.84%
Jun 2026	-3.57%
Jul 2026	-3.54%
Aug 2026	-3.72%



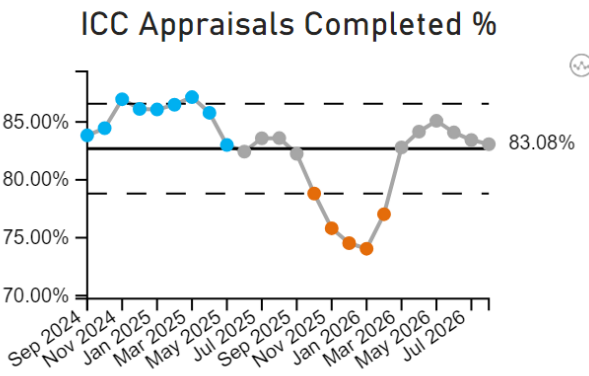
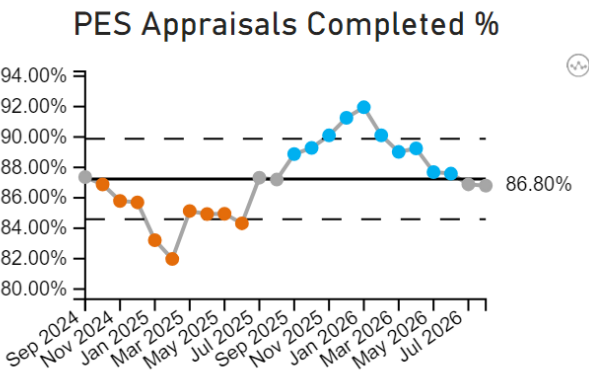
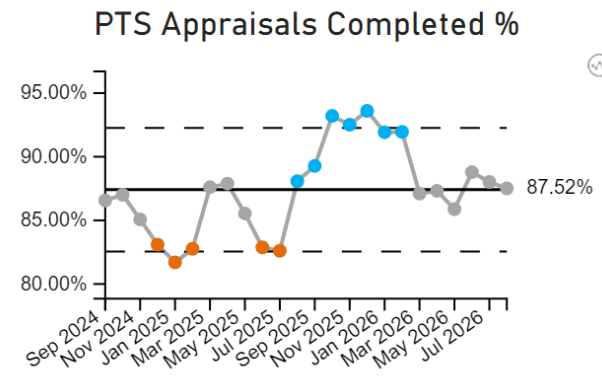
Summary: In the main overall and service line vacancy gaps are not a cause for concern. The overall position in PES remains strong, although there are some emerging risks with recruitment and training plans operating at maximum capacity, creating limited resilience to absorb unexpected workforce pressures, turnover or changes in service demand. Delivery of these plans has been adversely impacted by external C1 testing delays and reductions in EMT1 course fill. In PTS, the impact of the contract decision and demobilisation on GM PTS may lead to increasing gaps over the remaining 6 months of the service provision.

Actions: workforce plans are being monitored closely. Robust recruitment and training plans are established across all frontline service lines and are subject to regular joint monitoring. A range of mitigations are being actively explored at pace to mitigate UEC delivery risks.

OH6 Appraisals



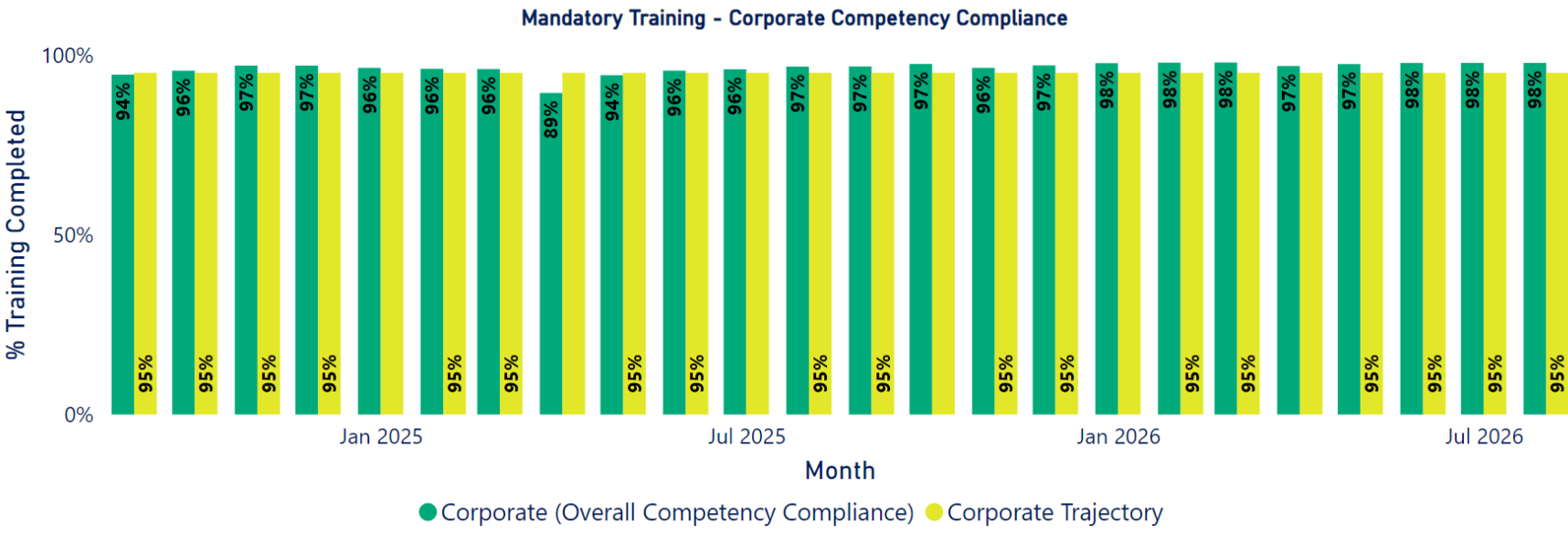
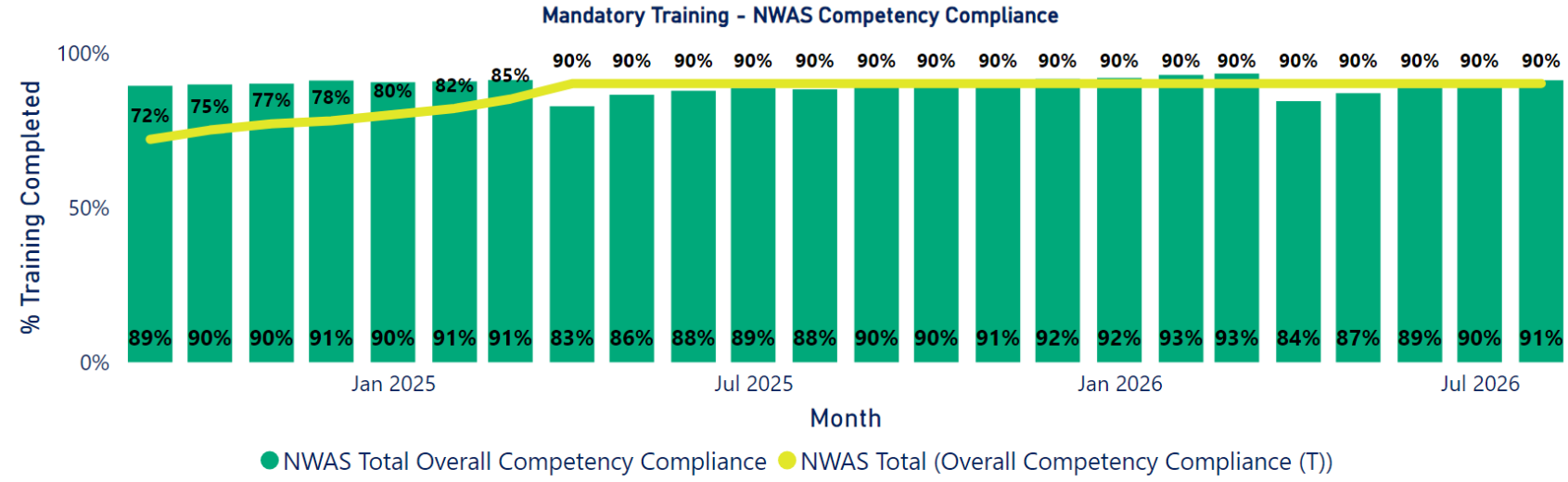
Month	NWAS Total % Complete Appraisals
Sep 2025	87.63%
Oct 2025	87.18%
Nov 2025	86.95%
Dec 2025	87.47%
Jan 2026	87.68%
Feb 2026	87.30%
Mar 2026	87.49%
Apr 2026	87.57%
May 2026	86.54%
Jun 2026	86.41%
Jul 2026	85.94%
Aug 2026	85.91%



Summary: Overall compliance is in line with target with ICC and corporate recovery actions in place.

Actions: 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.

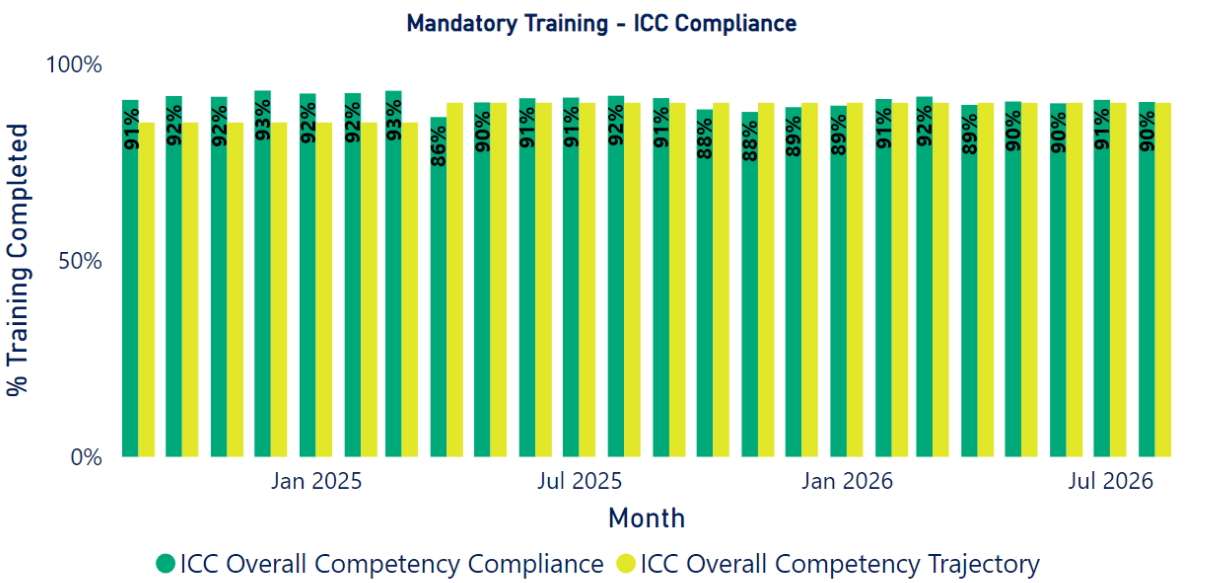
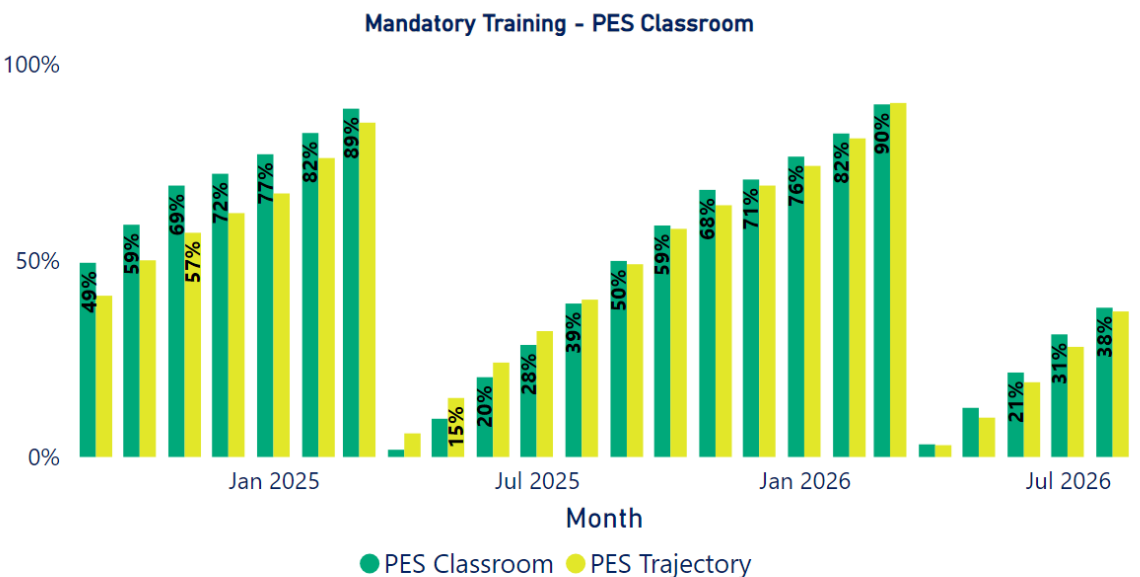
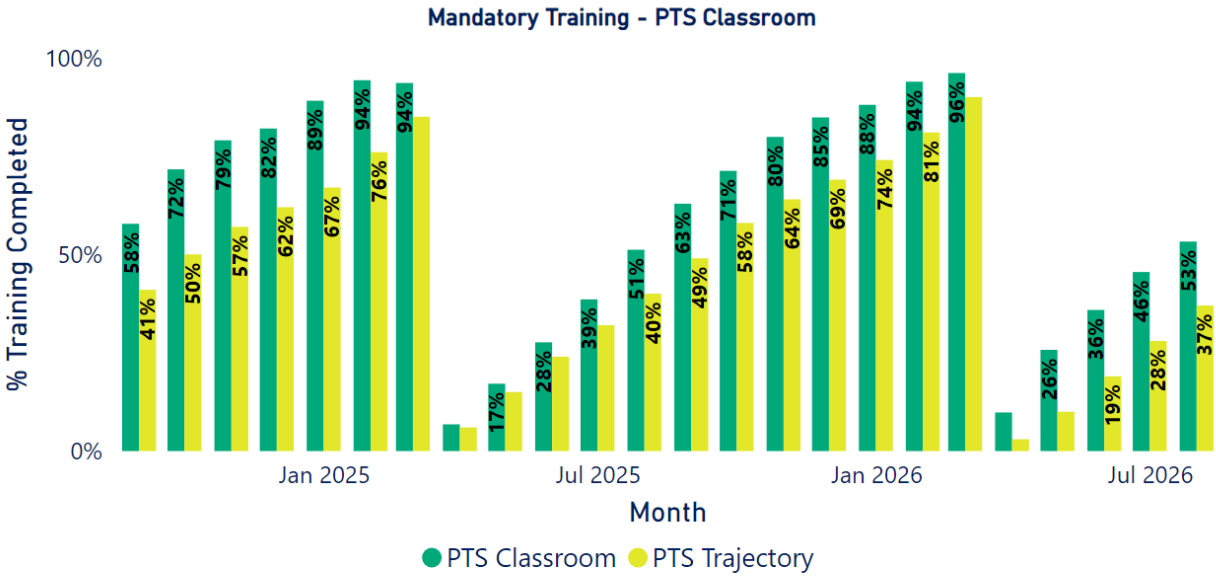
OH7 Mandatory Training



Summary: Overall compliance is above target at 91%.

Actions: Actions focused on targeting staff who have not attended training in 24 months to further minimise risks.

OH7 Mandatory Training



Summary: 2026~27 cycle Classroom attendance is above the target for both PES and PTS.

Action: Mandatory training compliance continues to be regularly monitored.

