North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 27 May 2020
9.45 am - 1.00 pm

Microsoft TEAMS

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
INTRODUCTION					
BOD/2021/1	Apologies for Absence	09:45	Information	Chairman	
BOD/2021/2	Declarations of Interest	09:45	Decision	Chairman	
BOD/2021/3	Minutes of Previous Meeting	09:45	Decision	Chairman	3 - 10
BOD/2021/4	Board Action Log	09:45	Assurance	Chairman	11 - 12
BOD/2021/5	Committee Attendance	09:50	Information	Chairman	13 - 14
BOD/2021/6	Register of Interest	09:50	Assurance	Chairman	15 - 16
STRATEGY					
BOD/2021/7	Chairman & Non-Executives' Update	09:50	Information	Chairman	
BOD/2021/8	Chief Executive's Report Month 1 2020-21	10:00	Assurance	Chief Executive Officer	17 - 32
GOVERNANCE AND RISK MANAGEMENT					
BOD/2021/9	Board Assurance Framework and Corporate Risk Register Quarter 4 Position 2020/21	10:10	Decision	Director of Corporate Affairs	33 - 70
BOD/2021/10	Risk Appetite Statement	10:10	Decision	Director of Corporate Affairs	71 - 76
BOD/2021/11	Freedom to Speak Up - 2019/20 Quarter 4 Position and Annual Report	10:15	Assurance	Director of Corporate Affairs	77 - 108
BOD/2021/12	Core Governance Documents	10:25	Decision	Director of Corporate Affairs	109 - 204
BOD/2021/13	Annual Self Certifications: General Condition FT4 - Corporate Governance Declaration	10:40	Decision	Director of Corporate Affairs	205 - 214
BOD/2021/14	Annual Self Certifications: General Condition 6 - Systems for Compliance with Licence Conditions	10:45	Decision	Director of Corporate Affairs	215 - 224
BOD/2021/15	Common Seal Annual Report	10:50	Assurance	Director of Corporate Affairs	225 - 228
BOD/2021/16	Quality and Performance Committee Annual Report and Terms of Reference	10:55	Decision	Prof A Chambers	229 - 244
BOD/2021/17	Resources Committee Annual Report and Terms of Reference	11:00	Decision	Mr M O'Connor	245 - 260
QUALITY AND PERFORMANCE					
BOD/2021/18	Integrated Performance Report Month 1	11:05	Assurance	Director of Quality,	261 -

				Innovation and Improvement	316
BOD/2021/19	Accountable Officer for Controlled Drugs Annual Report	11:30	Assurance	Medical Director	317 - 336
BOD/2021/20	IPC Annual Report	11:40	Assurance	Director of Quality, Innovation and Improvement/Chief Nurse	337 - 350
BOD/2021/21	Safeguarding Annual Report	11:50	Assurance	Director of Quality, Innovation and Improvement	351 - 362
BOD/2021/22	Health and Safety Annual Report	12:00	Assurance	Director of Quality, Innovation and Improvement	363 - 374
BOD/2021/23	Senior Information Risk Owner Annual Report	12:10	Assurance	Director of Quality, Innovation and Improvement	375 - 384
BOD/2021/24	Complaints Annual Report	12:20	Assurance	Director of Quality, Innovation and Improvement	385 - 396
BOD/2021/25	Audit Committee Assurance Report - from the meeting held on 22nd May 2020	12:30	Assurance	Mr D Rawsthorn	397 - 402
BOD/2021/26	Quality and Performance Committee Assurance Report - from the meeting held on 20th April 2020 and 18th May 2020	12:35	Assurance	Prof A Chambers	403 - 414
WORKFORCE					
BOD/2021/27	Workforce Update	12:40	Assurance	Interim Director of Organisational Development	415 - 438
COMMUNICATIONS					
BOD/2021/28	Communications and Engagement Dashboard Report - Q4 2019-20	12:50	Assurance	Director of Strategy and Planning	439 - 450
CLOSING					
BOD/2021/29	Any Other Business Notified Prior to the Meeting	13:00	Decision	Chair	
BOD/2021/30	Items for Inclusion on the BAF	13:00	Decision	Chair	

Date and Time of Next Meeting 9.45 am Wednesday, 29 July 2020. Venue tbc.

NHS North West Ambulance Service NHS Trust

Minutes
Board of Directors

Details: Wednesday 25th March 2020, 9.45am
Ladybridge Hall, 399 Chorley New Road, Heaton, Bolton, BL1 5DD

Present:

Mr P White	Chairman
Mr G Blezard	Director of Operations
Prof A Chambers	Non-Executive Director
Mr S Desai	Director of Strategy & Planning
Mr M Forrest	Deputy Chief Executive
Dr C Grant	Medical Director
Dr D Hanley	Non-Executive Director
Mr D Mochrie	Chief Executive
Mr M O'Connor	Non-Executive Director
Mr D Rawsthorn	Non-Executive Director
Prof R Thomson	Associate Non-Executive Director (Clinical)
Ms L Ward	Interim Director of Organisational Development
Ms A Wetton	Director of Corporate Affairs
Ms C Wood	Director of Finance

In attendance:

Mrs P Harder	Head of Corporate Affairs (Minutes)

Minute Ref:

BM/1920/159 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mr R Groome, Non-Executive Director and Ms C Wade, Associate Non-Executive Director.

BM/1920/160 DECLARATIONS OF INTEREST

No declarations of interest were raised.

BM/1920/161 MINUTES OF PREVIOUS MEETING HELD ON 29th JANUARY 2020

The minutes of the previous meeting held on 29th January 2020 were agreed as a true and accurate record, subject to the amendment of minute reference BM/1920/156 relating to Prof R Thomson's role at Public Health England being changed to Cheshire East Council.

BM/1920/162 ACTION LOG

The Board noted the action log and update.

BM/1920/163 COMMITTEE ATTENDANCE

The Board noted the committee attendance presented for information.

BM/1920/164 REGISTER OF INTEREST

The Board noted the 2019/20 register of interest presented for information.

BM/1920/165 CHAIRMAN AND NON-EXECUTIVES DIRECTORS UPDATE

The Chairman advised that he had met with a number of Chairs from Acute Trusts and that positive meetings had been held in relation to Every Minute Matters. He also reported he had visited 111 and commended the staff for undertaking their roles particularly whilst the Trust was under immense pressure.

The Board:

- Noted the update.

BM/1920/166 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented a report to provide members with information on a number of areas since the last report to the Trust Board on 29th January 2020. The report covered (i) performance, (ii) issues to note, and (iii) general updates.

The Chief Executive provided the Board with a high level brief relating to COVID-19 as follows:

- 111 activity had increased 116% compared to the same time last year, with 15,000 calls received per day.
- 999 call activity had increased by 6%, with lengthy on scene time due to Respiratory Protective Equipment (RPE), with over 5,000 999 calls received per day.
- 700 staff are self-isolating
- NHSE/I have declared a national emergency: this is a level 4 incident with a full command structure now in place. All NHS Regions have been requested to establish an operational COVID-19 Incident Command Centre to liaise with NHS organisations, CCGs and other health providers and Local Resilience Forums. He noted the NHS North West Incident Command Team included Graham Urwin and Bill McCarthy.
- In order to support PES and urgent PTS discharges to free up beds, PTS had been stood down at the end of last week. All stakeholders and commissioners were made aware of this decision.
- Following discussion with the Executive Leadership Committee, the strategic intention and key priorities continue to be to protect 999 and call handlers and how to increase 999 capacity. The demand and resource modelling is now under review from London Ambulance Service and Italy.
- Staff welfare remains a top priority, in particular ensuring the supply chain is in place and working with the wider system to ensure capacity across the North West.
- It is extremely busy, with lengthy waits and queues in 111 however the Trust continues to manage any clinical risk.

The Director of Finance provided the Board with a verbal update in relation to planning and contracting and advised that in order to relieve the burden around the transactional processes, the commissioning contract and operational plan for 2020/21 had been suspended and payment by results would apply to the majority of acute trusts for the foreseeable future. The Trust however had been notified it would receive a block payment, plus top up payments in relation to the Trust's

COVID-19 response and therefore the Board would not receive operational and budget planning reports. She stated contracting would be suspended as notified by Simon Stevens and there would be no new revenue or business investments unless linked to COVID-19. In addition, the implementation of IFRS 16 in the public sector had been deferred until 2021/22.

The Chairman congratulated the Deputy Chief Executive on his appointment and noted the support of the Board in his new role. He also noted the current pressure on staff and Executive Directors and on behalf of the Board and Non-Executive colleagues noted their appreciation for the work being undertaken. He referred to the number of staff in self-isolation and queried whether staff testing was being undertaken to allow staff to return to work. In terms of the PTS decision, he requested that Non-Executive Directors receive a weekly update on decisions being made.

The Chairman also queried the measures in place to ensure COVID-19 funding is being used appropriately. The Director of Finance advised it is a block payment based on M9 spend with monthly requirements to apply for additional funding and for financial governance purposes all spend associated with COVID-19 is recorded.

In response to the Chairman's queries, the Chief Executive advised that the Trust were working with Public Health England around staff testing. In terms of the decision to suspend PTS operations, he advised that this was in line with our Major Incident Continuity Plan and ensured the message was consistent with West Midlands Ambulance Service NHS Trust communications for the PTS contract in Cheshire, with approval sought from NHSE/I and commissioners however agreed to ensure NEDs are kept up to date. In response to the Chairman's query relating to the safety nets for patients as a result of the increased calls to 111, he advised that the Patient Safety/Clinical Sub Group chaired by the Medical Director would monitor pressure and delays in 111 and try and support operations to manage the risk and that the Quality and Performance Committee would oversee this going forward.

In response to Prof A Chambers query around working with the hospitals to discharge patients in order to free up beds, the Chief Executive advised that PTS would continue for renal patients, cancer patients, end of life care patients and discharge/transfer to another setting. He noted significant communications had been undertaken with system partners and engagement with staff had been well received internally and externally, led by the Director of Strategy and Planning.

The Board:

- Received and noted the contents of the report.

BM/1920/167 NWAS PANDEMIC INFLUENZA PLAN

The Director of Operations presented the latest version of the NWAS Pandemic Influenza Plan following annual review and provided assurance it was in line with EPRR framework stipulations. He added the Plan had been updated in line with publication of revised guidance from the World Health Organisation (WHO), Department of Health and Public Health England (as well as the release of debrief reports from the 2009/10 Pandemic), together with best practice recommendations.

He advised of the possibility that the Influenza Plan may change in the next iteration of the Assurance Framework to a general Pandemic management plan and noted a COVID-19 Response Plan was under development in order to cover

the current outbreak and would be presented to the Quality and Performance Committee.

The Board noted that the presentation of the NWAS Pandemic Influenza Plan formed part of the required evidence for the 2020/21 NHS England EPRR Assurance process.

The Board:

- Reviewed and approved the Pandemic Influenza Plan.

BM/1920/168 AMENDMENT TO STANDING ORDERS – EMERGENCY POWERS

The Director of Corporate Affairs presented a report requesting the Board to approve an amendment to clause 5.2 of the Standing Orders relating to Emergency Powers and Urgent Decisions. She advised that due to COVID-19 and the consequential impact on the Trust's corporate governance arrangements and delay of the submission of the revised core governance documents to the Board of Directors to May 2020, an amendment to the Trust's Standing Orders was required relating to Emergency Powers and Urgent Decisions.

She reported under the existing Standing Orders (clause 5.2), emergency powers can only be exercised by the Chairman and Chief Executive having consulted with two Non-Executive Directors and recommended the proposal to amend this to include two Executive Directors (voting) to ensure balance of powers around decision making.

In response to Mr D Hanley's query relating to instances where Board members are not available, the Director of Corporate Affairs stated the business continuity plan provided the detail for the next nominated deputies.

The Board:

- Approved the resolution to amend Clause 5.2 Emergency Powers and Urgent Decisions to ensure balance of powers around decision-making.

BM/1920/169 BOARD ASSURANCE FRAMEWORK 2020/21

The Director of Corporate Affairs presented the proposed Board Assurance Framework (BAF) risks for 2020/21 for approval by the Board of Directors. However, she advised the Board that the current key risk related to COVID-19 due to the impact of having to manage and respond to COVID-19, specifically in relation to the financial impact, operational plans and public safety. She therefore recommended that the risks are approved until such a time the Trust was ready for business restoration

In response to the Chairman's query as to when this would be included into the BAF, the Director of Corporate Affairs stated it was under development and would appear as a single risk and circulated once agreed by the Executive Leadership Committee. Mr D Rawsthorn queried whether it would be an additional Strategic Risk however the Director of Corporate Affairs advised it be the only Strategic Risk on the BAF. The Chief Executive supported this as the Trust would not be able to deliver on the Trust's strategy.

The Board:

- Approved the proposed BAF risks for 2020/21
- Agreed that COVID-19 should be the only BAF risk at this time.
- Noted that the articulation of the risk would be circulated to the Board.

BM/1920/170 CHAIRMAN'S ANNUAL FIT AND PROPER PERSONS' DECLARATION

The Interim Director of Organisational Development presented the Chairman's annual declaration stating all Executive Directors and Non-Executive Directors met the requirements of the Fit and Proper Persons Test (Regulation 5), together with assessment of the independence of Non-Executive Directors. She advised that the statement was informed by MIAA's internal audit of Fit and Proper Persons during 2019/20, which provided independent High Assurance.

The Board:

- Noted the assurance provided by the Chairman that he is confident the Trust is compliant with regulations and that the Board meets the Fit & Proper Persons criteria.

BM/1920/171 INTEGRATED PERFORMANCE REPORT

The Director of Quality, Innovation and Improvement presented the Integrated Performance Report to provide the Board with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework for February 2020.

The Chairman referred to the ROSC data reported within the ACQIs and noted the Trust's performance was low. In response, the Medical Director accepted the Trust's low ranking however noted the data was 6 months old. He advised of the importance of patients and outcomes and stated the need to ensure patients are taken to hospital and noted the Trust was at the top of the ambulance service in this respect.

The Chairman noted the PES Friends and Family response was low during February 2020 and queried whether this related to pressures at the time. The Director of Strategy and Planning noted that the Friends and Family Test is to change from 1 April 2020 however agreed to provide the detail.

The Chief Executive commented on the need to balance what is critical business and the areas the Board need to focus on over the next 2-3 months, which is COVID-19, clinical, performance and staff health and well-being. The Chairman agreed and noted that the next Board meeting required a dedicated agenda item for COVID-19 to cover these areas.

The Board:

- Noted the contents of the report.

BM/1920/172 QUALITY AND PERFORMANCE COMMITTEE ASSURANCE REPORTS – 17TH FEBRUARY 2020 AND 9TH MARCH 2020

Prof A Chambers presented the assurance reports from the Quality and Performance Committees held on 17th February 2020 and 9th March 2020.

She highlighted the meeting on 9th March 2020 had been held earlier than scheduled which resulted in some of the data for reporting being unavailable. She referred to the meeting held on 17th February 2020 and issues around 111 and PES performance, particularly C3 and C4 and highlighted the Committee requested further information around medicines management and the Service Delivery Improvement Plan for additional assurance.

The Chairman noted that agendas for future Quality and Performance Committee would be reviewed in light of COVID-19.

The Board:

- Noted the assurance report from the Quality and Performance Committee meetings held on 17th February 2020 and 9th March 2020.

BM/1920/173 RESOURCES COMMITTEE ASSURANCE REPORT – 20TH MARCH 2020

Mr M O'Connor presented the assurance report from the Resources Committee held on 20th March 2020. He reported the Committee held a discussion relating to the staff survey results to identify how the Committee could support the drive for improvements and bring workforce issues to the forefront. He advised that the Committee would provide further focus on this area in the Autumn and noted the importance of the Board being visible.

Mr M O'Connor referred to the large number of digital projects and highlighted the need for prioritisation. The Director of Quality, Innovation and Improvement agreed and re-assured the Board that the Executive team are aware however need to balance against the list of demands and noted COVID-19 had taken precedence. She noted the risk in terms of balancing business as usual and continuing with project work and referred to the plan to create a permanent project team however appreciated the support from the Resources Committee.

The Chief Executive noted the Corporate Programme Board had commenced this work by identifying what COVID-19 means to the strategic objectives and overarching strategy. The Director of Strategy and Planning was undertaking this work and would be presented to Board however need to manage expectations and understand what needs to continue and what is likely to be delayed.

The Chairman noted full support of the Board in terms of digital improvement as it is critical to the strategy going forward. He referred to Unified Communications Programme and requested clarification around the slippage. The Director of Quality, Innovation and Improvement advised servers for the project had been re-purposed to support remote working in EOCs and that whilst updates and changes were required, the need to delay was important as it would disturb the system, when it is currently under so much pressure. The Chairman thanked the Director of Quality, Innovation and Improvement for her transparency and commented that the digital agenda had moved on tremendously.

Mr D Rawsthorn echoed the Chairman's comments however queried whether the communications system was in danger of being out of support. The Director of Quality, Innovation and Improvement advised that it was an increased risk across the board for IT infrastructure and stated the systems health would be monitored.

The Board:

- Noted and took assurance from the update.

BM/1920/174 STAFF SURVEY

The Interim Director of Organisational Development presented a summary of the 2019 staff survey report published by the National NHS Staff Survey Co-ordination Centre. She reported whilst it was a good result and above average in a number of areas, the need to see more themes above average would correlate with an outstanding CQC outcome.

She provided an overview of the report and noted the areas of improvement related to i) health and wellbeing ii) immediate line managers/morale iii) bullying and harassment iv) safety culture and v) staff engagement.

She reported the score for violence had worsened due to a 1% increase in staff experiencing violence from patients and referred to the Trust's approach to violence and aggression and the pilot for staff to wear body worn cameras, which may help to counteract this. In terms of team working, responses referred to workload pressures in addition to teams having less chance to meet. She noted COVID-19 was now the focus with immediate manager support critical.

In terms of next steps, the Interim Director of Organisational Development reported that COVID-19 had delayed work and would affect the Trust's objectives, with the focus on local plans unlikely to move on at speed. In terms of staff health and wellbeing, she noted the importance of providing support over the next few months. She reported that the culture survey would have the most impact on staff experience and help to drive forward interventions however had been delayed until the autumn.

Mr M O'Connor advised the results were discussed at the Resources Committee and whilst it was a good survey result, a deep dive would be undertaken in the Autumn, particularly around how the Committee could support the drive for improvements through visible leadership and focus on areas outside the workforce strategy to contribute to the results. The Deputy Chief Executive commented that the Trust had much to be proud of and how staff are treated makes a difference to the staff survey.

The Chairman noted the importance of future surveys and for the Board to be visible as leaders and support staff concerns. The Deputy Chief Executive reported the Workforce/Wellbeing command cell were reviewing family support, for example if a staff member of member of their family is lost to COVID-19 and to ensure Executives are talking to managers.

The Interim Director of Organisational Development advised of the need to keep a balance in terms of delivering a service and recognising the anxieties of managers and staff to understand concerns and that it is not a blanket approach.

In terms of PPE, the Medical Director provided an update and noted the message to staff is that the Trust is doing all it can to keep staff safe.

The Board:

- Noted the impact of work in 2019 to the staff survey results
- Received and noted the assurance on plans to progress.

BM/1920/175 ANY OTHER BUSINESS

CQC Update

The Chief Executive advised that the CQC had suspended the Well-Led inspections across the provider landscape. The Director of Quality, Innovation and Improvement advised that the Trust still held 110 additional data items as a result of the unannounced visit and anticipated a report from the visits. She reported CQC teams are active and required engagements meetings to be scheduled for next year. The inspection teams have come out of an intense period of inspection and now ramping up to respond to COVID-19.

The Board:

- Noted the update.

BM/1920/176 ITEMS FOR INCLUSION ON THE BOARD ASSURANCE FRAMEWORK

The Board noted the BAF would include only COVID-19.

BM/1920/177 DATE, TIME AND VENUE OF NEXT MEETING

The next meeting of the Board of Directors will be held on Wednesday 27th May 2020 at Ladybridge Hall, Bolton. BL1 5DD.

Signed: _____

Date: _____

Status:	
Complete & for removal	
In progress	
Overdue	

BOARD OF DIRECTORS MEETING - ACTION TRACKING LOG

Action Number	Meeting Date	Minute No	Minute Item	Agreed Action	Responsible	Original Deadline	Forecast Completion	Status/Outcome	Status
41	29/01/20	1920/148	Board Assurance Framework	The evidence captured within the Board Assurance included a date, to provide the right level of assurance in terms of the evidence being relevant/up to date.	AW	27.05.20	29.07.20	This will be incorporated into the 2020/21 Board Assurance Framework.	
42	25/03/20	1920/171	Integrated Performance Report	To advise Chairman of reasons for low response to PES Friends and Family Test	SD	25.05.20		Chairman advised on 26/03/20 that fluctuations are seen monthly as the Trust is reliant on patients completing and returning postal surveys. For PES it only relates to the Hear and Treat patient cohort.	

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Board and Committee Attendance 2020/21

Board of Directors														
	3rd April	6th May	27th May		29th July		30th September		25th November		27th January		31st March	
	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
Ged Blezard	✔	✔												
Prof Alison Chambers	✔	✔												
Salman Desai	✔	✔												
Mick Forrest	✔	✔												
Dr Chris Grant	✔	✔												
Richard Groome	✔	✔												
Dr David Hanley	x	✔												
Daren Mochrie	✔	✔												
Michael O'Connor	✔	✔												
Prof Maxine Power	x	✔												
David Rawsthorn	✔	✔												
Prof Rod Thomson	x	✔												
Clare Wade	✔	✔												
Lisa Ward	✔	✔												
Angela Wetton	✔	✔												
Peter White ©	✔	✔												
Carolyn Wood	✔	✔												

Audit Committee					
	17th April	22nd May	10th July	23rd October	23rd October
Dr David Hanley	Cancelled due to COVID-19	✔			
Michael O'Connor		✔			
David Rawsthorn ©		✔			
Prof Rod Thomson		✔			

Resources Committee						
	18th May	24th July	25th September	20th November	22nd January	26th March
Ged Blezard	Cancelled due to COVID-19					
Salman Desai						
Richard Groome						
Michael O'Connor ©						
Prof Maxine Power						
David Rawsthorn						
Lisa Ward						
Clare Wade						
Carolyn Wood						

Quality and Performance Committee										
	20th April	18th May	15th June	20th July	21st September	19th October	16th November	18th January	15th February	15th March
Ged Blezard	✔	✔								
Prof Alison Chambers (c)	✔	x								
Micahel Forrest	✔	✔								
Dr Chris Grant	✔	✔								
Richard Groome	✔	✔								
Dr David Hanley	✔	✔								
Prof Maxine Power	✔	✔								
Rod Thomson	✔	✔								
Carolyn Wood	x	x								

Charitable Funds Committee		
	29th April	28th October
Ged Blezard	Cancelled due to COVID-19	
Salman Desai		
Richard Groome		
Dr David Hanley		
David Rawsthorn ©		
Lisa Ward		
Angela Wetton		
Carolyn Wood		

Nomination & Remuneration Committee							
	14th April	27th May	29th July	30th September	25th November	27th January	31st March
Prof Alison Chambers	✔						
Richard Groome	✔						
Dr David Hanley	x						
Michael O'Connor	✔						
David Rawsthorn	✔						
Prof Rod Thomson	✔						
Clare Wade	x						
Peter White ©	✔						

CONFLICTS OF INTEREST REGISTER
NORTH WEST AMBULANCE SERVICE - BOARD OF DIRECTORS

North West Ambulance Service NHS
NHS Trust

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal	Indirect Interests		Apr-19	Mar-20	
Ged	Blezard	Director of Operations	Wife is a manager within the Trust's Patient Transport Service				√	Other Interest	Apr-19	Present	To be decided by Chairman if decision ifs required with a meeting, in relation to the service line.
Alison	Chambers	Non-Executive Director	Husband is a very senior NHS Manager				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governor at Wigan and Leigh College			√		Position of Authority	Apr-20	Present	N/A
Salman	Desai	Director of Strategy and Planning	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Michael	Forrest	Deputy Chief Executive	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Richard	Groome	Non-Executive Director	Director, Westbury Management Services Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Chair, Fix360 (part of Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Deputy Chair , Your Housing Group	√				Position of Authority	Apr-19	Present	N/A
David	Hanley	Non-Executive Director	Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Board Member/Director - Association of Ambulance Chief Executive's		√			Position of Authority	Sep-19	Present	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Board Member/Director - NHS Pathways Programme Board		√			Position of Authority	Mar-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care		√			Position of Authority	Apr-19	Present	N/A
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Aintree University Hospital NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Michael	O'Connor	Non-Executive Director	Partner in Addleshaw Goddard LLP	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director and Trustee of Central Manchester Concert Hall Ltd (Bridgewater Hall) (Charity)				√	Position of Authority	Apr-19	Present	N/A
			Chair, Festival Medical Services		√			Position of Authority	Apr-19	Present	N/A
			Company Secretary of Cartwright Care Balmoral Management Ltd 38 Montpelier Grove Ltd	√				Position of Authority	Apr-20	Present	N/A
			Company Secretary of Talia Lipkin Connor Ltd	√				Position of Authority	Apr-20	Present	N/A
			Non Executive Director and Trustee of Factory Youth Zone (Harpurhey) Ltd				√	Position of Authority	Apr-19	Present	N/A
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Member of Green Party			√		Other Interest	May-19	Present	Will not use NED position in any political way and will avoid any political activity in relation to the NHS.
Rod	Thomson	Non-Executive Director	Visiting Professor at the Universities of Chester, Staffordshire and Liverpool John Moores University		√			Position of Authority	Sep-19	Present	No conflict
			Trustee of the mental health charity "listening ear". The charity is based in Merseyside and provides services in the NW region,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Volunteer at Severn Hospice, Shewsbury and do so as part of CPD requirements for NMC registration.		√			Volunteer	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governing Body Member, Royal College of Nursing		√			Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Locum Consultant in Public Health, Cheshire East Council	√				Position of Authority	Jan-20	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Fellow of the Royal College of Nursing and the Faculty of Public Health,		√			Position of Authority	Sep-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Clare	Wade	Associate Non-Executive Director (Digital)	Head of Patient Safety, Royal College of Physicians	√				Position of Authority	Jul-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Lisa	Ward	Interim Director of Organisational Development	Member of the Labour Party	N/A	N/A	√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
Peter	White	Chairman	Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Non-Executive Director – Riverside Housing	√				Position of Authority	Apr-19	Present	N/A
			Non-Executive Director – Miocare Ltd	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Angela	Wetton	Director of Corporate Affairs	Husband is Operations Director of The Senator Group who supply the NHS, amongst many others, with office and hospital furniture.				√	Other Interest	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Carolyn	Wood	Director of Finance	Husband was Director of Finance at East Lancashire Hospitals NHS Trust				√	Other Interest	Apr-19	Jul-19	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.
			Husband is Director of Finance/Deputy Chief Executive at Lancashire Teaching Hospitals NHS Foundation Trust				√	Other Interest	Aug-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved.

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North West Ambulance Service NHS Trust

REPORT

AGENDA ITEM:

Board of Directors				
Date:	27 May 2020			
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 Chief Executive's report to the Trust Board on 25 March 2020. The highlights from this report are as follows: **Performance** • The trust experienced significant challenges relating to COVID-19 call, incidents and absent staff in the early phase • BT call script and the National pandemic triage protocol card 36 was implemented at the request of the NHSE/I and is part of a national response to manage call volumes • Additional resources have been put in place to manage the response phase of COVID-19 • The trust is now, for the first time, meeting all 999 response time performance standards **Issues to note** • The Chief Executive attended a number of engagement events with local and regional stakeholders and staff.			
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):

SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21	☐

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	**N/A**
Date:	
Outcome:	

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1. PURPOSE

1.1 This report seeks to provide a summary of the key activities undertaken by the Chief Executive and the local, regional and national issues of note in relation to the Trust since the last report to the Trust Board on 25 March 2020.

2. PERFORMANCE

2.1 **999**

During March and April Paramedic Emergency Service (PES) operations experienced significant challenges relating to COVID-19. Calls increased in March by 11.1 % compared to the previous year and decreased in April by 8.1 % during this period, we also experienced a large number of staff being absent from the workplace due to self-isolation, decreased vehicle availability from self-isolation, down time for staff to undergo Personal Respiratory Protection (PRP) face mask fit testing and resources spending extended time on scene to don and doff Personal Protective Equipment (PPE).

In response to this the trust rapidly developed a COVID-19 Response plan to mitigate the risks generated by the pandemic outbreak and NHS level 4 major incident. The key strands to the response were delivered by the all departments within the Trust and are outlined below:

- Create a strategic command structure with Exec oversight
- Increase vehicle availability to 420 vehicles at peak, utilising Patient Transport Service (PTS) converted vehicles, retention of vehicles due to be de-commissioned, Voluntary Ambulance Support (VAS) and Private Ambulance providers
- Maximise operational staffing with the use of PTS support staff and second year student paramedics
- Increase call taking capacity by circa 180 WTE via recruitment and first year student paramedics
- Increase 111 staffing by 98 with first year student paramedics
- Non-operational staff being released to support operations such as loggists, supporting logistics, staff testing to name but a few.
- Volunteers across the Trust including Fire & Rescue Personnel supporting with face fit mask testing, Police colleagues supporting driver training, volunteers supporting packing PPE, moving equipment and welfare vehicles and moving supplies around the Trust.

The trust also adopted at the request of NHS England the BT Pandemic call script and the National Pandemic Triage protocol card 36 (as part of a national response) with the MPDS triage system to manage call volumes appropriately.

These actions did take some time to implement over a short period, however towards the end of April benefits to patient safety and ARP standards were realised with all targets now being achieved in the month of May, the first time ever that the Trust has achieved all standards.

111

March and April have continued to be challenging for NWAS 111 due to the ongoing demand created by the COVID-19 outbreak. Towards the middle of April we have seen a settling of the demand to a new “normal”, however this is approximately 35% additional calls each day.

The call demand profile has also changed due to the number of people not in their

workplace, with the highest demand on a week day falling in the morning, where previously 111 experienced a significant demand spike at 18:30, which has presented a requirement to look at re rostering.

Over the 2 months the 111 team have been creative in optimising the current resources and processes and utilising additional student paramedic resource without the need for 8 weeks pathways training.

The impact has been a stabilisation of performance towards the end of April, facilitating a period of time to recruit additional 136 Health Advisors (79 wte). Training has commenced and will be continuous until the end of July 2020.

Action has also had to be taken in regard to IPC (Infection Prevention and Control), with maintaining 2m social distancing being our greatest challenge. The 111 estates profile has changed to try to maintain the social distancing with 111, moving into the PTS space at Estuary Point and the 1st floor of Middlebrook being converted to operational delivery desks. Perspex screens are to be fitted across all control rooms soon, to reduce infection transmission risk.

PTS

Overall activity during April 2020 was 67% below contract baselines with Lancashire 74% below contract baselines whilst Merseyside is operating at -56% (-14022) Journeys below baseline. For the year to date position (July 2019 - April 2020) PTS is performing at -10% (-128440 journeys) below baseline. Within these overall figures, Cumbria, Greater Manchester and Lancashire are operating at 14%, 5% and 19% below baseline whilst Merseyside is operating at 3% above baseline.

In terms of unplanned activity, cumulative position within Greater Manchester is 18% (7247 journeys) above baseline. 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, Lancashire and Merseyside are 29% (3592 journeys), 14% (7051 journeys) and 1% (259 journeys) below baseline.

In terms of overall trend analysis, overall activity levels had plateaued for all contracts up to March 2020 where the impact of Covid-19 has led to a significant reduction in planned activity and a further reduction in EPS activity. Unplanned activity has remained relatively stable.

Aborted activity for planned patients averaged 14% during April 2020 however Cumbria experiences 9%, Greater Manchester operates with 21% whilst Lancashire and Merseyside both experience 10% & 12% aborts respectively. Within EPS (renal and oncology) overall aborts average 4% aborts. Cumbria has 1%, Greater Manchester 6% , Lancashire and Merseyside operate with 3% and 4% respectively. Unplanned (on the day) activity experiences an average 12% with variances of 10% in Cumbria, 13% in Greater Manchester, 10% in Lancashire and 12% Merseyside.

PTS staff have also been doing a tremendous job supporting the wider health system with priority patients, discharges, transfers and the surge capacity to support the PES service.

3 ISSUES TO NOTE

3.1 Local Issues

3.2 Regional Issues

Site Visits

I spent three days in Cumbria joining a crew from Distington. We attended seven older patients with medical conditions ranging from shortness of breath and infection to overdose and falls.

We visited Flimby and Egremont stations and the fleet workshop team. I had the opportunity to visit a local community college to say a massive thank you to the Head teacher and her staff who had attended to one of their 15 year old pupils who had suffered a cardiac arrest. The whole chain of survival from the early 999 call, CPR and defibrillation before the arrival of our crews, meant that the patient was transferred to Newcastle Freeman's Hospital to make a good recovery.

I also had an opportunity to visit Carlisle Ambulance Station, Salkeld Hall and Carlisle NHS 111 contact centre and it was great to speak to the staff about how PTS has changed over the years and we discussed how we might look to develop PTS staff who may wish to progress onto PES in the future. I also discussed with staff about how we might use video conferencing more in the future and how the trust could use digital for things like safeguarding referrals etc. I was able to hear first-hand some of the NHS 111 calls being received and how promoting NHS 111 on line eases the pressure on the NHS 111 service for call handlers and clinicians. As always, I gained invaluable insight from spending time with our people.

I met a number of PES and PTS colleagues on station at Old Swan, South Liverpool and Oldham PTS Control and station. We talked about the key role PTS colleagues have in supporting major incidents and the impact of hospital handover delays. The trust is working with its hospital colleagues to improve handover delays as these affect our ability to respond to other patients out in the community as well as our response times and associated performance. The third equally important aspect is the effect on our staff who are well aware of the position they are in but are frequently unable to change it. They continue to provide care and compassion to patients whilst waiting to hand patients over for often considerable lengths of time and have to maintain their professionalism whilst feeling frustrated. In addition they may potentially be missing important meal breaks and enduring delayed finishes. All of these factors significantly affect the health and wellbeing of our staff.

I also visited Chester station to thank staff for what they were doing to respond to the COVID pandemic. We will continue to work hard to improve this situation and my thanks to all the managers and staff that I met for sharing their views and experiences with me.

CQC Inspection

The trust was given 30 minutes' notice of an unannounced Care Quality Commission (CQC) inspection at the end of February. My thanks to the CQC inspection co-ordination team who did a great job supporting the inspectors and keeping us all updated.

A number of scheduled interviews took place during this part of the inspection process and they visited various sites around the trust, as well as each of the three EOCs, Medicines Hub and hospital emergency departments where they were able to speak to staff. It can be daunting being approached by people in this way, but the feedback from the inspectors has been extremely positive and they commented that they were made to feel very welcome. They have also been very positive about how engaged staff were and how evident was the commitment to our patients.

The key points of interest have included training, patient records, clinical briefings to staff, SPTLs, induction and mentoring, incident debriefs, the management of serious incidents

and safeguarding.

I have seen for myself the care and compassion our staff give to patients and the dedication they have to their roles – both patient facing and behind the scenes and have every right to feel proud of demonstrating those attributes to the inspectors.

While this has predominately been an inspection focussing on PES and EOC, the inspectors did attend the PTS SMT meeting and while on station, spoke with patient transport staff.

With any such intense inspection, there were a small number of things that were picked up that the trust could either do better or had not done in line with our own practices. The draft report was received on 20 April and following agreement to an extension, the trust had until 13 May to check for factual accuracy and provide any additional information to inform the CQC's judgement of our service. We will share the final report as soon as we receive it.

3.3 **National Issues**

Coronavirus

The novel coronavirus (COVID-19) outbreak presented a significant challenge for the health and social care system, but the trust along with the rest of the NHS and UK Government had extensive plans that have been in action since the outbreak began

We have a dedicated Incident Command Team based at Parkway operating 24/7 and led by a strategic and tactical commanders who is supported by clinicians and EOC staff. The primary function of this team is to have a single point of contact for liaison and co-ordination for all COVID-19 patient management alerts, referrals, transport and tracking. Our HART teams are actively involved in transporting confirmed cases to specialist centres and the wider paramedic emergency service in responding to patients who may be affected. Many staff are involved in daily teleconferences with local, regional and national partners to ensure we are abreast of the latest developments and sharing information as it becomes available and many will have been involved in reviewing and refreshing our business continuity plans to ensure we can maintain business critical services as well as protect our staff and patients.

The UK is extremely well prepared for these types of outbreaks – although this has been unprecedented. We established a Coronavirus Strategic Working Group to meet on a daily and weekly basis and ensure we have plans and processes in place to deal with the developing situation.

I am also well aware of the additional pressure on our NHS 111 colleagues who continue to do an amazing job responding to the significant increases in calls across all of our three centres, many of which relate to concerns about coronavirus. The NHS 111 service that we deliver for the population of the North West saw an unprecedented increase from the public with daily demand fluctuating between 40% and 70% higher than this time last year. The increase in the number of calls meant considerable numbers of patients were waiting for their calls to be answered and additional pressures were put on our staff. NHS England invested in the 111 service across the country to provide additional capacity to support the increased demand and the online 111 service and coronavirus checker have been well used during this time.

Guidance was issued regarding the locking down of our control centres to the public to minimise the potential for transmission of the infection. We did not take these decisions lightly but felt the need to protect our staff, the patients we serve as well as ensuring we

are able to maintain key service lines is of paramount importance.

The ICT team are playing an important part in supporting the efforts and some of the work under the ICT's remit includes:

- Ensure we have processes in place to ensure timely returns of any information needed nationally and that there is trust representation on any NHS England and NHS Improvement regional teleconferences.
- Review business continuity arrangements to ensure that we can maintain business critical services.
- Ensure that any member of staff, including bank staff and sub-contractors, who have to be physically present to carry out their duties, receive full pay for any period in which they are required to self-isolate as a result of public health advice.
- Refresh business continuity plans for the maintenance of essential services.

The Coronavirus outbreak presented a significant challenge as the numbers of patients increased and new daily measures to help to keep us safe were announced by the Government. The trust regularly monitors the changing situation and adapts our COVID-19 response plan accordingly. We are also communicating the latest information, its impact on the trust and how it affects staff as quickly as possible both internally and externally.

I visited teams at Estuary Point and saw first-hand the volume of calls both 111 and EOC colleagues are handling. On one day alone we received over 18,000 calls for help across the two service lines. Corporate colleagues without clinical training or qualifications were also asked to provide administrative support to the front line teams and whether any of those staff have the C1 category on their driving licence and are able to undertake driving duties with appropriate training.

Since the start of the pandemic, we have seen many changes happen across the service, and we have boosted our workforce to support the region bringing in more than 450 new workers to the frontline in recent weeks. We have also increased the number of ambulances available by converting 80 non-emergency PTS vehicles and adding the equipment needed to respond to emergencies. An additional 187 staff are in place to handle 999 calls in our emergency operations centres, 150 additional NHS 111 health and service advisors have joined the 111 team and 150 PTS staff have upskilled and are now operational within PES. I have seen and heard some fantastic feedback about their professionalism and compassion and I know their contribution is greatly valued by PES colleagues.

The trust received many offers of support from former employees, retired colleagues who are volunteering to come back to work to help us and a list of these people together with their skill and experience level was compiled to see how they might best assist us. All of these measures will help us to keep providing essential services for the communities we serve.

Temporary training centres have been set up using empty spaces in local schools to help train student paramedics, apprentices, staff redeployed from other parts of the trust; increasing our workforce at this pace and scale has taken a real team effort across the organisation.

Whilst our patient transport service (PTS) were still transporting renal, end of life, haemodialysis patients and continuing to provide discharge and transfer services, our commissioners agreed to a temporary suspension of conveyance to routine outpatient and clinic appointments.

In addition to PTS converted vehicles we are utilising our workshop spare PES vehicles as well as bringing back to the front line a number of vehicles that were due to be decommissioned

The trust issued information relating to the closure of schools, wrap around care and nursery provision as well as the latest advice in relation to safeguarding, deep cleaning, homeworking and staff support.

The trust are also working with health partners to support an increase in available bed capacity, in particular critical care ventilated bed capacity and are part of the operation to build an additional large hospital facility in central Manchester, the Nightingale Hospital

The trust announced opportunities for staff to stay in hotel accommodation where people in the same household are displaying symptoms and where they are prepared to continue to come to work rather than self-isolate at home.

Many organisations are showing their support for NHS staff at this time with most supermarkets offering special restricted hours for NHS staff to do their shopping. In addition we have seen boxes of fruit and veg, snacks and other items being delivered to trust sites to demonstrate the support and good will of local communities.

It was with great sadness that I reported the death of Stuart Monk from COVID-19. Stuart, a paramedic from Wigan with 28 years' service, had been in hospital being treated for the virus and sadly passed away on Friday 17 April. Stuart was married with two children and our hearts and thoughts go out to them for their devastating loss. He will be sorely missed by his NWAS family, his friends and colleagues. Following the announcement the trust has been overwhelmed with messages of support and condolence from people around the world. It is truly comforting to see how well thought of our staff are. Unfortunately currently circumstances led to Stuart not receiving a full service funeral, but I was honoured to join many of our colleagues lining the grounds of Wigan Station to pay our respects whilst the cortege drove by.

It was also with great sadness I announced the death of a second colleague from COVID-19. Phil Rennie, a PTS Care Assistant based in Oldham, had spent some time in hospital being treated for the virus and sadly passed away on Sunday 10 May. Phil leaves his wife, Karen; son, Adam and extended family. His family are in our thoughts and I know he will be sorely missed by all who knew him and we all will feel this tragic loss. Phil has been part of the NWAS family since 2015 and had dedicated his career to serving the public; previously working in local authority and public services. Phil was extremely proud to work for NWAS, offering comfort and care to those in need. Our role is a privileged one, we meet people at their most vulnerable and I am sure there are many people whose lives were touched by Phil during his career.

Losing a much loved colleague is something every organisation fears - I know from throughout my career in the ambulance service that we are more than colleagues. We are friends and we are family and to hear of a colleague's passing is devastating – we mourn together.

Current position

The expected COVID-19 peak in the North West has indeed the rest of the UK has passed. The Trust is now focusing on recovery but also robust plans should any second wave materialise. We still have a number of staff in self isolation, which has reduced significantly since the start of the outbreak. To help get staff back to work as safely and as soon as possible, we have been undertaking a number of things to support the health & wellbeing of staff across the Trust. We continue to provide support around health & wellbeing, rapid

swab testing and ongoing advice. This will continue on an ongoing basis.

We continue to work tirelessly to secure sufficient and appropriate PPE and have effective systems in place to move it around the region to wherever it is needed most. We have also employed a 'swop shop' approach with the Northern Ambulance Alliance trust, which consists of NWAS, North East, Yorkshire and East Midlands Ambulance Services, whereby we are swopping what PPE we have a lot of, for what they have and we need. This is monitored through our tactical incident command cell 24/7. With regards to level three face masks (FFP3) we have face fit tested the majority of front line clinical staff with the exception of those off sick or not at work long term. This will continue to be monitored through the tactical incident command cell, risks managed through regular audit and contact tracing to identify any possible exposure to our staff.

The Board and I are also grateful that our Trade Union colleagues are supportive of everything we are doing to ensure our staff remain protected on the frontline. It is really important that we all understand the latest PHE guidance and continue to undertake a dynamic risk assessment and then choose the appropriate level of PPE, so that we can protect ourselves, our families, colleagues and patients. Aerosol Generating Procedures make up a small proportion of our daily activity, therefore in line with PHE guidance, the use of an FFP3 mask should only be required in a small number of incidents a day.

On a positive note, calls to both 111 and 999 have reduced, more so to the 999 service and we are generally doing well against all targets. See & Treat and Hear & Treat are performing well and hospital handovers times have improved considerably. Hospitals have good bed occupancy rates, and we continue to support the mobilisation and day to day movement of patients into and out of the new Nightingale Hospital NW.

Thank Yous

Matt Hancock, Secretary of State for Health and Social Care, paid tribute to the NHS and all public service workers pulling together to keep people safe at this time.

Bill McCarthy NHSE/I North West Regional Director asked me to pass on his personal thanks to all our staff for their hard work in dealing with the additional demand due to Coronavirus and to offer his ongoing support. He recognises the extreme pressure our staff have been under but also recognises the role we have been playing to support the wider health care system across the Region.

The Trust continues to receive a stream of kind messages, drawings, cards and donations from a very grateful community, a selection of these are contained in the new Feel Good Friday bulletin together with information on additional support services available for staff members to access, if needed. One edition included reference to a letter of thanks from the new High Sheriff of Greater Manchester, Eamonn O'Neal, who recently took up his role and one of his first actions was to write to the trust to offer his thanks, support and appreciation for the work the trust does every day.

In addition the High Sheriff of Cheshire, Nick Hopkinson recently commented "As the Queen's representative for law and order in Cheshire I want to reinforce the Queen's *As* Queen's representative for law and order in Cheshire I want to reinforce the Queen's gratitude, the county's gratitude and my own gratitude to all front line workers for making sure that the ones who get the dreaded COVID-19 virus have a chance to enjoy their future. The Ambulance Service plays a central role in beating this virus. We all need to play our part now and continue to stay at home and give you all a fighting chance of success. You are all proving that the impossible is now the possible".

I passed on another very important thank you to all staff families. It must be a worrying

time for them given that so many of our staff are out on the frontline delivering care to the most in need and doing it with compassion and selflessness day in day out. We are working hard to ensure that staff are as protected as possible and that support is available to anyone and everyone who needs it.

I would also like to thank our staff who have been working hard on carrying out the testing, as well as our emergency service colleagues from the fire service who have been helping us with face fit testing and to police colleagues who have been helping with driver training.

I wanted to say thank you and well done to all the departments who have been involved - from IT to estates, education and training, HR, transformation and programme management teams, as well as all the clinical and operational staff who have welcomed new colleagues and supported them.

A thank you also to staff across all service lines and in every department of the trust, who are all working tirelessly to support our response to these unprecedented challenges. It is likely that the situation will get worse before it gets better and both the wider health system and the trust will have to adapt our response to meet this. Board colleagues and I are well aware of the commitment, compassion and care being shown to patients at this most challenging of times despite concerns for our own families and loved ones. Every person across the trust is doing their bit in this combined effort to keep vital services running and our communities and ourselves safe. My sincere thanks to everyone from those taking calls in our NHS 111 and EOC centres to those responding and everyone in between: cleaners, fleet, procurement; finance, HR, communications, IT as well of course as our volunteers.

I joined some of our colleagues at the weekly 'clapping for our carers' on Thursday at Wigan Ambulance and Fire station and the one minute's silence to remember Stuart Monk, this was a particular poignant time for all who are based there; the huge turn out and appreciation shown was very special to witness.

Unfortunately we also sadly lost another member of the NWAS family last week. A colleague, who was based at Estuary Point passed away following a long period of sickness. Whilst we have been asked by the family not to disclose further details, I on behalf of the Board expressed our sincere condolences to our EOC member's colleagues, family and friends.

At 11am on 28 April all of NHS England's national and regional teams were asked to pay their respects to the friends and colleagues they have lost over the last two months due to the virus.

4 GENERAL

NHS Staff Survey results

The results of the 2019 staff survey have been released by NHS England and I am pleased to note that we have maintained our level of engagement with a total of 2,774 response. My thanks to all staff who took the time to complete the survey and give their views. It really is important to do this so we have a clear picture of what is going well and what we still need to improve on. Feedback will be used to inform trust wide and local improvement plans.

Whilst it is good that some of our results show staff would recommend our trust as a place to work and feel that if a friend or relative needed care they would be happy with the standard of care we provided, I remain concerned by the increase in reported cases of both harassment/bullying/abuse as well as physical violence to staff. We all have a part to play in demonstrating positive behaviours, reinforced by supportive leadership. Our

Organisational Development colleagues met with local Heads of Service to explore how these findings can best influence local level plans.

With regard to violence against staff, it is positive that staff feel able to report it and do not consider it part of the job. There is a multi-disciplinary anti-violence and aggression working group who will use the results of the recent survey to identify which areas to tackle and what the priorities are. The trust will always seek to prosecute perpetrators of violence to staff wherever possible and some partnership work is in progress with the Crown Prosecution Service to encourage more prosecutions as well as use of impact statements in court. Supporting this process, I signed a victim impact statement on behalf of the trust which will be used to support our staff and highlight the effects of violence they can suffer in their working and home lives.

A number of campaigns have also been developed to raise awareness externally and invite public support. These included 'Stop Abuse' and more recently '#GetBehind999' which saw 1,100 pledges of support condemning acts of violence and aggression against all emergency service staff.

The violence and aggression group is currently working on an internal project to further encourage reporting and clarify the prosecution process. A manager's guide has been produced and will shortly be published to enable managers to better support their staff through the prosecution process. In addition we also have a task and finish group working on the trust's body camera trial. Neither I, nor my fellow Board members are prepared to tolerate violence against our staff and will continue to do all we can to protect staff and bring about improvements.

Building Better Rotas

The new rotas have gone live in the Greater Manchester and Cumbria & Lancashire areas. The introduction of these new rotas follows many months of hard work by all involved and I would like to thank everyone for their contribution. The first working parties met in June of last year and many useful lessons have been learned from them, and others, which have been applied to other areas as we have progressed with the project. Everyone has been very receptive to the need for change and our trade unions have also been very supportive, working with operational, human resources, finance and communications colleagues to name a few of those helping to deliver this important change. Over the coming weeks we will be looking closely at how the new rotas have worked and their impact on performance and other areas. This is a huge step change for the trust and one I believe will ultimately benefit our colleagues and our patients.

The new rotas for NHS 111 have also gone live. This is the first time NWAS NHS 111 has undertaken a rota review, which will result in a number of benefits for staff and the service itself. Established rotas will provide a greater sense of stability for staff in terms of their work/home life balance and the service overall will become more robust.

I would like to pass on my thanks to all those staff and volunteers who have been involved in the working parties enabling this to be taken forward.

Stable Lives

It was a privilege to meet Tim Byrom, Advanced Paramedic and his wife, who run Stable Lives, a charity based at the Parbold Equestrian Centre. It is based in an area of outstanding beauty and offers a safe and calm space for those who visit. The Stable Lives team use horses and ponies that they have rehabilitated from exposure to mental and physical trauma to provide a link to individuals who may be struggling with PTSD, depression, low self-esteem etc.

The team has strong military links and utilise the horses within courses and respite days together with support from an experienced team, to begin to build confidence, self-worth and new skills for those attending, giving new hope and focus for the future.

I am keen to look at ways in which we might work together in the future and help support our staff and their families through challenging situations.

The Project Way

I was pleased to hear the Programme Management Office (PMO) has continued to roll out training on the Project Way, the trust's approved project management framework. Urgent and Emergency Care teams and members of the Quality Improvement team have now both received training and the feedback has been excellent. Both the training and the Project Way framework have been developed to provide a consistent approach to project delivery within the trust.

#ThankYouNWAS campaign

Following the launch of the thank you campaign which was part of our Communication Team's fairy tale themed winter campaign to support operational demand, it's been heart-warming to see the impact the campaign had. So many grateful patients and families came forward wanting to share their appreciation helping us to highlight real life examples of people who have received life-saving intervention to positively reinforce the message that the ambulance service is here for emergencies.

We have had hundreds of comments from our frontline workers and the public who have joined in the conversation on social media using #ThankYouNWAS. Talking about the campaign staff said:

- "It's given me a better understanding of the impact we can have on people in such a short space of time."

- "It just confirms that the sacrifices and hard work is worth it, as we really did make a difference to someone's life, not to mention those around them.

- "Receiving a letter of thanks, an email or even just hearing someone say thank you us the biggest boost you can get in this job!"

As part of the campaign, staff were asked to score out of ten how they felt when recognised by the public for saving a life, or making a massive difference to a family – the average was nine out of ten. For this reason we'll be taking this forward as part of our 2020/2021 campaign plans and intend to look at ways to make it trust-wide and share the genuine appreciation that is out there across our patient transport and NHS 111 services.

The Right Care

A group of advanced paramedics from Greater Manchester earlier this year organised a Continuing Professional Development (CPD) which was themed on providing the right care. Attending on behalf of the executive leadership team was Director of Quality Innovation and Improvement, Maxine Power who spoke about improvement science. Other topics covered on the day included research, risk assessments, diamond debriefing, confused patients, medical errors, culture, cardiac patients and sick children; the day was a great success

Accountability Reviews

Accountability Reviews were introduced into NWAS back in September 2019 to give the

Executive Leadership Committee (ELC) and myself an oversight of all service line key metrics and to provide senior managers with a platform to showcase good areas of practice to the ELC.

These reviews have proved successful in providing assurance from local teams to the ELC and offering support to service lines across the trust. These will be re-started as we move from COVID 19 response to recovery phase.

Board Development Day

At the last Board development day, some of the items discussed included a session on a refresh of our trust values lead by Lisa Ward, Interim Director of Organisational Development and Delve, who are supporting us in this work. We also discussed the trust's appetite for risk and our thoughts for 2020/21 in a session lead by Jonathan Taylor, Senior Risk and Assurance Manager. Rachel Clarke from NHS Improvement lead a discussion on Freedom to Speak Up, the role of the Board and the trust's Guardian in creating an effective speaking up culture, what new initiatives might be introduced and how we might measure them. There was also a focus on the CQC inspection well-led framework led by AQuA Director, Cath Hill.

Edge Hill University lecture

Salman Desai, Director of Strategy and Planning recently gave a lecture to students from a range of services undertaking a Professional Doctorate in Emergency Services at Edge Hill University. The invitation to provide the ambulance perspective was made by the University's Professor of Leadership & Management and Director of Research.

Salman's lecture focussed on contemporary issues and challenges in the management practice of emergency services and was also attended by the students' supervisors. Other speakers included both past and present Chief Fire Officers for Cheshire and Lancashire.

The trust enjoys a very positive working relationship with many universities across the North West footprint which is vitally important to us in terms of recruitment and professional development. My thanks to Salman for taking the time to deliver this lecture which I understand was hugely useful and well received by all those attending.

Directors' planning day

The Executive Directors held a very successful planning meeting at which we discussed and reviewed our current and future financial positions; including upcoming pressures and development for 2020/21.

We also looked at the trust strategy, the structures of the service delivery and quality directorates and finally we undertook a team development session for the executive team. Our next planning day is to be held in early June.

Star Awards

Myself, along with the Chairman and Director of Strategy & Planning and one of our newly established Patient and Public Panel members, Amanda Clarke, had the pleasure of reading and judging the Star Awards nominations, which have been submitted over the past six months. It was extremely difficult to choose a shortlist for each category as there were so many worthy winners. It was very humbling to read about the great work being done and the high regard staff have for their fellow colleagues.

Unfortunately the trust had to take the decision, due to the Coronavirus, to postpone the

STAR Awards together with the Cheshire and Merseyside Achieving Clinical Excellence Awards and the Every Minute Matters Hospital Handover Summit

Mothers Day

Whilst our daily routines are being altered by the challenges of coronavirus, I took the opportunity at the end of March to thank all our mothers, past and present for all they bring to our lives, even if the day was spent taking calls, keeping vehicles on the road, responding to patients or taking part in COVID-19 teleconferences and response plans for the trust. I was particularly heartened to see the Mother's Day message to EMT 1, Alison Sefton on social media:

Alison joined #TeamNWAS 19 years ago and worked as part of our patient transport service before moving to urgent care and then becoming an EMT1 in 2009. Alison is currently at university training to become a paramedic. Alison has inspired her 19 year old daughter Bethany to follow in her footsteps and she became a CFR in January giving up her time to attend emergencies in her local area as part of the New Longton CFR Group.

With ambitions to become a paramedic herself, Bethany said: "When I first knew I wanted to become a paramedic, my mum encouraged me to volunteer which would give me an insight of what it's like dealing with the public and responding to emergencies. I love what I do and knowing that I have cared for people and made a difference to their lives is very rewarding. Every time my mum left for work, I was always a little bit jealous because it was something I always wanted to do and I feel proud of what she does knowing that she save lives!"

New staff Facebook group launched

I am delighted to announce the launch of a new staff Facebook group. This is a closed group for the entire workforce to use, to post comments and ask questions for response by the executive directors. Each staff member will be asked three questions, which are in effect the terms and conditions of using the site

The trust has also arranged Friday Facebook Live session. To date there have been three such sessions, the first one with myself and the second with Dr Chris Grant, Executive Medical Director together with Lisa Ward, Interim Director of Organisational Development and the third featured Ged Blezard, Director of Operations together with Ian Stringer, Head of PTS. These live sessions with staff are proving extremely popular with well over 1,500 staff and in some cases 1,900 staff viewing these.

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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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	Wednesday 27 May 2020
Subject:	Board Assurance Framework (BAF) Q4 Review & Corporate Risk Register
Presented by:	Angela Wetton, Director of Corporate Affairs
Purpose of Paper:	For Decision
Executive Summary:	The CRR can be viewed for information in **Appendix 1**. The proposed Q4 position for the BAF risks as agreed by ELC with associated CRR scored ≥15 can be viewed in **Appendix 2**. The BAF Heat Maps for 2019/20 year to date can be viewed in **Appendix 3**. Following a full review of both controls and assurances across the BAF there has been the following changes proposed: • SR01 increase current risk score from 12 to 16 • SR03 increase current risk score from 15 to 20 • SR04 decrease current risk score from 12 to 8 • SR08 increase current risk score from 8 to 12 As part of the Q4 BAF review, a proposal for a new strategic risk has been identified, pertaining to the COVID-19 outbreak and the additional pressures that has been placed on the organisation, with the proposed current risk score of a 20. The proposed 2020/21 Q1 reporting process and timescales can be viewed in **Appendix 4**.
Recommendations, decisions or actions sought:	The Board of Directors are requested to: • Agree the increase in current risk score for SR01 from 12 to 16 • Agree the increase in current risk score for SR03 from 15 to 20 • Agree the decrease in current risk score for SR04 from 12 to 8 • Agree the increase in current risk score for SR08 from 8 to 13 • Agree the newly proposed COVID-19 Strategic Risk to feature on the BAF with the current risk score of 20. • Agree the Q4 position of the Board Assurance

	Framework.			
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
☒	☒	☒	☒	☒	☒	☒	☒	☐

Are there any Equality Related Impacts:	None Identified
Previously Submitted to:	Assurance Committees, ELC and Audit Committee
Date:	Throughout Q4
Outcome:	For Assurance

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1. PURPOSE

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

This paper provides an opportunity for the Board of Directors to review the Q4 Board Assurance Framework (BAF) position along with the Corporate Risk Register, risks scored 15 and above that are aligned to each BAF risk. In addition, themes and gaps that the Senior Risk and Assurance Manager has identified as part of the risk profiling work completed. This work has also been informed through discussions with Directors and Senior Managers across the organisation.

2. RISK ASSURANCE PROCESS

The BAF risks are reviewed at Board Committees providing the opportunity to identify where assurances support potential mitigation of risks, commission where appropriate, additional assurance and identify any associated risk that may require escalating or de-escalating through the Chair's reporting process. Risks identified on the Corporate Risk Register are mapped to the BAF risks and are included within the reports, providing the position in terms of the progression of each risk. This in turn, supports the identification of any additional assurances that may need to be commissioned by the Chair as well as recognising where the achievement of risk mitigation may impact positively or negatively on the BAF risks.

To support the Q4 review of the BAF, the Senior Risk and Assurance Manager has collated assurance information reported throughout the quarter onto the Assurance Map. The information has been identified through attendance at Committee meetings and review of the Chair's assurance reports from both Management and Committee meetings. The assurance mapping has been used to support discussions with Executive Directors and assist with updating of the BAF risks.

3. REVIEW OF CORPORATE RISK REGISTER

The review of the Corporate Risk Register takes place at Executive Leadership Committee (ELC) as well as the Board Committee meeting in the organisation. Here, assurances is sought that controls and mitigations are applied and actions are in place to ensure that the risk is being actively managed. The Corporate Risk Register can be viewed for information in **Appendix 1**.

4. REVIEW OF STRATEGIC RISKS Q4

The quarterly review process provided an opportunity for the Director Lead to meet with the Senior Risk and Assurance manager to discuss the update of their relevant risks. These meetings have taken place either with Director leads or their senior manager responsible for updating the BAF. Adjustments to the BAF risks has subsequently been undertaken. The proposed Q4 position for the BAF risks with associated Corporate Risk Register risks scored 15 and above can be viewed in

Appendix 2.

The Heat Maps for 2019/20 year to date can be viewed in **Appendix 3**.

Following a full review of the controls and assurances across the BAF, there has been the following changes proposed:

SR01: If we do not meet and maintain the expected level of quality and safety standards, this may impact on the Trust's compliance with regulatory requirements

- Increase in risk score from 12 to 16 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	Q3 Score	Q4 Score	2019/20 Target	Final Target	Exec Lead
16 4x4 CxL	16 4x4 CxL	12 4x3 CxL	12 4x3 CxL	16 4x4 CxL	12 4x3 CxL	8 4x2 CxL	M Power DoQII

This risk has increased in risk score from 12 to 16 following the Q4 review with the following rationale applied by the Executive Lead:

1. The COVID-19 has impacted on quality and safety standards across the organisation
2. Conclusion of the Medicines Management Strategic Review has identified some key risk areas pertaining to ambient temperature monitoring, controlled drug procurement and record books and the administration of non-parental prescription only medicines.

SR03: If the Trust does not deliver the Urgent and Emergency Care Strategy and national performance standards, then patient care could be compromised resulting reputational damage to the Trust. If the Trust does not fully engage with wider health sector, then the delivery of national agenda could be impacted

- Increase in risk score from 15 to 20 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	Q3 Score	Q4 Score	2019/20 Target	Final Target	Exec Lead
15 5x3 CxL	15 5x3 CxL	15 5x3 CxL	15 5x3 CxL	20 5x4 CxL	10 5x2 CxL	5 5x1 CxL	G Blezard DoOps

This risk has increased in risk score from 15 to 20 as following the Q4 review with the following rationale applied by the Executive Lead:

1. The COVID-19 has impacted on ARP performance and in NHS 111
2. Significant increase in the call volumes in NHS 111
3. Increases in incidents/ call volumes against commissioning plans.

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

- Reduction in risk score from 12 to 8 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	Q3 Score	Q4 Score	2019/20 Target	Final Target	Exec Lead
12 4x3 CxL	12 4x3 CxL	12 4x3 CxL	12 4x3 CxL	8 4x2 CxL	8 4x2 CxL	4 4x1 CxL	L Ward Int. DoOD

This risk has decreased in risk score from 12 to 8 following the Q4 review with the following rationale applied by the Executive Lead:

1. Significant progress in delivering the first year of the Workforce Strategy
2. Vacancy position in Q4 is positive with targets and growth being met, turnover remains stable
3. Mandatory training compliance has been delivered for 2019 and appraisals remain stable.
4. Paramedic upskilling targets are on track; apprenticeships rates are above average.
5. Ofsted outcome provided external assurance of the quality of training.

SR08: If the Board experiences significant leadership changes, it may not provide sufficient strategic focus and leadership to support delivery of its vision and Corporate Strategy

- Increase in risk score from 8 to 12 as follows:

Opening Score 01.04.2019	Q1 Score	Q2 Score	Q3 Score	Q4 Score	2019/20 Target	Final Target	Exec Lead
12 4x3 CxL	12 4x3 CxL	8 4x2 CxL	8 4x2 CxL	12 4x3 CxL	8 4x2 CxL	4 4x1 CxL	D Mochrie CEO

This risk has increased in risk score from 8 to 12 following the Q4 review with the following rationale applied by the Executive Lead:

1. Recent announcement of the restructure of the Executive Portfolios
2. Currently a substantive post for Executive Director of People being advertised
3. Number of outstanding actions following the Deloitte Well Led review
4. Launch of the shadow board to enable Board succession planning

5. IDENTIFICATION OF A NEW STRATEGIC RISK

The Trust is currently experiencing a significant impact on the delivery of the Trust strategic objectives due to the COVID-19 outbreak. As a result of these heightened pressures, a new strategic risk has been proposed, which will feature of the Board

Assurance Framework during Q4 2019/20 and transitioning into 2020/21.

BAF Risk	Risk Description at 01.04.2019
SR10	If we do not have robust processes and resources in place pertaining to the coronavirus outbreak, this may impact on the delivery of the Trust's objectives

Opening Score 01.04.2019	Q1 Score	Q2 Score	Q3 Score	Q4 Score	2019/20 Target	Final Target	Exec Lead
N/A				20 5x4 CxL	20 5x4 CxL	5 5x1 CxL	Add DoOps

6. LEGAL and/or GOVERNANCE IMPLICATIONS

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

7. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the increase in current risk score for SR01 from 12 to 16
- Agree the increase in current risk score for SR03 from 15 to 20
- Agree the decrease in current risk score for SR04 from 12 to 8
- Agree the increase in current risk score for SR08 from 8 to 13
- Agree the newly proposed COVID-19 Strategic Risk to feature on the BAF with the current risk score of 20
- Agree the Q4 2019/20 position of the Board Assurance Framework.

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Appendix 1: Corporate Risk Register
Board of Directors
Extracted from Datix on 27 March 2020

Corporate Risk Register											
DX ID	Risk Description	Lead(s)	Rating (initial)	Likelihood (current)	Consequence (current)	Rating (current)	Risk Score Journey (Since Last Reported to Board of Directors)	Rating (Target)	Forecast Completion Date	Last reviewed	Date of next review
2262	There is a risk of high clinical advisor vacancy gap in 111 because of recruitment shortages and high turnover which could result in adverse performance and have a quality impact.	Ward, Lisa	20	4	4	16	No change in risk score	8	31/03/2020	03/03/2020	31/03/2020
2480	There is a risk that unsupported software and hardware - due to lack of asset ownership, risk and renewal road Map for existing systems and governance for cyber security which could result in costly last minute updates, potential cyber attacks and loss of systems.	Power, Mrs Maxine	20	4	4	16	No change in risk score	8	30/06/2020	06/02/2020	09/03/2020
2504	There is a risk of mandatory training compliance in NHS111 due to the operational and organisational pressures which could result in an impact on performance, clinical quality and patient care delivery.	Blezard, Mr Ged	16	4	4	16	Risk Escalated to CRR Increase in risk score	4	31/03/2020	22/03/2020	22/04/2020
2748	There is a risk that we will not be able to deliver key business as usual projects and innovations due to lack of capacity and project management expertise in the IT team which could result in unsecure systems, system disruption or loss of critical systems	Power, Mrs Maxine	20	4	4	16	No change in risk score	8	30/06/2020	06/02/2020	30/03/2020
2765	There is a risk that if a timely decision is not reached on lease arrangements for the Parkway site post-expiry of the current term in December 2023 which could result in significant cost implications and reduced operational capacity.	Wood, Carolyn	20	5	4	20	Risk Escalated to CRR Increase in risk score	8	30/12/2022	17/03/2020	17/04/2020
2766	There is a risk that if the Trust does not decide in a timely manner to invoke the terms of the lease break (if required) for 111 Middlebrook in September 2020 this could result in significant financial implications (5 years extra lease payments to end of lease term).	Wood, Carolyn	20	5	4	20	Increased in risk score	4	30/09/2020	17/03/2020	17/04/2020
2919	There is a risk that if the Trust does not deliver on all ARP performance standards then patient care could be comprised which could result in reputational damage to the Trust, potential loss of income and an increase in patients complaints.	Blezard, Mr Ged	25	4	5	20	No change in risk score	5	31/03/2020	22/03/2020	22/04/2020

2920	There is a risk that sufficient workforce resources are not in place across NHS 111 service leading to the inability to meet contracted KPIs which could result in comprised patient care and reputational damage to the Trust.	Blezard, Mr Ged	20	5	4	20	Increased in risk score	4	30/09/2020	22/03/2020	22/04/2020
2921	There is a risk that if excessive ambulance handover delays occur at hospital sites then performance standards and patient care could be comprised due to lack of available resources which could result in non delivery of ARP standards and reputational damage to the Trust.	Blezard, Mr Ged	20	3	5	15	No change in risk score	5	31/03/2020	22/03/2020	22/04/2020
2976	There is a risk that failure to identify and deliver CIP schemes to achieve the 2019/20 CIP plan will result in the Trust not delivering the 2019/20 financial plan and having an increased efficiency requirement in 2020/21	Wood, Carolyn	16	4	4	16	No change in risk score	8	29/04/2020	25/02/2020	25/03/2020
3026	There is a risk that the Trust will have insufficient driver training instructors as a result of increased demand for driver training combined with national and local driving instructor shortages which could result in an impact on delivery of front-line emergency driver training and compliance with regulatory framework	Ward, Lisa	20	4	4	16	No change in risk score	8	##########	##########	##########
3136	There is a risk that appropriate vehicle checks may not be taking place across PES in relation to tyre pressure and depth checks which could result in a breach of legislation and potential loss of vehicles due to breakdowns/faults.	Blezard, Mr Ged	20	3	5	15	Risk Escalated to CRR Increase in risk score	5	30/06/2020	22/03/2020	22/04/2020
3159	There is a risk the PTS will overspend significantly against plan because the service line has not been able to achieve the actions identified in the 2019-2020 cost recovery plan which may lead to failure to meet the Trust's financial targets.	Wood, Carolyn	20	4	4	16	No change in risk score	8	31/12/2020	18/03/2020	30/04/2020
3187	There is a risk that the Trust could have poorly located sites due to the Trust not planning effectively for the future configuration of its estate which could result in a negative impact on operational performance (PES and PTS).	Wood, Carolyn	25	3	5	15	Risk Escalated to CRR Increase in risk score	5	31/03/2020	26/02/2020	26/03/2020
1181	There is risk that the Trust's Critical Telephone System (999) and/or the Voicemail messaging service fails which could result in an inability to appropriately respond and treat patients within agreed target timescales.	Power, Mrs Maxine	20	3	5	15	No change in risk score	5	02/11/2020	13/12/2019	22/01/2020

North West Ambulance Service NHS Trust

Appendix 2

Board Assurance Framework 2019/20

Board of Directors Part 1
Wednesday 27 May 2020

Quality & Performance Cttee:	16/03/2020
Resources Cttee:	20/03/2020
Executive Leadership Cttee:	15/04/2020
Audit Cttee:	22/05/2020
Board of Directors:	27/05/2020

Data Extracted from Datix: 27 March 2020

Delivering the right care, at the right time, in the right place; every time

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

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

Director Lead:

CEO	Chief Executive
DoQII	Director of Quality Innovation & Improvement
MD	Medical Director
DoF	Director of Finance
DoOps	Director of Operations
DoOD	Director of Organisational Development
DoS&P	Director of Strategy & Planning
DoCA	Director of Corporate Affairs

Board Assurance Framework Legend

Strategic Priorities	The 2018/2023 strategic priority that the BAF risk has been aligned to				
BAF Risk	The title of the strategic risk that threatens the achievement of the aligned strategic priority				
Rationale for Current Risk Score	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk				
Operational Risk Exposure	The key areas of operational risks scored 15 and above that align with the BAF risk and have the potential to impact on the score				
Controls	The measures in place to reduce the risk likelihood or risk consequence and assist secure delivery of the strategic priority /				
Assurances	The measures in place to provide confirmation that the controls are working effectively in supporting the mitigation of the risk				
Evidence	This is the platform that reports the assurance				
Gaps in Controls	Areas that require attention to ensure that systems and processes are in place to mitigate the BAF risk				
Gaps in Assurance	Areas where there is limited or no assurance that processes and procedures are in place to support the mitigation of the BAF risk				
Required Action	Actions required to close the gap in control(s)/ assurance(s)				
Lead	The person responsible for completing the required action				
Target Completion	Deadline for completing the required action				
Monitoring	The forum that will monitor completion of the required action				
Progress	A BRAG rated assessment of how much progress has been made on the completion of the required action	Incomplete/ Overdue	In Progress	Completed	Not Commenced

OUR STRATEGY AT A GLANCE

Our vision is to be the best ambulance service in the UK.

Our strategic goal is to deliver the right care, at the right time, in the right place; every time.

Our values

THE RIGHT CARE,

delivering quality services which are safe, effective and patient-centred

AT THE RIGHT TIME,

responding appropriately to patients who contact our emergency and urgent care services, and use our transport service

IN THE RIGHT PLACE;

providing patients with advice and treatment closer to home where clinically appropriate to prevent unnecessary hospital attendances and admissions

EVERY TIME.

focusing on every patient and our commitment to continuously drive down variation in our performance, working in partnership with health and care providers locally so that no patient is needlessly waiting for help

Our priorities:

RIGHT CARE

- Ensure our services are:
  - **Safe:** protecting our patients from avoidable harm
  - **Effective:** reducing unwarranted variation in treatment and outcomes
  - **Patient-centred:** providing the best experience for patients and staff

RIGHT TIME

- Provide patients with the right response, first time and attend to life-threatening emergencies as quickly as possible, by achieving the national Ambulance Response Programme (ARP) performance standards
- Answer calls as quickly as possible, both for emergency services, 111 and the Patient Transport Service (PTS) by achieving the national standards

RIGHT PLACE

- Provide the right care to more patients over the telephone (hear and treat) and face-to-face while on scene (see and treat) where appropriate
- Reduce the number of patients taken to Emergency Departments (ED) by treating them on scene or transporting them to a more suitable healthcare provider
- Provide patients with less severe conditions access to clinical advice on the phone and online, by rolling out enhanced triage across urgent care services and supporting the introduction of 111 Online and direct booking of appointments

EVERY TIME

- Empower staff by developing leadership skills and expertise
- Develop our workforce through increased access to training and development opportunities
- Engage with our workforce with a focus on increasing the staff health and wellbeing offer and achieving equality for all

To support these priorities, we will:

- Provide our staff with access to digital technologies and accurate, timely information to improve ways of working and continue to develop our premises to ensure safe and suitable workplaces
- Continue to develop our fleet of vehicles so they will meet future requirements, reducing carbon emissions and the impact on the environment
- Ensure risks are managed and lessons are learned if things go wrong
- Work with partners to promote healthy living to keep people well

You can view our full strategy at:
www.nwas.nhs.uk/strategy

www.nwas.nhs.uk

@NWambulance

BOARD ASSURANCE FRAMEWORK DASHBOARD 2019/20

SP	BAF RISK	Committee	Lead	01.04.19	Q1	Q2	Q3	Q4	2019/20 Target	Final Target
Right Care	**SR01:** If we do not meet and maintain the expected level of quality and safety standards, this may impact on the Trust's compliance with regulatory requirements	Quality & Performance	DoQII MD	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**8** 4x2 CxL
Every Time	**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	Resources	DoF	**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**5** 5x1 CxL
Right Time	**SR03:** If the Trust does not deliver the Urgent & Emergency Care Strategy and national performance standards, then patient care could be compromised resulting in reputational damage to the Trust. If the Trust is not fully engaged with the wider health sector then the delivery of national agendas could be impacted.	Quality & Performance	DoOps	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**20** 5x4 CxL	**10** 5x2 CxL	**5** 5x1 CxL
Every Time	**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	Resources	DoOD	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**4** 4x1 CxL
Every Time	**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	Resources	DoF	**12** 3x4 CxL	**12** 3x4 CxL	**12** 3x4 CxL	**12** 3x4 CxL	**12** 3x4 CxL	**6** 3x2 CxL	**3** 3x1 CxL
Right Place	**SR06:** If the Trust does not establish effective partnerships within the regional health economy and integrated care systems then it may be able to 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	Board	DoS&P	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**4** 4x1 CxL
Every Time	**SR07:** If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity	Resources	DoQII	**20** 4x5 CxL	**20** 4x5 CxL	**16** 4x4 CxL	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**8** 4x2 CxL
Right Time	**SR08:** If the Board experiences significant leadership changes it may not provide sufficient strategic focus and leadership to support delivery of its vision and Corporate Strategy	Board	CEO	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**4** 4x1 CxL
Right Time	**SR09:** If the UK Government leaves the EU without a deal then availability of key medicines, equipment and resources may be challenged resulting in inflated costs, disruption to supplies and loss of workforce. The 'no deal' withdrawal may impact on our ability to share, process and access data	Board	DoS&P	**9** 3x3 CxL	**9** 3x3 CxL	**9** 3x3 CxL	**3** 3x1 CxL	Closed	**6** 3x2 CxL	**3** 3x1 CxL

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR01: If we do not meet and maintain the expected level of quality and safety standards, this may impact on the Trust's compliance with regulatory requirements	**LEAD DIRECTOR:** DoQII / MD	**DATIX:** TBC

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:

- Medicines Management; CDs
- Non-parental POMs
- Ambient temperatures monitoring of medicines
- COVID-19

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
16	16	12	12	16	12	8
4x4	4x4	4x3	4x3	4x4	4x3	4x2
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 score has increased in risk score from a 12 to a 16 due to the impact on the COVID-19 outbreak and the pressures that have additionally been placed on the organisation. The Chief Pharmacist has concluded the Medicines Management (including storage) Strategic Review, which has highlighted some key risk areas pertaining to ambient temperature monitoring, controlled drug procurement and record books and the administration of non-parenteral prescription only medicines. Assurances have been reported against the delivery of the Right Care Strategy and the proposed goals for 2019/20.

CONTROLS	ASSURANCES	EVIDENCE
Incident Reporting		
Level 2: Incident Reporting Procedure	**Level 2:** Incident Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Level 2: Increased review of L4 & L5 Incidents & scruitiny at ROSE to determine identification of Serious Incidents	**Level 2:** Reportable Events Report	Reported to SMG/ Board of Directors (Part 2)
Serious Incidents		
Level 2: Serious Incidents Investigations Prcoedure	**Level 2:** Serious Incident Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Level 2: Increased review & scruitiny at ROSE to determine identification of Serious Incidents	**Level 2:** Management Plans for identified Serious Incidents	Reported to SMG
Level 2: SI submission trajectory	**Level 2:** Serious Incident Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Complaints		
Level 2: Complaints Procedure	**Level 2:** Complaints Performance Data	Reported to Quality & Performance Cttee/ Board of Directors via IPR
Level 2: Increased review of L4 & L5 Incidents & scruitiny at ROSE to determine identification of Serious Incidents	**Level 2:** Reportable Events Report	Reported to SMG/ Board of Directors (Part 2)
Health, Safety & Security		
Level 1: Mandatory Training in Health & Safety	**Level 2:** Mandatory Training Compliance Report	Reported to Safety Management Group
Level 2: Internal Health & Safety Visits (Inc. Vehicles)	**Level 2:** Right Care Strategy Progress Update Report	Reported to SMG/ Quality & Performance Cttee
Safeguarding		
Level 1: Mandatory Training in Safeguarding	**Level 2:** Mandatory Training Compliance Report	Reported to Safety Management Group
Level 2: Safeguarding Policies & Procedures	**Level 2:** Safeguarding Performance Data	Reported to SMG/ Quality & Performance Cttee/ Board of Directors
Level 2: Safeguarding Reportable Events	**Level 2:** Reportable Events Report	Reported to Board of Directors (Part 2)
Level 2: NWAS Safeguarding Practices	**Level 3:** MIAA Internal Audit Report on Safeguarding	Reported to Audit Cttee

Infection, Prevention & Control					
Level 1: Mandatory Training in IPC	**Level 2:** Mandatory Training Compliance Report	Reported to Clinical Effectiveness Management Group			
Level 2: IPC Policy and Procedures	**Level 2:** IPC Performance Data	Reported to Quality & Performance Cttee/ Board of Directors			
Level 2: Internal IPC Audits	**Level 2:** Right Care Strategy Progress Update Report	Reported to SMG/ Quality & Performance Cttee			
Medicines Management					
Level 2: Medicines Management Procedures	**Level 1:** Dashboard Monthly Reporting to Sector & Station Group **Level 2:** Reported via Quality Measures	Reported to MEG/ Quality & Performance Cttee			
Level 2: Pharmacy Technician Station Audits	**Level 2:** Station Medicines Management Audit Reports	Reported to MEG/ Quality & Performance Cttee			
Level 2: NWAS Medicines Management Practices	**Level 3:** MIAA Internal Audit Report on Medicines Management	Reported to Audit Cttee			
Safety					
Level 2: Quality and Performance Data	**Level 2:** Weekly Quality & Performance Dashboards	Reported to ELC			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Serious Incidents					
Improvements with confirmation to report for SI	Increase the proportion of cases to 90% where the confirmation to report interval is within the agreed 60 day timeframe	A Hansen	Q4: March 2020	Q&P Cttee	WIP
Complaints					
Improvements with complaint closures	Increase severity 1-2 complaints closed within 24 hours by 40%	A Hansen	Q4: March 2020	Q&P Cttee	WIP
Health, Safety & Security					
Reduction in the number of RIDDORs	Reduction in RIDDORs by 20% Year on Year	A Hansen	Q4: March 2020	Q&P Cttee	WIP
Increase the number of Operational Managers qualified in Health and Safety Management	25% of Operational Managers with advanced training in Health and Safety Management	A Hansen	Q4: March 2020	Q&P Cttee	WIP
Vehicles receiving Annual Health and Safety Review	50% vehicles receiving an annual review of Health and Safety	A Hansen	Q4: March 2020	Q&P Cttee	WIP
Medicines Management					
Reduction in expired drugs remaining in circulation	Less than 1% of medicine pouches with expired drugs remaining in circulation 1 week beyond their expiry date	Dr C Grant	Q4: March 2020	Q&P Cttee	WIP

Risks Scored 15+ Aligned to BAF Risk: SR01					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks on the Corporate Risk Register scored 15+ pertaining to this BAF Risk					

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK 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

LEAD DIRECTOR: DoF

DATIX: TBC

STRATEGIC PRIORITY: Every Time

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:

- Calculation of holiday pay
- Cost Improvement Programme (CIP)
- Rebanding of SPTLs
- Non-recurrent income linked to delivery of ARP
- Impact of Discount Rate

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
20	20	15	15	15	10	5
5x4	5x4	5x3	5x3	5x3	5x2	5x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 score of this BAF risk has remained at a score of 15 due to the Trust's financial position at Month 11 is a surplus of £2.527m, which is £0.164m better than the planned surplus of £2.363m. Income is over recovered by £3.676m, pay is overspent by £3.178m and non-pay is overspent by £0.334m. In June 2019, the Trust was notified by NHSI of a post 2018/19 accounts event in relation to additional Provider Sustainability Fund (PSF) of £0.111m. The Trust's financial plan will achieve the notified financial control total of £2.708m surplus. The overall financial performance risk rating at 29 February 2020 is 1. Cost Improvement Programme (CIP) for the year is £9.808m, as at M11 the YTD target is £8.732m and the Trust has achieved £8.969m. At 29 February 2020, the cash and cash equivalents balance is £43.966m. There is recurrent CIP of £1.7m being transferred into 2020/21.

CONTROLS	ASSURANCES	EVIDENCE
Financial Position		
Level 2: 2019/20 Financial Operating Plans	**Level 2:** Delivery against Financial Operating Plans	Reported to Board of Directors
Level 2: 2019/20 Financial Plans for Capital Programme	**Level 2:** Delivery against Capital Programme	Reported to Board of Directors
Level 2: Standing Financial Instruction, Standing Orders & Scheme of Delegation	**Level 2:** Maintenance of compliance with documentation	Reported to Audit Cttee & Board of Directors
Level 2: Business Case process for all significant change project(s)	**Level 2:** ELC monitoring of business cases	Reported to ELC
Level 2: Monthly accounts comparing actual spend against budget	**Level 2:** Review management of accounts **Level 2:** Monthly scrutiny of in year budgets statements	Reported to Resources Cttee/ ELC
Level 2: CIP Monitoring and Delivery	**Level 2:** Review of progress against CIPs	Reported to CIP Steering Group
Level 2: Patient Transport Service Financial Recovery Plan	**Level 2:** Monitoring of finances and scrutiny of budgets	Reported to Resources Cttee
Level 2: 5 Year Financial Plan	**Level 2:** STP Financial Strategic Planning & Review Report	Reported to Resources Cttee/ Board of Directors
Financial Score		
Level 3: NHS Improvement Single Oversight Framework	**Level 3:** Forecast Risk Rating for the Trust is 1	Reported to Resources & Board of Directors
Agency Expenditure		
Level 3: 2019/20 reporting to NHS Improvement in respect of agency costs	**Level 3:** Compliance with Regulator Guidance on Agency spend **Level 3:** NHSI monthly submissions and monitoring meetings	Reported to Board of Directors via IPR Reported to Resources Cttee & ELC

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Lack of CIP schemes to deliver identified value	Working with Executive Directors to identify deliverable recurrent schemes	DoF	March 2020	CIP Steering Group	Overdue

Risks Scored 15+ Aligned to BAF Risk: SR02					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2976	Finance Directorate	There is a risk that failure to identify and deliver CIP schemes to achieve the 2019/20 CIP plan will result in the Trust not delivering the 2019/20 financial plan and having an increased efficiency requirement in 2020/21	**16 Significant**	**16 Significant**	8 High
3159	Finance Directorate	There is a risk that PTS will overspend significantly against plan because the service line has not been able to achieve the actions identified in the 2019/20 cost recovery plan which may lead to failure to meet the Trust's financial targets	**20 Significant**	**16 Significant**	8 High

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR03: If the Trust does not deliver the Urgent & Emergency Care Strategy and national performance standards, then patient care could be compromised resulting in reputational damage to the Trust. If the Trust is not fully engaged with the wider health sector then the delivery of national agendas could be impacted.	**LEAD DIRECTOR:** DoOps	**DATIX:** TBC

STRATEGIC PRIORITY: Right Time

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:

- Non-delivery of ARP Performance Standards
- Clinical Advisor Gaps in NHS 111
- Delayed Hospital Handovers
- COVID-19

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
15	15	15	15	20	10	5
5x3	5x3	5x3	5x3	5x4	5x2	5x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 score of this BAF risk has increased in score from 15 to a score of 20 due the COVID-19 outbreak and the pressures that have additionally been placed on the organisation in particular the performance in NHS 111 and EOCs. Activity during Q4 continues to see an increase in incident/ call volume against the commissioning plans. The Trust has remained at REAP Level 3, in order to focus on wider organisational response on the delivery of safe patient care.

CONTROLS	ASSURANCES	EVIDENCE
Performance		
Level 1: Increased EMD Deployments	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee/ Board of Directors
Level 1: Auto-Divert to Cat1 Calls	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee/ Board of Directors
Level 1: Enhanced Working Practices in EOC & CHUB	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee/ Board of Directors
Level 1: Clinical Leadership in EOC	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee/ Board of Directors
Level 2: Awareness Campaigns (PES and NHS111)	**Level 2:** Communications Quarterly Report	Reported to Resources Cttee/ Board of Directors
Level 3: NHS111 Performance Improvement Plan	**Level 2:** NHS111 Performance Report	Reported to Quality & Performance Cttee/ Board of Directors
Activity		
Level 1: Ambulance Liasion Officers	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee/ Board of Directors
Level 2: Robust Civil Contingencies	**Level 3:** NARU HART Compliance & Quality Assurance Standards	Reported to Quality & Performance Cttee/ Board of Directors
Level 2: Suitably Trained Commanders	**Level 2:** Emergency Planning Preparedness Report	Reported to Quality & Performance Cttee/ Board of Directors
Level 2: Contigency Planning	**Level 2:** Winter Plan 2019/20	Reported to Quality & Performance Cttee/ Board of Directors
Level 3: Joint Strategic Partnership Framework for Ambulance Handover and Turnaround	**Level 2:** Perfornance Update Report: Hospital Handover & Turnaround & Performance Data	Reported to ELC/ Quality & Performance Cttee/ Board of Directors
Resources		
Level 1: Increased Number of Double Crewed Ambulances (Paramedic on majority of responding vehicles)	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee/ Board of Directors
Level 1: Strategic, Tactical and Operational Managers focused on delivery of ARP Standards	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee/ Board of Directors
Level 2: Recruitment/ Staffing to Establishment	**Level 2**: PES Performance Report & Workforce Indictors Report	Reported to Quality & Performance Cttee & Resources Cttee
Level 3: Roster Review for NHS111/ PES/ EOC and CHUB	**Level 2:** Building Better Rota's Project Update Report	Reported to Quality & Performance Cttee & Resources Cttee

Level 3: Private Ambulance Providers	**Level 2:** PES Performance Update Report & Performance Data	Reported to Quality & Performance Cttee			
Level 3: FCMS (NHS111 Call Taking)	**Level 2:** NHS111 Performance Update Report & Performance Data	Reported to Quality & Performance Cttee			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Improvements in PES performance in line with ORH Modelling	Continued monthly improvements in ARP 999 call pick up	DoOps	March 2020	Q&P Cttee	Overdue
	Cat 1 to 4 performance towards the Mean and 90th Centile national targets	DoOps	March 2020	Q&P Cttee	Overdue
	Develop innovative ways to improve Cat 3 & C4 performance	DoOps	March 2020	Q&P Cttee	Overdue
Lack of robust Meal Break Policy	Robust enforcement of the Meal Break Policy	DoOps	March 2020	Q&P Cttee	Overdue
Improvements in NHS 111 performance in with contract by year-end	Positioning the Trust for the new EUC 111 specification	DoOps	March 2020	Q&P Cttee	Overdue

Risks Scored 15+ Aligned to BAF Risk: SR03					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2262	Organisational Development	There is a risk of high clinical advisor vacancy gap in 111 because of recruitment shortages and high turnover which could result in adverse performance and have a quality impact	**20 Significant**	**16 Significant**	8 High
2919	Service Delivery	There is a risk that if the Trust does not deliver on all ARP performance standards then patient care could be comprised which could result in reputational damage to the Trust, potential loss of income and an increased in patients complaints	**25 Significant**	**20 Significant**	5 Moderate
2920	Service Delivery	There is a risk that insufficient workforce resources are not in place across NHS 111 Service leading to inability to meet contracted KPIs which could result in comprised patient care and reputational damage to the Trust	**20 Significant**	**20 Significant**	4 Moderate
2921	Service Delivery	There is a risk that if excessive ambulance handover delays occur at hospital sites then performance standards and patient care could be compromised due to lack of available resources which could result in non-delivery of ARP standards and reputational damage to the Trust	**20 Significant**	**15 Significant**	5 Moderate
3136	Service Delivery	There is a risk that appropriate vehicle checks may not be taking place across PES in relation to tyre pressure and depth checks which could result in a breach of legislation and potential loss of vehicles due to breakdowns/ faults	**20 Significant**	**15 Significant**	5 Moderate

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK 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

LEAD DIRECTOR: DoOD

DATIX: TBC

STRATEGIC PRIORITY: Every Time

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:

- Increased demand for driver training
- Clinical Advisor Gap in NHS 111
- National Paramedic Supply

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
12	12	12	12	8	8	4
4x3	4x3	4x3	4x3	4x3	4x2	4x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 score of this BAF risk has reduced to a risk score of 8 due to the Trust making significant progress in delivering the first year of the Workforce Strategy implementation plan and this has been demonstrated through assurance reports to Committee and through key workforce indicators and external audit. The Trust vacancy position in Q4 is positive with targets for growth being met; turnover remains stable, mandatory training compliance has been delivered for 2019 and appraisal remains stable. Paramedic upskilling targets are on track; apprenticeship completion rates are above average and the Ofsted outcome gave external assurance of the quality of training. At the end of Q4 therefore it is felt that the progress made in delivering the first year of the Workforce Strategy has delivered the sufficient progress to reduce the likelihood of the risk.

