AGENDA

NHS
North West Ambulance Service
NHS Trust

Board of Directors
Wednesday, 24th April 2024
9.45am – 11.30am
In the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Item No	Agenda Item	Time	Purpose	Lead
INTRODUCTION				
BOD/2425/01	Apologies for Absence	09:45	Information	Chair
BOD/2425/02	Declarations of Interest		Decision	Chair
BOD/2425/03	Register of Interest		Assurance	Chair
GOVERNANCE AND RISK MANAGEMENT				
BOD/2425/04	Board Assurance Framework Q4 2023/24 Position	09:50	Decision	Director of Corporate Affairs
BOD/2425/05	Opening Position of the Board Assurance Framework 2024/25	10:00	Decision	Director of Corporate Affairs
BOD/2425/06	Risk Management Policy	10:10	Decision	Director of Corporate Affairs
BOD/2425/07	Annual Review of Core Governance Documents • Standing Orders and Reservation of Powers • Scheme of Delegation Review • Standing Financial Instructions	10:20	Decision	Director of Corporate Affairs / Director of Finance
BOD/2425/08	Standards of Business Conduct: Policy on Register of Interests, Gifts and Hospitality and Sponsorship	10:30	Decision	Director of Corporate Affairs
BOD/2425/09	Code of Governance – Position of Compliance 2023/24	10:40	Assurance	Director of Corporate Affairs
BOD/2425/10	Non-Executive Terms of Office; Committee Membership 2024/25 and Non-Executive Champion roles	10:50	Assurance	Director of Corporate Affairs
BOD/2425/11	Board of Directors Terms of Reference	10:55	Decision	Director of Corporate Affairs
BOD/2425/12	Board of Directors Cycle of Business 2024/25	11:05	Decision	Director of Corporate Affairs
BOD/2425/13	Trust Governance Structure	11:10	Decision	Director of Corporate Affairs
BOD/2425/14	Board Assurance Committee Terms of Reference 2024/25	11:15	Decision	Director of Corporate Affairs

BOD/2425/15	Quality and Performance Committee Annual Report 2023/24	11:20	Assurance	Prof A Esmail, Chair, Quality and Performance Committee
BOD/2425/16	Resources Committee Annual Report 2023/24	11:25	Assurance	Dr D Hanley, Chair, Resources Committee
BOD/2425/17	Audit Committee Annual Report 2023/24	11:30	Assurance	Mr D Whatley, Chair, Audit Committee

DATE AND TIME OF NEXT MEETING

9.45am on Wednesday, 29th May 2024 in the Oak Room, Ladybridge Hall, Trust Headquarters, Bolton

Exclusion of Press and Public:
In accordance with Public Bodies (Admission to Meetings) Act 1960 representatives of the press and other members of the public are 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.

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	
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.
			Non Executive Director Pennine Care Foundation Trust				√	Position of Authority	Jul-23		Withdrawal from the decision making process if the organisation(s) listed within the declaration were involved.
Salman	Desai	Deputy Chief Executive/Chief Operating Officer	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	
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.
			Trustee, Christadelphian Nursing Homes			√		Other Interest	Jul-19	Present	N/A
Daren	Mochrie	Chief Executive	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 NW 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

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	
Maxine	Power	Director of Quality, Innovation and Improvement	Daughter employed at NWAS as Service Delivery Programme Assurance Manager in PES.			√		Non financial personal interest.	Sep-23	Present	Declare an interest and withdraw from discussions as and when required.
			Advisor (Associate Specialist) to The Value Circle - a specialist agency providing advice to NHS organisations		√			Advisory role	Dec-23	Present	All advice provided out of working hours and not linked to my role at NWAS. Benefits to be declared if applicable.
Lisa	Ward	Director of People	Member of the Labour Party			√		Other Interest	Apr-20	Present	Will not use position in any political way and will avoid any political activity in relation to the NHS.
			Member of Chartered Institute of Personnel and Development		√			Non financil professional interest	Jun-23	Present	Declare an interest and withdraw from discussions as and when required.
			Daughter employed at DHSC as economic analyst			√		Non financial personal interest.	Sep-21	Sep-23	Declare an interest and withdraw from discussions as and when required.
Angela	Wetton	Director of Corporate Affairs	Nil Declaration	N/A	N/A	N/A	N/A	N/A	N/A		N/A
David	Whatley	Associate Non Executive Director	Trustee Pendle Education Trust		√				Apr-23		Withdrawal from the decision making process if the organisations listed within the declarations were involved.
			Governor, Nelson and Colne College Group		√				Apr-23		
			Independent Member of Audit Committee, Pendle Borough Council		√				Apr-23		
			Wife is employed at Manchester Teaching Hospitals NHS FT as a Biochemist				√		Apr-23		
Peter	White	Chairman	Chair of Lancashire Teaching Hospitals NHS Foundation Trust	√				Second Trust Chair Position in another NHS organisation	Aug-23	Present	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
			Director – Bradley Court Thornley Ltd	√				Position of Authority	Apr-19	Present	No Conflict
			Non-Executive Director -Miocare (Oldham Care and Support Limited is a subsidiary)	√				Position of Authority	Apr-19	30.9.23	Withdrawal from the decision making process if the organisation(s) listed within the declarations were involved
Carolyn	Wood	Director of Finance	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.

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Board Assurance Framework Q4 2023/24 Position
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Q4 2024/25 position of the Board Assurance Framework.
EXECUTIVE SUMMARY	The proposed 2023/24 Q4 position of the BAF risks with associated CRR risks scored ≥15 can be viewed in Appendix 1. The BAF Heat Maps for 2023/24 year to date can be viewed in Appendix 2. As part of the Q4 review, there are no proposed changes to the risk scores.
PREVIOUSLY CONSIDERED BY	Trust Management Committee and Audit Committee
	Date: 17th April 2024 and 19th April 2024
	Outcome: TMC recommended to Board for approval

1. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework (BAF) identifies the strategic risks which may threaten the achievement of the Trust's strategic objectives/aims.

2. RISK ASSURANCE PROCESS

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

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

3. REVIEW OF THE Q4 POSITION

The proposed 2023/24 Q4 Position of the Board Assurance Framework with associated Corporate Risk Register risks scored 15 and above can be viewed in Appendix 1.

The BAF Heat Maps for 2023/24 can be viewed in Appendix 2.

There are no closures to report and the BAF risks will continue into 2024/25 as approved by the Board of Directors on 27th March 2024.

4. RISK CONSIDERATION

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

The Board Assurance Framework contains the application of the Trust's Risk Appetite Statement and has been reviewed as part of the Q4 BAF Review process.

5. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Q4 2023/24 position of the Board Assurance Framework.

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK 2023/24

Proposed Q4 Position

Board of Directors

24th April 2024

Q4 2023/24 Reporting Timescales:

Trust Management Cttee:	17/04/2024
Audit Cttee:	19/04/2024
Resources Cttee:	24/05/2024
Quality & Performance Cttee:	22/04/2024
Board of Directors:	24/04/2024

BOARD ASSURANCE FRAMEWORK KEY

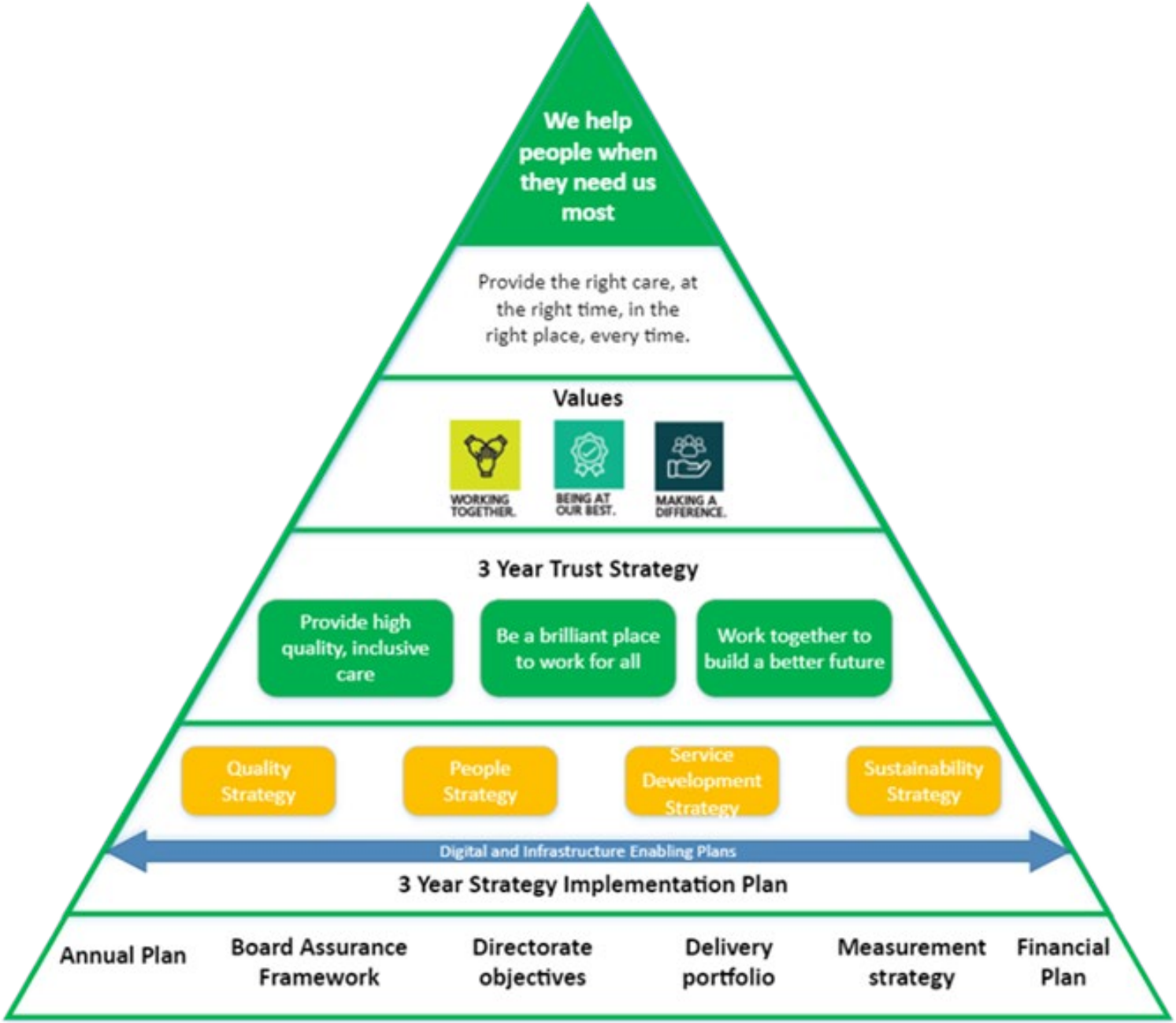
Risk Rating Matrix (Likelihood x Consequence)

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
DOO	Chief Operating Officer
DoP	Director of People
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

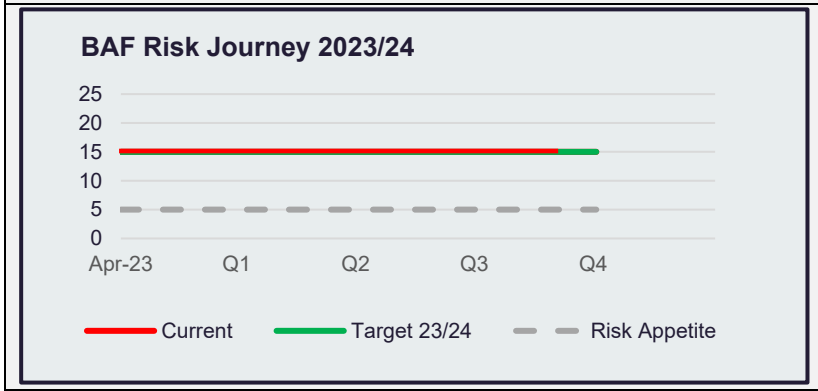
BAF Risk	Committee	Exec Lead	01.04.23	Q1	Q2	Q3	Q4	2023/24 Target	Aspirational Target
SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 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 high quality (safe and effective) services	**Resources**	**DoF**	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 CxL	**12** 4x3 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**	**COO**	**20** 5x4 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 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	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 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	**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**	**10** 5x2 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** **5x3** **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**	**COO**	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**8** 4x2 CxL	**4** 4x1 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	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**15** 5x3 CxL	**10** 5x2 CxL	**5** 5x1 CxL
SR09: There is a risk that the Trust attracts negative media attention arising from long delays and harm leading to significant loss of public confidence	**Resources**	**COO**	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL	**10** 5x2 CxL	**10** **5x2** **CxL**	**10** 5x2 CxL	**10** 5x2 CxL
SR10: (**Sensitive Risk**	**Resources**	**COO**	**16** 4x4 CxL	**16** 4x4 CxL	**16** 4x4 CxL	**12** 4x3 CxL	**12** 4x3 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	Aspirational Target
	15	15	15	15	15	15	5
	5x3	5x3	5x3	5x3	5x3	5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk remains at a score of 15 due to persistent challenges delivering ARP and hospital turnaround times remaining high. However, the Trust is in a strong national standing for C1 and C2 performance and hospital handover has improved although remains persistently above the 30 minute target. 111 performance is stable but remains challenged in delivering the national standards. Cardiac ACQI metric show improvement and performance above national average. The number of complaints received and closed are stable, the most common theme is violence and aggression for non patient incidents. In terms of hear and treat, the Trust is ranked 4th. In terms of long waits, C1 has decreased by 18% and C2 by 53% compared to the last Integrated Performance Report (January 2024).

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
The Trust is moving out of winter pressures with an expectation of decreased demand and improving hospital handover delays. There is an anticipated increase to hear and treat within C2 segmentation.

CONTROLS	ASSURANCES	EVIDENCE
QUALITY		
Patient Safety Strategy	**Level 2:** PSIRF Local Priorities **Level 2:** PSIRF Governance Arrangements: Terms of Reference **Level 2:** PSIRF Plan and Policy **Level 2:** PSIRF Q3 Assurance Report	Reported to QPC (QPC/2324/040) Reported to QPC (QPC/2324/065) Reported to ELC (ELC/2324/211) Reported to QPC (QPC/2324/135)
Quality Strategy	**Level 2:** Supporting Strategies	Reported to BoD (BoD/2324/053)
Mental Health Plan	**Level 2:** Serious Incident Thematic Review – Mental Health (22/23)	Reported to QPC (QPC/2324/110)
Midwifery Plan	**Level 2:** Approval of Trust Maternity and Neonatal Care Policy	Reported to ELC (ELC/2324/512)
Medicines management	**Level 2:** NWAS Pharmacy Stock Management System & Electronic CD Register Strategic Outline Case	Reported to ELC (ELC/2324/586)
Digital Capacity 111 Telephony Capacity	**Level 2:** Digital Update	Reported to Resources Cttee (RC/2324/150

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY					
Patient Safety Strategy	Further training required to ensure embedding of PSIRF learning responses.	Dr M Power	March 2024	Q&P Cttee	In Progress
	Development of safety improvement plans for local priorities informed by data and learning outcomes	Dr M Power	March 2025	Q&P Cttee	In Progress
	Work to ensure Patient Safety Partners are remunerated as per the framework and access information in line with governance requirements. - op	Dr M Power	July 2024	Q&P Cttee	In Progress
	Patient Safety Partner Policy is in advanced draft is produced awaiting review by Legal Services -op	Dr M Power	June 2024	Q&P Cttee	In Progress

Safety Culture	Devise a plan to improve performance on safety culture & F2SU	Dr M Power Dr C Grant	April 2024	Q&P Cttee	In Progress
Learning	Establish an integrated regional learning forum	Dr M Power	March 2024	Q&P Cttee	Complete
	Evaluate effectiveness of area forums - OP	Dr M Power	April 2025	Q&P Ctee	In Progress
Safety Education	Training needs analysis for safety training	Dr M Power/ Ms L Ward	June 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	June 2024	Q&P Cttee	In Progress
Clinical Audit	Scope and implement next generation of a Clinical Audit Tool.	Dr C Grant	March 2024	Q&P Cttee	Partial Completion
DIGITAL					
Digital Strategic Plan	Complete and seek Board approval	Dr M Power	May 2024	Resources Cttee	In Progress

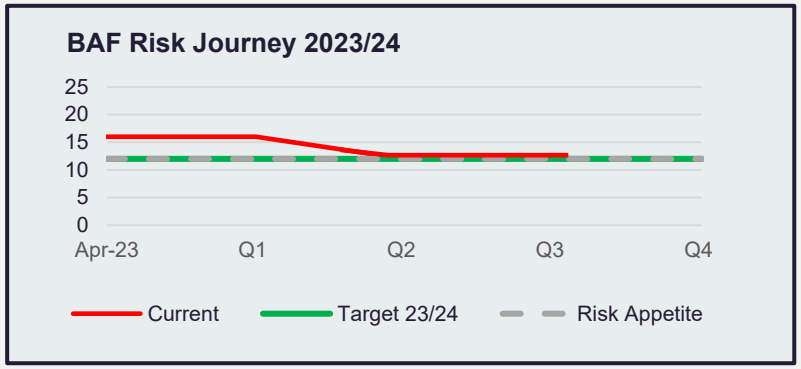
Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of national standards, training, exercising, and subsequent competency assurance, the EOC leadership team are not adequately prepared to manage large scale, significant or major incidents, which may result in serious avoidable patient harm or death and cause significant reputational damage to the Trust.	15 High	15 High	⇔	5 Low
490	Operational/ Operational Performance	There is a risk that due to the roll-out speed of the of the UK Government's National Framework Agreement: Right Care, Right Person (RCRP), the necessary alternative services will not be available or lack sufficient capacity, leading to NWAS becoming the default organisation for all incidents involving people with mental health needs.	15 High	15 High	⇔	5 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	Aspirational Target
	16	16	12	12	12	12	8
	4x4	4x4	4x3	4x3	4x3	4x3	4x2
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Within	Within	Within	Within	Within

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the Q4 position of this BAF risk SR02 remains at a score of 12. The ICB contracts remain unsigned at this stage but income is being received in full, including UEC recovery funding. The year end position is a surplus as a result of bank interest being greater than planned and a benefit from the change in discount rate, and is in line with the forecast position. The efficiency target has been achieved in full and though there remains a gap of £1.5m to be identified recurrently, this has reduced from the shortfall of £2m at Q3.

Projected Forecast Q1: **Deteriorating**
Stable
Improving

Rationale: Deteriorating
The risk score will deteriorate as we move into the new financial year. Whilst draft plans have been approved by the Board of Directors plans are yet to be finalised following the publication of the national guidance and CIP schemes continue to be developed.

CONTROLS	ASSURANCES	EVIDENCE
Opening 2023/24 Financial Plans	**Level 2:** Financial Plan Update	Reported to Resources Cttee (RC/2324/009) Reported to BoD (BoD/2324/012)
Recurrent Funding	**Level 2:** Financial Plan Update	Reported to Resources Cttee (RC/2324/009) Reported to BoD (BoD/2324/012)
Financial Performance	**Level 2:** M03 Financial Position **Level 2:** M04 Financial Position **Level 2:** M05 Financial Position **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 Resources Cttee (RC/2324/032) Reported to ELC (ELC/2324/249) Reported to Resources Cttee (RC/2324/060) Reported to ELC (ELC/2324/369) Reported to Resources Cttee (RC2324/084) Reported to ELC (ELC/2324/454) Reported to Resource Cttee (RC/2324/116) Reported to ELC (ELC/2324/537) Reported to Resource Cttee (RC/2324/137)
2024/25 Financial Planning	**Level 2:** 2024/25 Financial Planning and Opening Budgets	Reported to BoD: BoD/2324/082

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
2024/25 Financial Planning	Approval of 2024/25 Financial Plans by Resources Cttee & BoD	Ms C Wood	May 2024	Resources Cttee / BoD	In Progress

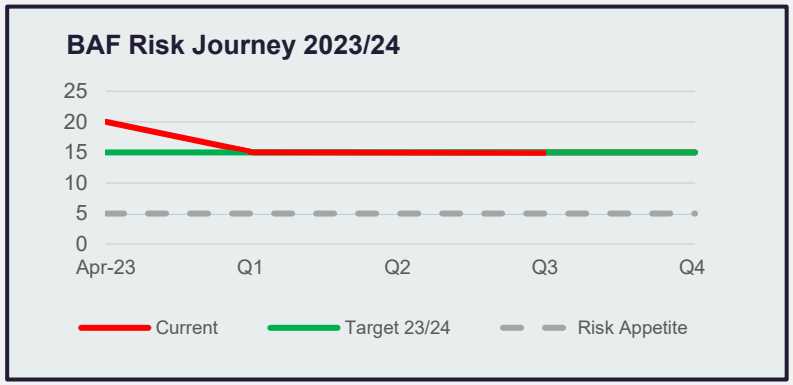
Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
ERM ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score

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: COO

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.23	Q1	Q2	Q3	Q4	23/24 Target	Aspirational Target
	20	15	15	15	15	15	5
	5x4	5x3	5x3	5x3	5x3	5x3	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk remains at a score of 15 due to increased hospital handover times, worse in some areas over others which has resulted in a notable variation in response across operational areas. The Trust has consistently achieved ARP call pick up standards and 111 has delivered improved performance for Q4 vs previous years both in terms of calls answered and CPU KPIs. This is due to improved recruitment and national call handling support. C1 90th standard has been sustained however due to increases in hospital handovers times across the systems, other ARP standards have not been achieved during Q4. The UEC recovery plan is progressing well however, the benefits of increases in hear & treat via C2 segmentation are not yet being realised. The operational modelling from staff deployment is complete, with all additional vehicles active in the rostering system (GRS). Recruitment specific to UEC recovery is not likely to deliver all staff until the end of Q1 2024-25 due to the time taken to recruit and train the numbers of staff needed. Whilst PTS performance is relatively stable, the service line is experiencing challenges regarding management capacity which is being addressed via a focussed improvement plan.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
The trust continues to experience increased hospital handover delays across the region, with some systems consistently performing worse than others, which impacts our ability to provide a timely response and achieve the ARP constitutional standards in Q4.

CONTROLS	ASSURANCES	EVIDENCE
Recruitment Plan Clinical Hub and Operational Staff	**Level 2:** Strategic Workforce Chairs Assurance Report	Reported to Resources Cttee (RC/2324/068)
Improve Hear and Treat Performance	**Level 2:** Integrated Performance Report	Reported to BoD (BoD/2324/146)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recurrent Financial Gap 111	111 Financial gap is unresolved in that the contract has been extended until 2025.	Mr S Desai	2025	ELC	In Progress
Service Delivery Leadership Review (SR09)	Delivery of SDLR to improve working practices	Mr S Desai	September 2024	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff (SR09)	Robust recruitment plan to be delivered to maximise resources to the most efficient level	Mr S Desai Mrs L Ward	November 2024	Q&P Cttee	In Progress
Reduce Hospital Handovers	Hospital handover management with ICBs and acute providers	Mr S Desai Dr M Power	March 2024	Q&P Cttee	In Progress
Improve Hear and Treat Performance	Improve Hear and Treat Performance	Mr S Desai	March 2024	Q&P Cttee	In Progress

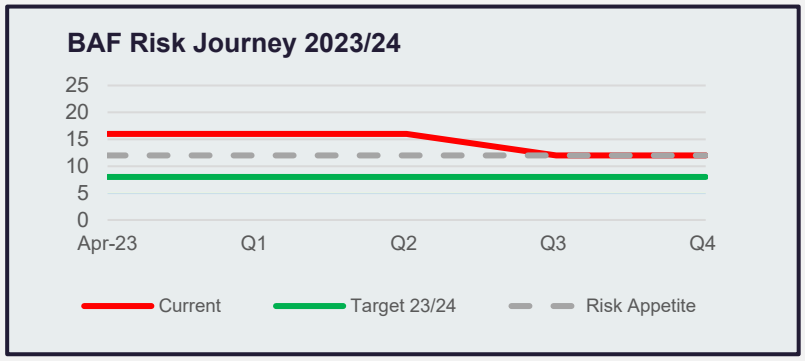
Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk.						

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	Aspirational Target
	16	16	16	12	12	8	4
	4x4	4x4	4x4	4x3	4x3	4x2	4x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Exceeded	Exceeded	Exceeded	Within	Within	Within	Below

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk has maintained a score of 12. At the end of Q4 the frontline emergency staffing position for EMTs and Paramedics shows a 0.8% vacancy gap against the new establishment incorporating UEC growth. This demonstrates the delivery of the majority of UEC growth. There remain risks in other service lines. 111 continues to present risk but the vacancy position has closed over Q4 and performance is stable. Major external recruitment campaign commenced at start of Q4 and applicants continue to be processed. The PTS position also remains challenged. Additional funding to invest in capacity to support sickness and wellbeing has completed in Q3. Work to improve attendance is ongoing. Sickness data has been tracking below 22/23 but the overall 1.8% reduction target has not been met. Overall score remains at 12 in recognition of specific service line risks and continuing absence levels.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Improving
Gaps closing in 111, robust plans to maintain position in other service lines.

CONTROLS	ASSURANCES	EVIDENCE
Recruitment Plans	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Strategic Workforce Chairs Assurance Report **Level 2:** Workforce Indicators Report	Reported to Resources Cttee (RC/2324/096) Reported to Resources Cttee (RC/2324/043) Reported to Resources Cttee (RC/2324/145)
111 Retention Plans	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2324/145)
Sickness and Wellbeing Assurance	**Level 2:** Wellbeing Biannual Assurance Report **Level 2:** Staff Health and Wellbeing Annual Report 2022/23 **Level 2:** Absence and Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2324/016) Reported to Resources Cttee (RC/2324/040) Reported to Resources Cttee (RC/2324/097)
Flu Vaccination	**Level 2:** Flu Campaign 2023/24 **Level 2:** Workforce Indicators Assurance Report **Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2324/067) & BoD (BoD/2324/087) Reported to Resources Cttee (RC/2324/096 Reported to Resources Cttee (RC/2324/145)
Attendance	**Level 2:** Workforce Indicators Assurance Report	Reported to Resources Cttee (RC/2324/145)

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

Operational Risks Scored 15+ Aligned to BAF Risk: SR04

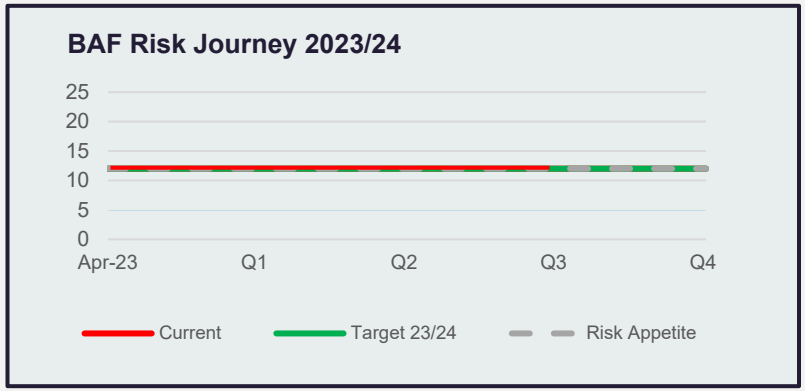
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
490	Operational/ Operational Performance	There is a risk that due to the roll-out speed of the of the UK Government's National Framework Agreement: Right Care, Right Person (RCRP), the necessary alternative services will not be available or lack sufficient capacity, leading to NWAS becoming the default organisation for all incidents involving people with mental health needs.	15 High	15 High	⇔	5 Low

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	Aspirational Target
	12	12	12	12	12	12	4
	4x3	4x3	4x3	4x3	4x3	4x3	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 remains at a score of 12. 2023 staff survey results indicate continued 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. Staff survey 2023 also shows significantly improved response rate. Progress continues to be made in delivering planned improvements set out in annual plans through the leadership development programme Making a Difference; roll out of the revised disciplinary policy; changes to induction to embed Civility Saves Lives; reverse mentoring programme; CPD platform launch; aspirant EMT1 development programme launch; sexual safety steering group work. The People Strategy has been approved and clear plans commenced for 23/24 on a range of cultural and inclusion improvement. The Trust has also been selected to take part in the second wave Retention Exemplar programme.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
Plans are in place to deliver improvement but many will deliver longer term impact. Whilst staff survey indicates improvement, but plans are ongoing into 2024/25.