OH8 Case Management

NWAS Summary

Service Line	Live cases	Prevalence live cases (per 100 staff)	Cases closed in 12 months	Prevalence closed cases in 12 months (per 100 staff)	Avg weeks to close in 12 months (top 4 case type)
Operations ~ PES	76	1.82	288	6.90	12.90
PES CAL	15	1.17	115	9.00	11.19
PES CAM	36	2.63	103	7.51	14.43
PES GM	24	1.63	69	4.69	13.56
PES Other	1	1.95	1	1.95	14.57
Operations ~ ICC	42	2.46	180	10.53	11.01
Operations ~ PTS	24	3.55	71	10.50	11.11
Operations ~ Resilience	0	0.00			
Corporate	21	2.65	45	5.67	9.51
Other	6	0.00	8	0.00	15.43
Total	169	2.26	592	7.91	11.92

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 Sep 2025 to Aug 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	12	54	14.27
Disciplinary	56	155	22.42
Fact Finding	34	163	4.28
Grievance	30	148	8.35
Litigation	24	20	
Organisational Change	4	4	
Performance	9	48	
Total	169	592	11.92

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	1	3		12
Disciplinary	24	19	13		56
Fact Finding	29	4	1		34
Grievance	23	6	1		30
Litigation	9	4	7	4	24
Organisational Change	2		1	1	4
Performance	4	3	2		9
Total	99	37	28	5	169

Most common opening reasons for Disiplinary cases in 12 months

Opening reason	Count
Inappropriate / Unprofessional Behaviour	32
Dereliction of duty	20
Sexual misconduct	18
Failure to follow reasonable management instructions/procedures	13
Negligent Behaviour	11

Case Dismissals in last month

Case Type	Case Sub Type	Department	Outcome Date
ABS LTS	Non work related	CAL - Morecambe	05/08/2026
ABS LTS	Non work related	CAL - South Lancs	10/08/2026
ABS LTS	Non work related	GM - West	03/08/2026
ABS STS	Stage 4	CAL - Fylde	04/08/2026
Disciplinary	Gross misconduct	CAL - Fylde	04/08/2026
Disciplinary	Gross misconduct	ICC Call Handling	20/08/2026

New Litigation cases in last month

Case Type	Case Sub Type	Department	Received Date
Litigation	Discrimination		06/08/2026

Disciplinarys: Suspensions or alternative duties (live or in last month)

Status	Count
Alternative duties	0
Restricted practice (alt to suspension)	2
Suspension	13
Total	15

Summary: 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.

Actions: There remains a strong focus on reducing the number of long-standing cases while ensuring new cases are managed within tighter timescales. Timeliness continues to be affected by factors including police involvement, long-term sickness absence and availability of those involved in investigations. However, case progression is subject to robust oversight within directorates and through Trust Management Committee governance arrangement.

Average case times remains under 12 weeks, currently at 11.92. This is due to both volume and complexity of cases and we aim to keep that stable.



REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 27 May 2026
SUBJECT	2026 Winter Assurance Plan
PRESENTED BY	Dan Ainsworth, Executive Director of Operations
PURPOSE	Decision

STRATEGIC AIM(S)	Choose an item.							
BOARD ASSURANCE FRAMEWORK (BAF)	SR01	☒	SR02	☒	SR03	☒	SR04	☒
	SR05	☒	SR06	☒	SR07	☒	SR08	☒

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

ACTION REQUIRED	The Board of Directors is asked to: Approve the 2026/27 Winter Assurance Plan	
EXECUTIVE SUMMARY	The NWAS Winter Assurance plan has been fully revised and will form the strategic direction that will enable NWAS areas to revise and refine their tactical winter plans at each NWAS area level. This plan forms part of the wider assurance to NHSE and the Board Assurance Framework already circulated to NED colleagues. NWAS operational teams will use this strategic plan to underpin local, more detailed tactical plans with the objectives of supporting staff wellbeing, maintaining operational resilience, patient safety, workforce availability, and service continuity during winter. It is aligned with NHS England expectations and supports approval, monitoring and escalation through Trust and system governance routes.	
PREVIOUSLY CONSIDERED BY	Trust Management Committee	
	Date	23.9.2026
	Outcome	Approved



1. BACKGROUND

The plan provides a high-level assurance account for NWAS governance groups, NHS England, Integrated Care Boards, and system partners. It complements, rather than replaces, operational, tactical, clinical safety, business continuity, and adverse weather plans, and applies across all staff, services and departments.

The NWAS operational environment is working at or near full capacity all year round. There is limited scope to sustain long periods of increased operational resource deployment because of the need to balance this against planned training and other abstractions.

NWAS generally relies upon suspension of mandatory training during December, alongside reduction of annual leave over the festive fortnight to temporarily augment operational capacity.

Additional cover from private providers has already been procured this year and is at or near the capacity that the private sector can deliver.

Demand mitigation through public communication messaging forms part of the NWAS planning, along with response mitigation through maximisation of hear and treat.

2. HISTORIC DEMAND

NWAS emergency incident activity is predictable, while winter pressure primarily results from longer call cycle times, hospital handover delays, reduced patient flow, and constrained partner capacity. Delayed responses can also generate additional 999 calls from people seeking updated arrival times.

NWAS winter arrangements include demand forecasting, surge management, the Resource Escalation Action Plan, the Clinical Safety Plan, public wellness messaging, clinical validation, hear and treat, see and treat, safe non-conveyance, alternative care pathways, workforce and wellbeing measures, vaccination communications, fleet and logistics planning, severe weather arrangements and business continuity controls.

The charts below demonstrate that:

- The winter of 2022/23 was unusual, in that there were high numbers of 999 calls, but comparatively low numbers of incidents because fewer patients were prepared to wait because of long response times. This position was mirrored nationally and led to both investment in front line resources and the introduction of the interim C2 30 minute standard.
- Calls and incidents have been consistent over the last 3 winter periods, with short spikes, over the festive fortnight.
- Demand reduces back to the baseline by the end of January.
- Call cycle elongation occurs both on scene (+4 minutes) and at hospital (+12 minutes)
- Handovers in excess of 45 minutes can be predicted to increase beyond upper control limits.

- Average handover and handovers over 45 minutes do not correlate with average daily ED arrivals.
- HAS compliance has been improving for 3 years and has been consistently high since summer 2025. HAS compliance does not correlate with long handover.

3. NEXT STEPS

Each Area Head of Operations will produce a tactical delivery plan, with assurance provided by the relevant Area Director through existing area meetings. Weekly Resource Escalation Action Plan reporting, operational intelligence, regional coordination, system escalation discussions, and NHS England routes will support monitoring.

Winter command resilience will be increased by doubling tactical commanders in areas and formalising a standalone strategic oversight and coordination role.

4. RISK CONSIDERATION

The plan identifies risks involving system resilience, demand and acuity, adverse weather, workforce sickness and fatigue, moral injury, hospital handover, ambulance availability, supply chains, fleet, vulnerable people, digital and infrastructure resilience, and compound disruption.

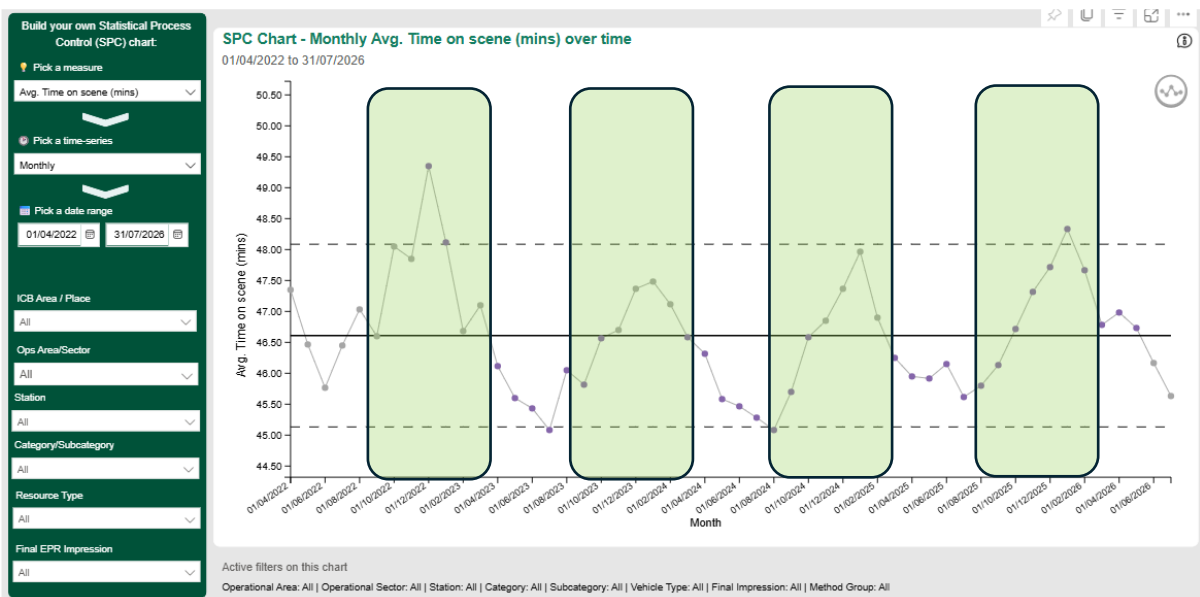
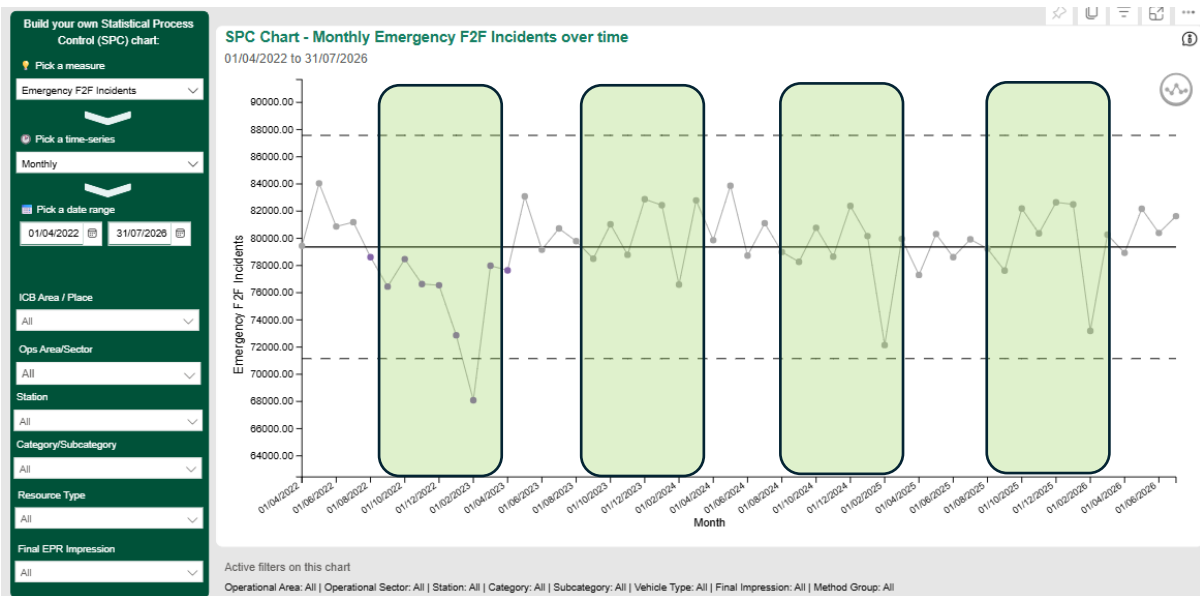
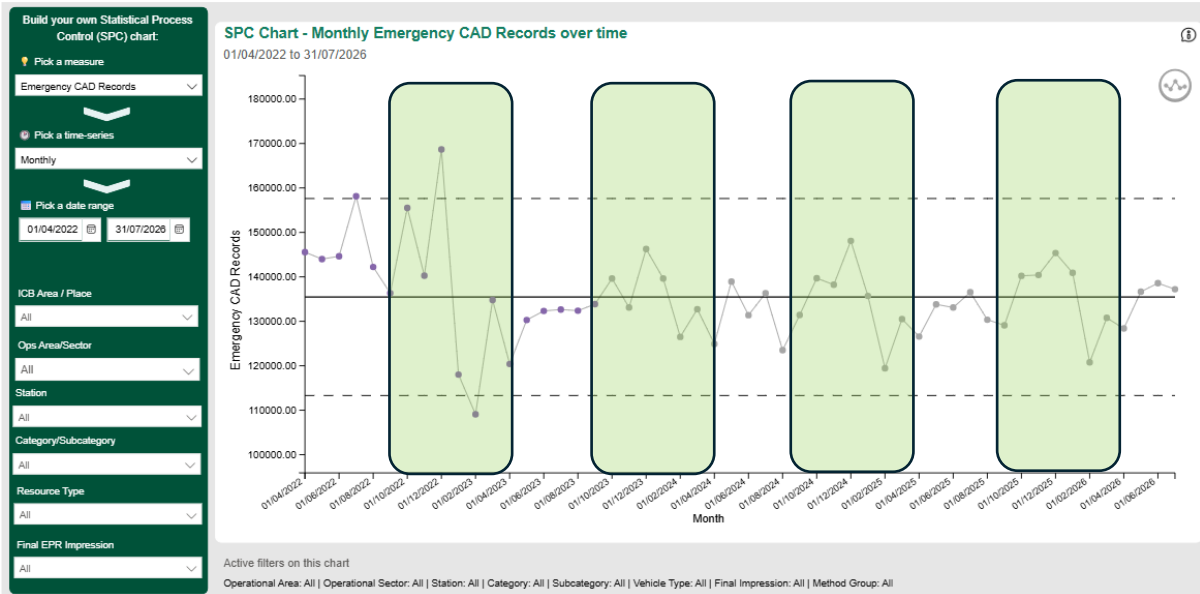
Dependence on partner organisations to maintain patient flow and alternative pathways remain a significant factor affecting ambulance availability and clinical risk in the community.

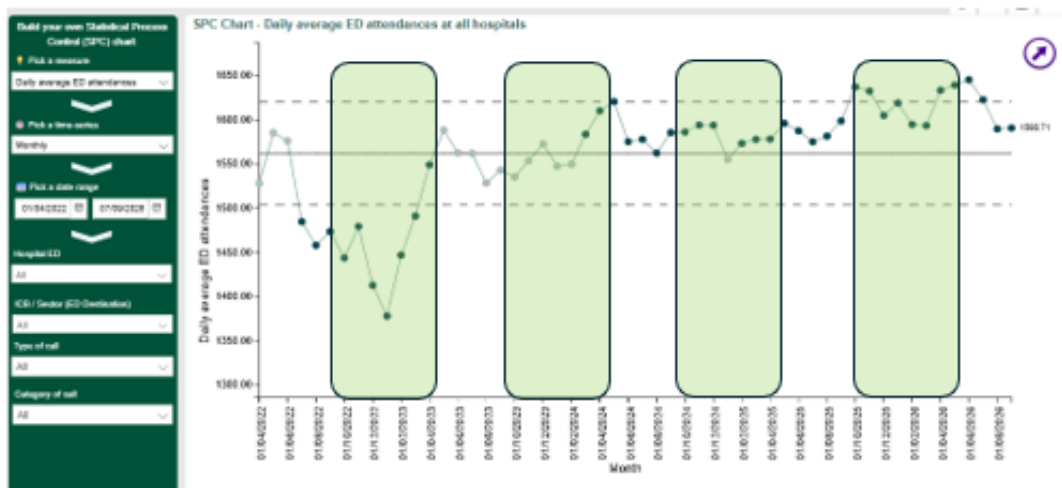
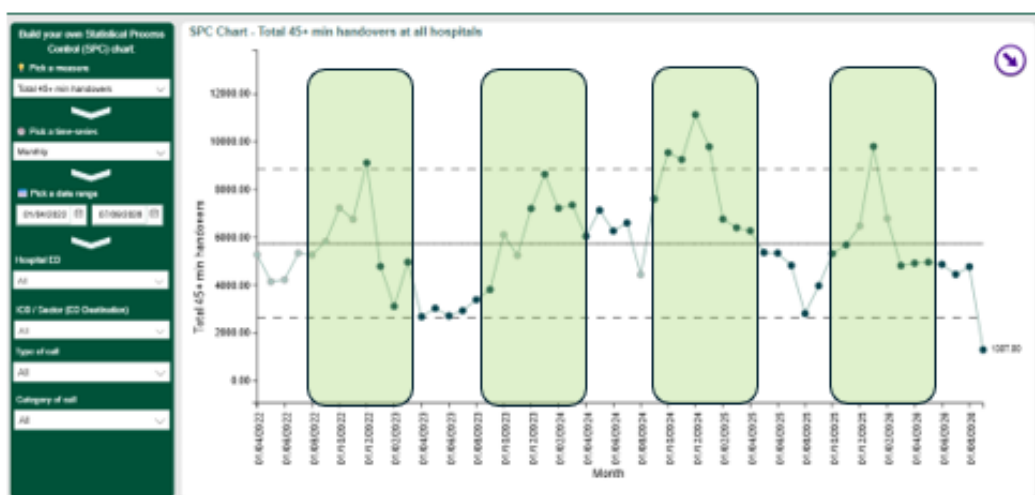
5. EQUALITY/ SUSTAINABILITY IMPACTS

There has been a Stage 1 EQIA completed alongside the planning template, and a round table discussion at TMC acting as a panel in line with the Stage 2 EQIA process.