CONTROLS	ASSURANCES	EVIDENCE
Strategic		
Level 2: Workforce Strategy	**Level 2:** 3 Year Implementation Plan/ Bi-Annual Progress Report	Reported to Resources Cttee
Level 2: 2019/20 Objectives	**Level 2:** Progress Report against delivery of objectives	Reported to ELC, Resources Cttee & Board of Directors
Level 2: Integrated Business Plan	**Level 2:** Identified Deliverables	Reported to Board of Directors
Recruitment and Retention		
Level 2: Recruitment & Selection Prcoedure (Revised 2019)	**Level 2:** Compliance against procedure	Reported to Resources Cttee
Level 2: Workforce Plan	**Level 2:** Vacancy Gap **Level 2:** Workforce Indicators Report	Reported to Audit Cttee/ Resources Cttee/ ELC/ Board of Directors
Level 2: Criminal Records Checks	**Level 3:** MIAA Internal Audit	Reported to Audit Cttee
Level 2: Clinical Registration Policy (Revised 2019)	**Level 2:** Compliance against policy	Reported to ELC
Level 2: Safer Staffing Assessment	**Level 2:** Completion against national safe staffing requirements	Reported to Resources Cttee
Level 3: HEE & HEI Paramedic Supply Plan (Revised 2019)	**Level 3:** Funding agreed for commissioned places **Level 2:** Internal Progression Programme	Reported to ELC
Developing Potential		
Level 2: Mandatory Training Procedure	**Level 2:** Workforce Indicators Report **Level 2:** Bi-Annual Audit **Level 3:** MIAA Internal Audit	Reported to Resources Cttee/ Audit Cttee/ Board of Directors via IPR
Level 2: Appraisal Policy and Procedure	**Level 2:** Workforce Indicators Report **Level 2:** Bi-Annual Audit	Reported to Resources Cttee/ Board of Directors via IPR Updated procedure reported to EMT
Level 2: Perceptorship Policy	**Level 2:** Monthly return to NHSI/ National AIP WF Development Group	Reported to AIP WF Development Group/ NENAS
Level 2: Apprenticeships	**Level 2:** Self assessment report **Level 2:** Annual Quality Improvement Plan	Reported to Annual Public Sector Duty Return/ ELC

	Level 3: OFSTED Inpsection: Good with areas of Outstanding **Level 3:** Reappointed as Employers Providers for Apptenticeships	
Level 2: Paramedic Upskilling Training Plan	**Level 2:** Delivery of upskilling training plan **Level 2:** Monthly return to NHSI	Reported to Resources Cttee/ NHSI & National AIP
Level 3: Future Quals	**Level 3:** Future Quals Accreditation	Reported to ELC
Wellbeing		
Level 1: Attendance Improvement Plan: PTS & NHS 111	**Level 2:** Compliance with Improvement Plan	Reported to Resources Cttee & National AIP
Level 2: Sickness Absence Procedure & Action Plan	**Level 2:** Workforce Indicators Report **Level 2:** Quarterly Sickness Absence Audits **Level 3:** Action Plan with NHSI **Level 3:** MIAA Internal Audit	Reported to Resources Cttee/ Audit Cttee/ Board of Directors via IPR
Level 2: Bullying & Harassment Action Plan	**Level 2:** Policy Review **Level 2:** Establishment of Working Group	Reported to Resources Cttee, ELC and Board of Directors
Level 2: Flu Campaign	**Level 2:** Annual Flu Plan for 2019/20 **Level 2:** Statistical Data of Flu Update Report	Reported to Resources Cttee, ELC and Board of Directors
Level 2: Staff Survey Action Plan	**Level 2:** Localised Engagement Plan **Level 3:** 2019/20 Staff Survey Results	Reported to Resources Cttee, ELC and Board of Directors
Level 3: Occupational Health Contract	**Level 2:** Agreed and signed by Board of Directors **Level 2:** Monitoring of monthly KPIs	Reported to NWAS Contract Manager/ Board of Directors
Level 3: Occupational Health Procedure	**Level 2:** Procedure Review	Reported to ELC
Level 3: NHSI Health & Wellbeing Diagnostic Tool	**Level 2:** Completion of self-assessment tool	Reported to NHS Improvement/ Resources Cttee
Level 2: Health and Wellbeing Practices	**Level 3:** Distinction in Health and Wellbeing Award	Reported to Board of Directors
Inclusion		
Level 2: WRES Measure	**Level 2:** Annual WRES Report & Action Plan **Level 2:** EDI Annual Report	Reported to Resources Cttee/ ELC/ Board of Directors
Level 2: WDES Measure	**Level 2:** Annual WDES Report **Level 2:** WDES Action Plan	Reported to Resources Cttee/ ELC/ Board of Directors
Level 2: Gender Pay Gap Action Plan	**Level 2:** Monitoring & Reporting of Action Plan **Level 2:** Women in Leadership Programme	Reported to Resources Cttee/ ELC/ Board of Directors
Level 2: Equlaity & Diversity Assessment 2	**Level 2:** Delivery of action plan **Level 1:** Self Assessment of EDS 2	Reported to Resources Cttee
Level 2: Annual Equality & Diversity Plan	**Level 2:** WF Strategy Measures	Reported to Board of Directors/ ELC/ Board of Directors
Level 2: Reservist Procedure (Revised 2019)	**Level 3:** Gold Standard Accredition Recognition **Level 3:** Shortlisted for Reverist Support Initiative	Reported to ELC/ Board of Directors
Leadership		
Level 2: Leadership Framework	**Level 2:** Implementation Plan **Level 2:** Delivery against identified milestones	Reported to ELC/ Board of Directors Reported to Resources Cttee
Level 2: Board Succession Planning in Place	**Level 2:** Summary of talent conversations and potential **Level 2:** Shadow Board Development Plan	Reported to Resources Cttee

Level 2: Talent Management Tool	**Level 2:** Tool part of succession planning guidance **Level 3:** NW HPMA Award for 'We Look After out Talent'	Reported to Resources Cttee			
Level 2: Leadership Recruitment Approach	**Level 2:** Delivering Workforce Strategy **Level 2:** Board Development Session	Reported to ELC			
Level 2: Leadership Induction Programme	**Level 2:** Revised induction developed, pilot with SPTLs	Reported to ELC			
Level 3: CMI Accreditated Centre	**Level 3:** External Assurance Visits	Reported to ELC/ Board of Directors			
Improvement and Innovation					
Level 2: Organisational Change Policy	**Level 2:** Agreed Policy	Reported to ELC			
Level 2: Rota Review Programme	**Level 2:** Project Steering Group **Level 2:** Funding agreed	Reported to ELC/ Board of Directors			
Level 2: Rotational Working Project	**Level 2:** Evaluation of UCP Pilot Scheme **Level 2:** Internal & External Roational Working Task & Finish Groups	Reported to CPB			
Level 2: Policy Framework	**Level 3:** Partnership Agreement to Review (ACAS) **Level 2:** Policy Group	Reported to Resources Cttee			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
N/A	N/A	N/A	N/A	N/A	

Risks Scored 15+ Aligned to BAF Risk: SR04					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2262	Organisational Development	There is a risk of high clinical advisor vacancy gap in 111 because of recruitment shortages and high turnover which could result in adverse performance and have a quality impact	**20 Significant**	**16 Significant**	8 High
2504	Service Delivery	There is a risk that mandatory training compliance in NHS 111 due to the operational and organisational pressures which could result in an impact on performance, clinical quality and patient care delivery	**16 Significant**	**16 Significant**	4 Moderate
2920	Service Delivery	There is a risk that sufficient workforce resources are not in place across NHS 111 service leading to the liability to meet contracted KPIs which could result in comprised patient care and reputational damage to the Trust	**20 Significant**	**20 Significant**	4 Moderate
3026	Organisational Development	There is a risk that the Trust will have insufficient driver training instructors as a result of increased demand for driver training combined with national and local driving instructor shortages which could result in an impact on delivery of front-line emergency driver training and compliance with regulatory framework	**20 Significant**	**16 Significant**	8 High

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK 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	**LEAD DIRECTOR:** DoF	**DATIX:** TBC

STRATEGIC PRIORITY: Every Time

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:

- Terms of lease breaks
- National restraints on Capital Funding
- Capacity to deliver the Estates Strategy
- Interdependencies between work streams
- ORH Modelling

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
12	12	12	12	12	6	3
3x4	3x4	3x4	3x4	3x4	3x2	3x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 score of this BAF risk has remained at a risk score of 12, there has been some risk mitigations that have taken place including the procurement of the facet survey and the improved assurance of reporting compliance with statutory requirements. The Trust has recently devised and approved its Sustainable Development Management Plan. It is recognised that they are on-going works in relation to ORH, Make Ready Schemes; including Hub and Spoke. They are ongoing concerns with the 111 Estates and the EOC reconfiguration.

CONTROLS	ASSURANCES	EVIDENCE
Level 1: Estate Maintenance	**Level 2:** Compliance with statutory and regulations **Level 3:** Drivers Jonas completed 6-facet surveys (2019)	Reported to Resources Cttee
Level 2: Station relocation and closures to enable the Strategy	**Level 2:** Annual Capital Reciepts for reinvestment	Reported to Resources Cttee
Level 2: Funding availability committed expenditure in line with existing Capital programme	**Level 2:** Identified programmes and costings established for 2019/20	Reported to Resources Cttee
Level 2: Sustainable Development Management Plan	**Level 2:** Deliverables against NHS Carbon Reduction Strategy	Reported to Resources Cttee
Level 2: Compliance with statutory requirements	**Level 2:** Fleet & Estates Assurance Report	Reported to Resources Cttee
Level 2: Partnership with other services in line with strategy	**Level 3:** Shared facilities with other blue light services/ public bodies	Reported to Resources Cttee
Level 2: Performance Measurement and Benchmarking	**Level 3:** Participation in benchmarking & DHSC Annual Estates Returns Information Collection (ERIC)	Reported to Resources Cttee
Level 2: Centralised reporting of estate issues	**Level 2:** Communications on reporting estate issues to QFM	Reported to Resources Cttee
Level 2: Estate Strategy	**Level 2:** Estates Assurance Report	Reported to Resources Cttee
Level 3: Energy Performance of Buildings	**Level 3:** New buildings designed to achieve SDMP	Reported to Resources Cttee

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Lack of a detailed plan for ongoing estate maintenance	Develop backlog maintenance improvements plan for existing sites based on 2019 Facet Survey Report	DoF	March 2020	Resources Cttee	Overdue
ORH Modelling: Mapping Operational Requirements to Estates	Estates Team to lead on development based upon Optima Modelling to assure ARP provides prime focus	DoF	March 2020	Resources Cttee	Overdue
Establish PTS Operations Location in line with Contract	Estates Team to lead on development based upon demand analysis and contractual parameters	DoF	March 2020	Resources Cttee	Overdue
Utilisation of the Model Ambulance	Contribution to NHSI working on measures to deliver model Ambulance	DoF	April 2020	Resources Cttee	Overdue

Risks Scored 15+ Aligned to BAF Risk: SR05					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2765	Finance	There is a risk that if a timely decision is not reached on lease arrangements for the Parkway site post-expiry of the current term in December 2023 which could result in significant cost implications and reduced operational capacity	**20 Significant**	**20 Significant**	8 High
2766	Finance	There is a risk that if the Trust does not decide in a timely manner to invoke the terms of the lease break (if required) for 111 Middlebrook in September 2020 this could result in significant financial implications (5 years extra lease payments to end of lease term).	**20 Significant**	**20 Significant**	4 Moderate
3136	Service Delivery	There is a risk that appropriate vehicle checks may not be taking place across PES in relation to tyre pressure and depth checks which could result in a breach of legislation and potential loss of vehicles due to breakdowns/ faults	**20 Significant**	**15 Significant**	5 Moderate
3187	Finance	There is a risk that the Trust could have poorly located sites due to the Trust not planning effectively for the future configuration of its estate which could result in a negative impact on operational performance for PES and PTS	**25 Significant**	**15 Significant**	5 Moderate

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR06: If the Trust does not establish effective partnerships within the regional health economy and integrated care systems then it may not be able to 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	**LEAD DIRECTOR:** DoS&P	**DATIX:** TBC

STRATEGIC PRIORITY: Right Place

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:

- Sustainability and Transformation Partnerships (STPs)/ Integrated Care Systems

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
8	8	8	8	8	8	4
4x2	4x2	4x2	4x2	4x2	4x2	4x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 score of this BAF risk is maintained at a score of 8 and met it's 2019/20 in year target due to the capacity to engage with STPs and system partners, in addition the complexity of the environment, for example, STPs are at different stages across the North West. Work will continue across the three areas to ensure that we continue to engage with STPs/ICS across the areas, and put in place mechanisms to work more effectively going forward.

CONTROLS	ASSURANCES	EVIDENCE
Level 1: Representation and attendance at key meetings	**Level 2:** Early indictors of potential changes that may be introduced to the system	Reported to Board of Directors
Level 1: Designated Executive Lead for each of the STP footprints/ County areas	**Level 2:** Executive Leads in each of the STP areas allows for focus within each area	Reported to ELC and Board of Directors
Level 1: Nominated Senior Management Leads for each area	**Level 2:** Reports of ongonig work within allocated area	Reported to ELC and Board of Directors
Level 2: Representation on STP Finance & Investment Group	**Level 2:** Senior Trust representation across the STP workstreams	Reported to ELC and Board of Directors
Level 2: Feedback in gathering and sharing strategic intelligence with key staff across the Trust	**Level 2:** Emerging strategic issues and consequential impact on the Trust's operational function	Reported to ELC and Board of Directors
Level 2: Centralised process for collating and cascading information from adhoc meetings	**Level 2:** Sharepoint site provides a central repository for all information from key meetings to enable access to key leads	Reported to ELC and Board of Directors
Level 2: Changes to Commissioning landscape	**Level 2:** Review of system wide reconfiguration through use of Optima to understand collective impact	Reported to ELC and Board of Directors
Level 2: Executive leads aware of roles in light of changes to leadership	**Level 2:** Adequate coverage across STP footprint	Reported to ELC and Board of Directors
Level 2: Board Development Session surrounding GM Devolution	**Level 2:** Updates and chamges regarding GM Devoultion and emerging changes in Commissioning	Reported to Board of Directors

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Lack of robust feedback loop	Implementation of robust feedback loop to discuss issues and consequential impact on the operational function of the Trust	DoS&P	March 2020	BoD	Overdue

Risks Scored 15+ Aligned to BAF Risk: SR06					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks on the Corporate Risk Register scored 15+ pertaining to this BAF Risk					

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR07: If the Trust does not maintain and improve its digital systems through implementation of the digital strategy, it may fail to deliver secure IT systems and digital transformation leading to reputational risk or missed opportunity	**LEAD DIRECTOR:** DoQII	**DATIX:** TBC

STRATEGIC PRIORITY: Every Time

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:

- Inability to deliver business as usual and projects due to capacity and capability within the IT team
- Critical Telephone Systems
- Continued work is required to get a robust risk and renewal road map for Trust wide systems and trained Asset Owners
- Unsupported software and hardware (including 2008 servers) leading to potential cyber-attacks

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
20	20	16	16	16	12	8
4x5	4x5	4x4	4x4	4x4	4x3	4x2
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 risk score has maintained at a score of 16 and therefore not achieving the 2019/20 in year target due to unsupported software and hardware, gaps in capacity for project support and the critical telephony systems being end of life. Mitigations to Asset Management and Cyber Security have made significant progress; the Trust are able to identify all assets in the organisation and have a list of assets with associated owners. A process has begun of engagement and training for asset owners with regular meetings scheduled. There has been an enterprise agreement with Microsoft which locks down prices and simplifies procurement processes. The CAD has been migrated to a new server and is no longer unsupported. The IT health dashboard has been operationalised to enable real time monitoring of assets, this level of visibility and assurance represents a significant improvement for the Trust in terms of ability to monitor and manage assets against possible threats. MIAA specialists are now working onsite to produce an action plan for cyber security and the Trust has been awarded Cyber essentials.

CONTROLS	ASSURANCES	EVIDENCE
Executive Leadership		
Level 1: Executive Leadership vacancies within Digital	**Level 1:** Leadership structure in place	Reported to ELC
Cyber Security		
Level 1: Cyber Security Specialist Support	**Level 3:** MIAA contracted to provide specialist support	Reported to ELC & Resources Cttee
Level 1: Cyber Essentials Assessment	**Level 1:** Assessment completed	Reported to Digital Oversight Forum
Level 1: IT Health Dashboard	**Level 2:** Monitoring of assets, visability of security threats and vulnerabilities & assurance of completion of mitigation	Reported to Digital Oversight Forum
Level 2: Asset License Management	**Level 3:** Monitoring provided by Trustmarque	Reported to Resources Cttee
Level 3: Cyber Essentials Framework	**Level 3:** MIAA Internal Audit Report	Reported to Resources Cttee
Level 3: Cyber Security/ Email User Behaviour Exercise	**Level 3:** MIAA Internal Audit Report	Reported to ELC & Audit Cttee
Level 3: Testing for vulnerabilities	**Level 3:** Microsoft Report	Reported to ELC & Audit Cttee
Digital System & Developments		
Level 1: Change Control Processes	**Level 1:** Review of changes are widely communicated	Reported to Change Advisory Board
Level 1: Supplier Engagement on high impact service changes	**Level 2:** Service Level Agreements in place with suppliers	Reported to ICT SMT
Level 2: Review and prioritisation of unsupported critical systems	**Level 2:** Critical Systems Recovery Plan	Reported to DOF and Resources Cttee
Level 2: Interdependancies and prioritisation issues	**Level 2:** Review of interdependancies for large scale digital programmes	Reported to Corporate Programme Board (CPB)
Level 2: IT Health Dashboard	**Level 2:** Live Status Data for Reporting	Reported to ELC/ Resources Cttee

Level 2: Business Continunity Plans	**Level 2:** Review of BCM Plans	Reported to Board of Directors			
Level 2: Ensure Supported Environment	**Level 2:** SQL and Microsoft Email Licencing Agreed	Reported to ELC and Board of Directors			
Level 3: Data Protection Practices	**Level 3:** ICO Audit Report	Reported to ELC			
Level 3: External Penetration Testing and Social Engineering	**Level 3:** External Audit Report	Reported to ICT Security Forum/ IG Management			
Level 3: Assessment of readiness for transition to cloud based	**Level 3:** Shape and Cloud Review/ Audit	Reported to ELC			
Level 3: Mobile Computering Device Audit	**Level 3:** MIAA Internal Audit	Reported to ELC/ Resources Cttee & Audit Cttee			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Lack of specific training for agreed Information Asset owners in relation to requirements of the role and core standards	Develop & deliver a programme of training for Information Asset Owners	Chief D&I	March 2020	IG Management	Overdue
ICT Standards require review in light of Cyber Essentials Plus to ensure there are clear auditable standards for the ICT architecture	Review ICT Standards as part of Cyber Essentials Plus action plan	Chief D&I	March 2020	ELC	Overdue
Lack of specific system resilience testing as part of Business Continuity Testing	Develop Programme of system resilience testing in line with ICT structure review	Chief D&I	March 2020	ELC	Overdue
5 areas of improvement identified from Internal Audit review covering system controls	Development of an overarching plan to address findings from both assessments and demonstrate compliance with Cyber Essentials Plus	Chief D&I	March 2020	Resources Cttee	Overdue
Action plan in response to the NHS Digitial Assessment of Cyber readiness to be developed - to be monitored by IMG					
Unsupported 2008 Servers	Conduct a review to establish which servers can be transitioned to the new neutanix servers	Chief D&I	March 2020	Resources Cttee	Overdue
Lack of protected resource and expertise for projects	Strucutre to be proposed	Chief D&I	March 2020	ELC	Overdue

Risks Scored 15+ Aligned to BAF Risk: SR07					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
1181	Quality	There is a risk that the Trust's Critical Telephone System (999) and/or the Voicemail messaging service fails which could result in an inability to appropriately respond and treat patients within agreed target timescales	**20 Significant**	**15 Significant**	5 Moderate
2480	Quality	There is a risk that unsupported software and hardware due to the lack of asset ownership, risk and renewal road map for existing systems and governance for cyber security will lead to costly last minute updates, potential cyber-attacks and loss of systems	**20 Significant**	**16 Significant**	8 High
2748	Quality	There is a risk that we will not be able to deliver key business as usual projects and innovations due to lack of capacity and project management expertise in the IT team which may lead to unsecure systems, system disruption or loss of critical systems	**20 Significant**	**16 Significant**	8 High

BOARD ASSURANCE FRAMEWORK 2019/20

BAF RISK SR08: If the Board experiences significant leadership changes it may not provide sufficient strategic focus and leadership to support delivery of its vision and Corporate Strategy	**LEAD DIRECTOR:** CEO	**DATIX:** TBC

STRATEGIC PRIORITY: Right Time

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:

- Embedding to the Corporate Governance Structure & Meetings
- Executive Structures
- Substantive Executive Director Vacancy

RISK SCORE:

01.04.19	Q1	Q2	Q3	Q4	19/20 Target	Final Target
12	12	8	8	12	8	4
4x3	4x3	4x2	4x2	4x2	4x2	4x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The Q4 score of this BAF risk has increased to a score to a 12 due to the recent announcement of the restructure of Executive portfolios. There is currently a substantive post for an Executive Director of People which is currently being advertised, which may result in potential changes to the Board of Directors and Executive Team. Following the Deloitte Well Led Review, they are a number of actions that require completion. However, the Trust has received approval for the substantive Deputy Chief Executive post. The launch of the Shadow Board is a key enabler of Board Succession Planning, identifying a strong Deputy structure across the Trust with the potential to step-up to as a Board member in the future. The Board skills matrix has been completed which has identified any learning and development opportunities with a robust Board Development Programme.

CONTROLS	ASSURANCES	EVIDENCE
Level 2: Executive Portfolio Reviews	**Level 2:** Executive Objectives & Priorities agreed and set	Reported to NAR Cttee
Level 2: NED Induction Programme	**Level 2:** Completed Induction Checklist	Reported to Board of Directors
Level 2: Board Skills Matrix	**Level 2:** Board Development Programme for 2019/20	Reported to Board of Directors
Level 2: Board Succession Plan	**Level 2:** Approved NHS Leadership Academy Shadow Board	Reported to Board of Directors
Level 2: Chief Executive Visits	**Level 2:** Chief Executive Report on Internal Engagement Visits	Reported to Board of Directors
Level 2: Board Well-Led Self Assessment	**Level 2:** Approved Rating of Well-Led Self Assessment	Reported to Board of Directors
Level 3: External engagement meetings	**Level 2:** Chief Executive Report on External Engagement Meetings	Reported to Board of Directors
Level 3: Independent Well-Led Review	**Level 3:** Deloitte Well-Led Review	Reported to Board of Directors

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Structure of System Engagement	Maintain increased stakeholder engagement, where appropriate	CEO	March 2020	ELC	
Executive Induction Programme	Creation of a Executive Induction Programme for new Executives	CEO	March 2020	ELC	Overdue
Executive Team Development	A programme for development opportunities for Executive Team	CEO	March 2020	ELC	Overdue
Actions from Deloitte Well Led Review	Delivery of actions identified following the Deloitte Well Led Review	CEO	March 2020	BoD	Overdue

Risks Scored 15+ Aligned to BAF Risk: SR08					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2480	Quality	There is a risk that unsupported software and hardware due to the lack of asset ownership, risk and renewal road map for existing systems and governance for cyber security will lead to costly last minute updates, potential cyber-attacks and loss of systems	**20 Significant**	**16 Significant**	8 High
2748	Quality	There is a risk that we will not be able to deliver key business as usual projects and innovations due to lack of capacity and project management expertise in the IT team which may lead to unsecure systems, system disruption or loss of critical systems	**20 Significant**	**16 Significant**	8 High

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Appendix 3:
Board Assurance Framework (BAF) Heat Maps
Quarter 4 Position

NHS North West Ambulance Service NHS Trust

2019/20 Opening BAF Risk Scores

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

Likelihood

Populated: 17 April 2019
Owner: Snr Risk & Assurance Manager

Q1 BAF Risk Scores

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

Likelihood

Populated: 31 July 2019
Owner: Snr Risk & Assurance Manager

Q2 BAF Risk Scores

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

Likelihood

Populated: 01 October 2019
Owner: Snr Risk & Assurance Manager

Q3 BAF Risk Scores

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

Likelihood

Populated: 24 December 2019
Owner: Snr Risk & Assurance Manager

Q4 BAF Risk Scores

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

Likelihood

Populated: 27 March 2020
Owner: Snr Risk & Assurance Manager

2019/20 Target BAF Risk Scores

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

Likelihood

Populated: 17 April 2019
Owner: Snr Risk & Assurance Manager

Final Target BAF Risk Scores

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

Likelihood

Populated: 17 April 2019
Owner: Snr Risk & Assurance Manager

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North West Ambulance Service NHS Trust

REPORT

Board of Directors								
Date:	Wednesday 27 May 2020							
Subject:	Risk Appetite Statement 2020/21							
Presented by:	Angela Wetton, Director of Corporate Affairs							
Purpose of Paper:	For Decision							
Executive Summary:	The Trust's Risk Appetite Statement underwent a full revision by the Board of Directors during the Board Development Session held in February 2020. The Trust refreshed its Corporate Strategy in November 2019 with some changes to the strategic priorities. The proposed 2020/21 Risk Appetite Statement has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.							
Recommendations, decisions or actions sought:	The Board of Directors are requested to approve the Risk Appetite Statement for 2020/21.							
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
☒	☒	☒	☒	☒	☒	☒	☒	☐

Are there any Equality Related Impacts:	None Identified
Previously Submitted to:	Executive Leadership Committee & Audit Committee
Date:	Wednesday 20 May 2020 & Friday 22 May 2020
Outcome:	Supported Onward Reporting to Board of Directors

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1. PURPOSE

This report provides the Board of Directors with an opportunity to consider the Risk Appetite Statement for 2020/21.

2. BACKGROUND

The Trust's Risk Appetite Statement underwent a full revision by the Board of Directors in February 2020 during a developmental session with the Board. The Trust refreshed its Corporate Strategy in November 2019, with changes to the Strategic Priorities.

The proposed Risk Appetite Statement for 2020/21 has been discussed with the Board of Directors and can be viewed in **Appendix 1** for review.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

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

4. RECOMMENDATIONS

The Board of Directors are requested to approve the Risk Appetite Statement for 2020/21.

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North West Ambulance Service NHS Trust

RISK APPETITE STATEMENT 2020/21

North West Ambulance Service NHS Trust endeavours to establish a positive risk culture within the organisation, where unsafe practice (clinical, financial, etc.) is not tolerated and where every member of staff feels committed and empowered to identify and correct/escalate system weaknesses.

The Board of Directors is committed to ensuring a robust infrastructure is in place to manage risks from operational level to board level, and that where risks crystallise, demonstrable improvements can be put in place.

North West Ambulance Service (NWAS) NHS Trust recognises that its long term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff and volunteers, members of the public and strategic partners.

As such:

- NWAS has low appetite to accept risks that could result in poor quality care or unacceptable clinical risk, noncompliance with standards or poor clinical or professional practice.
- NWAS has low appetite to accept any risk that could result in staff being non-compliant with legislation, or any frameworks provided by professional bodies.
- NWAS has a moderate appetite to accept risks that impact on finance/ value for money, however, budgetary constraints will be exceeded where required to mitigate risks to patient or staff safety or quality of care.
- NWAS has a moderate appetite regarding pursuit of commercial development and partnerships. The preference is for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.

The Trust commits to review its risk appetite statement on an annual basis and/or following any significant changes or events.

…….. ……..

Chairman **Chief Executive Officer**

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NHS
North West
Ambulance Service
NHS Trust

REPORT

Board of Directors	
Date:	27th May 2020
Subject:	Freedom to Speak Up Report Q4 and Annual Summary for 2019/2020
Presented by:	Rachael Foot, Freedom to Speak Up Guardian
Purpose of Paper:	For Assurance
Executive Summary:	2019/20 FTSU NGO statistics show the cases raised for the year under the 5 categories monitored: • Number of Cases • Raised Anonymously • Patient Safety • Unacceptable Behaviours • Staff Detriment National benchmarking shows that NWAS has the second highest rate of FTSU referrals across the England Ambulance services (see appendix 1) The Guardian received sixty seven concerns during Quarter 4 2019/20: • Patient Safety : 2 • Working Practices : 12 • HR Matter :12 • Data/Confidentiality Breach : 5 • B&H Allegation : 13 • COVID 19 Concerns : 19 • Other : 4 Details of outcomes/ lessons learned can be seen in **Appendix 2**. The updated Action Plan can be seen at **Appendix 3**
Recommendations, decisions or actions sought:	The Board is asked to: • Note the work of the Guardian • Continue to support the development of the Trust's Freedom to Speak Up strategy • Actively promote and robustly support the Freedom to Speak Up principles • Support the development of a Freedom to Speak Up training plan that is aligned to the NGO's recommendations when it becomes available • Support the revision of the Freedom to Speak Up Policy in line with NHSI once it has been published • Support 'embedding any learning from concerns being raised across the Trust'

	• Consider any risks and further actions for the Trust			
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
☒	☐	☐	☐	☐	☐	☐	☐	☐

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

This report provides the Board with an overview of the Freedom to Speak Up activity during Quarter 4 2019/20 as well as an annual summary for the year.

The Freedom to Speak Up Guardian (FTSUG) role aims at developing cultures where safety concerns are identified and addressed at an early stage. Freedom to Speak Up (FTSU) has three components:

- Improving and protecting patient safety
- Improving and supporting staff experience
- Visually promoting learning cultures that embrace continual improvement.

Having a healthy speaking up culture is an indicator of a well led trust. This report provides assurance to members of the Board that concerns are robustly and sensitively managed in line with current best practice. The report also provides benchmark information against other Ambulance trusts. Finally, the report includes information about the number of cases received, shared learning, key themes and actions taken to improve.

2. BACKGROUND

Sir Robert Francis QC has urged NHS Boards and managers to welcome staff raising concerns, in the same way as staff are encouraged to report incidents. North West Ambulance Service Raising Concerns (whistleblowing) Policy is in line with the NHSI National Integrated Policy.

The Freedom To Speak Up Guardian role is not a replacement for traditional practices which are already in existence for staff to raise concerns; it is an additional resource for staff to access should they feel that their concerns have not been dealt with appropriately, or indeed if their concern is of a more serious nature. The role also offers the opportunity for staff to raise issues in confidence and, if necessary, anonymously. Staff are encouraged to raise their concerns openly to enable a more transparent way of dealing with concerns, but also to challenge any workplace stigma attached to ‘whistleblowing’ or raising concerns.

No-one should experience detriment or be discriminated against for speaking up, but we know fear of this can prevent staff from doing so. Those who raise concerns via the Freedom to Speak Up process can expect to be thanked for speaking up and receive support and advice from the Trust’s Freedom to Speak Up Guardian and Champions.

3. CONCERNS RAISED

Freedom to Speak Up has continued to promote the role of speaking up, whilst supporting staff members who raise concerns via this channel. This section highlights the number of concerns raised during Q4 2019/20 and for the year 2019/20 as a whole and provides further detailed breakdown.

It is the responsibility of the FTSU Guardian to record and monitor all concerns raised and report them to the Trust’s Board of Directors and the National Guardian’s Office on a quarterly basis.

3.1 Quarter 4 2019/20 Activity

The Freedom To Speak Up Guardian received sixty seven (67) concerns during Q4, a significant increase on the same reporting period of the previous year which by comparison, recorded sixteen (16) concerns raised.

As previously reported in Q3 Board report, the awareness and visibility of FTSU has increased significantly in the last year. The recruitment of more Champions across the geographical footprint of the service and the continued promotion of FTSU either via face-to-face engagement in a variety of forums or by social media and Regional Bulletins, has helped to raise awareness of this function which the Guardian believes accounts for some of the increase in concerns being raised.

Of the sixty seven cases raised during Q4, thirteen cases relate to bullying and harassment, which includes attitudes and behaviours. Of the thirteen, seven relate to the alleged behaviours of managers.

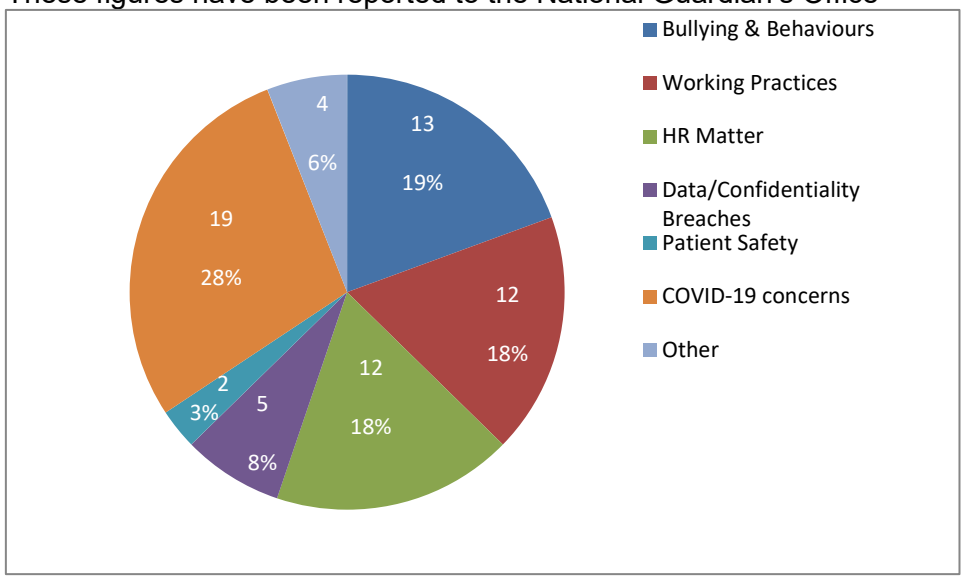
The largest number of concerns raised during Q4 2019/20 fall within the Working Practices category - some examples of these are:

- Unfair recruitment processes
- EMD staying in 'not ready status' on a frequent basis.
- Violence and Aggression incidents – Datix incidents not always being actioned and lack of feedback to staff who raised the incident/concerns
- Peer supporter(s) not feeling supported themselves

Towards the end of Q4, there was a spike in FTSU activity due to the increase in concerns being raised around the Covid-19 crisis. Concerns included:

- Inadequate PPE equipment
- Insufficient supplies of PPE
- Pregnancy related concerns due to COVID-19
- Working from home
- Social distancing
- IPC

These figures have been reported to the National Guardian's Office

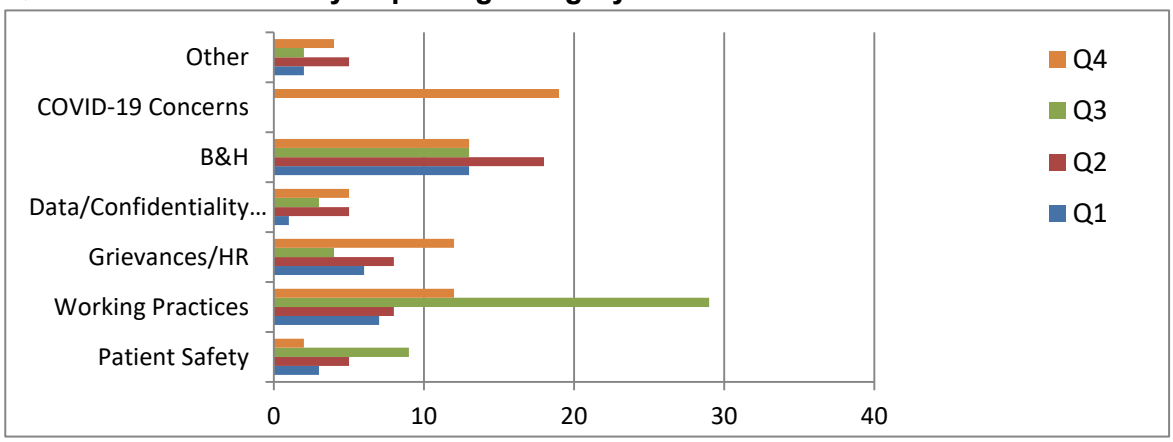


The category ‘Other’ includes:

- A witness to an incident came forward to speak up
- A NWAS employee witnessed a patient safety concern at one of the hospitals (concern passed to the FTSU Guardian at that hospital)
- ECFR raising concerns around PIDA following completion of mandatory training
- Issues around unauthorised pay deductions

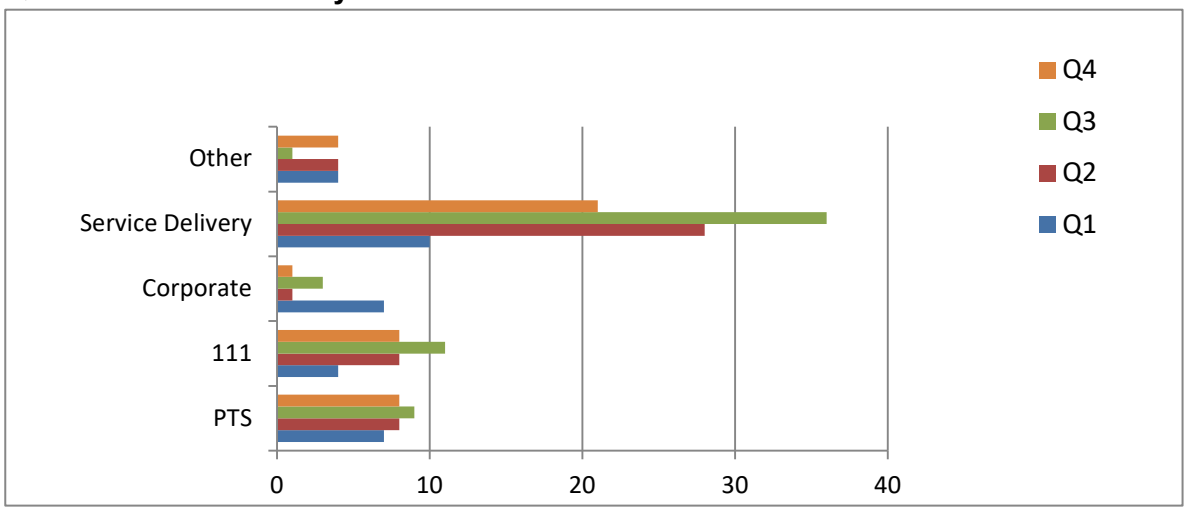
Details of Concerns

Q4 2019-20 Concerns by Reporting Category



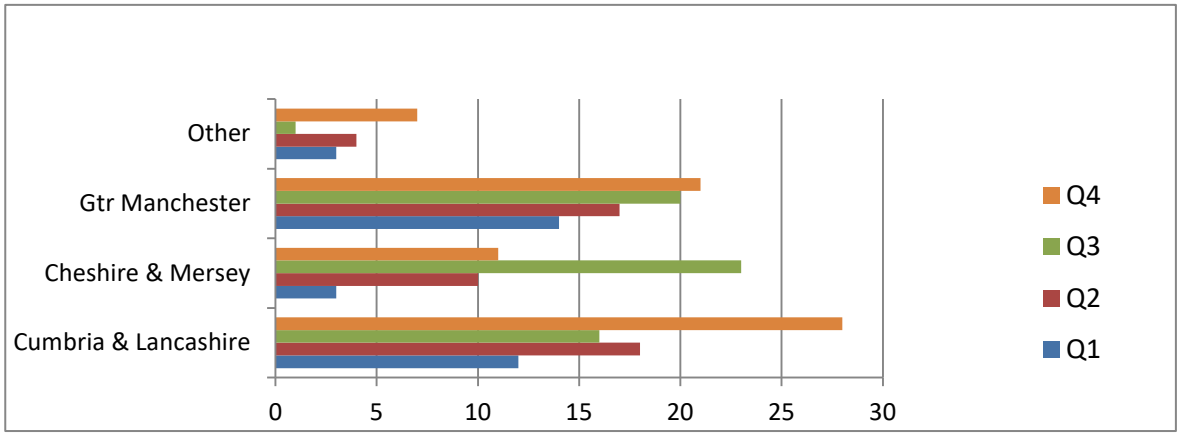
Other – Includes concerns raised by ex-employees

Q4 2019-20 Concerns By Service Line:



Other – Includes concerns raised by ex-employees and unknown.

Q4 2019-20 Concerns by Area:



Please note - the activity as detailed above reflects only cases reported via FTSU. Concerns raised with local managers and HR are not included in these figures.

Comparative data to the end of Q3 2019-20 for the whole Ambulance sector is shown at Appendix 1 – the Q4 figures have not yet been published by the National Guardian's Office (as at 21/05/20).

Data highlights that concerns raised continue to be dominated by our clinical colleagues which is entirely consistent with their operating environment, providing care at the 'front end' of Urgent and Emergency care.

During the reporting period, there have been five (5) truly anonymous concerns raised with the Guardian and nineteen (28%) concern raisers requested the Guardian and/or Champion protect their anonymity. The reason given for this was fear of reprisal as a result of speaking up. The Guardian and Champions continue to look at ways in which they can encourage confidence and support staff to raise their concerns openly.

The Guardian believes that the feedback obtained from the culture review being carried out by ZEAL "Moving Towards an Outstanding Culture" and the subsequent work that will follow will continue to assist in addressing this.

During the reporting period, four (4) colleagues have reported having suffered 'perceived detriment' as a result of raising a concern - of these cases, none have been substantiated. NWAS policies make it clear that such behavior is not tolerated.The Guardian is currently working with HR to implement a clear process for handling these concerns. This work also involves understanding what detriment might look or feel like and how managers can help prevent it from occurring. The Guardian regularly confirms with the concern raiser, both during the period the case is open and after the case has been closed that they do not consider themselves to be suffering detriment. This is in line with recommendations from the National Guardian's Office

The National Guardians Office has highlighted in its case reviews of Trusts that a barrier to speaking up has been flagged - staff are sometimes told by managers that the concerns they want to raise are not within the scope of the Guardian's role and that they should not be raising them with the Guardian and/or Champions. This is not correct and managers need to refrain from making these statements. Guardians and Champions are there to support staff to raise any concern, whether or not those matters carry their own set of policies and procedures. In

such circumstances, the Guardian and Champions can help staff explore the best way to speak up and which policy applies. The Guardian's role is also to promote learning and improvement within their organisation, helping to ensure that lessons learned from the issues raised by staff are actioned appropriately to deliver improvement.

Feedback is requested from 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.

During this quarter, the Guardian has seen an increase in the number of feedback responses received, albeit it verbally. The evaluation process has been widened to enable colleagues to provide feedback verbally (instead of just in writing). The feedback received, demonstrates that the majority of colleagues giving the feedback 'would speak up again given their experience of doing so'. The Guardian also takes this opportunity, whilst obtaining verbal feedback to capture the demographics of the person raising the concern where possible.

The Guardian can report that FTSU has received a number of concerns raised by staff identified as 'vulnerable' and from diverse backgrounds.

The Guardian has begun working more closely together with the Risk Management team and Patient complaints/experience team to enable information to be correlated and triangulated so that common themes and 'hot spots' can be identified. This activity is in its infancy but it is anticipated a proactive response can be taken to prevent incidents from happening in the first place which may help to reduce risk and harm to both staff and patients

Common Themes Identified

There have been a number of themes identified during Q4, the five main themes are:

1. Independence of investigators – although there has been some improvement during this quarter, this does continue to be a challenge. According to the NGO and NHSE/I guidance, investigations must be conducted by someone trained and suitably independent to do so. This has also been raised during a recent MIAA audit review of FTSU. The Guardian has asked the NGO to review the FTSU and ACAS Code of Practice guidance around this matter as they contradict each other.
   ACAS Code:
   - *In the majority of cases, where the matter to be investigated appears to be clear and the facts are not in dispute, the role of the investigator may be carried out by an appropriate line manager*
   - *If the evidence to be investigated is more serious or complex (such as potential gross misconduct, discrimination or bullying) then, where possible, appointing someone more senior or experienced may be beneficial.*

   From a FTSU prospective, allowing line managers, or appointing more senior managers (within that line) to carry out investigations, can be perceived by staff to be biased especially if they are geographically close.

2. Feedback - feedback must be provided in response to a concern having been raised, irrespective of the reporting method (i.e. Datix). This includes feedback on who is investigating the concern, where possible, the timescales and ultimately the outcome of

the investigation. Feedback is essential to avoid misunderstandings (a sense that nothing happened or that it wasn't important enough causes unnecessary stress and anxiety) and helps create a positive learning culture.

3. Handling of concerns – although there has been some improvement, unfortunately there are still some discrepancies in the level of investigation warranted (proportionate to the concern) – This has created some issues around timeliness and the independence of the investigator. For example, a local manager had been appointed to carry out a fact finding exercise, however staff speaking up had concerns relating to that manager and found it uncomfortable raising their concerns directly with them.

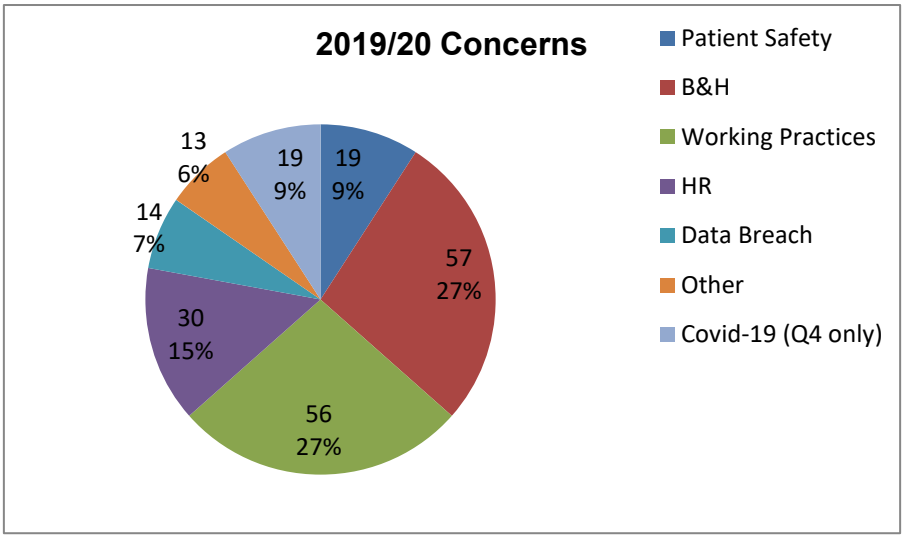
4. Issues around leadership at departmental level specifically where staff have spoken up to their Line Manager and no action has been taken.

5. Managers' attitudes and behaviours and lack of trust in them.

3.2 Freedom to Speak Up Concerns Raised During 2019/2020

2019-2020	Q1	Q2	Q3	Q4	Total for 19/20	Total for 18/19
Total number of concerns raised	32	49	60	67	208	60
Number of cases raised anonymously	3	2	0	5	10	20
Patient safety concerns	3	5	9	2	19	18
Cases related to bullying and harassment including behaviours and attitudes	13	18	13	13	57	17
where people indicate that they are suffering detriment as a result of speaking up	3	0	0	4	7	0
Feedback received*	4	7	5	28	44	13

*Feedback in this quarter may refer to concerns raised in previous quarters as not all concerns are completed within the reporting timeframe



3.3 Outstanding Cases 2019/20

Q1 2019-20
Currently four cases remain open from Q1:

- Three cases relate to workplace bullying and conflicts which has been investigated by an independent external investigator. The Head of Service and HR are currently reviewing the report findings and some recommendations have been implemented, whilst the rest of the report is being considered.
- One case is still open awaiting feedback following the review of the handling of the case. HR is currently in the process of writing to the individual concerned.

Q2 2019-20
Currently six open cases from Q2:

- One case is still open awaiting a review of the handling of the case. HR is currently in the process of writing to the individual concerned.
- Five cases relate to allegations of bullying, poor management, management behaviours and lack of support. These cases are currently being investigated by an independent investigator external to the Trust. These five cases relate to two of the cases currently open from Q1. These are expected to be concluded and closed during Q1 2020.

Q3 2019-20

Currently eight open cases from Q3 :

- Two cases are still open relating to historic Violence and Aggression incidents which are currently being investigated. Unfortunately the investigating officer (IO) is currently on long term sick. The Guardian has asked the Exec Lead to consider appointing a new investigating officer.
- Two cases relate to allegations of bullying. These cases have been reviewed by an independent investigator external to the Trust. These two cases relate to two of the cases currently open from Q1 and five currently open from Q2. These are expected to be concluded and closed during Q1 2020.
- One case relates to an allegation of concerns regarding the behaviours of EOC staff using staying on line as a break opportunity
- Three relate to concerns having submitted Datix and no feedback having been given. These have all been following incidents around violence and aggression.

Q4 2019-20

Currently thirty two open cases during Q4. A breakdown of cases closed and lessons learned during this period can be seen in **Appendix 2.**

4. Review of 2019/20

Engagement Activity / Raising Awareness

National Freedom to Speak Up Month

October was National FTSU month. The Guardian raised the profile of Freedom to Speak Up by promoting the role of the Guardian and Champions via social media through daily tweets using NWAS communications function. The Guardian also met with fellow Guardians at their Trusts to share ideas and tips whilst offering peer support to one another during the busy speaking up period. The Guardian visited staff across the Trust to promote “Speak Up To Me” month. During October, thirty six concerns were raised.

Awareness of FTSU is also promoted in other ways, including NWAS Regional Bulletins, CEO messages, NED walk around, Exec walk around and twitter feeds.

Staff Engagement

In order to encourage and promote Freedom to Speak Up at North West Ambulance Service, a number of activities have been undertaken during this financial year and are set out below:

- EOC (walkarounds)
- Guardian attendance - Disability Forum
- Guardian attendance -BAME Forum
- Guardian attendance - LGBT Forum
- Non-Clinical Learning Forum
- Station visits
- Hospital visits
- 111 visits
- CFR Network
- HART visit
- Fleet services
- SMT Meetings

- A FTSU intranet page is in place. This includes details of the FTSU Guardian, FTSU champions and how to raise concerns. This has been updated following the launch of the green room.
- Health and Wellbeing Team – The Guardian represents FTSU and supports the campaigns the H&WB team promote.

The Guardian continues engaging with staff across the Trust and working with Champions to ensure FTSU obtains maximum exposure.

External Engagement

The NGO recommended that the Guardian hold regular engagement sessions with the CQC relationship holder for NWAS. The Guardian is due to meet with Pritpal Singh-Jagatia in March, however due to unforeseen circumstances (COVID-19 national crisis), this meeting has been proponed.

There are quarterly sessions scheduled for the FTSU Guardians to come together as a support and learning network - Regional and NAN (ambulance sector)

MIAA

An internal audit of the Freedom to Speak Up processes was carried out at the Trust during the early part of Q4 as per the requirements Internal Audit Plan.

The review highlighted a range of improvements regarding investigation processes including independence of investigators and investigation training compliance.

NHS/I Board Development Session

Rachel Clarke and Tom Grimes both visited the Trust in February 2020 to deliver a Freedom to Speak Up development session to the Board. The session involved an open discussion with members of the Board to identify any areas of development and improve the effectiveness of leadership and governance arrangements in relation to FTSU.

Freedom to Speak Up Policy

The policy was reviewed and revised during Q3 and approved by Board in January 2020. The NHSI national integrated whistleblowing policy was adopted which helps standardise the way NHS organisations support staff who raise concerns for the benefit of all patients. NHSI are due to publish their revised policy in the summer

FTSU service - National and Regional Updates

Following national advice regarding Covid-19, the regional conference in March was cancelled and instead a shorter version was held by video link. This is available to listen to on the National Guardian's Office website via the following link: https://www.youtube.com/playlist?list=PL-Ouw5bZd3PI9h7slhv-GSJRGUV0aTLYj

Dr Henrietta Hughes, the National Guardian has written to all Trusts' Chairpersons to ask that Freedom to Speak Up Guardians are considered as 'key workers' and continue in their roles as Freedom to Speak Up Guardians during the COVID-19 crisis to enable staff to have an alternate route to raise or discuss any concerns.

NHS Improvement and the National Guardian's Office published guidance setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement. The self-review tool accompanying the guide enables boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The National Guardian's office has published a National report detailing 100 voices - cases. Data only tells part of the story and to get a real understanding of what Freedom to Speak Up means, it is important to hear from staff themselves. That's why the NGO office launched the 100 Voices campaign: to share the stories that describe the current reality of speaking up in health.

The Guardian's Office Case Review reports published to date have included seven trusts, (including North West Ambulance Service) and 95 recommendations have been made to those Trusts. The NGO also recommend all Trusts benchmark themselves and where appropriate adopt these recommendations to improve their speaking up processes and culture. The focus of the reviews remain learning and improvement for the whole system and in line with the NGO's recommendations NWAS implemented an action plan (consolidated with action from the Board guidance self-assessment tool) following the review to enable the Trust to improve its speaking up systems and the 13 identified areas were:

- Training Requirements
- Vision
- Meetings
- Exec Lead access to FTSU Files
- Assurance
- Monitoring
- Feedback
- Scope of FTSU Guardian
- Single Policy
- Engagement Process
- Timeliness and handling of Investigations
- Mediation
- Clarity around FTSU Champions/Advocacy

An example of one of the recommendations now embedded at North West Ambulance Service is to ensure that any letters to suspended workers clearly states they are able to access the FTSU Guardian.

The Guardian worked with the HR team to ensure that the 'Exit Interview Form' incorporates FTSU advising staff that they can access the Guardian if they feel that they would like to discuss any of the issues raised in the questionnaire or raise any other concerns prior to them leaving the trust. This is a great opportunity to understand more about their experience at NWAS and their input is valuable to us.

In one of its case reviews, the NGO observed that training on Freedom to Speak Up had not kept pace with developments in the field and did not fully reflect the NHS's approach to speaking up. The NGO therefore undertook to develop national guidelines. (Published August 2019). These guidelines are designed to improve the quality, clarity and consistency of training on speaking up across the health sector to support those commissioning and delivering training. A training package is currently being looked at nationally and will be standardised across all organisations in Spring.

The Guardian's Office continues to work closely with the CQC and Freedom to Speak Up is now included in the CQC Well Led domain of Ambulance Service inspections. The NGO has provided guidance to CQC inspectors and guardians with knowledge and learning from the past three years being used to improve quality as part of the review of the Well Led Framework.

The NGO has also asked the CQC to remove the word 'Whistleblowing' from their pre-inspection request as this causes confusion and distress in trusts. They have agreed to do this and to replace it with the words 'Freedom to Speak Up'.

During the year the National Guardian's Office appointed Regional Liaison Leads to identify and develop speaking up networks across primary care and FTSU Guardians from secondary care Trusts have been asked to support this integration.

Finally during 2019/20 the National Guardians Office raised the topic of 'Support for Guardians'. The Guardian feels very supported within the organisation and externally. For example, the Guardian is a member of the North West Regional Network and the National Ambulance Network and has been allocated a 'buddy' in each of these groups. The Guardian also has

access to the National Guardian's Office confidential 24-hour advice line 'PAM Assist'

Support for the NWAS Freedom to Speak Up Guardian

- Revised FTSU Policy (Raising Concerns/Whistleblowing) with clarity over roles and process.
- Monthly meetings held between the FTSU Guardian; Chief Executive, FTSU Executive Lead and the Interim Director of Organisational Development to provide oversight that the Trust's systems and processes for speaking up are working effectively and to escalate any specific areas of concern.
- Monthly meetings between FTSU Guardian and Head of HR to follow up outstanding cases and to identify themes and hot spots. This enables the Guardian to carry out 'targeted' visits in areas.
- Regular 1:1 meetings held with FTSU Executive Lead to discuss FTSU matters and seek support when necessary.
- Dedicated diary time scheduled with Non-Executive Director Lead to feedback themes that are emerging from speaking up activity and to seek guidance if necessary.

Benchmarking

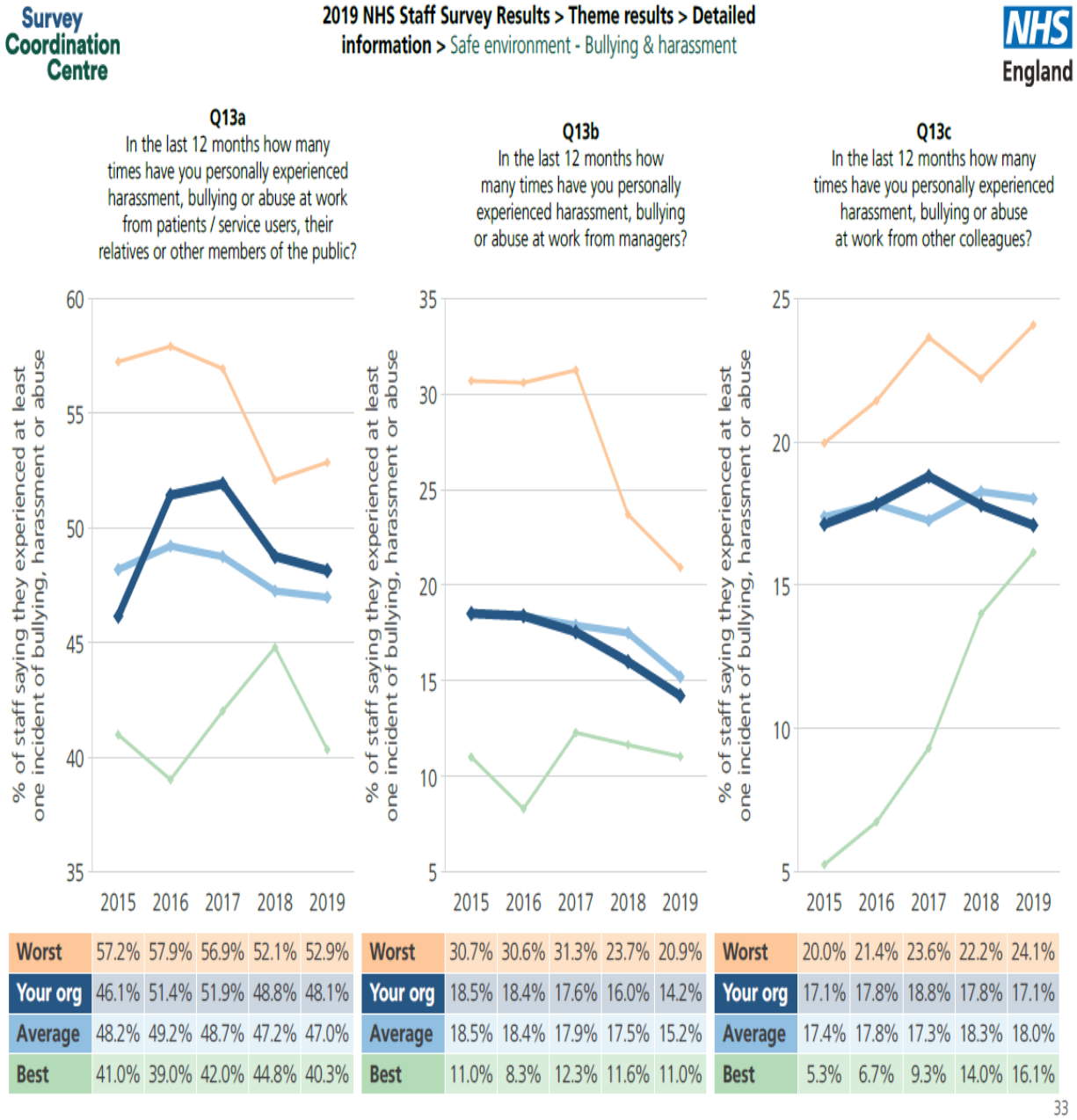
The National Guardians Office (NGO) published a FTSU Index report for 2019, a new metric taken from the NHS Annual staff survey, The **Freedom to Speak Up Index** helps trusts understand how their staff perceive the **speaking up** culture. The Index shows that a positive speaking up culture may be correlated with higher performing organisations.

The National Guardian's Office collected data from Freedom to Speak Up Guardians in all Trusts and Foundation Trusts on cases raised with them in 2019/20. The Guardian compares all published NGO data and themes against internal data to identify any learning.

The annual NHS staff survey contains several questions that serve as helpful indicators of the speaking up culture. Working with NHS England, the National Guardian's Office has brought four questions together into a 'Freedom to Speak Up (FTSU) index'. This is to enable trusts to see at a glance how their FTSU culture compares with others. This will promote the sharing of good practice and enable trusts that are struggling, to 'buddy up' with those that have recorded higher index scores.

NHS Staff Survey – NWAS 2019-20

Question	NWAS	National Average
Would feel secure raising concerns about unsafe clinical practice	65.9%	66.2%
Confident that our organisation would address their concern	55.3%	54.6%
Our organisation acts on concerns raised by patients/service users	67.9%	67.0%
Our organisation treats staff who are involved in an error, near miss or incident fairly	49.1%	49.1%
When errors, near misses or incidents are reported, our organisation takes action to ensure that they do not happen again	56.5%	57.6%
Given feedback about changes made in response to reported errors, near misses and incidents.	41.7%	50.2%



Whilst these figures are an improvement on the 2018 results they still not at the level the Trust would like and further work is needed. They are not a perfect indicator of the culture of Speaking Up in the Trust as the questions specifically refer to clinical concerns only and we know from the data we report to Board each quarter that the majority of concerns raised through Freedom to Speak Up at NWAS are around working practices and attitudes and behaviours. The 2019 Staff Survey results reveal a slight decrease in staff experiencing harassment, bullying or abuse from their managers and/or colleagues. This does still highlight the need for our Freedom to Speak Up Strategy to feed into the broader Workforce Strategy, specifically around how we support leadership and cultural change within NWAS.

Learning and Improvement

The Trust is committed to continuing to learn and improve its systems and processes for raising concerns and to share that learning.

This is done through:

- Meetings held between the freedom to Speak Up Guardian, CEO, Executive Lead, Interim Director of Organisational Development and the Non-Executive Lead.
- Noting and acting on recommendations from NGO case reviews, surveys and other publications and guidance.
- Responding to themes and significant issues highlighted by speaking up.
- Taking account of best practice in speaking up developed in other sectors.
- Encouraging workers to be involved in driving improvement at organisational level.
- You said, we did poster.
- FTSU feeds in to the Trust's Learning forum
- Key messages and awareness are raised to all staff through the intranet, weekly communications bulletins and other internal communications e.g. screensavers.
- CEO weekly messages.
- Lessons and feedback on cases are also shared locally with staff via the Service Directors, through team meetings and face-to-face meetings where relevant.

Details of outcomes/ lessons learned during Q4 can be seen in **Appendix 2**

5. SUMMARY OF 2019/20

The last financial year has seen a significant increase in the number of concerns being raised via FTSU. The majority of concerns raised are from our clinical colleagues carrying out various job roles. A comparison with the data for 2018-2019 shows a 347% annual increase in concerns being raised which could suggest staff are becoming more aware and confident in raising concerns through the FTSU Service. Whilst there has been an increase in concerns being raised, the data shows there are fewer colleagues raising concerns truly anonymously which may suggest colleagues feel more able to raise concerns at North West Ambulance Service and access the FTSU Service in confidence and without fear of detriment. This links with the data shown from the results of the National Staff Survey detailed above which confirms an increase year on year in staff confidence re raising concerns.

Concerns raised around patient safety are shared with our Executive Director of Operations and our Medical Director to give an overview of the types of concerns raised through the FTSU Service and it enables the Directors to monitor and address common themes identified across their divisions and to take ownership, share and embed any learning from them.

All concerns raised are directed to the Executive lead for the directorate the concern relates to and actions are put in place to address these concerns which are audited to ensure concerns are being taken seriously. Some concerns are escalated to more than one person as the concerns may cut across several areas.

Work continues to promote the FTSU Service and improve the culture to ensure all staff have the confidence to raise and discuss any concerns they may have.

6. Priorities for 2020/21 (Covid-19 Allowing)

1. The original Freedom to Speak Up Strategy is due to be refreshed and is awaiting the outcome of the ZEAL cultural development work to help inform some of the key areas of

focus as agreed with NHSEI and it will be presented to the Board once it has been drafted. The work will be led by the Freedom to Speak up Guardian, supported by the Director of Corporate Affairs as the exec lead.

2. FTSU Champion Review - The Freedom to Speak up role is ever evolving for the Guardian. As part of the process of evolution, the Guardian re-visited the role of the Champion. The Champion model has been refreshed to include a full application process and training. The Trust elected to have an open process which was advertised through internal communications inviting staff to volunteer to become Freedom to Speak Up Champions. The Guardian looked to appoint Champions who are geographically spread out and diverse in terms of demographics, background and experience. By increasing the diversity of our Freedom to Speak Up networks, the needs of any group that may face particular barriers to speaking up, be that based on a protected characteristic, a working pattern, or other factors such as geographic isolation can be met. The NGO is looking to introduce a standardised approach to Freedom to Speak Up training for staff employed in the health sector. They have issued guidelines on the types of training that should be provided, including how to speak up (for all staff); how to support people who speak up (for managers) and how to create a culture where people can speak up (for Execs and other senior leaders). Further guidance is expected during 2020. The NGO are working with HEE with a view to produce in the spring a widely accessible training package at a national level that organisations could utilise to train their workers, line and middle managers and senior leaders as described in the NGO national guidelines on training. Once published, the Guardian will develop and implement the training plan for the national Freedom to Speak Up training programme in line with recommendations from the NGO/NHSEI.

3. Promoting FTSU Champions to enable them to have ring fenced time and play a more 'front facing' role in the FTSU agenda and supporting staff across the Trust will take place and include training Champions in each Division to ensure there is support across the Trust locally within each Division. This fulfils one of the CQC's recommendations to ensure staff know who to raise concerns with.

4. Revise our FTSU Policy in line with NHSI's revised policy which is scheduled to be published this Summer.

5. Ensure any learning from concerns being raised is embedded across the Trust.

Future Planned Activity During 2020/21

- The Guardian is attending team meetings where possible to raise awareness and offer reassurance on raising concerns.
- The Guardian will continue to improve the service by implementing the FTSU Action Plan following the revision of the NHSI self-assessment tool and benchmarking NWAS against recommendations made from the National Guardians Office Case Reviews.
- Continued contribution and input into the current "Moving towards an outstanding culture" steering group run by ZEAL - Survey asking staff about speaking up processes and their understanding of them. The work has been designed through engagement with staff and aims to focus on the cultural and leadership changes required to improve employee experience and well-being.
- Pulse Survey – to measure the effectiveness of speaking up in NWAS.

- Ongoing discussions with our risk department about the development of DATIX as a confidential reporting platform for raising concerns to empower and encourage staff to speak up safely.
- Continuing to promote the role of the FTSU Guardian and Champions at trust induction, staff networks, and other staff forums.
- Link in with other departments, including HR to triangulate data and look at how the data fits in with grievances/exit interviews/sick leave etc. in order to identify emerging hot spots.
- Mandatory Training (MT) – FTSU is included in the MT cycle to raise awareness and to improve the skills, knowledge and capability or staff to speak up, to support others to do so, and respond to the issues they raise effectively

7. LEGAL and/or GOVERNANCE IMPLICATIONS

All NHS Trusts and NHS Foundation Trusts are required by the NHS contract to have a nominated Freedom to Speak Up Guardian.

8. RECOMMENDATIONS

The Board is asked to:

- Note the work of the Guardian
- Continue to support the development of the Trust's Freedom to Speak Up strategy
- Actively promote and robustly support the Freedom to Speak Up principles
- Support the development of a Freedom to Speak Up training plan that is aligned to the NGO's recommendations when it becomes available
- Support the revision of the Freedom to Speak Up Policy in line with NHSI once it has been published
- Support 'embedding any learning from concerns being raised across the Trust'
- Consider any risks and further actions for the Trust

Appendix 1 - Ambulance Trusts Comparison Data During Q3 (2019-20), Q1, Q2 and Q3 2019-20

The data for Q4 has not yet been published by the National Guardians Office.

	Trust Size*	Total Cases			Anonymous			Patient Safety			Behaviours, B&H			Reported Detriment		
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
LAS	Medium	67	66	71	1	1	0	7	6	5	18	14	21	0	0	9
NWAS	Medium	32	49	**60**	3	2	**0**	3	5	**9**	13	18	**13**	3	0	**0**
SECAMB	Small	20	21	19	1	3	2	0	0	1	10	9	10	0	1	0
YAS	Medium	11	17	25	0	0	0	1	1	2	2	6	3	0	0	0
EMAS	Small	3	5	NDR	2	5	NDR	2	0	NDR	1	1	NDR	0	0	NDR
EEAST	Medium	7	6	12	0	1	2	2	1	3	5	2	5	0	0	2
WMAS	Medium	1	1	1	1	0	1	0	0	0	0	0	1	0	0	0
SWAST	Small	12	9	23	1	0	0	2	2	2	2	2	4	0	0	0
SCAS	Small	29	23	21	1	3	0	1	1	2	5	2	7	0	0	0
NEAS	Small	3	1	NDR	0	1	NDR	1	0	NDR	1	0	NDR	1	0	NDR

*No data received (NDR)

*Trust Size:
Small (up to 5,000 staff)
Medium (between 5,000 and 10,000 staff)

Appendix 2 – Freedom to Speak Up (cases closed during Q4 2019-20) and outcomes/ lessons identified.

Case Number	Date Opened	Theme	Date Closed	Outcome/Learning
261	02/01/2020	Working Practices	27/02/2020	Incident reporting encouraged to allow information sharing in the area/across the teams
263	08/01/2020	Working Practices/Patient Safety	14/02/2020	Robust cleaning measures and facilities put in place – H&S inspection carried out
267	09/01/2020	Working Practices	17/03/2020	Uplift to reimbursement – pence per mile for voluntary car drivers to be reviewed annually in line with the Trusts financial planning cycle.
269	09/01/2020	Bullying	13/02/2020	HR matter
271	20/01/2020	Grievance	13/02/2020	Case not pursued by the concern raiser
272	20/01/2020	Grievance	19/02/2020	HR matter
274	21/01/2020	Working Practices	27/01/2020	No learning identified
276	27/01/2020	Grievance	17/02/2020	Facilitated conversation held
278	28/01/2020	Grievance	12/02/2020	HR matter
279	29/01/2020	Working Practices	13/02/2020	Case not pursued by the concern riser
281	31/01/2020	Dara Breach	07/02/2020	Case not pursued by the concern raiser
282	31/01/2020	Patient Safety	21//02/2020	Allegation(s) unsubstantiated - no learning identified
283	31/01/2020	Other	05/02/2020	None NWAS related
289	03/03/2020	Other	12/02/2020	No learning identified
290	10/02/2020	Bullying	11/02/2020	Case not pursued by the concern raiser
291	11/02/2020	Confidentiality Breach	11/02/2020	Case not pursued by the concern raiser
293	12/02/2020	Grievance	13/02/2020	HR matter
294	17/02/2020	Grievance	17/02/2020	HR matter
295	24/02/2020	Grievance	18/03/2020	HR matter

296	26/02/2020	Bullying	26/02/2020	Case not pursued by the concern raiser
302	07/03/2020	Bullying	13/03/2020	Case not pursued by the concern raiser
313	26/03/2020	COVID-19 HR	26/03/2020	HR matter – bulletins and guidance in place/issued
317	26/03/2020	COVID-19 HR	31/03/2020	HR matter – bulletins and guidance in place/issued
320	28/03/2020	COVID-19 WP	31/03/2020	No learning identified
321	28/03/2020	COVID-19 HR	31/03/2020	HR matter – bulletins and guidance around staff sickness in place/issued
323	29/03/2020	COVID-19 PPE	31/02/2020	Bulletins and guidance in place/issued

NHS
North West
Ambulance Service
NHS Trust

Freedom To Speak Up

Consolidated Action Plan 2019-20

FREEDOM TO SPEAK UP ACTION PLAN

The National Guardians Office (NGO) visited NWAS on 31 January and 1 February 2019 to gather information for its review. The NGO returned in May 2019 with NHS Improvement to discuss the provisional findings and to agree actions which the Trust need to put in place.

Their recommendations have helped furnish the NWAS Freedom to Speak Up (FTSU) Action Plan, which also incorporates internal actions the Trust has identified. The consolidated actions are shown below in the draft NWAS FTSU Action Plan 2019/20:

The 13 identified areas are:

- Training Requirements
- Vision
- Meetings
- Exec Lead access to FTSU Files
- Assurance
- Monitoring
- Feedback
- Scope of FTSU Guardian
- Single Policy
- Engagement Process
- Timeliness and handling of Investigations
- Mediation
- Clarity around FTSU Champions/Advocacy

Area: Training Requirements						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
1	Training requirements to be embedded for FTSU Guardian and Executive Lead	The FTSU Guardian/s and the Executive Lead for FTSU should be given training in the HR processes of the organisation such that they apply to the management of grievances, investigations, disciplinary cases, etc. Ongoing Training schedule Bespoke session providing understanding of relevant HR policy and process delivered 3rd March. Guardian to attend Dignity at Work and disciplinary masterclasses.	Director of OD	Complete Masterclasses During 2020 - ongoing		NGO
2	Trust Board to be knowledgeable, up to date and able to articulate the FTSU vision as well as aware of all NGO guidance	Formal Training for Board linked into the Board Development matrix. Director of Corporate Affairs arranged session with NHSEI 26/02/20. Also planning session with NHSE/I and Senior Leadership Group for July 2020.	FTSU Guardian	Complete		Internal
3	Trust Board to challenge and scrutinise FTSU	Monitoring information on FTSU to be provided on a regular basis where Trust Board can develop a culture of scrutiny and continuous improvement. FTSU Guardian reports to Board on a quarterly basis and captures all items identified within the NHSI/E board guidance.	FTSU Guardian	Complete		Internal
Area: Vision						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**

4	Develop a clear FTSU Vision incorporating patient safety, staff experience and continuous improvement	Develop a FTSU Strategy and Vision A FTSU Vision & Strategy was approved by the Board during Q3 2018-19, however, this is being reviewed and refreshed, supported by NHSEI, following the outcome of the work with ZEAL which has been delayed.	Director Corporate Affairs	Q4		Internal
5	FTSU Champions to be aware, understand and support the vision	Communications and training around Vision and Values A review and refresh of the current Champion model is underway and a proposal as to the shape of the model and the support/training required was planned to be presented to Executive Leadership Committee during Q4, however, Covid-19 pressures has pushed this back until BAU is restored. Expressions of Interest received and comms sent to individuals advising of the delay.	Director Corporate Affairs	Q4		
Area: Meetings						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
6	Ensure regular cooperation and consultation between FTSU and nominated lead non exec for FTSU	NWAS should ensure that regular meetings take place between the FTSU Guardian/s and the nominated lead NED for FTSU. Meeting dates for 2020/21 planned in until end July 2020.	FTSUG and NED	Complete		NGO
Area: Exec Lead access to FTSU Files						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
7	Policy for access to FTSU files	NWAS to develop a clear policy in relation to authorising the Executive Lead's access to FTSU Files in circumstances where there are concerns	Director Corporate Affairs	Q4		NGO

		relating to the actions (or otherwise) of the FTSU Guardian. This policy should be developed with the NGO Contacted NGO – no response. NHSEI chased NGO, no response. Chased again – Out of Office til 9th March. Response received 12 March: The National Guardian's Office does not agree this is a joint activity. The FTSU Guardian and Director of Corporate Affairs to draft a protocol for approval during Q1.				
Area: Assurance						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
8	Annual review of FTSU Policy and Process	• Review internally in line with NGO guidance • Internal Audit The policy was reviewed and refreshed by the HR team in conjunction with the FTSUG and approved at January 2020 Board Meeting.	FTSU Guardian	Complete		Internal
9	Quarterly reporting to Board	Quarterly reporting of all FTSU complaints received and progress being made Quarterly reporting to Board has been in place since 2017, however, the report continues to be refined in line with guidance.	FTSU Guardian	Complete		Internal
10	Review of guidance and case reviews	FTSU Guardian and Executive Lead to review all guidance and case reviews from NGO to identify improvements	Director Corporate Affairs & FTSU Guardian	Complete		Internal

11	Annual survey of FTSU	Via survey monkey Rescheduled for Q2 due to Covid-19	FTSU Guardian	Q4		Internal
Area: Monitoring						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
12	Sample review by external audit of all FTSU cases to ensure consistent application of policy and process	• Identify cases to be reviewed per quarter • Review fully and provide report Mersey Internal Audit carried out audit during Q3 – management responses and actions agreed Q4.	FTSU Guardian	Complete		Internal
13	Regular quarterly auditing	Quarterly audit via Datix Datix Cloud IQ due to go live April 2020 – rescheduled Q3 20/21 due to Covid-19	FTSU Guardian	Q4 2020		Internal
14	Comparative Data	Compare data over differing periods and Quarters to ascertain trends This is already being done in the quarterly Board Report	FTSU Guardian	Ongoing & Complete		Internal
Area: Feedback						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
15	Build in feedback stages for complainants	Ensure regular feedback to complainants to advise of status of investigation This has been in place since the launch of FTSU; however there is now a monthly 1:1 with senior HR and weekly telephone meetings to get updates to feed back.	FTSU Guardian	Ongoing & Complete		NGO
16	Feedback from complainants to inform improved processes	Gain feedback and operationalise improvements This has been in place since the launch of FTSU; however it is reliant on feedback from complainants.	FTSU Guardian	Ongoing and complete		Internal
Area: Scope of FTSU Guardian						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**

17	Greater clarity of remit around the scope of the FTSU Guardian.	Follow NGO guidance around remit of FTSU Guardian regardless of type of issue raised The FTSU Guardian role is clearly defined via a Job Description which has been shared with NHSE/I. The role is also clearly defined within the revised FTSU Policy. Recruitment for substantive post March 2020, however delayed interviews until June 2020 (under review dependant on Covid-19 situation. Acting Guardian remains in post)	Director Corporate Affairs	Complete.		NGO
		Deliver FTSU awareness through mandatory training with requisite reference to the new guidance. Previous mandatory training already delivered. Mapping against revised national guidance and action plan to be developed for implementation once national guidance issued. National core skills for health e-learning implemented in this year's mandatory training on 3 year refresher cycle.	Director of OD	February 2020		NGO
		NWAS to look for positive ways to promote FTSU The Guardian promotes FTSU via Twitter and is working with the comms team on a programme for 2020/21	Director Corporate Affairs	Complete		NGO
18	FTSU Guardian to have access to Senior Managers and Trust Board	Put in place reporting arrangements / access / flowchart so that patient safety issues can be progressed rapidly	Director Corporate Affairs/FTSUG	Complete		Internal
19	FTSU Guardian to have bilateral relationships with regulators / inspectors and other FTSU Guardians	FTSU to arrange regular meetings with NGO and other FTSU Guardians FTSUG meets quarterly with CQC and attends both national network meetings and ambulance sector	FTSUG	Complete		Internal

		meetings. Local and sector buddying arrangements in place.				
Area: Single Policy						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
20	Single Policy	Ensuring the new policy is clear that all workers can seek support from FTSU Guardian about any issue by merging the Policies of: • Raising Concerns at Work (Whistle Blowing) Policy and Procedure • Freedom to Speak up Policy The policy has been reviewed and refreshed and approved at January Board meeting	Director Corporate Affairs	Complete		NGO
		Revise Freedom to Speak to Policy to reflect the updated national policy The policy has been reviewed and refreshed and the Guardian has had input to ensure national guidance is reflected.	Director Corporate Affairs	Complete		NGO
		Advise staff of all revisions to policies through communications. Comms January 2020	Director Corporate Affairs	Complete		NGO
Area: Engagement Process						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
21	Trust Board to be visible and use variety of methods to seek feedback regarding FTSU	• Progress Executive Walkarounds • Engagement interaction Workshops • FTSU campaigns • Senior Manager briefings	Director Corporate Affairs	Q4		Internal

22	Encourage staff to speak up	Work with HR to promote the FTSU principles Treat Me Right campaign will reference FTSU as a route to raise concerns at work.	FTSUG	Ongoing & Complete		Internal
23	Thanking Staff for Speaking Up	The trust will ensure: The trust's new speaking up policy will include a reference to thanking all workers who speak up. The policy has been reviewed and refreshed and includes a reference to thanking all workers and was approved at January Board Meeting.	FTSUG	Complete		NGO
Area: Timeliness and handling of Investigations						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
24	Timescales , handling and reporting back mechanisms to be reviewed	Ensure that policy reflects reasonable timescales are set for investigations and that these are fed back. The trust is continuing to train managers in investigation training to address this issue.	Director of OD	Complete		NGO
		Ensure that details of which policy or procedure is being used is communicated at the outset	Director of OD	Complete		NGO
		Give proper scope and clarity to investigators	Director of OD	Complete		NGO
		Review the protocols setting out the working arrangements between FTSU guardian and HR to ensure principles are embedded	Director of OD	31 March 2020.		Internal

25	Review of current policies to incorporate independence of investigators as a key element	The trust to review its relevant policies in relation to investigations to ensure that: Policies take proper and reasonable account of workers' objections relating to the perceived independence of investigators, and that a clear rationale for any decisions regarding investigators is given to workers in response to such objections. Policies provide more transparency about the way in which the trust will manage potential conflicts of interest relating to investigations.	Director of OD	January 2020 – revised FTSU policy Completed Disciplinary policy review – June 2020 Already covered in investigations training		NGO
Area: Mediation						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**
26	Explaining the benefits of mediation at the outset	Trust to take appropriate steps to ensure that managers and HR staff are up to date with existing guidance on explaining the value of mediation to workers. Revised guidance available on Green Room, issued to managers and HR teams. Will be more widely distributed as part of Treat Me Right campaign	Director of OD	Complete		NGO
Area: Clarity around FTSU Champions / Advocacy						
No.	**Goal**	**Action Required**	**Lead Manager**	**Target Date**	**Complete**	**Plan**

27	Clarity around description and role of FTSU Champions in terms of "Advocacy", "Impartiality" and "Objectivity"	Clear definition of role of FTSU in revised Policies FTSU Policy reviewed and refreshed. Approved by Board of Directors January 2020.	Director of OD	Complete		NGO
		Engage with existing Champions to ensure they are clear on role, responsibilities and objectives especially when individuals hold more than one voluntary role which may create conflict or confusion to the works they support e.g. peer supporter role A review and refresh of the current Champion model is underway and a proposal as to the shape of the model and the support/training required was planned to be presented to Executive Leadership Committee during Q4, however, Covid-19 pressures has pushed this back until BAU is restored. Expressions of Interest received and comms sent to individuals advising of the delay.	Director Corporate Affairs / Director of OD	Q4		NGO
		Clarity around Champions being impartial and objective and not "taking sides" or acting as "advocates" (see above)The FTSU Guardian is clear with existing champions re the role and the expectations	Director Corporate Affairs	Q4		NGO
		Gain guidance and support from NGO in ensuring this is met going forward Awaiting further NGO Guidance Nationally	FTSUG	Ongoing		NGO

North West Ambulance Service NHS Trust

REPORT

Board of Directors					
Date:	27 May 2020				
Subject:	Review of Core Governance Documents				
Presented by:	Angela Wetton, Director of Corporate Affairs				
Purpose of Paper:	For Decision				
Executive Summary:	The Trust's core governance documents have been subject to annual review, as per the Standing Orders. The outcome of the review resulted in a number of changes to the Standing Orders and Reservation of Powers to the Board and Standing Financial Instructions and can be identified as tracked changes within the documents. Due to the significant size of the Scheme of Delegation following review by Executive Directors and their teams, the format of the Scheme of Delegation has been reviewed and transformed to a simpler format which will be included within the Standing Orders and Reservations of Powers to the Board.				
Recommendations, decisions or actions sought:	The Board of Directors is 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):					
SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.				☒
Are there any Equality Related Impacts:	**N/A**				
Previously Submitted to:	**Executive Leadership Committee Audit Committee**				
Date:	**20th May 2020 and 22nd May 2020**				
Outcome:	**Recommended to the Board of Directors 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 approval by Board of Directors.

2. BACKGROUND

As per the Standing Orders, the Trust's core governance documents are subject to annual review. The outcomes of the latest review were submitted for consideration by the Executive Leadership Committee on 20 May 2020 and Audit Committee on 22 May 2020.

3. REVIEW OUTCOMES

The outcome of the review resulted in a number of changes to the Standing Orders and Reservation of Powers to Board and Standing Financial Instructions and can be identified as tracked changes within the documents.

Due to the significant size of the Scheme of Delegation following review by Executive Directors and their teams, the format has been reviewed and transformed to a simpler format and will be included within the Standing Orders and Reservations of Powers to the Board.

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

3. 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 is 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 & Reservation of Powers

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	24 April 2019
16	Annual Review, March 2020	

CONTENTS

STANDING ORDERS

RESERVATION OF POWERS

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 Interpretations

The Chair of the Trust is the final authority in the interpretation of Standing Orders (on the advice of the Chief Executive and Director of Corporate Affairs).

1.3 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.
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 Accountable Chief Officer of the Trust
Committee	A committee appointed by the Board of Directors

Terminology	Definition
Director	A member of the Board of Directors
Director of Finance	The Chief Financial 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.

1.4 NHS Framework

1.4.1 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.

1.4.2 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 makes various requirements concerning possible conflicts of interest of members of the Board.

1.4.3 The Code of Practice on Openness in the NHS sets out the requirements for public access to information on the NHS.

1.5 Delegation of Powers

1.5.1 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 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 included within these Standing Orders and (Reservation of Powers to the Board and Scheme of Delegation. The Standing Financial Instructions is a separate document. These documents have effect as if incorporated into these Standing Orders.

1.6 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 Board of Directors

2.1.1 In accordance with the Establishment Order 2006 No 1662 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
- Executive Director of Finance
- Executive Medical Director
- Executive Director of Operations

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

- Director of Quality, Innovation & Improvement
- Director of People
- Director of Strategy & Planning
- Director of Corporate Affairs

2.2 Appointment of Chair and Executive Directors/Directors

2.2.1 The Chairman and Non-Executive Directors of the Trust are appointed by NHSE/I, on behalf of the Secretary of State for Health.

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

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

2.2.4 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 as one person.

2.3 Terms of Office

2.3.1 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 NHSE/I, under its delegated authority from Secretary of State for Health.

2.3.2 In line with the FT Code of Governance (Monitor), any term beyond six years (eg two three year terms) for a non-executive director should be subject to rigorous review and consideration of progressive refreshing of the Board should be taken into account. In exceptional circumstances, Non-Executive Directors may serve longer than six years however should be subject to annual re-appointment by NHSE/I. Serving more than six years could be relevant to the determination of a non-executive's independence.

2.4 Appointment and Powers of Vice-Chairman

2.4.1 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.

2.4.2 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.

2.4.3 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.

2.4.4 In order to appoint the Vice-Chairman, nominations will be invited by the Chairman. 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

2.5.1 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 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

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

2.6.2 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.

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

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

2.7.1 .

2.7.2 The Board 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 areincorporated 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 six 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.

3.1.8 The Board of Directors or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting, shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the Board of Director meetings without express permission of the Board of Directors.

3.1.7 Nothing in these 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 five 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 may request that a matter isincluded on an agenda. This request should be made in writing to the Chairman and 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 Chairman of the Meeting

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

3.6.2 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.

3.6.3 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.

3.7 Voting

3.7.1 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.

3.7.2 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.

3.7.3 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

3.7.4 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.

3.7.5 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

3.7.6 Under no circumstances may an absent director vote by proxy.

3.7.7 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.

3.7.8 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.

3.7.9 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.

3.8 Quorum

3.8.1 No business shall be transacted at a meeting of the Board unless at least six of the Directors who are eligible to vote (including at least three Executive and three Non-Executive Directors with voting powers) are present.

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

3.8.3 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.

3.9 Record of Attendance

3.9.1 The names of the directors and others invited by the Chairman present at the meeting, shall be recorded in the minutes.

3.9.2 If a director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

3.10 Minutes

3.10.1 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.

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

3.10.3 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.

3.11 Notices of Motion

3.11.1 Subject to the provision of Standing Order 3.11 and 3.14 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.

3.12 Motions: Procedure at and During a Meeting

3.12.1 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

3.12.2 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.

3.13 Rights of reply to motions.

3.13.1 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.

3.14 Motion to Rescind a Decision of the Trust Board

3.14.1 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.

3.14.2 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.

3.15 Suspension of Standing Orders

3.15.1 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.