CONTROLS	ASSURANCES	EVIDENCE
EDI Annual Report	**Level 2:** EDI Annual Report 2022/23	Reported to Resources Cttee (RC/2324/017) Reported to BoD (BoD/2324/038)
People Strategy	**Level 2:** Supporting Strategies **Level 2:** 2023/24 Annual Plan Q2 Assurance	Reported to BoD (BoD/2324/053 Reported to Resourcces Cttee (RC/2324/083)
EDI Priorities	**Level 2:** WRES WDES Gender Pay Gap Reporting **Level 2:** Strategic Workforce Chairs Assurance Report **Level 2:** Diversity and Inclusion Chairs Assurance Report	Reported to Resources Cttee (RC/2324/041) Reported to Resources Cttee (RC/2324/068) Reported to Resources Cttee (RC2324/147)
Wellbeing	**Level 2:** Sickness Absence & Assurance Update **Level 2:** Staff Health and Wellbeing Annual Report 2022/23 **Level 2:** Absence and Health and Wellbeing Assurance Report	Reported to Resources Cttee (RC/2324/016) Reported to Resources Cttee (RC/2324/040) Reported to Resources Cttee (RC/2324/097)
Leadership	**Level 2:** Strategic Workforce Chairs Assurance Report	Reported to Resources Cttee (RC/2324/068)
Sexual Safety Campaign	**Level 2:** D&I Sub Committee Chairs Assurance Report	Reported to Resources Cttee (RC/2324/098)
Staff Survey	**Level 2:** National Staff Survey 2023 **Level 2:** Strategic Workforce Chairs Assurance Report **Level 2:** Delivery of Staff Survey 2023	Reported to ELC (ELC/2324/235) Reported to Resources Cttee (RC/2324/068) Reported to BoD (BoD/2324/152)
Operations and Clinical Management Restructure	**Level 2:** Leadership Review	Reported to ELC (ELC/2324/432)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Clinical Management Restructure	Implementation of Operational & Clinical management Restructure	Mr S Desai Ms L Ward Dr C Grant	September 2024	ELC	In Progress
EDI Priorities	Delivery of Year 3 Action Plans (workforce elements)	Ms L Ward	March 2024	Resources Cttee	In Progress
Fully Embedding Just Culture Principles	Evaluation of Disciplinary Procedure	Ms L Ward	June 2024	Resources Cttee	In Progress

Partnership Agreement	Review of Partnership Agreement	Ms L Ward	September 2024	ELC	In Progress
Wellbeing	Implementation of mental health pledge and AACE commitment	Ms L Ward	June 2024	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	August 2024	Resources Cttee	In Progress
Sexual Safety Campaign	Delivery of Campaign	Ms L Ward	June 2024	Resources Cttee	In Progress
Staff Survey	Development of Trust and Local plans from 2023 survey	Ms L Ward	June 2024	Resources Cttee	In Progress

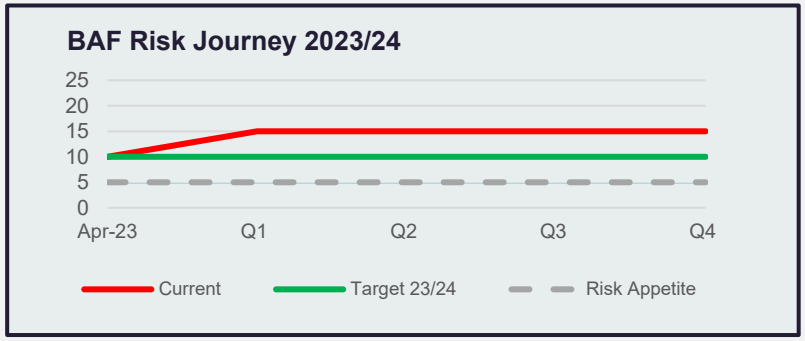
Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 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	Aspirational Target
	10	15	15	15	15	10	5
	5x2	5x3	5x3	5x3	5x3	5x2	5x1
	CxL	CxL	CxL	CxL	CxL	CxL	CxL
Risk Appetite	Within	Exceeded	Exceeded	Exceeded	Exceeded	Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk remains at a score of 15. Regular engagement was maintained during Q4 with our new CQC relationship manager. Planning continues to transition to the CQC single assessment framework that involves changes to the NWAS quality assurance visit processes. Stage 2 of the HSE inspectorate visits have been concluded and we await feedback. We have also notified NHSE of some delays in submitting clinical audit data (ACQI) due to our transition to EPR and the challenges of extracting information. The two risks associated with Lithium-Ion batteries remain however mitigation has been put into place relating to operational responses which will reduce that risk score. The organisation contributed to the national review into the statutory duty of candour undertaken by the Department of Health and Social Care and is due to conclude in Q1 2024/25. The risk associated with controlled drugs licensing remains.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
Progress is being made, however some of the identified inspections, gaps in controls and actions will not be completed until Q2 2024/25.

CONTROLS →	ASSURANCES →	EVIDENCE
PEOPLE		
Mandatory Training Compliance (85%)	**Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report **Level 2:** Strategic Workforce Chairs Assurance Report	Reported to Resources Cttee (RC/2324/096) Reported to BoD (BoD/2324/104) Reported to Resources Cttee (RC/2324/068)
Appraisal Compliance 2023/24	**Level 2:** Strategic Workforce Chairs Assurance Report **Level 2:** Workforce Indicators Assurance Report **Level 2:** Integrated Performance Report	Reported to Resources Cttee (RC/2324/068) Reported to Resources Cttee (RC/2324/096) Reported to BoD (BoD/2324/104)
Controlled Drugs and Medicines Management	**Level 2:** Ongoing review and mangement of medicines procedures **Level 2:** Clinical Effectiveness Sub Committee Chairs Assurance Report	Reported to Clinical Effectiveness Sub Committee (CESC/2324/118) Reported to QPC (QPC/2324/182)
QUALITY & SAFETY IMPROVEMENTS		
Quality Assurance Processes	**Level 2:** Quality Assurance Visits Year End Assurance Report 23/24	Reported to QPC (QPC/2324/177)
Duty of Candour	**Level 2:** Duty of Candour Update	Reported to ELC (ELC/2324/163, ELC/2324/236)
Fit Testing	**Level 2:** IPC Annual Report 2022/23 **Level 2:** IPC BAF	Reported to QPC (QPC/2324/068) and BoD (BoD/2324/081) Reported to BoD (BoD/2324/105)

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	Development of Clinical Audit tool to ensure new e-PRF can be audited	Dr C Grant Dr M Power	March 2024	Q&P Cttee	In Progress
Duty of Candour	Ongoing compliance monitoring and action plan to strengthen position with associated reporting for assurance. MIAA Audit being undertaken Q3/4	Dr M Power	March 2024	Q&P Cttee	In Progress

Essential Checks	Improve compliance around vehicle and premises checks	Mr S Desai	March 2024	Q&P Cttee	In Progress
	Improve medicine checks in Safecheck to 90% Data required to improve compliance on tyre checks	Dr C Grant Mr S Desai	March 2024	Q&P Cttee	In Progress
Information Governance	Improve compliance on mandatory training to 95	Dr M Power L Ward	June 2024	Resources Cttee	In Progress
Electronic Quality Measurement Auditing/Reporting Systems	Develop automated systems for non-clinical audits	Dr M Power	December 2023	Q&P Cttee	In Progress
PEOPLE					
Appraisal Compliance 2023/24	Achieve 85% compliance	Ms L Ward	March 2024	Resources Cttee	In Progress
Mandatory Training Compliance 2023/24	Achieve 85% compliance	Ms L Ward	March 2024	Resources Cttee	In Progress

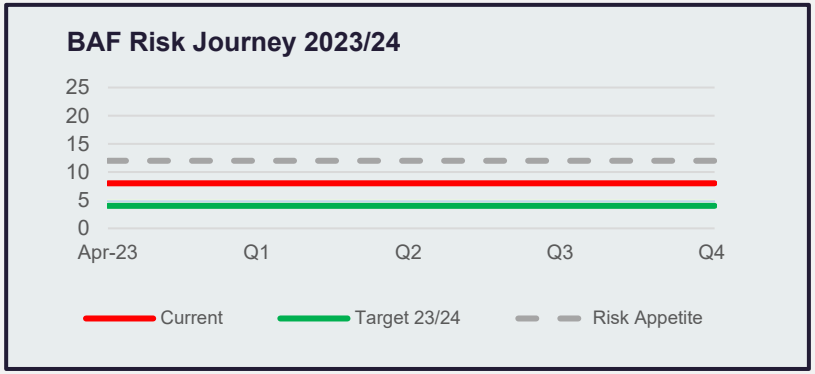
Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where 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
474	Strategic/ Estates & Facilities Management	There is a risk that a fire on NWAS premises involving a lithium-ion battery may present a serious threat of harm to staff and catastrophic damage to the premises itself.	15 High	15 High	⇔	5 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: COO

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk remains at 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 refreshed in Q4 2023/24 for each of the areas. Areas are aware of the external meetings that require attendance, this has been emphasised at the area accountability reviews. 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. Compliance challenges remain in 1 out of the 3 areas of the trust and this is currently being addressed through the accountability reviews.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
Focus on external engagement and relationship management will continue in all areas.

CONTROLS →	ASSURANCES →	EVIDENCE

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	Q1 24-25	Resources Cttee	In Progress
External Engagement Assurance	Service Delivery areas to provide evidence that important external meetings are being attended	Mr S Desai	Q1 24-25	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07

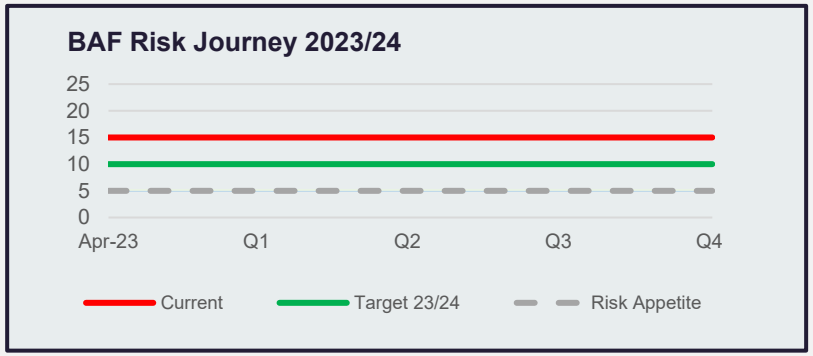
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 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: DQII

Risk Appetite Category: Compliance/Regulatory - Low



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of the BAF remains at a score of 15. There continues to be a high threat of cyber-attacks, which is based on global cyber activity and threat levels. The Trust continues to be responsive to nationally issued guidance and is progressing the cyber security work plan. Work is ongoing towards submission of the DSPT in June 2024, with an action plan developed for Data Security Awareness training which is at 87%. Patching compliance remains high, with good oversight of cyber controls. The new penetrations tests are planned for May 2024 and will be on a broader remit than the minimum required for .DSPT. The Trust continues to work in partnership with other Trusts, NHSE and suppliers on cyber threats and intelligence.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
Despite increased risk of cyber globally, we continue to add threat protection software, increase surveillance and remain vigilant in responding to national alerts from NHSE which under normal circumstances would reduce the risk, hence the risk remains stable as the gains in internal controls are offset by the external environment.

CONTROLS	ASSURANCES	EVIDENCE
Patching (999 and NHS 111)	**Level 2:** Digital Strategy Update	Reported to Resources Cttee (RC/2324/14, RC/2324/099)
Data Security Protection Toolkit Compliance	**Level 2:** Information Governance Sub Committee Chairs Assurance Report	Reported to Audit Cttee (AC/2324/08, AC/2324/060, AC/2324/85)
SIRO Key Performance Indicators	**Level 2:** Information Governance Sub Committee Chairs Assurance Report	Reported to Audit Cttee (AC/2324/08, AC/2324/060)
SIRO Annual Report	**Level 2:** SIRO Annual Report 2022/23	Reported to Audit Cttee (AC/2324/59) Reported to BoD (BoD/2324/60)
Supported Systems (Unsupported Servers 2008)	**Level 2:** Digital Update	Reported to Resources Cttee (RC/2324/099) Reported to Resources Cttee (RC/2324/150)
Patching (999 and NHS 111)	**Level 2:** Digital Update	Reported to Resources Cttee (RC/2324/150)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Dr M Power	May 2024	Audit Cttee	In Progress
Out of Hours Resilience	Implement recommendations from desktop worst case scenario	Dr M Power	March 2024	Audit Cttee	In Progress

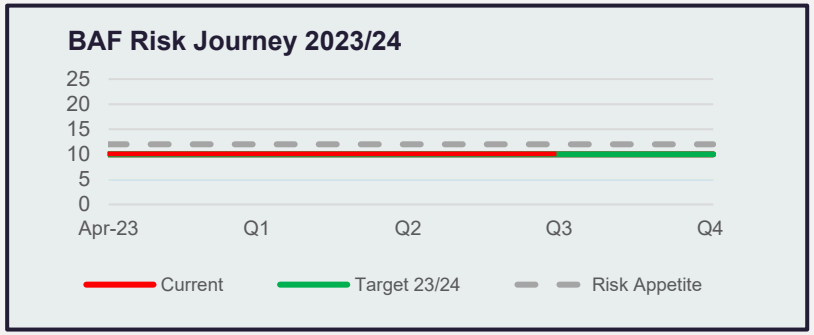
Operational Risks Scored 15+ Aligned to BAF Risk: SR08						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
330	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust 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: COO

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

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

RATIONALE FOR CURRENT RISK SCORE: The risk score for the Q4 position of this BAF risk remains at a risk score of 10. Whilst the trust performed well during Q4, industrial action and hospital handover delays continued to attract negative media attention. The negativity 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.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
Whilst there are still delays at hospitals impacting on our ability to respond to 999 calls, resources and demand has stabilised. However this could change at any time due to seasonal spikes, industrial action and harm to patients, which may lead to greater media interest and adverse coverage.

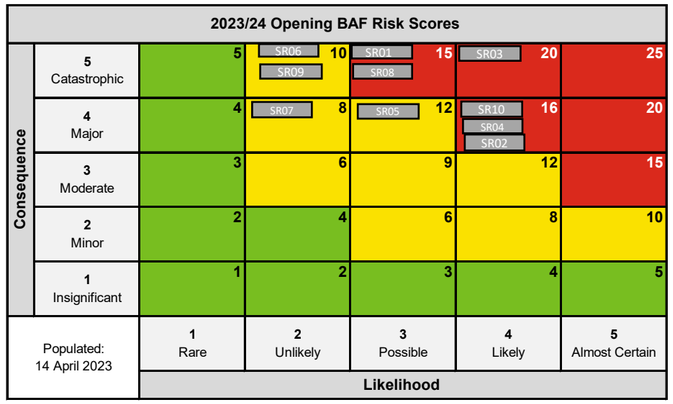
CONTROLS	ASSURANCES	EVIDENCE
Communications and Engagement Dashboard	**Level 2:** Q1 Assurance **Level 2:** Q2 Assurance Level 2: Q3 Assurance	Reported to BoD (BoD/2324/40) Reported to BoD (BoD/2324/109) Reported to BoD (BoD/2324/130)
Recruitment Plan Clinical Hub and Operational Staff	**Level 2:** Strategic Workforce Chairs Assurance Report	Reported to Resources Cttee (RC/2324/068)
Production of operational service lines demand management plans for NHS 111 and PES	**Level 2:** Annual Review of the Heat Wave Plan **Level 2:** NWAS Strategic Winter Plan 2023/24	Reported to QPC (QPC/2324/036) Reported to QPC (QPC/2324/074)

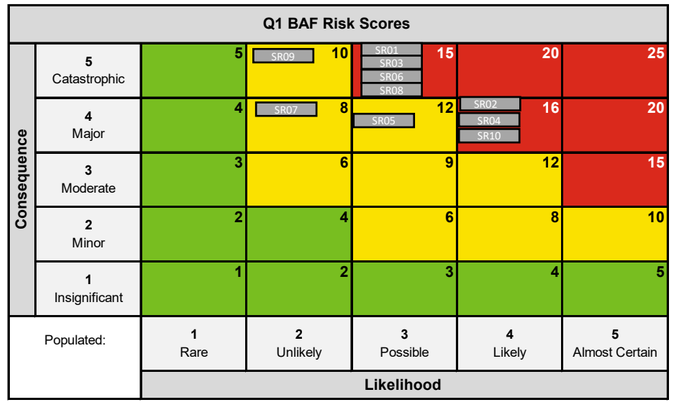
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Delivery Leadership Review	Delivery of SDLR to improve working practices	Mr S Desai	September 2024	Q&P Cttee	In Progress
	Maximise resources to the most efficient level	Mr S Desai	September 2024	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff	Robust recruitment plan to be delivered	Mr S Desai Mrs L Ward	November 2024	Q&P Cttee	In Progress

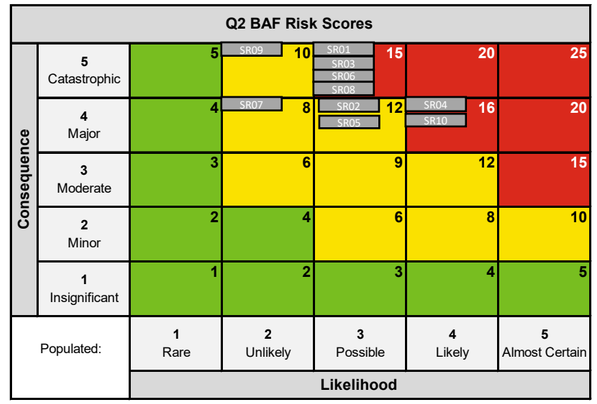
Operational Risks Scored 15+ Aligned to BAF Risk: SR09						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

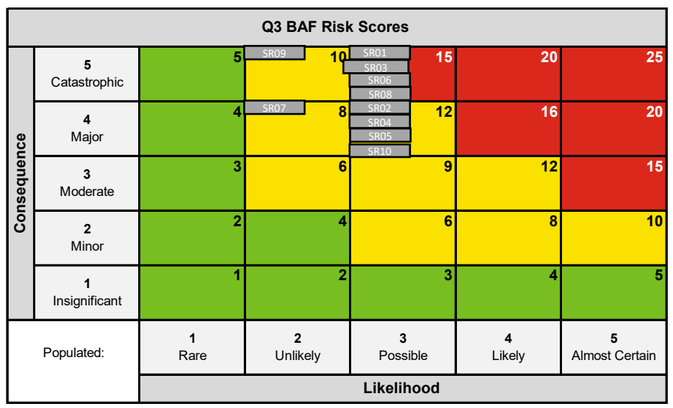
Appendix 2:
2023/24 Board Assurance Framework (BAF) Heat Maps
Q4 Position

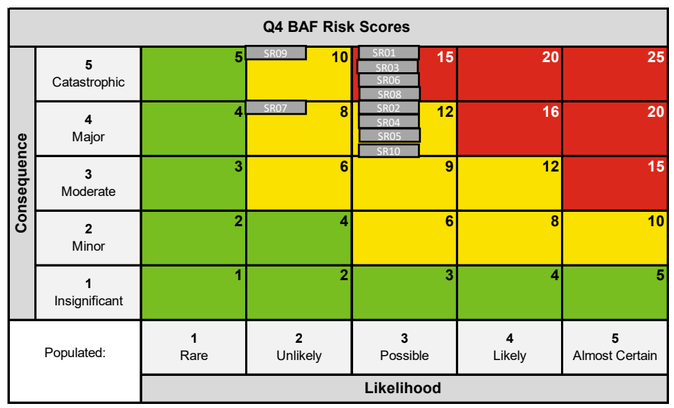
North West Ambulance Service NHS Trust

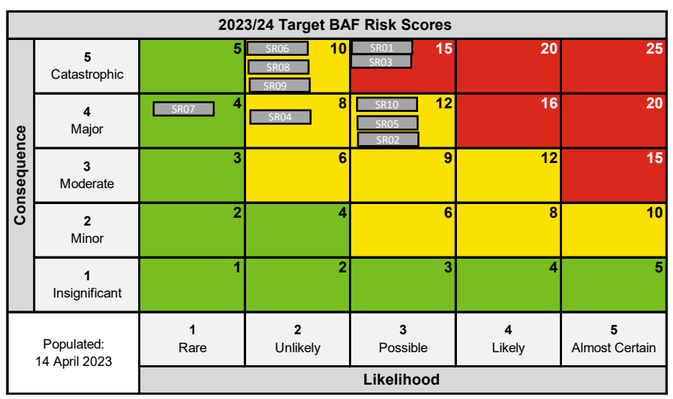


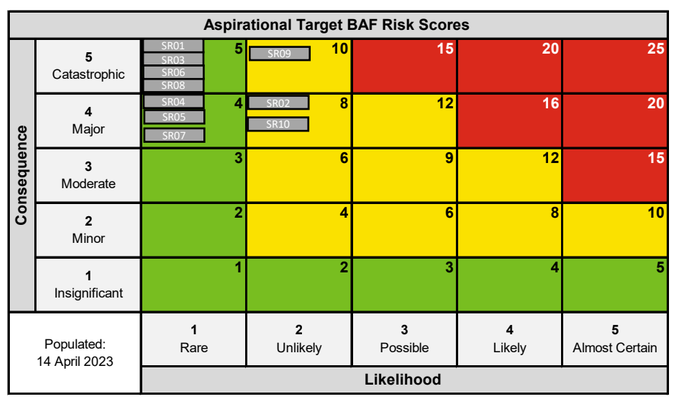












NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Opening Position of the Board Assurance Framework 2024/25
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the opening position of the Board Assurance Framework 2024/25.	
EXECUTIVE SUMMARY	The proposed 2024/25 Opening Position of the BAF risks with associated CRR risks scored ≥15 can be viewed in **Appendix 1**. The following opening risk scores are proposed and further detail and rationale can be seen in S2: • SR01 opening risk score of 15 • SR02 opening risk score of 16 • SR03 opening risk score of 15 • SR04 opening risk score of 12 • SR05 opening risk score of 12 • SR06 opening risk score of 15 • SR07 opening risk score of 8 • SR08 opening risk score of 15 • SR09 opening risk score of 10	
PREVIOUSLY CONSIDERED BY	Trust Management Committee and Audit Committee	
	Date	17th April and 19th April 2024
	Outcome	TMC recommended to Board for approval

1. BACKGROUND

The report provides the opportunity for the Board of Directors to review the 2024/25 Opening Position of the Board Assurance Framework (BAF) position along with the Corporate Risk Register (CRR) risks scored >15 that are aligned to each BAF risk.

2. RISK ASSURANCE PROCESS

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 2024/25 OPENING POSITION

The proposed 2024/25 strategic risks were approved 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 01.04.2024	Exec Director Lead
15 5x3 CxL	Dr C Grant Medical Director

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

- Challenges continue around delivering ARP and 111 performance
- Hospital handover times remain consistently above 30 minute target

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 01.04.2024	Exec Director Lead
16 5x4 CxL	Mrs C Wood Director of Finance

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

- Risk continues with the draft financial plan due to income values still awaiting agreement and contracts not yet signed

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

Opening Score 01.04.2024	Exec Director Lead
15 5x3 CxL	Mr S Desai Chief Operating Officer

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

- Challenges in delivery of the national ARP remain.
- Hospital handover improved however still higher than target in some areas
- Contract award for PTS under extended standstill period.
- Improvement required against KPIs in 111 and PTS

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 01.04.2024	Exec Director Lead
12 4x3 CxL	Ms L Ward Director of People

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

- Persistent challenges in closing vacancy gaps in 111 and PTS.
- Sickness levels continues to impact on resource availability.

SR05: There is a risk that the Trust does not improve its culture and staff engagement and this impacts adversely on retention and staff experience.

Opening Score 01.04.2024	Exec Director Lead
12 4x3 CxL	Ms L Ward Director of People

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

- There are a range of challenges relating to staff experience arising from data relating to the staff survey and People Promise themes and Ambulance Culture Review.
- Opening score reflects the improving position relating to retention and staff experience.

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

Opening Score 01.04.2024	Exec Director Lead
15 5x3 CxL	Dr M Power Director of Quality, Innovation and Improvement

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

- Engagement with the CQC relationship manager continues.
- Feedback awaited from HSE visits.
- Delays continue relating to the submission of clinical audit data due to EPR and challenges of extracting information.
- Risks associated with Lithium batteries and controlled drugs under Home Office Licence.

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

Opening Score 01.04.2024	Exec Director Lead
8 4x2 CxL	Mr S Desai Chief Operating Officer

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

- Challenges remain in 2 out of 3 areas in relation to recording attendance at external meetings.

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

Opening Score 01.04.2024	Exec Director Lead
15 5x3 CxL	Dr M Power Director of Quality, Innovation and Improvement

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

- Persistent threat of cyber attached and global unrest.

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

Opening Score 01.04.2024	Exec Director Lead
10 5x2 CxL	Mr S Desai Chief Operating Officer

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

- Industrial action and hospital handover delays continues to attract negative media attention

3. RISK CONSIDERATION

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

The BAF contains the application of the Trust's Risk Appetite Statement and has been reviewed as part of the Opening Position of the BAF.

4. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the 2024/25 Opening Position of the BAF.

North West Ambulance Service NHS Trust

BOARD ASSURANCE FRAMEWORK 2024/25

Opening Position

Board of Directors

24th April 2024

Opening Position Reporting Timescales:

Trust Management Cttee:	17/04/2024
Audit Cttee:	19/04/2024
Resources Cttee:	24/05/2024
Quality & Performance Cttee:	22/04/2024
Board of Directors:	24/04/2024

BOARD ASSURANCE FRAMEWORK KEY

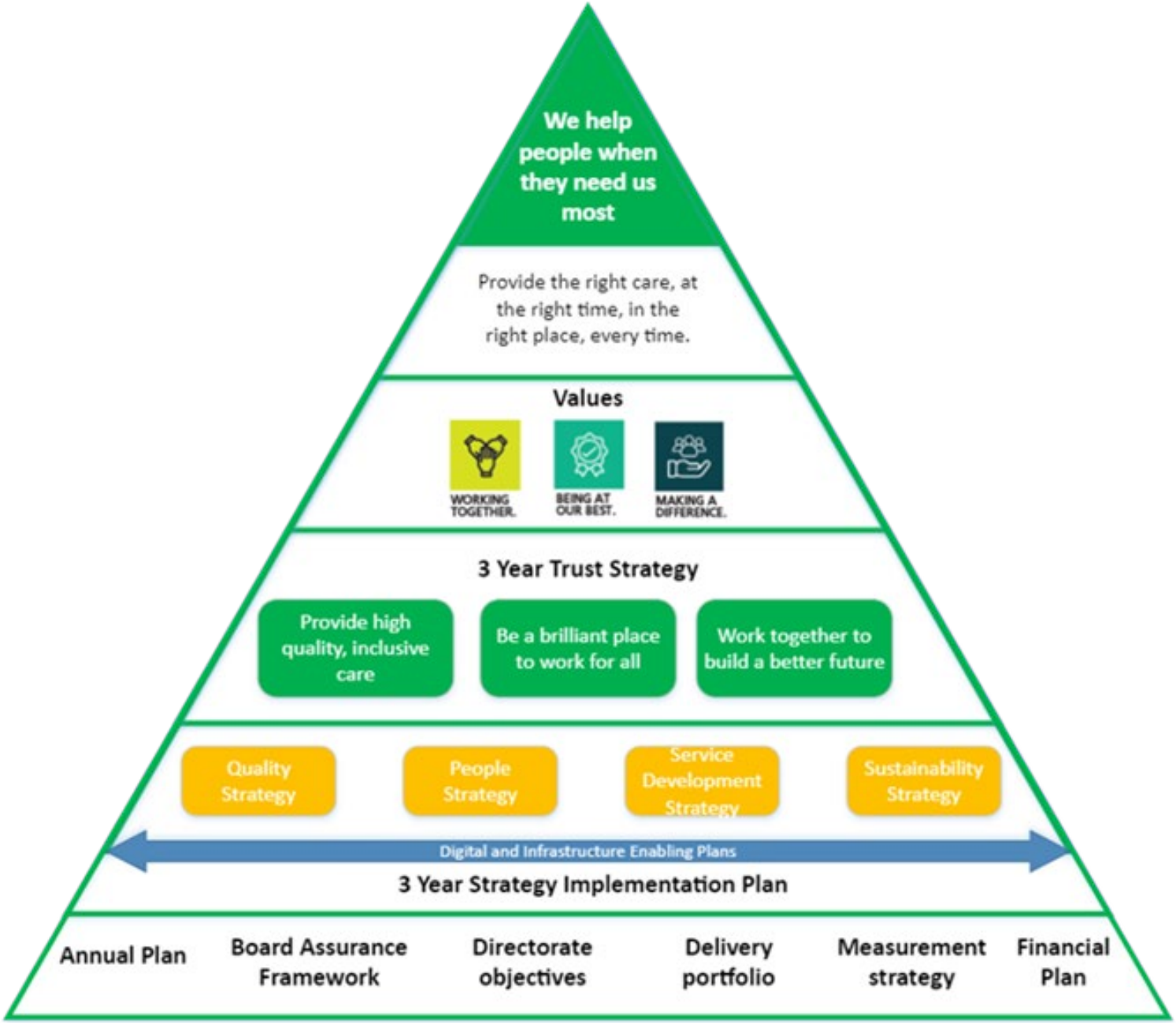
Risk Rating Matrix (Likelihood x Consequence)

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
DOO	Chief Operating Officer
DoP	Director of People
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 2024/25

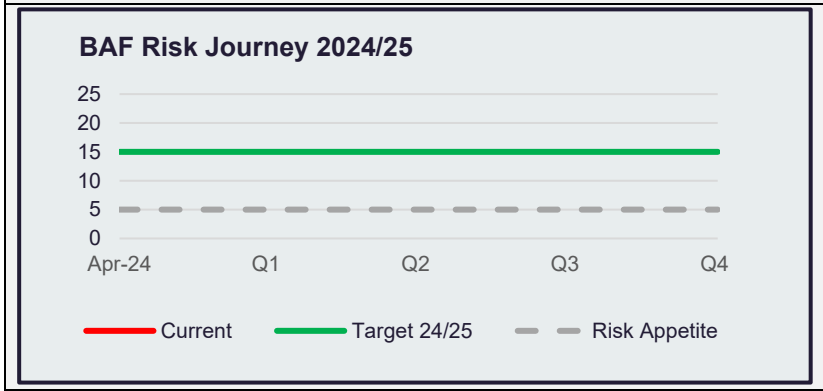
BAF Risk	Committee	Exec Lead	01.04.24	Q1	Q2	Q3	Q4	2024/25 Target	Risk Appetite Tolerance
SR01: There is a risk that the Trust does not provide high quality, inclusive care leading to avoidable harm, poorer patient outcomes and reduction in patient satisfaction	**Quality & Performance**	**MD**	**15** 5x3 C&L					**15** 5x3 CxL	**1-5**
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	**6-12**
SR03: There is a risk that the Trust does not deliver improved national and local operational performance standards resulting in delayed care and/or harm	**Quality & Performance**	**COO**	**15** 5x3 CxL					**15** 5x3 CxL	**1-5**
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**	**12** 4x3 CxL					**8** 4x2 CxL	**6-12**
SR05: There is a risk that the Trust does not improve its culture and staff engagement and this impacts adversely on retention and staff experience.	**Resources**	**DoP**	**12** 4x3 CxL					**12** 4x3 CxL	**6-12**
SR06: There is a risk that non-compliance with legislative and regulatory standards could result in harm and/or regulatory enforcement action	**Quality & Performance**	**DoQII**	**15** 5x3 CxL					**10** 5x2 CxL	**1-5**
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**	**COO**	**8** 4x2 CxL					**4** 4x1 CxL	**6-12**
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					**15** 5x3 CxL	**1-5**
SR09: There is a risk that the Trust attracts negative media attention arising from long delays and harm leading to significant loss of public confidence	**Resources**	**COO**	**10** 5x2 CxL					**10** 5x2 CxL	**6-12**
SR10: (**Sensitive Risk**):	**Resources**	**COO**	**12** 4x3 CxL					**12** 4x3 CxL	**6-12**

BOARD ASSURANCE FRAMEWORK 2024/25

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:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15					15	1-5
	5x3					5x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded					Exceeded	

RATIONALE FOR RISK SCORE: The risk score for the opening position of this BAF risk remains at a score of 15 due to persistent challenges delivering ARP and hospital turnaround times remaining high. However, the Trust is in a strong national standing for C1 and C2 performance and hospital handover has improved although remains persistently above the 30 minute target. 111 performance is stable but remains challenged in delivering the national standards. Cardiac ACQI metric show improvement and performance above national average. The number of complaints received and closed are stable, the most common theme is violence and aggression for non patient incidents. In terms of hear and treat, the Trust is ranked 4th. In terms of long waits, C1 has decreased by 18% and C2 by 53% compared to the last Integrated Performance Report (January 2024).