It is important to note that the assurance plan brings together elements of existing operational plans (most notably the Clinical Safety Plan) that have individually been assessed and assured from an EQIA perspective. This assurance plan does not add any new risk.

There is no sustainability risk associated with this strategic plan.









NWAS

Winter Assurance Plan

2026-2027

NWAS Winter Assurance 2026-2027		Page:	1
Author:	Business Continuity Manager	Version:	2.5
Date of Approval:		Status:	Draft
Date of Issue:		Date of Review	

Recommended by:	Assistant Director of EPRR Steve Hynes
Approved by:	Ian Moses – Area Director – Cheshire & Merseyside
Approval date:	
Version number:	2.5
Review date:	
Responsible Director:	Dan Ainsworth – Executive Director of Operations
Responsible Manager (Sponsor):	Joanne Hodson Head of Contingency Planning
Responsible Manager (Author):	Andy Jackson Business Continuity Manager
For use by:	All staff and departments

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

NWAS Winter Assurance 2026-2027		Page:	2
Author:	Business Continuity Manager	Version:	2.5
Date of Approval:		Status:	Final
Date of Issue:	30 Sept 2026	Date of Review	31 Mar 2027

Change record form.

Version	Date of change	Date of release	Changed by	Reason for change
0.1	21/08/2023		A Jackson	Document creation
0.2	25/09/2024		C. O'Neill	Commissioner Comments/Review following discussion with NWAS colleagues on 24/09/2024
0.3	29/09/2024		J Hodson	Amendment of wording in line with the aim of provision of assurance.
0.4	07/10/2024		A Jackson	Amended to reflect above reviews.
1.0	12/12/2024	12/12/2024	A Jackson	Approved at TMC on the 27 November
1.1	01/07/2025		A Jackson	Review of document
1.2	10/07/2025		A Jackson	Following review by Winter Lead AD I Moses, additional information around specific risks for this year added. Also added forecasting data to the appendices following update from HoRP GL.
1.3	11/07/2025		A Jackson	Changes made following update from NHSE around section 4 and winter escalation. Other changes made to sentence structure on a number of points following a further review by Winter Lead AD I Moses
2.0	23.7.2025		I Moses	Approved at TMC
2.1	27/07/2026		A Jackson	Document Review Updated all sections to reflect the publication of the NHSE Winter planning guidance 2026-2027 - Added section 3 – Scope to reflect national guidance
2.2	05/08/2026		A Jackson	Updated following initial comments by IM.
2.3	06/08/2026		I Moses	Reviewed and comments added.
2.4	28/08/2026		A Jackson	Updated following review by IM, added: - Assurance Timeline - On-Call Hierarchy Info Graphic Reviewed and tighten section 2.

NWAS Winter Assurance 2026-2027		Page:	3
Author:	Business Continuity Manager	Version:	2.5
Date of Approval:		Status:	Final
Date of Issue:	30 Sept 2026	Date of Review	31 Mar 2027

2.5	13/9/2026		I Moses	Amendment to on call diagram and demand section.
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NWS Winter Assurance 2026-2027		Page:	4
Author:	Business Continuity Manager	Version:	2.5
Date of Approval:		Status:	Final
Date of Issue:	30 Sept 2026	Date of Review	31 Mar 2027

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Appendix 1 – Winter Forecast 2026-2027- Top 10 activity days 19

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Author:	Business Continuity Manager	Version:	2.5
Date of Approval:		Status:	Final
Date of Issue:	30 Sept 2026	Date of Review	31 Mar 2027

1. Introduction

- 1.1. The North West Ambulance Service (NWAS) NHS Trust provides urgent and emergency ambulance services across a large and diverse geographical area, serving a population of more than seven million people. Winter creates a predictable period of increased operational pressure for the Trust, driven in part by seasonal illness, adverse weather, higher levels of system demand and the potential for disruption across partner services.
- 1.2. Experience over recent years suggests that the primary cause of pressure on NWAS comes from how well partner acute trusts can deal with Emergency Department pressure and patient flow. NWAS operational demand is predictable and generally does not increase significantly in winter. What changes is the time taken to deal with that demand, as individual 999 call cycle times become lengthened, causing queues to form.
- 1.3. Further, normal NWAS community based referral pathways into primary care are affected by capacity because of lower level seasonal illnesses and increased pressure in those primary care services.
- 1.4. As a Category 1 responder under the Civil Contingencies Act 2004, NWAS is required to maintain robust emergency preparedness, resilience and response arrangements, including effective business continuity planning, risk assessment, warning and informing, and cooperation with system partners (Cabinet Office, 2004; NHS England, 2022). The Trust will therefore continue to monitor changes in local, regional and national risk profiles, including those reflected in the National Risk Register (HM Government, 2026), and ensure that winter planning is aligned to its statutory duties under the Civil Contingencies Act 2004 and wider NHS EPRR assurance responsibilities (Cabinet Office, 2004; NHS England, 2022).
- 1.5. NHS England published *Winter planning 2026/27 – expectations and assurance* on 17 July 2026, with the publication updated on 22 July 2026 (NHS England, 2026). This now provides the primary national framework for winter preparedness and assurance, replacing the previous expectation that a separate winter letter would follow later in the year. The publication sets out the national expectations for winter planning and includes board assurance statement self-assessment templates for trusts, integrated care boards and ambulance services. NWAS will use this guidance, alongside existing urgent and emergency care priorities and local system planning arrangements, to evidence preparedness, identify any outstanding gaps, and support assurance through Trust and system governance routes.
- 1.6. For the winter period in 2026-2027, NWAS will focus winter planning and assurance on the national expectations set out by NHS England (NHS England, 2026), including the requirement for robust, clinically led and deliverable winter plans, a named executive winter lead, testing through regional stress test exercises, and Trust Management Committee (TMC) approval using the relevant board assurance statement self-assessment template by 30 September 2026 (NHS England, 2026). The following areas will form the core focus of NWAS winter preparedness and assurance:
 - 1.6.1. **Clinically led winter planning and assurance** – NWAS will contribute to system winter plans that are clinically led, deliverable, and supported by clear planning assumptions, evidenced through our experience of delivering high quality of care in times of high service pressure. Trust arrangements will be reviewed through internal governance and aligned to the ambulance services Board Assurance Self-assessment process.
 - Demand, capacity and surge arrangements will be informed by winter forecasting, previous winter learning, local system intelligence and operational planning assumptions.

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- NWAS will continue to support clinical validation, hear and treat, see and treat, and appropriate non-conveyance where clinically safe, working with ICBs and system partners to maintain access to alternative pathways.
- Assurance will include the evidence used to demonstrate preparedness, including operational plans, escalation arrangements, workforce plans, clinical safety arrangements, adverse weather planning and business continuity controls.

1.6.2. Ambulance performance, patient safety and flow – NWAS will maintain focus on timely response, clinical safety, safe management of demand, hospital handover, ambulance availability and system flow throughout the winter period.

- Operational focus will include reducing avoidable conveyance where clinically appropriate, supporting access to urgent community response, same day emergency care, mental health, frailty, falls and other agreed alternative pathways.
- NWAS will continue to work with acute providers and ICBs to minimise ambulance handover delays and ensure timely release of ambulance resources back into the community.
- Escalation arrangements will support dynamic risk assessment, senior clinical decision-making and clear communication between NWAS, ICBs, acute providers and regional teams.
- Operational response and prioritisation will be determined by well-rehearsed measures set out within the NWAS Clinical Safety Plan.

1.6.3. System partnership and regional assurance – NWAS will work at area level with ICBs, NHS England regional teams, providers, local authorities, social care and wider partners to support shared situational awareness, coordinated escalation and delivery of agreed winter mitigations.

1.6.4. Workforce, wellbeing and vaccination – NWAS will maintain focus on workforce availability, abstraction management, staff wellbeing, sickness resilience and vaccination uptake, recognising the effect that winter illness and sustained operational pressure can have on service delivery.

- Plans will consider operational staffing, Integrated Contact Centre (ICC) resilience, clinical hub support, leadership and on call command capacity and the impact of seasonal illness, fatigue and adverse weather on staff availability.
- Staff communications will support vaccination, winter wellbeing, operational awareness and access to available wellbeing and leadership support during periods of sustained pressure.

1.6.5. Business continuity, severe weather and critical dependencies – NWAS will review the resilience of key operational dependencies, including fleet, estates, logistics and consumable items, medicines, oxygen, digital systems, communications, fuel, staff access and partner capacity.

This will include consideration of compound and cascading risks, where winter demand coincides with adverse weather, infrastructure disruption, workforce pressures, supply chain issues or wider system escalation.

- Business continuity plans will be reviewed to confirm that critical services can continue during periods of disruption.

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- Adverse weather arrangements will support safe operational delivery, staff access, vehicle availability and estates resilience.
- Critical dependencies will remain under review through winter governance, escalation and assurance processes.

1.3.6 Review and Approval

NWAS will use the ambulance services board assurance self-assessment (BASA) template to support assurance, review and approval of winter preparedness arrangements. Evidence will include winter forecasts, formation or area based tactical plans, escalation arrangements, business continuity plans, workforce and wellbeing arrangements, clinical safety processes, severe weather planning, system partner engagement and lessons identified from previous winter periods. The NHSE BASA document provides a high-level summary of those arrangements and will support assurance through Trust and system governance routes.

2. Purpose

- 2.1. This document provides a single, high-level source of assurance on NWAS preparedness for winter 2026-2027. It enables the Trust to demonstrate to its governance groups, NHS England, Integrated Care Boards (ICBs) and system partners that appropriate arrangements are in place to maintain operational resilience, patient safety and quality of care.
- 2.2. The document supports completion of the ambulance services board assurance self-assessment against NHS England's *Winter planning 2026/27 – expectations and assurance* publication (NHS England, 2026). It brings together the principal risks, controls, evidence sources and governance routes used to assess preparedness and identify any gaps, residual risks or dependencies requiring escalation.
- 2.3. Its purpose is assurance rather than operational direction. Delivery remains governed through the Trust's operational and tactical plans, escalation arrangements, clinical safety processes, workforce plans, adverse weather arrangements and business continuity controls, which provide the evidence underpinning this document.
- 2.4. Where assurance identifies a gap or material dependency, this will be assigned, monitored and escalated through the appropriate Trust, regional or system governance route. This maintains a clear line of sight between operational readiness, identified risk and senior oversight throughout the winter period.
- 2.5. Taken together, this provides an evidence-based account of preparedness, highlights matters requiring further action and supports transparent oversight of NWAS winter resilience for 2026-2027.

3. Scope and strategic intent

- 3.1. This document applies to NWAS winter assurance arrangements for 2026-2027 and provides a high-level summary of the Trust's preparedness, risks, mitigations, and evidence sources. It supports the Trust's response to NHS England's winter planning publication (NHS England, 2026) and the associated ambulance services board assurance self-assessment (BASA) process. It should be read alongside, rather than in place of, the Trust's operational plans, Incident Response Plan, tactical winter plans, Resource Escalation Action Plan, Clinical Safety Plan, Adverse Weather Plan, business continuity arrangements, and relevant system partner plans.

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- 3.2. The scope of this document includes arrangements for maintaining operational resilience, patient safety, workforce availability, business continuity, severe weather preparedness, demand and surge management, system escalation, hospital handover mitigation, and partnership working. It also describes how NWAS will use winter forecasting, previous winter learning, local risk assessment, and system intelligence to support evidence-based assurance through Trust and system governance routes. Although the primary focus is maintaining NWAS operational response and patient safety, the scope extends to all Trust staff, services, and departments, including operational, Integrated Contact Centre, clinical, corporate and support functions. This includes workforce health and wellbeing, seasonal vaccination, staff access during severe weather and departmental business continuity arrangements.
- 3.3. This document does not replace live operational decision-making, local command and control arrangements, departmental business continuity plans, area tactical plans, ICB winter plans or national reporting requirements. These arrangements remain managed through existing governance, escalation, and operational command structures. The document instead provides an assurance summary of the Trust's approach and the key evidence that supports winter preparedness for 2026-2027.
- 3.4. The NWAS strategic intent is to maintain response capability to patients and to ensure ongoing command and wellbeing support to operational staff.

4. Historic activity patterns

- 4.1 NWAS emergency incident activity is highly predictable. Whilst winter pressure generates some 'hot spot' periods, these are also predictable, are attributable to the activity on the wider health system, rather than to gross changes in inbound demand. The predictably higher activity days before and after Christmas are manageable because of efforts in acute trusts to maximise discharge pre-Christmas, and through the suspension of elective activity during the holiday season. The days of highest demand are predictably the first working days after New Year.
- 4.2 Our ability flex additional operational and ICC cover is delivered by a reliance upon pausing of mandatory training during December, embargoing of annual leave and widespread availability of overtime to work additional rostered hours.
- 4.3 Fleet services plan to do reactive maintenance and repair only during December.
- 4.4 999 call activity is affected by response capability. When responses are delayed, 999 calls increase because of secondary and tertiary ETA enquiries. In this scenario, the number of calls rises disproportionately to the number of incidents.
- 4.5 SPC analysis of activity over time demonstrates that emergency incidents have remained within upper and lower control limits over the last 4 years, with little seasonal variation. Incident counting for some Hear and Treat related activity in summer 2025 accounts for a notable change from autumn 2025 onwards.
- 4.6 Call management methodology has changed over time, with significant reliance upon the NWAS Clinical Hub to call back and safety-net waiting demand, and to safely close incidents with Hear and Treat outcomes.
- 4.7 Call cycle times, specifically time spent on scene and hospital handover increase significantly over winter, creating a demand and resource mismatch.

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5. Risks

5.1. NWAS' winter risk profile for 2026-2027 reflects the predictable increase in operational pressure associated with seasonal illness, adverse weather, higher system demand and reduced capacity across health and care partners. These risks can affect ambulance response, clinical safety, hospital handover, workforce availability, business continuity, and the Trust's ability to maintain timely and effective care. The risks outlined below will remain under active review through Trust governance, winter reporting, and escalation arrangements.

5.1.1. System resilience: Structural changes both locally and regionally, with loss of reporting structures and organisational knowledge will require additional NWAs leadership oversight and intervention.

5.1.2. Demand, acuity and surge pressure: Seasonal illness, respiratory infection, frailty, falls, worsening long-term conditions and festive-period demand can increase 999 and NHS 111 activity. This may place additional pressure on call handling, clinical validation, dispatch, ambulance availability, and access to appropriate alternative pathways.

5.1.3. Adverse weather and transport disruption: Snow, ice, flooding, storms, or prolonged cold weather can affect road networks, staff access to work, vehicle movement, estates resilience and access to patients, particularly in rural, remote, or poorly connected areas.

5.1.4. Workforce availability, sickness, and fatigue: Seasonal illness, caring responsibilities, adverse weather, sustained operational pressure and abstraction can affect operational, Integrated Contact Centre, clinical hub, support services and leadership capacity. Extended periods of pressure can also increase fatigue and wellbeing risks for staff.

5.1.5. Moral injury and external relationship breakdown: It is vital to acknowledge the impact of circa 3 years of persistent delays and queueing at some hospital sites. There has been little, if any, respite since last winter, indeed some sites are far worse, leading to frustration and fractured relationships.

5.1.6. Hospital handover, system flow and ambulance availability: Increased hospital occupancy, emergency department crowding, delays to discharge and reduced community or social care capacity can affect patient flow. Ambulance handover delays reduce the availability of ambulance resources in the community and can increase risk for patients awaiting response.

5.1.7. Supply chain, fleet and critical resource availability: Disruption to medicines, oxygen, consumables, fuel, vehicle maintenance, make-ready services, logistics or equipment supply could affect operational delivery. These risks may increase due to severe weather, wider infrastructure disruption or increased system demand.

