Board of Directors Meeting

Wednesday, 26th April 2023
9.45am – 11.50am
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

AGENDA

Item No	Agenda Item	Time	Purpose	Lead
INTRODUCTION				
BOD/2324/01	Apologies for Absence	09:45	Information	Chair
BOD/2324/02	Declarations of Interest	09:45	Decision	Chair
BOD/2324/03	Register of Interest	09:50	Assurance	Chair
GOVERNANCE AND RISK MANAGEMENT				
BOD/2324/04	Board Assurance Framework Q4 2022/23	10:00	Decision	Director of Corporate Affairs
BOD/2324/05	Board Assurance Framework 2023/24 Opening Position	10:10	Decision	Director of Corporate Affairs
BOD/2324/06	Risk Management Policy Review	10:20	Decision	Director of Corporate Affairs
BOD/2324/07	Annual Review of Core Governance Documents • Standing Orders and Reservation of Powers • Scheme of Delegation Review • Standing Financial Instructions	10:30	Decision	Director of Corporate Affairs
BOD/2324/08	FT Code of Governance – 2022/23 Position of Compliance	10.40	Assurance	Director of Corporate Affairs
BOD/2324/09	Non-Executive Terms of Office; Committee Membership 2023/24 and Non-Executive Champion Roles	10.50	Assurance	Director of Corporate Affairs
BOD/2324/10	Freedom to Speak Up (FTSU) Annual Report 2022-23	10.55	Assurance	Freedom to Speak Up Guardian
BOD/2324/11	Quality and Performance Committee Annual Report 2022-23	11:05	Assurance	Prof A Esmail, Chair Quality and Performance Committee
BOD/2324/12	Resources Committee Annual Report 2022-23	11:15	Assurance	Mr D Hanley, Chair Resources Committee
BOD/2324/13	Audit Committee Annual Report 2022-23	11:25	Assurance	Mr D Rawsthorn, Chair Audit Committee
BOD/2324/14	Board Assurance Committee Terms of Reference 2023/24 • Audit Committee • Charitable Funds Committee • Nominations & Remuneration Committee • Quality & Performance Committee • Resources Committee	11:35	Decision	Director of Corporate Affairs
BOD/2324/15	Board of Directors Annual Cycle of Business 2023/24	11:45	Decision	Director of Corporate Affairs
CLOSING				
BOD/2324/16	Any Other Business Notified Prior to the Meeting	11:50	Decision	Chair
BOD/2324/17	Items for Inclusion on the BAF	11:50	Decision	Chair

DATE AND TIME OF NEXT MEETING
9.45 am on Wednesday 31st May 2023 in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton BL1 5DD

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	Present	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	Present	Withdraw from decision making process if the organisations listed within the declaration were involved.
			Director / Shareholder for 4 Seasons Garden Companies: 4 Seasons Garden Maintenance Ltd 4 Seasons Gardens (Norden) Ltd 4 Seasons Design and Build Ltd 4 Seasons lawn treatments Ltd CFR HR Ltd (not currently operating) - removed 25th May 2022				√	Position of Authority	Apr-22	Present	4 Seasons garden maintenance Ltd has secured and operates NHS Contracts for grounds maintenance and improvement works at other NW NHS Acute Trusts but these pre date and are disassociated with my NED appointment at NWAS. To withdraw from the meeting and any decision making process if the organisations listed within the declaration were involved.
Alison	Chambers	Non-Executive Director	Self Employed, A&A Chambers Consulting Ltd	√				Self employment	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Trustee at Pendle Education Trust		√			Position of Authority	Jan-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Husband appointed as CEO at East Grinstead NHS Trust				√	Other Interest	Feb-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
			Husband works for Liverpool CCG (Cheshire and Mersey ICB)				√	Other Interest	Feb-22	31-Jan-23	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Governor at Wigan and Leigh College			√		Position of Authority	Apr-20	31-Mar-22	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	30-Apr-22	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, Partnerships and Transformation	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Aneez	Esmail	Non-Executive Director	Board member of Charity Dignity in Dying			√		Board member	May-22	Present	
			Employed at the University of Manchester		√			Professor of General Practice	Apr-21	3rd Mar 22	N/A
			Work in GP Practice - Non Exec Chairman of Board	√	N/A	N/A	N/A	Position of Authority	Apr-21	3rd Mar 22	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
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
			A member of Festival Medical Services, a 'not for profit' registered charity staffed by volunteers, delivering professional medical services at events throughout the country. NWAS does not sub-contract events nor does FMS operate any significant activity in the North West.		√			Non Financial Professional Interest.	Jul-22	Present	If FMS run events in the North West, these would be undertaken via usual NWAS command functions and EPRR planning and I would remove myself from any interactions and engage with the NWAS Deputy Director should involvement be required from the Medical Directorate.
David	Hanley	Non-Executive Director	Associate Consultant for the Royal College of Nursing	√				Trainer (part time)	Jan-22	Present	No conflict.

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	Hanley	Non-Executive Director	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
Maxine	Power	Director of Quality, Innovation and Improvement	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Rawsthorn	Non-Executive Director	Trustee and Treasurer of Citizens Advice Carlisle and Eden (CACE)			√		Position of Authority	Apr-19	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	Director of People	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.
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
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
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

REPORT TO BOARD OF DIRECTORS

DATE:	26th April 2023
SUBJECT:	Q4 Board Assurance Framework 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** ☒ **SR11** ☒ **SR12** ☒
PURPOSE OF PAPER:	For Decision
EXECUTIVE SUMMARY:	The proposed Q4 (closing) position of the Board Assurance Framework (BAF) for 22-23 with any associated corporate risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2022-23 can be viewed in Appendix 2. The Executive Leadership Committee (ELC) recommend the following Q4 changes (s4): • Decrease in risk score of SR01 from 25 to 15 • Decrease in risk score of SR03 from 25 to 20 • Decrease in risk score of SR04 from 16 to 12
RECOMMENDATIONS:	The Board of Directors are requested to approve the: • Decrease in risk score of SR01 from 25 to 15 • Decrease in risk score of SR03 from 25 to 20 • Decrease in risk score of SR04 from 16 to 12 • Q4 position of the Board Assurance Framework
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☒ Quality Outcomes ☒ People ☒ Financial / Value for Money ☒ Reputation ☒ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☐	Sustainability	☐

<table>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Executive Leadership Committee and Audit Committee</td></tr>
<tr><td>Date:</td><td>19th April and 21st April 2023</td></tr>
<tr><td>Outcome:</td><td>For Assurance</td></tr>
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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 2022-23 Q4 closing position of the Board Assurance Framework (BAF) along with the Corporate Risks aligned to each BAF risk.

2. ASSURANCE PROCESS

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

The evidenced based assurance information reported throughout the quarter via the assurance committees and identified via a 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 Q4 BAF POSITION

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

Opening Score 01.04.2022	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
15 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**25** 5x5 CxL	**15** 5x3 CxL	Dr C Grant

The risk has decreased in risk score following review, with the following rationale provided by the Medical Director and Director of Quality, Innovation and Improvement:

- Stabilisation of system pressures across 111, PTS and 999 services resulting in improved ARP performance.
- Pilot of the joint response with mental health providers in EOC has had a positive impact on increased hear and treat.

BAF RISK 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	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Exec Lead
20 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**25** 5x5 CxL	**20** 5x4 CxL	G Blezard

The risk has decreased in risk score following review, with the following rationale applied by the Director of Operations:

- Improvements in call pick up and all response standards.
- Reduction in overall activity
- Reduction in hospital handover times
- Benefits of NHS Pathways implementation and reduction in C1 and C2 long waits.

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

Opening Score 01.04.2022	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	L Ward

The risk has decreased in risk score following review, with the following rationale applied by the Director of People:

- Pause of industrial action
- Improved workforce indicators relating to safe staffing levels.
- Improved vacancy gaps across service lines due to robust recruitment and training plans.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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

The Board Assurance Framework is linked to both the organisation's strategic priorities and the Trust's Risk Appetite Statement.

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors are requested to approve the:

- Decrease in risk scores of SR01 from 25 to 15
- Decrease in risk score of SR03 from 25 to 20
- Decrease in risk score of SR04 from 16 to 12
- Q4 position of the Board Assurance Framework

BOARD ASSURANCE FRAMEWORK 2022/23

BOARD OF DIRECTORS – PART 1

26TH APRIL 2023

Q4 2022/23 Reporting Timescales:

Resources Cttee:	24/03/2023
Executive Leadership Cttee:	19/04/2023
Audit Cttee:	21/04/2023
Quality & Performance Cttee:	24/04/2023
Board of Directors:	26/04/2023

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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	**15** 5x3 CxL	**25** 5x5 CxL	**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	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 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	**15** 5x3 CxL	**25** 5x5 CxL	**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	**12** 4x3 CxL	**16** 4x4 CxL	**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	**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**	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**5** 5x1 CxL
SR07: There is a risk that the proposed change 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	**8** 4x2 CxL	**8** 4x2 CxL	**4** 4x1 CxL
SR08: (**Sensitive Risk**)	**Resources**	**DoSPT**	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**8** 4x2 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	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**5** 5x1 CxL
SR10: (**Sensitive Risk**)	**Resources**	**DoSPT**	**20** 5x4 CxL	**20** 5x4 CxL	**20** 5x4 CxL	**15** 5x3 CxL	**10** 5x2 C&L	**15** 5x3 CxL	**10** 5x2 CxL
SR11: (**Sensitive Risk**)	**Resources**	**DoOps**		**12** 4x3 CxL	**12** 4x3 CxL	**8** 4x2 CxL	**4** 4x1 CxL	**4** 4x1 CxL	**4** 4x1 CxL
SR12: (**Sensitive Risk**)	**Resources**	**DoOps**			**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**4** 4x1 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	15	25	15	15	5
	5x3	5x3	5x3	5x5	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 the Q4 position of this BAF risk has reduced to 15 due to system pressures stabilising across NHS 111, PTS and 999 services that sees an improved performance against ARP standards. The greatest clinical risks are deemed to reside in excessive waits in Category 2 incidents. In addition, national industrial action led to additional significant organisational operational demands and clinical risk. In terms of improvement steps, considerable ongoing focus is required to address worsening hospital handover delays and the harm associated. Significant work continued to increase access to falls services and ensuring referral routes are available via the DOS. The pilot of the joint response with mental health providers in the EOC has demonstrated a positive impact on increased hear and treat.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Quality Performance	**Level 2:** NWAS Quality Account	Reported to BoD (PBM/ 2223/24)
Quality and Operational Metric Surveillance	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Reportable Events Report **Level 2:** HS&S Sub Cttee Chairs Assurance Report **Level 2:** Patient Safety Sub Cttee Chairs Assurance Report **Level 2:** Clinical Effectiveness Sub Cttee Chairs Assurance Report	Reported to BoD (BoD/188) Reported to BoD (PBM/ 2223/90) Reported to Q&P Cttee (QPC/ 2223/196) Reported to Q&P Cttee (QPC/ 2223/196) Reported to Q&P Cttee (QPC/ 2223/196)
Clinical Audit	**Level 2:** 2022/23 Clinical Audit Plan	Reported to Q&P Cttee (QPC/ 2223/189)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework **Level 2:** IPC Sub Cttee Chairs Assurance Report **Level 2:** IPC Annual Report	Reported to Q&P Cttee (QPC/ 2223/53) Reported to Q&P Cttee (QPC/ 2223/196) Reported to Q&P Cttee (QPC/ 2223/97)
Digital Capture and Monitoring of Clinical Outcomes	**Level 2:** Clinical Effectiveness Sub Cttee Chairs Assurance Report	Reported to Q&P Cttee (QPC/2223/196)
Safety Culture	**Level 2:** Q&P Chairs Assurance Report **Level 2:** Plans to improve performance on patient safety & FTSU	Reported to BoD (BoD/2223/59) Reported to BoD (BoD/2223/147&153)
Single Primary Triage	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BoD/2223/147)
Winter Plan	**Level 2:** NWAS Winter Plan	Reported to BoD (BoD/2223/76)
Constant Care Action Plan	**Level 2**: NWAS Operation Constant Care Plan 2022	Reported to ELC (ELC/2223/311)
Duty of Candour	**Level 2:** Duty of Candour Policy **Level 2:** Duty of Candour Implementation Plan	Reported to ELC (ELC/2223/381) Reported to Q&P Cttee (QPC/2223/193)
Learning Disability and Austim Plan	**Level 2:** Learning Disability and Autism Assurance Report	Reported to Q&P Cttee (QPC/2223/145)
Hospital Handover	**Level 2:** System working arrangements established	Reported to Q&P Cttee (QPC/2223/188)
Digital Interoperability	**Level 2:** Digital Strategy Update	Reports to Resources Cttee (RC/2223/143)

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	March 2023	Q&P Cttee	Overdue
Mental Health, Dementia, LD & Autism Strategic Plan	Develop an integrated MH joint review & response model	Dr M Power	March 2023	Q&P Cttee	Overdue
Digital Capture and Monitoring of Clinical Outcomes	Deliver Phase 2 EPR roll out and systems for automating clinical audit	Dr C Grant	2023/24	Q&P Cttee	In Progress
NHS Patient Safety Strategy	Implementation of the Patient Safety Incident Response Framework	Dr M Power Ms A Wetton	September 2023	Q&P Cttee	In Progress
DIGITAL					
Out of Hours Technical Resilience	Development of proposal in conjunction with operations	Dr M Power	March 2023	Audit Cttee	In Progress
Quality & Safety Business Intelligence	Triangulation of data with performance activity to predict key risks	Dr M Power	March 2023	Q&P Cttee	In Progress
Digital Capacity 111 Telephony Capacity	Implementation of SIP Telephony	Dr M Power	March 2024	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
319	Operational/ Patient Safety	There is a risk, due to the lack of a detailed emergency response specification for the use of private ambulance providers in the provision of PES, that variations in provision of drugs and associated training results in difficulties regarding assurance checks and could result in medicines not being administered in accordance with NWAS protocols leading to serious patient safety incidents.	15 High	15 High	⇔	5 Low
328	Operational/ Patient Safety	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.	20 High	20 High	⇩	5 Low
329	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	20 High	⇔	4 Low
378	Operational/ Patient Safety	There is a risk that due to significantly increased demand the Trust will run out of NHS 111 telephony line capacity again, leading to patients not being able to access the service.	25 High	16 High	⇔	4 Low

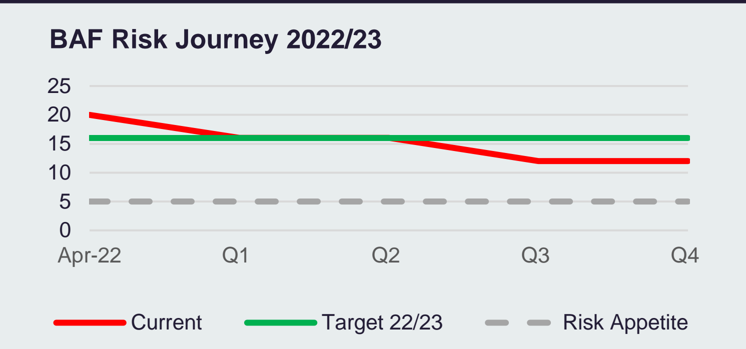
BOARD ASSURANCE FRAMEWORK 2022/23

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	16	12	12	16	8
	4x5	4x4	4x4	4x3	4x3	4x4	4x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Within	Within	Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q4 position of this BAF has remained at a score of 12. The revised and break-even plan was submitted and approved by Board in July with a high efficiency requirement of 4.18%. As at month 11, the latest reported position, financial performance is on plan to achieve the revised forecast of a £4.8m surplus, following the publication of the discount rate in January. The year-to-date surplus is £4.1m. The full efficiency requirement of £15.5m has been identified with £13.7m achieved as at month 11. The recurrent efficiency target of £8.2m has been fully identified.

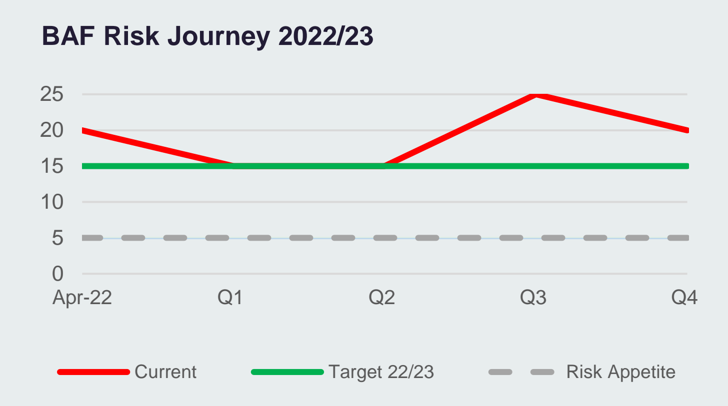
CONTROLS	ASSURANCES	EVIDENCE
Financial Controls	**Level 3:** MIAA Internal Audit: Key Financial Controls	Reported to Audit Cttee (AC 2021/114)
Annual Accounts/ VfM Statement	**Level 3:** Audit Completion Report (ISA 260) **Level 3:** Independent Auditors Report **Level 3:** Audited Annual Accounts 2021/22	Reported to Audit Cttee (AC/ 2223/48 & AC/ 2223/49) Reported to BoD (PBM/ 2223/20 & PBM/ 2223/21)
2022/23 Opening Financial Plans (Revenue and Capital)	**Level 2:** 2022/23 Opening Financial Plans & M01 Financial Position	Reported to Resources Cttee (RC/ 2223/07)
Reviewed 2022/23 Financial Plans	**Level 2:** Update and approval of Financial Plans 2022/23	Reported to BoD and Resources Cttee (RC/2223/28 & PBM/2223/30)
Financial Performance	**Level 2:** M06 Financial Position **Level 2:** M07 Financial Position **Level 2:** M08 Financial Position **Level 2:** M09 Financial Position **Level 2:** M10 Financial Position **Level 2:** M11 Financial Position	Reported to ELC (ELC/ 2223/309) Reported to Resources Cttee (RC/2223/89) Reported to ELC (ELC/2223/391) Reported to Resources Cttee (RC/2223/112) Reported to ELC (ELC/2223/455) Reported to Resources Cttee (RC/2223/129)
2022/23 Planning Guidance from NHSEI	**Level 2:** Update and approval of Financial Plans 2022/23	Reported to BoD and Resources Cttee (RC/2223/28 & PBM/2223/30)
2023/24 Financial Planning	**Level 2:** Receipt of 2023/24 Planning Guidance from NHSEI **Level 2:** Draft 2023/24 Financial Plan (Revenue and Capital) **Level 2:** Approval of 2023/24 financial plans	Reported to Resources Cttee (RC/2223/113) Reported to Resources Cttee (RC/2223/130) Reported to BoD (BoD/2223/84)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	July 2023	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
ERM 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 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	15	25	20	15	5
	5x4	5x3	5x3	5x5	5x4	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 has decreased to 20 due to improvements in call pick up, reduction in activity and improvement in all response standards. There has been a significant reduction in hospital handover times and the Trust has operated at REAP Level 2 predominantly during Q4, only escalated during periods of industrial action. The Trust continues to see the benefits of the implementation of NHS Pathways and has seen significant reductions in C1 and C2 long waits. 111 has seen a stabilisation in call volumes, and whilst not achieving the performance standards the service has performed at maximum capacity for the funded level of activity. Also contract discussions have concluded relating to the PTS contract.

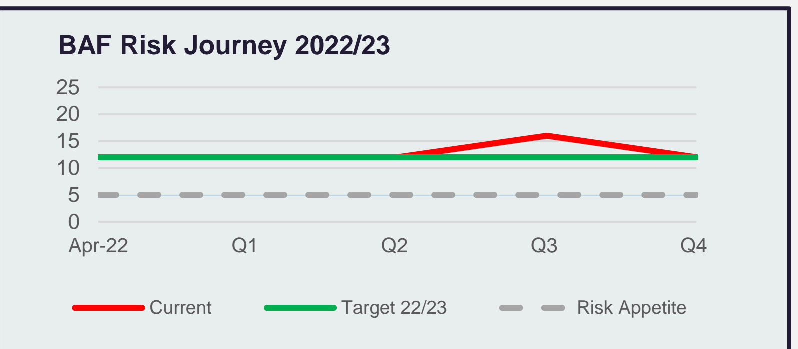
CONTROLS	ASSURANCES	EVIDENCE
Operational Performance Surveillance	**Level 2:** Integrated Performance Report (IPR)	Reported to BoD (BoD/ 2223/147)
Single Primary Triage System	**Level 2:** Integrated Performance Report (IPR) **Level 2:** CEO Board of Directors Report **Level 2:** Deep Dive – 6 month review of SPT & NHS Pathways	Reported to Q&P (Q&P/2223/95) Reported to BoD (BoD/2223/72) Reported to Q&P (Q&P/2223/187)
PTS Contracts	**Level 2:** Engagement with Commissioners surrounding PTS Contracts	Reported to ELC (ELC/2223/506) Reported to QPC (QPC/2223/187)
Alternative Care Pathways	**Level 2:** Integrated Performance Report (IPR) **Level 2:** Single Primary Triage Project/NHS Pathways	Reported to QPC (Q&P/2223/188)
Hospital Handover	**Level 2:** Integrated Performance Report (IPR)	Reported to QPC (Q&P/2223/188)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	April 2023	ELC	In Progress
	Engagement with Commissioners surrouding NHS111 contracts	Mr G Blezard	September 2023	ELC	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve working practices	Mr G Blezard	May 2023	Q&P Cttee	In Progress
	Maximise use of existing resources	Mr G Blezard	2023/24	Q&P Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
327	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	15 High	⬇	5 Low
328	Operational/ Patient Safety	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.	20 High	20 High	⬇	5 Low
378	Operational/ Patient Safety	There is a risk that due to significantly increased demand the Trust will run out of NHS 111 telephony line capacity again, leading to patients not being able to access the service.	25 High	16 High	⬇	4 Low
379	Operational/ Patient Safety	There is a risk that due to the new National Intelligent Routing Platform (IRP) NWAS Digital Team will not be able to fault find or make changes to the 999 telephony platform leading to slower response to telephony issues or outages.	16 High	16 High	⬄	4 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	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	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q4 position of this BAF risk has reduced to a score of 12. During Q4 the industrial action paused and the dates where IA did take place were managed safely. Other workforce indicators linked with safe staffing have improved during the quarter. Robust recruitment and training plans have enabled vacancy gaps to be improved across most service lines. Risk area remains in 111 where attraction challenges have impacted on the vacancy position despite improving turnover. The work of the Attendance Improvement Team also demonstrated impact with sickness rates across the quarter lower than during the same period last year and significant improvements in long term sickness recorded, contributing to improved staffing levels. Turnover has stabilised with improved position seen in the contact centre workforce. Workforce plans already developed and in train for 2023/24 to deliver required growth under the UEC recovery plan.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
Strategic People Plan	**Level 2:** NWAS People Plan	Reported to Resources Cttee (RC/ 2223/12, 2223/86)
Workforce Plan	**Level 2:** Operating Plan Submission	Reported to Resources Cttee (RC/ 2223/07)
Recruitment Delivery Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Strategic Workforce Assurance Report	Reported to Resources Cttee (RC/ 2223/139) Reported to Resources Cttee (RC/2223/141)
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report **Level 2**: Integrated Performance Report	Reported to Resources Cttee (RC/ 2223/139) Reported to BoD (BOD/2223/147)
Attendance	**Level 2:** Thematic Analysis: Attendance Management **Level 2:** Strategic Workforce Assurance Report **Level 2:** Deep Dive:Sickness Absence & Attendance Improvement	Reported to Resources Cttee (RC/ 2223/11) Reported to Resources Cttee (RC/2223/141) Reported to Resources Cttee (RC/2223/109)
Vaccination	**Level 2:** Vaccination Report 2022/23 **Level 2:** Workforce Indicators Report	Reported to BoD & Resources Cttee (RC/2223/68) Reported to BoD & Resources Cttee (RC/2223/139)
Retention	**Level 2:** Strategic Workforce Assurance Report **Level 2:** Deep Dive 111 Retention	Reported to Resources Cttee (RC/ 2223/84)

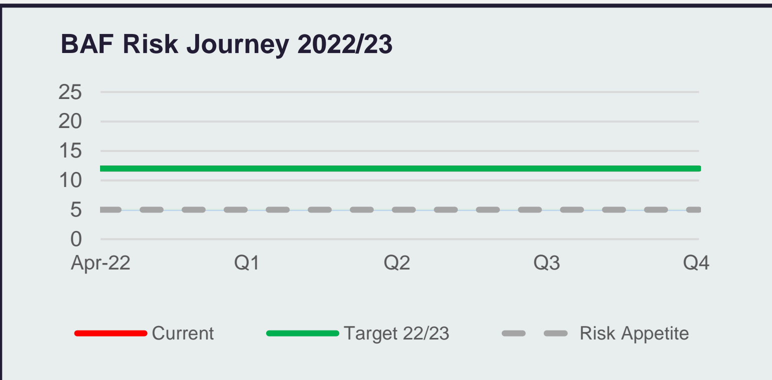
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of Q4 Recruitment Plans	Ms L Ward	May 2023	Resources Cttee	In Progress
Retention Plans	Delivery of Retention Plans	Ms L Ward	May 2023	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR04

Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
317	Operational/ People	Sensitive	20 High	15 High	⇔	10 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	12	12	12	12	4
	4x3	4x3	4x3	4x3	4x3	4x3	4x1
	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 the Q4 position of this BAF risk has maintained at a score of 12. There continues to a good health and wellbeing offer that remains in place and has been further strengthened through additional NHSE funding. The staff survey results for 2022 have shown improvements in key areas related to negative behaviours; line management scores; H&WB; and respect for difference. Overall, the Trust is average or slightly above average on most themes. There is a clear plan for developing work to improve culture and staff experience being implemented as has been reported to Resources Cttee. Key elements of the work have commenced including leadership development roll out, revision to disciplinary policy to embed a just culture approach and equality and inclusion work. Continuing high levels of demand combined with the operational pressures of industrial action and management capacity ahead of the leadership restructure are impacting on the roll out of initiatives and the experience of staff in work on a day-to-day basis, affecting impact.

