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North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 24 April 2019
9.45 am - 1.00 pm

Oak - North West Ambulance Service, Trust HQ

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
1.	Patient Story	09:45	Information	S Desai	
INTRODUCTION					
2.	Apologies for Absence	10:00	Information	Chair	
3.	Declarations of Interest	10:00	Decision	Chair	
4.	Minutes of Previous Meeting	10:00	Decision	Chair	3 - 14
5.	Board Action Log	10:00	Assurance	Chair	15 - 16
6.	Committee Attendance	10:00	Information	Chair	17 - 18
7.	Chairman & Non-Executives' Update	10:00	Information	Chair	
STRATEGY					
8.	Chief Executive's Report M1 2018-19	10:05	Assurance	Chief Executive	19 - 28
GOVERNANCE AND RISK MANAGEMENT					
9.	Board Assurance Framework	10:15	Assurance	Director of Corporate Affairs	29 - 40
10.	Core Governance Documents	10:25	Decision	Director of Corporate Affairs	41 - 254
11.	Standards of Business Conduct Policy	10:35	Decision	Director of Corporate Affairs	255 - 288
12.	Common Seal Annual Report	10:40	Assurance	Director of Corporate Affairs	289 - 292
13.	Audit Committee Assurance Report - from the meeting held on 18th April 2019 - Verbal	10:45	Assurance	Mr D Rawsthorn	
14.	Audit Committee Annual Report 2018/19	10:50	Assurance	Mr D Rawsthorn	293 - 304
15.	Policy Update - Quarter 4	10:55	Assurance	Director of Corporate Affairs	305 - 310
16.	Freedom to Speak Up 2019/20 - Quarter 4 Update	11:00	Assurance	Director of Corporate Affairs	311 - 318
QUALITY AND PERFORMANCE					
17.	Integrated Performance Report	11:05	Assurance	Director of Quality, Innovation and Improvement	319 - 380
18.	Monthly Finance Report 2019-20	11:30	Assurance	Director of Finance	381 - 396
19.	Finance, Investment and Planning Committee Annual Report	11:40	Assurance	Mr M O'Connor	397 - 402

20.	Quality Committee Assurance Report - from the meeting held on 8th April 2019	11:45	Assurance	Dr M Ahmed	403 - 404
21.	Quality Committee Annual Report 2018/19	11:50	Assurance	Dr M Ahmed	405 - 408
22.	Performance Committee Annual Report	11:55	Assurance	Chair	409 - 412
23.	Senior Information Risk Owner Annual Report	12:00	Assurance	Director of Quality, Innovation and Improvement	413 - 420
24.	Health and Safety Annual Report	12:05	Assurance	Director of Quality, Innovation and Improvement	421 - 428
25.	Quarterly Communications Update	12:15	Assurance	Director of Strategy and Planning	429 - 434
WORKFORCE					
26.	Workforce Committee Assurance Report - from the meeting held on 23rd April 2019 - Verbal	12:30	Assurance	Mr R Groome	
27.	Workforce Committee 2018/19 Annual Report	12:35	Assurance	Mr R Groome	435 - 438
CLOSING					
28.	Any Other Business Notified Prior to the Meeting		Decision	Chair	
29.	Items for Inclusion on the BAF		Decision	Chair	

Date and Time of Next Meeting: 9.45 am Wednesday, 29 May 2019 at Oak - North West Ambulance Service, Trust HQ

Minutes
Board of Directors

Details: Wednesday 27th March 2019, 9.45am
Ladybridge Hall, 399 Chorley New Road, Heaton, Bolton, BL1 5DD

Present:

Mr P White	Chairman
Dr M Ahmed	Non-Executive Director
Mr G Blezard	Director of Operations
Ms M Brooks	Interim Director of Finance
Mr S Desai	Director of Strategy & Planning
Mr M Forrest	Interim Chief Executive
Mr R Groome	Non-Executive Director
Ms M Power	Director of Quality, Innovation & Improvement
Dr D Ratcliffe	Medical Director
Mr D Rawsthorn	Non-Executive Director
Ms L Ward	Interim Director of Organisational Development
Mrs A Wetton	Director of Corporate Affairs

In attendance:

Ms J Lancaster	Corporate Governance Manager (Minutes)
Ms C Turner	Communications Officer (Part)

Minute Ref:

BM/1819/204 STAFF STORY

A film was shown to members, featuring a patient who made frequent calls to the Trust. Members were advised that due to redundancy and issues experienced at home, the patient had become homeless. As a result, the Trust had received numerous calls within a 9 month period from this patient, resulting in 43 admissions to A&E.

Sara Harris, Community Specialist Paramedic was involved with this patient and explained that she formed part of the One Trafford Response. This consisted of multiple agencies working together to support vulnerable patients.

As a result of the support that was provided to this patient, he was now in his own home and had only made one 999 call since August 2018.

Members commended the work that had been carried out and it was noted that providing services on a local level would improve performance and reduce the number of frequent callers.

The Director of Quality, Innovation and Improvement commented on the work carried out by the Community Specialist Paramedic and stated that she was very

much part of the Health and Social Care Community. It was noted that the work carried out at this level was invisible to the Commissioners and wider healthcare economy's.

Reference was made to the NHS 10 Year Plan and the focus on patients who led an hectic lifestyle. It was noted that each CCG had been asked to identify 50 individuals that utilised public services on a regular basis, to identify if a different offer could be provided.

The Interim Chief Executive commented on the role of primary care and stated that there was a need to build alliances.

Dr M Ahmed stated the patient story provided an excellent example of what support and services could be provided within the community.

The Chair commented that front line staff were in a good position to identify talent and asked the Interim Director of Organisational Development to consider this in terms of future recruitment plans. He added that in terms of delivering performance and the right care, a multi-agency approach was very important.

The Board:

- Noted the patient story.

BM/1819/205 APOLOGIES FOR ABSENCE

An apology for absence was submitted from Mr M O'Connor, Non-Executive Director.

At this point in the meeting, the Chair welcomed Mr D Rawsthorn, Non-Executive Director to the Trust.

BM/1819/206 DECLARATIONS OF INTEREST

No declarations of interest were declared.

BM/1819/207 MINUTES OF PREVIOUS MEETING HELD ON 27th FEBRUARY 2019

The minutes of the previous meeting held on 27th February 2019 were presented to members for approval.

The Board:

- Approved the minutes from the meeting held on the 27th February 2019.

BM/1819/208 ACTION LOG

The action log was reviewed and updated accordingly.

BM/1819/209 COMMITTEE ATTENDANCE

Members were presented with a copy of the Committee attendance, for information.

The Board:

- Noted the committee attendance and suggested a number of minor amends.

BM/1819/210 REGISTER OF INTEREST

Members were presented with the Board of Directors – Register of Interests 2018/19.

The Corporate Governance Manager advised members that a declaration of interest form would be required to be completed by all members for 2019/20.

The Board:

- Noted the update

BM/1819/211 CHAIRMAN AND NON-EXECUTIVES DIRECTORS UPDATE

The Chairman advised that the Non-Executive Director and two Associate Non-Executive Director (NED) vacancies were currently being advertised.

In terms of the Associate NED for Digital, NHS Digital had been asked to consider/recommend candidates. Members were advised that prior to interviews being held, the relevant NED/Executive would be asked for their feedback on the applicant's CV.

The Chair advised that he had spent a day shadowing staff within the Patient Transport Service. He commented that the standard of care provided by the service was excellent and that staff were committed to being part of the Trust.

Feedback was provided from the Ambulance Leadership Forum that was held on 19th and 20th March 2019. The Chair advised that he fed back to the Care Quality Commission that consistency of inspectors was of paramount importance.

The Board:

- Noted the update.

BM/1819/212 CHIEF EXECUTIVE'S REPORT

The Interim Chief Executive presented a report to provide members with information on a number of areas since the last report to the Trust Board on 27th February 2019.

An update was provided in relation to 999 performance and members were presented with information that illustrated continuing improvements. Mr R Groome applauded the good performance that had been achieved in conjunction with an increase in demand. The Interim Chief Executive commented that a lot of work had been carried out to improve performance and this had been recognised by NHSI.

Mr D Rawsthorn requested that the table that had been presented in relation to 999 performance, included a column to highlight the target for each measure.

In terms of 111 performance, whilst performance had shown a slight decline in the February 2019 position, performance was better compared to the same period in 2018. It was noted that during March 2019, significant improvements had been made.

The Interim Chief Executive thanked Dr David Ratcliffe for his time, clinical leadership and enthusiasm during the 10 years he had worked at the Trust. The Board wished Dr David Ratcliffe every success in his future and career.

Mr D Rawsthorn commented on the flu vaccination campaign and questioned how the Trust compared to other Trusts. The Interim Director of Organisational Development explained that the Trust was currently at the mid-point, in terms of comparison. The Interim Chief Executive explained that approximately 800 – 1000 staff received the vaccination from another provider but this number could not be included within the Trusts reported figures. The Interim Director of Organisational Development added that the Trust experienced cultural challenges from staff who would not receive the vaccination. It was noted that best practice was being sought from other Trusts, including the Northern Ambulance Alliance.

The Director of Quality, Innovation and Improvement referred to the Ambulance Leadership Forum (ALF) and stated it had been highlighted that Boards required further understanding of the Lord Carter Review. It was noted that quarterly reports would be presented to Board and regular reporting happened via the Finance, Investment and Planning Committee.

Members were advised that Steven Scholes had delivered an excellent presentation at ALF. It was suggested that ALF would be held in the North of England in 2020 and therefore, NWAS would be more involved in terms of the agenda/delivery of the conference.

The Chair commented on the importance of working with partners including the Northern Ambulance Alliance. The Director of Strategy and Planning advised that he had a meeting scheduled with the Managing Director week commencing 1st April 2019.

The Chairman referred to the 111 contract and commented that the Board needed to understand the contract processes in terms of moving forward. The Interim Chief Executive advised that work would progress on the 111 contract, following the PES contract sign off.

The Chairman thanked Dr D Ratcliffe for all of his commitment and hard work during his employment at the Trust.

The Board:

- Received and noted the contents of the report.

BM/1819/213 URGENT AND EMERGENCY CARE STRATEGY

The Medical Director presented the Urgent and Emergency Care Strategy, for approval.

Members were advised that page 35 of the strategy detailed the objectives and a driver diagram explained how the Trust would achieve these objectives.

The Medical Director explained that a full implementation plan would be developed to include a summary of objectives, deliverables, timescales, benefits and measures.

The Director of Operations supported the Strategy but stressed the importance of the Strategy being delivered in conjunction with performance.

Mr R Groome referred to the workforce section and stated that this work stream needed to be resourced properly. The Interim Director of Finance advised that the financial aspects of the resources were included within the 2019/20 financial plan and would be discussed in the part 2 meeting.

The Director of Corporate Affairs commented that the strategy had been discussed and reviewed by the Executive Management Team on numerous occasions. She added that it was the right direction for the Trust to progress.

The Director of Strategy and Planning commented that the Strategy links to the Trusts Corporate Strategy. He advised that an integrated business plan would be developed to ensure all of the Trust's strategies were aligned in terms of delivering the right care, at the right time, in the right place, every time.

Dr M Ahmed made reference to the implementation plan and stated that an evaluation against the plan was crucial. She made reference to the role of Physician Associates and how this role could support delivery of the strategy. The Medical Director supported this view and stated this could be considered during the development of the implementation plan.

The Director of Strategy and Planning welcomed the strategy and stated there was a need to identify the implications in terms of the long term plan that needed to be factored in.

The Interim Director of Finance commented that the Urgent and Emergency Care Strategy formed part of the PES contract negotiations. It was noted that there was a need to be clear on the minimum base resource going forward.

The Interim Director of Organisational Development explained that a cultural shift was required in terms of delivery of the strategy and therefore, leadership was key.

The Director of Quality, Innovation and Improvement commented that the strategy challenged the core of what the Trust was about. She added that the implementation plan was key in terms of delivery of the strategy. The Medical Director support this view.

The Interim Chief Executive welcomed all of the comments made, stating they were key. In terms of cultural shift, he stated that this work would become part of the core business. He added that evaluation and external engagement was key.

The Chairman summarised the discussion and commented that the consensus of members was that the strategy was the right way forward. He supported all of the comments made and stressed the importance of performance being achieved in conjunction with delivery of the strategy, to maintain reputation.

The Board:

- Approved the Urgent and Emergency Care Strategy.

BM/1819/214 BOARD ASSURANCE FRAMEWORK

The Director of Corporate Affairs presented the Board Assurance Framework (BAF), summarising the position of the Trusts strategic risks at the end of the financial year 2018-19.

Members were advised that the 2018/19 BAF contained nine strategic risks and details were provided regarding the change in risk scores from May 2018 – March 2019.

The Director of Corporate Affairs presented the Strategic Risks for 2019/20 as agreed by the Executive team and noted that the wording of SR05 would be revised slightly.

Mr D Rawsthorn made reference to the risks listed in the BAF being presented to the part 2 meeting and questioned why no reference was made to these risks in part 1. The Director of Corporate Affairs advised that NHS England had made it clear not to include details of risks relating to Brexit in Public Board. Mr D Rawsthorn commented that it would be useful for the public to know that the Trust was working on the implications and effectively managing any risks relating to Brexit. The Director of Strategy and Planning advised that any progress relating to Brexit was included within the Chief Executive's report.

Mr R Groome commented that the Board had come a long way in terms of understanding the BAF. He added that the reduction in risk scores over the course of the year had been poor and reducing risks was now a priority.

The Interim Chief Executive stressed the need for risks to be actively managed, via the Board of Directors and Committees. He added that if risk scores did not change, an explanation should be provided.

The Board:

- Reviewed the current Board Assurance Framework,
- Discussed the proposed risks for 2019-20, and
- Agreed to the further development of these risks for inclusion in the 2019-20 Board Assurance Framework.

BM/1819/215 CORPORATE RISK REGISTER

The Director of Corporate Affairs presented the Corporate Risk Register (CRR) and reminded members of their responsibility to retain oversight of any risks with a net risk score of 15 and above.

Members were advised that since the last reporting period in January 2019, (i) two new risks had been identified or increased in score, (ii) three had reduced in score and therefore removed from the register, and (iii) two risks had increased in score.

Mr D Rawsthorn commented on the Unified Communications Programme and stated he would have expected to see this within the CRR. The Director of Operations explained that this had been picked up within the project risk register. The Director of Quality, Innovation and Improvement added that she was in the process of reviewing IT risks.

Mr R Groome questioned the score of risks included on the CRR and the Director of Corporate Affairs stated that risks with a net score of 15 and above were included on the CRR.

Mr R Groome suggested that there was a large number of risks on the CRR and the Director of Corporate Affairs explained that the number of risks listed was actually low compared to other healthcare providers. Mr M Tattersall confirmed that in his experience the NWAS CRR actually contained few risks compared to other providers.

The Director of Operations referred to risk 2575 – 'The Trust may be unable to achieve and maintain Category 2 mean and 90th percentile national performance targets' and advised that despite performance improving, the risk score had increased as a result of how the risk was written.

The Director of Operations made reference to risk 2262 – 'risk of high clinical advisor vacancy gap in 111' and advised that Conduit were currently providing additional resource however, this was not sustainable.

The Interim Chief Executive suggested that consideration be given to listing the BAF/CRR to the beginning of Committee agendas.

The Board:

- Reviewed the risks contained within the Corporate Risk Register,
- Considered whether actions were appropriate to enable the target score to be achieved,
- Noted the removal of those risks that had reduced in score, and
- Consideration be given to listing the BAF and CRR at the beginning of Board and Committee agendas.

BM/1819/216 MODERN SLAVERY ACT 2015

The Interim Director of Finance presented the NWAS Modern Slavery Act 2015 – Statutory statement for the year ending March 2019, for approval. Members were advised that the statement would be included within the annual report and on the Trust's website.

The Board:

- Approved the NWAS Modern Slavery Act 2015 – Statutory statement for the year ending March 2019.

BM/1819/217 INTEGRATED PERFORMANCE REPORT OCTOBER 2018

The Director of Quality, Innovation and Improvement presented a report to provide members with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of February 2019.

The Chairman commented that a detailed report was presented to the Quality Committee in terms of complaints and serious incidents and it was noted that the process was under review, in conjunction with the Right Care Strategy. The Director of Operations advised that the bulk of unscored incidents were in the Emergency Operations Centres and resources were now in place to manage these incidents. The Medical Director explained that the quality of reporting and learning was improving.

A discussion ensued in relation to mandatory training within 111 and assurance was sought in terms of improvement. The Interim Director of Organisational Development explained that a mandatory training system was in place within 111 that was impacting on the online mandatory training completion. Changes had now been made to review the refresher timetable to ensure consistency and to plan training into rotas. The Director of Operations explained that a rosta review was being implemented that would allow training and appraisals to be scheduled.

The Interim Director of Organisational Development advised that an increase in sickness was anticipated during winter. It was noted that whilst sickness rates had increased during winter, compared to the same period in the previous two periods, sickness rates had actually improved. With regards to sickness with the Patient Transport Service, it was noted that a detailed action plan was being developed.

Mr R Groome commented on the retention of staff and stressed the importance of career plans being in place, including training. The Interim Director of Organisational Development explained that appraisals provided the platform to

discuss performance and training with members of staff.

The Director of Quality, Innovation and Improvement referred members to the 111 provider comparison figures and commented that the Trust was 7th out of 18 providers in terms of the number of calls answered in 60 seconds. The Trust was 3rd in terms of the number of call backs in 10 minutes, demonstrating a remarkable turnaround in performance. This was acknowledged by members.

A discussion ensued in relation to the Ambulance Clinical Quality Indicators (ACQIs) and the Medical Director advised that a national review of the validity of data was being carried out.

The Board:

- Noted and took assurance from the update.

BM/1819/218 **FINANCE REPORT - MONTH 11 2018/19**

The Director of Finance presented the Committee with the financial performance for the Trust at Month 11.

Members were advised that the Trust was reporting a surplus of £1.835m, which was £0.225m better than the planned surplus of £1.610m. Income was over recovered by £5.748m, pay was overspent by £3.530m and non-pay was overspent by £1.993m.

The Interim Director of Finance explained that the Trust forecast as at Month 11 was £2.088m which was £0.250m above the control total of £1.838m. It was noted that this was an improvement on the notified financial control total of £1.838m surplus and therefore the Trust anticipated full payment of the £2.422m Provider Sustainability Fund (PSF). Members were informed that the Trust anticipated to be paid a pound for pound incentive for any agreed achievement above the control total. The £0.250m had been agreed with NHSI.

Mr D Rawsthorn referred to the summary financial position by Directorate and stated that the three core services had all overspent. The Interim Chief Executive advised that this related to the contract position and would be resolved within contract negotiations.

In terms of the control total, the Interim Director of Finance explained it was envisaged that this would be higher at year-end.

The Board:

- Noted and took assurance from the update,
- Noted that the overall financial performance risk rating as at 28th February 2019 was 1,
- Noted that the Cost Improvement Programme (CIP) for the year was £9.834m, as at Month 11 the year to date target was £8.787m and the Trust had achieved £9.056m (103.06%),
- Noted that the forecast CIP was £9.834m in 2018/19 and £8.707m recurrently leaving no shortfall in-year and £1.002m recurrently,
- Noted the 2018/19 capital plan was £21.306m. Expenditure as at Month 11 was £16.332m and sale of assets at £0.382m, and
- Noted that at 28th February 2019 the cash and cash equivalents balance was £44.074m.

BM/1819/219 **CHAIRS ASSURANCE REPORT – QUALITY COMMITTEE HELD ON 5TH MARCH 2019**

The Chairman presented an assurance report from the meeting of the Quality Committee held on 5th March 2019.

A discussion ensued in relation to mental health provision and the Director of Quality, Innovation and Improvement advised that a review of the provision and infrastructure was almost complete. A report would be presented to the Executive Management Team.

The Board:

- Took assurance from the matters discussed at the meeting of the Quality Committee held on 5th March 2019.

BM/1819/220 **CHAIRS ASSURANCE REPORT - FINANCE, INVESTMENT AND PLANNING COMMITTEE HELD ON 22nd MARCH 2019**

The Chairman provided a verbal update from the meeting of the Finance, Investment and Planning Committee held on 22nd March 2019.

Members were advised that the Committee had reviewed the Unified Communications Programme Business Case in detail.

It was noted that the implementation of EPR was on track.

The Board:

- Took assurance from the matters discussed at the meeting of the Finance, Investment and Planning Committee held on 22nd March 2019.

BM/1819/221 **CHAIRS ASSURANCE REPORT - PERFORMANCE COMMITTEE HELD ON 18th MARCH 2019**

The Chairman presented an assurance report from the meeting of the Performance Committee held on 18th March 2019.

It was noted that the Committee had received assurance that improvements were being made across performance.

The Board:

- Took assurance from the matters discussed at the meeting of the Performance Committee held on 18th March 2019.

BM/1819/222 **STAFF SURVEY 2018 REVIEW AND FINDINGS**

The Interim Director of Organisational Development presented a report to provide members with an overview of the 2018 staff survey results taken from the national staff survey results, which were published at the end of February 2019.

Members were advised that overall, the results were positive. Details were provided in relation to the top 5 key improvements since 2017 and it was noted that this was due to work being carried out in relation to complaints, incident management, first line management and staff engagement.

In terms of areas for improvement, it was noted that (i) leadership, (ii) appraisals,

(iii) bullying and harassment, (iv) incident management, and (v) health and wellbeing had been identified and were reflected within the Workforce Strategy.

The Interim Director of Organisational Development referred members to section 11 of the report, which detailed the next steps. This included utilising the results from the survey to inform organisational development priorities. Mr D Rawsthorn suggested that future reports made the priorities for action explicit.

The Chairman commented that the Workforce Committee would review and monitor the priorities for action, in detail. He added that bullying and harassment had been raised at the Ambulance Leadership Forum and the Interim Director of Organisational Development explained that an action plan and Working Group was in place.

The Board:

- Took assurance and noted the contents of the report,
- Considered and endorsed the suggested priorities for action.

BM/1819/223 THE NWAS PATIENT AND PUBLIC PANEL

The Director of Strategy and Planning presented a report, providing the agreed framework to increase patient and public engagement and involvement between the communities of the North West and the Trust through the creation of a Patient and Public Panel (PPP).

Members were advised that best practice and national advice had been sought and it was noted that the purpose of the PPP was about patient and public involvement that added value.

The Director of Strategy and Planning advised that the patient and public involvement would be categorised into three areas (i) influence, (ii) co-produce, and (iii) consult. It was noted that it was key to attract a good calibre and representation of members and the importance of engaging with various communities.

Members were advised that feedback would be presented to Board on a quarterly basis. It was anticipated that the PPP would meet as a panel on a bi-annual basis, in addition to ad-hoc work.

Dr M Ahmed advised that modest aspirations be set at the outset, whilst the process evolved. She added that a minimum commitment was required. The Director of Strategy and Planning advised that a charter was being developed.

The Interim Chief Executive welcomed the proposal and suggested it aligned to work being carried out to manage risk and complaints. He added that patient and public engagement would contribute to the Trust providing outstanding services.

The Chairman expressed his support and commented that roles and responsibilities should be clear from the outset.

The Board:

- Noted the agreed framework to establish a patient and public panel.

BM/1819/224 ANY OTHER BUSINESS

The Chairman acknowledged that this was the last Board meeting that the Interim Director of Finance would attend within this capacity. He commented that

she had succeeded in post and had carried out an excellent job.

The Chairman addressed the Interim Chief Executive and commented that he had also done an excellent job, despite the challenges within the Trust. He added that his leadership and support had been invaluable and the (i) CQC rating, (ii) improving performance, and (iii) Urgent and Emergency Care Strategy were all a testament to the work that had been carried out.

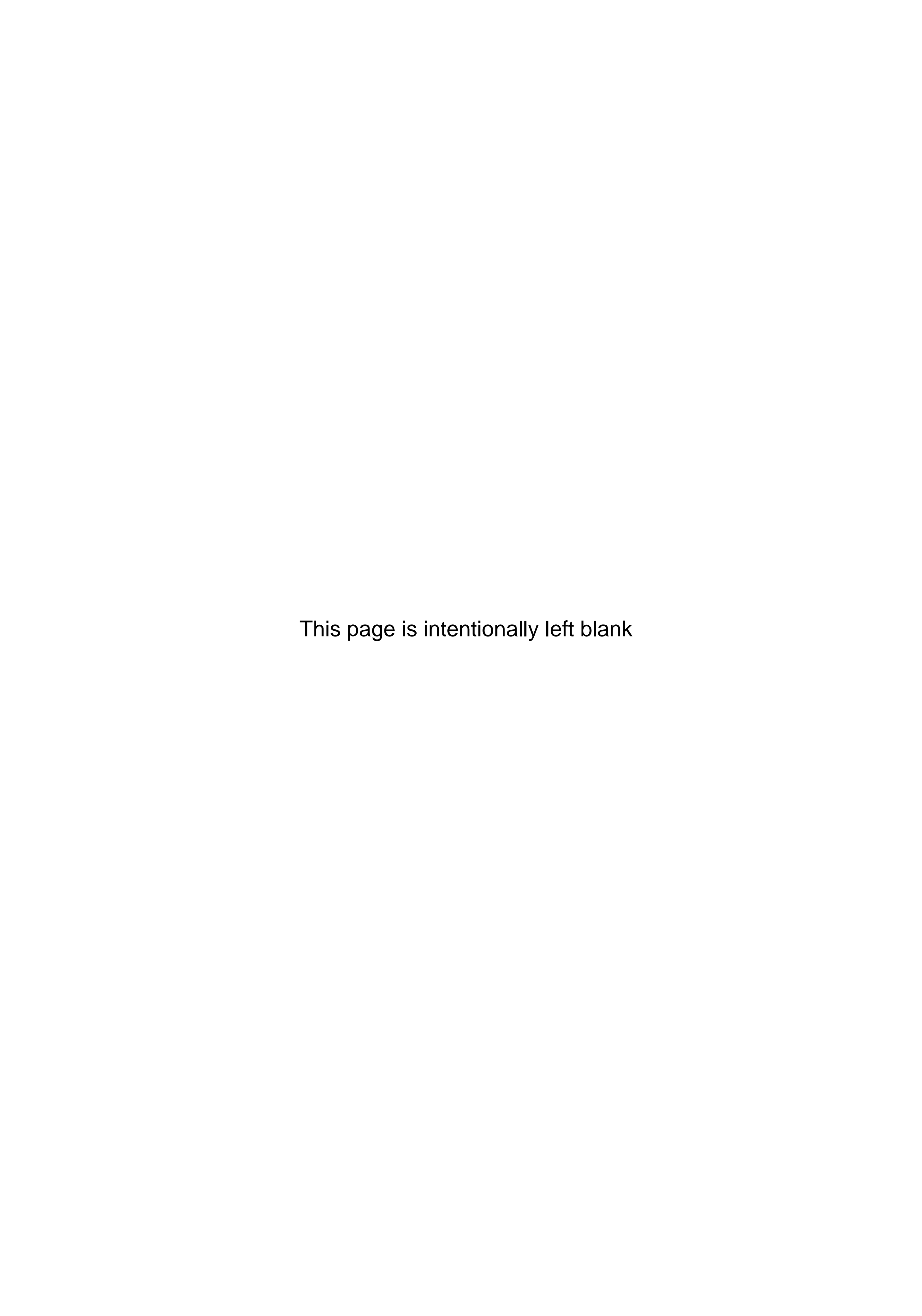
BM/1819/225 ITEMS FOR INCLUSION ON THE BOARD ASSURANCE FRAMEWORK

No additional items were identified, to be included on the Board Assurance Framework.

BM/1819/226 DATE, TIME AND VENUE OF NEXT MEETING

The next meeting of the Board of Directors will be held on Wednesday 24th April 2019, 09:45 am, at Ladybridge Hall, 399 Chorley New Road, Heaton, Bolton, BL1 5DD.

Signed: ____________________________
Date: ______________________________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BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Status:	
Completed on Time	
In progress	
Incomplete & Overdue	
On Current Agenda	

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
4	25-Jul-18	1819/75	July Performance Committee - Assurance Report	Requested that consideration be given to developing a Digital Strategy to support the Corporate Strategy.	MP/TE	Update to be provided on 26.09.18	27.03.19	Work is underway to develop a Digital Strategy. Progress will be updated through the FIP Committee with the final strategy sign off at Board in March 2019.	
19									

Agenda Item 5

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Board and Committee Attendance

Board of Directors	24th April		29th May	26th June		31st July		25th September		30th October		27th November		29th January		26th February		25th March	
	Part 1	Part 2	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2	Part 1	Part 2
Peter White																			
Richard Groome																			
Michael O'Connor																			
Maria Ahmed																			
David Rawsthorn																			
Daren Mochrie																			
Mick Forrest																			
Ged Blezard																			
Chris Grant																			
Carolyn Wood																			
Angela Wetton																			
Salman Desai																			
Maxine Power																			
Lisa Ward																			

Audit Committee	18th April	24th May	19th July	18th October	17th January
David Rawsthorn	✔				
Richard Groome	✔				

Finance Investment & Planning Committee	20th May	26th July	23rd September	22nd November	24th January	21st February	20th March
Michael O'Connor							
David Rawsthorn							
Carolyn Wood							
Ged Blezard							
Maxine Power							
Salman Desai							
Lisa Ward							

Quality Committee	8th April	13th May	3rd June	8th July	9th September	7th October	4th November	6th January	3rd February	2nd March
Maria Ahmed	✔									
Richard Groome	x									
Mr P White	✔									
Maxine Power	✔									
Ged Blezard	✔									
Chris Grant	x									
Carolyn Wood	✔									

Performance Committee	21st May	16th July	17th September	19th November	21st January	17th March
Peter White						
Richard Groome						
Carolyn Wood						
Ged Blezard						
Mick Forrest						
Lisa Ward						

Workforce Committee	23rd April	23rd July	22nd October	21st January
Peter White				
Richard Groome				
Carolyn Wood				
Ged Blezard				
Lisa Ward				

Charitable Funds Committee	24th April	26th June	25th September	30th October	27th November	29th January	25th March
David Rawsthorn	Cancelled						
Richard Groome							
Angela Wetton							
Ged Blezard							
Salman Desai							
Carolyn Wood							
Lisa Ward							

Nomination & Remuneration Committee	24th April	29th May	26th June	31st July	25th September	30th October	27th November	29th January	26th February	25th March
Peter White										
Richard Groome										
Michael O'Connor										
David Rawsthorn										
Angela Wetton										
Maria Ahmed										

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REPORT

AGENDA ITEM:

Board of Directors	
Date:	24th April 2019
Subject:	Chief Executive's Report
Presented by:	Daren Mochrie, Chief Executive
Purpose of Paper:	For Assurance
Executive Summary:	The purpose of this report is to provide members with information on a number of areas since the last report to the Trust Board 27th March 2019.
Recommendations, decisions or actions sought:	Receive and note the contents of the report.

Link to Strategic Goals:				
	Right Care	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**
☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	
Date:	
Outcome:	

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1. PURPOSE

1.1 The purpose of this report is to provide members with information on a number of areas since the last report to the Trust Board on 27th March 2019.

2. PERFORMANCE

2.1 999

The table below represents the significant improvements the Trust has made in the past 12 months. The comparison over that period demonstrates that all aspects within NWAS control have made significant improvements. The areas that have increased are call volumes and activity to the Trust which are difficult for NWAS to have control over.

These improvements have been established through system changes to the Computer Aided Dispatch (CAD) system and how we process calls. Further improvements will follow through further CAD development and investment in new operational resources following the recent contract renewal.

Date	Mar-18	Mar-19	Std	Impact
Calls	133466	135156		1690
Incidents	93239	98958		5719
CPU	57.06%	83.44%	95.00%	26.38%
H&T	4211 4.31%	7349 7.43%		3138 3.12%
S&T	22412 24.04%	25936 26.21%		3524 2.17%
C1 Mean	00:08:41	00:07:27	00:07:00	00:01:14
C1 90th	00:14:46	00:12:37	00:15:00	00:02:09
C2 Mean	00:32:31	00:22:28	00:18:00	00:10:03
C2 90th	01:14:10	00:47:42	00:40:00	00:27:28
C3 Mean		01:01:22	01:00:00	
C3 90th	03:13:55	02:26:30	02:00:00	00:46:25
C4 90th	03:26:02	03:01:53	03:00:00	00:24:09
Hosp	67596	66498		-1098
HTT	00:39:07	00:31:46	00:30:00	00:07:21

The Trust said goodbye to Paul Bailey who has worked for GMAS/NWAS for the past 38.5 years. He had operational roles within the Salford/Trafford area of Manchester and for the past 20 years he has been heavily involved in Resilience. Paul played a significant role in the 2002 Commonwealth Games planning, 2012 Olympic Games in London and most

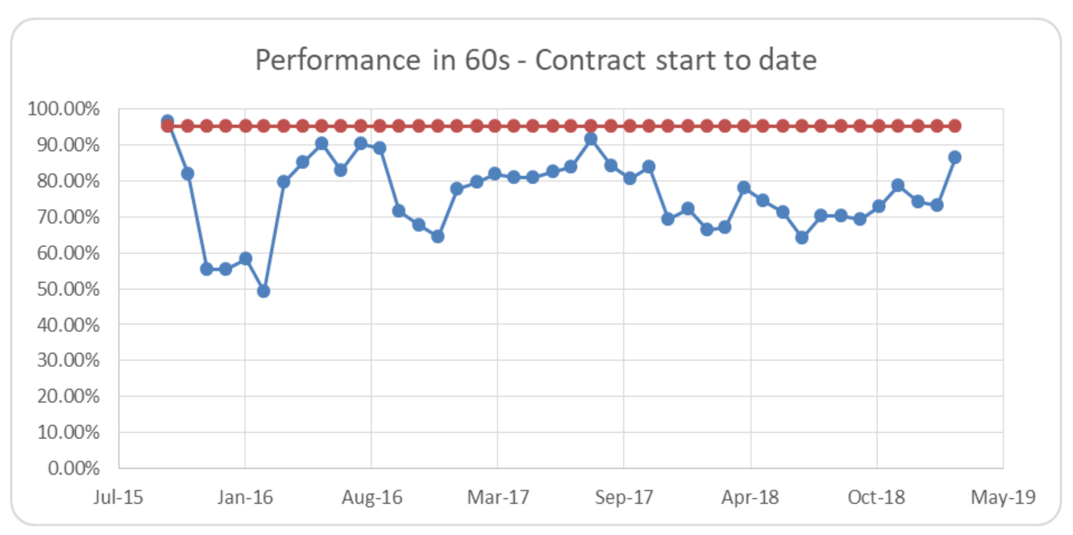
recently he helped to devise the Mass Casualty Plan that helped save a number of lives in the Manchester Arena attack. On behalf of the Trust I would like to thank Paul for everything he has done for the Ambulance Sector and patients over many years and wish him all the best for the future.

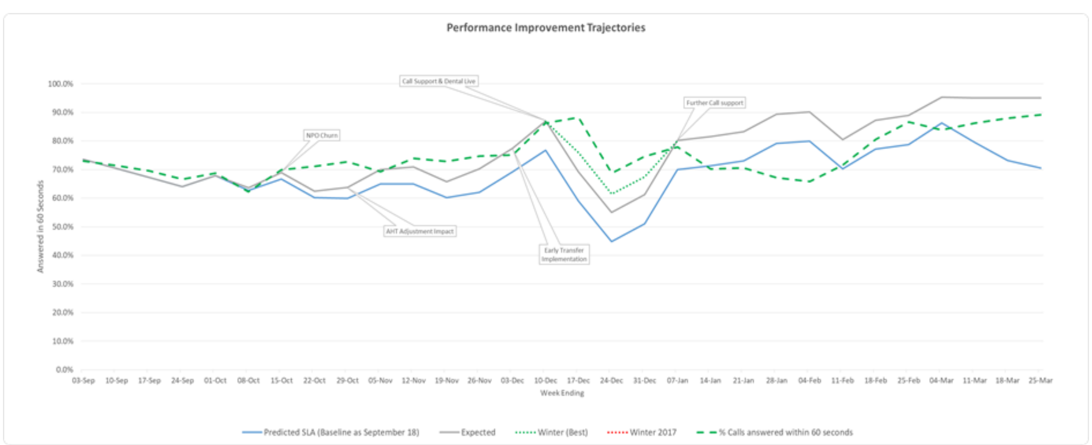
It is with regret that I announce the death of John Betteridge, he was one of our Operational Managers in the Cheshire & Mersey area. John passed away after a short illness. On behalf of the Trust I send our thoughts and condolences to John's family at this time.

The Trust resilience teams have been busy planning and supporting a significant number of events most notably the Grand National and three north West teams in the Champions League Quarter Finals which all need planning and resourcing for. I was delighted to be able to attend and see first-hand our planning, preparations and management of these large scale events.

111

During March 2019, the 111 team delivered its best performance for calls answered in 60 seconds and lowest abandoned calls since August 2017 (see graph 1). This has been achieved through the delivery of the PIP projects, with increased recruitment and a decrease in Health Advisor attrition being the key deliverables. This has come at a financial cost with a potential full year effect overspend of £1.6m. We are working with commissioners to discuss the contract value and we are currently undertaking a demand modelling review to support this premise. With the achievement of the performance improvement trajectory (see graph 2), commissioners have agreed to remove the contract performance notice on the 111 contract.





PTS

Overall activity during March 2019 was 2% (2,836 journeys) below contract baselines mainly due to Lancashire being 9% (4,553 journeys) below baseline. For the year to date position (July 2018 – March 2019) PTS is performing at 1% (11,441 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are 2% and 9% below baseline whilst Greater Manchester and Merseyside are 2% and 10% above baseline respectively. In terms of overall trend analysis, Greater Manchester has experienced upward activity movement for the 12 months up to around October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also plateauing whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity.

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 21% (7,587 journeys) and 7% (1,216 journeys) above baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges in achieving contract KPI performance. Cumbria and Lancashire are 17%

(1,957 journeys) and 8% (3,620 journeys) below baseline.

Aborted activity for planned patients averages 7% for the period July 2018 - March 2019 however Cumbria experiences 4%, Greater Manchester operates with 11% whilst Lancashire and Merseyside both experience 6% aborts. There is a similar trend within EPS (renal and oncology) patients with an average of 5% aborts whereas Cumbria has 2% and Greater Manchester 8% Lancashire and Merseyside operate with 3% and 5% respectively. Unplanned (on the day) activity experiences the largest volumes of aborts with an average 18% (1 in 5 patients) with variances of 10% in Cumbria, 24% in Greater Manchester, 15% in Lancashire and 17% in Merseyside.

3 ISSUES TO NOTE

Welcome

On behalf of the Board I would like to formally welcome our two new board members, Carolyn Wood and Dr Chris Grant.

Carolyn, our new Director of Finance, started in the NHS in 1995 and qualified as a Chartered Public Finance Accountant in 2000. Since that time Carolyn has gained a broad range of financial services experience and knowledge by working within a range of organisations in the North West, including acute providers, commissioners, including NHS England, and the Strategic Health Authority. Our new Medical Director, Dr Chris Grant, joined the trust six months ago to help drive improvements to both the Medical and Quality Directorates before being appointed as Medical Director. Chris will continue to work at the Major Trauma Centre in Liverpool as a Consultant in Critical Care Medicine. I am delighted to have them working with me and fellow Board members and wish them every success in their roles.

Armed Forces Insight Day

I am pleased to record the success of the recent Armed Forces Insight Day attended by service leavers and veterans from across the country. The event provided the opportunity to find out about roles and career progression via a marketplace comprising stands represented by all service areas. In addition, presentations were given by Geraldine Bennett, HR Hub, on ‘A Guide to NWAS Recruitment’ and by Christian Durrant, who is ex-Forces who talked about his journey in the role of Ambulance Care Assistant.

The event was also supported by the College of Military Veterans, who help people make a smooth transition from life in the uniformed services to civilian life, Career Transition Partnership who provide resettlement services for those leaving the Armed Forces and SSAFA, who provides support to serving personnel, veterans and military families. My thanks to all of the staff who came and supported this event and made it such a positive event.

Ambulance Leadership Forum

The Trust attended this year's Ambulance Leadership Forum which is organised and managed by the Association of Ambulance Chief Executives in Warwick last month. At the evening Gala Awards Dinner, Chairman Peter White picked up an award for former Chairman Wyn Dignan, which was presented in recognition of her contribution to the ambulance service and wider NHS during her term as NWAS Chairman. Congratulations to Wyn.

Estuary Point

I am delighted to confirm that in addition to completing the migration of all of our Cheshire and Merseyside corporate services staff to Estuary Point, our PTS colleagues previously based at the Countess of Chester have also moved to their new workplace. In addition Liverpool based PES mandatory training courses are now also running from Estuary Point and feedback on the new facilities continues to be very positive. Despite a number of delays installing the network infrastructure, our overall aim to move the EOC, Urgent Care and 111 teams from Elm House by late Spring remains and our Estuary Point Board and Project Teams are working closely with Virgin Media's Blue Light Escalation team to help compress the overall timeline and establish a firm date. As you will no doubt expect we want to make sure the transition is seamless given that this is a critical infrastructure installation.

Health and Wellbeing Update

The third Invest in Yourself Health & Wellbeing Event was held in Cheshire & Mersey on Tuesday 26th March 2019 at Haydock Park Racecourse. The day consisted of speakers on the Importance of Positive Emotions at Work and at Home, Animal Therapy, TASC charity offerings, Injury Prevention, Mental Wellbeing & Nutrition and Mindfulness. Around 30 staff in total attended the day which was really well received.

MIND Support for the Blue Light Programme came to an end at the end of March 2019 but as a Trust we are continuing to support this internally by re-signing the Time to Change Blue Light Pledge at the February Trust Board Meeting and plans are also underway to bring the Blue Light Champions Network in-house. In addition, the Trust is piloting Occupational Health Support Sessions to provide self-care and safeguarding to our Peer Support Leads and support to those staff who are Peer Supporters, TRiM Assessors and Blue Light Champions. The sessions will be facilitated by a trained counsellor who has been sourced via the Occupational Health Service.

Every Minute Matters Event - Hospital Handover

On 1st April 2019 we hosted over 150 NHS staff at the summit of the Every Minute Matters collaborative. This event marked the end of a six month programme of work to bring together six of our largest receiving sites to work on improving handover in A&E. The collaborative has demonstrated that improvements can be made through the systematic adoption of improvement methodology, measurement insights, knowledge exchange and leadership support. The event was attended by participating teams and senior leaders from across the NHS.

Discussions are ongoing with the stakeholder group (NHSE, NHSI, ECIST, GMHSCP) to determine next steps. The participants continue to work to improve but are currently not receiving support for scale up from NWAS. Funding is required to secure a phase II programme. The Director of Quality, Innovation and Improvement is working on a proposal to submit to regulators by 30th April 2019. This proposal will address how we continue to develop the work of the super six to reliable implementation, bring on board an additional 12 sites and share the successful changes with all sites across NWAS and the wider northern alliance. The preparation for this work has commenced with an anticipated ‘go live’ date of September 2019 in anticipation of receipt of additional funds.

EMT1 progression

The Trust has launched an extensive Continuing Professional Development opportunity for its entire EMT1 staff who has not been recruited through the apprenticeship route. All these staff have been offered the opportunity to gain the Level 4 Associate Ambulance Practitioner (AAP) qualification. This will put them in a position to be able to access internal progression opportunities to train to become Paramedics in the future. Although this opportunity has been offered previously, numbers had been limited so it is exciting to be able to offer this to all EMT1s. Workshops have been run to explain the opportunity and

the commitment required and the first six workshops were attended by over 200 EMT1 staff. There are further workshops planned for April, with the programme also commencing this month.

4. EXTERNAL / INTERNAL ENGAGEMENTS

Since joining the Trust on 1st April I have managed to spend time was staff, managers and stakeholders across the Region. I have also been active on social media and I would like to thank everyone for their very warm welcome. Below is a brief summary of some of the engagements over the past few weeks:

- 26th March – meeting with Greater Manchester Health & Social Care Partnership
- 29th March – Armed Forces Leavers & Veterans Insight Day
- 1st April – Every Minute Matters Summit with NHS partners & stakeholders
- 2nd April – Northern Ambulance Alliance
- 2nd April – visit to 111, Middlebrook
- 3rd April – visit to EOC, Elm House
- 4th April – visit to PTS, Broughton
- 5th April – visit to Medicines Supply Hub, Preston
- 5th April – visit to EOC & Fleet Maintenance team, Broughton
- 5th April – visit to Salkeld Hall Support Centre, PTS and staff
- 6th April – visit to Estuary Point
- 6th April - meeting multi agency partners and observing Grand National
- 9th April – meeting at Wrightington Wigan & leigh hospital to meet staff and CEO
- 9th April – observing how NWAS support major events at Anfield
- 10th April – visit to EOC, Parkway
- 10th April – observing how NWAS support major events at Old Trafford
- 11th April – attending the GM SPTL Away Day
- 15th April – Joint Ambulance Improvement Programme Board webex
- 16th April – attending the CM SPTL Away Day
- 16th April – Northern Ambulance Alliance Board meeting
- 17th April – Association of Ambulance Chief Executives Council Meeting
- 17th April – Association of Ambulance Chief Executives CEO Group Meeting
- 17th April - observing how NWAS support major events at Ethiad

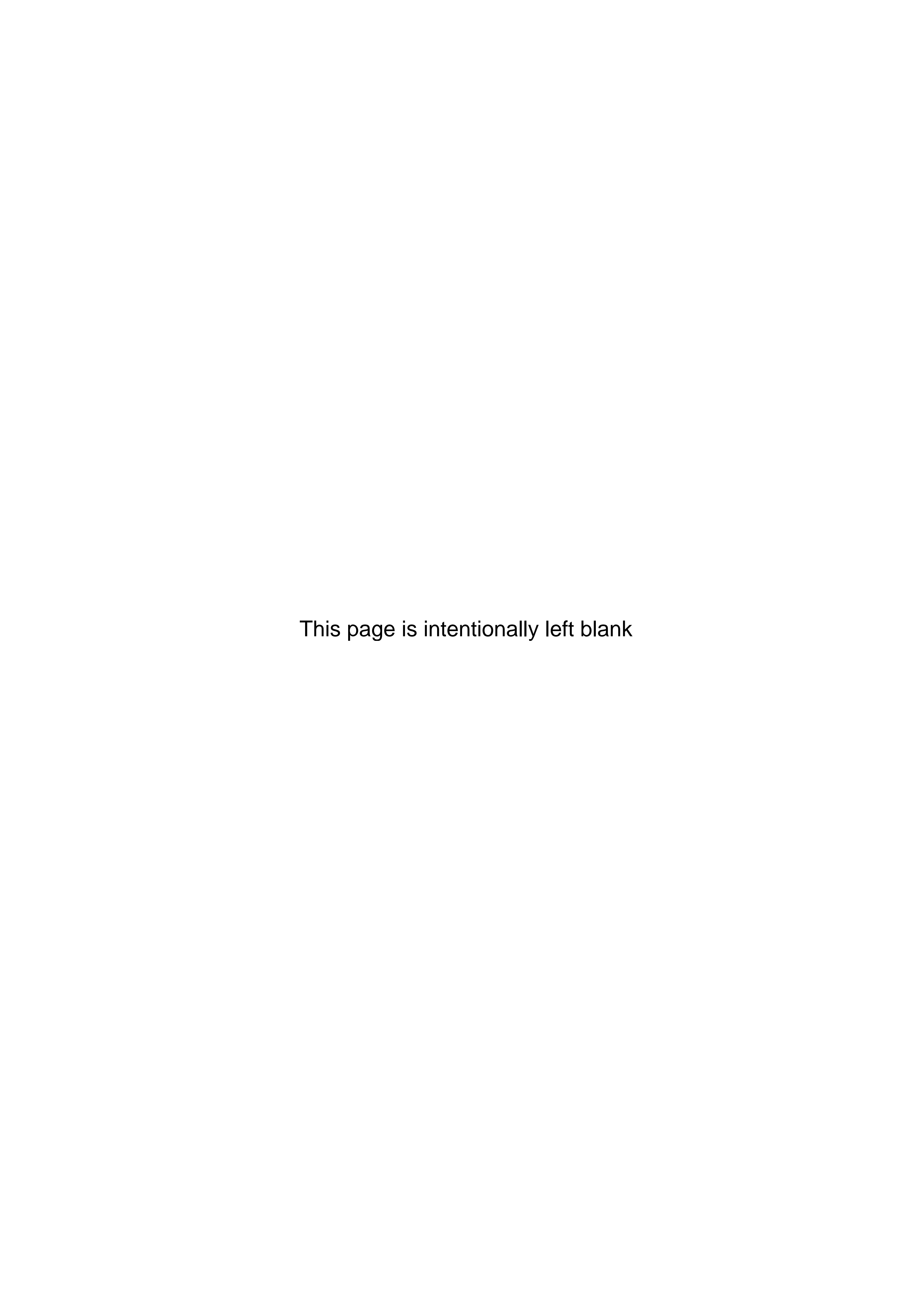
5 LEGAL IMPLICATIONS

5.1 There are no legal implications associated with the content of this report.

6. RECOMMENDATION(S)

6.1 The Board of Directors is recommended to:

- Receive and note the contents of the report.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REPORT

Board of Directors	
Date:	24 April 2019
Subject:	Board Assurance Framework
Presented by:	Angela Wetton, Director of Corporate Affairs
Purpose of Paper:	For Discussion
Executive Summary:	The Board Assurance Framework (BAF) identifies the strategic risks and ensuring that systems and controls are in place are adequate to mitigate any significant risks which threaten the achievement of the strategic objectives. The purpose of the report is to provide the Board of Directors with the updated BAF template and reporting arrangements for 2019/20. The key changes to the BAF are outlined in Appendix 1 and include: • Layout and format • Definitions on BAF key • BAF Dashboard • Clear alignment of controls and assurances • Evidence of assurance section • Mitigating actions for gaps in controls/ assurances • Key changes from quarter to quarter • Operational Risk Exposure Summary A template is shown at Appendix 2
Recommendations, decisions or actions sought:	Board of Directors are requested to: • Review the information provided • Approve the updated BAF template • Clarify the BAF reporting arrangements for 2019/20

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):									
SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**	**SR09**	**SR10**
☒	☒	☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	**None Identified**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

This paper provides the Board of Directors with an opportunity to consider the opening position of the Board Assurance Framework (BAF) and the updated BAF arrangements for 2019/20.

2. BACKGROUND

The Board of Directors has overall responsibility for ensuring that systems and controls are in place are adequate to mitigate any significant risks which threaten the achievement of the strategic objectives.

As part of the BAF 2019/20 process, the BAF has been reviewed in detail with each risk owner. The review has considered:

- The need to consider the re-scoring of the BAF risk taking into account of an assessment of the assurances and controls and any gaps identified during the transfer of the BAF risks from the end of 2018/19 to the opening of 2019/20.

- Work to strengthen the analysis of mitigating actions required to close the gap between the current risk score and the target risk score.

- Ensuring that systems and controls are in place that are adequate to mitigate any significant strategic risks, which threaten the achievement of the strategic objectives.

3. RISK ASSURANCE PROCESS

The BAF risks are reviewed at Committees providing the opportunity to identify where assurances support potential mitigation of the risks, commission where appropriate additional assurance is needed and identify any associated operational risks that may require escalating or de-escalating through the Chair's reporting process.

To support the review of the BAF and the starting position for 2019/20, the Senior Risk and Assurance Manager has collated assurance information from Committee meetings and Chair's Assurance Reports onto an Assurance Map. The assurance mapping has been used to support discussions with Executive Directors and assist with the population and updating the BAF risks.

4. UPDATED BAF ARRANGEMENTS

The Senior Risk and Assurance Manager has undertaken a review of the BAF template and reporting arrangements.

As part of the review, the Senior Risk and Assurance Manager has reviewed a number of BAFs to identify best practice and is also a member of the North West Governance, Assurance and Risk (GARNet) Forum and previous meetings held

have discussed the elements that should be included within the BAF. Furthermore, the GARNet have published a publication in associated with the Good Governance Institute (GGI) to provide guidance of what constitutes a good BAF and developed a standardised approach to risk, assurance and BAFs.

As a result of the review some of the layout and content of the previous BAF has been changed to provide a more concise and visual appealing BAF. The key changes to the BAF template are described in **Appendix 1**. The new BAF template (example) can be viewed in **Appendix 2**.

5. RATIONALE FOR UPDATING THE BAF ARRANGEMENTS

The Care Quality Commission (CQC) inspected the Trust between in June and July 2018. Detailed within the inspection report published in November 2018, it was referenced that inspection team were not assured that the Board Assurance Framework provided a framework for strategic direction. The Trust should continue to work to revise the Board Assurance Framework so that it can be used to underpin strategic objectives.

This is an action the Trust should take, because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

6. ROLE OF BOARD AND AUDIT COMMITTEE IN RELATION TO THE BAF

With the Board having overall responsibility for ensuring that systems and controls are adequate to mitigate any significant strategic risks, the BAF is one of the tools used by the Board to monitor strategic priorities and identify inherit risks. The Board are required to review and approve the quarterly review of the BAF.

As outlined in the HFMA Audit Committee handbook, the Audit Committee's primary role in relation to the BAF is to provide assurance that the BAF itself is valid. The role of Audit Committee is not to manage the process of populating the BAF, but to satisfy itself that the systems and processes surrounding the BAF are working as they should.
This includes reviewing whether:

- The format of the BAF is appropriate and fit for purpose
- The way in which the BAF is developed is robust
- The objectives in the BAF reflect the Board priorities
- Key risks are identified
- Adequate controls are in place and assurances are reliable
- Actions are in place to address gaps in controls and assurance

These factors have been taken into consideration when carrying out the review of the BAF template and reporting arrangements. The updated arrangements have been designed to enable Audit Committee to have confidence in the system and processes for the BAF.

7. REFRESHED BAF REPORTING ARRANGEMENTS

The BAF brings together in one place all of the relevant information on the risks to the Board's strategic objectives. It is an essential tool that provides insight into the organisation and risks in a structured means of identifying and mapping the main sources of assurance in an organisation.

The BAF risks are owned by an Executive Director and a review of the risks will take place on a quarterly basis. This provides an opportunity to review the activity that has taken place during the quarter and determine if it has a material impact on the scoring of the risks. The introduction of assurance mapping will identify information from corporate governance meetings and will be used to inform the review of the controls and assurances related to each of BAF risks and drive the agendas of meetings.

The refreshed reporting arrangements during 2019/20 are described below:

- **Management Meetings:** Provided with the BAF risks aligned to the management meeting so that members can consider whether agenda items provide any additional controls or assurances. The report also provides an opportunity to review the gaps in controls/ assurances to ensure gaps are being closed or highlighted any additional actions that need to be commissioned. Operational risks scored 15 and above that are aligned to BAF risks are provided in the report.

- **Committee Meetings:** Provided with the BAF risks aligned to the Committee. This provides the opportunity to review the controls, assurances, gaps in controls and assurances.

- **Executive Management Team (EMT) Meetings:** Provided with the BAF quarterly review paper for review prior to submission to Audit Committee and Board of Directors. This will provide an opportunity to review the changes made to the BAF as a result of the quarterly review, along with the operational risks scored 15 and above. EMT will also receive a risk report during the quarter which includes risk analysis to ensure EMT are sighted on the high level risks.

- **Audit Committee Meetings:** Provided with the BAF quarterly review report containing all BAF risks is provided to Audit Committee prior to submission to Board of Directors.

- **Board of Directors Meetings:** Provided with the BAF quarterly review paper for approval. This provides an opportunity to review and approve the changes made to the BAF as a result of the quarterly review.

8. BAF OPENING POSITION 2019/20

The Senior Risk and Assurance Manager is in progress with meeting with all Executive Directors to determine their original risks score at the commencement of the financial year. The primary focus for achieving and collating this information will

be submission to the Board of Directors in April 2019.

BAF Risk Scores at 01 April 2019:

BAF RISK	Lead	Score at 01.04.2019
SR01: If the Trust does not maintain and improve its quality of care through implementation of the Right Care Strategy it may fail to deliver safe, effective and patient centred care leading to reputational damage	Director of Quality, Improvement & Innovation	**16**
SR02: If the Trust does not maintain efficient financial control systems then financial performance will not be sustained and efficiencies will not be achieved leading to failure to achieve its strategic objective	Director of Finance	**20**
SR03: If the Trust does not deliver the Urgent & Emergency Care Strategy then it may not be able to meet demand for emergency care leading to inability to meet performance standards	Director of Operations	**15**
SR04: If the Workforce Strategy is not delivered, then the Trust may not have sufficient skilled, committed and engaged staff and leaders to deliver its strategic objectives	Director of HR & OD	12
SR05: If the Trust does not deliver the benefits of the Estates Strategy then the Trust will not maximise its estate to support operational performance leading to failure to create efficiencies and achieves its strategic objectives	Director of Finance	12
SR06: If STP/ Devolution results in different or more complex commissioning of our services it may result in an unintended adverse impact on our ability to deliver the Trust's strategic goals	Director of Strategy & Planning	10
SR07: If the Trust does not maintain and improve its digital systems through implementation of the Digital Strategy, it may fail to secure IT systems and digital transformation leading to reputational risk or missed opportunity	Director of Quality, Improvement & Innovation	**20**
SR08: If the Board experience significant leadership changes it may not provide sufficient strategic focus and leadership to support delivery of its vision and Corporate Strategy	Chief Executive	12
SR09: If the Trust does not establish effective partnerships within the regional health economy then it may not be influence the future development of local services leading to unintended consequences on the sustainability of the Trust and its ability to deliver Urgent and Emergency Care	Director of Strategy & Planning	10

5. LEGAL and/or GOVERNANCE IMPLICATIONS

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

6. RECOMMENDATIONS

The Board of Directors are requested to:

- Review the information provided
- Approve the updated BAF template
- Clarify the BAF reporting arrangements for 2019/20.

APPENDIX 1: KEY CHANGES TO THE BAF

Change	Reason for change
Layout and format	The BAF has been transferred onto a Microsoft Word document as opposed to a Microsoft Excel Spreadsheet in order to provide a more concise and visually appealing BAF.
Definitions on BAF key	The introduction of definitions on the BAF Key has been introduced to reflect the sections of the BAF and aims to enhance understanding. This includes definitions for: • Controls • Assurances • Evidence • Gaps in Controls/ Assurance • Required Actions • Required Action Lead • Implemented by • Monitoring • Progress.
BAF Dashboard	The introduction of a BAF dashboard has been provided to make it clearer and easier to understand all strategic risks and any changes to risk score throughout the year.
Clear alignment of controls and assurances	Rather than having a separate list of controls and assurances that have no connection, the new template is designed to ensure that there is now a link. This is considered as best practice and the assurances will be used to show how the controls stated are operating effectively.
Evidence of assurance section	This is a new section that is linked to the controls and assurances list on the BAF. It will record evidence and timescales of where assurance come from to ensure that only relevant and up to date assurance is included that has been reported through the governance structure. This will increase the confidence that the controls and assurances are accurate and timely.
Mitigating actions for gaps in controls/ assurances	The BAF will now identify the mitigating actions required to close the gaps. This includes identifying an action lead, implementation date, monitoring committee and progress. This will provide a greater focus on the mitigating actions that will have a material impact on the BAF risks.
Key changes from quarter	

to quarter	The BAF template includes a page which highlights the key changes that have been made to each BAF risk from quarter to quarter. This enables those reviewing the BAF to identify key changes. Where required, further narrative will be provided within the covering paper of report to explain the changes in detail.
Operational Risk Exposure Summary	The BAF template will include a section to theme operational risks scored 15 and above that align with the BAF risk and that have a potential to impact on the risk score. A key activities section will provide Audit Committee and Board of Directors to be sighted on the key activities and risks that could impact the BAF in order to provide the lenses into operational activities and risk, which have a potential impact on the score. This will be expanded on, in the narrative of the BAF paper that goes to EMT and Board of Directors.

Appendix 2:

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR01: If the Trust does not maintain and improve its quality of care through implementation of the Right Care Strategy it may fail to deliver safe, effective and patient centred care leading to reputational damage	**LEAD DIRECTOR:** DoQI&I / MD	**DATIX:** 0000

STRATEGIC PRIORITY: Right Care

OPERATIONAL RISK EXPOSURE SUMMARY:
There are a number of operational risks and key activities pertaining to this area that has the potential to impact this BAF Risk. These are:

- Add
- Add
- Add
- Add

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target

RATIONALE FOR CURRENT RISK SCORE:
Add Narrative

CONTROLS	ASSURANCES	EVIDENCE
Level 1: Add Control	**Level 1:** Add Assurance	
Level 2: Add Control	**Level 2:** Add Assurance	
Level 3: Add Control	**Level 3:** Add Assurance	

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress

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REPORT

Board of Directors	
Date:	**24 April 2019**
Subject:	**Annual Review Core Governance Documents**
Presented by:	**Angela Wetton, Director of Corporate Affairs**
Purpose of Paper:	**For Decision**
Executive Summary:	**The purpose of the report is to present the outcomes of the annual review of the Trust's core governance documents:** • **Standing Orders** • **Reservation of Powers to the Board** • **Scheme of Delegation** • **Standing Financial Instructions**
Recommendations, decisions or actions sought:	**The Board of Directors are recommended to:** • **Note the outcomes of the annual review of core governance documents** • **Approve the revised core governance documents.**

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	**Audit Committee**
Date:	**18 April 2019**
Outcome:	**Recommended to Board for approval.**

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1. PURPOSE

The purpose of this report is to present the outcomes of the annual review of the Trust's core governance documents for consideration by the Board of Directors.

2. BACKGROUND

As per the Trust's Scheme of Delegation, the Trust's core governance documents are subject to annual review. The outcomes of the latest review are scheduled for consideration by the Executive Management Team on 17 April 2019 and any matters will be reported to the Committee on 18 April 2019.

3. REVIEW OUTCOMES

The annual review was conducted during March 2019 with copies of the core governance documents forwarded to Executive and Deputy Directors for feedback and comment. A number of changes to the documents have been made in tracked changes. The Standing Orders and Reservations of Powers will be combined as one document following approval by the Board of Directors. The documents have been updated and a summary of the main changes are as follows:

Standing Orders	**Reservations of Powers**
• SO2.1 – Composition of the Trust • SO2.4 – Appointment and Powers of Vice-Chairman • SO3.11 – Quorum • SO4.6 – Statutory and Mandatory Committees • SO6 – Declarations of Interests and Register of Interests	Section 3 – Powers reserved to the Board: • S3.2 – Appointments and dismissals • S3.3 – Strategy, Plans and budgets • S3.4 – Policy determination • S3.5 – Audit • S3.7 - Monitoring

The Standing Financial Instructions have been reviewed by the Finance Directorate and Corporate Affairs with minor amendments.

There have been a number of changes to the Scheme of Delegation, the majority of these changes relate to changes in managerial responsibilities.

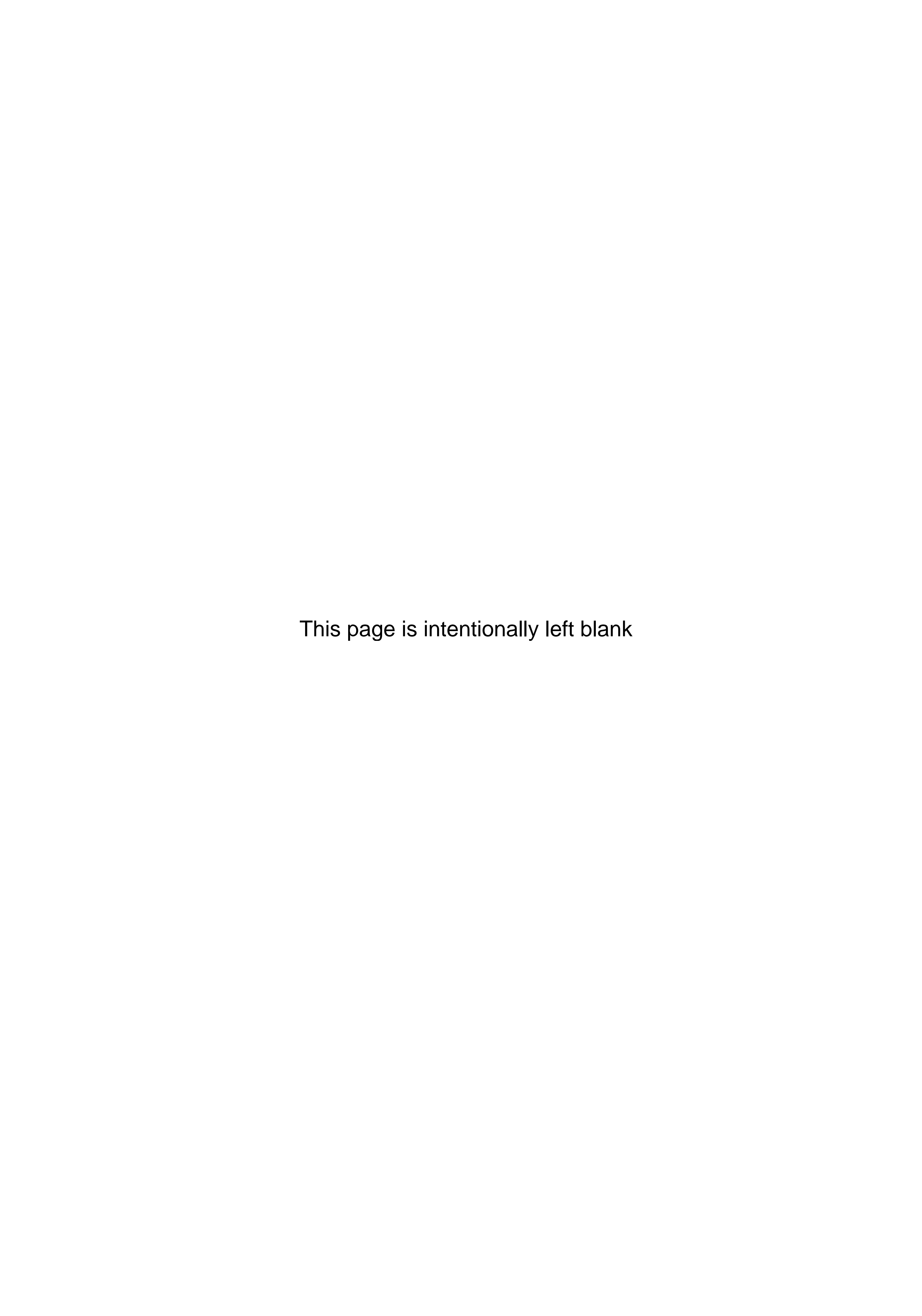
4. LEGAL and/or GOVERNANCE IMPLICATIONS

Valid and up to date governance documents are essential to any organisation and serve to mitigate the risk of any future legal implications.

4. RECOMMENDATIONS

The Board of Directors are recommended to:

- Note the outcomes of the annual review of core governance documents
- Approve the revised core governance documents.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Standing Orders

North West Ambulance Service NHS Trust

Approved by the Board of Directors:

Record of amendments

Number	Section	Date
1	Updated document issued for implementation	1 July 2006
2	Updated following Board approval, 27 September 2006	1 October 2006
3	Annual review, July 2007	25 July 2007
4	Annual review, September 2008	1 October 2008
5	Annual review, September 2009	30 September 2009
6	Annual review, November 2010	24 November 2010
7	Annual review, January 2012	25 January 2012
8	Annual review, January 2013	27 February 2013
9	Annual review, September 2014	24 September 2014
10	Annual review, September 2015	30 September 2015
11	Temporary amendment to the Composition of the Trust	24 February 2016
12	Annual Review, September 2016	28 September 2016
13	Change in Voting Rights and Board Membership General Review and Refresh	31 October 2017
14	Temporary Change in Voting Rights during Interim Period	26 September 2018
15	Annual Review, March 2019	

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1. Introduction

1.1 Statutory Framework

1.1.1 North West Ambulance Service NHS Trust ('the Trust') is a statutory body which came into existence on 1 July 2006, under (Establishment) Order No 2006/1622.

1.1.2 The principal place of business of the Trust is:

Ladybridge Hall,
Chorley New Road,
Bolton,
BL1 5DD.

1.1.3 NHS Trusts are governed by statute, mainly the National Health Service Act 1977 (NHS Act 1977), the National Health Service and Community Care Act 1990 (NHS & CC Act 1990) as amended by the Health Authorities Act 1995, the Health Act 1999 and the Health and Social Care Act 2012. The statutory functions are conferred by this legislation.

1.1.4 As a statutory body, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

1.1.5 The Code of Accountability for NHS Boards requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

1.1.6 These Standing Orders apply to the North West Ambulance Service NHS Trust and its statutory elements.

1.2 Definitions

Terminology	Definition
Accountable Officer	Is the officer responsible and accountable for funds entrusted to the Trust; and is responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive, or their appointed replacement, is the Accountable Officer for this Trust
Board of Directors	The Board of Directors means the Chairman; Non-Executive Directors and both voting and non-voting Executive Directors.
~~**Budget**~~	~~Is the plan, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.~~
Chairman of the Board of Directors	Is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chairman of the Trust" shall, if the Chairman is absent from the meeting or otherwise unavailable, be deemed to include the Vice-Chairman of the Trust, or other Non-Executive Director.
Chief Executive	The Chief Officer of the Trust
Committee	A committee established or appointed by the Board of Directors

Terminology	Definition
Director	A member of the Board of Directors
Director of Finance	The Chief Financial~~e~~ Officer of the Trust
The Trust	North West Ambulance Service NHS Trust
Funds held on Trust	Are those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
Nominated Officer	An Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust
Secretary	A person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the Law, Standing Orders and Department of Health guidance

All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

1.5 NHS Framework

1.5.1 In addition to the statutory requirements the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter. The majority of these can be found on the department of health website.

1.5.2 The Code of Accountability for NHS Boards requires that, *inter-alia*, Boards draw up a schedule of decisions reserved to the Board known as the 'Reservation of Powers to the Board' and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives through a Scheme of Delegation. The Code also requires the establishment of Audit and Remuneration Committees with formally agreed terms of reference. The Code of Conduct for NHS Boards (provided at appendix 2) makes various requirements concerning possible conflicts of interest of members of the Board.

1.5.3 The Code of Practice on Openness in the NHS ~~(provided at appendix 6)~~ sets out the requirements for public access to information on the NHS.

1.6 Delegation of Powers

1.6.1 The Trust has powers to delegate and make arrangements for delegation. These Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions by Delegation (SO5), the Board is given powers to 'make arrangements for the exercise, on behalf of the Trust, of any of their functions by a Committee, Management Group or Joint Committee appointed by virtue of SO4~~6~~ or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust sees fit or as the Secretary of State may direct'. Delegated powers are covered in separate documents (Reservation of Powers to the Board ~~and~~ Scheme of Delegation and Standing Financial Instructions). These documents have effect as if incorporated into these Standing Orders.

1.7 Integrated Governance

Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will ensure decision-making is informed by intelligent information. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. The Board of Directors: Composition of Membership, Tenure and Role of Members

2.1 Composition of the Trust

In accordance with the Establishment Order and Membership and Procedure Regulations 1990 (as amended) the voting membership of the Board of Directors shall comprise the Chairman and five Non-Executive Directors, together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chairman, shall be independent Non-Executive Directors.

In addition to the Chairman, the Non-Executive Directors shall normally include:

- one appointee nominated to be the Deputy or Vice-Chairman
- one appointee nominated to be the Senior Independent Director
- up to three non-voting Associate Non-Executive Directors.

The Voting Executive Directors shall include:

- Chief Executive
- Deputy Chief Executive
- Director of Finance
- Medical Director
- Director of Operations
- Director of Quality, Innovation & Improvement

The Board may appoint additional Executive Directors, to be non-voting members of the Trust Board, these currently include:

- Director of Quality, Innovation & Improvement
- Interim Director of Organisational Development
- Director of Strategy & Planning
- Director of Corporate Affairs

2.2 Appointment of Members of the Board of Directors

The Chairman and Non-Executive Directors of the Trust are appointed by NHS Improvement, on behalf of the Secretary of State for Health.

The Chief Executive is appointed by the Chairman and the Non-Executive Directors.

Other Executive Directors shall be appointed by a committee comprising the Chairman and the Non-Executive Directors, under recommendation from the Chief Executive.

Where more than one person is appointed jointly to an Executive Director post in the Trust, those persons shall become appointed as an Executive Director, jointly. Where the post has voting rights attached, the joint appointees will have the power of one vote; and shall count for the purpose of Standing Order 2 as one person.

2.3 Terms of Office

The regulations governing the period of tenure of office of the Chairman and Non-Executive Directors and the termination or suspension of office of the Chairman and Non-Executive Directors

are contained in the Membership and Procedure Regulations and as directed by NHS Improvement, under its delegated authority from Secretary of State for Health.

2.4 Appointment and Powers of Vice-Chairman

To enable the proceedings of the Trust to be conducted in the absence of the Chairman, the Board of Directors may elect one of the Non-Executive Directors to be Vice-Chairman, for a period that does not exceed the remainder of their appointed term as a Non-Executive Director of the Trust.

Any Non-Executive Director so elected may at any time resign from the office of Vice-Chairman by giving notice in writing to the Chairman. The appointment as Vice-Chairman will end with the termination for any reason of that Non-Executive Director's period of office as a director. On such resignation or termination the Board of Directors may then appoint another Non-Executive Director as Vice-Chairman, in accordance with the provision of this Standing Order.

When the Chairman is unable to perform his duties due to illness or absence for any reason, his duties will be undertaken by the Vice-Chairman who shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties.

In order to appoint the Vice-Chairman, nominations will be invited. Where there is more than one nomination, a vote will be conducted and the results announced at the subsequent meeting of the Board. In the event of there being only one nomination and this being acceptable to the Directors present, the Board will be requested to confirm that person as Vice-Chairman at the meeting in which the nomination is made.

2.5 Role of Members

The Board will function as a corporate decision-making body, Officer and Non-Officer members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

Executive Members
Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

Chief Executive
The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. He/she is the **Accountable Officer** for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

Director of Finance
The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Members
The Non-Executive Members shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chairman
The Chairman shall be responsible for the operation of the Board and chair all Board meetings when present. The Chairman has certain delegated executive powers. The Chairman must comply with the terms of appointment and with these Standing Orders.

The Chairman shall work closely with the Chief Executive and ensure that key and appropriate issues are discussed by the Board in a timely manner, together with all necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

2.6 Corporate Role of the Board

All business shall be conducted in the name of the Trust.

All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided in SO3.

~~The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Reservation of Powers to the Board and have effect as if incorporated into Standing Orders.~~

2.7 Schedule of Matters reserved to the Board and Scheme of Delegation

The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Reservation of Powers to the Board and have effect as if incorporated into Standing Orders.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to individuals and other bodies are contained in the Scheme of Delegation.

3. Meetings of the Trust

3.1 Ordinary Meetings of the Trust Board

3.1.1 All ordinary meetings of the Board of Directors shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

3.1.2 Ordinary meetings of the Board of Directors shall be held at regular intervals at such times and places as the Board of Directors may from time to time determine. A minimum of ten meetings shall be held each year.

3.1.3 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

> 'That representatives of the press and other members of the public be 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'

as required under s.1(2) of the Public Bodies (Admission to Meetings) Act 1960.

3.1.3 The Chairman (or person presiding at the meeting) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature

of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

> 'That, in the interests of public order, the meeting adjourn for [the period specified] to enable the Board to complete business without the presence of the public'

as required under s.1(8) of the Public Bodies (Admission to Meetings) Act 1960.

3.1.7 Nothing in the Standing Orders shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Board.

3.3 Notice of Meetings and the Business to be Transacted

3.3.1 *Regular meeting of the Trust*

Agendas will be sent to members at least seven days before the meeting. Supporting papers, whenever possible, shall accompany the agenda and will in any event be despatched no later than three clear days before the meeting, except in an emergency.

3.3.2 *Exceptional meetings of the Trust*

A notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an Officer of the trust authorised by the Chairman to sign on their behalf, shall be delivered to every Director, so as to be available to them at least three clear days before the meeting.

3.3.3 *Meetings called by Directors*

In the case of a meeting called by Directors in the event that the Chairman has not called the meeting, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

3.3.4 *Public notice*

Before each meeting of the Board, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting, as required under s.1(4)(a) of the Public Bodies (Admission to Meetings) Act 1960.

3.4 Setting the Agenda

3.4.1 The Trust may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

3.4.2 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chairman or Director of Corporate Affairs at least seven clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than seven days before a meeting may be included on the agenda at the discretion of the Chairman.

3.4.3 Where a petition has been received by the Trust, the Chairman shall include the petition as an item for the agenda of the next Board meeting.

3.5 Annual Public Meeting

The Trust will publicise and hold an annual public meeting in accordance with the NHS Trusts (Public Meetings) Regulations 1991. The meeting shall take place no later than 30 September

each year. The Annual Report and Annual Accounts of the preceding year shall be presented at that meeting.

3.6 Notices of Motion

Subject to the provision of Standing Order 3.7 and 3.8, a director of the Trust desiring to move a motion shall give notice of this in writing, to the Chairman, at least seven working days before the meeting. The Chairman shall insert all such notices that are properly made in the agenda for the meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

3.7 Motions: Procedure at and During a Meeting

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion
- the adjournment of the discussion, or the meeting
- that the meeting proceed to the next business
- that the question should now be put
- the appointment of an ad-hoc Committee to deal with a specific item of business
- that a member/Director be not further heard
- a motion under Section 1(2) or Section 1(8) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public including the press

The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the seconder and the consent of the Trust Board.

Rights of reply to motions. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment to it.

3.8 Motion to Rescind a Decision of the Trust Board

3.8.1 Notice of a motion to rescind any decision of the Board of Directors (or general substance of any decision) which has been passed within the preceding six calendar months, shall bear the signature of the director who gives it and also the signature of four other directors who are eligible to vote.

3.8.2 When the Board of Directors has debated any such motion, it shall not be permissible for any director, other than the Chairman to propose a motion to the same effect within a further period of six calendar months.

3.9 Chairman of the Meeting

3.9.1 The Chairman shall preside at any meeting of the Trust Board, if present. In his absence, the Vice Chairman shall preside.

3.9.2 If the Chairman and Vice-Chairman are absent, the directors present, who are eligible to vote shall choose a Non-Executive Director who shall preside. An Executive Director may not take the chair.

3.9.3 The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and his interpretation of the Standing Orders shall be final. In this interpretation he shall be advised by the Director of Corporate Affairs and in the case of Standing Financial Instructions he shall be advised by the Director of Finance.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting of the Board unless at least six of the ~~one-third of the~~ whole number of Directors who are eligible to vote (including at least ~~one~~ three Executive and three~~one~~ Non-Executive Directors) are present.

3.11.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.11.3 A director will not count towards the quorum on a matter where he is ruled to be ineligible to participate in the discussion, or vote, due to the declaration of a conflict of interest. If a quorum is not available for the passing of a resolution on any matter, that matter may be discussed further at the meeting, but no resolution can be made. That position shall be recorded in the minutes of the meeting.

3.12 Voting

3.12.1 It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chairman shall be responsible for deciding whether a vote is required and what form this will take.

3.12.2 Where it is necessary to take a vote to determine an issue, the decision shall be determined by a majority of the votes of the directors present and eligible to vote. If the result of the vote is equal, the Chairman of the meeting shall have a second or casting vote.

3.12.3 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may be held, if a majority of the directors present and eligible to vote so request. Unless specifically agreed beforehand, the voting record of each individual director will not be made public, or recorded

3.12.4 The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors present and eligible to vote so request.

3.12.5 If a director so requests, his vote will be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded

3.12.7 In no circumstances may an absent director vote by proxy.

3.12.8 An officer who has been appointed formally by the Trust to act up for an Executive Director during a period of incapacity, or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of that Executive Director. An officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence, but without formal acting up status, may not exercise the voting rights of that Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.12.9 Where the office of a director who is eligible to vote is shared jointly by more than one person:

- either or both of those persons may attend and take part in the meetings of the Trust Board.
- if both are present at a meeting they will cast one vote if they agree.
- in the case of disagreement no vote will be cast.
- the presence of either or both of those persons will count as the presence of one person for the purpose of establishing a quorum.

3.12.10 Where necessary, a director may be counted as present when available constantly for discussions through an audio or video link and may take part in voting on an open basis.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the directors of the Trust are present and the majority of those present, vote in favour of suspension.

3.13.2 In this instance:

- a decision to suspend Standing Orders shall be recorded in the minutes of the meeting
- a separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Directors
- no formal business may be transacted while Standing Orders are suspended
- the Audit Committee shall review every decision to suspend Standing Orders

3.14 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

- a notice of motion under SO 3.6 has been given; and
- no fewer than half of the appointed Non-Executive Directors vote in favour of the amendment; and
- at least two-thirds of the Directors who are eligible to vote are present; and
- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State

3.15 Minutes

3.15.1 The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

3.15.2 There should be no discussion on the minutes, other than as regards their accuracy, unless the Chairman considers discussion appropriate.

3.15.3 Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

4. Committees

4.1 Appointment of Committees

Subject to such directions as may be given by the Secretary of State for Health, the Board of Directors may appoint committees of the Trust.

4.2 Applicability of Standing Orders ~~and Standing Financial Instructions~~ to Committees

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees established by the Trust. In which case the term ‘Chairman’ is to be read as a reference to the Chairman of other Committees as the context permits and the term ‘member’ is to be read as a reference to a member of other Committees also as the context permits. There is no requirement to hold meetings of Committees established by the Trust in public.

4.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation and regulation or direction issued by the Secretary of State. Such terms of reference shall have effect as if incorporated into the Standing Orders.

Approved Terms of Reference for all Board Committees are held by the Director of Corporate Affairs.

4.4 Delegation of Powers by Board Committees

Committees may not delegate any executive powers unless expressly authorised by the Board.

4.5 Approval of Appointments to Committees

The Board shall approve the appointments to each of the Committees which it has formally constituted. Where the Board determines and regulations permit that persons, who are not Directors, shall be appointed to a Committee, the terms of such appointment shall be determined by the Board.

4.5 Appointments for Statutory Functions

Where the Trust is required to appoint persons to a Committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

4.6 Statutory and Mandatory Committees

The committees required to be established by the Board are:

4.6.1 Audit Committee

In line with the requirements of the ~~NHS Audit Committee Handbook,~~ NHS Codes of Conduct and Accountability ~~and, more recently, the Higgs Report~~, an Audit Committee will be established and constituted to provide the Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. The Terms of Reference are approved by the Board and will be reviewed on a periodic basis. The ~~Higgs Report recommends~~Committee will comprise of a minimum of three Non-Executive Directors ~~be appointed~~ of which one must have significant, recent and relevant financial experience.

4.6.2 Audit Panel

The Auditor Panel's functions are to advise the Board of Directors on the selection and appointment of the External Auditor. This includes the following:

i. Agree and oversee a robust process for selecting the External Auditors in line with the organisation's normal procurement rules.
ii. Make a recommendation to the Board of Directors as to who should be appointed.
iii. Ensure that any conflicts of interest are dealt with effectively.
iv. Advise the Board of Directors on the maintenance of an independent relationship with the appointed External Auditor.
v. Advise the Board of Directors on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
vi. Advise on (and approve) the contents of the organisation's policy on the purchase of non-audit services from the appointed External Auditor.
vii. Advise the Board of Directors on any decision about the removal or resignation of the External Auditor.

4.6.3~~2~~ **Nominations & Remuneration Committee**

In line with the requirements of the Membership and Procedure Regulations, Regulations 17-18~~NHS Codes of Conduct and Accountability and, more recently, the Higgs Report~~, a Remuneration Committee will be appointed and constituted to advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Very Senior Managers including:

- All aspects of salary (including any performance related elements)
- Provisions for other benefits, including pensions and cars
- Arrangements for termination of employment and other contractual terms

4.6.4 **Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non-charitable funds, the Board will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

4.6.5~~4~~ **Non-Mandatory Committees**

~~4.6.1~~ The Board of Directors shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board.

~~4.6.2 The current non-mandatory committees in place are (July 2017):~~

- ~~Finance, Investment & Planning Committee~~
- ~~Quality Committee~~
- ~~Performance Committee~~
- ~~Workforce Committee~~

These are subject to change at the discretion of the Board of Directors. All new or amended non-mandatory committees will have the same standing and will be subject to the same standing orders.

5. Arrangements for the Exercise of Functions by Delegation

5.1 Introduction

5.1.1 Subject to Reservation of Powers to the Board, the Scheme of Delegation and such directions as may be given by the Secretary of State, the Board of Directors may delegate any of its functions to a committee or sub-committee appointed by virtue of SO4, or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the Board thinks fit.

5.2 Emergency Powers and Urgent Decisions

The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chairman acting jointly and~~, if possible,~~ after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairman shall be reported to the next formal meeting of the Board of Directors for ratification.

5.4 Delegation to Committees

5.4.1 The Board of Directors shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Board of Directors shall approve the constitution and terms of reference of these committees and their specific powers.

5.5 Delegation to Officers

5.5.1 Those functions of the Trust, which have not been retained as reserved by the Board of Directors or delegated to a committee of the Trust Board, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust Board.

5.6 Schedule of Decisions Reserved for the Board of Directors

5.6.1 The Board of Directors shall adopt a Schedule of Decisions Reserved for the Board of Directors setting out the matters for which approval is required by the Trust Board.

5.6.2 The Board of Directors shall review such Schedule at such times as it considers appropriate; and shall update after each review.

