NHS
North West
Ambulance Service
NHS Trust

Board of Directors Meeting

Wednesday, 27th April 2022
1.00pm – 2.15pm
Via Microsoft Teams

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
INTRODUCTION				
BOD/2223/1	Apologies for Absence	13.00	Information	Chairman
BOD/2223/2	Declarations of Interest	13.00	Decision	Chairman
BOD/2223/3	Register of Interest	13.05	Assurance	Chairman
GOVERNANCE AND RISK MANAGEMEMT				
BOD/2223/4	Board Assurance Framework and Corporate Risk Register Q4 Closing Position 2021/22	13.10	Decision	Director of Corporate Affairs
BOD/2223/5	Board Assurance Framework 2022/23 Opening Position	13:20	Decision	Director of Corporate Affairs
BOD/2223/6	Annual Review of Core Governance Documents • Standing Orders, Reservation of Powers and Scheme of Delegation • Scheme of Delegation Review • Standing Financial Instructions	13:30	Decision	Director of Corporate Affairs
BOD/2223/7	FT Code of Governance Compliance Declaration	13.35	Decision	Director of Corporate Affairs
BOD/2223/8	Common Seal Bi Annual Report	13:40	Assurance	Director of Corporate Affairs
BOD/2223/9	Freedom to Speak Up (FTSU) Annual Report 2021-22	13:45	Assurance	Director of Corporate Affairs
BOD/2223/10	Quality and Performance Committee Annual Report 2021-22	13:50	Decision	Prof A Chambers, Chair Quality and Performance Committee
BOD/2223/11	Resources Committee Annual Report 2021-22	13:55	Decision	Mr D Hanley, Chair Resources Committee
BOD/2223/12	Audit Committee Annual Report 2021-22	14:00	Decision	Mr D Rawsthorn, Chair Audit Committee
BOD/2223/13	Board Assurance Committee Terms of Reference 2022/23 • Audit Committee • Charitable Funds Committee • Nominations & Remuneration Committee • Quality & Performance Committee • Resources Committee	14:05	Decision	Director of Corporate Affairs
BOD/2223/14	Board of Directors Annual Cycle of Business 2022/23	14:10	Decision	Director of Corporate Affairs
CLOSING				
BOD/2223/15	Any Other Business Notified Prior to the Meeting	14:15	Decision	Chairman
BOD/2223/16	Items for Inclusion on the BAF	14.15	Decision	Chairman
DATE AND TIME OF NEXT MEETING				
9.45 am, Wednesday 25th May 2022 via Microsoft Teams				

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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
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.
Catherine	Butterworth	Non-Executive Director	HR Consultant (no live commissions) for NLaG Acture Trust and Beacon GP Care Group				√	Position of Authority	Apr-22		Agreed with Chairman not to accept or start any NHS HR contracts without his prior approval and support.
			Non Executive Director - 3 x Adult Health and Social Care Companies owned by Oldham Countil				√	Position of Authority	Apr-22		Withdraw from decision making process if the organisations listed within the declaration were involved.
			Director / Shareholder for 4 Seasons Garden Companies: 4 Seasons Garden Maintenance Ltd 4 Seasons Gardens (Norden) Ltd 4 Seasons Design and Build Ltd 4 Seasons lawn treatments Ltd CFR HR Ltd (not currently operating)				√	Position of Authority	Apr-22		4 Seasons garden maintenance Ltd has secured and operates NHS Contracts for grounds maintenance and improvement works at other NW NHS Acute Trusts but these pre date and are disassociated with my NED appointment at NWAS. To withdraw from the meeting and any decision making process if the organisations listed within the declaration were involved.
Alison	Chambers	Non-Executive Director	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
			Husband works for Liverpool CCG (Cheshire and Mersey ICB)				√	Other Interest	Feb-22	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Husband is CEO at Barking and Havering and Redbridge University Hospitals NHS Trust				√	Other Interest	Aug-19	Feb-22	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	Employed at the University of Manchester		√			Professor of General Practice		Present	N/A
			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
David	Hanley	Non-Executive Director	Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	Present	No conflict.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	Chair of Association of Ambulance Chief Executives (AACE) Advisory role to the NHS Leadership Review Team		√				Jan-22	Present	No conflict.
			Member of the JESIP Ministerial Board, HM Government		√			Position of Authority	Jan-22	Present	No conflict.
			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
			Member of NHSE/I Ambulance Review Implementation 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

Name	Surname	Current position (s) held- i.e. Governing Body, Member practice, Employee or other	Declared Interest- (Name of the organisation and nature of business)	Type of Interest				Nature of Interest	Date of Interest		Action taken to mitigate risk
				Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests	Indirect Interests		From	To	
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	31.3.22	N/A
			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
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	Jan-22	-
			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	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
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.
			Board Member - Association of Ambulance Chief Executives		√			Position of Authority	Nov-21	Present	No Conflict

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 27 April 2022				
SUBJECT:	Q4 Board Assurance Framework Review				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The Corporate Risk Register can be seen in Appendix 1 and the proposed Q4 (as of 31 March 2022) of the Board Assurance Framework (BAF) with the associated Corporate Risk Register (CRR) risks scored ≥15 can be viewed in Appendix 2. The BAF Heat Maps for 2021/22 year to date can be viewed in Appendix 3. The Executive Leadership Committee (ELC) recommends the following Q4 changes (s4): • Decrease in risk score of SR04 from 16 to 12 • Decrease in risk score of SR09 from 20 to 15				
RECOMMENDATIONS:	The Board of Directors are requested to: • Agree the decrease in risk score of SR04 from 16 to 12 • Agree the decrease in risk score of SR09 from 20 to 15 • Agree the Q4 position of the Board Assurance Framework.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	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 to mitigate any significant strategic risks which have the potential to threaten the achievement of the Trust's strategic objectives.

This paper provides an opportunity for the Board of Directors to review the 2021/22 Q4 position of the Board Assurance Framework (BAF) along with the Corporate Risk Register (CRR) risks scored 15 and above that are aligned to each BAF risk.

2. ASSURANCE PROCESS

The BAF and associated corporate risks are reviewed via the Integrated Governance Structure.

The evidenced based assurance information reported throughout the quarter via the assurance committees and identified via as review of Chair's Assurance Reports is collated on the Assurance Map. The assurance mapping has been utilised to support and inform discussions with Executive Directors and assist with the population of the assurance framework.

3. REVIEW OF THE CORPORATE RISK REGISTER

The review of the CRR takes place monthly at the Executive Leadership Committee (ELC) as well as via the Integrated Governance Structure. The CRR is available for review in Appendix 1.

4. REVIEW OF THE Q4 BAF POSITION

The Executive Leadership Committee has reviewed the Q4 position and recommends the following changes to the Board of Directors for approval:

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

- Decrease in current risk score for Q4 from 16 to 12

Opening Score 01.04.2021	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
12 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**16** 4x4 CxL	**12** 4x3 CxL	Ms L Ward

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

1. Improvements in abstraction levels across the Trust
2. Deployment of the Trust's Military Aid for Civil Contingencies (MACA)

3. The COVID-19 vaccination as a condition of employment legislation was withdrawn which mitigated the risk of forecasted reductions in frontline staffing arising from non-vaccinated staff
4. Q4 recruitment and training plans have been delivered with the end of year forecasted position being over-established in PES and EOC

SR09: There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm

- Decrease in current risk score for Q4 from 20 to 15

Opening Score 01.04.2021	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
12 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**20** 5x4 CxL	**15** 5x3 CxL	Prof M Power

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

1. High standard of oversight and processes for cyber security despite a high threat level
2. Significant progress in assurances and controls to protect the Trust from cyber-attack including improved governance between Information Governance and Cyber Security workstreams
3. Good visibility of the Trust estate through the IT health dashboard
4. Progress to patch systems and replace where required any unsupported systems
5. Increases to resilience and expertise in the Digital and Innovation team have provided better infrastructure; firewalls and security systems to protect emails

5. 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.

6. EQUALITY OR SUSTAINABILITY IMPLICATIONS

None identified.

7. RECOMMENDATIONS

The Board of Directors are requested to:

- Agree the decrease in risk score of SR04 from 16 to 12
- Agree the decrease in risk score of SR09 from 20 to 15
- Agree the Q4 position of the Board Assurance Framework.

Appendix 1 - Corporate Risk Register

Extracted from Datix 31/03/2022

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
2311	28/07/2017	There is a risk that due to insufficient resource/resilience the Estates department will be unable to service the demands of the Trusts critical infrastructure and projects which could result in project failure and detrimental operational performance.	Approved Risks	Operational	Estates and Facilities Management	Corporate and Commercially Sensitive Risk Register	Carolyn Wood	16	Treat - Implement controls and mitigating actions to reduce the risk.	4	4	16	1. Any Estates specific project/s fully considers any impact on Estates Staffing levels. 2. Any project that has Estates requirements are encouraged to involve Estates at the Project outline or Project Initiation stage so that an understanding of Estates requirements are built into the business case for that project. 3. Core projects have PMO oversight. 5. Estates Strategy was given Board approval. Reviewed and updated November 2020. 6. All estates development projects fall within the CPB framework and have EOF oversight Priorities have been agreed with Director of Finance taking into account current constraints. Recruitment is in progress, offer made to start in January and March 2022 and two posts oustanding Monthly Estates Management Meeting	Induction periods of new staff Recruitment to two posts outstanding. Once concluded will have a positive effect on reducing the risk.	Monthly Estates Management Meetings held Estates Annual Management Plan monitored on a monthly basis PMO post appointed to on 19 October 20 Post C-19 review completed and SIP approved - further resource workshop completed Nov 20, proposal approved Jan 21 High level programme map of key strategic projects produced Head of Estates post filled (start date 01-Oct-21) Recruitment part successful one manger post offered to start in Jan-22. Prioritisation of key schemes of work agreed and will be regularly reviewed	Posts approved Recruitment part successful, new post started in Jan currently undertaking induction programme. Sustainability manager started in post 1 April undergoing induction. Estates manager operations will start in post 1 April. Estates project manager post will go out to advert early March with a view to starting in post early summer 2022	4	08/03/2022	08/04/2022
2480	19/12/2017	There is a risk of unsupported software and hardware due to lack of asset ownership, risk and renewal roadmap for existing systems and governance for cyber security which could result in costly last minute updates, potential cyber attacks and loss of systems.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Maxine Power	20	Treat - Implement controls and mitigating actions to reduce the risk.	4	5	20	1. A system census has been completed with system end of life information and system business owner who will lead on replacement of each identified systems. 2. The system census is reviewed 3. Asset license management monitoring provided by Trustmarque as part of an annual programme of work 4. Leadership structure in place 5. IT health dashboard enabling real time monitoring of assets, visability of security threats and vulnerabilities, and assurance around completion of mitigation (e.g. patching and carecerts) 7. Microsoft Enterprise Agreement in place (locking down prices) 8. Cyber essentials assessment completed (2019 - 2020) 10. Work underway to close or re license unsupported software (upgraded CAD software and hardware, closed several servers). 11. Work plan for Q4 19/20 has been created for unsupported servers and will be presented to DOF. 12. Desktop central is utilised for maintaining software updates. 13.Radically reduced the number of servers below 2012 - as of 17/06/2021 25 2008 servers are left 14. Patching effectiveness is very high 17. New Cyber Security Manager recruited and in place. 18. Windows 10 fully rolled out and a continual plan to keep the OS on the latest version 19. New Firewalls were implemented at the end of 2020 20. Implementation of Mimecast email security service. Protecting NWAS from new and emerging threats through email 21. Microsoft ATP implemented on all servers. This is monitored by the Trust and NHSD	Logj4 vulnerability Unsupported systems in use or due to end eg. 2008 server windows operating systems. 8 servers remain. Some to be upgraded some to be decommissioned by the end of 2021.	IT Healthdash Board Trustmarque Quarterly Software asset report Desktop Central assurance dashboard NHS Digital / Microsoft Advanced Threat Protection New Cyber Security Manager recruited and in place.	Currently reviewing change processes to assist in identifying data owners Not all data owners identified across all systems. Process of reviewing all unsupported software systems with data owners to understand future requirements of systems	4	19/10/2021	31/03/2022
2507	01/02/2018	There is a risk that the current Meal Break Policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	16	Treat - Implement controls and mitigating actions to reduce the risk.	4	4	16	01. Strategic Meal Break Dining Instructions. 02. Meal break management of operational resources within Meal Break Window Memorandum. 03. Establishment of Meal Break Review Group to review current practices including review of the Policy. 04. Terms of Reference for Meal Break Review Group. 05. NWAS Strategic meetings taken place re meal break management (May 19 & 23 July 19). 06. Meal break workshop took place (8th July), led by Strategic Head of EOC. 07. Paper to be developed and presented back to Strategic Group by end of September 19. 08. Rota Review which may support meal break management due to stagger times implemented in GM and C&L. 09. Additional focus from the Covid-19 command cell re meal break management compliance (currently at 70%).	01. Review and Implement new Meal Break Policy - GB - March 21. 02. TU engagement and agreement to amend existing Policy 03. Meal Break Policy V11.5 04. Strategic Meal Break Guidance (EOC001) 05. Operational Meal Break Guidance V.1	01. Meal Break Reports submitted to SD SMT. 02. ORH and ACE to support NWAS model with recommendations made 03. Links with Trade Unions and have their agreement 04. Interim Head of Service for Cheshire & Merseyside reviewing Demand and Capacity 05. Daily measurement of meal break compliance. 06. Proposal to be sent to the Service Model Review Board November 2021	01. Gaps in compliance following MIAA Reporting re Meal Break Management. 02. Revised Meal Break Policy	4	01/03/2022	01/04/2022

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
3136	07/10/2019	There is a risk that appropriate vehicle checks may not be taking place across PES in relation to tyre pressure and depth checks due to operational pressures which would lead to a breach of legislation and potential loss of vehicles due to breakdowns/faults.	Approved Risks	Operational	Fleet	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	3	5	15	01. Visual checks required in addition to tyre pressure and tread checks. 02. Sector Quality Visits. 03. SafeCheck Implementation Plan now developed. 04. Tyre pressure tool available to order via NWAS normal ordering processes. 05. SafeCheck live Directorate wide. 06. North Sector (CAM) trialling electronic solution to monitor tyre pressures. 07.Compressors and tyre checking equipment available on each station and are of a standard type; 08. SafeCheck provides audit trails of where tyre checks are being carried out; 09. Tyre and safety checks to be carried out and documented with staff as part of their SPTL contact shift. 10. SPTL Teams atasked with improving weekly check completions as of 28/02/2022	01. Staff training completion is below expectation. 02. Management team focus has been reduced throughout periods of REAP escalation due to competing operational demands. 03. Internet connection at stations is poor affecting the upload of accurate data 04. Installtion and upgrade of Broadband routers to enable data flow due to demand 05. Training module on how to check tyres on MyESR in draft. 06. Intermin random checks on tyres across the sectors 07. Lack of understanding around training requirements prior to the use of compressors 08. SafeCheck isn't being used by staff.	01. Vehicle Check Books. 02. SafeCheck live across PES Operational areas 03. Random sampling of SafeCheck takes place in C & M and identifies any issues. 04. Fleet Management System (Tranman) records shceduled and non scheduled events relevent to vehicles inlc pending maintenance 05. Vehicles are on an 8 week service schedule at respective workshops 06.Tyre related issues are dealt with through a contract with ATS Euormaster 07. Fleet have in place the Maintenance Winter Planning 2021 08. Via Quality & Performance Sub-Committee (Pillars of Quality in Health & Safety and Security Reports) 09. Via Health, Safety & Security Sub-Committee (Pillars of Quality in Health & Safety and Security Reports) 10. Weekly SafeCheck data showing Trust wide compliance as at Week 49 - 85.77% as of 13/03/2022	01. Level of compliance from Safecheck to be determined. 02. SafeCheck data for Service Delivery Directorate to demonstrate compliance levels 03.SafeCheck completion rates are below compliance level. 04. Weekly robust data remains unavailable for review and assurance. 05. Data error entries identified by Head of Clinical & Digital Innovation	5	01/03/2022	01/04/2022

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
3171	12/11/2019	There is a risk that media coverage during the Manchester Arena Inquiry detailing the role and response of the Trust during the incident will result in sustained negative publicity and reputational damage.	Approved Risks	Reputational	Emergency Preparedness	Corporate and Commercially Sensitive Risk Register	Salman Desai	20	Treat - Implement controls and mitigating actions to reduce the risk.	4	4	16	Patient and Public Engagement Patient and Public Panel engagement Press and Public Relations Stakeholder Communications Communications on Social Media Platforms Trust Campaigns and Communications (External) Positive Communications on NWAS (External Sources) Procured Media Monitoring Platform to capture all media coverage during evidence giving Monitoring of Media Coverage via Platform during evidence giving Regular Staff Briefings Key messages regarding refraining from commenting publicly Key messages shared via Staff Facebook group and CEO Bulletin Stakeholders briefed ahead of NWAS witnesses giving evidence Liaison between Legal and Comms Teams Media/ Social Media handling protocol agreed for Comms Team Media Training scheduled to be undertaken by ELC Consideration to seeking of external consultant support prior to report being published Regular updates to ELC ahead of report release Report response options to be presented to Board for discussion and decision	2. Timeframes of Inquiry report release 3. Outcome of the Inquiry report 4. Maintain crisis communications skills within team 5. Potential additional resources in communications team to manage additional workload 6. Media Specialist Training for Executive Directors by end of March 2022 1. Unknown nature of publicity	Quarterly Communications Report to Board of Directors Daily Briefings for Chairman and CEO External Publicity (Media/ Social Media) Regular updates to ELC ahead of report release Report response options appraisal discussed at ELC Report response options appraisal presented to Board of Directors Discussions with other Emergency Services Communications Leads on their report response		4	15/03/2022	15/04/2022
3254	24/04/2020	There is a risk that due to staff taking carried over leave accrued during the COVID-19 pandemic, operational resources will not meet demand resulting in delayed patient response and delivery of national ARP standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	3	5	15	01. Maximum abstraction rates. 02. Option to carry some leave over into the next financial year. 03 Introduction of the NWAS annual leave buy back scheme. (8.47% of staff within PES took up the offer). 04. NHS Employers guidance re annual leave carry forward provision (2 years). 05. NWAS Operational Performance Calls. 06. Operational, Tactical and Strategic Management. 07. Performance Management Framework. 08. Overtime opportunities on selected shifts at selected times 09. Use of Third Party Providers and VAS. 10. Increase scope of Third Party Providers and VAS. 11. NWAS Patient Safety Plan. 12. Clinical Leadership Model. 13. ROCC Tactical and Strategic Commanders. 14.Mandatory training temporarily cancelled from January 2022. 15. PTS resources used in PES support work. 16. NWAS COVID-19 Response Plan. 17. Agreed additional funding to increase PES workforce establishment. 18. 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). 19. Resources from MACA and eCFRs 20. Annual leave to be taken across the leave period 1 April 2021 - 31 March 2022. 21. Buy back scheme offered to Service Delivery staff to ease pressure on resources.	01.Number of operational staff opting to utilise the annual leave buy back scheme. 02.Use of Overtime and impact on Trust financial position 03.Increased use of PAS/VAS impacting on Trust's financial position 04.Sustainability of using non-PES clinical resources 05.Timescale of staff vaccination programme 06.Subsequent COVID-19 peaks/waves 07.Changing regional tier system and national/local lockdown restrictions. 08.Evolving guidance on higher risk individuals who should be shielding 09.Feedback on National ARP Standards. 10.Funding for additional resources. 11. Continued increases in staff sickness across Service Delivery.	01.Abstraction Reports. 02.NWAS Annual Leave Buy Back Scheme is being re-introduced in 2022 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 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.	01. Adherence to abstraction rates on abstraction reporting. 02. Sustainability of using University students for PES Support 03. PTS Uplift staff working in PES Support roles 04. An additional days annual leave has been provided to staff across 2021/22 period	5	01/03/2022	01/04/2022
													01. Local management engagement with hospitals within their Sector 02. NWAS Executive Management engagement with hospitals 03. Implemented HALOs at hospital sites to improve delays 04. Hospital Handover Project to reduce delays at hospitals 05. Installed Hospital Arrival Screens for all hospitals across the NW 06. A&E Delivery Board with NWAS representation 07. Attendance at National calls regarding hospital handovers 08. QI Approach to hospital handover		01.NWAS Hospital Handover Performance Data to Commissioners and NW NHSE/I				

