Public Document Pack

North West Ambulance Service NHS Trust

Board of Directors Meeting

Wednesday, 28 April 2021
11.00 am - 12.15 pm

via Microsoft Teams

AGENDA

Item No	Agenda Item	Time	Purpose	Lead	Page No
INTRODUCTION					
BOD/2122/1	Apologies for Absence	11:00	Information	Chairman	
BOD/2122/2	Declarations of Interest	11:00	Decision	Chairman	
BOD/2122/3	Register of Interest	11:05	Assurance	Chairman	3 - 4
GOVERNANCE AND RISK MANAGEMENT					
BOD/2122/4	Board Assurance Framework and Corporate Risk Register Quarter 4 Closing Position 2020/21	11:05	Decision	Director of Corporate Affairs	5 - 56
BOD/2122/5	Board Assurance Framework 2021/22 Opening Position	11:15	Decision	Director of Corporate Affairs	57 - 74
BOD/2122/6	Core Governance Documents	11:20	Decision	Director of Corporate Affairs	75 - 172
BOD/2122/7	FT Code of Governance Compliance Declaration	11:30	Assurance	Director of Corporate Affairs	173 - 204
BOD/2122/8	Common Seal Annual Report	11:35	Assurance	Director of Corporate Affairs	205 - 208
BOD/2122/9	Freedom to Speak Up Report - Q3/Q4 Position and Annual Report 2020/21	11:40	Assurance	Director of Corporate Affairs	209 - 228
BOD/2122/10	Quality and Performance Committee Annual Report and Terms of Reference	11:50	Decision	Prof A Chambers, Chair, Quality and Performance Committee	229 - 244
BOD/2122/11	Resources Committee Annual Report and Terms of Reference	11:55	Decision	Mr R Groome, Chair, Resources Committee	245 - 260
BOD/2122/12	Audit Committee Annual Report and Terms of Reference	12:00	Decision	Mr D Rawsthorn, Chair, Audit Committee	261 - 278
BOD/2122/13	Board of Directors Annual Cycle of Business 2021/22	12:05	Decision	Director of Corporate Affairs	279 - 288
CLOSING					
BOD/2122/14	Any Other Business Notified Prior to the Meeting	12:10	Decision	Chair	
BOD/2122/15	Items for Inclusion on the BAF	12:15	Decision	Chair	
12:15pm - 12:30pm - Board of Directors Part 2 meeting					
1.00pm - 3.30pm - Board Development Session					

Date and Time of Next Meeting 9.45 am Wednesday, 26 May 2021 via Microsoft Teams

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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		Apr-19		
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 is required within a meeting, in relation to the service line.
Alison	Chambers	Non-Executive Director	Husband is CEO at Barking and Havering and Redbridge University Hospitals NHS Trust				√	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
			Pro Vice Chancellor, Faculty of Health and Social Care and Member of University Executive Group, Manchester Metropolitan University	√				Position of Authority	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Salman	Desai	Director of Strategy and Planning	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Work in GP Practice - Non Exec Chairman of Board	√	N/A	N/A	N/A	Position of Authority		Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
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
			Director of Avantage (Cheshire) Ltd	√				Position of Authority	Dec-20	Present	Withdrawal from any Cheshire Care Home related discussions.
			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	Aug-20	No conflict.
			Registered with the Health Care Professional Council as Registered Paramedic		√			Position of Authority	Apr-19	Present	N/A
			Member of the College of Paramedics		√			Position of Authority	Apr-19	Present	N/A
			Chair of Association of Ambulance Chief Executives (AACE)		√			Position of Authority	Aug-20	Present	N/A
			Member of the Royal College of Surgeons Edinburgh (Immediate Medical Care)		√			Position of Authority	Apr-19	Present	N/A
			Member of the Regional People Board		√			Position of Authority	Sep-20	Present	N/A
			Member of Joint Emergency Responder Senior Leaders Board		√			Position of Authority	Sep-20	Present	N/A
			Board Member/Director - NHS Pathways Programme Board		√			Position of Authority	Mar-20	Aug-20	Appointment declined
Chris	Grant	Medical Director	NHS Consultant - Critical Care Medicine - Liverpool University Hospitals NHS Foundation Trust	√				Connection with organisation contracting for NHS Services	Apr-19	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
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.
			Member of Cumbria Wildlife Trust			√		Other Interest	Apr-19	Present	N/A
Gillian	Singh	Associate Non-Executive Director (Digital)	Non-Executive Director - The Riverside Group	√				Position of Authority	Jan-20	Present	N/A
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
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 – The Riverside Group	√				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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NHS North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 April 2021		
SUBJECT:	Q4 Board Assurance Framework Review & Corporate Risk Register (CRR)		
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs		
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction.	☒
	SR02	There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements and infrastructure.	☒
	SR03	There is a risk that the Trust does not deliver improved national and local operational standards resulting in unsafe or delayed care.	☒
	SR04	There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services.	☒
PURPOSE OF PAPER:	For Decision		
EXECUTIVE SUMMARY:	The proposed Q4 position (as at 31 March 2021) of the BAF with the associated CRR risks scored ≥15 can be viewed in **Appendix 2.** The BAF Heat Maps for 2020/21 year to date can be viewed in **Appendix 3**. As part of the Q4 review, the following proposed changes have been identified (s4): • Reduction in risk score for SR01 from 15 to 10 • Reduction in risk score for SR02 from 20 to 15 • Reduction in risk score for SR03 from 20 to 15 • Reduction in risk score for SR04 from 16 to 12 • Reduction in risk score for SR05 from 12 to 9. In total, 16 mitigating actions identified on the BAF have been deemed as 'delayed'. (s5) The CRR can be viewed for information in **Appendix 1.**		
RECOMMENDATION:	The Board of Directors are requested to: • Agree the Q4 closing position of the Board Assurance Framework 2020/21		
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability ☐
PREVIOUSLY CONSIDERED BY:	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 and adequately mitigate any significant risks which threaten the achievement of the Trust's strategic objectives.

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

2. BACKGROUND

The BAF risks are reviewed at Board Committees providing the opportunity to identify where assurances support potential mitigation of risks, commission additional assurance where appropriate and identify any further associated risks that may require escalating or de-escalating through the Chair's Assurance Reporting process. Risks identified on the CRR 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 Head of Risk & Assurance has collated assurance information reported via Committees throughout the quarter onto the Assurance Map. The assurance mapping has been used to support discussions with Executive Directors and assist with updating the BAF risks.

3. REVIEW OF THE CORPORATE RISK REGISTER

Oversight of the CRR, which can be seen in Appendix 1, is the remit of the Executive Leadership Committee (ELC).

4. REVIEW OF STRATEGIC RISKS Q4

The quarterly review process provides an opportunity for the Director Leads to meet with the Head of Risk & Assurance, to discuss the updates of their relevant risks. These meetings have taken place with either Director Leads or their senior lead responsible for updating the BAF.

The proposed Q4 closing position of the BAF 2020/21 risks with associated Corporate Risk Register risks scored 15 and above can be viewed in **Appendix 2**.

The Heat Maps showing the journey of each risk for 2020/21 can be viewed in **Appendix 3**.

Following a full review of the controls and assurances across the BAF during Q4, the following changes are proposed:

SR01: If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety

- Reduction in risk score for Q4 from 15 to 10

Opening Score 01.04.2019	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
15 5x3 CxL		**15** 5x3 CxL	**15** 5x3 CxL	10 5x2 CxL	Prof M Power

This risk has decreased in risk score following review, with the following rationale applied by the Executive Lead:

1. Good progress has been made during 2020/21 against the identified gaps in controls and assurances surrounding:
    - complaints,
    - incidents and serious incident reporting,
    - health, safety and security,
    - infection, prevention and control,
    - medicines management,
    - safety and compliance and
    - clinical effectiveness.

SR02: If we do not have effective financial management, this may impact on the Trusts' financial position

- Reduction in risk score for Q4 from 20 to 15

Opening Score 01.04.2019	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
25 5x5 CxL		**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL	Ms C Wood

The risk has decreased in risk score following review, with the following rationale applied by the Executive Lead:

1. ICS forecasts were agreed both regionally and nationally
2. The increase in annual leave accrual and shortfall in non-NHS income have been deemed to be allowable gaps against the system funding envelope
3. Funding for non-NHS income shortfall has been received and 80% increase in non-NHS accrual has been received on account and will be corrected following year-end accounts
4. Year-end position will be break-even.

SR03: If we do not meet national and local operational performance standards through transition to an integrated service model within the

funding envelope, this may impact on providing timely patient care

- Reduction in risk score for Q4 from 20 to 15

Opening Score 01.04.2019	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
25 5x5 CxL		**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL	Mr G Blezard

This risk has decreased in risk score following review, with the following rationale applied by the Executive Lead:

1. Significant improvements to patient safety
2. Minimal number of patients waiting within the stack and improved response times
3. Seeing improved performance due to the continued support from PTS and additional support from private ambulance providers
4. The Trust is currently realigning operational resources to ensure they are effectively and efficiently utilised to maximise usage ad continue to improve performance
5. Improvements seen in NHS 111 due to additional staffing to meet demands from the 111 First programme
6. Additional call taking capacity has been established at Middlebrook for NHS 111
7. The Trust has launched a new telephony system which will assist in the delivery of performance
8. Total number of COVID-19 abstractions has reduced due to increased compliance with IPC measures and staff testing
9. PTS continue to support PES and provide core PTS business
10. The PTS contract has been extended until July 2023.

SR04: If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on of the delivery of the Trust's objectives

- Reduction in risk score for Q4 from 16 to 12

Opening Score 01.04.2019	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
16 4x4 CxL		**16** 4x4 CxL	**16** 4x4 CxL	12 4x3 CxL	Ms L Ward

This risk has decreased in risk score following review, with the following rationale applied by the Executive Lead:

1. Q4 has seen a reduction in the impact of staff absences on workforce availability
2. Continued deployments of additional resources across EOC/ PES and the mobilisation of 111 First

3. Recovery arrangements and trajectories are in place for appraisal and mandatory training
4. Student programmes and induction training have been remobilised
5. Recovery of key culture improvements has commenced with good progress on EDI priorities, values refresh and the culture audit.

SR05: If we do not review our estate and fleet to reflect th needs of the future service model and commit to reduce emission, this may impact on the Trusts' infrastructure and achieving environmental efficiencies

- Reduction in risk score for Q4 from 12 to 9

Opening Score 01.04.2019	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
12 3x4 CxL		**12** 3x4 CxL	**12** 3x4 CxL	9 3x3 CxL	Ms C Wood

This risk has decreased in risk score following review, with the following rationale applied by the Executive Lead:

1. Completed review of the Trust estate in terms of backlog maintenance, this will inform prioritisation of capital schemes to undertake remedial works
2. Compliance with the estate is monitored and reviewed using a Statutory Compliance Audit Tool
3. ORH modelling has been captured within the internal Optima system and used to assess the impact on performance of future identified locations
4. Several Hub and Spoke developments have been initiated
5. The fleet profile from ORH modelling review will be used to inform future replacement programmes
6. The Trust has been actively involved and a key ambulance lead, with both NHSI ERIC Ambulance Teams to develop ERIC and the model ambulance.

5. EXCEPTION REPORT ON THE MITIGATING ACTIONS IDENTIFIED ON THE BAF

In total, 16 mitigating actions identified on the BAF have been deemed as 'delayed'. The Corporate Risk Team will continue to work with Executive Director leads to ensure these are transferred onto 2021/22 BAF where relevant.

6. LEGAL, GOVERNANCE AND/OR RISK 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 Q4 closing position of the Board Assurance Framework 2020/21.

Corporate Risk Register & Commercially Sensitive Risk Register
**Extracted from Datix on 1 April 2021*

NHS North West Ambulance Service NHS Trust

Corporate Risk Register

DX ID	Opened	Risk Type	Risk Subtype	Risk Description	Role Type	Lead	Rating (initial)	Key Controls in place	Likelihood (current)	Consequence (current)	Rating (current)	Risk Evaluation	Gaps in controls	Assurance	Gaps In Assurance	Rating (Target)	Forecast Completion Date	Last reviewed	Date of next review
2568	26/03/2018	Operational	Reputation	There is a risk that the response to an MTA outside of the Model Response sites of Liverpool and Manchester may be delayed due to the vast majority of MTA staff (AIT/Cs) being stationed in or around the above areas. This could result in potential delays of triage, treatment and transport in the warm zone of such an incident further afield.	SD - Special Operations (inc. HART)	Ged Blezard	20	1. NWAS action cards updated. 2. NWAS Major Incident Response Plan/National Decision Making Model/JESIP ethos embedded across NWAS. 3. Ballistic Personal Protective Equipment issued to trained staff with spare stores held on ISUs. 4. All HART staff trained. 5. 63 Uplift staff trained with further training planned. 6. All Gx Sx Bx Commanders and APs attended training. 7. Numerous multi agency live and table top exercises conducted. 8. Cadre of specially trained Ambulance Intervention Team Commanders available. 9.All Tactical Advisors and National Interagency Liaison Officers (NILOs) have been trained. 10. Specialist medical equipment procured. 11. Mutual Aid available from adjacent Trusts under the national mutual aid procedure. 12. Trained Commanders identify themselves to Support Centre when on call. 13. Operational uplift staff on duty identified on C3 and PROCLUS twice daily. 14. Random sampling of trained staff on duty. 15. Refresher training for Commanders, HART and uplift staff on continually rolling programme. 16. NARU suggestion that NWAS can uplift their number of MTFA trained staff. 17. 2 courses scheduled with GMP for 28 NWAS operational staff. 18. 1 course delivered for 14 staff to increase required numbers.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Outcome of national decision re MTFA capability. There is a lack of staff trained in MTA who cover the Lancashire & Cumbria area	01.Approved Policies and Procedures. 02.Workforce Committee re reporting of staff trained. 03.National Capabilities Audit to NARU/NHSE. 04.Service Delivery SMT. 07. The deployment of resources into the hot and warm zones may include both specialist and non-specialist multi-agency responders with the correct PPE. 08.Commanders should decide when and how their responders are deployed (informed by the attack methodology). 09.The intention to deploy should be to minimise the risk to the public (including the injured) whilst maximising the safety of responders. 06.Agreed SORT uplift as agreed nationally – funding agreed (option 12) and roll out of SORT uplift in 2021 05.Approval of Option 12 has been given and commissioned and funded from April 2021	01. National decision re MTFA funding.	5	31/03/2021	30/03/2021	04/05/2021
2867	22/02/2019	Operational	Innovation	There is a risk of oversight or system issues, due to a high number of high impact projects linked to critical systems being delivered simultaneously, which could result in system failures.	QII - IM&T	Maxine Power	16	1. Change Control process to ensure the change is robust, widely communicated and contingency plans are in place where possible. 2. Supplier engagement on high impact service changes 3. Key programmes have PMO support and individual risks 4. Corporate programme Board 5. Project support for Digital projects (SPMS) and aligned with key projects 6. CIO Role in post 7. Continuous reviews of plans 8. Structure review for additional resources to support projects agreed and progressing 9. Increased VDI infsatrcuture	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	Multiple training programmes being delivered symultaneously on and offsite Multiple projects running at same time -UCP, embedding SPMS, 111 First, ESMCP, infrastructure work Lack of detailed scoping of interdepndacies between changes to critical systems Firewall capacity may not be sufficent	CPB and DOF oversight - minutes System resilience measures	01. System resilience and continuity audit - underway with MIAA	8	26/02/2021	11/11/2020	23/12/2020
3027	03/07/2019	Operational	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	PD - Human Resources	Lisa Ward	20	01. Increased numbers for direct entry and in-service conversion programmes for 2019/2020 starts. 02. 2019/20 in-service conversion rescheduled to maximise staff availability over winter periods (2019 and 2020) 03. National specification out to tender for paramedic apprenticeship (in-service conversion route from 2020 onwards). 04. Active recruitment 05. EMT approved 3 year transition to new skill mix July 2019 06. EMT approved increase in internal progression to 170 in July 2019, 165 starts. 07. Paramedic apprenticeship preferred supplier in place and contract award approved by Board. 08. Turnover remains stable. 09. Plans agreed with HEIs to prevent COVID from delaying completion of programmes 10. HCPC approval of UDC apprenticeship programme. 11. Recruitment to paramedic apprenticeships commenced 12. HEE funding secured for rotational working pilots and recruitment to infrastructure posts commenced 13. ELC approved key decisions for Paramedic apprenticeship, including supporting posts, cohort size and pay and conditions 14. Paper approved for application of sponsor licence. 15. Assessments completed for paramedic apprenticeship and offers made 16. Adverts opened for paramedic pilots	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	01. Local Paramedic supply insufficient to meet potential demand 02. Impact of GP reform on retention unclear 03. Change in GP contract to band 7 funding for Paramedic posts. Further proposal also suggest Band 8A might be added to the ARRS. 04. Delay to rotational pilots as a result of COVID-19 05. PCN recruitment plans unclear	01. EMT1 AAP CPD Bridging Programme expansion, with over 250 EMT1s on track to achieve the AAP qualification. 02. AACE and HRD oversight of impact of GP reforms 03. Prevoius paper to EMT approving over-establishment of paramedics and increases in provision 04. EMT paper July 2019 - agreed 3 year transition to increased skill mix 05. Agreed ToR and project plan for rotational working groups 06. ELC approval of Paramedic apprenticeship supplier - January 2020 07. Confirmation of HCPC validation of apprenticeship course. 08. Contract for apprenticeship awarded. 09. POC case to ELC 19/08/20 which identifies Pilot Schemes. 10. Develop trust offer for rotational paramedic working both internal and externally - model in place and advanced discussions. 11. Pilot Schemes identified 12. ELC report Nov 20, confirmed continuation of two pilot scheme 13. ELC report Nov 2020, assurance on Paramedic apprenticeship progress and key decision milestones 14. Resources Committee, assurance on Paramedic apprenitcesip and ORH plans - November 2020 15. UEC Oversight Forum and CPB regular reporting on rotational working project 16. HEE fundin bid approved for rotational working infrastructure pilots 17. Intelligence from HEE suggests that the initial recruitment under the GP refrom may not be as high as intiially predicted for next year. 18. ELC approved sponsorship license application January 2021 19. Further intelligence suggests recruitment plan from PCN will be	01. STP/ICS oversight of paramedic demand outside of ambulance trust. 02. Clear understanding about how the healthcare system is proposing to use paramedics to fill staffing gaps.	4	31/03/2021	23/03/2021	29/04/2021

DX ID	Opened	Risk Type	Risk Subtype	Risk Description	Role Type	Lead	Rating (Initial)	Key Controls in place	Likelihood (current)	Consequence (current)	Rating (current)	Risk Evaluation	Gaps in controls	Assurance	Gaps In Assurance	Rating (Target)	Forecast Completion Date	Last reviewed	Date of next review
3062	13/08/2019	Clinical	Patient Safety	There is a risk that 999 call takers fail to identify key words and phrases relating to respiratory calls which could result in the wrong categorisation and/or delay the response leading to detrimental patient care, increase in complaints and reputational damage to the Trust.	SD - Emergency Operations Centre	Ged Blezard	20	01. EMD & EMD Support Staff Training Programme 02. MPDS Certification 03. EMD & EMD Support Staff Mentoring Process 04. EOC Audit Team Monitoring Compliance 04. EOC Education & Learning Information; Bulletins, EMD CDE 05. Planned move to MPDS v13.1 06. EMD Training Planned for move to MPDS v13.1 07. Established T&F Group; Review of SI, Learning & Training 08. Engagement with other AMPDS Trust 09. Establish Best Practice and Shared Learning with other Trusts 10. HoS EOC raise concerns with L&D team around risk 11. Introduction of mandatory training module 12. MPDS v13.2 implemeneted across the Trust 13. MPDS v13.2 Briefings issued to EMDS 14. Audits post MPDS v13.2 demonstrate improved compliance 15. 1 hour training module developed; 2020/21 Mandatory Training 16. Established T&F Group to review 999 respiratory calls 17. Continued engagement with other NHS Ambulance Trusts 18. Reviewed new systems for auditing and leveling compliance 19. Recommedations from T&F Group reporting to EOC Gov Group 20. Joint discussions surrounding mitigations to the risk 21. Continual monitoring through QBG and Assurance reports	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Inconsitent application of MPDS process Human Factors Recognised as a national risk within MPDS Disparity with National and MPDS definitions for `Inneffective breathing`.	01.Call Audits 02.EMD Training Records 03.EMD Briefings & Bulletins 04.MPDS Certificates 05.T&F Group ToR 06.T&F Group Minutes 07.Incident Report Forms 08.Mandatory Training Module for EMDs 09.Serious Incidents 10.Serious Incident Reports 11.NWAS Workforce Indicatos report 12. Working with ORH Stakeholder Group, Chaired by Director of Operations 13. `Early Predict Improvement Plan in place 14. Target of Cat I of 60% is set.	01.New Mandatory Training Module Compliance 02. Current target of Cat I is 51%	5	31/03/2021	30/03/2021	04/05/2021
3210	26/02/2020	Financial	Estates & Facilities	There is a risk that if inter-dependencies between other strategies such as EOC, training and medicines management which feed into and drive the Estates Strategy are not aligned in a timely manner this could result in delays and non-delivery of key elements of the Estates Strategy.	FIN - Estates & Facilities	Carolyn Wood	20	1. Estates Contact Centre Programme Group 2. Trust IBP has links with all key Trust strategies 3. Corporate Programme Board has oversight of Estates Strategy progress 4. Oversight Forum established August 20	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Functional strategies from all key areas including estates elements Outcome of options from Estates Contact Centre Programme Group Draft report to be completed and sent to march Corporate Programme Board	Strategic Implementation Plan Through quarterly meeting reports to Resources Committee Meeting held with property management (Orbit) to gain their understanding and support EOF established Aug 20	01. PMO High Level Plan due March 21	5	31/03/2021	23/02/2021	23/03/2021
3243	13/04/2020	Compliance & Regulatory	Infection Protection Control	There is a risk that social distancing may not be adhered to during the coronavirus pandemic due to staff needing to be less than two meters from the patient or each other and increased numbers of workforce in our working locations which may result in increased transmission of coronavirus	QII - Clinical Safety	Maxine Power	20	01. Accessibility to PPE 02. National Guidance 03. Working from Home Arrangements 04. NWAS Bulletins & Communications 05. IPC Policies and Procedures 06. Managers encouraging and enforcing Social Distancing 07. PTS - Reduction in the number of patients in a vehicle 08. Virtual Meetings 09. Suspension of Face to Face Meetings 10. PHE Guidance; Ambulance Service 11. COVID-19 Risk Assessments 12. Social Distancing Information Posters 13. Localised Audits in EOC & Contact Centres by CSPs 14. reviewed national guidance 15. communications plan in place 16. new stickers and posters in place 17. outbreak sites risk assessment follow up	5	4	20	Treat - Implement controls and mitigating actions to reduce the risk.	Resource to Complete Audits Incorrect use of PPE Continued supply of PPE Workstations are less than 2m apart Social Distancing in Vehicles Human Factors; Staff Behaviours	IPC Audits by Clinical Safety Practitoners COVID-19 Secure Workplace Certification COVID-19 Premises Risk Assessments Assurance Reports to Safety Management Group Chair's Assurance Report from Safety Management Group to Q&P Cttee	01. Development of Audit Tool for Local Managers 02. Audit Programme	4	31/03/2021	19/02/2021	19/03/2021

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3254	24/04/2020	Operational	Patient Safety	There is a risk that PES operational resources will be insufficient to cover demand because of staff taking carried over leave which they were unable to take due to Covid-19. This may result in delayed patient response times and delivery of national ARP standards as it has been offered staff within EOC and CHUB for the Q4 leave period 2020.	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	Ged Blezard	20	1. Maximum abstraction rates. 2. Option to carry some leave over into the next financial year. 3. Introduction of the NWAS annual leave buy back scheme. (8.47% of staff within PES took up the offer) 4. NHS Employers guidance re annual leave carry forward provision (2 years). 5. NWAS Operational Performance Calls 6. Operational, Tactical and Strategic Management 7. Performance Management Framework 8. Overtime opportunities 9. Use of Third Party Providers and VAS 10. Increase scope of Third Party Providers and VAS. 11. NWAS Patient Safety Plan 12. NWAS Communications and use of Social Media 13. Clinical Leadership Model. 14. ROCC Tactical and Strategic Commanders. 15. Deferring of Mandatory training 16. PTS resources used in PES Support work. 17. Implementation of National Pandemic Card 36. 18. NWAS COVID-19 Response Plan 19. Agreed additional funding to increase PES workforce establishment. 20. Issue of taking carried over leave in Q1 of 2021 raised with ELC again on the 16 Dec 2020 and awaiting a decision - Q1 is likely to see continued high demand. 21. ELC have agreed to extend the period of time in which annual leave can be taken (up to 20 days carried forward in line with National recommendation). 22. Resources from MACA and 23. eCFRs.	4	5	20	Treat - Implement controls and mitigating actions to reduce the risk.	Number of operational staff opting to utilise the annual leave buy back scheme. Use of Overtime and impact on Trust Financial position Increased use of PAS/VAS impacting on Trust financial position Sustainability of using non-PES clinical resources Timescale of staff vaccination programme Subsequent COVID-19 peaks/waves Changing regional teir system and national/local lockdown restrictions. Evolving guidance on higher risk individuals who should be shielding	01.Abstraction Reports. 02.NWAS Annual Leave Buy Back Scheme. 09. Return to Work process in place for those who have been shielding. 10. Confirmation on the amount of annual leave that can be carried over from HR. 03.National Performance Data 04.ORH Modelling Report 05.NWAS Integrated Performance Report 06.NWAS Performance Reporting to Commissioners 07.NWAS Performance Reporting to NHSE/I 08.NWAS Workforce Indicators Report	01. Adherence to abstraction rates on abstraction reporting. 02. Mandatory Training deferred until February 2021 03. Sustainability of using University Students for PES Support 04. PTS Uplift staff working in PES Support roles	5	31/03/2021	30/03/2021	04/05/2021
3320	14/05/2020	Operational	People	There is a risk that the reduction in hearings will lead to conduct or capability matters not being effectively dealt with leading to impact on patient care	PD - Human Resources	Lisa Ward	20	01. Any suspensions that were in place at the start of the pandemic are still in place and being regularly reviewed. 02. A small number of more serious cases have continued to be brought to conclusion. 03. A risk assessment process has been developed to flag a priority order when resuming investigations / hearings. 04. HRBP Team are looking at ways in whih cases can be expediated by reviewing and suggesting a temporary adjustment to the Scheme of Delegation. 05. Principles regards employee relations cases agreed with Trade Unions to commence.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	01. ET application responses from the Trust being delayed due to postal service delays and home working arrangements within the Team. 02. Lack of Operational and Clinical resources to pursue cases resulting in very lengthly investigations and potentially adverse impact on individual staff members. 03. The impact of the current situation with regards the Trusts strategic intentions around Just and Learning Culture and the associated review of the Disciplinary Procedure. 04. Further pause to hearings agreed Jan 13 2021	01. Temporary Scheme of delegation approved by ELC. 02. SPF document issued to Trusts to pause until 30/09 unless agreements reached. 03. Principles for managing ER cases agreed with local trade Unions. 04. HR Team prioritising cases in line with agreed principles. 05.ER tracker with ER cases now reported on a monthly basis to ELC.	None recorded.	5	31/03/2021	23/03/2021	29/04/2021
3376	21/07/2020	Operational	Estates & Facilities	There is risk if the Trust does not effectively prepare for the renewal/award of the PTS contracts across the trust in July 2021 this could result in an estate which does not adequately support service delivery.	FIN - Estates & Facilities	Carolyn Wood	20	Leases in place for dedicated PTS premises until July 2021 Dialogue commenced with PTS senior management	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	No clear indication with regard to contracts position post july 2021 No alternative premises have been identified if leases are not extended Confirmation and lease extensions awaited from existing landlords	Trust decision to remian at existing properties until March 23 PTS have representation at the Estates Oversight Forum	01. Uncertainty around the future contractual arrangements for PTS 02. Uncertainty around the future contractual arrangements for PTS	8	30/07/2021	15/03/2021	15/04/2021

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3409	11/09/2020	Operational	Emergency Prepardness	There is risk due to the National UK terror threat level increasing to 'Severe' there is an increasing likelihood of a terror attack within the NWAS geographical footprint which may impact on the delivery of urgent and emergency care.	SD - Directorate Wide Risk	Ged Blezard	20	01. Major Incident Response Plan 02. Action Cards within the MIRP for dedicated roles 03. Major Incident training for all operational staff at induction 04. Command and Control System in operation 24/7 05. Dedicated NILO role 24/7 06. Annual refresher training for On Call Commanders 07. HART Teams located in Liverpool and Manchester 08. Established staff role of Ambulance Intervention Team (AIT) 09. Commanders trained to deploy in an MTA Incident 10. Training of Commanders to deploy staff in an MTA Incident 11. NWAS Cascade System 12. Business Continuity Plans 13. Internal movement of resources (Strategic Redeployment) 14. National MoU with other UK Ambulance Trusts for mutual aid 15. Attendance in Local Resilience Forums (LRFs) 16. NWAS Communications Bulletin; Increase in current threat level 17. All Major Incident Fleet checked by Resilience Manager & HART 18. Collaboration with other Emergency Services & Agencies 19. National funding approved for UK Ambulance Service focused specifically on MTA	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	1. Audits of Commanders on National NOS Standards are not undertaken.	Mass Casualty Dispersal Plan BCM Plans Major Incident Response Plan National Threat level has reduced to `substantial` (08/02/2021).	01. BCM Plans 02. Military assests are asisting NWAS with low acuity work.	5	31/03/2021	08/03/2021	06/04/2021
3433	26/10/2020	Financial	Financial	There is a risk that NWAS are recruiting staff and committing funds associated to Estates, IMT & support staff structures in relation to NHS 111 First without any agreed recurrent funding in place which may result in NWAS carrying a large financial risk in to 2021/22 and beyond.	FIN - Management Accounts	Carolyn Wood	16	1, The Director of Finance presented a paper to the Regional Leadership Group on 14th October, which outlined the 2020/21 and recurrent funding required. 2020/21 funding was agreed but there has been no agreement yet on recurrent funding. 2, NHSE/I, commissioners and the Regional Leadership Group are all aware of the recurrent financial impact for NWAS. 3, Ongoing dialogue between Finance and 111 Operations to minimise the recurrent impact as possible without impacting on service provision. 4, 111 Operations, Finance and HR are in regular dialogue regarding the trajectory of recruitment to mitigate the recurrent impact.	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	No confirmed recurrent funding information available as the phase 3 financial regime covers 1st October 2020 to 31st March 2021 NHSE/I have confirmed that the current financial framework will roll over into Q1 2021/22, however no further information has been received relating to financial values.	Reported to the Regional Leadership Group on 14th October	01. NHSE/I have confirmed that the current financial framework will roll over into Q1 2021/22, however no further information has been received relating to financial values.	4	31/03/2021	12/02/2021	15/03/2021
3435	30/10/2020	Operational	Business / Continuity Planning	There is a risk that if the number of Covid related cases and outbreaks continue to rise within the second wave of the pandemic and business continuity plans need to be enacted, the plans may be insufficient and therefore services may be adversely affected which can result in patient harm.	QII - Clinical Safety	Maxine Power	20	Enhanced IPC support - temporary Outbreak executiveled trust- wide reporting meeting structure Early escalation of issues Tactical/strategic command structure re- established Improved data reporting mechanisms via informatics/MIAA Reap Level controls	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	limited ipc staff - currently temp staf being used to support team - not substansive outbreak manaagement requires further operational support limited TTT support Continuinty plans not yet enacted - consider REAP review	weekly oversight by ELC weekly oversight by IPC and 111 on current position NSE/I and commissioners oversight and reporting local operational report to weekly trust outbreak group	01. consideration of increasing reap to address potential failire of BCP. 02. trust wide action plan to plan for worst case scenario in relation to covid outreaks	5	31/05/2021	22/03/2021	12/04/2021