5.1.8. Vulnerable people and health inequalities: Vulnerability may be more likely to affect the oldest and youngest people in our communities, people with long-term conditions or respiratory illness, individuals experiencing mental health crisis, and those who are socially isolated or affected by fuel poverty. These groups may be disproportionately affected during winter. Delays in access to care, reduced community capacity or severe weather may increase the risk of harm.

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5.1.9. Digital, communications and infrastructure resilience: Disruption to telephony, CAD, other Integrated Contact Centre systems, digital platforms, interoperable communications, power, water, fuel or estates infrastructure could affect service delivery, situational awareness and command arrangements during periods of winter pressure.

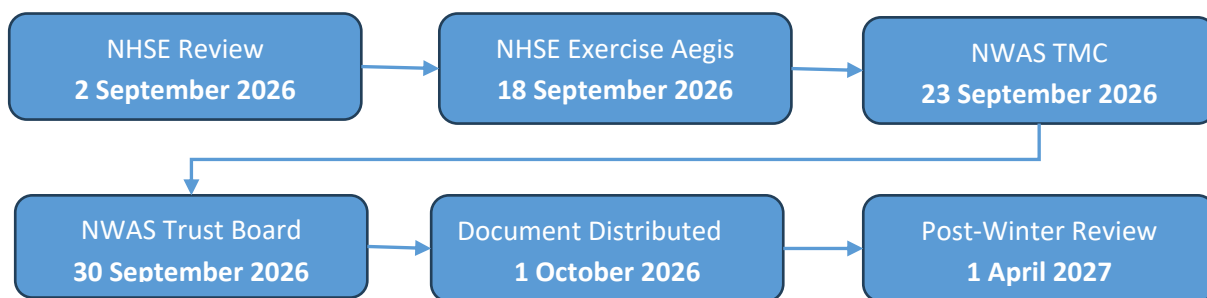
5.1.10. Compound and cascading disruption: Winter risks may occur concurrently, for example high demand combined with adverse weather, workforce sickness, handover delay, fuel disruption, digital outage or wider system escalation. These interdependencies may increase the overall impact and reduce the effectiveness of individual mitigations if not managed as a combined risk profile.

5.2. Risk mitigation for winter 2026-2027 will be supported by existing Trust plans, seasonal preparedness activity and system partnership arrangements. This includes demand forecasting, continuation of REAP and escalation arrangements, the Clinical Safety Plan, case by case response to notified periods of adverse weather, workforce and wellbeing plans, including the seasonal vaccination programme, fleet and logistics planning, business continuity arrangements, winter communications, and continued work with ICBs, acute providers and regional teams to manage system pressure.

5.3. Assurance will be maintained through review of the controls in place, including operational and tactical plans, business continuity plans, winter forecasts, workforce and clinical safety arrangements, adverse weather planning, reporting and escalation routes, and learning from previous winter periods. Where risks exceed normal tolerance or mitigations are dependent on wider system action, these will be escalated through the appropriate Trust, regional and system governance arrangements.

The winter risk profile will remain dynamic and will be reviewed throughout the winter period using operational intelligence, demand data, staff availability, handover performance, weather warnings, system escalation levels, business continuity updates and feedback from local and regional coordination routes. This will support timely adjustment of mitigations and provide an evidence base for post-winter review and organisational learning.

Assurance Timeline



6. Reporting & Escalation

6.1. **Winter reporting and assurance route:** Winter reporting arrangements will support timely situational awareness, risk escalation and assurance throughout the 2026-2027 winter period. NWS will use internal reporting, operational intelligence, demand data, handover performance, workforce information, weather alerts and system updates to monitor pressure, identify emerging risks and support decision-making. Reporting

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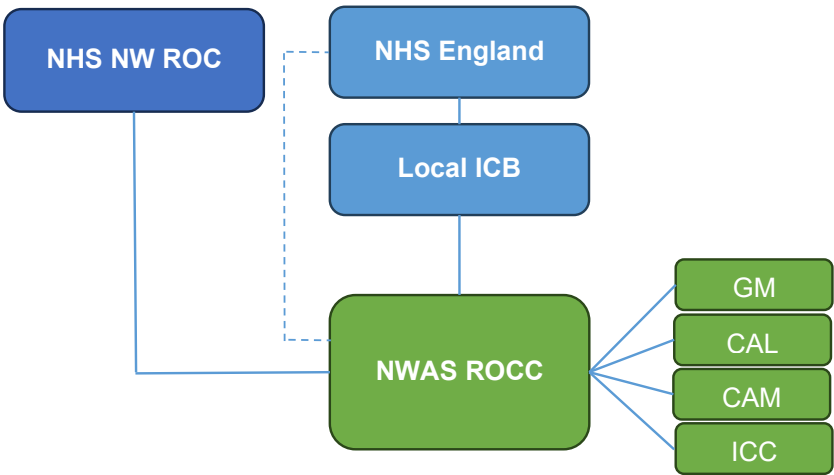
will be aligned to Trust governance, regional coordination arrangements and any national or NHS England regional winter reporting requirements.

6.1.1. Following publication of this strategic plan, each area Head of Operations will draw up a tactical delivery plan. That tactical plan will be assured through existing area assurance meetings by each Area Director.

6.1.2. NWAS will maintain situational awareness through established weekly internal REAP reporting and regional coordination routes during the winter period. This will include the use of NWAS operational reporting, Regional Operational Coordination Centre (ROCC) arrangements, system escalation information and relevant updates from NHS England regional teams and ICB System Coordination Centres (SCCs).

6.1.3. Regional reporting will support shared understanding of demand, ambulance handover, system pressure, staffing, adverse weather, operational disruption and any emerging risks to patient safety or service continuity. The frequency and format of reporting meetings will be adjusted in line with national, regional and system requirements, informed by the level of operational pressure and dynamic risk assessment.

6.1.4. Where pressures increase or risks emerge outside routine reporting arrangements, additional escalation discussions may be convened through NWAS, NHS England regional teams, ROCC, SCCs and relevant system partners. These discussions will support timely decision-making, agreed mitigations and clear escalation of issues requiring senior or multi-agency action.



6.2. System Partnership and ICB Coordination

6.2.1. During the winter period, NWAS will work with Integrated Care Boards (ICBs), NHS England regional teams, acute providers, community services, mental health services, local authorities and social care partners to support shared situational awareness, patient flow, demand management and coordinated escalation. This partnership approach will support delivery of the national winter planning expectations and the evidence required for assurance through Trust and system governance routes.

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- **Shared system coordination and patient flow:** NWAS will continue to work with ICBs, acute providers, community services and social care partners to support coordinated system management, improve patient flow and reduce ambulance handover delays. This will include shared escalation discussions and joint mitigations where system pressure affects ambulance availability or patient safety.
- **Alternative pathways and capacity management:** NWAS will work with ICBs and system partners to support the availability and use of appropriate alternative pathways, including urgent community response, same day emergency care, frailty, falls, mental health and other agreed services. This will help ensure that patients are directed to the most appropriate care setting and that avoidable conveyance is reduced where clinically safe.
- **Data sharing, communication and situational awareness:** NWAS will continue to support timely information sharing with ICBs and system partners to maintain a shared understanding of demand, capacity, handover performance, escalation levels, adverse weather, operational disruption and emerging risks. Clear communication routes will support decision-making during periods of increased pressure.
- **Proactive management of patients with complex needs:** NWAS will continue to work with ICBs, primary care, community services, mental health services and social care partners to support proactive management of patients with complex needs, long-term conditions, frailty or mental health needs. This will support care closer to home where appropriate and reduce avoidable demand on urgent and emergency care services.
- **Senior decision-making, escalation and system mitigation:** NWAS will work with ICBs, NHS England regional teams and provider partners to support timely senior decision-making where winter pressures affect patient flow, ambulance handover, clinical risk or service continuity. This will include escalation to appropriate senior and system forums where coordinated action is required.

6.2.2. Through this partnership approach, NWAS will support system resilience while maintaining focus on operational delivery, patient safety and high-quality care during the winter period. The effectiveness of these arrangements will be reviewed through reporting, escalation, assurance and post-winter learning processes.

7. Organisational Resilience

7.1. Organisational resilience for winter 2026-2027 will be supported by area, departmental and corporate tactical plans and business continuity plans that describe how NWAS will maintain safe and effective operational delivery during periods of increased demand, adverse weather, staffing pressure and wider system escalation. These plans sit alongside the Trust's Resource Escalation Action Plan, Clinical Safety Plan, Adverse Weather Plan, business continuity arrangements and local operational procedures. Together, they provide the evidence base for winter assurance and support the Trust's ability to maintain patient safety, staff welfare and service continuity throughout the winter period. The main assurance areas are:

7.1.1. Demand Forecasting & Surge Management

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Demand, forecasting and surge arrangements will support the Trust's ability to anticipate and respond to increased 999 and NHS 111 activity during the winter period. Plans will use winter forecasting, previous winter learning, operational intelligence and system information to inform resource allocation, escalation decisions, clinical safety measures and the use of available capacity. This will include consideration of call handling, clinical validation, dispatch, ambulance availability, alternative pathways and safe non-conveyance where clinically appropriate.

This approach will be supported by established Trust arrangements, including:

- Resource Escalation Action Plan (REAP) (NWS, 2021)
- Clinical Safety Plan (CSP) (NWS, 2025)

Call demand modelling is undertaken by the NWS Regional Planning Team and is included in Appendix 1. The modelling informs planning assumptions for the winter and festive period and supports evidence-based review of anticipated demand, capacity and surge requirements.

- Review of historical emergency call data, excluding periods where activity was materially affected by COVID-19.
- Consideration of seasonal patterns, including day of the week, bank holidays, festive-period behaviour and previous winter demand trends.

The Regional Planning Team will review forecast demand against actual activity following the winter period. This will support learning, improve confidence in future forecasting and inform post-winter review.

7.1.2. Fleet, logistics and critical resources

Fleet, logistics and critical resource arrangements will support the continued availability of ambulances, specialist vehicles, medicines, oxygen, consumables, equipment, fuel and make-ready services during the winter period. Planning will include vehicle maintenance, adverse weather readiness, supply chain monitoring and arrangements for maintaining access to essential resources during periods of disruption or increased demand. The Trust will continue to review fleet and logistics risks through operational, business continuity and escalation processes.

7.1.3. Area Tactical Implementation

Each operational area will translate the requirements and assurance themes within this document into a locally owned tactical winter plan. The plan will describe the actions, resources, decision-making arrangements and escalation triggers required to maintain safe service delivery under anticipated winter conditions, while remaining sufficiently adaptable to respond to emerging or compound pressures.

As a minimum, each area tactical plan will identify local risks and planning assumptions, named leads and responsibilities, readiness actions, escalation triggers, critical resources and dependencies, staff welfare arrangements, and interfaces with Trust and system partners. Plans will align with REAP, the Clinical Safety Plan, adverse weather and business continuity

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arrangements, and clearly set out how actions which will be activated, monitored and escalated. Any unresolved risks or dependencies requiring wider Trust or system action will be raised through the appropriate governance route.

Tactical plans will also confirm command arrangements and any special command considerations in place for known high activity dates (New Years Eve for example).

7.1.4. System collaboration, patient flow and alternative pathways

The effectiveness of area tactical plans will depend on close collaboration with system partners throughout the winter period. NWAS will continue to work with ICBs, acute providers, community services, mental health services, local authorities and social care partners to support patient flow, reduce ambulance handover delays and maintain access to appropriate alternative pathways. This includes coordinated escalation, shared situational awareness and joint mitigations where system pressure affects ambulance availability, patient safety or service continuity. The availability and use of urgent community response, same day emergency care, frailty, falls, mental health and other agreed pathways will remain an important part of winter resilience.

7.1.5. Workforce, wellbeing and vaccination

Workforce resilience arrangements will focus on maintaining operational, Integrated Contact Centre, clinical hub, support service and leadership capacity during the winter period. Planning will consider seasonal sickness, abstraction, fatigue, adverse weather, staff access and the effect of sustained operational pressure on wellbeing. Workforce information will be used alongside demand, handover and escalation data to support dynamic risk assessment and decision-making.

Staff wellbeing and vaccination communications will support staff to remain well, access support and understand winter operating arrangements. This will include promotion of vaccination, wellbeing resources, operational updates and leadership communication during periods of increased pressure. The Trust will continue to monitor workforce risks and escalate concerns where staffing, fatigue or wellbeing issues affect service resilience.

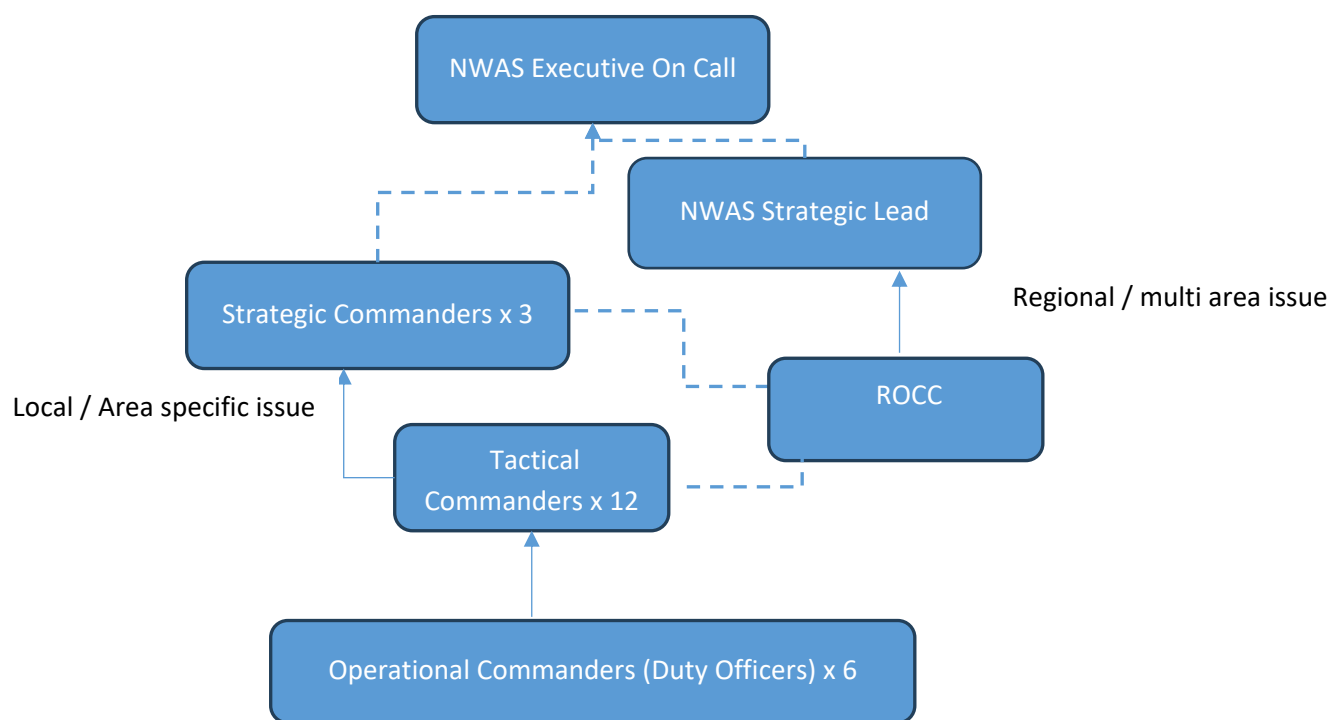
7.1.6. Communications, public messaging and operational awareness

Effective communication will support demand management, staff awareness and coordinated system response during winter. Public messaging will promote appropriate use of 999 and NHS 111, support people to stay well, and signpost to alternative care options where appropriate. Internal communications will ensure that staff are aware of operational changes, escalation arrangements, weather alerts, capacity issues and welfare support. NWAS will work with NHS England, ICBs and system partners to support consistent public and staff messaging during periods of pressure.

7.1.7. Command Resilience

NWAS maintains a resilient on-call command structure to support the effective management of operational pressures, incidents and escalation requirements throughout the winter period. The command hierarchy, shown below, provides Executive, Strategic, Tactical and Operational leadership capacity across the Trust.

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7.2. For Winter 2026/27 the On call structure will be enhanced by doubling the number of tactical commanders available in areas, and buy formalising a standalone strategic lead oversight and coordination role. This role will not remove the decision making authority of the area strategic commander, but where issues (for example protracted handover) it will provide a single regional response for engagement with NHSE etc. This function will be carried out by Area Directors and Heads of Operations only.