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
3445	17/11/2020	There is a risk that due to the excessive handover delays at hospitals across the North West, there maybe increased numbers of patients being held on the back of ambulances and the number of available ambulances may diminish which may result in increased numbers of delayed responses for our patients.	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Ged Blezard	20	Treat - Implement controls and mitigating actions to reduce the risk.	4	5	20	09. The Hospital Handover Safety Checklist is supported by the Medical and Quality Directorate and can be used in all Emergency Departments 10. Every Minute Matters` collaboration with Hospitals to improve handover times 11. Attendance at NHSE/I North West Winter Planning Meeting 12. Attendance at NHSE/I Hospital Handover Delays Review Meetings 13. Identification of Hospitals to participate in `Every Minute Matters` 14. NWAS concerns raised with AACE for National level discussion 15. Strategic meeting chaired by Prof. A Marsh to review delays 16. NHSE/I and Commissioners taking the lead to reduce hosptial handover times 17. Escalations with Chief Executive Officers of appropriate Acute Trusts 18. Hospital outliers escalated to the Regional Director of NHSE 19. Targeted recovery plans for hospital handover improvements 20. Continued liaison between NWAS and Acute services (Gold Cell meetings in Cheshire and Mersey Region); 21. Monitoring is taking place between Acute and CQC 23 joint monitoring arrangements between lead Commissioners and NWAS. 22. National Handover meeting with AACE 23. Operational Orders being reviewed. 24. Hospital Handover Action Cards to assist with managing a deteriorating patient 25. Commissioners are leading on working with Acutes and monitoring bi-weekly with NHSE 26. Roll-out in Cheshire and Merseyside 27. National Pilot `Rapid Release` at Lancashire Teachng Hospitals (Royal Preston Hospital) as of 01/02/2022 28. Introduction of NHS Pathways during March 2022 - July 2022 in EOC aimed at reducing A & E journeys & redirect to alternative services	01. Not all NW hospitals have signed up to the `Every Minute Matters` collaboration 02. Unpredictable increases in demand across the Service Directorate 03. Increased pressure within hospitals are increasing delays for the release of ambulances 04. DCA vehicle specification for 2023/24 does not include the provision of wheelchairs	02. NWAS Hospital Handover Safety Checklist developed and being rolled out across the NW. Two sites fully implemented 03.NWAS Integrated Performance Report 04.Hospital Handover Project Documentation 05.Every Minute Matters Project Docmentation 06. Right Care Closer to Home` allocated to SPTLs. 07. Acute Frailty Unit at Whiston Hospital as of September 2021 08. NHSE/I have a focused piece of work to reduce hospital handover delays. 09.Documents include Ambulance Handover Safety Checklist, and Handover Safety Checklist Resource Pack 10. Revised Divert and Deflection Policy (V12.3) 11. NWAS Hospital Handover Fit2Sit developed and being rolled out across the NW. One site fully implemented 12. NWAS Hospital Handover Process redesign developed and being rolled out across the NW. Four sites fully implemented 13. SDEC Pathways and ED avoidance being implemented 14. Resource packs received from Medical Director (Ambulance Handover Safety Checklist Pack & Resocurce Pacls) 15. Successful trial of Escaltion process to improve release of vehicles 16. Delayed admissions report to highlight areas of improvement and areas to have greater focus	01. Continued hospital presssures affect NWAS' ability to handover patients in a timely manner 02. Continued abstraction rates of PES staff remains challenging to provide extra vehicles 03. National Performance Data 04. National Hospital Handover Performance Data 05. NWAS Hospital Handover Process redesign not fully implemented the NW 06. NWAS Hospital Handover Safety Checklist not fully implemented across the NW 07. NWAS Hospital Handover Fit2Sit ongoing with Tameside	5	01/03/2022	01/04/2022

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
3447	17/11/2020	There is a risk that due to increasing operational demand and call volumes, the health and wellbeing of our workforce may deteriorate leading to absenteeism negatively impacting on staff safety.	Approved Risks	Operational	People	Corporate and Commercially Sensitive Risk Register	Ged Blezard	16	Treat - Implement controls and mitigating actions to reduce the risk.	4	4	16	01. Local Health and Wellbeing Plans 02. Organisational Policies and Procedures 03. Staff Self-Referral Schemes to Occupational Health for mental health advice and support 04. Health & Wellbeing initiatives 05. HR Business Partnering Team 06. Increase in provision of Welfare vehicles in Greater Manchester, Cheshire and Merseyside and Cumbria and Lancashire 07. Additional funding approved by commissioners of £0.434m for expansion to the NWAS Mental Health Team 08. Vouchers to be issued to all staff during the Festive period as a Thank You. 09. Increase in the number of welfare vehicles to support staff 10. Individual Stress Risk Assessment for Occupational Health Services in place	01. Outcome of internal Service Delivery Model Review 02. Welfare vehicle provision isn`t 24/7 or consistent across all Sectors 03. Non-reoccuring funding from Commissioners	01. Reinforcement of local level engagement and partnership with Trade Unions 02. Sickness and Data Officer position created to manage sickness. 03. Return to Work procedures taking place for those who have been shielding. 04. Increase in support from militrary (January 2022) has decreased workload on NWAS operational staff	01. Receipt of commissioner funding following ORH review 02. Self-isolation guidance from NWAS remains unchnaged from 04/03/2022	4	01/03/2022	01/04/2022
3452	17/11/2020	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	Approved Risks	Operational	Operational Performance	Corporate and Commercially Sensitive Risk Register	Ged Blezard	25	Treat - Implement controls and mitigating actions to reduce the risk.	4	5	20	01.Shared learning via AACE and other NHS Ambulance Trusts 02.Preparatory workforce planning including overtime and recruitment opportunities 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 and frequent reviews of PDAs 06. Implemented clinical leadership across all EOCs and Trauma cells 07. Auto-allocation to improve response times 08. Management of IFT/ HCP activity 09. DCA, RRV and ORH Modelling Review Building & Better Rota's Project 10. Fleet Replacement Programme 11. Operational Policies & Procedures and Operational Guidance 12. Operational, Tactical and Strategic Management 13. Performance Management Framework 14. Additional resources utilised to support performance, e.g. use of Third Party Providers with increased scope of practice, use of CFRs and PTS supporting PES work 15. NWAS Communications; use of social media 16. Clinical Leadership Model 17. NWAS Operational Performance Calls 18. ROCC Tactical Commanders & Strategic Commanders 19. Cancellation of mandatory training & appraisals 20. NWAS Winter Plan 21. Engagement with System Leaders & Acute Hospitals 22. Engagement with NHSE/I 23. Engagement with NWAS Lead Commissioner 24.Temporary suspension of Mandatory Training during winter 2021/22 25. Initiated actions for REAP 4 as agreed by ELC 26. Review of strategic intentions with increases in pressures. 27. Additional 45 DCAs being utilised as part of Winter Plan 28. Additional 90 PTS staff being upskilled for PES up to 31 March 2022 29. Additional funding for 111 Service 30. Six Point Plan jointly devleoped with Commissioners to cover - Increase Resources, increase Hear and Treat, reduce loss of vehicle hours 31. Discussions with NHSE re `levelling up` investment 32. MACCA assets are temporarily deployed within NWAS 33. Military assets are being deployed in three phases W/C 17/01/22 34. International recriutment is being Project led by NHSEE for NWAS	01.Confirmation of the receipt of additional finances from Commissioner 02.Delivery of Urgent and Emergency Care Strategy 03. Workforce Planning 04. Awaiting outcome of ORH review 05. Continued increases in abstraction rates across Service Delivery (circa 31%)) due to omicron 06. Monthly monitoring by Lead Commisisoner to facilitate release of funding 07. International appointees will not be in post until circa Sept 2022 08. Current military resources are depleting in stages up to 31/03/2022 following which no further resources will be available.	01.National Performance Data 02.National ARP Data 03.ORH Modelling Report 04.NWAS Integrated Performance Report 05.NWAS Performance Reports to Commissioners 06.NWAS Performance Reports to NHSE/I 07.NWAS Business Cases for Fleet Replacement 08.NWAS Workforce Indicators Report 09. National Hospital Handover Performance Data 10. NWAS Hospital Handover Performance Data to Commissioners 11. NWAS Hospital Handover Performance Data to NW NHSE/I 12. NWAS Integrated Performance Report 13. Hospital Handover Project partly implemented across NW Acutes 14. Every Minute Matters Project Documentation 15. £6.23 m investment to cover short-term increase in resources from September 2021 - 31 March 2022 16. Commissioners and NHSE are engaged in improving ED hospital delays 17. Buddy system from NHS Ambulanbce Trusts to alleviate pressures on EOC when required 18. Financial Investment and Monitoring Winter Plan presentation (30/11/21) provides projections of exenditure 19. MACCA application approved January 2022 20. 150 military assets deployed assisting NWAS between January 2022 - 31 March 2022 21. There has been a recorded improvement in performance in late January - early February 2022 22. There has been a reduction in abstractions 23. NWAS at REAP 3 as of 02/02/2022 24. NWAS engaged with NHSEE International recruitment pilot of Paramedics from Australia	01. AACE to simplfy the operating model. 02. Continued hospital pressures 03. No confirmation for re-occuring funding levels for resourses from 01 April 2022 04. Delay in Australian Paramedics coming into to post May - September 2022.	5	01/03/2022	01/04/2022

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
3537	17/06/2021	There is a risk that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially Sensitive Risk Register	Maxine Power	15	Treat - Implement controls and mitigating actions to reduce the risk.	4	5	20	IT health dashboard enabling real time monitoring of assets, visibility of security threats and vulnerabilities, and assurance around completion of mitigation (e.g. patching and CareCERTs) Cyber essentials Compliant assessment completed (2019 - 2020) Desktop central is utilised for maintaining software updates. Radically reduced the number of servers below 2012 - as of 17/06/2021 25 2008 servers are left Patching effectiveness is very high. Regular security updates deployed for the latest security patches New Cyber Security Manager recruited and in place (Oct 2020) New Firewalls were implemented at the end of 2020 offering better security and visibility Implementation of Mimecast email security service. Protecting NWAS from new and emerging threats through email Microsoft ATP implemented on all servers. providing protection and visibility. This is monitored by the Trust and NHSD Mobile Device Management in use to control services on some mobile devices Anti-virus protection (including malware protection) on both physical and virtual clients/server's Device encryption on all laptops and some mobile devices mobile devices to protect data Automated daily threat assessment in place for Windows 10 Business Continuity Plans Regular Audits undertaken by MIAA Regular Pen Tests undertaken Mandatory staff cyber training via ESR External and internals scans and patching completed as released in hours	Admin Accounts have internet access There is only 1 backup No MFA on backups High number of Global Admin accounts Out of support software No SIEM No Specific Cyber Incident Management Plan/Policy Lack of uptake in staff security awareness Logj4 vulnerability	brithd01.northwestambulance.nhs.uk Cyber Essential Certificate Desktop Central - http://epdskc01.northwestambulance.nhs.uk:2581/homePage.do?actionToCall=homePageDetails Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of unsupported Operating Systems Regular Reporting via IT Security Forum to the Information Governance Sub Committee on number of patched/unpatched devices and servers Firewall alerts and dashboard Mimecast dashboard - https://login-uk.mimecast.com/u/login/?gta=apps&link=/home#/login ATP Dashboard - https://security.microsoft.com/endpoints/dashboard# MDM Intune portal - https://endpoint.microsoft.com/#@nwas.nhs.uk/dashboard/private/b259b43f-b7b8-47df-b8e0-a2109214d03a Malware protection dashboard - https://eptrnd01:4119/SignIn.screen BC plans are managed within continuity2 Yearly Staff Training figures reported to IG team Pen Test - External Vulnerability & DSPT Assessment (Internal) Feb 2021 Pen Test - External Vulnerability & DSPT Assessment (External) Feb 2021 Pen Test - External Vulnerability & DSPT Assessment (Safe check) Feb 2021 MIAA IT Continuity Audit Dec 2020 MIAA User Privilege Audit Dec 2020 New Cyber Security Manager recruited and in place (Oct 2020) IT Health dashboard has provided significant oversight of log j4 patching status External scans undertaken to search for logj4 vulnerabilities	Lack of defined KPI's relating to Cyber Security & governance/assurance process Actions from NHS Digital, Pen Tests & MIAA assessments to be addressed &b monitored Lack of independent evaluation of security training re Social Engineering Lack of multiple and immutable backups	5	23/02/2022	31/03/2022
3540	17/06/2021	There is a risk that due to digital expansion/interoperability increasing the Trust's attack surface which in turn increases overall risk to the Trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	Approved Risks	Operational	Digital and Innovation	Corporate and Commercially	Maxine Power	12	Treat - Implement controls and	4	4	16	DPIA Process for all systems, processes and applications SLSP process for all systems, processes and applications Logging and monitoring Risk Management Process Digital Design Forum Interoperability Forum	Incomplete Information Asset Register Not all systems have a completed SLSP or DPIA Processes are not known by all staff Logj4 vulnerability	Pen Test - External Vulnerability & DSPT Assessment (Internal) Feb 2021 Pen Test - External Vulnerability & DSPT Assessment (External) Feb 2021 Pen Test - External Vulnerability & DSPT Assessment (Safe check) Feb 2021 MIAA User Privilege Audit Dec 2020 New Cyber Security Manager recruited and in place (Oct	Lack of a robust supplier assurance process No all staff follow the correct route when developing digital solutions	4	23/02/2022	31/03/2022
3595	23/11/2021	There is a risk due to conflict with operational response priorities that operational staff will not be compliant with statutory and mandatory training requirements (85%), resulting in potential adverse impact on patient care/safety due to staff competence and also resulting in adverse regulatory scrutiny.	Approved Risks	Operational	People	Corporate and Commercially	Lisa Ward	20	Treat - Implement controls and	4	4	16	01. Policy & Procedure in place 02. Recovery plan in place and revised trajectories 03. Weekly reports for PES on attendances and booking 04. Monthly reporting by service lines 05.Regular engagement with PES and PTS service line leads	01. Recovery plan for EOC 02. Recovery plan for Safeguarding level 3 03. Recovery plan for information governanance 04. Engagement with EOC service line leads	01.Monthly reporting to Board via IPR Dashboard 02. Quarterly Education Assurance Management Group - standing item 03. Monthly update to ELC compliance meeting 04. Substantial Assurance - from MIAA Internal Audit 05. Weekly reporting of bookings and uptake (PES)	01. Service line assurance of abstraction plans to meet 85%	8	24/12/2021	25/02/2022

DX ID	Opened	Risk Description	Approval status	Risk Type	Risk Subtype	Risk Register	Lead(s)	Rating (initial)	Risk Treatment	Likelihood (current)	Consequence (current)	Rating (current)	Controls	Gaps in controls	Assurance	Gaps in assurance	Rating (Target)	Last reviewed	Date of next review
3611	03/02/2022	There is a risk due to the gaps in assurance surrounding the enactment of Duty of Candour for incidents that do not meet the Serious Incidents threshold, that regulatory Duty of Candour conversations will be missed, leading to regulatory enforcement, financial implications and loss of service user confidence	Approved Risks	Operational	Patient Safety	Corporate and Commercially Sensitive Risk Register	Maxine Power	20	Treat - Implement controls and mitigating actions to reduce the	5	3	15	01. Duty of Candour Procedure (Serious Incidents) 02. Duty of Candour Training 03. Duty of Candour Enactment Documentation 04. Duty of Candour Documentation in DatixWeb System 05. Openness and Transparency Questions during Incident Reporting in DatixWeb System 06. Openness and Transparency Questions during Complaint Handling in DatixWeb System vv 07. Duty of Candour Questions Available during Incident Management in DatixWeb System 08. Duty of Candour Questions Available during Complaint Management in DatixWeb System	01. Inaccuracies within Duty of Candour Procedure 02. Organisational awareness of Duty of Candour 03. Enhanced Duty of Candour Training Package 04. Duty of Candour Repository 05. Duty of Candour Audits/ Compliance Reviews	Duty of Candour Training Compliance Data Duty of Candour Compliance Reviews (Serious Incidents)	Duty of Candour Assurance Reporting to Patient Safety Sub Cttee	4	02/03/2022	11/04/2022

APPENDIX 2

North West Ambulance Service NHS Trust

Board Assurance Framework 2021/22

BOARD OF DIRECTORS PART 1

WEDNESDAY 27 APRIL 2022

nwas.nhs.uk

Q4 2021/22 Reporting Timescales:

Quality & Performance Cttee:	25/04/2022
Resources Cttee:	25/03/2022
Executive Leadership Cttee:	20/04/2022
Audit Cttee:	22/04/2022
Board of Directors:	27/04/2022

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
DoSPT	Director of Strategy, Partnerships & Transformation
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	**15** 5x3 CxL	15 5x3 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 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	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 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 delayed care	**Quality & Performance**	**DoOps**	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 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	**12** 4x3 CxL	**12** 4x3 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**4** 4x1 CxL
SR05: There is a risk that organisational culture change does not sufficiently develop, impacting adversely on staff wellbeing and engagement with organisational changes, resulting in poor quality services and staff harm	**Resources**	**DoP**			**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**4** 4x1 CxL
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Quality & Performance**	**DoQII**			**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**5** 5x1 CxL
SR07: There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint	**Resources**	**DoSPT**			**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**4** 4x1 CxL
SR08: **(COMMERCIALLY SENSITIVE)**	**Resources**	**DoSPT**			**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**4** 4x1 CxL
SR09: There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm.	**Resources**	**DoQII**				**20** 5x4 CxL	15 5x3 CxL	15 5x3 CxL	**12** 4x3 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 & Digital

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	15	15	20	20	20	5
	5x3	5x3	5x3	5x4	5x4	5x4	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q4 of this BAF remains at a score of 20 due to continuing impact of hospital handover delays, long waits and clinical call backs within NHS 111 which impacts on quality, safety and patient experience. There is continual work to focus on patient safety and maintenance of quality to deliver our strategic intentions, the Trust has escalated to REAP Level 4 due to recovering from COVID-19 pandemic and winter demands. There was an increased number in serious incidents declared at the commencement of the quarter which heightens the importance of a significant focus on quality, safety and patient experience for those who interact with our services. Funding for the Clinical Coordination Desk has been confirmed to oversee all long waits across the Trust. Associated plans for the implementation of the NHS Patient Safety Strategy and the next iteration of the Right Care Strategy in draft format. An internal review of Duty of Candour has been completed, with recommendations being implemented during the next financial year. The ongoing focus will include delivering the milestones in the Right Care Strategy and delivering the requirements of the new regulatory regime.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Quality Performance	**Level 2:** NWAS Quality Account	Reported to BoD (BoD/2122/43)
Quality and Operational Metric Surveillance	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Reportable Events Report	Reported to BoD (BoD/2122/152) Reported to BoD (BOD/ 2122/82)
Clincial Audit	**Level 2:** Clinical Audit Plan 2021/22 **Level 2:** Clinical Audit Q3 Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/15) Reported to Q&P Cttee (Q&PC/ 2122/200)
Quality Surveillance	**Level 2:** Quality Assurance Visit Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/199)
Right Care Strategy Implementation	**Level 2:** Quarterly Right Care Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/181)
CQC Transitonal Monitoring	**Level 2:** CQC Assurance Report & Action Plans	Reported to Q&P Cttee (Q&PC/ 2122/34)
Quality Systems and Process	**Level 2:** MIAA Quality Audit Plans	Reported to Audit Cttee (AC/ 2122/12)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework	Reported to BoD (BoD/2122/106)
DIGITAL		
Digital Strategy	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2122/199)
Data Security and Quality	**Level 3:** Data Secruty Protection Toolkit **Level 3:** MIAA Digital Audit Plans	Reported to Audit Cttee (AC/ 2122/10)
UCP Programme	**Level 2:** Implementation of a Stable 999 Telephony Platform	Reported to Resources Cttee (RC/2122/89) Reported to BoD (BOD/ 2122/98)
EPR Functionality	**Level 2:** EPR Business Case	Reported to BoD (BoD/2122/69)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Complaints and Incident Management	Develop and deliver a new operating model service line accountability for the management of complaints and incidents	Prof M Power	Q4	Q&P Cttee	Completed
Midwifery Strategic Plan	Develop the NWAS Midwifery Strategic Plan	Dr C Grant	Q4	Q&P Cttee	Completed
NHS Patient Safety Strategy	Develop a plan to implement appropriate elements of the NHS PS Strategy	Prof M Power	Q4	Q&P Cttee	Completed
Electronic Quality Measurement Auditing/ Reporting Systems	Develop automated systems for non-clinical audits	Prof M Power	2022/23	Q&P Cttee	In Progress
Digital Capture and Monitoring of Clinical Outcomes	Deliver Phase 1 EPR roll out and embed systems for automating clinical audit	Prof M Power	Q4	Q&P Cttee	Completed
Quality Assurance & Improvement Plan	Draft the next iteration of the Right Care Strategy	Prof M Power	Q4	Q&P Cttee	Completed
Safety Culture	Devise a plan to improve performance on safety culture & F2SU	Prof M Power	2022/23	Q&P Cttee	In Progress
Mental Health, Dementia, LD & Autism Strategic Plan	Develop MH, Dementia, LD & Autism Strategic Plan Devise and embed appropriate pathways for patients	Prof M Power	2022/23	Q&P Cttee	In Progress
	Deliver MH, Dementia, LD & Autism Strategic Plan	Prof M Power	2022/23	Q&P Cttee	In Progress
Duty of Candour	Undertake an internal review of Duty of Candour processes	Prof M Power	Q4	Q&P Cttee	Completed
DIGITAL					
Out of Hours Technical Resilience	Development of proposal in conjunction with operations	Prof M Power	2022/23	Audit Cttee	In Progress
Single Primary Triage System	Delivery of Phase 1: Migration to Single Primary Triage System	Prof M Power	Q4	Resources Cttee	Completed

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2507	Operational/ Operational Performance	There is a risk that the current Meal Break Policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 Significant	16 Significant	⇔	4 Moderate
3445	Operational/ Patient Safety	There is a risk that due to the excessive 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.	20 Significant	20 Significant	⇔	5 Moderate
3611	Operational/ Patient Safety	There is a risk due to the gaps in assurance surrounding the enactment of Duty of Candour for incidents that do not meet the Serious Incidents threshold, that regulatory Duty of Candour conversations will be missed, leading to regulatory enforcement, financial implications and loss of service user confidence.	20 Significant	16 Significant	⇩	4 Moderate

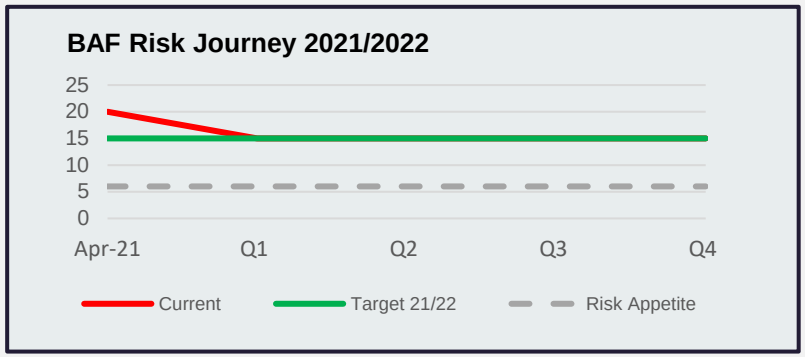
BOARD ASSURANCE FRAMEWORK 2021/22

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	15	15	15	15	5
	5x4	5x3	5x3	5x3	5x3	5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q4 of this BAF risk has maintained at a score of a 15 due to delivery of breakeven position for H2, however non-recurrent delivery of Cost Improvement Programmes (CIP) carries a financial gap into the new financial year. In addition, financial plans for 2022/23 are being finalised with discussions continuing with ICS's. Plans have been established in line with the draft planning guidance with the final guidance yet to be published. Draft financial plans have been reported to the Resources Committee and the Board of Directors.