3.15.2 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

3.16 Variation and Amendment of Standing Orders

3.16.1 These Standing Orders shall be amended only if:

- a notice of motion under SO 3.11 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

4. Committees

4.1 Appointment of Committees

4.1.1 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 to Committees

4.2.1 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

4.3.1 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 shall be held by the Director of Corporate Affairs.

4.4 Delegation of Powers by Board Committees

4.4.1 The Board of Directors shall authorise any delegation of powers to be exercised by its formally constituted Committees. The Board of Directors shall approve the terms of reference of these committees and any specific powers.

4.5 Approval of Appointments to Committees

4.5.1 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.

4.6 Appointments for Statutory Functions

4.6.1 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.

4.7 Minutes

4.7.1 Minutes, or a representative summary of the issues considered and decisions taken, of any Committee appointed under this Standing Order are to be formally recorded. The Chairman of such Committees and sub-committees are to provide a representative summary of the issues considered and any decisions taken to the next Board of Directors meeting.

4.8 Statutory and Mandatory Committees

The mandated committees to be established by the Board are:

4.8.1 Audit Committee

In line with the requirements of the NHS Codes of Conduct and Accountability, an Audit Committee will be established and constituted to provide the Board with an independent and objective review of the financial systems and of general control systems that ensure the Trust achieves its objectives, the reliability of thefinancial information used by the Trust and of 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 Committee will comprise of a minimum of three Non-Executive Directors of which one must have significant, recent and relevant financial experience.

4.8.2 Auditor 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.

4.8.3 Nominations & Remuneration Committee

In line with the requirements of the 1990 Membership and Procedure Regulations, Regulations 17-18, 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

4.8.4 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.

4.8.5 Non-Mandatory Committees

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.

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

5.2.1 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 after having consulted with at least two Non-Executive Directors and two 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.

5.3 Delegation to Committees

5.3.1 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.

5.4 Delegation to Officers

5.4.1 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.

5.5 Schedule of Decisions Reserved for the Board of Directors

5.5.1 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.

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

5.5.3 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.

5.6 Scheme of Delegated Authorities

5.6.1 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.

5.6.2 The direct accountability, to the Board of Directors, 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

5.7 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 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
- 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 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 All 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 should also refer to the Trust's Standards of Business Conduct; Policy on Managing Conflicts of Interest, Gifts & Hospitality and Sponsorship.

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 Trust 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 bi-annually.

9. Partnership Arrangements – Memorandum of Understanding (MoUs)

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

9.2 For governance purposes, it is imperative that such partnership arrangements are subject to formal approval by the Executive Leadership Committeeprior to any commitment to join the partnership.

9.3 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.

9.4 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.'

Reservation of Powers to the Board

1. Introduction

1.1 Standing Order 1.6 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 SO5.2.

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 complaints.

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.

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

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

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

3.1.13 Receive reports on instances of use of the seal.

3.1.14 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 SO5.7.

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 Executive
- Appoint the Executive Directors

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 interests

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.

3.3 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 Final Business Cases for Capital Investment schemes where the value exceeds £500,000.

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

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

3.3.7 Approve PFI proposals.

3.3.8 Approve the opening of bank accounts.

3.3.9 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.

3.3.10 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.

3.4 Policy determination

3.4.1 Receive a quarterly report detailing the approved new or revised policies and procedures by the Executive Leadership Committeeor relevant Executive Director.

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

- Health and Safety Policy
- Risk Management Policy
- Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak Up PolicyPolicy
- Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts, Hospitality & Sponsorship
- Investigations Policy
- Performance Management and Assurance Framework
- Learning from Deaths Policy

3.5 Audit Arrangements

3.5.1 Approve the appointment (and where necessary dismissal of External Auditors recommended by the Auditor Panel).

3.5.2 Approve 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.

3.5.3 Receive the Auditors Annual Report from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

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 Assurance Reports from Chairs of 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.

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Standing Financial Instructions

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	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	24 April 2019
15	Annual Review, April 2020	

Standing Financial Instructions

Table of Contents

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 Leadership Committee.

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

Terminology	Definition
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) or manpower budget 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.
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.

Terminology	Definition
Non-Officer	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
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
Ultra vires transactions	Latin meaning "beyond the powers." Describes actions taken by government bodies or corporations that exceed the scope of power given to them by laws or corporate charters.
Virement	A movement between non-pay to pay on the same cost centre. A budget virement is a movement between cost centres in the same service line/just between service lines.

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; and
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; and
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; and
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 in, 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; and
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; and
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; and
- 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 the NHS Counter Fraud Authority (NHS CFA). The Trust shall act in accordance with:

a. the NHS Fraud and Corruption Manual; and
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 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 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).

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. Income, 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; and
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; and
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 non-pay virement within their areas of responsibility;
e. achievement of planned levels of service; and
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 Resources Committee in a form approved by the Committee 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; and
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. Financial performance is included in the Integrated Performance Report to the Board of Directors
c. the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible
d. investigation and reporting of variances from financial, workload and manpower budgets
e. the monitoring of management action to correct variances
f. arrangements for the authorisation of budget transfers
g. 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 budget 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; and

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 approved financial plan..

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; and
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; and
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; and
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; and
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 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; and
- that SLAs / contracts are based on integrated care pathways and are affordable.

7.1.2 The appropriate NHS Standard Contract must be developed and adopted involving key stakeholders including clinicians, Patient and Public Panel representation,, appropriate service/business management, Quality, Contracting and Finance Directorate representation, and public health professionals when appropriate. 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; and
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 Peoplein 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; and
d. agreeing method of payment.

8.4.2 The Director of People 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; and
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 People 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; and
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 People's instructions and in the form prescribed by the Director of People; and
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 People 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 People 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 People 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; and
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; and
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; and
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); and

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, and
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 (PDC) 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; and

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.

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

11.1.5 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; and
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.

11.1.6 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 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;* and
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; and
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.

11.4.2 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; and
g. reporting, recording and safekeeping of cash, cheques and negotiable instruments.

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

11.4.4 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.

11.4.5 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.

11.4.6 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; and
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.

12.3.2 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; and
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.

13.2.3 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. 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 NHS Resolutions 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; and
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; and
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 Planning 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 region 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; and
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; and
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; and
   V. treatment of offers for personal gifts; and

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; and
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; and

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; and
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; and
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; and
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; and
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) 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); and
- the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and for disposals.

For tenders 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; or
e. where the requirement is covered by an existing contract; or
f. where NHS Supply Chain agreements are in place and have been approved by the Board of Directors; or
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; or
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; or
i. where specialist expertise is required and is available from only one source (also includes memberships/subscriptions/licences); or
j. 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; or
k. 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; or
l. 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; or
m. where allowed and provided for in the NHS Trust Capital Accounting Manual; or
n. Single source supplier – one accredited supplier for service; or
o. 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; or
p. Single source supplier – Original Equipment Manufacture's maintenance provision for existing equipment. Engagement with an alternative provider for the additional work would be impractical; or
q. Where it was necessary to obtain goods/services without raising a Purchase Order in advance and a retrospective order is required; or
r. 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; or
s. 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 17.3.1 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' and
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; and

    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; and

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) 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 shall be opened by the Director of Corporate Affairs 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 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 Director of Corporate Affairs. In the absence of the 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 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 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 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 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 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 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.

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.

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 incoming 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 (£4,000 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
Non-voting Director	4	Up to £49,999
A4C Band 8d/9	5	Up to £24,999
A4C Band 8b / 8c	6	Up to £9,999
A4C Band 8a	7	Up to £7,499
A4C Band 6 / 7	8	Up to £4,999
A4C band 4 / 5	9	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 (£4,000 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 £9,999
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 Leadership Committee
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 Leadership Committee =>£500k Board of Directors

* To be 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.

Scheme of Delegation

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
1. Corporate Affairs			
Approval of the Trust's Standing Orders and Reservations of Powers for the Board of Directors, Standing Financial Instructions and Scheme of Delegation of Powers (including variations and amendments)	Board of Directors	Director of Corporate Affairs	SO 1
Final authority in interpretation of Standing Orders	Chair, advised by Chief Executive and Director of Corporate Affairs	Chair, advised by Chief Executive and Director of Corporate Affairs	SO 1
Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Directors and employees	
Suspension of Standing Orders for the Board of Directors / Standing Financial Instructions	Board of Directors	Audit Committee	SO 3.15
Review suspension of Standing Orders for the Board of Directors / Standing Financial Instructions	Chief Executive	Director of Corporate Affairs	
Use of emergency powers relating to the authorities retained by the Board of Directors	Chairman & Chief Executive after having consulted with 2 NEDs & 2 Executive Directors	Chairman & Chief Executive after having consulted with 2 NEDs & 2 Executive Directors	SO 5.2
Advice on the interpretation or application of the Standing Financial Instructions	Director of Finance	Deputy Director of Finance	SFI 1
Advice on the interpretation or application of the Scheme of Reservation and Delegation of Powers	Director of Corporate Affairs	Head of Corporate Governance	SO 1
Establishment and Disestablishment of Formal Committees of the Board	Board of Directors	Director of Corporate Affairs	SO 4
Annual Report - Approval of Annual Report - Recommendation Annual Report for approval by Board of Directors - Preparation of Annual Report in line with DHSC Group Accouting Manual	 Board of Directors Audit Committee Director of Corporate Affairs	 Audit Committee Director of Corporate Affairs Head of Corporate Governance	RoP 3.6
Common Seal - Receipt of a bi-annual report on use of Common Seal - Authorise use of Common Seal - Custody of Common Seal and Register of all sealings	 Board of Directors Chair and Chief Executive Director of Corporate Affairs	 Director of Corporate Affairs Director of Corporate Affairs Head of Corporate Governance	SO 8
Register of Interests	Director of Corporate Affairs	Head of Corporate Governance	SO 6
Receiving Sponsorship	Board of Directors	Executive Leadership Committee	SO 7
Waiver of Standing Orders / Standing Financial Instructions	Director of Corporate Affairs/Director of Finance/Chief Executive	Head of Procurement	SFI 17
Approval of Strategies, Policies & Procedures	Board of Directors	Director of Coprorate Affairs	RoP 3.4
Appointment of Internal Auditors	Audit Committee	Director of Finance	SFI 2
Receiving Gifts and Hospitality	Director of Corporate Affairs	Head of Corporate Governance	SO 7
Partnership Arrangements – Memorandum of Understanding (MoUs)	Director of Corporate Affairs	Head of Legal Services & Head of Corporate Governance	SO 9
Annual Governance Statement	Chief Executive	Director of Corporate Affairs	SFI 2 & 20
Risk Management	Director of Corporate Affairs	Senior Risk and Assurance Manager	SFI 20 Risk Management Policy Risk Management Strategy
Freedom to Speak Up	Chief Executive	Director of Corporate Affairs	Freedom to Speak Up Policy
Claims: Employer's Liability, Public Liability and Medical Negligence	Director of Corporate Affairs	Head of Legal Services	SFIs: Losses, write off and Compensation Claims Policy
2. Finance			
Annual Accounts	Board of Directors	Audit Committee	RoP3, SFI 4 DHSC Group Accounting Manual Audit Committee Terms of Reference
Approval of Capital Programme	Director of Finance	Head of Technical Accounts	SFI 11
Approval of Individual Capital and PFI Schemes	Director of Finance	Head of Finance	SFI 11 and 17
Asset Register, Capital Charges and Security of Assets	Director of Finance	Head of Technical Accounts	SFI 11
Banking Arrangements and Cash	Director of Finance	Budget Holders	SFI 5
Budget Setting	Director of Finance	Deputy Director of Finance	SFI 3
Charitable Funds Expenditure	Board of Directors	Director of Finance	SFI 16
Charitable Funds Annual Accounts	Board of Directors	Director of Finance/Director of Corporate Affairs	SFI 16
External Borrowing	Director of Finance	Head of Technical Accounts	SFI 10
Healthcare Service and Financial Framework Agreements – Financial and Performance Monitoring Arrangements	Director of Finance	Head of Informatics/Head of Financial Planning	SFI 7
Healthcare Service and Financial Framework Agreements – Income	Director of Finance	Deputy Director of Finance	SFI 7
Investments	Board of Directors	Director of Finance	SFI 10
Other Income (including Income Generation)	Director of Finance	Head of Financial Planning	SFI 6
Petty Cash	Director of Finance	Senior Managers	SFI 9
Scheme of Budgetary Control	Chief Executive	Director of Finance	SFI 3
Fraud and Corruption	Board of Directors	Audit Committee	SFI 2
3. Strategy and Planning			
Business Planning	Director of Strategy and Planning	Head of Strategic Planning	
Reconfigurations of Services and Clinical Pathway Changes	Director of Strategy and Planning	Head of Service Development	
Freedom of Information	Director of Strategy and Planning	Head of Communications and Engagement	Freedom of Information & Environmental Regulations Policy Freedom of Information Act 2005

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Corporate Communications and Engagement	Director of Strategy and Planning	Head of Communications and Engagement	Communication and Engagement Strategy
Patient Engagement	Director of Strategy and Planning	Head of Communications and Engagement	Comunications and Engagement Strategy
Patient and Public Panel (patient involvement and engagement)	Director of Strategy and Planning	Head of Communications and Engagement	Communication and Engagement Strategy
Approval and Management of Projects: - Approval authority outlined in SFI Requirements to Obtain Quotes and Tenders	Director of Strategy and Planning	Head of PMO	SFI Requirement to obtain Quotes and Tenders (all Revenue and Capital items)
4. Service Delivery			
Resilience/Emergency Planning	Director of Operations	Head of Contingency Planning	Major Incident Response Plan v7 2020
5. Procurement			
Disposals - Board of Directors to approve disposal of land, buildings and equipment with a value in excess of £25,000 on completion of tender action. - Director of Finance to approval dispoal of surplus equipment between £2,500 and £24,999 on completion of competitive quottation process - Directors to approve disposal of surplus equipment with a value of up to £2,499	Director of Finance	Head of Procurement	SFI 13
Appointment of Consultants for the provision of Specialist Advice - Board of Directors to approve business cases for contracts with a whole life cost in excess of £50,000 (where costs are above £50,000 NHSE/I need to approve business case) - Executive Leadership Committee to approve business cases for whole life cost of up to £49,999	All Directors	Deputy Directors	SFI 17
Lease Car Arrangements	Director of Finance	Assistant Director Estates, Fleet and Facilities Management	
Authorisation of Purchase Orders	Director of Finance	Deputy Director of Finance	SFI: Annex A
Purchasing and New Tender Specification Authorisation	Director of Finance	Head of Procurement	SFI 17
Authorisation of Requisition Forms for goods and services (all Revenue and Capital): - £500,000 and above - Up to £499,999 - Up to £249,999 - Up to £99,999 - Up to £49,999 - Refer to Annex A of SFI for other levels	 Board of Directors Chief Executive Director of Finance Voting Directors Non-Voting Directors		SFI Annex A
Approval of Competitive Tendering Awards and Appointment of Tender Evaluation Panels - Refer to SFIs for Requirements to Obtain Quotes and Tenders	Director of Finance	Head of Procurement	SFI Requirement to obtain Quotes and Tenders (all Revenue and Capital items)
Pool Vehicle Arrangements	Director of Finance	Assistant Director Estates, Fleet and Facilities Management	Pool Vehicle Policy
Insurance (Motor and Workshops)	Director of Finance	Deputy Director of Finance	
6. Information Management			
Clinical Records Management - Overall accountabilty to ensure the Trust adheres to the Cllinical Records Management legislation, Trust Policies and procedures and NHS Standards - Review and agree internal protocols governing the protection and use of patient identifiable information by Trust staff - Ensure adoption and adherence to confidentiality policies and procedures are in line with Caldicott Guardian accountability	 Director of Quality Innovation & Improvement (SIRO) Medical Director (Caldicott Guardian) Medical Director (Caldicott Guardian)	 Head of Informatics Head of Informatics Head of Informatics	Clinical Records Management Policy & Procedure
Corporate Records Management	Director of Quality Innovation & Improvement (SIRO)	Head of Informatics	Data Protection and Security Policy
Disclosure of Patient Identifiable Information	Medical Director (Caldicott Guardian) & Director of Quality, Innovation & Improvement (SIRO)	Head of Informatics	
IM&T Systems Access Control	Director of Quality, Innovation and Improvement	Chief of Digital and Innovation	
Ambulance Quality Indicator Reporting	Director of Quality, Innovation and Improvement/Director of Operations/Medical Director	Chief of Digital and Innovation	
7. Quality, Innovation and Improvement			
Health, Safety and Security Management	Director of Quality, Innovation and Improvement	Head of Safety	Health, Safety & Security Policy Health and Safety A-Z Toolkit
Incident Reporting, Management and Investigation	Director of Quality, Innovation and Improvement	Chief Nurse	Incident Reporting Procedure Health, Safety & Security Policy Serious Incident Procedure Investigation Policy Reporting of Serious Incidents, Diseases and Dangerous Occurrences Regulations 1995 Blackpool CCG SI Policy
Clinical Effectiveness (Governance)	Medical Director	Chief Nurse/Chief Consultant Paramedic/Chief Pharmacist	Right Care Strategy Health Notifications and Alert Process v3 2019 Clinical Audit Policy
Medicine Management	Medical Director (CDAO)	Chief Pharmacist	NWAS Medicine Management Policy v5.1 2019
Clinical Safety Management	Director of Quality, Innovation and Improvement	Head of Clinical Safety	
Infection Prevention & Control	Chief Nurse (DIPC)	Head of Clinical Safety	Infection Prevention Policy Communicable Diseases Policy
Vulnerable Persons Management (Safeguarding)	Director of Quality, Innovation and Improvement/Chief Nurse	Head of Clinical Safety	Vulnerable Persons Policy
Clinical Delegation	Medical Director	Chief Consultant Paramedic	

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Complaints Management	Director of Quality, Innovation and Improvement	Chief Nurse	Complaints and External Procedure NHS Complaints Regs (SE 2004 No 1768) NHS Compalints Amended Regs 2006 (SI 2006 No 2084)
Single Oversight Framework	Director of Quality, Innovation and Improvement	Chief of Digital and Innovation	Single Oversight Framework NHS Information Governance Handbook
CQC Registration	Chief Executive (Nominated Individual)	Director of Quality, Innovation and Improvement	NHS 111 Provider Handbook
Quality Account	Director of Quality, Innovation and Improvement	Deputy Director of Quality	
8. Duties of Individuals			
Code of Conduct for NHS Managers	Chief Executive	Director of People	
9. Human Resources			
Recruitment and Appointments	Director of People	Deputy Director of OD	
Disciplinary Arrangements & Appeals - Refer to Disciplinary Policy and Procedure for decision making authority to apply disciplinary actions	Director of People	Senior Managers	Disciplinary Policy and Procedure
Grievance Procedure - Refer to Individual and Collective Grievance Policy and Procedure	Director of People	Senior Managers	Individual and Collective Grievance Policy & Procedure
Funded Establishment	Board of Directors	Chief Executive	
Remuneration and Conditions of Service	Nominations and Remuneration Committee	Executive Leadership Committee	
Payroll Processes: - Security and auding of all payroll processes - Establish procedures and documentation for new new starters, variations and terminations and other changes affecting payments to individuals - Agreement of dates and methods of payment - Management of payroll - Review contract for payroll services	 Director of Finance Director of People	 Deputy Director of Finance Deputy Director of OD	
Education and Learning	Director of People	Assistant Director Workforce & OD	
Performance Appraisal Policy & Procedure	Director of People	Assistant Director Workforce & OD	Performance Appraisal Policy and Procedure
Pay Progression Deferral	Director of People	Assistant Director Workforce & OD	Performance Appraisal Policy and Procedure
Sickness Warning Arrangements	Director of People	Deputy Directors/Senior Managers	Sickness Absence Procedure
Agency Rules	Director of People	Deputy Director of OD	Agency Rules - NHS Improvement March 2016

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North West Ambulance Service NHS Trust

REPORT

Board of Directors								
Date:	27 May 2020							
Subject:	Annual Self Certifications: General Condition FT4 – Corporate Governance Declaration							
Presented by:	Angela Wetton, Director of Corporate Affairs							
Purpose of Paper:	For Decision							
Executive Summary:	A review has been carried out for the Corporate Governance Statement as can be seen in the Appendix, and based on the evidence presented in the current arrangements the proposal is that the Board makes a positive declaration and declares 'Confirmed' to each clause and also confirms that no material risks have been identified.							
Recommendations, decisions or actions sought:	Approve the 'Confirmed' declarations and confirm that no material risks have been identified as described within this paper							
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
☒	☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

Although NHS trusts do not need to hold a provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate.

NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including conditions G6 and FT4) and must self-certify under these licence conditions.

2. FT4

Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4.

Before making the statement, providers should review whether their governance systems and processes enable them to achieve compliance with condition FT4.

A review of the Corporate Governance Statement has been undertaken and can be seen in the Appendix.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including conditions G6 and FT4) and must self-certify under these licence conditions.

4. RECOMMENDATIONS

The Board is recommended to:

- Approve the ‘Confirmed’ declarations and confirm that no material risks have been identified as described within this paper.

Corporate Governance Statement	Response	Current Arrangements	Risks & Mitigations
The Board is satisfied that North West Ambulance Service NHS Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	**CONFIRMED**	Compliance with Monitor's Code of Governance for Foundation Trusts, where applicable – reported to Audit Committee with evidence during Q3. The Trust's governance committee structures in place and reviewed on an annual basis – new governance structure implemented during Q1 2019/20. CQC 'good' rating following well-led inspection during Q2 2018/19. Unannounced inspections to PES and EOC service lines took place during Q4 2019/20. Final reports are awaited by the Trust. Trust expected the CQC to undertake a Well-Led Inspection end March 2020/beginning April 2020 however due to COVID-19 was postponed. CQC recognition of the Trusts fit and proper person test processes for board and senior staff. Internal audit review of Fit and Proper Persons in July 2019 resulted in High Assurance. Systems and controls assurances are obtained via the Audit Committee as described in the Annual Governance Statement 2019/20. The Trust has an internal audit programme and assurance cycle. The Head of Internal Audit Opinion for 2019/20 stated overall opinion of *'substantial assurance, can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.'* Effectiveness review of Board committees undertaken and reported to Board via Committee annual reports.	No material risk identified
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	**CONFIRMED**	A fundamental part of the Director of Corporate Affairs role is to ensure any guidance requirements and the impact on the Trust are disseminated to the Board either via the Chief Executive's bi-monthly report or a separate report. Any guidance requirements are routinely assessed and implemented as necessary - overview of guidance	No material risk identified

Corporate Governance Statement	Response	Current Arrangements	Risks & Mitigations
		provided by MIAA and KPMG in updates received at each Audit Committee meeting. Membership of NW FT Company Secretary network and NHS Providers Company Secretary Network.	
The Board is satisfied that North West Ambulance Service NHS Trust has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	**CONFIRMED**	Standing committees are established with clear lines of reporting. Board approved Terms of Reference are in place for all standing committees clearly stating responsibilities, reporting arrangements, memberships. Annual report from each committee is presented to the Board for assurance. Clear reporting lines within the Board, Executive and service areas provided through the Trusts governance framework Review of service delivery governance structures being undertaken to ensure accountabilities are appropriate across the Trust Standardised Chair's Assurance reports are in place to confirm assurance and escalate concerns in line with reporting structure. Annual Governance statement provides the Board with assurance surrounding the responsibilities of the Board and its committees. Outcome of Deloitte Well-led Review during Q3 2019/20 identified no major / significant issues relating to the governance of the organisation.	No material risk identified
The Board is satisfied that North West Ambulance Service NHS Trust has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the	**CONFIRMED**	a) Strong systems of financial governance in place. All statutory audits and reporting requirements fulfilled. All statutory and regulatory financial duties achieved during 2091/20. External Audit – Review of Value for Money arrangements. b) The Trust's IPR (seen bi-monthly at Board) provides assurance on delivery of the Annual Plan objectives and supports quality and performance improvement. The themes of the IPR reflect those of NHSI Single Oversight Framework.	No material risk identified

Corporate Governance Statement	Response	Current Arrangements	Risks & Mitigations
NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		c) Systems and processes in place to ensure compliance with national and local healthcare standards - internal and external assurance systems in place. CQC rated the Trust 'Good' in July 2018. d) Detailed financial plans in place and approved by the Board of Directors. Cost Improvement programme agreed with directorates. Internal Audit Plan includes review of financial systems Contracts, service level agreements and leases under constant review. Financial performance scrutinised via Resources Committee with Chair's Assurance Report to Board of Directors e) Committee structure fully serviced. Accurate, comprehensive, up-to-date information available for committees. f) Board Assurance Framework/Corporate Risk Register in place that identifies and ensures appropriate oversight of all principal and material risks. g) Corporate business planning arrangements in place. h) Applicable legal requirements, against principal objectives and activities of the organisation reviewed and managed appropriately as part of the corporate governance arrangements.	
The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	**CONFIRMED**	a) Robust appraisal and performance review arrangements in place at Board level (and throughout the organisation). NEDs and Associate NEDs individually bring extensive experience and expertise from many different areas of private and public sector activity including medical, finance, emergency services, governance, law and public health. b) Quality of care fully integrated within all planning and decision-making processes. Standardised risk	No material risk identified

Corporate Governance Statement	Response	Current Arrangements	Risks & Mitigations
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		assessment (Quality Impact Assessment) of all efficiency workstreams. c) (and d) Integrated Performance Reports include patient experience data and are presented bi-monthly to the Board of Directors and Quality and Performance Committee. Data accuracy audits reported and reviewed via Quality and Performance Committee. A Patient or Staff story is presented to the Board at the start of each Board Meeting and a Patient story is presented at each Quality and Performance Committee. e) Updated Quality (Right Care) Strategy approved by the Board in January 2020. The Quality and Performance Committee reviews performance against a suite of key quality indicators; standardised risk assessment (Quality Impact Assessment) of all efficiency workstreams, and robust arrangements for staff, patients and members of the public to raise concerns with respect to the quality of care including Freedom to Speak Up Guardian. Friends and Family Test systems in place. Comms and Engagement Strategy in place. Patient and Public Panel established during 2019/20. f) Clear accountability for quality of care throughout the Trust, systems of integrated governance allow for appropriate escalation to Board of Directors.	

Corporate Governance Statement	Response	Current Arrangements	Risks & Mitigations
The Board is satisfied that there are systems to ensure that North West Ambulance Service NHS Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**CONFIRMED**	NWAS' Establishment Order sets out required numbers for Board members. Established Nomination & Remuneration Committee (NARC) for Executive Director appointments and remuneration (ED) with Terms of Reference, with responsibility for review of Board composition. ED Job Descriptions and Person Specifications in place as developed via NARC. Workforce Strategy in place. Code of Conduct and suitable contractual arrangements in place for Board members, incorporating requirements relating to 'fit and proper persons'.	No material risk identified

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2019/20 | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material risk identified.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No material risk identified.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risk identified.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	No material risk identified.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.		[including where the Board is able to respond 'Confirmed']	Please Respond
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	No material risk identified.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	Signature
Name Peter White	Name Daren Mochrie

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

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North West Ambulance Service NHS Trust

REPORT

Board of Directors					
Date:	27 May 2020				
Subject:	Annual Self Certifications: General Condition 6 – Systems for Compliance with Licence Conditions				
Presented by:	Angela Wetton, Director of Corporate Affairs				
Purpose of Paper:	For Decision				
Executive Summary:	Although NHS trusts are not issued with a provider licence, they are required to self-certify whether or not they have complied with conditions equivalent to the licence that NHS Improvement has deemed appropriate: • Condition G6 (3): Providers must certify that they have taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution (Condition G6 (3))				
Recommendations, decisions or actions sought:	Approve this year's annual GC6 self-certification as described within this paper				
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
☒	☒	☒	☒	☒	☒	☒	☒	☒

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	**N/A**
Date:	**N/A**
Outcome:	**N/A**

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1. PURPOSE

Although NHS trusts do not need to hold a provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate.

NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including conditions G6 and FT4) and must self-certify under these licence conditions.

2. GENERAL CONDITION 6

General Condition 6 within the Licence requires providers to have in place effective systems and processes to ensure compliance with licence conditions and related obligations.

A management review has been undertaken confirming compliance with General Condition 6 of the NHS Provider Licence (Appendix 1).

The Trust is required to publish a G6 self-certification (Appendix 2) by 31st May 2020.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

Although NHS trusts do not need to hold a provider licence, directions from the Secretary of State require NHS Improvement to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate.

4. RECOMMENDATIONS

The Board is recommended to:

- Approve this year's annual GC6 self-certification as described within this paper

General Condition 6	Current Arrangements / Evidence
The Licensee shall take all reasonable precautions against the risk of failure to comply with: (a) the Conditions of this Licence, (b) any requirements imposed on it under the NHS Acts, and (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.	The NWAS Operational and Financial Plans 2019/20, submitted to NHSI on 4th April 2019, comprised of a series of statements, templates and declarations, including the Finance, Activity and Performance Trajectory, Workforce and Triangulation returns. The submission included a narrative which reflected Year 1 of the 5 year Integrated Business Plan, building on the Trust strategy and Vision to be the Best ambulance Service in the UK by achieving the strategic goals of delivering the Right Care at the Right time in the Right Place, Every Time. This overarching plan echoes the Right Care (Quality) Strategy and the Urgent & Emergency Care (Right Time, Right Place) Strategy. The planning process highlighted the vital areas of development over the next five years, together with key enablers which will be required from the Every Time strategies and work-plans such as: Workforce, Digital, Estates, Fleet, Business Development, Communications and Engagement; and STP engagement. During 2019/20, the Trust achieved all of the statutory and regulatory financial duties; the 2019/2020 financial plan for Q3 included expenditure directly related to COVID-19 which is reported directly to NHSE/I as per national guidance. The draft Operational and Financial Plans 2020/21 were submitted to NHSE/I on 5th March 2020, however, due to COVID-19, on 17th March 2020 NHSE/I provided notification in relation to the next steps on NHS response to COVID-19 which included guidance on the amended financial arrangements for the period 1 April 2020 to 31 July 2020. The Trust has established emergency budgets and financial plans for this period. Further guidance from NHSE/I was also received on 28th March 2020 advising a pause relating to the Long Term Plan operational planning as a result of COVID-19. The Board Assurance Framework assesses risk to delivery and provides assurance on delivery of the Trust's objectives. Annual reviews are undertaken against the Trust's core governance documents 1) Standing Orders and Reservations of Powers to the Board 2) Scheme of Delegation and 3) Standing Financial Instructions. The Trust also takes account of the FT Code of Governance and is reported bi-annually to the Audit Committee. Committee Terms of Reference are also reviewed on an annual basis to assess that all functions delegated by the Board have been undertaken. NWAS has a Risk Management Strategy and Policy in place, authorised by the Board. This provides a framework for managing risks across the Trust, which is consistent with best practice and Department of Health guidance. The Strategy describes the framework that enables the Board to gain

General Condition 6	Current Arrangements / Evidence
	assurance across organisational delivery systems and how exceptions are escalated. It also contains a risk appetite statement that describes the level of risk the Board is prepared to take in order to achieve the Trust's strategic objectives. The Policy seeks to provide a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation for the benefit of patients, staff, visitors and other stakeholders. NWAS is registered with the Care Quality Commission and systems exist to ensure compliance with the registration requirements, detailed in the respective Annual Governance Statements. On 25th February 2020, the CQC undertook unannounced inspections to the PES and EOC service lines over a period of three days. Final reports are awaited by the Trust. Additionally, a Well-Led inspection was planned for 31st March 2020 until 2nd April 2020 however due to COVID-19 was postponed. The Trust maintains an overall CQC rating of 'Good' following the Well-Led inspection in June 2018. 2019/20 Corporate Governance Statements – Reviewed by the Board of Directors, with no material risks identified. Audit Committee received a summary of the Trust's corporate governance arrangements and compliance against the FT Code in October 2019. Updates will be provided to the Audit Committee twice a year. Audit Committee considered and approved the Internal Audit Plan for 2019/20 (April 19). The Internal Audit Plans are risk based, with an ongoing programme of internal audits in finance, operations and governance. During the course of the year, Audit Committee monitored progress against the Internal Audit Plans and reviewed the work and findings of the Internal Auditor. The Internal Audit Assurance Framework Review 2019/20 confirmed that: 1. the organisation's Assurance Framework is structured to meet the NHS requirements 2. is visibly used by the organisation 3. clearly reflects the risks discussed by the Board.' 4. Identifies controls and assurances are relevant. NWAS' Annual Report and Annual Accounts 2019/20 – Prepared in accordance with DoH Group Accounting Manual and subsequent guidance from NHSE/I relating to streamlined reporting as a result of COVID-19. The Audit Committee have received valuable insight and benchmarking information from the External Auditors. Due to the extended deadlines to submit the Annual Report and Accounts 2019/20 by 25 June 2020, the Audit

General Condition 6	Current Arrangements / Evidence
	Committee will receive their findings following the audit of the Annual Report and Accounts in June 2020. NWAS Quality Report 2019/20 – Prepared in line with requirements for Quality Reports 2019/20. Due amended regulations as a result of COVID-19 NHS Providers have a revised deadline of 15 December 2020. Submission of compliance reports to NHS Improvement as required.
Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include: (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and (b) regular review of whether those processes and systems have been implemented and of their effectiveness.	The Board Assurance Framework, is based on six key elements: • Clearly defined and agreed strategic objectives together with clear lines of responsibility and accountability; • Clearly defined key strategic risks to the achievement of these objectives together with assessment of their potential impact and likelihood; • Key controls by which these risks can be managed, this includes involvement of stakeholders in agreeing controls where risks impact on them; • Management and independent assurances that risks are being managed effectively; • Board level reports identifying that risks are being reasonably managed and objectives being met together with gaps in assurances and gaps in risk control; • Board level action plans which ensure the delivery of objectives, control of risk and improvements in assurances. The workplan of committees is linked so that the Board of Directors is assured that there is an aligned independent and executive focus on strategic risk and assurance. Routine referral of issues exists between committees ensuring a respective understanding of risk and assurance concerns. The Board of Directors oversees the management of all significant risks, which are actively addressed by the Executive Leadership Committee. The NWAS Corporate Risk Register is considered alongside the Board Assurance Framework thereby ensuring that risks are not only managed and communicated efficiently, but that the management of them is embedded in the Trust's practice. The NWAS Board Assurance Framework and Corporate Risk Register are reviewed on a quarterly basis by the Board of Directors and monthly by the Executive Leadership Committee. Key controls and assurances, and any identified gaps are reviewed and action plans developed and progressed accordingly. Annual Corporate Governance Statements – Reviewed by Board, May 2020 confirming "The Board had extensive and effective governance assurance

General Condition 6	Current Arrangements / Evidence
	systems in operation enabling the identification and control of risks reported through the Board Assurance Framework and Corporate Risk Register. Internal and external reviews, audits and inspections had provided sufficient evidence to state that no significant internal control issues have been identified during 2019/20, and that these control systems are fit for purpose." The NWAS financial plan is approved by the Board of Directors and is subsequently submitted to NHS Improvement. The plan, including forward projections, is monitored on a bi-monthly basis by the Resources Committee and key performance indicators and financial sustainability metrics are also reviewed bi-monthly by the Board of Directors. Standardised risk assessment (Quality Impact Assessment) of all productivity improvement workstreams. Board of Directors and/or Audit Committee review of: − Register of Interests to ensure compliance with the Trust's Standards of Business (bi-monthly) − The arrangements by which staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure arrangements are in place for the proportionate and independent investigation of such matters and appropriate follow-up action (quarterly) − Anti-Fraud Plans and Reports (quarterly) − Internal Audit Annual Programme, progress reports and audit outcomes (quarterly) − All risk and control related disclosure statements in particular the Annual Governance Statement, Corporate Governance Statement, together with the accompanying Head of Internal Audit statement and External Audit Opinion (annually)

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Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | 2019/20 | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Peter White	**Name**	Daren Mochrie
Capacity	Chairman	**Capacity**	Chief Executive
Date	27 May 2020	**Date**	27 May 2020

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27 May 2020			
Subject:	Use of Common Seal 2019/20 Annual Report			
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 24 April 2019. During the period 1 April 2019 – 31 March 2020, the Trust's Common Seal was applied on a total of 20 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. • Note compliance with s8 of the Standing Orders			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):		
SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

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 2019/20.

2. USE OF 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 2019 – 31 March 2020, the Trust's Common Seal was applied on a total of 13 occasions. These were:

Reg No	Date	Reason
122	4 March 2019	Warranties for the new Burnley Ambulance Station
123	24 April 2019	Electricity Supply for new Burnley Ambulance Station
124	25 June 2019	Sale of land at Glossop Ambulance Station
125	25 June 2019	Licence to Alter Leased premises at PTS Oldham
126	15 July 2019	Sale of Formby Ambulance Station
127	15 July 2019	Licence for Alterations – Estuary Point
128	16 September 2019	Lease of space at Ladybridge Hall to Bolton Mountain Rescue Team
129	22 October 2019	Lease of Burnley Ambulance Station
130	22 October 2019	Sale of Nelson Ambulance Station
131	14 November 2019	Preston Ambulance Station
132	27 November 2019	Former Darwen Ambulance Station – Deed of Covenant transferred
133	17 January 2020	Lease of Parkway 4
134	20 February 2020	Lease for temporary use of Station Helen's Fire 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 requires the signatures of both the Chairman and Chief Executive 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 8 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 2019/20.
- Note compliance with s8 of the Standing Orders

North West Ambulance Service NHS Trust

Board of Directors	
Date:	27th May 2020
Subject:	Quality and Performance Committee Annual Report & Terms of Reference
Presented by:	Prof A Chambers, Chair, Quality and Performance Committee
Purpose of Paper:	For Decision
Executive Summary:	Section 4 of the terms of reference requires that the Committee evaluates its own membership and reviews the effectiveness and performance of the group and recommend any changes to the Board of Directors for approval. The terms of reference have been reviewed and a number of minor amendments have been made- • Format • Name of parent committee (following review of committee structure in July 2019), • Membership – removal of Director of Finance. • Duties and interrelations. The committee effectiveness review highlighted that the group has met the majority of its remit and functions. However, a number of key improvements have been identified: • Timeliness of submission of some of the reports. • Assurance reports to be presented to the Audit Committee during 2020/21, in relation to the Clinical Audit Plan. • Quality of content of assurance reports from management groups. • Reporting assurance in relation to medical devices. • Reporting against the Research and Development Strategy. • A deep dive will be included as a standing agenda item for committees during 2020/21, which will be linked to the risks listed on the BAF, pertinent to this committee.
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Review the Quality and Performance Committee Annual Report,

	• Approve the Quality and Performance Committee Terms of Reference, • Note and support the recommendation to the Director of Corporate Affairs to amend the Scheme of Delegation prior to approval by the Board of Directors that complaints are reported to the Safety Management Group, in conjunction with reporting against the Right Care Strategy, and • Note and support the recommendation to the Director of Corporate Affairs to include the process for approving Memorandum of Understanding in the Scheme of Delegation prior to approval by the Board of Directors.			
Link to Strategic Goals:	**Right Care**	☐	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):		
SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	
Previously Submitted to:	Quality and Performance Committee
Date:	20/04/20
Outcome:	Recommendation to Board of Directors for review and approval.

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1 PURPOSE

The purpose of this report is to formally report to the Board of Directors on the work of the Quality and Performance Committee during the period 1st April 2019 to 31st March 2020 and to set out how it has met its terms of reference and priorities.

2 BACKGROUND

Section 4 of the terms of reference requires that the Quality and Performance Committee evaluates its own membership and reviews the effectiveness and performance of the group and recommend any changes to the Board of Directors for approval.

3 ROLE OF THE QUALITY AND PERFORMANCE COMMITTEE

The purpose of the Committee is to provide the Board with assurance on all aspects of quality, safety and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

4. **COMMITTEE MEMBERS AND ATTENDANCE**

At its meeting held on the 29th May 2019, the Board of Directors approved a recommendation that the Quality Committee and the Performance Committee merge to become the Quality and Performance Committee and meet on a monthly basis.

Meetings of the Quality and Performance Committee have been held as scheduled in the corporate calendar. There has been no instances where a quorum was not present. Details of meeting attendance based on the membership set out in the terms of reference, are shown below.

Meetings of the Quality Committee were held as scheduled. The Performance Committee scheduled to be held on the 21st May 2019 was cancelled.

Quality and Performance Committee								
	17th June	15th July	16th September	21st October	18th November	20th January	17th February	9th March
Maria Ahmed	☒	✓						
Richard Groome	✓	✓	✓	✓	✓	✓	☒	✓
Peter White		✓ (observing)	✓ (observing)					
David Rawsthorn								
Maxine Power	✓	✓	✓	✓	☒	✓ (Telecom)	✓	✓
Ged Blezard	✓	✓	✓	✓	✓	✓	✓	☒
Chris Grant	✓	☒	✓	✓	✓	✓	☒	✓
Michael Forrest	✓	✓	☒	✓	☒	✓	☒	✓
David Hanley	✓	✓	✓	✓	✓	✓	✓	✓
Rod Thomson			✓	✓	✓ (Telecom)	✓ (Telecom)	✓	✓
Alison Chambers			✓	✓	✓	✓	✓	✓
Carolyn Wood	✓	✓	✓	☒	✓	✓	☒	✓

Quality Committee		
	8th April	13th May
Maria Ahmed	✓	✓
Richard Groome	☒	✓
Peter White	✓	
David Rawsthorn	✓	✓
Maxine Power	✓	✓
Ged Blezard	✓	✓
Chris Grant	☒	✓
Michael Forrest		
David Hanley		
Rod Thomson		
Alison Chambers		
Carolyn Wood	✓	✓

Performance Committee	
	21st May
Peter White	Cancelled
Richard Groome	
Carolyn Wood	
Ged Blezard	
Lisa Ward	

5 QUALITY AND PERFORMANCE COMMITTEE SELF-ASSESSMENT

The current terms of reference have been reviewed by the Quality and Performance Committee. The Board should note that the majority of the functions set out within the terms of reference have been discharged however the following points should be noted by the Board:

5.1 - Strategic Risks
The committee receives a risk update at every meeting and members monitor and consider the risks within the Board Assurance Framework that are relevant to the committees remit. The agenda is also structured around the BAF and reports presented clearly articulate which strategic risk it relates to.

A deep dive will be included as a standing agenda item for committees during 2020/21, which will be linked to the risks listed on the BAF, pertinent to this committee.

5.2 - Quality (Right Care Strategy)

The committee receives regular updates in relation to progress being made in relation to the Right Care Strategy.

In addition, dedicated reports in relation to (i) complaints, (ii) incident reporting, (iii) health, safety and security, (iv) safeguarding, (v) infection, prevention and control, and (vi) medicines management are received by the Committee on a bi-annual basis.

The quality of reports presented the committee continues to improve.

Regular CQC updates are presented to the committee including updates against actions pertinent to this committee.

5.3 - Clinical Audit Plan

The committee approves and receives progress reports against the annual clinical audit programme. Assurance reports to be presented to the Audit Committee during 2020/21.

5.4 Research and Development

Updates in relation to the Research and Development Strategy were not presented to the Committee during 2019/20.

A new substantive Research and Development Manager is now in post and will review and refresh the Strategy for onward reporting to this committee.

5.5 Performance

The Committee receives regular reports in relation to PES, 111 and PTS performance.

The Integrated Performance Report will be reported to meetings of this committee alternate to meetings of the Board.

Quarterly updates are received in relation to Community First Responders.

5.6 Urgent and Emergency Care Strategy

The Committee has received regular updates in terms of development the strategy and approved the implementation plan.

Progress against delivery of the strategy will be received by the committee during 2020/21

5.7 Management Groups

The Clinical Effectiveness Management Group, Safety Management Group and Non-Clinical Learning Forum all report into the Quality and Performance Committee. Regular assurance reports are received by the committee.

An annual report from each management group was presented to the Quality and Performance Committee and the following was noted:

Clinical Effectiveness Management Group:

The group has met the majority of its functions. Meetings of the group have been held as scheduled in the corporate calendar and there has been no instances where a quorum was not present. Attendance from some of the members requires improvement and this will be monitored by the Chair during 2020/21.

Reporting in terms of clinical governance activities within PES/EOC/111 is not consistent. To improve reporting, a report template has been produced and co-ordinated by the Strategic Business Support Officer for sectors and work streams. The report will provide a general update for the reporting period, details of any statistics/themes and trends overview of the trends in clinical incident reporting, complaints and external incidents, learning that is identified and any risks.

No assurance reported in relation to the management of patient care improvement focus areas (mental health, falls and frailty). There is currently no resource aligned to the falls and frailty work stream.

The 2018/19 Quality Account was circulated to members of the Group, for comment. The Quality Account should be reported to the Group and will be picked up during 2020/21.

No evidence has been captured in terms of how the group provides advice on clinical practice activities within the Trust including clinical training activities and all clinical protocols, practices and procedures. This will be addressed during 2020/21.

Throughout the year, the group has received and approved Memorandum of Understanding (MoU), relating to clinical governance, clinical care and joint working. Therefore the group recommended to the Director of Corporate Affairs to include the process for approving Memorandum of Understanding in the Scheme of Delegation prior to approval by the Board of Directors.

Safety Management Group:

The group has met the majority of its functions. Meetings of the group have been held as scheduled in the corporate calendar and there has been no instances where a quorum was not present. Attendance from some of the members requires improvement and this will be monitored by the Chair during 2020/21.

Assurance in relation to the Patient Transport Service (PTS) will be reported to the Safety Management Group.

No assurance reported in relation to medical devices. The Management and Accountability of Medical Equipment Procedures is in place and a recent discussion at the ROSE indicated reports should be via the Safety Management due to (i) patient safety, and (ii) health and safety implications of devices. This element will be included within the remit for the Safety Management Group during the interim period whilst a permanent solution is developed.

Duplication of complaints reporting between the Clinical Effectiveness Management Group and the Safety Management Group has resulted in sporadic reporting. Therefore, it was recommended to the Director of Corporate Affairs to amend the Scheme of Delegation prior to approval by the Board of Directors that complaints are reported to the Safety Management Group, in conjunction with reporting against the Right Care Strategy.

Clinical related complaints will continue to be reported to the Clinical Effectiveness Management Group within the PES report. The group will also receive exception reports from the Safety Management Group if and when any issues arise.

There is no evidence captured in relation to how risks are managed in some areas across both management groups and therefore, a dedicated risk report will be presented to both management group meetings throughout 2020/21.

Non-Clinical Learning Forum

The forum has met the majority of its functions. Meetings of the Forum have been held as scheduled in the corporate calendar. There has been no instances where a quorum was not present. Attendance from some of the members requires improvement and this will be monitored by the Chair during 2020/21.

Evidence in terms of learning that is identified and then cascaded and embedded throughout the organisation can be found on the in the 'Green Room'. This lists the Lessons Learnt Newsletters that have been produced for staff, over time. There is an opportunity to improve in this area, to further understand if the learning is in fact being embedded.

6 IMPROVEMENTS/KEY LEARNING THE QUALITY AND PERFORMANCE COMMITTEE CAN TAKE INTO 2020/21

For 2020/21, the following areas could be improved:

- Timeliness of submission of some of the reports.
- Assurance reports to be presented to the Audit Committee during 2020/21, in relation to the Clinical Audit Plan.
- Quality of content of assurance reports from management groups.
- Reporting assurance in relation to medical devices.
- Reporting against the Research and Development Strategy.

- A deep dive will be included as a standing agenda item for committees during 2020/21, which will be linked to the risks listed on the BAF, pertinent to this committee.

7 TERMS OF REFERENCE

The Group has reviewed the Terms of Reference and proposed a number of changes, included at appendix a. The changes relate to:

- Format,
- Name of parent committee (following review of committee structure in July 2019),
- Membership – removal of Director of Finance,
- Duties and Interrelations.

8 LEGAL and/or GOVERNANCE IMPLICATIONS

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

The revised terms of reference will require approval from the Board of Directors.

9 RECOMMENDATIONS

The Board of Directors is recommended to:

- Review the Quality and Performance Committee Annual Report,
- Approve the Quality and Performance Committee Terms of Reference,
- Note and support the recommendation to the Director of Corporate Affairs to amend the Scheme of Delegation prior to approval by the Board of Directors that complaints are reported to the Safety Management Group, in conjunction with reporting against the Right Care Strategy, and
- Note and support the recommendation to the Director of Corporate Affairs to include the process for approving Memorandum of Understanding in the Scheme of Delegation prior to approval by the Board of Directors.

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NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE - QUALITY AND PERFORMANCE COMMITTEE

CONTENTS

1. ROLE AND PURPOSE

The Quality and Performance Committee has been established as a formal committee of the Board of Directors. The purpose of the Committee is to provide the Board with assurance on all aspects of quality, safety and operational performance including delivery, governance, clinical risk management, research & development and the regulatory standards of quality and safety ~~relating to the provision of care and services in support of getti~~thereby ensuring~~ng~~ the best clinical outcomes and experience for patients.

The Chair of the Committee will report in writing to the Board of Directors a summary of the business that has been transacted and basis for any recommendations made. 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.

2. MEMBERSHIP

The Committee shall comprise the following membership:

- Three Non-Executive Directors – one of whom shall be the nominated Chair and one with relevant clinical experience
- Director of Quality, Innovation & Improvement
- Medical Director
- Director of Operations
- Deputy Chief Executive
- Clinical Associate Non-Executive Director

The following officers shall be invited ~~routinely~~ to attend meetings of the Committee in an advisory capacity when agenda items require them to be present. They are not routinely required to attend:

- Chief Consultant Paramedic
- Chief Pharmacist
- Chief Nurse

- Associate Medical Director (111)
- Deputy Director of Quality
- Deputy Director of Operations
- Head of 111
- Head of PTS
- Strategic Head of Emergency Operation Centres

There is an expectation that members will attend a minimum of 8 out of 10 ~~75% of~~ Committee meetings during each financial year.

In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting.

Other Officers of the Trust shall attend at the request of the Committee in order to present and provide clarification on agenda items, and with the consent of the Chair will be permitted to participate in the debate.

The quorum necessary for the transaction of Committee business shall be five, which is to include at least two Non-Executive Directors, which may include the Associate Non-Executive Director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the powers exercisable by the Committee.

3. ACCOUNTABILITY

Quality and Performance Committee authority is as set out in the NWAS Scheme of Delegation.

4. REVIEW ARRANGEMENTS

The Committee will identify annual objectives of the Committee, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Committee's terms of reference and a review of the effectiveness of the committee. Any changes to the Terms of Reference must be recommended to the Board of Directors for approval.

Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance Department providing administrative support to the Committee. Any concerns in relation to compliance will be reported to the Chair of the Committee and the Director of Corporate Affairs. In addition, the annual review will include a summary on compliance with the Terms of Reference.

5. WORKING METHODOLOGY

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.

The Committee will normally meet on a monthly basis and as a minimum ten times per year. The Chair may, however, call a meeting at any time provided that notice of the meeting is

given.

The Committee shall be supported administratively by the Corporate Governance Department, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Committee on pertinent areas.

The minutes of meetings shall be formally recorded by a member of the Corporate Governance Department, checked by the Chair and submitted for agreement at the next meeting, whereupon they will be signed by the person presiding at it.

6. DUTIES AND INTERRELATIONS

The Quality & Performance Committee shall :

Quality

Assure the Trust's maintenance of compliance with the Care Quality Commission registration through assurance of the systems of control, with particular emphasis on the Fundamental Standards of quality and safety – including Duty of Candour; Complaints; Medical Devices etc

Oversee and assure the Board on statutory and mandatory requirements, relating to quality of care e.g. Friends & Family Test, incidents and serious incidents etc

Oversee and seek assurance on effective systems for safety within the Trust, with particular focus on; patient safety and wider health & safety requirements.

Oversee and seek assurance on the effectiveness of the clinical systems developed and implemented by the Clinical Effectiveness Management Group to ensure they maintain compliance with the Care Quality Commission' Fundamental Standards of quality & safety

Oversee and seek assurance on the Trust's arrangements for compliance with obligations for the protection of children and vulnerable adults (safeguarding); and the Trust's effective participation in partnership arrangements;

Oversee and seek assurance on the systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control;

Oversee and seek assurance on the systems in place to ensure compliance with statutory and regulatory requirements for medicines management (Medicines Act (1968) and Controlled Drugs (Supervision of Management and Use) Regulations (2013))

Approve the annual Clinical Audit programme, monitor compliance on a regular basis and provide assurance to the Audit Committee of delivery and its effectiveness;

Oversee the preparation of the Trust's Quality Account and recommend to the Board of Directors for approval;

Oversee and seek assurance on the clinical impacts from transforming the provision of Trust services and ensure that all efficiency programmes have had a quality impact assessment

Performance

Monitor performance positions for PES, PTS, 111 and Urgent Care and the trajectories for each including a predicted year end position and seek assurance on any performance improvement plans,

Seek assurance on the performance contribution from each of the resource components, including complementary resources and consider the value for money,

~~Seek performance assurance from the planning, in relation to known or potential activity fluctuations/events/incidents,~~

Consider and review resilience performance against national and local resilience standards, including Business Continuity Management,

Seek assurance on the robustness and effectiveness of the Trusts Strategic Winter Plan, Tactical Winter Plan; Flu Pandemic Plan and Easter Plan and commission any post-incident reviews~~,~~

~~To receive an overview of the Complementary Resource Department performance contribution and benefits brought to patient care and outcomes.~~

General

Seek assurance on delivery of milestones against the following strategies and any subsequent action plans:

- Right Care Strategy,
- Research & Development Strategy,
- Urgent and Emergency Care Strategy,

The Chair of the Committee shall maintain an effective relationship with the Chair of the Audit Committee and may, from time to time, refer matters to the Audit Committee and / or other Board Committees as appropriate for consideration.

7. DELEGATED AUTHORITY

The Committee is authorised by the Board to:

Investigate any activity within its terms of reference

Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee

Obtain independent professional advice, having due regard to recognised Trust procedures, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. INWARD REPORTING ARRANGEMENTS

The Committee shall receive Chair Assurance Reports from meetings of the following Management Groups:

- Clinical Effectiveness Management Group
- Safety Management Group
- Non-Clinical Learning Forum
- Review of Serious Events (ROSE) Bi-annually.

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North West Ambulance Service NHS Trust

Board of Directors				
Date:	27th May 2020			
Subject:	Resources Committee Annual Report & Terms of Reference			
Presented by:	Mr M O'Connor, Chair, Resources Committee			
Purpose of Paper:	For Decision			
Executive Summary:	Section 4 of the terms of reference requires that the Committee evaluates its own membership and reviews the effectiveness and performance of the group and recommend any changes to the Board of Directors for approval. The terms of reference have been reviewed and a number of minor amendments have been made- • Format • Name of parent committee (following review of committee structure in July 2019), • Duties and interrelations. The committee effectiveness review highlighted that the group has met its remit and functions. However, a number of improvements have been identified: • Timeliness of submission of some of the reports. • Assurance purview to be reviewed by the committee. • A deep dive will be included as a standing agenda item for committees during 2020/21, which will be linked to the risks listed on the BAF, pertinent to this committee. • Assurance reports to be received from the (i) Cost Improvement Management Group, (ii) Capital Management Sub Group and (iii) Sustainable Sub Group.			
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Review the Resources Committee Annual Report, • Approve the Resources Committee Terms of Reference,			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):		
SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	
Previously Submitted to:	Resources Committee
Date:	20/03/20
Outcome:	Recommendation to Board of Directors for review and approval.

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1 PURPOSE

The purpose of this report is to formally report to the Board of Directors on the work of the Resources Committee during the period 1st April 2019 to 31st March 2020 and to set out how it has met its terms of reference and priorities.

2 BACKGROUND

Section 4 of the terms of reference requires that the Resources Committee evaluates its own membership and reviews the effectiveness and performance of the group and recommend any changes to the Board of Directors for approval.

3 ROLE OF THE RESOURCES COMMITTEE

The Resources Committee has been established as a formal committee of the Board of Directors. The purpose of the Committee is to obtain assurance on behalf of the Board of Directors that the Trust's business, financial, digital and workforce plans are viable and that risks have been identified and mitigated. The Committee will monitor governance arrangements established to address internal and external service developments and will seek assurance on the delivery of corporate projects. The Committee will also seek assurance and advise the Board accordingly on subjects relating to employees and volunteers.

4. **COMMITTEE MEMBERS AND ATTENDANCE**

At its meeting held on the 29th May 2019, the Board of Directors approved a recommendation that the Finance, Investment and Planning Committee and the Workforce Committee merge to become the Resources Committee and meet on a bi-monthly basis.

Meetings of the Resources Committee have been held as scheduled in the corporate calendar. There has been no instances where a quorum was not present. Details of meeting attendance based on the membership set out in the terms of reference, are shown below.

Meetings of the Finance, Investment and Planning Committee and Workforce Committee were held as scheduled.

FIPC	Resources Committee					
	20th May	**26th July**	**23rd September**	**22nd November**	**24th January**	**20th March**
Michael O'Connor	✔	✔	☒	✔	✔	✔
David Rawsthorn	✔	✔	✔	✔	✔	✔
Richard Groome		☒	☒	✔	✔	☒
Carolyn Wood	✔	Michelle Brooks	✔	✔	✔	✔
Ged Blezard	✔	✔	✔	☒	☒	☒
Maxine Power	✔	✔	☒	✔	✔ Part	☒
Salman Desai	✔	✔	☒	✔	✔	☒
Lisa Ward	✔	✔	✔	✔	✔	✔
Clare Wade		✔	✔	✔	✔	✔

Workforce Committee	
	23rd April
Peter White	✔
Richard Groome	✔
Carolyn Wood	✔
Ged Blezard	✔
Lisa Ward	✔

5 RESOURCES COMMITTEE SELF-ASSESSMENT

The current terms of reference have been reviewed by the Resources Committee. The Board should note that during 2019-20 all functions set out within the Terms of Reference have been discharged.

It was noted that the composition of the committee membership has greatly improved, that now included a Non-Executive Director with digital expertise.

5.1 Strategic Risks

The committee receives a risk update at every meeting and members monitor and consider the risks within the Board Assurance Framework that are relevant to the committees remit. The agenda is also structured around the BAF and reports presented clearly articulate which strategic risk it relates to.

A deep dive will be included as a standing agenda item for committees during 2020/21, which will be linked to the risks listed on the BAF, pertinent to this committee.

5.2 Financial Plans

The Committee receives a host of finance reports, allowing members to monitor the holistic financial position of the Trust.

All contract award proposals (in line with the Scheme of Delegation and Standing Financial Instructions) were reviewed by the committee, prior to recommendation for approval by the Board of Directors.

Regular updates are presented to the committee in relation to long term financial plans.

Members receive updates in relation to the Cost Improvement Programme (CIP) and progress against this. The CIP Steering Group currently reports in the Executive Leadership Committee and therefore consideration is required to the group reporting into this committee.

The committee is pro-active in terms of reviewing contracts/bids, escalating issues to the Board of Directors as appropriate.

5.3 Fleet and Estates

The Fleet Strategy 2019 – 2024 was presented to the committee, prior to submission to the Board of Directors for approval. In addition, regular updates are presented in relation to fleet including vehicle servicing and inspections, insurance, vehicle replacement programme, carbon reduction strategy and waste assurance.

The committee received assurance in relation to estates including NHS sites, progress against NHS Carbon Reduction Strategy, NHS Carbon Reduction Strategy and Benchmark measures utilising the "Model Ambulance Trust". The Estates Strategy implementation will be discussed at the Board of Directors Development Session being held in April and this committee will have responsible to monitor progress against the implementation plan.

5.4 Digital and Innovation

Regular updates are presented to the committee in relation to progress against the Digital Strategy. Updates have also been presented in relation to major schemes including the Unified Communications Programme and Electronic Patient Record System.

Regular Chairs assurance reports are submitted to the committee by the Chair of the Information Management Group.

5.5 Workforce

Regular updates in relation to progress against the Workforce Strategy are presented to the committee and members monitor performance against key workforce indicators.

The committee plays a key role in relation to monitoring progress against equality and diversity goals arising from the Equality Delivery System and has reviewed reports in relation to EDI goals and WRES.

During 2019/20 the committee received assurance in relation to the management of volunteers.

5.6 Strategy

The committee receives regular updates in relation to delivery against the Integrated Business Plan.

At the Board of Directors meeting held on 31st July 2019, a request was made that progress against the recommendations made by Lord Carter be reviewed by the Resources Committee. Therefore, reporting commenced from this date.

5.7 Management Groups

The Information Management Group reports into the Resources Committee. Regular assurance reports are received by the committee.

Following a review of the integrated governance structure, a number of management groups have been identified that should report into this committee including (i) Cost Improvement Management Group, (ii) Capital Management Sub Group and (iii) Sustainable Sub Group.

The committee received an annual report from the Information Management Group and the following was noted:

Information Management Group:

The group has met all of its functions. Meetings of the group have been held as scheduled in the corporate calendar and there has been no instances where a quorum was not present. Attendance from some of the members requires improvement and this will be monitored by the Chair during 2020/21.

The Group has responsibility to monitor levels of performance and compliance against the Data Security and Protection Toolkit. Regular assurance reports are presented to the Group including progress against the assertions.

The Group discusses all risks that are linked to SR07 (Digital).

The Group receives regular reports in relation to performance against KPIs for Freedom of Information legislation, Subject Access Requests and Data Protection Requests

The Trust received an overall "reasonable" (Second highest) rating for data protection compliance from a voluntary mini audit conducted by the Information Commissioner's Office. The Group receives regular assurance reports in relation to progress against the action plan and is reported in the assurance report to the Resources Committee.

The ICT Department has re-established an IT Security Forum that will make decisions and provide assurances on behalf of the Information Management Group on all aspects of information technology security within the Trust. Regular assurance reports are presented to the Group.

The Terms of Reference indicates that the Group will be joined by the Caldicott Guardian as required at agreed intervals. There has been no requirement for this, this year. However, the Information Governance Manager does meet with the Caldicott Guardian to discuss any issues regarding information sharing that arise from the meetings.

6 IMPROVEMENTS/KEY LEARNING THE RESOURCES COMMITTEE CAN TAKE INTO 2020/21

For 2020/21, the following areas could be improved:

- Timeliness of submission of some of the reports.
- Assurance purview to be reviewed by the committee.
- A deep dive will be included as a standing agenda item for committees during 2020/21, which will be linked to the risks listed on the BAF, pertinent to this committee.
- Assurance reports to be received from the (i) Cost Improvement Management Group, (ii) Capital Management Sub Group and (iii) Sustainable Sub Group.

7 TERMS OF REFERENCE

The Group has reviewed the Terms of Reference and proposed a number of changes, included at appendix a. The changes relate to:

- Format,
- Name of parent committee (following review of committee structure in July
- Duties and Interrelations.

8 LEGAL and/or GOVERNANCE IMPLICATIONS

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

The revised terms of reference will require approval from the Board of Directors.

9 RECOMMENDATIONS

The Board of Directors is recommended to:

- Review the Resource Committee Annual Report,
- Approve the Resources Committee Terms of Reference.

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NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE – RESOURCES COMMITTEE

CONTENTS

1. ROLE AND PURPOSE

The Resources Committee has been established as a formal committee of the Board of Directors. The purpose of the Committee is to obtain assurance on behalf of the Board of Directors that the Trust's business, financial, digital and workforce plans are viable and that risks have been identified and mitigated. The Committee will monitor governance arrangements established to address internal and external service developments and will seek assurance on the delivery of corporate projects. The Committee will also seek assurance and advise the Board accordingly on subjects relating to employees and volunteers.

The Chair of the Committee will report in writing to the Board of Directors a summary of the business that has been transacted and basis for any recommendations made. 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.

2. MEMBERSHIP

The Committee shall comprise the following membership:

- Three Non-Executive Directors – one of whom shall be the nominated Chair
- Associate Non-Executive Director (Digital)
- Director of Finance
- Director of Operations
- Director of People
- Director of Quality, Improvement and Innovation
- Director of Strategy and Planning

The following officers shall be invited to attend meetings of the Committee in an advisory capacity when agenda items require them to be present. They are not routinely required to attend:

- Deputy Director of Finance
- Deputy Director of People
- Chief of Digital and Innovation

There is an expectation that members will attend a minimum of 5 out of 6 Committee meetings during each financial year.

In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting.

Other Officers of the Trust shall attend at the request of the Committee in order to present and provide clarification on agenda items, and with the consent of the Chair will be permitted to participate in the debate.

The quorum necessary for the transaction of Committee business shall be five, which is to include at least two Non-Executive Directors, which may include the Associate Non Executive Director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the powers exercisable by the Committee.

3. ACCOUNTABILITY

Resources Committee authority is as set out in the NWAS Scheme of Delegation.

4. REVIEW ARRANGEMENTS

The Committee will identify annual objectives of the Committee, produce an annual work plan in the agreed Trust format, measure performance at the end of the year and produce an annual report. This will also include an assessment of compliance with the Committee's terms of reference and a review of the effectiveness of the committee. Any changes to the Terms of Reference must be recommended to the Board of Directors for approval.

Compliance with the Terms of Reference will be monitored on an ongoing basis by the member of the Corporate Governance Department providing administrative support to the Committee. Any concerns in relation to compliance will be reported to the Chair of the Committee and the Director of Corporate Affairs. In addition, the annual review will include a summary on compliance with the Terms of Reference.

5. WORKING METHODOLOGY

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 five clear days before the meeting.

The Committee will normally meet on a bi-monthly basis and as a minimum six times per year. The Chair may, however, call a meeting at any time provided that notice of the meeting is given.

The Committee shall be supported administratively by the Corporate Governance Department, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Committee on pertinent areas.

The minutes of meetings shall be formally recorded by a member of the Corporate Governance Department, checked by the Chair and submitted for agreement at the next meeting, whereupon they will be signed by the person presiding at it.

~~The Chair and the Director of Finance and/or the Director of People and/or the Director of Quality, Innovation and Improvement (where appropriate) 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.~~

6. DUTIES AND INTERRELATIONS

The Committee shall:

i. Inform the development and provide assurance against the following Trust strategies, associated policies, action plans and annual reports:

- Financial Plan
- Long Term Financial Model
- Our Strategy 2018 – 2023
- Digital Strategy
- Estates Strategy
- Fleet Strategy
- Workforce Strategy

ii. Monitor and consider the Strategic Risks within the Board Assurance Framework that are relevant to the Committee's remit, including the control and mitigation of high-level related risks and provide assurance to the Board that such risks are being effectively controlled and managed.

iii. Receive external assurance reports from the CQC and other regulatory/statutory bodies in relation to the finance and workforce agenda and ensure that management responses/actions plans are robust.

Finance, Investment and Planning

iv. Review the financial elements of the Trust's Business Plan via the Long Term Financial Model and ensure that key assumptions are both realistic and explicit (the Board of Directors will remain responsible for approval of the Business Plan).

v. Monitor the financial performance of the Trust, the financial forecast and the key financial risks.

vi. Monitor delivery of the Capital Expenditure programmes and seek assurance on the preparation of comprehensive programmes for subsequent years. Recommend the Capital Expenditure programme to the Board of Directors for approval and review Capital and Revenue investment proposals over £500k

vii. Monitor delivery of Cost Improvement Programmes and seek assurance on the preparation of comprehensive programmes for subsequent years, recommend the Cost Improvement Programme to the Board of Directors for approval.

viii. Review contract proposals in relation to Emergency Services, Patient Transport

Services, 111 Service and any other clinical or commercial venture under consideration by the Board and assess the financial implications of performance against the Trust's principal contracts.

ix. Review contract award proposals (in line with the Scheme of Delegation and Standing Financial Instructions) and make appropriate recommendations to the Board of Directors

x. Recommend projects over £500k, to the Board of Directors for approval

xi. Review the Trust's Integrated Business Plans, Financial Strategy and Long Term Financial Plans.

xii. Seek assurance in relation to fleet activity including vehicle servicing and inspections, insurance, vehicle replacement programme, carbon reduction strategy and waste assurance.

xiii. Receive assurance in relation to estates including NHS sites, progress against NHS Carbon Reduction Strategy, NHS Carbon Reduction Strategy and Benchmark measures utilising the "Model Ambulance Trust".

xiv. Review business and commercial development proposals, for recommendation to the Board of Directors.

Digital

xv. Review the Digital and Information Management and Technology (IM&T) programme of work to ensure it aligns with the Trust's strategic plans and monitor progress on major schemes.

xvi. Review the Trust's Data Security and Protection arrangements and monitor the Trust's plans and Toolkit submission in relation to this.

xvii. Review the recommendations from any external reviews in relation to IM & T and monitor progress on major schemes.

Workforce

xviii. Seek assurance on the development and delivery of comprehensive workforce plans.

xix. Monitor performance against key workforce indicators such as: sickness absence, appraisal review, mandatory training and turnover.

xx. Review the development of a vibrant volunteer cohort and receive assurance in relation to the recruitment, training and management of volunteers

xxi. Monitor progress against equality and diversity goals arising from the Equality Delivery System, WRES, WDES, gender pay gap reporting and other regulatory requirements to ensure compliance with the Equality Act 2010.

xxii. Seek assurance that the essential standards of quality and safety (as determined by CQC's registration requirements) in relation to staff are at a minimum being met by every service that the organisation delivers.

xxiii. Ensure that there is an effective Learning Needs Analysis process in place across the Trust and monitor its effectiveness.

xxiv. Provide assurance to the Board on compliance with relevant HR legislation and best practice including paramedic, doctors and nursing revalidation.

xxv. To monitor any action plans relating to the staff survey and seek assurance that satisfaction levels are improving.

The Chair of the Committee shall maintain an effective relationship with the Chair of the Audit Committee and may, from time to time, refer matters to the Audit Committee and / or other Board Committees as appropriate for consideration.

7. DELEGATED AUTHORITY

The Committee is authorised by the Board to:

Investigate any activity within its terms of reference

Seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee

Obtain independent professional advice, having due regard to recognised Trust procedures, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. INWARD REPORTING ARRANGEMENTS

The Committee shall receive Chair Assurance Reports from meetings of the following Management Groups:

- Information Management Group
- Cost Improvement Management Group
- Capital Management Sub Group
- Sustainable Sub Group

REPORT

Board of Directors	
Date:	27th May 2020
Subject:	Integrated Performance Report
Presented by:	Director of Quality, Innovation and Improvement
Purpose of Paper:	For Assurance
Executive Summary:	The Integrated Performance Report for May 2020 shows performance on Quality, Effectiveness, Finance, Operational Performance and Organisational Health during April 2020. During the month of April the trust continued to see Special cause variation across a number of performance measures due to the effects that the Covid-19 pandemic is placing on the trust. Several of the measures, although still showing special cause variation, do appear to be moving back to normal. The highlights from this report are as follows; **Quality** • The Trust is on track with the strategic goal of reducing complaints per 1000 WTE staff. The fiscal year monthly average is currently 12 complaints per 1000 WTE staff, against a strategy goal of 31. • 58% of complaints with a risk score of 1-3 have been completed within the SLA which is slightly below the Strategy Goal (65%). 45% of Complaints with a risk score of 4-5 have been completed with SLA exceeding the 40% Strategy Goal. • 3 Serious Incidents were reported during April. **Effectiveness** • There has been a reduction in FFT returns for PES, 111 and PTS from last month which is attributable to Covid-19. • Performance against all Ambulance Clinical Quality Indicators shows common cause variation. • We are demonstrating a reduction in conveyance, from 65.2% to 52% over the past 12 months. With a reduction from 64% in February 20 (pre Covid-19) to 55.9% in March 20 and 52% in April. • Hear & Treat Performance for April 2020 was 11.53 % and the number of incidents with no face to face response being 10,616. This is a 3.31%

point increase in performance in comparison to April 2019.
- April See &Treat performance was 36.5%.

Month	H&T	S&T	S&C
April	11.5%	36.5%	52%

Finance

- The Financial Risk Rating metrics have been removed and will return when then new operating framework is launched after transition from the Covid-19 financial framework.

Patient Emergency Service (PES)

- Call Pick Up performance was 96.7% in March 2020.
- There is special cause variation in number of calls picked up which is was below the lower confidence limit for two consecutive weeks and number of calls answered in 5 seconds which has been at the upper confidence limit for 3 consecutive weeks. This is indicating a lower than "normal" number of calls and a higher performance for the number picked up within 5 seconds.
- Average Hospital Turnaround Time for April 2020 was 31 minutes 58 seconds across the North West.

ARP Performance

	Target	Actual
C1 (Mean)	7:00	7:25
C1 (90th)	15:00	12:17
C2 (Mean)	18:00	24:45
C2 (90th)	40:00	53:53
C3 (Mean)	1:00:00	01:15:35
C3 (90th)	2:00:00	3:00:00
C4 (90th)	3:00:00	3:38:00

NHS 111

- Rate of Calls answered within 60 seconds is at 52% against a target of 95% for the year to date with a monthly performance for April being 52%.
- All metrics are showing special cause variation.– this is due to call volumes as a result of Covid-19.

PTS

- Activity in April for the Trust was 67% below contract baselines, whilst the year to date position (July 2019 –

	February 2020) is performing at 10% below baseline. This is due to Covid-19. **Organisational Health** • **Sickness**: The overall sickness absence rate for the latest reporting month (March 2020) was 5.70%. • **Turnover:** The turnover figure for April was 8.46%. • **Agency:** Due to the impact of Covid-19 agency costs have risen at the trust and stand at 1.1% in April. • **Vacancy**: Positions across the Trust show a position of being under establishment by 0.86%. • **Appraisal:** The overall appraisal completion rate for April was 78% against a Trust target of 95% this was lower than the 84% in March and the drop is due to the effect of Covid-19. • **Mandatory Training:** Mandatory training was suspended mid-March due to Covid-19 and focus will move to recovery plans for all service lines with mandatory training to restart in June.
Recommendations, decisions or actions sought:	The Board of Directors is asked to: • Note the content of the report • Clarify any items for further scrutiny

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

Link to Board Assurance Framework (Strategic Risks):		
SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☐

Are there any Equality Related Impacts:	
Previously Submitted to:	Quality and performance (in part)
Date:	18th May 2020
Outcome:	Assurance

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1. PURPOSE

The purpose of this report is to provide the Quality and Performance committee with an overview of integrated performance on an agreed set of metrics required by the Single Oversight Framework up to the month of April 2020. The report shows the historical and current performance on Quality, Effectiveness and Operational performance. 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?

Covid-19

The trust is continuing to see special cause variation across a number of performance measures with several though starting to move back towards normal variation. This is mainly due to the impact of Covid-19 within the trust. This includes the impact upon call answer times within the 111 service line, the ARP measures within the 999 service and the outcome measures for 999 where See and Convey and See and Treat remain in special cause variation but are moving back towards the pre COVID-19 levels.

2. INTEGRATED PERFORMANCE SUMMARY

2.1 Quality

Q1 – Complaints and Compliments

In April 2020, 71 complaints were received, against a 12 month average of 173 per month. 129 compliments were received this month. The rate of complaints (severity 1 and 3) is low with 60 being received.

A total of 157 complaints were closed in April 2020 (137 cases were risk scored 1-3 and 20 were risk scored 4-5). Overall, 58% of cases risk scored 1-3 were closed within the agreed timescales. 45% of level 4-5 complaints were closed within agreed timescales. Whilst the percentage of risk score 4&5 complaints closed within SLA has improved in April, there has been a reduction in percentage closed within SLA of risk score 1-3 complaints. This is due to the low number of new complaints vs the number ready for closure i.e. 97 of the complaints closed had been open prior to 01 April 2020, some of which were already in the backlog. At the time of writing 70 cases are being actively managed within the system and 31 are already overdue. Given the reduction in complaints and the backlog vs cases open, this goal is likely to prove challenging in the coming weeks. To meet some of these system challenges, Patient Safety personnel have now started using a team approach to investigation to distribute the workload, which now includes external incidents and Serious Incidents.

Q2 – Incidents

In April 2020, 997 incidents were opened, significantly lower than the 12 month average of 1093 per month. Since the start of the pandemic we have had 1633 incidents relating to Covid-19 with 356 of these relating to April 2020.

Q3 - Serious Incidents (SIs)

3 Serious Incidents (SIs) were reported in April 2020. 9 SI reports were due with the commissioners and 11 reports were submitted.

Q5 - Safety Alerts and Health and Safety

There have been 15 new alerts in April 2020. The total number of CAS/NHS Improvement alerts received between May 2019 and April 2020 is 40, with no alerts applicable. 17 MHRA Medical Equipment Alerts have been received with no alerts applicable. 57 MHRA Medicine alerts have been received, with 1 alert applicable. 6 IPC alerts have been received, with 6 alerts applicable.

2.2 Effectiveness

E1 - Patient Experience

A significant drop of 41.9% is seen this month, (from 43 in February to 25 in March) for PES FFT returns. This drop is attributed to the pandemic and the national decision to pause all patient experience surveying. A significant increase of 26.2% in satisfaction rating is also noted (from 69.8% to 96.0%).

At the end of Q4, the 50% improvement goal in terms of average returns set in Q1 was exceeded.

Nationally, the trust continues to hold second position in terms of number of responses received – for both January and February. And in terms of recommendation remained in 4th having moved from 5th in the previous month (February 2020 data).

The trust has an FFT implementation plan for April 20202 when the new national guidance on the submission of the PES (see and treat) takes effect but as a result of the COVID-19 pandemic, this rollout has been put on hold by NHS England. There is still the requirement for national submissions for PTS FFT responses post Apr 2020, but as a result of the COVID-19 pandemic, this has been put on hold by NHS England.

E2 – ACQIs

NHS England have suspended all AQI outcome data from April to June 2020 which means that the last published data was the November 2019. In November, 6.8% of patients suffering an out of hospital cardiac arrest survived to hospital discharge (national mean 7.8%). The figure for the Utstein sub-group was 20.6% (national mean 26.7%). This performance saw the Trust ranked 6th and 9th respectively for English ambulance trusts.

The rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group was 43.6% (national mean 53.6%), ranking 9th nationally. For the overall group the rate was 27.2% (national mean 28.8%) ranking the Trust in 7th position nationally.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of 2h 16mins; the Trust's performance was 2h 24mins for these patients.

Mean call to door time for patients suffering a hyper acute stroke was just outside of the national mean of 1h 26mins; the Trust's performance was 1h 28mins for these patients.

The stroke care bundle result of 98.6% was marginally ahead of the national mean of 96.9%. Care bundle data for STEMI and sepsis was not published for November as is consistent with the NHSE reporting schedule.

E3 – H&T, S&T & S&C Outcomes

There is special cause variation for all three outcomes. H&T and S&T both show an increase in the rate and sit above the upper confidence limit. S&C is showing a decrease and is below the lower confidence limit. All are due to Covid-19. We have also seen a move back towards the respective confidence limit and 'norm' over the past two months.

April 2020 seen a large reduction in conveyance from 64.3% in February 2020 to 52. % in April 2020. This is primarily due to the increase in H&T and S&T.

Additional funding was released to support the COVID 19 Pandemic which has allowed an increase in both workforce in Clinical Hub and IT infrastructure to provide efficiencies and enable home and remote working.

Hear & Treat Performance for April 2020 was 11.53 % and the number of incidents with no face-to-face response being 10,616. This is a 3.31% increase in performance in comparison to April 2019 and is the highest H&T Performance to date. Compared to previous year, 2495 more patients in April 2020 received a H&T outcome which better met their needs and saved valuable resource for our sickest patients.
The increase in H&T also enabled better protection for NWAS responders, North West Health Economy overall and patients, enabling them to remain at home and reduce risk of infection.

2.3 Finance

F1 – Finance

For the four months of the COVID-19 framework, the 2020/21 monthly financial returns have been redesigned to collect a minimum dataset to reduce the burden on organisations wherever possible, whilst maintaining a monthly data collection process.

The Financial Risk Rating metrics have been removed and we will add back once the new operating framework is launched after transition from the COVID-19 financial framework.
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2.4 Operational

PES Activity

OP1 – Call Pick Up

Call pick up has significantly improved across all performance metrics. Calls answered in 5 seconds stands above 95% for the first time since ARP went live in August 2017. The mean and centile performance is also significantly improved. The 95th centile has improved by 73 seconds vs previous month. The improvement in call pick up is reflected in the national picture for call handling performance. NWAS has been number one in the sector three of the previous four weeks for call pick up.

There is special cause variation for both Calls with pick up and those picked up within 5 seconds. For call pick up the reduction in call volume can be attributed to two primary factors. Firstly there has been a reduction in initial/primary calls from the public. This appears to indicate public behavior has changed during the COVID-19 pandemic. This is clear when reviewing NWAS's emergency call volume and the sector as a whole. All ambulance services have seen a reduction in call volume. The second factor reducing call volume is the reduction in secondary/follow up calls known as duplicates. Duplicate calls occur in the primary when a patient or caller, re contacts NWAS, either because the patient has worsened or (and more likely) to ask for an ETA for a response. NWAS response times have improved and as a result duplicates have reduced.

Special cause variation for call pick up within 5 seconds can be attributed to two primary factors also. Firstly the reduction in call volume, the rationale has been previously described and secondly due to increases in workforce. NWAS EOC has recruited an additional 180 call handling staff. This is driving the improvements to call answer times.

OP2 – Hospital Turnaround

The hospital turnaround times remain stable. There are improvements at the Trust level where the performance is at the lower control limit which should be seen as a positive.

The NWAS element of the handover time is still well below the15 minute standard however there is some slight deterioration. This can be attributable to vehicle cleaning following CV-19 incidents.

OP3 – ARP Standards

	C1 Mean	C1 90th	C2 Mean	C2 90th	C3 Mean	C3 90th	C4 90th
Apr 2020	00:07:25	00:12:17	00:24:45	53:35	01:15:35	03:00:00	03:38:00
Target	00:07:00	00:15:00	00:18:00	40:00	01:00:00	02:00:00	03:00:00

The introduction of protocol 36 (pandemic) has seen a significant shift in patient categories. A reduction in C1 and C2 patients have been moved into the C3 category. For January to March 2020 we saw on average 64.6% of incidents being classified as C1 or C2 (C1 average 10%, C2 average of 54.6%) against 55.5% in April 2020 (C1 8.1% and C2 47.4%). For C3 January to March 2020 we saw an average of 17.4% for C3 incidents compared to 24.7% in April.

OP4 – 111

April continues to present NWAS 111 with increased call demand and despite training 98 first year paramedic students, the 111 performance standards have not been achieved.

Calls answered within 60 seconds shows a slight improvement but is still below the lower confidence limit. The average call to answer time, has shown significant improvement and has almost halved from March to April. The contribution of the student paramedics and a new cohort of Service Advisors has delivered this improvement. The average time for call back is showing special cause variation but for the second consecutive month is moving back towards the upper confidence limit.

The percentage of calls answered is showing special cause variation being above the upper confidence limit though has shown significant improvement from March to April. The percentage of time under 10 minutes for call back is at the lowest confidence limit for April but has shown improvement from March.

OP5 – PTS Activity

Overall activity during April 2020 was 67% below contract baselines with Lancashire 74% below contract baselines whilst Merseyside is operating at -56% (-14022) Journeys below baseline. For the year to date position (July 2019 - April 2020) PTS is performing at -10% (-128440 journeys) below baseline. Within these overall figures, Cumbria, Greater Manchester and Lancashire are operating at 14%, 5% and 19% below baseline whilst Merseyside is operating at 3% above baseline.

In terms of unplanned activity, cumulative position within Greater Manchester is 18% (7247 journeys) above baseline. 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, Lancashire and Merseyside are 29% (3592 journeys), 14% (7051 journeys) and 1% (259 journeys) below baseline.

In terms of overall trend analysis, overall activity levels had plateaued for all contracts up to March 2020 where the impact of Covid-19 has led to a significant reduction in planned activity and a further reduction in EPS activity. Unplanned activity has remained relatively stable.

Aborted activity for planned patients averaged 14% during April 2020 however Cumbria experiences 9%, Greater Manchester operates with 21% whilst Lancashire and Merseyside both experience 10% & 12% aborts respectively. Within EPS (renal and oncology) overall aborts average 4% aborts. Cumbria has 1%, Greater Manchester 6%, Lancashire and Merseyside operate with 3% and 4% respectively. Unplanned (on the day) activity experiences an average 12% with variances of 10% in Cumbria, 13% in Greater Manchester, 10% in Lancashire and 12% Merseyside.

2.5 Workforce

OH1 – Sickness

The overall sickness absence rates for March 2020 were 5.70% with figure OH1.1 displaying a downward position over a 4 month period.

The position is slightly higher than the same time last year which was 5.62% in March 2109. The cumulative sickness position for 2019/20 was 6.19% which represented an increase on the previous year. The Trust sickness improvement goal for 2019/20 was not met.

There were no special clause variations but progress across all services lines should be noted with particular improvements in both EOC and 111.

Please note that although the impact of COVID-19 started to be experienced in March, in the absence of staff testing, most of the impact has been recorded as self-isolation and is not shown in the sickness figures.

OH2 – Turnover

Turnover is calculated on a rolling year average and this does lead to some small variations between months with April 2020 turnover at 8.46% which continues to show a stable trend within narrow control limits.

Special clause variations with regards to the lower control limits show 111 and EOC at the lower confidence levels. This is a positive indicator of the focused work in these two areas. 111 work is supported through an NHSE/I enabled retention plan. PTS are also close to the lower control limit and work to understand the reasons for this trend is underway.

PES turnover remains within narrow control limits but there signs of special cause variation with small increases over the last 8 months, indicative of opportunities within the wider system.

Overall the Trust is continuously below the national turnover rate for Ambulance Service which was at 9.08% in January 2020.

OH4 – Temporary Staffing

Use of agency staffing has increased in both March and April as a result of the need to increase capacity rapidly to support the COVID-19 response. This has primarily been in the EOC with the use of agency staff to support call taking.

Agency staff have been employed on a temporary to permanent basis enabling the transfer of staff onto permanent contracts without additional charge at the end of 12 weeks.

This does mean that current levels are likely to be maintained through May and June. This has impacted on the agency ceiling in month 1 and OD and Finance will work jointly to ensure that the recovery plan brings expenditure back within ceiling for the financial year.

OH5 – Vacancy Gap

In light of the pause in contract negotiations and the emergency budget. Staffing establishments have remained the same. The majority of temporary staffing has been moved internally, employed on bank or agency contracts so is not shown in these graphs. They show the underlying substantive staffing position which was a strong point from which to enable capacity increases.

This shows an over establishment at the end of April 2020 in both EOC and 111. 111 has an agreed plan to over-establish by c 80 posts by year end and recruitment has already commenced to deliver this.

Workforce Plans for all services lines are currently being reviewed following the Covid-19 response to take into account additional pressures moving into the winter period.

The PTS vacancy position is -5.86% in April 2020. However, they are also experiencing the impact of 155 staff supporting PES in relation to the COVID-19 response. Workforce plans are currently being reviewed to ensure that PTS have a robust plan moving into winter.

OH6 – Appraisals

Appraisal compliance overall has been stable until the impact of Covid-19 with the April 2020 position being at 78.48%. The Trust target is 95% of staff have an up to date appraisal.

Appraisal was paused for all service lines in mid-March. As a result all service lines have seen a special clause variation with a worsening position in March and April.

Focus will now move into the recovery plans for all service lines with recovery action starting in Phase 1 by the end of June 2020. In order to support the recovery plan we are currently considering streamlining the approach to 2020/21 appraisals.

OH7– Mandatory Training

A new classroom Mandatory Training cycle started in January 2020, however the Trust moved in 2019 to competence reporting. The aim therefore is for staff to complete their classroom based training and their online training before their competence expires. In practice this requires the profiling of classroom training for staff at a similar time to the previous year. If this takes place competence compliance should remain at the target of 95%.

Classroom based mandatory training and online training in EOC & 111 was paused in mid-March. The graphs therefore show cumulative completion for this year's classroom attendances plateauing in March. Overall competence has declined as modules go out of their refresher date.

Focus will now move into the recovery plans for all service lines with mandatory training to restart in June 2020. However, there will be continuing challenges to recovery due to the ongoing demands on operations and also the need to social distance in classroom which may affect numbers who can attend.

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 Quality and Performance Committee is recommended to:

- Note the content of the report
- Clarify any items for further scrutiny through the appropriate assurance committee

Q1 COMPLAINTS

Figure Q1.1

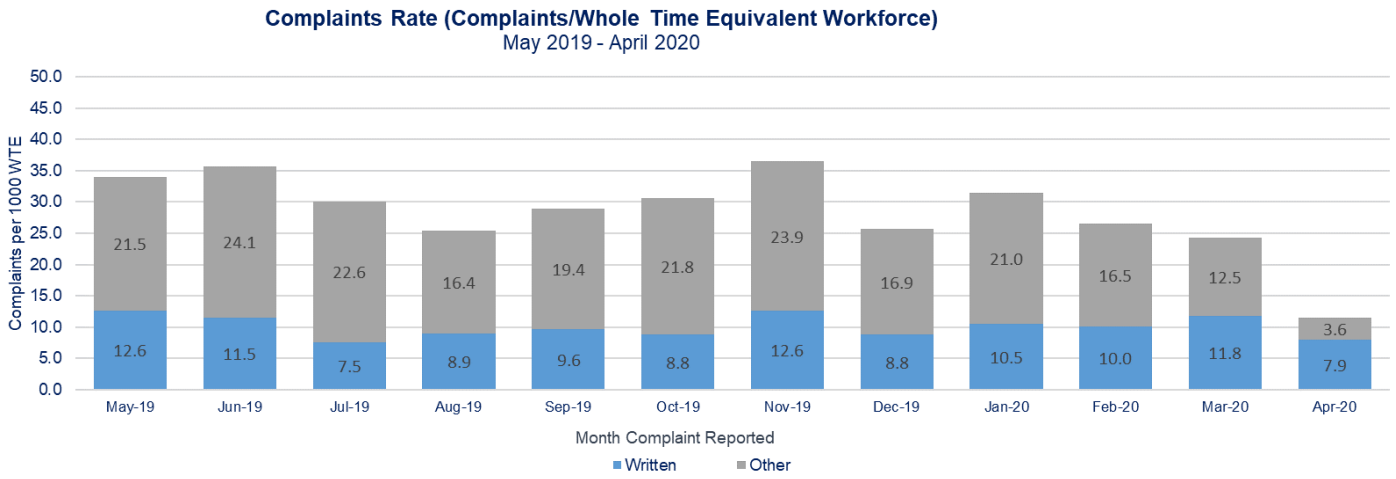


Table Q1.1: Complaints Opened by Month

Severity	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1. Minimum	36	45	39	32	17	13	15	10	15	11	13	7	6	9
2. Minor	172	140	133	150	125	109	131	142	159	109	147	123	108	38
3 Moderate	25	18	26	19	26	23	17	16	32	17	19	15	28	13
4 Major	8	3	3	9	10	8	10	15	14	13	15	18	8	7
5 Serious	2	3	2	3	3		2	5	6	8	1	1	2	4
Total	**243**	**209**	**203**	**213**	**181**	**153**	**175**	**188**	**226**	**158**	**195**	**164**	**152**	**71**
Compliments	122	113	109	35	135	112	127	146	123	113	148	76	137	129

Complaints & Compliments

In April 2020, 71 complaints were received, against a 12 month average of 173 per month. 129 compliments were also received this month.