5.6.3 The Schedule of Decisions Reserved for the Board of Directors shall take precedence over any terms of reference or description of functions of any committee established by the Trust Board. The powers and functions of any committee shall be subject to and qualified by the reserved matters contained in that Schedule.

5.7 Scheme of Delegated Authorities

5.7.1 The Board of Directors shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them.

5.7.2 The direct accountability, to the Trust Board, of the Director of Finance and other Executive Directors to provide information and advise the Board of Directors in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities

5.8 Duty to Report Non-Compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance, shall be reported to the next formal meeting of the Board for action or ratification by the Director of Corporate Affairs. All members of the Board and all staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. Declarations of Interest and Register of Interests

6.1 Declaration of Interests

6.1.1 ~~The NHS Code of Accountability~~In addition to the statutory requirements relating to pecuniary interests, the Trust's Standards of Business Conduct Policy requires Board members to declare interests annually, or as and when they arise, which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.

6.1.2 Interests which should be regarded as relevant and material are:

- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
- Shareholdings and ownership interests in any publicly listed, private or not might reasonably be expected to do business with the organisation

- A position of authority in another NHS organisation, commercial, charity, voluntary, professional, statutory or other body which could be seen to influence your role within the organisation
- A position on an advisory group or other paid or unpaid decision making forum that could influence how the organisation spends taxpayers money
- Are or could be involved in the recruitment or management of close family members and relatives, close friends and associates and business partners
- Any connection with a private, public, voluntary or other organisation contracting for NHS services
- Any other commercial interest relating to any relevant decision to be taken by the organisation
- ~~Directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of dormant companies).~~
- ~~Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.~~
- ~~Majority or controlling shareholdings in organisations in the field of health and social care.~~
- ~~A position of authority in a charity or voluntary organisation in the field of health and social care.~~
- ~~Any connection with a voluntary or other organisation contracting for NHS services.~~
- Research funding/grants that may be received by an individual or their department.

6.1.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Director of Corporate Affairs.

6.1.4 At the time that Directors' interests are declared they should be recorded in the Board minutes and the Register of Interests. Any changes in interests should be declared at the next Board meeting following the change occurring and will be recorded in the minutes of that meeting.

6.1.5 During the course of a Board meeting, if a conflict of interest is established, the Director(s) concerned should declare such likely conflict of interest and withdraw from the meeting unless requested to remain by the Board members present. The Director should play no part in the relevant discussion or decision.

6.2 Register of Interests

6.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally, declarations of interest of the Board. In particular the register will include details of all Directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in SO 6.1.2.

6.2.2 The Register of Interests shall be published on the website~~available to the public~~ and shall be reviewed at least on an annual basis.

6.3 Exclusion of Chairman and Members in Proceedings on Account of Pecuniary Interest

6.3.1 Subject to the following provisions of this Standing Order, which is taken from the Membership Procedure Regulations 1990 (as amended), if the Chairman or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or any other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement, disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.3.2 The Board may exclude the Chairman or a member of the Board from a meeting of the Board while any contract, proposed contract or other matter in which that person has a pecuniary interest is under consideration.

6.3.3 Any remuneration, compensation or allowances payable to the Chairman or a Director by virtue of the NHS (Consolidation) Act 2006 Schedule 3 Part 1 Paragraph 10, NHS Act 1997 Schedule 5A Paragraph 11(4) or the 1999 Act Schedule 1 (pay and allowances) shall not be treated as pecuniary interest for the purpose of this regulation.

6.3.4 Subject to SO 6.3.3 and any conditions imposed by the Secretary of State, the Chairman or a Director shall be treated for the purpose of this regulation as having indirectly a pecuniary interest in a contract, proposed contract or other matter if:

- The Director, or a nominee of theirs, is a Director of a company or other body, not being a public body, with which the contract was made or is proposed to be made, which has a direct pecuniary interest in the other matter under consideration; or
- The Director is a partner of, or is in the employment of, a person with whom the contract was made, or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.
- In the case of married persons or persons living together as partners, the interest of one spouse/cohabitee shall, if known to the other, be deemed to be also the interest of that spouse/cohabitee.

6.3.5 For the purpose of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- *'Spouse'* shall include any person who lives with another person in the same household. (Any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse).
- *'Contract'* shall include any proposed contract or other course of dealing.

6.3.6 The Chairman or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

- Of their (or a person connected to them) membership of a company or other body if they have no beneficial interest in any securities of that company or other body.
- Of an interest in any company, body or person with which they are connected, as detailed in SO 6.3.2, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of, or in voting on, any question with respect to that contract or other matter.
- The total nominal value of those securities does not exceed £5,000 or one hundredth of the total nominal value of the issued share capital of the company or body, whichever is the lower, provided however, that the person shall nevertheless be obliged to disclose/declare their interest in accordance with SO 6.1.2.

6.4 Powers of the Secretary of State

The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to them in the interests of the National Health Service that the disability shall be removed.

6.5 Committee Responsibilities

This regulation applies to a Committee of the Trust as it applies to the Board and applies to any member of any such Committee (whether or not they are also a Director of the Trust) as it applies to a Director of the Trust.

7. Standards of Business Conduct

7.1 Policy

7.1.1 Staff must comply with the national guidance contained in HSG(93)5 'Standards of Business Conduct for NHS Staff'. The following provisions should be read in conjunction with that guidance and staff ~~which is proved at Appendix 5. Staff~~ should also refer to the Trust's Standards of Business Conduct; Policy on Managing Conflicts of Interest, Gifts & ~~,~~ Hospitality and Sponsorship. ~~Interests.~~

7.1.2 It is the responsibility of all Trust staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their official duties.

7.1.3 It is an offence under the Bribery Act 2010 for an employee of the Trust to accept corruptly any inducement or reward for doing, or refraining from doing, anything in their official capacity, or corruptly showing favour or disfavour in the handling of contracts.

7.1.4 It is the responsibility of the Trust to ensure that its Officers are aware that breach of the provision of the Act renders them liable to prosecution and may also lead to the termination of their contracts of employment and superannuation rights within the NHS.

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of a Director or an Officer of the Trust that a contract in which he has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or Director of Corporate Affairs of the fact that he is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer must also declare to the Chief Executive any other employment or business or other relationship of their partner, or of a co-habiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.2.3 The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.3 Canvassing of and Recommendations by Directors in Relation to Appointments

7.3.1 Canvassing of Directors of the Trust or members of any Committee of the Trust directly or indirectly, for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Orders shall be included in application forms or otherwise brought to the attention of candidates.

7.3.2 A Director of the Trust shall not solicit for any person, any appointment under the Trust or recommend any person for such an appointment. But this paragraph of Standing Orders shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.3.3 Unsolicited informal discussions outside appointment panels or Committees should be declared to the panel or Committee.

7.4 Relatives of Directors or Officers

7.4.1 Candidates for any staff appointment shall when making an application, disclose in writing whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to dismissal.

7.4.2 The Chairman and every Director or Officer of the Trust shall disclose to the Board any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the tTrust whether they are related to any other Director or holder of any office under the Trust.

7.4.4 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, the Standing Order headed 'Exclusion of Chairman and Members in Proceedings on Account of Pecuniary Interest ' (SO 6.3) shall apply.

8. Custody of Seal and Sealing of Documents

8.1 Custody of Seal

The common seal of the Trust shall be kept by the Director of Corporate Affairs in a secure place.

8.2 Sealing of Documents

8.2.1 The Seal of the Trust shall only be attached to documents where the sealing has first been approved by the Trust Board, or the Chairman, or the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegated Authorities

8.2.2 The seal shall be affixed in the presence of the signatories.

8.4 Register of Sealings

The Director of Corporate Affairs shall keep a register of sealings. An entry of every sealing shall be made and a report of all sealings shall be made to the Board at least annually.

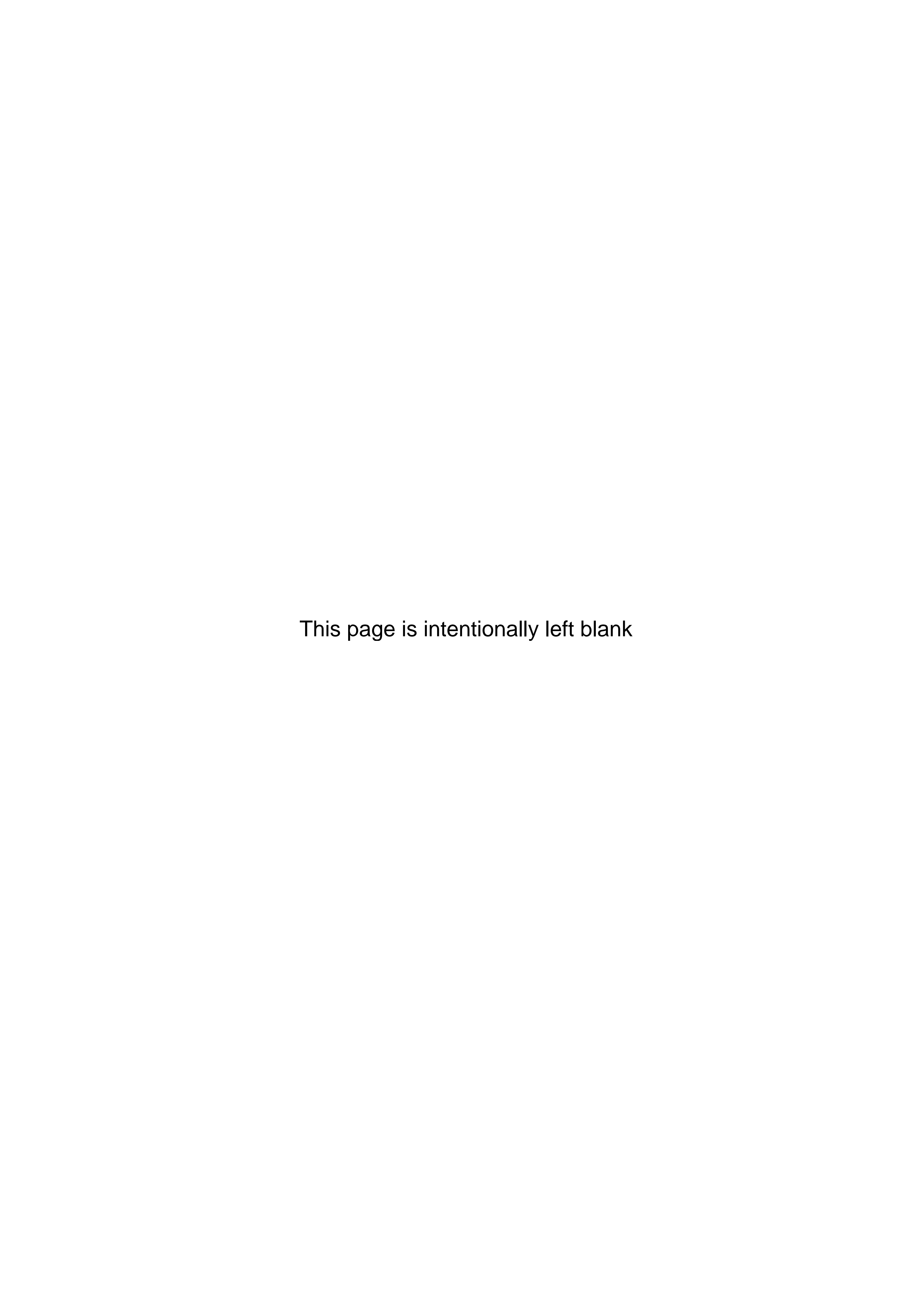
9. Partnership Arrangements

The Trust will from time to time, establish partnership arrangements with external organisations or groups (NHS or non NHS) with the aim of achieving identified benefits for the parties involved in the partnership.

For governance purposes, it is imperative that such partnership arrangements are subject to formal approval by the Executive Management Team prior to any commitment to join the partnership.
The anticipated outcomes and duration of partnership arrangements will be measured and monitored by the relevant lead Officer. The Director of Corporate Affairs will maintain a register of partnership arrangements which will be presented to the Board for scrutiny on a 6 monthly basis.

For the avoidance of doubt, the definition of a Partnership is as follows:

'A relationship established between the Trust and an external organisation for the furtherance or development of the Trust's activities, which aim to deliver identified benefits to the satisfaction of all Partners in the relationship. Such relationships would be in addition to the purchaser/provider or client/customer relationships which arise through the Trust's normal business activities.'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Reservation of Powers to the Board

North West
Ambulance Service
NHS Trust

Approved by the Board
of Directors:

Record of amendments

Number	Section	Date
1	Updated document issued for implementation	1 July 2006
2	Updated following Board approval, 27 September 2006	1 October 2006
3	Annual review, July 2007	25 July 2007
4	Annual review, September 2008	1 October 2008
5	Annual review, September 2009	30 September 2009
6	Annual review, November 2010	24 November 2010
7	Annual review, November 2011	29 November 2011
8	Annual review, January 2013	27 February 2013
9	Annual review, September 2014	24 September 2014
10	Annual review, September 2015	30 September 2015
11	Annual Review, March 2019	

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1. Introduction

1.1 Standing Orders ~~article~~ 1.6~~2~~ requires that the Trust must adopt a Reservation of Powers and Scheme of Delegation which define the powers retained by the Board. Those powers so determined are detailed below.

2. General enabling provision

2.1 The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

3. Powers reserved to the Board

3.1 Regulations and control

3.1.1 Approval of Standing Orders, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

3.1.2 Suspension of Standing Orders.

3.1.3 Approve variations or amendments to the Standing Orders, schedule of matters reserved to the Board and Standing Financial Instructions.

3.1.4 Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with S~~tanding~~ O~~rders Article~~ 5.2~~3~~.

3.1.5 Approval of a scheme of delegation of powers from the Board to committees and officers.

3.1.6 Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.

3.1.7 Require and receive the declaration of officers' interests that may conflict with those of the Trust.

3.1.8 Approve arrangements for dealing and responding to ~~with~~ complaints.

~~3.1.9 Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.~~

~~3.1.10~~3.1.9 Receive reports from committees, including those that the Trust is required by the Secretary of State or other regulation to establish, and take appropriate action.

~~3.1.11~~3.1.10 Confirm the recommendations of the Trust's committees where the committees do not have executive powers.

~~3.1.12~~3.1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

~~3.1.13~~3.1.12 Establish terms of reference and reporting arrangements for all committees and sub-committees that are established by the Board.

3.1.143.1.13 Receive reports on instances of use of the seal.

3.1.153.1.14 Ratify, or otherwise, instances of failure to comply with Standing Orders or Standing Financial Instructions brought to the Chief Executive's attention in accordance with SOtanding Orders Article 5.86.

3.2 Appointments and dismissals

3.2.1 Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

- Appoint the Chief ExecutiveVice Chairman of the Board.
- Appoint the Executive Directors

3.2.1 Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interestsAppoint and dismiss committees (and individual members) that are directly accountable to the Board.

3.2.2 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements of the Trust's Standing Orders.

3.2.3 Approve the disciplinary procedure for officers of the Trust.

3.2.4 3.2.2 Appoint, appraise, discipline and dismiss Executive Directors (subject to SO 3.8 S).

3.2.3 Confirm appointment of members of any committee of the Trust as representatives on outside bodies.

3.2.4 Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.

3.3 Strategy, plans and budgets

3.3.1 Define the strategic aims and objectives of the Trust.

3.3.2 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.

3.3.3 Approve the Trust's policies and procedures for the management of risk.

3.3.4 Approve Outline and Final Business Cases for Capital Investment schemes where the value exceedsith a value in excess of £500,000.

3.3.5 Approve the Trust's annual revenue and capital budgets.

3.3.6 Approve annually the Trust's proposed organisational development proposals.

3.3.73.3.6 Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

3.3.83.3.7 Approve PFI proposals.

3.3.93.3.8 Approve the opening of bank accounts.

3.3.103.3.9 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 during the duration

of the contract.

3.3.113.3.10 Approve proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and Director of Finance (for losses -and special payments) previously approved by the Board.

3.3.12 Review proposals for action on litigation against or on behalf of the Trust.

3.3.13 Review use of NHSLA risk pooling schemes (LPST / CNST / RPST).

3.4 Policy determination

3.4.1 Receive a quarterly report detailing the approved policies and procedures by the Executive Management Team or relevant Executive Director.

3.4.2 The Board shall maintain responsibility for approving Approve the following policies:

- Health and Safety Policy
- Risk Management Policy
- Counter Fraud and Corruption Policy
- Raising Concerns at Work (Whistleblowing) Policy and Procedure
- Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts, Hospitality & Sponsorship
- Investigations Policy
- management policies including personnel policies incorporating

the arrangements for the appointment, removal and remuneration of staff.
The Board may, from time to time, delegate authority for the approval of management policies to Committees of the Board but will retain authority for the initial approval of any new policies.

3.5 Audit

3.5.1 Approve the appointment (and where necessary dismissal of External Auditors recommended by the Audit Panel. Approval of external auditors' arrangements for the separate audit of funds held on Trust, and submission of reports to the Audit Committee meetings which will take appropriate action.

3.5.13.5.2 Receive the annual management letter from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.

3.5.2 Receive an annual report from the Internal Auditor and agree action on recommendations, where appropriate, of the Audit Committee.

3.6 Annual report and accounts

3.6.1 Receive and approve the Trust's Annual Report and Annual Accounts.

3.6.2 Receive and approve the Annual Report and Accounts for funds held on trust.

3.6.3 Receive and approve the Trust's Quality Account.

3.7 Monitoring

3.7.1 Receive monthly assurance~~pt~~ from Committees~~ of reports as the Board sees fit from committees~~ in respect of their exercise of delegated powers. The remit of each Committee is specified within the relevant Committee Terms of Reference available via the Trust's intranet.

3.7.2 Continuous appraisal of the affairs of the Trust by means of the provision to the Board of reports from directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and the Charity Commission shall be reported, at least in summary, to the Board.

3.7.3 Receive reports from the Director of Finance on financial performance against budget.

4. Review

4.1 This Reservation of Powers to the Board document will be reviewed on an annual basis in conjunction with the annual review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Standing Financial Instructions

North West Ambulance Service NHS Trust

Approved by the Board of Directors: ~~29th November 2017~~

Record of amendments

Number	Section	Date
1	Updated document issued for implementation	1 July 2006
2	Updated following Board approval, 27 September 2006	1 October 2006
3	Annual review, July 2007	25 July 2007
4	Annual review, September 2008	1 October 2008
5	Annual review, September 2009	30 September 2009
6	Annual review, November 2010	24 November 2010
7	Annual review, November 2011	25 January 2012
8	Annual review, January 2013	27 February 2013
9	Interim Amendment May 2014	7 May 2014
10	Annual review, September 2014	24 September 2014
11	Annual review, September 2015	30 September 2015
12	Annual Review, September 2016	28 September 2016
13	Annual Review, November 2017	17 November 2017
14	Annual Review, March 2019	

Standing Financial Instructions

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1. Introduction

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State, which require that each Trust shall agree Standing Financial instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated within Standing Orders (SOs).

1.1.2 The Code of Conduct and Accountability in the NHS issued by the Department of Health and Social Care requires that each NHS organisation shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions are issued in accordance with the Code. They shall have effect as if incorporated within Standing Orders (SOs).

1.1.3 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers to the Board and the Scheme of Delegation adopted by the Trust.

1.1.4 These SFIs identify the financial responsibilities which apply to everyone working for the Trust (see also s.1.2.2 below) and its constituent organisations, including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Director of Finance must endorse all financial procedures prior to formal approval by the Executive Management Team.

1.1.5 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs. Failure to comply with Standing Financial Instructions and Standing Orders is a disciplinary matter, which could result in dismissal.

1.1.6 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.1.7 These SFIs apply to North West Ambulance Service NHS Trust and its statutory elements.

1.2 Terminology

1.2.1 In Standing Orders, Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation the following definitions apply:

Terminology	Definition
The 1990 Act	National Health Service and Community Care Act 1990
The 1977 Act	National Health Service Act 1977
Accountable Officer	Shall be the Officer responsible and accountable for funds entrusted to the Trust in accordance with the NHS Trust Accounting Officer Memorandum. They shall be responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive is the designated Accountable Officer.
Board of Directors	The Board of Directors means the Chairman, Executive and Non-Executive members of the Trust collectively as a body.
Budget	A resource, expressed in financial or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
Budget holder	The director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chairman of the Board of Directors	The person appointed by the Secretary of State to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression 'Chairman of the Trust' shall be deemed to include the Vice-Chairman of the Trust if the Chairman is absent from the meeting or is otherwise unavailable.
Chief Executive	The Chief Officer of the Trust.
Committee	A Committee established and appointed by the Trust.
Contracting and Procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
Director	A member of the Board of Directors.
Director of Finance	The Chief Finance Officer of the Trust.
The Trust	North West Ambulance Service NHS Trust
Funds held on Trust	Those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

Terminology	Definition
Member	An Executive or Non-Executive member of the Board as the context permits. Member in relation to the Board does not include its Chairman.
Nominated Officer	An Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Non-Officer member	A member of the Trust who is not an officer of the Trust and is not to be treated as an Officer by virtue of reg.1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust.
Partner	in relation to another person, a member of the same household living together as a family unit
~~Secretary~~Director of Corporate Affairs	a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health and Social Care guidance.
Standing Financial Instructions	(SFIs) regulate the conduct of the Trusts financial matters
Standing Orders	(SOs) regulate the business conduct of the Trust

In accordance with the provisions of the Interpretation Act 1978, all references to the masculine gender shall be deemed to apply equally to the feminine gender when used in these instructions.

1.2.2 Wherever the title Chief Executive, Director of Finance, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

1.2.3 Wherever the term 'employee' is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust. Including nursing and medical staff and consultants practising on the Trust premises and members of staff of the PFI contractor or trust staff working for the contractor under a retention of employment model.

1.3 Responsibilities and delegation

1.3.1 The Board of Directors exercises financial supervision and control by:

a. formulating the financial strategy;
b. requiring the submission and approval of budgets within overall income;
c. defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision; and
d. defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document

1.3.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Reservation of Powers to the Board document. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation adopted by the Trust.

1.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and, as the accountable officer, for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.4 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions. All staff shall be responsible for ensuring compliance with the Standing Orders, Standing Financial Instructions and financial procedures of the Trust.

1.3.6 The Director of Finance is responsible for:

a. implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies; (The SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes)
b. maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions
c. ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time and, without prejudice to any other functions of directors and employees to the Trust, the duties of the Director of Finance include:

    - the provision of financial advice to other members of the Board of Directors and employees
    - the design, implementation and supervision of systems of internal financial control, and
    - the preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.7 All directors and employees, severally and collectively, are responsible for:

a. the security of the property of the Trust
b. avoiding loss
c. exercising economy and efficiency in the use of resources
d. compliance with the requirements of Standing Orders, Standing Financial Instructions, the Scheme of Delegation and Financial Procedures

1.3.8 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

2. Audit

2.1 Audit Committee

2.1.1 In accordance with Standing Orders, the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference, and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

a. overseeing Internal and External Audit services
b. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing of significant financial reporting judgements
c. the monitoring of compliance with Standing Orders and Standing Financial Instructions
d. reviewing schedules of losses and compensation and making recommendations to the Board of Directors
e. reviewing the effective implementation of corporate governance measures to enable the Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control-related disclosure statements; for example the Annual Governance Statement and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the Board of Directors
f. review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

2.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.1.3 Where the Audit Committee considers there is evidence of *ultra vires* transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board of Directors (to the Director of Finance in the first instance).

2.1.4 It is the responsibility of the Director of Finance to ensure adequate internal and external audit services are provided and the Audit Committee shall be involved in the selection process when an audit service provider is changed.

2.2 Director of Finance

2.2.1 The Director of Finance is responsible for:

a. ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function and the coordination of other assurance arrangements
b. ensuring that the internal audit is adequate and meets the NHS mandatory audit standards
c. deciding at what stage to involve the police in cases of fraud, misappropriation and other irregularities, including theft -not involving fraud or corruption
d. ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

I. a clear opinion on the effectiveness of internal controls in accordance with current assurance framework guidance issued by the Department of Health

and Social Care, including for example, compliance with control criteria and standards

II. major internal financial control weaknesses discovered
III. progress on the implementation of internal audit recommendations
IV. progress against plan over the previous year
V. strategic audit plan
VI. a detailed plan for the coming year

2.2.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

a. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
b. access at all reasonable times to any land, premises, members of the Board of Directors or employee of the Trust
c. the production of any cash, stores or other property of the Trust under a member of the Board of Directors or employee's control; and
d. explanations concerning any matter under investigation.

2.3 Internal audit

2.3.1 The NHS Trust Accounting Officer Memorandum requires the Trust to have an internal audit function.

2.3.2 Role of Internal Audit:

The role of internal audit embraces two key areas:

- the provision of an independent and objective opinion to the Accountable Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- the provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements

Internal audit will review, appraise and report upon:

a. the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures
b. the adequacy and application of financial and other related management controls
c. the suitability of financial and other related management data
d. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

I. fraud and other offences
II. waste, extravagance or inefficient administration
III. poor value for money or other causes

e. Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care (DHSC).

2.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities, including theft, concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.3.4 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.5 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report directly to the Chairman or a non-executive member of the Trust's Audit Committee.

2.3.6 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate, when remedial action has failed to take place within a reasonable period, the matter shall be reported to the Director of Finance.

2.4 External audit

2.4.1 The External Auditor is appointed by the Trust and the service provided is paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, these should be raised with the Director of Finance in the first instance who will seek to resolve issues with the senior representative of the External Audit provider.

2.5 Fraud and corruption

2.5.1 The Trust shall take all necessary steps to counter fraud relating to its functions and in accordance with the requirements of the NHS Standard Contract relevant clauses and having regard to any reasonable guidance or advice issued by ~~NHS Protect and~~the NHS Counter Fraud Authority (NHS CFA). The Trust shall act in accordance with:

a. the NHS Fraud and Corruption Manual
b. the policy statement 'Applying appropriate sanctions consistently' published by NHS Protect

2.5.2 The Chief Executive and Director of Finance shall monitor and ensure compliance with the requirements of the NHS Standard Contract clauses on fraud, bribery and corruption matters.

2.5.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Fraud and Corruption Manual and guidance.

2.5.4 The Local ~~Counter~~ Anti-Fraud Specialist shall report to the Trust's Director of Finance and shall work with the staff in the NHS Protect in accordance with the NHS Fraud and Corruption Manual.

2.5.5 The Local ~~Counter~~ Anti-Fraud Specialist will provide a written plan and report, at least annually, on anti fraud work within the Trust.

2.6 Security management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with the requirements of the NHS standard contract relevant clauses on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS). ~~as specified by NHS Protect guidance on NHS security management.~~

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. Allocations/payment by results, business planning, budgets, budgetary control and monitoring

3.1. Preparation and approval of business plans/Service Development Strategy and budgets

3.1.1 The Chief Executive will compile and submit to the Board of Directors a Strategic Direction document that encompasses an annual plan and takes into account financial targets and forecast limits of available resources. The annual plan will contain:

a. a statement of the significant assumptions on which the plan is based
b. details of major changes in workload, delivery of services or resources required to achieve the plan

3.1.2 Prior to the start of the financial year, the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

a. be in accordance with the aims and objectives set out in the Trust's annual plan and the commissioners' local delivery plans
b. accord with workload and manpower plans
c. be produced following discussion with appropriate budget holders
d. be prepared within the limits of available funds
e. identify potential risks
f. be based on reasonable and realistic assumptions and reflect year-on-year cost improvement programmes.

3.1.3 The Director of Finance shall monitor the financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Director of Finance to the Board of Directors as soon as they come to light and the Board of Directors shall be advised of action to be taken in respect of such variances.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

3.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year and will have a responsibility for the year-on-year identification of cost improvement schemes.

3.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an ongoing basis to all budget holders to help them manage successfully.

3.2 Budgetary delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a. the amount of the budget
b. the purpose(s) of each budget heading
c. individual and group responsibilities
d. authority to exercise virement
e. achievement of planned levels of service
f. the provision of regular reports

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purposes(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

3.3 Budgetary control and reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a. regular financial reports to the Board of Directors in a form approved by the Board of Directors containing:

   I. income and expenditure to date showing forecast year-end position
   II. balance sheet, including movements in working capital
   III. cash flow statement
   IV. capital programme expenditure and forecast against plan
   V. explanations of any material variances from plan/budget
   VI. performance against cost improvement programmes
   VII. details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation

b. the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible
c. investigation and reporting of variances from financial, workload and manpower budgets
d. the monitoring of management action to correct variances
e. arrangements for the authorisation of budget transfers
f. advising the Chief Executive and Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects and review of the bases and assumptions used to prepare the budgets

In the performance of these duties the Director of Finance will have access to all budge holders on budgetary matters and shall be provided with such financial and statistical information as is necessary.

3.3.2 Each budget holder is responsible for ensuring that

a. any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors
b. officers shall not exceed the budget limit set
c. year on year cost improvement schemes are identified
d. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the requirements of the Trust's budgetary control procedures
e. no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board of Directors

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the financial plan and a balanced budget.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in section 11). A Project Sponsor will be identified who will assume responsibility for the budget relating to the scheme.

3.5 The monitoring returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation within specified time-scales.

4. Annual accounts and reports

4.1 Accounts

4.1.1 The Director of Finance, on behalf of the Trust, will:

a. prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies and International Financial Reporting Standards
b. prepare and submit annual financial reports to the Department of Health and Social Care certified in accordance with current guidelines
c. submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetables prescribed by the Department of Health and Social Care

The Trust's annual accounts must be audited by an external auditor appointed by the Trust.

The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.2 Annual Reports

4.2.1 The Trust will publish an annual report, in accordance with guidelines on local accountability and present it at a public meeting. The document will comply with the Department of Health and Social Care's Group Accounting Manual (GAM).

5. Bank and Government Banking Service Accounts

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. Since 2010 the Trust has used the Government Banking Services (GBS) in line with national guidance for NHS Trusts.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank and Government Banking Service Accounts

5.2.1 The Director of Finance is responsible for:

a. bank accounts and Government Banking Service accounts, and other forms of working capital financing that may be available from the Department of Health and Social Care
b. establishing separate bank accounts for the Trust's non-exchequer funds (NEF) i.e. Charitable Funds.
c. ensuring payments made from NEF and GBS accounts do not exceed the amount credited to the account except where arrangements have been made
d. reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn (together with the remedial action taken).

All accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purpose of furthering Trust activities.

5.3 Banking procedures

5.3.1 The Director of Finance will prepare detailed instructions on the operation of NEF and GBS accounts, which must include:

a. the conditions under which each NEF and GBS accounts is to be operated
b. the limit to be applied to any overdraft
c. those authorised to sign cheques or other orders drawn on the Trust's accounts

5.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 The Director of Finance shall approve security procedures for any cheques issued without a hand-written signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

6. Income, fees and charges and security of cash, cheques and other negotiable instruments

6.1 Income Systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

6.1.3 The Director of Finance is also responsible for the prompt banking of all monies received.

6.1.4 The Chief Executive is responsible for ensuring appropriate arrangements are in place for the authorisation of contracts of service provision either through NHS or Non NHS income activities.

6.1.5 The Scheme of Delegation for the authorisation of income contracts is outlined in the Schedule of Delegated Limits (Annex 1 of these SFIs)

6.2 Fees and charges other than Trust contract

6.2.1 The Trust shall follow the Department of Health and Social Care's advice in the 'Costing Manual' in setting prices for NHS service agreements.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt recovery

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts. Overpayments should be detected (or preferably prevented) and recovery initiated.

6.3.2 Income not received should be dealt with in accordance with losses procedure.

6.4 Security of cash, cheques and other negotiable instruments

6.4.1 The Director of Finance is responsible for:

a. approving the form of all receipt books, agreement forms or other means of officially acknowledging or recording monies received or receivable; (no form of receipt which has not been specifically authorised by the Director of Finance should be issued)
b. ordering and securely controlling any such stationery

c. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys and for coin operated machines
d. prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

6.4.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques etc.

6.4.4 All cheques, postal orders, cash etc, shall be banked promptly intact under arrangements approved by the Director of Finance.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Director of Finance and Internal Audit via the incident reporting system. Where there is *prima facie* evidence of fraud or corruption this should follow the form of the Trust's Anti-Fraud and Corruption Policy and the guidance provided by the Local ~~Counter~~ Anti-Fraud Specialist. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Trust's Losses and Compensations Procedures.

7. NHS service agreements for provision of services

7.1 Service Level Agreements / contracts

7.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) or contracts with service commissioners for the provision of NHS services.

All SLAs / contracts should aim to implement agreed local priorities and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected
- the relevant national service framework (if any)
- the provision of reliable information on cost and volume of services
- the NHS National Performance Assessment Framework
- that SLAs / contracts build where appropriate on existing Joint Investment Plans
- that SLAs / contracts are based on integrated care pathways

7.1.2 A good SLA or contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and commissioning of the service required. The SLA / contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

7.1.3 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA / contract. This will include information on costing arrangements.

8. Terms of service, allowances and payment of members of the Board of Directors and employees

8.1 Remuneration Committee

8.1.1 In accordance with Standing Orders the Board of Directors shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition and the arrangements for reporting.

8.1.2 The Committee will:

a. advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other executive directors including:

   I. all aspects of salary (including any performance related elements / bonuses)
   II. provisions for other benefits, including pensions and cars
   III. arrangements for termination of employment and other contractual terms

b. make such recommendations to the Board of Directors on the remuneration and terms of service of executive directors to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate
c. monitor and evaluate the performance of individual executive directors
d. advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3 The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board of Directors meetings should record all decisions.

8.1.4 The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.5 The Trust will pay allowances to the Chairman and non-officer members of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care
.

8.2 Funded establishment

8.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Delegation. The Finance Department are responsible for verifying that funding is available.

8.3 Staff appointments

8.3.1 No Executive Director or employee may engage, re-engage or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a. unless authorised to do so by the Chief Executive
b. within the limit of their approved budget and funded establishment as defined in the Scheme of Delegation

8.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service etc for employees.

8.4 Processing the payroll

8.4.1 The Director of Organisational Development in conjunction with the Director of Finance is responsible for:

a. specifying timetables for submission of properly authorised time records and other notifications
b. the final determination of pay and allowances, including verification that the rate of pay and relevant conditions of service are in accordance with current agreements
c. making payment on agreed dates
d. agreeing method of payment

8.4.2 The Director of Organisational Development and Director of Finance will issue instructions regarding:

a. procedures for payment by cheque, bank credit or cash to employees
b. procedures for the recall of cheques and bank credits
c. pay advances and their recovery
d. maintenance of regular and independent reconciliation of pay control accounts
e. separation of duties of preparing records and handling cash
f. a system to ensure the recovery from leavers of sums of money and property due by them to the Trust

8.4.3 The Director of Organisational Development will issue instructions regarding:

a. verification and documentation of data
b. the timetable for receipt and preparation of payroll data and the payment of employees and allowances
c. maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay
d. security and confidentiality of payroll information
e. checks to be applied to completed payroll before and after payment
f. authority to release payroll data under the provisions of the Data Protection Act
g. methods of payment available to various categories of employee

8.4.4 Appropriately nominated managers have delegated responsibility for:

a. processing a signed copy of the contract / appointment form and such other documentation as may be required immediately upon an employee commencing duty
b. submitting time records and other notifications in accordance with agreed timetables
c. completing time records and other notifications in accordance with the Director of Organisational Development's instructions and in the form prescribed by the Director of Organisational Development

d. submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of Organisational Development must be informed immediately. In circumstances where fraud might be expected this must be reported to the Director of Finance.

8.4.5 Regardless of the arrangements for providing the payroll service, the Director of Organisational Development in conjunction with the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 Contracts of employment

8.5.1 The Board of Directors shall delegate responsibility to the Director of Organisational Development for:

a. Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment and health & safety legislation
b. Dealing with variations to or termination of contracts of employment

9. Non-pay expenditure

9.1 Delegation of authority

9.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

9.1.2 The Chief Executive will set out

a. The list of managers who are authorised to place requisitions for the supply of goods and services
b. The maximum level of each requisition and the system for authorisation above that level

The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services

9.2 Choice, requisitioning, ordering, receipt and payment for goods and services

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In doing so, the advice of the Trust's advisor shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

9.2.2 The Director of Finance shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payment Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3 The Director of Finance will:

a. advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and once approved, the thresholds should be incorporated in Scheme of Reservation and delegation and regularly reviewed
b. prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds
c. be responsible for the prompt payment of all properly authorised accounts and claims
d. be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

    I. a list of directors / employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system. The list should be updated and reviewed on an ongoing basis.

    II. certification that:

        — Goods have been duly received, examined and are in accordance with specification and the prices are correct

- Work done or services rendered have been satisfactorily carried out in accordance with the order and where applicable, the materials used are of the requisite standard and the charges are correct
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with appropriate rates, the materials have been checked as regards quantity, quality and price and the charges for the use of vehicles, plant and machinery have been examined
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
- The account is arithmetically correct
- The account is in order for payment

Where an officer certifying accounts relies upon other officers to do preliminary checking, they shall wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

III. a timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

IV. instructions to employees regarding the handling and payment of accounts within the Finance Department.

e. be responsible for ensuring that payment for goods and services is only made once the goods and services are received

9.2.4 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In such instances:

a. prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate

b. the appropriate officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments

c. the Director of Finance will need to be satisfied with the proposed arrangements before contractual agreements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold)

d. the budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official orders must:

a. be consecutively numbered
b. be in a form approved by the Director of Finance
c. state the Trust terms and conditions of trade; and
d. only be issued to, and used by, those duly authorised by the Chief Executive

9.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a. all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget) leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made
b. contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND8621)
c. where consultancy advice is obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care
d. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
    I. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars
    II. conventional hospitality, such as lunches in the course of working visits

e. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive
f. all goods, services or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards
g. verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked 'Confirmation Order'
h. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds
i. goods are not taken on trial or loan in circumstances that could commit the Trust to a future un-competitive purchase
j. changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance
k. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance
l. petty cash records are maintained in a form as determined by the Director of Finance
m. orders are not required to be raised for utility bills, NHS recharges, audit fees and adhoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non-pay expenditure

9.2.7 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the NHS Trust Capital Accounting Manual. The technical audit of these contracts shall be the responsibility of the relevant director.

9.2.8 Under no circumstances should goods be ordered through the Trust for personal or private use.

9.3 Joint finance arrangements with local authorities and voluntary bodies

9.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

10. External borrowing and investments

10.1 Public Dividend Capital

10.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Director of Finance is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

10.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

10.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

10.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money and comply with the latest guidance from the Department of Health and Social Care.

10.1.5 Any short term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

10.1.6 All long term borrowing must be consistent with the plans outlined in the current LTFM and be approved by the Board of Directors.

10.2 Investments

10.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

10.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

10.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11. Capital investment, private financing, fixed assets registers and security of assets

11.1 Capital Investment

11.1.1 The Chief Executive:

a. Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans

b. Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost

c. Shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges

11.1.2 For capital expenditure proposals the Chief Executive shall ensure (in accordance with the list outlined in the Scheme of Delegation):

a. that a business case (in line with the guidance contained within the NHS Trust Capital Accounting Manual) is produced setting out:

I. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs
II. appropriate project management and control arrangements
III. the involvement of appropriate Trust personnel and external agencies; and

b. that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case

11.1.3 Where capital schemes are carried out under a contract which makes provision for staged / progress / interim payments, these payments shall be valued and certified in accordance with the terms of that contract prior to the approval and payment of any resulting invoice.

The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

a. specific authority to commit expenditure
b. authority to proceed to tender
c. approval to accept a successful tender

in accordance with the requirements contained within the Trust’s Scheme of Delegation.
The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the NHS Trust Capital Accounting Manual guidance and the Trust’s Standing Orders

11.1.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 Private finance

11.2.1 The Trust should normally test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a. the Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers risks to the private sector
b. where the sum involved exceeds delegated limits, the business case must be referred to the Department of Health and Social Care~~oH~~ for approval or treated as per current guidelines
c. the proposal must be specifically agreed by the Board of Directors in the light of such professional advice as should reasonably be sought in particular with regard to providing assurance that the proposal is not *ultra vires*
d. the selection of a contractor / finance company must be on the basis of competitive tendering or quotations

11.3 Asset registers

11.3.1 The Chief Executive is responsible for maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating and arranging for a physical check of assets against the Asset Register to be conducted once a year.

11.3.2 The Trust shall maintain an Asset Register recording fixed assets. As a minimum, the minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health and Social Care.

11.3.3 Additions to the fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

a. Properly authorised and approved agreements, architects certificates, suppliers invoices and other documentary evidence in respect of purchases from third parties
b. Stores, requisitions and wages records for own materials and labour including appropriate overheads
c. Lease agreements in respect of assets held under a finance lease and capitalised

11.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed Asset Registers.

11.3.6 The value of each asset shall be adjusted to current values in accordance with methods specified in the Capital Accounting Manual issued by the Department of Health and Social Care.

11.3.7 The value of each asset shall be depreciated using methods and rates as specified in the Capital Accounting Manual by the Department of Health and Social Care.

11.3.8 The Director of Finance shall calculate and pay capital charges as specified by the Department of Health and Social Care.

11.4 Security of assets

11.4.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Director of Finance.

Asset control procedures (including fixed assets, cash, cheques and negotiable instruments and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a. recording managerial responsibility for each asset
b. identification of additions and disposals
c. identification of all repairs and maintenance expense
d. physical security of assets
e. periodic verification of the existence of, condition of and title to, assets recorded
f. identification and reporting of all costs associated with the retention of an asset
g. reporting, recording and safekeeping of cash, cheques and negotiable instruments

11.4.2 All significant discrepancies revealed by verification of physical assets to the fixed Asset Register shall be notified to the Director of Finance.

11.4.3 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routines security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

11.4.4 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

11.4.5 Where practical, assets should be marked as Trust property.

12. Stock, stores and receipt of goods

12.1 Stock and stores

12.1.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:

a. controlled stores – specific areas designated for the holding and control of goods
b. departments – goods required for immediate usage to support operational services
c. manufactured items – where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

12.1.2 Such stocks should be kept to a minimum and for:

a. controlled stores and other significant stores (as determined by the Director of Finance) should be subjected to an annual stock take or perpetual inventory procedures and
b. valued at the lower of costs and net realisable value

12.1.3 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day to day responsibility may be delegated by them to departmental employees and stores managers / keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of any fuel oil of a designated estates manager.

12.1.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as NHS property.

12.1.5 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipts of goods, issues and returns to stores and losses. Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

12.1.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

12.1.7 The designated manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of surplus and obsolete goods.

12.2 Receipt of goods

12.2.1 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and/or weight and inspected as to quality and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

12.2.2 All goods received shall be entered onto an appropriate goods received / stock record (whether a computer or manual system) on the day of receipt. If goods received are

unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

12.2.3 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice. This may also apply for high-level low volume items such as stationery.

12.3 Issue of stocks

12.3.1 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a ‘topping up’ system is used, a record shall be maintained as approved by the Director of Finance. Regular comparisons shall be made of the quantities issued to departments and explanations recorded of significant variations.

All transfers and returns shall be recorded on forms / systems provided for the purpose and approved by the Director of Finance.

13. Disposals and condemnations, insurance, losses and special payments

13.1 Disposals and condemnations

13.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

13.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3 All unserviceable articles shall be:

a. condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance
b. recorded by the condemning officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

13.1.4 The condemning officer shall satisfy themself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

13.2 Losses and special payments

13.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments. The Director of Finance must also prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform the Director of Finance who will liaise with the Chief Executive or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Director of Finance who will liaise with the Chief Executive.

Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud or corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform their Local Counter Fraud Specialist who will inform NHS Protect before any action is taken and reach agreement how the case is to be handled.

13.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial the Director of Finance must immediately notify:

a. The Board of Directors
b. The External Auditor
c. NHS CFA~~Protect~~ (through the Local ~~Counter~~ Anti-Fraud Specialist)

13.2.4 Within limits delegated by the Department of Health and Social Care, the Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegated Financial Limits.

13.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

13.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded. All losses and special payments must be reported to the Audit Committee.

13.3 Compensation claims

13.3.1 The Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Trust will follow the requirements and note the recommendations of the Department of Health and Social Care and the NHS Litigation Authority (NHSLA) in the management of claims. Every member of staff is expected to cooperate fully, as required, in assessment and management of each claim.

13.3.2 The Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by:

I. adopting prudent risk management strategies including continuous review
II. implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants
III. adopting a systematic approach to claims handling in line with the best current and cost effective practice
IV. following guidance issued by the NHS Resolution relating to clinical negligence
V. maintaining Care Quality Commission registration standards
VI. implementing an effective system of Clinical Governance

13.3.3 The Director of Corporate Affairs is responsible for clinical negligence, for managing the claims process and informing the Board of Directors of any major developments on claims related issues.

14. Information technology

14.1 Responsibilities and duties of the Director of Finance

14.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a. devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and the Computer Misuse Act 1990.
b. ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system
c. ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment
d. ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks
e. ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out

14.1.2 The Director of Finance shall satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.1.3 The Director of Strategy and PlanningQuality shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model publication scheme approved by the Information Commissioner. A publication scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

14.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

14.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of NHS Organisations in the regionStrategic Health Authority wish to sponsor jointly) all responsible directors and employees will send to the Director of Finance:

a. Details of the outline design of the system
b. In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement

14.3 Contracts for computer services with other health bodies or outside agencies

14.3.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

14.4 Requirement for computer systems which have an impact on corporate financial systems

14.4.1 Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy themself that:

a. Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology strategy
b. Data produced for use with financial systems is adequate, accurate, complete and timely and that a management (audit) trail exists
c. Director of Finance staff have access to such data
d. Such computer audit reviews as are considered necessary are being carried out

14.5 Risk assessment

14.5.1 The Director of Finance shall ensure that risks to the Trust's financial systems arising from the use of IT are effectively identified, considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15. Patients property

15.1 General

15.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as ‘property’) handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in transit or dead on arrival.

16. Funds held on trust

16.1 General

16.1.1 The Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission.

16.1.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear how decisions where discretion must be exercised are to be taken and by whom.

16.1.3 As management processes overlap most of the sections, these Standing Financial Instructions will apply to the management of funds held on trust.

16.1.4 The over-riding principle is that the integrity of each Trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from exchequer activities and funds.

16.1.5 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England.

16.1.6 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds, including an Investment Register.

16.1.7 The Director of Corporate Affairs shall be responsible for the day-to-day management and operation of the charity.

16.2 Existing Charitable Funds

16.2.1 The Director of Finance shall arrange for the administration of all existing funds. A 'Deed of Establishment' must exist for every fund and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Deed of Establishment shall identify the restricted nature of certain funds and it is the responsibility of fund managers, within their delegated authority and the Corporate Trustee, to ensure that funds are utilised in accordance with the terms of the Deed.

16.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3 The Director of Finance shall ensure that all funds are currently registered with the Charities Commission in accordance with the Charities Act 1993 or subsequent legislation.

16.3 New Charitable Funds

16.3.1 The Director of Finance shall recommend the creation of a new fund where funds and / or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund. All new funds must be covered by a Deed of Establishment and must be formally approved by the Corporate Trustee.

16.3.2 The Deed of Establishment for any new fund shall clearly identify, *inter alia*, the objects of the new fund, the nominated fund manager, the estimated annual income and where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

16.4 Sources of new funds

16.4.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Director of Finance before accepting any gift. Advice to the Corporate Trustee on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Director of Finance.

16.4.2 All gifts, donations and proceeds of fund raising activities, which are intended for the Charity's use, must be handed immediately to the treasury office to be banked directly to the Charitable Funds Bank Account.

16.4.3 In respect of donations, the Director of Finance alongside of Director of Corporate Affairs shall:

a. provide guidelines to officers of the Trust as to how to proceed when offered funds. These will include:

   I. the identification of the donor's intentions
   II. where possible, the avoidance of creating excessive numbers of funds
   III. the avoidance of impossible, undesirable or administratively difficult objects
   IV. sources of immediate further advice
   V. treatment of offers for personal gifts

b. provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted

16.4.4 In respect of Legacies and Bequests, the Director of Finance shall be kept informed of and record all enquiries regarding legacies and bequests.

16.4.5 In respect of fund raising, the final approval for major appeals will be given by the Board of Directors or Charitable Funds Committee. The Director of Finance along with the Director of Corporate Affairs shall:

a. advise on the financial implications of any proposal for fund raising activities
b. deal with all arrangements for fund raising by and / or on behalf of the Charity and ensure compliance with all statutes and regulations
c. be empowered to liaise with other organisations / persons raising funds for the Charity and provide them with an adequate discharge
d. be responsible for alerting the Charitable Funds Committee and the Board of Directors to any irregularities, including theft regarding the use of the Charity's name or its registration numbers
e. be responsible for the appropriate treatment of all funds received from this source

16.4.6 In respect of Trading Income (see also NHS Charitable Funds Guidance chapter 6), the Director of Finance along with the Director of Corporate Affairs shall:

a. Be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity

b. Be primarily responsible for the appropriate treatment of all funds received from this source

16.4.7 In respect of Investment Income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below)

16.5 Investment management

16.5.1 The Corporate Trustee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Director of Finance shall be required to provide advice to the Charitable Funds Committee shall include:

a. the formulation of investment policy which meets statutory requirements (Trustee Investment Act 1961) with regard to income generation and the enhancement of capital value
b. the appointment of advisors, brokers and where appropriate, investment fund managers and

    I. the Director of Finance shall recommend the terms of such appointments; and for which
    II. written agreements shall be signed by the Chief Executive

c. pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme
d. the participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds
e. that the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines
f. the review of the performance of brokers and fund managers
g. the reporting of investment performance

16.5.2 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording investment and accounting for Charitable Funds

16.6 Expenditure from Charitable Funds

16.6.1 Expenditure from Charitable Funds shall be managed by the Charitable Funds Committee or the Board of Directors on behalf of Corporate Trustee. In so doing the committee shall be aware of the following:

a. The objects of various funds and the designated objectives
b. The availability of liquid funds within each trust
c. The powers of delegation available to commit resources
d. The avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time
e. That funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the trust
f. The definition of ‘charitable purposes’ as agreed by the Department of Health and Social Care with the Charity Commission

16.6.2 Delegated authority to incur expenditure which meets the purpose of the funds are set out in the Scheme of Delegations; exceptions are as follows:

a. Any staff salaries / wages costs require Charitable Funds Committee of the Board of Directors approval
b. No Funds are to be 'overdrawn'.

16.7 Banking services

16.7.1 The Director of Finance shall advise the Charitable Funds Committee and with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.8 Asset management

16.8.1 Assets in the ownership of or used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust. The Director of Finance shall ensure:

a. that appropriate records of all donated assets owned by the Trust are maintained and that all assets, at agreed valuations are brought to account
b. that appropriate measures are taken to protect and / or to replace assets. These to include decisions regarding insurance, inventory control and the reporting of losses
c. that donated assets received on Trust shall be accounted for appropriately
d. that all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

16.9 Reporting

16.9.1 The Director of Finance shall ensure that regular reports are made to the Corporate Trustee with regard to, *inter alia*, the receipt of funds, investments and expenditure.

16.9.2 The Director of Finance shall prepare annual accounts in the required manner, which shall be submitted, to the Corporate Trustee within agreed timescales.

16.9.3 The Director of Finance shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Charitable Funds Committee.

16.10 Accounting and audit

16.10.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.10.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall be performed on a basis determined by the Director of Finance.

16.10.3 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. They will liaise with external audit and provide them will all the necessary information.

16.10.4 The Corporate Trustee shall be advised by the Director of Finance on the outcome of the annual audit.

16.11 Taxation and excise duty

16.11.1 The Director of Finance shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17. Tendering and contract procedure

17.1 Duty to comply

17.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with the Standing Orders and Standing Financial Instructions (except where Suspension of Standing Orders is applied).

17.1.2 The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care 'Capital Investment Manual' and 'Estate Code' in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance 'The Procurement and Management of Consultants within the NHS'.

17.1.3 The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

17.2 EU directives governing public procurement

17.2.1 Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC~~oH~~) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the Standing Orders and Standing Financial Instructions. Procedure notes detailing EU thresholds and the differing procedures adopted must be maintained within the Trust.

17.3 Formal competitive tendering

17.3.1 The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC~~DoH~~)
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and for disposals

~~Where the Trust elects to invite~~ T~~t~~enders for the supply of healthcare these Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure.

17.3.2 Formal tendering procedures are not required where:

a. the estimated expenditure or income does not, or is not reasonably expected to, exceed the limit set in the Schedule of Financial Delegated Limits, (this figure to be reviewed annually); or
b. the supply is proposed under special arrangements negotiated by the Department of Health and Social Care or other Public sector representatives (for example Association of Ambulance Chief Executives (AACE) in which event the said special arrangements must be complied with ; or
c. regarding disposals as set out in Standing Financial Instruction 'Disposals and Condemnations'

Formal tendering procedures may be waived in the following circumstances:

d. in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures and the circumstances are detailed in an appropriate Trust record
e. where the requirement is covered by an existing contract
f. where NHS Supply Chain agreements are in place and have been approved by the Board of Directors
g. where a consortium arrangement is in place and a lead organisation has been appointed to carry out a tendering activity on behalf of the consortium members
h. where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender
- where specialist expertise is required and is available from only one source (also includes memberships/subscriptions/licences)

i. when the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate
j. there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering
k. for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.
l. where allowed and provided for in the NHS Trust Capital Accounting Manual
m. Single source supplier – one accredited supplier for service
n. Single source supplier – goods compatible with existing equipment and are essential to complete a project. In addition, engagement with an alternative provider for the additional work would be impractical.
o. Single source supplier – Original Equipment Manufacture's maintenance provision for existing equipment. Engagement with an alternative provider for the additional work would be impractical.
p. Where it was necessary to obtain goods/services without raising a Purchase Order in advance and a retrospective order is required.
q. Where the principal contractor or a key sub-contractor has gone into liquidation, administration or bankruptcy and is unable to complete a current project or commence a scheme which has just been awarded
r. request approval for accepting a quotation/tender which is not the lowest as evaluations have shown that the clinical and operational benefits outweigh the financial savings of the lowest cost option.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee as each meeting.

17.3.3 Fair and adequate competition

Where the exceptions set out in SFI Nos 17.1 and 17.3.2 do not apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms / individuals to provide fair

and adequate competition as appropriate and in no case less than two firms / individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required. However, in the unusual event that only one commercial organisation can provide the goods or services required consideration should given to ensures that relevant procurement regulations are complied too.

17.3.4 Use of regional / national contracts

The Trust will, as far as is practicable, procure goods and services through established regional or national contracts or frameworks. Such contracts or frameworks are typically those awarded by the Shared Business Service Commercial Procurement Solution (SBSCPS), NHS Supply Chain, Crown Commercial Service (CCS) and other collaborative procurement organisations. The Trust will need to comply with the rules of the framework and the guidance supplied by the framework owner, relating to mini-competition or direct award.

17.3.5 Building and engineering construction works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance without Department of Health and Social Care approval.

17.3.6 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

17.4 Contracting / tendering procedure

17.4.1 Invitation to tender

I. All invitations to tender shall state the date and time as being the latest time for the receipt of tenders

II. All invitations to tender shall state that no tender will be accepted unless submitted through the appropriate process as instructed within the tender documentation, either:

a. hard copy submitted in a plan sealed package or envelope bearing a pre printed label supplied by the Trust (or the word 'tender' followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated manager

b. electronically using either the EU Supply (CTM) or Government Procurement Service eSourcing systems

c. that tender envelopes / packages shall not bear any names or marks indicating the sender. The use of courier / postal services must not identify the sender on the envelope or on any receipt so required by the deliverer

III. Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

IV. Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply

with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A) or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and in minor respects, to cover special features of individual projects.

17.4.2 Receipt and safe custody of tenders

The Chief Executive or their nominated representative (the Director of Corporate Affairs~~Corporate Secretary~~) will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope / package.

Electronic tenders will be held and locked electronically until the allocated time and date for opening.

17.4.3 Opening tenders and register of tenders

I. As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, hard copy responses~~they~~ shall be opened by the Director of Corporate Affairs~~Corporate Secretary~~ and one Director who is not from the originating department. In the case of electronic tenders, all such tenders will be opened by the Procurement lead, as delegated by the Head of Procurement or~~and~~ the Trust Procurement Manager.

II. The 'originating' department will be taken to mean the department sponsoring or commissioning the tender.

III. The involvement of Finance Department staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved senior manager from the Finance Department from serving as one of the two senior managers to open tenders.

IV. All Executive Directors will be authorised to open tenders in conjunction with the ~~Corporate Secretary~~Director of Corporate Affairs. In the absence of the ~~Corporate Secretary~~Director of Corporate Affairs, the opening of tenders may be conducted by two Directors neither of whom should be from the originating department.

V. Every tender received shall be marked with the date of opening and initialled by those present at the opening.

VI. A register of hard copy tenders shall be maintained by the ~~Corporate Secretary~~ Director of Corporate Affairs to show for each set of competitive tender invitations despatched:

- The names of all firms individuals invited
- The names of firms individuals from which tenders have been received
- The date the tenders were opened
- The persons present at the opening
- The price shown on each tender
- A note where price alterations have been made on the tender

Each entry to this register shall be signed by those present

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

In the case of electronic tenders, a full electronic record of the tenders received will be available in accordance with the agreed system parameters.

VII. Incomplete tenders i.e. those from which information necessary for the adjudication of the tender is missing and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders (SFI No 17.4.5)

17.4.4 Admissibility

I. If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

II. Where only one tender is sought and / or received, the Chief Executive and Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

17.4.5 Late tenders

I. Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the ~~Corporate Secretary~~ Director of Corporate Affairs decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer or, in the case of electronic submissions, connectivity issues.

II. Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the ~~Corporate Secretary~~ Director of Corporate Affairs or their nominated officer or if the process of evaluation and adjudication has not started.

III. While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded and held in safe custody by the ~~Corporate Secretary~~ Director of Corporate Affairs or their nominated officer. Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

17.4.6 Acceptance of formal tenders (see overlap with SFI No 17.5)

I. Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

II. The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. It is accepted that for professional services such as

management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

a. experience and qualifications of team members
b. understanding of client's needs
c. feasibility and credibility of proposed approach
d. ability to complete the project on time

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file and the reason(s) for not accepting the lowest tender clearly stated.

III. No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these instructions except with the authorisation of the Chief Executive and Director of Finance and subject to the requirements contained within the Trust's Scheme of Delegation.

IV. The use of these procedures must demonstrate that the award of the contract was:

a. not in excess of the going market rate / price current at the time the contract was awarded
b. the best value for money was achieved

V. All tenders should be treated as confidential and should be retained for inspection.

17.4.7 Tender reports to the Board of Directors

Reports to the Board of Directors will be made in accordance with the Trust's Scheme of Delegation

17.4.8 Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

17.5 Quotations: competitive and non-competitive

17.5.1 General position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed the sum defined in the Schedule of Financial Delegated Limits.

17.5.2 Competitive quotations

I. Quotations should be obtained from at least 3 firms / individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust
II. Quotations should be in writing unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
III. All quotations should be treated as confidential and should be retained for inspection.

IV. The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trist, then the choice made and the reasons why should be recorded in a permanent record.

17.5.3 Non-competitive quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

a. the supply of propriety or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations
b. the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts
c. miscellaneous services, supplies and disposals
d. where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e. (i) and (ii) of this SFI) apply.

17.5 Quotations to be within financial limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

17.6 Authorisation of tenders and competitive quotations

17.6.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the staff as defined in the Scheme of Delegation. These levels of authorisation may be varied or changed. Formal authorisation must be out in writing. In the case of authorisation by the Board of Directors this shall be recorded in their minutes.

17.7 Instances where formal competitive tendering or competitive quotation is not required

17.7.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

a. The Trust shall use NHS Supply Chain national frameworks or contracts for procurement of all goods and services unless the Chief Executive or nominated officers deem it appropriate. The decision to use alternative sources must be documented.

b. If the above provision does not apply, where tenders or quotations are not required, because expenditure is below the levels defined in the Scheme of Delegation, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

17.8 Private finance for capital procurement (see overlap with SFI No 11)

17.8.1 The Trust should normally market–test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a. The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

b. Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health and Social Care for approval or treated as per current guidelines.

c. The proposal must be specifically agreed by the Board of the Trust.

d. The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

17.9 Compliance requirements for all contracts

17.9.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

a. the Trust's Standing Orders and Standing Financial Instructions
b. EU Directives and other statutory provisions
c. any relevant directions including NHS Trust Capital Accounting Manual, Estatecode and guidance on the Procurement and Management of Consultants
d. such of the NHS Standard Contract Conditions as are applicable
e. contracts with Trusts must be in a form compliant with appropriate NHS guidance
f. where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited
g. in all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust

17.10 Personnel and agency or temporary staff contracts

17.10.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

17.11 Healthcare service level agreements / contracts (see overlap with SFI No 7)

17.11.1 Service level agreements / contracts with NHS providers for the supply of healthcare services shall be drawn up in accordance with the National Health Service Act 2006. Such service level agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Benefit Corporation, is legally binding and is enforceable in law.

17.11.2 The Chief Executive shall nominate officers to commission service level agreements with providers of healthcare in line with a commissioning plan approved by the Board of Directors (refer to Scheme of Delegation)

17.12 Disposals (see overlap with SFI No 13)

17.12.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a. any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer
b. obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust
c. items to be disposed of with an estimated sale value of less than that defined on the Scheme of Delegation, this figure to be reviewed on a periodic basis
d. items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract
e. land or buildings concerning which DH Guidance has been issued but subject to compliance with such guidance

17.13 In-house services

17.13.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

17.13.2 In all cases where the Board of Director determines that in-house services should be subject to competitive tendering, the following groups shall be set up:

a. specification group, comprising the Chief Executive or nominated officer/s and specialist
b. in-house tender group, comprising a nominee of the Chief Executive and technical support
c. evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative.

17.13.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

17.13.4 The evaluation team shall make recommendations to the Board of Directors.

17.13.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

17.14 Applicability of SFIs on tendering and contracting to funds held in trust (see overlap with SFI No 16)

17.14.1 These instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust’s trust funds and private resources.

18. Acceptance of gifts and hospitality by staff

18.1 Policy

18.1.1 The ~~Director of Finance~~Director of Corporate Affairs shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy should follow the guidance contained in the NHS England guidance on managing conflicts of interest in the NHS ~~Department of Health and Social Care Standards of Business Conduct for NHS Staff~~ and is also deemed to be an integral part of the Standing Orders and Standing Financial Instructions.

Refer to the Trust's Standards of Business Conduct: Policy on Managing Conflicts, Gifts and Hospitality and Sponsorship.

~~Refer also to Standing Orders Appendix 5, Standards of Business Conduct for NHS Staff.~~

19. Retention of documents

19.1 Context

19.1.1 All NHS records are public records under the terms of the Public Records Act 1958 section 3 (1) – (2). The Secretary of State for Health and all NHS organisations have a duty under this Act to make arrangements for the safe keeping and eventual disposal of all types of records. In addition, the requirements of the Data Protection Act 1998 and the Freedom of Information act 2000 must be achieved.

19.2 Accountability

19.2.1 The Chief Executive and senior managers are personally accountable for records management within the organisation. Additionally, the organisation is required to take positive ownership of and responsibility for, the records legacy of predecessor organisations and / or obsolete services. Under the Public Records Act 1958 all NHS employees have responsibility for any records that they create or use in the course of their duties. Thus any records created by an employee of the NHS are public records and may be subject to both legal and professional obligations.

19.2.2 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in NHS Digital Records Management Code of Practice for Health and Social Care 2016.Department of Health and Social Care guidance, Records Management Code of Practice.

19.3 Types of record covered by the Code of Practice

19.3.1 The guidelines apply to NHS records of all types (including records of NHS patients treated on behalf of the NHS in the private healthcare sector) regardless of the media on which they are held:

- Patient health records (electronic or paper based)
- Records of private patients seen on NHS premises
- Accident and emergency, birth and all other registers
- Theatre registers and minor operations (and other related) registers
- Administrative records (including e.g. personnel, estates, financial and accounting records, notes associated with complaint handling)
- X-ray and imaging reports, output and other images
- Photographs, slides and other images
- Microform (i.e. fiche / film)
- Audio and video tapes, cassettes, CD-ROM, etc
- E-mails
- Computerised records
- Scanned records
- Text messages (SMS) and social media (both out-going from the NHS and in-coming responses from the patient) such as Twitter and Skype
- Websites and intranet sites that provide key information to patients and staff.

19.4 Retrieval

19.4.1 The documents held in archives shall be capable of retrieval by authorised persons.

19.5 Disposal

19.5.1 Documents held in accordance with the Records Management Code of Practice shall only be destroyed at the express instigation of the Chief Executive; records shall be maintained of documents so destroyed.

20. Risk Management

20.1 Programme of Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board of Directors.

The programme of risk management shall include:

a. a process for identifying and quantifying risks and potential liabilities
b. engendering among all levels of staff, a positive attitude towards the control of risk
c. management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover and decisions on the acceptable level of retained risk
d. contingency plans to offset the impact of adverse events
e. audit arrangements including: internal audit, clinical audit, health and safety review
f. a clear indication of which risks shall be insured
g. arrangements to review the Risk Management programme

The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by current guidance.

20.2 Insurance: Risk Pooling Schemes administered by NHS Resolution

20.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of risk areas (clinical, property and employers / third party liability) covered by the scheme this decision shall be reviewed annually.

20.3 Insurance arrangements with commercial insurers

20.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

I. Trusts may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use
II. where the Trust is involved with a consortium in a **Private Finance Initiative Contract** and the other consortium members require that commercial insurance arrangements are entered into
III. where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose, the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements, the Director of Finance should consult the Department of Health and Social Care.

20.4 Arrangements to be followed by the Board of Directors in agreeing insurance cover

20.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution, the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

20.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

20.4.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Schedule of financial delegated limits - Annex A

Authorisation of Purchase Requisitions (all Revenue and Capital items)

For all term related agreements, e.g. leases or long term maintenance contracts the authorisation limit relates to the total value of the contract. As an example a lease car with an annual value of £4,000 and with a three year agreement would have a contract value of £12,000 (£4k x 3) in terms of authority for signature.

Post holder	Level	Authorisation limits (including VAT)
Chief Executive	1	Up to £499,999
Director of Finance	2	Up to £249,999
Voting Director)	3	Up to £99,999
A4C Band 8d/9	4	Up to £24,999
A4C Band 8b / 8c	5	Up to £9,999
A4C Band 8a	6	Up to £7,499
A4C Band 6 / 7	7	Up to £4,999
A4C band 4 / 5	8	Up to £2,499

Note:

Expenditure of £500,000 and above requires authorisation by the Board of Directors as detailed in Reservation of Powers to the Board. In these cases, authorisation of requisition forms will be completed by the Chief Executive following appropriate Board approval.

Authorisation of Purchase Orders (all Revenue and Capital items)

For all term related agreements, e.g. leases or long term maintenance contracts the authorisation limit relates to the total value of the contract. As an example a lease car with an annual value of £4,000 and with a three year agreement would have a contract value of £12,000 (£4k x 3) in terms of authority for signature.

Post holder	Authorisation limits (including VAT)
Procurement Officer	Up to £2,499
Senior Procurement Officer	Up to £94,999
Operational Procurement Manager	Up to £24,999
Head of Procurement or Trust Procurement Manager	Up to £99,999
Deputy Director of Finance	Up to £499,999
Chief Executive or Director of Finance (Deputy Director of Finance in the absence of Director of Finance)	>£500,000

Note:

1. Purchase Orders for all lease agreements must be authorised by the Director of Finance regardless of value. Scheme of Delegation SG04 refers.

Requirement to obtain Quotes and Tenders (all Revenue and Capital items)

Value range (inc VAT)	Requirement	Hard copy opened by	Electronic copy opened by	Adjudicated by	Contract awarded by
0-£9,999 (annual aggregated value)	At budget holder discretion	N/A	N/A	**N/A**	**N/A**
£10,000 to £24,999	Minimum of 3 formal written quotations	Head of Supplies	Lead Procurement Manager	Appropriate Service Line Finance Lead	Director
£25,000 to OJEU threshold	Minimum of 3 formal tenders*	Director of Corporate Affairs and 1 Director	Lead Procurement Manager	Evaluation Panel (must include a Finance member)	<£500k Executive Management Team
Above OJEU threshold	OJEU process must be followed**	Director of Corporate Affair and 1 Director	Lead Procurement Manager	Evaluation Panel (must include a Finance member)	<£500k Executive Management Team =>£500k Board of Directors

* To be ~~publshed~~published online on the Government Contracts Portal, Contracts Finder

**To be published online via Contracts Finder and Tenders Electronic Daily

Authorisation of Charitable Funds expenditure

Post holder	Authorisation limits (including VAT)
Deputy Director of Finance or Head of Technical Accounts or Director of Corporate Affairs	0 to £2,499
Director of Finance or Chief Executive	£2,500 to £24,999
Board of Directors on behalf of Corporate Trustee	>£25,000

Condemnation and Disposal of Assets

Post holder	Authorisation limits (including VAT)
Relevant Executive Director and relevant Service Line Head of Finance	Where the net book value is up to £2,499 (subject to informal quotations for disposal)
Director of Finance	Where the net book value is between £2,500 and £24,999, (subject to competitive quotations for disposal)
Board of Directors	Where the net book value is in excess of £25,000, (subject to formal tender action for disposal)

Losses, write off and compensation

Board of Directors	Write-off individual non-NHS debts in excess of £10,000. Ex-gratia payments for loss of personal effects above £10,000 (up to a maximum of £50,000). Losses (including cash) due to theft, fraud, overpayment and others in excess of £10,000 (up to a maximum of £50,000). Fruitless payments (including abandoned capital schemes) in excess of £10,000 (up to a maximum of £250,000). Damage to buildings, fittings furniture & equipment and loss of equipment and property in stores and in use to culpable causes (e.g. fraud, theft, arson) or other in excess of £10,000 (up to a maximum of £50,000). Personal injury claims involving negligence where legal advice has been obtained and guidance applied in excess of £50,000 (up to a maximum of £1m). Clinical negligence claims where legal advice has been obtained and guidance applied in excess of £50,000 (up to a maximum of £1m).
Chief Executive	Ex-gratia payments for loss of personal effects between £5,000 and £10,000. Losses (including cash) due to theft, fraud, overpayment & others between £5,000 and £10,000. Fruitless payments (including abandoned capital schemes) between £5,000 and £10,000. Damage to buildings, fittings furniture & equipment and loss of equipment and property in stores and in use to culpable causes (e.g. fraud, theft, arson) or other between £5,000 and £10,000.
Director of Finance	Write-off individual non-NHS debts up to £10,000. Ex-gratia payments for loss of personal effects between £500 and £5,000. Losses (including cash) due to theft, fraud, overpayment and others up to £5,000. Fruitless payments (including abandoned capital schemes) up to £5,000. Damage to buildings, fittings furniture & equipment and loss of equipment and property in stores and in use to culpable causes (e.g. fraud, theft, arson) or other up to £5,000. Compensation payments made under legal obligation (no limit).

	Personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £50,000. Clinical negligence claims where legal advice has been obtained and guidance applied up to £50,000.
Head of Technical Accounts	Write-off individual non-NHS debts between £11 and £100
Financial Services Manager	Write-off individual non-NHS debts up to £10

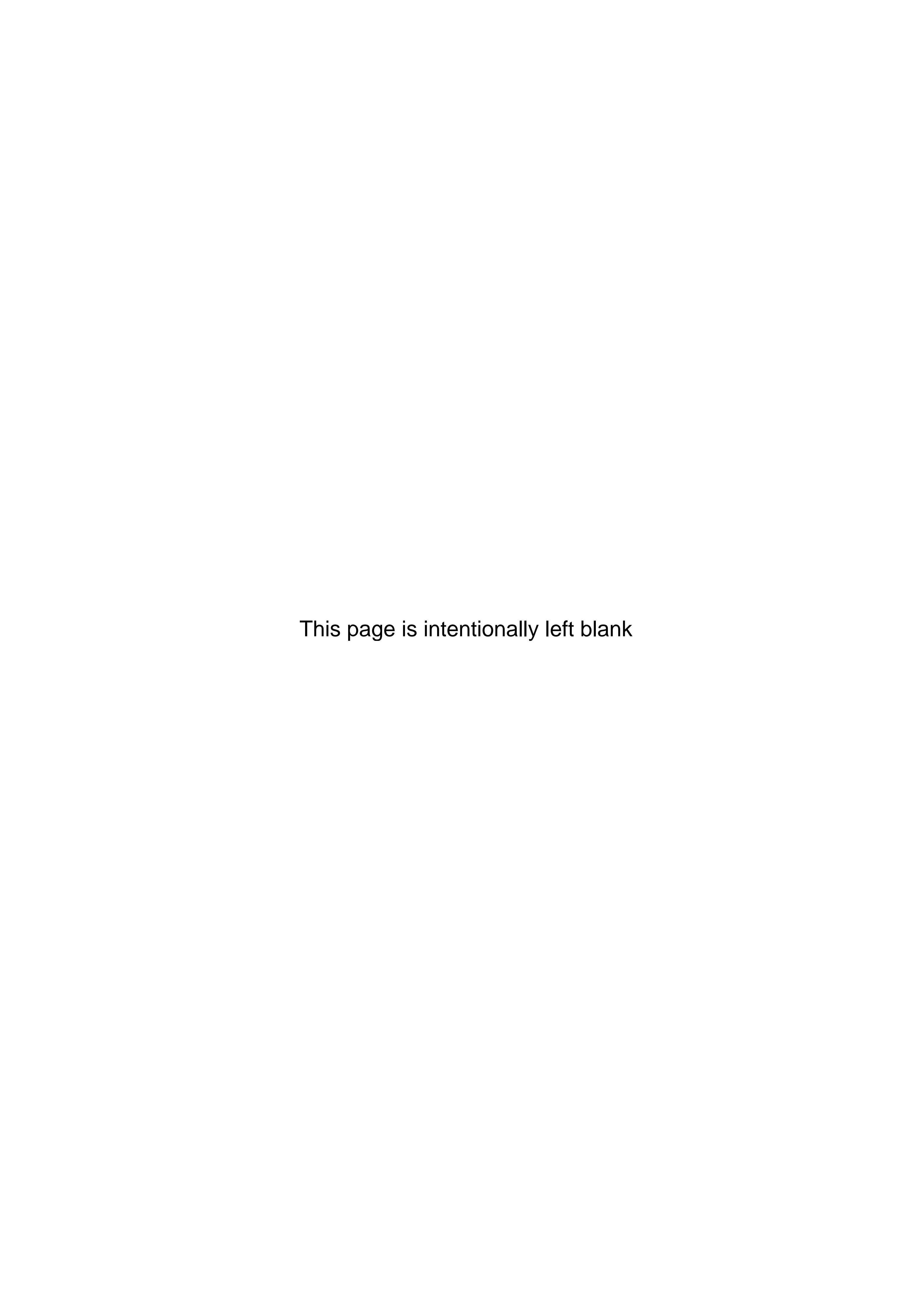
Authorisation of Income Contracts/New Service Initiatives

Post holder	**Authorisation limits (including VAT)**
Director of Finance	Up to £250,000
Chief Executive	Over £250,000

Deputisation

Post holders with delegated powers are able to assign their powers to a nominated deputy (agreed by the relevant Line Director) in the event of planned absences. Such assignment to be documented in a memorandum to the nominated deputy setting out precisely what authority is being assigned to.

In the event of unplanned absences a similar procedure is to be followed although the memorandum would be prepared by the absent post holder's Line Manager.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Scheme of Delegation

North West Ambulance Service NHS Trust

Approved by the Board of Directors: ~~31 January 2018~~

Record of amendments

Number	Section	Date
1	Updated document issued for implementation	1 July 2006
2	Updated following Board approval, 27 September 2006	1 October 2006
3	Annual review, July 2007	25 July 2007
4	Annual review, September 2008	1 October 2008
5	Annual review, September 2009	30 September 2009
6	Annual review, November 2010	24 November 2010
7	Annual review, November 2011	25 January 2012
8	Annual review January 2013	27 February 2013
9	Interim Amendment May 2014	7 May 2014
10	Annual review, September 2014	24 September 2014
11	Annual review, September 2015	30 September 2015
12	Annual Review, September 2016	28 September 2016
13	Annual Review, January 2018	31 January 2018
14	Annual Review, April 2019	

Scheme of Delegation

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SCHEME OF DELEGATION

Reference: **CG01**

Title: **Standing Orders/Standing Financial Instructions/Scheme of Delegation**

Decision Maker	**Responsibilities**
Board of Directors:	Approval.
Committee:	**Audit Committee** Recommendation to the Board.
Chief Executive:	To ensure that Directors and all staff of managerial grade receive copies and understand their responsibilities with regard to Standing Orders, Standing Financial Instructions and the Scheme of Delegation.
Director:	**Director of Finance** To e~~E~~nsure~~ing~~ up to date Standing Financial Instructions are in place through annual review.~~.~~ **Director of Corporate Affairs** To e~~E~~nsure~~ing~~ up to date an ~~Standing Orders and~~ Scheme of Delegation is in place through annual review. To ensure Standing Orders are kept up to date and are subject to annual review. **Other Directors** Duty to understand and comply with Standing Orders, Standing Financial Instructions and the Scheme of Delegation and to bring these documents to the notice of subordinates in their departments.
Senior Manager:	**Head of Technical Accounts** Drafting of Standing Financial Instructions Drafting of Standing Financial Instructions with input from relevant managers. **Head of Corporate Affairs** Drafting of Standing Orders and Scheme of Delegation with input from relevant managers.
Other Managers:	Duty to understand and comply with Standing Orders, Standing Financial Instructions and the Scheme of Delegation and to bring these documents to the notice of all staff in their departments.

Source documentation:
Department of Health (March 2006) Model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

SCHEME OF DELEGATION

Reference: **CG02**

Title: **Establishment and Dismissal of Formal Committees of the Board**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of formal committees. Appointment of members and Chairs of formal committees. Approval of Terms of Reference for committees.
Director:	**Director of Corporate Affairs** Recommendation to the Board of Directors on the requirement for committees. Ensuring there are up-to-date Terms of Reference for committees. Ensuring committee effectiveness reviews are carried out on an annual basis Monitor and review the operation of the Board and its Committees and recommend any changes to the Board of Directors.
Senior Manager	**Head of Corporate Affairs** Drafting of Terms of Reference for committees Carrying out effectiveness reviews for committees and recommending any actions that need to be taken

Source documentation:
The Healthy NHS Board – Principles for Good Governance 2013

SCHEME OF DELEGATION

Reference: **CG03**

Title: **Annual Report**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of Annual Report prior to publication. Subject to timescales the Board of Directors may delegate this to the Audit Committee.
Committee:	**Audit Committee** Recommendation to the Board.
Director:	**Director of Finance** Preparation and checking of Annual Accounts details for inclusion in Annual Report. **Director of Corporate Affairs** Preparation and checking of the Annual Report Liaise with External Audit for validation review Submission and presentation of Annual Report to Audit Committee and Board of Directors **All Directors** Preparation of relevant sections of the Annual Report
Senior Manager:	**Head of Corporate Affairs** Co-ordination and preparation of the draft Annual Report **Head of Communications** Production and distribution of approved Annual Report document. **All Senior Managers** Contribute to preparation of relevant sections of the Annual Report.

Source documentation:
Department of Health and Social Care - Group Accounting Manual

SCHEME OF DELEGATION

Reference: **CG04**

Title: **Common Seal**

Decision Maker	**Responsibilities**
Board of Directors:	Receipt of an ~~bi-~~annual report on all sealings.
Chief Executive:	Authorisation of use of the seal in conjunction with the Chairman~~Director of Finance~~.
Director:	~~**Director of Finance**~~ ~~Authorisation of use of the seal in conjunction with the Chief Executive.~~ **Deputy Chief Executive/Vice Chairman** Authorise use of the seal in the event of absence of the Chief Executive/Vice Chairman. **Director of Corporate Affairs** Recommendation to the Chief Executive for use of the Common Seal. Custody of the Common Seal. Ensure there is -a register of all sealings. ~~Bi-~~A~~a~~nnual report to the Board of Directors of any sealings.
Senior Manager:	~~**Deputy Director of Finance**~~ ~~Authorise use of the seal in the event of absence of the Director of Finance~~ **Head of Corporate Affairs** Recommendation to the Chief Executive for use of the common seal in the absence of the Director of Corporate Affairs. Maintenance of a Register of Sealings Preparation of an~~bi-~~annual report to the Board of Directors

Source documentation:
Standing Orders Section 8

SCHEME OF DELEGATION

Reference: **CG05**

Title: **Register of Interests**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Monthly review of Directors' Register of Interests.
Audit Committee:	Annual review of the Trust's Register of Interests. To receive quarterly updates relating to impacts of any breaches of interests.
Chief Executive:	Responsible for ensuring that a Register of Interests is established and maintained for the Board of Directors.
Director:	**Director of Corporate Affairs** Responsible for establishing and maintenance of a register of directors' interests and submission of monthly register- to the Board for review. Responsible for maintenance of a register of interests for all other staff. Annual review of declarations for all decision making staff. **All Directors** All Directors are required to notify the Director of Corporate Affairs in writing of any interests as they arise.
Manager:	**All Managers** Responsible for ensuring that the requirement to declare interests is communicated to all members of their departments.
All staff:	All staff are required to declare in writing to their manager, copied to the Director of Corporate Affairs, any potential conflict that may arise between their role as a Trust employee and any external interest, including related parties.

Source documentation:
Code of Conduct and Code of Accountability for NHS Boards - Department of Health 1994
NHS England Guidance on Managing Conflicts of Interest in the NHS
Standards of Business Conduct Policy: Managing Conflicts of Interest; Gifts & Hospitality & Sponsorships

SCHEME OF DELEGATION

Reference: **CG06**

Title: **Receiving Sponsorship**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approve sponsorship proposals over £20,000 taking into consideration ethical, environmental and health issues.
Executive Management Team:	Approve sponsorship proposals between £5,000 and £20,000 taking into consideration ethical, environmental and health issues.
Director:	**Executive Directors** Approve sponsorship proposals up to £5,000 taking into consideration ethical, environmental and health issues.
Senior Manager:	**All Senior Managers** Prepare report for consideration by the Executive Management Team, or Executive Directors for any sponsorship proposals.
Other Managers:	Refer any proposed sponsorship deal to their Senior Manager.

N.B.

It is outside of the Trust's powers to provide sponsorship to other organisations.

SCHEME OF DELEGATION

Reference: **CG07**

Title: **Waiver of Standing Orders/Standing Financial Instructions**

Decision Maker — **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Delegates authority to the Audit Committee.
Committee:	**Audit Committee** Authority delegated by the Board of Directors to monitor compliance with Standing Orders and Standing Financial Instructions. To receive a quarterly report on all instances of waivers of Standing Orders and Standing Financial Instructions.
Chief Executive:	Approval of any waivers after consideration of the recommendation by the Director of Finance and Director of Corporate Affairs.
Deputy Chief Executive:	Authorisation of waivers in the absence of the Chief Executive.
Director:	**Director of Finance** Verify scrutiny of requests by Director of Corporate Affairs and make recommendation for approval to the Chief Executive. ~~Authorisation of waivers in absence of Chief Executive.~~ **Director of Corporate Affairs** Review requests~~Scrutiny of all requests~~ for waivers prior to submission to Chief Executive~~ ~~and~~/~~Director of Finance for approval. Forward reviewed waiver requests to Director of Finance and ~~/~~ Chief Executive.~~ with appropriate recommendation.~~ Preparation of quarterly report for Audit Committee on all waivers of Standing Orders and Standing Financial Instructions Ensure there is a Master Waiver Register in place to~~ ~~log ~~of~~ all waivers~~issues~~. **All Directors** Verification of requests from relevant Directorate prior to submission to Director of Corporate Affairs for scrutiny.
~~Senior Manager:~~	~~**All Senior Managers**~~ ~~Preparation of requests for waivers and obtaining verification from relevant Director prior to submission of requests to Director of Corporate Affairs for scrutiny.~~
Other Managers:	**Head of Procurement** To provide a~~A~~dvice and assistance to managers in order to minimise instances where waivers become necessary. Submit to Director of Corporate Affairs for review.
Senior Manager:	**All Senior Managers**

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	To obtain waiver form from Procurement and Supplies. Prepare waiver requests and obtain verification from relevant Director prior to submitting requests to Procurement & Supplies.

SCHEME OF DELEGATION

Reference: **CG08**

Title: **Approval of Strategies, Policies and Procedures**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approve~~a~~ new ~~l of all~~ strategy ~~and new policy~~ documents.~~ May delegate subsequent approval of policy documents to relevant Committees~~ ~~ subject to ratification by the Board.~~ Receive quarterly report of all new and revised policy documents. Approve policies in accordance with those documented in the Reservations of Powers to the Board.
Committee:	Consider~~ation of any~~ strategies ~~and policies~~ relevant to that Committee with recommendations made to the Board of Directors. Approve~~al of~~ policies under delegated authority from the Board of Directors.
Executive Management Team:	Approve new~~Consideration of all~~ strategy and policy documents with recommendations.~~ made to the relevant Committee or Board of Directors.~~ Approve procedures to support policies. Ensure appropriate consultation of strategies and policies with the relevant internal and external stakeholders.
Director:	**Director of Corporate Affairs** Ensuring a central library of all approved Trust strategies, policies and procedures is maintained. Ensure the Policy Framework is kept up to date. Report new and reviewed policies quarterly to the Board of Directors. **All Directors** Presentation of draft new strategy and policy documents to the Executive Management Team for consideration and approval. Presentation of draft procedures to support policies to the Executive Management Team for approval. To approve amendments to existing policies and advise Corporate Governance. In the case of substantial changes to policies, the Lead Director must present to the Executive Management Team for approval.
Senior Manager:	**All Senior Managers** Preparation and sponsorship of strategy, policy and procedure documents.
All Staff:	Compliance with all approved Trust strategies, policies and procedures.