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3445	17/11/2020	Operational	Patient Safety	There is a risk that due to the excessive hospital handover delays at hospitals across the North West, the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	SD - Directorate Wide Risk	Ged Blezard	20	01. Local management engagement with hospitals 02. Executive management engagement with hospitals 03. Implemented HALOs at hospital sites to improve delays 04. Hospital Handover Project 05. Installed Hospital Arrival Screens for all hospitals across the NW 06. A&E Delivery Board with NWAS representation 07. NWAS Demand Management Plan 08. Attendance at National Calls regarding Hospital Handover 09. QI Approach to Hospital Handover 10. Safety Checklists 11. Every Minute Matters Collaboration with Hospitals 12. Attendance at NHSE/I North West Winter Planning Meeting 13. Attendance at NHSE/I Hospital Handover Delays Review Meetings 14. Identification of Hospitals to participate in Every Minute Matters 15. NWAS concerns raised with AACE 16. Strategic Meeting Chaired by Prof. A Marsh to review delays 17. Hospital outliers reported to NHSE/I 18. Escalations with Hospital Chief Executive Officer 19. NWAS concerns raised with NHSE/I NW & Lead Commissioners 20. Targeted Recovery Plans for Hospital Handover Improvements 21. There is continued liaison between NWAS and Acute services (Gold Cell meetings in Cheshire and Mersey Region); 22. Monitoring is taking place between Acute and CQC 23 Joint monitoring arrangements between Lead Commissioners and NWAS.	4	5	20	Treat - Implement controls and mitigating actions to reduce the risk.	1. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration	01.National Performance Data 02.National Hospital Handover Performance Data 03.NWAS Hospital Handover Performance Data to Commissioners 04.NWAS Hospital Handover Performance Data to NW NHSE/I 05.NWAS Integrated Performance Report 06.Hospital Handover Project Documentation 07.Every Minute Matters Project Docmentation 08. DATIX reports have seen a measured reduction in the number of vehicles being delayed opustide of hospitals. 09. PES abstraction rates are reducing 10. Right Care Closer to Home` allocated to SPTLs.	01. Continued hospital presssures 02. Abstraction rates of PES staff remain high.	5	31/03/2021	30/03/2021	04/05/2021
3446	17/11/2020	Operational	Patient Safety	There is a risk that due to the pressures at hospitals across the North West, increased numbers of patients will be held on the back of ambulances leading to excessive delays at hospitals which may result in increased numbers of delayed responses for our patients.	SD - Directorate Wide Risk	Ged Blezard	20	01. Local management engagement with hospitals 02. Executive management engagement with hospitals 03. HALOs at hospital sites to prevent cohorting of patients 04. A&E Delivery Boards with NWAS representation 05. NWAS Demand Management Plan 06. National Calls regarding Delayed Handover & Cohorting 07. NWAS Concerns raised with AACE 08. Strategic Meeting Chaired by Prof. A Marsh 09. Hospital outliers reported to NHSE/I 10. Escalations with Hospital Chief Executive Officer 11. NWAS Concerns raised with Lead Commissioners 12.Hospital handover Action Cards have been developed 13.DATIX Incident forms monitored and escalated accordingly 14.SPTLs link in with their local hospitals as required.	5	3	15	Treat - Implement controls and mitigating actions to reduce the risk.	01. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration	05. Incidents leading to patient harm are montiored via DATIX incident reports 06. DATIX reports have seen a measured reduction in the number of vehicles being delayed outside of hospitals. 04. ELC approval to engage locally to progress Patient Safety Checklist starting with 3 as per NHSEI plan for improvement. 03. New mitigations and reduced incident numbers reflect reduction in risk 01. Delays are monitored by the ROCC 02. Incidents leading to patient harm are montiored via DATIX incident reports	01. Working with Acutes to sign up to `Every Minute Matters`	5	31/03/2021	30/03/2021	04/05/2021
3447	17/11/2020	Operational	People	There is a risk that due to increasing operational demands and call volumes across NWAS, the health and wellbeing of our workforce may deteriorate leading to sickness and absenteeism which may impact on staff safety	SD - Directorate Wide Risk	Ged Blezard	16	01. Local Health and Wellbeing Plans 02. Organisational Policies and Procedures 03. Self-Referral Schemes 04. Health & Wellbeing initiatives 05. Occupational Health 06. HR Business Partnering Team	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.		01. Demand levels have seen a recent decrease 02. Reinforcement of local level engagement and partnership with Trade Unions 03. Sickness and Data Officer position created to manage sickness. 04. Return to Work procedures taking place for those who have been shielding.	None recorded.	4	31/03/2021	08/02/2021	02/03/2021

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3448	17/11/2020	Operational	Performance	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	SD - Directorate Wide Risk	Ged Blezard	20	01. NWAS COVID-19 Response Plan 02. NWAS Bulletins (Operational and Clinical) 03. NWAS IPC Guidance across all sites 04. NWAS IPC Consumables available across all sites 05. NWAS Internal Test, Track & Trace Function 06. NWAS COVID-19 Cells; chaired by Exec Directors 07. BCM in place across Service Delivery areas 08. COVID-19 Staff Risk Assessments 09. COVID-19 Premises Risk Assessments 10. Home working options 11. Lockdown of EOCs/ NHS 111 & PTS Contact Centre's 12. Access to Occupational Health 13. Organisational Policies and Procedures 14. Alternative Duties 15. HR Business Partnering Team for Advice & Support 16. Lateral Flow Tests are offered to all staff.	4	5	20	Treat - Implement controls and mitigating actions to reduce the risk.	01. Reluctance by staff to comply with the wearing of PPE. 02. Vistors to Trust sites not adhering to NWAS IPC Policies and Procedures.	11. Return to Work procedures taking place for those who have been shielding. 12. No current outbreaks across Service Delivery. 07.PTS report abstarction rates are reducing 08.PES report abstraction rates are reducing 09.Monitoring taking place via the Service Delivery Leadership Group 10.Communications Team to pick up isses with Media Visitors to EOC. 01.NWAS Staff Abstraction Report 02.NWAS Workforce Indicators Report 03.NWAS Communication Bulletins 04.NWAS COVID-19 Response Plan 05.Local NWAS Staff Abstraction Report 06.Local NWAS Sickness Report	None recorded.	5	31/03/2021	30/03/2021	04/05/2021
3449	17/11/2020	Operational	People	There is a risk that due to the current operational demand, appraisals, mandatory training and other workforce activities may be paused which may impact on the competency of our staff.	SD - Directorate Wide Risk	Ged Blezard	20	01. Local area monitoring of workforce indicators 02. Directorate monitoring of workforce indicators 03. NWAS monitoring of workforce indicators 04. Appraisal Workshop Training 05. Performance Management Framework.	4	5	20	Treat - Implement controls and mitigating actions to reduce the risk.	Staff Abstractions Staff Absenteeism	01. Reporting to The Board as part of IPR 03. New cycle released from April 2021. 02. Operational HoS leading delivery of resus competence for any staff not attended MT in last 24months	01. Appraisals on hold throughout February 2021.	5	31/03/2021	30/03/2021	04/05/2021
3450	17/11/2020	Operational	People	There is a risk that due to an increase in operational demand, completion of clinical supervision may not be completed to the required frequency which may impact on the competency of our staff.	SD - Directorate Wide Risk	Ged Blezard	20	01. SPTL Contact Shifts 02. NWAS Supervisory Framework	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	National Ambulance Supervisory Framework SPTL to PES Operations Staff Ratio Cyclical Contact Shifts	01. Reporting to The Board as part of IPR	01. Appraisals on hold throughout February 2021.	5	31/03/2021	30/03/2021	04/05/2021

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3451	17/11/2020	Compliance & Regulatory	Performance	There is a risk that due to COVID-19 restrictions and lockdown arrangements set out by the UK Government, NWAS and partner agencies may miss opportunities to multi-agency exercise local plans which may lead to commanders not fulfilling their National Occupational Standards impacting on our compliance with Statutory Duties.	SD - Directorate Wide Risk	Ged Blezard	20	01. NWAS engagement at Local Resilience Forums 02. LRFs exploiting opportunities for multi-agency exercises 03. NWAS Command arrangements allow for live learning	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	01. There is a lack of available resources across NWAS. 02. Multi-Agency talks to plan future exercises.	01. Ongoing NOS Training for Commanders 02. UK Government has released a road map in March for the easing of lockdown, aimed to be fully lifted by end of June 2021.	01. There is no date when Mulit-Agency exercises can recommence.	5	31/03/2021	30/03/2021	04/05/2021
3452	17/11/2020	Operational	Performance	There is a risk that the existing operating model for NWAS may not be effective due to insufficient workforce resources, vehicles and processes not being in place currently which may impact on our ability to achieve our ARP standards.	SD - Directorate Wide Risk	Ged Blezard	25	01. Shared learning via AACE and other NHS Ambulance Trusts 02. Preparatory workforce planning 03. Senior operational representation at National level 04. NWAS representation on monthly conference calls 05. Implemented Pre-Determined Attendance (PDAs) part of ARP v2.3 06. Frequent reviews of Pre-Determined Attendance (PDAs) 07. Implemented clinical leadership across all EOCs 08. Implementation of Demand Management Plan 09. Auto-allocation 10. Management of IFT/ HCP activity 11. Building Better Rota's Project 12. DCA and RRV Review 13. ORH Modelling Review 14. Fleet Replacement Programme 15. Operational Policies & Procedures 16. Operational Guidance	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Additional Finances from Commissioner Delivery of Urgent and Emergency Care Strategy Workforce Planning	09. NWAS REAP levels reduced to level 2 in March 2021. National Performance Data National ARP Data ORH Modelling Report NWAS Integrated Performance Report NWAS Performance Reports to Commissioners NWAS Performance Reports to NHSE/I NWAS Business Cases for Fleet Replacement NWAS Workforce Indicators Report	01. AACE to simplfy the operating model.	4	31/03/2021	30/03/2021	04/05/2021
3455	17/11/2020	Operational	Patient Safety	There is a risk that due to an increase in operational demand and patient acuity across PES, resources will be limited or not available for effective and efficient utilisation across the region which could result in delayed responses to patients.	SD - Directorate Wide Risk	Ged Blezard	20	01. Operational, Tactical and Strategic Management 02. Performance Management Framework 03. Overtime opportunities 04. Recruitment opportunities 05. Use of Third Party Providers 06. Increased scope of practice for Third Party Providers 07. Additional resources utilised to support performance 08. NWAS Demand Management Plan 09. NWAS Communications; use of social media 10. Clinical Leadership Model 11. Trauma Cell in EOCs 12. Utilisation of CFRs 13. NWAS Operational Performance Calls 14. ROCC Tactical Commanders & Strategic Commanders 15. Cancellation of mandatory training & appraisals 16. PTS Resources being utilised for PES Support Work 17. Implementation of National Pandemic Card 36 18. NWAS COVID-19 Response Plan 19. NWAS Winter Plan 20. ORJ Modelling Review 21. Engagement with System Leaders & Acute Hospitals 22. Engagement with NHSE/I 23. Engagement with NWAS Lead Commissioner 24. BT Scripts for COVID-19 Calls into NWAS 25. Agreed additional funding to increase PES workforce establishment	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	01. Continued high abstraction rates of staff and limited resources.	01. Weekly monitoring of resources 02.Military assests provide limited resources. 03. Reduction in NWAS REAP Levels to Level 2 in March 2021 04. Weekly Strategic Delivery and Performance Cell meeting reduced to bi-weekly meetings until week 2 April 2021.	01. Inability to cover all abstractions	5	31/03/2021	30/03/2021	04/05/2021

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3459	19/11/2020	Operational	People	There is a risk that due to the increasing numbers of staff sickness and abstractions across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards	SD - Directorate Wide Risk	Ged Blezard	16	01. BCM in place across Service Delivery areas 02. Access to Occupational Health 03. Organisational Policies and Procedures 04. Alternative Duties 05. HR Business Partnering Team for Advice & Support 06. Military assets are being utilised to support PES and PTS with low acuity calls.	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	01. The military assets are unable to back fill the vacancies by 100% of the current abstractions.	01. Military assests are able to provide a level of support to PES and PTS. 02. Staff abstraction rates have reduced;	01. Waitng confirmation from Heads of Service across Service Delivery	4	31/03/2021	30/03/2021	04/05/2021
3460	17/11/2020	Operational	Infection Protection Control	There is a risk that if IPC COVID-19 measures are not followed, the continued COVID -19 outbreaks across the Service Delivery Directorate may impact on our ability to achieve operational performance standards.	SD - Directorate Wide Risk	Ged Blezard	20	01. NWAS Bulletins 02. NWAS Policies & Procedures 03. NWAS TTT 04. Daily & Weekly Calls with NWAS IPC Team 05. IPC Specialist Nurse Available for Advice & Support 06. IPC Audits 07. Quality Assurance Visits 08. Premises Cleaning 09. COVID-19 Secure Premises 10. COVID19 Premises Risk Assessments 11. COVID-19 Checkpoint Stations 12. Temperature Taking 13. Reduced Access to Contact Centres 14. Utilisation of PPE 15. COVID-19 Testing	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	01. The measurement of staff`s temperature is self policing.	02. There are no reported outbreaks across Service Delivery (29 March 2021); 03. Abstraction rates within PTS reducing 01.IPC Audit results are fed into the following groups: Safety Management Group; Quality & Performance Group; Senior Management Group; IPC Forum and Outbreak Cell.	01. The measurement of staff`s temperature is self policing. 02. There is no record of staff`s temperature or monitoring	4	31/03/2021	30/03/2021	04/05/2021
3466	04/12/2020	Compliance & Regulatory	Patient Safety	There is a risk that there is currently no consistent approach, across the Trust, to the reporting and management of level 1 to 3 internal and external incidents, which will result in missed opportunities for managing identified harm for staff and patients, potentially identifying higher levels of harm, learning and the prevention of reoccurrence.	QII - Safety	Maxine Power	15	All staff are aware of the requirement to report incidents via a (Datix) IRF. All managers are aware of the need to score and investigate all IRFs. All managers are aware of the need to provide an investigation report via Datix.	5	3	15	Treat - Implement controls and mitigating actions to reduce the risk.	Lack of recent trust approved ducumentation to support the requirement to manage level 1-3 internal and external incidents Lack of a clear agreed process for the management of level 1-3 internal and external incidents Lack of clear magerial ownership for the management of level 1-3 internal and external incidents		None recorded.	5	31/03/2021	19/02/2021	19/03/2021

DX ID	Opened	Risk Type	Risk Subtype	Risk Description	Role Type	Lead	Rating (initial)	Key Controls in place	Likelihood (current)	Consequence (current)	Rating (current)	Risk Evaluation	Gaps in controls	Assurance	Gaps In Assurance	Rating (Target)	Forecast Completion Date	Last reviewed	Date of next review
3474	15/12/2020	Compliance & Regulatory	Infection Protection Control	There is a risk the Aerosol Generated Procedure audit 'live ring back' in EOCs will fail because a suitable robust resource has not been identified to continue the audit once the COVID19 cell was disestablished which may result in NWAS not being able to assure the HSE that clinical staff are adequately protected when attending such an incident.	SD - Emergency Operations Centre	Ged Blezard	12	1. Mandatory training team providing skeletal cover in EOCs to undertake the audit. This cover will be withdrawn from 4th January 2021 2.Clinical Audit team lead identified to undertake thematic analysis 3. Alternate duties staff member from EOC training team supporting the live call back through remote access C3 from w/c 1 Feb 2021 until beginning of April 2021. 4. CAL resourced to continue audit 5. CAM resourcing erroneously identified as not available risk reduced back to 12 22/03/2021	4	4	16	Treat - Implement controls and mitigating actions to reduce the risk.	Robust mechanism to ensure live audit data and conversation is captured in each EOC	01. AGP audits to be embedded within `Business as Usual` within EOC audits; 02. Being reviewed by RPE Group;	01. Audits inconsistent across EOCs. 02. Proposal for EOC/CHUB clinician to conduct audits	6	31/05/2020	30/03/2021	04/05/2021
3487		Compliance & Regulatory	Information Governance Risk	There is a risk that the Trust will not meet compliance with the Data Security and Protection Standards for health and care, due to the low compliance with the Mandatory Training Data Security Awareness Module, which may result in non-compliance with regulatory standards	QII - Informatics	Maxine Power	12	01. Data Security Awareness Training Module in MyESR 02. Compliance with Mandatory Training discussed at Local Meetings & IMG 03. Mail Merge completed from MyESR to all non-compliant staff 04. Communication Bulletin	5	3	15	Treat - Implement controls and mitigating actions to reduce the risk.	Lack of awareness of compliance with Data Security Awareness Training Lack of timescales for completion of Mandatory Training across the Trust Monitoring of compliance by Local Managers Operational pressures of the Trust Compliance of 95% for Data Secruity Awareness Training MyESR Notifications	Mandatory Training Compliance Spreadsheets Workforce Indicators Assurance Report to Resources Cttee Information Governance Key Performance Indicators Report to IMG MIAA DSPT Readiness Audit	01. Local Level Mandatory Training Compliance 02. Trust-wide Mandatory Training Compliance 03. Completed MIAA Audit on DSPT	10	30/04/2021	30/03/2021	04/05/2021
3498	12/02/2021	Compliance & Regulatory	Infection Protection Control	There is a risk of staff contracting covid19 because of an inability to maintain social distancing on Westmorland Station due to an increased number of staff on site and lack of space which may result in increased staff sickness and outbreak issues.	SD - Paramedic Emergency Services Operations (Inc. Urgent Care)	Roger Jones	15	1) IPC check point on station entry 2) Supply of masks, wipes and hand gel on site 3) Staff wearing masks on site where 2M distancing cannot be maintained 4) Covid19 signage displayed 5) Covid19 risk assessments reviewed regularly in line with trust requirements 6) Alternative locations agreed with UHMB for PTS staff at Westmorland, Barrow and Ulverston stations to use at FGH, RLI and WGH, open 24/7. 7) Memo issued to PTS staff informing them of new rest facilities issued 23/02/2021. 8) Covid19 vaccination programme for staff.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	1) Lack of available space 2) Availability of staff welfare pods	7) Active covid19 vaccination programme 07) Active covid19 vaccination programme. 08.PTS reviewing availablity of local hospitals for canteen facilities 09. Costings sent to Executive Management Team on provision of `pods` to accomodate staff 1) IPC walkarounds 2) Daily IPC checks 3) Weekly IPC checks 4) Covid19 risk assessments 5) Agreement in place with UHMB Trust to utilise canteen facilities 6) Memo issued to PTS staff 22/02/2021 informing them of canteen facilities available	01. Station is too small for the number of staff being deployed 02. Unable to redeploy staff to other sites due to nature of planned workload or station risk assessment 03. Unable to redeploy to acute location as a suitable location is not available	3	30/06/2021	25/03/2021	25/04/2021

DX ID	Opened	Risk Type	Risk Subtype	Risk Description	Role Type	Lead	Rating (Initial)	Key Controls in place	Likelihood (current)	Consequence (current)	Rating (current)	Risk Evaluation	Gaps in controls	Assurance	Gaps In Assurance	Rating (Target)	Forecast Completion Date	Last reviewed	Date of next review
3502	16/02/2021	Compliance & Regulatory	Information Governance Risk	There is a risk that the trust cannot actively monitor performance or conduct proactive tuning/patching of our underlying data infrastructure/servers, because we currently do not have a DBA (Database Administrator) function within the Trust. This may result in significant service outages and total data loss, which would need to be reported to regulatory bodies.	QII - Informatics	Abigail Harrison	15	Some retrospective corrective actions are completed by informatics, this ensures any failures or patches can be resolved, after the fact	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.		Correctative actions are completed when required, following any outage or patch	None recorded.	5	30/06/2021	31/03/2021	30/04/2021
1181	30/01/2014	Operational	Innovation	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.	QII - IM&T	Maxine Power	20	1. Robust National 999 Network 2. Constantly monitored by National Operator Centre 3. Full Business Continuity plans developed in partnership with all telecom providers. 4. Resilient telephone system and network design including diverse routing. 5. NWAS operate a virtual regional network 6. 24/7 specialist support from NWAS staff and Third party suppliers 7. There is constant liaison with the core provider 999 liaison teams who will monitor and advise of any threat that may interrupt the service. 8. SMT Team meetings to review system updates/ outages 9. Change request process in place and meets weekly as part of a formal CAB 10. A back up voicemail server is being purchased to enable a swap out in the event of failure, greatly reducing downtime. 11.Unified Communications Programme has submitted a business case to replace all telephony and the voicemail solution which will eliminate this risk. 12. Unified Communications Business case approved and work underway.	3	5	15	Treat - Implement controls and mitigating actions to reduce the risk.	Current telephony systems are end of life and are no longer supported by Avaya with only limited support from BT available. Full Business Continuity plans need to be reviewed and tested in partnership with the providers and EOC Avaya are no longer providing any security patching or updates after April 19 The Voicemail server is end of life ,vulnerable to cyber attack and sits on the NWAS LAN, any outages would result in no messages being heard and dropped call rates Due to increased capacity of home workers due to COVID-19 the CISCO infrastructure may exceed capacity	BT providing interim maintenance and support Any system downtime reported to ICT SMT meetings Changes to telephony are strictly monitored and controlled via CAB	01. Report from third party to show preventative maintenance outcome	5	02/11/2020	29/03/2021	30/06/2021

North West Ambulance Service NHS Trust

Appendix 2

Board Assurance Framework 2020/21

Board of Directors
Wednesday 28 April 2021

Q4 2020/21 Reporting Timescales:

Quality & Performance Cttee:	15/03/2021
Resources Cttee:	26/03/2021
Executive Leadership Cttee:	21/04/2021
Audit Cttee:	23/04/2021
Board of Directors:	28/04/2021

Data Extracted from Datix: 31 March 2021

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
DCEO	Deputy Chief Executive
DoQII	Director of Quality Innovation & Improvement
MD	Medical Director
DoF	Director of Finance
DoOps	Director of Operations
DoP	Director of People
DoSP	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 RAG rated assessment of how much progress has been made on the completion of the required action — Incomplete/ Overdue | Action In Progress | Completed Late | Completed on Time

OUR STRATEGY AT A GLANCE

Our vision is to be the best ambulance service in the UK by delivering the right care, at the right time, in the right place; every time.

Values:

- Working Together for Patients
- Commitment to Quality of Care
- Respect and Dignity
- Compassion
- Everyone Counts
- Improving Lives

North West Ambulance Service - Our Strategy 2019 - 2024

Priorities:

Urgent and Emergency Care

Increasing service integration and leading improvements across the healthcare system in the North West.

Quality

Delivering appropriate care, which is safe, effective and patient centered for each individual.

Digital

Radically improving how we meet the needs of patients and staff every time they interact with our digital services.

Business and Commercial Development

Developing skills and capability to explore business opportunities for current and new viable contracts, services or products.

Workforce

Engaging and empowering our leaders and staff to develop, adapt and embrace new ways of delivering the right care.

Stakeholder relationships

Building and strengthening relationships that enable us to achieve our vision.

Infrastructure

Reviewing our estates and fleet to reflect the needs of the future service model.

Environment

Committing to reduce emissions by embracing new technology including electric vehicles.

Supporting strategies:

- Urgent and Emergency Care Strategy
- Quality (Right Care) Strategy
- Digital Strategy
- Finance plan - long term financial model
- Workforce Strategy
- Communications and Engagement Strategy
- Estates and Fleet Strategies

BOARD ASSURANCE FRAMEWORK DASHBOARD 2020/21

BAF Risk	Committee	Exec Lead	01.04.20	Q1	Q2	Q3	Q4	2020/21 Target	Final Target
SR01: If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trusts' compliance with regulatory requirements for quality and safety	**Quality & Performance**	**DoQII**	**15** 5x3 CxL		**15** 5x3 CxL	**15** **5x3** **CxL**	**10** 5x2 CxL	**10** 5x2 CxL	**5** 5x1 CxL
SR02: If we do not have effective financial management, this may impact on the Trusts' financial position	**Resources**	**DoF**	**25** 5x5 CxL		**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL
SR03: If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care	**Quality & Performance**	**DoOps**	**25** 5x5 CxL		**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**5** 5x1 CxL
SR04: If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of the Trusts' objectives	**Resources**	**DoP**	**16** 4x4 CxL		**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL
SR05: If we do not review our estate and fleet to reflect the needs of the future service model and commit to reduce emission, this may impact on the Trusts' infrastructure and achieving environmental efficiencies	**Resources**	**DoF**	**12** 3x4 CxL		**12** 3x4 CxL	**12** 3x4 CxL	**9** 3x3 CxL	**9** 3x3 CxL	**3** 3x1 CxL
SR06: If we do not build and strengthen stakeholder relationships across systems, localities and neighbourhoods, this may impact on the Trusts' reputation and ability to achieve our vision to be the best ambulance service in the UK	**Board of Directors**	**DoSP**	**8** 4x2 CxL		**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**4** 4x1 CxL
SR07: If we do not improve and maintain our digital systems, this may impact on the delivery of secure IT systems and digital transformation	**Resources**	**DoQII**	**12** 4x3 CxL		**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL
SR08: If we do not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the Trusts' ability to compete and gain business and commercial opportunities that will generate income and protect our core services	**Resources**	**DCEO**	**15** 5x3 CxL		**15** 5x3 CxL	**15** 5x3 CxL	**5** 5x1 CxL	**10** 5x2 CxL	**5** 5x1 CxL
SR09: If the organisation experiences further change at Board level during 2020/21, this may impact on relationships and ability to deliver the Trusts' strategic objectives	**Board of Directors**	**CEO**	**12** 4x3 CxL		**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**4** 4x1 CxL
SR10: If the UK Government leaves the EU during the transitionary period with a no deal may impact on our ability to provide the service at the required levels resulting in inflated costs, disruption to supplies and loss of workforce	**Board of Directors**	**DoSP**			**12** 3x4 CxL	**6** 3x2 CxL	**CLOSED**	**6** 3x2 CxL	**3** 3x1 CxL
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	**Board of Directors**	**CEO/ DCEO**	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**5** 5x1 CxL

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR01: If we do not deliver appropriate safe, effective and patient-centred care, this may impact on the Trust's compliance with regulatory requirements for quality and safety

LEAD DIRECTOR: DoQII

Compliance/ Regulatory/ Quality Risk Appetite: Low

STRATEGIC PRIORITY: Quality

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 length of time taken to close high level complaints
- Alternative pathways for mental health patients
- The roll out of the national Child Protection Information Sharing system
- The creation of an implementation plan to embed 'Just Culture' across the organisation

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
15		15	15	10	10	5
5x3		5x3	5x3	5x2	5x2	5x1
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has decreased in risk score to a 10 due to the good progress that has been made during 2020/21 against the identified gaps in controls and assurances surrounding complaints, incident and serious incident reporting, health, safety and security, Infection prevention and control, medicines management, safety and compliance and clinical effectiveness.

CONTROLS	ASSURANCES	EVIDENCE
Incident Reporting		
Level 4 & 5 Incident Scruitiny & Review at ROSE	**Level 2:** Reportable Events Report	Reported to BoD (BOD/2021/114)
Serious Incidents		
NHSE Serious Incident Framework	**Level 2:** ROSE Review of Learning Assurance Report	Reported to Q&P Cttee (Q&PC/2021/221)
Complaints		
Complaint Management	**Level 2:** Complaints Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/10)
Level 4 & 5 Complaint Scuitiny & Review at ROSE	**Level 2:** Reportable Events Report	Reported to BoD (BOD/2021/114)
Health, Safety & Security		
Health and Safety Management	**Level 2:** Health, Safety & Security Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/31)
Working Safely During COVID-19	**Level 2:** COVID-19 Premises Risk Assessments	Reported to Q&P Cttee (Q&PC/2021/102a)
Safeguarding		
Safeguarding Practices & Processes	**Level 2:** Safeguarding Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/37)
Safeguarding Serious Case Reviews	**Level 2:** Reportable Events Report	Reported to BoD (BOD/2021/114)
Infection, Prevention & Control		
NWAS Internal IPC Audits	**Level 2:** IPC Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/32)
NWAS IPC Practices	**Level 2:** IPC Board Assurance Framework	Reported to BoD (BOD/2021/171)
Medicines Management		
Medicine Administration & Management Practices	**Level 3:** MIAA Audit Medicine Management – Events (2019/20)	Reported to Audit Cttee
PGD Medicines Management	**Level 2:** Medicines Management Assurance Report	Reported to Q&P Cttee (Q&PC/2021/173)

Compliance with NICE PGD Guidance	**Level 2:** Medicines Management Assurance Report	Reported to Q&P Cttee (Q&PC/2021/173)			
NWAS Internal Medicines Audits	**Level 2:** Medicines Management & CD Annual Report 2019/20	Reported to Q&P Cttee (Q&PC/2021/34)			
Systems & Governance of Safe and Secure Handling of Medicines	**Level 2:** Medicines Management Assurance Report	Reported to Q&P Cttee (Q&PC/2021/173)			
CD Procurement and Supply	**Level 2:** Medicines Management Assurance Report	Reported to Q&P Cttee (Q&PC/2021/173)			
Safety/ Compliance					
Quality Assurance Visits	**Level 2:** Quality Assurance Visits Assurance Report	Reported to Q&P Cttee (Q&PC/2021/219)			
CQC Action Plan	**Level 2:** CQC Action Plan against 10 'Should Do' Recommendations	Reported to Q&P Cttee (Q&PC/2021/154)			
SafeCheck	**Level 2:** CQC Inspection Action Plan Update	Reported to Q&P Cttee (Q&PC/2021/153)			
Effectiveness					
Major Trauma Care & Enhanced Pre-Hospital Care	**Level 3:** North West Major Trauma Operational Delivery Networks Peer Review	Reported to Q&P Cttee (Q&PC/ 2021/97)			
Timely response to patients to prevent harm	**Level 2:** Implementation of Clinical Co-ordination Desk in EOC	Reported to Q&P Cttee (Q&PC/2021/178)			
Learning from Deaths	**Level 2:** Learning from Deaths Assurance Report	Reported to Q&P Cttee (Q&PC/2021/175)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Complaints					
Timely Closure of high level Complaints	Level 4 & 5 Complaints are closed within timeframe	Ms C Wade	Transfer to 21/22	Q&P Cttee	**Delayed**
Safeguarding					
Rejections of Safeguarding Concerns	Devise and embed alternative pathways for Mental Health patients	Ms D Bullock	Transfer to 21/22	Q&P Cttee	**Delayed**
Child Protection Information Sharing in 999	Roll out of national Child Protection Information Sharing system	Ms D Bullock	Transfer to 21/22	Q&P Cttee	**Delayed**
Effectiveness					
Just Culture Organisation	Creation of an implementation plan to embed 'Just Culture' across the organisation	Dr C Grant Ms L Ward	Transfer to 2021/22	Q&P Cttee	**Delayed**

Risks Scored 15+ Aligned to BAF Risk: SR01					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3062	Service Delivery	There is a risk that 999 call takers fail to identify key words and phrases relating to respiratory calls which could result in the wrong categorisation and/or delay the response leading to detrimental patient care, increase in complaints and reputational damage to the Trust.	**20 Significant**	**15 Significant**	5 Moderate
3243	Quality	There is a risk that social distancing may not be adhered to during the coronavirus pandemic due to staff needing to be less than two meters from the patient or each other and increased numbers of workforce in our working locations which may result in increased transmission of coronavirus.	**20 Significant**	**20 Significant**	4 Moderate
3435	Quality	There is a risk that if the number of Covid related cases and outbreaks continue to rise within the second wave of the pandemic and business continuity plans need to be enacted, the plans may be insufficient and therefore services may be adversely affected which can result in patient harm.	**20 Significant**	**15 Significant**	5 Moderate
3446	Service Delivery	There is a risk that due to the pressures at hospitals across the North West, increased numbers of patients will be held on the back of ambulances leading to excessive delays at hospitals which may result in increased numbers of delayed responses for our patients.	**20 Significant**	**15 Significant**	5 Moderate
3466	Quality	There is a risk that there is currently no consistent approach, across the Trust, to the reporting and management of level 1 to 3 internal and external incidents, which will result in missed opportunities for managing identified harm, potentially identifying higher levels of harm, learning and the prevention of reoccurrence.	**15 Significant**	**15 Significant**	5 Moderate
3474	Service Delivery	There is a risk the Aerosol Generated Procedure audit 'live ring back' in EOCs will fail because a suitable robust resource has not been identified to continue the audit once the COVID19 cell was disestablished which may result in NWAS not being able to assure the HSE that clinical staff are adequately protected when attending such an incident.	12 High	**16 Significant**	6 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR02: If we do not have effective financial management, this may impact on the Trust's financial position	**LEAD DIRECTOR:** DoF	**Financial/ VfM Risk Appetite:** Moderate

STRATEGIC PRIORITY: ALL

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:

- M7-12 Financial Operating Plans

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
25		20	20	15	15	10
5x5		5x4	5x4	5x3	5x3	5x2
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has decreased in risk score to a score of 20 due to the ICS forecasts were agreed both regionally and nationally. The increase in annual leave accrual and shortfall in non-NHS income have been deemed to be allowable gaps against the system funding envelope. Funding for non-NHS income shortfall has been received and 80% of increase in non-NHS accrual has been received on account and will be corrected following year-end accounts. Excluding these items, the year-end position will be break-even.