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
The Trust is moving out of winter pressures with an expectation of decreased demand and improving hospital handover delays. There is an anticipated increase to hear and treat within C2 segmentation.

CONTROLS →	ASSURANCES →	EVIDENCE
QUALITY		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
CLINICAL					
Clinical Audit	Implement next general of Clinical Audit Tool	Dr C Grant	March 2025	Q&P Cttee	Not commenced
QUALITY					
Patient Safety Strategy	Further training required to ensure embedding of PSIRF learning responses.	Dr M Power	March 2024	Q&P Cttee	In Progress
	Development of safety improvement plans for local priorities informed by data and learning outcomes -	Dr M Power	March 2025	Q&P Cttee	In Progress
	Work to ensure Patient Safety Partners are remunerated as per the framework and access information in line with governance requirements. - op	Dr M Power	July 2024	Q&P Cttee	In Progress
	Patient Safety Partner Policy is in advanced draft is produced awaiting review by Legal Services	Dr M Power	June 2024	Q&P Cttee	In Progress
Implementation of the quality strategy	Service line plans for improvement of safety, effectiveness and experience	Dr M Power / Mr S Desai	September 2024	Q&P Cttee	In Progress
Progressing maturity of NHS Impact	Deliver Improvement Academy (10 teams)	Dr M Power	September 2024	Q&P Cttee	In Progress
Insight and intelligence	Integrated quality and performance reporting for service lines and sectors	Ms J Wharton	September 2024	TM Cttee	In Progress
Delays in responding to patients in mental health crisis	Mental health strategic plan implementation	Ms E Orton /Mr S Desai	September 2024	TM Cttee	In Progress

	RCRP task and Finish group				
Avoidable conveyance to hospital & long waits at ED impacting resource availability and response	See and Treat Improvement Programme	Mr S Desai	March 2025	TM Cttee	In Progress
Safety Culture	Scope plan to improve performance on safety culture and FTSU	Dr M Power Dr C Grant	April 2024	TM Cttee	In Progress
Safety Education	Training needs analysis for safety training	Dr M Power/ Ms L Ward	June 2024	Q&P Cttee	In Progress
Variation in handover delays and process impacting patient safety	Specific work with the Cheshire and Mersey partnership to focus on excess dealys	Mr S Desai / Dr C Grant	March 2025	TM Cttee	In Progress
DIGITAL					
Digital Strategic Plan	Complete and seek Board approval	Dr M Power	May 2024	BoD	In Progress

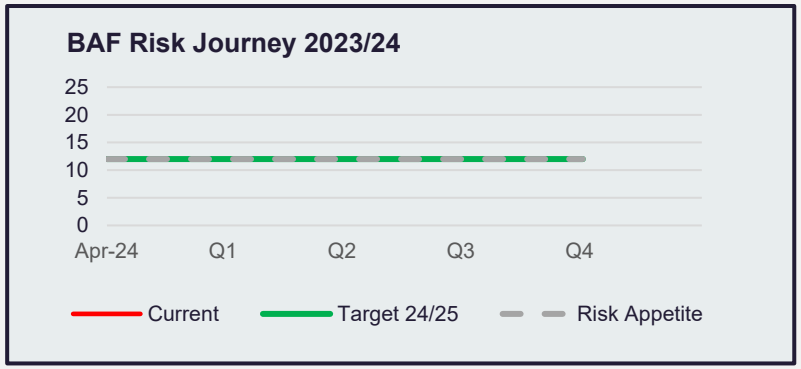
Operational Risks Scored 15+ Aligned to BAF Risk: SR01						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
412	Operational/ Emergency Preparedness	There is a risk that, due to a lack of national standards, training, exercising, and subsequent competency assurance, the EOC leadership team are not adequately prepared to manage large scale, significant or major incidents, which may result in serious avoidable patient harm or death and cause significant reputational damage to the Trust.	15 High	15 High	⇔	5 Low
490	Operational/ Operational Performance	There is a risk that due to the roll-out speed of the of the UK Government's National Framework Agreement: Right Care, Right Person (RCRP), the necessary alternative services will not be available or lack sufficient capacity, leading to NWAS becoming the default organisation for all incidents involving people with mental health needs.	15 High	15 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2024/25

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:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	16					12	6-12
	4x4					4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded					Within	

RATIONALE FOR CURRENT RISK SCORE:
The risk score for the opening position of this BAF risk is 16. Whilst a balanced draft financial plan has been submitted there is still risk within the plan as income values are yet to be agreed and contracts are yet to be signed. The efficiency requirement is £11.5m with plans to be delivered in full.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Deteriorating
The risk score will deteriorate as we move into the new financial year. Whilst draft plans have been approved by the Board of Directors plans are yet to be finalised following the publication of the national guidance and CIP schemes continue to be developed.

CONTROLS	ASSURANCES	EVIDENCE
2024/25 Financial Planning	**Level 2:** 2024/25 Financial Planning and Opening Budgets	Reported to BoD: (BoD/2324/082)

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
FINANCE					
Final 2024/25 financial plans	Final 2024/25 financial plan	Ms C Wood	May 2024	Resources Cttee / BoD	In Progress
2025/26 Financial Planning	Receipt of 2025/26 planning guidance from NHSE	Ms C Wood	January 2025	Resources Cttee	Not Commenced
	Draft 2025/26 Financial Plan (Revenue & Capital)	Ms C Wood	March 2026	Resources Cttee / BoD	Not Commenced
	Approval of 2025/26 Financial Plans by Resources Cttee & BoD	Ms C Wood	March 2026	Resources Cttee / BoD	Not Commenced

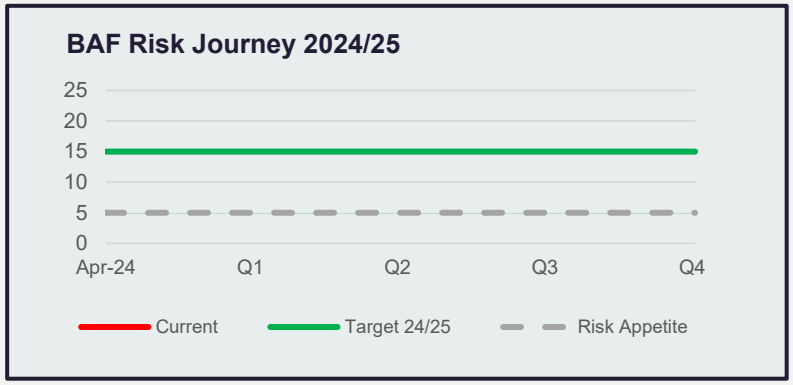
Operational Risks Scored 15+ Aligned to BAF Risk: SR02						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk.						

BOARD ASSURANCE FRAMEWORK 2024/25

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

Executive Director Lead: COO

Risk Appetite Category: Quality Outcomes – Low



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15					15	1-5
	5x3					15x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded					Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position is 15 primarily because delivery of the national ARP standards is still challenged with only one of the seven standards currently being met. Hospital handover whilst marginally improved remains over 40 minutes average at trust level, but higher in some areas. PTS contract award under extended standstill period, further improvement required against the planned arrivals and enhanced priority service KPIs. In 111, KPIs continue to improve year on year yet still below the national standard.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable.
The delivery of the UEC recovery plan is progressing well with most of the recruitment and deployment of additional resources in place. PTS continues to take forward an ambitious improvement plan in to 24/25 and similarly NHS 111 will maintain a focus on workforce and vacancies supported by national support at 15% of total calls – an increase from 5-10% we received in 23/24.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Improve Hear and Treat Performance	Improve Hear and Treat Performance from 15% to 16.4%	Mr S Desai	March 2025	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff (SR09)	Robust recruitment plan to be delivered to maximise resources to the most efficient level	Mr S Desai Mrs L Ward	November 2024	Q&P Cttee	In Progress
Service Delivery Leadership Review (SR09)	Delivery of SDLR to improve working practices	Mr S Desai	September 2024	Q&P Cttee	In Progress

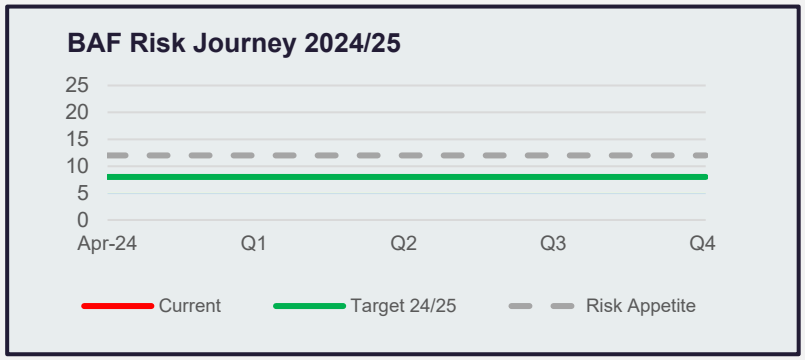
Operational Risks Scored 15+ Aligned to BAF Risk: SR03						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk.						

BOARD ASSURANCE FRAMEWORK 2024/25

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:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	12					8	6-12
	4x3					4x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within					Below	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position of this BAF risk is 12. Whilst the opening vacancy position across emergency operations is strong, there remain a high number in training and there are persistent challenges in closing vacancy gaps in 111 and PTS. Sickness absence remains above sector average and continues to impact on resource availability. The score of 12 reflects these ongoing risks but recognises that current performance indicates that safe staffing is being maintained

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Improving
The deployment position in Operations is expected to improve across Q1 and progress to be made in closing vacancy gaps in 111 and PTS.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Recruitment Plans	Delivery of recruitment plans	Ms L Ward	March 2025	Res Cttee	In Progress
Retention Plans	Delivery of EOC Retention Plans	Ms L Ward	March 2025	Res Cttee	In Progress
Flu Vaccination Programme	Delivery of 2024/25 Campaign	Ms L Ward	February 2025	Res Cttee	In Progress
Attendance Improvement Teams – Improvement Plans	Continued implementation of improvement plans	Ms L Ward	March 2025	Res Cttee	In Progress

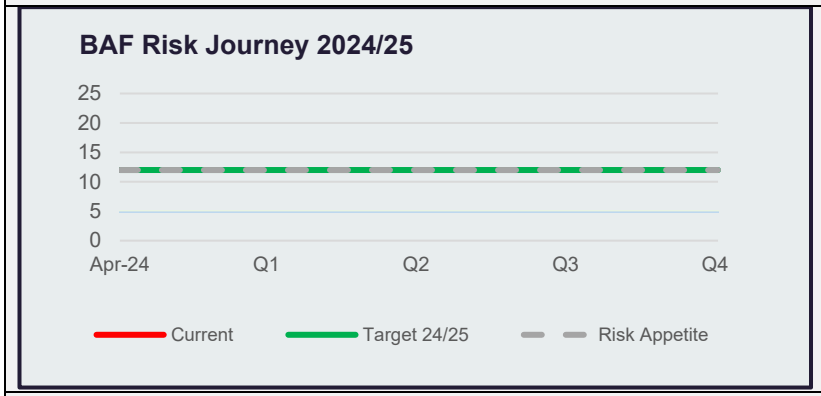
Operational Risks Scored 15+ Aligned to BAF Risk: SR04						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
490	Operational/ Operational Performance	There is a risk that due to the roll-out speed of the of the UK Government's National Framework Agreement: Right Care, Right Person (RCRP), the necessary alternative services will not be available or lack sufficient capacity, leading to NWAS becoming the default organisation for all incidents involving people with mental health needs.	15 High	15 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2024/25

BAF RISK SR05:
There is a risk that the Trust does not improve its culture and staff engagement, and this impacts adversely on retention and staff experience

Executive Director Lead: DoP

Risk Appetite Category: People - Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	12					12	6-12
	4x3					4x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within					Within	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position of this BAF risk is 12. Whilst 2023 staff survey results indicate continued 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 range of challenges to staff experience identified through data and through the Ambulance Culture Review. Progress continues to be made in delivering planned improvements set out in the People Strategy and Annual Plans but these will take some time to deliver the changes required. The current score of 12 reflects that retention and staff experience feedback is in an improving position.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
There are clear plans in place to progress improvements in culture and staff experience but these are expected to take time to achieve a step change in experience so the position is expected to remain stable.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Operations and Clinical Management Restructure	Implementation of Operational & Clinical Management Restructure	Mr S Desai	September 2024	Resources Cttee	In Progress
EDI Priorities	Refresh of EDI priorities	Ms L Ward	June 2024	Resources Cttee	In Progress
	Delivery of year 1 action of plan	Ms L Ward	2024/25	Resources Cttee	In Progress
Fully Embedding Just Culture Principles	Evaluation of Disciplinary Procedure	Ms L Ward	June 2024	Resources Cttee	In Progress
Partnership Agreement	Implementation of revised Partnership Agreement	Ms L Ward	September 2024	Resources Cttee	In Progress
Wellbeing	Implementation of mental health improvement plans	Ms L Ward	June 2024	Resources Cttee	In Progress
Leadership	Delivery of full Making a Difference Programme	Ms L Ward	August 2024	Resources Cttee	In Progress
Sexual Safety Campaign	Delivery of Campaign	Ms L Ward	June 2024	Resources Cttee	In Progress
Staff Survey	Development of Trust and Local Plans from 2023 Survey	Ms L Ward	June 2024	Resources Cttee	In Progress
	Delivery of Staff Survey 2024	Ms L Ward	December 2024	Resources Cttee	In Progress
Culture review	Deliver identified actions and support national work programme	Ms L Ward	2024/25	Resources Cttee	In Progress
People Promise Exemplar Programme	Deliver improvements in identified priority areas: flexible working; staff engagement	Ms L Ward	2024/25	Resources Cttee	In Progress
Induction	Implement revsied onboarding and induction	Ms L Ward	2024/25	Resources Cttee	In Progress

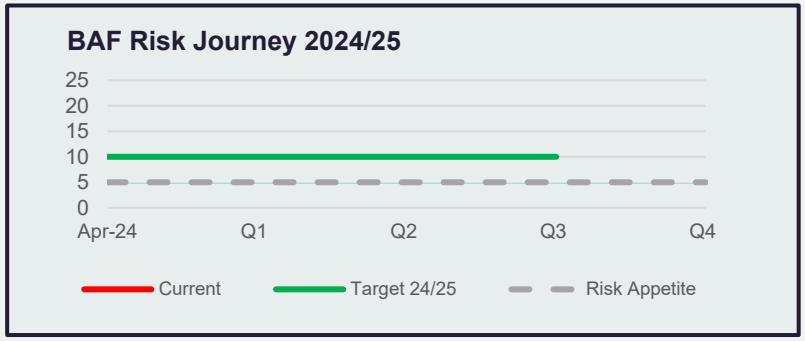
Operational Risks Scored 15+ Aligned to BAF Risk: SR05						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

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:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15					10	1-5
	5x3					5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded					Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position of this BAF risk is 15, Regular engagement continued into Q1 with our new CQC relationship manager. Planning continues to transition to the CQC single assessment framework that involves changes to the NWAS quality assurance visit processes. Stage 2 of the HSE inspectorate visits have been concluded and we await feedback. We have also notified NHSE of some delays in submitting clinical audit data (ACQI) due to our transition to EPR and the challenges of extracting information. The two risks associated with Lithium-Ion batteries remain however mitigation has been put into place relating to operational responses which will reduce that risk score. The organisation contributed to the national review into the statutory duty of candour undertaken by the Department of Health and Social Care and is due to conclude in Q1 2024/25. The risk associated with controlled drugs licensing remains.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
Progress is being made, however some of the identified inspections, gaps in controls and actions will not be completed until Q2 2024/25.

CONTROLS →	ASSURANCES →	EVIDENCE
PEOPLE		
QUALITY & SAFETY IMPROVEMENTS		

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
QUALITY & SAFETY IMPROVEMENTS					
Duty of Candour	Ongoing compliance monitoring and action plan to strengthen position with associated reporting for assurance.	Dr M Power	March 2025	Q&P Cttee	In Progress
Essential Checks	Improve compliance of vehicle and equipment checks	Dr M Power / Mr S Desai	March 2025	Q&P Cttee	In Progress
Medicines management	Business case and procurement of dedicated medicines management system	Dr C Grant	September 2024	Q&P Cttee	In Progress
Digital Clinical Safety	Creation and implementation of digital clinical safety procedures	Ms J Wharton	June 2024	Q&P Cttee	In Progress
	Completion of digital clinical safety process on Electronic Patient Record	Ms J Wharton	September 2024	Q&P Cttee	In Progress
	Assessment of all systems to determine systems requiring application of digital clinical safety	Ms J Wharton	September 2024	Q&P Cttee	In Progress
Information Governance	Improve compliance on mandatory training to 95%	Dr M Power L Ward	June 2024	Resources Cttee	In Progress
PEOPLE					

Appraisal Compliance 2023/24	Achieve 85% compliance	Ms L Ward	May 2024	Resources Cttee	In Progress
Appraisal Compliance 2024/25	Achieve 85% compliance	Ms L Ward	March 2025	Resources Cttee	In Progress
Mandatory Training Compliance 2023/24	Achieve 85% compliance	Ms L Ward	March 2025	Resources Cttee	In Progress

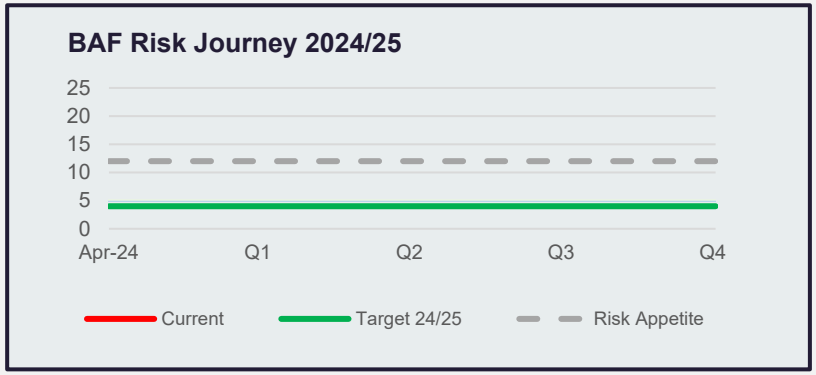
Operational Risks Scored 15+ Aligned to BAF Risk: SR06						
Datix ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
318	Operational/ Patient Safety	There is a risk that due to the variation in security provisions at ambulance bases where 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
474	Strategic/ Estates & Facilities Management	There is a risk that a fire on NWAS premises involving a lithium-ion battery may present a serious threat of harm to staff and catastrophic damage to the premises itself.	15 High	15 High	⇔	5 Low

BOARD ASSURANCE FRAMEWORK 2024/25

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: COO

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	8					4	6-12
	4x2					4x1	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Within					Below	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position of this BAF risk is 8. Areas are aware of the need to maintain good local engagement and relationships with external partners. The demands on the teams are significant and consistency of representation and quality of input remains a challenge in some forums. The P&I team will work with all directorates to ensure evidence and assurance of external engagement is documented and shared internally.

Projected Forecast Q1:
Deteriorating
Stable
Improving

Rationale: Stable
Focus on external engagement and relationship management will continue in all areas.

CONTROLS →	ASSURANCES →	EVIDENCE

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	Q1	Resources Cttee	In Progress
External Engagement Assurance	Service Delivery areas to provide evidence that important external meetings are being attended	Mr S Desai	Q1	Resources Cttee	In Progress

Operational Risks Scored 15+ Aligned to BAF Risk: SR07

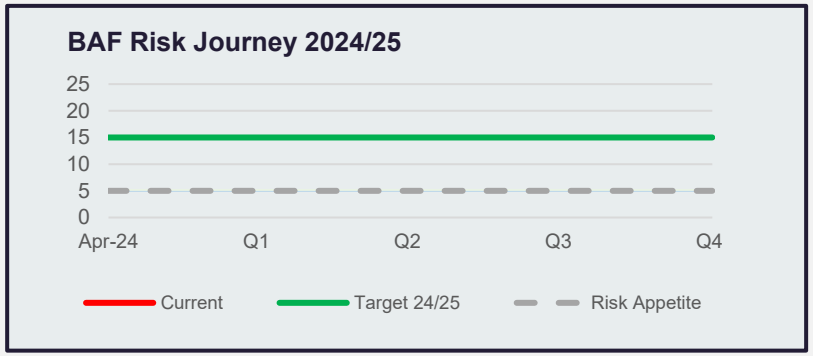
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

BOARD ASSURANCE FRAMEWORK 2024/25

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:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	15					15	1-5
	5x3					5x3	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Exceeded					Exceeded	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position of the BAF is a risk score of 15 due to the persistent threat of cyber attacks and global unrest. Our digital systems are expanding rapidly and with that comes an increasing risk of attack based on the 'expansion of the threat surface'. This is necessary for us to achieve our strategic goals and will be scrutinised with the introduction of new governance in FY 24-25. We have digital monitoring systems in place which require continual updates to maintain their safety based on a continuous flow of intelligence (alerts) from agencies such as NHSE. We must maintain high levels of training compliance and carry out simulation to ensure our staff understand how their actions impact on system safety. Cascading this through information asset owners is partially complete.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable / Deteriorating
Based on the external cyber environment and unrest and the requirement for continual investment (people and money) in threat protection systems and ageing digital estate.

CONTROLS →	ASSURANCES →	EVIDENCE

Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Digital Strategic Plan	Define the process for creating the digital strategic plan	Dr M Power	September 2024	Resources Committee	Not Commenced
Cyber Assurance Framework	Implement Multi factor authentication on all required systems	Dr M Power	June 2024	Resources Committee	In Progress
Data Security Protection Toolkit Compliance	Achieve 95% compliance with Data Security Awareness Training	Dr M Power	March 2025	Audit Cttee	In Progress
	Critical system mapping completed	Dr M Power	September 2025	Audit Cttee	In Progress
	Information Asset Register completed with data flow mapping	Dr M Power	March 2025	Resources Committee	In Progress
Out of Hours Resilience	Implement recommendations from desktop worst case scenario	Dr M Power	June 2024	Audit Cttee	In Progress
EPRR resilience and response	Conduct a mock cyber incident session with operational and clinical colleagues	Dr M Power	June 2024	Resources Committee	Not started
Information Asset Owner Assurance	Define a assurance process for IAO to follow	Dr M Power	June 2024	Audit?	Not started

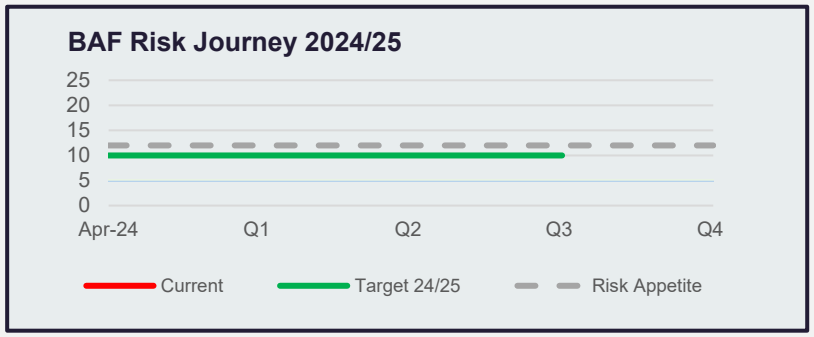
Operational Risks Scored 15+ Aligned to BAF Risk: SR08						
ERM ID	**Directorate**	**Risk Description**	**Initial Score**	**Current Score**	**Trend Analysis**	**Target Score**
330	Operational/ Digital and Innovation	There is a risk that due to gaps in controls and user education/awareness, the Trust 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 2024/25

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: COO

Risk Appetite Category: Reputation – Moderate



BAF RISK SCORE JOURNEY:

	01.04.24	Q1	Q2	Q3	Q4	24/25 Target	Risk Appetite
	10					10	6-12
	5x2					5x2	
	CxL	CxL	CxL	CxL	CxL	CxL	
Risk Appetite	Below					Below	Within

RATIONALE FOR CURRENT RISK SCORE: The risk score for the opening position of this BAF risk is a risk score of 10. Whilst the trust performed well during Q4 24/25, industrial action and hospital handover delays continued to attract negative media attention. The negativity 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.

Projected Forecast Q1: Deteriorating / Stable / Improving

Rationale: Stable
Whilst there are still delays at hospitals impacting on our ability to respond to 999 calls, resources and demand has stabilised. However this could change at any time due to seasonal spikes, industrial action and harm to patients, which may lead to greater media interest and adverse coverage.

CONTROLS	ASSURANCES	EVIDENCE

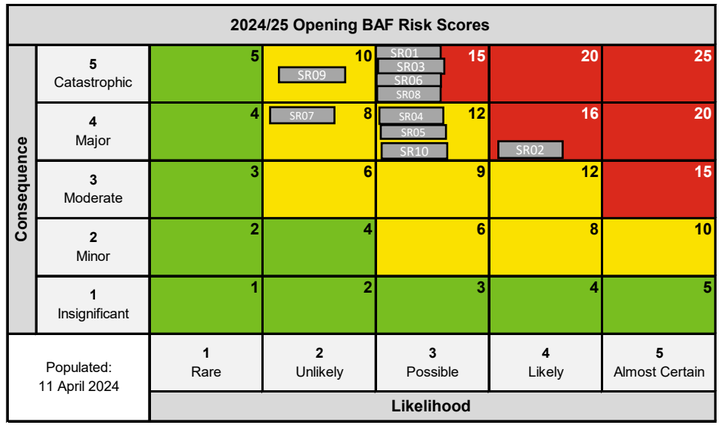
Gaps in Controls/ Assurances	Required Action	Action Lead	Target Completion	Monitoring	Progress
Service Delivery Leadership Review	Delivery of SDLR to improve working practices	Mr S Desai	September 2024	Q&P Cttee	In Progress
	Maximise resources to the most efficient level	Mr S Desai	September 2024	Q&P Cttee	In Progress
Recruitment Plan Clinical Hub and Operational Staff	Robust recruitment plan to be delivered	Mr S Desai Mrs L Ward	November 2024	Q&P Cttee	In Progress

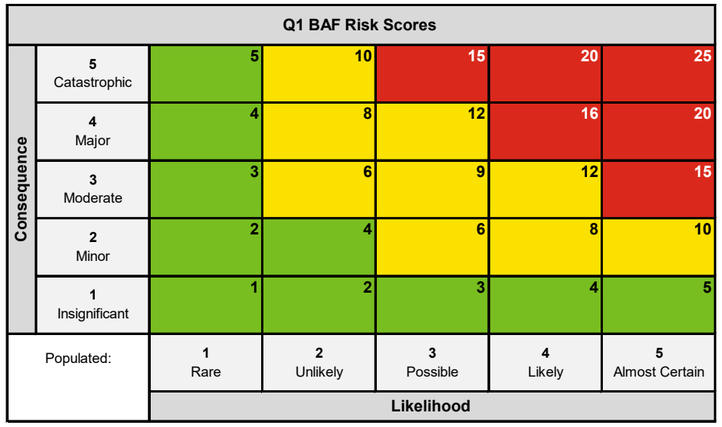
Operational Risks Scored 15+ Aligned to BAF Risk: SR09

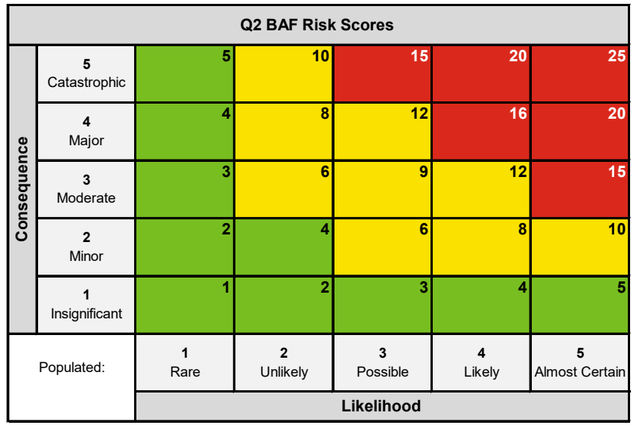
Datix ID	Directorate	Risk Description	Initial Score	Current Score	Trend Analysis	Target Score
There are no operational risks scored 15+ aligned to this BAF risk						

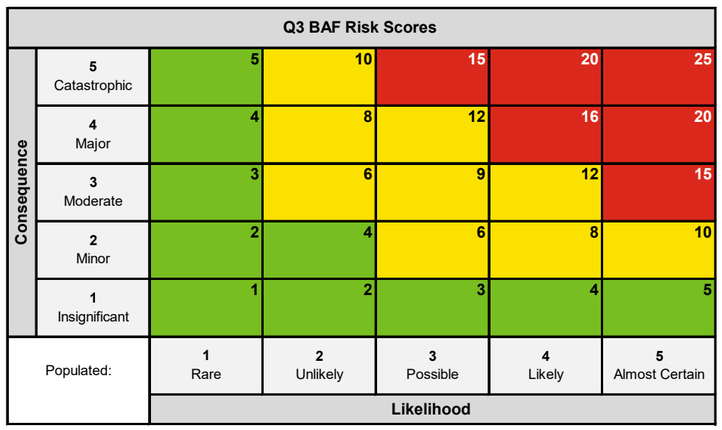
Appendix 2:
2024/25 Board Assurance Framework (BAF) Heat Maps
Opening Position

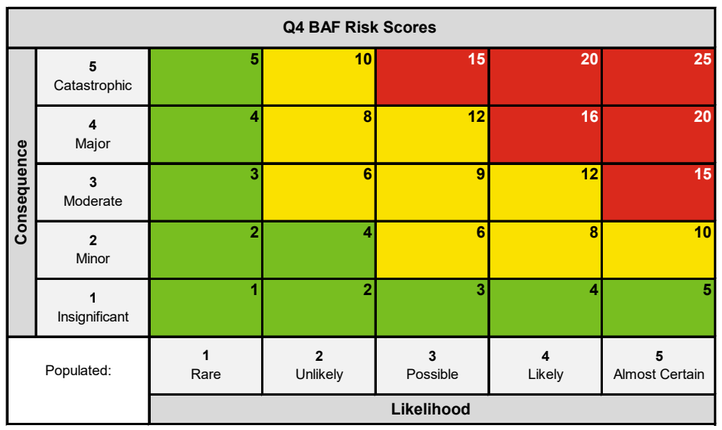
NHS North West Ambulance Service NHS Trust

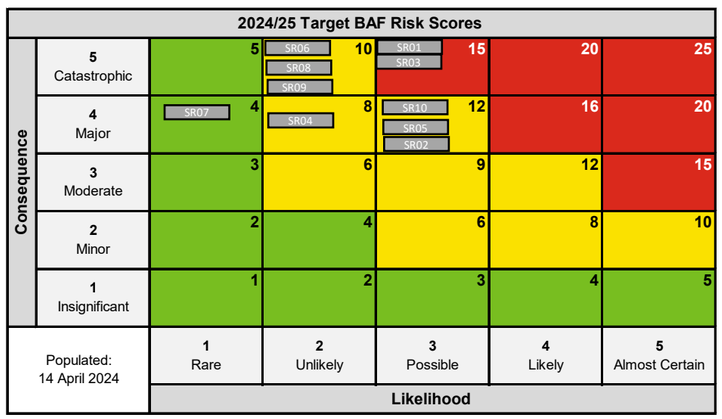


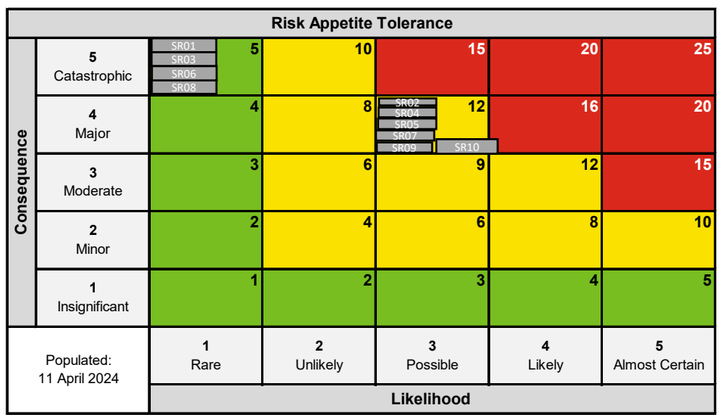












NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Risk Management Policy
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the updated Risk Management Policy for the trust.	
EXECUTIVE SUMMARY	The Risk Management Policy has been through an annual review and refresh. Risk management is a statutory requirement and an indispensable element of good management. 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 to principles and techniques of risk management to be applied consistently throughout the organisation. A summary of the changes made to the policy are detailed in S3. The Risk Management Policy can be viewed in **Appendix 1**.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 19 April 2024
	Outcome	Recommended for approval

1. 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 all our people (staff and volunteers) at all levels.