Source documentation:
Reservation of Powers to the Board
Policy on the Development & Management of Strategy, Policy & Procedure Documents

SCHEME OF DELEGATION

Reference: **CG09**

Title: **Appointment of Internal Auditors**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Ensure that the Trust has an effective internal audit service. Approval of contract award in accordance with Reservation of Powers.
Committee:	**Audit Committee** Establishes the selection process when an Internal Audit service provider is changed and recommends provider to the Board for approval. Performance manages the audit provider via monitoring of the audit plan.
Director:	**Director of Finance** Ensuring that an adequate internal audit service is provided to the Trust in accordance with NHS audit guidelines. Ensure that appointment is made in accordance with the relevant procurement regulations.
Other Managers:	**Head of Procurement** Manages the tender process when an Internal Audit service provider is changed.

Source documentation:
Standing Financial Instructions Section 2
Reservation of Powers to the Board
Audit Committee Terms of Reference

SCHEME OF DELEGATION

Reference: **CG10~~1~~**

Title: **Receiving Gifts and Hospitality**

Decision Maker	Responsibilities
Board of Directors:	**All Board Members** Declare any **offers** of gifts and hospitality to the Director of Corporate Affairs **Chairman** Approve the acceptance of gifts and hospitality by Chief Executive and Non-Executive Directors. Inform Director of Corporate Affairs of all instances where approval is given.
Committee:	**Audit Committee** Review register of gifts and hospitality on an annual basis. Recommend Standards of Business Conduct: Managing Conflicts of Interest, Gifts and Hospitality and Sponsorship Policy to the Board of Directors.
Chief Executive:	Approve the acceptance of gifts and hospitality by individual Directors. Inform Director of Corporate Affairs of all instances where approval is given.
Director:	**Director of Corporate Affairs** Ensure Policy on Gifts, Hospitality & Interests. Ensure ~~maintainence~~maintenance of Trust register of gifts and hospitality. **All Directors** Declare any **offers** of gifts and hospitality to the Director of Corporate Affairs. Approve the acceptance of gifts and hospitality by senior managers. Inform Director of Corporate Affairs of all instances where approval is given.
Senior Manager:	**Head of Corporate Affairs** Maintain register of gifts and hospitality. Prepare policy of Gifts and Hospitality, **All Senior Managers** Declare any **offers** of gifts and hospitality to the Director of Corporate Affairs. Approve the acceptance of gifts and hospitality by managers and staff within own area of responsibility. Inform Director of Corporate Affairs of all instances where approval is given.
Other Manager:	**All Managers**

	Declare any **offers** of gifts and hospitality to the Director of Corporate Affairs. Review offers reported by staff within own area of responsibility and approve acceptance if appropriate. Forward full details of offers made to staff and relevant outcome to the Director of Corporate Affairs.
All staff:	Declare any **offers** of gifts or hospitality to the relevant Line Manager.

Source documentation:
Standards of Business Conduct Policy on Managing Gifts, Conflicts of Interest, Gifts & Hospitality and Sponsorship

SCHEME OF DELEGATION

Reference: **CG112**

Title: **Delegation of Authority to Other Bodies**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval.
Executive Management Team:	Consider proposals and make recommendation to the Board of Directors for delegation of authority to other bodies.
Director:	Submit proposals to the Executive Management Team for delegation of authority to other bodies.

SCHEME OF DELEGATION

Reference: **CG123**

Title: **Partnership Arrangements**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Review register of Partnership Arrangements on a 6-monthly basis.
Executive Management Team:	Approve Trust participation in Partnership Arrangements. Review register of Partnership Arrangements in advance of consideration by Board of Directors.
Director:	**Director of Corporate Affairs** Ensure register of Partnership Arrangements. Initiate periodic review of register and report results to EMT and Board of Directors. **All Directors** Present proposals for Trust participation in Partnership Arrangements to EMT for approval.
Senior Managers:	**Head of Corporate Affairs** Maintain Register of Partnerships **All Senior Managers** Formulate proposals for Trust participation in Partnership Arrangements for presentation to EMT. Conduct periodic review of Partnership Arrangements. **Head of Financial Planning** Conduct review of the financial performance of partnerships.

Source documentation:
Standing Orders Section 911

Definition:
A Partnership is defined as: *A relationship established between the Trust and an external organisation for the furtherance or development of the Trust's activities that aims to deliver identified benefits to the satisfaction of all Partners in the relationship. Such relationships would be in addition to the Purchaser / Provider or Client / Customer relationships which arise through the Trust's normal business activities.*

SCHEME OF DELEGATION

Reference: **CG134**

Title: **Annual Governance Statement (AGS)**

Decision Maker	Responsibilities
Board of Directors:	Approve AGS as part of Annual Report.~~al.~~
Committee:	**Audit Committee** Recommendation to Board of Directors for approval.
Chief Executive:	Signing of the AGS for submission with the Annual Accounts and inclusion in the Annual Report.
Director:	**Director of Corporate Affairs** Overall responsibility for preparation and production of the AGS in accordance with guidance and annual timescales set by the Department of Health and Social Care (DHSC).~~oH.~~ Submission of the AGS to external auditors as part of the annual submission of Annual Report timetable. **All Directors** Contribute to preparation of AGS content as requested by the Director of Corporate Affairs.
Senior Managers:	**Head of Corporate Affairs** Preparation and production of the draft AGS in accordance with ~~DoH~~DHSC guidance and timescales. **All Senior Managers** Contribute as necessary to the drafting of the AGS and provision of related documents to the Director of Corporate Affairs.

Source documentation:

Department of Health and Social Care Group Accounting Manual

SCHEME OF DELEGATION

Reference: **CG14~~6~~**

Title: **Risk Management**

Decision Maker	Responsibilities
Board of Directors:	Approval of the Risk Management Policy and Strategy. Ownership of the Board Assurance Framework. Receive assurance via the Board Assurance Framework and Risk Register process that risks are effectively managed~~ and mitigated~~. To ensure there is a robust systems of internal control in place and appropriately resourced. To encourage a culture whereby risk management is embedded across the Trust. Routinely consider risks and collectively receive assurance that risks are being effectively managed. Set out the Trust's risk appetite in respect of mitigation of risk when delivering a safe and high quality service.
Committee:	**Audit Committee** Seek assurance on the effectiveness of the Trust's strategic processes for risk management, internal control and governance ~~processes and~~ R~~r~~eport assurance or areas of concern to the Board of Directors. **Other Board Committees** Board Assurance Committees to review aligned BAF risks, assurance and controls. Recommend the inclusion of new or revised risks for matters where further assurance is required. ~~**Risk and Oversight Management Group**~~ ~~Recommend the Risk Management Policy for approval to EMT / Board of Directors as appropriate.~~ ~~Ensure a consistent approach to risk management practice through reviews of the Board Assurance Framework, Corporate Risk Register and directorate Risk Registers with reference to articulation of risk, relevance of controls and assurances.~~
Chief Executive:	Accountable officer with responsibility for ensuring all statutory and legal requirements are in place for the risk management business of the Trust.
Executive Management Team:	Approve Risk Management Procedures. Provide the Board of Directors with assurance that risks are being identified, effectively managed and mitigated. Ensure that the Board Assurance Framework is maintained and that high level risks are being identified and managed.
Director:	**Director of Corporate Affairs** Executive lead for ~~all~~ Risk Management ~~With the Head of Corporate Affairs, review the Board Assurance Framework and corporate risk registers to ensure that they remain current and reflective of valid risks.~~ **Executive Directors**

	With their own Deputy Directors/risk leads or equivalent, review the Board Assurance Framework, corporate risk register and Directorate risk registers to ensure that they remain current and reflective of valid risks.
Senior Manager:	**Senior Risk and Assurance Manager** Review and recommend to Executive Management Team the Risk Management Policy and Procedures Ensure implementation of published Policy and Procedures. Drafting of the Risk Management Policy & procedures Custodian of the electronic risk management system (DATIX). Custodian of the corporate risk register and Board Assurance Framework. With the appropriate Service Line management teams review the Corporate Risk Register and directorate risk register to ensure that they remain current and reflective of valid risks. Ensure the Assurance Framework and Corporate Risk Registers are maintained, current and valid. Ensure EMT and Board of Directors reports are available in a timely manner. Monitor compliance with published Policy and Procedures. Ensure completion of departmental risk registers ~~**Head of Corporate Affairs**~~ ~~Review and recommend to Executive Management Team the Risk Management Policy and Procedures~~ ~~Ensure implementation of published Policy and Procedures.~~ **All Deputy Directors/Risk Leads (or equivalent)** Take ownership of the relevant content of the Board Assurance Framework; Corporate Risk Register and Directorate Risk Registers Identify directorate and corporate risks to their director. Report risks of a score of 15 and above to the Risk Management Team Report control weakness to their executive leads.
Other Managers:	~~**Corporate Risk Manager**~~ ~~Drafting of the Risk Management Policy & procedures~~ ~~Custodian of the electronic risk management system (DATIX).~~ ~~Custodian of the corporate risk register and Board Assurance Framework.~~ ~~With the appropriate Service Line management teams review the Corporate Risk Register and directorate risk register to ensure that they remain current and reflective of valid risks.~~ ~~Ensure the Assurance Framework and Corporate Risk Registers are maintained, current and valid.~~ ~~Ensure EMT and Board of Directors reports are available in a timely manner.~~ ~~Monitor compliance with published Policy and Procedures.~~ ~~Ensure completion of departmental risk registers~~ **All Managers** Custodian of any departmental risk register Identify risks in their own area and report them to their Service Line Management Team, line manager or Senior Risk and Assurance~~Corporate Risk~~ Manager/Risk Management Business Partner~~.~~ Implement appropriate risk treatment.

All staff:	Monitor and report risks within their own area and maintain a safe environment.

Source documentation:
Risk Management Policy
~~Health & Safety at Work etc. Act 1974~~

Useful Websites:
https://resolution.nhs.uk/

SCHEME OF DELEGATION

Reference: **CG15**

Title: **Raising Concerns/Freedom to Speak Up**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Ensure that there is an effective Raising Concerns At Work (Whistleblowing) policy which provides staff with a mechanism to highlight matters of serious concern. Such policy should provide appropriate protection to the individual. Approve Freedom to Speak Up Policy. To receive quarterly Freedom to Speak Up reports **Non-Executive Director/Senior Independent Director** Lead Board responsibility for raising concerns and Freedom to Speak Up.
Chief Executive:	Deal with matters brought to his/her attention either directly or having first been raised with other parties, ensuring appropriate investigation and response.
Executive Management Team:	Recommend Raising Concerns and Freedom to Speak Up policies to the Board of Directors and ensure its availability to all staff.
Director:	**All Directors** To exercise corporate and individual responsibility by addressing any matters brought to his/her attention, ensuring appropriate investigation and response. **Director of Corporate Affairs** Lead Director with responsibility and oversight of all issues relating to Freedom to Speak Up Development, implementation and monitoring of Raising Concerns at Work (Whistleblowing) policy and procedure Responsible for ensuring appropriate policies and procedures are in place for all staff relating to Freedom to Speak Up issues.
Freedom to Speak Up Guardian	To develop processes and procedures in accordance with speak up best practice and guidance. Responsible for monitoring of all Freedom to Speak Up issues in liaison with HR and relevant directors. Provide report to Board on a quarterly basis identifying themes/trends and pertinent information
Other Managers:	Deal with matters brought to his/her attention, escalating as necessary. Ensure that concerns are appropriately reported through Datix. To adhere to any policy and procedure relating to Freedom to Speak up processes and procedures.
All staff:	Raise matters in accordance with the Raising Concerns at Work (Whistleblowing) Policy and Procedure and Freedom to Speak Up Policy.

Source documentation:
Raising Concerns at Work (Whistleblowing) Policy and Procedure
Freedom to Speak Up Policy

SCHEME OF DELEGATION

Reference: **FN01**

Title: **Annual Accounts**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of Annual Accounts in accordance with the timetable prescribed by the Department of Health and Social Care (DHSC). Receives the recommendation to approve the annual report and accounts from the Audit Committee subject to receipt of a satisfactory ISA 260 report from External Audit and there being no material changes made to the accounts following scrutiny by the Board of Directors. Presentation of the Annual Accounts at the Annual General Meeting (to be held before 30 September each year).
Committee:	**Audit Committee** Receives the annual governance report (in accordance with ISA 260) from the Auditors, reviews the annual accounts together with the annual report and recommends the approval of the accounts to the Board of Directors.
Chief Executive:	Certification of accounts and the Annual Governance Statement (following approval by the Board of Directors) as the Accountable Officer. .
Director:	**Director of Finance:** Preparation of the Accounts in accordance with the timetable prescribed by the DHSC.~~epartment of Health.~~ Submission of the audited accounts to the Board of Directors.
Other Managers:	**Head of Procurement/Fleet Manager:** Arrangements for stocktake to be held on 31st March and provision of a certified stock list to the Director of Finance within the specified timescale. **Budget Holder:** Compliance with year-end procedures issued by the Director of Finance.

Source documentation:
Department of Health and Social Care Group Accounting Manual
Standing Financial Instructions Section 4
Audit Committee Terms of Reference

SCHEME OF DELEGATION

Reference: **FN02**

Title: **Approval of Capital Programme**

Decision Maker	Responsibilities
Board of Directors:	Approval of the capital programme.
Finance, Investment & Planning Committee:	Monitor progress against the capital programme and make appropriate recommendations in order to provide assurance to the Board of Directors that statutory and regulatory requirements are achieved.
Executive Management Team:	To receive the recommended capital programme each year from the Capital Management Group and make appropriate recommendation to the Board of Directors and/or Finance, Investment & Planning Committee. To ensure the development of long term capital replacement programmes for estates, fleet and IT.
Director:	**Director of Finance** Review and ensure that the capital plan and revenue consequences are reasonable from the information supplied. Collate capital programme and present the capital programme to the Executive Management Team, Finance, Investment and Planning Committee and Board of Directors.
Capital Management Group:	Assess and prioritise a draft capital programme for recommendation to the EMT. Ensure the effective monitoring and management of the capital programme and its schemes throughout the year. To receive proposals to revise and amend the capital programme in year and make appropriate recommendations to the EMT, Finance, Investment & Planning Committee and Board of Directors.
Service Line / Support Services / Directorate Meetings:	Consider, prioritise and submit proposals for each years capital programme in accordance with the required timescale. Ensure effective engagement with all internal and external stakeholders. Develop business cases for each scheme for submission to the CMG. Monitor and manage approved schemes through the year identifying any variances against agreed budgets and timescales. Provide monthly progress reports to the CMG.
Other Managers:	**Head of Technical Accounts** Communication of the capital programme and progress on schemes to the relevant managers ensuring that procurement and tendering processes are followed Monitoring and management of the overall programme. **Head of Procurement**

	Advise the CMG on procurement issues affecting the overall programme. Assist Directorate managers with procurement aspects of all stages of the process.

N.B. **Approval of the capital programme shall not constitute approval for expenditure on any scheme.** Each scheme requires business approval on an individual basis before expenditure can be committed.

Source documentation:
Standing Financial Instructions Section 11

SCHEME OF DELEGATION

Reference: **FN03**

Title: **Approval of Individual Capital and PFI Schemes**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval for all schemes in excess of £500,000 subject to the costs being within the Trust's delegated limits.
Executive Management Team:	Scrutinise all schemes in excess of £500,000 and make recommendations to the Board of Directors. Approval for schemes with a value of up to £499,999 subject to: 1. Costs being within the overall capital programme provision, and 2. Costs being within the Trust's delegated limits. To receive and approve all scheme business cases.
Capital Management Group:	To monitor and co-ordinate the capital plans for the financial year and assist in developing future years' plans. To receive business proposals/cases for each scheme and subject them to detailed appraisal. To refer all schemes for formal approval to the EMT.
Director:	**Director of Finance** Appraisal of the funding options and the impact on the Trust's CRL and EFL. Ensuring that revenue consequences of funding (including capital charges/leasing) are included in the Business Case. Ensure that all proposed schemes receive appropriate financial review and sign off by the relevant Director and / or the Head of Finance. To receive exception reports and give approval to changes that do not exceed the agreed budget by 10% or £25,000, whichever is the smaller figure, provided that the necessary resources are available within the overall programme. **All Directors** Scrutiny and approval of all bids from within their Directorate and scheme business cases prior to submission to the Executive Management Team.
Other Managers:	**All Managers** Preparation of a Business Case for the proposed scheme and submission to the Executive Management Team. **Head of Finance** Undertake appropriate financial review and sign off all proposed schemes for onward referral to the Executive Management Team.

Source documentation:
Delegated limits for approval
Capital Investment Manual
Standing Financial Instructions Sections 11 and 17

SCHEME OF DELEGATION

Reference: **FN04**

Title: **Asset Register, Capital Charges and Security of Assets**

Decision Maker **Responsibilities**

Board of Directors:	Ensure that an appropriate register of assets is kept and reviewed to ensure that it meets the organisation's operational needs.
Committee:	**Audit Committee** Receive the Auditor's recommendations regarding the validity and accuracy of the Trust's Asset Register and ensure that appropriate actions are taken and, if necessary, make recommendations to the Board of Directors.
Director:	**Director of Finance** Ensure that an asset register is maintained recording fixed assets as specified in the Capital Charges Manual. Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on the fixed asset register. Approve procedure for the periodic verification of physical assets.
Other Managers:	**Head of Technical Accounts** Maintain asset register and prepare capital charge estimates. **All Managers:** Responsible for the safeguarding of all assets Notify the Director of Finance of a. Additions, transfers & disposals of assets in accordance with the Capital Assets Procedure Note b. Any loss or damage to assets in accordance with the procedure for reporting losses Periodic verification of physical assets to the fixed asset register as requested by the Director of Finance. Maintenance of all assets in the Asset Register. Maintenance of an inventory detailing all durable departmental equipment with a value below the capital threshold of £5,000. e.g desks and chairs.

Source documentation:
Capital Assets Procedure Note
Capital Investment Manual
Standing Financial Instructions Section 11

SCHEME OF DELEGATION

Reference: **FN05**

Title: **Banking Arrangements and Cash**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of the Trust's banking arrangements.
Director:	**Director of Finance** Recommend banking arrangements to the Board of Directors including those authorised to sign cheques or other orders drawn on the Trust's accounts. Setting of detailed instructions on the operation of bank and Government Banking Service accounts. Setting of procedures for the security of cash, cheques and other negotiable instruments.
Other Managers:	**Budget Holder** Make adequate arrangements for all cheques, postal orders, cash etc to be banked intact promptly.
All staff:	Acknowledge all monies received using official receipt books or other official Trust stationery Ensure monies are stored in safes or lockable cash boxes until banked Ensure the prompt banking of monies held within 5 working days. Under no circumstances must official money be used for the encashment of private cheques.

Source documentation:
Cash & Banking Procedure Note
Standing Financial Instructions Section 5

SCHEME OF DELEGATION

Reference: **FN06**

Title: **Budget Setting**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of Annual Budget by 31st March.
Finance, Investment & Planning Committee:	Review the proposed budgets, including cost pressures, developments, Cost Improvement Plans and income assumptions and make recommendations to the Board of Directors as appropriate.
Executive Management Team:	Recommendation of budget to the Board of Directors (including pressures, developments and cost improvement programme). Approve the list of pressures and developments to be included in the commissioning process. Identification of cost improvement programmes in line with prevailing NHS guidance.
Director:	**Director of Finance** Preparation of budget proposals (including pressures, developments and cost improvement programme) for the Executive Management Team. Recommend pressures and development proposals for inclusion in the commissioning process.
Service Line / Support Services Management Teams:	Identification and approval of cost pressures and cost improvements for consideration in the budget setting process.
Senior Manager:	**Deputy Director of Finance** Collation of cost pressures, developments and cost improvements for consideration by the Director of Finance and the Executive Team. The identification of service development cost and funding as part of the Business Case process.
Other Manager:	**Head of Financial Planning** Ensure that cost pressures and proposed service developments are fed into the commissioning process **Budget Holder** Identification and notification of pressures to the Finance Department promptly together with any rectification plans. Budgets for any Service developments should be agreed as part of the Business Case process. Identification and implementation of cost improvements. **Heads of Finance** Responsible for developing the annual budgets for the service lines and co-ordinating the budget setting process for the Trust.

Source documentation:
Standing Financial Instructions Section 3

SCHEME OF DELEGATION

Reference: **FN07**

Title: **Charitable Funds Expenditure**

Decision Maker	Responsibilities
Board of Directors:	Approval of expenditure from the charitable funds over £2510,000. Exercises governance of the charitable funds which comply with the Charity Commission guidance.
Committee:	**Charitable Funds Committee** Monitoring all income and expenditure. Ensures that expenditure complies with the purposes of the charitable funds.
Chief Executive:	Authorisation of expenditure from the charitable fund up to £24,999.
Director:	**Director of Finance** Authorisation of expenditure from the charitable fund up to £24,999. Authorisation of Investments. Advise the Charitable Funds Committee and Board of Directors on guidance issued from the Charity Commission.
Deputy Director of Finance / Heads of Finance	Authorisation of expenditure from the charitable fund up to £2,499.
Other Managers:	Requests for retirement gifts and flowers or cards for employees.
All staff:	Suggestions to Chief Executive for use of charitable funds.

Source documentation:
Charitable Funds Procedure Note
Standing Financial Instructions Section 16

Useful websites:
www.charity-commission.gov.uk
www.doh.gov.uk/finman.htm
https://www.gov.uk/government/collections/department-of-health-group-accounting-guidance#general-nhs-finance-guidance
www.nao.gov.uk

SCHEME OF DELEGATION

Reference: **FN08**

Title: **Charitable Funds Annual Accounts**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of Annual Accounts.
Committee:	**Charitable Funds Committee** Receives recommendation from the Auditors and recommends the accounts to the Board of Directors.
Chief Executive:	Certification of accounts on behalf of the Corporate Trustee.
Director:	**Director of Finance** Preparation of the Accounts in accordance with the timetable prescribed by the Department of Health and Social Care and the Charity Commission (currently, filed accounts and reports completed within 9 months of the end of the accounting period). Submission of accounts to the Board of Directors **Director of Corporate Affairs** Advise the Charitable Funds Committee and Board of Directors on guidance issued from the Charity Commission. Oversee the preparation of the annual report.

Source documentation:
Charitable Funds Procedure Note
Standing Financial Instructions Section 16

Useful websites:
www.charity-commission.gov.uk
https://www.gov.uk/government/collections/department-of-health-group-accounting-guidance#general-nhs-finance-guidance
www.nao.gov.uk

SCHEME OF DELEGATION

Reference: **FN09**

Title: **External Borrowing**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Note the reasons for all loans and overdrafts entered into. Ensure compliance with the External Finance Limit (EFL). All long term borrowing.
Director:	**Director of Finance** Applications for loans or overdrafts. Short term borrowing in excess of one month. Regularly report to the Board of Directors compliance with EFL.
Other Managers:	**Head of Technical Accounts** Cash flow forecasts identifying at the earliest opportunity any requirement for external borrowing. Produce cash flow forecasts which ensure that the Trust does not breach its EFL. To ensure that any leasing arrangements satisfy the Operating Lease test thereby not being categorized as borrowing. **All Managers** Ensure that any proposals for leasing or use of capital or cash resource are approved by the Director of Finance.

Source documentation:
Standing Financial Instructions Section 10

Useful websites:
https://www.gov.uk/government/collections/department-of-health-group-accounting-guidance#general-nhs-finance-guidance

SCHEME OF DELEGATION

Reference: **FN10**

Title: **Healthcare Service and Financial Framework Agreements & Contracts – Financial and Performance monitoring arrangements**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Monitor financial and contractual performance and agree, where necessary, any corrective action required.
Committee:	**Finance, Investment & Planning Committee** Seek assurance on financial and contractual performance on behalf of the Board Make recommendations to the Board of Directors as appropriate.
Executive Management Team:	Monitor financial and contractual performance and recommend, where necessary, any corrective action required.
Director:	**Director of Finance** Submit bi-monthly financial and contractual performance reports to the Finance, Investment & Planning Committee.
Other Managers:	**Head of Informatics** Provide monthly activity and contract performance reports for budget holders, Executive Management Team, Finance and Commissioners to agreed timescales **Head of Financial Planning** Prepare monthly financial and contractual performance reports for the Director of Finance and ensure that income is in accordance with agreed SLA's **All Managers** Ensure that service delivery complies with the SLA and that any variance in service has prior agreement through the Business Case process.

Source documentation:
Service Level Agreement documentation
Standing Financial Instructions Section 7
Commissioning Framework

SCHEME OF DELEGATION

Reference: **FN11**

Title: **Healthcare Service and Financial Framework Agreements & Contracts - Income**

Decision Maker	Responsibilities
Chief Executive:	Approval and sign off of Service Level Agreements and contracts with a value in excess of £100,000. Establishing arrangements for the provision of extra contractual services. Provision of services to patients in accordance with the annual plan.
Executive Management Team:	Agreement of cost pressure and service developments to be included in commissioning negotiations. Approval of ECR fees and charges.
Director:	**Director of Finance** Costing of Service Level Agreements and contracts in accordance with DHSC~~OH~~ guidance. Pricing of variations to Service Level Agreements and contracts at agreed rates, where applicable. Recommendation of ECR fees and charges to the EMT. Recommend Service Level Agreements and contracts to the Chief Executive. In appropriate instances (e.g. timescales) approve and individually sign off Service Level Agreements and contracts on behalf of the Chief Executive. Ensure that all Healthcare Service and Financial Frameworks are commissioned in line with prevailing NHS commissioning guidelines. Sign off Service Level Agreements and contracts with a value of up to £100,000.
Service Line / Support Services Directorate Teams:	Identification and approval of cost pressures and service developments.
Senior Manager:	**Deputy Director of Finance** Negotiation of all Service Level Agreements and contracts for submission to the Director of Finance.
Other Managers:	**Head of Financial Planning** In conjunction with the Deputy Director of Finance ~~-~~prepare Service Level Agreements and contracts in line with DHSC~~OH~~ national contracts. Collation and submission of cost pressures and service developments to the Executive Management Team for approval. **Service Line Heads of Service / Heads of Service Development**

	Identification of cost pressures arising from ongoing service delivery and ensure that Service developments follow the business case approval process. Support the Deputy Director of Finance in negotiating Service Level Agreements and contracts.

Source documentation:
Standing Financial Instructions Section 7
Commissioning Framework

SCHEME OF DELEGATION

Reference: **FN12**

Title: **Investments**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of public or private sector investments within the Trust's delegated limits.
Director:	**Director of Finance** Production of detailed procedural instructions on the operation of investment accounts and the records to be maintained. Authorise short term investments with institutions other than the Trust's bankers. To make recommendations on investment portfolios within the Trust's delegated limits.

Source documentation:
Standing Financial Instructions Section 10

SCHEME OF DELEGATION

Reference: **FN13**

Title: **Other Income (including Income Generation)**

Decision Maker	**Responsibilities**
Board of Directors:	Establishment of Income Generation schemes that comply with prevailing Department of Health and Social Care guidance.
Executive Management Team:	Approval of fees and charges.
Director:	**Director of Finance** Establishing arrangements for the proper recording, invoicing, collection and coding of all monies due. Review (at least annually) all fees and charges and make recommendations to the Executive Management Team. Review profitability of Income Generation activities and present memorandum Trading Accounts to the Executive Management Team at least annually for formal income generation schemes.
Other Managers:	**Head of Financial Planning** In liaison with the Heads of Finance and budget holders ensure that fees and charges are reviewed at least annually and prepared in accordance with DHSC~~OH~~ costing guidance.
All staff:	**All Employees** Implementation and compliance with procedures for proper recording, invoicing, collection and coding of all monies due.

Source documentation:
Standing Financial Instructions Section 6
Income and Debtors Procedure Note

SCHEME OF DELEGATION

Reference: **FN14**

Title: **Petty Cash**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Director:	**Director of Finance** Setting of procedures for the use of petty cash.
Senior Manager:	**Heads of Departments** Reimbursement of monies for single transactions between £30 and £50.
Other Managers:	**Petty Cash Holder** Responsible for the security of the cash float and all supporting documents and receipts. Reimbursement of monies up to £30 for any single transaction.

Source documentation:
Petty Cash Procedure Note

SCHEME OF DELEGATION

Reference: **FN15**

Title: **Scheme of Budgetary Control**

Decision Maker **Responsibilities**

Board of Directors:	Ensure the Trust's achievement of its statutory duties by the ongoing monitoring and reporting of the Trust's financial performance. Ensure that effective action plans are in place to address any adverse variance. Authorise budget virement in excess of £100,000.
Committee:	**Finance, Investment & Planning Committee** Monitor the Trust's in-year financial position against relevant control targets and make appropriate recommendations to the Board of Directors and/or Executive Management Team to address imbalances.
Chief Executive:	Delegate budgets to budget holders. Submission of monitoring returns to the NHSI. Ensure that the Trust has an approved financial plan at the start of the financial year. To provide leadership in regard to delivery of cost improvement programmes and any action plans to correct adverse budget variances. Authorise budget virement between £10,000 and £99,999 (jointly with Director of Finance).
Executive Management Team:	Approval of expenditure for which no specific provision exists within delegated budgets. Ensure that expenditure remains within the financial plans agreed at the start of the financial year. To provide guidance on the delivery of cost improvement programmes and approve action plans to rectify adverse budget variances.
Director:	**Director of Finance** Preparation of monthly budget statements and Board Report. Preparation of monitoring returns for NHSI. Authorise budget virement between £10,000 and £99,999 (jointly with the Chief Executive). Authorise budget virement between £5,000 and £9,999 (jointly with relevant Director). **All Directors** Authorise budget virement between £5,000 and £9,999 (jointly with Director of Finance). Authorise budget virement between £500 and £4,999. Lead the development of year on year cost improvement schemes in relevant areas of responsibility.

Service Line / Support Services Management Teams	Ensure the achievement of the financial budgets including the monitoring of target savings agreed via the CIP process to ensure achievement on a recurrent basis. Ensure that effective action plans are in place to address any adverse variance.
Other Managers:	**Heads of Finance** Preparation of monthly budget statements and reporting of the financial position to the Service Lines / Support Services Management Team / Director of Finance / Executive Management Team / Finance, Investment & Planning Committee and Board of Directors. **Budget Holder** To ensure that expenditure is only committed for items within the delegated budget and to comply with any financial thresholds by ensuring that goods and services are ordered in accordance with Trust procedures avoiding manipulation of the orders which may result in a breach of financial thresholds. All goods, services or works are ordered on an official order. Orders are not split so as to avoid financial thresholds. Expenditure and Income must be coded to the correct budget line. Authorise budget virement between £1 and £499. Seek authorisation for budget virement in excess of £500 from relevant Director. Monitor the financial position on at least a monthly basis and immediately notify the Head of Finance/Director of Finance of any overspend or reduction in income as soon as it becomes known and identify action plans which would bring the budget back into balance. To monitor any target savings agreed via the CIP process to ensure achievement on a recurrent basis.
All staff:	Exercise efficiency and economy in the use of the Trust's resources. Conform to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures, Scheme of Delegation and Anti- Fraud & Corruption Policy.

Source documentation:
Purchasing and Payments Procedure Note
Standing Financial Instructions Section 3

SCHEME OF DELEGATION

Reference: **FN16**

Title: **Fraud and Corruption**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Establishes an anti- fraud culture and complies with the Secretary of State Directions on counter fraud.
Committee:	**Audit Committee** Review the adequacy of the policies and procedures for all work related to Fraud and Corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority (NHS CFA). Monitor the performance of the Local Anti-Fraud Service through the delivery of the annual action plan.
Internal Audit:	Local Anti-Fraud Specialist to investigate all referred cases and liaise with the Director of Finance, as Trust lead for Anti-Fraud, and the Director of Organisational Development with regard to the application of parallel sanctions. Local Anti-Fraud Specialist to promote a strong anti-fraud culture within the organisation.
Director:	**Director of Finance** Inform the Local Anti-Fraud Specialist of all suspected cases and agree the most appropriate course of action. Ensure that the Trust has an Anti-Counter Fraud and Corruption Policy in place. **Director of Organisational Development** Liaise with the Local Anti-Fraud Specialist with regard to the application of parallel sanctions.
All Managers:	Line managers to inform the Director of Finance of any reported cases of suspected fraud as soon as possible, irrespective of whether the Line Manager feels that there is cause for concern.
All staff:	To report all cases of suspected fraud and corruption in accordance with the Anti-Fraud, Bribery and Corruption Policy and Response Plan

Source documentation:
Anti-Fraud, Bribery and Corruption Policy and Response Plan
Useful Websites:
https://cfa.nhs.uk/

SCHEME OF DELEGATION

Reference: SPCM01

Title: Freedom of Information

Decision Maker	Responsibilities
Board of Directors:	Consider summary reports of Freedom of Information requests.
Executive Management Team:	Receive regular reports and assurances of FOI management. Monitor policy compliance against Freedom of Information Act.
Director:	**Chief Executive** Executive lead for Freedom of Information matters.
Senior Manager:	**Director of Planning & Strategy** Responsible for development and implementation of Freedom of Information Policy and Procedure documents. Ensure requests for information under the Act are acted upon – this role is delegated to the Head of Communications for implementation and management.. **All Senior Managers** Provision of requested information as appropriate.
Other Manager:	**Head of Communications** Responsible for delivering the FOI function Ensure adequate team resources to deliver a professional, effective and timely service in line with demand. Responsible for strategic review of FOI Policy, performance reporting to Information Governance and board and analysis of request themes. Responsible for receiving and approving all responses, checking for appropriate level of service area involvement, accuracy, consistency and overall compliance with FOI Act. Responsible for keeping abreast of new legislation To support the Communications Manager and Communications Officers with regard to vexatious requests and exempt information as required. To liaise with requestors in relation to reviews undertaken by or on behalf of the Chief Executive. **Communications Team** Responsible for day to day management of FOI requests, To receive, log and respond to FOI requests and provide appropriate advice and guidance to managers and directors on the release of information. **All Other Managers** Provision of requested information as appropriate.
All Staff:	Referral of Freedom of Information requests to the Communications Department or Head of Communications.

Source documentation:

Freedom of Information Policy
Freedom of Information Act 2005

SCHEME OF DELEGATION

Reference: **SP~~CM~~02**

Title: **Corporate Communications and Engagement**

Decision Maker	**Responsibilities**
Board of Directors:	Consider annual report on the effectiveness of the Trust's Corporate Communication and Engagement Strategy.
Executive Management Team:	Consider quarterly reports and assurances of corporate communications and engagement management.~~. and issue management.~~
Director:	**Director of Strategy and Planning** Executive lead for corporate communication and engagement matters.
Senior Manager:	**Head of Communications** Preparation and delivery of the Communication and Engagement Strategy. Preparation of quarterly and annual reports for the Executive Management Team and Board respectively.

Source documentation:
Communication and Engagement Strategy

SCHEME OF DELEGATION

Reference: SP03~~HG14~~

Title: **Patient Experience**

Decision Maker	Responsibilities
Board of Directors:	Consider quarterly reports on Patient Experience.
Committee:	**Quality Committee** To seek assurance on patient experience matters on behalf of the Board of Directors.
Executive Management Team:	Consider quarterly reports on patient experience.
Director:	**Director of Strategy and Planning~~Quality, Innovation & Improvement~~** Executive lead for patient experience Present quarterly integrated reports to the Board of Directors
Senior Manager:	**Head of Communications and Engagement~~Safety and Patient Experience~~** Preparation of patient experience programmes. Preparation of quarterly reports on patient experience activity for consideration by the Executive Management Team, Committees and Board of Directors respectively.
Other Manager:	**Patient ~~Experience~~ Engagement Manager** Deliver the requirements of the patient experience programme at a service line level. Prepare reports and information on patient experience activity for consideration by the Service Line / Support services Management Teams.

Source documentation:

Quality Improvement Strategy

SCHEME OF DELEGATION

Reference: **SP04**

Title: **Patient and Public Panel (patient involvement and engagement)**

Decision Maker **Responsibilities**

Board of Directors:	Consider quarterly reports on Patient and Public Panel activities and outputs.
Committee:	**Quality/Workforce Committee or other relevant Committee (dependent on subject matter of panel involvement work)** To seek assurance on patient experience matters on behalf of the Board of Directors.
Executive Management Team:	Consider quarterly reports on patient and public panel activities.
Director:	**Director of Strategy and Planning** Executive lead for patient and public panel work. Present quarterly integrated reports to the Board of Directors
Senior Manager:	**Head of Communications and Engagement** Preparation of patient and public panel work programmes. Preparation of quarterly reports on patient and public panel activities and outputs for consideration by the Executive Management Team, Committees and Board of Directors respectively.
Other Manager:	**Patient Engagement Manager** Deliver the requirements of the patient and public panel work plan at a service line level. Prepare reports and information on patient and public panel activities and outputs for consideration by the Strategy and Planning Directorate.

Source documentation:

Communications and Engagement Strategy

SCHEME OF DELEGATION

Reference: SP05SD04

Title: Approval and Management of Projects

Decision Maker — **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	To appoint the Finance, Investment & Planning Committee and approve Terms of Reference.
Committee:	**Finance, Investment & Planning Committee** To monitor progress with delivery of all corporate strategic projects within the Trust, ensuring that they are completed in accordance with the project plan and budget. To receive and monitor reports from Directorates on the progress of their projects. To ensure that effective cross-departmental working takes place in all projects, ensuring full stakeholder involvement.
Executive Management Team:	To receive all new business cases for proposed projects and identify whether they should be allowed to proceed, taking into account the proposal's fit with the Trust's strategic direction, the ability to deliver the project together with the costs and benefits. To determine whether each project should be classed as corporate or directorate. To refer corporate projects to the Finance, Investment & Planning Committee for monitoring purposes. To refer directorate projects to the relevant directorate meeting for ongoing approval and management up to the level of their delegated authority.
Director:	**All Executive Directors** In their role as Workstream Sponsor: 1. approve projects in their area of responsibility for submission to the Executive Management Team 2. ensure that all projects within their directorate are properly conducted and report any exceptions to the Finance, Investment & Planning Committee with the appropriate action plans
Directorate Meetings:	To receive and approve documentation for directorate projects and monitor progress.

Source documentation:

NWAS Project Management Process
Programme and Project Management Guide (June 2007)

SCHEME OF DELEGATION

Reference: **SD01**

Title: **Resilience**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Consider periodic assurance reports on the Trust's Resilience arrangements.
Executive Management Team:	Approve procedures and action plans to support Resilience policies.
Director:	**Director of Operations** Preparation of reports for consideration by the Executive Management Team and Board of Directors on all national and regional developments with Resilience. Ensuring that the Trust meets all the relevant requirements of Civil Contingencies Act 2004 (CCA), NHS Emergency Planning Guidance 2005 and Standard Ambulance Contract Schedule 2 – Part 3.
Senior Manager:	**Head of Contingency Planning** Preparation of strategy, policy and procedure documents on Resilience. Ensuring that the Trust has appropriate representation and influence with regional and national resilience initiatives. **Business Continuity Manager** Ensure compliance with the statutory duties of the CCA and that resilience arrangements are tested, valid, and robust. Ensure the delivery of appropriate training and exercising for all resilience arrangements across the Trust. Manage the Trust's Business Continuity Management Programme ensuring that robust and tested Business Continuity arrangements are in place for all aspects of its business. Provide leadership and guidance, for Resilience at local level and coordinate robust emergency preparedness arrangements for the locality. Ensure health emergency planning integration with external partners and agencies through Local Resilience Forums and sub groups. **Head of Special Operations** Ensure the delivery and development of the HART programme across the Trust. Engagement with regional and national partners to ensure the Trust's HART capability is reflective of national direction and local needs. Ensure HART (including Incident Response and Urban Search & Rescue) functions are appropriately trained and exercised, including multi agency integration.
Other Manager:	**Emergency Planning Managers**

	Ensuring that each geographical location has arrangements in place to provide an effective and appropriate operational response to major/protracted and special incidents including Chemical, Biological, Radiological and Nuclear (CBRN) and decontamination issues. Provision of on call Tactical Advice capability to Command Team. Delivery of all relevant training and exercise programmes for emergency Preparedness at sector and area level Liaison with internal and external partners and agencies in compliance with the statutory legislative duties of the CCA and the NHS Emergency Planning Guidance 2005,

Source documentation:

Cabinet Office (2005): Civil Contingencies Act (2004) – Statutory Instruments
Department of Health: (2005): Emergency Planning Guidance
HM Government (2005): Emergency Preparedness – Guidance on Part 1 of the Civil Contingencies Act 2004.
HM Government (2005): Emergency Response and Recovery – Non statutory guidance to complement Emergency Preparedness
Home Office (2000): 'Recovery' – An Emergency Management Guide
Business Continuity Institute (2005): Business Continuity Management, Good Practice Guidelines, 1.2
British Standards (2005): BS 25999 -1, Code of Practice Standards for BCM.
NWAS Civil Contingencies Strategy 2008 - 2013
NWAS: Business Continuity Programme 2005-11
NWAS Major Incident Plan V2 2009
Taking Healthcare to the Patient
NHS Standard Ambulance Contract Schedule 2 Part 3

SCHEME OF DELEGATION

Reference: **SG01**

Title: **Disposals**

Decision Maker	Responsibilities
Board of Directors:	Approve disposal of land, buildings and equipment with a value in excess of £25,000 on completion of tender action.
Director of Finance:	Approve disposal of surplus equipment with a value between £2,500 and £24,999 on completion of competitive quotation process.
Director	**Director** Approve disposal of surplus equipment with a value up to £2,499. ~~with Head of Finance for budget area~~
Other Managers:	**Head of Procurement** Provide advice and manage the tender process for disposals with a value in excess of £25~~,~~,000 or competitive quotation process for disposals with a value between £2,500 and £24,999. Provide advice on informal quotation process for disposals with a value up to £2,499. **All Managers** Identification of surplus assets and undertake appropriate disposals process in conjunction with Head of Procurement.

Source documentation:
Guidance for Disposal of Surplus Assets
SFI section 13

SCHEME OF DELEGATION

Reference: **SG02**

Title: **Appointment of Consultants for the provision of Specialist Advice**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of Business Case for contracts with a whole life cost in excess of £50,000. In addition where consultancy costs are above £50,000 the business case needs to be approved by NHS Improvement.
Executive Management Team:	Approval of all Trust-wide Business Cases for contracts with a whole life cost of up to£49,000. Recommendation to Board of Directors of Business Case for contracts with a whole life cost of £50,000 and above.
Director:	**All Directors** Present Business Case for use of Consultants to Executive Management Team.
Senior Managers:	**Deputy Directors / Heads of Departments** Preparation of Business Case. **Head of Financial Planning / Heads of Finance** Preparation of financial data.
Other Managers:	Contribute to preparation of Business Case as required.

Source documentation:
Standing Orders
Standing Financial Instructions
NHS Improvement consultancy spending approval process

SCHEME OF DELEGATION

Reference: **SG03**

Title: **Lease Car Arrangements**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	**Chairman** Approval of Chief Executive's Lease Vehicle Agreement.
Committee:	**Remuneration Committee** Approval of Lease Car Allowances for Directors and other Very Senior Managers.
Chief Executive:	Authorisation of Lease Vehicle Agreements for Directors. Authorisation of Vehicle Selection forms for Directors.
Executive Management Team:	Approval of lease car provision for corporate posts below Director level.
Director:	**Director of Finance** Ratification of all Vehicle Selection forms. **Directors** Authorisation of Lease Vehicle Agreements for corporate posts in the relevant Directorate. Authorisation of Vehicle Selection forms for corporate posts in the relevant Directorate subject to ratification by Director of Finance.
Senior Managers:	**Head of Estates & Fleet** Responsible for administration of Trust Lease Car Scheme. **Deputy Director of Finance** Periodic review of Lease Car Allowances for consideration by Executive Management Team / Remuneration Committee (minimum of three yearly). Periodic review of the Trust's Lease Car Scheme in conjunction with Deputy Director of Organisational Development.

Source documentation:
Trust Lease Car Policy

SCHEME OF DELEGATION

Reference: **SG04**

Title: **Authorisation of Purchase Orders for Non-Catalogue items**

Decision Maker	**Responsibilities**
Chief Executive:	Authorisation of Purchase Orders with a value in excess of £500,000 (with the exception of lease contracts).
Director:	**Director of Finance** Authorisation of Purchase Orders with a value in excess of £500,000 in the absence of the Chief Executive. Authorisation of Purchase Orders with a value of between £100,000 and £499,999. Authorisation of all Purchase Orders in relation to lease agreements.
Senior Managers:	**Deputy Director of Finance** Authorisation of -Purchase Orders with a value of between £100,000 and £499,999. Authorisation of purchase orders in relation to lease agreements in the absence of Director of Finance.
Other Managers:	**Head of Procurement / Trust Procurement Manager** Authorisation of Purchase Orders with a value up to £99,999.
All staff:	**Operational Procurement Manager** Authorisation of purchase orders with a value up to £24,999. **Senior Procurement and Supplies Officers** Authorisation of Purchase Orders with a value up to £94,999. **Procurement Officer~~and Supplies Assistants~~** Authorisation of Purchase Orders with a value up to £2,499.

Notes

1. **The authorisation of purchase orders is subject to the approval of any required business case and associated competitive tendering arrangements together with an appropriately approved requisition form.**

Source documentation:
Standing Orders
Standing Financial Instructions

SCHEME OF DELEGATION

Reference: **SG05**

Title: **Purchasing and New Tender Specification Authorisation**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Executive Management Team:	Approval of new tender specifications for Trust-wide contracts with a value in excess of £25,000. Approval of new tender specifications for Service Line requirements with a value of goods and services exceeding £100,000.
Director:	**Director of Finance** Determine the systems of control over stores and receipt of goods. Maintenance of signatory list of persons authorised to requisition goods and services. Recommendation on financial limits. Arrangements for financial control of building and engineering contracts. Authorisation of orders for goods and services delivered over a period in excess of 12 months. Authorised signatory of contracts for goods and services and any subsequent variations to contracts.
Service Line Management Team:	Approval of new tender specifications for Service line-specific contracts with a value up to £100,000. Preparation of new tender specification for approval by Executive Management Team where the value of goods and services exceed £100,000.
Senior Managers:	**Deputy Director / Heads of Departments** Preparation of tender specifications.
Other Managers:	**All Managers** Obtain quotations where the value of goods and services is less than £9,999 **Head of Procurement** Obtain competitive quotations where the value of goods and services exceed £10,000 up to a value of £24,999 Obtain competitive tenders where the value of goods and services exceed £25,000

Source documentation:
Standing Orders
Standing Financial Instructions
Purchasing and Payment Procedures
Authorised Signatory Register
Stores Procedure Note

SCHEME OF DELEGATION

Reference: **SG06**

Title: **Authorisation of Requisition Forms**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Authorisation of expenditure for goods and services with a value in excess of £500,000.
Chief Executive:	Signature on behalf of the Board of Directors authorised Requisitions for goods and services with a value in excess of £500,000. Authorisation of Requisitions for goods and services with a value of up to £499,999.
Director:	**Director of Finance** Authorisation of Requisition for goods and services with a value of up to £249,999 **Director of Operations / Medical Director / Director of Organisational Development** Authorisation of Requisitions for goods and services with a value of up to £99,999.
Senior Managers:	**Deputy Directors and Senior Managers Band 9 and 8d** Authorisation of Requisitions for goods and services with a value of up to £24,999.
Other Managers:	**Band 8b & 8c Managers** Authorisation of Requisitions for goods and services with a value of up to £9,999. **Band 8a Managers** Authorisation of Requisitions for goods and services with a value of up to £7,499 **Band 6 & 7 Managers** Authorisation of Requisitions for goods and services with a value of up to £4,999
All staff:	**Band 4 & 5 Staff** Authorisation of Requisitions for goods and services with a value of up to £2,499.

Source documentation:
Standing Orders
Standing Financial Instructions
Purchasing and Payment Procedures

SCHEME OF DELEGATION

Reference: **SG07**

Title: **Approval of Competitive Tender Awards and Appointment of Tender Evaluation Panels**

Decision Maker	Responsibilities
Board of Directors:	Determination of financial thresholds as part of approval of Standing Orders and Standing Financial Instructions. Approval of contract award on completion of tender action where the value is in excess of £500,000.
Committee:	**Audit Committee** Review of register of all instances where the requirement for formal tendering or the quotation process has been waived.
Chief Executive:	Appointment of evaluation panel for assessing all tenders with a value in excess of £100,000. Approval of requests for Waiver of Standing Orders.
Executive Management Team:	Approval of contract award on completion of tender action up to a value of £499,999.
Director:	**Director of Finance** Approval of requests for Waiver of Standing Orders in the absence of the Chief Executive. **Director of Corporate Affairs** Scrutiny of requests for Waiver of Standing Orders prior to approval by Chief Executive / Director of Finance. **All Directors** Appointment of evaluation panel for assessing Service line-specific tenders with a value of up to £100,000. Reporting the results of tender action to • the Executive Management Team to award contracts up to the value of £499,999 • the Executive Management Team to support a recommendation to award contracts to the Board of Directors for contracts above £500,000 • the Finance, Investment and Planning Committee for information and noting the recommendation to award for contract above £500,000. • the Board of Directors for award of contracts above £500,000.
Senior Managers:	**All Senior Managers** Preparation of request for Waiver of Standing Orders for scrutiny by Director of Finance and approval by Chief Executive.
Other Managers:	**Head of Procurement** Provide advice and manage tender process.

All staff:	Awareness of financial threshold where tender action is required (£25,000 and above).

Source documentation:
Standing Orders
Standing Financial Instructions

SCHEME OF DELEGATION

Reference: **SG08**

Title: **Pool Vehicle Arrangements**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Executive Management Team:	Approve Trust pool vehicle scheme. Approve business case for pool vehicles.
Director:	**Director of Finance** Ensure that the scheme complies with Inland Revenue guidance, is affordable and represents good value for money.
Senior Managers:	**Assistant Director ~~Head of~~ Estates & Fleet** Responsible for the administration of Lease arrangements for pool cars.
Other Managers:	Submission of business case for acquisition of pool vehicle(s) for their department. Responsible for administration of Pool Vehicle Scheme within areas of their control.
All Staff:	Compliance with Pool Vehicle scheme

Source documentation:

SCHEME OF DELEGATION

Reference: **SG09**

Title: **Insurance (Motor and Workshops)**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approve continued involvement with insurance providers. Approve any corrective action recommended by the Finance, Investment & Planning Committee or the Executive Management Team.
Committee:	**Finance, Investment & Planning Committee** Recommend any changes in insurance provider. Recommend to the Board of Directors any corrective measures that will reduce the risk to the Trust.
Director:	**Director of Finance** Undertake contract reviews with insurance provider. Provide reports to the Finance, Investment & Planning Committee where a change of insurance provider is recommended.
Senior Managers:	**All Senior Managers** Review claims summaries on a monthly basis. Recommend to the Executive Management Team any corrective measures that will reduce the risk to the Trust. **Deputy Director of Finance** Manage appropriate procurement process for insurance provision (in accordance with agreed tendering processes). **Head of Fleet** Provide claims summaries to Senior Managers on a monthly basis.
Other Managers:	**Fleet Support Manager** Liaise with insurer and provision of required information. Issue of certificates of insurance. Identify personal injury claims which fall under motor insurance policy. Issue certificates of insurance to lease car holders. **Other Managers** Retain insurance certificates in safe place for vehicles under their control. Carry out appropriate investigations of RTAs and other incidents.
All staff:	Completion of RTA and Incident reports forms following incident involving vehicles.

SCHEME OF DELEGATION

Reference: **IN01**

Title: **Medical Records Management**

Decision Maker	Responsibilities
Board of Directors:	Trust compliance with any relevant legislation within the overall area of Medical Records Management.
Executive Management Team:	Accountable to resolve any events which may be potential liabilities or failures to adhere to legislation or NHS standards and to ensure the Board of Directors is made aware.
Director:	**Director of Quality, Innovation and Improvement** Overall accountability for the Trust to adhere to the Clinical~~Medicals~~ Records Management legislation, Trust policies and procedures and NHS Standards. **Medical Director** Review and agree internal protocols governing the protection and use of patient identifiable information by Trust staff. Ensure that adoption and adherence to confidentiality policies and procedures are in line with Caldicott Guardian accountability.
Senior Manager:	**Head of Informatics** Responsible for Trust adherence to the ~~Medical~~Clinical Records ~~Management~~ legislation, Trust policies and procedures and NHS standards/guidance.~~.~~ Reporti~~ng~~ any ~~Medical~~Clinical ~~-~~Records Management issues to the Board of Directors and Executive Management Team as appropriate. Reporti~~ng~~ identified risks to the Information ~~Governance~~ Management Group.
Other Managers:	**Information Governance Manager** Management of service line-related Information Governance requirements and work programmes incorporating Clinical~~Medical~~ Records. Responsible for reporting to the Executive Management Team and Information ~~Governance~~ Management Group. **Clinical Records and ePR Manager** Manage the Trust's Clinial Records and ePR system in accordance with the provisions of the Public Records Act, the Data Protection Act, GDPR, DoH Records Management Code of Practice, Caldicott Principles, the recommendations of the National Archives and, as far as is practicable, in accordance with British standards.~~Maintaining Clinical Records Management procedures and identification of breaches and subsequent investigations.~~ ~~Responsible for assessment and resolution of any Clinical Records Management issues identified through the incident reporting process.~~ ~~Responsible for the retrieval and release (if appropriate) of patient identifiable information.~~ **All Managers** Ensuring that the Clinical Records Management Policy and P~~p~~rocedures are understood and adhered to within their areas of managerial accountability.

All staff:	To maintain and store ~~medical~~clinical records as it applies to their Department in accordance with the procedures detailed in the Clinical Records Management Policy, at all times maintaining the security and confidentiality of patient information. Advising line management of any potential breaches with regard to Clinical Records Management Policy and procedures.

SCHEME OF DELEGATION

Reference: **IN02**

Title: **Corporate Records Management**

Decision Maker — **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Ensuring that the Trust complies with any relevant legislation within the overall area of Records Management.
Executive Management Team:	Consideration of issues referred from the Director of Quality, Innovation and Improvement approve corrective action and/or refer to the Board of Directors as appropriate.
Director:	**Director of Quality, Innovation and Improvement (SIRO)** Responsible for Corporate Records Management within the Trust and ensuring compliance with all legislation and NHS standards.
Senior Manager:	**Head of Informatics** Responsibility for coordinating the dissemination of Corporate Records Management requirements in order to ensure that the Trust is complying with all legislation and NHS standards. Responsibility for reporting and monitoring through the Information ~~Governance~~ Management Group any Corporate Records Management issues to the Executive Management Team as appropriate. **All Senior Managers/ Information Asset Owners** Ensuring that they are up to date with legislative requirements and NHS standards within their own remit and to ensure that this information is disseminated to all staff within their respective areas. Accountable for monitoring within their individual Departments and Directorates that legislation and NHS standards with regard to Records Management are being adhered to and that any failures are formally reported to the Information ~~Governance~~ Management Group.
Other Managers:	**Information Governance Manager** Ensuring that ~~the Records Management and Lifecycle Policy and Strategy are regularly reviewed~~ advice and guidance on the implementation of the NHS Records Management Code of Practice 2016 is provided as detailed in the Data Protection and Security Policy to maintain compliance with current legislative requirements. Overall monitoring of adherence to legislation and NHS standards and reporting exceptions to the Head of Informatics and the Information ~~Governance~~ Management Group.
All staff:	To maintain and store records in order to adhere to the ~~Records Management & Lifecycle Policy as it applies to their Department and in particular are aware of the requirement for the security and~~ NHS Records Management Code of Practice 2016. ~~confidentiality of patient information.~~ Advising line management of any potential breaches with regard to Records Management ~~policies~~.

Source documentation:
Data Protection and Security Policy~~Records Management Strategy~~
~~Records Management and Lifecycle Policy~~

SCHEME OF DELEGATION

Reference: **IN03**

Title: **Disclosure of Patient Identifiable Information**

Decision Maker	Responsibilities
Board of Directors:	Accountability to adhere to legislation and NHS Standards within the overall area of Patient Identifiable Information.
Executive Management Team:	Accountable to resolve any events which may be potential liabilities or failures to adhere to legislation or NHS standards and to ensure the Board of Directors is made aware.
Director:	**Medical Director** Overall accountability for the Trust to adhere to the legislation, Trust policies and procedures and NHS Standards with regard to the disclosure of patient identifiable information. Primary accountability for adoption and adherence to Confidentiality policies and procedures in line with Caldicott Guardian responsibility. Primary responsibility for reporting any patient identifiable information issues to the Board of Directors and Executive Team as appropriate. **Director of Quality, Innovation & Improvement (SIRO)** Secondary accountability for adoption and adherence to Confidentiality policies and procedures. Secondary responsibility for reporting any patient identifiable information issues to the Board of Directors and Executive Team as appropriate.
Senior Manager:	**Head of Legal Services** Provision of legal advice for the release of patient identifiable information. **Head of Informatics** Overall responsibility for the identification and management of breaches of patient confidentiality and subsequent investigations and the reporting of such breaches to the Medical Director and / or Director of Quality, Innovation and Improvement. **All Senior Managers / Information Asset Owners** Ensuring that all staff in their areas of responsibility are aware of and adhere to Confidentiality policy and procedures.
Other Managers:	**Information Governance Manager** Coordination of Serious Untoward Incident reporting process for information security and confidentiality incidents. Responsible for reporting incidents and subsequent investigations to the Information Governance Management Group. Audit and monitoring of confidentiality in line with Confidentiality Policy and procedures. **Legal Services**

	Day to day management and production of responses to Data Protection requests. **All Managers** Ensuring that all potential requests for the release of patient identifiable information are passed to the Legal Services Administrator. Ensuring that confidentiality of patient information is maintained in line with Trust Confidentiality policies and procedures. Report breaches of patient confidentiality to the Information Governance Manager.
All staff:	Advising line management of any potential breaches with regard to disclosure of patient identifiable information.

SCHEME OF DELEGATION

Reference: **IN04**

Title: **IM&T Systems Access Control**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Director:	**Director of Quality, Innovation and Improvement and Director of Finance** Joint accountability for adherence to IM&T Access Control Policy.
Senior Managers:	**All Senior Managers / Information Asset Owners** Ensure that their staff comply with the IM&T Systems Access Control procedures. Ensure that notified breaches are fully investigated and appropriate corrective action taken. Responsible for ensuring that all new systems have a privacy impact assessment carried out prior to implementation. **Head of ICT Service Delivery / Information Governance Manager** Responsible for maintaining IM&T Access Control procedures and identification of breaches and subsequent investigation.
Information Security Forum:	The forum is responsible for assessment and resolution of information security breaches which includes IM&T Access Control.
Other Managers:	**All Managers** To ensure that all staff requiring access to NWAS IM&T Systems follow the necessary procedures through the IM&T Department.
All Staff:	Comply with IM&T Systems Access Control procedures.

Source documentation:
IM&T Access Control Policy
PS08 Access Authentication

SCHEME OF DELEGATION

Reference: **IN05**

Title: **Ambulance Quality Indicator Reporting**

Decision Maker	Responsibilities
Board of Directors:	Receive copies of Ambulance Quality Indicators (AQI) return and report for information.
Executive Management Team:	Receive copies of the monthly Ambulance Quality Indicator (AQI) return and report.
Director:	**Director of Quality, Innovation and Improvement / Director of Operations / Medical Director** Joint responsibility for approval of data submissions and early view of the Ambulance Quality Clinical Indicators.
Senior Manager:	**Head of Informatics** Final quality assurance (QA) of Ambulance Quality Indicators (System Indicators) and preparation of report for approval by Directors. ~~**Deputy Director of Quality**~~ ~~Final review and approval of Ambulance Quality Indicators (Clinical Indicators - early view) for approval by Directors.~~
Other Managers:	**Senior Clinical Quality Manager** Final review and approval of Ambulance Quality Indicators (Clinical Indicators - early view) for approval by Directors. **Deputy Head of Informatics** QA of System Indicator data in accordance with agreed QA procedure. Review and assurance of Director approval report and review of submission entry. **~~Senior~~ Clinical Quality Officer ~~Manager~~** Final QA of Ambulance Quality Indicators (Clinical Indicators – early view) and preparation of report. Final QA of Ambulance Quality Indicators (Clinical Indicators) prior to submission and final QA of updated clinical data revisions in accordance to the clinical data revision time-table. ~~Review and assurance of early view report for Director approval.~~ Submission of AQI Clinical indicators once data finalised. Review and assurance of all data at specified re-submission dates in accordance to QA SOPs. Submission of updated ACQI clinical indicators in accordance to clinical data revision time-table.

Source documentation:
Annual Ambulance System Indicators and Ambulance Quality Indicators
Useful Websites:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm

SCHEME OF DELEGATION

Reference: QII~~HG~~01~~3~~

Title: Health, Safety and Security Management

Decision Maker	Responsibilities
Board of Directors:	Receive assurance that the Health, Safety and Security Policy is being fully implemented. Ensure that the Trust is fully compliant with all relevant Health and Safety (H&S) legislation. Ensure appropriate resources are provided for the effective management of H & S business within the Trust. Ensure that Trust staff and site security is being managed effectively and within the Trust Risk management process. Approve the appointment of an Executive Director and a Non-Executive Director with responsibility for Security Management.~~ in line with Secretary of State Directions.~~
Committee:	**Quality Committee** Seek assurance on the effectiveness of the Trust's management of health, safety and security (HSS)~~.~~ **~~Health &~~ Safety Management Group** As per the Safety Representatives and Safety Committee regulations 1977 (as amended) advise the Board in the furtherance of its obligation with regard to health, safety and security legislation and practice. Promote cooperation between the Trust and its employees in the instigation, development and application of measures to ensure the health, safety, security and welfare of employees whilst at work and that of any other who may be affected by the undertakings of the Trust.
Chief Executive:	Act as the accountable officer for all H&S related Trust business. Approve the appointment of a ~~Security Management~~ Director with responsibility for HSS.~~in line with Secretary of State Directions.~~
Executive Management Team:	Receive and consider reports upon breaches of staff and site security and performance against security risk management Indicators and approve any necessary remedial action. Receive and approve action plans in relation to HSS improvements within the Trust.
Director:	**Director of Quality, Innovation and Improvement** Executive lead for all HSS~~Security~~ Management matters,~~ in line with Secretary of State Directions.~~ Submit reports upon breaches of staff and site security and performance against security risk management Indicators to the Quality Committee and Safety Management Group~~Executive Management Team~~ and where appropriate Board of Directors. Chair the ~~Health and~~ Safety Management Group Executive lead for all HSS Trust business and report appropriately to the EMT and Board of Directors.

	Ensure reports identifying the need for appropriate resources are provided to the EMT and where appropriate to the Board of Directors to ensure the effective management of H & S business within the Trust. **Directors** Ensure that Service Line Health & Safety Business Groups meet on a regular basis. To ensure compliance with HSS legislation and Trust policies within their area of control. To ensure effective utilisation of available resources.
Senior Manager:	**Head of Safety & Patient Experience** Take the lead on compiling and reviewing Trust Policy. ~~Submit reports on breaches of staff and site security and performance against Security risk management Indicators to the Executive lead for SMS.~~ Co-ordinate the reporting and investigation of all relevant incidents. Compile and review Trust Policy and Procedures. Ensure implementation of published Policy and Procedures. Ensure appropriate reports are completed for submission to the ~~Health &~~ Safety Management Group. Lead on the compilation and review of the Health, Safety & Security Policy. Collate information on the reporting and investigation of all relevant incidents. To ensure appropriate consultation with staff side. To ensure the Board of Directors is advised of any HSS issues that cause serious or immediate concern To ensure appropriate reports are completed for submission to the Safety Management Group.
Other Managers:	**Health, Safety and Security Manager** Monitor compliance with published Policy and Procedures. Ensure that security matters are being managed within the Trust risk management process. To monitor activities to ensure best practice across the Trust. **All Managers** Comply with HSS legislation. Comply with internal/external safety notices. Ensure that all incidents reports are submitted correctly and within legislated time limits. Ensure compliance with the H&S at Work Act 1974 and all other relevant legislation. Investigate appropriate incidents. **~~Health,~~ Safety & Security Practitioners** Act as the Trust Local Security Management Specialist in line with Secretary of State Directions. Provide specialist advice regarding patient and staff health, safety and welfare **All Managers** Comply with HSS legislation. Comply with internal/external safety notices.

	Ensure that all incidents reports are submitted correctly and within legislated time limits. Ensure compliance with the H&S at Work Act 1974 and all other relevant legislation. Investigate appropriate incidents.
All staff:	Report security breaches, physical and non-physical, using the Trust Incident Reporting system. Ensure compliance with the Health & Safety at Work etc. Act 1974

Source documentation:
Secretary of State Directions on Security Management Measures.
Health and Safety at Work Act 1974 and associated legislation
Health, Safety & Security Policy
Health and Safety A-Z Toolkit
Security Procedure
Useful Websites:
www.nhsbsa.nhs.uk
www.hse.gov.uk

~~Health and Safety at Work Act 1974 and associated legislation~~
~~Health, Safety & Security Policy~~
~~Health and Safety A-Z Toolkit~~

~~**Useful Websites:** www.hse.gov.uk~~

SCHEME OF DELEGATION

Reference: **QII02~~HG05~~**

Title: **Incident Reporting**

Decision Maker	**Responsibilities**
Board of Directors:	Receive assurance that the Incident Reporting procedure~~& Investigation Policy~~ is being fully implemented. ~~Receive and approve incident reporting summaries together with any recommendations regarding corrective actions.~~ Receive monthly updates relating to incident reporting, Serious Incidents and Serious Events.
Committee:	**Quality Committee** Seek assurance on the effectiveness of the Trust's management of incident reporting including Trust SI (Serious Incident)~~-~~ reports. **Clinical Effectiveness~~Governance~~/~~Health and~~ Safety Management Groups** Receive and approve, for submission to the Board, incident reporting summaries, together with any recommendations regarding corrective actions and required changes to policy and/or procedure. Monitor compliance with the Incident Reporting procedure.~~& Investigation Policy.~~
Executive Management Team:	Ensure that the Incident Reporting procedure~~ & Investigation Policy~~ is adhered to. Receive appropriate incident reports. Performance manage the completion of Trust SI reports. ~~Monthly review of SI Reports.~~ Weekly update of SI Reports.
Director:	**Director of Quality, Innovation and Improvement** Executive lead for all incident reporting including where necessary to the EMT and Board of Directors. Ensure compliance with the Incident Reporting procedure ~~& Investigation policy~~ within their area of control. Notify the Executive Management Team of all relevant incidents, in accordance with the Incident Reporting procedure~~ and Investigation Policy~~. **Medical Director** Chair the Review of Serious Events meeting.
Senior Manager:	**Chief Nurse~~Deputy Director of Quality~~** Provide advice on the completion of SI investigation reports Facilitate the performance management and completion of Trust SI Reports **Head of Safety & Patient Experience** Take the lead on compiling and reviewing the Incident Reporting procedure~~and Investigation Policy~~. Ensure appropriate external and internal StEIS reporting. Ensure the implementation of the Incident Reporting procedure.~~and Investigation Policy~~.

	Ensure that appropriate reporting systems are in place for areas of responsibility and compliance with all duties in relation to the Incident Reporting and Investigation Policy. ~~Ensure compliance with external reporting requirements.~~ Be responsible for the management of the SI reporting function Act as point of contact with the lead commissioner for SI reporting. **Head of Clinical Safety** Ensure compliance with external reporting requirements, as necessary. Monitor and collate Trust wide statistics on clinical incidents being reported and investigated, including those reported externally Ensure that the Clinical Effectiveness ~~Governance~~ Management Group is furnished with appropriate statistics on a quarterly basis Monitor incident reports to enable the correct reporting system to be employed when early trends in risks to the Trust are identified. Receive and action accordingly, all clinical and external Incidents reported Day to day management of the relevant sections within the Incident Reporting procedure and Investigation Policy **All Deputy Directors / Heads of Service** Ensure compliance with the Incident Reporting procedure & Investigation Policy within their area of control. Monitor all relevant incidents ensuring that any recommendations regarding corrective actions are implemented locally.
Other Managers:	**Senior Risk and Assurance Manager** Through Datix, ensure that appropriate reporting systems are in place for areas of responsibility and compliance with all duties in relation to the Incident Reporting procedure. Ensure compliance with external reporting requirements. **Health, Safety & Security Manager** Monitor and collate Trust wide statistics on non-clinical incidents being reported and investigated, including those reported externally Ensure that the Health and Safety Management Group is furnished with appropriate statistics on a quarterly basis Monitor incident reports to enable the correct reporting system to be employed when early trends in risks to the Trust are identified. Ensure compliance with RIDDOR requirements. **Health, Safety & Security Practitioner** Receive and action accordingly, all Health, Safety and non-clinical Incidents reported. Day to day management of the relevant sections within the Incident Reporting procedure and Investigation Policy. **Clinical Safety Manager** Receive and action accordingly, all clinical and external Incidents reported Day to day management of the relevant sections within the Incident Reporting procedure and Investigation Policy. **All Managers:** Carry out initial management investigations into all i~~I~~ncident r~~R~~eport submissions.

Source documentation:

Incident Reporting procedure ~~and Investigation Policy~~
Health, Safety & Security Policy
Serious Incident procedure
Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 1995
Blackpool CCG SI Policy

SCHEME OF DELEGATION

Reference: QII03~~HG06~~

Title: **Incident Investigation**

Decision Maker	**Responsibilities**
Board of Directors:	Receive assurance that the ~~Incident Reporting &~~ Investigation Policy is being fully implemented.
Committees:	**Quality Committee** Seek assurance on the effectiveness of the Trust's management of incident investigation. **Clinical Effectiveness~~Governance~~ Management Group** Obtain assurance in relation to all clinical governance and safety activities within the Trust. Receive and approve clinical incident investigation summaries, together with any recommendations regarding corrective actions and required changes to policy and/or procedure. **~~Health &~~ Safety Management Group** Receive and approve non-clinical incident investigation summaries for major injury RIDDOR incidents together with any recommendations regarding corrective actions and required changes to policy and / or procedure.
Executive Management Team:	Where appropriate, review major and catastrophic serious~~catastrophic serious~~ incident investigation reports to ensure that assurances can be given to the Board of Directors.
Director:	**Director of Quality, Innovation and Improvement/Medical Director** Investigate all catastrophic untoward incidents and report findings to the Review of Serious Events (ROSE)~~Quality Committee~~. Receive copies of all high level incident investigation reports for comment. **Executive Directors** Ensure that all incidents, involving their directorate staff, are investigated and reported upon, in accordance with the ~~Incident Reporting &~~ Investigation Policy. Ensure compliance with the ~~Incident Reporting &~~ Investigation Policy within their area of control. Approve appropriate major and catastrophic serious incident investigation reports
Senior Manager:	**Chief Nurse/Associate and Assistant Medical Directors** Approve Serious Incident investigation reports on behalf of the Director of Quality, Innovation and Improvement and the Medical Director. **Head of Safety & Patient Experience** Lead on compilation and review of the ~~Incident Reporting &~~ Investigation Policy. Provide professional advice and guidance to all levels of Trust management with regard to incident investigations.

	Be responsible for overseeing the investigations into StEIS reportable incidents to ensure compliance with the requirements of StEIS reporting **Senior Patient Safety Manager** Responsible for the delivery of Serious Incident process. Acts as a point of advice, guidance and review of investigations. **All Deputy Directors (or equivalent)** Ensure compliance with the ~~Incident Reporting &~~ Investigation policy within their area of control. Ensure that incidents, involving their departmental staff, are investigated and reported upon, in accordance with the ~~Incident Reporting and~~ Investigation policy. Ensure that recommendations made during the investigation are implemented as soon as is reasonable and practicable. ~~,~~ **Head of Clinical Safety** ~~**, Head of Clinical Quality**~~ Provide professional advice and guidance to all levels of Trust management with regard to incident investigations and l~~L~~earning l~~L~~essons.
Other Managers:	**All Managers** Ensure compliance with the ~~Incident Reporting &~~ Investigation policy within their area of control. Ensure that incidents, involving their departmental staff, are investigated and reported upon, in accordance with the ~~Incident Reporting and~~ Investigation policy. Ensure that recommendations made during the investigation are implemented as soon as is reasonable and practicable. **Health &~~,~~ Safety/Safety & Security Practitioner/Clinical Safety Practitioners/Serious Incidents Investigations Officer** Assist in the completion of root cause analysis where required Provide specialist advice, guidance and support to m~~M~~anagers who are completing investigations **All Managers and Supervisors~~/Advanced Paramedics~~** Investigate all incidents in accordance with the ~~Incident Reporting &~~ Investigation Policy.
All staff:	Report all incidents using Trust Incident Report Form, in accordance with the Trust's Incident Reporting procedure.~~and Investigation Policy.~~

Source documentation:
Investigation Policy
Incident Reporting Procedure
Serious Incidents procedure~~and Investigation Policy~~
Blackpool CCG SI Policy

SCHEME OF DELEGATION

Reference: QII04HG07

Title: Clinical Quality

Decision Maker	Responsibilities
Board of Directors:	Receive assurance that the Clinical Governance policies and procedures are being fully implemented. Ensure that the Trust is fully compliant with all relevant Clinical Governance legislation and guidance. Ensure appropriate resources are provided for the effective management of Clinical Governance business within the Trust.
Committee:	**Clinical Governance Effectiveness Management Group:** Obtain assurance in relation to all clinical governance and safety activities. Receives reports on all Clinical Governance activities within the Trust and ensures that effective action is in place to provide assurance to the Quality Committee and Board of Directors. Advises the Trust on Clinical practice activities within the Trust including Paramedic Training activities and all Clinical protocols, practices and procedures.
Director:	**Medical Director** Responsibility for reporting on all relevant Clinical Governance activities to the Board of Directors via the Clinical Governance Management Group and Quality Committee. **Directors** Ensure the principles of the Trust's Right CareClinical Governance Strategy and Policy are adhered to within their own area of control. Identify relevant Clinical Governance activity relevant to their area of control.
Senior Manager:	**Chief Consultant Paramedic** Take the lead on compiling and reviewing clinical policies and associated procedures. Responsibility for managing and coordinating all relevant Clinical Governance activities and requirements of the Trust. **All Deputy Directors / Heads of Service/Consultant Paramedics** Responsibility for ensuring that the principles of Clinical Governance are embedded throughout their own areas of control. Manage Clinical Governance activity relevant to their area of control. Responsible for the local implementation of Clinical Governance related policies and strategies. **Head of Clinical Quality** Responsible for the provision of expert advice in relation to Clinical Quality Governance activities. Responsible for managing the Clinical Audit function within the Trust. Responsibility for developing and implementing Clinical Governance related strategy and policy, including a Clinical Governance Development Plan. Responsible for coordinating Clinical Governance activities and their performance management.

	~~Responsibility for the provision of support and advice in relation to Clinical Governance.~~ ~~Responsible for the local implementation of Clinical Governance related policies and strategies.~~ ~~Responsibility for the management of Clinical Audit activity and the associated quality improvement processes.~~ ~~Responsibility for the performance management of Clinical Governance activities.~~
Other Managers:	**Senior Clinical Quality Manager** Responsible for the provision of expert advice in relation to Clinical Quality Governance activities. Responsible for managing the Clinical Audit function within the Trust. Responsible for coordinating Clinical Governance activities and their performance management. Responsibility for the provision of support and advice in relation to Clinical Governance. Responsibility for the management of Clinical Audit activity and the associated quality improvement processes. Responsibility for the performance management of Clinical Governance activities. Responsible for the day to day coordination of clinical governance activities across the Trust. Responsible for providing support to internal and external stakeholders in relation to Clinical Governance issues. Responsible for the development and monitoring of the Clinical Audit Plan, including the collection of data for Trust-wide audit reports. Responsible for managing the Clinical Performance Indicator Process for the Trust. ~~**Clinical Governance Manager**~~ ~~Responsible for providing support and advice to local staff regarding Clinical Governance.~~ ~~Responsible for supporting service delivery managers and clinical leaders in the day to day management of Trust-wide and local audit plans..~~ ~~Responsible for supporting service delivery managers and clinical leaders to ensure the CPI process is fully embedded, including a quality improvement process.~~ **Clinical Quality Officer~~Performance Facilitator~~** Responsible for providing support and advice to local staff regarding Clinical Governance. Responsible for supporting service delivery managers and clinical leaders in the day to day management of Trust-wide and local audit plans.. Responsible for supporting service delivery managers and clinical leaders to ensure the CPI process is fully embedded. Responsible for undertaking clinical audit activity to meet the requirements of the Trust and local Clinical Audit plans. Responsible for day to day management of the CPI process and facilitating quality improvements within service delivery through an action planning process. Responsible for managing data systems for the collection, analysis and storage of clinically related information. **All Managers / Advanced Paramedics** Responsibility for ensuring that the principles of Clinical Governance are embedded throughout their own areas of control.

All Staff:	Adhere to the principles of Clinical Governance identified within the Trust's Clinical Governance framework.

Source documentation:

"A first class service: Quality in the new NHS" (NHC 1999 – 33)
~~Clinical Governance Strategy January 2008~~
CHI Clinical Governance Review Report – July 2002

Useful websites:
HQIP

SCHEME OF DELEGATION

Reference: **QII05HG08**

Title: **Clinical Effectiveness**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Ensure the appropriate Clinical Effectiveness elements of the Quality Strategy are in place.
Committee:	**Quality Committee:** Obtain assurance in relation to clinical effectiveness arrangements. Receive reports on all Clinical Effectiveness activities within the Trust and ensure that effective action is in place to provide assurance to the Board of Directors. Advise the Board of Directors on Clinical practice activities within the Trust including Paramedic Training activities and all Clinical protocols practices and procedures.
Director:	**Medical Director** Responsibility for reporting on all relevant Clinical Effectiveness activities to the Board of Directors via the Clinical Governance Effectiveness Management Group and Quality Committee. **Directors** Ensure the principles of the Trust's Clinical Governance Strategy are adhered to within their own area of control.
Senior Manager:	**Chief Consultant Paramedic** Responsibility for managing and coordinating all relevant Clinical Effectiveness activities and requirements of the Trust. **All Deputy Directors / Heads of Service/Consultant Paramedics** Responsibility for ensuring that the principles of Clinical Effectiveness are embedded throughout their own areas of control in accordance with the Right Care Strategy. Responsibility for the local management of a Quality Business Group. via adherence to the Trust's Clinical Effectiveness Policy.
Other Managers:	**Senior Clinical Quality Manager** Responsible for the provision of advice in relation to clinical effectiveness. Responsible for the development and implementation of policy and systems to support clinical effectiveness activities. Responsible for the management of systems to ensure review and, where appropriate, the implementation of national guidance such as NICE, NSFs etc. Responsibility for provision of advice and support in relation to clinical effectiveness activities. Responsibility for the implementation of related policies, strategies and systems. Responsible for the day to day coordination of clinical effectiveness related activities and systems, including the production of review reports. **Clinical Quality OfficerClinical Governance Manager**

	Responsibility for assisting with the day to day Clinical Effectiveness activities (i.e. clinical effectiveness, clinical audit and research & development) of the Trust. Responsible for implementing and reviewing Trust clinical effectiveness policies, strategies and systems. ~~**Clinical Performance Facilitator**~~ Responsible for facilitating processes to support clinical effectiveness, ~~including the administration of a Clinical Effectiveness Forum~~. **All Managers / Advanced Paramedics** Responsibility for ensuring that the principles of Clinical Effectiveness are embedded throughout their own areas of control via adherence to the Right Care Strategy. ~~Trust's Clinical Effectiveness Policy~~.
All Staff:	Adhere to the principles of the Right Care Strategy.~~Trust's Clinical Effectiveness Policy~~.

Source documentation:

"A first class service: Quality in the new NHS" (NHC 1999 – 33)
Right Care Strategy
~~Clinical Governance Strategy January 2008~~
CHI Clinical Governance Review Report – July 2002
Combined Ambulance Standards for Pre-Hospital care

SCHEME OF DELEGATION

Reference: QII06~~HG09~~

Title: **Medicine Management**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Receive assurance that the Medicine Management Policy is being fully implemented. Minimise the risks associated with medicine management.
Committee:	**Quality Committee:** Receives reports on medicine management quality indicators within the Trust and ensure that effective action is in place to provide assurance to the Board of Directors. Receives reports on the clinical elements of medicine management.
Director:	**Medical Director** Responsibility for reporting on all relevant medicine management activities to the Board of Directors via the Clinical ~~Governance~~ Effectiveness Management Group and Quality Committee. Accountable Officer for the Management of Controlled Drugs Accountable for the development of PGDs Accountable for the development of a Medicine formulary
Senior Manager:	**Chief Consultant Paramedic** Take the lead on compiling and reviewing Trust Strategy and Policy. Responsibility for managing and coordinating all relevant medicine management activities and requirements of the Trust. Responsible for co-ordinating the ~~annual~~ review of the Trust's Medicine Management Policy every two years.~~.~~ Responsible for the development of PGDs Responsible for the development of a Medicine formulary **All Deputy Directors~~ / ~~Heads of Service/Consultant Paramedics** Responsibility for ensuring adherence to the elements of Medicine Management Policy relevant to their own areas of control. ~~**Head of Clinical Quality**~~ ~~Responsible for the provision of expert advice in relation to Medicine Management – including Controlled Drug Management.~~ ~~Responsible for the development and implementation of Medicine Management Policies and Procedures to comply with legislation and guidance.~~ ~~Responsible for ensuring the provision of pharmacy services to the Trust that are fit for purpose.~~ ~~Responsible for the performance management and provision of assurance in relation to Medicines Management against agreed standards.~~ ~~Responsible for the development, review and management of a Trust-wide Drug Formulary.~~ ~~Responsibility for the provision of advice and support in relation to medicines management.~~ ~~Responsibility for the implementation of related policies and procedures.~~

	~~Responsibility for the performance management of medicines management against agreed standards.~~
Other Managers:	**Senior Clinical Quality Manager** Responsible for the provision of expert advice in relation to Medicine Management – including Controlled Drug Management. Responsible for the development and implementation of Medicine Management Policies and Procedures to comply with legislation and guidance. Responsible for ensuring the provision of pharmacy services to the Trust that are fit for purpose. Responsible for the performance management and provision of assurance in relation to Medicines Management against agreed standards. Responsible for the development, review and management of a Trust-wide Drug Formulary. Responsibility for the provision of advice and support in relation to medicines management. Responsibility for the implementation of related policies and procedures. Responsibility for the performance management of medicines management against agreed standards. Responsible for coordination of medicine management activities across the Trust, including Drug Alerts and related Public Health Alerts etc. Responsible for the development and management of CPIs for Medicine Management. Responsible for coordinating work in relation to the management of a Trust-wide Drug Formulary. **Medicines Performance Facilitator** Responsible for supporting local implementation and management of Medicine Management policies and procedures. Responsibility for contributing to the review and development of related policies and procedures. ~~**Medicines Performance Facilitator**~~ Responsible for facilitating process to improve adherence to Medicines Management policy and procedures. Responsible for independent monitoring of compliance with Medicines Management policy and procedures. **All Managers** Responsibility for ensuring adherence to the relevant sections of the Trust's Medicine Management Policy, within their own areas of control.

Source documentation:

Medicine Management Policy
Combined Ambulance Standards for Pre-Hospital care

Useful Websites:
CASU website
Royal Pharmaceutical Society

SCHEME OF DELEGATION

Reference: **QII07~~HG10~~**

Title: **Clinical Safety ~~Management~~**

Decision Maker	**Responsibilities**
Board of Directors:	Ensure that the Trust is fully compliant with all relevant Clinical Safety guidance and legislation.
Committee:	**Quality Committee** Receives reports on clinical safety management activities within the Trust and ensure that effective action is taken to mitigate clinical risks and provide assurance to the Board of Directors. **Clinical ~~Governance~~ Effectiveness Management Group:** Advises the Board on clinical safety risks arising from clinical practice activities within the Trust ~~including Paramedic Training activities~~ and all Clinical protocols practices and procedures.
Director:	**Director of Quality, Innovation and Improvement** Responsibility for reporting on all relevant clinical safety management activities to the Board of Directors via the Clinical ~~Governance~~ Effectiveness Management Group and the Quality Committee. Ensure that all clinical safety risks are identified within the Trust's corporate risk register. **Directors** Ensure the principles of the Trust's clinical safety management elements of the Right Care Strategy~~Clinical Governance strategy and policy~~ are adhered to within their own area of control. Identify Clinical Safety ~~management~~ activity relevant to their area of control. Identify any clinical safety risk issues with a risk score of 12~~5~~ and above and report to the Risk Management Team for inclusion on the ~~Executive~~ Corporate Risk Register. Ensure, where required, that Root Cause Analysis Investigations are carried out by the appropriate level of management for high risk clinical safety issues.
Senior Manager:	**Head of Clinical Safety** Take the lead on compiling and reviewing Trust Strategy and Policy in relation to Clinical Safety. Responsibility for managing and co-ordinating all relevant clinical safety management activities and requirements of the Trust. Identify all clinical safety risks to line manager for inclusion in the Trust's corporate risk register. On a corporate basis strategic responsibility for the delivery of clinical safety across the Trust and development of relevant clinical safety strategies. Development of annual clinical safety plan including development of key performance indicators to provide assurance to relevant committees of the Board of Directors. Overseeing root cause analysis investigations and ensure delivery of learning based outcomes for individuals and the organisation. Promotion of a fair blame culture for all staff in relation to incident investigation.