CONTROLS	ASSURANCES	EVIDENCE
PEOPLE		
People Plan	**Level 2:** People Plan 2022/23 Objectives **Level 2:** People Plan Implementation Plan 2022/23	Reported to Resources Cttee (RC/ 2223/07) Reported to Resources Cttee (RC/ 2223/86)
Appraisals & Wellbeing	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Wellbeing Annual Report **Level 2:** Health and Wellbeing Report	Reported to Resources Cttee (RC/ 2223/39, 2223/67, 2223/85) Reported to Resources Cttee (RC/ 2223/40) Reported to Resources Cttee (RC/2223/87)
CULTURE		
Equality & Diversity Priorities	**Level 2:** EDI Annual Report **Level 2:** D&I Chairs Assurance Report **Level 2:** EDI Assurance Report	Reported to BoD & Resources Cttee (RC/ 2223/14) Reported to Resources Cttee (RC/ 2223/88) Reported to BoD & Resources Cttee (RC/ 2223/69)
Staff Networks	**Level 2:** EDI Annual Report **Level 2:** D&I Chairs Assurance Report	Reported to BoD & Resources Cttee (RC/ 2223/14) Reported to Resources Cttee (RC/ 2223/88)
Just Culture & Treat Me Right	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Trust Disciplinary Policy Review **Level 2:** Workforce Indicators Report	Reported to Resources Cttee (RC/ 2223/85) Reported to Board of Directors (BoD/2223/152) Reported to Resources Cttee (RC/2223/110
Violence and Aggression	**Level 2:** Violence and Aggression Assurance Report	Reported to Q&P Cttee (QPC/ 2223/52)
Leadership	**Level 2:** Strategic Workforce Assurance Report	Reported to Resources Cttee (RC/2223/41, 2223/70, 2223/141)
Implementation of Phase 1 Management Restructure	**Level 2:** Strategic Updates and Proposals to ELC	Reported to ELC (ELC/2223/231)
EDI Priorities Review of Delivery Year 1 Action Plans (Workforce Elements)	**Level 2:** EDI Statutory and Regulatory Reporting	Reported to Resources Cttee (RC 2223/69)
Freedom to Speak Up (FTSU) Delivery of Agreed Actions	**Level 2:** Freedom to Speak Up Bi-Annual Report **Level 2:** Staff Survey Result & Speak Up Review of Ambulance Services	Reported to BoD (BoD/ 2223/95) Reported to BoD (BoD/ 2223/153)
Trailblazer for National Health and Wellbeing Framework	**Level 2:** Progress against Wellbeing Guardian Principles and National Health and Wellbeing Commitments	Reported to Resources Cttee (RC/2223/87)

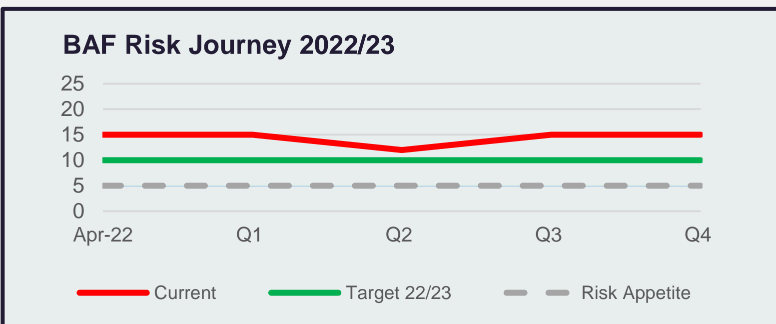
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Medical Management Restructure	Implementation of Operational & Clinical management Restructure	Mr G Blezard Ms L Ward	September 2023	ELC	In Progress
EDI Priorities	Review delivery of Year 2 Action Plans (Workforce Elements)	Ms L Ward	May 2023	Resources Cttee	In Progress
Fully Embedding Just Culture Principles	Implementation of Disciplinary Procedure	Ms L Ward	April 2023	Resources Cttee	In Progress
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	April 2023	ELC	In Progress
Wellbeing	Implementation of mental health pledge and AACE commitment	Ms L Ward	2023/24	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	March 2024	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR05

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 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	22/23 Target	Final Target
	15	15	10	15	15	10	5
	5x3	5x3	5x2	5x3	5x3	5x2	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 the Q4 position of this BAF risk has remained at 15 due to continued pressures on assurance reporting and checks and the compliance findings from the review of Duty of Candour.
Further ARP performance is still not meeting standards despite the CQC 'should do' for improvement in this area following the recent inspection. A revised Duty of Candour Policy has been approved and training delivered. However, a review of completion rates for Q4 did demonstrate gaps. An improvement implementation plan has been approved. A review of safety checks has been completed and the development of Safecheck2.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY & SAFETY		
CQC Overall Rating of 'Good'	**Level 3:** CQC Inspection Report	Reported to BoD (2020)
CQC UEC System Inspection	**Level 2:** CQC Assurance Report	Reported to BoD (BoD/ 2223/37)
Prevention and Control of Infection	**Level 2:** IPC Board Assurance Framework	Reported to Q&P Cttee (QPC/ 2223/53)
Complaints & Incidents	**Level 2:** Integrated Performance Report	Reported to Q&P Cttee (QPC/2223/95) Reported to Board (BOD/2223/73)
Medical Devices	**Level 2:** CESC Chairs Assurance Report	Reported to Q&P Cttee (QPC/2223/149)
PEOPLE		
People Plan	**Level 2:** People Plan 2022/23 Objectives	Reported to Resources Cttee (RC/ 2223/07)
People Metric Surveillance	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2223/13, 2223/139)
Mandatory Commander Competencies	**Level 2:** Mandatory Commander Training Assurance Report **Level 2**: EPRR Assurance Report **Level 2:** EPRR Sub Committee Chairs Assurance Report	Reported to Q&P Cttee (QPC/2223/26) Reported to Q&P Cttee (QPC/2223/164) Reported to Q&P Cttee (QPC/2223/165)
Mandatory and Statutory Training Compliance (75%)	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2223/39)
Appraisals Compliance (80%)	**Level 2**: Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2223/139)
Quality and Safety Metrics (Complaints and Incidents)	**Level 2:** Complaints and Incidents Assurance Report	Reported to Q&P Cttee (QPC/2223/166&167)
Learning from IPC and RPE Audits	**Level 2:** IPC BAF **Level 2:** IPC Chairs Assurance Report	Reported to BoD (BOD/2223/122) Reported to Q&P Cttee (QPC/2223/196)
Clinical Audit Submissions (Development of APEX tool)	**Level 2:** Integrated Performance Report	Reported to BoD (BoD/2223/121)

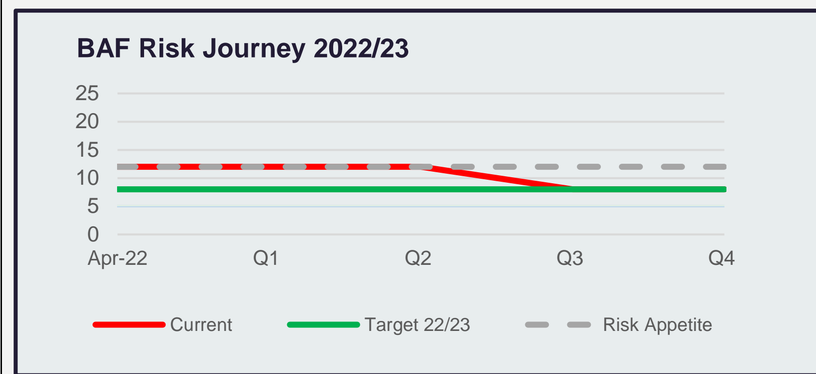
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Quality Assurance Processes	Redesign of Quality Assurance Visits	Dr M Power	March 2024	Q&P Cttee	In Progress
Essential Checks	Improve compliance around essential vehicle and premises checks	Mr G Blezard Ms C Wood	September 2023	Q&P Cttee	In Progress
Clinical Audit Submissions	Undertake a review of all clinical audits including AGP	Dr M Power	March 2023	Q&P Cttee	In Progress
Electronic Quality Measurement Auditing/ Reporting Systems	Develop automated systems for non-clinical audits	Dr M Power	September 2023	Q&P Cttee	In Progress
PEOPLE					
Mandatory Training Compliance	Achieve 85% compliance	Ms L Ward	March 2023	Resources Cttee	Complete

Operational Risks Scored 15+ Aligned to BAF Risk: SR06

Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
304	Reputational/ Clinical Effectiveness	There is a risk that capacity constraints within the Digital team mean that new ACQI for 'Older people Falls not conveyed' is not included within phase 1 of APEX, and will lead to non-completion and non-submission of clinical audit information and participation within national quality frameworks meaning non-compliance with national clinical reporting standards.	12 Moderate	15 High	⇔	5 Low
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low
328	Operational/ Patient Safety	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.	**20** High	**20** High	⇩	**5** Low
329	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	**20** 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	12	12	8	8	8	4
	4x3	4x3	4x3	4x2	4x2	4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Within	Within	Within	Within	Within	Below

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q4 position of this BAF risk has remained at a score of 8 due to the trust working effectively across the ICS areas. However, the gaps in control remain because we do have reliable or consistent use of the knowledge vault and compliance remains a challenge. Stakeholder mapping – we have undertaken a mapping exercise across the trust which has enabled each area to identify their key external meetings and representatives. To date, we have no assurance that attendance is happening as the recording of information is not being provided.

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)
ICS		
Involvement in ICS Structures	**Level 2:** P&I Team involved in establishing relationships	Reported to BoD (BOD/2122/97) & (BOD/2122/98)
Involvement in ICS Structures	**Level 2:** P&I Team involved in establishing relationships	Reported to BoD (BOD/2122/97) & (BOD/2122/98)

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	Q2 2023/24	Resources Cttee	In Progress
	Familiarisation sessions for managers across all three areas of the Trust	Mr S Desai	Q2 2023/24	Resources Cttee	In Progress
Stakeholder Mapping	Refresh stakeholder mapping across the Trust for external meetings	Mr S Desai	Q2 2023/24	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						

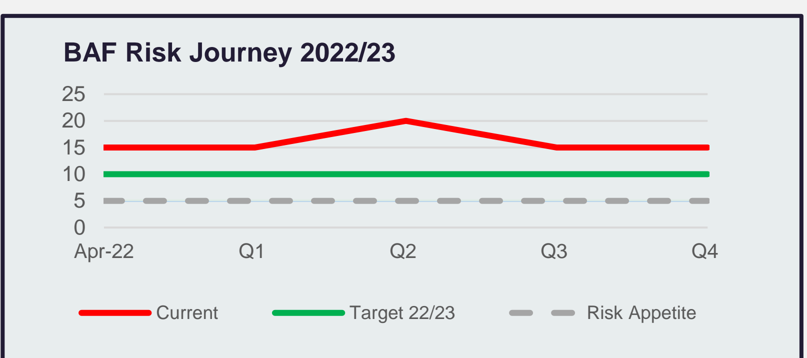
BOARD ASSURANCE FRAMEWORK 2022/23

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	20	15	15	10	5
	5x3	5x3	5x4	5x3	5x3	5x2	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 the Q4 position of this BAF risk has remained at 15. Patching compliance remains high, with good oversight of cyber controls. There continues to be a high threat of a cyber-attacks, which is based on global cyber activity and threat levels. Digital change and development has increased our attack surface, however controls are in place and monitored through the Trust's Information Governance Sub Committee. The baseline submission for DSPT was completed and roles to increase specialist expertise were recruited to, however, information governance training compliance remains below the expected standard. The Trust continues to be responsive to nationally issued guidance and is progressing the cyber security work plan. Multifactorial authentication has concluded with deployment across the Trust and completion in Q2. A new backup solution has been implemented and our focus remains on closing the small number of unsupported servers.

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/ 2223/16)
Patching	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2223/16)
Penetration Testing	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2223/16)
Monitoring and Surveillance	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/ 2223/16)
Additional Back-ups	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (AC/2223/42)
Access Controls Multi factoral Authentication (email)	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (AC/2223/42)
Develop business case for 24/7 support	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2223/72)
Business Continuity Team to desktop worst case scenario	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2223/72)
Critical System Security	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2223/143)
Supported Systems	**Level 2:** Digital Strategy Assurance Report	Reported to Resources Cttee (RC/2223/143)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Supported Systems	Decomission unsupported servers	Dr M Power	June 2023	Audit Cttee	Overdue
	Upgrade windows operating systems to within a supported 12 month version	Dr M Power	June 2023	Audit Cttee	In Progress
	Replacement of all system using SQL 2008 and 2008 R2	Dr M Power	June 2023	Audit Cttee	In Progress
Patching (999 and NHS 111)	Enable monthly failover & patching opportunities	Dr M Power	May 2023	Audit Cttee	In Progress

Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Dr M Power	March 2024	Audit Cttee	In Progress
	Implement findings from DSPT Audit findings	Dr M Power	May 2023	Audit Cttee	In Progress
Out of Hours Resilience	Implement recommendations from desktop worst case scenario	Dr M Power	December 2023	Audit Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR09

ERM ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
330	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
331	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

Q4 Position

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 SR01, SR03, SR06, SR09	20 SR10	25
4 Major	4	8	12 SR04, SR05, SR07, SR08, SR11	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: 08 July 2022 — Likelihood

Q2 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR01, SR03, SR12	20 SR09, SR10	25
4 Major	4	8	12 SR04, SR05, SR06, SR07, SR08, SR11	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: — Likelihood

Q3 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15 SR06, SR09, SR10, SR12	20	25 SR01, SR03
4 Major	4	8 SR07, SR08, SR11	12 SR02, 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: — Likelihood

Q4 BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10 SR10	15 SR01, SR06, SR09, SR12	20 SR03	25
4 Major	4 SR11	8 SR07, SR08	12 SR02, SR04, SR05	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

Populated: 14 April 2023 — Likelihood

2022/23 Target BAF Risk Scores

Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10 SR06, SR09	15 SR01, SR03, 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, SR09	10 SR10	15	20	25
4 Major	4 SR04, SR05, SR07, SR08	8 SR02	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: 11 April 2022 — Likelihood

REPORT TO BOARD OF DIRECTORS

DATE:	26th April 2023				
SUBJECT:	2023-24 Board Assurance Framework Opening Position				
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 2023/24 Opening Position for the BAF risks with associated CRR risks scored ≥15 can be viewed in **Appendix 1**. The following proposed opening risk scores have been identified as follows: • SR01 opening risk score of 15 • SR02 opening risk score of 16 • SR03 opening risk score of 20 • SR04 opening risk score of 16 • SR05 opening risk score of 12 • SR06 opening risk score of 10 • SR07 opening risk score of 8 • SR08 opening risk score of 15 • SR09 opening risk score of 1				
RECOMMENDATIONS:	The Board of Directors are requested to: • Approve the opening position of the 2023-24 Board Assurance Framework				
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☒ Quality Outcomes ☒ People ☒ Financial / Value for Money ☒ Reputation ☒ Innovation				

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
	ELC and Audit Committee			

PREVIOUSLY CONSIDERED BY:	Date:	19th April 2023 and 21st April 2023
	Outcome:	Recommended to Board for Approval

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1. PURPOSE

This paper provides the opportunity for the Board of Directors to review the 2023/24 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 ensures that any systems and controls that are in place are adequate to mitigate any significant risk which may threaten the achievements of the strategic objectives.

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

3. REVIEW OF THE STRATEGIC RISKS 2023/24 OPENING POSITION

The proposed 2023/24 Strategic Risks have already been agreed at the March Board of Directors meeting, however, this paper details the opening position of the BAF with associated Corporate Risks – the BAF can be viewed in full in Appendix 1.

SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction

Opening Score 01.04.2023	Exec Lead
15 5x3 CxL	Dr C Grant (Medical Director)

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

- Demand levels have reduced, with improved safety measures within the emergency operations environment during Q4 2022/23.
- The ongoing and developing work to strengthen the Trusts position in relation to safety, effectiveness and experience of patients and developing an open culture.

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

Opening Score 01.04.2023	Exec Lead
16 4x4 CxL	C Wood (Director of Finance)

This risk has been scored at a 16 following review, with the following rationale applied by the Executive Lead:

- Financial plan submitted however there are risks within the plan as contracts have not been signed and there remains the significant financial gap within the host ICS.
- Efficiency requirement is £12.2m with £4.3m to be identified in year and £6.0m recurrently.

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

Opening Score 01.04.2023	Exec Lead
20 5x4 CxL	G Blezard (Director of Operations)

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

- Delivery of national ARP standards remains challenged with only one of seven targets being met.
- Increase in hospital handover times
- Delivery of the UEC recovery plan will take time with benefits not realised until later in the financial year.
- Discussions to commence regarding the 111 contract which is due for renewal in September 2023.

SR04: There is a risk that the Trust will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualified staff impacting adversely on delivery of performance standards and patient outcomes

Opening Score 01.04.2023	Exec Lead
16 4x4 CxL	L Ward (Director of People)

This risk has been scored at a 16 following review, with the following rationale applied by the Executive Lead:

- Delivery of ambitious recruitment and training plans across all service lines due to key UEC Recovery targets.
- Staffing levels will remain lower than the funded establishment until the plans are realised.
- Challenges in terms of the recruitment market remain.
- Opportunity for further investment in the Attendance Improvement Team as a result of the UEC funding, with plans to be implemented.

SR05: There is a risk that the Trust does not deliver its People Strategy to improve its culture and staff engagement and this impacts on NWAS being a brilliant place to work

Opening Score 01.04.2023	Exec Lead
12 4x3 CxL	L Ward (Director of People)

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

- Results from the Staff Survey 2022 indicate progress across a number of indicators.
- The Trust is average or slightly above average for the sector against the key People Promise themes.
- Improvement work being undertaken in a number of areas

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

Opening Score 01.04.2023	Exec Lead
10 5x2 CxL	Dr M Power (Director of Quality Innovation & Improvement)

This risk has been scored at a 10 following review, with the following rationale applied by the Executive Lead:

- Trust currently at REAP Level 2 with sufficient capacity forecast to ensure completion of safety checks and assurance visits.
- ARP performance improved in line with regulatory 'should dos'.
- Enhanced ongoing IPC standards for control and cleaning due to new national IPC guidance.
- Improvement as a result of actions to resolve Duty of Candour, NRLS data uploads and Controlled Drugs risks remain on track.
- Testing of draft dashboards for tyre checks, medicines and IPC within PowerBI and ongoing work with APEX for submission of national ACQIs.
- Fit testing processes in place with resources in place to sustain new ways of working.

SR07: There is a risk that the Trust does not work together with our partners in the health and social care system to shape a better future leading to poor effects on our communities and the environment

Opening Score 01.04.2023	Exec Lead
8 4x2 CxL	S Desai (Deputy CEO/Director of Strategy, Planning & Transformation)

This risk has been scored at an 8 following review, with the following rationale applied by the Executive Lead:

- Area teams to work closer with partnership organisations shaping external service delivery processes and ensure constructive dialogue is held with partners at the right level.
- Important to evidence external engagement with partners in the health and social care system; this should be included in the Knowledge Vault as assurance.
- Compliance challenges in 2 of the 3 areas of the Trust.

SR08: There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm

Opening Score 01.04.2023	Exec Lead
15 5x3 CxL	Dr M Power (Director of Quality Innovation & Improvement)

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

- Continued high threat of cyber-attacks based on global cyber activity and threat levels.
- Digital change development has increased the Trust's attack surface, controls are in place and monitored through the Information Governance Sub Committee.
- Information governance training compliance below expected standard.

SR09: There is a risk that the Trust continues to attract negative media attention arising from long delays and harm leading to significant loss of public confidence

Opening Score 01.04.2023	Exec Lead
10 5x2 CxL	S Desai (Deputy CEO/Director of Strategy, Planning & Transformation)

This risk has been scored at a 10 following review, with the following rationale applied by the Executive Lead:

- The constant risk of negative media attention arising from long delays and potential harm that requires annual communications plans to respond to seasonal and other demands.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS ***(including consideration of the Trust's Risk Appetite Statement)***

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

- Approve the opening position of the 2023-24 Board Assurance Framework.

BOARD ASSURANCE FRAMEWORK 2023/24

BOARD OF DIRECTORS – PART 1

26TH APRIL 2023

Q1 2023/24 Reporting Timescales:

Executive Leadership Cttee:	19/07/2023
Audit Cttee:	21/07/2023
Resources Cttee:	21/07/2023
Quality & Performance Cttee:	24/07/2023
Board of Directors:	26/07/2023

BOARD ASSURANCE FRAMEWORK KEY

Risk Rating Matrix (Likelihood x Consequence)

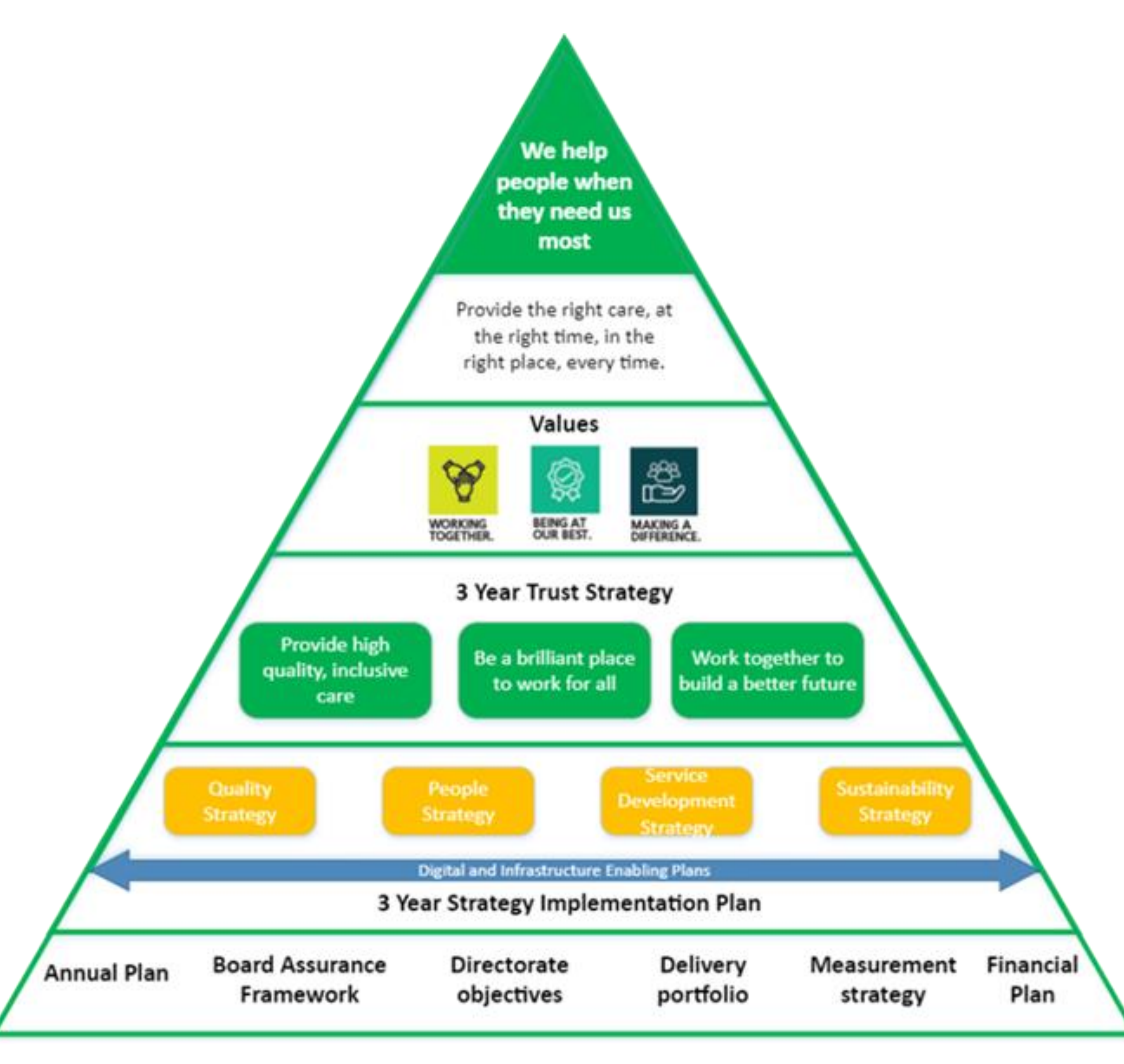
Consequence ↓	Likelihood → Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5	5 Low	10 Moderate	15 High	20 High	25 High
Major 4	4 Low	8 Moderate	12 Moderate	16 High	20 High
Moderate 3	3 Low	6 Moderate	9 Moderate	12 Moderate	15 High
Minor 2	2 Low	4 Low	6 Moderate	8 Moderate	10 Moderate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

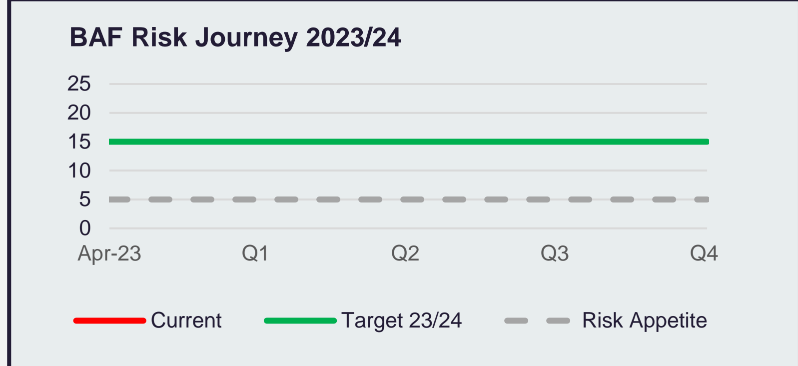
BAF Risk	The title of the strategic risk that threatens the achievement of the aligned strategic priority				
Rationale for Current Risk Score	This narrative is updated on a quarterly basis and provides a summary of the information that has supported the assessment of the BAF risk				
Risk Appetite	The 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


We help people when they need us most
Provide the right care, at the right time, in the right place, every time.
Values
WORKING TOGETHER.
BEING AT OUR BEST.
MAKING A DIFFERENCE.
3 Year Trust Strategy
Provide high quality, inclusive care
Be a brilliant place to work for all
Work together to build a better future
Quality Strategy
People Strategy
Service Development Strategy
Sustainability Strategy
Digital and Infrastructure Enabling Plans
3 Year Strategy Implementation Plan
Annual Plan
Board Assurance Framework
Directorate objectives
Delivery portfolio
Measurement strategy
Financial Plan