Right Care Strategy Goals Performance:

2020/21 target to reduce the overall numbers of complaints per 1000 WTE staff by 20% (8) of the baseline per 1000 WTE.

The number of complaints in April 2020 is 11 per 1000 WTE.

Special Cause variation is observed in **Figure Q1.2** It's apparent that the reduction in low risk complaints is directly related to Covid-19. Through April there has been a significant reduction in PTS journeys which correlates with a reduction in low risk complaints. Theoretically the public perception of the NHS has also changed during the response to Covid-19 and this is also likely to have caused a reduction in complaints.

Despite the increase in C2 - C4 response time and the increase in see and treat, this does not seem to have impacted on **Figure Q1.3** (number of high risk complaints). Our experience of receiving high risk complaints suggests that there is ordinarily a lag time of between 4 & 6 weeks prior to submission.

As the pressures of Covid-19 start to reduce it is anticipated that an increase of high risk complaints will be received.

Figure Q1.2

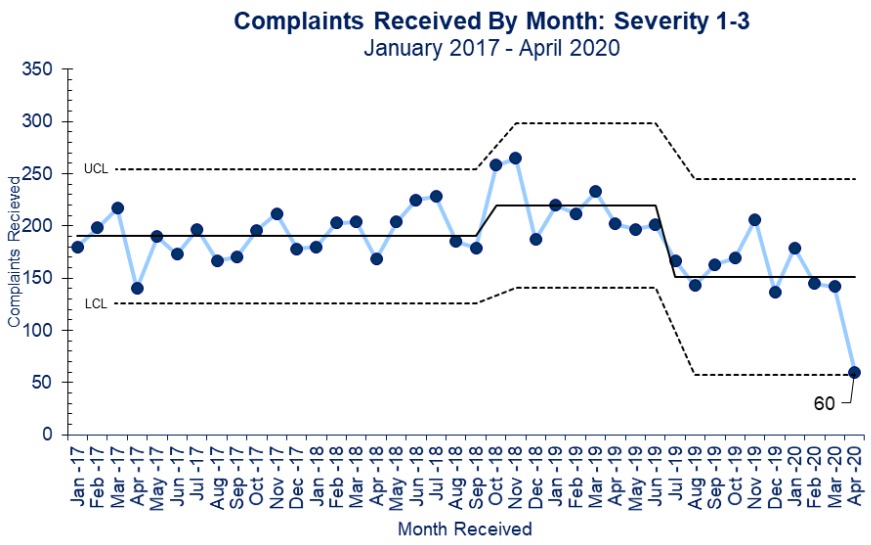


Figure Q1.3

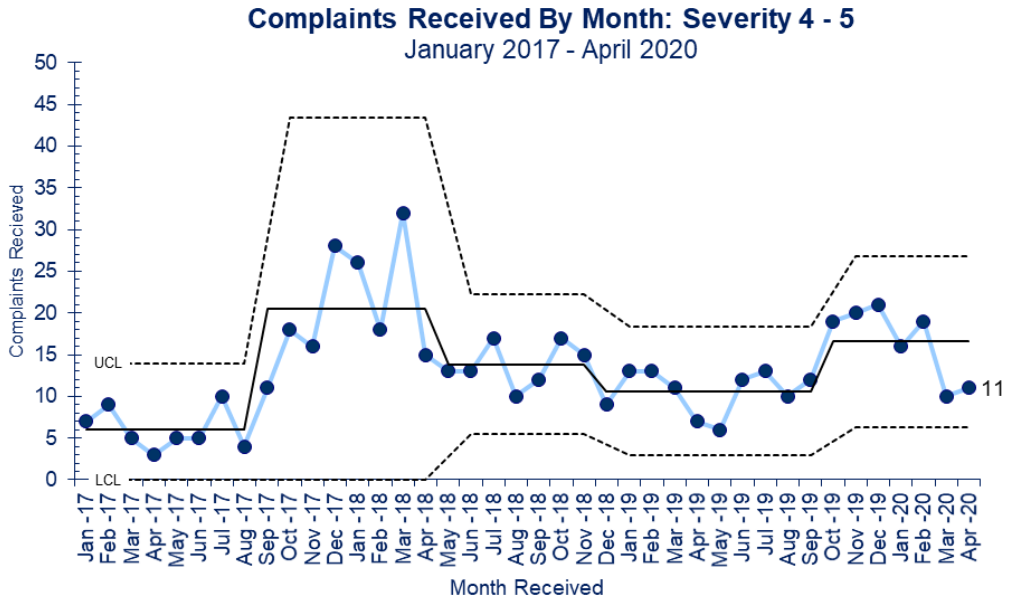


Figure Q1.4

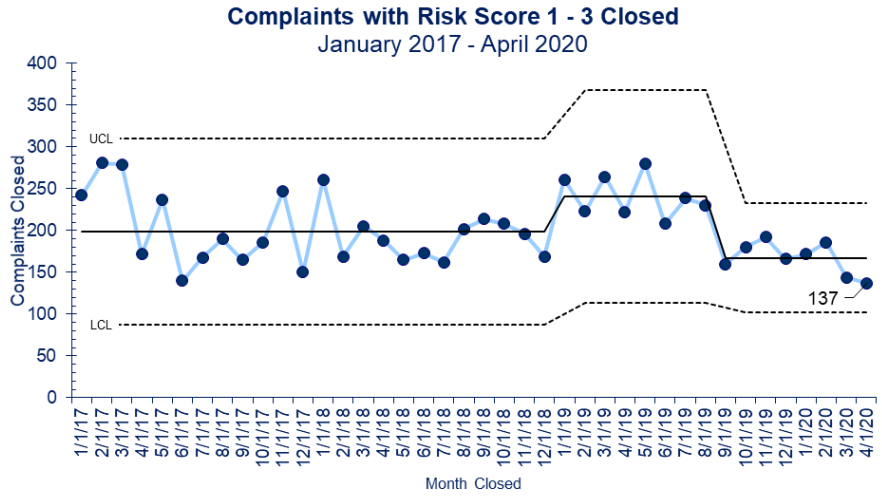


Figure Q1.5

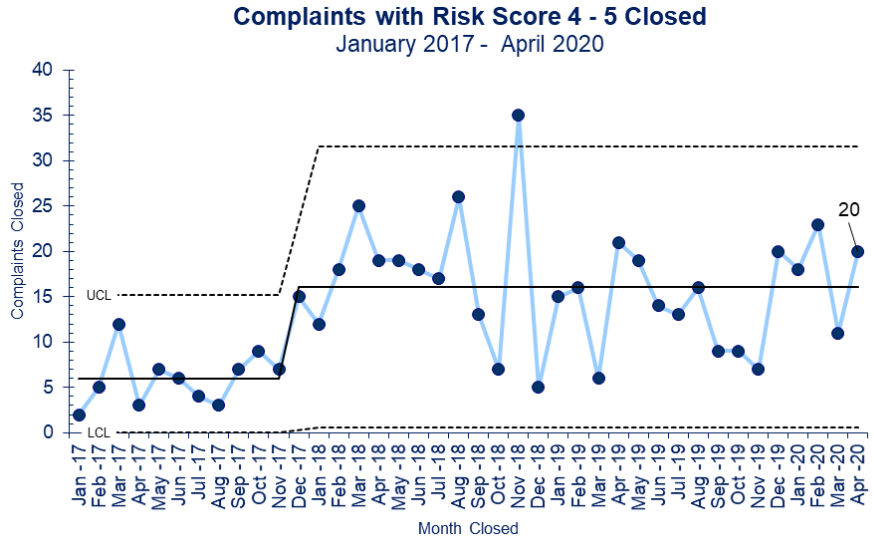


Figure Q1.6

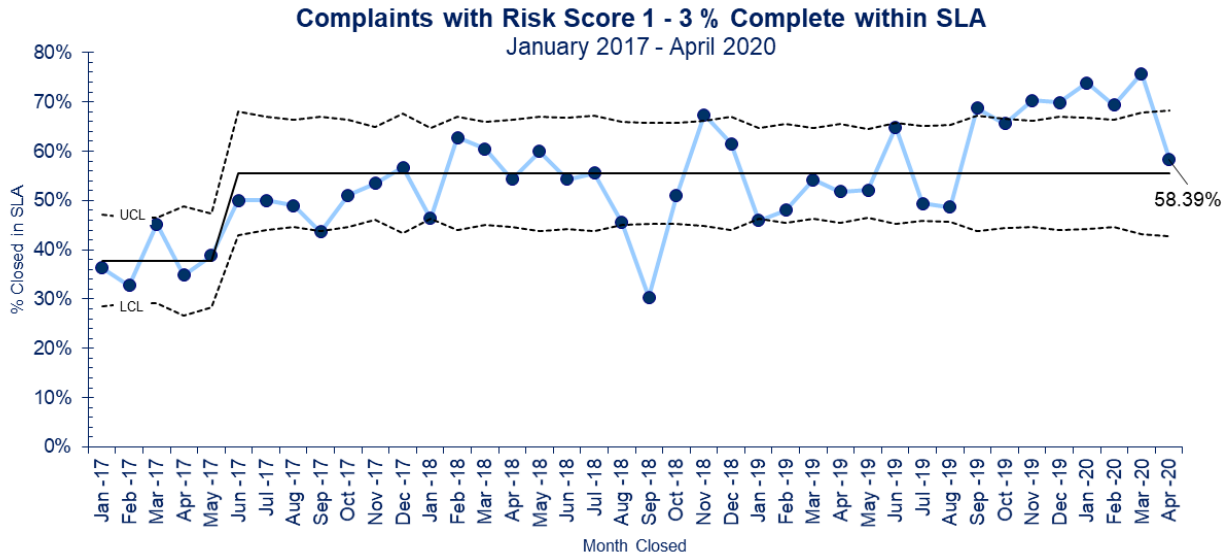
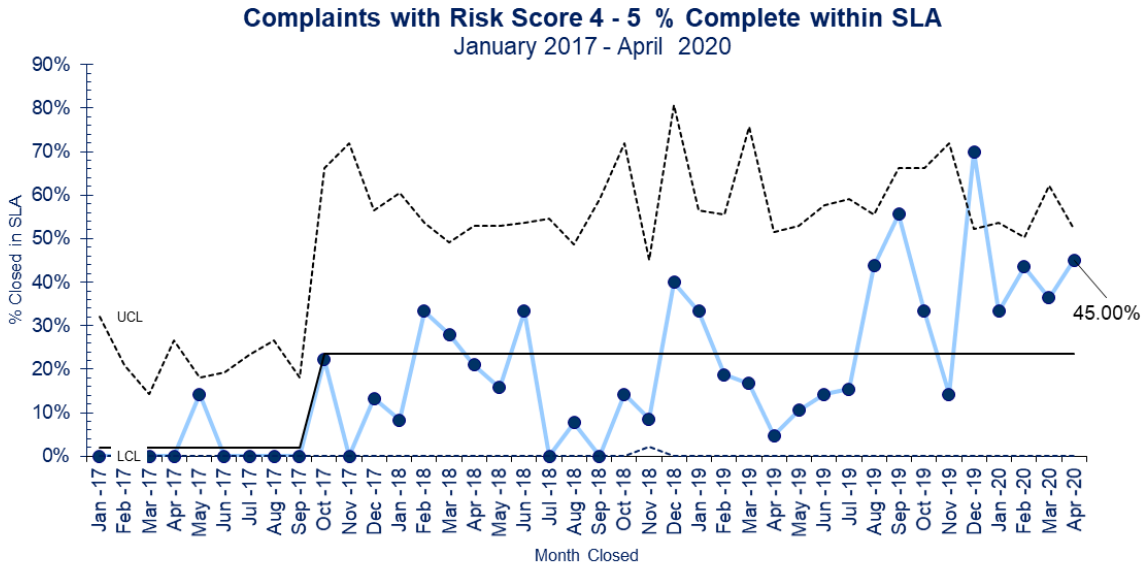


Figure Q1.7



Complaints Closure

A total of 157 complaints were closed in April 2020 (137 cases were risk scored 1-3 and 20 were risk scored 4-5).

Overall, 58% of cases risk scored 1-3 were closed within the agreed timescales. 45% of level 4-5 complaints were closed within agreed timescales.

Right Care Strategy Goals Performance:

1. 75% of complaints with a risk score of 1 to 3 will be closed within agreed timeframes by the end of 2020/21.

2. 75% of complaints with a risk score of 4 to 5 will be closed within agreed timeframes by the end of 2020/21.

Whilst the number of new complaints have reduced the number of complaints closed has remained consistent with previous months (**Figures Q1.4 & Q1.5**).

Whilst the percentage of risk score 4&5 complaints closed within SLA has improved in April, there has been a reduction in percentage closed within SLA of risk score 1-3 complaints. This is due to the low number of new complaints vs the number ready for closure i.e. 97 of the complaints closed had been open prior to 01 April 2020, some of which were already in the backlog.

At the time of writing 70 cases are being actively managed within the system and 31 are already overdue. Given the reduction in complaints and the backlog vs cases open, this goal is likely to prove challenging in the coming weeks.

To meet some of these system challenges, Patient Safety personnel have now started using a team approach to investigation to distribute the workload, which now includes external incidents and Serious Incidents.

BAF Risk: SR01 (Risk ID 2829)

Q2 INCIDENTS

Figure Q2.1

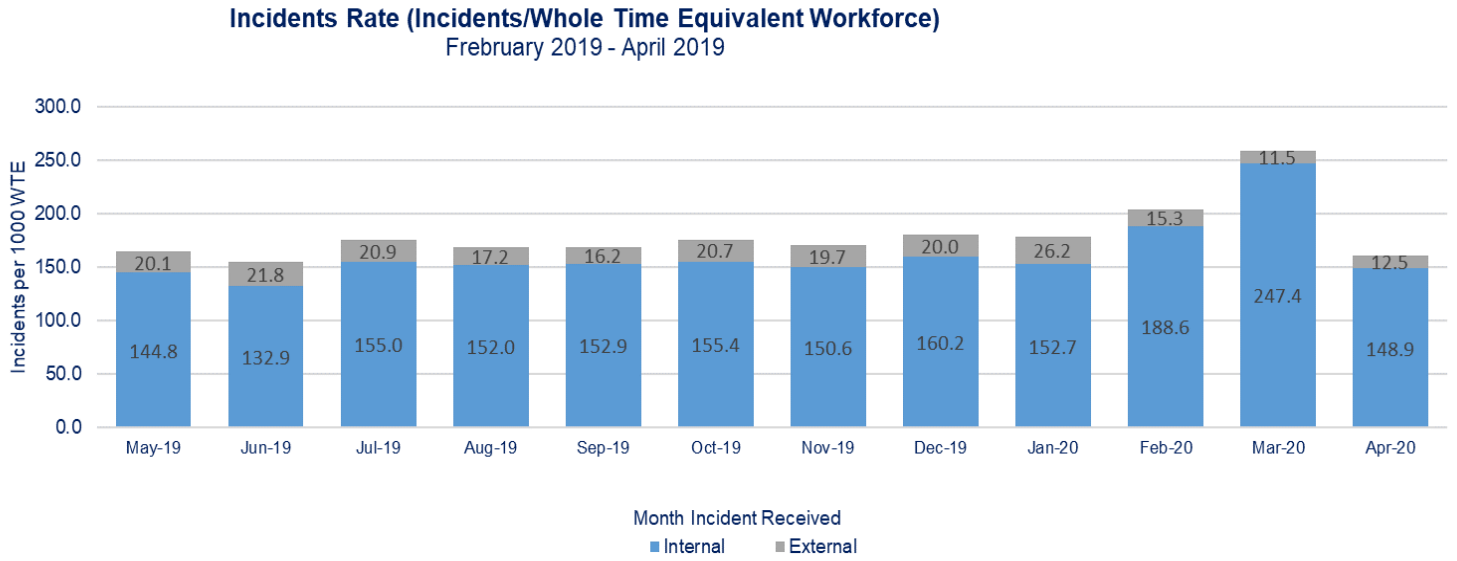


Table Q2.1

Severity	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
1. Insignificant	177	169	147	190	171	187	190	143	157	173	237	258	147
2. Minor	641	648	593	701	699	630	695	686	681	673	767	1034	526
3. Moderate	156	152	165	142	132	174	153	175	217	201	213	204	196
4. Major	9	3	5	11	10	7	9	11	14	9	16	7	16
5. Catastrophic		1		1	1	3	5	1	2	2	2	7	8
Unscored	15	11	12	13	9	20	31	42	42	64	29	116	104
Total	**998**	**983**	**922**	**1058**	**1020**	**1021**	**1081**	**1054**	**1110**	**1104**	**1263**	**1607**	**997**
Unscored %	1.50%	1.12%	1.30%	1.23%	0.88%	1.96%	2.87%	3.98%	3.78%	5.80%	2.30%	7.22%	10.43%

Incidents

In April 2020 997 internal and external incidents were opened, against a 12 month average of 1093.

Right Care Strategy Goals:
Reduce reported unscored incidents in the IPR to 25 in previous reported month by 2020/21.

There has been a slight fall in numbers of incidents reported during April. All Covid-19 related incidents are reviewed each week. The Clinical Safety Team follow up each incident and review the infection status for individuals concerned to ensure that welfare advice is provided to the staff involved. As the pressures of Covid-19 start to reduce it is anticipated that there will be an increase in external incidents received. All incidents that the team review are risk scored. The team address any unscored incidents by working with managers at Area Learning Forums to emphasise the importance of early scoring in identifying potential high risk incidents.

Figure Q2.2

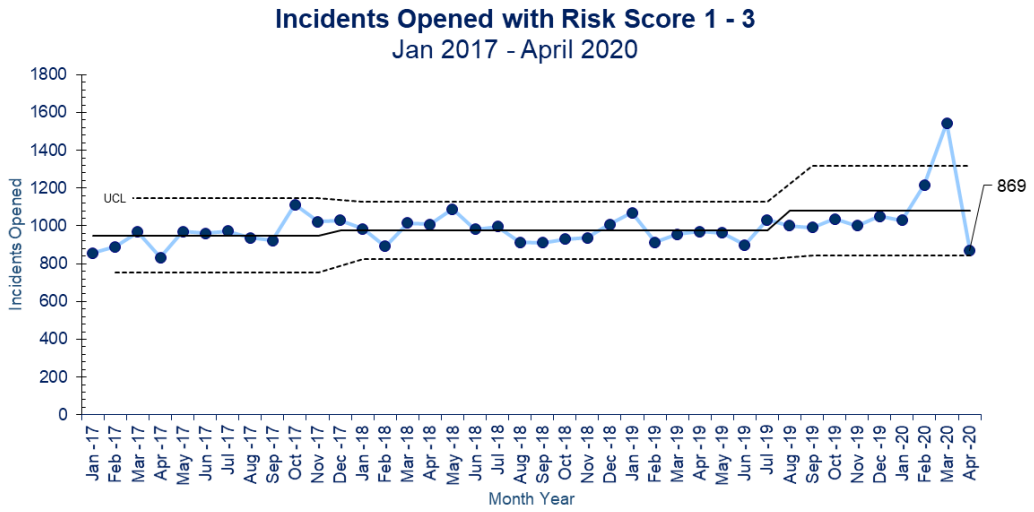
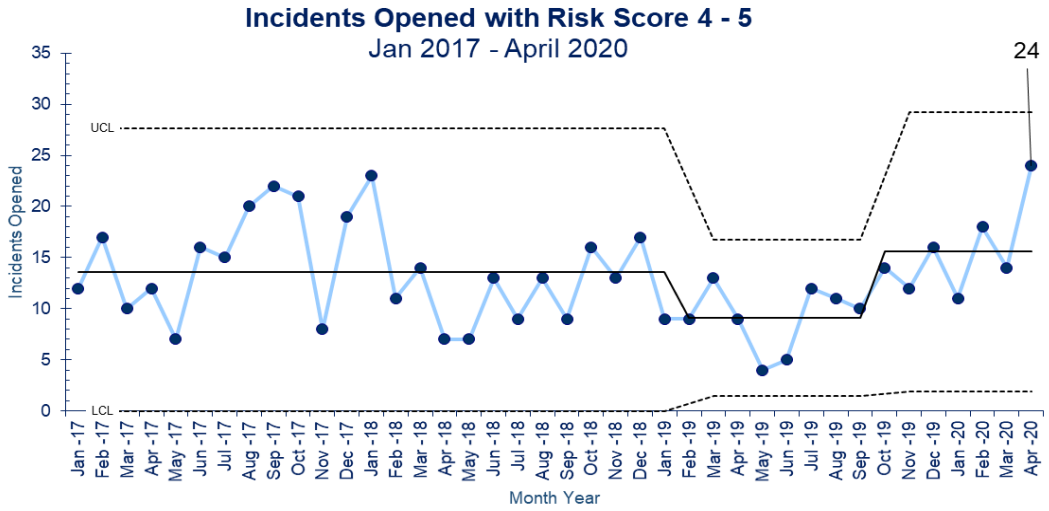


Figure Q2.3



The main findings indicate that the majority of the incidents reported relate to the communication of information to the attending crews. The reporting clinicians have felt that they have been exposed to potentially avoidable risks when attending patients with insufficient information on the patient's infectious status. On review in most of these incidents the information is not forwarded to the call taker by the caller, rather than from control to our crews.

There have been very few incidents reporting the unavailability of PPE by staff with only a handful raising concerns about the FFP3 masks and lack of fit testing.

Table Q2.1 – Top 10 Incident Categories Opened in April 2020

Category	06/04/2020	13/04/2020	20/04/2020	27/04/2020	Total
Information	26	26	9	6	67
Infection Control	21	20	19	10	70
Staff Welfare	9	13	14	10	46
Communication	11	10	8	6	35
111 Assessment/Advice	13	12	15	4	44
Vehicle Issue	9	4	13	11	37
Exposure to Harmful Substanc	12	3	10	3	28
Equipment Missing / Lost	14	11	13	4	42
Medicine Management	10	9	9	3	31
111 Issue with other service	7	3	8	5	23

Figure Q2.5

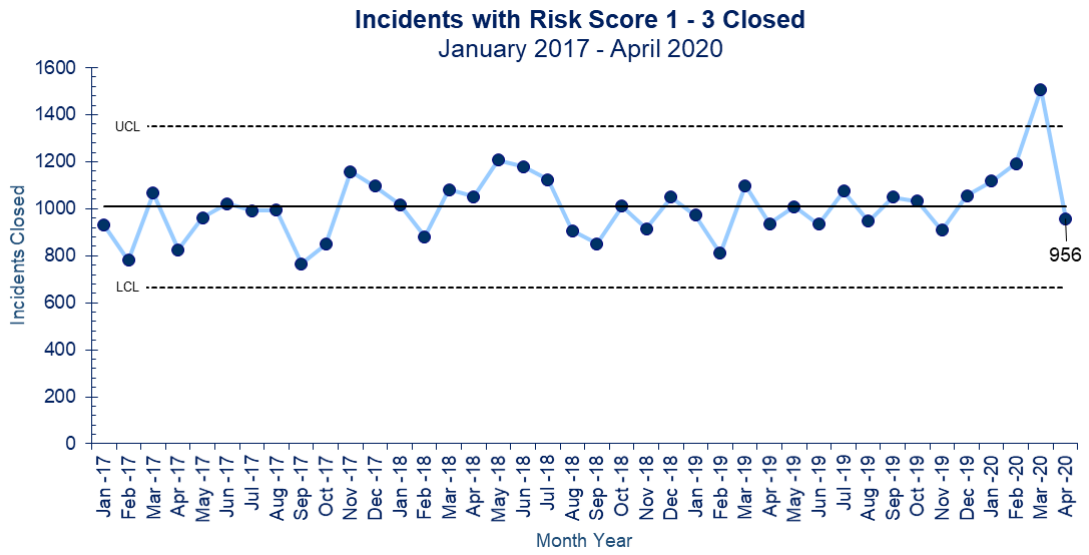
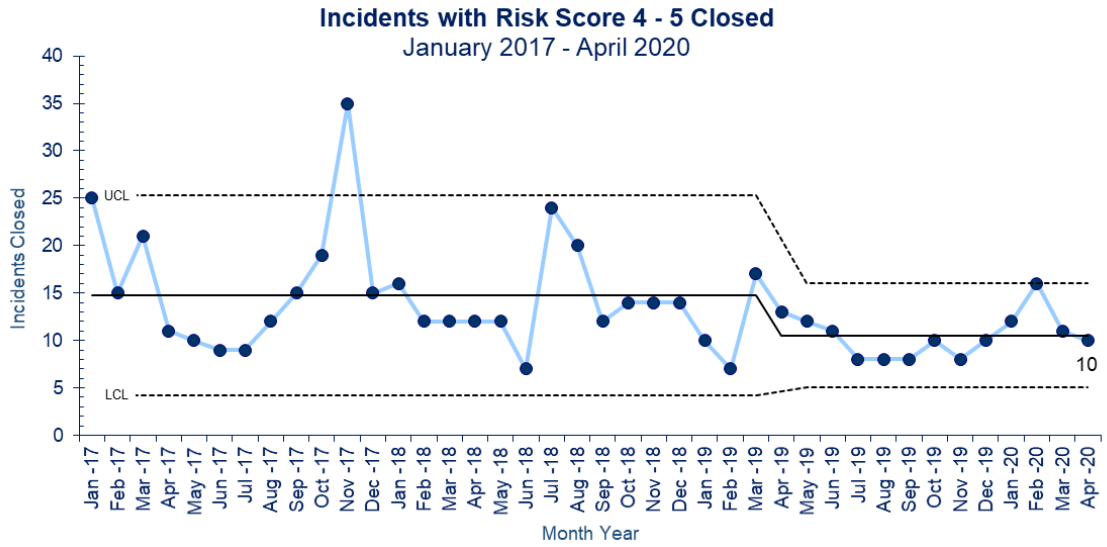


Figure Q2.6



Incidents Closure

In total, 956 incidents (level 1-5) were closed during April 2020. Of these, 69% level 1-3 and 0% level 4-5 incidents were closed within the agreed standard.

Right Care Strategy Goals Performance:

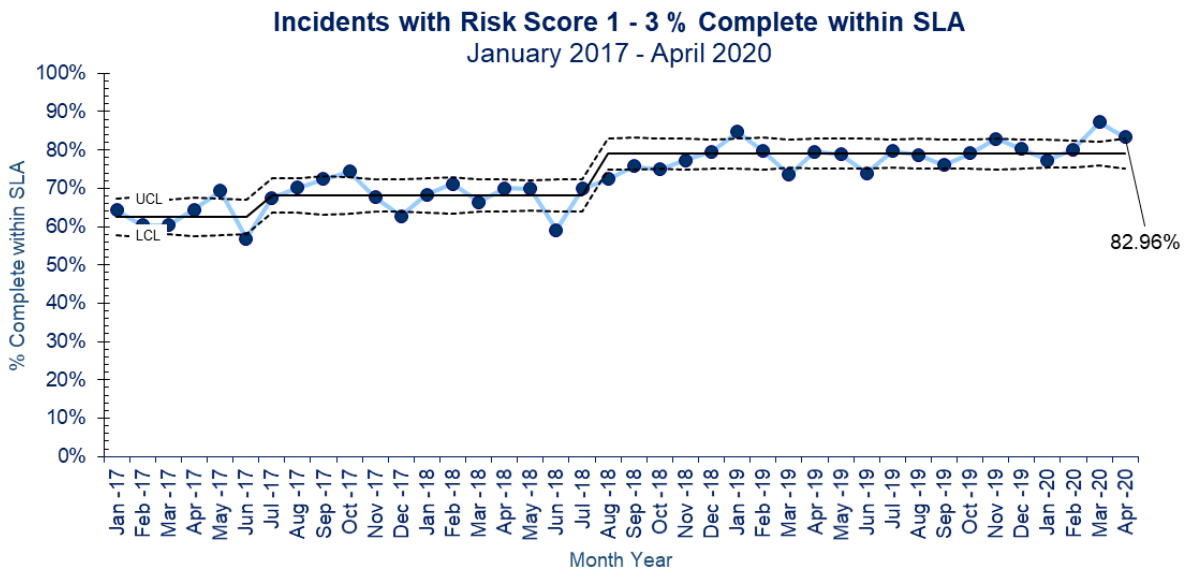
1. Increase closure within agreed timeframes to 85% by 2020/21 for severity 1-3 (**Figure Q2.7**)

The Trust has been achieving their Strategy Goal (80%) for Risk 1-3 Incident Closures in the agreed timeframe.

2. Increase closure within agreed timeframes to 82% by by 2020/21for severity 4-5 (**Figure Q2.8**).

During April the Trust has achieved the Strategy Goal (60%) for risk scored 4-5 incidents within the agreed timeframe for closure.

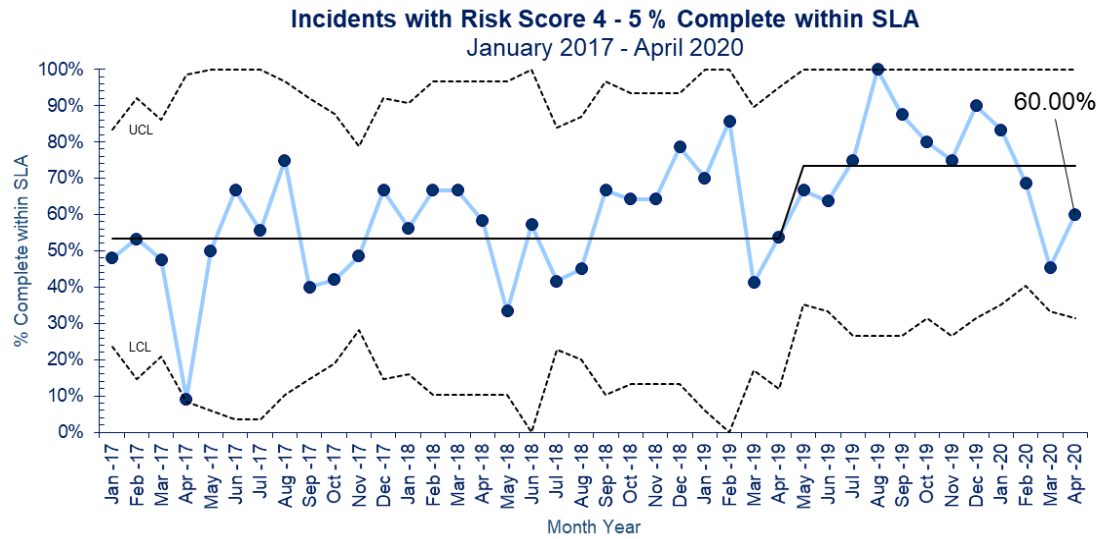
Figure Q2.7



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

Figure Q2.8



Q3 SERIOUS INCIDENTS

Figure Q3.1

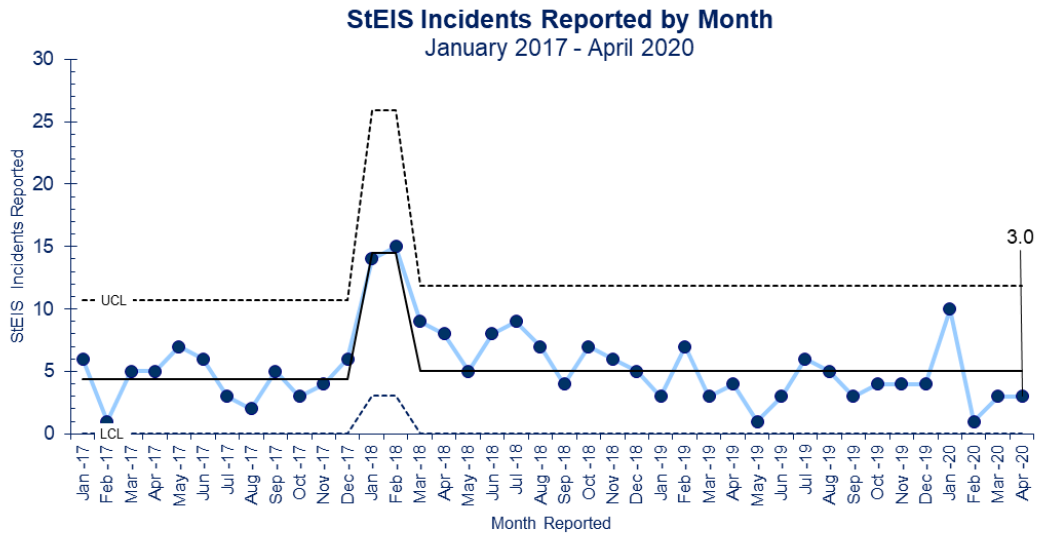


Table Q3.1: StEIS Incidents Opened in April 2020 by Source

Source	SD - Emergency Operations Centre	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	Total
Complaint/StEIS			
External/StEIS			
IRF/StEIS	2	1	**3**
Legal/StEIS			
Total	**2**	**1**	**3**

Serious Incidents

3 Serious Incidents (SIs) were reported in April 2020.

9 SI reports were due with the commissioners in April 2020. 11 reports were submitted which included the small backlog that had formed.

Right Care Strategy Goals:

1. Increase the proportion of cases where the notify-to-confirm interval is within the agreed timeframes to 85% by 2020/21.

The notify to confirm interval is completed within agreed timescales.

2. Increase the proportion of cases where the confirmation to report interval is within the agreed 60 day timeframe to 95% by 2020/21.

Whilst the notify-to-confirm interval goal has been met, the confirmation to report remains a challenge.

This has improved significantly and delays are now generally a few days instead of months. The approvals process is the bottleneck and we a developing a proposal re approval of reports.
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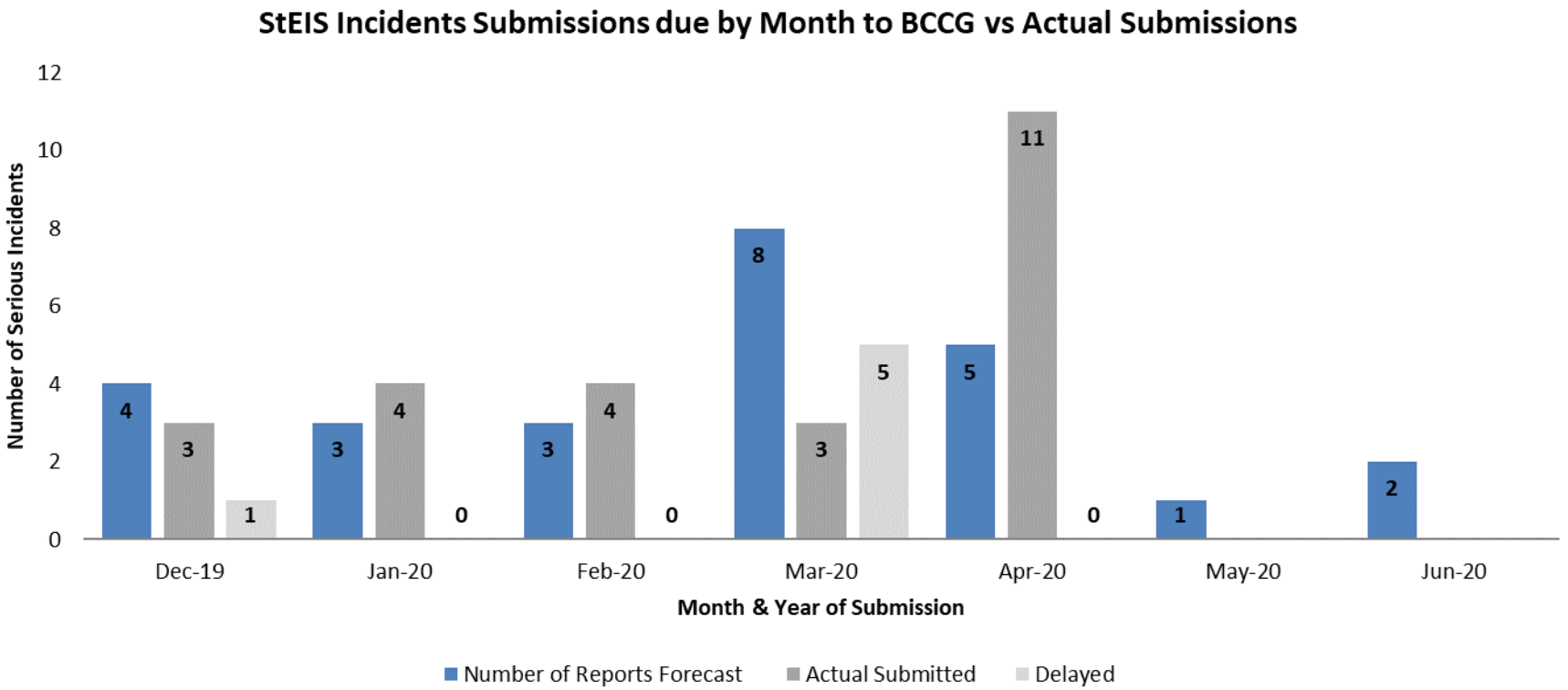
BAF Risk: SR01.

Figure Q3.2: Current trajectory of StEIS submissions to BCCG per month vs actual submissions in the month.



Q5 SAFETY ALERTS

Figure Q5.1:

Safety Alerts	Number of Alerts Received (May 19 – Apr 20)	Number of Alerts Applicable (May 19 – Apr 20)	Number of Open Alerts
CAS/ NHS Improvement	40	0	0
MHRA – Medical Equipment	17	0	0
MHRA - Medicine Alerts	57	1	0
IPC	6	6	0

Medicines – Alerts Applicable

1. **Glucose 10% 500ml infusion bags** - Company led drug recall for certain batches issued 07/05/2019.
Actions: Not general NWAS stock but stock was located on the DoH Mass Casualty Vehicles held in HART. Current stocks checked for affected batches and all found have been removed and replaced with non-affected stock. Disposed of affected stocks.
Action Date: All actions completed by 05/06/2019. Alert now closed.

IPC – Alerts Applicable

1. Measles - 5 cases 1 NWAS staff member and 4 public cases throughout the period of January February 2020 . Actions: Staff member contained and vaccinated will finish incubation period 18/01/2020. Contact staff members referred to occupational health staff that may pose a risk to patients and staff have removed from working. Patient contact of infected member of staff , 02/01/2020 warn and inform letters sent out to them,08/01/2020. Comms information and advisory bulletin sent out. 09/01/2020 .NWAS working alongside Public Health England and other Health care organisations. LEAD: LDonovan (Clinical Safety practioner lead GM) Fran Dreniw (Sector Manager South) Senior management informed and monitoring.
2. Coronavirus is a viral disease (COVID19). Coronavirus has been spreading throughout the world therefore it has been declared as a national pandemic and is still ongoing. There is a multi faceted action plan that operates across the trust, this includes HR, Procurement, Communications, Operations and the quality teams. This is being discharged via A Hansen (LEAD and DiPC) and the executive leadership committee (ELC).

NWAS Response

There have been 15 new safety alerts in April 2020.

The total number of CAS/NHS Improvement alerts received between May 2019 and April 2020 is 40, with no alerts applicable.

17 MHRA Medical Equipment Alerts have been received with no alerts applicable.

57 MHRA Medicine alerts have been received, with 1 alert applicable.

6 IPC alerts have been received, with 6 alerts applicable.

BAF Risk: SR01.

E1 PATIENT EXPERIENCE

Figure E1.1

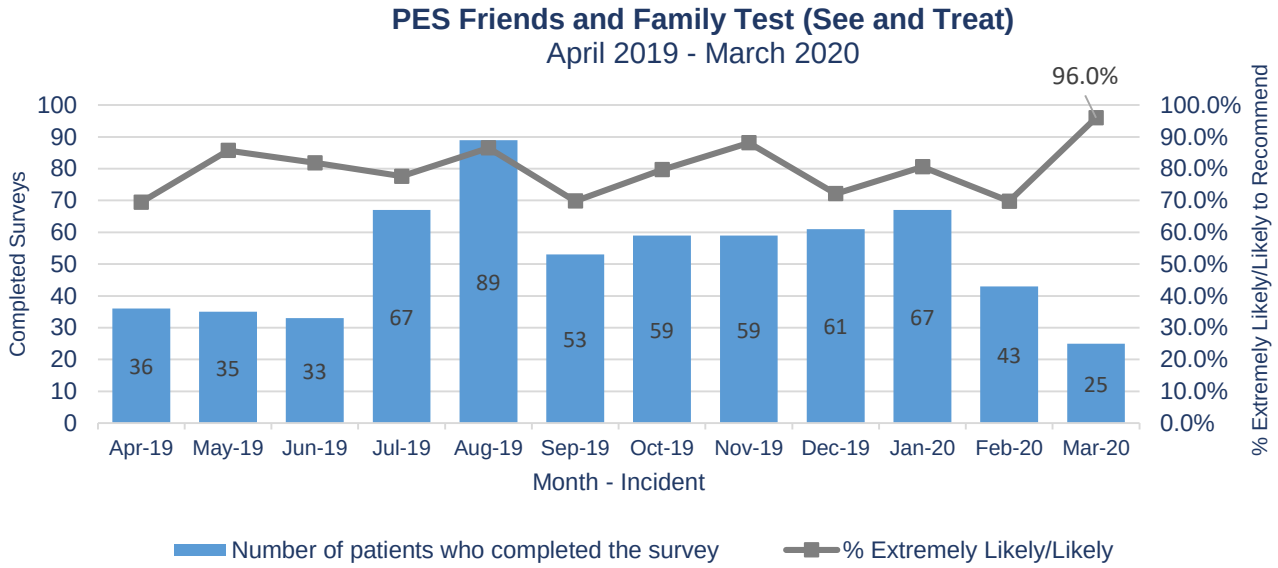


Table E1.1 National PES See and Treat FFT – February 2020

Organisation Name	Total Responses	Percentage Recommended	Percentage Not Recommended
England	232	91%	4%
EAST OF ENGLAND AMBULANCE SERVICE	31	100%	0%
SOUTH CENTRAL AMBULANCE SERVICE	10	100%	0%
NORTH EAST AMBULANCE SERVICE	132	97%	2%
WEST MIDLANDS AMBULANCE SERVICE	5	80%	20%
NORTH WEST AMBULANCE SERVICE	43	70%	16%
EAST MIDLANDS AMBULANCE SERVICE	6	67%	17%
YORKSHIRE AMBULANCE SERVICE	0	NA	NA
ISLE OF WIGHT	0	NA	NA
LONDON AMBULANCE SERVICE	1	*	*
SOUTH WESTERN AMBULANCE SERVICE	4	*	*

Patient Experience (PES)

A significant drop of 41.9% is seen this month, (from 43 in February to 25 in March) for PES FFT returns. This drop is attributed to the pandemic and the national decision to pause all patient experience surveying. A significant increase of 26.2% in satisfaction rating is also noted (from 69.8% to 96.0%).

At the end of Q4, the 50% improvement goal in terms of average returns set in Q1 was exceeded.

Nationally, the trust continues to hold second position in terms of number of responses received – for both January and February. And in terms of recommendation remained in 4th having moved from 5th in the previous month (February 2020 data).

The trust has an FFT implementation plan for April 2020 when the new national guidance on the submission of the PES (see and treat) takes effect but as a result of the COVID-19 pandemic, this rollout has been put on hold by NHS England.

Figure E1.2

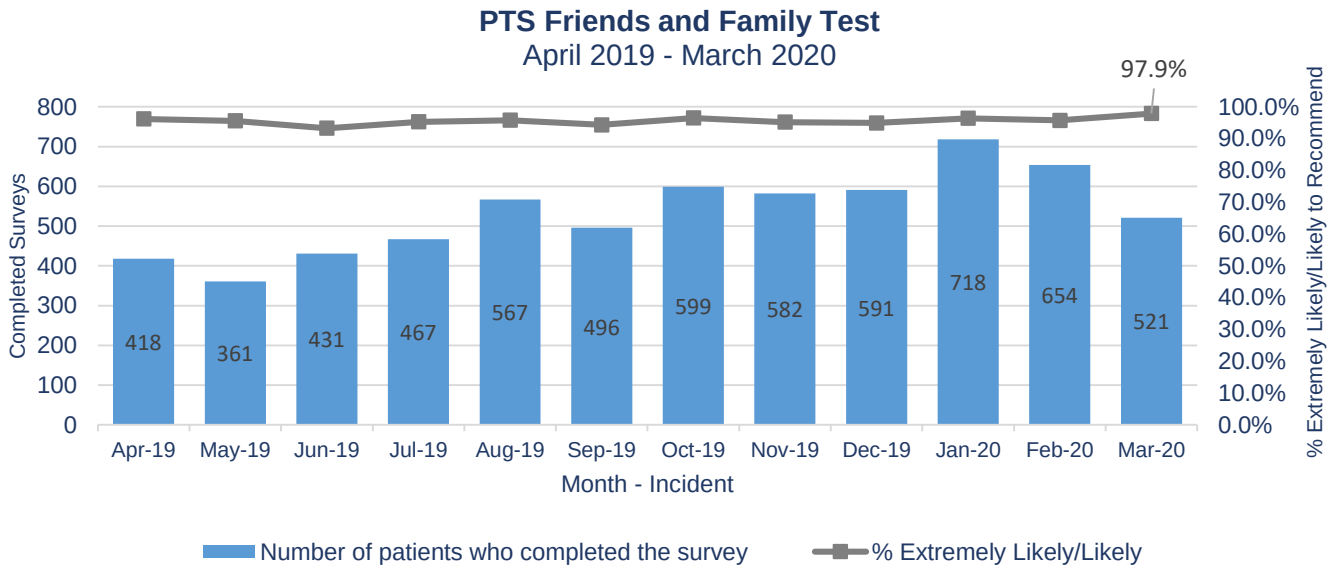


Table E1.2 National PTS FFT – February 2020

Organisation Name	Total Responses	Percentage Recommended	Percentage Not Recommended
England	2,460	91%	4%
NORTH EAST AMBULANCE SERVICE	9	100%	0%
ERS MEDICAL	140	99%	0%
NORTH WEST AMBULANCE SERVICE	654	96%	3%
ISLE OF WIGHT	19	95%	0%
WEST MIDLANDS AMBULANCE SERVICE	32	94%	0%
GUY'S AND ST THOMAS'	1075	91%	3%
EAST OF ENGLAND AMBULANCE SERVICE	163	90%	4%
EAST MIDLANDS AMBULANCE SERVICE	7	86%	14%
UNIVERSITY COLLEGE LONDON HOSPITALS	250	85%	7%
SOUTH CENTRAL AMBULANCE SERVICE	5	80%	20%
IMPERIAL COLLEGE HEALTHCARE	106	76%	17%
YORKSHIRE AMBULANCE SERVICE	0	NA	NA

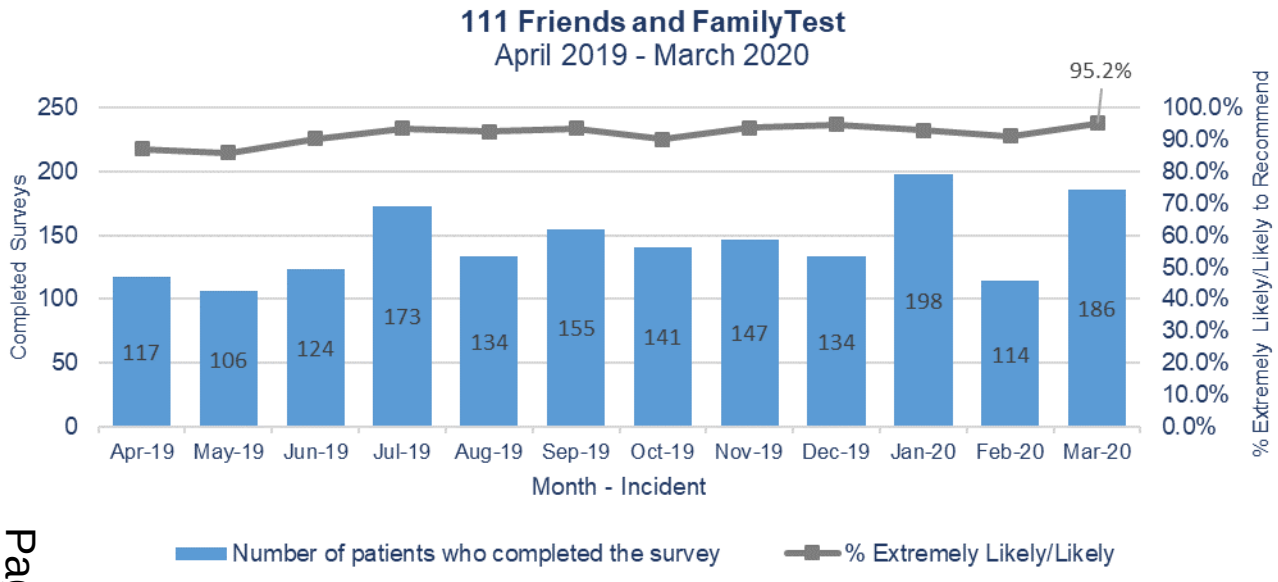
Patient Experience (PTS)

The number of patients who completed the FFT has reduced from 654 in February to 521 in March (a drop of 20.3%). This drop is attributed to the pandemic and the national decision to pause all patient experience surveying. The satisfaction rate has increased from 2.2% for the same period (95.7% to 97.9%).

Nationally, the trust continues to maintain the second highest spot in terms of number of responses, same as the previous month. In terms of satisfaction levels, this month sees the trust drop into 2nd spot (Ambulance Trust) from 1st in the previous month of January (February 2020 data).

There is still the requirement for national submissions for PTS FFT responses post Apr 2020, but as a result of the COVID-19 pandemic, this has been put on hold by NHS England.

Figure E1.3



Patient Experience (111)

The number of NHS 111 FFT responses saw a significant increase from 114 in February to 186 in March, (increase of 63.1%).
We also saw an increase of 4.0% in satisfaction levels from 91.2% in January to 95.2% in March.

Given the impact of the pandemic and the national decision to pause all patient experience surveying , the number of NHS 111 FFT returns does not follow the same trend as PES or PTS returns which have both decreased in number. This may be due to the very significant increase in calls to the NHS 111 service during this period.

E2 AMBULANCE CLINICAL QUALITY INDICATORS

Table E2.1: ACQI November 2019

ACQI Indicator		YTD Performance (%)	Sample Size (Current Month)	November 19 Performance (% / hrs: mins)	October 19 Performance (%)*	November 19 Rank position	Rank movement	Performance Range % / hrs: mins (national mean)
Cardiac Arrest ROSC	Overall	33.0%	235	27.2%	32.0%	7	↓	23.3-33.7 (28.8)
	Utstein	55.5%	39	43.6%	50.0%	9	↔	37.9-75.0 (53.6)
	Resus Care Bundle	65.4%	N/A	N/A	57.9%	N/A	N/A	N/A
Cardiac Arrest Survival to Discharge	Overall	9.1%	222	6.8%	7.8%	6	↑	5.1-11.9 (7.8)
	Utstein	28.3%	34	20.6%	10.5%	9	↑	20.0-31.4 (26.7)
Acute STEMI	PPCI (mean call to PPCI time)	N/A	146	2hrs 24 mins	2hrs 34 mins	7	↑	1hr 52 mins - 5hr 25 mins (2hr 16 mins)
	Care Bundle	76.5%	N/A	N/A	78.1%	N/A	N/A	N/A
Stroke	Hyper acute (mean call to door time)	N/A	568	1hr 26 mins	N/A	4	↑	1hr 10 mins - 1hr 42 mins (1hr 28 mins)
	Care Bundle	98.6%	907	98.6%	N/A	N/A	N/A	83.6-99.6 (96.9)
Sepsis	Care Bundle	N/A	N/A	N/A	N/A	N/A	N/A	N/A

ACQIs – November 2019

NHS England have suspended all AQI outcome data from April to June 2020 which means that the last published data was the November 2019.

In November, 6.8% of patients suffering an out of hospital cardiac arrest survived to hospital discharge (national mean 7.8%). The figure for the Utstein sub-group was 20.6% (national mean 26.7%). This performance saw the Trust ranked 6th and 9th respectively for English ambulance trusts.

The rates of the Return of Spontaneous Circulation (ROSC) achieved during the management of patients suffering an out of hospital cardiac arrest for the Utstein group was 43.6% (national mean 53.6%), ranking 9th nationally. For the overall group the rate was 27.2% (national mean 28.8%) ranking the Trust in 7th position nationally.

Mean call to PPCI time for patients suffering a myocardial infarction was outside of the national mean of 2h 16mins; the Trust's performance was 2h 24mins for these patients.

Mean call to door time for patients suffering a hyper acute stroke was just outside of the national mean of 1h 26mins; the Trust's performance was 1h 28mins for these patients.

The stroke care bundle result of 98.6% was marginally ahead of the national mean of 96.9%. Care bundle data for STEMI and sepsis was not published for November as is consistent with the NHSE reporting schedule.

Cardiac Outcomes over time (SPC)

Figure E2.1

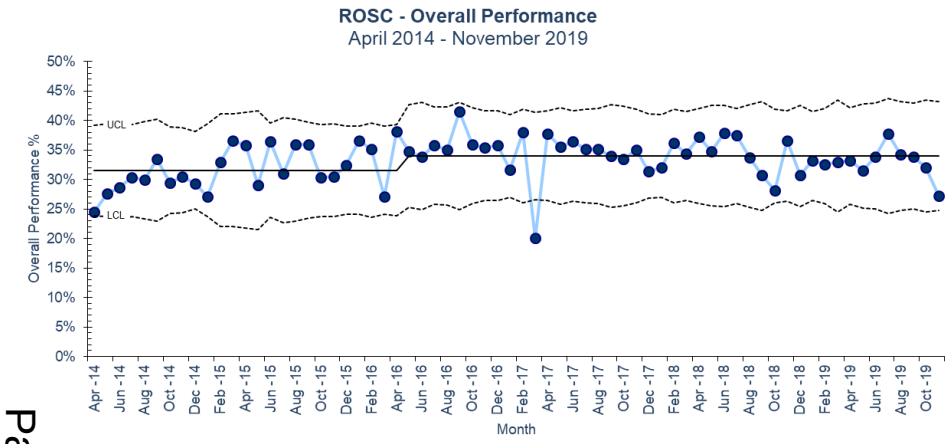


Figure E2.2

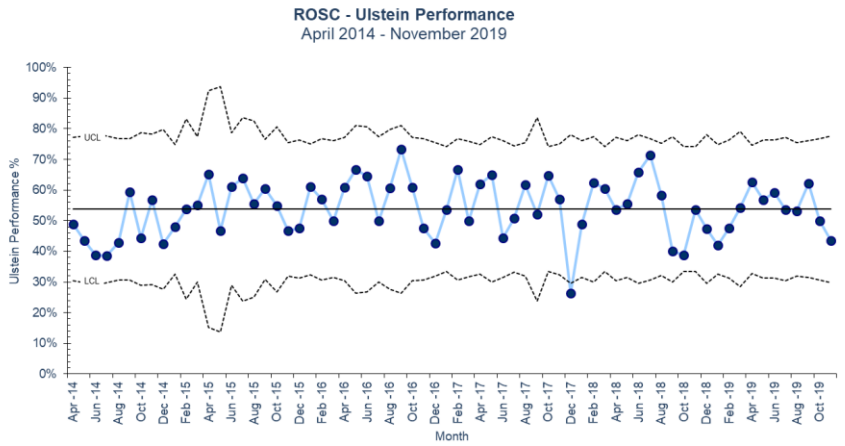


Figure E2.3

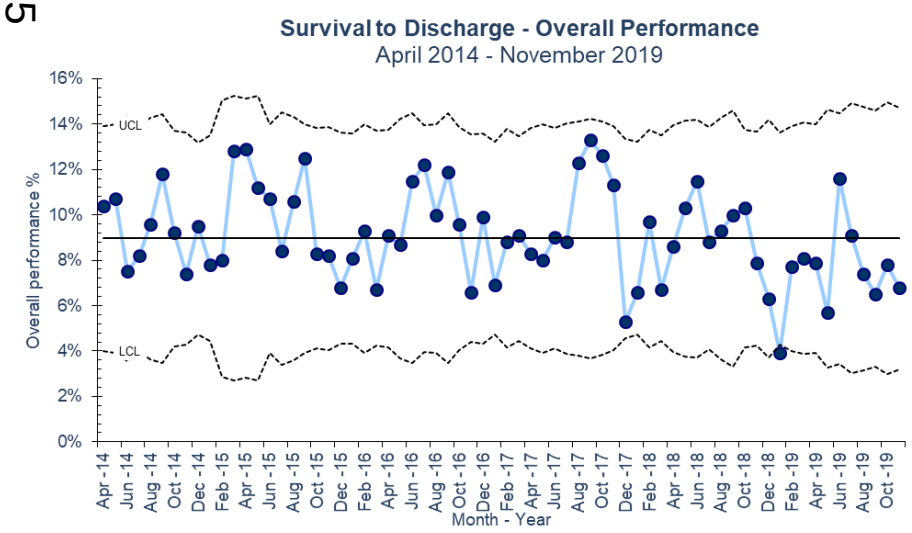
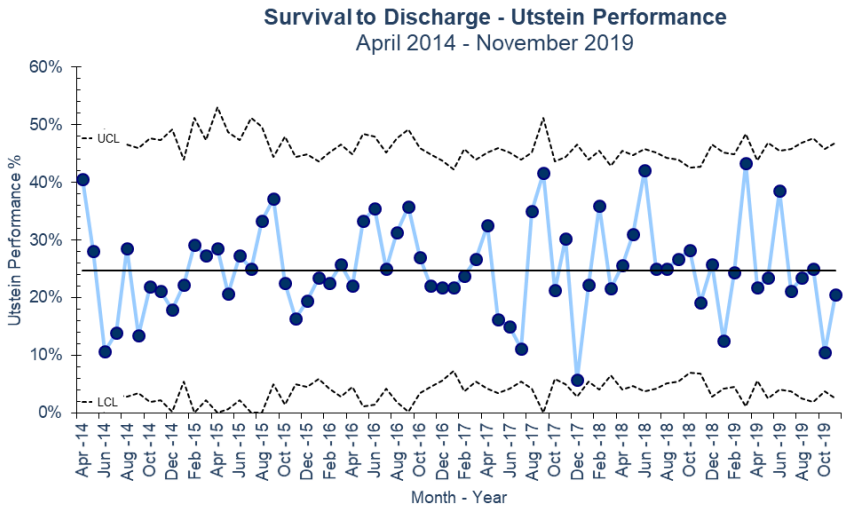


Figure E2.4



Care Bundles Cardiac and Stroke (SPC)

Figure E2.5

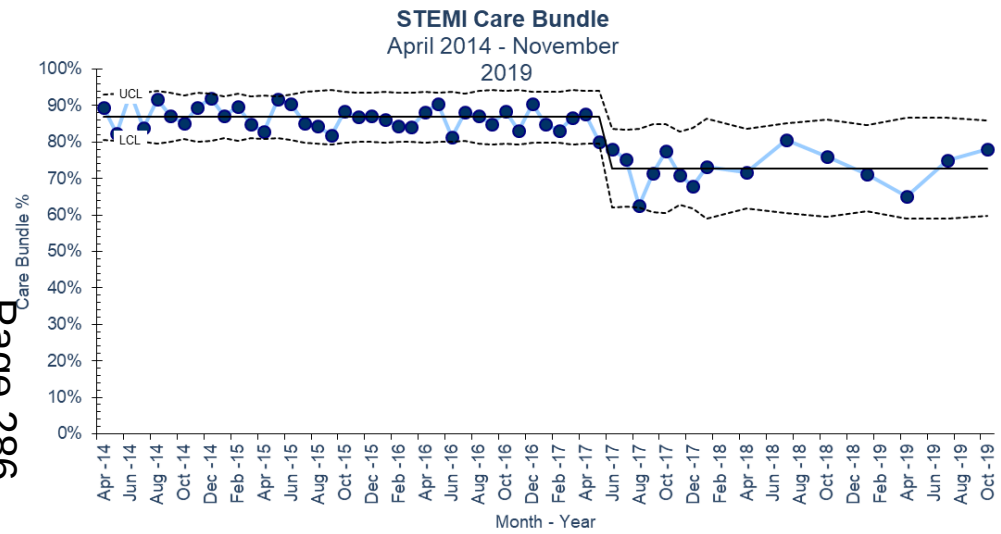
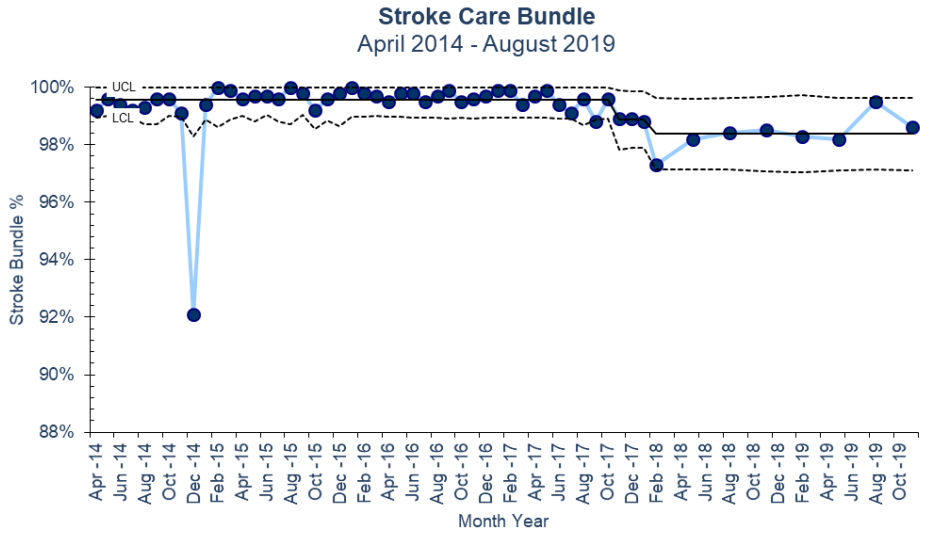


Figure E2.6



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

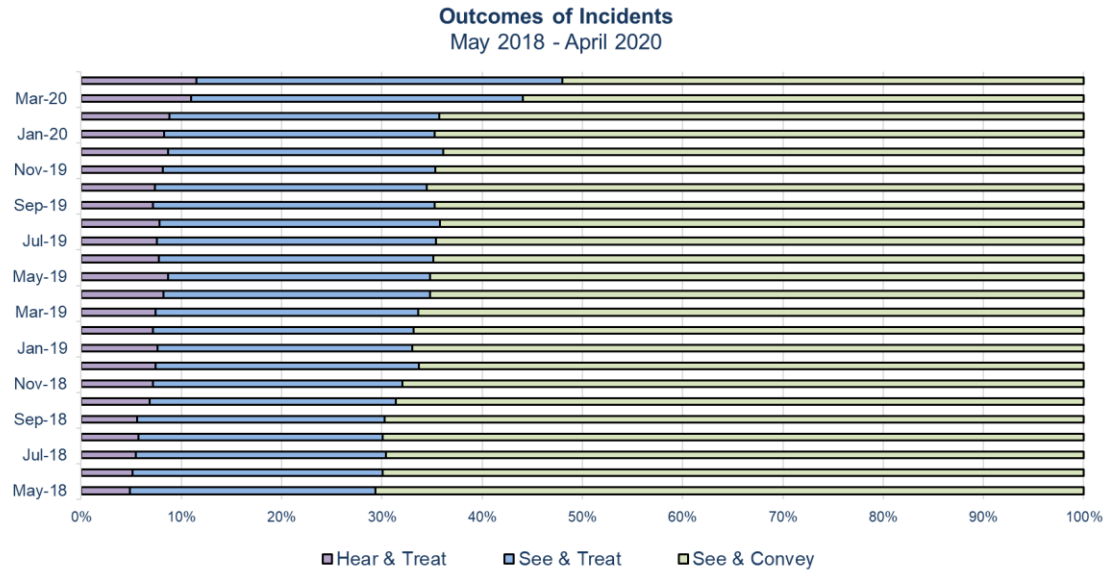


Table E3.1

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 %
May-19	8,741	8.7%	26,394	26.1%	65,844	65.2%
Jun-19	7,503	7.7%	26,554	27.4%	62,889	64.9%
Jul-19	7,565	7.6%	27,849	27.9%	64,554	64.6%
Aug-19	7,640	7.8%	27,280	27.9%	62,729	64.2%
Sep-19	6,782	7.1%	26,711	28.1%	61,423	64.7%
Oct-19	7,249	7.3%	26,863	27.2%	64,792	65.5%
Nov-19	8,101	8.1%	27,031	27.2%	64,357	64.7%
Dec-19	9,064	8.6%	28,779	27.5%	66,966	63.9%
Jan-20	8,170	8.3%	26,612	27.0%	63,873	64.7%
Feb-20	7,867	8.8%	24,033	26.9%	57,381	64.3%
Mar-20	10,602	11.0%	31,921	33.1%	54,002	55.9%
Apr-20	10,616	11.5%	33,586	36.5%	47,852	52.0%

Outcomes

April 2020 seen a large reduction in conveyance from 64.3 % in February 2020 to 52.% in April 2020. This is primarily due to Covid-19.

Additional funding was released to support the Covid-19 Pandemic which has allowed an increase in workforce in Clinical Hub. IT infrastructure has been developed to provide efficiencies and enable home and remote working.

Hear & Treat Performance for April 2020 was 11.53 % and the number of incidents with no face-to-face response being 10,616. This is a 3.31% increase in performance in comparison to April 2019 and is the highest H&T Performance to date.
Compared to previous year, 2495 more patients in April 2020 received a H&T outcome which better met their needs and saved valuable resource for our sickest patients.
The increase in H&T also enabled better protection for NWAS responders, North West Health Economy overall and patients, enabling them to remain at home and reduce risk of infection.

Figure E3.2

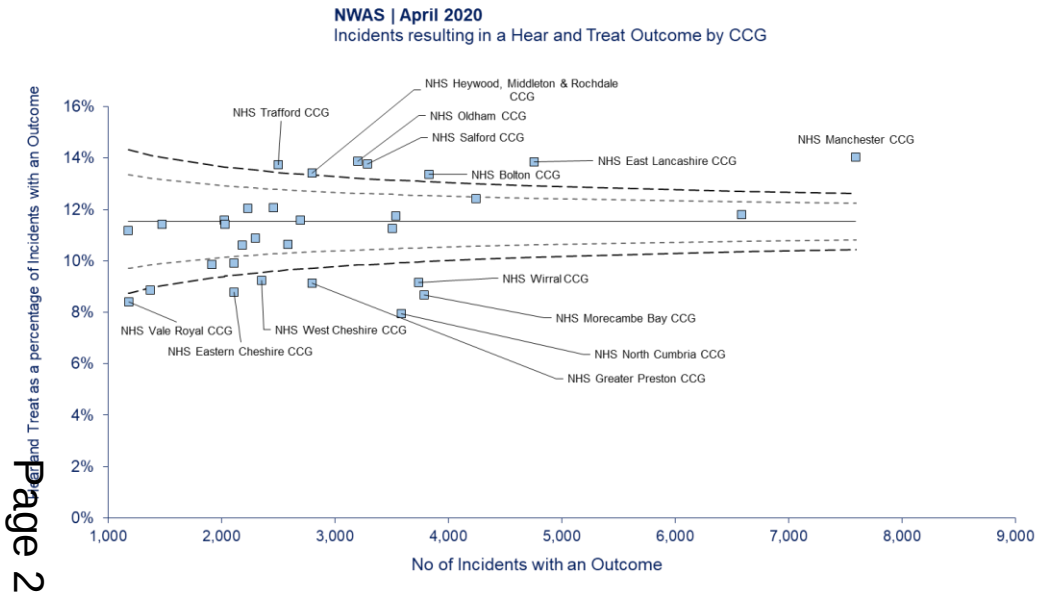
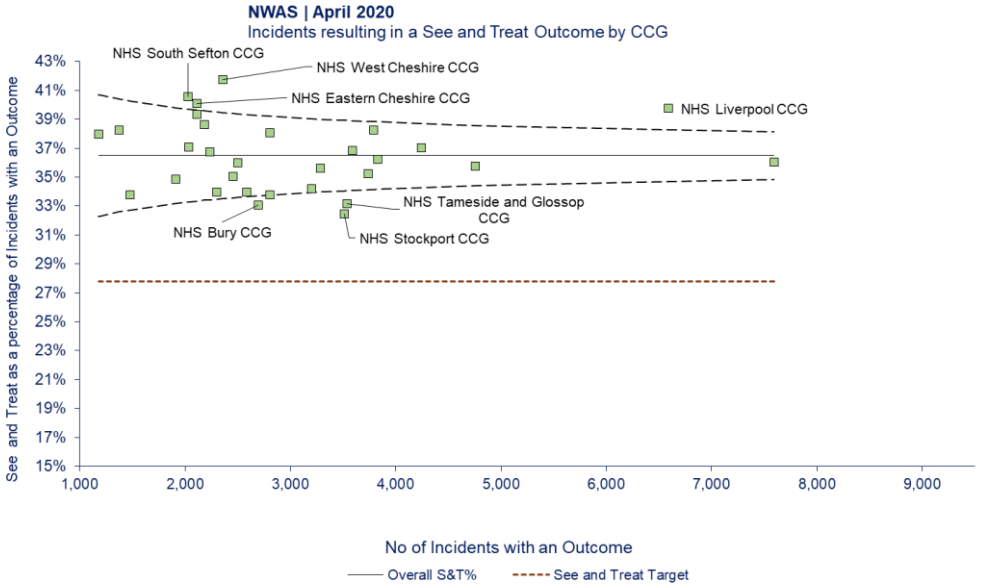


Figure E3.3



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There is special cause variation in **Figures E3.4, 5 and 6**. **Figures E3.4 and E3.5** both show an increase in the rate and sit above the upper confidence limit. **Figure E3.6** is showing a decrease and is below the lower confidence limit. All are due to Covid-19. We have also seen a move back towards the respective confidence limit and 'norm' over the past two months.

Figure E3.4

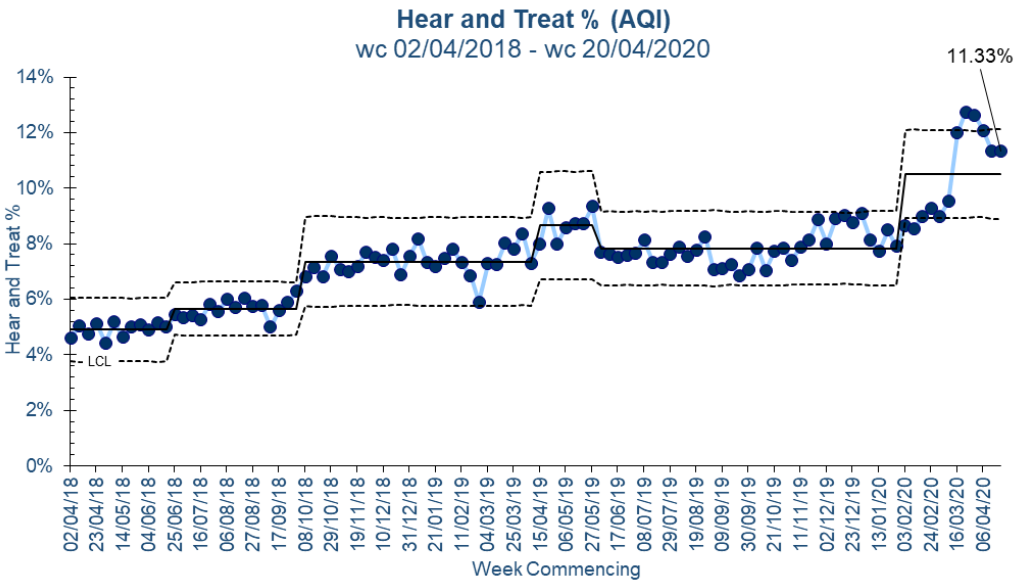


Figure E3.5

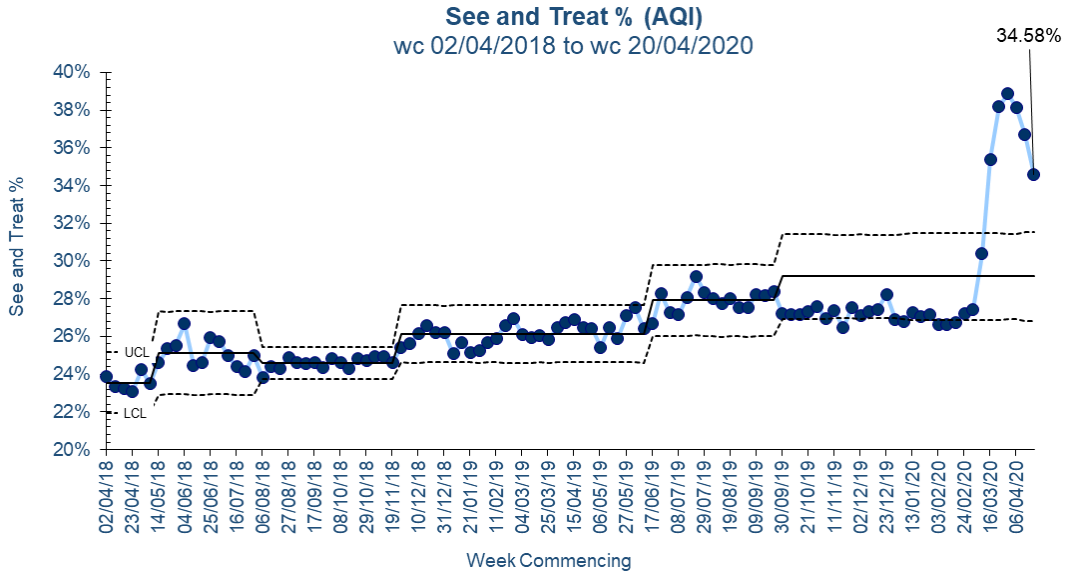
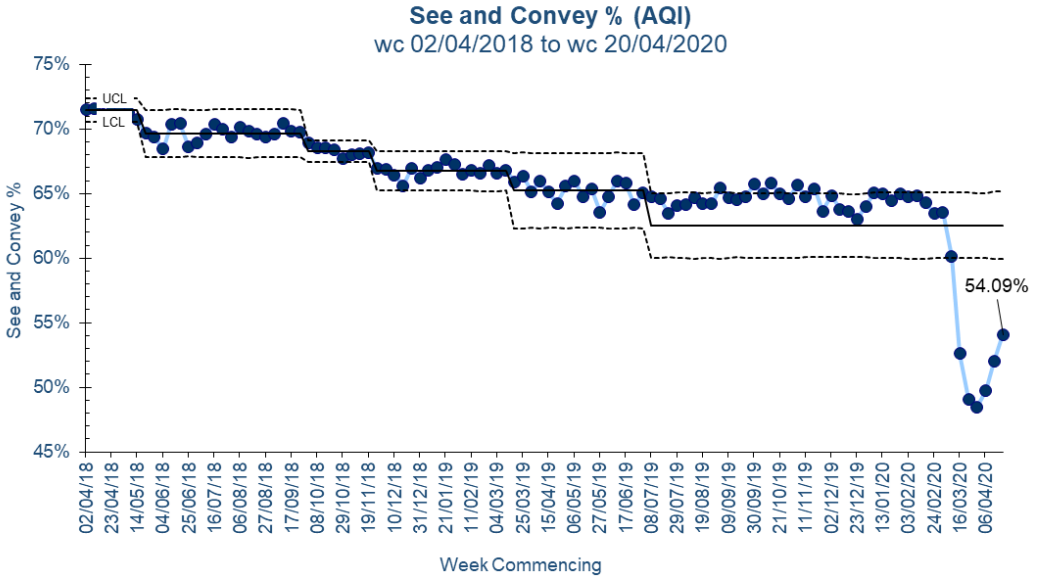


Figure E3.6



F1 FINANCIAL SCORE

Figure F1.1

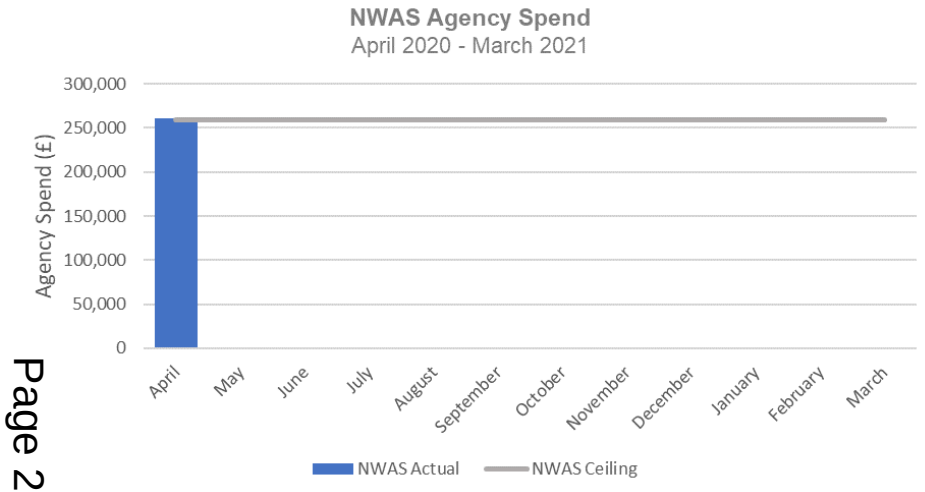


Figure F1.2

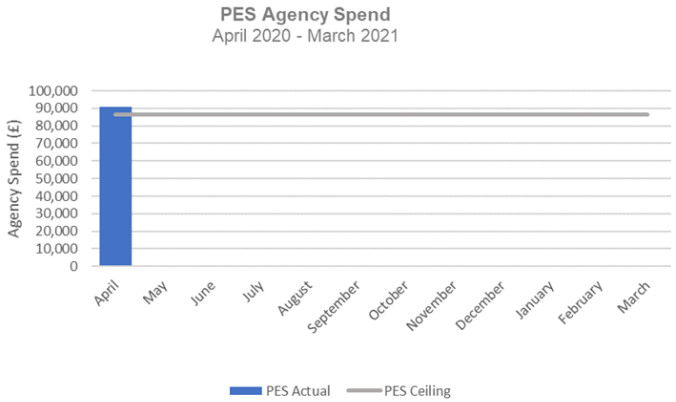


Figure F1.3

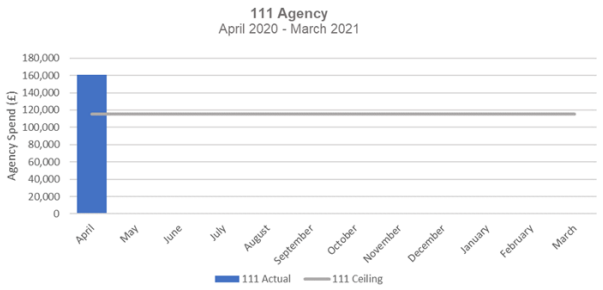


Figure F1.4

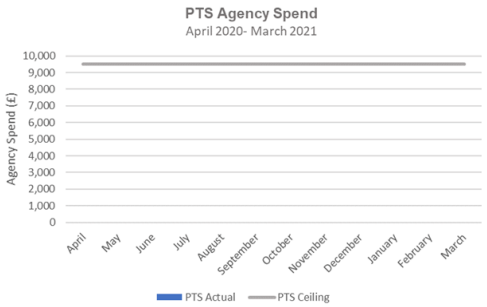
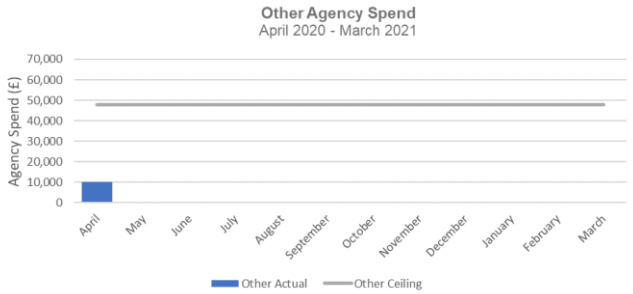


Figure F1.5



Finance Position – April 2019

Month 01 Finance Position:

Agency Expenditure

The year to date expenditure on agency is £0.261m which is £0.002m above the year to date ceiling of £0.259m.

Please Note: The agency ceiling is based on 2019/20 ceiling figures and will be updated as soon as we have the information.

Risk Rating

For the four months of the COVID-19 framework, the 2020/21 monthly financial returns have been redesigned to collect a minimum dataset to reduce the burden on organisations wherever possible, whilst maintaining a monthly data collection process.

The Financial Risk Rating metrics have been removed and we will add back once the new operating framework is launched after transition from the COVID-19 financial framework.

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O1 CALL PICK UP

Figure O1.1

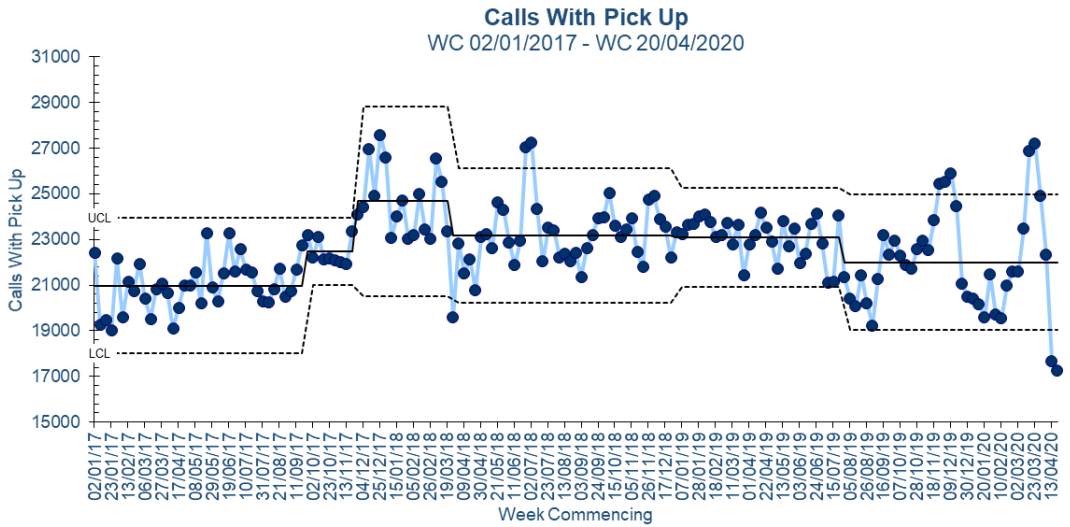
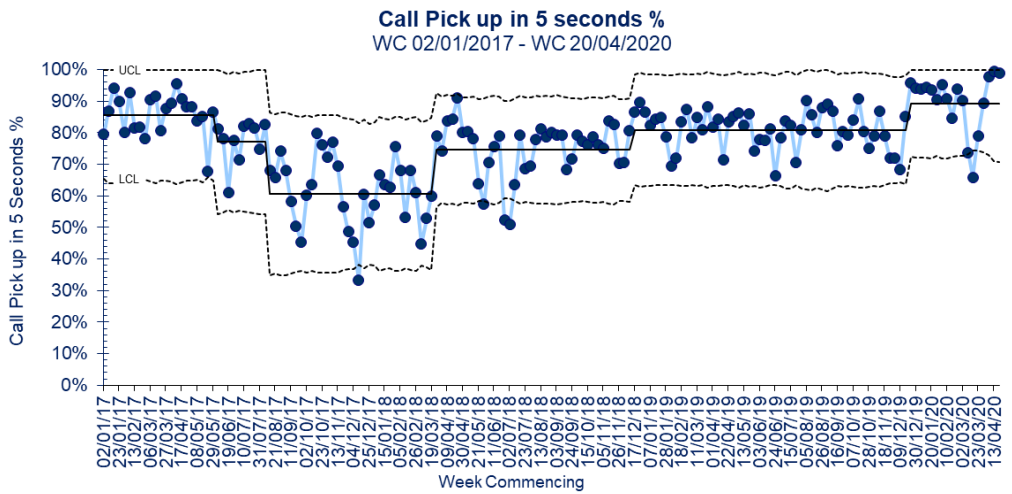


Figure O1.2



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 April 2020, call pick up performance was at 96.7%. 2808 calls took longer than 5 seconds to pick up.

Call pick up has significantly improved across all performance metrics. Calls answered in 5 seconds stands above 95% for the first time since ARP went live in August 2017. The mean and centile performance is also significantly improved. The 95th centile has improved by 73 seconds vs previous month. The improvement in call pick up is reflected in the national picture for call handling performance. NWAS has been number one in the sector three of the previous four weeks for call pick up.

There is special cause variation in both **Figure 01.1** and **01.2**. For **Figure 01.1** the reduction in call volume can be attributed to two primary factors. Firstly there has been a reduction in initial/primary calls from the public. This appears to indicate public behaviour has changed during the Covid-19 pandemic. This is clear when reviewing NWAS's emergency call volume and the sector as a whole. All ambulance services have seen a reduction in call volume. The second factor reducing call volume is the reduction in secondary/follow up calls known as duplicates. Duplicate calls occur in the primary when a patient or caller, re contacts NWAS, either because the patient has worsened or (and more likely) to ask for an ETA for a response. NWAS response times have improved and as a result duplicates have reduced.

Special cause variation for **Figure 01.2** can be attributed to two primary factors also. Firstly the reduction in call volume, the rationale has been previously described and secondly due to increases in workforce. NWAS EOC has recruited an additional 180 call handling staff. This is driving the improvements to call answer times.