	Provision of expert advice in relation to clinical safety issues and learning lessons. Responsibility for the provision of advice and support in relation to clinical safety. Responsibility for the implementation and performance management of the Trusts Clinical Safety Policies. Responsibility for ensuring clinical safety incidents are managed and reported appropriately. Managing and reporting clinical safety risks to the Chief Nurse, Director of Quality, Innovation and Improvement and appropriate Committee. **All Deputy Directors (or equivalent)** Responsibility for ensuring that the principles of clinical safety management are embedded throughout their own areas of control.
Other Managers:	**Clinical Safety Manager** Co-ordination of clinical risk activities across the Trust and development of performance management framework. Establish effective systems of monitoring the progress of all clinical risk objectives, plans and key performance indicators. Co-ordination of investigations of adverse events relating to clinical safety. Assist with design and implementation of ~~polices~~policies and procedures in relation to clinical safety. Compile departmental clinical safety risk register. Responsibility for managing the area day to day clinical safety activities of the Trust. Contribute to the clinical safety development plan. Provide expert clinical advice and support in relation to clinical safety issues. **Clinical Safety Practitioners** Responsible for supporting local implementation and management of clinical Safety policies and procedures. Responsibility for contributing to the review and development of related policies and procedures. **All Managers** Responsibility for ensuring that the principles of clinical safety management are embedded throughout their own areas of control.
All Staff:	Adhere to the principles of the Trust's clinical safety agenda.

Source documentation:
"A first class service: Quality in the new NHS" (NHC 1999 – 33)
~~Clinical Governance Strategy January 2008~~
CHI Clinical Governance Review Report – July 2002
Combined Ambulance Standards for Pre-Hospital care

Useful Websites:
Care Quality Commission website
NPSA website

SCHEME OF DELEGATION

Reference: QII08~~HG11~~

Title: Infection Prevention & Control

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Receive assurance that the Infection Prevention & Control Policy is being fully implemented.
Committee:	**Quality Committee** Obtain assurance in relation to all Infection Prevention & Control activities. Receives reports on Infection Prevention & Control activities within the Trust and ensure that effective action is in place to provide assurance to the Board of Directors. Consider issues upon Infection Prevention & Control and approve/recommend corrective action as appropriate.
Executive Management Team:	Obtain assurance in relation to all Infection Prevention & Control activities. ~~Receive reports on Infection Prevention & Control activities and ensures that effective action is in place to provide assurance to the Board of Directors.~~ Consider Infection Prevention & Control issues and approve / recommend corrective action as appropriate.
Director:	**Chief Nurse (DIPC)~~Director of Quality, Innovation and Improvement~~** Acts as Director of Infection Prevention and Control. Responsibility for reporting on all relevant Infection Prevention & Control activities to the Board of Directors via the Quality Committee. When appropriate convene a meeting of the Trust's Infection Prevention & Control Team to respond to adverse Infection Prevention & Control incidents. **Directors** Ensure the principles of the Infection Prevention & Control Policy and procedures are adhered to within their own area of control.
Senior Manager:	**Head of Clinical Safety** Acts as deputy DIPC (Director of Infection Prevention and Control) Take the lead on compiling and reviewing Trust Policy. Responsibility for managing and coordinating all relevant Infection Prevention & Control activities and requirements of the Trust. Responsible for co-ordinating any review of the Trust's Infection Control Policy and associated Procedures. Where appropriate, commission external advice and expertise. Development of Infection and Prevention Control Policy and associated Procedures compliant with legislation and best practice. Development and implementation of annual Infection and Prevention Control work ~~control~~ plan.

	Provision of advice and support in relation to Infection and Prevention Control issues by liaison with the Health Protection Agency & Public Health England. Responsibility for the provision of advice and support in relation to Infection and Prevention Control Responsibility for the implementation and performance management of the Trust's Infection and Prevention Control –policies and procedures. **All Deputy Directors (or equivalent)** Responsibility for ensuring adherence to the elements of Infection and Prevention Control and associated procedures relevant to their own areas of control.
Other Managers:	**Clinical Safety Practitioners** Provision of specialist advice in relation to Infection and Prevention Control- issues. Establish effective electronic based Infection and Prevention Control audit tools. Assist with design and implementation of policies in relation to Infection and Prevention Control and special infectious diseases. Responsibility for coordinating day to day Infection and Prevention Control activities. Responsibility for monitoring Infection and Prevention Control -audit for assurance. Ensure compliance with Infection and Prevention Control -policies and procedures. Liaise with the Clinical Safety Manager on Infection and Prevention Control risks. **All Managers** Responsibility for ensuring adherence to the relevant sections of the Trust's Infection Prevention and Control policy, within their own areas of control.

Source documentation:
Infection Prevention and Control Policy
Communicable Diseases Policy
Infection Prevention & Control -Annual Report
~~CHI Clinical Governance Review Report – July 2002~~
The Health Act 2008: Code of Practice for the Prevention and Control of Health Care Associated Infections.
Department of Health's Standards for Better Health.
NHSLA Pre-hospital combined risk management ambulance standards.
Department of Health's Essential Steps to Safe, Clean Care.
Clinical Safety Milestone Plan 2018~~Development Plan~~
Infection Prevention and Control Action Plan

Useful Websites:
Health Protection Agency website

SCHEME OF DELEGATION

Reference: **QII09~~HG12~~**

Title: **Vulnerable Persons Management**

Decision Maker	**Responsibilities**
Board of Directors:	Receive assurance that the Vulnerable Persons policy is being fully implemented.
Committee:	**Quality Committee:** Obtain assurance in relation to vulnerable persons arrangements. Receive reports on child protection and vulnerable adult activities within the Trust and ensure that effective action is in place to provide assurance to the Board of Directors.
Executive Management Team:	Refer emergent vulnerable adult and child protection issues to the relevant Committee making recommendations where appropriate.
Director:	**Director of Quality, Innovation and Improvement/Chief Nurse** Responsibility for reporting on all relevant vulnerable adult and child protection activities to the EMT and Board of Directors via the Quality Committee. Responsibility for approving content of serious case review submissions in accordance with relevant legislation.
Senior Manager:	**Head of Clinical Safety** Take the lead on compiling and reviewing Trust Policy and procedures. Responsibility for initiating a periodic review of vulnerable children and adult activities (safeguarding) and making appropriate recommendations to ensure that the Trust maintains a current and valid policy and procedures within these areas. Responsibility as one of the Child Protection Officer / N~~n~~amed Professional of the Trust. **Safeguarding Manager** ~~**Safeguarding & Mental Health Strategic Advisor**~~ Responsibility as a named professional for the Trust. Responsibility for managing the day to day vulnerable children and adult activities of the Trust including maintenance of secure databases. Compile and review Safeguarding Policies and associated procedures. Responsible for implementing any review of the Trust's Safeguarding Vulnerable Persons Policy and associated Procedures. Responsible for liaising with all external stakeholders and share information where appropriate. Responsible for serious case review reports, SUDICA reports, CDOP reports and co-ordination of requests for information for legal cases
Other Managers:	**Safeguarding Practitioners** Assist with management of the day to day vulnerable persons activities of the Trust including maintenance of a secure database. Responsible for all relevant follow up contact in relation to vulnerable adult referrals made by the Trust.

	Responsible for all vulnerable persons activity carried out by the NWAS Support Centre. **Clinical Safety Administrator** Assist the Safeguarding Manager ~~& Mental Health Strategic Advisor~~ and Practitioners with ensuring compliance with safeguarding vulnerable persons policies and procedures. Liaise with Safeguarding Practitioners and provide information with regard to serious case reviews, SUDICA, CDOP, DHR and legal cases. Provide link between operational staff and the Safeguarding ~~Practice~~ Manager in order to facilitate information requests from external sources. **All Managers** Responsibility for ensuring adherence to the relevant sections of the Trust's safeguarding vulnerable children policy and safeguarding vulnerable adult policy and procedures within their own areas of control. **NWAS Support Centre** Co-ordinate all Safeguarding Adult and Child referrals for the Trust. Maintain a secure database of vulnerable adult and child activity from within the Trust. Provide a liaison point for all relevant follow up contact in relation to vulnerable adult and child referrals made by the Trust.

Source documentation:
Vulnerable Persons Policy
Annual Report
DOH – "What to do if you are worried a child is being abused."
DOH – Working Together to safeguard children
The Children Act 1989/2004
Care Act 2014

SCHEME OF DELEGATION

Reference: QII10~~HG13~~

Title: **Clinical Delegation**

Decision Maker	Responsibilities
Board of Directors:	Ensure that appropriate resources are provided for the effective management of Clinical Delegation business within the Trust.
Committee:	**Clinical ~~Governance~~ Effectiveness Management Group** Receive and review the policy for the scheme of clinical delegation and report and make appropriate recommendations to the Board of Directors for continuous improvement. Receive and review clinical untoward incidents.
Director:	**Medical Director** Accountability for the scheme of clinical delegation. Provide assurance of compliance with the scheme by all clinicians operating within the Trust through a process of exception reporting. **Directors** Ensure systems are in place to monitor compliance with scheme and that all clinical staff within respective areas are aware of their delegated authority in relation to clinical decision making.
Senior Manager:	**Chief Consultant Paramedic** Ensure compliance with the policy and provide assurance to the Clinical ~~Governance~~ Effectiveness Management Group. Implementation and monitoring of agreed actions following any changes to delegated authority. **Deputy Director of Quality/Chief Nurse** Ensure appropriate measures are in place to improve clinical risk management. **Associate Medical Directors** Provide clinical leadership in respective a~~A~~reas of responsibility ensuring that clinicians operate within their delegated limits. **Consultant Paramedic – Education~~Head of Clinical Education~~** Ensure the availability of appropriate resources to support the development of competence in clinical education. ~~Coordinate the education and awareness of the policy and scheme of clinical delegation.~~
Other Managers:	**Area Consultant Paramedics~~Area Clinical Education Manager~~** Provide education and awareness raising to clinical staff. ~~Support the Area Head of Governance in~~ P~~p~~rovid~~e~~ing clinical advice to all levels of management.

SCHEME OF DELEGATION

Reference: QII11~~HG15~~

Title: **Complaints Management**

Decision Maker	**Responsibilities**
Board of Directors:	Ensure that the Trust fulfils the requirements of complaints legislation through approval of the Trust's Complaints and Externals procedure.~~Making Experiences Count Policy.~~ Ensure compliance with national policy with regard to complaints management. Receive summary reports of complaints management including Care Quality Commission and/or parliamentary healthcare ombudsman reports.
Committee:	**Quality Committee** Obtain assurance on Complaints Management arrangements. Receive and review ~~formal complaints reports and~~ recommendations for change where appropriate. **Clinical ~~Governance~~ Effectiveness Management Group** Obtain assurance in relation to all complaints, receiving complaint ~~summaries~~themes, together with any recommendations regarding corrective actions and required changes to policy and/or procedure.
Executive Management Team:	Monitor and review formal complaints reports and monitor the Trust's performance on responding to complaints within the relevant timescales.
Director:	**Director of Quality, Innovation and Improvement** Responsibility as Executive lead and as such is required to provide reports on all formal complaints to the EMT and Board of Directors via the Quality Committee. **Directors** Ensure compliance with the Complaints and Externals procedure ~~Making Experiences Count Policy~~ within areas of control and ensure that issues are reported to the Director of Quality, Innovation and Improvement, EMT or Quality Committee as appropriate.
Senior Manager:	**Chief Nurse~~Deputy Director of Quality~~** Periodic review of complaints management processes making appropriate recommendations to ensure that the Trust maintains current and valid complaints management strategies and policies which comply with legislation and best practice. **Head of Safety & Patient Experience** Preparation and review of Complaints and Externals procedure. ~~Making Experiences Count Policy.~~ Responsibility for ensuring the effective management and coordination of complaints including corporate reporting requirements. Initiation of root cause analysis investigations where required.

	Preparation of quarterly reports on integrated Patient Experience activity for consideration by the EMT, Quality Committee and Board of Directors. **All Deputy Directors /Heads of Service** Ensuring adherence to the Trust's Investigation Policy and Complaints and External procedure Making Experiences Count Policy within their areas of control.
Other Managers:	**Senior Patient Safety Manager** Responsible for the delivery of complaints process. Acts as a point of advice, guidance and review for complaints. Oversees complaints referred to the Parliamentary and Health Service Ombudsman. Initiation of root cause analysis investigations where required. **Patient Experience Safety Manager** Coordination of the complaints management process across the Trust including management of the corporate reporting processes. Ensuring processes are in place for investigators to cConducting a risk assessment of each complaint received with the risk score determining the level of management responsible for overseeing the investigation. Ensuring that complaints are managed within the relevant timescales and responded to appropriately. Ensuring that the KO41 return is submitted to the Department of Health and Social Care. **Investigation Officer/Investigation Support Officers/Case Workers/111 Clinical Governance Lead** Provide support as required to the Patient Safety Manager, with Support the Patient Experience Manager as required with responsibility for: • Undertaking the investigation. • Production of an investigation pack as necessary. • Identification of findings. • Maintaining complaint records. This process to be completed within agreed timescales and in accordance with any relevant legislation and good practice. **Service Delivery Managers** • Oversee the investigation and support the investigation officerlead. • Agree and sign off recommendations and any further action required. • Ensure that recommendations and associated actions are implemented.

Source Documentation:
Making Experiences Count Policy
NHS Complaints Regulations (SI 2004 No 1768)
NHS Complaints Amended Regulations 2006 (SI 2006 No 2084)
Health and Social Care (Community Health & Standards) Act 2003
Complaints and External Procedure
Raising Concerns at Work (Whistle Blowing) Policy

Useful Websites:
www.dh.gov.uk
Care Quality Commission website
NPSA website

SCHEME OF DELEGATION

Reference: **QII12SD02**

Title: **Single Oversight Framework**

Decision Maker	**Responsibilities**
Board of Directors:	To receive assurance and approve the Trust's performance against compliance with the Single Oversight Framework, via the Integrated Performance Report (IPR). To receive assurance reports on progress against corporate objectives and performance against standards and indicators. To identify areas of concern and request further reports on controls and actions required.
Committee:	**Finance, Investment & Planning Committee** To provide the Board with assurance on progress against corporate objectives and delivery of corporate projects.
Executive Management Team:	To oversee performance management across the organisation, receiving and acting on all relevant reports. Responsible for delivery of corporate objectives and performance against standards and indicators.
Director:	**Director of Quality, Innovation and Improvement** Lead director for all performance management processes within the organisation. **Director of Strategy and Planning** Lead director for reporting progress against corporate objectives. **All Directors** To report to the EMT on performance relating to their areas of responsibility. To ensure that required controls and actions are in place and implemented effectively.
Senior Manager:	**Head of Informatics** To advise the Director of Quality, Innovation and Improvement and EMT on reporting requirements and procedures To ensure that all required reports are available to the EMT and Board in accordance with the Single Oversight Framework **Head of Strategy and Planning** To advise the Director of Strategy and Planning on reporting progress against corporate objectives. **Deputy Head of Informatics** To produce and promulgate all performance information in required formats to meet internal and external requirements, ensuring that information accords with the standards set out in the NHS Information Governance Handbook.
Other Manager:	**All Managers**

	Responsible for delivery of performance in own areas of responsibility and providing relevant information in accordance with the Single Oversight Framework Framework.

Source documentation:
Single Oversight Framework
NHS Information Governance Handbook

SCHEME OF DELEGATION

Reference: QII13SD03

Title: CQC Registration

Decision Maker	**Responsibilities**
Board of Directors:	To receive and approve confirmation of ongoing compliance with Care Quality Commission's Fundamental standards of quality and safety. To identify any further action required.
Committee:	**Quality Committee** To provide the Board with the necessary assurance that correct and appropriate processes have been adopted to ensure the organisation's ongoing compliance.
Executive Management Team:	To ensure that the necessary steps have been identified and implemented in order to achieve ongoing compliance. To identify any corrective action and ensure the necessary implementation of action plans.
Director:	**Director of Quality, Innovation and Improvement** Lead director for CQC Registration and the necessary processes for reporting and management. **Lead Directors** Ensure appropriate actions are taken to give assurance of ongoing compliance with their designated outcomes.
Senior Manager	**Deputy Director of Quality** To act as the lead single point of contact for the CQC. To advise on compliance and on areas for improvement. To ensure that an effective and honest self-assessment is carried out against the registration standards against the required schedule. To ensure that necessary actions to achieve improvements are identified and implemented to maximise the trust's overall performance. To liaise with CQC inspectors to ensure an open and constructive relationship is maintained with the Commission. **Compliance Manager** To work with the Deputy Director of Quality and the NWAS CQC Engagement Manager to ensure that the day to day and inspection requirements of the CQC are met.
Other Manager:	**All Managers** Accountable for ensuring compliance in own areas of responsibility and providing the necessary evidence to demonstrate continued compliance with registration standards. To identify corrective action where required and develop and implement necessary action plans.

Source Documentation:
NHS 111 Provider Handbook
NHS Ambulance Services Provider Handbook

www.cqc.org.uk/content/provider-handbooks

SCHEME OF DELEGATION

Reference: QII14~~CG15~~

Title: **Quality Account**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approve the Quality Account Approve the areas for improvement to be included in the Quality Account.
Committee:	**Quality Committee** Approve the programme for the development of the Quality Account. Approve the draft Quality Account for circulation to stakeholders for comment. Recommend the areas for quality improvement to the Board of Directors and monitor progress in the improvement areas.
Executive Management Team:	Oversee the production, dissemination and monitoring of the Quality Account
Director:	**Director of Quality, Innovation and Improvement** Lead director for the production, dissemination and monitoring of the Quality Account **All Directors** To provide input on their areas of responsibility featuring in the Quality Account.
Senior Manager:	**Deputy Director of Quality** To advise the Director of Quality, Innovation and Improvement and EMT on the Quality Account requirements To produce the draft Quality Account for circulation and the final version for approval. To circulate the Draft Quality Account to stakeholders for comment.
Other Manager:	**All Managers** Responsible for production and submission of the necessary content relating to their areas of responsibility in the appropriate format and timescales. Responsible for delivery of performance in their areas of responsibility.

Source documentation:
NHS Quality Accounts Toolkit

SCHEME OF DELEGATION

Reference: **DI01**

Title: **Code of Conduct for NHS Managers**

Decision Maker	Responsibilities
Board of Directors:	To approve core governance documents which incorporate; Code of Conduct for NHS Boards, Code of Conduct for NHS Managers and Standards of Business Conduct for NHS Staff.
Chief Executive:	Conform to Code of Conduct and investigate any breaches.
Executive Management Team:	Determine levels of manager to whom Code should apply within the Trust.
Director:	**All Directors** Conform to Code of Conduct. **Director of Organisational Development** Incorporate Code of Conduct into management contracts. Issue Code of Conduct to new Managers.
Senior Manager:	Conform to Code of Conduct as directed by the Executive Management Team.
Other Managers:	Conform to Code of Conduct as directed by the Executive Management Team.
All staff:	Identify and report breaches (or suspected breaches) of the Code of Conduct in accordance with the relevant policy or reporting procedure e.g. Grievance procedure.

Source documentation:
Appendix to Standing Orders
Code of Conduct for NHS Managers

SCHEME OF DELEGATION

Reference: **HR01**

Title: **Recruitment and Appointments**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	**Chairman** Recommend appointment of Chief Executive. **Non-Executive Directors** To take part in selection panels for posts of Executive Directors.
Committee:	**Remuneration Committee** Approve appointment of Chief Executive (subject to salary approval by NHS Improvement). Approval of appointments of Executive Directors (subject to salary approval by the NHS Improvement). **Nominations Committee** Determine skill set and person specification for members of the Board of Directors both voting and non-voting and approve selection process.
Director:	**Director of Organisational Development** Development and implementation of Trust Recruitment and Selection Policy. Statement of Written Particulars of Employment for Very Senior Managers. Confirmation of appointments / contracts of employment. Compliance with Fit and Proper Person Regulations **Directors** Approval of appointments to post of Deputy Directors.
Senior Manager:	**Deputy Director of Organisational Development** Monitoring and development of internal and external recruitment and selection procedures within the Trust. Audit of Recruitment Service process. Monitoring and development of recruitment practice. Placing of adverts through the agreed supplier. Ensuring processes to confirm that posts advertised have a funded establishment are advertised at the correctly funded level and evaluated grade and approved for recruitment through the agreed vacancy control process. Approval of Vacancy Control Process requests to advertise posts. Statement of Written Particulars of Employment and offer letters for all positions on an Agenda for Change contract of employment. **Deputy Director of Finance** Approval of Vacancy Control Process requests to advertise posts.
Other Managers:	**Finance Managers** Verification that requests for recruitment are within the funded establishment. **All Budget holders**

	Approval of appointments to subordinate posts. Ensuring that requests for recruitment are for posts with a funded establishment and have been evaluated. Completion of Vacancy Control documentation for all positions requiring approval prior to recruitment. **All Managers** Compliance with the Recruitment and Selection policy procedure. Preparation of job descriptions and person specifications.

SCHEME OF DELEGATION

Reference: **HR02**

Title: **Disciplinary Arrangements and Appeals**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	**Chairman** Hearing officer for dismissal of CEO.
Chief Executive:	Hearing officer for disciplinary cases against Executive Directors.
Non-Executive Directors	Appeal panel members for disciplinary cases against the Chief Executive and Executive Directors. Panel members for appeals against dismissal.
Director:	**Director of Organisational Development** Development of Trust Disciplinary Policy & Procedure and Code of Conduct **Directors** Acting as Hearing Officers for disciplinary cases where required. Acting as panel members on Appeals against dismissal in accordance with approved procedures. (Appeal panels to comprise of two members drawn from the following groups –Directors, Non-Executive Directors, and Deputy Directors).
Senior Manager:	**Deputy Directors** Act as panel members on appeals against dismissal in accordance with approved procedures. **Head of HR /Strategic HR Manager / HR Managers** Responsible for arrangements for appeals against dismissal for all staff. Attending Appeals Panel for appeals against dismissal as required in accordance with approved procedures. Responsible for advice and administration of the relevant policies. Advice to Hearing Officer during a disciplinary hearing or appeals hearing when a fellow Manager is the hearing officer. **All Deputy Directors / Heads of Service** Act as hearing officer in the following situations: • For disciplinary cases involving Gross Misconduct. • Where the individual is subject to a current final written warning. • Any cases where dismissal is a possible sanction. • Where they are the immediate line manager for the person charged. Act as Appeals Officer in the following circumstances: • All cases where the disciplinary hearing has been heard by one of the managers reporting directly to them. • For staff dismissed during their probationary period. In certain circumstances, determined by Senior Human Resources Managers, and in order to ensure reasonable timescales, these matters may be delegated to appropriate managers at a level one removed.
Other Managers:	**Middle Managers** Act as hearing officer in cases where the sanction applied may be up to and including a final written warning. Act as Appeals Officer in cases where the disciplinary hearing has been heard by one of the managers reporting directly to them.

	Act as hearing officer for disciplinary cases for probationary staff up to and including dismissal. **Managers** Act as hearing officer in cases where the sanction applied may be up to and including a final written warning. Act as Appeals Officer in cases where the disciplinary hearing has been heard by one of the managers reporting directly to them. **HR Managers/Advisors** Provide advice to hearing officers during disciplinary hearings and appeals.
All staff:	Compliance with Code of Conduct Participation in investigative procedures

Source documentation:
Disciplinary Policy and Procedure

SCHEME OF DELEGATION

Reference: **HR03**

Title: **Grievance Procedure**

Decision Maker	Responsibilities
Board of Directors:	Two members of the Board or one member of Board and a Deputy Director will be responsible for hearing Grievance Appeals (Stage 3).
Chief Executive	Hearing Officer for grievance cases from Directors.
Director:	**Directors, Non-Executive Directors or Deputy- Directors** Hearing grievances from their immediate staff or at Stage 3 Grievance Appeal Panels. **Director of Organisational Development** Development and implementation of Trust Individual and Collective Grievance Policy & Procedure.
Senior Manager:	**Deputy Directors** To hear Stage 3 Grievance Appeals with a Trust Board Member / Director. **Head of HR-/-Strategic HR Manager-/-HR Managers** To advise the Grievance Appeal Panel (Stage 3) and to ensure appropriate arrangements are made for hearings. To ensure robust monitoring and application of the procedure locally. **All Deputy Directors/-Heads of Service/Senior Service Delivery Managers /PTS General Managers** To hear grievances at Formal Grievance Review (Stage 2) and for their immediate staff. (In certain circumstances and in order to ensure reasonable timescales, these matters may be delegated to appropriate managers at a level one removed). **HR Managers** Ensure managers across the Trust are aware of their responsibilities under appropriate use of the Individual and Collective Grievance Policy & Procedure. To hear grievances from immediate staff and to advise at grievance hearings.
Other Managers:	**Line Managers** (PES Band 6 and above-/-PTS Band 4 and above) To hear grievances from staff at Initial Grievance Meeting (Stage 1) as appropriate. **HR Advisors** Provide advice to managers hearing grievances and to implement monitoring arrangements. Provide direct support at Stage 1 and 2 grievances (HR support is only required at Stage 1 for grievances of a sensitive nature).
All staff:	To use the grievance procedure where appropriate to raise issues of concern.

Source Documentation:
Individual and Collective Grievance Policy & Procedure

SCHEME OF DELEGATION

Reference: **HR04**

Title: **Funded Establishment**

Decision Maker **Responsibilities**

Decision Maker	Responsibilities
Board of Directors:	Approval of funded establishment as part of annual budget setting.
Committee:	**Remuneration Committee** Approval of restructure proposals affecting Directors subject to Very Senior Manager Pay arrangements.
Chief Executive:	To authorise in-year all increases, decreases or other changes to establishments following appropriate authorisation by Finance and Human Resources.
Executive Management Team:	Approval of in-year proposals for re-structure which result in establishment changes that do not affect Directors subject to Very Senior Manager Pay arrangements.
Director:	**All Directors** Preparation of Business Case proposals for restructure within their own Directorates for submission to Executive Management Team. Monitor numbers of staff in post against the funded establishment. **Director of Organisational Development** Responsible for monitoring of establishment in conjunction with Director of Finance. Submission of workforce reports to the Board of Directors on numbers of staff in post against funded establishment, a minimum of six monthly **Director of Finance** Developing and managing establishment control processes.
Senior Manager:	**Deputy Director of Organisational Development** Preparation of procedures relating to establishment control in conjunction with Deputy Director of Finance. Approval of vacancy control applications. Maintain work structures within ESR. **Deputy Director of Finance** Preparation of procedures relating to establishment control. Maintenance of funded positions in ESR and reconciliation with the general ledger. Approval of vacancy control applications. **Deputy Director of Organisational Development and Deputy Director of Finance** Jointly agree vacancy control and recruitment approval processes
Other Managers:	**Budget Holders** Seek authorisation for changes to funded establishment through completion of appropriate Establishment Changes forms.

	Ensuring that funded establishment is accurate through budgetary reporting mechanisms. **Management Accountant** Provision of information to assist in the development of a business case for restructuring within departments. Costing of establishment changes forms to identify budgetary impact. **HR Hub Manager** Ensure accurate management of staff in post, enabling accurate establishment reporting. **Workforce Information Manager** Maintenance of work structures. Provision of reporting to enable monitoring and audit of establishment control.

SCHEME OF DELEGATION

Reference: **HR05**

Title: **Remuneration and Conditions of Service**

Decision Maker **Responsibilities**

Committee:	**Remuneration Committee** Approval of the following: 1. Authorisation of all pay, benefits and grading issues for Directors subject to Very Senior Manager Pay arrangements and NHS Improvement (NHSI) approval. 2. Recommendation of non-contractual termination payments to the NHSI and Treasury for approval 3. Approval of costs incurred in relation to Directors subject to Very Senior Manager Pay arrangements, Senior Managers and other cases where the cost exceeds £50,000. 4. Approval of business cases for redundancy where the costs exceed £50,000. 5. Recommend contractual terminations to the NHSI where costs exceed £100,000
Executive Management Team:	Recommendation of application for recruitment and retention premia to the NHSI for approval. Approval of all local terms and conditions (with the exception of Directors subject to Very Senior Manager Pay arrangements).
Director:	**Director of Organisational Development/Director of Finance** Jointly approve business cases for redundancy/premature retirement applications where the cost does not exceed £50,000. **Director of Organisational Development** Recommendations for changes to conditions of service and cost related retirement/redundancy cases. Maintenance and implementation of procedures to support job evaluations. Advise the Board and EMT on the interpretation and application of terms and conditions and employment legislation. Advise the Remuneration Committee on the interpretation and application of terms and conditions and employment legislation for Very Senior Managers.
Senior Manager:	**Deputy Director of Organisational Development/Head of HR Business Partnering** Approval in conjunction with Heads of Finance of appointment salary for posts where it varies from funded establishment Approval of starting salary where it exceeds the normal starting salary within the band. Advise Trust managers on the interpretation and application of terms and conditions and employment legislation. Recommendations to the Director of Organisational Development for premature retirement/redundancy payments.
Other Managers:	**HR Hub Manager** Issue of Written Particulars of Employment for staff other than managers.

	All Managers Agreement to changes in working hours within funded establishments.

SCHEME OF DELEGATION

Reference: **HR06**

Title: **Payroll Processes**

Decision Maker | **Responsibilities**

Decision Maker	Responsibilities
Director:	**Director of Finance** Responsible for the security and auditing of all payroll processes. **Director of Organisational Development** Establishing procedures and relevant documentation for new starters, variations and terminations or other changes affecting payments to individuals. Agreement of dates and methods of payment. Management of payroll contract. Review the contract for Payroll services.
Senior Manager:	**Deputy Director of Finance** Reconciliation of payroll information to BACS payments. Verification of all Finance related changes on payroll forms. **Deputy Director of Organisational Development** Establishment and maintenance of any locally agreed payscales (Non Agenda for Change) Ensuring accurate maintenance of ESR and paper based recording systems. Appropriate audit of ESR input. Specification of timescales for submission of appropriate documentation. **All Senior Managers** All requests for a pay advance or BACS recall to be authorised by relevant Senior Manager or Head of HR/Head of Finance.
Other Managers:	**Budget Holder/Authorised signatory** Verification and authorisation of payroll documentation including timesheets, Records of Hours Worked, overtime and expenses claims. Timely submission of payroll documentation to payroll provider. Making a written request for a pay advance or supplementary pay in cases where underpayment of wages has been made. Timely and accurate completion and authorisation of payroll new starter, termination and changes forms.
All staff:	Accurate recording of hours worked. Submission of e-expense claims on a monthly basis. Notifying manager of changes to personal details.

SCHEME OF DELEGATION

Reference: **HR07**

Title: **Education and Learning~~Development~~**

Decision Maker	**Responsibilities**
~~Executive Management Team~~	~~Recommend Education and Development policies to Board of Directors for approval.~~ ~~Approve training and development procedures.~~
Director:	**Director of Organisational Development** **Development of Trust Education and Learning polices** Identification of organisation wide training needs. Provide assurance to the Board and EMT on delivery of training and development activities against performance targets **Directors** Identifying and facilitating development opportunities for staff. Maintaining CPD. Identify Directorate learning needs.
Senior Manager:	**Head of Workforce & Organisational Development** Develop policies and strategies supporting Workforce Development. Develop training specifications and identify training providers for leadership development and training. Establishment of annual training and development plans. Identifying organisational training needs. **Strategic Organisational Development Manager** Set criteria for assessing development requests. Authorise and prioritise development training requests against criteria and available funding. Issue of training agreements. Collation and prioritisation of PDPs. **Head of Clinical Education & Training** Develop Higher Education pre-registration and post-registration programmes. Develop continuing professional development (for all clinical roles) in order to meet~~ing~~ changing Service needs. Develop and implement effective education governance procedures. Plan, deliver and monitor core training courses to meet service needs. Develop and monitor delivery of statutory and mandatory training to appropriate standards. **All Senior Managers** Identifying and facilitating development opportunities for staff. Maintaining CPD.
Other Managers:	**All Managers** Identifying development opportunities within sphere of control. Identifying training and skills requirements for posts. Ensuring that their staff complete required mandatory training.

	Ensuring delivery of high quality appraisals for staff managed to determine training needs.
All staff:	Identifying own development needs. Engage actively in appraisal processes. Undertake any development identified within their personal development plans Maintaining Continuing Professional Development portfolios as required. Undertake mandatory training.

SCHEME OF DELEGATION

Reference: **HR08**

Title: **Performance Appraisal Policy and Procedure**

Decision Maker	Responsibilities
~~Board of Directors~~	~~Responsible for determining approval of the Trust's policy on performance appraisal and for providing appropriate resources to enable effective implementation of the policy.~~
~~Executive Management Team:~~	~~Recommend performance appraisal policy to Board of Directors for approval. Approve relevant procedures.~~
Director:	**Director of Organisational Development** Development and implementation of appraisal policies and procedures. ~~Advising the Board of Directors on performance appraisal policies and procedures and ensuring such policies and procedures meet all relevant legal and appropriate good practice guidelines.~~ **Directors** Responsible for ensuring the implementation of the policy and procedure within their areas of responsibility and determining who has delegated responsibilities for pay progression deferral/approval and resolution of any appeals.
Senior Manager:	**Head of Workforce & Organisational Development** Develop relevant policies and procedures; engaging with and consulting with staff side organisations on performance appraisal and ensuring effective implementation. Ensuring the appropriateness and availability of training for staff to allow them to reasonably achieve the competence necessary to meet the requirements of the policy and procedure. Reporting on the completion of reviews and numbers of staff who have had incremental progression deferred. **Strategic Organisational Development Manager** Responsible for the management of the Trust's Performance Appraisal process, ensuring that adequate and appropriate provision is offered to target groups. Manage the compliance administration and production of reports to the Trust. Analyse and address areas of non-compliance and action as appropriate, tackling poor areas of compliance within the Trust.
Other Managers:	**All Trust Managers** Ensuring that their staff have high quality annual appraisals, that staff performance is managed, that they are encouraged and have reasonable opportunity to undertake their mandatory training and achieve competences. Responsible for determining and advising staff of any pay progression deferral, of justifying the reason for any such deferral or otherwise Submitting notice for payroll purposes of any annual incremental pay deferral as appropriate in a timely manner.

	Responsible for ensuring that they are adequately competent in the effective management of performance appraisals and to enable them to make appropriate and fair decisions on the deferral of pay progression for employees under their control.
All Staff:	Individual members of staff have a responsibility to take part in the appraisal process, to behave appropriately at work, to undertake their work in a competent manner, to ensure that they attend and complete any training required, including mandatory training, and accept and engage in any appropriate development opportunities, reviews or support that is provided to them.

SCHEME OF DELEGATION

Reference: **HR09**

Title: **Pay Progression Deferral**

Decision Maker	Responsibilities
Director:	**Director of Organisational Development** Development and implementation of pay progression deferral policies and procedures. **All Directors** Responsible for ensuring the implementation of the policy and procedure within their areas of responsibility and determining who has delegated responsibilities for pay progression deferral/approval and resolution of any appeals.
Senior Manager:	**Head of Workforce & Organisational Development** Reporting on the numbers of staff who have had incremental progression deferred.
Other Managers:	**Managers of Reviewing Managers or Director nominated lead** Review the decision taken by the reviewing manager to defer pay and make a decision on whether the decision by the reviewing manager was appropriate. **Reviewing Managers** Undertake ongoing reviews with appraisee throughout the year. To make a decision at the appraisal meeting on whether pay progression is appropriate based on the performance of the appraisee throughout the year. Provide clear rationale on the decision why pay is to be deferred.

SCHEME OF DELEGATION

Reference: **HR10**

Title: **Sickness Warning Arrangements**

Decision Maker	Responsibilities
Board of Directors:	**Chairman** Hearing officer for dismissal of CEO. **Non-Executive Directors** Appeal panel members for cases against the Chief Executive and Executive Directors.
Chief Executive:	Hearing officer for cases against Executive Directors.
Director:	**Director of Organisational Development** Development of Trust policy & procedure. **Directors** Acting as Hearing Officers Acting as panel members on Appeals against dismissal in accordance with approved procedures. (Appeal panels to comprise of two members drawn from the following groups – Executive Directors, Non-Executive Directors, Non-Voting Directors and Deputy Directors.
Senior Manager:	**Deputy Directors** Act as panel members on appeal against dismissal in accordance with approved procedures. **Heads of HR /Strategic HR Manager/ HR Managers** Responsible for arrangements for appeals against dismissal for all staff. Attending Appeals Panel for appeals against dismissal as required in accordance with approved procedures. Responsible for advice and administration of the relevant policies. Advice to Hearing Officer during a hearing or appeals hearing when a fellow Manager is the hearing officer. **All Deputy Directors/Heads of Service/PTS General Managers** Act as hearing officer in the following situations: • Stage 4 hearings and Long Term Sickness Capability Hearings • Where the employee is subject to a current final written warning. • Any cases where dismissal is a possible sanction. • Where they are the immediate line manager for the person charged. Act as Appeals Officer in the following circumstances: • All appeals against a final written warning. • All cases where the hearing has been heard by one of the managers reporting directly to them.
Other Managers:	**Middle Managers or above** Act as hearing officer in cases where the sanction applied may be up to and including a final written warning (Stages 2 to 3). Act as Appeals Officer in cases where the sanction applied is a formal written warning.

	Human Resources Managers/Advisors Provide advice to hearing officers during formal hearings and appeals. **First line Managers** **Stage 1 –** Delivered by Team Leaders / Supervisor / Senior Paramedic Team Leaders
All staff:	Compliance with policy Participation in investigative procedures

SCHEME OF DELEGATION

Reference: **HR11**

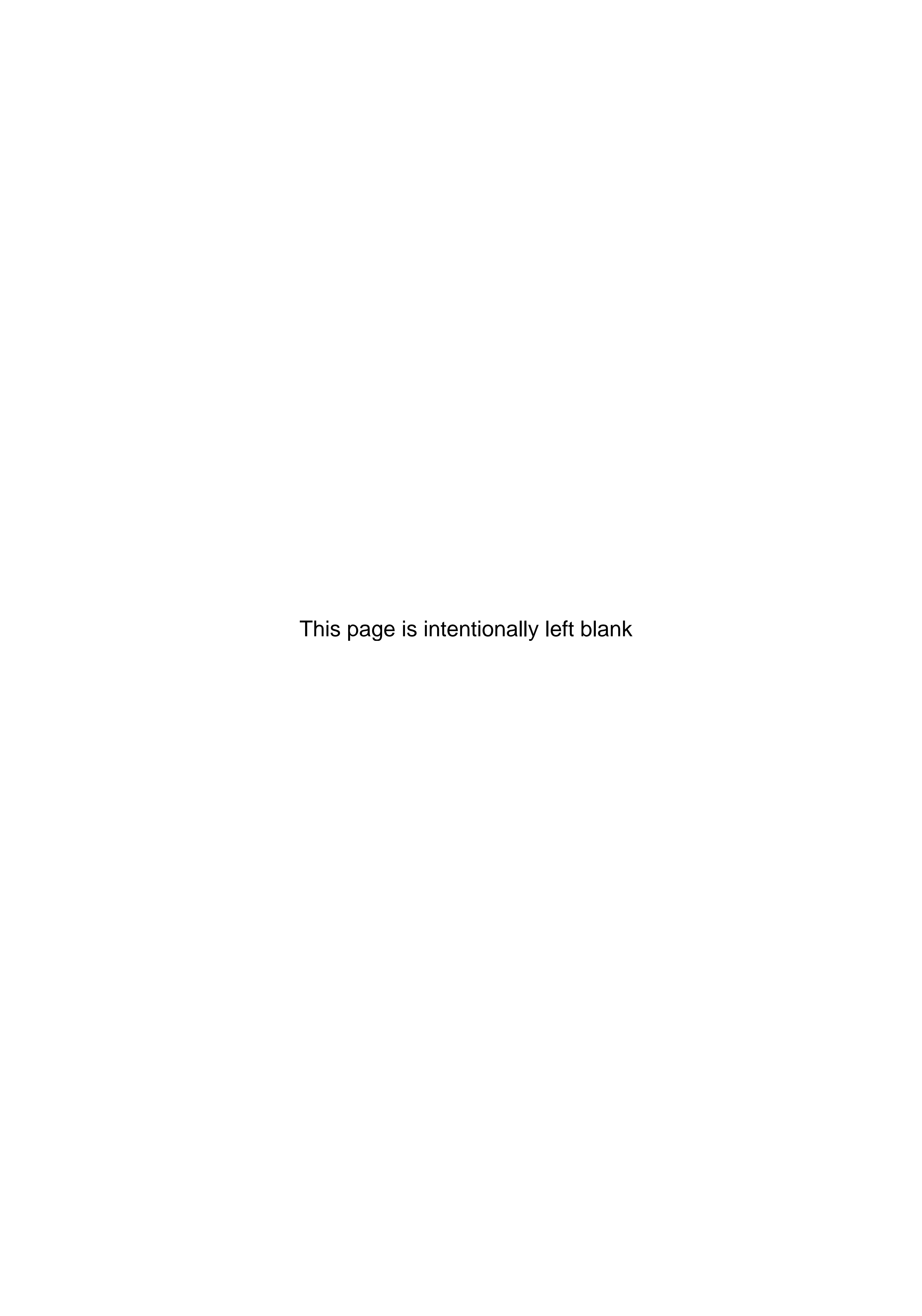
Title: **Agency Rules**

Decision Maker	**Responsibilities**
Board of DirectorTrust Board:	Approval of governance processes for management of agency rules.
Committee:	**Finance, Investment and planning Committee** Monitoring of agency expenditure and overrides
Executive Management Team:	Approval of procedures for management of agency rules. Monitoring of agency expenditure and overrides.
Director:	**Director of Organisational Development** Accountable officer for agency expenditure and compliance with agency rules. **Directors** Authorisation of overrides to agency rules within their own Directorate. Authorisation of overrides as executive on-call.
Senior Manager:	**Deputy Director Organisational Development** Weekly submission of override submissions to NHS Improvement Ensuring appropriate controls in place to prevent breach through VCP/recruitment process **Deputy Director of Finance** Setting of service line targets. Ensuring appropriate controls in place to prevent breach through procurement. **Senior Service line managers** Overview of rota planning within service line and level of agency usage in comparison with target. Ensuring compliance with agency rules within service line and escalation of any potential breach of targets or rules override. Completion and signature of authorisation form for potential breaches/rules override. Implementing actions to ensure that service line remains within agency expenditure target
Other Managers:	**Managers with responsibility for rotas** Ensuring rota construction is within agency rules and internal procedure. Escalation of any potential breaches of agency rules for authorisation before commitment. **Head of Procurement** Ensuring appropriate knowledge across procurement team to provide advice to managers on appropriate agency use within rules.

	HR Hub Manager Ensuring temporary agency staff sourced through HR Hub are compliant with agency rules. Providing appropriate advice to managers on agency rules

Associated SoD references:

Source documentation:
Agency Rules – NHS Improvement March 2016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Agenda Item 11

REPORT

Board of Directors	
Date:	**24th April 2019**
Subject:	**Revised Standards of Business Conduct Policy**
Presented by:	**Angela Wetton, Director of Corporate Affairs**
Purpose of Paper:	**For Decision**
Executive Summary:	**A governance review was undertaken by Deloittes early in 2018/19 which resulted in a number of recommendations to strengthen the policy. In addition, Mersey Internal Audit Agency (MIAA) reviewed the tender and waiver process during September and October 2018, which resulted in recommendations for inclusion in the Standards of Business Conduct.** **The changes can be seen in the attached document.**
Recommendations, decisions or actions sought:	**The Board of Directors ratify the decision of the Audit Committee and approve the revised Standards of Business Conduct: Policy on Managing Conflicts of Interest; Gifts and Hospital and Sponsorship.**

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**N/A**
Previously Submitted to:	**Audit Committee**
Date:	**18th April 2019**
Outcome:	**Approved**

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1. PURPOSE

The revised Standards of Business Conduct: Policy on Managing Conflicts of Interest; Gifts and Hospitality and Sponsorship are presented to the Board of Directors.

BACKGROUND

NHS England issued new guidance on managing conflicts of interest that came into force on 1 June 2017. The new guidance introduced i) common principles and rules for managing conflicts of interest, ii) advice to staff and organisations about what to do in common situations and iii) supports good judgement about how interests should be approached and managed.

The Trust revised its Standards of Business Conduct in line with the model policy provided by NHS England in May 2017 to reflect the new guidance.

A governance review was undertaken by Deloittes early in 2018/19 which resulted in a number of recommendations to strengthen the policy. In addition, Mersey Internal Audit Agency (MIAA) reviewed the tender and waiver process during September and October 2018, which resulted in recommendations for inclusion in the Standards of Business Conduct.

2. CURRENT POSITION

The Deloitte recommendations included within the policy are as follows:

1. The Trust should seek to clarify the approach to be taken either through taking a more prescriptive approach to defining those relationships which should be declared or, more preferably, defining an officer or committee of the Trust as the final arbiter of what constitutes reasonable common sense and encouraging individuals towards an attitude of, “if in doubt consult or declare” .
2. The definition of “outside employment” should be expanded to include other similar appointments which are not strictly speaking employment.
3. The Trust should implement a policy that appropriate permission should be sought prior to the acceptance of any external appointments to allow a considered decision to be made prior to any conflict arising.
4. The policy should be updated such that where conflicts of interest are identified the manager be required to describe, on the authorised declarations form submitted to the corporate centre, the proposed mitigations and safeguards.
5. The declaration, complete with proposed mitigations and safeguards, should then be subject to independent review and approval (or review and rejection if the conclusion is that the risk is not mitigated).
6. A decision should be taken within Corporate Affairs as to whether active monitoring of the mitigations and safeguards should be implemented.
7. Returns, including nil returns, should be checked against a list of required returns and any non-responses followed up as a matter of urgency.

8. Nil returns should be retained as evidence of the employee’s compliance with the policy for future reference in the event of challenge.
9. The procurement team should be required to provide declarations of interests prior to involvement in any procurement exercises.
10. When procurement exercises are undertaken the register of interests should be consulted prior to issuing the invitation to tender, any relevant interests identified and, where necessary, precautionary steps taken to ensure that the member of staff declaring the relevant interest remains fully isolated from the procurement exercise.
11. The Trust should retain documentation of the precautionary steps taken in each case to assist in defending against any future challenges.
12. The contents of the register of interests should be used to periodically interrogate the supplier and customer ledgers to ensure that all connected party transactions are identified, considered and completed in an open, transparent and arm’s length basis.

The MIAA review identified that ex-employees had become suppliers of the Trust through the waiver process. The policy has been updated to include any supplier that previously worked for the Trust should complete a declaration to avoid any conflicts.

The above recommendations can be found in tracked changes within the Appendix 1.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

- Bribery Act (2010)
- Freedom of Information Act (2000)
- Employment Law

4. RECOMMENDATIONS

The Board of Directors ratify the decision of the Audit Committee and approve the revised Standards of Business Conduct: Policy on Managing Conflicts of Interest; Gifts and Hospital and Sponsorship.

Standards of Business Conduct

Policy on Managing Conflicts of Interest; Gifts & Hospitality and Sponsorship

Recommended by	Executive Management Team
Approved by	Audit Committee
Approval date	~~31st May 2017~~ 24 April 2019
Version number	4.0~~3.0~~
Review date	~~May 2020~~April 2022
Responsible Director	Director of Corporate Affairs
Responsible Manager (Sponsor)	Head of Corporate Affairs
For use by	All Employees

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

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
1.0	25 Jul 2007	26 Jul 2007	P Buckingham	Board Approval
x.2	19 Oct 2011	21 Oct 2011	P Buckingham	Policy Review
2.0	30 Nov 2011	30 Nov 2011	P Buckingham	Audit Committee Approval
x.3	December 2015	17 Feb 2016	Penny Harder	Policy Review
3.0	May 2017	1 June 2017	A Wetton	To reflect NHS England's guidance
3.1	~~August~~ November 2018		Penny Harder	Deloitte & MIAA Recommendations

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1. Introduction

The North West Ambulance Service NHS Trust (the 'organisation'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community.

As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…
• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf • Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent • Regularly consider what interests you have and declare these as they arise. If in doubt, declare. • **NOT** misuse your position to further your own interests or those close to you • **NOT** be influenced, or give the impression that you have been influenced by outside interests • **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do. • Identify a team or individual with responsibility for: ○ Keeping this policy under review to ensure they are in line with the guidance. ○ Providing advice, training and support for staff on how interests should be managed. ○ Maintaining register(s) of interests. ○ Auditing this policy and its associated processes and procedures at least once every three years. • **NOT** avoid managing conflicts of interest. • **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

This policy should be considered alongside these other organisational policies:

- Anti-Fraud, Bribery & Corruption Policy & Response Plan
- Raising Concerns at Work (Whistleblowing) Policy
- Disciplinary Policy & Procedure

2. Definitions

A 'conflict of interest' is:

"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- **Actual** - there is a material conflict between one or more interests
- **Potential** – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Section 10 of this policy identifies the sanctions in instances where interests have not been identified, declared or managed appropriately and effectively.

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career
- **Indirect interests:**
  Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

[1] This may be a financial gain, or avoidance of a loss.
[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

A list of examples of interests that should be regarded as 'relevant and material' is provided below however is not exhaustive. Further guidance is provided at Annex A:

- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
- Shareholdings and ownership interests in any publicly listed, private or not might reasonably be expected to do business with the organisation
- A position of authority in another NHS organisation, commercial, charity, voluntary, professional, statutory or other body which could be seen to influence your role within the organisation
- A position on an advisory group or other paid or unpaid decision making forum that could influence how the organisation spends taxpayers money
- Are or could be involved in the recruitment or management of close family members and relatives, close friends and associates and business partners
- A position of influence that exists in the context of the specification for, or award of, a contract
- Any connection with a private, public, voluntary or other organisation contracting for NHS services
- Any other commercial interest relating to any relevant decision to be taken by the organisation.

Conflicts can occur because of interests held by a close family member, business partner, close friend or associate. If staff are aware of material interests (or could be reasonably expected to know about these) then these should be declared. In this context, a close family member is defined as:

- Spouse or civil partner
- Any other person with whom the individual cohabits
- Children or step children
- Parents
- Grandparents
- Siblings.

3. Staff Duties / Responsibilities

At North West Ambulance Service NHS Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees (including Non-Executive Directors);
- All prospective employees – who are part-way through recruitment;
- Previous employees who become a supplier of the Trust;
- Contractors and sub-contractors; and
- Agency staff.; and

Some frequently asked questions for specific staff groups on the issues posed and how the guidance applies to them can be found at www.england.nhs.uk/ourwork/coi

Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this organisation are:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Those at Agenda for Change band 8a and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions

4. Identification, Declaration and Review of Interests

4.1 Identification & declaration of interests (including gifts and hospitality)

All staff, including Directors and Non-Executive Directors, should identify and declare material interests at the earliest opportunity (and in any event within 28 days of the interest occurring). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered.

Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

Declarations of interest(s) forms are available here.

Declarations should be made to: declarations.inbox@nwas.nhs.uk

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

All gifts and hospitality, sponsorship declarations that have been accepted and declined must be reviewed independently by the Director of Corporate Affairs.

4.2 Proactive Review of Interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return. Nil returns will be retained as evidence of compliance with this policy for future use in the event of a challenge. Any staff who fail to respond to the annual review of declarations will be followed up bycontacted by a member of the Corporate Governance Team, except for where it is known these staff have left the employment of the Trust.

On an annual basis, Non-Executive Directors will be required to review the complete list of declared related parties and make an additional declaration that there are no known relationships between the parties with whom they have declared an interest and the wider pool of declared related parties, or where such relationships do exist to provide details of these.

The Board seeks to encourage a culture of full, complete and transparent disclosure from all staff in order to reach a collective view on potential interests that could arise.

The Director of Corporate Affairs will report annually to the Audit Committee in respect of all declarations, including any breaches and responses.

5. Records and Publication

5.1 Maintenance

The organisation will maintain:

- Register of Board of Directors' Interests
- Register of Interests
- Register of Gifts and Hospitality

All declared interests that are material will be promptly transferred to the register(s) by the Corporate Governance ManagerTeam.

5.2 Publication

We will:

- Publish the interests declared by Board members and decision making staff in the Register of Interests.
- Refresh this information annually
- Make this information available on the Trust website

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Director of Corporate Affairs to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

5.3 Wider transparency initiatives

North West Ambulance Service NHS Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website here.

6. Management of Interests – General

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and North Wwest Ambulance Service NHS Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

7. Management of Interests – Common Situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

7.1 Gifts

Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. Staff should also consider those relationships outlined in Section 2, that may potentially create any threats to independence in relation to gifts and hospitality..

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6.00 in total, and need not be declared.
- Gifts from other sources (e.g. patients, families, service users):
  - Gifts of cash and vouchers to individuals should always be declined.
  - Staff should not ask for any gifts.
  - Gifts valued at over £50 should be treated with caution and only be accepted on behalf of North West Ambulance Service NHS Trust Charitable Funds and not in a personal capacity. **These should be declared by staff.**
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

What should be declared?

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Whether the gift was accepted or rejected
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75 - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).
- Travel and accommodation:

- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
  - offers of business class or first class travel and accommodation (including domestic travel)
  - offers of foreign travel and accommodation.

-**What should be declared?**

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Whether the hospitality was accepted or rejected
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

The Trust's Gifts and Hospitality Form is available here.

Once the form is completed and submitted, an independent review of the declaration will be undertaken by the Director of Corporate Affairs.

7.3 Outside Employment

Outside employment means employment and other engagements, outside of formal employment arrangements. The list below is not exhaustive but can include:

- Directorships
- Non-Executive roles
- Self-employment
- Consultancy Work
- Charitable Trustee roles
- Political Roles
- Roles within Not-for-Profile organisations
- Paid advisory positions; and
- Paid honorariums relation to bodies likely to do business with the organisation.
- Employment with another NHS organisation/non-NHS organisation
- Employment with another organisation which might be in a position to supply goods/services to the organisation;

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.

- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

Secondary Employment Application forms are available from the intranet site. All application forms need to include formal permission from Line Managers to ensure there is no detrimental impact on an individual's work and that there are no conflicts of interest. Where conflicts/risks have been identified by the Line Manager, the staff member should complete a Declaration of Interests form and include the agreed actions/mitigations that provides safeguards for both the Trust and the staff member concerned. The declaration will require further independent review and approval or rejection should sufficient mitigations not be provided, by the Director of Corporate Affairs/Chief Executive/relevant Director.

The Corporate Governance Team will liaise with the relevant Director to ensure regular active monitoring of the implemented safeguards and mitigations recorded on the Declaration of Interest are being undertaken.

What should be declared?

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.4 Shareholdings and other ownership issues

Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What should be declared?

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.

- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared?

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

7.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What should be declared?

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.7 Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be

accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared?

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

7.8 Sponsored Events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the organisation.

What should be declared?

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

7.9 Sponsored Research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.

- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.
- Staff should declare involvement with sponsored research to the organisation.

What should be declared?

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
  - their name and their role with the organisation.
  - Nature of their involvement in the sponsored research.
  - relevant dates.
  - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.10 Sponsored Posts

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What should be declared?

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

7.11 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.

- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines, which can be found here

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What should be declared?

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

9. Management of Interests – Advice in Specific Contexts

9.1 Strategic decision making groups

In common with other NHS bodies, the organisation ~~North West Ambulance Service NHS Trust~~ uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

It is important that t~~T~~he interests of those ~~who are~~ involved in these groups are~~should be~~ well known to ~~so that they~~ensure they are~~can be~~ managed effectively.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.

- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

9.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

The Procurement Team are required to provide declarations of interest prior to any involvement in procurement exercises for and on behalf of the Trust and submitted to the Corporate Governance Team. These records will provide
~~Those involved in procurement exercises for and on behalf of the organisation should keep records that show~~ a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

Prior to the commencement of any procurement exercise, the Register of Interests should be consulted prior to issuing an invitation to tender. Where relevant interests have been identified, and where necessary, precautionary steps should be taken to ensure that the member of staff declaring the relevant interest is isolated from the procurement exercise.

The contents of the register of interests should be used to periodically interrogate the supplier and customer ledgers to ensure that all connected party transactions are identified, considered and completed in an open, transparent and arm's length basis.

10. Dealing with Breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

10.1 Identifying and reporting breaches

Staff who are aware of~~about~~ actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Director of Corporate Affairs and/or make representations to the Trust's nominated Anti-Fraud Specialist.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. Further information about how

concerns should be raised can be found in the Raising Concerns at Work (Whistleblowing) Policy, ~~and~~ the Anti-Fraud, Bribery and Corruption Policy and Freedom to Speak Up Policy.~~.~~

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve ~~any~~ the staff member ~~involved~~ and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

10.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources); fraud, bribery and corruption (e.g. Anti-Fraud Specialists); members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS ~~Protect~~Counter Fraud Authority (NHS CFA), the Police, statutory health bodies (such as NHS England, NHS Improvement or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Disciplinary action against staff, which might include:
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.

- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

10.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee at least quarterly.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Trust website as appropriate, or made available for inspection by the public upon request.

11. Personal Conduct

11.1 Corporate Responsibility

All officers have a responsibility to respect and promote the corporate or collective decision of the organisation, even though this may conflict with their personal views. There may be instances where individuals are invited to comment on issues where the organisation has not agreed a response, in these circumstances it should be made clear this is a personal view and not the view of the organisation.

When speaking as a member of the organisation, whether to the media, in a public forum or in a private or informal discussion, officers should ensure that they reflect the current policies or view of the organisation. For any public forum or media interview, approval should be sought in advance from:

- In the case of the Board of Directors, from the Chairman and/or Chief Executive or their nominated deputies, and Communications Team;
- All other officers should contact the Communications Team for approval and guidance in these circumstances.

11.2 Use of Social Media

Officers should be aware that social networking websites are public forums and should not assume that their comments will remain private. Officers communicating via social media must comply with the Policy on Social Media. Officers must not:

- Conduct themselves in a way that brings the organisation into disrepute;
- Disclose information that is confidential to the organisation, staff or service users.
- Staff should refer to the Trust's Policy on Social Media for further guidance.

11.3 Gambling

No officer may bet or gamble when on duty or on the organisation's premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand National, among immediate colleagues within the same offices where no profits are made or the lottery is wholly for purposes that are not for private or commercial gain.

11.4 Lending and Borrowing

The lending or borrowing of money between officers should be avoided, whether informally as a business, particularly where the amounts are significant.

It is a particularly serious breach of discipline for any officer to use their position to place pressure on someone on a lower payband, a business contact, or a member of the public to loan them money.

11.5 Trading on the organisation's Premises

Trading on official premises is not prohibited, whether for personal gain or on behalf of others. This includes but is not limited to:

- Flyers advertising services/products in common areas
- Catalogues in common areas
- Staff must not use their Trust email address to generate income for personal gain or on behalf of others.

Canvasing within the office by, or on behalf of, outside bodies or firms is also prohibited. Trading does not include small tea or refreshment arrangements solely for officers.

121. Review

This policy will be reviewed every three years unless an earlier review is required. This will be led by the Director of Corporate Affairs.

132. Associated Documentation

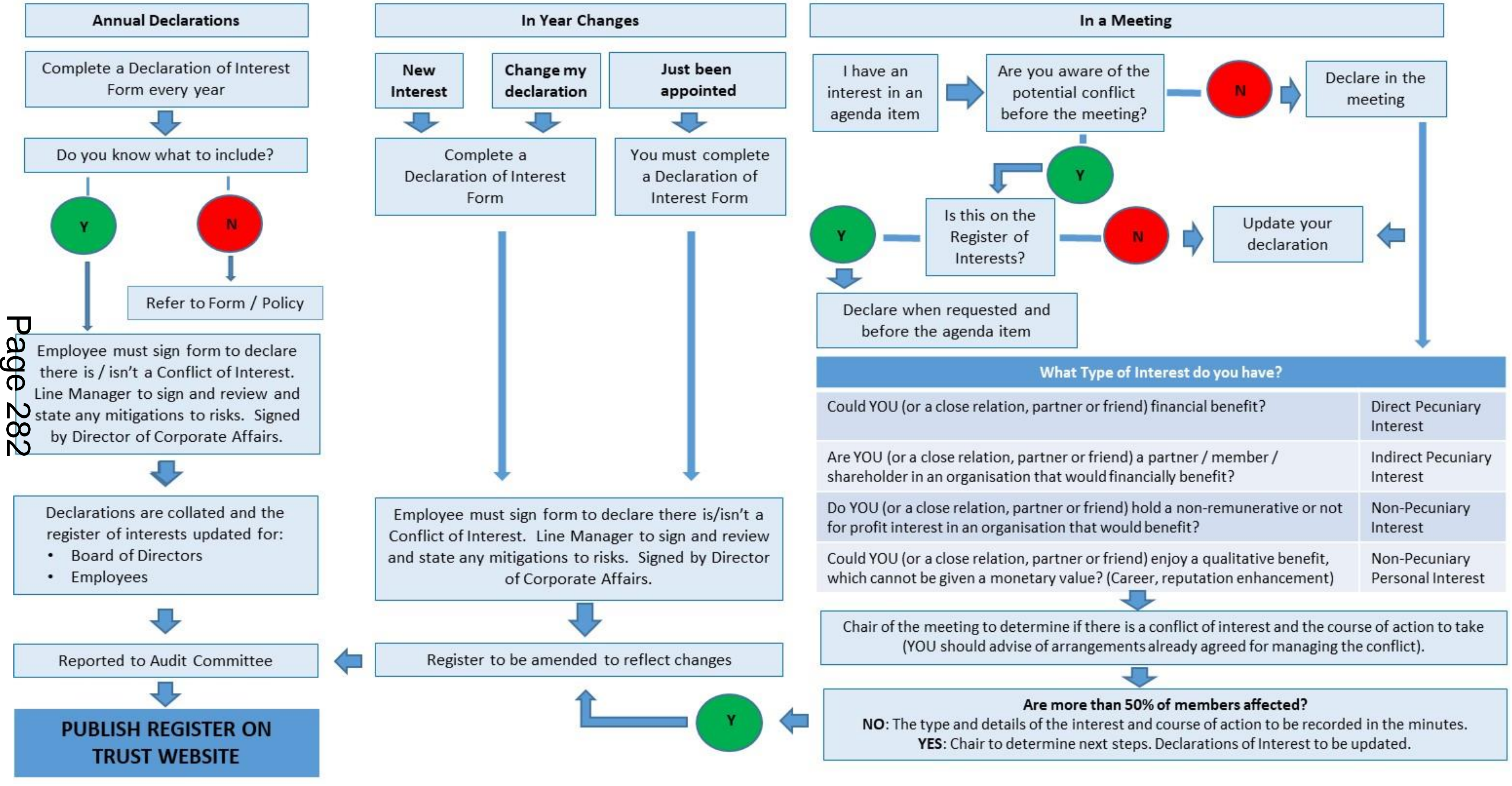
- Freedom of Information Act (2000)
- Data Protection Act 2018
- NHS England Guidance – Managing Conflicts within the NHS
- The Code of Practice for the Pharmaceutical Industry 20194
- Code of Conduct: Code of Accountability in the NHS 2004
- Anti-Fraud, Bribery & Corruption Policy & Response Plan
- Raising Concerns at Work (Whistleblowing) Policy
- Disciplinary Policy and Procedure
- Social Media Policy

Annex A

Examples of Types of Interest (not exhaustive)

Type of Interest	Description
Financial Interest	This is where an individual may get direct financial benefit from the consequences of a decision they are involved in making. This could, for example, include being: • A director (including non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; • A shareholder, partner, or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; • Someone in secondary employment • Someone in receipt of secondary income • Some in receipt of a grant • Someone in receipt of other payments (eg honoraria, day allowances, travel or subsistence) • Someone in receipt of sponsored research.
Non-financial professional interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • An advocate for a particular group of patients; • A clinical with a special interest • An active member of a particular specialist body • An advisor for the CQC or National Institution of Health and Care Excellence • A research role.
Non-financial personal interests	This is where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions that are involved in making in their professional career. This could include where the individual is: • A member of a voluntary sector board or has a position of authority within a voluntary organisation • A member of a lobbying or pressure group with an interest in health and care
Indirect interests	This is where an individual has a close association with an individual who has a financial interest, a non-professional personal interest or a non-financial personal interest who would stand to benefit from a decision they are involved in.
Loyalty interests	As part of their role, officers may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall into the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making.

Annex B



Appendix 1 – Declaration of Interest Form

NAME:
HOME ADDRESS:
POSITION HELD: Choose an item.
DEPARTMENT:

Description of Interest:	Choose an item.	
Reason for Completing Form:	Choose an item.	
To be completed by Procurement Team if related to quotation/tender responses and waivers:	☐	**I agree** that I will not use any NHS contracts for personal benefit, whether directly to me as an individual or to any company, organisation or group that I may be part of.
	☐	**I acknowledge** that any gifts or hospitality accepted from external organisations must be in line with Trust policy on hospitality and that any gifts or hospitality accepted should be registered.
	☐	**I am aware** that I must declare any conflict of interest or potential conflict of interest with any supplier that is used by the Trust to provide a product or service.
	☐	**I will advise** my line manager immediately where any actual or potential conflict arises during my employment, and will advise the details of my actual *or* potential conflict so that my line manager, or Head of Procurement, can decide whether any conflict of interest actually exists, and what action is required to prevent both me and the Trust from risks in Procurement processes. Where it is agreed that a conflict may or does exist I will complete a new declaration and list the supplier/s and the details of the conflict of interest.
	☐	**I agree** that I will advise my line manager if any offer or promise is made to me that could be intended to influence me to perform an activity in an improper manner (e.g. showing bias in a tender process). This is specifically prohibited under The Bribery Act 2010.
	☐	**I further accept** that if any such offer or promise is made I must notify my line manager, the Head of Procurement or the ***Trust's Anti-Fraud Specialist*** ~~a Counter Fraud Officer~~ immediately. Where I am uncertain I will also raise these for an appropriate manager to determine whether any improper approach has been made, which may include involvement from the ***Trust's Anti-Fraud Specialist***~~Counter Fraud Service~~ or the NHS~~H~~ CFA.
Type of Interest:	Choose an item.	
Detail any conflicts:		

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Detail the actions agreed with Line Manager to mitigate any risks:	

I confirm that the above information does not represent a Conflict of Interest		
Employee Signature:	**Print Name:**	**Date:**

Line Manager:	**Print Name:**	**Date:**

Director of Corporate Affairs Signature:	**Print Name:**	**Date:**

Upon completion this form should be returned to: ***declarations.inbox@nwas.nhs.uk***

I declare that the information I have provided on this form is complete and correct as at the time of signing/submission. I acknowledge that any changes in these declarations must be notified to the North West Ambulance Service NHS Trust as soon as practicable and no later than 28 days after the interest arises. I understand that if I knowingly provide false or misleading information this may result in criminal, civil, professional and/or disciplinary action. I consent to the disclosure of information contained on this form to the Trust for the purposes of any internal investigation and consent to disclosure by the Trust to the professional body, the Trust's Anti-Fraud Specialist and/or the NHS CFA for the purposes of ~~external~~ investigation ~~and/or to the Trust's Anti-Fraud Specialist for the purpose of investigation~~, prevention, detection and prosecution of fraud, bribery and/or corruption offences.

Appendix 2 – Gifts and Hospitality Form

REGISTER OF INTEREST
GIFTS & HOSPITALITY FORM

NAME:	
POSITION HELD:	
DEPARTMENT:	

Date of offer:	
Description of Gift or Hospitality Offered:	
Value:	
Name of Supplier/ Offeror & Address:	
Accepted/Declined & reasons for doing so:	
Details of any previous offers or acceptance by this supplier/offeror:	
Details of any management approval sought before acceptance: (Independent Review must be sought from the Director of Corporate Affairs prior to any acceptance)	

I declare that the gift / hospitality declared and/or received/rejected was entirely consistent with the requirements of the Standards of Business Conduct: Policy on Managing Conflicts of Interest; Gifts & Hospitality and Sponsorship. I confirm that the information provided on this form~~above~~ is complete and correct at the time of signing/submission. I acknowledge that any changes in these declarations must be notified to North West Ambulance Service NHS Trust as soon as practicable and no later than 28 days after the ~~interest~~ gift/hospitality arises. I understand that if I knowingly provide false or misleading information this may result in criminal, civil, professional and/or disciplinary action. I consent to the disclosure of information contained on this form to the Trust for the purposes of any internal investigation and consent to disclosure by the Trust to the professional body, the Trust's Anti-Fraud Specialist and/or the NHS CFA for the purposes of investigation, prevention, detection and prosecution of fraud, bribery and/or corruption offences.~~am aware that if I do not~~

~~*make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result.*~~		
Employee Signature:	**Print Name:**	**Date:**

Line Manager:	**Print Name:**	**Date:**

Executive Signature:	**Print Name:**	**Date:**

Director of Corporate Affairs Signature:	**Print Name:**	**Date:**

Upon completion this form should be returned to: declarations.inbox@nwas.nhs.uk

The information submitted will be held by North West Ambulance Service NHS Trust for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act ~~1998~~2018. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that North West Ambulance Service NHS Trust holds.

Appendix 3 – Application for Sponsorship Approval

REGISTER OF INTEREST
APPLICATION FOR SPONSORSHIP APPROVAL

NAME: **POSITION HELD:** **DEPARTMENT:** **ADDRESS:** **EMAIL:**	

EVENT DETAILS (Name; Date; Location; Brief Outline of Purpose):	**ORGANISER:**
SPONSORSHIP DETAILS AND VALUE:	**PROPOSED SPONSOR**
CONTACT NAME	**CONTACT TELEPHONE**
OUTLINE OF SPONSORSHIP (what provided, what in return etc) & ESTIMATED COST	
BENEFITS TO THE EVENT AND TRUST	
POTENTIAL RISKS	

I declare that the proposed sponsorship is entirely consistent with the requirements of the Standards of Business Conduct: Policy on Managing Conflicts of Interest; Gifts & Hospitality and Sponsorship. I confirm that the information provided on this form~~above~~ is complete and correct at the time of signing/submission. I acknowledge that any changes in these declarations must be notified to North West Ambulance Service NHS Trust as soon as practicable and no later than 28 days after the ~~interest~~ sponsorship arises. I understand that if I knowingly provide false or misleading information this may result in criminal, civil, professional and/or disciplinary action. I consent to the disclosure of information contained on this form to the Trust for the purposes of any internal investigation and consent to disclosure by the Trust to the professional body, the Trust's Anti-Fraud Specialist and/or the NHS CFA for the purposes of investigation, prevention, detection and prosecution of fraud, bribery and/or corruption offences~~am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary, or professional regulatory action may result~~.

Employee Signature:	**Print Name:**
Date:	

Line Manager:	**Print Name:**
Date:	

Executive Signature:	**Print Name:**
Date:	

Director of Corporate Affairs Signature:	**Print Name:**
Date:	

Upon completion this form should be returned to:
declarations.inbox@nwas.nhs.uk

The information submitted will be held by North West Ambulance Service NHS Trust for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 2018~~1998~~. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that North West Ambulance Service NHS Trust holds.

REPORT

Board of Directors	
Date:	**24 April 2019**
Subject:	**Use of Common Seal 2018/19**
Presented by:	**Angela Wetton, Director of Corporate Affairs**
Purpose of Paper:	**For Assurance**
Executive Summary:	**Use of the Common Seal is determined by Section 8 of the Trust's Standing Orders. Clause 8.4 of Section 8 requires the occasions of use to be reported to the Board on an annual basis with the previous report received by the Board on 25 April 2018.** **During the period 1 April 2018 – 31 March 2019, the Trust's Common Seal was applied on a total of 17 occasions and the details can be found in s2.**
Recommendations, decisions or actions sought:	**The Board of Directors is recommended to:** • **Note the occasions of use of the Common Seal as detailed at s2 of the report.**

Link to Strategic Goals:				
	Right Care	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**N/A**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

The purpose of this report is to report the use of the Common Seal to the Board of Directors during 2018/19.

2. USE OF THE COMMON SEAL

Use of the Common Seal is determined by Section 8 of the Trust's Standing Orders. Clause 8.4 of Section 8 requires the occasions of use to be reported to the Board on an annual basis with the previous report received by the Board on 25 April 2018.

During the period 1 April 2018 – 31 March 2019, the Trust's Common Seal was applied on a total of 17 occasions. These were:

Reg No	Date	Reason
106	17 April 2018	Licence Agreement to use Bolton-le-Sands Fire Station as a deployment point.
107	17 April 2018	Counterpart lease documents for PES Service Co-location and occupation of the Penrith Fire Station
108	2 May 2018	Standby Point: Parking at Leigh Community Fire Station
109	2 May 2018	Standby Point: Parking at Atherton Community Fire Station
110	2 May 2018	Standby Point: Parking at Hindley Community Fire Station
111	2 May 2018	Lease of rooms - Irlam Community Fire Station
112	2 May 2018	Lease of rooms - White Community Fire Station
113	2 May 2018	Lease of rooms - Phillips Park Community Fire Station
114	21 May 2018	NWAS selling existing Burnley Ambulance Station to Lancashire County Council and lease back to Peppercorn rent until new facility built
115	30 May 2018	Lease of ambulance station at Burnley Hospital (until new ambulance station built)
116	18 August 2018	Broughton bypass – Licence agreement as Lancashire County Council altering curve of the road on NHS Land
117	11 September 2018	Variation and Licence for alterations and Virgin Media Wayleave Agreement
118	3 October 2018	Penrith Hospital – Co-location New plans from Council following query from Land Registry to ensure ease of identification
119	20 December 2018	Underlease – Land at Burnley General Hospital fronting onto Briercliffe Road, Burnley
120	20 December 2018	Renewal lease between Lancashire County Council and the Trust

121	20 December 2018	South Lakeland District Council and the Trust. Tenancy agreement of Unit 1D, Tollbar Estate Cumbria
122	4 March 2019	Warrantees for new Burnley Ambulance Station

A Register of Use of the Common Seal is maintained by the Director of Corporate Affairs and includes either the supporting documentation for each entry or details of the final distribution of the relevant documentation. The Director of Corporate Affairs is responsible for the safe custody of the Common Seal. Authorisation for Use of the Common Seal required the signatures of both the Chief Executive and Director of Finance and the application of the Seal is witnessed by a further 2 senior managers.

Authorisation and witness signatures are incorporated in the Trust's Register of Sealings.

Compliance with the requirements of Section 10 of Standing Orders is being maintained.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

There are no associated legal implications.

4. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the occasions of use of the Common Seal during 2018/19.

REPORT

Board of Directors	
Date:	**24th April 2019**
Subject:	**Annual Report of the Audit Committee 2018/19**
Presented by:	**David Rawsthorn, Chair of Audit Committee**
Purpose of Paper:	**For Assurance**
Executive Summary:	**The report summarises the activities of the Trust's Audit Committee for the financial year 2018/19 setting out how it has met its terms of reference and key priorities.** **The Audit Committee is a formal committee of the Board of Directors, required by statute.** **The report was approved by the Audit Committee on 18th April 2019 for presentation to the Board of Directors.**
Recommendations, decisions or actions sought:	**The Board of Directors is recommended to:** • **Review and note the Trust's Audit Committee activities during the financial year 2018/19** • **Approve the Terms of Reference.**

Link to Strategic Goals:				
	Right Care	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	**Audit Committee**
Date:	**18th April 2019**
Outcome:	**Approved**

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Audit Committee Annual Report 2018/19

Introduction
This report provides information on the how the Audit Committee has met its Terms of Reference during the 2018/19 financial year. It is presented to the Board of Directors to inform them of the activities of the Audit Committee for the period 1 April 2018 to 31 March 2019.

Role of the Committee
The Audit Committee co-ordinates the assurance process and advises the Board of Directors on the overall level of assurance and on any significant weaknesses in internal control. The Committee continuously reviews the structure and effectiveness of the Trust internal control and risk management arrangements and agrees an audit programme with external and internal auditors'.

Five meetings of the Audit Committee were held during the year. Regular attendees at the Committee meetings are KPMG (External Auditors), MIAA (Internal Audit and Anti-Fraud Services), Director of Finance and Director of Corporate Affairs. During the reporting period, the Committee invited Executive Directors and senior managers to attend the meeting to provide further assurance where required. On 21 February 2019, Committee members met in a session facilitated by Internal Audit to undertake a self-assessment of its effectiveness and review the Terms of Reference. The session confirmed compliance with its Terms of Reference and identified areas for further development and follow-up action.

Committee Members and Attendance
During 2018/19 the Audit Committee consisted of the following members:

Committee Member		Attendance
Mr M Tattersall	Non-Executive Director (Chair)	5/5
Mr R Groome	Non-Executive Director	4/5
Mr P White	Non-Executive Director	3/5

The Committee met on the following occasions during 2018/19:

20 April 2018
25 May 2018
20 July 2018
2 November 2018
25 January 2019

Audit Committee Activity
The Committee works to an annual plan of scheduled agenda items in addition to considering any relevant issues which may arise in the year. A number of reports were presented to the Committee over the year and a list of these items is attached at **Appendix 1**.

The Committee discussed the reports and requested further information and/or action where appropriate. This included monitoring progress on implementing recommendations especially where the audit opinion was that the system of controls only provided limited assurance.

Board Assurance Framework & Risk Management
During the year the Trust has continued to develop and embed the Board Assurance Framework and Risk Management System by reviewing the risk management processes developed to strengthen risk management across the Trust. It also reviewed the Board Assurance Framework which provides a clear focus on the risks, key controls and assurances in relation to achieving the Trust's Strategic Objectives.

In order to fulfil the Committee's remit for seeking assurance on risk management systems and processes, the Committee introduced a 2-year programme of Risk Owner presentations whereby risk owners from the service lines (PES, EOC and PTS) attended the Committee to present their risk management and governance arrangements. The final presentation from NHS111 is scheduled for April 2019. The presentations focus on the top 5 risks; the management of incidents, complaints and main themes; risk management and escalation process; governance structure and challenges for the next 12 months. The aim of the programme for 2019/20 will be for Risk Owners to return and present a further update to demonstrate their maturing approach to risk management and governance.

The programme to date has provided the Audit Committee with assurance in terms of how the operational service lines have arranged their own internal control systems. By the end of the two year programme the Committee expects to have seen evidence that risk maturity has grown and developed.

Internal Audit

MIAA acted as Internal Auditors for the Trust during the year. Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. Internal Audit focusses activity on the key strategic risks and on any aspects of risk management, control or governance affected by material changes to the Trust's operating environment, subject to Audit Committee approval.

A detailed programme of work is agreed with the Executive Team via the Director of Finance and is reviewed and approved by the Audit Committee. The programme is set out for each year in advance and is then carried out along with any additional activity that may be required during the year. In approving the Internal Audit Work Programme, the Committee uses a planning and mapping framework to ensure all key risk areas are reviewed at the appropriate frequency.

The plan priorities and risk assessment are built from considering the national priorities of the NHS Counter Fraud Authority (NHS CFA) along with specific requirements made within their Standards for Providers, place based developments and local strategic risk assessment.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. During the year, the Committee invited Executive Directors and Senior Management to meetings where a 'limited assurance' opinion had been provided in audit reports. This attendance by senior managers helped to provide further assurance on these areas. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

Specific attention has been focussed during the year on the following areas:

- Bank Arrangements
- New PTS Contracts
- Nurse & Paramedic Revalidation
- ESR
- Information Governance Toolkit
- Assurance Framework Opinion
- Serious Incidents
- Core Financial Systems
- Tenders & Waivers
- Safeguarding
- Recruitment
- Management of Overtime
- Sickness Absence Management
- Complaints Management
- Quality Accounts
- Performance Management and Board Reporting
- Mobile Computing

The Internal Audit Progress Report considered at each Committee meeting includes summaries of each of the final reports issued by MIAA in respect of the key systems examined.

During 2018/19, the Head of Internal Audit overall opinion for the period 1 April 2018 to 31 March 2019 was substantial assurance. This confirmed there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

External Audit
KPMG has continued its role as External Auditors to the Trust and during the year reported on the 2017/18 Annual Report and Financial Statements and no material or significant issues were raised in respect of the statements. Technical support has been provided to the Committee on an ongoing basis and representatives of KPMG attend each meeting.

At the meeting on 25 May 2018, the Committee received the ISA260 Audit Memorandum relating to the Financial Statements Audit and review of the Annual Report. The Annual Report and Accounts were approved and External Audit confirmed an unqualified Audit Report would be issued.

Anti-Fraud Activity
The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness presentations along with providing Intelligence Bulletins issued by the NHS CFA and Information Alerts to the Trust.

The Audit Committee received regular progress reports from the AFS and also received an annual report providing a summary of the work undertaken against each of the four generic areas of anti-fraud activity as set out by NHS CFA; 1) Inform and Involve 2) Prevent and Deter 3) Hold to Account and 3) Strategic Governance.

No significant cases or issues of Anti-Fraud took place or were identified during the year.

Summary
The Audit Committee did not find any areas of significant duplication or omission in the systems of governance in the Trust.

The Audit Committee was not aware of any major break-down in internal control that could have led to a significant loss.

The Audit Committee was not aware of any major weakness in the governance systems that had exposed, or may continue to expose, the Trust to an unacceptable risk.

Committee members participated in the Committee self-assessment facilitated by MIAA against the Terms of Reference on 21 February 2019. The revised Terms of Reference are attached at **Appendix 2** for approval by the Board of Directors.

The Committee consider that the proceedings of its meetings including the various reports discussed at those meetings confirm that the Committee has discharged its duties throughout the year.

Recommendation

The Committee intend that the Board will find this an informative report and invite them to consider its contents and approve the revised Terms of Reference.

Mr D Rawsthorn
Non-Executive Director
Audit Committee Chair 24 April 2019

APPENDIX 1

REPORTS TO THE AUDIT COMMITTEE DURING 2018/19

Reports produced by the Trust
Audited Accounts 2017/18
Annual Report 2017/18
Annual Governance Statement 2017/18
Audit Committee Effectiveness Review (undertaken on 20 July 2018)
Audit Committee Terms of Reference (undertaken on 20 July 2018)
Waiver of Standing Orders
Losses and Compensation
Letter of Representation
Audit Committee Work Plan
Reports produced by KPMG, External Auditors
Annual Audit Letter 2017/18
External Audit Plan 2018/19
External Audit Technical Updates
Report to those charged with Governance (ISA260)
Independent Auditors Report to Board of Directors 2018
Reports produced by MIAA
Internal Audit Progress Reports
Internal Audit Plan 2018/19
Director of Internal Audit Opinion 2017/18
Follow Up Reviews
Internal Audit Charter
Performance Against KPIs 2017/18
Individual Audit Reports:
Proposal – Risk Owner Presentations
Audit Committee Annual Report 2017/18
Claims Handling Policy
Audit Committee Effectiveness Review Actions/Development
Revised Committee Terms of Reference
Policy for Engagement of External Auditors for Non-Audit Work
UK Code of Governance Update
Risk Management Strategy
Legal Services Updates
Bad Debt Report
Clinical Audit Annual Report 2017/18
Clinical Audit Progress Reports
Reports produced by the Anti-Fraud Specialist
Anti-Fraud Fraud Annual Work Plan 2018/19
Anti-Fraud Progress Reports
Anti-Fraud Annual Report 2017/18
Self-Review Toolkit (SRT)
Management Action Tracker Follow Up Report 2017/18

Appendix B

NORTH WEST AMBULANCE SERVICE NHS TRUST
AUDIT COMMITTEE

TERMS OF REFERENCE

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1. CONSTITUTION

1.1 The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Audit Committee *(hereinafter referred to as 'the Committee')*. The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated within these terms of reference.

2. REMIT AND FUNCTIONS OF THE COMMITTEE

2.1 The Committee is established to advise the Board of Directors on the effectiveness of the Trust's strategic processes for risk management, internal control and governance; to advise on the appropriateness and effectiveness of internal and external audit activities and ensure that accounting policies applied within the Trust comply with relevant requirements.

2.2. The Committee will consider the appointment of internal and external auditors and the internal and external audit plans. The Committee will consider auditors' recommendations and make recommendations for action to the Board of Directors as appropriate.

2.3 The main functions of the Committee are:

2.3.1 ***Internal audit.*** The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017~~3~~ and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

i. consideration of the provision of the internal audit service and the costs involved, review and approval of the annual internal audit plan and more detailed programme of work; ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

ii. consideration of the major findings of internal audit work (and management's response) and ensuring co-ordination between the internal and external auditors to optimise audit resources

iii. ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation

iv. completing an annual review of the effectiveness of internal audit

2.3.2 ***External audit***. The Committee shall review and monitor the external auditors' independence and objectivity of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

i. consideration of the appointment and performance of the external auditor, as far as the rules governing the appointment permit (and make recommendations to the Board of Directors when appropriate)

ii. discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan.

iii. discussion with the external auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

iv. review of all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work carried out outside the annual audit plan, together with the appropriateness of management responses

v. Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

2.3.3 ***Financial reporting***. The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

2.3.4 The Committee should ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board of Directors.

2.3.5 The Committee shall review and approve the annual report and financial statements under delegated authority from the Board of Directors, focusing particularly on:

i. the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee

ii. changes in, and compliance with, accounting policies, practices and estimation techniques

iii. unadjusted mis-statements in the financial statements

iv. significant judgements in preparation of the financial statements

v. significant adjustment resulting from the audit

vi. Letter of Representation

vii. Explanations for significant variances

2.3.6 ***Governance, risk management and internal control***. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities – both clinical and non-clinical – that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy and effectiveness of:

i. all risk and control-related disclosure statements, and in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit ~~statement~~opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board

ii. the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

iii. the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification

iv. the policies and procedures for all work related to counter fraud and security as required by the NHS Counter F~~f~~raud Authority.