BOARD ASSURANCE FRAMEWORK DASHBOARD 2023/24									
BAF Risk	Committee	Exec Lead	01.04.23	Q1	Q2	Q3	Q4	2023/24 Target	Final Target
SR01: There is a risk that the Trust does not provide high quality, inclusive 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 high quality (safe and effective) services	**Resources**	**DoF**	**16** 4x4 CxL					**12** 4x3 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 maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualified staff impacting adversely on delivery of performance standards and patient outcomes	**Resources**	**DoP**	**16** 4x4 CxL					**8** 4x2 CxL	**4** 4x1 CxL
SR05: There is a risk that the Trust does not deliver its People Strategy to improve its culture and staff engagement and this impacts on NWAS being a brilliant place to work.	**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**	**10** 5x2 CxL					**10** 5x2 CxL	**5** 5x1 CxL
SR07: There is a risk that the Trust does not work together with our partners in the health and social care system to shape a better future leading to poor effects on our communities and the environment	**Resources**	**DoSPT**	**8** 4x2 CxL					**4** 4x2 CxL	**4** 4x1 CxL
SR08: There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm	**Resources**	**DoQII**	**15** 5x3 CxL					**10** 5x2 CxL	**5** 5x1 CxL
SR09: There is a risk that the Trust continues to attract negative media attention arising from long delays and harm leading to significant loss of public confidence	**Resources**	**DoSPT**	**10** 5x2 CxL					**10** 5x2 CxL	**10** 5x2 CxL
SR10: (**Sensitive Risk**):	**Resources**	**DoSPT**	**16** 4x4 CxL					**12** 4x3 CxL	**8** 4x2 CxL

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Executive Director Lead:** MD
	Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 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: There is a clear link between operational performance (SR03) and safety, effectiveness and patient experience. This BAF risk is scored in the context of the current levels of reduced demand and improved safety measures in the emergency operations environment in Q4 (2022-23). The score reflects the ongoing work required to further develop and strengthen the safety, effectiveness and experience of our patients, working with our staff to ensure that they are working in an open culture, where they feel free to speak up and where they are assured that actions are taken. The opening position reflects the work required in year to further strengthen our position.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Patient Safety Strategy	Implement PSIRF and family engagement officers for Duty of Candour Patient safety partners	A Wetton / Dr M Power	September 2023	Q&P Cttee	In Progress
Safety Culture	Devise a plan to improve performance on safety culture & F2SU	Dr M Power Dr C Grant	March 2024	Q&P Cttee	In Progress
Learning	Establish an integrated regional learning forum & evaluate effectiveness of area forums	Dr M Power	March 2024	Q&P Cttee	In Progress
Improvement	Improvement plan linked to safety and quality learning (PSIRF)	Dr M Power	January 2024	Q&P Cttee	In Progress
Safety Education	Training needs analysis for safety science training	Dr M Power/ Lisa Ward	December 2024	Q&P Cttee	In Progress
Mental Health Plan	Deliver the NWAS mental health plan	Dr M Power	March 2024	Q&P Cttee	In Progress
Midwifery Plan	Deliver the NWAS Midwifery Plan	Dr M Power	March 2024	Q&P Cttee	In Progress
Medicines management	Scope and procure a medicines management platform for increased oversight	Dr C Grant	March 2024	Q&P Cttee	In Progress
DIGITAL					
Digital Capacity 111 Telephony Capacity	Implementation of SIP Telephony	Dr M Power	March 2024	Resources Cttee	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
319	Operational/ Patient Safety	There is a risk, due to the lack of a detailed emergency response specification for the use of private ambulance providers in the provision of PES, that variations in provision of drugs and associated training results in difficulties regarding assurance checks and could result in medicines not being administered in accordance with NWAS protocols leading to serious patient safety incidents.	15 High	15 High	⇔	5 Low
328	Operational/ Patient Safety	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.	20 High	20 High	⇩	5 Low
378	Operational/ Patient Safety	There is a risk that due to significantly increased demand the Trust will run out of NHS 111 telephony line capacity, leading to patients not being able to access the service and the resilient lines built in being in use.	25 High	16 High	⇔	4 Low
379	Operational/ Patient Safety	There is a risk that due to the new National Intelligent Routing Platform (IRP) NWAS Digital Team will not be able to fault find or make changes to the 999 telephony platform leading to slower response to telephony issues or outages.	16 High	16 High	⇔	4 Low

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR02: There is a risk that the Trust cannot achieve financial sustainability impacting on its ability to deliver high quality (safe and effective) services	**Executive Director Lead:**	DoF
	Risk Appetite Category: Finance/ VfM – Moderate	

BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	16					12	8
	4x4					4x3	4x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded					Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF risk is scored at a 16. Whilst a balanced financial plan has been submitted there is still risk within the plan as contracts are yet to be signed and there remains a significant financial gap within the host ICS. The efficiency requirement is £12.2m with £4.3m still to be identified in year and £6.0m recurrently.

CONTROLS	ASSURANCES	EVIDENCE
Opening 2023/24 Financial Plans	**Level 2:** 2023/24 Financial Plan Update **Level 2:** Approval of 2023/24 financial plans	Reported to Resources Cttee (RC/2223/130) Reported to BoD (BoD/2223/84)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
Product and Efficiency Oversight Forum	Establishment of the Product and Efficiency Oversight Forum	Ms C Wood	July 2023	Resources Cttee	In Progress
Recurrent Funding	Recurrent funding requirement for PES and 111 to deliver safe & effective services	Ms C Wood	May 2023	Resources Cttee	In Progress
2024/25 Financial Planning	Receipt of 2024/25 planning guidance from NHSE	Ms C Wood	January 2024	Resources Cttee	Not Commenced
	Draft 2024/25 Financial Plan (Revenue & Capital)	Ms C Wood	March 2024	Resources Cttee / BoD	Not Commenced
	Approval of 2024/25 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2024	Resources Cttee / BoD	Not Commenced

Operational Risks Scored 15+ Aligned to BAF Risk: SR02

ERM ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
317	Operational/ People	Sensitive	20 High	15 High	⇔	10 Moderate

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care	**Executive Director Lead:**	DoOps
	Risk Appetite Category: Quality Outcomes – Low	

BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 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 delivery of the national ARP standards is still challenging with only one of the seven currently being met. Hospital handover have increased over recent weeks and are nearing 40 minutes on average. The delivery of the UEC recovery plan will take a substantial amount of time and the benefits will not materialise until later in the financial. Only investment in 999, no investment in 111, discussions need to commence around 111 contract which is due for renewal in September 2023.

CONTROLS	ASSURANCES	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recurrent Financial Gap	Engagement with Commissioners	Mr G Blezard	April 2023	ELC	In Progress
	Engagement with Commissioners surrouding NHS111 contracts	Mr G Blezard	September 2023	ELC	In Progress
Service Delivery Model Review	Delivery of SDMR project to improve working practices	Mr G Blezard	May 2023	Q&P Cttee	In Progress
	Maximise resources to the most efficient level	Mr G Blezard	2023/24	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff	Robust recruitment plan to be delivered	Mr G Blezard Mrs L Ward	March 2024	Q&P Cttee	Not commenced
Reduce Hospital Handovers	Hospital handover collaborative with ICBs	Mr G Blezard Dr M Power	March 2024	Q&P Cttee	In Progress
Improve Hear and Treat Performance	Improve Hear and Treat Performance from 15% to 20%	Mr G Blezard	March 2024	Q&P Cttee	Not commenced

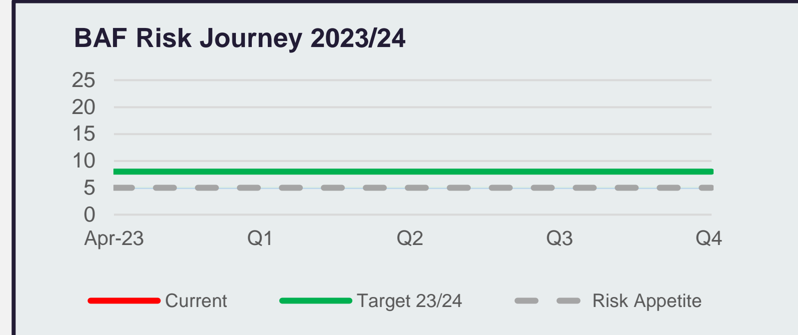
Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
327	Operational/ Performance	There is a risk that due to increases in operational demand, limited resource and processes the existing operating model for NWAS may be ineffective resulting in delayed patient response and inability to achieve ARP standards.	25 High	15 High	↓	5 Low
328	Operational/ Patient Safety	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.	20 High	20 High	↓	5 Low

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR04:
There is a risk that the Trust will be unable to maintain safe staffing levels through effective attraction, retention and attendance of sufficient suitably qualified staff impacting adversely on delivery of performance standards and patient outcomes

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	16					8	4
	4x4					4x2	4x1
	CxL				CxL	CxL	CxL
Risk Appetite	Exceeded					Within	Within

RATIONALE FOR CURRENT RISK SCORE:
Whilst the overall vacancy position at the end of 2022/23 was under 5% (PES 1%), the Trust has been advised of further investment growth linked directly to the delivery of key UEC Recovery targets. These targets will require the delivery of ambitious recruitment and training plans across all service lines. Plans are in place and in the process of being implemented but until progress is made on delivery, staffing levels will remain much lower than funded establishment, and a challenging recruitment market remains in place, hence the opening risk position of 16. In addition, an ambitious reduction in sickness absence of 1.8% is targeted for the year. The Attendance Improvement team remains in place with the opportunity for further investment as a result of UEC funding but these plans are still to be implemented.

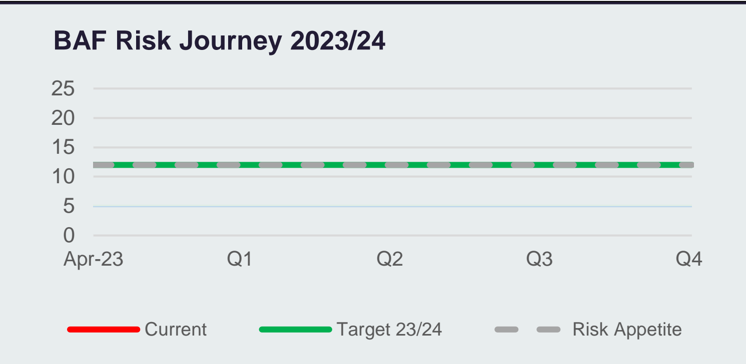
CONTROLS	ASSURANCES	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of Q4 Recruitment Plans	Ms L Ward	May 2023	Resources Cttee	In Progress
	Delivery of UEC recovery growth	Ms L Ward	March 2024	Resources Cttee	In Progress
	Delivery of international recruitment targets	Ms L Ward	March 2024	Resources Cttee	In Progress
Retention Plans	Delivery of Retention Plans	Ms L Ward	May 2023	Resources Cttee	In Progress
Attendance	Delivery of AIT improvement plans	Ms L Ward	March 2024	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

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR05: There is a risk that the Trust does not deliver its People Strategy to improve its culture and staff engagement and this impacts on NWAS being a brilliant place to work.	**Executive Director Lead:**	DoP
	Risk Appetite Category: People - Moderate	



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	12					12	4
	4x3					4x3	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within					Within	Within

RATIONALE FOR CURRENT RISK SCORE:
2022 staff survey results indicate progress has been made across a range of indicators and that overall the Trust is average or slightly above average for the sector against the key People Promise themes. There are a number of pieces of work in progress which will contribute to improvement including the Making a Difference leadership programme, the revised disciplinary policy and equality and inclusion work but further work is required to continue to improve the position.

CONTROLS	ASSURANCES	EVIDENCE

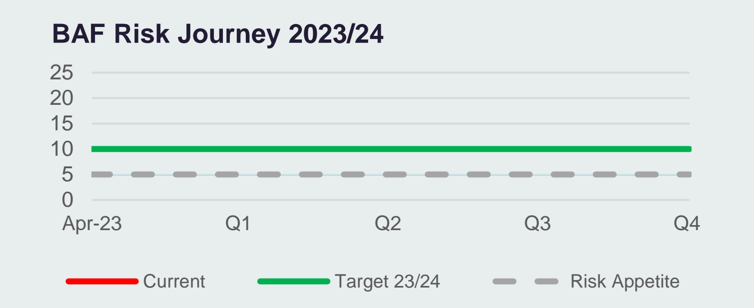
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Medical Management Restructure	Implementation of Operational & Clinical management Restructure	Mr G Blezard Ms L Ward	September 2023	ELC	In Progress
EDI Priorities	Review delivery of Year 2 Action Plans (Workforce Elements)	Ms L Ward	May 2023	Resources Cttee	In Progress
Fully Embedding Just Culture Principles	Implementation of Disciplinary Procedure	Ms L Ward	April 2023	Resources Cttee	In Progress
Partnership Agreement	Review of Partnership Agreement	Ms L Ward	April 2023	ELC	In Progress
Wellbeing	Implementation of mental health pledge and AACE commitment	Ms L Ward	2023/24	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	March 2024	Resources Cttee	In Progress
Recruitment Plans	Delivery of Q4 Recruitment Plans	Ms L Ward	May 2023	Resources Cttee	In Progress
	Delivery of UEC recovery growth	Ms L Ward	March 2024	Resources Cttee	In Progress
	Delivery of international recruitment targets	Ms L Ward	March 2024	Resources Cttee	In Progress
Retention Plans	Delivery of Retention Plans	Ms L Ward	May 2023	Resources Cttee	In Progress
Attendance	Delivery of AIT improvement plans	Ms L Ward	March 2024	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR05

Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Executive Director Lead:**	DoQII
	Risk Appetite Category: Compliance & Regulatory – Low	



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	10					10	5
	5x2					5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within					Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening Q1 position of this BAF risk is 10. This score is due to REAP Level 2 and sufficient capacity being forecast to ensure completion of safety checks and assurance visits planned during the quarter including rectification actions. Whilst the ARP performance remains pressured it improved against previous quarters inline with regulatory 'should do's'. New national guidance for IPC has been developed ensuring ongoing IPC standards for control and cleaning can be enhanced, again responding to the 'should do' in this area of work. Actions to resolve Duty of Candour, NRLS data uploads and Controlled Drugs risks remain on track and improvement has been noted. Draft dashboards for tyre checks, medicines and IPC are in user-testing within PowerBI, and work continues with APEX for submission of the national ACQIs. Fit testing processes are working well and resources to sustain the new ways of working are now in place. New assurance and reporting structures from the service lines following the service review are now in place.

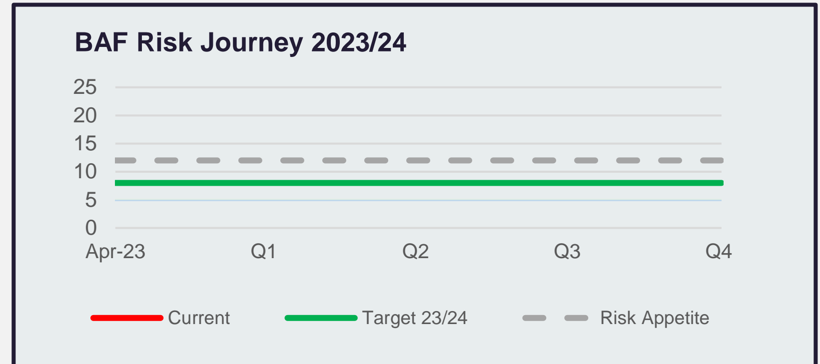
CONTROLS	ASSURANCES	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Quality Assurance Processes	Redesign of Quality Assurance Visits and other safety checks and systems to align with new regulatory model	Dr M Power	March 2024	Q&P Cttee	In Progress
Clinical Audit Submissions (Regulation 17)	Development of APEX tool to ensure new e-PRF can be audited	Dr C Grant Dr M Power	June 2023	Q&P Cttee	In Progress
Controlled Drugs and Medicines Management	Review and refresh all medicines and controlled drugs policies and procedures and monitor compliance.	Dr C Grant	March 2024	Q&P Cttee	In Progress
Duty of Candour	Ongoing compliance monitoring and reporting to strengthen position	Dr M Power	September 2023	Q&P Cttee	In Progress
Essential Checks	Improve compliance around essential vehicle and premises checks	Mr G Blezard Ms C Wood	September 2023	Q&P Cttee	In Progress
Fit Testing	Establish internal fit testing team and maintain compliance	DIPC	December 2024	Q&P Cttee	Not commenced
Compliance to Essential Checks	Improve compliance on tyre and medicines checks in safecheck to 90%	G Blezard	March 2024	Q&P Cttee	In Progress
Information Governance	Improve compliance on mandatory training to 95%	Dr M Power L Ward	March 2024	Resources Cttee	In Progress
Electronic Quality Measurement Auditing/Reporting Systems	Develop automated systems for non-clinical audits	Dr M Power	September 2023	Q&P Cttee	In Progress
PEOPLE					
Mandatory Training Compliance	Achieve 85% compliance	Ms L Ward	March 2023	Resources Cttee	Complete

Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where controlled drugs (CDs) are stored, the Trust will breach Home Office licence security requirements resulting in subsequent enforcement action and/or removal of the licence leading to a significant adverse impact in the Trust's ability to provide emergency care.	15 High	15 High	⇔	5 Low
329	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	**20** High	⇔	**4** Low

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR07: There is a risk that the Trust does not work together with our partners in the health and social care system to shape a better future leading to poor effects on our communities and the environment	**Executive Director Lead:**	DoSPT
	Risk Appetite Category: Reputation – Moderate	



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	8					4	4
	4x2					4x1	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within					Below	Below

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position is a risk score of 8. Area teams need to work more closely with partner organisations to shape external service delivery processes as well as ensuring we have constructive dialogue with partners at the right level. A mapping exercise was conducted in 2022 and each area is aware of the external meetings that require attendance. It is also important to evidence the external engagement with partners in the health and social care system and for this should be recorded in the Knowledge Vault as assurance for the trust. There are compliance challenges in 2 of the 3 areas of the trust.

CONTROLS	ASSURANCES	EVIDENCE
NWAS		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Knowledge Vault	Utilisation of the KV by all three areas of the Trust	Mr S Desai	Q2	Resources Cttee	In Progress
External Engagement Assurance	Service Delivery areas to provide evidence that important external meetings are being attended	Mr S Desai	Q2	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07

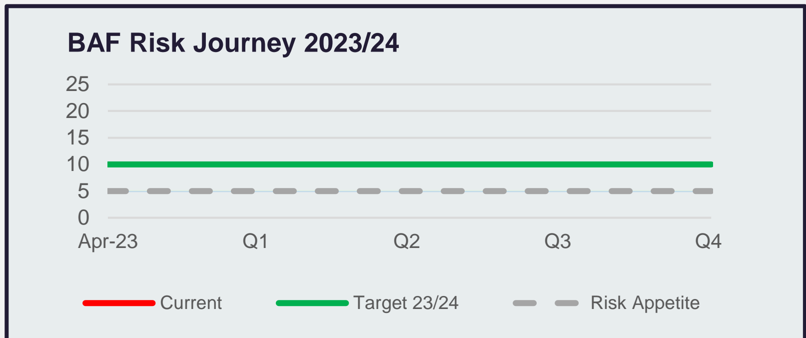
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR08:
There is a risk the Trust suffers a major cyber incident due to persistent attempts and/or human error resulting in a partial or total loss of service and associated patient harm

Executive Director Lead: DoQII

Risk Appetite Category: Compliance/Regulatory - Low



BAF RISK SCORE JOURNEY:

	01.04.22	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	15					10	5
	5x3					5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded					Within	Within

RATIONALE FOR CURRENT RISK SCORE:
There continues to be a high threat of cyber-attacks, which is based on global cyber activity and threat levels. Digital change and development has increased our attack surface, however controls are in place and monitored through the Trust's Information Governance Sub Committee. The baseline submission for DSPT was completed and roles to increase specialist expertise were recruited to, however, information governance training compliance remains below the expected standard. The Trust continues to be responsive to nationally issued guidance and is progressing the cyber security work plan. Multifactorial authentication has concluded with deployment across the Trust and completion in Q2. A new backup solution has been implemented and our focus remains on closing the small number of unsupported servers. Patching compliance remains high, with good oversight of cyber controls

CONTROLS	ASSURANCES	EVIDENCE

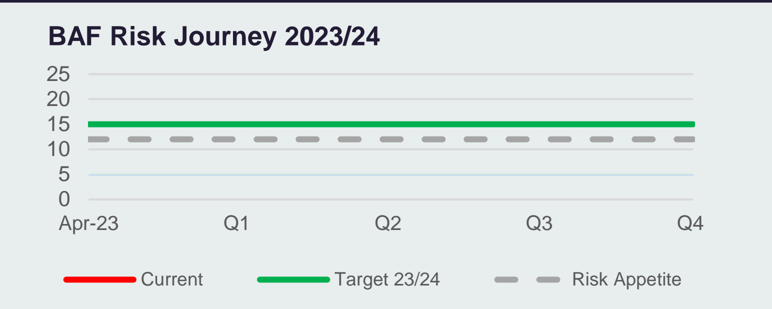
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Supported Systems	Decomission unsupported servers (2008) and (2008 R2)	Dr M Power	June 2023	Audit Cttee	
	Upgrade windows operating systems to within a supported 12 month version	Dr M Power	June 2023	Audit Cttee	
	Replacement of all system using SQL 2008 and 2008 R2	Dr M Power	June 2023	Audit Cttee	
Patching (999 and NHS 111)	Enable monthly failover & patching opportunities	Dr M Power	May 2023	Audit Cttee	
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Dr M Power	March 2024	Audit Cttee	
	Implement findings from DSPT Audit	Dr M Power	May 2023	Audit Cttee	
Out of Hours Resilience	Implement recommendations from desktop worst case scenario	Dr M Power	December 2023	Audit Cttee	

Operational Risks Scored 15+ Aligned to BAF Risk: SR08

ERM ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
330	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
331	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

BOARD ASSURANCE FRAMEWORK 2023/24

BAF RISK SR09: There is a risk that the Trust continues to attract negative media attention arising from long delays and harm leading to significant loss of public confidence	**Executive Director Lead:**	DoSPT
	Risk Appetite Category: Reputation – Moderate	



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Final Target
	10					10	10
	5x2					5x2	5x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within					Within	Within

RATIONALE FOR CURRENT RISK SCORE: Negative media attention arising from long delays and potential harm is a constant risk that requires annual communications plans and approaches that can respond to seasonal and other circumstantial demands. Our aim is to keep the risk at a moderate and managed level.

CONTROLS	ASSURANCES	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Production of operational service lines demand management plans for NHS 111 and PES	Operational service lines to produce their own demand management plans and share them with the Communications Team so that communications approaches can be aligned	Ged Blezard	Ongoing throughout 23/24	ELC QPC	In progress

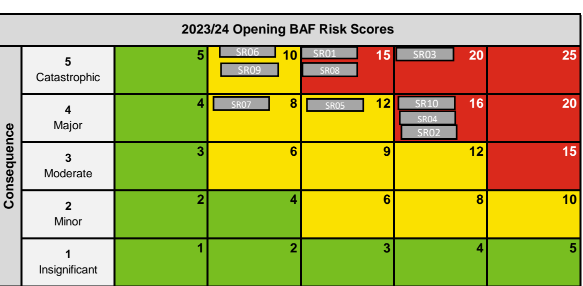
Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

Appendix 2:

2022/23 Board Assurance Framework (BAF) Heat Maps

Opening Position

NHS North West Ambulance Service NHS Trust



2023/24 Opening BAF Risk Scores					
Consequence					
5 Catastrophic	5	SR06, SR09 10	SR01, SR08 15	SR03 20	25
4 Major	4	SR07 8	SR05 12	SR10, SR04, SR02 16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated: 14 April 2023	**1** Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost Certain
	Likelihood				

Q1 BAF Risk Scores					
Consequence					
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:	**1** Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost Certain
	Likelihood				

Q2 BAF Risk Scores					
Consequence					
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:	**1** Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost Certain
	Likelihood				

Q3 BAF Risk Scores					
Consequence					
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:	**1** Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost Certain
	Likelihood				

Q4 BAF Risk Scores					
Consequence					
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:	**1** Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost Certain
	Likelihood				

2023/24 Target BAF Risk Scores					
Consequence					
5 Catastrophic	5	SR06, SR09 10	SR01, SR03 15	20	25
4 Major	SR07 4	SR08, SR04 8	SR10, SR05 12	SR02 16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5
Populated: 14 April 2023	**1** Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost Certain
	Likelihood				

Final Target BAF Risk Scores					
Consequence					
5 Catastrophic	SR01, SR03, SR06 5	SR09 10	15	20	25
4 Major	SR04, SR05, SR07, SR08 4	SR02, SR10 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: 14 April 2023	**1** Rare	**2** Unlikely	**3** Possible	**4** Likely	**5** Almost Certain
	Likelihood				

REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="5">26th April 2023</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Risk Management Policy Review</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="5">Angela Wetton, Director of Corporate Affairs</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td><td>SR05</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>SR06</td><td>SR07</td><td>SR08</td><td>SR09</td><td>SR10</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="5">For Decision</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="5">The Risk Management Policy has been through an annual review and refresh.

A summary of the changes made to the policy are detailed in s4.

The Risk Management Policy can be viewed in Appendix 1.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="5">The Board of Directors are recommended to approve the Trust's Risk Management Policy.</td></tr>
<tr><td>CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)</td><td colspan="5">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☒ Compliance/Regulatory
☒ Quality Outcomes
☒ People
☒ Financial / Value for Money
☒ Reputation
☒ Innovation</td></tr>
<tr><td colspan="6">INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td>Equality:</td><td>☐</td><td colspan="2">Sustainability</td><td>☐</td></tr>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="5">Audit Committee</td></tr>
<tr><td>Date:</td><td colspan="4">21st April 2023</td></tr>
<tr><td>Outcome:</td><td colspan="4">Recommended to the Board of Directors for approval</td></tr>
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1. PURPOSE

The purpose of the report is to provide the Board of Directors with the revised and refreshed Risk Management Policy.

2. BACKGROUND

The Risk Management Policy has been reviewed and revised to define the approach taken by the organisation in applying risk management consistently across the Trust.

Risk management is a statutory requirement, and it is a fundamental part of the approach to quality, corporate and clinical governance. Good risk management is integral to the effectiveness of all the Trust's activities and as such must be integrated into the day-to-day practice of all functions and embedded within the culture of the organisation so that appropriate risk-based decisions are regularly made by managers and staff at all levels.

3. PURPOSE OF THE RISK MANAGEMENT POLICY

The main objective of this policy is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

The Risk Management Policy applies to all areas of the Trust and at all levels. It defines the basic principles and techniques of risk management that the organisation has decided to adopt and forms the basis of all risk-based decision making.

The full refreshed Policy can be viewed in **Appendix 1**.