CONTROLS	ASSURANCES	EVIDENCE
Financial Position		
Financial Management & Performance	**Level 2:** 2020/21 M11Financial Report	Reported to Resources Cttee (RC/2021/116)
Code of Conduct and Accountability	**Level 2:** Standing Financial Instructions, Standing Orders & Scheme of Delegation	Reported to Audit Cttee & BoD
Financial Plans	**Level 2:** 2020/21 Financial Plans for Capital Programmes **Level 2:** M7-12 Finanical Plans	Reported to BoD Reported to Resources Cttee & BoD
Significant Change Project(s)	**Level 2:** Business Cases with Financial Impact	Reported to ELC & CPB
Financial Systems Key Controls	**Level 3:** MIAA Audit Financial Systems Key Controls (2020/21)	Reported to Audit Cttee (AC/2021/114)
Charitable Funds	**Level 3:** MIAA Audit Charitable Funds (2019/20)	Reported to Audit Cttee
2020/21 Cost Improvement Programmes	**Level 2:** Financial Assurance Reports	Reported to Resources Cttee (RC/2021/64/66/68)
M7-12 Financial Operating Plans	**Level 2:** Financial Performance Report	Reported to Resources Cttee (RC/2021/63)
Agency Expenditure		
Internal Monitoring of Agency Costs against 2019/20 NHSI Ceiling	**Level 2:** Financial Performance Report	Reported to Resources Cttee
Procurement		
Procurement Strategy	**Level 2:** Procurement Assurance Report	Reported to Resources Cttee (RC/2021/99)

Risks Scored 15+ Aligned to BAF Risk: SR02					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3433	Finance	There is a risk that NWAS are recruiting staff and committing funds associated to Estates, IMT & support staff structures in relation to NHS 111 First without any agreed recurrent funding in place which may result in NWAS carrying a large financial risk in to 2021/22 and beyond	**16 Significant**	**16 Significant**	4 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR03: If we do not meet national and local operational performance standards through transition to an integrated service model within the funding envelope, this may impact on providing timely patient care

LEAD DIRECTOR: DoOps

Compliance/ Regulation/ Quality Risk Appetite: Low
Financial/ VfM Risk Appetite: Moderate

STRATEGIC PRIORITY: Urgent & Emergency 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:

- Hospital Handover Delays
- NWAS Operating Model
- Post COVID-19 Restrictions

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
25		20	20	15	15	5
5x5		5x4	5x4	5x3	5x3	5x1
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has reduced in risk score to a 15 due to within quarter there has been a significant improvement to patient safety; as well as the minimal number of patients waiting within the stack and improved response times. We are seeing improved performance due to the continued support from PTS and additional support from private ambulance providers. The Trust is currently realigning operational resources to ensure they are effectively and efficiently utilised to maximise usage and continue to improve performance. 111 improvements continue following investment in additional staffing to meet demands from the 111 First programme. Additional call taking capacity has been established at Sefton House. The Trust has launched the new telephony system within the quarter, which will assist in the delivery of performance. The number of COVID-19 abstractions has reduced across 111, due to increased compliance with IPC measures and staff testing. PTS continues to provide support to PES in terms of vehicles and staff, whilst maintaining core PTS business. The PTS Contract has been extended until July 2023, which aligns and collectively joins all service delivery contracts across the Trust.

CONTROLS	ASSURANCES	EVIDENCE
Strategy		
Urgent and Emergency Care Strategy	**Level 2:** Strategy Progress Assurance Report	Reported to Q&P Cttee (Q&PC/ 2021/214)
Performance		
Increased Workforce (PES and NHS 111)	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)
ORH Modelling	**Level 2:** ORH Modelling Report	Reported to Q&P Cttee (Q&PC/ 2021/145)
Utilisation of PTS Workforce & Student Paramedics	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)
Increased Operational Resources	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)
Hospital Handover	**Level 2:** Hospital Handover Report	Reported to Q&P Cttee (Q&PC/ 2021/30)
Enhanced Clinical Stack Management Maximising H&T Outcomes	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/175)
Greater Manchester Clinical Assessment Service	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/175)
Engagement with NHS Providers – Reduction in PTS Aborted Journies	**Level 2:** PTS Performance Assurance Report	Reported to Q&P Cttee (Q&PC/ 2021/176)
Activity		
Contingency Planning	**Level 2:** 2020/21 Heat Wave Plan **Level 2:** 2020/21 Strategic Winter Plan	Reported to Q&P Cttee & BoD (Q&PC/ 2021/144) Reported to Q&P Cttee & BoD (Q&PC/ 2021/128)
NWAS Operating Level	**Level 1:** REAP Level	Reported to ELC (Weekly)
Demand Management Plan	**Level 1:** ELC Performance Reports	Reported to ELC (Weekly)

Mutual Aid Framework	**Level 3:** National Agreement	Reported to ELC/ Q&P Cttee/ BoD			
National Agreement for Protcol 36	**Level 3:** Agreement at NDOG/ NASMED/ AACE	Reported to BoD (PBM/2021/05)			
2020/21 Winter Plan	**Level 2:** Implentation of Trust Strategic Winter Plan 2020/21	Reported to Q&P Cttee (Q&PC/2021/128 and 144)			
Resources					
Increased Operational Resources	**Level 2:** Q&P Cttee Integrated Performance Report	Reported to Q&P Cttee (Q&PC/ 2021/19)			
Utilisation of Private Providers	**Level 2:** Directorate Service Provision Paper	Reported to ELC (ELC/ 2021/04c)			
Commissioner Engagement	**Level 3:** ORH Demand and Capacity Review	Reported to Q&PC Cttee (Q&PC/2021/169) Reported to Res Cttee (RC/2021/88)			
Commissioner Funding to Deliver Performance	**Level 3:** ORH Demand and Capacity Review	Reported to Q&PC Cttee (Q&PC/2021/169)			
Independent Review of Resources	**Level 3:** ORH Demand and Capacity Review	Reported to Q&PC Cttee (Q&PC/2021/145)			
Optima Review	**Level 3:** ORH Demand and Capacity Review	Reported to Q&PC Cttee (Q&PC/2021/145)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Simplify the Resource Model	Undertake a review with AACE to streamline the process	Mr G Blezard	March 2021	Q&P Cttee	Completed
Staff Abstractions due to Track and Trace	Ensure adherance to IPC Standards across the Directorate and utilisation of Private Providers when abstractions are high	Mr G Blezard	March 2021	Q&P Cttee	Completed

Risks Scored 15+ Aligned to BAF Risk: SR03					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
2568	Service Delivery	There is a risk that the response to an MTA outside of the Model Response sites of Liverpool and Manchester may be delayed due to the vast majority of MTA staff (AIT/Cs) being stationed in or around the above areas. This could result in potential delays of triage, treatment and transport in the warm zone of such an incident further afield.	**20 Significant**	**15 Significant**	5 Moderate
3027	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	**20 Significant**	**16 Significant**	4 Moderate
3062	Service Delivery	There is a risk that 999 call takers fail to identify key words and phrases relating to respiratory calls which could result in the wrong categorisation and/or delay the response leading to detrimental patient care, increase in complaints and reputational damage to the Trust.	**20 Significant**	**15 Significant**	5 Moderate
3254	Service Delivery	There is a risk that operational resources will be insufficient to cover demand because of staff taking carried over leave which they were unable to take due to Covid-19 which may result in delayed patient response times and delivery of national ARP standards.	**20 Significant**	**20 Significant**	5 Moderate
3446	Service Delivery	There is a risk that due to the pressures at hospitals across the North West, increased numbers of patients will be held on the back of ambulances leading to excessive delays at hospitals which may result in increased numbers of delayed responses for our patients.	**20 Significant**	**15 Significant**	5 Moderate
3448	Service Delivery	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards	**20 Significant**	**16 Significant**	5 Moderate
3451	Service Delivery	There is a risk that due to COVID-19 restrictions and lockdown arrangements set out by the UK Government, NWAS and partner agencies may miss opportunities to multi-agency exercise local plans which may lead to commanders not fulfilling their National Occupational Standards impacting on our compliance with Statutory Duties.	**20 Significant**	**15 Significant**	5 Moderate
3452	Service Delivery	There is a risk that the existing operating model for NWAS may not be effective due to insufficient workforce resources, vehicles and processes not being place currently which may impact on our ability to achieve our ARP standards.	**25 Significant**	**15 Significant**	5 Moderate
3455	Service Delivery	There is a risk that due to an increase in operational demand and patient acuity across PES, resources will be limited or not available for effective and efficient utilisation across the region which could result in delayed responses to patients.	**20 Significant**	**15 Significant**	5 Moderate
3459	Service Delivery	There is a risk that due to the increasing numbers of staff sickness and abstractions across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	**16 Significant**	**16 Significant**	4 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR04: If we do not have sufficient staff and do not engage, empower and support our workforce to develop, adapt and embrace new ways of developing right care, this may impact on the delivery of the Trust's objectives

LEAD DIRECTOR: DoP

Compliance/ Regulatory/ Quality Risk Appetite: Low

STRATEGIC PRIORITY: Workforce

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:

- Impact of ORH Growth & GP Contract Reform on Paramedic Workforce
- COVID-19
- Manchester Arena Inquiry

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
16		16	16	12	12	8
4x4		4x4	4x4	4x3	4x3	4x2
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has reduced to a score of 12. Q4 has seen a reduction in the impact of staff absences on workforce availability, along with the continued deployment of additional resources across EOC/PES and the mobilisation of 111 First. Recovery arrangements and trajectories are in place for appraisal and mandatory training and student programmes and induction training have been remobilised. Recovery of key culture improvements has commenced with good progress on EDI priorities, values refresh and the culture audit.

CONTROLS	ASSURANCES	EVIDENCE
Strategic		
Workforce Strategy	**Level 2:** 3 Year Implementation Plan/ Bi-Annual Progress Report	Reported to BoD (BoD/2021/52)
COVID-19 Recovery	**Level 2:** Recovery Plan **Level 2:** MIAA Workforce Assurance Self-Assessment	Reported to Resources (RC/2021/16)
National People Plan	**Level 2:** NWAS Implementation Plan & Progress Report	Reported to Resources Cttee (RC/2021/131)
Recruitment and Retention		
Recruitment Inc. Criminal Records & Clinical Registration	**Level 2:** Clinical Registration & Revalidation Assurance Report **Level 3:** MIAA Audit Staff Responders (2019/20) **Level 3:** MIAA Audit Driving Licence Checks (2020/21)	Reported to Resources Cttee (RC/2021/45) Reported to Audit Cttee Reported to Audit Cttee (AC/2021
Safer Staffing Assessment	**Level 2:** Completion of National Safe Staffing Requirements	Reported to Resources Cttee
Staff Retention	**Level 3:** NHSI Retention Plan	Reported to Resources Cttee
Workforce Planning	**Level 2:** Phase 3 Planning Submission **Level 2:** ORH Demand and Capacity Report	Reported to Resources Cttee (RC/2021/51) Reported to Resources Cttee (RC/2021/88)
Developing Potential		
Mandatory Training & Appraisals	**Level 2:** Workforce Indicators Report **Level 2:** Integrated Performance Report **Level 2:** Developing Potential Annual Report	Reported to Resources Cttee (RC/2021/126) Reported to BoD (BOD/2021/75) Reported to Resources Cttee (RC/2021/77)
CQC Action Plan for Mandatory Training & Appraisals	**Level 2:** CQC Workforce Action Plan Assurance Report	Reported Resources Cttee (RC/2021/126)
Perceptorships	**Level 2:** Clinical Education Assurance Report **Level 3:** MIAA Audit Newly Qualified Paramedics (2019/20)	Reported to Resources Cttee (RC/2021/129)R0 Reported to Audit Cttee & Resources Cttee
Apprenticeships	**Level 2:** Clinical Education Assurance Report **Level 2:** Apprenticeship Annual Report **Level 3:** OFSTED Inspection **Level 3:** Accredited on Register of Apprenticeship Training Providers **Level 3:** Future Quals Accredition	Reported to Resources Cttee (RC/2021/129) Reported to Resources Cttee (RC/ 2021/76) Reported to Resources Cttee & BoD

Wellbeing		
Absence Management	**Level 2:** Workforce Indicators Report & Quarterly Sickness Audits **Level 3:** NHSI Action Plan	Reported to Resources Cttee (RC/2021/126) Reported to Audit Cttee
Staff Survey Action Plan	**Level 2:** Localised Engagement Plan **Level 3:** Staff Survey 2020 Review & Findings Assurance Report	Reported to Resources Cttee (RC/2021/42) Reported to Resources Cttee (RC/2021/127)
Health & Wellbeing Initiatives	**Level 2:** Workforce Inidicators Assurance Report **Level 2:** Risk Assessments **Level 2:** Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2021/126) Reported to BoD (BoD/2021/27) Reported to Resources Cttee (RC/2021/79)
NHSI Health & Wellbeing Diagnostic Tool	**Level 2:** Completed Diagnostic Self-Assessment	Reported to Resources Cttee/ NHSI
2020/21 Flu Vaccination Programme	**Level 2:** Flu Assurance Report **Level 2:** Publication of National Best Practice Checklist **Level 2:** Workforce Indicators Report	Reported to Resources Cttee (RC/2021/43) Reported to BoD (BOD/2021/75) Reported to Resources Cttee (RC/2021/126)
Zeal Culture Audits	**Level 2:** Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2021/79)
COVID-19 Vaccination Programme	**Level 2:** COVID Vaccination Assurance Report **Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/ 2021/102) Reported to Resources Cttee (RC/ 2021/126)
COVID-19 Wellbeing support	**Level 2:** Workforce Wellbeing Provision During COVID-19	Reported to Board (BoD/ 2021/27)
Inclusion		
WRES & WDES Measures	**Level 2:** Annual WRES & WDES Reports & Action Plans **Level 2:** EDI Annual Report **Level 3:** Employed Network for Equality & Inclusion Silver Award	Reported to Resources Cttee (RC/2021/44) Reported to BoD (BOD/2021/75)
Gender Pay Gap (Improved Position for 2020)	**Level 2:** Monitoring & Reporting of Action Plan **Level 3:** NW HPMA Award for 'We Look After Our Talent'	Reported to Resources Cttee (RC/2021/44) Reported to BoD (BOD/2021/75)
Equality & Diversity System Assessment 2	**Level 2:** Completed Self-Assessment & External/ Staff Assessment **Level 2:** Annual Equality & Diversity Plan	Reported to Resources Cttee (RC/2021/19) Reported to BoD (BOD/2021/50)
Staff Networks & Exec Champions	**Level 2:** Infrastructure for Networks	Reported to ELC
Reservists	**Level 3:** Gold Standard Accredition Recognition	Reported to Resources Cttee & BoD
Ethinic Minorities Risk Assessments	**Level 2:** Workforce Indicators Assurance Report **Level 2**: Risk Assessment Process	Reported to Resources Cttee (RC/2021/75) Reported to Board (BoD/ 2021/27)
Leadership		
Board Succession Planning	**Level 2:** Shadow Board Development Plan	Reported to Resources Cttee
Talent Management Tool	**Level 3:** NW HPMA Award for 'We Look After Our Talent'	Reported to Resources Cttee & BoD
Leadership Framework Inc. Recruitment & Induction	**Level 2:** Leadership Assurance Paper **Level 3:** CMI Accredited Centre	Reported to Resources Cttee & BoD
Organisational Values Project	**Level 3:** External Organisation Leading on Project	Board Development Session
Organisational Values Refresh	**Level 2:** NWAS Values Refresh Assurance Report	Reported to ELC & BoD (BOD/2021/111)
Improvement and Innovation		

Policy Framework	**Level 2:** Policy Progress Assurance Report **Level 3:** Partnership Agreement Review with ACAS	Reported to BoD (BOD/2021/66) Reported to Resources Cttee & BoD			
Projects & Programmes Inc. Rota Review & Rotational Working	**Level 2:** Project Progress Reports Inc. POC & PID **Level 3:** Funding Approved by HEE	Reported to CPB			
HR & Financial Systems	**Level 3:** MIAA Audit ESR (HR/ Payroll Interface) (2018/19)	Reported to Audit Cttee			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
NQP Audit Recommendations	Delivery of Recommended Actions in NQP Audit	Ms L Ward	March 2021	Resources Cttee	Completed
Freedom to Speak Up	Complete actions identified by MIAA Internal Audit	Ms L Ward Ms A Wetton	Transfer to 21/22	Resources Cttee	**Delayed**
Zeal Outstanding Culture	Delivery of Zeal Outstanding Culture Project through to Action Plan	Ms L Ward	Transfer to 21/22	Resources Cttee	**Delayed**
HR Financial Systems	MIAA Internal Audit – HR/Payroll Systems (Q4)	Ms L Ward	Transfer to 21/22	Audit Cttee	**Delayed**
Policy Group	Mobilisation of the Policy Group during Q4	Ms L Ward	March 2021	Resources Cttee	Completed

Risks Scored 15+ Aligned to BAF Risk: SR04					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3027	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	**20 Significant**	**16 Significant**	4 Moderate
3243	Quality	There is a risk that social distancing may not be adhered to during the coronavirus pandemic due to staff needing to be less than two meters from the patient or each other and increased numbers of workforce in our working locations which may result in increased transmission of coronavirus.	**20 Significant**	**20 Significant**	4 Moderate
3320	People	There is a risk that the reduction in hearings will lead to conduct or capability matters not being effectively dealt with leading to impact on patient care.	**20 Significant**	**15 Significant**	5 Moderate
3447	Service Delivery	There is a risk that due to increasing operational demands and call volumes across NWAS, the health and wellbeing of our workforce may deteriorate leading to sickness and absenteeism which may impact on staff safety.	**16 Significant**	**16 Significant**	4 Moderate
3448	Service Delivery	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	**20 Significant**	**16 Significant**	5 Moderate
3449	Service Delivery	There is a risk that due to the current operational demand, appraisals, mandatory training and other workforce activities may be paused which may impact on the competency of our staff.	**20 Significant**	**20 Significant**	5 Moderate
3450	Service Delivery	There is a risk that due to an increase in operational demand, completion of clinical supervision may not be completed to the required frequency which may impact on the competency of our staff.	**20 Significant**	**15 Significant**	5 Moderate
3452	Service Delivery	There is a risk that the existing operating model for NWAS may not be effective due to insufficient workforce resources, vehicles and processes not being place currently which may impact on our ability to achieve our ARP standards.	**25 Significant**	**15 Significant**	5 Moderate
3459	Service Delivery	There is a risk that due to the increasing numbers of staff sickness and abstractions across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	**16 Significant**	**16 Signficant**	4 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR05: If we do not review our estate and fleet to reflect the needs of the future service model and commit to reduce emission, this may impact on the Trust's infrastructure and achieving environmental efficiencies

LEAD DIRECTOR: DoF

Compliance/ Regulatory Risk Appetite: Low
Financial/ VfM Risk Appetite: Moderate

STRATEGIC PRIORITY: Environment & Infrastructure

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:

- National Restraints on Capital Funding
- Capacity to Deliver the Estate Strategy
- Interdependencies between Work Streams
- Climate Change

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
12		12	12	9	9	3
3x4		3x4	3x4	3x3	3x3	3x1
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has reduced to a score of 9 due to the completed review of the estate in terms of backlog maintenance, this will inform prioritisation of capital schemes to undertake remedial works across the Trust. Compliance within the estate is monitored and reviewed using a Statutory Compliance Audit Tool. ORH modelling has been captured within the internal Optima system and will be used to assess the impact on performance of future identified locations. Several Hub and Spoke developments have been initiated with progress being reported to the Resources Cttee. The fleet profile from ORH modelling reviewed will be used to inform future replacement programmes. The Trust has been actively involved, and a key ambulance lead, with both NHSI ERIC and NHSI Ambulance Teams to develop ERIC and the model ambulance; the data has been completed and submitted to NHSI.

CONTROLS	ASSURANCES	EVIDENCE
Strategic		
Estate & Fleet Strategies	**Level 2:** Strategy Progress Assurance Report **Level 2:** Estate Strategy Review	Reported to Resources Cttee & BoD (2018/19) Reported to Resources Cttee (RC/ 2021/72)
Estates		
Estate Maintenance	**Level 2:** Estate & Fleet Assurance Report **Level 3:** Oakleaf completed Facet Surveys (2020)	Reported to Resources Cttee (RC/2021/123) Reported to Resources Cttee (RC/ 2021/74)
Estate Performance Measurement & Benchmarking	**Level 3:** DHSC Annual Estates Returns Information Collection (ERIC)	Reported to Resources Cttee
Green Plan (Review in 2021)	**Level 2:** Delivering Green Plan Assurance Report **Level 2:** Green Plan Annual Report **Level 2:** SDAT Submissions	Reported to Resources Cttee (RC/2021/124)
Funding Committed Expenditure (Exisiting Captial Programme)	**Level 2:** 2020/21 Captial Programme & Costings	Reported to Resources Cttee
Estate Business Cases Fully Implemented to enable Strategy	**Level 2:** Annual Capital Receipts for Re-Investment	Reported to ELC/ Resources Cttee
Joint Partnerships with Services in line with Estates Strategy	**Level 2:** Joint Partnership Agreements for Estates	Reported to Resources Cttee & BoD
Management of Clinical Waste	**Level 2:** Waste Assurance Report	Reported to Resources Cttee
New Buildings Designed to Comply with Green Plan & NHS Delivering a Net Zero Health Service	**Level 3:** Energy Performance of Estate	Reported to Resources Cttee
Detailed Plan for Ongoing Estate Maintenance	**Level 2:** Backlog Maintenance Log for Exisiting Estate and 5 year plan	Reported to Nov Resources Cttee (RC/2021/74) Approved by BoD (BOD/2021/95)
Fleet		
Fleet Maintenance	**Level 2:** Fleet Assurance Report	Reported to Resources Cttee
Vehicle Replacement Programmes & National Ambulance Spec.	**Level 2:** National Procurement of DCA Report **Level 2:** Vehicle Replacement Programme 2020/21	Reported to Resources Cttee (RC/ 2021/69)

	Level 2: Major Incident Vehicle Replacement Programme 21/22	Reported to Resources Cttee (RC/ 2021/70)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Operational Requirements to Reflect Estate based on ORH Modelling	To Map and Develop Estate based upon ORH Modelling to assure ARP Provides Prime Focus	Ms C Wood	March 2021	Resources Cttee	Completed
Operational Requirements to Reflect Fleet based on ORH Modelling	To Map and Develop Fleet profiles based upon ORH Modelling to assure peak fleet requirements	Ms C Wood	March 2021	Resources Cttee	Completed
Utilisation of Model Ambulance	NWAS Contribution to NHSI Working Measures to Deliver Model Ambulance	Ms C Wood	March 2021	Resources Cttee	Completed

Risks Scored 15+ Aligned to BAF Risk: SR05					
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3376	Finance	There is risk if the Trust does not effectively prepare for the renewal/award of the PTS contracts across the trust in July 2021 this could result in an estate which does not adequately support service delivery.	**20 Significant**	**16 Significant**	8 High
3452	Service Delivery	There is a risk that the existing operating model for NWAS may not be effective due to insufficient workforce resources, vehicles and processes not being place currently which may impact on our ability to achieve our ARP standards.	**25 Significant**	**15 Significant**	5 Moderate

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR06: If we do not build and strengthen relationships across systems, localities and neighbourhoods, this may impact on the Trust's reputation and ability to achieve our vision to be the best ambulance service in the UK	**LEAD DIRECTOR:** DoSP	**Reputation Risk Appetite:** Moderate

STRATEGIC PRIORITY: Stakeholder Relationships

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:

- System Integration and Partnership Structure Implementation
- Manchester Arena Inquiry

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
8		12	12	12	8	4
4x2		4x3	4x3	4x3	4x2	4x1
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has remained at a 12 due to stakeholder relationships not being renewed because of COVID-19 and the Manchester Arena Inquiry which commenced on 07 September 2020 which will look into the emergency services response from January 2021 onwards and specifically the actions of NWAS. We have seen a number of significant headline since the start of the Inquiry across both digital and broadcast media. The implementation of the new Partnership Integration structure is now scheduled for completion by the start of May 2021. Successful candidates are expected to commence, by 01 August 2021.

CONTROLS	ASSURANCES	EVIDENCE
Stakeholder Relationships		
Representation and attendance at key meetings	**Level 2:** Stakeholder Engagement Assurance Reports	Reported to BoD
Designated Excecutive Lead for each ICS/ STP footprints	**Level 2:** Executive Director Portfolio Reviews	Reported to BoD
Sharing Intelligence	**Level 2:** Stakeholder Engagement Assurance Report	Reported to BoD
Changes to Commissioning Landscape	**Level 2:** Optima Utilisation to establish collective impact	Reported to BoD
Information Sharing across Key Partners	**Level 2:** Reconfiguration Matrix	Reported to SPB/ ELC
Nominated Senior Manager Leads	**Level 2:** Service Development Team Restructure Paper	Report to ELC (ELC/ 2021/204)
Reputation		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Development Team	Implementation of agreed Structure	Mr S Desai	Transfer to 2021/22	Resources Cttee	Delayed
Stakeholder & Relationships Assurance Report	Bi-annual Assurance Reporting to Board of Directors	Mr S Desai	Transfer to 2021/22	Board of Directors	Delayed

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 2020/21

BAF RISK SR07: If we do not improve and maintain our digital systems, this may impact on the delivery of secure IT systems and digital transformation

LEAD DIRECTOR: DoQII

Innovation Risk Appetite: Moderate

STRATEGIC PRIORITY: Digital

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:

- Critical Telephone Systems Require Replacing
- Robust Asset Ownership of Hardware and Software; Including IAO Training and Full Risk and Renewal Road Map
- Unsupported Software & Hardware (Inc. 2008 Servers)
- Understanding and Management of Data Consumption
- Resilience of On Call Service for Specialist Support
- Multiple high impact changes to critical systems being undertaken simultaneously

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
12		12	12	12	12	8
4x3		4x3	4x3	4x3	4x3	4x2
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has remained at a score of 12 as progress continues to be made and the EPR implementation is going well, the Critical Telephony System requires replacement and the Unified Communications Programme is experiencing delays caused by third party issues and complexity of deliver across the NAA. Multiple critical system transformation programmes continue simultaneously with continued roll out of EPR, increasing call taking capacity for 111 First, the telephony replacement, ESMCP and Body Worn Cameras. Asset ownership meetings have been difficult to progress due to the pressure operational teams are experiencing although the digital asset register is in place. System resilience measures are being monitored frequently, progress has been made in replacing unsupported hardware and software and the desktop replacement is almost complete to ensure we have a fully supported environment. IT health dashboard is operational with real time monitoring. Work to implement the DSPT as standard practice and implementation of a data consumption monitoring tool which will enable policy development.

CONTROLS	ASSURANCES	EVIDENCE
Leadership & Governance		
Interdependancies and Prioritisation	**Level 2:** Interdependancies Review of Large Scale Digital Programmes	Reported to Corporate Programme Board
Governance Structures	**Level 2:** Terms of Reference for CPB and DOF	Reported to Resources Cttee
Digital Strategy	**Level 2:** Digital Strategy Review	Reported to Resources Cttee (RC/2021/134)
Digital First Culture/ Solving Everyday Problems		
Digital Design Forum	**Level 1:** Digital Strategy Assurance Report	Reported to Corporate Programme Board & Resources Cttee
Electronic Patient Record Project Plan	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/133)
Clinical Leadership; Chief Clinical Information Officer & Heads of Clinical Digital Innovation	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/47)
Measurement of Digital Culture and Confidence	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/103)
Data Consumption	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/103)
Connectivity	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/103)
Secure & Joined Up Systems		
Prioritisation of Unsupported Critical Systems	**Level 2:** Critical Systems Recovery Plan	Reported to Resources Cttee (RC/2021/47)
Supported Environment	**Level 2:** Agreed Microsoft Email Licensing	Reported to Board of Directors
Asset Management	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2021/133)

Remote Access & Management to NWAS Digital Systems	**Level 3:** MIAA Audit 3rd Party Remote Access & Mngmt (2019/20)	Reported to Audit Cttee			
Information Asset Owner Training Data Security and Protection Toolkit	**Level 2:** Digital Strategy Assurance Report **Level 3:** MIAA Audit Data Security and Protection Toolkit (2019/20)	Reported to Resources Cttee (RC/2021/ Reported to Audit Cttee			
External Penetration Testing and Social Engineering	**Level 3:** External Audit Report	Reported to IG Management Group			
Digital Asset Register	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/81&103)			
Clinical Safety Risk Assessments for Digital Systems	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/81&103)			
System Resilience, Continutity and User Privileges	**Level 3:** MIAA Audit (2020/21)	Reported to Audit Cttee (AC/ 2021/114)			
Quarterly System Resilience and Failover Tests	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2021/133)			
Critical System Transformation					
Unified Communications Programme; Business Case, PID & Plan	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee			
Supported CAD Infrastructure	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/133)			
NAA Review of CAD Replacement	**Level 2:** NAA Feasibility Study	Reported to Resources Cttee (RC/2021/47)			
SPMS Programme	**Level 2:** Digital Strategy Assurance Report **Level 3:** SPMS External Review	Reported to Resources Cttee (RC/2021/133)			
Technical Project Support	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/133)			
System Resilience	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2021/133)			
Multiple Large Scale Critical Systems Changing Simultaneously	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/81&103&133)			
Management of Interdependancies	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2021/133)			
Smarter Decisions					
999 Data Warehouse	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/133)			
Power BI	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/133)			
Digital Pioneers					
Safecheck	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/133)			
Intellectual Property Agreement for SafeCheck	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2021/81&103)			
Gaps in Controls/ Assurances	**Required Action**	**Action Lead**	**Target Completion**	**Monitoring**	**Progress**
Digital First Culture/ Solving Everyday Problems					
Ambulance Station Infrastructure	Secure funding and implementation of upgrades	Ms A Harrison	March 2021	Resources Cttee	In Progress
Secure & Joined Up Systems					

End of Life Telephony	Implementation of Unified Communications Programme, including firewall replacement	Ms A Harrison	Transfer to 2021/22	Resources Cttee	**Delayed**
Alignment of RA Function	Reviwew of current functionality and proposal aligned to 2021/22 Digital Structures	Ms A Harrison	Transfer to 2021/22	ELC	**Delayed**
DSPT – Information Security Mandatory Training Uptake	Implemetation of Action Plan with OD; 100% criteria met for DSPT	Ms A Harrison	March 2021	Resources Cttee	In Progress
Full 24/7 Support Service	Review of On Call and Support Model Consideration of 24/7 Support Model	Ms A Harrison	Transfer to 2021/22	Resources Cttee	**Delayed**
Smarter Decisions					
Lack of Data Quality Function	Review requirements for Data Quality Create proposal and secure funding	Ms A Harrison	Transfer to 2021/22	Resources Cttee	**Delayed**
Power BI Roadmap	Agreement of priorities with CPB and develop warehouse roadmap and implement	Ms A Harrison	March 2021	Resources Cttee	In Progress
Digital Pioneers					
Development Team	Recruitment to roles and set up team & Secure funding for 2021/22	Ms A Harrison	Transfer to 2021/22	Resources Cttee	**Delayed**
Digital Maturity Assessment & Benchmarking	Work with NAA to agree approach	Ms A Harrison	March 2021	Resources Cttee	In Progress

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
2867	Quality	There is a risk of oversight or system issues, due to a high number of high impact projects linked to critical systems being delivered simultaneously, which could result in system failures.	**16 Significant**	**16 Significant**	8 High
3487	Quality	There is a risk that the Trust will not meet compliance with the Data Security and Protection Standards for health and care, due to the low compliance with the Mandatory Training Data Security Awareness Module, which may result in non-compliance with regulatory standards.	12 High	**15 Significant**	3 Low

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR08: If we do not develop skills, capabilities and capacity to explore business opportunities for current and new contracts, services or products, this may impact on the Trust's ability to compete and gain business and commercial opportunities that will generate income and protect our core services

LEAD DIRECTOR: DCEO

Financial/ VfM Risk Appetite: Moderate

STRATEGIC PRIORITY:
Business and Commercial Developments

FOIA Exemption: Section 43

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:

- None Identified

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
15		15	15	5	10	5
5x3		5x3	5x3	5x1	5x2	5x1
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has reduced in risk score to a 5 due to the four PTS contracts having been negotiated with Commissioners and subsequently extended until 2023. In addition, the uncertainty surrounding the 111 First programme has been resolved and the Trust received funding in November 2020.