2. 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 ad 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 revised Policy can be viewed in Appendix 1.

3. SUMMARY OF POLICY CHANGES

Following the annual review and refresh, the following changes have been made:

- Resilience and response; this has been refreshed and updated to achieve compliance with the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) Core Standards.

- Identifying controls; utilising enterprise risk management best practice, reference to the four types of controls have been included with examples to assist with control identification.

- Language change throughout the Policy from Corporate Risk and Assurance Team to Events and Risk Assurance Team.

- Risk management governance structure; a full review and refresh of the corporate governance structure, the Policy now reflects the new governance structure, including new names of groups and Committees and removal of Sub Committees.

- Risk reporting and assurance diagram; refreshed diagram to reflect the new corporate governance structure. The diagram highlights how the Trust aims to assure, scrutinise, escalate, and alert on risk management matters.

- Consequence scoring matrix; has been subject to a full review and refresh with subject matter experts. The consequence matrix has been condensed and aligned to the risk appetite categories.

- Equality impact assessment; has been subject to a full review and refresh.

4. RISK CONSIDERATION

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

5. EQUALITY/ SUSTAINABILITY IMPACTS

None identified. Updated EIA attached to the policy.

6. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Risk Management Policy for the trust.

North West Ambulance Service NHS Trust

Policy on Risk Management

Policy on Risk Management		Page:	Page **1** of **29**
Author:	Head of Risk and Assurance	Version:	0.5
Date of Approval:	TBC	Status:	Final
Date of Issue:	TBC	Date of Review	April 2027

Recommended by	Audit Committee
Approved by	Board of Directors
Approval date	
Version number	0.5
Review date	April 2027
Responsible Director	Director of Corporate Affairs
Responsible Manager (Sponsor)	Head of Risk and Assurance
For use by	All our people

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	April 2023	S White	Annual Review
0.5	February 2024		J Taylor	Annual Review

Policy on Risk Management

Contents	

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
- Bringing to the attention of 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.

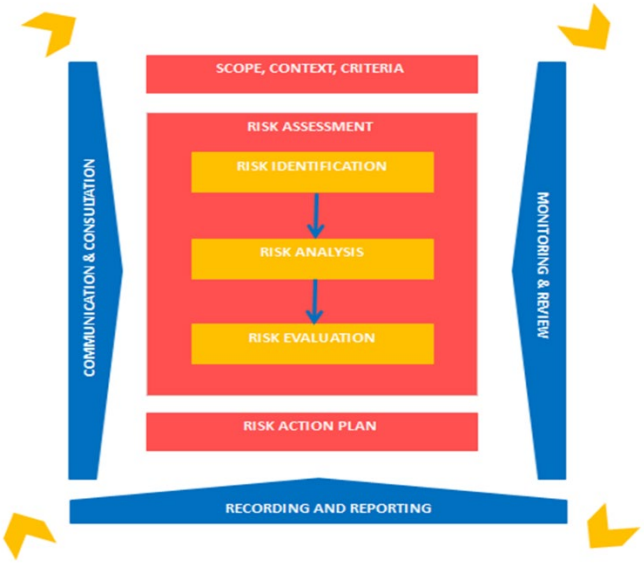


Figure 1: *ISO 3100:2018 Risk Management Process*

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.

Resilience and Response
The NWAS Resilience Team work with partners in the Local Resilience Forums and Local Health Resilience Partnerships to examine National and Community Risk Registers and plan for multiagency risk mitigation and response. This is reviewed for the potential impact on the Trust, anything identified is recorded in accordance with this Policy and highlighted to the Emergency Preparedness, Resilience and Response (EPRR) Group, chaired by the Accountable Emergency Officer.

Recommendations from critical, major, or business continuity incidents and exercises are captured within the risk management processes to ensure the delivery of actions to reduce the 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

Likelihood	Consequence				
	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 Events and Risk Assurance Team and a decision made by the Trust Management 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 Trust Management 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 Trust Management 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.

Preventative	Designed to limit the possibility of an undesirable outcome being realised. They are important to stop an undesired outcome. It is crucial to implement these types of controls. *For example, elimination of the hazard/ physically remove the hazard if possible/ substitute with hazard with something less risky*
Corrective	Designed to limit the scope for loss and reduce any undesired outcomes that have been realised. These may also provide a route of recourse to achieve recovery against loss or damage. *For example, isolating people from the hazard, the use of guards, or barriers, or reducing the exposure of the hazard*
Directive	Designed to ensure that a particular outcome is achieved. This is based on giving directions to people on how to ensure that losses do not occur. These are important but depend on people following established safe systems of work. *For example, administrative controls such as changing the way people work, training and supervision to enforce policies, procedures, processes, pathways, use of Personal Protective Equipment (PPE)*
Detective	Designed to identify occasions when undesirable outcomes have been realised. Their definition, 'after the event' they are only appropriate when loss or damage has occurred. *For example, monitoring and surveillance, such as closed-circuit television (CCTV), smoke detectors, fire alarms.*

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	Trust Management Committee
Trust Management Committee	Board of Directors

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

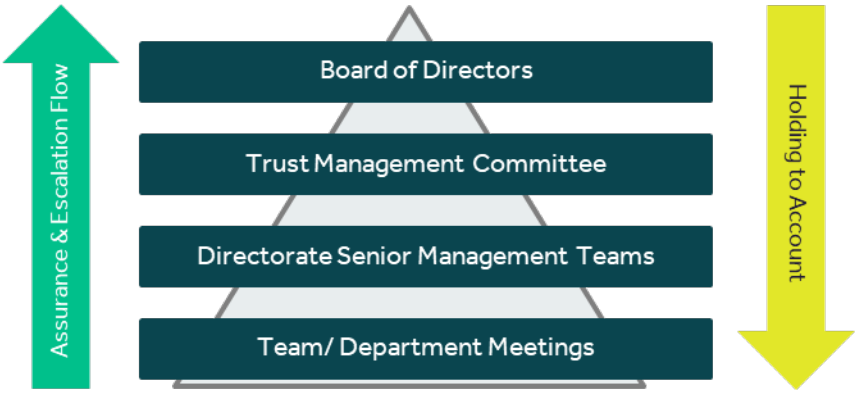


Figure 2: *NWAS Assurance and Escalation Pyramid*

8. Executive Oversight

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

- All new risks scored 15 and above are reviewed and analysed by the Events and Risk 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 Trust Management 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
Trust Management 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
Executive Led Groups	Visibility of risks scored 12 and above relating to the executive groups area of focus	Group Risk 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 alert on risk management from front line to Board:

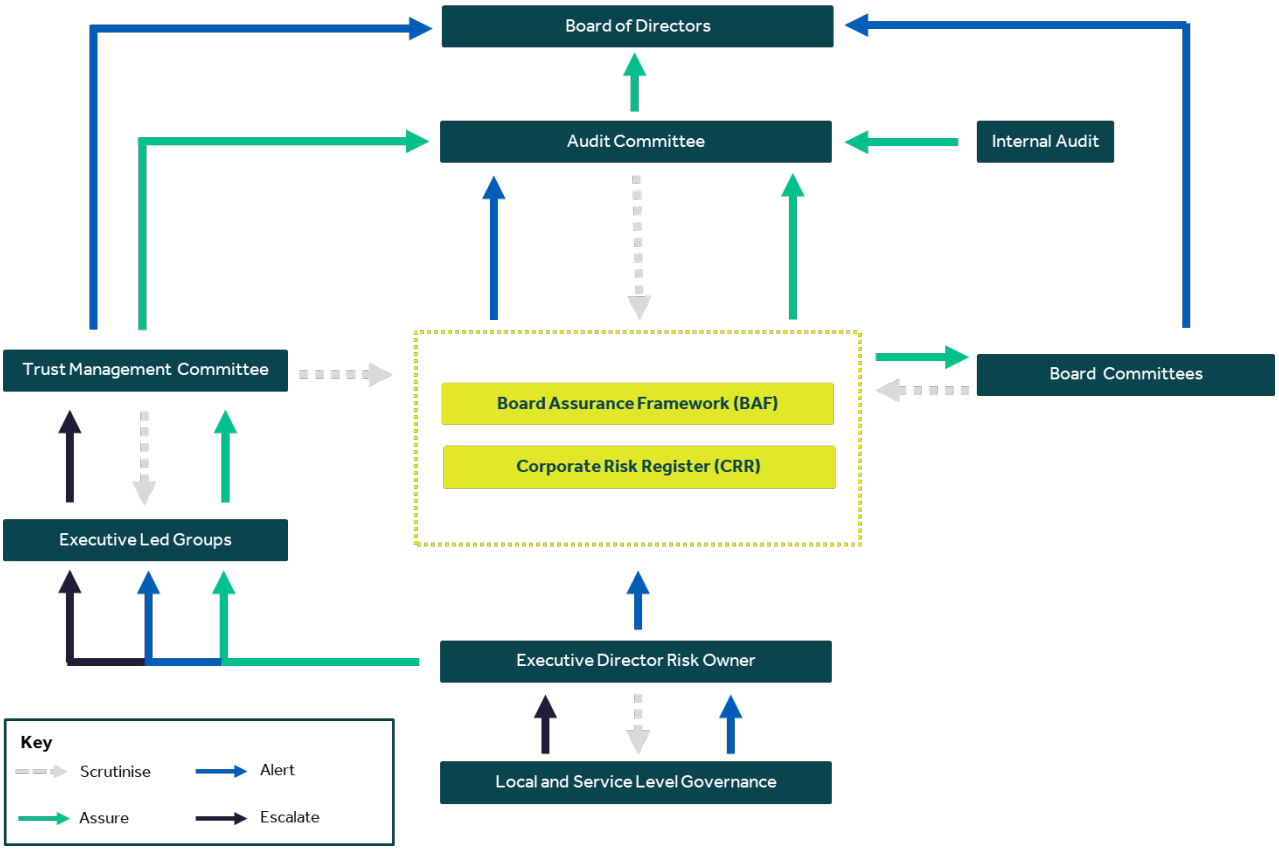


Figure 3: *North West Ambulance Service NHS Trust; Risk Reporting and Assurance Diagram*

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 Trust Management 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 Trust Management 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. Executive Led Groups

Executive Led Groups have the following roles regarding the operational risks pertaining to their areas of focus:

- Review the management of the operational risks (risks scored 12+) pertaining to their areas of focus;
- Report to the Trust Management Committee 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 Led Groups 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 2024* 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 Trust Management 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 Events and Risk 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 Trust Management 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 (2023), 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 (2018). 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

Moeller, R 2011). COSO Enterprise Risk Management: Establishing Effective Governance, Risk, and Compliance Processes. 2nd ed. New Jersey: Wiley & Sons.

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, (2023). 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: NWAS Governance Structure: Levels of Assurance, Escalation & Risk

APPENDIX 4: Equality Impact Assessment

APPENDIX 5: 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

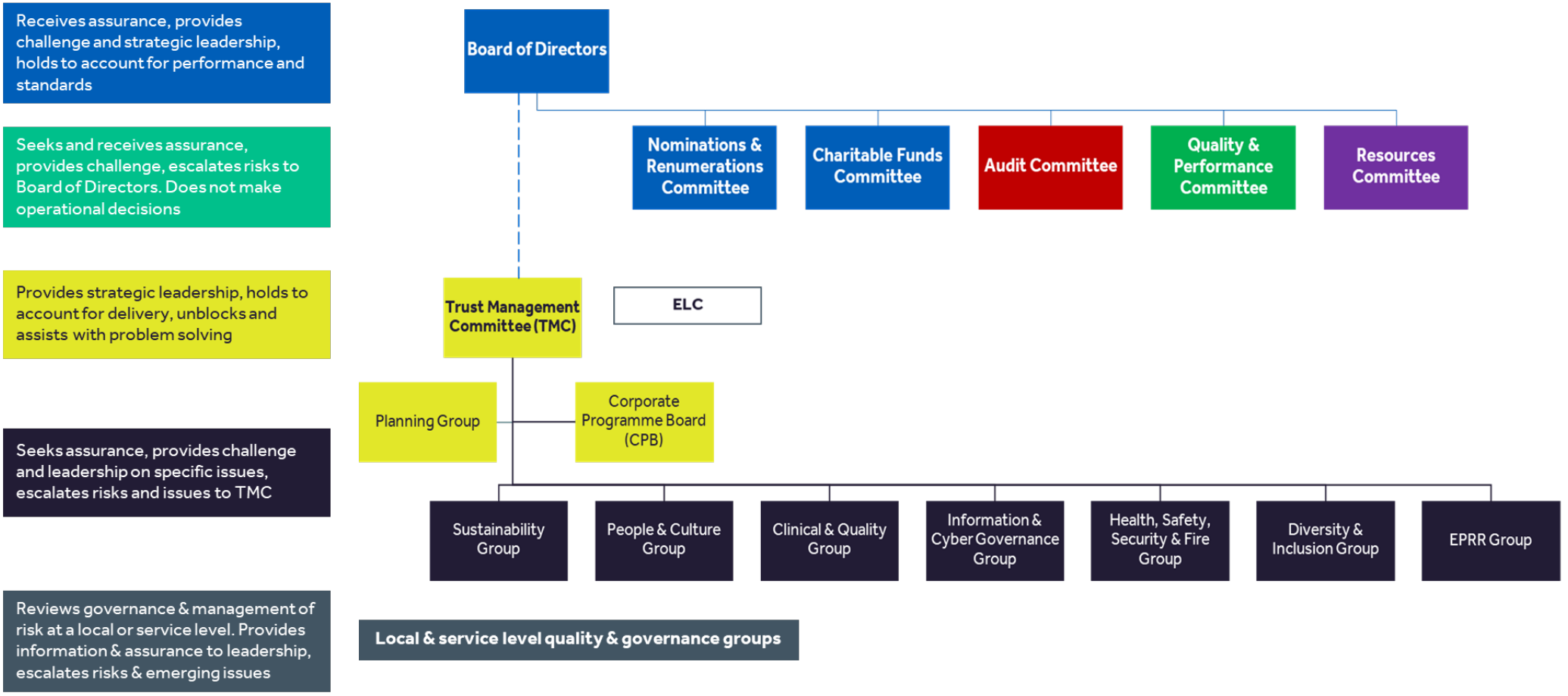
Appendix 2: Consequence Scoring Matrix

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Compliance: Legislative & Regulatory	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation	Single breach in statutory duty	Enforcement action, multiple breaches in statutory duty	Multiple breaches in statutory duty Inabolity to meet legislative requirements Breach of law Prosecution
Quality Outcomes	No/ minimal disruption/ impact to the provision of timely and accurate quality care Near-miss, no harm (physical and psychological) caused	Minor disruption/ impact to the provision of timely and accurate quality care Low physical/ psychological harm	Moderate disruption/ impact to the provision of timely and accurate quality care Moderate physical/ psychological harm	Severe disruption/ impact to the provision of timely and accurate quality care Severe physical/ psychological harm	Permanent loss/ inability to provide timely and accurate quality care Fatal
People	No injury or minor injury with no treatment required Aggression/ verbal abuse with minimal impact No staff sickness/ absence Temporary short term low staffing levels (less than 1 day)	Minor physical injury, illness or mental health illness requiring minor treatment Physical violence, assault, or verbal abuse with minor impact Short term staff sickness/ absence (less than 3 days) Insignificant staff attendance at mandatory/ key training (5%) Low staffing levels reducing service quality (1-5 days)	Moderate physical injury, illness, or mental health illness requiring hospital treatment Physical violence, assault, or verbal abuse causing moderate distress Staff sickness/ absence (more than 7 days) and/or RIDDOR reportable Poor staff attendance at mandatory/ key training (6-10%) Unsafe staffing levels (1-2 weeks)	Major physical injury, illness, or mental health illness requiring long term treatment or community care intervention Serious physical violence, assault, or verbal abuse leading to psychological harm Long term staff sickness/ absence Frequent poor staff attendance at mandatory/ key training (11-20%) Unsafe staffing levels (> 1 month), loss of key staff	Fatality of staff member, life threatening injury, illness, or harm. Permanent injury, harm/ incapacity/ disability. Significant/ persistent low uptake of staff attendance at mandatory/ key training (>21% or 2 months+) Prolonged unsafe staffing levels, loss of several key staff, including industrial action
Finance	Small budget loss or claim between £0-£5k	Budget loss of 0.1-0.25% or a claim between £5k-£10k	Budget loss of 0.25-0.5% or a claim between £10k-£100k	Budget loss of 0.5-1.0% or a claim between £100k-£1m Uncertain delivery of key objective Purchase failing to pay on time	Budget loss of >1% or a claim >£1m Loss of significant contract/ income. Non-delivery/ failure to meet key objective/ specification.
Reputation	Localised issue, ad-hoc public or political concern	Short term local media interest, reduction in public confidence and/or local political concern	Sustained local media interest, extending to regional interest, regional public and/or political concern with reduction in public confidence	Regional and/or national media interest with significant public and/or political concern and reputational damage	National media interest, parliamentary interest, public inquiry with loss of public confidence and credibility in NWAS

Domain	Insignificant	Minor	Moderate	Major	Catastrophic
	1	2	3	4	5
Innovation	Minimal or no loss of information containing identifiable data Cyber threat is expected to have negligible impact	Loss/ compromised security of one record containing identifiable data Cyber threat is expected to have limited impact	Loss/ compromised security of 2-100 records containing confidential/ identifiable data Cyber threat is expected to have serious impact	Loss/ compromised security of 101+ records containing identifiable data Cyber threat is expected to have severe or catastrophic impact	Serious breach with potential for identity theft/ compromised security of an application/ system/ facility containing identifiable data Cyber threat is expected to have multiple severe or catastrophic impact
Business/ Service	Interruption to provide NWAS services >1 hour	Interruption to provide NWAS services >4 hours	Interruption to provide NWAS services >6 hours Small-scale CBRN attack	Interruption to provide NWAS services >1 day Medium-scale CBRN attack Accidental fire Outbreak of emerging infectious disease	Prolonged/ permanent loss of NWAS service or facility Loss of critical system Terrorism Large-scale CBRN attack Major fire Pandemic

Appendix 3: NWAS Governance Structure: Levels of Assurance, Escalation and Risk

NWAS Governance Structure: Levels of Assurance, Escalation & Risk



North West Ambulance Service NHS Trust

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: **Head of Risk and Assurance**

Initial date of completion: **26 February 2024**

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 relating to the needs of people with protected characteristics. The Trust has staff and systems in place to identify equality related risks.
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 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 5: 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 Led Groups	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 Led Groups	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 Led Groups	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 Trust Management Committee monthly*	Head of Risk and Assurance	Director of Corporate Affairs/ Trust Management 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 Led Groups	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/ Trust Management 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 & Head of Corporate Governance	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 & Head of Corporate Governance	Director of Corporate Affairs/ Audit Committee	Internal Audit Review	Annually

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Annual Review of Core Governance Documents
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the revised core governance documents.	
EXECUTIVE SUMMARY	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. These core governance documents (as can be seen in the Appendices) have been subject to annual review and this has resulted in a number of changes (tracked in the documents) to the: • Standing Orders and Reservation of Powers to the Board • Scheme of Delegation • Standing Financial Instructions	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 19 April 2024
	Outcome	Recommended to the Board of Directors for approval.

1. BACKGROUND

As per the Standing Orders, the Trust's core governance documents are subject to annual review. The documents are scheduled for final approval by the Board of Directors on 24th April 2024.

2. REVIEW OUTCOMES

The core governance documents are:

- Standing Orders and Reservation of Powers to the Board
- Scheme of Delegation
- Standing Financial Instructions

As can be seen in the Appendices, the changes are tracked in the documents.

3. LEGAL CONSIDERATION

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.

4. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the revised core governance documents.

North West Ambulance Service NHS Trust

Standing Orders, Reservation of Powers & Scheme of Delegation

Approved by the Board of Directors:

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	26 April 2023
20	Temporary Change to Voting Rights and Board Membership	27 September 2023
21	Annual Review, March 2024	

CONTENTS

STANDING ORDERS

RESERVATIONS OF POWERS TO THE BOARD OF DIRECTORS

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~~Secretary of State for Health and Social Care.

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~~Secretary of State for Health and Social Care 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

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 and Social Care 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.

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~~Secretary of State for Health and Social Care 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
- Chief Operating Officer / Deputy Chief Executive
- Executive Director of Quality, Innovation and Improvement
- Executive Director of Finance
- Executive Medical Director

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

- Director of People
- 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, 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.

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, under its delegated authority from ~~Secretary of State~~Secretary of State for Health and Social Care ~~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 their 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.

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.

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:

> '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.

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.

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.

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.

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

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

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.

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.

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.

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.

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

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.

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.

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 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.

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~~Secretary of State for Health and Social Care, 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~~Secretary of State for Health and Social Care

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 and Social Care, 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.

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~~Secretary of State for Health and Social Care. 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 for Health and Social Care, 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 for Health and Social Care.~~.~~

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.

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 for Health and Social Care, 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.

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

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.

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.

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.

6.3.4 Subject to SO 6.3.3 and any conditions imposed by the Secretary of State for Health and Social Care, 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:

- 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:

- 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 for Health and Social Care

The Secretary of State for Health and Social Care may, subject to such conditions as they 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.

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.

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 Trust Management ~~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.

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 for Health and Social Care 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~~Secretary of State for Health and Social Care.

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.

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.

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 Directors~~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~~ Investigation Policy
- ~~Performance Management and Assurance Framework~~
- Learning from Deaths Policy
- Policy on Prevention and Reduction of Violence

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 Escalation and 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 website and staff 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 Social Care 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		SO 7
Waiver of Standing Orders / Standing Financial Instructions	Director of Corporate Affairs/Director of Finance/Chief Executive/Deputy Chief Executive (COO)	~~Executive Leadership Committee~~Trust Management Committee	SFI 17
Approval of Strategies, Policies & Procedures: - Approval of all strategies - Approval of policies reserved for Board - Approval of other policies and procedures	Board of Directors Board of Directors Board of Directors Executive Lead	Director of Corporate Affairs Lead Executive ~~Executive Leadership Committee~~Trust Management Committee	 RoP 3.3 RoP 3.4 Policy Management Framework
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~~ Non-clinical incident management and reporting	Director of Corporate Affairs	Head of Risk and Assurance	Incidents and Near Misses Policy Incident Reporting Procedure

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Complaints & PALS Management - Level 1-3 - Level 4 and 5	Director of Corporate Affairs Resolution Manager Head of Resolution/Assistant Director of Legal, Resolution & PALS to approve prior to Deputy CEO sign off	Assistant Director of Legal, Resolution & PALS	Complaint Investigation Policy ~~, Incidents and Investigations~~ Complaints ~~and External~~ Procedure NHS Complaints Regs (SE 2004 No 1768) NHS Complaints Amended Regs 2006 (SI 2006 No 2084) Redress Procedure
Claims: Employer's Liability, Public Liability and Medical Negligence - Employers Liability upto £25k - 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 Solicitors Assistant Director Legal, Resolution & PALS Director of Corporate Affairs Solicitors Assistant Director Legal, Resolution & PALS Assistant Director Legal, Resolution & PALS Assistant Director Legal, Resolution & PALS Clinical Negligence Panel (Medical Director, Chief Consultant Paramedic, Director of Corporate Affairs)	Assistant Director of Legal, Resolution & PALS	SFIs: Losses, write off Claims Procedure
Redress	Director of Corporate Affairs	Assistant Director of Legal, Resolution & PALS	Redress Procedure
Litigation Papers	Director of Corporate Affairs	Assistant Director of Legal, Resolution & PALS	Claims Procedure
Health, Safety and Security and Fire Management	~~Director of Quality, Innovation and Improvement~~ Director of Corporate Affairs	~~Chief of Regulatory Compliance and Improvement~~ Assistant Director of Legal, Resolution & PALS	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
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	Relevant Head of Finance~~: Technical Accounts~~/Head of Strategic Financial Planning	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 Strategic 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~~Chief Executive	~~Audit Committee~~Director of Finance	SFI 2
3. Strategy, Partnerships and Transformation			
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	Communications and Engagement Strategy
Patient and Public Panel (patient involvement and engagement)	Director of Strategy, Partnerships and Transformation	Head of Communications and Engagement	Communications and Engagement Strategy
Approval and Management of Projects: - Approval authority outlined in SFI Requirements to Obtain Quotes and Tenders - Corporate Programme Board ~~- 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 3.4.1 & 11.1.2 ~~SFI Requirement to obtain Quotes and Tenders (all Revenue and Capital items 3.4.1 & 11.1.2)~~
4. Service Delivery			
Resilience/Emergency Planning	Chief Operating Officer	Assistant Director of Resilience	Incident Response Plan v8.5

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
5. Procurement			
Disposals - Board of Directors to approve disposal of land, buildings and equipment with a value in excess of £250,000 on completion of tender action. - Trust Management Committee to approve disposals between £25,000 to £249,999 (subject to formal tender action to disposal) - Director of Finance to approval disposal of surplus equipment between £2,500 and £24,999 on completion of competitive quotation 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 need to approve business case) - Trust Management 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~~Head of Fleet and Logistics	
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): - £1,000,000 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 £999,999 - 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~~Head of Fleet and Logistics	Pool Vehicle Policy
Insurance (Motor and Workshops)	Director of Finance	Deputy Director of Finance	
6. Information Management			
Clinical Records Management - Overall accountability to ensure the Trust adheres to the Clinical 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) Medical Director (Caldicott Guardian)	 ~~Deputy Director of Quality, Innovation and Improvement~~ Deputy SIRO and Chief Information Officer 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.~~ Deputy SIRO and Chief Information Officer	Data Protection and Security Policy Safe Haven
Disclosure of Patient Identifiable Information	Medical Director (Caldicott Guardian)	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~~ Deputy SIRO and Chief Information Officer Chief Clinical Information Officer (CCIO)	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