4. SUMMARY OF POLICY CHANGES

Following the annual review of the Risk Management Policy the below changes have been made:

- Roles and responsibilities: Area and Assistant Directors are referenced within s3 of the Policy.
- Language change throughout the Policy from staff to our people, this terminology reflects both staff and volunteers.
- Fraud risk management: new addition under the risk identification section within the Policy.
- Risk monitoring and review: risks with a consequence of 5 to have a monthly risk review.
- Implementation: refreshed implementation date following the Policy approval process.
- Equality Impact Assessment (EIA): reviewed and refreshed.
- Risk Matrix: review and refresh with relevant subject matter experts.

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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

6. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

7. RECOMMENDATIONS

The Board of Directors are recommended to approve the Trust's Risk Management Policy.

Policy on Risk Management

Recommended by	Audit Committee
Approved by	Board of Directors
Approval date	
Version number	0.4
Review date	April 2024
Responsible Director	Director of Corporate Affairs
Responsible Manager (Sponsor)	Head of Risk and Assurance
For use by	All staff and volunteers

This policy is available in alternative formats on request. Please contact the Corporate Governance Office on 01204 498400 with your request.

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
0.1	December 2020	-	J Taylor	New Policy
0.2	January 2021	January 2021	J Taylor	Amendments from Audit Committee
0.3	April 2022	April 2022	J Taylor	Annual Review
0.4	February 2023		S White	Annual Review

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1. Introduction

Risk management is both a statutory requirement and a key element of good management and risk management is everyone's responsibility, with the principles of effective risk management forming an integral component of decision making at all levels.

The activities associated with caring for patients, recruiting our people (staff and volunteers), providing facilities and services, and managing finances are all, by their nature, activities that involve risk. These risks are present on a day-to-day basis throughout the organisation and whilst it may not always be possible to eliminate these risks, they can be managed to an acceptable level by ensuring that risk management is embedded into day-to-day practice and the culture of the organisation so that appropriate risk-based decisions are regularly made by managers and staff at all levels.

Effective risk management enables the Board of Directors to determine the extent of risk exposure it currently faces with regard to the achievement of its objectives. As a key component of the internal control framework, regular review and routine monitoring of this policy will also inform the Trust's Annual Governance Statement.

2. Purpose

The purpose of this Risk Management Policy is to define the approach taken by North West Ambulance Service NHS Trust (the Trust) in applying risk management to its decision making at all levels and the main objective is to establish the foundations for a culture of effective risk management throughout the organisation.

This policy sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.

The principles and techniques of risk management as defined in this policy should be fully integrated within the formal governance arrangements and decision making processes of the organisation.

All our people are responsible for making sure that they are aware of the organisation's aims and objectives and are empowered to make decisions to manage risks as long as those decisions are within the scope of their role and level of authority.

Where a risk is identified but cannot be managed without some significant change to the way the organisation operates, it must be escalated through the relevant line management structure.

The Risk Management Policy applies to all areas and levels of the Trust. It defines the basic principles and techniques of risk management that the organisation has decided to adopt and forms the basis of all risk-based decision making.

All risk management activities in the Trust will follow the process described within this document to ensure a common and robust approach is adopted to risk management.

3. Roles & Responsibilities

This section details those groups and individuals within the Trust that have specific responsibilities with regard to the Risk Management Policy.

The **Board of Directors** is responsible for providing strategic leadership to risk management throughout the organisation, which includes:

- Maintaining oversight of strategic risks through the Board Assurance Framework (BAF)
- Leading by example in creating a culture of risk awareness

The **Audit Committee** is responsible for reviewing the established and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisations' activities. The Committee will provide assurance to the Board of Directors that there are effective systems operating across the Trust.

The **Chief Executive** as the ***Accountable Officer*** is responsible for ensuring an effective system of internal control is maintained to support the achievement of the Trust's strategic objectives. This includes:

- The establishment and maintenance of effective corporate governance arrangements
- Ensuring that this Risk Management Policy is applied consistently and effectively throughout the Trust
- Ensuring that the Trust is open and communicates effectively about its risks, both internally and externally
- Retaining sufficient professional risk management expertise to support the effective implementation of this Policy

The **Director of Corporate Affairs** is accountable to the Board of Directors and Chief Executive for the Trust's Governance and Risk Management activities. With Executive responsibility for governance and risk management the Director of Corporate Affairs (with support from the Head of Risk and Assurance) provides a clear focus for the management of organisational risks and for coordinating and integrating all of the Trust's risk management arrangements on behalf of the Board of Directors.

Members of the **Executive** and **Directorate Senior Management Teams** are responsible for the consistent application of this Policy within their areas of accountability, which includes:

- Maintaining an awareness of the overall level of risk within the organisation
- The management of specific risks that have been assigned to them, in accordance with the criteria set out in this policy
- Promoting a risk aware culture within their teams and in the course of their duties

Area Directors/ Assistant Directors/ Heads of Operations/ Service/ Area Consultant Paramedics are responsible for the consistent application of this Policy within their areas of accountability, which includes:

- Making active use of the Trust risk register and the processes described in this Policy to support the management of their service
- The management of specific risks that have been assigned to them in accordance with the criteria set out in this policy
- Promoting a risk aware culture within their teams and in the course of their duties
- Ensuring that as far as possible risk assessments carried out within their service are based on reliable evidence

All of our people (staff and volunteers) are responsible for identifying and managing risks within their day-to-day work, which includes:

- Maintaining an awareness of the primary risks within their service
- The identification and as far as possible the management of risks that they identify in the course of their duties.
- Escalating to their line manager any risks that are beyond their ability or authority to manage.

4. Risk Management Approach

The basic principle at the heart of the Trust's risk management approach is that an awareness and understanding of risk should be used to inform decision making at all levels.

This requires not only the active engagement of all our people with risk management activity in practice, but also the integration of risk management principles and techniques within the formal governance arrangements of the organisation.

This will ensure that major strategic, policy and investment decisions are made with a full and reliable appreciation of the risks associated with them as well as any existing risks that those decisions may serve to mitigate.

5. Risk Management Process

The risk management process, which can be seen in Figure 1 below, involves the identification, analysis, evaluation and treatment of risks. More importantly, the process provides iterative steps, which when taken in a coordinated manner can support recognition of uncertain events which could lead to a negative outcome and therefore allows actions to be put in place to minimise the likelihood (how often) and consequence (how bad) of these risks occurring.

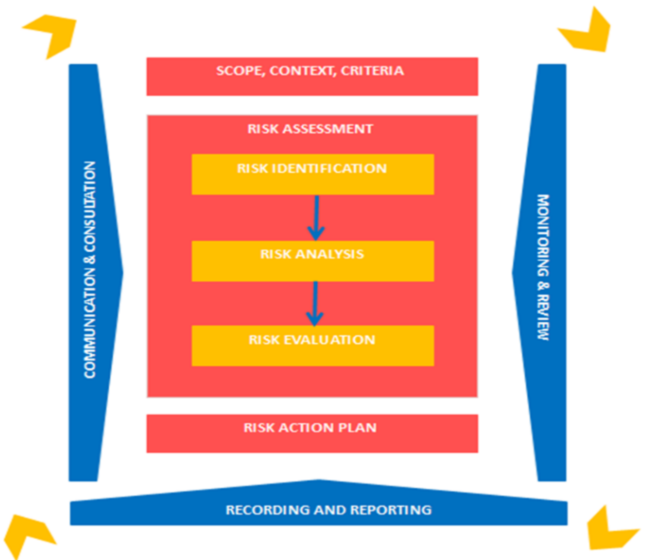

Figure 1: *ISO 3100:2018 Risk Management Process*

5.1. Scope, Context and Criteria

The Trust Strategy sets out our purpose to help people when they need us the most and a vision to deliver the right care, at the right time, in the right place; every time. This is broken down into 3 aims, these are:

- Providing high-quality, inclusive care.
- Be a brilliant place to work for all.
- Work together to shape a better future.

Risks are linked to our aims because failing to control risks may lead to non-achievement of our strategic aims and/ or objectives.

5.2. Risk Assessment

Risk assessment is an objective process and where possible, staff should draw upon evidence or qualitative data to aid assessment of risk. Where evidence or data is not available, assessors will be required to make subjective judgement.

Risk vs Issue

It is important to understand the difference between a risk and an issue/ incident.

The fundamental difference between a risk and an issue/incident is that an issue/incident has **already happened**, there is no uncertainty, and it is a matter of fact.

A risk is an uncertain event that has **not yet happened**, but if it did, it could affect the achievement of an objective.

Risk	Issue/ Incident
An uncertain event that **HAS NOT** happened	An unplanned event that **HAS** happened

Risk Articulation

In order to assist the risk management process, it is essential that risks are described in a way that allows them to be understood by all who read them. Articulating a risk in this way will enable effective controls, assurances and action plans to be put in place to mitigate the risk.

There should be three components to the description of a risk:

Cause (Source of Risk)	Risk (Uncertain Event)	Consequence (Impact)
What has caused the risk? Where has the risk originated from?	The uncertain event (risk) that may happen if we do nothing	What would be the impact if the risk materialised?
Risk descriptions must tell a convincing story		
There is a risk 'as a result of/ due to/ because of'… *existing condition* **Present Condition**	*An uncertain event…* may occur **Uncertain Future**	Which would lead to… *effect on objectives* **Conditional Future**

Risk Identification

New risks and factors which increase a known risk may be identified at any time and by anyone within the organisation and can take many different forms.

All our people play a vital role in the identification of risk. All new risks should be reported and discussed with your line manager in the first instance, who will consider the best approach to manage the risk; this could be actions to immediately eliminate the risk, signposting of the risk to the appropriate person to manage the risk or inclusion on a risk register with an action plan in place.

Some risks can be managed effectively by the person identifying them taking appropriate action themselves or within their immediate team. This is particularly true with types of safety risk, where identification and removal of the hazard will often be sufficient to manage the risk.

Our people should initially consider what their main areas of work are and how these relate to their local objectives, and the objectives of the Trust. Every work activity that has a significant hazard should be assessed for risk. Identification using a systematic approach is critical because a potential risk not identified at this stage will be excluded from further analysis.

All risks, whether under the control of the Trust or not, should be included at this stage. The aim is to generate an informed list of events that might occur. Key sources that will inform this exercise include (but are not limited to):

- Compliance requirements with regulators and stakeholders such as the CQC, HSE, NHSE etc
- Recommendations from recent internal / external audit reports
- Thematic and trend analysis of incidents, inquiries, complaints, claims and inquests
- Performance data
- Quality Assurance Audits
- Quality Impact Assessments
- Safety Alerts
- Trend and forecasting analysis
- Risks associated with the achievement of corporate objectives
- Other methods of horizon scanning.

Business Continuity Exercises

Recommendations from business continuity exercises are captured within the risk management process to ensure the delivery of actions to reduce risk of failure in the event of an actual incident.

Fraud Risk Management

Recommendations from thematic exercises from NHS Counter Fraud Authority (CFA) are captured within the risk management process to ensure the delivery of actions to reduce risk of failure in the event of an actual fraud, bribery, theft, and corruption incident.

5.3. Risk Analysis

The purpose of analysing and scoring a risk is to estimate the level of exposure which will then help inform how the risk should be managed.

When analysing a risk, you will need to:

- Identify who is affected and what is the potential consequence/ impact should the risk occur
- Estimate the likelihood (how often) the risk may possibly occur
- Assess and score the level of exposure to that risk using the risk scoring process below.

Risk Analysis Process

Risks are analysed using the Trust Risk Matrix. The Trust has adopted a 5x5 matrix with the risk scores taking account of the consequence and likelihood of a risk occurring.

The scoring of a risk is a 3-step process:

Step 1: Evaluate the consequence of a risk occurring. The consequence score has five descriptors:

Score	Consequence Descriptor	Consequence Description
1	Insignificant	Please see **Appendix 2** for Consequence Descriptions
2	Minor	
3	Moderate	
4	Major	
5	Catastrophic	

Step 2: Analysing the likelihood (how often) a risk may occur. The table below gives the descriptions of the likelihood of a risk occurring:

Score	Likelihood Descriptor	Likelihood Frequency	Likelihood Probability
1	Rare	Not expected to occur in years	May only occur in exceptional circumstances
2	Unlikely	Expected to occur at least annually	Unlikely to occur
3	Possible	Expected to occur at least monthly	Reasonable chance of occurring
4	Likely	Expected to occur at least weekly	Likely to occur
5	Almost Certain	Expected to occur at least daily	More likely to occur

Step 3: To calculate the risk score, multiply the consequence score with the likelihood score:

CONSEQUENCE score x **LIKELIHOOD** score = **RISK** score

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

5.4. Risk Evaluation

Once the risk analysis process has been completed, the risk score should now be compared with the level of risk criteria below which enables the Trust to measure the potential level of risk exposure and proceed to identify appropriate actions and management plans.

Level of Risk
1 - 5 (Low)
6 - 12 (Moderate)
15 - 25 (High)

Each risk will be assigned 3 risk scores: initial, current and target. The risk scoring process above will be carried out three times for each score using the guidance below.

1. **Initial Risk Score**
   The initial risk score is when the risk is first identified, the risk analysis process for initial risk scores should be a measure of the consequence and likelihood before any controls/ mitigating actions are proposed. The initial risk score will not change for the lifetime of the risk.

2. **Current Risk Score**
   The current risk score, the risk analysis process for current risks should be a measure of the consequence and likelihood once controls and mitigating actions are in place, taking into account the effectiveness of the controls added.

3. **Target Risk Score**
   The target risk score, the risk analysis process for the target risk should be a realistic measure of the consequence and likelihood once improved mitigating actions have been achieved and improved controls added.

5.5. Risk Management

Effective risk management requires a reporting and review structure to ensure that risks are effectively identified, analysed and that appropriate controls and responses are in place.

Risk Treatment

Risk treatment is a process to modify risk and the selection and implementation of measures to treat the risk. This includes as its major element, risk control/ mitigation, but extends further to the appropriate selection of a risk treatment option, these are outlined in the table below.

Tolerate (Accept)	**Can we accept the risk as it is i.e., without further controls? Would the cost of controlling the risk outweigh the benefits to be gained?** Where the ability to do anything about certain risks may be limited or the cost of taking any further action may be disproportionate to the potential benefit gained. In these cases, the response is to manage the risk to as low as reasonably practicable (ALARP) then tolerate the risk. This option can also be

	supplemented by contingency planning for handling the consequences that may arise if the risk is realised. Where the status of the risk is to tolerate, the risk must be monitored and reviewed by the risk owner at least annually. All risks tolerated, will be subject to review by the Corporate Risk and Assurance Team and a decision made by the Executive Leadership Committee if the risk should be tolerated or not.
Treat (Reduce or Remove)	**Can we put controls in place to reduce the likelihood of the risk occurring or its impact?** Treat is the most widely used approach and will be the course of action to take for the majority of risks within the Trust before any other course of action is considered.
Terminate (Suspend the risk situation/ activity)	**Can we avoid or withdraw from the activity causing risk? Can we do things differently?** A decision will be made by the Executive Leadership Committee if the risk should be terminated or not.
Transfer (Responsibility)	**Can we transfer or share, either totally or in part, by way of partnership, insurance or contract?** This course of action should only be taken following consideration and decision by the Executive Leadership Committee.

Identifying Controls and Gaps
Controls are arrangements that are already in place to mitigate or manage the risk and these can include policies and procedures, monitoring and audit.

Every control should be relevant to the risk that has been described, it should be clear that the control directly impacts on managing the risk and the strength of the control should be considered when deciding the influence this will have on the risk score.

Despite having identified controls, where the service has established a risk exists, it is the uncontrolled issues that are articulated as gaps. Gaps are issues which are not controlled and directly affect our mitigation of the risk. Gaps require clear and proportionate actions to address them.

Risk Mitigating Action Plans
The purpose of risk action plans is to document how the chosen treatment options will be implemented.

Information should include:

- A description of what the planned action is
- Expected benefit(s) gained
- Responsibilities (risk owners and action owners)
- Reporting and monitoring requirements
- Resourcing requirements
- Timing and scheduling

Differentiating between Controls, Gaps and Actions

To summarise:

- Controls are things that are already in place to manage or monitor the risk
- Gaps are the issues that we need to address to control the risk fully
- Actions describe how you will address the gaps to reduce the risk identified.

Contributory Factors

Contributory factors are the influencing and casual factors that contribute to the identified risk. These factors affect the chain of events and can be positive as well as negative, and they may have mitigated or minimised the outcome of the risk materialising. More than one contributory factor can be selected.

Risk Monitoring and Review

The monitoring process should provide assurance that there are appropriate controls and risk mitigating actions in place. The frequency of ongoing monitoring and review depends upon the seriousness of the risk. As a **minimum**, this must be:

Current Risk Score	Review Timescales
1 - 5 (Low)	Bi-Annually
6 - 12 (Moderate)	Quarterly
15 - 25 (High)	Monthly

Consequence Score	Review Timescales
5	Monthly

6. Risk Registers

A risk register is a centralised repository of identified risks that may threaten the delivery of services. A risk register should be live, dynamic, and populated through the risk assessment and evaluation process. The Datix Cloud IQ (DCIQ) Enterprise Risk Management (ERM) system is used by the Trust to record, manage and monitor risks throughout the organisation. Where risks cannot be immediately resolved, these risks should be recorded onto the Departmental/ Team Risk Register.

The purpose of the risk register is to:

- Provide a summary and overview of potential risks to each Directorate
- Evaluate the level of existing internal control in place to manage the risk
- Be an active live system to record and report risks using the risk management process.

Risk registers must:

- Be fully complete
- Be updated and reviewed regularly
- Have measurable controls added for all live risks
- Have action plans in place
- Be discussed and reported to Directorate SMT Meetings at least quarterly.

7. Risk Escalation

The Trust aims to support staff throughout the organisation to manage risk at the most appropriate level in the organisation whilst ensuring that there is a clear process for risk to be escalated when necessary to ensure discussion, action, advice, and support can be provided.

All risk owners can escalate a risk for discussion, action, advice, and support via the risk record in the DCIQ system. The risk owner must clearly articulate the reasons for the risk escalation. The table below shows the team to Board escalation route.

Escalation From	Escalation To
Team/ Department	Directorate Senior Management Team
Directorate Senior Management Team	Executive Leadership Committee
Executive Leadership Committee	Board of Directors

The diagram below defines the 'Assurance and Escalation Pyramid' and demonstrates the route of assurance and escalation takes.

Figure 2: *NWAS Assurance and Escalation Pyramid*

8. Executive Oversight

All risks held in the ERM Module in DCIQ scored 15 and above are automatically reviewed by the Corporate Risk and Assurance Team. The below steps are followed to ensure the Executive Leadership Committee have oversight of all high risks to the organisation.

- All new risks scored 15 and above are reviewed and analysed by the Corporate Risk and Assurance Team
- Risks are discussed with Risk Owners and Executive Lead to explore the risk in further detail and ensure risk scoring is accurate
- Corporate & Commercially Sensitive Risk Register is submitted to Executive Leadership Committee monthly for review, discussion, and approval of risks for inclusion onto the Corporate & Commercially Sensitive Risk Register.

9. Risk Management Governance Structure

Risks are overseen at various levels throughout the Trust as per the table below:

Meeting	Type of Risk	Report Type	Risk Cycle
Board of Directors	Risks identified against delivery of strategic objectives	Quarterly Board Assurance Framework	As per Terms of Reference
Board Committees	Risks identified against delivery of strategic objectives relevant to their area of focus	Committee Board Assurance Framework Report	As per Terms of Reference
Audit Committee	Risks identified against delivery of strategic objectives	Quarterly Board Assurance Framework	As per Terms of Reference
Executive Leadership Committee	New & existing risk(s) scored 15 and above which indicate a high level of risk or where support is requested by the Directorates in the management of risk	Quarterly Board Assurance Framework Corporate & Commercially Sensitive Risk Register	As per Terms of Reference
Sub Committees	Visibility of risks scored 15 and above relating to the management groups area of focus	Sub Committee Board Assurance Framework Report	As per Terms of Reference
Directorate Senior Management Team Meetings	Risks identified on the Directorate Risk Register	Directorate Risk Register	At least quarterly

Directorate Senior Management Teams are responsible for exporting their own risk registers and ensuring risks on team/ departmental risk registers are being managed and reviewed in accordance with this Policy.

10. Risk Reporting and Assurance Diagram

The risk reporting and assurance diagram highlights how the Trust aims to assure, scrutinise, escalate, and inform on risk management from front line to Board:

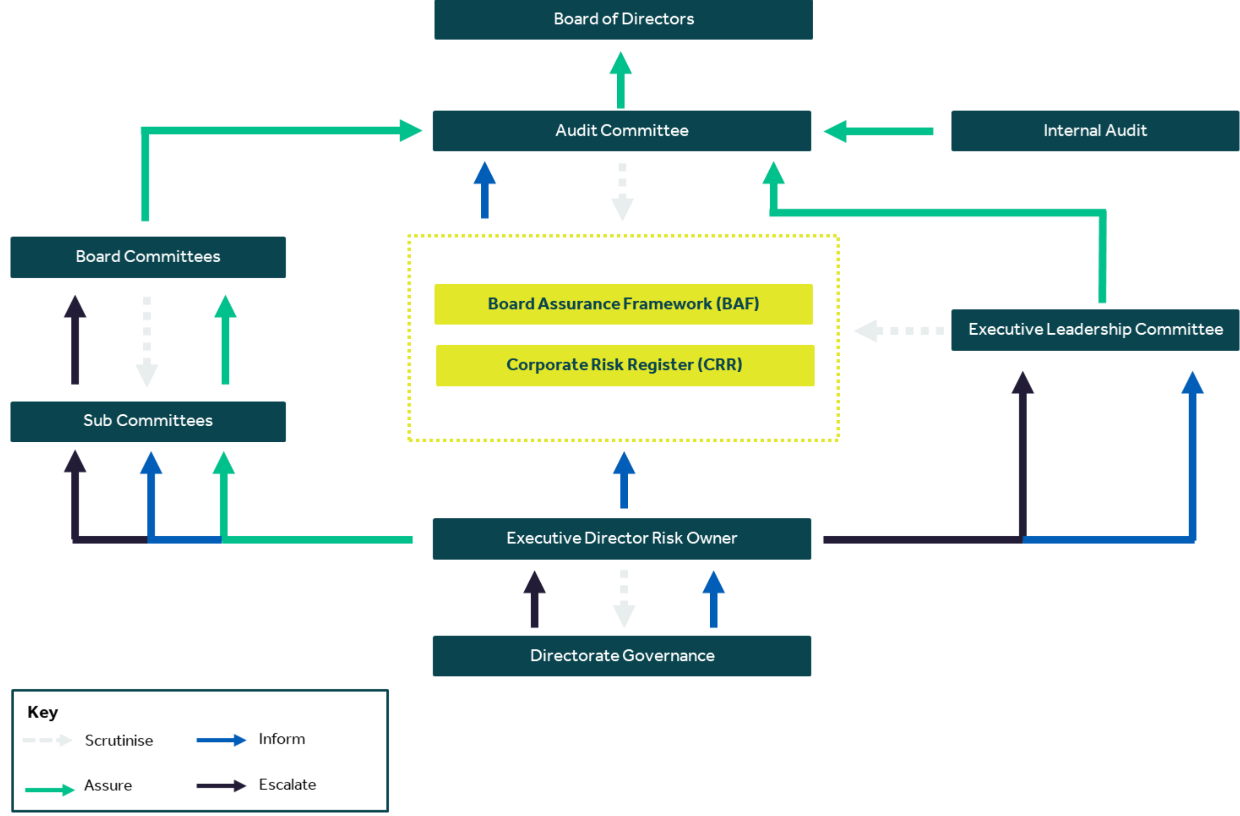

Figure 3: *North West Ambulance Service NHS Trust; Risk Reporting and Assurance Diagram*

11. Assurance

A key element of the Trust's risk management system is providing assurance. Assurance provides evidence that risks are effectively managed by ensuring the effectiveness of controls and actions being put in place are making a positive impact and mitigating risks appropriately.

12. Corporate and Commercially Sensitive Risk Register

The Corporate Risk Register allows the Executive Leadership Committee to have oversight of risks where:

- Risk owners have communicated the need for additional support;
- The risk has a current risk score of 15 and above; and/or;
- The risk indicates a significant/ increased risk;
- The risk has the potential to significantly impact a strategic objective

Risks held on the Corporate and Commercially Sensitive Risk Register must continue to be managed at their current level, with input and support from the Executive Leadership Committee where appropriate.

13. The Board Assurance Framework (BAF)

The Board Assurance Framework is a key document used to record and report the Trust's key strategic objectives, risks, controls, and assurances to the Board of Directors. The Board Assurance Framework takes into account the recommendations from Audit, Executive Leads and Committees of the Board as to what should be included, amended, or removed. The Board Assurance Framework is updated and approved by the Board of Directors four times per year.

13.1. Audit Committee

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

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

13.2. Board Assurance Committees

Board Assurance Committees have the following responsibilities pertaining to the BAF risks pertaining to their areas of focus:

- Review of the BAF to ensure the Board of Directors receive assurance that effective controls are in place to manage strategic risk;
- Report to the Audit Committee/ Board of Directors on any significant risk management and assurance issues.

13.3. Sub Committees

Sub-Committees/ Management Groups have the following roles regarding the BAF risks pertaining to their areas of focus:

- Review of the BAF to ensure their parent Board Assurance Committee receives assurances that effective controls are in place to manage strategic risks;
- Review the management of the operational risks pertaining to the Sub-Committee/ Management Groups areas of focus;
- Report to their parent Board Assurance Committee of any significant risk management and assurance issues.

14. Annual Governance Statement (AGS)

The Chief Executive is responsible for 'signing off' the Annual Governance Statement, which forms part of the statutory Annual Report and Accounts.

The organisation's Board Assurance Framework gathers all the evidence required to support the Annual Governance Statement alongside the Head of Internal Audit's annual opinion on the overall adequacy and effectiveness of the organisation's risk management, control, and governance processes.

15. Clinical Risk Management

Clinical risk management can be defined as:
"The continuous improvement of the quality and safety of healthcare services by identifying the factors that put patients at risk of harm and then acting to control/ prevent those risks."

Clinical risk is identified through the analysis of patient safety incidents, clinical negligence claims, and complaints, identified areas of sub-optimal care, clinical audit and non-compliance with clinical policies, guidance, and training.

16. Risk Governance and Internal Audit

The Executive Leadership Committee and the Audit Committee continually review and monitor all aspects of the Trust's risk management system and play a key role in the standardisation and moderation of risks that are added to the Trust-wide risk register.

The Head of Internal Audit (HoIA) provides an annual opinion, based upon, and limited to the work carried out to assess the overall adequacy and effectiveness of the organisations' risk management, control, and governance processes.