2.3.7 In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

2.3.8 ***Other assurance functions***. The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to, reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors, such as Care Quality Commission, NHS Resolution etc, or professional bodies with responsibility for the performance of staff or functions, such as ~~-~~Royal Colleges, Health Professions Council, NHS Counter Fraud Authority. ~~etc.~~

2.3.9 In addition, the Committee shall review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work.

2.3.10 ***Clinical Audit -*** In reviewing clinical governance arrangements and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

2.3.11 ***Counter Fraud.*** The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption ~~-and security~~ that meet the NHS Counter F~~f~~raud Authority's standards, and shall review the outcomes of work in these areas.

In accordance with 3.2 of the NHS CFA's Fraud Commissioners Standards, the Audit Committee has 'stated its commitment to ensuring commissioners achieve these standards and therefore requires assurance that they are being met via NHS CFA's quality assurance programme'.

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS CFA.

2.3.12 ***Management***. The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the organisation, such as clinical audit for example.

2.3.13 ***Other duties***. Other duties of the Committee are:

i. to review proposed changes to Standing Orders and Standing Financial Instructions

ii. to examine the circumstances associated with each occasion that Standing Orders are waived

iii. to review losses and compensation payments and make recommendations to the Board of Directors

3. COMPOSITION AND CONDUCT OF THE COMMITTEE

3.1 The Committee shall be appointed by the Board of Directors from amongst its independent Non-Executive Directors of the Trust and shall consist of not less than three members. One of the members shall be appointed as Chair of the Committee by the Board of Directors. The Chairman of the Board of Directors shall not be a member of the Committee. There is an expectation that members will attend a minimum 75% of Committee meetings during each financial year.

3.2 In the event that the Chair of the Committee is unable to attend a meeting, the members present shall decide upon a Deputy Chair to conduct the meeting.

3.3 The Director of Finance, Director of Corporate Affairs and appropriate internal and external audit representatives shall normally attend meetings. However, at least once a year, the Committee should meet privately with the internal and external auditors without the presence of the Executives.

3.4 The Chief Executive should be invited to attend at least annually to present the process for assurance that supports the Annual Governance Statement. The Chief Executive should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

3.5 Other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. Deputies may attend in the absence of any of the Executive Directors.

3.6 Other Officers of the Trust may attend at the request of the Committee in order to present and provide clarification on issues which require a decision from the Committee, but may not vote on decisions.

3.7 ***Quorum****.* No business shall be transacted unless at least two members are present. .

3.8 ***Notice of meeting****.* Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

3.9 ***Frequency of meetings****.* The Committee will normally meet at least five times per year. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 3.8 above. The appropriate internal or external audit representatives may request a meeting if they consider that one is necessary.

3.10 ***Minutes.*** The minutes of meetings shall be formally recorded by the Corporate Governance Team, checked by the Chair and submitted for agreement at the next ensuing meeting, whereupon they will be signed by the person presiding at it. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or require executive action.

3.11 ***Emergency powers****.* The Chair and one other Non-Executive Director may, in an emergency, exercise the functions of the Committee jointly. A full report shall be prepared as for the Committee and a signed authorisation appended. The exercise of such powers, together with the report, shall be submitted to the next formal meeting for ratification.

3.12 ***Administrative Support****.* The Committee shall be supported administratively by the Corporate Governance Team, who shall:

- agree agendas with the Chair and attendees
- prepare, collate and circulate papers in good time
- ensure that those invited to each meeting attend
- take the minutes and help the Chair to prepare reports as required
- keep a record of matters arising and issues to be carried forward
- ensuring that action points are taken forward between meetings
- ensure that Committee members receive the development and training they need

4. DELEGATED AUTHORITY

4.1 The Committee is authorised by the Board to:

i. investigate any activity within its terms of reference

ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

ii.iii. Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS AND ITS COMMITTEES

5.1 The Committee will report in writing to the Board of Directors the basis for its recommendations. The Board will use that report as the basis for their decisions, but would remain accountable for taking the decision. Minutes of the meetings of the Board of Directors will record such decisions.

5.2 The Committee will report to the Board of Directors annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business. This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

6. REVIEW

6.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

6.2 Compliance with the Terms of Reference will be monitored on an ongoing basis by the Director of Corporate Affairs and any concerns in relation to compliance will be reported to the Chair of the Committee. In addition, the annual review described in s6.1 will include compliance with the Terms of Reference.

REPORT

Board of Directors				
Date:	24th April 2019			
Subject:	Policy Framework Update Q4 1st January 2019 – 31st March 2019			
Presented by:	Angela Wetton, Director of Corporate Affairs			
Purpose of Paper:	For Assurance			
Executive Summary:	Details of the policies and procedures approved, in line with the process described in s2, during the period 1st January 2019 – 31st March 2019 can be found at appendix 1.			
Recommendations, decisions or actions sought:	The Board of Directors are asked to note the policies and procedures approved during the period 1st January 2019 – 31st March 2019			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	**EIA required to be completed for each policy.**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

The purpose of this report is to provide details of the policies and procedures approved by either the Executive Management Team or individual Executive Directors during the period 1st January 2019 – 31st March 2019.

2. BACKGROUND

New Policies

The need for a new policy or procedure may be prompted by a change in national legislation, policy or guidance or it may be identified within the Trust either as a result of learning from experience, such as complaints or incidents, or as a result of a risk being identified by a specialist advisor. New policies may also be required as a result of the development of a new service or new way of working.

1. The first step should be to establish whether a new policy or procedure is required or whether the requirement can be met by amending an existing policy or procedure. The aim should be to keep the number of policies to a minimum. The lead director should be able to provide a clear justification for the development of any new policy.
2. It is the responsibility of the lead Director for a policy to ensure that the document is appropriately consulted on during the development process with key stakeholders e.g. Unions; HR; Legal; etc.
3. The lead director is responsible for ensuring the policy is scheduled into an Executive Management Team meeting for approval.
4. Following approval – the corporate governance team will update the Policy Database
5. The lead director will be responsible for dissemination and training in relation to the policy and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation i.e. ensuring the approved document is uploaded to the intranet.

Amendments to Existing Policies

1. The lead director reviews the policy on the agreed cyclical basis and if nothing requires updating, signs off the policy with a new review date; ensures the new document is uploaded to the intranet and advises the corporate governance team so the database can be updated.
2. If changes are made but they are minor, e.g. job titles, then the lead director signs off the amended policy; ensures the new document is uploaded to the intranet and advises the corporate governance team so the database can be updated
3. If the changes needed are significant i.e. driven by legislative changes, then the lead director is responsible for ensuring that the revised document is consulted on with key stakeholders e.g. Unions; HR; Legal; etc.
4. The lead director is responsible for ensuring the policy is scheduled into an Executive Management Team meeting for approval.
5. Following approval – the corporate governance team will update the policy database

6. The lead director will be responsible for dissemination and training in relation to the policy changes and for ensuring the most current version is in use and obsolete versions have been withdrawn from circulation i.e. ensuring the approved document is uploaded to the intranet.

3. APPROVED POLICIES

Details of the policies and procedures approved, in line with the above process during the period 1st January 2019 – 31st March 2019 can be found at appendix 1.

4. LEGAL IMPLICATIONS

A robust Policy Framework is a key element of a corporate governance framework.

5. RECOMMENDATION(S)

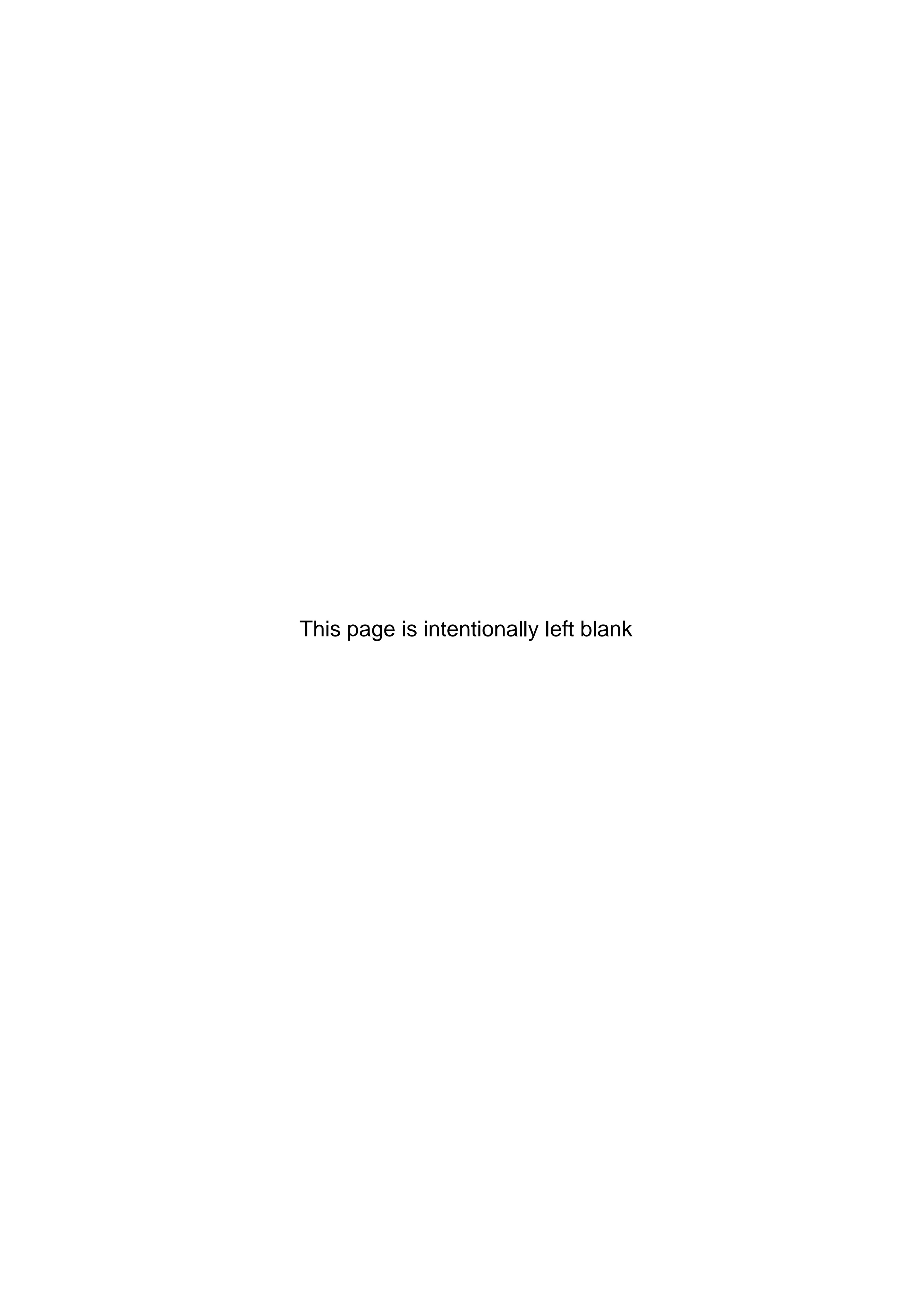
The Board of Directors is recommended to:

- Note the policies and procedures approved during the period 1st January 2019 – 31st March 2019

Policies approved between 1st January 2019 - 31st March 2019

Jan-19		
Estates Policy	DOF	29/01/19
Fleet Department Procedure for the Utilisation of Trust Premises for the Maintenance of Personal Vehicles	DOF	29/01/19
Health, Safety and Security Policy	BOD	30/01/19
Feb-19		
Clinical Hub - Repeat Caller Escalation Procedure	EMT	13/02/19

Key
EMT - Executive Management Team
QC - Quality Committee
DDOF - Deputy Director of Finance
DOF - Director of Finance
DDOD - Director of Organisational Development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REPORT

AGENDA ITEM:

Board of Directors	
Date:	24th April 2019
Subject:	Freedom To Speak Up Guardian Report Q4 2019
Presented by:	Rachael Foot, Freedom to Speak Up Guardian & Angela Wetton, Director of Corporate Affairs
Purpose of Paper:	For Assurance
Executive Summary:	During Q4 2019, the Guardian received sixteen concerns. • Working Practices 2 • Patient Safety 3 • Fraud 1 • Bullying & Harassment 9 • Other 1 Comparative data for the Ambulance sector is shown at Appendix 1 for Q1-Q3 of 2018-19 – the Q4 figures have not yet been published by the National Guardian's Office.
Recommendations, decisions or actions sought:	**The Board is asked to:** • **The Board is asked to note the contents of this report**

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☐	☐	☒	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**NO**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

This paper summarises the work of the Freedom to Speak Up Guardian during Quarter 4, January - March 2019

2. BACKGROUND

"Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS" (Francis) was published in February 2015. The aim of the review was to provide advice and recommendations to ensure that NHS staff feel safe to raise concerns, confident that they will be listened to and the concerns will be acted upon.

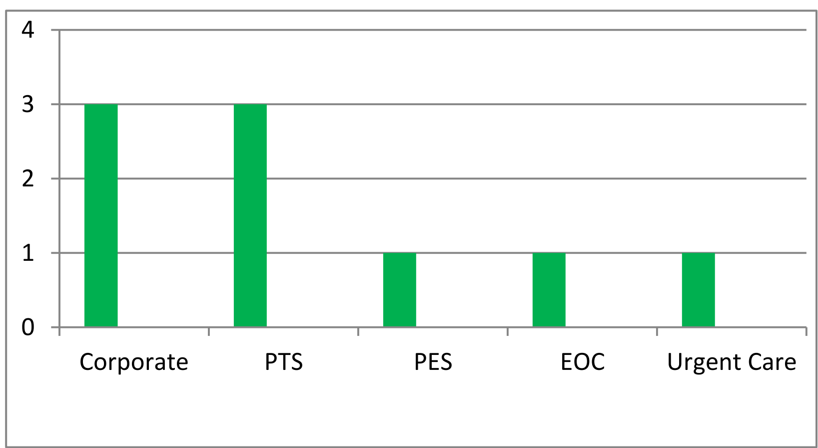
The Freedom to Speak Up Guardian role is permanently established at NWAS, with eleven FTSU Champions appointed across the Trust to support the Guardian. Two of the eleven Champions are recent appointments.

Every NHS trust in England reports quarterly to the National Guardian's office providing brief details of those concerns raised through the Freedom to Speak Up (FTSU) process.

3. QUARTER 4 2018-2019 ACTIVITY

During the reporting period, the Freedom To Speak Up Guardian received sixteen concerns and these have been reported to the National Guardian's Office. By comparison, during the same reporting period of the previous year, thirteen concerns were raised.

Of the sixteen cases, nine (9) relate to Bullying and Harassment which is a higher usual (the previous quarterly figures can be seen in Appendix 1) and the data has been broken down into service lines (see graph below).

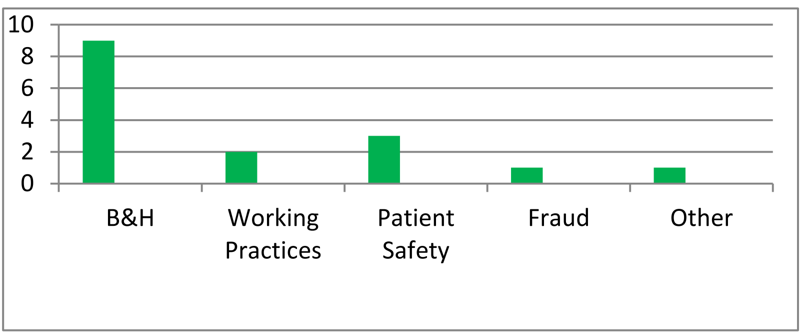


During the reporting period, no one has reported suffering detriment as a result of raising a concern - the Guardian regularly confirms this with concern raisers both during the period the case is open and after the case has been closed.

Feedback is collected from members of staff who have raised concerns and monitored to assess any inequalities that require addressing and to identify any areas for

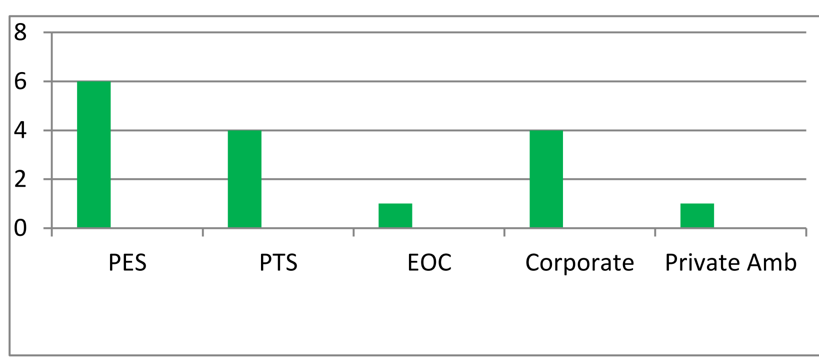
improvement in the handling of the concerns.

Q4 2018-19 Concerns by Reporting Category:



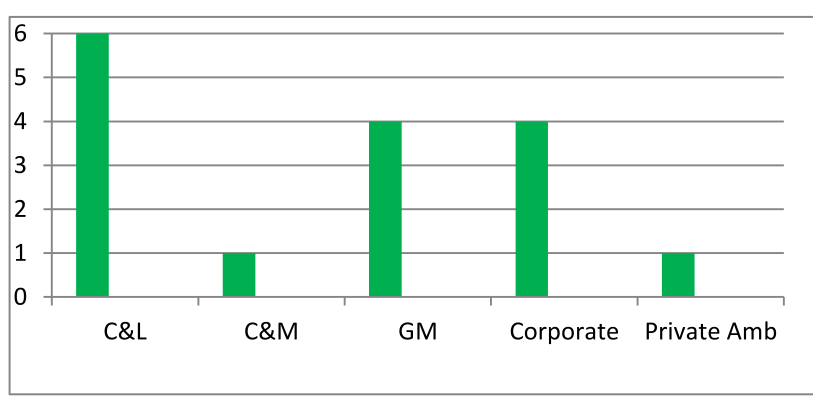
Graph 1

Q4 2018-19 Concerns By Service Line:



Graph2

Q4 2018-19 Concerns by Area:



Graph3

Please note - the activity as detailed above reflects only cases reported centrally. Concerns raised with local managers are not captured within this data.

There is always a difference of opinion around what an open, engaging and transparent Trust would look like in respect to FTSU concerns. Some argue that a high number of reported concerns suggest an open and engaging workforce who are not afraid to report issues or concerns while a contrasting viewpoint argues that a low number of reported concerns indicates a 'safe' organisation. Irrespective of these two contrasting viewpoints there is a general consensus that all Trusts will generate some FTSU concerns even in

small numbers and those trusts who are reporting zero or “no data” may need to revisit their FTSU strategy.

Comparative data for the Ambulance sector is shown at **Appendix 1** for Q1-Q3 of 2018-19 – the Q4 figures have not yet been published by the National Guardian’s Office. It is also suggested that Trusts who receive a larger number of anonymous concerns may have an issue with the workforce not having confidence to speak up and being fearful of suffering detriment.

Cases to Note During Q4

A case has been raised from the Gazetteer team relating to violence and aggression markers, where the various NWAS systems don’t allow for updating. The Director of Operations has appointed an investigator.

Open Cases at the end of Q4

Of the 118 concerns received since the FTSU programme commenced at NWAS in April 2017, there are currently 7 concerns that remain open.

NHSI Board Self-Assessment

During Q3, the Board assessed the FTSU work against the NHSI framework and areas for further development were identified. An action plan was drafted by the FTSU Guardian, however, following engagement with NHSI it was agreed that the action plan would remain in draft until the NGO review report was published so that a single plan encompassing all elements could be drawn up and agreed. This has not prevented work from being carried out, such as, information sharing protocol between FTSU and Human Resources.

FTSU Engagement

As per the engagement plan, awareness of FTSU has been delivered through attendance at:

- Trust Learning Forums where key themes and learning are disseminated
- Health and Wellbeing Groups and Events
- Bullying & Harassment Forums
- BME Staff Forum
- Station Visits

The Guardian also attended the National Freedom to Speak Up Conference 2019 at Central Hall Westminster.

Meetings have been held with the executive lead, the CEO and the NED lead.

FTSU NGO Speaking up Engagement Meeting

The National Guardian’s Office (NGO) visited NWAS on 31st January and 1st February 2019.

Their visit was prompted by staff involved in case numbers 62 and 64 who had asked the NGO to review the handling of their cases. The purpose of the visit was to:

- Meet the Exec Lead; CEO: Director of OD and NED Lead
- Discuss the handling of speaking up cases by trust workers, where they have given their consent
- Identify examples of good practice and innovation by the trust that can be shared with other organisations
- Learn how the trust is implementing the speaking up guidance for boards from NHS Improvement
- Learn how the trust is implementing good speaking up practice recommended by the NGO.

The Trust is currently waiting for the NGO to publish their report and feedback on their findings and recommendations made.

4. NATIONAL WORK

The National Guardian's Office (NGO) is an independent body sponsored equally by the Care Quality Commission, NHS Improvement and NHS England, with a remit to lead culture change in the NHS so that speaking up becomes business as usual. The national guardian's office is designed to support the local guardians but has no formal statutory powers.

In June 2017, The National Guardian's Office launched a 12-month trial of case review process, a key recommendation from the Francis Freedom to Speak Up review. Case reviews listen hard to the experience of workers and look at the speaking up culture in NHS trusts, including how individuals' cases have been handled.

Case reviews call out areas for improvement and also commend good practice. The NGO publish their reports and, working collaboratively with trusts and regulators, ensure the recommendations are implemented.

The NGO has published 5 reports to date:

- Southport and Ormskirk Hospital NHS Trust
- Northern Lincolnshire and Goole NHS Foundation Trust
- Derbyshire Community Health Services NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Royal Cornwall Hospitals NHS Trust

Case review findings are published on its website https://www.cqc.org.uk/national-guardians-office/content/case-reviews

As mentioned previously, the NGO visited NWAS in January 2019 and the high level feedback is awaited. The Trust looks forward to receiving the final report in due course.

"*By carrying out a "gap analysis", guardians in trusts throughout England have been able to review their own practices, processes and policies and use the learning to make improvements."- Dr Henrietta Hughes*

5. LEGAL and/or GOVERNANCE IMPLICATIONS

All NHS Trusts and NHS Foundation Trusts are required by the NHS contract to nominate a Freedom to Speak Up Guardian.

6. RECOMMENDATIONS

The Board is asked to note the contents of this report.

Appendix 1

Ambulance Trusts Comparison Data Q1–Q3 2018-19

The data for Q4 has not yet been published.

	Trust Size*	Total Cases			Anonymous			Patient Safety			B&H			Reported Detriment		
		Q1	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**	**Q1**	**Q2**	**Q3**
LAS	Medium	0	16	42	0	1	1	0	1	4	0	5	19	0	0	0
NWAS	Medium	9	11	**24**	2	2	**12**	2	1	**12**	3	2	**3**	0	0	**0**
SECAMB	Small	4	10	22	3	0	2	3	0	0	1	4	16	0	1	3
YAS	Medium	7	14	15	0	0	0	3	5	3	3	5	3	1	0	1
EMAS	Small	11	12	12	1	0	0	6	5	3	6	7	4	2	2	0
EEAST	Medium	6	8	12	1	1	0	0	0	2	3	4	8	1	0	0
WMAS	Medium	2	9	6	0	2	1	0	3	2	1	3	6	0	0	0
SWAST	Small	3	3	4	2	0	0	0	0	0	3	1	4	0	0	0
SCAS	Small	0	3	1	0	1	0	0	0	0	0	1	0	0	2	1
NEAS	Small	2	2	0	0	1	0	0	0	0	0	2	0	0	0	0

*Trust Size:
Small (up to 5,000 staff)
Medium (between 5,000 and 10,000 staff)

REPORT

AGENDA ITEM: 24

Board of Directors	
Date:	24 April 2019
Subject:	Integrated Performance Report
Presented by:	Director of Quality, Improvement & Innovation
Purpose of Paper:	For Assurance
Executive Summary:	The Integrated Performance Report for April 2019 shows performance on Quality, Effectiveness, Finance, Operational Performance and Organisational Health during March 2019. The highlights from this report are as follows; **Quality** • **Complaints:** For Quarter 3, NWAS reported a rate of 0.083% - a mid-pack rank position compared with other ambulance trusts (NEAS at 0.099% (highest) and SCAS at 0.051% (lowest)). • **Incidents:** A continued focus on prompt review of incidents has resulted in 86 unscored incidents reported in March (8.7% of reported) significantly below the 18/19 trajectory (150). • **Serious Incidents:** Three new serious incidents were reported (compared with 8 in the previous year 03/18) and eleven serious incident reports were submitted to commissioners 69% of the improvement trajectory. Two SI's are associated with delayed response. • **Safety Alerts:** There have been no new Health & Safety alerts during March. Lifepak 15 alert: software upgrade has been successful and the rectification programme is drawing to a close; completion - 3rd May 2019 **Effectiveness** • **Patient Experience** (FFT) recommendation rates remain high in PTS and 111 at 95.5% and 92.4% respectively. The PES survey return rate remains low with 28 responses in March 19. Of those surveys returned, 64.3% would recommend the service. • **ACQI's:** The Trust has experienced stable performance in all ACQI measures, no special cause variation has been observed on statistical process

control charts. Fluctuations continue in rank position month to month in line with predicted normal variation. Focus continues on call to door time.

- **Hear & Treat** performance was 7.4% in March and 6.3% for the 2018/19 year overall matching the target.
- **See & Treat** performance was to 26.2% in March and 25.1% for the 2018/19 year overall achieving above the 24.3% target.
- **Variation:** Significant unexplained variation still exists between CCG's in both H&T and S&T.

Finance

- The 2018/19 end of year financial position for the Trust is a surplus of £2.513m. This is £0.675m better than planned.
- The overall forecast risk rating for the Trust is a 1.

Operational Performance

- **Call Pick Up** performance for March achieved 83.4% and the lowest mean call answer time (7 seconds) since ARP was introduced in August 2017.
- **Hospital Turnaround** Time in March saw the best performance across 2018/19 with an average of 31 minutes and 47 seconds.
- **Ambulance Response Programme**: maintenance of position in ARP standards within control limits and an improved national rank position.

	C1	C1 90th	C2	C2 90th	C3	C3 90th	C4 90th
Target (mins)	7	15	18	40	60	120	180
Actual	7:27	12.37	22.27	43.12	61	146	181
Rank	7/10	6/10	6/10	6/10	5/10	5/10	5/10

- **111** performance in March has shown its strongest position since August 2017 and NWAS is now in the top third of providers for calls answered in 60 seconds and clinician call back times (ranked 6th nationally).
- **PTS** activity during March 2019 was 2% (2,836 journeys) below contract baselines.

Organisational Health

- Sickness absence rates for February 2019 were 6.5%, where a previous 7 month upward trend has now plateaued.
- Turnover for March is at 8.6% which is the lowest in the latest 12 month period.
- Proportion of agency cost to total staff cost is at its

	lowest over the latest 12 month period at 0.61%. • Vacancy Gap position in March is now 0.33% overstaffed. • Appraisal compliance is at 83% for March against a target of 95%. • PES appraisal compliance has shown significant improvement in recent months, with EOC, 111 and PTS remaining below target. • For 2019, the Trust has moved to competency based compliance reporting for Mandatory Training. The overall position at the end of March 2019 is 55% compliance against a target of 45%. • Corporate, 111 and EOC remain behind compliance targets.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: 1. Note the content of the report 2. Clarify any items for further scrutiny through the assurance committees

Link to Strategic Goals:				
	Right Care	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☒	☒	☒	☒	☐	☒	☒	☒

Are there any Equality Related Impacts:	**None**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

The purpose of this report is to provide the Board of Directors with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of March 2019. The report shows the historical and current performance on quality, effectiveness, finance, operational performance and organisational health. Where possible it includes agreed regulatory and practice standards. It also includes information about the performance of peers to address three important assurance questions:

- How are we performing over time? (as a continuously improving organisation)
- How are we performing with respect on strategic goals?
- How are we performing compared with our peers and the national comparators?

2. INTEGRATED PERFORMANCE SUMMARY

2.1 Quality

Q1 – Complaints

During March 2019, 241 complaints were received at a rate of 40 complaints per 1000 WTE staff. More complaints were closed than opened and the trajectory to close 60 complaints per week to aid the recovery of the backlog position has been met. The timescales for complaint closures met the standards contained within the Right Care Strategy. The combination of the centralised EOC team, changes to PTS case handling, robust initial case assessment and actions, focussing on early conversations with complainants and the continued work of 111 has led to improvements in the closure rate within timescales, particularly for lower risk complaints; this is expected to continue through April. Higher risk complaints remain more challenging though there has been a marked improvement in the approvals process; this remains an area of focus jointly between the complaints team and operational colleagues.

The National Ambulance Patient Experience Group currently collates PES complaint figures in comparison to activity levels. For Quarter 3, NWAS reported a rate of 0.083%. This compares to NEAS at 0.099% (highest) and SCAS at 0.051% (lowest). Year-end figures are currently being collated.

Q2 – Incidents

989 internal and external incidents were opened in March 2019 at a rate of 166 incidents per 1000 WTE staff. Included in this total are 86 'unscored' internal incidents, which account for 8.7% of incidents opened that month, meaning that the 18/19 target of 150 unscored has been surpassed. In total 1109 incidents (level 1-5) were closed during March, with 72.7% closed within SLA timescales, meeting the required 18/19 standard (70%). Work is continuing to reduce the numbers of unscored incidents. The Clinical Safety Team are attending the Area Learning Forums to feedback and resolve any specific issues with risk scoring.

Q3 - Serious Incidents (SIs)

Three Serious Incidents were reported in March 2019 and eleven reports were submitted to Commissioners against a trajectory of sixteen. The backlog of approvals required from senior managers was cleared in March. Investigators do find the requirements of completing investigations a challenge amongst other demands. Achieving the submission trajectory for April will continue to require focused support, particularly from Service Delivery.

Q5 - Safety Alerts and Health and Safety

There have been no new alerts in March 2019. The total number of CAS/NHS Improvement alerts received between April 2018 and March 2019 was 35, with 6 alerts applicable. There has been 48

MHRA Alerts have been received in the same time period with 1 alert applicable, 25 MHRA Medicine alerts with 0 alerts applicable and 1 IPC alerts remains applicable and on the National Ambulance Resilience Unit agenda. The actions to close the alert regarding the Lifepak 15s will be completed on 3rd May 2019.

2.2 Effectiveness

E1 - Patient Experience

The PES survey return rate remains low with 28 responses in March 19. Of those surveys returned 64.3% of patients would recommend the service. There were 6 responses with comments explaining the low recommendation score and these referred to delays or arrangements for alternative transportation (i.e. taxi). The proposals to amend ambulance services FFT has been presented to the National Ambulance Commissioners Network by NHS England, which suggests a series of patient experience projects across the country replacing See and Treat FFT. PTS and 111 patient levels of satisfaction remain consistent; with 95.5% and 92.4% of responding patients recommending the service, respectively. There are no plans to change the 111 and PTS FFT surveys.

E2 – ACQIS

The rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest moved back towards the average performance for both the Utstein and overall groups. The Trust's national rank rose to 1st nationally for the overall group and 4th for the Utstein sub-group. However, these rates did not translate to increases in survival to discharge, with both overall and Utstein rates below the national means for the month at 6.3% and 14.9% respectively. For patients experiencing an acute stroke, the mean call to door was 1 hour 13 minutes. This ranked the Trust in 5th position nationally and moved in line with the national mean.

E3 - HT, ST & SC Outcomes

Performance has been maintained, achieving 7.4% hear and treat and 26.2% for March 2019. For the 2018/19 year NWAS achieved 6.3% hear and treat (in line with 6.3% target) and 25.1% see and treat (above 24.3% target). MTS and frailty training for paramedics has now been completed, with 98% now trained in its application to aid identifying those patients that could be supported away from ED if there are local services available. The feedback from staff receiving this training has been overwhelmingly positive. New staff in the clinical hub are now all fully trained and embedded in the role and on 5th March 2019, a 90 day Greater Manchester Extended APAS trial commenced. This originally started with reduced hours (0800-2300) but is now operating 24/7.

2.3 Finance

F1 – Finance

The 2018/19 end of year financial position for the Trust is a surplus of £2.513m. This is £0.675m better than the planned surplus of £1.838m. The trust will receive a further Provider Sustainability Funding (PSF) payment of £0.675m for finance performance incentive, taking the overall financial surplus to £3.188m. The overall forecast risk rating for the Trust is a 1.

2.4 Operational

PES Activity

PES activity in March 2019 saw 125,183 contacts (emergency and urgent calls answered and 111 direct pass throughs). Calls answered in isolation were 100,378. During March 19, 98,958 incidents occurred, 0.31% above plan and across the 2018/19 year there were 1,131,556 incidents at -1.03% below plan.

OP1 – Call Pick Up
For March 2019, call pick up performance was at 83.4%. March has seen strong performance on a number of measures, including the lowest mean call answer time (7 seconds) since ARP was introduced and the highest percentage of calls answered in 5 seconds, again since ARP implementation. This improvement is a reflection of the long term improvements made over the last twelve months, such as reduction in call length and improvements in availability on line. The improvements during March 19 can also be attributed to the daily focus on aligning overtime to key areas of staffing shortfalls.

OP2 – Hospital Turnaround
There were 59,493 hospital attendances during March 2019 with an average turnaround of 31 minutes 47 seconds, which is the best performance across the 2018/19 year. There has been a further improvement in the average arrival to notification time, however further work is required to achieve overall average of 30 minutes and less. On the 1st April the Trust hosted an 'Every Minute Matters Summit' which was attended by all stakeholders including CEOs from Acutes across the region. The event was an opportunity to present progress made through the quality improvement programme and discuss its next steps to ensure further improvement is made across all Acutes in the North West.

OP3 – ARP Standards
Overall NWAS has managed to maintain performance within its control limits during March 2019 and has improved its position nationally across all its performance targets. NWAS has been commended for its role in the national Inter Facility Transfer and Health Care Professional pilot, which will now be rolled out nationally. Work continues on the regional roster review with all NWAS Trade Unions engaged, with plans in place to re-align resources better to demand and realise the full potential of the increased resources.

OP4 – 111
March proved the best performance in 111 since August 2017 following the implementation of the performance improvement plan. Call pick up performance is on the upper control limit in Figure O4.1 and achieved 86.5% in March 2019 with the average call answer time at 39 seconds. With improvement in calls answered we see a corresponding improvement in abandoned calls, which is now aligned to the national average at 2.6%. Time taken for a clinician call back is now well above the national average at 53.2% within 10 minutes and a reduced average call back time of 27 minutes 34 seconds. This has been achieved through the implementation of Early Transfer to Out of Hours providers, resulting in increased clinician availability to make the patient call backs. When viewed nationally in tables O4.2-O4.3 NWAS are now in the top third of 111 providers across the country

OP5 – PTS Activity
Overall activity during March 2019 was 2% (2,836 journeys) below contract baselines mainly due to Lancashire being 9% (4,553 journeys) below baseline. For the year to date position (July 2018 – March 2019) PTS is performing at 1% (11,441 journeys) below baseline. In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 21% (7,587 journeys) and 7% (1,216 journeys) above baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges in achieving contract KPI performance. Aborted activity for planned patients averages 7% for the period July 2018 - March 2019.

2.5 Workforce

OH1 – Sickness
The overall sickness absence rates for February 2019 were 6.5%, which following a 7 month upward trend has now plateaued. 111 sickness is currently at 5.6% with this area of work will remaining a

priority to improve the attendance levels and stabilise the position. Additional HR resource will be allocated to 111 from mid-May and a targeted plan now being implemented. EOC sickness rates have increased again during February at 7.8% and a high level review is now taking place monthly by the Deputy Director of Operations and HR. PTS has 6.3% sickness with a targeted plan to improve attendance in PTS now being implemented.

OP2 – Turnover
Turnover for March 2019 is at 8.6% which is at its lowest in the last twelve months. Teams are in place with a specific focus on areas of high turnover in 111 and EOC at 22.9% and 11.4% respectively. For 111, the focus will be on retention in 111 to further reduce turnover and stabilise the position. Within EOC further recruitment is taking place and developments are underway to introduce Apprenticeships in the Autumn in order to improve retention.

OP4 – Temporary Staffing
Proportion of agency cost to total staff cost has reduced for the 3rd month in a row, sitting at the lowest proportion over the last 12 month period at 0.61%. Over the last 12 months, the Trust has been proactive in reducing Agency usage. In particular, 111 has seen a great improvement with ongoing recruitment to move staff onto permanent contracts.

OP5 – Vacancy Gap
The NWAS vacancy position is now 0.33% overstaffed for March 2019. EOCs are 5.4% overstaffed. For both PES and EOC the contract settlement will lead to increased establishments and NWAS has also had confirmation that the current Health Professional Calls/Inter Facility Transfer pilot will be rolled out across all Ambulances Services allowing the Band 2 roles to be baselined as part of the EOC establishment. PTS has maintained the improved position at -8.1% and new starters are planned in PTS over the coming months to further reduce the vacancy gap. 111 have seen further reductions in the vacancy position and the March 2019 figure is now 1.6% over establishment. The focus for 111 is now on the retention of staff and continuing to improve the clinical advisor vacancy position

OP6 – Appraisals
Appraisal compliance is at 83% for March 2019 against a target of 95%. PES has shown significant improvement in the last four months with current compliance at 87.95% for March 2019. The other service lines, EOC, 111 and PTS remain below target with EOC at 73.74% and 111 at 74.7%. PTS have seen a significant reduction with current compliance being at 68.32%. This drop for PTS relates to the Arriva Transport TUPE transfers where there were no appraisals in place prior to transfer resulting in large numbers of staff having an appraisal at the same time and then going out of date at the same time. This has been exacerbated by delays in reporting. There is an action plan in place to stagger this over the coming months to avoid the sharp drop off again.

OP7– Mandatory Training
Classroom training attendance for PTS is ahead of trajectory at 44% with PES reporting slightly under at 26% against a trajectory of 30% by March 2019. For 2019 we have moved to competency based compliance reporting for Mandatory Training. Each element of mandatory training is set as a competence allowing reporting of all completions which are in date. The overall Trust position at the end of March 2019 is 55% compliance against a target of 45%. Corporate, 111 and EOC remain behind target and OD is working with these service lines to ensure targets are achieved and maintained.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

3.1 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.

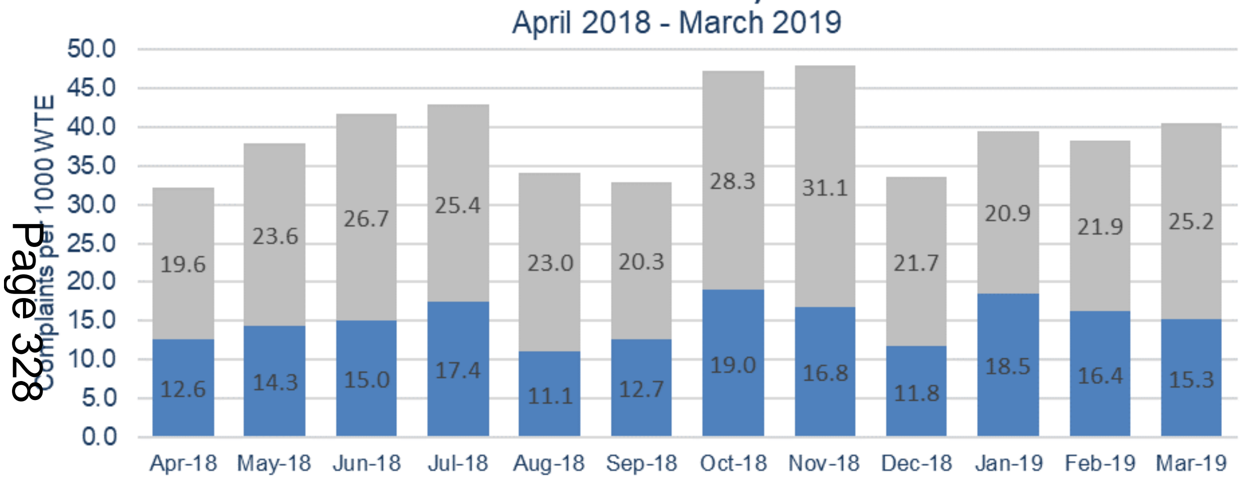
4. RECOMMENDATIONS

4.1 The Board of Directors is asked to:

1. Note the content of the report
2. Clarify any items for further scrutiny through the assurance committees

Q1 COMPLAINTS

Figure Q1.1



Annual Average:
227 per month
39 per 1000 staff

Table Q1.1: Complaints Opened by Month

Severity	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct- 18	Nov-18	Dec- 18	Jan- 19	Feb- 19	Mar- 19
1. Minimum	23	35	38	35	28	36	56	45	39	27	21	26
2. Minor	131	154	176	175	139	122	165	184	122	161	161	175
3 Moderate	16	14	14	19	18	23	34	34	28	32	30	19
4 Major	5	11	7	10	6	7	9	14	6	7	8	8
5 Serious	9	3	4	7	5	2	10	3	1	5	7	3
Total	**184**	**217**	**239**	**246**	**196**	**190**	**274**	**280**	**196**	**232**	**227**	**241**
Compliments	165	180	121	114	190	124	144	121	103	102	106	122

Complaints & Compliments

In March 2019, 241 complaints were received, (average is 227 per month) which remains within the expected control limits, as displayed in Figures Q1.2 and Q1.3.

This is equivalent to 40 complaints per 1000 WTE staff.

In addition, 122 compliments were received, which is equivalent to 20 compliments per 1000 WTE staff.

Improvement Goals:

In line with the Right Care Strategy, the improvement goals are to:-

1. Reduce the number of complaints per 1000 WTC staff. This baseline is set at 39 and the expected reduction will be to 35 by the end of quarter 4.
2. Increase the % of complaints with severity of 1-2 closed within 24 hours. This will necessitate change in how complaints are recorded and reported.
3. Increase closure within timeframes in line with the Right Care Strategy by end March 2020 to:

Risk score 1-3	65%
Risk score 4-5	40%

Figure Q1.2

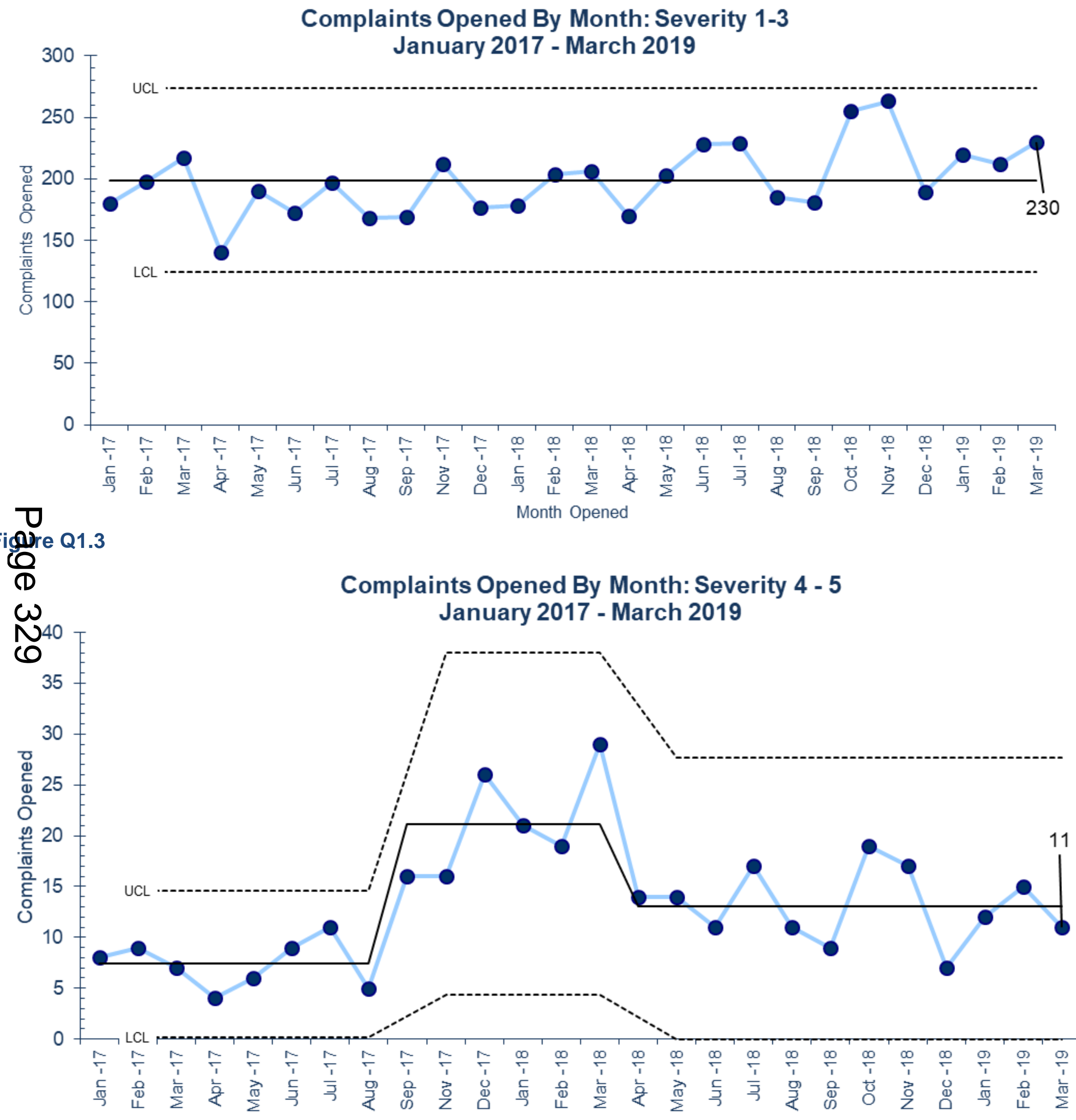


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Figure Q1.3

Figure Q1.4

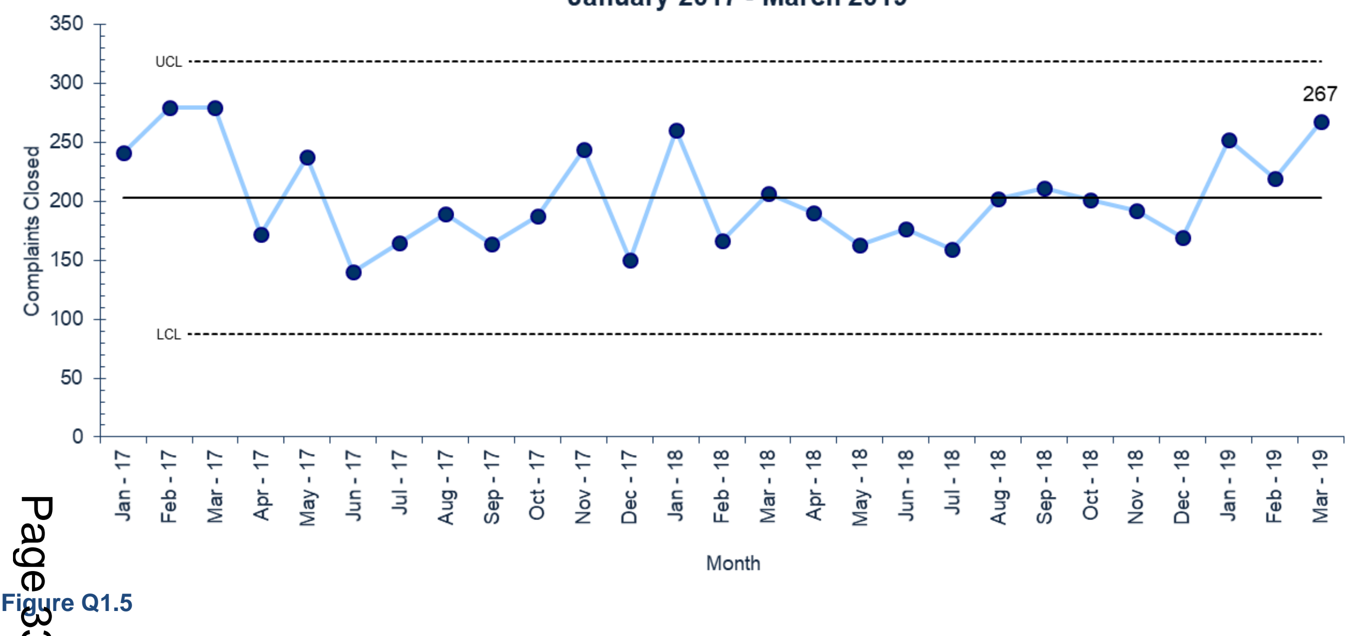
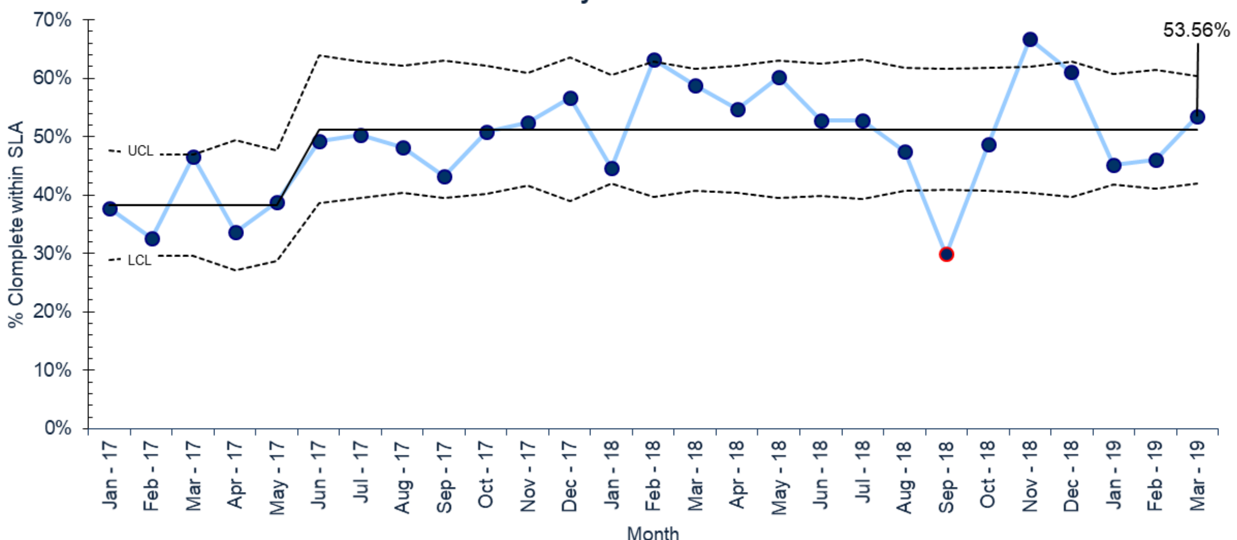


Figure Q1.5



Complaints Closure

A total of 273 complaints were closed in March 2019. (267 with a risk score of 1-3 and 6 with a risk score of 4-5). 54% of level 1-3 and 17% of level 4-5 complaints were closed within the agreed standard.

The trajectory to close 60 complaints per week to aid the recovery of the backlog position has been met. The combination of the centralised EOC team, changes to PTS case handling, robust initial case assessment and actions, focussing on early conversations with complainants and the continued work of 111 has led to improvements in the closure rate within timescales, particularly for lower risk complaints; this is expected to continue through April.

Higher risk complaints remain more challenging though there has been a marked improvement in the approvals process. This remains an area of focus jointly between the complaints team and operational colleagues.

The National Ambulance Patient Experience Group currently collates PES complaint figures in comparison to activity levels. For Quarter 3, NWAS reported a rate of 0.083%. This compares to NEAS at 0.099% (highest) and SCAS at 0.051% (lowest). Year-end figures are currently being collated.

Assurance

- Monitored by Quality Committee.
- Deviations from plan escalated to board via the Quality Committee Chair.
- BAF SR01 (risk id 2829)

Figure Q1.6

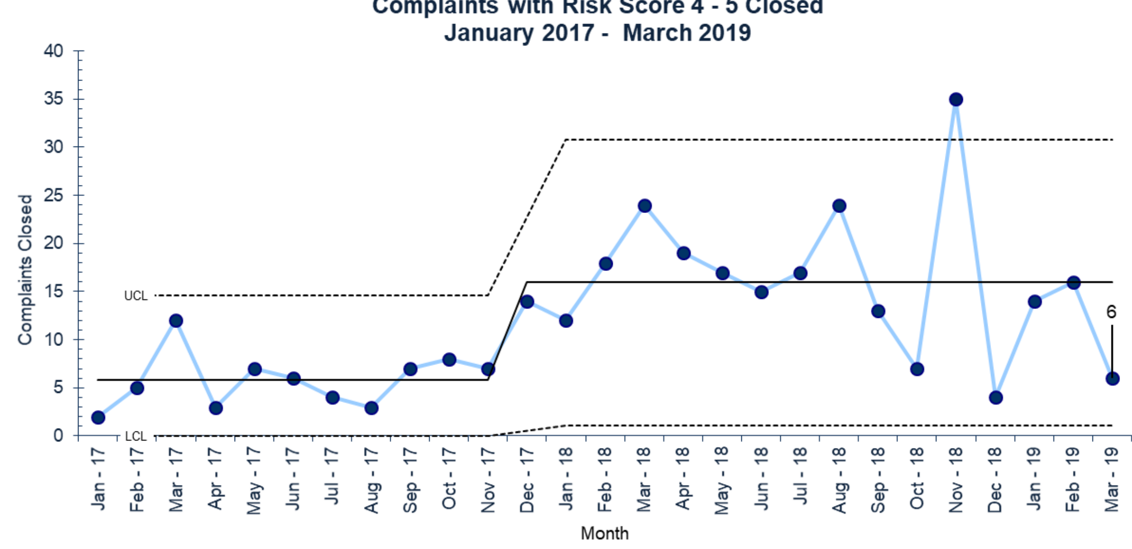
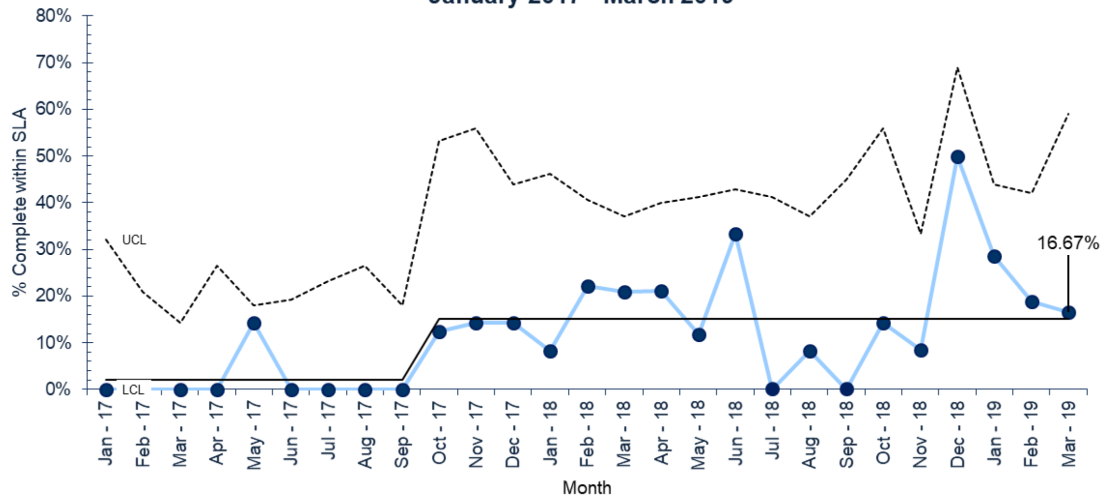


Figure Q1.7



SLAs are calculated using the following measures/targets. No exceptions are taken into account:

Risk Score	Target Days to Close Incident (From Date Received)
1	20
2	20
3	40
4	60
5	60

Q2 INCIDENTS

Figure Q2.1

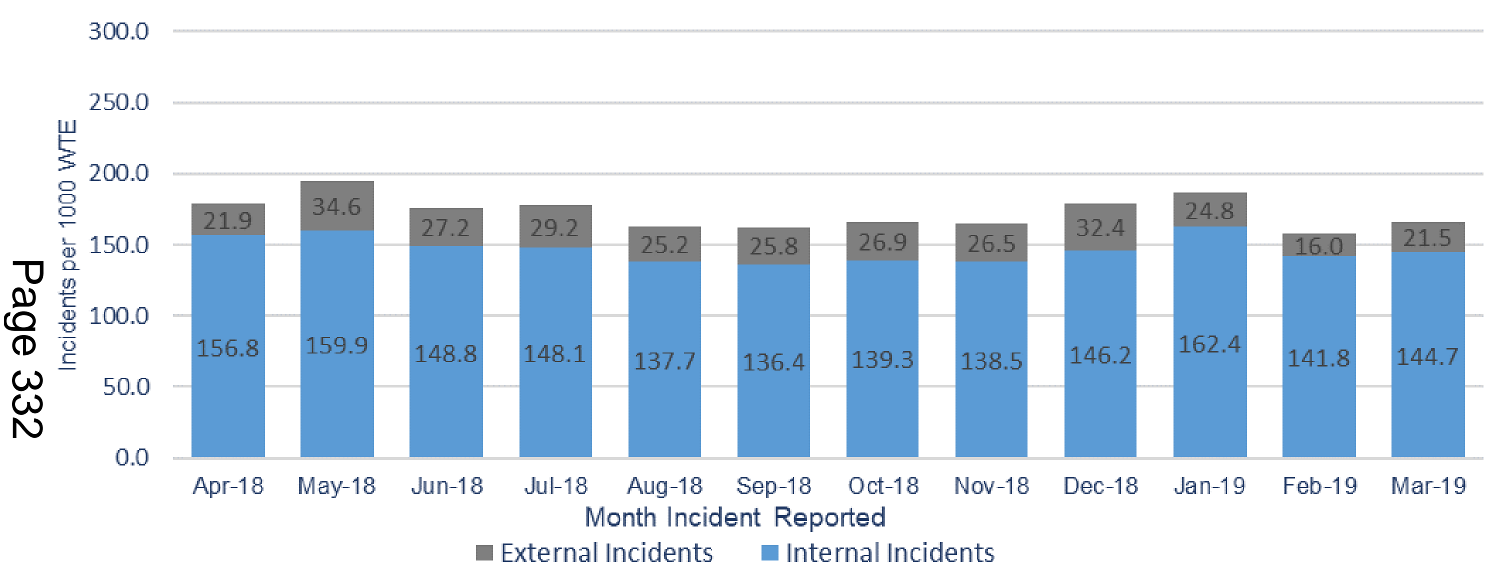


Table Q2.1

Severity	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
1. Insignificant	225	216	182	204	182	199	207	225	194	174	188	172
2. Minor	608	687	620	623	571	563	544	517	616	655	534	551
3 Moderate	174	185	179	165	159	145	172	187	191	219	177	168
4 Major	6	5	10	6	9	7	13	13	15	9	6	12
5. Catastrophic	1	2	3	3	4	2	3	0	2	3	3	0
Unscored	6	18	13	18	11	20	25	23	26	42	28	86
Total	1020	1113	1007	1019	936	936	964	965	1044	1102	936	989
Unscored %	0.6%	1.6%	1.3%	1.8%	1.2%	2.1%	2.6%	2.4%	2.5%	3.8%	3.0%	8.7%

Incidents

989 internal and external incidents were opened in March 2019 at a rate of 166 incidents per 1000 WTE staff, which remains within existing control limits.

Included in this total are 86 'unscored' internal incidents, which accounts for 8.7% of the total number of incidents opened this month.

Work is continuing to reduce the numbers of non-scored incidents and the Clinical Safety Team are following up any unscored incidents they review with the incident reporters. The Clinical Safety Team are attending the Area Learning Forums to feedback and resolve any specific issues with non-risk scoring. Reducing the total number of non-risk scored incidents is a challenge but working collaboratively with the clinical area teams will improve performance.

Figure Q2.2

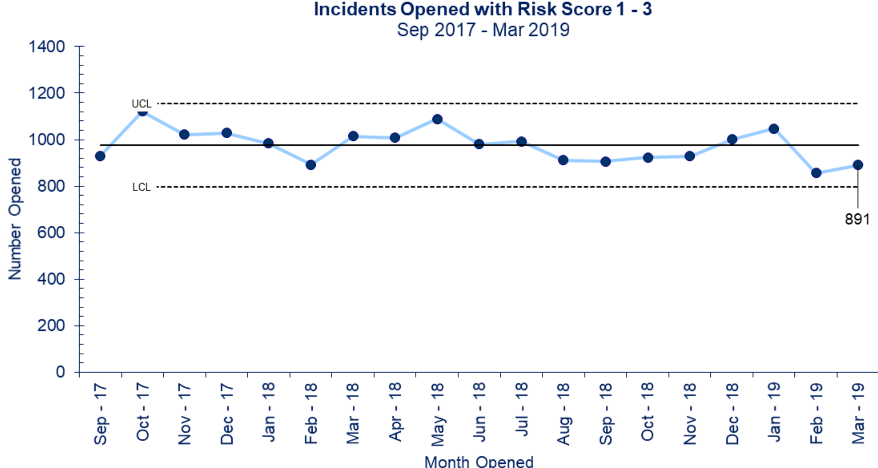


Figure Q2.3

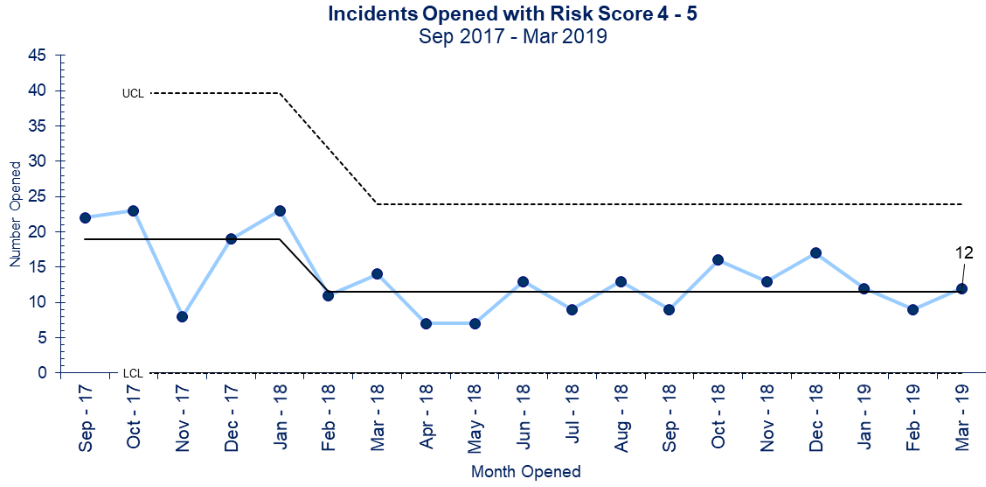


Figure Q2.4

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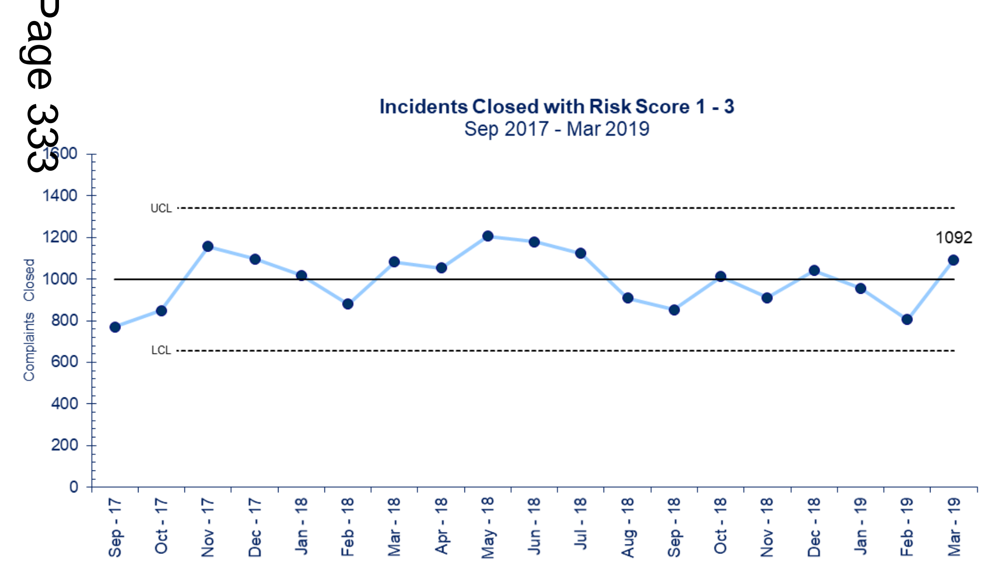
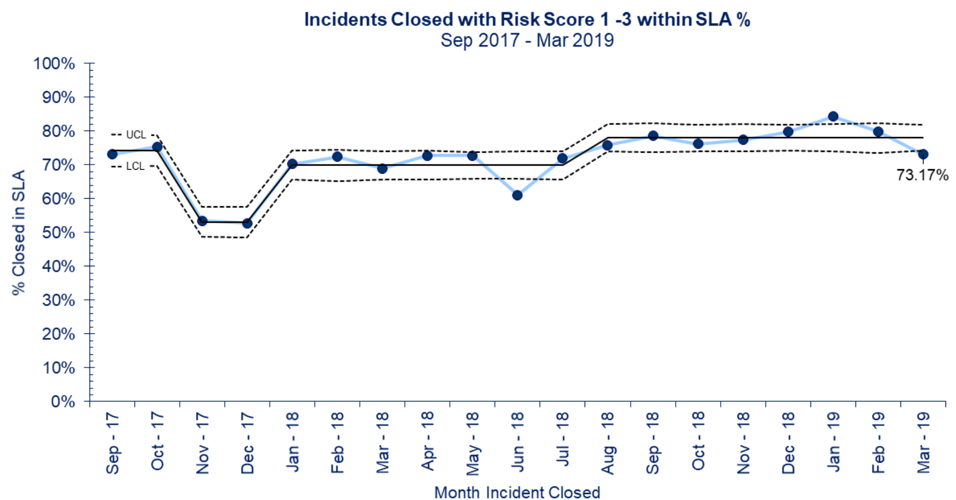
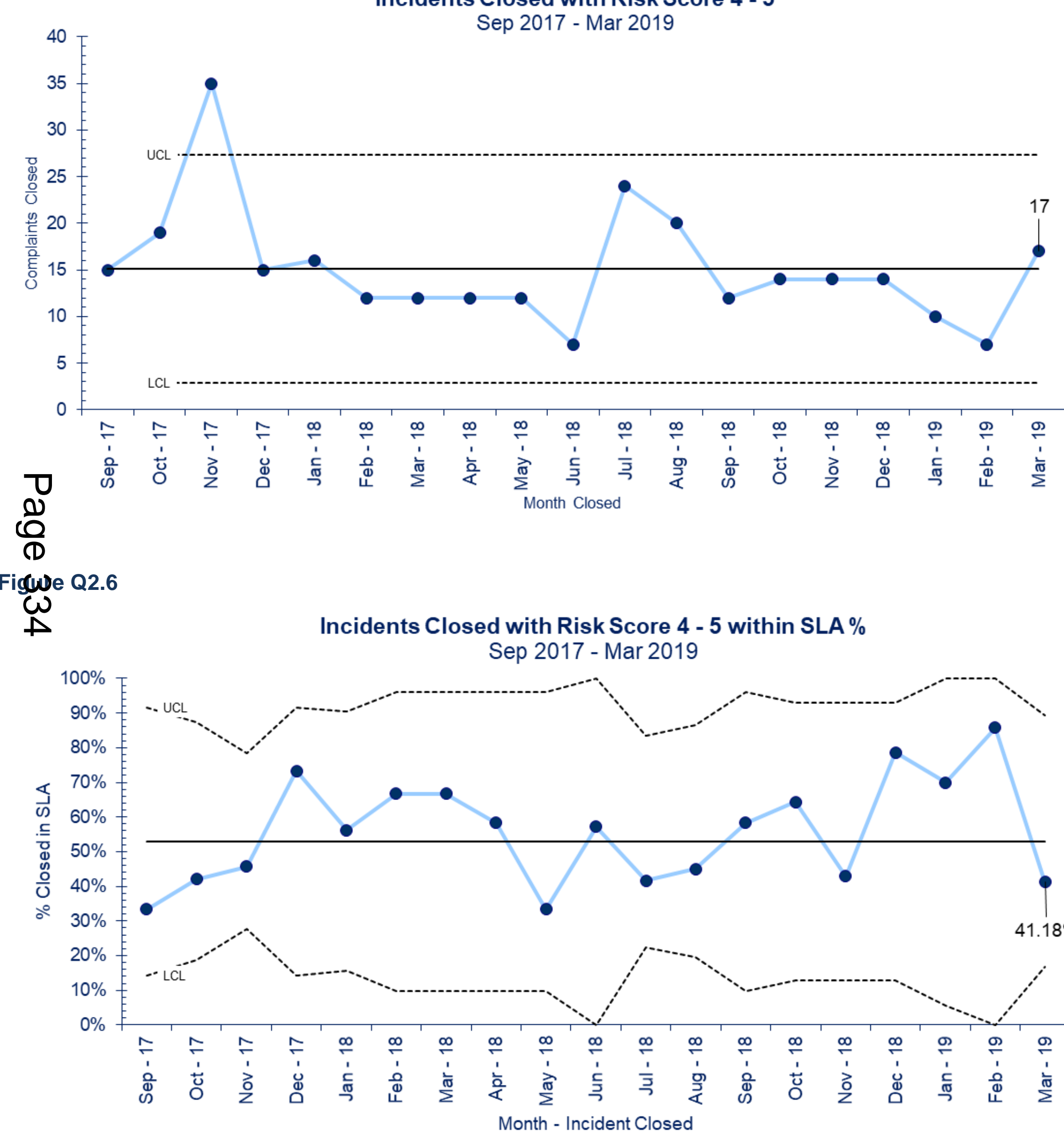


Figure Q2.5





Incidents Closure

In total, 1109 incidents (level 1-5) were closed during March 2019. Of these, 73% of level 1-3 and 41% of level 4 & 5 were closed within the agreed standard.

The Clinical Safety Team are reviewing all outstanding high level concise investigations on a weekly basis. As soon as the investigations are complete, responses are prepared for sign off and incidents are closed. As more and more staff within the Trust undertake the incident investigation training, it is expected that more incidents will be closed within the SLA target time.

Improvement Goals:

In line with the Right Care Strategy, the improvement goals are to:-

1. Reduce reported unscored incidents in the board IPR to zero
2. Increase closure within timeframes in line with the Right Care Strategy by end March 2020 to:
   - Risk score 1-3 80%
   - Risk score 4-5 60%

Assurance

- Monitored by Quality Committee.
- Deviations from plan escalated to board via the Quality Committee Chair.
- BAF SR01 (risk id 2869)

SLAs are calculated using the following measures/targets:

Risk Score	Target Days
1	20
2	20
3	40
4	60
5	60

Q3 SERIOUS INCIDENTS

Figure Q3.1:

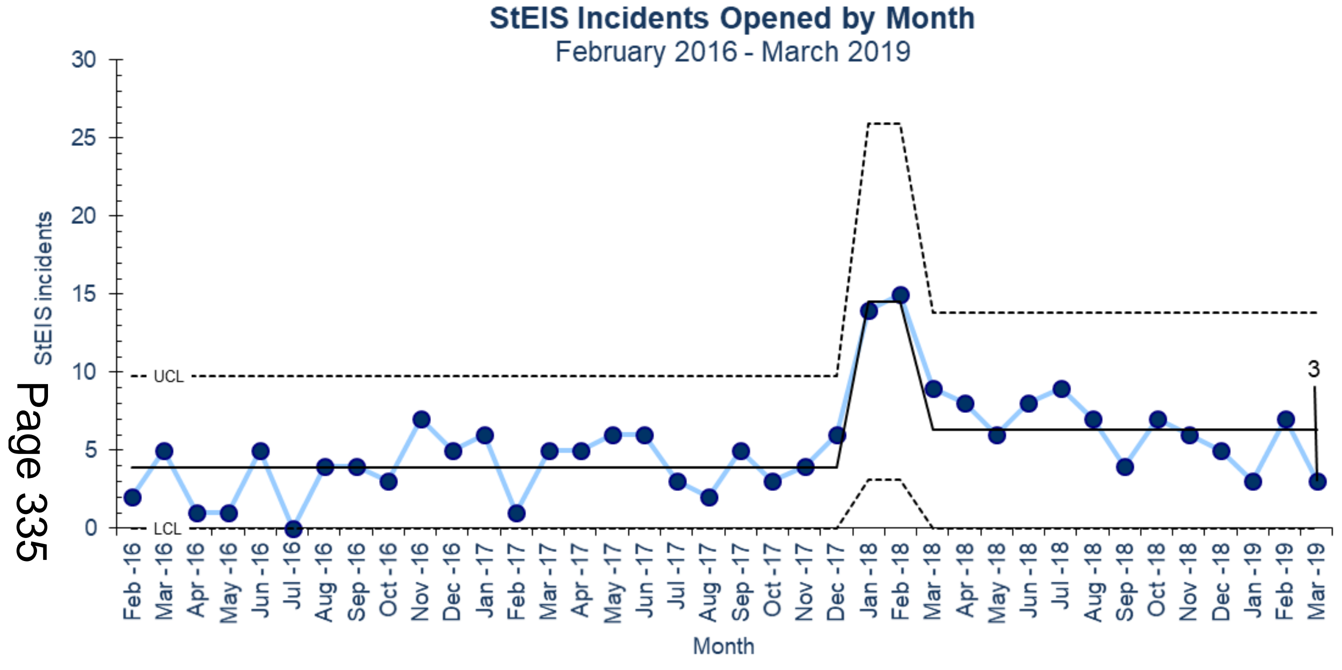


Table Q3.1: StEIS Incidents Opened in March 2019 by Source

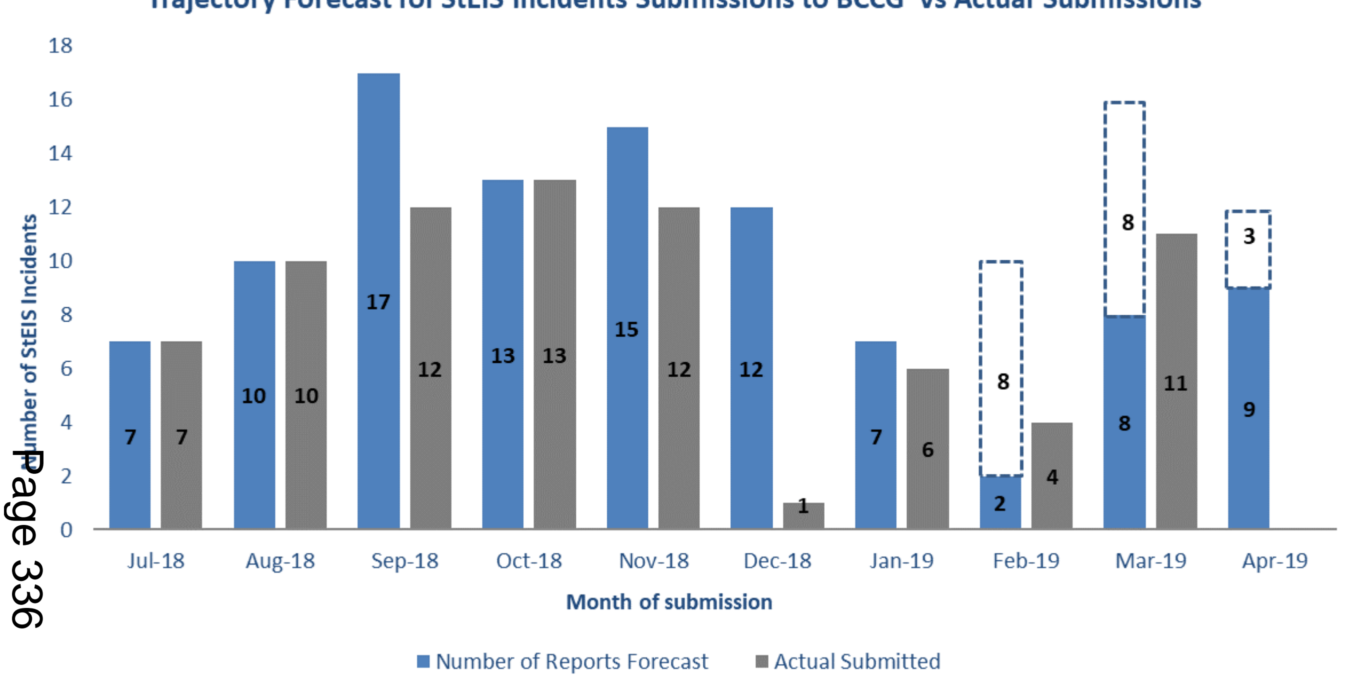
Source	Paramedic Emergency Services Operations	Emergency Operations Centre	Total
Complaint/StEIS	0	1	**1**
IRF/StEIS	1	1	**2**
Total	**1**	**2**	**3**

Serious Incidents

3 Serious Incidents (SIs) were reported in March 2019 and 11 reports were submitted to our Commissioners for closure, against our trajectory of 16.

Two reports arose from delays to emergency calls and one from staff conduct.

Figure Q3.2: Current trajectory of StEIS submissions to BCCG per month vs actual submissions in the month.



Serious Incident Trajectory

The layout of the report submission trajectory now identifies those reports due within 60 days (solid colour) and those over 60 days (dotted line).

The trajectory for the submission of SI reports remains a significant challenge and requires focused support, particularly from Service Delivery colleagues, to meet this requirement.

Investigators do find the requirements of completing investigations a challenge amongst other demands. They and their line managers are required to provide an update on the status of their investigations.

The backlog of approvals required from senior managers was cleared in March. There are currently 12 reports over the 60 day deadline.

Standards for adherence to reporting timescales and application of Duty of Candour remain in place.

In line with the Right Care Strategy, the improvement goals are to:-

1. Increase the proportion of cases where the notify-to-confirm interval is within the agreed timeframes – this is being achieved.
2. Increase the proportion of cases where the confirmation to report interval is within the agreed 60 day timeframe

Assurance

- Monitored by Quality Committee.
- Deviations from plan escalated to board via the Quality Committee Chair.
- BAF SR01 (risk id 2868)

Q5 SAFETY ALERT COMPLIANCE

Figure Q4.1:

Safety Alerts	Number of Alerts Received (Apr 18 – Mar 19)	Number of Alerts Applicable (Apr 18 – Mar 19)	Number of Open Alerts
CAS/ NHS Improvement	35	6	0
MHRA – Medical Equipment	48	1	0
MHRA - Medicine Alerts	25	0	0
IPC	2	1	0

CAS – Alerts Applicable

1. **Risk of harm from inappropriate placement of pulse oximeter probes**.
   Action: Clinical bulletin sent out by Chief Consultant Paramedic number CL648
   Action date: 08/01/2019, alert closed.

2. **Fire risk from personal rechargeable electronic devices**.
   Action: Health & Safety Bulletin sent out by Head of Safety & Patient Experience number HS033
   Action Date: 14/01/2019, alert closed.

3. **Integrated Plumbing System (IPS) Panels - risk of accidental detachment**.
   Action: Estates Managers carried out a full review of these panels and found none that fit the description of the alert.
   Action Date: 08/11/2018, alert closed.

4. **Andrews Water Heaters Direct Fired Domestic Hot Water Heaters.**
   Action: Estate department carried out a review of all water heater from this manufacture and found none to be defected and most were new ones.
   Action Date 08/11/2018, alert closed.

5. **UPDATE - Reporting of Defects and Failures and disseminating Estates and Facilities Alerts.**
   Action: This alert was for information only and was sent to the Estates department who acknowledge the alert and its contents.
   Action Date: 11/06/2018, alert closed.

NWAS Response

There have been no new alerts in March 2019.

The total number of CAS/NHS Improvement alerts received between April 2018 and March 2019 is 35, with 6 alerts applicable to NWAS.

In the same time period,

48 MHRA Medicine Equipment Alerts have been received with 1 alert applicable.

25 MHRA Medicine alerts have been received, with 0 alerts applicable and

1 IPC alert received in September 2018 remains applicable in relation to monkey pox. This remains on the agenda for the National Ambulance Resilience Unit (NARU) and the Lancashire Resilience Forum.

6. **Resources to support the safe adoption of the revised National Early Warning Score (NEWS2).**
   Action: An implementation plan was drafted for presentation to EMT/Board for support by Consultant Paramedic
   Action Date: 25/06/2018, alert closed.

MHRA Medical Equipment - Alerts Applicable

1. **Professional use monitor/defibrillator: LIFEPAK 15 at risk of device failure during patient treatment.**
   Action: Urgent Operation bulletin OI670 sent out and follow up bulletin OI671 by Director of Operations. The software upgrade has been successful and the rectification programme is drawing to a close; this should be completed by 3rd May 2019, depending on the release of vehicles in order to complete the work.
   Action date: 22/02/19

IPC - Alerts Applicable

1. **Monkeypox**
   Actions: NWAS working in collaboration with NHS England & Public Health England. Risk assessments completed on symptomatic patients or who have travelled areas affected or had contact with known infected patients within 21 days. Work is ongoing through NARU including the RAF taking the lead on air transfers for high consequence infectious disease transfers with HART support.
   Action date: Actions taken over a period of time, date of issue was 14th September 2018.
   Responsible Officer: Resilience Manager

E1 PATIENT EXPERIENCE

Figure E1.1

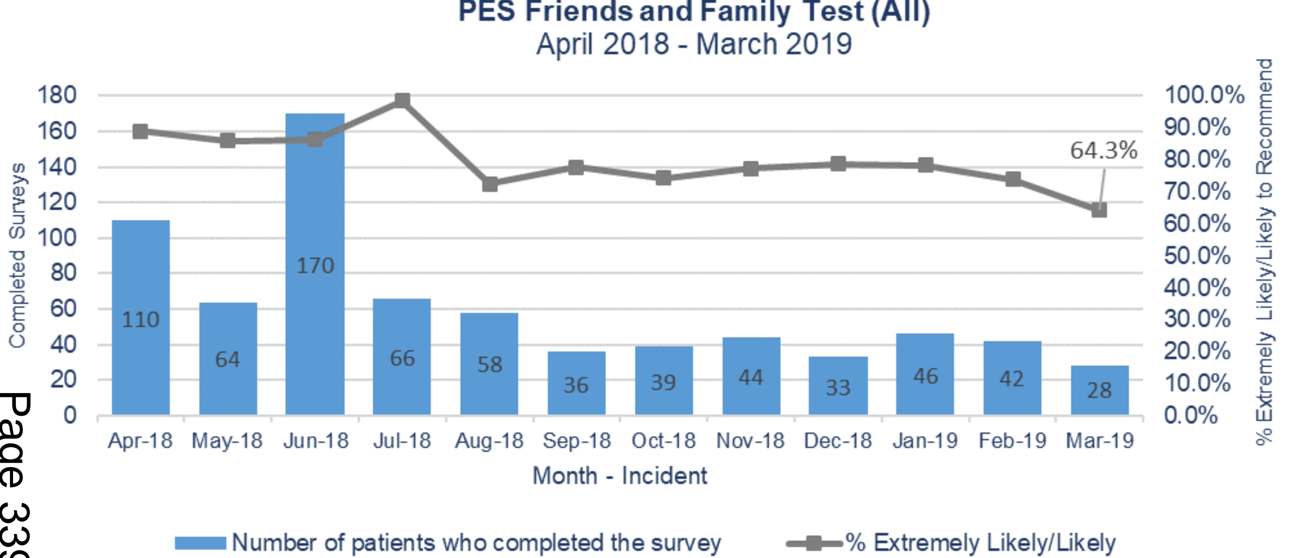


Table E1.1 National PES See and Treat FFT – February 2019

Organisation Name	Total Responses	Percentage Recommended	Percentage Not Recommended
England	**257**	**92%**	**6%**
WEST MIDLANDS AMBULANCE SERVICE	8	100%	0%
NORTH EAST AMBULANCE SERVICE	139	98%	1%
EAST OF ENGLAND AMBULANCE SERVICE	38	95%	0%
SOUTH WESTERN AMBULANCE SERVICE	8	88%	13%
SOUTH CENTRAL AMBULANCE SERVICE	20	85%	10%
NORTH WEST AMBULANCE SERVICE	42	74%	24%
ISLE OF WIGHT	0	NA	NA
LONDON AMBULANCE SERVICE	1	*	*
YORKSHIRE AMBULANCE SERVICE	1	*	*

Patient Experience (PES)

During March 2019, 483 patients responded to FFT surveys across all service lines, which is in line with previous reporting.

The return rate for surveys remains low, with a low recommendation rate. There were 6 responses with comments explaining the low recommendation score and these all referred to delays or dissatisfaction at alternative transport (i.e. taxi).

In line with the changes to support the delivery of the Right Care Strategy, the responsibility for patient experience has been transferred to the Communications team who will be reviewing how the Trust can improve both engagements and satisfaction rates.

The proposals to amend ambulance services FFT has been presented to the National Ambulance Commissioners Network (NACN) by NHSE. Commissioners were supportive of the suggestions to establish a series of patient experience projects across the country replacing See and Treat FFT. Trusts would share and learn from each other, supported by a joint national annual report showcasing work over time.