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
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~~ Quality Strategy Health Notifications and Alert Process v3 2019 Clinical Audit Policy Learning from Deaths Policy Mental Health & Dementia Strategic Plan High Intensity User Policy High Intensity User Procedure Maternity and Neonatal Care Policy
Ambulance Quality Indicator Reporting	Medical Director ~~Director of Quality, Innovation and Improvement~~ ~~Chief Operating Officer~~	Chief Consultant Paramedic ~~Chief of Regulatory Compliance and Improvement~~ ~~Deputy Director of Quality, Innovation and Improvement, Chief of Digital and Innovation~~ Deputy SIRO and Chief Information Officer	Clinical Audit Policy ~~Right Care (Quality) Strategy~~ Quality Strategy Digital Strategy
Research and Development	Medical Director	Consultant Paramedic - Medical Directorate	Research and Development Policy
Public Health	Medical Director	Consultant Paramedic - Medical Directorate	NWAS Public Health Plan
Freedom to Speak Up	Chief Executive	Medical Director	Freedom to Speak Up Strategy Freedom to Speak Up Policy
8. Quality, Innovation and Improvement			
Patient Safety Management	Director of Quality, Innovation and Improvement	~~Patient Safety Specialist~~Head of PSIRF	Learning from Experiences Policy Learning Framework Duty of Candour Policy
Patient Safety Incident Response Framework (PSIRF) - Declaration of Patient Safety Incident Investigation (PSII) - Approval of patient Safety Incident Investigation (PSII)	Director of Quality, Innovation and Improvement - Patient Safety Event Cases (PSEC) Medical Director - Approval of Patient Safety Incident Investigation (PSII)	Head of PSIRF	Patient Safety Incident Response Plan Patient Safety Incident Response Policy
Infection Prevention & Control	Director of Quality, Innovation and Improvement	Assistant Director of Nursing and Quality (DIPC)	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/	~~Head of Clinical Safety~~ Assistant Director of Nursing and Quality	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 Performance Report - Delivery of Single Oversight Framework	Director of Quality, Innovation and Improvement All Executive Directors	~~Chief of Digital and Innovation~~ Deputy SIRO and Chief Information Officer	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~~ Assistant Director of Nursing and Quality	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	
Violence and Aggression (VPR Standards)	Director of Quality, Innovation and Improvement	Chief of Regulatory Compliance and Improvement	VPR Standards Policy on Prevention and Reduction of Violence
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/Chair	Director of People Deputy Director of People Head of Corporate HR	Recruitment and Selection Policy Criminal Records Check Policy Fit and Proper Person Test Procedure
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 including 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, ICC Middle Managers)	Deputy Director of People	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 Immediate Line Manager Immediate Line Manager OR More Senior Manager than Stage 2 More Senior Manager than at Stage 1/ 2 More Senior Manager than at Stage 1 / 2 More Senior Manager than at Stage 1 Ordinarily grievances should be heard by an appropriate manager as close to the aggrieved employee as possible and in most cases, this will be the employees direct line Manager. Subsequent stages of the grievance process should then be heard by a more senior Manager than at the previous stage. Immediate line Manager (In cases where the grievance relates to the line Manager then a more senior Manager or a manager from an alternative department will Chair).	Deputy Director of People	Individual and Collective Grievance Policy & Procedure
Workplace 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, where dismissal is an option, or hear cases at Stage 1 and/or 2 where employee reports to their immediate reports. Act as Appeal Officer where sanction was imposed by one of the managers reporting directly to them (up to final written warning). - Hearing Officers in cases where sanction available is up to and including a final written warning. Appeals Officers against formal written warning sanction (Stage 1). - To manage initial informal performance management of staff and monitor the performance of staff who report into them and are being managed under the Performance Management Policy.	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~~ Deputy Director of People	Workplace Performance Management Policy
~~Workplace conflict / bullying~~Dignity at Work - 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~~ Deputy Director of People	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 appropriate authorisation by Finance - Approve in year proposals for restructure within budget establishment changes Approve in-year proposals for re-structure resulting in establishment changes not affecting Directors subject to Very Senior Manager Pay Arrangements where there is a cost pressure	Board of Directors Nominations and Remuneration Committee Chief Executive Executive Directors ~~Executive Leadership Committee~~ Trust Management Committee	Chief Executive	Organisational Change Policy
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 England (NHSE) ~~Improvement (NHSI)~~ approval. - Recommendation of non-contractual termination payments to the ~~NHSI~~ NHSE 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 NHSE 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

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Payroll Processes: - Security and auding of all payroll processes - Establish procedures and documentation for new starters, variations and terminations and other changes affecting payments to individuals - Agreement of dates and methods of payment - Management of payroll - Review contract for payroll services	 Director of Finance Director of People	 Deputy Director of Finance Deputy Director of People	Establishment Control Procedure
Education and Learning	Director of People	Assistant Director Workforce & OD	
Performance Appraisal Policy & Procedure	Director of People	Assistant Director Workforce & OD	Performance Appraisal Policy and Procedure
Pay Progression Deferral - Deferring individual pay progression - Appeal against pay progression	Director of People Line Manager Senior Manager	Assistant Director Workforce & OD / Deputy Director of People	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 - 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 including 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).	Director of People Chair Chief Executive NEDs Director (Exec Dir/Area Dir) Executive Director/Area Director or Deputy Director Senior Manager (Deputy Directors/Area Heads of Operations/Heads of Dept/~~Area~~ Head of PTS/ICC Senior Managers) Middle Managers or above (e.g. Sector Managers, ICC Middle Manager) 111 Team Manager	Deputy Directors/Senior Managers	Sickness Absence Procedure

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
- Conduct Stage 1 sickness review meetings with immediate staff.	First Line managers		
Decisions on Injury Allowance Applications	Director of People	Head of Operations and Head of HR BP	Sickness Absence Procedure
Agency Rules	Director of People	Deputy Director of People	Agency Rules - NHS Improvement March 2016
Recovery of overpayments - Overpayments write off	Director of People Director of Finance	Deputy Director of Finance / Deputy Director of People	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	26 April 2023
19	Annual Review, April 2024	

Standing Financial Instructions

Table of Contents

1. Introduction

1.1 General

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

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

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

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

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

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

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

1.2 Terminology

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

Terminology	Definition
The 1990 Act	National Health Service and Community Care Act 1990
The 1977 Act	National Health Service Act 1977
Accountable Officer	Shall be the Officer responsible and accountable for funds entrusted to the Trust in accordance with the NHS Trust Accounting Officer Memorandum. They shall be responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive is the designated Accountable Officer.
Board of Directors	The Board of Directors means the 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 for Health and Social Care 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.

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.

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~~example, the Annual Governance ~~Statement and~~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).

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~~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.

2.4.2 In line with the Code of Governance for NHS Provider Trusts, the Trust will adhere to the following requirements if the external auditors are engaged in any non-audit services for the Trust. It is not about work linked to the core audit activity of the Trust but relates to any additional work that may be commissioned. The Trust should not be deprived of relevant advice and expertise, when is it needed, should the External Auditors be able to demonstrate higher quality and more cost-effective service than other providers.

- A transparent procurement and approval process will be in place for any non-audit services, which will incorporate the following principles:
    - The Trust's External Auditor should not be prevented from competing for non-audit service work offered by the Trust, unless there is a clear conflict of interest. They will be required to provide a statement as to how any potential or likely conflict of interest will be addressed in any work it wishes to compete for.
    - The staff it supplies for such an engagement must be separate and independent from the staff who deliver the external audit service.
    - The team responsible for the appointment of the External Audit service should not form the majority of the representation of the tender selection process for the other non-audit service.
    - The fee for the provision of non-audit services should not exceed nor form a substantial percentage (<70%) of the External Audit fee in any given financial year.
    - Following tender and Audit Committee approval, a requisition will be raised for all non-audit services to ensure transparency of the work requested.

- Any non-audit services from the External Auditors will be approved, by the Audit Committee prior to commencement. This will be managed through the Audit Committee, as it is fundamental that the independence of the Trust's External Auditors in reporting to NWAS and the Non-Executive directors is not, or does not appear to be,

compromised in terms of the objectivity of their opinion on the financial statement of the Trust.

- In exceptional circumstances and where the meeting schedule does not enable Audit Committee approval to be sought; a recommendation from the Executive Directors, agreed by the Audit Committee Chair can be passed to the Trust Secretary to exercise the use of emergency powers of the Trust.

- There will be transparent reporting, through the audit committee, of the value and nature of any non-audit work undertaken by the Trust's External Auditor.

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

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.

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~~timescales.

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 ~~N~~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~~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.

6.3 Debt recovery

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

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

6.4 Security of cash, cheques and other negotiable instruments

6.4.1 The Director of Finance is responsible for:

a. approving the form of all receipt books, agreement forms or other means of officially acknowledging or recording monies received or receivable; (no form of receipt which has not been specifically authorised by the Director of Finance should be issued);
b. ordering and securely controlling any such stationery;
c. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys and for coin operated machines; and
d. prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust

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

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

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

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

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

7. NHS service agreements for provision of services

7.1 Service Level Agreements / contracts

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

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

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

7.1.2 The appropriate NHS Standard Contract must be developed and adopted involving key stakeholders including clinicians, Patient and Public Panel representation, appropriate service/business management, Quality, Contracting and Finance Directorate representation, and public health professionals when appropriate. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and commissioning of the service required. The SLA / contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

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

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

8.1 Remuneration Committee

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

8.1.2 The Committee will:

a) advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive, 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~~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.

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.

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.

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, and ensure compliance with section 12.2 of the SFIs in relation to receipt of goods and services.

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

- 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:

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.

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~~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~~short-term borrowings at the next Board meeting.

10.1.6 All ~~long term~~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 for Health and Social Care 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, and Property

11.1.1 The Chief Executive:

a. Shall ensure that there is an adequate appraisal and approval process in place for determining capital and investment 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 capital resources as well as ~~to finance~~ all revenue consequences, including capital charges

11.1.2 For capital and revenue 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/ Strategic Outline Case for Change for investments ~~including SMART investment~~ identifying 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 comprehensive investment appraisal be undertaken considering ~~option appraisal of~~ potential benefits, risks and financial costs to determine ~~compared with known net present social costs~~ and ~~to determine~~ the option with the highest net present societal benefit to ~~to~~ cost ratio~~n~~.

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.

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.

11.4 Security of assets

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

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

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

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

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

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

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

12. Stock, stores and receipt of goods

12.1 Stock and stores

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

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

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

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

12.1.3 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The ~~day to day~~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.

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

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

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

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

13.3 Compensation claims

13.3.1 The Trust is committed to effective and timely investigation and response to any claim which includes allegations of clinical negligence, employee and other compensation claims. The Trust will follow the requirements and note the recommendations of the Department of Health and Social Care and 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.

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.

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 p~~P~~ublic 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.

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.

*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

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

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

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

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~~generally electronically.~~:~~

~~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;~~

~~electronically~~ via the Trusts preferred electronic tendering portal.~~using either the EU Supply (CTM) or Government Procurement Service eSourcing systems; and~~

~~b. 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 comply with the specific national guidance relating to estates and construction, such as the NHS Estatecode documents. ~~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. The lead Procurement Officer will unlock the tender to review the tender responses.

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~~ tenders will be opened by the Procurement lead, as delegated by the Head of Procurement or the Trust Procurement Manager or the Deputy Head of Procurement.~~.~~

~~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.~~ The Trust's tendering portal will hold a full electronic record of all the tenders received in accordance with agreed system parameters. ~~Every tender received shall be marked with the date of opening and initialled by those present at the opening.~~

~~VI.~~ A register of tenders will be held in the Procurement Department. ~~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.~~II. ~~In~~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. The electronic tender portal will not allow late submissions without a positive intervention from the lead Procurement Officer. Only in exception circumstance will this be permitted. The tender register will log the date and time of acceptance. A full justification must be recorded in the tender folder. The final decision to accept or reject late responses will be made by the Director of Finance with advice from the Head of Procurement

~~I.~~II. ~~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 not be “opened” and held confidentially and securely on the tender portal. ~~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.

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 for Health and Social Care and shall comply with:

a. the Trust's Standing Orders and Standing Financial Instructions
b. ~~EU~~ National Procurement Directives and Regulations 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 Social Care 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 £149,999
A4C Band 8b~~a~~	8	Up to £9,97~~,4~~99
A4C Band 8a~~6 / 7~~	9	Up to £74,4~~9~~99
A4C band 6/74 ~~/ 5~~	10	~~Up to £2,499~~ Up to £4,999
A4C Band 4/5	11	Up to £2,499

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.

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 £2,499~~9,999~~
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	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**
£10,000 to £29,999	Minimum of 3 formal written quotations	Lead Procurement Manager	Appropriate Service Line Finance Lead	Director
£30,000 to FTS threshold	Minimum of 3 formal tenders*	Lead Procurement Manager	Evaluation Panel (must include a Finance member)	<£1m Trust Management Committee~~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*	Lead Procurement Manager	Evaluation Panel (must include a Finance member)	<£1m Trust Management Committee~~Executive Leadership Committee~~: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement. =>£1m Board of Directors: delegated to the Executive Director of Finance.

* To be published Find a Tender Portal ~~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.

Contract and Service Level Agreement Sign off (Electronic or Physical)

All contracts and service level agreements must be reviewed by the Procurement Department before they are submitted for signing.

Value range (inc VAT)	Contract/ agreements which do not commit the Trust to expenditure over one financial year.	Contracts/ agreement which commit the Trust to expenditure over more than one financial year.
0-£9,999 (annual aggregated value)	N/A	Executive Director of Finance
£10,000 to £29,999	Executive Director of Finance, Delegated to Head of Procurement if contract ward decision ratified.	Executive Director of Finance
£30,000 to FTS threshold	<£1m Trust Management~~Executive Leadership~~ Committee: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement	<£1m Trust Management ~~Executive Leadership~~ Committee: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement
Above FTS threshold	<£1m Trust Management~~Executive Leadership~~ Committee: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement. =>£1m Board of Directors: delegated to the Executive Director of Finance.	<£1m Trust Management~~Executive Leadership~~ Committee: delegated to the Executive Director of Finance, if the recommendation is endorsed by the Head of Procurement. =>£1m Board of Directors: delegated to the Executive Director of Finance.

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

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~~19~~924,999, (subject to competitive quotations for disposal)
Trust Management~~Executive Leadership~~ Committee	£25~~200~~,000 to £24~~99~~,999 (Subject to formal tender action to disposal)
Board of Directors	Where the net book value is =>£250~~500~~,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~~absences, a similar procedure is to be followed although the memorandum would be prepared by the absent post holder's Line Manager.

NHS
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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts & Hospitality and Sponsorship
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	Not Applicable									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Approve the revised policy.	
EXECUTIVE SUMMARY	The Standards of Business Conduct: Policy on Managing Conflicts of Interest, Gifts & Hospitality and Sponsorship has been subject to a full review and is attached with tracked changes. The amended declaration process which was paper-based but is now using MS Forms can be seen in the flowchart in Appendix 2 of the policy document.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 19 April 2024
	Outcome	Recommended to Board for approval

1. BACKGROUND

The current policy is based on NHSE's Managing Conflicts of Interest in the NHS guidance for staff and organisations and remains as best practice guidance.

2. REVIEW OUTCOMES

Changes made to the policy following the latest review can be seen via tracked changes in the attached policy document and the amended declaration process which was paper-based but is now using MS Forms can be seen in the flowchart in Appendix 2 of the policy document.

3. RISK CONSIDERATION

The Trust and all employees have a duty to ensure that all our dealings are conducted under the highest standards of integrity and transparency.

4. EQUALITY/ SUSTAINABILITY IMPACTS

An EIA has been completed and included and no impacts have been identified.

5. ACTION REQUIRED

The Audit Committee is asked to:

- Approve the revised policy.

North West Ambulance Service NHS Trust

Standards of Business Conduct

Policy on Managing Conflicts of Interest; Gifts & Hospitality and Sponsorship

Document Control	
Policy Title	Standards of Business Conduct Policy on Managing Conflicts of Interest; Gifts & Hospitality and Sponsorship
Policy Reference Number	GV-002
Version number	5
Approval date	April 2024
Approved by	Board of Directors
Date for Review:	March 2027
Executive Sponsor	Director of Corporate Affairs
Policy Lead	Head of Corporate Governance
For use by	All Employees

Change record form

Version	Date of change	Date of release	Changed by	Reason for change
1.0	25 Jul 2007	26 Jul 2007	P Buckingham	Board Approval
x.2	19 Oct 2011	21 Oct 2011	P Buckingham	Policy Review
2.0	30 Nov 2011	30 Nov 2011	P Buckingham	Audit Committee Approval
x.3	December 2015	17 Feb 2016	Penny Harder	Policy Review
3.0	May 2017	1 June 2017	A Wetton	To reflect NHS England's guidance
3.1	November 2018		Penny Harder	Deloitte & MIAA Recommendations
4	March 2023		Penny Harder	Policy Review
5	March 2024		Penny Harder	Policy Review

CONTENTS

1. Introduction

The North West Ambulance Service NHS Trust (the 'organisation'), and the people who work with and for us, collaborate closely with other organisations, delivering high quality care for our patients.

These partnerships have many benefits and should help ensure that public money is spent efficiently and wisely. But there is a risk that conflicts of interest may arise.

Providing best value for taxpayers and ensuring that decisions are taken transparently and clearly, are both key principles in the NHS Constitution. We are committed to maximising our resources for the benefit of the whole community.

As an organisation and as individuals, we have a duty to ensure that all our dealings are conducted to the highest standards of integrity and that NHS monies are used wisely so that we are using our finite resources in the best interests of patients.

Adhering to this policy will help to ensure that we use NHS money wisely, providing best value for taxpayers and accountability to our patients for the decisions we take.

As a member of staff you should…	As an organisation we will…

• Familiarise yourself with this policy and follow it. Refer to the guidance for the rationale behind this policy https://www.england.nhs.uk/wp-content/uploads/2017/02/guidance-managing-conflicts-of-interest-nhs.pdf
• Use your common sense and judgement to consider whether the interests you have could affect the way taxpayers' money is spent
• Regularly consider what interests you have and declare these as they arise. If in doubt, declare.
• **NOT** misuse your position to further your own interests or those close to you
• **NOT** be influenced, or give the impression that you have been influenced by outside interests
• **NOT** allow outside interests you have to inappropriately affect the decisions you make when using taxpayers' money
	• Ensure that this policy and supporting processes are clear and help staff understand what they need to do.
	• Identify a team or individual with responsibility for:
	  ○ Keeping this policy under review to ensure they are in line with the guidance.
	  ○ Providing advice, training and support for staff on how interests should be managed.
	  ○ Maintaining register(s) of interests.
	  ○ Auditing this policy and its associated processes and procedures at least once every three years.
	• **NOT** avoid managing conflicts of interest.
	• **NOT** interpret this policy in a way which stifles collaboration and innovation with our partners

This policy will help our staff manage conflicts of interest risks effectively. It:

- Introduces consistent principles and rules
- Provides simple advice about what to do in common situations.
- Supports good judgement about how to approach and manage interests

This policy should be considered alongside ~~these~~ the following ~~other~~ organisational policies that can be found on the Green Room:~~:~~

- Anti-Fraud, Bribery & Corruption Policy & Response Plan
- ~~Raising Concerns at Work (Whistleblowing) Policy~~
- Freedom to Speak Up Policy
- Disciplinary Policy & Procedure

2. Definitions

A 'conflict of interest' is:

"A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

A conflict of interest may be:

- **Actual** - there is a material conflict between one or more interests
- **Potential** – there is the possibility of a material conflict between one or more interests in the future

Staff may hold interests for which they cannot see potential conflict. However, caution is always advisable because others may see it differently and perceived conflicts of interest can be damaging. All interests should be declared where there is a risk of perceived improper conduct.

Section 10 of this policy identifies the sanctions in instances where interests have not been identified, declared or managed appropriately and effectively.

Interests fall into the following categories:

- **Financial interests:**
  Where an individual may get direct financial benefit[1] from the consequences of a decision they are involved in making.
- **Non-financial professional interests:**
  Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- **Non-financial personal interests:**
  Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career
- **Indirect interests:**
  Where an individual has a close association[2] with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

[1] This may be a financial gain, or avoidance of a loss.

A list of examples of interests that should be regarded as 'relevant and material' is provided below however is not exhaustive. Further guidance is provided at Annex A:

- Directorships, including non-executive directorships, held in private companies or PLCs
- Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
- Shareholdings and ownership interests in any publicly listed, private or not might reasonably be expected to do business with the organisation
- A position of authority in another NHS organisation, commercial, charity, voluntary, professional, statutory or other body which could be seen to influence your role within the organisation
- A position on an advisory group or other paid or unpaid decision making forum that could influence how the organisation spends taxpayers money
- Are or could be involved in the recruitment or management of close family members and relatives, close friends and associates and business partners
- A position of influence that exists in the context of the specification for, or award of, a contract
- Any connection with a private, public, voluntary or other organisation contracting for NHS services
- Any other commercial interest relating to any relevant decision to be taken by the organisation.

Conflicts can occur because of interests held by a close family member, business partner, close friend or associate. If staff are aware of material interests (or could be reasonably expected to know about these) then these should be declared. In this context, a close family member is defined as:

- Spouse or civil partner
- Any other person with whom the individual cohabits
- Children or step children
- Parents
- Grandparents
- Siblings.

3. Staff Duties / Responsibilities

At North West Ambulance Service NHS Trust we use the skills of many different people, all of whom are vital to our work. This includes people on differing employment terms, who for the purposes of this policy we refer to as 'staff' and are listed below:

- All salaried employees (including Non-Executive Directors);
- All prospective employees – who are part-way through recruitment;
- Previous employees who become a supplier of the Trust;
- Contractors and sub-contractors; and
- Agency staff.

[2] A common sense approach should be applied to the term 'close association'. Such an association might arise, depending on the circumstances, through relationships with close family members and relatives, close friends and associates, and business partners.

Decision Making Staff

Some staff are more likely than others to have a decision making influence on the use of taxpayers' money, because of the requirements of their role. For the purposes of this guidance these people are referred to as 'decision making staff.'

Decision making staff in this organisation are:

- Executive and non-executive directors (or equivalent roles) who have decision making roles which involve the spending of taxpayers' money
- Those at Agenda for Change band 8a and above
- Administrative and clinical staff who have the power to enter into contracts on behalf of their organisation
- Administrative and clinical staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions

4. Identification, Declaration and Review of Interests

4.1 Identification & declaration of interests (including gifts and hospitality)

All staff, including Directors and Non-Executive Directors, should identify and declare material interests at the earliest opportunity (and in any event within 28 days of the interest occurring). If staff are in any doubt as to whether an interest is material then they should declare it, so that it can be considered.

Declarations should be made:

- On appointment with the organisation.
- When staff move to a new role or their responsibilities change significantly.
- At the beginning of a new project/piece of work.
- As soon as circumstances change and new interests arise (for instance, in a meeting when interests staff hold are relevant to the matters in discussion).

Registration of Declarations of Interest(s) ~~-~~should be made electronically using the form~~s~~ available on the Green Room or by scanning the QR code below.~~ are available here.~~

Queries relating to declarations should be made to: declarations.inbox@nwas.nhs.uk

After expiry, an interest will remain on register(s) for a minimum of 6 months and a private record of historic interests will be retained for a minimum of 6 years.

All ~~gifts and hospitality, sponsorship~~ declarations that have been accepted and declined must be reviewed independently by the Director of Corporate Affairs.

4.2 Proactive Review of Interests

We will prompt decision making staff annually to review declarations they have made and, as appropriate, update them or make a nil return. Nil returns will be retained as evidence of compliance with this policy for future use in the event of a challenge. Any staff who fail to respond to the annual review of declarations will be contacted by a member of the Corporate Governance Team, except for where it is known these staff have left the employment of the Trust.

On an annual basis, Non-Executive Directors will be required to review the complete list of declared related parties and make an additional declaration that there are no known relationships between the parties with whom they have declared an interest and the wider pool of declared related parties, or where such relationships do exist to provide details of these.

The Board seeks to encourage a culture of full, complete and transparent disclosure from all staff in order to reach a collective view on potential interests that could arise.

The Director of Corporate Affairs will report annually to the Audit Committee in respect of all declarations, including any breaches and responses.

5. Records and Publication

5.1 Maintenance

The organisation will maintain:

- Register of Board of Directors' Interests
- Register of Interests
- Register of Gifts and Hospitality

All declared interests that are material will be promptly transferred to the register(s) by the Corporate Governance Team.

5.2 Publication

We will:

- Publish the interests declared by Board members and decision making staff in the Register of Interests.
- Refresh this information annually
- Make this information available on the Trust website

If decision making staff have substantial grounds for believing that publication of their interests should not take place then they should contact the Director of Corporate Affairs to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

5.3 Wider transparency initiatives

North West Ambulance Service NHS Trust fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These "transfers of value" include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

Further information about the scheme can be found on the ABPI website: https://www.abpi.org.uk/publications/code-of-practice-for-the-pharmaceutical-industry-2019/

6. Management of Interests – General

If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

- restricting staff involvement in associated discussions and excluding them from decision making
- removing staff from the whole decision making process
- removing staff responsibility for an entire area of work
- removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

Each case will be different and context-specific, and North West Ambulance Service NHS Trust will always clarify the circumstances and issues with the individuals involved. Staff should maintain a written audit trail of information considered and actions taken.

Staff who declare material interests should make their line manager or the person(s) they are working to aware of their existence.

7. Management of Interests – Common Situations

This section sets out the principles and rules to be adopted by staff in common situations, and what information should be declared.

7.1 Gifts

Staff should not accept gifts that may affect, or be seen to affect, their professional judgement. Staff should also consider those relationships outlined in Section 2, that may potentially create any threats to independence in relation to gifts and hospitality.

Gifts from suppliers or contractors:

- Gifts from suppliers or contractors doing business (or likely to do business) with the organisation should be declined, whatever their value.
- Low cost branded promotional aids such as pens or post-it notes may, however, be accepted where they are under the value of £6.00 in total, and need not be declared.
- Gifts from other sources (e.g. patients, families, service users):
    - Gifts of cash and vouchers to individuals should always be declined.
    - Staff should not ask for any gifts.
    - Gifts valued at over £50 should be treated with caution and only be accepted on behalf of North West Ambulance Service NHS Trust Charitable Funds and not in a personal capacity. **These should be declared by staff.**
- Modest gifts accepted under a value of £50 do not need to be declared.
- A common sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
- Multiple gifts from the same source over a 12 month period should be treated in the same way as single gifts over £50 where the cumulative value exceeds £50.

What should be declared?

- Staff name and their role with the organisation.
- A description of the nature and value of the gift, including its source.
- Whether the gift was accepted or rejected
- Date of receipt.
- Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.2 Hospitality

- Staff should not ask for or accept hospitality that may affect, or be seen to affect, their professional judgement.
- Hospitality must only be accepted when there is a legitimate business reason and it is proportionate to the nature and purpose of the event.
- Particular caution should be exercised when hospitality is offered by actual or potential suppliers or contractors. This can be accepted, and must be declared, if modest and reasonable. Senior approval must be obtained.

Meals and refreshments:

- Under a value of £25 - may be accepted and need not be declared.
- Of a value between £25 and £75 - may be accepted and must be declared.
- Over a value of £75 - should be refused unless (in exceptional circumstances) senior approval is given. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept.
- A common sense approach should be applied to the valuing of meals and refreshments (using an actual amount, if known, or a reasonable estimate).
- Travel and accommodation:
- Modest offers to pay some or all of the travel and accommodation costs related to attendance at events may be accepted and must be declared.
- Offers which go beyond modest, or are of a type that the organisation itself might not usually offer, need approval by senior staff, should only be accepted in exceptional circumstances, and must be declared. A clear reason should be recorded on the organisation's register(s) of interest as to why it was permissible to accept travel and accommodation of this type. A non-exhaustive list of examples includes:
    - offers of business class or first class travel and accommodation (including domestic travel)
    - offers of foreign travel and accommodation.

What should be declared?

- Staff name and their role with the organisation.
- The nature and value of the hospitality including the circumstances.
- Whether the hospitality was accepted or rejected
- Date of receipt.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

Registration of Gifts and Hospitality should be made electronically using the form on the Green Room or by scanning the QR code below.

Once the form is completed and submitted, an independent review of the declaration will be undertaken by the Director of Corporate Affairs.

7.3 Outside Employment

Outside employment means employment and other engagements, outside of formal employment arrangements. The list below is not exhaustive but can include:

- Directorships
- Non-Executive roles
- Self-employment
- Consultancy Work
- Charitable Trustee roles
- Political Roles
- Roles within Not-for-Profile organisations
- Paid advisory positions; and
- Paid honorariums relation to bodies likely to do business with the organisation.
- Employment with another NHS organisation/non-NHS organisation
- Employment with another organisation which might be in a position to supply goods/services to the organisation;

- Staff should declare any existing outside employment on appointment and any new outside employment when it arises.
- Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.
- Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

Secondary Employment Application forms are available from the intranet site. All application forms need to include formal permission from Line Managers to ensure there is no detrimental impact on an individual's work and that there are no conflicts of interest. Where conflicts/risks have been identified by the Line Manager, the staff member should complete a Declaration of Interests form and include the agreed actions/mitigations that provides safeguards for both the Trust and the staff member concerned. The declaration will require further independent review and approval or rejection should sufficient mitigations not be provided, by the Director of Corporate Affairs/Chief Executive/relevant Director.

The Corporate Governance Team will liaise with the relevant Director to ensure regular active monitoring of the implemented safeguards and mitigations recorded on the Declaration of Interest are being undertaken.

What should be declared?

- Staff name and their role with the organisation.
- The nature of the outside employment (e.g. who it is with, a description of duties, time commitment).
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.4 Shareholdings and other ownership issues

Staff should declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

What should be declared?

- Staff name and their role with the organisation.
- Nature of the shareholdings/other ownership interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.5 Patents

- Staff should declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.
- Staff should seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.
- Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

What should be declared?

- Staff name and their role with the organisation.
- A description of the patent.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)

7.6 Loyalty interests

Loyalty interests should be declared by staff involved in decision making where they:

- Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.
- Sit on advisory groups or other paid or unpaid decision making forums that can influence how an organisation spends taxpayers' money.
- Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.
- Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

What should be declared?

- Staff name and their role with the organisation.
- Nature of the loyalty interest.
- Relevant dates.
- Other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.7 Political Interests

Membership of a political party may present a conflict of interest. The extent of involvement in a political party will be judged on the nature and level of the individual's role. Individuals may be asked for the name of the organisation to which the political involvement relates if it is relevant for considering the declaration.

If individuals are involved in political activity they must not use the Trust's name or make reference to their engagement with the Trust to further their political objectives, nor should individuals engage in any political activity during the course of their employment or on Trust property.

What should be declared?

- Employees name and name of political party
- Nature of the loyalty interest
- Relevant dates
- Other relevant information (eg action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.8~~7~~ Donations

- Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but should always be declared. A clear reason should be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

- Staff should not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.
- Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.
- Donations, when received, should be made to a specific charitable fund (never to an individual) and a receipt should be issued.
- Staff wishing to make a donation to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

What should be declared?

- The organisation will maintain records in line with the above principles and rules and relevant obligations under charity law.

7.~~9~~8 Sponsored Events

- Sponsorship of events by appropriate external bodies will only be approved if a reasonable person would conclude that the event will result in clear benefit the organisations and the NHS.
- During dealings with sponsors there must be no breach of patient or individual confidentiality or data protection rules and legislation.
- No information should be supplied to the sponsor from whom they could gain a commercial advantage, and information which is not in the public domain should not normally be supplied.
- At the organisation's discretion, sponsors or their representatives may attend or take part in the event but they should not have a dominant influence over the content or the main purpose of the event.
- The involvement of a sponsor in an event should always be clearly identified.
- Staff within the organisation involved in securing sponsorship of events should make it clear that sponsorship does not equate to endorsement of a company or its products and this should be made visibly clear on any promotional or other materials relating to the event.
- Staff arranging sponsored events must declare this to the organisation.