17. Risk Awareness & Management Training and Support

Risk management guidance and advice are provided through the Corporate Risk and Assurance Team. Risk management training is made available for staff, via MyESR as per the below table.

Staff/ Group	Type of Training	Type of Delivery	Frequency of Training
All staff	Level 1 Risk Awareness Training	E-Learning	3 Yearly
All staff who require access DCIQ Enterprise Risk Manager Module	DCIQ ERM Module Training	Virtually	Once
First line, Middle & Senior Managers	Level 2 Risk Management Training	E-Learning	3 Yearly
Board of Directors	Level 3 - Risk Management and Assurance Training	E-Learning	Annually

18. Implementation

Taking into consideration the implications associated with this policy, it is considered that a target date of *01 April 2023* is achievable for communications about changes in this Policy, with any specific training being implemented on an ongoing basis. This will be monitored by the Executive Leadership Committee and the Audit Committee through the review process. If at any stage there is an indication that the target date cannot be met, then the Policy author will implement an action plan.

19. Equality, Diversity, and Inclusion

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. The Equality Impact Assessment can be viewed in **Appendix 3**.

20. Monitoring Compliance

Monitoring of compliance with this policy will be undertaken on a day-to-day basis by the Corporate Risk and Assurance Team, discussing any issues with the relevant team/ department/ Directorate and, if necessary, reporting to the Director of Corporate Affairs and relevant Executive Director Leads. The monitoring matrix can be viewed in **Appendix 4** for further information.

21. Consultation and Review

This is an existing policy which has had moderate changes that relate to operational and/ or clinical practice and therefore requires a consultation process. The Head of Risk and Assurance has consulted with the Director of Corporate Affairs, Internal Audit and Local Counter Fraud to invite any comments or suggestions regarding this policy.

The policy will be presented to the Executive Leadership Committee, Audit Committee and to the Board of Directors for approval.

22. References

Baker, T (2015). *Board Assurance: A toolkit for health sector organisations*. England: LLP

CQC (2010), *Guidance about compliance; Essential standards of quality and safety.* England: Care Quality Commission (CQC).

CQC (2017), Enforcement Decision Tree. England: Care Quality Commission (CQC).

Deloitte, Enterprise Risk Management Approach, A ‘risk-intelligent’ approach.

Good Governance Institute, Risk Appetite for NHS Organisations.

HMFA (2014). *NHS Audit Committee Handbook.* (3rd ed.). England: Healthcare Financial Management Association (MHFA).

Health Act 1999, Ch 8

Health and Social Care Act 2008, Ch 14

Health and Social Care Act 2012, Ch 7

Health and Social Care Act (Safety and Quality) Act 2015, Ch 28

Hopkin, P (2010). Fundamentals of Risk Management: Understanding, Evaluating and Implementing Effective Risk Management. 5th ed. London: IRM.

Lark, J (2015). *ISO 31000 Risk Management.* (1st Ed). Switzerland: ISO

NHS Providers (2018). Enterprise Risk Management.

PwC (2017). Delivering system wide sustainability: Managing risk in healthcare transformation. England: LLP.

The Orange Book: Management of Risk – Principles and Concepts, (2020). HM Treasury. London.

Vincent, C (2005). Clinical Risk Management. 2nd ed. London: BMJ Books.

APPENDIX 1: Risk Management Definitions

APPENDIX 2: Consequence Scoring Matrix

APPENDIX 3: Equality Impact Assessment

APPENDIX 4: Monitoring Compliance

Appendix 1: Risk Management Definitions

Term	Definition
Action	A response to control or mitigate risk
Action Plan	A collection of actions that are specific, measurable, achievable, realistic and targeted
Assessment	Means by which risks are evaluated and prioritised by undertaking the 4 stage risk assessment processes
Assurance	Confidence based on sufficient evidence that internal controls are in place, operating effectively and objectives are achieved
Board Assurance Framework	A document setting out the organisation's strategic objectives, the risks to achieving them, the controls in place to manage them and the assurance that is available
Consequence (Impact)	The effect on the Trust if a risk materialises
Control	Action taken to reduce the likelihood and or consequence of a risk
Gaps in Control	Action to be put in place to manage risk and achieve objectives
Frequency	A measure of rate of occurrence of an event
Internal Audit	An independent, objective assurance and consulting activity designed to add value and improve organisations' operations
Initial Risk	The score on identification before any controls are added
Likelihood	Evaluation of judgement regarding the changes of a risk materialising, established as probability or frequency
Mitigation	Actions taken to reduce the risk or the negative impact of the risk
Current Risk Score	The score with controls/ actions in place
Risk Appetite	The total amount of risk an organisation is prepared to accept in pursuit of its strategic objectives
Risk Matrix	A grid that cross references consequence against likelihood to assist in assessing risk
Risk Owner	The person responsible for the management and control of all aspects of individual risks
Risk Rating	The total risk score worked out by multiplying the consequence and likelihood scores on the risk matrix
Risk Register	The tool for recording identified risks and monitoring action plans against them
Risk Tolerance	The degree of variance from the Risk Appetite that the Trust is willing to tolerate
Strategic Risk	Risks that represent a threat to achieving the Trusts' Strategic Objectives
Operational Risk	Risks which are a by-product of the day to day running of the Trust

Appendix 2: Consequence Scoring Matrix

Domain	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Adverse Publicity/ Reputation/ Public Confidence	Localised issue. Ad-hoc public or political concern.	Short term local media interest. Short-term reduction in public confidence. Local area public/ political concern. Anecdotal comments.	Sustained local media interest – extending to regional interest. Regional public/ political concern. Reduction in public confidence. Damage to reputation.	Regional/ national media interest. Significant public/ political concern. Loss of credibility and confidence in organisation. Independent external enquiry. Significant damage to reputation.	Sustained national media interest. Total loss of public confidence and credibility in organisation. Full national/ parliamentary/ public enquiry. Major damage to reputation.
Business Programmes/ Projects	Temporary defects causing minor short-term consequences to time and quality.	Elements of public expectation not being met. (Performance may be related to time, cost & quality – either singularly or in combination of).	Poor project performance shortfall in area(s) of secondary importance. (Performance may be related to time, cost & quality – either singularly or in combination of).	Poor performance in area(s) of critical or primary objective. (Performance may be related to time, cost & quality – either singularly or in combination of).	Significant failure of the project to meet its critical or primary objective.
Clinical Audit **(Provision of Clinical Information)**	No or limited/ single disruption to the provision of timely and accurate clinical information across NWAS. Meets local clinical audit standards.	Minor disruption to the provision of timely and accurate clinical information on an individual CBU/ business area. Minor discrepancy with local clinical audit standards.	Reduction in the provision of timely and accurate clinical information in CBU's/ business areas. Moderate discrepancy with meeting local clinical audit standards.	Inconsistent production of timely and accurate clinical information across all CBU's/ business areas. Non-compliance with local clinical audit standards agreed by NWAS. Delay in participation with national and local quality frameworks.	Failure to produce clinical information or participate within any local or national quality framework. Non-compliance with national clinical and standards.
Clinical: Medication Error	Incorrect medication supplied but not taken.	Wrong medicine or dosage administered, with no adverse effects.	Wrong medicine or dosage administered with potential adverse effects.	Wrong medicine or dosage administered with adverse effects.	Unexpected death or permanent incapacity Incident leading to long-term health problems.

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Cyber Security	The threat is expected to have negligible adverse effect on Trust operations, assets, individuals, or other organisations	The threat is expected to have limited adverse effect on Trust operations, assets, individuals, or other organisations. A limited adverse effect means that the threat might: Cause a degradation in capability to an extent and duration that the Trust is able to perform its primary functions, but the effectiveness of the functions is notably reduced. Results in minor damage to Trust assets. Minor financial loss . Minor harm to individuals.	The threat could be expected to have a serious adverse effect on Trust operations, assets, individuals, or other organisations. A serious adverse effect means that the threat might: Cause significant degradation in capability to an extent and duration that the Trust is able to perform its primary functions, but the effectiveness of the functions is significantly reduced. Results in significant damage to Trust assets. Significant financial loss. Significant harm to individuals that does not result in loss of life or serious lie threatening injuries.	The threat could be expected to be a severe or catastrophic adverse effect on Trust operations, assets, individuals, or other organisations. A severe or catastrophic adverse effect means that the threat might: Cause severe degradation in capability to an extended and duration that the Trust is not able to perform one or more of it primary functions. Results in major damage to Trust assets. Major financial loss. Severe or catastrophic harm to individual that results in loss of life or serious life-threatening injuries.	The threat could be expected to have a multiple severe or catastrophic adverse effect on Trust operations, assets, individuals or other organisations.
Data Confidentiality/ Security	Email containing non-sensitive information sent to incorrect recipient within the Trust.	Email containing sensitive information sent to an incorrect recipient within the Trust. Staff who are not entitled to share sensitive information cc'd in a chain of emails. Loss of an encrypted laptop. Paper records posted without appropriate labelling/protection.	Emailing an incorrect file containing personal data to an external non-NHS correct addressee such as a solicitor or a data subject. Patient information disclosed via a Trust WhatsApp group.	Disclosure of patient information on an open social media site. Member of staff accessing own family medical records. Employee abusing of his/her position in the Trust to misuse colleagues' personal data.	Death/ Catastrophic event arising from breach.
Environmental Impact	Minimal or no impact on the environment: (Small spillage or escape of non-clinical or non-harmful material on Trust premises).	Minor impact on environment: (Spillage or escape of clinical or toxic waste with effects contained within unit or department).	Moderate impact on environment: (Spillage or escape of clinical or toxic waste affecting an entire building).	Major impact on environment: (Significant spillage or escape of clinical or toxic waste with effects contained to Trust property).	Catastrophic impact on environment: (Significant discharge or escape of clinical or toxic waste with widespread effects beyond Trust property.
Financial	Small loss. Risk of claim remote (£0-£5,000).	Loss of 0.1-0.25% of budget. Claim less than (£5,000-£10,000).	Loss of 0.25-0.5% of budget. Claim(s) between (£10,000-£100,000).	Loss of 0.5-1.0% of budget. Claim(s) between (£100,000-£1 million). Uncertain delivery of key objective. Purchase failing to pay on time.	Loss of >1% of budget. Claim(s) (>£1 million). Loss of significant contract/ income. Non-delivery/ failure to meet key objective/ specification.

Domain	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Infection Prevention & Control	Exposure to blood/ body fluids/ other sources of infection with no risk.	Exposure to blood/ body fluids/ other sources of infection with minimal risk/ no sickness. Outbreak involving 2 or more people. Physically unwell – GP treatment or treated by staff. Inoculation contamination from person with no known infection.	Exposure to blood/ body fluids/ other sources of infection resulting in short term sickness (minimum 3 days). Outbreak causing disruption to service or short-term closure (days/ weeks). Physically unwell – planned admission/ attendance at A&E (not blue light) or transfer to general medical ward. Inoculation contamination from person with no known infection	Exposure to blood/ body fluid/ other sources of infection resulting in very serious infection, long term sick leave. Outbreak causing medium term closure (weeks/ months). Physically unwell – emergency admission to general hospital. Inoculation contamination from infected person.	Sudden or unexpected death (including where evidence may be related to exposure to infection) Outbreak causing long term closure or termination of service. Inoculation contamination causing life threatening disease or death.
Moving/ Manual Handling	Malfunction/ fault with equipment. Slipping, falling with no injuries.	Minor injury as a result of moving or handling. Short term staff sickness/ absence (less than 3 days off work). Slipping, falling with minor injuries requiring first aid only. Short term staff sickness/ absence (less than 3 days off work).	Moderate injury to staff as a result of moving or handling. Staff sickness – more than 7 days off work (RIDDOR reportable). Slip/ trip/ fall resulting in injury such as a sprain, requiring medical attention. Staff sickness – more than 7 days off work (RIDDOR reportable).	Serious injury to staff resulting in long term damage. Long term staff sickness (RIDDOR reportable). Slip/ trip/ fall resulting in injury such as dislocation/ fracture/ head injury, requiring medical attention and hospitalisation. Long term staff sickness (RIDDOR reportable).	Unexpected death or permanent incapacity. Incident leading to long-term health problem. Unexpected death or permanent incapacity. Incident leading to long-term health problem.
Patient Safety .	No harm caused to a person or the Trust.	Low harm: patient required extra observations or minor treatment.	Moderate harm: patient required further treatment or transfer of care. Prolonged psychological harm: Psychological harm a service user has experienced or is likely to experience for a continuous period of more than 28 days.	Severe: Permanent or long-term harm or significant deterioration in condition. Death: Not related to the service provided by the trust.	Death: Likely due to the service provided by the trust.

Domain	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Physical Violence/ Aggression	Aggression with minimal or no impact. Verbal abuse with minimal impact.	Physical attack/ assault such as pushing, shoving, pinching, slapping, hair pulling etc. Minor injury (not requiring immediate medical assessment or treatment) Threats to prevent staff member leaving property but is persuaded and allows exit. Verbal abuse with minor impact with no further action.	Assault on patients, public or staff which may have physical health/ psychological implication on the victim. Injury may require A&E or GP assessment but no further treatment. Deliberate delay in the departure of staff using minor threats or physical obstruction. Verbal abuse causing moderate distress requiring further action.	Serious assault resulting in physical injuries that require hospital treatment. Deliberate delay in the departure of staff using significant threats or physical obstruction. Verbal abuse causing distress and psychological impact requiring reporting and investigation.	Homicide or attempted homicide resulting in death or serious prolonged injury or disability. Staff member held hostage using physical force. Verbal abuse causing severe distress and psychological impact requiring investigation.
Service/ Business Interruption	Loss of ability to provide services. (Interruption of >1 hour)	Loss of ability to provide services. (Interruption of >8 hours)	Loss of ability to provide services. (Interruption of >1 day)	Loss of ability to provide services. (Interruption of >1 week)	Permanent loss of service or facility
Staff Competence	Staff are adequately equipped with the appropriate skills, knowledge, and competence to undertake their duties. Staff attendance at mandatory/ key training. Insignificant effect on delivery of service objectives due to failure to maintain professional registration. (less than 10 staff)	Minor error due to a lack of appropriate skills, knowledge, and competence to undertake duties. Insignificant staff attendance at mandatory/ key training. (Within 5%) Minor effect on delivery of service objectives due to failure to maintain professional development or status. (between 11-50 staff)	Moderate error due to limited skills, knowledge & competence to undertake duties. Poor staff attendance for mandatory/ key training. (6 – 10%) Moderate effect on delivery of service objectives due to failure to maintain professional developments or status. (between 51-100 staff)	Serious error or due to limited skills, knowledge & competence to undertake duties. Regular poor/ low attendance at mandatory/ key training. (11 – 20%) Major effect on delivery of service objectives due to failure to maintain professional development or status. (between 101-250 staff)	Critical error due to limited skills, knowledge & competence to undertake duties. Significant/ inconsistent low uptake of attendance at mandatory/ key training. (>21 or 2 months+) Significant effect on delivery of service objectives due to failure to maintain professional development or status. (more than 250 staff)
Staff Safety	No time off work. Minor injury not requiring first aid or no apparent injury.	Minor injury, illness, Mental Health issue or first aid treatment needed. Requiring intervention. Short term staff sickness/ absence. (less than 3 days off work)	Moderate injury, illness, Mental Health issue requiring hospital treatment/ outpatient appointments/ assessment of social care needs. Staff sickness – more than 7 days off work. Possible RIDDOR/ MHRA/ StEIS reportable incident.	Major injury, illness, Mental Health issue requiring long term treatment or community care intervention. Long term staff sickness. More than 15 staff affected. Post-traumatic stress disorder.	Death. Life threatening injury or illness or harm. Permanent injury/ damage/ loss of limb/ long term incapacity or disability. StEIS.

Domain	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Staffing Levels	Short-term low staffing levels that temporarily reduces service quality. (less than 1 day)	Low staffing levels that reduce the service quality. (1-5 days)	Late delivery of key objective/ service due to lack of staff/ capacity. Unsafe staffing level. (1-2 weeks) Staff Turnover.	Uncertain delivery of key objective/ service due to lack of staff. Unsafe staffing level. (more than a month) Loss of key staff. Staff Turnover.	Non-delivery of key objective/ service due to lack of staff. Constant ongoing unsafe staffing levels or competence. Loss of several key staff.
Statutory Duty/ Inspection	No breach/ minimal impact of guidance/ statutory duty.	Single breach identified which if repeated would result in significant infringement of any person's rights or welfare (of less than one week duration), minor reduction in quality of life, minor reversible health condition.	Single breach, if repeated, would result in a risk of harm including temporary disability (of more than one week's but less than one month's duration), reversible adverse health condition, significant infringement of any person's rights or welfare (of more than one week but less than one month duration) and /or moderate reduction in quality of life.	More than one breach of a regulation or relevant requirements at the same location (sector, Directorate) or across the whole or part of the service, which may indicate that the current conduct is part of a pattern. Failure to make improvements since previously identified breach or enforcement action. Known failure to assess or act on a breach. Breaches that may result in civil enforcement action, low performance rating or improvement notices.	Breaches that result in criminal enforcement action or removal of registration for example: A breach/ multiple breaches that has resulted in death of one or more patient.

North West Ambulance NHS Trust
Equality Impact Assessment Form (EIA) - Policies & Procedures

Name of policy or procedure being reviewed: **Risk Management**

Equality Impact Assessment completed by: **Risk and Assurance Officer**

Initial date of completion: **24 February 2023**

It is anticipated that this EIA will be reviewed throughout the lifecycle of the policy or guidance. Relevant documentation should be maintained relating to the review. Please also record any stakeholders who input into this now or in the future. There is a longer version of this form for assessing the impact of strategy and major plans.

Section 1 – Overview

What kind of policy/procedure is this – eg clinical, workforce?

This 'Corporate' policy is to ensure a structured and systematic approach to risk management is implemented throughout the Trust.

Who does it affect? (Staff, patients or both)?

This policy is intended to cover ALL employees of the Trust, bank staff, and agency staff, all self-employed NHS Professionals, trainees, student placements working for NWAS (herein known as NWAS staff). In addition, all volunteers are expected to adhere to this policy.

How do you intend to implement it? (Trust wide communications plan or training for all staff)?

The policy will be placed on the Green Room for all staff to access.

Section 2 – Data and consultation

In order to complete the EIA it may be useful to consider the following:-

- What data have you gathered about the impact of policy or guidance on different groups?
- What does it show?
- Would it be helpful to have feedback from different staff or patient groups about it?

Please document activity below:

Equality Group	Evidence of Impact
Age	The policy includes litigation risks; this will incorporate any risks in relation to Equality legislation and other standards

Disability – considering visible and invisible disabilities	relating to the needs of people with protected characteristics. The Trust has staff and systems in place to identify equality related risks.
Gender	
Marital Status	
Pregnancy or maternity	
Race including ethnicity and nationality	
Religion or belief	
Sexual Orientation	
Trans	
Any other characteristics e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee	

Section 3: Impact Grid

Having considered the data and feedback through consultation, please detail below the impact on different groups (Age, Disability – considering visible and invisible disabilities, Gender, Marital Status, Pregnancy or maternity, Race including ethnicity and nationality, Religion or belief, Sexual Orientation, Trans, Any other characteristics for patient or staff e.g. member of Armed Forces family, carer, homeless, asylum seeker or refugee):

Equality Group	Evidence of Impact	Is the impact positive or negative?
All groups	This is a corporate policy relating to the application of Risk Management across the Trust for all staff equally.	Neither

Section 4 – Action plan

At this point, you should prepare an action plan which details the group affected, what the required action is with timescales, and expected progress. You may still be seeking further information as part of your plan. You can use the table 3 above to detail any further action.

Section 5 – Monitoring and Review

You should document any review which takes place to monitor progress on the action plan or add any information through further data gathering or consultation about the project. It is sensible for the review of this to be built into any plans. More information about resources can be found on the greenroom.

Further information about groups this policy may affect can be found here pages 10-11.
https://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

Appendix 4: Monitoring Compliance

Monitoring	Monitoring Lead	Reported to Person/ Group	Monitoring Process	Monitoring Frequency
Identifying Risk *Effective use of DCIQ ERM form*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Quarterly review of risks on DCIQ ERM Module	Quarterly
Assessing Risk *All new risks will be reviewed for completeness and quality of information against guidance in Policy*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Quarterly review of risks on DCIQ ERM Module	Quartey
Assessing Risk *All risks will be scored and graded according to consequence and likelihood using the Trust Risk Matrix*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on DCIQ ERM Module	Monthly
Managing Risk *New & existing risks with a current risk score of 15 and above will be discussed, managed, and presented to Executive Leadership Committee monthly*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Weekly review of risks on DCIQ ERM Module	Monthly
Reviewing Risk *Risks will be reviewed by Directors consistently against guidance in Policy*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Quarterly review of risks on DCIQ ERM Module	Quarterly
Reviewing Risk *All tolerated/ transferred/ accepted risks will be reviewed annually*	Head of Risk and Assurance	Director of Corporate Affairs/ Executive Leadership Committee	Monthly review of risks on DCIQ ERM Module	Monthly
Reviewing Risk *Strategic risks will be reviewed each quarter with the appropriate Executive Director and recorded on the BAF*	Head of Risk and Assurance	Director of Corporate Affairs/ Board of Directors	Board Assurance Framework	Quarterly

Risk Management Process *Annual review of the Trust risk management process undertaken by Internal Audit*	Head of Risk and Assurance	Director of Corporate Affairs/ Audit Committee	Internal Audit Review	Bi-Annually
Risk Management Process *Annual review of the BAF process undertaken by Internal Audit*	Head of Risk and Assurance	Director of Corporate Affairs/ Audit Committee	Internal Audit Review	Annually

REPORT TO BOARD OF DIRECTORS

DATE:	26th April 2023				
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 OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☒ Quality Outcomes ☒ People ☒ Financial / Value for Money ☒ Reputation ☒ Innovation				

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☐	Sustainability	☐
	ELC and Audit Committee			

PREVIOUSLY CONSIDERED BY:	Date:	19th April 2023 and 21st April 2023
	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.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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

4. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

5. RECOMMENDATIONS

The Board of Directors is recommended to:

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

Standing Orders, Reservation of Powers & Scheme of Delegation

Approved by the Board of Directors:

Record of amendments

Number	Section	Date
1	Updated document issued for implementation	1 July 2006
2	Updated following Board approval, 27 September 2006	1 October 2006
3	Annual review, July 2007	25 July 2007
4	Annual review, September 2008	1 October 2008
5	Annual review, September 2009	30 September 2009
6	Annual review, November 2010	24 November 2010
7	Annual review, January 2012	25 January 2012
8	Annual review, January 2013	27 February 2013
9	Annual review, September 2014	24 September 2014
10	Annual review, September 2015	30 September 2015
11	Temporary amendment to the Composition of the Trust	24 February 2016
12	Annual Review, September 2016	28 September 2016
13	Change in Voting Rights and Board Membership General Review and Refresh	31 October 2017
14	Temporary Change in Voting Rights during Interim Period	26 September 2018
15	Annual Review, March 2019	24 April 2019
16	Annual Review, March 2020	27 May 2020
17	Annual Review, March 2021	28 April 2021
18	Annual Review, March 2022	27 April 2022
19	Annual Review, March 2023	

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1. Introduction

1.1 Statutory Framework

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

1.1.2 The principal place of business of the Trust is:

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

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

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

1.1.5 The 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 Chair; Non-Executive Directors and both voting and non-voting Executive Directors.
Chair 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 Chair of the Trust" shall, if the Chair is absent from the meeting or otherwise unavailable, be deemed to include the Vice-Chair 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

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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)
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 Chair 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 or the Freedom of Information Act 2000 and sets out the requirements for public access to information on the NHS.

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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 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 Chair and five Non-Executive Directors, together with up to five Executive Directors. At least half of the membership of the Trust Board, excluding the Chair, shall be independent Non-Executive Directors.

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

- one appointee nominated to be the Deputy or Vice-Chair
- 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 Chair and Non-Executive Directors of the Trust are appointed by NHSE/I, on behalf of the Secretary of State for Health and Social Care.

2.2.2 Associate Non-Executive Directors are appointed by the Trust.

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

2.2.4 Other Executive Directors/Directors shall be appointed by a committee comprising the Chair 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.

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2.3 Terms of Office

2.3.1 The regulations governing the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office of the Chair 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 NHS England's Code of Governance for NHS Provider Trusts, Chairs and Non-Executive Directors should not remain in post beyond nine years from the date of their first appointment and any decision to extend a term beyond nine years should be subject to rigorous review and consideration of progressive refreshing of the Board should be taken into account. In exceptional circumstances, terms may be extended for a limited time beyond nine years however should be subject to annual re-appointment by NHS England. Serving more than nine years could be relevant to the determination of a non-executive's independence.

2.4 Appointment and Powers of Vice-Chair

2.4.1 To enable the proceedings of the Trust to be conducted in the absence of the Chair, the Board of Directors may elect one of the Non-Executive Directors to be Vice-Chair, 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-Chair by giving notice in writing to the Chair. The appointment as Vice-Chair 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-Chair, in accordance with the provision of this Standing Order.

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

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

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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.

Chair
The Chair shall be responsible for the operation of the Board and chair all Board meetings when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair 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.

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Senior Independent Director

The Senior Independent Director shall be available to hear any issues or concerns that individuals feel unable to raise with the Chair or any Executive Director.

2.5.2 In line with NHS England's Code of Governance for NHS Provider Trusts, where directors have concerns about the operation of the Board or the management of the trust that cannot be resolved, these should be recorded in board minutes. In the case of the resignation of a Non-Executive Director, any such concerns should be provided in a written statement to the Chair for circulation to the Board.

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 Chair (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:

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> '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 Chair or by an Officer of the trust authorised by the Chair 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.

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3.2.3 *Meetings called by Directors*

In the case of a meeting called by Directors in the event that the Chair 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.

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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 Chair 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 Chair.

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

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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 Chair of the Meeting

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

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3.5.2 If the Chair and Vice-Chair 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.

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

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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 Chair shall be responsible for deciding whether a vote is required and what form this will take.

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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 Chair of the meeting shall have a second or casting vote.

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3.6.3 All questions put to the vote shall, at the discretion of the Chair 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

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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 Chair present at the meeting, shall be recorded in the minutes.

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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 Chair considers discussion appropriate.

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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 Chair, at least seven working days before the meeting. The Chair shall insert all such notices that are properly made in the agenda for the

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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 Chair to propose a motion to the same effect within a further period of six calendar months.

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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 'Chair' is to be read as a reference to the Chair 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.