Arrangements for PTS and 111 would remain in place.

Figure E1.2

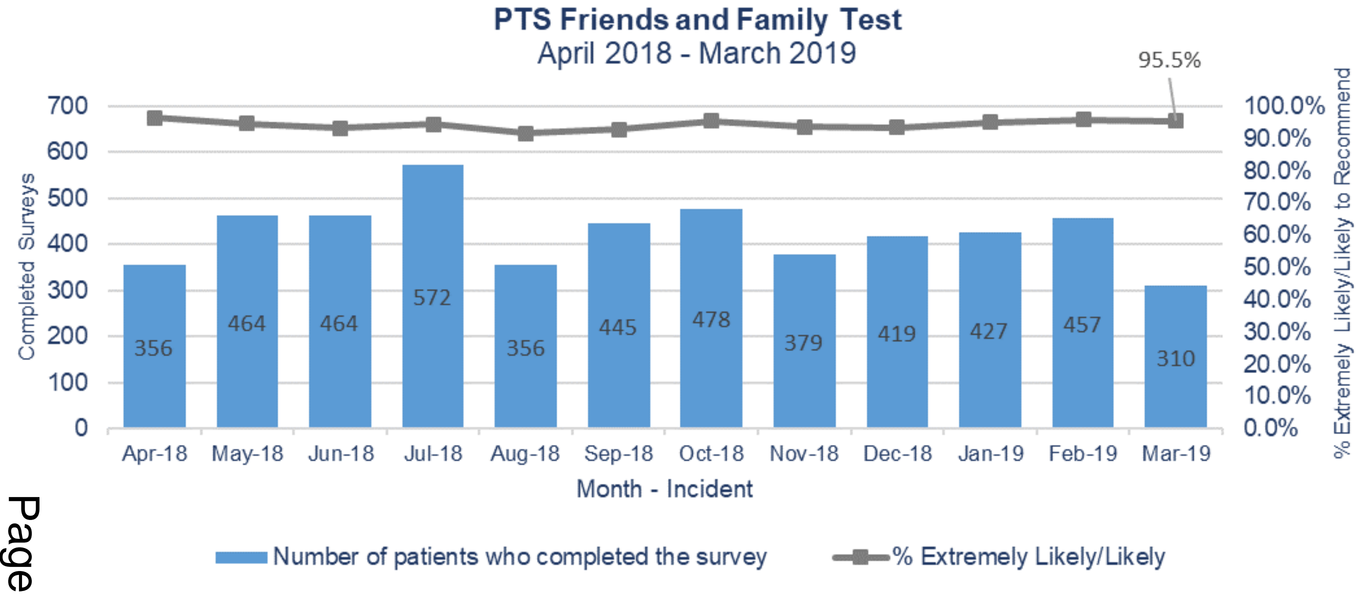


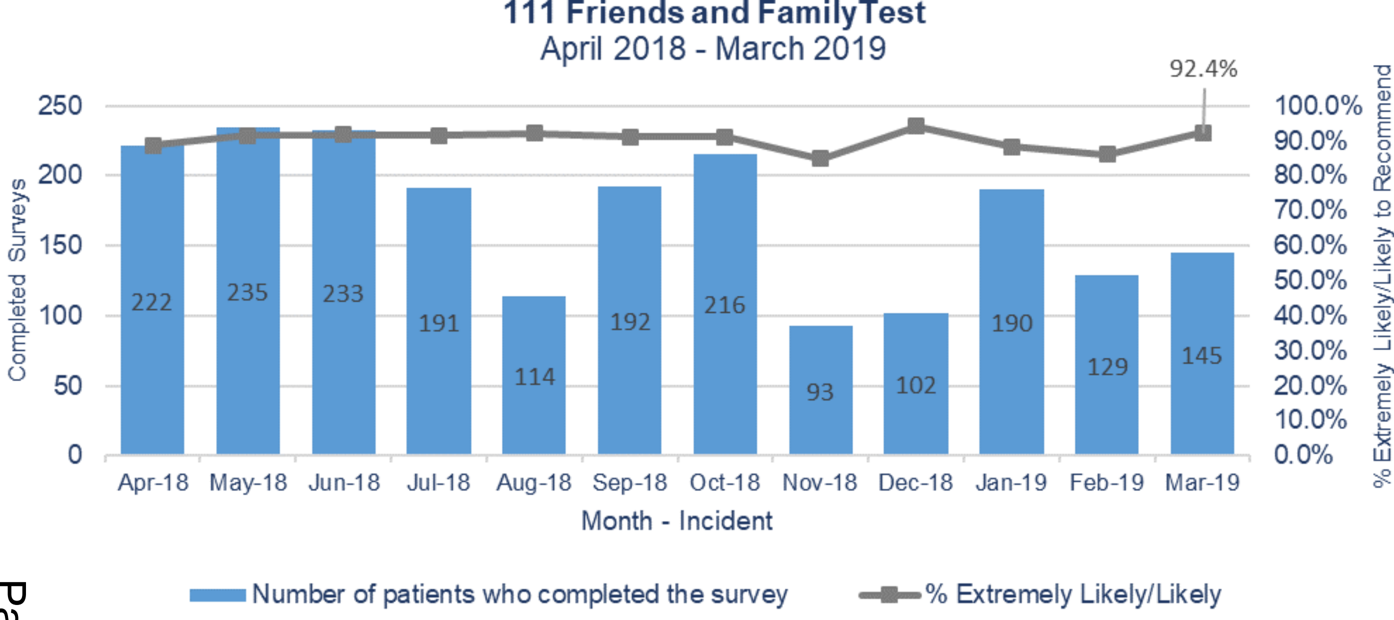
Table E1.2 National PTS FFT – February 2019

Organisation Name	Total Responses	Percentage Recommended	Percentage Not Recommended
England	**3,153**	**93%**	**3%**
NORTH EAST AMBULANCE SERVICE	68	100%	0%
ISLE OF WIGHT	33	100%	0%
NORTH WEST AMBULANCE SERVICE	499	95%	3%
GUY'S AND ST THOMAS'	972	95%	3%
IMPERIAL COLLEGE HEALTHCARE	317	93%	4%
UNIVERSITY COLLEGE LONDON HOSPITALS	185	92%	4%
EAST OF ENGLAND AMBULANCE SERVICE	141	91%	4%
ARRIVA TRANSPORT SOLUTIONS LIMITED	698	91%	4%
SOUTH CENTRAL AMBULANCE SERVICE	63	90%	8%
WEST MIDLANDS AMBULANCE SERVICE	177	89%	3%
YORKSHIRE AMBULANCE SERVICE	0	NA	NA

Patient Experience (PTS)

In line with previous reporting, PTS patients continue to record high levels of satisfaction with the service reporting 95.5% recommendation.

Figure E1.3



Patient Experience (111)

Following a dip in previous months, there was an increased reporting in satisfaction from 111 patients to 92.4%

Improvement Goal

1. 95% patients left at home (S&T) recommend our service to a family member or friend
2. Increase survey participation

Assurance

- Monitored by Quality Committee.
- BAF SR01

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Table E2.1: AQCI November 2018

ACQI Indicator		YTD Performance (%)	Sample Size (Current Month)	November 18 Performance (% / hrs: mins)	October 18 Performance (%)	November 18 Rank position	Rank movement	Performance Range % / hrs: mins (national mean*)
Cardiac Arrest ROSC	Overall	34.6%	337	36.5%	28.4%	1	↑	19.1-36.5 (28.5)
	Utstein	54.7%	54	53.7%	39.6%	4	↑	41.3-63.4 (51.3)
	Resus Care Bundle	76.3%	N/A	N/A	72.3%	N/A	N/A	N/A
Cardiac Arrest Survival to Discharge	Overall	9.4%	315	6.3%	7.9%	9	↑	5.8-16.1 (9.2)
	Utstein	27.3%	47	14.9%	22.9%	9	↔	14.3-37.5 (26.6)
Acute STEMI	PPCI (mean call to PPCI time)	N/A	91	2hrs 27 mins	2hrs 26 mins	10	↓	1hr 53mins - 2hr 27 mins (2hr 13 mins)
	Care Bundle	73.6%	N/A	N/A	75.8%	N/A	N/A	N/A
Stroke	Hyper acute (mean call to door time)	N/A	690	1hr 13mins	1hr 12 mins	5	↓	1hr 9mins - 1hr 30 mins (1hr 14 mins)
	Care Bundle	97.8%	697	98.6%	N/A	5	N/A	95.3-100 (98.4)
Sepsis	Care Bundle	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Management of falls	Care bundle	Data publication TBC						

ACQIs – November 2018

The rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest returned towards the average during November for both the Utstein and overall groups. These improvements saw the Trust's national rank rise to 1st nationally for the overall group and 4th for the Utstein sub-group.

These rates however did not translate to increases in survival to discharge for patients in the North West during November. This measure is reflective of the health system's performance and the declines experienced in the performance for the North West resulted in levels of survival to discharge below the national means for both groups for the month.

The Trust's performance in these areas continues to be closely monitored; the Trust's Resuscitation Group continues to monitor and proactively target all aspects of the delivery of high quality care to patients suffering an out of hospital cardiac arrest. Recommendations are reviewed by the senior clinical leadership team and actioned via the established structures within the Trust.

The mean call to door times for patients experiencing both an acute stroke and STEMI both increased by 1 minute each for November. The performance for acute stroke was marginally inside the national mean ranking the Trust 5th nationally. The performance for STEMI was 14 minutes outside of the national mean and ranked the Trust in 10th position for the month.

Care bundle data for STEMI was not published for November as is consistent with the NHSE reporting schedule. The acute stroke care bundle result placed the Trust in 5th position and ahead of the national mean for the month.

Cardiac Outcomes over time (SPC)

Figure E2.1

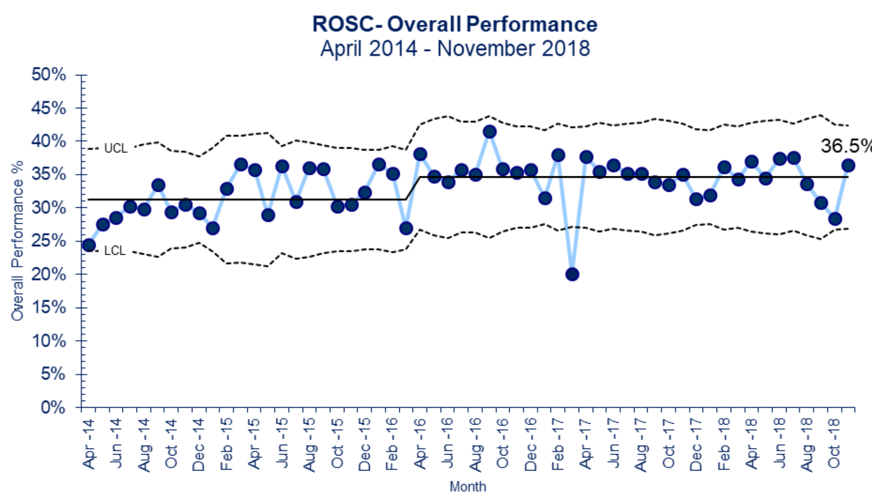


Figure E2.2

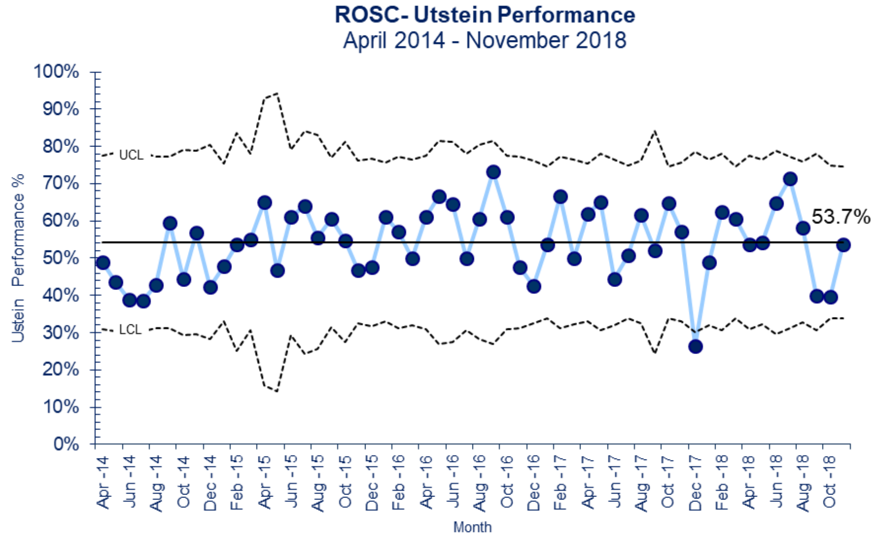


Figure E2.3

Survival to Discharge - Overall Performance
April 2014 - November 2018

Overall Performance %

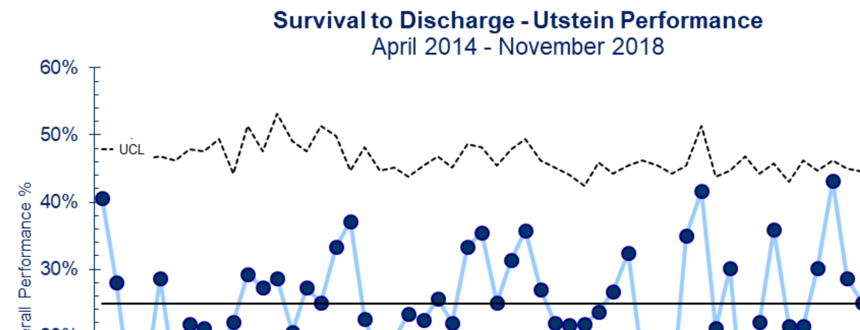
Month

UCL

LCL

6.3%

Figure E2.4



Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

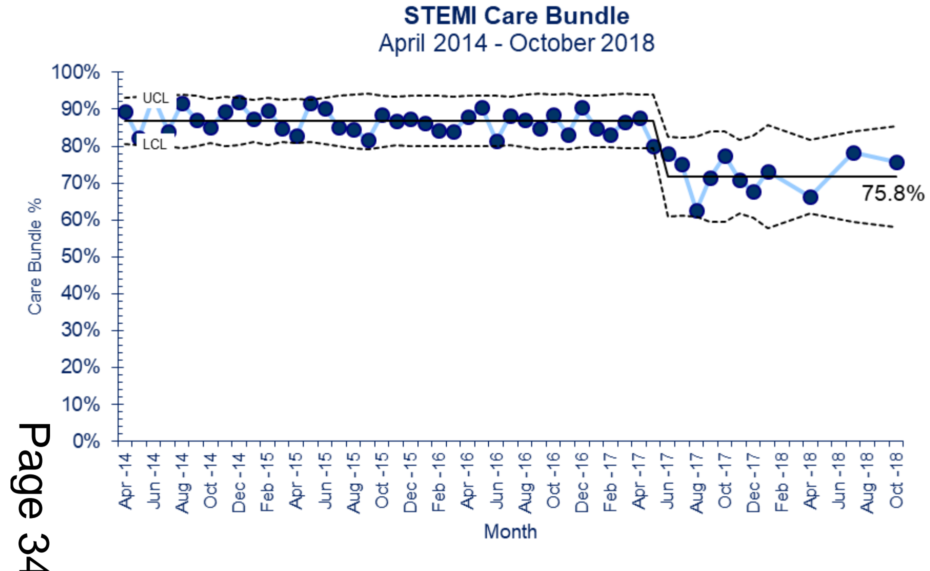
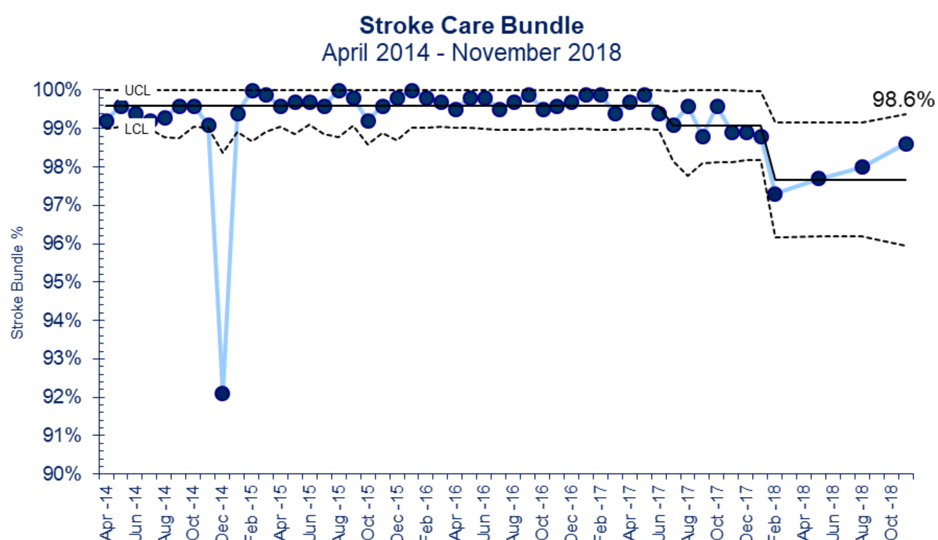


Figure E2.6



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N.B. **Stroke CB data now published nationally 1 month in 3: February, May, August and November (data produced internally on monthly basis).**
STEMI CB now published nationally 1 month in 3: January, April, July and October (data produced internally on monthly basis).

E3 H&T, S&T, S&C OUTCOMES

Figure E3.1

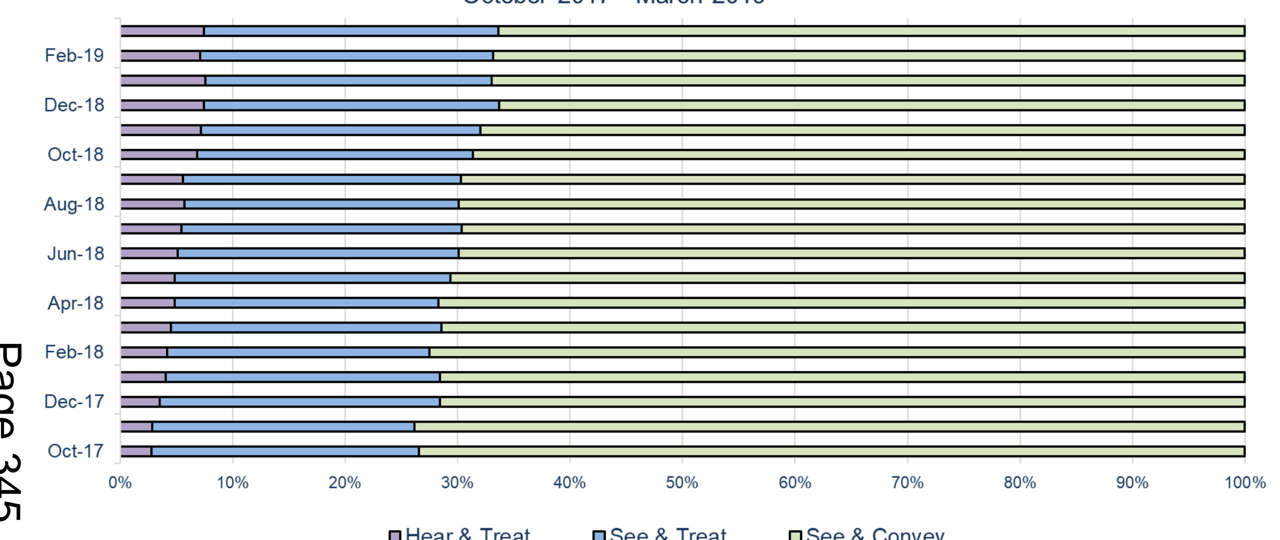


Table E3.1

Month/Yr	Incidents with no face to face response	Hear and Treat %	F2F Incidents with no transport	See & Treat %	F2F Incidents with transport	See & Convey %
Apr-18	4,285	4.8%	20,837	23.5%	63,724	71.7%
May-18	4,601	4.8%	23,305	24.5%	67,065	70.6%
Jun-18	4,693	5.1%	22,809	25.0%	63,863	69.9%
Jul-18	5,108	5.4%	23,396	24.9%	65,315	69.6%
Aug-18	5,201	5.7%	22,065	24.4%	63,209	69.9%
Sep-18	5,056	5.6%	22,108	24.7%	62,398	69.7%
Oct-18	6,562	6.8%	23,568	24.5%	65,911	68.6%
Nov-18	6,837	7.2%	23,627	24.8%	64,668	68.0%
Dec-18	7,559	7.5%	26,608	26.2%	67,248	66.3%
Jan-19	7,641	7.6%	25,653	25.4%	67,595	67.0%
Feb-19	6,381	7.1%	23,296	26.0%	59,798	66.8%
Mar-19	7,349	7.4%	25,936	26.2%	65,672	66.4%

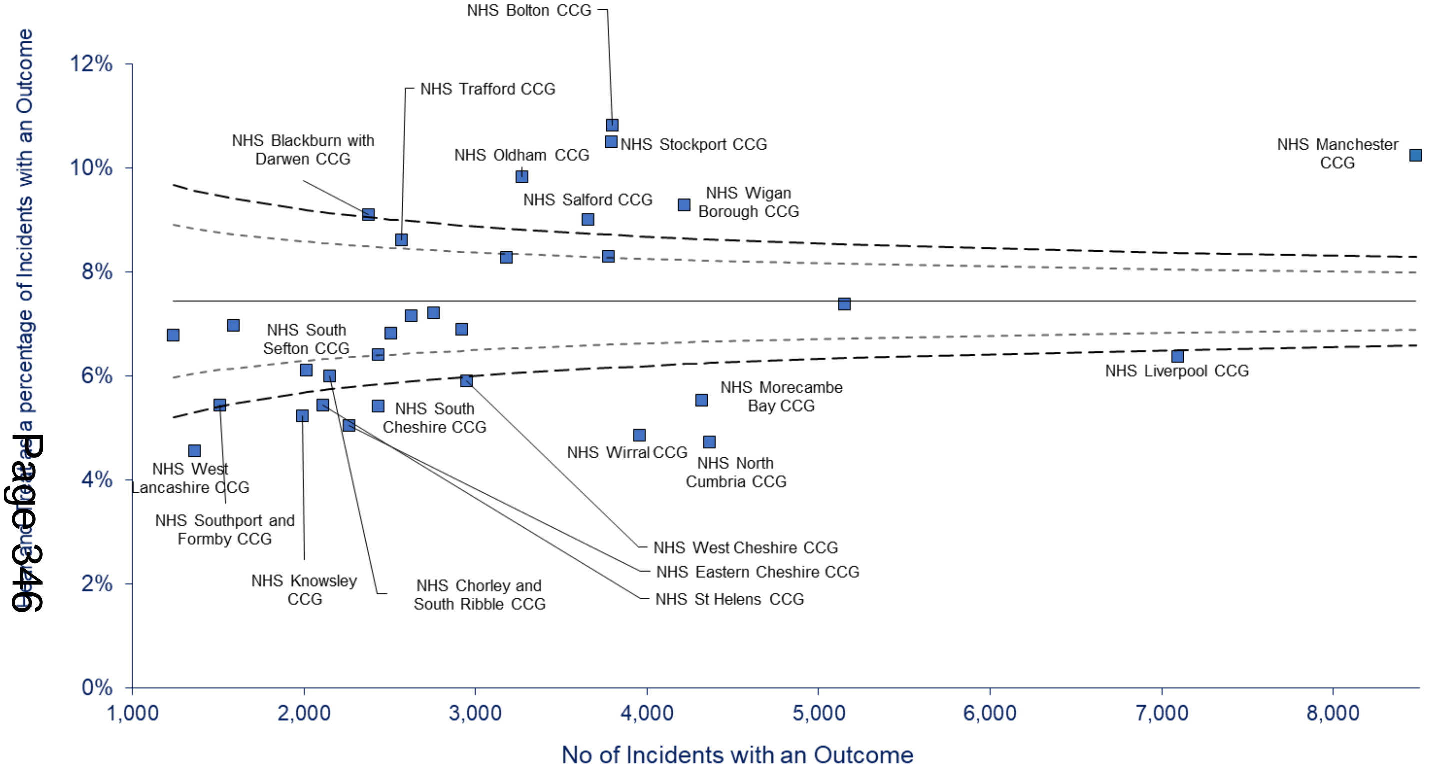
Outcomes

Following the continued implementation of enhanced working practices NWAS has continued to demonstrate a steady reduction in conveyance, from 71.7% to 66.4 % over the past 12 months.

S&T in March continues to remain high at 26.2%, with the very start of the month seeing an all-time peak for the year.

This coincides with the completion of MTS and frailty training for paramedics, with 98% now trained in its application to aid identifying those patients that could be supported away from ED if there are local services available. It also aimed to empower clinicians with the knowledge of unintentional harm hospitals can sometimes cause to the more frail patients when admitted, and that maintaining this cohort at home where possible has better outcomes for the patient. The feedback from staff receiving this training has been overwhelmingly positive.

Figure E3.2



Hear & Treat Performance for March was 7.4% and the number of incidents with no face to face response being 7349. This is a 2.9% improvement in performance in comparison to March 2018 and a percentage increase of 48.7% H&T incidents.

This is ostensibly due to increases in Hear & Treat made possible by maximising Clinical Hub efficiency and using the Adastra and Orion platforms to aid interoperability, together with increase in staff in Clinical Hub working independently, the rise in the total number of calls triaged was realised. New staff into the department over the last 12 months are now all fully trained and embedded in the role.

On 5th March 2019, a 90 day Greater Manchester Extended APAS trial commenced. This originally started with reduced hours (0800-2300) but is now operating 24/7. There are 4 providers taking part which make up the Alliance, Mastercall, Bardoc, GTD and Wigan GP Alliance. It's worth noting that 1,002 of the 1,945 APAS referrals in March were sent to the 4 providers in GM who are taking part in the 90 day trial.

Figure E3.3

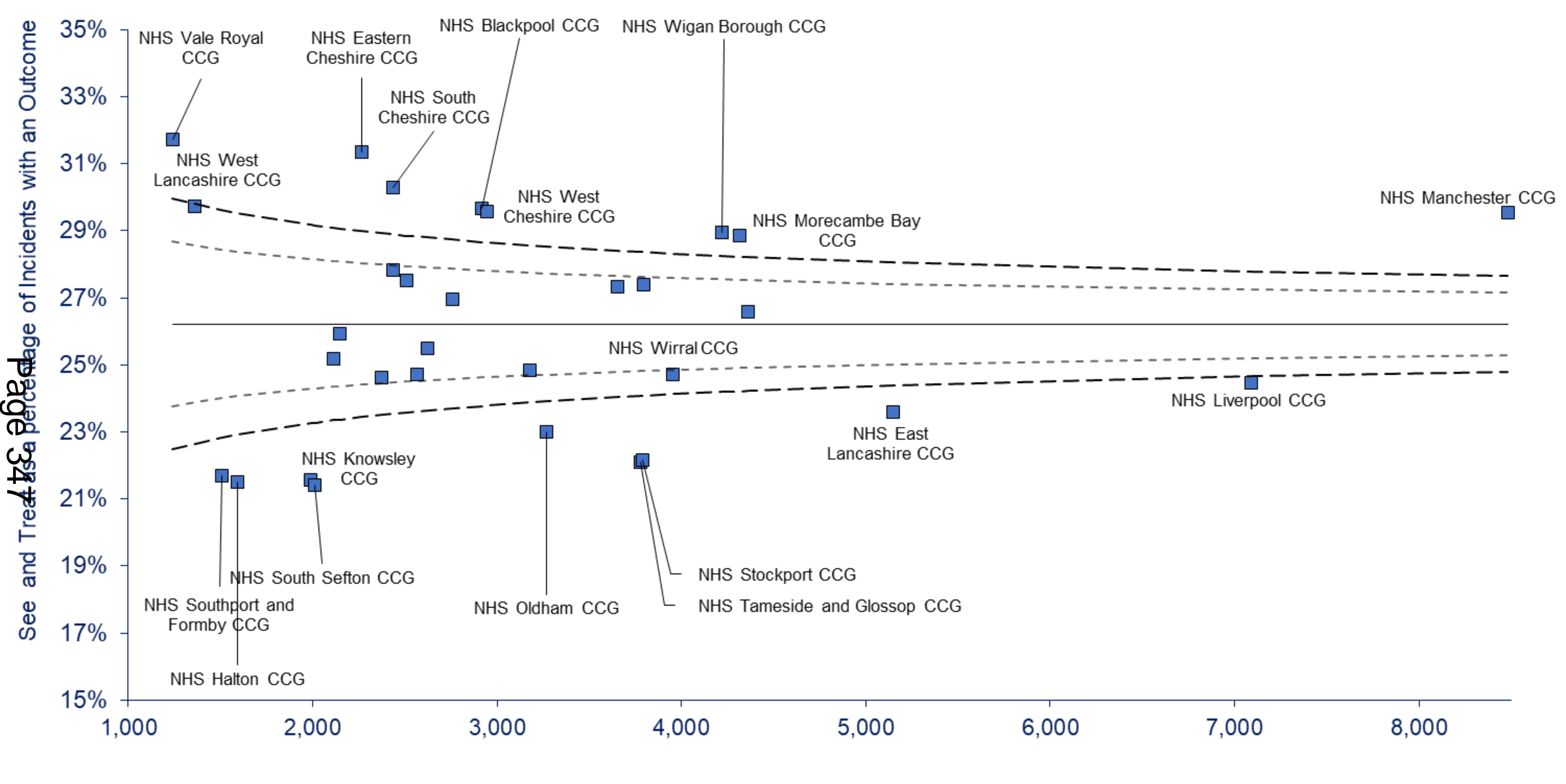


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Figure E3.4

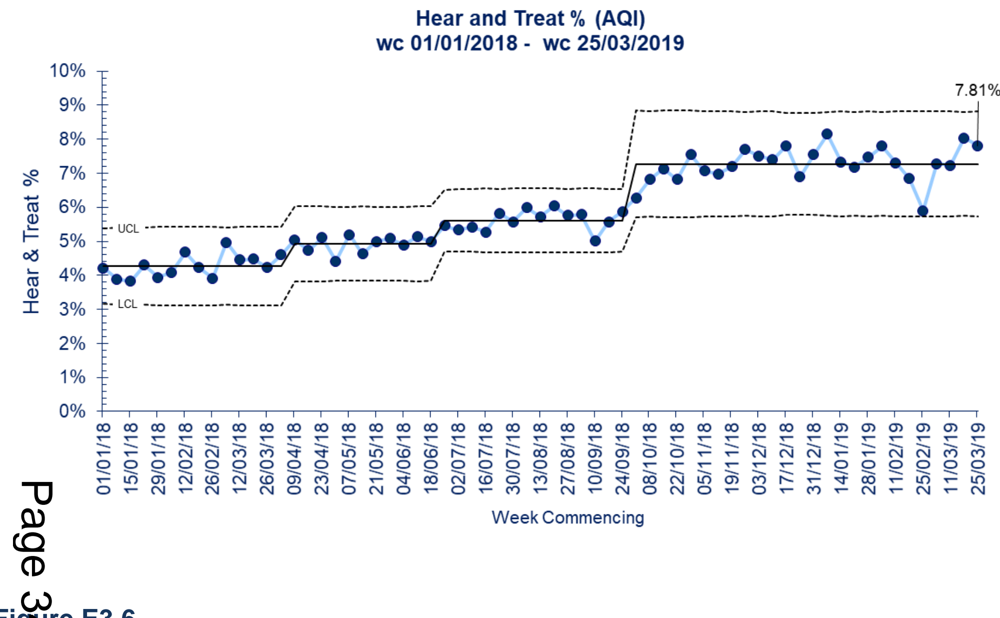


Figure E3.5

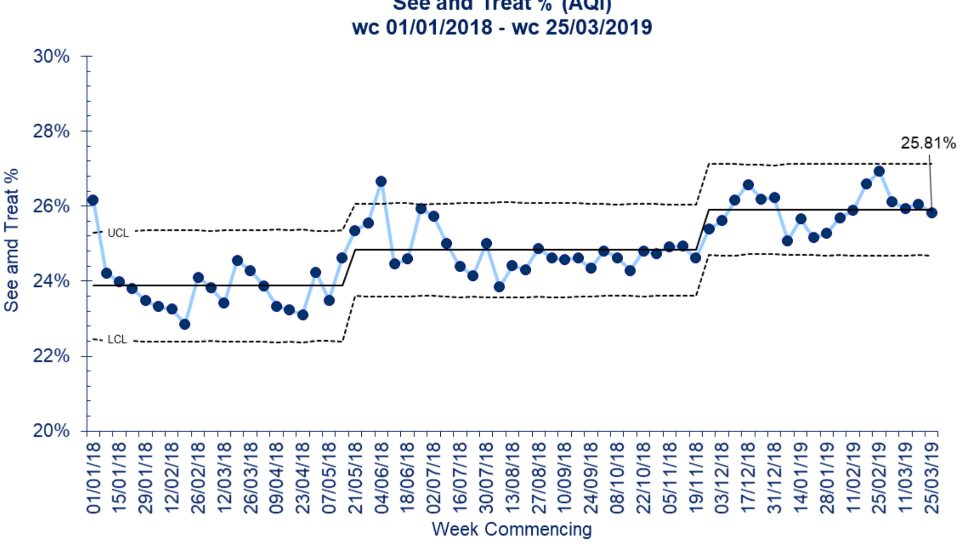
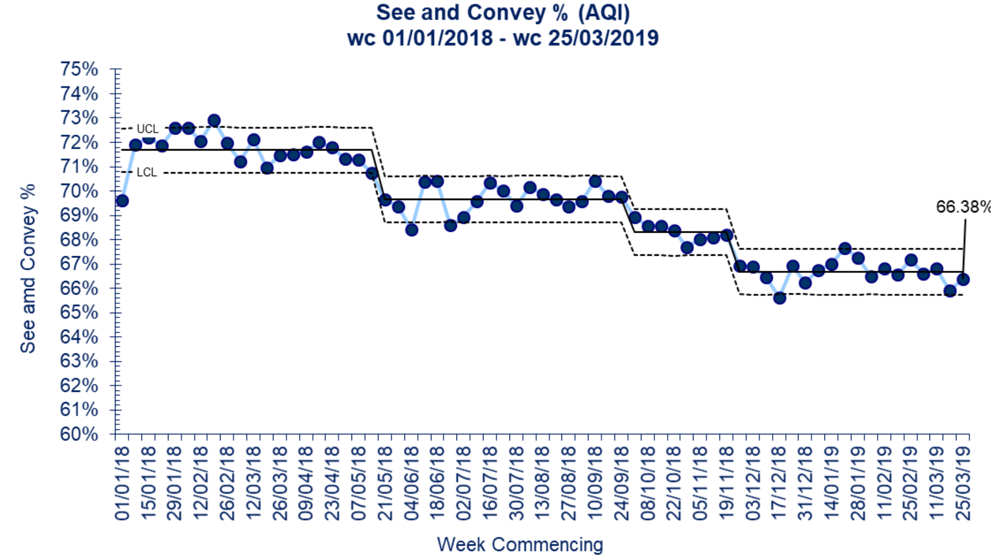


Figure E3.6

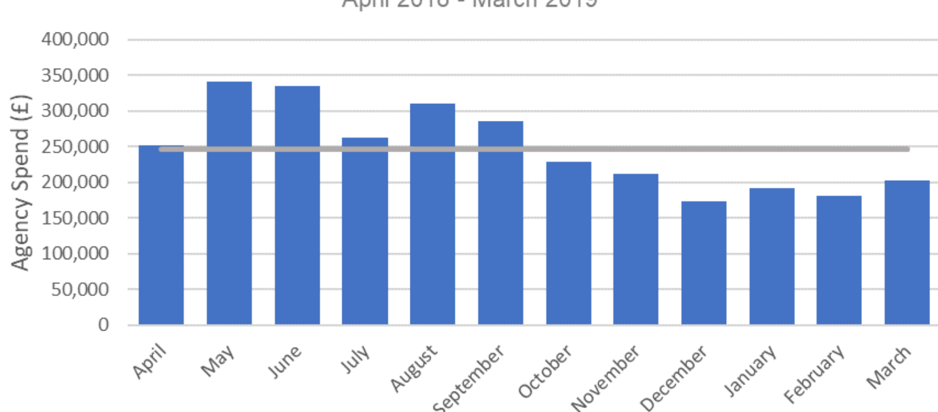


F1 FINANCIAL SCORE

Table F1.1 Financial Sustainability Risk Rating

	2018/19 YTD Score	Plan Score	Weight
Liquidity	1	1	0.2
Capital Servicing	1	1	0.2
I&E Margin	2	2	0.2
Distance from Plan	1	1	0.2
Agency	2	1	0.2
Overall Unrounded	1.4	1.2	
Rounded Score before override	1	1	
OVERALL SCORE AFTER OVERRIDE (Triggered if any of the score are 4)	1	1	

Figure F1.1



Finance Position – March 2019

Month 12 Finance Position:
The 2018/19 end of year financial position for the Trust is a surplus of £2.513m, this is £0.675m better than the planned surplus of £1.838m. The trust will receive a further Provider Sustainability Funding (PSF) payment of £0.675m for finance performance incentive, taking the overall financial surplus to £3.188m.

Financial Score
The overall forecast risk rating for the Trust is a 1.

Agency Expenditure
The full year expenditure on agency is £2.978m which is £0.021m above the ceiling of £2.957m, equivalent to 0.7% above the ceiling which results in an agency financial metric of 2. The overall financial risk score for the Trust for 2018/19 is 1.

The Trust has seen a reduction in agency expenditure in the last few months and has reduced the percentage above the agency ceiling.

Figure F1.2

PES Agency Spend
April 2018 - March 2019

Agency Spend (£)
100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000

April May June July August September October November December January February March

PES Actual PES Ceiling

Figure F1.3

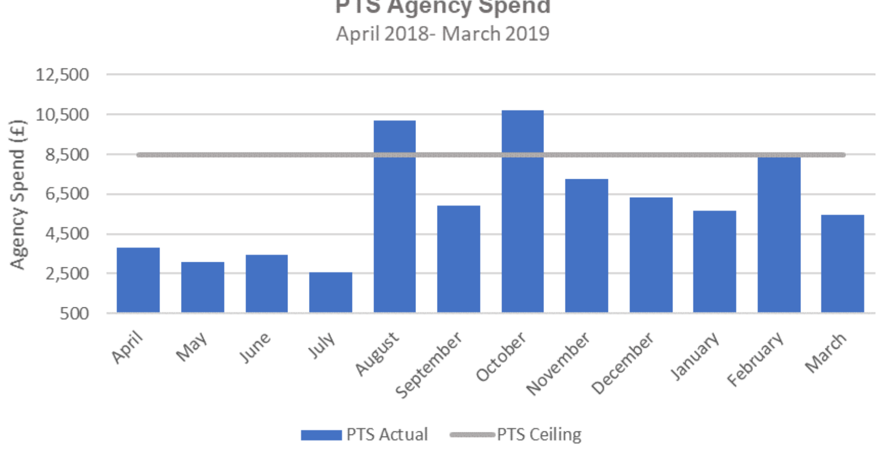


Figure F1.4

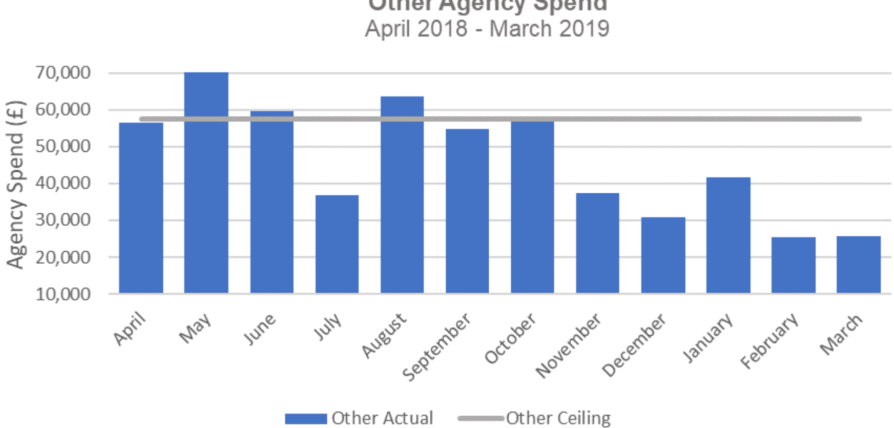
111 Agency
April 2018 - March 2019

Agency Spend (£)
210,000
190,000
170,000
150,000
130,000
110,000
90,000
70,000
50,000
30,000
10,000

April May June July August September October November December January February March

111 Actual 111 Ceiling

Figure F1.5



O1 CALL PICK UP

Figure O1.1:

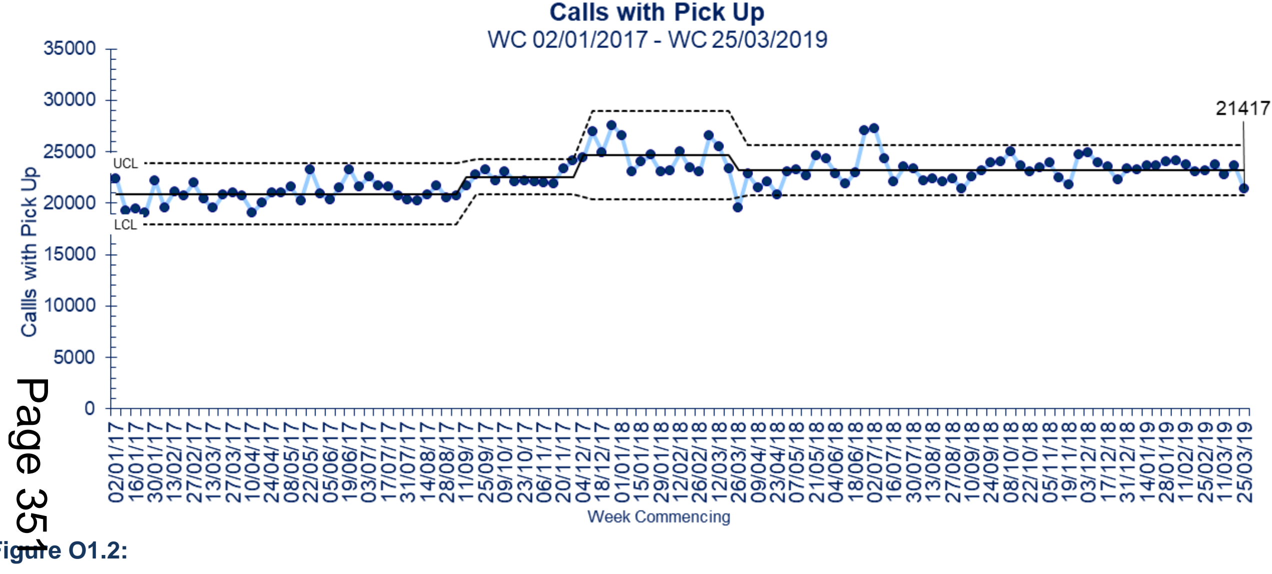
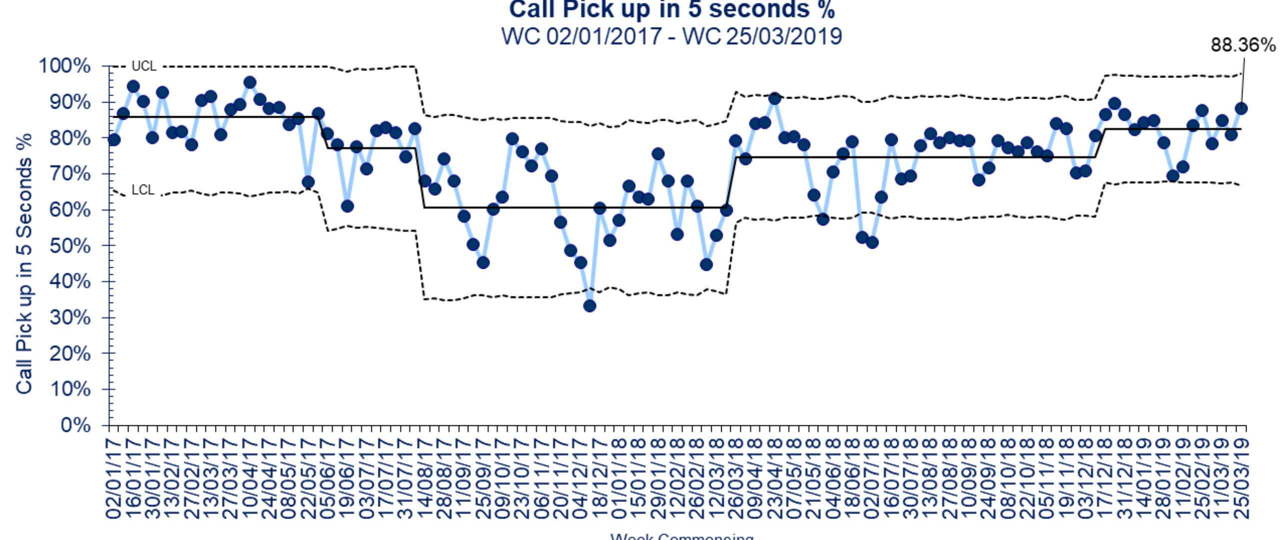


Figure O1.2:



Call Pick Up

Definition: The percentage of emergency calls recorded in the CAD system and answered with 5 seconds, excluding 111 direct entries. Call pick up is not a national standard, but is widely used by ambulance trusts to monitor call handling performance with a target of 95%.

Performance: For March 2019, call pick up performance was at **83.4%.** In total, 17,274 calls took longer than 5 seconds to pick up.

March has seen the continuation of improvement in call pick up. The highlights being;

- The lowest mean call answer since ARP was introduced (7 seconds mean represents a 50 second reduction vs Dec 17)
- The highest percentage of calls answered in 5 seconds since ARP was introduced (83% represents a 26% improvement vs March 17).
- Second lowest 95th percentile since ARP was introduced.
- 99th percentile is improved vs March 17 and more stable than previous year.
- Best C1 performance since ARP introduced.

Figure O1.3:

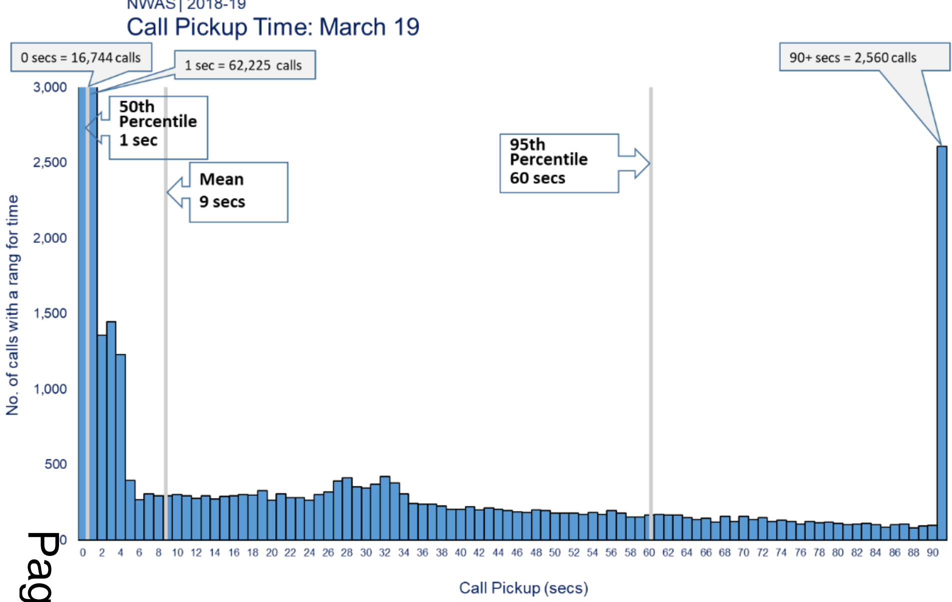


Table O1.1: Calls and Call Answer Times (Source – AQI)

Month/Yr	Contact Count	Calls answered	Call answer times (seconds) Total	Mean (Switch)	Median (50th centile)	95th centile	99th centile
Apr-18	127,184	97,763	1,015,065	10	1	70	133
May-18	141,285	109,402	1,839,366	17	1	93	149
Jun-18	134,928	105,700	2,085,480	20	1	100	154
Jul-18	143,373	113,072	2,647,801	23	1	110	167
Aug-18	131,596	102,646	1,357,953	13	1	83	147
Sep-18	129,192	100,544	1,541,202	15	1	91	147
Oct-18	143,522	110,811	1,379,357	12	1	77	136
Nov-18	136,311	103,941	1,173,027	11	1	73	128
Dec-18	136,894	109,551	1,152,801	11	1	70	125
Jan-19	133,555	107,917	849,948	8	1	58	117
Feb-19	119,275	95,828	1,088,632	11	1	74	127
Mar-19	125,183	100,378	717,376	7	1	60	139

This improvement is a reflection of the long term improvements made over the last twelve months, including reduction in call length and improvements in availability on line. The diversification of call handling has also driven improvements in CPU and long tails, especially for our sickest patients. The introduction of the EMD Support role across IFT/HCP calls and routine blue light enquiries demonstrate this. In addition, CPU has driven improvements in C1 alongside the improvements to early identification of C1 patients (highest % identified in month) and improvements to the percentage of calls auto dispatched.

The improvements will continue and these will be driven by recruiting towards full EMD and Dispatch establishment (19/20 establishment) which will increase the staff in post by around 50 WTE (across EMD and dispatch). This will occur by the end of Q2.

The improvements during March 19 can also be attributed to the daily focus on aligning overtime to key areas of staffing shortfalls. Previously, the afternoons have seen demand outstripping resource, over the last three months the mornings (08:00-10:00 specifically) have seen deteriorating CPU performance. The realignment of resources has improved this position.

O2 A&E TURNAROUND

Figure O2.1

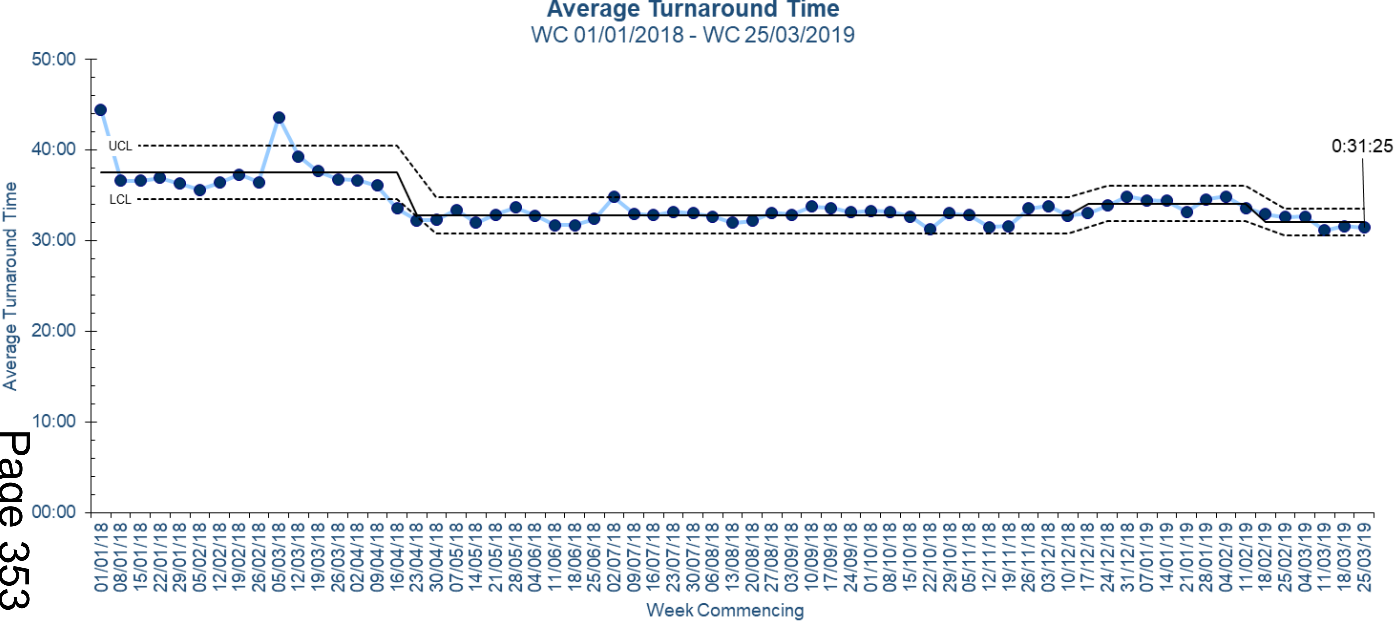


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
Apr - 18	57,862	34:35	22:47	11:33
May - 18	60,792	32:51	20:41	12.01
Jun - 18	57,654	32:10	20:13	12:11
Jul - 18	59,401	33:26	21:10	12:02
Aug - 18	57,721	32:25	20:10	12:05
Sep - 18	56,605	33:22	21:21	11:48
Oct – 18	59,814	32:41	20:49	11:41
Nov - 18	58,650	32:21	20:55	11:21
Dec – 18	61,286	33:24	22:01	11:16
Jan – 19	61,812	34:19	23:03	11:11
Feb - 19	54,380	33:36	22:19	11:10
Mar – 19	59,493	31:47	20:16	11:20

A&E Turnaround Times

The average turnaround for March 2019 was 31 minutes 47 seconds across the North West.

The 5 hospitals with the longest turnaround times during March 2019 were:

Royal Lancaster	37:34
Southport District	36:09
Aintree University	35:47
Arrowe Park	35:01
Furness General	34:48

The focus on hospital turnaround times continues. March 2019 has seen the hospital element of the handover achieve its best performance within quarter 4 which in turn has presented the best overall average turnaround time of 31:47 across the year 2018/2019.

Further work is still required on the hospital element of the handover to achieve the overall average of 30 minutes and less. On the 1st April the Trust hosted an 'Every Minute Matters Summit' which was attended by all stakeholders including CEOs from Acutes across the region. The event was an opportunity to present progress made through the quality improvement programme and discuss its next steps to ensure further improvement is made across all Acutes in the North West.

Figure O2.2

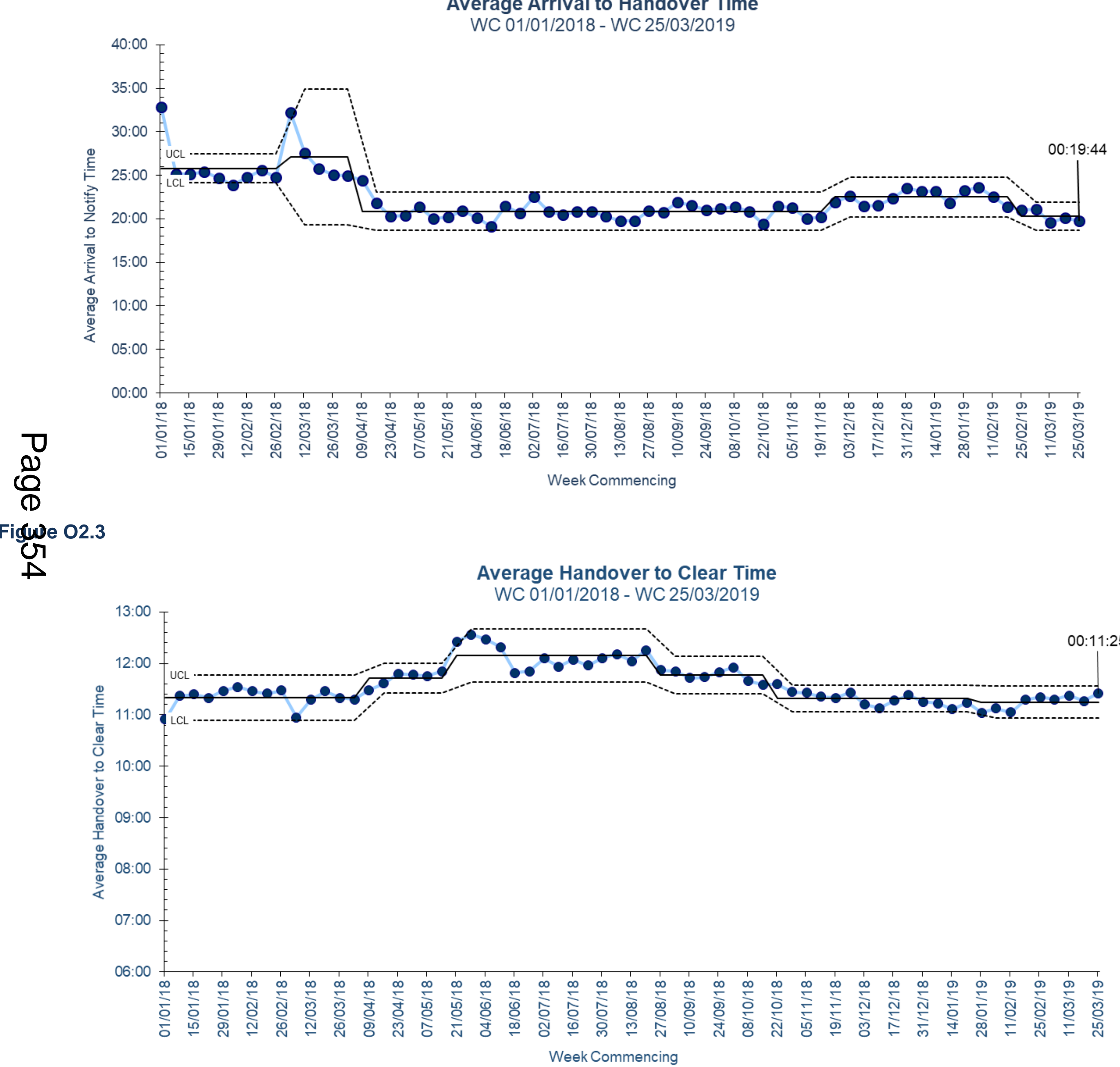


Figure O2.3

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O3 ARP RESPONSE TIMES

Table O3.1 - Incidents with a response

Month/Yr	C1	C2	C3	C4
Apr-18	9,156	45,526	21,096	3,992
May-18	9,688	48,661	23,025	4,169
Jun-18	9,355	46,990	21,925	4,043
Jul-18	9,840	48,267	22,171	3,747
Aug-18	8,372	46,632	21,983	3,705
Sep-18	8,005	47,385	21,618	3,346
Oct-18	8,606	51,063	22,462	3,206
Nov-18	8,360	50,764	21,208	3,233
Dec-18	9,277	53,147	21,787	4,305
Jan-19	9,579	53,775	20,486	3,993
Feb-19	8,768	47,251	18,699	3,594
Mar-19	9,323	51,495	21,189	4,288
NWAS YTD	**108,329**	**590,956**	**257,649**	**45,621**

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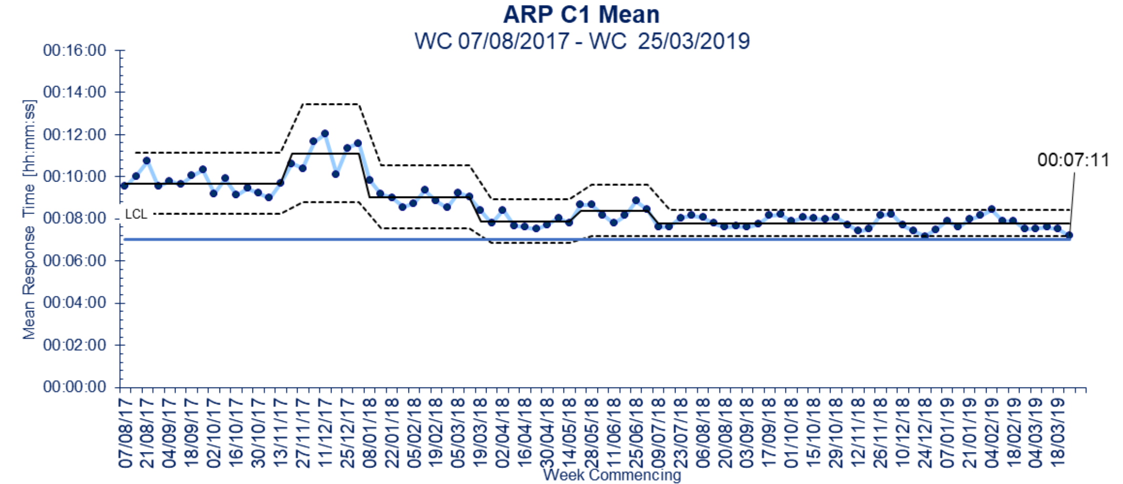
Figure O3.1



Activity

C1 Performance

C1 Mean

Target:	7 minutes
NWAS	
March 19:	7:27
YTD:	7:54
National:	
March 19:	7:00
Top three trusts:	
North East	6:08
London	6:18
Yorkshire	6:44
NWAS Position	**7 / 10**

Overall, NWAS has managed to maintain performance within its control limits during March 2019, whilst improving its position nationally across all its performance targets. Only C1 90th percentile target was achieved in March, however all other standards have indicated an improved position over recent weeks.

NWAS was one of two Ambulance Trusts (WMAS) involved in a national pilot for Inter-Facility Transfer (IFT) and Health Care Professional (HCP) which has now completed and will be rolled out nationally. NWAS has been commended for its role in the pilot. Work continues on the regional roster review with all NWAS Trade Unions engaged, with plans in place to re-align resources better to demand and realise the full potential of the increased resources.

Figure O3.2

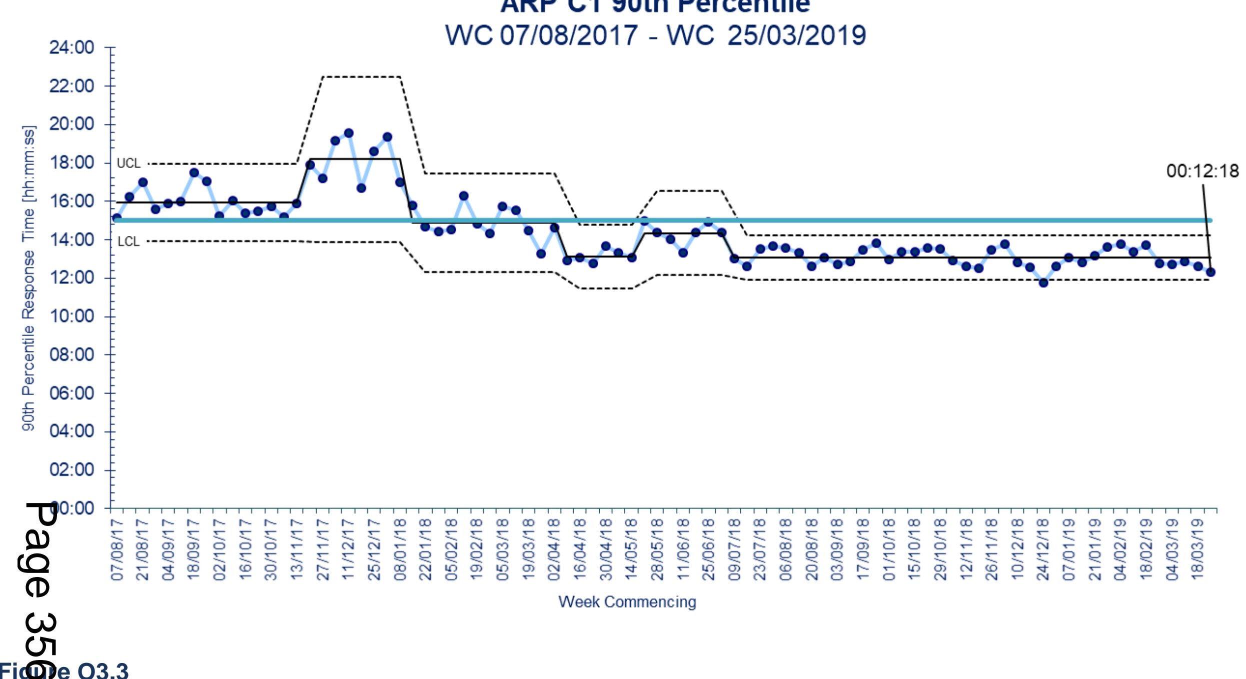
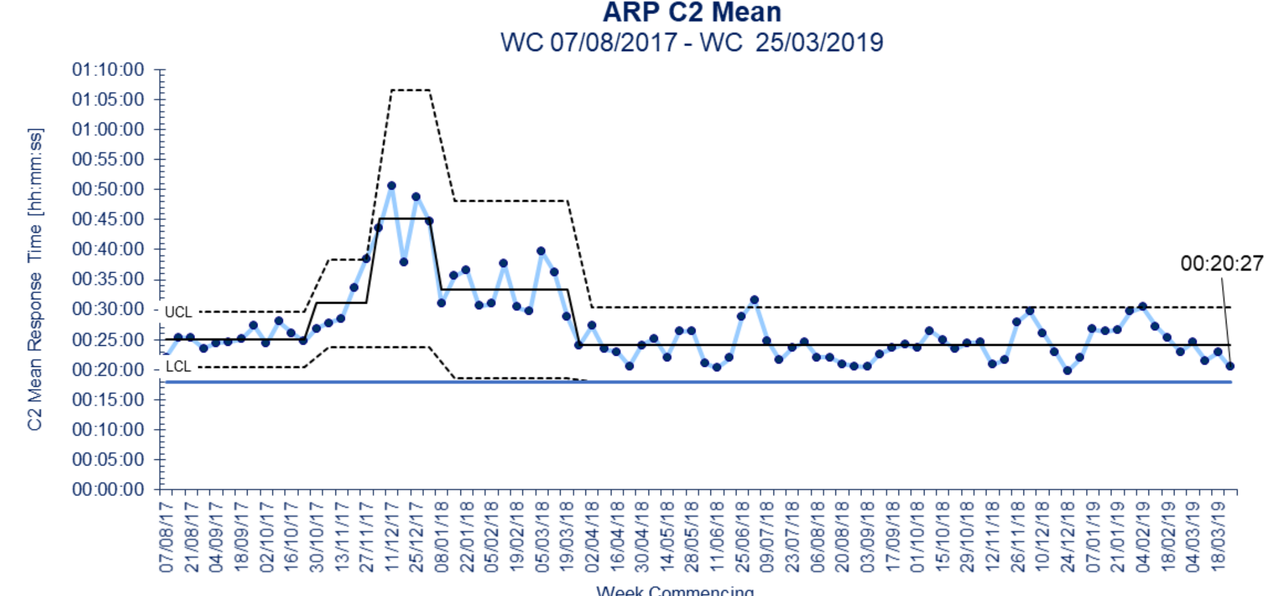


Figure O3.3



C1 90th Percentile

Target:	15 Minutes
NWAS	
March 19:	12:37
YTD:	13:19
National:	
March 19:	12:11
Top three trusts:	
London	10:24
North East	10:51
Yorkshire	11:28
NWAS Position	**6 / 10**

C2 Performance

C2 Mean

Target:	18 minutes
NWAS:	
March 19:	22:27
YTD:	24:14
National:	
March 19:	21:15
Top three trusts:	
West Midlands	11:58
Yorkshire	17:40
London	18:15
NWAS Position	**6 / 10**

Figure O3.4

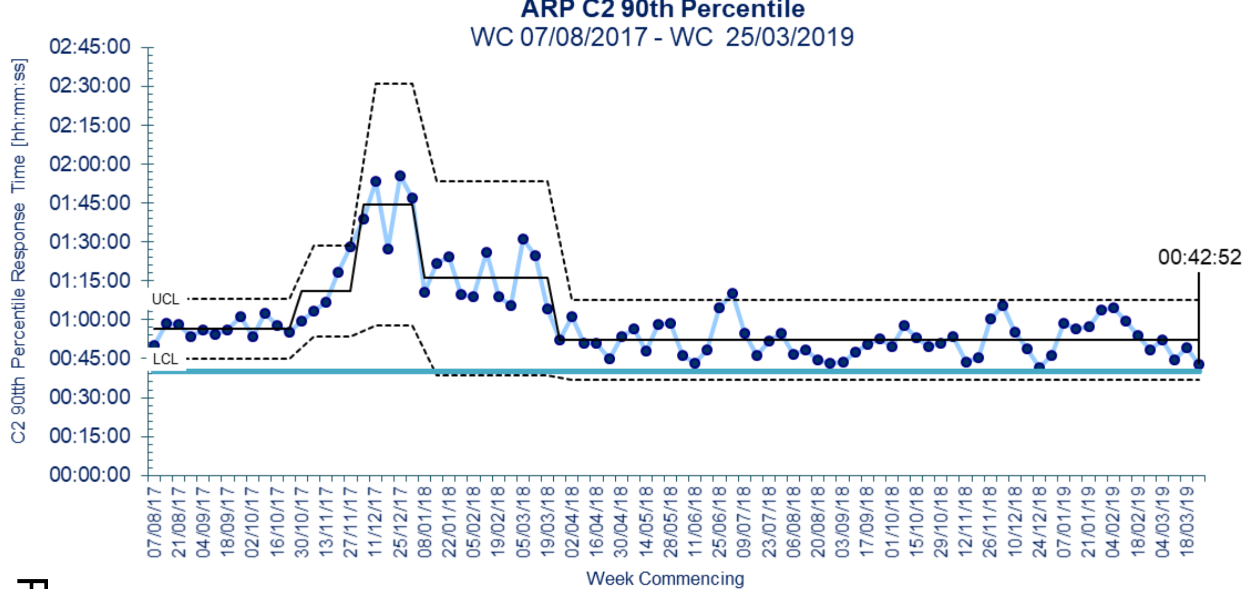
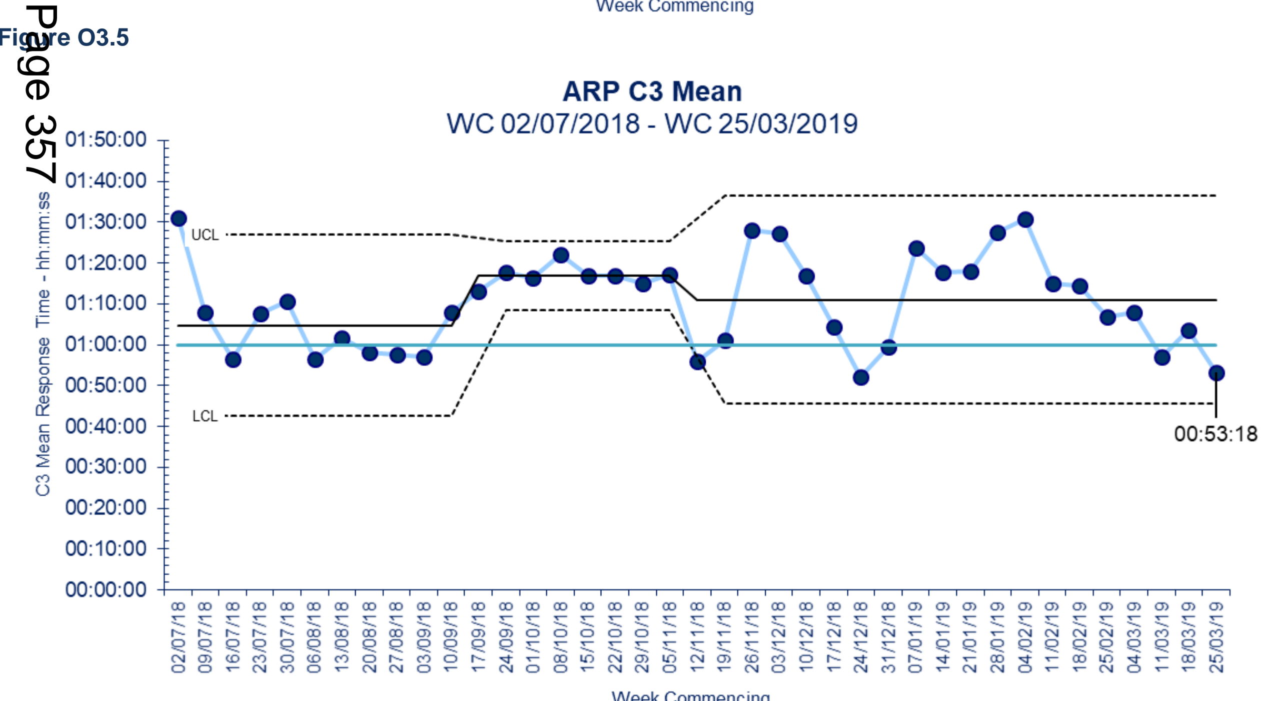


Figure O3.5



C2 90th Percentile
Target: 40 Minutes

NWAS	
March 19:	47:42
YTD:	52:33
National:	
March 19:	43:12
Top three trusts:	
West Midlands	21:46
Yorkshire	35:35
South Central	37:00
NWAS Position	**6 / 10**

C3 Performance

C3 Mean

Target:	1 Hour
NWAS:	
March 19:	01:01:22
YTD:	01:08:30
National:	
March 19:	1:01:24
Top three trusts:	
West Midlands	32:44
Yorkshire	38:16
London	50:11
NWAS Position	**5 / 10**

Figure O3.6

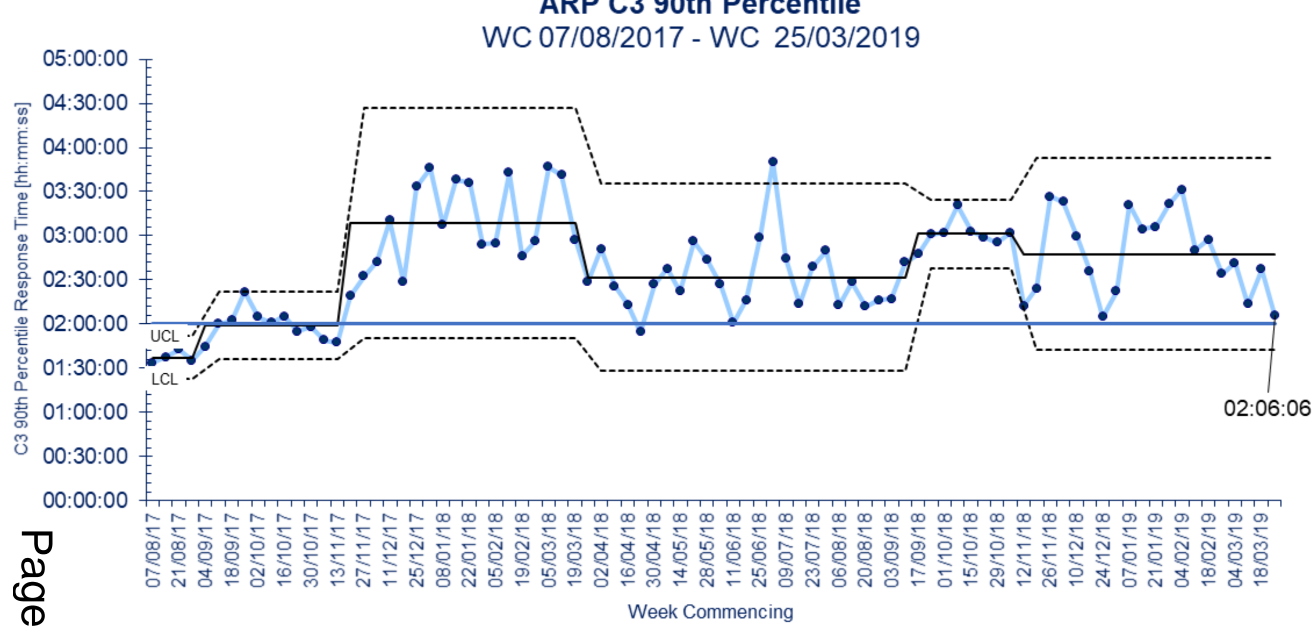


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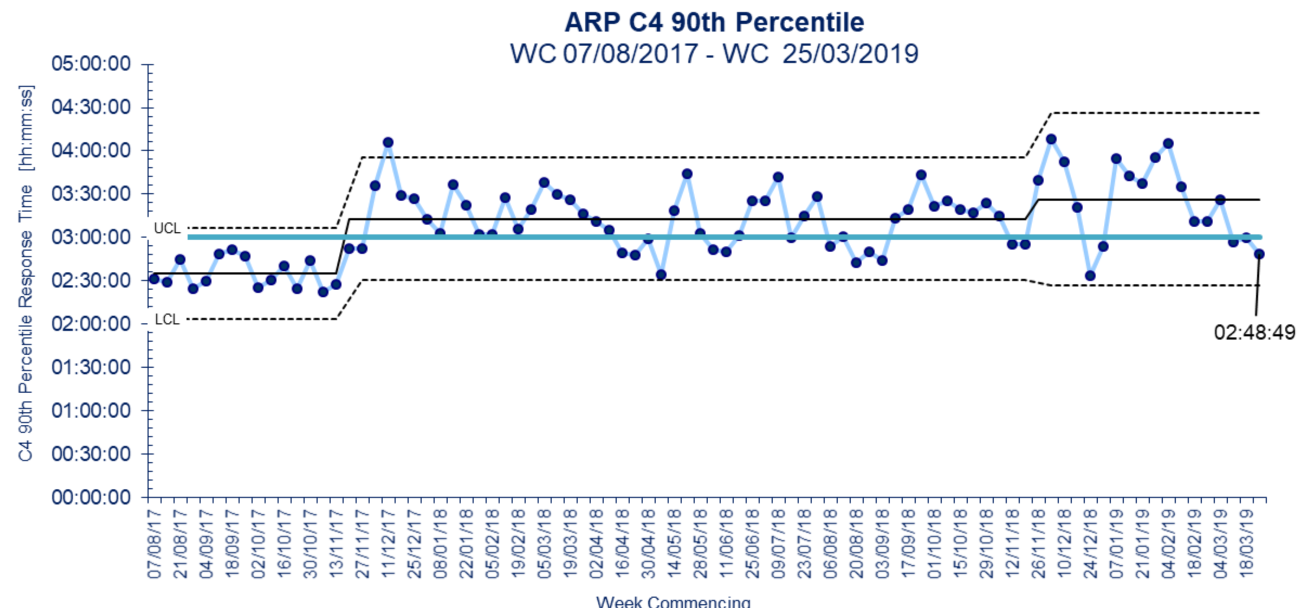
Figure O3.7



C3 90th Percentile
Target: 2 Hours

NWAS
March 19: 02:26:31
YTD: 02:43:22

National
March 19: 2:25:11

Top three trusts:
West Midlands 1:13:04
Yorkshire 1:29:42
London 1:57:59

NWAS Position 5 / 10

C4 Performance

C4 90th Percentile
Target: 3 Hours

NWAS
March 19: 03:01:53
YTD: 03:13:57

National
March 19: 3:03:45

Top three trusts:
West Midlands 1:49:44
Yorkshire 2:21:05
London 2:53:24

NWAS Position 5 / 10

Figure O3.8

NWAS | 2018-19

Time to arrival at scene for incidents with final ARP category of C1: March 19

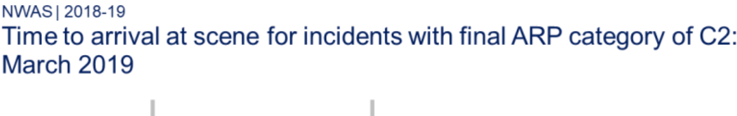
Mean 7:28

90th Percentile 12:37

No. of incidents with a response

Time to arrival (mins)

Figure O3.9



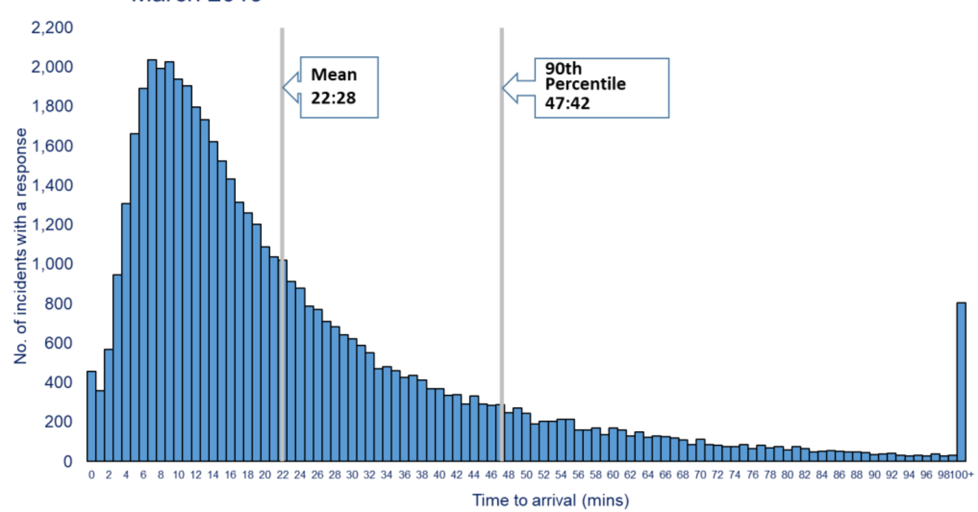


Figure O3.10

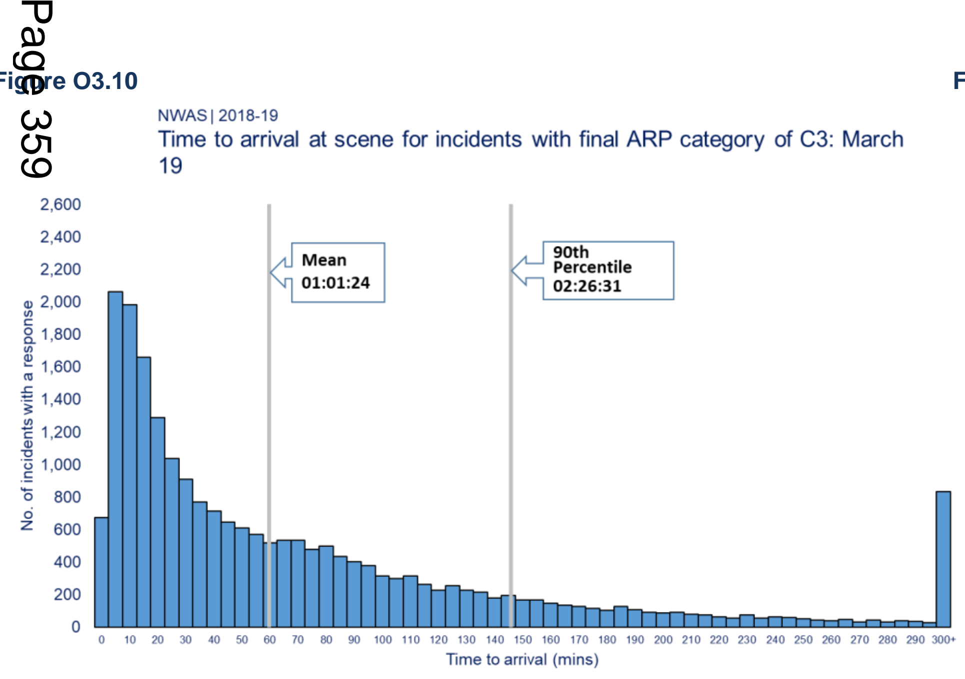


Figure O3.11

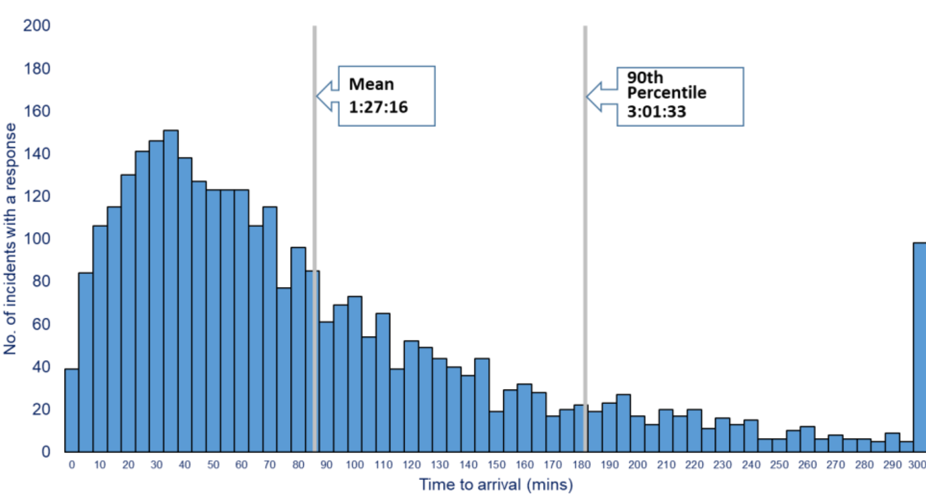
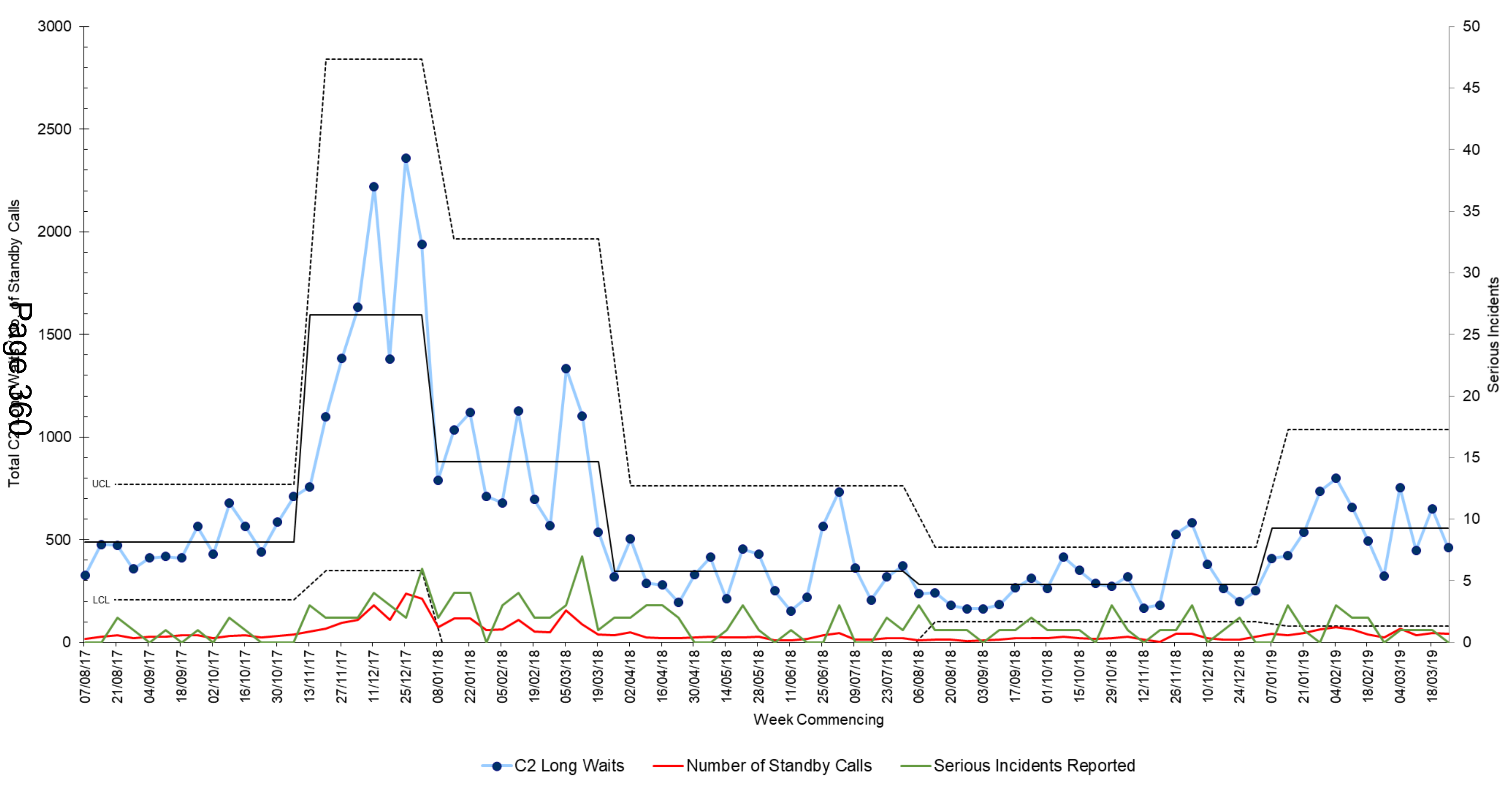


Figure O3.12



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O4 111 PERFORMANCE

Figure O4.1:

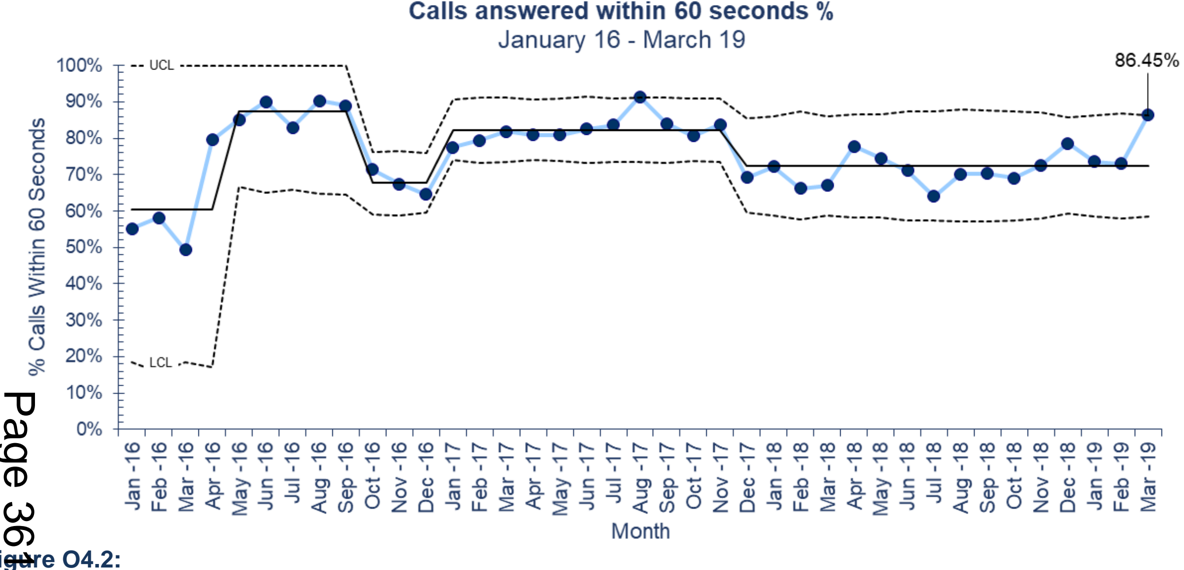
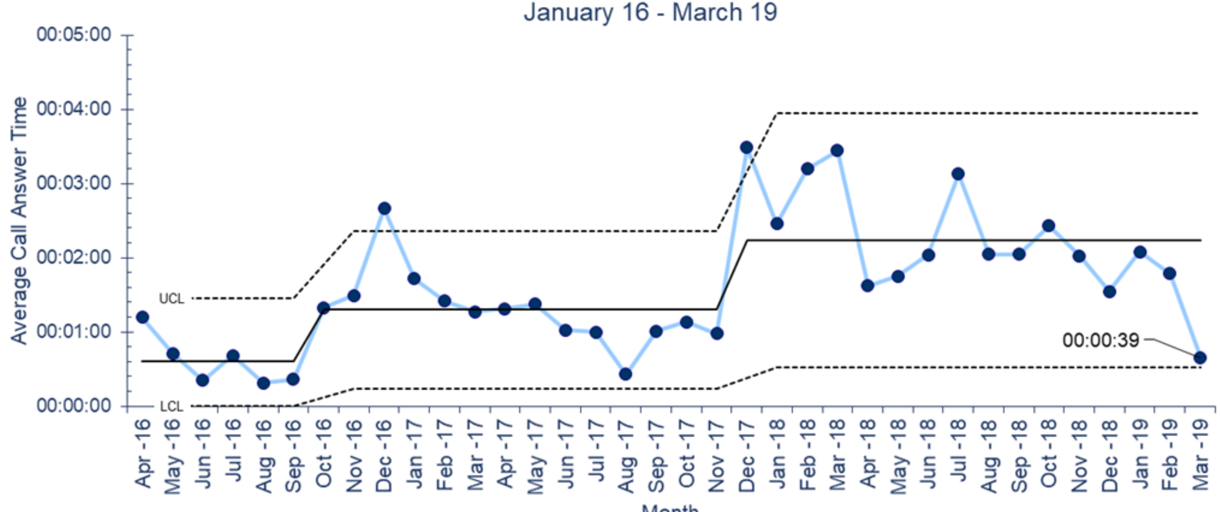


Figure O4.2:



111 Performance

Calls Answered within 60 seconds %

Target:	95%

NWAS

March 19:	86.5%
YTD:	73.8%

National

March 19:	85%

March 19 has demonstrated the gains in performance with all the Performance Improvement Plan (PIP) initiatives put in place over the preceding 4 months. March proved the best performance in 111 since August 2017. Staffing has been good, with sickness much lower than over the previous 12 months.