7.3. By integrating these tactical plans, controls and assurance processes into the overall winter assurance approach, NWAS will be better able to mitigate seasonal pressures, maintain operational effectiveness and provide safe, high-quality care throughout the 2026-2027 winter period.

8. Review

8.1. This Winter Assurance document will be reviewed following the 2026-2027 winter period to confirm whether it remained fit for purpose and aligned to NHS England’s winter planning expectations. The review will consider operational performance, winter risks, escalation activity, system pressures, assurance evidence, stakeholder feedback and learning identified during the period.

8.2. The area tactical plans and departmental or corporate business continuity arrangements that support this document will be reviewed to confirm whether the planned mitigations, controls and escalation arrangements were effective. Where learning identifies a need to amend local arrangements, changes will be agreed through the appropriate operational, resilience, business continuity or governance route.

8.3. Business as usual arrangements will continue to apply throughout the winter period, supported by dynamic risk assessment and escalation where required. Where a business continuity incident, critical incident or significant surge-related event occurs, NWAS will undertake an appropriate debrief process to identify immediate safety issues, improvement actions and any learning requiring wider dissemination.

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- 8.4. NWAS will participate in relevant NHS England regional, ICB or system-led exercises, stress tests and debriefs to support assurance, test capacity plans and identify opportunities for improvement. Learning from these activities will be used to refine winter arrangements and inform future planning.
- 8.5. At the end of the defined winter period, NWAS will complete an internal structured debrief and engage with system partners in external debrief processes where required. Learning will be reviewed through appropriate Trust governance routes and used to support post-winter reporting, future winter planning and organisational resilience.

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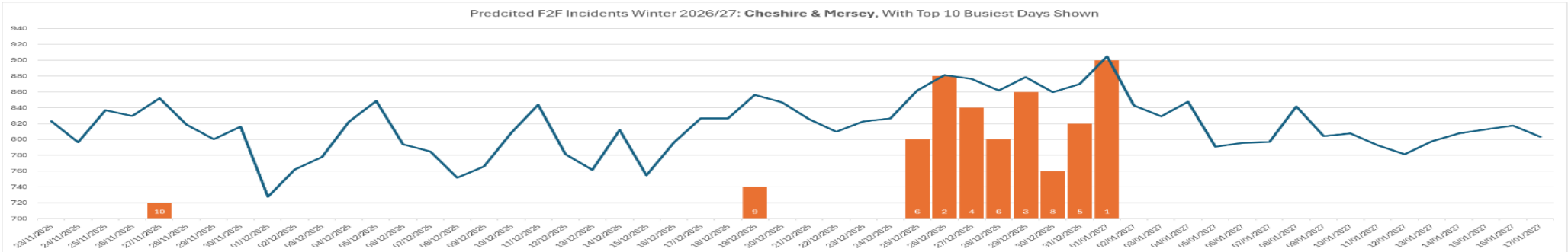
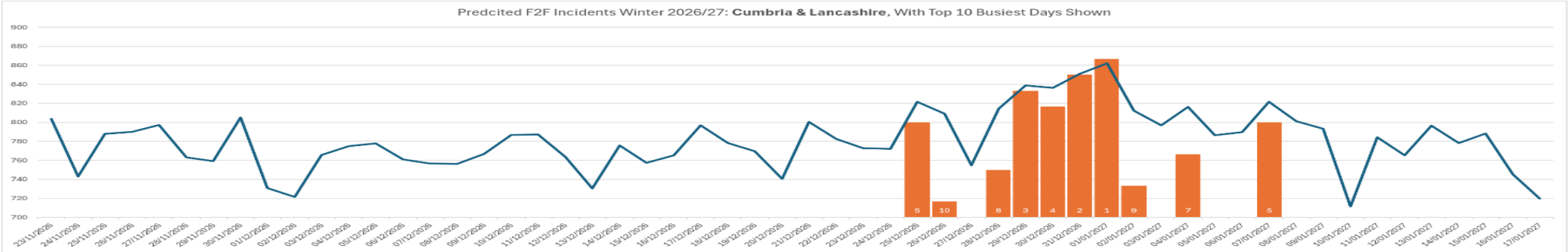
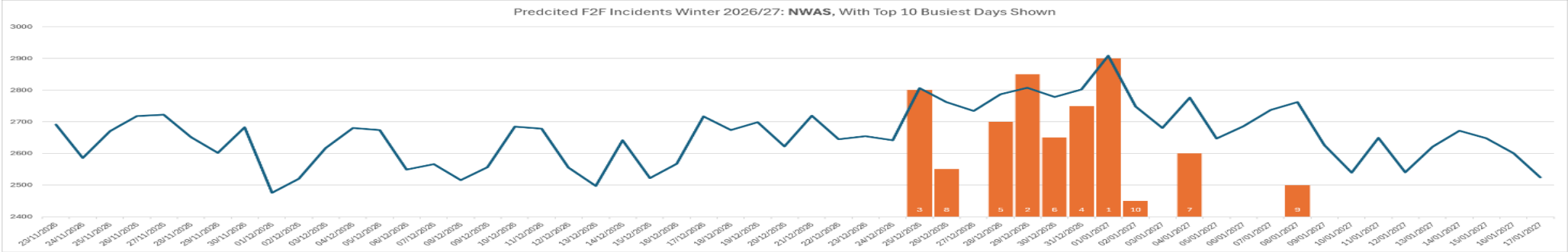
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Appendix 1 – Winter Forecast 2026-2027- Top 10 activity days



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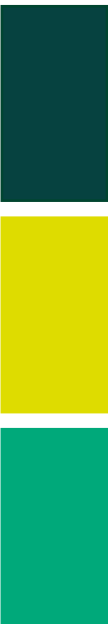
REPORT TO THE BOARD OF DIRECTORS

DATE	30/09/2026
SUBJECT	EPRR Core Standards Annual Assurance
PRESENTED BY	Director of Operations
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 assurance on NWS readiness, preparedness and EPRR activity during the reporting period. - Note the principal risks, gaps and improvement priorities. - Be satisfied that governance and resource arrangements are sufficient for the Trust to discharge its EPRR duties.
EXECUTIVE SUMMARY	NWS is reporting a substantially compliant position for the 2026 EPRR Core Standards. The Interoperable Capabilities Standards are partially compliant at 88%. This principally relates to SORT deployment arrangements, ICC training and control room readiness, commander assurance and HART estate, staffing and reporting requirements. The Board can take assurance that NWS has maintained the core arrangements required to discharge its EPRR responsibilities, including risk assessment, planning, training, exercising, command and control, specialist response, business continuity and multi-agency engagement. The areas of partial compliance are understood, have identified improvement routes and are being monitored through established governance. Assurance is supported by evidence from incident response, plan review, training, business continuity activity and 106 recorded exercises involving NWS. Learning from incidents, exercises, debriefs, Prevention of Future Deaths reports, external reviews and Joint Organisational Learning is now being coordinated through the



	Resilience Learning Oversight Group, strengthening the route from learning identified to action and impact monitored.	
	The 2026/27 EPRR improvement plan will focus on SORT deployment review, ICC JESIP compliance, routine ICC testing, completion and validation of plans, business continuity exercising, commander assurance and stronger evidence that learning is embedded and reduces recurrence. No new corporate risks are proposed at this stage because the gaps are being managed through active improvement programmes and existing governance routes; this position will be reviewed if delivery timescales slip or residual risk increases.	
PREVIOUSLY CONSIDERED BY	N/A	
	Date	
	Outcome	

1. BACKGROUND

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could include adverse weather, infectious disease outbreaks, major transport accidents, cyber incidents or terrorism. This is underpinned by the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022.

NHS England EPRR Core Standard 3 requires the Chief Executive Officer to ensure that the Accountable Emergency Officer provides EPRR reports to the Board no less than annually and that the organisation publicly states its readiness and preparedness activities within its regulatory reporting requirements. The public Board report must include training and exercising, incidents since the previous report, lessons and learning, and the outcome of the latest annual EPRR assurance process.

This report therefore provides assurance on whether NWS has prepared for the right risks, maintains current and usable arrangements, can mobilise a competent response, has tested its preparedness, has learned and improved, and has an evidence-based overall assurance position.

2. ANNUAL ASSURANCE

The 2026 EPRR annual assurance process has reviewed evidence across governance, risk, plans, training, exercising, response, business continuity, specialist capabilities and lessons management. **NWS is reporting a substantially compliant position for the main EPRR Core Standards and partially compliant in the Interoperable Capabilities Standards.**

Focus	2025		2026	
Ambulance provider	93%	Substantially compliant	95%	Substantially compliant
Interoperability	90%	Substantially compliant	88%	Partially compliant

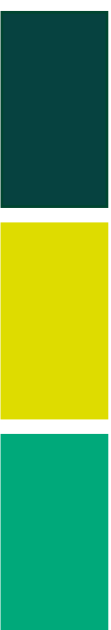
The main EPRR Core Standards position has improved from 2025. The Interoperable Capabilities Standards percentage has reduced from 90% to 88%, moving from substantially compliant to partially compliant. These standards are being treated as an improvement priority because testing has identified changes required to the deployment model, control room arrangements and supporting documentation. ICC restructures have also affected some training figures as new staff come into post.

No new corporate risks have been added for these standards at this stage because the gaps are already being managed through active improvement programmes and existing governance routes. The position will be reviewed if delivery timescales slip, assurance does not improve, or residual risk increases.

EPRR Core standards – gaps and actions

There are 3 standards that have been reported as partially compliant.

5 EPRR resource: Partial compliance reflects the limited ability to exercise wider frontline staff within current resource arrangements. This remains dependent on the national funding position. In the interim, the Trust will continue to explore proportionate options to increase frontline exercising within available capacity.



26 Incident Coordination Centre: The Trust has ICC facilities in place, but evidence of regular testing is not yet sufficiently available. This links directly to the control room improvement work identified within the Interoperable Capabilities Standards. The Core Standard gap relates to facility and routine testing assurance, while the Interoperable Capabilities gaps relate to operational readiness, role structure, action cards, JESIP compliance and familiarisation with specialist response capabilities. Recovery will be progressed through ICC-led improvement work and linked into the developing Regional Operational Coordination Centre arrangements.

51 Business continuity audit: Partial compliance relates to the planned alignment with ISO 22301. The approach was supported during the Board development day and the Resilience Team is working with other ambulance services to identify the most cost-effective delivery route. An update will be provided to EPRR Group in October 2026.

Interoperable Capabilities Standards – gaps and actions

Sixteen standards have been submitted as partially compliant. The themes are summarised below, with the detailed standard-by-standard table included in Appendix 2.

HART: Partial compliance relates to staffing consistency, response standard reporting, attendance expectations for strategic sites and estate provision. Recruitment has improved the staffing position and compliance is close to the required level, with full compliance dependent on sustained delivery over a rolling three-month period. Further work is in hand to identify a more effective digital reporting solution, review attendance arrangements with ICC and continue the Ashburton Point estate update.

SORT: Testing of SORT deployment arrangements identified the need to streamline tasking, clarify incident identification and strengthen response time arrangements. The assurance concern is not that arrangements are absent, but that testing has shown they need updating to ensure they are consistently usable under operational pressure. These actions are being addressed through the SORT plan review, ICC role structure and action card review, with an update scheduled for EPRR Group in October 2026.

Control rooms: ICC compliance has been affected by changes to the control room staffing structure and role requirements. Training compliance, control room familiarisation with specialist capabilities and JESIP awareness are below the expected position. Recovery is being led by the Assistant Director ICC as part of a wider training package review, with performance monitored through established governance routes.

Commander standards: Commander assurance is below the 90% minimum threshold in several areas, including National Occupational Standards compliance, CPD evidence, exercise attendance, competence assessment and loggist CPD. Compliance varies across strategic, tactical and operational cohorts, with some figures affected by small cohort size and roster changes. Area Directors are reviewing commander compliance, the CARE team is developing a methodology to assess evidence quality and commander competence, and loggist requirements are being reviewed to ensure they remain appropriate and achievable.

More detail is given in appendix 2.

3. LEARNING AND IMPROVEMENT

Learning continues to be identified from incidents, exercises, debriefs, Prevention of Future Deaths reports, external reviews and Joint Organisational Learning. Recurring themes include JESIP and shared situational awareness, communications and interoperability, command role clarity, CBRN preparedness, scene management, information quality, proportionate resourcing, plan usability and action cards.

The new Resilience Learning Oversight Group provides a formal route to review learning sources, allocate recommendations, monitor actions and link with wider clinical learning where appropriate. The current gap is not the identification of learning, but the consistency of evidence that learning has been implemented, embedded and has reduced recurrence. This is a priority for the 2026/27 improvement plan.

4. ORGANISATIONAL READINESS AND PREPAREDNESS

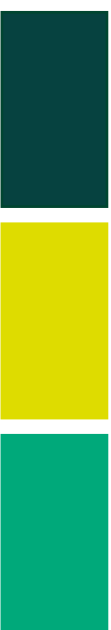
NWAS continues to plan against national, regional, community and organisational risks. The Resilience Risk Register currently contains 13 active risks, including utilities disruption, infectious disease, pandemic, industrial action, major incident vehicle availability, threat-level escalation and logbook storage. Two newer risks relating to threat level increase and working at critical threat level are being progressed with Resilience and Health and Safety colleagues. Risks are reviewed through EPRR Group, supported by Resilience and Risk teams. NWAS also actively input into Local Resilience Forum risk assessment arrangements.

The Trust maintains site-specific plans, operational orders, risk-specific plans and business continuity plans. Risk-specific plans are reviewed and tested through workshops and tabletop exercises. There are 18 risk-specific plans: 14 are in date, including three recently tested and being updated; four are overdue but under review. Completion of overdue reviews, plan validation and business continuity exercising remain areas for continued focus.

Training and competence arrangements remain in place for command, command support and specialist roles through the Trust Training Needs Analysis, annual commander training, exercises, JESIP e-learning, CBRN command courses, Principles of Health Command, MAGIC, media training and NILO development routes. JESIP e-learning compliance is above the 90% minimum threshold across most staff groups, but ICC remains below threshold at 85%, requiring targeted follow-up.

Preparedness has been tested through 106 recorded exercises between September 2025 and September 2026, covering varied scenarios and exercise types, with the majority involving multi-agency partners. Non-specialist staff participation remains limited and is reflected in partial compliance for the relevant Core Standard and the national discussion regarding additional funding.

Major incidents involving NWAS during the reporting period included the Crumpsall synagogue attack, the Shap train derailment and the Burscough level crossing incident. Business continuity incidents were predominantly associated with ICC systems disruption, including Directory of Service, CAD and other system failures. Response arrangements are being used in practice, but notification, reporting, review and learning processes require continued strengthening.



Overall, NWS has maintained the core arrangements required to prepare for, respond to and recover from disruptive incidents and emergencies. The areas requiring further improvement are known and are being managed through the 2026/27 EPRR improvement plan.

5. RISK CONSIDERATION

Failure to maintain effective EPRR arrangements could reduce organisational readiness, regulatory confidence and the Trust's ability to respond to incidents and emergencies. The 2026 assurance position remains substantially compliant; however, partial compliance areas require continued oversight through the 2026/27 improvement plan, particularly SORT deployment review, ICC JESIP compliance, business continuity exercising and evidence of embedded learning.

6. EQUALITY/ SUSTAINABILITY IMPACTS

Effective EPRR arrangements support equitable access to safe care during incidents, emergencies and periods of disruption. The Resilience Team continues to work with operational, clinical and corporate teams to ensure preparedness, response, recovery and business continuity arrangements consider equality, equity and sustainability impacts.