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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 Chair 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.

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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 Panel**

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

The Audit 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 Chair 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 Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

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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 Chair and Members in Proceedings on Account of Pecuniary Interest

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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 Chair 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.

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6.3.2 The Board may exclude the Chair 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.

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6.3.3 Any remuneration, compensation or allowances payable to the Chair 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.

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6.3.4 Subject to SO 6.3.3 and any conditions imposed by the Secretary of State, the Chair 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:

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

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- 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 Chair 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.

Deleted: Chairman

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 Chair and Members in Proceedings on Account of Pecuniary Interest ' (SO 6.3) shall apply.

Deleted: Chairman

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 Chair and Chief Executive in public session in accordance with SO5.2.

Deleted: Chairman

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

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

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

3.1.8 Approve arrangements for dealing and responding to complaints.

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

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

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

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

3.1.13 Receive reports on instances of use of the seal.

3.1.14 Ratify, or otherwise, instances of failure to comply with Standing Orders or Standing Financial Instructions brought to the Chief Executive's attention in accordance with SO5.7.

3.2 Appointments and dismissals

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

- Appoint the Chief Executive
- Appoint the Executive Directors

Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests

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

3.2.3 Approve the disciplinary procedure for officers of the Trust.

3.3 Strategy, plans and budgets

3.3.1 Define the strategic aims and objectives of the Trust.

3.3.2 Approve all Trust strategies

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.

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

3.3.5 Approve Final Business Cases for Capital Investment schemes where the value exceeds £1,000,000.

Deleted: 500,000

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

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

3.3.8 Approve PFI proposals.

3.3.9 Approve the opening of bank accounts.

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 £1,000,000 during the duration of the contract.

Deleted: 500,000

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.

3.4.2 Approval of policies is delegated to the Executive Leadership Committee however 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
- Disciplinary Policy
- Policy on Prevention and Reduction of Violence

Deleted: ¶

Deleted: 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 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 Director of Finance	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 Voting Directors	Chairman & Chief Executive after having consulted with 2 NEDs & 2 Executive Voting 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, Deputy 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/Deputy Chief Executive	Head of Procurement Head of Corporate Governance	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 Head of Risk and Assurance	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 Corporate Affairs	Head of Risk and Assurance	Complaints, Incidents and Investigations Policy Incident Reporting Procedure Serious Incident Investigation Procedure
Patient Safety Incident Response Framework (PSIRF)	Director of Corporate Affairs	Head of Risk and Assurance	Patient Safety Incident Reponse Plan Patient Safety Incident Response Policy
Serious Incidents - Declaration of SI - Approval of Clinical SI Report - Approval of Non-Clinical SI Report	Director of Corporate Affairs ROSE/Medical Director Medical Director Director of Corporate Affairs	Head of Risk and Assurance	Serious Incident Procedure
Complaints Management - Level 1-3 - Level 4 and 5	Director of Corporate Affairs Patient Safety Manager Senior Patient Safety Manager to approve prior to CEO sign off	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) Redress Procedure

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Claims: Employer's Liability, Public Liability and Medical Negligence - Employers' Liability upto £500k - Employers' Liability £500k+ - Public Liability and Property Damage upto £25k - Public Liability and Property Damage upto £500k - Clinical Negligence upto £500k - Clinical Negligence over £500k	Director of Corporate Affairs Head of Legal Service Director of Corporate Affairs Solicitors Head of Legal Services Head of Legal Services Clinical Negligence Panel	Head of Legal Services	SFIs: Losses, write off and Compensation Claims Policy
Redress	Director of Corporate Affairs	Head of Legal Services	Redress Procedure
Litigation Papers	Director of Corporate Affairs	Head of Legal Services	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 - Upto £2,499 - £25,000 to £50,000 - Above £50,001	 Deputy Director of Finance/Head of Technical Accounts or Director of Corporate Affairs Director of Finance or Chief Executive Charitable Funds Committee or Board of Directors	Director of Finance	SFI 16 Charitable Funds Procedure
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	Annual Plan National Planning Guidance
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 2000
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 - Project approval authority outlined in SFI requirements	Director of Strategy, Partnerships and Transformation Director of Strategy, Partnerships and Transformation	Head of PMO Head of Partnership and Integration	The Project Way, Benefits Management Framework SFI Requirement to obtain Quotes and Tenders (all Revenue and Capital items)
4. Service Delivery			
Resilience/Emergency Planning	Director of Operations	Assistant Director of Resilience	Incident Response Plan v8.5
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 to a maximum of £25m capital costs for property and non digital investments; or £30m whole life costs for digital improvements - 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) Chief Clinical Information Officer (CCIO)	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~~ 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 Information Asset Owners	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 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 Duty of Candour Policy

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: - Reporting of Single Oversight Framework through Integrated Peformance Report - Delivery of Single Oversight Framework	Director of Quality, Innovation and Improvement All Executive Directors	Chief of Digital and Innovation	Single Oversight Framework NHS Information Governance Handbook
CQC Registration - Accountable Officer - Registered Manager	Chief Executive Director of Quality, Innovation and Improvement	Deputy Chief Executive Deputy 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 inclduing a final written warning.	Director of People Chairman Chief Executive Non-Executive Directors Director (Executive Director/Area Director/Deputy 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 inclduing 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 apropraite authorisation by Finance - Approve in-year proposals for re-structure resulting in establishment changes not affecting Directors subject to Very Senior Manager Pay Arrangements	 Board of Directors Nominations and Remuneration Committee Chief Executive Executive Leadership Committee	 Chief Executive	
Remuneration and Conditions of Service: Very Senior Manager Pay arrangements: - Authorisation of all pay, benefits and grading issues for Directors subject to Very Senior Manager Pay arrangements and NHS Improvement (NHSI) approval. - Recommendation of non-contractual termination payments to the NHSI and Treasury for approval - Approval of costs incurred in relation to Directors subject to Very Senior Manager Pay arrangements, Senior Managers and other cases where the cost exceeds £50,000. - Approval of business cases for redundancy where the costs exceed £50,000. - Recommend contractual terminations to the NHSI where costs exceed £100,000 - Jointly approve business cases for redundancy/premature retirement applications where the cost does not exceed £50,000	 Nominations and Remuneration Committee Director of People and Director of Finance	 Director of People	SFI S8
Payroll Processes: - Security and auding of all payroll processes	 Director of Finance	 Deputy Director of Finance	Establishment Control Procedure

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
- 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 People	Deputy Director of People	
Education and Learning	Director of People	Assistant Director Workforce & OD	
Performance Appraisal Policy & Procedure	Director of People	Assistant Director Workforce & OD	Performance Appraisal Policy and Procedure
Pay Progression Deferral	Director of People	Assistant Director Workforce & OD	Performance Appraisal Policy and Procedure Pay Progression Guidance
Sickness Warning Arrangements - 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 - Any cases where dismissal is a possible sanction - 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 inclduing 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:

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	27 April 2022
18	Annual Review, April 2023	

Standing Financial Instructions

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1. Introduction

1.1 General

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

1.1.2 The Code of Conduct and Accountability in the NHS issued by the Department of Health and Social Care (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 Chair, 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.
Chair 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 'Chair of the Trust' shall be deemed to include the Vice-Chair of the Trust if the Chair 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.

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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 Chair.
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 Chair 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.

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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 Chair 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).

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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 Chair 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 Chair 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, including Audit Committee oversight, 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 Counter Fraud Authority.

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 Anti-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 Counter Fraud Authority in accordance with the NHS Fraud and Corruption Manual.

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

2.6 Security management

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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 aligned and agreed within our lead Integrated Care System (ICS) 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;
f. be based on reasonable and realistic assumptions and reflect year-on-year cost efficiency and productivity programmes;
g. be in line with national planning guidance issued by NHS England.

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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 will 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.

3.3 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.
   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 have the authority from the Director of Finance in relation to any transactions which result in income for fees and charges for the Trust, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

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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.

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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, Executive Directors and other Very Senior Managers in conjunction with NHSE where required ensuring that officers are fairly rewarded for their individual contribution to the Trust – having proper regard 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)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

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 Chair 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 plans are incorporated within the annual pay budget and 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.

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monitor and evaluate the performance of individual executive directors; and¶
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. ¶

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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, and in line with the Trust's procedures on recruitment

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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 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.

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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 shall be sought.

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 via 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

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- 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 The Trust will enter into contracts with suppliers for good and services via the Trust's official orders. Budget holders should not be signing contracts with suppliers for services. The official orders must:

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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 purchase order permitted within the Scheme of Delegation or delegated budget) leases, tenancy agreements and other commitments which may result in a financial liability are notified and agreed by the Director of Finance in advance of any commitment being made;
b. contracts above specified thresholds are advertised and awarded in accordance with the latest national policy and legislation, including any specific procuring in a national emergency guidance (e.g. Covid), 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 supplier 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/purchase order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;
f. all goods, services or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or on purchasing cards;
g. verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked 'Confirmation Order';
h. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
i. goods are not taken on trial or loan in circumstances that could commit the Trust to a future un-competitive purchase;
j. changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;
k. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;
l. petty cash records are maintained in a form as determined by the Director of Finance;
m. orders are not required to be raised for utility bills, NHS recharges, 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.
o. Credit card purchase records are maintained in a form as determined by the Director of Finance.
p. No local agreements/contracts for any goods or services should be signed without prior engagement with the Procurement Department.

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.

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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 is produced in line with the guidance contained within the NHSE *Capital regime, investment and property business case approval guidance for NHS trusts* and HM Treasury Green Book 5 Case Model, identifying the following:):

I. Business Justification Case for Change for investment including SMART investment objectives, strategic alignment, risks, constraints and planned benefits (financial and non-financial) internal to NWAS; across the Public Sector; and the wider societal benefits, with the involvement of appropriate Trust personnel and external agencies.

II. an economic option appraisal of potential benefits compared with known net present social costs to determine the option with the highest benefit to cost ration.

III. the commercial/procurement requirements to secure the best Value For Money (VFM) solution

IV. the appropriate project management and control arrangements to ensure successful delivery including benefits realisation plan and post project evaluation methodology.

V. 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 10% 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.

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.

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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.
d. Lease agreements in respect of Right of Use (ROU) assets that were previously treated as operating leases.

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 Where leases that are treated as ROU assets are terminated their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

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

11.3.7 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.

11.3.8 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.

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

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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.

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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 Anti-Fraud Specialist who will inform NHS Counter Fraud Authority before any action is taken and reach agreement how the case is to be handled.

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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 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 independent review.

Deleted: 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.

Deleted: ~~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'.

17.3.2 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.

17.3.3 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.

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17.3.4 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.

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*Note. The waiver process is a process of **last resort** and Procurement will explore all other options before supporting a waiver.*

17.3.5 Fair and adequate competition

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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.

17.3.6 Use of regional / national contracts

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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.

17.3.7 Building and engineering construction works

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

17.3.8 Items which subsequently breach thresholds after original approval

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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

17.5.1 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.

Deleted:

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 £999,999
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	6	Up to £24,999
A4C Band 8b / 8c	7	Up to £9,999
A4C Band 8a	8	Up to £7,499
A4C Band 6 / 7	9	Up to £4,999
A4C band 4 / 5	10	Up to £2,499

Deleted: 499,999

Note:

Expenditure of £1,000,000 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.

Deleted: 500,000

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 999
Operational Procurement Officer	Up to £9,999
Senior Procurement Officer	Up to £24,999
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:

Purchase Orders for all lease agreements must be authorised by the Director of Finance regardless of value.

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 £29,999	Minimum of 3 formal written quotations	Head of Procurement	Lead Procurement Manager	Appropriate Service Line Finance Lead	Director
£30,000 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

Note, to comply with Public Procurement Note 05/21 from April 2023 contracting authorities with an annual spend of £100m or more are required to publish procurement pipelines.

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 £50,000
Charitable Funds Committee or Board of Directors on behalf of Corporate Trustee	>£50,001

Deleted: 24,999

Deleted: 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.

REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="5">26th April 2023</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">FT Code of Governance – 2022/23 Position of Compliance</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="5">Angela Wetton, Director of Corporate Affairs</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td><td>SR05</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>SR06</td><td>SR07</td><td>SR08</td><td>SR09</td><td>SR10</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="5">For Assurance</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="5">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) 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.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="5">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.</td></tr>
<tr><td>CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)</td><td colspan="5">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Compliance/Regulatory
☐ Quality Outcomes
☐ People
☐ Financial / Value for Money
☐ Reputation
☐ Innovation</td></tr>
<tr><td colspan="6">INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td colspan="2">Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
</table>

<table>
<tr><td rowspan="3">PREVIOUSLY CONSIDERED BY:</td><td colspan="2">Audit Committee</td></tr>
<tr><td>Date:</td><td>21st April 2023</td></tr>
<tr><td>Outcome:</td><td></td></tr>
</table>

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1. PURPOSE

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

2. NHS CODE OF GOVERNANCE

From 1st April 2023, all provider trusts will be required to report against the updated Code of Governance on a comply or explain basis. The Committee received an update at the January 2023 meeting outlining the corporate governance processes to be strengthened as a result of the updated Code.

Some of this work has been included in the annual governance review processes however will continue to be implemented throughout 2023/24. A full update will be provided to the April 2024 Committee meeting.

3. COMPLIANCE AGAINST THE FT CODE

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

The Trust is able to declare compliance with all relevant clauses.

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

4. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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 the Code's relevant clauses.

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

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 strategic goals. The Board 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. Performance reports are not subject to any	• IPR • Planning process • Financial report includes efficiency updates • Trust Strategy • Right Care Strategy • Urgent and Emergency Care Strategy • Board Assurance Framework • Quality Account • Annual Plan • ICS Operational Planning Submissions	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		exemptions under FOIA and appear in the Board held in public.		
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. Each committee and subcommittee is subject to an annual effectiveness review against their terms of reference. The Board of Directors receive an Annual Report from each of the Committees detailing the work undertaken during the year. Terms of Reference for all Committees and Subcommittees are reviewed and approved by the Board or parent Committee. Subcommittees to support the Audit, Resources and Quality & Performance Committees are in place. 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	√
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 Trust has a systematic approach to clinical governance which is focused on the relevant policy guidance and regulatory framework and	• Right Care (Quality) Strategy	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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.	supported by the Trust's Right Care (Quality) Strategy. The Quality and Performance Committee obtains assurance from the Clinical Effectiveness Subcommittee. The Quality and Performance Committee meets monthly and receives assurance reports from the Chair of the Clinical Effectiveness Subcommittee following each meeting. The Chair of the Subcommittee 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 Report from the Quality and Performance Committee is submitted to every meeting.	• Clinical Audit reports • Minutes of Quality and Performance Committee • Quality and Performance Committee Workplan • Clinical Effectiveness Subcommittee minutes • Clinical Effectiveness Subcommittee Workplan • IPR to Board of Directors • Quality Account • Audit Committee Minutes • Internal Audit Reports	

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
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 NHSE.	• 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 Board of Directors are required to sign the Code of Conduct on an annual basis along with a Fit & Proper Persons declaration. 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.	• Board Standing Orders • Code of conduct signed by all members of the Board • Annual FPPR declaration by all members of the Board • Register of Interests • Standards of Business Conduct policy • Trust Values • Our Strategy 2022-2025	√
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	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.	• Web site – Trust Board • Standards of Business Conduct Policy	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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 matters) and make clear how potential conflicts of interest are dealt with.	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.	• Code of Conduct • Register of Interests	
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	The Trust does not have Directors & Officers Liability insurance. The NHS Resolution Liability insurances offers an element of protection. However, as the Trust is not an FT, there is financial protection for Directors and Officers underwritten by the Secretary of State.		N/A
A.2	**Division of Responsibilities** **There should be a division of responsibilities at the head of the NHS Foundation Trust between the chairing of the Boards of Directors and Council of Governors, and the executive responsibility for the running of the NHS Foundation Trust affairs. No one individual should have unfettered powers of decision.**			
A.2.1	The division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the Board of Directors.	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.	• Signed MOU • 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. NHSE leads the appointment process for NHS Trusts on behalf of the Secretary of State. On appointment the Chair met the independence criteria and had not previously been a chief	• NHSE Appointment processes. • Declaration of Interest	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		executive of the Trust. The Chair continues to meet the independence criteria.		
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 Trust is not an FT and therefore does not have a Council of Governors. The role of SID was undertaken by a Non-Executive Director, who also acted as the Vice Chair. The Trust had a nominated NED lead for Freedom to Speak Up during 2022/23. 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 Chair 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 Chair was undertaken by the SID during 2022/23 in accordance with the NHSE 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	The Trust values embrace NHS values that 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	• Trust Board Minutes • Exit interviews	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	chairperson for circulation to the board, if they have any such concerns.	escalation of concerns. All Board members are encouraged to articulate their views in Board meetings and the minutes clearly and accurately reflect this.		

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 2022/23

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 by NHSE.	• 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 • Employment Contracts	√
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 for final approval.	• Committee ToR • Committee minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

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 however the Trust will undertake additional 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. The Chair makes an annual assurance declaration to the Board.	• Annual revalidation process F&PPT Declaration • Annual Chair Assurance declaration to Board • 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. NHSE is responsible for the appointment and terms and conditions of Non-Executives and Chair.	• Terms of Reference • Committee minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.2.4	The chairperson or an independent non-executive director should chair the Nominations Committee.	The Chair of the Trust Chairs the Nominations and Remuneration Committee.	• Committee minutes • Attendance register • ToR	√
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 is not a FT and therefore does not have a Council of Governors. The Trust Chair is appointed by NHSE 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	• ToR • Minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		that allow for an independent advisor to attend meetings.		
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 additional 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 Chair/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 the induction. In addition, NEDs are informed of any additional external 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.	• Chair/NED Induction Pack • Board Development Programme • Mandatory Training • NED Training/Event Register	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		All Directors and Non-Executive Directors are expected to complete their mandatory training. The Trust does not have a council of governors.		
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.	NHSE set the appraisal requirements for Non-Executives however the chair identifies any training & development required through annual appraisals. The Chief Executive undertakes the appraisals for Executive Directors and will identify any relevant additional training and development required for their role. The outcome of these appraisals is reported to the Nominations & Remuneration Committee on a bi-annual basis.	• Appraisal documentation. • Minutes of Committee • Committee ToR	√
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 covering sheet of Board papers provides clarity over a paper's salient points and the action required during the meeting. The Board of Directors 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.	• Board paper front Cover • Cycle of Business • Board minutes • ToR	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	the NHS foundation trust that it deems necessary to discharge its duties, including access to senior management and other employees.	All committee terms of reference allow for members to call upon other staff members to attend to answer queries and/or provide information.		
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	The Corporate Governance Team support the Board of Directors and its assurance committees.	• Board/Committee structure	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	governors is provided with sufficient resource to undertake its duties with such arrangements agreed in advance.			
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 Chair is undertaken by the SID in accordance with NHSE 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 2022/23 and the following board development sessions have taken place:
		• 24th May 2022 – Leadership Development
		• 30th August 2022 – Leadership Development
		• 26th October 2022:
		  ○ EDI – WRES/WDES/Gender Pay Gap
		  ○ Employee Relations
		  ○ Service Delivery Update
		  ○ BLS / Community First Responders
		• 22nd February 2023 – NED Development Session:
		  ○ Annual Operational Plan and Financial Plan 2023/24
		  ○ Future contracts and investment
		  ○ Strategic Risks & Risk Appetite Statement 2023/24
			• Board Development Sessions Programme
			• Attendance List
			• Board Skills Matrix
				√

B.6.5	Led by the chairperson, the council of governors should periodically assess their collective performance and they should regularly communicate to members and the	Not applicable		

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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.			
B.6.6	There should be clear policy and fair process, agreed and adopted by the council of governors for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council of governors or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors. In addition, it may be appropriate for the process to provide for removal from the council of governors where behaviours or actions of a governor or group of governors may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be requested to consider the evidence and determine whether the proposed removal is reasonable or otherwise.	Not applicable		

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
B.8	**Resignation of Directors** **The board of directors is responsible for ensuring ongoing compliance by the NHS foundation trust with its licence; its constitution; mandatory guidance issued by Monitor; relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate succession planning.**			
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	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 NHSE for mitigations.	• Minutes NARC and Board meetings • Executive Employment Contracts	√
C	**ACCOUNTABILITY**			
C.1	**Financial, quality and operational reporting** **The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects.**			
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	The Directors receive assurance from the Auditors at year-end which is reported to the Board of Directors and declared within the Annual Report. The Director of Finance presented the Board with a paper on Going Concern at the Board Meeting on 29th March 2023 for agreement.	• Annual Report and Accounts • Auditors Opinion • Board Minutes	√
C.1.3	At least annually and in a timely manner, the board of directors should set out clearly it's financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow	All of this information is disseminated within the Annual Report as per Group Accounting Manual (GAM) Requirements.	• Annual Report • Audit Committee minutes • Board minutes	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	members and governors to evaluate its performance. Further requirements are included in the NHS FT ARM.			
C.2	**The Board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.** **The board of directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHSFTs assets and service quality. The board should report on internal control through the Annual Governance Statement in the annual report.**			
C.2.1	The Board of directors should maintain continuous oversight of the effectiveness of the NHS FTs risk management and internal control systems and should report to members and governors that they have done so in the annual report. A regular review should cover all material controls, including financial, operational and compliance controls.	The Risk Appetite Statement for 2022/23 was approved by the Board on 30th March 2022 and is reviewed on an annual basis. The Board of Directors receive the Board Assurance Framework quarterly and Board committees receive an update at each meeting. As Accountable Officer, the Chief Executive has responsibility for maintaining a sound system of internal control which is reflected annually within the Annual Governance Statement and included in the Annual Report. The Risk Management Policy defines the approach taken by the Trust in applying risk management to its decision making at all levels and the main objective is to establish the foundations for a culture of effective risk management throughout the organisation. It sets out clear definitions, responsibilities, and process requirements to enable the principles and techniques of risk management to be applied consistently throughout the organisation.	• Risk Management Strategy • Risk Management Policy • Risk Appetite Statement • Board Assurance Framework • Annual Report • Head of Internal Audit Opinion • Annual Governance Statement • Minutes of Committee Meetings • Minutes of Board Meetings	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
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 which is contained in the Annual Report. 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 4 Non-Executives Directors, including the Chair of the Audit Committee as members. The Chair of the Audit Committee has the relevant recent financial experience. The Trust Chair is not a member of the committee.	• ToR • Standing Orders • Minutes of Audit committee	√
C.3.3	The council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing the external auditors. The council of governors will need to work hard to ensure they have the skills and knowledge to choose the right external auditor and monitor their performance. However, they should be supported in this task by the audit committee, which provides information	Not applicable		

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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 a procurement 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. These processes should also reassure individuals	The Freedom to Speak Up Policy and Procedure was approved by the Board of Directors on 30 November 2022. 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 2022/23, the executive lead for Freedom to Speak Up was the Medical Director, with a nominated Non-Executive lead.	• Bi-annual FTSU Report to Board • Board minutes • Freedom to Speak Up Policy	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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.	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 guidance. These payments are subject to approval from the Nominations & Remuneration Committee and NHSE and are based on evidence presented around annual performance and delivery of objectives.	• NARC minutes • Annual PDR documentation	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	• 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 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 for Non-Executives is are dictated by NHSE for NHS Trusts.	• 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. Since 2019, new director appointments reflect a 'earn 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	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	• NARC Committee ToR • Annual Report	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
	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.	pay structure is governed by the DH VSM Pay Framework of 2013 and NHSE Guidance from 2018. The Trust's definition of a senior manager is those on VSM pay, including the Chief Executive and Executive Director posts.		
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, staff, partners, members, volunteers, political influencers and statutory organisations. The Trust is the only ambulance service within the North West operating across 5 ICSs. It is increasingly important that the Trust engages in any potential discussions and plans to change services at a very early stage so any options can	• Communications and Engagement Strategy • Right Care Strategy • Friends and Family Test • Patient and Public Panel	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		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. • '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.		

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2022/23

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
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. NHSE, commissioners at system level (ICSs) and the CQC. Members of the Board and senior leadership are the nominated contacts for these organisations. Regular engagement meetings take place. The Trust's Partnership and Integration team produce a regular briefing 'NWAS Link' for managers that engage externally for each ICS. The briefing supports consistent messaging/asks of the system with the provision of one service knowledge to be shared with stakeholders. The Trust's Knowledge Vault is a central knowledge and information database developed	• ELC Minutes • Board Minutes • NWAS Link Knowledge Vault • Stakeholder mapping and analysis • Integrated Care System Profiles	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		for use across the Trust. The online platform holds information and intelligence to inform decision making, together with details of external engagements, meetings and papers. It provides the ability to drawdown information and history from previous meetings, including discussions and actions.		
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. The Trust is the only ambulance service within the North West operating across 5 ICSs. It is 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	• Communications and Engagement Strategy • Stakeholder Mapping and Analysis	√

CODE	CODE PROVISION	TRUST POSITION	Evidence	Comply?
		community groups, statutory bodies such as Healthwatch and Scrutiny Committees, commissioner and health and social care partners in the region. Executive Directors are aligned as leads for the ICS areas and the Chair attends meetings to engage with Chairs at system level across the areas, such as: • Greater Manchester Provider Federation Board Chairs Meeting, • Lancashire and South Cumbria Provider Chairs Meetings • Engagement meetings with Chief Executive and Lead ICB • Combined NW system and Chairs Meetings		

REPORT TO BOARD OF DIRECTORS

DATE:	26th April 2023
SUBJECT:	Non-Executive Terms of Office; Committee Membership 23/24 and Non-Executive Champion Roles
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:

This report confirms Non-Executive Directors Terms of Office (s2) and provides assurance to the Board of Directors that:

1. The Board can declare compliance with the NHS Code of Governance provision 4.3 with respect to Non-Executive Directors Terms of Office.
2. The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended)

The Non-Executive Director Committee membership for 2023/24 can be seen in s3.

The approach to non-executive director champion roles can be seen in s4.

RECOMMENDATIONS:

The Board of Directors is asked to note:

- The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended); and
- Compliance with the NHS Code of Governance in respect to Non-Executive Directors Terms of Office.
- The Non-Executive Directors Committee membership for 2023/24.
- The Non-Executive Director Champion Roles

CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)

The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:

☐ Compliance/Regulatory
☐ Quality Outcomes
☐ People
☐ Financial / Value for Money
☐ Reputation
☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT				
ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	N/A			
	Date:			
	Outcome:			

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1. PURPOSE

The purpose of this report is to raise Board awareness of Non-Executive Directors Terms of Office and to provide assurance to the Board of Directors that:

1. The Board can declare compliance with the NHS Code of Governance provision 4.3 with respect to Non-Executive Directors Terms of Office.
2. The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended)

This paper also confirms the Non-Executive Director Committee membership for 2023/24.