What should be declared?

- The organisation will maintain records regarding sponsored events in line with the above principles and rules.

7.10~~9~~ Sponsored Research

- Funding sources for research purposes must be transparent.
- Any proposed research must go through the relevant health research authority or other approvals process.
- There must be a written protocol and written contract between staff, the organisation, and/or institutes at which the study will take place and the sponsoring organisation, which specifies the nature of the services to be provided and the payment for those services.
- The study must not constitute an inducement to prescribe, supply, administer, recommend, buy or sell any medicine, medical device, equipment or service.

- Staff should declare involvement with sponsored research to the organisation.

What should be declared?

- The organisation will retain written records of sponsorship of research, in line with the above principles and rules.
- Staff should declare:
  - their name and their role with the organisation.
  - Nature of their involvement in the sponsored research.
  - relevant dates.
  - Other relevant information (e.g. what, if any, benefit the sponsor derives from the sponsorship, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

7.110 Sponsored Posts

- External sponsorship of a post requires prior approval from the organisation.
- Rolling sponsorship of posts should be avoided unless appropriate checkpoints are put in place to review and withdraw if appropriate.
- Sponsorship of a post should only happen where there is written confirmation that the arrangements will have no effect on purchasing decisions or prescribing and dispensing habits. This should be audited for the duration of the sponsorship. Written agreements should detail the circumstances under which organisations have the ability to exit sponsorship arrangements if conflicts of interest which cannot be managed arise.
- Sponsored post holders must not promote or favour the sponsor's products, and information about alternative products and suppliers should be provided.
- Sponsors should not have any undue influence over the duties of the post or have any preferential access to services, materials or intellectual property relating to or developed in connection with the sponsored posts.

What should be declared?

- The organisation will retain written records of sponsorship of posts, in line with the above principles and rules.
- Staff should declare any other interests arising as a result of their association with the sponsor, in line with the content in the rest of this policy.

7.121 Clinical private practice

Clinical staff should declare all private practice on appointment, and/or any new private practice when it arises including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

Clinical staff should (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.

- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines, which can be found here

Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

What should be declared?

- Staff name and their role with the organisation.
- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

9. Management of Interests – Advice in Specific Contexts

9.1 Strategic decision making groups

In common with other NHS bodies, the organisation uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts.
- Awarding grants.
- Making procurement decisions.
- Selection of medicines, equipment, and devices.

It is important that the interests of those involved in these groups are well known to ensure they are managed effectively.

These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.

- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

See Annex B – Declarations of Interest Flow chart.

9.2 Procurement

Procurement should be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

The Procurement Team are required to provide declarations of interest prior to any involvement in procurement exercises for and on behalf of the Trust~~ and submitted to the Corporate Governance Team.~~ These records will provide a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement steps should be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process.

Prior to the commencement of any procurement exercise, the Register of Interests should be consulted prior to issuing an invitation to tender. Where relevant interests have been identified, and where necessary, precautionary steps should be taken to ensure that the member of staff declaring the relevant interest is isolated from the procurement exercise.

The contents of the register of interests should be used to periodically interrogate the supplier and customer ledgers to ensure that all connected party transactions are identified, considered and completed in an open, transparent and arm's length basis.

10. Dealing with Breaches

There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as 'breaches'.

10.1 Identifying and reporting breaches

Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach, should report these concerns to the Director of Corporate Affairs and/or make representations to the Trust's nominated Anti-Fraud Specialist.

To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. Further information about how concerns should be raised can be found in the Freedom to Speak Up Policy ~~Raising Concerns at Work (Whistleblowing) Policy~~, and the the Anti-Fraud, Bribery and Corruption Policy.

The organisation will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

Following investigation the organisation will:

- Decide if there has been or is potential for a breach and if so what the severity of the breach is.
- Assess whether further action is required in response – this is likely to involve the staff member and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware
- Take appropriate action as set out in the next section.

10.2 Taking action in response to breaches

Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources); fraud, bribery and corruption (e.g. Anti-Fraud Specialists); members of the management or executive teams and organisational auditors.

Breaches could require action in one or more of the following ways:

- Clarification or strengthening of existing policy, process and procedures.
- Consideration as to whether HR/employment law/contractual action should be taken against staff or others.
- Consideration being given to escalation to external parties. This might include referral of matters to external auditors, NHS Counter Fraud Authority (NHS CFA), the Police, statutory health bodies (such as NHS England~~, NHS Improvement~~ or the CQC), and/or health professional regulatory bodies.

Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Disciplinary action against staff, which might include:
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

10.3 Learning and transparency concerning breaches

Reports on breaches, the impact of these, and action taken will be considered by the Audit Committee at least quarterly.

To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and published on the Trust website as appropriate, or made available for inspection by the public upon request.

11. Personal Conduct

11.1 Corporate Responsibility

All officers have a responsibility to respect and promote the corporate or collective decision of the organisation, even though this may conflict with their personal views. There may be instances where individuals are invited to comment on issues where the organisation has not agreed a response, in these circumstances it should be made clear this is a personal view and not the view of the organisation.

When speaking as a member of the organisation, whether to the media, in a public forum or in a private or informal discussion, officers should ensure that they reflect the current policies or view of the organisation. For any public forum or media interview, approval should be sought in advance from:

- In the case of the Board of Directors, from the Chairman and/or Chief Executive or their nominated deputies, and Communications Team;
- All other officers should contact the Communications Team for approval and guidance in these circumstances.

11.2 Use of Social Media

Officers should be aware that social networking websites are public forums and should not assume that their comments will remain private. Officers communicating via social media must comply with the ~~Policy on Social Media~~ Social Media Policy. Officers must not:

- Conduct themselves in a way that brings the organisation into disrepute;
- Disclose information that is confidential to the organisation, staff or service users.
- Staff should refer to the Trust's ~~Policy on~~ Social Media Policy for further guidance.

11.3 Gambling

No officer may bet or gamble when on duty or on the organisation's premises, with the exception of small lottery syndicates or sweepstakes related to national events such as the World Cup or Grand

National, among immediate colleagues within the same offices where no profits are made or the lottery is wholly for purposes that are not for private or commercial gain.

11.4 Lending and Borrowing

The lending or borrowing of money between officers should be avoided, whether informally as a business, particularly where the amounts are significant.

It is a particularly serious breach of discipline for any officer to use their position to place pressure on someone on a lower payband, a business contact, or a member of the public to loan them money.

11.5 Trading on the organisation's Premises

Trading on Trust official premises is prohibited, whether for personal gain or on behalf of others. This includes but is not limited to:

- Flyers advertising services/products in common areas
- Catalogues in common areas
- Staff must not use their Trust email address to generate income for personal gain or on behalf of others.

Canvasing within the office by, or on behalf of, outside bodies or firms is also prohibited. Trading does not include small tea or refreshment arrangements solely for officers.

12. Review

This policy will be reviewed every three years unless an earlier review is required. This will be led by the Director of Corporate Affairs.

13. Associated Documentation

- Freedom of Information Act (2000)
- Data Protection Act 2018
- NHS England Guidance – Managing Conflicts within the NHS
- The Code of Practice for the Pharmaceutical Industry 2019
- Code of Conduct: Code of Accountability in the NHS 2004
- Anti-Fraud, Bribery & Corruption Policy & Response Plan
- Freedom to Speak Up Policy ~~Raising Concerns at Work (Whistleblowing) Policy~~
- Disciplinary Policy and Procedure
- Social Media Policy

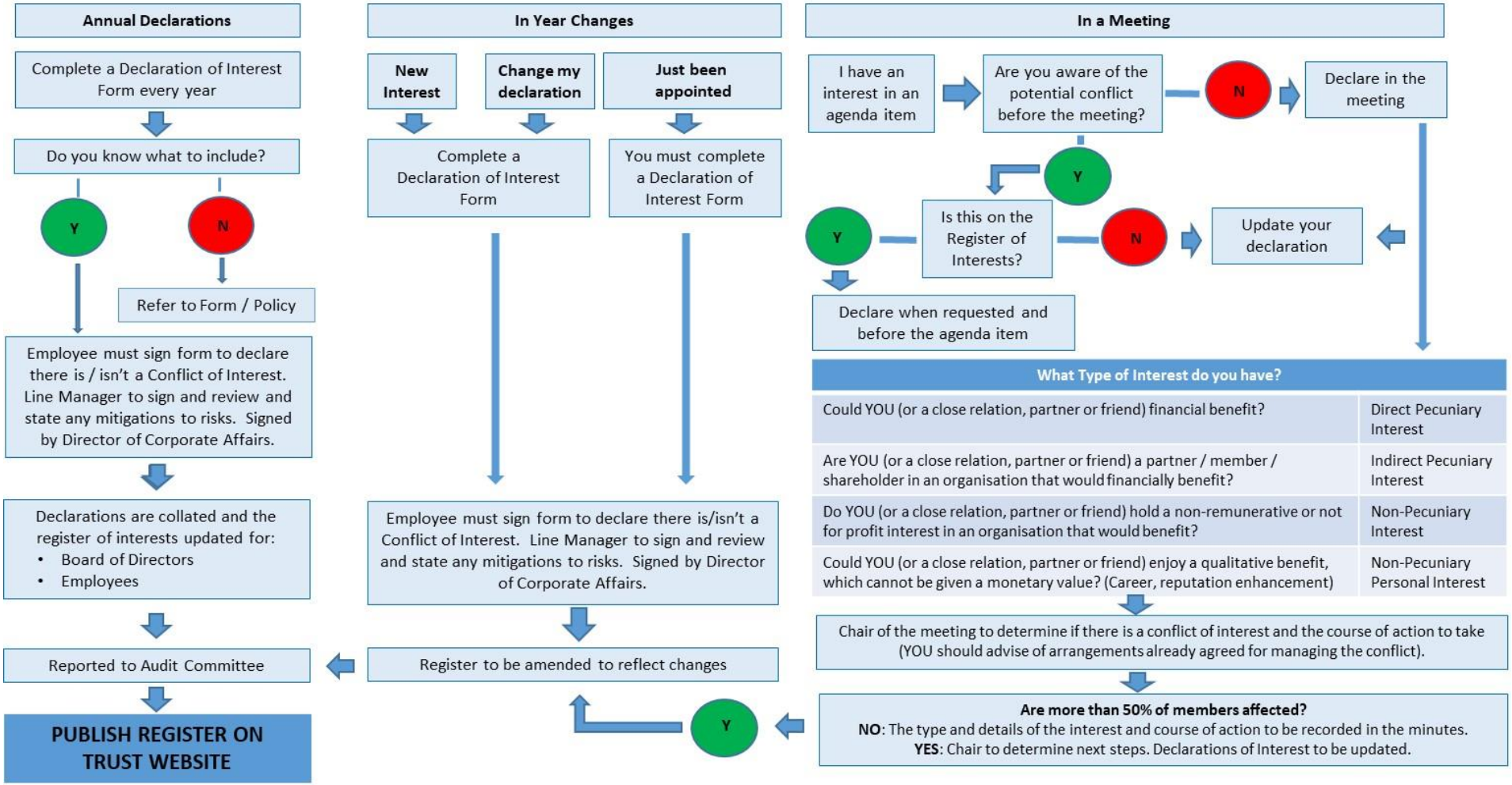
Appendix 1

Examples of Types of Interest (not exhaustive)

Type of Interest	Description
Financial Interest	This is where an individual may get direct financial benefit from the consequences of a decision they are involved in making. This could, for example, include being: • A director (including non-executive director) or senior employee in another organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; • A shareholder, partner, or owner of an organisation which is doing, or is likely to do business with an organisation in receipt of NHS funding; • Someone in secondary employment • Someone in receipt of secondary income • Some in receipt of a grant • Someone in receipt of other payments (eg honoraria, day allowances, travel or subsistence) • Someone in receipt of sponsored research.
Non-financial professional interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or status or promoting their professional career. This could include situations where the individual is: • An advocate for a particular group of patients; • A clinical with a special interest • An active member of a particular specialist body • An advisor for the CQC or National Institution of Health and Care Excellence • A research role.
Non-financial personal interests	This is where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions that are involved in making in their professional career. This could include where the individual is: • A member of a voluntary sector board or has a position of authority within a voluntary organisation • A member of a lobbying or pressure group with an interest in health and care
Indirect interests	This is where an individual has a close association with an individual who has a financial interest, a non-professional personal interest or a non-financial personal interest who would stand to benefit from a decision they are involved in.
Loyalty interests	As part of their role, officers may need to build strong relationships with colleagues across the NHS and in other sectors. These relationships can be hard to define as they may often fall into the category of indirect interests. They are unlikely to be directed by any formal process or managed via any contractual means, however these 'loyalty' interests can influence decision making.

Appendix 2

Declarations of Interest Flowchart



EQUALITY IMPACT & RISK ASSESSMENT SCREENING TOOL (STAGE 1)
Policies, Procedures and Strategies

Directorate:	**Team:**
Corporate Affairs	Corporate Governance
Name of policy/procedure or strategy:	**EIA lead/author:**
Standards of Business Conduct: Policy on Managing Conflicts of Interest; Gifts and Hospitality and Sponsorship	Penny Harder, Head of Corporate Governance
Date of completion:	**Date of review:**

Brief overview of the proposals (policy/procedure or strategy) being assessed, and intended outcomes	**The policy provides guidance for all employees that the organisation and individual employees have a duty to ensure all dealings are conducted to the highest standard of integrity and that NHS resources are used wisely and in the best interests of patients. The policy helps staff manage conflicts of interest risks effectively and introduces consistent principles and rules, advice about what to do in common situations and how to appraoch and manage interests. The policy has been written in accordance with NHS England's Managing Conflicts of Interest in the NHS Guidance for staff and organisations relleased in 2017. The guidance was released to provide consistent principles and rules for managing conflicts of interest; to provide simple advice to staff and organisations about what to do in common situations and supports good judgement about how interets should be approached and managed.**

GENERAL GUIDANCE
Please use the rationale box to provide more information, particularly in relation to responses which turn 'red'. The tool will provide an indication of whether a Stage 2 EIA is required. The reccomendation can be discussed with the ED&I Team before proceeding.

QUESTION No.	EQUALITY IMPACT	Enter Y or N	Rationale *If you have indicated 'yes' for any questions, please briefly explain*
1	**Is this a new policy/procedure or strategy?**	N	
2	**Is the policy/procedure or strategy proposing significant changes to current ways of working?**	N	
3	**Does the policy/procedure or strategy relate to service users?**	N	
4	**Does the policy/procedure or strategy relate to NWAS staff? If so, please outline which staff groups**	Y	The policy is applicable to all employees of the Trust.
5	**Does the policy/procedure or strategy have an impact on the way service users access NWAS services?**	N	
6	**Does the policy/procedure or strategy impact on the ways of working for staff?**	N	
7	**Can you foresee a negative impact(s) on any Protected Characteristic Group(s), or inclusion health groups?** If YES please state which ones and what the impacts could be.	N	*More information about these groups is on the 'Guidance' tab*
	EQUALITY RISK	**Enter Y or N**	**Rationale** *If you have indicated 'yes' for any questions, please briefly explain*
8	**Have you collated and reviewed any data relating to the impact of the proposals on patients/staff?** If YES, please list any relevant data/documents.	N	Whilst the policy is applicable to all staff.
9	**Have you taken specialist advice? (Legal, ED&I Team, etc).** If YES, please explain.	N	Policy is based on NHSE guidance (see overview)
10	**Have you considered whether the proposals contravene the Public Sector Equality Duty?** Please provide a rationale.	Y	The policy does not contravene the Public Sector Equality Duty.
11	**Can you mitigate or minimise any potential negative effects Protected Characteristic groups?** Please state how.	Y	There are no potential negative effects to Protected Characteristic groups.
12	**Have you identified stakeholders (patient/carer/staff groups) to engage with on the proposals?** Please indicate which stakeholders have been identified	Y	The policy has been in place since 2007 and has received a number of revisions since it was introduced. Awareness of the reviewed policy and process will be undertaken through the Staff Bulletin.
13	**Have you already undertaken engagement with stakeholders, or are planning to do so?** Please explain	N	The new process for declaring interests has been piloted with the Board of Directors. The process has been redesigned to be less onerous for the Corporate Governance Team and easier for staff to access the form and declare any interests.
	HUMAN RIGHTS IMPACT		**Rationale**
18	**Do the proposals potentially adversely impact the human rights of the patients, carers or staff? If so, please provide an explanation**		No.
	Human Rights: **A2 Right to Life** **A3 Prohibition of torture, inhuman or degrading treatment** **A4 Prohibition of slavery and forced labour** **A5 Right to liberty and security** **A6 Right to a fair trial** **A7 No punishment without law** **A8 Right to respect for private and family life** **A9 Freedom of thought, conscience and religion** **A10 Freedom of expression** **A11 Freedom of assembly and association** **A14 Prohibition of discrimination** **P1A2 Right to education**		
	Are you intending on proceeding to complete a Stage 2 EIA? ***If no, please provide a rationale***		No. The rationale is because there are no equality impacts, equality risks or human rights impacted by the procedure or the changes made to the document.

Please send this completed EIA Screening Tool to the Equality, Diversity & Inclusion Team for review: inclusion.workforce@nwas.nhs.uk

Comments from the ED&I Team			
Reviewed by:	V Camfield	**Date**	11/04/2024

NHS
North West
Ambulance Service
NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	NHS England NHS Provider Code of Governance: Disclosure of Corporate Governance Arrangements 2023/24
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Assurance

LINK TO STRATEGY	Not Applicable									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Note the declaration of compliance with all of the Code's clauses.	
EXECUTIVE SUMMARY	Following review of the Trust's position during 2023/24, as can be seen in Appendix 1, the proposed position is for the Trust to declare compliance with all relevant clauses in the Provider Code of Governance. All clauses not applicable to the Trust have been highlighted in grey for ease.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 19 April 2024
	Outcome	Assurance noted.

1. BACKGROUND

Whilst the Trust is not an FT, the original FT Code from 2014 was used as a framework to improve governance arrangements and ensure best practice of public and private sector corporate governance.

The new NHS Code, released by NHSE on 1st April 2023 is applicable to all NHS Providers and provides an overarching framework for the application of effective corporate governance processes, updated to reflect the development of integrated care systems and best practice within the NHS and the private sector.

Some provisions within the NHS Code require a statement or information to be included within the annual report, with other provisions to be made publicly available.

The remaining provisions, those detailed in Appendix 1, require a comply or explain response and include evidence of how the Trust has met each provision.

2. DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS 2023/24

A review of the Trust's corporate governance arrangements against the NHS Code has been undertaken and the declaration for all provisions has been provided within Appendix 1 to reflect the position during 2023/24.

The proposed position is for the Trust to declare compliance with all relevant clauses in the Provider Code of Governance.

All clauses not applicable to the Trust have been highlighted in grey for ease.

3. LEGAL CONSIDERATION

The NHS Provider Code of Governance states that NHSE can use the evidence from the disclosures made by NHS FTs and NHS Trusts to determine if there is a risk of a breach of the licence condition 'Foundation Trust Condition 4: Governance in the NHS foundation trust'. However the licence conditions within the new NHS Provider licence are NHS2: Governance arrangements and CoS3: Standards of corporate governance, financial management and quality governance.

4. ACTION REQUIRED

The Board of Directors is asked to:

- Note the declaration of compliance with all of the Code's clauses.

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
A.2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.	The Trust operates across five ICSs within the north west region. The Trust's commitment to partnership working is recognised within Our Strategy 2022-2025 and recognises the four goals of ICSs as: • Working together and supporting integration • Reducing bureaucracy • Improving public confidence and accountability • Supporting public health, social care quality and safety. The Trust is a key partner within the urgent and emergency care (UEC) system and works together with system partners in delivering pre-hospital care, supporting the goals of all partners within the system. Our aims and objectives are supported through the financial and annual plans approved by the Board of Directors on an annual basis.	• Our Strategy 2022-2025 • Annual Plan • Board Minutes	√
A.2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Trust has strong systems of financial governance in place. All statutory audits and reporting requirements are fulfilled. The Trust's financial plans are developed in accordance with the NHS operational planning guidance, in addition to a system-based approach to funding and planning. The financial plans are developed within the Lancashire and South Cumbria Integrated Care System. 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, clinical effectiveness, finance, operational performance and organisational health. It also includes information	• IPR • Planning process • Financial report includes efficiency updates • Trust Strategy • Quality Strategy • Service Development Strategy • Board Assurance Framework • Quality Account • Annual Plan • ICS Operational Planning Submissions	√

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		relating to performance against peers, national comparators and the Trust's strategic goals. The Board receive reports from the executives 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 exemptions under FOIA.		
A.2.5	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 performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, 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 sub committee 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 Sub Committees are reviewed and approved by the Board or parent Committee. Sub committees to support the Audit, Resources and Quality and Performance Committees are in place. A programme of internal audits is agreed with MIAA	• IPR • Committee ToR • Minutes of Board • Minutes of Committees • Meeting Schedule • Chair's Assurance Reports to Board • Internal Audit reports • Audit Committee minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		to focus on high risk areas as identified within the Board Assurance Framework and/or Corporate Risk Register (risks of 15+).		
A.2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	The Trust has a systematic approach to clinical governance which is focused on the relevant policy guidance and regulatory framework and supported by the Quality Strategy. The Quality and Performance Committee obtains assurance from the Clinical Effectiveness Sub Committee. The Quality and Performance Committee meets monthly and receives assurance reports from the Chair of the Clinical Effectiveness Sub Committee following each meeting. The Chair of the Sub Committee is the Medical Director, who is also a member of the Quality and Performance Committee. The Medical Director is accountable for clinical governance. This formal assurance meeting is supported 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.	• Quality Strategy • Clinical Audit reports • Minutes of Quality and Performance Committee • Quality and Performance Committee Workplan • Clinical Effectiveness Sub Committee Group minutes • Clinical Effectiveness Sub Committee Workplan • IPR to Board of Directors • Quality Account • Audit Committee Minutes • Internal Audit Reports	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
A.2.7	The chair should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	The Chair regularly engages with Chairs at system level across the North West. The Board of Directors are provided with a verbal update in relation to the Chair and NEDs engagement activities with system partners, staff and patients at each meeting. The public meetings of the Board of Directors are observed by members of the Patient and Public Panel (PPP), staff and patient stories are shared to improve and promote understanding of patient and staff centred issues, included lessons learnt and new methods of working to make necessary improvements. The Board Development Sessions involve key strategic stakeholders, both internal and external. Board members attend PPP organised events throughout the calendar year. The Trust holds an Annual General Meeting in September to present the Annual Report and Accounts, system partners, staff and members of the public are invited to attend.	• Board Agendas • Board Minutes • Board Development Sessions • Non Executive Directors attendance at PPP events	√
A.2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	The Board of Directors approved the Freedom to Speak Up Policy and Procedure in November 2022. The Board also receive annual and bi-annual assurance reports relating to the FTSU arrangements in place, detailing themes and trends during the quarter and Response to the National Guardian Office 'Listening to Workers' report. The Medical Director is the executive lead for Freedom to Speak Up, with a nominated Non-Executive Lead. The Trust has a lead Freedom to Speak Up Guardian, who is supported by a further two guardians. The Guardians support staff raise concerns (anonymously if preferred) and progress	• Freedom to Speak Up Policy • Board Agenda • Board Minutes • Board work plan	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION A: BOARD LEADERSHIP AND PURPOSE				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		concerns towards resolution and where necessary refer concerns onto HR processes.		
A.2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement	The Trust follows the guidance provided by NHS England in relation to Managing Conflicts of Interest in the NHS. The Board of Directors are required to declare their interests on joining the Trust and are responsible for renewing/updating their declarations on an annual basis and if their interests change during the financial year. The Board Register of Interests is published on the Trust website and is considered at each Board meeting.	• Standards of Business Conduct: Policy on Managing Conflicts of Interest; Gifts & Hospitality and Sponsorship • Board Register of Interests • Board minutes	√
A.2.11	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 the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	The role of Senior Independent Director and the Director of Corporate Affairs support the escalation of concerns around the operation of the board or overall management of the Trust. All Board members are encouraged to articulate their views in Board meetings and the minutes clearly and accurately reflect this. In line with the NHS Provider Code of Governance, this requirement was included into Board of Directors Standing Orders in 2023/24.	• Board of Directors Standing Orders • Board minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
B.2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	The Chair has oversight of the Board agenda and meets with the Director of Corporate Affairs to ensure adequate time is available for sufficient discussion of all agenda items. In addition, to assist with agenda setting, there is an annual cycle of business approved by the Board. The cycle of business is a key component to ensure that the Board of Directors carry out their role effectively. The Board agenda is structured into themes: - Strategy - Governance and Risk Management - Quality and Performance - Workforce - Strategy, Partnerships and Transformation Alongside the annual cycle of business, other areas of risk and emerging matters are also considered.	• Board of Director meeting packs on Trust website • Board of Directors Annual Cycle of Business • Minutes of Board meetings	√
B.2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	The Board of Directors and its assurance committees have annual cycles of business to ensure that all key governance information is presented in the appropriate manner at the relevant time. Cover reports for all Board and Committee papers include for the provision of an executive summary, which provides clarity over a paper's salient points and the action required by Board members. Directors are required to review papers prepared by senior members of their teams to ensure accuracy of data and information prior to inclusion within the meeting pack. Agendas and accompanying papers are made available five days prior to Board or Committee	• Board and Committee reports • Board and Committee work plans • Board and Committee minutes • Committee ToR	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		meetings as per the Terms of Reference (ToR) to allow board members sufficient time to review and prepare for meetings.		
B.2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	The Chair personally demonstrates transparency and openness and facilitates effective discussion and challenge amongst the board. As part of Board Development, there has been a focus on board cohesion and understanding to foster effective relationships between executive and non-executive members of the board. Further assurance, scrutiny and monitoring of key issues is requested of Chairs of the Board Assurance Committees.	• Board minutes. • Board action log. • Committee Chairs Assurance Reports to Board • Board Development Sessions	√
B.2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	Not applicable		
B.2.5	The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	The Chair was appointed on 1st February 2019. NHSE leads the appointment process for NHS Trusts on behalf of the Secretary of State for Health and Social Care. On appointment, the Chair met the independence criteria and had not previously been a Chief Executive of the Trust. The Chair continues to meet the independence criteria and his final term of office will end 31st January 2025. The roles of the Chair and Chief Executive roles are documented within the Statement of Responsibilities approved by the Board of Directors in September 2023. The role of vice chair and senior independent director are undertaken by a nominated Non-Executive, as agreed by the Chair. The chair is not a member of the Audit Committee. The Audit Committee is chaired by an independent Non-Executive Director, the vice chair/senior	• NHSE Appointment processes • Declaration of Interest • Statement of Responsibilities • Audit Committee Terms of Reference	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		independent director is a member of the Audit Committee.		
B.2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	The composition of the Board of Directors is in accordance with the Membership and Procedure Regulations 1990 and consists of the Chair plus five Non-Executive Directors and five voting Executive Directors. All Non-Executive Director appointments (made by NHSE) are independent. Board members are required to declare interests on appointment.	• Board of Directors Register of Interests	√
B.2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	No members of the Board hold governor positions within a Foundation Trust.	• Board of Directors Register of Interest	√
B.2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	The Board reviews Committee membership on an annual basis and where appropriate, membership will be refreshed.	• Report to Board 26th April 2023: Non-Executive Terms of Office; Committee Membership 23/24 and Non-Executive Champion Roles	√
B.2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	The membership of the Nominations and Remuneration Committee (as per the Terms of Reference) is the Chair and Non-Executive Directors. The Director of People and Chief Executive attend in an advisory capacity to provide clarity on certain matters however are not included within the Committee membership and do not attend when matters to be discussed have a direct impact on them. The Audit Committee membership consisted of four independent Non-Executive Directors, plus an	• Nominations & Remuneration Committee Terms of Reference • Nominations & Remuneration Committee Terms of Reference • Audit Committee Terms of Reference	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		Associate Non-Executive Director. The Director of Finance, Director of Corporate Affairs, Local Counter Fraud and External Audit also attend all meetings. Other Executive Directors are invited to attend the Committee when discussing areas of risk or operation that falls within the remit of that director. The Chief Executive attends the Committee once a year to present his draft Annual Governance Statement.	• Audit Committee minutes	
B.2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.	The Board has appointed a Senior Independent Director. As an NHS Trust, the Chair's appraisal is undertaken by the Senior Independent Director, overseen by NHSE and in line with NHSE guidance 'Framework for Conducting Annual Appraisals of NHS Provider Chairs'.	• Board minutes • Appraisal documentation	√
B.2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	The Nominations and Remuneration Committee (NARC) approve the appointment and removal of the Chief Executive and Director posts in conjunction with NHSE. NARC receive the individual executive directors objectives and performance against objectives on an annual basis. Non-executives are members of the Board Assurance Committees where they provide scrutiny and challenge to assist with achievement of objectives. The Chair meets with Non-Executive Directors on request and on a regular basis throughout the year, both individually and collectively.	• NARC Terms of Reference • NARC minutes • Committee & Board Minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
B.2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	Clarification around any existing significant commitments has been built into the recruitment process for the Executive Director of Operations and for future Executive Director recruitment. Declaration of Interest process requires all Directors to declare their outside interests. The Standards of Business Conduct policy deals with outside employment and no outside employment can be sought without prior agreement from the Board, delegated to the Chief Executive for executive directors.	• Standards of Business Conduct Policy: Declaration of Interest, Gifts and Hospitality and Sponsorship • Board Register of Interests	√
B.2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	All directors have access to the Director of Corporate Affairs who fulfils the role of company secretary for the organisation. NARC approves the appointment and arrangements for the termination of employment of the company secretary.	• NARC Terms of Reference • Minutes	√
B.2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	The integrated governance structure facilitates assurance reporting on clinical, quality, patient safety to and from the Board. The Quality and Performance Committee has a comprehensive Work Plan which includes statutory and regulatory reporting requirements. Sub Committee Chairs of Clinical Effectiveness and Workforce are commissioned to provide assurance to the Board Assurance Committees. NED briefings include updates on regulatory reporting requirements and the Trust's Research and Development Annual Report 2023/24 includes key successes in education, training, and research.	• Integrated Governance Structure. • Board Assurance Committee Work Plans. • Sub Committee work plans. • NED briefings. • Research and Development Annual Report 2023/24.	√
B.2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular	The Board of Directors functions as a unitary board and all Directors are clear on their joint responsibilities for every board decision taken.	• Board of Director minutes. • Chief Executive Updates.	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	responsibilities of the chief executive as the accounting officer.	The Chair provides a summary at the end of each Board meeting articulating the discussions and decisions undertaken by the board in the meeting. Individual board member appraisals consider their contribution to the decision-making function of the board.	• Chair and Non-Executive Director updates. • Appraisal documentation.	
B.2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	All board members are aware of their responsibilities to provide constructive challenge, which is welcomed and effectively facilitated by the Chair. Board development sessions were held specifically focused on Board cohesion and constructive challenge throughout the previous year and early Q1 23/24. The Board have attended sessions in relation to the refresh of strategies, risk appetite statement and Board Assurance Framework during the year which has given all Board members the opportunity to engage and provide input. The Board receive the integrated performance report (IPR), which is based on an agreed set of metrics within the Single Oversight Framework and provides historical and current performance on quality effectiveness, operational performance, finance and organisational health. The Quality and Performance Committee receive the IPR relating to quality, effectiveness and operational data. The Resources Committee receive quarterly reports relating to progress against annual corporate objectives linked to the Trust strategies, together with general assurance reports. Where insufficient assurance has been provided the Board/Committee will commission further work/deep dives.	• Board of Directors minutes • Terms of Reference • Committee Minutes • Board of Directors Action Logs. • Committee work plans. • Committee Chairs Assurance Reports to Board • Board Development Programme • Internal Audit Plan • Board Assurance Framework	√