Figure O1.3: Source - CAD calls

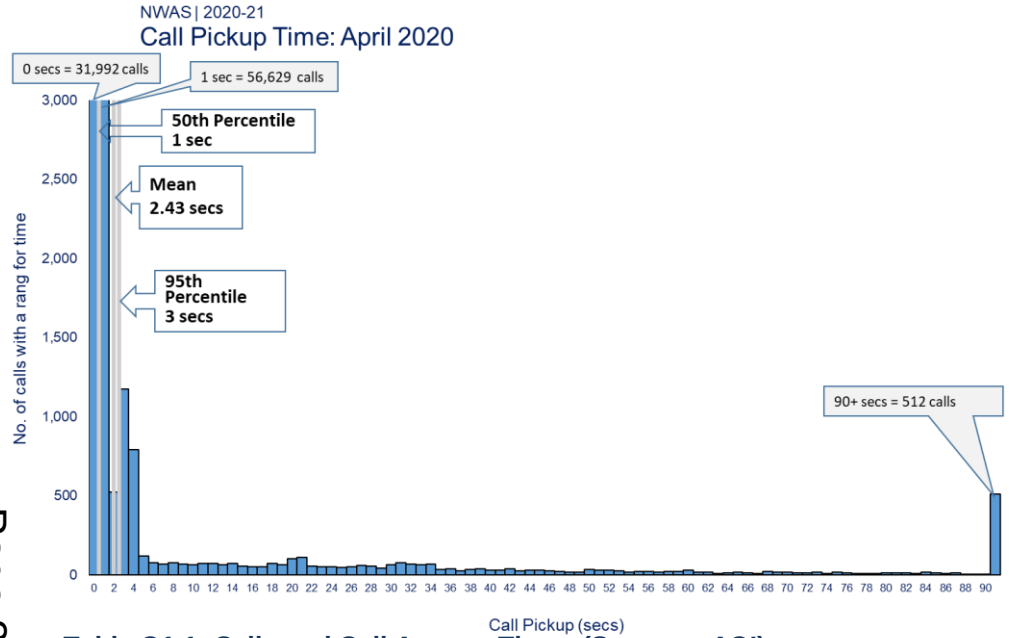


Table O1.1: Calls and Call Answer Times (Source – AQI)

			Call answer times (seconds)				
Month/Yr	Contact Count	Calls answered	Total	Mean (Switch)	Median (50th centile)	95th centile	99th centile
May-19	127,228	100,285	700,370	7	1	51	109
Jun - 19	127,636	103,571	1,423,103	14	1	85	141
Jul - 19	133,978	111,732	1,328,299	12	1	76	126
Aug - 19	129,170	106,821	962,210	9	1	62	120
Sep – 19	126,328	104,445	1,153,070	11	1	70	130
Oct - 19	134,676	120,721	1,120,257	9	1	64	120
Nov - 19	140,609	126,698	1,583,850	13	1	78	127
Dec – 19	146,720	130,786	1,548,068	12	1	76	124
Jan - 20	125,079	103,307	471,336	5	1	19	87
Feb - 20	117,409	98,259	531,953	5	1	36	69
Mar -20	142,039	123,743	1,504,031	12	1	74	133
Apr -20	116,584	96,542	196,505	2	1	1	52

O2 A&E TURNAROUND

Figure O2.1

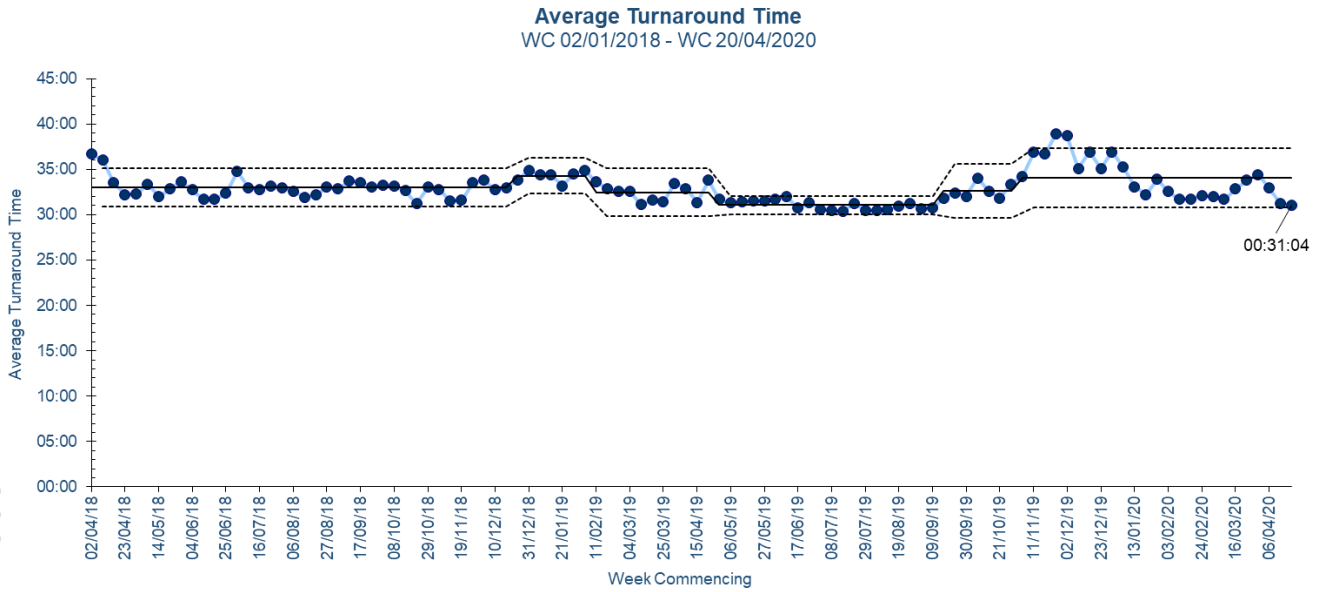


Table O2.1

Month	Hospital Attendances	Average Turnaround Time [mm:ss]	Average Arrival to Handover Time [mm:ss]	Average Handover to Clear Time [mm:ss]
May - 19	59,274	31:25	19:55	11:14
Jun - 19	56,635	31:26	20:03	11:09
Jul – 19	58,249	30:44	19:20	11:13
Aug - 19	56,602	30:44	19:18	11:10
Sep - 19	55,724	31:31	20:13	11:09
Oct - 19	58,933	32:34	21:31	11:03
Nov - 19	57,735	34:39	23:39	10:48
Dec - 19	61,304	37:22	26:42	10:42
Jan - 20	58,150	34:08	23:12	10:53
Feb – 20	52,392	32:08	20:51	11:07
Mar - 20	49,419	32:37	20:54	11:26
Apr - 20	41,267	31:58	19:45	12:06

A&E Turnaround Times

The average turnaround for April 2020 was 31 minutes 58 seconds across the North West.

The 5 hospitals with the longest turnaround times during April 2020 were:

Royal Lancaster	37:30
Royal Oldham	36:41
Royal Albert Edward Infirmary	34:48
Royal Blackburn	34:23
Fairfield General	33:34

The hospital turnaround times remain stable. There are improvements at the Trust level where the performance is at the lower control limit which should be seen as a positive.

The NWAS element of the handover time is still well below the15 minute standard however there is some slight deterioration. This can be attributable to vehicle cleaning following Covid-19 incidents.

Figure O2.2

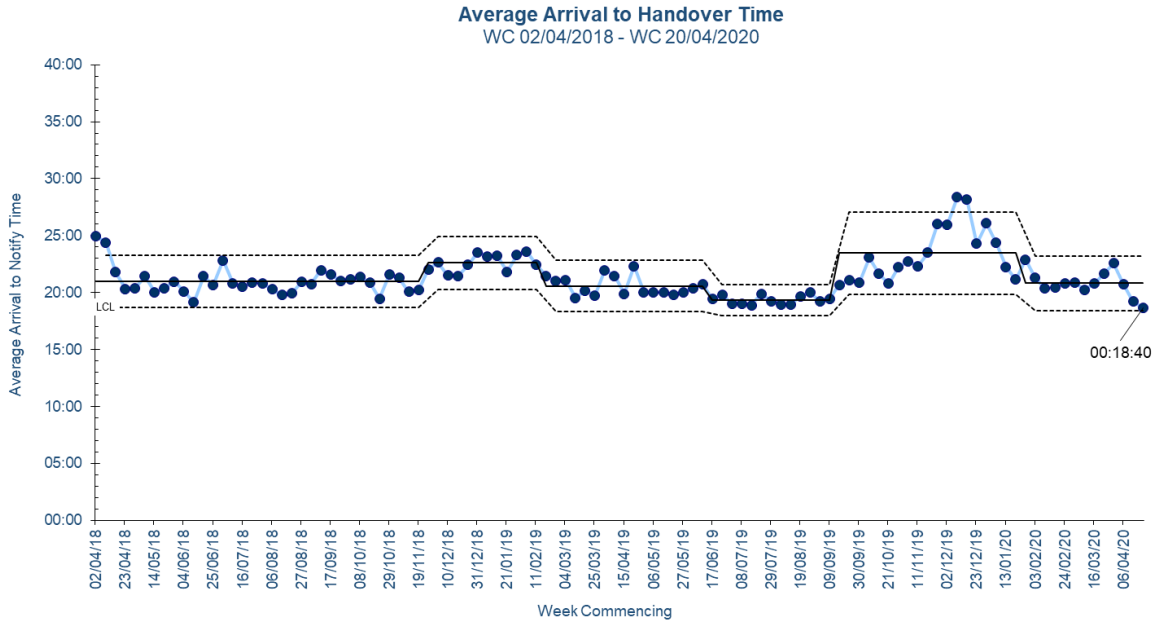
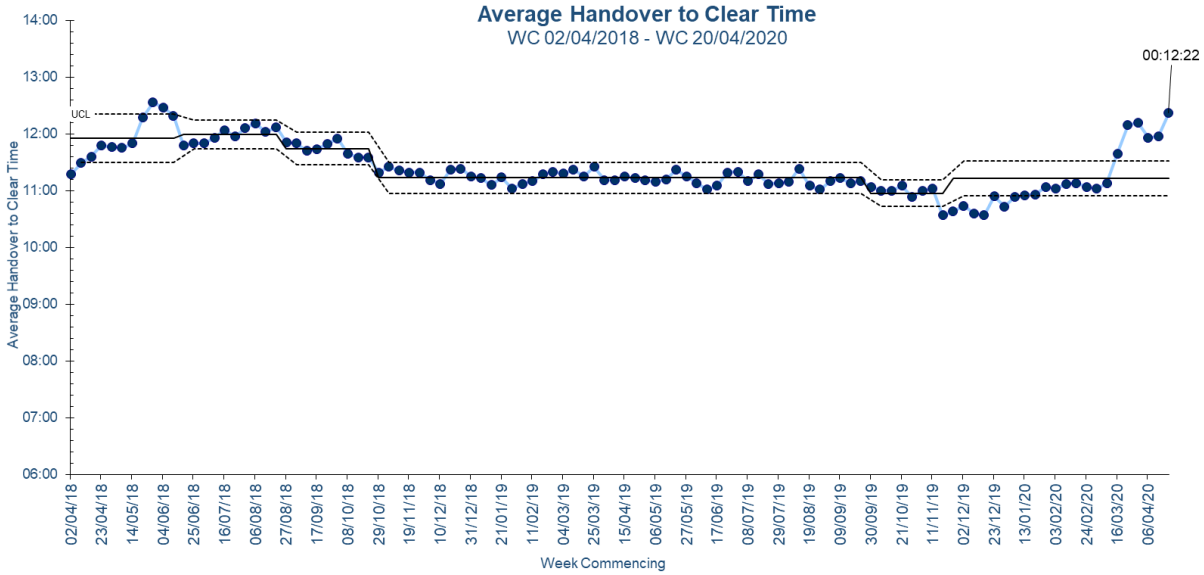


Figure O2.3

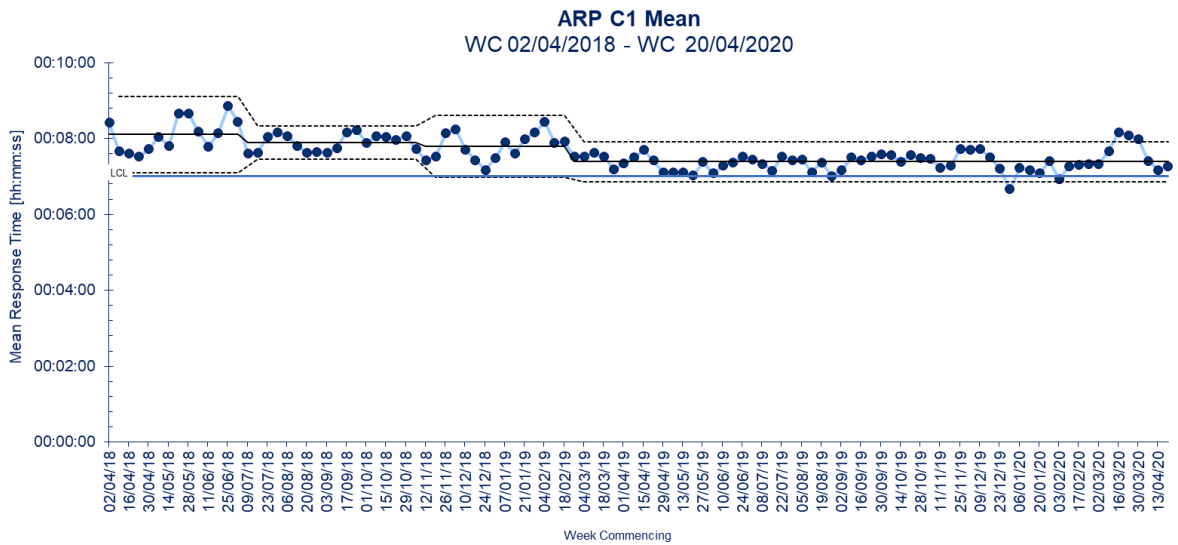


O3 ARP RESPONSE TIMES

Table O3.1 - Incidents with a response

Month/Yr	C1	C2	C3	C4
May-19	9,264	51,531	20,991	4,465
Jun-19	9,071	50,128	20,451	4,116
Jul-19	10,098	50,807	21,527	4,170
Aug-19	9,831	49,468	21,238	4,127
Sep-19	9,870	49,579	20,051	3,870
Oct-19	10,615	52,552	17,951	2,854
Nov-19	10,787	53,795	15,992	3,438
Dec-19	11,276	57,593	14,551	4,738
Jan-20	9,803	52,929	14,070	5,244
Feb-20	8,879	47,867	12,456	4,360
Mar-20	9,855	51,929	13,151	4,095
Apr-20	7,477	42,643	17,779	3,697

Figure O3.1



Activity

C1 Performance

C1 Mean

Target:	7 minutes
NWAS	
April 2020:	7:25
YTD:	7:25

In Table O3.1 growth in all categories of calls can be seen apart from C4.

The introduction of protocol 36 (pandemic) has seen a significant shift in patient categories. A reduction in C1 and C2 patients have been moved into the C3 category. For January to March 2020 we saw on average 64.6% of incidents being classified as C1 or C2 (C1 average 10%, C2 average of 54.6%) against 55.5% in April 2020 (C1 8.1% and C2 47.4%). For C3 January to March 2020 we saw an average of 17.4% for C3 incidents compared to 24.7% in April.

C1 mean and C1 90th have remained stable with some marginal improvements.

Figure O3.2

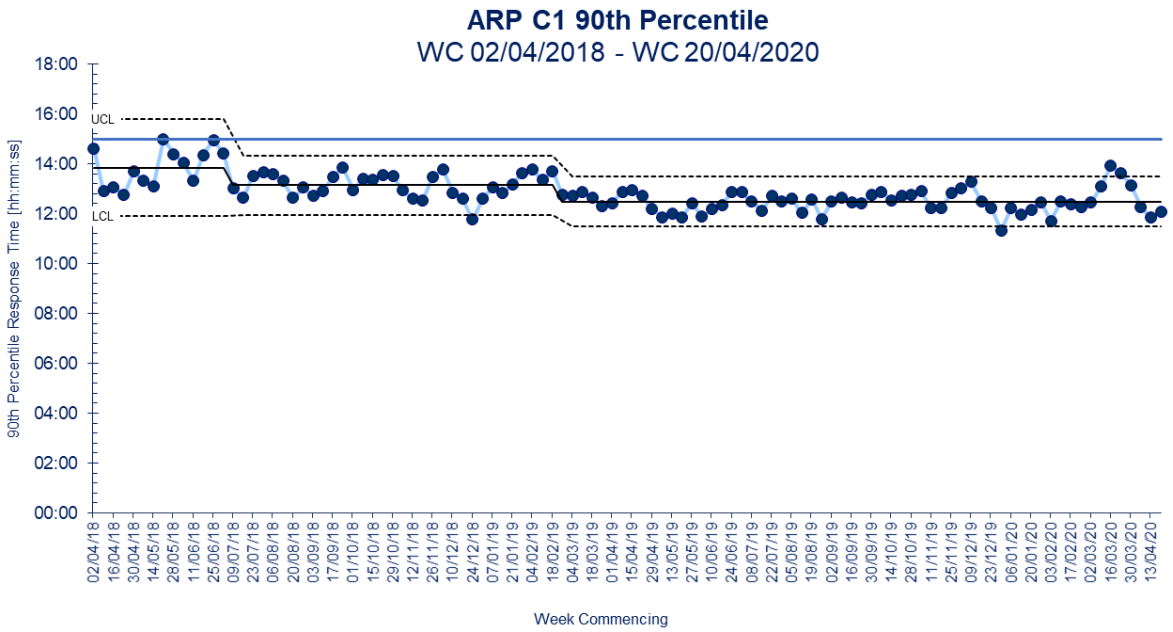
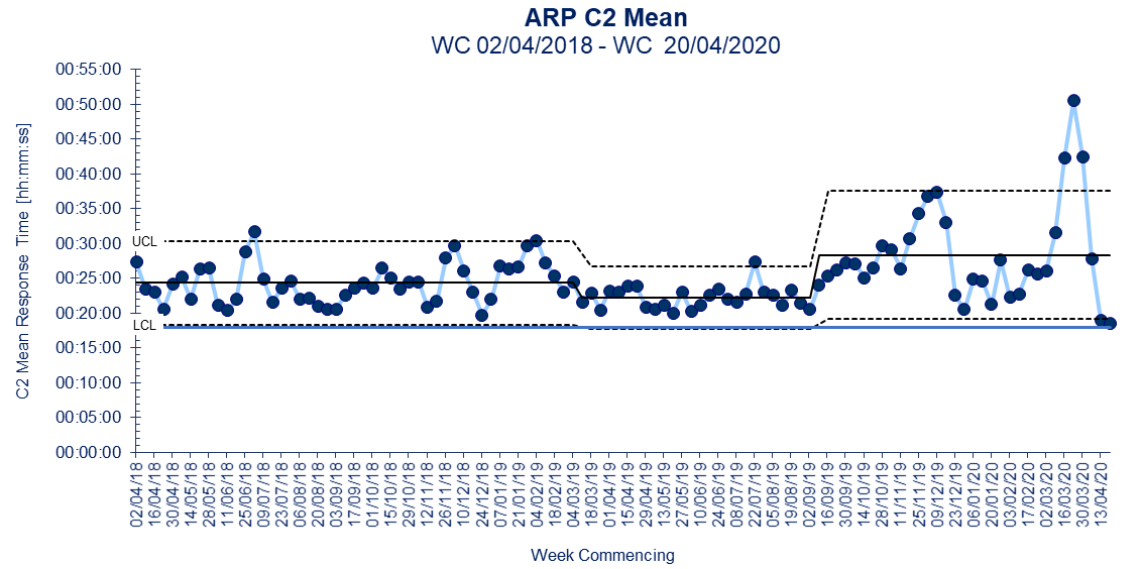


Figure O3.3



C1 90th Percentile

Target:	15 Minutes
NWAS	
April 2020:	12:17
YTD:	12:17

C2 Performance

C2 Mean

Target:	18 minutes
NWAS:	
April 2020:	24:45
YTD:	24:45

Following the rapid deterioration in March above the upper control limits, significant improvements have been seen in C2 mean and 90th. The improvements have been made by expanding the conveying resources through the use of PTS converted vehicles, PTS volunteers with additional training, year 2 student paramedics. The last 2 weeks of April saw both C2 standards being met.

Figure O3.4

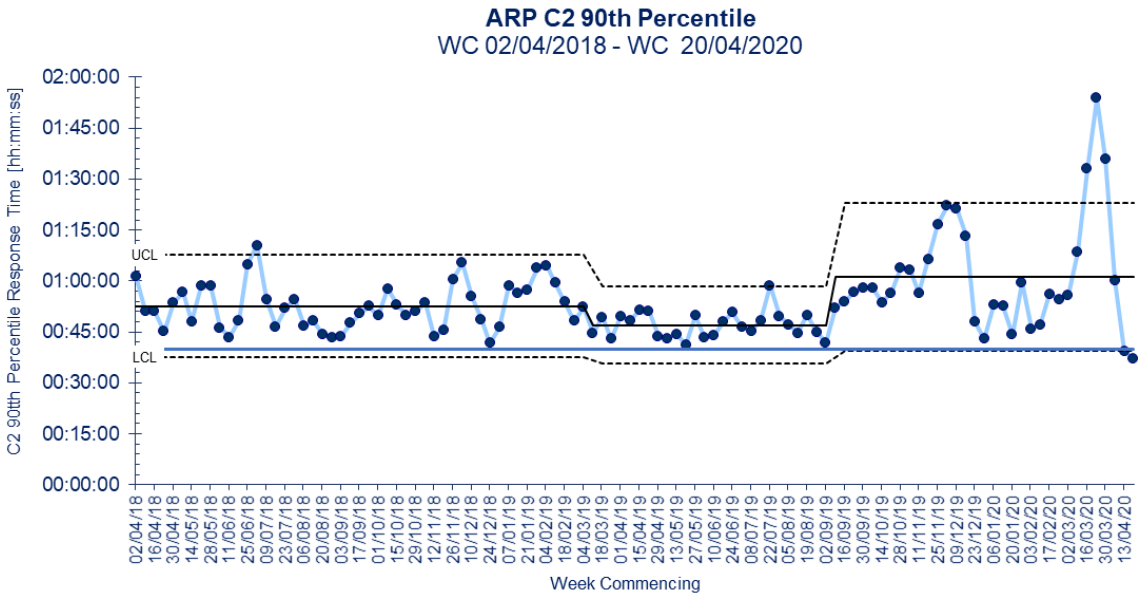
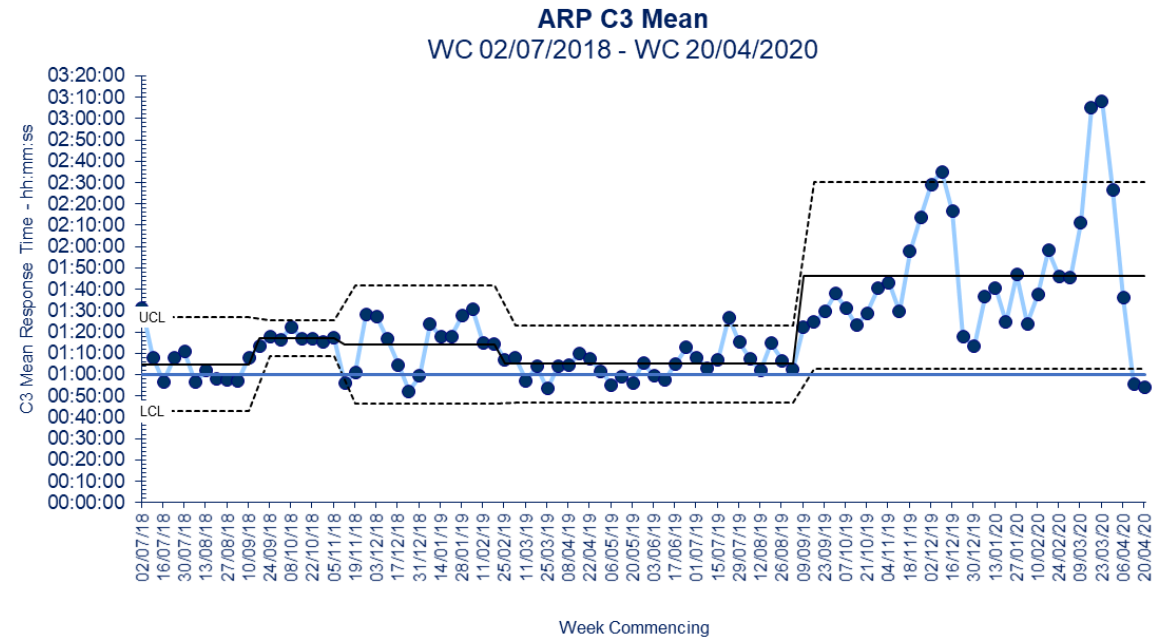


Figure O3.5



C2 90th Percentile

Target: 40 Minutes

NWAS

April 2020:	53:35
YTD:	53:35

C3 Performance

C3 Mean

Target:	1 Hour

NWAS:

April 2020:	01:15:35
YTD:	01:15:35

C3 mean and 90th performance followed a similar trend to C2. March saw some special cause variation (deterioration) followed by dramatic swing to improved performance when the planned resources came on line.

Again the standards were met at the end of April.

Figure O3.6

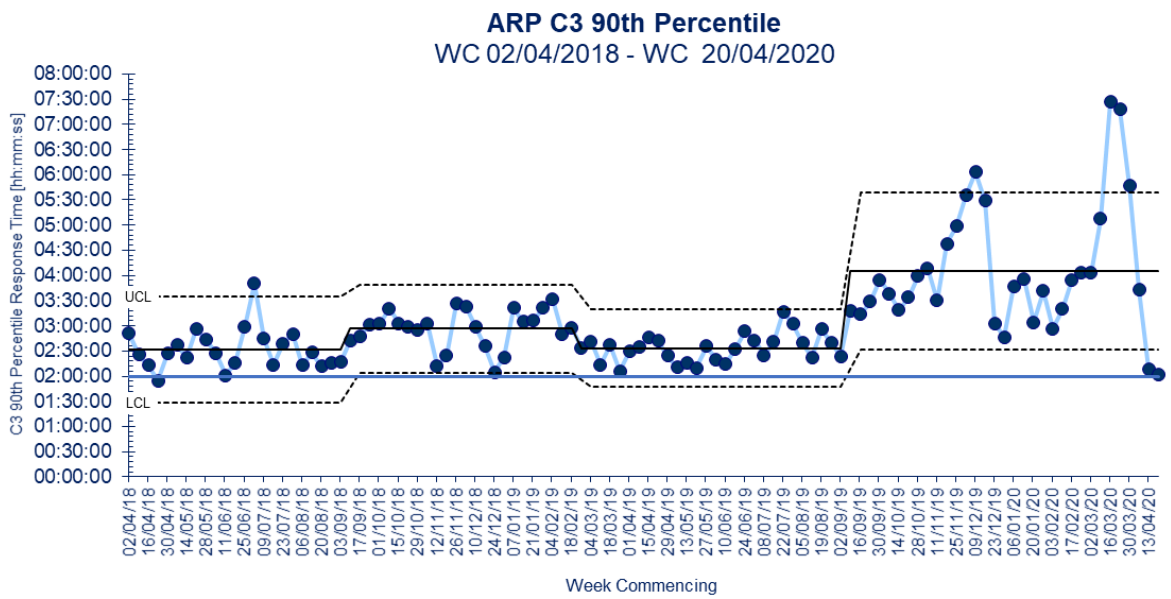
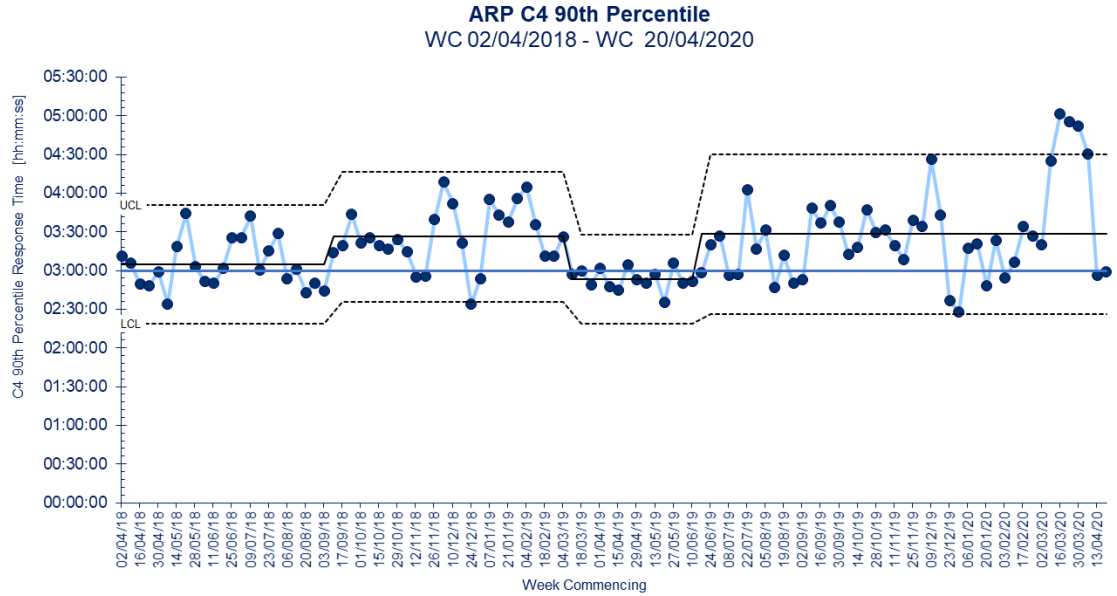


Figure O3.7



C3 90th Percentile

Target:	2 Hours
NWAS	
April 2020:	3:00:00
YTD:	3:00:00

C4 Performance

C4 90th Percentile

Target:	3 Hours
NWAS	
April 2020:	3:38:00
YTD:	3:38:00

C4 performance follows the same pattern as C2 and C3. Deterioration as the CV-19 followed by recovery as the recovery plan takes affect.

Figure O3.8

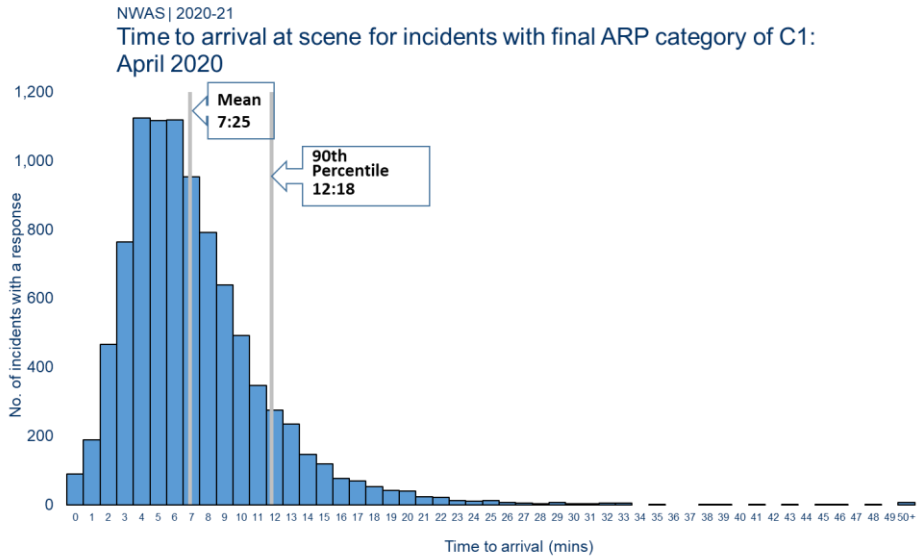


Figure O3.9

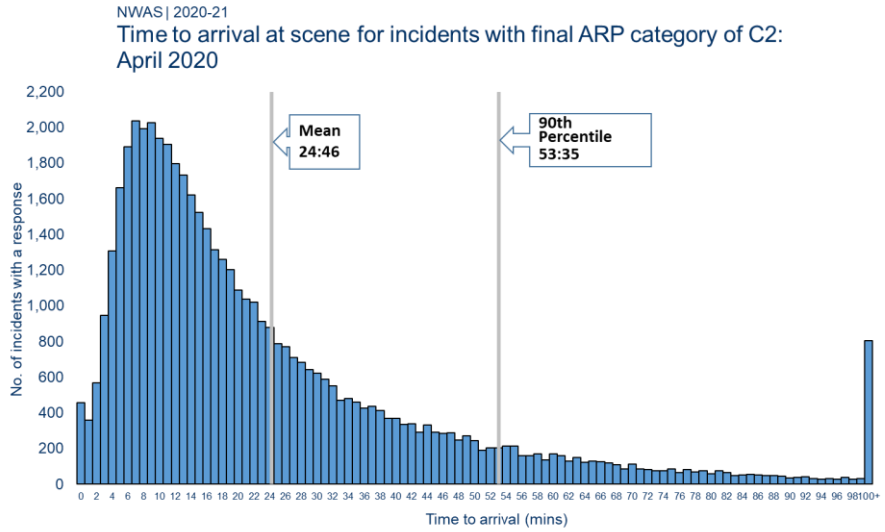


Figure O3.10

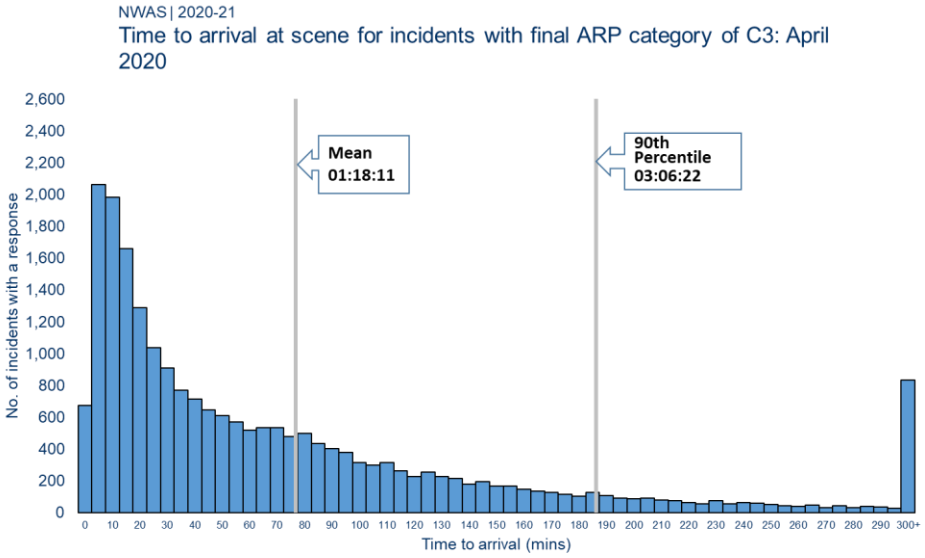
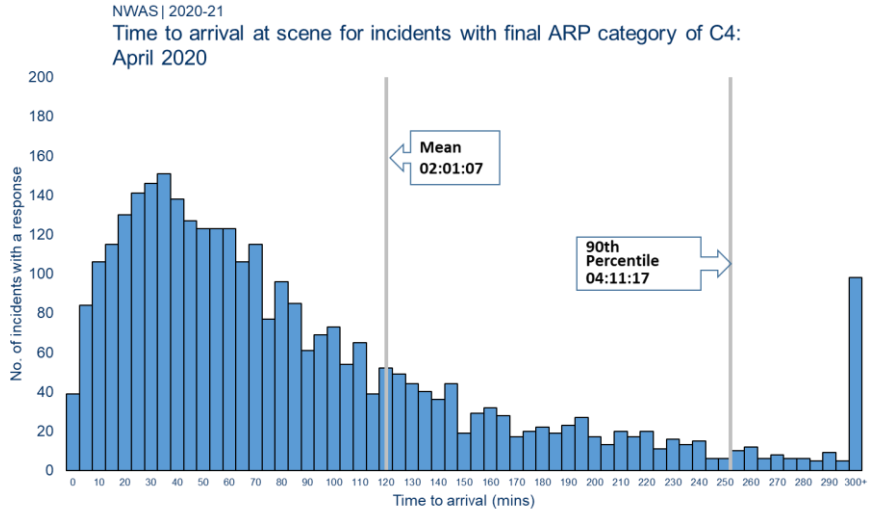


Figure O3.11



O4 111 PERFORMANCE

Figure O4.1

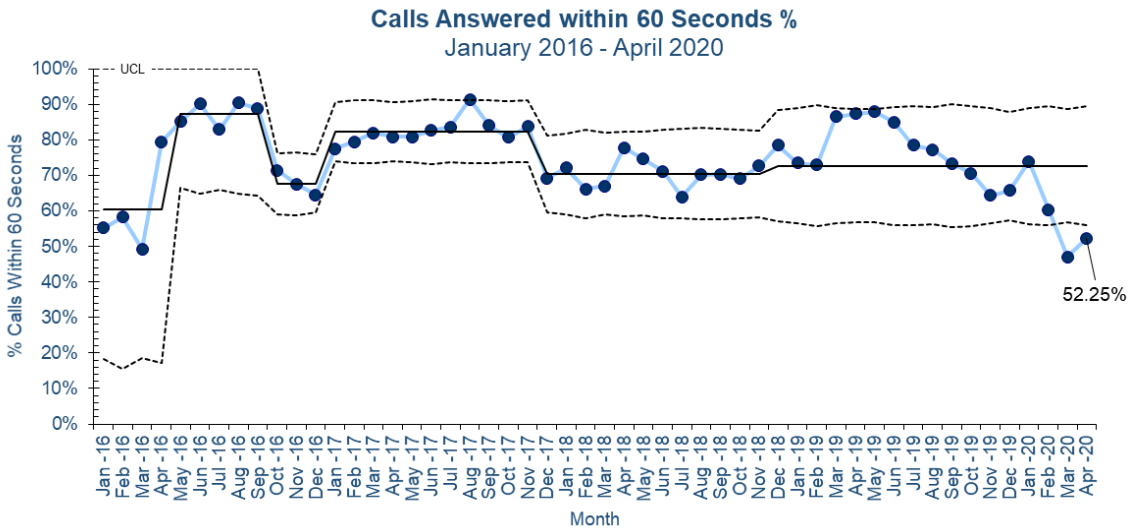
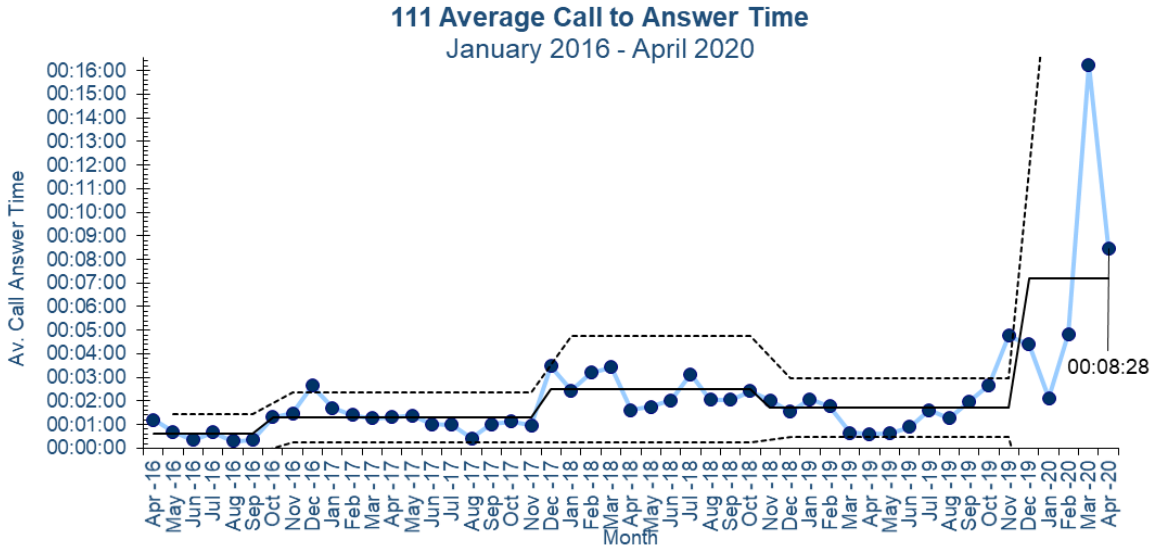


Figure O4.2



111 Performance

Calls Answered within 60 seconds %

Target: 95%

NWAS

April 2020: 52.25%

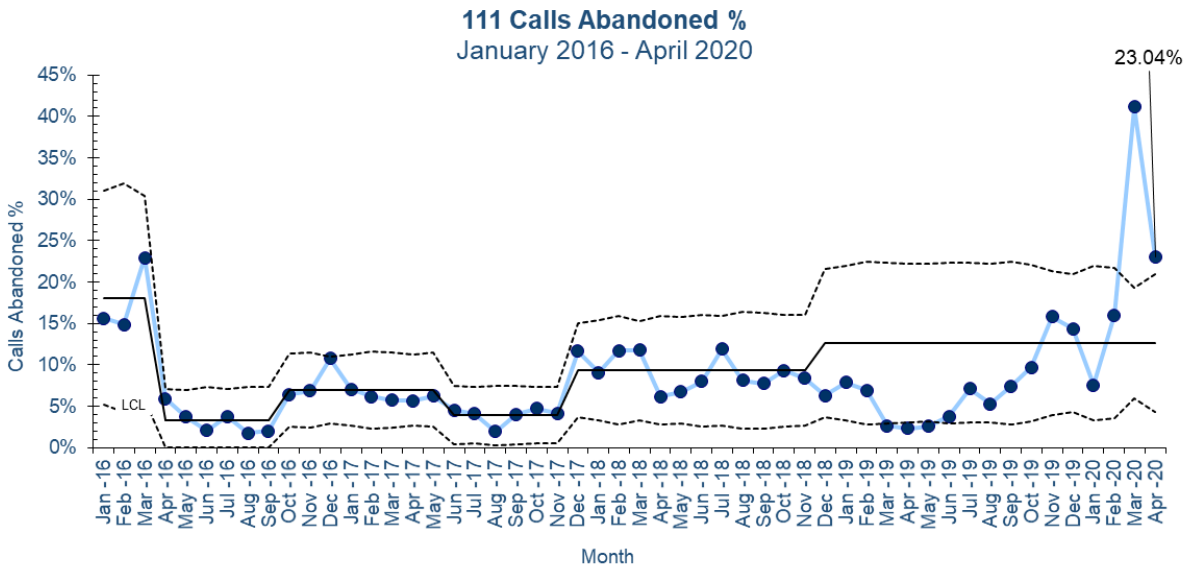
YTD: 52.25%

April continues to present NWAS 111 with increased call demand and despite training 98 first year paramedic students, the 111 performance standards have not been achieved.

Figure O4.1 shows a slight improvement in calls answered in 60 seconds but still below the lower confidence limit.

One metric that has seen a significant improvement is shown in **Figure O4.2** the average call to answer time, which has almost halved. The contribution of the student paramedics and a new cohort of Service Advisors has delivered this improvement.

Figure O4.3:



Calls Abandoned %

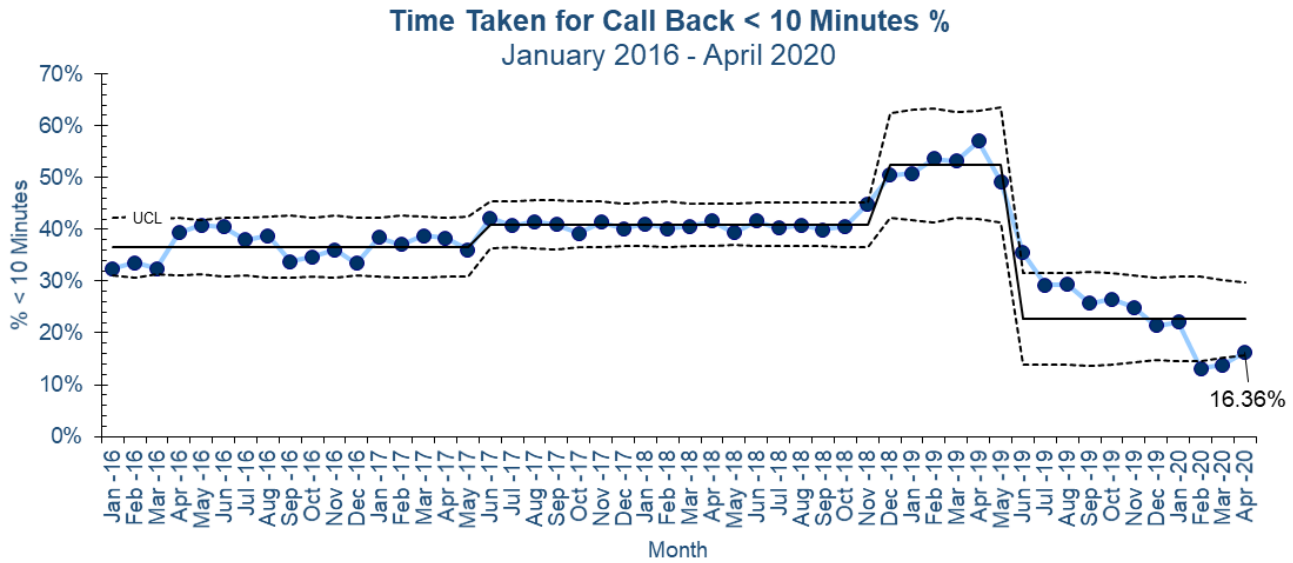
Target:	<5%

NWAS

April 20:	23.04%
YTD:	23.04%

In **Figure O4.3** the performance for April 2002 still sits above the upper confidence limit, however shows a improving picture from last month.

Figure O4.4



Call Back < 10 Minutes %

Target:	75%

NWAS

April 20:	16.36%
YTD:	16.36%

Call back in less than 10 minutes as illustrated in **Figure O4.4**. has seen a slight improvement over the past 3 months and aligns to reduced sickness absence in our clinical workforce with the use of home working for our shielding and symptomatic clinical team.

Figure O4.5

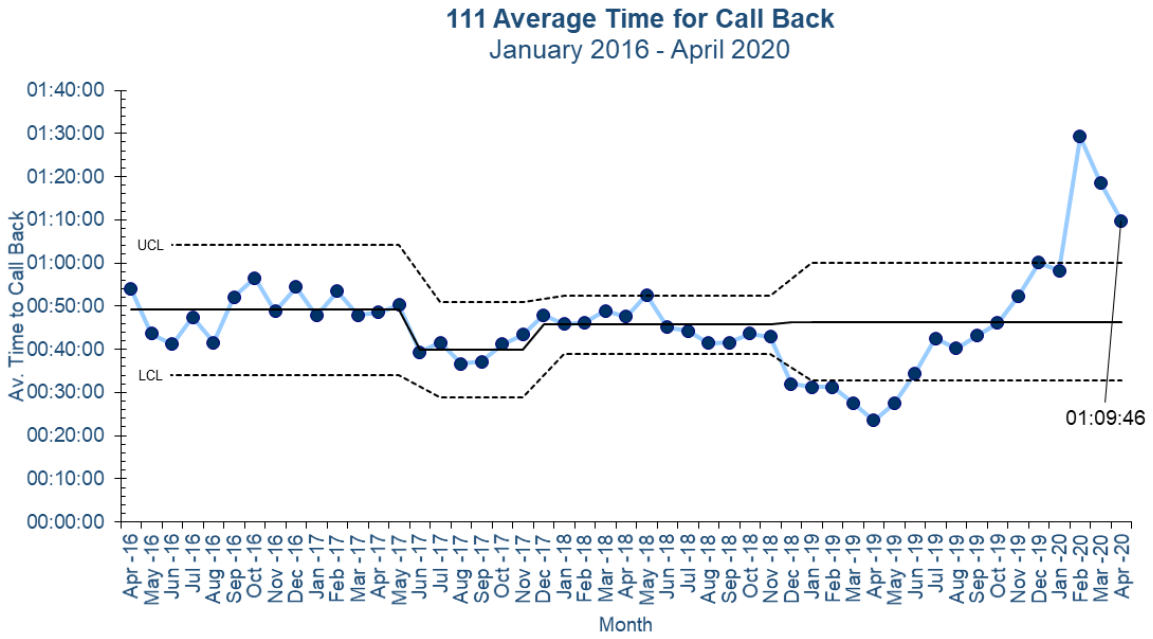
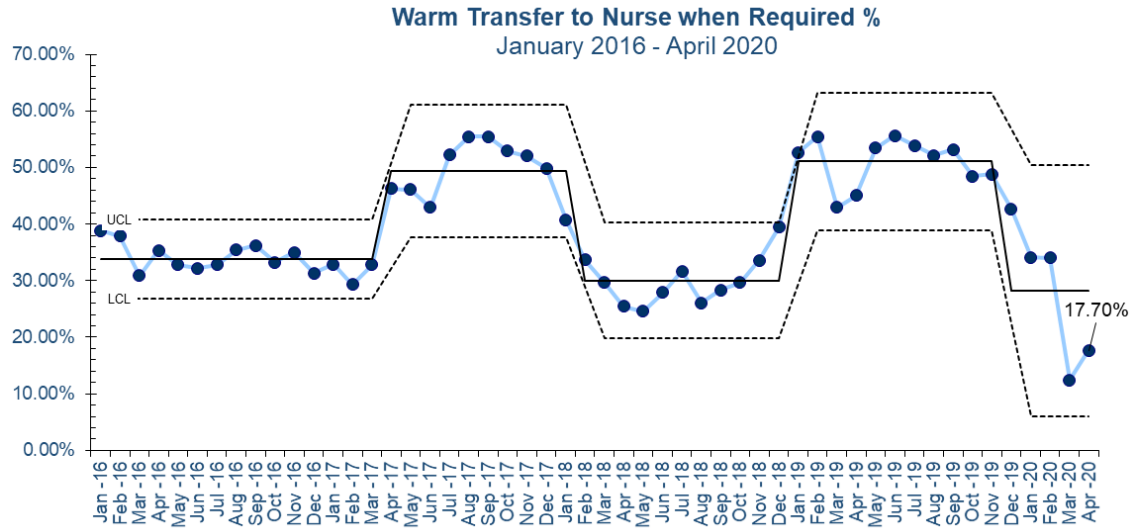


Figure O4.6



Warm Transfer to Nurse when Required%

Target: 75%

NWAS

April 20: 17.70%

YTD: 17.70%

Figure O4.5 shows 2 consecutive months of improvement of time to call back which aligns to the previous metric (Call back in 10), and has been delivered through more resource on shift through utilisation of home workers.

The final metric in **Figure O4.6** demonstrates the ability for Health Advisors to transfer a patient to a clinician live rather than putting the patient record on the clinical queue for a call back.

When the service has limited clinician availability then we see a drop in this performance metric; March saw high levels of clinician unavailability due to shielding and sickness absence, however with the use of functioning homeworking kits we have increased the clinical numbers and all metrics linked to clinicians has seen a little improvement.

O5 PTS ACTIVITY AND TARIFF

NORTH WEST AMBULANCE PTS ACTIVITY & TARIFF SUMMARY									
TOTAL ACTIVITY									
	Current Month: April 2020					Year to Date: July 2019 - April 2020			
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	168,290	14,024	3,670	(10,354)	(74%)	140,242	120,184	(20,058)	(14%)
Greater Manchester	526,588	43,882	15,770	(28,112)	(64%)	438,823	417,338	(21,485)	(5%)
Lancashire	589,181	49,098	12,559	(36,539)	(74%)	490,984	397,058	(93,926)	(19%)
Merseyside	300,123	25,010	10,988	(14,022)	(56%)	250,103	257,132	7,030	3%
NWAS	1,584,182	132,015	42,987	(89,028)	(67%)	1,320,152	1,191,712	(128,440)	(10%)

UNPLANNED ACTIVITY									
	Current Month: April 2020					Year to Date: July 2019 - April 2020			
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	479	(768)	(62%)	12,474	8,882	(3,592)	(29%)
Greater Manchester	49,133	4,094	2,858	(1,236)	(30%)	40,944	48,191	7,247	18%
Lancashire	58,829	4,902	2,239	(2,663)	(54%)	49,024	41,973	(7,051)	(14%)
Merseyside	22,351	1,863	854	(1,009)	(54%)	18,626	18,367	(259)	(1%)
NWAS	145,282	12,107	6,430	(5,677)	(47%)	121,068	117,413	(3,655)	(3%)

ABORTED ACTIVITY									
	April 2020								
Contract	Planned Activity	Planned Aborts	Planned Aborts %	Unplanned Activity	Unplanned Aborts	Unplanned Aborts %	EPS Activity	EPS Aborts	EPS Aborts %
Cumbria	520	45	9%	479	48	10%	2,671	28	1%
Greater Manchester	1,476	316	21%	2,858	362	13%	11,436	631	6%
Lancashire	1,332	135	10%	2,239	232	10%	8,988	258	3%
Merseyside	826	101	12%	854	103	12%	9,308	338	4%
NWAS	4,154	597	14%	6,430	745	12%	32,403	1,255	4%

PTS Performance

Overall activity during April 2020 was 67% below contract baselines with Lancashire 74% below contract baselines whilst Merseyside is operating at -56% (-14022) Journeys below baseline. For the year to date position (July 2019 - April 2020) PTS is performing at -10% (-128440 journeys) below baseline. Within these overall figures, Cumbria, Greater Manchester and Lancashire are operating at 14%, 5% and 19% below baseline whilst Merseyside is operating at 3% above baseline.

In terms of unplanned activity, cumulative position within Greater Manchester is 18% (7247 journeys) above baseline. 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, Lancashire and Merseyside are 29% (3592 journeys), 14% (7051 journeys) and 1% (259 journeys) below baseline.

In terms of overall trend analysis, overall activity levels had plateaued for all contracts up to March 2020 where the impact of Covid-19 has led to a significant reduction in planned activity and a further reduction in EPS activity. Unplanned activity has remained relatively stable.

Aborted activity for planned patients averaged 14% during April 2020 however Cumbria experiences 9%, Greater Manchester operates with 21% whilst Lancashire and Merseyside both experience 10% & 12% aborts respectively. Within EPS (renal and oncology) overall aborts average 4% aborts. Cumbria has 1%, Greater Manchester 6% , Lancashire and Merseyside operate with 3% and 4% respectively. Unplanned (on the day) activity experiences an average 12% with variances of 10% in Cumbria, 13% in Greater Manchester, 10% in Lancashire and 12% Merseyside.

OH1 STAFF SICKNESS

Figure OH1.1

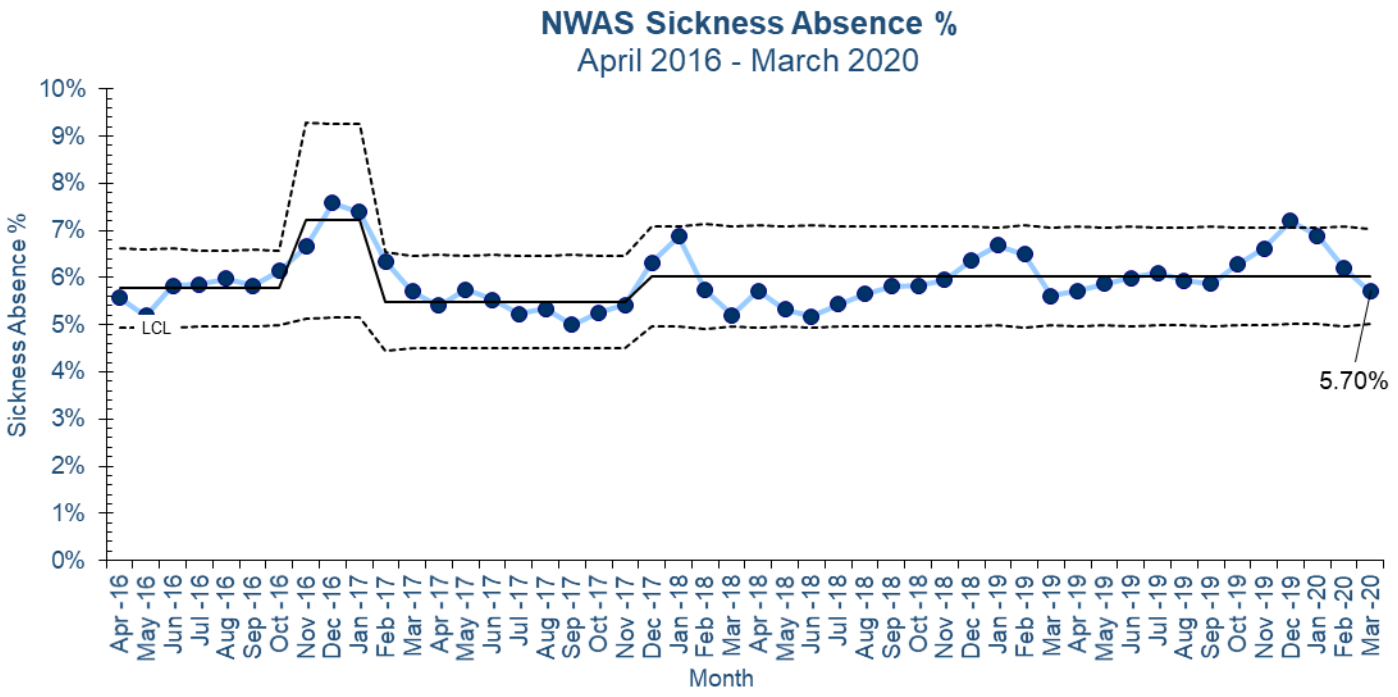


Table OH1.1

Sickness Absence	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
NWAS	5.72%	5.87%	5.99%	6.10%	5.94%	5.86%	6.27%	6.61%	7.19%	6.88%	6.20%	5.70%
Amb. National Average	5.52%	5.55%	5.50%	5.57%	5.78%	5.65%	5.85%	6.01%	6.60%			

Staff Sickness

The overall sickness absence rates for March 2020 were 5.70% with figure OH1.1 displaying a downward position over a 4 month period.

The position is slightly higher than the same time last year which was 5.62% in March 2109. The cumulative sickness position for 2019/20 was 6.19% which represented an increase on the previous year. The Trust sickness improvement goal for 2019/20 was not met.

There were no special clause variations but progress across all services lines should be noted with particular improvements in both EOC and 111.

Please note that although the impact of COVID-19 started to be experienced in March, in the absence of staff testing, most of the impact has been recorded as self-isolation and is not shown in the sickness figures.

BAF Risk: SR04.

Figure OH1.2:

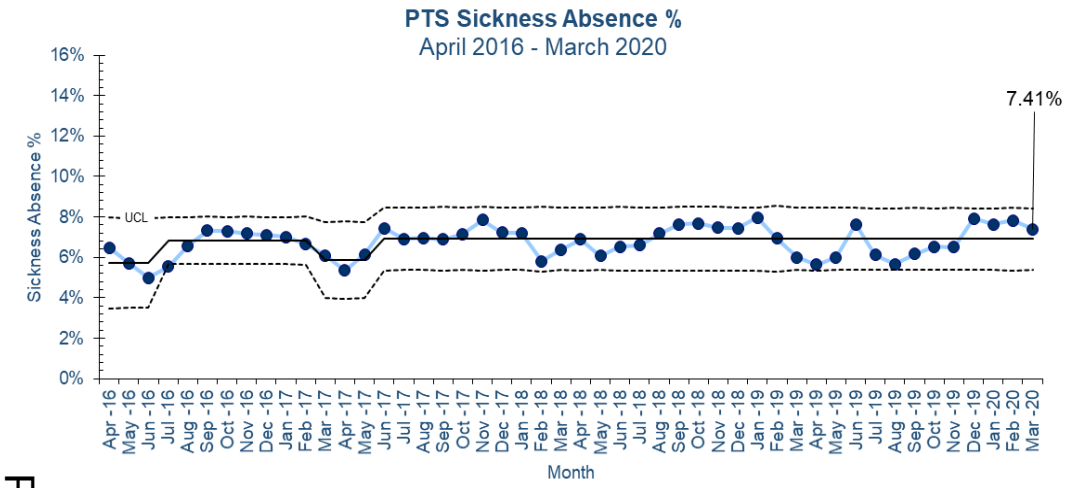


Figure OH1.3:

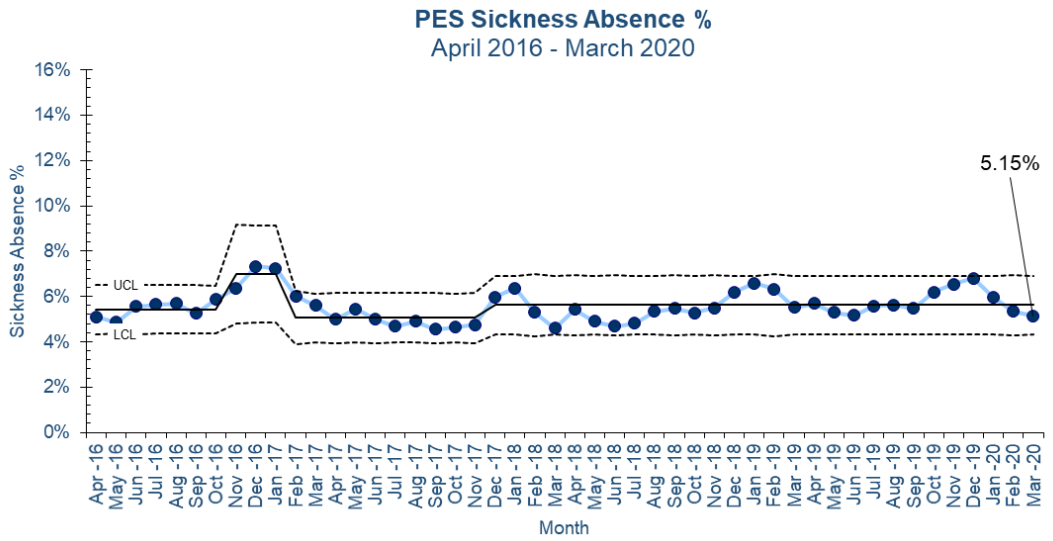
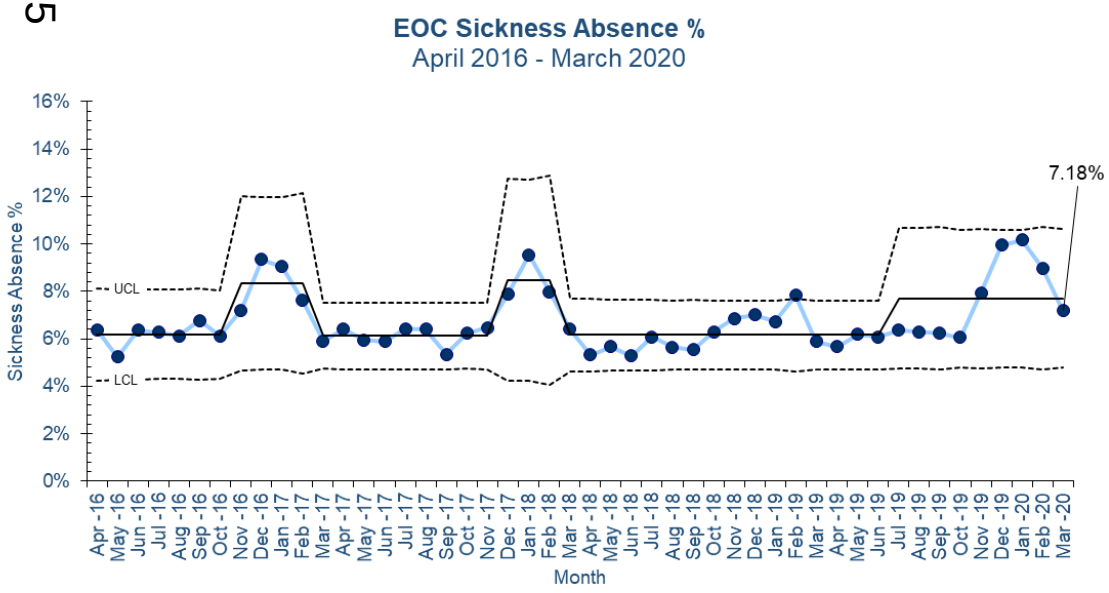


Figure OH1.4:



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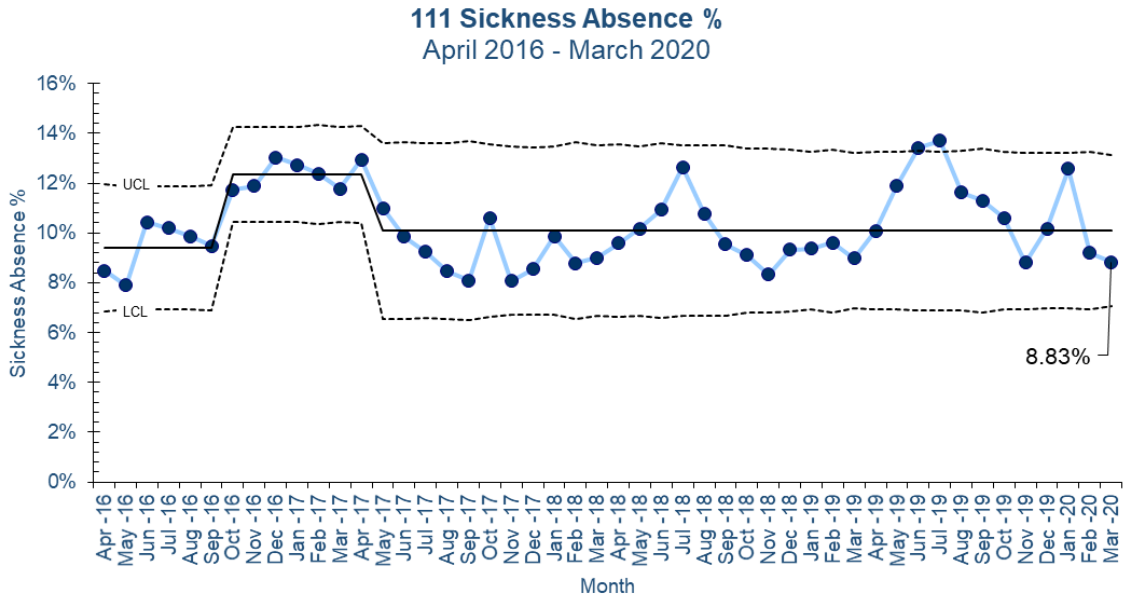


OH2 STAFF TURNOVER

Figure OH2.1

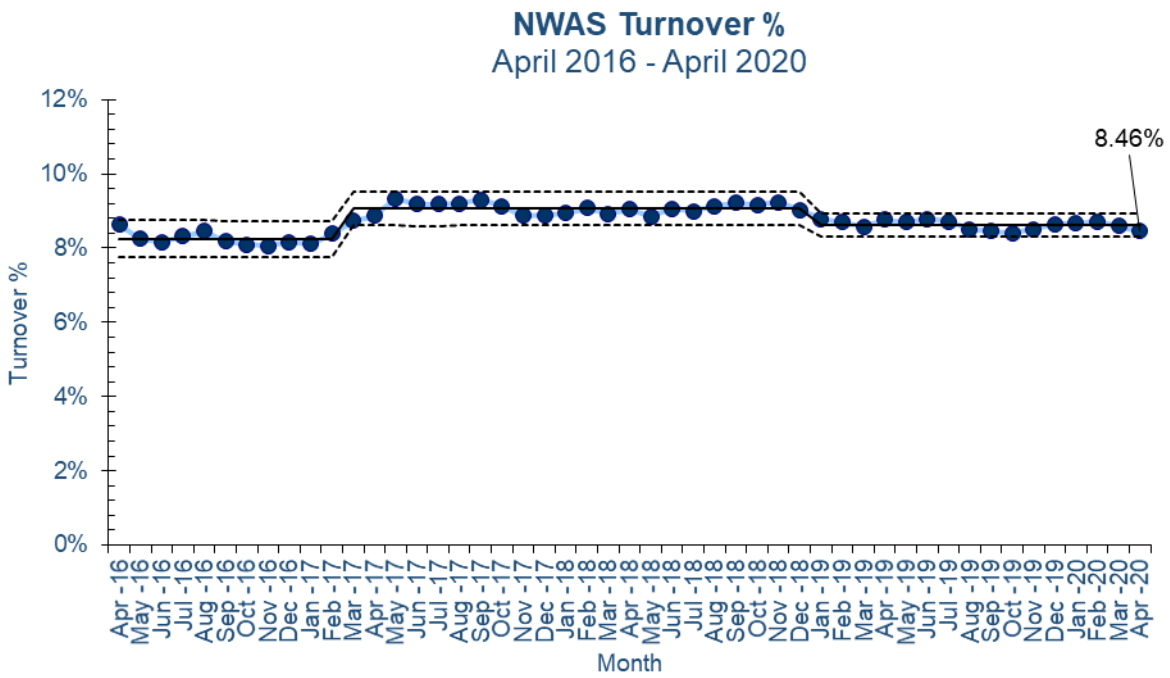


Table OH2.1

Turnover	May - 19	Jun - 19	Jul - 19	Aug - 19	Sep - 19	Oct - 19	Nov – 19	Dec - 19	Jan – 20	Feb - 20	Mar - 20	Apr - 20
NWAS	8.71%	8.79%	8.72%	8.51%	8.45%	8.41%	8.51%	8.65%	8.66%	8.72%	8.60%	8.46%
Amb. National Average	9.53%	9.39%	9.28%	9.31%	9.14%	9.21%	9.20%	8.92%	9.08%			

Staff Turnover

Turnover is calculated on a rolling year average and this does lead to some small variations between months with April 2020 turnover at 8.46% which continues to show a stable trend within narrow control limits.

Special clause variations with regards to the lower control limits show 111 and EOC at the lower confidence levels. This is a positive indicator of the focused work in these two areas. 111 work is supported through an NHSE/I enabled retention plan. PTS are also close to the lower control limit and work to understand the reasons for this trend is underway.

PES turnover remains within narrow control limits but there signs of special cause variation with small increases over the last 8 months, indicative of opportunities within the wider system.

Overall the Trust is continuously below the national turnover rate for Ambulance Service which was at 9.08% in January 2020.

BAF Risk: SR04.

Figure OH2.2

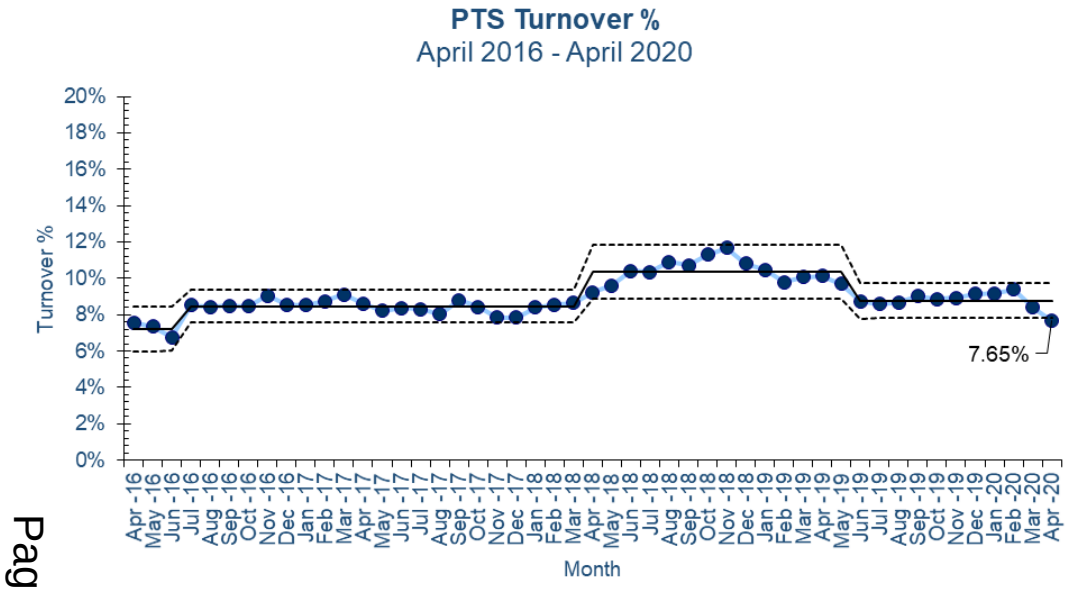


Figure OH2.3

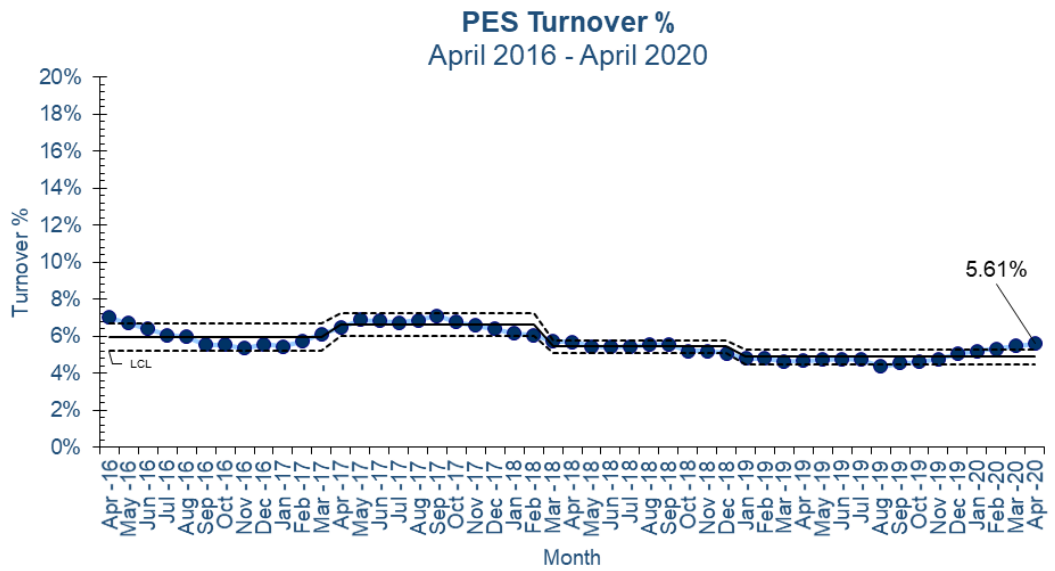


Figure OH2.4

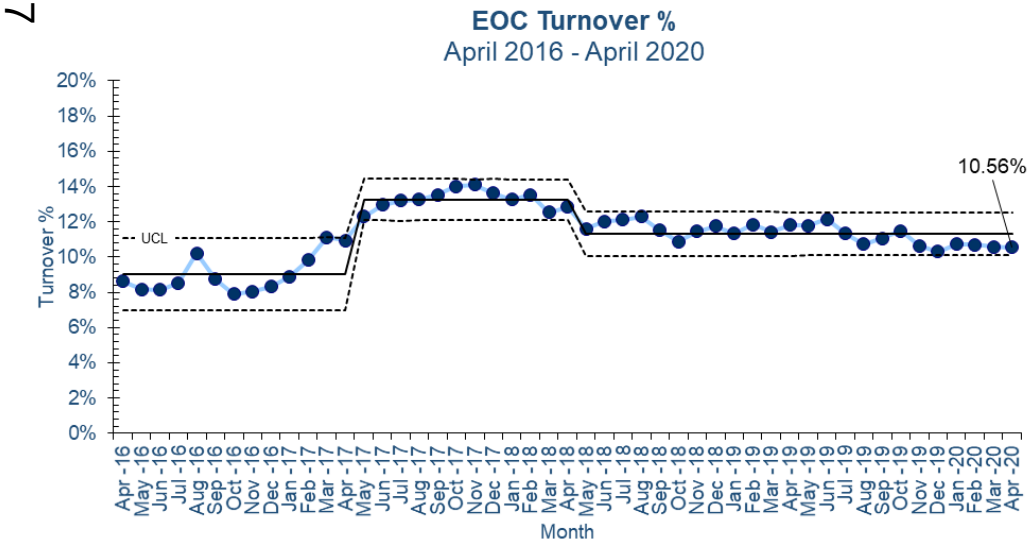
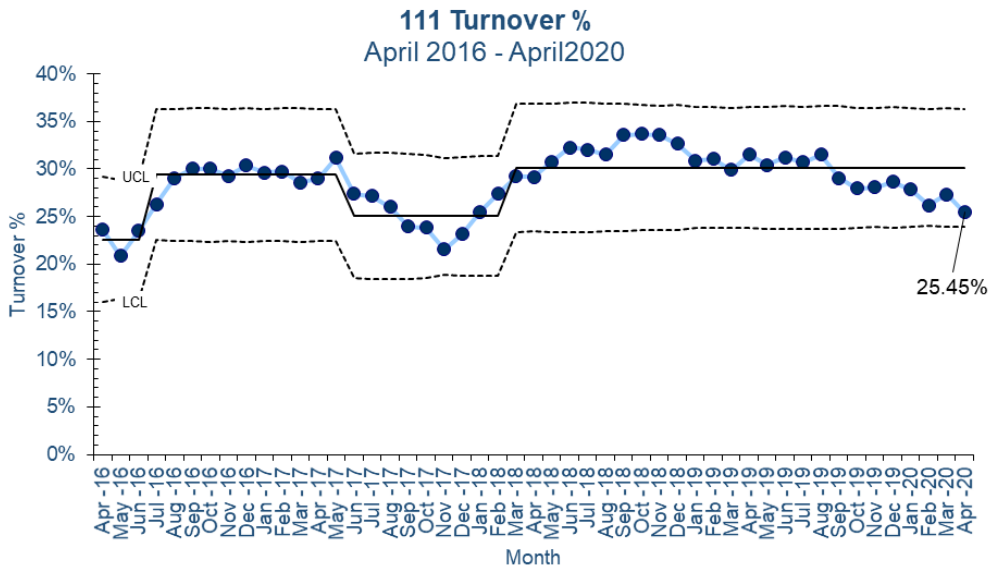
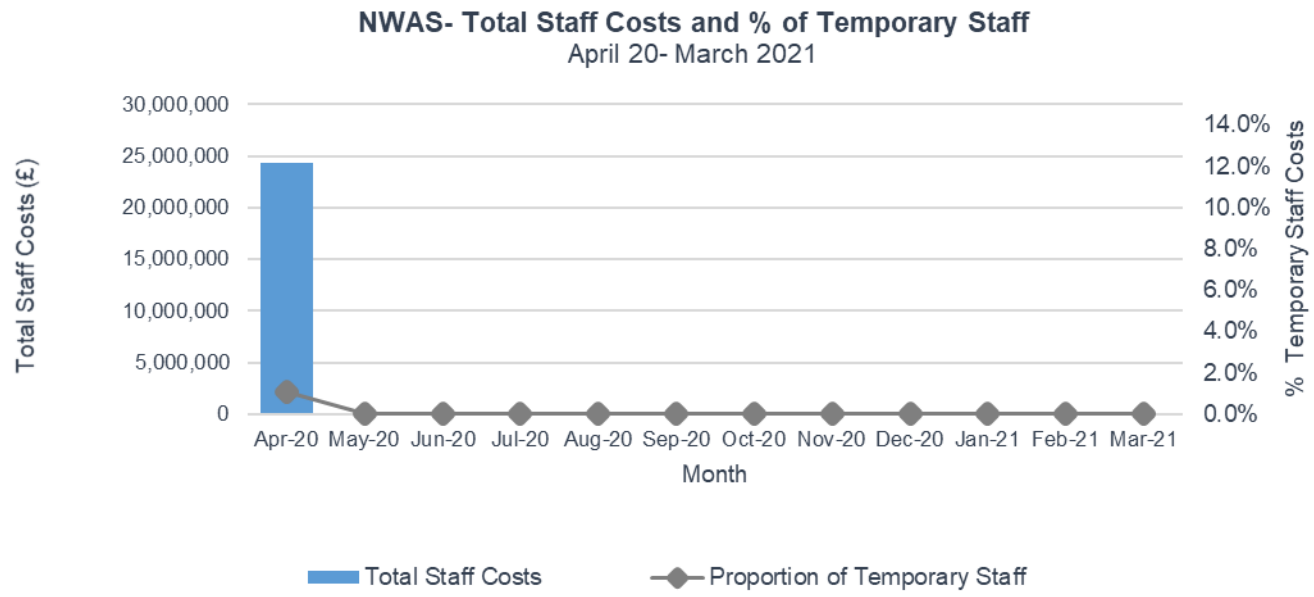


Figure OH2.5



OH4 TEMPORARY STAFFING

Figure OH4.1:



Temporary Staffing

Use of agency staffing has increased in both March and April as a result of the need to increase capacity rapidly to support the COVID-19 response. This has primarily been in the EOC with the use of agency staff to support call taking.

Agency staff have been employed on a temporary to permanent basis enabling the transfer of staff onto permanent contracts without additional charge at the end of 12 weeks.

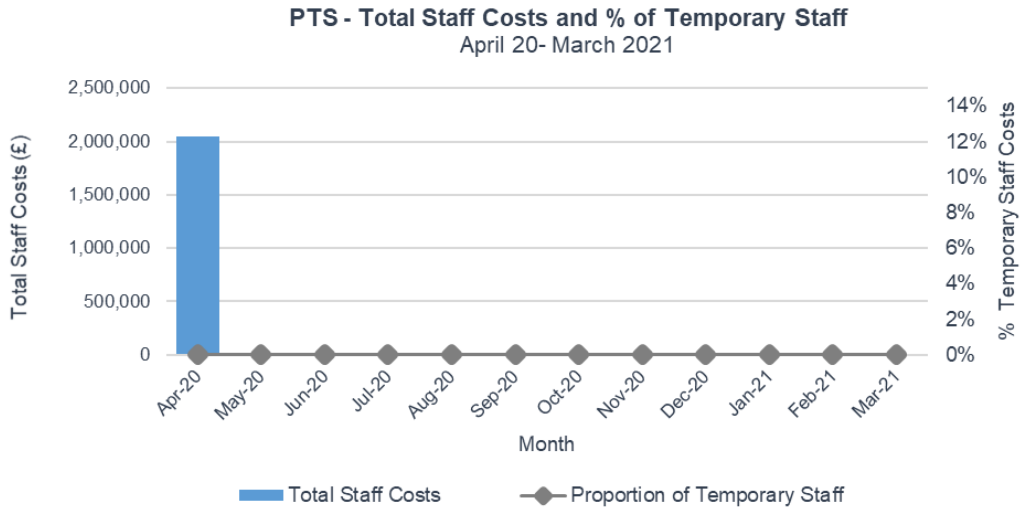
This does mean that current levels are likely to be maintained through May and June. This has impacted on the agency ceiling in month 1 and OD and Finance will work jointly to ensure that the recovery plan brings expenditure back within ceiling for the financial year.

BAF Risk: SR04; SR11

Table OH4.1

NWAS	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan -20	Feb-20	Mar-20	Apr-20
Agency Staff Costs (£)	175,326	169,134	161,001	142,550	102,471	83,441	82,553	79,503	57,922	80,913	153,153	261,425
Total Staff Costs (£)	21,671,356	21,667,396	21,686,448	21,692,684	21,460,515	21,982,878	21,758,192	21,083,687	21,613,064	22,646,658	21,904,103	24,361,995
Proportion of Temporary Staff %	0.8%	0.8%	0.7%	0.8%	0.5%	0.3%	0.1%	0.2%	0.6%	0.2%	0.4%	1.1%

Figure OH4.2:



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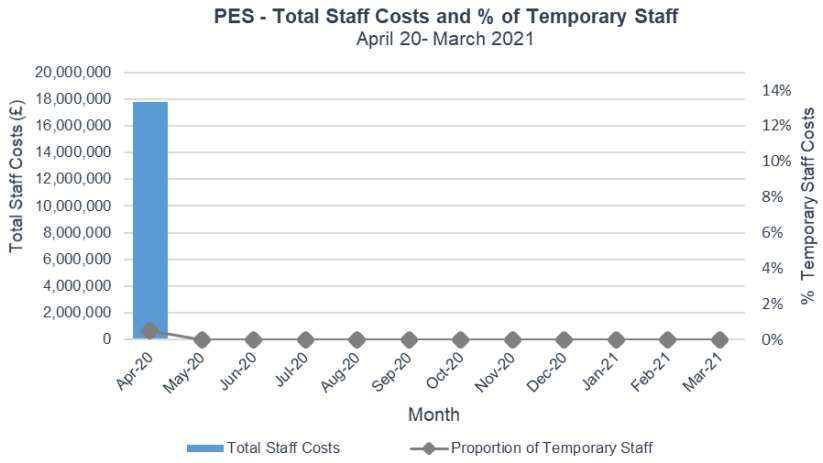


Figure OH4.4:

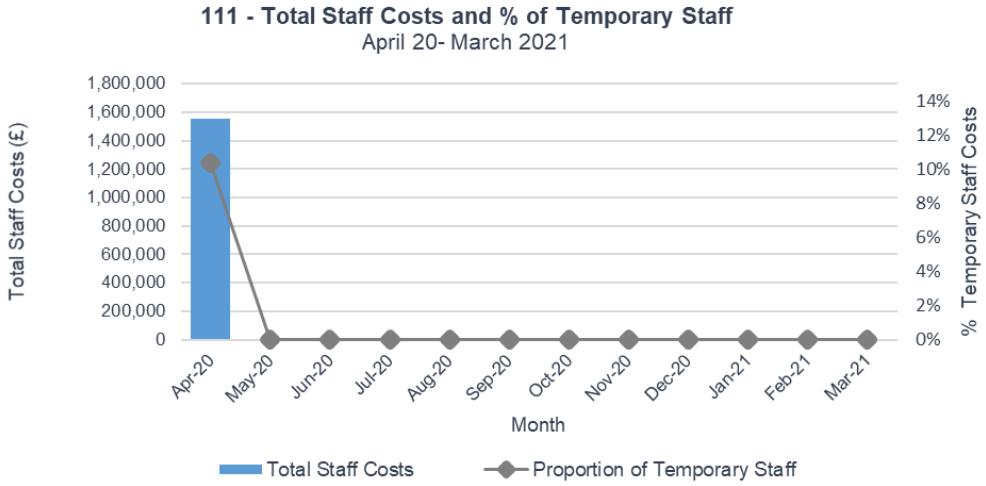
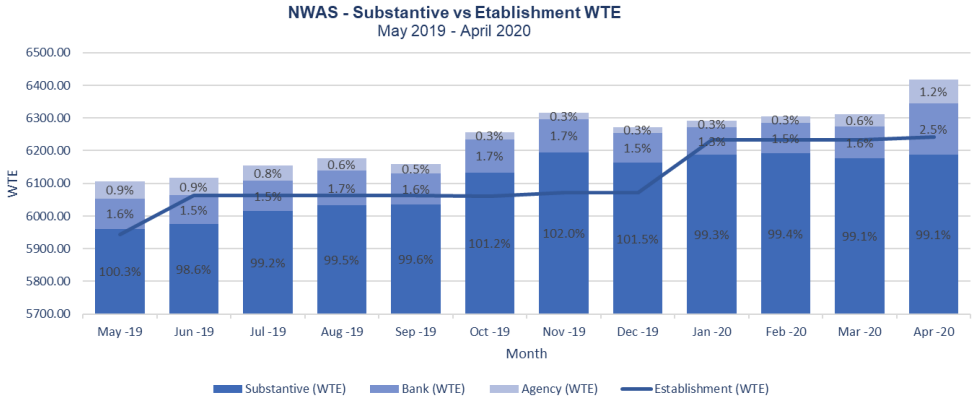


Figure OH4.5:



OH5 VACANCY GAP

Figure OH5.1

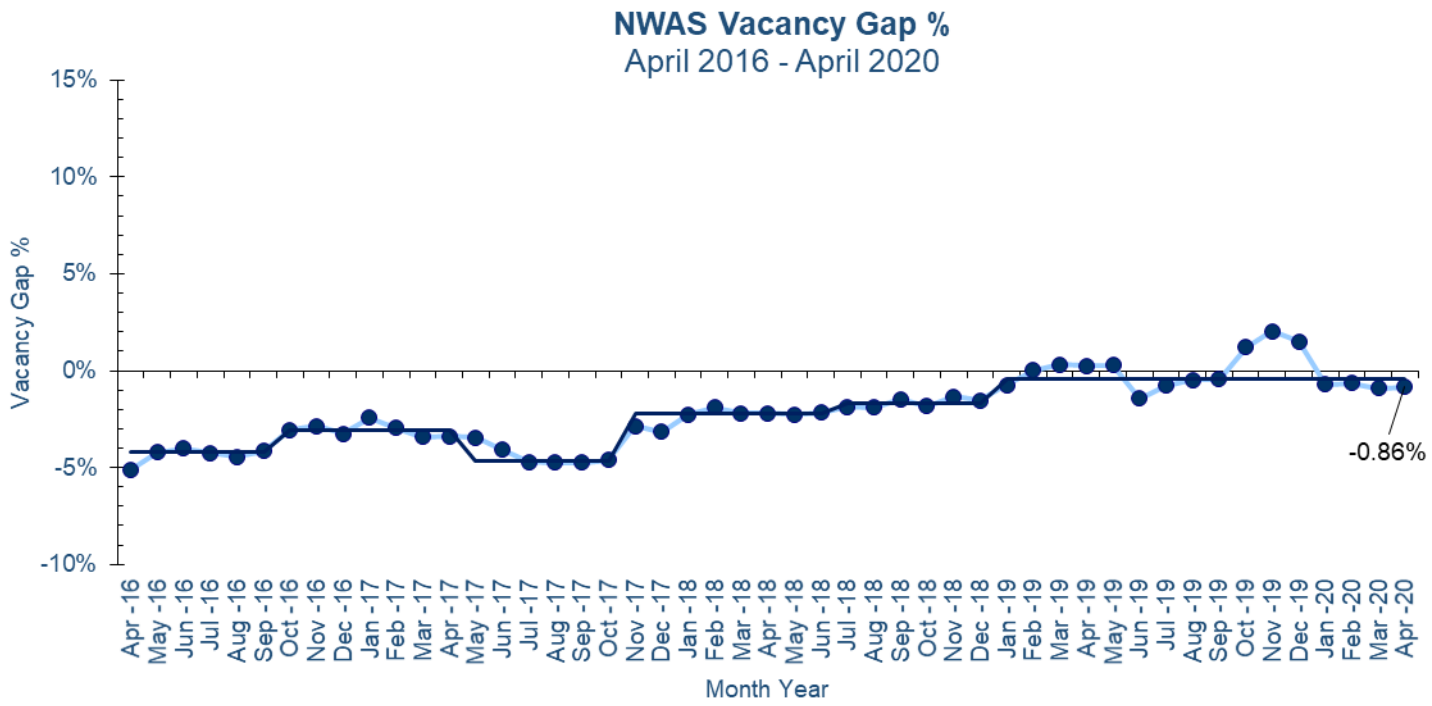


Table OH5.1

Vacancy Gap	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
NWAS	0.29%	-1.42%	-0.79%	-0.47%	-0.45%	1.20%	2.05%	1.51%	-0.72%	-0.64%	-0.90%	-0.86%

Vacancy Gap

In light of the pause in contract negotiations and the emergency budget. Staffing establishments have remained the same. The majority of temporary staffing has been moved internally, employed on bank or agency contracts so is not shown in these graphs. They show the underlying substantive staffing position which was a strong point from which to enable capacity increases.

This shows an over establishment at the end of April 2020 in both EOC and 111. 111 has an agreed plan to over-establish by c80 posts by year end and recruitment has already commenced to deliver this.

Workforce Plans for all services lines are currently being reviewed following the Covid-19 response to take into account additional pressures moving into the winter period.

The PTS vacancy position is -5.86% in April 2020. However, they are also experiencing the impact of 155 staff supporting PES in relation to the COVID-19 response. Workforce plans are currently being reviewed to ensure that PTS have a robust plan moving into winter.