2. TERMS OF OFFICE

In an NHS Trust, Non-Executive Directors are appointed by NHSE on behalf of the Secretary of State for Health for an initial term of office of 2 years and at the end of that 2-year period, consideration is given to extending their term of office with reappointment for a further 2 years.

The NHS Code of Governance provision 4.3 states that Chairs or Non-Executive Directors, to ensure independence, should not serve more than 9 years except in exceptional circumstances.

Terms of Office wef 1st April 2023 are shown below:

Non-Executive Directors	
Name	**Term of Office**
Peter White (Chairman) Non-Executive Director Terms of Office	01/02/23 – 31/01/25 01/02/19 – 31/01/23 Ended 31/1/19 30/04/18 – 30/04/20 01/05/16 – 30/04/18 01/05/14 – 30/04/16
David Hanley	Renewed 28/05/23 – 27/05/25 28/05/21 – 27/05/23 28/05/19 – 25/05/21
David Rawsthorn	Renewed 25/03/23 – 24/03/24 25/03/21 – 24/03/23 25/03/19 – 24/03/21
Alison Chambers	01/08/21 – 31/07/23 01/08/19 – 31/07/21
Prof Aneez Esmail	Renewed 01/04/23 – 31/03/26 01/04/21 – 31/03/23
Catherine Butterworth	01/04/22 – 31/03/24
David Whatley (Associate Non-Executive Director)	27/03/23 – 31/03/25

3. COMMITTEE MEMBERSHIP

As a result of the Chairman's annual review of Committee membership, the Non-Executive Director membership for 2023/24 is as follows:

Committee	Membership
Audit Committee	David Rawsthorn (Chair) Prof Alison Chambers Prof Aneez Esmail Catherine Butterworth David Whatley
Nominations & Remuneration Committee	Chair and all Non-Executive Directors
Quality and Performance Committee	Prof Aneez Esmail (Chair) Prof Alison Chambers Dr David Hanley
Resources Committee	Dr David Hanley (Chair) David Rawsthorn Catherine Butterworth David Whatley
Charitable Funds Committee	David Rawsthorn (Chair) Dr David Hanley Catherine Butterworth David Whatley

The Terms of Reference for each of these Committees will be updated to reflect the revised membership and presented to the Board of Directors in April 2023 for approval.

4. ENHANCING BOARD OVERSIGHT: NON-EXECUTIVE DIRECTOR CHAMPION ROLES

Following guidance issued in December 2021 regarding a move away from several champion roles, transitioning oversight into the Board Assurance Committees. The roles that continue to be retained can be seen below along with the named Non-Executive:

Role	Type of Role	Legal Basis	Named Non-Executive
Maternity board safety champion	Assurance	Recommended	Aneez Esmail
Wellbeing Guardian	Assurance	Recommended	Catherine Butterworth
FTSU NED Champion	Functional	Recommended	David Hanley
Security management NED champion	Assurance	Statutory	David Rawsthorn

5. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

In accordance with the Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended), the Trust is required to have five voting Non-Executive Directors plus a voting Non-Executive Chairman.

6. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

7. RECOMMENDATIONS

The Board of Directors is asked to note:

- The Board remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended); and
- Compliance with the NHS Code of Governance in respect to Non-Executive Directors Terms of Office.
- The Non-Executive Directors Committee membership for 2023/24.
- The Non-Executive Director Champion Roles

REPORT TO BOARD OF DIRECTORS

DATE:	26 April 2023
SUBJECT:	Freedom to Speak Up – Annual Report
PRESENTED BY:	Freedom to Speak Up Guardian

LINK TO BOARD ASSURANCE FRAMEWORK:

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

PURPOSE OF PAPER:	For Assurance

EXECUTIVE SUMMARY:

'The silence of missing voices costs careers, relationships, and lives' (Reitz, 2019)

This paper is to inform the board of the activities undertaken by the Freedom to Speak Up (FTSU) Guardians over the last financial year (2022/23). It includes details surrounding 'Speaking Up' within NWAS, alongside the work undertaken to improve our speaking up culture.

In 2022/23, the trust had 100 concerns raised via its Freedom to Speak Up Guardians, a slight increase from 97 concerns in the previous year.

In reference to our annual staff survey, 5 out of 10 staff believe we would address concerns around unsafe clinical practice, whilst 4 out of 10 believe we would address non-clinical concerns.

Throughout the last year, several national reports have been published for both ambulance services and other blue light organisations and have led to greater scrutiny of FTSU arrangements. These reports are vital in creating further valuable insights into our own cultural transformation.

The guardians have been very active over the past 12 months refreshing our approach and staff awareness of FTSU in all areas of the organisation.

RECOMMENDATIONS:

The Board is asked to:

- Recognise the work to date that commits our organisation to embed Speaking Up and Just Culture principle and practices.

	• Continue our commitment to ensuring every voice is listened to, by a full review and implementation of the National Guardian Office Report published February 2023. • Receive this Annual Report as evidence of the ongoing work of the Guardians in supporting our staff in making speaking up business as usual.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☒ Quality Outcomes ☒ People ☐ Financial / Value for Money ☒ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

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

This paper is to inform the Board of the activities undertaken by the Freedom to Speak Up Guardians over the last financial year. It includes details surrounding 'Speaking Up' within NWAS, alongside the work undertaken to improve our speaking up culture.

2. BACKGROUND

'The silence of missing voices costs careers, relationships, and lives' (Reitz, 2019)

This year has seen several reports published that involve patient safety within the NHS and the critical nature of 'Speaking Up'. Several ambulance trusts had their speaking up cultures reviewed by the Care Quality Commission, as well as the National Guardian Office (NGO) who published the 'Listening to Workers: A Speak Up Review of Ambulance Trusts in England' Report. In addition, other blue light services have seen national publications regarding their own culture. The 'Leading in Practice' review by the Committee on Standards in Public Life similarly emphasise the importance of not just hearing our workers but truly listening to their concerns and understanding them to lead to wider change. If we are simply hearing voices as opposed to listening to them, we will miss the true value.

The National Guardians Office describe fear and futility being the biggest barriers to speaking up and report the courage and bravery required to speak up. At our Trust, the 2022 staff survey found 6 out of 10 staff felt safe to speak up about both unsafe clinical practice or anything that concerns them. This is in line with the national average for ambulance trusts. However, 5 out of 10 staff believe we address concerns related to unsafe practice and only 4 out of 10 staff believe we would address any concern. Some of the Freedom to Speak Up concerns received in the past year also reflect this. Verbatim comments include:

'We can speak if you want to, but I am not sure it will achieve anything.'

'Already discussed some of our issues with our team leaders, ops manager and sector manager to no avail'.

'I feel I am not able to put my name to this due to reprisals I would receive'.

'The reason I am contacting this email and not my manager is because everyone here is aware this is going on, yet it is going unchallenged.'

'I don't think you can help me, but if I don't ask, nothing will change, I don't know what to do.'

Despite the concerns over fear and futility, this year we have seen a slight increase in the number of people speaking up via the Guardians, with 100 members of staff contacting the service for advice and support.

There are multiple additional actions taken throughout the last year, to further embed a speaking up culture:

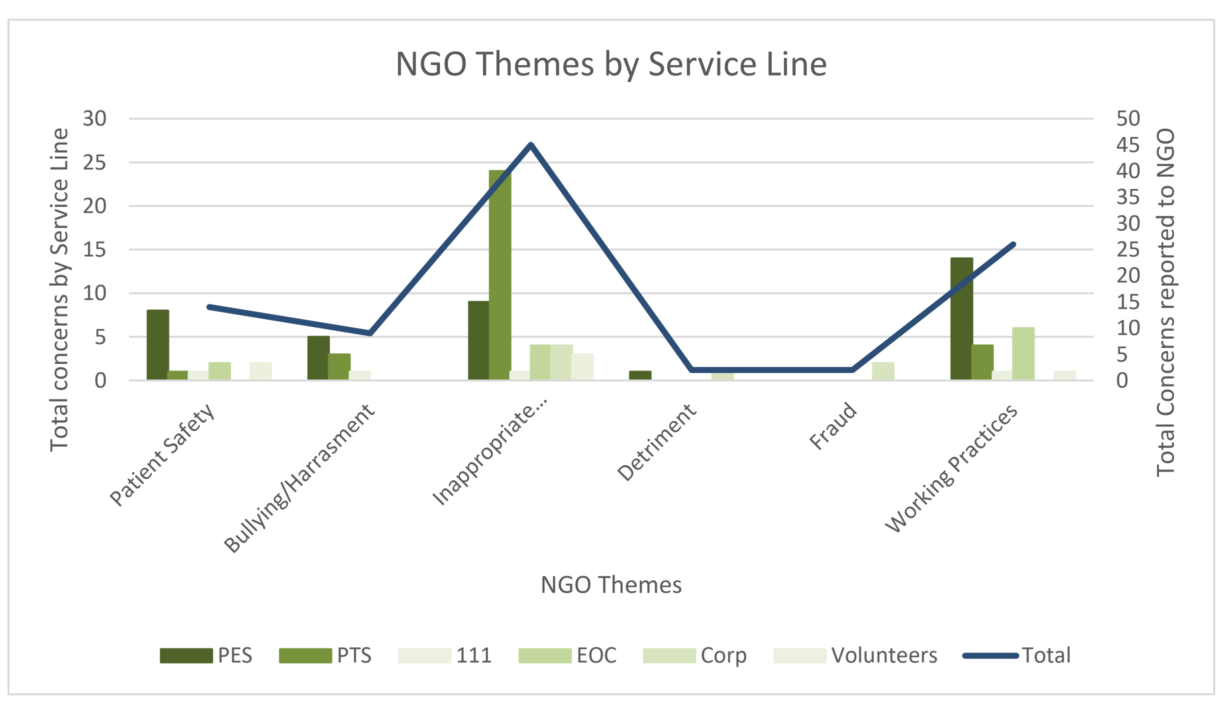
- Contact centres and several PES sectors have introduced online suggestion boxes.
- Implementation of Datix Cloud IQ and iPad role out programme has enabled staff to raise concerns direct from the frontline.
- The communications team manage a staff Facebook group, which allows issues to be raised and resolved directly with management staff.
- Area Directors and/or Area Head of Operations hold successful “open house” staff forums.
- ‘Team Talk’ sessions after Board meetings facilitate direct live access to Board members.
- A “CEO” email address allows direct access to all staff to raise issues to the Chief Executive.

Activity as outlined above is not part of this report, given it sits outside of the direct Freedom to Speak Up processes and data capture remit.

Thematic Analysis

In 2022/23, changes can be observed in the themes as per Figure 1. There is a reduction in bullying and harassment, but caution should be applied to this, given the numbers are very small each year but is still a welcome potential trend. Over time, the National Guardians Office have changed the way data is recorded and hence cross referencing with NHS Staff Survey is vital. At NWAS, the staff survey would also support a slight improvement in staff been subjected to bullying and harassment at work, which may offer some additional assurance.

Fig 1. Themes reported in 2022/23 - as defined by the National Guardians Office.



Inappropriate attitudes and behaviours is the most prominent theme to note. The NGO suggest this category would include:

- Actions contrary to an organisation's values
- Incivility
- Microaggressions.

However, this definition falls short of unwanted behaviour, which is further defined by them as:

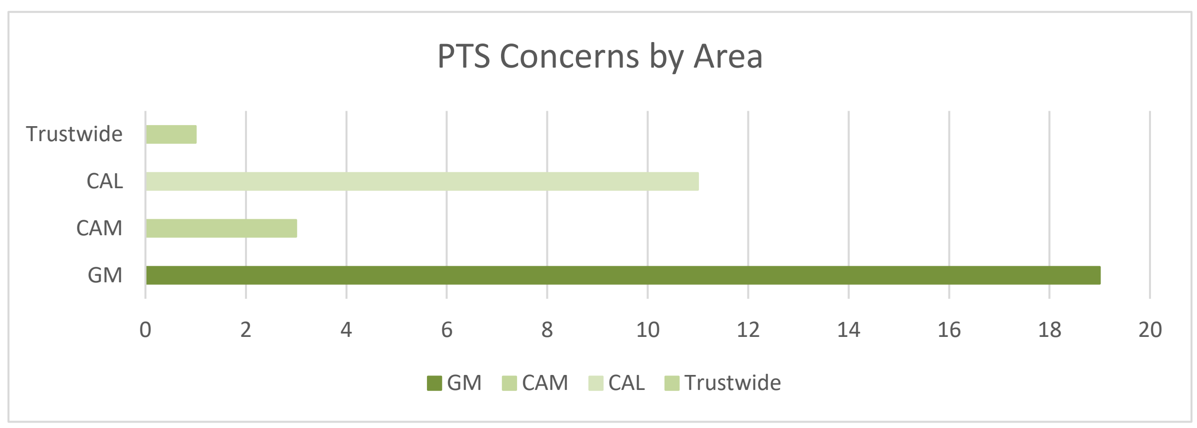
- intended to harm, hurt or humiliate another person.
- repeated (or has the potential to be repeated) over time.
- abuse or misuse of power in practice or perception

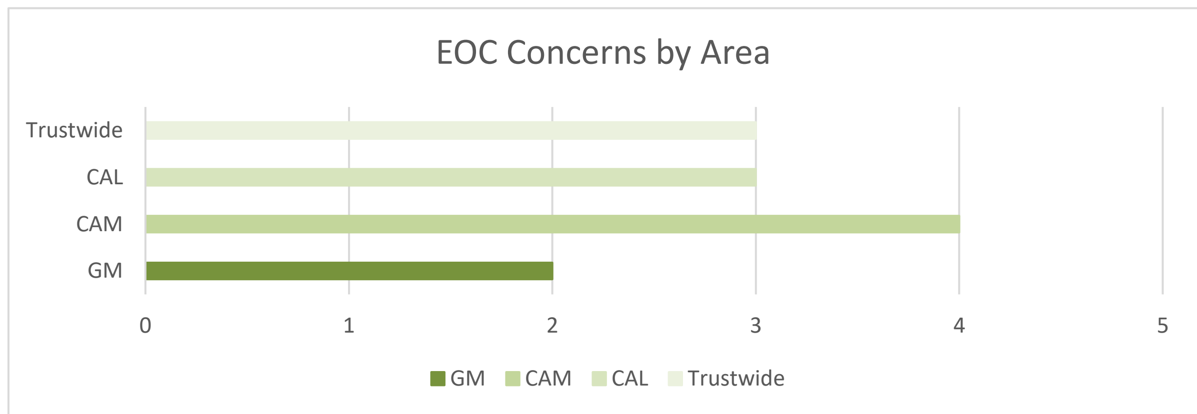
The Freedom to Speak Up Guardians have further analysed this data. Within the "inappropriate attitudes and behaviour" categorisation, there are several sub-themes emerging. These include reports of racism and misogyny, concerns over the way investigations have been conducted, communication between managers and staff and the interpretation of some policies.

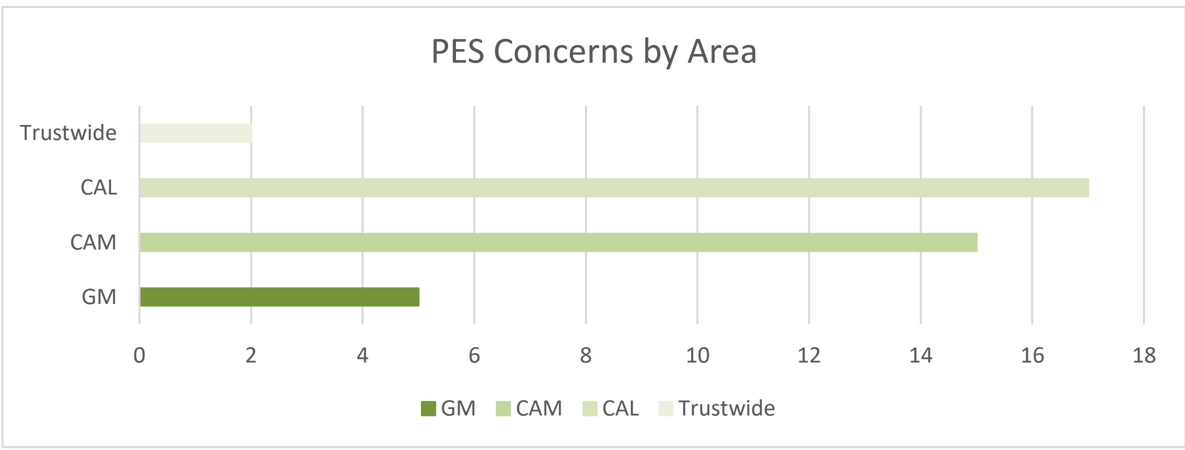
Regarding sub-themes emerging from the patient safety grouping, these include hospital handover delays, EOC policies & procedures and the management of community first responders.

In this coming year, the workplan includes efforts to effectively triangulate Freedom to Speak Up data with other sources of information such as operational data, HR data and the work being undertaken by corporate affairs. It should also be noted, there is a 31% decrease in the number of anonymous concerns from 2021/22. This could demonstrate that more staff have confidence in the Freedom to Speak Up process and have more confidence in the organisation to prevent them suffering detriment.

The following charts demonstrate the number of concerns raised by each geographical area and by service line. NWAS 111 and corporate services have a different operational model and hence not included in this analysis.







This data requires further triangulation in 2023/24. For example, the number of concerns raised via FTSU in Greater Manchester PES is lower than Cheshire & Merseyside and Cumbria & Lancashire. However, this may be due to speaking up in different ways, such as at staff forums, via Datix or openly with local managers.

Directorate Change

Freedom to Speak Up was moved in April 2022 from the Director of Corporate Affairs portfolio into the Medical Director's portfolio.

Guardian Recruitment

After the move to the Medical Directorate, the trust had two part time Guardians: Steve Bell (Consultant Paramedic) and Jon Price (Clinical Effectiveness Lead). The team was expanded further by employing administration support and an additional full-time Lead Guardian (Graham Pacey) was recruited via a formal process in June 2022.

Relaunch and Refresh

With the assistance of the communcations team, Freedom to Speak Up underwent a refesh. New posters and banners were developed, the Green Room page was revised and also a new anonymous tool developed to raise a concern.

Freedom to Speak Up Policy

A new national Freedom to Speak Up policy was published by NHS England. The Trust used this policy as a base for our own revised policy. A new simpler and streamlined policy was introduced in January 2023, which makes it easier for our staff to raise concerns.

Ways to Speak Up

Following the introduction of the new policy, new ways to Speak Up were introduced. Alongside the existing routes of email, phone and letter, the Guardian team have used our digital offer, using an online form (which offers greater anonymity), WhatsApp, and Twitter.

Freedom to Speak Up Month

October 2022 saw the national Freedom to Speak Up month. With support from communications, a detailed plan was created which consisted of bulletins, videos explaining FTSU and a roadshow. The roadshow included five days of travelling around the regions Emergency Departments to speak with staff, engagement events with PTS and volunteers, a visible presence in EOC's and corporate sites and an increased number of operational shifts. This was a good opportunity to work with the Race Equality Chair, Wes Proverbs, during both the Freedom to Speak Up Month and Black History Month.

Education and Learning

A change in the national requirements for e-learning meant a change to our online offer. NWAS have for some time mandated the 'Speak Up' module for all staff and the 'Listen Up' module for managers. This year we have mandated the 'Follow Up' module for all senior leaders. The current compliance rates can be found in fig 2.

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|MAND|Freedom to Speak Up - All Workers - No Specified Renewal|	7094	7094	6333	89.27%
NHS|MAND|Freedom to Speak Up - Managers - No Specified Renewal|	866	866	674	77.83%
NHS|MAND|Freedom to Speak Up - Senior Managers - No Specified Renewal|	71	71	57	80.28%

Fig 2

The Freedom to Speak Up team have also engaged with the Education and Training team and have attended multiple new employee inductions. In addition, work has occurred with all the universities, to talk about the importance of speaking up.

Staff Forums

The guardians have attended several staff forums.

National Freedom to Speak Up Guardian Conference

NWAS was represented at the National FTSU Guardian conference in London. This was an opportunity to hear from the CQC and others as to the changes being made to closer review speaking up arrangements in NHS Trusts. Further work was done surrounding futility, with new action points being brought back to the organisation.

CEO Meetings

Guardians continue to be supported by the CEO, Medical Director, and Director of People with monthly meetings to discuss themes and escalate any concerns.

NED Meetings

Guardians continue to be supported by Dr David Hanley, with a monthly meeting to offer assurance of our speaking up arrangements and an opportunity to discuss any concerns.

Reports

2022/23 saw a number of national reports published with a focus on speaking up, cultural concerns and patient safety.

In February 2023, the NGO released their report into speaking up with English ambulance trusts. Following this, the FTSU Guardian team completed a gap analysis based on the recommendations and will now look, alongside other directorates, to implement the recommendations. CQC reports from other organisations have allowed for further learning and changes to our own systems.

It is hoped that the changes made to FTSU in the last 12 months will have created a solid foundation on which we can further build our speak up culture, ensuring we embed listening up, a culture of problem sensing and inquisitiveness. Only by doing this will we ensure we listen to every voice and in turn save careers, relationships, and lives.

3. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

None

4. EQUALITY OR SUSTAINABILITY IMPACTS

None

5. RECOMMENDATIONS

The Board is asked to:

- Recognise the work to date that commits our organisation to embed Speaking Up and Just Culture principle and practices.

- Continue our commitment to ensuring every voice is listened to by a full review and implementation of the National Guardian Office Report published February 2023.

- Receive this Annual Report as evidence of the ongoing work of the Guardians in supporting our staff in making speaking up business as usual.

REPORT TO BOARD OF DIRECTORS

DATE:	26th April 2023
SUBJECT:	Quality and Performance Committee Annual Report 2022/23
PRESENTED BY:	Prof A Esmail, 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 Assurance

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 –

- Updated attendees.
- Updated inter relations and duties.

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

- More focused discussion during meetings, with clear actions and conclusions.
- Further work to improve papers presented.
- Ensure balance of quality and performance issues.
- Consider duration of the meetings and continue to review the frequency of meetings.

RECOMMENDATIONS:

The Board of Directors is recommended to:

- Review the Quality and Performance Committee Annual Report for 2022/23.

	• Note the amendments to the Terms of Reference for 2023/24 presented under separate cover for Board approval.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☒ Quality Outcomes ☐ People ☐ Financial / Value for Money ☒ Reputation ☐ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☐	Sustainability	☐

PREVIOUSLY CONSIDERED BY:	Quality and Performance Committee	
	Date:	27th March 2023
	Outcome:	Discussed and recommended to Board of Directors for approval.

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1. PURPOSE

The purpose of this report is to formally report to the Board of Directors on the work of the Quality and Performance Committee during the period 1st April 2022 to 31st March 2023 and to set out how it has met its terms of reference and priorities.

2. BACKGROUND

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

3. ROLE OF THE QUALITY AND PERFORMANCE COMMITTEE

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

4. COMMITTEE MEMBERS AND ATTENDANCE

Meetings of the Quality and Performance Committee have been held as scheduled in the corporate calendar except for the January meeting, which was cancelled due to the impact of industrial action on quoracy.

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 during 2022/23 all functions set out within the Terms of Reference have been discharged.

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 & Committee Dashboard

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. Bi monthly the Committee is also presented with the Committee Dashboard for focus and scrutiny of performance data.

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 Patient Safety, Serious Incidents, Learning from Deaths, and Legal Services Reports

The Committee has received reports in relation to Patient Safety, Serious Incidents, Learning from Deaths and Legal Services quarterly assurance. In addition, updates and a presentation on the impact of the national Patient Safety Incident Response Framework (PSIRF) have been received by the Committee.

5.5 Health, Safety, Fire, Infection, Prevention and Control and Safeguarding

The Committee has received health and safety reports in accordance with the Committee Work Plan and considered activity in relation to health and safety compliance and quality assurance visits.

The IPC Board Assurance Framework has been received and assurance reported in relation to the trust's safeguarding arrangements.

5.6 Sub Committee Chairs Assurance Reports

Bi monthly Chairs Assurance Reports have been received from the Trust's Sub Committees aligned to the Committee. These have been monitored in terms of actions taken to mitigate operational risk. Annual reviews of the sub committees have been considered and their terms of reference approved by the Committee.

6. KEY IMPROVEMENTS FOR THE COMMITTEE DURING 2023/24

The 2022/23 Annual Effectiveness Review highlighted the following areas for improvement during 2023/24 –

- More focused discussion during meetings, with clear actions and conclusions.
- Further work to improve papers presented.
- Ensure balance of quality and performance issues.
- Consider duration of the meetings and continue to review the frequency of meetings.

The Committee are encouraged to reflect on the above and consider any further areas for focus during the forthcoming year.

7. TERMS OF REFERENCE

The Terms of Reference have been reviewed by the Quality and Performance Committee at their meeting on 27th March 2023 and have been presented to the Board of Directors for approval.

8. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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.

9. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

10. RECOMMENDATIONS

The Board of Directors is recommended to:

- Review the Quality and Performance Committee Annual Report for 2022/23.
- Note the amendments to the Terms of Reference for 2023/24 presented under separate cover for Board approval.

REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="5">26th April 2023</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Resources Committee Annual Report 2022/23</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="5">Dr D Hanley, Chair of Resources Committee</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td><td>SR05</td></tr>
<tr><td>☐</td><td>☒</td><td>☐</td><td>☒</td><td>☒</td></tr>
<tr><td>SR06</td><td>SR07</td><td>SR08</td><td>SR09</td><td>SR10</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="5">For Assurance</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="5">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 Director of Quality, Innovation, and Improvement from the membership of the Committee.
• Duties and interrelations updated to reflect changes to overarching strategies and plans.