CONTROLS	ASSURANCES	EVIDENCE
Financial Plans	**Level 2:** 2021/22 Financial Plans	Reported to Resources Cttee (RC/2122/113) & BoD (BOD 2122/84)
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
2021/22 Capital Plan	**Level 2:** 2021/22 Capital Plan **Level 3:** NWAS 2021/22 Captial Plan	Reported to BoD (BOD/2122/15) (RC/2122/83) Reported to Lancashire & South Cumbria ICS Board
Annual Accounts/ VfM Statement	**Level 3:** Audit Completion Report (ISA 260) **Level 3:** Independent Auditors Report **Level 3:** Audited Annual Accounts 2020/21	Reported to Audit Cttee (AC/2122) and BoD (BOD/2122/20) Reported to Audit Cttee (AC/2122) and BoD (BOD/2122/21) Reported to Audit Cttee (AC/2122) and BoD (BOD/2122/22)
Financial Performance	**Level 2:** M11 Financial Report	Reported to Resources Cttee (RC/2122/112)
H2 Financial Plan	**Level 2:** Assurance of H2 Financial Plans, including efficencies	Reported to Resources Cttee (RC/2122/81)
2022/23 Financial Plans	**Level 2:** Draft 2022/23 Financial Plans	Reported to Resources Cttee (RC/2122/113) & BoD (BOD/2122/54)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2022/23 Planning Guidance	Receipt of 2022/23 Planning Guidance from NHSEI	Ms C Wood	2022/23	Resources Cttee	In Progress
2022/23 Financial Plan Revenue	Approval of 2022/23 Financial Plan (Revenue)	Ms C Wood	2022/23	Resources Cttee	In Progress
2022/23 Financial Plan Capital	Approval of 2022/23 Financial Plan (Capital)	Ms C Wood	2022/23	Resources Cttee	In Progress
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	2022/23	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2311	Operational/ Estates & FM	There is a risk that due to insufficient resource/resilience the Estates department will be unable to service the demands of the Trusts critical infrastructure and projects which could result in project failure and detrimental operational performance.	16 Significant	16 Significant	⇔	4 Moderate

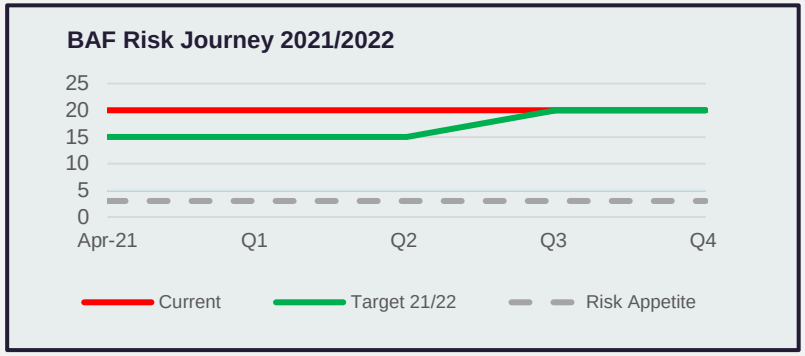
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR03:
There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed 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	20	20	20	20	20	5
	5x4	5x4	5x4	5x4	5x4	5x4	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q4 of this BAF risk has maintained a score of 20 due to sustained levels of operational pressures the Trust has seen across PES and NHS 111, resulting in REAP Level 4 in March 2022. The Trust continues to apply appropriate mitigating measures to assist with the operational pressures, including the use of third-party providers, shift enhancements and PTS providing support to PES. ETA scripts have remained in place throughout Q4 and continue to minimise the number of duplicate 999 calls. The Military Aid to Civil Contingencies (MACA) was stepped down in March 2022. During Q4, NWAS has received additional non-recurrent funding from the Government to assist with the current operational pressures and discussions are ongoing with Commissioners to secure additional funding. The escalation process for extended hospital handover times has been rolled out across the North West and whilst NWAS are above the national average, the Trust continues to experience a deterioration in handover times.

CONTROLS	ASSURANCES	EVIDENCE
Optima Independent Review of NWAS Resources	**Level 3:** ORH Demand and Capacity Review	Reported to Q&P Cttee (Q&PC 2021/145)
Operational Performance Surveillance	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Balanced Scorecard	Reported to BoD (BoD/2122/152) Reported to BoD (BoD2122/130)
Adverse Weather Planning	**Level 2:** Winter Plan **Level 2:** NWAS Annual Heatwave Plan	Reported to Q&P Cttee (Q&PC 2122/157) Reported to Q&P Cttee (Q&PC 2122/69)
ARP Performance	**Level 2:** Deep Dive & thematic analysis: long waits & resource modelling	Reported to Q&P Cttee (Q&PC 2122/84)
Urgent & Emergency Care (UEC) Strategy Implementation	**Level 2:** Quarterly UEC Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/142)
Operational Workforce Abstraction Rates	**Level 2:** Request and approval of Military Aid to Civil Contigencies (MACA)	Reported to Q&P Cttee (Q&PC/2122/156)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	2022/23	Q&P Cttee	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve patient care	Mr G Blezard	2022/23	Q&P Cttee	In Progress
	Maximise use of existing resources	Mr G Blezard	2022/23	Q&P Cttee	In Progress
Hospital Handover Delays	Develop escalation processes for extended handover delays	Mr G Blezard	January 2022	Q&P Cttee	Completed
	Participation in local and national programmes to reduce delays	Mr G Blezard	2022/23	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**
2507	Operational/ Performance	There is a risk that the current Meal Break Policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 Significant	16 Significant	⇔	4 Moderate
3254	Operational/ Performance	There is a risk that due to staff taking carried over leave accrued during the COVID19 pandemic, operational resources will not meet demand resulting in delayed patient response and delivery of national ARP standards.	20 Significant	15 Significant	⇩	5 Moderate
3445	Operational/ Patient Safety	There is a risk that due to the excessive 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.	20 Significant	20 Significant	⇔	5 Moderate
3452	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 Significant	25 Significant	⇔	5 Moderate

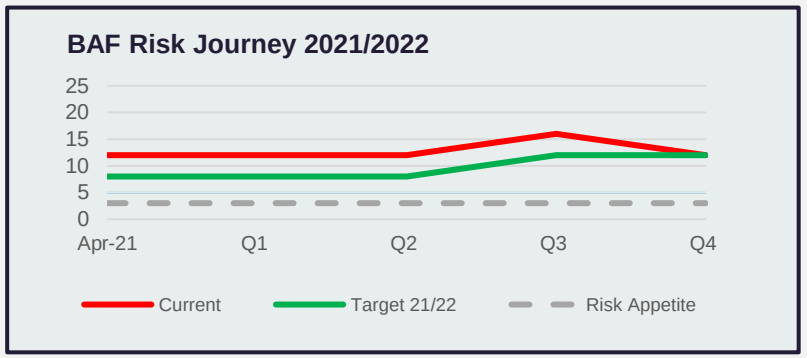
BOARD ASSURANCE FRAMEWORK 2021/22

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	12	12	16	12	12	4
	4x3	4x3	4x3	4x4	4x3	4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q4 of this BAF has decreased to a score of 12 due to improvements in abstractions levels across the Trust and the deployment of the Trust's Military Aid for Civil Contingencies (MACA) during Q4. The COVID-19 vaccination as a condition of employment legislation was withdrawn which mitigated the risk of forecasted reductions in frontline staffing arising from non-vaccinated staff. Q4 recruitment and training plans have been delivered with the end of year forecasted position being over established in PES and EOC. There is a key area of focus for the delivery of the NHS 111 retention plan, with short term retention incentives implemented along with other associated plans. The turnover in Health Advisors in NHS 111 demonstrates a reduction in February and March 2022.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Strategic People Plan	**Level 2:** NWAS People Plan **Level 2:** Workforce Plan 2022/23 Workforce Indicators Report **Level 2:** Operating Plans 2022/23 Workforce Indicators Report	Reported to Resources Cttee (RC/2122/91) & BoD (BOD/ 2122/37) Reported to Resources Cttee (RC/2122/108) Reported to Resources Cttee (RC/2122/108)
Strategic Workforce Plan	**Level 2:** H1 Planning Submission **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** H2 Planning Submission	Reported to BoD (BOD/ 2122/10) Reported to Resources Cttee (RC/2122/69 and RC/2122/110) Reported to Resources Cttee (RC/2122/88) & BoD (BOD/2122/54)
People Metric Surveillance	**Level 2:** Integrated Performance Report **Level 2:** Workforce Indicators Report **Level 2:** Staff Survey and Culture Audit Deep Dive	Reported to BoD (BOD/2122/105) Reported to Resources Cttee (RC/2122/90) Reported to Resources Cttee (RC/ 2122/07)
Recruitment Plans	**Level 2:** H1 Recruitment Plans **Level 2:** H2 Recruitment Plans	Reported to (RC/2122/66) Reported to (RC/2122/90)
Vaccination	**Level 2:** Flu Plans ~~and COVID booster roll out~~	Reported to Resources Cttee (RC/2122/68) & BoD (BOD/2122/86)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
111 Retention	Development of an action plan to improve retention in NHS 111	Ms L Ward	January 2022	Resources Cttee	Completed
Vaccination	Delivery of Flu Plan ~~and COVID booster~~	Ms L Ward	March 2022	Resources Cttee	Completed
Vaccination as a Condition of Deployment (VCOD)	Implementation of legislative requirements	Ms L Ward	March 2022	Resources Cttee	Completed
Recruitment Plans	Delivery Q4 recruitment plans	Ms L Ward	March 2022	Resources Cttee	Completed
Attendance	Delivery of actions to improve attedance including AIT	Ms L Ward	2022/23	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**
3447	Operational/ Workforce	There is a risk that due to increasing operational demand and call volumes, the health and wellbeing of our workforce may deteriorate leading to absenteeism negatively impacting on staff safety.	16 Significant	16 Significant	⇔	4 Moderate

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR05:
There is a risk that organisational culture change does not sufficiently develop, impacting adversely on staff wellbeing and engagement with organisational changes, resulting in poor quality services and staff harm

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	12	12	12	4
			4x3	4x3	4x3	4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite			Exceeded	Exceeded	Exceeded	Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q4 of this BAF has maintained a score of 12 as whilst the Trust continues to build on its improvements, it continues to face a significant number of challenges in a climate where pressures on staff and managers from demand, activity and recovery from COVID-19 continues to be significant. There remains a good health and wellbeing offer in place. This has been further strengthened through additional NHSEI funding which has been focused on addressing managerial burnout and proactive wellbeing calls for frontline staff. The staff survey results have shown an improvement in comparison with sector scores and provides a foundation for the Trust to build upon for the next financial year. Good movements have been seen in areas such as confidence in speaking up and bullying and harassment. This builds on the implementation during this financial year of the refreshed values, treat me right campaign, increased focus on inclusion and steps to improve the just culture approach to HR casework. Whilst the climate reflects continuing pressures on staff and impacts are being seen on engagement.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
NHS People Plan	**Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/2122/91) & BoD (BOD/2122/110)
NWAS People Plan Implementation	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/2122/110) Reported to BoD (BoD2122/37)
Implementation of Revised Trust Values	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/110)
Appraisal Policy & Procedure	**Level 2:** Workforce Indicators Report & Integrated Performance Report **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/90) & BoD (BoD/2122/80) Reported to Resources Cttee (RC/2122/110)
Staff Survey Inc. Local Plans	**Level 1:** Local Wellbeing Plans **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/110)
Leadership Development Inc. BTD Leadership Recruitment	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/110)
Health and Wellbeing Provision	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2122/110) Reported to BoD (BOD/122/111)
EDI		
Equality & Diversity Priorities	**Level 2:** WRES, WDES, Gender Pay Gap **Level 2:** EDI Annual Report **Level 2:** Diversity & Inclusion Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/67) & BoD (BoD/2122/85) Reported to Resources Cttee & BoD (BoD/2122/36) Reported to Resources Cttee (RC/2122/118)
Diversity & Inclusion Plans	**Level 2:** Diversity & Inclusion Assurance Report **Level 2:** D&I Sub Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/ 2122/67) Reported to Resources Cttee (RC/2122/118)
Staff Networks	**Level 2:** Diversity & Inclusion Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/118)
CULTURE		
Culture & Wellbeing Audit	**Level 2:** Culture & Wellbeing Deep Dive	Presented to Resources Cttee (RC/2122/07)

Speaking Up Processes	**Level 2:** FTSU Annual Report **Level 2:** FTSU Action Plan	Reported to Resources Cttee & BoD (BoD/2122/101)
Just Culture Inc. Displinary & DAW Processes and Treat Me Right	**Level 2:** Workforce Indicators Report & Integrated Performance Report **Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report **Level 2:** Assurance on People Practices (Inc. Just Culture)	Reported to Resources Cttee (RC/2122/108) & BoD (BoD/2122/152) Reported to Resources Cttee (RC/2122/110) Reported to BoD (BoD/2122/55)
Culture Dashboards	**Level 2:** Strategic Workforce Sub-Cttee Chairs Assurance Report	Reported to Resources Cttee (RC/2122/110)
Just Culture Principles and Investigations Training	**Level 2:** Equalities, Diversity, and Inclusions Priorities Assurance Report	Reported to Resources Cttee: (RC/ 2122/66)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Medical Management Restructure	Implementation of Phase 1 Senior Management Restructure	Mr G Blezard Ms L Ward	May 2022	SDMR Project Board	In Progress
Additional H&WB Funding	Implementation of H&WB Plans associated with NHSEI Funding	Ms L Ward	March 2022	Resources Cttee	Completed
EDI Priorities	Review of year 1 delivery of Action Plans (Workforce Elements)	Ms L Ward	2022/23	Resources Cttee	In Progress
National Health and Wellbeing Framework	Implementation of the National Health and Wellbeing Framework	Ms L Ward	March 2022	Resources Cttee	Completed
	Review and report outcomes from dianostic with Resources Cttee	Ms L Ward	2022/23	Resources Cttee	In Progress
FTSU Action Plan	Delivery of agreed actions	Ms L Ward Ms A Wetton	2022/23	Resources Cttee	In Progress
Fully embedding Just Culture Principles	Investigation training compliance	Ms L Ward	2022/23	Resources Cttee	In Progress
	Review of Disciplinary Procedure	Ms L Ward	2022/23	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	2022/23	Resources Cttee	Not Commenced
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	2022/23	Resources Cttee	Not Commenced
Evaluation of Trust Values	Undertake an evaluation on the impact on the Trust Values	Ms L Ward	2022/23	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2507	Operational/ Performance	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 Significant	16 Significant	⇔	4 Moderate

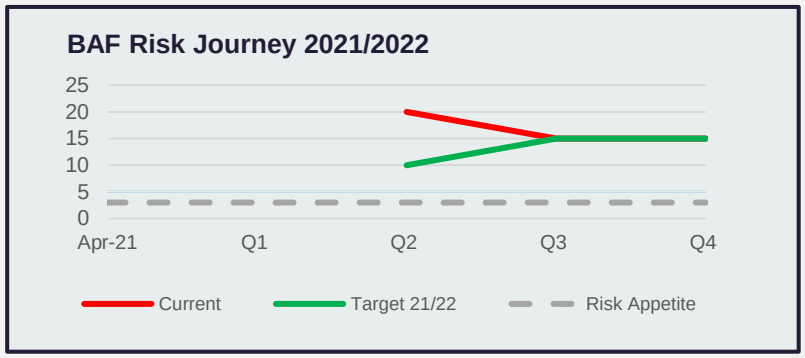
BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR06:
There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q4 of this BAF remains a score of 15 due to continued external demand and pressures that are contributing to further exacerbation of overall safety and workforce risks. Performance pressures and COVID prevalence continue to impact on key areas of compliance and there remains further action to be undertaken to mitigate risks in relation to mandatory training compliance. There has been improvements in appraisal compliance where we met the goal for March and other measures reported in our compliance scorecard including tyre checks. The Trust has contributed to system wide inspection by taking part in gathering evidence and new processes with positive engagement sessions with the CQC. Work continues to improve processes around FFP3 FIT testing and Quality Assurance Visit re-design. Good progress has been made on appraisal compliance with targets being met in February. The current classroom mandatory training programme has been extended to May to enable recovery.

CONTROLS	ASSURANCES	EVIDENCE
PATIENT SAFETY		
CQC Overall Rating of 'Good'	**Level 3:** CQC Inspection Report	Reported to BoD (2020)
CQC Inspection Action Plan	**Level 2:** CQC Action Plan Assurance Report	Reported to Q&P Cttee (Q&PC 2122/13)
CQC Regulation	**Level 2:** CQC Regulation Assurance Report	Reported to Q&P Cttee (Q&PC 2122/34)
IPC Practices	**Level 2:** IPC Board Assurance Framework	Reported to Q&P Cttee (Q&PC 2122/135)
Right Care Strategy Implementation	**Level 2:** Quarterly Right Care Strategy Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/181)
Quality Assurance Processes	**Level 2:** Quality Assurance Visit Assurance Report	Reported to Q&P Cttee (Q&PC/ 2122/199)
PEOPLE		
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2122/108)
Speaking Up Processes	**Level 2:** FTSU Annual Report **Level 2:** FTSU Action Plan	Reported to Resources Cttee & BoD (BoD/2122/101)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
PATIENT SAFETY IMPROVEMENTS					
Response Model Inc. Long Waits & Handover Delays	Deliver Q3 & Q4 actions alongside regional 6 point winter plan	Dr C Grant	March 2022	Q&P Cttee	Completed
Quality Assurance Processes	Development of a monthly Quality Assurance Compliance Scorecard	Prof M Power	Q4	Q&P Cttee	Completed
	Redesign of the Quality Assurance Visits	Prof M Power	2022/23	Q&P Cttee	In Progress

Patient Safety Management (Incidents & Complaints)	Improve compliance with patient safety metrics	Prof M Power	March 2022	Q&P Cttee	Completed
Non-Compliance with IPC & RPE	Improve compliance with IPC practices and RPE across the Trust	Prof M Power	March 2022	Q&P Cttee	Completed
	Improve processes for FFP3 face fit testing	Prof M Power	2022/23	Q&P Cttee	In Progress
Clinical Audit Submissions	Development of APEX tool to ensure new e-PRF can be audited	Dr C Grant	2022/23	Q&P Cttee	In Progress
	Undertake a review of all clinical audits including AGP	Prof M Power	2022/23	Q&P Cttee	In Progress
Essential Checks (Vehicle)	Improve compliance by working with operational teams	Mr G Blezard	Q4	Q&P Cttee	Completed
Essential Checks (Premises)	Improve compliance by working with the estates team	Mrs C Wood	Q4	Resources Cttee	Completed
Freedom to Speak Up Index	Review the detailed breakdown of all Index Indicator Scores	Prof M Power	2022/23	Q&P Cttee	In Progress
	Devise Corporate and Local Action Plans	Prof M Power	2022/23	Q&P Cttee	In Progress
PEOPLE					
HR Casework	Improving the timeliness of HR cases	Ms L Ward	March 2022	Resources Cttee	Completed
Mandatory & Statutory Training Compliance	Achieve 85% compliance by May 2022	Ms L Ward	May 2022	Resources Cttee	In Progress
Appraisal Compliance	Achieve 75% compliance by March 2022	Ms L Ward	March 2022	Resources Cttee	Completed

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3136	Operational/ Fleet	There is a risk that appropriate vehicle checks may not be taking place across PES in relation to tyre pressure and depth checks due to operational pressures which would lead to a breach of legislation and potential loss of vehicles due to breakdowns/faults.	20 Significant	15 Significant	⇩	5 Moderate
3445	Operational/ Patient Safety	There is a risk that due to the excessive 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.	20 Significant	20 Significant	⇔	5 Moderate
3595	Operational/ People	There is a risk due to conflict with operational response priorities that operational staff will not be compliant with statutory and mandatory training requirements (85%), resulting in potential adverse impact on patient care/safety due to staff competence and also resulting in adverse regulatory scrutiny.	20 Significant	16 Significant	⇔	8 High
3611	Operational/ Patient Safety	There is a risk due to the gaps in assurance surrounding the enactment of Duty of Candour for incidents that do not meet the Serious Incidents threshold, that regulatory Duty of Candour conversations will be missed, leading to regulatory enforcement, financial implications and loss of service user confidence.	20 Significant	16 Significant	⇔	4 Moderate

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR07:
There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint

Strategic Priority: Stakeholder Relationships

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate

BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE:
The BAF risk score for Q4 has maintained at 12 due to the new structures and work programmes being progressed by the Trust which will help to ensure that the changes proposed and going Parliament for the ICS to be placed on a statutory footing are mitigated. However, there is a degree of uncertainty as the implantation of the legislation has now been delayed until 1 July 2022. The trust will continue to work with the approval process. The ongoing issue remains around clarity on how the Ambulance Service will work and function with the various ICSs. The trust will utilise the extra time to embed processes and systems in place for effective engagement and influencing across the various ICSs and places across our catchment area.