CONTROLS	ASSURANCES	EVIDENCE
NHS 111 Contract Extension & Funding from 01 October 2020	**Level 3:** Commissioners NHS 111 Contract Extension	Reported to BoD (BOD/2021/49)
PTS Contract Options	**Level 2:** PTS Contract Position	Reported to BoD (BOD/2021/96)
PES Contract Negotiations	**Level 3**: Commissioners PES Contract Extension	Reported to BoD
Resourcing for NHS 111 First	**Level 2:** Launch of NHS 111 First - Live on 12th January 2021	Reported to BoD (BOD/2021/121)

Risks Scored 15+ Aligned to BAF Risk: SR08					
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Target Score
There are no risks scored 15+ on the Corporate Risk Register that are aligned to this BAF risk					

BOARD ASSURANCE FRAMEWORK 2020/21

BAF RISK SR09: If the organisation experiences further change at Board level during 2020/21 it may impact on relationships and ability to deliver the Trust's strategic objectives	**LEAD DIRECTOR:** CEO	**Compliance/ Regulatory Risk Appetite:** Low **Reputation Risk Appetite:** Moderate

STRATEGIC PRIORITY: Workforce

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:

- Independent Well-Led Review
- Board of Directors Development

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
12		12	12	12	8	4
4x3		4x3	4x3	4x3	4x2	4x1
CxL		CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has remained at a score of 12 due to the small number of the Board of Directors leaving the organisation at the end of the financial year, it is recognised that changes at Board level can impact on Board cohesion and effectiveness, whilst new Directors become familiar with th operation of the Trust. Recruitment has taken place to fill all the Non-Executive Director roles and there is an improved increase in BME representation at Trust Board level.

CONTROLS	ASSURANCES	EVIDENCE
Fit and Proper Persons	**Level 3:** MIAA Audit Fit & Proper Persons (2019/20)	Reported to Audit Cttee
Board Development	**Level 2:** 2020/21 Board Development Programme	Reported to BoD
Independent Well-Led Review	**Level 3:** Deloitte Well-Led Review	Reported to BoD

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Executive Induction Programme	Devise an Executive Induction Programme for new Executives	DCEO	Transfer to 21/22	BoD	Delayed
Executive Team Development	Devise a programme for development opportunities for Executives	CEO	Transfer to 21/22	BoD	Delayed
Non-Executive Director Development	Devise a programme for development opportunities for NEDs	Chairman	Transfer to 21/22	BoD	Delayed
Actions from the Independent Well-Led Review	Delivery of actions identified following the Deloitte Well Led Review	Ms A Wetton	Transfer to 21/22	BoD	Delayed

Risks Scored 15+ Aligned to BAF Risk: SR09					
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 2020/21

BAF RISK 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	**LEAD DIRECTOR:** CEO/ DCEO	**Compliance/ Regulatory/ Quality Risk Appetite:** Low

STRATEGIC PRIORITY: ALL

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:

- National COVID-19 Restrictions
- Post National COVID-19 Restrictions
- Localised COVID-19 Outbreaks

RISK SCORE:

01.04.20	Q1	Q2	Q3	Q4	20/21 Target	Final Target
20	15	15	15	15	10	5
5x4	5x3	5x3	5x3	5x3	5x2	5x1
CxL	CxL	CxL	CxL	CxL	CxL	CxL

RATIONALE FOR CURRENT RISK SCORE:
The risk score for this BAF risk at the end of Q4 has remained at a score of 15 due to the ongoing National Restrictions for COVID-19 and the wider impact on the organisation once restrictions are eased. There is a risk surrounding the unknown impact on COVID-19 and the associated impact this may have on the organisation. However, the COVID-19 Vaccination Programme has been a success and continued engagement work is being undertaken to increase the vaccination uptake across the Trust. Staff testing across the organisation is ongoing, with the encouragement of staff to complete Lateral Flow or LAMP testing twice weekly. The organisation has reduced from REAP 4 to REAP 2. The support from the military ended during March 2021 and the ELC have approved the Winter Surge Plan for 2021.

CONTROLS	ASSURANCES	EVIDENCE
Regulatory Compliance/ Safety		
COVID-19 Incident Management	**Level 2:** Directorate Service Provision Paper	Reported to ELC (ELC/ 2021/04c)
COVID-19 Infection Prevention Control Practices	**Level 2:** PPE for Cardiac Arrest Paper	Reported to ELC (ELC/ 2021/20)
Staff Testing Inc. Swab & Antibody	**Level 2:** COVID-19 Staff Testing	Reported to ELC (ELC/ 2021/135c)
Additional Third Party Provider Inspections	**Level 2:** Directorate Service Provision Paper	Reported to ELC (ELC/ 2021/04c)
IPC & Social Distancing Guidance	**Level 2:** NWAS Stations IPC Guidance & Social Distancing Paper	Reported to ELC (ELC/ 2021/95c)
Patient Safety/ Clinical		
Single Regional Trauma Cell & Dispatch Senior Clinician Role	**Level 2**: Trauma Cell Reconfiguration & Dispatch Paper	Reported to ELC (ELC/ 2021/12)
Self Care Pathways used by Pathfinder Qualified EMT1s	**Level 2:** EMT1 SCP Use Paper	Reported to ELC (ELC/ 2021/13)
Implementation of Early Recognition of Futile Resuscitation in EOCs	**Level 2:** Early Recognition of Futile Resuscitation Paper	Reported to ELC (ELC/ 2021/14)
Move to JRCALC Clinical Guidelines for Cardiac Arrests	**Level 2:** JRCALC Resuscitation Guidelines Paper	Reported to ELC (ELC/ 2021/15)
Closure of Uncontacted 'Elective Testing' COVID-19 Incidents	**Level 2:** COVID-19 Testing/ Swabbing Calls in ADASTRA Paper	Reported to ELC (ELC/ 2021/16)
Temporary Stand Down of GoodSAM Responders	**Level 2:** GoodSAM Temporary Stand Down within the NW Paper	Reported to ELC (ELC/ 2021/17)
Purchase Mechanical CPR Devices	**Level 2:** Mechanical CPR Devices Paper	Reported to ELC (ELC/ 2021/18)
Unchanged Auto-Allocation & PDA Process for 999 calls	**Level 2:** Auto Allocation and PDA Paper	Reported to ELC (ELC/ 2021/19)
Implementation of Card 36 Protocol	**Level 2:** MPDS Protocol 36 Monthly Assurance Paper	Reported to ELC (ELC/ 2021/58d)
Finance, Fleet & Logistics		

PPE and Safety Equipment Installation of Screens in Contact Centres	**Level 2:** PPE and Safety Equipment Paper **Level 2:** Supply and Installation of Plastic Screens Paper	Reported to ELC 9ELC/ 2021/79c) Reported to ELC (ELC/ 2021/75e)
Emergency Budget	**Level 2:** 2020/21 Emergency Financial Plan	Reported to BoD (BoD/ 2021/28)
Recovery of M1 COVID-19 Costs	**Level 2:** Month 1 Financial Position Paper	Reported to BoD (BoD/ 2021/27)
PTS Vehicle Conversions	**Level 2:** COVID-19 PTS Vehicle Conversions Assurance Paper	Reported to ELC (ELC/ 2021/114e)
Increased Capacity for Additional Call Takers	**Level 2:** Estate Reconfiguration Paper	Reported to ELC (ELC/ 2021/ 88)
Working Safely During COVID-19	**Level 2:** COVID-19 Premise Planning Recovery Paper	Reported to ELC (ELC/ 2021/ 161f)
Operations		
Increased Operational Resources (Inc. Emergency Ambulances)	**Level 2:** Weekly Performance Reports (ELC)	Reported to ELC (ELC/ 2021/04a)
Increased Call Taking Capacity in Contact Centres	**Level 2:** COVID-19 Workforce & Wellbeing Update	Reported to ELC (ELC/ 2021/04b)
PTS supporting PES Operations	**Level 2:** PTS Assisting Emergency Service Paper	Reported to BoD (BoD/ 2021/15)
Increased Utilisation of Third Party Providers & Taxi Providers	**Level 2:** Operational Response Paper	Reported to ELC (ELC/ 2021/75a)
Responding to the Pandemic	**Level 2:** Strategic Winter Plan 2020/21	Reported to Q&P Cttee (Q&PC/144) Approved by BoD (BOD/2021/97)
Workforce & Wellbeing		
Increased Workforce Capacity Inc. Returners	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Utilisation of University Students & Associated Training	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Introduction of Family Liaison Officers & Action Cards	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Upskilling Training Programmes	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Staff Risk Assessments Inc. BME	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Homeworking Arrangements Inc. Clinical and Corporate Staff	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
National Agreement on Terms and Conditions	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Q1 Annual Leave Buy Back Scheme	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Break in Learning for Apprenticeships	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Health and Wellbeing Initatives Inc. Mental Health & Financial	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Trade Union Engagements	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
National Social Partnership Forum Agreement: Ceasing Hearings & Investigations	**Level 2:** Workforce Update Assurance Report	Reported to BoD (BoD/ 2021/27)
Communications & Engagement		

COVID-19 Communications Inc. Engagement with Stakeholders	**Level 2:** COVID-19 Communciations Plan	Reported to ELC (ELC/ 2021/037h)
Digital		
Review of Projects	**Level 2:** Project Prioritisation During COVID-19 Activity Report	Reported to ELC (ELC/ 2020/50)
BCP/ Restoration of Normality		
NWAS COVID-19 Recovery Briefing Document	**Level 2:** Restoration Plan Framework	Reported to BoD (BoD/2021/13)
Recovery		
Staff Testing	**Level 2:** Roll out of Lateral Flow Testing for Staff	Reported to Q&P Cttee (Q&PC/2021/170)
COVID-19 Vaccination	**Level 2:** Staff COVID-19 Vaccination Programme & Hub	Reported to Resources Cttee (RC/2021/102) Reported to BoD (BOD/2021/132)
Assurance Checklist		
MIAA Financial Governance Checklist	**Level 2:** COVID-19 Financial Governance Checklist	Reported to Audit Cttee (AC/2021/24)
MIAA Governance Checklist	**Level 2:** COVID-19 Strategic Governance Checklist	Reported to Audit Cttee (AC/2021/29)
MIAA Risk Management Checklist	**Level 2:** COVID-19 RM Adapting & Responding Checklist	Reported to Audit Cttee (AC/2021/63)
MIAA Gifts and Hospitality Checklist	**Level 2:** COVID-19 Gifts & Hospitality Checklist	Reported to Audit Cttee (AC/2021/68)
MIAA Procurement Checklist	**Level 2:** COVID-19 Procurement Checklist	Reported to Audit Cttee (AC/2021/94)
MIAA Data Protection Checklist	**Level 2:** COVID-19 Data Protection Checklist	Reported to Audit Cttee (AC/2021/97)
MIAA COVID-19 Checklist – NAO Guidance	**Level 2:** COVID-19 NAO Guidance	Reported to Audit Cttee (AC/2021/117)

Risks Scored 15+ Aligned to BAF Risk: SR11					
RISK ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Target Score**
3254	Service Delivery	There is a risk that operational resources will be insufficient to cover demand because of staff taking carried over leave which they were unable to take due to Covid-19 which may result in delayed patient response times and delivery of national ARP standards.	**20 Significant**	**20 Significant**	5 Moderate
3435	Quality	There is a risk that if the number of Covid related cases and outbreaks continue to rise within the second wave of the pandemic and business continuity plans need to be enacted, the plans may be insufficient and therefore services may be adversely affected which can result in patient harm.	**20 Significant**	**15 Significant**	5 Moderate

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Appendix 03:
Board Assurance Framework (BAF) 2020/21 Heat Maps

NHS North West Ambulance Service NHS Trust

2020/21 Opening BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	SR01, SR08 — 15	SR11 — 20	SR02, SR03 — 25
4 Major	4	SR06 — 8	SR07, SR09 — 12	SR04 — 16	20
3 Moderate	3	6	9	SR05 — 12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 02 July 2020

Likelihood

Q1 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	SR11 — 15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 02 July 2020

Likelihood

Q2 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	SR01, SR08, SR11 — 15	SR02, SR03 — 20	25
4 Major	4	8	SR07, SR09, SR06 — 12	SR04 — 16	20
3 Moderate	3	6	9	SR05, SR10 — 12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 08 October 2020

Likelihood

Q3 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	SR01, SR08, SR11 — 15	SR02, SR03 — 20	25
4 Major	4	8	SR07, SR09, SR06 — 12	SR04 — 16	20
3 Moderate	3	SR10 — 6	9	SR05 — 12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 14 January 2021

Likelihood

Q4 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	SR08 — 5	SR01 — 10	SR02, SR03, SR09, SR11 — 15	20	25
4 Major	4	8	SR04, SR06, SR07, SR09 — 12	16	20
3 Moderate	3	6	SR05 — 9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 13 April 2021

Likelihood

2020/21 Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	SR01, SR08, SR11 — 10	SR03 — 15	SR02 — 20	25
4 Major	4	SR06, SR09 — 8	SR04, SR07 — 12	16	20
3 Moderate	3	6	SR05 — 9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 02 July 2020

Likelihood

Final Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	SR01, SR03, SR08, SR11 — 5	SR02 — 10	15	20	25
4 Major	SR06, SR09 — 4	SR04, SR07 — 8	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

Populated: 02 July 2020

Likelihood

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NHS North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 April 2021		
SUBJECT:	2021/22 Opening Position of the Board Assurance Framework		
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs		
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction.	☒
	SR02	There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements and infrastructure.	☒
	SR03	There is a risk that the Trust does not deliver improved national and local operational standards resulting in unsafe or delayed care.	☒
	SR04	There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services.	☒
PURPOSE OF PAPER:	For Decision		
EXECUTIVE SUMMARY:	The proposed 2020/21 Opening Position for the BAF risks with associated CRR risks scored ≥15 can be viewed in **Appendix 1**. The proposed opening risk scores are shown below and further details including the rationale can be seen in s3: • SR01 opening risk score of 15 • SR02 opening risk score of 20 • SR03 opening risk score of 20 • SR04 opening risk score of 12		
RECOMMENDATION:	The Board of Directors are requested to: • Agree the 2021/22 Opening Position of the Board Assurance Framework.		
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability ☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee & Audit Committee		
	Date:	21 & 23 April 2021	
	Outcome:	Supported Onward Reporting	

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1. PURPOSE

This paper provides the opportunity for the Board of Directors to review the 2021/22 Opening Position of the Board Assurance Framework (BAF) position, along with the Corporate Risk Register risks scored ≥15 that are aligned to each BAF risk.

2. BACKGROUND

The Board Assurance Framework (BAF) identifies the strategic risks and ensuring that systems and controls are in place are adequate to mitigate any significant risk which may threaten the achievements of the strategic objectives.

Whilst the Board of Directors delegates authority to its Board Assurance Committees to monitor assurance against its strategic risks, it is ultimately responsible for the oversight of the BAF and the Board Assurance Committees are expected to escalate any significant assurance issues as they arise.

3. REVIEW OF THE STRATEGIC RISKS 2021/22 OPENING POSITION

The proposed 2021/22 Opening Position of the Board Assurance Framework with associated Corporate Risk Register risks scored 15 and above can be viewed in **Appendix 1**.

SR01: There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction

Opening Score 01.04.2021	Exec Lead
15 5x3 CxL	Dr C Grant

This risk has been scored at a 15 following review, with the following rationale applied by the Executive Lead:

1. The commencement of Q1 demonstrates the significant improvements to both quality and clinical effectiveness over the past 18 months
2. During Q1, the Trust welcomes our new, Consultant Midwife
3. The biggest risk for 2021/22 is the resource implications to fund the proposed Clinical Leadership Model for both operations and corporate
4. The ongoing focus remains on the delivery of the Right Care Strategy

SR02: There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure

Opening Score 01.04.2021	Exec Lead
20 5x4 CxL	Ms C Wood

This risk has been scored at a 20 following review, with the following rationale applied by the Executive Lead:

1. No balanced and agreed revenue H1 (April – September) Financial Plan for the ICS that has been submitted and approved nationally
2. Details of the financial planning requirements for the H2 are yet to be received
3. Draft Capital Plans have been submitted to the ICS but additional Capital Resource (CRL) is required to be approved before the Trust can progress with the full Capital Programme for 2021/22.

SR03: There is a risk that the Trust does not delver improved national and local operational performance standards resulting in unsafe or poor quality care

Opening Score 01.04.2021	Exec Lead
20 5x4 CxL	Mr G Blezard

This risk has been scored at a 20 following review, with the following rationale applied by the Executive Lead:

1. The temporary mitigating measures that were in place during Q4 of 2020/21 are no longer sustainable
2. There are no financial/ contract settlement for 2021/22 at present
3. The Trust is working with AACE and ORH with the initial findings to be scheduled to be published at the end of Q1.

SR04: There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services

Opening Score 01.04.2020	Exec Lead
12 4x3 CxL	Ms L Ward

This risk has been scored at a 12 following review, with the following rationale applied by the Executive Lead:

1. The overall position at the commencement of Q1 shows a stable turnover and a continuing buoyant recruitment market
2. Planned apprenticeship training has been remobilised
3. Recruitment plans are in place for Q1 and Q2, which will maintain the

current strong position

4. Planned culture and inclusion work is being recovered
5. Refreshed Trust values and ‘Treat Me Right’ campaign due to launch in April 2021
6. Board agreed inclusion priorities set.

4. LEGAL, GOVERNANCE AND/OR RISK 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.

4. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the 2021/22 Opening Position of the Board Assurance Framework.

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North West Ambulance Service NHS Trust

Appendix 1

Board Assurance Framework 2021/22

Board of Directors
Wednesday 28 April 2021

Q1 2021/22 Reporting Timescales:

Quality & Performance Cttee:	26/07/2021
Resources Cttee:	23/07/2021
Executive Leadership Cttee:	21/07/2021
Audit Cttee:	16/07/2021
Board of Directors:	28/07/2021

Data Extracted from Datix: 12 April 2021

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
DoP	Director of People
DoSP	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				
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives				
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)				
Action 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 RAG 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 by delivering the right care, at the right time, in the right place; every time.

Values:

WORKING TOGETHER.

We work together to understand and value every role in achieving our shared purpose. We live and breathe inclusivity, everyone matters.

BEING AT OUR BEST.

We challenge ourselves to be the best we can be. We are curious and push boundaries to improve everything we do.

MAKING A DIFFERENCE.

We make a difference through doing the right thing by our staff, patients, partners and communities. We act with compassion and kindness.

Priorities:

Urgent and Emergency Care

Increasing service integration and leading improvements across the healthcare system in the North West.

Quality

Delivering appropriate care, which is safe, effective and patient centered for each individual.

Digital

Radically improving how we meet the needs of patients and staff every time they interact with our digital services.

Business and Commercial Development

Developing skills and capability to explore business opportunities for current and new viable contracts, services or products.

Workforce

Engaging and empowering our leaders and staff to develop, adapt and embrace new ways of delivering the right care.

Stakeholder relationships

Building and strengthening relationships that enable us to achieve our vision.

Infrastructure

Reviewing our estates and fleet to reflect the needs of the future service model.

Environment

Committing to reduce emissions by embracing new technology including electric vehicles.

Supporting strategies:

- Urgent and Emergency Care Strategy
- Quality (Right Care) Strategy
- Digital Strategy
- Finance plan - long term financial model
- Workforce Strategy
- Communications and Engagement Strategy
- Estates and Fleet Strategies

BOARD ASSURANCE FRAMEWORK DASHBOARD 2021/22

BAF Risk	Committee	Exec Lead	01.04.21	Q1	Q2	Q3	Q4	2021/22 Target	Final Target
SR01: There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** **5x3** **CxL**					**10** 5x2 CxL	**5** 5x1 CxL
SR02: There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure	**Resources**	**DoF**	**20** **5x4** **CxL**					**15** 5x3 CxL	**5** 5x1 CxL
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in unsafe or poor quality care	**Quality & Performance**	**DoOps**	**20** **5x4** **CxL**					**15** 5x3 CxL	**5** 5x1 CxL
SR04: There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services	**Resources**	**DoP**	**12** **4x3** **CxL**					**8** 4x2 CxL	**4** 4x1 CxL

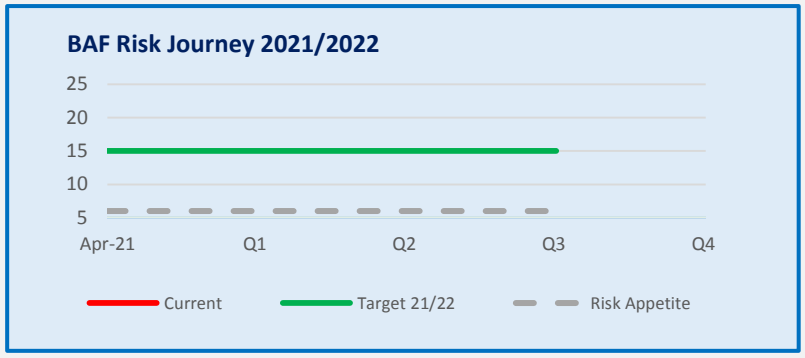
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR01:
There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction

Strategic Priority: Quality

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	15					10	5
	5x3					5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded					Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF risk is scored at a 15 due to commencement of Q1 demonstrates the significant improvements to both quality and clinical effectiveness over the past 18 months. During Q1, the Trust welcomes our Consultant Midwife, the biggest risk for 2021/22 is the resource implications to fund the proposed Clinical Leadership Model for both operations and corporate. The ongoing focus will include delivering the milestones as outlined in the Right Care Strategy.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Timely closure of high level complaints	Closure of Level 4 & 5 complaints in a timely manner	Prof M Power	TBC	Q&P Cttee	In Progress
Rejections of Safeguarding Concerns	Devise and embed alternative pathways for Mental Health patients	Prof M Power	TBC	Q&P Cttee	In Progress
Child Protection Information Sharing in 999	Roll out of national Child Protection Information Sharing system	Prof M Power	TBC	Q&P Cttee	In Progress
Operational Clinical Leadership Model	Service Delivery Review - Operational Clinical Leadership Model	Dr C Grant	Q4	Q&P Cttee	Not Commenced
Corporate Clinical Leadership Model (inc. Clinical Audit & ACQIs)	Service Delivery Review - Corporate Clinical Leadership Model	Dr C Grant	Q4	Q&P Cttee	Not Commenced
Review of Maternity Care	Undertake a strategic review of maternity care provided by NWAS	Dr C Grant	Q3	Q&P Cttee	Not Commenced
Audit Capability for Learning from Deaths	Recruitment to EOC audit team to facilitate end-to-end reviews	Dr C Grant	Q2	Q&P Cttee	Not Commenced
Controlled Drugs – Vehicle Audits	Improved compliance against CD05 via SafeCheck	Ms R Fallon	Q2	Q&P Cttee	In Progress
CD Home Office Licence	Secure approval via the Home Office for an NWAS CD Licence	Ms R Fallon	Q2	Q&P Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**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
2568	Service Delivery	There is a risk that the response to an MTA outside of the Model Response sites of Liverpool and Manchester may be delayed due to the vast majority of MTA staff (AIT/Cs) being stationed in or around the above areas. This could result in potential delays of triage, treatment and transport in the warm zone of such an incident further afield.	20 Significant	15 Significant	↑	5 Moderate
3062	Service Delivery	There is a risk that 999 call takers fail to identify key words and phrases relating to respiratory calls which could result in the wrong categorisation and/or delay the response leading to detrimental patient care, increase in complaints and reputational damage to the Trust.	20 Significant	15 Significant	⇔	5 Moderate
3243	Quality	There is a risk that social distancing may not be adhered to during the coronavirus pandemic due to staff needing to be less than two meters from the patient or each other and increased numbers of workforce in our working locations which may result in increased transmission of coronavirus.	20 Significant	20 Significant	↑	4 Moderate
3254	Service Delivery	There is a risk that operational resources will be insufficient to cover demand because of staff taking carried over leave which they were unable to take due to Covid-19 which may result in delayed patient response times and delivery of national ARP standards.	20 Significant	20 Significant	↑	5 Moderate
3435	Quality	There is a risk that if the number of Covid related cases and outbreaks continue to rise within the second wave of the pandemic and business continuity plans need to be enacted, the plans may be insufficient and therefore services may be adversely affected which can result in patient harm.	20 Significant	15 Significant	↓	5 Moderate
3446	Service Delivery	There is a risk that due to the pressures at hospitals across the North West, increased numbers of patients will be held on the back of ambulances leading to excessive delays at hospitals which may result in increased numbers of delayed responses for our patients.	20 Significant	15 Significant	↓	5 Moderate
3448	Service Delivery	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	20 Significant	16 Significant	↓	5 Moderate
3459	Service Delivery	There is a risk that due to the increasing numbers of staff sickness and abstractions across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	16 Significant	16 Significant	↑	4 Moderate
3466	Quality	There is a risk that there is currently no consistent approach, across the Trust, to the reporting and management of level 1 to 3 internal and external incidents, which will result in missed opportunities for managing identified harm for staff and patients, potentially identifying higher levels of harm, learning and the prevention of reoccurrence.	15 Significant	15 Significant	⇔	5 Moderate
3474	Service Delivery	There is a risk the Aerosol Generated Procedure audit 'live ring back' in EOCs will fail because a suitable robust resource has not been identified to continue the audit once the COVID19 cell was disestablished which may result in NWAS not being able to assure the HSE that clinical staff are adequately protected when attending such an incident.	12 High	16 Significant	↓	6 Moderate
3487	Quality	There is a risk that the Trust will not meet compliance with the Data Security and Protection Standards for health and care, due to the low compliance with the Mandatory Training Data Security Awareness Module, which may result in non-compliance with regulatory standards	12 High	15 Significant	↑	3 Low

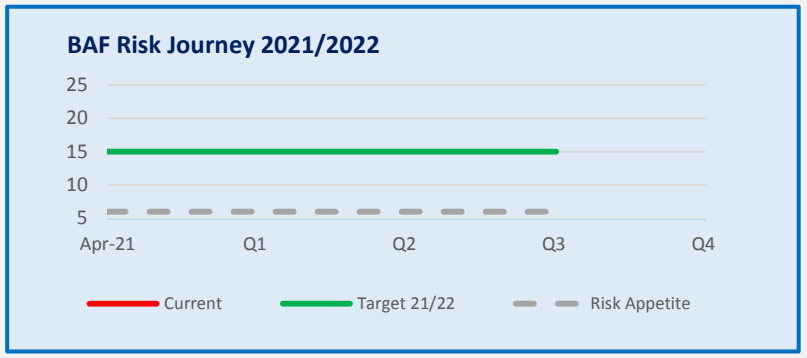
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR02:
There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements to infrastructure

Strategic Priority: ALL

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	20					15	5
	5x4					5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded					Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF risk is scored at a 20 due to there being no balanced and agreed revenue H1 (Apr-Sep) financial plan for the ICS that has been submitted and approved nationally. Details of the financial planning requirements for the second half of the financial year are yet to be received. Draft capital plans have been submitted to the ICS but additional capital resource (CRL) is required to be approved before the organisation can progress with the full capital programme for 2021/22.

CONTROLS	ASSURANCES	EVIDENCE
Financial Plans	**Level 2:** 2021/22 Financial Plans	Reported to BoD (BoD 2021/120)
Financial Controls	**Level 3:** MIAA Internal Audit – Key Financial Controls	Reported to Audit Cttee (AC 2021/114)
Significant Change Projects	**Level 2:** Business Cases with Financial Impact	Reported to ELC & CPB

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	June 2021	Resources Cttee	In Progress
H2 Planning Guidance	Receipt of H2 Planning Guidance from NHSI	Ms C Wood	May 2021	Resources Cttee	Not Commenced
2021/22 Capital Plan	Approved 2021/22 Captial Plan	Ms C Wood	May 2021	Resources Cttee	In Progress
2021/22 Revenue Financial Plan	Approved 2021/22 Revenue Financial Plan	Ms C Wood	May 2021	Resources Cttee	Not Commenced
2021/22 Efficiencies	Delivery of 2021/22 Efficiency Savings	Ms C Wood	March 2022	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**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
2867	Quality	There is a risk of oversight or system issues, due to a high number of high impact projects linked to critical systems being delivered simultaneously, which could result in system failures.	16 Significant	16 Significant	⇔	8 High
3376	Finance	There is risk if the Trust does not effectively prepare for the renewal/award of the PTS contracts across the trust in July 2021 this could result in an estate which does not adequately support service delivery.	20 Significant	16 Significant	↑	8 High
3433	Finance	There is a risk that NWAS are recruiting staff and committing funds associated to Estates, IMT & support staff structures in relation to NHS 111 First without any agreed recurrent funding in place which may result in NWAS carrying a large financial risk in to 2021/22 and beyond.	16 Significant	16 Significant	⇔	4 Moderate

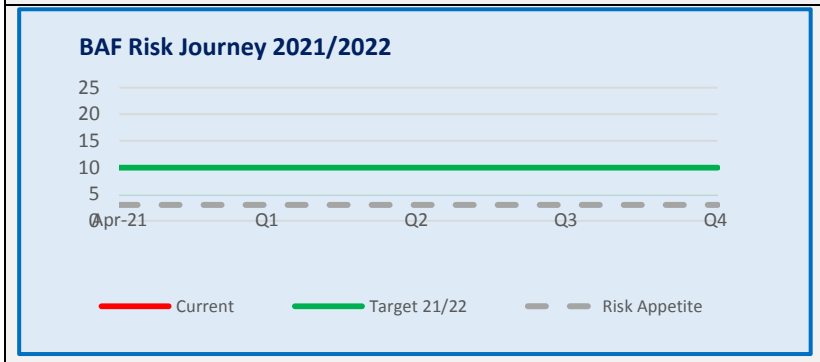
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR03:
There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in unsafe or poor quality care

Strategic Priority: Urgent & Emergency Care

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	20					15	5
	5x4					5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded					Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF risk is scored at a 20 due to the temporary mitigating measures being in place throughout 2020/21 Q4 are no longer sustainable. There are no financial/ contract settlement for 2021/22 at present. In mitigation, the Trust is working with AACE and ORH with the initial findings scheduled to be published at the end of Q1.

CONTROLS	ASSURANCES	EVIDENCE
Paramedic Emergency Services (PES)		
Optima Independent Review of NWAS Resources	**Level 3:** ORH Demand and Capacity Review	Reported to Q&P Cttee (Q&PC 2021/145)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Paramedic Emergency Services (PES)					
Financial Gap	Engagement with Commissioners	Mr G Blezard	October 2021	Q&P Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2568	Service Delivery	There is a risk that the response to an MTA outside of the Model Response sites of Liverpool and Manchester may be delayed due to the vast majority of MTA staff (AIT/Cs) being stationed in or around the above areas. This could result in potential delays of triage, treatment and transport in the warm zone of such an incident further afield.	20 Significant	15 Significant	↑	5 Moderate
3027	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	20 Significant	16 Significant	⇔	4 Moderate
3448	Service Delivery	There is a risk that due to the increasing number of positive COVID-19 cases, increased numbers of staff abstractions due to self-isolation/ shielding and absenteeism across the Service Delivery Directorate, this may impact on our ability to achieve operational performance standards.	20 Significant	16 Significant	↓	5 Moderate
3451	Service Delivery	There is a risk that due to COVID-19 restrictions and lockdown arrangements set out by the UK Government, NWAS and partner agencies may miss opportunities to multi-agency exercise local plans which may lead to commanders not fulfilling their National Occupational Standards impacting on our compliance with Statutory Duties.	20 Significant	15 Significant	⇔	5 Moderate
3452	Service Delivery	There is a risk that the existing operating model for NWAS may not be effective due to insufficient workforce resources, vehicles and processes not being in place currently which may impact on our ability to achieve our ARP standards.	25 Significant	15 Significant	⇔	5 Moderate
3455	Service Delivery	There is a risk that due to an increase in operational demand and patient acuity across PES, resources will be limited or not available for effective and efficient utilisation across the region which could result in delayed responses to patients.	20 Significant	15 Significant	⇔	5 Moderate

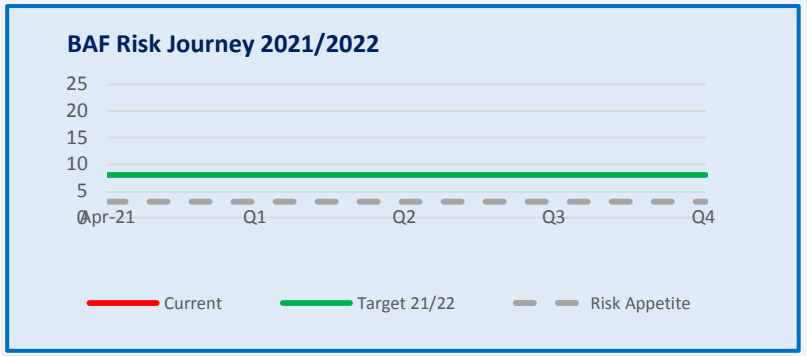
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR04:
There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
	12					8	4
	4x3					4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded					Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF risk is scored at a 12 due to the overall position at the commencement of Q1 shows a stable turnover and a continuing buoyant recruitment market. Planned apprenticeship training has been remobilised and there are agreed recruitment plans in place for both Q1 & Q2, which will maintain the current strong position. Planned culture and inclusion work is being recovered with refreshed values and 'Treat Me Right' campaign due to launch in April and Board agreed inclusion priorities set.