Recruitment continues to improve the staffing numbers with Health Advisor recruitment now focussed on the resource gaps of weekend and evening shifts only. Clinical Advisor recruitment however continues to be a challenge, however with the discussions regarding rotational working in Cumbria, it is hoped this will attract a new cohort of clinicians into NWAS111.

March 19 has seen a significant improvement in time to answer calls. Again aligned to the calls answered in 60 seconds, this is the best performance since August 17.

Figure O4.3:

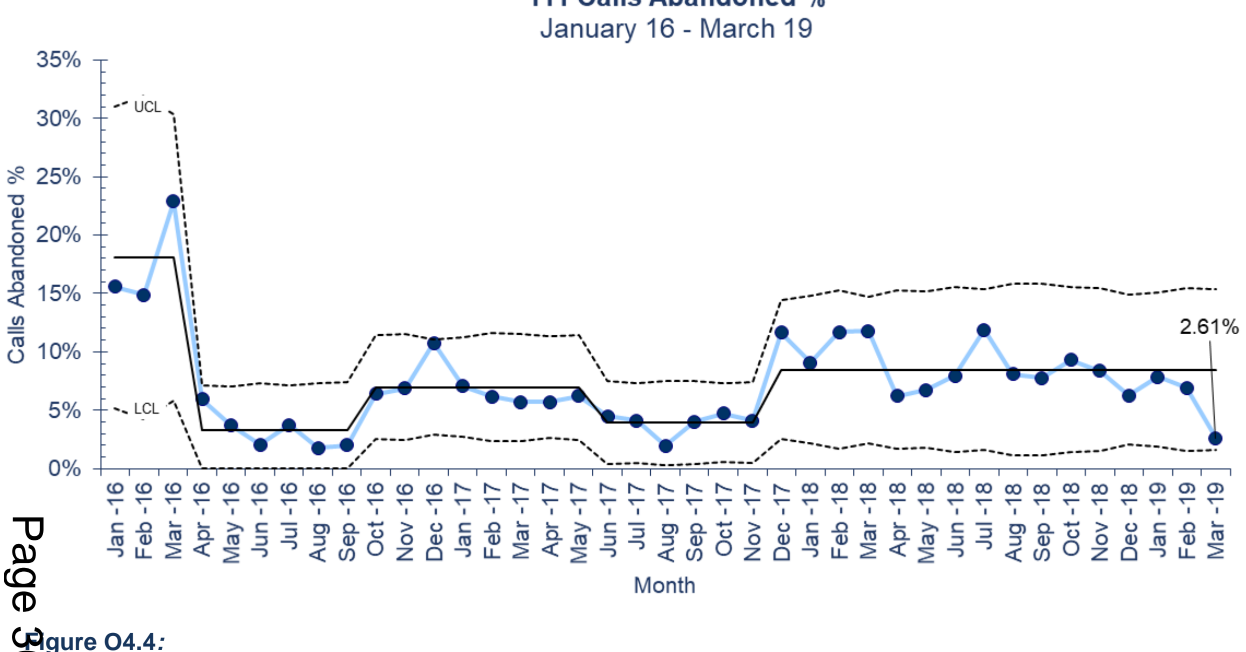


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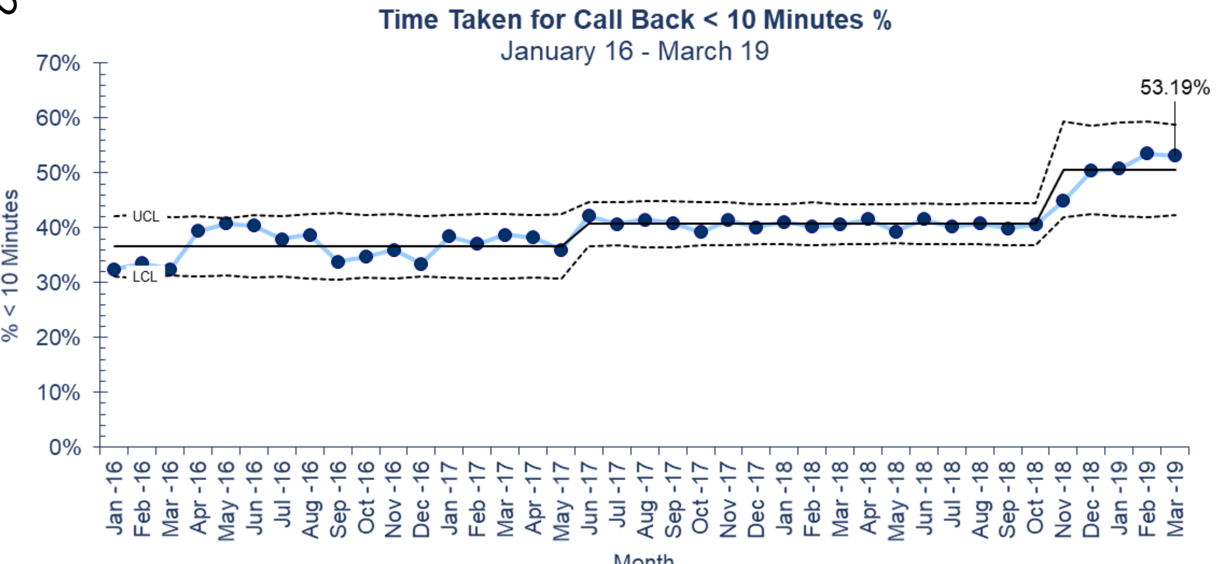
Figure O4.4:



Calls Abandoned %

Target:	<5%

NWAS

March 19:	2.6%
YTD:	7.5%

National

March 19:	2.4%

There is a direct correlation between performance of calls answered in 60 seconds and calls abandoned. With the excellent performance of calls answered we see a corresponding improvement in abandoned calls, with NWAS 111 performance now aligned to the National average.

Call Back < 10 Minutes %

Target:	75%

NWAS

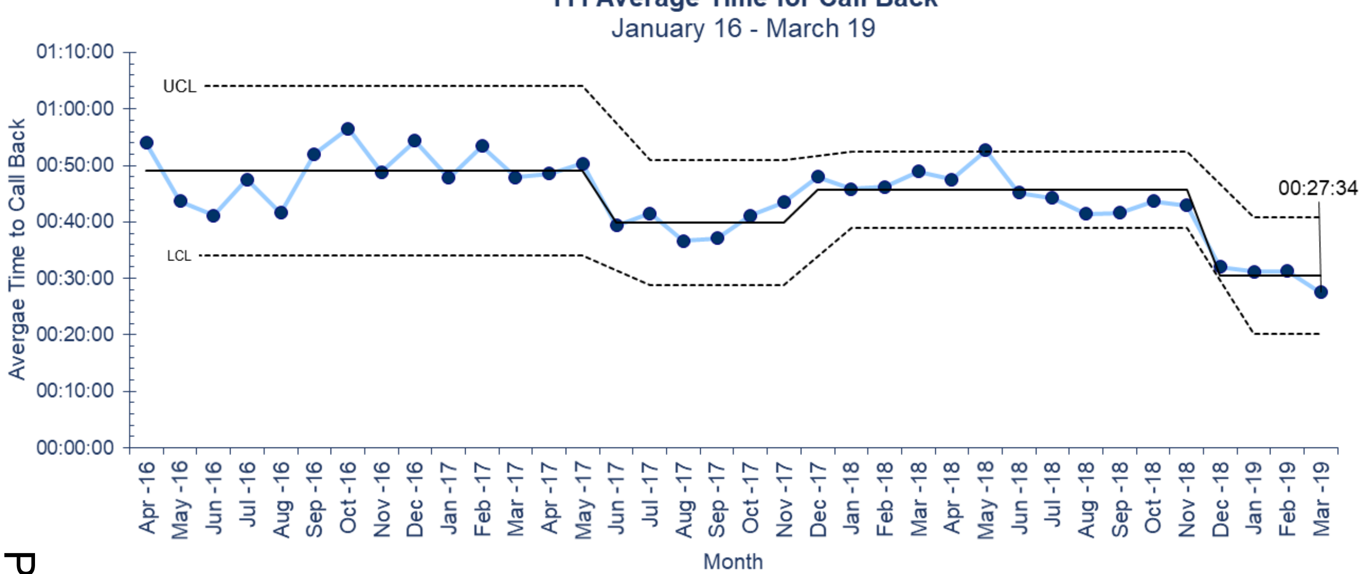
March 19:	53.2%
YTD:	44.8%

National

March 19:	36.5%

This National KPI is one which has only ever been achieved by 1 small GP led service in south England. As demonstrated by the figures above, the National average for March 19 was 36.5% and NWAS 111 performed far better at 53.2%. Again this is directly correlated to the call back time KPI, and is attributable to the additional clinical resources through the implementation of Early Transfer to Out of Hours services.

Figure O4.6:



In line with the Time taken to call back within 10 minutes % the NWAS 111 call back average time has decreased to 27 minutes 34 seconds.

As previously stated all performance standards have improved due to the delivery of the PIP initiatives. When viewed nationally in tables O4.1- O4.3 NWAS are now in the top 1/3 of 111 providers across the country.

Focus continues on staffing with the ORH review and linked roster review plans progressing, as well as the shortly to commence recruitment in Cumbria for rotation practitioners across Primary Care, NWAS 111 and the Acute Trust.

111 Provider Comparison Figures – March 2019

Table O4.1

Provider	Of calls offered, abandoned after at least 30 seconds
Devon Doctors Ltd.	0.6%
Derbyshire Health United	1.0%
Yorkshire Ambulance Service	1.0%
Care UK	1.3%
South Central Ambulance Service	1.5%
Integrated Care 24	1.8%
North East Ambulance Service	1.9%
North West Ambulance Service	2.6%
London Ambulance Service	2.6%
Kernow Health	3.0%
Herts Urgent Care	3.1%
Isle of Wight NHS Trust	3.5%
Devon Doctors	4.2%
Medvivo	4.3%
Vocare	4.7%
South East Coast Ambulance Service	4.8%
London Central & West Unscheduled Care Collaborative	5.7%
South West Ambulance Service	6.9%

Table O4.2

Provider	Of calls answered, calls answered in 60 seconds
Derbyshire Health United	96.2%
Isle of Wight NHS Trust	92.8%
Devon Doctors Ltd.	92.3%
North East Ambulance Service	88.8%
Care UK	88.1%
North West Ambulance Service	86.4%
Integrated Care 24	86.4%
South Central Ambulance Service	86.3%
Yorkshire Ambulance Service	86.1%
Kernow Health	83.1%
Herts Urgent Care	82.4%
South East Coast Ambulance Service	79.4%
London Ambulance Service	79.3%
Medvivo	78.2%
Devon Doctors	73.8%
London Central & West Unscheduled Care Collaborative	73.8%
Vocare	73.1%
South West Ambulance Service	71.1%

Table O4.3

Provider	Of call backs, call backs in 10 minutes	Provider	Of call backs, call backs in 10 minutes
Herts Urgent Care	64.7%	Vocare	40.0%
Devon Doctors	55.9%	London Ambulance Service	36.3%
North West Ambulance Service	53.2%	North East Ambulance Service	33.3%
London Central & West Unscheduled Care Collaborative	50.0%	Derbyshire Health United	28.7%
Isle of Wight NHS Trust	49.6%	Yorkshire Ambulance Service	27.1%
South East Coast Ambulance Service	47.0%	South West Ambulance Service	26.7%
Kernow Health	45.4%	Integrated Care 24	23.7%
Medvivo	43.2%	Devon Doctors Ltd.	22.3%
Care UK	40.5%	South Central Ambulance Service	21.3%

O5 PTS ACTIVITY & TARIFF

Table O5.1

TOTAL ACTIVITY									
	Current Month: March 2019					Year to Date: July 2017 - March 2019			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	168,291	14,024	13,367	(657)	(5%)	126,218	123,423	(2,795)	(2%)
Greater Manchester	526,588	43,882	44,015	133	0%	394,941	404,406	9,465	2%
Lancashire	589,180	49,098	44,545	(4,553)	(9%)	441,885	400,528	(41,357)	(9%)
Merseyside	300,123	25,010	27,252	2,242	9%	225,092	248,338	23,246	10%
NWAS	1,584,182	132,015	129,179	(2,836)	(2%)	1,188,136	1,176,695	(11,441)	(1%)

Table O5.2

UNPLANNED ACTIVITY									
	Current Month: March 2019					Year to Date: July 2017 - March 2019			
Contract	Annual Baseline	Current Month Baseline	Current Month Activity	Current Month Activity Variance	Current Month Activity Variance%	Year to Date Baseline	Year to Date Activity	Year to Date Activity Variance	Year to Date Activity Variance%
Cumbria	14,969	1,247	933	(314)	(25%)	11,227	9,270	(1,957)	(17%)
Greater Manchester	49,133	4,094	4,716	622	15%	36,850	44,437	7,587	21%
Lancashire	58,829	4,902	4,459	(443)	(9%)	44,122	40,502	(3,620)	(8%)
Merseyside	22,351	1,863	1,913	50	3%	16,763	17,979	1,216	7%
NWAS	145,282	12,107	12,021	(86)	(1%)	108,962	112,188	3,227	3%

PTS Performance

Table O5.1

Overall activity during March 2019 was 2% (2,836 journeys) below contract baselines mainly due to Lancashire being 9% (4,553 journeys) below baseline. For the year to date position (July 2018 – March 2019) PTS is performing at 1% (11,441 journeys) below baseline. Within these overall figures, Cumbria and Lancashire are 2% and 9% below baseline whilst Greater Manchester and Merseyside are 2% and 10% above baseline respectively. In terms of overall trend analysis, Greater Manchester has experiencing upward activity movement for the 12 months up to around October 2018 where activity has plateaued. Lancashire has experienced a downward trend over the same period which is also plateauing whilst Cumbria and Merseyside are experiencing relatively consistent levels of activity.

Table O5.2

In terms of unplanned activity, cumulative positions within Greater Manchester and Merseyside are 21% (7,587 journeys) and 7% (1,216 journeys) above baseline respectively. As unplanned activity is generally of a higher acuity requiring ambulance transportation, increased volumes in this area impact on resource availability leading to challenges in achieving contract KPI performance. Cumbria and Lancashire are 17% (1,957 journeys) and 8% (3,620 journeys) below baseline.

Table O5.3

ABORTED ACTIVITY									
Current Month: March 2019									
Contract	**Planned Activity**	**Planned Aborts**	**Planned Aborts %**	**Unplanned Activity**	**Unplanned Aborts**	**Unplanned Aborts %**	**EPS Activity**	**EPS Aborts**	**EPS Aborts %**
Cumbria	9,004	337	4%	933	104	11%	3,430	53	2%
Greater Manchester	23,579	2,465	10%	4,716	1,036	22%	15,720	1,214	8%
Lancashire	25,434	1,357	5%	4,459	670	15%	14,652	439	3%
Merseyside	14,301	896	6%	1,913	330	17%	11,038	521	5%
NWAS	72,318	5,055	7%	12,021	2,140	18%	44,840	2,227	5%

Table O5.3

Aborted activity for planned patients averages 7% for the period July 2018 - March 2019 however Cumbria experiences 4%, Greater Manchester operates with 11% whilst Lancashire and Merseyside both experience 6% aborts. There is a similar trend within EPS (renal and oncology) patients with an average of 5% aborts whereas Cumbria has 2% and Greater Manchester 8% Lancashire and Merseyside operate with 3% and 5% respectively. Unplanned (on the day) activity experiences the largest volumes of aborts with an average 18% (1 in 5 patients) with variances of 10% in Cumbria, 24% in Greater Manchester, 15% in Lancashire and 17% in Merseyside.

OH1 STAFF SICKNESS

Figure OH1.1

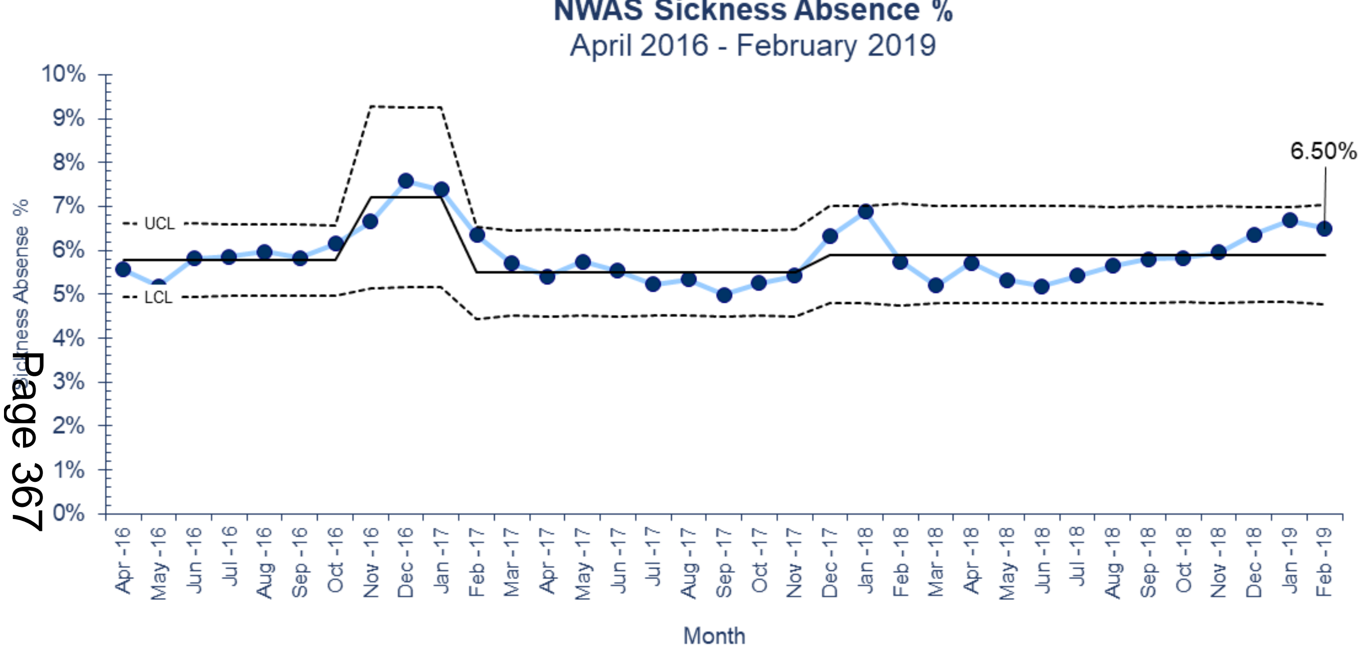


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Table OH1.1

Sickness Absence	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
NWAS	5.20%	5.72%	5.32%	5.18%	5.43%	5.64%	5.81%	5.82%	5.95%	6.37%	6.68%	6.50%
Amb. National Average	5.49%	5.17%	5.02%	5.09%	5.28%	5.47%	5.37%	5.49%	5.62%			

Staff Sickness

The overall sickness absence rates for February 2019 were 6.50%. As figure OH1.1 shows this indicates a change to the upward trend which had been seen over the last 7 months. However, February 2019 position is 0.76% higher than the same time in February 2018.

The 111 sickness position is at 9.61% for February 2019. This area of work will remain a priority in 111 to improve the attendance levels and stabilise the position. Additional HR resource will be allocated to 111 from mid-May. A targeted plan to improve attendance in 111 is being implemented.

EOC rates remain high at 7.83% for February 2019 nearing the upper control limit in Figure OH1.4. High level case reviews are ongoing with the Deputy Director of Operations and HR holding monthly review meetings.

PTS has 6.93% sickness absence in February 2019. This is a 1% reduction from the January 2019 position. A targeted plan to improve attendance in PTS is being implemented.

Figure OH1.2:

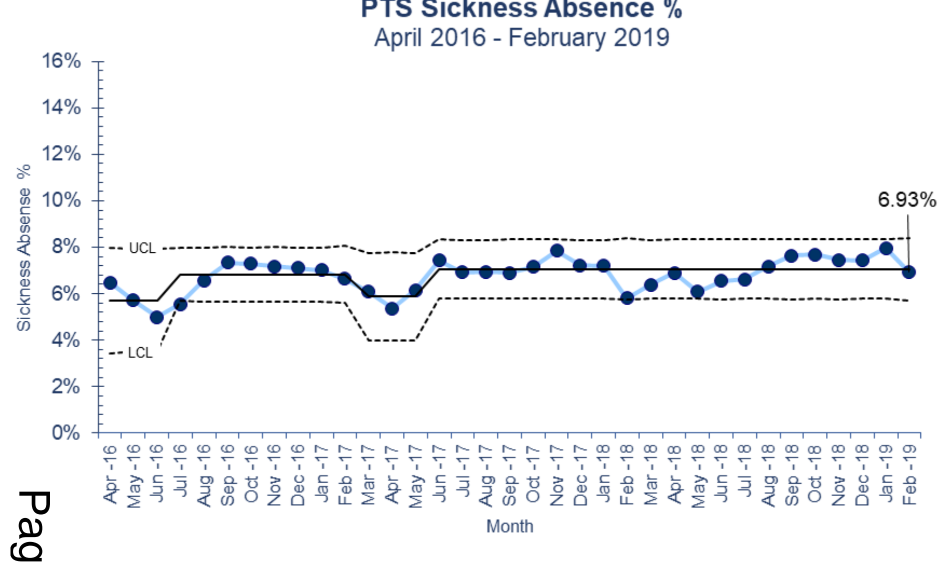


Figure OH1.3:

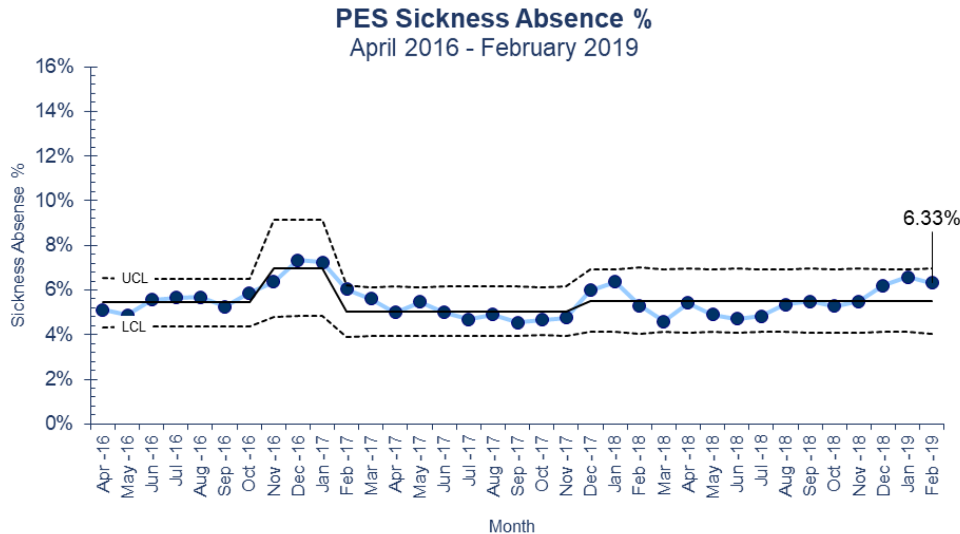


Figure OH1.4

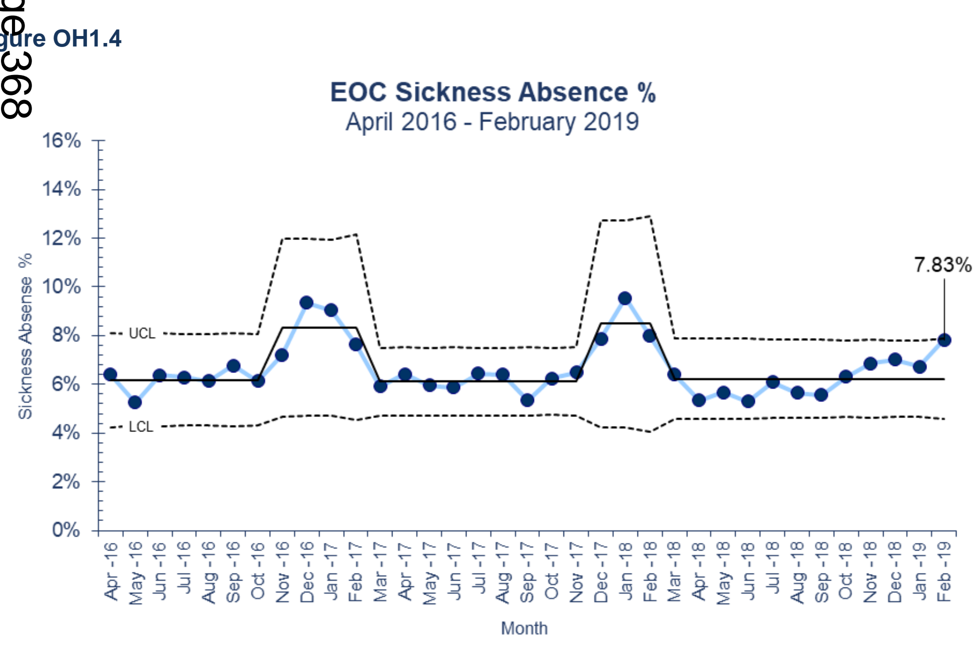


Figure OH1.5

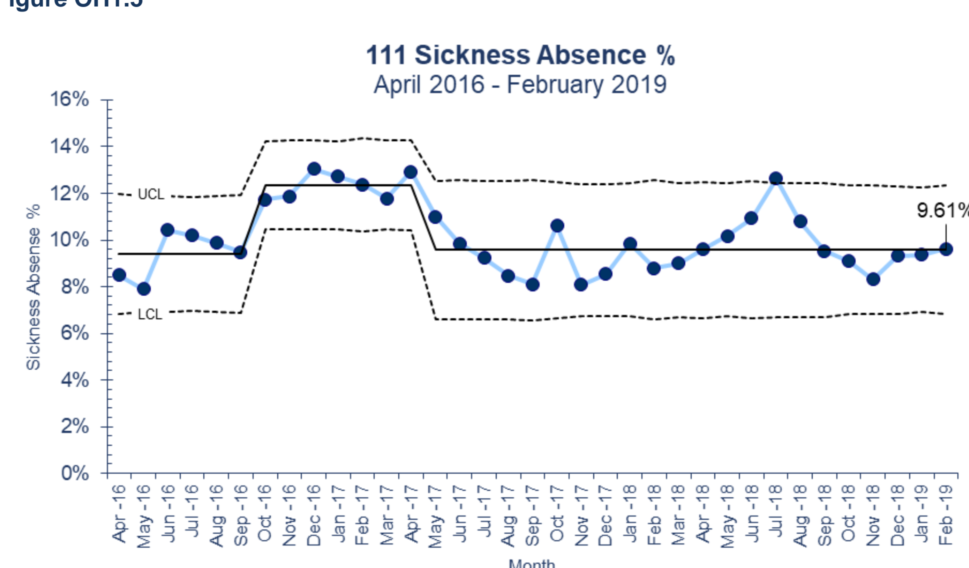


Table OH1.2 – Trust Comparison Figures

Trust	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
East Mids Amb	4.85%	4.72%	5.07%	5.47%	5.66%	5.45%	5.09%	5.10%
East of Eng Amb	5.68%	5.54%	5.67%	5.84%	5.88%	6.06%	6.00%	6.63%
London Amb	4.99%	5.02%	5.31%	5.20%	5.42%	5.20%	5.45%	5.41%
North East Amb F	6.40%	6.01%	6.18%	6.11%	6.00%	5.63%	5.79%	5.30%
North West Amb	5.33%	5.36%	5.20%	5.45%	5.68%	5.78%	5.77%	5.95%
South Central Amb F	4.96%	5.13%	5.68%	6.18%	6.49%	6.24%	6.07%	6.22%
South East Coast Amb F	4.84%	4.41%	4.34%	4.87%	4.86%	5.20%	5.19%	4.84%
South West Amb F	4.58%	4.57%	4.61%	5.02%	5.31%	5.32%	5.33%	5.74%
Welsh Ambulance Services	7.15%	6.72%	6.63%	6.63%	7.24%	6.72%	7.09%	7.41%
West Mids Amb F	3.36%	3.25%	3.10%	3.28%	3.26%	2.97%	3.58%	3.47%
Yorkshire Amb	5.66%	5.23%	5.15%	5.09%	5.43%	5.29%	5.70%	6.12%
National Average	**5.17%**	**5.02%**	**5.09%**	**5.28%**	**5.47%**	**5.37%**	**5.49%**	**5.62%**

OH2 STAFF TURNOVER

Figure OH2.1

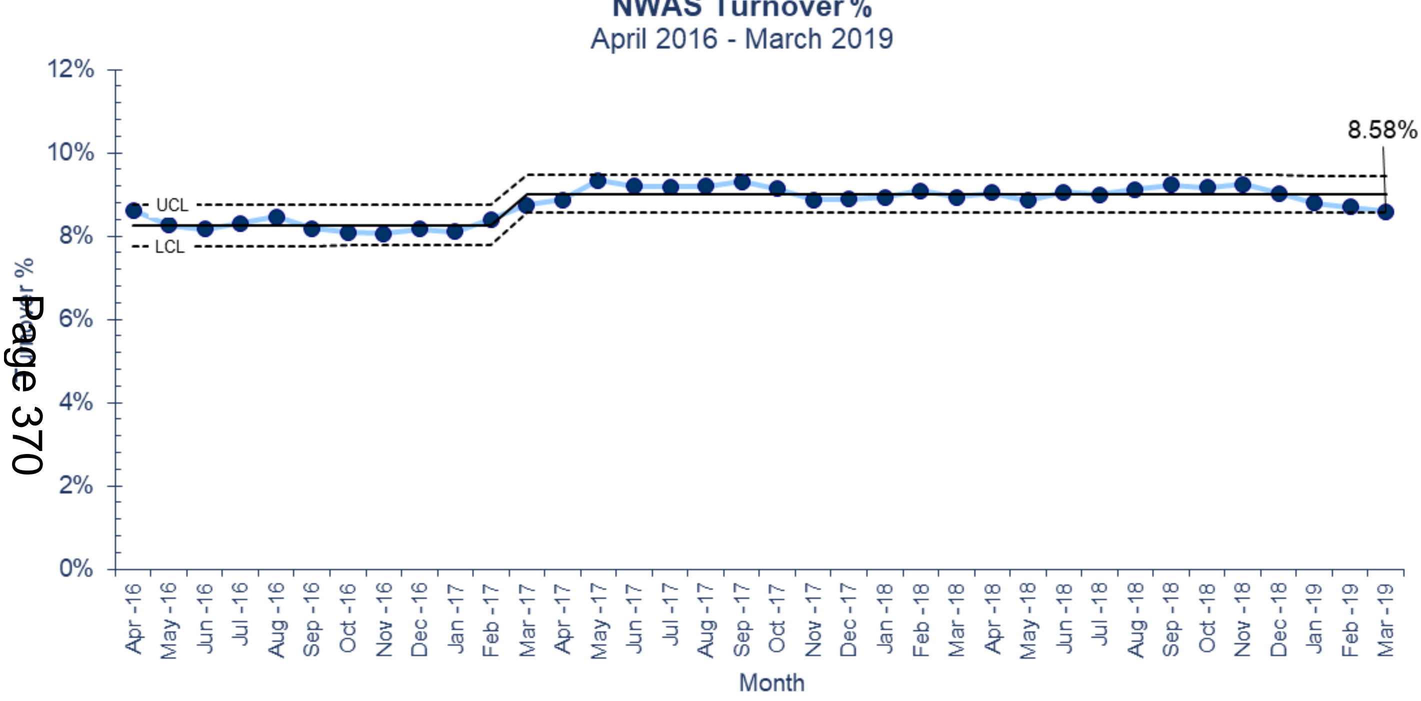


Table OH2.1

Turnover	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan - 19	Feb - 19	Mar - 19
NWAS	9.04%	8.85%	9.06%	8.99%	9.13%	9.23%	9.17%	9.24%	9.03%	8.79%	8.69%	8.58%
Amb. National Average	9.68%	9.60%	9.46%	9.36%	9.19%	9.27%	9.12%	9.07%	9.02%			

Staff Turnover

Turnover is calculated on a rolling year average and this does lead to some small variations between months with March 2019 turnover being 8.58%.

Teams are in place with a specific focus on areas of high turnover in 111 and EOC.

111 turnover is 29.92% for March 2019. We will continue to focus on retention in 111 to further reduce turnover and stabilise the position.

Turnover in EOC is reported at 11.43% for March 2019, reduced by 1% compared with the same time last year. Further recruitment is taking place in EOC and plans are well developed to introduce Apprenticeships in the autumn to improve retention.

PES and PTS turnover rates remain stable.

Figure OH2.2

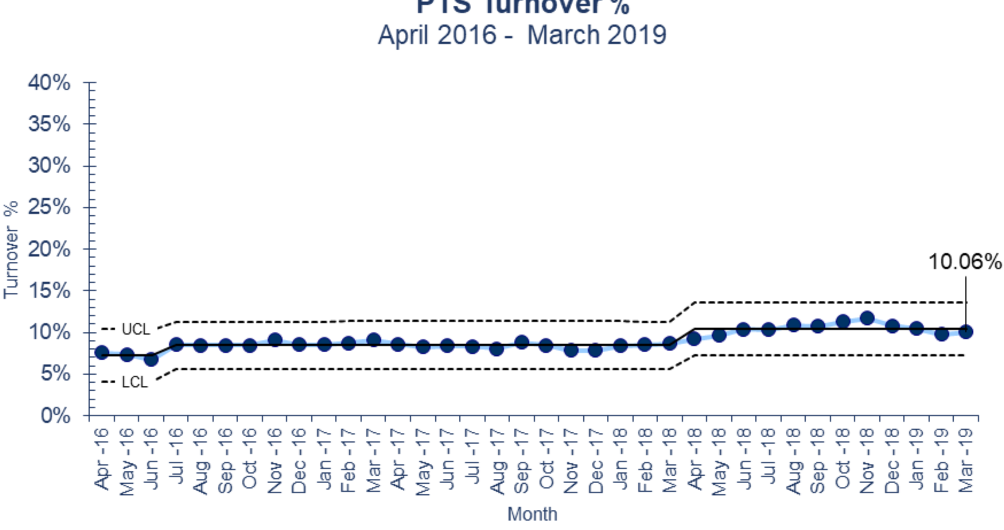


Figure OH2.3

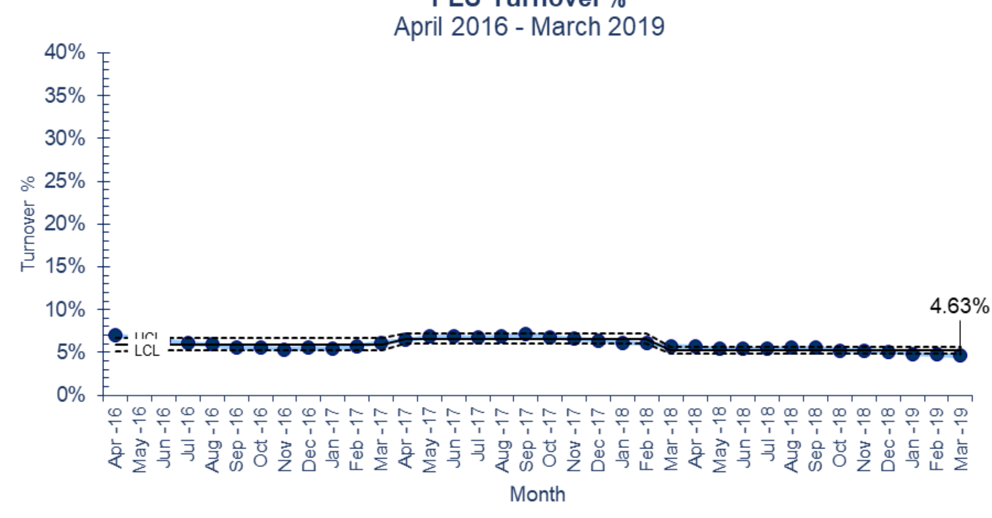


Figure OH2.4

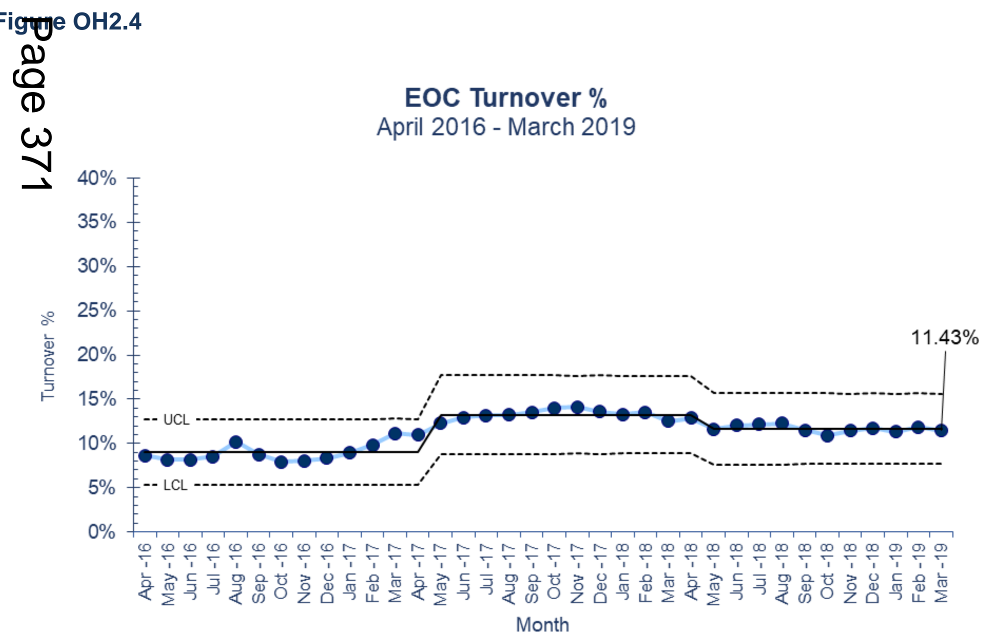
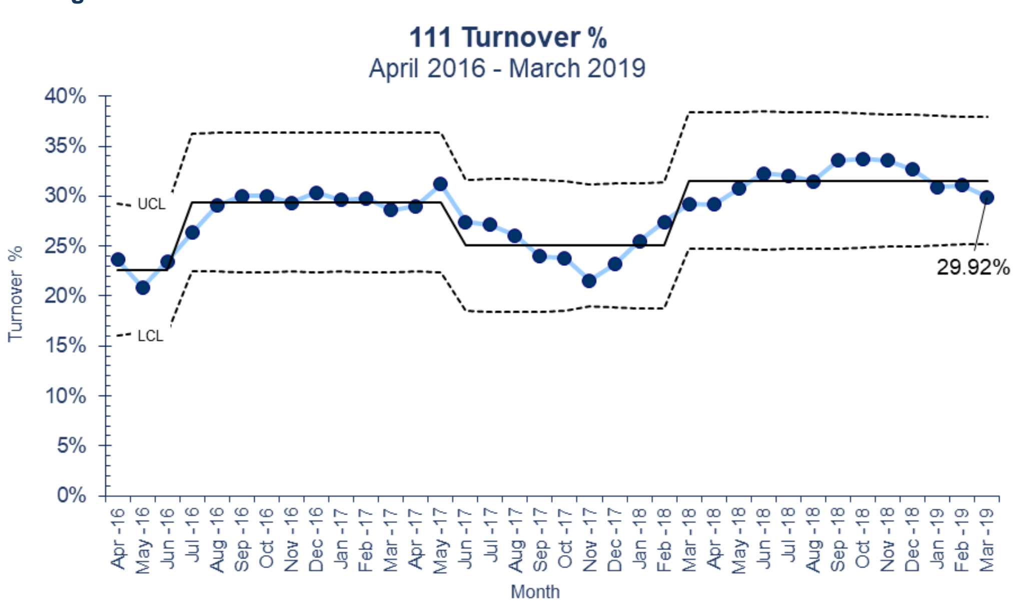
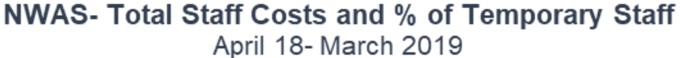


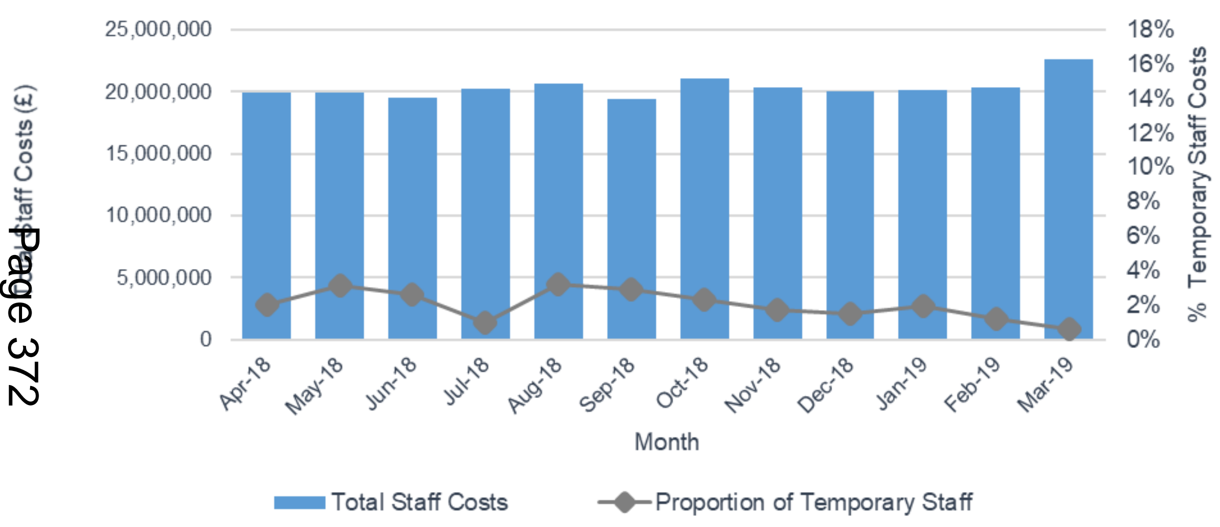
Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:





Temporary Staffing

The Trust remains in strong position regarding Agency costs. Proportion of Agency costs reduced further in March 2019 at 0.61% of total staffing costs. This expenditure is under the agency ceiling.

Over the last 12 months the Trust has been proactive in reducing Agency usage, particularly within 111 with ongoing recruitment to move staff onto permanent contracts. This can be seen in OH4.4.

The Trust has also adopted a more robust assessment of Agency usage when requests are received.

Table OH4.1

NWAS	Apr-2018	May2018	Jun-2018	Jul-2018	Aug-2018	Sep-2018	Oct -2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019
Agency Staff Costs (£)	252,567	341,240	334,497	262,694	310,041	285,989	229,598	212,061	173,766	191,843	180,676	203,421
Total Staff Costs (£)	19,978,113	19,888,139	19,550,684	20,263,029	20,674,865	19,401,547	21,048,733	20,394,454	20,058,775	20,169,610	20,354,432	22,621,645
Proportion of Temporary Staff %	2%	2%	2%	1%	3%	3%	2%	2%	1%	2%	1%	1%

Figure OH4.2:

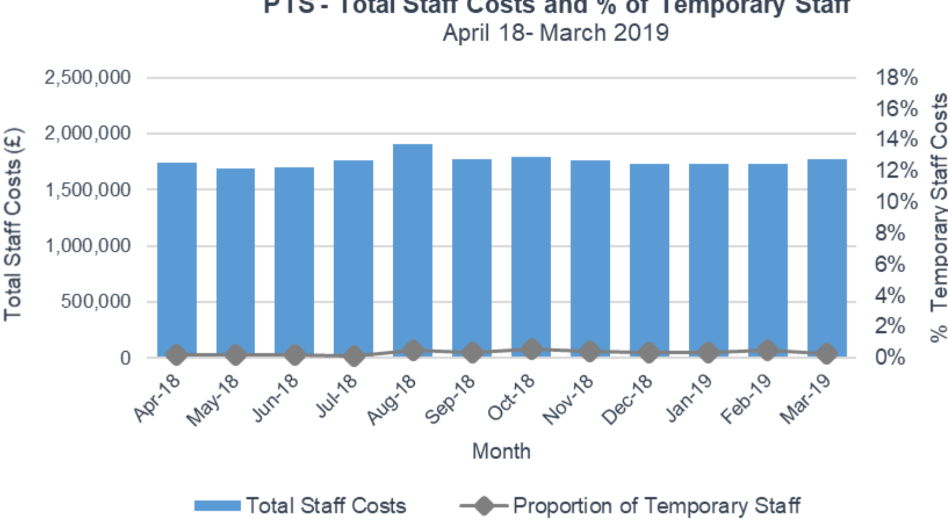


Figure OH4.3

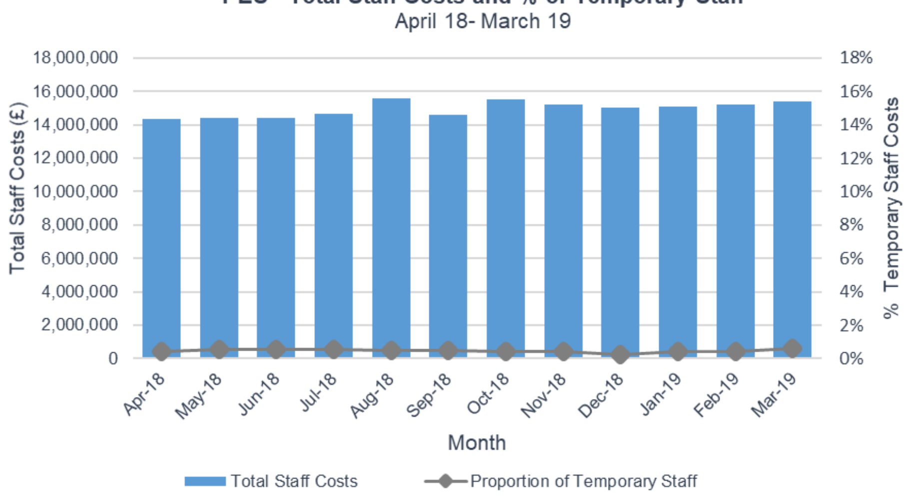


Figure OH4.4:

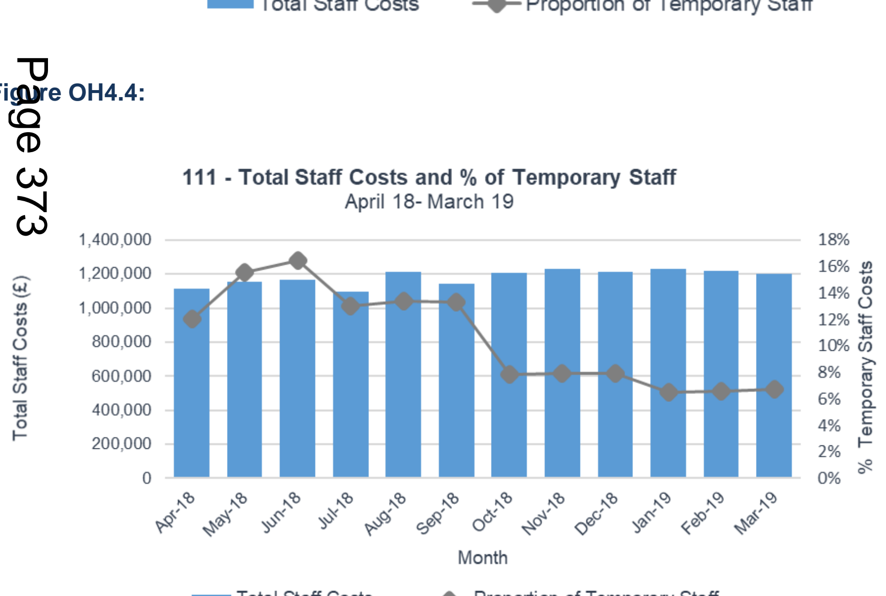
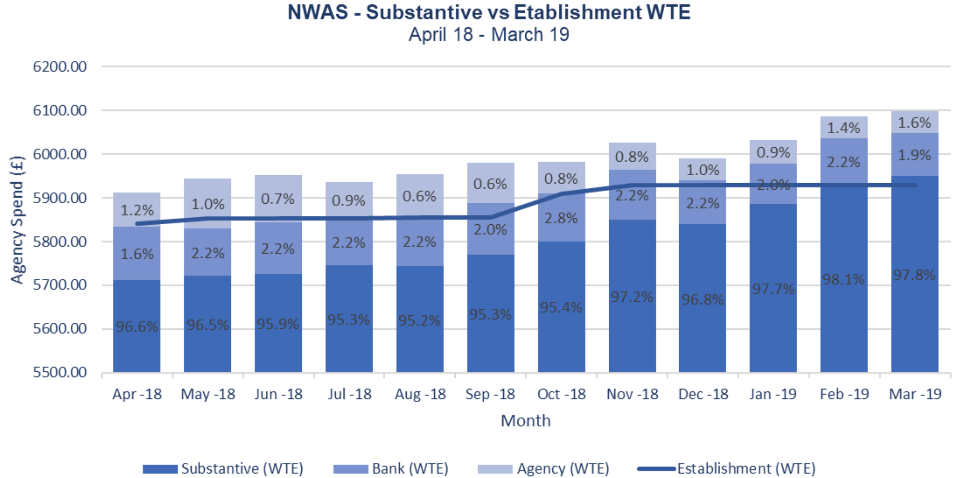


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

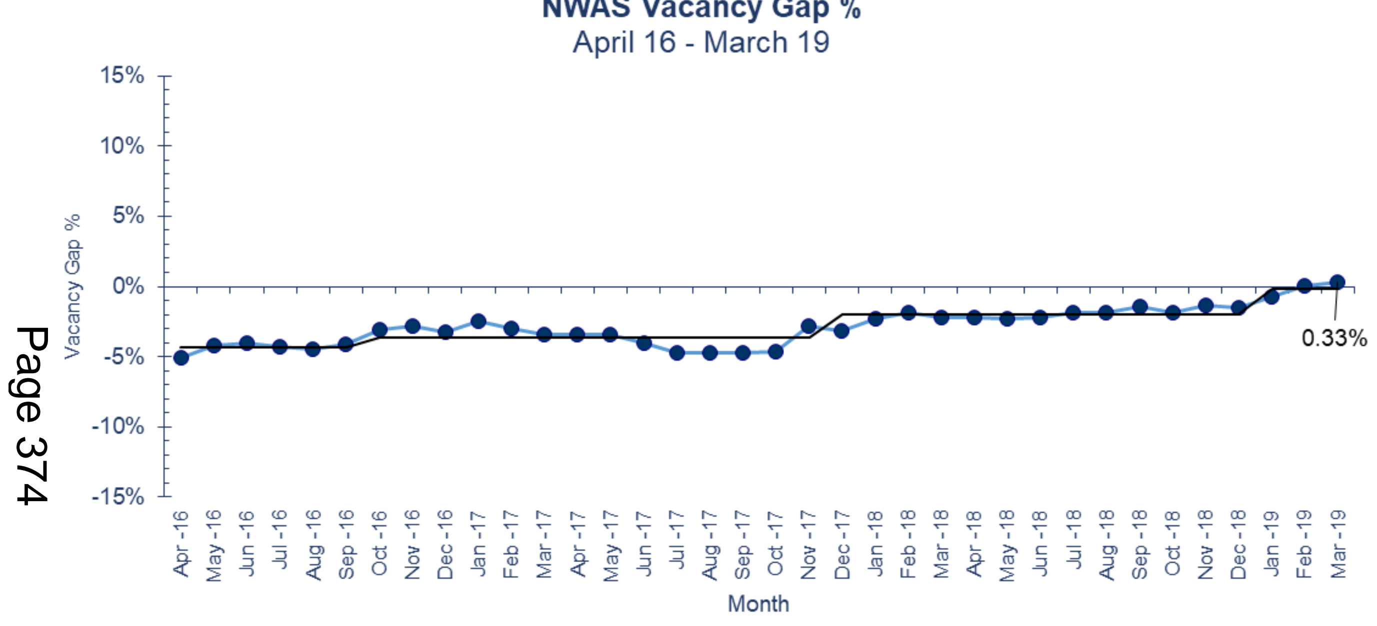


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Table OH5.1

Vacancy Gap	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
NWAS	-2.20%	-2.26%	-2.17%	-1.86%	-1.90%	-1.47%	-1.83%	-1.35%	-1.52%	-0.74%	0.01%	0.33%

Vacancy Gap

The vacancy position continues to remain stable with the Trust being slightly over-established overall. Frontline PES vacancy position remains positive with frontline staff being 1.7% overstaffed.

The March 2019 position for EOCs is 5.4% overstaffed. For both PES and EOC the contract settlement will lead to increased establishments and the current position places the Trust in a strong position to meet this growth challenge.

NWAS has also had confirmation that the current Health Professional Calls/Inter Facility Transfer pilot will be rolled out across all Ambulances Services allowing the Band 2 roles to be baselined as part of the EOC establishment.

PTS vacancy position is -8.1% in March 2019 which continues the improved position and new starters are planned in PTS over the coming months to further reduce the vacancy gap.

111 have seen further reductions in the vacancy position and the March 2019 figure is now 1.6% over establishment. The focus for 111 is now on the retention of staff and continuing to improve the clinical advisor vacancy position. The plan for 111 to be included in Phase 1 of the Rota Review will hopefully enable the improvement in retention figures.

Figure OH5.2

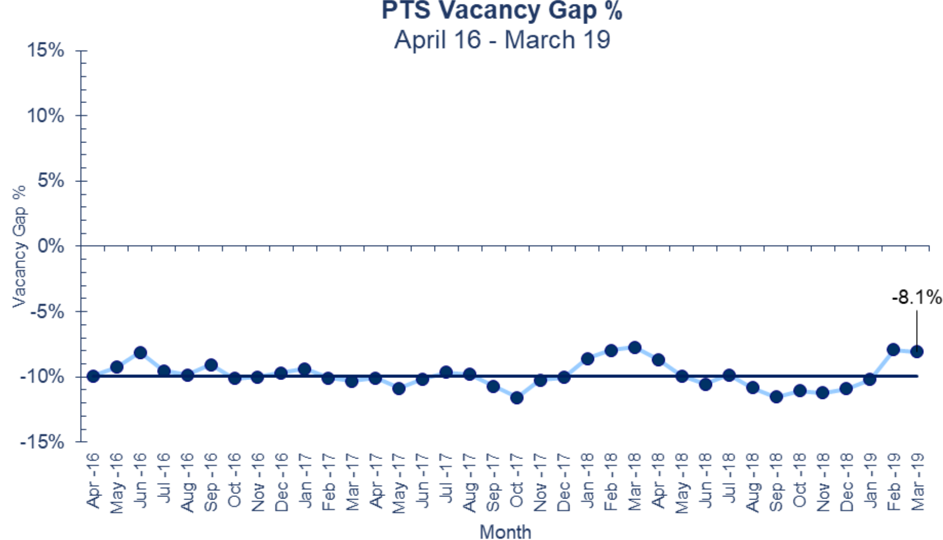


Figure OH5.3

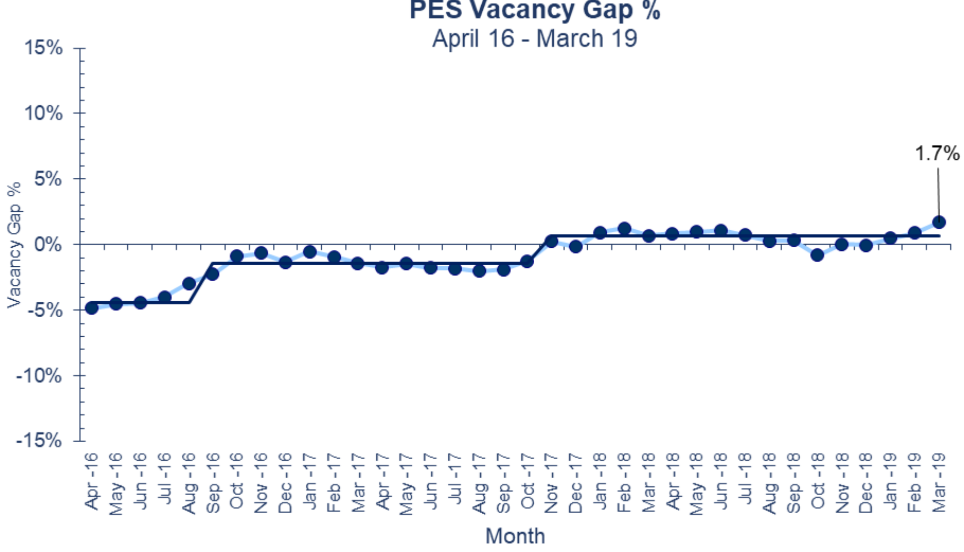


Figure OH5.4

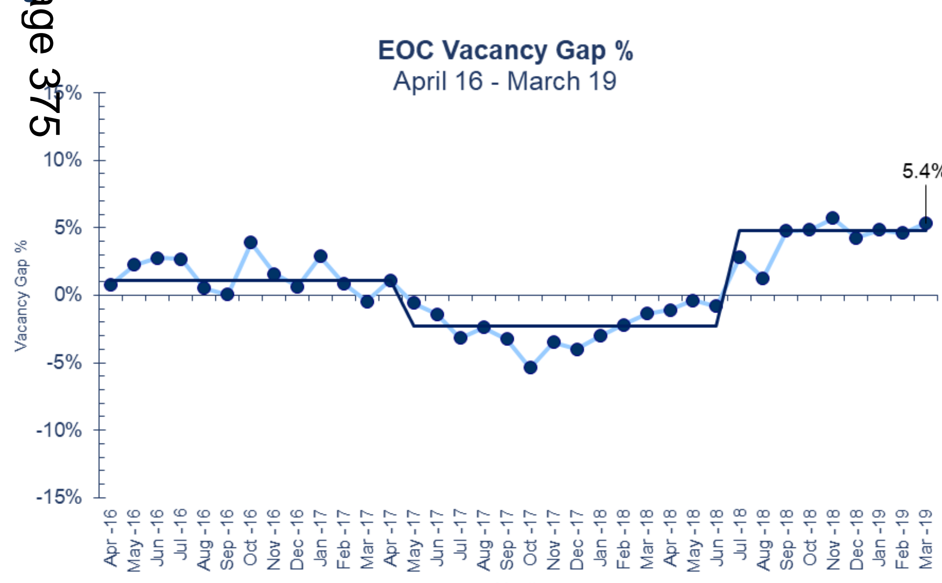
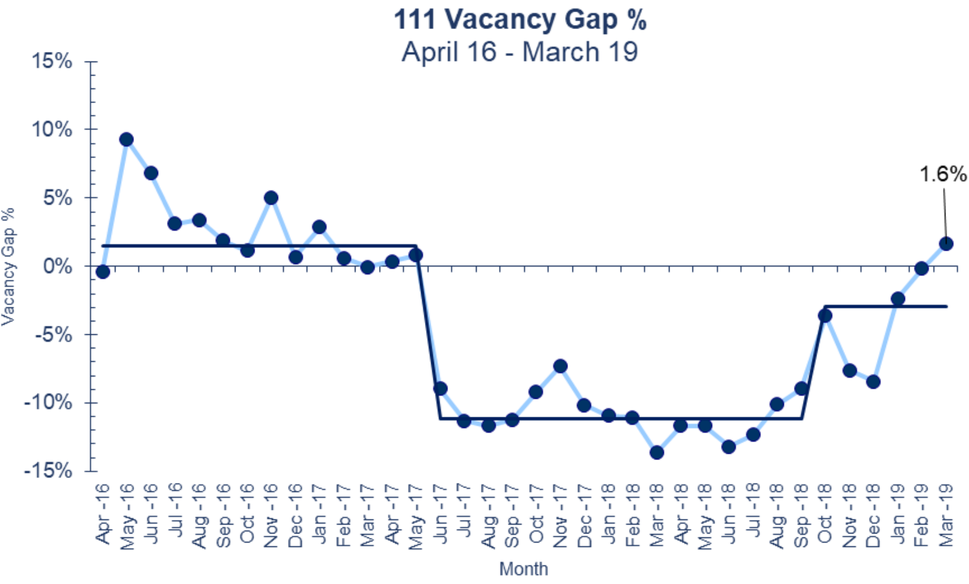


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

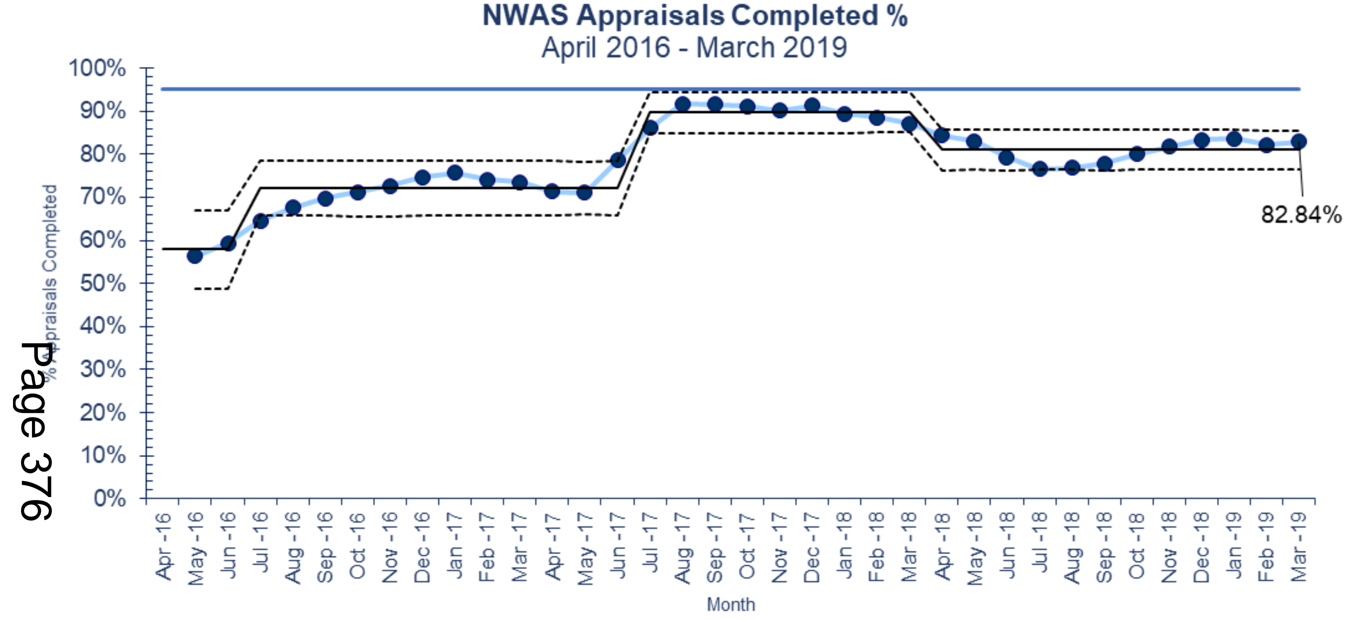


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Table OH6.1

Appraisals	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec18	Jan -19	Feb -19	Mar-19
NWAS	84%	83%	79%	77%	77%	78%	80%	82%	83%	84%	82%	83%

Appraisals

Appraisal compliance overall has been variable, with March 2019 being a slightly improved position at 83% against a target of 95%.

PES has shown significant improvement in the last four months with current compliance at 87.95% for March 2019. This is an upward trend since last June.

The other service lines, EOC, 111 and PTS remain below target with EOC at 73.74% and 111 at 74.70%. However 111 have improved from the previous month at 71.15% and a significant improvement since the August 18 position of 50%.

PTS have seen the most variation from previous months, the current compliance being at 68.32%. This drop for PTS relates to the Arriva Transport Solutions Ltd TUPE transfers where there were no appraisals in place prior to transfer resulting in large numbers of staff having an appraisal at the same time and then going out of date at the same time. This has been exacerbated by delays in reporting. The Sector Manager has an action plan to stagger this over the coming months to avoid the sharp drop off again.

Work is underway to develop a plan to support improvement on other service lines.

Figure OH6.2

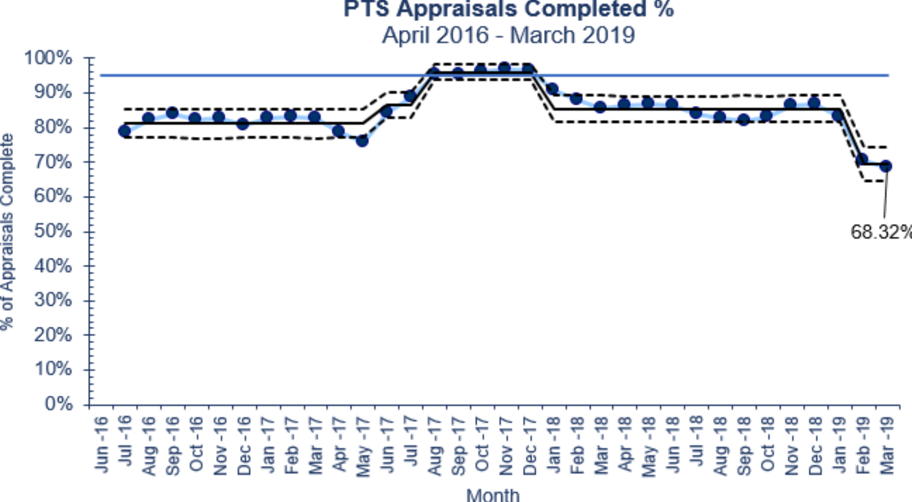

Figure OH6.3

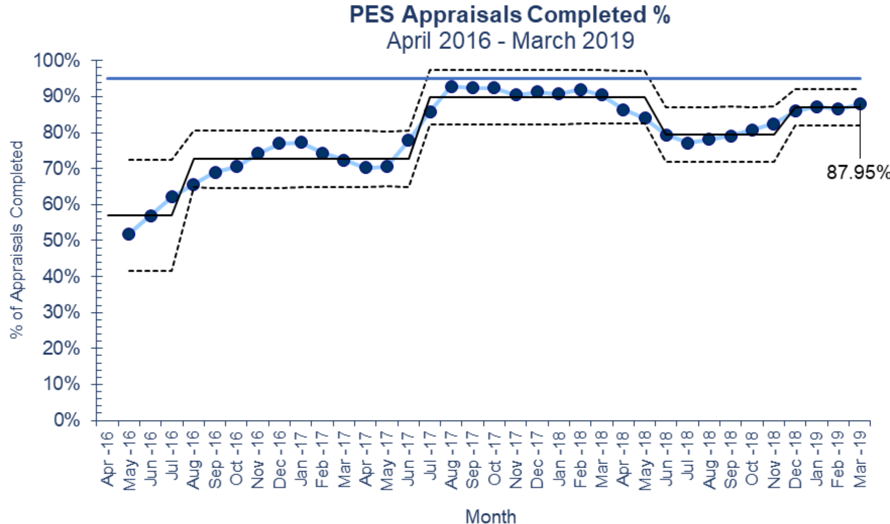

Figure OH6.4

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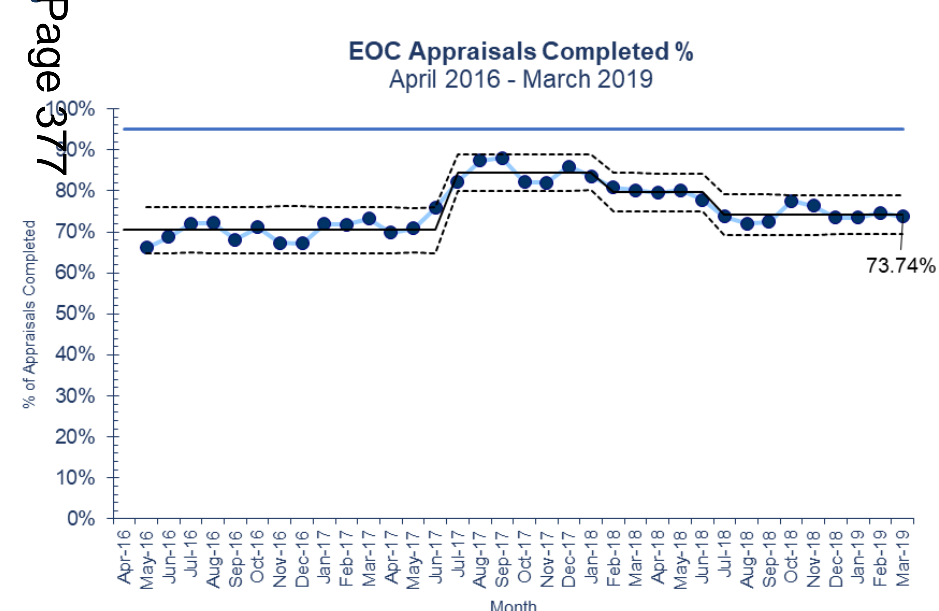
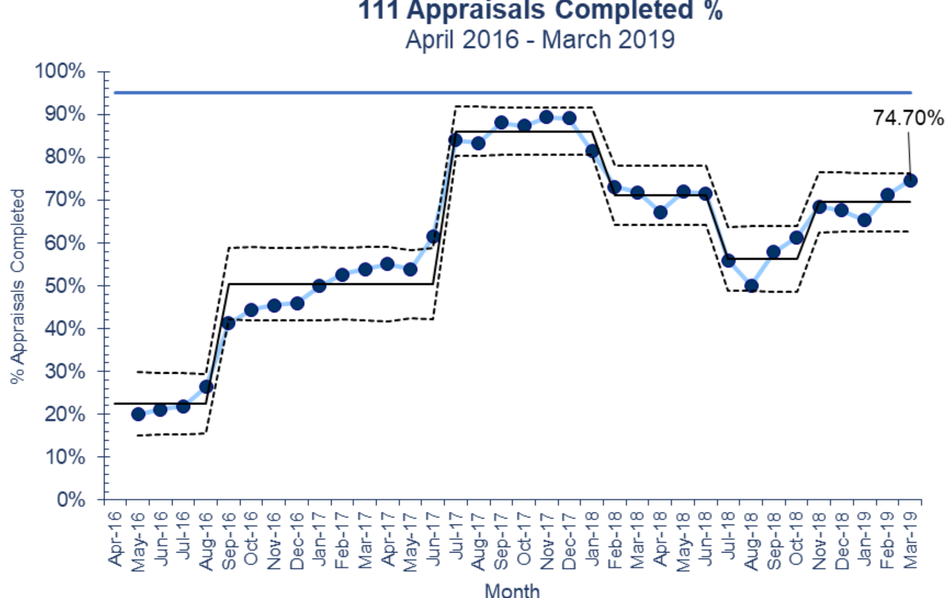


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

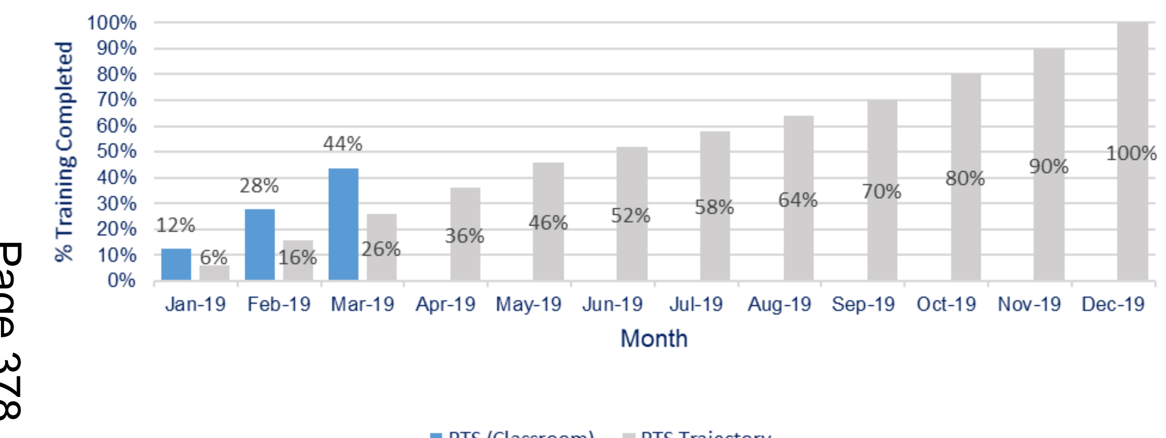
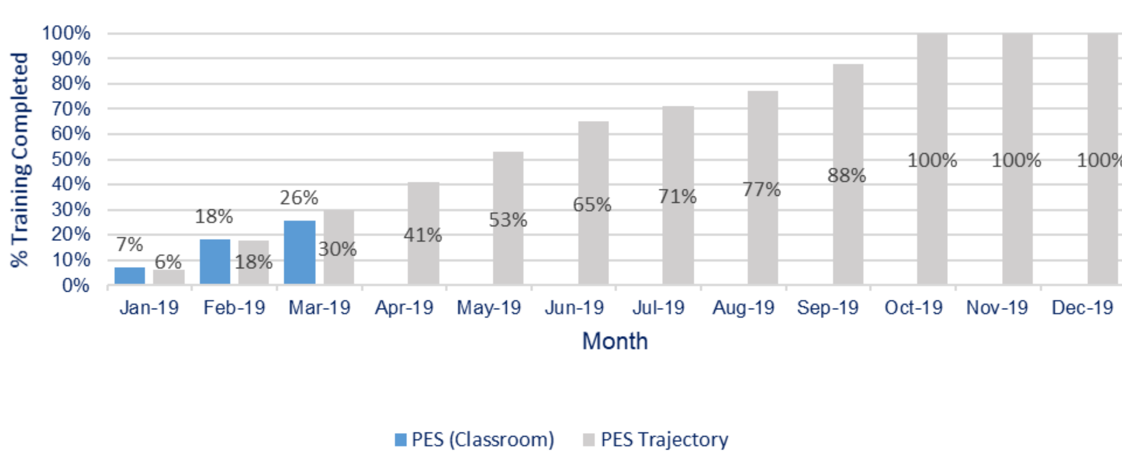


Figure OH7.2



Mandatory Training

The classroom Mandatory Training for the 2019 cycle commenced in January 2019. Attendance for PTS is ahead of trajectory with PES reporting slightly under at 26% against a trajectory of 30% by March 2019.

For 2019 we have moved to competency based compliance reporting for Mandatory Training. Each element of mandatory training is set as a competence allowing reporting of all completions which are in date. The overall Trust position at the end of March 2019 is 55% compliance against a target of 45%.

Corporate, 111 and EOC remain behind target and OD is working with these service lines to ensure targets are achieved and maintained.

For 2019 all non-classroom delivery is via e-learning which is accessed through ESR self-service (MyESR) and this is reported through ESR which is included in the monthly workforce dashboards.

Figure OH7.3

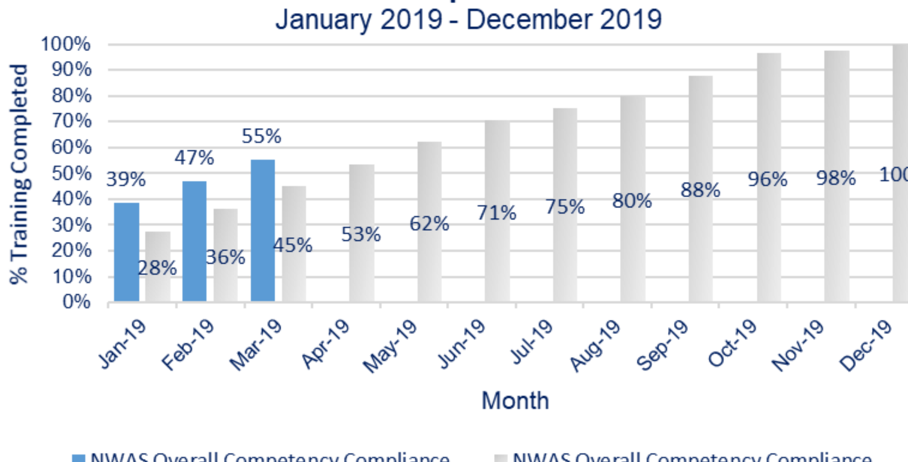


Figure OH7.4

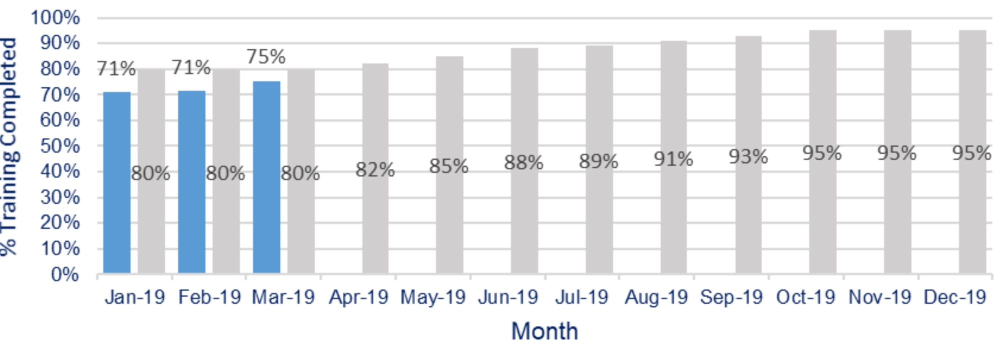
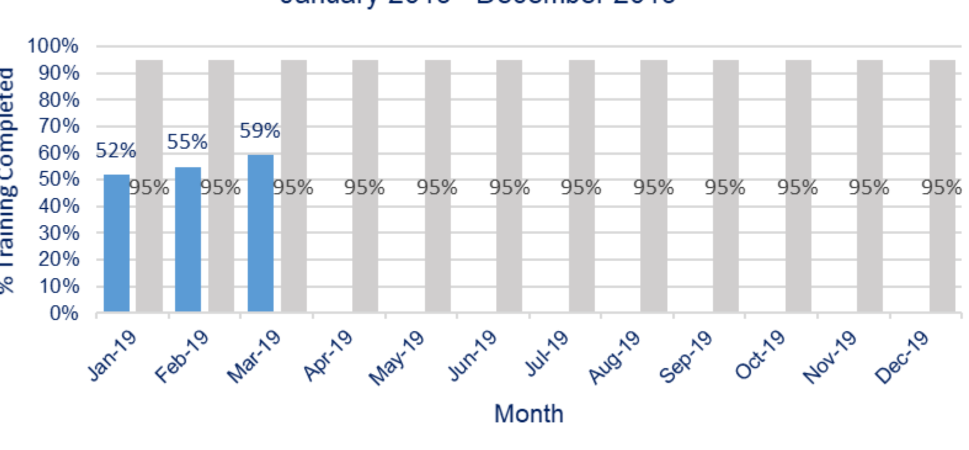


Figure OH7.5

Figure OH7.6



REPORT

Board of Directors	
Date:	24th April 2019
Subject:	**Finance Report to 31st March 2019 – Month 12 2018/19**
Presented by:	**Carolyn Wood, Director of Finance**
Purpose of Paper:	For Assurance
Executive Summary:	The purpose of this report is to inform the Board of Directors of the financial position (unaudited) for the year to 31st March 2019. The 2018/19 end of year financial position for the Trust is a surplus of £2.513m, this is £0.675m better than the planned surplus of £1.838m. The trust will receive a further Provider Sustainability Funding (PSF) payment of £0.675m for finance performance incentive, taking the overall financial surplus to £3.188m. The Trust is awaiting final notification of the Bonus and General Distribution PSF, which will increase the surplus, this will then be included in the draft accounts submission. Other areas to note: • The overall financial performance risk rating as at 31st March 2019 is 1. • The 2018/19 full year Cost Improvement Programme (CIP) of £9.834m has been achieved in year. • The recurrent unidentified CIP has remained at £1.002m and has been added to the 2019/20 CIP Target. • The 2018/19 capital plan is £21.306m. Expenditure as at Month 12 is £21.259m and sale of assets at £0.382m. • At 31st March 2019 the cash and cash equivalents balance is £40.962m. The Trust has achieved the Better Practice Payment Code targets for 2018/19.
Recommendations, decisions or actions sought:	The Board of Directors is asked to note the 2018/19 reported financial performance for the year to 31st March 2019.