BAF Risk; SR04; SR11

Figure OH5.2

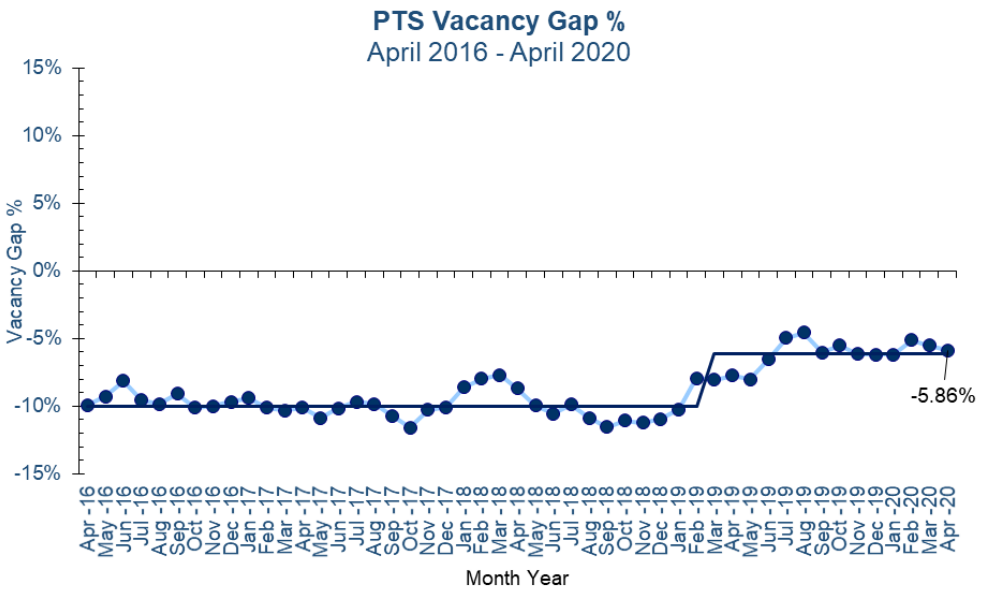


Figure OH5.3

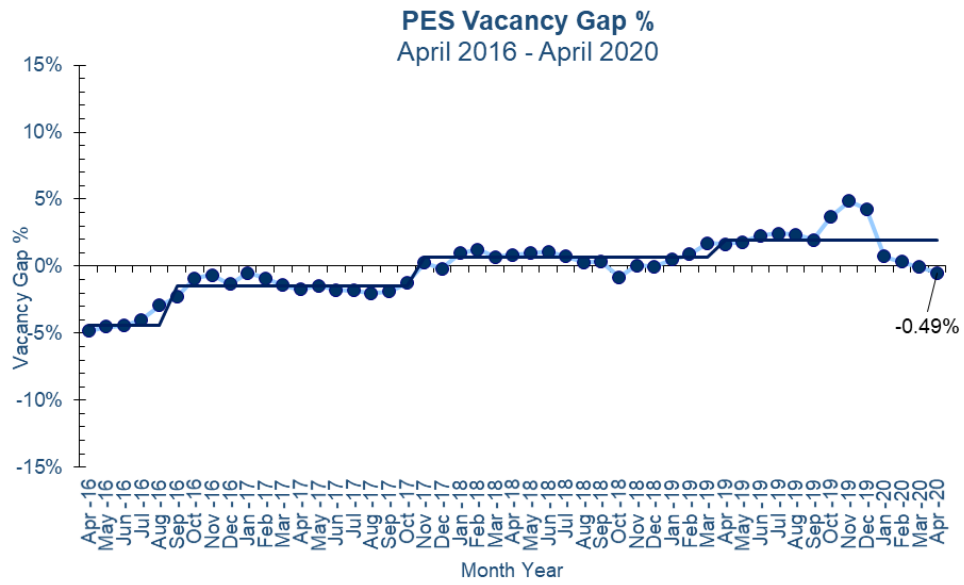


Figure OH5.4

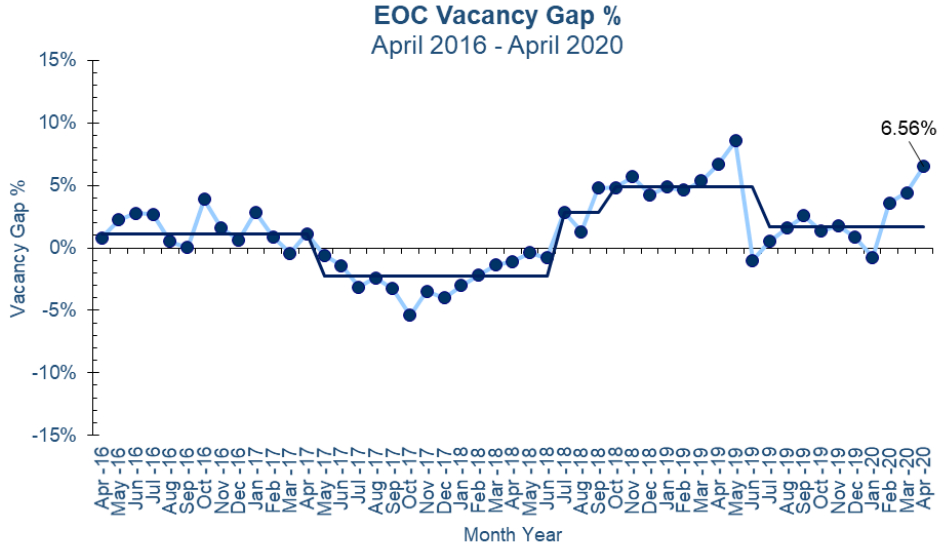
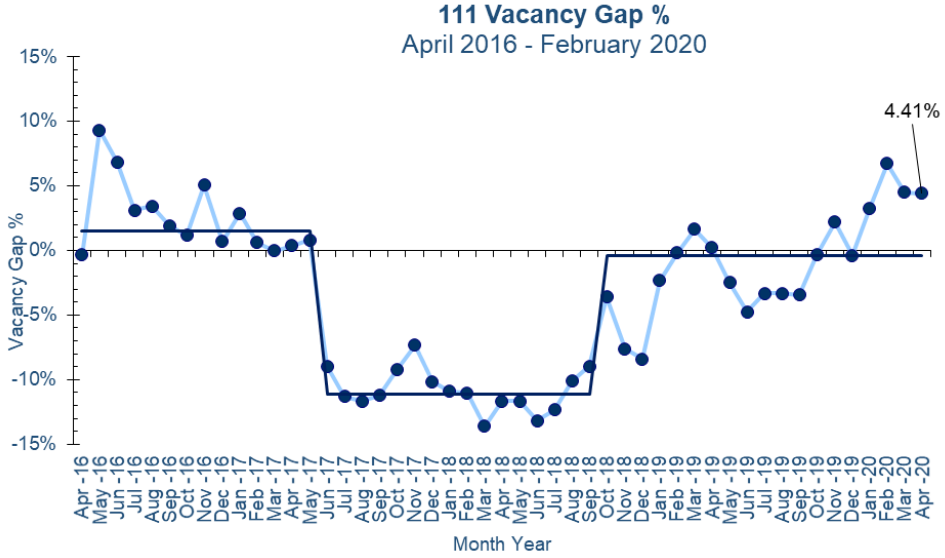


Figure OH5.5



OH6 APPRAISALS

Figure OH6.1

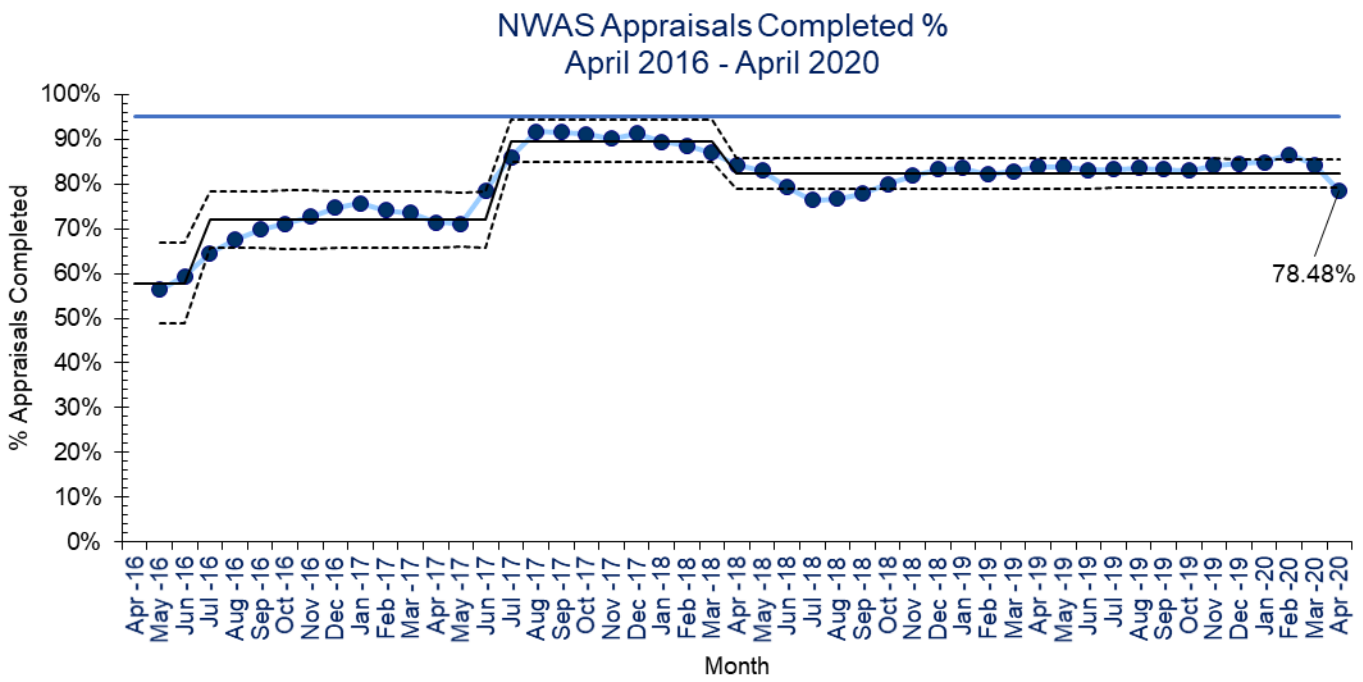


Table OH6.1

Appraisals	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb -20	Mar-20	Apr-20
NWAS	84%	83%	83%	84%	83%	83%	84%	85%	85%	87%	84%	78%

Appraisals

Appraisal compliance overall has been stable until the impact of Covid-19 with the April 2020 position being at 78.48%. The Trust target is 95% of staff have an up to date appraisal.

Appraisal was paused for all service lines in mid-March. As a result all service lines have seen a special clause variation with a worsening position in March and April.

Focus will now move into the recovery plans for all service lines with recovery action starting in Phase 1 by the end of June 2020. In order to support the recovery plan we are currently considering streamlining the approach to 2020/21 appraisals.

BAF Risk: SR04; SR11

Figure OH6.2

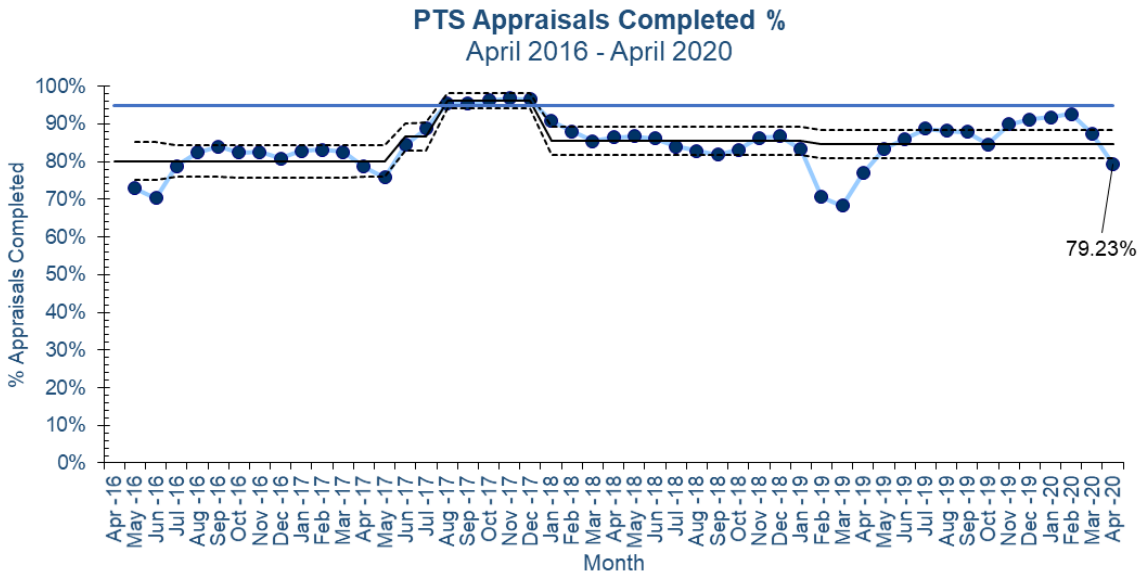


Figure OH6.3

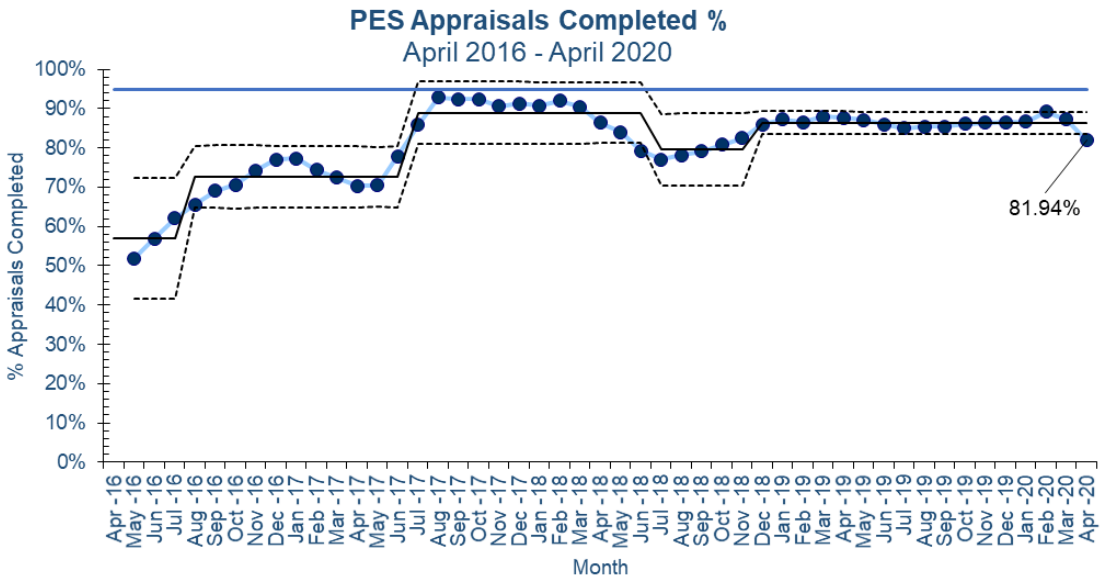


Figure OH6.4

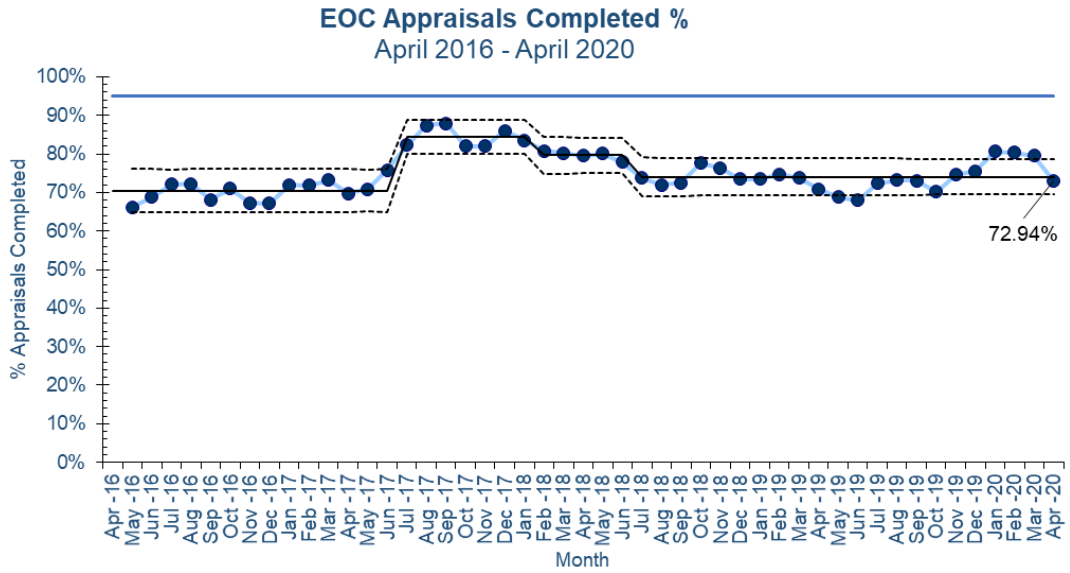
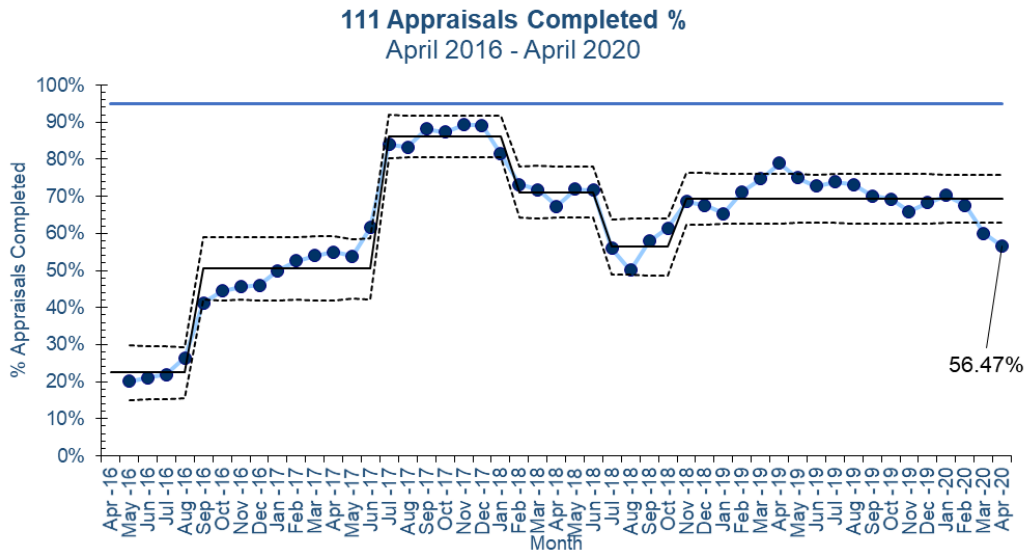


Figure OH6.5



OH7 MANDATORY TRAINING

Figure OH7.1

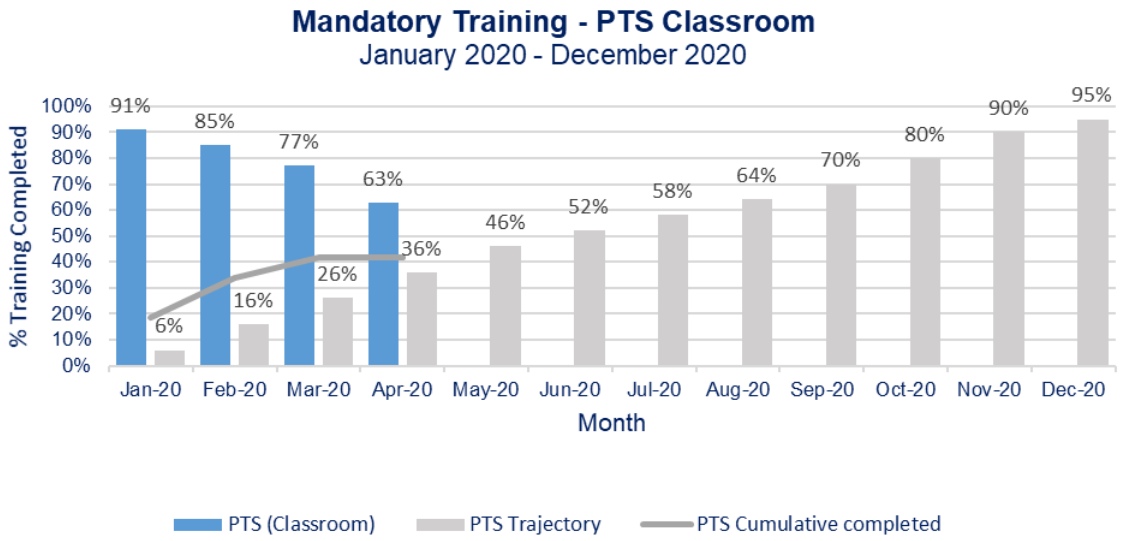
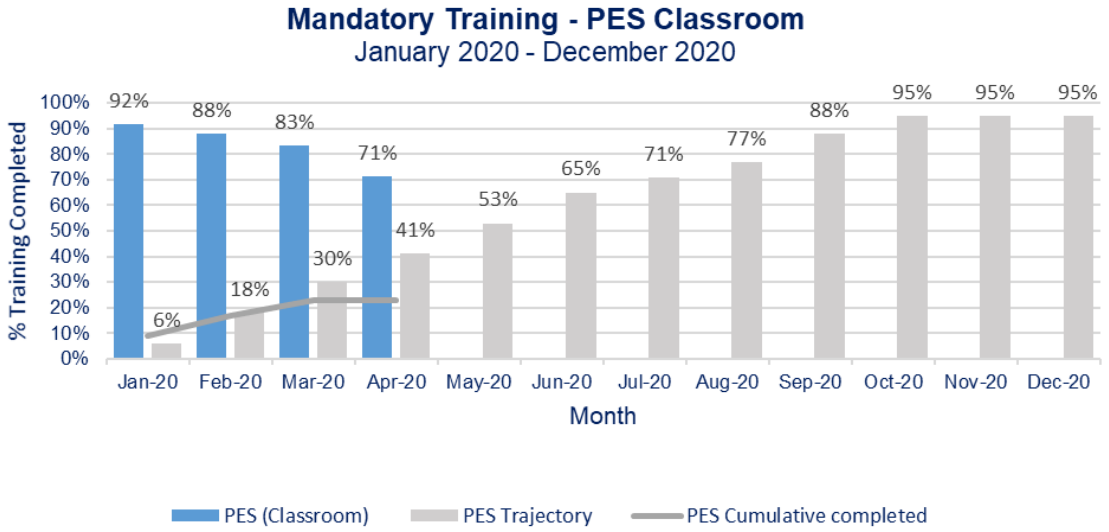


Figure OH7.2



Mandatory Training

A new classroom Mandatory Training cycle started in January 2020, however the Trust moved in 2019 to competence reporting. The aim therefore is for staff to complete their classroom based training and their online training before their competence expires. In practice this requires the profiling of classroom training for staff at a similar time to the previous year. If this takes place competence compliance should remain at the target of 95%.

Classroom based mandatory training and online training in EOC & 111 was paused in mid-March. The graphs therefore show cumulative completion for this year's classroom attendances plateauing in March. Overall competence has declined as modules go out of their refresher date.

Focus will now move into the recovery plans for all service lines with mandatory training to restart in June 2020. However, there will be continuing challenges to recovery due to the ongoing demands on operations and also the need to social distance in classroom which may affect numbers who can attend.

BAF Risk: SR04, SR11

Figure OH7.3

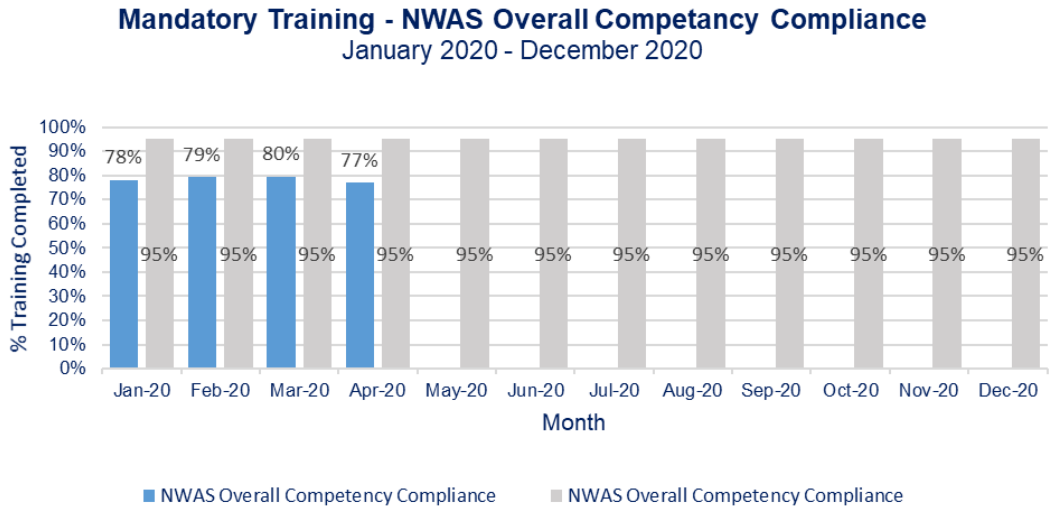
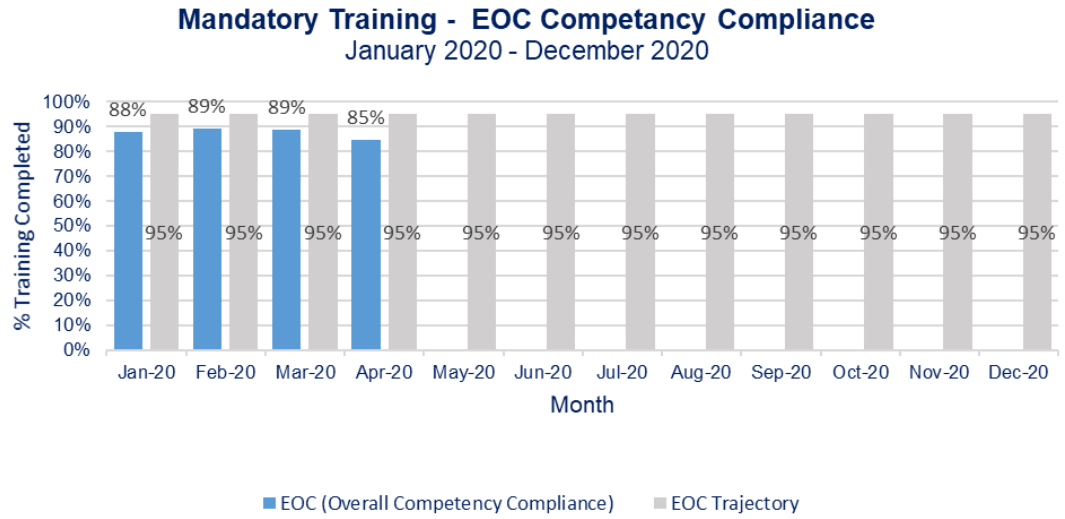


Figure OH7.4



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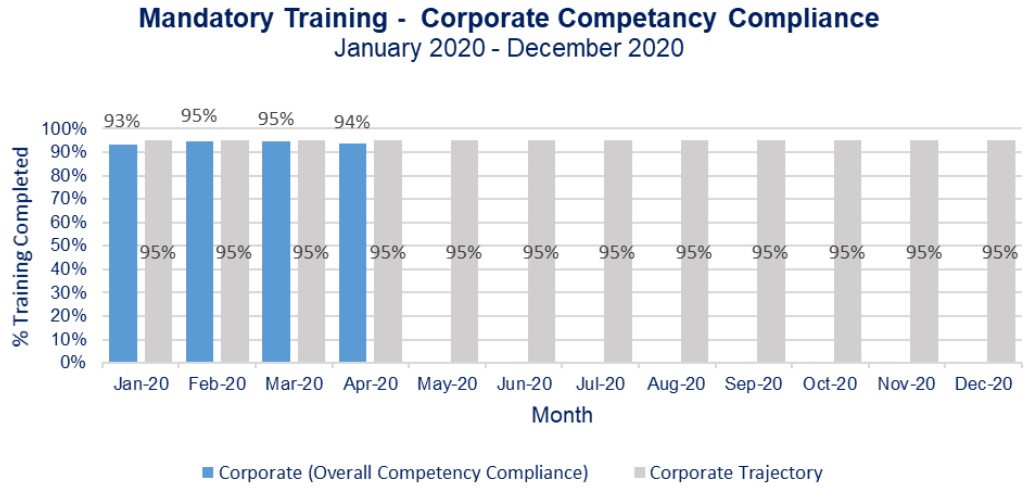
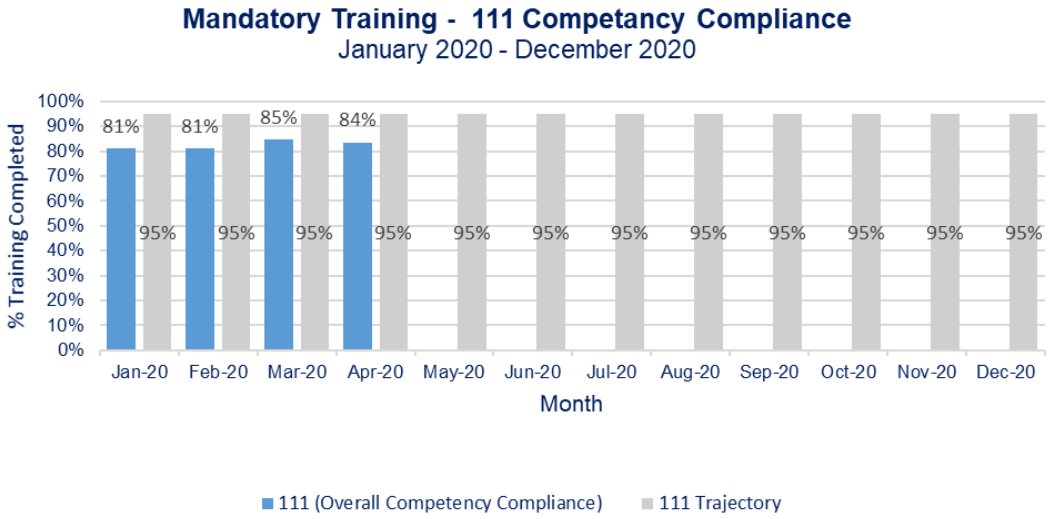


Figure OH7.6



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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27th May 2020
Subject:	Medicines Management Annual Report 2019/20 including the Controlled Drugs Annual Report
Presented by:	Chris Grant, Exec Medical Director
Purpose of Paper:	For Assurance
Executive Summary:	2019/20 saw significant changes in the Medicines Management agenda. This included: • Appointment of new Chief Pharmacist • Implementation of Controlled Drugs (CD) tagging • Delivery of the first two (of three) goals for medicines management in the Right Care Strategy. • PGDs are fully compliant and on target for renewal in 2020/21 with e-learning and competency assessments on track for completion by the end of Q2. • Risk assessments for non-parenteral POM use completed and actioned for EMTs and Paramedics. • Station management of CDs improved with the introduction of bespoke CD record books, reduction in number of sites holding CDs and ensuring registered paramedics are solely responsible for receiving deliveries. • Medicine incidents are stable year on year, for both CDs and general medicines. • Processes to manage incidents and learning from medicine errors has been enhanced. • Medicines Management Quality Indicators (MMQIs) reflected a high level of assurance for all indicators, with the exception of CD5. • Mersey Internal Audit Agency review of external events with removal of CDs from event stadia. The focus for 2020/21 will be on SSHM, ongoing PGD compliance, training and education of all clinicians on medicines, digital enhancements through use SAFECHECK at vehicle check level and barcoding for stock management. COVID 19 has introduced delays to a number of projects. The impact of these delays will be monitored via MEG.

Recommendations, decisions or actions sought:	To note the content of the report and the ongoing strategic plan for medicines optimisation in 2020/21.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):

SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	**Nil**
Previously Submitted to:	**Quality & Performance Committee**
Date:	**18th May 2020**
Outcome:	**Approved**

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1 PURPOSE

A range of general medicines and controlled drugs (CDs) are stocked and administered to patients across NWAS. This annual report seeks to provide assurance to the Trust that NWAS is managing its medicines, including controlled drugs, safely and in accordance with legislation, best practice and NWAS protocols.

2 BACKGROUND

This report covers:

2.1 Medicines Arrangements
2.2 Medicines Optimisation Strategy
2.3 Monitoring
2.4 Policy and Procedures
2.5 Medicines Related Incidents
2.6 Audit
2.7 Medicines Related Risks
2.8 Partnership Working
2.9 Constraints

2.1 Medicines Arrangements:

2.1.1 Medicines Used:

Medicines stocked in NWAS are a mix of controlled drugs (CDs), prescription only medicines (POMs), pharmacy medicines (P) and & General Sale List (GSL). No changes to the medicines used have been made this year. A list of the CDs used are detailed in table 1. The following documents have been produced and approved this year and are available on the intranet:

- Medicines Formulary
- Medicines Use by Job Role
- Medicines Storage Location and Supply Route
- Medicines Temperature Storage Conditions

Importantly, the 'Medicines Use by Job Role' ensures it is clear under what legislation medicines are being used. Any changes to these documents require approval from the Medicines Effectiveness Group (MEG).

Medicines are also used by the North West Air Ambulance (NWAA) and the National Ambulance Resilience Unit (NARU) provide a supply of medicines for the mass casualty vehicles based at NWAS. The Medicines Team have contacts with both of these teams and provide advice, support and share information. It is likely that additional assurance work is required in both these areas in 2020/21.

Table 1: Controlled Drugs Used

Controlled Drug	Schedule	Profession	Restrictions
Ketamine 200mg/20ml	2	Paramedic	Advanced level practice only
Morphine 10mg in 1ml Injection	2	Paramedic	N/A
Diazepam emulsion 10mg/2ml injection	4 (part 1)	Paramedic	N/A
Diazepam rectal 5mg tubes	4 (part 1)	Paramedic	N/A
Midazolam 5mg/5ml injection	3	Paramedic	Advanced level practice only

2.1.2 Medicines Supplies:

Medicines are received via various routes:

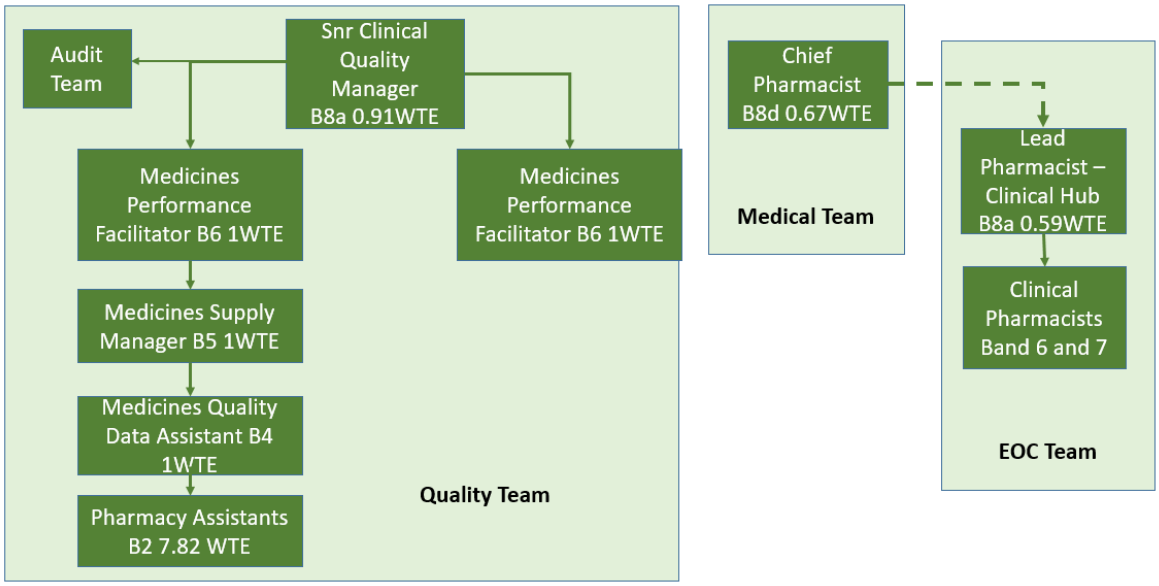
- General medicines are procured from Wirral University Teaching Hospitals.
- CDs are procured from a community pharmacy.
- NWAA procures it's medicines from Lancashire Teaching Hospitals.
- NARU stocks are distributed at a national level.

Only the general medicines go through the Medicines Supply Hub. This has disadvantages for NWAS but as all services have the relevant licences required, the current system is a legal method to access the medicines. A project is underway looking at CD procurement and supply within NWAS and this is part of the Quality Strategy pledges.

2.1.3 Staffing:

In Sept 2019 a new Chief Pharmacist for NWAS started in post and the service level agreement with Manchester Foundation Trust (MFT) to provide pharmaceutical advice came to an end in March 2019. In October 2019, the lead clinical pharmacist working in the Clinical Hub and the team of pharmacists transferred from MFT to NWAS. The lead pharmacist is the only permanent employee, all other staff work on the NWAS bank. The current staff within pharmacy and medicines teams are shown in figure 1. A paper reviewing this structure has been submitted to the Executive Leadership Committee alongside a review of the Quality Team.

Figure 1: Medicines/Pharmacy Staff – Current



The Controlled Drug Accountable Officer is Chris Grant, Executive Medical Director and he is registered with the CQC for this role.

2.1.4 Tasks for 2020/21:

- Review of medicines management support for NWAA and NARU
- Staffing review in conjunction with the Quality Directorate restructure.

2.2 Medicines Optimisation Strategy:

2.2.1 Pledges:

The Medicines Optimisation Strategy forms part of NWAS Right Care Strategy. It is one of the six pillars. Performance against the pledges and goals for monitored by the Quality and Performance Committee. The Medicines Management Pledges are as follows:

- Barcoding: Our systems for managing stock of medicines will be enhanced through the adoption of barcoding.
- PGDs: Patient Group Directives (PGDs) will be reviewed as appropriate to service development.
- Prescribing: We will review governance systems to support prescribing by paramedics.
- CD Licence: A strategic plan will detail options for CDs to be stored and supplied under licence by NWAS

2.2.2 Progress against the pledges in 2019/20 and plans for 2020/21:

- Barcoding

The flow of medicines within the Medicines Supply Hub has been mapped and barcodes have been created to support the process. After delays, due to technical issues outside of the Medicines Team control, in Q4 it had been arranged for Ingenica to install the initial barcoding phase into the Medicines Supply Hub. However, due to the COVID19 pandemic,

the Medicines Supply Hub has been closed to non-essential personnel and hence progress delayed. The Medicines Supply Hub is a critical service within NWAS and the priority is to maintain supplies of medicines.

- PGDs:

A quarterly report on PGDs is provided to the MEG. All PGDs have been in date throughout the year and available on the intranet and JRCALC + as appropriate. Each clinician who wants to use a PGD needs to be "signed off" to do so. As of the 31st March 2020, the uptake rate of the PGD by the clinicians required to work within them is shown in table 2. Currently obtaining this information is very labour intensive but provides excellent assurance around our use of medicines. All PGDs are for use by paramedics with the only exception being influenza vaccine PGD, which allows both nurses and paramedics to use it. A report on each year's use of the flu vaccine will be provided to the Medicines Effectiveness Group.

Table 2: PGD Uptake Status as of 31/03/2020

PGD	Uptake %	PGD Expiry
Tranexamic acid 500mg in 5ml injection	92%	30.09.20
Flumazenil 100microgram/ml injection	100%	31.03.21
Ketamine 10mg/ml injection	100%	31.03.21
Midazolam 1mg per 1ml for injection	100%	31.03.21

A risk assessment on use of non-parenteral prescription only medicines within NWAS was carried out. This led to a review of the training provided to emergency medical technician (EMTs) as part of their apprenticeship.
2020/21 will also see a development of e-learning packages for PGDs and the digitalisation of the "sign off" process.
The Medicines Team will focus work on PGDs in 2020/21 to support compliance with the NICE PGD guidance and also meet any outstanding actions from the MIAA PGD audit (see audit section).

Non-Medical Prescribing:

The pledge for this for 2020/21 has been amended to include any non-medical prescriber and not just paramedics. NWAS also employs nurses and pharmacists who are eligible to be NMPs. A review with key stakeholders has been carried out to understand the drivers and aspirations of NWAS around utilising non-medical prescribers. At this point in time, NWAS does not employ any NMPs and there are no immediate plans to change this. A NMP framework will be developed to ensure appropriate governance is in place should the NWAS strategy require utilisation of these clinical skills.
The Medicines Team supported the bid for the GP Out of Hours contract in early 2020 with responses specifically around medicines management to support the service. This would have required procurement/storage/supply of a whole new range of medicines, facilitating the use of FP10 prescriptions and e-prescribing in addition to medicines management support and advice for the service. Of note, this would have required the employment of NMPs to support the running the service.

CD licence:

CDs are currently procured via a community pharmacy. This has several disadvantages for NWAS but it a legal method for NWAS to access the medicines. A risk assessment regarding NWAS receiving medicines that are not going through the Medicines Supply Hub is underway. A project will commence to undertake a review of the procurement of CDs and

options appraisal developed. For NWAS to procure the medicines via the Medicines Supply Hub (rather than a community pharmacy), we would require a CD Home Office licence. This would require infrastructure investment within the Medicines Supply Hub and investment in personnel. Delays to this project have been incurred due to COVID19.

2.2.3 Pledges 2020/21:

The Medicines Optimisation Strategy has been reviewed by the Chief Pharmacist for 2020/21 and the additions/changes to the pledges are shown in bold below. These changes reflect the current issues for medicines management.

- Barcoding: Our systems for managing stock of medicines will be enhanced through the adoption of barcoding.
- PGDs: Patient Group Directions (PGDs) will be reviewed as appropriate to service development.
- NMP: We will also set up governance systems to support **non-medical** prescribing.
- **SSHM: Systems and governance of the safe and secure handling of medicines (SSHM) will be reviewed and enhanced including whether NWAS should store and supply controlled drugs under licence.**
- **Incidents: Systems for handling medicine related incidents will be improved.**

Plans for the first three pledges have already been outlined. For SSHM and incidents the information is as following:

SSHM:

This will form a large part of the Medicines Teams work plan over the coming year. Key issues will be the focus on the CD project (as outlined in the section above), ambient temperature monitoring in ambulance stations and the development and implementation of an audit of SSHM for ambulance stations. Some key pieces of work have already commenced/completed:

- During Q4 2019/20, new controlled drug record books for ambulance stations were designed and rolled out across all ambulance stations in NWAS. These bound books are bespoke for NWAS and provide better record keeping for CDs and make it easier to establish what should be in the CD cupboard for the daily CD checks.
- CD cupboards in ambulance stations were designated paramedic access only.
- CD cupboards that were to be designated as a delivery point for CDs were decommissioned. Chief Pharmacist will now review any estate plans that involve CD storage.
- CD deliveries must now be receipted by a paramedic at each ambulance station.

Incidents:

Links with the NW Medicines Safety Officers Network has been established (the Chief Pharmacist is the Vice Chair of the Network) and a detailed quarterly report to the MEG of incidents (including CDs) has been developed. Two pharmacy technicians have undertaken training in Human Factors and Incident Investigation and a 'lessons learnt' newsletter will be published on medicines issues. Further work will focus on a review of past medicine related patient safety alerts and Healthcare Safety Investigation Branch reports for relevance for NWAS. This will include a review of how these alerts plus relevant NHSE alerts will be processed.

2.2.4 Goals 2019/20 and plans for 2020/21:

Expired Medicines:

Reduce the percentage of medicine pouches with expired drugs remaining in circulation 1 week beyond their expiry date to less than 1%. Baseline = 4.4% expired pouches in circulation 1 week beyond expiry. (Based on data from 08/18 to 03/19)

At the end of year 3% (144) of 4876 pouches currently in circulation have expired. Of the 144 expired pouches, 52 (36.1%) expired within the last month. The figures are generated from pouches returned to the medicine supply hub up to 1 week after the expiry to allow 1 courier collection per station to have occurred.

This target has not been met.

The target to reduce the percentage of medicine pouches with expired drugs remaining in circulation 1 week beyond their expiry date to less than 1%, has not been met. Results have reduced from the 4.4% baseline to 3%, suggesting that progress is being made, albeit not at the rate desired. In order to address this, work is underway to look at using the SAFECHECK system to book medicines onto and off vehicles to enable better tracking of medicines. This will allow operational management teams and the Medicines Team access to live data to view the expiry dates of medicines across all vehicles. This should improve the recall process for expiring medicine pouches. Further digital enhancements include the use of barcode tracing for medicine stocks from receipt in the medicine supply hub to the issue out to stations.

In addition, the way Staff Responders are issued medicines and how this is recorded is under review. The target for 2020/21 has been requested to remain at <1% to replace the published target of 0%.

Medicines Waste:

Reduce the percentage of medicines disposed of as waste by 25%. Baseline data for 2018/19 identified 130,870 units of medicines wasted amounting to £188,180. 25% reduction = 98,153 units wasted in 2019/20.

The total number of units wasted for June 2019 to March 2020 totalled 65,706. On average, there are 248,427 units of medicine in circulation stored in medicine pouches. The ratio of waste to stock is 26%.
This target has been met.

In 2020/21 this will not be reported on quarterly but information on waste will be provided in the annual medicines management report.

Medicines Dashboard:

Pilot medicine management performance metrics dashboard.

The medicines management quality indicators (MMQI) dashboard has been developed and is received each month by local operational teams. Feedback on the content of the

dashboard has been positive and work is on-going to improve performance. See the audit section of this report for MMQIs.
This target has been met.

2.2.5 Goals 2020/21:

Two new goals have been set for 2020/21:

- % Controlled Drugs (CD) Station Audits completed every 6 months by the Medicines Team.

This goal demonstrates our commitment to support ensuring the SSHM within NWAS with a focus on ambulance stations. Preliminary work has been carried out to develop the audit and also to support operational staff with advice regarding SSHM in Q4, this included recommendations on the handling of medical gases and flu vaccines. Due to the current COVID19 pandemic, there will be a delay in commencing the audits.

- % of Patient Group Directions (PGDs) in date each quarter.

In Q2/3 it is expected that a package of new/updated PGDs will be approved and available for use each with an accompanying e-learning package.

2.2.6 Tasks for 2020/21:

- Work with the SAFECHECK project team to optimise it for supporting tracking medicines within NWAS and supporting improved governance of expired medicines.
- PGDs will be a large focus for the Medicines Team in 2020/21 providing assurance of compliance with the NICE guidance on PGDs.
- Flu vaccine report to Medicines Effectiveness Group.

2.3 Monitoring:

2.3.1 Stock Management:

A report on stock management by the Medicines Supply Hub is provided quarterly to the Medicines Effectiveness Group and monitors any medicines out of stock and any MHRA drug recalls received and action taken. Brexit and COVID19 has provided challenges with stock management nationally. The impact for the front line has been minimal but there has been more input required by the Medicines Team to ensure medicines availability. Good links with the Regional Procurement Lead Pharmacist has provided timely access to information.

2.3.2 General Medicines Financial Costs:

Total spend on general medicines in 2019/20 was £420,820. This represents an approx. 8% decrease compared to 2018/19 which was £459,052.

Amiodarone syringes were changed to ampoules following an analysis of use/waste and cost. This was fully implemented in January 2020 and has a potential saving of £65,363/annum exc. VAT.

In 2020/21 the influenza vaccines will be procured directly by NWAS rather than going via a third party. This will provide an expected saving of £7,500 on the 5,000 influenza vaccines NWAS procures a year.

2.3.3 Controlled Drug Ordering Monitoring:

Within NWAS, CDs are only used by paramedics. Systems must be in place to monitor CD usage within an organisation. This is not straightforward. At a national level the amount of CDs ordered by individual paramedics will be monitored as they use individual prescribing codes. Within NWAS, these CDs are not used by the individual (we do not issue CDs as personal possession) but to individual vehicles. When orders are placed prior to the order being sent to the community pharmacy the Medicines Supply Hub cross checks the orders for any in the previous 2 weeks against the vehicle and not the paramedic. If a previous order is identified this is investigated.

2.3.4 Controlled Drug Usage:

The volume of CDs being ordered does not represent the amount of CDs used as some will be expired or damaged. A jump in the amount supplied could be due to a batch of a CD expiring and not necessarily representing increased usage. The Electronic Patient Record (EPR) will enhance the ability to provide assurance on appropriate use of CDs alongside the use of SAFECHECK. Table 4 shows the amount of CDs dispensed to NWAS by Lloyds pharmacy during 2018/19 and 2019/20.

Table 4: Comparison of CD supplies from 2018/19 to 2019/20

Controlled Drug Supplied	2018/19	2019/20	Variation +/-
Morphine Sulphate 10mg/1ml Ampoules	46880	41950	-4930
Diazemuls 10mg/2ml Emulsion Ampoules	6640	9720	+3080
Diazepam 5mg Rectal Tubes	5385	6440	+1055
Ketamine 200mg/20ml Injection	91	120	+29
Midazolam 5mg/5ml Ampoules	150	190	+40
Total	**59146**	**58420**	**-726**

Note – this data/processes do not include NWAA (where more CDs are used and doctors are users) or NARU stocks.

2.3.5 Controlled Drug Financial Costs:

Table 5 shows the financial value of the CD stock purchased via Lloyds pharmacies. This is the cost for the stock supplied and does not include additional service fees charged for this contract.

Controlled Drug Supplied	Value of Units exc VAT)	Value of Units (inc VAT)
Morphine Sulphate 10mg/1ml Ampoules	£48,121.10	£57,751.20
Diazemuls 10mg/2ml Emulsion Ampoules	£8,796.60	£10,555.92
Diazepam 5mg Rectal Tubes	£7,106.70	£8,528.04
Ketamine 200mg/20ml Injection	£607.20	£728.60
Midazolam 5mg/5ml Ampoules	£190.32	£228.44
Total	**£64,821.92**	**£77,792.20**
Total minus morphine rebate *		**£34,279.56**

Table 5: Controlled drugs supplied to NWAS by Lloyds 01/4/19 – 31/3/20 – source Lloyds monthly management reports

*NWAS has a non-contractual agreement with Martindale Pharmaceuticals (the manufacturer of the morphine sulphate that NWAS procures) to rebate the cost per unit to the agreed NHS price of £1.00 per box (10 ampoules). Lloyds are a non NHS organisation and therefore, cannot access the same pricing structure agreed nationally for NHS organisations procuring medicines. The rebate for 2019/20 totalled £43,512.64 inc VAT but 2 months rebate was missed due to time constraints with the data. It is worth noting that Martindale have agreed to a new Rebate but this will expire in December 2020. It is not as much as previously achieved, as the prices we pay fluctuate each month. Martindale will not be offering us a further rebate beyond December 2020 unless negotiations with procurement can be agreed.

2.3.5 Tasks for 2020/21:

- Review how a live EPR can enhance assurance of appropriate use of CDs.

2.4 Policies and Procedures

2.4.1 NWAS has a Medicines Policy was updated and approved May 2019 this includes a section on CDs and PGDs. The General Medicines and Controlled Drug (CD) Standard Operating Procedures Toolkit were both updated and approved Nov 2019.

2.4.2 Tasks for 2020/21:

- Review the Medicines Policy in 2020/21.
- Separate out the PGD part of the Medicines Policy into a standalone policy and update to reflect NICE guidance.
- Develop a webpage for all the medicines management information to be located. This will include key posters, tools, newsletters, policies, SOPs, contact details, PGDs, etc.

2.5 Medicines Related Incidents

2.5.1 General Incident Management:

Any medication incident that occurs is reported and investigated via DATIX. These incidents are viewed by the Medicines Team as they are reported. Support is provided to the operational team for any investigation or follow up. A quarterly report is provided to the Medicines Effectiveness Group (MEG). The CD related incidents are also submitted quarterly to NHS England. The Medicines Team has a dedicated email address, controlled.drugs@nwas.nhs.uk where any concerns around the use of CDs within NWAS or in the wider health economy, can be escalated. If an incident is reported that has occurred outside of NWAS, these are followed up by the Medicines Team with the relevant personnel. This may be the Medicines Safety Officers for hospitals or the Community Pharmacy Contract Leads for community pharmacies. This is recorded in DATIX. The incidents reported show a good reporting culture across NWAS and no serious incidents reported this year.

2.5.2 Controlled Drug Incidents:

CD incidents are comparable to the previous years. CD damage rates are primarily due to a change in manufacturers packaging of Diazemuls, which has been highlighted as an area to review and improve for 2020/21. There was one area of concern which involved morphine missing over a number of consecutive months in 2019. Three boxes of 10 in total were reported missing during April, June and July in the same geographical area. A full investigation was completed with the operational team, the Medicines Team, the police and the CD local intelligence network. No explanation was found. Since July, all morphine has been fully accounted for with no further incidents reported. There was one other incident of morphine not being recovered and reported as missing. This incident involved two vials. It is thought they were accidently disposed of in a bin outside a hospital. Thorough attempts were made to recover the two ampoules but the waste had already been removed and crushed.

There have been no serious incidents and no 'Never Events'.

Controlled Drug Incident Breakdown by Area 2019/20						
Incident Subcategory	**CL**	**CM**	**GM**	**HART**	**NWAA**	**TOTALS**
CD Administration Error	3	6	2	0	0	**11**
CD Adverse Reaction	0	1	1	0	0	**2**
Any Other CD problems	19	10	7	0	0	**36**
CD Damaged	26	26	67	3	5	**127**
CD Missing	7	5	2	0	1	**15**
CD Safe Access Problem	7	7	6	0	0	**20**
CD Stock Problem	2	19	7	0	0	**28**
CD Documentation Error	41	34	45	0	0	**120**
Suspected Misuse	0	0	0	0	0	**0**
Total	**105**	**108**	**137**	**3**	**6**	**359**

Table 6: CD incident types reported per area 2019/20

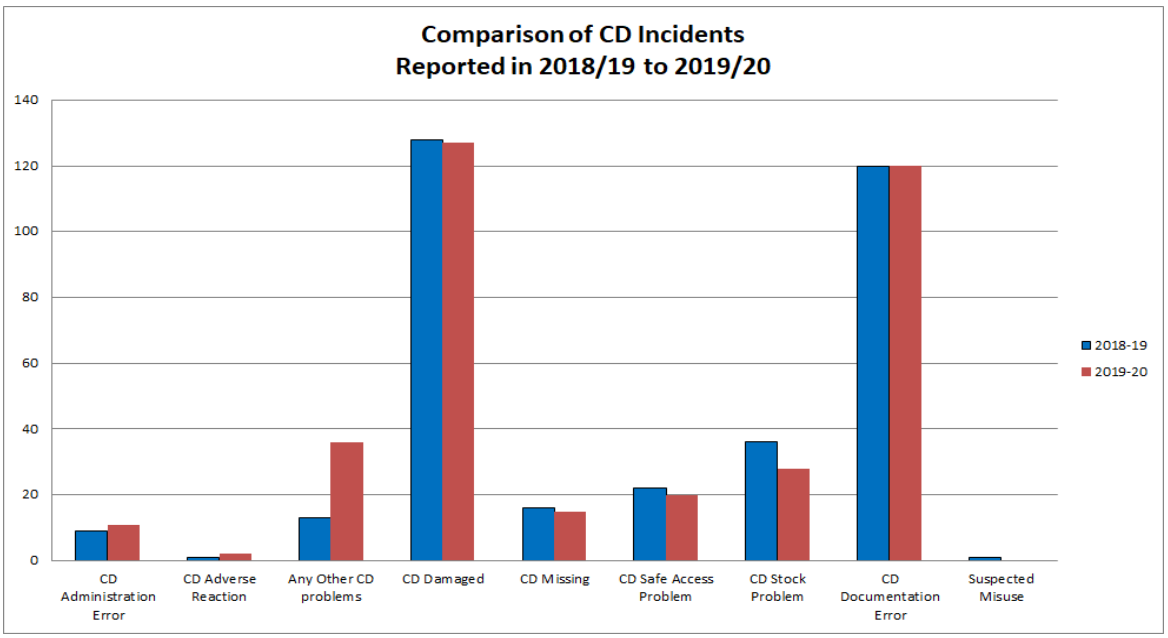


Chart 2: Comparison of CD incidents reported in 2018/19 and in 2019/20.

2.5.3 General Medicine Incidents:

There has been a similar level of general medicine incidents occurring in 2019/20 compared to the previous year, just 16 fewer incidents in total (shown in chart 3). Table 7 shows the types of errors by area. Most notably, an increase in documentation errors but more importantly a decrease in administration errors. A review of the medicines involved in the administration errors was undertaken in 2019 and reported to the MEG. This showed that a theme of 7 out of the 58 errors were due to adrenaline 1 in 1000 being given by the wrong route of administration; intravenously rather than intramuscularly. No harm came to the patients, the error was recognised whilst on scene with the patient and under duty of candour all patients were informed of the error. A bulletin was issued reminding clinicians of the correct route of administration. Q4 2019/20 did not see any incidents reported. This is not unique to NWAS and is nationally the biggest medicine related incident in the ambulance service. The error is sighted on a national level, with a request for the ambulance service load list to have autoinjector pens on stock instead of pre-filled syringes to prevent the mix up of wrong route administration. These pens are more expensive, but more importantly despite three manufacturers the supply chain is unstable and has been for a number of years. Hence availability has prevented adoption in our sector.

General Medicine Incidents 2019/20							
Incident Category	**CL**	**CM**	**GM**	**HART**	**NWAA**	**EOC/111**	**TOTALS**
Administration Error	21	19	16	1	0	1	**58**
Adverse Reaction	1	1	0	0	0	0	**2**
Documentation Error	14	15	22	0	1	1	**53**
Medicines Damaged	1	3	4	0	0	0	**8**
Medicines Missing	6	10	18	0	0	0	**34**
Stock Problem	6	2	10	0	0	1	**19**
Suspected Misuse	1	1	0	0	0	0	**2**
Procedural Complication	3	1	5	0	1	0	**10**
Inappropriate Clinical Advice	0	0	0	0	0	0	**0**
Total	**53**	**52**	**75**	**1**	**2**	**3**	**186**

Table 7: General medicines incidents reported 2019/20 – source DATIX

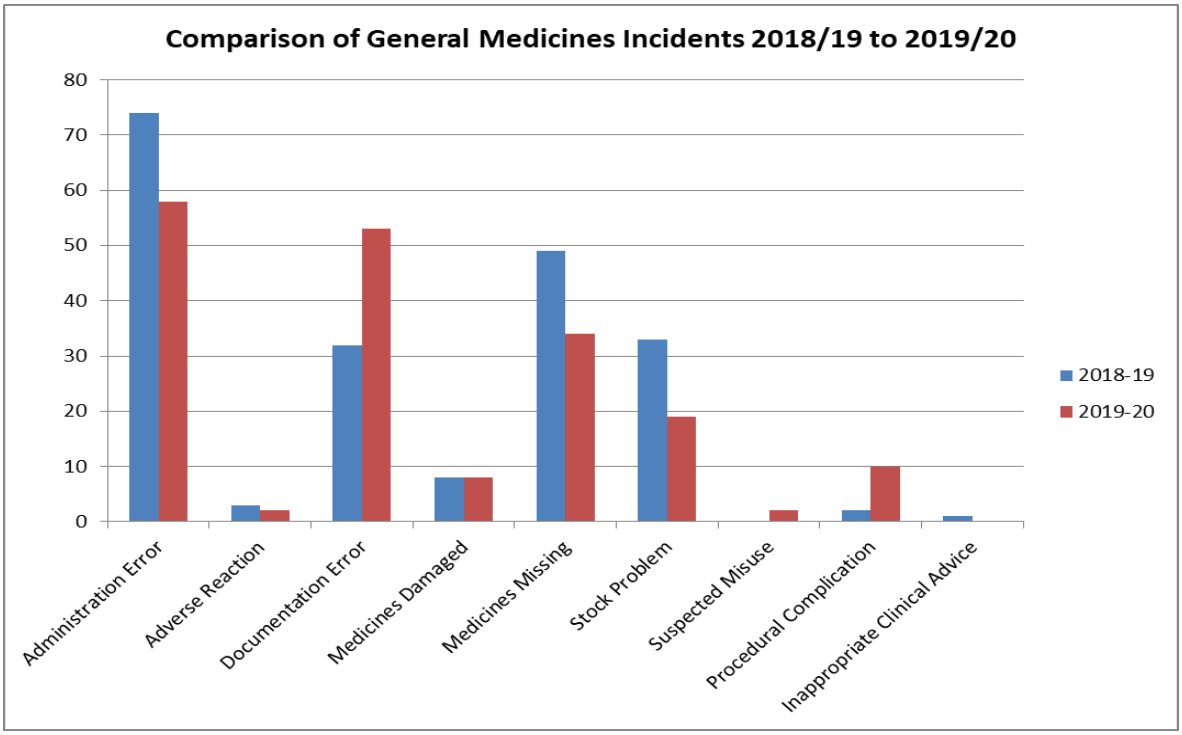


Chart 3: Comparison of general medicine incidents reported in 2018/19 and in 2019/20.

Following a risk assessment on the use of non-parenteral prescription only medicines in Feb 2020, a bulletin was issued stating if a EMT needed to administer a salbutamol nebuliser to a patient (due to no paramedic on scene) it should be documented via DATIX. These figures are not included in the general medicine incident report but are reported separately and reviewed at the MEG.

There were no serious incidents reported and no 'Never Events'.

2.5.4 Actions taken to minimise errors:

- Medicines Management – Learning Lessons Bulletin covering four key issues. This will be repeated annually.
- Reviewed of uses of injectables (in line with NPSA 20) with a recommendation to introduce syringe labels, syringe bungs and filter needles.
- Clinical Information Bulletin raising awareness of adrenaline 1:1000 administration via the wrong route.
- Escalated to NWAA about potential to mix up rocuronium and midazolam vials due to similar packaging. NWAA disseminated a bulletin to staff to raise awareness.
- Escalated to NARU the mass casualty vehicles stock high strength midazolam which paramedics cannot use and may also not realise it is a different strength. Administration of the wrong strength is classed as a 'Never Event'. This has been agreed for prompt removal.
- Clinical bulletin to paramedics about morphine dosing. Doses above 20mg must involve contact for senior clinical advice.
- Introduction of the CD tagging system to increase compliance with daily CD checks and support investigations.
- Sourced and introduced bubble wrap pouches in an effort to reduce the diazepam ampule breakages. This was due to a rise in breakages after seizure pouches were introduced.
- Published a 5 minute briefing on SSHM including raising the awareness to check medical gases.
- Reviewed PGDs to ensure the rate of administration for injectable medicines is clear.
- Added into the paramedic emergency services 'must have' conversation list for clinical contacts to raise medicines and CD expiry checks and daily CD checks.

2.5.6 Tasks for 2020/21:

- Implement the syringe labels, filter needles and syringe bungs.
- Register a Medicines Safety Officer for NWAS (like NWAS have a Medical Devices Officer) who will be responsible for validating all medicines related incidents and supporting investigations and learning from errors. This will be put in place once the resource is recruited.

2.6 Audit

2.6.1 Vehicle Medicines Audit Compliance (MMQIs):

All vehicles that hold a stock of general medicines or CDs should conduct a monthly audit. This ensures compliance against the quality indicators designed to provide assurance that they are being managed in accordance with procedure and legislation. During 2019/20, there was compliance with all 5 general medicine audit measures and 5 out of 6 of the controlled drug measures displayed in chart 4.
The fall in audits seen in July (see chart 5) was related to the suspension of the other audits (due to cyber security concerns) which also inadvertently affected the medicine audits.

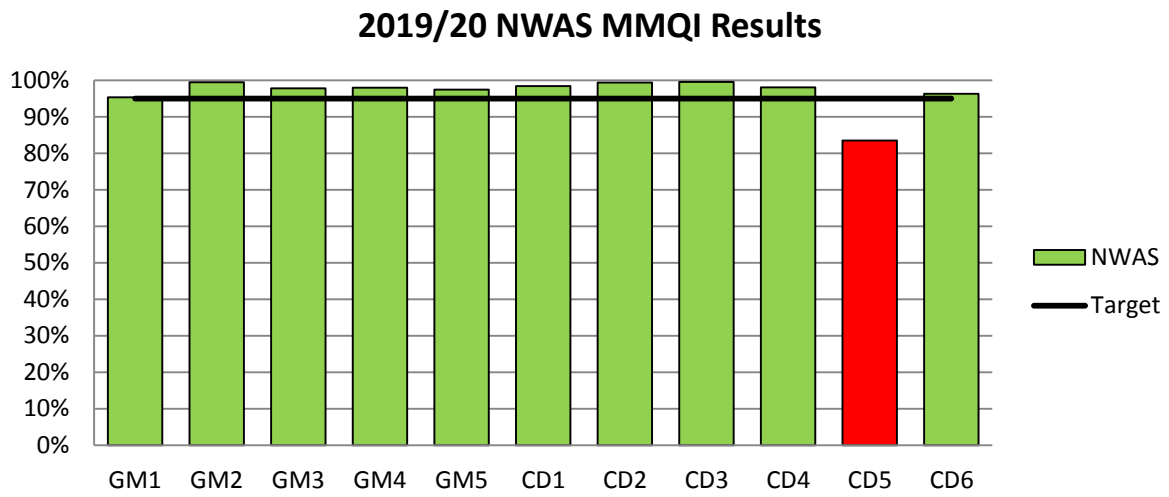


Chart 4: MMQI audit compliance for 2019/20 - data extracted from SNAP.

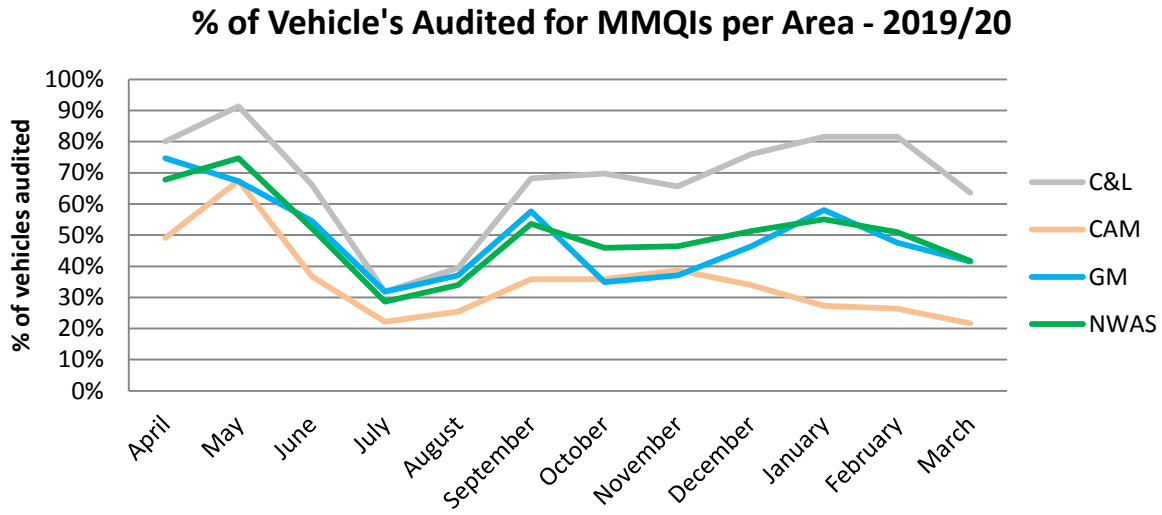


Chart 5: Vehicle audit rates for 2019/20 – data extracted from SNAP

The measure requiring further improvement and review for 2020/21 is CD5, which involves the daily CD check. The progress of this measure since April 2018 to the end of March 2020 is displayed in Chart 6, showing a slow but gradual improvement. During 2019, tagging of CD drug safes and the creation of a tagged seizure pouch was implemented across NWAS. This was viewed as operationally beneficial for the management and security of CDs. Since its introduction there has been a steady rate of compliance with CD5 of 83% of the last 8 months. A full review of CD5 has been provided in a separate report for the Quality and Performance Committee including highlighting the concern that not all vehicles are being audited.

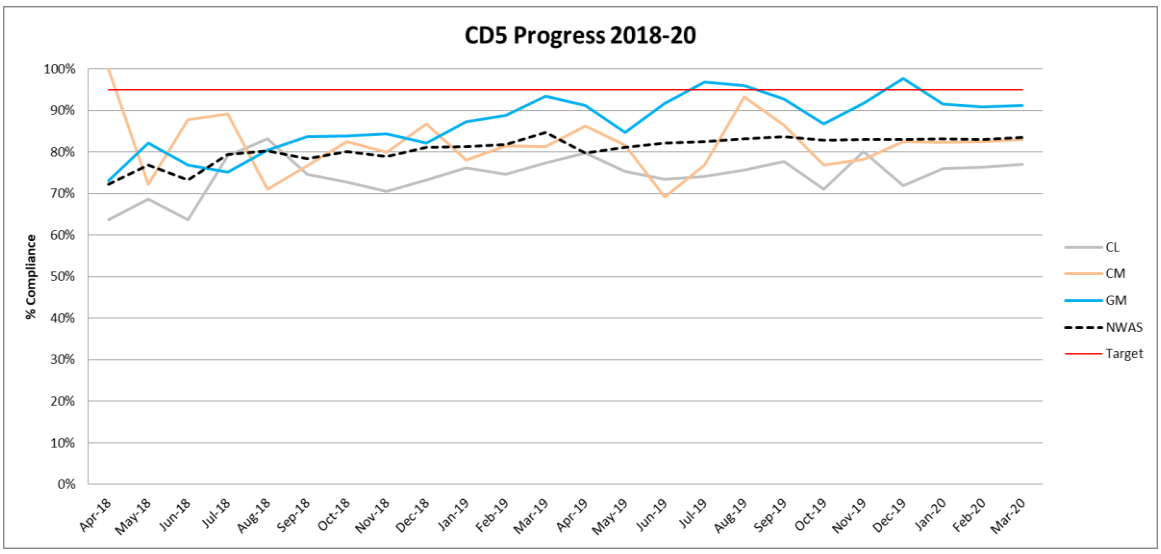


Chart 6: Progress with compliance with daily CD checks since 2018.

2.6.2 PGD Management Audit by MIAA:

A review of the use and governance of the PGDs was undertaken by MIAA with recommendations provided in the final report. The majority of actions have been completed. There are 3 outstanding actions but all are part of the work plan for 2020/21. These are:

- Developing training and competency assessments for PGD medicines – on track for completion by Q2.
- PGD compliance audits to be undertaken – a template has been approved and initial audit work commenced, this has been delayed due to COVID19.
- Reduction of waste of PGD medicines also featured in the report. This is linked to the barcode scanning being introduced in 2020 (see 2.2.2) and obtaining larger medicine pouches.

2.6.3 Events CD Management Audit by MIAA:

This audit provided limited assurance. On review of the results, it was agreed that all CDs need to be brought back onto NWAS premises and cannot be stored on events premises. A bulletin was disseminated to all staff reminding them of the key CD processes that must be followed.

2.6.4 Tasks for 2020/21:

- Conduct a PGD audit annually.
- Implement an audit of SSHM for ambulance stations.

2.7 Medicines Related Risks:

A risk register report is provided to the MEG quarterly and progress is monitored regularly The risk register has 6 medicine related risks, these are:

- CDs and Home Office licence
- PGDs x 3 (following the MIAA audit report)
- Ambient Storage of Medicines in Ambulance Stations
- Non Parenteral POM Administration

All the above have been discussed in this report.

2.8 Partnership Working

The Medicines Team links in with the following groups:

- CD Local Intelligence Networks
- NW Medicines Safety Officers Network
- NW Chief Pharmacist's Network
- NW Chief Pharmacy Technician's Network
- Ambulance Pharmacist's Network
- Specialist Pharmacy Services (includes experts in procurement, quality assurance and medicines information).

Some of these links are new for NWAS in 2019/20. This provides vital professional support for the Medicines Team, enables knowledge to be up to date, peer support, harvesting new ideas, raising the profile of the ambulance sector and supporting systems wide approach to medicines.

2.9 Constraints:

The following are some of the constraints to optimising medicines within NWAS:

- Lack of space for staff and for medicines
- Lack of resource within the Medicines Team
- COVID19: This is bringing challenges with procurement, additional medicines availability, set up of new medicines pouches to support new services (PES/PTS and HEMS critical care), implementation of PGDs and training for HEMS staff and advice on medicines.
- Lack of live electronic patient records

2.10 Summary

The Medicines Team is a very small team, with minimal capacity outside of maintaining core business as usual. The team are aspirational and highly capable. The aim is to be outstanding with excellent medicines optimisation across the service.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

This report demonstrates a robust approach to governance is being taken to the handling of medicines within NWAS in terms of procurement of medicines from appropriate licence holders, monitoring in place for the use of medicines, policy and procedures in place to guide use of medicines, PGDs in place and in date, an audit process, a medicines risk register in place, regular reporting in the MEG on key issues and an overall strategy guiding priorities.

4 RECOMMENDATIONS

The Board is asked to note the assurance provided in this report and the plans in place to further support the handling of medicines within NWAS.

Appendix 1: Tasks for 2020/21

Following a review of medicines management, including controlled drugs, over 2019/20 alongside the medicines optimisation strategy on medicines (monitored by the Right Care Strategy) the following tasks will be undertaken.

Medicines Arrangements:

- Review of Medicines Management support for NWAA and NARU.
- Staffing review in line with the Quality Directorate restructure.

Meds Optimisation Strategy:

- Work with the SAFECHECK project team to optimise it for supporting tracking medicines within NWAS and supporting improved governance of expired medicines.
- PGDs will be a large focus for the Medicines Team in 2020/21 providing assurance of compliance with the NICE guidance on PGDs.
- Flu vaccine report to Medicines Effectiveness Group.

Monitoring:

- Review how a live EPR can enhance assurance of appropriate use of CDs

Policies and Procedures:

- Review the Medicines Policy in 2020/2021.
- Separate out the PGD part of the Medicines Policy into a standalone policy and update it to reflect NICE guidance.
- Develop a webpage for all the medicines management information to be located. This will include: key posters, tools, newsletters, policies, SOPs, contact details, PGDs, etc.

Medicine related incidents:

- Implement the syringe labels, filter needles and syringe bungs.
- Register a Medicines Safety Officer for NWAS (like NWAS have a Medical Devices Officer) who will be responsible for validating all medicines related incidents and supporting investigations and learning from errors. This will be put in place once the resource is recruited.

Audit:

- Conduct a PGD audit annually.
- Implement an audit of SSHM for ambulance stations.

North West Ambulance Service NHS Trust

REPORT

AGENDA ITEM:

Board of Directors	
Date:	27 May 2020
Subject:	Infection Prevention and Control (IPC) 2019/20 Annual Report
Presented by:	Chief Nurse - Director of Infection Prevention & Control
Purpose of Paper:	For Assurance
Executive Summary:	This report provides an overview of Infection Prevention and Control (IPC) activity within the Trust during the period 2019-2020. The report gives assurance of the Clinical Safety team's progress against key improvement goals agreed in the Trust's Right Care Strategy 2018-2023. **Vehicle Deep Clean**: Performance targets have been achieved despite COVID-19 challenges. Average Trust performance across the last 12 months has been 86.9% of vehicles cleaned within 7 days of their scheduled 6 weekly clean (target 85%). **IPC Audits**: IPC audit questions have been reviewed and converted into an automated online tool, which was implemented in December 2019. IPC data is being captured through an online portal and performance data for the last quarter of 2019/20 indicates that Trust wide compliance against vehicle cleanliness is high (88.2%). The management of equipment was 78.7% Trust wide and the management of waste & linen was 88.2%). The Trust is working to maintain and improve these standards through a comprehensive system of audits and regular feedback and review. Work with 'SNAP' to migrate to an agreed output report was halted in March, due to the COVID-19 pandemic. **Quality Assurance Visits:** Observational Clinical Safety Practitioner (CSP) audits are completed bi-monthly. Trust wide Quality Assurance Visits (QAV) completed throughout the year included agreed criteria which provides impartial audit data conducted in a standardised format. **Hand Hygiene:** Audits continued throughout the year and overall compliance is high at 89.8% (in year target 85%). Hand wipes are available for staff to effectively clean their hands when no soap/water is available. Throughout this year the Trust has been improving its standards of hand hygiene and embedding national guidance on staff being Bare Below the Elbow (BBE)

	Cannulation Policy: The IV Cannulation Policy has been approved and implemented. The team have developed the cannulation audit tool to measure compliance against the policy and learning materials such as a cannulation video. **Wipe It Out Campaign:** An internal campaign entitled 'Wipe it Out' ran throughout the year as part of the NWAS Infection Prevention and Control work plan for 2019/20.The campaign focused on key areas every quarter as follows: Q1: Hand hygiene Q2: Cannulation Q3: Aseptic None Touch Technique (ANTT) Q4: Personal Protective Equipment (PPE) In Q4 with the emergence of the COVID-19 global pandemic the whole Clinical Safety team has become heavily involved in dealing with daily tasks associated with managing the outbreak within our organisation. All information in relation to the Trust's involvement is still being produced and will be approved via the Trust's necessary Governance processes before being released.
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Note and approve the IPC 2019/20 Annual Report.

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

Link to Board Assurance Framework (Strategic Risks):

SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	**N/A**
Previously Submitted to:	Quality and Performance Committee
Date:	18 May 2020
Outcome:	Recommended for approval by the Board of Directors

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1. EXECUTIVE SUMMARY

North West Ambulance Service (NWAS) is committed to the prevention and control of infections and minimising the risks and impact of healthcare associated infections for all service users and staff in line with The Health and Social Care Act (2008)(updated 2015), and current national guidance. The NWAS Chief Executive has overall accountability for ensuring that the Trust maintains adequate and appropriate controls to minimise the risks of infection to staff and all service users.

The Director of Infection Prevention and Control (DIPC) is responsible for the Trust's infection prevention and control annual plan and provides assurance to the Board that the Trust has effective systems in place to minimise, prevent and control the risks of health care associated infections (HCAIs). It is well recognised by all staff that infection prevention and control is everyone's' responsibility and ensures best outcomes for all service users.

PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with the key Infection Prevention and Control (IPC) activity and development during the period 2019-2020 and our ambitions for 2020-2021.

2. BACKGROUND

2.1 The Chief Nurse fulfils the role of Director of Infection Prevention and Control, supported by the Head of Clinical Safety, Clinical Safety Manager, three Clinical Safety Practitioners (CSPs), and a Clinical Safety Co-ordinator. The team is responsible for supporting staff to ensure they adopt best practice and provide expert advice on a safe environment and safe equipment and vehicles. The team supports the health and wellbeing of staff, patients and visitors by offering specialist advice. The CSPs provide assurance for Infection Prevention and Control for the stations and vehicles through independent audits as well as working with the wider Service Delivery teams to ensure goals and targets are met.

2.2 The Trust has a Consultant Paramedic within each area who manages a group of Advanced Paramedics (AP). The APs lead on clinical safety and IPC within Service Delivery and support the CSPs in the development and implementation of new initiatives and improving standards.

2.3 **Right Care Strategy**

NWAS is committed to promoting the highest standards of infection prevention and control within the organisation. The management of infection prevention and control has been developed in line with the Trust's Right Care Strategy with 5 key improvement goals.

Goal 1: Increase the percentage of vehicles deep cleaned within the 6 week standard.

Goal 2: IPC audits on stations and vehicles reviewed & new compliance standards implemented via operational manager.

Goal 3: IPC standards on stations and vehicles checked via quality visits.

Goal 4: Compliance with the World Health Organisation (WHO) 5 moments of hand hygiene.

Goal 5: Compliance with the cannulation policy & procedure guidance.

2.4 **Wipe It Out Campaign 2019/2020.**

The Trust has run a year-long internal campaign entitled 'Wipe it Out' as part of the NWAS infection prevention and control work plan for 2019/20.

The Wipe It Out campaign helped to embed compliance with the Heath & Social Care Act 2012. We are expected to demonstrate that appropriate monitoring and management systems are in place to identify risk of infection to susceptible service users and staff and any risk that their environment may pose to them. This programme of work is aligned to the Care Quality Committee (CQC) registration compliance criteria.

NWAS is committed to ensuring the highest standards of IPC for its patients and staff. Our achievements in recent years will be maintained and a renewed focus on personal protective equipment, hand hygiene, cannulation and standardisation of IPC products and procedures will be achieved. We will also deliver new standards of vehicle and station cleanliness through our quality visits programme.

3. RIGHT CARE STRATEGY; ACHIEVEMENTS AND AMBITIONS

3.1 Goal 1: Vehicle Deep Clean.

All front line ambulances (Paramedic Emergency Service (PES), Patient Transport Service (PTS), Rapid Response Vehicles (RRV), and Urgent Care (UC)) are rostered to have a deep clean completed every 6 weeks. There is a 2 week window to allow for vehicles not being available due to operational needs or maintenance reasons. This deep clean does not replace routine and acute cleaning of the vehicle or equipment as this is carried out after every patient contact.

All patient facing vehicles are scheduled for deep cleaning every 6 weeks. Measurement captures vehicles scheduled for that month, cleaned within 7 days either side of their due date. Reporting for the vehicles in scope runs from 7 days prior to month start to 7 days after month end.

Example – PES CL East Lancashire, 30 due in month, 30 cleaned but only 28 cleaned within 7 day window, result 93.3% compliance.

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days	% complete +/- 7 days
Target 85%	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**	**85.0%**
Total Fleet	83.7%	85.7%	89.1%	86.3%	76.7%	81.2%	90.9%	92.3%	84.4%	93.2%	88.3%	91.6%
Total PES	83.0%	83.8%	88.1%	85.7%	76.0%	77.7%	89.4%	91.9%	84.2%	92.7%	87.7%	92.4%
Total PTS	85.2%	89.0%	91.1%	87.4%	78.0%	86.5%	93.5%	93.1%	84.8%	94.1%	89.5%	90.1%
PES C&L	75.0%	76.6%	88.6%	79.1%	66.7%	79.1%	86.3%	88.8%	73.5%	91.5%	81.1%	90.9%
CL E Lancs	66.7%	65.5%	100.0%	81.8%	76.9%	72.4%	96.6%	100.0%	84.8%	93.3%	92.6%	100.0%
CL Fylde	76.5%	90.0%	100.0%	90.0%	94.7%	94.1%	85.7%	95.2%	94.7%	100.0%	100.0%	84.2%
CL N Cumb	83.3%	75.0%	81.5%	88.0%	93.1%	72.7%	77.4%	77.8%	59.5%	91.7%	79.3%	91.4%
CL S Cumb	65.5%	84.0%	90.5%	74.1%	0.0%	88.9%	88.2%	94.7%	63.9%	73.1%	46.7%	87.5%
CL S Lancs	85.7%	74.2%	76.0%	65.5%	76.5%	78.1%	83.3%	78.6%	76.9%	100.0%	100.0%	87.5%
PES GM	85.0%	91.0%	92.6%	88.2%	81.8%	87.2%	94.0%	91.7%	95.2%	92.9%	95.1%	92.4%
GM Central	72.5%	90.6%	85.7%	83.8%	61.1%	72.7%	82.4%	81.1%	95.2%	95.1%	92.3%	86.8%
GM East	91.9%	91.4%	94.4%	92.7%	91.7%	91.9%	97.6%	91.7%	97.5%	97.4%	97.1%	95.2%
GM South	90.5%	88.9%	92.5%	93.0%	81.4%	93.6%	94.7%	95.5%	91.1%	86.0%	97.1%	93.2%
GM West	85.4%	93.9%	100.0%	82.5%	93.9%	87.2%	100.0%	97.5%	97.5%	94.9%	94.4%	93.9%
PES C&M	85.9%	81.1%	81.7%	87.4%	74.6%	63.0%	87.4%	94.0%	80.6%	93.4%	85.2%	93.8%
CM East	88.9%	90.9%	89.3%	94.4%	84.8%	55.9%	93.1%	94.1%	89.5%	97.1%	90.9%	91.4%
CM North	96.2%	86.4%	97.4%	86.5%	86.4%	95.2%	98.1%	93.9%	86.3%	94.3%	86.7%	96.0%
CM South	77.4%	56.7%	40.9%	82.8%	40.6%	23.1%	70.4%	95.2%	71.0%	96.2%	80.0%	93.1%
CM West	72.4%	88.0%	84.6%	84.6%	82.8%	60.0%	76.9%	93.1%	66.7%	81.8%	80.0%	93.3%
PTS East	90.6%	87.6%	88.9%	87.1%	90.8%	85.4%	95.3%	98.3%	90.2%	94.2%	94.8%	99.3%
PTS West	78.5%	90.5%	93.3%	87.9%	65.6%	87.9%	91.3%	87.4%	78.9%	94.0%	84.6%	78.8%

The headline targets were achieved despite COVID-19 challenges. The average Trust performance across the last 12 months has been 86.9% of vehicles cleaned within 7 days of their scheduled 6 weekly clean (target 85%). PES CL South Cumbria & CM West

responded well after 3 months of poor performance and PES GM continues to be strongest area throughout NWAS. The most recent positon (Mar 20) being above this average at 91.6%.

Goal Achievements 2019/20:
The CSPs have met with local area Sector Managers and Operational Managers during their sector visits to ensure regular cycles of deep clean are conducted and any issues with this are escalated. This has helped to maintain a clean safe working environment for all patients, relatives and staff.

Goal Ambition for 2019/20:
The Trust is aiming to improve reporting and demonstrate improved compliance against the 6 week vehicle deep cleaning standard. The goal for 2020/21 is to attain 85% compliance for all vehicles reaching the agreed target. Deep cleaning performance data will be incorporated as part of the IPC dashboard available at Sector and Station Level.

3.2 **Goal 2: IPC audits on stations and vehicles reviewed & new compliance standards implemented via operational managers.**
IPC performance and assurance audits are conducted on a monthly basis and the data is collated and audited to provide assurance on IPC standards. The IPC audit questions have been reviewed and converted into a new automated online tool, which was implemented in December 2019. Compliance within each of the categories for ambulance vehicle audits is shown in the three charts below.

Compliance levels are reviewed to identify any risk areas where an action plan is required to address the issue. The IPC audit questions are reviewed annually to ensure that they focus on areas requiring improvement until a consistent and high standard is achieved.

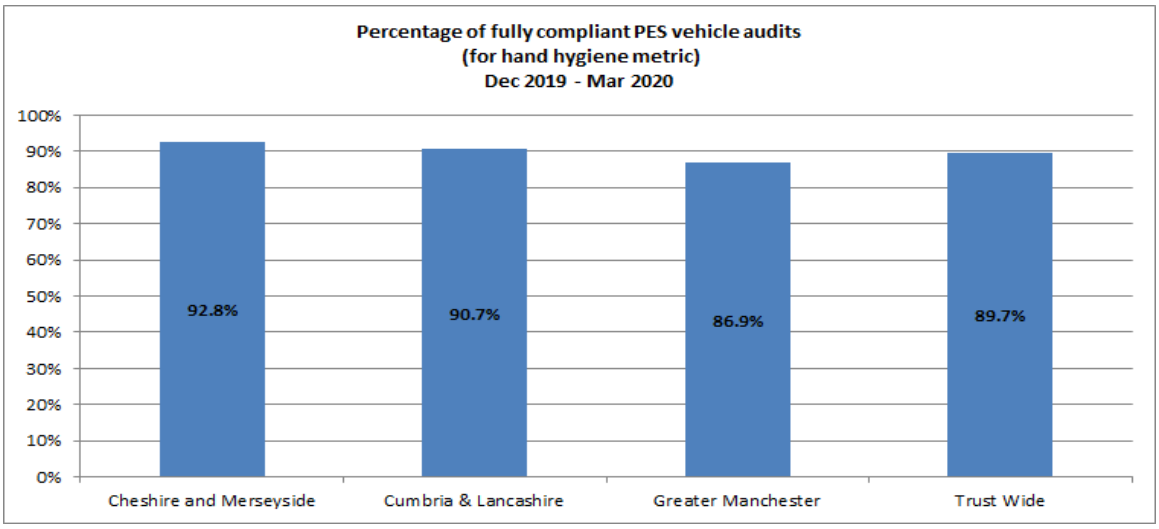


Chart 1

The Trust wide compliance against hand hygiene is high (89.7%). Cheshire and Merseyside area have performed well in this area at 92.8% compliant.

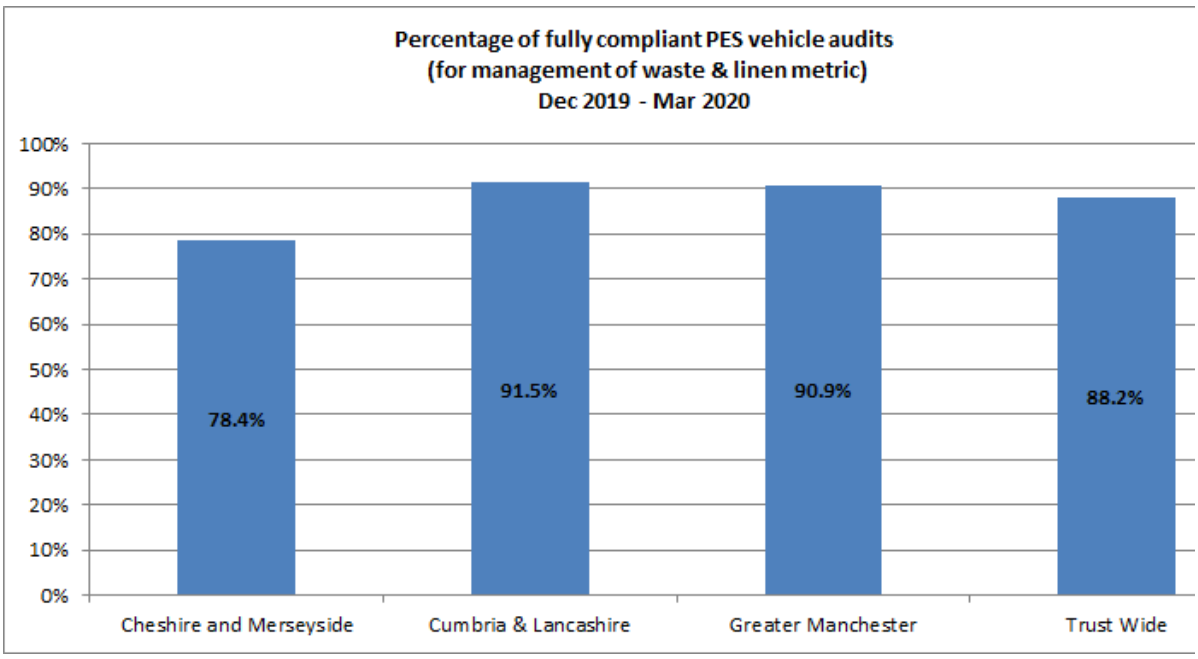


Chart 2

Trust wide compliance against the management of waste and linen is 88.2%. Improvement plans for Cheshire and Merseyside are in place and are monitored through the local area Learning Forums.