CONTROLS	ASSURANCES	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Zeal Outstanding Culture	Delivery of Zeal Outstanding Culture Project through to Action Plan	Ms L Ward	May 2021	Resources Cttee	In Progress
Workforce Plans	Development of Operating Plan and Sign Off	Ms L Ward	May 2021	Resources Cttee	In Progress
Freedom to Speak Up	Complete actions identified by MIAA Internal Audit	Ms L Ward/ Ms A Wetton	September 2021	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3027	People	There is a risk that the Trust will suffer a Paramedic shortfall because of the combined outcome of the ORH demand analysis, paramedic skill mix change and potential impact of GP reform, which could result in an inability to meet operational demand.	20 Significant	16 Significant	⇔	4 Moderate
3320	People	There is a risk that the reduction in hearings will lead to conduct or capability matters not being effectively dealt with leading to impact on patient care.	20 Significant	15 Significant	⇔	5 Moderate
3447	Service Delivery	There is a risk that due to increasing operational demands and call volumes across NWAS, the health and wellbeing of our workforce may deteriorate leading to sickness and absenteeism which may impact on staff safety.	16 Significant	16 Significant	⇔	4 Moderate
3449	Service Delivery	There is a risk that due to the current operational demand, appraisals, mandatory training and other workforce activities may be paused which may impact on the competency of our staff.	20 Significant	20 Significant	↑	5 Moderate
3450	Service Delivery	There is a risk that due to an increase in operational demand, completion of clinical supervision may not be completed to the required frequency which may impact on the competency of our staff.	20 Significant	15 Significant	⇔	5 Moderate

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th April 2021			
SUBJECT:	Annual Review of Core Governance Documents			
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
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.			
RECOMMENDATION:	The Board of Directors is recommended to: • Note the outcomes of the annual review of core governance documents. • Approve the revised core governance documents.			
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Audit Committee			
	Date:	23rd April 2021		
	Outcome:	Recommended to Board for approval		

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1. PURPOSE

The purpose of this report is to present the outcomes of the annual review of the Trust's core governance documents for approval by the 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 considered by the Executive Leadership Committee on 14th April 2021 for onward recommendation to the Audit Committee on 23rd April 2021 and final approval by the Board of Directors on 28th April 2021.

3. REVIEW OUTCOMES

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.

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

4. LEGAL, RISK 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.

5. 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 & Scheme of Delegation

North West Ambulance Service NHS Trust

Approved by the Board of Directors: ~~27 May 2020~~

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	27 May 2020
17	Annual Review, March 2021	

CONTENTS

STANDING ORDERS

RESERVATION OF POWERS & SCHEME OF DELEGATION

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 Membership and Procedure Regulations (1990) as amended ~~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

Terminology	Definition
Committee	A committee appointed by the Board of Directors
Directors	Are the Non-Executive Directors and Executive Directors (including non voting Directors and Associate Non-Executive Directors) ~~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
- Executive Director of Quality, Innovation and Improvement~~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 Associate Non-Executive Directors are appointed by the Trust.

2.2.3~~2~~ The Chief Executive is appointed by the Chairman and the Non-Executive Directors.

2.2.4~~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~~.~~

2.2.5~~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 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 are incorporated into the Standing Orders. Those powers which it has delegated to individuals and other bodies are contained in the Scheme of Delegation.

3. Meetings of the Trust

3.1 Ordinary Meetings of the Trust Board

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

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

3.1.4 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.

3.1.5 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.

3.1.6 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.

3.2 Notice of Meetings and the Business to be Transacted

3.2.1 *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.

3.2.2 *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.

3.2.3 *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.

3.2.4 *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.

3.3 Setting the Agenda

3.3.1 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.

3.3.2 A Director may request that a matter is included 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.

3.3.3 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.

3.4 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.

3.5 Chairman of the Meeting

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

3.5.2 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.

3.5.3 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.

3.6 Voting

3.6.1 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.

3.6.2 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.

3.6.3 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

3.6.4 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.

3.6.5 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

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

3.6.7 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.

3.6.8 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.

3.6.9 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.

3.7 Quorum

3.7.1 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.

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

3.7.3 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.

3.8 Record of Attendance

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

3.8.2 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.

3.9 Minutes

3.9.1 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.

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

3.9.3 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.

3.10 Notices of Motion

3.10.1 Subject to the provision of Standing Order 3.11 and 3.13 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.

3.11 Motions: Procedure at and During a Meeting

3.11.1 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

3.11.2 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.

3.12 Rights of reply to motions.

3.12.1 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.

3.13 Motion to Rescind a Decision of the Trust Board

3.13.1 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.

3.13.2 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.

3.14 Suspension of Standing Orders

3.14.1 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.

3.14.2 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

3.15 Variation and Amendment of Standing Orders

3.15.1 These Standing Orders shall be amended only if:

- a notice of motion under SO 3.10 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.

4.3.2 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

The Board of Directors shall appoint a committee to undertake the role of an audit committee. This role shall include providing the Board of Directors with an ~~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 the financial information used by the Trust and of compliance with laws, guidance and regulations and codes of conduct governing the NHS. The Committee will comprise of a minimum of three Non-Executive Directors of which one must have significant, recent and relevant financial experience. This Committee will pay due regard to good practice guidance, including, in particular the NHS Audit Committee Handbook.

~~e~~ The Terms of Reference of the Audit Committee shall be ~~are~~ approved by the Board of Directors and will be reviewed on a periodic basis.

4.8.2 Auditor Panel

The Board of Directors shall nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

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 (Regulations 15-16, Membership and Procedure Regulations).

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 and the Director of Finance, 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 Committee prior 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 Committee or relevant Executive Director.

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

- Health, Safety and Security ~~and Safety~~ Policy
- Risk Management Policy
- Anti-Fraud, Bribery and Corruption Policy
- Freedom to Speak Up Policy
- Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts, Hospitality & Sponsorship
- Complaints, Incidents and 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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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 Accounting 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 ~~Chairman and~~ Chief Executive and Director of Finance 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 Corporate 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): Review of MoUs and Partnership Arrangements Approval of MoUs and Partnership Arrangements Register of Partnership Arrangements to be presented to Executive Leadership Committee	 Director of Corporate Affairs Executive Leadership Committee Director of Corporate Affairs	 Head of Legal Services Executive Lead Head of Corporate Governance	SO 9
Annual Governance Statement	Chief Executive	Director of Corporate Affairs	SFI 2 & 20
Risk Management	Director of Corporate Affairs	Head of Risk and Assurance	SFI 20 Risk Management Policy Risk Management Strategy
Freedom to Speak Up	Chief Executive	Director of Corporate Affairs	Freedom to Speak Up Strategy 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
Appointment of External Auditors	Board of Directors	Audit Panel	SO 4
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

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
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
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)
System Partnership and Integration	Director of Strategy and Planning	Head of Partnership and Integration	
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	

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
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 Digital Intelligence and Informatics Head of Digital Intelligence and Informatics Head of Digital Intelligence and Informatics	Clinical Records Management Policy & Procedure ePRF Procedures GDPR Regulations
Corporate Records Management	Director of Quality Innovation & Improvement (SIRO)	Head of Digital Intelligence and Informatics	Data Protection and Security Policy Safe Haven
Disclosure of Patient Identifiable Information	Medical Director (Caldicott Guardian) Director of Quality, Innovation & Improvement (SIRO)	Head of Digital Intelligence and Informatics	Subject Access Request Procedure Data Protection and Security Policy Data Retention Policy
IM&T Systems Access Control	Director of Quality, Innovation and Improvement	Chief of Digital and Innovation	Computer Misuse Act 1990 NWAS ICT Systems and Applications Guide ICT Business Continuity Strategy General Security Computer Aiding and Monitoring Use of Anti-virus Software Software Development & Change Control Password Management Encryption Standard Use of the Intrant Remote Access Access Control Laptop User Guide Acceptable Websites Reporting Security Incidents Acceptable use of NWAS iPads Using Equipment Off-site Objectionable Material
Ambulance Quality Indicator Reporting	Medical Director Director of Quality, Innovation and Improvement Director of Operations	Chief Consultant Paramedic Chief of Regulatory Compliance and Improvement Chief of Digital and Innovation	Clinical Audit Policy Right Care (Quality) Strategy
7. Quality, Innovation and Improvement			
Health, Safety and Security Management	Director of Quality, Innovation and Improvement	Chief of Regulatory Compliance and Improvement	Health & Safety at Work Act Health, Safety & Security Policy Health and Safety A-Z Toolkit Violence & Aggression Policy Reporting of Serious Incidents, Diseases and Dangerous Occurrences Slip, Trip and Falls Procedure Security Procedure Stress Procedure
Incident Reporting, Management and Investigation	Director of Quality, Innovation and Improvement	Patient Safety Specialist	Complaints, Incidents and Investigations Policy Incident Reporting Procedure Health, Safety & Security Policy Serious Incident Investigation Procedure Reporting of Serious Incidents, Diseases and Dangerous Occurrences Regulations 1995 Blackpool CCG SI Policy Duty of Candour Procedure
Clinical Effectiveness (Governance)	Medical Director	Chief Consultant Paramedic Chief Pharmacist Assistant Director of Nursing and Quality Chief of Regulatory Compliance and Improvement	JRCALC Guidelines Right Care (Quality) Strategy Health Notifications and Alert Process v3 2019 Clinical Audit Policy Learning from Deaths Policy Mental Health & Dementia Strategic Plan High Intensity User Policy High Intensity User Procedure
Medicine Management	Medical Director (CDAO)	Chief Pharmacist	NWAS Medicine Management Policy v5.1 2019 General Medicines Toolkit Controlled Drugs Toolkit
~~Clinical~~ Patient Safety Management	Director of Quality, Innovation and Improvement	Patient Safety Specialist	Learning from Experiences Policy Learning Framework
Infection Prevention & Control	Assistant Director of Nursing and Quality (DIPC)	Head of Clinical Safety	Infection Prevention and Control Policy Communicable Diseases Policy Health & Social Care Act 2008 Wound Care Policy & Procedure Linen Policy Peripheral Intravenous Cannulation Policy and Procedure Latex Sensitivity Policy

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Vulnerable Persons Management (Safeguarding)	Director of Quality, Innovation and Improvement/~~Chief Nurse~~ Assistant Director of Nursing and Quality	Head of Clinical Safety	Safeguarding Vulnerable Persons and Control Policy Safeguarding Vulnerable Persons Procedures Childrens Act PREVENT Policy High Intensity User Policy High Intensity User Procedure Domestic Abuse Procedure
Clinical Delegation	Medical Director	Chief Consultant Paramedic Assistant Director of Nursing and Quality Chief of Regulatory Compliance and Improvement Chief Pharmacist	Clinical Supervision Structure JRCALC Guidelines Quality Impact Assessment Approval & Review Procedure
Complaints Management	Director of Quality, Innovation and Improvement	Patient Safety Specialist	Complaints, Incidents and Investigations Policy Complaints and External Procedure NHS Complaints Regs (SE 2004 No 1768) NHS Complaints Amended Regs 2006 (SI 2006 No 2084) Duty of Candour Procedure Redress Procedure
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	CQC Regulations NHS 111 Provider Handbook
Quality Account	Director of Quality, Innovation and Improvement	~~Deputy Director of Quality~~ Chief of Regulatory Compliance and Improvement	
8. Duties of Individuals			
Code of Conduct for NHS Managers	Chief Executive	Director of People	

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
9. ~~Human Resources~~ Workforce			
Recruitment and Appointments: - Recommend appointment of Chief Executive - Involvement in selection panel for Non-Executive Directors - Approve appointment of Chief Executive and Executive Directors (subject to salary approval by NHSE/I) - Determine skill set and person specification for members of the Board of Directors both voting and non-voting and approval selection process - Development and implementation of Trust Recruitment and Selection Policy. - Statement of Written Particulars of Employment for Very Senior Managers. - Confirmation of appointments / contracts of employment. - Compliance with Fit and Proper Person Regulations	 Chairman Chairman Nominations and Remuneration Committee Nominations and Remuneration Committee Director of People	Director of People Deputy Director of People	Recruitment and Selection Policy
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
Performance Management - Refer to Performance Management Procedure	Director of People	Senior Managers	Performance Management Policy
Workplace conflict / bullying - Refer to Dignity at Work Policy	Director of People	Senior Managers	Dignity at Work Policy
Funded Establishment: - Approval of funded establishment as part of annual budget setting - Approval of restructure proposals affecting Directors subject to Very Senior Manager Pay arrangements - To authorise in-year all increase, decreases or other changes to establishments following apropraite authorisation by Finance - Approve in-year proposals for re-structure resulting in establishment changes not affecting Directors subject to Very Senior Manager Pay Arrangements	 Board of Directors Nominations and Remuneration Committee Chief Executive Executive Leadership Committee	 Chief Executive	
Remuneration and Conditions of Service: Very Senior Manager Pay arrangements: - Authorisation of all pay, benefits and grading issues for Directors subject to Very Senior Manager Pay arrangements and NHS Improvement (NHSI) approval. - Recommendation of non-contractual termination payments to the NHSI and Treasury for approval - Approval of costs incurred in relation to Directors subject to Very Senior Manager Pay arrangements, Senior Managers and other cases where the cost exceeds £50,000. - Approval of business cases for redundancy where the costs exceed £50,000. - Recommend contractual terminations to the NHSI where costs exceed £100,000 - Jointly approve business cases for redundancy/premature retirement applications where the cost does not exceed £50,000	 Nominations and Remuneration Committee Director of People and Director of Finance	 Director of People	SFI S8
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~~People	
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 Pay Progression Guidance
Sickness Warning Arrangements	Director of People	Deputy Directors/Senior Managers	Sickness Absence Procedure
Agency Rules	Director of People	Deputy Director of ~~OD~~ People	Agency Rules - NHS Improvement March 2016

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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	27 May 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
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 workforce establishment~~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 workforce establishment~~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.

Terminology	Definition
Member	An Executive or Non-Executive member of the Board as the context permits. Member in relation to the Board does not include its Chairman.
Nominated Officer	An Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.
Non-Officer	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 activity~~workload~~ and workforce establishment~~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 efficiency and productivity ~~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 efficiency and productivity~~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 assist with financial management within the NHS finance regime ~~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. statement of financial position~~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 efficiency and productivity~~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 significant variances from financial, activity~~workload~~ and workforce establishment plans ~~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 efficiency and productivity~~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 efficiency and productivity 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 Nominations and 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 workforce establishment~~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 unless:

a. ~~unless~~ authorised to do so by the Chief Executive; or
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 People in conjunction with the Director of Finance is responsible for:

a. specifying timetables for submission of properly authorised time records and other notifications;
b. the final determination of pay and allowances, including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;
c. making payment on agreed dates; 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~~them self 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~~them self 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 ofr 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 Public Contracts~~EU~~ directives governing public procurement

17.2.1 The Public Contracts 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:

- 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
- where the requirement is covered by an existing contract; ~~or~~

~~where NHS Supply Chain agreements are in place and have been approved by the Board of Directors; or~~

~~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~~

- 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
- where specialist expertise is required and is available from only one source (also includes memberships/subscriptions/licences); or
- 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
- 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
- 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
- where allowed and provided for in the NHS Trust Capital Accounting Manual; or
- Single source supplier – one accredited supplier for service; or
- 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
- 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
- Where it was necessary to obtain goods/services without raising a Purchase Order in advance and a retrospective order is required; or
- 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
- 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 be 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 set ~~up~~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 DHSC 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~~Resolution. 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~~Resolution 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 FTS~~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: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement.~~<£500k Executive Leadership Committee~~
Above FTS~~OJEU~~ threshold	FTS~~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: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement. =>£500k Board of Directors~~<£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.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th April 2021			
SUBJECT:	FT Code of Governance – 2020/21 Position of Compliance			
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
PURPOSE OF PAPER:	For Assurance			
EXECUTIVE SUMMARY:	Whilst the Trust is not a Foundation Trust, it takes full account of the NHS Foundation Trust Code of Governance published by Monitor (now NHS England/Improvement) for Trust Boards. Appendix 1 provides a summary of the Trust's corporate governance arrangements against the FT Code for assurance. The Trust is able to declare compliance with all relevant clauses with the exception of 1 which is partially compliant – Clause A.2.1 requires an action to be taken as the document referenced is several years old. All non-relevant clauses are highlighted in grey.			
RECOMMENDATION:	The Board of Directors is recommended to: • Take assurance from the report regarding the Trust's declaration of compliance with all but one of the Code's clauses.			
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Audit Committee			
	Date:	23rd April 20221		
	Outcome:	Noted for assurance.		

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1. PURPOSE

The purpose of this report is to provide the Board of Directors with an update of the Trust's compliance against the NHS Foundation Trust Code of Governance (FT Code) originally published by Monitor (now NHS Improvement) in 2006 and subsequently updated in 2010 and 2014.

2. BACKGROUND

The UK Code ensures companies report annually against the code which is a benchmark of good corporate governance. It was first published in 1992 by the Cadbury Committee and defined corporate governance as the 'system by which companies are directed and controlled' and has been updated over the years to take account of the increasing demands of the UK's corporate governance framework.

The NHS Foundation Trust Code of Governance (FT Code) was first published in 2006 by Monitor (now NHS Improvement) and revised in 2010 and 2014 as a result of the 2012 Act and developments to meet regulatory requirements. The FT Code brings best practice from the private sector into the NHS Foundation Trust sector and ensures a strong governance structure is in place to enable high-quality patient care.

3. COMPLIANCE AGAINST THE FT CODE

A review of the Trust's corporate governance arrangements against the FT Code has been undertaken and the declaration against all the clauses has been updated to reflect the latest position.

The Trust is able to declare compliance with all relevant clauses with the exception of 1 which is partially compliant – Clause A.2.1 requires an action to be taken as the document referenced is several years old.

All non-relevant clauses have been highlighted in grey as they are not applicable to the Trust.

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

Whilst the Trust is not a Foundation Trust, it takes full account of the FT Code for Trust Boards to assist in improving their governance arrangements and is utilised to ensure best practice of public and private sector corporate governance.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

- Take assurance from the report regarding the Trust's declaration of compliance with all but one of the Code's clauses.

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DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A	**LEADERSHIP**			
A.1.	**The Board of Directors** **Every NHS foundation trust should be headed by an effective board of directors, since the board is collectively responsible for the exercise of the powers and the performance of the NHS foundation trust.**			
A.1.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundations trust's effectiveness, efficiency and economy as well as the quality of its health care delivery. The board should regularly review the performance of the NHS foundation trust in these areas against regulatory and contractual obligations, and approved plans and objectives.	The Trust has strong systems of financial governance in place. All statutory audits and reporting requirements are fulfilled. The Board of Directors measure and monitor the Trust's performance through the Integrated Performance Report (IPR). The IPR provides assurances against the delivery of performance against set metrics required by the Single Oversight Framework and provides assurances on current and historical performance relating to quality, effectiveness, finance, operational performance and organisational health. It also includes information relating to performance against peers, national comparators and its strategic goals. The Board also receive reports from the executive outlining any changes to targets/standards and guidance as they arise. Systems and processes are in place to ensure compliance with national and local healthcare standards – internal and external assurance systems are in place. The Trust's CQC rating of 'Good' across all five domains including Well-Led. Board papers are published on the Trust's website 5 days before the meeting.	• IPR • Planning process • Financial report includes CIP updates • Trust Strategy • Right Care Strategy • Urgent and Emergency Care Strategy • Digital Strategy • Board Assurance Framework • Quality Account • Annual Plan • Five Year Integrated Business Plan (IBP)	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		Performance reports are not subject to any exemptions under FOIA.		
A.1.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate and in particular high risk or complex areas, independent advice, for example from the internal audit function, should be commissioned by the board of directors to provide an adequate and reliable level of assurance.	The IPR (aligned to the Single Oversight Framework) is the basis of the performance dashboard where key metrics and milestones are collated and reported to the Board. The Board Assurance Committees also review and receive assurance on key performance targets, KPIs and quality metrics. The Board committee structure has been developed to ensure efficiency of time for Executive and Non-Executive Directors and to remove any duplication of reporting at Committees. The effectiveness of the structure was reviewed through an externally facilitated Well-Led developmental review of leadership and governance during Q4 2019/20. In addition, each committee and Management Group is subject to an annual effectiveness review against their terms of reference. The Board of Directors approved the revised sub-Board governance structure and development of additional sub committees to support the Audit, Resources and Quality and Performance Committees. This new structure is effective from 1st April 2021. A programme of internal audits is agreed with MIAA to focus on high risk areas as identified within the Board Assurance Framework and/or Corporate Risk Register (risks of 15+).	• IPR • Committee ToR • Minutes of Board • Minutes of Committees • Meeting Schedule • Chair's Assurance Reports to Board • Internal Audit reports • Audit Committee minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.1.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidance set out by the DH, NHS England, the CQC and Monitor. The board should record where within the structure of the organisation, consideration of clinical governance matters occur.	The Trust has a systematic approach to clinical governance which is focused on the relevant policy guidance and regulatory framework and supported by the Trust's Right Care (Quality) Strategy. The Quality and Performance Committee obtains assurance from the Clinical Effectiveness Management Group. The Quality and Performance Committee meets monthly and receives assurance reports from the Chair of the Clinical Effectiveness Management Group following each meeting. The Chair of the Group is the Medical Director, who is also a member of the Quality and Performance Committee. The Medical Director is accountable for clinical governance. This formal assurance meeting is fed by an integrated governance framework, which permeates the organisation, facilitates the achievement of improving clinical standards through the implementation of the quality strategy. The Quality and Performance Committee considers the overall system of clinical governance and the outcomes of a programme of clinical audit as part of its annual work plan. The Director of Quality, Innovation & Improvement is also a member of the Quality and Performance Committee. The Audit Committee is charged with reviewing clinical governance arrangements as part of the overall system of controls. To meet this requirement, a copy of the Chairs Assurance	• Right Care (Quality) Strategy • Clinical Audit reports • Minutes of Quality and Performance Committee • Quality and Performance Workplan • Clinical Effectiveness Management Group minutes • Clinical Effectiveness Management Group Workplan • IPR to Board of Directors • Quality Account • Audit Committee Minutes • Internal Audit Reports	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		Report from the Quality and Performance Committee is submitted to every meeting.		
A.1.7	The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board of directors and the council of governors and for recording and submitting objections to decisions considered or taken by the board of directors in matters of propriety or regularity and on issues relating to the wider responsibilities of the accounting officer for economy, efficiency and effectiveness.	The Chief Executive is fully aware of his responsibilities as Accounting Officer and follows the procedure as set out by NHS Improvement.	• Signed copy of the Accountable Officer Memorandum on appointment 1 April 2019. • Signed declaration within Annual Report	√
A.1.8	The board of directors should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life, which includes the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership (The Nolan Principles)	The Board Standing Orders includes role descriptions and code of conduct for the Trust Board. Clear and transparent procedures for declaration of interests are in place and all corporate meetings require declarations to be made. Work was undertaken during 2020/21 to move to a bespoke set of values and behaviours specific to the Trust. The Trust's new values are Working Together; Making a Difference; and Being at our Best. These new values will underpin the Trust's strategic objectives and leadership approach taken by the organisation.	• Code of conduct signed by all members of the Board • Register of Interests • Standards of Business Conduct policy • Trust Values • Annual plan • Our Strategy 2019-2024	√
A.1.9	The board of directors should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility. The board of directors should follow a policy of openness and transparency in its proceedings and decision making unless this is in conflict with the need to protect the wider interests of the public or the NHS	The Board of Directors have signed a code of conduct which is based on public service values of Accountability; Probity and Openness. All minutes of public Board meetings and key papers are published on the Trust web site and	• Web site – Trust Board • Standards of Business Conduct Policy • Code of Conduct	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	foundation trust (including commercial in confidence matters) and make clear how potential conflicts of interest are dealt with.	only those papers which are specifically exempt under the FOIA are unpublished.	• Register of Interests	
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	The Trust does not have Directors & Officers Liability insurance. The NHS Resolution Liability insurances offers an element of protection. However, as the Trust is not an FT, there is financial protection for Directors and Officers underwritten by the Secretary of State.		N/A
A.2	**Division of Responsibilities** **There should be a division of responsibilities at the head of the NHS Foundation Trust between the chairing of the Boards of Directors and Council of Governors, and the executive responsibility for the running of the NHS Foundation Trust affairs. No one individual should have unfettered powers of decision.**			
A.2.1	The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the Board of Directors.	Last approved by Board January 2014. This document needs to be updated to current Chair and Chief Executive and submitted to the Board of Directors for approval. A summary of the division of responsibilities is included within the Chair/NED Induction Pack.	• Board of Director minutes 29 January 2014. • Chair/NED Induction Pack	
A.3	**The Chairperson** **The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.**			
A.3.1	The chairperson should, on appointment, by the council of governors, meet the independence criteria set out in B.1.1. A chief executive should not go on to be chairperson of the same NHS foundation trust.	The Chair was appointed 1st February 2019. NHS Improvement leads the appointment process for NHS Trusts on behalf of the Secretary of State. On appointment the chairman met the independence criteria and had not previously been a chief executive of the Trust. The Chairman continues to meet the independence criteria.	• NHSI Appointment processes. • Declaration of Interest	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.4	**Non-Executive Directors** **As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.**			
A.4.1	In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channel of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.	The role of SID was undertaken by a Non-Executive Director who was also the NED lead for Freedom to Speak Up during 2020/21. The roles will be split and undertaken by two Non-Executive Directors from 1st April 2021. The SID is available to all Directors if they have concerns that contact through the normal channel of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate.	• Appointment agreed by Board – July 2019 Board minutes	√
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present. Led by the senior independent director, the non-executive directors should meet without the chairperson at least annually to appraise the chairperson's performance and on such other occasions as are deemed appropriate.	The Chairman meets with Non-Executive Directors on request and on a regular basis throughout the year. Whilst the Trust is not an FT, the appraisal of the Chairman was undertaken by the SID during 2020/21 in accordance with new guidance released by NHSE/I in November 2019 'Framework for Conducting Annual Appraisals of NHS Provider Chairs'.	• Appraisal documentation	√
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chairperson for circulation to the board, if they have any such concerns.	The Trust values embrace NHS values and underpin the Trust's strategic objectives and the leadership approach taken by the organisation. The role of the Senior Independent Director and Director of Corporate Affairs support the escalation of concerns. All Board members are encouraged to articulate their views in Board	• Trust Board Minutes • Exit interviews	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		meetings and the minutes clearly and accurately reflect this.		

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
A.5	**Governors** **The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed objectives and the overall strategy of the NHS foundation trust.**			
A.5.1	The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year, Governors should, where practicable, make every effort to attend the meetings of the council of governors. The NHS foundation trust should take appropriate steps to facilitate attendance.	Not applicable.		
A.5.2	The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly as described in B.6.5	Not applicable.		
A.5.4	The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.	Not applicable.		
A.5.5	The chairperson is responsible for leadership of both the board of directors and the council of governors (see A.3) but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other executives and non-executives, as appropriate. In these meetings other	Not applicable.		

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	members of the council of governors may raise questions of the chairperson or his/her deputy, or any other relevant directors present at the meeting about the affairs of the NHS foundation trust.			
A.5.6	The council of governors should establish a policy for engagement with the board of directors for those circumstances when they have concerns about the performance of the board of directors, compliance with the new provider licence or other matters related to the overall wellbeing of the NHS foundation trust. The council of governors should input into the board's appointment of a senior independent director (see A.4.1).	Not applicable.		
A.5.7	The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective. In particular, by agreeing the availability and timely communication of relevant information, discussion and the setting of advance meeting agendas and, where possible, using clear, unambiguous language.	Not applicable.		
A.5.8	The council of governors should exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chairperson with the senior independent director in the first instance.	Not applicable.		
A.5.9	The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, for example, clinical statistical data and operational data.	Not applicable.		