CONTROLS	ASSURANCES	EVIDENCE
NWAS		
CEO via AACE Role Engagement with NHSE/I	**Level 2:** CEO Report	Reported to BoD (BOD/2122/97) & (BOD/2122/98)
Designated Executive Director Lead for each ICS	**Level 2:** Executive Portfolios	Reported to BoD (BOD/2122/87)
Partnership & Integration Team	**Level 2:** Established in September 2021	Reported to BoD (BOD/2122/87)
NWAS Manager Representation at Key Meetings	**Level 2:** Assessment to ensure the right expertise is in attendance	Reported to Board (BOD/2122/87)
Stakeholder Mapping	**Level 2:** Full mapping exercise is in place	Reported to BoD (BOD/21/22/87)
ICS		
Involvement in ICS Structures	**Level 2:** P&I Team involved in establishing relationships	Reported to BoD (BOD/2122/97) & (BOD/2122/98)
Working & monitoring national, regional & local groups	**Level 2:** Relevant NWAS Managers are part of these groups	Reporting to BoD (BOD/2122/87)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Knowledge Vault	Design, develop and implement so intelligence & information is shared	Mr S Desai	Q4	Resources Cttee	Completed
	Familiarisation for Trust Staff internally, including Execs / NEDs	Mr S Desai	Q4	Resources Cttee	Completed
	Utilisation and monitoring by Senior Managers within the Trust	Mr S Desai	2022/23	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2021/22

BAF RISK SR09:
There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Compliance/Regulatory - Low

BAF RISK SCORE JOURNEY:

	01.04.21	Q1	Q2	Q3	Q4	21/22 Target	Final Target
				20	15	15	12
				5x4	5x3	5x3	4x3
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite				Exceeded	Exceeded	Exceeded	Exceeded

RATIONALE FOR CURRENT RISK SCORE:
The risk score for Q4 of this BAF has decreased to a score of 15 due to a high standard of oversight and processes for cyber security although the threat level remains high. Significant progress in assurances and controls protect the Trust from cyber attack including improved governance between Information Governance and Cyber Security work streams. There continues to be good visibility of the Trust estate through the IT health dashboard and progress also continues to patch systems and replace where required any unsupported systems. Increases to resilience and expertise in the digital and innovation team have provided better infrastructure; firewalls and security systems to protect emails. The key focus continues to be around significant volumes of attempted cyber breaches locally, nationally, and globally including responding to national guidance due to increased threat from Russia. A new backup has been procured but not yet implemented We have implemented monthly external scans to look for vulnerabilities. Other key focuses include multifactorial authentication and business continuity planning with the Operations Directorate.

CONTROLS	ASSURANCES	EVIDENCE
Data Security Protection Toolkit	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/119)
CareCert Compliance	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/119)
Patching	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/119)
Penetration Testing	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/119)
Monitoring and Surveillance	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC 2122/119)
Independant external vulnerability scans	**Level 3:** Information Governance KPI Report	Reported to IG Sub-Cttee (IGSC/2122/41)
External Audit	**Level 3:** Digital Updates	Reported to Resources Cttee (RC/2122/65 and RC/2122/119)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Additional Back-ups	Identify and implement additional back-ups required	Prof M Power	March 2022	Resources Cttee	Completed
	Implement additional back-ups as required	Prof M Power	2022/23	Resources Cttee	In Progress
	Implement additional training within team	Prof M Power	March 2022	Resources Cttee	Completed
Cyber Security Strategy	Devise a new cyber security strategy	Prof M Power	March 2022	Resources Cttee	Completed
Patching	Reach 85% systems patches in the last month	Prof M Power	March 2022	Resources Cttee	Completed
	External scanning for vulnerabilities	Prof M Power	2022/23	Resources Cttee	Completed

	To ensure logj4 vulberabilities are patched	Prof M Power	2022/23	Resource Cttee	Completed
	Enable monthly failover & patching opportunities	Prof M Power	2022/23	Resources Cttee	In Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Prof M Power	2022/23	Resources Cttee	In Progress
	Strengthen the Trust's Password Policy aligned to best practice and national recommendations	Prof M Power	2022/23	Resources Cttee	In Progress
	Undertake a Critical Systems Security Internal Audit	Prof M Power	2022/23	Resources Cttee	Completed
Out of Hours Resilience	Develop business case for 24/7 support	Prof M Power	2022/23	Resources Cttee	In Progress
	Work with Business Continuity Team to desktop worst case scenario	Prof M Power	2022/23	Resources Cttee	In Progress
	Implement recommendations from desktop worst case scenario	Prof M Power	2022/23	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2480	Operational/ Digital and Innovation	There is a risk of unsupported software and hardware due to lack of asset ownership, risk and renewal roadmap for existing systems and governance for cyber security which could result in costly last minute updates, potential cyber-attacks and loss of systems.	20 Significant	20 Significant	⇔	4 Moderate
3537	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	15 Significant	15 Significant	⇔	5 Moderate
3540	Operational/ Digital and Innovation	There is a risk that due to digital expansion/interoperability increasing the Trust's attack surface which in turn increases overall risk to the Trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	12 High	16 Significant	⇔	4 Moderate

Appendix 3:

2021/22 Board Assurance Framework (BAF) Heat Maps

Quarter 4 Position

NHS North West Ambulance Service NHS Trust

2021/22 Opening BAF Risk Scores

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

Populated: 01 April 2021

Likelihood

Q1 BAF Risk Scores

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

Populated: 07 July 2021

Likelihood

Q2 BAF Risk Scores

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

Populated: 07 October 2021

Likelihood

Q3 BAF Risk Scores

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

Populated: 13 January 2022

Likelihood

Q4 BAF Risk Scores

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

Populated: 11 April 2022

Likelihood

2021/22 Target BAF Risk Scores

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

Populated: 01 April 2021
Updated: 13 January 2022

Likelihood

Final Target BAF Risk Scores

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

Populated: 01 April 2021

Likelihood

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 27 April 2022				
SUBJECT:	2022/23 Opening Position of the Board Assurance Framework				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☐	☒	☐
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	The proposed 2022/23 Opening Position of the BAF risks with associated CRR risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2022/23 can be viewed in Appendix 2. The following proposed opening risk scores have been identified as: • SR01 opening risk score of 15 • SR02 opening risk score of 20 • SR03 opening risk score of 20 • SR04 opening risk score of 12 • SR05 opening risk score of 12 • SR06 opening risk score of 15 • SR07 opening risk score of 12 • SR09 opening risk score of 15				
RECOMMENDATIONS:	The Board of Directors are requested to: • Approve the 2022/23 Opening Position of the Board Assurance Framework.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee & Audit Committee			
	Date:	20 April & 22 April 2022		
	Outcome:	Supported for onward reporting		

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1. PURPOSE

This paper provides the opportunity for the Board of Directors to review the 2022/23 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 2022/23 STRATEGIC RISKS OPENING POSITION

The 2022/23 Opening Position of the Board Assurance Framework provided an opportunity for the Executive Director Leads to meet with the Head of Risk and Assurance and the Senior Risk and Assurance Manager to discuss, review and update their relevant BAF risks.

The proposed 2022/23 Opening Position of the Board Assurance Framework with associated Corporate Risk Register risks scored 15 and above can be viewed in **Appendix 1**.

The following proposed opening risk scores are to note:

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 01.04.2022	Exec Director Lead
15 5x3 CxL	Dr C Grant Medical Director

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

1. Commencement of Q1 demonstrates continued improvements in quality, safety and patient experience, with continual focus throughout 2022/23
2. Continued focus for improvements in hospital handover, long waits and timely clinical call backs within NHS 111.

SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver safe and effective services

Opening Score 01.04.2022	Exec Director Lead
20 4x5 CxL	Ms C Wood Director of Finance

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

1. Unbalanced financial plan for 2022/23, with efficiency requirements reaming high at 5%
2. Gap between resources available and the draft expenditure plans with further capacity modelling scheduled to be undertaken within the first six months of the year to inform the recurrent funding required to deliver safe and effective services.

SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care

Opening Score 01.04.2022	Exec Director Lead
20 5x4 CxL	Mr G Blezard Director of Operations

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

1. Sustained operational pressures continue at the commencement of the 2022/23 within PES and NHS 111
2. The Trust continues discussions with Commissioners to secure additional funding to address the recurrent financial gap
3. The Trust continues to focus on applying risk mitigating measures to assist with sustained levels of operational pressures.

SR04: There is a risk that the Trust will be unable to attract or retain sufficient suitably qualified staff and maintain low abstraction levels, which may impact on our ability to maintain safe staffing levels

Opening Score 01.04.2022	Exec Director Lead
12 4x3 CxL	Ms L Ward Director of People

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

1. Continuing volatility in staff abstractions with PES and EOC being over-established with substantive staffing
2. Reduction in frontline resourcing following the end of the military deployment and the temporary arrangements in place with Trade Unions impacting on PTS upskill positions and overtime enhancements

3. Plans are in place for continuation of recruitment at risk to maximise staffing.

SR05: There is a risk that sufficient progress is not made in developing a compassionate, inclusive and supportive culture, impacting adversely on staff wellbeing and engagement, resulting in poor quality services, staff harm and reduced productivity

Opening Score 01.04.2022	Exec Director Lead
12 4x3 CxL	Ms L Ward Director of People

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

1. Continued challenges in a climate where pressure on staff and managers from demand, activity and COVID-19 recovery continues to be significant
2. Staff survey results show an improvement in comparison with sector and provides a foundation for the Trust to build upon during 2022/23.

SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action

Opening Score 01.04.2022	Exec Director Lead
15 5x3 CxL	Prof M Power Director of Quality, Innovation & Improvement

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

1. Continued external demand and pressures that are contributing to further exacerbation of the overall safety and associated workforce risks at the commencement of 2022/23
2. Ongoing performance pressures and COVID-19 prevalence continue to impact on areas of compliance with further risk mitigating action to be undertaken
3. The Trust contributes to system wide inspections and positive engagement sessions with the Care Quality Commission (CQC).

SR07: There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint

Opening Score 01.04.2022	Exec Director Lead
12 4x3 CxL	Mr S Desai Director of Strategy, Partnerships & Transformation

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

1. The new structures and work programmes being proactively progressed by the Trust which will assist to ensure the proposed Parliamentary changes for the ICS
2. The degree of uncertainty remains as the implementation of the legislation has been delayed until 01 July 2022 with ongoing issues remain surrounding the clarity on how the Ambulance Service will work and function with the various ICSs.

SR09: There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm

Opening Score 01.04.2022	Exec Director Lead
15 5x3 CxL	Prof M Power Director of Quality, Innovation & Improvement

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

1. Continued high standards of oversight and process for cyber security but equally due to the continued high threat level
2. Focuses for 2022/23 continues to be the significant volumes of attempted cyber breaches, locally, nationally and globally.

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.

5. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

6. RECOMMENDATIONS

The Board of Directors are requested to:

- Approve the 2022/23 Opening Position of the Board Assurance Framework.

APPENDIX 1

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK 2022/23

BOARD OF DIRECTORS PART 1

WEDNESDAY 27 APRIL 2022

nwas.nhs.uk

Q1 2022/23 Reporting Timescales:

Quality & Performance Cttee:	25/07/2022
Resources Cttee:	22/07/2022
Executive Leadership Cttee:	20/07/2022
Audit Cttee:	21/07/2022
Board of Directors:	27/07/2022

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 Low	10 Moderate	15 High	20 High	25 High
Major 4	4 Low	8 Moderate	12 Moderate	16 High	20 High
Moderate 3	3 Low	6 Moderate	9 Moderate	12 Moderate	15 High
Minor 2	2 Low	4 Low	6 Moderate	8 Moderate	10 Moderate
Negligible 1	1 Low	2 Low	3 Low	4 Low	5 Low

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
DoSPT	Director of Strategy, Partnerships & Transformation
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 2022/23

BAF Risk	Committee	Exec Lead	01.04.22	Q1	Q2	Q3	Q4	2022/23 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					**15** 5x3 CxL	**5** 5x1 CxL
SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver safe and effective services	**Resources**	**DoF**	**20** 4x5 CxL					**16** 4x4 CxL	**8** 4x2 CxL
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Quality & Performance**	**DoOps**	**20** 5x4 CxL					**15** 5x3 CxL	**5** 5x1 CxL
SR04: There is a risk that the Trust will be unable to attract or retain sufficient suitably qualified staff and maintain low abstraction levels, which may impact on our ability to maintain safe staffing levels	**Resources**	**DoP**	**12** 4x3 CxL					**12** 4x3 CxL	**4** 4x1 CxL
SR05: There is a risk that sufficient progress is not made in developing a compassionate, inclusive and supportive culture, impacting adversely on staff wellbeing and engagement, resulting in poor quality services, staff harm and reduced productivity	**Resources**	**DoP**	**12** 4x3 CxL					**12** 4x3 CxL	**4** 4x1 CxL
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Quality & Performance**	**DoQII**	**15** 5x3 CxL					**10** 5x2 CxL	**5** 5x1 CxL
SR07: There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint	**Resources**	**DoSPT**	**12** 4x3 CxL					**8** 4x2 CxL	**4** 4x1 CxL
SR08: (**Commercially Sensitive Risk**)	**Resources**	**DoSPT**	**12** 4x3 CxL					**8** 4x2 CxL	**4** 4x1 CxL
SR09: There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm.	**Resources**	**DoQII**	**15** 5x3 CxL					**15** 5x3 CxL	**12** 4x3 CxL
SR10: (**Commercially Sensitive Risk**)	**Resources**	**DoSPT**	**20** 5x4 CxL					**15** 5x3 CxL	**10** 5x2 CxL

BOARD ASSURANCE FRAMEWORK 2022/23

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 & Digital

Executive Director Lead: MD

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	15					15	5
	5x3					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 15 due to the commencement of Q1 demonstrates the continued improvements to both quality, safety, and clinical effectiveness over the previous financial year. During Q1, the Trust continues to focus on improvements to quality, safety, and patient experience, which incorporates hospital handover, long waits and timely clinical call backs within NHS 111. The Patient Safety Team have transferred from the Quality, Innovation, and Improvement Directorate to the Corporate Affairs Directorate due to the synergies with legal services and risk management.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Midwifery Strategic Plan	Deliver the NWAS Midwifery Strategic Plan	Dr C Grant	2022/23	Q&P Cttee	In Progress
NHS Patient Safety Strategy	Delivery and implementation of the NHS Patient Safety Strategy	Prof M Power	2022/23	Q&P Cttee	In Progress
Electronic Quality Measurement Auditing/ Reporting Systems	Develop automated systems for non-clinical audits	Prof M Power	2022/23	Q&P Cttee	In Progress
Digital Capture and Monitoring of Clinical Outcomes	Deliver Phase 2 EPR roll out and systems for automating clinical audit	Prof M Power	2022/23	Q&P Cttee	In Progress
Safety Culture	Devise a plan to improve performance on safety culture & F2SU	Prof M Power	2022/23	Q&P Cttee	In Progress
Mental Health, Dementia, LD & Autism Strategic Plan	Develop MH, Dementia, LD & Autism Strategic Plan	Prof M Power	2022/23	Q&P Cttee	In Progress
	Devise appropriate pathways for MH, Dementia, LD & Autism Patients	Prof M Power	2022/23	Q&P Cttee	In Progress
	Deliver MH, Dementia, LD & Autism Strategic Plan	Prof M Power	2022/23	Q&P Cttee	In Progress
Duty of Candour	Implementation of Duty of Candour review recommendations	Prof M Power	2022/23	Q&P Cttee	In Progress
DIGITAL					
Out of Hours Technical Resilience	Development of proposal in conjunction with operations	Prof M Power	2022/23	Audit Cttee	In Progress

Single Primary Triage System	Delivery of Phase 2: Migration to Single Primary Triage System	Prof M Power	2022/23	Audit Cttee	In Progress
Quality & Safety Business Intelligence	Triangulation of data with performance activity to predict key risks	Prof M Power	2022/23	Audit Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2507	Operational/ Operational Performance	There is a risk that the current Meal Break Policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 High	16 High	⇔	4 Low
3445	Operational/ Patient Safety	There is a risk that due to the excessive 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.	20 High	20 High	⇔	5 Low
3611	Operational/ Patient Safety	There is a risk due to the gaps in assurance surrounding the enactment of Duty of Candour for incidents that do not meet the Serious Incidents threshold, that regulatory Duty of Candour conversations will be missed, leading to regulatory enforcement, financial implications and loss of service user confidence.	20 High	16 High	⇩	4 Low

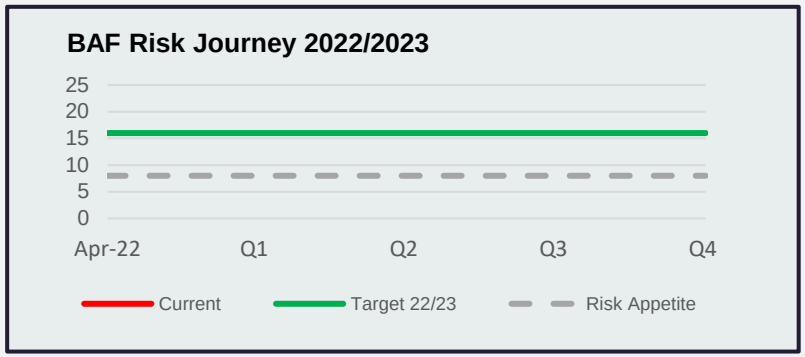
BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR02:
There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver safe and effective services

Strategic Priority: ALL

Executive Director Lead: DoF

Risk Appetite Category: Finance/ VfM – Moderate



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	20					16	8
	4x5					4x4	4x2
	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 an unbalanced financial plan for 2022/23 with efficiency requirements remaining high at 5%. There remains a gap between resources available and the draft expenditure plans. Further capacity modelling will be undertaken during the first six months of the year to inform the recurrent funding required to deliver safe and effective services.