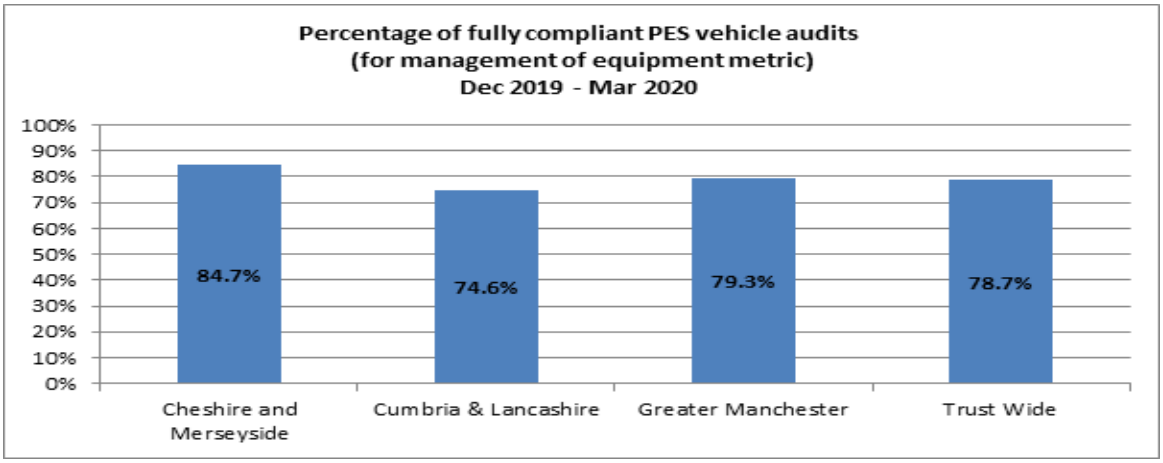


Chart 3

Trust wide compliance against the management of equipment is 78.7%. Improvement plans for each area are in place and are monitored through the local area Learning Forums.

IPC audit compliance for ambulance station audits is shown in the two graphs below. These are reviewed to identify any risk areas where an action plan is required to address any issues compliance identified.

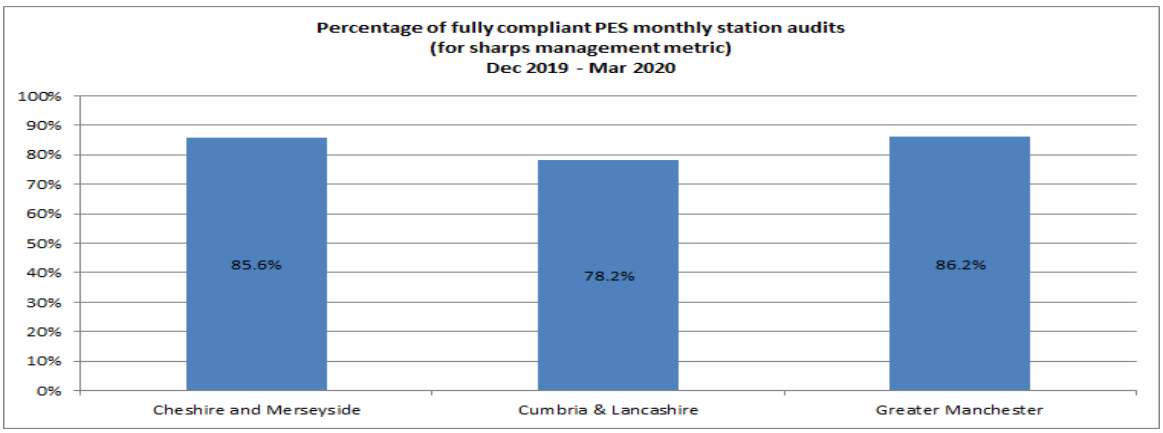


Chart 4

Performance data for the last quarter of 2019/20 indicates that the Trust wide station compliance against the management of sharps is good at 83.3%.

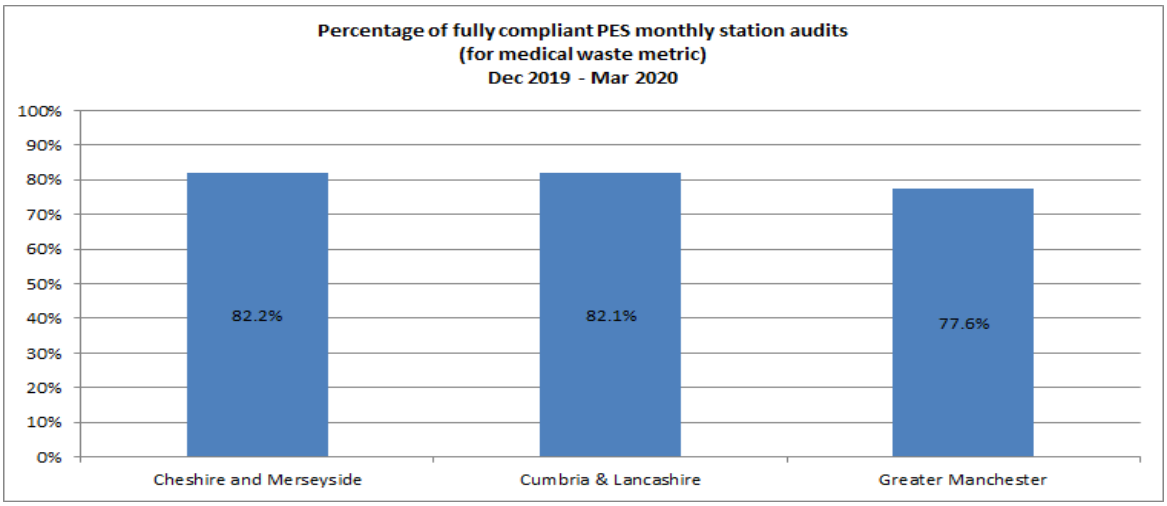


Chart 5

Performance data for the last quarter of 2019/20 indicates that the Trust wide station compliance against the management of medical waste is 80.6%. The Trust is working to constantly improve performance in this area and is working closely with the waste collection companies and its staff to ensure standards are kept very high.

Goal Achievements 2019/20:

The suite of audit questions have been reviewed to make them succinct and appropriate. The Clinical Safety team and Clinical Quality team have been working together to ensure the Trust's approach to reporting audit data is presented in a new revised standardised format.

Goal Ambitions for 2020/21:

The revised IPC audit questions will be reviewed and further developed throughout 2020/2021. They will incorporate intelligence and information that is being gained during the current COVID-19 global pandemic.

Our aim is to be able to provide up to date Sector and Station level IPC performance data that can be displayed on IPC dashboards within stations. The Clinical Safety team will continue to work with Service Delivery managers to ensure that auditing is consistent throughout the Trust.

3.3

Goal 3: IPC standards on stations and vehicles checked via quality visits.

Observational audits are undertaken by Clinical Safety Practitioners (CSPs) on a bi-monthly basis, visiting a sector every two months and reporting their findings to the local

management teams and the Area Learning Forums. Whilst more audits have been undertaken, the results show that there is still work to be done in highlighting best practice. All non-compliances are addressed with the crews at the time by the clinical lead. Work on education and compliance has continued on hand hygiene, including training for senior clinicians, posters and a hand hygiene video.

A Trust wide Quality Assurance Visit (QAV) audit programme has run throughout the year. This has incorporated many of the directorate teams including Medicines Management, Health and Safety, IPC, Estates Services, Safeguarding and Vehicle safety. This audit programme has provided quality assurance against a range of quality indicators. This programme is conducted by impartial quality visitors using a standard format.

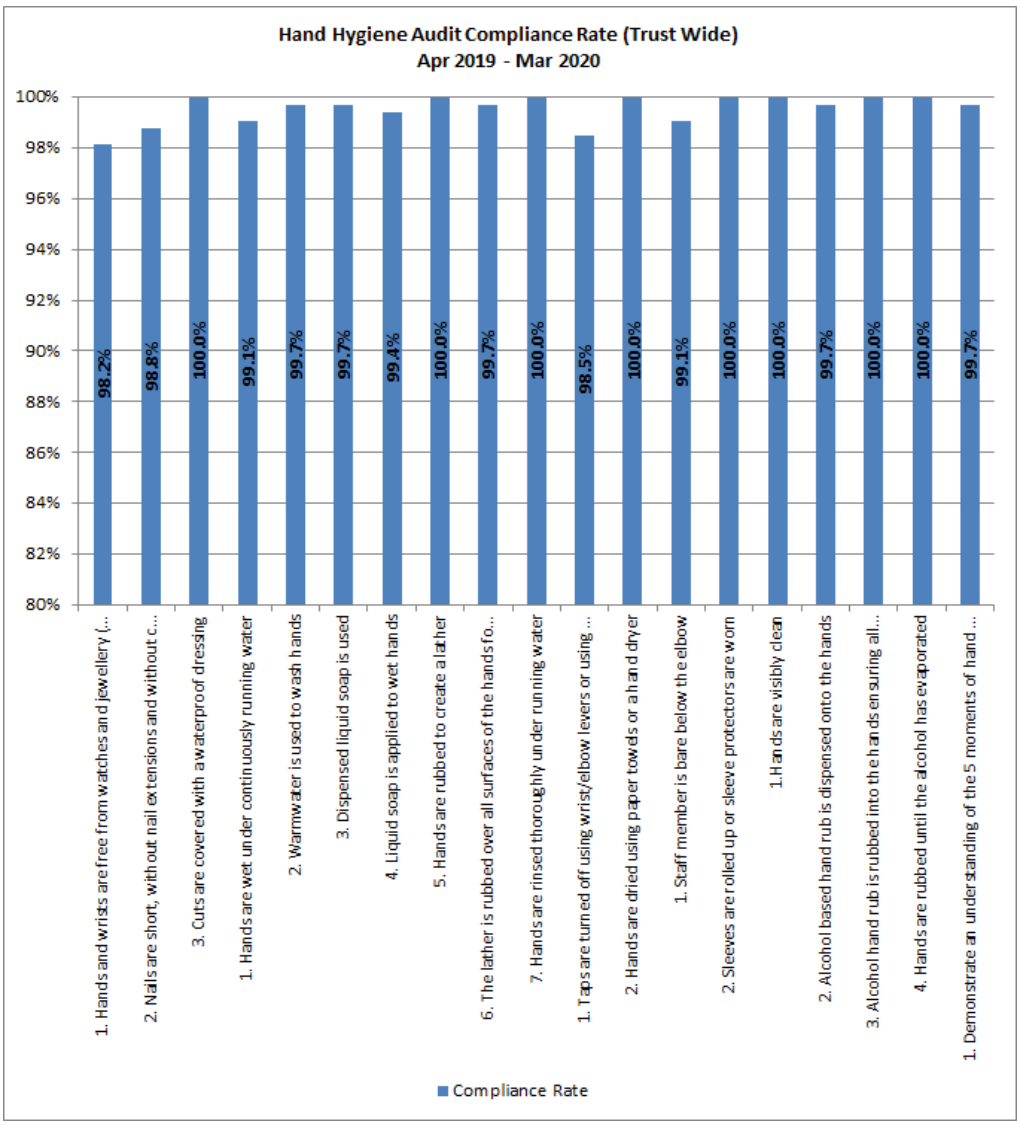
Achievements 2019/20:
The CSPs have continued to conduct observational audits scheduled in each area. These visits have shown that station standards for IPC are consistently improving. The CSPs visibility on stations gives staff opportunities to ask questions and gain clarity on IPC matters. As part of the observational audits any actions required to improve practice are addressed.

The IPC questions for the Sector Quality Assurance Visits (QAVs) have been reviewed and standardised. Underpinning criterion guidance has been written which helps to ensure information obtained is objective.

Ambitions for 2020/21:
QAVs will be planned throughout 2020/21. The QAV teams will visit every station and use the quality indicator questions with associated criteria to perform a high level audit. The audits will use agreed guidance criteria to ensure consistency in standards which will provide high quality, objective data on IPC within NWAS.

3.4

Goal 4: Compliance with the World Health Organisation (WHO) 5 moments of hand hygiene.
Good and efficient hand hygiene is the single most important factor in the prevention and spread of infection. By improving hand hygiene all staff can reduce the risk of transmission of infection.



Goal Achievements 2019/20:

Audits have continued throughout the year and overall compliance is high at 89.8% (in year target 85%). All our front line clinicians are requested to be audited and the audits have shown very high performance. These audits assess staff knowledge of good hand hygiene, compliance with bare below the elbow, the Uniform Policy and Dress Code. As part of the Wipe It Out campaign the Clinical Safety team are also conducting covert observational hand hygiene audits during the course of the year with the aim of giving constructive and supportive feedback when poor compliance is recorded.

In addition to the audits being done, the team has trained local Hand Hygiene Champions who are responsible for training colleagues, auditing practice and providing guidance on hand hygiene at a local level. Hand hygiene detergent wipes are now available for all staff that can be used in situations where staff have no access to soap and water.

Goal Ambitions for 2020/21:

One of our ambitions is to ensure high levels of hand hygiene compliance by incorporating good hand hygiene practice in every aspect of care provision. The CS Team will continue to review hand hygiene audit data. A process for monitoring the use of the detergent wipes will be incorporated in the Hand Hygiene Audit later this year.

A short film had been created with the help of a Consultant Paramedic and our Communications Team to demonstrate good hand hygiene. This has helped to allay any
3.5 commonly held myths about the use of gloves.

Goal 5: Compliance with the IV Cannulation Policy & Procedures.
The Trust aims to give assurances of high competence in all aspects of IPC practice by reviewing and, where applicable, re-writing current IPC procedures and policies. A new IV Cannulation policy is now in place in the organisation.

Goal Achievements 2019/20:
A policy and procedure for intravenous cannulation is now in place and a competency tool to measure baseline performance is now in use. The Clinical Safety team with the help of a Consultant Paramedic have created a training video for all staff to access. This will allow all clinicians to achieve and maintain standardised IPC practices through improved training, Trust wide monitoring, auditing and maintenance of a central staff record system.

***Ambitions for 2020/21*:**
Our intention is for all our relevant clinical staff to have, where applicable through assessment, completed additional intra-venous cannulation training and to embed a cannulation competency training tool.

3.6

Additional IPC Ambitions for 2020/2021.
To provide greater assurances that the Trust is achieving the highest standards of IPC in order to reduce the incidence of Sepsis and Anti-Microbial resistant drugs (in accordance with the National Health Service England (NHSE) Sepsis Action Plan).

The deep cleaning contract for vehicles was renewed in 2018 and the team is working with the Contracts Manager and the cleaning contractor to improve the standard of the environment so that care delivered to patients by our staff continues to be clean, safe and infection free.

To ensure that all of the Trust's Control and Contact Centres are compliant with IPC standards and regular assurance audits are carried out by our CSPs. These audits are to be carried out in line with the latest COVID-19 guidance.

To empower patient and service users to feel confident to ask clinicians if they have practiced a high standard of IPC including hand hygiene.

3.7

Infection Prevention and Control Incidents
The Trust encourages an open reporting culture for adverse incidents. A Trust IPC milestone plan is in place and the Trust Board receives information on compliance against agreed improvement goals relating to cleanliness of vehicles and stations.

The number of IPC related incidents reported remain a very small fraction of a percentage in comparison to overall number of incidents recorded.

Top Five Infection Prevention and Control Incidents 2019-2020
It should be noted that the top 5 sub-categories for previous years are not the same as the current year's top 5

Incident Type	No. of Incidents 2016-17	No. of Incidents 2017-18	No. of Incidents 2018-19	No. of Incidents 2019-20
Crew contact with known infectious disease	14	23	22	324
Crew not notified of patient's infection status	10	14	6	258
Dirty needle stick (with injury)	49	58	51	58
Contaminated vehicle	7	8	18	39
Decontamination certificate missing	32	8	10	29
Totals (including all incident types)	**202**	**226**	**247**	**802**

2019/20
The table above shows the number of incidents reported in the last 12 months in comparison to previous years. In Q4 2019/20 with the emergence of the COVID-19 global pandemic a sharp rise in incidents reported has been seen within our organisation. Every incident reported is thoroughly reviewed each week and any trends are analysed and reported to the Executive team. Close monitoring of covid-19 related incidents will continue so that the Trust is able to put plans in place to provide a safe working environment for staff.

Although there have been **802** reported PES IPC incidents over the last twelve months, the number of calls received by our control centres has also increased equating the incident increase rate to **0.07**% of all PES calls. All IPC incidents reported are investigated and any training needs are actioned and recorded. Any learning from the incidents If Trust wide learning is incorporated into mandatory training for all clinical staff or published in communication the Trust bulletins.

4. EDUCATION AND TRAINING

4.1 In 2019-2020 the Clinical Safety Practitioners (CSPs) have reviewed the IPC training materials and have revised the standardised training package for all staff. This new focus includes hand hygiene, Aseptic Non-Touch Technique (ANTT), Intravenous cannulation, sharps safety, personal protective equipment, environmental cleaning and waste management. The training sessions encourage clinicians to take on a positive role in the reduction of Antimicrobial Resistance (AMR) and reducing the incidence of Sepsis amongst patients.

The team has delivered 37 training sessions this year with further dates planned for 2020-2021. This has included training to new staff, Student Paramedics, Emergency Medical Technicians (EMTs) and Patient Transport Service (PTS) staff. Feedback has been very positive with a high rates of satisfaction for the training presentations.

The IPC training sessions include, as a minimum:

- Hand hygiene is an integral component of all clinical courses.
- IPC training for all clinical staff in universal precautions, vehicle and equipment cleaning and decontamination in the form of an e-learning package with brief learning materials.
- The safe use and disposal of sharps and actions to take in the event of an inoculation incident with an e-learning package and learning materials.
- Assessment of staff knowledge on the main principles of ANTT, Personal Protective Equipment (PPE), Sharps use and safety and clinical waste management.

Additional competence based review and assessments of all aspects of IPC practice is carried out for all clinicians during their clinical contact shifts with their Senior Paramedic Team Leaders (SPTLs). The Infection Prevention and Control Policies and Procedures are made available to staff in a variety of formats and hard copy on stations.

5. COVID-19

In the last quarter of 2019/20, the Trust has been focused on the response to the COVID-19 pandemic. Since the beginning of the Pandemic 28th February 2020, The Trust Pandemic Plans have been initiated with daily and weekly calls chaired by Strategic and Tactical Commanders. These regular meetings have enabled the Trust to continuously

process and respond to national advice and implement evidence based ways of working to maintain safety of patients and staff. This has resulted in over 40 bulletins and guidance issued to staff to date.

The Chief Nurse and Head of Clinical Safety have also been attending regular meetings with the North West Science and Technical Advice Cell (STAC) for COVID-19. The NW STAC was convened to provide timely and co-ordinated scientific, technical, environmental and public health advice to the five Strategic Co-ordinating Groups (SCGs) across the North West, during the COVID-19 pandemic situation. Relevant advice and required actions from NW STAC group are discussed and cascaded via Strategical and Tactical meetings.

Due to the pandemic, the Trust had seen a significant increase in the number of incidents reported which are under review at the time of writing this report. Like all NHS providers, the Trust recognise the inherent level of risk posed by COVID-19 for staff and patients, and continuously identify, manage and mitigate appropriately in line with national guidance.

6. LEGAL and/or GOVERNANCE IMPLICATIONS

6.1 This section identifies the key documents which have impacted on the infection prevention and control agenda and have been used to inform the Infection prevention and Control Annual Work Plan 2018-19.

- The Health and Social Care Act 2012 Code of Practice on the prevention and control of infections and related guidance www.dh.gov.uk/publications - this was updated in December 2010 and July 2015
- Care Quality Commission (2008) Registering with the Care Quality Commission (CQC) in relation to HCAI: Guidance for trusts 2009/10. CQC, London.
- Essential standards of quality and safety: Guidance about compliance: Care Quality Commission. March 2010.
- Standard Infection Control Precautions: National Hand Hygiene and Personal Protective Equipment Policy (NHS England and NHS Improvement March 2019)
- Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. High Impact Intervention (HII) No. 2 Peripheral intravenous cannula care bundle. DH, London.
- Department of Health (2008) Ambulance guidelines: reducing infection through effective practice in the pre-hospital environment. DH, London.
- Department of Health (2007) The NHS in England: the operating framework for 2008/09. DH, London.
- National Standard Operating Procedure for Healthcare Cleanliness: Specifications, Methodology and good practice (NHS Improvement April 2019)

7. RECOMMENDATIONS

7.1 The Board of Directors is recommended to;

- Note and approve the IPC 2019/20 Annual Report.

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North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	20 May 2020
Subject:	Safeguarding Annual Report 2019-2020
Presented by:	Angela Hansen – Chief Nurse
Purpose of Paper:	For Assurance
Executive Summary:	This Safeguarding Annual Report provides an overview of safeguarding activity within the Trust during 2019-2020 and assurance relating to the scoping; development and implementation of safeguarding related processes. • Safeguarding activity has continued to rise across the Trust in 2019/20. A number of improvement projects have been identified to ensure continuing safeguarding demand will be met. • Safeguarding Training – The publication of the child and adult intercollegiate document (Royal College of Nursing, 2019), made recommendations of the required levels of safeguarding training. Safeguarding Manager together with the Learning and Development Lead have reviewed this and as a result all PES patient facing staff are now being trained to level 3 safeguarding. In addition, staff identified on the Training Needs Analysis (TNA) as requiring level 3 safeguarding training will continue to receive this training. Level 2 training is overseen in collaboration with the Safeguarding Team by the Learning and Development Team. A bespoke safeguarding training session is also being written. • Safeguarding Case Reviews – The Safeguarding Team continue to be involved in serious case reviews, safeguarding adult reviews and domestic homicide reviews. NWAS has particular learning in relation to concealed and denied pregnancy which has been incorporated into the level 3 safeguarding training. • Safeguarding Assurance Framework – This has been submitted to the Commissioners and an evidence request has been received, which is being completed to support the assurance framework. • Project Emerald is the title of the safeguarding innovation project which will introduce a new platform for the recording of safeguarding concerns. The new platform will replace the current Eriss system. • Updates on safeguarding are reported regularly to the

	Safety Management Group, to provide a detailed overview of the safeguarding activity within the Trust.
	• The Safeguarding Team currently has a number of low level risks recorded on the corporate risk register.
	  • 2962 – There is a risk that staff are not receiving level 1 and 2 safeguarding training in a timely manner in line with the Intercollegiate document. This risk is currently scored as a 6.
	  • 2963 - There is a risk that safeguarding governance is not managed by the Safeguarding Team in NHS 111 which could result in standards, processes and support are not sufficient within NHS 111 and integrated urgent care safeguarding. This risk is currently scored as a 4.
	  • 2978 – There is a risk that CP-IS is not compatible with the current NWAS systems. NHS Digital are working with the Trust to overcome the digital issues. This risk is currently scored as a 3.The Safeguarding Management Team will continue to scrutinise these risks and take actions to reduce them and mitigate against further issues.

Recommendations, decisions or actions sought:	The Board of Directors is recommended to; • Note the contents and approve the Safeguarding Annual Report 2019-20

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

Link to Board Assurance Framework (Strategic Risks):		
SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	
Previously Submitted to:	Quality and Performance Committee
Date:	18 May 2020
Outcome:	Recommended to the Board of Directors for assurance and approval.

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1. PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with an overview of safeguarding activity during 2019-2020. The achievements are set against the Right Care Strategy and ambitions taken from the forward plan 2020-21.

2. BACKGROUND

2.1 Safeguarding child and adult standards are determined nationally for NHS Provider organisations and are monitored via the regulator (Care Quality Commission) and via audits. In addition to safeguarding practice and processes the audit standards relate to policies and procedures, HR and recruitment processes, and leadership. The specific standards are contained within:

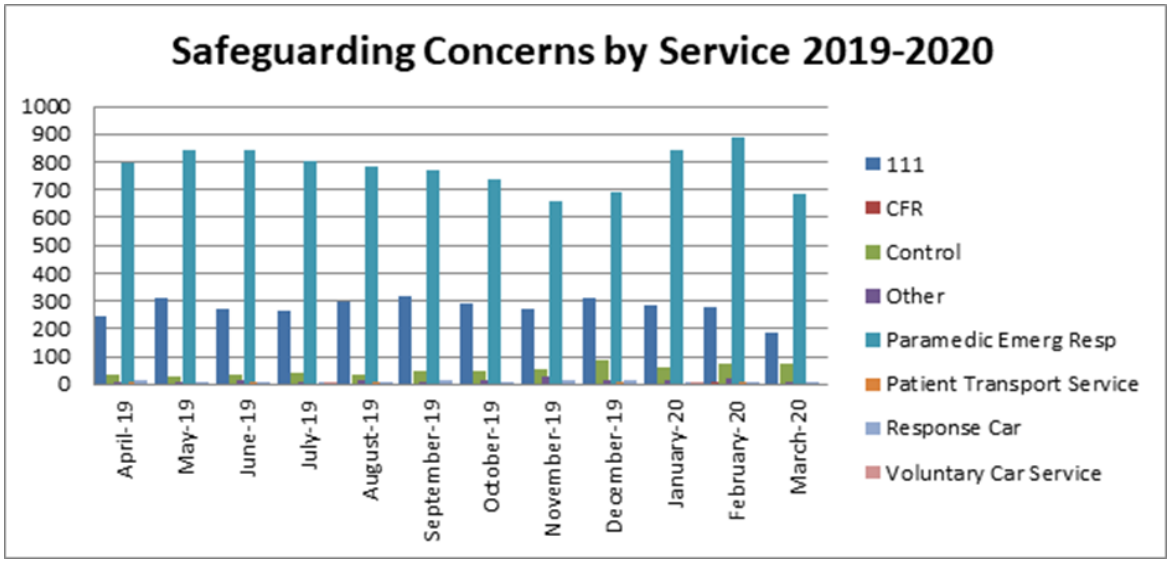
- Safeguarding Assurance Framework (SAF) which is presented annually to the lead Commissioners.
- Mersey Internal Audit Agency (MIAA) who conduct safeguarding audits on behalf of the Trust Audit Committee and have been auditing bi-annually.
- Care Quality Commission (CQC) inspection of the Trust including safeguarding arrangements took place in 2018 and 2020.

2.2 Safeguarding activity has continued to increase significantly in 2019-2020 across the trust against a backdrop of increasing activity within the Paramedic Emergency Services (PES) and within 111. Chart 1 demonstrates the number of safeguarding concerns raised during the past 12 months. The reduction in safeguarding calls in March reflected the Coronavirus pandemic, this reduction is mirrored in safeguarding activity experienced by both child and adult Social Care.

Chart 1 – Numbers of notifications

Concerns raised	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult	4288	4490	4367	4596	4735	4433	4735	4485	4714	5061	4652	3858
Child	1105	1192	1166	1131	1145	1166	1107	1029	1117	1211	1262	951
Total	**5393**	**5682**	**5533**	**5727**	**5880**	**5599**	**5842**	**5514**	**5831**	**6272**	**5914**	**4809**

Chart 2 Breakdown of notifications by service area



2.3 **Safeguarding Team**

The Safeguarding team comprises of one whole time equivalent (wte) Band 8a Safeguarding Manager (Named Professional for adults and children) and three wte Band 6 dedicated Safeguarding Practitioners. One for each geographical area of the Trust, Cumbria & Lancashire, Greater Manchester and Cheshire & Mersey. The practitioners report directly to the Safeguarding Manager, and are an integral part of the Clinical Safety team. The Clinical Safety team is managed by the Head of Clinical Safety who reports to the Chief Nurse. The team are also supported by 2.75 wte Band 3 Clinical Safety administrators. Capacity of the Clinical Safety administrators continues to be monitored and the split in role means that the administrators do not always have the capacity to carry out more in depth analysis work to support the Safeguarding team.

The Safeguarding Practitioners are engaged with the Quality Business groups, the localised PES/111 Learning Lessons forums and the Patient Transport Senior Management Team meetings to share safeguarding data, lessons to be learned and patient stories, to improve practice.

2.4 **Right Care Strategy**

In 2018 the Right Care Strategy for the Trust was implemented. This is a five year Strategy with key milestones for each year based on pillars of quality.

The number of safeguarding concerns being reported to local authorities by NWAS has continued to rise during 2019/2020. Safeguarding training has remained a high priority for the safeguarding team. A large number of face to face level 3 safeguarding training sessions have been delivered over the past 12 months by the team, these sessions have been well received with positive feedback. Learning from safeguarding incidents remains at the forefront of the safeguarding agenda. Learning is collated through the individual PES/111 learning forums, the corporate learning tracker and the PTS learning tracker.

Monitoring of these incidents allows for identification of any themes and trends. Wider learning from published safeguarding reports allows for proactive information sharing, to Trust staff, to highlight changes in practice and emerging safeguarding trends. A joint frequent caller and safeguarding database has been designed in collaboration with the Frequent Caller Manager which enables both teams to capture the most frequent callers and the safeguarding repeat concerns, on a weekly basis. This collaborative working allows for the most vulnerable and at risk patients to be identified. Proactive work then takes place between the Trust and Social Care or directly with patients.

The Right Care Strategy Safeguarding ambitions 2019-20 – Pillars of Quality Goals:

- Training compliance for Levels 2, 3, & 4 is compliant with the recently reviewed Training Needs Analysis. The team are currently reviewing the new Training Needs Analysis to match competencies against skill set and staff grades.

- Safeguarding performance metrics reported on a dashboard – this ensures greater detail and scrutiny to provide increased assurance. The safeguarding dashboard has been designed and is functioning. The dashboard gives easy oversight of the numbers of safeguarding concerns that are raised. Currently this data can be broken down into area, day/month activity. The replacement of the ERIS system with a new safeguarding platform will allow for more in depth recording and reporting.

Systems for linking, flagging, monitoring and responding to repeat referrals with escalation to SMT & stakeholders, as appropriate. The Frequent Caller Manager and the Safeguarding Manager have worked in collaboration to design the joint frequent caller and safeguarding repeat caller recording platform.

2.5 **Safeguarding Audit Compliance**

Throughout the year safeguarding standards are audited to ensure the safeguarding process is effective and robust. 2019 has seen the introduction of audits for consent and repeat safeguarding concerns. A separate consent audit paper is to be produced during 2020/21, for presentation to the Safety Management Group. Repeat safeguarding concerns are monitored for children. If 3 safeguarding concerns are identified for a child, the Safeguarding Practitioner for that area contacts the relevant Social Care team in order to obtain feedback on the current situation of the child.

2.6 **Safeguarding Concerns Rejections**

The Safeguarding team monitor the concerns that are rejected by Adult and Children's Social Care Services. The largest number of rejections continue to be for patients who are suffering with mental ill health. The Safeguarding Manager has continued to work with the Mental Health and Dementia lead, and alternative pathways are now available for patients who are suffering with mental health. The safeguarding concern form is being changed to reflect this and will be rolled out with the introduction of the Adastra system. The Mental health and dementia lead has given assurances that crisis care services are available across the majority of the Trust geographical footprint. If dedicated mental health services are not available, Trust staff are directed to notify the patients GP.

The Safeguarding Manager has made enquiries at the National Ambulance Safeguarding Group (NASG) regarding hear and treat capacity assessments. The findings from NASG is that no ambulance service currently has a hear and treat capacity assessment. The Safeguarding Manager and the Advanced Practitioner for Mental Health have started discussions in relation to the development of a hear and treat capacity assessment for clinicians.

2.7 **Training**

Level 2 and 3 training is included in the mandatory training delivery for PES, and level 1 and 2 is delivered for the PTS service. Figures that are reported on a monthly basis as a rolling programme include the safeguarding module compliance. The end of year training figures for compliance for Level 1 & 2 training was 82% across the Trust, for Level 3 77.25% and for Level 4 100%. The Safeguarding team continue to work with the corporate Learning and Development Department and local Service Delivery areas to improve the compliance figures.

Level 3 safeguarding training has been subject to significant review in 2019, and an

agreement has been reached with the Learning and Development team that level 3 safeguarding training will be delivered via mandatory training from January 2020. Level 3 training is written by the Safeguarding Team and mapped against the Intercollegiate Document and the National Training Guidance. The Intercollegiate document recommends that all Paramedics should be trained to level 3 in safeguarding. However, due to the way in which mandatory training is delivered within the Trust both Emergency Medical Technicians (EMT) and Paramedics are receiving level 3 safeguarding training. Although it is not a requirement for EMTs to receive level 3 training this provides improved assurance with regards to the consistency and focus of safeguarding training. The Safeguarding team has monitored the level 3 compliance over the past 12 months, and have escalated those staff members who have not attended level 3 safeguarding training. Escalation to management ensures that sufficient staffing can be planned to ensure adequate safeguarding advice is available.

The safeguarding team has dedicated a number of hours to deliver train the trainer sessions to the Clinical Practice Trainers (CPT). Collaborative working between the two internal teams helps to ensure relevant and appropriate safeguarding training is being delivered across the whole Trust. Centralised training of the CPT's ensures Trust wide consistency is applied to safeguarding training.

The Safeguarding Manager, the Head of Clinical Safety and the Chief Nurse all attend level 4 training as the Trust 'Named' Professionals for safeguarding. The information gathered from such training is cascaded through the Trust and enables the frontline staff to be empowered with the most up to date information in their local area.

The Safeguarding Manager and the Head of Clinical Safety attend the National Ambulance Safeguarding Groups (NASG). Engagement with NASG ensures the Trust are abreast with safeguarding activity nationally amongst fellow ambulance Trusts. Best practice activity is shared and the group acts as a support network for the Safeguarding Team. Safeguarding supervision is gained from the national group by both attendees.

Safeguarding supervision is carried out both within the safeguarding team and sought from external sources within the local safeguarding arena. A programme of safeguarding supervision for all staff is currently being scoped and the proposal is that safeguarding supervision will take place during clinical contact sessions. Safeguarding supervision provides the Practitioners and Managers with the opportunity to ensure that the team's practice and training are up to date, and that the safeguarding agenda is clearly understood. In addition, the Safeguarding team visit front line service areas on a regular basis through quality sector visits to raise safeguarding awareness and support staff engagement.

The Safeguarding Practitioners continue to work hard to maintain the visibility of the Safeguarding team. In addition to the quality sector visits, the safeguarding team also attend bespoke Senior Paramedic Team Leader away days and engage with the Trust university partners to deliver training.

2.8 **Safeguarding Board Engagement**

Increased notifications, improved visibility and Board engagement has resulted in increased numbers of requests to be involved in Safeguarding Adult Reviews, Domestic Homicide Reviews, Serious Case Reviews, Learning Disability Reviews and Strategy Meetings.

During 2019/2020 the Safeguarding team were involved in 161 safeguarding reviews, these are collated into the following sub categories; 70 adult reviews, 67 child reviews and 24 domestic homicide reviews. In direct comparison 2018/19 saw the Team engage in 155 safeguarding reviews.

The Safeguarding team work alongside senior managers and clinicians to ensure engagement with the Boards is visible and specific to local needs. There are currently 46 Safeguarding Boards across the geographical footprint of North West Ambulance Service and the team have committed to attend each board, as a minimum, once per year, or, as per local board request. Board engagement is monitored by the Safeguarding Team.

Each 'Local Safeguarding Board' is formally written to on an annual basis by the Safeguarding Manager to inform them of our commitment to engagement and to establish good working relationships in each area. In addition, practitioners and managers are involved in Local Safeguarding Board sub-groups. Engagement includes:

- Child Death Overview Panel
- Rapid Response Meetings
- Alternative Life Threatening Event meetings
- Serious Case Review Groups
- Safeguarding Adults Review Groups
- Front line visits with local board members
- Wider stakeholder meetings
- County leadership groups
- Multi-agency review meetings following the Sudden Unexplained Death of a Child (SUDC).

2.9 **Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews (DHR)**

Engagement with both children and adult safeguarding boards remains a priority. The Safeguarding team are committed to working collaboratively to ensure the safety of patients and the implementation of multi-agency learning (see charts 4, 5 and 6). These lessons are captured in the individual reports, and then disseminated through the corporate learning forum, the regional learning forums, directly with the staff involved, via the Trust wide weekly regional bulletins and built into the mandatory training scenarios.

Chart 4 – Number of Serious Case Reviews per month and area for 2019/2020

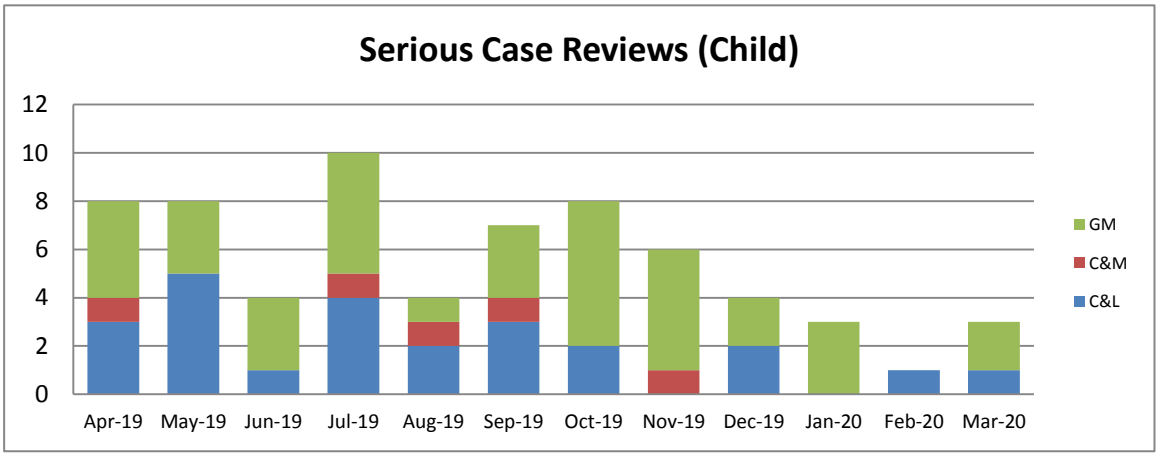


Chart 5 – Chart to show the number of Safeguarding adult reviews commissioned by area for 2019/2020

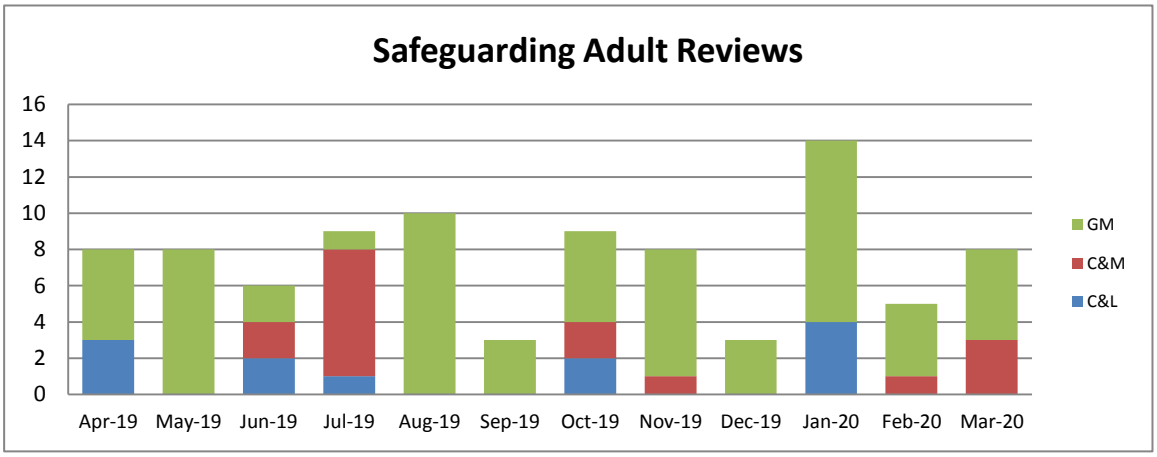
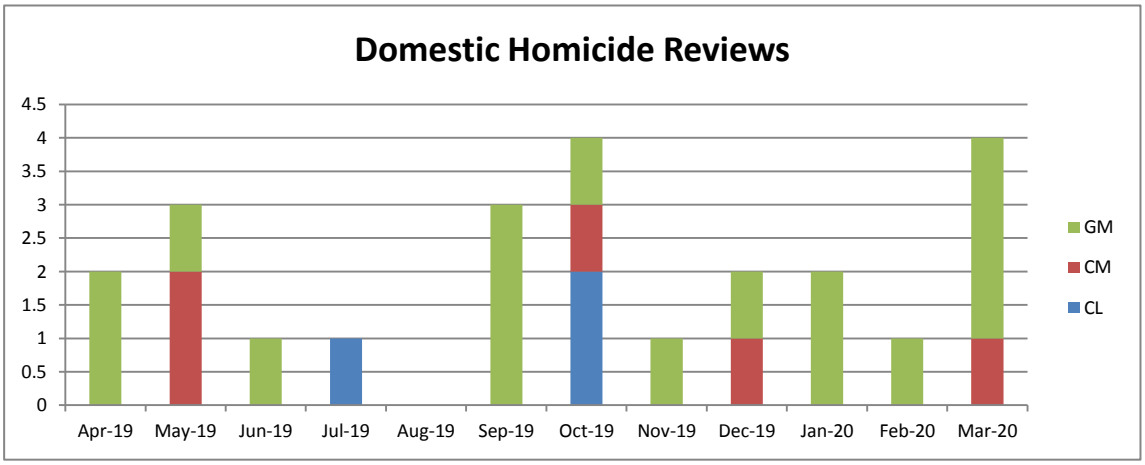


Chart 6- Information in relation to the number of Domestic Homicide Reviews by area for 2019/2020



All SCR, SAR and DHR's are reported to the NWAS Board through the 'reportable events' paper which is presented on a bi monthly basis. Safeguarding activity is also reported at the regional quality business groups and via the Safety Management Group.

2.10 **PREVENT**

During 2019-2020 the Trust has made 16 PREVENT referrals to the regional anti-terrorism teams. Feedback has been received for some of the referrals made and this has been fed back to the Trust staff as appropriate..

WRAP 3 continues to be delivered to all staff at induction and the Safeguarding team provide an annual update to the Learning and Development team for training purposes. The update for this training cycle has been incorporated into a scenario.

2.11 **Project Emerald**

Project Emerald is the title for the safeguarding and digital innovation programme, which has been in the planning and development process during the latter part of 2019. The purpose of Project Emerald is to introduce an alternative process for raising safeguarding concerns. The current system Eriss is an external programme which is costly to the Trust and rigid in its make-up. It was recognised that the current Eriss safeguarding process would not be able to continue to meet the increasing number of safeguarding concerns that are being raised.

The impact of telephone referral is significant, specifically the time taken to answer calls has been particularly problematic. This has impacted on the availability of clinicians to

respond to emergencies. A further issue has emerged which relates to the number of dropped calls that were being recorded. Despite best efforts NWAS have no assurance that the call makers have called back which potentially could leave patients at risk of harm from abuse. This issues was added to the risk register (2709).

The digital platform which will replace Eriss is still being procured. The safeguarding platform has been designed and tested. The safeguarding concern pages have been updated to reflect the current information requirements of Social Care departments. The changes to the safeguarding system will give Trust staff the ability to raise their own safeguarding concerns which will be shared with the relevant Social Care team. Quality will be one of the focuses during the testing phase of the project. The redesign of the safeguarding concern forms will also allow for more accurate data collection and reporting.

There is a dedicated Project Emerald team who have been instrumental in the design and of the process. The project will be tested and analysed prior to full implementation by the end of 2020.

2.12 **Child Protection Information Sharing (CP-IS)**

Child Protection Information Sharing System (CP-IS) has gone live (successfully) this year within the NHS 111 Service and UCD. CP-IS will continue to be rolled out as part of the national programme with NHS Digital and NHS England, and will include the 999 Emergency and Urgent Care Services informing staff of safeguarding concerns.

Safeguarding flags are being added to the Eriss system to enable call takers to highlight concerns to staff at the time of the call. During the year there have been 103 safeguarding flags placed, this is an increase on the previous year when 72 flags were placed.

2.13 **Local Authority Designated Officers (LADO)**

The Safeguarding Manager receives enquiries from the LADO. These enquiries are in relation to members of Trust staff or volunteers. Enquiries are received when the LADO has information in relation to a member of staff which may mean that they pose a potential risk to Trust patients. The Safeguarding Manager liaises with the HR Manager and the Sector Manager in relation to the information, and a risk assessment is completed and actions agreed.

18 allegations against staff were received in 2019/20, which were investigated. Feedback was provided to the LADO. On the rare occasion that a member of staff is dismissed by the Trust, HR Managers may need to complete a disclosure and barring form.

2.14 Allegations against staff may also come into the Trust from other sources and on occasions do not come directly into the safeguarding team. It is the responsibility of the receiving member of Trust management to share this information with the Safeguarding Manager.

Achievements 2019-2020

- 2 new Safeguarding Practitioners have been recruited to cover the Cumbria and Lancashire and the Greater Manchester areas. The practitioners are a welcome addition to the team which had been experiencing significant pressure due to staffing vacancies.

- The Safeguarding Team continue to work with NHS 111 service to ensure high levels of safeguarding assurance can be given to the senior leadership team.

- The Trust were partially inspected by the CQC, and the safeguarding leads were interviewed by a CQC Inspector, in addition to providing evidence. The Trust are awaiting the final report from the inspection.

- Project Emerald has been designed and tested, and the safeguarding concern sheet has been streamlined. There has been a working group in place for the latter half of the year, and a testing timetable has been agreed. Following a rigorous testing process Project Emerald will be rolled out across the Trust.

- Numerous level 3 safeguarding face to face courses have been delivered by the safeguarding team to assure high levels of escalation processes are available.

- The Trust is committed to the safeguarding of adults with learning disabilities and are engaged with the LeDeR programme which makes all deaths involving adults with learning disabilities notifiable. The learning disabilities mortality review aims to make improvements to the lives of people with learning disabilities. The LeDeR programme was set up following a recommendation from the CIPOLD, funded by the Department of Health, to investigate the premature deaths of people with learning disabilities.

2.15

Ambitions 2020-2021

- Management and leadership of the safeguarding activity within NHS 111 services to be streamlined under the corporate safeguarding team remit.

- Increase the size of the safeguarding team to include an additional Practitioner to oversee the safeguarding activity within the Clinical Hub and NHS 111 services.

- Move to a fully electronic safeguarding concern raising system. Project Emerald will continue and allow for this ambition to be achieved.

- Establish a Safeguarding Champions Network across the Trust to provide support to all staff including PES, PTS, 111 and EOC staff.

- Develop a system for sharing information with schools for children who are identified as suffering from an adverse childhood experience. This work is underway and has been presented to the Digital Design Forum. The Safeguarding Manager is working with the IT team to continue to develop this.
- To monitor repeat adult concerns and engage with Adult Social Care agencies to offer a holistic, multi-agency approach.

- Continued engagement in the Serious Case Review process and the development of level 3 training modules using lessons learned from the reviews. When a child or adult review is completed a report is produced by the commissioning Safeguarding Board, included in the report is any learning that has been identified. The Safeguarding Manager will ensure that this learning is applied to the Trust's safeguarding processes where relevant.

- The Safeguarding Manager and the Chief Nurse will engage with all of the regional safeguarding systems lead groups. These groups have been setup to have input from all aspects of health to ensure safe consistent safeguarding approaches are taking place across large geographical areas.

- To develop early help safeguarding contacts with multi-agency partners to allow safeguarding concerns to reach the appropriate Social Care Teams.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

3.1 The Trust has a statutory duty to comply with:

- The Children's Act 1989; 2004
- The Care Act 2014
- The Serious Crimes Act 2015
- Mental Capacity Act 2005
- Mental Health Act 1983; 2007
- Deprivation of Liberty Safeguards: Codes of Practice (2008).
- Health & Social Care Act (2008)
- Care Quality Commission's Registration Standards.
- Modern Slavery Act 2015
- Female Genital Mutilation Act 2003; 2015

4. RECOMMENDATIONS

4.1 The Board of Directors is recommended to;

- Note the assurance provided and approve the report.

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	20 May 2020
Subject:	Health, Safety and Security 2019/20 Annual 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 following activities tor the year ending March 2020: • Achievement against the five health, safety and security goals detailed within the Right Care Strategy. - Goal 1 – Achieved (stretch target not met) - Goal 2 – Achieved (stretch target met) - Goal 3 – Not met (affected by COVID-19 response) - Goal 4 – Not met (affected by COVID-19 response) - Goal 5 – Not met (affected by COVID-19 response) • Through ongoing strong consultation arrangements with staff side safety representatives, there has been revision and approval of a number of Trust health, safety and security, procedures, guidance documents, risk assessments and in depth safety reports examining and mitigating known risks to staff and patients. • The most common reason for RIDDOR reporting remains incidents involving manual handing, slips, trips and falls and physical assaults. • Manual handling and violence and aggression remain active areas of focus, in line with the Trust's Strategy. • All sites have been visited in year for health and safety inspections with actions taken as necessary and all sites have both fire and security assessments in place. • The management of violence and aggression markers to ensure their validity remains in place. • The Health, Safety and Security Team continue to provide advice and guidance in line with the requirements of the Management of Health and Safety at Work Regulations. • The continued support to the Trust's COVID-19 Pandemic response.

Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Note the assurances provided within this Health, Safety and Security Annual report and the work undertaken during 2019/20.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☒
	Right Place	☒	**Every Time**	☒

Link to Board Assurance Framework (Strategic Risks):

SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	None more that already identified
Previously Submitted to:	Quality and Performance Committee
Date:	18 May 2020
Outcome:	Recommended to the Board of Directors for Approval

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1. PURPOSE

1.1 The purpose of this report is to provide the Board of Directors with the key health, safety and security activity during the period 2019-2020 and our ambitions for 2020-2021.

The report will set out how the Trust has, over the last 12 months, been managing the health, safety and security agenda, ensuring compliance with the requirements of relevant health and safety legislation and applicable standards.

2. BACKGROUND

2.1 The Chief Executive Officer holds overall responsibility for the health, safety and security of the organisation. This responsibility is devolved to the Director of Quality, Innovation and Improvement supported by the Finance Director and the Director of Organisational Development.

2.2 There is also an appointed lead Non-Executive Director for health, safety and security which is reflected in Trust Policy.

2.3 Advice and guidance on all health, safety and security matters rests with the Health, Safety and Security team. All staff and managers have a responsibility for the application of the standards agreed in line with the Trust's Health, Safety & Security Policy and Procedures.

3. ANNUAL REPORT

3.1 **Strategy, Procedures and Guidance**

Meeting the goals related to health, safety and security within the Right Care Strategy has been a predominant focus of the work undertaken throughout the year for the team.

For health, safety and security specifically, five pillars of quality have been identified:

- Goal 1 - A year on year reduction in RIDDORs.
- Goal 2 - A reduction in incident reports with confirmed harm from lifting and handling.
- Goal 3 - An agreed % of operational managers with advanced training in Health and Safety management.
- Goal 4 - An agreed % of NWAS sites receiving a biannual rapid review of Health and Safety.
- Goal 5 - An agreed % of vehicles receiving an annual review of Health and Safety.

3.2 **Goal One – A year on year reduction in RIDDORs**

In this reporting year, there were a total of 130 incidents reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

The timely reporting of RIDDORs following notification remains a responsibility of the Health, Safety and Security team.

The Board of Directors receives a bi-monthly update on RIDDORs reported, via the

RIDDOR reporting remains in line with the overall profile for staff reporting incidents. Taking levels of activity into account, NWAS remains one of the lowest reporters of RIDDORs, for ambulance services, nationally.

Table 1 below details the top three reasons for staff reporting injury and the corresponding number of RIDDOR reports associated with that risk. Staff injuries are predominantly reported within the Paramedic Emergency Service, as would be expected.

Injury type April 2019 - March 2020	Staff Injury	RIDDOR reported
Manual Handling	314	51
Slips, Trips or Falls	184	33
Physical Assault	346	14
Total	**844**	**98**

Table 1: Top three reasons for staff injury and RIDDOR reporting

The baseline at the beginning of the year was established as an average of 34 RIDDORs per quarter or 135, throughout the year.

To meet the stretch target of a reduction of 20% in RIDDOR reports, no more than 26 RIDDORs had to be reported, each Quarter.

From the table 2 below, it is evident that this was achieved for Q1 and also for Q4, whereas within Q2 and Q3, the target was not achieved. However when considering the data and comparing the number per quarter from the last financial year, we have seen a reduction in Q1, Q3 and Q4.

Although the goal of reducing RIDDOR reporting year on year has been met the stretch target of reducing this by 20%, has not been met.

RIDDOR reported over quarters 2018-2020			
18/19 Q1	29	19/20 Q1	25
18/19 Q2	28	19/20 Q2	41
18/19 Q3	40	19/20 Q3	39
18/19 Q4	38	19/20 Q4	25
Total	135	Total	130

Table 2: 2018/2019 and 2019/2020 RIDDOR numbers

In order to reduce the overall number of RIDDORs, manual handling remains the focussed area of attention, recognising that staff are sustaining repeated injuries through length of service and the environments they work in.

Chart 1 below details staff injury reporting for the Paramedic Emergency Service from April 2015 to March 2020 with noticeable stepped decreases in the number of staff reporting injuries over the five year period, whereas RIDDOR reporting remains

reasonably static.

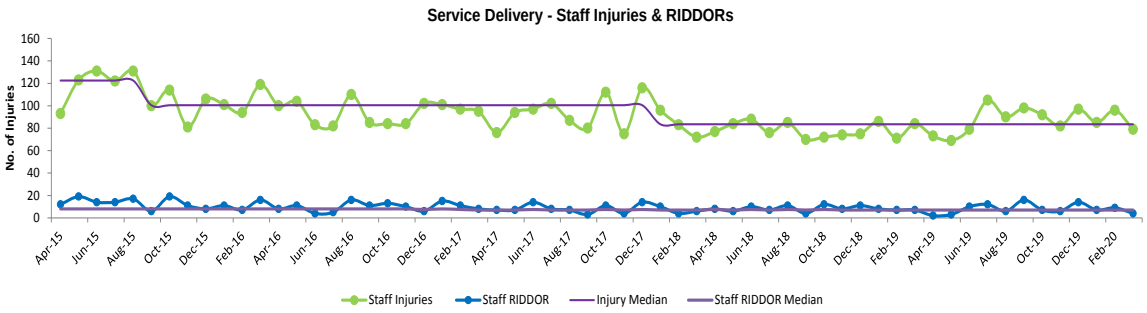

Chart 1: PES staff injuries and associated RIDDORs, April 2015 – March 2020

3.3 Goal 2: Reducing harm from manual handling incidents

The stretch target was to reduce the number of reported injuries from moving and handling by 20% by March 2020. As table 3 below indicates within 2019/2020, there were 352 staff injuries through manual handing tasks reported.

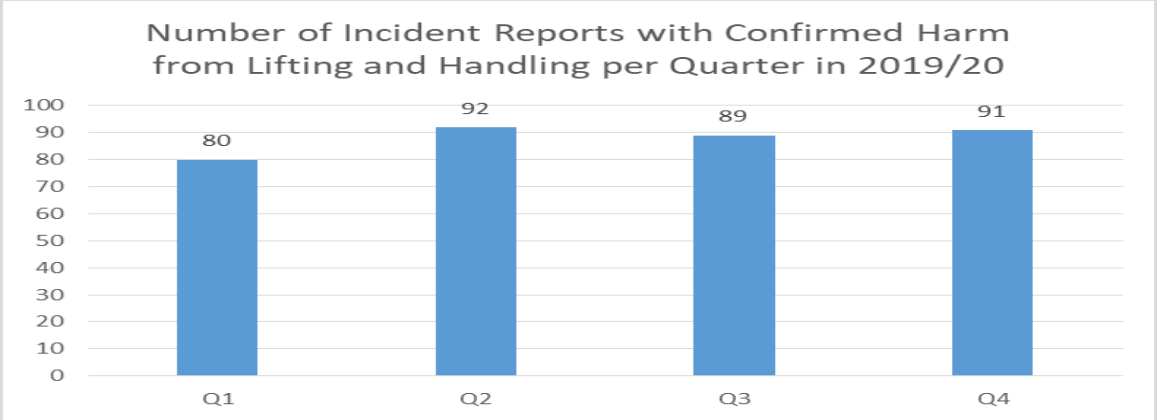

Table 3: Number of incidents per quarter

To meet the 20% reduction stretch target, no more than 90 manual handling injuries had to be reported, each Quarter.

From the table 3 above, it is evident that this was achieved for Q1 and also for Q3, whereas within Q2 and Q3, the target was not achieved. However, when considering the data across the financial year, the stretch target of reducing reported manual handling incidents by 20%, has been met.

The chart below demonstrates the overall reduction in the number of Paramedic Emergency Service reported manual handling injuries over recent years.

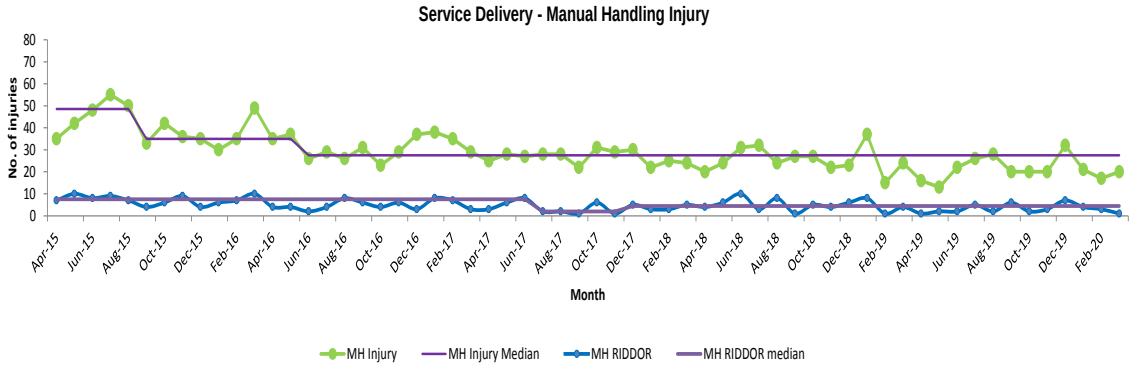

Chart 2: PES manual handling injuries and associated RIDDORs, April 2015 – March 2020

In Q3 2019, the Trust facilitated a symposium at Manchester Metropolitan University (MMU) in order to further support the reduction of moving and handling injuries. This was a well attend event by all ambulance services, along with the Health and Safety Executive (HSE) and Specialists from MMU.

The presentation subject matters were:

- Setting the moving and handling agenda in the ambulance sector- delivered by NWAS and Alan Craddock, HSE
- Behaviour change to promote avoidance of poor manual handling practice- delivered by Dr Joseph Keenan, Lecturer in Psychology. MMU
- Lower back pain at work**-** delivered by Ashley James, Physiotherapist, MMU
- Preventing musculoskeletal disorders- delivered by Steve Forman & Mike Paton, HSE

The rest of the day was divided into workshops:

Workshop 1 - Prevention

- Recruitment
- Induction and ongoing training standards
- Building Resilience

Workshops 2 – Controls to reduce risks

- Risk assessment / decision making support for staff
- Equipment and vehicle design, including provision for bariatric patients

Workshop 3 - Supporting Staff

- Returning to work
- The role of occupational health
- Managing sickness absence

Further work is being undertaken from the findings of the workshops with The National Ambulance Risk and Safety forum (NARSAF) to identify further improvements.

3.4 **Goal 3: Advanced Training in Health and Safety Management.**

The Health and Safety training programme for managers was developed within Q2 and implemented in Q3, building on the existing induction and mandatory training structures.

The training uses the ‘Be Think Do’ model and helps managers to understand their duties under legislation and Trust Policy for, risk assessment and the arrangements in place to ensure staff and patient safety.

The stretch target was for 25% of operational managers to receive the training. Between October 2019 and the end of February 2020, 46 staff received Level Two Training, and 20 staff received Level Three training. In Addition to this, 15 members of the Board received Level Four Training as part of their annual board development programme which took place on the 10 December 2019.

The numbers of staff trained has been less than anticipated. Sessions were planned but unfortunately in some cases the number of attendees was low. This was reported to be due to difficulties releasing staff over the winter period and in addition to this, all sessions planned in March 2020 were cancelled due to the current COVID-19 pandemic and the associated priorities for the Trust's response.

3.5 **Goal 4: Sites receiving a biannual rapid review of H&S (Snap Shot Visits)**

In relation to the goal that 80% of Trust sites would receive a biannual H&S rapid review, 100% of sites received one rapid review, within the first two quarters of 2019/2020.

The second round of premises visits, commenced in September 2019, and have, where possible, continued through Q4. These second visits were undertaken in conjunction with Estates Managers to reflect the findings throughout the primary visits.

In total 72% of premises were visited for the second time within 2019/2020, which is slightly less than the target of 80%. The reason for this was that all the March 2020 scheduled visits had to be cancelled due to the Trust's COVID-19 pandemic response requirements and associated priorities.

3.6 **Goal 5: Vehicles receiving an annual review of H&S**

In respect of the goal that 50% of vehicles receive an annual H&S review, this goal has been wholly supported by light duties staff from Service Delivery, due to the insufficient capacity for the Health Safety and Security team to action this goal alone.

The number completed at the end of March 2020 remains unchanged from the Q3 position at 34%, due to the Trust's COVID-19 pandemic response requirements and associated priorities. Therefore the target of 50% was not met but this process will continue to evolve.

The table 4 below shows the number of vehicles inspected, per area:

Number of Vehicle Cheshire and Mersey	Number of Vehicle Cumbria and Lancashire	Number of Vehicle Greater Manchester
111	125	110

Table 4: Vehicle inspection area breakdown

3.7 **Incident Reporting**

There was an increase (9.5%) in incident reporting across the Trust for the year ending March 2020, with an expected distribution of reporting across our Directorates.

Table 5 below shows the incidents (clinical, non-clinical and road traffic incident reports) reported since 1st April 2016, by Directorate.

	2016/7	2017/8	2018/9	2019/20	Total
Service Delivery Directorate * (PES,	10391	10832	10409	11676	**43308**

EOC, UCS, PTS etc.)					
Finance Directorate (Finance/Fleet/Estates etc.)	980	878	1076	1013	**3947**
Quality Directorate	225	125	76	123	**549**
Medical Directorate	10	58	67	63	**198**
OD Directorate	19	22	32	25	**98**
Corporate Affairs Directorate	2	5	10	12	**29**
Strategy & Planning Directorate	0	3	7	11	**21**
Chief Executives Directorate	9	2	0	0	**11**
Transformation Directorate	0	0	0	2	**2**
Board of Directors (strategic risks only)	0	0	1	0	**1**
Total	**11662**	**11972**	**11707**	**12950**	**48291**

Table 5: Incidents recorded in Datix.

*PTS transferred over to Service delivery 1st Feb and all incidents have been batched updated to that directorate.

The most common types of incidents recorded are staff raising concerns (n=3245), 111 incidents (n=2209) and clinical incidents (n=1790).

Detailed and regular reports are supplied to the Safety Management Group regarding incidents reporting across the Trust, in order to identify areas of risks for mitigation.

3.8 **Health, Safety and Security A-Z Toolkit:**

The Trust's Health, Safety and Security A-Z Toolkit (a suite of 58 documents covering a range of health, safety and security subjects) has continued to be revised and refreshed.

The Toolkit provides procedures and guidance across a variety of topics and represents relevant legislation and/or identified areas of risk to the Trust.

Each document is subject to review and consultation before approval and the following documents have been reviewed and approved in year;

- Safety Representative and Committees Guidance
- Security Procedure
- Bomb Threats Procedure
- Electrical Safety at Work
- First Aid at Work
- Confined Spaces Guidance
- Lone Workers Guidance
- Lifting Equipment and Lifting Operations Guidance
- Risk Assessment Guidance

3.9 **Consultation:**

The Trust has a suite of 18 well established generic risk assessments covering all the main activities across Service Lines. Within the year generic risk assessments have been consulted on and completed for;

- MERIT
- Driving for Work
- Cycle Responders Risk Assessment
- Event Risk Assessment
- Volunteer Car Driver Risk Assessment

- Office Risk Assessment
- PES Risk Assessment
- PTS Risk Assessment
- RRV & Advanced Paramedic Risk Assessment
- Other (task specific for vehicles, equipment, fire etc)

For the year ending March 2020, the revised composition of the Safety Management Group has continued to be the cornerstone of the Trust's consultation arrangements, in line with the requirements of the Safety Committees and Safety Consultation Regulations 1977.

This provides ongoing and effective working relationships with staff side colleagues. The Group is supported by other health & safety sub-groups where specific matters need addressing; e.g. Manual Handling sub-group.
During 2019/20, the Safety Management Group considered three in depth reports in year including;

- Fire Safety Assurance,
- External Compliance, and
- Security and Physical Assaults Reports.

3.10 **Inspections and Compliance:**
In addition to the rapid H&S inspections visits, all sites have both a fire and security risk assessment in place, in line with legislative requirements, which is also the responsibility of the Health, Safety and Security team.

The Trust continues to fulfil its requirements for providing training to all staff on health, safety and security matters through the delivery of the mandatory training programme overseen by the Organisational Development Directorate.

3.11 **Violence and Aggression:**
The Gazetteer team are responsible to applying 'markers' to the Trust's systems and for overseeing which 'markers' require review. Based on the information provided by the Gazetteer team, the Health, Safety and Security team review markers after 12 months to assess whether these 'markers' should remain in place or be removed.

In support of the Trust's management of address markers, the Health, Safety and Security team have also continued to work closely with local managers and the Gazetteer team to ensure that all violence and aggression address markers are accurately applied and reviewed regularly to ensure their validity. This area of activity remains one of the priority goals for the team.

The Safety and Security Practitioners review the information available, liaises with local police services, where necessary, and ensures that the marker is accurately applied. Markers are categorised as per the Violence & Aggression (V&A) Policy as either a cautionary marker or a violence marker. Currently, as of the end of March 2020, there are 1763 V&A markers in place on our system.

The Health and Safety Team have also been an integral part of the Trust pilot for the use

of body worn cameras to reduce the impact of violence and aggression on our staff.

3.12 **Safety Alerts:**

The receipt of and action taken for safety alerts received by the Trust are reported to the Board of Directors via the Integrated Performance Report.

For the year ending March 2020, the Trust received 71 safety alerts of which none were applicable to us an Ambulance Trust. Table 6 below details the Safety Alerts received;

Safety Alerts	Number of Alerts Received (April 19 – March 20)	Number of Alerts Applicable (April 19 – March 20)
Central Alert System/ NHS Improvement	12	0
Medicines and Healthcare Products Regulation Agency – Medical Equipment	39	0
MHRA - Medicine Alerts	20	0

Table 6: Safety Alerts received and applicable April 2018 – March 2019.

3.13 **Response to COVID-19/Coronavirus:**

During February and March 2020, the Health, Safety and Security team have been central to the organisation's response to COVID-19 pandemic, providing advice and support on a range of subjects including PPE, safety equipment, RIDDOR reporting and the face fit testing of masks. This activity continues as we progress through April 2020 and beyond.

4. AIMS FOR THE FUTURE

4.1 The Health, Safety and Security team continue to provide advice and guidance to all managers across a range of topics in order to support the application of robust safety standards across the Trust and the provision of the Management of Health and Safety at Work Regulations.

4.2 The Right Care Strategy will continue to be the platform for improvement until 2022, with the continued goals of reducing RIDDORs and manual handling injuries whilst developing managerial knowledge and increasing inspection regimes and assurance processes.

4.3 In addition to the above, work will also be undertaken to both test and provide assurance on the security, standard and safety of our personnel, property, buildings and information in order to ensure that people, vehicles, property and information is protected as far as is reasonably practicable. This will be driven through and reported to the Safety Management Group work plan and business.

5. LEGAL and/or GOVERNANCE IMPLICATIONS

5.1 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 prosecution. It also exposes the Trust to the risk of civil litigation for negligence.

6. RECOMMENDATIONS

6.1 The Board of Directors is recommended to:

Note the assurances provided within this Health, Safety and Security Annual report 2019/20.

North West Ambulance Service NHS Trust

REPORT

Board of Directors	
Date:	27 May 2020
Subject:	Senior Information Risk Owner (SIRO) Report 2019/20
Presented by:	Maxine Power, Director of Quality, Innovation and Improvement (SIRO)
Purpose of Paper:	For Assurance
Executive Summary:	The Trust has undertaken a programme of work to manage information risk over the past 12 months. The Information Commissioners Office gave the Trust a rating of "reasonable" assurance in the audit and the final report was received in November 2019. MIAA provided an assurance rating of 'Substantial Assurance' from the Data Security and Protection Toolkit (DSPT) audit they completed in December 2019. The Trust has since completed a submission for the Data Security and Protection Toolkit (DSPT). The score for the submission is 115 of 116 mandatory assertions. The assertion the Trust has not met is the training assertion that 95% of staff have to complete data and security awareness training. This score means that the Trust's published status will be "Standards not met" however this represents a significant improvement on the 2018/19 submission. During 2019/20 a total of 172 breaches were reported. Of these, nine were externally reported on the DSPT. Seven of these breaches were reported as a complaint to the Data Protection Officer All externally reported breaches met the criteria for notification to the Information Commissioners Office (ICO). One of these met the criteria for Department of Health and Social Care and NHS England notification. The IG team have completed screening questions for 17 information assets, only one of these assets did not

	require a Data Protection Impact Assessment (DPIA). Three Data Protection Impact Assessments that have been completed and approved for the Intranet/Internet project, Giltbytes Easy Expenses and Microcare Technologies. The Information Governance team have created a simplified DPIA that has been developed for use with urgent data protection/IT developments during the COVID-19 Coronavirus outbreak. A short DPIA has been completed for the Clinical hub home working project and this has been sent to the SIRO and Caldicott Guardian for assurance. There are four short DPIAs currently in progress: JRCLAC plus, GoodSam, Qhealth, Microsoft 365 Teams. The IG team has reviewed and processed 5 information sharing agreements and 19 agreements have been reviewed and processed for the GP connect program. A programme of asset management is underway including asset owner training and ongoing upkeep of the asset register.
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 Office gave the Trust a rating of reasonable assurance from the mini DSPT audit they completed in January 2019 final report was received in November 2019. • Take assurance that MIAA provided an assurance rating of Substantial Assurance from the DSPT audit they completed in December 2019.

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

Link to Board Assurance Framework (Strategic Risks):

SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	

Previously Submitted to:	Executive Leadership Committee
Date:	20 May 2020
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 2019/20 has been progressed through the Trust's Information Management Group and from assertions set out in Data Security & Protection Toolkit. The Trust appointed an interim Data Protection Officer in July 2019 to ensure mandatory compliance with GDPR.

3. LEGAL and/or GOVERNANCE IMPLICATIONS

3.1 The Information Management Group is chaired by the Trust's Senior Information Risk Owner (SIRO).

3.2 The terms of reference and membership were refreshed during 2019/20 following completion of the Management Group Effectiveness Review and Group Self-Assessment facilitated by the Corporate Governance Team.

3.3 The Group provides assurance to the Board of Directors via the Resources Committee.

3.4 For day to day information risk management the SIRO is supported by the Medical Director, as the Caldicott Guardian and the Data Protection Officer.

4. INFORMATION COMMISSIONER'S OFFICE "MINI" AUDIT

4.1 During January 2019 a consensual audit was carried out by the ICO, the final audit report was received in March 2019 with 27 recommendations. Of these the Trust accepted 18 recommendations and the Trust was given a "reasonable" assurance rating.

4.2 The follow up audit was carried out in November 2019 to provide the ICO with a level of assurance that the agreed recommendations were appropriately implemented to mitigate the identified risks. It was recorded that the Trust

responded to these recommendations positively, agreeing to formally document procedures and implement further compliance measures.

To summarise; out of the 27 recommendation 18 were accepted by the Trust and 17 were rated as high priority, of these 9 recommendations have been completed, 4 have not started and 4 are in progress. In these instances, there remains the residual risk of non-compliance with data protection legislation.

4.3 The main improvements include the Data Protection and Security Policy has been updated to include direct links to privacy notices, the Clinical Records Policy and links to several procedures and to where they can be found on the intranet.

The Data Security Training Presentation was reviewed and now includes the rights of individuals including the right to make a subject access request and how staff is able to recognise a request.

A Removable Media Policy has been published and disseminated to staff via the Cyber Information Bulletin on the intranet.

The Trust workbook completion rates has increased within PES and PTS programmes and a process has been implemented to gain assurance that volunteer drivers are completing their induction training as required.

4.4 It was noted that there are still some main risks outstanding such as: a permanent Information Security Manager is still to be recruited (although the job is due to go out to advert shortly and we have a contract with MIAA to fulfil the role) and a training needs analysis is required for volunteer staff and first responders. Since the audit has been completed the privacy notice has been updated to include information about how to patients, end users and staff can submit a request for their information and what identification would be required.

4.5 The ICO audit concluded that; “The Trust has made meaningful progress to complete most of the actions agreed in the original audit.” And the ICO “recognise that meaningful progress is being made to mitigate the risk of non-compliance”.

5. DATA SECURITY PROTECTION TOOLKIT PERFORMANCE

5.1 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.

5.2 NHS Digital expects organisations to achieve “standards met” in the DSPT which is defined as completion of all 116 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.

5.3 Due to the current Pandemic caused by COVID 19, the final submission deadline for the Data Security and Protection Toolkit (DSPT) was moved from 31st March 2020 to 30th September 2020.

5.4 The Trust has completed a submission for the Data Security and Protection Toolkit (DSPT). The score for the submission is 115 of 116 mandatory assertions completed which is an increase from the 72 out of a 100 completed in 2018/19. The assertion which the Trust has not met is the training assertion: 95% of staff have to complete data and security awareness training. The training assertion is challenging for a lot of organisations to achieve. In March, the Trust reported 76% of staff completion of the data security and awareness training. An improvement plan has been submitted with details on how the Trust will improve staff completion of the data security and awareness training. This score means that the Trust's published status will be "Standards not met".

5.5 The DSPT self-assessment score has been partially verified by Mersey Internal Audit Agency (MIAA). MIAA completed an audit of three of the ten standards the Trust is assessed against. These were:

- Training
- Continuity Planning
- Unsupported Systems

The audit also included the progress and completion of recommendations highlighted in the detailed feedback spreadsheet for the 18/19 audit reporting mechanisms for any actions highlighted on the Trust improvement plan as part of its 18/19 submission.

5.6 MIAA confirmed the validity of the Trust's declaration of met/not met for all areas the Trust has received an overall rating of "Substantial Assurance".

6. DATA BREACHES

6.1 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.

6.2 The Trust uses the Datix Incident Report Form to capture data breaches reported by all levels of staff. During 2019/20 a total of 172 breaches were reported. Of these, nine were externally reported on the DSPT. Seven of these breaches were reported as a complaint to the Data Protection Officer All externally reported breaches met the criteria for notification to the Information Commissioners Office (ICO). One of these met the criteria for Department of Health and Social Care and

NHS England notification.

7. COMPLAINTS

7.1 The Data Protection Officer also received five complaints from data subjects and the ICO regarding the Trust process for handling subject access requests. Three of the recorded complaints are closed and two are still ongoing. The breaches reported to the ICO required full root cause analysis investigations by investigating officers of the Trust.

8. DATA PROTECTION IMPACT ASSESSMENTS

8.1 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.

The team have completed screening questions for 17 information assets, only one of these assets did not require a Data Protection Impact Assessment (DPIA).
Three Data Protection Impact Assessments that have been completed and approved are the Intranet/Internet project, Giltbytes Easy Expenses and Microcare Technologies.

DPIAs that are in progress are Adastra, Datix IQ Cloud, EPR, & Bodycams.

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.

8.2 SHORT DPIA during COVID 19

8.3 The Information Governance team have created a simplified DPIA that has been developed for use with urgent data protection/IT developments during the COVID-19 Coronavirus outbreak, so as to not delay the development/deployment of essential services during the pandemic. It has been designed to ensure rudimentary due diligence in line with Data Protection Legislation, to capture and manage any immediate data protection concerns. It does not cover all elements required of a standard DPIA that would be used within a business as usual scenario. If the information processing is to continue after the immediate pandemic has subsided then a full DPIA will have to be completed.

8.4 A short DPIA has been completed for the Clinical hub home working project and this has been sent to the SIRO and Caldicott Guardian for assurance.
There are four short DPIA's currently in progress:

- JRCLAC plus, is for the Trust's staff (predominantly operational staff) to view videos and bulletins through the app and to enable the Trust to

monitor how many staff a reviewing each bulletin/video.

- Good Sam is to be used for video consultation within the 111 setting to enable better triage and reduce the pressure on the emergency services.
- Qhealth is to be used for video consultation within the Clinical Hub to also aid better triage and redirect the patients where necessary.
- Microsoft 365 Teams is part of the rapid roll out within the NHS to aid home working and limit face to face contact during the COVID 19 pandemic.

9. INFORMATION SHARING REQUESTS

9.1 Information sharing requests are processed via the Information Sharing Gateway (ISG), but not all organisations use the ISG due to cost or resource. Therefore, some requests are still processed via paper. The Information Governance Manager reviews all information sharing requests. The Caldicott Guardian will approve signatory of all paper requests.

9.2 A sharing agreement has been signed through the Information Sharing Gateway which relates to a Partnership Agreement between NWAS and the Clinical Commissioning Groups who commission GP services to support direct care across Lancashire and South Cumbria. This agreement has been signed by multiple organisations with the purpose to provide health professionals with access to a patient's clinical documents and primary care records allowing cross boundary transmission at the point of care which aims to provide improved patient care.

NWAS access these records through the Clinical Portal via the Medical Interoperability Gateway (MiG).

A sharing agreement has been approved and signed which relates to an agreement between numerous signatory controllers and Countess of Chester Hospital (NHS) Foundation Trust (COCH). The signatories to this agreement have agreed to contract Countess of Chester Hospital as a processor for the purpose of management of approved sub-processor contracts for the supply of systems and services. The agreement regulates the processing of personal confidential data (PCD) by COCH and its sub-processors on behalf of the signatories.

The Allerdale Local Focus Hub is an agreement between The Chief Constable of Cumbria Police and partner agencies. This is an overarching agreement to enable routine and effective sharing of personal and special category information incorporating measures aimed at facilitating a coordinated approach that targets crime, facilitates the collection and exchange of relevant information and promotes a partnership working. This sharing allows for joint working to resolve community issues and delivers the activity that is requested by the community.

Virgin Care is an overarching agreement to facilitate the exchange of data between two parties North West Ambulance Service and Virgin Care. The purpose of the agreement is to facilitate the sharing of information for the purposes of direct care to support West Lancashire Adult Community Services. This will also be used to support the Short Intensive Support Service (SISS). Personal and special category data will be processed for the purposes of safeguarding children and young adults and to support patient care and onward referrals.

Share2Care is a collaborative programme between Cheshire and Merseyside and the Lancashire & South Cumbria Health and Care Partnerships. The organisations

involved in the Share2Care programme who are in scope of this agreement are NHS providers and local authorities. The purpose of the agreement is to deliver the electronic sharing of health and care records. Through the Share2Care programme, the connect/e-Xchange work stream will both connect and support the integration of our local health and care organisations. The work stream will ensure that information is available to the right people, in the right place, at the right time to deliver service delivery, integration and transformation. The solution is known as e-Xchange. e-Xchange will give providers of health and care access to the information which is necessary, proportionate and relevant to their role.

9.3 GP CONNECT – Approval of information sharing agreements

9.4 GP Connect is one of the services that is part of the wider Digital Interoperability Platform. The GP Connect service allows GP practices and clinical staff to share GP Practice clinical information and data between IT systems, quickly and efficiently via Application Programming Interfaces (APIs). NHS Digital has been directed under Section 254 of the Health and Social Care Act 2012 by the Department of Health and Social Care to establish and operate the GP Connect Service.

9.5 The Information Governance team reviewed and approved 19 information requests for the GP connect project. The approval of the requests enables the 111 call takers to book a patient an appointment at their GP practise.

10. ASSET MANAGEMENT

10.1 The Information Governance team have reviewed and updated the asset register including information assets and have a comprehensive plan for asset owner training and ongoing engagement, upkeep of the asset register and management of assets including ensuring renewed DPIAs.

11. RECOMMENDATIONS

11.1 The Board of Directrors 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 and final report was received in November 2019.
- Take assurance that MIAA provided an assurance rating of Substantial Assurance from the DSPT audit they completed in December 2019.

North West Ambulance Service NHS Trust

REPORT

Board of Directors				
Date:	27 May 2020			
Subject:	Complaints Update and Annual Report			
Presented by:	Director of Quality, Innovation and Improvement			
Purpose of Paper:	For Assurance			
Executive Summary:	From 1 April 2019 until 31 March 2020, the Trust has received an average of 168 complaints per month. Comparison data from the same dates within 2018/2019, has shown that there has been a decrease from an average of 198 complaints per month. In terms of closure of complaints, from 1 April 2019 until 31 March 2020, we have closed an average of 195 complaints per month, which has supported the reduction of a backlog that had previously developed. There are currently 101 complaints open in our system, which is a significant improvement from the number of open complaints in September 2019 which at that time was 199 complaints open in our system. Of the 101 current open complaints, 55 (54%) are past their due date for closure and are in the backlog. There are six areas of potential risk, five have high assurance and one has moderate. The area of moderate assurance is the timeliness of response to complaints though this is an improving picture and is reflected on the risk register (ref 2829).			
Recommendations, decisions or actions sought:	The Board of Directors is recommended to; • Note that the Safety Management Group receive regular reports on the management of complaints which will be reported through the Chair's Assurance report. • Agree to receive assurance reports bi-annually. • Note the work ongoing to reduce the number of open complaints. • Be assured that complaints are being managed. • Note the risk within the system; this is reflected on the risk register and is closely monitored.			
Link to Strategic Goals:	**Right Care**	☒	**Right Time**	☐
	Right Place	☐	**Every Time**	☐

Link to Board Assurance Framework (Strategic Risks):		
SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	**No**
Previously Submitted to:	Quality and Performance Committee
Date:	10 April 2020
Outcome:	Recommended for approval by the Board of Directors

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1. PURPOSE

The purpose of this report is to assure Board members that:

- There are systems in place to ensure the Trust is compliant with the requirements of NHS complaints regulations and the Ombudsman's guidance on complaints handling.
- The risks identified for complaints handling are being addressed.
- The improvement aims within the Right Care Strategy continue to be on track for delivery

This report will cover the reporting period from 1st April 2019 up until the 31st March 2020.

2. BACKGROUND

2.1 Our commitment is that whenever possible, we will provide open and transparent resolution to enquiries within 24 hours. Where it is not possible to provide an immediate response, we commit to conducting a fair and proportionate investigation within agreed timeframes.

2.2 The standards we work to are:

- Each complainant has a named individual to co-ordinate their complaint.
- All complaints are acknowledged within 3 working days, in line with legislative requirements.
- The complaint handler agrees a communication plan with the complainant and discusses their concerns with them in full.
- All findings are communicated to enquirers and they can expect to be informed of any learning that has been identified through the investigation.
- Where learning has been significant, enquirers will be provided with the opportunity to share their story through a multi-media approach for the benefit of organisational learning.

2.3 The Right Care Strategy sets out four pillars of quality and in relation to complaint handling the goals are noted below:

	2018 – 19	**2019 – 20**	**2020 – 21**	**2021 – 22**
Reduce the overall numbers of complaints per 1000 WTE staff	Baseline = 39	10%	20%	30%

	2019 – 20	**2020 – 21**	**2021 – 22**
Increase the percentage of severity 1 – 2 complaints closed within 24 hours	40%	60%	75%
Increase closure within agreed timeframes to 100% for severity 1-3	65%	75%	100%
Increase closure within agreed timeframes to 100% for severity 4-5	40%	75%	100%

3. COMPLAINTS PROFILE

3.1 The overarching goal of the Right Care Strategy in relation to complaints and patient experience has been to reduce the number of complaints received by the Trust by 10% within 2019/2020. Over the last 12 months, the Trust has received an average of 168 complaints per month. In terms of meeting the requirements of the goals within the Right Care Strategy, comparison data from the same dates within 2018/2019, has shown that there has been a decrease from the previous average of 198 complaints per month.

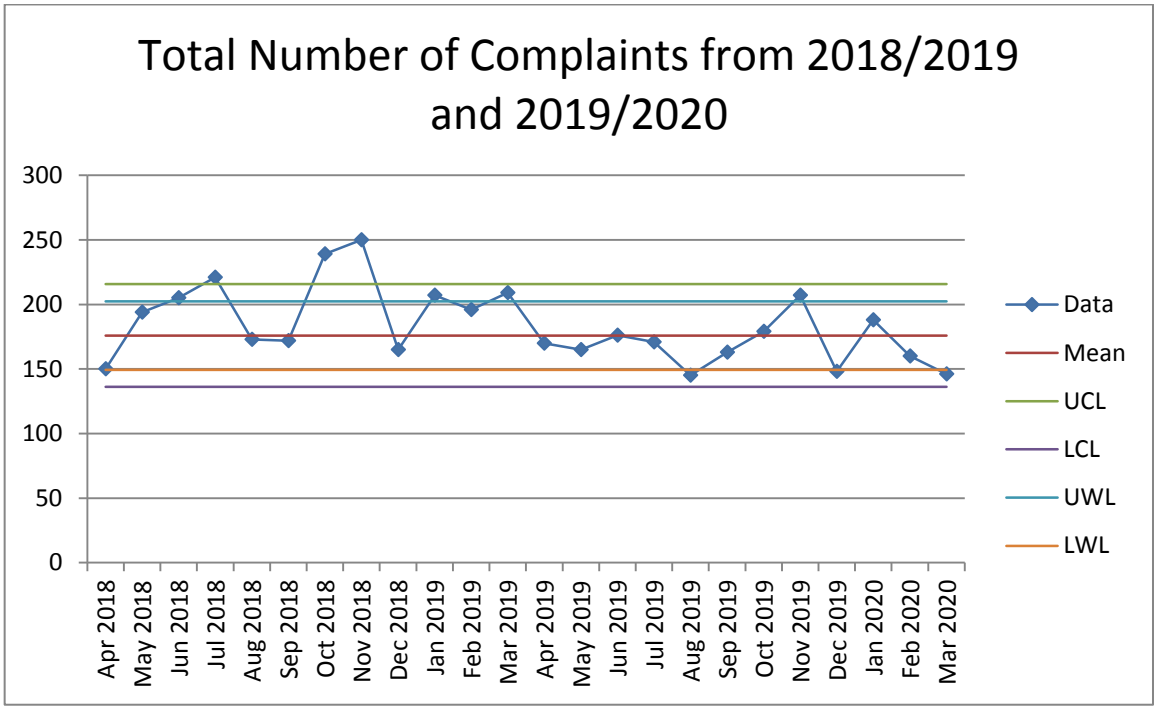

Chart 1: Number of complaints received 1st April 2018 to 31st March 2020

3.2 Level 1 and 2 Complaints 2019/2020:

	Q1	Q2	Q3	Q4	Total
Complaints In	431	388	415	390	**1624**
Complaints Closed	529	512	434	422	**1897**

3.3 Level 3 Complaints 2019/2020:

	Q1	Q2	Q3	Q4	Total
Complaints In	57	58	58	54	**227**
Complaints Closed	76	74	64	60	**274**

3.4 Level 4 and 5 Complaints 2019/2020:

	Q1	Q2	Q3	Q4	Total
Complaints In	23	33	61	45	**162**
Complaints Closed	53	37	35	50	**157**

3.5 Themes

A review has established that the top six most common reasons for complaints throughout 2019/2020 has been:

- PTS journey times
- Care and treatment
- Staff conduct
- Emergency response
- Communication and information
- Driving Standards

The figures in relation to these themes are below:

Theme/Level	Level 1 Minimum	Level 2 Minor	Level 3 Moderate	Level 4 Major	Level 5 Serious	Total
PTS journey times	2	710	9	1	0	**722**
Care and treatment	7	269	92	39	8	**415**
Staff conduct	34	285	18	4	1	**342**
Emergency response	0	64	96	71	23	**254**
Communication and information	35	111	10	1	0	**157**
Driving Standards	40	43	1	0	0	**89**

The PTS journey time complaints account for 36% (722) of overall complaints and the majority of these (98%) were assessed as being minimum or minor in terms of levels of risk. These complaints are both reports of journey delays and/or perceived early arrival at appointments and/or collection.

A further 21% (415) of complaints received are reported to be in relation to care and treatment, and 17% (342) due to staff conduct. Further analysis has concluded that care and treatment complaints frequently have a staff conduct element, and care and treatment category and staff conduct category are frequently interchangeable.

4. Right Care Strategy – Progress against the goals identified

4.1 Within this reporting period, a total of 2,013 complaints were received. Complaints that have been received by telephone or e-mail are automatically provided with a verbal and/or automated acknowledgment at point of contact.

4.2 During 2019/2020, there were only 54 complaints received by letter which only account for 2.23% of all complaints for 19/20, to ascertain if these letters were acknowledged within 3 working days, it would require a physical check into each case, in light of increase pressures due to the coronavirus this has not been possible to undertake, this has been agreed via the strategic command cell.

4.3 Progress against the 2019/2020 goals:

	2019 – 20 Target	**2019/2020 Actual**	**Achieved Yes/No**
Reduce the overall numbers of complaints per 1000 WTE staff Number of complaint received 2018/2019 = 2381 **Baseline per 1000 WTE Staff = 39**	10% reduction Target per 1000 WTE Staff = 35.5	Number of complaints received = 2013 The average for the fiscal year is 30 complaints per 1000 WTE Numbers per 1000 WTE staff for the last 3 months has been: Jan 2020 – 31.5 Feb 2020 - 27 Mar 2020 – 25	Yes
Increase the percentage of severity 1 – 2 complaints closed within 24 hours **2018/2019 baseline was 7%**	40% Improvement	9%	No
Increase closure within agreed timeframes to 100% for severity 1-3	65% Improvement	Jan 172 (74%) Feb 187 (69%) Mar 144 (76%) **Average for Q4 = 73%**	Yes
Increase closure within agreed timeframes to 100% for severity 4-5	40% Improvement	Jan 18 (33%) Feb 23 (43%) Mar 11 (36%) **Average for Q4 = 37%**	No

5. MANAGEMENT OF COMPLAINTS

5.1 In reviewing the management of complaints, there are five areas of high assurance and one area of moderate assurance. The complaints process has been reviewed by MIAA reaching significant assurance and all arising actions from this audit have been closed.