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B	**EFFECTIVENESS**			
B.1.	**The Composition of the Board** **The board of directors and its committees should have the appropriate balance of skills, experience, independence and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.**			
B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	The Trust's Establishment Order sets out the authorised numbers for voting Board members. In addition, the Trust's Standing Orders sets out the statutory roles of the Board of Directors. There is 1 Non-Executive Chair, and 5 Non-Executive Directors and 5 voting Executive Directors (3 or which are statutory roles). The appointment process for Non-Executive appointments is undertaken through NHS Improvement. The longest serving Non-Executive Director Terms of office expired in March 2021 after serving a 7 year term.	• Establishment Order • Standing Orders • Annual Report	√
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	The Standing Orders/Employment Contracts prevents an individual holding office as both director and governor at the same time.	• Standing Orders • Register of Interests	√
B.2	**Appointments to the Board** **There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be 'fit and proper' to meet the requirements of the general conditions for the provider licence.**			
B.2.1	The Nomination Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The Nomination Committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the NHS foundation trust and the skills and expertise required within the board.	The Nomination and Remuneration Committee has responsibility for Chief Executive and Executive Directors appointments and terms & conditions. Upon identification of a vacancy, the skills requirement is considered prior to drafting a job description and recruitment process taking place. The Committee then makes recommendations to NHSE/I for final approval.	• Committee ToR • Committee minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2.2	Directors on the board of directors and governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those without certain recent criminal convictions and director disqualifications, and those who are not bankrupt (undischarged). In exceptional circumstances and at Monitor's discretion an exemption to this may be granted. Trusts should also abide by the updated guidance from the CQC regarding appointments to senior positions in organisations subject to CQC regulations.	All Non-Executive and Executive Directors, Deputy Directors, and Associate Non-Executive Directors are subject to the 'fit and proper' test which is undertaken as part of the appointment process, including senior interim appointments. Non-Executive Director 'fit and proper person' checks are undertaken by NHSE/I however the Trust will undertake Occupational Health Assessment, Proof of Identity and DBS checks. There is an annual revalidation process in place which is reported to the Board. The Director of People has accountability for the FPPR application and compliance.	• Annual revalidation process F&PPT Declaration • Fit and Proper Person Test Procedure • Register of Interests • Contracts • Board Minutes • Internal Audit Findings	√
B.2.3	There be may one or two Nominations Committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chairperson). The Nominations Committee(s) should regularly review the structure, size and composition of the board of directors and make recommendations for changes where appropriate. In particular, the Nominations Committee(s) should evaluate, at least annually, the balance of skills, knowledge and experience on the board of directors, and, in light of this evaluation, prepare a description of the role and capabilities required for appointment of both executive and non-executive directors, including the chairperson.	The Trust has a Nominations and Remuneration Committee for considering executive director appointments and terms & conditions. NHS Improvement is responsible for the appointment and terms and conditions of non-Executive and Chairman appointments.	• Terms of Reference • Committee minutes	√
B.2.4	The chairperson or an independent non-executive director should chair the Nominations Committee.	The Chairman of the Trust Chairs the Nominations and Remuneration Committee.	• Committee minutes • Attendance register • ToR	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new chairperson and non-executive directors. Once suitable candidates have been identified the Nominations Committee should make recommendations to the council of governors.	The Trust Chairman is appointed through NHS Improvement on behalf of the Secretary of State.	• Appointment letter	√
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist only of a majority of governors. If only one nominations committee exists, when nominations for non-executive, including the appointment of the chairperson or a deputy chairperson, are being discussed, there should be a majority of governors on the committee and also a majority governor representation on the interview panel.	Not applicable		
B.2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	Not applicable		
B.2.8	The annual report should describe the process followed by the council of governors in relation to appointments of the chairperson and non-executive directors.	Not applicable		
B.2.9	An independent external adviser should not be a member of or have a vote on the Nominations Committee(s).	There is no provision within the Nominations and Remuneration Committee Terms of Reference that allow for an independent advisor to attend meetings.	• ToR • Minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.3	**Commitment** **All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively.**			
B.3.3	The board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.	The Declaration of Interest process requires all Directors to declare their outside interests. The Standards of Business Conduct policy deals with outside employment and no outside employment can be sought without prior agreement from the Board.	• Register of Interests • Standards of Business Conduct Policy	√
B.4	**Development** **All directors and governors should receive appropriate induction on joining the Board of Directors or the Council of Governors and should regularly update and refresh their skills and knowledge. Both directors and governors should make every effort to participate in training that is offered.**			
B.4.1	The chairperson should ensure that directors and governors receive a full and tailored induction on joining the Board or council of governors. As part of this, directors should seek out opportunities to engage with stakeholders, including patients, clinicians and other staff. Directors should also have access, at the NHS FTs expense, to training courses and/or materials that are consistent with their individual and collective development programme.	An Induction pack for Chairs/Non-Executive Directors exists which provides an overview of the Trust and its governance arrangements. Included in the document is a summary of the induction process which identifies the various elements to be met as part of their induction. In addition, NEDs are informed of any additional conferences/training programmes to assist them in their role and a record of attendance is kept. There is a Board Development work plan in place where additional training is provided to all Board members. The Chief Executive is responsible for the induction of new Executive Directors. All Directors and Non-Executive Directors are expected to complete their mandatory training. The Trust does not have a council of governors.	• Chair/NED Induction Pack • Board Development Programme • Mandatory Training • NED Training/Event Register	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.4.2	The chairperson should regularly review and agree with each director their training and development needs as they relate to their role on the board.	NHSI set the appraisal requirements for NEDs however the chair identifies any training & development required through annual appraisals with the NEDs. The Chief Executive undertakes the appraisals for Executive Directors and will identify any relevant additional training and development required for their role.	• Appraisal documentation.	√
B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	Not applicable		
B.5	**Information and Support** **The board of directors and council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties**			
B.5.1	The board of directors and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decision they have to make. The board of directors and the council of governors should agree their respective information needs with the executive directors through the chairperson. The information for the boards should be concise, objective, accurate and timely, and it should be accompanied by clear explanations of complex issues. The board of directors should have complete access to any information about the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	The covering sheet of Board papers provides clarity over a paper's salient points and the action required during the meeting. The BoD has an annual cycle of business to ensure that all key governance information is presented in the appropriate manner at the relevant time. Further in depth information is provided to the Board assurance committees. Should any additional reporting be required this can be arranged. All committee terms of reference allow for members to call upon other staff members to attend to answer queries and/or provide information.	• Board paper front Cover • Cycle of Business • Board minutes • ToR	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.5.2	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board of directors, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis to be carried out in a timely manner, within the NHS foundation trust. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The SFIs/SoD allow for the provision of professional advice where appropriate.	• SFIs/SoD	√
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. Decision to appoint an external adviser should be the collective decision of the majority of directors. The availability of independent external sources of advice should be made clear at the time of appointment.	The SFIs/SoD allow for the provision of professional advice where appropriate. External advice will only be sought if deemed appropriate by all members.	• SFIs/SoD	√
B.5.4	Committees should be provided with sufficient resources to undertake their duties. The board of directors should also ensure that the council of governors is provided with sufficient resource to undertake its duties with such arrangements agreed in advance.	The Corporate Governance Team support the Board of Directors and its assurance committees.	• Board/Committee structure	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.6	**Evaluation**			
B.6.3	The senior independent director should lead the performance evaluation of the chairperson within a framework agreed by the council of governors and taking into account the views of the directors and governors.	The appraisal process for the Chairman is undertaken by the SID and in according with NHSE/Is Framework for Conducting Annual Appraisals of NHS Provider Chairs	• Appraisal documentation	√
B.6.4	The chairperson, with the assistance of the Company Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties.	Due to the COVID-19 pandemic, Board Development was postponed until October 2020 and since then the following board development sessions have taken place on the following topics: • Winter Preparation and Planning Overview including COVID-19 Wave 2 (October 2020) • NHS 111 First(October 2020) • PTS (October 2020) • Capacity and Demand(October 2020) • Strategic Planning Process for Q4 and 2021/22(October 2020) • Integrated Care System (February 2021) • Urgent and Emergency Care Metrics and Measurements (February 2021) • Strategic Planning (February 2021) • Finance (February 2021)	• Board Development Sessions Programme • Attendance List • Board Skills Matrix	√
B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities, including their impact and effectiveness on:	Not applicable		

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	• Holding the non-executive directors individually and collectively to account for the performance of the board of directors • Communicating with their member constituencies and the public and transmitting their views to the board of directors; and • Contributing to the development of forward plans of the NHS foundation trust. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.			
B.6.6	There should be clear policy and fair process, agreed and adopted by the council of governors for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	Not applicable		

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.8	**Resignation of Directors** **The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its licence; its constitution; mandatory guidance issued by Monitor; relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate succession planning.**			
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	The Deputy Chief Executive left the Trust on 31 March 2021 and provided 6 months' notice as per the employment contract. In the rare circumstance where appropriate notice is not served, agreement will be sought from the Nominations & Remuneration Committee and NHS Improvement for mitigations.	• Minutes NARC and Board meetings • Executive Employment Contracts	√
C	**ACCOUNTABILITY**			
C.1	**Financial, quality and operational reporting** **The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.**			
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	The Directors receive assurance from the Auditors at year-end which is reported to the Board of Directors and declared within the Annual Report. The Director of Finance presented the Board with a paper on Going Concern at the Board Meeting on 31st March 2021 for agreement.	• Annual Report and Accounts • Auditors Opinion • Board Minutes	√
C.1.3	At least annually and in a timely manner, the board of directors should set out clearly it's financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and	All of this information is disseminated within the Annual Report as per Group Accounting Manual (GAM) Requirements.	• Annual Report • Board minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	operation, including clinical outcome data, to allow members and governors to evaluate its performance. Further requirements are included in the NHS FT ARM.			
C.2	**The Board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.** **The board of directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHSFTs assets and service quality. The board should report on internal control through the Annual Governance Statement in the annual report.**			
C.2.1	The Board of directors should maintain continuous oversight of the effectiveness of the NHS FTs risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	The Risk Appetite Statement for 2020/21 was approved by the Board on 27th May 2020 and is reviewed on an annual basis. The Board of Directors receive the Board Assurance Framework quarterly. As Accountable Officer, the Chief Executive has responsibility for maintaining a sound system of internal control which is detailed within the Annual Governance Statement and included in the Annual Report.	• Risk Management Strategy • Risk Management Policy • Risk Appetite Statement • Board Assurance Framework • Annual Report • Head of Internal Audit Opinion • Annual Governance Statement • Minutes of Committee Meetings • Minutes of Board Meetings	√
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) If it does not have an internal audit function, that fact and the processes it employs for evaluating	Reference to Internal Audit is detailed within the Annual Governance Statement. As an NHS Trust, the Annual Report is prepared in compliance with the requirements detailed within the Group Accounting Manual.	• Annual Governance Statement • Annual Report • Group Accounting Manual	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	and continually improving the effectiveness of its risk management and internal control processes.			
C.3	**Audit Committee & Auditors** **The board of directors should establish formal and transparent arrangements for considering how they should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.**			
C.3.1	The board of directors should establish an audit committee composed of at least 3 members who are all independent non-executive directors. The board should satisfy itself that the membership of the audit committee has sufficient skills to discharge its responsibilities effectively; including ensuring that at least one member of the audit committee has recent and relevant financial experience. The chairperson of the trust should not chair or be a member of the audit committee. He can, however, attend meetings by invitation as appropriate.	The Audit Committee Terms of Reference include 3 Non-Executives and 2 Associate Non-Executive as members. The Chair of the Audit Committee has the relevant recent financial experience. The Trust Chair is not a member of the committee.	• ToR • Standing Orders • Minutes of Audit committee	√
C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing the external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information to the governors on the external auditor's performance as well as overseeing the NHS foundation trust's internal financial reporting and internal auditing.	Not applicable		
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances,	The Audit Panel reviewed the procurement process to appoint an External Auditor through the SBS Framework in Q3 2019/20. In January	• Minutes of Audit Committee • Audit Panel Minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	operations and forward plans of the NHS foundation trust. The current best practice is for a three-to-five year period of appointment.	2020, the Audit Panel evaluated the outcome of the exercise and recommended the appointment of the External Auditor to the Board of Directors in January 2020.	• Audit Committee Minutes	
C.3.7	When the council of governors ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Not applicable		
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The audit committee's objective should be to ensure that arrangements are in place for appropriate follow-up action. This should include ensuring safeguards for those who raise concerns are in place and operating effectively. Such processes should enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure that valid concerns are promptly addressed. These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.	The Freedom to Speak Up Policy and Procedure was approved by the Board of Directors on 29 January 2020. The Trust has a dedicated Freedom to Speak Up Guardian and during 2020/21 a number of Freedom to Speak Up Champions were appointed across the Trust to assist the Guardian and to support staff to speak up. The executive lead for Freedom to Speak Up is the Director of Corporate Affairs and there is also an independent Non-Executive lead.	• Quarterly FTSU Report to Board • Board minutes • Freedom to Speak Up Strategy • Internal Audit Report	√

D	REMUNERATION			
D.1	**The level and components of remuneration** **Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead an NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements.**			
D.1.1	Any performance related elements of the remuneration of executive directors should be designed to align their interest with those of patients, service users and taxpayers to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: • The remuneration committee should consider whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients. • Pay-outs or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria which reflect the performance of the NHS foundation trust relative to a group for comparator trusts in some key indicators, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed. • The remuneration committee should consider the pension consequences and associated	The Trust is able to pay performance related pay to those Directors who are paid under the VSM framework, providing the Trust adheres to NHSE/I guidance. These payments are subject to approval from the Nominations & Remuneration Committee and NHSI and are based on evidence presented around annual performance and delivery of objectives.	• NARC minutes	√

	costs to the NHS foundation trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.			
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	The levels of remuneration are dictated by NHS Improvement for NHS Trusts. However, in November 2019 NHS Improvement published a structure to align remuneration for Chairs and Non-Executive Directors of NHS Trusts and NHS Foundation Trust. This will introduce a single uniform annual rate of pay to apply in addition to local discretion to award supplementary payments in recognition of designated extra responsibilities. This will be implemented over a 2.5 year period beginning October 2019 and concluding in April 2022.	• Appointment letters	√
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	If the Trust were to make a redundancy/severance any claw back arrangements would be reflected in a settlement agreement, stating the requirement for the individual to pay back a proportion of the payment if they were to take up another NHS post. However, the employment contracts do not reflect a departing directors requirement for compensation to be reduced. Since 2019, new director appointments reflect a 'claw back' agreement subject to achieving performance criteria which means all Executive Directors currently in post have this clause in their contracts.	• Employment contracts (from 2019)	√

D.2	**Procedure** **There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration.**			
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of senior management for this purpose should be determined by the board, but should normally include the first layer of management below board level.	The Nominations and Remuneration Committee have responsibility for setting executive directors remuneration including compensation payments and pension rights. This is reflected in the Committee Terms of Reference. The executive pay structure is governed by the DH VSM Pay Framework of 2013 and NHSI Guidance from 2018. The Trust's definition of a senior manager is the Chief Executive and Executive Director posts.	• NARC Committee ToR • Annual Report	√
D.2.3	The council of governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Remuneration is set by NHS Improvement for Chair and Non-Executive Directors for NHS Trusts. However, in November 2019 NHS Improvement published a structure to align remuneration for Chairs and Non-Executive Directors of NHS Trusts and NHS Foundation Trust. This will introduce a single uniform annual rate of pay to apply in addition to local discretion to award supplementary payments in recognition of designated extra responsibilities. This will be implemented over a 2.5 year period beginning October 2019 and concluding in April 2022.		√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2020/21

E	RELATIONS WITH STAKEHOLDERS			
E.1	**Dialogue with members, patients and the local community**			
E.1.2	The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums (e.g. local Healthwatch, the OSC, the League of Friends and staff groups).	The Communications and Engagement Strategy states engagement activities are extensive, including but not limited to, commissioners, NHS Trust providers, regulators, A&E Delivery Boards, local MPs and patient and public groups. The Trust is engaged with stakeholders across the North West covering 31 CCGs and are involved in any potential discussions early to ensure options can be impact assessed for safe and sustainable delivery. Local MPs are offered regular briefings, meetings and the opportunity to accompany a crew on an ambulance or visit one of the trust's EOCs. Strong links have been forged with many community groups, statutory bodies such as Healthwatch and Scrutiny Committees, commissioner and health and social care partners in the region. The Trust has a Patient and Public Panel (PPP) its aims are specifically to: • Ensure the voices of patients/the public are heard and acted upon. • Remedy an identified weakness in our lack of community engagement and structured patient and public involvement. • Create the infrastructure to enable patients/the public to become involved at a	• Communications and Engagement Strategy • Right Care Strategy • Friends and Family Test • Patient and Public Panel	√

		level that suits them and in their selected area(s) of interest. • Set out clear expectations from both the patient/public and the trust's perspective. • Develop a work-plan for patient and public engagement and involvement. • Provide meaningful opportunities for patients/the public to influence service planning and delivery and to develop service improvements using co-production methodology. • Ensure patient and public representation can act as a critical friend for the trust's business.		
E.1.3	The chairperson should ensure that the view of governors and members are communicated to the board as a whole. The chairperson should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors to listen to their views in order to help develop a balanced understanding of the issues and concerns of governors.	Not applicable.		
E.2	**Co-operation with third parties with roles in relation to NHS foundation trusts** **The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.**			
E.2.1	The board of directors should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.	The Board has built relations with 3rd party bodies with which it has a duty to co-operate e.g. NHS Improvement; NHS England, Lead Commissioner and CQC. Members of the Board and senior leadership are the nominated contacts for these organisations.	• ELC Minutes • Board Minutes	√

E.2.2	The board of directors should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.	The Communications and Engagement Strategy states engagement activities are extensive, including but not limited to, commissioners, NHS Trust providers, regulators, A&E Delivery Boards, local MPs and patient and public groups. The Trust is engaged with stakeholders across the North West covering 31 CCGs and are involved in any potential discussions early to ensure options can be impact assessed for safe and sustainable delivery. Local MPs are offered regular briefings, meetings and the opportunity to accompany a crew on an ambulance or visit one of the trust's control centres. Strong links have been forged with many community groups, statutory bodies such as Healthwatch and Health Scrutiny Committees, commissioner and health and social care partners as well as Health and Wellbeing Boards in the region.	• Communications and Engagement Strategy	√

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th April 2021			
SUBJECT:	Use of Common Seal Bi-Annual Report			
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
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 a bi-annual basis with the previous report received by the Board on 25th November 2020. During the period 1st October 2020 to 31st March 2021, the Trust's Common Seal was applied on a total of 6 occasions and the details can be found in s2.			
RECOMMENDATION:	The Board of Directors is recommended to: • Note the occasions of use of the Common Seal as detailed in s2 of the report. • Note compliance with s8 of the Standing Orders.			
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:			
	Outcome:			

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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 between the period 1st October 2020 to 31st March 2021.

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 a bi-annual basis with the previous report received by the Board on 25th November 2020.

During the period 1st October to 31st March 2021, the Trust's Common Seal was applied on a total of 6 occasions. There were:

Reg No	Date	Reason
140	6 October 2020	Broughton Mast Lease
141	3 November 2020	Lease of Sefton House, Middlebrook
142	10 November 2020	Land at Cell 22, Liverpool Innovation Park
143	28 January 2021	Supplemental Agreement to vary a contract – Ulverston Ambulance Station
144	23 February 2021	Sale and leaseback of Huyton Ambulance Station
145	16 March 2021	Cumbria County Council & NWAS – Lease Ulverston Blue Light Hub

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, GOVERNANCE AND/OR RISK 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 as detailed in s2 of the report.
- Note compliance with s8 of the Standing Orders.

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NHS
North West
Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28 April 2021		
SUBJECT:	Freedom to Speak Up Guardian Report Q3 and Q4 2020-2021		
PRESENTED BY:	Rachael Foot, Freedom to Speak Up Guardian Angela Wetton, Director of Corporate Affairs		
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	There is a risk that the Trust may not deliver safe, effective and patient centred care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction.	☒
	SR02	There is a risk that the Trust cannot evidence value for money and effectiveness in the use of resources that could impact on its ability to invest in improvements and infrastructure.	☐
	SR03	There is a risk that the Trust does not deliver improved national and local operational standards resulting in unsafe or delayed care.	☐
	SR04	There is a risk that the Trust is unable to attract or retain suitably qualified and diverse staff, this may impact on our ability to deliver safe services.	☒
PURPOSE OF PAPER:	For Assurance		
EXECUTIVE SUMMARY:	Ninety three concerns were raised during the latter half of 2020-21 (further analysis s3.1 and 3.2): • Attitudes and Behaviours : 12 • B&H Allegation : 9 • HR Matter : 21 • Working Practices : 8 • COVID 19 : 13 • Other : 14 • Detriment : 1 • Patient Safety : 13 • Fraud : 2 • 1 colleague has reported having suffered 'perceived 'detriment' as a result of raising a concern. • 3 truly anonymous concerns received (where the identity of the concern raiser is unknown). • 36 (38%) of concern raisers requested the Guardian and/or Champion protect their anonymity. A selection of cases closed and details around learning/outcomes can be seen in Appendix 1. The comparative data to the end of Q3 2020-21 for the whole Ambulance sector, can be seen at Appendix 2.		
RECOMMENDATION:	The Board of Directors are requested to: • Note the work of the Guardian. • Note and comment on the themes, trends, issues and learning identified in this report.		

	• Determine whether this report sufficiently assures the Board that the Trust promotes a culture of open and honest communication to support staff to speak up. • Consider any risks and further actions for the Trust.			
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:	N/A		
	Outcome:	N/A		

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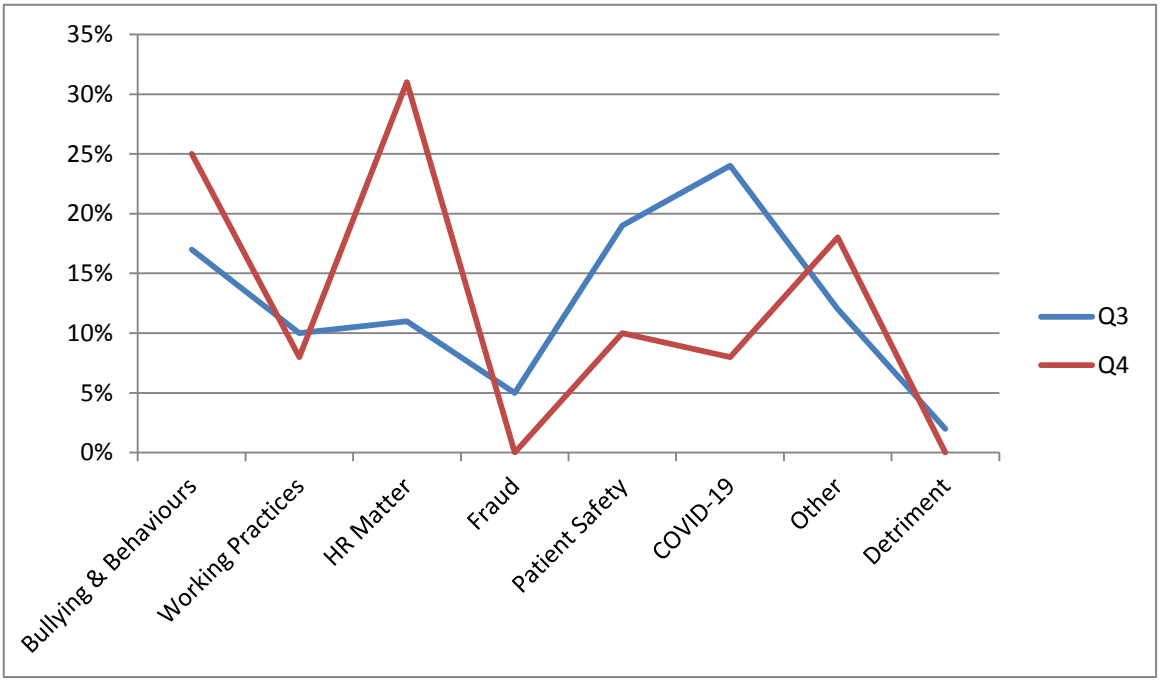
1.	**PURPOSE**
	The purpose of the paper is to provide assurance to the Board of a healthy and effective Freedom to Speak Up (FTSU) culture in line with current best practice (NHSEI; July 2019 and National Guardians Office; July 2018) for Quarter three and Quarter four 2020/2021. The role of the Board in relation to FTSU is key. It is the expectation of the National Guardian's Office (NGO), CQC and NHS Improvement that senior leaders are knowledgeable on FTSU matters and work in partnership with the Freedom to Speak Up Guardian (FTSUG) to actively shape the speaking up culture. Freedom to Speak Up Guardians support workers to speak up, as well as working with others in their organisation to tackle barriers to speaking up. Effective speaking up arrangements protect patients and improve the experience of NHS workers. 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. As the Covid-19 situation evolves, it is even more essential that staff have the freedom to speak up. Speaking up, and listening up, is critical in times of challenge, when our staff are stretched to their very limits. The report includes benchmark information against other Ambulance trusts published by the NGO. This can be seen at appendix 2. Finally, the report includes information about the number of cases received, shared learning, key themes and actions taken to improve.
2.	**BACKGROUND**
	Freedom to Speak Up Guardians were established in every trust in England in the wake of the Francis Inquiry into the events at Mid-Staffordshire Foundation. Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. Fostering a culture in which staff are supported to speak up and removing barriers that may prevent them from doing so, is in the best interests of every trust that wants to deliver the highest quality care possible. The FTSUG role incorporates being an additional route for 'raising concerns' but extends well beyond, aiming at developing cultures where safety concerns are identified and addressed at an early stage. The Guardian ensures that policies are in place and that staff know who to contact if they have concerns. 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 FTSU process can expect to be thanked for speaking up and receive independent, impartial support and advice from the Trust's FTSUG and Champions.
3.	**QUARTER 3 and 4 2020/21 ACTIVITY**
	FTSU 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 Q3 and Q4 2020/21 and provides further detailed breakdown. It is the responsibility of the FTSUG to record and monitor all concerns raised and report them to the Trust's Board of Directors on a bi-annual basis and to the NGO on a quarterly basis.
3.1	**Concerns Raised** The FTSUG received forty two concerns during Q3 and fifty one concerns during Q4. This is a decrease in the number of cases raised during the same reporting period of the previous year which by comparison, recorded sixty concerns during Q3 and sixty seven concerns during Q4. The number of FTSU cases is not solely reflective of the speaking up culture in NWAS. There are many existing routes for staff to raise concerns, through incident reporting mechanisms, via their line manager or HR, or directly to an executive or non-executive director amongst others. There has been continuous promotion of FTSU in a variety of virtual forums or via social media and regional bulletins. This has helped to raise and maintain the awareness and profile of the FTSU function during the pandemic. Of the forty two cases raised during Q3: Eight cases in total relate to bullying, attitudes and behaviours. • Two of these concerns have an accusation of racism raised in them. • Seven of these concerns relate to the behaviour of staff who are in a position of authority and some examples are: o A manager felt a lack of support from senior management and on occasions has felt excluded from any decision making. o Senior manager using what has been described as a 'threatening tone' during telephone conversations, causing the member of staff some distress. o Senior manager using what has been described as a 'threatening tone' on numerous occasions and has been described as an 'intimidating individual'. o Team leader making an indirect racist comment. Of the fifty one cases raised during Q4: o Thirteen relate to bullying, attitudes and behaviours. o Ten relate to the behaviour of staff that are in a position of authority and some examples of these concerns are: o Senior manager allegedly breaching government restrictions during a period of national lockdown.

- Senior manager using what has been described as a 'threatening and intimidating tone' when speaking to staff that have made a suggestion for improvement in the department.
- Team Leader's inappropriate attitude in relation to a staff member raising a concern about self-isolating.
- A number of Team Leaders allegedly discussing staff who are off sick in a derogatory manner with other colleagues and making inappropriate comments on the GRS rota against their names for other staff to see.



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

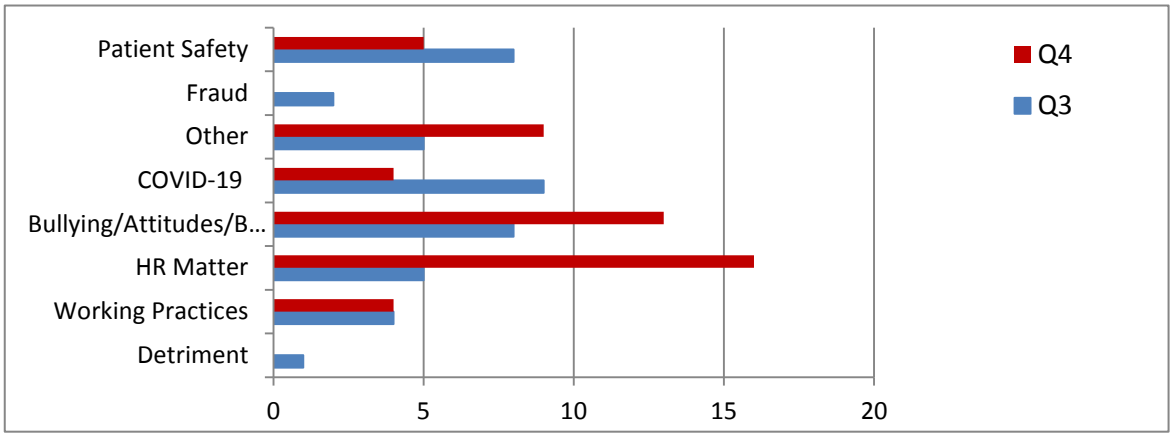
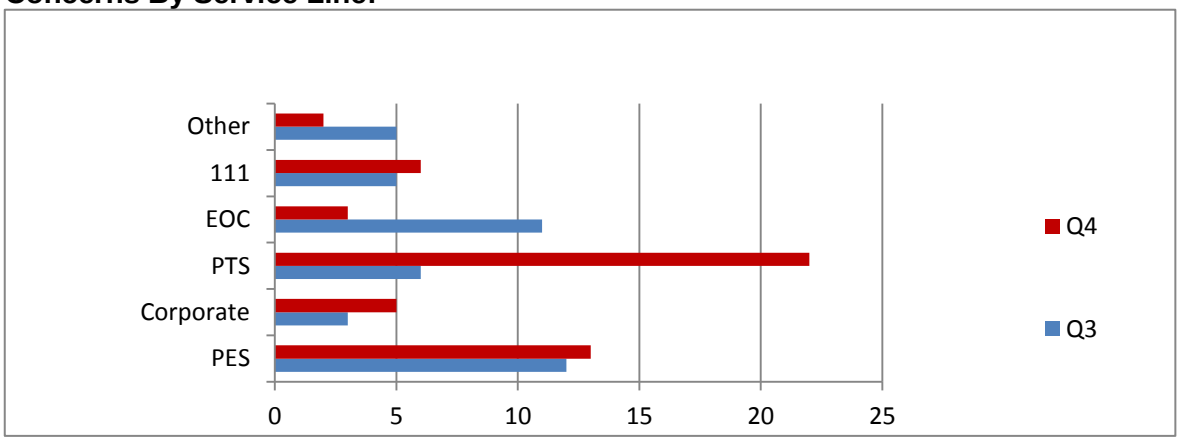
The category 'Other' includes:

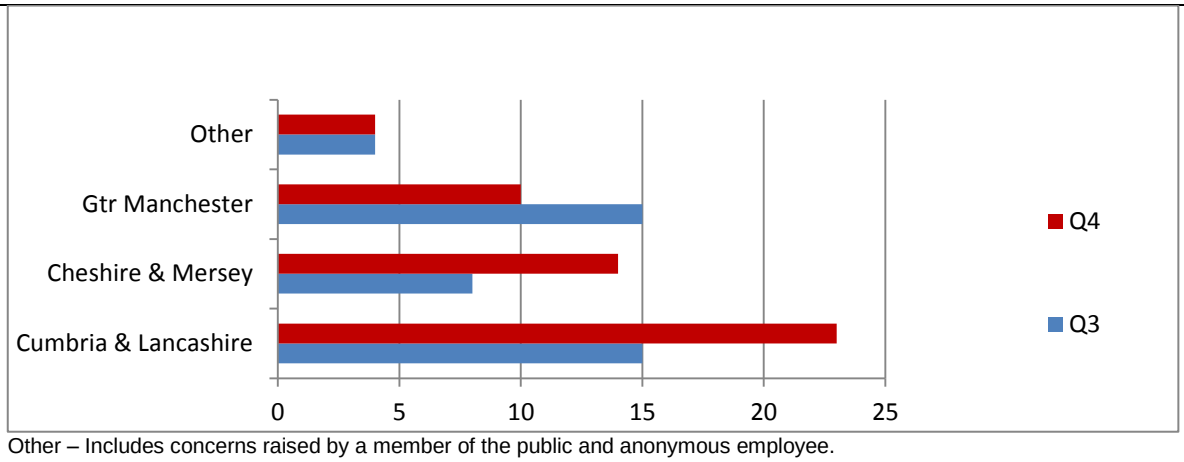
- Issues obtaining new uniform, despite a number of requests having been made to local management.
- Member of the public concerned that a neighbour is abusing the use of the Ambulance Service
- Health and Safety concerns relating to the seat belt position in some of the FIAT Ambulances.

Covid-19:

During Q3 and Q4, FTSU continued to see concerns being raised in relation to the Covid-19 pandemic. Concerns included:

- Quality of a brand of masks (poor) which has caused a number of staff some health issues.
- Staff requesting that screens are placed in-between desks, giving protection to those staff sat side by side with one another.
- Health and Safety concerns relating to the fire doors being propped open to prevent the number of staff having to physically touch the doors in order to help eliminate the spread of infection.

3.2	**Year to Date Breakdown of Concerns** **Concerns by National Reporting Category:**  Other – Includes concerns raised by a member of the public. **Concerns By Service Line:**  Other – Includes concerns raised by a member of the public and an ex-employee. Data highlights that concerns raised continue to be dominated by our colleagues on the front line which is entirely consistent with their operating environment, providing care at the 'front end' of Planned, Urgent and Emergency care. Within national reporting, the National Guardian's Office have demonstrated that more issues are raised through FTSU concerning staff experience than patient safety; this is consistent with NWAS experience. **Concerns by Geographical Area:**



Other – Includes concerns raised by a member of the public and anonymous employee.
Please note - the activity as detailed above reflects only cases reported via FTSU. Concerns raised with local managers and directly with HR are not included in these figures.

Concerns continue to be dealt with via the relevant policies and procedures within the trust, for example, HR and operational management have been consulted to decide on next steps which are proportionate and balanced in relation to the seriousness of the complaint.

National Data

The comparative data to the end of Q3 2020-21 for the whole Ambulance sector can be seen at Appendix 2. It has been highlighted in previous reports that when compared to Trusts of similar employee size NWAS continues to see a higher number of concerns being raised.

Anonymity

During the reporting period, there has been three truly anonymous (i.e. unknown source) concerns raised with the Guardian. This would suggest that staff feel confident to speak up particularly when considered alongside the overall number of cases raised.

During Q3, seventeen concern raisers requested the Guardian and/or Champion protect their anonymity and during Q4 this figure was nineteen. The reason given for this was a fear of suffering reprisal as a result of speaking up.

This is an increase in the number of staff asking for their anonymity to be protected in comparison to the previous quarter, in which the Guardian and/or Champion protected twelve staff members' anonymity. The Guardian and Champions will continue to work with staff speaking up, to empower them to raise their concerns in confidence and openly. The FTSUG asks that the Board continues to affirm that we will not tolerate the victimisation of staff who have spoken up and will act swiftly should this occur.