CONTROLS	ASSURANCES	EVIDENCE
2022/23 Financial Plans	**Level 2**: Draft 2022/23 Financial Plans	Reported to Resources Cttee (RC/2122/113) & BoD (BOD/2122/54)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2022/23 Planning Guidance	Receipt of 2022/23 Planning Guidance from NHSEI	Ms C Wood	2022/23	Resources Cttee	In Progress
2022/23 Financial Plan Revenue	Approval of 2022/23 Financial Plan (Revenue)	Ms C Wood	2022/23	Resources Cttee	In Progress
2022/23 Financial Plan Capital	Approval of 2022/23 Financial Plan (Capital)	Ms C Wood	2022/23	Resources Cttee	In Progress
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	2022/23	Resources Cttee	In Progress
Allocation Funding	Funding allocation to PES and 111 to deliver safe & effective services	Ms C Wood	2022/23	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2311	Operational/ Estates & FM	There is a risk that due to insufficient resource/resilience the Estates department will be unable to service the demands of the Trusts critical infrastructure and projects which could result in project failure and detrimental operational performance.	16 High	16 High	⇔	4 Low

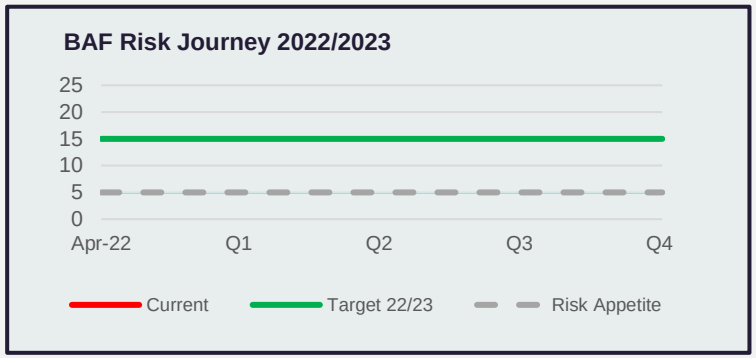
BOARD ASSURANCE FRAMEWORK 2022/23

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

Strategic Priority: Urgent & Emergency Care

Executive Director Lead: DoOps

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 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 the sustained levels of operational pressures the Trust has seen across PES and NHS 111, resulting in being at REAP Level 4 at the commencement of the new financial year. The Trust continues to hold discussions with Commissioners to secure additional funding to address the recurrent financial gap. During Q1, the Trust continues to focus on applying risk mitigating measures to assist with the sustained levels of operational pressures.

CONTROLS	ASSURANCES	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Singel Primary Triage System	Phase 2 migration to Single Primary Triage System	Mr G Blezard	Q2	Q&P Cttee	In Progress
Hospital Handover Delays	Participation in local and national programmes to reduce delays	Mr G Blezard	2022/23	Q&P Cttee	In Progress
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	2022/23	Q&P Cttee	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve patient care	Mr G Blezard	2022/23	Q&P Cttee	In Progress
	Maximise use of existing resources	Mr G Blezard	2022/23	Q&P Cttee	In Progress
Directory of Services (DoS)	Ensure appropriateness and relevancefor PES and NHS 111	Mr G Blezard	2022/23	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**
2507	Operational/ Performance	There is a risk that the current Meal Break Policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 High	16 High	⇔	4 Low
3254	Operational/ Performance	There is a risk that due to staff taking carried over leave accrued during the COVID19 pandemic, operational resources will not meet demand resulting in delayed patient response and delivery of national ARP standards.	20 High	15 High	⇩	5 Low
3445	Operational/ Patient Safety	There is a risk that due to the excessive 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.	20 High	20 High	⇔	5 Low
3448	Operational/ 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.	20 High	15 High	⇩	5 Low
3452	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 High	25 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR04:
There is a risk that the Trust will be unable to attract or retain sufficient suitably qualified staff and maintain low abstraction levels, which may impact on our ability to maintain safe staffing levels

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	12					12	4
	4x3					4x3	4x1
	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 has been opened at a score of 12 due to the continuing volatility in relation to staff abstractions. PES and EOC are over-established with substantive staffing, there has been a reduction in additional available support to frontline resourcing following the end of the military deployment and the ending of the temporary agreement in place with the Trade Unions. The ending of the temporary agreement impacts on the PTS upskill positions and associated overtime enhancements. Sickness remains higher than average. NHS 111 recruitment and retention remains a risk, plans are being implemented which are showing early signs of improvement and continue to remain a key area of focus during Q1. Robust plans are in place for continuing recruitment at risk to maximise staffing.

CONTROLS →	ASSURANCES →	EVIDENCE
PEOPLE		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of Q1 Recruitment Plans	Ms L Ward	March 2023	Resources Cttee	In Progress
Attendance	Delivery of actions to improve attedance including AIT	Ms L Ward	2022/23	Resources Cttee	In Progress
Vaccination	Delivery of 2022/23 Flu Campaign	Ms L Ward	2022/23	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3447	Operational/ Workforce	There is a risk that due to increasing operational demand and call volumes, the health and wellbeing of our workforce may deteriorate leading to absenteeism negatively impacting on staff safety.	16 High	16 High	⇔	4 Low
3595	Operational/ People	There is a risk due to conflict with operational response priorities that operational staff will not be compliant with statutory and mandatory training requirements (85%), resulting in potential adverse impact on patient care/safety due to staff competence and also resulting in adverse regulatory scrutiny.	20 High	16 High	New Risk	8 Moderate

BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR05:
There is a risk that sufficient progress is not made in developing a compassionate, inclusive and supportive culture, impacting adversely on staff wellbeing and engagement, resulting in poor quality services, staff harm and reduced productivity

Strategic Priority: Workforce

Executive Director Lead: DoP

Risk Appetite Category: Quality Outcomes – Low

BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	12					12	4
	4x3					4x3	4x1
	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 has been opened at a score of 12 due to the Trust continuing challenges in a climate where pressure on staff and managers from demand, activity and recovery from COVID-19 continues to be significant. A good health and wellbeing remain in place and has been further strengthened though addition NHSEI funding. The staff survey results shown an improvement in comparison with sector scores and provides a foundation for the Trust to build upon in 2022/23.

CONTROLS →	ASSURANCES →	EVIDENCE
PEOPLE		
CULTURE		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Medical Management Restructure	Implementation of Phase 1 Senior Management Restructure	Mr G Blezard Ms L Ward	May 2022	ELC	In Progress
	Implementation of Operational & Clinical management Restructure	Mr G Blezard Ms L Ward	March 2023	ELC	In Progress
EDI Priorities	Review delivery of Year 1 Action Plans (Workforce Elements)	Ms L Ward	2022/23	Resources Cttee	In Progress
Trailblazer for National Health and Wellbeing Framework	Review and report outcomes from dianostics	Ms L Ward	2022/23	Resources Cttee	In Progress
FTSU Action Plan	Delivery of agreed actions	Ms L Ward	2022/23	Resources Cttee	In Progress
Fully embedding Just Culture Principles	Improved investigation training compliance	Ms L Ward	2022/23	Resources Cttee	In Progress
	Review of Disciplinary Procedure	Ms L Ward	2022/23	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	2022/23	Resources Cttee	Not Commenced
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	2022/23	Resources Cttee	Not Commenced
Evaluation of Trust Values	Undertake an evaluation on the impact on the Trust Values	Ms L Ward	2022/23	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2507	Operational/ Performance	There is a risk that the current meal break policy/system does not provide optimum patient care or support performance standards which could result in a detrimental impact to staff welfare.	16 High	16 High	⇔	4 Low

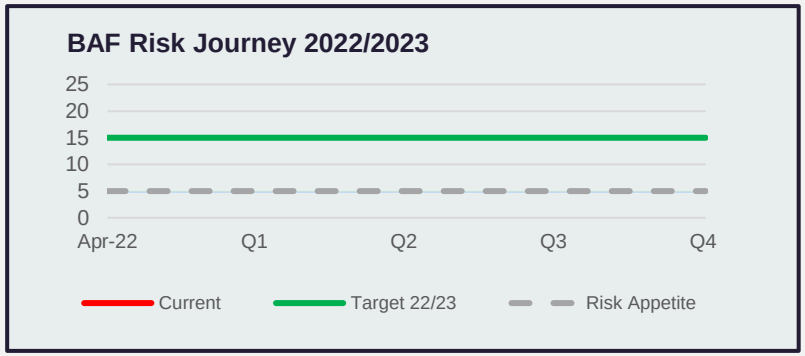
BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR06:
There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Compliance & Regulatory – Low



BAF RISK SCORE JOURNEY:

	01.04.22	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	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF is opened at a score of 15 due to the continued external demand and pressures that are contributing to further exacerbation of the overall safety and associated workforce risks at the commencement of Q1. Ongoing performance pressures and COVID-19 prevalence continue to impact on areas of compliance with further risk mitigating actions to be undertaken in relation to mandatory training compliance. At the commencement of Q1, the Trust has continued to contribute to system wide inspections and positive engagement session with the CQC.

CONTROLS	ASSURANCES	EVIDENCE
PATIENT SAFETY		
PEOPLE		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
PATIENT SAFETY IMPROVEMENTS					
Quality Assurance Processes	Redesign of Quality Assurance Visits	Prof M Power	2022/23	Q&P Cttee	In Progress
Quality and Safety Metrics (Complaints & Incidents)	Devise improvement action plan to address the backlog	Ms A Wetton	2022/23	Q&P Cttee	In Progress
Non-Compliance with IPC & RPE	Improve compliance with IPC practices and RPE across the Trust	Prof M Power	2022/23	Q&P Cttee	In Progress
	Improve processes for FFP3 Face Fit Testing	Prof M Power	2022/23	Q&P Cttee	In Progress
Clinical Audit Submissions	Development of APEX tool to ensure new e-PRF can be audited	Dr C Grant	2022/23	Q&P Cttee	In Progress
	Undertake a review of all clinical audits including AGP	Prof M Power	2022/23	Q&P Cttee	In Progress
Essential Checks	Improve compliance around essential vehicle and premises checks	Mr G Blezard Mrs C Wood	2022/23	Q&P Cttee	In Progress
Freedom to Speak Up Index	Review the detailed breakdown of all Index Indicator Scores	Prof M Power	2022/23	Q&P Cttee	In Progress
	Devise Corporate and Local Action Plans	Prof M Power	2022/23	Q&P Cttee	In Progress
PEOPLE					

Mandatory & Statutory Training Compliance	Achieve 85% compliance by May 2022	Ms L Ward	May 2022	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
3136	Operational/ Fleet	There is a risk that appropriate vehicle checks may not be taking place across PES in relation to tyre pressure and depth checks due to operational pressures which would lead to a breach of legislation and potential loss of vehicles due to breakdowns/faults.	20 High	15 High	↑	5 Low
3445	Operational/ Patient Safety	There is a risk that due to the excessive 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.	20 High	20 High	⇔	5 Low
3595	Operational/ People	There is a risk due to conflict with operational response priorities that operational staff will not be compliant with statutory and mandatory training requirements (85%), resulting in potential adverse impact on patient care/safety due to staff competence and also resulting in adverse regulatory scrutiny.	20 High	16 High	⇔	8 Moderate
3611	Operational/ Patient Safety	There is a risk due to the gaps in assurance surrounding the enactment of Duty of Candour for incidents that do not meet the Serious Incidents threshold, that regulatory Duty of Candour conversations will be missed, leading to regulatory enforcement, financial implications and loss of service user confidence.	20 High	16 High	⇔	4 Low

BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR07:
There is a risk that the proposed changes to legislation reduces the Trust's ability to engage effectively and influence across all the ICS within its regional footprint

Strategic Priority: Stakeholder Relationships

Executive Director Lead: DoSPT

Risk Appetite Category: Reputation – Moderate

BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	12					8	4
	4x3					4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within					Within	Below

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF is opened at a score of 12 due to associated new structures and work programmes being proactively progressed by the Trust which will assist to ensure the proposed Parliamentary changes for the ICS to be placed on a statutory footing are mitigated. At the commencement of Q1, the degree of uncertainty remains as the implementation of the legislation has been delayed until 01 July 2022. Ongoing issues remain surrounding the clarity on how the Ambulance Service will work and function with the various ICSs. The Trust will be utilising the extra time to embed processes and systems in place for effective engagement and influencing across the various ICSs and ICPs across the NWAS catchment area.

CONTROLS	ASSURANCES	EVIDENCE
NWAS		
ICS		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Knowledge Vault	Utilisation and monitoring by Senior Managers within the Trust	Mr S Desai	Q1	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

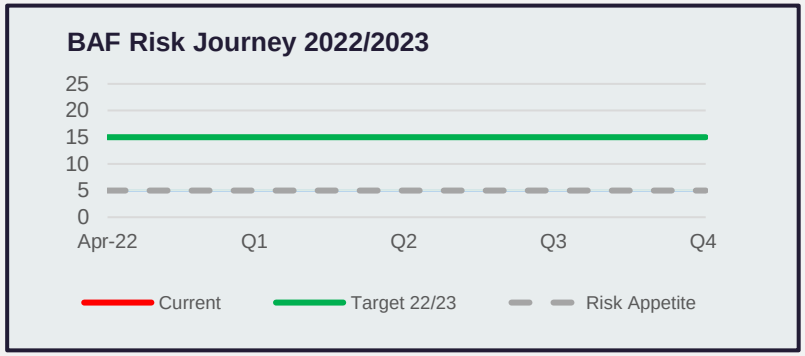
BOARD ASSURANCE FRAMEWORK 2022/23

BAF RISK SR09:
There is a risk that due to persistent attempts and/or human error, NWAS may suffer a major cyber incident resulting in a partial or total loss of service and associated patient harm

Strategic Priority: ALL

Executive Director Lead: DoQII

Risk Appetite Category: Compliance/Regulatory - Low



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	22/23 Target	Final Target
	15					15	12
	5x3					5x3	4x3
	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 is opened at a score of 15 due to the continued high standard of oversight and process for cyber security but also due to the continued high threat level. The focuses for 2022/23 continues to be the significant volumes of attempted cyber breaches, locally, nationally, and globally, responsive to nationally issuing guidance and progressing the cyber security work plan which include multifactorial authentication and robust business continuity planning.

CONTROLS	ASSURANCES	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Additional Back-ups	Implement additional back-ups as required	Prof M Power	2022/23	Audit Cttee	In Progress
Cyber Security Plan	Implement the Cyber Security plan	Prof M Power	2022/23	Audit Cttee	In Progress
	Implementation of BeyondTrust	Prof M Power	2022/23	Audit Cttee	In Progress
Patching	Enable monthly failover & patching opportunities	Prof M Power	2022/23	Audit Cttee	In Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Prof M Power	2022/23	Audit Cttee	In Progress
Critical System Security	Implement recommendations from MIAA Internal Audit for Cleric	Prof M Power	2022/23	Audit Cttee	In Progress
Access Controls	Strengthen Password Policy in line wth best practice & national recommendations	Prof M Power	2022/23	Audit Cttee	In Progress
	Implement Multi-Factoral Authentication	Prof M Power	2022/23	Audit Cttee	In Progress
	Implement express route in Azure to block public route	Prof M Power	2022/23	Audit Cttee	In Progress
Out of Hours Resilience	Develop business case for 24/7 support	Prof M Power	2022/23	Audit Cttee	In Progress
	Work with Business Continuity Team to desktop worst case scenario	Prof M Power	2022/23	Audit Cttee	In Progress
	Implement recommendations from desktop worst case scenario	Prof M Power	2022/23	Audit Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
2480	Operational/ Digital and Innovation	There is a risk of unsupported software and hardware due to lack of asset ownership, risk and renewal roadmap for existing systems and governance for cyber security which could result in costly last minute updates, potential cyber-attacks and loss of systems.	20 High	20 High	⇔	4 Low
3537	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust may be subject to a ransomware attack resulting in disruption to digital operations including critical systems, causing an impact to normal business operations.	15 High	15 High	⇔	5 Low
3540	Operational/ Digital and Innovation	There is a risk that due to digital expansion/interoperability increasing the Trust's attack surface which in turn increases overall risk to the Trust resulting in a loss of critical systems and business disruption or exfiltration of confidential data.	12 Moderate	16 High	⇔	4 Low

Appendix 2:

2022/23 Board Assurance Framework (BAF) Heat Maps

Opening Position

NHS North West Ambulance Service NHS Trust

2022/23 Opening BAF Risk Scores

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

Populated: 11 April 2022

Likelihood

Q1 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	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:

Likelihood

Q2 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	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:

Likelihood

Q3 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	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:

Likelihood

Q4 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	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:

Likelihood

2022/23 Target BAF Risk Scores

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

Populated: 11 April 2022

Likelihood

Final Target BAF Risk Scores

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

Populated: 11 April 2022

Likelihood

NHS
North West Ambulance Service
NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th April 2022				
SUBJECT:	Annual Review of Core Governance Documents				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☒
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, Scheme of Delegation and Standing Financial Instructions and can be identified as tracked changes within the documents.				
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 to the Board of Directors for approval.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:	Executive Leadership Committee and Audit Committee				
	Date:	20th April 2022 and 22nd April 2022			

	Outcome:	Onward recommendation to the Board of Directors for approval.

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1. PURPOSE

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

2. BACKGROUND

As per the Standing Orders, the Trust's core governance documents are subject to annual review.

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, Scheme of Delegation and Standing Financial Instructions and can be identified as tracked changes within the documents.

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

4. LEGAL, GOVERNANCE AND/OR RISK 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. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

6. 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.

North West Ambulance Service NHS Trust

Standing Orders, Reservation of Powers & Scheme of Delegation

Approved by the Board of Directors: ~~28 April 2021~~

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	28 April 2021
18	Annual Review, March 2022	

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

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

1.2 Interpretations

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

1.3 Definitions

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

Terminology	Definition
Committee Members	Formally appointed by the Board of Directors to sit on, or to chair specific committees
Directors	Are the Non-Executive Directors and Executive Directors (including non-voting Directors ~~and Associate Non-Executive 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.
Motion	A formal proposition to be discussed and voted on during the course of a Board of Directors or Committee meeting
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
Vice Chair	The Non-Executive Director appointed by the Trust to take on the chair's duties is the Chair is absent for any reason

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, Sub 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
- 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 People
- Director of Strategy, Partnerships and Transformation
- 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 The Chief Executive is appointed by the Chairman and the Non-Executive Directors.

2.2.4 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 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 the Chairman's ~~his~~ interpretation of the Standing Orders shall be final. In this interpretation the Chairman ~~he~~ shall be advised by the Director of Corporate Affairs and in the case of Standing Financial Instructions the Chairman ~~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 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.

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

4.8.2 Audit~~or~~ Panel

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

The Audit~~or~~ 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 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.

~~3.3.1~~3.3.2 Approve all Trust strategies

~~3.3.2~~3.3.3 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~~3.3.4 Approve the Trust's policies and procedures for the management of risk.

~~3.3.4~~3.3.5 Approve Final Business Cases for Capital Investment schemes where the value exceeds £500,000.

~~3.3.5~~3.3.6 Approve the Trust's annual revenue and capital budgets.

~~3.3.6~~3.3.7 Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

~~3.3.7~~3.3.8 Approve PFI proposals.

~~3.3.8~~3.3.9 Approve the opening of bank accounts.

~~3.3.9~~3.3.10 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~~3.3.11 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 Approve the process for approval, dissemination and implementation of policies.
~~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 Approval of policies is delegated to the Executive Leadership Committee however ~~T~~the Board shall maintain responsibility for approving the following policies:

- Health, Safety and Security 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
- Violence and Aggression Policy

3.5 Audit Arrangements

3.5.1 Approve the appointment (and where necessary dismissal of External Auditors recommended by the Audit~~or~~ 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.