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	**N/A**
Date:	
Outcome:	**N/A**

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1. PURPOSE

1.1 The purpose of this report is to inform the Board of Directors of the financial performance for the year to 31st March 2019.

1.2 It should be noted that this reported position includes the Provider Sustainability Fund (PSF) notified to the Trust on 18th April 2019. The position reported here is the unaudited position. The Annual Accounts for the financial year are currently being completed and are due to be completed and submitted by the 24th April 2019. The Annual Accounts will be audited by external audit and then presented to Audit Committee and approved by Board on 24th May 2019. The submission of the audited Annual Accounts is by noon on 29th May 2019.

2. FINANCIAL PERFORMANCE DASHBOARD

2.1 The Financial Performance Dashboard uses the following criteria for assessing the key financial performance indicators for the Trust, with current and forecast assessments of the position against these indicators. The risk rating system is in line with similar ratings used by the Trust, using a traditional Red, Amber, Green traffic light status.

Table 1 – Performance Indicator Ratings

Indicator Status	Description of Status
GREEN	We are on target currently and/or we would expect to remain on target at the year-end to achieve the required metric indicator.
AMBER	We are not yet achieving our desired target level, but we are close and working towards it, and/or that we are concerned that current plans may not achieve the target by the year end.
RED	We are not at our target level, and are some way off, and/or that we do not have sufficiently robust plans to indicate that we would be confident of achieving the target by the year end.

2.2 The 2018/19 full year position for the Trust is a surplus of £2.513m, this is £0.675m better than the planned surplus of £1.838m. The trust will receive a further Provider Sustainability Funding (PSF) payment of £0.675m for finance performance incentive, taking the overall financial surplus to £3.188m.

Income is over recovered by £6.811m, pay is overspent by £5.900m and non-pay is overspent by £0.236m.

2.3 The Trust's financial plans only include the pay award for 2018/19 at 1%, as per the national planning guidance at the time. In relation to the final agreed Agenda for Change (A4C) pay settlement the Trust has received confirmation that it has been allocated an additional £3.484m of income for 2018/19. As at Month 12 the Trust has received £3.484m of this additional income, which offsets the additional pay costs incurred to date of £3.484m. This is included in the current financial performance and explains the over-recovery on income against the plan and pay overspending detailed at section 2.2 of this report.

2.4 The control total for the 2018/19 year end is £1.838m surplus, which includes core Provider Sustainability Fund of £2.422m

2.5 **Table 2 – 2018/19 Notified PSF incentive funding**

2018/19 Notified PSF	£000
Core PSF included in plan	2,422
Incentive – financial performance	675
Incentive – general	TBC
Incentive – bonus	TBC
Total 2018/19 Notified PSF	3,097

Table 3 – Financial Performance Dashboard

Metric	Commentary	Year to Date Rating	Year End Rating	Paragraph for detail
Financial Sustainability Risk Rating	The planned rating was a 1, the year-end actual rating is a 1.			4
Revenue	The year-end outturn surplus is £3.188m which is £1.350m better than plan, including core and financial performance incentive PSF			5 & 7
CIP Delivery	The Trust has achieved 100% of the £9.834m CIP target during 2018/19.			6
Capital	The year-end capital expenditure is £21.259m and sale of assets at £0.382m.			8
Cash	The Trust has achieved the External Financial Limit (EFL). The cash balance at 31st March 2019 is £40.962m.			9

3. RISKS 2018/19

3.1 The table below **Table 4 – Significant Risks & Mitigation Plans** highlights the significant financial risks the Trust has faced during 2018/19 and identifies how they have been treated in the financial position.

Table 4 – Significant Risks & Mitigation Plans

Risk	Narrative	Included / Excluded for reported outturn
Provider Sustainability Funding (PSF)	The Trusts financial position £3.188m which includes £2.422m of core Provider Sustainability Fund and £0.675m financial performance incentive PSF.	Total PSF included £3.097m

Cost Improvement Programme slippage (CIP)	The Trust has achieved 100% of the target in year of £9.834m, however there is still a shortfall of £1.002m recurrently.	Included – schemes of £9.834m delivered in year
CQUIN Schemes	There was a shortfall of £0.146m at the end of Quarter 3 and a further £0.211m shortfall in Quarter 4 resulting in total estimated CQUIN loss of £0.357m.	£0.357m income loss included

4. FINANCIAL SUSTAINABILITY RISK RATING (FSRR)

4.1 NHS Improvement introduced a new Single Oversight Framework that came into effect from the 1st October 2016. It assesses the providers via "Use of Resources Metrics (UOR)" that helps to identify providers that need support. The UOR Metrix comprise of five elements:

4.2 Continuity of Services

1. Liquidity: days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown.
2. Capital servicing capacity: the degree to which the organisation's generated income covers its financing obligations.
3. Underlying performance: I&E margin percentage, which measures the surplus against the income.
4. Variance in I&E margin as a percentage of income: This measures if the actual surplus is in line with the planned surplus.
5. Agency usage: This measures how far providers are above or below their agency ceiling.

There are four rating categories ranging from 1, which represents the providers with maximum autonomy i.e. least risk, to 4, representing the providers in special measures i.e. most risk. If any of the elements score at 4, the maximum overall score the provider could be scored at is 3 regardless of the remaining elements i.e. it triggers override to bring the score to 3.

Table 5 - Risk Ratings

Financial Metric	2018/19 YTD Score	Plan Score	Weight
Liquidity	1	1	0.2
Capital Servicing	1	1	0.2
I&E Margin	2	2	0.2
Control total rating	1	1	0.2
Agency	2	1	0.2
Overall Unrounded	1.4	1.2	
Rounded Score before override	1	1	
OVERALL SCORE AFTER OVERRIDE (Triggered if any of the score are 4)	1	1	

4.3 The full year expenditure on agency is £2.978m which is £0.021m above the ceiling of £2.957m, equivalent to 0.7% above the ceiling which results in an agency financial metric of 2. The overall financial risk score for the Trust for 2018/19 is 1. The Trust has seen a reduction in agency expenditure in the last few months and has reduced the percentage above the agency ceiling.

5. SUMMARY REVENUE FINANCIAL POSITION

5.1 The summary financial position is shown in **Table 6 – Summary Financial Position**.

5.2 The EBITDA position for year-end is a surplus of £12.707m which is £0.926m below the planned EBITDA surplus.

5.3 It should be noted that the EBITDA position does not include depreciation, amortisation, interest and dividends and after accounting for these items the Trust's financial performance against the control total is a surplus of £2.513m which is a £0.675m favourable variance to the plan.

Table 6 – Summary Financial Position

Statement of Comprehensive Income	Year to Date - Month 12		
	Budget	Actual	Variance
	£000s	£000s	£000s
Total Income	**(332,170)**	**(338,981)**	**(6,811)**
Pay Expenditure	238,454	244,354	5,900
Non Pay Expenditure	80,083	81,919	1,836
Total Expenditure	**318,537**	**326,273**	**7,736**
EBITDA	**(13,633)**	**(12,708)**	**925**
Depreciation & Amortisation	10,903	10,363	(540)
Dividends	1,285	1,324	39
Other Gains & Losses	(153)	(185)	(32)
Interest payable	0	0	0
Interest receivable	(230)	(251)	(21)
Other finance costs	11	(11)	(22)
(SURPLUS)/DEFICIT	**(1,817)**	**(1,468)**	**349**
Donated Assets	21	21	0
Impairment Losses	0	1,024	1,024
Reported NHS Financial Performance	**(1,838)**	**(2,513)**	**(675)**
Provider Sustainability Funding (PSF)	0	675	675
Overall Reported NHS Financial Performance	**(1,838)**	**(3,188)**	**(1,350)**

6. COST IMPROVEMENT PROGRAMME PERFORMANCE

6.1 The financial plans set a 2018/19 CIP target of £9.834m, which the Trust has achieved 100% in year. A summary of the CIP performance by scheme to the end of March is shown in **Table 7 - CIP requirements 2018/19.**

Table 7 - CIP requirements 2018/19

Scheme	Full Year Plan £000s	YTD Plan £000s	YTD Actual £000s	Variance £000s
Estates and Fleet	0.610	0.610	0.146	(0.464)
Finance and Procurement	0.120	0.120	0.090	(0.030)
Chief Executive	0.066	0.066	0.004	(0.062)
Organsational Development	0.275	0.275	0.000	(0.275)
IMT	0.281	0.281	0.025	(0.256)
Quality	0.140	0.140	0.000	(0.140)
Medical	0.011	0.011	0.000	(0.011)
PES	6.630	6.630	5.895	(0.735)
PTS	0.561	0.561	0.563	0.002
111	0.219	0.219	0.219	0.000
Resilience	0.032	0.032	0.000	(0.032)
Other Additional	0.762	0.762	0.461	(0.301)
Sub Total Recurrent Schemes	**9.707**	**9.707**	**7.403**	**(2.304)**
CIP Non Recurrent	0.127	0.127	2.431	2.304
GRAND TOTAL	**9.834**	**9.834**	**9.834**	**0.000**

7. MARCH 2019 (MONTH 12) – COMMENTARY ON DIRECTORATES – EXCEPTION REPORTING

7.1 The summary for each directorate is shown in **Table 8 – Summary Financial Position by Directorate**.

Table 8 – Summary Financial Position by Directorate

	Year to Date - Month 12		
	Budget (£'000)	**Actual (£'000)**	**Variance (£'000)**
Operations			
PES	(55,358)	(53,773)	1,585
111 Service	(2,834)	(2,239)	595
Resilience	272	(366)	(638)
Total Operations	**(57,920)**	**(56,378)**	**1,542**
Finance			
PTS	(3,792)	(2,629)	1,163
Estates & Fleet	20,475	20,139	(336)
Corporate	(532)	(1,793)	(1,261)
Total Finance	**16,151**	**15,717**	**(434)**
Other Directorates			
Quality	12,529	12,315	(214)
Organisational Development	6,961	6,842	(119)
Chief Executive	6,782	6,943	161
Medical	1,864	1,853	(11)
Total Other Directorates	**28,136**	**27,953**	**(183)**
EBITDA	**(13,633)**	**(12,708)**	**925**
Depreciation & Amortisation	10,903	10,363	(540)
Dividends	1,285	1,324	39
Other Gains & Losses	(153)	(185)	(32)
Interest Payable	0	0	0
Interest Receivable	(230)	(251)	(21)
Other Finance Costs	11	(11)	(22)
(Surplus) / Deficit	**(1,817)**	**(1,468)**	**349**
Donated Assets	21	21	0
Impairment Losses	0	1,024	1,024
Reported NHS Financial Performance	**(1,838)**	**(2,513)**	**(675)**
Provider Sustainability Funding (PSF)	0	675	675
Overall Reported NHS Financial Performance	**(1,838)**	**(3,188)**	**(1,350)**

7.2 **Paramedic Emergency Services**

The PES directorate ended the year reporting a £1.585m overspend. Income is over-recovered by £0.580m mainly due to additional non-recurrent income from CCGs for various initiatives and income from staff secondments.

Pay is £0.688m overspent, primarily due to the levels of overtime carried out to meet operational pressures being higher than the vacancies in various areas. However an element of the pay overspending is recouped through secondment and other recharges.

Non-pay is £1.477m overspent, with the main overspending areas being £0.418m on meal break

payments and the net impact of the £0.435m underspending on VAS in Quarter 1 relating to the additional capacity investment from Commissioners and a £1.406m VAS overspend from Month 4 to Month 12.

7.3 **111 Service**

The 111 service is £0.595m overspent at the year-end. Pay is £0.374m overspent primarily due to the use of bank staff and agency usage being above the budgeted vacant posts however during the year plans were implemented to reduce agency expenditure levels which led to a 45% reduction in agency spend in the last six months compared to the first six months.

Non-pay is overspent by £0.275m which in the main is due to purchasing additional call capacity from external providers to support the performance improvement plan.

7.4 **Patient Transport Service**

The year-end position for PTS service is £1.162m overspent. The majority of the overspending is on non-pay (£2.444m overspent) due to third party vehicle costs overspending against budget. Income overall is £1.172m over recovered

Agency expenditure to date totals £0.073m which includes £0.030m in control and £0.043m in call taking.

7.5 **Finance**

The Finance Corporate Directorate is underspent by £0.433m. This includes Trust Reserves, Finance and Commissioning budgets.

7.6 **Other Directorates**

Other directorates are £0.183m underspent. Income is over-recovered by £1.639m due to apprenticeship levy and funded secondments outside the Trust.

8. CAPITAL PROGRAMME

8.1 The capital plan is included in **Appendix 1** – Capital Programme 2018/19 and shows the actual expenditure to date of £21.642m and sale of assets at £0.382m. The full year plan is for £21.305m expenditure against the confirmed Capital Resource Limit (CRL) of £21.260m, making it £0.045m underspent.

9. STATEMENT OF FINANCIAL POSITION

9.1 The Statement of Financial Position as at 31st March 2019 is included in **Appendix 2 – Statement of Financial Position**.

9.2 **Property, Plant & Equipment and Intangible Assets**

Table 9 - Property, Plant & Equipment and Intangible Assets

	Current Position		
	28th February 2019	31st March 2019	Increase/ (Decrease)
	£000s	£000s	£000s
Property, Plant and Equipment	87,150	90,463	3,313
Intangible Assets	1,451	1,955	504
Total	**88,601**	**92,418**	**3,817**

9.3 **Cash and Cash Equivalents**

The Trust's cash and cash equivalents balance at the end of March 2019 is healthy standing at £40.962m. More detail is provided in **Appendix 3 – Cash flow forecast.**

Table 10 – Cash

	Current Position		
	28th February 2019	31st March 2019	Increase/ (Decrease)
	£000s	£000s	£000s
Cash Held with GBS	44,072	40,960	(3,112)
Cash in Hand	2	2	0
Total	**44,074**	**40,962**	**(3,112)**

9.4 **Receivables**

Table 11 – Current Receivables

	28th February 2019	31st March 2019	Increase/ (Decrease)
	£000s	£000s	£000s
Cash Held with GBS	44,072	40,960	(3,112)
Cash in Hand	2	2	0
Total	**44,074**	**40,962**	**(3,112)**
Accrued Income	6,577	4,968	(1,609)
Prepayments	3,460	2,448	(1,012)
VAT	234	251	17
Other	253	434	181
Total	**54,598**	**49,063**	**(5,535)**
RTA - Accrued income (>1yr)	**1,390**	**1,396**	**6**

Table 12 – Ageing Analysis of Trade Receivables

March 19						
	NHS		Non NHS		Total	
Age	£000s	%	£000s	%	£000s	%
0 - 30 days	1,260	86%	249	42%	1,509	74%
31 - 60 days	133	9%	107	18%	240	12%
61 - 90 days	3	0%	137	23%	140	7%
91 + days	66	5%	98	17%	164	8%
Total	**1,462**	**100%**	**591**	**100%**	**2,053**	**100%**
February 2019						
	NHS		Non NHS		Total	
Age	£000s	%	£000s	%	£000s	%
0 - 30 days	1,290	91%	382	44%	1,672	73%
31 - 60 days	14	1%	320	16%	334	15%
61 - 90 days	57	4%	38	4%	95	4%
91 + days	55	4%	133	16%	188	8%
Total	**1,416**	**100%**	**873**	**100%**	**2,289**	**100%**

9.5 **Trade and Other Payables**

Payables relate to those items of expenditure for which the Trust has yet to make cash payment. The classification between current and non-current is dependent upon the expected timing of the payment.

Current trade and other payables relate to those payments the Trust expects to make within the next 12 months. The movements and forecast balances are detailed in **Table 13 - Trade and Other Payables.**

Table 13 - Trade and Other Payables

	28th February 2019	31st March 2019	Increase/ (Decrease)
Current	£000s	£000s	£000s
Trade Payables - NHS	(209)	(1,328)	(1,119)
Trade Payables - non NHS	(911)	(572)	339
Accruals	(22,378)	(18,664)	3,714
Deferred Income	(1,300)	(1,049)	251
Social Security Costs	(5,045)	(5,028)	17
Pension Liabilities	(2,673)	(3,250)	(577)
Capital Creditors	(1,936)	(2,286)	(350)
Other	(700)	(134)	566
Total	**(35,152)**	**(32,311)**	**2,841**

10. BETTER PAYMENT PRACTICE CODE

10.1 The Better Payment Practice Code requires the Trust to pay 95% of all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Table 14 - Better Payment Practice Code

	Total Number	Paid within target		Total Value of	Paid within target	
	Invoices Paid	Number	%	Invoices Paid £000s	Value of £000	%
Non NHS	6,267	6,041	96.39%	17,996	17,179	95.46%
NHS	72	70	97.22%	300	295	98.33%

10.2 The Trust has achieved 96.39% of all invoices by number and 95.46% by value which shows a big improvement in comparison to last month and both indicators are above 95% target.

10.3 Year to date the target is achieved, with 95.76% of invoices by number and 95.27% by value to March 2019. In respect of meeting the 10 day payment best practice the Trust has achieved 33.45% by number and 53.23% by value.

11. RECOMMENDATION

11.1 The Board of Directors are asked to note the 2018/19 reported financial performance to the 31st March 2019.

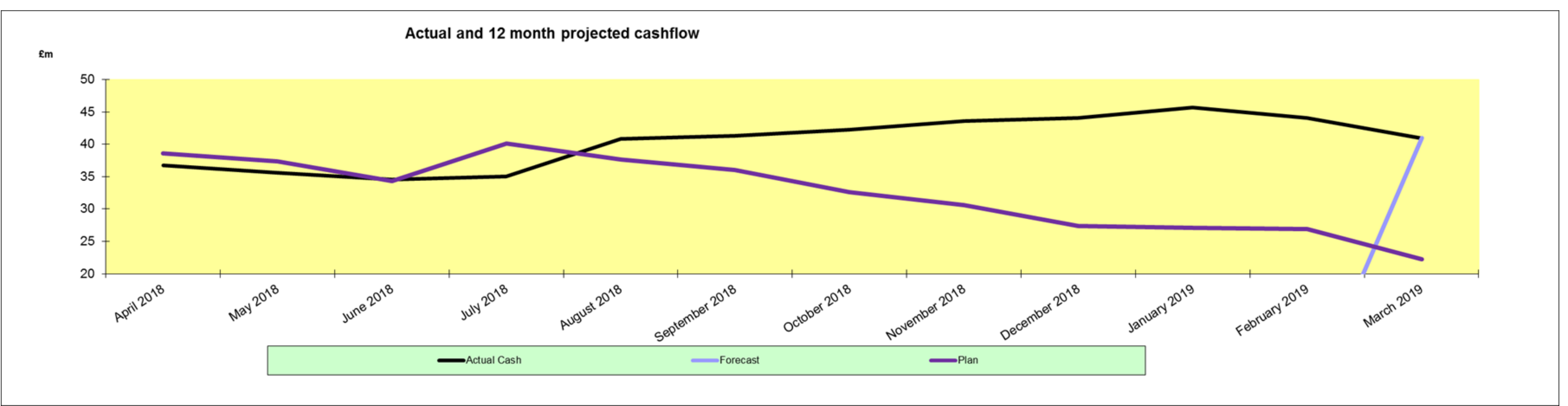
APPENDIX 1 – CAPITAL PROGRAMME 2018/19

	Revised Plan	YTD Spend
	£	£
Vehicles and Equipment		
17/18 PES Vehicles	1,380,633	1,340,799
18/19 PES Vehicles	8,593,304	8,615,951
18/19 PTS Vehicles	2,190,000	2,686,569
17/18 Write Off vehicles	288,000	185,753
18/19 Engines	245,000	162,985
Defibs	1,500,000	1,541,897
Stretchers for Training	0	0
Bareatrics	0	335,000
Estates Costs		
Penrith	60,000	29,598
Oldham station (general improvements)	100,000	0
Millom	20,000	0
Ulverston	0	0
Wigan	0	0
Middleton	50,000	148,748
Burscough	320,000	92,770
Rossendale	0	0
South Liverpool	79,000	67,291
Toxteth	200,000	225,231
18/19 EOC resilience	30,000	19,809
Altrincham	0	36,414
Burnley	100,000	178,932
Lancaster	20,000	40,153
Estuary Car Park	0	0
Skelmerdale - Gates	0	35,744
Salkheld Hall	6,500	6,479
Energy Scheme	0	0
Preston	132,000	26,000
Norwich	0	15,554
Bootle	0	31,056
Oldham PTS	0	0
Shorelines (Live Buildings)	0	0
Electric shorelines covers GMA	0	75,836
19/20 Estates Programme	0	0
Professional Fees	0	0
VAT recovery	(232,304)	(259,894)
Bolton South	0	0
GMA workshops	0	17,100
Central Station	0	3,423
Whitefield Site	0	22,770
Dukinfield Station	0	5,010
Sharston Station	0	4,579
Bootle Station	0	0
Bebbington Station	0	10,681
ICT		
Backup Solution	0	0
Other ICT	42,000	41,326
Telephony	50,000	33,374
GRS App	45,000	0
New tech (Nexus in Broughton)	480,000	698,593
Firewalls	0	9,408
VM ware s/w and h/w	0	429,949
Total Regular Capital Projects	**15,699,133**	**16,914,888**
PMO		
Sharepoint Developments	0	0
Fleet System	160,000	174,542
CAD Developments	20,000	11,880
Intranet	80,000	32,603
Lightfoot	100,000	274,334
Working Time Solution	292,500	238,456
Working Time Solution - 111	30,000	0
Other	92,533	0
111 Digital info	0	40,933
Total Regular Capital Projects	**775,033**	**772,748**
Total Capital Spend on Ordinary Programmes	**16,474,166**	**17,687,636**
Additional Large Developments		
EOC - Fit Out	3,163,000	3,548,509
EOC - IT	838,000	258,432
Airwave	0	0
New Technology	0	0
EPRF	0	0
Technology on vehicles	355,000	146,936
Total Large Developments	**4,356,000**	**3,953,877**
Other		
Assets Disposal	(475,397)	(381,833)
Total Asset Disposal	(475,397)	(381,833)
Total Capital	**20,354,769**	**21,259,680**
Depreciation	11,024,000	0
Additional CRL Awarded	6,621,000	0
Allocated CRL	3,660,563	0
Avaliable CRL	0	0
Available Resource	**21,305,563**	**0**

APPENDIX 2 – STATEMENT OF FINANCIAL POSITION

Period Ending 31st March 2019			
Statement of Financial Position	**Actual 31st March 2018 £000s**	**Actual 31st March 2019 £000s**	**Plan 31st March 2019 £000s**
NON-CURRENT ASSETS:			
Property, Plant and Equipment	80,475	90,635	92,157
Intangible Assets	1,401	1,781	813
Trade and Other Receivables	1,405	1,396	1,405
TOTAL Non-Current Assets	83,281	93,812	94,375
CURRENT ASSETS:			
Inventories	764	897	764
Trade and Other Receivables	12,945	9,408	13,445
Cash and Cash Equivalents	42,207	40,962	22,286
Total Current Assets	55,916	51,267	36,495
Non-Current Assets Held For Sale	209	209	0
TOTAL Current Assets	56,125	51,476	36,495
TOTAL ASSETS	139,406	145,288	130,870
CURRENT LIABILITIES			
Trade and Other Payables	(34,599)	(32,311)	(25,122)
Provisions	(5,134)	(5,493)	(4,993)
Total Current Liabilities	(39,733)	(37,804)	(30,115)
NET CURRENT ASSETS/(LIABILITIES)	16,392	13,672	6,380
TOTAL ASSETS LESS CURRENT LIABILITIES	99,673	107,484	100,755
NON-CURRENT LIABILITIES:			
Provisions	(18,322)	(17,377)	(17,587)
Borrowings	(79)	(78)	(79)
Total Non-Current Liabilities	(18,401)	(17,455)	(17,666)
ASSETS LESS LIABILITIES (Total Assets Employed)	81,272	90,029	83,089
Financed by Taxpayers' Equity			
Public Dividend Capital	92,720	99,341	92,720
Retained Earnings Reserve	(14,393)	(12,661)	(12,576)
Revaluation Reserve	2,945	3,349	2,945
Other Reserves			
TOTAL Taxpayers' Equity	81,272	90,029	83,089

APPENDIX 3 – CASH FLOW FORECAST



£m	APR 2018		MAY 2018		JUN 2018		JUL 2018		AUG 2018		SEP 2018		OCT 2018		NOV 2018		DEC 2018		JAN 2019		FEB 2019		MAR 2019 FULL YEAR	
APR	A	36.7	F1	35.7	F2	34.7	F3	39.2															FYF	22.3
MAY			A	35.6	F1	34.1	F2	38.6	F3	36.2													FYF	22.3
JUN					A	34.6	F1	40.2	F2	37.8	F3	36.2											FYF	28.9
JUL							A	35	F1	37.3	F2	36.3	F3	32.7									FYF	28.9
AUG									A	40.9	F1	37.3	F2	33.7	F3	31.0							FYF	29.7
SEP											A	41.3	F1	38.7	F2	35	F3	32.8					FYF	29.7
OCT													A	42.3	F1	38.7	F2	37.9	F3	37.7			FYF	29.7
NOV															A	43.6	F1	41.7	F2	38.1	F3	33.1	FYF	29.7
DEC																	A	44.1	F1	41.6	F2	36.6	FYF	29.7
JAN																			A	45.6	F1	38.5	FYF	29.7
FEB																					A	44.1	FYF	29.7
MAR																							A	41.0

A Actual **F** Forecast **FYF** Full Year Forecast

REPORT

Board of Directors							
Date:	24th April 2019						
Subject:	Finance, Investment and Planning Committee Annual Report						
Presented by:	Mr M O'Connor						
Purpose of Paper:	For Assurance						
Executive Summary:	The report summarises the activities of the Trust's Finance, Investment and Planning Committee for the financial year 2018-19 setting out how it has met its terms of reference and key priorities.						
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Review and note the Trust's Finance, Investment and Planning Committee activities during the financial year 2018/19.						
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒			
	Right Place	☒	**Every Time**	☒			
Link to Board Assurance Framework (Strategic Risks):							
SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**
☐	☒	☐	☐	☒	☐	☐	☐
Are there any Equality Related Impacts:	**No**						
Previously Submitted to:							
Date:							
Outcome:							

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1. INTRODUCTION

1.1 The purpose of this report is to formally report to the Board of Directors on the work of the Finance, Investment and Planning Committee during the period 1st April 2018 to 31st March 2019 and to set out how it has met its terms of reference and priorities.

2. ROLE OF THE COMMITTEE

2.1 The role of the Finance, Investment and Planning Committee is to obtain assurance on behalf of the Board of Directors that the Trust's business and financial plans are viable and that risks have been identified and mitigated. The Committee also has the responsibility to monitor governance arrangements established to address internal and external service developments and assurance on the delivery of corporate projects.

3. COMMITTEE MEMBERS AND ATTENDANCE

3.1 For 2018/19 the Finance, Investment and Planning Committee consisted of the following members:

Committee Member		Attendance
Mr M O'Connor	Non-Executive Director (Chair)	6/7
Mr M Tattersall	Non-Executive Director	6/6
Ms T Ellery	Director of Finance	5/5
Ms M Brooks	Interim Director of Finance	2/2
Mr G Blezard	Director of Operations	5/7
Mr M Forrest	Director of Organisational Development	1/1
Ms L Ward	Interim Director of Organisational Development	4/6
Mr S Desai	Director of Strategy and Planning	4/7

3.2 The Committee met on the following dates during 2018/19:

18th May 2018
20th July 2018
21st September 2018
20th November 2018
25th January 2019
22nd February 2019
22nd March 2019

4. FINANCE, INVESTMENT AND PLANNING COMMITTEE ACTIVITY

4.1 The Board should note that all functions set out within the Committees Terms of Reference have been discharged.

The Committee has received regular reports in relation to the Trust's Financial Performance, Cash Flow and Aged Debt Position, Capital Programme, Cost Improvement Programme, CQUIN, Bad Debt Review and Estuary Point.

A number of business cases were presented to the Committee and recommended to the Board of Directors for approval, including the Unified Communication Programme Business Case, Defibrillator Maintenance Contract Award, Vehicle Tail Lift Examination, Weight Testing and Maintenance, PES and PTS vehicle replacement programme, Preston Ambulance Station, Disposal of Formby Ambulance Station and the supply of water and waste water contract.

Following approval by the Board of Directors for the significant investment into the provision of a new electronic patient report form solution (ePR), the Committee has received regular updates in relation to the implementation of this system.

The Information Management Group now reports into the Committee and therefore, assurance reports are provided on a regular basis. The Director of Quality, Innovation and Improvement took over responsibility for Information Management and Technology (IM&T) from 1st December 2018 and is a member of the Committee. As a result, detailed updates have been provided to the Committee in terms of IM&T, Informatics and Information Governance.

The Committee has scrutinised the Trust's financial performance and where appropriate, instructed deep dives to be carried out. For example, the committee received details of previous and current arrangements regarding the procurement, selection, usage and costs of taxis used by the Patient Transport Service (PTS) and the Paramedic Emergency Service (PES).

5. IMPROVEMENTS/KEY LEARNING THE PERFORMANCE COMMITTEE CAN TAKE INTO 2019/20

For 2019/20, the following areas could be improved:

- To map the work programme against the BAF for 2019/20.
- To receive assurance against the (i) Financial Plan, (ii) Long Term Financial Model, (iii) Our Strategy 2018 – 2023, (iv) Digital Strategy, (v), Estates Strategy and (vi) Fleet Strategy.

6. SUMMARY

The Committee believe it has fulfilled its role in the year and met the requirements defined in its Terms of Reference and submit this report to the Trust Board for review.

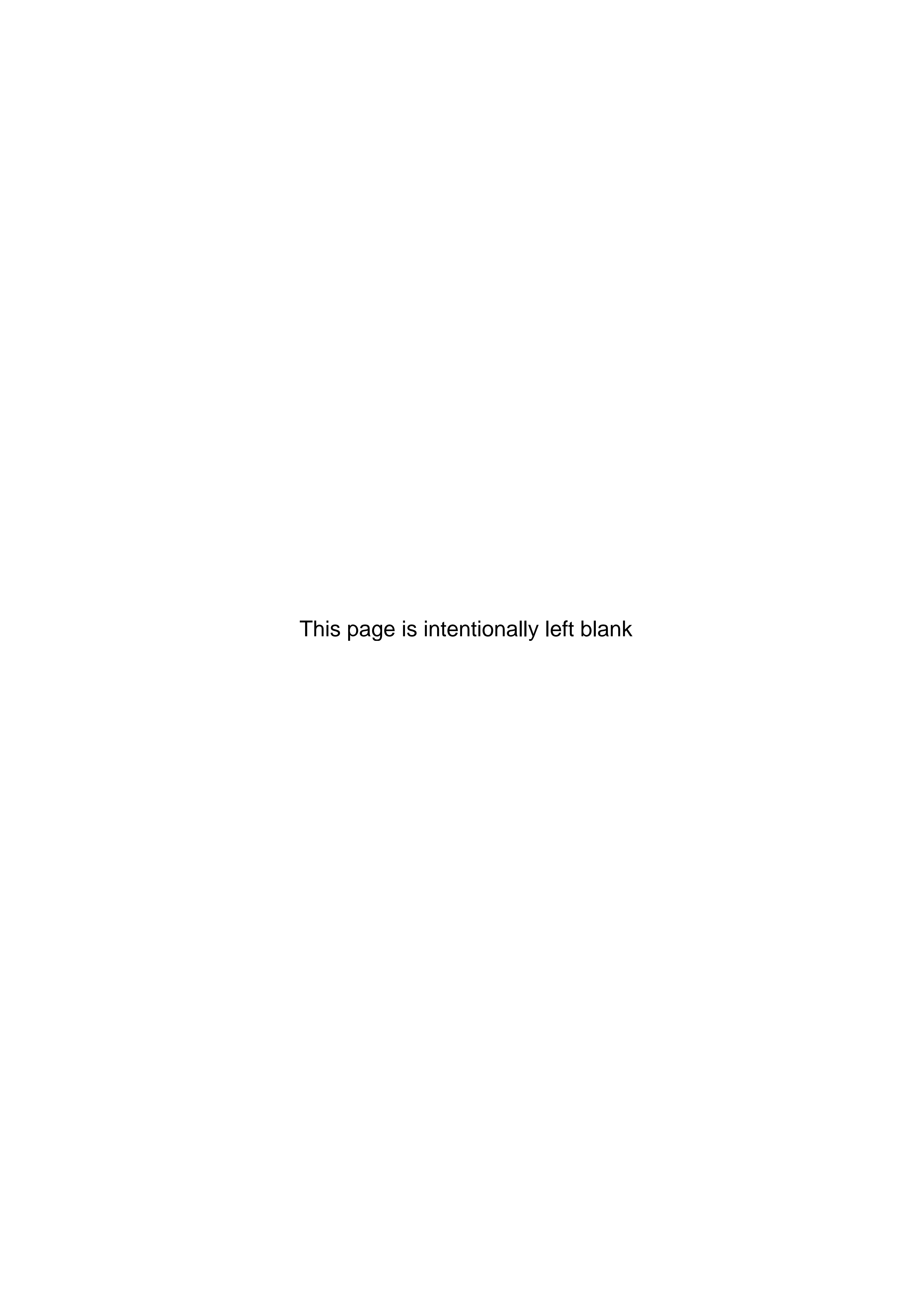
7. LEGAL IMPLICATIONS

7.1 There are no direct legal implications arising out of the subject matter of this report.

8. RECOMMENDATION

8.1 The Board of Directors is recommended to:

- Review and note the Trust's Finance, Investment and Planning Committee activities during the financial year 2018/19.



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Report Title	Chairs Assurance Report - Quality Committee held on the 8th April 2019
Non-Executive Lead	Dr M Ahmed
Executive Lead	Ms M Power, Director of Quality, Innovation and Improvement
Action Required	The Board is requested to: a) Take assurance from the matters discussed at the meeting of the Quality Committee held on 8th April, 2019 b) Discuss and agree actions on the matters escalated to the Board.
Purpose	Note ☐ Approve ☑ Assure

Key Matters considered at the Meeting of the Quality Committee held on 8th April, 2019.

ALERT

Safeguarding

It was noted that a business case was being developed in terms of Safeguarding resources, provision and systems and would be reported to the Executive Management Team.

ASSURANCE IN RELATION TO BAF

The 2019/20 BAF is being developed.

Medicines Management Update

Members received a report in relation to performance against the Medicines Management Indicators as at February 2019.

Members requested that a revised report be presented to the next Quality Committee to include (i) objectives as listed within the Right Care Strategy, and (ii) risks and mitigation against these risks.

ADVISE

Committee Terms of Reference and Self-Assessment

A review of the committees Terms of Reference (ToR) self-assessment was carried out.

It was noted that in 2019/20, the Committee was required to sign off the Clinical Audit Plan and receive progress reports against this. In addition, assurance to the Committee in relation to statutory requirements, guidance and other expectations of the CQC was required.

Further work was being carried out in relation to the Committee's Terms of Reference and would be reported to the Board in May 2019, for approval.

Patient Story

A patient story was presented and provided an example of how intervention within the frequent caller's team had successfully supported a patient.

This had involved a multi-agency approach and had resulted in a positive outcome for the patient and her family.

Right Care Strategy – Overview of Implementation

Members were presented with details of the Right Care Strategy implementation plan, including resources within the quality improvement team, to deliver the improvements.

The Safety Management Group and Clinical Effectiveness Management Group Terms of Reference were presented and approved. Each had been developed in conjunction with statutory responsibilities, the Right Care Strategy and Scheme of Delegation.

Learning Forum Terms of Reference

The Learning Forum Terms of Reference were presented and approved. It was requested that the title of the management group be changed to Non-Clinical Learning Forum.

Highlight Reports

Highlight reports were submitted from the (i) Clinical Governance Management Group, (ii) Learning Forum, and (iii) Health and Safety Management Group.

It was noted that work was progressing in terms of the proposed Restraint Policy.

Members were advised that the Trust had an opportunity to work with the Health and Safety Executive to identify health and safety improvements.

NEW RISKS IDENTIFIED AT THE MEETING AND PLANNED MITIGATING ACTIONS:

None.

REPORT

Board of Directors				
Date:	24th April 2019			
Subject:	Quality Committee Annual Report			
Presented by:	Dr M Ahmed			
Purpose of Paper:	For Assurance			
Executive Summary:	The report summarises the activities of the Trust's Quality Committee for the financial year 2018-19 setting out how it has met its terms of reference and key priorities.			
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Review and note the Trust's Quality Committee activities during the financial year 2018/19.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08
☒	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	
Date:	
Outcome:	

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1. INTRODUCTION

1.1 The purpose of this report is to formally report to the Board of Directors on the work of the Quality Committee during the period 1st April 2018 to 31st March 2019 and to set out how it has met its terms of reference and priorities.

2. ROLE OF THE COMMITTEE

2.1 The role of the Quality Committee is to obtain assurance on behalf of the Board of Directors on the management and effectiveness of service quality.

3. COMMITTEE MEMBERS AND ATTENDANCE

3.1 For 2018/19 the Quality Committee consisted of the following members:

Committee Member		Attendance
Mr P White	Non-Executive Director (Chair)	9/9
Mr R Groome	Non-Executive Director	9/9
Dr M Ahmed	Non-Executive Director	3/3
Ms M Power	Director of Quality, Innovation and Improvement	7/9
Ms T Ellery	Director of Finance	6/8
Ms M Brooks	Interim Director of Finance	1/1
Mr G Blezard	Director of Operations	7/9
Dr D Ratcliffe	Medical Director	7/9
Ms K Noble	Associate Medical Director (111)	3/7
Mr M Jackson	Chief Consultant Paramedic	0/4

3.2 The Committee met on the following dates during 2018/19:

10th April 2018
29th May 2018
3rd July 2018
10th September 2018
9th October 2018
6th November 2018
4th December 2018
8th January 2019
5th March 2019

The meeting scheduled for 5th June 2018, 7th August 2018 and 5th February 2019 were all

cancelled.

4. QUALITY COMMITTEE ACTIVITY

4.1 The Board should note that the majority of functions set out within the Committees Terms of Reference have been discharged.

The Right Care Strategy was developed during 2018 and approved by the Board in October 2018. The Strategy supports the Trust's ambition to be the best ambulance service within the UK and the Right Care Strategy sets the direction for the provision of the 'Right Care' in NWAS. Following approval of the Strategy, the Committee has received regular reports in terms of the implementation of this Strategy and started to receive regular reports in relation to the pillars of quality.

The Committee has responsibility of oversight of the Trust's compliance with statutory requirements, guidance and other expectations of the CQC, particularly relating to periodic inspections. The Committee needs to maintain oversight and receive assurance against this element of the Terms of Reference during 2019/20 and any reporting needs to be aligned to the Committee prior to being submitted to the Board.

The 2019/20 Clinical Audit Plan is required to be signed off by the Committee and regular reporting in terms of progress against this plan.

5. IMPROVEMENTS/KEY LEARNING THE PERFORMANCE COMMITTEE CAN TAKE INTO 2019/20

For 2019/20, the following areas could be improved:

- Feedback reports from Patient Stories illustrating that the learning identified has been cascaded throughout the organisation.
- Improved reporting of the Trust's compliance with statutory requirements, guidance and other expectations of the CQC, particularly relating to periodic inspections.
- Approval of the 2019/20 Clinical Audit Plan and progress reports against the plan.
- Monitor progress against the Right Care Strategy.

6. SUMMARY

The Committee believe it has fulfilled its role in the year and met the requirements defined in its Terms of Reference and submit this report to the Trust Board for review.

7. LEGAL IMPLICATIONS

7.1 There are no direct legal implications arising out of the subject matter of this report.

8. RECOMMENDATION

8.1 The Board of Directors is recommended to:

- Review and note the Trust's Quality Committee activities during the financial year 2018/19.

REPORT

Board of Directors							
Date:	24th April 2019						
Subject:	Performance Committee Annual Report						
Presented by:	Mr P White						
Purpose of Paper:	For Assurance						
Executive Summary:	The report summarises the activities of the Trust's Performance Committee for the financial year 2018-19 setting out how it has met its terms of reference and key priorities.						
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Review and note the Trust's Performance Committee activities during the financial year 2018/19.						
Link to Strategic Goals:	**Right Care** ☒	**Right Time** ☒					
	Right Place ☒	**Every Time** ☒					
Link to Board Assurance Framework (Strategic Risks):							
SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**
☐	☐	☒	☒	☐	☐	☐	☐
Are there any Equality Related Impacts:	**No**						
Previously Submitted to:							
Date:							
Outcome:							

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1. INTRODUCTION

1.1 The purpose of this report is to formally report to the Board of Directors on the work of the Performance Committee during the period 1st April 2018 to 31st March 2019 and to set out how it has met its terms of reference and priorities.

2. ROLE OF THE COMMITTEE

2.1 The role of the Performance Committee is to obtain assurance on behalf of the Board of Directors on the management of operations and its performance against national and local standards, assurance on matters relating to resilience and emergency planning and also the associated organisational risk within the service lines.

3. COMMITTEE MEMBERS AND ATTENDANCE

3.1 For 2018/19 the Performance Committee consisted of the following members:

Committee Member		Attendance
Mr P White	Non-Executive Director (Chair)	5/5
Mr R Groome	Non-Executive Director	4/5
Ms T Ellery	Director of Finance	2/4
Ms M Brooks	Interim Director of Finance	1/1
Mr G Blezard	Director of Operations	4/5
Ms L Ward	Interim Director of Organisational Development	3/4

3.2 The Committee met on the following dates during 2018/19:

21st May 2018
16th July 2018
17th September 2018
19th November 2018
18th March 2019

The meeting scheduled for 28th January 2019 was cancelled, due to the meeting not being in quorum.

4. PERFORMANCE COMMITTEE ACTIVITY

4.1 The Board should note that all functions set out within the Committees Terms of Reference have been discharged.

In terms of the Ambulance Response Programme (ARP), the committee identified challenges and improvements and received a regular report in relation to ARP performance.

The committee continued its scrutiny around Urgent Care, resilience and helped scrutinise and support the delivery of performance plans for the PTS and 111 service.

The committee received assurance on key performance related risks and received regular risk reports.

The committee received details of the standards for NHS Ambulance Service Command and Control and received assurance in terms of the Trusts compliance against those standards.

In addition, the committee scrutinised preparations for the 2018/19 winter plans.

5. IMPROVEMENTS/KEY LEARNING THE PERFORMANCE COMMITTEE CAN TAKE INTO 2019/20

For 2019/20, the following areas could be improved:

- Continued scrutiny of resourcing model for delivery of ARP.
- Recruitment to the NED vacancy to expand the NED membership of this committee.
- To receive assurance in relation to delivery against the Urgent and Emergency Care Strategy.

6. SUMMARY

The Committee believe it has fulfilled its role in the year and met the requirements defined in its Terms of Reference and submit this report to the Trust Board for review.

7. LEGAL IMPLICATIONS

7.1 There are no direct legal implications arising out of the subject matter of this report.

8. RECOMMENDATION

8.1 The Board of Directors is recommended to:

- Review and note the Trust’s Performance Committee activities during the financial year 2017/18.

REPORT

Board of Directors				
Date:	24h April 2019			
Subject:	Senior Information Risk Owner Report 2018/19			
Presented by:	Senior Information Risk Owner			
Purpose of Paper:	For Assurance			
Executive Summary:	The Trust has undertaken a programme of work to manage information risk over the past 12 months. This Senior Information Risk Owner (SIRO) Report for 2018/19 provides a high level summary of this programme.			
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Take assurance that the Trust has effective systems and process in place to maintain the security of information • Take assurance that the Information Commissioners Officer gave the Trust a rating of reasonable assurance from the mini DSPT audit they completed in January 2019. • Take assurance that MIAA provided an assurance rating of moderate from the DSPT audit they completed in April 2019.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☐	☐	☐	☐	☒	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	**Information Management Group**
Date:	**9th April 2019**
Outcome:	

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1. PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with a summary of the work completed over the past twelve months to manage information risk within the Trust.

2. BACKGROUND

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

2.2 Data protection gives organisations and individuals assurance that personal information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care. The programme of work associated with IG in 2018/19 has been progressed through the Trust's Information Management Group and the General Data Protection Regulation (GDPR) Compliance Project which ran from May 2017 until July 2018.

3. GENERAL DATA PROTECTION REGULATION PROJECT

3.1 The GDPR Compliance Project had executive sponsorship from the Director of Quality, Innovation and Improvement, the Trust SIRO. The Project Board met monthly and monitored progress against actions designed to achieve GDPR compliance. The actions were identified through gap analysis by the Information Governance Team using the Information Commissioner's Office (ICO) Data Protection Self-Assessment Toolkit. The Project Board identified, recorded and worked to mitigate risks to the Trust related to GDPR and recommended procedural changes to the Executive Management Team for approval and implementation. The Trust appointed a Data Protection Officer in May 2018 to monitor compliance with the GDPR after project closure.

4. INTERNAL ASSURANCE STRUCTURE

4.1 The Information Management Group is chaired by the Trust's Senior Information Risk Owner (SIRO).

4.2 The terms of reference and membership were refreshed during 2018/19 following completion of the Management Group Effectiveness Review and Group Self-Assessment facilitated by the Corporate Governance Team.

4.3 The Group provides assurance to the Board of Directors via the Finance Investment and Planning Committee.

4.4 For day to day information risk management the SIRO is supported by the Medical Director, as the Caldicott Guardian and the Data Protection Officer.

5. INFORMATION COMMISSIONER'S OFFICE "MINI" AUDIT

5.1 On 21st November 2018 the ICO wrote to the Trust to seek agreement to carry out a consensual audit. Through engagement with other Ambulance Trust Information Governance leads in England it was established that the ICO had requested the same from three other Ambulance Trusts.

5.2 The primary purpose of the audit was to provide the ICO and the Trust with an independent opinion of the extent the Trust (within the scope of this agreed audit) is complying with data protection legislation and highlight any areas of risk to compliance.

5.3 The audit also reviewed the extent to which the Trust (within the scope of the audit) demonstrates good practice in data protection governance and management of personal data.

5.4 NWAS agreed to host two ICO auditors, one lead, one in training for a two day audit on site at Estuary Point in January 2019 following completion of a desktop review of evidence submitted to them during December 2018.

5.5 The final audit report was issued by the ICO on 22nd March 2019. The overall opinion is based on the existence and effectiveness of the processes, policies, procedures and practices operating to mitigate any identified risks to complying with data protection legislation.

5.6 The scale of assurance rating consists of four categories, in descending order of level of assurance these are:

- High Assurance
- Reasonable Assurance
- Limited Assurance
- Very Limited Assurance

5.7 The Trust has been given a "reasonable" assurance rating indicating that:

"There is a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified some scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation."

5.8 One area of good practice was identified by the Audit Team relating to the Committee Effectiveness Reviews completed by Corporate Governance:

"The effectiveness of the IMG has been assessed by the Trust's Corporate Governance department which undertakes regular reviews of this kind of the Trust committees to assess how well they are carrying out their function."

5.9 The final report also contains details of all observations and non-conformities identified during the course of the audit. Recommendations have been made based on the ICO Audit Team's findings. An action plan to remedy these has been agreed by the Executive Management Team (EMT).

5.10 The IMG work plan has been updated to include monitoring of completion of the action plan at each meeting until January 2020 when final confirmation of completion will have been received from the ICO after their follow up audit which is scheduled for the week commencing 11th November 2019.

6. DATA SECURITY AND PROTECTION TOOLKIT PERFORMANCE

6.1 The annual self-assessment against information management standards previously named the Information Governance Toolkit was replaced in April 2018 by the Data Security and Protection Toolkit. The Data Security and Protection Toolkit (DSPT) is designed to provide assurance to the Department of Health of local implementation of the ten data security standards as set out in the National Data Guardian's 2016 review and some elements of the GDPR. There is emphasis on data security leadership and obligations concerning people, processes and technology. The DSPT assurance will form the basis of CQC inspections within the Well Led Key Lines of Enquiry.

6.2 NHS Digital expects organisations to achieve "standards met" in the DSPT which is defined as completion of all 100 mandatory assertions. Organisations' statuses are published with the aim of providing assurance to working partners and patients of the standard of information management within NHS Trusts.

6.3 The Trust has completed a submission for the Data Security and Protection Toolkit (DSPT). The score for the submission is 72 of100 mandatory assertions completed and 21 of 40 groups of assertions confirmed as complete. This score means that the Trust's published status will be "Standards not met".

6.4 The DSPT self-assessment score has been partially verified by Mersey Internal Audit Agency (MIAA). MIAA completed an audit of four of the ten standards the Trust is assessed against. These were:

- Personal Confidential
- Managing Data Access
- Responding to incidents
- Accountable Suppliers

6.5 MIAA confirm the validity of the Trust's declaration of met/not met for all areas. As not all standards were met the Trust has received an overall assurance rating of moderate.

6.6 NHS Digital has issued guidance for organisations that have not met all assertions. Where organisations are approaching a level of "standards met" in all but a few areas, an improvement plan of how they are going to bridge the gap between their current position and meeting the DSPT standards has to be submitted. NHS Digital will review improvement plans and if agreed the organisation's published status will be "Standards not fully met (Plan Agreed)".

6.7 The Trust has submitted an improvement plan to NHS Digital. Completion of the plan will be monitored at IMG with regular updates provided to NHS Digital and the Trust's Finance, Investment and Planning Committee.

7. DATA BREACHES

7.1 The GDPR became law on 25th May 2018. It introduces a duty on all organisations to report certain types of personal data breach to the relevant supervisory authority. The Security of Network and Information Systems Directive ("NIS Directive") also requires reporting of relevant incidents to the Department of Health and Social Care (DHSC) as the competent authority from 10th May 2018. The Trust reports both of these types of breach through a new NHS Digital provided web based tool – the DSPT Incident Reporting Tool. Reports are directed to recipients based on criteria such as number of individuals' affected, source of breach and level of harm caused to individuals by the breach. Prior to 25th May, the Trust used the incident reporting tool on the NHS Digital Information Governance Toolkit that has been replaced by the DSPT.

7.2 The Trust uses the Datix Incident Report Form to capture data breaches reported by all levels of staff. During 2018/19 a total of 552 breaches were reported. Of these, 23 were externally reported on either the DSPT or IG toolkit Incident Reporting Tool. All externally reported breaches met the criteria for notification to the ICO. 1 of these met the criteria for Department of Health and Social Care and NHS England notification.

7.3 The breaches reported to the ICO required full root cause analysis investigations by investigating officers of the Trust. The ICO subsequently referred a number of these to their Criminal Investigations Team; none saw prosecution of individuals. Two have been closed to date with the ICO deeming the Trust imposed disciplinary sanction on the individual equivalent to that which a Court would have imposed.

8. COMPLAINTS

8.1 The Trust has been the subject of one complaint to the ICO by a data subject in relation to the handling of a subject access request. This complaint was received into the Trust on 27th February 2019. The ICO requested the Trust undertake an investigation and provide details of improvements that would be made where there had been an infringements of the data subject's rights. The Head of Legal Services and Data Protection Officer worked together to provide the information and determined the response had been provided outside the required timescale. In all other ways the request had been handled appropriately. The ICO on receipt of the information closed the complaint with no further action to be taken as they were assured by the Trust plans to overhaul Individuals' Rights request management during the 2019/20 financial year. More information on this process is included in the Individuals' Rights section of this report.

8.2 The Data Protection Officer received three further complaints during the year from both patients and staff. Two related to data breach handling by the Trust and have subsequently been closed as no evidence of mismanagement has been found. The third relates to handling of a subject access request and is ongoing.

9. DATA PROTECTION IMPACT ASSESSMENTS

9.1 Over the past year the IG team's focus has been on ensuring that the introduction of new information assets, changes to existing assets and procedures introduce only acceptable levels of information risk. Assessment of risk prior to information processing commencing is the best way to do this. The Trust has introduced a comprehensive assessment which is facilitated by the IG team and involves internal and external stakeholders with knowledge of the information asset and purposes of information processing.

9.2 The team have screened 42 information asset introductions/changes during the year, with 25 of these progressing to a full data protection impact assessment. The time for the full assessment to be completed is averaging at 16 weeks; the availability of internal stakeholders and provision of pertinent information by external stakeholders being the key elements to timely completion.

9.3 The Executive Management Team has approved full publication of all data protection impact assessments presented to them demonstrating their commitment to transparency in data processing.

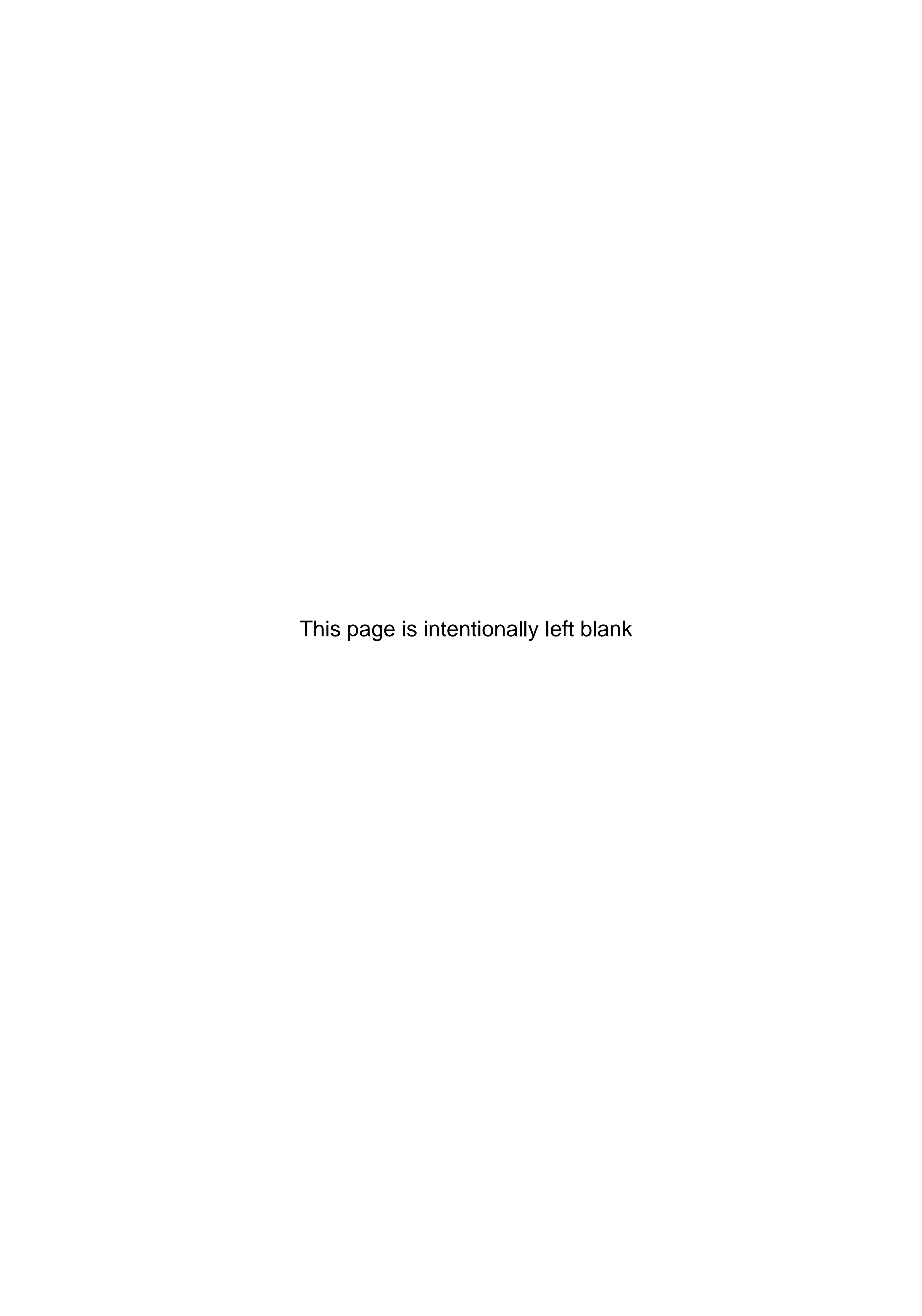
10. RECOMMENDATIONS

The Board of Directors is recommended to:

- Take assurance that the Trust has effective systems and process in place to maintain the security of information

- Take assurance that the Information Commissioners Officer gave the Trust a rating of reasonable assurance from the mini DSPT audit they completed in January 2019.

- Take assurance that MIAA provided an assurance rating of moderate from the DSPT audit they completed in April 2019.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REPORT

AGENDA ITEM:

Board of Directors	
Date:	24th April 2019
Subject:	Health, Safety and Security Report
Presented by:	Maxine Power, Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	The Board of Directors are requested to note: • The Quality Committee continues to receive assurance on the management of health, safety and security. • The Health and Safety Management Group (now Safety Management Group) continues to be an effective conduit for all health, safety and security matters. • The Pillars of Quality are being implemented. • Overall incident reporting numbers remain steady, with a noted increase for PTS for year ending March 2019. This can indicate a more positive reporting culture. • NWAS remains a low reporter of RIDDORS compared to national colleagues.
Recommendations, decisions or actions sought:	The Board are asked to:- • Note the content of the report • Be assured that the health, safety and security agenda is being appropriately monitored. • Ensure organisational wide commitment to the pillars of quality. • Continue to support the Health, Safety and Security team.

Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):

SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**
☒	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**

Previously Submitted to:	**Board of Directors**
Date:	**October 2018**
Outcome:	**Continued reporting in line with work plan**

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1.	**PURPOSE**
	The purpose of this report is to provide assurance to the Board of Directors that health, safety and security matters are being effectively managed across the Trust, are being overseen by the Quality Committee and that the Right Care strategy is being implemented.
2.	**BACKGROUND**
2.1	The Chief Executive holds overall responsibility for health, safety and security; this is devolved to the Director of Quality, Innovation and Improvement. The Health, Safety and Security policy now recognises the appointment of the lead non-Executive Director. Advice and guidance on all health, safety and security matters is the responsibility of the Health, Safety and Security team who support staff and managers with their responsibilities for applying the standards agreed.
2.2	Advice and guidance on all health, safety and security matters is the reasonability of the Health, Safety and Security team with staff and managers responsible for applying the standards agreed.
3.	**CURRENT SITUATION**
3.1	The Trust is committed to ensuring that we continually improve our standards of health, safety and security. The Right Care strategy has focussed attention to reduce harm from the three consistent areas of risk - moving and handling, violence and aggression and slips, trips and falls. Commitment is required from all leaders and the Health, Safety and Security team will support them to develop the skills to deliver safe services. Support will also be provided through biannual reviews of all sites and annual review for vehicles will be undertaken, including logbooks.
3.2	Further to the previous Board report in October 2018, the Quality Committee have received two detailed assurance reports including actions against the implementation of the Right Care strategy.
3.3	The Health and Safety Management Group has continued to provide an effective forum of staff side and managers from a variety of disciplines. The group takes responsibility for overseeing all the guidance, risk assessments, topic area reports (e.g. fire, hazardous substance, violence and aggression) and non-clinical incident reporting across the Trust. This group has been amended to the Safety Management Group to broaden its remit in line with the strategy.
3.4	In the last six months, the Health and Safety Management Group have reviewed and approved ten supporting documents with three currently in process. These have included both the Health, Safety and Security policy and the competency framework by which managers will be educated and supported to develop their skills, in support of the Right Care strategy; this will include a training and education package for Board members in line with Board development sessions.
3.5	The group has been assured that all generic risk assessments are in place and are current and have examined the findings of a report into the application of control measures specifically designed to minimise the risk to staff from violence and aggression. This work is

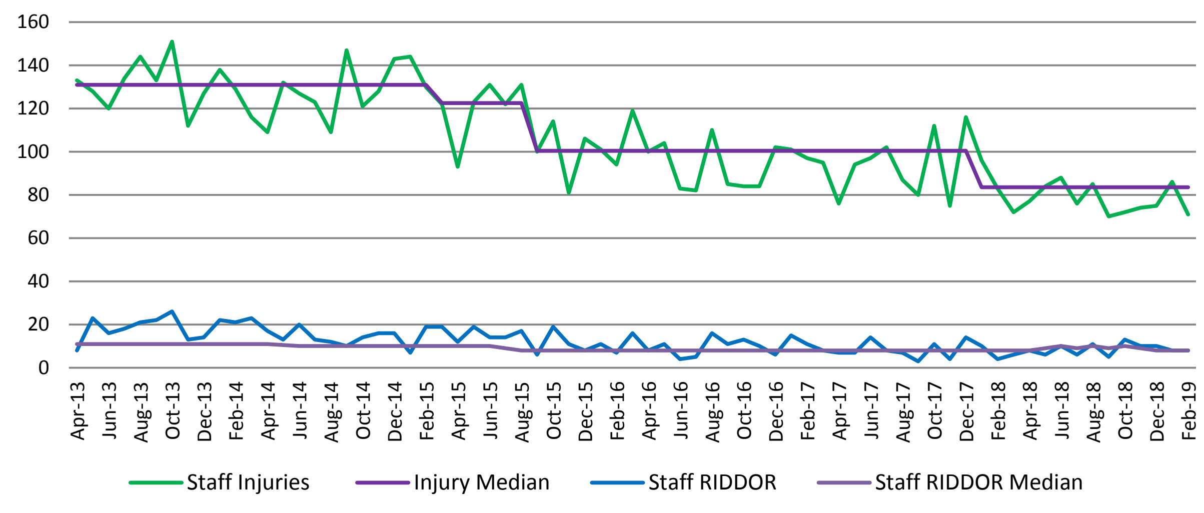
being supported by the Strategic Violence and Aggression Group, chaired by the Director of Operations and by the Task and Finish group reviewing Trust procedure and process for establishing rendezvous points, chaired by the Consultant Paramedic (Greater Manchester).

4. **INCIDENT REPORTING**

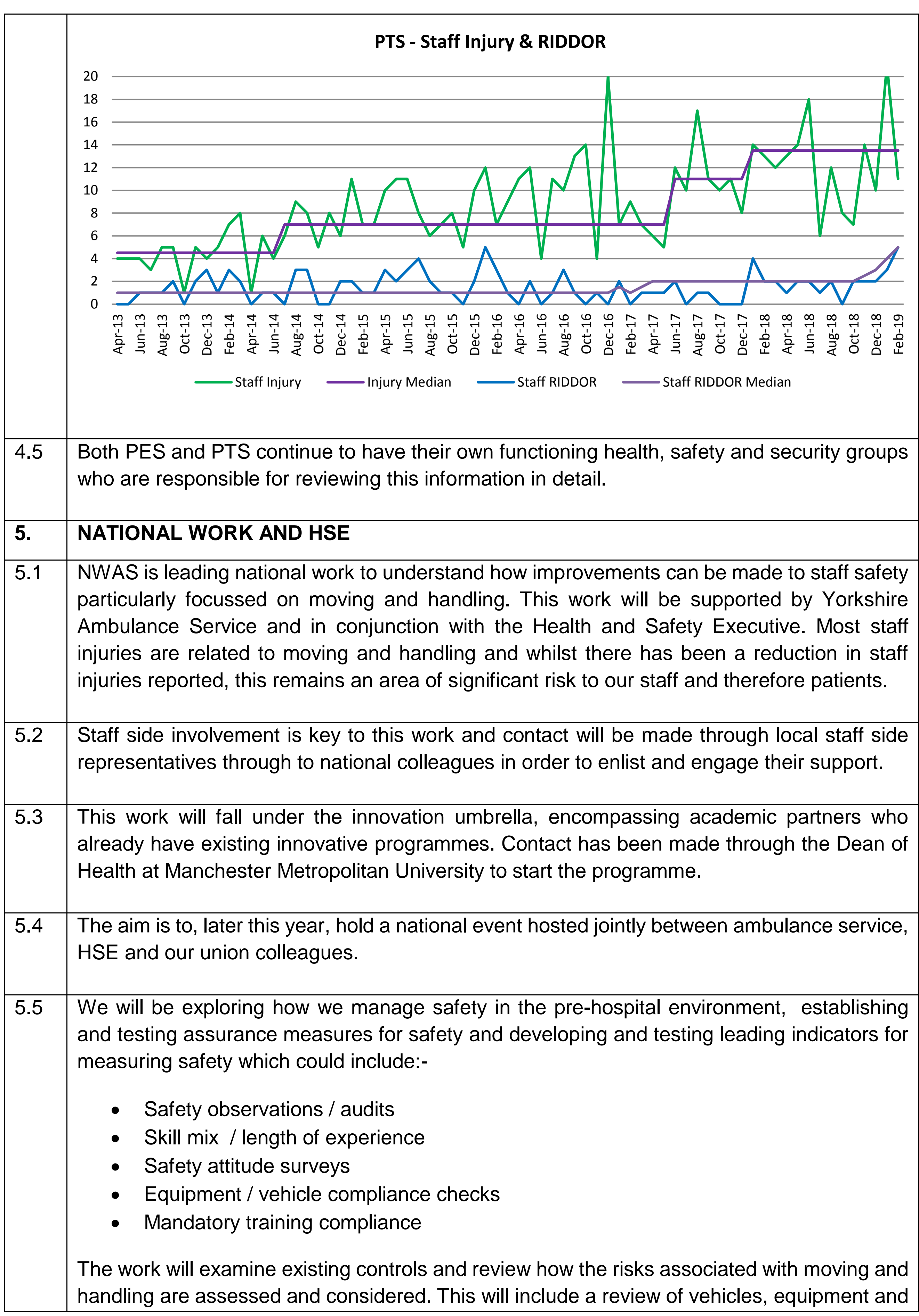
4.1 In line with previous reporting, the Paramedic Emergency Service continues to understandably generate most of the incident reporting. These figures include all the reports contained within the Datix system (clinical, non-clinical and road traffic).

	2015/6	2016/7	2017/8	2018/9	Total
Service Delivery Directorate (PES, EOC, 111 etc.)	7382	9564	10015	10497	37458
Finance Directorate (PTS/Finance/Fleet etc.)	570	801	679	1080	3130
Quality Directorate	70	224	124	78	496
Medical Directorate	13	2	51	73	139
Organisational Development Directorate	20	15	15	35	85
Corporate Affairs Directorate	11	8	6	12	37
Strategy & Planning Directorate	0	0	6	7	13
Total	8066	10614	10896	11782	41358

It should be noted that there was an increase in the number of reports raised by PTS for year ending March 2019; indicating an improving reporting culture. The number of incidents reported for raising a concern and near misses increased with a reduction in staff injury reports though patient injury reports have increased.

4.2	As demonstrated in the chart below, for the Paramedic Emergency Service the lower staff injury rate has remained steady since October 2017, with the RIDDOR rate also being consistent. 
4.3	The Board can be assured that NWAS continues to measure favourably alongside national ambulance colleagues when staffing and journeys are taken into account. RIDDORs are closely monitored by the Health and Safety Management Group and feature as a Pillar of Quality within the Right Care Strategy.
4.4	For the Patient Transport Service, the chart below demonstrates an increase in the over level of reporting however the numbers remain low, especially considering the levels of activity involved.

RIDDOR Data for April – Dec 2018	National average	NWAS rate
Injuries x 1000 / no. of journeys (staff injuries only)	0.12	0.04
Injuries x 1000 / no. of employees (staff injuries only)	22.16	14.11



4.5 Both PES and PTS continue to have their own functioning health, safety and security groups who are responsible for reviewing this information in detail.

5. NATIONAL WORK AND HSE

5.1 NWAS is leading national work to understand how improvements can be made to staff safety particularly focussed on moving and handling. This work will be supported by Yorkshire Ambulance Service and in conjunction with the Health and Safety Executive. Most staff injuries are related to moving and handling and whilst there has been a reduction in staff injuries reported, this remains an area of significant risk to our staff and therefore patients.

5.2 Staff side involvement is key to this work and contact will be made through local staff side representatives through to national colleagues in order to enlist and engage their support.

5.3 This work will fall under the innovation umbrella, encompassing academic partners who already have existing innovative programmes. Contact has been made through the Dean of Health at Manchester Metropolitan University to start the programme.

5.4 The aim is to, later this year, hold a national event hosted jointly between ambulance service, HSE and our union colleagues.

5.5 We will be exploring how we manage safety in the pre-hospital environment, establishing and testing assurance measures for safety and developing and testing leading indicators for measuring safety which could include:-

- Safety observations / audits
- Skill mix / length of experience
- Safety attitude surveys
- Equipment / vehicle compliance checks
- Mandatory training compliance

The work will examine existing controls and review how the risks associated with moving and handling are assessed and considered. This will include a review of vehicles, equipment and

	training to fully understand where improvements could be made and where innovation can inform future standards.
5.6	The Executive Management Team are receiving a report in April 2019 with further detail and further updates will be provided through the Safety Management Group and the Quality Committee.
5.7	This work will enhance and support the existing National Risk and Safety Group.
6.	**LEGAL and/or GOVERNANCE IMPLICATIONS**
	Failure to ensure the health, safety and security of both employees and non-employees, affected by the Trust's undertaking so far as is reasonably practicable would be a breach of the general duties of the Health and Safety at Work Act 1974 potentially leading to criminal prospection. It also exposes the Trust to the risk of civil litigation for negligence.
7.	**RECOMMENDATIONS**
	The Board of Directors is recommended to :- • Note the contents of this report • Be assured that the health, safety and security agenda is being appropriately monitored. • Ensure organisational wide commitment to the pillars of quality. • Continue to support the Health, Safety and Security team.

REPORT

Board of Directors				
Date:	24th April 2019			
Subject:	Communications and Engagement Dashboard			
Presented by:	Salman Desai			
Purpose of Paper:	For Discussion			
Executive Summary:	The Communications and Engagement Team have created a new style dashboard to provide the Board of Directors with a quarterly summary of key outputs and associated highlights. Statistical content is provided on: Press and public relations, social media and online coverage together with stakeholder communications. Information is also provided on internal communications, projects and campaigns together with FOI performance, patient engagement activity and film production.			
Recommendations, decisions or actions sought:	For discussion, noting and the provision of any comments.			
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☐
	Right Place	☐	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR01	SR02	SR03	SR04	SR05	SR06	SR07	SR08	SR09	SR10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	
Date:	
Outcome:	

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1. PURPOSE

To provide the Board of Directors with a quarterly summary of key outputs and associated highlights on the work of the newly combined Communications and Engagement Team.

2. BACKGROUND

The Communications and Engagement Team have created a new style dashboard providing high level statistical content and themes on:

Press and public relations, social media and online coverage together with stakeholder communications.

Information is also provided on internal communications, projects and campaigns together with FOI performance, patient engagement activity and film production.

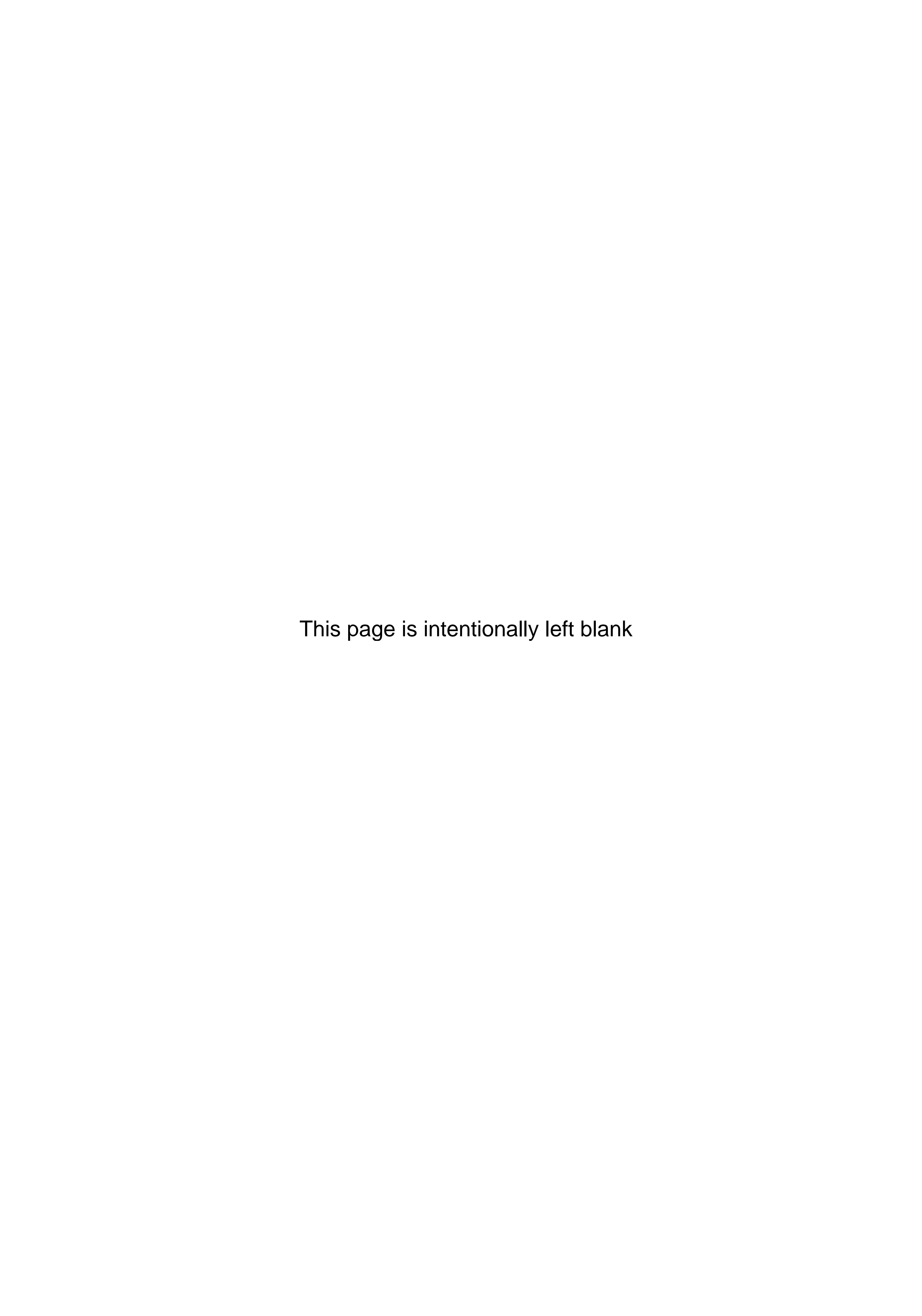
3. LEGAL and/or GOVERNANCE IMPLICATIONS

All of the trust's communication and engagement activities adhere to the following legislation:

- Freedom of Information Act 2000
- Health and Social Care Act 2006 (to involve and consult with patients and the public in the way it develops and designs services).
- Department of Health's Code of Practice for promotion of NHS Services 2008.
- NHS England Patient and Public Participation Policy2015 (listening to and involving communities, their representatives and others, in the way we plan and provide our services).

4. RECOMMENDATIONS

The Board of Directors is asked to note the attached dashboard and provide any comments on its content or what they may wish to see on future dashboards.



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Communications and engagement dashboard
Q4 2019: Jan - March

PRESS AND PR

Activity:

Handled **185** 'incident check' calls

Issued **25** proactive media stories / interviews

Prepared **39** statements in response to press enquiries

220 pieces of media coverage:

- **54%** incidents*
- **40%** positive
- **4%** negative
- **2%** neutral

**incident coverage is mostly neutral and is where NWAS is mentioned as attending an incident, with the press office confirming the details. Sentiment for other coverage is based on how NWAS is represented in the article.*

Including:

- National Apprenticeship Week generated positive coverage with a visit from Rt Hon Anne Milton MP and the issuing of case studies to local media.
- A press release calling for a stop to vandalism of ambulances resulted in a number of media articles in support of NWAS.
- BBC collated FOI data of average ambulance response times split by postcode area showed slower times in some rural areas, attracting negative media interest. We issued statements to address this.
- Filming for the next series of BBC One's 'Ambulance' continued in Merseyside and Greater Manchester.

EXTERNAL STAKEHOLDER COMMUNICATIONS

6 bulletins issued | **6** MP letters responded to | **4** OSC reports prepared

Stakeholder comms topics included:
- Filming for BBC One's Ambulance in Merseyside
- Requesting ambulance transport (IFT/HCP pilot)
- Winter Watch operational overview

CAMPAIGNS

- **Make the right call** winter campaign encouraging use of 111 online
- **I am NWAS** social media content promoting the variety of jobs in NWAS
- **Star in a car** campaign to recruit more volunteer car drivers to support PTS

FACEBOOK

35,401 total followers

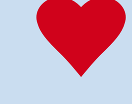
703 this quarter

1,959,753 reach

52,720 engagements

Top post:

"An ambulance is out of action thanks to mindless vandalism. It was a close call for our crew last night as a bottle was thrown at a moving ambulance..."


1,758 shares

1,550 reactions

270k reach

TWITTER

39,425 total followers

1,060 this quarter

1,418,000 reach

28,924 engagements

Top post:

"FFS- Friday fact share! So we got this call on New Year's Day... a man called us for a DNA test after accusing his partner of cheating."
(with audio of call)

244 retweets

322 likes

70k reach

WEBSITE

295,375 page views ▲ 18%

102,964 total visitors ▲ 26%

Most visited page:

Contact Us - **7,755** views

21,239 'news' views

Top news story:

"A week in the life of an ambulance service apprentice"

INSTAGRAM

3,691 total followers

707 this quarter

43,716 reach

2,539 engagements

Top post:

247 likes

2,573 reach

Photo of apprentice mechanic, Elsa

FREEDOM OF INFORMATION

104 FOIs completed

98% within 20 working day target

PATIENT ENGAGEMENT

9,851 Patient surveys sent **2,681** (26%) returned

92% of respondents said the overall service received was 'very good' or 'fairly good'

92% were likely to recommend the service to friends and family

95% agreed they were cared for appropriately with dignity, compassion and respect

8 community events attended, including:

- Older Persons Fair
- Be Bold and Breakthrough
- Naw-Ruz arabic event
- Careers event at Nelson and Colne College

INTERNAL PROJECTS / CAMPAIGNS

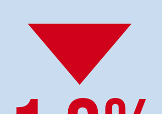
Flu campaign

Supported with:

- Bulletins
- Posters for all sites
- Stickers
- Used new Greater Manchester Partnership campaign materials

Results:

- **65.9%** vaccination uptake for 2018/19


1.3% from 2017/18

Staff survey

Supported with:

- Bulletins
- Posters and comms tailored to different service areas to highlight improvements

Results:

- **46%** uptake

4.4% from 2017/18

STAR Awards

- Promoted through bulletin, app and posters
- **240** nominations received
- **16** awards
- **£13,800** sponsorship secured
- Ceremony organised for 18 April 2019
- **250** attendees confirmed

Others priorities this quarter included:

- Supporting development of Urgent and Emergency Care and Digital strategies
- Board announcements
- Transforming Patient Care 'wind down'
- Paper to EMT re: Patient and Public Panel

INTERNAL BULLETINS

This quarter, we issued:

17 Clinical bulletins **16** Operational bulletins **8** staff comms bulletins

plus **14** others, including Education and Training, Human Resources and PTS bulletins

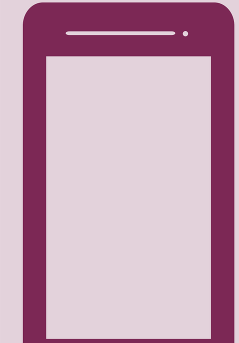
Topics included:

- New Chairman appointed
- New epaulettes for advanced clinicians
- Transforming Patient Care - two years on

13 Weekly Regional Bulletins with...

162 ...staff news stories/updates

STAFF APP



2,321 total downloads

448 this quarter

Most popular pages:

1) Email | 2) GRS | 3) ESR

FILMS

4 films completed **3** films underway

Topics included:

- New website film
- Staff story for Board
- Two education and learning films

TEAM NEWS

Towards the end of this quarter, we got ready to merge the Patient Engagement and the Communications Teams, becoming the Communications and Engagement Team from 1st April 2019.

communications@nwas.nhs.uk

Board of Directors							
Date:	24th April 2019						
Subject:	Workforce Committee Annual Report						
Presented by:	Mr R Groome						
Purpose of Paper:	For Assurance						
Executive Summary:	The report summarises the activities of the Trust's Workforce Committee for the financial year 2018-19 setting out how it has met its terms of reference and key priorities.						
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Review and note the Trust's Workforce Committee activities during the financial year 2018/19.						
Link to Strategic Goals:	**Right Care** ☒	**Right Time** ☒					
	Right Place ☒	**Every Time** ☒					
Link to Board Assurance Framework (Strategic Risks):							
SR01	**SR02**	**SR03**	**SR04**	**SR05**	**SR06**	**SR07**	**SR08**
☒	☐	☐	☐	☐	☒	☐	☐
Are there any Equality Related Impacts:	**No**						
Previously Submitted to:							
Date:							
Outcome:							

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1. INTRODUCTION

1.1 The purpose of this report is to formally report to the Board of Directors on the work of the Workforce Committee during the period 1st April 2018 to 31st March 2019 and to set out how it has met its terms of reference and priorities.

2. ROLE OF THE COMMITTEE

2.1 The role of the Workforce Committee is to obtain assurance on behalf of the Board of Directors on subjects relating to the Trust's employees and volunteers.

3. COMMITTEE MEMBERS AND ATTENDANCE

3.1 For 2018/19 the Workforce Committee consisted of the following members:

Committee Member		Attendance
Mr R Groome	Non-Executive Director (Chair)	4/4
Mr P White	Non-Executive Director	2/4
Ms L Ward	Interim Director of Organisational Development	3/4
Ms T Ellery	Director of Finance	3/4
Mr G Blezard	Director of Operations	1/4

3.2 The Committee met on the following dates during 2018/19:

16th April 2018
7th August 2018
23rd October 2018
28th January 2019

4. WORKFORCE COMMITTEE ACTIVITY

4.1 The Board should note that all of the functions set out within the Committees Terms of Reference have been discharged.

The Committee received regular assurance reports in relation to key workforce indicators and measures against the Trust Strategy.

Due to challenges within the 111 Service with regards to workforce issues, the Committee instructed a deep dive to be carried out and continue to monitor performance.

The NHS pay deal came into effect during 2018/19 and as a result, the Committee received a report with regards to the Trust's progress in implementing the National Pay Restructure for staff on NHS Terms & Conditions of Service (AfC) for 2018 and beyond for a period of 3 years.

The Committee has played an active role in terms of the staff survey, monitoring progress against actions as a result of the survey. For example, the Committee received and update in relation to the Trusts Be Think Do Leadership Programme.

The Trust has a Cost Improvement Programme and the Committee has received assurance in terms of the impact to staff.

5. IMPROVEMENTS/KEY LEARNING THE PERFORMANCE COMMITTEE CAN TAKE INTO 2019/20

For 2019/20, the following areas could be improved:

- The Trust utilises the support of a number of volunteers and during 2018 the Committee received two separate reports relating to Voluntary Car Drivers and Community First Responders. Members should consider whether there is a requirement to define the purpose of our volunteer schemes in a more strategic form by adopting the model of a Volunteers Strategy, which is widely utilised in the Acute Sector and links this activity to the delivery of our Corporate Strategy.
- The role of the Committee is to provide scrutiny and challenge prior to the final data being presented to the Board. Consideration should be given as to whether this can scheduled at an earlier stage in the Committee's work programme.
- The Trust participates in an approved apprentice scheme for EMT1 apprentice placements. The Committee should receive an annual report and also have oversight of any associated action plans.
- To receive assurance around the CQC registration requirements, in particular the Key Lines of Enquiry (KLOEs).
- The Committee should consider the Pledges to Staff as set out within the NHS Constitution and identify whether sufficient assurance is received.

6. SUMMARY

The Committee believe it has fulfilled its role in the year and met the requirements defined in its Terms of Reference and submit this report to the Trust Board for review.

7. LEGAL IMPLICATIONS

7.1 There are no direct legal implications arising out of the subject matter of this report.

8. RECOMMENDATION

8.1 The Board of Directors is recommended to:

- Review and note the Trust's Workforce Committee activities during the financial year 2018/19.