Appendix 1

Glossary

Term	Explanation
CBRN	Chemical, biological, radiological and nuclear — incidents involving hazardous substances or materials that may require specialist response arrangements.
COMAH	Control of Major Accident Hazards — regulations for industrial sites where major accidents involving dangerous substances could occur.
DO	Duty Officer — an operational manager who may respond as an Operational Commander and support incident management.
EPRR	Emergency Preparedness, Resilience and Response — the arrangements used to plan for, respond to and recover from incidents and emergencies.
HART	Hazardous Area Response Team
Hazmat	Hazardous materials — substances that may present a risk to people, responders or the environment.
HCID	High consequence infectious diseases — serious infectious diseases that may require specialist public health and operational arrangements.
ICC	Integrated Contact Centre — the Trust function responsible for emergency call handling, dispatch and associated control room functions.
IOR	Initial Operational Response
JESIP	Joint Emergency Services Interoperability Principles — a national approach to help emergency services work together effectively during incidents.
JOL	Joint Organisational Learning — a national process for sharing learning from incidents and exercises across responder organisations.
MAGIC	Multi-Agency Gold Incident Command — strategic-level training for senior leaders involved in multi-agency incident response.
MERIT	Medical Emergency Response Incident Team
METHANE	Situation reporting method as per method
MTA	Marauding Terrorist Attack — an attack involving one or more mobile attackers where specialist multi-agency response arrangements may be required.
NILO	National Inter-Agency Liaison Officer — a specialist advisor who supports information sharing and joint working between agencies.
NOS	National Occupational Standards — recognised standards describing the competence required for specific roles or functions.
REPIR	Radiation (Emergency Preparedness and Public Information) Regulations — requirements for planning and public information in relation to radiation emergencies.
RVP	Rendezvous Point
SORT	Special Operational Response Team
TNA	Training Needs Analysis — a process used to identify the training required for roles, staff groups or functions.
TTX	Tabletop exercise — a discussion-based exercise used to test plans, roles and decision-making.

Appendix 2

Core standards progress tables

NWAS submit the general set of core standards which includes 111 and Patient Transport service. The Trust also submits the interoperability core standards which covers specialist operations, command, and embedding of JESIP.

The tables below show the reported compliance position by domain. The main EPRR position improved, and the interoperability position affected by identified SORT deployment review requirements. Actions are underway to address the partially compliant standards and improve the assurance around the others.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	4	1	0
Warning and informing	4	4	0	0
Cooperation	5	5	0	0
Business Continuity	11	10	1	0
Hazmat/CBRN	1	1	0	0
CBRN Support to acute Trusts	7	7	0	0
Total	58	55	3	0

Interoperable capabilities	Total standards applicable	Fully compliant	Partially compliant	Non compliant
HART	32	28	4	0
SORT	40	37	3	0
MassCas	14	14	0	0
C2	36	29	7	0
JESIP	13	10	3	0

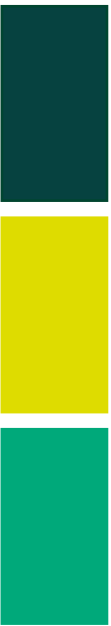
Total	135	118	17	0
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Overall assessment:	Substantially compliant
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Interoperable capabilities:	Partially compliant
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Interoperable capabilities core standards	
Standard	Action
H8 6 HART staff on duty	An increase in staff has taken place through recruitment. This standard will be shown as completed when 100% of shifts are compliant over a rolling 3-month period. Currently stands around 99%.
H16 HART compliance with response standards	Currently updated manually, digital solution still to be found. Other services have implemented an MIS module but don't find it successful
H24 Attendance at strategic sites	Plans are being reviewed with ICC to ensure staff can achieve the time goals set in the standards. This is also reliant on having 6 staff on duty. The work is part of the SORT plan review package.
H32 Capital estate provision	Work continues to update Ashburton Point.
S15 Effective SORT deployment processes	These were tested in a workshop and require updating to streamline tasking. It is part of the ICC role structure and action card review. It is linked with S16 and S40.
S16 identification of appropriate incidents for SORT	Part of the plan review. Update to be taken to EPRR Group in October 2026.
S29 SORT response time.	Part of the plan review. Update to be taken to EPRR Group in October 2026.
C18 Strategic commander compliance with NOS.	Parafolio platform shows 79% are compliant with the national occupational standards. Target is 90% minimum while working towards 100%. This is being reviewed by Area Directors.
C20 Tactical commander compliance with NOS.	Parafolio platform shows 70% are compliant with the national occupational standards. 4 are non-compliant and 3 partial. There have been new staff moving on to the rota which may account for the change. Target is 90% minimum while working towards 100%. This is being reviewed by Area Directors.
C24 Commander maintenance of CPD	This has been judged on compliance with the NOS combined with Training Needs Analysis. Strategic 81% (small cohort) Tactical 79% Operational 91% Overall 84% Target is 90% minimum while working towards 100%. This is being reviewed by Area Directors.
C25 Commander exercise attendance	Strategic 89% (small cohort) Tactical 89% Operational 83% Overall 86% Target is 90% minimum while working towards 100%. This is being reviewed by Area Directors.
C27 assessment of competence and evidence	CARE team are developing a methodology to assess the quality of evidence added to the Parafolio platform and ways to assess commanders.
C31 Loggist CPD	There are 9 on call loggists which affects perception of the percentage compliance. CPD (TNA and NOS) compliance is 73%. They are now booking on to JESIP courses which is being monitored, 100% have completed the elearning. The TNA is also being reviewed for relevance.

C35 control room familiarisation with capabilities	Due to changes in the control room staffing structure, not all staff have attended the appropriate courses. Training compliance for ICC over the last 2 courses is 79%. This is being addressed by Assistant Director ICC and is part of a wider training package review.
J6 JESIP awareness for control room staff	Elearning is 81% Figures will be affected by role changes but the target is 90% minimum while working towards 100%. This is being addressed by Assistant Director ICC and is part of a wider training package review.
J10 Interoperability command courses	The title is misleading, it refers to reflective practice regarding JESIP at exercises or incidents over an 18-month period. Although NWAS can show compliance data for exercise attendance, the Parafolio platform can only be interrogated manually for evidence of reflection. This will be discussed with Class Publishing during the next review.





REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 30 September 2026
SUBJECT	Learning from Deaths - Summary Report and Dashboard Q4 2025/26
PRESENTED BY	Dr Chris Grant – Executive Medical Director
PURPOSE	Assurance

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

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

ACTION REQUIRED	The Board is asked to: - Support the quarterly dashboard (Appendix A) as the report to be published on the Trust's public website as evidence of the Trust's developing engagement with a formal process of learning from deaths. - Support publication of the annual dashboard for 2025/26 (Appendix B). - Acknowledge the impact of the Structured Judgement Review (SJR) process in identifying opportunities for improving care. - Support the dissemination process as described in Section 4.
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EXECUTIVE SUMMARY

The Trust is required to publish a quarterly and annual summary of learning on its public website.

The Q4 2025/26 dashboard (Appendix A) describes the opportunities to learn from deaths. The main concerns raised internally and externally, identified in DatixCloudIQ (DCIQ), were attributed to problems in ICC and PES, specifically around call-handling errors, equipment malfunction issues, and care and treatment. Of the concerns closed, there was one incident where death was likely due to the service provided by the Trust.

The key areas for improvement this quarter focused on call taking and patient assessment. The level of probing by EMAs during calls continues to be identified within SJR reviews, including both under- and over-probing. Within this quarter, lack of probing around breathlessness and level of consciousness was seen. However, good levels of probing and active listening were also identified within incidents this quarter, indicating some improvement.

Patient record quality has improved this quarter, with poor or very poor ratings reduced to 18% (down from 27% and 44% in previous quarters). There has been a significant increase in good documentation, with 39% of cases rated positively (13 cases), compared to just two cases in Q3. While this reflects clear progress, documentation quality remains a key improvement priority and continues to be reinforced through SJR reporting and engagement with senior clinical colleagues. Examples of high-quality EPRs have been identified and will be used as exemplars to support ongoing learning and improvement.

In Q4, the panel welcomed 27 observers from all areas of the Trust, some of whom will continue to attend panels on a regular basis.

Improvements have been implemented to resolve the issues identified in Q2 relating to the extraction of relevant incidents and complaints from DCIQ. A reliable process is now established to ensure that deaths in care are consistently and accurately flagged to the Learning from Deaths team. As a result, the lower number of deaths with concerns recorded in Q3 is considered an accurate reflection of data quality, rather than reduced identification.

During Q3, issues were identified with the BI export used to identify cases requiring Structured Judgement Review (SJR). These were subsequently resolved by the informatics team, with full rectification achieved following completion of Q3 reviews, and normal sampling parameters restored for Q4. While this impacted activity levels during Q3, the reviews undertaken remained aligned with framework expectations and continued to provide a sufficient and meaningful sample to support organisational learning.

This provides assurance against the Trust Strategic Plans, specifically in relation to:



PREVIOUSLY CONSIDERED BY	1. Quality Strategy:	
	Objective 2: Improve the effectiveness of care by prioritising improvement activity for patients who experience sub-optimal care because of recognised health inequalities.	
	High Level Deliverable:	
	8. Scope areas of improvement in our activity for patients who experience sub-optimal care as a result of recognised health inequalities. This scoping will provide the insight into any areas of deficit to enable us to prioritise remedial action in a targeted and measurable manner.	
PREVIOUSLY CONSIDERED BY	2. Clinical Strategy:	
	Objective: Assessment	
	High Level Deliverable:	
	7. Target health inequalities by optimising assessment and proactive interventions for priority groups, shifting from reactive to preventative care.	
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	07 September 2026
	Outcome	Accepted

1. PURPOSE

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

Appendix A is a summary dashboard of the Q4 2025/26 Learning from Deaths review, and it is proposed that this document is published on the Trust's public website by **30 September 2026**, in accordance with the national framework and Trust policy. The dashboard includes output from moderation panels held following the Structured Judgement Reviews (SJRs) for Q4. Learning from the panels is discussed later in this paper.

Appendix B is the annual dashboard which also requires publication.

2. BACKGROUND

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

3. LEARNING FROM DEATHS COHORT SUMMARY

- 3.1 The number of patients whose deaths were identified as in scope for review was **84 (48 concerns raised in Datix and 36 sampled for SJR)**.

3.2 Deaths raised in DCIQ Discussion

The data regarding DCIQ concerns was last accessed on 02/04/2026. Please note that, due to the complexity, granular updates for previous quarters will be included within other patient safety reports, and the thematic analysis will be captured within the annual Learning from Deaths report.

The breakdown of concerns raised:

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

Three (3) concerns were raised both internally and externally.

3.2.1 Internal Concerns

Of the **34** internal concerns, **30** were reviewed and closed. In **one (1)** of these cases, the investigation found that the Trust had contributed to the patient's death.

3.2.2 External Concerns

Of the **11** external concerns that have been reported, **four (4)** are still in the early stages of review, and it is unknown at the time of writing if the care given was in line with best practice. **Seven (7)** concerns have been closed with no causal factors identified.

3.2.3 Outcomes from Concerns Raised

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

3.2.4 DCIQ Updates

During Q2, issues were identified in the extraction of data relating to deaths from the DCIQ system. These issues resulted in the reported figures appearing lower than in previous Q2 and Q3 reporting periods. The discrepancy was linked to recent changes within the DCIQ modules, which altered the search criteria used to identify relevant cases and affected both the completeness and reliability of the extraction.

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

3.2.5 Informatics Extract Issue

During Q3, issues were identified with the Business Intelligence (BI) export used to identify cases requiring Structured Judgement Review (SJR). These issues were subsequently resolved by the informatics team; however, the corrections were implemented after the completion of Q3 reviews.

As a result, the level of recorded SJR activity for Q3 appears lower than in previous periods. Normalised sampling processes have since been reinstated and were fully operational from the start of Quarter 4.

3.3 SJR Stage 1 Outcomes

Thirty-three (33) patient deaths were presented by reviewers and, following the moderation panels, the outcomes of the reviews were determined as described in the dashboard (Appendix A). Three cases that were within scope could not be reviewed due to long-term staff sickness.

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

3.3.1 SJR Stage 2 Outcomes

Sixteen (16) cases were identified as requiring second-stage review following Stage 1. The second-stage review concluded that eight (8) deaths were not avoidable, four (4) cases had led to harm, and in four (4) cases it was uncertain whether poor practice had led to harm. The care experienced by these patients in terms of patient assessment, management plan and call taking was below expected levels.

As in previous quarters, we have continued to ensure that any information that would be beneficial to the crew attending the incident is fed back. This includes both areas for improvement and examples of good practice identified during case reviews. Feedback is delivered through the Sector Clinical Leads to ensure they maintain visibility of incident-related learning within their respective sectors. This approach supports continuous learning, promotes reflective practice and reinforces positive clinical behaviours across the workforce.

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

3.3.2 SJR and Concerns Learning Themes

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

ICC

- Lack of probing by EMAs regarding breathlessness, level of consciousness and ACS symptoms
- Incorrect coding of call
- Miscommunication between ICC and crews on scene

PES:

- Limited information regarding clinical assessment/examination
- Equipment failures reported – with different elements of defibrillators
- Poor communication with patients and families or hospital staff
- No referral to AVS/OOHGP when appropriate to do so
- Issues with ALS treatment, including airway management and medicines not given in line with guidance

Trust:

- Delays in allocation for category 2 and 3 calls, including five (5) calls that exceeded expected dispatch times. This is noted as being at a similar level to the previous quarter and was likely attributable to hospital handover delays. This continues to be closely monitored within the Trust.

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

PES:

- Thorough history taking and assessment
- Good recognition and escalation of critically unwell patients
- Involvement of those important to the patient, including family and other relevant services.
- Holistic decision making undertaken in the patient's best interests, supporting care and death in the patient's preferred place

ICC:

- Good recognition and escalation of a critically unwell patient by EMAs during 999 calls

- Use of active listening and appropriate probing to achieve the most appropriate outcome for the patient

3.3.3 General Areas for Improvement

Additional learning themes were also identified within reviews that received an 'adequate' rating. While these were not necessarily 'poor' or 'good' themes, they were recurrently seen in reviews throughout Q4 and demonstrate where additional learning can be found, as well as highlighting further examples of good practice. These include:

Areas for improvement:

- Lack of probing by EMA
- EPR tiles not completed when appropriate
- Frailty and pain scores not recorded within observations
- Detailed worsening advice not documented

Good practice:

- Appropriate level of probing by EMAs
- Good use of Non-Clinical Advice Hunt by EMAs for escalation
- Clinicians using holistic decision making and advocating for patients' best interests

These recurring general themes have remained consistent throughout the reporting period. Ongoing feedback has been provided to Sector Clinical Leads and ICC colleagues, with the expectation that this will support incremental improvement over time. A dedicated ICC workstream is in place to address levels of clinical probing by EMAs. While some errors within this area persist, reviewers have also identified areas of clear and measurable improvement, indicating that targeted actions are beginning to have a positive impact.

4. OUTCOME OF LEARNING THEMES

The clinical leadership team has committed to disseminating and promoting good practice through regional and local area learning forums (ALFs) and with individual frontline staff. The Q4 2025/26 Learning from Deaths infographic (Appendix C) will be shared with the clinical leadership team.

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

Any incidents in which we feel the care has met one of the PSIRF priorities are raised in the usual way to be reviewed locally and presented to CCRG as appropriate. This ensures that we triangulate data across teams and contribute to PSIRF learning.

We continue to welcome observers to our panels from all departments of the Trust. Within Q4, we had **27** observers from ICCs, corporate teams and operational staff, and feedback from observers has continued to be positive.

Observers have continued to note that the SJR reviewers demonstrated knowledge and professionalism while recognising good practice and providing constructive criticism. They noted a positive culture in which colleagues are comfortable challenging and being challenged to fully understand the incident being reviewed. They also noted the importance of writing a clear and detailed EPR and stated that they would take this into their own practice going forward.



Colleagues from other departments have requested to attend the panels more regularly, both for their own learning and development and to support collaborative working. This will help to ensure that any gaps in practice, pathways or learning can be addressed with the most appropriate teams. This has greatly improved the breadth of knowledge and expertise within the panels and further contributes to richer learning from these incidents.

5. RISK CONSIDERATION

Duty of Candour has specific legal implications associated with it; however, the Learning from Deaths process only extends to advising local management that it should be considered and does not mandate that it should be enacted. There are no other legal implications associated with the content of this report, and the data gathered to produce the dashboard has been managed in accordance with the Data Protection Act 2018.

6. EQUALITY / SUSTAINABILITY IMPACTS

No equality or sustainability implications have been identified as arising from this report.

The Board is asked to:

- Support the quarterly dashboard (Appendix A) as the report to be published on the Trust's public website as evidence of the Trust's developing engagement with a formal process of learning from deaths.
- Support publication of the annual dashboard for 2025/26 (Appendix B).
- Acknowledge the impact of the Structured Judgement Review (SJR) process in identifying opportunities for improving care.
- Support the dissemination process as described in Section 4.