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 1.4
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 3.14
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
Register of Interests, Gifts and Hospitality - Register of Interests for Board of Directors - Register of Interests for Staff - Gifts and Hospitality Register	Chief Executive Director of Corporate Affairs Director of Corporate Affairs Directors of Corporate Affairs	 Head of Corporate Governance Head of Corporate Governance Head of Corporate Governance	SO 6 Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts and Hospitality and Sponsorship
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 Chief Executive and Director of Finance Director of Corporate Affairs	 Director of Corporate Affairs Director of Corporate Affairs Head of Corporate Governance	SO 8
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: - Approval of all strategies - Approval of policies and procedures	Board of Directors Board of Directors Board of Directors	Director of Corporate Affairs Lead Executive Executive Leadership Committee	 RoP 3.3 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
Incident Reporting, Management and Investigation	Director of Corproate Affairs	Head of Risk and Assurance	Complaints, Incidents and Investigations Policy Incident Reporting Procedure
Complaints Management	Director of Corporate Affairs	Head of Legal Services	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
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

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
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 Finance: Technical Accounts	SFI 11
Approval of Individual Capital and PFI Schemes	Director of Finance	Head of Finance: Technical Accounts	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 Finance: Technical Accounts	SFI 11
Banking Arrangements and Cash	Director of Finance	Head of Finance: Technical Accounts	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 Finance: 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 Strategic Financial Planning	SFI 6
Petty Cash	Director of Finance	Senior Managers	SFI 9
Scheme of Budgetary Control	Chief Executive	Director of Finance	SFI 3
Fraud and Corruption	Board of Directors	Audit Committee	SFI 2
3. Strategy and Planning			
Corporate Strategy	Director of Strategy, Partnerships and Transformation	Head of Strategy, Planning and Transformation	Trust Strategy
Business Planning	Director of Strategy, Partnerships and Transformation	Head of Strategy, Planning and Transformation	
Transformation	Director of Strategy, Partnerships and Transformation	Head of Strategy, Planning and Transformation	
Reconfigurations of Services and Clinical Pathway Changes	Director of Strategy, Partnerships and Transformation	Head of Partnership and Integration	
Freedom of Information	Director of Strategy, Partnerships and Transformation	Head of Communications and Engagement	Freedom of Information & Environmental Regulations Policy Freedom of Information Act 2005
Corporate Communications and Engagement	Director of Strategy, Partnerships and Transformation	Head of Communications and Engagement	Communication and Engagement Strategy
Patient and Public Engagement	Director of Strategy, Partnerships and Transformation	Head of Communications and Engagement	Comunications and Engagement Strategy
Patient and Public Panel (patient involvement and engagement)	Director of Strategy, Partnerships and Transformation	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, Partnerships and Transformation	Head of PMO	SFI Requirement to obtain Quotes and Tenders (all Revenue and Capital items) Project Way
System Partnership and Integration	Director of Strategy, Partnerships and Transformation	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 - 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 Area 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)	Deputy Director of Quality, Innovation and Improvement (Deputy SIRO and Chief Information Officer) Clinical Information Officer	Clinical Records Management Policy & Procedure ePRF Procedures GDPR Regulations
Corporate Records Management	Director of Quality Innovation & Improvement (SIRO)	Deputy Director of Quality, Innovation and Improvement (Deputy SIRO and Chief Information Officer) Chief of Digital and Innovation	Data Protection and Security Policy Safe Haven
Disclosure of Patient Identifiable Information	Medical Director (Caldicott Guardian) Director of Quality, Innovation & Improvement (SIRO)	Deputy Director of Quality, Innovation and Improvement (deputy SIRO and Chief Information Officer Chief Clinical Information Officer	Subject Access Request Procedure Data Protection and Security Policy Data Retention Policy
IM&T Systems Access Control	Director of Quality, Innovation and Improvement	Deputy Director of Quality, Innovation and Improvement (CIO) 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
7. Medical			
Medicine Management	Medical Director (CDAO)	Chief Pharmacist	NWAS Medicine Management Policy v5.1 2019 General Medicines Toolkit Controlled Drugs Toolkit
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
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
Freedom to Speak Up	Chief Executive	Medical Director	Freedom to Speak Up Strategy Freedom to Speak Up Policy
8. Quality, Innovation and Improvement			
Ambulance Quality Indicator Reporting	Medical Director Director of Quality, Innovation and Improvement Director of Operations	Chief Consultant Paramedic Chief of Regulatory Compliance and Improvement Deputy Director of Quality, Innovation and Improvement, Chief of Digital and Innovation	Clinical Audit Policy Right Care (Quality) Strategy Digital Strategy
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
Patient Safety Management	Director of Quality, Innovation and Improvement	Patient Safety Specialist	Learning from Experiences Policy Learning Framework

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Infection Prevention & Control	Assistant Director of Nursing and Quality (DIPC)	IPC Specialist	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
Vulnerable Persons Management (Safeguarding)	Director of Quality, Innovation and Improvement/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
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, Improvement and Innovation Chief of Regulatory Compliance and Improvement	
9. 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
10. 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 Criminal Records Check Policy
Disciplinary Arrangements & Appeals - Hearing Officer for dismissal of Chief Executive - Hearing Officer for disciplinary cases against Directors - Appeal panel members for disciplinary cases against Chief Executive & Executive Directors - Hearing Officers for Disciplinary cases as required/ Panel members for appeals against dismissal - Hearing Officers for disciplinary cases / appeals officer for probationary period dismissals or cases heard by one of their managers. - Hearing Officers in cases where sanction available is up to and incldluing a final written warning.	Director of People Chairman Chief Executive Non-Executive Directors Director (ExecutiveDirector / Area Director) Senior Manager (Deputy Director / Area Heads of Operations / Heads of Dept) Middle Managers or above (e.g. Sector Managers, 111 Service Delivery Managers)		Disciplinary Policy and Procedure
Grievance Procedure - Hearing Officer for grievance cases from Directors - Hearing Officers for Grievance from immediate staff or panel members for Stage 3 Grievance Appeal cases. - To hear Grievances at Stage 2 and from immediate staff / panel members for Stage 3 Grievance Appeal cases. - To hear Grievances at Stage 2 and for their immediate staff. To hear Stage 3 Grievance appeals associated with D@W complaints. - To hear Stage 2 grievances associated with Dignity At Work complaints. - To hear grievances from immediate staff at Initial Grievance Meeting (stage 1)	Director of People Chief Executive Director (Executive Director/Area Director/NED Deputy Director Area Heads of Operations / Heads of Dept / Senior Delivery Managers / PTS Sector Managers Middle Managers (e.g. PES & EOC Sector Managers, 111 Service Delivery Managers, senior line managers) Line Managers & above		Individual and Collective Grievance Policy & Procedure
Performance Management - Hearing Officer for dismissal of Chief Executive - Hearing Officer for cases against Directors. - Appeal panel members for cases against Chief Executive & Executive. Directors - Hearing Officers for cases against Deputy Directors. Panel members on appeals against dismissal. - Panel members on appeals against dismissal. - Hearing Officers for cases at Stage 3 of policy or hear cases at Stage 1 and/or 2 where employee reports immediately to them. Act as Appeal Officer where sanction imposed by by one of the managers reporting directly to them is an immediate staff subject to current final written warning, where dismissal is a possible sanction/ appeals officer for probationary period dismissals or cases heard by one of their managers. - Hearing Officers in cases where sanction available is up to and incldluing a final written warning. Appeals Officers against formal written warning sanction (Stage 1). - To manage initial informal performance management of staff who report into them.	Director of People Chairman Chief Executive Non-Executive Directors Director (Exec Director / Area Director) Deputy Directors Senior Manager (e.g. Deputy Director / Area Heads of Operations / Heads of Dept) Middle Managers or above (e.g. Sector Managers, 111 Service Delivery Managers) Line Managers	Senior Managers	Performance Management Policy
Workplace conflict / bullying - Respond to Dignity At Work complaints received from direct reports; take immediate steps to address inappropriate behaviour and work with individuals involved to improve work relationships.	Director of People Line Managers	Senior Managers	Dignity at Work Policy Disciplinary 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 aproprate 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 People	Establishment Control Procedure
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

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Sickness Warning Arrangements - Hearing Officer for dismissal of Chief Executive - Hearing Officer for cases of Executive Directors - Appeal panel members for cases against Chief Executive and Executive Directors. - Hearing Officers for cases involving Deputy Directors / Heads of Department / Area Heads of Ops. Panel members on appeals against dismissal - Act as panel members on appeal against dismissal cases - Hearing Officers for Stage 4 & Health Capability hearings / cases against staff for whom they are the immediate line manager. Appeals Officers for appeals against final written warning and cases heard by one of the managers who reports directly to them - Hearing Officers in cases where sanction available is up to and incldluing a final written warning (Stages 1-3). - Hearing Officer for cases where the sanction applied may be up to and including a written warning (Stage 2). - Conduct Stage 1 sickness review meetings with immmediate staff.	Director of People Chairman Chief Executive NEDs Director (Exec Dir / Area Dir) Deputy Director Senior Manager (Deputy Directors / Area Heads of Operations / Heads of Dept / PTS Sector Managers) Middle Managers or above (e.g. Sector Managers, 111 Service Delivery Managers) 111 Team Manager First Line managers	Deputy Directors/Senior Managers	Sickness Absence Procedure
Agency Rules	Director of People	Deputy Director of People	Agency Rules - NHS Improvement March 2016
Recovery of overpayments	Director of People	Deputy Director of Finance	Over and Under payment of Salary Procedure

Standing Financial Instructions

North West
Ambulance Service
NHS Trust

Approved by the Board of Directors: ~~28th April 2021~~

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
16	Annual Review, April 2021	28 April 2021
17	Annual review, April 2022	

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 (DHSC) 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 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 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 and workforce establishment 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 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 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.

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 pay or non-pay virement within their areas of responsibility, any proposed virement of budget between non-pay to pay or pay to non-pay requires approval by the Director of Finance, via the finance team-;
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 and willmay be considered as Productivity and Efficiency savings, or 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.

~~3.2.5 Please refer and follow **Section 9: Workforce** of the **Scheme of Delegation** for proposals to transfer budget between non-pay and pay.~~

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, 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 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.
~~VII.~~VIII. Details of financial risks and the mitigating actions

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 and workforce establishment plans
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 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 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. 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 procurement team~~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 ad hoc services such as private hospital fees. Payments must be authorised in accordance with the delegated limits set for non-pay expenditure.
n. Purchases by credit cards are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance.
~~m.~~o. Credit card purchase records are maintained in a form as determined by the Director of Finance.

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~~ *Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts)*) 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
~~III.~~IV. *Any changes to the forecast expenditure associated with an approved business case where the final value of the completed scheme is forecast to be more than 5% or £500k (whichever is lower) in excess of the value requires re-approval by the appropriate Committee commensurate with the SFIs Scheme of Delegation limits.~~*~~by Board~~*

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 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, Partnerships and Transformation ~~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 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.

Where staff take custody of personal property belonging to patients, local procedures should be followed.

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 or 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 directives governing public procurement

17.2.1 The Public Contracts Directives 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 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;
- 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 ensure 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 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 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 NHS 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 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 NHS 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
Area Directors	5	Up to £49,999
A4C Band 8d/9	~~5~~6	Up to £24,999
A4C Band 8b / 8c	~~6~~7	Up to £9,999
A4C Band 8a	~~7~~8	Up to £7,499
A4C Band 6 / 7	~~8~~9	Up to £4,999
A4C band 4 / 5	~~9~~10	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~~ Assistant	Up to ~~£2,499~~ 999
~~Senior~~ Operational Procurement Officer	Up to £9,999
~~Operational~~ Senior Procurement Officer ~~Manager~~	Up to £24,999
~~Head of Procurement or Trust~~ Procurement Manager	Up to £49,999
Head of Procurement or Deputy Head of Procurement	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 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
Above FTS threshold	FTS 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

* 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:	27th April 2022				
SUBJECT:	FT Code of Governance Compliance Declaration				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision				
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. All non-relevant clauses are highlighted in grey.				
RECOMMENDATIONS:	The Board of Directors is recommended to: • Take assurance from the report and confirm the Trust's declaration of compliance with the Code's relevant clauses.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	

PREVIOUSLY CONSIDERED BY:	Audit Committee	
	Date:	22nd April 2022
	Outcome:	Recommended to the Board of Directors for Approval

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1. PURPOSE

The purpose of this report is to provide the Audit Committee 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 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.

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. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

6. RECOMMENDATIONS

The Board of Directors is recommended to:

- Take assurance from the report and confirm the Trust's declaration of compliance with all the Code's relevant clauses.

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2021/22

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 efficiency updates • Trust Strategy • Right Care Strategy • Urgent and Emergency Care Strategy • Digital Strategy • Board Assurance Framework • Quality Account • Annual Plan • ICS Operational Planning Submissions	√

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. Each committee and sub committee is subject to an annual effectiveness review against their terms of reference. The Board of Directors approved the revised sub-Board governance structure and establishment of additional sub committees to support the Audit, Resources and Quality and Performance Committees. This new structure was 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 2021/22

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 Sub Committee. The Quality and Performance Committee meets monthly and receives assurance reports from the Chair of the Clinical Effectiveness Sub Committee following each meeting. The Chair of the Sub Committee 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 Committee Workplan • Clinical Effectiveness Sub Committee Group minutes • Clinical Effectiveness Management Group Workplan • IPR to Board of Directors • Quality Account • Audit Committee Minutes • Internal Audit Reports	√

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. The Trust has a bespoke set of values: Working Together; Making a Difference; and Being at our Best. These values 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 foundation trust (including commercial in confidence	The Board of Directors sign a code of conduct on an annual basis 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 only those papers which are specifically exempt under the FOIA are unpublished.	• Web site – Trust Board • Standards of Business Conduct Policy • Code of Conduct • Register of Interests	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	matters) and make clear how potential conflicts of interest are dealt with.			
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.	Memorandum of Understanding between the Chair and Chief Executive established to set out leadership responsibilities approved by the Board of Directors on 29th September 2021. A summary of the division of responsibilities is also included within the Chair/NED Induction Pack.	• Board of Director minutes 29 September 2021 • 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 2021/22

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 also acted as the Vice Chair. The Trust also nominated a new NED lead for Freedom to Speak Up during 2021/22. 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.	• Appraisal documentation	√
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 2021/22 in accordance with the NHSE/I guidance '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 2021/22

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

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2021/22

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 2021/22

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 of 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 2022 after 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 2021/22

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 2021/22

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 2021/22

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 2021/22

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 2021/22

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 2021/22

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.	There has been a focus on Board Development during 2021/22 and the following board development sessions have taken place: • Anti-Racism, Raising Awareness (April 2021) • NWAS Engaging Effectively with ICS Partnerships (June 2021) • Strategy, Systems and Integration (June 2021) • Estates (June 2021) • CQC Preparation (July 2021) • ZEAL Cultural Audit (October 2021) • Corporate Programmes Update (October 2021) • Cyber Security (October 2021) • Digital Development Programme (October 2021) • Charitable Funds Direction (December 2021) • Horizon Scanning for Year Ahead/Forward Planning/Legislation (February 2022) • Approaches to Public Health (February 2022) • Revisit Anti-Racism (February 2022)	• Board Development Sessions Programme • Attendance List • Board Skills Matrix	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		• Tailored Development Programme hosted by Impact (March 2022)		
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: • 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.	Not applicable		
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	Not applicable		

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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.			
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.	Executive Directors are required to provide 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.	• Annual Report and Accounts • Auditors Opinion • Board Minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2021/22

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		The Director of Finance presented the Board with a paper on Going Concern at the Board Meeting on 31st March 2022 for agreement.		
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 operation, including clinical outcome data, to allow members and governors to evaluate its performance. Further requirements are included in the NHS FT ARM.	All of this information is disseminated within the Annual Report as per Group Accounting Manual (GAM) Requirements.	• Annual Report • Audit Committee minutes • Board minutes	√
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 2021/22 was approved by the Board on 31st March 2021 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	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
			• 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 and continually improving the effectiveness of its risk management and internal control processes.	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	√
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	Not applicable		

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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.			
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, operations and forward plans of the NHS foundation trust. The current best practice is for a three-to-five year period of appointment.	The Audit Panel reviewed the procurement process to appoint an External Auditor through the SBS Framework in Q3 2019/20. In January 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 for a period of up to 4 years.	• Minutes of Audit Committee • Audit Panel Minutes • 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.	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 Freedom to Speak Up Champions to assist the Guardian and to support staff to speak up. During 2021/22, the executive lead for Freedom to Speak Up was the Director of Corporate Affairs and there was also an independent Non-Executive lead.	• Quarterly FTSU Report to Board • Board minutes • Freedom to Speak Up Strategy • Internal Audit Report	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	These processes should also reassure individuals raising concerns that they will be protected from potential negative repercussions.			

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. 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 introduced 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 has been implemented over a 2.5 year period beginning October 2019 and concludes 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.	Not applicable		
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 ICS, commissioners, NHS Trust providers, regulators, A&E Delivery Boards, local MPs and patient and public groups. The strategy covers the trust's strategic approach to communication and engagement with all key stakeholders in particular patients and the public,	• Communications and Engagement Strategy • Right Care Strategy • Friends and Family Test • Patient and Public Panel	√

		staff, partners, members, volunteers, political influencers and statutory organisations. As the only ambulance service currently covering 28 CCGs (to become 3 ICS areas which will have a statutory legal footing from July 2022) in the North West it has become increasingly important that the Trust engages in any potential discussions and plans to change services at a very early stage so any options can be impact assessed for safe and sustainable delivery. This shift from commissioner/provider relationships to area or system/provider relationships enables the Trust to work in partnership and integrate with stakeholders and organisations to a greater extent. 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. Engagement with our public, patients and community groups has also been enhanced with the further development of our Patient and Public Panel (PPP). The PPP has an infrastructure to enable patients and the public to become involved at a level that suits them however at present, all levels are engaging virtually until further notice:		

		• 'Consult': ad hoc feedback via surveys, on new policies, events and information materials, • 'Co-produce': Helping to bring about service improvements through their involvement on a task and finish basis, using a co-productive approach and, • 'Influence': Regularly attending trust meetings, committees and Board to give their perspective as a patient.		
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 England/Improvement, Commissioners (to become 3 ICS) 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 ICS, commissioners, NHS Trust providers, regulators, A&E Delivery Boards, local MPs and patient and public groups. The strategy covers the trust's strategic approach to communication and engagement with all key stakeholders in particular patients and the public, staff, partners, members, volunteers, political influencers and statutory organisations. As the only ambulance service currently covering 28 CCGs (to become 3 ICS areas which will have a statutory legal footing from April 2022) in the North West it has become increasingly important that the Trust engages in any potential discussions and plans to change services at a very early stage so any options can be impact assessed for safe and sustainable delivery. This shift from commissioner/provider relationships to area or system/provider relationships enables the Trust to work in partnership and integrate with stakeholders and organisations to a greater extent. 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.	• Communications and Engagement Strategy	√

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th April 2022				
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**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☒	☒	☒	☒
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 24th November 2021. During the period 1st October 2021 to 31st March 2022, the Trust's Common Seal was applied on a total of 4 occasions and the details can be found in s2.				
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.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:					
	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 2021 to 31st March 2022.

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 24th November 2021.

During the period of 1st October 2021 to 31st March 2022, the Trust's Common Seal was applied on a total of 4 occasions. These were:

Reg No	Date	Reason
153	26th October 2021	Counterpart Lease: Devonshire Road, Blackpool
154	24th November 2021	Contract and TP1: Sale of freehold land with vacant possession: 6 Sherdley Road, Lostock Hall
155	24th November 2021	Lease Renewal: 3B Lillyhall West Industrial Estate, Workington
156	18th January 2022	Lease Renewal: Red Scar Business Park, Preston

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 Chief Executive and Director of Finance and the application of the Seal is witnessed by a further 2 senior managers.

Authorisation and witness signatures are incorporated in the Trust's Register of Sealings. Compliance with the requirements of Section 8 of Standing Orders is being maintained.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

The Trust is required to comply with Section 8 of the Trust's Standing Orders relating to the Use of the Common Seal.

4. EQUALITY OR SUSTAINABILITY IMPACTS

Not applicable.

5. 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.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	Wednesday 27th April 2022				
SUBJECT:	Freedom to Speak Up (FTSU) Annual Report 2021/22				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☐	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☐	☐	☐	☐
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	During 2021/22 a total of 98 concerns were raised via the FTSU service. S3 gives details of the key themes with the main category Bullying/Attitudes/Behaviours remaining consistent with previous years. The FTSU Index was released in May 2021 and s4 gives further insight into the ambulance sector and an upcoming review of the sector by the National Guardian's Office to understand why the FTSU Index scores don't appear to correlate with CQC ratings, unlike other NHS sectors.				
RECOMMENDATIONS:	The Board of Directors is recommended to: • Note the contents of the report • Consider any risks and further actions for the Trust				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☒	Sustainability	☐	
	N/A				

PREVIOUSLY CONSIDERED BY:	**Date:**	N/A
	Outcome:	N/A

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1. PURPOSE

The purpose of the paper is to provide the Board of Directors with details of concerns reported via the Freedom to Speak Up service during 2021-22.

2. BACKGROUND

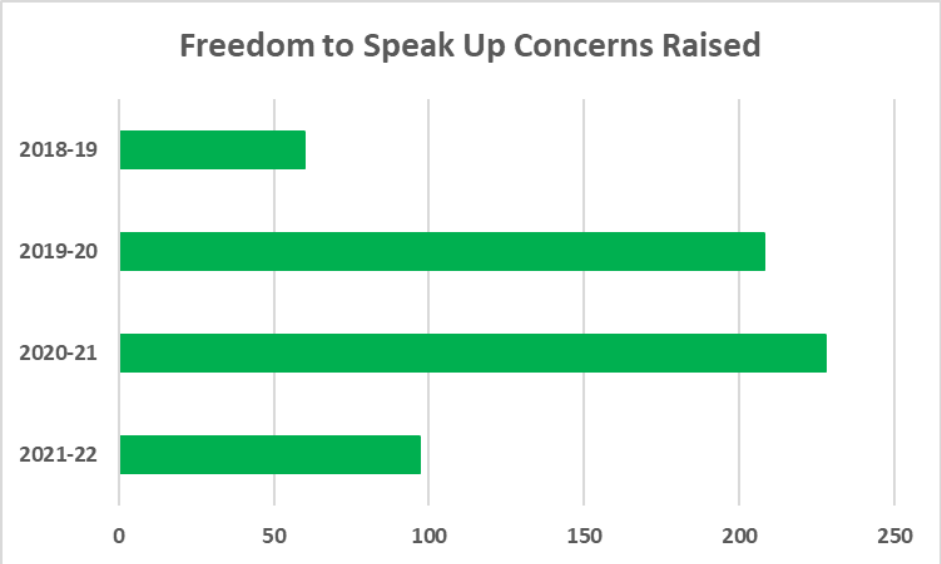
Freedom to Speak Up (FTSU) is a national programme that supports staff, students and volunteers to raise concerns in confidence. Mid staffs hospital demonstrated the negative impact on an organisation if staff feel unable to raise a concern. It is vital that everyone at NWAS knows how to raise concerns and to feel safe when they do so.

The Freedom to Speak Up Guardian and Champions remain determined in our commitment to ensure that staff feel they can speak up safely and that their concerns will be heard and taken seriously. No-one should experience detriment or be discriminated against for speaking up, but we know fear of this can prevent staff from doing so.