SECTION B DIVISION OF RESPONSIBILITIES				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
		The Board Assurance Framework (BAF) is presented to each Committee meeting and quarterly to the Board of Directors. The BAF is a pivotal document that helps drive discussion and scrutiny, with executive directors held to account on progress made to mitigate the risks during the quarter. The Audit Committee, through the work of internal audit, receive the outcome of an annual review of data quality, progress against any high/medium or low recommendations are tracked through the Audit Committee. Where internal audit reviews receive limited assurance, the Audit Committee will request attendance of the responsible Executive Lead to provide plans for improvement and progress against recommendations. The Audit Committee is charged with seeking assurances in relation to the effectiveness of the overarching systems of internal control through integrated governance, risk management and other assurance functions. Alongside the executive reports and those of internal and external audit, the Committee receives Chair's assurance reports from the Quality and Performance Committee who are charged with clinical governance and the Resources Committee who are charged with monitoring the Trust's financial performance.		
B.2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	The board of directors meets on a bi-monthly basis and has a work programme. The Reservations of Powers and Scheme of Delegation provide a schedule of matters reserved for Board decisions.	• BoD work programme. • Reservations of Powers • Scheme of Delegation • Board of Directors minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION C: COMPOSITION, SUCCESSION AND EVALUTION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
C.2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.	Not applicable		
c.2.2	There may be 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 chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	Not applicable		
C.2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	Not applicable		
C2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have	Not applicable		

SECTION C: COMPOSITION, SUCCESSION AND EVALUTION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	been identified, the nominations committee should make recommendations to the council of governors.			
C2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.	Not applicable		
C.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	Not applicable		
C.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		
C.3.1	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	The NARC membership consists of the non-executive directors who approve the appointment of the Chief Executive. The Chief Executive joins NARC to recommend the appointment of other executive directors. NHSE is included on the selection panel as an external assessor for all executive and non-executive appointments. All executive posts and T&Cs are subject to approval by NHSE.	• NARC Terms of Reference	√

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
C.4.1	Directors on the board of directors and, for foundation trusts, 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 having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	The Fit and Proper Persons Test (FPPT) is applicable to all Board members ie Non-Executive and Executive Directors, Associate Non-Executive Directors and senior interim appointments. FPPT 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 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 FPPT application and compliance.	• Annual revalidation process FPPT Declaration • Fit and Proper Person Test Procedure • Register of Interests • Contracts • Board Minutes • Internal Audit Findings	√
C.4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.	The Chair was appointed 1st February 2019. The current term of office is due to end in January 2025.	• NHSE Appointment processes • Standing Orders	√
C.4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior	Not applicable		

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
	performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.			
C.4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	Terms of Reference for the Board of Directors have been developed for implementation during 2024/25. Formal evaluation of the Board of Directors will be undertaken during Q4 2024/25. Committees and Sub-Committees of the Board are subject to annual evaluation in respect of the following themes: focus, engagement, teamworking, committee effectiveness, and leadership. The outcome of the Committee evaluations are included with the Committee Annual Report to the Board of Directors. The chair and individual directors are subject to annual performance appraisals, the Chair's evaluation is undertaken by the senior independent director in line with NHSE Chair Appraisal Framework and the Chief Executive and individual directors performance outcome is reported to the NARC. The NHS Leadership Competency Framework is being utilised as part of executive appraisals from 1 April 2024.	• Minutes • Terms of Reference • Appraisal Documentation	√
C.4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	The chair identifies any training and development needs through annual appraisal of non-executive director which is shared with NHSE. The Chief Executive undertakes the appraisals for Executive Directors and will identify any training and development required for their role. The outcome of the appraisals is reported to the Nominations and Remuneration Committee on an annual basis.	• Appraisal Documentation • Committee Minutes • Committee ToR	√
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and	Not applicable		

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
	regularly communicate to members and the public 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 • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors. Section C, 4.10 (NHS foundation trusts only) In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances:			

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
	where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.			
C.4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	Not applicable		
C.4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	The Nominations and Remuneration Committee review succession planning for all directors, taking into consideration future challenges, the skills and experience required for the future.	• NARC ToR • NARC Minutes	√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION C: BOARD APPOINTMENTS				
CODE PROVISION				
C.4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Executive Directors are required to provide 6 months' notice as per the employment contract. In the rare circumstance where appropriate notice is not served, agreement will be sought from the Nominations & Remuneration Committee and NHS England for mitigations.	• Minutes NARC and Board meetings • Executive Employment Contracts	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
C.5.1	All directors and, for foundation trusts, 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, for foundation trusts, governors should make every effort to participate in training that is offered.	An Induction pack for Chairs/Non-Executive Directors exists which provides an overview of the Trust and its governance arrangements. Included in the document is a summary of the induction process which identifies the various elements to be met as part of their induction. In addition, NEDs are informed of any additional conferences/training programmes to assist them in their role and a record of attendance is kept. All new NEDs are expected to attend the NHS Providers NED Induction Programme. There is an annual Board Development work programme in place where additional education is provided to all Board members around a variety of subjects. The Chief Executive is responsible for the induction of new Executive Directors. All new executive directors are expected to attend the Executive Director induction programme facilitated by NHS Providers in partnership with NHS England. All Directors and Non-Executive Directors are expected to complete mandatory training. The appraisal process for both Executive Directors and NEDs also identifies development requirements.	• Chair/NED Induction Programme • NED Training Record • Board Development Annual Programme • Appraisal documentation • Mandatory training records	√
C.5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts,	An Induction pack for Chairs/Non-Executive Directors exists which provides an overview of the Trust and its governance arrangements. Included in the document is a summary of the induction process which identifies the various elements to be met as part of their induction. These consist of site visits to Integrated Contact Centres, ambulance stations,	• Chair/NED Induction Pack • Board Development Programme • Mandatory Training records • NED Training/Event Register	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
	governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	regional Trust offices and ambulance/111/PTSobservation shifts. In addition, NEDs are informed of any additional conferences/training programmes to assist them in their role and a record of attendance is kept. There is a Board Development work plan in place where additional training is provided to all Board members. The Chief Executive is responsible for the induction of new Executive Directors. All Directors and Non-Executive Directors are expected to complete their mandatory training. The Trust does not have a council of governors. During 2023/24, all Executive Directors attended the Trust's Unconscious Bias leadership module as part of their mandatory training requirements. Board Development Sessions during 2023/24 have included sessions relating to EDI Priorities and the NW BAME Assembly Anti Racist Framework.		
C.5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	The Trust core governance documents, key strategies and vision and values are shared with directors on joining the Trust. Policies reserved for Board approval have been identified and are listed within the Reservations of Powers to the Board and the Policy Management framework. Directors are also required to spend time within services such Integrated Contact Centres, 111, PTS and the Paramedic Emergency Service and other service line visits to observe work practices and familiarise themselves with the Trust's operations and staff. All Directors are invited to attend Community events which gives an opportunity to	• Reservations of Powers to the Board • Standing Orders • Standing Financial Instructions • Policy Management Framework	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
		meet and interact with both members of staff and members of our communities.		
C.5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	An Induction pack for Chairs/Non-Executive Directors exists which provides an overview of the Trust and its governance arrangements. Included in the document is a summary of the induction process which identifies the various elements to be met as part of their induction. Non-Executive Directors are also required to visit and spend time in operational services such as Integrated Contact Centres, 111, PTS, Paramedic Emergency Service and other service line visits to observe work practices and familiarise themselves with the Trust's operations and staff. All Directors are invited to attend Community events. In addition, NEDs are informed of any additional conferences/training programmes to assist them in their role and a record of attendance is kept. There is a Board Development work plan in place where additional education is provided to all Board members. The Chief Executive is responsible for the induction of new Executive Directors. All Directors and Non-Executive Directors are expected to complete their mandatory training. The Trust does not have a council of governors.	• Chair/NED Induction Pack • Board Development Programme • Mandatory Training • NED Training/Event Register	√
C.5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	The chair is responsible for undertaking the annual appraisals of non-executive directors where training and development needs will be identified and agreed. The Chief Executive is responsible for undertaking Executive Director appraisals where any training and	• Appraisal documentation. • Board Development Programme	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
		development needs are identified and agreed with the relevant director. To supplement this, the Board Development Session aims to offer training and development for the board as a whole, often linked with their corporate responsibilities.		
C.5.6	A foundation trust 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		
C.5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	The covering sheet of Board papers provides clarity over a paper's salient points and the action required during the meeting. The Board has an annual cycle of business to ensure that all key governance information is presented in the appropriate manner at the relevant time. Further in depth information is provided to the Board assurance committees. Should any additional reporting be required this can be arranged. All committee terms of reference allow for members to call upon other staff members to attend to answer queries and/or provide information. Agendas and accompanying papers are made available five days prior to Board or Committee meetings as per the Terms of Reference.	• Board paper front Cover • Board Cycle of Business • Board minutes • Committee ToR	√
C.5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	The Board integrated governance structure has been designed to allow information to flow effectively from sub Committees to their parent Committee and Committees to the Board. During 2023/24 this was facilitated through a Chairs Assurance Report, which is used as a mechanism to provide assurance around subjects as well as escalate concerns where limited assurance has been received and details the	• Committee Chairs Assurance Reports • Board minutes • Audit Committee minutes • Chair/NED induction programme.	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
		further work required to gain assurance.(During 24/25 this Chair's Assurance Report will change to the 3A model) The Audit Committee also receives the Chairs Assurance Reports from the Quality and Performance Committee and Resources Committee as part of its remit to have assurance on the overall system of control. C.5.4 details the arrangements to facilitate induction and any professional development is identified by the Chair or Chief Executive.		
C.5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	The BoD and all committees or Groups have an annual cycle of business to ensure that all key information/data is seen in the appropriate forum. The members of the meetings agree these annual business cycles and ensure that all the required information is mapped across the year. Further assurance can be sought and the business cycle document is seen at each meeting to facilitate any changes that are needed. All committee terms of reference allow for members to call upon other staff members to attend to answer queries and/or provide information.	• Board paper front Cover • Cycle of Business • Board minutes • Committee Terms of Reference	√
C.5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should 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 within the trust in a timely manner. On occasion,	All Board members are encouraged to challenge assurances provided by the Executives. Executives should have sufficient knowledge and expertise to respond to any challenge/questions and be able to confidently provide information/assurance to facilitate Board decisions. For subject areas where insufficient assurance has been provided, the Board will commission further work/deep dives for assurances to be provided either directly to the board or to the relevant Committee.	• Board minutes • Committee minutes	√

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
	non-executives may reasonably decide that external assurance is appropriate.	For complex or high risk issues, non-executives are able to seek external assurance through using internal audit review or external body.		
C.5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive 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 sought if deemed appropriate by all members. Information relating to the availability of independent external sources of advice will be included within the Chair/NED induction programme.	• SFIs/SoD	√
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	The Corporate Governance Team provide the secretariat support for the Board of Directors and its assurance committees. The team provide corporate governance advice to the members of the meetings and hold pre meets with Committee Chairs to provide a brief overview of the meeting agenda and to highlight areas where further assurance may be required.	• Board/Committee Structure • Terms of Reference	√
C.5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Non-Executive members of the board and committees are provided with papers five days prior to the meeting. Appropriate challenge is provided in relation to any decisions required by the Board and where necessary further information is provided to facilitate decision making. Non-executive directors are selected by the Trust based on how their skills and experience meet the specific requirements of the Trust. For example: Clinical NED or Audit Chair NED.	• Board minutes • Committee minutes	√
C.5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS	Not applicable		

SECTION C: DEVELOPMENT, INFORMATION AND SUPPORT				
CODE PROVISION				
	foundation trust's plans, and explain the reasons for any not being included.			
C.5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	The NHS Resolution Liability insurances offers an element of protection, with financial protection for Directors and Officers underwritten by the Secretary of State.		√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION D: AUDIT, RISK AND INTERNAL CONTROL				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
D.2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	The Audit Committee Terms of Reference include 4 Non-Executives Directors members, including the Chair of the Committee. The Chair of the Audit Committee has the relevant recent financial experience. The Trust Chair is not a member of the committee. The vice chair/SID is not the Chair of the committee but is a member.	• Audit Committee Terms of Reference	√
D.2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity	A key element of the Audit Committee's remit is to review the Trust's draft and final annual accounts prior to formal adoption by the Board of Directors. External auditors provide their financial reporting judgements through the Annual Audit Report to the Audit Committee and Board of Directors. The Annual Audit Report is produced for publication on the Trust's website and contains the outcome of the audit of the financial statements, annual report and annual governance statement. During 2023/24, the internal audit plan included reviews against the key internal financial controls and effectiveness of risk management processes. Both reviews received high assurance ratings. MIAA operate systems to ISO Quality Standards. Public Sector Internal Audit Standards (PSIAS) require internal auditors to 'develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity.' This programme must include internal and external assessments. External assessments must be conducted at least once every five years. Internal audit's last external assessment was completed in	• Audit Committee Terms of Reference • Internal Audit Plan • Internal Audit Progress Reports • Board minutes • Audit Committee Annual Report • Annual Audit Report	√

SECTION D: AUDIT, RISK AND INTERNAL CONTROL				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	• reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.	2020 and the outcome concluded full compliance with PSIAS. Regular internal assessments are also undertaken by internal audit to ensure ongoing compliance with requirements. Annual self-assessment of compliance with PSIAS are undertaken and internal audit confirmed full compliance with PSIAS. A formal review of the effectiveness of the Trust's external auditors was reported to the Audit Committee in January 2023. The Audit Committee have committed to undertake an evaluation of external audit every three years. The Chair of the Audit Committee submits an annual report to the Board of Directors to evidence how the Committee fulfilled its Terms of Reference during the financial year.		
D.2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.	The Trust appoints External Auditors following a procurement exercise to implement a contract. This is undertaken every four years. The Board of Directors supported the recommendation of the Audit Panel to award the contract to Mazars LLP in January 2024.	• Audit Panel • Board of Directors • Minutes	√
D.2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	The Trust has not used External Auditors, Mazars for any non-audit services during the last 3 financial years. If this was the case, it would be managed through an appropriate procurement and tender process to ensure there were no conflicts of interest. However the Standing Financial Instructions have been updated (s2.4) to ensure transparency and controls around procuring non-audit services, particularly from the current External Auditors and therefore a separate policy is not required.	• Standing Financial Instructions (2024/25)	√

SECTION E: REMUNERATION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
E.2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and 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. • 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. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable	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 and Remuneration Committee and NHSE and are based on evidence presented around annual performance and delivery of objectives	• NARC Minutes • Annual PDR documentation	√

SECTION E: REMUNERATION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
	remuneration, especially for directors close to retirement.			
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	The levels of remuneration for Non-Executives is set by NHSE for NHS Trusts.	• NHSE Guidance: Structure to align remuneration for chairs and non-executive directors of NHS Trusts and NHS Foundation Trusts (November 2019) • Chair and NED appointment letters	√
E.2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	If the Trust were to make a redundancy/severance any claw back arrangements would be reflected in a settlement agreement, stating the requirement for the individual to pay back a proportion of the payment if they were to take up another NHS post. However, the employment contracts do not reflect a departing directors requirement for compensation to be reduced. Since 2019, new director appointments reflect a 'claw back' agreement subject to achieving performance criteria which means all Executive Directors currently in post have this clause in their contracts.	• Employment contracts (from 2019)	√
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	The Trust is required to liaise with NHSE's regional director as part of the process for any contractual or non-contractual severance payments. The Nominations and Remuneration Committee (NARC) would receive a report detailing the outcome of any discussion held. There have been no such severance payments during 2023/24.		√

DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS FOR 2023/24

SECTION E: REMUNERATION				
CODE PROVISION		**TRUST POSITION**	**Evidence**	**Comply?**
E.2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	The Nominations and Remuneration Committee have responsibility for setting executive directors remuneration including compensation payments and pension rights. This is reflected in the Committee Terms of Reference. The executive pay structure is governed by the DH VSM Pay Framework of 2013 and NHSI Guidance from 2018. The Trust's definition of a senior manager is the Chief Executive and Executive Director posts.	• NARC Terms of Reference • Annual Report	√

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Non-Executive Terms of Office; Committee Membership 2024/25 and Non-Executive Champion Roles
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Assurance

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to note: • That it remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended) and the NHS Code of Governance in respect to Non-Executive Directors Terms of Office. • The Non-Executive Directors Committee membership for 2024/25. • The Non-Executive Director Champion Roles
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 2024/25 can be seen in s3. The approach to non-executive director champion roles can be seen in s4.
PREVIOUSLY CONSIDERED BY	Not Applicable
	Date: Not Applicable
	Outcome: Not Applicable

DELIVERING THE RIGHT CARE,
AT THE RIGHT TIME,
IN THE RIGHT PLACE;
EVERY TIME.

1. BACKGROUND

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 2024/25.

2. TERMS OF OFFICE

In an NHS Trust, Non-Executive Directors are appointed by NHSE on behalf of the Secretary of State for Health & Social Care 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 6 years, however, in exceptional circumstances and following a prescribed process and receipt of approval from NHSE, the term may run to an absolute maximum of 9 years.

Terms of Office wef 1st April 2024 are shown below:

Non-Executive Directors	
Name	**Term of Office**
Peter White (Chairman)	(Final Term)01/02/23 – 31/01/25
	01/02/19 – 31/01/23
Non-Executive Director	Ended 31/1/19
	30/04/18 – 30/04/20
	01/05/16 – 30/04/18
	01/05/14 – 30/04/16
David Hanley	(Final Term) 28/05/23 – 27/05/25
	28/05/21 – 27/05/23
	28/05/19 – 25/05/21
Alison Chambers	(Final Term) 01/08/23 – 01/08/25
	01/08/21 – 31/07/23
	01/08/19 – 31/07/21
Prof Aneez Esmail	01/04/23 – 31/03/26
	01/04/21 – 31/03/23
Catherine Butterworth	Renewed 01/04/24 – 31/03/26
	01/04/22 – 31/03/24
David Whatley	
Non-Executive Director	25/03/24 – 24/03/26
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 2024/25 is as follows:

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

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

Following guidance issued by NHSE 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	Alison Chambers

5. LEGAL CONSIDERATION

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 Chair.

6. ACTION REQUIRED

The Board of Directors is asked to note:

- That it remains compliant with Establishment Order 2006 No 1662 and Membership and Procedure Regulations 1990 (as amended); and the NHS Code of Governance in respect to Non-Executive Directors Terms of Office.

- The Non-Executive Directors Committee membership for 2024/25.
- The Non-Executive Director Champion Roles

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Board of Directors Terms of Reference
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Terms of Reference.	
EXECUTIVE SUMMARY	Terms of Reference for the Board of Directors have been developed in order to ensure compliance against C.4.5 of the NHS Provider Code of Governance. The Terms of Reference focus on the following key areas of the Board's remit in relation to: ❖ Leadership and Culture ❖ Strategy ❖ Quality and Performance ❖ Finance ❖ Governance and Compliance ❖ Risk Management and Internal Control Formal evaluation of the Board will be undertaken during Q4 2024/25.	
PREVIOUSLY CONSIDERED BY	Not Applicable	
	Date	Not Applicable
	Outcome	Not Applicable

1. BACKGROUND

The new NHS Code, released by NHSE on 1st April 2023 is applicable to all NHS Providers and provides an overarching framework for the application of effective corporate governance processes, updated to reflect the development of integrated care systems and best practice within the NHS and the private sector.

Section C.4.5 of the NHS Code states 'there should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors'.

2. NHS CODE COMPLIANCE

Whilst the outcome of the review of the Trust's compliance against the NHS Code during 2023/24 confirmed all provisions were met, it identified the requirement for Board of Directors Terms of Reference to formally evaluate the performance of the Board and meet the full requirements of C.4.5.

The Terms of Reference have therefore been developed and focus on the following key areas of the Board's remit in relation to:

- Leadership and Culture
- Strategy
- Quality and Performance
- Finance
- Governance and Compliance
- Risk Management and Internal Control

Formal evaluation of the Board will be undertaken during Q4 2024/25.

3. GOVERNANCE CONSIDERATION

Full compliance against the NHS Code, specifically provision C.4.5 will ensure robust processes are in place to evaluate performance of the Board and to meet its statutory duties.

4. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Terms of Reference

TERMS OF REFERENCE

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BOARD OF DIRECTORS

CONTENTS

1. COMPOSITION

Role and Purpose

The Board of Directors (hereinafter referred to as 'the Board') is accountable to the Secretary of State for the effective direction of the affairs of North West Ambulance Service NHS Trust. The purpose of the Board is to govern the organisation effectively and ensure that the Trust provides safe, high quality, patient centred care.

The Board leads the organisation by undertaking the following key roles:

- Formulating strategy, defining the organisation's purpose and identifying priorities
- Ensure accountability by holding the organisation to account for the delivery of the strategy and scrutinising performance
- Seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
- Shaping a positive culture for the board and organisation through the Trust values: Working Together; Being at our Best; Making a difference.

The Board exercises all the powers of the Trust on its behalf but may delegate powers to a Board Committee or to one or more Executive Directors. This is detailed in the Scheme of Delegation and Standing Financial Instructions.

The Board may establish additional Board Committees as required and will approve their terms of reference and the designated members. The Board has established the following Committees:

- Audit Committee
- Nominations and Remuneration Committee
- Quality and Performance Committee
- Resources Committee
- Charitable Funds Committee

Each Board Committee should report regularly to the Board in line with their Terms of Reference. The Trust Board remains responsible for the activities of, and powers delegated to, its Committees.

The Board, acting on behalf of the Corporate Trustee, takes responsibility for the overall management and governance of charitable funds and related fundraising activity.

Membership

The Board will consist of 11 voting members as per Establishment Order 2006 No. 1622. The Composition of the Board is set out in the Trust's Standing Orders (Section 2.1.1).

Quoracy

The required quorum for the transaction of business shall be six; three Non-Executive Directors and three Executive Directors (voting), including the Chair/Vice Chair.

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

Attendance of Meetings

It is expected all members of the Board will attend all Board meetings. Apologies for absence, stating the reason for absence, should be provided in advance of the meeting to the Chair and Corporate Governance team.

A register of attendance for all Board and Committee meetings will be presented to each meeting. Poor attendance will be followed up by the Chair.

Meeting frequency

The Board will meet bi-monthly or more frequently, if required. The following meetings will be held:

- Meeting held in public (Part 1)
- Private Meeting (Part 2)
- Board Development Sessions to support board development strategic planning

Board Secretariat

Secretariat for the Board will be provided by the Corporate Governance Team. The agenda and any working papers will be circulated to members at least five days before the date of the meeting. Formal minutes of the Meeting will be produced for review by the Chair within 72 hours of the meeting.

2. RESPONSIBILITIES AND DUTIES OF THE BOARD

The Board is responsible for decision-making associated with:

- The strategic direction of the Trust
- The provision of high-quality pre-hospital clinical care
- Overall performance of the Trust in relation to standards set by regulatory bodies
- Ensuring the Trust exercises its functions effectively, efficiently and economically;
- Ensuring effective arrangements are in place for governance and risk management.
- Ensuring compliance with the Trust's Provider Licence and associated legislation, regulation and best practice.

At all times the Board will conform to the Standing Orders, Scheme of Delegation, Reservations of Power to the Board and Standing Financial Instructions.

Duties

Leadership and Culture

The Board:

- Ensures there is a clear strategy for the trust that is understood and implemented within a framework of prudent and effective controls;
- Agrees values, ensuring they are widely communicated, adhered to and that the behaviour of the board is entirely consistent with those values;
- Promotes a patient-centred culture of openness, transparency and candour, has an intolerance of poor standards and fosters a culture that puts patients and staff first;
- Ensures the Trust is an excellent employer through the development of a workforce strategy and its appropriate implementation and operation;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced;
- Implements an effective Board and Committee structure and clear lines of accountability and reporting throughout the organisation;
- Ensures that there are appropriate appointment arrangements for senior appointments such as the Chief Executive and Executive Directors;
- Promotes the health and wellbeing of staff;
- Implements effective board and committee structures and clear lines of reporting and accountability throughout the organisation;
- Maintains and promotes a positive speak up culture

Strategy

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives ensuring that the necessary financial, physical and human resources are in place for it to meet its objectives;
- Develops and maintains an annual business plan, and ensures its delivery as a means of taking forward the strategy of the trust to meet the expectations and requirements of stakeholders;
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

Quality and Performance

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience are achieved;
- Monitors and reviews management performance to ensure the Trust's objectives are met and identifies opportunities for improving the delivery of high quality services;
- Fosters a culture that puts patients first and ensures there are sound processes and mechanisms in place to:
  - Monitor feedback relating to the experiences of patients;
  - Engage with all its stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with when required;
  - Encourage effective patient involvement with regard to the review of quality of services provided and the development of new services;
- Ensure there are sounds processes in place to ensure compliance with, and awareness of equality, diversity and inclusion standards;
- Ensure that the organisation promotes research and development.

Finance

The Board:

- Has accountability for financial control and ensuring the Trust meets it statutory duty to break even;
- Ensures that the trust operates effectively, efficiently, economically to ensure the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of services responsibilities are fulfilled;
- Ensures the achievement of targets and requirements of stakeholders within the available resources;

Governance and Compliance

The Board:

- Ensures compliance with the overarching framework of good corporate governance in order to meet its statutory and regulatory obligations and by having regard to contemporary guidance and appropriate codes of conduct to ensure accountability, openness and transparency;
- Ensures that the trust has comprehensive governance arrangements in place to guarantee that the resources vested in the Trust are appropriately managed and deployed;
- Ensures that all required returns and disclosures are made to the Regulators;
- Formulates, implements and reviews Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of Trust business;
- Agrees the matters reserved for decision by the Board;
- Ensures proper management of, and compliance with, statutory requirements of the Trust and, ensures the statutory duties of the Trust are effectively discharged;
- Approves the Annual Report, Quality Account and Annual Accounts
- Acts on behalf of the Corporate Trustee for the Trust's charitable funds;
- Conducts an annual appraisal of the Board's effectiveness.

Risk Management and Internal Control

The Board:

- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Ensures that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- Ensures an effective system of integrated governance, risk management and internal control across the whole of the trust's activities;

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Board of Directors Annual Cycle of Business 2024/25
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	For Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Annual Cycle of Business for 2024/25 as per the attachment at Appendix 1.	
EXECUTIVE SUMMARY	The annual cycle of business (Appendix 1) is one of the key components to support the Trust Board in effectively carrying out its role and delivering its purpose. The Trust Board may receive additional reports throughout the year on areas of emerging risk 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.	
PREVIOUSLY CONSIDERED BY	Not Applicable	
	Date	Not Applicable
	Outcome	Not Applicable

1. BACKGROUND AND PURPOSE

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 supporting the Trust Board to effectively carry out its role.

A proposed cycle of business 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 may receive additional reports throughout the year on areas of emerging risk 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.

2. ACTION REQUIRED

The Board of Directors is asked to:

- Approve the Annual Cycle of Business for 2024/25 as per the attachment at Appendix 1.