5.2 In terms of high assurance, the Committee can be confident there are multiple ways to access the Trust in order to make a complaint including post, e-mail, telephone and through the website. Telephone contact remains the most common method of contacting the trust with a dedicated telephone number. There are three administrators who are responsible for the answering of the telephone and responding to the caller, and there is also a telephone answering message in place for when the lines are busy or during out of answering hours.

Complaints continue to be acknowledged within agreed timeframes.

Complainants always have an assigned contact from the Patient Safety or 111 teams.

The Committee can be assured of the quality of case assessments early in the complaints process. This ensures that complaints are risk scored appropriately, in line with the agreed standards outlined in the procedure. Any member of the team can increase a complaint risk score however a downgrade must be authorised by a manager supported by appropriate rationale.

The Committee can also be assured about the quality of investigations, it is rare for the review of an initial investigation to reveal anomalies in the investigation process. This is supported by the extremely low numbers of complaints referred to the Ombudsman and for findings to arise from those Ombudsman investigations, all Ombudsman investigations are included within the Reportable Events Paper which is submitted to Board every two months.

Within Q4, a Complaints Review Panel has also been convened with support from a patient representative in order to provide further assurance on our responses to complainants.

5.3 Only moderate assurance can be reported with regards to our timely response to complaints. It is acknowledged that there continues to be a backlog of complaints. However it should be noted that this is be addressed through an agreed trajectory and is continuing to improve.

There are currently 101 complaints open in our system, which is a significant improvement from the number of open complaints in September 2019 which at that time was 199 open complaints. Of the 101 current open complaints, 55 complaint (54%) are past their due date for closure and are in the current backlog. The increased focus on reducing our back log of complaints will continue into 2020/2021, and will possibly be impacted upon by the current response to the coronavirus pandemic; the timely response to complaints is reflected within the risk register (ref 2829).

Charts 2, 3 and 4 below demonstrate the improvement of timely closure of both open complaints and decreasing backlog for each of the risk scores.

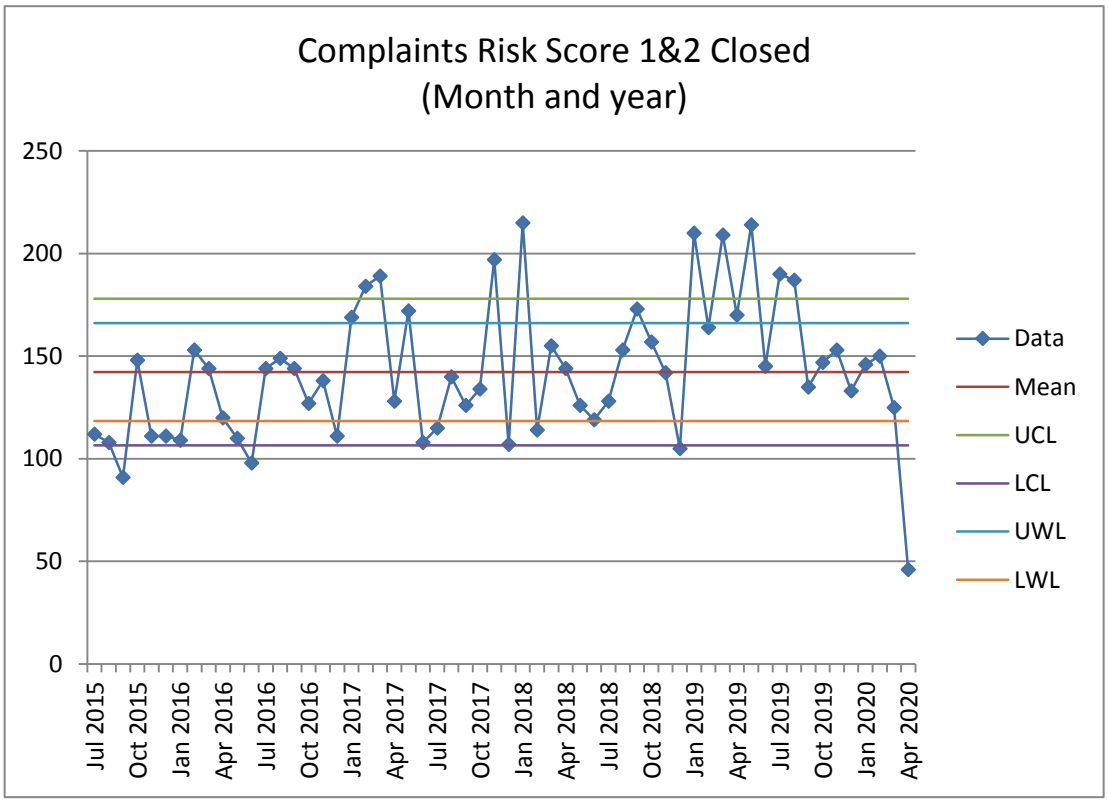

Chart 2: Closed Complaints Risk Score 1&2

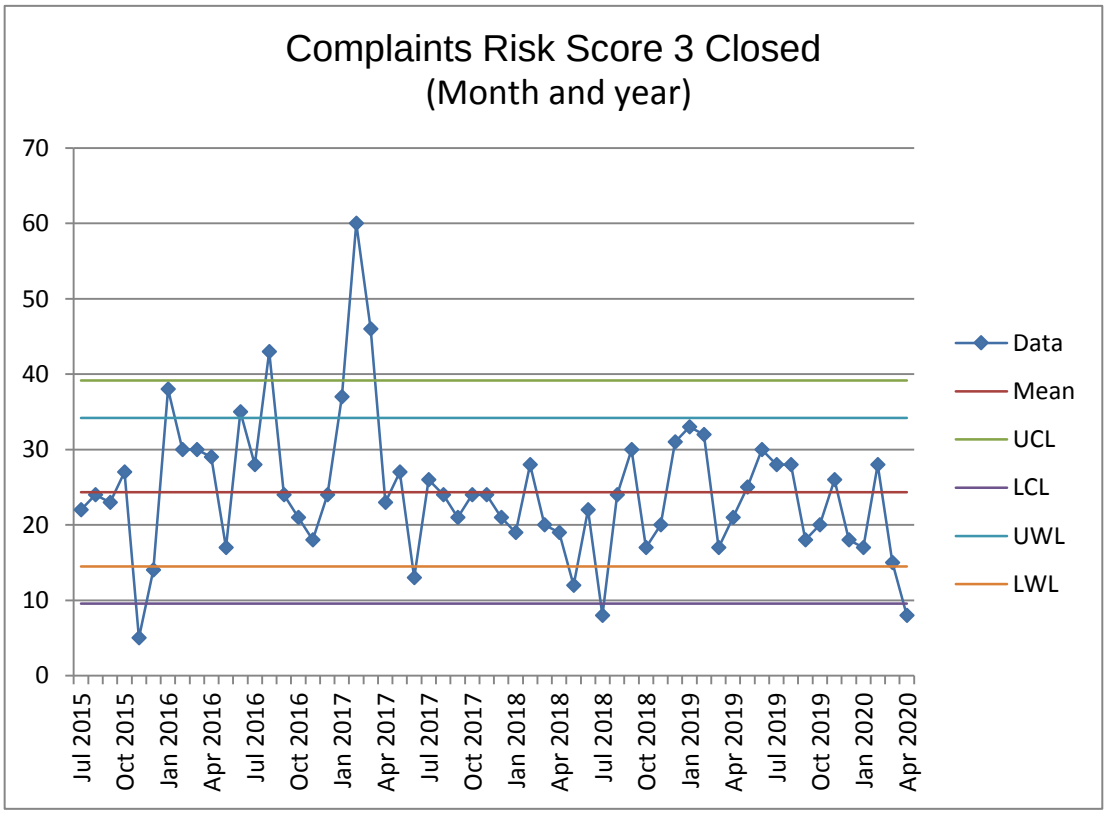

Chart 3: Closed Complaints Risk Score 3

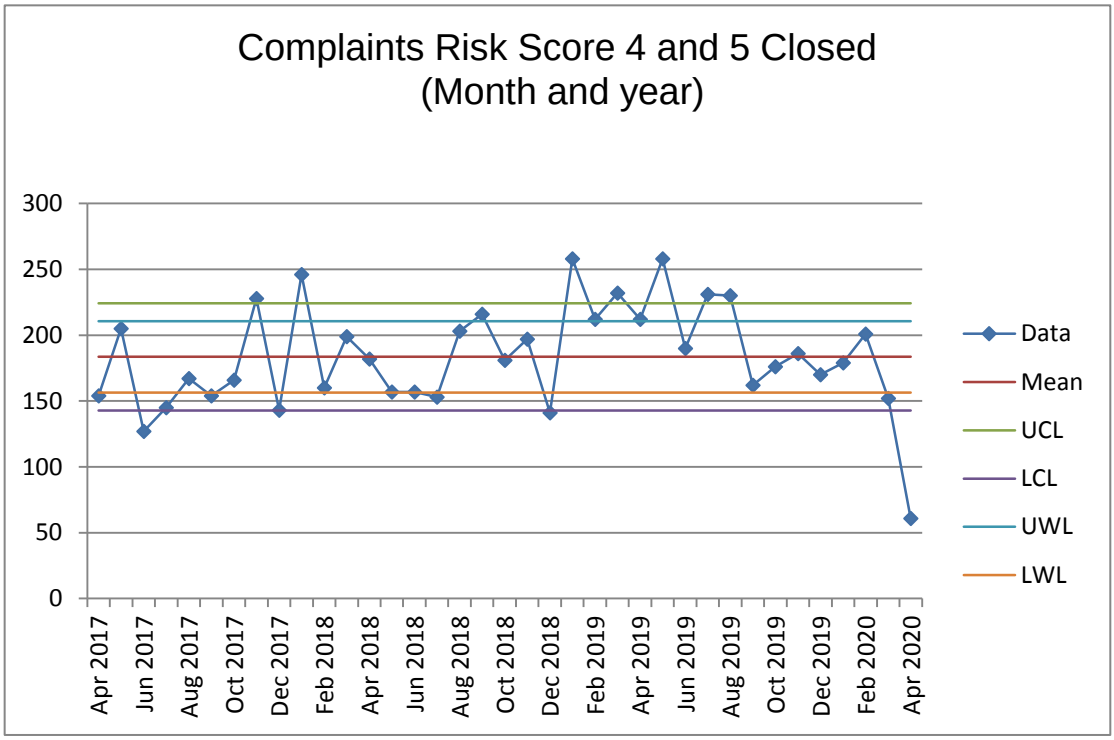

Chart 4: Closed Complaints Risk Score 4&5

All three charts above indicate that there is special cause variation for April 2020, although this will be partly due to the month only being part way through, the most significant rationale for the variation is the current coronavirus pandemic where we are seeing a sharp decline in the number of complaints received. This is being monitored closely, and the team are supporting the organisation in terms of its response to the pandemic in a range of ways. This will be reported in the next report at the end of September 2020 when the impact of the pandemic on complaints will be better understood.

6. SYSTEM IMPROVEMENTS

6.1 The Committee can take assurance that within 2019/2020, system improvements were identified to ensure the sustained improvement in the management of complaints. Having undertaken the capacity and demand review complaint handling processes have been made leaner by:

- Revision of the case assessment/investigation and advice template.
- Reviewing and revising the Patient Safety telephone line options to minimise the handling of general enquiries.
- Awaiting further revision of Datix to enable primary look up of contacts in the initial stages
- Revision of verbal proforma document for primary complainant contact.
- Installation of upgraded IT for administration staff.
- Implementation of an emergency procedure folder at each site, which includes bomb threat procedures and revised procedures if a complainant becomes unwell on the telephone.
- All Patient Safety Managers have received safeguarding level 3 training to ensure

safeguarding advice is accessible to the team when handling complaints.
- Test of change with low risk complaints.
- Revision to recording of cases handled within 24 hours.

6.2 The Committee are asked to note that the commitment from all organisational teams has had a significant impact on the organisation's ability to respond to reduce the backlog and complaints within agreed timeframes.

6.3 All Paramedic Emergency Service Heads of Service have met with the Senior Patient Safety Manager. A presentation facilitated discussion on aspects of complaint handling. Some PES management teams have also benefitted from the presentation and further discussion.

Staff behaviour and conduct is being reviewed as part of observation shifts ensuring staff work in line with values and behaviours; this will hopefully maintain a focus on potential staff conduct concerns.

6.4 In order to support the closure of older PTS complaints, representatives from the PTS management team and the Senior Patient Safety Manager worked as a collaborative for 3 dedicated days. This work was very positive and learning for both teams has been beneficial. Both teams are now considering the possibility of regularly arranging the combined focus which will help moderate the number of PTS complaints open.

Following this, changes are being made to the messaging to patients at the start and end of the phone call bookings in order to help manage patient expectation in terms of the likely wait times for transport; it is hoped that this will reduce some complaints if patients are more aware of these times.

The Senior Patient Safety Manager, Senior Corporate Risk and Assurance Manager and Head of Legal Services met with the PTS management team in September to discuss incident/complaint management and claims. A Patient Safety Manager has also assisted PTS in focussed improvement efforts to enhance service provision and reduce incidents/complaints and claims.

7. COMMITTEE REPORTING

The Committee are asked to note that the Safety Management and Clinical Effectiveness Groups receive regular reports on complaints management through the agreed work plan to ensure compliance with the requirements of NHS complaints legislation and the applicable CQC standards; this is reflected in the Chair's Assurance Report. The Board and Executive Management Team also receive regular updates through the Integrated Performance Report (IPR) on the complaints profile. The Committee can be assured that there is regular and robust reporting across the Trust.

8. LEGAL and/or GOVERNANCE IMPLICATIONS

Investigating and responding to complaints and queries forms a fundamental part of the management of risk within the Trust. This ensures that staff and patient safety is understood and protected. This is in compliance with the Local Authority Social Service and National Health Complaints (England) Regulations 2009 and CQC standard Responsive 4, responding to complaints

9. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note that the Safety Management Group receive regular reports on the management of

complaints which will be reported through the Chair's Assurance report.

- Agree to continue to receive assurance reports bi-annually.
- Note the continued ongoing work to reduce the number of open complaints.
- Note the assurance for parts of the identification and management of complaints.
- Note there are also risks noted within the system; these are reflected on Trust risk registers and are closely monitored.

Chairs Assurance Report

Name of Committee/Group:	**Audit Committee**	**Report to:**	**Board of Directors**
Date of Meeting:	**22nd May 2020**	**Quorate (yes/no):**	**Yes**
Chair:	**David Rawsthorn, Non-Executive Director**	**Executive Lead:**	**Director of Finance / Director of Corporate Affairs**
Members present:	**Michael O'Connor, Senior Independent Director Prof Rod Thomson, Associate Non-Executive Director Dr David Hanley, Non-Executive Director**	**Key Members not present:**	
Board Assurance Risks Aligned to Committee:	**No specific risks aligned to Audit Committee, however, the Committee is charged with a specific role in relation to oversight of the BAF.**		

Key Agenda Items	RAG	Key Points	Action/Decision
Limited Assurance Report – Freedom to Speak Up		• The Director of Corporate Affairs and the Interim Director of Organisational Development attended to provide an update on the actions being implemented to address the 2 high, 1 medium and 2 low risk recommendations. • The Committee noted that some of the recommendations had been addressed and closed down however some had been delayed due to COVID-19 and that progress was expected over the next 3-4 months.	The Committee noted the assurance provided and that progress would be monitored through the Internal Audit follow up reports that come to each meeting of the Audit Committee
Internal Audit Progress Report Q4 2019/20		The Committee received the update report from MIAA with the following highlighted: • Data Security and Protection Toolkit – Significant Assurance • Third Party Remote Access and Management – Substantial Assurance • ESR HR Payroll Interface – Substantial Assurance • Freedom to Speak Up – Limited Assurance • Newly Qualified Paramedics – Moderate Assurance	Noted the assurance provided.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Internal Audit Work Plan		• The Internal Audit Plan 2020/21 was presented to the Committee for approval.	Approved the Internal Audit Plan 2020/21.
Head of Internal Audit Opinion & Annual Report		• The Committee received the 2019/20 Head of Internal Audit Opinion and the overall opinion for the period 1st April 2019 to 31st March 2020 which provided Substantial Assurance, that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. • The report also included the planned internal audit coverage and outputs during 2019/20 and MIAA Quality of Service Indicators.	Noted the assurance provided.
Internal Audit Charter		• The Internal Audit Charter was presented to the Committee. This is mandated through the Public Sector Internal Audit Standards (2016) and is a formal document that defines the internal audit activity's purpose, authority and responsibility.	Approved the charter
Anti-Fraud Annual Report including NHSCFA's Self Reporting Tool submission		• The Committee received the Anti-Fraud Annual Report 2019/20 outlining the wide range of activities aligned to the NHS CFA's Standards for Providers undertaken by the anti-fraud specialist (AFS) during 2019/20. • The report also included the Self Reporting Tool submission against NHS CFA's Standards for Providers which provided the current level of compliance with the standards for 2020/21. An overall rating of GREEN has been applied indicating a high level of compliance.	Noted the assurance provided.
Anti-Fraud Management Action Tracker Report 2019/20		• The AFS presented the Final Management Action Tracker Report 2019/20, which detailed all recommendations made by the AFS as a result of both proactive and reactive activities that have been followed up by the AFS during 2019/20.	Noted the assurance provided.

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Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
		• The Committee noted that during 2019/20, the AFS followed up 60 recommendations relating to improvements in respect of identified weaknesses in controls, processes and/or procedures which have been documented in sixteen management action plans issued to the Trust (2 issued during 2017/18, 6 issued during 2018/19 and 8 issued during 2019/20).	
Anti-Fraud Final Work Plan 2020/21		• The Committee received the Final Anti-Fraud Work Plan for 2020/21 which had been developed taking into account the risk management activities and subsequent discussions with the Director of Finance, Deputy Director of Finance and MIAA's Senior Audit Manager.	The Committee approved the Anti-Fraud Final Work Plan 2020/21.
External Audit Progress Report		• External Audit provided an update regarding their progress of the audit of the financial accounts and annual report 2019/20.	The Committee noted the assurance provided.
Risk Appetite Statement 2020/21		• The Committee received the proposed 2020/21 Risk Appetite Statement following consideration of risk appetite by the Board of Directors at their Development session held in February 2020.	The Committee supported the onward recommendation to the Board of Directors for approval.
Board Assurance Framework Q4 2019/20		• Committee members considered the report within the context of their role as Audit Committee.	Noted the assurance provided.
Quality and Performance Chair's Assurance Reports		• The Committee received assurance reports relating to Clinical Governance from the meetings held on: 20 January 2020, 17 February 2020, 9 March 2020 and 20 April 2020 which included the Local Clinical Audit Plan 2020/21).	Noted the assurance provided within the reports. It was noted that a number of assurances were amber. This will be revisited at the July audit committee meeting when a senior clinical officer will be present
Losses & Compensation		• Losses and Compensations for the 2019/20 financial year totalled £970k year to date.	Noted the assurance provided in the report.

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North West Ambulance Service NHS
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Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Estates revaluation Report		• The Committee received a report detailing the impact of the 2019/20 estates revaluation and subsequent impairments.	Noted the assurance in the report.
Draft Annual Accounts 2019/20		• The unaudited accounts for 2019/20 were presented to the Committee for review.	Reviewed the unaudited accounts 2019/20.
COVID-19 Financial Governance Checklist		• As a follow up to recent guidance and governance checklists produced by professional NHS finance bodies including HFMA and MIAA to support governance arrangements, an assessment against the checklist was undertaken to provide the Committee with assurance of the Trust's financial systems and controls.	Noted the assurance provided within the checklist.
Contract award for Internal Audit and Counter Fraud Services		• The Committee received a report detailing the outcome of the procurement exercise undertaken to appoint Internal Audit and Counter Fraud Services to the Trust. The report was approved via virtual Audit Committee on the 22 April 2020 and was presented for ratification of the decision.	The Committee ratified the decision to appoint Mersey Internal Audit Agency for a period of 12 months,

Legal Services Q4 2019/20 and Annual Review		• 274 new HM Coroner's inquests (s3.1)
		  ○ 11 Contentious/Potentially contentious
		  ○ 263 are non-contentious
		• 1 Regulation 28 PFD Report (s3.10)
		• 22 new claims(s3.11)
		  ○ 9 are Clinical Negligence claims
		  ○ 9 are Employer's Liability claims
		  ○ 4 are Public Liability
		• The Manchester Arena Inquiry has been rescheduled to September 2020 in light of the Covid-19 Pandemic.
		• The Committee noted that there has been a 34% increase in claims, mainly Clinical Negligence and inquests.
			Chair of the Committee agreed to request the Quality & Performance Committee to investigate the following:
			- undertake a deep dive to investigate the theme identified within the Reg 28.
			- Reasons for the 100%+ increase of Clinical Negligence Claims from 2018/19 to 2019/20.

Waiver of Standing Orders Q4 2019/20		• 15 waivers had been received during Q4.	Noted the assurance provided. One waiver was drawn to the attention of

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Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
			committee in accordance with waiver rules.
Draft Annual Report 2019/20		• The Committee received the draft Annual Report 2019/20 and noted it had been prepared against the mandatory requirements set out in the DH Group Accounting Manual 2019/20 and subsequent revised guidance as a result of COVID-19.	Noted the draft Annual Report 2019/20.
COVID-19 Strategic Governance Checklist		• As a result of COVID-19, NHSE/I recommended that each organisation undertook an urgent review of their overall governance structures to ensure that decisions to commit resources in response to COVID-19 are robust. • The Committee received an assessment of the Trust's governance arrangements following MIAA circulating a detailed checklist designed to support NHS organisations in reviewing and assessing their governance arrangements.	Noted the assurance provided within the report.
Audit Committee Annual Report		• The Audit Committee Annual Report 2019/20 was presented by the Chair of the Committee providing information on how the Audit Committee met its Terms of Reference during the 2019/20 financial year. • The report will be presented to the Board of Directors on 17th June 2020.	Noted the assurance provided within the report.
Committee Self-Effectiveness Report		• The Committee were presented with a summary of the MIAA self-assessment and responses received from members and management attendees which highlighted areas for further discussion. • The Committee had intended to discuss the outcomes at a session in March 2020 however was postponed due to the Covid-19 outbreak.	Noted the outcome of the self-assessment. The Committee will meet informally to discuss the results of the effectiveness survey. The resultant action plan will be presented to the next audit committee

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North West Ambulance Service NHS
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Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Annual Review of Committee's Terms of Reference		• The Committee received the revised Terms of Reference following annual review.	The revised Terms of Reference will be presented to the Board of Directors for approval on 17th June 2020.
Declarations of Interest, Gifts & Hospitality Annual Review		• The Committee reviewed the 2019/20 registers for Declarations of Interest and Gifts and Hospitality.	Noted the assurance that there had been no breaches in relation to any declarations raised during 2019/20.
Draft Annual Governance Statement 2019/20		• The Chief Executive joined the meeting to present the draft Annual Governance Statement for incorporation into the Annual Report 2019/20.	Noted the assurance provided within the report.
Annual Review of Core Governance Documents • **Standing Orders and Reservation of Powers to the Board** • **Scheme of Delegation** • **Standing Financial Instructions**		• The Committee received the revised core governance documents for review prior to recommending to the Board of Directors for approval. • Changes to the Standing Orders and Reservation of Powers to the Board and Standing Financial Instructions were identified as tracked changes within the document. • It was noted that The Scheme of Delegation had been transformed to a simpler format for inclusion within the Standing Orders and the Reservations of Power to the Board.	Recommended the core governance documents to the Board of Directors for approval.
Review of meeting effectiveness		• The meeting was considered to have been effective. Several points were noted that would help future remote meetings.	

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North West Ambulance Service NHS
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Chairs Assurance Report

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	20.04.20	**Quorate (yes/no):**	Yes
Chair:	Prof Alison Chambers	**Executive Lead:**	Ged Blezard, Director of Operations Dr Chris Grant, Medical Director Maxine Power, Director of Quality, Innovation and Improvement
Members present:	Mr G Blezard , Director of Operations Prof A Chambers, Non-Executive Director (Chair) Mr M Forrest, Deputy Chief Executive Dr C Grant, Medical Director Mr R Groome, Non-Executive Director Dr D Hanley, Non-Executive Director Prof M Power, Director of Quality, Innovation and Improvement Prof R Thomson, Associate Non-Executive Director (part, via telecom)	**Key Members not present:**	
Board Assurance Risks Aligned to Committee:	**SR11:** If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.		

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North West Ambulance Service NHS
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Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Terms of Reference Annual Review and Committee Self-Assessment		• The committee effectiveness review highlighted that the group has met the majority of its remit and functions. • A number of improvements had been identified to be implemented during 2020/21.	• Annual report and terms of reference to be presented to the Board of Directors for review and approval.
Board Assurance Framework		• The Committee reviewed the 2020/21 COVID-19 strategic risk, as approved by the Board of Directors on 25th March 2020. • Detailed discussion held in relation to PPE.	• Noted and received the moderate assurance from the report.
Regulatory Compliance Changes		• It was noted that the quality, innovation and improvement directorate would provide services on behalf of the Trust, in line with the minimum quality regulatory requirements. • Noted that a restoration plan was being developed and would be reported to a future meeting of the Board of Directors.	• Noted and received assurance from the update. • Requested that an update be presented to the next meeting of this committee to include the implications associated with either modifying or suspending a service.
CQC Update		• The Trust continues to engage with the CQC. • Noted that the Trust was expecting a report back from the CQC following the unannounced PES inspection.	• Noted and received assurance from the update.
Complaints Update		• A report was presented to advise members (i) there were systems in place to ensure that the Trust was compliant with the requirements of NHS complaints regulations and the Ombudsman's guidance on complaints handling, (ii) that the risks identified for complaints handling were being addressed, and (iii) the improvement aims within the Right Care Strategy continued to be on track for delivery.	• Noted and received moderate assurance from the update. • Requested that further reports include information in terms of what action was being taken to address the themes.

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Chairs Assurance Report

		• A numbers of goals within the Right Care Strategy had not been achieved in 2019/20 and as a result a dedicated work programme was being developed.	
ROSE Annual Report		• A report was presented to update members on the work being carried out by ROSE.	• Noted and received moderate assurance from the update. • Requested that future reports include details of the actions being taken to address risks that had been highlighted.
Clinical Decisions		• A report was presented to members to provide information regarding decisions made during the month of March 2020, by the Strategic Clinical Reference Group. • It was noted that some decisions had been made in principle but were currently not enacted.	• Noted and received moderate assurance from the update. • Requested that consideration be given to the clinical decisions being made at the Executive Leadership Committee and if they required to be reported to this Committee.
Ambulance Clinical Quality Indicators		• It was noted that the Trust was compliant with the data submission schedule for ACQIs. • It was noted that there was a risk arising from the decision to no longer collect the National Clinical Quality Audit data for the months that the audit submission to NHSE had been suspended. This would result in the inability to provide the missing data once the submission revision window resumed resulting in a corresponding time gap of published national data from the Trust.	• Noted and received moderate assurance from the update.
NWAS COVID-19 Response Plan		• The committee received the NWAS COVID-19 Response Plan to inform members of the current status of the	• Noted and received assurance from the update.

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Chairs Assurance Report

		Trust's preparedness and response to the current pandemic. • It was noted that a robust command structure was in place.	•
Clinical Effectiveness Management Group Annual Report and Terms of Reference		• The committee noted that the management group had met the majority of its functions. • Attendance of some members was low. It was noted this would be monitored by the Chair. • The committee approved the terms of reference, making a recommendation to the Director of Corporate Affairs to amend the Scheme of Delegation in relation to reporting of complaints to the Safety Management Group. • Noted that dedicated risk reports will be presented to future meetings.	• Noted and received moderate assurance from the update. • Assurance reports to be presented from the group, to this committee.
Safety Management Group Annual Report and Terms of Reference		• The committee noted that the management group had met the majority of its functions, • The committee approved the terms of reference, • Noted that dedicated risk reports will be presented to future meetings.	• Noted and received moderate assurance from the update. • Assurance reports to be presented from the group, to this committee.
Non-Clinical Learning Forum		• The committee noted that the management group had met the majority of its functions and a number of improvements had been identified. • The committee approved the terms of reference,	• Noted and received moderate assurance from the update. • Assurance reports to be presented from the group, to this committee.
Integrated Performance Report		• A report was received by the Committee containing data relating to quality, effectiveness and operational performance. • During March 2020, call pick up performance had deteriorated as a result of the demand. In terms of calls intercepted via the EOC, a reduction was now being	• Noted and received moderate assurance from the update. • Welcomed future updates.

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	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Chairs Assurance Report

		seen. However, with regards to 111 the demand had increased across 24/7. • Performance at time of reporting - four out of seven targets were being achieved and during the previous weekend, six out of seven standards had been achieved	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
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North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Name of Committee/Group:	Quality and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	18.05.20	**Quorate (yes/no):**	Yes
Chair:	Mr R Groome	**Executive Lead:**	Ged Blezard, Director of Operations Dr Chris Grant, Medical Director Maxine Power, Director of Quality, Innovation and Improvement
Members present:	Mr G Blezard , Director of Operations Mr M Forrest, Deputy Chief Executive Dr C Grant, Medical Director Mr R Groome, Non-Executive Director (Chair) Dr D Hanley, Non-Executive Director Prof M Power, Director of Quality, Innovation and Improvement Prof R Thomson, Associate Non-Executive Director (part, via telecom)	**Key Members not present:**	Prof A Chambers
Board Assurance Risks Aligned to Committee:	**SR11:** If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.		

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North West Ambulance Service NHS
NHS Trust

Chairs Assurance Report

Key Agenda Items	RAG	Key Points	Action/Decision
Terms of Reference Review and Committee Annual Report		• The annual report review highlighted that the group has met the majority of its remit and functions. • A number of improvements have been identified to be implemented during 2020/21.	• Annual report and terms of reference to be presented to the Board of Directors for review and approval.
Board Assurance Framework		• The Committee reviewed the 2020/21 COVID-19 strategic risk, as approved by the Board of Directors on 25th March 2020. • Noted that (i) Two new risks have emerged that related to the inability to recover national clinical quality audit data and the absence of a senior compliance manager within the organisation, (ii) zero risks have increased in score, (iii) 2 risks have decreased in score relating to the pandemic 36 and performing AGP procedures due to fit testing, and (iv) one risk has been closed with regards to the potential reduction and/or suspension of call audits in EOC.	• Noted and received the moderate assurance from the report.
Regulatory Compliance Changes		• It was noted that the quality, innovation and improvement directorate would provide services on behalf of the Trust, in line with the minimum quality regulatory requirements. • Noted that a restoration plan is being developed and will be reported to a future meeting of the Board of Directors. • Any associated risks have been included on the risk register. • Noted the Innovation and improvement work has been impacted.	• Noted and received moderate assurance from the update.
Right Care Strategy Quarter 4 Update		• A high level update was presented in relation to the key deliverables of the Right Care Strategy. • A number of goals had not been achieved:	• Noted and received moderate assurance from the update.

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Chairs Assurance Report

		- to increase closure within agreed timeframes to 40% for severity 4-5 - increase the percentage of severity 1-2 complaints closed within 24 hours by 40% - reduce the percentage of medicine pouches with expired drugs remaining in circulation 1 week beyond expiry - Safeguarding training compliance for levels 1,2,3 and 4 is 95% compliant with training needs analysis. • The pilot IPC audits on stations and vehicles that have been reviewed and new compliance standards implemented via operational managers was on track but has been halted due to Covid-19.	• Committee to receive quarterly updates in relation to progress against the strategy. • Revisions to the Strategy to be presented to the Board of Directors for approval.
Hospital Handover		• A presentation was delivered to members in relation to the every minute matters quality improvement initiative. • Noted the current challenges related to re-starting the project due to the current demands.	• Noted and received moderate assurance from the report. • Welcomed future updates.
Health, Safety and Security 2019/20 Annual Report		• A report was presented to advise members of the key health, safety and security activity during the period 2019-20 and the Trusts ambitions for 2020-21. • It was noted that out of the five health, safety and security goals, two goals had been achieved. Three goals had not been achieved and were affected by the COVID-19 response. • From 2020 -21 the Trust's compliance with FFP3 face fit testing for staff in workshops and estates will be included within future health, safety and security reports.	• Noted and received moderate assurance from the update. • The health, safety and security annual report will be presented to the Board of Directors.
Infection, Prevention and Control (IPC) 2019/20 Annual Report		• A report was presented to advise members of the key IPC activity during the period 2019-20 and the Trusts ambitions for 2020-21.	• Noted and received moderate assurance from the update.

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Chairs Assurance Report

		• It was noted that (i) performance targets in relation to vehicle deep cleans had been achieved, (ii) IPC audits, the automated recording function had been paused due to the Covid-19 pandemic, (iii) observation clinical safety practitioner audits were now carried out on a bi-monthly basis, (iv) hand hygiene audits continued throughout the year and overall compliance was high at 89.8%, (v) cannulation policy had now been approved and implemented, and (vi) wipe it out campaign delivered throughout 2019/20.	• The IPC annual report will be presented to the Board of Directors
Face Fit Testing		• A report was received to provide assurance to members that the Trust had a programme of FFP3 Face Fit Testing to ensure regulatory compliance with Health and Safety Executive and Public Health England. • Received an update with regards to processes put in place to manage and monitor IPC activity.	• Noted and received moderate assurance from the update. • Further assurance reports to be presented to this Committee.
Medicines Management Annual Report 2019/20		• It was noted that a report to provide assurance to members that the Trust was managing medicines, including controlled drugs safely and in accordance with legislation, best practice and NWAS protocols. • Members were advised of the processes being put in place to mitigate against the controlled drugs incidents and general medicines incidents.	• Noted and received moderate assurance from the update. • The medicines management annual report will be presented to the Board of Directors
CD5 Medicines Management Quality Indicator		• The committee received an update in relation to the system being considered in order to manage this indicator.	• Noted and received moderate assurance from the update.
Serious Incidents Report		• A report was presented to advise members of the serious incidents activity during the period 2019-20 and the Trusts ambitions for 2020-21.	• Noted and received moderate assurance from the update.

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Chairs Assurance Report

		• It was noted that the Review of Serious Events Group had established a task and finish group to address the backlog.	• The Serious Incidents annual report will be presented to the Board of Directors
Safeguarding Update and 2019/20 Annual Report		• A report was presented to advise members of the safeguarding activity during the period 2019-20 and the Trusts ambitions for 2020-21. • Noted that safeguarding activity had continued to rise across the Trust in 2019/20, highlighting the increased awareness. • Noted the challenges in relation to safeguarding concerns rejections.	• Noted and received moderate assurance from the update. • The Safeguarding annual report will be presented to the Board of Directors
Clinical Audit Progress Report Quarter 4		• The committee received the clinical audit progress report for quarter 4.	• Noted the impact of the suspension of audit data collection and the associated risk. • Noted the suspension of local audits during Q4 where data collection proved to be not possible due to the impact of COVID-19 • Assurance reports presented to the Audit Committee.
Safety Management Group Chairs Assurance Report		• The committee received the chairs assurance report from the Safety Management Group held on 5th May 2020.	• Noted and received moderate assurance from the update. • Assurance reports to be presented from the group, to this committee.
Integrated Performance Report		• A report was received by the Committee containing data relating to quality, effectiveness and operational performance.	• Noted and received moderate assurance from the update. • Welcomed future updates.

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Chairs Assurance Report

		• During April 2020, the Trust continued to experience special cause variation across a number of performance measures, due to the effects and demands that the Covid-19 pandemic was placing on the Trust. • Noted that currently, the majority of standards were being achieved. • The 111 service had experienced a significant increase in demand as a result of Covid-19 and therefore adversely impacted on performance.	• IPR to be presented to the Board of Directors.
PTS Activity and Performance		• A report was received to provide members with the PTS performance position. • Noted that the PTS had been instructed to suspend eligibility criteria and Key Performance Indicators (KPIs) in PTS contracts linked to activity and payment with immediate effect for the period of the level 4 emergency incident. • PTS staff are providing a significant amount of support to PES. • Considerations now required in terms of the eligibility criteria.	• Noted and received moderate assurance from the update. • Welcomed future updates.

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North West Ambulance Service NHS Trust

REPORT

Date:	27 May 2020
Subject:	Workforce and Wellbeing COVID response
Presented by:	Lisa Ward, Interim Director of Organisational Development
Purpose of Paper:	For Assurance
Executive Summary:	The paper provides an overview of the key areas of work undertaken by the Workforce and Wellbeing executive sub-group in response to the COVID-19 outbreak. The main areas of work have been focused on increasing capacity, staff management and welfare, health and wellbeing and trade union engagement. Capacity for frontline resources and command structures has been increased by 607 staff, across PES, EOC and 111. This has primarily been achieved through the deployment of students, upskilling 155 PTS staff, agency recruitment, returners and the redeployment of corporate staff on a temporary basis. Much of this increased capacity is short term but work is progressing to identify how some of the increased capacity can be maintained in the medium to long term. Capacity has also been enhanced through the offer to sell annual leave which has resulted in 20,000 additional hours being available in Q1. Board should note that the Trust has varied from its normal employment checks processes in order to achieve this capacity increase. This has been approved at ELC and is within the temporary national framework for checks released as part of the COVID-19 response. There has also been a short term impact on agency spend which has put the Trust in breach of the ceiling. Work is in place to recover this over the course of the financial year. A risk assessment process and underlying matrix has been developed with occupational health to enable the Trust to risk assess those staff who have been nationally identified as at higher risk as a result of age, pregnancy or underlying conditions. Initial assessments have resulted in 290 staff currently shielding or working from home. This process has recently been adapted to enable the risk assessment of BME staff following the emerging evidence

	of a disproportionate impact of BME communities from the virus. All BME staff have been written to and there is ongoing engagement through the race forum. All staff are being risk assessed and ELC has confirmed specific actions to protect BME staff who have failed fit testing. Home working on either a full time or rotational basis has been implemented across corporate teams and to support clinical staff unable to attend work to undertake clinical triage at home where this is possible. This has worked effectively and recovery will consider ensuring that the benefits of agile working are captured and embedded. New processes have been developed to record and manage self-isolation and COVID-19 related sickness. National agreements have also been reached on temporary terms and conditions payments which have had to be interpreted, agreed and applied locally. There are some concerns regarding some of these national agreements relating to overtime and bank working which are being raised nationally through the HRDs group. Given the circumstances being faced, a clear process has been developed to manage family liaison from the point of staff hospitalisation through to death in service. Action cards have been developed to ensure clarity of responsibilities and there is a clear framework in place for families and colleagues in the event of a death, to ensure that we can provide effective bereavement and mental health support. The process also helps to manage the regulatory requirements for investigation and look back. There has also been a concerted focus on enhancing the health and wellbeing provision, especially around mental health at both a national and local level. Locally we have focused on more bespoke podcasts and resources, targeted at the needs of frontline ambulance staff; developing chaplaincy support; targeted support to those shielding and the development of a financial wellbeing package. Regular messaging occurs to support H&WB, especially through the Wellbeing Wednesday Bulletin and the staff app. There has been regular, at times daily, engagement with trade union colleagues through a partnership cell and this has proved extremely positive in being able to address issues quickly and effectively. The pandemic has resulted in the cessation of a number of business as usual activities and projects which impacts on the delivery of the Workforce Strategy. As we move into the recovery phase we will review the strategy and associated implementation plan. There are a number of workforce risks associated with the pandemic and particular attention is drawn in the paper to several of these.

	In particular, the deployment of students to frontline roles has led to a reduction in study for a 12 week period and careful recovery will need to be put in place in order to ensure that programme completion is not impacted. There will be challenges in reinstating support for placements with the additional risks of having a further individual in a vehicle. Breaks in learning have been put in place for apprenticeships as end point assessments could not be completed and workplace support could not be sustained. NWAS has led on the development of an adapted EPA that should enable recovery for EMT1 apprentices but the pilot schemes in EOC will need review in the context of the short term measures put in place. Mandatory training and appraisal have also been paused. Although we are working to recommence these as soon as possible, there are challenges to recovery arising from social distancing requirements in classroom learning.
Recommendations, decisions or actions sought:	The Board of Directors is recommended to: • Note the work undertaken through the Workforce and Wellbeing sub-group of the COVID response • Consider the risks and impact identified

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

Link to Board Assurance Framework (Strategic Risks):

SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	☒

Are there any Equality Related Impacts:	There are clearly identified risks to some protected groups from the pandemic. This includes pregnancy, race, age and disability related risks from the disease itself which have been managed through the risk assessment detailed in the main paper. The impact of a cessation of childcare arrangements has adversely impacted on gender and those maintaining a beard for religious reasons are impacted in terms of the effectiveness of PPE protection. This is being managed by restricting attendance at AGPs and through prioritisation for hood distribution. Overall the Trust has committed to undertaking an equality impact assessment on the workforce aspects of our response to the crisis to ensure that any other potential detriment is identified and mitigated.
Previously Submitted to:	Various papers and reports provided at ELC
Date:	March to May

Outcome:	Approval

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1. PURPOSE

1.1 The purpose of this paper is to provide assurance on the actions taken by the Workforce and Wellbeing Executive Sub group of the COVID response in line with the strategic response objectives and to advise the Board of risks and mitigations arising from these actions.

2. BACKGROUND

2.1 The Trust established its command structure at the start of the pandemic. This included a number of Executive sub-groups focused on key aspects of the response required. The Workforce and Wellbeing subgroup is led by the Interim Director of Organisational Development.

2.2 The NWAS COVID-19 Response Strategic Intentions document sets out the overriding approach and aims in delivery of the response. This clearly identifies the following specific workforce related intentions:

Maintain effective capacity management within the Paramedic Emergency Service, Emergency Operations Centres, NHS111, Urgent Care Service, Patient Transport Service by:

- *Mapping employee and other resource assets and capabilities to ensure potential sources of staff and logistics support are identified and utilised.*

The Trust will preserve and protect the health, safety and physical and mental wellbeing of the workforce to enable staff to stay healthy and protect themselves, colleagues, patients and families as they continue to deliver the service through this challenging period. In the event of any adverse incident involving an NWAS staff member(s) the trust will respond in a timely manner with empathy and compassion in line with its values.

2.3 The Workforce and Wellbeing sub-group has its own strategic intentions document which is included at Appendix A. In summary however, the sub-group has been focused on four key areas of activity:

- Increasing Capacity
- Staff terms and conditions, management and welfare
- Health and Wellbeing
- Trade Union engagement

2.4 The work of the sub-group has been impacted heavily by agreements reached nationally, especially around terms and conditions, management of high risk groups of staff, deployment of students and management of employment processes. There has also been some relaxation of a number of national expectations, for example on publication of equality measures, standards around appraisal and mandatory training (primarily in the NHSE/I letter of 28th March) but all of these areas will require recovery.

2.5 The following provides a summary of the key areas of work delivered since the commencement of the pandemic.

3. INCREASING CAPACITY

3.1 The main focus of the cell in this area has been the rapid and safe increase in availability of frontline resources to ensure an effective response to increased demand. Much of this has been short term in order to respond to the initial expected peak in demand but there is now a need to focus on sustaining higher levels of resource to manage continuing demand.

3.2 The table in Appendix B shows the increases which have been delivered since the start of the pandemic and equates to 607 additional frontline staff across PES. The second table shows the dates by which this was mobilised.

3.3 In order to deliver this increase, amendments have been made to the normal employment checks procedures. Some of this has been driven by necessity as references in particular have been difficult to source as businesses have closed as a result of lockdown. All checks have been completed within the revised national framework published by NHS employers and have continued to include OH and DBS clearance for all frontline staff. The revised approach has been approved by ELC and is included in Appendix C.

3.4 <u>Paramedic Emergency Service</u>

Increases in PES resources have been achieved through three main routes. Firstly, the trust approached recent retirees and has been able to restart a number of clinical and managerial staff to support the command structures and direct response. We are still working through some of these offers where staff have retired some time ago and need some bespoke training support to return to practice. This has been supplemented by a small number of staff who came via the national returner schemes.

3.5 Secondly, we have upskilled 155 PTS staff and 12 UCS staff to undertake a PES Assistant role. This role has a specific scope of practice, developed by the Medical directorate and agreed with the Trade Unions, which is designed to enable them to work alongside an attending technician or paramedic to provide general assistance with equipment and direct support for certain procedures such as resuscitation.

3.6 Thirdly, we took the decision to cease student placements on 27th March but we have worked with Health Education England and Higher Education Partners to deploy our students to support the COVID response. 194 year 2 students have been trained to undertake a UCS/PES Assistant role and are being deployed for a time limited period. This is initially up until the end of June when we are expected to have to start programme recovery if we are to avoid delays to programme completion.

3.7 In both cases upskilled staff have only been trained to drive vehicles under normal road conditions. Driving capacity and vehicle availability have been a challenge which has been met partly through collaborative work with Merseyside and

Lancashire Police force support, who have released driving instructors to us to support the programmes.

3.8 111

The primary resource increase in 111 has been delivered through the training and deployment of 87 year 1 students into Service Advisor and COVID specific roles and with a small number of corporate staff being redeployed. Again this is time limited but a number of the students have already indicated their willingness to continue to work in a bank or part time capacity once their studies resume and 111 are training these staff in the full Health Advisor programme.

3.9 In light of the discussions regarding contract extension and the indication of the commitment of additional resources, ELC has approved the over recruitment of 111 Health Advisor by an additional 78.59 wte over the current establishment of 193.86 wte positions. Recruitment has been managed through telephone and virtual means and the first courses will commence in June. The success of maximising technology to support recruitment during COVID-19 has led to consideration of whether virtual interviews should be considered as standard during future recruitment to these posts.

3.10 Based on the workforce plan for 2020/21 by December 2020 the Trust will have recruited 100 Health Advisors and after accounting for estimated turnover will be over established by 78.59 wte. The plan is based on front loading recruits in Q1 to Q3 to allow the majority of the years planned resources to be in place and operational by Christmas.

3.11 Unfortunately the national and regional nurse returner schemes have not proved fruitful for 111. Nurses within the 111 environment require an emergency or urgent care background and many of these were directed to acute settings. The nurses offered to 111 were often those requiring home working and did not have the necessary experience to enable safe unsupervised telephone triage. The learning that can be taken from this is that the Trust may wish to consider facilitating an expansion of homeworking for the clinical advisor staff to improve the current vacancy gap. The experience during COVID-19 indicates an interest from the nursing community to work in 111 but to do this on a homeworking basis.

3.12 EOC

Increases in EOC have been met through student deployment, corporate staff redeployment and agency staff. A truncated training courses has been developed which is three weeks in length supported by one week of mentoring. This provides the minimum training to be able to initially take 999 calls and operate MPDS effectively to then hand calls over to fully trained EMDs as required. Overall 139 additional call taking staff have been deployed to date. Against a normal call taking establishment of 272 WTE this represent around a 50% increase.

3.13 The use of agency staff has provided a rapid option for increasing staffing and contractually these individuals can transfer to NWAS contracts with no additional fee after a 12 week period. Their use has however, put the agency ceiling under pressure and this is likely to remain the case for the first three months of the

financial year. Work has been undertaken to review this risk and to ensure recovery can be enabled across the financial year.

3.14 Corporate Review

All corporate teams reviewed their plans and resources at the start of the pandemic in order to identify whether resources could be released to support the effort. Overall over 40 staff (some full time and some part time) have been redirected on a temporary basis to direct frontline duties or to support frontline activities. In other cases staff have been redirected within corporate teams to new activities, for example, the improvement team have been leading the staff testing initiative and OD staff have been redirected to supporting welfare and wellbeing efforts or from work based training to support direct upskilling delivery. These arrangements are being kept under review and as recovery commences, plans to return staff to corporate functions will have to be managed.

3.15 Staff redeployed to NWAS under the North West MOU

Under the North West MOU, the Trust has been offered staff from North West Trusts, predominantly CCGs. A small number of staff have been successfully redeployed into the Trust in areas such as 111, PES administration and the Communications Team.

3.16 Fortunately, due to good resource levels in the Trust there has not been a requirement to seek further support at this stage. However, should the Trusts resources position worsen there is an option to review any further support that the CCGs may be able to offer.

4. STAFF TERMS AND CONDITIONS, MANAGEMENT AND WELFARE

4.1 Protecting staff

Government guidance was issued very early on regarding those individuals likely to be at higher risk in the crisis. This was primarily individuals who were pregnant, aged over 70 and those who were clinically vulnerable, some of the latter were specifically advised to shield for a period of 12 weeks.

4.2 The trust has undertaken risk assessments of all the staff falling into the above groups and also those staff living with family members who are shielding. These have been undertaken in the first instance by managers and the focus has been on finding ways to mitigate the risk but keep people in work where this is possible, although clearly there are some staff who have had to be asked to stay at home. The process has been supported internally through the clinical leadership structure and the Assistant Medical Directors, along with occupational health advice. The process is also underpinned by an occupational health risk matrix supporting mangers to identify the level of risk for certain underlying conditions.

4.3 There are currently 290 staff who are medically suspended as a result of shielding or following risk assessment. 31 of these are staff are working full time at home. We also have a further 49 staff who have been deployed to alternative duties following risk assessment.

4.4 In the last two weeks there has been a focus on the emerging evidence regarding the disproportionate impact of the disease on BME communities. This issue has been discussed in detail at Executive Leadership Committee and an agreed plan put in place to address the risks.

4.5 The Trust has responded by writing to all BME staff, providing assurance around the available support and protection and setting out next steps. This has been supported through a letter from the national BME network and local engagement with the Race Forum has taken place and this will now be regularly held on a virtual basis with Executive attendance.

4.6 The risk assessment process which we have been using to assess staff in other risk categories has been revised in order to support conversations with all our BME staff. This focuses both on the potential impact of co-morbidities and face fit testing on risk but also enables a discussion around psychological impact and wellbeing support. The underpinning risk matrix developed by Occupational Health has also been revised to incorporate information on the impact on underlying risk associated with health conditions and being from BME communities.

4.7 ELC have recognised the potential risk for those BME staff who have not yet been face fit tested or have failed face fit testing and have advised that duties should be adapted in the short term to mitigate this risk by reducing the risk of attendance at incidents requiring AGPs. Staff will also be prioritised for the issue of hoods.

4.8 <u>Home working</u>

Alongside the corporate review, an extensive piece of work was undertaken to enable home working. This was focused on the following key objectives:

- Provide resilience for critical clinical and corporate functions
- Reduce the risk to staff, patients and public by offering alternative working arrangements which enable social distancing
- Enable flexible workforce management due to the constant changing landscape of staffing across each department.

4.9 The work was carried out jointly across IT and the Workforce and Business Continuity cells. The project has enabled high levels of home working in corporate teams, often on a rotational basis to limit risks of cross infection in the workplace. It has also enabled flexibility of working time for those impacted adversely by school and nursery closure. In the main the programme has been very successful with productivity remaining good, although there have been some concerns about some more junior staff in terms of support, team cohesion and isolation. However, from a recovery perspective there is a real opportunity to consider the benefits which have been seen and to develop a more agile approach to working for the future.

4.10 <u>Managing self-isolation and sickness</u>

Revised processes for capturing self-isolation and sickness have had to be designed and implemented, both to enable monitoring of the impact but also in order to ensure that the national guidance around payment and separation from sickness triggers can be managed. HR teams have also taken on a lot of the welfare support required during self-isolation to support managers in keeping in

contact with staff and managing returns. Close work has been undertaken with the staff testing cell to ensure seamless management of staff through this process.

4.11 Terms and conditions

There has been national agreement to variation of existing terms and conditions arrangements across an extensive range of scenarios, some of which are very problematic to implement locally and could cause ongoing risks. Examples include changes to cover payments during sickness and self-isolation which are at full pay and are advised to include average overtime which is contrary to the position being taken in the Flowers case nationally and cannot be paid automatically through the payroll; and payments to bank staff during sickness and self-isolation which is outside of normal contractual arrangements.

4.12 This has involved extensive work to quickly resolve how these payments can be made, to engage with the trade unions over interpretation of the payments and we have also worked nationally as a sector to share best practice and try and ensure some consistency of approach.

4.13 Employee procedures

The Trust has currently ceased the majority of hearings and investigations. This is a result of a national Social Partnership Forum agreement which mandates cessation in the majority of cases until the end of June. At the start of the pandemic hearings could not practically be managed and a cessation made sense to enable focus on the response, however, the position has now stabilised. As a result we are looking to develop an agreed framework to enable some resumption of work in this area and to take the opportunity to consider how we streamline processes. There obviously remain challenges regarding social distancing which would need to be overcome.

4.14 Annual Leave

The trust has run an annual leave buyback scheme for any staff wishing to sell annual leave during Q1, ensuring that statutory requirements for leave can continue to be met. This has provided an additional 20,000 hours back to the Trust.

5 HEALTH AND WELLBEING

5.1 Family Liaison and Death in Service

It was recognised that there was a risk that if NWAS did not develop a joined-up co-ordinated approach to providing staff and family support, it may cause confusion, anxiety or increased distress for staff and families who may be critically unwell or bereaved as a result of COVID-19. It may also become difficult to undertake any investigations or reports, as required, and provide a robust, well-documented log of communication and interventions as part of legal/litigation processes. There was also concern that if hospitalisation of staff was high and/or combined with heavy demand requiring high management input that additional corporate support for normal family liaison may be required.

5.2 As a result a small sub-group working across the Organisational Development and Quality teams, supported by the business continuity cell, worked to develop a clear process for ensuring effective and consistent support in the event of hospitalisation

or death of a staff member. The work was informed by learning from our first death in service.

5.3 There are now clear actions cards in place which set out the responsibilities for the command structure, local managers, HR teams, patient experience teams and communications to ensure that we deliver all the support that we can for families from the point of hospitalisation and also to meet reporting requirements. It is supported by guidance from occupational health on the best way to support colleagues from the point of a death through the following weeks. It also includes clear support options for staff which has included the mobilisation of on station drop in counselling support, particularly at critical points such as following a death, memorial or funeral.

5.4 The process also prompts a review of staff's work in the 14 days prior to symptoms to support the organisation in managing any statutory, regularity or legal requirements such as RIDDOR reporting. It also includes processes for national reporting of deaths within the NHS, including permission to share next of kin details with the Secretary of State.

5.5 Mental Health Support

Although the Trust already had a good structure of mental health support in place through peer support, TRiM support and self-referral to counselling, we have been seeking to enhance this locally and this has been supported by national NHS initiatives. The following outlines some of the additional offer implemented for staff:

- Local Employee Assistance Programme offering general support, telephone based counselling, bereavement support and CBT and financial advice – available 24 hours until the end of June
- National mental health helpline – providing telephone based counselling, bereavement support and CBT and financial advice – available 7-11 and staffed by the Samaritans. This also provides the opportunity for group activities supported by psychological support.
- Bespoke podcast and other resources on mental health and wellbeing, nutrition and exercise – these have been developed by Manchester Stress Institute specifically for NWAS and have been well received since launch
- Chaplaincy access through a network of acute Trusts and continuing work on developing a bespoke network
- Specific cards being developed to thank staff and to focus on support for those shielding
- Ensure up to date access to the range of benefits and offers available to NHS staff both locally and nationally

5.6 Mental Health Awareness week (commencing 18th May) is being marked in a number of ways including the launch of the AACE mental health film, similar to the one released in NWAS before Christmas, national opportunities for staff to get together virtually to discuss the mental health impact of the crisis and a local focus on available support, new podcasts and materials and acts of kindness.

5.7 Financial Wellbeing

Approval has also been given by ELC to progress a financial wellbeing offer through Neyber. This will sit within the context of existing sources of financial advice, access to credit unions and other sources of financial support. It will offer a financial education platform including training and resources but they also offer a loan and loan consolidation service as an alternative to payday loans. They have worked extensively across the NHS. Work in this area has always formed part of the Workforce Strategy but has been expedited recognising the additional financial challenges being faced by families in the current crisis.

4.8 There is a dedicated area of the Green Room where the Health and Wellbeing offer is consolidated and this is supported by Wellbeing Wednesday and Feel-good Friday communications.

6 TRADE UNION ENGAGEMENT

6.1 The Trust has continued to work closely in partnership with our trade unions during this period. A specific Trade Union Partnership cell has been established with daily updates currently in place and a weekly formal meeting. This has enabled us to discuss and agree rapid change such as the PTS upskilling and to work through issues of concern very quickly. This arrangement has been very constructive and positive with all parties focused on the need to move quickly to ensure our patients and staff are protected during this difficult time.

7. IMPACT AND RECOVERY

7.1 The pandemic has had a significant impact on normal working and the strategic plans across the directorate.

7.3 Work has commenced on recovery plans and fundamental to this will be a review of the Workforce Strategy and the supporting implementation plan. Key projects and deliverables planned for 2020/21 such as the Zeal outstanding culture work, the review of the partnership arrangements, staff survey engagement, rotational working and just culture work have all been delayed as a result of the pandemic. This work will be reported through future meetings of the Resources Committee.

7.4 The Workforce cell has identified its risks and these are incorporated into the overall COVID risk register which has been presented to Board. There has been particular impact on training and development activity which has created some of our higher scoring risks and also some significant challenges in recovery. Board is asked to note the following in particular:

7.5 Paramedic programmes

The Trust decided that it could no longer offer student placements as a result of the demands associated with the crisis and the changes made to the skill mix. As a result a cessation in Paramedic programmes of 12 weeks was agreed with HEIs. During this period students have 20% study time to continue programme activities, however, a cessation of activity of this length does place overall programme length at risk, particularly for internal progression students on a one year programme. At present, working with HEI partners we believe that the programmes are recoverable

but the changing nature of the pandemic means that placement activity may be more difficult to resume and operational resource will be impacted by a higher requirement for theory recovery for internal progression students.

7.6 The issue of student deployment has also produced some national challenges for the sector. Ambulance services were quick off the mark to move from placement to deployment but this placed us slightly in conflict with subsequent national guidance. Locally we have managed this through engagement with HEIs and HEE and nationally we have been engaged with HEE and AHP leads on behalf of the sector to resolve these issues. The national guidance does, however, continue to pose challenges around the resumption of placements on a paid basis.

7.7 The pandemic has also delayed the development of the Paramedic apprenticeship with our chosen partner, the University of Cumbria, as the pandemic has delayed HCPC verification visits to confirm the programme and some other aspects of the work. We will be working on recovery of this programme as soon as possible but a delay to the first autumn cohort is likely.

7.8 Apprenticeships

A break in learning has been applied to all apprenticeships in the trust and financial arrangements agreed to ensure that no detriment is suffered as a result of this decision. This was partly as a result of the difficulties in continuing to support apprentices in the workplace and also because of the cancellation of end point assessments. NWAS has led the work nationally to develop an adapted and virtual approach to end point assessment which should enable us to start to recover this position. We are confident that planned levy income will be recovered in year.

7.9 The Trust had commenced piloting of the call handler apprenticeship within EOC and this has been impacted by the need to quickly upskill a range of new starters and creates challenges in running two different pathways. From a strategic perspective apprenticeships provide the right medium term solution to meet the challenges of integrated working across 111 and 999 and to address retention issues but recovery will need to consider the short term options for maintaining current cohorts.

7.10 Mandatory training and appraisal

Both mandatory training and appraisal were paused as a result of the pandemic and the impact of this can be seen in the IPR. Consideration is now being given to recovery of both of these with PTS mandatory training recommencing from 11th May 2020 and discussions in place with EOC and PES. However, classroom training will need to consider social distancing which may limit class sizes and release may not immediately return to planned levels so consideration is being given to how recovery is best managed for 2020.

8. LEGAL and/or GOVERNANCE IMPLICATIONS

8.1 Where decisions have been made in the workforce cell which may have implications for legal or statutory compliance then legal advice has been taken.

Decisions to cease mandatory training, appraisals, changes to employment checks and revalidation could have regulatory implications for CQC compliance but these are all covered by national advice.

9. RECOMMENDATIONS

9.1 The Board of Directors is recommended to:

- Note the work undertaken through the Workforce and Wellbeing sub-group of the COVID response
- Consider the risks and impact identified

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North West Ambulance Service NHS Trust

NWAS COVID-19 Response

WORKFORCE / WELLBEING SUBGROUP

STRATEGIC INTENTIONS

The workforce and wellbeing subgroup will work within the overall strategic aims of the NWAS COVID-19 response with the aim of responding to and managing the impact of the COVID-19 Coronavirus in a way that protects and saves lives, reduces humanitarian suffering and is compatible with the vision and values of the NHS.

The intent of this subgroup will be:

1. To maintain and maximise the response capability of the organisation through
   - Increasing available resource
   - Supporting staff to remain in work and stay well
   - Improving flexibilities

2. To support the wellness and wellbeing of staff, including co-ordinating OH response.

3. To ensure fairness in the application of terms and conditions.

4. To implement national guidance regarding healthcare workers and the general public in a way which balances the needs of individuals and the organisation.

5. To maintain business continuity of the People team to ensure continuing support for the organisation and maintenance of business critical activity.

6. To provide continuing advice to the other sub-groups and wider command structure on workforce matters.

7. To ensure continuing engagement with Trade Union partners.

8. To identify long term impact and risks from workforce related decisions, along with mitigations and recovery.

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COVID Staffing by Sector and Start date

Paramedic Students Year 1

	Greater Manchester		Cheshire and Merseys	Cumbria and Lancashii	Grand Total
Row Labels	Middlebrook	Parkway	Estuary Point	Broughton	
111					
111 Covid-19 Service Advisor (Bank)					
06/04/2020	18				18
08/04/2020	18				18
15/04/2020	9				9
18/04/2020			36		36
111 Service Advisor (Bank)					
06/04/2020	6				6
EOC					
EMD (Bank)					
06/04/2020			9	7	16
15/04/2020				13	13
27/04/2020		11	10		21
Grand Total	**51**	**11**	**55**	**20**	**137**

Paramedic Students Year 2

	Greater Manchester					Cheshire and Merseyside			Cumbria and Lancashire							Grand Total
Row Labels	CAM East	GM Central	GM East	GM South	GM West	CAM East	CAM North	CAM South	CAM West	East Lancashire	Fylde	Fylde	Morecambe Bay	North Cumbria	South Lancashire	
PES	1	14	17	13	18	8	32	8	21	16	3	4	12	10	17	194
Urgent Care Assistant (Bank)	1	14	17	13	18	8	32	8	21	16	3	4	12	10	17	194
17/04/2020		2			1	3	9	2	1	1					2	21
18/04/2020		2	5	4	4											15
19/04/2020							1	1		6	1		3	3	3	18
20/04/2020						2	3	3	7							15
21/04/2020		3	4	4	2				1	1				4		19
22/04/2020										3	2		2		4	11
23/04/2020		1	1			2	5	2	2						1	14
24/04/2020		3	3	3	4											13
25/04/2020					1					3		1	2	1	3	11
26/04/2020							7		6							13
27/04/2020		2	2	1	2					1			2	1		11
28/04/2020										1		2	2	1	1	7
29/04/2020						1	5		4			1	1		2	14
30/04/2020	1	1	2	1	4											9
01/05/2020							2								1	3
Grand Total	**1**	**14**	**17**	**13**	**18**	**8**	**32**	**8**	**21**	**16**	**3**	**4**	**12**	**10**	**17**	**194**

Ex-NWAS Staff

Ex NWAS Staff			Area			
Department	Position	Start date	C&L	C&M	GM	Grand Total
Clinical HUB	Clinical HUB Performance Manage	30/03/2020		1		1
EOC	Dispatcher	11/04/2020	1			1
	EMD	03/04/2020			1	1
		06/04/2020	1	2	1	4
		15/04/2020	1			1
		(blank)	1	2	1	4
PES	EMT	(blank)		1		1
	EMT1	(blank)	1	1	1	3
	Paramedic	(blank)	2	6	2	10
	Senior Paramedic	(blank)	1			1
	Covid 19 Manager	30/03/2020		1	1	2
	COVID-19 PPE Manager	24/03/2020			1	1
	Operations Manager	(blank)	1			1
	Rostering	27/04/2020			1	1
	Senior Support Office COVID-19	06/04/2020		1		1
UCS	Specialist Practitioner	(blank)		1		1
Grand Total			**9**	**16**	**9**	**34**

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COVID Temporary Staffing Trajectories

Recruitment Sources	PES	EOC	UCD	111	Total
Paramedic Students Year 1		50		87	137
Paramedic Students Year 2	194				194
Ex Nwas	21	11	2		34
Agency		78			78
Externals				1	1
NHS England Nurses			3		3
HEE Paramedics	5				5
PTS to PES Upskilling	155				155
Total	375	139	5	88	607

COVID Staffing by Area

Paramedic Students Year 1

Position Title	Cheshire and Merseyside	Cumbria and Lancashire	Greater Manchester	Grand Total
111	36		51	87
111 Covid-19 Service Advisor (Bank)	36		45	81
111 Service Advisor (Bank)			6	6
EOC	19	20	11	50
EMD (Bank)	19	20	11	50
Grand Total	**55**	**20**	**62**	**137**

Paramedic Students Year 2

Position Title	Cheshire and Merseyside	Cumbria and Lancashire	Greater Manchester	Grand Total
PES	69	62	63	194
Urgent Care Assistant (Bank)	69	62	63	194
Grand Total	**69**	**62**	**63**	**194**

Ex-NWAS Staff

Ex NWAS Staff Position Title	Area C&L	C&M	GM	Grand Total
Clinical HUB		1		1
Clinical HUB Performance Manager		1		1
EOC	4	4	3	11
Dispatcher	1			1
EMD	3	4	3	10
PES	5	10	6	21
EMT		1		1
EMT1	1	1	1	3
Paramedic	2	6	2	10
Senior Paramedic	1			1
Covid 19 Manager		1	1	2
COVID-19 PPE Manager			1	1
Operations Manager	1			1
Rostering			1	1
Senior Support Office COVID-19		1		1
UCS		1		1
Specialist Practitioner		1		1
Grand Total	**9**	**16**	**9**	**34**

Agency

Position Title	Estuary Point Cheshire and Merseyside	Broughton Cumbria and Lancashire	Parkway Greater Manchester	Grand Total
EOC				
Emergency Medical Dispatcher	26	21	31	78
Grand Total	**26**	**21**	**31**	**78**

Externals

Position Title	Parkway	Grand Total
Clincial HUB	1	1
Specailist Practitioner	1	1
Grand Total	**1**	**1**

NHS England Nurses

Position Title	(blank)	Grand Total
UCD-Clinical HUB	3	3
Specialist Practitioner	3	3
Grand Total	**3**	**3**

HEE Paramedics

Position Title	GM	LANCS	Grand Total
PES	4	1	5
Paramedic	4	1	5
Grand Total	**4**	**1**	**5**

PTS to PES Upskilling

Position Title	Cumbria and Lancashire	Cheshire and Merseyside	Greater Manchester	Grand Total
PES	76	25	54	155
Urgent Care Assistant	76	25	54	155
Grand Total	**76**	**25**	**54**	**155**

EMPLOYMENT MODEL AND PRE-EMPLOYMENT CHECKS FOR SOURCES OF SUPPORT FOR COVID-19

Notes:

ID checks - normally ID checks are completed with original documentation having to be sighted before offer. Given restrictions on essential travel, photographs of documents will be accepted and ID then checked on first day to provide verification

Occupational Health – all OH to be undertaken by paper screen and follow up telephone discussion if necessary. Vaccinations will not be provided. Ex-staff will have records from previous employment and all students will have had appropriate OH and vaccinations prior to placement.

Sources of support	Area of work	Contract	Pre-employment checks	Training requirement
Ex-NWAS staff	PES / 111 / EOC	Bank	OH – paper/telephone assessment DBS Right to work Registration (where required) Driving license (where required) To start at risk if left within last 6 months (this is similar to current bank process). If more than 6 months – commence refresher training at risk whilst DBS/OH completed Reference check not required – check undertaken with ex-local manager	No additional requirement if left within the last 6 months Training to do a TNA if left NWAS over 6 months
Other NHS staff (not redeployed but have independently come to the Trust)	PES / 111 / EOC	Bank	OH DBS Right to work Registration	Training to be identified

			Driving license (where necessary) References aim to seek at least one reference from the individual's current or previous employer, either via email or over the phone. To start at risk where training allows sufficient times for OH/DBS completion.	
Staff on loan / redeployed from other NHS Trusts during COVID-19	111 / EOC / admin roles	Honorary contract as will remain on their NHS employer's payroll	Confirmation of checks from existing employer. DBS where not undertaken in current role To start at risk where training allows sufficient times for DBS completion.	Training to be identified
Students from uni	111 / EOC / PES	Bank	Confirmation of checks to be sought from university	Training to be identified
COVID 19 Returners – national call for retired clinicians	111 / PES	Bank	As per the national process – will be confirmed by Placement officers at NW LA	Training to be identified

North West Ambulance Service NHS Trust

REPORT

Date:	27 May 2020
Subject:	Communications and Engagement Dashboard Report – Q4 2019-20
Presented by:	Salman Desai, Director of Strategy and Planning
Purpose of Paper:	For Discussion
Executive Summary:	The Communications and Engagement Team provides a dashboard report for the Board of Directors with a quarterly summary of key outputs and associated highlights. For quarter 4 (Q4 – January to March 2020), statistical content and themes are provided on: **Patient and public engagement** A summary of our patient and public engagement activity for Q4, including the number of public engagement events attended, the number of patient surveys sent out and the findings from them. For example, this quarter: • 5 public engagement events held • 2 community events were arranged but postponed due to COVID-19 • 11,275 patient surveys sent out and 2,871 returned, around 14% fewer than last quarter • 94% were likely to recommend the service to friends and family • 94% agreed they were cared for appropriately with dignity, compassion and respect **Patient and public panel (PPP)** A summary of the Q4 activity for the PPP, including up-to-date figures for panel recruitment and information about events the PPP has been involved in over the last few months. For example, this quarter: • 18 new panel members confirmed and inducted to the trust in Q4 • 72 panel members in total • 32 new expressions of interest in Q4 • 125 panel 'voices' to call on for a piece of work • 25 requests for panel involvement by end of Q4 **Press and public (patient) relations** A summary of our media relations activity for Q4. This includes the number of incident check calls and some

	highlights of the positive, pro-active media relations work that has been undertaken this quarter. There has been a small decrease (-13%) in media coverage in Q4 but this follows a huge 136% increase in Q3. In Q4: • 185 incident check calls • 75 proactive media stories, an increase on last quarter • 20 statements prepared in response to press enquiries • 288 pieces of media coverage, down 13% from last quarter • Highlights included a press release about positive staff survey results • At the start of the quarter and the start of the COVID-19 response, all coronavirus related media queries were passed to the Department of Health and Social Care **FOI performance** An update on the FOI performance against the target of 95% completion within 20 days, plus mention of any FOIs requested by the media. In Q4, we hit 96% against the target and media requests included information about hospital handovers, call outs to certain addresses and PTS enquiries. **Stakeholder communications** A summary of stakeholder activity for Q4, including the number of MP letters written and bulletins issued, along with any other activity. For example, this quarter: • 2 stakeholder bulletins • 2 'Winter Watch' bulletins issued • 6 MP letters or briefings **Social media: Facebook, Twitter and Instagram** A summary of our social media statistics for this quarter. Overall, Q4 saw a decrease in reach and engagement across all our social media channels which could be caused by a levelling out of figures after a large spike in Q3, plus a slight shift in the type of social media activity and content as we headed into the COVID-19 pandemic. **Website** A summary of statistics for the new website, including page views and visitor numbers. The number of views to the news page has decreased this quarter following a huge increase in Q3. Page views have increased slightly while visitors has decreased but not significantly. We expect these figures to fluctuate quarter-to-quarter but would act to understand any significant or consistent changes. **External (public/patient facing) campaigns** Brief information about key campaigns that ran in Q4, including: • Happily ever after • Fairy tale

	Internal projects and campaigns Highlights and figures about the main internal communication projects and campaigns from Q4, including the rota review, flu vaccination, NHS 111, urgent and emergency care transformation, Equality Delivery System, CQC (Operation Outstanding) and the learning forum. **Internal bulletins and the Staff App** Figures showing how many internal communication bulletins have been issued and up-to-date statistics on the staff app. For example, in Q4: • 33 Clinical bulletins • 21 staff communication bulletins • 1 Exec Director blog • 614 more staff app downloads **Films produced in-house** A summary of in-house videography activity. Q3 saw a 114% increase in the number of films produced in house, and for this quarter (Q4) we again produced almost as many films, including some for staff on the flu vaccination and COVID-19. **Team news** Information about three award wins or shortlists this quarter for the Communications Team and two new appointments. **Miscellaneous** Additional activities completed by the team during Q4, including involvement in the GP Out of Hours tender process, communications plan development for the Manchester Arena enquiry and nominations for colleagues for various schemes including the Queen's Ambulance Medal. **Focus on…** An overview of how the Communications and Engagement Team has responded to the COVID-19 pandemic during Q4, from an internal and external communications perspective, as well as patient and public engagement.
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):

SR11	If the COVID-19 pandemic continues for an extended period, then the Trust will be unable to deliver its strategic objectives during 2020/21.	□

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 summary of key outputs and associated highlights on the work of the combined Communications and Engagement Team for Q4 (January – March 2020).

2. BACKGROUND

The Communications and Engagement Team have created a dashboard providing high level statistical content and themes from Q4 activity on:

- Patient and public engagement
- Patient and public panel
- Press and public (patient) relations
- FOI performance
- Publications
- Stakeholder communications
- External (public/patient facing) campaigns
- Social media: Facebook, Twitter and Instagram
- Website
- Internal projects and campaigns
- Internal communications including the Staff App
- Films produced in-house
- Team news

Each report also goes into more detail on some priority pieces of work. This quarter's dashboard provides an overview of how the team has supported the response to COVID-19.

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 2019/20: Jan - March

NHS North West Ambulance Service NHS Trust

CORONAVIRUS (COVID-19)

The Comms and Engagement Team has adapted to support the response to COVID-19, which had some impact on 'business as usual'. This will be referenced throughout the report for Q4 2019/20 and is explained further on **pg 4**.

PATIENT AND PUBLIC ENGAGEMENT

5 public engagement events including: Stepping Stones learning disability group, Deafway Accessibility and Salix Homes tenancy support service. Topics included ways to improve accessibility.

2 community events were due to take place in March 2020 were cancelled, along with any scheduled in April 2020 due to COVID-19. These will be resumed when it is safe to do so.

- A piece of work began with the Patient and Public Panel to further develop the engagement board game and gather new ideas for public engagement.
- Initial plans were made for 5 NWAS-hosted community events - now on hold.
- An annual learning day was held to identify learning from all engagement work and create an action plan
- An update was provided for the Right Care Strategy

11,275 Patient surveys sent out ▼ 14%

2,871 (25%) returned ▼ 14%

94% of respondents said the overall service received was 'very good' or 'fairly good' ▲ 1%

94% were likely to recommend the service to friends and family = TO Q3

94% agreed they were cared for appropriately with dignity, compassion and respect ▼ 1%

NOTES

Public engagement events *are where we attend specific patient groups and take the NWAS engagement board game to encourage attendees to share their experience of the service and learn more.*

We also attend ***community events*** *where we engage with the public about various topics. These are seasonal and were due to begin in Q4 but are now on hold.*

For ***patient surveys****, there was a small decrease in the number of surveys issued due to COVID-19 impacting this piece of work towards the end of the quarter.*

New family and friends test (FFT) guidance was due to come into force early Q1 2020/21 and the team had done some work on this. However, with agreement agreement from NHS England and commissioners the FFT and all patient experience surveys are on hold.

PATIENT AND PUBLIC PANEL (PPP)

18 new panel members confirmed and inducted to the trust in Q4

72 panel members now in total

32 new expressions of interest in Q4

53 of the panel members are involved in two levels of participation meaning we have...

125 panel voices to call on for a piece of work

- **71** Consult
- **35** Co-produce
- **19** Influence

8 'influence' members had governance training to develop understanding of the Board processes.

5 taster events were held, including one 'virtual' as we adhered to COVID-19 guidance.

4 induction sessions, including two 'virtual' events.

25 requests for panel involvement by the end of Q4.

PRESS AND PUBLIC (PATIENT) RELATIONS

Handled **185** 'incident check' calls

75 proactive media stories / interviews ▲ 27%

Prepared **20** statements in response to press enquiries ▼ 20%

288 pieces of media coverage ▼ 13%

- **74%** incidents
- **17%** positive
- **6%** negative
- **3%** neutral

Including:

- A press release about our staff survey results which showed an increase in staff voting NWAS as a good place to work, led to positive news coverage.
- In February, we launched our Cardiac Smart Accreditation Scheme to recognise, celebrate and support the contributions of those who actively help to increase survival rates from cardiac arrest.
- Staff from Cheshire featured on a special episode of Top Gear which saw emergency services teams take on various challenges to be named the fastest. Team NWAS proudly took home the trophy on behalf of the ambulance service.

NOTES

Incident coverage *is mostly neutral - NWAS is mentioned as attending an incident, with the press office confirming details. Sentiment for other coverage is based on how NWAS is represented in an article.*

Proactive media stories have increased for the third quarter in a row but overall coverage is down slightly - this is compared to Q3 which had a massive 136% increase due to a couple of really popular stories.

The number of incident checks is down this quarter as press interest shifted to COVID-19. Initially, we were unable to respond to any COVID-19 media requests and instead these were passed to DHSC.

FREEDOM OF INFORMATION (FOI)

106 FOIs completed

96% within 20 working day target

▼ 2%

16 requests came from the media

Topics included:

- Hospital handovers
- Call outs to certain addresses
- PTS transfers
- PTS costs
- Recruitment

NOTES

FOIs: *We have a statutory duty to reply to eligible FOIs within 20 working days and have a 95% target for this. Performance dropped slightly but is still above target.*

In light of COVID-19 pressures, the Information Commissioners Office has suggested there would be some leniency if organisations struggle to meet the target.

Stakeholders: *this group is external audiences such as MPs, commissioners, patient groups and other healthcare professionals / partner organisations.*

PUBLICATIONS

1 Your Call magazine (Spring edition) – highlights included interviews with Mick Forrest and Angela Hansen as well as a piece about the role of the rotational paramedic.

STAKEHOLDER COMMUNICATIONS

2 stakeholder bulletins

2 'Winter Watch'

6 MP letters / briefings

- MP Letters re: rota review, ambulance delays, road works access, local performance data and volunteer car driver mileage.
- 2 x Winter Watch fact sheets about activity
- 2 x bulletins, one with general NWAS news and one COVID-19 specific bulletin

FACEBOOK

45,589 total followers

1,549 this quarter

▼ **35%** rate of growth in new followers

2,114,988 reach ▼ 30%

175,722 engagements ▼ 60%

Top post:
A post about EMD apprenticeships

724 shares

1,072 reactions

130,468 reach

TWITTER

46,512 total followers

541 this quarter

▼ **70%** rate of growth in new followers

1,790,145 reach ▼ 32%

56,067 engagements ▼ 22%

Top post:
A post in support of "clap for carers" on a Thursday evening:

260 retweets

1,846 likes

109,161 reach

INSTAGRAM

6,818 total followers

629 this quarter

▲ **19%** rate of growth in new followers

7,466 engagements ▲ 18%

Top post:
A post about electric vehicles

289 likes

NB: Changes to Instagram analytics mean we are unable to report on 'reach' this quarter. We should be able to report in more detail next quarter.

NOTES

*"**Reach**" is the number of people who may have seen our content.*

*"**Engagements**" is when someone engages with our content e.g. clicks on a link, reacts to it by clicking 'like', shares or retweets it.*

FACEBOOK: *Facebook figures dropped this quarter, particularly the number of engagements. Q3 had very high engagement due to multiple winter campaigns running and a few very popular posts. This, combined with a slight shift in social media activity with the COVID-19 pandemic, could explain the lower figures for Q4.*

TWITTER: *All Twitter figures rose significantly last quarter and seem to have steadied out again for Q4,. Reach for Q3 was up by 48% and has evened out again with a 32% drop this quarter. As with Facebook, this could be explained by the unusually high figures in Q3 combined with a slight shift in activity due to COVID-19.*

INSTAGRAM: *Instagram is our least popular social media channel so we continued to spend time looking at how to increase engagement from our existing followers and use Instagram differently. There is more work to be done but engagement and rate of new followers did improve slightly for Q4.*

WEBSITE: *The number of views to the news page was the most significant decrease this quarter. However, Q3 reported a huge increase of 117% with a very popular news story so it could be expected that this figure would even out this quarter. The team will continue to refresh news content on the website as often as possible to keep this figure up.*

Page views have increased slightly while visitors has decreased but not significantly. We expect these figures to fluctuate quarter-to-quarter but would act to understand any significant or consistent changes.

WEBSITE

331,867 page views ▲ 4%

96,946 total visitors ▼ 13%

Most visited page:
1 Careers/vacancies
68,027 views

22,668 'news' views ▼ 61%

Top news story:
"Emergency driving put to the test in Top Gear special"

- A 6-month review of the website, including 'mystery shopping', was undertaken and a number of improvements were made subsequently.
- A link was added to the Modern Gov site.
- A full accessibility review of the website has been commissioned.

EXTERNAL (PUBLIC/PATIENT) CAMPAIGNS

- **Happily ever after** – Following on from the 'once upon a call' video, we launched this campaign to positively promote emergencies to reinforce when it's appropriate to call 999. The campaign was also designed to engage staff and show them that they are appreciated by the public for the work they do, using the hashtag #ThankYouNWAS. **Five** life saver stories where filmed securing **13** pieces of regional media coverage including broadcast, online, print and radio.
- **Fairy tale –** We launched the NWAS fairy tale book as the final instalment of the winter campaign designed to educate children early on what constitutes as emergency situation. Stories such as Snow White and the Seven Dwarfs and Sleeping Beauty were given a modern twist in the book which is available to primary school children across the region. **Four** pieces of broadcast coverage and **20** regional pieces of media coverage helped to promote the book and the message behind the campaign.
- A full evaluation was carried out on the above campaigns and will help to inform planning for next winter.

INTERNAL (STAFF) PROJECTS / CAMPAIGNS

Flu vaccination

- A series of promotional/myth busting bulletin articles
- Poster distribution
- In-house film of the 'flu angels'
- Uptake rate was the highest ever - **67.3%** (2018/19 figure 65.9%) ▲ 1.4%

CQC (Operation Outstanding)

- **9** '5 minute briefings' issued on topics including: health, safety and security; recruitment and training; safeguarding; infection prevention and control; medicines management and more.
- **6** briefings for Non-Exec Directors on each of the key lines of enquiry (KLOEs)
- Toolkit for staff on the Green Room

Rota Review

- Over **140** surveys created and published for Cheshire and Merseyside
- Weekly voting number updates to the CAM team
- Weekly staff bulletins

Learning forum

- Produced learning forum bulletins and supported Lessons Learned report

Urgent and emergency care transformation

- Continued to support Contact Centre Review project - held 2 x 'tea and talk' focus groups and collated 110 survey responses before producing recommedations paper on continued staff comms and engagement in contact centres
- Supported otherworkstreams inc.CAS with 111 and Clinical Hub comms about changes to Adastra
- Produced rotational working case studies for sharing internally and externally

Equality Delivery System (EDS)

- Supported the EDS assessment staff and stakeholder sessions to ensure we are meeting the requirements of four equality goals: Better health outcomes; Improved patient access and experience; A representative and supportive workforce; Inclusive leadership

NHS 111

- Series of newsletters with CQC focus
- Support to keep website updated for Directory of Services team (DoS)
- Posters made of learning forum outcomes

INTERNAL (STAFF) BULLETINS

This quarter, we issued:

13 CEO weekly bulletins
33 Clinical bulletins
12 Operational bulletins
13 Weekly Regional Bulletins
21 Staff communications bulletins

plus **28** others, including education and training, HR, health and safety, Rota Review and PTS, **1** Team Talk and **5** lessons learnt docs

Topics included:

- Staff guidance on coronavirus (COVID-19)
- Mandatory training updates
- Datix amendments to reflect the Executive Leadership changes

There was also **1** executive director blogs uploaded to the Green Room, written by Maxine Power.

FILMS

14 completed **6** underway
▼ 1 (7%)

- 2 x Flu Jab films
- 6 x #ThankYouNWAS films – 5 patient stories and 1 combined film
- CEO CQC message to staff
- Patient story (audio only) for Board
- Achievements film for CQC
- 2 x CEO messages regarding COVID-19
- NHS 111 video consultation demo for NHS Digital

Videos are filmed in-house using skills and equipment within the team. Q3 saw a 117% increase in the number of films we completed, and almost as many were completed again this quarter.

STAFF APP

4,213 total downloads
614 this quarter
Most popular pages: email, GRS and ESR

TEAM NEWS

- Won the Communications Team award at the Unsung Heroes awards
- Highly commended in 'Excellence in Communication and Engagement' at the Leading Healthcare Awards.
- Shortlisted in the national Chartered Institute of Public Relations (CIPR) Excellence Awards in the 'In-house public relations team' category. This will be announced in June.
- Appointed to Digital Communications Officer (web) and Videography/Photography Communications Officer posts

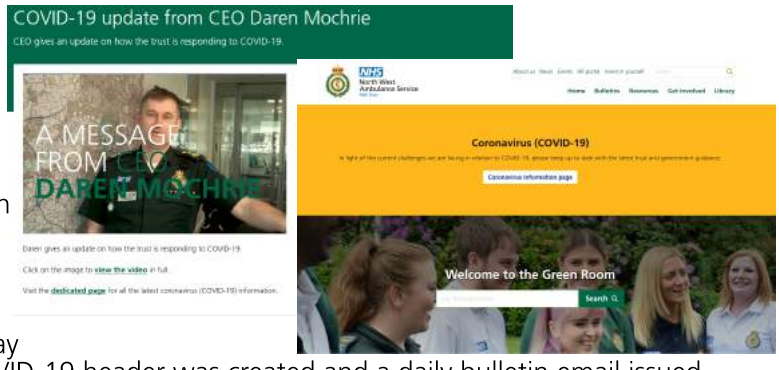
MISCELLANEOUS

- Supported NHS England winter communications cell feeding into national and regional process
- Submitted nominations for colleagues to attend the Royal Garden Party and for the Queen's Ambulance Medal
- Submitted an award nomination to AACE for 'outstanding service in a clinical but non-paramedic role'
- Assisted in the production of a banner and narrative for use on the Ambulance Leadership Forum (ALF) website
- Submitted copy for a feature in Ambulance publication intended to be shared at ALF- unfortunately cancelled due to COVID-19
- Supported GP Out of Hours Service tender proposal with content on patient engagement, stakeholder engagement, relationship management and social value
- Produced comms plan for the Manchester Arena incident enquiry and considered training options for the team and others to support media requests and crisis management

FOCUS ON... COVID-19 response

The Communications and Engagement Team response to the COVID-19 pandemic began in January and continued throughout Q4 and into Q1 of 2020/21. Here's an overview of communications and engagement activity in Q4.

INTERNAL COMMS:



- Staff briefings were issued from January about the repatriation of British citizens from Wuhan to Arrowe Park
- A COVID-19 specific comms plan was developed
- A comms representative has been present on strategic and tactical conference calls throughout
- In March, a dedicated COVID-19 page was set up on the Green Room, hosting the latest information and guidance for staff
- An alert was installed on the Green Room homepage to signpost to the page
- A summary of the Minister's briefing was shared with the Executive Leadership Committee every day
- To help manage the volume of information, a COVID-19 header was created and a daily bulletin email issued
- Video messages for staff from CEO Daren Mochrie and Medical Director Chris Grant were recorded and shared
- Approval was gained and preparations were made for a staff-only Facebook group which was to be monitored daily by the communications team (this was set up at the start of Q1 2020/21 and currently has was set up and is monitored by the communications team daily - it currently has 1,600 members)

EXTERNAL COMMS:

- In January and February, the team took part in daily multi-agency communications cell calls led by NHS England around the repatriation of British citizens from Wuhan to Arrowe Park isolation centre.
- Initial media enquiries were referred to the Department of Health and Social Care
- Social media messaging were focused on government messages to stay at home, protect the NHS and save lives
- Positive social media messaging celebrated the 'Team NWAS superstars' to help profile some of the hard work of staff and volunteers and share uplifiting content
- Generous donations and offers of support were promoted through social media
- A public message from CEO Daren Mochrie was filmed and shared
- Regular stakeholder bulletins have been issued to keep key groups updated
- Letters to key stakeholders, including MPs and senior managers for other healthcare providers, have been written as required to ensure latest relevant updates are shared with key groups or in response to questions
- Media enquiries have been responded to, working closely with NHS England
- The team has represented the organisation in comms cell calls for each local resilience forum and other national and regional communications conference calls

PATIENT/PUBLIC ENGAGEMENT:

- Patient and Public Panel engagement events were remodelled - those which were already scheduled were successfully completed as 'virtual events'
- Membership has continued to grow and regular 'keeping in touch' calls have been made to all existing members
- Other aspects of public engagement have had to be put on hold, e.g. the community events, but the team are exploring possibilities for alternative events on a smaller scale in the future

TEAM MANAGEMENT:

- Comms and engagement decisions and actions were captured in the directorate log and evidence log
- Home working guidance was produced for the team
- Business continuity plans were updated and a critical systems/actions review took place
- A Team A/B system was introduced, with half the team working from home and half from the office on a rotational basis to support social distancing
- Members of the team required to shield were supported to ensure they had the necessary equipment to work from home and a 'wellbeing officer' was appointed within the team to check in regularly with colleagues - over and above the daily team huddle held via Skype