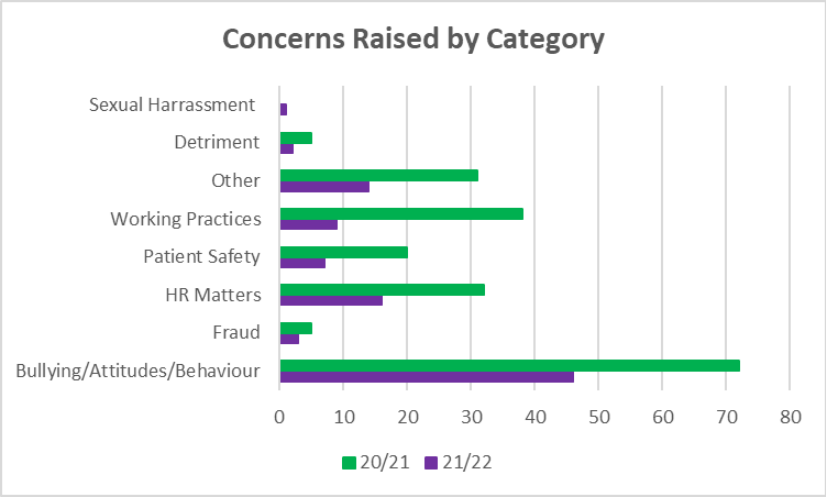
3. CONCERNS RAISED DURING 2021-22

During 2021-22 98 cases were reported by the Freedom to Speak Up (FTSU) Guardian or Champions. This is a noticeable decrease on the previous reporting period (2020/21) when 228 cases were raised and this has been the common narrative throughout the Regional and National network. The figures for 20/21 included 37 concerns raised re Covid, however, no Covid related concerns are recorded on the register for 2021/22.

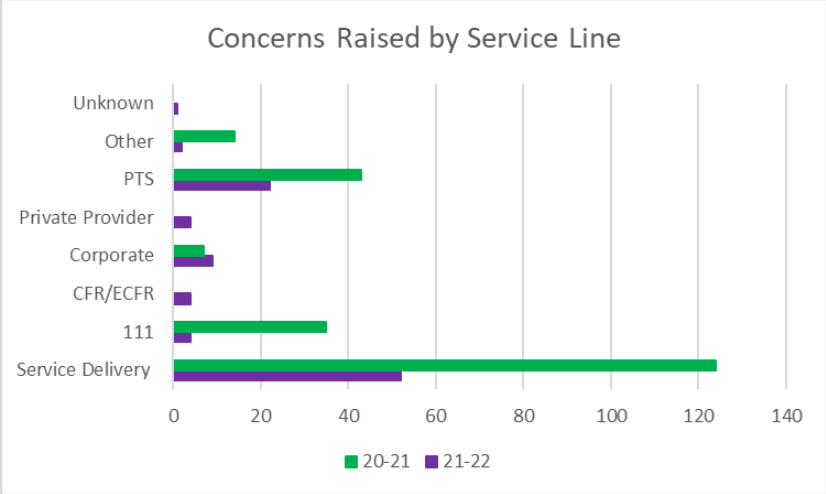
Freedom to Speak Up Concerns Raised



2021/22 Concerns by Category



2021/22 Concerns Raised by Service Line



Service Delivery includes EOC.

As always – the activity detailed above reflects only cases reported via FTSU. Concerns raised with local managers or directly with HR colleagues are not included. Other incudes concerns raised by private provider and other Trusts.

During the reporting period, two anonymous concerns were raised – whilst it is understandable that some staff members may feel nervous about openly raising concerns, it does make it difficult to obtain further information to assist with any investigations. A further twenty one concern raisers asked the Guardian to protect their identity.

Two concerns were received alleging detriment had been suffered as a result of previously speaking up. No evidence was found to substantiate either concern.

Key Themes
The three main themes are:

- Bullying, Attitudes and Behaviours continue to dominate the theme of the concerns being raised. Almost all of these cases are either individual grievances or individual dignity at work complaints. This remains consistent with previous years.

- HR Matters includes a variety of subjects including:
    - Alleged non-adherence to recruitment processes
    - Pay discrepancy queries
    - Sickness absence process queries
    - Terms & Conditions queries

- Other includes matters such as:
    - Data breaches
    - Social media posts

It may be possible to improve the categorisation of these matters in the future and the Guardians will give consideration to this during 2022/23.

Occasionally, staff contact the Guardian to report concerns in confidence but then decide not to proceed with taking the matter further – the Guardian records these concerns on the log and one such example is the sexual harassment case whereby the concern raiser decided they did not want to pursue the matter. However, where there are safeguarding matters the FTSU Guardian ensures appropriate advice is sought from the Safeguarding team and appropriate escalation is carried out.

Supporting Freedom to Speak Up

During 2021/22 a variety of internal support mechanisms were in place:

- Monthly meetings 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. Provides an opportunity to escalate and seek advice.
- 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
- Six weekly meeting with the Head of Service EOC to review open FTSU cases relating to this function.
- Concerns raised around patient safety are shared with the Executive Director of Operations and Medical Director to give an overview of the types of concerns and it enables Directors to monitor and address common themes identified across their directorates and to take ownership, share and embed any learning from them.
- All concerns raised are directed to the Executive lead for the directorate the concern relates to and actions are put in place to address these concerns which are audited to ensure concerns are being taken seriously. Some

concerns are escalated to more than one person as the concerns may include more than one category or area of concern.

4. FTSU INDEX 2021

The Freedom to Speak Up index was published by the National Guardian's Office in May 2021. The index is derived from the mean average of the following four questions in the NHS 2020 annual staff survey:

- % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)
- % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)
- % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 17b)

The four questions used in the FTSU Index are clinical and incident-centric and may not have the same applicability to all staff groups and trust types. Moreover, while they give an indication of FTSU culture, a healthy speaking up culture is about more than these issues and includes making improvement suggestions.

There was an additional question included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally:

- % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation (question 18f)

Question 18f was not included in this year's FTSU Index – to allow for comparability to previous years – but has been analysed alongside the index score for this report.

The ambulance sector consistently remains the lowest performing across the NHS, with all ambulance services placing in the bottom third of the overall index, however, there have been some slight improvements from last year.

	Index	Qu 18f
SCAS	77.9	64.4
EMAS	76.9	60.8
LAS	76.7	56.3
SWAST	76.0	62.3
WMAS	75.9	59.1
NEAS	75.3	57.6
YAS	75.3	58.8
SECAMB	74.9	57.7
NWAS	74.2	58.3
EASTAMB	66.6	43.7

In early 2020, the NGO proposed a speak up review of NHS Ambulance Trusts in light of consistent findings that the speaking up culture in these trusts tends to be more challenged despite their ratings by the Care Quality Commission (CQC). This

review was postponed during the pandemic, however, as pressures ease, they are hoping to commence this work during Q1 2022/23. Stage one will be desk-based research, followed by a further stage of undertaking interviews, surveys and focus groups. A report is expected during early Q2 22/23.

4. KEY NATIONAL UPDATES

November 2021

Clinical leader and registered nurse, Dr Jayne Chidgey-Clark, was appointed as the new National Guardian for Freedom to Speak Up in the NHS in England

February 2022

Recording Data
The National Guardian's Office (NGO) issued updated guidance on recording cases and reporting data. The new guidance is clearer, more accessible and takes into account the needs of the broader range of organisations that are now supported by Freedom to Speak Up Guardians. The NGO has also introduced a new category to record any case that includes an element of other inappropriate attitudes or behaviours that do not constitute bullying or harassment. This guidance comes into effect for all cases received on or after 1 April 2022.

Twelve Principles for Responding to FTSU Concerns
The NGO also published twelve principles for responding to FTSU concerns as part of the strategic framework:

1. There will be clear and accessible information on how to speak up.
2. Speaking up processes will be designed so that all workers can speak up easily.
3. Everyone who speaks up will be thanked.
4. Where appropriate, workers will be encouraged and supported to speak up locally.
5. If another organisation (e.g. another national body) better addresses a matter, workers will be supported to speak up to that organisation.
6. Workers will be offered information on other sources of advice and support.
7. Workers speaking up will be provided with a response in a timeframe that is made clear to them.
8. Responses to speaking up will include details setting out how the information provided was used for learning and improvement.
9. The confidentiality of those who speak up will be respected, subject to the need to ensure safeguarding requirements are met.
10. Where matters are raised anonymously, they will be responded to in accordance with these principles to the extent possible.
11. Workers will be given the opportunity to feedback on their experience of speaking up.
12. The speaking up arrangements' effectiveness will be monitored, and opportunities to improve taken.

During April 2022, the final module of the elearning package developed between Health Education England and the NGO is expected. This module is called "Follow

Up" and is for senior leaders including executives and non-executives and topics include:

- What is a healthy speaking up culture?
- Benefits and drivers – including improved safety and organisational performance; reducing harm and costs; and worker retention
- Measuring the effectiveness of a speaking up culture
- The role of leaders in setting the tone
- Supporting your Freedom to Speak Up Guardian

5. FREEDOM TO SPEAK UP 2022/23

NWAS has had an active FTSU service since April 2017 and the Executive Lead for that time has been the Director of Corporate Affairs and Company Secretary, in addition to having in place a dedicated FTSU Guardian and 10 FTSU local champions.

As part of annual Executive portfolio planning, a stock check was taken to determine what would be the best arrangements going forward for FTSU. Taking into consideration the findings in the Francis Report, which showed unacceptable levels of patient care due to staff cultures deterred from raising concerns, it was determined that FTSU would be ideally placed under the Executive Medical Director with enhanced FTSU guardian support to him but continuing with the strong links already in place between the FTSU team, Non-Executive Director lead and Director of People.

The previous Guardian left the Trust towards the end of December 2021 and immediate mitigations were needed to ensure the service continued to function for the remainder of the financial year until longer term arrangements were further developed and in place i.e. transition into the medical directorate.

After discussion with Executive Leadership Committee colleagues and relevant Board members (Chair and the Non-Executive Director for FTSU) the Director of Corporate Affairs/Company Secretary took temporary oversight responsibility for FTSU, supported by the network of FTSU champions which would mitigate any potential risk of staff perhaps not wishing to use FTSU during this short transitional period. At the end of Q4, seven new concerns were raised through FTSU which gives the Board some assurance that the FTSU service was still being accessed. Prior to the previous Guardian leaving, permission was sought from concern raisers who had open cases to pass their cases over during the transition period and eleven cases were handed over.

Once the FTSU Guardian's end of tenure had been confirmed, the next available National Guardians Office (NGO) training was immediately secured on 27 January 2022 and following expressions of interest within the Medical Directorate, a Consultant Paramedic and Advanced Paramedic, along with Dr Grant (Executive Medical Director), attended the NGO training session. This was registered with the NGO, with an email confirming access to the reporting portal but noting that it may take up to 6 weeks for the website to be updated. Dr Grant's attendance was to

ensure full knowledge of current NGO training and practices, but he will be Executive Lead only and is not registered as a Guardian.

Further investment has been made in the FTSU service with a full recruitment process for a Band 7 FTSU Lead Guardian taking place during Q1 2022/23. This role will be supported by the Consultant Paramedic and Advance Paramedic Guardians who have completed the FTSU Guardian training. A single Guardian position is not one reflected in other Trust's arrangements and given the geographical nature of NWAS and the need for resilience and leave cover, an investment and strengthening of arrangements by having three trained Guardians feels more representative of models in the sector. The Consultant Paramedic has responsibilities for Learning from Deaths and the Advanced Paramedic is the Trust Lead for Clinical Effectiveness, which were significant considerations. Furthermore, investment has been made in administration officer support for FTSU and work is currently being scoped to develop the new DATIX Cloud IQ to further enhance reporting and analytical capabilities.

6. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

7. EQUALITY OR SUSTAINABILITY IMPACTS

Protected Characteristics of staff raising concerns will be monitored by the Freedom to Speak Up Guardian through the Feedback Forms following the raising of a concern.

Though demographic monitoring is not part of the NGO reporting requirements, the Guardians will continue to improve the capture of this data in the coming year and this information will be shared with the WRES team.

8. RECOMMENDATIONS

The Board of Directors is recommended to:

- Note the contents of the report
- Consider any risks and further actions for the Trust

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th April 2022				
SUBJECT:	Quality and Performance Committee Annual Report 2021/22				
PRESENTED BY:	Prof A Chambers, Chair of the Quality and Performance Committee				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☐	☒	☐	☐
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☐	☐	☐	☐
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 – • Removal of the Clinical Associate Non-Executive Director. • Updates to the titles of members and Directorate representatives. • Amendment to the quoracy and a Non-Executive Director with medical clinical responsibilities. • Inter relations to include an effective relationship with Chair of the Resources Committee. The committee effectiveness review highlighted that the group has met its remit and functions. However, a number of improvements have been identified: • Members need to ensure questions are succinct and responses are sufficiently clear. • Papers to the Committee to be refined to allow focus on key areas of assurance. • Deeper scrutiny to be undertaken by members in relation to the BAF and holding Executive Directors to account for their areas of work. • To portray topics to a non-clinical audience.				

<table>
<tr><td></td><td colspan="4">

- To consider frequency of meetings from monthly to bi-monthly, to allow time to focus on the narrative within the IPR report and provide further insight and depth, to support triangulation reviews by the Committee.

</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="4">The Board of Directors is recommended to:

• Review the Quality and Performance Committee Annual Report for 2021/22.

• Note the amendments to the Terms of Reference for 2022/23 presented under separate cover for Board approval.</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
(DECISION PAPERS ONLY)</td><td colspan="4">The Trust’s Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Financial/ VfM
☒ Compliance/ Regulatory
☒ Quality Outcomes
☐ Innovation
☒ Reputation</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Quality and Performance Committee</td></tr>
<tr><td>Date:</td><td colspan="3">28th March 2022
25th April 2022</td></tr>
<tr><td>Outcome:</td><td colspan="3">Approved</td></tr>
</table>

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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 2021 to 31st March 2022 and to set out how it has met its terms of reference and priorities.

2. BACKGROUND

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

3. ROLE OF THE 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 except for the June meeting which was not quorate due to Covid-19 pressures and attendance at the Manchester Arena Inquiry. Attendance has been based on membership set out in the terms of reference.

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 Board Assurance Framework and Strategic Risks

The Committee has continued to receive and monitor the risks within the Board Assurance Framework and considered actions taken each quarter. Discussion and challenge regarding the risks aligned to the Committee has matured and risk has been triangulated with the content of the Integrated Performance Reports.

5.2 Integrated Performance Report

The Integrated Performance Report (IPR) has continued to provide a key focus for the Committee and facilitated scrutiny and debate particularly in relation to performance, demand pressures, complaints, and patient safety.

5.3 Chairs Assurance Reports

Chairs Assurance Reports have continued to reflect the challenges facing the organisation and provided a key focus for meetings of the Board of Directors.

5.4 Serious Incidents, Learning from Deaths and Legal Services Reports.

The Committee has received Serious Incidents, Learning from Deaths and Legal reports which have provided a focus for discussion. Further triangulation and learning from these reports will be developed by the Committee during 22/23.

5.5 Health & Safety and Infection Prevention and Control

The Committee has received health and safety reports in accordance with the Committee Work Plan and considered the Trust's new Violence and Aggression Policy, health and safety compliance and quality assurance visits activity.

The IPC Board Assurance Framework has been received and assurance reporting has considered the actions related to the Covid-19 pandemic pressures. IPC compliance has been a key focus for the Committee during 2021/22.

5.6 Sub Committees

Chairs Assurance Reports from the bimonthly meetings of the Patient Safety Sub Committee, Clinical Effectiveness Sub Committee, Infection Prevention and Control Sub Committee and Health Safety and Security Sub Committee have provided assurance that operational risks and assurances are being monitored. Annual reviews of the effectiveness of the sub committees have been considered and their Terms of Reference approved by the Committee.

6. KEY IMPROVEMENTS FOR THE COMMITTEE DURING 2022/23

The committee effectiveness review highlighted that the group has met its remit and functions. However, a number of improvements have been identified:

- Members need to ensure questions are succinct and responses are sufficiently clear.
- Papers to the Committee to be refined to allow focus on key areas of assurance.
- Deeper scrutiny to be undertaken by members in relation to the BAF and holding Executive Directors to account for their areas of work.
- To portray topics to a non-clinical audience.

- To consider frequency of meetings from monthly to bi-monthly, to allow time to focus on the narrative within the IPR report and provide further insight and depth, to support triangulation reviews by the Committee.

7. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

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

8. EQUALITY AND SUSTAINABILITY IMPLICATIONS

There are no equality or sustainability implications directly associated with the content of the report.

9. RECOMMENDATIONS

The Board of Directors are recommended to:

- Review the Quality and Performance Committee Annual Report for 2021/22.

- Note the amendments to the Terms of Reference for 2022/23 presented under separate cover for Board approval.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th April 2022				
SUBJECT:	Resources Committee Annual Report 2021/22				
PRESENTED BY:	Dr D Hanley, Chair of Resources Committee				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☐	☒	☐	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☐	☒	☒	☒	☐
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 – • Removal of the Associate Non-Executive Director (Digital). • Titles and directorate membership updated. • Duties and interrelations updated to reflect changes to Strategies and policies. • Strategy, Planning and Transformation reporting items reviewed to reflect the Trust's strategic annual planning cycle. The committee effectiveness review highlighted that the group has met its remit and functions. However, a number of improvements have been identified: • Further maturity of work and scrutiny related to the Board Assurance Framework. • To continue to assess meeting effectiveness during the year, at the end of each meeting.				
RECOMMENDATIONS:	The Board of Directors is recommended to: • Review the Resources Committee Annual Report for 2021/22.				

<table>
<tr><td></td><td colspan="4">• Note the amendments to the Terms of Reference for 2022/23 presented under separate cover for Board approval.</td></tr>
<tr><td>CONSIDERATION TO RISK APPETITE STATEMENT
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<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="4">Resources Committee</td></tr>
<tr><td>Date:</td><td colspan="3">25th March 2022</td></tr>
<tr><td>Outcome:</td><td colspan="3">Approved</td></tr>
</table>

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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 2021 to 31st March 2022 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 MEMBERSHIP AND ATTENDANCE

Meetings of the Committee have been held as scheduled in the corporate calendar except for the January meeting which was cancelled due to Covid-19 pressures. There have been no instances where a quorum was not present.

5. RESOURCES COMMITTEE SELF ASSESSMENT

The current terms of reference have been reviewed by the Resources Committee. The Board should note that during 2022/23 all functions set out within the Terms of Reference have been discharged.

The following areas were highlighted as key achievements during the year -

5.1 Strategic Risks

The committee received a Board Assurance Framework (BAF) update at every meeting and members monitor and consider the strategic risks that are relevant to

the committee's remit. The agenda is also structured around the BAF and reports presented clearly articulate which strategic risk it relates to.

5.2 Digital Agenda

The committee has supported the progression of the digital agenda throughout the year and received comprehensive assurance updates from the Chief of Digital Innovation, which have provided the opportunity to scrutinise and obtain assurances on the delivery of strategic digital projects.

5.3 Workforce Compliance and Targets

The committee received an update on Workforce Indicators at every meeting and has scrutinised targets in relation to mandatory training, appraisal targets, sickness absence and retention. The committee instructed a deep dive into 111 recruitment and retention which was provided to the Board of Directors in January 2022.

5.4 Financial Plans

The committee has maintained a sharp focus on Finance and Trust resources. It has received regular finance reports and detailed progress updates on H1 and H2 planning, which has allowed 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 and Business Cases, including Hub and Spoke strategic projects.

5.5 Fleet and Estates

The committee received regular updates in relation to estates and fleet, including vehicle replacement programme and carbon reduction strategy assurances.

Significant progress has been made in relation to the Trust's carbon reduction initiatives which have been recognised nationally.

5.6 Strategy

The committee has received comprehensive updates from the Director of Strategy, Partnerships and Transformation on ICS and stakeholder developments. Planning updates have been provided and well presented to the Committee for assurance.

5.7 Sub Committee Assurances

The committee received Chairs Assurance Reports from the Strategic Workforce Sub Committee and Diversity and Inclusion Sub Committee and has reviewed their annual effectiveness during 2021/22.

6. COMMITTEE IMPROVEMENTS FOR 2022/23

The 2021/22 Annual Effectiveness Review highlighted the following areas for improvement during 2022/23 –

- Further maturity of work and scrutiny in relation to the Board Assurance Framework.

- To continue to carry out effectiveness reviews at the end of each Committee meeting.

7. TERMS OF REFERENCE

The Terms of Reference have been reviewed by Resources Committee at their meeting on 25th March 2022 and have been presented to the Board of Directors for approval.

8. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS

Section 4 of the Committee's Terms of Reference state a review of the effectiveness of the Committee should be undertaken on an annual basis.

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

- Review the Resources Committee Annual Report for 2021/22.

- Note the amendments to the Terms of Reference for 2022/23 presented under separate cover for Board approval.