NWAS Learning from Deaths Dashboard Q4 25/26

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

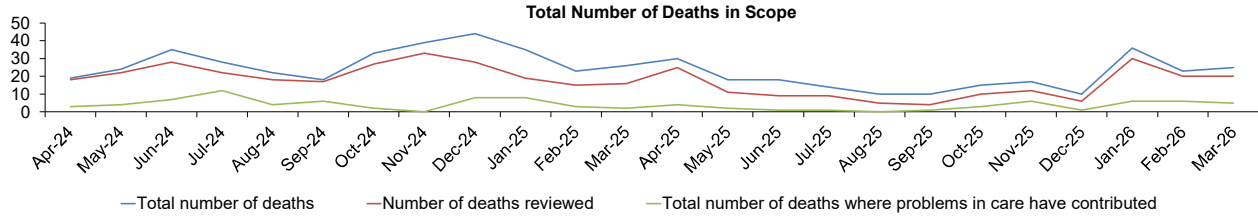


Figure 1

Concerns Raised in DCIQ

Internal Concerns

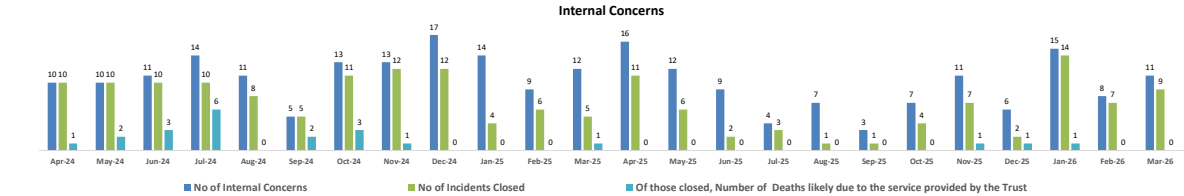


Figure 2

Learning Identified from all Internal Concerns raised in DCIQ

PES:

Care & Treatment

- Re-contact within 24hrs after patient was left at home - only minor individual learning (x8)
- Issue with airway management during cardiac arrest (x1)
- Issue with patient management during hospital handover (x1)
- Termination of resuscitation outside of guidance (x1)

Equipment

- Schiller defib stopped working in rainy conditions (x1)
- Defib pads wouldn't stick to patient (x1)
- ETCO2 not working on Schiller defib (x1)
- Suction unit not working (x1)
- SP02 monitor not working (x1)

ICC:

Call Handling

- Error in call handling/pathways management (x3)
- Incorrect coding of call (x2)
- Delay requesting fire for access (x1)

Dispatch

- Incorrect crew allocation/management (x1)

Clinical Delivery:

- Incident held on telephone triage stack for too long which caused a potential delay in allocation of a vehicle (x1)

Trust:

- Category 2 delays - 20-45mins (x3)
- Category 3 delays - 4hrs - 7hrs (x2)
- Category 5 delay - patient made own way and collapsed enroute (x1)
- Lack of availability of bariatric vehicle (x1)

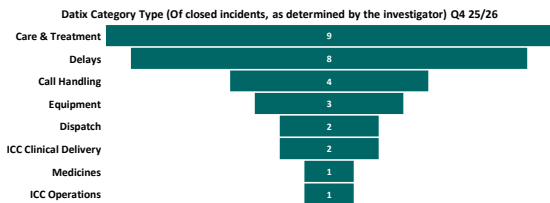


Figure 3

External Concerns

External Concerns

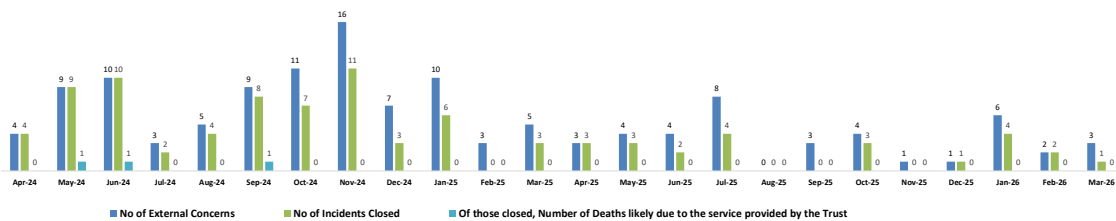


Figure 4

Learning Identified: ICC

Problem with communication:

- Lack of information on referral to OOHGP caused delay in patient contact (x1)
- Issues in communication between call taker and HCP making call (x1)

Problem with call taking/response allocation:

- Delay in attending category 3 call - errors in call handling and dispatch contributed to delay (x1)

Learning Identified: PES

Problem with patient disposition:

- Potential inappropriate disposition - patient left at home on HCP admission (x1)

Problem with communication:

- Poor communication with patient and/or family (x3)
- Miscommunication between crew and hospital staff regarding correct department for patient (x1)
- Miscommunication with family regarding reason why patient was left at home (x1)

Table 2

Internal and External Concerns

Table 3

Concerns raised both internally & externally

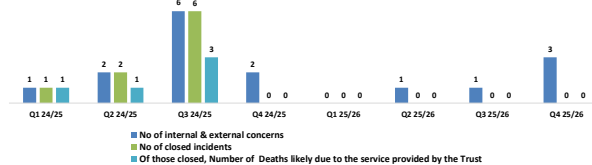


Figure 5

NWAS Learning from Deaths Dashboard Q4 25/26

Structured Judgement Review (SJR) Sample

Reporting Year	Incidents used for the sample criteria	Number of Deaths Reviewed	Total number of deaths where care is deemed to be less than adequate
24/25	Q1	23	14
	Q2	19	18
	Q3	33	26
	Q4	29	26
25/26	Q1	18	18
	Q2	9	9
	Q3	11	11
	Q4	36	33
Total		178	155

Table 4

SJR Stage 1 Overall Care Assessment for Year (Lowest Overall Rating for Case)

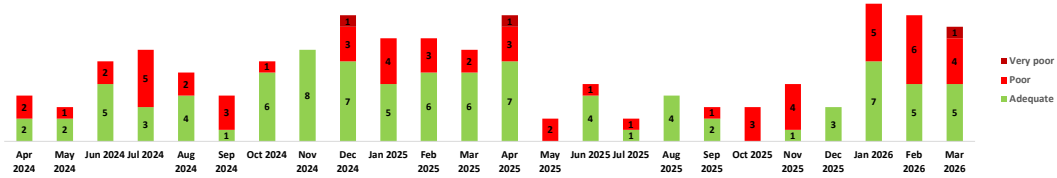


Figure 6

Individual Case Rating - Initial Contact				
Initial Contact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good
Right Time	Call Handling/Resource Allocation	9	22	2
Right Care	Patient Assessment Rating	6	23	4
	Management Plan/Procedure Rating	8	20	5
Right Place	Patient Disposition Rating	5	24	4

Table 5

Individual Case Rating - Recontact				
Recontact	SJR Element	1 or 2 - Poor or Very Poor	3 - Adequate (Appropriate)	4 or 5 - Good or Very Good
Right Time	Call Handling/Resource Allocation	1	21	3
Right Care	Patient Assessment Rating	0	24	1
	Management Plan/Procedure Rating	0	23	2
Right Place	Patient Disposition Rating	0	25	0

Table 6

SJR Learning Themes

Evidence of Poor/Very Poor Practice

Findings identified from 'Poor' ratings

ICC Lack of probing by EMA regarding: - breathlessness symptoms (x2) - level of consciousness (x2) - ACS symptoms & treatment (x2) - Missed opportunity to allocate an earlier vehicle (x3) - Over probing at pre-alert caused delay in cat 1 response - Not enough information to downgrade call - impacted response time Clinical Delivery - Medical model & cardiac assessment not used - Lack of clear treatment plan - No worsening/red flag advice Poor Quality of EPR (x6)	PES Problem with patient assessment: 12 lead ECG not completed when appropriate (x2) - Assessment didn't fully investigate presenting symptoms (x2) - Lots of detail missing from patient assessment (x2) Problem with treatment & management plan: - Lack of detail in management plan/treatment given to patient (x3) - Symptoms did not return to normal following treatment but no further treatment given (x2) - Cardiac symptoms not fully assessed or considered Problem with patient disposition: - No referral to AVS/OOHGP when appropriate (x3) - MTS not applied correctly - No documentation of plan/worsening advice - No exploration of other care considerations Problem with resuscitation: - Medicines not given in line with JRCALC guidelines (x2)
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Evidence of Poor/Very Poor Practice

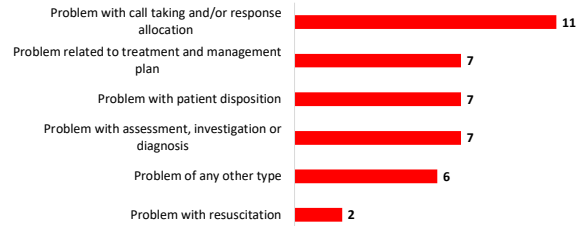


Figure 7

Table 7

Evidence of Good/Very Good Practice

Evidence of Good/Very Good Practice

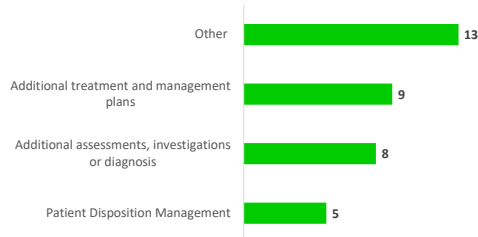


Figure 8

Findings identified from 'Good' ratings

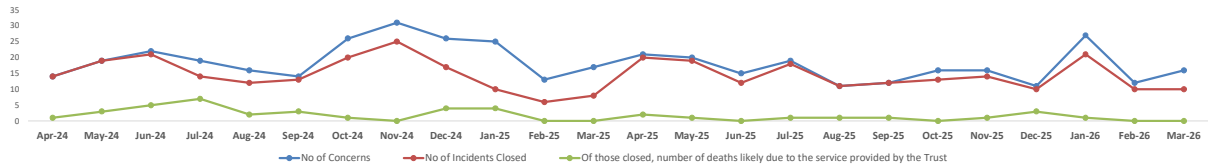
PES Additional assessments, investigations & diagnosis: - Thorough history taking and assessment completed (x2) - Recognition and escalation of critically unwell patient (x2) - Thorough and in depth assessment of presenting symptoms Additional treatment & management plan: - Multiple sets of observations and discussed patients condition with GP and family (x2) - Good recognition and escalation of a critically unwell patient (x2) - Involvement of those important to the patient (x2) - Good management of patient expectations and concerns - Patient centred decisions around frailty and history Patient disposition management: - Multiple referrals made to ensure the patient received the care they required at home (x2) - Clear and appropriate holistic decision making inclusive of the patient and family members - Crew ensured dignity for both patient and family Good Quality of EPR (x13)	ICC - Good recognition and escalation of a critically unwell patient by EMA (x4) - EMA used active listening and good amount of probing to get the most appropriate outcome for the patient
---	---

Table 8

NWAS Learning from Deaths Annual Dashboard 2025-26

Deaths with concerns raised in DCIQ

All Deaths with Concerns raised in DCIQ (Internal & External)



Internal Concerns

	Number of Incidents	Number of Incidents Closed	Of those closed, number of deaths likely caused by service by the trust	% death likely caused by the trust
Q1	37	33	2	6.1%
Q2	21	21	3	14.3%
Q3	26	24	4	16.7%
Q4	35	31	1	3.2%
25/26	119	109	10	9.2%

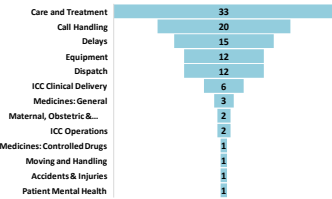
External Concerns

	Number of Incidents	Number of Incidents Closed	Of those closed, number of deaths likely caused by service by the trust	% death likely caused by the trust
Q1	17	16	0	0.0%
Q2	20	19	0	0.0%
Q3	16	12	0	0.0%
Q4	17	9	0	0.0%
25/26	70	56	0	0.0%

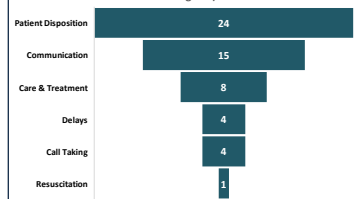
Concerns raised both Internally & Externally

	Number of Incidents	Number of Incidents Closed	Of those closed, number of deaths likely caused by service by the trust	% death likely caused by the trust
Q1	2	2	1	50.0%
Q2	1	1	0	0.0%
Q3	1	1	0	0.0%
Q4	3	1	0	0.0%
25/26	7	5	1	20.0%

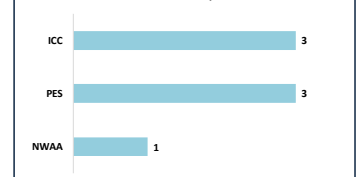
Category Type (Of closed incidents, as defined by the investigator)



Category Type (Of closed incidents, as defined by the investigator)



Concerns raised both internally & externally by service line (For all incidents)



Themes from Closed Internal Incidents

ICC: 25	
Call Handling	
Errors in triage which resulted in the incorrect category	5
Missed opportunity to re-triage and get a higher category	4
Poor communication by EMA with patient	2
Delay in taking information by EMA caused delays	2
Abandoned call not correctly escalated by EMA	1
Dispatch	
Missed allocation of earlier/closer vehicle	4
Vehicle incorrectly stood down for meal break	2
No pre-alert sent due to misunderstanding	2
No causal factors found	3
PES: 54	
Care & Treatment	
Re-contact death within 24hrs - individual learning identified	18
Maternity death - no harm identified	2
Re-contact death within 24hrs - MTS discriminator missed on first contact	1
Lack of observations during protracted hospital handover	1
Equipment	
Issues and/or malfunction with defibrillators (Schiller) - ETCO2 monitor stopped working, stopped working in rain, screen not displaying rhythm, failed to deliver shock	7
Razor not sufficient for shaving chest for defib	2
Failure of suction unit	2
Medicine	
Administered out of date medicine	2
Errors in ALS medicines	2
Incorrect dose of morphine given	1
No causal factors found	16

Themes from Closed External Incidents

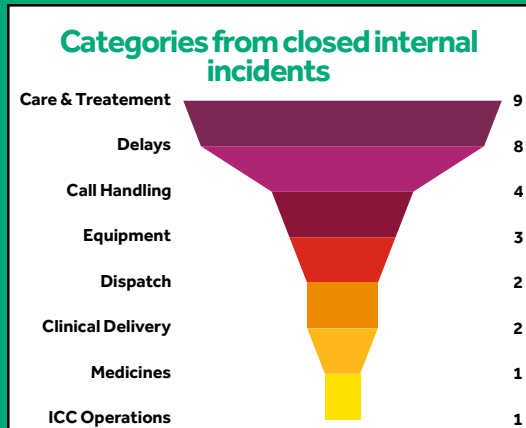
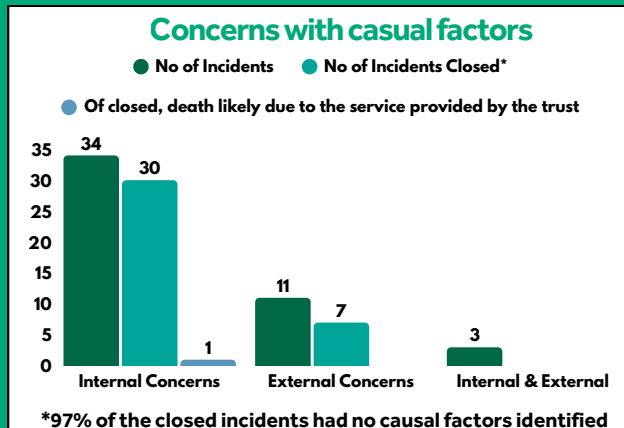
ICC: 9	
Call Handling/Dispatch	
Call categorised/coded incorrectly	5
Poor communication with patient/family	3
Insufficient information conveyed to ED	1
PES: 40	
Care & Treatment	
Symptoms missed/not considered within treatment plan	4
Failure to recognise potential seriousness and complexity of condition	3
Incorrect MTS application	1
Communication	
Poor communication with patients/family	13
Crew did not act appropriately	3
Patient Disposition	
Correct pathway not followed	7
Missed opportunity to convey patient to ED	6
Incorrect hospital destination	3
Clinical Delivery Learning Across All Concerns 14	
Errors in assessment/red flags missed during clinical assessment	5
Potential inappropriate referral to CAS provider	2
Potential inappropriate disposition - patient not suitable to be sent in taxi	2
Delay in allocation due to clinician not moving call into dispatch stack	2
Call incorrectly closed under WINFO policy	1
Correct pathway not followed	1
Missed opportunity to convey patient to ED	1