Board of Directors
Work Programme 2024/25

NHS North West Ambulance Service NHS Trust

	Date of meeting	24.4.24	29.5.24	19.6.25	31.7.24	25.9.24	27.11.24	29.1.25	26.3.25
	Report Deadline	**17.4.24**	**22.5.24**	**12.6.24**	**24.7.24**	**18.9.24**	**20.11.24**	**22.1.25**	**19.3.25**
Agenda Item	**Introduction**								
Minutes of the Previous Meeeting (Chair)			√		√	√	√	√	√
Action Log (Chair)			√		√	√	√	√	√
Committee Attendance (Chair)		√	√		√	√	√	√	√
Declarations of Interest (Chair)		√	√		√	√	√	√	√
Register of Interest (Chair)		√	√		√	√	√	√	√
Annual Cycle of Business (Work Plan)		√							
Patient/Staff Story (Director of Strategy & Planning)			√		√	√	√	√	√
Agenda Item	**Strategy**								
Chairman & Non Executive Directors Update			√		√	√	√	√	√
Chief Executive's Report			√		√	√	√	√	√
Agenda Item	**Governance and Risk Management**								
Chair's Assurance Report - Audit Committee (NED Chair)			√		√		√	√	
Annual Governance Documents (Director of Corporate Affairs)									
Standing Orders, SFIs, SoD, Matters Reserved		√							
Annual Report of Audit, Q&P and Resources Committees		√							
Board of Directors Terms of Reference Approval		√							
Annual Board Evaluation (April 2025)									
Board Assurance Committees Terms of Reference		√							
Annual Audit Letter (Director of Finance)			√						
Annual Report & Accounts (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 (Medical Director)			Annual Report				Bi Annual Report		

Board Assurance Framework (Director of Corporate Affairs)	Quarter 4 Opening Position			Quarter 1		Quarter 2	Quarter 3	
Risk Appetite Statement (Director of Corporate Affairs)								√
Health, Safety, Security and Fire Annual Report (Director of Corporate Affairs)		√						
Annual Staff Survey Results (Director of People)								√
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)				√				
NHSE Flu Letter / Annual Flu Campaign (Director of People)					√			
Learning from Deaths (Medical Director)				Quarter 4	Quarter 1		Quarter 2	Quarter 3
Quality, Patient Safety, Effectiveness and Experience **Annual Reports** (Director of Quality, Innovation and Improvement)								
Safeguarding		√						
DIPC					√			
Senior Information Risk Owner Annual Report		√						
Complaints Annual Report (Director of Corporate Affairs)		√						
Quality Account (Director of Quality, Innovation and Improvement)			√					
Modern Slavery Act 2015 Statement (Director of Finance)								√
Emergency, Preparedness, Resilience and Response (EPRR) Bi Annual Assurance (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)					√			

Equality, Diversity and Inclusion (Director of People)		Annual Report		EDI Regulatory reports, WRES, WDES, Gender Pay				
Health and Wellbeing Annual Report (Director of People)				√				
Approach to Planning (Director of Strategy & Planning)	**To be confirmed on an annual basis**							
Strategy and Planning **Agenda Item**								
Communications Update (Director of Strategy, Partnerships and Transformation)		√				√	√	√
CQC Update: As required (Director of Quality, Innovation and Improvement)								
Bi Annual Assurance Report - Stakeholder Engagement				√			√	
Consent Agenda **Agenda Item**								
Policies and Strategies: As required								

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Trust Governance Structure
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is asked to: • Approve the Trust Governance Structure.
EXECUTIVE SUMMARY	Following recent Board Development sessions and work done with all Board Members, the Trust's integrated governance structure was reviewed with the following objectives: • A reduction in the layers of Board Assurance • Refocus of the Board Committees' business – the fundamentals • Improvement in link between executive assurance and Board assurance It is important to note that the fundamentals of the governance model remain the same, with the Board retaining oversight, delegation to the CEO/Execs, as well as maintaining individual accountability of key roles as per any regulatory expectation.
PREVIOUSLY CONSIDERED BY	• Executive Leadership Committee • Chair and Non-Executive Directors
	Date: 6th December 2023 and 5th February 2024
	Outcome: Recommended for Board approval

Governance Structure Showing Levels of Assurance, Escalation and Risk

Receives assurance, provides challenge and strategic leadership, holds to account for performance and standards

Seeks & receives assurance, provides challenge, escalates risks to Board. (do not make operational decisions)

Provides strategic leadership, holds to account for delivery, unblocks and assists with problem solving

Seeks assurance, provides challenge & leadership on specific issues, escalates risks & issues to leadership team

Reviews governance & management of risk at a local or service level. Provides information & assurance to leadership, escalates risks & emerging issues

Board of Directors
Chair: PW
Vice Chair: AC
Meets: Bi-monthly

- NARC — Chair: PW; Vice Chair: AC; Meets: As needed
- Charitable Funds Committee — Chair: NED (DW); Meets: Quarterly
- Audit Committee — Chair: NED (DW); Meets: Quarterly
- Quality & Performance Committee — Chair: NED (AE); Meets: Monthly
- Resources Committee — Chair: NED (DH); Meets: Bi-monthly

ELC

Trust Management Committee
Chair: CEO
Dep: Dep CEO
Meets: Monthly

- Planning Group — Chair: Dep CEO; Dep: tbc; Meets: Quarterly
- Corporate Programme Board — Chair: CEO; Dep: DepCEO; Meets: Monthly

- **Sustainability Group** — Chair: DoF; Dep: HOF&L; Meets: Quarterly
- **People & Culture Group** — Chair: DoP; Dep: DepDoP; Meets: Bi-monthly
- **Clinical & Quality Group** — Chair: MD; Dep: ADON&Q; Meets: Bi-monthly
- **Information & Cyber Gov Group** — Chair: DQII; Dep: CIO; Meets: Quarterly
- **HSS&F Group** — Chair: DoCA; Dep: Asst Dir Legal ….; Meets: Bi-monthly
- **D&I Group** — Chair: Dep CEO; Dep: DoP; Meets: Bi-monthly
- **EPRR Group** — Chair: DOps; Dep: Asst Dir Resilience; Meets: Quarterly

Local & service level governance groups

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Board Assurance Committee Terms of Reference
PRESENTED BY	Angela Wetton, Director of Corporate Affairs
PURPOSE	For Decision

LINK TO STRATEGY	All Strategies									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☒	**SR03**	☒	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☒	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☒	Quality Outcomes	☒	People	☒
	Financial/ Value for Money	☒	Reputation	☒	Innovation	☒

ACTION REQUIRED	The Board of Directors is recommended to: • Approve the Terms of Reference for all Board Assurance Committees.
EXECUTIVE SUMMARY	In accordance with Section 4 of the Committee Terms of Reference, an annual review of the Terms of Reference has been undertaken and any changes have been made in conjunction with the Committee Chairs. 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 • Trust Management Committee
PREVIOUSLY CONSIDERED BY	Not applicable
	Date: Not Applicable
	Outcome: Not Applicable

TERMS OF REFERENCE

NHS
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AUDIT COMMITTEE

CONTENTS

1. COMPOSITION

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 provide an assurance report to the Board of Directors based on the 3A model. 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.

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 Chair~~man~~ 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 Director of Quality, Innovation and Improvement or the Medical Director will attend for clinical governance agenda items.~~

~~However, a~~At least once a year, the Committee should meet privately with the internal and external auditors and the Local Counter Fraud Specialist without the presence of the Executives. Additional meetings may be scheduled to discuss specific issues if required.

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.

Access

The Head of Internal Audit and representative for External Audit have a right of direct access to the chair of the committee, this also extends to the local counter fraud specialist.

Quoracy

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

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.

Meeting frequency

The Committee will meet on a quarterly basis and will hold a minimum of six meetings per year in order to allow it to discharge all of its responsibilities to review the draft Annual Accounts, Annual Governance Statement and Annual Report.

To assist in the management of business over the year an annual work plan will be maintained, capturing the main items of business at each scheduled meeting.

Meeting Support

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

2. REMIT OF THE GROUP

The remit of the Committee is as follows:

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:

- ~~consideration~~ considering~~of~~ the provision of the internal audit service and the costs involved
- 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
- ~~consideration of~~considering the major findings of internal audit work (and management's response) and
- ensuring co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
- completing an annual review of the effectiveness of internal audit and monitoring their effectiveness

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness 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:

- ~~consideration of~~considering 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)

- 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.
- discussion with the external auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- 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

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:

- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- Letters of Representation
- Explanations for significant variances

Integrated Governance, risk management and internal control

The Committee shall review the adequacy and effectiveness~~establishment and maintenance~~ of the ~~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:

- 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
- the underlying assurance processes that indicate the degree of the achievement of ~~corporate~~ strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, include the NHS Code of Governance and NHS Provider Licence ~~related reporting and self-certification~~
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by ~~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, where relevant to the ~~and consider the implications for the~~ governance, risk management and assurance of the organisation. These ~~will~~ may include, but will not be limited to:

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

As part of its integrated approach, the Committee will have effective relationships with other key committees (Quality and Performance Committee ~~the~~ and Resources Committee~~) and Information Governance sub committee)~~ to understand processes and to ~~, 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.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

~~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 (for example compliance reviews or accreditation reports) ~~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:

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

System for raising concerns
The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance regulatory compliance
The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS code of governance and the fit and proper persons test process.

The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Behaviours and conduct – Trust Values

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's constitution, standing orders, and standards of business conduct policy.

Equality and diversity
Members must demonstrably consider the equality and diversity implications of decisions they make.

Accountability and reporting
The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements

- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

The annual report should also describe how the committee has fulfilled its terms of reference and provide details of any significant issues considered by the Committee in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the Committee and Board of Directors. The Audit Committee will review these terms of reference on an annual basis and recommend any changes to the board.

TERMS OF REFERENCE

NHS
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Charitable Funds Committee

CONTENTS

1. COMPOSITION

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 provide a 3A assurance report to the Board of Directors/Corporate Trustee after each meeting. 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/Corporate Trustee will record such decisions.

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~~ Chief Operating Officer/Deputy Chief Executive
- 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.

Quoracy

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.

Other officers of the trust shall attend at the request of the Committee in order to present and provide clarification on agenda items.

Meeting frequency

The Group will meet on a quarterly basis.

Meeting Support

The Committee will be supported administratively by a member of the Corporate Governance Team, who will agree the agenda with the Chair, collate the papers and produce minutes from the meeting within 48 hours of the meeting.

2. REMIT OF THE GROUP

The Committee will:

- ❖ 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.

TERMS OF REFERENCE

NHS
North West
Ambulance Service
NHS Trust

Nominations and Remuneration Committee (NARC)

CONTENTS

1. COMPOSITION

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.

Membership

- Chair 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 Chair, 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.

Quoracy

The required quorum for the transaction of business shall be the Chair and at least two members.

Other officers of the trust shall attend at the request of the Committee in order to present and provide clarification on agenda items.

Meeting frequency

The Group will meet on a bi-monthly ~~XXX~~ basis or as required.~~.~~

Meeting Support

The Group will be supported administratively by either the Director of Corporate Affairs or the Head of Corporate Governance, who will agree the agenda with the Chair, collate the papers and produce action minutes from the meeting within 48 hours of the meeting.

2. REMIT OF THE GROUP

The Committee will:

- 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 NHSE~~I~~.
- 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 NHSE~~I~~ 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

TERMS OF REFERENCE

NHS
North West Ambulance Service
NHS Trust

QUALITY AND PERFORMANCE COMMITTEE

CONTENTS

1. COMPOSITION

Role and purpose

The Quality and Performance Committee has been established as a formal Committee of the Board of Directors. The Quality and Performance Committee (hereinafter referred to as 'the Committee') has no executive powers.

The purpose of the Committee is to provide assurance relating to all aspects of quality, safety and operational performance including delivery, governance, clinical risk management, research and 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 provide a report to the Board of Directors after each meeting based on the 3A model.

Membership

- Three Non-Executive Directors – one of whom shall be the nominated Chair and one with relevant clinical experience.
- Director of Quality, Innovation, and Improvement
- Medical Director
- Chief Operating Officer/Deputy Chief Executive
- 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

Quoracy
The required quorum for the transaction of 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 and Improvement or the Medical Director.

Meeting frequency
The Committee will meet bimonthly.

Meeting Support
The Committee will be supported administratively by a member of the Corporate Governance Team, who will agree the agenda with the Chair, collate the papers and produce minutes within 48 hours of the meeting.

2. REMIT OF THE COMMITTEE

The Committee will:

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, (e.g. the Kirkup Maternity Review) as well as those made internally, (e.g. 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.

TERMS OF REFERENCE

NHS
North West Ambulance Service
NHS Trust

RESOURCES COMMITTEE

CONTENTS

1. COMPOSITION

Role and purpose

The Resources Committee has been established as a formal Committee of the Board of Directors. The Resources Committee (hereinafter referred to as 'the Committee') has no executive powers.

The purpose of the Committee is to provide assurance relating to all aspects of Trust business, and 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 provide a report to the Board of Directors after each meeting based on the 3A model.

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
- Chief Information Officer
- Head of Strategy, Planning & Transformation
- ~~Assistant Director of Estates and Fleet~~ Head of Estates
- Head of Fleet and Logistics
- Head of Procurement

Quoracy
The required quorum for the transaction of business shall be five, which is to include at least two Non-Executive Directors, which may include an Associate Non-Executive Director.

Meeting frequency
The Committee will meet bi-monthly.

Meeting Support
The Committee will be supported administratively by a member of the Corporate Governance Team, who will agree the agenda with the Chair, collate the papers and produce minutes within 48 hours of the meeting.

2. REMIT OF THE COMMITTEE

The Committee will:

- Inform the development and provide assurance against the following Trust strategies, associated policies, action plans and annual reports:
  - Our Strategy
  - Digital Strategic Plans
  - Estates, ~~Fleet~~ and ~~Facilities Management~~ Fleet strategic plans
  - Workforce Strategy
  - Procurement compliance
  - 3 Year Implementation Roadmap
  - Long Term Financial Model
  - Financial Plan
  - Annual Plan (incl. financial and operational plans)

- 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.

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

Finance, Investment and Planning

- Review the financial elements of the Trust's Business Plan and ensure that key assumptions are both realistic and achievable (the Board of Directors will remain responsible for approval of the Business Plan).

- Monitor the ongoing financial performance of the Trust, the financial forecast, and the key

financial risks.

- 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 £1,000,000.
- Monitor delivery of efficiency programmes and seek assurance on the preparation of comprehensive programmes for subsequent years.
- Review tender bids in relation to Patient Transport Services, 111 Service and any other clinical or commercial venture under consideration by the Board and assess the financial implications of performanceagainst the Trust's statutory purpose.
- Review contract award proposals (in line with the Scheme of Delegation and Standing Financial Instructions) and make appropriate recommendations to theBoard of Directors
- Recommend projects over £1,000,000 to the Board of Directors for approval.
- Seek assurance in relation to fleet activity including vehicle servicing and inspections, insurance, vehicle replacement programme, carbon reductionstrategy and waste assurance.
- Receive assurance in relation to estates including NHS sites, progress against Net Zero Strategy and Benchmark measures utilising the "Model Ambulance".
- Review business and commercial development proposals, for recommendationto the Board of Directors.

Digital

- 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.
- Review the recommendations from any external reviews in relation to digital andmonitor progress on major schemes.

Workforce

- Seek assurance on the development and delivery of comprehensive workforceplans.
- Receive assurance relating to performance against key workforce indicators such as: sickness absence, appraisal review, mandatory training, and turnover.
- Seek assurance on the development of the recruitment, training, and management of volunteers.

- 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.

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

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

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

Strategy, Planning and Transformation

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

    - 3 Year Strategy implementation/transformation roadmap.
    - Supporting Strategies including development, alignment, and implementation.
    - Annual Planning Cycle including –
    - Development of trust-level annual plan and directorate business plans
    - Alignment between strategy and strategic risk management
    - Alignment between strategy and operational planning (incl. any external submissions)
    - Quarterly assurance against objectives (incl. achievements and learning)
    - 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.

TERMS OF REFERENCE

NHS
North West
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TRUST MANAGEMENT COMMITTEE

CONTENTS

1. COMPOSITION

Role and purpose

The Trust Management Committee (hereinafter referred to as 'the Committee) has been established by the Trust Board and has executive powers as defined within the Trust's Standing Financial Instructions and Scheme of Reservation & Delegation.

The purpose of the Committee is to provide the Board with assurance concerning all aspects of delivering the Trust's operations and strategic direction along with any associated operational plans.

The Chair of the Committee will provide a report to the Board of Directors after each meeting based on the 3A model.

Membership

- Chief Executive (Chair)
- Deputy CEO (Deputy Chair)
- Director of Quality, Innovation and Improvement
- Director of Operations
- Director of Finance
- Medical Director
- Director of People
- Director of Corporate Affairs
- 4 x Area Directors (GM, C&L, C&M, ICC)
- Chief Consultant Paramedic
- Chief Information Officer
- Assistant Director of Nursing and Quality (DIPC)

Quoracy

The required quorum for the transaction of business shall be eight including either the Chair/Deputy Chair, plus at least four other Executive Directors and 3 other members.

Other officers of the trust shall attend at the request of the Committee in order to present and provide clarification on agenda items.

Meeting frequency
The Committee will meet on a monthly basis.

Meeting Support
The Group will be supported administratively by a member of the Executive Business Support Team who will provide minutes within 48 hours of the meeting. The Corporate Governance team will agree the agenda with the Chair, collate and circulate the papers five days before the meeting.

2. REMIT OF THE COMMITTEE

The Committee will:

- Monitor the delivery of the overall Trust Strategic goals and plans.
- Monitor progress with in-year implementation plans of key Trust strategies including – Quality Strategy, People Strategy, Service Delivery Strategy
- Monitor Trust performance across all key metrics (dashboards)
- Approve business cases to deliver key Trust strategic objectives and business plan which are ≤£1m and recommend to the Board of Directors via Resources Committee, any >£1m.
- Receive regular updates from Executive Directors to ensure effective operational integration with the following:
  - Trust policy & strategy
  - National & local strategies, policies and developments
  - Legal issues
- Review the Corporate Risk Register on a monthly basis to be assured on the proactive management and escalation of risks.
- Agree the Board Assurance Framework on a quarterly basis prior to submission to the Board of Directors
- Receive 3A reports from the following Executive led groups:
  - People and Culture Group
  - Diversity and Inclusion Group
  - Information and Cyber Governance Group
  - Clinical and Quality Group
  - Health, Safety, Security and Fire Group
  - Sustainability Group
  - Emergency Preparedness, Resilience and Response (EPRR) Group

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Quality and Performance Committee Annual Report 2023/24
PRESENTED BY	Prof A Esmail, Chair of the Quality and Performance Committee
PURPOSE	Assurance

LINK TO STRATEGY	Quality Strategy									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☒	**SR02**	☐	**SR03**	☒	**SR04**	☐	**SR05**	☐
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☒	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Vale for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Review the Quality and Performance Committee Annual Report for 2023/24. • Note the amendments to the Committee Terms of Reference for 2024/25 presented under separate cover.
EXECUTIVE SUMMARY	Section 4 of the current terms of reference requires that the Committee evaluates and reviews its own effectiveness and performance and recommends any changes to the Board of Directors for approval. The terms of reference have been reviewed and the following amendments have been made – • The frequency of meetings. The Committee effectiveness review highlighted that the group has met its remit and functions. However, key areas of focus have been identified: • To develop triangulation of data presented over time, and across other Committees. • Some papers are too operational and should be directed to the Executive Leadership Committee rather than the Committee.

	• Improvement to the delivery of papers - authors presenting papers should be briefed by their executive leads on the need to be succinct and concise. • Continued monitoring of the effectiveness of PSIRF reporting.	
PREVIOUSLY CONSIDERED BY	Quality and Performance Committee	
	Date	Monday, 25 March 2024
	Outcome	Recommended to the Board of Directors

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 2023 to 31st March 2024 and to set out how it has met its terms of reference and priorities.

2. REVIEW OF EFFECTIVENESS

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 SUB 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 April and June meetings, when agenda items were deferred to the next meeting.

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 2023/24 all functions set out within the Terms of Reference have been discharged.

The following points should be noted by the Board –

Board Assurance Framework and Strategic Risks:

The Committee has continued to receive and monitor the Board Assurance Framework risks and considered monthly progress made. Discussion and challenge regarding the risks aligned to the Committee has matured and risk has been triangulated with the content of Integrated Performance Reports.

Integrated Performance Report and Quality Dashboard

The Committee has received the IPR and Quality Dashboard reports. These continue to provide a key focus for members and facilitate scrutiny and debate, particularly in relation to performance, demand pressures, complaints, and patient safety activity.

Chairs Assurance Reports

Chairs Assurance Reports have continued to reflect the challenges facing the organisation and assurances presented to the Board of Directors.

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

The Committee has received quarterly reports in relation to patient safety, serious incidents, learning from deaths and legal services activity. In addition, the Committee has received updates on the Patient Safety Incident Response Framework (PSIRF).

Health, Safety, Fire and Security, IPC, 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.

6. KEY AREAS OF FOCUS FOR THE COMMITTEE DURING 2024/25 –

- To develop triangulation of data presented over time, and across other Committees.
- Some papers are too operational and should be directed to the Executive Leadership Committee rather than the Committee.
- Improvement to the delivery of papers - authors presenting papers should be briefed by their executive leads on the need to be succinct and concise.
- Continued monitoring of the effectiveness of PSIRF reporting.

7. TERMS OF REFERENCE

The Terms of Reference have been reviewed by the Quality and Performance Committee at their meeting on 25th March 2024 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 obligations directly associated with the content of this report.

9. EQUALITY OR SUSTAINABILITY IMPACTS

None Identified.

10. ACTION REQUIRED

The Board of Directors is recommended to:

- Review the Quality and Performance Committee Annual Report for 2023/24.
- Note the amendments to the Committee Terms of Reference for 2024/25 presented under separate cover.

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REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Resources Committee Annual Report 2023/24
PRESENTED BY	Dr D Hanley, Chair of the Resources Committee
PURPOSE	Assurance

LINK TO STRATEGY									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☒	**SR03**	☐	**SR04**	☒	**SR05**	☒
	SR06	☒	**SR07**	☒	**SR08**	☒	**SR09**	☐	**SR10**	☒

Risk Appetite Statement *(Decision Papers Only)*						
	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Board of Directors is asked to: • Review the Resources Committee Annual Report for 2023/24. • Note the amendments to the Committee Terms of Reference for 2024/25 presented under separate cover for Board approval.
EXECUTIVE SUMMARY	Section 4 of the current terms of reference requires that the Committee evaluates and reviews its own effectiveness and performance and recommends any changes to the Board of Directors for approval. The terms of reference have been reviewed and the following amendments have been made – • Quoracy • Remit of the Committee - Updates to assurance reporting 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: • Equal Non-Executive Director and Executive Director challenge during meetings. • To adopt a broader approach to deep dives. • More frequent re-ordering of agenda items.
PREVIOUSLY CONSIDERED BY	Resources Committee

Date	Friday, 22 March 2024
Outcome	Recommended to the Board of Directors

1. BACKGROUND

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 2023 to 31st March 2024 and to set out how it has met its terms of reference and priorities.

2. 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.

3. COMMITTEE MEMBERSHIP AND ATTENDANCE

Meetings of the Committee have been held as scheduled in the corporate calendar, except for the September meeting, which was rescheduled to the following week, due to annual leave commitments. There have been no instances where a quorum was not present.

4. 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 –

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.

Leadership and meetings

Members felt overall the effectiveness of the committee and the Chair's role had worked well during the year and noted -

- agendas more focused and manageable.
- an overall positive improvement in the openness of the Committee, and the balance of support and challenge has improved.
- an improvement at ensuring the committee's wide remit did not lead to an overwhelmingly long agenda with meetings more focused and managed.

Deep Dives

Although deep dives were commissioned during the year, there was a comment that deep dives could be more focused on the Board Assurance Framework (BAF) risks.

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.

The Committee has maintained oversight of productivity and efficiencies.

Fleet, Estates and Facilities Management

The committee received regular updates in relation to estates, fleet, and facilities management, including vehicle replacement programmes and sustainability assurances.

Strategy

The committee has received comprehensive updates from the Chief Operating Officer & Deputy Chief Executive on Trust Strategy and annual plans, supported by quarterly assurance reports.

Sub Committee Assurances

The committee received Chairs Assurance Reports from the Strategic Workforce Sub Committee and Diversity and Inclusion Sub Committee.

5. COMMITTEE IMPROVEMENTS FOR 2024/25

The 2023/24 annual effectiveness review highlighted the following areas for improvement during 2024/25 –

- Equal Non-Executive Director and Executive Director challenge during meetings.
- To adopt a broader approach to deep dives.
- More frequent re-ordering of agenda items.

6. TERMS OF REFERENCE

The terms of reference have been reviewed by the Resources Committee at the meeting held on 22nd March 2024 and presented to the Board of Directors for approval.

7. RISK CONSIDERATION

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.

8. EQUALITY/ SUSTAINABILITY IMPACTS

None identified.

9. ACTION REQUIRED

The Board of Directors is asked to:

- Review the Resources Committee Annual Report for 2023/24.
- Note the amendments to the Committee Terms of Reference for 2024/25 presented under separate cover for Board approval.

North West Ambulance Service NHS Trust

REPORT TO THE BOARD OF DIRECTORS

DATE	Wednesday, 24 April 2024
SUBJECT	Audit Committee Annual Report
PRESENTED BY	Mr D Whatley, Chair of Audit Committee
PURPOSE	Assurance

LINK TO STRATEGY	Not Applicable									
BOARD ASSURANCE FRAMEWORK (BAF)	**SR01**	☐	**SR02**	☒	**SR03**	☐	**SR04**	☐	**SR05**	☐
	SR06	☒	**SR07**	☐	**SR08**	☐	**SR09**	☐	**SR10**	☐

Risk Appetite Statement *(Decision Papers Only)*	Compliance/ Regulatory	☐	Quality Outcomes	☐	People	☐
	Financial/ Value for Money	☐	Reputation	☐	Innovation	☐

ACTION REQUIRED	The Audit Committee is asked to: • Note the Audit Committee Annual Report 2023/24.	
EXECUTIVE SUMMARY	The Audit Committee Annual Report provides information on how the Audit Committee met its Terms of Reference during the 2023/24 financial year.	
PREVIOUSLY CONSIDERED BY	Audit Committee	
	Date	Friday, 19 April 2024
	Outcome	Approved

DELIVERING THE RIGHT CARE,
AT THE RIGHT TIME,
IN THE RIGHT PLACE;
EVERY TIME.

Audit Committee Annual Report 2023/24

Introduction
This report provides information on the how the Audit Committee has met its Terms of Reference during the 2023/24 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 2023 to 31 March 2024.

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 21 April 2023.

Committee Members and Attendance
During 2023/24 the Audit Committee consisted of the following members:

Committee Member		**Attendance**
Mr D Rawsthorn	Non-Executive Director (Chair)	6/6
Dr A Chambers	Non-Executive Director	6/6
Prof A Esmail	Non-Executive Director	6/6
Mrs C Butterworth	Non-Executive Director	6/6
Mr D Whatley	Associate Non-Executive Director (Audit Chair Designate)	6/6

The Committee met on the following occasions during 2023/24:

21 April 2023
19 May 2023
21 June 2023
21 July 2023
20 October 2023
19 January 2024

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 Committee continued to receive Chair's Assurance Reports from the Information Governance Sub Committee during the year, further strengthening assurances received in relation to data quality and cyber security arrangements.

Board Assurance Framework (BAF) & Risk Management
During the year the Trust continued to develop and embed the BAF and risk management arrangements by providing a supportive framework to embed risk management into policy making, planning and decision making processes across the Trust.

The Committee 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 2023/24 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 receive the chair's assurance reports from the Quality and Performance Committee. In addition, the Committee continued to receive quarterly updates against the Clinical Audit Plan. Either the Medical Director or the Director of Quality, Innovation and Improvement attended the committee for consideration of clinical governance matters.

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 recommendations have been completed, are presented to the Committee by Internal Audit at each meeting throughout the year. The Committee acknowledge the positive position relating to management proactively implementing recommendations. Where a 'limited assurance opinion' is issued, the Committee requests attendance from the responsible Senior Management to meetings however during the reporting period there were no limited assurance reports issued. The committee considered all high priority audit recommendations during the year whereby attendance is required by senior managers 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:

5 High Assurance Opinions	**3 Substantial Assurance Opinions**
Fit & Proper Persons	Data Security & Protection Toolkit
Key Financial Transactional Processing Controls	Freedom to Speak Up
Risk Management – Core Controls	Health, Safety & Security Policy
Review of HFMA Improving NHS Financial Sustainability Checklist	
ESR/HR Payroll	
2 Moderate Assurance Opinions	**0 Limited Assurance Opinions**
Clinical Safety Plan	
Duty of Candour	
0 No Assurance Opinions	

MIAA undertook an additional review relating to the Assurance Framework, the review consisted of 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. Processes to update the Assurance Framework are robust and visibly reviewed by the organisation and the Audit Committee and that the organisation's objectives are subject to review and update;
- The organisation considered the risk appetite regularly and was used to inform the management of the Assurance Framework;
- That the Assurance Framework is visibly used by the organisation;
- The quality and alignment of the Assurance Framework clearly reflects the risks discussed by Board.

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 2023/24, the Head of Internal Audit overall opinion for the period 1 April 2023 to 31 March 2024 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.

Regular progress reports were received from the AFS against the agreed anti-fraud work plan, detailing compliance with counter fraud standard requirements and responses to any referrals/investigations. The Committee also received an annual report providing a summary of the work undertaken during the year.

The Trust is required to submit an annual statement of assurance against the Counter Fraud Functional Standard Return (CFFSR). 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 return is completed by the Anti-Fraud Specialist, reviewed and authorised by the Director of Finance and the Chair of the Audit Committee. Confirmation of the submission is made by the Anti-Fraud

Specialist (AFS) on behalf of the Trust is reported to the Audit Committee. Compliance ratings against each component of the CFFSR was assessed as green.

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 2023/24 financial year and will report on the 2023/24 Annual Report and Financial Statements. The audit for the financial year 2023/24 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 19 June 2024, 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 Q1 2024/25, MIAA will carry out the self-assessment and report the findings to the July 2024 Committee meeting.

Members of the Audit Committee met privately with external auditors in April 2023 and internal auditors in July 2023.

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 24th April 2024 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 Whatley
Non-Executive Director
Audit Committee Chair 19th April 2024

APPENDIX 1 - REPORTS TO THE AUDIT COMMITTEE DURING 2023/24

Management Reports

Quarterly Board Assurance Framework Reports

Opening Position of the Board Assurance Framework 2022/23

Risk Management Policy

Quarterly Losses and Compensation Reports

Estates Revaluation 2022/23

Accounting Policies for 2022/23

Annual Review of Core Governance Documents

Audit Committee Annual Report 2022/23

Audit Committee Terms of Reference

Declarations of Interest, Gifts & Hospitality Annual Report 2022/23

FT Code of Governance Compliance Declaration

Waiver of Standing Orders Quarterly Reports

MIAA 2023/24 Checklist Series:

- Pre-employment Checks
- Fit and Proper Persons Test

Chairs Assurance Reports from:

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

Information Governance Sub Committee Annual Report and Terms of Reference

Quarterly Clinical Audit Updates

Draft and Audited Accounts 2022/23

Annual Report 2022/23

Annual Governance Statement 2022/23

Letter of Representation

SIRO Annual Report

Annual Risk Management Report

Reports produced by Mazars, External Auditors

Audit Progress and Technical Updates

Audit Completion Report

Auditors Annual Report

Audit Strategy Memorandum

Reports produced by MIAA

Internal Audit Progress Reports

Internal Audit Work Plan 2023/24

Head of Internal Audit Opinion

Follow Up Reviews

Limited Assurance Reports

Critical and High Risk Recommendations Overdue

Internal Audit Charter

Reports produced by the Anti-Fraud Specialist

Anti-Fraud Progress Reports

Anti-Fraud Annual Report 2022/23 including Self Review Toolkit (SRT) Ratings

Anti-Fraud Annual Work Plan 2023/24