Detriment

The NGO requires every FTSUG to report against whether staff speaking up feel they have suffered detriment as a direct result of speaking up.

During Q3, one colleague has reported having suffered 'perceived detriment' as a result of raising a concern. The HR team has looked to understand and address the concern which they have found to be unsubstantiated. NWAS policies make it clear that such behaviour is not tolerated. The Care Quality Commission will consider this when evaluating how well-led organisations are.

There have been no concerns raised during Q4 in relation to staff having suffered detriment as a result of having spoken up.

A plan of protection for staff who raise serious concerns and a robust process to review any claims of detriment has been raised nationally with the NGO and we await a response.

Feedback
Feedback is sought from staff about their speaking up experience.

NGO guidance states that FTSU Guardians should seek feedback when a case is closed, even when the individual speaking up may be unhappy with the outcome of their case.

During Q3 and Q4, the FTSUG has seen a slight increase in the number of feedback responses received, twenty three in total which have predominantly been received verbally.

The feedback received, indicates that those feeding back 'would speak up again given their experience and several staff wished they had spoken up sooner.

The feedback obtained is also supportive of the FTSU process. Staff have reported feeling listened to and supported during the process of speaking up. The feedback obtained shows positive experiences from speaking up to the FTSUG and/ or Champion, including gratitude to have an independent person whom they could speak to.

It should be noted that of these twenty three staff members who have stated that they would speak up again, seventeen are staff who have asked that the FTSUG and/or Champion protect their anonymity.

Mental Health Impact
The Guardian continues to monitor and log the number of staff reporting the negative impact speaking up has had on their family life and mental health and during Q3 and Q4 there have been three accounts of this being the case.

Intelligence received from our FTSU Champions who have been physically in the workplace, has also highlighted the impact the pandemic is having on staff wellbeing, leading to stress and burnout.

Demographics
The Guardian also takes this opportunity to capture demographic information of concern raisers where they are happy for this to happen.

The FTSUG can report that there has been a number of concerns raised by staff who have a protected characteristic but no obvious trends relating to these protected characteristics or particular groups of staff have been identified.

The pandemic has significantly impacted on the opportunities for the FTSUG to link in with teams around the trust and has reduced many of the engagement sessions that would normally have taken place with all face to face meetings and arranged visits to venues. The FTSUG has been working from home in line with national and local guidelines.

3.3 **Key Themes**

Cases generally do not fall naturally into one category of concern; they cut across two or sometimes three. The most fitting category is discussed with each staff member and agreed. HR matters have become the most prominent concern during Q4, with Bullying, attitudes and behaviours coming a close second.

The main themes identified during Q3 and Q4 are:

- Identification of hot spots of concerns via the FTSUG or FTSU Champions about culture, behaviour or morale.
- Behaviours and attitudes of workers, particularly managers is an emerging theme. A number of cases were raised about managers being unapproachable, leadership styles, communication issues and general behavioural matters. There is also a perception of cliques and favouritism where personal, social and work relationships can determine some access to development. In relation to the emerging themes regarding management and leadership, the Trust has a range of commitments in place through its Workforce Strategy which will continue to improve leadership capacity and capability, as well as overall organisational culture.
- Concerns have been raised around systems and processes not being consistently followed and this has been identified as a common theme resulting in a number of cases being referred to HR. These concerns are regularly linked to reports of management issues, relationships and favouritism.
- The FTSUG has seen an increase in the number of cases where staff speaking up needed a listening ear and reassurance, and not necessarily for action to be taken.
- Timeliness in investigating matters continues to be an ongoing issue, however this has been a national issue during the pandemic and NWAS is not an outlier.

Learning and Outcomes

Sixty three cases were closed during the reporting period and some examples of learning and outcomes from these cases can be seen in Appendix 1. The learning covers a wide range of topics, however, some key areas include:

- Raising awareness of key policies and processes already in place
- Expected behaviours
- Infection Prevention & Control measures
- Communications with staff
- Support for new members of staff.

3.4 **Outstanding Cases as at End of Q4 2020/21**

2019-20	
Q4	Numerous allegations of bullying, attitudes and behaviours of management in a particular area. Due to the nature and extent of the concerns raised, the Trust had initially appointed an independent investigator external to the Trust, who unfortunately due to unforeseen circumstances was unable to carry out the investigation, therefore, the Trust has appointed a senior manager from PES to investigate and that investigation has now concluded and the Guardian and complainant await a formal outcome of the findings which will be delivered during Q1 2021.
2020-21	
Q1	Two separate allegations have been raised that some staff in a department have been manufacturing their own overtime and that managers have authorised this. Although the audit has concluded,

		the case remains open as the individuals who have spoken up still need to be interviewed as part of the process. Seven allegations relate to the attitudes and behaviours of staff in a position of authority in a specific sector. These matters have been investigated as part of a cultural review and the Guardian and complainants await a formal outcome of findings which will be delivered at the beginning of Q1 2021.
	Q2	Six allegations relate to the attitudes and behaviours of staff in a position of authority in a specific sector. These matters have been investigated as part of a cultural review and feedback will be delivered to the complainants at the beginning of Q1 2021. Five allegations relate to the attitudes and behaviours of a member of staff in a specific sector are not in line with Trust values. These matters are currently being investigated. A Head of Service is currently reviewing a number of allegations raised by the same member of staff over a long period of time to ensure that the matters were robustly investigated and that the outcomes were fair and proportionate to the concern.
	Q3	An allegation that a member of staff who is currently in an acting up role has made an indirect racist comment and demonstrates an unprofessional attitude and behaviour. A number of students allegedly claiming mileage expenses despite car sharing. Health and safety concerns relating to the position of the seat belts in the FIAT ambulances. Two concerns relate to the attitude and behaviour of a manager in a senior role and a change to a procedure which the staff raising the concerns do not feel puts patient care first. Four concerns relate to dispatch closing sub calls into history whilst the EMD is still on the line to the patient. EMD is unable to retrieve information including DLS links without having to close the CAD that they are in and re-open the original CAD, this causing a delay in call handling. Two Dignity at Work concerns have been raised which have been signposted to HR. These include concerns relating to the attitude and behaviour of managers. A concern has been raised alleging that service records have been doctored to show that maintenance works had been carried out when they hadn't.
	Q4	A number of concerns have been raised by a member of staff from a private provider relating to patient and staff safety concerns due to mechanical issues and equipment issues i.e. staff driving un-roadworthy vehicles. Member of the public raising concerns about the number of ambulance call outs his neighbour makes. A Grievance has been raised relating to the alleged bullying attitudes and behaviours of a senior manager which are not in line with trust values. A Grievance has been raised in relation to how management have allegedly treated a member of staff who has resigned from the trust on the day that they submitted their resignation. A concern has been raised in relation to the attitude and behaviours of a number of staff on a particular team which are not in line with trust values. Two concerns have been raised in relation to the bullying, attitude and behaviour of a senior manager in a department.

			A Dignity at Work has been submitted in relation to a number of serious bullying allegations within a particular sector. Two members of staff have copied the FTSUG in to their email trails following a first stage Grievance. Concerns relate to an unfair rostering system. The matter is due to be heard at a second stage Grievance by the Head of Service during Q1 2021. A concern has been raised in relation to a number of SPTL's unprofessional conduct and concerns about there being 'cliques' at a particular station. One concern relates to the attitudes and behaviours of managers and the bullying and hostile environment shown towards students by their mentors at a particular station. A concern has been raised in relation to management in a certain area being unapproachable. FTSUG awaits further specific information before the matter can be progressed. A Grievance has been submitted relating to an unfair recruitment process.
3.5	**Actions to Improve Speaking Up Culture** During Q3 and Q4 the FTSU Guardian undertook the following activities to raise the profile and to promote speaking and listening up: • Regular promotion of FTSU in Regional Bulletin • Weekly FTSU Champion introductions via social media throughout October • Attendance and contribution at FTSU Regional Network • Attendance and contribution at FTSU National Ambulance Network • Attendance and contribution at Violence and Aggression Operational Group Forum • Attendance and contribution at Race Equality Forum • Attendance and contribution at Wellbeing and Engagement Group • Attendance and contribution at Disability Forum • Guardian worked with Communications to participate in NGO 'Speaking Up' campaign • Launch of FTSU icon on the staff app which allows staff to search for information relating to FTS and Raise a Concern **Freedom to Speak Up Month (October 2020)** • Launch of the FTSU Icon on staff app • Weekly FTSU article "raising Champions profiles" published in the Regional Bulletin • FTSUG and CEO "Speak Up to Me" video launched • FTSUG following principles of National Guardians Office (NGO) Alphabet of FTSU. **Learning and Improvement** The Trust is committed to continuing to learn and improve its systems and processes for raising concerns. This is done through: • Regular meetings held between the FTSUG, CEO, Executive Lead, Director of People 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 • 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. **Supporting Freedom to Speak Up** • Monthly meetings held between the FTSU Guardian; Chief Executive, FTSU Executive Lead and the Director of People to provide oversight that the Trust's systems and processes for speaking up are working effectively • 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 have 'targeted' visits in areas which have been detected • 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 to feedback themes that are emerging from speaking up activity • Freedom to Speak Up Champions - The Freedom to Speak Up Champions act as a point of contact for staff wishing to raise a concern but who feel unable to raise concerns with their line manager or feel a concern has not been sufficiently addressed at a local level. They promote the culture of raising concerns.
3.6	**National and Regional Updates** Due to the current pandemic, there has been a delay in rolling out the training packages which the NGO and HEE have been working on; however the first two of three e-learning modules 'speak up, listen up' has now been released and has been implemented across the Trust. The FTSU Part two training for middle managers was introduced in January with Level three delayed until later in the year. The National Guardians Office (NGO) pledged earlier in the year to undertake a review of ambulance services. The FTSU index suggests a positive speaking up culture and is associated with higher-performing organisations as rated by the CQC. This correlation is less apparent with ambulance trusts which tend to perform comparatively less well in the index despite most of them receiving 'good' ratings by the CQC. The NGO will be undertaking a review to work with ambulance trusts and their partners to understand why ambulance trusts tend to perform comparatively less well in the index. The NGO carries out case reviews to identify learning and support improvements in speaking up and is developing the way it decides what is reviewed. These changes seek to: • Allow more workers to inform matters that are reviewed by the office, including workers who may face barriers to speaking up • Ensure reviews undertaken by the office have the greatest impact on the greatest number of workers by focusing on priority areas. Potential themes for review will be identified through use of a broad range of indicators, including: • Staff engagement data (e.g. the NHS Staff Survey)

	Speaking up to: • Freedom to Speak Up Guardians • Professional and systems regulators • Workers' representative bodies • The NGO. The NGO will launch this new process during Q1 2021/22 **The Model Hospital** The Model Hospital is an NHS digital information service designed to help the NHS improve productivity, quality and efficiency. This digital tool allows NHS trusts, including FTSU Guardians in those organisations as well as others in the health system to compare metrics and identify areas of opportunity and improvement. During Q3 the Model Hospital (Ambulance) platform announced its latest update which included FTSU. The Q3 update included a newly developed 'culture and engagement' area. This area of the Model Hospital has been populated with a range of speaking up indicators, including data from Freedom to Speak Up (FTSU) Guardians in NHS Trusts on the speaking up cases raised with them. Data submission to the NGO – staff are to be identified not only by profession but also by professional level of 'worker', 'manager' or 'senior leader'. A recent addition of Ambulance (Operational) by the NGO to the Professional groups has provided better clarity between operational and non-operational staff. This is the highest category followed by Allied Health Professionals which includes supervisors and managers from across the Trust. The Administrative group now includes Maintenance and Ancillary which broadens the category. **Regional** The FTSU Guardian continued to attend virtual regional meetings. The regional update reflected the experience of the Guardian. It has been agreed that regional meetings will be held monthly.
4.	**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.
5.	**RECOMMENDATIONS** The Board of Directors are requested to: • To continue to proactively support the work of the FTSU Guardian, addressing concerns raised directly with Executive team members, appropriately and seeking the support of the Guardian as/when appropriate. • Note and comment on the themes, trends, issues and learning identified in this report. • Determine whether this report sufficiently assures the Board that the Trus.t promotes a culture of open and honest communication to support staff to speak up.

	• Consider any risks and further actions for the Trust.

Appendix 1 - A selection of cases closed during Q3 and Q4 2020-21

Case No & Quarter Opened	Date Opened	Theme	Date Closed	Outcome/Learning	Feedback (Given your experience, would you speak up again? yes/no/maybe/unknown
Q4					
298	28/02/2020	Fraud and unfair recruitment	27/11/2020	The outcome of Fact finding is that there is no evidence to support the allegations made.	Yes
Q1					
355	28/04/2020	Bullying	12/10/2020	Case closed at the request of the concern raiser. From the discussion, IO felt that it was an isolated low level concern and that informal resolution would be the most likely outcome therefore agreed to close the case with no further action based on the concern raiser's request.	No
404	18/06/2020	Bullying	08/10/2020	In line with the Trust procedures for managing workplace conflict, it was recommended that if willing to participate the complainant be offered the opportunity to have a facilitated conversation with [redacted] in order for the complainant to express how [redacted] has been left feeling and for all parties to agree a way forward. The complainant declined the opportunity.	No
Q2					
430	16/07/2020	Bullying	19/10/2020	No evidence to support any unfair treatment or inconsistency towards staff members by the management team. 1) Awareness for all staff on Dignity at Work processes and how to raise concerns informally, in line with the policy. 2) Service Delivery Managers ensure the [redacted] management teams document conversations on file notes and place on personal files for anything that could lead to disciplinary action if informal warnings aren't heeded. 3) Documentation to be completed when a meeting has been unable to take place and the reasons why, this will ensure a clear timeline is available in the event of queries. 4) Regional Manager to arrange informal mediation with [redacted] and [redacted] to ensure a professional working relationship can continue given the nature of allegations made.	Maybe
435	27/07/2020	Bullying	31/12/2020	• Staff need support from OM and AP when having difficult conversations, or when raising concerns. • Some staff described as 'toxic' and managers need to be given the tools and the confidence to make them aware that their behaviours are unacceptable in line with the Trust values. • Staff need to be given the courage to be able to raise concerns and have confidence that they will be addressed – this was first raised in 2017. The culture of openness and learning needs to be visible and evidenced. • All managers require training in difficult conversations and conflict resolution • Estate layout means station is very fragmented, lots of office and wasted space yet crew room is too small. Also difficult to find space if staff want to breakaway	Yes

				• OM and AP both require extra support and training to lead change and improvement and to support their wellbeing.(consider co-location with other OM/AP's) • Unstable management structure, request for greater stability in team from HoS to SPTL.	
442	06/08/2020	Covid-19	24/11/2020	It is recommended that staff within [redacted] are reminded of the guidance that has been issued in relation to the wearing of face masks and assurance that the Executive Team are constantly looking at measures that can be implemented to ensure the safety of staff during this ever changing time.	Yes
445	25/08/2020	Working Practices	23/10/2020	Concerns raised in relation to the newly trained recruits being rostered to work ten consecutive shifts in a row. New staff have reported feeling exhausted and unable to concentrate. • There are no shift patterns in place which would result in an individual working 10 days in a row. • The only way this can happen is 1) the individual has requested/arranged shift swaps which resulted in the consecutive days being worked, or 2) a genuine oversight by the Resource and laPnning team when producing the rota. • In the event of 2) above then once this has been brought to the attention of the Resource and Planning team it would be rectified immediately.	Yes
446	25/08/2020	HR Matter	10/12/2020	Guardian signposted to HR – Grievance upheld.	Yes
451	04/09/2020	Detriment	06/10/2020	Concern raiser felt that the handling of their concern was not in line with Trust policy as they had not been interviewed as part of the process. Concern raiser feels this was because they had spoken up about a matter previously. There was no evidence to support detriment had been suffered, however it was accepted that a letter sent to the concern raiser did not clearly articulate the reasons for meeting. This will be picked up as a learning point for the HR Team and will feed into the Just & Culture Review.	Maybe
454	10/09/2020	Covid-19	24/12/2020	Concern that mandatory temperature checking process in place at [redacted] was not being followed. It has been recommended that staff within [redacted] are reminded of the guidance that has been issued in relation to the Covid-19 checkpoints and equally challenge a staff member or visitor that they witness not adhering to such guidance. It is all of our responsibility to keep each of us safe from risk of Covid-19. [redacted] management team provide assurance to staff that the Executive Team are constantly looking at measures that can be implemented to ensure the safety of staff during this ever changing time.	Yes
460	18/09/2020	Covid-19	26/10/2020	Concern relating to some staff feeling it very insensitive of senior management to inform them via a bulletin of the Covid outbreak in their department and then allegedly not respond to any of their concerns raised via email, seeking some re-assurances. Investigation outcome identifies that unfortunately it does not appear that specific feedback was given to the individual complaint and this from the review looks to be due to a breakdown in communication. Comprehensive communications have been sent to staff around IPC and Covid. In the first instance it is recommended that staff should go to their immediate line manager for guidance.	Yes

				It is recommend that one of the Clinical Service Managers makes contact with the individual/s to explain that on this occasion a breakdown in communication has led to delay in coming back and to encourage the staff to contact their line manager in the first instance. In regard to the concern around alerting staff by way of a briefing, this is entirely appropriate given the number of staff in [redacted], it would not be possible to hold individual sessions for everyone. A frequently asked questions has now been written and will be shared with staff imminently.	
462	30/09/2020	Data Breach	19/11/2020	Concern raiser submitted Datix reporting the breach. Signposted concern raiser to their Trade Union.	Yes
Q3					
463	01/10/2020	HR Matter	29/10/2020	Concerns raised in relation to some staff allegedly being aware of the interview questions prior to being interviewed. The review has indicated that the issues in relation to the potential sharing of interview questions was dealt with in parallel to the normal pre-employment check process and the collation of sector preferences.	Yes
465	06/10/2020	Covid-19	14/10/2020	Concerns raised relating to the staff members safe return to work having had surgery and feeling anxious due to the Covid outbreak. Local management supported the member of staff and explained the infection control measures currently in place and the various options available to them their during preceptorship	Yes
469	10/10/2020	Covid-19	03/11/2020	Concerns relating to social distancing measures not being adhered to and staff are keen to push for screen dividers at the side of the desks. This has been identified following various audits that have been taking place in contact centres across the Trust. Screens are required between staff from the front and the side and this is already in place at some centres however there has been a delay in fitting of these in other areas of the Trust. An additional report has been submitted to the ELC where it has been approved to purchase further screens as well as retrofit some of the screens in contact centres to provide greater protection to staff. This is currently underway and estates expect this to be completed in the next two to three weeks.	Yes
470	12/10/2020	HR Matter	20/10/2020	Concerns raised in relation to pay enhancements given to those staff currently shielding/isolating. This is deemed unfair on those staff who are currently in the workplace unable to claim the enhancements. In summary, the Trust has implemented the national T&C. NHS Employers issued all NHS Trusts with updated guidance on Terms & Conditions of Service on 10 April 2020 which included detailed information / instruction that NHS Trusts should, for those staff **absent** due to COVID-19 '…full pay should be inclusive of enhancements. This should also include any overtime as part of the calculation when staff are absent'. The Trust has implemented the national contract and updated T&C in relation to COVID-19 absences."	Unknown
471	14/10/2020	Patient Safety	20/10/2020	Concerns relating to sub-calls being closed when the call handler is still on the line to the patient/caller. It is covered within Procedure 15 Sub Calls, point 19 as per below: 19 The Dispatcher is responsible for stopping off any incidents they are not allocating on, ensuring EMD has exited the incident, prior to stopping. What has been highlighted at [redacted] is a glitch within C3. Usually, C3 alerts a dispatcher (or anyone else) that an EMD is still in the call, however, C3 is not behaving the way it should be. Assurances from ICT that this will be rectified as a priority.	Yes

479	26/10/2020	Bullying/Racism	02/11/2020	A member of staff felt that they were being treated differently and unfairly compared to that of their peers. They believed that this was because of their ethnicity. Following a number of discussions with this member of staff who was feeling very anxious about raising their concerns, it was agreed that the best approach would be for them to speak to their local management team. The Guardian also put the member of staff in touch with the WRES team.	Yes
Q4					
525	26/01/2021	Patient Safety	22/02/2021	A staff member raised a concern relating to missing safety equipment and missing contents from supplies on a PES vehicle. The FTSUG signposted this member of staff to their local management team to address. FTSUG received confirmation that the matter had been dealt with and is now resolved.	
529	03/02/2021	Unfair Recruitment	29/03/2021	A secondment opportunity allegedly wasn't advertised and staff felt that this was unfair as equal opportunities should be open to all. The outcome is that a fair open and transparent process for a learning and development opportunity had been advertised. It is recommended that any future communication clearly states at the top of the e-mail that this is an expression of interest for a learning and development opportunity, not role.	Yes
541	03/03/2021	Attitudes and Behaviours	30/03/2021	A member of staff raised concerns about some staffs attitude and behaviours in a certain team. Local management arranged for a staff forum to be held where other staff could[join the meeting and discuss their concerns. A union representative and a member of HR were also in attendance. Staff felt satisfied that they had been listened to and were given some re-assurance around their concerns.	Yes
544	07/03/2021	Unfair Recruitment	31/03/2021	Concern raised in relation to an unfair recruitment process aimed at university students who had allegedly been promised an interview, despite not having completed the application process. This concern was found to be unsubstantiated.	Yes

Appendix 2 - Ambulance Trusts Comparison Data During Q2 and Q3 2020-21

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

Ambulance Service	Trust Size*	Total Cases		Anonymous		Patient Safety/Quality		Behaviours including B&H		Detriment (having raised a concern)	
		Q2	Q3	Q2	Q3	Q2	Q3	Q2	Q3	Q2	Q3
LAS	**Medium**	60	31	0	1	5	4	14	12	0	0
NWAS	**Medium**	51	42	1	1	1	8	26	2	3	1
SECAMB	**Small**	33	66	2	3	1	2	27	47	0	2
YAS	**Medium**	11	24	0	2	0	2	0	7	0	0
EMAS	**Small**	NDS	7	NDS	2	NDS	3	NDS	4	NDS	0
EEAST	**Medium**	13	NDS	1	NDS	1	NDS	1	NDS	2	NDS
WMAS	**Medium**	2	1	0	0	0	0	1	0	0	0
SWAST	**Small**	21	NDS	0	NDS	0	NDS	3	NDS	0	NDS
SCAS	**Small**	33	26	0	1	17	3	7	2	0	0
NEAS	**Small**	4	4	0	1	1	0	4	4	2	0

Note: No data submitted (NDS)

*Trust Size:

Small (up to 5,000 staff)

Medium (between 5,000 and 10,000 staff)

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th April 2021			
SUBJECT:	Quality and Performance Committee Annual Report & Terms of Reference			
PRESENTED BY:	Prof A Chambers, Chair of the Quality and Performance Committee			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☐	☒	☐
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 the following amendments have been made- • Non-Executive Director Membership – from three to four Non-Executive Director members. • Executive Director Membership - removal of Deputy Chief Executive Officer and addition of Director of Corporate Affairs • Quoracy – from five to six, to include at least three Non-Executive Directors, one of which must be the Non-Executive Director with clinical responsibilities and at least three Executive Directors, one of which must be either the Director of Quality, Innovation and Improvement or the Medical Director. • Name of inward reporting sub committees (following review of integrated governance structure in March 2021). The committee effectiveness review highlighted that the group has met its remit and functions during 2020/21. However, the following key improvements have been identified: • Noted that membership would be enhanced by clinical representation from a Non-Executive Director.			

	• Deep dive items to be scheduled by the Chair and Non-Executives of the Committee. • The Audit Committee have recommended that the Committee receive annual assurances from third party providers of 111 service and Private Ambulance Service during 2021/22, for inclusion in the Committee work plan.			
RECOMMENDATION:	The Board of Directors is recommended to: • Review the Quality and Performance Committee Annual Report. • Approve the Quality and Performance Committee Terms of Reference for 2021/22.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee			
	Date:	26th April 2021		
	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 2020 to 31st March 2021 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

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 at appendix 1.

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 functions set out within the terms of reference have been discharged and the following points should be noted by the Board:

5.1 Covid-19 Assurance reporting

The committee has held and maintained meeting quoracy during the financial year, amidst the significant operational pressures.

5.2 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 state and articulate which strategic risk it relates to.

5.3 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.

The quality of reports presented to the Committee is good, however the executive summaries still require improvement.

Regular Covid-19 pandemic updates have been presented to the committee to provide assurance against IPC actions pertinent to this committee.

5.4 Management Groups/Sub Committees

The Committee has received regular assurance reports from the Clinical Effectiveness Management Group, Safety Management Group and Non-Clinical Learning Forum which will be replaced by the newly formed sub committees.

5.5 Clinical Audit Plan

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

5.6 Learning from Deaths

The committee has received and approved quarterly reports on learning from deaths prior to onward reporting to the Board of Directors.

5.7 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 for assurance, prior the meeting of the Board of Directors.

Quarterly updates are received in relation to Community First Responders.

The Committee has received regular updates for assurance on the decision gateways for the Single Primary Triage System.

5.8 Urgent and Emergency Care Strategy

The Committee has received regular updates in terms of development, refresh and implementation plans of the strategy.

Quarterly progress against delivery of the strategy will be received by the committee during 2021/22.

5.9 Inward reporting of Management Groups

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

An annual report from each management group was presented to the Quality and Performance Committee on 26th April 2021 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.

As a result of a review of the Board Assurance Committees immediate sub-structure, the terms of reference include the change of nomenclature from a Management Group to Sub-Committee. A review of the remit of the sub committee has been undertaken to ensure there is no overlap/duplication with Patient Safety Sub-Committee.

Safety Management Group:

The group has met its remit and 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.

Patient and staff stories are reported at each meeting and include relevant subject matter to promote learning.

Progress against the Safety related pillars of quality goals are reported more frequently than the specified 3 times a year on the work plan and minutes provide updates under each of the section headings.

Health, Safety and Security is reported as a minimum, 3 times per year in accordance with the terms of reference and work programme (Health and Safety is also reported via the safety dashboard).

The Management Group had revised the BAF risks to ensure the Quality & Performance Committee receive assurances that effective controls are in place to manage strategic risks.

The Group's Chairs Assurance Reports and RAG ratings have been routinely reported to Quality & Performance Committee meetings to facilitate scrutiny and assurance.

Chairs Assurance reports have been presented to the Group from the IPC/Respiratory Protective Equipment meetings to provide progress and assurance on the Trust's HSE plan and the AGP Audits.

Non-Clinical Learning Forum

The forum has met the majority of its functions. Meetings of the Forum have been held scheduled in the corporate calendar. There has been no instances where a quorum was not present. 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.

6 IMPROVEMENTS/KEY LEARNING THE QUALITY AND PERFORMANCE COMMITTEE CAN TAKE INTO 2021/22

For 2021/22 the following areas of improvement were identified:

- Noted that membership would be enhanced by clinical representation from a Non-Executive Director.
- Deep dive items to be scheduled by the Chair and Non-Executives of the Committee.
- The Audit Committee have recommended that the Committee receive annual assurances from third party providers of 111 service and Private Ambulance Service during 2021/22, for inclusion in the Committee work plan.

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:

- Non-Executive Director Membership – from three to four Non-Executive Director members.

- Executive Director Membership - removal of Deputy Chief Executive Officer and addition of Director of Corporate Affairs

- Quoracy – from five to six, to include at least three Non-Executive Directors, one of which must be the Non-Executive Director with clinical responsibilities and at least three Executive Directors, one of which must be either the Director of Quality, Innovation and Improvement or the Medical Director.

- Name of inward reporting sub committees (following review of integrated governance structure in March 2021).

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 for 2020/21.
- Approve the Quality and Performance Committee Terms of Reference for 2021/22.

APPENDIX 1 QUALITY AND PERFORMANCE COMMITTEE MEETING ATTENDANCE RECORD

Quality and Performance Committee 2020/21										
	20th April	18th May	15th June	20th July	21st September	19th October	16th November	18th January	15th February	15th March
Ged Blezard	✔	✔	✔	x	x	✔	✔	✔	✔	✔
Prof Alison Chambers (c)	✔	x	✔	✔	✔	✔	✔	✔	✔	✔
Micahel Forrest	✔	✔	✔	✔	✔	✔	✔	x	x	✔
Dr Chris Grant	✔	✔	✔	✔	✔	✔	✔	✔	x	✔
Richard Groome	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Dr David Hanley	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Prof Maxine Power	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Prof Rod Thomson	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔

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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 thereby ensuring 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~~Four 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
- Director of Corporate Affairs
- Clinical Associate Non-Executive Director

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:

- Chief Consultant Paramedic
- Chief Pharmacist
- ~~Chief Nurse~~
- ~~Associate Medical Director (111)~~Deputy Medical Director

- Assistant Director of Nursing and Quality
- Head of Clinical Safety
- Patient Safety Specialist
- 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 –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~~ six, which is to include at least ~~two~~three Non-Executive Directors one of which must be the Non-Executive Director with clinical responsibilities; and at least three Executive Directors, one of which must be either the Director of Quality, Innovation & Improvement or the Medical 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;

Approve the quarterly reporting of Learning from Deaths prior to onward reporting to the Trust Board;

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,

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

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~~ Sub Committees:

- Clinical Effectiveness Sub Committee
- Health, Safety & Security Sub Committee
- Patient Safety Sub Committee
- IPC Sub Committee
- Diversity and Inclusion Sub Committee
- EPRR Sub Committee
- Non-Clinical Learning Forum

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th April 2021			
SUBJECT:	Resources Committee Annual Report & Terms of Reference			
PRESENTED BY:	Mr R Groome, Chair of Resources Committee			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☐	☒	☐	☒
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 Committee and recommend any changes to the Board of Directors for approval. The terms of reference have been reviewed and the following amendments have been made- • Re-name the inward reporting groups, now sub committees (following review of integrated governance structure in March 2021), • Duties and interrelations includes strategy and planning assurance reporting. • The Committee will no longer receive Chairs Assurance reports form the following groups - Information Management Group (now Information Governance Sub Committee); Cost Improvement Management Group, Capital Management Sub Group and Sustainable Sub Group. The committee effectiveness review highlighted that the group has met its remit and functions. However, a number of improvements have been identified: • Current agendas are long, with more time to scrutinise and debate preferred. • Due to time pressure, the running order of agenda items to be rotated to allow equal time for discussion of items. • To facilitate in year reviews of effectiveness of meetings to be included on meeting agendas.			
RECOMMENDATION:	The Board of Directors is recommended to: • Review the Resources Committee Annual Report for 2020/21. • Approve the Resources Committee Terms of Reference for 2021/22.			

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Resources Committee			
	Date:	26th March 2021		
	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 2020 to 31st March 2021 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 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

Meetings of the Committee have been held as scheduled in the corporate calendar with the exception of the May meeting which was cancelled due to Covid-19 pandemic pressures. There have been no instances where a quorum was not present. Members meeting attendance is included within the Committee self-assessment at Appendix 1.

5. RESOURCES COMMITTEE SELF ASSESSMENT

The current terms of reference have been reviewed by the Resources Committee. The Board should note that during 2020/21 all functions set out within the Terms of Reference have been discharged.

5.1 Strategic Risks

The committee receives a Board Assurance Framework (BAF) update at every meeting and members monitor and consider the strategic risks 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.

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.

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

Regular updates are presented in relation to estates and fleet including vehicle servicing and inspections, insurance, vehicle replacement programme, carbon reduction strategy and waste assurance.

In relation to the Estates Strategy and implementation, the Committee will have responsibility 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 2020/21 the committee received assurance in relation to the pandemic and Covid-19 vaccination programme.

5.6 Strategy

The committee receives regular updates and assurance reports in relation to delivery against the Integrated Business Plan including refreshed directorate objectives due to Covid-19 pressures.

5.7 Management Groups/Sub committees

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

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

Information Management Group:

The group has met the majority of its functions.

Meetings of the Group have been held as scheduled in the corporate calendar. There have been no instances where a quorum was not present. The meeting in April 2020 was postponed due to the Covid-19 pandemic.

The Group discussed all risks that are linked to SR07 (Digital) and during the year risk reporting has been strengthened.

The Group has received assurance reports relating to cyber security during the year, the terms of reference have been revised to reflect this.

The RAG ratings within the Information Management Group Chairs Assurance reports are robust with discussion to seek assurances.