Themes from Closed Concerns Raised Internally & Externally

PES: 3	
Care & Treatment	
Problem with communication of handover	2
Elements of treatment plan missed	1
ICC: 3	
Call Handling	
Missed opportunity to upgrade low acuity incident	2
Call categorised incorrectly	1
Trustwide Themes Across All Concerns	
Category 2: 20min - 1hr20 delays	10
Category 3: 2hrs - 8hrs delays	4
Category 4: 5hrs	2
System pressures - delays caused by:	
Hospital handover delays	6
Staffing pressures:	
No enhanced care available for a trauma incident	2
Lack of availability of bariatric vehicle	
Learning Over Time	
Overall number of incidents meeting the LFD criteria has dropped compared to the previous year	
Care & treatment and delays remain 2 of the highest reported categories	
The number of delays and system pressure incidents has reduced compared to the previous year	



DEATHS WITH CONCERNS RAISED IN DATIX



Learning from Paramedic Emergency Service (PES)

Problem with treatment & management plan:

- Re-contact incident where the patient passed away - only minor individual learning (x8)
- Issue with airway management during cardiac arrest
- Issue with patient management during handover

Equipment:

- Schiller issue - stopped working in rainy conditions
- Schiller issue - ETCO2 monitor not working
- Defib pads would not stick to patient chest

Communication:

- Poor communication between clinicians and either patient/family or hospital staff (x5)



Other Learning Opportunities

Learning from ICC:

- Error in call handling/Pathways management (x3)
- Incorrect coding of call (x2)
- Miscommunication between ICC and external HCP providers (x2)

Trust Learning:

- Cat2 delays- 20-45 mins (x3)
- Cat3 delays - 4hrs - 7hrs (x2)
- Lack of availability of barriatric vehicle (x1)

Other Learning Opportunities

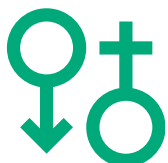
Learning Over Time:

- The number of incidents relating to delays increased slightly from the previous quarter, but is lower than the same quarter last year
- Communication issues continues to be a recurring theme - mainly within external complaints raised
- Equipment issues are still being reported but less frequently than in previous quarters

Structured Judgement Reviews (SJRs)

Patient Demographics

42% Female



58% Male

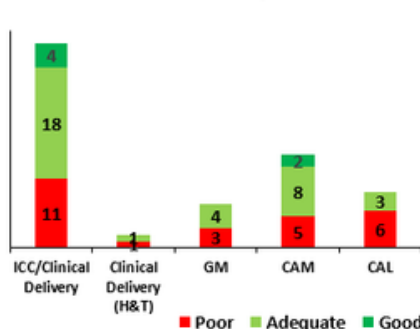
91% of the sample were over 65 years old



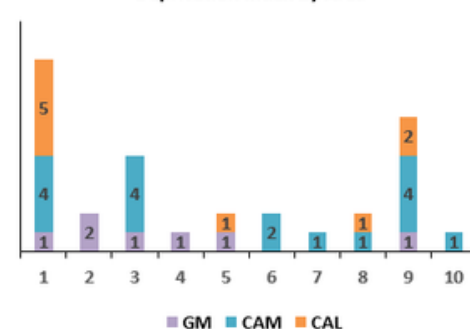
Ethnicity	
White (British)	70%
Unknown	18%
White (Other)	6%
Asian/Asian British (Bangladeshi)	3%
Asian/Asian British (Other)	3%

Incident Demographics

Number of SJRs by Area



Deprivation Index by Area



Structured Judgement Reviews (SJRs)

Deaths in Scope

Re-contact within 24hrs

 **26**

Category 3/4 Deaths

 **4**

Category 1/2 Delays

 **6**

Deaths Reviewed

Total sample

N = 36

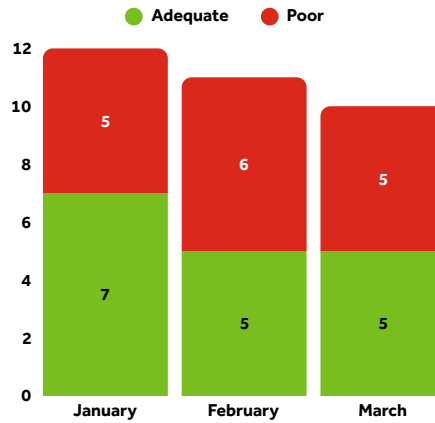
Excluded from review

Not moderated = 3

Included for review

n = 33**

SJR Stage 1 Care Assessment



****51.5% had no causal factors identified**

Stage 2 = 16 incidents

No causal factors identified

 **8**

Uncertain poor practice led to harm

 **4**

Poor practice led to harm

 **4**

SJR - Themes

Problem with call taking and/or response allocation



Problem with patient assessment



Problem with patient disposition



Problem with treatment & management plan



Problem with resuscitation



Stage 2

Most common findings in ICC:

- Lack of probing by EMA regarding breathlessness, level of consciousness & ACS symptoms (6)
- Missed opportunity to allocate an earlier vehicle (3)
- Over probing at pre-alert caused delay in cat 1 response
- Not enough information to downgrade call - impacted response time

Stage 2

Most common findings in PES:

- Lack of detail in management plan (3)
- No referral to AVS/GP when appropriate (3)
- 12 ECG not completed when appropriate (2)
- Assessment didn't fully investigate presenting symptoms (2)
- Lots of detail missing from patient assessment (2)
- ALS medicines not given in line with JRCALC guidelines (2)

SJR GENERAL LEARNING THEMES

Areas for Improvement



- EPR tiles not completed when appropriate
- Lack of probing by EMA
- Detailed worsening advice not documented
- Frailty and pain scores missing from observations
- Incomplete/irregular observations documented

Good Practice



- Good amount of probing by EMA
- Good use of Non-Clinical Advice Hunt by EMA for escalation
- Quick recognition and early escalation of an unwell patient
- Crews using holistic decision making
- Crew advocating for patients best interest

SJR ACTIONS

- Positive feedback to be given to crew (x7)
- Learning feedback to be given to crew (x4)
- Dispatch decisions to be reviewed (x2)
- Case escalated to the leadership team for CCRG/PSIRF consideration (x3)
- EMA call audit requested and outcome fed back to staff member (x7)

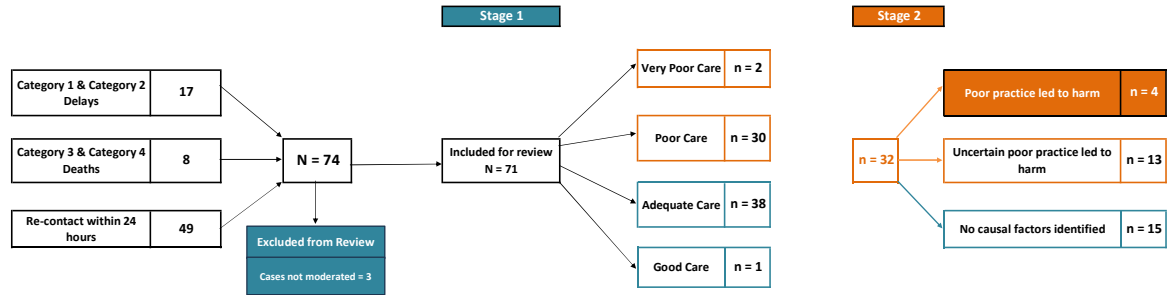


SJR IMPROVEMENTS

- To continue to circulate learning points from Learning from Deaths to all staff networks and learning forums
- To continue to work with the PSIRF team to triangulate learning themes and identify areas for improvement
- To continue to welcome observers from all areas of the trust to the monthly panels - in this quarter **27** colleagues attended and participated in discussions

NWAS Learning from Deaths Annual Dashboard 2025-26

Structured Judgement Reviews (SJRs)



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

PES:	
Problem with assessment	
Limited information recorded regarding clinical assessment and examination	10
12 lead ECG not performed when appropriate to do so	3
No medical model used	2
Breathing assessment lacks detail	1
Clinical examination poorly documented	1
Problem related to treatment & management plan	
Lack of clear management plan and diagnosis	4
MTS not used or not applied correctly	3
No documentation of plan or SOS advice	2
Other individual learning points	4

PES:	
Problem with patient disposition	
No referral to AVS/GP when appropriate to do so	4
Detailed worsening advice not documented	3
Incorrect MTS outcome used	1
Problem with resuscitation	
ALS medicines not given in line with JRCALC guidance	2
Clinical Delivery:	
No medical model used	2
Lack of clear management plan	2
No worsening advice given	2
Missed opportunity to upgrade call during telephone triage	1
BLS instructions not given when required	1
Poor quality of Electronic Patient Record (EPR)	19

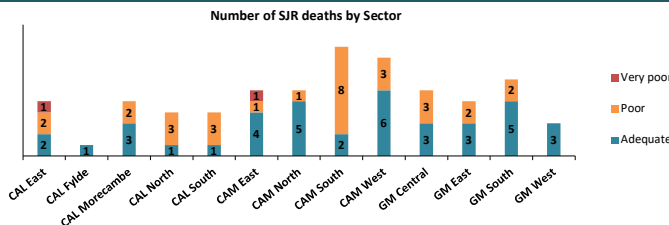
ICC:	
Problem with call taking/response allocation	17
Dispatch:	
Missed opportunity to allocate closer vehicle	4
Call taking:	
Missed opportunity to upgrade call	4
Lack of probing regarding ACS/chest pain symptoms	2
Lack of probing regarding breathlessness symptoms	2
Lack of probing regarding level of consciousness	2
Delay in obtaining category 1 response due to incorrect answers input	2
Elements of Pathways advice not given to caller	1

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

PES:	
Additional assessments	
Extensive & thorough patient assessment	6
Involvement of those important to the patient	2
Patient centred decisions around history & comorbidities	1
Holistic decision not to resuscitate	1
Additional treatment & management plans	
Good recognition & escalation of a critically unwell patient	4
Decisions made with involvement of patient & family	3
Multiple observations taken & clinicians discussed plan with patient, family and GP	3
Holistic decisions made in the patients best interest	2
Recognition of EOL and empowerment of crew to make decisions in the absence of care plans	2

PES:	
Patient disposition management	
Holistic decision making inclusive of the patient and their family	3
Crew assisted family following patient passing away	1
Crew challenged HCP decision to respect patient wishes	1
Multiple referrals made to safety net patient	1
Good quality of Electronic Patient Record (EPR)	19
ICC:	
Good active listening by EMA to ensure the best outcome for the patient	4
Good amount of probing by EMA	2
EMA showed compassion and empathy during difficult call	1
Clear and encouraging instructions during BLS	1
Quick and appropriate dispatch	1

SJR Demographics

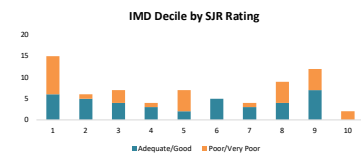


Sample Split
36 35

93% of the sample were 65 years and older

72% of patient ethnicity recorded as White (British)
23% cases were had no ethnicity recorded
5% White (Other) & Asian (Other)

51 Good practice letters sent!



Top Call Reasons by Category

Category 1 & Category 2 Delays

- Breathing problems: 29%
- Vomiting: 18%

Category 3 & Category 4 Deaths

- Falls: 67%
- Confusion/SOB: 33%

Re-contact within 24 hours

- Breathless/DIB: 29%
- Falls: 17%
- Unconscious/unresponsive: 13%

SJR Rated Adequate or Above by Area

Cumbria & Lancashire
42%

Cheshire & Merseyside
55%

Greater Manchester
67%

Overall cases which received adequate or good care in 25/26
55%

Outcomes from SJRs

Whilst the sample size is smaller than the previous year, the learning generated from the reviewers for Structured Judgement Reviews (SJRs) includes much richer detail and the number and frequency of feedback actions to disseminate learning has greatly improved. We have continued to collaborate with many areas of the trust, including the Regional Clinical Improvement Group (RCLIG), the Patient Safety Team, and Quality Improvement projects. As a result several key themes and priority areas for improvement have been identified. These include the use of learning loops to raise awareness around topics such as naloxone administration, as well as the identification errors within ALS which have fed into the learning already identified within the QI Academy. The reviews also supported ongoing themes within contact centres, such as levels of probing during Pathways assessments and the good care, compassion and empathy shown by our call handling teams.

This approach supports continuous learning and the dissemination of best practices across clinical teams as well as integrated contact centres (ICCs). Additionally, there is a growing emphasis on triangulating learning from multiple sources to gain a deeper, system-level understanding of clinical practice. For example, clinical documentation continues to be highlighted for both areas of improvement and areas of excellent practice. Whilst the number of EPRs gaining a 'poor' rating has remained at a similar level to last year, the number of EPRs which received a 'good' rating has increased from 14% to 26% which shows a good improvement. Similarly, we have sent out 51 good practice letters to operational and contact centre colleagues compared with 13 the previous year, which further emphasises the good elements of practice being highlighted and praised within the SJR reviews.



ESCALATION AND ASSURANCE REPORT

Report from the Quality & Performance Committee

Date of meeting	Monday, 07 September 2026			
Members present	Ms C Todd (Chair)	Non-Executive Director	Quorate	Yes
	Mr N Gower	Non-Executive Director		
	Mr D Ainsworth	Director of Operations		
	Dr C Grant	Medical Director		
	Dr E Strachan-Hall Improvement	Director of Quality and		

Key escalation and discussion points from the meeting

ALERT:

- The Committee received Statutory Duty of Candour – review of organisational quality and compliance – findings against areas of focus were noted as well as opportunities for further improvement. Follow up progress report will be received in February 2027.

ADVISE:

- The Q&P Dashboard highlighted:
 - Overall performance remained broadly stable, with improved complaints capacity, stable patient experience and clinical quality indicators above national averages.
 - Operationally, turnaround improved and lower-acuity response times strengthened during July.
 - C2 performance also improved on the previous month returning within UEC target and reducing long waits.
 - However, NHS 111 telephony deteriorated further, largely due to sickness and demand peaks.
- PSIRF Priorities Improvement Update – the Committee noted progress against the priorities as well as risk and challenges and noted that audit of the organisation's learning was currently under way.
- The Committee received two additional presentations under urgent business:
 - Winter Planning: Expectations and Assurance
 - National Oversight Framework

ASSURE:

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

- Board Assurance Framework approved Q1 2026/27 Position – the Committee requested the next SR01 update would include further information on inequalities.
- UEC Delivery Assurance Report – the Committee noted progress against delivery of the 2026/27 UEC Improvement Programme.
- As per request from the Board, the Committee received and extended Private Provider Assurance reports regarding the contractual management and assurance arrangements for third-party ambulance providers.
- Emergency, Planning, Resilience, Response (EPRR) Annual Assurance – the Committee noted that the 2026 EPRR Annual Assurance process was underway and NWAS was forecasting a Substantial Assurance outcome.
- Complaints Assurance Report Q1 2026/27.
- Learning from Deaths Q4 2025/26.
- Medicines Management Q1 2026/27.

Extended discussions took place for each agenda item, with in-depth considerations including focus on strengthening triangulation between complaints, patient experience, patient safety, workforce and survey data and developing reporting on the implementation and impact of learning actions.

The Committee emphasised that organisational learning should not be limited to incidents or areas requiring improvement but should also draw on the experience of the majority of staff who were delivering their work to a high standard.

RISKS

Risks discussed:

- SR01, SR03

New risks identified:

- No new risks identified.



RISK APPETITE STATEMENT (RAS) 2026/27

The Risk Appetite Statement sets out the level and type of risk North West Ambulance Service (NWS) 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.

Headquarters:
Chair:
Chief Executive:

Ladybridge Hall, 399 Chorley New Road, Bolton BL1 5DD
Julia Mulligan
Salman Desai KAM

Delivering the **right care**,
at the **right time**,
in the **right place**;
every time.

	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.