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th April 2022				
SUBJECT:	Audit Committee Annual Report 2021/22				
PRESENTED BY:	David Rawsthorn, Chair of Audit Committee				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Assurance				
EXECUTIVE SUMMARY:	The Board of Directors are presented with the Audit Committee's Annual Report for 2021/22. The report details the activities of the Audit Committee during the 2021/22 financial year.				
RECOMMENDATIONS:	The Board of Directors is recommended to: note the Audit Committee Annual Report 2020/21.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Financial/ VfM ☐ Compliance/ Regulatory ☐ Quality Outcomes ☐ Innovation ☐ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:	Audit Committee				
	Date:	22nd April 2022			
	Outcome:	Approved			

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Audit Committee Annual Report 2021/22

Introduction

This report provides information on the how the Audit Committee has met its Terms of Reference during the 2021/22 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 2021 to 31 March 2022.

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's 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.

Six meetings of the Audit Committee were held during the year. Regular attendees at the Committee meetings were Mazars (External Auditors), MIAA (Internal Audit and Counter-Fraud Services), Director of Finance and Director of Corporate Affairs.

The revised Terms of Reference were approved at the Audit Committee on 23nd April 2021.

Committee Members and Attendance

During 2021/22 the Audit Committee consisted of the following members:

Committee Member		Attendance
Mr D Rawsthorn	Non-Executive Director (Chair)	6/6
Prof A Chambers	Non-Executive Director	5/6
Prof A Esmail	Non-Executive Director	6/6
Prof R Thomson	Associate Non-Executive Director	6/6
G Singh	Associate Non-Executive Director	3/4

The Committee met on the following occasions during 2021/22:

23 April 2021
11 May 2021
11 June 2021
16 July 2021
22 October 2021
21 January 2022

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

The Committee continued to receive assurance against actions identified to improve the Trust's overall level of Data Quality following the MIAA audit review in Q4 2020/21. The Committee has also received Chair's Assurance Reports from the Information Governance Sub Committee during the year in order to strengthen assurances to the Committee in relation to data quality and cyber security.

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 2021/22 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.

Clinical Governance
The committee continued to strengthen its role in relation to clinical governance by receiving the chair's assurance reports from the Quality and Performance Committee. In addition, the Committee received the Clinical Audit Plan and quarterly updates. 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. In previous years, the Committee requests responsible Senior Management to meetings where a 'limited assurance' opinion had been provided in audit reports however during 2021/22, there have been no limited assurance opinions issued. 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.

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

High Assurance	Substantial Assurance
Lessons Learnt	Estates Strategy
Budgetary Control	Mandatory Training
Accounts Payable	Recording of Staff Hours/Application of AfC Section 2
Accounts Receivable	Risk Management
Treasury Management	Project Management Office
General Ledger	Data Security Protection Toolkit
	Data Quality
	Management of Third Party Providers – 365 Response
	ESR/HR Payroll Controls

Moderate Assurance	Limited Assurance
None received	None received
No Assurance	
None received	

MIAA undertook an additional review relating to the Assurance Framework. 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 identified that:

- The structure of the Assurance Framework meets the NHS requirements;
- There has been Board engagement in the review and use of the Assurance Framework throughout the financial year; and
- The quality of the content of the Assurance Framework demonstrates clear connectivity with the Board agenda and external environment.

MIAA reviewed the final submission of the Trust's Data Security and Protection Toolkit self-assessment in order to provide assurance of the Trust's intended final submission and to consider whether the submission was reasonable based on the evidence submitted but to also provide assurance on the extent to which information risk had been managed. MIAA provided substantial assurance against the self-assessment.

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 2021/22, the Head of Internal Audit overall opinion for the period 1 April 2021 to 31 March 2022 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 populated by MIAA, reviewed and authorised by the Director of Finance and the Chair of the Audit Committee. Confirmation of the submission made by the -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.

External Audit
Mazars were the External Auditors to the Trust for the 2021/22 financial year and during the year reported on the 2021/22 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.

For the first time the auditors were required to present an Auditor's Annual Report which detailed the outcome of the audit of the Trust's financial statements. The report also included commentary around the Trust's Value for Money arrangements which identified no significant weaknesses.

At the meeting on 17 June 2022, the Committee will receive the Audit Completion Report relating to the Financial Statements Audit and review of the Annual Report. The Annual Report and Accounts were [insert whether approved or not] and External Audit [insert]. This will be accompanied by the Auditor's Annual Report

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 relation to the Committee self-assessment, the HFMA Audit Committee Handbook provides two checklists to aid facilitation of the Committee self-assessment in relation to 1) to test the committee processes; and 2) to test its effectiveness. During Q4 2020/21, MIAA undertook an assessment of the committee processes, the outcome of the assessment was positive and identified that all actions from the previous year had been addressed however highlighted further action relating to the Committee formally considering how it integrates with other committees reviewing risk. As a result, it was agreed that the Chair's Assurance Report from the Resources Committee would be submitted to each meeting.

Following a recommendation from a previous self-assessment a revised induction process had been developed for new committee members and all members have now been appropriately inducted.

The revised Terms of Reference will be submitted to the Board of Directors on 27th April 2022 for approval.

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 take assurance from the report.

Mr D Rawsthorn
Non-Executive Director
Audit Committee Chair DATE

APPENDIX 1

REPORTS TO THE AUDIT COMMITTEE DURING 2021/22

Reports produced by the Trust

Audited Accounts 2020/21

Annual Report 2020/21

Annual Governance Statement 2020/21

Audit Committee Self-Assessment

Audit Committee Terms of Reference

Waiver of Standing Orders

Losses and Compensation

Estates Revaluation 2020/21

Letter of Representation

Audit Committee Work Plan

Annual Review of Declarations of Interest, Gifts & Hospitality 2020/21

Audit Committee Annual Report 2020/21

FT Code of Governance Compliance Declaration

Annual Review of Core Governance Documents

Quarterly Board Assurance Framework Reports

Legal Services Update Q4 2020/21 and Annual Review of 2020/21

Chairs Assurance Reports from:

- Quality and Performance Committee
- Resources Committee
- Information Governance Sub Committee

Information Governance Sub Committee Terms of Reference

Clinical Audit Plan

Quarterly Clinical Audit Updates

Data Quality Updates

Reports produced by Mazars, External Auditors

Audit Progress and Technical Updates

Audit Completion Report

Auditors Annual Report

Audit Strategy Memorandum

Independent Auditors Report to Board of Directors

Reports produced by MIAA

Internal Audit Progress Reports

Internal Audit Work Plan 2021/22

Head of Internal Audit Opinion and Annual Report 2020/21

Follow Up Reviews

Limited Assurance Reports

Critical and High Risk Recommendations Overdue

Committee Self Assessment

Internal Audit Charter

Reports produced by the Anti-Fraud Specialist

Anti-Fraud Progress Reports

Anti-Fraud Annual Report 2020/21 including Self Review Toolkit (SRT) Ratings

Anti-Fraud Annual Work Plan 2020/21

NWAS Anti-Fraud Bribery and Corruption Policy and Response Plan

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th April 2022				
SUBJECT:	Board Assurance Committee Terms of Reference				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☒
PURPOSE OF PAPER:	For Decision				
EXECUTIVE SUMMARY:	In accordance with Section 4 of the Committee Terms of Reference, an annual review of the Terms of Reference has been undertaken. Changes are highlighted in tracked changes within each of the Terms of Reference for the following Committees: • Audit Committee • Charitable Funds Committee • Nominations and Remuneration Committee • Quality and Performance Committee • Resources Committee				
RECOMMENDATIONS:	The Board of Directors is recommended to approve the Terms of Reference for all Board Assurance Committees.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐	
PREVIOUSLY CONSIDERED BY:					
	Date:				

	Outcome:	

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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~~ six 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~~ six 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 Audit~~or~~ 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, the Committee will wish to satisfy itself that controls are adequate and that assurances are sound and sufficient. After each meeting of the Quality and Performance Committee the chair compiles an assurance report which are

reported through to the Audit Committee. 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 provide assurance that the appropriate counter fraud arrangements are in place and ensure a coordinated approach to protecting public services against the risk of fraud, bribery and corruption.

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, including 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:

- Quality and Performance Committee
- Resources Committee

- Information Governance Sub-Committee

NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE – CHARITABLE FUNDS COMMITTEE

CONTENTS

1. ROLE AND PURPOSE

The Committee is established to manage, monitor and review the charitable funds of the Trust, as required by the Charities Act 2011. The Committee will work in accordance with relevant guidance published by the Charities Commission and/or the Department of Health.

The Trust is Corporate Trustee of charitable funds registered together under charity registration 1122470 and the Committee is appointed as the Trust's agent in accordance with s16 of the NHS Trusts (Membership and Procedures) Regulations 1990.

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 appointed Chair and one of whom shall have appropriate financial qualifications or experience
- Director of Finance
- Director of Corporate Affairs
- Director of Operations
- Director of People
- Director of Strategy, Partnerships and Transformation ~~& Planning~~

The following officer 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:

- Head of Technical Accounts
- Head of Charity

There is an expectation that members will endeavour to attend all scheduled Committee meetings.

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 numbers 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 four, which is to include two Non-Executive Directors and two Executive Directors. 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

Charitable Funds Committee authority is as set out in the NWAS Standing Financial Instructions.

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 bi-annually however the Chair may call a meeting at any time provided that notice of the meeting is given as specified above.

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. Following a meeting, the Committee shall submit a Chair's Report to Board of Directors, and the Chair of the

Committee shall draw to the attention of the Board any issues that require disclosure or require executive action.

6. DUTIES AND INTERRELATIONS

The main functions of the Committee are:

i. ensuring the stewardship and effective management of funds which have been donated, bequeathed and given to the North West Ambulance Service NHS Trust Charitable Fund for charitable purposes;
ii. co-ordinating the provision of assurance to the corporate trustee of the funds, that the funds are accounted for, deployed and where appropriate, invested in line with legal and statutory requirements;
iii. considering and recommending the annual accounts for charitable funds for submission to and approval by the Board of Directors, acting as trustee of the funds;
iv. satisfying itself that an appropriate control environment is maintained to manage the key risks faced by the charity and to ensure compliance with Charity Law and Charity Commission regulations

The duties and responsibilities of the Committee shall be:

Governance, Risk Management and Internal Control

The Committee shall:

- review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the charity's activities that support the achievement of the charity's objectives.
- provide reports to the corporate trustee to provide assurance that the charity is properly governed and well managed across the full range of activities

Assurance

The Committee shall:

- ensure effective management of the affairs of the North West Ambulance Service NHS Trust Charitable Fund within the terms of its declaration of trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations;
- ensure systems and processes are in place to receive, account for, deploy and invest where appropriate charitable funds in accordance with charity law to include the effective implementation of procedures and policies to ensure fund holders and staff appropriately receive funds and access funds;
- scrutinise requests for use of charitable funds (in accordance with the Scheme of Delegation) to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear due diligence to Charity Commission and trust guidance regarding the ethical use of funds and acceptance of donations;
- shall receive and approve income and expenditure statements;
- shall receive and consider the annual report and accounts, before submission to the Board of Directors for approval.

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

8. INWARD REPORTING ARRANGEMENTS

Not applicable.

NORTH WEST AMBULANCE SERVICE NHS TRUST
TERMS OF REFERENCE – NOMINATIONS AND REMUNERATION COMMITTEE

CONTENTS

1. ROLE AND PURPOSE

In accordance with the requirements of the National Health Service Trusts (Membership and Procedure) Regulations 1990 (as amended) ("The Regulations"), the Board of Directors hereby resolves to establish a Committee of the Board, to be known as the Nominations & Remuneration Committee (hereinafter referred to as 'the Committee'). The Committee is a non-executive Committee of the Board and has no executive powers, other than those specifically delegated within these terms of reference.

2. MEMBERSHIP

The Committee shall comprise the following membership:

- Chairman of the Board of Directors
- All Non-Executive Directors

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

In the event that the Chair of the Committee is unable to attend a meeting, the Vice Chair shall conduct the meeting in their absence.

The Chief Executive shall normally attend meetings and other Directors may be invited to attend by the Chairman, via the Director of Corporate Affairs.

Other officers of the Trust shall attend at the request of the Committee, via the Director of Corporate Affairs, in order to present and provide clarification on issues and with the consent of the Chairman will be permitted to participate in the debate.

The Chief Executive, other Directors and any other officers in attendance at the meeting shall not be present for discussions about their own remuneration and terms of service.

No business shall be transacted unless the Chair and at least two members are present.

3. ACCOUNTABILITY

The Nominations and Remuneration Committee authority is as set out in the NWAS Scheme of Delegation.

4. REVIEW ARRANGEMENTS

Compliance with these Terms of Reference will be monitored on an ongoing basis by the Director of Corporate Affairs. Any concerns in relation to compliance will be reported to the Chair of the Committee.

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 Chair may call a meeting via the Director of Corporate Affairs at any time provided that notice of the meeting is given.

The Committee shall be supported by the Director of Corporate Affairs or Head of Corporate Affairs advising the Committee on pertinent areas of governance.

The minutes of meetings shall be formally recorded by either the Director of Corporate Affairs or the Head of Corporate Affairs, 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 executive action.

Should it be necessary, the Chair and two other members may, in an emergency, exercise the functions of the Committee jointly. A full report shall be prepared as for the Committee and a signed authorisation appended. The exercise of such powers, together with the report, shall be submitted to the next formal meeting for ratification.

6. DUTIES AND INTERRELATIONS

The Committee shall:

- At least annually review the structure, size and composition (including the skills, knowledge and experience) of the Board of Directors and give full consideration to succession planning for all Directors in the course of its work, taking into account the challenges and opportunities facing the Trust, and the skills and experience needed in the future.
- Identify and appoint candidates to fill the position of Chief Executive and any Director vacancies in conjunction with NHSEI.
- Approve the description of the role and the capabilities required for new appointments.
- Constitute the membership of interview panels and determine the need for representatives from internal and external stakeholders

- Ensure that the full range of eligibility checks have been performed and references taken are found to be satisfactory
- Ensure that a robust and effective process is in place to meet the requirements of the Fit and Proper Persons Test for all existing and future directors (Executive and Non-Executive) appointments.
- With regard to the Chief Executive, Directors; Trust Secretary and other Very Senior Managers; in conjunction with NHSEI where required and ensuring that officers 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 :
    - approve all aspects of salary (including any performance-related elements, bonuses)
    - approve provisions for other benefits, including pensions and cars
    - approve arrangements for termination of employment and other contractual terms (decisions requiring dismissal shall be referred to the Board for ratification).
- Monitor the performance of all Directors including the Chief Executive,
- Consider and approve such strategies for the determination of pay and terms and conditions of service for staff groups not covered by national terms and conditions as may be necessary, and where such strategies affect contractual rights, having due regard to their cost-effectiveness and equity
- Approve costs incurred in relation to redundancy situations where the cost exceeds £50,000
- Act as the final stage of grievance and disciplinary procedures for Directors
- Approve the running of any MARS or Voluntary Redundancy Scheme

7. DELEGATED AUTHORITY

The Committee is authorised by the Board to:

- Carry out 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

8. INWARD REPORTING ARRANGEMENTS

Not applicable.

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, Partnerships & Transformation ~~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
- Head of Strategy, Planning & Transformation
- Assistant Director of Estates and Fleet
- Head of Procurement

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~~
- Our Strategy 2018-2023
- ~~Long Term Financial Model~~
- ~~Integrated Business Plan~~
- ~~Our Strategy 2018 – 2023~~
- Digital Strategy
- Estates Strategy
- Fleet Strategy
- Workforce Strategy
- Procurement Strategy
- 3 Year Implementation Roadmap
- Long Term Financial Model
- Financial Plan
- Annual Plan (incl. financial and operational plans)

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

Workforce

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

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

xix. Seek assurance on the development of a vibrant volunteer cohort and receive assurance inrelation to the recruitment, training and management of volunteers

xx. 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.

xxi. 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.

xxii. Receive assurance that there is an effective Learning Needs Analysis process in place across the Trust and monitor its effectiveness.

xxiii. 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 & Transformation

To seek assurance against and have oversight of ~~progress of~~ the Trust's - ~~Integrated Business Plan.~~

I. 3 Year Strategy implementation/transformation roadmap – i.e. what are the priorities and sequencing of outcomes to help us deliver the strategy over three years
II. Annual Planning Cycle including –

a. Development of trust-level annual plan and directorate business plans
b. Alignment between strategy and strategic risk management
c. Alignment between strategy and operational planning (incl. any external submissions)
d. Quarterly assurance against objectives (incl. achievements and learning)
e. Partnership working and system working

~~i.~~

i. ~~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

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 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
- Deputy Medical Director
- ~~Assistant Director of Nursing and Quality~~

- Head of Clinical Safety
- Patient Safety Specialist
- Deputy Director of Quality, Innovation and Improvement
- Chief of Regulatory Compliance and Improvement
- Consultant Midwife
- ~~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, which is to include at least two Non-Executive Directors ~~one of which must be the Non-Executive Director with medical 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 Resources 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 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~~

North West Ambulance Service NHS Trust

REPORT TO BOARD OF DIRECTORS

DATE:	27th April 2022				
SUBJECT:	Board of Directors Annual Cycle of Business 2022/23				
PRESENTED BY:	Angela Wetton, Director of Corporate Affairs				
LINK TO BOARD ASSURANCE FRAMEWORK:	**SR01**	**SR02**	**SR03**	**SR04**	**SR05**
	☒	☒	☒	☒	☒
	SR06	**SR07**	**SR08**	**SR09**	**SR10**
	☒	☒	☒	☒	☒
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 2022/23 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.				
RECOMMENDATIONS:	The Board of Directors are requested to – 1. Approve the Annual Cycle of Business for 2022/23 in the form of the attached Board of Directors work programme at appendix 1.				
CONSIDERATION TO RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Financial/ VfM ☒ Compliance/ Regulatory ☒ Quality Outcomes ☒ Innovation ☒ Reputation				
ARE THERE ANY IMPACTS RELATING TO:	Equality:	☐	Sustainability	☐	

(Refer to Section 4 for detail)				
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:			
	Outcome:			

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1. PURPOSE

To present the Board of Directors with an annual cycle of business for financial year 2022/23 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 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 IMPACTS

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 2022/23 in the form of the attached Board of Directors work programme at appendix 1.

Board of Directors
Work Programme 2022/23

	Date of meeting	27.4.22	25.5.22	17.6.22	27.7.22	28.9.22	30.11.22	25.1.23	29.3.23
	Report Deadline	21.4.22	18.5.22	10.6.22	20.7.22	21.9.22	23.11.22	18.1.23	22.3.23
Agenda Item				Introduction					
Minutes of the Previous Meeeting (Chair)			√		√	√	√	√	√
Action Log (Chair)			√		√	√	√	√	√
Committee Attendance (Chair)		√	√		√	√	√	√	√
Declarations of Interest (Chair)		√	√		√	√	√	√	√
Register of Interest (Chair)		√	√		√	√	√	√	√
Annual Cycle of Business (Work Plan)		√							
Patient/Staff Story (Director of Strategy & Planning)			√		√	√	√	√	√
Agenda Item				Strategy					
Chairman & Non Executive Directors Update Chairman's Board update (Chair)			√		√	√	√	√	√
Chief Executive's Report			√		√	√	√	√	√

Date of meeting	27.4.22	25.5.22	17.6.22	27.7.22	28.9.22	30.11.22	25.1.23	29.3.23
Report Deadline	21.4.22	18.5.22	10.6.22	20.7.22	21.9.22	23.11.22	18.1.23	22.3.23
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		√						
Standing Orders, SFIs, SoD, Matters Reserved	√							
Annual Report of Audit, Q&P and Resources Committees	√							
Boad Assurance Committees Terms of Reference								
Annual Audit Letter 2021/22 (Director of Finance)		√						
Separation of Duties CEO and Chairman (Director of Corporate Affairs)		√						
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)							√	
Freedom to Speak Up Report (Director of Corporate Affairs)	Quarter 4 & Annual Report					Bi Annual Report		
Board Assurance Framework 2022/23 and Corporate Risk Register (Director of Corporate Affairs)	Quarter 4 21/22			Quarter 1 22/23 *Corporate Risk Register*		Quarter 2 22/23 *Corporate Risk Register*	Quarter 3 22/23 *Corporate Risk Register*	
Risk Appetite Statement 2023/24								√
Annual Staff Survey Results								√

Date of meeting	27.4.22	25.5.22	17.6.22	27.7.22	28.9.22	30.11.22	25.1.23	29.3.23
Report Deadline	21.4.22	18.5.22	10.6.22	20.7.22	21.9.22	23.11.22	18.1.23	22.3.23
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 21/22	Quarter 1 22/23		Quarter 2 22/23	Quarter 3 22/23
Ockenden Review of Maternity Services								√
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		√						
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	27.4.22	25.5.22	17.6.22	27.7.22	28.9.22	30.11.22	25.1.23	29.3.23
Report Deadline	**21.4.22**	**18.5.22**	**10.6.22**	**20.7.22**	**21.9.22**	**23.11.22**	**18.1.23**	**22.3.23**
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								