The committee effectiveness review highlighted that the group has met its remit and functions. However, key improvements have been identified for focus during 2023/24:

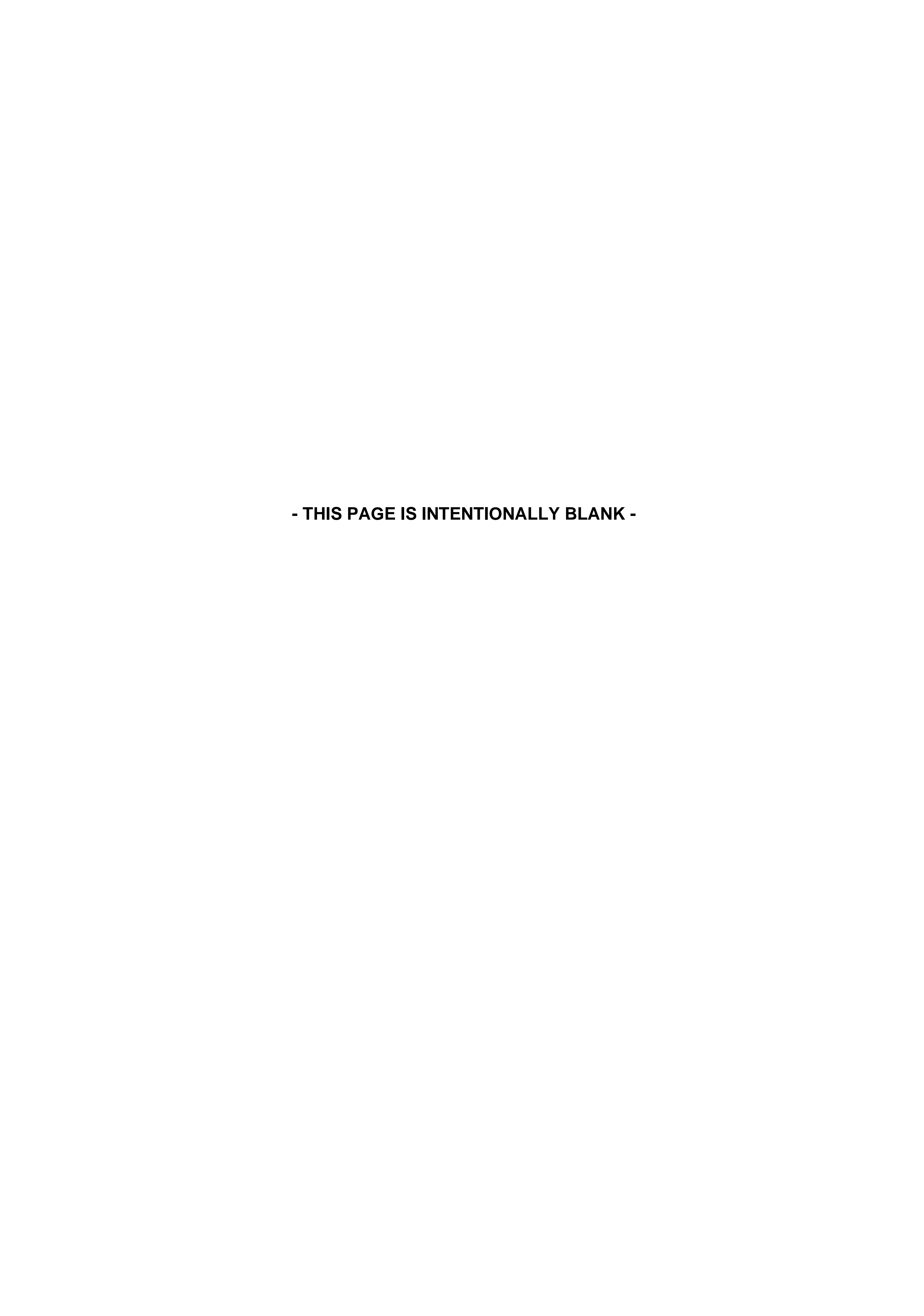
• To set objectives for the forthcoming year.
• Improve the level of challenge from executive members of the Committee.
• The order of agendas to ensure all items are given equal prominence.
• Deep dives more focused on BAF risk.</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="5">The Board of Directors is recommended to:

• Review the Resources Committee Annual Report for 2022/23.</td></tr>
</table>

	• Note the amendments to the Terms of Reference for 2023/24 presented under separate cover for Board approval.
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☒ Compliance/Regulatory ☐ Quality Outcomes ☒ People ☒ Financial / Value for Money ☐ Reputation ☒ Innovation

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: **(Refer to Section 4 for detail)**	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Resources Committee			
	Date:	24th March 2023		
	Outcome:	Discussed and recommended to Board of Directors for approval.		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1. PURPOSE

The purpose of this report is to formally report to the Board of Directors on the work of the Resources Committee during the period 1st April 2022 to 31st March 2023 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 staff volunteers.

4. COMMITTEE MEMBERSHIP AND ATTENDANCE

Meetings of the Committee have been held as scheduled in the corporate calendar and 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 Leadership and meetings

Members felt the overall effectiveness of the committee and the Chair's role during meetings had worked well during the year and the balance of support and challenge had improved.

5.3 Deep Dives

Deep dives commissioned and received during the year provided further assurance in relation to the trust's workforce and the trust's estate backlog.

5.4 Financial Plans

The committee has maintained a sharp focus on finance and trust resources. It has received regular finance reports and updates on national planning guidance and draft financial plans, 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, with further assurance sought, where necessary, in relation to timescales and contingency planning.

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 2022/23.

6. COMMITTEE IMPROVEMENTS FOR 2023/24

The 2022/23 Annual Effectiveness Review highlighted the following areas for improvement during 2023/24 –

- The Committee to set objectives for the forthcoming year.
- Improve level of challenge from executive members of the Committee.
- Order of agenda items to ensure items are given equal prominence.
- Deep dives to be more focused on BAF risk.

7. TERMS OF REFERENCE

The Terms of Reference have been reviewed by the Resources Committee at their meeting on 24th March 2023 and have been presented to the Board of Directors for approval.

8. LEGAL, GOVERNANCE AND/OR RISK IMPLICATIONS *(including consideration of the Trust's Risk Appetite Statement)*

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.

9. EQUALITY OR SUSTAINABILITY IMPACTS

None identified.

10. RECOMMENDATIONS

The Board of Directors is recommended to:

- Review the Resources Committee Annual Report for 2022/23.

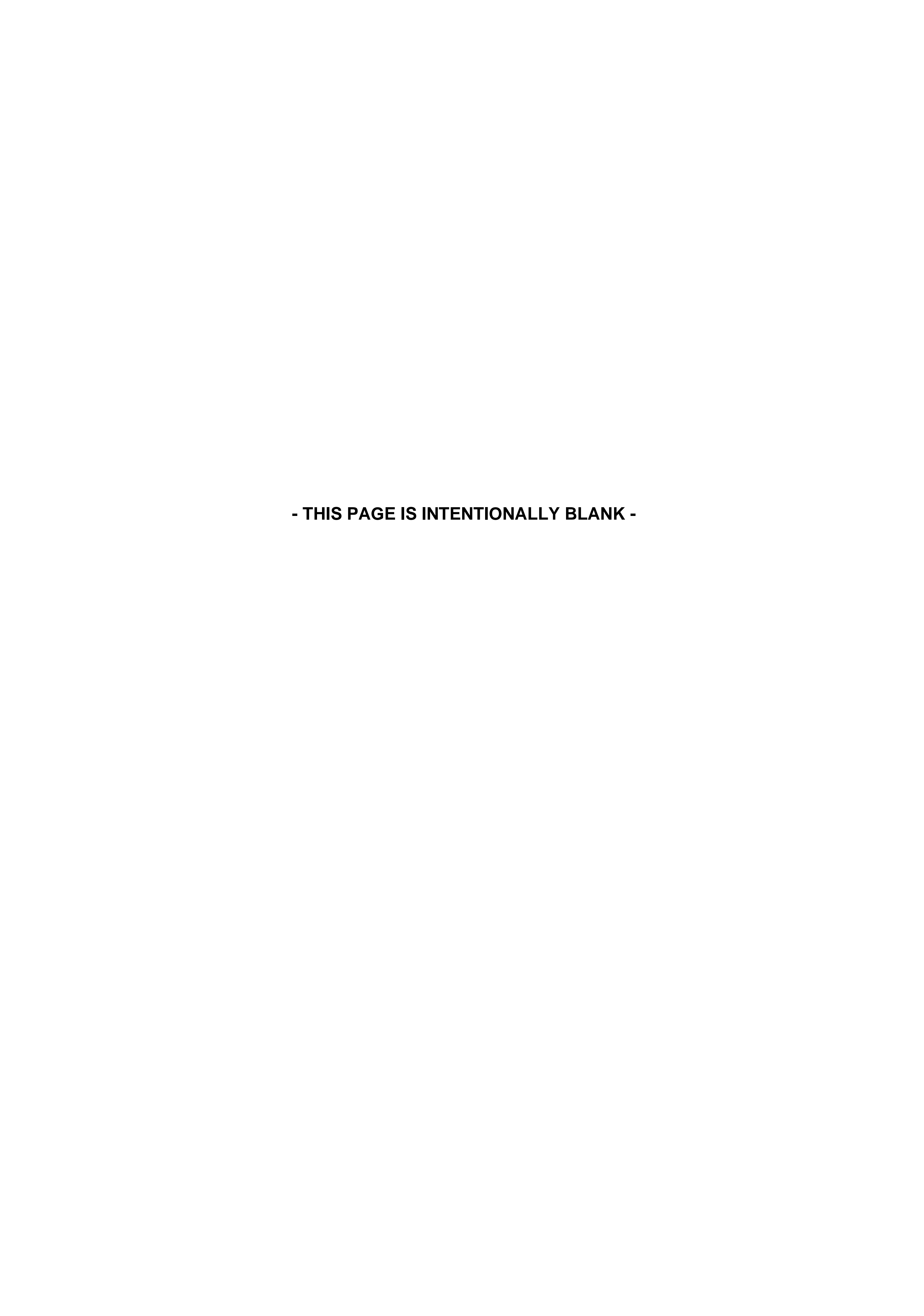
- Note the amendments to the Terms of Reference for 2023/24 presented under separate cover for Board approval.

REPORT TO BOARD OF DIRECTORS

DATE:	26th April 2023				
SUBJECT:	Audit Committee Annual Report 2022/23				
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 2022/23. The report details the activities of the Audit Committee during the 2022/23 financial year.				
RECOMMENDATIONS:	The Board of Directors is recommended to note the Audit Committee Annual Report 2022/23.				
CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)	The Trust's Risk Appetite Statement has been considered as part of the paper decision making process: ☐ Compliance/Regulatory ☐ Quality Outcomes ☐ People ☐ Financial / Value for Money ☐ Reputation ☐ Innovation				

INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT

ARE THERE ANY IMPACTS RELATING TO: (Refer to Section 4 for detail)	Equality:	☐	Sustainability	☐
PREVIOUSLY CONSIDERED BY:	Audit Committee			
	Date:	21st April 2023		
	Outcome:			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Audit Committee Annual Report 2022/23

Introduction

This report provides information on the how the Audit Committee has met its Terms of Reference during the 2022/23 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 2022 to 31 March 2023.

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 22 April 2022.

Committee Members and Attendance

During 2022/23 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	5/6
Mrs C Butterworth	Non-Executive Director	4/6

The Committee met on the following occasions during 2022/23:

22 April 2022
12 May 2022
17 June 2022
21 July 2022
21 October 2022
20 January 2023

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.

Information Governance

The received a presentation relating to Cyber Security following the National Cyber Security Centre (NCSC) recommendations for UK organisations to bolster online defences as a result of cyber attacks from Russia. The Committee continued to receive Chair's Assurance Reports from the Information Governance Sub Committee during the year with strengthened assurances received 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 2022/23 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. During the year, the Committee requested attendance from responsible Senior Management to meetings where a 'limited assurance' opinion had been provided in audit reports and during the reporting period one limited assurance opinion was 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**
Workforce Planning	Conflicts of Interest
	Data Security Protection Toolkit
	DBS Checks
	IMT Mobile Devices
	ESR/HR Payroll
Moderate Assurance	**Limited Assurance**
Stock Management – Vehicle Workshops	Cleric 111 – Clinical Hub
Team Rostering (Cheshire & Mersey)	
Blue Light Vehicles (Section 248a Exemptions)	
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.

In response to a briefing produced by the HFMA in April 2022 'Improving NHS financial sustainability: are you getting the basics right?' a detailed checklist was produced for organisations to use as a self-assessment. NHS England issued guidance requiring organisations to commission a review by internal auditors of the completed self-assessment. MIAA performed the review to provide an objective and unbiased assessment and provided assurance that the Trust had the evidence to support the self-assessment and that an action plan with deadline dates for improvement actions was in place.

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 2022/23, the Head of Internal Audit overall opinion for the period 1 April 2022 to 31 March 2023 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 4) 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 Anti-Fraud Specialist (AFS) on behalf of the Trust is reported to the Audit Committee.

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

External Audit
Mazars were the External Auditors to the Trust for the 2022/23 financial year and will report on the 2022/23 Annual Report and Financial Statements. The audit for the financial year 2022/23 is ongoing at the time of writing this report. Technical support has been provided to the Committee on an ongoing basis and representatives attend each meeting.

The auditors are required to present an Auditor's Annual Report which details the outcome of the audit of the Trust's financial statements. This report also includes commentary around the Trust's Value for Money arrangements which identified no significant weaknesses.

At the meeting on 21 June 2023, the Committee will receive the Audit Completion Report relating to the Financial Statements Audit and review of the Annual Report. 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 Q2 2022/23, MIAA undertook an assessment of the committee processes, the outcome of the assessment was positive however highlighted the requirement to assess the performance of external audit. The Committee received the review of the work of the external auditors at its January 2023 meeting. This concluded a high level of satisfaction in the work undertaken by the external auditors.

New committee members have been appropriately inducted following the implementation of an induction process.

The revised Terms of Reference will be submitted to the Board of Directors on 26th April 2023 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 21st April 2023

APPENDIX 1

REPORTS TO THE AUDIT COMMITTEE DURING 2022/23

Reports produced by the Trust
Cyber Security Presentation
Quarterly Board Assurance Framework Reports
Opening Position of the Board Assurance Framework 2022/23
Risk Management Policy
Quarterly Losses and Compensation Reports
Estates Revaluation 2021/22
Accounting Policies for 2021/22 Accounts and the Impact of the New Accounting Standard IFRS16
Annual Review of Core Governance Documents
Audit Committee Annual Report 2021/22
Audit Committee Terms of Reference
Declarations of Interest, Gifts & Hospitality Annual Report 2021/22
FT Code of Governance Compliance Declaration
Waiver of Standing Orders Quarterly Reports
MIAA Governance Checklist 2021/22
Chairs Assurance Reports from: – Quality and Performance Committee – Resources Committee – Information Governance Sub Committee
Information Governance Sub Committee Terms of Reference
Quarterly Clinical Audit Updates
Clinical Audit Plan
Audited Accounts 2021/22
Annual Report 2021/22
Annual Governance Statement 2021/22
Letter of Representation
SIRO Annual Report
Annual Risk Management Report
Audit Committee Self-Assessment
NHS Code of Governance Update
MIAA Fit and Proper Persons Checklist 2022/23
Audit Review Update – Team Rostering (Cheshire and Mersey)
Formal Assessment of External Auditors
Audit Committee Work Plan
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 2022/23
Head of Internal Audit Opinion and Annual Report
Follow Up Reviews
Limited Assurance Reports
Critical and High Risk Recommendations Overdue
Committee Self-Assessment
Internal Audit Charter
Review of HFMA Improving NHS Financial Sustainability Checklist

Reports produced by the Anti-Fraud Specialist

Anti-Fraud Progress Reports
Anti-Fraud Annual Report 2021/22 including Self Review Toolkit (SRT) Ratings
Anti-Fraud Annual Work Plan 2020/21
NWAS Anti-Fraud Bribery and Corruption Policy and Response Plan

REPORT TO BOARD OF DIRECTORS

<table>
<tr><td>DATE:</td><td colspan="5">26th April 2023</td></tr>
<tr><td>SUBJECT:</td><td colspan="5">Board Assurance Committee Terms of Reference</td></tr>
<tr><td>PRESENTED BY:</td><td colspan="5">Angela Wetton, Director of Corporate Affairs</td></tr>
<tr><td rowspan="4">LINK TO BOARD ASSURANCE FRAMEWORK:</td><td>SR01</td><td>SR02</td><td>SR03</td><td>SR04</td><td>SR05</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
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<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>PURPOSE OF PAPER:</td><td colspan="5">For Decision</td></tr>
<tr><td>EXECUTIVE SUMMARY:</td><td colspan="5">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</td></tr>
<tr><td>RECOMMENDATIONS:</td><td colspan="5">The Board of Directors is recommended to approve the Terms of Reference for all Board Assurance Committees.</td></tr>
<tr><td>CONSIDERATION OF THE TRUST'S RISK APPETITE STATEMENT (DECISION PAPERS ONLY)</td><td colspan="5">The Trust's Risk Appetite Statement has been considered as part of the paper decision making process:
☒ Compliance/Regulatory
☒ Quality Outcomes
☒ People
☒ Financial / Value for Money
☒ Reputation
☒ Innovation</td></tr>
<tr><td colspan="6">INCLUDE CONSIDERATION OF RISK APPETITE STATEMENT AT SECTION 3 OF REPORT</td></tr>
<tr><td>ARE THERE ANY IMPACTS RELATING TO:
(Refer to Section 4 for detail)</td><td colspan="2">Equality:</td><td>☐</td><td>Sustainability</td><td>☐</td></tr>
<tr><td rowspan="2">PREVIOUSLY CONSIDERED BY:</td><td colspan="5">Board Assurance Committees</td></tr>
<tr><td colspan="2">Outcome:</td><td colspan="3">Reviewed and discussed.</td></tr>
</table>

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

CONTENTS

1. Role and Purpose
2. Membership
3. Accountability
4. Relationship with the Board of Directors and its Committees
5. Review Arrangements
6. Working Methodology
7. Duties and Interrelations
8. Delegated Authority
9. Inward Reporting Arrangements

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 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 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 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, NHS Counter Fraud Authority etc.
ii. Professional bodies with responsibility for the performance of staff or functions, such as Royal Colleges, Health Professions Council,.

As part of its integrated approach, the Committee will have effective relationships with other key committees (Quality and Performance Committee the Resources Committee and Information Governance sub 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
2. Membership
3. Accountability
4. Review Arrangements
5. Working Methodology
6. Duties and Interrelations
7. Delegated Authority
8. Inward Reporting Arrangements

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
- Associate Non-Executive Director
- Director of Finance
- Director of Corporate Affairs
- Director of Operations
- Director of People
- Director of Strategy, Partnerships and Transformation

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
- Fundraising Manager

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 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
2. Membership
3. Accountability
4. Review Arrangements
5. Working Methodology
6. Duties and Interrelations
7. Delegated Authority
8. Inward Reporting Arrangements

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 and the Director of People as HR advisor 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 - QUALITY AND PERFORMANCE COMMITTEE

CONTENTS

1. Role and Purpose
2. Membership
3. Accountability
4. Review Arrangements
5. Working Methodology
6. Duties and Interrelations
7. Delegated Authority
8. Inward Reporting Arrangements

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

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
- Patient Safety Specialist
- Chief of Regulatory Compliance and Improvement
- Consultant Midwife

- DIPC / Assistant Director of Nursing

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

If 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 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 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 is accountable to the Board of Directors.

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, to be available at least three clear days before the meeting.

The Committee will normally meet monthly and as a minimum ten times per year.
The Chair may, however, call a meeting at any time, if 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

- Ensure that all statutory elements of clinical governance are adhered to within the Trust.
- Approve the Terms of Reference and membership of its reporting committees (as may be varied from time to time at the discretion of the Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the Committee in the sub-committee's terms of reference for consideration and action as necessary;
- Consider matters referred to the Committee by the Board of Directors or other committees thereof that require urgent attention.
- Consider matters escalated to the Committee by its own sub-committees;
- Approve the annual Clinical Audit Programme on behalf of the Board of Directors and ensure it is consistent with the audit needs of the Trust;
- Make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference;
- Ensure the registration criteria of the Care Quality Commission continue to be met
- Review Trust compliance with the national standards of quality and safety of the Care Quality Commission, and licence conditions that are relevant to the Committee's area of responsibility;
- Ensure that the Trust has appropriate processes in place that safeguard children and vulnerable adults;
- Seek assurance through review of the routine Legal and Clinical Governance reports that the Trust incorporates the recommendations from external bodies, (eg the Kirkup Maternity Review) as well as those made internally, (eg in connection with serious incident reports and adverse incident reports) into practice and has mechanisms to monitor their delivery;
- Ensure that robust arrangements are in place for the review of patient safety incidents (including never events, complaints, claims, PFD reports from HM Coroner) from within the Trust and wider NHS to identify similarities or trends and areas for focused or organisation-wide learning;
- Ensure that actions for improvement identified in incident reports, e.g. reports from HM Coroner, Learning from Deaths and other similar documents are addressed;
- Identify areas for improvement in respect of incident themes and complaint themes and ensure appropriate action is taken;
- Ensure implementation of the Patient Safety Incident Response Framework (PSIRF)
- Ensure that any areas of concern identified from the Committee's review of clinical quality and any identified gaps in controls in relation to delivery of relevant Trust strategic objectives are reflected on the Board Assurance Framework.

- Receive and review the Trust's annual Quality Report and make recommendations as appropriate for Trust Board approval;
- Ensure that the Trust has a robust process in place to proposals for cost improvement programmes and other significant service changes and to monitor the impact of proposals for cost improvement programmes and other significant service changes on the Trust's quality of care (ensuring that there is a clear process for staff to raise associated concerns and for these to be escalated to the Committee) and report any concern relating to an adverse impact on quality to the Trust Board;
- Ensure that there is an appropriate process in place to monitor and promote compliance across the Trust with clinical standards and guidelines including but not limited to NICE guidance and guidelines
- Monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate;
- Through the Trust's Annual Quality Report, monitor the development of quality indicators,
- Ensure that there is an appropriate mechanism in place for action to be taken in response to the results of clinical audit and the recommendations of any relevant external reports (e.g. from the Care Quality Commission);
- Ensure the Trust is outward-looking and incorporates the recommendations from external bodies into practice with mechanisms to monitor their delivery.
- Oversee and seek assurance on the systems in place to ensure compliance with statutory and regulatory requirements for infection prevention and control;
- Receive 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))
- 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 against nationally mandated KPIs and performance measures (e.g. ARP) issued by the regulator (NHSE) and other relevant regulatory bodies
- Provide detailed scrutiny of the monthly IPR and relevant NHSE returns and seek assurance of the actions in place to deliver against the targets and any mitigation where performance is not on track including but not limited to:
  - Emergency response times
  - Call pick up
  - Long waits
  - Benchmarking
  - Ambulance Handovers
  - 111 performance
  - PTS performance
- Review the Integrated Quality and Performance report ahead of the Trust Board
- Provide detailed scrutiny of the forward performance plan, including metrics required by the NHSE such as ARP trajectories, demand projections and incident outcomes
- Review performance against contractual performance targets agreed with commissioners - explicitly monitoring performance for all funded services as well as any subsequent variations or alterations to this plan
- Review Emergency Preparedness Resilience and Response plan and performance

- Consider issues referred by other Board Committees relating to Trust level performance issues
- Consider benchmarking information in relation to operational performance such as model ambulance and the ambulance balanced scorecard

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

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

CONTENTS

1. Role and Purpose
2. Membership
3. Accountability
4. Review Arrangements
5. Working Methodology
6. Duties and Interrelations
7. Delegated Authority
8. Inward Reporting Arrangements

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
- Director of Finance
- Director of Operations
- Director of People
- Director of Strategy, Partnerships & Transformation

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
- Deputy Director of Quality, Innovation and Improvement
- 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:

- Our Strategy 2022-2025
- Digital Strategy
- Estates Strategy / Implementation Plans
- Fleet Strategy / Implementation Plans
- 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 realisticand explicit (the Board of Directors will remain responsible for approval ofthe 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 and Benchmark measures utilising the "Model Ambulance".

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, Planning & Transformation

To seek assurance against and have oversight of the Trust's -

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. Supporting Strategies including development, alignment, and implementation.
III. 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

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

REPORT TO BOARD OF DIRECTORS

DATE:	26th April 2023				
SUBJECT:	Board of Directors Annual Cycle of Business 2023/24				
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 2023/24 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 2023/24 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 ☒ People ☒ Innovation ☒ Reputation				

<table>
<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">N/A</td></tr>
<tr><td>Date:</td><td colspan="3"></td></tr>
<tr><td>Outcome:</td><td colspan="3"></td></tr>
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1. PURPOSE

To present the Board of Directors with an annual cycle of business for the financial year 2023/24 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 2023/24 in the form of the attached Board of Directors work programme at appendix 1.

Board of Directors
Work Programme 2023/24

	Date of meeting	26.4.23	31.5.23	21.6.23	26.7.23	27.9.23	29.11.23	31.1.24	27.3.24
	Report Deadline	19.4.23	24.5.23	14.6.23	19.7.23	20.9.23	22.11.23	24.1.24	20.3.24
Introduction									
Agenda Item									
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)			√		√	√	√	√	√
Strategy									
Agenda Item									
Chairman & Non Executive Directors Update			√		√	√	√	√	√
Chief Executive's Report			√		√	√	√	√	√
Governance and Risk Management									
Agenda Item									
Chair's Assurance Report - Audit Committee (NED			√		√		√	√	
Annual Governance Documents (Director of Corporate									
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)		Annual Report					Bi Annual Report		
Board Assurance Framework 2023/24 (Director of Corporate Affairs)		Quarter 4 22/23			Quarter 1 23/24		Quarter 2 23/24	Quarter 3 23/24	
Risk Appetite Statement 2024/25									√
Disciplinary Policy					√				
Annual Staff Survey Results									√

Date of meeting	26.4.23	31.5.23	21.6.23	26.7.23	27.9.23	29.11.23	31.1.24	27.3.24
Report Deadline	**19.4.23**	**24.5.23**	**14.6.23**	**19.7.23**	**20.9.23**	**22.11.23**	**24.1.24**	**20.3.24**
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 22/23	Quarter 1 23/24		Quarter 2 23/24	Quarter 3 23/24
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)		√		√	√	√	√	√
IPC Board Assurance Framework (Director of Quality, Innovation and Improvement)				√			√	
Winter Plan (Director of Operations)					√			
NWAS People Plan				√				

Date of meeting	26.4.23	31.5.23	21.6.23	26.7.23	27.9.23	29.11.23	31.1.24	27.3.24
Report Deadline	19.4.23	24.5.23	14.6.23	19.7.23	20.9.23	22.11.23	24.1.24	20.3.24
Equality, Diversity and Inclusion (Director of People)		Annual Report			EDI Regulatory reports, WRES, WDES, Gender Pay			
Learning to Improve our People Practices (Director of People)	***Workforce cases to be included in the Reportable Events Paper to Part 2 Board during 23/24***							
Health and Wellbeing Annual Report				√				
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: As required								