6. IMPROVEMENTS/KEY LEARNING THE RESOURCES COMMITTEE CAN TAKE INTO 21/22

For 2021/22, the following areas of improvement/learning have been identified:

- Current agendas are long, with more time to scrutinise and debate preferred.
- Due to time pressure, the running order of agenda items to be rotated to allow equal time for discussion of items.
- To facilitate in year reviews of effectiveness of meetings to be included on meeting agendas.

7. TERMS OF REFERENCE

The Group has reviewed the Terms of Reference and proposed the following amendments –

- Re-name of the inward reporting sub committees (following review of integrated governance structure in March 2021),
- Duties and interrelations includes strategy and planning assurance reporting.
- The Committee will no longer receive Chairs Assurance reports form the following groups - Information Management Group (now Information Governance Sub Committee); Cost Improvement Management Group, Capital Management Sub Group and Sustainable Sub Group.

8. LEGAL, GOVERNANCE AND/OR RISK 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. EQUALITY OR SUSTAINABILITY IMPLICATIONS

There are no equality or sustainability implications.

10. RECOMMENDATIONS

- Review the Resource Committee Annual Report for 2020/21.
- Approve the Resources Committee Terms of Reference for 2021/22.

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APPENDIX 1 RESOUCES COMMITTEE MEETING ATTENDANCE 2020/21

Resources Committee - Meeting Attendance 2020/21						
	18th May	**24th July**	**25th September**	**20th November**	**22nd January**	**26th March**
Ged Blezard	Cancelled due to COVID-19	x	✓	x	x	✓
Salman Desai		✓	✓	✓	✓	✓
Richard Groome		✓	✓	✓	✓	✓
Michael O'Connor ©		✓	✓	✓	✓	✓
Prof Maxine Power		✓	✓	✓	✓	x
David Rawsthorn		✓	✓	✓	✓	✓
Lisa Ward		✓	✓	✓	✓	✓
Clare Wade		✓	✓			
Carolyn Wood		✓	✓	✓	✓	✓
M Forrest		✓	x	✓	x	x

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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 anannual 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.

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
- Integrated Business Plan
- 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. Receive assurance relating to performance against key workforce indicators such as: sicknessabsence, appraisal review, mandatory training and turnover.

xx. Seek assurance on the development of a vibrant volunteer cohort and receive assurance inrelation 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. Receive assurance 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.

Strategy and Planning

i. To seek assurance against progress of the Trust's Integrated Business Plan.

ii. Receive and seek assurance on performance against the Trust's Directorate Quarterly Objectives.

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:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires from any employee and all employees are directed to co- operate with any request made by the Committee
iii. Obtain independent professional advice, having due regard to recognised Trust procedures, and to secure the attendance of outsiders with relevant experience and expertise if itconsiders this necessary.

8. INWARD REPORTING ARRANGEMENTS

The Committee shall receive Chair Assurance Reports from meetings of the following Sub Committees –

- Diversity and Inclusion Sub Committee
- Strategic Workforce Sub Committee

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th April 2021			
SUBJECT:	Audit Committee Annual Report 2020/21			
PRESENTED BY:	David Rawsthorn, Chair of Audit Committee			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision			
EXECUTIVE SUMMARY:	The Board of Directors are presented with the Audit Committee's Annual Report for 2019/20. The report details the activities of the Audit Committee during the period 1st April 2020 to 31st March 2021. The revised Audit Committee Terms of Reference are attached at **Appendix 2** for approval by the Board of Directors.			
RECOMMENDATION:	The Board of Directors are requested to: • Note the Audit Committee Annual Report 2020/21; and • Approve the revised terms of reference.			
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Audit Committee			
	Date:	23rd April 2021		
	Outcome:	Approved		

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Audit Committee Annual Report 2020/21

Introduction

This report provides information on the how the Audit Committee has met its Terms of Reference during the 2020/21 financial year. It is presented to the Board of Directors to inform them of the activities of the Audit Committee for the period 1 April 2020 to 31 March 2021.

Role of the Committee

The Audit Committee co-ordinates the assurance process and advises the Board of Directors on the overall level of assurance and on any significant weaknesses in internal control. The Committee continuously reviews the structure and effectiveness of the Trust internal control and risk management arrangements. A key part of this is the oversight the committee exercises over the Board Assurance Framework. It also agrees an audit programme with external and internal auditors'.

Five meetings of the Audit Committee were held during the year. Regular attendees at the Committee meetings were KPMG (External Auditors up to 17 June 2020) and Mazars (External Auditors), MIAA (Internal Audit and Anti-Fraud Services), Director of Finance and Director of Corporate Affairs.

The revised Terms of Reference were approved at the Audit Committee on 22nd May 2020.

Committee Members and Attendance

During 2020/21 the Audit Committee consisted of the following members:

Committee Member		Attendance
Mr D Rawsthorn	Non-Executive Director (Chair)	5/5
Mr M O'Connor	Non-Executive Director	3/5
Dr D Hanley	Non-Executive Director	5/5
Prof R Thomson	Associate Non-Executive Director	5/5

The Committee met on the following occasions during 2020/21:

22 May 2020
17 June 2020
10 July 2020
23 October 2020
15 January 2021

Audit Committee Activity

The Committee works to an annual work programme of scheduled agenda items in addition to considering any relevant issues which may arise in the year. A number of reports were presented to the Committee over the year and a list of these items is attached at **Appendix 1**.

The Committee discussed the reports and requested further information and/or action where appropriate. This included monitoring progress on implementing recommendations especially where the audit opinion was that the system of controls only provided limited assurance.

Data Quality

As a result of a risk on the Corporate Risk Register relating to the Trusts inability to systematically cross reference and reconcile data outputs with the CAD and subsequently being highlighted on the Board Assurance Framework, the Committee received regular update reports to gain assurance against its progress. To further strengthen the Committee's role in relating to data quality and cyber security, the Information Governance Sub Committee from 1st April 2021 will report direct to the Audit Committee on such matters. MIAA completed their review on data quality in Q4 which received

Moderate Assurance. The Committee will continue to receive assurance with regard to progress against actions.

Board Assurance Framework (BAF) & Risk Management

During the year the Trust has continued to develop and embed the BAF and Risk Management System by reviewing the risk management processes developed to strengthen risk management across the Trust. It also reviewed the BAF which provides a clear focus on the risks, key controls and assurances in relation to achieving the Trust's Strategic Priorities. The Committee's primary role is to satisfy itself that the processes and systems of internal control around the BAF are valid and during 2020/21 received quarterly reviews prior to submission to the Board of Directors. The Quality and Performance Committee and Resources Committee received the BAF pertaining to their areas of focus to receive assurances that controls are in place and to report any significant risk management/assurance issues to the Board of Directors.

Additional assurance reports were also presented to the Committee during the reporting period 1) The Risk Appetite Statement 2020/21, 2) Revised Risk Management Strategy and 3) Risk Management Policy which were presented to the Committee for onward recommendation to the Board of Directors for approval.

During the year, MIAA circulated a detailed checklist which provided an assessment framework designed to support NHS organisations in reviewing their Assurance Frameworks and Risk Management processes during COVID-19. The Committee received assurance that appropriate robust risk management processes were in place and received a further deep dive into how learning from risk management arrangements in Wave 1 would inform future arrangements in the event of a second wave.

Clinical Governance

During the year the committee strengthened its role in relation to clinical governance. It now receives chair's assurance reports from the Quality and Performance committee, and reviews the initial clinical audit plan and its outturn. In addition, either the Medical Director or the Director of Quality, Innovation and Improvement attend the committee for consideration of clinical governance matters. The internal audit plan included an audit of clinical audit processes.

In this way the committee has considered the adequacy of controls and the soundness and sufficiency of assurances**.**

Internal Audit

Internal Audit is an independent and objective appraisal service which has no executive responsibilities within the line management structure. Internal Audit focusses activity on the key strategic risks and on any aspects of risk management, control or governance affected by material changes to the Trust's operating environment, subject to Audit Committee approval.

A detailed programme of work is agreed with the Executive Team via the Director of Finance and is reviewed and approved by the Audit Committee. The programme is set out for each year in advance and is then carried out along with any additional activity that may be required during the year. In approving the Internal Audit Work Programme, the Committee uses a planning and mapping framework to ensure all key risk areas are reviewed at the appropriate frequency.

Detailed reports, including follow-up reviews to ensure remedial actions have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. During the year, the Committee asked responsible Senior Management to meetings where a 'limited assurance' opinion had been provided in audit reports. Similarly the audit committee considered all high priority audit recommendations that had not been implemented by the agreed date and asked senior management to attend. This attendance by senior managers helped to provide further assurance on these areas. All such information and reports are fully recorded in the minutes and papers prepared for each Audit Committee meeting.

As a result of COVID-19, MIAA were unable to progress undertaking the planned reviews within Q1 and changed their focus to providing a wide range of briefings, updates and benchmarking materials to assist the Trust manage the challenges of COVID-19. These checklists provided assurance to the Committee that the Trust followed appropriate governance in the following areas:

- COVID-19 Financial Governance Checklist
- COVID-19 Strategic Governance Checklist
- MIAA Checklist: Risk Management - Adapting and Responding to COVID-19
- MIAA Checklist: Gifts and Hospitality During COVID-19
- MIAA COVID-19 Procurement Checklist
- MIAA COVID-19 Data Protection Checklist

During the year, specific attention has been focussed on the areas detailed below categorised by their review outcome:

High Assurance	**Substantial Assurance**
General Ledger	Risk Management
Accounts Payable	Safeguarding
Accounts Receivable	Clinical Audit Processes
Treasury Management	Driving Licence Checks
Budgetary Controls (including CIP)	111 Working from Home
Quality Accounts	Incident Management
	ESR (HR/Payroll Controls)
	User Privilege
Moderate Assurance	**Limited Assurance**
Data Quality	None received
IT Service Resilience and Continuity	
No Assurance	
None received	

In addition to the above, MIAA undertook additional reviews 1) Assurance Framework Review, an assessment against the Trust's approach to maintain and use the Assurance Framework to support the overall assessment of governance, risk management and internal control and 2) a readiness report relating to the Data Security and Protection Toolkit..

The Internal Audit Progress Report considered at each Committee meeting includes summaries of each of the final reports issued by MIAA in respect of the key systems examined.

During the year MIAA were subject to a mandatory external assessment. This is undertaken on a five yearly cycle. The report concluded that MIAA were fully compliant with the requirements of the Public Sector Internal Audit Standards. The external assessment was received by the January meeting of the committee.

During 2020/21, the Head of Internal Audit overall opinion for the period 1 April 2020 to 31 March 2021 was substantial assurance. This confirmed there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Anti-Fraud Activity

The Committee and the Trust are supported in carrying out Anti-Fraud activity by MIAA's Anti-Fraud Service (AFS) working to a programme agreed with the Audit Committee. The role of AFS is to assist in creating an anti-fraud culture within the Trust: deterring, preventing and detecting fraud, investigating suspicions that arise, seeking to apply appropriate sanctions and redress in respect of monies obtained through fraud. Where such cases are substantiated, the Trust will take appropriate disciplinary measures.

Pro-active work has also included induction and awareness presentations along with providing Intelligence Bulletins issued by the NHS CFA and Information Alerts to the Trust.

The Audit Committee received regular progress reports from the AFS and also received an annual report providing a summary of the work undertaken against each of the four generic areas of anti-fraud activity as set out by NHS CFA; 1) Inform and Involve 2) Prevent and Deter 3) Hold to Account and 3) Strategic Governance.

The Trust is required to submit an annual statement of assurance against the NHS Counter Fraud Standards to the NHSCFA; this is the Self Review Toolkit (SRT). This enables the Trust to produce a summary of the counter fraud work carried out during the year and includes a red, amber, green (RAG) rating for each of the key areas and an overall RAG rating of compliance. The SRT is compiled by MIAA, reviewed and authorised by the Director of Finance and the Chair of the Audit Committee. Confirmation of the submission made by the Anti-Fraud Specialist (AFS) on behalf of the Trust is reported to the Audit Committee.

No significant cases or issues of Anti-Fraud took place or were identified during the year.

Following a procurement exercise for the Internal Audit and Counter Fraud Services, the Board of Directors approved award of the contract to Mersey Internal Audit Agency.

External Audit
Mazars were the External Auditors to the Trust for the 2020/21 financial year and during the year reported on the 2020/21 Annual Report and Financial Statements and [opinion to be added on finalisation of audit] were raised in respect of the statements. Technical support has been provided to the Committee on an ongoing basis and representatives attend each meeting.

At the meeting on 10 June 2021, the Committee will receive the ISA260 Audit Memorandum relating to the Financial Statements Audit and review of the Annual Report. The Annual of Mazars Report and Accounts were [insert whether approved or not] and External Audit [insert].

Summary
The Audit Committee did not find any areas of significant duplication or omission in the systems of governance in the Trust.

The Audit Committee was not aware of any major break-down in internal control that could have led to a significant loss.

The Audit Committee was not aware of any major weakness in the governance systems that had exposed, or may continue to expose, the Trust to an unacceptable risk.

In March 2020, Committee members completed an assessment of the Committee's effectiveness using checklists within the HFMA NHS Audit Committee Handbook. MIAA collated all responses in readiness for the annual self-assessment session scheduled for 20 March 2020 which was cancelled due to COVID-19. Committee members completed the Committee self-assessment facilitated by MIAA which was reported to the Committee on 22 May 2020. A further session was held on 25 September 2020 to agree self-assessment outcomes and subsequent actions and was formally reported to the Committee in October 2020. The overall conclusion was that the committee operated effectively. Two areas of improvement were identified in relation to assurance from key third party providers and training for committee members. Both of these have been addressed.

The revised Terms of Reference are attached at **Appendix 2** for approval by the Board of Directors.

The Committee consider that the proceedings of its meetings including the various reports discussed at those meetings confirm that the Committee has discharged its duties throughout the year.

Conclusion

The Committee submit this report to the Board as evidence that it has fulfilled its Terms of Reference in place during the year.

Recommendation

The Board of Directors are requested to:

1. Take assurance from the report; and

2. Approve the revised Terms of Reference

Mr D Rawsthorn
Non-Executive Director
Audit Committee Chair DATE

APPENDIX 1

REPORTS TO THE AUDIT COMMITTEE DURING 2019/20

Reports produced by the Trust
Audited Accounts 2019/20
Annual Report 2019/20
Annual Governance Statement 2019/20
Audit Committee Effectiveness Report
Audit Committee Terms of Reference
Waiver of Standing Orders
Losses and Compensation
Impairment Report
Letter of Representation
Audit Committee Annual Report
Audit Committee Work Plan
Declarations of Interest, Gifts & Hospitality Annual Review
Provision of Internal Audit and Counter Fraud Services
Audit Committee Annual Report 2019/20
Annual Review of Core Governance Documents
Audit Committee Effectiveness Review Actions/Development
Annual Review of Declarations of Interest, Gifts and Hospitality 2019/20
Quarterly Board Assurance Framework Reports
Risk Appetite Statement 2020/21
Legal Services Updates
Chairs Assurance Reports from Quality and Performance Committee and Local Clinical Audit Plan
Clinical Audit Update
Data Quality Updates
COVID-19 Financial Governance Checklist
COVID-19 Strategic Governance Checklist
MIAA Checklist: Risk Management - Adapting and Responding to COVID-19
MIAA Checklist: Gifts and Hospitality During COVID-19
Management of Theft
Revised Risk Management Strategy
MIAA COVID-19 Procurement Checklist
MIAA COVID-19 Data Protection Checklist
Deep Dive into the COVID-19 Risk Management Arrangements
NWAS Anti-Fraud, Bribery and Corruption Policy and Response Plan
Risk Management Policy
Reports produced by KPMG, External Auditors
Annual Audit Letter 2019/20
External Audit Technical Updates
Report to those charged with Governance (ISA260)
Independent Auditors Report to Board of Directors

Reports produced by Mazars, External Auditors
External Audit Framework
Progress Report
Technical Update
Audit Strategy Memorandum
Reports produced by MIAA
Internal Audit Progress Reports
Internal Audit Work Plan 2020/21
Head of Internal Audit Opinion and Annual Report 2019/20
Follow Up Reviews
Limited Assurance Reports
Critical and High Risk Recommendations Overdue
KPI Report
Internal Audit Charter
Third Party Assurances
External Quality Assessment
Review of MIAA Covid-19 Checklists against NAO Guidance
Reports produced by the Anti-Fraud Specialist
Anti-Fraud Progress Reports
Anti-Fraud Annual Report 2019/20 including Self Review Toolkit (SRT)
Management Action Tracker Follow Up Report 2019/20
Anti-Fraud Annual Work Plan 2020/21
NWAS Anti-Fraud Bribery and Corruption Policy and Response Plan

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Appendix 2

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

CONTENTS

1. ROLE AND PURPOSE

The Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Audit Committee *('the Committee')*. The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated within these terms of reference.

The Committee is established to advise the Board of Directors on the effectiveness of the Trust's strategic processes for risk management, internal control and governance; to advise on the appropriateness and effectiveness of internal and external audit activities and ensure that accounting policies applied within the Trust comply with relevant requirements.

The Committee will consider the appointment of internal and external auditors and the internal and external audit plans. The Committee will consider auditors' recommendations and make recommendations for action to the Board of Directors as appropriate.

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 be appointed by the Board of Directors from amongst its independent Non-Executive Directors of the Trust and shall consist of not less than four members. One of the members shall be appointed as Chair of the Committee by the Board of Directors. The Chairman of the Board of Directors shall not be a member of the Committee.

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

In the event that the Chair of the Committee is unable to attend a meeting, the members

present shall decide upon a Deputy Chair to conduct the meeting.

The Director of Finance, Director of Corporate Affairs, Local Counter Fraud Specialist, appropriate internal and external audit representatives shall normally attend meetings. In addition, either the Quality Director or the Medical Director will attend for clinical governance agenda items. However, at least once a year, the Committee should meet privately with the internal and external auditors without the presence of the Executives.

The Chief Executive should be invited to attend at least annually to present the process for assurance that supports the Annual Governance Statement. The Chief Executive should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

Other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. Deputies may attend in the absence of any of the Executive Directors.

Other Officers of the Trust may attend at the request of the Committee in order to present and provide clarification on issues which require a decision from the Committee.

No business shall be transacted unless at least three members are present. .

3. ACCOUNTABILITY

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

4. RELATIONSHIP WITH THE BOARD OF DIRECTORS AND ITS COMMITTEES

The Committee will report in writing to the Board of Directors the basis for its recommendations. The Board will use that report as the basis for their decisions, but would remain accountable for taking the decision. Minutes of the meetings of the Board of Directors will record such decisions.

The Committee will report to the Board of Directors annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business. This annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

5. REVIEW ARRANGEMENTS

The Committee will identify annual objectives, 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 of 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 a senior member of the Corporate Governance Team 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.

6. 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 at least five times per year. The Chair may, however, call a meeting at any time provided that notice of the meeting is given. The appropriate internal or external audit representatives may request a meeting if they consider that one is necessary.

The minutes of meetings shall be formally recorded by a senior member of the Corporate Governance Team, checked by the Chair and submitted for agreement at the next ensuing meeting, whereupon they will be signed by the person presiding at it. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure or require executive action.

The Chair and one other Non-Executive Director may, in an emergency, exercise the functions of the Committee jointly. A full report shall be prepared as for the Committee and a signed authorisation appended. The exercise of such powers, together with the report, shall be submitted to the next formal meeting for ratification.

The Committee shall be supported administratively by a senior member of the Corporate Governance Team, who shall:

- agree agendas with the Chair and attendees
- prepare, collate and circulate papers in good time
- ensure that those invited to each meeting attend
- take the minutes and help the Chair to prepare reports as required
- keep a record of matters arising and issues to be carried forward
- ensuring that action points are taken forward between meetings
- ensure that Committee members receive the development and training they need

7. DUTIES AND INTERRELATIONS

The main functions of the Committee are:

Internal audit

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2017 and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

i. consideration of the provision of the internal audit service and the costs involved
ii. reviewing and approving the annual internal audit plan and more detailed programme of work; ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
iii. consideration of the major findings of internal audit work (and management's response)
iv. ensuring co-ordination between the internal and external auditors to optimise audit resources
v. ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
vi. completing an annual review of the effectiveness of internal audit

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

i. consideration of the appointment and performance of the external auditor (via the Auditor Panel), as far as the rules governing the appointment permit (and make recommendations to the Board of Directors when appropriate)
ii. discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan.
iii. discussion with the external auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
iv. review of all external audit reports, including the report to those charged with governance (before its submission to the Board of Directors) and any work carried out outside the annual audit plan, together with the appropriateness of management responses
v. ensuring co-ordination between the internal and external auditors to optimise audit resources

Financial reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board of Directors.

The Committee shall review and recommend the annual report and financial statements under delegated authority to the Board of Directors, focusing particularly on:

i. the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
ii. changes in, and compliance with, accounting policies, practices and estimation techniques
iii. unadjusted mis-statements in the financial statements
iv. significant judgements in preparation of the financial statements

v. significant adjustment resulting from the audit
vi. Letter of Representation
vii. Explanations for significant variances

Integrated Governance, risk management and internal control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy and effectiveness of:

i. all risk and control-related disclosure statements, and in particular the Annual Governance Statement, together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board
ii. the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
iii. the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
iv. the policies and procedures for all work related to counter fraud and security as required by the NHS Counter Fraud Authority.

In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Other assurance functions.
The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation. These will include, but will not be limited to:

i. Any reviews by the Department of Health and Social Care arm's length bodies or regulators/inspectors, such as Care Quality Commission, NHS Resolution etc.
ii. Professional bodies with responsibility for the performance of staff or functions, such as Royal Colleges, Health Professions Council, NHS Counter Fraud Authority.

As part of its integrated approach, the Committee will have effective relationships with other key committees (Quality and Performance Committee and Resources Committee), whose work can provide relevant assurance to the Committee's own scope of work.

Clinical Governance
In reviewing clinical governance arrangements ~~and issues around clinical risk management~~, the Committee will wish to satisfy itself that controls are adequate and that ~~on the~~ assurances are sound and sufficient. After each meeting ~~that can be gained from the clinical audit function provided by~~ of the Quality and Performance Committee the chair

compiles ~~-~~an assurance report which ~~: these~~ are reported through to the A~~a~~udit C~~c~~ommittee. The committee also seeks assurance from the clinical audit function~~.~~

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place to counter fraud, bribery and corruption in accordance with the NHS Counter Fraud Authority's (NHS CFA) Standards for Providers, and shall review the outcomes of counter fraud work carried out.

In accordance with the Government Functional Standard: GovS 013 Counter Fraud the Trust will ~~Standard 1.8 of the NHS CFA's Standards for Commissioners, the Committee has 'stated its commitment to ensuring commissioners achieve these standards' and therefore~~ provide~~s~~ assurance ~~to~~ that ~~the the commissioners that~~ appropriate counter fraud arrangements are in place and ensure a coordinated approach to protecting public services against the risk of fraud, bribery and corruption. ~~to demonstrate compliance with the quality assurance processes as defined in the standards.~~

The Committee will refer any suspicions of fraud, bribery and corruption to the NHS CFA.

Management

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee may also request specific reports from individual functions within the Trust such as clinical audit, as may be appropriate to the understanding of the overall arrangements.

The Committee has a specific role to receive assurance and scrutinise the arrangements relating to information governance, i~~I~~ncluding specifically data quality~~,~~ and cyber security.

Other duties

Other duties of the Committee are:

i. to review proposed changes to Standing Orders and Standing Financial Instructions
ii. to examine the circumstances associated with each occasion that Standing Orders are waived; and
iii. to review losses and compensation payments and make recommendations to the Board of Directors

8. DELEGATED AUTHORITY

The Committee is authorised by the Board to:

i. investigate any activity within its terms of reference
ii. seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee
iii. 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.

9. INWARD REPORTING ARRANGEMENTS

The Committee shall receive Chair Assurance Reports from:

- ~~the~~ Quality and Performance Committee
- Information Governance Sub-Committee~~.~~

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North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	28th April 2021			
SUBJECT:	Board of Directors Annual Cycle of Business 2021/22			
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs			
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**
	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision			
EXECUTIVE SUMMARY:	The purpose of the report is to set out the standard business to be conducted at Board of Directors meetings for 2021/22 and identifies the reports which will regularly be presented for consideration **(Appendix 1)** The annual cycle is one of the key supporting components to ensure the Trust Board is effectively carrying out its role and delivering its purpose. The Board of Directors will receive other reports throughout the year on areas of risk or significance and these will be kept under regular review to ensure that the Trust Board is receiving accurate and timely reports on its own business and the external environment in which it operates.			
RECOMMENDATION:	The Board of Directors are requested to – 1. Approve the Annual Cycle of Business for 2021/22 in the form of the attached Board of Directors work programme at appendix 1.			
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:	N/A		
	Outcome:	N/A		

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1. PURPOSE

To present the Board of Directors with an annual cycle of business for financial year 2021/22 and request approval of the proposed work programme at appendix 1.

2. BACKGROUND

The Board of Directors should approve an annual cycle of business which identifies the reports which will regularly be presented for consideration throughout the financial year.

The annual cycle is one of the key components in ensuring that the Trust Board is effectively carrying out its role.

A proposed cycle of business in the form of a work programme has been developed based on the previous year's cycle of business and is considered to be a comprehensive description of the regular business to be transacted by the Trust Board.

The Trust Board will receive other reports throughout the year on areas of risk or interest and these will be kept under regular review to ensure that the Board of Directors is receiving accurate and timely reports on its own business and the external environment in which it operates.

These reports, alongside business cases and other items will be collated and managed via the work programme.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

There are no associated legal implications.

4. EQUALITY OR SUSTAINABILITY IMPLICATIONS

There are no associated equality or sustainability implications.

5. RECOMMENDATIONS

The Board of Directors is requested to:

1. Approve the Annual Cycle of Business for 2021/22 in the form of the attached Board of Directors work programme at appendix 1.

Board of Directors
Work Programme 2021/22

	Date of meeting	28.4.21	26.5.21	11.6.21	28.7.21	29.9.21	24.11.21	26.1.22	30.3.22
	Report Deadline	21.4.21	19.5.21	11.6.21	28.7.21	29.9.21	17.11.21	19.1.22	23.3.22
Agenda Item	**Introduction**								
Minutes of the Previous Meeeting (Chair)			√		√	√	√	√	√
Action Log (Chair)			√		√	√	√	√	√
Committee Attendance (Chair)		√	√		√	√	√	√	√
Declarations of Interest (Chair)		√	√		√	√	√	√	√
Register of Interest (Chair)		√	√		√	√	√	√	√
Patient/Staff Story (Director of Strategy & Planning)			√		√	√	√	√	√
Agenda Item	**Strategy**								
Chairman & Non Executive Directors Update Chairman's Board update (Chair)			√		√	√	√	√	√
Chief Executive's Report			√		√	√	√	√	√
Northern Ambulance Alliance Progress Report (CEO)			√		√	√	√	√	√

Date of meeting	28.4.21	26.5.21	11.6.21	28.7.21	29.9.21	24.11.21	26.1.22	30.3.22
Report Deadline	21.4.21	19.5.21	11.6.21	28.7.21	29.9.21	17.11.21	19.1.22	23.3.22
Governance and Risk Management								
Agenda Item								
Chair's Assurance Report - Audit Committee (NED Chair)		√		√		√	√	
Annual Governance Documents (Director of Corporate Affairs) -								
Self Certification Condition G6/FT4		√						
Common Seal Annual Report 20/21	√							
Standing Orders, SFIs, SoD, Matters Reserved	√							
Annual Report of Q&P and Resources Committees	√							
Annual Audit Letter 2021/22 (Director of Finance)		√						
Separation of Duties CEO and Chairman (Director of Corporate Affairs)		√						
Annual Report of Audit Committee (Director of Corporate Affairs)	√							
Charitable Funds Annual Report & Accounts 2021/22 (Director of Finance)		√				√		
Bi Annual Common Seal Report (Director of Corporate Affairs)	√					√		
Fit & Proper Persons Requirements: Directors and Non-Executive Directors Chairman's Annual Declaration (Director of People)								√
Policy Update (Director of Corporate Affairs)		√		√	√	√	√	√
Freedom to Speak Up Report (Director of Corporate Affairs)	Quarter 4 & Annual Report					Bi Annual Report		
Board Assurance Framework 2021/22 and Corporate Risk Register (Director of Corporate Affairs)	Quarter 4 20/21			Quarter 1 21/22 *Corporate Risk Register*		Quarter 2 21/22 *Corporate Risk Register*	Quarter 3 21/22 *Corporate Risk Register*	
Annual Staff Survey Results								√

Date of meeting	28.4.21	26.5.21	11.6.21	28.7.21	29.9.21	24.11.21	26.1.22	30.3.22
Report Deadline	21.4.21	19.5.21	11.6.21	28.7.21	29.9.21	17.11.21	19.1.22	23.3.22
Quality, Patient Safety, Effectiveness and Experience								
Agenda Item								
Chairs Assurance Report - Quality & Performance Committee (NED Chair)		√		√	√	√	√	√
Accountable Officer for Controlled Drugs Annual Report (Medical Director)		√						
NHSI Flu Letter / Annual Flu Campaign (Director of People)					√			
Learning from Deaths (Medical Director)				Quarter 4 20/21	Quarter 1 21/22		Quarter 2 21/22	Quarter 3 21/22
Quality, Patient Safety, Effectiveness and Experience **Annual Reports** (Director of Quality, Innovation and Improvement)								
Safeguarding		√						
DIPC		√						
Health and Safety		√						
Senior Information Risk Owner Annual Report		√						
Complaints		√						
Quality Account (Director of Quality, Innovation and Improvement)						√		
Modern Slavery Act 2015 Statement (Director of Finance)								√
Annual Emergency, Preparedness, Resilience and Response Assurance Process (Director of Operations)						√		
Operational, Performance and Use of Resources								
Agenda Item								
Chair's Assurance Report - Resources Committee (NED Chair)		√		√	√	√	√	√
Chair's Assurance Report - Charitable Funds Committee (NED Chair)		√				√		
Integrated Performance Report (Director of Quality, Innovation and Improvement)		√		√	√	√	√	√

Date of meeting	28.4.21	26.5.21	11.6.21	28.7.21	29.9.21	24.11.21	26.1.22	30.3.22
Report Deadline	21.4.21	19.5.21	11.6.21	28.7.21	29.9.21	17.11.21	19.1.22	23.3.22
IPC Board Assurance Framework (Director of Quality, Innovation and Improvement)				√			√	
Winter Plan (Director of Operations)						√		
Equality, Diversity and Inclusion Annual Report (Director of People)		Annual Report						
Learning to Improve our People Practices (Director of People)							√	
Approach to Planning (Director of Strategy & Planning)	**To be confirmed on an annual basis**							
Strategy and Planning								
Agenda Item								
Communications Update (Director of Strategy & Planning)		√				√	√	√
CQC Update (Director of Quality, Innovation and Improvement)		√				√		
Bi Annual Assurance Report - Stakeholder Engagement				√				√
Consent Agenda								
Agenda Item								
Policies and Strategies: Ad hoc								

Board of Directors (Part 2)
Work Programme 2021/22

	Date of meeting	28.4.21	26.5.21	11.6.21	28.7.21	29.9.21	24.11.21	26.1.21	30.3.21
	Report Deadline	**21.4.21**	**19.5.21**	**11.6.21**	**28.7.21**	**29.9.21**	**17.11.21**	**19.1.21**	**23.3.21**
Introduction									
Agenda Item									
Minutes of the Previous Meeeting (Chair)		√	√	√	√	√	√	√	√
Action Log (Chair)		√	√	√	√	√	√	√	√
Declarations of Interest (Chair)		√	√	√	√	√	√	√	√
Quality and Performance									
Agenda Item									
Reportable Events Update		√	√	√	√	√	√	√	√
Governance and Risk Management									
Agenda Item									
Board Assurance Framework 2021/22 and Corporate Risk Register (Director of Corporate Affairs)		Quarter 4 20/21			Quarter 1 21/22		Quarter 2 21/22	Quarter 3 21/22	Quarter 4 21/22
Year End 2020/21									
ISA 260				√					
Independent Auditors Report				√					
Audited Financial Statements 2020/21				√					
Annual Report 2020/21 including Annual Governance Statement				√					
Letter of representation				√					
Business Cases/Strategies									
Agenda Item									
Adhoc Business Cases Strategies									
Approval of opening 22/23 Financial Plans									√

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